Office of the Chief Coroner
Bureau du coroner en chef

NORTHWEST TERRITORIES CORONER SERVICE

2024 ANNUAL REPORT

If you would like this information in another official language, call us.
Anglais

Si vous voulez ces informations dans une autre langue officielle, contactez-nous.
Français

Kīspin ki nitawihtīn ē nīhīyawihk ōma ācimōwin, tipwāsinān.
Cree

Tłı̨chǫ yatı k'ę̀è. Dı wegodı newǫ dè, gots'o gonede.
Tłı̨chǫ

ʔerıhtł'ís Dëne Sųłıné yatı t'a huts'elkër xa beyáyatı theɂą ɂat'e, nuwe ts'ën yółtı.
Chipewyan

Edı gondı dehgáh got'ı̨e zhatıé k'ę́ę́ edatł'éh enahddhę nıde naxets'é edahłí.
South Slavey

K'áhshó got'ı̨ne xǝdǝ k'é hederı ɂedı̨htl'é yerınıwę nídé dúle.
North Slavey

Jii gwandak izhii ginjìk vat'atr'ijąhch'uu zhit yinohthan jì', diits'àt ginohkhìi.
Gwich'in

Uvanittuaq ilitchurisukupku Inuvialuktun, ququaqluta.
Inuvialuktun

ᑖᑦᓱᐊ ᑎᑎᕐᒃᑲᐃᑦ ᐱᔪᒪᒍᕕᒋᑦ ᐃᓄᒃᑎᑐᓕᕐᒃᓯᒪᓗᑎᒃ, ᐅᕙᑦᑎᓐᓄᑦ ᐅᖄᓚᔪᓐᓇᖅᑐᑎᑦ.
Inuktitut

Hapkua titiqqat pijumagupkit Inuinnaqtun, uvaptinnut hivajarlutit.
Inuinnaqtun

Langues autochtones :

Français :
867-767-9348
866-561-1664 (sans frais)

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INTRODUCTION

The Coroner Service falls under the Territorial Department of Justice for administrative purposes and operates pursuant to the authorities conveyed by the *Coroners Act*, which was initially enacted in 1985 but has been subject to amendment since. The Office of the Chief Coroner is located in Yellowknife and oversees all death investigations. As of December 31, 2023, there were 19 coroners throughout the Northwest Territories, providing service in the communities and regions in which they reside.

All sudden and unexpected deaths occurring in the Northwest Territories must be reported to a coroner. The Coroner Service is responsible for the investigation of reportable deaths in order to determine the identity of the deceased, and the facts concerning when, where, how, and by what means they came to their death. The Coroner Service is supported in its efforts by the Royal Canadian Mounted Police, the Fire Marshal's Office, the Workers' Safety and Compensation Commission, the Transportation Safety Board, and various other agencies that also work closely with the Service.

The Chief Coroner is Garth Eggenberger. Mr. Eggenberger has been with the Coroner Service since 1987.

There are no facilities in the Northwest Territories staffed to perform autopsies. When an autopsy is required, the remains are transported to Edmonton, where the procedure is performed by the Chief Medical Examiner's Office. Following the post-mortem examination, the remains are sent to Foster and McGarvey Funeral Home, which holds a contract for preparation and repatriation. Toxicology services are provided to the Coroner Service by the Graham R. Jones Forensic Toxicology Laboratory.

HISTORY OF CORONER SERVICE

The office of the Coroner is one of the oldest institutions known to English law. The role of the "coroner" in England has been noted in references dating back to the time of the Saxon King Alfred in 925 A.D, but the evolution of the office is more evident after the Norman Conquest, when the coroner played an important role in the administration of justice.

It is generally accepted that the office was not regularly instituted until the end of the 12th century. One of the first statutes concerning coroners was the Statute of Westminster of 1276. The title of the office has varied from "coronator" during the time of King John to "crowner" a term still used occasionally in Scotland.

One of the earliest functions of the coroner was to inquire into sudden and unexpected deaths. The coroner was charged with the responsibility of establishing the facts surrounding a death - a duty that provides the basis for all coroner systems in use today.

The duties of the coroner have been modified over the centuries, but the primary focus continues to be the investigation of sudden and unexpected deaths. The rapid industrialization of the 19th century and the associated increase in workplace accidents, led to demands that the coroner also serve a preventative function. This remains an important responsibility of the Coroner Service.

There are two death investigation systems in Canada: the coroner system and the medical examiner system. The coroner system assigns the coroner four major roles to fulfill: investigative, administrative, judicial, and preventative. The medical examiner system involves medical and administrative elements. The coroner and the medical examiner both collect medical and other evidence to determine the cause and manner of death. The coroner receives the information from a variety of sources before examining the investigative material, determining facts, and coming to a quasi-judicial decision concerning the death of an individual. The coroner can also make recommendations that may prevent similar deaths.

In the Northwest Territories, the Coroner Service provides a multi-disciplinary approach to the investigation of death through the auspices of lay coroners appointed by the Minister of Justice. NWT coroners are assisted by the Royal Canadian Mounted Police, various professionals and other experts when required.

EDUCATION

The NWT Coroner Symposium is held annually to impart the principles of sudden death investigation and to provide continuing education to coroners, health care workers, police officers and others who contribute to the team effort involved in investigating sudden and unexpected deaths in the NWT.

MANNER OF DEATH

The Coroner or an Inquest Jury determines the cause and manner of death. All deaths investigated by the Coroner Service are classified in one of five distinct categories: Natural, Accidental, Suicide, Homicide or Undetermined.

NATURAL - A death which is consistent with the normal or expected course of events, occurring in conformity with the deceased's known or recorded medical history and not caused by any outside event or agency - human or otherwise.

ACCIDENTAL - An unexpected result of an action or actions by a person which results in death to himself or herself, or a death that results from the intervention of a non-human agency.

SUICIDE - A death is a suicide when a person takes his or her own life with intent to do so.

HOMICIDE - A homicide is a death caused directly or indirectly by another person. (Homicide is a neutral term that does not imply fault or blame.)

UNDETERMINED - A death that cannot be classified into one of the above categories is simply classified as "undetermined".

