2011 Annual Report

Office of the Chief Coroner
Nunavut

Government of Nunavut
Department of Justice

Introduction

The Nunavut Coroners Services falls within the Government of Nunavut Department of Justice. The Office of the Chief Coroner is located in the territories capital of Iqaluit. Currently there are 20 appointed "fee for service" coroners across the territory that provides coroner services in their respective communities in which they reside.

The purpose of the Nunavut Coroners Act is to provide for the appointments of a Chief Coroner and basic level coroners. Section 3(1) of the Act provides that the Minister of Justice appoints one or more persons as coroner for a term of three years. Section 4 of the Act provides that the Minister appoints a Chief Coroner for the Nunavut Territory.

The Act requires any persons to notify a coroner or the police of any death in certain circumstances so that a coroner may proceed with the necessary investigation and determine the causes of death as well as the circumstances surrounding it. The Act applies to all deaths that take place in Nunavut or deaths that transpire as a result of events in Nunavut.

In Nunavut, all sudden and unexpected deaths must be reported to a coroner. The Coroners Services is responsible for the investigation of all reported deaths in order to determine the identity of the deceased and the facts concerning when; where; how and by what means the deceased came to their death. Through the supported and the efforts of Nunavut's Royal Canadian Mounted Police; the Fire Marshall's Office of Nunavut; the Workers Safety Compensation Board; the Federal Transportation and Safety Board and various other agencies that work closely with the Coroner's Office.

There are no facilities in Nunavut at which post-mortems can be performed. When an autopsy is ordered, the body is transported for the use of facilities to 3 major southern cities to accommodate for each of Nunavut's three Regions. Following the post-mortem exam the remains are sent to a funeral home for preparation and repatriation.

Toxicology Services are provided by Dynacare Kasper Medical Laboratories based in Edmonton, and the Chief Medical Examiner's Office located in Alberta.

Padma Suramala B.Sc., RN, RM
Chief Coroner
Nunavut Territory

Historical Background of Coroners Service

The Office of Coroner, or Crowner, originated in medieval England shortly after the Norman Conquest in 1066, and has been adopted in many countries whose legal systems have at some time been subject to English or United Kingdom law. The title of the office has varied from "Coronator" during the time of King John to "Crowner" used in Scotland.

One of the early functions of the office was to enquire into sudden and unexpected deaths. It's the duty of the Crowner to establish the facts relating to the death. There was a rigid procedure enforced at every unexpected death, any deviation from the rules being heavily fined.

The rules were so complex that probably most cases showed some slip-up, with consequential financial penalty to someone. It was common practice either to ignore a dead body or even to hide it. Some people would even drag a corpse by night to another village so that they would not be burdened with the problem.

Failure to inform the coroner was a serious offence the town or village was liable for additional fine if no felon could be found responsible for this death. In Devonshire, in the 13th century for instance, a hedge was built around a corpse or buries, to keep the dogs away until coroner arrives. Failure to preserve the body for coroner to view was illegal. The coroner obligated to inspect the corpse continued right up until 1980.

This particular function of the Office of the Coroner was modified over the centuries, which presently exist in common law jurisdictions. The Coroners Act established the territorial jurisdiction of the Coroner.

There are two death investigation systems in Canada: the coroner system and the Medical Examiners system. The Coroner system has four main roles to fulfill: investigative, administrative, judicial and preventive. The Medical Examiner system involves medical and administrative elements. The coroner and the Medical Examiner both collect medical and other evidence in order to determine the medical cause and manner of death. The coroner examines the investigative material, comes to a judicial decision concerning the death and makes recommendations to prevent a similar death in future.

Our Mission

Coroner service is an independent and publicly accountable investigation of death agency. Coroner service is mandated by statute to review all suspicious deaths. Conduct inquest as may be required in the public interest and does not have a vested interest of any kind in the outcome of death investigations.

MANNERS OF DEATH

All Coroner Reports and Jury Verdicts determine the manner of each death. All deaths investigated by the Coroner's Service are classified in one of five distinct categories: Natural, Accidental, Suicide, Homicide or Undetermined.

Classifications are as follows

NATURAL covers all deaths primarily resulting from a disease of the body and not resulting from injuries or abnormal environmental factors.

ACCIDENTIAL covers all accidental deaths including motor vehicle incidents where there is no obvious intent to cause death. This classification includes any death resulting from an action or actions by a person that results in the unintentional death to him/herself or any death to any person that results from the intervention of a non-human agency.

SUICIDE refers to any death from a self-inflicted injury where there is apparent intent to cause death.

HOMICIDE includes any death resulting from injuries caused directly or indirectly by the actions of another person (with the exception of unintentional motor vehicle accidents). Homicide is a neutral term that does not imply fault or blame.

UNDETERMINED is any death which cannot be classified in any of the categories. The actual cause of death may or may not be known in these cases. An example of an undetermined death would be a drug overdose where it is unclear if the victim intended to die.

Coroners are instructed to make every effort to classify a death in one of the other existing categories before considering a classification of undetermined.

CORONER'S INVESTIGATION

The coroner's role is to investigate reportable deaths to determine who died; when they died; where they died; the cause of death; and the manner of death.

In the courses of their investigation the coroner will determine the circumstances and events leading up to the death. They have the authority to enter any building, seize any evidence also may take possession of the body in pursuit of their investigation. At times a coroner may order that a post mortem examination of the remains be performed.

The coroner's investigation is considered complete when the final Coroner Report has been prepared. This report is a public document and may be obtained from the Office of the Chief Coroner upon written request.

The Report of Coroner is a document outlining the result of a coroner's investigation. It provides classification of the facts and circumstances surrounding the death. The report establishes the identity of the deceased classify the death and includes any recommendations that may prevent a similar death. A Report of the Coroner and a Report of the Chief Coroner are completed all death investigations with the exception of cases where an inquest has been called. At the inquest the jury's verdict takes the place of a Coroner Report.

Recommendations are often made and are forwarded to the appropriate department person, or agency in hopes of providing valuable information that may prevent a similar death. A Coroner's Report containing recommendations are distributed as required and responses are monitored.

POST MORTEM EXAMINATION (AUTOPSY)

A post mortem examination is usually conducted when the cause or manner of death cannot be determined or when it appears appropriate by the Investigating Coroner. The autopsy may also help with determining the identity of the deceased. A total of 40 autopsies were performed in 2011.

Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
3	4	3	1	0	5	1	11	4	4	3	1

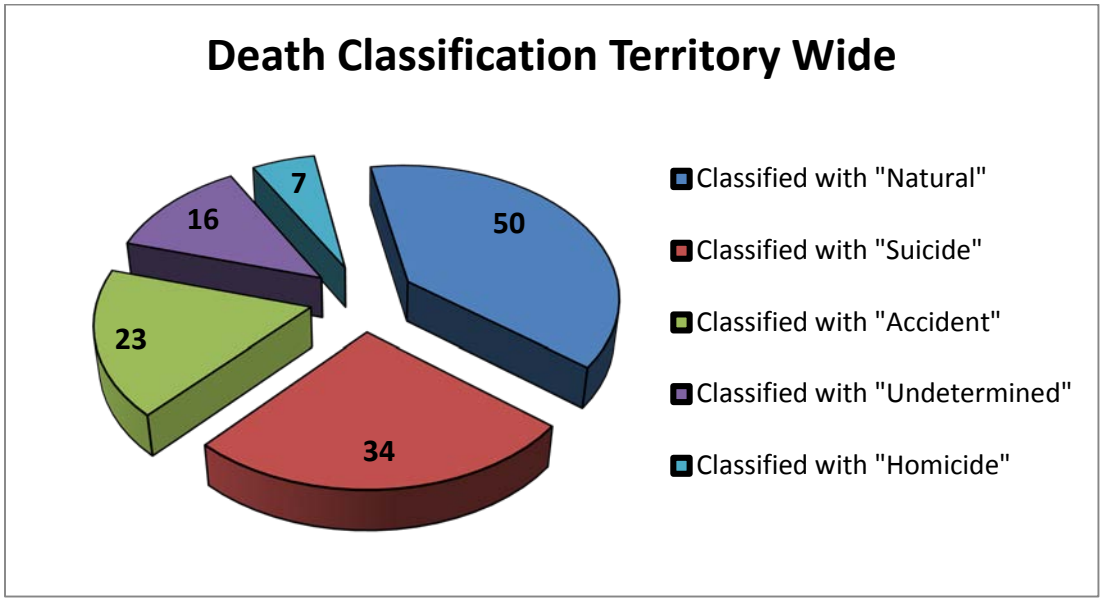
Due to the remote location of Nunavut's communities this procedure is usually performed at a southern facility. The Government of Nunavut is working together with Medical Examiners from the south through a memorandum of understanding.

2011 CASE STATISTICS

***130** Total Cases – 2011*

In 2011 the Office of the Chief Coroner registered a total of 130 Case files.

2011 Notification Breakdown	
Classified with "Natural"	50
Classified with "Suicide"	34
Classified with "Accident"	23
Classified with "Undetermined"	16
Classified with "Homicide"	7



Above is a breakdown of the classification and the total number of deaths for each category.

In the 3 charts below are break downs showing by community that the “Qikiqtaaluk Region” has the highest number of deaths, mainly from the capital “Iqaluit”.

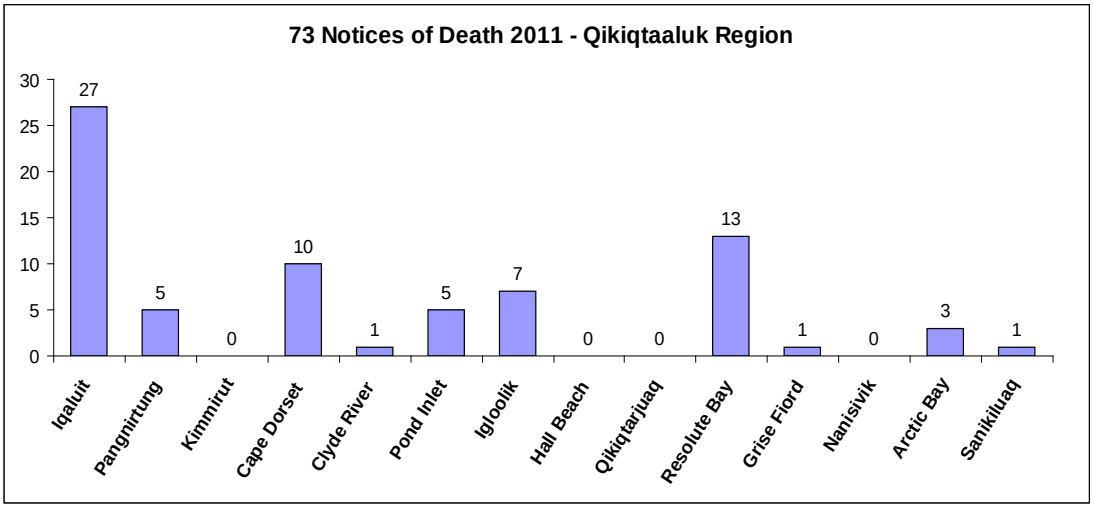


Chart 1: Qikiqtaaluk Region

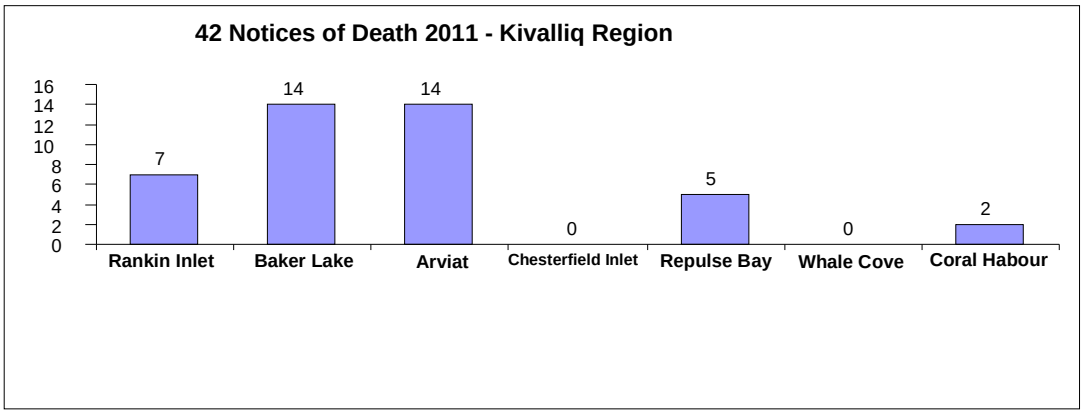


Chart 2: Kivalliq Region

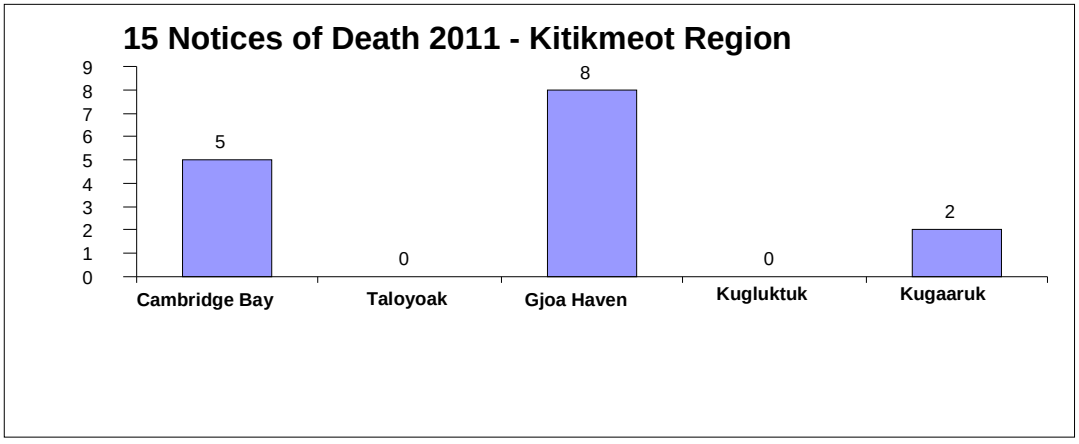
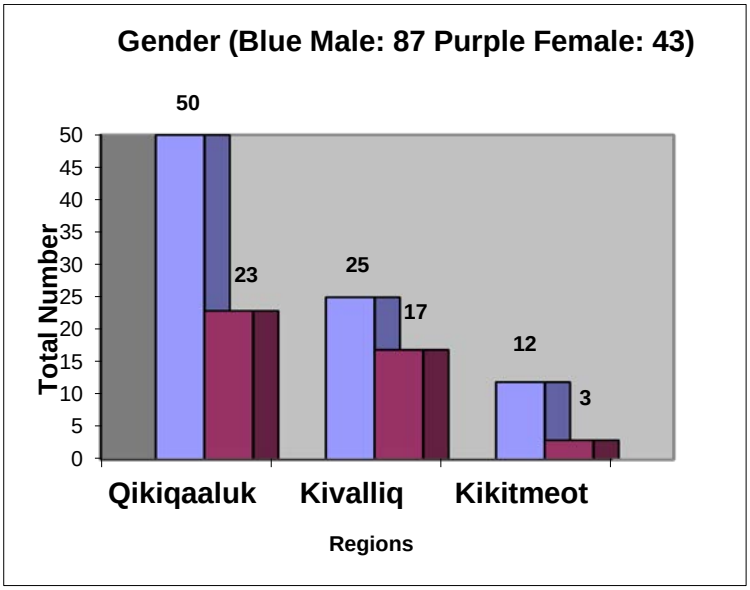


