Office of the Chief Coroner

Annual Report
2018

New Nouveau Brunswick

2018 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-Seventh Annual Report of the Chief Coroner for the period January 1, 2018 to December 31, 2018.

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 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 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 21.7 percent of the total of approximately 7,600 deaths per year in the Province. A high percentage of the investigated deaths are determined to be from natural causes. The coroner, in approximately 32.2 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 7,679 deaths in the Province of which 1,649 or 21.5% were reported to a coroner. By comparison in the previous year there were 7,530 deaths in the Province of which 1,602 or 21.3% 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 2018.

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

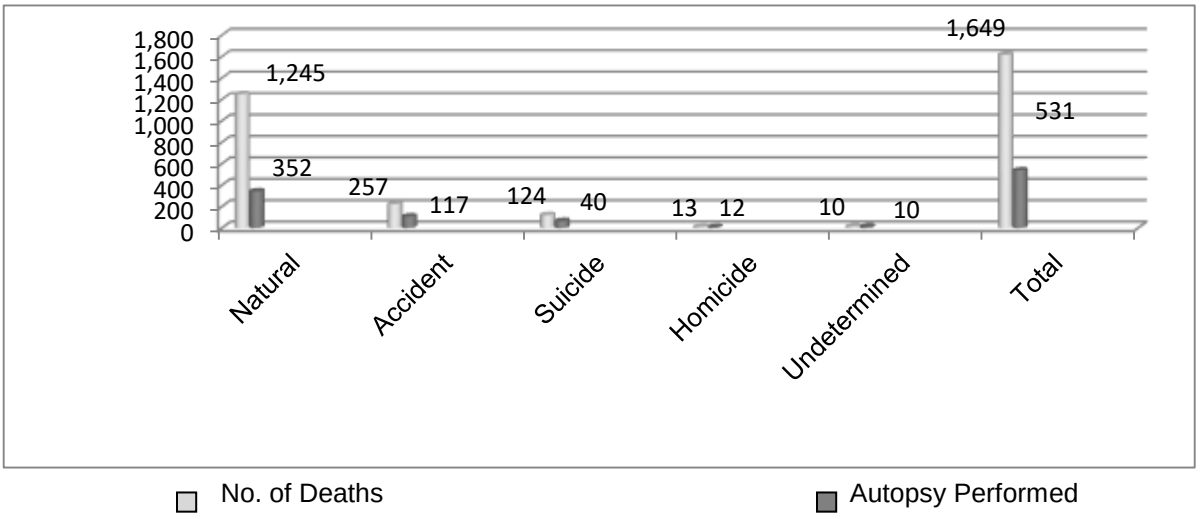
from 2018.01.01 to 2018.12.31

Classification	No. of Deaths	% of Deaths	Rate per 100,000 Population	Autopsy Performed	% of classification
Natural	1,245	75.5	161.4	352	28.3
Accident	257	15.6	33.3	117	45.5
Suicide	124	7.5	16.1	40	32.3
Homicide	13	0.8	1.7	12	92.3
Undetermined	10	0.6	1.3	10	100.0
Total	1,649	100.0		531	

Based on a population of 770,921

PROVINCIAL SUMMARY - SCHEDULE A-1

from 2018.01.01 to 2018.12.31



NOTE : Based upon Statistics Canada postcensal population estimates for N. B. census divisions (released June 6, 2020). Sub-county estimates are based on the 2018 Census population share of the county.

Provincial Summary - Deaths Investigated by Classification, by Month - Schedule A-2
from 2018.01.01 to 2018.12.31

Classification	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Total
Natural	124	108	104	115	117	96	67	98	94	95	100	127	1,245
Accident	24	17	15	10	15	22	27	35	19	22	25	26	257
Suicide	7	11	12	5	15	15	10	6	13	10	8	12	124
Homicide	0	0	0	1	0	0	1	6	2	1	1	1	13
Undetermined	1	0	0	0	2	1	1	2	0	1	1	1	10
Total	156	136	131	131	149	134	106	147	128	129	135	167	1,649

DEATHS INVESTIGATED BY JUDICIAL DISTRICT - SCHEDULE A-3
from 2018.01.01 to 2018.12.31

	Judicial Districts								
	Bathurst	Campbellton	Edmundston	Fredericton	Miramichi	Moncton	Saint John	Woodstock	Province
Natural	103	60	96	167	74	245	467	33	1,245
Accident	26	17	13	38	21	90	49	3	257
Suicide	16	8	9	18	15	34	19	5	124
Homicide	0	1	0	5	1	3	2	1	13
Undetermined	0	0	0	0	0	7	3	0	10
Total	145	83	118	228	111	379	540	42	1,649
% of Provincial Total	8.8	5.2	7.2	13.8	6.7	23.0	32.8	2.5	100
Population	79,156	31,089	41,463	144,480	45,543	219,022	173,208	36,960	770,921
Death Rate per 100,000 population									
Natural	130.1	193.0	231.5	115.6	162.5	111.9	269.6	89.3	161.5
Accident	32.8	54.7	31.3	26.3	46.1	41.1	28.2	8.1	33.3
Suicide	20.2	25.7	21.7	12.5	32.9	15.5	11.0	13.5	16.1
Homicide	0.0	3.2	0.0	3.5	2.2	1.4	1.2	2.7	1.7
Undetermined	0.0	0.0	0.0	0.0	0.0	3.2	1.7	0.0	1.3
Total deaths by trauma (accident, suicide, homicide)	42	26	22	61	37	127	70	9	394
Rate per 100,000 population	53.1	83.6	53.1	42.2	81.2	58.0	40.4	24.3	51.1

PROVINCIAL SUMMARY
ACCIDENTAL DEATHS BY AGE GROUP, GENDER AND JUDICIAL DISTRICT - SCHEDULE B-1
from 2018.01.01 to 2018.12.31

Judicial Districts	0 - 19		20 - 30		31 - 40		41 - 50		51 - 60		61 - 70		Over 70		Total Males	Total Females	Total	% of Classification	Autopsies	% of Classification
	M	F	M	F	M	F	M	F	M	F	M	F	M	F						
Bathurst	1	0	3	2	2	0	2	3	5	2	1	0	3	2	17	9	26	10.1	10	8.5
Campbellton	1	0	1	1	2	1	1	0	1	0	1	0	7	1	14	3	17	6.6	5	4.3
Edmundston	1	0	0	2	1	0	0	0	1	0	0	0	3	5	6	7	13	5.1	4	3.4
Fredericton	1	0	3	2	3	0	3	0	3	0	0	3	11	9	24	14	38	14.8	20	17.1
Miramichi	1	0	0	1	0	0	5	0	4	1	2	1	1	5	13	8	21	8.2	10	8.5
Moncton	5	0	5	4	1	3	5	2	14	2	9	4	14	22	53	37	90	35.0	33	28.2
Saint John	3	0	4	0	6	3	4	2	6	7	1	3	6	4	30	19	49	19.1	33	28.2
Woodstock	0	0	0	0	0	0	0	1	0	1	1	0	0	0	1	2	3	1.2	2	1.7
Males	13		16		15		20		34		15		45		158		257	100.0	117	100.0
% Total - Males	5.1		6.2		5.8		7.8		13.2		5.8		17.5		61.4					
Females	0		12		7		8		13		11		48			99				
% Total -Females	0.0		4.7		2.7		3.1		5.1		4.3		18.7			38.6				
Total for Age Group	13		28		22		28		47		26		93							
% of Classification Total	5.1		10.9		8.6		10.9		18.3		10.1		36.2							