*(**UNCLASSIFIED** is reserved for any case work that ultimately does not result in another classification. It is primarily used for found remains which are analyzed and determined to be of non-human origin.)*

CORONERS ACT – REPORTING DEATHS

Duty to Notify

8. (1) Every person shall immediately notify a coroner or a police officer of any death of which he or she has knowledge that occurs in the Northwest Territories, or as a result of events that occur in the Territories, where the death

(a) occurs as a result of apparent violence, accident, suicide or other apparent cause other than disease, sickness, old age or medical assistance in dying provided accordance with section 241.2 of the *Criminal Code*;

(b) occurs as a result of apparent negligence, misconduct or malpractice;

(c) occurs suddenly and unexpectedly when the deceased was in apparent good health;

(d) occurs within 10 days after a medical procedure or while the deceased is under or recovering from anaesthesia;

(e) occurs as a result of the deceased

(i) having incurred or contracted a disease or sickness,

(ii) having sustained an injury, or

(iii) having been exposed to a toxic substance,

as a result of or in the course of any employment or occupation of the deceased;

(f) is a stillbirth that occurs without the presence of a health care professional;

(g) occurs while the deceased is detained or in custody involuntarily pursuant to law in a jail, lock-up, correctional facility, medical facility or other institution;

(h) occurs while the deceased is detained by or in the custody of a police officer; or

(i) occurs while the Director of Child and Family Services has the rights and responsibilities of a parent under the *Child and Family Services Act* in respect of the person of the deceased.

Exception

(2) Notwithstanding subsection (1), a person need not notify a coroner or a police officer of a reportable death where the person knows that a coroner or police officer is already aware of the death

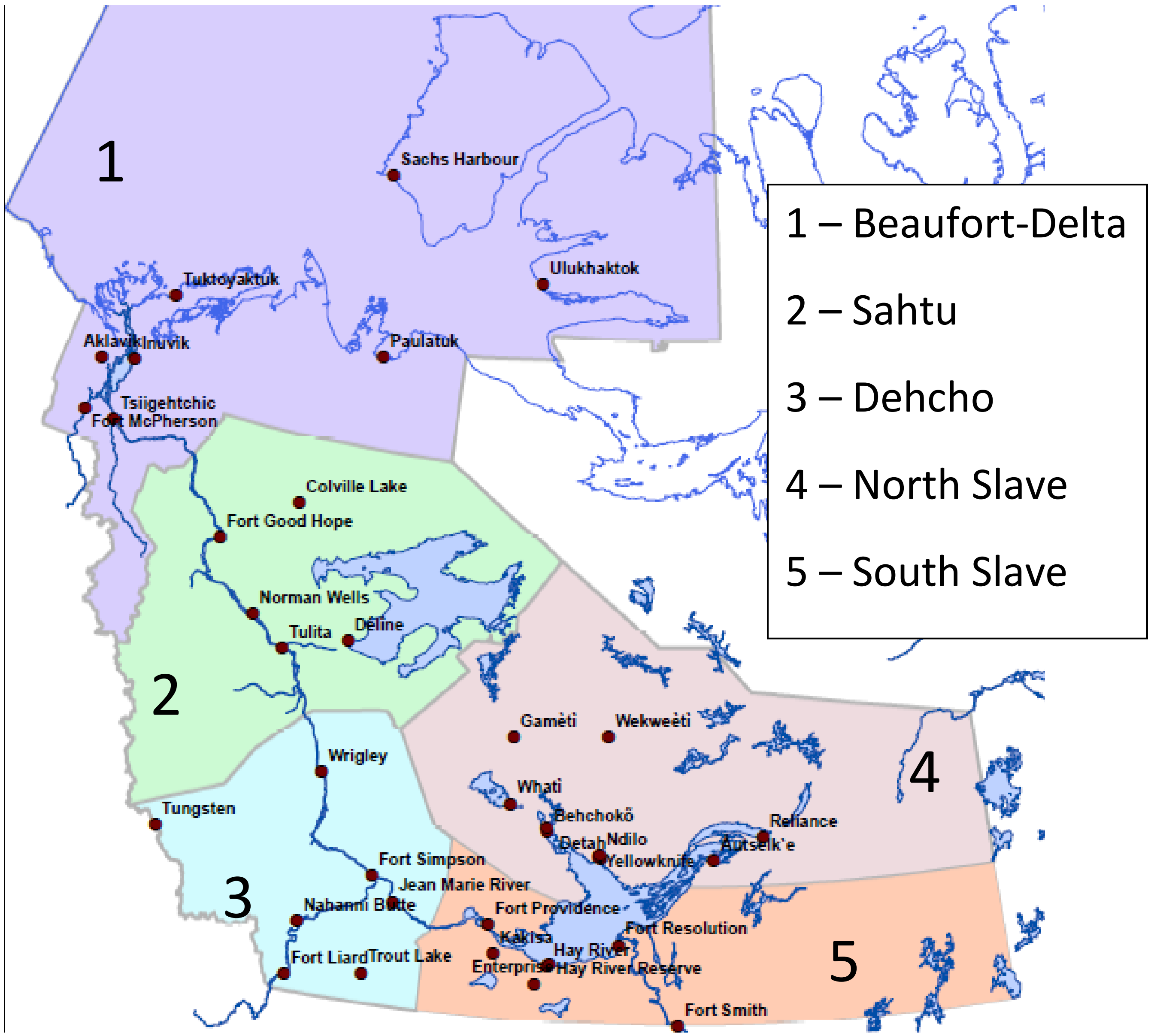
Duty of police officer

(3) A police officer who has knowledge of a reportable death shall immediately notify a coroner of the death.

Special reporting arrangements

(4) The Chief Coroner may make special arrangements with medical facilities, correctional facilities and the Royal Canadian Mounted Police for the efficient notification of reportable deaths by persons in those facilities or that organization. S.N.W.T. 2010,c.16,Sch.A,s.9 (3); S.N.W.T. 2015, c.22,s.5; S.N.W.T. 2017,c.16,s.3(2),(3).