Chart 3: Kitikmeot Region

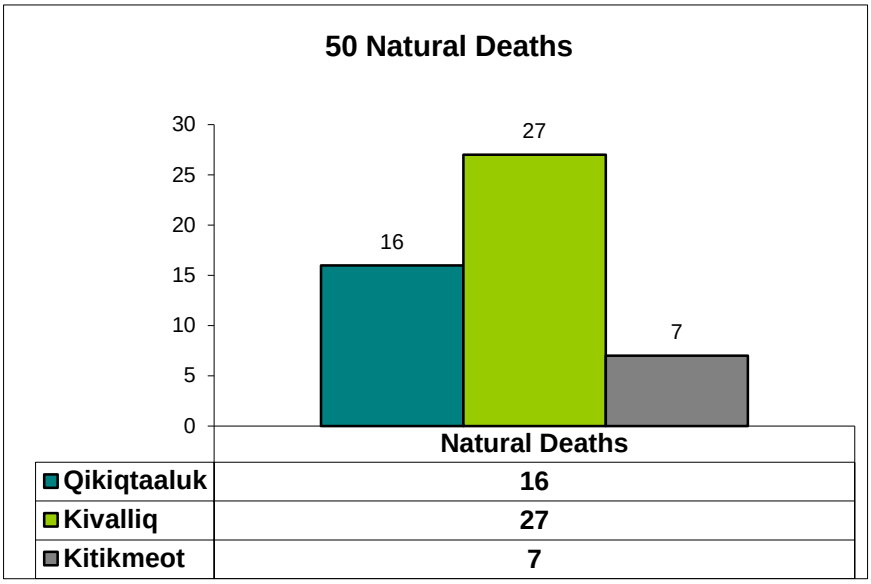


Communities	Male	Female
Iqaluit	15	12
Pangnirtung	4	1
Kimmirut		
Cape Dorset	7	3
Clyde River	1	
Pond Inlet	4	1
Igloolik	5	2
Hall Beach		
Qikiqtarjuaq		
Resolute Bay	10	3
Grise Fiord	1	
Nanisivik		
Arctic Bay	3	
Sanikiluaq		1
Rankin Inlet	4	3
Baker Lake	7	7
Arviat	9	5
Chesterfield Inlet		
Repulse Bay	4	1
Whale Cove		
Coral Habour	1	1
Cambridge Bay	4	1
Taloyoak		
Gjoa Haven	7	1
Kugluktuk		
Kugaaruk	1	1
TOTAL	**87**	**43**

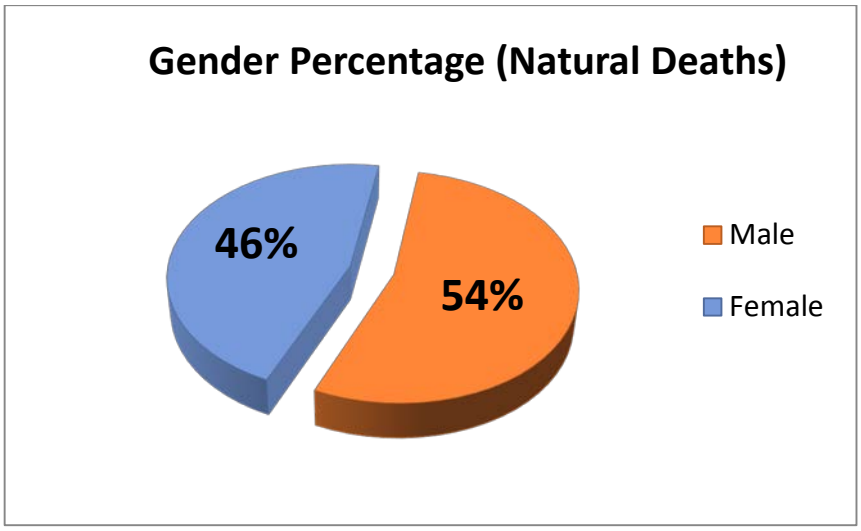
Natural Death

In 2011, there was a total of 50 Natural Deaths reported. Under the Nunavut Coroners Act the Coroner Service is responsible for investigating all sudden, unexpected and unexplained deaths. This does not include palliative care deaths, still births if attended by a Medical Practitioner.