PROVINCIAL SUMMARY
ACCIDENTAL DEATHS BY AGE GROUP, GENDER AND DEATH FACTOR - SCHEDULE B-2
from 2018.01.01 to 2018.12.31

Death Factor Description	0 - 19		20 - 30		31 - 40		41 - 50		51 - 60		61 - 70		Over 70		Total Males	Total Females	Total	% of Classification	Autopsies	% of Classification
	M	F	M	F	M	F	M	F	M	F	M	F	M	F						
Drowning - Open Water	2	0	0	1	2	0	1	0	1	0	0	0	0	0	6	1	7	2.7	5	4.3
Drowning - Other - marsh, dam, etc.	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0.4	1	0.9
Trauma of Vehicle Collision	2	0	5	3	5	1	6	3	7	1	2	1	4	4	31	13	44	17.1	16	13.6
Trauma of Vehicle Upset/Rollover	2	0	4	0	0	0	1	0	1	1	2	0	2	1	12	2	14	5.4	10	8.4
Trauma of Vehicle/Pedestrian Collision	0	0	1	1	0	2	0	0	1	1	1	0	1	0	4	4	8	3.1	2	1.7
Trauma of Recreational Vehicle Collision	1	0	1	0	1	0	0	0	2	0	0	0	0	0	5	0	5	1.9	1	0.9
Trauma of Recreational Vehicle Upset/Rollover	2	0	0	0	0	0	0	1	1	0	1	0	0	0	4	1	5	1.9	4	3.3
Crushed and/or Buried	1	0	0	0	1	0	0	0	0	0	0	0	0	0	2	0	2	0.8	1	0.9
Carbon Monoxide Poisoning - Vehicle Exhaust	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	1	0.4	1	0.9

PROVINCIAL SUMMARY
ACCIDENTAL DEATHS BY AGE GROUP, GENDER AND DEATH FACTOR - SCHEDULE B-2
from 2018.01.01 to 2018.12.31

Death Factor Description	0 - 19		20 - 30		31 - 40		41 - 50		51 - 60		61 - 70		Over 70		Total Males	Total Females	Total	% of Classification	Autopsies	% of Classification
	M	F	M	F	M	F	M	F	M	F	M	F	M	F						
Carbon Monoxide Poisoning	0	0	1	0	0	0	0	0	0	0	0	1	0	0	1	1	2	0.8	2	1.7
Exposure to cold	0	0	0	0	0	0	1	0	1	0	1	1	0	0	3	1	4	1.6	3	2.6
Lightning	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0	1	0.4	0	0.0
Allergic Reaction	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0	1	0.4	1	0.9
Electrocution	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	1	0.4	1	0.9
Excited Delirium Syndrome	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0.4	1	0.9
Burns – Heat	0	0	0	0	0	0	0	0	0	0	0	0	1	1	1	1	2	0.8	1	0.9
Fire – Structural	0	0	0	0	0	0	0	1	1	0	0	0	0	1	1	2	3	1.2	3	2.6
Fall or jump – same level	0	0	0	0	1	0	0	0	1	0	4	4	32	36	38	40	78	30.3	2	1.7
Fall or jump – different level height; eg. bridge, building	0	0	0	0	0	1	0	0	1	0	0	0	1	0	2	1	3	1.2	2	1.7
Blunt Trauma, Accidental	2	0	0	0	1	0	0	0	2	0	1	0	0	0	6	0	6	2.3	2	1.7

PROVINCIAL SUMMARY
ACCIDENTAL DEATHS BY AGE GROUP, GENDER AND DEATH FACTOR - SCHEDULE B-2
from 2018.01.01 to 2018.12.31

Death Factor Description	0 - 19		20 - 30		31 - 40		41 - 50		51 - 60		61 - 70		Over 70		Total Males	Total Females	Total	% of Classification	Autopsies	% of Classification
	M	F	M	F	M	F	M	F	M	F	M	F	M	F						
Blunt Trauma, Beating	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	1	0.4	0	0.0
Blunt Trauma	0	0	1	0	0	0	0	0	0	0	1	0	0	0	2	0	2	0.8	2	1.7
Object Caught in Throat	0	0	0	0	0	0	1	0	4	1	1	1	3	2	9	4	13	5.1	7	6.0
Aspiration	0	0	0	0	0	0	0	0	0	0	0	1	1	0	1	1	2	0.8	1	0.9
Asphyxia	0	0	0	1	0	0	1	0	1	0	0	0	0	0	2	1	3	1.2	3	2.6
Alcohol Intoxication	0	0	0	0	0	0	0	0	0	2	0	0	0	1	0	3	3	1.2	3	2.6
Alcohol and Drug	0	0	0	1	0	0	1	1	1	1	0	0	0	0	2	3	5	1.9	5	4.2
Alcohol	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0.4	1	0.9
Drug	0	0	1	4	3	2	4	2	7	5	1	2	0	2	16	17	33	12.8	31	26.4
Drug (street)	0	0	0	1	0	1	2	0	0	1	0	0	0	0	2	3	5	1.9	5	4.2
Males	13		16		15		20		34		15		45		158		257	100.0	117	100.0
Females	0		12		7		8		13		11		48			99				
Total for Age Group	13		28		22		28		47		26		93							

PROVINCIAL SUMMARY
ACCIDENTAL DEATHS BY AGE GROUP, GENDER AND ENVIRONMENT - SCHEDULE B-3
from 2018.01.01 to 2018.12.31

Environment Description	0 - 19		20 - 30		31 - 40		41 - 50		51 - 60		61 - 70		Over 70		Total Males	Total Females	Total	% of Classification	Autopsies	% of Classification
	M	F	M	F	M	F	M	F	M	F	M	F	M	F						
Work Place	1	0	0	0	2	0	0	0	0	0	1	0	0	0	4	0	4	1.6	3	2.5
Open water (river, lake, stream, brook)	1	0	0	0	0	0	1	0	0	0	0	0	0	0	2	0	2	0.8	1	0.9
Beach/Shoreline	0	0	0	0	1	0	0	0	1	0	0	0	0	0	2	0	2	0.8	2	1.7
Boating – personal watercraft, jet ski, etc.	1	0	0	1	1	0	0	0	0	0	0	0	0	0	2	1	3	1.2	2	1.7
Camping / Tenting	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0	1	0.4	0	0.0
Hospital Other (ward, ICU, etc.)	0	0	0	0	0	0	0	0	2	0	1	1	4	3	7	4	11	4.3	1	0.9
School – pupil (not employee)	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0.4	0	0.0
Logging/Tree Cutting - Commercial	0	0	0	0	0	0	0	0	1	0	1	0	0	0	2	0	2	0.8	2	1.7

PROVINCIAL SUMMARY
ACCIDENTAL DEATHS BY AGE GROUP, GENDER AND ENVIRONMENT - SCHEDULE B-3
from 2018.01.01 to 2018.12.31

Environment Description	0 - 19		20 - 30		31 - 40		41 - 50		51 - 60		61 - 70		Over 70		Total Males	Total Females	Total	% of Classification	Autopsies	% of Classification
	M	F	M	F	M	F	M	F	M	F	M	F	M	F						
Public Road - Driver	3	0	6	1	3	1	3	0	4	2	3	0	4	1	26	5	31	12.0	15	12.8
Public Road – motorcycle driver	1	0	1	0	1	0	0	1	3	0	1	0	0	0	7	1	8	3.1	4	3.4
Public Road – passenger	1	0	2	2	1	0	4	2	1	0	0	1	2	4	11	9	20	7.8	7	6.0
Public Road - pedestrian	0	0	1	1	0	2	0	0	2	0	1	0	1	0	5	3	8	3.1	3	2.5
Public Road – bicycle (not motorized vehicle)	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	1	0.4	0	0.0
ATV driver – on public road	0	0	1	0	1	0	0	0	1	0	0	0	0	0	3	0	3	1.2	2	1.7
ATV driver – off public road	1	0	0	0	0	0	0	0	0	0	1	0	0	0	2	0	2	0.8	1	0.9
Off Road Motorcycling (motocross, dirt bike, etc.)	2	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	2	0.8	1	0.9