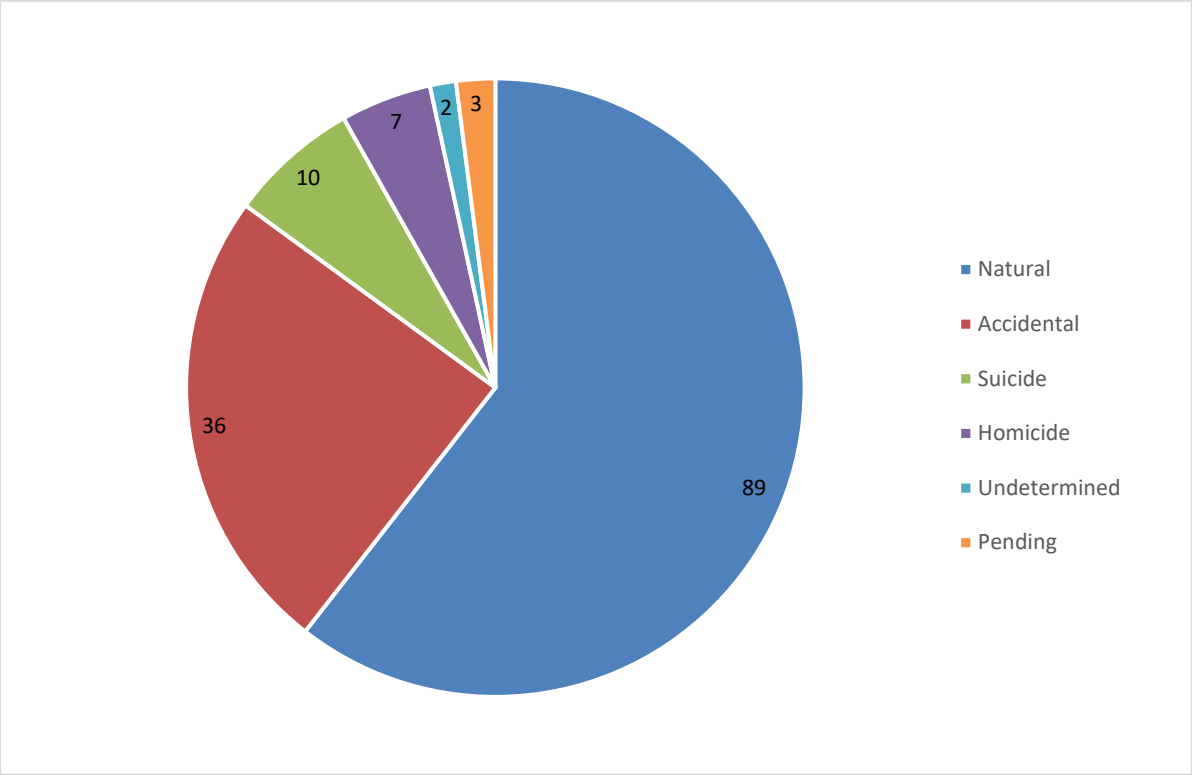
NWT REGIONS


1
2
3
4
5
Sachs Harbour
Ulukhaktok
Tuktoyaktuk
Aklavik
Inuvik
Paulatuk
Tsiigehtchic
Fort McPherson
Colville Lake
Fort Good Hope
Norman Wells
Tulita
Déline
Wrigley
Tungsten
Fort Simpson
Jean Marie River
Nahanni Butte
Fort Liard
Trout Lake
Gamètì
Wekweètì
Whati
Behchokö
Detah
Ndilo
Yellowknife
Reliance
Łutselk'e
Fort Providence
Kakisa
Fort Resolution
Hay River
Enterprise
Hay River Reserve
Fort Smith
1 – Beaufort-Delta
2 – Sahtu
3 – Dehcho
4 – North Slave
5 – South Slave

2024 CASE STATISTICS

TOTAL CASES

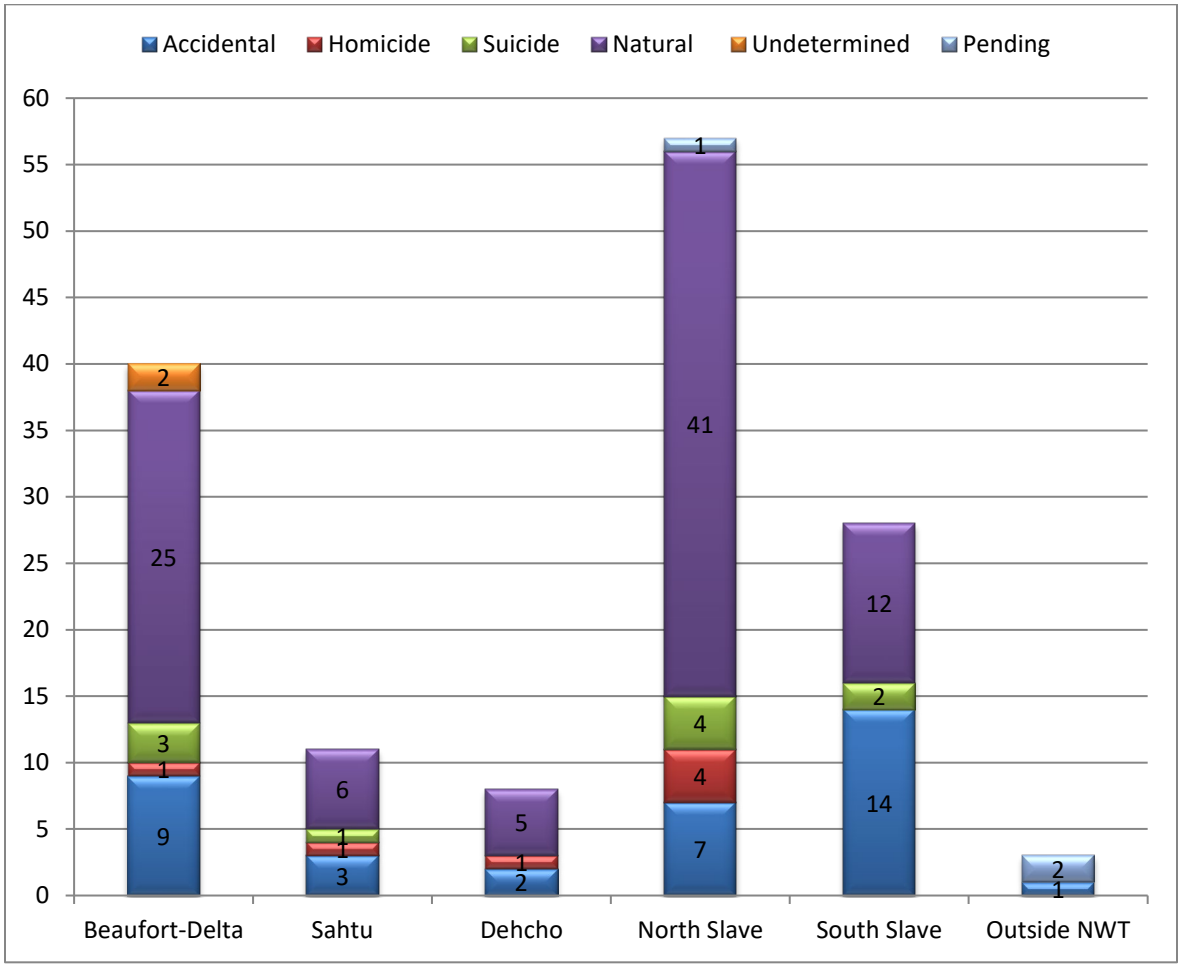
Total Cases			
Manner of Death	Number *	Cases %	Population % **
Natural	89	60.54%	0.1967%
Accidental	36	24.49%	0.0795%
Suicide	10	6.80%	0.0221%
Homicide	7	4.76%	0.0155%
Undetermined	2	1.36%	0.0044%
Pending	3	2.04%	0.0066%
Total	147	100.00%	0.3248%



