

**Government of Alberta** ■

Justice and Attorney General

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**OFFICE OF THE CHIEF MEDICAL EXAMINER  
ALBERTA JUSTICE**

**2007—Annual Review**

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## **OVERVIEW**

### **HISTORY**

The province of Alberta had a coroner's death investigation system, based upon the British Coroner's system, in place from the time it joined Confederation in 1905 until 1977. Following a review of the entire Alberta justice system, undertaken in the mid-1970's, Alberta changed to a medical examiner death investigation system, under the direction of a Chief Medical Examiner, with proclamation of the *Fatality Inquiries Act* in June 1977. The primary purpose of the change was to establish a separation between an investigation into the circumstances surrounding a death and the inquisitorial or public hearing portion of such an investigation. Traditionally, in the coroner's system, a coroner could conduct an investigation into a death and also preside over a public Coroner's Inquest into the circumstances of the death. Under the *Fatality Inquiries Act*, a medical examiner would be responsible for conducting the initial investigation, a board (the Fatality Review Board) would decide which cases should go to a public hearing (now referred to as a Public Fatality Inquiry), and that hearing would be held before a Provincial Court Judge. The *Fatality Inquiries Act* also stipulated that the Chief Medical Examiner must be a Pathologist. Dr. John Butt was the first Chief Medical Examiner for the province of Alberta. Under his guidance, two state-of-the-art autopsy/toxicology facilities were built in Edmonton and Calgary and the first medical investigator program was established in Canada. Alberta was also the first death investigation system in North America to exclusively recruit persons with medical training (primarily nurses) as full-time medical investigators.

### **JURISDICTION AND MANDATE**

The Office of the Chief Medical Examiner (OCME) is a branch within the Legal Services division of Alberta Justice. Its area of jurisdiction is the province of Alberta, with a population of approximately 3.4 million.

The OCME is responsible for the investigation and certification of all deaths in Alberta caused by violence, as well as all unexplained and some unattended natural deaths, in accordance with the *Fatality Inquiries Act* and the *Vital Statistics Act*. Certain hospital deaths, notably maternal deaths, deaths that are a direct or indirect result of anaesthesia, some post-operative deaths, and deaths of patients certified under the *Mental Health Act* are included. Any death of a person in police custody or in jail, any death of a child in the custody or guardianship of the government under the *Child, Youth and Family Enhancement Act*, and all occupational deaths are also investigated. Violent deaths are not just limited to homicides, but are actually all deaths not caused by natural diseases (including motor vehicle deaths, suicides, and drug-related deaths as common examples). The time of interval between an individual being injured and his or her death is of no consequence to a Medical Examiner's investigation. If a death can be reasonably linked to an injury, the death must be reported to and investigated by a Medical Examiner, even if that injury occurred decades ago.

The OCME is managed from two regional offices—one located in Edmonton and the other in Calgary. The Chief Medical Examiner is currently based in Edmonton. The Edmonton office administers all investigations in the northern part of the province, while the Calgary office administers the geographic area south of a line extending from Jasper to Hobbema and down to Provost.

## **FACILITIES AND STAFF**

The Chief Medical Examiner works in the Edmonton branch office and is responsible to Alberta Justice and the Minister of Justice for overseeing the investigation of deaths reported to medical examiners in accordance with the *Fatality Inquiries Act*. A Deputy Chief Medical Examiner works in the Calgary branch office and there is an Assistant Chief Medical Examiner in each of the two branch offices. Each one of these individuals is a Forensic Pathologist by training.

Approximately half of all deaths reported to the OCME are investigated and certified by these four individuals. A network of 112 fee-for-service medical examiners, all of whom are physicians, investigate the remaining cases with the assistance of the RCMP, municipal police forces, and hospital-based pathologists. Their continuing support and willingness to perform this valuable service has made it possible to maintain a high quality province-wide death investigation system.

A histology laboratory is located in the Calgary office and a toxicology laboratory is located in Edmonton. Two PhD chemists direct the toxicology laboratory. The office staff includes medical investigators, forensic pathology technicians, medico-legal record technicians, histology and toxicology technologists, a radiology technologist, a photographer, a research officer, administrators, and administrative support personnel. A medical investigator and medical examiner are available at all times for investigations and consultations in the Calgary and Edmonton regional offices. Autopsies and external examinations are performed in these offices on weekdays.