PROVINCIAL SUMMARY
ACCIDENTAL DEATHS BY AGE GROUP, GENDER AND ENVIRONMENT - SCHEDULE B-3
from 2018.01.01 to 2018.12.31

Environment Description	0 - 19		20 - 30		31 - 40		41 - 50		51 - 60		61 - 70		Over 70		Total Males	Total Females	Total	% of Classification	Autopsies	% of Classification
	M	F	M	F	M	F	M	F	M	F	M	F	M	F						
Dune buggy	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	1	0.4	0	0.0
Snowmobiling (anywhere off public road) – passenger	0	0	0	0	0	0	0	1	1	0	0	0	0	0	1	1	2	0.8	1	0.9
Living inside, residence or on property	1	0	5	7	4	3	10	3	12	10	4	9	23	13	59	45	104	40.4	60	51.2
Inside, Other than Residence (mall, restaurant, other public building)	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	1	0.4	0	0.0
Seniors Complex	0	0	0	0	0	0	0	0	1	0	0	0	1	5	2	5	7	2.7	2	1.7
Homes for Special Care	0	0	0	0	0	0	1	0	0	0	0	0	3	6	4	6	10	3.8	2	1.7
Nursing Home	0	0	0	0	0	0	0	0	1	0	0	0	5	15	6	15	21	8.1	1	0.9
Hotel / Motel	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	1	0.4	1	0.9

PROVINCIAL SUMMARY
ACCIDENTAL DEATHS BY AGE GROUP, GENDER AND ENVIRONMENT - SCHEDULE B-3
from 2018.01.01 to 2018.12.31

Environment Description	0 - 19 M	0 - 19 F	20 - 30 M	20 - 30 F	31 - 40 M	31 - 40 F	41 - 50 M	41 - 50 F	51 - 60 M	51 - 60 F	61 - 70 M	61 - 70 F	Over 70 M	Over 70 F	Total Males	Total Females	Total	% of Classification	Autopsies	% of Classification
Rooming/Boarding House/Halfway House/Group Home	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	1	0.4	1	0.9
Urban Outdoors – public place & other (not residence)	0	0	0	0	0	0	0	0	2	0	1	0	2	1	5	1	6	2.3	3	2.5
Rural Outdoors (not built up place or near residence)	0	0	0	0	0	1	0	0	1	0	0	0	0	0	1	1	2	0.8	2	1.7
Males	13		16		15		20		34		15		15		158		257	100.0	117	100.0
Females	0		12		7		8		13		11		48			99				
Total for Age Group	13		28		22		28		47		26		93							

PROVINCIAL SUMMARY
SUICIDE DEATHS BY AGE GROUP, GENDER AND JUDICIAL DISTRICT - SCHEDULE C-1
from 2018.01.01 to 2018.12.31

Judicial Districts	0 - 19		20 - 30		31 - 40		41 - 50		51 - 60		61 - 70		Over 70		Total Males	Total Females	Total	% of Classification	Autopsies	% of Classification
	M	F	M	F	M	F	M	F	M	F	M	F	M	F						
Bathurst	2	0	1	0	3	0	2	1	2	2	1	0	2	0	13	3	16	12.9	3	7.5
Campbellton	1	0	0	0	0	0	0	0	1	1	3	0	2	0	7	1	8	6.5	3	7.5
Edmundston	0	0	2	0	1	0	0	0	4	1	1	0	0	0	8	1	9	7.3	2	5.0
Fredericton	4	0	2	0	3	1	3	0	1	0	3	0	1	0	17	1	18	14.5	1	2.5
Miramichi	0	1	0	0	0	1	2	0	3	0	4	0	4	0	13	2	15	12.1	2	5.0
Moncton	0	0	6	3	1	1	5	3	7	2	4	1	1	0	24	10	34	27.4	8	20.0
Saint John	1	0	4	2	0	2	3	0	0	3	4	0	0	0	12	7	19	15.3	19	47.5
Woodstock	0	0	1	1	1	0	1	0	1	0	0	0	0	0	4	1	5	4.0	2	5.0
Males	8		16		9		16		19		20		10		98		124	100.0	40	100.0
% Total - Males	6.5		12.9		7.3		12.9		15.3		16.1		8.1		79.1					
Females	1		6		5		4		9		1		0			26				
% Total - Females	0.8		4.8		4.0		3.2		7.3		0.8		0.0			20.9				
Total for Age Group	9		22		14		20		28		21		10							
% of Classification Total	7.3		17.7		11.3		16.1		22.6		16.9		8.1							

PROVINCIAL SUMMARY
SUICIDE DEATHS BY AGE GROUP, GENDER AND DEATH FACTOR - SCHEDULE C-2
from 2018.01.01 to 2018.12.31

Death Factor Description	0 - 19		20 - 30		31 - 40		41 - 50		51 - 60		61 - 70		Over 70		Total Males	Total Females	Total	% of Classification	Autopsies	% of Classification
	M	F	M	F	M	F	M	F	M	F	M	F	M	F						
Undetermined	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	1	0.8	1	2.5
Hanging	5	1	9	5	5	4	5	0	10	2	8	0	5	0	47	12	59	47.7	17	42.5
Decapitation or Transection	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	1	0.8	0	0.0
Cuts, Stabs	0	0	0	1	0	0	1	0	1	0	0	0	0	0	2	1	3	2.4	1	2.5
Drowning - Open Water	0	0	0	0	0	0	2	0	0	0	0	0	1	0	3	0	3	2.4	1	2.5
Drowning - Bathtub	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	1	0.8	1	2.5
Asphyxia	0	0	0	0	0	0	0	0	0	1	1	0	0	0	1	1	2	1.6	1	2.5
Asphyxia due to Oxygen Depletion (Helium Gas)	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	1	0.8	0	0.0
Carbon Monoxide Poisoning - Vehicle Exhaust	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	1	0.8	1	2.5
Carbon Monoxide Poisoning	0	0	0	0	0	0	1	0	1	0	0	0	0	0	2	0	2	1.6	1	2.5
Fire - Structural	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	1	0.8	1	2.5

PROVINCIAL SUMMARY
SUICIDE DEATHS BY AGE GROUP, GENDER AND DEATH FACTOR - SCHEDULE C-2
from 2018.01.01 to 2018.12.31

Death Factor Description	0 - 19		20 - 30		31 - 40		41 - 50		51 - 60		61 - 70		Over 70		Total Males	Total Females	Total	% of Classification	Autopsies	% of Classification
	M	F	M	F	M	F	M	F	M	F	M	F	M	F						
Shooting - Rifle	1	0	3	0	2	0	3	0	2	0	3	0	2	0	16	0	16	12.9	1	2.5
Shooting - Shotgun	2	0	3	0	1	0	3	0	0	0	4	0	1	0	14	0	14	11.3	3	7.5
Shooting - Handgun	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0.8	1	2.5
Trauma of Vehicle Collision	0	0	0	0	0	0	1	0	0	0	1	0	0	0	2	0	2	1.6	1	2.5
Drug (street)	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	1	0.8	1	2.5
Drug	0	0	0	0	1	0	0	3	3	5	0	1	1	0	5	9	14	11.3	8	20.0
Fall or jump – different level, eg. bridge, bldg.	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	1	0.8	0	0.0
Males	8		16		9		16		19		20		10		98		124	100..80	40	100.0
Females	1		6		5		4		9		1		0			26				
Total for Age Group	9		22		14		20		28		21		10							

PROVINCIAL SUMMARY
SUICIDE DEATHS BY AGE GROUP, GENDER AND ENVIRONMENT - SCHEDULE C-3
from 2018.01.01 to 2018.12.31

Environment Description	0 - 19		20 - 30		31 - 40		41 - 50		51 - 60		61 - 70		Over 70		Total Males	Total Females	Total	% of Classification	Autopsies	% of Classification
	M	F	M	F	M	F	M	F	M	F	M	F	M	F						
Open Water (river, lake, stream, brook)	0	0	0	0	0	0	2	0	0	0	0	0	0	0	2	0	2	1.6	0	0.0
Living inside, residence or on property	6	1	12	6	5	3	12	4	18	8	14	1	7	0	74	23	97	78.3	29	72.5
Inside, Other than Residence (mall, restaurant, other public building)	0	0	1	0	0	0	1	0	0	0	0	0	0	0	2	0	2	1.6	0	0.0
Hotel/Motel	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	1	0.8	0	0.0
Work Place	0	0	0	0	0	1	0	0	0	0	0	0	1	0	1	1	2	1.6	1	2.5
Public Road - Driver	0	0	1	0	1	0	1	0	0	0	2	0	0	0	5	0	5	4.0	3	7.5

