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Canadian Coroner and Medical Examiner Database: Annual Report

2006 to 2008

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Public Health Agency of Canada

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Note of appreciation

Canada owes the success of its statistical system to a long-standing partnership between Statistics Canada, the citizens of Canada, its businesses, governments and other institutions. Accurate and timely statistical information could not be produced without their continued cooperation and goodwill.

Symbols

The following standard symbols are used in Statistics Canada publications:

.	not available for any reference period
..	not available for a specific reference period
...	not applicable
0	true zero or a value rounded to zero
0^s	value rounded to 0 (zero) where there is a meaningful distinction between true zero and the value that was rounded
p	preliminary
r	revised
x	suppressed to meet the confidentiality requirements of the *Statistics Act*
E	use with caution
F	too unreliable to be published

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Foreword

The Canadian Coroner and Medical Examiner Database (CCMED) is a new database developed at Statistics Canada in collaboration with the 13 provincial and territorial Chief Coroners and Chief Medical Examiners and the Public Health Agency of Canada. Currently, the CCMED combines data from 9 provincial and territorial databases to provide national information on the circumstances in which deaths reported to and investigated by coroners and medical examiners occur. Understanding these circumstances will facilitate the identification and characterization of emerging trends and unknown safety hazards. Such information will be significant in the CCMED's ultimate goal – the contribution to a decrease in preventable deaths in Canada.

Because of the wealth of information contained in the coroner and medical examiner records, in particular the detailed information on the circumstances in which the deaths occurred and the coroner's or medical examiner's final decision on the cause of death, their records are often consulted by researchers. If national data are required, the researchers must visit the offices of all 13 chief coroners or medical examiners to identify relevant records and abstract the data. Each jurisdiction has developed a data management system; the CCMED is a response to make the compilation of this data more efficient.

The 2006 to 2008 Canadian Coroner and Medical Examiner Report presents data on deaths investigated by a coroner or medical examiner, with a particular focus on deaths resulting from accidents, suicides, homicides, and deaths of undetermined intent. We hope that readers will find this report useful. Comments on its format or content may be addressed to Client Services at (613) 951-1746 or email at HD-DS@statcan.gc.ca.

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The collaboration of the data suppliers, the provincial and territorial chief coroner and chief medical examiner offices, is gratefully acknowledged. Ongoing activities of the CCMED are possible thanks to the financial support received from the Public Health Agency of Canada.

Introduction

The Coroner and Medical Examiner Systems

Death investigation is the responsibility of each individual Canadian province and territory—there is no overarching federal authority. As a result, each province and territory has developed their own system and legislation to fulfill the mandate of investigating deaths that are unexpected, unexplained, or as a result of injuries or drugs. Two different death investigation systems have developed in Canada: the Coroner's system and the Medical Examiner's system. The Coroner's system is used in the majority of provinces and territories. It is a system that is centuries old and originated in Great Britain. It is found throughout the world in countries that were former British colonies, including Canada. The Medical Examiner's system (used in Alberta, Manitoba, Nova Scotia, and Newfoundland and Labrador) is just over one century old and originated in the United States. Although there are some differences between the two systems, the ultimate goal of each is the same—to investigate certain deaths defined in their legislation and establish the identity of the deceased together with the cause of death and the manner of death.

Almost all Canadian Coroner and Medical Examiner systems have some provision for going beyond an investigation of the death to a public "inquisitional" hearing, referred to as an Inquest or Public Inquiry. One of the primary purposes of this type of hearing is to develop recommendations for the prevention of similar deaths in the future without making any findings of fault.

It is clear from the foregoing that the coroners and medical examiners are a rich source of information with respect to deaths that are of great public interest, including all injury- and drug-related deaths.

Cause and Manner of Death

As has been previously noted, coroners and medical examiners are required to categorize deaths according to what is called the cause of death and the manner of death, both of which are reflected on the death certificate. The cause of death is defined as the disease or injury that initiates the chain of events ending in death (with no implication of any time limit). The manner of death is also referred to as the means by which death occurs. The five manners are:

Natural:	All deaths where a disease initiates the chain of events ending in death.

Accident:	All deaths where an injury initiates the chain of events ending in death and there is no element of intent in the circumstances leading to the injury.
Suicide:	All deaths where a self-inflicted injury initiates the chain of events ending in death and where the decedent intends to cause their own death.
Homicide:	All deaths where an injury initiates the chain of events ending in death and there is evidence to indicate some intent on the part of another individual to cause harm.
Undetermined:	All deaths where investigation is unable to attribute one of the previous manners are categorized as undetermined. Note that in such instances, the cause of death may be known.

Some Canadian jurisdictions also use an “Unclassified” manner of death, but there is significant variability in how each jurisdiction defines and utilizes this manner.

An important consideration for both the cause and manner of death is that these are not facts but represent the opinion of the certifier. As with any opinion, there are bound to be differences between individuals certifying deaths that occur under similar circumstances and the strength of any opinion is dependent upon several factors, including the training, experience, biases, and integrity of the certifier.

The Collection of Death Data in Canada

Canadian Vital Statistics: Death Database

Prior to the CCMED, the only comprehensive national data on fatal injuries were those contained in Statistics Canada’s Canadian Vital Statistics: Death Database (CVS-D). The CVS-D collects demographic and medical (cause of death) information annually from all provincial and territorial vital statistics registries on all deaths in Canada. Provincial and territorial death registration forms include a medical certificate of cause of death section, completed by a physician or a coroner or medical examiner. The cause of death variable in the CVS-D is classified according to the World Health Organization’s "International Statistical Classification of Diseases and Related Health Problems" Tenth revision (ICD-10). There are approximately 230,000 deaths of Canadian residents registered in Canada each year.

Canadian Coroner and Medical Examiner Database

It is important to understand that the majority of deaths in Canada are caused by natural diseases that have been diagnosed by a physician; such that when death occurs the decedent's physician can complete a death certificate that documents the cause of death. These deaths do not require any involvement by a coroner or medical examiner. The remaining deaths are unexplained natural deaths, where a physician doesn't know the cause of death, and deaths caused by injuries or drugs. The latter are subdivided into four main categories referred to as manners of death: accidents (or unintentional injuries), suicides, homicides, and undetermined deaths (where there is considerable doubt about what the correct manner of death is). These deaths must be reported to and investigated by a coroner or medical examiner.

The provincial and territorial coroners and medical examiners hold data on all deaths that they investigate in their jurisdictions. Depending on the province or territory, the percentage of deaths investigated by a coroner or medical examiner can range approximately from 7% to 45% annually. Although the criteria for reporting deaths vary somewhat by jurisdiction, deaths caused by natural diseases account for about 61% of all coroner or medical examiner cases annually.

Until the development of the CCMED, there was no central collection of corner and medical examiner data. When national data was required, particularly as it pertains to injury/drug deaths, researchers needed to visit each of the 13 chief coroner or medical examiner offices to consult the relevant records and data. The CCMED project grew out of the recognition of a need for a national source of accessible, standardized information on the circumstances in which fatal injuries occur. Through the aggregation and centralization of coroner and medical examiner data, it will be easier to identify and link similar deaths across the country and reveal patterns of contributing factors in these deaths. The CCMED will also make it possible to obtain additional detail on deaths due to causes that are not specified to a unique code in the current version of the ICD but are important in Canada; for example, deaths involving the use of snowmobiles as a specific type of all-terrain vehicle, or the specific source of carbon monoxide (such as car exhaust) in intentional and unintentional carbon monoxide deaths.

Each province and territory has a list of data elements which they collect, store and report. A common data set was developed to allow the collection and aggregation of provincial and territorial coroner and medical examiner data. This system allows provinces and territories to maintain their own data but also support data collection for the national minimum data set. A CCMED record contains the following information:

- name, age and sex of the deceased;
- date of birth, date of death and/or date found dead;
- usual residence, place of death;

- manner of death, circumstances of injury, activity at time of event leading to death, safety devices;
- narrative/case summary, exact wording of the final cause of death on the medical certificate;
- whether the death is one of multiple deaths associated with a single event;
- whether recommendations were made to prevent similar deaths from occurring in the future;
- whether there was a coroner's inquest or a public inquiry.

Certain variables, such as the activity at the time of the event leading to death, usual residence type, circumstances of injury, location of the event leading to death, and safety devices are based on extensive code sets with an expanded classification.

Data Processing

Each province and territory has a distinct system for managing their data, which varies in the degree of automation and the amount of detailed information stored. Provinces and territories either map their electronically stored data to the national data requirements to produce an output file for the CCMED or use the data capture tool developed at Statistics Canada to capture their cases and produce an output file. Prince Edward Island, Nunavut, Northwest Territories, and the Yukon are currently using the data capture tool.

The CCMED went into production on March 1st, 2008 and began collecting data from 2006. To date, not all jurisdictions are able to provide data: for a number of reasons, data from Newfoundland and Labrador, Nova Scotia, Manitoba and Nunavut are not covered in this report.

Data files received from the provinces and territories are sent to the CCMED electronically and go through an extensive verification process to ensure that only valid data are accepted onto the system. Cases with fatal errors are not loaded onto the database; reports are returned to the jurisdiction for validation and correction. The case must be re-submitted to the CCMED and go through the verification process before it can be loaded onto the CCMED. Minimal changes are made centrally to the data submitted by the provinces and territories. Steps are taken to reduce the percentage of cases that fail validation. The Statistics Canada data capture tool contains the same validation rules as the CCMED, and cases must clear validation prior to being available for transmission to the CCMED. For the provinces and territories with their own databases that require mapping to the CCMED, the data mapping program was developed and thoroughly tested in conjunction with Statistics Canada, which allowed for the identification and correction of major sources of error.

Data Quality

As a newly implemented database, the CCMED requires a thorough analysis of its data integrity and quality. This report provided the first opportunity to test the robustness of the database and to identify gaps in some of the variables—specifically, those describing the circumstances and activities surrounding the event leading to death. Corrective measures should be implemented in order to release their analytical potential.

This report covers the universe of "closed" coroner and medical examiner cases and covers deaths that occurred during the period 2006 to 2008. When the year of death is unknown, the year in which the death was discovered is used. On the basis of these extraction parameters, a reconciliation exercise using the 2006 to 2008 data found a strong agreement between the provinces and territories and the CCMED data.

Coverage

There are situations where two jurisdictions may investigate the same death. As an example, if an injury occurs in one jurisdiction and the patient is sent to a trauma centre in a different jurisdiction where they die, the coroner or medical examiner in both jurisdictions might conduct investigations. For the purposes of the CCMED, the death record retained will be the one from the jurisdiction where the death occurred.

Undercoverage is thought to be minimal and may occur due to lengthy delays in the investigation of certain types of deaths. It is expected that a low percentage of cases will fail validation and thus limit the possibility of undercoverage. However, if the jurisdiction does not re-submit cases that fail validation, these would not be part of the final data file.

There will be no instances of complete nonresponse. That is, the CCMED obtains at least some information for each identified case. In the rare instances where little information is known about the decedent, the fields will be left blank or coded to unknown. There are situations where a coroner or medical examiner is notified of a death, and after an initial investigation it is decided that this is not a coroner or medical examiner case. These cases are identified and are excluded from the database.

Strengths and Limitations of the Canadian Coroner and Medical Examiner Database

The CCMED is the only centralized source of standardized coroner and medical examiner data in Canada. Coroner and medical examiner data are rich in detail on the circumstances leading to deaths, such as the location of the incident leading to the death, the activity at the time of the event leading to the death, whether there were any safety devices in use, or if this death was part of an incident leading to multiple deaths. This information will allow for better injury prevention research and analysis.

The CCMED provides additional detail on particular types of deaths that may not be specified in the current version of ICD-10 but are important to Canadians (such as snowmobile deaths or deaths due to carbon monoxide poisoning).

The collection of coroner and medical examiner data on the national level will aid in revealing patterns of factors and circumstances that contribute to death through detection of similar deaths and "clusters of deaths". In addition, the CCMED will greatly enhance the rate of information exchange between interested parties and address the information needs of a range of stakeholders, including: coroners and medical examiners, national information agencies, public health policy makers and researchers. In doing so, the CCMED will lead to better data collection around the country and will encourage the standardization and implementation of investigation protocols.

Despite these important advantages, the CCMED data has certain limitations. Different jurisdictions may have their specific definitions for certain data elements. Although an attempt is made to standardize data with the minimum dataset, the interpretation may vary within the different jurisdictions.

Individual coroner or medical examiner offices collect different levels of detail for particular deaths according to the importance of certain types of deaths in their jurisdiction. The minimum dataset of the CCMED may have only one level of detail for the same types of death, such that there are instances where this will result in a loss of detail in the information that was collected at the coroner or medical examiner office versus what was mapped and sent to the CCMED.

The CCMED will not be the best source of data for certain types of deaths. Since coroners and medical examiners only deal with a small percentage of deaths caused by natural disease, these will not be well reflected in the database. Information will not be collected on deaths of Canadians occurring outside the country. The CCMED data will not allow for the identification of all cases where alcohol or drugs were a factor in injury deaths. For example, it won't necessarily capture the role that alcohol or drugs played in a motor vehicle accident where the driver of the other vehicle that caused a collision was intoxicated but survived. On the other hand, if the drivers of both vehicles died in the same incident, the CCMED will link the two deaths.

International Efforts

The official inception of the Australian National Coroner Information System (NCIS) in July 2000 makes Australia the first country in the world to have developed a national database of coroner information. The success of their system is evidenced by the number of third party users who had online subscription access to the NCIS in 2009-10. This vast number of registered organizations includes various government and private industries: the Australian Department of Health and Ageing, the Consultative Council on Obstetric and Paediatric Mortality and Morbity, Safe Work Australia, the National Drug and Alcohol Research Centre, the Australian Institute for Suicide Research and Prevention, the Australian Institute of Criminology, the Monash University Accident Research Centre, the Queensland Fire & Rescue Service, the Australian Bureau of Statistics, and many others. The NCIS has demonstrated the immense potential and relevance of coroner's data in the area of injury prevention; NCIS data were critical in producing evidence to support the implementation of several significant Australian death and injury prevention initiatives.

This Report

The remainder of this report will profile the work of coroners and medical examiners in the nine provinces and territories for which the CCMED has received data and examine how caseload varies across jurisdictions. Effort will be made to put some of this information into greater context by using the information regarding the events and circumstances leading to death, and in doing so, highlight the strengths of the CCMED while identifying some of its limitations. The three appendices provide additional analysis and information to better put the observed results into context. Notably, Appendix C examines informally the differences in the circumstances under which the provincial and territorial coroners and medical examiners investigate deaths.