*The NWT Coroner Service assisted with two Alberta deaths and one Nova Scotia death.
** Based on an NT population estimate of 45,257 retrieved October 21, 2025, at http://www.statsnwt.ca/population/population-estimates/.

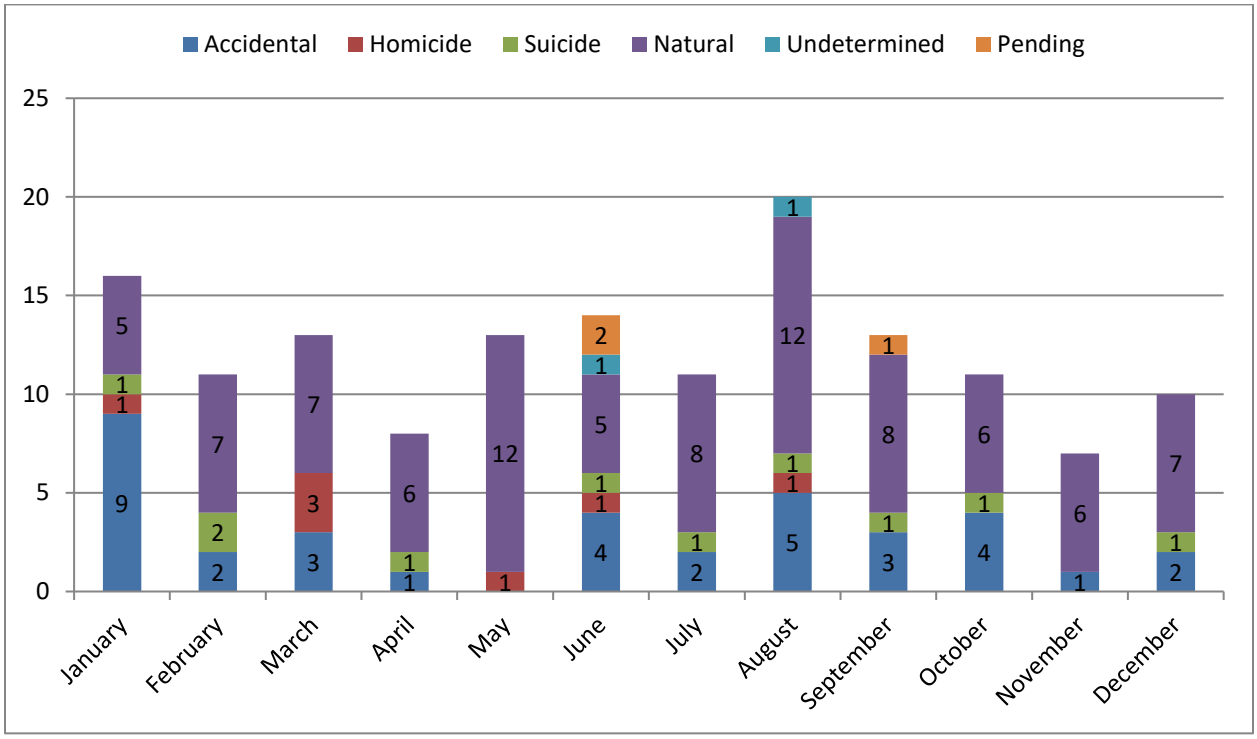
CASELOAD BY MANNER AND REGION

Region	Accidental	Homicide	Suicide	Natural	Undetermined	Pending	Total
Beaufort-Delta	9	1	3	25	2		40
Sahtu	3	1	1	6			11
Dehcho	2	1		5			8
North Slave	7	4	4	41		1	57
South Slave	14		2	12			28
Outside NWT	1					2	3
Total	36	7	10	89	2	3	147



CASELOAD BY MANNER AND MONTH

Month	Accidental	Homicide	Suicide	Natural	Undetermined	Pending
January	9	1	1	5		
February	2		2	7		
March	3	3		7		
April	1		1	6		
May		1		12		
June	4	1	1	5	1	2
July	2		1	8		
August	5	1	1	12	1	
September	3		1	8		1
October	4		1	6		
November	1			6		
December	2		1	7		
Total	36	7	10	89	2	3

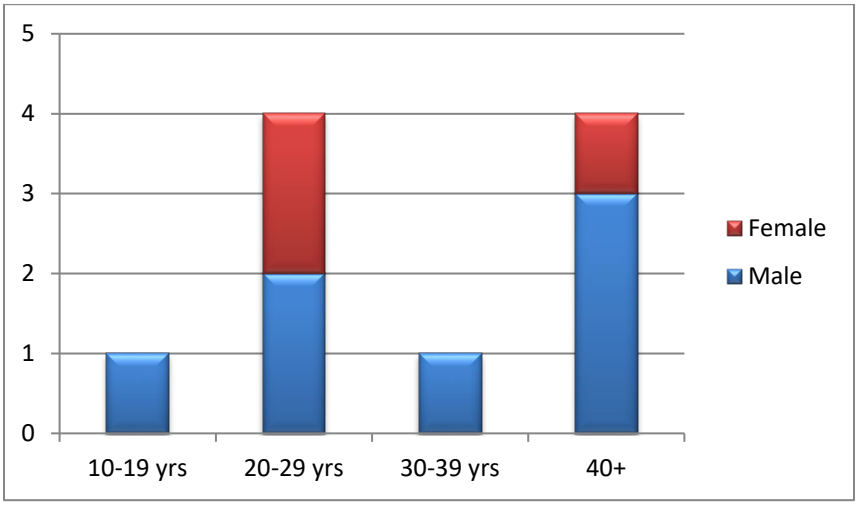


SUICIDE

Suicide refers to any death from a self-inflicted injury where there is apparent intent to cause death. In 2024 there were a total of 10 suicides out of a total of 147 deaths, accounting for 6.8% of deaths that year. Most of these suicides were male.