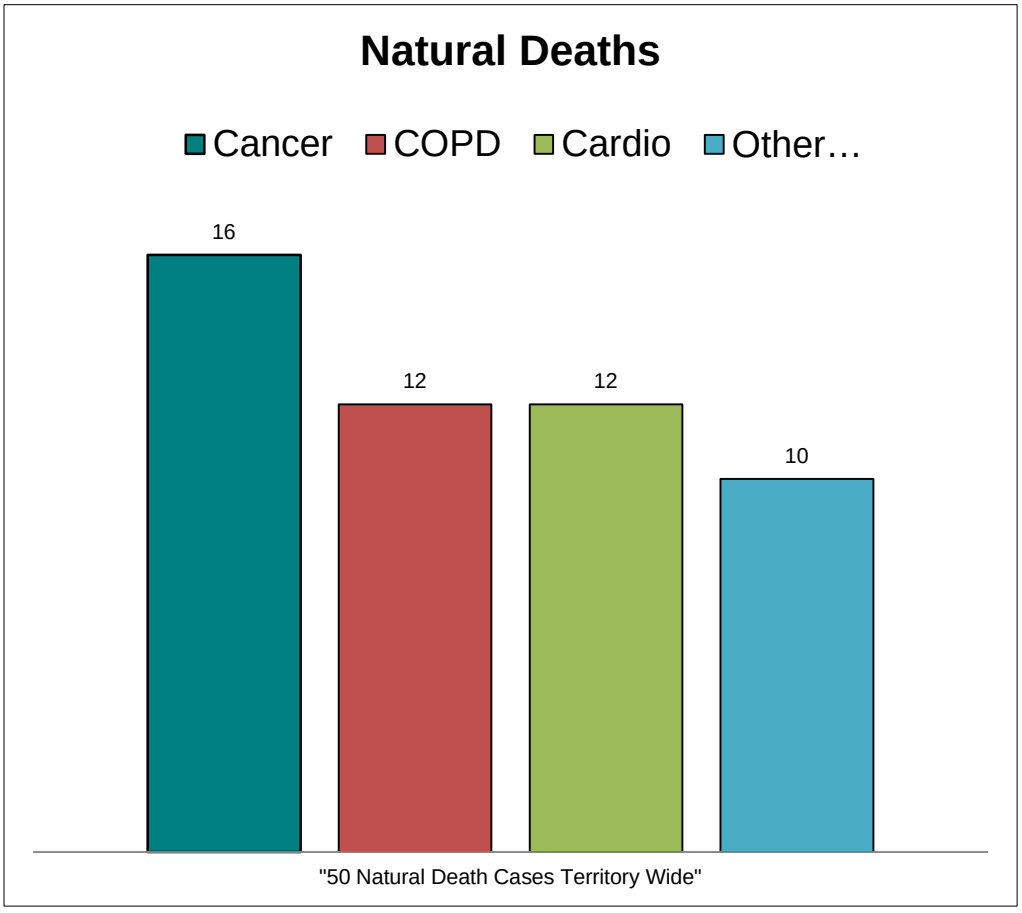
A high number of investigated deaths in Nunavut are classified as "Natural Deaths or Non-Coroner Cases." This term is used when the death is not covered by the Nunavut Coroners Act. The office of the Chief Coroner must still be notified.



This chart shows the total number of "Natural Deaths" in all three different regions

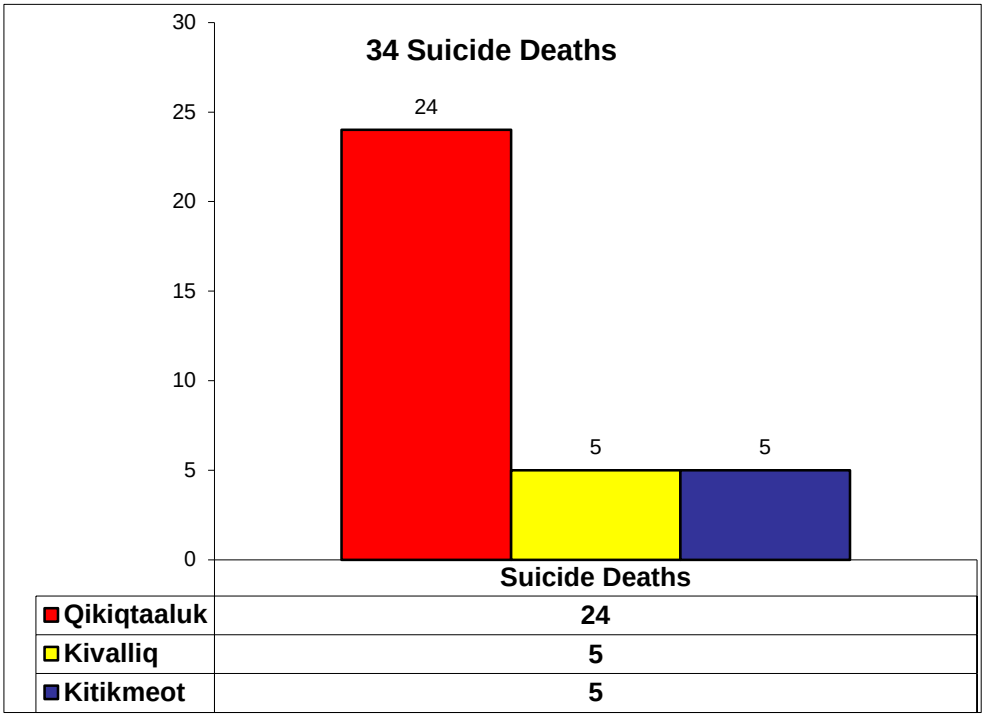


In 2011, a total of 50 deaths were classified as Natural Causes. Mainly due to 4 major causes of Death.



Suicide Deaths

The suicide rate in the Nunavut Territory remains fairly consistent over the past 5 years. This year has been the highest in Nunavut's history as a territory. In 2011, there were a total of 34 suicide deaths in Nunavut, which is the highest number since the birth of this territory in 1999.



This chart shows a comparison of each of Nunavut's three regions and the number of suicides from each region. Qikiqtaaluk region shows the highest number of suicides mainly from Iqaluit.

