Office of the Chief Coroner

Annual Report **2015**



2015 Annual Report

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The Honourable Denis Landry
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-fourth Annual Report of the Chief Coroner for the period January 1, 2015 to December 31, 2015.

Yours very truly,

GREGORY J. FORESTELL Chief Coroner Province of New Brunswick

Table of Contents Page	
Mission Statement5	
Historical Background5	
Origin of the Office of the Coroner5	
The New Brunswick Coroner System6	
Organizational Structure6	
Notification Requirement6	
Investigative Capacity of Coroner Services6	
Purpose of Coroner's Investigation	
The Inquest Decision7	
Summary8	
Statistical Summary of Investigated Deaths8	
Schedule "A.1" - Total Deaths by Classification	
Schedule "A.2" - Total Deaths by Month	
Schedule "A.3" - Total Deaths by Judicial District	
Schedule "B.1" - Accidental Deaths by Age Group, Gender and Judicial District	
Schedule "B.2" - Accidental Deaths by Age Group, Gender and Death Factor	
Schedule "B.3" - Accidental Deaths by Age Group, Gender and Environment	
Schedule "C.1" - Suicide Deaths by Age Group, Gender and Judicial District	
Schedule "C.2" - Suicide Deaths by Age Group, Gender and Death Factor	

(Summary of Inquests and Other Recommendaitons	. 42
	Schedule "F" – Undetermined Deaths	. 39
	Schedule "F.3" – Undetermined Deaths by Age Group, Gender and Environment	. 38
	Schedule "F.2" – Undetermined Deaths by Age Group, Gender and Death Factor	. 37
	Schedule "F.1" – Undetermined Deaths by Age Group, Gender and Judicial District	. 36
	Schedule "E.3" - Natural Deaths by Age Group, Gender and Environment	. 32
	Schedule "E.2" - Natural Deaths by Age Group, Gender and Death Factor	. 31
	Schedule "E.1" - Natural Deaths by Age Group, Gender and Judicial District	. 30
	Schedule "D.3" - Homicide Deaths by Age Group, Gender and Environment	. 29
	Schedule "D.2" - Homicide Deaths by Age Group, Gender and Death Factor	. 28
	Schedule "D.1" - Homicide Deaths by Age Group, Gender and Judicial District	. 27
	Environment	. 25

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 the 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, a cadre of 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, Miramichi, Bathurst and Edmundston and also the services of the Provincial Forensic Toxicologist located at Saint John.

The identification of a death as a "Type II" case, which needs the special consideration of a forensic pathologist, results in the utilization of the forensic service and requires that the body be transported to Saint John 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 20.4 percent of the total of approximately 7,300 deaths per year in the Province. A high percentage of the investigated deaths are determined to be from natural causes. The coroner, in approximately 32.7 percent of the cases, orders autopsies and inquests are ordered in slightly less than one percent of all investigated deaths.

For the period covered by this Report, the Registrar of Vital Statistics recorded 7,290 deaths in the Province of which 1,491 or 20.5% were reported to a coroner. By comparison in the previous year there were 6,833 deaths in the Province of which 1,528 or 22.4% were reported to a coroner.

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

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

Comments should be directed to:

The Office of the Chief Coroner P. O. Box 6000

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

Statistical Summary of Investigated Deaths

The information provided in this Annual Report is presented for the calendar year 2015.

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

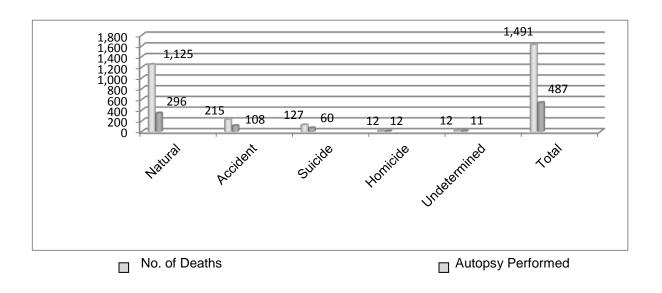
from 2015.01.01 to 2015.12.31

Classification	No. of Deaths	% of Deaths	Rate per 100,000 Population	Autopsy Performed	% of classification
Natural	1,125	75.5	149.1	296	26.3
Accident	215	14.4	28.5	108	50.2
Suicide	127	8.5	16.8	60	47.2
Homicide	12	0.8	1.6	12	100.0
Undetermined	12	0.8	1.6	_11	91.7
Total	1,491	100.0		487	

Based on a population of 754,309

PROVINCIAL SUMMARY - SCHEDULE A-1

from 2015.01.01 to 2015.12.31



NOTE: Based upon Statistics Canada postcensal population estimates for N. B. census divisions (released March 8, 2017). Sub-county estimates are based on the 2011 Census population share of the county.

Provincial Summary - Deaths Investigated by Classification, by Month - Schedule A-2 from 2015.01.01 to 2015.12.31

Classification	Jan	Feb	Mar	April	Мау	June	July	Aug	Sept	Oct	Nov	Dec	Total
Natural	120	116	120	83	98	62	87	62	28	101	8	89	1,125
Accident	16	17	10	16	20	21	15	20	25	15	24	16	215
Suicide	6	7	2	10	10	15	13	6	12	13	10	10	127
Homicide	7	~	~	0	0	က	7	α	0	0	0	_	12
Undetermined	0	-	0	1	2	0	0	1	2	2	_	2	12
Total	147	146	136	110	118	118	117	111	120	131	119	118	1,491

DEATHS INVESTIGATED BY JUDICIAL DISTRICT - SCHEDULE A-3 from 2015.01.01 to 2015.12.31

			jbnC	Judicial Districts					
	Bathurst	Campbellton	Edmundston	Fredericton	Miramichi	Moncton	Saint John	Woodstock	Province
Natural Accident Suicide Homicide Undetermined	24 24 24 0	57 15 6	83 21 13 0	145 29 21 1	83 10 11 0	207 55 22 3	416 45 27 3	40 41 3 0	1,125 215 127 12 12
Total	146	80	118	198	104	294	493	58	1,491
% of Provincial Total	8.6	5.4	7.9	13.3	6.9	19.7	33.1	3.9	100
Population	75,603	31,184	40,901	139,999	46,937	211,837	171,105	36,743	754,309
Death Rate per 100,000 population Natural Accident Suicide Homicide Undetermined	124.3 34.3 31.7 2.6 0.0	182.7 48.1 19.2 3.2 3.2	202.9 51.3 31.8 2.4 0.0	103.6 20.7 15.0 0.7 1.4	176.8 21.3 23.4 0.0 0.0	97.7 26.0 10.4 1.4 3.3	243.1 26.3 15.8 1.8	108.9 38.1 8.2 2.7 0.0	149.1 28.5 16.8 1.6
Total deaths by trauma (accident, suicide, homicide)	52	22	35	12	21	80	75	18	354
Rate per 100,000 population	68.8	70.5	85.6	36.4	44.7	37.8	43.8	49.0	46.9

PROVINCIAL SUMMARY
ACCIDENTAL DEATHS BY AGE GROUP, GENDER AND JUDICIAL DISTRICT - SCHEDULE B-1
from 2015.01.01 to 2015.12.31

Autopsies % of Classification	8 7.4 10 9.3 10 9.3 5 4.6 29 26.8 30 27.8 9 8.3	108 100.0	
% of Classification	12.0 7.0 9.8 13.5 4.7 25.6 20.9	100.0	
Total	26 15 21 29 10 55 45	215	
Total Females	6 E L L L L L L L L L L L L L L L L L L	81	
Total Males	17 10 10 14 14 28 7	62.3	
Over 70 M F	7 6 6 7 7 8 8 7 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9	30 14.0 34 15.8	64
61 - 70 M F	0 0 7 7 0 0 1 1 1 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3	13.5	42
51 - 60 M F	5 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	17 7.9 10 4.7	27
41 - 50 M F	8 + 8 + 4 5 4 0 + 0 2 0 + 2 2 +	11.6	4£ 0
31 - 40 M F	0 1 0 1 0 4 2 1	9 4.2 7 7 3.3	91 7
20 - 30 M F	3 1 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1.4	6 0
0 - 19 M	0 0 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3.7 3.7 5	د «
Judicial Districts	Bathurst Campbellton Edmundston Fredericton Miramichi Moncton Saint John Woodstock	Males % Total - Males Females % Total - Females	Total for Age Group % of Classification