BY AGE AND GENDER

Age Group	Male	Female	Total
10-19 yrs	1		1
20-29 yrs	2	2	4
30-39 yrs	1		1
40+	3	1	4
Total	7	3	10



SUICIDE CONTINUED

Suicides by Month, Region, Method, Alcohol, and Drug Involvement

Month	Region	Method	Alcohol Involvement	Drug Involvement
January	South Slave	Hanging		Yes
February	North Slave	Carbon Monoxide Poisoning		
February	North Slave	Hanging		
April	Beaufort-Delta	Gunshot Wound		
June	Sahtu	Alcohol & Drug Toxicity	Yes	Yes
July	North Slave	Hanging		
August	Beaufort-Delta	Hanging		
September	Beaufort-Delta	Hanging	Yes	
October	North Slave	Hanging		
December	South Slave	Gunshot Wound		

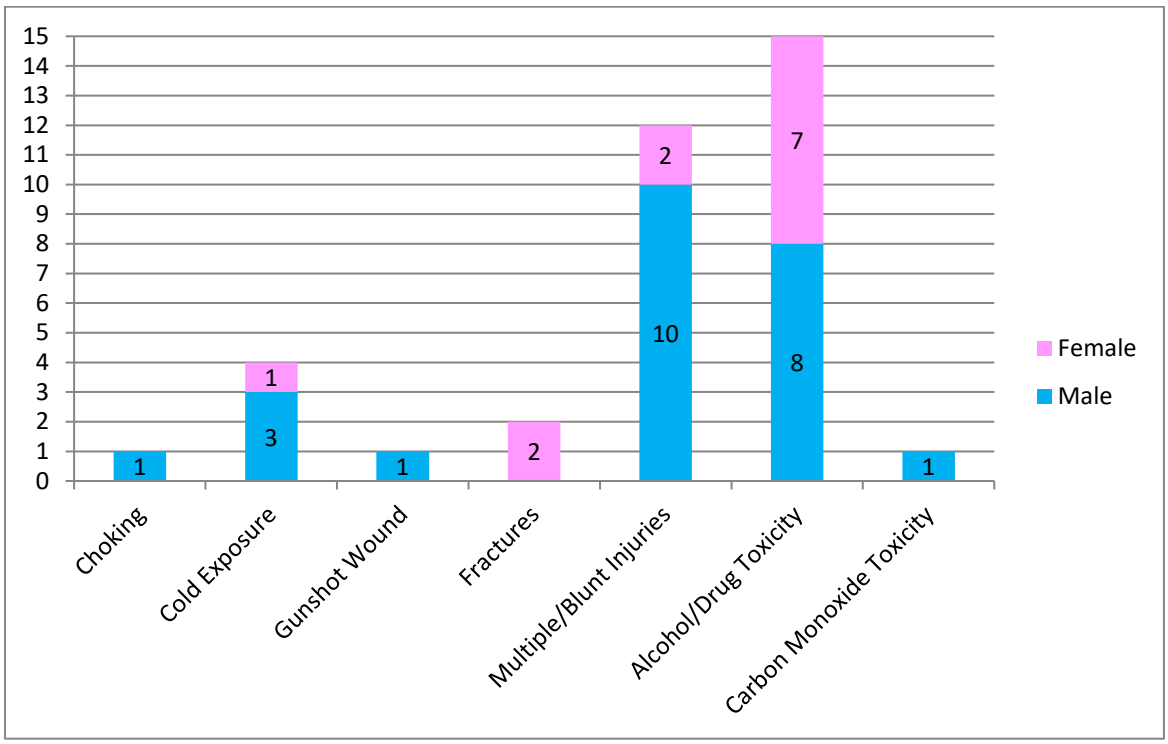
In 2024, most suicides occurred in the North Slave Region followed closely by the Beaufort-Delta. The most common method was hanging. Three out of the ten suicides had alcohol and/or drugs as a contributing factor in these deaths.

ACCIDENTAL

BY CAUSE AND GENDER

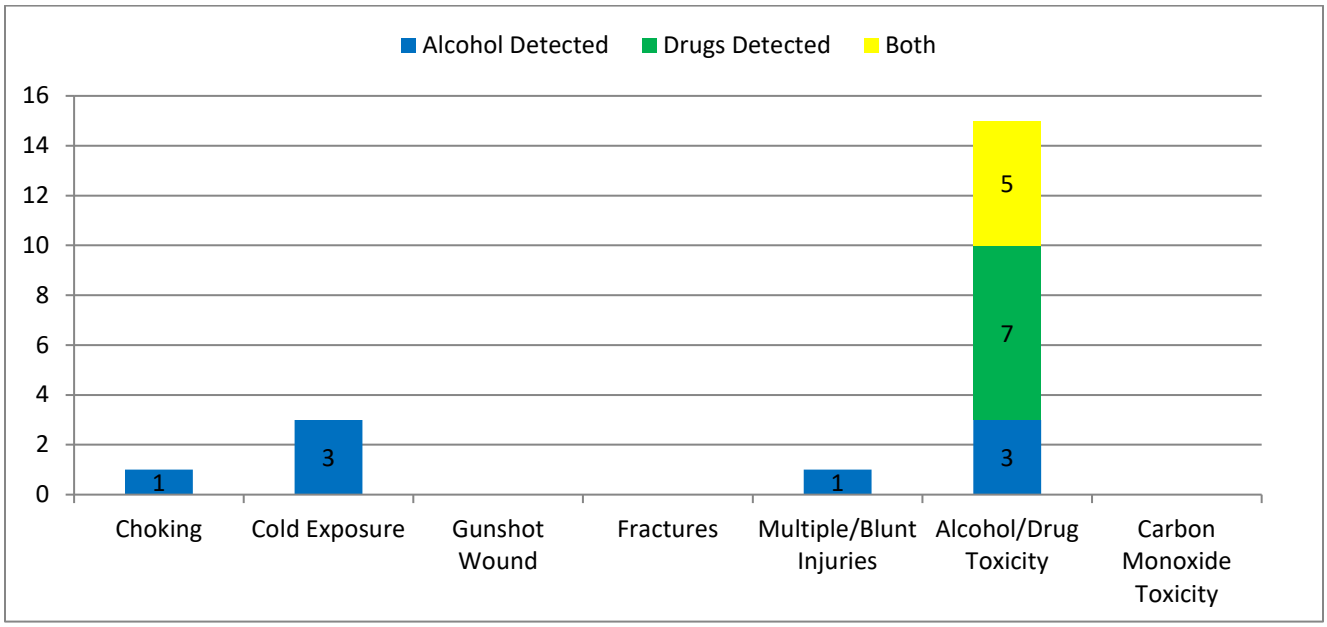
Cause of Death	Male	Female	Total
Choking	1		1
Cold Exposure	3	1	4
Gunshot Wound	1		1
Fractures		2	2
Multiple/Blunt Injuries	10	2	12
Alcohol/Drug Toxicity	8	7	15
Carbon Monoxide Toxicity	1		1
Totals	24	12	36

Accidental deaths accounted for approximately 24.49% of reported deaths in 2024. The majority of accidental deaths (24 of 36 or 67%) were males.