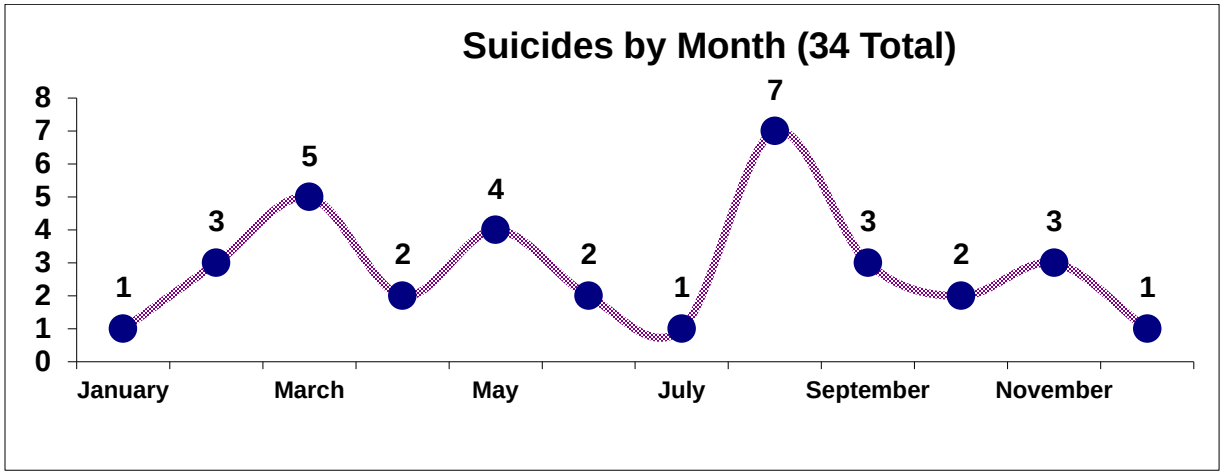
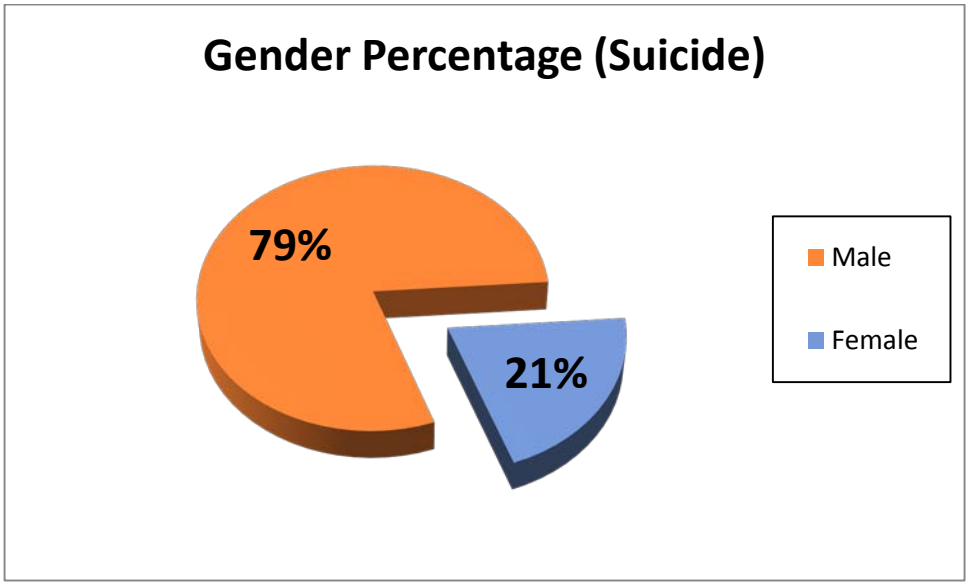
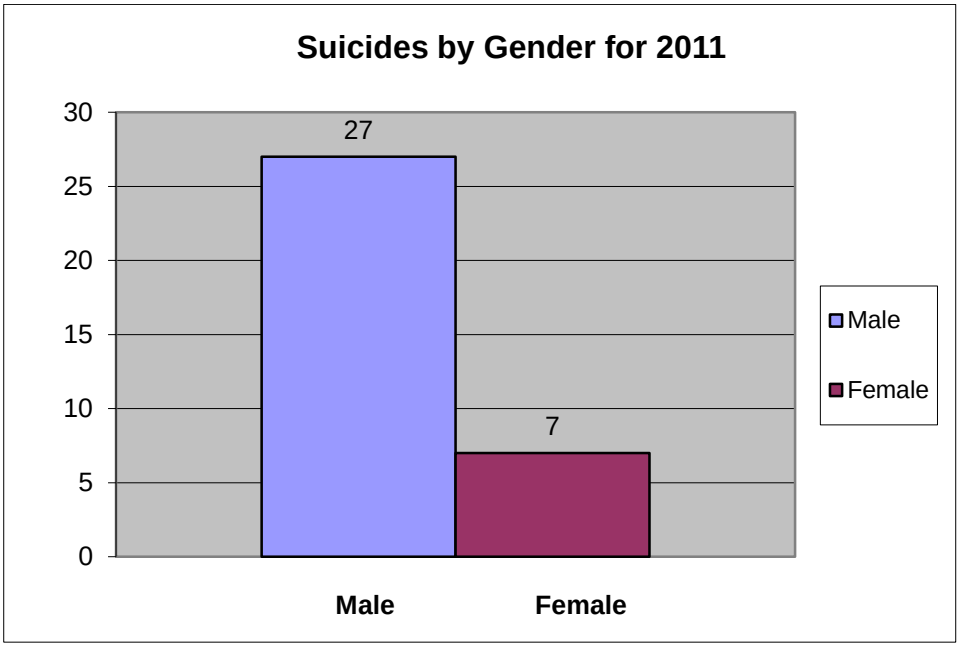


Chart above show a monthly number of suicide deaths throughout the territory, August showing the highest number in Nunavut.



The percentage of male gender committing suicide had been consistent since the birth of the territory averaging around the 80 percentage. Males have been registered higher than the female.

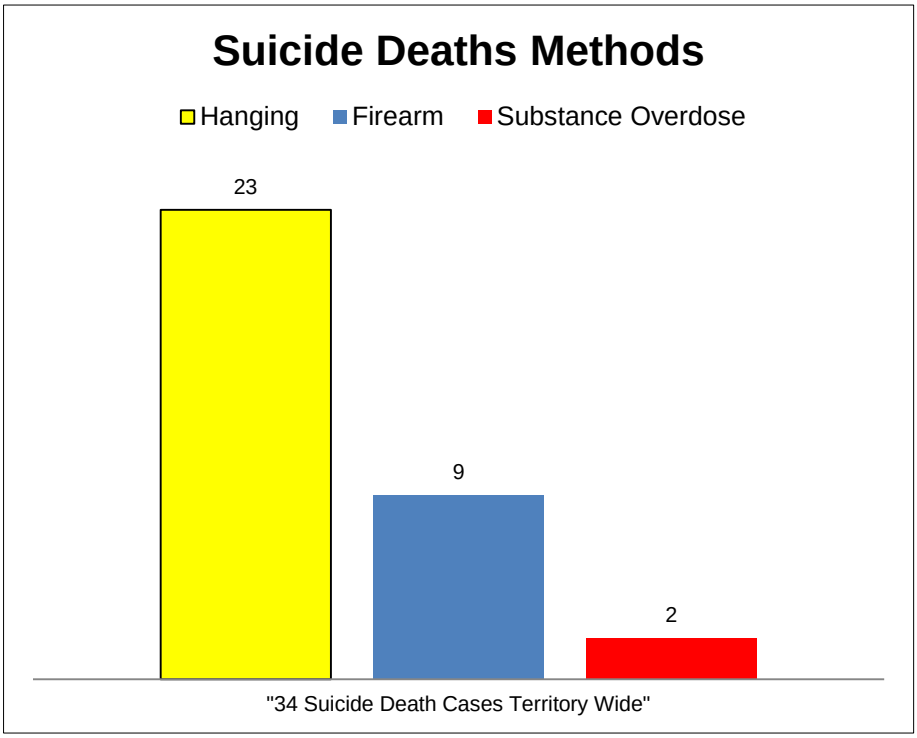


Completed Suicides Gender and Mode of Suicide

(April 1999 – January 2012)

Male:	**296**
Female:	**65**
Firearm:	**79**
Hanging:	**265**
Self-inflicted stab:	**4**
Asphyxia:	**2**
Overdose:	**3**
Drowning:	**1**
Exposure:	**1**
Unknown:	**6**

1. One third of the school age deaths (19 yrs. and under) were documented as being students at the time of their death. The total number of school age deaths is likely to be higher than reported as we do not always receive information on whether the individual was a registered student or not.
2. Clearly, the highest risk groups in Nunavut are males ranging 12-30 years of age.
3. From 1999 suicides have come from every age ranging from 12-62 years.