Note to readers – Key information about the CCMED

- The CCMED is a dynamic database, which means it is updated regularly to reflect changes in the status of the records submitted by coroners and medical examiners. For this reason, any information disseminated and generated by the CCMED is a function of a specific date which must be taken into account when making statistical comparisons, the relevant date for this report being **September 1st, 2011**.

General Statistics

Caseload Overview

Table 1 Number of deaths investigated by a coroner or medical examiner, by year, Provinces and Territories, 2006 to 2008

	2006	2007	2008	All years
Prince Edward Island				
Number of deaths investigated by a coroner or medical examiner	227	233	242	702
Total number of deaths	1,149	1,130	1,172	3,451
Population	137,920	138,161	139,604	...
New Brunswick				
Number of deaths investigated by a coroner or medical examiner	1,602	1,587	1,649	4,838
Total number of deaths	6,053	6,367	6,477	18,897
Population	745,674	745,515	747,023	...
Quebec				
Number of deaths investigated by a coroner or medical examiner	4,245	4,109	3,798	12,152
Total number of deaths	54,067	56,348	56,924	167,339
Population	7,631,552	7,687,423	7,750,735	...
Ontario				
Number of deaths investigated by a coroner or medical examiner	18,678	18,151	17,343	54,172
Total number of deaths	84,846	87,563	88,262	260,671
Population	12,665,346	12,792,937	12,934,499	...
Saskatchewan				
Number of deaths investigated by a coroner or medical examiner	1,365	1,378	1,469	4,212
Total number of deaths	9,067	9,084	9,263	27,414
Population	992,122	1,000,257	1,013,922	...
Alberta				
Number of deaths investigated by a coroner or medical examiner	3,599	3,699	3,905	11,203
Total number of deaths	19,658	20,329	21,176	61,163
Population	3,421,253	3,512,691	3,591,791	...
British Columbia				
Number of deaths investigated by a coroner or medical examiner	3,661	3,503	3,799	10,963
Total number of deaths	30,809	31,382	32,184	94,375
Population	4,243,580	4,309,632	4,384,047	...

Note: Table 1 continued on the following page.

Table 1 Number of deaths investigated by a coroner or medical examiner, by year, Provinces and Territories, 2006 to 2008 - (continued)

	2006	2007	2008	All years
Yukon				
Number of deaths investigated by a coroner or medical examiner	53	44	59	156
Total number of deaths	174	174	192	540
Population	32,276	32,569	33,113	…
Northwest Territories				
Number of deaths investigated by a coroner or medical examiner	76	77	72	225
Total number of deaths	175	172	199	546
Population	43,198	43,545	43,681	…
All provinces and territories				
Number of deaths investigated by a coroner or medical examiner	33,506	32,781	32,336	98,623
Total number of deaths	205,998	212,549	215,849	634,396
Population	29,912,921	30,262,730	30,638,415	…

Sources: Statistics Canada, Canadian Coroner and Medical Examiner Database and Tables 102-0501and 051-0001, CANSIM.

A total of 98,623 cases were successfully loaded onto the CCMED for the period 2006 to 2008. The majority of these cases are from Ontario, followed by Quebec, Alberta and British Columbia. From Table 2, roughly 15% to 16% of deaths were investigated by a coroner or medical examiner annually, although this varied greatly by province and territory, from a high of over 40% in the Northwest Territories, to a low of around 7% in Quebec. Elsewhere, the intervention of a coroner or medical examiner was required in 11 to 30% of deaths annually. New Brunswick had the highest rate of investigation of all provinces, both in terms of the percentage of all deaths investigated by a coroner or medical examiner (around 25% annually) and relative to its population (2.1 coroner's investigations per 1,000 population), where it led all jurisdictions; Quebec had the lowest for both rates.

In the seven provinces, the annual coroner or medical examiner caseloads were relatively stable over the three years, both in terms of raw number and the percentage of deaths investigated. In the two territories, the number of deaths investigated by the coroners seems somewhat more variable, however in each case there is general agreement for two of the three years. For these reasons, much of the information presented in what follows will be expressed as aggregates for the three-year period 2006 to 2008.

Table 2 Deaths investigated by a coroner or medical examiner as a percentage of all deaths, by year, Provinces and Territories, 2006 to 2008

	2006	2007	2008	All years
Prince Edward Island				
Percentage of all deaths	19.8	20.6	20.6	20.3
Rate per 1,000 population	1.6	1.7	1.7	...
New Brunswick				
Percentage of all deaths	26.5	24.9	25.5	25.6
Rate per 1,000 population	2.1	2.1	2.2	...
Quebec				
Percentage of all deaths	7.9	7.3	6.7	7.3
Rate per 1,000 population	0.6	0.5	0.5	...
Ontario				
Percentage of all deaths	21.9	20.7	19.6	20.7
Rate per 1,000 population	1.5	1.4	1.3	...
Saskatchewan				
Percentage of all deaths	15.1	15.1	15.8	15.4
Rate per 1,000 population	1.4	1.4	1.4	...
Alberta				
Percentage of all deaths	18.3	18.2	18.4	18.3
Rate per 1,000 population	1.1	1.1	1.1	...
British Columbia				
Percentage of all deaths	11.9	11.2	11.8	11.6
Rate per 1,000 population	0.9	0.8	0.9	...
Yukon				
Percentage of all deaths	30.5	25.3	30.7	28.9
Rate per 1,000 population	1.6	1.4	1.8	...
Northwest Territories				
Percentage of all deaths	43.4	44.8	36.2	41.2
Rate per 1,000 population	1.8	1.8	1.6	...
All provinces and territories				
Percentage of all deaths	16.3	15.4	15.0	15.5
Rate per 1,000 population	1.1	1.1	1.1	...

Note: Percentages and rates exclude stillbirths.
Sources: Statistics Canada, Canadian Coroner and Medical Examiner Database and Tables 102-0501and 051-0001, CANSIM.

Table 3 presents the number of deaths investigated by a coroner or medical examiner, by age and sex of the deceased. In general, 80% or more of the cases involved persons aged 30 to 89 years of age, with male decedents accounting for almost two thirds of coroner or medical examiner caseload and investigations involving males age 50 to 69 representing the greatest share of coroner or medical examiner cases. The latter holds true, in all provinces and territories except New Brunswick and Ontario, where males aged 70 to 89 represented the greatest share of coroner or medical examiner caseload.

Table 3 Number of coroner or medical examiner investigations, by sex and age group, Provinces and Territories, 2006 to 2008

	P.E.I.	N.B.	Que.	Ont.	Sask.	Alta.	B.C.	Y.T.	N.W.T	All provinces and territories
	number									
Males										
Stillbirths	1	0	0	92	2	1	0	0	0	96
0 to 4 years	3	33	118	382	57	134	152	2	9	890
5 to 14 years	3	12	101	158	24	72	60	1	0	431
15 to 29 years	22	184	1,329	1,899	316	1,072	932	9	24	5,787
30 to 49 years	64	398	2,783	5,286	575	2,032	2,015	34	50	13,237
50 to 69 years	191	1,010	2,976	10,521	876	2,735	2,792	49	69	21,219
70 to 89 years	177	1,191	1,202	12,097	791	1,597	1,406	18	18	18,497
90 years and over	7	122	99	1,591	110	122	138	1	2	2,192
Females										
Stillbirths	0	0	0	88	1	0	0	0	0	89
0 to 4 years	0	20	66	281	42	83	93	0	5	590
5 to 14 years	1	10	52	112	23	48	44	0	2	292
15 to 29 years	11	56	392	726	144	338	329	5	11	2,012
30 to 49 years	23	146	889	2,100	209	791	750	14	14	4,936
50 to 69 years	60	447	1,102	4,394	294	982	994	13	14	8,300
70 to 89 years	106	937	842	10,636	550	962	968	9	3	15,013
90 years and over	28	272	173	3,783	194	170	225	1	1	4,847
Both sexes										
Stillbirths	1	0	0	180	3	1	0	0	0	185
0 to 4 years	3	53	184	663	99	217	245	2	14	1,480
5 to 14 years	4	22	153	270	47	120	104	1	2	723
15 to 29 years	33	240	1,721	2,625	460	1,410	1,261	14	35	7,799
30 to 49 years	87	544	3,672	7,386	784	2,823	2,765	48	64	18,173
50 to 69 years	251	1,457	4,078	14,915	1,170	3,717	3,786	62	83	29,519
70 to 89 years	283	2,128	2,044	22,733	1,341	2,559	2,374	27	21	33,510
90 years and over	35	394	272	5,374	304	292	363	2	3	7,039

Note: Excludes 195 cases where sex and/or age were not specified; among them are 3 stillbirths.
Source: Statistics Canada, Canadian Coroner and Medical Examiner Database, 2006 to 2008.

Among females, investigations involving those aged 70 to 89 represented the greatest share of coroner or medical examiner cases, although this result is driven by Ontario, and to a lesser extent New Brunswick and Saskatchewan; elsewhere, caseload share was similar between the 50 to 69 and 70 to 89 age groups.

In all provinces and territories and in all age groups, except those aged 90 and over, male decedents, subject to a coroner or medical examiner investigation, outnumber their female counterparts. From Table 4, with some exception in Prince Edward Island and the territories, the same observation holds true for the percentage of deaths investigated by a coroner or medical examiner. Persons aged 15 to 29 years were the most likely subjects of a coroner or medical examiner investigation in both males and females, where between 72% and 92% of deaths were coroner or medical examiner cases, depending on province or territory. However, it was the 30 to 49 and 50 to 69 age groups that showed the greatest disparities between males and females: the death of a male in these age groups was between 1.4 and 2.9 times more likely to have been the subject of a coroner or medical examiner investigation than the death of a female.

Table 4 Deaths investigated by a coroner or medical examiner as a percentage of all deaths, by sex and age group, Provinces and Territories, 2006 to 2008

	P.E.I.	N.B.	Que.	Ont.	Sask.	Alta.	B.C.	Y.T.	N.W.T	All provinces and territories
	percent									
Males										
0 to 4 years	60.0	55.0	16.5	27.2	35.2	25.3	45.0	40.0	69.2	27.5
5 to 14 years	75.0	66.7	57.7	59.0	75.0	61.5	67.4	50.0	...	61.1
15 to 29 years	71.0	87.2	84.5	82.5	88.3	89.2	86.5	100.0	92.3	85.2
30 to 49 years	67.4	70.3	51.7	62.4	65.6	68.5	60.5	70.8	87.7	60.7
50 to 69 years	38.6	40.3	12.9	31.6	29.7	32.7	23.1	42.6	62.2	25.6
70 to 89 years	19.3	23.0	2.6	16.6	10.4	9.9	5.3	14.1	15.9	10.6
90 years and over	3.9	12.8	1.5	13.2	5.9	4.4	2.7	5.9	14.3	7.4
Females										
0 to 4 years	0.0	54.1	11.2	26.0	31.6	18.8	36.2	0.0	100.0	23.2
5 to 14 years	100.0	52.6	50.0	57.7	65.7	57.8	57.9	...	100.0	56.8
15 to 29 years	73.3	82.4	66.3	74.5	80.0	81.3	71.5	71.4	91.7	73.9
30 to 49 years	35.9	44.2	26.6	39.3	40.6	45.8	38.8	51.9	58.3	37.1
50 to 69 years	22.3	28.1	7.2	20.2	15.8	18.2	13.2	23.6	21.5	15.4
70 to 89 years	11.6	18.1	1.8	14.6	7.8	6.4	3.9	10.0	3.7	8.7
90 years and over	6.1	12.5	1.0	13.6	5.2	2.8	2.1	2.8	4.5	7.1
Both sexes										
0 to 4 years	42.9	54.6	14.1	26.7	33.6	22.3	41.2	33.3	77.8	25.6
5 to 14 years	80.0	59.5	54.8	58.4	70.1	60.0	63.0	50.0	100.0	59.3
15 to 29 years	71.7	86.0	79.6	80.1	85.5	87.1	82.0	87.5	92.1	82.0
30 to 49 years	54.7	60.7	42.1	53.5	56.4	60.1	52.5	64.0	79.0	51.8
50 to 69 years	32.9	35.6	10.6	27.1	24.3	27.0	19.3	36.5	47.2	21.6
70 to 89 years	15.4	20.5	2.2	15.6	9.1	8.2	4.6	12.4	10.8	9.6
90 years and over	5.5	12.6	1.1	13.5	5.4	3.3	2.3	3.8	8.3	7.2

Note: Excludes 192 CCMED cases and 26 CVS-D cases where sex and/or age were not specified.
Sources: Statistics Canada, Canadian Coroner and Medical Examiner Database and Canadian Vital Statistics: Death Database, 2006 to 2008.

The differences observed by age, sex and province or territory in this section are the result of several factors, including the structure of the provincial and territorial populations, socio-economic factors and the circumstances under which the different provincial and territorial coroners and medical examiners are mandated to investigate deaths. The following sections will attempt to use the contextual data of the CCMED to provide a better perspective on these differences.

Manner of Death

There are five manners of death commonly used: natural, accident, suicide, homicide and undetermined. Some jurisdictions also include unclassified, but with different meanings; in Alberta, unclassified deaths are those where alcohol was a factor in the death, in the Northwest Territories, unclassified deaths refer to non-human remains, while in Ontario, unclassified deaths refer to skeletal remains where it is not possible to determine a cause of death. For the purposes of this report, all unclassified deaths for Alberta were recoded to “undetermined”; for Ontario and the Northwest Territories, unclassified deaths are excluded from the CCMED. A small number of cases in Saskatchewan coded “unclassified” were excluded from the tabulations where noted.

The figures in Appendix A present the annual caseloads, by manner of death, for each province and territory. In general, the caseload distributions are very stable over the three years, with some exception in the territories.