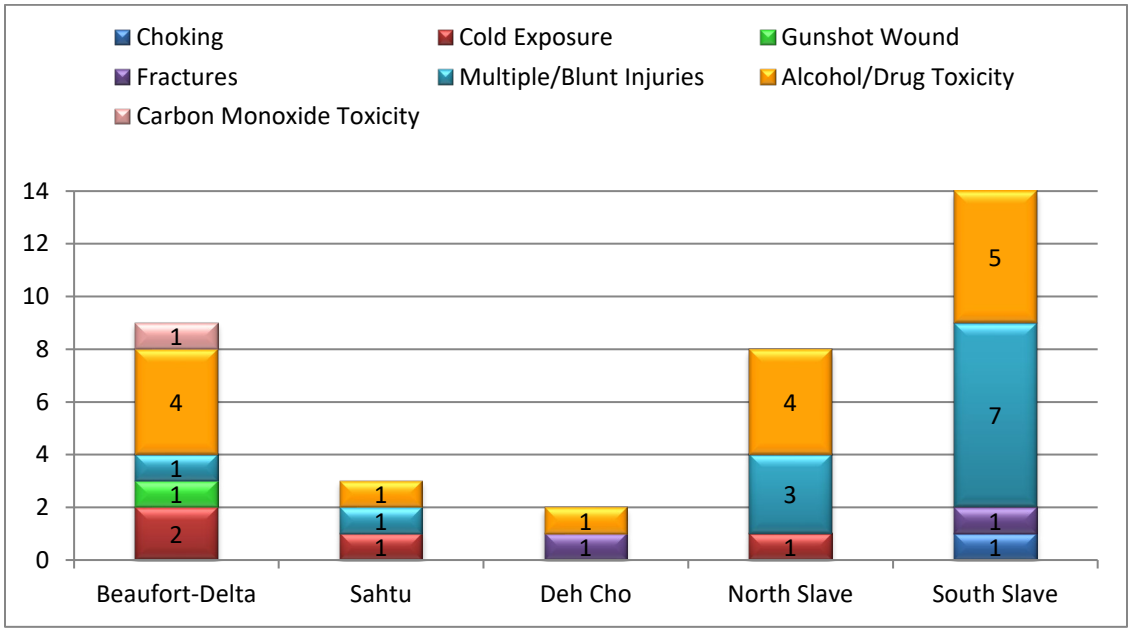
ACCIDENTAL CONTINUED

BY METHOD AND ALCOHOL/DRUGS



Twenty of the thirty-six (56%) accidental deaths were alcohol and/or drug related.

BY REGION AND METHOD



Most accidental deaths occurred in the South Slave Region (14 out of 36 or 39%).

HOMICIDE

HOMICIDES BY AGE AND GENDER

Age Group	Male	Female	Total
0-19	0	0	0
20-29	3	0	3
30-39	2	1	3
40-49	1	0	1
Total	6	1	7

In 2024, there were seven homicides. Homicides accounted for 4.76% of reported deaths. Most of the homicide deaths were males at 86%.

HOMICIDES BY REGION

Region	Total
Beaufort-Delta	1
Sahtu	1
Dehcho	1
North Slave	4
South Slave	0
Total	7

HOMICIDES BY METHOD

By Method	Total
Blunt Injury	3
Gunshot Wound	3
Stabbing	1
Total	7

The majority of homicides occurred in the North Slave Region (57%).

NATURAL AND NON-CORONER CASES

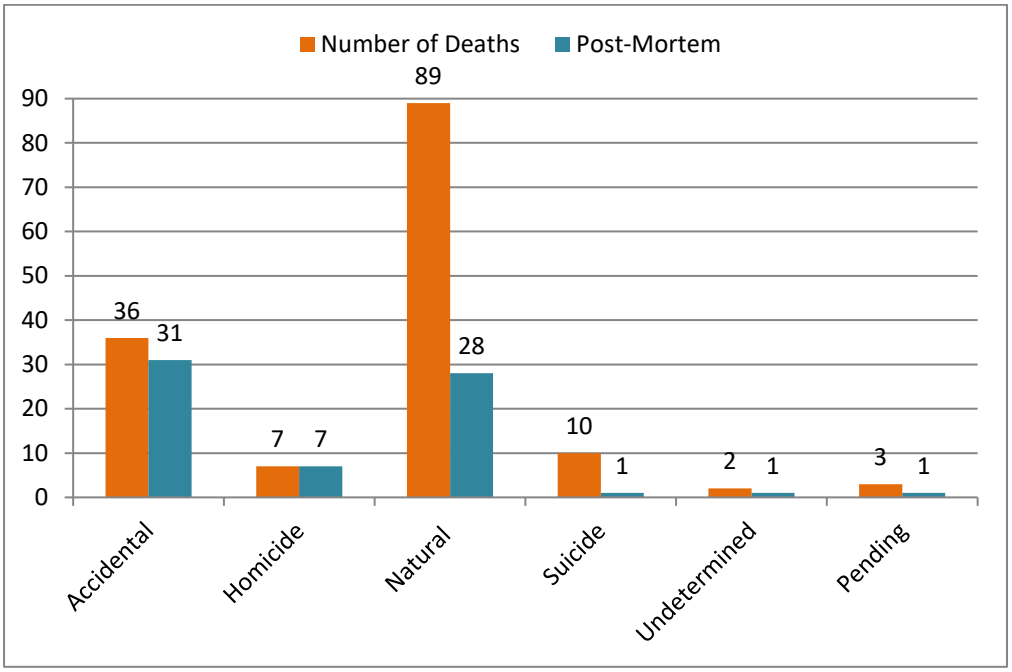
In 2024 there were a total of 89 natural deaths, 81 of which were coroner cases and 8 of which were non-coroner cases. Non-coroner cases are natural deaths that are reported to the Coroners Service but are not captured by the reporting criteria required under the *Coroners Act*.