PROVINCIAL SUMMARY
SUICIDE DEATHS BY AGE GROUP, GENDER AND ENVIRONMENT - SCHEDULE C-3
from 2018.01.01 to 2018.12.31

Environment Description	0 - 19 M	0 - 19 F	20 - 30 M	20 - 30 F	31 - 40 M	31 - 40 F	41 - 50 M	41 - 50 F	51 - 60 M	51 - 60 F	61 - 70 M	61 - 70 F	Over 70 M	Over 70 F	Total Males	Total Females	Total	% of Classification	Autopsies	% of Classification
Urban Outdoors - public place and other (not residence)	1	0	1	0	1	0	0	0	0	0	2	0	1	0	6	0	6	4.8	3	7.5
Rural Outdoors (not built up place or near residence)	1	0	1	0	1	1	0	0	1	1	2	0	1	0	7	2	9	7.3	4	10.0
Males	8		16		9		16		19		20		10		98		124	100.0	40	100.0
Females	1		6		5		4		9		1		0			26				
Total for Age Group	9		22		14		20		28		21		10							

PROVINCIAL SUMMARY
HOMICIDE DEATHS BY AGE GROUP, GENDER AND JUDICIAL DISTRICT - SCHEDULE D-1
from 2018.01.01 to 2018.12.31

Judicial Districts	0 - 19		20 - 30		31 - 40		41 - 50		51 - 60		61 - 70		Over 70		Total Males	Total Females	Total	% of Classification	Autopsies	% of Classification
	M	F	M	F	M	F	M	F	M	F	M	F	M	F						
Campbellton	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	1	7.7	0	0.0
Fredericton	0	0	0	0	0	1	2	1	0	0	1	0	0	0	3	2	5	38.5	5	41.7
Miramichi	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	1	7.7	1	8.3
Moncton	0	0	0	0	1	2	0	0	0	0	0	0	0	0	1	2	3	23.1	3	25.0
Saint John	0	0	0	0	0	0	0	0	1	1	0	0	0	0	1	1	2	15.4	2	16.7
Woodstock	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	7.7	1	8.3
Males	0		0		1		2		1		1		0		5		13	100.0	12	100.0
% Total - Males	0.0		0.0		7.7		15.4		7.7		7.7		0.0		38.5					
Females	1		0		4		1		2		0		0			8				
% Total - Females	7.7		0.0		30.8		7.7		15.4		0.0		0.0			61.6				
Total for Age Group	1		0		5		3		3		1		0							
% of Classification Total	7.7		0.0		38.5		23.1		23.1		7.7		0.0							

PROVINCIAL SUMMARY
HOMICIDE DEATHS BY AGE GROUP, GENDER AND DEATH FACTOR - SCHEDULE D-2
from 2018.01.01 to 2018.12.31

Death Factor Description	0 - 19		20 - 30		31 - 40		41 - 50		51 - 60		61 - 70		Over 70		Total Males	Total Females	Total	% of Classification	Autopsies	% of Classification
	M	F	M	F	M	F	M	F	M	F	M	F	M	F						
Blunt Trauma	0	0	0	0	1	0	0	0	1	0	0	0	0	0	2	0	2	15.4	2	16.8
Cuts, Stabs	0	1	0	0	0	1	0	0	0	2	1	0	0	0	1	4	5	38.4	4	33.3
Shooting - Rifle	0	0	0	0	0	1	2	1	0	0	0	0	0	0	2	2	4	30.8	4	33.3
Shooting - Unspecified	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	1	7.7	1	8.3
Asphyxia	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	1	7.7	1	8.3
Males	0		0		1		2		1		1		0		5		13	100.0	12	100.00
Females	0		0		4		1		2		0		0			8				
Total for Age Group	1		0		5		3		3		1		0							

PROVINCIAL SUMMARY
HOMICIDE DEATHS BY AGE GROUP, GENDER AND ENVIRONMENT - SCHEDULE D-3
from 2018.01.01 to 2018.12.31

Environment Description	0 - 19 M	0 - 19 F	20 - 30 M	20 - 30 F	31 - 40 M	31 - 40 F	41 - 50 M	41 - 50 F	51 - 60 M	51 - 60 F	61 - 70 M	61 - 70 F	Over 70 M	Over 70 F	Total Males	Total Females	Total	% of Classification	Autopsies	% of Classification
Police Provincial Jail	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	1	7.7	1	8.3
Living Inside, Residence or on Property	0	1	0	0	0	1	0	0	0	2	1	0	0	0	1	4	5	38.5	4	33.3
Urban Outdoors - public place and other (not residence)	0	0	0	0	0	2	2	1	1	0	0	0	0	0	3	3	6	46.1	6	50.1
Rural Outdoors (not built up place or near residence)	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	1	7.7	1	8.3
Males	0		0		1		2		1		1		0		5		13	100.0	12	100.0
Females	1		0		4		1		2		0		0			8				
Total for Age Group	1		0		5		3		3		1		0							

PROVINCIAL SUMMARY
NATURAL DEATHS BY AGE GROUP, GENDER AND JUDICIAL DISTRICT - SCHEDULE E-1
from 2018.01.01 to 2018.12.31

Judicial Districts	0 - 19		20 - 30		31 - 40		41 - 50		51 - 60		61 - 70		Over 70		Total Males	Total Females	Total	% of Classification	Autopsies	% of Classification
	M	F	M	F	M	F	M	F	M	F	M	F	M	F						
Bathurst	0	0	1	0	2	1	6	0	17	3	8	10	35	20	69	34	103	8.3	24	6.8
Campbellton	0	0	1	0	1	1	0	0	9	3	4	5	19	17	34	26	60	4.8	12	3.4
Edmundston	0	0	0	0	1	1	4	3	15	4	20	5	21	22	61	35	96	7.7	24	6.8
Fredericton	1	1	0	0	4	1	2	1	16	12	31	8	54	36	108	59	167	13.4	66	18.8
Miramichi	0	1	1	1	0	0	3	1	14	3	11	2	25	12	54	20	74	5.9	23	6.5
Moncton	1	2	1	3	3	3	6	5	14	12	51	19	68	57	144	101	245	19.7	84	23.8
Saint John	1	2	3	3	5	4	18	10	38	17	82	54	114	116	261	206	467	37.5	110	31.3
Woodstock	0	0	0	0	0	2	2	0	4	2	8	4	8	3	22	11	33	2.7	9	2.6
Males	3		7		16		41		127		215		344		753		1,245	100.0	352	100.0
% Total - Males	0.2		0.6		1.3		3.3		10.2		17.3		27.6		60.5					
Females	6		7		13		20		56		107		283			492				
% Total - Females	0.5		0.6		1.0		1.6		4.5		8.6		22.7			39.5				
Total for Age Group	9		14		29		61		183		322		627							
% of Classification Total	0.7		1.1		2.3		4.9		14.7		25.9		50.4							

PROVINCIAL SUMMARY
NATURAL DEATHS BY AGE GROUP, GENDER AND DEATH FACTOR - SCHEDULE E-2
from 2018.01.01 to 2018.12.31

Death Factor Description	0 - 19 M	0 - 19 F	20 - 30 M	20 - 30 F	31 - 40 M	31 - 40 F	41 - 50 M	41 - 50 F	51 - 60 M	51 - 60 F	61 - 70 M	61 - 70 F	Over 70 M	Over 70 F	Total Males	Total Females	Total	% of Classification	Autopsies	% of Classification
Natural Disease	3	6	7	7	16	13	41	20	127	56	215	107	343	283	752	492	1244	99.9	350	99.4
Sudden Unexpected Death Syndrome	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	1	0.1	1	0.3
Males	3		7		16		41		127		215		344		753		1,245	100.0	352	100.0
Females	6		7		13		20		56		107		283			492				
Total for Age Group	9		14		29		61		183		322		627							

