Office of the Chief Coroner

Annual Report 2021

New Nouveau Brunswick

2021 Annual Report

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The Honourable Kris Austin
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 Fiftieth Annual Report of the Chief Coroner for the period January 1, 2021 to December 31, 2021.

Yours very truly,

Heather Brander
Chief Coroner
Province of New Brunswick

Table of Contents **Page**

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/her 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), although 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 the person 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 six 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 six Regional Coroners, approximately 35 Community Coroners, experienced investigative fee-for service staff, provide services primarily on nights and weekends across the province.

The Regional Coroners provide guidance to the Community 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, and Moncton 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 King’s Bench of New Brunswick, a member of the Executive Council or the Chief Coroner

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

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

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

Summary

Coroner Services investigates about 21.7 percent of the total of approximately 7,500 deaths per year in the Province. A high percentage of the investigated deaths are determined to be from natural causes. The coroner, in approximately 33.7 percent of the cases, orders autopsies and inquests are ordered in slightly less than one percent of all investigated deaths.

For the period covered by this Report, the Registrar of Vital Statistics recorded 8,076 deaths in the Province of which 1,709 or 21.2 percent were reported to a coroner. By comparison in the previous year there were 7,486 deaths in the Province of which 1,637 or 21.9 percent 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 2021.

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. It is important to understand that the classification of homicide in a Coroner's investigation or inquest is defined as any case of a person dying by the actions of another. It does not imply culpability, which is not within the mandate of the Coroner or the Inquest jury.

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.

The following statistics, where broken down by region, capture data based on the region in which a death occurred and not necessarily the region where the decedent resided. This would occur if, for example, the deceased was visiting another region in the province at the time of death, or if a patient is transferred to a major hospital for specialist treatment and the death occurs at that hospital.

PROVINCIAL SUMMARY - SCHEDULE A-1

from 2021.01.01 to 2021.12.31

Classification	No. of Deaths	% of Deaths	Rate per 100,000 Population	Autopsy Performed	% of classification
Natural	1317	77.1%	166.6	427	31.2%
Accident	281	16.4%	35.6	148	50.9%
Suicide	94	5.5%	11.9	34	36.2%
Homicide	10	0.6%	1.3	10	80%
Undetermined	7	0.4%	0.9	7	100%
Total	1709	100.00	216.2	626	

NOTE : Based upon Statistics Canada postcensal population estimates of 790,398 for N. B. census divisions, 3rd quarter 2021. Sub-county estimates are based on the 2020 Census population share of the county.

Provincial Summary - Deaths Investigated by Classification, by Month - Schedule A-2
from 2021.01.01 to 2021.12.31

Classification	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Total
Natural	123	102	126	90	102	70	115	106	119	113	120	131	1317
Accident	24	16	25	21	27	14	24	34	23	30	19	24	281
Suicide	6	4	10	11	8	9	6	11	6	11	5	7	94
Homicide	0	1	1	0	0	1	1	1	1	0	1	3	10
Undetermined	0	0	1	0	2	1	0	2	0	1	0	0	7
Total	153	123	163	122	139	95	146	154	149	155	145	165	1,709

DEATHS INVESTIGATED BY JUDICIAL DISTRICT - SCHEDULE A-3
from 2021.01.01 to 2021.12.31537

	Judicial Districts								
	Bathurst	Campbellton	Edmundston	Fredericton	Miramichi	Moncton	Saint John	Woodstock	Province
Natural	132	53	89	177	93	345	386	42	1,317
Accident	30	12	17	33	20	94	61	14	281
Suicide	12	7	7	17	9	18	17	7	94
Homicide	1	1	1	2	0	3	1	1	10
Undetermined	0	0	0	0	0	1	5	1	7
Total	175	73	114	229	122	461	470	65	1,709
% of Provincial Total	10.2	4.3	6.7	13.4	7.1	27.0	27.5	3.8	100
Population	79,711	31,156	41,707	148,810	45,904	228,694	176,927	37,489	790,398
Death Rate per 100,000 population									
Natural	165.6	170.1	213.4	118.9	202.6	150.9	218.2	112.0	166.6
Accident	37.6	38.5	40.8	22.2	43.6	41.1	34.5	37.3	35.6
Suicide	15.1	22.5	16.8	11.4	19.6	7.9	9.6	18.7	11.9
Homicide	1.3	3.2	2.4	1.3	0.0	1.3	0.6	2.7	1.3
Undetermined	0.0	0.0	0.0	0.0	0.0	0.4	2.8	2.7	0.9
Total deaths by trauma (accident, suicide, homicide)	43	20	25	52	29	115	79	22	385
Rate per 100,000 population	53.9	64.2	59.9	34.9	63.2	50.3	44.7	58.7	48.7

PROVINCIAL SUMMARY
ACCIDENTAL DEATHS BY AGE GROUP, GENDER AND JUDICIAL DISTRICT - SCHEDULE B-1
from 2021.01.01 to 2021.12.31

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
Bathurst	0	1	4	1	5	0	4	1	1	2	1	0	4	6	19	11	30	10.7	12	8.1
Campbellton	0	0	0	1	1	1	1	1	0	0	1	0	3	3	6	6	12	4.3	4	2.7
Edmundston	0	1	0	1	0	0	1	1	0	0	3	0	6	4	10	7	17	6.0	7	4.7
Fredericton	2	0	1	3	2	3	3	0	3	1	1	0	7	7	19	14	33	11.7	19	12.8
Miramichi	0	0	1	0	0	2	1	1	1	1	1	3	2	7	6	14	20	7.1	11	7.4
Moncton	3	0	5	1	6	5	6	1	13	3	13	4	14	20	60	34	94	33.5	40	27.0
Saint John	0	0	6	2	8	2	8	7	5	4	9	1	5	4	41	20	61	21.7	46	31.1
Woodstock	0	0	1	0	1	1	4	0	5	0	0	0	2	0	13	1	14	5.0	9	6.1
Males	5		18		23		28		28		29		43		174		281	100.0	148	100.0
% Total - Males	1.8		6.4		8.2		10.0		10.0		10.3		15.3		62.0					
Females	2		9		14		12		11		8		51			107				
% Total -Females	0.7		3.2		5.0		4.3		3.9		2.8		18.1			38.0				
Total for Age Group	7		27		37		40		39		37		94							
% of Classification Total	2.5		9.6		13.2		14.2		13.9		13.2		33.5							

PROVINCIAL SUMMARY
ACCIDENTAL DEATHS BY AGE GROUP, GENDER AND DEATH FACTOR - SCHEDULE B-2
from 2021.01.01 to 2021.12.31

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	0	0	0	0	0	0	1	0	0	0	0	0	1	0	1	0.4	1	0.7
Trauma of Vehicle Upset / Rollover	1	1	1	0	1	1	1	0	1	0	1	0	1	0	7	2	9	3.2	7	4.7
Medical Procedure	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	1	0.4	1	0.7
Trauma of Vehicle / Pedestrian Collision	0	0	0	2	1	0	1	0	0	0	1	0	1	0	4	2	6	2.1	3	2.0
Trauma of Vehicle Collision	3	0	4	1	5	3	5	0	5	0	2	1	1	4	25	9	34	12.1	18	12.2
Trauma of Recreational Vehicle Collision	1	0	2	0	3	0	2	0	0	0	0	0	0	0	8	0	8	2.8	6	4.1
Trauma of Recreational Vehicle Upset/Rollover	0	0	1	0	1	0	2	0	1	0	1	0	1	0	7	0	7	2.5	4	2.7
Natural Disease	0	0	0	0	0	0	1	2	0	0	2	1	1	1	4	4	8	2.8	4	2.7
Carbon Monoxide Poisoning - Vehicle Exhaust	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	1	0.4	1	0.7

PROVINCIAL SUMMARY
ACCIDENTAL DEATHS BY AGE GROUP, GENDER AND DEATH FACTOR - SCHEDULE B-2
from 2021.01.01 to 2021.12.31

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						
Exposure to Cold	0	0	1	1	0	1	0	0	4	0	0	0	0	1	5	3	8	2.8	7	4.7
Blunt Trauma, Accidental	0	0	1	0	0	0	3	0	4	1	3	0	5	0	16	1	17	6.0	9	6.1
Drowning - Open Water	0	0	1	0	2	0	1	0	0	0	4	0	2	0	10	0	10	3.6	8	5.4
Drowning - Bathtub	0	0	0	0	0	0	0	1	0	0	1	0	0	0	1	1	2	0.7	1	0.7
Drowning – Other (Marsh, Dam, etc.)	0	0	0	0	0	0	0	0	0	0	1	0	1	0	2	0	2	0.7	1	0.7
Intestinal Obstruction	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	1	0.4	0	0.0
Fire – Structural	0	0	1	0	0	0	0	0	0	0	0	0	0	1	1	1	2	0.7	2	1.4
Fall or jump – same level	0	0	0	0	0	0	1	0	1	0	6	1	25	40	33	41	74	26.3	5	3.4
Fall or jump – different level height; eg. bridge, building	0	0	0	0	1	0	0	0	1	1	0	0	2	1	4	2	6	2.1	2	1.4
Electrocution	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	1	0.4	1	0.7

PROVINCIAL SUMMARY
ACCIDENTAL DEATHS BY AGE GROUP, GENDER AND DEATH FACTOR - SCHEDULE B-2
from 2021.01.01 to 2021.12.31

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						
Burns - Heat	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	1	0.4	1	0.7
Object Caught in Throat	0	0	0	0	0	0	0	1	0	1	0	0	2	1	2	3	5	1.8	0	0.0
Aspiration	0	0	0	1	0	0	0	0	0	1	0	1	0	1	0	4	4	1.4	2	1.4
Asphyxia	0	1	0	1	0	0	2	0	0	0	1	1	0	0	3	3	6	2.1	5	3.4
Sexual Asphyxia	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0.4	0	0.0
Alcohol Intoxication	0	0	0	0	0	0	1	0	1	0	0	0	0	0	2	0	2	0.7	2	1.4
Alcohol Poisoning	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	1	0.4	0	0.0
Alcohol and Drug	0	0	0	0	0	0	1	0	0	1	0	1	0	0	1	2	3	1.1	3	2.0
Drug	0	0	2	1	1	0	3	4	5	3	2	2	1	0	14	10	24	8.5	23	15.5
Drug (street)	0	0	3	2	7	7	3	3	4	2	3	0	0	0	20	14	34	12.1	29	19.6
Chronic Use of Prescribed Medicines	0	0	0	0	0	0	1	1	0	0	0	0	0	0	1	1	2	0.7	2	1.4

PROVINCIAL SUMMARY
ACCIDENTAL DEATHS BY AGE GROUP, GENDER AND DEATH FACTOR - SCHEDULE B-2
from 2021.01.01 to 2021.12.31

	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						
Males	5		18		23		28		28		29		43		174					
Females	2		9		14		12		11		8		51			107				
Total for Age Group	7		27		37		40		39		37		94				281	100	148	100

PROVINCIAL SUMMARY
ACCIDENTAL DEATHS BY AGE GROUP, GENDER AND ENVIRONMENT - SCHEDULE B-3
from 2021.01.01 to 2021.12.31

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	0	0	0	0	1	0	1	0	2	0	0	0	0	0	4	0	4	1.4	3	2.0
Open water (river, lake, stream, brook)	0	0	0	0	2	0	1	0	0	0	1	0	2	0	6	0	6	2.1	5	3.4
Boating – personal watercraft, jet ski, etc.	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	1	0.4	1	0.7
Hospital Other (ward, ICU, etc.)	0	0	0	0	0	0	0	0	0	0	1	0	1	1	2	1	3	1.1	0	0.0
Public Road - Driver	2	1	6	1	5	4	7	0	4	1	2	1	3	2	29	10	39	13.9	22	14.9
Public Road – motorcycle driver	1	0	0	0	1	0	0	0	3	0	1	0	0	0	6	0	6	2.1	4	2.7
Public Road – passenger	1	0	0	0	0	0	0	0	0	1	0	0	0	2	1	3	4	1.4	1	0.7
Public Road - pedestrian	0	0	0	1	1	0	1	0	0	0	2	0	1	0	5	1	6	2.1	2	1.4
Public Road – bicycle (not motorized vehicle)	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	1	0.4	1	0.7
Rooming/Boarding/ Halfway House	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	1	0.4	0	0.0

PROVINCIAL SUMMARY
ACCIDENTAL DEATHS BY AGE GROUP, GENDER AND ENVIRONMENT - SCHEDULE B-3
from 2021.01.01 to 2021.12.31

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						
ATV driver – on public road	0	0	0	0	1	0	0	0	1	0	0	0	0	0	2	0	2	0.7	1	0.7
ATV driver – off public road	1	0	1	0	2	0	1	0	0	0	1	0	1	0	7	0	7	2.5	6	4.1
Snowmobiling (on public road) - driver	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0	1	0.4	1	0.7
Snowmobiling (anywhere off public road) – driver	0	0	2	0	0	0	2	0	0	0	0	0	0	0	4	0	4	1.4	2	1.4
Off Road Motorcycling (motocross, dirt bike, etc.)	0	0	1	0	0	0	1	0	0	0	0	0	0	0	2	0	2	0.7	1	0.7
Living inside, residence or on property	0	1	7	5	8	6	10	11	10	8	15	7	27	20	77	58	135	48.0	79	53.4