Table 5 Distribution of coroner or medical examiner investigations, by manner, Provinces and Territories, 2006 to 2008

	Manner of death					Total
	Natural	Accident	Suicide	Homicide	Undetermined	
Prince Edward Island						
Number of investigations	550	97	36	1	17	701
Percentage of all coroner or medical examiner investigations	78.5	13.8	5.1	0.1	2.4	100.0
New Brunswick						
Number of investigations	3,787	700	282	22	47	4,838
Percentage of all coroner or medical examiner investigations	78.3	14.5	5.8	0.5	1.0	100.0
Quebec						
Number of investigations	4,395	3,845	3,388	261	263	12,152
Percentage of all coroner or medical examiner investigations	36.2	31.6	27.9	2.1	2.2	100.0
Ontario						
Number of investigations	38,253	10,368	3,275	590	1,503	53,989
Percentage of all coroner or medical examiner investigations	70.9	19.2	6.1	1.1	2.8	100.0
Saskatchewan						
Number of investigations	2,328	1,273	385	100	121	4,207
Percentage of all coroner or medical examiner investigations	55.3	30.3	9.2	2.4	2.9	100.0
Alberta						
Number of investigations	5,338	2,668	1,420	302	1,471	11,199
Percentage of all coroner or medical examiner investigations	47.7	23.8	12.7	2.7	13.1	100.0
British Columbia						
Number of investigations	4,849	4,021	1,399	273	421	10,963
Percentage of all coroner or medical examiner investigations	44.2	36.7	12.8	2.5	3.8	100.0
Yukon						
Number of investigations	81	57	10	2	6	156
Percentage of all coroner or medical examiner investigations	51.9	36.5	6.4	1.3	3.8	100.0
Northwest Territories						
Number of investigations	128	68	22	3	4	225
Percentage of all coroner or medical examiner investigations	56.9	30.2	9.8	1.3	1.8	100.0
All provinces and territories						
Number of investigations	59,709	23,097	10,217	1,554	3,853	98,430
Percentage of all coroner or medical examiner investigations	60.7	23.5	10.4	1.6	3.9	100.0

Note: Total excludes all stillbirths, 2 cases coded "unclassified" in Saskatchewan, and 3 cases coded "pending" in Alberta.
Source: Statistics Canada, Canadian Coroner and Medical Examiner Database, 2006 to 2008.

Table 5 provides a breakdown of cases by manner of death, by province and territory for the period 2006 to 2008. Over 60% of all coroner or medical examiner investigations led to a determination of death by natural causes, followed by accidental death at 24%, suicides, undetermined and homicides. This pattern holds true for most of

the provinces and territories. Quebec had a more balanced caseload than the other provinces, with natural deaths accounting for 36% of investigations, followed closely by accidents (32%) and suicides (28%). Elsewhere, there seems to be an east-west disparity with respect to caseload distribution: Prince Edward Island, New Brunswick and Ontario have similar distributions in the East; and the three western provinces and two territories have similar distributions.

Appendix B examines the distribution of caseload, by manner of death, for individual age groups. Further refinement of the youngest age groups presented in Tables 3 and 4 was done to examine differences in infant, preschool and school-aged children categories. In general, natural causes was the predominant manner of death in people aged 0 to 23 months and people aged 39 years or older, with accidental deaths representing the second highest proportion of deaths in these age groups. Exceptionally, in deaths of people aged 0 to 11 months, the manner of death could not be determined for over 25%.

Among those aged 2 to 29 years, accidental deaths accounted for the largest percentage of coroner or medical examiner investigations, with natural deaths accounting for the second largest share of caseload. The lone exception was for decedents aged 15 to 29, where suicide accounted for 25% of deaths investigated by a coroner or medical examiner, and natural deaths only 11%. Not surprisingly, this was also the group for which a coroner or medical examiner investigation was most likely.

As mentioned previously, even though provincial and territorial coroners and medical examiners share a common goal, their practice can vary according to different legislations and/or definitions of coroner or medical examiner concepts. The remainder of this section will focus individually on each manner of death in an effort to tease out some of these differences.

Natural Deaths

Deaths categorized as natural are those where a disease initiated the chain of events ending in death. Among deaths that occurred in 2006 to 2008, coroners and medical examiners investigated 59,709 deaths that were determined to be natural. Statistics for this period (Table 6) show that roughly 60%—over 70% in the territories—of these were male decedents. This is similar to the male-female split observed for all coroner or medical examiner cases. Generally, for both sexes, the majority of deaths investigated are in age groups 50 to 69 and 70 to 89. Natural deaths in people aged 90 years and over are more often deaths of females.

Table 6 Distribution of natural deaths investigated by a coroner or medical examiner, by sex and age group, Provinces and Territories, 2006 to 2008

	P.E.I.	N.B.	Que.	Ont.	Sask.	Alta.	B.C.	Y.T.	N.W.T	All provinces and territories
	percent									
Males										
0 to 4 years	0.4	0.7	1.5	0.5	1.1	1.6	1.7	1.2	6.3	0.8
5 to 14 years	0.0	0.1	0.2	0.2	0.1	0.2	0.4	0.0	0.0	0.2
15 to 29 years	0.2	0.4	2.0	0.6	0.7	1.4	1.7	1.2	1.6	0.9
30 to 49 years	6.6	4.9	14.9	5.9	8.1	9.9	11.1	9.9	14.1	7.4
50 to 69 years	28.4	20.9	30.7	21.4	26.9	31.3	34.2	39.5	41.4	24.3
70 to 89 years	28.8	28.5	14.5	26.0	25.6	21.3	17.7	19.8	12.5	24.2
90 years and over	1.3	3.0	1.5	3.1	2.8	1.2	1.0	1.2	1.6	2.6
All ages	**65.7**	**58.4**	**65.4**	**57.8**	**65.3**	**66.9**	**67.7**	**72.8**	**77.3**	**60.5**
Females										
0 to 4 years	0.0	0.3	1.1	0.4	0.6	1.0	1.2	0.0	3.1	0.6
5 to 14 years	0.0	0.1	0.2	0.1	0.1	0.1	0.5	0.0	0.8	0.2
15 to 29 years	0.2	0.3	1.1	0.5	0.9	0.6	1.2	1.2	0.8	0.6
30 to 49 years	2.9	2.2	5.8	2.6	3.4	4.1	4.8	3.7	6.3	3.1
50 to 69 years	9.0	9.6	11.2	8.6	8.9	10.9	10.6	11.1	9.4	9.2
70 to 89 years	17.4	22.8	12.0	22.5	16.8	14.0	11.8	9.9	1.6	19.8
90 years and over	4.8	6.4	3.2	7.5	3.9	2.3	2.1	1.2	0.8	6.1
All ages	**34.3**	**41.6**	**34.6**	**42.2**	**34.7**	**33.1**	**32.3**	**27.2**	**22.7**	**39.5**

Note: Excludes 140 cases where sex and/or age were not specified.
Source: Statistics Canada, Canadian Coroner and Medical Examiner Database, 2006 to 2008.

To better understand the circumstances under which the coroners and medical examiners investigate natural deaths, it might be informative to look at the place of death. Table 7 shows that, not surprisingly, most natural deaths occur in a private residence or medical services facility. But what is interesting is that almost half (48%) of the natural deaths investigated by a coroner or medical examiner occurred in a hospital, health professional's office, nursing home, long-term care facility or hospice, and that this percentage varies considerably by province and territory, from a low of 24% in the Yukon to a high of 87% in New Brunswick. This observation points perhaps to jurisdictional differences as to when, in a medical setting, the intervention of a coroner or medical examiner is required. For example, in Ontario every tenth death occurring in a long term care facility must be investigated by a coroner.

Table 7 Distribution of natural deaths investigated by a coroner or medical examiner, by place of death, Provinces and Territories, 2006 to 2008

Place of death	P.E.I.	N.B.	Que.	Ont.	Sask.	Alta.	B.C.	Y.T.	N.W.T	All provinces and territories
	percent									
Private residence	38.5	11.6	24.4	44.9	68.7	63.4	60.0	63.0	49.2	45.0
Residential or correctional institution	1.8	0.2	1.5	2.1	0.3	0.5	1.1	0.0	0.0	1.6
Medical services facility	41.3	87.2	55.5	50.8	26.2	24.2	27.8	23.5	42.2	48.1
School, eductional facility, daycare	0.0	0.0	0.0	< 0.1	0.0	0.0	< 0.1	0.0	0.0	< 0.1
Sports and athletics facility	0.2	0.0	0.0	< 0.1	0.0	0.0	0.2	0.0	0.0	< 0.1
Recreational/public/ entertainment/commercial area	1.6	0.2	1.3	0.7	0.9	1.9	4.6	4.9	4.7	1.1
Transport area	0.5	0.2	< 0.1	< 0.1	0.4	1.1	3.5	4.9	0.8	0.4
Industrial/construction area or place of primary production	0.0	< 0.1	0.0	0.1	0.0	1.3	0.0	0.0	1.6	0.2
Farm or ranch	0.0	0.0	0.0	0.0	1.2	0.3	0.1	0.0	0.0	0.1
Countryside	0.0	0.1	0.0	0.2	2.1	0.4	0.4	0.0	0.0	0.3
Body of water	0.0	0.0	0.0	0.0	0.0	0.0	0.6	0.0	0.0	< 0.1
Swimming pool	0.0	0.0	0.0	0.0	0.0	0.0	< 0.1	0.0	0.0	< 0.1
Other specified place of death	0.5	0.0	0.2	1.3	0.0	0.0	0.0	3.7	1.6	0.9
Not applicable	0.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	< 0.1
Not specified	15.1	0.5	17.1	0.0	0.2	7.0	1.6	0.0	0.0	2.2

Source: Statistics Canada, Canadian Coroner and Medical Examiner Database, 2006 to 2008.

Accidental Deaths

Deaths categorized as accidental are those where an injury initiates the chain of events ending in death and there is no element of intent in the circumstances leading to the injury. Among deaths that occurred in 2006 to 2008, coroners and medical examiners investigated 23,097 accidental deaths. From Table 8, 65% of these were male decedents; in the territories and Alberta, males accounted for over 70% of accidental deaths. Like natural deaths, the male-female split for accidental deaths is similar to that observed for all coroner or medical examiner cases. Generally, males aged 15 to 69 account for just under a half or more of all such deaths (44% in Saskatchewan to around 70% in the Northwest Territories); exceptionally, in Ontario, this age-sex group represented just over a third of all accidental deaths, and males and females aged 70 to 89 years accounted for 17% and 18% of accidental deaths respectively. Like natural deaths, accidental deaths in people aged 90 years and over are more often deaths of females, owing to the structure of the population.

Table 8 Distribution of accidental deaths investigated by a coroner or medical examiner, by sex and age group, Provinces and Territories, 2006 to 2008

	P.E.I.	N.B.	Que.	Ont.	Sask.	Alta.	B.C.	Y.T.	N.W.T	All provinces and territories
	percent									
Males										
0 to 4 years	0.0	0.6	1.1	0.5	1.4	1.1	0.5	0.0	1.5	0.7
5 to 14 years	3.1	1.1	1.8	0.7	1.3	1.7	0.8	1.8	0.0	1.1
15 to 29 years	15.5	16.9	18.2	8.7	12.6	18.6	13.4	7.0	17.6	12.8
30 to 49 years	15.5	17.4	22.3	14.6	17.8	19.6	23.0	36.8	32.4	18.3
50 to 69 years	18.6	17.9	19.7	12.4	13.2	16.6	18.3	22.8	20.6	15.4
70 to 89 years	13.4	12.1	9.0	17.4	12.7	13.6	9.9	1.8	2.9	13.7
90 years and over	0.0	1.3	0.5	3.7	3.5	1.7	2.0	0.0	0.0	2.5
All ages	**66.0**	**67.3**	**72.7**	**58.0**	**62.5**	**72.9**	**68.0**	**70.2**	**75.0**	**64.5**
Females										
0 to 4 years	0.0	0.7	0.5	0.5	0.8	0.6	0.1	0.0	1.5	0.4
5 to 14 years	1.0	0.7	0.8	0.4	1.4	1.2	0.4	0.0	1.5	0.6
15 to 29 years	7.2	4.4	5.3	3.1	5.2	5.6	4.6	5.3	11.8	4.2
30 to 49 years	5.2	4.4	6.5	5.2	6.3	5.8	7.9	17.5	5.9	6.0
50 to 69 years	8.2	8.9	7.3	6.2	3.9	5.1	7.5	5.3	2.9	6.4
70 to 89 years	10.3	9.4	6.1	18.2	11.8	7.0	8.4	1.8	1.5	12.5
90 years and over	2.1	4.1	0.8	8.5	8.0	1.8	3.0	0.0	0.0	5.3
All ages	**34.0**	**32.7**	**27.3**	**42.0**	**37.5**	**27.1**	**32.0**	**29.8**	**25.0**	**35.5**

Note: Excludes 31 cases where sex and/or age were not specified.
Source: Statistics Canada, Canadian Coroner and Medical Examiner Database, 2006 to 2008.

To gain greater insight into the nature of accidental deaths, it might be interesting to look at the activity in which the deceased was engaged at the time of the event leading to death. Table 9 provides the distribution of accidental deaths by activity. Note that for New Brunswick and Saskatchewan, this information is not routinely collected, and British Columbia seems to code activity as not applicable for most of its cases. Looking at the coroners' narratives for the latter, it seems that "not applicable" is used in instances of traffic accidents and accidental deaths involving the use of drugs and/or alcohol. Elsewhere it seems that this information was rarely specified, with the exception of the territories. The end result is that this information has limited analytic value, but can be used along with other information in the database, like information regarding the circumstances and conditions surrounding the events leading to death and the use of safety devices, to help researchers identify cases of potential interest.

Table 9 Distribution of accidental deaths investigated by a coroner or medical examiner, by activity at the time of event leading to death, Provinces and Territories, 2006 to 2008

Activity	P.E.I.	N.B.	Que.	Ont.	Sask.	Alta.	B.C.	Y.T.	N.W.T	All provinces and territories
	percent									
Paid work	2.1	.	0.2	2.8	.	< 0.1	5.3	7.0	8.8	2.3
Unpaid work	1.0	.	0.0	0.0	.	0.0	0.1	0.0	0.0	< 0.1
Water-based leisure, sport and recreation	5.2	.	0.0	2.1	.	1.8	2.5	7.0	22.1	1.7
Snow and ice-based leisure, sport and recreation	0.0	.	0.0	0.8	.	0.9	1.5	5.3	5.9	0.7
Air-based leisure, sport and recreation	0.0	.	0.0	< 0.1	.	0.1	0.7	0.0	2.9	0.2
Land-based leisure, sport and recreation	9.3	.	0.0	1.1	.	3.3	2.5	12.3	5.9	1.4
Leisure, sport and recreation - Not further specified	0.0	.	0.0	0.0	.	0.0	0.4	0.0	1.5	0.1
Other specified activity	10.3	.	1.8	0.3	.	0.9	0.0	21.1	38.2	0.8
Not applicable	4.1	.	0.0	0.0	.	0.1	86.9	1.8	2.9	15.2
Not specified/unknown	68.0	.	98.1	93.0	.	92.9	0.0	45.6	11.8	69.2

Source: Statistics Canada, Canadian Coroner and Medical Examiner Database, 2006 to 2008.