PROVINCIAL SUMMARY
NATURAL DEATHS BY AGE GROUP, GENDER AND ENVIRONMENT - SCHEDULE E-3
from 2018.01.01 to 2018.12.31

Environment Description	0 - 19 M	0 - 19 F	20 - 30 M	20 - 30 F	31 - 40 M	31 - 40 F	41 - 50 M	41 - 50 F	51 - 60 M	51 - 60 F	61 - 70 M	61 - 70 F	Over 70 M	Over 70 F	Total Males	Total Females	Total	% of Classification	Autopsies	% of Classification
Beach/Shoreline	0	0	0	0	0	0	0	0	2	0	0	0	0	0	2	0	2	0.2	2	0.6
School - Employee (Teacher, Janitor)	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	1	0.1	0	0.0
Gymnasium/Health Club	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0.1	1	0.3
Seniors Complex	0	0	0	0	0	0	0	0	0	0	1	1	3	18	4	19	23	1.8	3	0.9
Nursing Home	0	0	0	0	0	0	0	1	1	0	5	3	20	32	26	36	62	5.0	10	2.7
Homes for Special Care	0	0	1	0	0	0	0	0	1	0	2	1	9	17	13	18	31	2.4	1	0.3
Unlicensed Residential Homes (retirement, rest, etc.)	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	1	0.1	1	0.3
Living inside, residence or on property	2	5	4	5	13	13	22	19	113	54	190	97	286	207	640	400	1040	83.4	300	85.0
Rooming/Boarding House/Halfway House/Group Home	0	0	0	0	0	0	1	0	2	0	0	0	0	0	3	0	3	0.2	2	0.6

PROVINCIAL SUMMARY
NATURAL DEATHS BY AGE GROUP, GENDER AND ENVIRONMENT - SCHEDULE E-3
from 2018.01.01 to 2018.12.31

Environment Description	0 - 19		20 - 30		31 - 40		41 - 50		51 - 60		61 - 70		Over 70		Total Males	Total Females	Total	% of Classification	Autopsies	% of Classification
	M	F	M	F	M	F	M	F	M	F	M	F	M	F						
Inside, other than residence (mall, restaurant, other public building)	0	0	0	0	1	0	1	0	0	1	3	0	0	1	5	2	7	0.6	3	0.9
Hotel / Motel	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	2	2	0.2	1	0.3
Hospital Other (ward, ICU, etc.)	1	1	0	0	0	0	1	0	1	0	3	0	3	1	9	2	11	0.9	0	0.0
Hospital Operating Room	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	1	0.1	1	0.3
Hospital Post Op (recovery room)	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	1	0.1	0	0.0
Hospital Emergency – NON DOA	0	0	0	0	0	0	0	0	1	1	0	2	0	0	1	3	4	0.3	1	0.3
Psychiatric Hospital	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	1	0.1	1	0.3
Doctor's Office	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	1	0.1	0	0.0
Custody Provincial Institution	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0	1	0.1	1	0.3

PROVINCIAL SUMMARY
NATURAL DEATHS BY AGE GROUP, GENDER AND ENVIRONMENT - SCHEDULE E-3
from 2018.01.01 to 2018.12.31

Environment Description	0 - 19		20 - 30		31 - 40		41 - 50		51 - 60		61 - 70		Over 70		Total Males	Total Females	Total	% of Classification	Autopsies	% of Classification
	M	F	M	F	M	F	M	F	M	F	M	F	M	F						
Custody Federal Institution	0	0	0	0	0	0	1	0	0	0	2	0	3	0	6	0	6	0.5	0	0.0
Work Place	0	0	1	0	0	0	0	0	1	0	0	0	0	0	2	0	2	0.2	2	0.6
Factory, Plant, Warehouse (inside)	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	1	0.1	1	0.3
Factory, Plant, Warehouse (outside)	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	1	0.1	1	0.3
Camping / Tenting	0	0	0	0	0	0	1	0	0	0	1	0	1	1	3	1	4	0.3	3	0.9
Public Road – Driver	0	0	0	0	0	0	1	0	0	0	0	2	4	2	5	4	9	0.7	3	0.9
Public Road - Passenger	0	0	0	0	0	0	0	0	0	0	0	0	1	2	1	2	3	0.2	0	0.0
Public Road – bicycle (not motorized vehicle)	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	1	0.1	0	0.0

PROVINCIAL SUMMARY
NATURAL DEATHS BY AGE GROUP, GENDER AND ENVIRONMENT - SCHEDULE E-3
from 2018.01.01 to 2018.12.31

Environment Description	0 - 19 M	0 - 19 F	20 - 30 M	20 - 30 F	31 - 40 M	31 - 40 F	41 - 50 M	41 - 50 F	51 - 60 M	51 - 60 F	61 - 70 M	61 - 70 F	Over 70 M	Over 70 F	Total Males	Total Females	Total	% of Classification	Autopsies	% of Classification
Snowmobiling (anywhere off public road) - driver	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0	1	0.1	1	0.3
Urban Outdoors-public place and other (not residence)	0	0	0	2	1	0	1	0	2	0	5	1	6	0	15	3	18	1.4	11	3.0
Rural Outdoors (not built up place or near residence)	0	0	0	0	0	0	0	0	1	0	1	0	4	0	6	0	6	0.5	2	0.6
Males	3		7		16		41		127		215		334		753		1,245	100.0	352	100.0
Females	6		7		13		20		56		107		283			492				
Total for Age Group	9		14		29		61		183		322		627							

PROVINCIAL SUMMARY
UNDETERMINED DEATHS BY AGE GROUP, GENDER AND JUDICIAL DISTRICT - SCHEDULE F-1
from 2018.01.01 to 2018.12.31

Judicial Districts	0 - 19 M	0 - 19 F	20 - 30 M	20 - 30 F	31 - 40 M	31 - 40 F	41 - 50 M	41 - 50 F	51 - 60 M	51 - 60 F	61 - 70 M	61 - 70 F	Over 70 M	Over 70 F	Total Males	Total Females	Total	% of Classification	Autopsies	% of Classification
Moncton	1	0	1	0	0	1	0	0	1	3	0	0	0	0	3	4	7	70.0	7	70.0
Saint John	1	0	0	0	0	0	1	0	1	0	0	0	0	0	3	0	3	30.0	3	30.0
Males		2		1		0		1		2		0		0	6		10	100.0	10	100.0
% Total - Males		20.0		10.0		0.0		10.0		20.0		0.0		0.0	60.0					
Females		0		0		1		0		3		0		0		4				
% Total - Females		0.0		0.0		10.0		0.0		30.0		0.0		0.0		40.0				
Total for Age Group		2		1		1		1		5		0		0						
% of Classification Total		20.0		10.0		10.0		10.0		50.0		0.0		0.0						

PROVINCIAL SUMMARY
UNDETERMINED DEATHS BY AGE GROUP, GENDER AND DEATH FACTOR - SCHEDULE F-2
from 2018.01.01 to 2018.12.31

Death Factor Description	0 - 19 M	0 - 19 F	20 - 30 M	20 - 30 F	31 - 40 M	31 - 40 F	41 - 50 M	41 - 50 F	51 - 60 M	51 - 60 F	61 - 70 M	61 - 70 F	Over 70 M	Over 70 F	Total Males	Total Females	Total	% of Classification	Autopsies	% of Classification
Drowning – Open Water	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	1	10.0	1	10.0
Drowning - Bathtub	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0	1	10.0	1	10.0
Natural Disease	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	1	10.0	1	10.0
No Anatomical Cause	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	1	10.0	1	10.0
Undetermined	2	0	1	0	0	1	0	0	1	1	0	0	0	0	4	2	6	60.0	6	60.0
Males	2		1		0		1		2		0		0		6		10	100.0	10	100.0
Females	0		0		1		0		3		0		0			4				
Total for Age Group	2		1		1		0		5		0		0							

PROVINCIAL SUMMARY
UNDETERMINED DEATHS BY AGE GROUP, GENDER AND ENVIRONMENT - SCHEDULE F-3
from 2018.01.01 to 2018.12.31

Environment Description	0 - 19 M	0 - 19 F	20 - 30 M	20 - 30 F	31 - 40 M	31 - 40 F	41 - 50 M	41 - 50 F	51 - 60 M	51 - 60 F	61 - 70 M	61 - 70 F	Over 70 M	Over 70 F	Total Males	Total Females	Total	% of Classification	Autopsies	% of Classification
Living inside, residence or on property	2	0	0	0	0	1	0	0	1	2	0	0	0	0	3	3	6	60.0	6	60.0
Rooming / Boarding House /Halfway Home / Group Home	0	0	0	0	0	0	1	0	0	1	0	0	0	0	1	1	2	20.0	2	20.0
Rural Outdoors (not built up place or near residence)	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	1	10.0	1	10.0
Open Water (river, lake, stream, brook)	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	1	10.0	1	10.0
Males	2		1		0		1		2		0		0		6		10	100.0	10	100.0
Females	0		0		1		0		3		0		0			4				
Total for Age Group	2		1		1		1		5		0		0							

Schedule F

Undetermined Deaths
(Means of death impossible to determine)

There were ten deaths classified as Undetermined.