PROVINCIAL SUMMARY
ACCIDENTAL DEATHS BY AGE GROUP, GENDER AND ENVIRONMENT - SCHEDULE B-3
from 2021.01.01 to 2021.12.31

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						
Seniors Complex	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	1	0.4	0	0.0
Homes for Special Care	0	0	0	0	0	0	0	0	0	1	0	0	1	4	1	5	6	2.1	1	0.7
Nursing Home	0	0	0	0	0	0	0	0	0	0	0	0	6	20	6	20	26	9.3	0	0.0
Commercial Drivers – Truck, Taxi, School Bus, etc.	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	1	0.4	0	0.0
Hotel / Motel	0	0	0	0	0	0	1	0	2	0	0	0	0	0	3	0	3	1.1	3	2.0
Camping/Tenting	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	1	0.4	1	0.7
Urban Outdoors – public place & other (not residence)	0	0	0	2	0	1	0	0	2	0	1	0	0	1	3	4	7	2.5	4	2.7
Homeless Shelter	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0	1	0.4	1	0.7
Non-public Road, driver	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	1	0.4	1	0.7
Non-public Road, pedestrian	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	1	0.4	0	0.0

PROVINCIAL SUMMARY
ACCIDENTAL DEATHS BY AGE GROUP, GENDER AND ENVIRONMENT - SCHEDULE B-3
from 2021.01.01 to 2021.12.31

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
Factory, Plant, Warehouse (outside)	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	1	0.4	1	0.7
Hospital Emergency -- DOA	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	1	0.4	1	0.7
Hospital Emergency – non-DOA	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	1	0.4	0	0.0
Beach, Shoreline	0	0	0	0	0	0	0	0	1	0	1	0	0	0	2	0	2	0.7	2	1.4
Rural Outdoors (not built up place or near residence)	0	0	1	0	1	1	1	0	1	0	1	0	0	0	5	1	6	2.1	4	2.7
Males	5		18		23		28		28		29		43		174		281	100.0	148	100.0
Females	2		9		14		12		11		8		51			107				
Total for Age Group	7		27		37		40		39		37		94							

PROVINCIAL SUMMARY
SUICIDE DEATHS BY AGE GROUP, GENDER AND JUDICIAL DISTRICT - SCHEDULE C-1
from 2021.01.01 to 2021.12.31

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
Bathurst	0	0	1	0	3	0	4	0	1	0	0	1	1	1	10	2	12	12.8	1	2.9
Campbellton	0	0	0	0	2	0	2	0	1	0	0	1	1	0	6	1	7	7.4	1	2.9
Edmundston	0	1	1	0	2	0	1	0	0	0	2	0	0	0	6	1	7	7.4	4	11.8
Fredericton	0	1	2	1	0	1	1	0	3	1	4	0	2	1	12	5	17	18.1	5	14.7
Miramichi	0	0	0	0	1	0	4	0	3	0	0	0	1	0	9	0	9	9.6	4	11.8
Moncton	0	0	2	0	1	2	3	3	3	0	2	1	1	0	12	6	18	19.1	3	8.8
Saint John	2	0	1	0	4	0	2	1	2	0	0	2	3	0	14	3	17	18.1	11	32.4
Woodstock	0	1	0	0	0	0	2	0	2	0	1	0	1	0	6	1	7	7.4	5	14.7
Males	2		7		13		19		15		9		10		75		94	100.0	34	100.0
% Total - Males	2.1		7.4		13.8		20.2		16		9.6		10.6		79.7					
Females	3		1		3		4		1		5		2			19				
% Total - Females	3.2		1.1		3.2		4.3		1.1		5.3		2.1			20.3				
Total for Age Group	5		8		16		23		16		14		12							
% of Classification Total	5.3		8.5		17.0		24.5		17.0		14.9		12.8							

PROVINCIAL SUMMARY
SUICIDE DEATHS BY AGE GROUP, GENDER AND DEATH FACTOR - SCHEDULE C-2
from 2021.01.01 to 2021.12.31

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						
Hanging	0	1	4	0	7	1	6	1	8	0	4	0	4	0	33	3	36	38.3	6	17.6
Cuts, Stabs	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	1	1.1	0	0.0
Strangulation	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0	1	1.1	0	0.0
Drowning - Open Water	1	0	0	0	0	0	0	0	0	0	1	0	0	1	2	1	3	3.2	1	2.9
Drowning - Bathtub	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	1	1.1	1	2.9
Asphyxia	0	0	0	0	0	0	3	0	1	0	0	1	0	0	4	1	5	5.3	2	5.9
Carbon Monoxide Poisoning	0	0	1	0	2	0	0	0	0	0	1	0	1	0	5	0	5	5.3	3	8.8
Carbon Monoxide Poisoning – Vehicle Exhaust	0	0	0	0	1	0	1	0	1	0	0	0	0	0	3	0	3	3.2	1	2.9
Fire - Vehicle	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	1	1.1	1	2.9
Fall or jump – different level, eg. bridge, bldg.	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	1	0.9	0	0.0
Other Gases, Fumes	0	0	0	0	0	0	0	1	1	0	0	0	0	0	1	1	2	2.1	1	2.9
Undetermined	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	1	1.1	1	2.9
Trauma of Vehicle Collision	0	0	1	0	0	0	1	0	1	0	0	0	0	0	3	0	3	3.2	1	2.9

PROVINCIAL SUMMARY
SUICIDE DEATHS BY AGE GROUP, GENDER AND DEATH FACTOR - SCHEDULE C-2
from 2021.01.01 to 2021.12.31

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	0	0	1	1	0	1	2	0	2	0	1	0	0	0	6	2	8	8.5	4	11.8
Shooting - Shotgun	0	0	0	0	1	0	2	0	1	0	1	1	1	0	6	1	7	6.5	1	2.8
Shooting - Handgun	1	0	0	0	0	0	2	0	0	0	0	0	1	0	4	0	4	4.3	1	2.9
Alcohol and Drug	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	1	1.1	1	2.9
Alcohol Poisoning	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	1	1.1	1	2.9
Drug Street	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	1	1.1	1	2.9
Drug	0	2	0	0	0	0	1	1	0	1	0	1	2	1	3	6	9	9.6	5	14.7
Males		2		7		13		19		15		9		10	75		94	100.0	34	100.0
Females		3		1		3		4		1		5		2		19				
Total for Age Group		5		8		16		23		16		14		12						

PROVINCIAL SUMMARY
SUICIDE DEATHS BY AGE GROUP, GENDER AND ENVIRONMENT - SCHEDULE C-3
from 2021.01.01 to 2021.12.31

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
Open Water (river, lake, stream, brook)	0	0	0	0	0	0	0	0	0	0	1	0	0	1	1	1	2	2.1	0	0.0
Beach/ Shoreline	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	1	1.1	1	2.9
Living inside, residence or on property	1	3	5	0	11	2	13	3	12	1	7	4	9	1	58	14	72	76.6	25	73.5
Non Public Road -- Driver	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	1	1.1	0	0.0

PROVINCIAL SUMMARY
SUICIDE DEATHS BY AGE GROUP, GENDER AND ENVIRONMENT - SCHEDULE C-3
from 2021.01.01 to 2021.12.31

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
Public Road – Driver	0	0	1	0	0	0	1	0	1	0	0	0	0	0	3	0	3	3.2	1	2.9
Public Road - Pedestrian	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	1	1.1	0	0.0
Urban Outdoors - public place and other (not residence)	1	0	0	0	0	1	2	0	1	0	0	0	0	0	4	1	5	5.3	3	8.8
Rural Outdoors (not built up place or near residence)	0	0	1	1	1	0	3	0	1	0	1	0	1	0	8	1	9	9.6	4	11.8
Males	2		7		13		17		15		9		10		75		94	100.0	34	100.0
Females	3		1		3		4		1		5		2			19				
Total for Age Group	5		8		16		21		16		14		12							

0.0**PROVINCIAL SUMMARY**

HOMICIDE DEATHS BY AGE GROUP, GENDER AND JUDICIAL DISTRICT - SCHEDULE D-1

from 2021.01.01 to 2021.12.31

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	0	0	0	0	0	1	0	0	0	0	0	0	0	1	1	10.0	1	10.0
Edmundston	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	1	10.0	1	10.0
Fredericton	0	0	0	0	1	0	1	0	0	0	0	0	0	0	2	0	2	20.0	2	20.0
Campbellton	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	1	10.0	1	10.0
Moncton	1	0	0	0	1	0	0	0	1	0	0	0	0	0	3	0	3	30.0	3	30.0
Saint John	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	1	10.0	1	10.0
Woodstock	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	1	10.0	1	10.0
Males	1		0		4		1		2		0		0		8		10	100.0	10	100.0
% Total - Males	10.0		0.0		40.0		10.0		20.0		0.0		0.0		80.0					
Females	0		0		1		1		0		0		0			2				
% Total - Females	0.0		0.0		10.0		10.0		0.0		0.0		0.0			20.0				
Total for Age Group	1		0		5		2		2		0		0							
% of Classification Total	10.0		0.0		50.0		20.0		20.0		0.0		0.0							

PROVINCIAL SUMMARY
HOMICIDE DEATHS BY AGE GROUP, GENDER AND DEATH FACTOR - SCHEDULE D-2
from 2021.01.01 to 2021.12.31

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 - Shotgum	0	0	0	0	1	0	0	0	1	0	0	0	0	0	2	0	2	20.0	2	20.0
Cuts, Stabs	0	0	0	0	0	0	0	1	1	0	0	0	0	0	1	1	2	20.0	2	20.0
Shooting - Rifle	0	0	0	0	2	0	0	0	0	0	0	0	0	0	2	0	2	20.0	2	20.0
Shooting - Handgun	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	1	10.0	1	10.0
Shooting - Unspecified	0	0	0	0	0	1	1	0	0	0	0	0	0	0	1	1	2	20.0	2	20.0
Trauma of Vehicle – Pedestrian Collision	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	10.0	1	10.0
Males	1		0		4		1		2		0		0		8		10	100.0	10	100.00
Females	0		0		1		1		0		0		0			2				
Total for Age Group	1		0		5		2		2		0		0							

PROVINCIAL SUMMARY
HOMICIDE DEATHS BY AGE GROUP, GENDER AND ENVIRONMENT - SCHEDULE D-3
from 2021.01.01 to 2021.12.31

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	0	0	0	0	2	1	0	0	1	0	0	0	0	0	3	1	4	40.0	4	40.0
Urban Outdoors - public place and other (not residence)	1	0	0	0	0	0	1	1	1	0	0	0	0	0	3	1	4	40.0	4	40.0
Rural Outdoors (not built up place or near residence)	0	0	0	0	2	0	0	0	0	0	0	0	0	0	2	0	2	20.0	2	20.0
Males	1		0		4		1		2		0		0		8		10	100.0	10	100.0
Females	0		0		1		1		0		0		0			2				
Total for Age Group	1		0		5		2		2		0		0							

PROVINCIAL SUMMARY
NATURAL DEATHS BY AGE GROUP, GENDER AND JUDICIAL DISTRICT - SCHEDULE E-1
from 2021.01.01 to 2021.12.31

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	2	0	1	1	1	4	3	14	7	26	6	42	25	87	45	132	10.0	25	5.9
Campbellton	0	0	0	0	0	1	4	1	3	1	6	9	16	12	29	24	53	4.0	9	2.1
Edmundston	0	1	0	0	0	1	3	0	6	5	13	12	25	23	47	42	89	6.8	21	4.9
Fredericton	2	1	2	0	1	0	5	2	21	5	38	11	46	43	115	62	177	13.4	74	17.3
Miramichi	0	0	0	1	1	1	5	2	5	2	21	9	27	19	59	34	93	7.1	30	7.0
Moncton	3	1	1	2	1	0	12	4	37	16	55	28	109	76	218	127	345	26.2	110	25.8
Saint John	1	1	0	2	6	7	13	10	38	16	74	34	100	84	232	154	386	29.3	139	32.6
Woodstock	0	0	0	0	0	0	2	0	9	2	4	2	12	11	27	15	42	3.2	19	4.4
Males	6		3		10		48		133		237		377		814		1,317	100	427	100
% Total - Males	0.5		0.2		0.8		3.6		10.1		18		28.6		61.8					
Females	6		6		11		22		54		111		293			503				
% Total - Females	0.5		0.5		0.8		1.7		4.1		8.4		22.2			38.2				
Total for Age Group	12		9		21		70		187		348		670							
% of Classification Total	0.9		0.7		1.6		5.3		14.2		26.4		50.9							