## **DOCUMENTS/COSTS/FEEES**

The overall cost of death investigations, including the transportation of bodies from the scene of the death to the site of examination, is borne by the OCME. The OCME produces written documentation for each case that is reported to a medical examiner, irrespective of whether a complete investigation is conducted. This documentation contains information on the identity of the decedent, together with the cause of death, the manner of death (i.e. natural, homicide, suicide, accident, undetermined, or unclassified), and the circumstances surrounding the death. This information is available to the next of kin, and to certain interested parties, upon written request and payment of fees stipulated in the *Fatality Inquiries Regulation*. The majority of the documentation is maintained in MEDIC, a database system developed specifically for the OCME, which also serves as the basis for generation of statistical data, including this Annual Review.

## **EDUCATION**

The OCME is associated with the University of Alberta and the University of Calgary and provides training to students and professionals in a number health and law related disciplines.

A Medical Examiner's Symposium is held every second year in order to provide continuing education to medical examiners, pathologists, medical investigators, police officers, and others who are part of the team effort involved in investigating sudden deaths in Alberta. During the inbetween years, the OCME and Edmonton Police Service host "The Golden Triangle". This is a five-day seminar on the principles of sudden death investigation, specifically designed for police and medical investigators, which has come to enjoy a nationwide attendance.

## FATALITY REVIEW BOARD/PUBLIC FATALITY INQUIRIES

The Fatality Review Board looks at a proportion of the cases investigated by medical examiners, principally those deaths that are accidental, and makes a recommendation to the Minister of Justice as to which cases should go to Public Fatality Inquiry. All deaths caused by a police officer in the line of duty go to Public Fatality Inquiry. In addition, all deaths of certified patients under the *Mental Health Act*, children in the custody or guardianship of the government under the *Child, Youth and Family Enhancement Act*, and individuals in custody or in jail automatically go to Public Fatality Inquiry unless the death was due entirely to natural causes, was not preventable, and the Fatality Review Board feels that the public interest would not be served by an Inquiry. A Public Fatality Inquiry is held before a Provincial Court judge and is primarily intended to make the circumstances surrounding a death public. The judge cannot make any legal findings of blame or responsibility for the death, but may make recommendations for the prevention of similar deaths in the future.

### TYPES OF CASES

In 2007, a total of 5953 deaths were reported to a Medical Examiner representing approximately one third of all deaths in Alberta during that year. Investigations were conducted into 3704 deaths or 62% of the deaths reported to the OCME. Deaths investigated by the OCME accounted for approximately 20% of all deaths in Alberta.

Case Type	#
Acceded*	185
Medical Examiner Case	3519
No Case	619
Refereed**	1630
<b>Total</b>	<b>5953</b>
<b>Total Investigated</b>	<b>3704</b>

*\*Acceded: a case that should have been reported to a medical examiner but was not reported at the time of death. Often these cases are late effects of old injury or disease. When an application for cremation is submitted these cases are usually captured as OCME cases.*

*\*\*Refereed: a case of natural death notifiable to a medical examiner, usually because the attending physician did not see the patient within the 14 days prior to death, or because a patient died within 10 days of a surgical procedure. In such cases the attending physician is given permission to sign the Medical Certificate of Death by the medical examiner .*

## TYPES OF EXAMINATIONS

The medical examiner must decide whether to order an autopsy or conduct an external examination, wherein the body of the decedent is viewed and examined externally without resorting to an examination of the internal organs. In many cases, documentation of the decedent's history, the circumstances of the death, and the scene findings provide sufficient information about identification, cause of death, and manner of death that an external examination of the body, with collection of appropriate toxicology specimens, is all that is needed to complete the investigation. In other cases, a complete autopsy will be ordered by the medical examiner and conducted by a pathologist. A medical examiner does not require permission from the next of kin to proceed with an autopsy. Family members may object to an autopsy being performed on their loved one for personal or religious reasons. Under such circumstances the OCME will take the family's concerns into consideration, but ultimately the final decision will rest upon whether the medical examiner can properly document the cause and manner of death without resorting to a complete autopsy. Autopsies were performed in 38% of the cases investigated by the OCME each year.