Coroner	Non-Coroner	Natural
81	8	89

In 2024 there were 12 natural deaths where alcohol was the primary cause of death. Natural alcohol-related deaths are distinct from toxicity deaths. Rather than resulting from acute alcohol poisoning, these deaths occur due to prolonged alcohol use, which gradually impairs bodily functions over time.

POST-MORTEMS BY MANNER

A post-mortem examination (autopsy) is conducted when the cause and/or manner of death cannot otherwise be determined or when it appears appropriate to conduct the procedure. An autopsy may also be a means of determining the identity of the deceased. A total of 69 autopsies were conducted in 2024.



CORONER APPOINTMENTS

The Chief Coroner has the statutory authority to recommend the appointment and removal of coroners. It is desirable for each community to have resident coroners, and recruitment of local coroners is facilitated by the Office of the Chief Coroner and the Government of the Northwest Territories. The Chief Coroner then forwards a recommendation for appointment to the Minister of Justice. The applicant's MLA is also advised of the proposed appointment. Coroners are appointed by the Minister of Justice for a three-year term.

As of December 31, 2024, there were 17 coroners across the Northwest Territories, with 8 women and 9 men.

There are currently no coroners residing in the communities of Aklavik, Colville Lake, Enterprise, Fort Good Hope, Fort Liard, Fort Providence, Gametì, Łutselk'e, Nahanni Butte, Paulatuk, Sambaa K'e, Tsiigehtchic, Tulita , Wekweètì, Whatì, and Wrigley.

CONCLUDING CORONER INVESTIGATIONS

All coroner cases are generally concluded either by a coroner's report or by inquest. The most common method used is the "Report of Investigating Coroner".

REPORT OF INVESTIGATING CORONER

The Report of Investigating Coroner is a document outlining the results of a coroner's investigation. It summarizes and clarifies the facts and circumstances surrounding the death. The Report establishes the identity of the deceased, classifies the manner of death, and may include recommendations for the prevention of similar deaths. The report is completed in all death investigations except for cases where an inquest is being held. At an inquest the jury verdict takes the place of the Report of Investigating Coroner.

Recommendations are often made and are forwarded to the appropriate department, agency, or person in hopes of providing information and advice that may prevent similar deaths. Reports of Investigating Coroners containing recommendations are distributed as required, and responses are monitored. A synopsis of selected reports containing recommendations is attached (See Appendix "A").

INQUESTS

Coroner cases that are not concluded by a Report of Investigating Coroner would usually be inquired into through a Coroner's Inquest. An inquest is a formal quasi-judicial proceeding that allows for the public presentation of evidence relating to a death.

An inquest proceeding features a presiding coroner and a six-member jury selected in accordance with the *Jury Act*. The inquest hears testimony from sworn witnesses and allows represented parties to participate in cross-examination and to make oral arguments. The jury may make recommendations to prevent future deaths in similar circumstances.

A coroner must hold an inquest when the deceased had been involuntarily detained in custody at the time of the death, unless the coroner is satisfied that the death was due to natural causes and was not preventable. An inquest can also be held when, in the opinion of a coroner, it is necessary:

a) to identify the deceased or determine the circumstances of the death,
b) to inform the public of the circumstances of the death where it will serve some public purpose,
c) to bring dangerous practices or conditions to the knowledge of the public and facilitate the making of recommendations to avoid a preventable death; or
d) to inform the public as to dangerous practices or conditions to avoid preventable deaths.

A synopsis of selected reports containing recommendations resulting from inquests is attached (See Appendix "B").

APPENDIX "A"
SUMMARY OF SELECTED CORONER REPORTS CONTAINING RECOMMENDATIONS (CONCLUDED IN 2024)

Case #1

This 18-year-old female was found hanging in her bedroom closet at home. The investigation revealed that she had been suffering from increased mental health issues in the weeks leading up to her death, and that she sought medical attention for mental health issues several times from the local health centre before her death

It was determined that the cause of death was Hanging, and the manner of death was classified as Suicide.

Comments and Recommendations

The NWT Coroner Service made the following recommendations to The Northwest Territories Health and Social Services Authority (NTHSSA).

1. Increase awareness and educate youth and the public about available mental health services in their communities and the Northwest Territories.

2. An independent third-party review of this case should be conducted to ensure that appropriate mental health services were identified for this individual and to determine if anything else could have been done to prevent this death.

3. An independent third-party review should be conducted to assess the care she received while interacting with the Department of Social Services, to determine if anything could have been identified earlier to have her seen by a mental health professional.

4. Create an education package for all staff specifically tailored to the needs of adolescents and young adults with mental health concerns.

5. Enhanced recruitment and funding are necessary to hire more mental health professionals in the Northwest Territories and to expand mental health services throughout the territory.

6. The establishment and progression of an advocate for children, youth, and seniors in the Northwest Territories.

7. A review should be conducted of the current NTHSSA Child and Youth Suicide Risk Assessment to address the potential influence of subjective feelings on the form. Refresher training should be conducted annually.

8. The establishment of a council to advise on the rights of children and youth's health, led by young people, for example, the Youth Advisory Council in the Province of New Brunswick.

The NWT Coroner Service makes the following recommendations to The Child and Youth Fatality Review Committee.

1. A review of this file will be conducted to identify any areas of improvement and make recommendations to The Northwest Territories Health and Social Services Authority if needed.

Case #2

This 77-year-old man complained of upper abdominal pain before he collapsed and became unresponsive after doing yard work. His wife called 911 and started cardiopulmonary resuscitation (CPR). EMS was delayed due to a miscommunication from 911, and it was noted that a 911 operator was not providing instructions to his wife when time was imperative for CPR.

It was determined that the cause of death was Atherosclerotic Cardiovascular Disease and that Hypertension was a contributing factor in his death. The manner of death was classified as Natural.

Comments and Recommendations

The NWT Coroner Service made the following recommendations to The Minister of Municipal and Community Affairs (MACA – GNWT).