PROVINCIAL SUMMARY
ACCIDENTAL DEATHS BY AGE GROUP, GENDER AND DEATH FACTOR - SCHEDULE B-2 from 2015.01.01 to 2015.12.31

% of Classification	9.9	6:0	6:0	6:0	18.5	7.4	2.8	2.8	3.7
Autopsies	2	-	1	1	20	8	е	е	4
% of Classification	4.2	0.5	0.5	0.5	19.4	6.5	2.8	2.3	2.8
Total	6	-	1	1	42	14	9	5	9
Total Females	1	0	0	0	13	3	2	0	ю
Total Males	8	~	1	-	29	11	4	5	3
Over 70 M F	0 0	0 0	1 0	0 0	3 5	2 0	1 0	0 0	0 0
61 - 70 M F	1 1	1 0	0 0	0 0	3 1	3 0	0 1	0 0	0 0
51 - 60 M F	2 0	0 0	0 0	0 0	4 2	2 0	0 0	0 0	2 0
41 - 50 M F	3 0	0 0	0 0	1 0	8	1 0	0 0	0 0	1
31 - 40 M F	0 0	0 0	0 0	0 0	3 0	0 1	0 0	1 0	0 0
20 - 30 M F	2 0	0 0	0 0	0 0	4 0	2 1	1 1	3 0	0 1
0 - 19 M F	0 0	0 0	0 0	0 0	3 2	1 1	2 0	1 0	0 1
Death Factor Description	Drowning Open Water	Drowning - Pond/Quary	Drowning – Private Pool	Drowning – Bathtub	Trauma of Vehicle Collision	Trauma of Vehicle Upset/Rollover	Trauma of Vehicle/Pedestrian Collision	Trauma of Recreational Vehicle Collision	Trauma of Recreational Vehicle Upset/Rollover

ACCIDENTAL DEATHS BY AGE GROUP, GENDER AND DEATH FACTOR - SCHEDULE B-2 from 2015.01.01 to 2015.12.31

% of Autopsies % of Classification	0.5 1 0.9	0.5 1 0.9	1.9 4 3.7	1.9 4 3.7	28.3 5 4.6	2.8 2 1.9	3 2.8	1.4 2 1.9
Total %	-	-	4	4	19	ø	4	е
Total Females	0	0	2	-	31	2	0	0
Total Males	-	-	2	ю	30	4	4	е
Over 70 M F	0 0	0 0	0 0	0 0	19 26	2 1	0 0	0 0
61 - 70 M F	0 0	0 0	0 0	۶ 1	7 3	2 0	3 0	1 0
51 - 60 M F	0 0	0 0	-	0 0	3 2	0	1 0	1 0
41 - 50 M F	0 0	0	0	0 0	1 0	0	0 0	1 0
31 - 40 M F	0	0 0	0	0 0	0 0	0 0	0 0	0 0
20 - 30 M F	0 0	0 0	0 0	0 0	0 0	0 0	0 0	0 0
0 - 19 R	0 0	0 0	0 0	0 0	0 0	0 0	0 0	0 0
Death Factor Description	Carbon Monoxide Poisoning – Vehicle Exhaust	Carbon Monoxide Poisoning	Exposure to cold	Fire – Structural	Fall or jump – same level	Fall or jump – different level height; eg. bridge, building	Blunt Trauma, Accidental	Crushed and/or Buried

ACCIDENTAL DEATHS BY AGE GROUP, GENDER AND DEATH FACTOR - SCHEDULE B-2 from 2015.01.01 to 2015.12.31

	0 - 19	20 - 30	31 - 40	41 - 50	51 - 60	61 - 70	Over 70	Total	Total	Total	% of	Autopsies	% of
Death Factor Description	M F	M	М F	М	M F	MF	MF	Males	Females		Classification		Classification
Shooting – Handgun	0 0	0 0	0 0	1 0	0 0	0 0	0 0	1	0	1	0.5	1	0.9
Asphyxia	0 0	0 0	0 0	0 0	1 0	0 0	1 0	2	0	2	6.0	-	6:0
Aspiration	0 0	0 0	0 0	0 0	0 1	1 0	0 0	1	1	2	6:0	0	0.0
Alcohol Intoxication	0 0	0 0	0 0	3 0	0 1	1 0	0 0	4	1	5	2.3	5	4.6
Alcohol and Drug	0 0	0 0	0 0	0 1	0 0	2 0	0 0	2	1	3	4.1	е	2.8
Drug	-	2 0	4 5	2 4	0 2	9	1 2	11	20	31	14.3	27	25.1
Drug (street)	0 0	1 0	0 0	0 0	0 0	0 0	0 0	1	0	1	0.5	-	6.0
Males	8	16	6	25	21	29	30	134		215	000	, 80	7000
Females	5	3	7	6	10	13	34		81	2		2	2
Total for Age Group	13	19	16	34	7.7	42	64						

% of Classification

2.8

0.0

0.0

6.0

6.

	Autopsies	3	0	0	1	5	2	1	1
OULE B-3	% of Classification	1.4	0.9	0.5	0.5	2.8	6:0	0.5	0.5
SCHEI	Total	3	2	1	1	9	2	1	1
NMENT -	Total Females	0	0	0	0	0	1	0	0
r ENVIROI :31	Total Males	3	2	1	1	9	1	1	1
PROVINCIAL SUMMARY IE GROUP, GENDER AND EN from 2015.01.01 to 2015.12.31	Over 70 M F	0 0	0	0 0	0 0	0 0	0 0	0 0	0 0
INCIAL S IP, GENE 5.01.01 t	61 - 70 M F	1 0	0	0 0	0 1	0 0	1	1 0	0 0
PROV SE GROU from 201	51-60 M F	2 0	0 0	0 0	0 0	1 0	0 0	0 0	0 0
IS BY AG	41 - 50 M F	0 0	1 0	0 0	0 0	3 0	0 0	0 0	0 0
PROVINCIAL SUMMARY ENTAL DEATHS BY AGE GROUP, GENDER AND ENVIRONMENT - SCHEDULE B-3 from 2015.01.01 to 2015.12.31	31 - 40 M F	0 0	0 0	0 0	0 0	0 0	0 0	0 0	0 0
ACCIDENT,	20 - 30 M F	0 0	0 0	1 0	0 0	2 0	0 0	0 0	0 0
Ā	0 - 19 M F	0 0	0 0	0 0	0 0	0 0	0 0	0 0	1 0
	Environment Description	Work Place	Factory, Plant, Warehouse (Inside)	Logging/Tree Cutting - Commercial	Commercial Drivers – Truck, Taxi, School Bus, etc.	Open water (river, lake, stream, brook)	Beach / Shoreline	Boating – personal watercraft, jet ski, etc.	Snowmobiling (anywhere off public road) - passenger

PROVINCIAL SUMMARY
ACCIDENTAL DEATHS BY AGE GROUP, GENDER AND ENVIRONMENT - SCHEDULE B-3
from 2015.01.01 to 2015.12.31

					+			+										
	0 - 19	19	20 - 30	31 - 40		41 - 50	51 - 60		61 - 70	ŏ	Over 70	Total	Total	Total	% of	Autopsies	% of	
Environment Description	Σ	ш	L ≥	Σ	Σ	L V	Σ	L L	L S	Σ	ш	लब <u>ल</u> स			Classification		Classification	
Snowmobiling (anywhere off public road) - driver	0	0	2 0	0		0 0	0		0	0	0	4	0	4	1.9	8	1.9	
ATV driver - on public road	0	0	0 0	0 0		0 0	1 0		0 0	0	0	-	0	-	0.5	0	0.0	
ATV driver – off public road	0	0	1 0	0		-	0 0		0 0	0	0	2	-	3	4.1	ဗ	2.8	
ATV passenger – on public road	0	-	0 0	0 0		0 0	0 0		0 0	0	0	0	-	-	0.5	0	0.0	
Public Road - driver	2	0	0 8	£	6	2	3 1		1	4	3	28	8	36	16.6	17	15.7	
Public Road - passenger	7	ဗ	1 2	0 0	0	-	0 0		0 0	0	2	е	80	11	5.1	ω	4.6	
Public Road – motorcycle driver	0	0	1 0	0 0	-	0	3 0		1 0	0	0	9	0	9	2.8	4	3.7	
Public Road – motorcycle passenger	0	0	0 0	0 0	0	0	0 1		0 0	0	0	0	-	-	0.5	0	0.0	
Public Road – bicycle (not motorized vehicle)	-	0	0 0	0	0	0	0 0		0 0	0	0	-	0	-	0.5	0	0:0	