Table 10 presents the distribution of accidental deaths by circumstances of injury. Deaths involving falls or jumps accounted for over a quarter of the accidental deaths investigated by a coroner or medical examiner. This result is driven by Ontario, where fall or jump was provided as a circumstance of injury in 45% of accidental deaths. In fact, in Ontario, nearly 6 in 10 (not shown) of the accidental deaths involving women involved a fall or jump. Elsewhere, deaths that involved occupants of standard road vehicles (half of the deaths in Alberta) and drug and alcohol poisonings (nearly one third of deaths in British Columbia) accounted for important portions of the accidental deaths investigated by a coroner or medical examiner. For a significant number of cases in Saskatchewan, Quebec, Prince Edward Island, Yukon and the Northwest Territories no circumstances of injury were provided.

Table 10 Distribution of accidental deaths investigated by a coroner or medical examiner, by circumstances of injury, Provinces and Territories, 2006 to 2008

Circumstances of injury	P.E.I.	N.B.	Que.	Ont.	Sask.	Alta.	B.C.	Y.T.	N.W.T	All provinces and territories
	percent									
Pedestrian	7.2	0.0	0.0	3.4	0.0	0.8	5.3	3.5	0.0	2.6
Occupant of standard road vehicle	11.3	37.0	4.2	18.8	0.0	50.9	25.8	24.6	8.8	20.8
Occupant of vehicle designed for a specific use	1.0	0.0	0.3	0.0	0.0	< 0.1	0.6	0.0	2.9	0.2
Occupant of vehicle designed for off-road use	5.2	4.7	3.7	0.8	0.0	1.9	1.4	8.8	1.5	1.6
Occupant of unspecified other vehicle	16.5	0.0	< 0.1	0.0	0.0	0.1	< 0.1	1.8	2.9	0.1
Occupant of watercraft	2.1	0.0	0.0	0.9	0.0	0.0	0.0	1.8	14.7	0.5
Occupant of aircraft	0.0	0.1	0.0	0.2	0.0	0.9	1.2	3.5	14.7	0.5
Other specified transport	3.1	0.0	2.7	0.3	0.0	0.1	0.3	5.3	2.9	0.7
Not further specified transport	0.0	0.0	10.6	0.0	0.0	0.0	0.0	0.0	0.0	1.8
Fall or jump	2.1	21.6	0.0	45.3	0.0	16.6	21.8	0.0	4.4	26.7
Water related	0.0	3.9	0.0	3.1	0.0	3.7	4.5	0.0	4.4	2.7
Fire or explosion	0.0	3.1	0.7	2.3	0.0	2.7	3.1	1.8	8.8	2.1
Involving firearm	0.0	0.0	0.0	0.1	0.0	0.1	0.2	0.0	0.0	0.1
Involving sharp objects	0.0	0.1	0.0	0.2	0.0	< 0.1	< 0.1	0.0	0.0	0.1
Involving blunt objects or a blunt weapon	1.0	2.6	0.0	0.9	0.0	2.9	0.0	0.0	1.5	0.8
Strangulation	0.0	0.3	0.0	< 0.1	0.0	0.1	0.0	0.0	0.0	< 0.1
Other specified accidental exposure to mechanical force	0.0	0.3	0.0	2.0	0.0	0.7	1.9	0.0	0.0	1.3
Not further specified accidental exposure to mechanical force	0.0	0.0	0.0	0.0	0.0	0.0	< 0.1	0.0	0.0	< 0.1
Environmental threat	0.0	3.3	0.0	1.3	0.0	3.4	2.1	1.8	1.5	1.4
Animal related	0.0	0.1	0.0	0.1	0.0	0.3	0.1	0.0	0.0	0.1
Health care events	5.2	0.3	0.1	0.9	0.0	0.6	2.3	0.0	0.0	0.9
Electricity	0.0	0.3	0.0	0.3	0.0	0.3	0.0	0.0	0.0	0.2
Poisoining / acute drug toxicity	0.0	13.6	0.2	14.5	0.0	3.1	32.6	0.0	1.5	13.0
Other specified non-transport	0.0	1.7	0.0	0.0	0.0	10.8	8.3	1.8	1.5	2.7
Not further specified non-transport	0.0	6.1	0.0	0.0	0.0	0.7	2.4	0.0	0.0	0.7
Other specified	2.1	0.0	0.0	4.7	0.0	0.8	0.0	3.5	2.9	2.2
Not specified	43.3	0.9	77.5	0.0	100.0	0.6	0.1	43.9	25.0	18.9

Note: Sum of columns may be greater than 100%, as multiple circumstances of injury are sometimes stated for a single case.
Source: Statistics Canada, Canadian Coroner and Medical Examiner Database, 2006 to 2008.

Suicides

All deaths where a self-inflicted injury initiates the chain of events ending in death and where the decedent intends to cause their own death are classified as suicides. After natural and accidental manner of death, suicide is the manner of death most often investigated by coroners and medical examiners.

Among deaths that occurred in the period 2006 to 2008, coroners and medical examiners investigated 10,217 suicides. Males accounted for nearly three quarters or more of suicides in all provinces and territories (73% in Saskatchewan to 90% in the Yukon), and with some exception, the highest proportion of coroner or medical examiner cases deemed suicide among the age groups belonged to those aged 30 to 49 years. In the Northwest Territories, however, decedents aged 15 to 29 accounted for half or more of all

suicides. Unlike natural and accidental deaths, men aged 90 and older accounted for more suicides than their female counterparts.

Table 11 Distribution of suicides investigated by a coroner or medical examiner, by sex and age group, Provinces and Territories, 2006 to 2008

	P.E.I.	N.B.	Que.	Ont.	Sask.	Alta.	B.C.	Y.T.	N.W.T	All provinces and territories
	percent									
Males										
5 to 14 years	0.0	0.7	0.5	0.3	1.3	0.3	0.1	0.0	0.0	0.4
15 to 29 years	16.7	16.3	13.5	13.4	23.6	17.2	14.0	20.0	40.9	14.6
30 to 49 years	30.6	28.0	33.8	31.1	25.7	29.9	27.9	40.0	31.8	31.1
50 to 69 years	30.6	27.3	23.6	22.2	14.3	20.6	23.1	30.0	9.1	22.4
70 to 89 years	11.1	8.2	5.7	7.6	7.8	5.0	9.2	0.0	0.0	6.8
90 years and over	0.0	0.4	0.4	0.3	0.3	0.7	0.4	0.0	0.0	0.4
All ages	**88.9**	**80.9**	**77.5**	**75.0**	**73.0**	**73.7**	**74.7**	**90.0**	**81.8**	**75.8**
Females										
5 to 14 years	0.0	0.7	0.2	0.5	0.5	0.3	0.1	0.0	0.0	0.3
15 to 29 years	2.8	3.5	3.3	4.6	11.2	6.2	3.9	0.0	9.1	4.5
30 to 49 years	2.8	8.9	8.9	10.2	7.5	11.2	9.5	10.0	9.1	9.6
50 to 69 years	5.6	5.0	8.3	7.6	6.2	7.1	9.1	0.0	0.0	7.8
70 to 89 years	0.0	1.1	1.8	2.1	1.6	1.3	2.5	0.0	0.0	1.9
90 years and over	0.0	0.0	0.1	0.1	0.0	0.1	0.1	0.0	0.0	0.1
All ages	**11.1**	**19.1**	**22.5**	**25.0**	**27.0**	**26.3**	**25.3**	**10.0**	**18.2**	**24.2**

Note: Excludes 7 cases where sex and/or age were not specified.
Source: Statistics Canada, Canadian Coroner and Medical Examiner Database, 2006 to 2008.

The circumstances of injury enable us to identify the mechanism of death in the case of suicides. Tables 12-A and 12-B provide the circumstances of injury for deaths deemed to be suicides by coroners and medical examiners, for men and women respectively. Note that Saskatchewan does not routinely collect this information, and it is rarely provided in the case of suicides in Prince Edward Island, Quebec, and to a lesser extent the Yukon. In cases where other circumstances are specified, often (89% of instances; 98% of instances in Ontario and in Alberta, and 64% of instances in British Columbia) reference is made to hanging or asphyxiation, and should be assigned one of the standard codes. With that in mind, where circumstances are provided, strangulation (hanging and other forms of self-asphyxiation), firearms, poisoning / acute drug toxicity (intentional drug overdose) and fall or jump are most often cited, though the order of importance varied by sex and jurisdiction. Strangulation was most often a circumstance of death in male suicides (over 40% in Ontario), followed by drug overdose and use of a firearm. For women, drug overdose was most often a circumstance of death (cited in over half of female suicides in both Alberta and British Columbia), followed by strangulation and a smaller proportion attributed to fall or jump.

Table 12-A Distribution of suicides investigated by a coroner or medical examiner, by circumstances of injury, men, Provinces and Territories, 2006 to 2008

Circumstances of injury	P.E.I.	N.B.	Que.	Ont.	Sask.	Alta.	B.C.	Y.T.	N.W.T	All provinces and territories
	percent									
Land transportation	0.0	2.2	0.1	2.2	0.0	2.2	2.3	0.0	0.0	1.4
Other specified transport	0.0	0.0	0.0	3.0	0.0	0.0	0.0	0.0	0.0	1.0
Not further specified transport	0.0	0.0	0.6	0.0	0.0	0.0	0.0	0.0	0.0	0.2
Fall or jump	0.0	2.6	0.0	8.4	0.0	2.8	9.2	0.0	5.6	4.4
Water related	0.0	1.8	0.0	2.1	0.0	1.3	3.0	0.0	0.0	1.3
Fire or explosion	0.0	0.4	0.0	0.3	0.0	0.6	0.3	0.0	0.0	0.2
Involving firearm	6.3	34.2	0.0	15.8	0.0	23.6	19.9	0.0	33.3	12.0
Involving sharp objects	0.0	1.8	0.0	3.9	0.0	3.5	2.7	0.0	0.0	2.1
Involving blunt objects or a blunt weapon	0.0	1.3	0.0	0.0	0.0	0.2	0.0	0.0	0.0	0.1
Strangulation	3.1	28.1	0.0	0.3	0.0	0.3	0.0	0.0	27.8	1.0
Other specified violence or exposure to mechanical force	0.0	0.0	0.0	41.6	0.0	0.0	1.7	0.0	5.6	13.4
Environmental threat	0.0	0.9	0.0	7.0	0.0	0.2	0.2	0.0	0.0	2.3
Health care events	0.0	0.0	0.1	0.1	0.0	0.0	1.4	0.0	0.0	0.3
Electricity	0.0	0.0	0.0	0.1	0.0	0.1	0.0	0.0	0.0	0.1
Poisoining / acute drug toxicity	0.0	15.8	0.0	12.8	0.0	28.2	27.8	0.0	0.0	12.1
Other specified non-transport	0.0	0.4	0.0	0.0	0.0	36.5	35.4	22.2	0.0	9.8
Not further specified non-transport	0.0	7.9	0.0	0.0	0.0	0.2	0.9	0.0	0.0	0.4
Other specified	0.0	0.0	0.0	2.5	0.0	0.0	0.0	0.0	0.0	0.8
Not specified	90.6	2.6	99.2	0.0	100.0	0.5	0.0	77.8	27.8	38.0

Note: Sum of columns may be greater than 100%, as multiple circumstances of injury are sometimes stated for a single case.
Source: Statistics Canada, Canadian Coroner and Medical Examiner Database, 2006 to 2008.

Table 12-B Distribution of suicides investigated by a coroner or medical examiner, by circumstances of injury, women, Provinces and Territories, 2006 to 2008

Circumstances of injury	P.E.I.	N.B.	Que.	Ont.	Sask.	Alta.	B.C.	Y.T.	N.W.T	All provinces and territories
	percent									
Land transportation	0.0	1.9	0.0	1.6	0.0	1.1	0.8	0.0	0.0	0.8
Other specified transport	0.0	0.0	0.0	3.5	0.0	0.0	0.0	0.0	0.0	1.2
Not further specified transport	0.0	0.0	0.8	0.0	0.0	0.0	0.0	0.0	0.0	0.2
Fall or jump	0.0	3.7	0.0	11.1	0.0	2.7	12.1	0.0	0.0	5.9
Water related	0.0	5.6	0.0	3.7	0.0	1.3	4.2	0.0	0.0	2.1
Fire or explosion	0.0	0.0	0.0	1.1	0.0	0.3	0.3	0.0	0.0	0.4
Involving firearm	0.0	1.9	0.0	1.3	0.0	3.2	3.1	0.0	0.0	1.4
Involving sharp objects	0.0	5.6	0.0	2.0	0.0	2.4	2.3	0.0	0.0	1.5
Involving blunt objects or a blunt weapon	0.0	1.9	0.0	0.0	0.0	0.3	0.0	0.0	0.0	0.1
Strangulation	0.0	27.8	0.0	0.2	0.0	0.3	0.0	0.0	75.0	0.8
Other specified violence or exposure to mechanical force	0.0	0.0	0.0	30.5	0.0	0.0	1.1	0.0	0.0	10.3
Environmental threat	0.0	0.0	0.0	3.7	0.0	0.0	0.6	0.0	0.0	1.3
Health care events	0.0	0.0	0.0	0.0	0.0	0.0	2.3	0.0	0.0	0.3
Electricity	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.0	0.0	< 0.1
Poisoining / acute drug toxicity	0.0	40.7	0.0	37.8	0.0	55.3	51.7	0.0	25.0	29.2
Other specified non-transport	0.0	0.0	0.0	0.0	0.0	32.1	26.0	0.0	0.0	8.6
Not further specified non-transport	0.0	7.4	0.0	0.0	0.0	0.3	0.6	0.0	0.0	0.3
Other specified	0.0	0.0	0.0	3.4	0.0	0.3	0.0	0.0	0.0	1.2
Not specified	100.0	3.7	99.2	0.0	100.0	0.8	0.6	100.0	0.0	35.2

Note: Sum of columns may be greater than 100%, as multiple circumstances of injury are sometimes stated for a single case.
Source: Statistics Canada, Canadian Coroner and Medical Examiner Database, 2006 to 2008.