### Examination Performed by Manner of Death, 2007 Medical Examiner Cases Only

<b>Manner of Death</b>	<b>Autopsy</b>	<b>External Only</b>	<b>None*</b>	<b>Total</b>	<b>% Autopsy</b>
Accidental	133	694	5	832	16.0%
Homicide	87	3	0	90	96.7%
Natural	622	1015	11	1648	37.7%
Suicide	96	368	8	472	20.3%
Unclassified	296	98	0	394	75.1%
Undetermined	59	22	1	82	72.0%
<b>Total</b>	<b>1332</b>	<b>2200</b>	<b>26</b>	<b>3518*</b>	<b>37.9%</b>

\* 1 case of unidentified remains not included

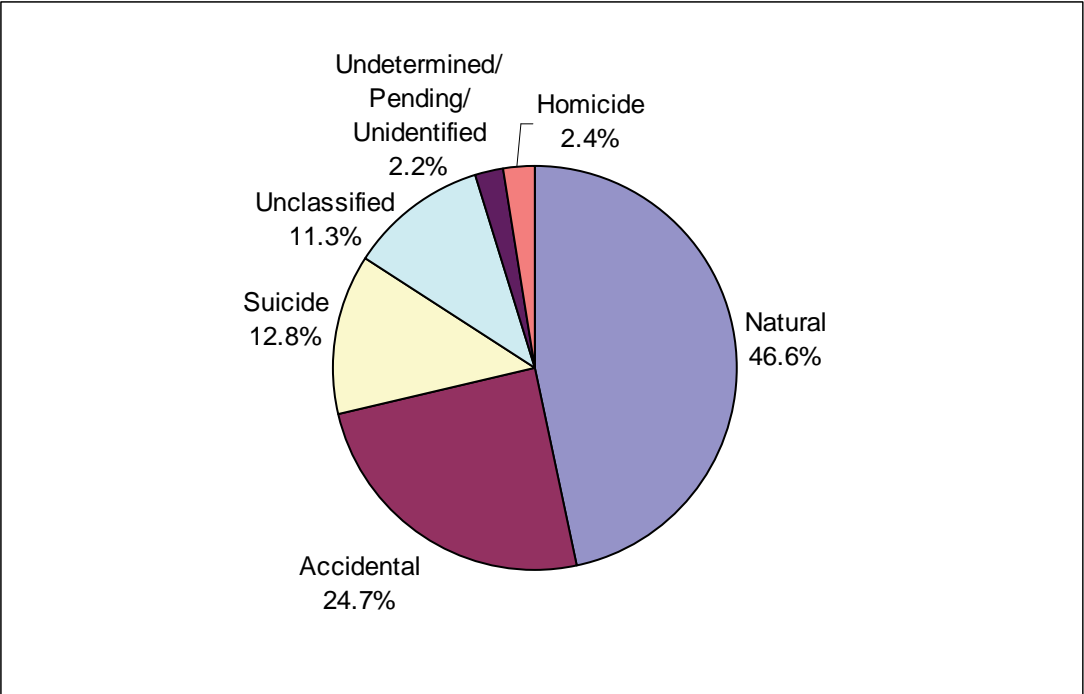
\*Autopsy was done in hospital, or no autopsy required as there was sufficient medical documentation as a result of a long standing condition.

# Caseload Statistics

## Total Cases

Manner of Death	Total Cases	Percentage of Investigated Cases
Natural	1724	46.5%
Accidental	916	24.7%
Suicide	473	12.8%
Unclassified	417	11.3%
Undetermined/Pending	83	2.2%
Homicide	90	2.4%
Unidentified Remains	1	0.0%
Other Cases*	2249	
<b>Total</b>	<b>5953</b>	

\*Cases that are reported but do not require a full investigation.