PROVINCIAL SUMMARY
NATURAL DEATHS BY AGE GROUP, GENDER AND DEATH FACTOR - SCHEDULE E-2
from 2021.01.01 to 2021.12.31

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	6	6	3	5	9	11	47	22	132	54	236	111	375	291	808	500	1308	99.3	419	98.1
Aspiration	0	0	0	0	0	0	0	0	1	0	0	0	0	1	1	1	2	0.2	1	0.2
Drowning- Bathtub	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	1	0.1	1	0.2
Infectious Disease	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	1	0.1	1	0.2
Fall or Jump- same level	0	0	0	0	0	0	0	0	0	0	0	0	1	1	1	1	2	0.2	2	0.4
Chronic Use of Alcohol	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	1	0.1	1	0.2
Drug (street)	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	1	0.1	1	0.2
Chronic Use of Prescribed Medications	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0	1	0.1	1	0.2
Males	6		3		10		48		133		237		377		814		1317	100.0	427	100.0
Females	6		6		11		22		54		111		293			503				
Total for Age Group	12		9		21		70		187		348		670							

PROVINCIAL SUMMARY
NATURAL DEATHS BY AGE GROUP, GENDER AND ENVIRONMENT - SCHEDULE E-3
from 2021.01.01 to 2021.12.31

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
Gymnasium/Health Club	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0.1	0	0
Seniors Complex	0	0	0	0	0	0	0	0	1	1	0	0	8	9	9	10	19	1.4	2	0.5
Nursing Home	0	0	0	0	0	0	0	1	2	1	4	4	16	31	22	37	59	4.5	7	1.6
Homes for Special Care	0	0	0	0	0	0	0	0	2	0	4	4	10	17	16	21	37	2.8	5	1.2
Community Residence	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	1	0.1	0	0
Homeless Shelter	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0	1	0.1	1	0.2
Unlicenced Residential Homes (retirement, rest, etc.)	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	1	0.1	0	0
Living inside, residence or on property	3	5	3	5	8	10	42	18	111	50	206	95	312	223	685	406	1091	82.8	364	85.2
Rooming/Boarding House/Halfway House/Group Home	0	0	0	0	1	0	0	0	1	0	0	0	1	0	3	0	3	0.2	2	0.5
Inside, other than residence (mall, restaurant, other public building)	0	0	0	0	0	0	0	0	0	0	1	0	2	4	3	4	7	0.5	1	0.2

PROVINCIAL SUMMARY
NATURAL DEATHS BY AGE GROUP, GENDER AND ENVIRONMENT - SCHEDULE E-3
from 2021.01.01 to 2021.12.31

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						
Hotel / Motel	0	0	0	0	0	0	1	0	3	0	0	0	0	0	4	0	4	0.3	3	0.7
Hospital Other (ward, ICU, etc.)	2	1	0	1	1	0	0	0	1	0	4	4	11	6	19	12	31	2.4	7	1.6
Hospital Post Op (recovery room)	0	0	0	0	0	0	0	0	0	0	0	0	1	1	1	1	2	0.2	1	0.2
Hospital Emergency – NON DOA	0	0	0	0	0	0	1	0	0	0	0	1	1	0	2	1	3	0.2	2	0.5
Ambulance	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	1	0.1	0	0.0
Psychiatric Hospital	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	2	2	0.2	1	0.2
Factory, Plant, Warehouse (inside)	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	1	0.1	0	0.0
Work Place	0	0	0	0	0	0	0	0	3	1	6	0	1	0	10	1	11	0.8	7	1.6
Construction	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	1	0.1	0	0.0
Custody Federal Institution	0	0	0	0	0	0	0	0	1	0	1	0	1	0	3	0	3	0.2	2	0.5

PROVINCIAL SUMMARY
NATURAL DEATHS BY AGE GROUP, GENDER AND ENVIRONMENT - SCHEDULE E-3
from 2021.01.01 to 2021.12.31.0

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
Camping / Tenting	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	1	0.1	1	0.2
Federal Institution	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0	1	0.1	1	0.2
Rural Outdoors (not built up place or near residence)	0	0	0	0	0	0	0	0	1	0	3	0	2	0	6	0	6	0.5	4	0.9
Urban Outdoors-public place and other (not residence)	0	0	0	0	0	0	1	1	3	0	1	0	5	0	10	1	11	0.8	6	1.4
Other Outdoor Recreation	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	1	0.1	1	0.2
ATV driver off public road	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	1	0.1	1	0.2
Public Road – Driver	0	0	0	0	0	1	1	0	2	0	1	1	2	0	6	2	8	0.6	5	1.2
Non Public Road- Driver	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	1	0.1	1	0.2
Public Road - Passenger	0	0	0	0	0	0	0	1	0	0	1	0	0	0	1	1	2	0.2	0	0.0
Public Road - Pedestrian	0	0	0	0	0	0	0	0	0	0	3	0	1	0	4	0	4	0.3	0	0.0
Public Road – Motorcycle Driver	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0.0
Public Transit (bus, train, et.c)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0.0

PROVINCIAL SUMMARY
NATURAL DEATHS BY AGE GROUP, GENDER AND ENVIRONMENT - SCHEDULE E-3
from 2021.01.01 to 2021.12.31

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
Ocean	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	1	0.1	1	0.2
Open Water (river, lake, stream, brook)	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	1	0.1	1	0.2
Males	6		3		10		48		133		237		377		814		1317	100	427	100
Females	6		6		11		22		54		111		293			503				
Total for Age Group	12		9		21		70		187		348		670					100		

PROVINCIAL SUMMARY
UNDETERMINED DEATHS BY AGE GROUP, GENDER AND JUDICIAL DISTRICT - SCHEDULE F-1
from 2021.01.01 to 2021.12.31

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
Bathurst	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Campbellton	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Edmunston	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Fredericton	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Miramichi	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0
Moncton	0	0	0	0	0	0	0	0	2	0	0	0	0	0	1	0	1	14.3	1	14.3
Saint John	0	1	0	1	1	0	0	0	1	0	1	0	1	0	3	2	5	71.4	5	71.4
Woodstock	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	14.3	1	14.3
Males	0		0		1		0		1		1		1		4					
% Total - Males	0		0		14.3		0.0		14.3		14.3		14.3		57.2					
Females	2		1		0		0		0		0		0			3	7	100.0	7	100.0
% Total - Females	28.6		14.3		0		0		0		0		0			42.9				
Total for Age Group	2		1		1		0		1		1		1							
% of Classification Total	28.6		14.3		14.3		0		14.3		14.3		14.3							

PROVINCIAL SUMMARY
UNDETERMINED DEATHS BY AGE GROUP, GENDER AND DEATH FACTOR - SCHEDULE F-2
from 2021.01.01 to 2021.12.31

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
Fall or Jump-same level	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	1	14.3	1	14.3
Cuts, Stabs	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	14.3	1	14.3
Natural Disease	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	14.3	1	14.3
Undetermined	0	0	0	1	1	0	0	0	1	0	0	0	1	0	3	1	4	57.1	4	57.1
Males	0		0		1		0		1		1		1		4		7	100.0	7	100.0
Females	2		1		0		0		0		0		0			3				

PROVINCIAL SUMMARY
UNDETERMINED DEATHS BY AGE GROUP, GENDER AND ENVIRONMENT - SCHEDULE F-3
from 2021.01.01 to 2021.12.31

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	0	2	0	1	1	0	0	0	1	0	1	0	1	0	4	3	7	100	7	100
Males	0		0		1		0		1		1		1		4		7	100.0	7	100.0
Females	2		1		0		0		0		0		0			3				
Total for Age Group	2		1		1		0		1		1		1							

Schedule F

Undetermined Deaths
(Means of death impossible to determine)

There were seven deaths classified as Undetermined.

One was in the Woodstock Judicial District:

Death Factor: Undetermined
Environment: Living Inside, Residence or on Property
Age Group: 0-19
Sex: Female
An autopsy was performed. This case remains under investigation.

One was in the Moncton Judicial District:

Death Factor: Undetermined
Environment: Living Inside, Residence or on Property
Age Group: 51-60
Sex: Male
An autopsy was performed.

Five were in the Saint John Judicial District:

Case #1
Death Factor: Undetermined
Environment: Living Inside, Residence or on Property
Age Group: 0-19
Sex: Female
An autopsy was performed. This case remains under investigation.

Case #2
Death Factor: Undetermined
Environment: Living Inside, Residence or on Property
Age Group: 20-30
Sex: Female
An autopsy was performed. This case remains under investigation.

Case #3
Death Factor: Undetermined
Environment: Living Inside, Residence or on Property
Age Group: 31 - 40
Sex: Male
An autopsy was performed.

Case #4
Death Factor: Undetermined
Environment: Living Inside, Residence or on Property
Age Group: 61-70
Sex: Male
An autopsy was performed. This case remains under investigation.

Case #5
Death Factor: Undetermined
Environment: Living Inside, Residence or on Property
Age Group: over 70
Sex: Male
An autopsy was performed.

Summary of Inquests and Recommendations

Five inquests were ordered during the reporting period. This report covers the replies received by the Office of the Chief Coroner in response to the recommendations on these inquests.

Michel Vienneau

An investigation into the death of Michel Vienneau was held from April 27 to May 3, 2021, at Danny's Convention Center at 1223 Principale Street in Beresford to comply with COVID-19 physical distancing regulations.

Mr. Vienneau died on January 12, 2015, as a result of injuries suffered when shot by a police officer during a police operation in the parking lot of the Bathurst train station. Twenty-one witnesses were heard during the investigation, and the five-person jury made the following recommendations:

1. Always have a person responsible for getting access to Crime Stoppers information (including weekends) so information is shared as quickly as possible.

2. Unmarked cars should be inspected regularly just like patrol cars to ensure that all equipment is in working order.

3. Ensure that flashing lights on unmarked cars are standardized and clearly visible when activated.

4. At the time of intervention, police should wear or put on outer clothing clearly identifying them as police officers.

5. A patrol car with a police officer in uniform should be part of the intervention.

These recommendations were sent to the President of the New Brunswick Chiefs of Police Association and to the Bathurst Police Force who responded to the letter.

Recommendation # 1

Always have a person responsible for getting access to Crime Stoppers information (including weekends) so information is shared as quickly as possible.

The Chief of Police of the Bathurst Police Force stated that the Bathurst Police Force has identified two police officers as coordinators for the Crime Stoppers Program. The Duty Sergeant and the Inspector in charge of police operations now both receive immediate notification through email, which is readily accessible from their cellular telephones at all times. Following a Crime Stoppesr Tip notification, the proper units will immediately be informed and investigate any information received of urgent nature. All other non-urgent information will be investigated accordingly.

Recommendation # 2

Unmarked cars should be inspected regularly just like patrol cars to ensure that all equipment is in working order.

The Chief of Police of the Bathurst Police Force stated that the Duty Sergeant for the Bathurst Police Force is now responsible for the monthly inspection of all police fleet, including unmarked police vehicles. An inspection report is forwarded to the Deputy Chief in charge of administration and any identified issues will be addressed at their earliest opportunity. Police vehicles, marked or unmarked, deemed unfit for emergency operations will not be used until the appropriate repairs have been done.

Recommendation # 3

Ensure that flashing lights on unmarked cars are standardized and clearly visible when activated.

The Chief of Police of the Bathurst Police Force stated that all Bathurst Police Force marked police vehicles are currently equipped with 360 degree visible blue and red lighting clearly indicative of a police vehicle. All Bathurst Police Force unmarked police vehicles are currently equipped with visible blue and red lighting clearly indicative of a police vehicle in the front and the rear of each vehicle. As an improvement to this, the Bathurst Police Force are equipping all of their unmarked police vehicles with police lighting on both sides of the vehicles in order to achieve 360 degree visible blue and red lighting clearly indicative of a police vehicle, similar to that of our marked police vehicles. The timeline for achieving this objective is by year-end 2021.

Recommendation # 4

At the time of intervention, police should wear or put on outer clothing clearly identifying them as police officers.

The Chief of Police of the Bathurst Police Force stated that all Bathurst Police Force non-uniformed police officers have been equipped with a jacket (known as “take down jackets”) that has readily accessible visible “Bathurst Police Force Badging Insignia” on the left and right shoulders as well as pull down “POLICE” badging on the front chest and rear back area, which is consistent with jackets worn by uniformed police officers. These jackets, when worn with the insignias displayed, are highly visible and legible to the public.

Michel Vienneau (continued)

Recommendation # 5

A patrol car with a police officer in uniform should be part of the intervention.