Homicides

Homicides include all deaths where an injury initiates the chain of events ending in death and there is evidence to indicate some intent on the part of another individual to cause harm. Among deaths that occurred in the period 2006 to 2008, coroners and medical examiners investigated 1,554 homicides, making it the least frequently assigned manner of death. Males accounted for three quarters of all homicides, with males in the 15 to 29 age group representing the victims of one third of all homicides. Among women, those aged 30 to 49 years represented the largest share of victims.

Table 13 Distribution of homicides investigated by a coroner or medical examiner, by sex and age group, Provinces and Territories, 2006 to 2008

	P.E.I.	N.B.	Que.	Ont.	Sask.	Alta.	B.C.	Y.T.	N.W.T	All provinces and territories
	percent									
Males										
0 to 4 years	0.0	4.5	1.5	2.0	2.0	1.0	0.0	0.0	0.0	1.4
5 to 14 years	0.0	0.0	1.2	1.9	0.0	1.0	1.5	0.0	0.0	1.4
15 to 29 years	0.0	9.1	22.3	35.3	42.0	39.4	33.7	50.0	33.3	33.7
30 to 49 years	100.0	36.4	23.5	22.9	30.0	27.2	31.1	0.0	66.7	26.0
50 to 69 years	0.0	13.6	16.2	8.0	9.0	8.9	9.5	0.0	0.0	9.9
70 to 89 years	0.0	0.0	5.0	3.9	3.0	3.0	0.7	0.0	0.0	3.2
90 years and over	0.0	0.0	0.0	0.2	0.0	0.0	0.0	0.0	0.0	0.1
All ages	**100.0**	**63.6**	**69.6**	**74.2**	**86.0**	**80.5**	**76.6**	**50.0**	**100.0**	**75.7**
Females										
0 to 4 years	0.0	0.0	0.4	1.7	3.0	1.0	0.4	0.0	0.0	1.2
5 to 14 years	0.0	0.0	0.8	1.2	0.0	0.7	0.7	0.0	0.0	0.8
15 to 29 years	0.0	9.1	7.3	7.3	4.0	6.3	4.8	50.0	0.0	6.5
30 to 49 years	0.0	18.2	12.3	9.2	4.0	7.9	10.3	0.0	0.0	9.4
50 to 69 years	0.0	9.1	5.4	4.2	3.0	2.0	4.0	0.0	0.0	3.9
70 to 89 years	0.0	0.0	4.2	2.2	0.0	1.7	3.3	0.0	0.0	2.4
90 years and over	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
All ages	**0.0**	**36.4**	**30.4**	**25.8**	**14.0**	**19.5**	**23.4**	**50.0**	**0.0**	**24.3**

Note: Excludes 2 cases where sex and/or age were not specified.
Source: Statistics Canada, Canadian Coroner and Medical Examiner Database, 2006 to 2008.

As death and the event leading to death sometimes occur in different locations, the place of death provides little insight into such deaths. For example, death often occurs or is pronounced in a hospital following an injury sustained elsewhere. Table 14 presents the distribution of homicides by place of the event leading to death type. Where this information is provided—Saskatchewan does not routinely collect this information, and it is not specified elsewhere—the largest share of homicides occurred in private residences, followed by the countryside, which includes remote areas and provincial and national parks; recreational, public, entertainment and commercial areas; and, transport areas, which include roadways, sidewalks, railways, air, water and land transportation terminals and some transport vehicles.

For more comprehensive information on homicide, researchers might be better served using data that incorporate police and coroner or medical examiner findings. That being said, the CCMED does provide a convenient source of information for examining

certain topics that cut across manners of death, for example deaths involving firearms, which could involve any combination of homicides, suicides, accidental and undetermined deaths.

Table 14 Distribution of homicides investigated by a coroner or medical examiner, by place of event leading to death, Provinces and Territories, 2006 to 2008

Place of event	P.E.I.	N.B.	Que.	Ont.	Sask.	Alta.	B.C.	Y.T.	N.W.T	All provinces and territories
	percent									
Private residence	0.0	59.1	58.2	43.3	.	44.7	50.9	0.0	33.3	47.8
Residential or correctional institution	0.0	0.0	2.3	2.0	.	0.0	1.1	0.0	0.0	1.4
Medical services facility	0.0	4.5	0.0	2.7	.	1.3	0.7	50.0	33.3	1.7
School, eductional facility, daycare	0.0	0.0	0.0	0.3	.	0.0	0.4	0.0	0.0	0.2
Sports and athletics facility	0.0	0.0	0.0	0.0	.	0.0	0.4	0.0	0.0	0.1
Recreational/public/entertainment/commercial area	0.0	4.5	12.3	11.0	.	18.5	6.2	0.0	33.3	11.8
Transport area	0.0	22.7	11.9	0.2	.	14.9	25.3	0.0	0.0	10.4
Industrial/construction area or place of primary production	0.0	0.0	0.0	0.2	.	0.7	0.0	0.0	0.0	0.2
Farm or ranch	0.0	0.0	0.0	0.0	.	0.7	0.0	0.0	0.0	0.1
Countryside	0.0	9.1	1.1	27.7	.	3.6	0.7	0.0	0.0	12.5
Body of water	0.0	0.0	0.4	0.2	.	0.0	2.9	50.0	0.0	0.8
Other specified place of death	0.0	0.0	8.4	12.4	.	0.0	0.0	0.0	0.0	6.5
Not specified	100.0	0.0	5.4	0.0	.	15.6	11.4	0.0	0.0	6.4

Source: Statistics Canada, Canadian Coroner and Medical Examiner Database, 2006 to 2008.

Undetermined deaths

Undetermined deaths are those where there is significant doubt as to which of the previous manners the death should be attributed. Among deaths that occurred in the period 2006 to 2008, coroners and medical examiners investigated 3,853 deaths where it was not possible to determine the manner of death. Deaths of people aged 30 to 69 years of age accounted for over 70% of all such deaths. As was the case for natural and accidental deaths, the decedent is male in 63% of coroner and medical examiner cases where the manner of death could not be determined.

It might be difficult to understand the circumstances under which the manner of death could not be determined. Review of the coroner's or medical examiner's narrative (currently unavailable for New Brunswick and Quebec) and information regarding the cause and conditions of death from the death certificate might reveal the exact nature of debate, for example accidental death vs. suicide. Closer study of a sample of these cases indicates that they are predominantly a mixture of cases where medication or drug overdose occurred, or situations where these and/or alcohol were used; sudden and unexplained deaths of infants; and, situations where elements that would suggest

intentional harm or injury were present, but where there was insufficient evidence to conclude intent.

Table 15 Distribution of coroner or medical examiner investigations where the manner of death is undetermined, by sex and age group, Provinces and Territories, 2006 to 2008

	P.E.I.	N.B.	Que.	Ont.	Sask.	Alta.	B.C.	Y.T.	N.W.T	All provinces and territories
	percent									
Males										
0 to 4 years	5.9	4.3	1.9	7.5	9.2	1.3	12.1	16.7	0.0	5.3
5 to 14 years	0.0	0.0	1.1	0.3	0.0	0.5	1.0	0.0	0.0	0.5
15 to 29 years	0.0	6.4	10.0	6.7	5.0	9.5	6.4	16.7	0.0	7.9
30 to 49 years	5.9	10.6	26.1	23.6	26.7	33.0	20.0	16.7	100.0	26.8
50 to 69 years	41.2	29.8	13.0	18.7	12.5	21.6	16.9	16.7	0.0	19.2
70 to 89 years	17.6	6.4	5.7	4.2	0.8	1.9	6.7	16.7	0.0	3.7
90 years and over	0.0	0.0	0.0	0.3	0.0	0.0	0.2	0.0	0.0	0.1
All ages	**70.6**	**57.4**	**57.9**	**61.2**	**54.2**	**67.8**	**63.2**	**83.3**	**100.0**	**63.5**
Females										
0 to 4 years	0.0	10.6	0.0	4.3	11.7	0.8	6.9	0.0	0.0	3.3
5 to 14 years	0.0	0.0	0.8	0.1	0.0	0.1	0.2	0.0	0.0	0.2
15 to 29 years	11.8	0.0	5.0	2.4	7.5	3.3	5.0	0.0	0.0	3.4
30 to 49 years	5.9	6.4	19.5	13.1	15.0	16.4	9.5	0.0	0.0	14.3
50 to 69 years	5.9	8.5	13.8	13.8	9.2	10.9	10.5	16.7	0.0	12.1
70 to 89 years	5.9	12.8	2.7	4.2	1.7	0.7	4.5	0.0	0.0	2.8
90 years and over	0.0	4.3	0.4	0.7	0.8	0.0	0.2	0.0	0.0	0.4
All ages	**29.4**	**42.6**	**42.1**	**38.8**	**45.8**	**32.2**	**36.8**	**16.7**	**0.0**	**36.5**

Note: Excludes 14 cases where sex and/or age were not specified.
Source: Statistics Canada, Canadian Coroner and Medical Examiner Database, 2006 to 2008.

Inquests and recommendations

Inquests are held in order to inform the public of the circumstances surrounding a specific death and to make policy recommendations to prevent similar deaths from occurring in the future. The CCMED does not track the number of recommendations that were made for a specific case or the details of specific recommendations. However, it does keep track of whether or not recommendations were made for each case by the coroner or medical examiner or by a jury, provided this information is available from the province or territory. The availability of such information strengthens the preventive role of the CCMED. This data can be of great assistance for researchers and other coroners or medical examiners to search for similar cases and learn from the experience of other jurisdictions.

Among deaths investigated by a coroner or medical examiner that occurred in the period 2006 to 2008, there were a total of 791 for which an inquest was, or would be, held. This represents less than 1% of all coroner or medical examiner cases during this time. While Ontario held the highest number of inquests (595), the Yukon had the highest percentage of cases for which inquests were held (almost 2%), although inquests in the territories and Prince Edward Island were infrequent. And while inquests were more

frequent in cases of natural (278) and accidental (266) deaths, an inquest was most likely in the case of a homicide (3.7%) or death where the manner could not be determined (3.2%). These last results are driven by Ontario, where inquests were held in 6.4% of homicides and 6.8% of undetermined deaths.

Table 16 Number and percentage of coroner or medical examiner cases where inquests were held, by manner, Provinces and Territories, 2006 to 2008

	Manner of death					Total /
	Natural	Accident	Suicide	Homicide	Undetermined	Average
Prince Edward Island						
Number	4	0	0	0	0	4
Percent	0.7	0.0	0.0	0.0	0.0	0.6
Quebec						
Number	21	6	0	0	0	27
Percent	0.5	0.2	0.0	0.0	0.0	0.2
Ontario						
Number	242	168	45	38	102	595
Percent	0.6	1.6	1.4	6.4	6.8	1.1
Alberta						
Number	9	48	15	9	20	101
Percent	0.2	1.8	1.1	3.0	1.4	0.9
British Columbia						
Number	1	42	5	11	2	61
Percent	0.0	1.0	0.4	4.0	0.5	0.6
Yukon						
Number	1	2	0	0	0	3
Percent	1.2	3.5	0.0	0.0	0.0	1.9
Northwest Territories						
Number	0	1	0	0	0	1
Percent	0.0	1.5	0.0	0.0	0.0	0.4
All provinces and territories						
Number	278	266	65	58	124	791
Percent	0.5	1.2	0.6	3.7	3.2	0.8

Note: Information regarding inquests is not available for New Brunswick and Saskatchewan.
Source: Statistics Canada, Canadian Coroner and Medical Examiner Database, 2006 to 2008.

Recommendations were made in 1,225 coroner or medical examiner cases over the period 2006 to 2008. Quebec accounted for over half of these, with recommendations made in 845 cases, however it is in the Northwest Territories where recommendations were most likely (10% of cases). Recommendations are most likely in the case of an accidental death—recommendations were made in 3.1% of accidents investigated by a coroner or medical examiner —though the percentage varies greatly by province and territory.

Table 17 Number and percentage of coroner or medical examiner cases where recommendations were made, by manner, Provinces and Territories, 2006 to 2008

	Manner of death					Total /
	Natural	Accident	Suicide	Homicide	Undetermined	Average
New Brunswick						
Number	6	25	7	1	0	39
Percent	0.2	3.6	2.5	4.5	0.0	0.8
Quebec						
Number	196	499	108	3	39	845
Percent	4.5	13.0	3.2	1.1	14.8	7.0
Ontario						
Number	22	16	12	1	5	56
Percent	0.1	0.2	0.4	0.2	0.3	0.1
Alberta						
Number	4	21	10	2	11	48
Percent	0.1	0.8	0.7	0.7	0.7	0.4
British Columbia						
Number	38	137	12	12	7	206
Percent	0.8	3.4	0.9	4.4	1.7	1.9
Yukon						
Number	1	7	0	0	0	8
Percent	1.2	12.3	0.0	0.0	0.0	5.1
Northwest Territories						
Number	5	18	0	0	0	23
Percent	3.9	26.5	0.0	0.0	0.0	10.2
All provinces and territories						
Number	272	723	149	19	62	1225
Percent	0.5	3.1	1.5	1.2	1.6	1.2

Note: Information regarding recommendations is not available for Prince Edward Island and Saskatchewan.
Source: Statistics Canada, Canadian Coroner and Medical Examiner Database, 2006 to 2008.

Future Work

The preceding pages have profiled the work of nine of the provincial and territorial coroner and medical examiners, while touching on some of the strengths and limitations of the CCMED. In the future, more focused research topics—for example, deaths involving snowmobiles—will be used to unleash the true analytic and investigative potential of the database. Statistics Canada will continue to work with the project stakeholders, the coroners and medical examiners and the research community to improve the quality, completeness and usefulness of the CCMED. We hope to obtain data from all provinces and territories to make the CCMED a truly representative national coroner and medical examiner database. We will investigate also possible enhancements to the database by linking the CCMED to additional data sources to provide even greater context to the coroner and medical examiner data. One such data product is the Canadian Vital Statistics: Death Database (CVS-D).