Seven 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.

Case #2

Death Factor: Undetermined
Environment: Rural Outdoors (not built up place or near residence)
Age Group: 20 - 30
Sex: Male
An autopsy was performed.

Case #3

Death Factor: Undetermined
Environment: Living Inside, Residence or on Property
Age Group: 30 - 40
Sex: Female
An autopsy was performed.

Case #4

Death Factor: Natural
Environment: Living Inside, Residence or on Property
Age Group: 50 - 60
Sex: Female
An autopsy was performed.

Undetermined Deaths
(Means of death impossible to determine)

Case #5

Death Factor: Undetermineed
Environment: Living Inside, Residence or on Property
Age Group: 50 - 60
Sex: Female
An autopsy was performed.

Case #6

Death Factor: Undetermined
Environment: Living Inside, Residence or on Property
Age Group: 50 - 60
Sex: Male
An autopsy was performed.

Case #7

Death Factor: No Anatomical Cause
Environment: Rooming/Board House/Halfway House/Group Home
Age Group: 50 - 60
Sex: Female
An autopsy was performed.

Three were in the Saint John 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 (continued)
(Means of death impossible to determine)

Case #2

Death Factor: Drowning - Bathtub
Environment: Rooming/Board House/Halfway House/Group Home
Age Group: 40 - 50
Sex: Male
An autopsy was performed.

Case #3

Death Factor: Drowning – Open Water
Environment: Open Water (river, lake, stream, brook)
Age Group: 50 - 60
Sex: Male
An autopsy was performed.

Summary of Inquests and Recommendations

Four inquests were 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 inquests conducted during the year.

James Baker

A mandatory inquest into the death of James Baker was held March 19-20 in Woodstock. Baker died on October 27, 2014, from injuries sustained during his employment at a pit in Caraquet. An inquest is a formal court proceeding that allows for public presentation of all evidence relating to a death.

The five-person jury selected from the community made the following recommendations:

1. Dedicated supervision at any site that is separated by one kilometre or more from another' this should be a foreman or a safety co-ordinator.

2. WorkSafeNB to oversee start-up of any road construction site, gravel pits and quarries. Every two months having an inspection of all safety and training records of all employees for compliance.

James Baker (continued)

The Presiding Coroner also made recommendations which are as follows:

1. That WorkSafeNB consider changes to the regulations on working near water to require the daily posting of water depths in a prominent location on site.

2. That WorkSafeNB consider changes to the regulations to require a Joint Health & Safety Committee regardless of the number of employees where there are two or more employers working on a construction project site.

The recommendations were forwarded to the President and CEO of WorkSafeNB.

Recommendation #1

Dedicated supervision at any site that is separated by one kilometre or more from another' this should be a foreman or a safety co-ordinator.

The President and CEO of WorkSafeNB advises that while WorkSafeNB is of the opinion that the proximity of the supervisor to where the work is being carried out may be a factor in ensuring that workers are adequately supervised, there are other important factors that also need to be considered and be in place to ensure the health and safety of workers.

In New Brunswick legislation, 'supervision' or 'supervisor' is not defined. However, the definition of employer includes *"(b) a manager, superintendent, supervisor, overseer or any person having authority over an employee".* Legislation also places the obligation on employers to ensure that the necessary supervision is in place. The extent that a supervisor carries out the employer's duties depends on many factors, including the responsibilities assigned to the supervisor. The key factors include:

1. Level of risk and complexity in the job (for example, are there existing controls in place?)

2. The employees' age and work experience (are they competent?)

3. Responsibilities assigned, authority and resources provided to the supervisor (by the employer) to carry out their duties, and

4. The supervisor's competency.

James Baker (continued)

In addition, the competency of the supervisor is evaluated on the following:

1. Qualified to supervise the work (training and experience of the supervisor);

2. Knowledgeable about the *Act* and regulations, and

3. Is aware of the hazards associated with the work being supervised.

It is our belief that the effectiveness of supervision is critical to the health and safety of employees. WorkSafeNB will soon be introducing web-based resources to guide employers and contractors in meeting their legal obligations in ensuring that they have adequate supervision at their workplace, but more importantly to ensure the health and safety of their employees. The introduction of the new resources will be followed up with a Communications campaign informing our stakeholders of the availability of this new information.

It is WorkSafeNB's opinion and as provided for by the *Occupational Health and Safety Act*, once the above factors are considered and met, it the responsibility of the employer to decide on who is suitable to supervise their operations and where to locate their staff to ensure that the work carried on a project is done in a safe manner. The new resources introduced by WorkSafeNB will provide assistance to employers and contractors to achieve this.

Recommendation #2

WorkSafeNB to oversee start-up of any road construction site, gravel pits and quarries. Every two months having an inspection of all safety and training records of all employees for compliance

The President and CEO of WorkSafeNB advises that with respect to the oversight matter, it is important to note that overseeing the start-up of any project is outside the scope of WorkSafeNB's mandate. The responsibility for that oversight lies with the project owner or contractor for the project.

In addition, it is important to note that the *Occupational Health and Safety Act* (*OHS Act*) is based on the internal responsibility system, which requires all individuals in the workplace to take primary responsibility for the health and safety of themselves and

James Baker (continued)

others. The *OHS Act* defines the rights and responsibilities of every individual in the workplace regarding health and safety including owners, employers and contractors responsible for a project site. Owners or contractors who establish the health and safety ground rules at the start of project would be partially meeting some of their obligations of the legislation.

While oversight of the start-up of a project is outside of WorkSafeNB's mandate, compliance staff have on numerous occasions participated at the start-up meeting of a project with the contractors, sub-contractors and their employees to share with the participants their roles and responsibilities for the duration of the project. Staff have also made themselves available to answer any questions or concerns regarding health and safety matters. Please be aware that staff will continue to do so when appropriate.

With respect to the matter of the frequency of compliance inspections and what to examine during these inspection, recognizing that WorkSafeNB has limited resources, and that New Brunswick has many diversified industries including construction projects, WorkSafeNB focuses on specific industries, processes and employers to receive services from WorkSafeNB that will assist in improving health and safety at the workplace.

The places of employment chosen to receive services or the types of services offered is based on:

1. WorkSafeNB's focus strategy, which identifies high risk industries and employers;

2. An analysis of accident statistics;

3. The employer's historical performance; or

4. Other measures or strategies as WorkSafeNB determines appropriate.

In addition, WorkSafeNB allocates its resources (including compliance) where its services will have the greatest impact on:

1. Compliance with the *OHS Act* and Regulations;

2. Accident prevention in the place of employment;

James Baker (continued)

3. recommendation of legislative and regulatory amendments when appropriate.

4. The creation of a safety culture where all workers and employers believe workplace injuries are unacceptable; and

Advancing safety through the promotion of best practices, including the WorkSafeNB raises these items because while bi-monthly inspections examining safety and training records of employees may be appropriate for some projects, other projects based on our analysis, experience and processes of a project may require more frequent and/or different types of interventions to meet the desired outcome of a safer project.

Based on the above, WorkSafeNB believes that it has met the intent of this recommendation and will not take further action at this time.

Presiding Coroner's Recommendations:

Recommendation #1

That WorkSafeNB consider changes to the Regulations on working near water to require the daily posting of water depths in a prominent location on site.

The President and CEO of WorkSafeNB advises that WorkSafeNB's policy for proposed amendments to occupational health and safety legislation requires consultation with affected stakeholders, followed by approval of WorkSafeNB's Board of Directors then proposals proceed to government for the change(s) to occur.