PROVINCIAL SUMMARY
ACCIDENTAL DEATHS BY AGE GROUP, GENDER AND ENVIRONMENT - SCHEDULE B-3
from 2015.01.01 to 2015.12.31

	0 - 19	6	20 - 30	31 - 40	41 - 50	51 - 60	0 61 - 70	<u>و</u>	Over 70	-	Total	Total	% of	Autopsies	% of
Environment Description	Σ	ш	ш ∑	L Σ	L ∑	E E	Σ	ш	E E	Made			Classification		Classification
Public Road - pedestrian	0	0		0 0	0 0	0 0	0	-	1 0	2	2	4	1.9	2	1.9
Non Public Road - passenger	0	0	0	0 0	0 0	0 0	0	0	0 0	-	0	-	0.5	7	0.9
Hospital Other (ward, ICU, etc.)	0	0	0 0	0 0	0 0	1 0	0	0	2 2	ю	2	9	2.3	0	0.0
Custody Federal Institution	0	0	0 0	0 0	0 0	0 0	-	0	0 0	-	0	-	0.5	0	0.0
Living inside, residence or on property	2	_	2 0	4	9 5	4 7	15 1	10	14 13	50	42	85	42.7	52	48.1
Seniors Complex	0	0	0 0	0	0 0	0 0	0	0	2 0	2	0	2	6:0	0	0:0
Homes for Special Care	0	0	0 0	0 0	1 0	0 0	0	0	2 6	ю	9	6	4.2	7	6:0
Nursing Home	0	0	0 0	0 0	0 0	0 0	٢	0	4 7	Ŋ	7	12	5.5	2	1.9

PROVINCIAL SUMMARY
ACCIDENTAL DEATHS BY AGE GROUP, GENDER AND ENVIRONMENT - SCHEDULE B-3 from 2015.01.01 to 2015.12.31

Environment Description	0 - 19 M F	20 - 30 M F	31 - 40 M F	41 - 50 M F	51 - 60 M F	61 - 70 M F	Over 70 M F	Total Males	Total Females	Total	% of Classification	Autopsies	% of Classification
Hotel / Motel	0 0	0 0	0	0 0	0 0	0	0 0	2	0	2	6:0	7	6:1
Urban Outdoors – public place & other (not residence)	0	0	0	0	-	0	-	ю	7	S	2.3	ო	2.8
Rural Outdoors (not built up place or near residence)	0	0	0	0 0	0 0	0	0	-	0	-	0.5	-	0.9
Males	ω	91	6	25	17	29	30	134		215	100.0	108	100.0
Females	Ŋ	ю	7	o	10	5	34		28				
Total for Age Group	13	19	16	34	27	42	64						

PROVINCIAL SUMMARY
SUICIDE DEATHS BY AGE GROUP, GENDER AND JUDICIAL DISTRICT - SCHEDULE C-1
from 2015.01.01 to 2015.12.31

% of Classification	10.0	3.3	5.0	11.7	15.0	11.7	40.0	3.3			100.0			
Autopsies	9	7	ო	7	თ	7	24	2			09			
% of Classification	18.9	4.7	10.2	16.5	8.7	17.3	21.3	2.4			100.0			
Total	24	9	13	21	7	22	27	3		ļ	127			
Total Females	4	_	4	2	ო	က	9	1			24	18.8		
Total Males	20	5	თ	19	œ	19	21	2	103	81.2				
Over 70 M F	0 4	0	0	2 0	0 0	2 0	2	1 0	12	9.4	2	9.1	41	11.0
61 - 70 M F	0 9	1 0	2 1	2 0	4 0	<u></u>	2 1	0 1	18	14.2	4	3.1	22	17.3
51 - 60 M F	2 0	3	2	3	1 2	5 1	0 2	1 0	27	21.3	4	3.1	31	24.4
41 - 50 M F	3 2	0 1	2 1	4	1	4 0	5 2	0 0	19	15.0	8	6.3	27	21.3
31 - 40 M F	1 2	0 0	2 0	2 0	0	0 9	3	0 0	18	14.2	4	3.1	22	17.3
20 - 30 M F	1 0	0 0	0 1		1 0	_	2 0	0 0	7	5.5	2	1.6	6	7.1
0 - 19 R	0 0	0 0	0 0	2 0	0 0	0 0	0 0	0 0	2	1.6	0	0.0	2	1.6
Judicial Districts	Bathurst	Campbellton	Edmundston	Fredericton	Miramichi	Moncton	Saint John	Woodstock	Males	% Total - Males	Females	% Total - Females	Total for Age Group	% of Classification Total

PROVINCIAL SUMMARY
SUICIDE DEATHS BY AGE GROUP, GENDER AND DEATH FACTOR - SCHEDULE C-2 from 2015.01.01 to 2015.12.31

	0 - 19	20 - 30	30	31 - 40	41 - 50	51 - 60	61 - 70	02	Over 70	-	Total	Total	Total	Jo%	Autopsies	% of
Death Factor Description	LL ∑	Σ	ш	LL E	L	L Σ	Σ	ш	Σ	∑ 		Females		Classification		Classification
Hanging	1 0	4	2	12 2	11 3	13 2	ى	0	5	0	48	6	57	44.9	18	30.0
Decapitation or Transection	0 0	0	0	0 0	0 0	1	0	0	0	0	-	1	2	1.6	2	3.3
Cuts, Stabs	0 0	-	0	0 0	0 0	1 0	0	0	0	0	2	0	2	1.6	2	3.3
Drowning Open Water	0 0	0	0	1 0	1 0	0 0	0	_	2 0	_	4	-	5	9.6	5	8.3
Asphyxia	0 0	0	0	0 0	1 0	0 0	0	0	1 0	_	2	0	2	1.6	0	0.0
Strangulation	0 0	0 0		0 0	0 0	0 1	0	0	0 0		0	1	-	0.8	1	1.7
Carbon Monoxide Poisoning - Vehicle Exhaust	0 0	0	0	0 0	0 0	0	0	0	0 0	_	-	0	-	0.8	-	1.7
Carbon Monoxide Poisoning	0 0	-	0	0 0	0 1	1 0	0	-	0 0		2	2	4	3.1	-	1.7
Fire – Self	0 0	0	0	0 0	0 0	0 0	-	0	0 0		1	0	_	0.8	0	0.0
Fire - Vehicle	0 0	0	0	1 0	0 0	0 0	0	0	0 0		-	0	-	0.8	-	1.7

PROVINCIAL SUMMARY
SUICIDE DEATHS BY AGE GROUP, GENDER AND DEATH FACTOR - SCHEDULE C-2
from 2015.01.01 to 2015.12.31

Death Factor Description	0 - 19 M F	20 - 30 M F	31 - 40 M F	41 - 50 M F	51 - 60 M F	61 - 70 M F	Over 70 M F	7.0 F	Total Males	Total Females	Total	% of Classification	Autopsies	% of Classification
Shooting - Rifle	1 0	1 0	2 0	3 1	2 0	4 0	4	0	17	1	18	14.2	6	15.0
Shooting - Shotgun	0 0	0 0	1 0	1 0	5 0	3 0	0	0	10	0	10	7.9	9	10.0
Shooting - Handgun	0 0	0 0	0 0	1 0	0 0	0 0	7	0	ю	0	က	2.4	-	1.7
Ethylene Glycol	0 0	0 0	0 0	0 0	0 0	0 1	0	0	0	1		0.8	0	0.0
Alcohol and Drug	0 0	0 0	0 0	0 0	0 0	1 0	0	0	-	0	-	0.8	1	1.7
Drug	0 0	0 0	0 2	£ 0	3 0	4 0	1	1	8	9	14	11.0	10	16.6
Fall or jump – different level, eg. bridge, bldg.	0 0	0 0	0 0	1 0	0 0	0 1	0	-	-	2	Э	2.4	2	3.3

PROVINCIAL SUMMARY
SUICIDE DEATHS BY AGE GROUP, GENDER AND DEATH FACTOR - SCHEDULE C-2
from 2015.01.01 to 2015.12.31

Autopsies / % of Classification	0.0	60 100.0		
% of Classification	0.8	100.0		
Total	1	127		
Total Females	0		24	
Total Males	-	103		
Over 70 M F	0 0	12	2	14
61 - 70 M F	0 0	18	4	22
51 - 60 M F	0 0	27	4	31
41 - 50 M F	0 0	19	8	27
31 - 40 M F	1 0	18	4	22
20 - 30 M F	0 0	7	7	0
0 - 19 M F	0 0	7	0	7
Death Factor Description	Fall or jump - same level	Males	Females	Total for Age Group

PROVINCIAL SUMMARY
SUICIDE DEATHS BY AGE GROUP, GENDER AND ENVIRONMENT - SCHEDULE C-3
from 2015.01.01 to 2015.12.31

	0 - 19	20	20 - 30	31 - 40	41 - 50	09	51 - 60	O	61 - 70	Ove	Over 70	Total	Total	Total	% of	Autopsies	% of
Environment Description	L . Σ	Σ	ш	ш ∑	Σ	ш	L Σ	Σ	ш	Σ	ш	מפונים	9		Classification		Cassilla
Custody Federal Institution	0 0	0	0	0 0	0	0	0 1	0	0	0	0	-	0	-	0.8	-	1.7
Living inside, residence or on property	0	2	2	12 4	4	ω	22 3	16	2	თ	8	62	21	100	78.7	41	68.3
Hospital Other (ward, ICU, etc.)	0 0	0	0	0 0	-	0	0 0	0	0	0	0	-	0	-	0.8	1	1.7
Hotel/Motel	0 0	0	0	0 0	0	0	0 0	-	0	0	0	-	0	-	0.8	1	1.7
Public Road - Driver	0 0	0	0	1 0	0	0	0 0	0	0	0	0	-	0	-	0.8	-	1.7
Public Road- Pedestrian	0 0	0	0	1 0	0	0	0 0	0	0	0	0	-	0	-	0.8	0	0.0
Railway – Not on Board (Crossing Tracks)	0 0	0	0	0 0	0	0	0	0	0	0	0	0	-	-	0.8	-	1.7
Open Water (river, lake, stream, brook)	0 0	0	0	1 0	-	0	0 0	0	-	8	0	4	-	5	3.9	5	8.3
Ocean	0 0	0	0	0 0	0	0	0 0	0	-	0	0	0	1	-	0.8	1	1.7