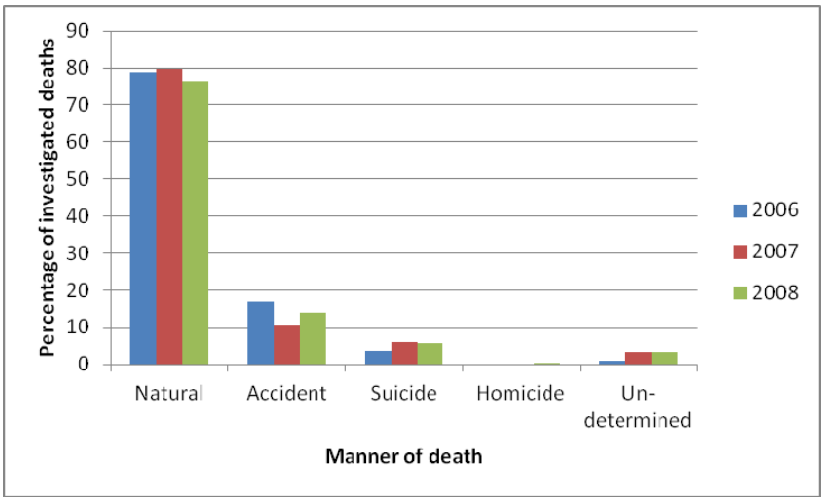
Record linkage of the CCMED to Canadian Vital Statistics: Death Database

A record linkage of the CCMED with the CVS-D will allow the ICD-10 underlying cause and multiple cause-of-death codes to be added to each CCMED record. The underlying cause of death codes are used to select records for particular statistical reports and research projects, and to compare statistics derived from the CCMED with those from other sources, including the CVS-D, that use ICD codes. The CCMED/CVS-D linkage will allow for a complementary and comprehensive analysis of death data which will be extremely valuable for injury prevention and health and safety research, and the development of public health policy.

Data from the CCMED will complement the information we currently have on the CVS-D. The coroner and medical examiner data provide an in-depth analysis of the circumstances surrounding injury-related deaths, including the use safety devices, the activity at the time of the event leading to death, and the place of the event leading to death. This valuable detail is not available in the CVS-D. The length of time required to finalize a coroner or medical examiner investigation may range from a few days to 2 years. As a result, the final decision of the coroner or medical examiner in determining the cause of death may not be incorporated into the CVS-D in time for publication. This may lead to an underestimation of the number of suicides, homicides, and unintentional injuries (accidents) in the mortality data published by Statistics Canada. This in turn leads to an overestimation in the number of deaths classified as “unknown” since they may still be under investigation.

Appendix A: Distribution of coroner or medical examiner cases by manner and year

Figure A-1 Distribution of coroner or medical examiner cases by manner of death, Prince Edward Island, 2006 to 2008

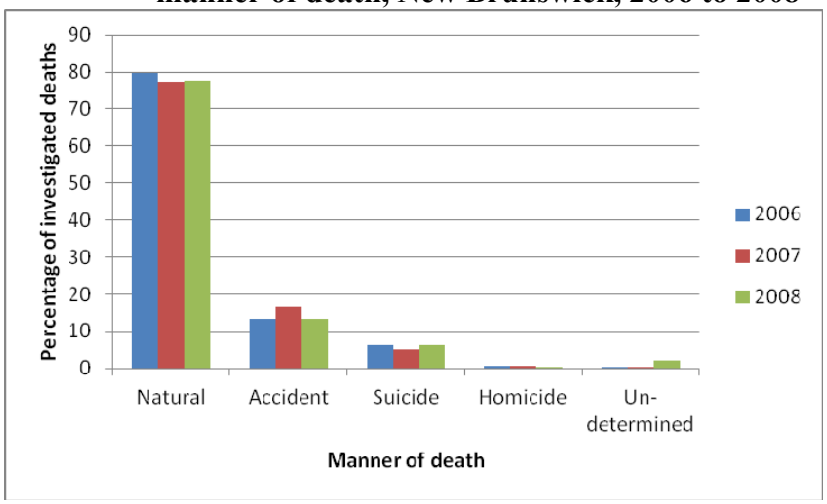


Source: Statistics Canada, Canadian Coroner and Medical Examiner Database, 2006 to 2008.

Natural deaths represented the majority of caseload share in Prince Edward Island (Figure A-1), accounting for 76% to 80% of coroner or medical examiner investigations annually. These were followed by accidental deaths (11% to 17%), suicides (4% to 6%), undetermined deaths (1% to 3%) and homicides (there was single homicide investigated by the coroner's office over the period 2006 to 2008). In general, caseload shares were stable over the three-year period, with slight increases to the proportion of suicides and undetermined deaths in 2007 and 2008 compared to 2006.

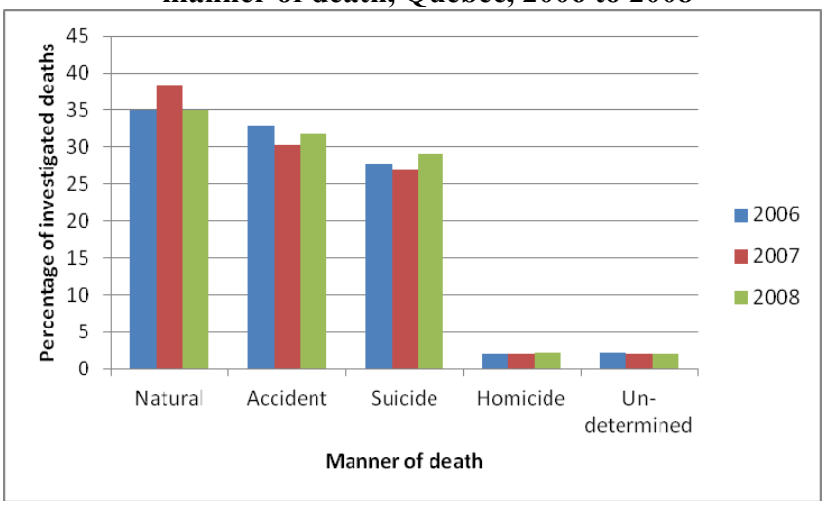
Natural deaths represented the majority of caseload share in New Brunswick (Figure A-2), accounting for 77% to 80% of coroner or medical examiner investigations annually. These were followed by accidental deaths (13% to 17%), suicides (5% to 6%) and homicides (less than 1%) or undetermined deaths (less than 1% to 2%). In general, caseload shares were stable over the three-year period.

Figure A-2 Distribution of coroner or medical examiner cases by manner of death, New Brunswick, 2006 to 2008



Source: Statistics Canada, Canadian Coroner and Medical Examiner Database, 2006 to 2008.

Figure A-3 Distribution of coroner or medical examiner cases by manner of death, Quebec, 2006 to 2008

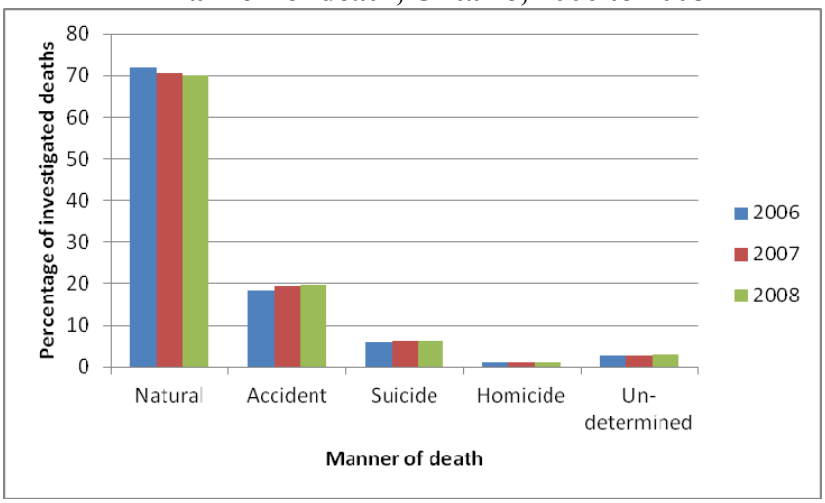


Source: Statistics Canada, Canadian Coroner and Medical Examiner Database, 2006 to 2008.

Natural deaths represented the largest portion of caseload in Quebec (Figure A-3), accounting for 35% to 38% of coroner or medical examiner investigations annually. These were followed closely by accidental deaths (30% to 33%) and suicides (27% to 29%). Homicides and undetermined deaths each accounted for approximately 2% of coroner or medical examiner investigations annually. In general, caseload shares were stable over the three year period, with greater agreement between 2006 and 2008 than with 2007.

In Ontario (Figure A-4), natural deaths represented the majority of caseload share, accounting for 70% to 72% of coroner or medical examiner investigations annually. These were followed by accidental deaths (18% to 20%), suicides (around 6%), undetermined deaths (around 3%) and homicides (around 1%). Caseload shares were stable over the three-year period.

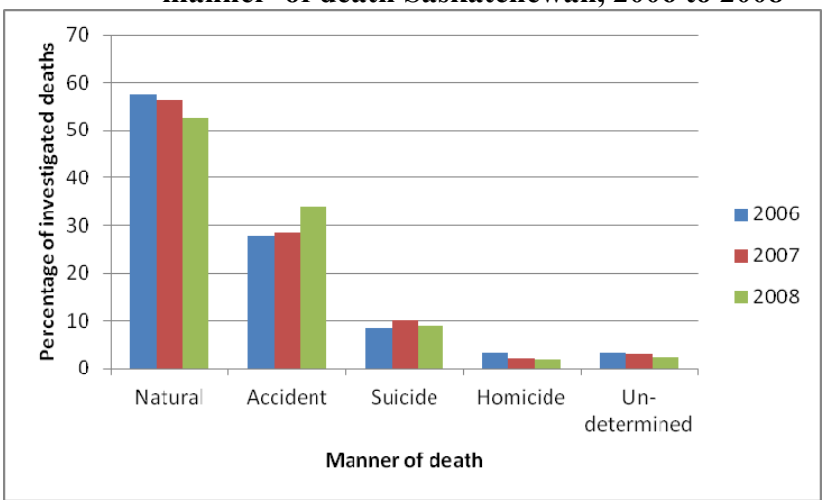
Figure A-4 Distribution of coroner or medical examiner cases by manner of death, Ontario, 2006 to 2008



Source: Statistics Canada, Canadian Coroner and Medical Examiner Database, 2006 to 2008.

Natural deaths represented the majority of caseload share in Saskatchewan (Figure A-5), accounting for 53% to 57% of coroner or medical examiner investigations annually. These were followed by accidental deaths (28% to 34%), suicides (8% to 10%) and homicides (2% to 3%) or undetermined deaths (2% to 3%). The increase in the share of accidental deaths over the three year period is offset in most part by a decrease in the share of natural deaths over the same period.

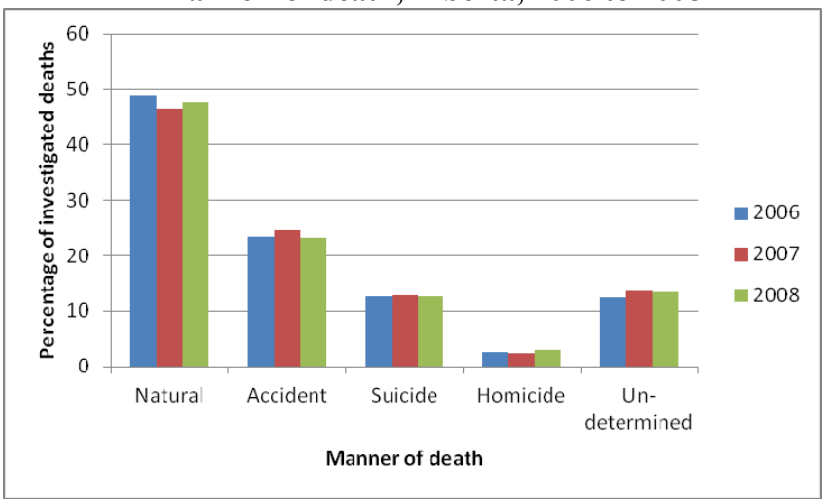
Figure A-5 Distribution of coroner or medical examiner cases by manner of death Saskatchewan, 2006 to 2008



Source: Statistics Canada, Canadian Coroner and Medical Examiner Database, 2006 to 2008.

In Alberta (Figure A-6), natural deaths represented the largest portion of caseload, accounting for 47% to 48% of coroner or medical examiner investigations annually. These were followed by accidental deaths (23% to 25%), undetermined deaths (12% to 14%), suicides (around 13%) and homicides (2% to 3%). Caseload shares were stable over the three-year period.

Figure A-6 Distribution of coroner or medical examiner cases by manner of death, Alberta, 2006 to 2008

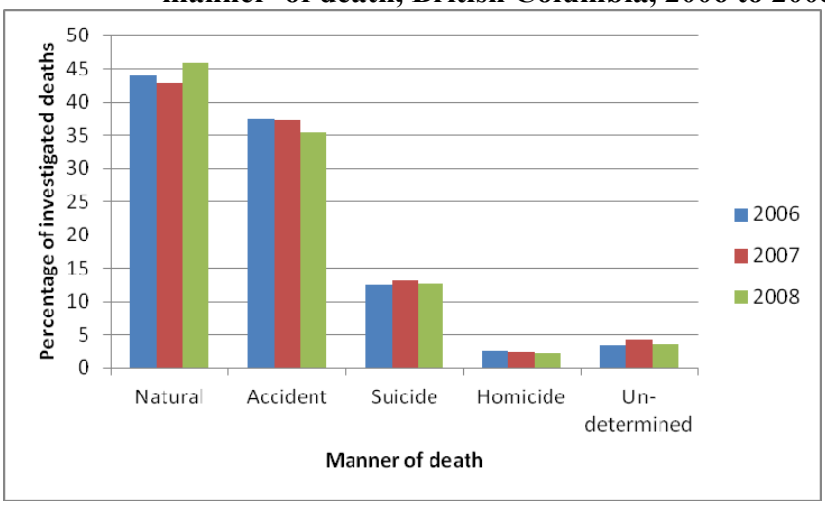


Source: Statistics Canada, Canadian Coroner and Medical Examiner Database, 2006 to 2008.

Natural deaths represented the largest portion of caseload in British Columbia (Figure A-7), accounting for 43% to 46% of coroner or medical examiner investigations annually. These were followed by accidental deaths (35% to 37%), suicides (12% to 13%), undetermined deaths (3% to 4%) and homicides (2% to 3%). Annual caseload

shares were stable, with small decreases to the share of accidental deaths and homicides over the three years.