The Chief of Police of the Bathurst Police Force stated that specialized units are often working covert operations and the presence of a marked police vehicle and/or uniformed officer in the vicinity could compromise the integrity of their investigation and put the safety of the covert officers at risk. Although it is practical to have a marked police vehicle and uniformed officer take part of interventions, it is not always possible or safe. Specialized Unit officers such as drug investigators often do surveillance where there is no intention of arrest; however, unexpected circumstances may dictate that an arrest has to take place in which case waiting for a marked police vehicle and/or uniformed officer to arrive is not practical nor safe for the officers or members of the public. In spite of these possible scenarios, the Bathurst Police Force agrees that any **"planned"** intervention should include a patrol car with a police officer in uniform to be readily available for arrests or emergencies.

William Gregg

A mandatory coroner's inquest into the death of William Douglas Gregg was held July 6 – 7, 2021, in Saint John. Gregg died on February 29, 2016 from injuries sustained during his employment at the J. D. Irving Sawmill in Sussex.

The five-member jury heard from 12 witnesses during the inquest and made the following recommendations:

1. It should be clear on roles and responsibilities of who is responsible for start up and shut down of equipment.

2. Clear and defined handoff procedures should be established between production mode vs maintenance mode when equipment is being shut down or locked out.

3. Training plans, safety observations and audits should be used to ensure employees remain proficient and that work practices remain safe.

4. Emergency response plans should include instructions on communication to local authorities and instructions for site access. Response plans could be enhanced through the use of mock drills.

The recommedations were forwarded to the President and CEO of WorkSafeNB and J. D. Irving Ltd.

Recommendation # 1

It should be clear on roles and responsibilities of who is responsible for start up and shut down of equipment.

J.D Irving, Ltd (JDI) stated that the Sawmill Division of J.D. Irving, Limited has in place detailed policies clearly identifying who is responsible for startup and shut down of equipment as part of our Lock Out Tag Out procedures. Lockout policies and procedures are laid out in policies entitled Lockout Policy, Lockout Procedure, and Lockout Training Process.

Recommendation # 2

Clear and defined handoff procedures should be established between production mode vs maintenance mode when equipment is being shut down or locked out.

JDI stated that the Sawmill Division of J.D. Irving, Limitedhas a detailed policy regarding the shut down and lock out of equipment as part of their Lock out and Tag Out work policy noted above. The Training policy "Operating the Chip plant process" provides detail.

Recommendation # 3

Training plans, safety observations and audits should be used to ensure employees remain proficient and that work practices remain safe.

JDI responded that the Sawmill Division of J.D. Irving, Limited has in place a detailed policy and training procedure in addition to a structured observation and audit system which ensures all employees receive proper safety and operational training before beginning a new position and also receive regular updates on both safety and operation training.

Recommendation # 4

Emergency response plans should include instructions on communication to local authorities and instructions for site access. Response plans could be enhanced through the use of mock drills.

JDI submitted “Emergency Response Sussex Site” and “Sussex Emergency Preparedness Plan for the Sussex Site.” They state that they have contacted the following emergency responders in the Sussex area: RCMP Detachment, Sussex Fire Department, Ambulance New Brunswick, have provided them with an updated diagram of the Sussex Site, and have invited representatives to attend for a refresher regarding the configuration of the Sussex Site.

**

WorkSafeNB did not respond to individual recommendations but signalled their agreement with all recommendations. Worksafe stated they would share the recommendations with the New Brunswick Forest Safety Association, an industry-funded safety association that focuses on training specific to sawmill operations and on whose Board of Directors a WorkSafe NB representative sits.

Rodney Levi

An inquest into the death of Rodney Levi was held September 28 to October 8, 2021 in Miramichi.

On June 12, 2020 Levi showed up at the residence of a local pastor in Sunny Corner. Levi was not acting like himself, so the family invited him to stay for supper. After the meal Levi was seen exiting the home with two large knives, when he would not put them down the family called 911. RCMP responded and attempted to convince Levi to drop the knives, when he would not, an officer attempted to use a conductive energy weapon three times; however, this was unsuccessful. Levi moved in the direction of the other officer pointing the knives at him. The officer fearing death or grievous bodily harm discharged his firearm twice and Levi fell to the ground. First aid was provided, and Levi was transported by ambulance to the Miramichi Hospital where he died as a result of his injuries.

The five-member jury heard evidence from 27 witnesses during the inquest and made the following recommendations:

Recommendations for Aboriginal Policing

1. Recommend the re-instatement of the Aboriginal Band Constable Program.

2. Until the re-instatement of the Aboriginal Band Constable Program, that the RCMP utilize a designated Aboriginal Community liaison person.

Recommendations for Mental Health Services

3. That counselling services for witnesses, victims, and family members of a traumatic event in a timely manner.

4. First Nations communities be provided with increased mental health services and facilities.

5. That detox facilities are readily available in First Nation communities.

6. In situations involving mental wellness checks on First Nations, RCMP should not be the first responder – but be on standby for Mobile Crisis Units or an Aboriginal liaison for the community.

7. That Mobile Crisis Units should be dispatched in a similar fashion to other emergency services (i.e.: RCMP and Fire Department).

8. That Mobile Crisis Units should be a 24-hour service.

Rodney Levi continued

9. For mental wellness checks the Mobile Crisis Unit should be dispatched along with other emergency services.

10. Information sessions on mental health and addictions be offered to First Nations communities regularly.

Recommendations for RCMP

11. That RCMP implement mandatory First Nation cultural sensitivity and awareness training at depot level.

12. That the RCMP provide dedicated, uniformed liaison officers to each detachment that has a First Nation community in its jurisdiction.

13. That the RCMP provide mandatory scenario-based suicide intervention training to cadets.

14. That the RCMP expedite the deployment of body cameras to all officer's nation wide.

15. That the RCMP implement mandatory CEW training at depot.

16. That the RCMP increase their time in field training from six to twelve months.

17. That new RCMP officers be paired for their field training with an officer who has a minimum of 5 years experience.

18. That the RCMP increase manpower.

19. That scenes are cleaned by a professional cleaning service (i.e. Service Master).

20. That the RCMP adopt the training recommendations submitted by Sgt. Kelly Keith to this inquiry which include.

    20.1 - Training Recommendation

    A specific training plan should be developed – focusing solely on the balance between the safety of the individual, third parties and the officers on scene. The overall goal of which is to make the actions of the RCMP Officers instinctual – as it should be for all police officers attending any scene.

    Such a training plan would encompass both the theory and practical training incorporated in reality-based training with scenarios in which the sole objective is to apply the techniques of mitigating Ability, Intent, Means and Opportunity of the subject, in combination with making a scene safe for all people which police can work in.

Rodney Levi continued

20.2 - Training Recommendation

After any crisis call or force encounter involving an officer, with or without a weapon, there should be a verbal debriefing with a Use of Force and De-escalation reviewer who is trained in the balance of the safety and de-escalation tactics. This will re-enforce the importance and value of the balance of safety for all. The police officer doing this review would need to fully understand and have some specific training to understand this balance.

Unfortunately, there are times when officers put themselves or others in jeopardy and are rewarded with some commendation when things work out versus looking at the balance of the officers' actions in combination with the safety of everyone. With the above-mentioned review process in place, it could also be used as another way of showing the importance of mitigating the Ability, Intent, Means and Opportunity by rewarding the officers with a commendation when the call is handled extraordinarily.

20.3 - Training recommendation

When Instructors put students through reality-based training the objectives need to be "laser focused" versus multiple options being accepted and student passing. If a student does the proper tactics and very minimal force if any is used in the scenario, this should be the objective of that scenario. Having a student fail to do the proper tactics that result in shooting the subject should NOT be an acceptable outcome.

20.4 - Training Recommendation

The RCMP crisis intervention / de-escalation training is an on-line theory course which is very informative and extremely detailed. Unfortunately, it is only theory. The officer themselves do not get to practice or get tested in the theories they learned as the on-line course is strictly theory with no practical applications including reality-based training used for evaluating the officers.

Theory is an important part of the training however for an instructor to be able to judge or measure if the student can apply the theory or and understand the drills in a situation only comes through the student going through practical exercises and then reality-based training to be tested if they can put the "when and which" techniques to apply combined with all other factors such as 3rd party, subject of concern and police officer concerns. Practical exercises and reality-based training should be added to the on-line course.

Rodney Levi (continued)

20.5 - Training Recommendation

I believe that police training in all topics including crisis intervention / de-escalation should not occur in isolation, and albeit the focus of the lesson plan needs to be centred on what the topic is, any related training to the topic should be reviewed and intertwined with the main topic. An example: knives and guns are common weapons involved when someone is in crisis and both lesson plans should re-enforce and relate to the other lesson plans key points.

Recent videos showing good and bad examples of what is expected including balancing the safety of all and crisis intervention and de-scalation in each other's lesson plans are important for the officers have proper perspectives.

20.6 - Training Recommendation

A trained crisis counsellor available in some manner for police officers and callers/subjects to provide mental health support over the phone would be an additional resource that may save lives. This suggestion would be far more powerful if the person in crises themselves called and is immediately put through to the crisis counsellor from the communication centre. The mobile crisis unit could also be used however for safety reasons the communication centre would be listening in on call and at times may need to interject. The more real time information police officers are receiving the better their risk assessment will be upon arriving.

20.7 - Training Recommendation

Call takers should also assist in priming the scene for the officers responding to a crisis. Priming the scene may include getting all third parties to a safer location. It may be to ensure doors are left open and exit is always to the police officers or public's advantage. Understanding risk assessments, they could stay on the phone with the caller giving the officer attending real time updates regarding what is occurring.

The recommendations were forwarded to New Brunswick RCMP, Department of Justice and Public Safety and the Department of Health.

Recommendation # 1

That the Aboriginal Band Constable Program be reinstated.

The Department of Justice and Public Safety responded that the Aboriginal Band Constable Program was a federally funded program and was terminated by the Government of Canada on March 31, 2015, ceasing all financial contributions. The previously allocated funding, with a 48% provincial subsidy, was redirected to the

Rodney Levi (continued)

Community Program Officer initiative, in which civilian employees under the RCMP are designated to implement community based programs that contribute to the prevention and reduction of crime through education, and awareness, intervention and diversion, and sustainable community engagement. The Province is not able to reinstate the Aboriginal Band Constable Program without a supported federal funding agreement. Departmental representatives have discussed at the federal level the concept of community safety programs dedicated to Indigenous communities.

Recommendation # 2

That, until the re-instatement of the Aboriginal Band Constable Program, the RCMP utilize a designated Aboriginal Community liaison person.

The RCMP responded that it is not a funding agency and that therefore such program requests should be sought by the Indigenous Communities through negotiations with Canada and provinces/territories. Many Indigenous communities are implementing safety programs for their respective communities and submitting proposals for enhanced safety programs to assist the RCMP. J Division Indigenous Policing Services is continuously engaged with the community's implementation of the programs through the province.

The RCMP's Community Program Officer for Indigenous Communities (CPOI) will continue their work in the communities and catalogue the different resources and services of each community.

J Division RCMP's Community Program Officer for Indigenous Communities (CPOI) are non-uniformed civilian employees whose focus is on crime prevention activities, increased visibility, and enhanced community engagement through crime prevention and crime diversion programs in Indigenous communities. Preference is given to Indigenous applicants as part of the CPOI hiring process, however we also have non-indigenous CPOIs who demonstrate cultural humility, cultural sensitivity, and are respected by the Indigenous communities they serve. CPOIs implement community-based programs and initiatives that contribute to the prevention and reduction of crime through education and awareness, intervention and diversion, and sustainable community engagement, therefore it would not be part of their mandate to respond to calls for service. Although CPOIs do not respond to calls for service, they are responsible for compiling and maintaining a catalogue of the different resources and services of each Indigenous community, which will serve as a tool for regular members responding to calls for service. The catalogue of resources and services will be accessible to the Risk Managers in the Telecommunication Section and Specialized Policing Units within the Division. J Division has also assigned uniformed liaison officers for each Indigenous community, (Indigenous and non-Indigenous regular members) whose role in addition to General Duty Policing, is to establish and maintain relationships with the local Indigenous communities. In this particular instance, the call

for service did not occur in an Indigenous community, therefore Indigenous community supports were not as readily available. It has however highlighted the importance to ensure our membership is culturally sensitive and aware of local resources that are established within the Indigenous communities should they be required. (Mental Health resources within the Indigenous community, etc.)

Recommendation # 3

That counselling services for witnesses, victims, and family members of a traumatic event be available in a timely manner.

The Department of Health notes that the provision of individual or group interventions to community members who have experienced stressful or traumatic events is the responsibility of Addiction and Mental Health Centres. Primary victims, witnesses, people who assisted or helped are among those to whom Individual Crisis Interventions can be provided in the form of a one -on-one meeting and may be initiated as a crisis intervention or a referral for intake. A Crisis Management Briefing, for medium t large groups, can be held to provide known facts, dispel rumours, review signals of distress and share information about stress management.