While WorkSafeNB agrees in principle that a safer environment could be achieved with signage near water filled pits and other bodies of water while operating powered mobile equipment, a comprehensive analysis of the issues and consultation with affected stakeholders would have to be undertaken before making a recommendation to the Board of Directors and government for a regulatory amendment.

In the interim, while legislative amendments are being pursued, WorkSafeNB commits to reviewing the presiding Coroner's recommendations with industry stakeholders for their feedback and, if feasible, work with industry to voluntarily adopt as best practice the proposed regulatory amendment.

James Baker (continued)

Recommendation #2

WorkSafeNB to consider changes to the Regulations to require a joint Health & Safety Committee regardless of the number of employees where there are two or more employers working on a construction project site.

The President and CEO of WorkSafeNB advises that current New Brunswick legislation has the following requirements for either a health and safety representative or a joint health and safety committee (JHSC) on a construction project:

1. Projects with five to 29 employees (regardless of project duration), and projects with 30 to 499 employees if the project is less than 91 days, require at least one health and safety representative selected jointly by the employer and the employees;

2. Projects with a duration of more than 90 days, and between 30 and 500 employees require a JHSC; and

3. Projects with more than 500 employees regardless of the duration of the project also require a JHSC.

Other legislative factors include:

- While the number of employers or contractors does not factor into when a health and safety representative or a JHSC is required, the membership of a committee may be impacted by this factor;

- A health and safety representative has the same duties and responsibilities of a JHSC;

- The minimum number for a JHSC is two members unless there is a disagreement at the workplace where the Chief Compliance Officer will decide on the size of the committee;

- Designated health and safety representatives and members of the JHSC must take a three-day training program to assist them in carrying out their duties.

James Baker (continued)

In looking at the factors above, you will note that the only projects that would not require either a health and safety representative or a JHSC are projects with four employees or fewer. When the above provisions were introduced into legislation in 2007, the stakeholders who proposed these amendments to WorkSafeNB's Board of Directors and government believed that requiring projects with fewer than five employees to have either a trained health and safety representative or a JHSC would be an undue burden on the affected employers.

Based on the above, WorkSafeNB is of the opinion that the intent of this recommendation is met through the current legislative requirements and therefore will not proceed with further action at this time.

Ronald Warren

Mr. Ronald Warren was an employee with Twin Rivers Paper Company LTD., in Plaster Rock NB. On Wednesday September 23, 2015 he was operating a loader to transport bundles of lumber from the mill to the lumber yard for temporary storage. As an operator, Mr. Warren was working alone. Bundles would be ready for pick up at the mill approximately every three minutes.

At approximately 14:25 hrs., a radio call from the planer mill indicating that the lumber was now backed up by six bundles. Employees went looking for Mr. Warren and he was subsequently located pinned between the bundles of lumber that were on the loader and on the ground. Mr. Warren was removed but upon the arrival of the paramedics he was deceased. A mandatory inquest into the death of Ronald Warren was held May 1-2 in Edmundston.

The five-person jury selected from the community made the following recommendations:

1. That security cameras be installed and monitored where employees work alone

2. That timely follow-ups be made upon non-response of employees to any communication attempts by co-worker.

3. That the study of use of operator presence seat devices to engage park brake and/or engine shut off when operator is off the seat after a certain amount of time.

Ronald Warren (continued)

4. That chock blocks be used during stop procedure at all times

5. That square skids be utilized instead of log skids

The Presiding Coroner added the following recommendation:

That WorkSafeNB recirculates hazard alerts in reference to safe parking.

The recommendations were forwarded to the President and CEO of WorkSafeNB.

Recommendation #1

That security cameras be installed and monitored where employees work alone

The President and CEO of WorkSafeNB advises that the Province of New Brunswick currently has a regulation (Regulation 92-133 *Code of Practice for Working Alone*) for employees who work alone. Key provisions include:

> *2 An employer shall establish a code of practice to ensure, so far as is reasonably practicable, the health and safety of an employee who works alone at any time at a place of employment from risks arising out of, or in connection with, the work assigned.*
>
> *3 An employer shall ensure that the code of practice referred to in section 2 includes, without being limited to, the following information:*
>
> > *(a) the name, address, location and telephone number of the place of employment;*
> > *(b) the name, address, location and telephone number of the employer;*
> > *(c) the nature of the business conducted at the place of employment;*
> > *(d) identification of the possible risks to each employee who works alone that arise out of or in connection with the work assigned;*
> > *(e) the procedures to be followed in order to minimize the risks identified in paragraph (d); and*
> > *(f) details of the means by which an employee who works alone can secure emergency assistance and the employer can provide emergency assistance in the event of injury or other circumstances which may endanger the health or safety of the employee.*

Ronald Warren (continued)

> *4 An employer shall provide any equipment required in a code of practice established under section 2 and shall ensure that the code of practice is adhered to at the place of employment.*

WorkSafeNB agrees that the presence of cameras where employees work alone could enhance the safety of those employees. It is their opinion that the regulation provides the necessary latitude for employers (in consultation with affected employees) to determine whether security cameras should be part of their code of practice. As a result, WorkSafeNB will consider a communications initiative to remind employers of their obligations to develop a code of practice for employees who work alone.

Recommendation #2

That timely follow-ups be made upon non-response of employees to any communication attempts by co-worker.

The President and CEO of WorkSafeNB advises that they agree in principle with this recommendation. It is their opinion that as with first recommendation, this is a matter that can be addressed in the development of workplace's code of practice. The principles of this recommendation can be included in any communications initiative on codes of practice for employees who work alone.

Recommendation #3

That the study of use of operator presence seat devices to engage park brake and/or engine shut off when operator is off the seat after a certain amount of time.

The President and CEO of WorkSafeNB advises that while they agree in principle with this recommendation, it is their belief that this matter is best raised with mobile equipment manufacturers. They believe that implementing this recommendation will require engineering experts in the design and manufacture of mobile equipment, resources that are not readily available to them. As a result, they will take no further action with respect to this recommendation.

Ronald Warren (continued)

Recommendation #4

That chock blocks be used during stop procedure at all times

The President and CEO of WorkSafeNB advises that they agree in principle with this recommendation and will undertake a review of current regulatory requirements for the various types of vehicles in use at New Brunswick workplaces. They will review enforcement procedures regarding the existing regulatory requirements when parking and exiting vehicles and mobile equipment. They will also include information regarding the benefits of using chock blocks when parking mobile equipment in the communications initiative outlined under the presiding coroner recommendation below.

Recommendation #5

That square skids be utilized instead of log skids

The President and CEO of WorkSafeNB advises that while they agree in principle with this recommendation, it is their opinion that the recommendation should be raised with stakeholders in the forest products industry. The use of skids appears unique to the forest industry and it is their belief that there may be other safe work practices used by the industry as a substitute to the use of log skids. The forest products industry would be in a better position to make this determination.

Presiding Coroner's Recommendations:

That Worksafe NB recirculates hazard alerts in reference to safe parking.

The President and CEO of WorkSafeNB advises that they agree in principle with this recommendation. In addition, because safe parking of mobile equipment is integral to the safety of employees working with and around mobile equipment, they have undertaken a communications initiative in partnership with the construction and forest products industry.

Ronald Warren (continued)

The initiative will include the development of posters (for the workplace) and stickers (for mobile equipment) that will remind operators of the importance of safe parking and include equipment-specific steps for safe parking. In addition, various forms of media will be used to communicate with affected stakeholders on safe parking practices and the new products that can be used to advise their workers of the safe work practices. Finally, the hazard alert mentioned above will be circulated as part of this initiative.

Jean-Guy Boudreau

Mr. Jean-Guy Boudreau was a contractor, owner of Beresford Housing Inc., 2001. On July 4, 2016, Mr. Boudreau died from injuries sustained during the course of his employment at a construction project site in Beresford. He was transported by ambulance to the Bathurst hospital but all efforts to resuscitate him were ineffective.

This inquest was mandatory under section 7(b) of the New Brunswick *Coroners Act* as Mr. Boudreau was working at a construction site at the time of his death.