PROVINCIAL SUMMARY
SUICIDE DEATHS BY AGE GROUP, GENDER AND ENVIRONMENT - SCHEDULE C-3
from 2015.01.01 to 2015.12.31

es % of Classification		3.3	10.0	100.0		
Autopsies		2	9	09		
% of Classification		3.9	6.7	100.0		
Total		5	10	127		
Total		0	0		24	
Total		5	10	103		
Over 70	L . Σ	0 0	0	12	7	41
61 - 70	L Σ	0 0	1 0	18	4	22
51 - 60	ш ∑	0	0	27	4	31
41 - 50	L . ∑	3 0	0 0	19	∞	27
31 - 40	L . ∑	1 0	2 0	18	4	22
20 - 30	LL ∑	0 0	2 0	7	N	თ
0 - 19	ц ∑	0 0	0 1	2	0	2
	Environment Description	Urban Outdoors - public place and other (not residence)	Rural Outdoors (not built up place or near residence)	Males	Females	Total for Age Group

PROVINCIAL SUMMARY
HOMICIDE DEATHS BY AGE GROUP, GENDER AND JUDICIAL DISTRICT - SCHEDULE D-1
from 2015.01.01 to 2015.13.1

% of	Classification	16.8	8.3	8.3	8.3	25.0	25.0	8.3		100.0				
Autopsies		2	~	~	~	ဇ	ဇ	-		12				
% of	Classification	16.8	8.3	8.3	8.3	25.0	25.0	8.3		100.0				
Total		2	_	_	_	က	က	-		12				
Total	ב ב ב ב ב ב ב ב ב ב ב ב ב ב ב ב ב ב ב	0	0	~	0	~	2	-			5	41.7		
Total	Name of the second	2	_	0	_	2	_	0	7	58.3				
Over 70	A	0 0	0 0	0 0	0 0	0 0	0 0	0 0	0	0.0	0	0.0	0	0.0
61 - 70	L Z	0 0	0 0	0 0	0	0 0	0 0	0	-	8.3	0	0.0	-	8.3
51 - 60	L Σ	1 0	0 0	1	0 0	0 0	0	0	-	8.3	2	16.8	က	25.0
41 - 50	L S	1 0	1 0	0 0	0 0	0 0	1	0 0	2	16.8	7	8.3	က	25.0
31 - 40	L Σ	0 0	0 0	0 0	0 0	0 1	1 0	0	-	8.3	1	8.3	2	16.7
20 - 30	A	0 0	0 0	0 0	0 0	1 0	0	0 0	-	8.3	-	8.3	2	16.7
0 - 19	L Z	0 0	0 0	0 0	0 0	0	0 0	0 0	-	8.3	0	0:0	-	8.3
	Judicial Districts	Bathurst	Campbellton	Edmundston	Fredericton	Moncton	Saint John	Woodstock	Males	% Total - Males	Females	% Total - Females	Total for Age Group	% of Classification Total

PROVINCIAL SUMMARY
HOMICIDE DEATHS BY AGE GROUP, GENDER AND DEATH FACTOR - SCHEDULE D-2
from 2015.01.01 to 2015.12.31

_									1
% of	Classification	25.0	7.14	16.7	8.3	8.3	00 00		
Autopsies		ε	9	2	1	1	12	į	
% of	Classification	25.0	41.7	16.7	8.3	8.3	1000		
Total		ю	2	2	-	1	12	į	
Total	Females	1	2	1	0	1		9	
Total	Males	2	ဧ	1	1	0	2		
Over 70	M	0 0	0 0	0 0	0 0	0 0	0	0	0
61 - 70	М F	0 0	1 0	0 0	0 0	0 0	1	0	1
51 - 60	A	1 0	1 0	0 0	1 0	0 0	-	2	က
41 - 50	A	1 0	0 0	1	0 0	0 0	2	-	ю
31 - 40	М	0 0	1 1	0 0	0 0	0 0	1	1	2
20 - 30	M	1 0	0 0	0 0	0 0	0 1	-	1	2
0 - 19	М F	0 0	1 0	0 0	0 0	0 0	-	0	1
	Death Factor Description	Blunt Trauma, Beating	Cuts, Stabs	Shooting – Shotgun	Shooting – Handgun	Strangulation	Males	Females	Total for Age Group

PROVINCIAL SUMMARY
HOMICIDE DEATHS BY AGE GROUP, GENDER AND ENVIRONMENT - SCHEDULE D-3
from 2015.01.01 to 2015.12.31

	0 - 19	20 - 30	31 - 40	41 - 50	51 - 60	61 - 70	Over 70	Total	Total	Total	% of	Autopsies	% of
Environment Description	ш. ∑	ш Б	μ	ш ∑	LL ∑	ц Б	L Z	Males			Classification		Classification
Living Inside, Residence or on Property	1 0	0	-	2 7	0 2	0	0	5	4	O	75.1	ത	75.1
Rural Outdoors (not built up place or near residence)	0 0	1	0 0	0 0	0 0	0 0	0 0	0	-	+	8.3	1	8.3
Urban Outdoors - public place and other (not residence)	0 0	1 0	0 0	0 0	0 0	0 0	0 0	1	0	-	8.3	1	8.3
Public Road - Driver	0 0	0 0	0 0	0 0	1 0	0 0	0 0	1	0	+	8.3	1	8.3
Males	1	7	-	2	7	1	0	2					
Females	0	-	-	-	2	0	0		5	12	100.0	12	100.0
Total for Age Group	1	2	5	3	ε	-	0						

PROVINCIAL SUMMARY
NATURAL DEATHS BY AGE GROUP, GENDER AND JUDICIAL DISTRICT - SCHEDULE E-1
from 2015.01.01 to 2015.12.31

	0 - 19	20 - 30	31 - 40	41 - 50	51 - 60	61 - 70	Over 70	Total	Total	Total	% of	Autopsies	% of
Judicial Districts	L	LL S	LL S	L	ц ∑	Σ	LL S	Males	Females		Classification		Classification
Bathurst	0 0	0 1	0	6 1	12 4	13 9	24 23	55	39	94	8.4	26	8.8
Campbellton	0 0	0 0	0 0	3 2	4 6	10 5	12 15	29	78	22	5.1	13	4.4
Edmundston	0	0 0	0	е е	6 5	11 11	23 21	43	40	83	7.4	19	6.4
Fredericton	_	1 0	1	5 3	12 4	20 19	39 39	78	29	145	12.9	62	20.9
Miramichi	0	2 0	0	7 1	9	12 3	17 25	49	34	83	7.4	59	8.6
Moncton	0 0	1 2	2 0	10 6	11 10	32 18	74 41	130	77	207	18.4	29	19.9
Saint John	4	2 3	2	11 8	41 21	84 28	108 101	253	163	416	37.0	29	22.6
Woodstock	0 0	0	-	1 2	2 3	5 5	13 6	23	17	40	3.6	21	7.1
Males	7	7	9	46	26	187	310	099					
% Total - Males	9.0	0.6	0.5	4.1	8.6	16.6	27.6	58.6		1 105	, ,	900	7000
Females	2	9	5	26	29	86	271		465	27.	0.000	067	2.00
% Total - Females	0.2	0.5	0.4	2.3	5.1	8.7	24.1		41.3				
Total for Age Group	6	13	11	72	154	285	581						
% of Classification Total	0.8	1.2	1.0	6.4	13.7	25.3	51.6						