One-at-a-time therapy is now offered at all community addictions and mental health clinics to walk-in clients and by appointment, vitually or in person. This new service provides people with rapid access to mental health services.

Recommendation # 4

That First Nations communities be provided with increased mental health services and facilities.

The Department of Health responded that currently Addiction and Mental Health Services are offered through Regional Health Authorities; Health Centres within First Nations communities and Mental Health Wellness Teams also offer mental health services.

The Department reported that it recently funded a pilot project call Wolastoqewi Nation Mental Wellness Program – Wampum CISM/Crisis Response in order to hire a coordinator who will work with all Maliseet First Nation communities to help develop community crisis response plans. Funding will also serve to provide Wampum CISM to help ensure that all Maliseet First Nation communities have access to this service.

Rodney Levi (continued)

Recommendation # 5

That detox facilities are readily available in First Nation communities.

The Department of Health responded that there are currently seven detox units in the province, which are available to all. The detox services allow for a safe environment with medical supervision as individuals are going through withdrawal from substances. This is a volunteer service and individulas may stay between 5 and 10 days depending on the substance of use and their medical needs. Other services exist in communities such as opioid agonist therapy treatment for those struggling with substance use.

Recommendation # 6

In situations involving mental wellness checks on First Nations, RCMP should not be the first responder – but be on standby for Mobile Crisis Units or an Aboriginal liaison for the community.

The Department of Health responded that the Mobile Crisis Services Unit (MCSU) conists of trained addiction and mental health clinicians who provide community-basedassistance to persons with addiction or mental health concerns. They often attend private residences to help people in a mental health crisis to facilitate the appropriate treatment. Although the MSCU has the authority to carry out this role, its personnel are not trained to handle emergency public safety issues or violent incidents. Typically, once contacted directly by people in need, the MSCU deploys a clinician who can provide crisis intervention. However, if there is any indication of a threat or safety issue, the clinician will call the police force to conduct the intervention together. By forming a tactical partnership, mobile crisis clinicians can attend to addiction and mental health-related calls accompanied by police members to ensure their safety. The clinician is then able to perform an assessment on the person in crisis which will allow appropriate treatment to be commenced and which may prevent the need to take the person into custody under the *Mental Health Act* and transport them to the hospital. The current practice is the following:

1. After receiving the notice of the police force or RCMP, clinicians travel to the address provided and wait in a safe place until the police have been able to check the security of the premises. Clinicians also remain available for a telephone consultation when travel may cause a delay.
2. After the police determine that the scene is safe, clinicians enter and proceed with an evaluation and intervention for the person in crisis.
3. They discuss with the police officers at the scene if their presence is required for the duration of the intervention (e.g., is the client calm, cooperative and not a danger to self or others?).
4. They notify the police if the person should be taken to hospital. The person may be transported to the hospital by RCMP, ambulance, taxi, family, etc.

Rodney Levi (continued)

5. They follow police directions throughout the intervention and at the scene regarding personal and public safety concerns.
6. They travel to, or call, the Emergency Department to relay information related to the crisis and the assessment to expedite services and ensure a continuum of services.
7. They complete the assessment and the intervention and make appropriate recommendations and referrals to services. The clinician prepares a plan with the person and loved ones for follow-up in the community, if indicated.

Note: Mobile Crisis clinicians do not intervene if the person has just attempted suicide, as they require immediate medical attention (e.g., medication/drug/alcohol use, deep cuts, or serious injuries). The person must therefore be transported directly to the hospital. They cannot assess the mental health of a person who is incoherent because of drug or alcohol use. However, they can assess the individual once the effects of the substance have worn off.

Recommendation # 7

That Mobile Crisis Units should be dispatched in a similar fashion to other emergency services (i.e.: RCMP and Fire Department).

The Department of Health responded that individuals in an emergency are to contact 911. The Mobile Crisis Services Unit work in collaboration with Ambulance New Brunswick and policing services across the province.

Mobile Crisis Services are available to all individuals (all age groups) who are experiencing an addiction and/or mental health crisis, their significant others, communities, service providers, health care providers, first responders, etc. The individual experiencing a crisis may or may not be a current client of Addiction and Mental Health Services.

Clients can expect:

- Initial support and triage over the phone and mobile visit by the mobile crisis clinician if deemed appropriate.
- Assessment of the presenting situation (completion of the CSDS Mobile Crisis Assessment tool, to be developed), support and resources.
- Strength-based, recovery-oriented, supportive, and collaborative approach.
- Referral to appropriate follow-up services.
- Consultation/advocacy with existing supports and services.
- Short-term crisis management, as necessary.

Rodney Levi (continued)

Recommendation # 8

That Mobile Crisis Units should be a 24-hour service.

The Department of Health responded that the New Brunswick Provincial Health Plan promises to implement in 2022-2023 a new provincial phone service to ensure addiction and mental health crisis response services are available 24 hours a day, seven days a week. Data is being collected to better inform the need for 24/7 mobile response.

Recommendation # 9

For mental wellness checks the Mobile Crisis Unit should be dispatched along with other emergency services.

The Department of Health responded that partnerships with police forces are being developed across the province to address community addiction and or mental health crisis in order to enhance service delivery in a confidential, efficient, effective manner. By forming a tactical partnership, MCSU clinicians are able to attend to addiction and or mental health-related calls accompanied by police members in order to ensure their safety.

Recommendation # 10

Information sessions on mental health and addictions be offered to First Nations communities regularly.

The Department of Health responded that the Community Addiction and Mental Health Services are available to connect and offer information sessions through the Prevention Coordinators upon request. Data is being collected to better inform the need for 24/7 mobile responses. Information on available resources can also be found on Bridge the Gapp: https://nb.bridgethegapp.ca

Recommendation # 11

That RCMP implement mandatory First Nation cultural sensitivity and awareness training at depot level.

The RCMP responded that it has launched the mandatory Cultural Awareness and Humility (CAH) course for all employees, which is designed to increase knowledge, enhance self-awareness and strengthen the skills of RCMP employees who work both directly and indirectly with different cultures including Indigenous cultures. Consultation

Rodney Levi (continued)

for this course was broad and included Indigenous leaders, subject matter experts and advocates.

Specifically in the CAH course, Module 5 – Cultural Awareness in Indigenous Communities, discusses important concepts such as communication, restorative justice, spirituality, values, intergenerational trauma and the principles of healing from the perspective of what this means for policing in Canada.

The RCMP has have also acquired permission to host the Canada School of Public Service's Indigenous Learning Series on our Learning Management System. The series consists of 4 separate courses (K100, K101, K102, K103) which represent a contemporary view of learning about First Nations, Inuit and Métis communities, and has been widely consulted and informed by Indigenous Peoples.

The RCMP will continue to make efforts to strengthen its knowledge and cultural sensitivity, of the communities we serve. An intercultural learning strategy is being developed and will be informed by those communities.

The Cadet Training Program currently includes training on cultural sensitivity/awareness, including curriculum specifically related to Indigenous cultural sensitivity/awareness. As well, there are related competencies against which cadets' performance and behaviour is formally and informally assessed throughout the 26 weeks of training. Module 13 in Applied Police Sciences (missing person investigation) is set in an Indigenous community, and cadets are required to apply culturally sensitive/awareness principles as part of resolving the situation and providing an effective policing service. The Indigenous cultural sensitivity/awareness curriculum includes the Kairos Blanket Exercise, and material on Truth and Reconciliation, and the Missing and Murdered Indigenous Women and Girls Inquiry. In addition, Depot Division holds events outside of the formal curriculum in order to develop cadets' Indigenous cultural sensitivity/awareness. For example, in this past fiscal year, there was a teepee raised on base under the guidance of a local Elder, a traditional Indigenous feast was held, and the Indigenous Spirit Room was moved and renovated in collaboration with Indigenous community members. The Commanding Officer's Indigenous Advisory Committee plays an active role in guiding the Division on such activities.
In addition, Depot Division is currently revising the online History of the Force course from the Cadet Training Program so that there is greater focus on reconciliation. Several other courses are under review for applicants to complete prior to attending the Cadet Training Program which would provide additional material on the history of Indigenous peoples in Canada and reconciliation (e.g., University of Alberta Indigenous Canada, Canada School of Public Service Indigenous Awareness).

Depot Division is in the latter stages of a Kirkpatrick Level 3 Evaluation of the Cadet Training Program. This is an academic, evidence-based process designed to evaluate how well basic training is preparing new Members for the field. It will identify what needs to stay in the curriculum, what can be removed, and what needs to be added. Other

Rodney Levi (continued)

complementary evaluation processes have also been held over the past two years (e.g., legal review conducted by counsel from Public Prosecution Services of Canada, GBA+ review, etc.). The topic of Indigenous cultural sensitivity/awareness is being examined

through these evaluations. The sum results of these processes will be used to design and develop Version 10 of the Cadet Training Program over the next one to three years.

Recommendation # 12

That the RCMP provide dedicated, uniformed liaison officers to each detachment that has a First Nation community in its jurisdiction.

The RCMP responded that as it is not a funding agency, such program requests should be sought by the Indigenous Communities through negotiations with Canada and provinces/territories. Many Indigenous communities are implementing safety programs for their respective communities and submitting proposals for enhanced safety programs to assist the RCMP. J Division Indigenous Policing Services is continuously engaged with the community's implementation of the programs through the province.

J Division Indigenous Policing Services (IPS) adopted the Community Program Officer for Indigenous Communities in 2017. CPOIs are an integral part of the policing community, delivering a continuum of culturally relevant services to the Indigenous communities they serve. Various crime and victimization issues are addressed through the delivery of education and awareness activities within the Indigenous communities, working closely with Indigenous Wellness networks and determining root causes to reduce recidivism. CPOIs are the liaisons between Indigenous communities and police, CPOIs work collaboratively with the community stakeholders in establishing and maintaining partnerships that will ultimately assist those most vulnerable in Indigenous communities.

- Acting as liaisons between Indigenous communities and police, CPOIs work collaboratively with community stakeholders in establishing and maintaining partnerships that will ultimately assist those most vulnerable in Indigenous communities.
- Partnership initiatives focus on fostering resiliency and promoting mental health, and addressing risk factors associated with crime.
- Diversion from the criminal justice system continues to be one of the core responsibilities of the CPOI. CPOIs play a key role in completing risk screening and assessments in order to identify the risk factors that may be contributing to an individual's offending behavior, as well as any unmet mental health needs.
- As an integral part of the policing community, CPOIs are also uniquely positioned to engage with Indigenous community members in finding meaningful solutions to mutually agreed upon priorities as it relates to Indigenous Policing in New Brunswick, and to strengthen relationships between J Division RCMP and Indigenous communities.

Rodney Levi (continued)

The CPOIs have actively supported Divisional reconciliation initiatives such as the Eagle Feather rollout (Most CPOIs are Feather Keepers). The position's mandate for community engagement and knowledge of community resources uniquely positions the CPOIs to act as a liaison between Indigenous communities and the Division. Currently comprising a distinct unit that reports under the Specialized Policing Services structure,

the CPO/CPOI program continues to develop and implement sustainable crime prevention and reduction strategies in alignment with national, Divisional and provincial priorities.

J Division has also assigned uniformed liaison officers for each Indigenous community, (Indigenous and non-Indigenous regular members) whose role in addition to General Duty Policing, is to establish and maintain relationships with the local Indigenous communities. Risk Managers in the Telecommunication Section and Specialized Policing Units within the Division have access to this list of regular members. Both uniformed liaison officers and CPOIs play an integral part in community engagement, however the structured mandate of the CPOIs allows full dedication to the Indigenous communities that they serve.

Recommendation # 13

That the RCMP provide mandatory scenario-based suicide intervention training to cadets.

The RCMP responded that he Cadet Training Program currently includes training on suicide awareness, including "suicide by cop," and dealing with clients in a state of crisis. As well, there are related competencies against which cadets' performance and behaviour is formally and informally assessed in the 26 weeks of training. As part of this curriculum, cadets conduct a risk assessment on a scenario in which the client is at risk of suicide, are introduced to a suicide intervention strategy, and observe a high risk suicide situation role play.

Depot Division is in the latter stages of a Kirkpatrick Level 3 Evaluation of the Cadet Training Program. This is an academic, evidence-based process designed to evaluate how well basic training is preparing new Members for the field. It will identify what needs to stay in the curriculum, what can be removed, and what needs to be added. Other complementary evaluation processes have also been held over the past two years (e.g., legal review conducted by counsel from Public Prosecution Services of Canada, GBA+ review, etc.). The topic of suicide awareness/intervention is being examined through these evaluations. The sum results of these processes will be used to design and develop Version 10 of the Cadet Training Program over the next one to three years.

Rodney Levi (continued)

Recommendation # 14

That the RCMP expedite the deployment of body cameras to all officer's nation wide.