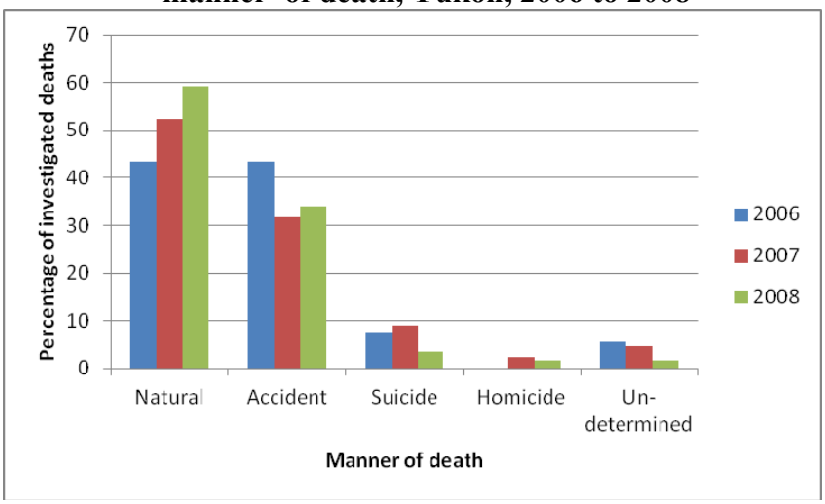
Figure A-7 Distribution of coroner or medical examiner cases by manner of death, British Columbia, 2006 to 2008



Source: Statistics Canada, Canadian Coroner and Medical Examiner Database, 2006 to 2008.

In the Yukon (Figure A-8), natural deaths represented the largest portion of caseload, accounting for 43% to 59% of coroner or medical examiner investigations annually. These were followed by accidental deaths (32% to 43%), suicides (3% to 9%), undetermined deaths (2% to 6%) and homicides (0% to 2%). The Yukon showed greater variability in caseload share than the provinces, with a relatively large increase in the proportion of deaths deemed natural in 2007 (9 percentage points) and again in 2008 (7 percentage points), and a considerable decrease (11 percentage points) in the proportion of deaths deemed accidental in 2007. Smaller changes are observed for the other manners.

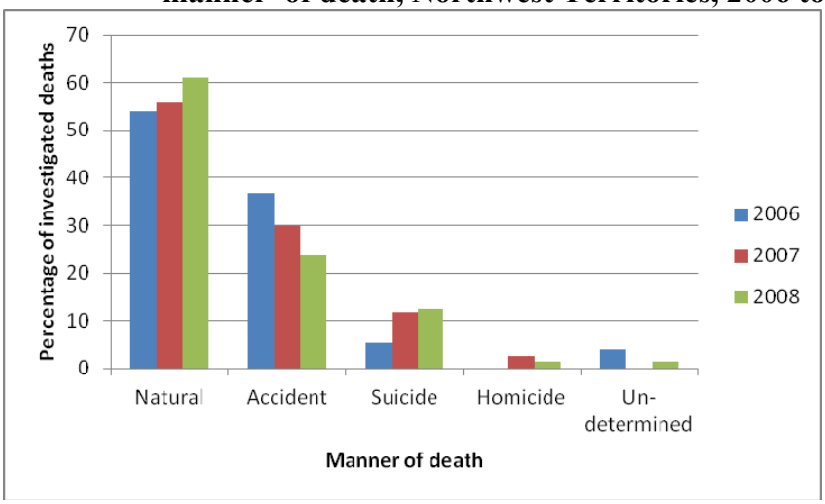
Figure A-8 Distribution of coroner or medical examiner cases by manner of death, Yukon, 2006 to 2008



Source: Statistics Canada, Canadian Coroner and Medical Examiner Database, 2006 to 2008.

In the Northwest Territories (Figure A-9), natural deaths represented the majority of caseload share, accounting for 54% to 61% of coroner or medical examiner investigations annually. These were followed by accidental deaths (24% to 37%), suicides (5% to 13%) and homicides (0% to 3%) or undetermined deaths (0% to 4%). Like the Yukon, the Northwest Territories showed greater variability to in caseload share than the provinces, with relatively large increases in the proportion of deaths deemed natural (7 percentage points) or suicide (8 percentage points) over the three year period, and a considerable decrease (13 percentage points) in the proportion deaths deemed accidental. Smaller changes are observed elsewhere.

Figure A-9 Distribution of coroner or medical examiner cases by manner of death, Northwest Territories, 2006 to 2008



Source: Statistics Canada, Canadian Coroner and Medical Examiner Database, 2006 to 2008.

Appendix B: Coroner or medical examiner cases by age group and manner

Natural deaths account for the largest proportion—and the majority in most provinces—of coroner or medical examiner investigations involving the death of a person aged 0 to 11 months (49% to 83% in the provinces; Table B-1). This is generally followed by undetermined deaths and accidents, with only a small number of homicides. This is the age group with the highest proportion of cases for which the manner of death could not be determined. The smaller jurisdictions investigated very few deaths in this age group.

Table B-1 Distribution of deaths of people aged 0 to 11 months investigated by a coroner or medical examiner, by manner of death, Provinces and Territories, 2006 to 2008

	P.E.I.	N.B.	Que.	Ont.	Sask.	Alta.	B.C.	Y.T.	N.W.T	All provinces and territories
Natural										
Number of deaths investigated	1	29	88	269	31	108	106	1	9	642
Percentage of all investigations	50.0	82.9	72.7	57.1	49.2	71.1	55.8	100.0	90.0	61.4
Accident										
Number of deaths investigated	0	1	26	39	8	14	11	0	1	100
Percentage of all investigations	0.0	2.9	21.5	8.3	12.7	9.2	5.8	0.0	10.0	9.6
Suicide										
Number of deaths investigated	0	0	0	0	0	0	0	0	0	0
Percentage of all investigations	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Homicide										
Number of deaths investigated	0	0	4	8	4	2	0	0	0	18
Percentage of all investigations	0.0	0.0	3.3	1.7	6.3	1.3	0.0	0.0	0.0	1.7
Undetermined										
Number of deaths investigated	1	5	3	155	20	28	73	0	0	285
Percentage of all investigations	50.0	14.3	2.5	32.9	31.7	18.4	38.4	0.0	0.0	27.3

Source: Statistics Canada, Canadian Coroner and Medical Examiner Database, 2006 to 2008.

Natural deaths account for the largest proportion—and the majority in most provinces and territories—of coroner or medical examiner investigations involving the death of a person aged 12 to 23 months (43% to 67% in the provinces; Table B-2). This is generally followed by accidents and undetermined deaths, with only a small number of homicides. The smaller jurisdictions investigated very few, if any, deaths in this age group.

Depending on the province, accidental or natural deaths accounted for the largest proportion of coroner or medical examiner investigations involving the death of a person aged 2 to 4 years (32% to 68% and 17% to 56% respectively; Table B-3), with the other representing the second largest. Homicides and undetermined deaths accounted for only a small number of cases. The smaller jurisdictions investigated very few, if any, deaths in this age group.

Table B-2 Distribution of deaths of people aged 12 to 23 months investigated by a coroner or medical examiner, by manner of death, Provinces and Territories, 2006 to 2008

	P.E.I.	N.B.	Que.	Ont.	Sask.	Alta.	B.C.	Y.T.	N.W.T	All provinces and territories
Natural										
Number of deaths investigated	0	4	18	32	6	17	14	0	2	93
Percentage of all investigations	...	44.4	54.5	42.7	50.0	54.8	66.7	0.0	66.7	50.3
Accident										
Number of deaths investigated	0	3	14	24	4	10	3	0	1	59
Percentage of all investigations	...	33.3	42.4	32.0	33.3	32.3	14.3	0.0	33.3	31.9
Suicide										
Number of deaths investigated	0	0	0	0	0	0	0	0	0	0
Percentage of all investigations	...	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Homicide										
Number of deaths investigated	0	0	0	5	0	1	0	0	0	6
Percentage of all investigations	...	0.0	0.0	6.7	0.0	3.2	0.0	0.0	0.0	3.2
Undetermined										
Number of deaths investigated	0	2	1	14	2	3	4	1	0	27
Percentage of all investigations	...	22.2	3.0	18.7	16.7	9.7	19.0	100.0	0.0	14.6

Source: Statistics Canada, Canadian Coroner and Medical Examiner Database, 2006 to 2008.

Table B-3 Distribution of deaths of people aged 2 to 4 years investigated by a coroner or medical examiner, by manner of death, Provinces and Territories, 2006 to 2008

	P.E.I.	N.B.	Que.	Ont.	Sask.	Alta.	B.C.	Y.T.	N.W.T	All provinces and territories
Natural										
Number of deaths investigated	1	3	8	62	4	11	19	0	1	109
Percentage of all investigations	100.0	33.3	25.8	53.0	16.7	32.4	55.9	...	100.0	43.4
Accident										
Number of deaths investigated	0	5	21	37	16	20	11	0	0	110
Percentage of all investigations	0.0	55.6	67.7	31.6	66.7	58.8	32.4	...	0.0	43.8
Suicide										
Number of deaths investigated	0	0	0	0	0	0	0	0	0	0
Percentage of all investigations	0.0	0.0	0.0	0.0	0.0	0.0	0.0	...	0.0	0.0
Homicide										
Number of deaths investigated	0	1	1	9	1	3	1	0	0	16
Percentage of all investigations	0.0	11.1	3.2	7.7	4.2	8.8	2.9	...	0.0	6.4
Undetermined										
Number of deaths investigated	0	0	1	9	3	0	3	0	0	16
Percentage of all investigations	0.0	0.0	3.2	7.7	12.5	0.0	8.8	...	0.0	6.4

Source: Statistics Canada, Canadian Coroner and Medical Examiner Database, 2006 to 2008.

Depending on the province, accidental or natural deaths accounted for the largest proportion of coroner or medical examiner investigations involving the death of a person aged 5 to 9 years (41% to 82% and 16% to 52% respectively; Table B-4), with the other representing the second largest. Homicides and undetermined deaths accounted for only a small number of cases. The smaller jurisdictions investigated very few, if any, deaths in this age group.

Table B-4 Distribution of deaths of people aged 5 to 9 years investigated by a coroner or medical examiner, by manner of death, Provinces and Territories, 2006 to 2008

	P.E.I.	N.B.	Que.	Ont.	Sask.	Alta.	B.C.	Y.T.	N.W.T	All provinces and territories
Natural										
Number of deaths investigated	0	0	9	53	4	9	21	0	0	96
Percentage of all investigations	0.0	0.0	16.1	51.5	18.2	17.6	50.0	...	0.0	34.0
Accident										
Number of deaths investigated	2	5	42	42	18	37	17	0	1	164
Percentage of all investigations	100.0	100.0	75.0	40.8	81.8	72.5	40.5	...	100.0	58.2
Suicide										
Number of deaths investigated	0	0	0	0	0	0	0	0	0	0
Percentage of all investigations	0.0	0.0	0.0	0.0	0.0	0.0	0.0	...	0.0	0.0
Homicide										
Number of deaths investigated	0	0	2	7	0	4	3	0	0	16
Percentage of all investigations	0.0	0.0	3.6	6.8	0.0	7.8	7.1	...	0.0	5.7
Undetermined										
Number of deaths investigated	0	0	3	1	0	1	1	0	0	6
Percentage of all investigations	0.0	0.0	5.4	1.0	0.0	2.0	2.4	...	0.0	2.1

Source: Statistics Canada, Canadian Coroner and Medical Examiner Database, 2006 to 2008.

Accidental deaths accounted for the largest proportion of coroner or medical examiner investigations involving the death of a person aged 10 to 12 years (38% to 74%; Table B-5), with natural deaths (9% to 50%) representing the second largest. This is the youngest age group for which suicides were observed. Homicides and undetermined deaths accounted for only a small number of cases. The smaller jurisdictions investigated very few, if any, deaths in this age group.

Table B-5 Distribution of deaths of people aged 10 to 12 years investigated by a coroner or medical examiner, by manner of death, Provinces and Territories, 2006 to 2008

	P.E.I.	N.B.	Que.	Ont.	Sask.	Alta.	B.C.	Y.T.	N.W.T	All provinces and territories
Natural										
Number of deaths investigated	0	4	7	23	1	3	8	0	1	47
Percentage of all investigations	0.0	50.0	20.0	33.3	9.1	11.1	25.0	...	100.0	25.5
Accident										
Number of deaths investigated	1	3	23	35	8	20	19	0	0	109
Percentage of all investigations	100.0	37.5	65.7	50.7	72.7	74.1	59.4	...	0.0	59.2
Suicide										
Number of deaths investigated	0	1	3	5	2	1	1	0	0	13
Percentage of all investigations	0.0	12.5	8.6	7.2	18.2	3.7	3.1	...	0.0	7.1
Homicide										
Number of deaths investigated	0	0	1	3	0	0	1	0	0	5
Percentage of all investigations	0.0	0.0	2.9	4.3	0.0	0.0	3.1	...	0.0	2.7
Undetermined										
Number of deaths investigated	0	0	1	3	0	3	3	0	0	10
Percentage of all investigations	0.0	0.0	2.9	4.3	0.0	11.1	9.4	...	0.0	5.4

Source: Statistics Canada, Canadian Coroner and Medical Examiner Database, 2006 to 2008.

Accidental deaths accounted for the largest proportion of coroner or medical examiner investigations involving the death of a person aged 13 to 14 years (43% to 58%; Table B-6). Depending on the province, natural deaths or suicides represented the second

largest (5% to 40% and 7% to 36% respectively). The smaller jurisdictions investigated very few, if any, deaths in this age group.

Table B-6 Distribution of deaths of people aged 13 to 14 years investigated by a coroner or medical examiner, by manner of death, Provinces and Territories, 2006 to 2008

	P.E.I.	N.B.	Que.	Ont.	Sask.	Alta.	B.C.	Y.T.	N.W.T	All provinces and territories
Natural										
Number of deaths investigated	0	1	3	36	1	8	12	0	0	61
Percentage of all investigations	0.0	11.1	4.8	36.7	7.1	19.0	40.0	0.0	...	23.7
Accident										
Number of deaths investigated	1	5	36	33	8	21	13	1	0	118
Percentage of all investigations	100.0	55.6	58.1	33.7	57.1	50.0	43.3	100.0	...	45.9
Suicide										
Number of deaths investigated	0	3	20	19	5	7	2	0	0	56
Percentage of all investigations	0.0	33.3	32.3	19.4	35.7	16.7	6.7	0.0	...	21.8
Homicide										
Number of deaths investigated	0	0	2	8	0	1	2	0	0	13
Percentage of all investigations	0.0	0.0	3.2	8.2	0.0	2.4	6.7	0.0	...	5.1
Undetermined										
Number of deaths investigated	0	0	1	2	0	5	1	0	0	9
Percentage of all investigations	0.0	0.0	1.6	2.0	0.0	11.9	3.3	0.0	...	3.5

Note: Table excludes one closed case in Alberta with manner of death pending investigation or inquest.
Source: Statistics Canada, Canadian Coroner and Medical Examiner Database, 2006 to 2008.