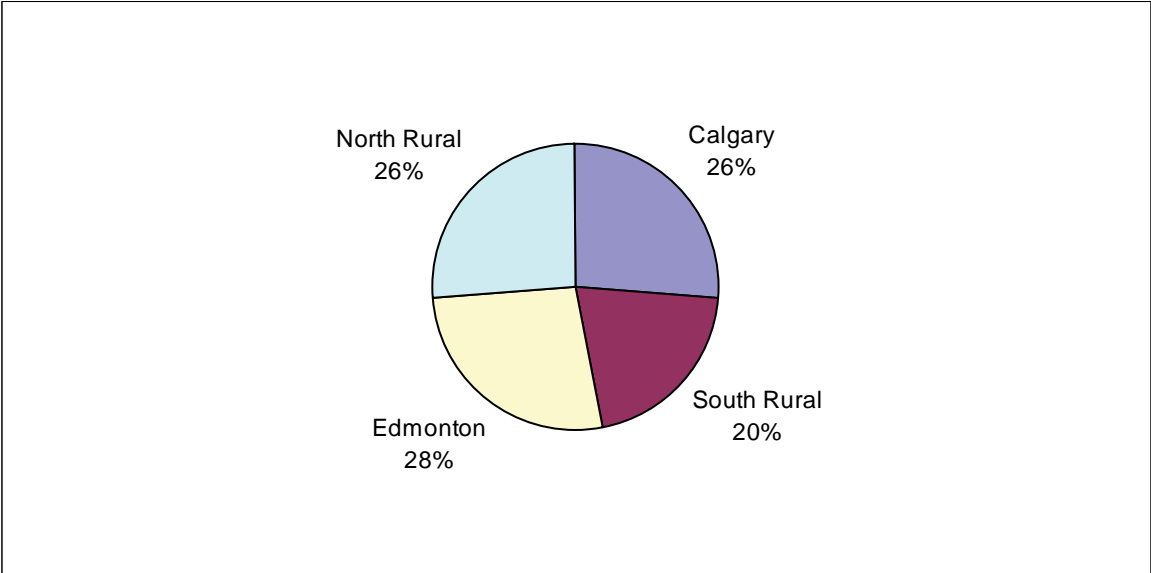


# Caseload Statistics

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## Regional Distribution of Cases

	Calgary	South Rural	Edmonton	North Rural	Total	Percent
Natural	465	304	513	442	1724	46.5%
Accidental	217	201	173	325	916	24.7%
Suicide	102	142	118	111	473	12.8%
Unclassified	137	79	137	64	417	11.3%
Undetermined	24	24	13	22	83	2.2%
Homicide	34	6	36	14	90	2.4%
Unidentified Remains	0	0	0	1	1	0.0%
<b>Total</b>	<b>979</b>	<b>756</b>	<b>990</b>	<b>979</b>	<b>3704</b>	<b>100%</b>

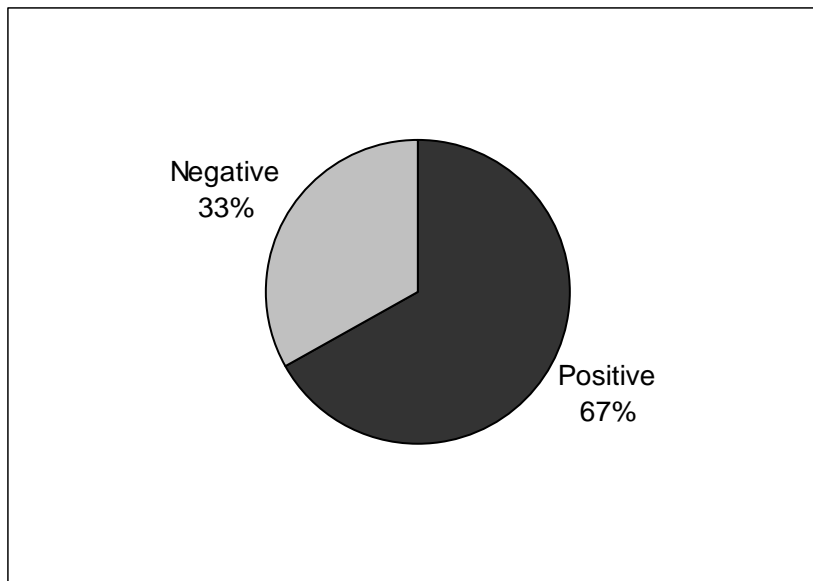


## TOXICOLOGY

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In 2007, there were 2124 cases where toxicology was performed and reported, representing 57% of all cases investigated by the Office of the Chief Medical Examiner. There were 1611 full drug screens and approximately 500 cases tested for alcohol or alcohol plus carbon monoxide.