The RCMP responded that its Learning and Development (L&D) is engaged with the Body Worn Camera (BWC) Project and Policy Centre Teams. A Training Needs Analysis (TNA) was completed and a draft report is being approved. As part of this TNA, a Gender-Based Analysis (GBA+) analysis identified some considerations that will inform the development of the BWC training, such as:

- For some Canadians, Body Worn Cameras may be perceived as a threat to their privacy rights.
- The RCMP serves a diverse, multicultural population. Different ethnic groups, cultures and/or communities may have values and beliefs that could feel threatened by BWC.
- Recent events along with historical relations between the RCMP and the communities served has resulted in the need to build trust and repair relationships.

L&D is committed to working with the Body Worn Camera Project to ensure national implementation is supported with training for front line personnel.

The Federal Government announced funding of $238.5 million over six years for the BWC initiative through the 2020 Fall Economic Statement. The initiative is currently in the procurement phase and field-testing of cameras is anticipated to begin in 2022, as part of a phased roll-out. This initiative will see over 10,000 cameras rolled-out across the country to general duty police officers who have direct interactions within communities.

Recommendation # 15

That the RCMP implement mandatory CEW training at depot.

The RCMP responded that the Cadet Training Program currently includes introductory training on the CEW, but it is not the full CEW User's Course, and cadets are not qualified to carry the CEW upon its conclusion. As part of this curriculum, cadets learn how the CEW works, the safe handling of the CEW and cartridges, the proper way to remove probes, and how to handcuff an individual who has not yet had probes removed.

Depot Division is in the latter stages of a Kirkpatrick Level 3 Evaluation of the Cadet Training Program. This is an academic, evidence-based process designed to evaluate how well basic training is preparing new Members for the field. It will identify what needs to stay in the curriculum, what can be removed, and what needs to be added. Other complementary evaluation processes have also been held over the past two years (e.g.,

legal review conducted by counsel from Public Prosecution Services of Canada, GBA+ review, etc.). The addition of the CEW User's Course is being examined through these evaluations. The sum results of these processes will be used to design and develop Version 10 of the Cadet Training Program over the next one to three years.

Recommendation # 16

That the RCMP increase their time in field training from six to twelve months.

The RCMP responded that Depot Division is beginning a Kirkpatrick Level 3 Evaluation of the Field Coaching Program and Field Coaches Course. This is an academic, evidence-based process designed to evaluate how well the Field Coaching Program is preparing new Members for the initial stages of their career, and how well the Field Coaches Course is preparing members to become Field Coaches. It will identify what needs to stay in the curriculum, what can be removed, and what needs to be added. Another complementary evaluation process is being started by National Program Evaluation Services, which is examining administrative elements of the Field Coaching Program. The required length of training will be informed through these evaluations. The sum results of these processes will be used to make revisions to the administration and curriculum of the Field Coaching Program and Field Coaches Course over the next one to three years.

Recommendation # 17

That new RCMP officers be paired for their field training with an officer who has a minimum of 5 years experience.

The RCMP responded that, as per policy, new RCMP officers are paired with their field coach who has a minimum of 2 years of service (Level 1), and has successfully completed the required training before assuming the roles and responsibilities of a Field Coach. Efforts are made to pair new cadets with more experienced members, depending on the resources available as well as taking into consideration our vacancies and operational pressures are at the time of placement. There is a Divisional Field Coach Program (FCP) Coordinator, at the rank of Corporal, who closely monitors and oversees the progress of both the cadet and the Field Coach. The FCP Coordinator provides clear guidance and support to everyone in the process.

Depot Division is in the midst of a Kirkpatrick Level 3 Evaluation of the Field Coaching Program and Field Coaches Course. This is an academic, evidence- based process designed to evaluate how well the Field Coaching Program is preparing new Members for the initial stages of their career, and how well the Field Coaches Course is preparing members to take on the role of a Field Coach. It will identify what needs to stay in the curriculum, what can be removed, and what needs to be added. Another

complementary evaluation process is being started by National Program Evaluation Services, which is examining administrative elements of the Field Coaching Program. One of the items that National Program Evaluation Services is examining is the selection of Field Coaches. The sum results of these processes will be used to make revisions to the administration and curriculum of the Field Coaching Program and Field

Coaches Course over the next one to three years. Thus, additional enhancements required over and above that are indicated in this document may be made in the future.

In addition, the FCP Coordinator is:

- actively looking at ways to shift the selection process for coaches towards leadership development;
- is working on a new Field Coaching survey that will help direct the FCP Coordinator's work with the Program; and
- working on updating the questionnaire used during the Initial Field Coaching Practicum to make it more representative of today's policing reality.

The FCP Coordinator is continually identifying best practices that can be shared with new and existing coaches. The RCMP considers Field Coaching as the second half of basic training. It is an integral part of a cadet's completion of basic training.

Recommendation # 18

That the RCMP increase manpower.

The RCMP responded that, in New Brunswick, it is contracted under the Provincial Policing Service Agreement (PPSA). Under the PPSA, New Brunswick pays Canada 70% of the cost of providing and maintaining the provincial police service. In the normal course (i.e. not during an emergency or a special event), as per the PPSA the Provincial Minister will make a written request to the RCMP Commissioner for an increase in the number of Members or RCMP support staff. The Commissioner will action this increase as soon as practicable within one year.

Recommendation # 19

That scenes are cleaned by a professional cleaning service (i.e. Service Master).

The RCMP responded that National RCMP Contract and Indigenous Policing and Operational Policy & Compliance (OP&C) has recently proposed amendments to RCMP policies regarding: Scene Security with the below inclusion and add a further link to the Human Deaths policy:

"The member is to contact the property owner when it is feasible and appropriate, when there is human blood or bodily substances at a scene."

Rodney Levi (continued)

This proposed inclusion will be for members to attempt to notify the property owner in circumstances where they are not aware of a crime scene resulting in blood or bodily fluid on their property. Ultimately, the property owner will decide if they wish to hire professional cleaning services.

The RCMP has processes in place for property representatives to seek reimbursement for property damage in relation to police actions.

However, in an incident such as a police-involved shooting, the scene would be turned over to the jurisdiction of an independent investigative body as-is, in order that evidence is left undisturbed until the incident can be properly investigated by the independent agency to determine if any offences were committed. The scene would remain under the jurisdiction of this investigative body through to the completion of their investigation. Any decisions or obligations regarding scene cleaning would fall under the authority of that body.

Recommendation # 20.1

A specific training plan should be developed – focusing solely on the balance between the safety of the individual, third parties and the officers on scene. The overall goal of which is to make the actions of the RCMP Officers instinctual – as it should be for all police officers attending any scene.

Such a training plan would encompass both the theory and practical training incorporated in reality-based training with scenarios in which the sole objective is to apply the techniques of mitigating Ability, Intent, Means and Opportunity of the subject, in combination with making a scene safe for all people which police can work in.

The RCMP responded that officer and public safety are key considerations in the design and development of training. A blended approach to the design, development and delivery of learning products provides a balance between knowledge based learning and opportunity to practice. Scenario based training (SBT) is an effective means of replicating real life, high stress situations in a safe and controlled training environment.

The scenarios are specifically designed to represent real police encounters. Members are expected to go through the motions of a risk assessment in order to determine the level of intervention necessary to control the situation and to then articulate the rationale behind their response based on the totality of the situation. The scenarios are designed to provide members with a variety of subject behaviours. While some are designed to be high-stress, low frequency situations, many more are representative of everyday police interactions requiring officer presence and communication and/or an intervention using intermediate weapons.

Rodney Levi (continued)

The RCMP utilizes the Incident Management Intervention Model (IMIM) to assist members in developing a comprehensive risk assessment for all situations that a police officer may face. Safety priorities have been introduced in the Public and Police Safety Instructor (PPSI) course to enable police intervention instructors to further understand and assist members in their risk assessment. This ensures that police officers consider the safety of all people at a scene, including victims, bystanders, subjects they are dealing with, the police officer themselves and their partners. A risk assessment considers several areas, including tactical considerations, officer perceptions, situational factors and subject behaviour. Tactical considerations include factors such as the number of officers present, the availability of backup and specialty units (e.g. Police Service Dog, Emergency Response Team), where the interaction is taking place and the availability of cover. An individual officer's perceptions are crucial during a risk assessment, and take into account the personal characteristics that an officer brings to a situation. Situational factors speak to that particular incident, in that moment in time. These include the environment, the number of subjects present, their perceived abilities, the officer's knowledge, or lack thereof, of the subject they are dealing with, time and distance available, and any threat cues that the subject may present. Subject behaviour ranges from co-operative to grievous bodily harm or death, and ability, intent and means is a component of the subject's behaviour. All factors need to be considered during an officer's risk assessment, and each will contribute to their decision to utilize a physical intervention or not. Behaviour alone does not determine if an officer's intervention was reasonable, necessary and proportionate, and thus lawful, as outlined by Canadian courts. RCMP officers are required to participate in scenario-based training, involving scripted scenarios for them to develop a risk assessment and make appropriate decisions.

The Cadet Training Program incorporates such principles in the design and development of the curriculum, particularly in the scenario-based training elements.

Recommendation # 20.2

After any crisis call or force encounter involving an officer, with or without a weapon, there should be a verbal debriefing with a Use of Force and De-escalation reviewer who is trained in the balance of the safety and de-escalation tactics. This will re-enforce the importance and value of the balance of safety for all. The police officer doing this review would need to fully understand and have some specific training to understand this balance.

Unfortunately, there are times when officers put themselves or others in jeopardy and are rewarded with some commendation when things work out versus looking at the balance of the officers' actions in combination with the safety of everyone. With the above-mentioned review process in place, it could also be used as another way of showing the importance of mitigating the Ability, Intent, Means and Opportunity by rewarding the officers with a commendation when the call is handled extraordinarily.

Rodney Levi (continued)

The RCMP responded that all RCMP officers are required to complete a Subject Behaviour / Officer Response (SB/OR) Report after every intervention that results in a subject injury, or involves the use of physical control hard, intermediate weapons, or lethal force. These reports detail the officer's intervention and associated risk assessment, as well as the subject's behaviour, and attempts at de-escalation, when tactically feasible. These reports are reviewed by their supervisors, and if issues are identified there is policy in place for further review. Several interventions and outcomes are flagged within the system for divisional Criminal Operations Secretariat, as well as national review. This enables officers in remote settings without immediate access to a PPSI to articulate their actions and have them reviewed and assessed by an uninvolved officer. Policy covers the requirements associated to a Major Police Incident and SB/OR reports. When these investigative bodies commence an investigation, officers involved, when not deemed a witness officer, are entitled to protections provided to all Canadians under the Charter of Rights and Freedoms, including choosing not to provide a statement when facing legal jeopardy. By requiring the officer to complete a detailed debrief with a "Use of Force and De-escalation reviewer," that reviewer could be compelled to be a witness against the officer, which could bring several legal complications. SB/OR policy recognizes this, and when a Major Police Incident occurs, the involved officer's supervisor completes the report with the information available at the conclusion of the investigation.

In J Division, an SBOR is completed and is a reviewed by a supervisor and a subject matter expert (J Division Tactical Training Unit). Following crisis calls or use of force encounters, we offer members a Critical Incident Stress Debriefing (CISD) following a critical incident. A Critical Incident Stress Debriefing (CISD) is a group or an individual session conducted by a psychologist with employees who have been through a critical incident. Debriefings are normally held at least 72 hours after the incident, and may be organized by the CISM team coordinator, a Peer to Peer coordinator or advisor, a Detachment Commander, or Unit Commander. CISD are mandatory for certain traumatic events. CISD provides an opportunity for normalization of stress reactions through education, support and intervention. The divisional psychologist conducts the CISD. RCMP Policy requires that CISD take place after certain types of incidents, and CISD is strongly recommended with other types of incidents. In any event, CISD should take place where one or more employees are thought to be significantly affected, or where any employee requests it.

Recommendation # 20.3

When Instructors put students through reality-based training the objectives need to be "laser focused" versus multiple options being accepted and student passing. If a student does the proper tactics and very minimal force if any is used in the scenario, this should be the objective of that scenario. Having a student fail to do the proper tactics that result in shooting the subject should NOT be an acceptable outcome.

Rodney Levi (continued)

The RCMP responded that scenarios it develops cover a multitude of behaviours, actions, and acceptable outcomes. The goal of many of these scenarios is to recognize the need to employ crisis intervention and de-escalation techniques, and do so effectively for a successful outcome. Depending on an individual officer's risk assessment, which includes their perceptions of the situation in the moment, there may be several acceptable outcomes within a scenario. The acceptable outcomes are clearly defined in all scenarios, and when a scenario proceeds towards an unacceptable outcome, instructors have the ability to intervene, provide coaching and training assistance, and assist officers in recognizing and working towards one of the acceptable outcomes. If necessary, members will be provided additional scenarios to achieve this.