1. An unbiased third-party review is needed to ensure that proper policies and procedures were followed during the 911 call and to make recommendations on how to prevent similar deaths in the future. There should be emphasis on the time a person waits for a 911 operator to respond after the initial call to dispatch emergency services. The third-party review would be done by an organization that has not worked with the current NWT 911 system.

2. To improve emergency response, work with community governments to create accurate street maps for 911 dispatchers, reducing reliance on online maps developed outside the territory. (i.e.. Google Maps, etc.)

3. Ensure that there are always two dedicated trained 911 operators working in the 911 operations center at all times to not rely on med-response to provide backup call support.

4. That over the course of the next two years, the NWT Fire Chiefs Association, along with other key stakeholders such as the RCMP, meet bi-annually with Municipal and Community Affairs (MACA - 911) to ensure that the residents of the Northwest Territories receive optimal service. These meetings will provide an opportunity for MACA and the stakeholders to exchange ideas, share successful approaches, and constructively address any issues or concerns that arise in a timely fashion.

Case #3

This twenty-five-year-old male was working as a wildfire firefighter when he was struck on the head by a falling tree.

It was determined that his cause of death was Blunt Force Injury of the Head due to a Falling Tree and that the manner of death was classified as Accidental

Comments and Recommendations

The NWT Coroner Service made the following recommendations to The Minister of Environment and Climate Change (ECC - GNWT).

1. The Department of ECC should ensure that all Crew Leaders/Supervisors have Danger Tree Assessor training before overseeing firefighters working in the field.

2. The Department of ECC should ensure that anyone certified to use a chainsaw as part of their work has Danger Tree Assessor training before using a chainsaw during live fire events.

3. The Department of ECC should conduct a third-party review of all safety equipment provided to its firefighters to ensure that they meet or exceed industry standards.

4. The Department of ECC should consider the more protective Bullard Wildfire Helmet FH911XL as a potential replacement for all front-line firefighters to help prevent future deaths.

5. The Department of ECC should use the Incident Command System (ICS) whenever firefighters are deployed during any type of fire operations (suppressing and controlling wildfires, constructing fire or containment lines, equipment operation, etc.).

6. The Department of ECC should review fire crew minimums when deploying personnel to fire events and ensure that no less than three "Type 1" certified wildfire fighters are deployed to active wildfires where they are engaging in initial attack, sustained attack, and mop-up.

7. The Department of ECC should only deploy "Type 3" firefighters for sustained attack and mop-up activities, and not as initial attack wildfire fighters.

8. The Department of ECC should establish specific fire crew personnel minimum staffing numbers for each task and ensure that crews are not deployed unless the minimum crew personnel number is met.

9. The Department of ECC develops and maintains a standardized Personal Protective Equipment (PPE) manual for all personnel within the Forestry Management Division to be included in the greater ECC Personal Protective Equipment (PPE) manual which will be reviewed minimally every 3 years.

APPENDIX “B”
SUMMARY OF CORONER’S INQUESTS

Case # 1

Verdict of Coroner's Jury

Deceased: Sylvia Panaktalok

Date and time of Death: Saturday, July 31, 2021, 23:59hrs

Place of Death: Tuktoyaktuk Health Centre

Cause of Death: Acute Ethanol Intoxication (Alcohol Poisoning)

Manner of Death: Accidental

Circumstances under which death occurred:

Shortly before 22:00hrs, a call was made to the Tuktoyaktuk RCMP to pick up an individual who appeared to be highly intoxicated. RCMP came to the house where the call was made and picked up Sylvia Panaktalok, who was on the steps of the residence. Two RCMP members, as well as a family member of Sylvia's assisted her into the back of the RCMP truck.

At 22:18hrs, the truck arrived into the bay of the detachment. Sylvia was aided in walking up the ramp towards the cells by RCMP members but became "dead weight" halfway up the ramp. One member brought a mat to the ramp and Sylvia was laid on it. Falling off, she was again placed on the mat. An officer then dragged the mat up the ramp and into the cells building, placing Sylvia in Cell 1. The officers lay Sylvia in a recovery position on the mat and left the cell.

The cell guard made an initial check on Sylvia at 22:25hrs, and again at 22:45hrs, 23:00hrs, 23:15hrs, and 23:27hrs. At the last check, the guard "did not see any visual breathing," and notified detachment members. Upon opening the cell, they determined that Sylvia was unresponsive and set about enacting emergency measures.

They dragged Sylvia on the mat back to the bay and attempted to load her into the back of the truck. Unable to do so and realizing that a nurse could not come to them from the health centre, they began CPR on Sylvia, along with the use of an AED device. Sylvia was then secured to a backboard and placed in the bed of the truck and transported to the health centre at 11:35hrs.

Upon arrival to the health centre, CPR was continued on Sylvia by a rotation of RCMP members while nurses took direction from a doctor via telephone. Medical care and CPR was administered until the doctor gave instructions to stop.

RECOMMENDATIONS:

1. The Tuktoyaktuk Detachment of the" G" Division of the Royal Canadian Mounted Police will ensure that all regular members and civilian guards review and discuss all cell block policies including the Chapters 19.2 of the Operational Manual and Chapter 19.2 of the "G" Division Operational Manual every six months in accordance with section 4.4.1.5.1 Chapter 19.3 of the National Operational Manual.

2. The Tuktoyaktuk Detachment of the" G" Division of the Royal Canadian Mounted Police will, within six months, conduct an audit of cell block operations pursuant to section 4.4.4.3 of Chapter 19.3 of the National Operational Manual.

3. The Tuktoyaktuk Detachment of the" G" Division of the Royal Canadian Mounted Police will, within the next year, ensure all regular members and civilian guards employed at their RCMP detachments have received arousability assessment training from the appropriate designated member at their detachments pursuant to section 2.1 of Chapter 19.3 of the "G" Division Operational Manual.

4. The Tuktoyaktuk Detachment of the" G" Division of the Royal Canadian Mounted Police, and all other "G" Division detachments whose communities lack appropriate emergency medical services, will make best efforts to ensure that their detachments have procedures on how to deal with a medical emergency in the detachment and will conduct quarterly emergency drills.

5. The Royal Canadian Mounted Police Prisoner Report change the descriptor within the Prisoner Screening Section from "Consciousness" to "Alertness."

EXPRESSIONS OF APPRECIATION

The NWT Coroner Service wishes to express appreciation to the RCMP, health care professionals, and the many other investigative partners that cooperated with and assisted coroners conducting death investigations over the past year. The Service would also like to thank the coroners who demonstrate - often under very difficult conditions - a high level of dedication and professionalism.