PROVINCIAL SUMMARY
NATURAL DEATHS BY AGE GROUP, GENDER AND DEATH FACTOR - SCHEDULE E-2
from 2015.01.01 to 2015.12.31

Death Factor Description	0 - 19 M F	20 - 30 M F		31 - 40 M F	41 - 50 M F	51-60 M F	61 - 70 M F	Over 70	- 70 F	Total Males	Total Females	Total	% of Classification	Autopsies	% of Classification	
	0 0	0	0	0 0	0 0	0 0	0 0	-	0	-	0	-	0.1	-	0.3	
Medical Procedure	0 0	0	0	1	0	2 0	0 0	0	0	က	-	4	0.4	~	0.3	
	0 0	-	0	0 0	0 0	0 0	0 0	0	0	-	0	1	0.1	0	0.0	
Live Birth (1 day)	0 1	0	0	0 0	0 0	0 0	0 0	0	0	0	1	1	0.1	0	0.0	
Natural Disease	7 1	9		4	45 26	95 57	186 98	309	271	654	463	1117	99.3	293	0.66	
Chronic Use of Alcohol	0 0	0 0	0	0 0	0 0	0 0	1 0	0	0	1	0	1	0.1	1	0.3	
	7	7		9	46	26	187		310	099		1125	100.0	296	100.0	
	2	9		2	26	29	86		271		465					
Total for Age Group	6	13	E	11	72	154	285		581							
	_															

PROVINCIAL SUMMARY
NATURAL DEATHS BY AGE GROUP, GENDER AND ENVIRONMENT - SCHEDULE E-3
from 2015.01.01 to 2015.12.31

Description M F Commercial Drivers - truck, taxi, school 0 0 bus, etc.		<u>.</u>	41 - 50	51 - 60	-	Over 70	Total Males	Total Females	Total	% of Classification	Autopsies	% of Classification	
ial Drivers xi, school 0	M	М	М	M	М Е	М							
_	0 0	0 0	0 0	0 0	1 0	0 0	-	0	-	0.1	-	6.0	
Work Place 0 0	0 0	0 0	0	0 0	1 0	0 0	2	0	2	0.2	1	6.0	
Construction 0 0	0 0	0 0	0 0	0	0 0	0 0	-	0	-	0.1	-	6.0	
Logging / Tree Cutting - Commercial	0 0	0	0 0	1 0	0 0	0	~	0	-	0.1	1	6.0	
Seniors Complex 0 0	0 0	0 0	0 0	0 1	1 0	8 13	6	41	23	2.0	0	0.0	
Community Residence 0 0	0 0	0 0	0 0	0 0	0 0	2 0	2	0	2	0.2	0	0.0	
Nursing Home 0 0	0 0	0 0	0 0	0 0	1 2	13 38	14	40	54	4.8	0	0.0	
Homes for Special 0 0	0 0	0 0	ь -	2 0	5 4	16 18	56	23	49	4.4	S	7.1	
Living inside, residence or on property	6 5	S S	34 22	82 53	158 86	255 193	543	364	206	80.6	257	8.98	-

PROVINCIAL SUMMARY
NATURAL DEATHS BY AGE GROUP, GENDER AND ENVIRONMENT - SCHEDULE E-3
from 2015.01.01 to 2015.12.31

Environment Description	0 - 19 F		20 - 30 M F	ω ≥	31 - 40 M F	41 - 50 M F	50 F	51-60 M F	- L	61 - 70 M F	l <u> </u>	Over 70 M F	0 п	Total Males	Total Females	Total	% of Classification	Autopsies	% of Classification
Rooming/Boarding House/Halfway Home/Group Home	0 0	0	0	0	0	0	0	0	0	0		_	0	2	0	2	0.2	2	7.0
Inside, other than residence (mall, restaurant, other public building)	0 0	-	0	0	0	-	0	0	0	0		-	0	4	0	4	0.4	м	0.1
Hotel / Motel	0 0	0	0 (0	0	1	2	0	0	0 0		0	0	1	2	3	0.3	2	0.7
Hospital Emergency – NON DOA	0 0	0	0	0	0	0	0	0	0	2 0) 0	0	2	0	2	0.2	0	0.0
Hospital Operating Room	0 0	0	0 (0	0	0	0	0	1	0 2) 0	0	0	3	3	0.3	0	0.0
Hospital Other (ward, ICU, etc.)	3 2	0	0 0	-	0	0	0	_	0	1 2		2	2	11	9	11	1.5	2	0.7
Hospital Post Op (Recovery Room)	1 0	0	0 0	0	0	0	0	0	0	0 0) 0	0	1	0	1	0.1	0	0.0
Psychiatric Hospital	0 0	0	0 (0	0	0	0	0	0	1 0		. 0	1	1	-	2	0.2	0	0.0
Community Mental Health Centre	0	0	0	0	0	0	0	0	0	1 0		0	0	-	0	1	0.1	0	0.0

PROVINCIAL SUMMARY
NATURAL DEATHS BY AGE GROUP, GENDER AND ENVIRONMENT - SCHEDULE E-3
from 2015.01.01 to 2015.12.31

i i	0 - 19	6	20 - 30	30	31 - 40	-	41 - 50	\vdash	51 - 60	-	61 - 70	-	Over 70	Total	Total	Total	% of	Autopsies	% of	
Environment Description	Σ	ь	Σ	ш	A		M		M		A	Σ	И F	Naid	- dilates		Classification		Olassilloanoli	
Rehabilitation Facility	0 0	0	0	0	0 0		0 0		1 0		0 0	0	0	-	0	1	0.1	0	0	
Gymnasium/Health Club	0 0	0	0	0	0 0		0 0		0 0	,,	1 0	0	0	-	0	1	0.1	0	0.0	
Custody Federal Institution	0	0	0	0	0 0		1 0		0 1	,,	0 1	_	0	4	0	4	0.4	-	0.3	
Custody Provincial Institution	0 0	0	0 1	1	0 0		0 0		0 0)	0 0	0	0	0	1	1	0.1	1	0.3	
Public Road – Driver	0 0	0	0	0	0 0		1 0		2 0	.,	2 0	2	L	7	1	8	7.0	4	1.4	
Public Road - Passenger	0	0	0	0	0 0		0 0		0 0		0 0	7	2	5	2	4	0.4	0	0.0	
Public Road - Pedestrian	0 0	0	0	0	0 0		1 0		0 0	,,	1 0	1	0	5	1	3	0.3	2	2.0	
Urban Outdoors- public place and other (not residence)	0 0		0	0	0 0		2 0		4 2		3 1	8	2	12	5	17	ر ئ	8	2.7	

PROVINCIAL SUMMARY
NATURAL DEATHS BY AGE GROUP, GENDER AND ENVIRONMENT - SCHEDULE E-3
from 2015.01.01 to 2015.13.1

Environment Description	0 - 19 M F	20 - 30 M F		31 - 40 M F	41 - 50 M F	51 - 60 M F	61 - 70 M F	Over 70 M F	Total Males	Total Females	Total	% of Classification	Autopsies	% of Classification	
Rural Outdoors (not built up place or near residence)	0 0	0	0	0	0 0	0 0	0 4	0	5	0	5	0.4	к	1.0	
Camping / Tenting	0 0	0 0	0	0	2 0	0 0	1 1	1 0	3	2	5	0.4	1	0.3	
Snowmobiling (anywhere off public road) - driver	0 0	0 0	0	0	0 0	1 0	0 0	0 0	1	0	1	0.1	1	0.3	
Males	7	7		9	46	26	187	310	099						
Females	2	9		2	56	22	86	127		465	1,125	100.0	296	100.0	
Total for Age Group	6	13		11	72	154	285	581							

PROVINCIAL SUMMARY
UNDETERMINED DEATHS BY AGE GROUP, GENDER AND JUDICIAL DISTRICT - SCHEDULE F-1
from 2015.01.01 to 2015.12.31

D 1 8.3 1 1 0 0 2 16.7 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		0 - 19	20 - 30	31 - 40	41 - 50	51 - 60	61 - 70	Over 70	Total	Total	Total	% of	Autopsies	% of	
0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Judicial Districts								Males	remales		Classification		Classification	
1	Campbellton								-	0	-	8.3	1	9.1	
1 0 1 0 1 0 1 0 1 0 1 0 1 0 0 0	Fredericton				0				2	0	2	16.7	~	9.1	
1 2 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Moncton	0	0		0				9	_	7	58.3	7	63.6	
18	Saint John								2	0	0	16.7	7	18.2	
11 10.00 11 10.00 10.0 25.0 0.0 91.7 1 12 100.0 11 12 100.0 11 11 12 10.00 11 12 100.0 11 11 12 10.00 11 12 10.00 11 11 12 11 12 11 13 10.0 10.0 10.0 10.0 10.0 10.0 10.	Males	က	2	-	2	0	က	0	7						
11	% Total - Males	25.0	16.7	8.3	16.7	0.0	25.0	0.0	91.7						
3 2 1 3 0.0 0.0 8.3 0.0 0.0 0.0 4tion 25.0 16.7 8.3 25.0 0.0	Females	0	0	0	0	~	0	0		~	12	100.0		100.0	
tition 25.0 16.7 8.3 16.7 8.3 25.0	% Total - Females	0.0	0.0	0.0	0.0	8.3	0.0	0.0		8.3					
25.0 16.7 8.3 16.7 8.3 25.0	Total for Age Group	င	7	-	7	_	е	0							
	% of Classification Total	25.0	16.7	8.3	16.7	8.3	25.0	0.0							