The Cadet Training Program incorporates such principles in the design and development of the curriculum, particularly in the scenario-based training elements.

Recommendation # 20.4

The RCMP crisis intervention / de-escalation training is an on-line theory course which is very informative and extremely detailed. Unfortunately, it is only theory. The officer themselves do not get to practice or get tested in the theories they learned as the on-line course is strictly theory with no practical applications including reality-based training used for evaluating the officers.

Theory is an important part of the training however for an instructor to be able to judge or measure if the student can apply the theory or and understand the drills in a situation only comes through the student going through practical exercises and then reality-based training to be tested if they can put the "when and which" techniques to apply combined with all other factors such as 3rd party, subject of concern and police officer concerns. Practical exercises and reality-based training should be added to the on-line course.

The RCMP responded that it continues to strengthen crisis intervention and de-escalation training for all its officers. Since 2016, the Crisis Intervention and De-escalation (CID) online training course has been mandatory for all RCMP officers. The purpose of the CID course is to ensure that RCMP officers will be able to use crisis intervention and de-escalation techniques, when tactically feasible, to effectively manage these situations, including incidents involving a person with a mental illness or person in crisis. The course includes a module on some of the major mental illnesses and their observable behaviours, which can assist police officers in tailoring their approach to the person in crisis.

The Crisis Intervention and De-escalation (CID) online course is one component of training RCMP officers receive in CID techniques and application. All officers are required to complete yearly the IMIM online recertification course, which as of April

Rodney Levi (continued)

2021 includes a module on CID. Scenario-based training is required to be completed every three years by all officers, and these scenarios include many opportunities for the practical application of CID techniques. All officers that are trained in the use of a Conducted Energy Weapon (CEW) are required to complete scenario-based training, which includes CID technique evaluation, every two years. In the intervening year where officers are not completing scenario-based training, these officers must complete a CEW online recertification. All of these courses and components have been developed to build on officer safety tactics, a critical component of which are CID techniques, and to work in conjunction with one another.

The Cadet Training Program combines the national online Crisis Intervention and De-escalation course with scenario-based training. Cadets are required to participate in a set of scenarios in which they apply principles from the online course to policing situations in which actors have been specially trained to demonstrate behaviours of a client in crisis. Their ability to intervene and de-escalate such situations is assessed by facilitators, and they are provided with feedback accordingly.

De-escalation is presently one of the key concepts in the Cadet Training Program. Cadets begin by learning principles of mediation, negotiation and conflict resolution in Module 1 of Applied Police Sciences. In Module 4 of Applied Police Sciences, we build upon those concepts by having the cadets learn about techniques for anger management and de-escalation, which they then apply for the first time in a full day of de-escalation scenarios with clients who are played by paid actors. From that point onwards, cadets are expected to apply their de-escalation knowledge and skills in all scenario-based training across the Cadet Training Program (Applied Police Sciences, Police Defensive Tactics, Firearms, etc.), and are formally and informally assessed on their ability to do so at numerous points.

Recommendation # 20.5

Police training in all topics including crisis intervention / de-escalation should not occur in isolation, and albeit the focus of the lesson plan needs to be centred on what the topic is, any related training to the topic should be reviewed and intertwined with the main topic. An example: knives and guns are common weapons involved when someone is in crisis and both lesson plans should re-enforce and relate to the other lesson plans key points.

Recent videos showing good and bad examples of what is expected including balancing the safety of all and crisis intervention and de-scalation in each other's lesson plans are important for the officers have proper perspectives.

The RCMP responded that significant effort is made to integrate training. The recent update to the IMIM (2021) included a CID module. In addition, scenarios involving crisis intervention and de-escalation training are also in place as a part of regular, in-person, operational skills maintenance training. This provides the officers with an opportunity to

Rodney Levi (continued)

practice applying CID strategies during a series of scenario based training. These scenarios were informed by actual public and police encounters.

As noted in response number four above, online and scenario-based training programs are built to work in conjunction with one another. When an officer participates in scenario-based training, they are put through several scenarios, both as the lead officer and as back-up. When in these scenarios, there is a pre-determined outcome, but the officer participating is unaware. They are required to observe the scenario, actively participate, and determine an appropriate course of action. This will range from de-escalation techniques to a physical intervention, including the potential for lethal force. The overall goal of an officer participating in scenario-based training is the same as when they are interacting with the public – to ensure the public and the officer's safety, and to utilize intervention options that are necessary and reasonable, given the totality of the situation.

The Cadet Training Program has been designed and developed using an integrated, problem-based learning methodology.. In this type of educational approach, cadets acquire the basic knowledge and skills they need for policing in the context within which they will be using them - in other words, by solving representative problems that they would typically face as police officers in the field. The Cadet Training Program is designed so that cadets begin with less complex scenarios to obtain foundational and transferable knowledge and skills that they later apply in increasingly more complex policing
situations. At the same time, they are required to conduct ongoing risk assessments that emphasize public and police safety. The problem-based, scenario approach provides cadets with opportunities to learn the intricacies of policing situations, discuss alternative responses, develop techniques for handling varied situations and engage in cooperative problem solving. Rather than be instructed on a particular content area in isolation, cadets learn to apply all content areas related to a particular type of incident or situation. For these reasons, the knowledge and skills are presented in an integrated and complementary manner.

Recommendation # 20.6

A trained crisis counsellor available in some manner for police officers and callers/subjects to provide mental health support over the phone would be an additional resource that may save lives. This suggestion would be far more powerful if the person in crises themselves called and is immediately put through to the crisis counsellor from the communication centre. The mobile crisis unit could also be used however for safety reasons the communication centre would be listening in on call and at times may need to interject. The more real time information police officers are receiving the better their risk assessment will be upon arriving.

Rodney Levi (continued)

The RCMP responded that it encourages a collaborative approach, such as mobile mental health unit response, for individuals experiencing symptoms of distress or in mental health crisis. Some jurisdictions have the resources to support mobile response units with mental health professionals. The establishment of such joint mental health responses is contingent on resources and support from provincial and municipal health services. Mobile mental health resources are not available in all jurisdictions, leaving RCMP officers to deal with these calls unsupported in the vast majority of cases.

In areas where a joint mental health response is available, and when situational factors permit, national RCMP policy guidance states that officers should consult with mental health personnel first.

The RCMP will continue to build upon recent efforts to provide a deeper understanding of the communities we serve and seek opportunities to establish joint mental health response units, which engage mental health professionals, to support individuals experiencing a mental health crisis or who are in distress.

F Division RCMP is piloting a collaborative project with the Saskatchewan Mental Health and Addiction Services, to assist members with assessment and intervention of strategies in real time. A Mental Health Nurse is co-located within the Operational Communications Centre (OCC). The nurse provides crisis intervention, assessment, support, information, recommendations and/or referrals. This project is funded by the provincial government.

The RCMP’s Contract and Indigenous Policing agrees with the goal of this objective and supports the development of such programs.

The limits of what the RCMP can do, in in relation to initiatives involving provincial/territorial health care services, are determined by agreements between Canada and the provinces/territories under which the RCMP provides provincial/territorial policing services. The provincial and territorial legislatures generally determine what health care and social services are provided in their jurisdictions.

At this time, no national policy exists to limit the implementation of the proposed initiative. The RCMP is always looking to utilize available resources to ensure public safety

Rodney Levi (continued)

Recommendation # 20.7

Call takers should also assist in priming the scene for the officers responding to a crisis. Priming the scene may include getting all third parties to a safer location. It may be to ensure doors are left open and exit is always to the police officers or public's advantage. Understanding risk assessments, they could stay on the phone with the caller giving the officer attending real time updates regarding what is occurring.

There is a comprehensive training curriculum to support OCC Operators that includes a foundational course, a Field Coaching Program to support transition on the job and ongoing refresher training.

OCC operational staff are trained in National Standards that include, "Introduction to a Critical Incident". The role of the OCC operator is to take control and maintain situational awareness at all times. The operator gathers information on the scene of the incident, nature of the incident, scope of the incident, identify scene hazards that could be a threat to responders and the public. The OCC operator keeps continuity of a critical incident, stays on the line with any caller that has live, current, vital information when possible giving the officer attending real time updates regarding what is occurring.

Donald Hawkes

A mandatory inquest into the death of Mr. Donald Hawkes was held November 3-4, 2021 in Saint John. On October 4, 2017 Mr. Hawkes was working at Springhill Infrastructure in a quarry at one of the company's asphalt plants in Fredericton. Mr. Hawkes was working in a trailer near where trucks were loaded with asphalt. A few moments later he was found injured and lying on the ground near the steps to the trailer. He was transported to the Dr. Everett Chalmers Regional Hospital by ambulance and later to the Saint John Regional Hospital. It was later determined that Mr. Hawkes had been run over by a transport truck. He died several days later on October 11, 2017 as a result of his injuries.

The five-person jury heard evidence from 15 witnesses and made the following recommendations:

1. Install a bubble mirror at the batch plant site to aid truck drivers and pedestrians to help eliminate blind spots,
2. Implement a pre-start up safety inspection audit or assessment by a trained, competent person for industry and public service sites,
3. Mandate a program to assess fit for duty. This would provide an opportunity for members of the community (family, co-workers, employers, friends) to refer an individual to be screened for fit for duty by a medical professional in a timely manner. The referral should be substantiated by changes which demonstrate need for assessment. The medical professional will then determine if the individual is fit for duty or if their privileges (i.e. license, work) should be suspended or revoked. This program should be promoted and be easily accessible at home, the workplace, on-line or via hot line etc. Fit for duty includes (but is not limited to) cognitive ability (operation of machinery or equipment), mobility, addictions, and mental state.
4. That employers provide fit for duty training for front line supervisors.

The Presiding Coroner made the following recommendation:

5. That a process be put in place to require operators of commercial vehicles to complete a 360-degree inspection around their vehicle prior to moving to ensure a clear path. This should be required any time a vehicle has been parked unless it is unsafe to do so.

The recommendations were forwarded to WorkSafe NB, Springhill Infrastructure and the Department of Justice and Public Safety.

Donald Hawkes (continued)

Recommendation # 1

Install a bubble mirror at the batch plant site to aid truck drivers and pedestrians to help eliminate blind spots.

Springhill Construction Limited responded that bubble mirrors have been purchased and were installed in the spring of 2022 prior to the beginning of the paving season.

WorkSafeNB, noting that recommendation is directed specifically to Springhill Infrastructure, indicated that this workplace will be inspected to ensure the recommendation is implemented. WorkSafeNB will provide instruction to our Prevention staff so that similar situations receive similar guidance.

Recommendation # 2

Implement a pre-start up safety inspection audit or assessment by a trained, competent person for industry and public service sites.

Springhill Construction Limited responded that this was previously implemented and now forms part of their Health & Safety Program (Job-Startup Hazard Assessments).

WorkSafeNB responded that it was in the process of developing a hazard alert that will highlight the importance of inspecting workplaces prior to restarting seasonal operations.

Recommendation # 3

Mandate a program to assess fit for duty. This would provide an opportunity for members of the community (family, co-workers, employers, friends) to refer an individual to be screened for fit for duty by a medical professional in a timely manner. The referral should be substantiated by changes which demonstrate need for assessment. The medical professional will then determine if the individual is fit for duty or if their privileges (i.e. license, work) should be suspended or revoked. This program should be promoted and be easily accessible at home, the workplace, on-line or via hot line etc. Fit for duty includes (but is not limited to) cognitive ability (operation of machinery or equipment), mobility, addictions, and mental state.

Springhill Construction Limited responded that employers mandating a Fit for Duty program would require a substantive amount of work on the part of the Province of NB to ensure that legislation, privcy laws and employee rights are all aligned to allow this type of program.

Donald Hawkes (continued)

WorkSafeNB responded that it believes that the Canadian Standards Association Group (CSA Group) is the most effective route to address this recommendation. The recommendation was shared with the CSA Group on November 23, 2021 and CSA Group responded that they have numerous standards that would benefit from this recommendation and it will be shared with their appropriate technical committees for review. Addressing the recommendation through CSA Group has the added benefit of addressing the recommendation at a national level.

Recommendation # 4

That employers provide fit for duty training for front line supervisors.

Springhill Construction responded that their Safety Director has included informal training in their Return to Work Orientation for 2022. They are not aware of any currently available Fit for Duty Training.

WorkSafeNB reports that this recommendation was shared with the CSA Group on November 23, 2021 and will be incorporated into the technical reviews of appropriate standards.

Recommendation # 5

That a process be put in place to require operators of commercial vehicles to complete a 360-degree inspection around their vehicle prior to moving to ensure a clear path. This should be required any time a vehicle has been parked unless it is unsafe to do so.

Springhill Construction Limited responded that they do not agree with this recommendation as it would create the opportunity for more conflicts between people and machines. When a truck comes into a quarry, they note, we instruct the drivers to remain in the cab at all times to avoid accidents between drivers and machines. They believe a better recommendation would be to push manufacturers for more vehicle cameras to monitor blind spots and/or the installation of additional bubble mirrors on trucks to monitor blind spots.