WorkSafeNB, Bathurst Police et the Coroner's Office held an investigation on this subject.

The jury, composed of five people chosen from the community, made the following recommendations:

1. Raise awareness and encourage the implementation of health and safety procedures at small and medium-sized businesses; and

2. Ask suppliers and manufacturers to provide additional recommendations regarding the safe manipulation and installation of items that are not standard.

The recommendations were forwarded to the President and CEO of WorkSafeNB.

Recommendation #1

Raise awareness and encourage the implementation of health and safety procedures at small and medium-sized businesses; and

The President and CEO of WorkSafeNB advises that his organization agrees that raising the awareness and encouraging the implementation of health and safety

procedures at small and medium sized businesses enhances the health and safety of their workers. To that end, WorkSafeNB continues to develop and implement media and other communications campaigns advising New Brunswick employers and employees of the importance of health and safety including the development, implementation and training of safe work procedures.

The most recent significant campaign highlighting the importance of safe work procedures was launched in 2014, to advise employers of new legislation requiring employers to develop health and safety programs and to provide new employee health and safety orientation and training. Requirements of the new legislation were provisions for the preparation of written work procedures and codes of practice required by the *Occupational Health and Safety Act* (OHSA) and the regulations and the identification of the types of work for which work procedures would be required. The communications campaign was followed up with compliance inspections focused on the new legislation.

WorkSafeNB believes that renewing such a campaign in light of recent workplace fatalities, such as the one experienced by Mr. Boudreau, is timely and our agency will explore options for an effective communications initiative to meet the intent of this recommendation.

Similar recommendations were made in the recent Report of the Task Force on WorkSafeNB. As an example, the Task Force recommended that:

> WorkSafeNB ensure that the Joint Health and Safety Committees (JHSC) are effective, representative of the employer and employee groups, and are sufficiently trained to carry out their duties.

Recommendation #2

Ask suppliers and manufacturers to provide additional recommendations regarding the safe manipulation and installation of items that are not standard.

The President and CEO of WorkSafeNB advises that current provisions for suppliers in *Occupational Health and Safety Act* (OHSA) include:

“supplier” means any person who manufactures, supplies, sells, leases, distributes or installs any tool, equipment, machine, device or any biological, chemical or physical agent to be used by an employee;

Jean-Guy Boudreau (continued)

Every supplier shall:

(a) take every reasonable precaution to ensure that any tool, equipment, machine or device or any biological, chemical or physical agent supplied by him

(i) is reasonably safe when used as directed by the supplier or in accordance with the directions supplied by the supplier, and
(ii) complies with this Act and regulations;

(b) provide directions respecting the safe use of any tool, equipment, machine or device or any biological, chemical or physical agent obtained by an employer to be used at a place of employment by employees; and

(c) ensure that any biological, chemical or physical agent supplied by him is labelled in accordance with the applicable federal and provincial regulations.

If suppliers follow the requirements of OHSA, the intent of this recommendation would be met. Therefore, to ensure suppliers are aware of this obligation, our agency will explore options for an effective communications initiative that will advise suppliers of their responsibilities.

Christopher Carleton

Christopher Adam Carleton, aged 33, was employed as an insulator by Grandview Insulation Contractors Inc.

On February 5, 2018, Mr. Carleton was insulating a heating pipe on the fourth level of the future Irving Oil Headquarters building located at the coroner of Kings Square South and Sydney Street in Saint John, New Brunswick. Shortly after lunch and while working on a 10 foot step ladder, Mr. Carleton fell off the ladder and landed on the concrete floor, striking his head. He suffered a catastrophic head injury and was subsequently pronounced deceased at 08:38 hours on February 6, 2018.

Following the investigation, WorkSafeNB did not recommend charges in this case, as they were unable to determine the root cause of the incident. They found that Mr. Carleton was a certified electrician, trained and oriented to the job and the job site, the ladder was new and its condition did not contribute to the incident and the physical condition of the work area did not contribute to the incident.

Christopher Carleton (continued)

The inquest, conducted on November 26 and 27, 2018 was mandatory pursuant to Section 7(b) of the *Coroners Act*, which states 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 13 witnesses testified in front of a 5-person jury, which made the following recommendations:

1. That if a trade requires working from a lift and/or a ladder that there be a mandatory requirement to have a different style of helmet than a hard hat such as a “climbers” style helmet that is snug and fitted (with a chin strap) and would stay on the head.

2. That where practical, persons required to work at heights should be required to use the most stable form of elevating equipment. For example, man lifts or industrial.

The recommendations were forwarded to the President and CEO of WorkSafeNB.

Recommendation #1

That if a trade requires working from a lift and/or a ladder that there be a mandatory requirement to have a different style of helmet than a hard hat such as a “climbers” style helmet that is snug and fitted (with a chin strap) and would stay on the head.

The President and CEO of WorkSafeNB advises that while WorkSafeNB has proposed regulatory changes to government with respect to head protection by adopting CSA Standard Z94.1-05 *Industrial protective headwear - Performance, selection, care, and use,* you will note from CSA's response that the standard does not address protection of the head in the case of falls during construction or other work. It is CSA's opinion, as well as WorkSafeNB's, that the best form of protection when working at heights is fall prevention or devices that limit the severity of falls. However, WorkSafeNB will recommend to CSA that the Stakeholder Technical Committee established to review CSA Z94.1, consider undertaking research to determine whether protective headwear designed to protect workers from falls from tools such as ladders be a part of this standard.

Christopher Carleton (continued)

Of note, WorkSafeNB is working to harmonize occupational health safety standards across all Atlantic provinces in conjunction with direction from the Council of Atlantic Premiers who recognize the importance of having all jurisdictions on board.

Recommendation #2

That where practical, persons required to work at heights should be required to use the most stable form of elevating equipment. For example, man lifts or industrial.

The President and CEO of WorkSafeNB advises that WorkSafeNB agrees with this recommendation and you will note that CSA promotes it as well, both in their response to us and in the publication of their standard on ladders. CSA 211-2012 *Portable Ladders* which is currently proposed as an amendment to the General Regulation 91-191, has the following provision in the selection, care, and use of portable ladders section of the standard:

> *Working on ladders should only be considered if the use of scaffolds or other work platforms are impractical to* use *due to space considerations, site conditions, soil conditions, etc., or in certain instances where work might not be performed using* a *work platform or scaffold due to the configuration of the work space or the location that needs to be reached by* a *user.*

WorkSafeNB is currently updating its publications and other communications material to reflect this important principle.

In addition, WorkSafeNB sought feedback from CSA to guide them in their response as current New Brunswick regulations reference CSA standards for both protective headwear and ladders. Their responses are as follows.

Recommendation #1

That if a trade requires working from a lift and/or a ladder that there be a mandatory requirement to have a different style of helmet than a hard hat such as a "climbers" style helmet that is snug and fitted (with a chin strap) and would stay on the head.

The CSA Group advises that CSA Z94.1 addresses headwear for the prevention of injury due to objects striking the head, as well as contact with electrical hazards. The

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standard does not address protection of the head in the case of falls. While a “climbers” style helmet might mitigate injuries from a low level fall or uncontrolled swinging of the body, the CSA technical committee (TC) is not aware of any helmets that would prevent serious injury from falls of more than two metres. The CSA TC have concluded that the best form of protection when working at heights is fall prevention or devices that limit the severity of falls. It should be noted that CSA Group’s Z259 Series of Standards address these preventive means (CSA Z259.17 provides general guidance on fall protection devices).

Recommendation #2

That where practical, persons required to work at heights should be required to use the most stable form of elevating equipment. For example, man lifts or industrial.

There are many choices available to constructors in accessing elevated work positions - powered lifting devices (CSA C225, CSA B354 Series), scaffold (CSA Z797), ladders (CSA Z11), suspended work positioning devices (CSA Z271), etc. CSA Group publishes standards that address all of these types of equipment. These standards also provide advice on the selection of this equipment for a wide variety of jobs / work environments, and can also be used as a basis for education of constructors and contractors on choosing the best equipment for the job, as well as training workers how to use the equipment safely.