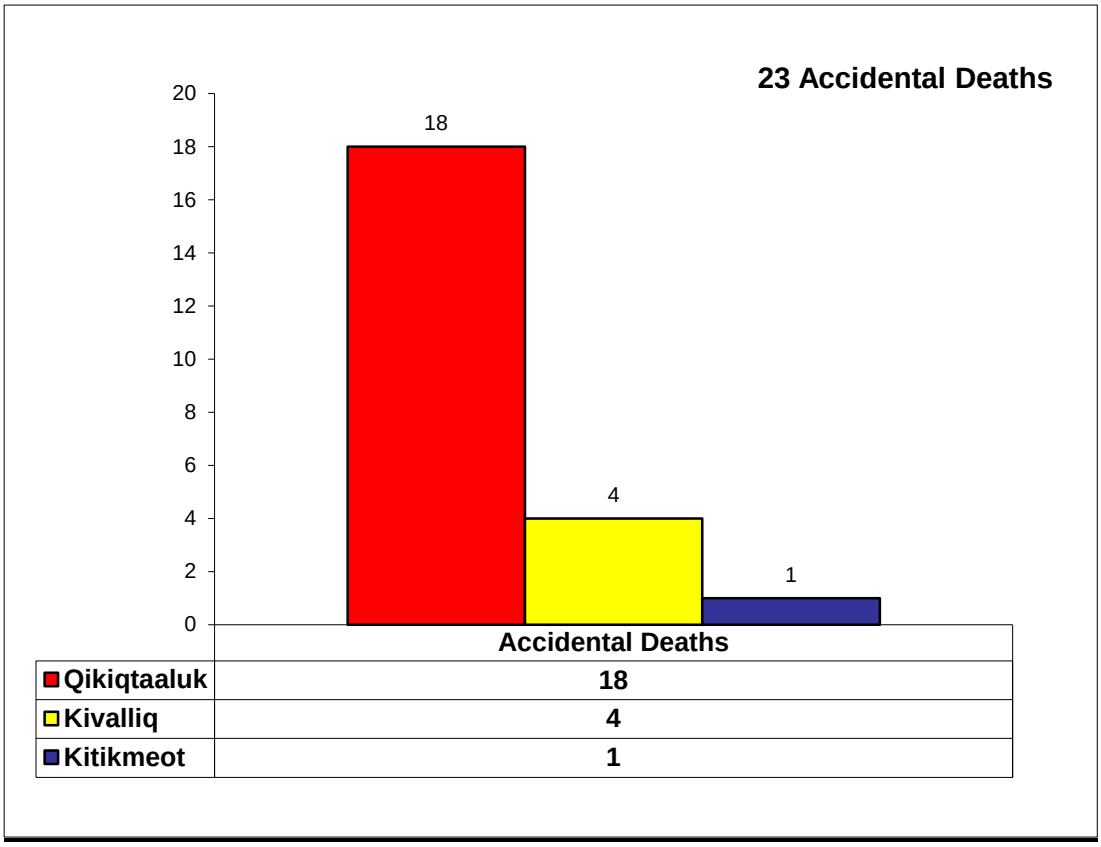
For both males and females the predominant methods of suicide in 2011 was by hanging with 23 deaths and second were of self-inflicted gunshot deaths with 9 choosing this method. Overdose was not a major issue in that only 2 deaths were registered.

Accidental Deaths

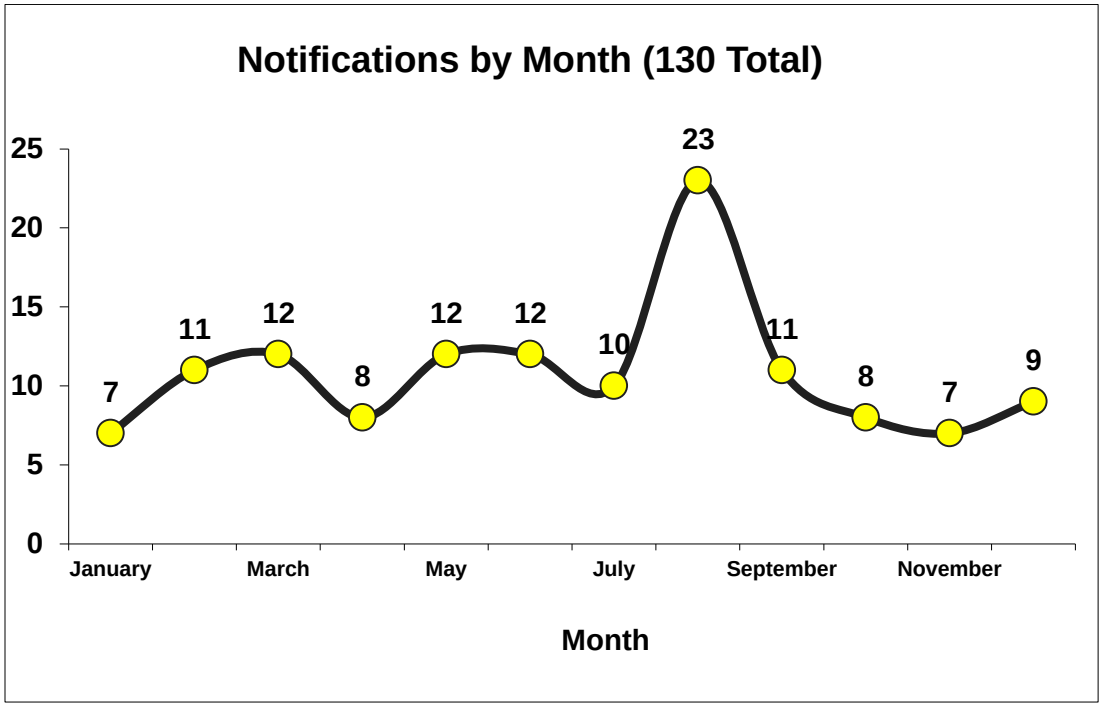
In 2011, there were 23 deaths registered as Accidental deaths in Coroner's Office.

"23 Accidental Death Cases Territory Wide"			
Drowning	**Exposure**	**Motor Vehicle**	**Aircraft**
7	0	4	12

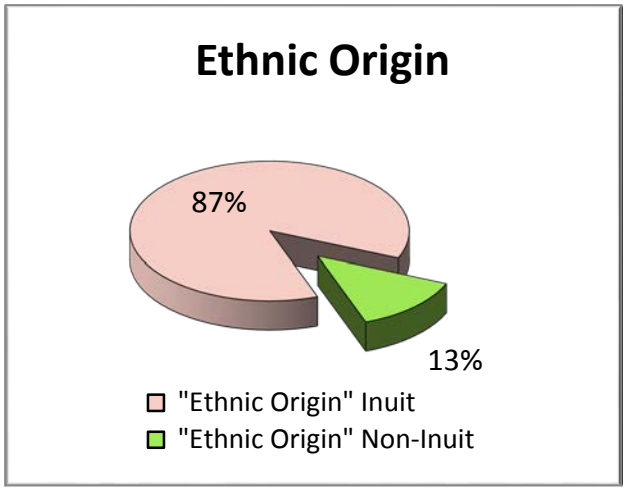
The majority of the accidental deaths in Nunavut in 2011 were due to the First Air Boeing 737-210C crash that happened in the community of Resolute Bay. 12 people lost their lives in the accident. Drowning Victims and Motor Vehicle Accidents are two other methods recorded.



Registered Death by Months



Throughout the year the number of deceased has been consistent ranging from 7-12 deaths with the exception of August registering with 23 deaths (a major plane crash being the exception in this month, in the community of Resolute Bay killing 12 people).



Ethnic Origin	
Inuit	**Non-Inuit**
113	17

The Inuit have a higher death rate over the Non-Inuit due to suicides and natural deaths.