The Department of Justice and Public Safety responded that the intention of the pre-trip inspection is for the safety of the vehicle and the load, this unfortunately does not include surroundings. The back-up beep should be used surroundings when a commercial vehicle is reversing. Existing legislation is in place for driver and vehicle safety primarily. Department officials have been asked to review pre-trip inspections under regulation 94-77 of the *Motor Vehicle Act* to determine if there are opportunities to strengthen regulation in order to prevent future deaths of similar circumstances from occurring.

Donald Hawkes (continued)

WorkSafeNB responded that, following the investigation of Mr. Hawkes incident, WorkSafeNB created a hazard alert to inform the industry on the hazards that led to the unfortunate death of Mr. Hawkes. WorkSafeNB is modifying the hazard alert to include the completion of a 360-degree inspection around commercial vehicles.

Chantel Moore

An inquest into the death of Chantel Moore was held May 16-19 2022 in Fredericton.

Moore, who lived in Edmundston, died on June 4, 2020, following an Edmundston Police Force intervention that took place at her home. In the early morning of June 4 2020 a former boyfriend of Ms. Moore who lived out of province received text messages from Ms. Moore that made him believe her safety could be at risk. He called the Edmundston Police to look into this. He did not know her address. Edmundston Police had previous encounters with Ms. Moore at the residence of her mother so they went there and were given Chantel's address.

An Officer proceeded to the apartment which was on the 3rd level of a multi unit apartment building. The officer was able to see Ms. Moore sleeping on the couch and knocked on the door, she eventually woke up and moved towards the door. While moving towards the door the officer noted that she had picked up a metallic object which was later found to be a knife. Ms. Moore exited the apartment and moved towards the officer, he backed up until there was no further to go. The officer had his gun pointed at Ms. Moore while directing her to drop the knife. She continued moving toward him refusing to drop the knife. The officer shot Ms. Moore and she fell to the ground. Ms. Moore was pronounced dead soon after by Paramedics at the scene.

The five-member jury heard evidence from 16 witnesses during the inquest and made the following recommendations:

1. That New Brunswick have one independent agency to oversee serious incidents involving the use of force by police.

2. That a clear, concise protocol is in place for activating the process of an independent review of serious incidents.

3. That officers be assessed on their comprehension of current procedures and policies.

4. That police undertake relationship-building actions with First Nations communities, including cultural sensitivity training and having a First Nations community liaison.

5. That police officers should be trained and maintain certification in standard CPR and first aid.

6. That police officers should be trained and provided the necessary equipment to provide combat casualty care.

7. That officers be provided with crisis intervention/de-escalation training.

8. That officers be provided scenario training that emphasizes situational awareness and repositioning and disengagement options.

Chantel Moore (continued)

9. That police policy on medical emergencies be reviewed.

10. That police policy on providing first aid after force has been applied be reviewed so that officers begin emergency medical aid as soon as possible and continue that aid until medical responders arrive and take over.

11. That police be provided training about the proper procedures following a serious incident involving serious injury or death and that front line supervisors be provided training on the critical aspects of immediate scene command and control to ensure the integrity of evidence and witnesses.

12. That police have a policy on the maintenance of equipment and the reporting of broken or non-functional equipment.

13. That police have a policy mandating the wearing of use-of-force equipment.

14. That officers have more access to less-lethal tools.

15. That police agencies have a process in place to learn from and make continuous improvement after every use-of-force event.

16. That protocols, where possible, require a minimum of two officers respond to mental health and welfare check requests.

17. That officer training reinforces the importance of making verbal police announcements.

The recommendations were forwarded to Edmundston Police Force and the Department of Justice and Public Safety. Responses from those agencies are provided below:

Recommendation # 1

That New Brunswick have one independent agency to oversee serious incidents involving the use of force by police.

Recommendation # 2

That a clear, concise protocol is in place for activating the process of an independent review of serious incidents.

The Department of Justice and Public Safety responded to recommendations #1 and #2 that the Government of New Brunswick has been working diligently on legislation to amend the New Brunswick *Police Act* to include an independent civilian police oversight

body to investigate serious incidents involving police. Legislation to amend the *Act* has received Royal Assent and supporting regulations have been drafted; both will come into force October 1, 2022. The Department of Justice and Public Safety will work to finalize an agreement with the Province of Nova Scotia to allow Nova Scotia's Serious Incident Response Team (SIRT) to act as the police oversight body for both provinces.

Recommendation # 3

That officers be assessed on their comprehension of current procedures and policies.

The Edmundston Police Force responded that each time an existing policy is modified or a new policy comes into effect within the Edmundston Police Force, its members must become familiar with the new policy and sign a document stating they have read and understood the new policy in effect.
To address any identified failures by a member to comply with certain policies, a new internal audit process was established to ensure the member in question fully comprehends the policy currently in effect.

Recommendation # 4

That police undertake relationship-building actions with First Nations communities, including cultural sensitivity training and having a First Nations community liaison.

The Edmundston Police Force responded that, although it does not serve the Madawaska Maliseet First Nation (MMFN), the members of the Edmundston Police Force have an excellent relationship with the members of the MMFN community, and the Police Chief of the Edmundston Police Force is working to carry out a project that would bring the two communities even closer together.

They further stated that the City of Edmundston also has a very good relationship with the MMFN and currently shares many services with the community. In addition, City representatives and the Police Chief have built connections with the MMFN to reinforce the relationship between the First Nation and the Edmundston Police Force.

Recommendation # 5

That police officers should be trained and maintain certification in standard CPR and first aid.

Edmundston Police Force responded that, pursuant to the provincial First Aid Regulation - Occupational Health and Safety Act (2004-130) and the City of Edmundston's administrative policy (7R2013) on workplace health and safety, all members of the Edmundston Police Force receive Workplace Standard First Aid training, which includes cardiopulmonary resuscitation (CPR) and is valid for three years. All officers on the police force keep their certification up to date and are required to act in accordance with the training they have received.

Recommendation # 6

That police officers should be trained and provided the necessary equipment to provide combat casualty care.

Edmundston Police Force responded that its members Force are not designated as medical first responders in their service area. Their area of jurisdiction is an urban centre, within which medical first responders have a very rapid response time. The Edmundston Police Force will nonetheless evaluate its needs in this regard and, if required, take steps to make improvements, such as providing training that is better adapted to police work.

Recommendation # 7

That officers be provided with crisis intervention/de-escalation training.

Recommendation # 8

That officers be provided scenario training that emphasizes situational awareness and repositioning and disengagement options.

Edmundston Police Force responded to recommendations #7 and #8 that, each year, it provides use-of-force training that is mandatory for all police officers. This training focusses on the use-of-force continuum and teaches officers to use communication to peacefully resolve situations. During the training, police officers are placed in disengagement scenarios with people who are in crisis or uncooperative. In these scenarios, they must practise using tactical repositioning, transition between use-of-force levels and use de-escalation techniques. In addition, during the annual mandatory firearms qualification, police officers are placed in practice scenarios in which they must

communicate with targets using verbal commands to try to peacefully resolve the situation.

The Force further stated that it is continuously seeking to improve the quality of its service and continues to train its members in the peaceful resolution of crisis situations. A training course called Verbal Judo is available to help police officers de-escalate difficult situations. The Edmundston Police Force is considering including this course in its use-of-force training.

Recommendation # 9

That police policy on medical emergencies be reviewed.

Recommendation # 10

That police policy on providing first aid after force has been applied be reviewed so that officers begin emergency medical aid as soon as possible and continue that aid until medical responders arrive and take over.

Edmunston Police Force responded to recommendations #9 and #10 that these recommendations relate to the provincial Use of Force policy, which is currently under review. They advised that these recommendations will be shared with members of the provincial committee for policy review to be taken into account during the review process.

Recommendation # 11

That police be provided training about the proper procedures following a serious incident involving serious injury or death and that front line supervisors be provided training on the critical aspects of immediate scene command and control to ensure the integrity of evidence and witnesses.

Edmundston Police Force responded that this recommendation also relates to the provincial Use of Force policy, which is currently under review, and it will also be shared with members of the provincial committee for policy review to be taken into account during the review process.

In addition, the Force notes, the Policing Standards and Contract Management branch has taken steps to establish an independent investigation team to review serious incidents that involve a member of the police force. Once established, this team’s mandate will be to investigate incidents of serious injury or death involving police intervention.

However, since the incident, a procedure was put in place within the Edmundston Police Force that clearly outlines the steps to follow when a police officer is involved in or witness to a major event. Members of the Edmundston Police Force were informed of this procedure, which is similar to that used by Quebec's Bureau des enquêtes indépendantes, and it can be accessed at all times, as needed.

Recommendation # 12

That police have a policy on the maintenance of equipment and the reporting of broken or non-functional equipment.

Edmundston Police Force reports that, since the incident, a procedure has been put in place requiring members to complete a report for each piece of damaged or lost equipment. These reports are submitted to the Deputy Chief of the police force, who ensures the equipment in question is repaired or replaced. A policy on this procedure is being drafted to ensure the procedure is followed.

The Department of Justice and Public Safety responded that the New Brunswick Policing Standards manual under "Support Services 9 – Facilities and Equipment," subsection 9.2 speaks to the following:

Police forces shall have a policy that governs, but is not limited to:
a) Sign-out procedures for service-controlled equipment such as a vehicle, weapons, radios and clothing;
b) Regular maintenance of service-controlled equipment to ensure operational readiness; and
c) Scheduled evaluations of all service-related equipment.

A provincial Use of Force policy exists which provides guidance to the officer, supervisor and CEW coordinator regarding the monitoring of CEW maintenance, testing, operational use, training, and the qualification status for all police officers authorized to use the CEW.

As of May 2021, provincial Body Worn Camera and In Car Camera System policies were developed which speak to the reporting and maintenance of this equipment. Each policy describes the responsibilities of the officer and supervisor to ensure the equipment is in working condition and identifies a process to report any equipment failure.

The Policing Standards and Contract Management branch is also responsible to conduct quality assurance reviews on all municipal and regional police forces. A new quality assurance review guide related to equipment was created in 2022 and speaks to the maintenance and operational status of specific equipment, including CEW.

Chantel Moore (continued)

Recommendation # 13

That police have a policy mandating the wearing of use-of-force equipment.

Edmundston Police Force responded that the current provincial Use of Force policy is under review at this time. Once the review has been completed, the policy should contain information on the members' obligation to wear the use-of-force equipment they have been trained to use. If the provincial policy does not specifically address this, an internal policy will be drafted on the matter.

The Department of Justice and Public Safety responded that, prior to June 4, 2020, no policy existed which mandated that police officers wear all their use of force equipment. However, since then, the Use of Force policy was recently revised by the Policing Standards Policy Committee, which is comprised of representatives from each municipal and regional police force and the RCMP. The draft policy, which has yet to be issued, states that all on duty officers shall carry all less lethal options for which they have received training. This draft Use of Force policy is now under the final steps for approval. Once approved, the provincial policy will be provided to all municipal and regional police forces.

Recommendation # 14

That officers have more access to less-lethal tools.

The Edmundston Police Force responded that it has purchased a new conducted-energy weapon since the incident in question and now possesses four functional conducted-energy weapons. In addition, all members have received training on and are equipped with oleoresin capsicum spay and telescopic batons as less-lethal tools. Regarding the acquisition of other less-lethal weapons, such as 12-gauge bean bag rounds and low-velocity 40-mm kinetic impact projectiles, the police force is evaluating the necessity of acquiring them and training members to use them. However, it should still be noted that in May, the Canadian Minister of Public Safety, Marco Mendicino, asked the commissioner of the RCMP to ban the use of certain less-lethal tools.

Recommendation # 15

That police agencies have a process in place to learn from and make continuous improvement after every use-of-force event.

The Edmundston Police Force responded that it is reviewing how it evaluates reports on the use of force, which are mandatory in certain cases when it is used as an intervention. This process will be modified to include the review of these reports by the

police force's use-of-force training facilitators, so that they can assess the members' interventions and discuss with them their strengths and weaknesses in that regard as part of the process of continuous improvement.

Recommendation # 16

That protocols, where possible, require a minimum of two officers respond to mental health and welfare check requests.

The Edmundston Police Force responded that it is reviewing its policies on how to respond to calls so it can make any necessary changes to ensure it more effectively and safely responds to different types of calls.

Recommendation # 17

That officer training reinforces the importance of making verbal police announcements.

The Edmundston Police Force responded that its use-of-force training and firearms qualifications emphasize the importance of making verbal police announcements containing the word "police," which is bilingual. In addition, all gear worn by uniformed officers contains the word "police" in easily legible writing to facilitate their identification in situations when it is not possible for them to verbally communicate with people with whom they are interacting.