PROVINCIAL SUMMARY
UNDETERMINED DEATHS BY AGE GROUP, GENDER AND DEATH FACTOR - SCHEDULE F-2 from 2015.01.01 to 2015.12.31

4														
	0 - 19	_	20 - 30	31 - 40	41 - 50	51 - 60	61 - 70	Over 70	Total	Total	Total	% of	Autopsies	% of
Death Factor Description	Σ		Ψ Ψ	Σ	Σ	L Σ	L Σ	μ	Males	Females		Classification		Classification
Drowning – Open Water	0 0		1 0	0 0	0 0	0 0	0 0	0 0	1	0	1	8.3	1	9.1
Exposure to Cold	0 0		0 0	0 0	1 0	0 0	0 0	0 0	1	0	1	8.3	1	9.1
Drug	0 0		1 0	0 0	0 0	1 0	0 0	0 0	1	1	2	16.7	2	18.2
Fall or Jump – same level	1 0		0 0	0 0	0 0	0 0	0 0	0 0	1	0	1	8.3	1	9.1
Natural Disease	0 0		0 0	1 0	0 0	0 0	0 0	0 0	1	0	1	8.3	1	9.1
No Anatomical Cause	0 0		0 0	0 0	0 0	0 0	1 0	0 0	1	0	1	8.3	1	9.1
Undetermined	2 0		0 0	0 0	1 0	0 0	2 0	0 0	5	0	5	41.7	4	36.4
Males	3		2	-	5	0	က	0	11					
Females	0		0	0	0	1	0	0		1	12	100.0	11	100.0
Total for Age Group	က		2	-	5	1	3	0						

PROVINCIAL SUMMARY
UNDETERMINED DEATHS BY AGE GROUP, GENDER AND ENVIRONMENT - SCHEDULE F-3
from 2015.01.01 to 2015.12.31

	4	90	-	2	7	5	G I	F	H	- I	3- 70		3- /0
Environment Description	- ∑	ZU - 3U	31 - 40 M F	M F	M F	0/-10 M	Over 70	l otal Males	Females	l otal	% of Classification	Autopsies	% or Classification
Rural Outdoors (not built up place or near residence)	0 0	0 0	0 0	0	0 0	0	0	-	0	-	8.3	0	0.0
Living inside, residence or on property	3 0	0	0 0	0	0	0 %	0	80	0	∞	66.8	∞	72.7
Federal Institution	0 0	0	0	0 0	0 0	0	0 0	-	0	-	8.3	7-	9.1
Public Road - Driver	0 0	0 0	0 0	0 0	0	0	0 0	0	-	-	8.3	-	9.1
Open Water (river, lake, stream, brook)	0 0	1 0	0 0	0 0	0 0	0 0	0	1	0	-	8.3	1	9.1
Males	3	2	1	2	0	8	0	11					
Females	0	0	0	0	7-	0	0		1	12	100.0		100.0
Total for Age Group	ε	2	←	2	-	ε	0						

Schedule F

Undetermined Deaths (Means of death impossible to determine)

There were twelve deaths classified as Undetermined.

One was in the Campbellton Judicial District:

Death Factor: Undetermined

Environment: Living Inside, Residence or on Property

Age Group: 60 - 70 Sex: Male An autopsy was performed.

Two were in the Fredericton Judicial District:

Case #1

Death Factor: Drowning - Open Water

Environment: Open Water (river, lake, stream, brook)

Age Group: 20 - 30 Sex: Male An autopsy was performed.

Case #2

Death Factor: Undetermined

Environment: Rural Outdoors (not built up place or near residence)

Age Group: 40 - 50 Sex: Male No autopsy was performed.

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.

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

Case #2

Death Factor: Drug

Environment: Living inside, residence or on property

Age Group: 20 - 30 Sex: Male An autopsy was performed.

Case #3

Death Factor: Asphyxia

Environment: Federal Institution

Age Group: 30 - 40
Sex: Male
An autopsy was performed

Case #4

Death Factor: Exposure to Cold

Environment: Living inside, residence or on property

Age Group: 40 - 50 Sex: Male An autopsy was performed

Case #5

Death Factor: Drug

Environment: Public Road - Driver

Age Group: 50 - 60 Sex: Female An autopsy was performed

Case #6

Death Factor: Undetermined

Environment: Living inside, residence or on property

Age Group: 60 - 70 Sex: Male An autopsy was performed

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

Case #7

Death Factor: No Anatomical Cause

Environment: Living inside, residence or on property

Age Group: 60 - 70 Sex: Male An autopsy was performed.

Two 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

Case #2

Death Factor: Fall or Jump - same level

Environment: Living inside, residence or on property

Age Group: 0 - 10 Sex: Male An autopsy was performed

Summary of Inquests and Recommendations

Three inquests were held during the reporting period. This report mentions the replies received by the Office of the Chief Coroner as of May 2016, in response to the recommendations on inquests conducted in 2015.

Inquest No. 1 – Serena Perry

On February 14, 2012, Serena Perry was found dead in the Amphitheatre of the Saint John Regional Hospital (SJRH). She had been hospitalized in the psychiatric unit of that facility pursuant to an order made under the *Mental Health Act*. Although an involuntary patient, she was allowed to take unsupervised breaks from the unit and had done so the evening of her death. During her break, Ms. Perry had been in the company of at least one other psychiatric patient.

At approximately 11:06 pm, two or three minutes prior to 11:09 pm when a "Code Blue" was announced, Ms. Perry was discovered lying unconscious and not breathing on the lower floor of the amphitheatre with a blue hospital housecoat wrapped and tied loosely around her neck; the knot, so-called, released easily. Resuscitation procedures were unsuccessful and she was pronounced dead at 11:23 pm.

The coroner's jury, based on the evidence presented by the pathologist who conducted the autopsy, came to the conclusion that the medical cause of death was asphyxia due to strangulation and ruled the death a homicide.

Along with the evidence presented regarding the circumstances of Ms. Perry's death, the jury also considered testimony in regards to the prevention of deaths under similar circumstances in the future by learning about the effectiveness of community treatment orders, the appropriateness of the current psychiatric facilities and operational issues such as appropriate staffing levels, smoking regulations/policies as they relate to psychiatric patients and ongoing professional development for all mental health providers.

As a result the jury made the following recommendations:

- Review the ratio of Registered Nurses (RN) to Licensed Practical Nurses (LPN) on the unit to optimize the care provided to patients. Compare with national benchmarks.
- 2. Recognizing that a large proportion of mental health patients' smoke and the detrimental effect of this on one's physical health, offer a program to support smoking cessation while in hospital with continued support post discharge.

- 3. Advocate for Community Treatment Orders (CTO's) in the province of New Brunswick with require the support of Flexible Assertive Community Treatment (FACT) Teams in the community. These are teams of professional mental health staff that offer support to patients/clients in the community. CTO's are a less restrictive option compared to involuntary hospitalization, helps the patient receive treatment in the community and reduces the risk of a worsening of the symptom severity.
- 4. Dedicated education and training for psychiatry unit staff especially in Dialectical Behavioral Therapy (DBT) a therapy designed to help people change patterns of behavior that are not helpful, such as a self-harm, suicidal thinking, and substance abuse and Cognitive Behavioral Therapy (CBT) a form of psychotherapy used to solve current problems and change unhelpful thinking and behavior. This training will assist staff in the delivery of therapeutic interventions to patients.
- 5. Explore options to enhance collaborative care for patients who will require ongoing support from the mental health system and from other agencies such as the Department of Social Development, Public Safety, Education ... At times, patients with complex needs require on-going support from various parts of the formal systems. The ability for these systems to work in a more coordinated approach will assist with improving patient centered care.
- 6. Enhance the patient information system as effective communication has been identified as a critical element in improving patient safety, particularly with regard to transition points at end of service and client movement to other health services or community-based providers.
- 7. Spot checks of patients that they do not have anything harmful when re-entering the ward.
- 8. Therapeutic recreation activities indoor and outdoor (music room, outdoor walks, gardening).
- 9. Specialized training for security staff dealing with incidents involving patients of the psych ward or other areas of the hospital.

- 10. Administration to have updated information from patients home phone cell phones for primary and secondary care persons.
- 11. The "Serena Law" which related to CTO's and Fact Teams which will come to fruition in the near future.

NICE TO HAVE IN THE FUTURE

1. As part of Master Space Planning, consider moving the psychiatry unit to the first floor, closer to the Emergency Department and having the nursing station situated at the entrance to the unit.

Benefits include:

- Eliminate challenges of transporting admitted patients from Tower A 1st floor to Tower D 4th floor. Some patients are not admitted voluntarily and pose challenges during transport.
- Eliminate the risk of patients' trying to break windows and incurring injuries.
- Provide a safe outdoor space without risk of injury should patients attempt to leave.
- Closer observation of persons entering and leaving the unit.