CLASSIFICATION BY COMMUNITIES AND MANNER OF DEATH

Communities	Natural	Suicides	Accident	Undetermined	Homicide	Total
Iqaluit	8	11	1	2	5	**27**
Pangnirtung	1	2	2			**5**
Kimmirut						**0**
Cape Dorset	1	6		3		**10**
Clyde River		1				**1**
Pond Inlet		3		2		**5**
Igloolik	3		1	3		**7**
Hall Beach						**0**
Qikiqtarjuaq						**0**
Resolute Bay	1		12			**13**
Grise Fiord		1				**1**
Nanisivik						**0**
Arctic Bay	1		2			**3**
Sanikiluaq	1					**1**
Rankin Inlet	4	1		1	1	**7**
Baker Lake	11	1	2			**14**
Arviat	9	1	1	3		**14**
Chesterfield Inlet						**0**
Repulse Bay	1	2	1	1		**5**
Whale Cove						**0**
Coral Habour	2					**2**
Cambridge Bay		3	1		1	**5**
Taloyoak						**0**
Gjoa Haven	7			1		**8**
Kugluktuk						**0**
Kugaaruk		2				**2**
TOTAL	**50**	**34**	**23**	**16**	**7**	**130**

APPENDIX "A"

SUMMARY OF SELECTED CORONERS' REPORTS CONTAINING RECOMMENDATIONS

CORONER'S INQUEST

Inquests are composed of six jurors whom are randomly selected from a list compiled under the Nunavut Jury Act. It is the responsibility of the coroner's jury to determine who died; where did they die; when did they die; the cause of death; and the manner of death. The coroner's jury may also make recommendations which if implemented may prevent similar deaths from occurring in the future upon completion of the investigation a coroner may order an inquest if in the opinion of the coroner a public inquest is necessary:

- To identify the deceased or determine the circumstance of death;
- To inform the public of the circumstance of the death where it will serve some public purpose;
- To bring dangerous practice or conditions to the knowledge of the public and facilitate the making of recommendations to avoid preventable deaths;
- To perform the public as to dangerous practices or conditions in order to avoid preventable deaths.

It is mandatory that a public inquest be held into the death of any person while detained or in custody by the police.

If it is determined that an inquest is not necessary the next of kin or other interested persons may request that an inquest be held. The Coroner shall consider the request and issue a decision. This may be applied to the chief coroner who shall consider the merits of the appeal and within 10 days of receipt of the appeal, provide a written decision with reason.

Case File: 09-065

Cause of Death: Head Injury
Classification: Accidental

Circumstances under which death occurred:

52 Year old female had consumed alcohol. She was asked to leave the licensed establishment. Upon leaving the premises she fell down the stairs and struck her head on the ground. An ambulance was called and was transported to the hospital. She was examined by two different doctors. Later she became agitated and was transferred to the police holding cell. Fourteen hours later she was found to be in distress and an ambulance was called to return to the hospital. It was determined at the hospital that in the fall she had suffered a serious brain injury. She was medevac'd to a hospital in Ottawa, Ontario on the following Monday the 10th of August. Examination confirmed that it was a head injury and that no medical procedure would be of any value to her. At that time medical support was withdrawn and she passed away on the 13th of August.

Recommendations of Jury

1. Every member of our society, no matter how they at a given circumstance, deserves to be given proper care with the fullest respect and dignity that a member of this society deserves.

2. The city of Iqaluit Fire Department should implement a version control protocol for their patient log file documents, so that changes and amendments made to a previously filed report can be traced showing changes made to the documents.

3. Have the City of Iqaluit Building Inspectors ensure to that licensed establishments and places accessible to the public are code complaint, and regularly assessed for continuing compliance, with the National Building Code in respect to the entrance and exit facilities (steps, railings, lighting and wheel chair ramp) of their premises.

4. The Iqaluit Fire Department EMS service shall implement a written log form detailing all known event history concerning a patient for hand off to QGH on patient transfer.

5. Full time video/digital recording are done by the Royal Canadian Mounted Police (RCMP) of all occupied cells, no matter the reasons as to why the cell is occupied, and kept for a minimum of six months unless a longer period of time is required by the justice system.

6. Consideration should be given to the RCMP adding a camera showing the outside door where prisoner enter the detachment.

7. The RCMP shall only employ guards who have received full and complete training on cell block procedures as outlined in the RCMP manuals for the Iqaluit detachment. Such training shall be updated and verified semi-annually. Such training materials provided to the guards will be continually available at the guard station.

8. To provide translation services to prisoners at all times.

9. The visibility through the cell door window is to be maintained at all times.

10. Cell block log entries are to be as detailed as possible, for each individual in the cells. The RCMP should consider computerizing their log book operations.

11. The RCMP should perform "4 R's test" on all intoxicated prisoners every 2 hours.

12. Ensure that emergency numbers are clearly posted and put on the guard station speed dial keys on the phone.

13. When patients are released from the local hospital to the RCMP they are to be released with a document that clearly indicates conditions of monitoring required and all special precautions to be taken. Clear instructions for the release of the individual are to be included, and signed off by the Doctor. Any follow up medical care required must be included on the form (time to return to hospital). One copy to be given to the RCMP at transfer and one copy to be kept in the medical file of the patient

14. A "CT" Scan machine with necessary systems and personal should be installed immediately. We believe that it would improve the health care for all citizens of Nunavut.

15. At each visit to the hospital the receptionist/admitting clerk shall verify and update next of kin information for that patient.

16. Where next of kin contact information exists in a patient's medical file, such information shall be displayed on the patients wrist band and used in the case that a patient who cannot communicate is in a life threatening situation.

17. Under no circumstances shall a patient with a suspected head injury be released from the hospital to the custody of the RCMP.

18. The hospital shall ensure that proper monitoring instructions in all cases of a head injury shall be communicated to the patient or their next of kin.

19. In the case where the medical staff feels a "CT" Scan is necessary, prompt medevac of the patient to a facility equipped with a "CT" Scanner shall be arranged.

20. The hospital shall implement a secure area for problematic patients who need medical care instead of using the RCMP detachment to hold them in custody.

21. A secure environment at Qikiqtani General Hospital is required 24/7. Additional staff (security staff) to cover for no shows or any other additional security needs shall be called in.

22. Security staff not to be used to supervise problematic patients and that such duties shall be left to the medical staff of the hospital. Where resources do not allow for such, additional medical staff shall be called in.

23. It is extremely important that orders issued by medical staff shall be properly communicated to all interested parties and not changed or modified in any way by any party. Instructions from the medical staff shall be written form.

24. To provide translation services to patients at all times in the hospital.

25. In case where an unconscious patient is being medevac'd to another health care facility and a medical escort is not travelling with the patient, the next of kin should be considered prior to the patient leaving the north. The purpose of the consultation is to determine acceptable medical intervention on the part of the receiving medical facility. A medical consent form expressing the wish of the family shall accompany the patient.

26. Due to issues with the Iqaluit cell phone system, the hospital shall implement a radio system that is able to communicate with the Ambulance Services of the Iqaluit Fire Department.

27. Before joining the medical staff of Qikiqtani General Hospital new staff members shall be made aware of all policies, rules, and regulations that pertain to the discharge of patients or the transfer of patients to the custody of the RCMP.

28. In order to reduce time line for medevac purposes, it is recommended that there should always be a medevac plane located in Iqaluit. Ensure that such provisions are part of all future contracts awarded for medevac purposes.

29. The Government of Nunavut's Department of Health and Social Services must implement a territory wide drug and alcohol abuse treatment programs immediately.