Table B-7 Distribution of deaths of people aged 15 to 29 years investigated by a coroner or medical examiner, by manner of death, Provinces and Territories, 2006 to 2008

	P.E.I.	N.B.	Que.	Ont.	Sask.	Alta.	B.C.	Y.T.	N.W.T	All provinces and territories
Natural										
Number of deaths investigated	2	28	136	422	39	110	136	2	3	878
Percentage of all investigations	6.1	11.7	7.9	16.1	8.5	7.8	10.8	14.3	8.6	11.3
Accident										
Number of deaths investigated	22	149	902	1,225	227	642	721	7	20	3,915
Percentage of all investigations	66.7	62.1	52.4	46.7	49.2	45.5	57.2	50.0	57.1	50.2
Suicide										
Number of deaths investigated	7	56	568	591	134	332	251	2	11	1,952
Percentage of all investigations	21.2	23.3	33.0	22.5	29.1	23.5	19.9	14.3	31.4	25.0
Homicide										
Number of deaths investigated	0	4	77	251	46	138	105	2	1	624
Percentage of all investigations	0.0	1.7	4.5	9.6	10.0	9.8	8.3	14.3	2.9	8.0
Undetermined										
Number of deaths investigated	2	3	39	136	15	188	48	1	0	432
Percentage of all investigations	6.1	1.3	2.3	5.2	3.3	13.3	3.8	7.1	0.0	5.5

Source: Statistics Canada, Canadian Coroner and Medical Examiner Database, 2006 to 2008.

In all jurisdictions, accidental deaths accounted for the largest proportion of coroner or medical examiner investigations involving the death of a person aged 15 to 29 years (46% to 67%; Table B-7). Suicides represented the second largest proportion (14% to 33%), with natural deaths representing about 11% of coroner or medical examiner investigations. Smaller proportions were attributed to homicides and undetermined deaths (around 8% and 6 % respectively).

With the exception of Quebec, natural or accidental deaths accounted for the greatest proportion of coroner or medical examiner investigations among people aged 30 to 49 years in all provinces and territories, with the other representing the second largest, and suicides the third (23% to 60%, 23% to 65% and 10% to 21% respectively; Table B-8). In Quebec, the number of deaths deemed suicides (1,446) outnumbered both the number deemed natural (909) and accidental (1,107).

Table B-8 Distribution of deaths of people aged 30 to 49 years investigated by a coroner or medical examiner, by manner of death, Provinces and Territories, 2006 to 2008

	P.E.I.	N.B.	Que.	Ont.	Sask.	Alta.	B.C.	Y.T.	N.W.T	All provinces and territories
Natural										
Number of deaths investigated	52	267	909	3,245	266	737	764	11	26	6,277
Percentage of all investigations	59.8	49.1	24.7	43.9	33.9	26.1	27.6	22.9	40.6	34.5
Accident										
Number of deaths investigated	20	153	1,107	2,051	306	673	1,241	31	26	5,608
Percentage of all investigations	23.0	28.1	30.1	27.8	39.0	23.8	44.9	64.6	40.6	30.8
Suicide										
Number of deaths investigated	12	104	1,446	1,353	128	583	523	5	9	4,163
Percentage of all investigations	13.8	19.1	39.4	18.3	16.3	20.6	18.9	10.4	14.1	22.9
Homicide										
Number of deaths investigated	1	12	93	190	34	106	113	0	2	551
Percentage of all investigations	1.1	2.2	2.5	2.6	4.3	3.8	4.1	0.0	3.1	3.0
Undetermined										
Number of deaths investigated	2	8	119	551	50	726	124	1	1	1,582
Percentage of all investigations	2.3	1.5	3.2	7.5	6.4	25.7	4.5	2.1	1.6	8.7

Source: Statistics Canada, Canadian Coroner and Medical Examiner Database, 2006 to 2008.

Natural deaths accounted for the greatest proportion of coroner or medical examiner investigations among people aged 50 to 69 years in all provinces and territories (45% to 81%; Table B-9), with accidental deaths representing the second largest (13% to 28%). Exceptionally, in Quebec, the number of deaths deemed suicides (1,080) slightly outnumbered those deemed natural (1,041).

Table B-9 Distribution of deaths of people aged 50 to 69 years investigated by a coroner or medical examiner, by manner of death, Provinces and Territories, 2006 to 2008

	P.E.I.	N.B.	Que.	Ont.	Sask.	Alta.	B.C.	Y.T.	N.W.T	All provinces and territories
Natural										
Number of deaths investigated	204	1,156	1,832	11,458	833	2,238	2,143	41	65	19,970
Percentage of all investigations	81.3	79.3	44.9	76.8	71.3	60.2	56.6	66.1	78.3	67.6
Accident										
Number of deaths investigated	26	187	1,041	1,933	218	576	1,040	16	16	5,053
Percentage of all investigations	10.4	12.8	25.5	12.9	18.7	15.5	27.5	25.8	19.3	17.1
Suicide										
Number of deaths investigated	13	91	1,080	976	79	393	451	3	2	3,088
Percentage of all investigations	5.2	6.2	26.5	6.5	6.8	10.6	11.9	4.8	2.4	10.5
Homicide										
Number of deaths investigated	0	5	56	72	12	33	37	0	0	215
Percentage of all investigations	0.0	0.3	1.4	0.5	1.0	0.9	1.0	0.0	0.0	0.7
Undetermined										
Number of deaths investigated	8	18	70	488	26	477	115	2	0	1,204
Percentage of all investigations	3.2	1.2	1.7	3.3	2.2	12.8	3.0	3.2	0.0	4.1

Note: Table excludes two closed cases in Saskatchewan with manner of death unclassified.
Source: Statistics Canada, Canadian Coroner and Medical Examiner Database, 2006 to 2008.

Natural deaths accounted for the majority coroner or medical examiner investigations among people aged 70 to 89 years in all provinces and territories (57% to 91%; Table B-10), with accidental deaths representing the second largest proportion (7% to 29%) and suicides the third (0 to 12%). Less than 1% of coroner or medical examiner investigations were attributed to each of homicides and undetermined deaths.

Table B-10 Distribution of deaths of people aged 70 to 89 years investigated by a coroner or medical examiner, by manner of death, Provinces and Territories, 2006 to 2008

	P.E.I.	N.B.	Que.	Ont.	Sask.	Alta.	B.C.	Y.T.	N.W.T	All provinces and territories
Natural										
Number of deaths investigated	252	1,942	1,162	18,569	988	1,873	1,414	24	18	26,242
Percentage of all investigations	89.0	91.3	56.8	81.7	73.6	73.2	59.6	88.9	85.7	78.3
Accident										
Number of deaths investigated	23	151	583	3,688	313	545	738	2	3	6,046
Percentage of all investigations	8.1	7.1	28.5	16.2	23.3	21.3	31.1	7.4	14.3	18.0
Suicide										
Number of deaths investigated	4	26	254	317	36	90	164	0	0	891
Percentage of all investigations	1.4	1.2	12.4	1.4	2.7	3.5	6.9	0.0	0.0	2.7
Homicide										
Number of deaths investigated	0	0	24	36	3	14	11	0	0	88
Percentage of all investigations	0.0	0.0	1.2	0.2	0.2	0.5	0.5	0.0	0.0	0.3
Undetermined										
Number of deaths investigated	4	9	22	126	3	38	47	1	0	250
Percentage of all investigations	1.4	0.4	1.1	0.6	0.2	1.5	2.0	3.7	0.0	0.7

Note: Table excludes one closed case in Alberta with manner of death pending investigation or inquest.
Source: Statistics Canada, Canadian Coroner and Medical Examiner Database, 2006 to 2008.

With the exception of British Columbia, where accidental deaths (204) outnumbered natural deaths (150), natural deaths accounted for the majority coroner or medical examiner investigations among people aged 90 years and older in all provinces

(51% to 94%; Table B-11), with accidental deaths representing the second largest proportion (6% to 48%). Less than 1% of coroner or medical examiner investigations were attributed to each of homicides, suicides and undetermined deaths. The two territories reported few, if any, coroner or medical examiner cases for this age group.

Table B-11 Distribution of deaths of people aged 90 years and over investigated by a coroner or medical examiner, by manner of death, Provinces and Territories, 2006 to 2008

	P.E.I.	N.B.	Que.	Ont.	Sask.	Alta.	B.C.	Y.T.	N.W.T	All provinces and territories
Natural										
Number of deaths investigated	33	353	207	4,084	155	186	150	2	3	5,173
Percentage of all investigations	94.3	89.6	76.1	76.0	51.0	63.7	41.3	100.0	100.0	73.5
Accident										
Number of deaths investigated	2	38	49	1,261	147	94	204	0	0	1,795
Percentage of all investigations	5.7	9.6	18.0	23.5	48.4	32.2	56.2	0.0	0.0	25.5
Suicide										
Number of deaths investigated	0	1	15	14	1	12	7	0	0	50
Percentage of all investigations	0.0	0.3	5.5	0.3	0.3	4.1	1.9	0.0	0.0	0.7
Homicide										
Number of deaths investigated	0	0	0	1	0	0	0	0	0	1
Percentage of all investigations	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Undetermined										
Number of deaths investigated	0	2	1	15	1	0	2	0	0	21
Percentage of all investigations	0.0	0.5	0.4	0.3	0.3	0.0	0.6	0.0	0.0	0.3

Source: Statistics Canada, Canadian Coroner and Medical Examiner Database, 2006 to 2008.

Appendix C: Circumstances under which a coroner or medical examiner investigation is required

The legislation that provides the mandate for coroners and medical examiners varies across the provinces and territories. The following table presents the circumstances under which deaths are investigated by a coroner or medical examiner. The table is not an exhaustive list of the conditions leading to investigation and it does not represent a formal statement of these conditions. Rather, it is based on the extraction of common or similar language used in the provincial and territorial coroner or medical examiner acts, and is provided here as guide to the reader in understanding some of the jurisdictional differences observed in this report.

Table C-1 Circumstances under which a coroner or medical examiner investigation is required, Provinces and Territories

Circumstances under which a coroner or medical examiner investigation is required	Provinces and Territories								
	P.E.I.	N.B.	Que.	Ont.	Sask.	Alta.	B.C.	Y.T.	N.W.T
Unexplained deaths			✓			✓	✓		
Unexplained death when deceased was in good health	✓				✓	✓	✓		✓
Suddenly of unknown cause		✓		✓					
Death as a result of violence, accident or suicide	✓	✓	✓	✓	✓	✓	✓	✓	✓
Death from a cause other than disease or sickness or old age	✓				✓		✓	✓	✓
From disease/sickness/unknown cause for which person was not treated		✓		✓			✓		
Any cause other than disease or natural cause		✓		✓					
Death during or following pregnancy that might be related to pregnancy		✓		✓		✓	✓		
Stillbirth not in the presence of medical practitioner	✓				✓				✓
Death as result of improper or negligent treatment, malpractice	✓	✓		✓	✓	✓	✓	✓	✓
Death during an operative procedure						✓			
Within 10 days of operative procedure	✓					✓			✓
While under anaesthesia	✓					✓			✓
After anaesthesia that may be attributed to anaesthesia	✓					✓	✓		✓
Result of poisoning						✓	✓		
Death while deceased was not under care of physician						✓	✓		
Death while in the custody of peace officer or as result of force by peace officer while on duty	✓			✓	✓	✓	✓		✓
Disease or ill-health contracted or incurred by deceased as result of employment or occupation						✓			✓
Injury sustained by deceased as result of employment or occupation	✓	✓		✓		✓	✓		✓
Toxic substance introduced into deceased as result of employment or occupation						✓			✓

Note: Table C-1 continued on the following page.

Circumstances under which a coroner or medical examiner investigation is required	Provinces and Territories								
	P.E.I.	N.B.	Que.	Ont.	Sask.	Alta.	B.C.	Y.T.	N.W.T
Death during the course of employment					✓				
Death while detained as defined in Corrections Act, Child, Youth and Family Enhancement Act, or Youth Criminal Justice Act, whether or not on the premises or in actual custody	✓	✓	✓	✓	✓	✓	✓		✓
Death while a formal patient in a facility defined by Mental Health Act, whether or not on the premises or in actual custody		✓	✓	✓	✓	✓	✓		✓
Death while in supported group living or intensive support residence for people with disability			✓	✓					
Death while in supported group living or intensive support residence, rehabilitation/social services for Cree Native persons			✓						
Death while restrained on premises of psychiatric facility/hospital			✓	✓			✓		
Death while in a long term care home				✓					
Person died after being transferred from secure custody to hospital				✓	✓		✓		
Death while detained as defined in Corrections Act, Child, Youth and Family Enhancement Act, or Youth Criminal Justice Act but while not on the premises or in actual custody				✓		✓	✓		
Death while a formal patient in a facility defined by Mental Health Act but while not on the premises or in actual custody				✓		✓	✓		
Death while an inmate or patient in any institution specified in the regulations but while not on the premises or in actual custody					✓	✓	✓		
Death of a child under guardianship or in directors custody	✓		✓	✓	✓	✓	✓		
Occurred in P/T and body is not available because body or part has been destroyed	✓				✓	✓	✓		✓
Occurred in P/T and body is in a place from which it cannot be recovered	✓				✓	✓	✓		✓
Occurred in P/T and body cannot be located	✓				✓	✓	✓		✓
P/T resident dies in another province and believe that should investigate death whether or not body is brought to P/T							✓		
Body is brought into P/T for disposal where investigation is believed to be necessary						✓	✓		
Circumstances that require investigation	✓	✓	✓	✓	✓		✓	✓	
Classes of deaths the Chief Coroner believes are in the public interest to investigate							✓		
Is a child							✓		

Source: Provincial and territorial coroner and medical examiner acts.