The recommendations were forwarded to the Department of Health and the President & CEO of Horizon Health.

Recommendation #1

Review the ratio of Registered Nurses (RN) to Licensed Practical Nurses (LPN) on the unit to optimize the care provided to patients. Compare with national benchmarks.

The Minister of Health, in collaboration with the President and CEO of Horizon Health Network, advises that this project is to begin with Horizon Health Network in October 2015. Psychiatry unit representatives from each of the Horizon Health Network regions (Saint John, Fredericton, Moncton and Miramichi) have been identified. The plan includes training on a skill mix tool, completing the tool in each area, analyzing the data and effecting changes based on results. It is anticipated that the standardized skill mix schedules will be fully implemented by June 2016.

Recommendation #2

Recognizing that a large proportion of mental health patients' smoke and the detrimental effect of this on one's physical health, offer a program to support smoking cessation while in hospital with continued support post discharge.

The Minister of Health, in collaboration with the President and CEO of Horizon Health Network, advises that the Saint John Regional Hospital inpatient psychiatry unit implemented the Ottawa Model on Smoking Cessation Program in August 2015. The hospital became smoke free on September 29, 2015. Staff training on Smoking Cessation was completed. Sessions were held in all Horizon areas with the Centre of Addictions and Mental Health (Toronto) Lead on Smoking Cessation, Lillian R. Allen, the week of September 14, 2015.

Recommendation #3

Advocate for Community Treatment Orders (CTO's) in the province of New Brunswick with require the support of Flexible Assertive Community Treatment (FACT) Teams in the community. These are teams of professional mental health staff that offer support to patients/clients in the community. CTO's are a less restrictive option compared to involuntary hospitalization, helps the patient receive treatment in the community and reduces the risk of a worsening of the symptom severity.

The Minister of Health advises that the Department of Health has struck a Task Force in response to the platform commitment to establish mandated provisions of supervised community based treatment in support of those suffering from serious mental illness. Task for membership includes:

- Persons with lived experience
- Fist Nations representation
- Member representing the voice of family
- Psychiatry
- Clinical and administrative staff from both Regional Health Authorities
- Department of Health staff
- Chairman of the Mental Health tribunal

The President and CEO of Horizon Health Network advises that the Network is represented on the Task Force led by the Department of Health related to the mandated provision of supervised community-based treatment for individuals suffering from serious mental illness. The committee will review mental health services in New Brunswick, explore opportunities for alternative interventions, and provide oversight to the development and submission of a proposal for a model moving forward including recommendations for implementation. The first meeting was held on September 24, 2015.

Recommendation #4

Dedicated education and training for psychiatry unit staff especially in Dialectical Behavioral Therapy (DBT) – a therapy designed to help people change patterns of behavior that are not helpful, such as a self-harm, suicidal thinking, and substance abuse and Cognitive Behavioral Therapy – (CBT) – a form of psychotherapy used to solve current problems and change unhelpful thinking and behavior. This training will assist staff in the delivery of therapeutic interventions to patients.

The Minister of Health, in collaboration with the President and CEO of Horizon Health Network, advises that through a generous grant, the Addiction & Mental Health Program has received \$100,000 to provide education and training for staff within Region 2. A steering committee has been struck and Dialectical Behavioural Therapy (DBT) and Cognitive Behavioural Therapy (CBT) will be offered to staff over the coming months. This training will assist staff in the delivery of therapeutic interventions to patients. There is also a possibility that the funding may be continued for two more years.

Recommendation #5

Explore options to enhance collaborative care for patients who will require ongoing support from the mental health system and from other agencies such as the Department of Social Development, Public Safety, Education ... At times, patients with complex needs require on-going support from various parts of the formal systems. The ability for these systems to work in a more coordinated approach will assist with improving patient centered care.

The Minister of Health advises that expectations are that the FACT care model, established in a recovery based approach, will provide necessary enhanced supports to those suffering from serious mental illness. FACT services ensures that treatment plans are developed to meet the patients' needs, allowing for staff to work beyond the typical intervention methods and assist the client in accessing services required in achieving recovery.

Additionally, the Departments of Health, Education and Early Childhood Development, Justice and Public Safety and Social Development, along with both Regional Health Authorities and the school districts continue to work at the Integrated Service Delivery (ISD) model of care. This framework removes the historical barriers between the various service providers, enabling an integrated approach to care planning. Province wide meetings, including the Directors of the Departments of Public Safety, Health, Education and Early Childhood Development and Social Development, Regional Health Authorities and the School Superintendents, occurred in October 2015. The purpose of these meetings was to identify challenges in the system for shared customers and to continue to move forward in the implementation of ISD.

The President and CEO of Horizon Health Network advises that a meeting was held in October 2015 which included the Directors of Justice and Public Safety, Addiction & Mental Health, Department of Social Development and the Superintendent of Anglophone South School District. The purpose of the meeting was to identify challenges in the system for shared clientele and develop an action plan to address those challenges.

Recommendation #6

Enhance the patient information system as effective communication has been identified as a critical element in improving patient safety, particularly with regard to transition points at end of service and client movement to other health services or community-based providers.

The Minister of Health, in collaboration with the President and CEO of Horizon Health Network, advises that protocols have been developed to ensure client/patient information is available at juncture points within the system:

• Community care information available to Emergency Room personnel.

- Emergency room assessments and physician's orders follow the patient to the psychiatric unit – the unit is provided the information before the patient arrives on the floor.
- Community Mental Health personnel attend team meetings and participate in discharge planning of patients on the psychiatry unit.
- Family physicians in the community receive discharge summaries of all hospitalizations.
- Discharge summaries are forwarded to Community Addiction & Mental Health Centres who provide follow-up care.

Recommendation #7

Spot checks of patients that they do not have anything harmful when re-entering the ward.

The Minister of Health, in collaboration with the President and CEO of Horizon Health Network, advises that while respecting patients' individual rights, dignity and autonomy in facilitating a safe environment for patients, their families, and staff, consistent spot checks occur as part of the admission process, and every time a patient returns from a pass. For example: all patients are asked if they are in possession of any items that may harm self or others. A spot check also occurs any time there is probable grounds that a patient may be at risk of harm to self or others.

Recommendation #8

Therapeutic recreation activities indoor and outdoor (music room, outdoor walks, gardening).

The Minister of Health, in collaboration with the President and CEO of Horizon Health Network, advises that there is a full-time Recreation Therapist on the Psychiatry Unit. Monthly activities are scheduled and posted on the unit which include both indoor and outdoor activities. Some examples include walking groups, swimming at the Aquatic Centre, gardening, "news of the day" groups, as well as art therapy and pet therapy. Patient meetings are held weekly whereby patients are encouraged to make suggestions for future activity plans.

Recommendation #9

Specialized training for security staff dealing with incidents involving patients of the psych ward or other areas of the hospital.

The Minister of Health, in collaboration with the President and CEO of Horizon Health Network, advises that the New Code White Policy was rolled out on October 5, 2015, with the Saint John Regional Hospital as the pilot site. In preparation for this, staff (including Safety Officers), have completed advanced training in the prevention and management of violent behaviour. Specifically on the Psychiatry Unit, 100% of the Registered Nurses (RNs) and 90% Licensed Practical Nurses (LPNs) have received advanced training. Training for allied health professionals (social workers, psychologists and occupational therapists) will be undertaken in February 2016.

Recommendation #10

Administration to have updated information from patients – home phone – cell phones for primary and secondary care persons

The Minister of Health, in collaboration with the President and CEO of Horizon Health Network, advises that upon admission to the unit, that patient is asked to identify next of kin and asked to provide both landline and cell phone numbers as applicable. This information is recorded on the Admission Form. Patients and families are asked to notify staff should these numbers change.

Recommendation #11

The "Serena Law" which related to CTO's and Fact Teams which will come to fruition in the near future.

The Minister of Health advises that the Department of Health has struck a Task Force in response to the platform commitment to establish mandated provisions of supervised community based treatment in support of those suffering from serious mental illness. Task for membership includes:

Persons with lived experience

- Fist Nations representation
- Member representing the voice of family
- Psychiatry
- Clinical and administrative staff from both Regional Health Authorities
- Department of Health staff
- Chairman of the Mental Health tribunal

The President and CEO of Horizon Health Network advises that the Network is represented on the Task Force led by the Department of Health related to the mandated provision of supervised community-based treatment for individuals suffering from serious mental illness. The committee will review mental health services in New Brunswick, explore opportunities for alternative interventions, and provide oversight to the development and submission of a proposal for a model moving forward including recommendations for implementation. The first meeting was held on September 24, 2015.

Recommendation

NICE TO HAVE IN THE FUTURE

As part of Master Space Planning, consider moving the psychiatry unit to the first floor, closer to the Emergency Department and having the nursing station situated at the entrance to the unit.