Case File: 10-106
Cause of Death: Head Injury
Classification: Accidental

Circumstances under which death occurred:

On November 5, 2010, a 55 year old male died in a boating accident in Koojesse Inlet located in Iqaluit's harbour. The deceased was a passenger in a 25 ft. aluminum boat with three others. As a result of the accident the male endured a severe blunt trauma to his head and neck.

Upon returning from a hunting and fishing trip they struck an unmarked mooring buoy in the harbour on approach to Iqaluit.

Due to the impact the male was thrown forward through the windshield of the small cabin. The driver and other two passengers were also injured in the collision but were able to get the boat underway and make their way towards the breakwater where they were to meet with the paramedics for transport to the hospital.

When the local EMS assessed the male in the boat and found that he had no pulse, was cold to touch and his pupils were not reacting to light. CPR was initiated and he was taken to the Qikiqtani General Hospital where further medical intervention was performed. Medical intervention was ceased at 2020hrs on November 5, 2010 and was pronounced dead by the Physician on scene.

The external exam revealed trauma to the face and neck. After reviewing the documentation and evidence the 55 year old male died of multiple blunt force traumas and classified the death was as "A*ccidental*."

Under Section 21(1) (c) a Coroner shall bring to the attention of the public to inform them the dangerous practice and conditions to avoid preventable deaths and to make recommendations accordingly.

Recommendations

1. Encourage their members and the public to obtain their personal watercraft operators certificate and other courses to promote the safe operation of small boats.
2. Implement an advertising campaign to make the public aware of the equipment required on small boats as well as the regulations regarding their operation in "Koojesse inlet."
3. The entrance to that part of the harbour should be clearly marked with warning signs indicating the danger of buoys in the area and requiring a slower speed by the boats using that entrance.
4. The Department of Fisheries and Oceans, Transport Canada, and the Coast Guards should set up a protocol for inspection of the buoys prior to being installed in the spring, and to be removed at the end of the session.

5. Ultimately, removals of all buoys whose owners are unidentified in Koojesse Inlet locate in Iqaluit's harbour.

6. The Breakwater should be modified to make it easier for people to get in and out of their boats and so that an ambulances or emergency vehicle can gain easy access to any craft that is in need of assistance.

Photo courtesy of The Office of the Chief Coroner

Case Files: 11-079 to 11-090

On August 20, 2011 a First Air Boeing 737-210C chartered aircraft was being flown from Yellowknife, Northwest Territories to Resolute Bay, Nunavut. At 1142hrs central daylight time during the approach to Runway 35T First Air's Flight 6560 impacted a hill at 396 feet above sea level and estimated one nautical mile east of the midpoint of the Resolute Bay's Airport runway. The aircraft was destroyed in multiple pieces by the impact forces and an ensuing evidence of post-crash fire.

Eight passengers and the four crew members suffered fatal injuries (12 deceased in total). Three passengers (2 adults and 1 child) suffered serious injuries and were rescued by the Canadian Military personal who were in Resolute Bay as part of their Military exercises.

The Chief Coroner attended the scene in Resolute Bay for the start of the investigation with the assistance of the Nunavut RCMP; Disaster Victim Identification (DVI) Unit; Transportation & Safety Board (TSB); Department of National Defense (DND); Canadian Coast Guards; Fire fighters of Resolute Bay and the Canadian Rangers.

All 12 bodies underwent full postmortem examinations. Identification was established through definitive means, either finger print comparisons by Forensic Identification Services or via Forensic Odontology by Senior Dentists from the Department of National Defense. Identifications were definitely established and agreed upon by the identification committee, chaired by Chief Coroner of Nunavut.

In January 2012 the RCMP in Iqaluit hosted an Airline Post Brief to discuss response to Major Air Disasters. The 45 attendees including 8 from the Airlines met and reviewed the responses to Flight 6560 Crash roles and responsibilities and recommendations.

The Office of the Chief Coroner has developed a "Multiple Fatalities Plan" stating and outlining the roles of the Coroner's Office in any disaster plan. Also, established emergency disaster supplies and more trained Coroners.

Coroners of Nunavut

The Office of the Chief Coroner has statutory authority to recommend the appointment and removal of all Coroners. It is desirable for each community to have a local coroner; therefore recruitment of local coroner is done by the Coroner's Office.

Candidates must complete an application form outlining any special skills or training that they have which would assist them in the position of coroner. Applicants are also required to have written support from their Municipality and local RCMP detachment. The letter of support and a recommendation of appointment by the Chief Coroner are sent to the Minister of Justice for appointment. Coroners are appointed by the Minister of Justice for a period of three years as per the *Nunavut Coroners Act* section 3(1).

Coroner's bags are provided to all Coroners to assist them to perform their assigned duties. The bag includes a training manual and policy documents; Coroner Forms and Warrants; a Coroner's fleece jacket; and Coroner ID name tags. At all times the Coroner's have 24 hours access to the Chief Coroner or designated. Formal training by means of an "in-person session" has been arranged in Iqaluit yearly. Recruitment, training and appointments of new community coroners are an ongoing process.

The Coroner's job is significant to the families who have lost their loved ones, also to the community to have someone assist with the deceased with dignity.

Currently there are 20 coroners across the Nunavut Territory of which 10 are "Inuit Beneficiary."

Coroner Name	Location
Frank Pearce	Iqaluit
Rene Gagne	Iqaluit
Runbir Hundal	Iqaluit
Martha Jaw	Cape Dorset
John Corkett	Cape Dorset
Asenath Kannutaq	Hall Beach
Pitsiula Michael	Kimmirut
Andrew Taqtu	Arctic Bay
David Kooneeliusie	Pangnirtung
Padma Suramala	Iqaluit

Coroner Name	Location
Elizabeth Copland	Arviat
Sandy Napier	Rankin Inlet
Eli Panipakoochoo	Pond Inlet
Mary Jaworenko	Pond Inlet
Brenda Rowbottom	Kugaaruk
Dustin Fredlund	Kugluktuk
Allen Niptanatiak	Kugluktuk
Eileen Grady	Cambridge Bay
Kimberly Dunlop	Cambridge Bay
James Eetoolook	Taloyoak

Conclusion

In conclusion I wish to acknowledge the co-operation and assistance of Nunavut's Royal Canadian Police. All pathologists who provide their services from Ottawa, Ontario Dr. Christopher Milroy and Dr. Parai Jacqueline; From Edmonton, Alberta Dr. Anny Sauvageau and Dr. Graeme Dowling; and from Winnipeg, Manitoba Dr. Bala Balachandra, Dr. Charles Littman and Dr. Susan Philips.

Office of the Chief Coroner is grateful to Dr. Roger Skinner the Regional Supervising Coroner of Ontario, NWT's Chief Coroner Cathy Menard and Garth Eggenberger who assist the office on a daily basis.

Appreciation is also expressed to the City of Iqaluit, the Department Health and Social Services in Nunavut, the Qikiqtani Inuit Association, the Airlines, the southern Medical Laboratories, local Law Enforcement Agencies, Community Coroner's, the local EMS, to all the southern Funeral Homes for their co-operation and contributions.

Respectively submitted

Padma Suramala. B.Sc. RN, RM
Chief Coroner for Nunavut