Benefits include:

- Eliminate challenges of transporting admitted patients from Tower A 1st floor to Tower D 4th floor. Some patients are not admitted voluntarily and pose challenges during transport.
- Eliminate the risk of patients' trying to break windows and incurring injuries.
- Provide a safe outdoor space without risk of injury should patients attempt to leave.
- Closer observation of persons entering and leaving the unit.

The Minister of Health, in collaboration with the President and CEO of Horizon Health Network, advises that Horizon Health Network has committed to complete a Master Program and Master Plan for the Saint John Regional Hospital. All programs and services will be part of this process. Once all of the information from stakeholders is gathered, consideration for this request will be made.

Inquest No. 2 – Maurice Roussel

Maurice Roussel, age 58, was employed as a construction labourer by Val Landry & Son.

On September 29, 2011, Mr. Roussel was fixing a leaking pipe at the AV Cell Mill in Atholville when he fell from a height of approximately 30 feet to a cement floor. Mr. Roussel was subsequently pronounced deceased, having succumbed to his injuries which included blunt force trauma to the head, torso and extremities.

Following the investigations, WorkSafeNB laid charges against Val Landry & Son and AV Cell who both pled guilty in Provincial Court and received fines of \$6,000.00 and \$69,000.00 respectively.

The inquest, conducted on November 23 and 24, 2015, was mandatory under Section 7(b) of the *Corners Act* which reads: "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". Such investigations are mandatory.

A total of 15 witnesses testified in front of a 5-person jury, which made the following recommendation: Have an independent intermediate committee authorized to check whether there is compliance with safety standards and if not, to report it to WorkSafeNB.

The recommendation was forwarded to the President & CEO of WorkSafeNB.

Recommendation

Have an independent intermediate committee authorized to check whether there is compliance with safety standards, and if not, to report it to WorkSafeNB.

The President and CEO of WorkSafeNB advises that in their opinion the *Occupational Health and Safety Act* has provisions that meet the intent of the jury's recommendation. Key provisions under the Act that addresses the recommendation include the following:

14(1) Every employer with twenty or more employees regularly employed at a place of employment shall ensure the establishment of a joint health and safety committee.

Inquest No. 2 – Maurice Roussel (continued)

- 14(2) A committee shall consist of such number of persons as may be agreed to by the employer and the employees.
- 14(3) A committee shall consist of equal representation from both the employer and the employees, and the employer shall designate his representative or representatives and the employees shall designate their representative or representatives.
- 14(4) Where the employer and employees cannot agree on the size of the committee, the Chief Compliance Officer may establish its size.
- 14(13) Where a committee cannot agree on a matter related to health and safety, the committee shall call an officer to resolve the problem.

In addition to the above, Section 15 of the Act outlines the duties that a committee may undertake:

15 A committee may

- (a) make recommendations for the establishment and enforcement of policies involving health and safety practices;
- (b) participate in the identification and control of health and safety hazards at the place of employment;
- (c) inform employees and the employer of existing or potential hazards at the place of employment and of the nature of the risks to their health and safety;
- (d) establish and promote health and safety programs for the education and information of the employer and employees;
- (e) receive, consider and make recommendations to the employer regarding complaints respecting the health and safety of the employees at the place of employment;
- (f) maintain records respecting the receipt of, the consideration of and recommendations respecting complaints;
- (g) obtain information from the employer respecting the identification of existing or potential hazards of conditions, tools, equipment, devices and machines at the place of employment;
- (h) carry out monitoring and measuring procedures by trained committee members where the Commission has determined there is a need for regular monitoring and measuring at the place of employment and has directed the committee to carry out such monitoring and measuring;
- (i) investigate any matter referred to in paragraph (e);

Inquest No. 2 – Maurice Roussel (continued)

- (j) participate in all inspections, inquiries and investigations concerning the health and safety of employees, and in particular the investigation of any matter referred to in section 43:
- (k) perform any other duties that
 - (i) the Commission may assign to a committee,
 - (ii) may be assigned to a committee by agreement between the employer and the employees, or
 - (iii) are prescribed by this Act or the regulations.

Not only does the Act require the establishment of a joint employer and employee committee to verify that safety standards are being met; there are also provisions for WorkSafeNB to intervene if the committee is unable to resolve health and safety matters within their own workplace.

In conclusion and based on the above, WorkSafeNB is of the opinion that there is adequate legislation to meet the jury's recommendation and therefore no further action is required at this time.

Inquest No. 3 – Eldon Bramble

Eldon Earle Bramble, age 65, was employed as a construction laborer by Lloyd Dutcher Developments Ltd.

On June 21, 2012, Mr. Bramble was working on a new home construction project when he fell from the second story through to the basement of the building. First Aid was immediately administered by his co-worker until emergency workers arrived, at which time they took over resuscitation efforts. These efforts were to no avail and Mr. Bramble died at the scene from his injuries.

An investigation was launched by WorkSafeNB, the Coroner's Office and the Fredericton Police Force.

As required under Section 7(b) of the *Coroners Act* of New Brunswick, an inquest was held as Mr. Bramble was employed at the time of his death at a construction project site.

The jury made the following recommendation:

When a residential construction permit is obtained from a municipality, resource information should be included with the permit that provides access to information on the WorkSafeNB Act and Regulations as they apply to their project.

Inquest No. 3 – Eldon Bramble (continued)

The Presiding Coroner also made a recommendation :

Prior to each residential construction season WorkSafeNB and/or the New Brunswick Construction Safety Association should issue a communiqué to all members of the Association concerning their obligations under the *Occupational Health and Safety Act*, as well as any relevant course offerings during that upcoming construction season.

The recommendations were forwarded to the Department of Environment & Local Government, NB Construction Safety Association and the President & CEO of WorkSafeNB.

Jury recommendation:

When a residential construction permit is obtained from a municipality, resource information should be included with the permit that provides access to information on the WorkSafeNB Act and Regulations as they apply to their project.

The Minister of Environment and Local Government advised that they have reviewed the recommendations and will work with WorkSafeNB, municipalities and Regional Service Commissions to encourage that the information on WorkSafeNB is provided along with building permits.

The President and CEO of WorkSafeNB advises that they accept in principle the recommendation of the jury that health and safety resource material be provided when building permits are issued. However, in order to successfully implement this recommendation, WorkSafeNB will require assistance from the agencies responsible for issuing building permits including municipalities, towns and the Department of Environment and Local Government for rural communities, unincorporated areas and Local Service Districts (LSDs).

Our commitment is to prepare the required information and seek cooperation from the identified agencies to distribute the safety information on our behalf.

The Chairperson of the New Brunswick Construction Safety Association (NBCSA) advices that it agrees with this approach. It would give contractors more information on their legal requirements at the time of obtaining the required permits. The association points out that contractors in all sectors should already be aware requirements as the Act is very clear that it is the employers' responsibility to know their legal requirements.

Inquest No. 3 – Eldon Bramble (continued)

Presiding Coroner recommendation:

Prior to each residential construction season WorkSafeNB and/or the New Brunswick Construction Safety Association should issue a communiqué to all members of the Association concerning their obligations under the *Occupational Health and Safety Act*, as well as any relevant course offerings during that upcoming construction season.

WorkSafeNB accepts the recommendation of the jury that communication with the construction industry be undertaken before the active residential construction season begins reminding them of their obligations to occupational health and safety. It is our understanding that the New Brunswick Construction Safety Association (NBCSA) undertakes such communications with their members. However, WorkSafeNB will explore the feasibility of a joint communications strategy involving both agencies.

The Chairperson of the New Brunswick Construction Safety Association advices that NBCSA already sends out newsletters twice a year to all registered members of our association. These newsletters give information on the legal requirements as well as a listing of all the courses offered and a calendar showing when and where they will be held. They also stress that we do "on demand" training for any member that calls requesting it. It would be a little more difficult to communicate with companies listing their obligations under the *Occupational Health and Safety Act* as each company is different and the work task they do are different which requires different training for each company.

The mandate of NBCSA is to provide proactive safety and safety-related programs and services to the construction industry. This will contribute to a safer workplace and a healthy and profitable economy. This will be done through efforts which facilitate compliance with the *Occupational Health and Safety Act*, the *Workers Compensation Act* and their regulations; increase the regional competitiveness of construction industry firms; and enhance the mobility of construction industry workers. Further, to work with regulatory bodies and the construction industry to develop and/or revise legislation or regulations affecting the safety of the industry.

They will continue to work with industry to help ensure that incidents in our industry that could cause harm or death to our workers are addressed. With the WorkSafeNB announcement last year that they would be increasing the amount of Health and Safety Officers they currently have and that they will be focusing on residential construction, we feel contractors that are not adhering to the rules of the *Occupational Health and Safety Act* will be addressed and we will be here to assist them.