### Drug Screen Results, 2007



# Types of Deaths Investigated and Certified

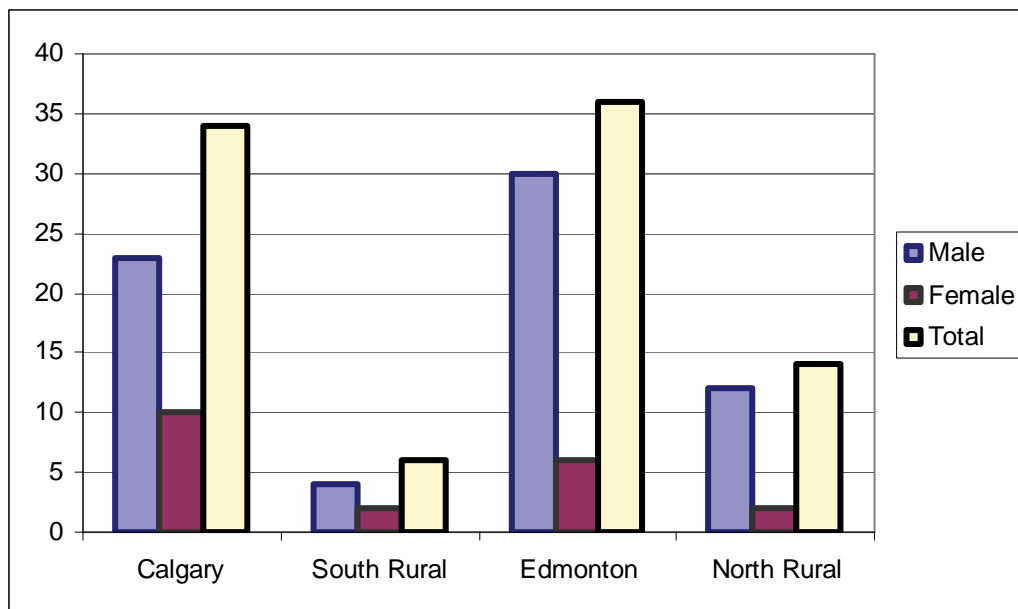
## Homicide

### Gender and Regional Distribution

Region	Male	Female	Total
Calgary	23	10	35
South Rural	4	2	6
Edmonton	30	6	36
North Rural	12	2	14
<b>Total</b>	<b>69</b>	<b>20</b>	<b>90</b>

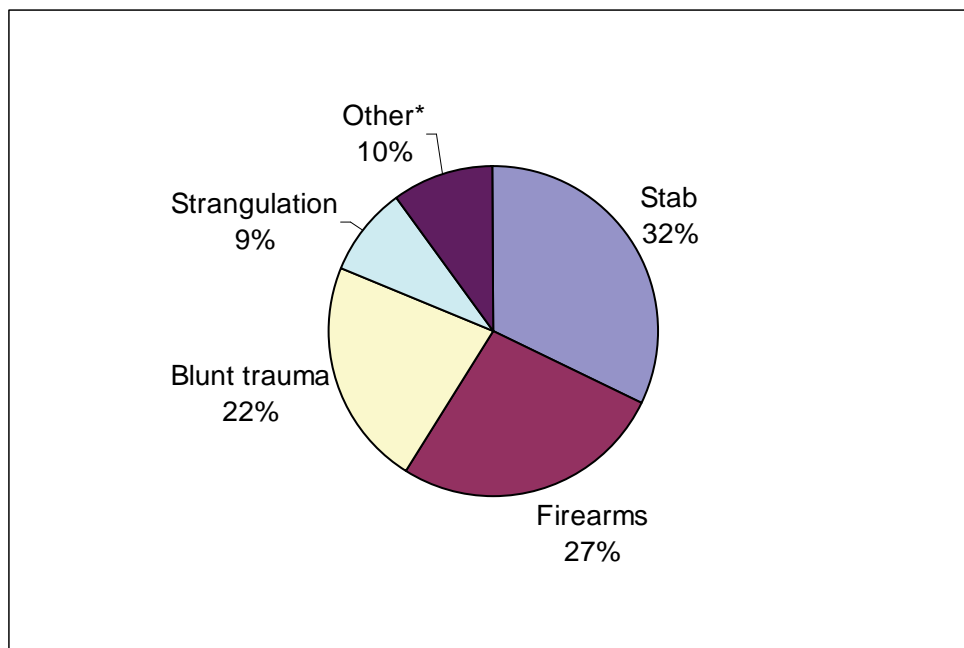
Alberta homicide rate = 2.6 per 100,000 population.

Crude rate per 100000 population based on the 2007 Alberta population of 3,416,498 as per Official Population Lists [http://municipalaffairs.gov.ab.ca/mc\\_official\\_populations.cfm](http://municipalaffairs.gov.ab.ca/mc_official_populations.cfm)



## Homicides by Cause of Death

Cause of Death	Edmonton	Calgary	North Rural	South Rural	Total
Stab/Slash/Chop	13	11	4	1	29
Firearms	11	7	4	2	24
Blunt trauma	11	5	3	1	20
Strangulation	0	5	1	2	8
Infant Cranial Trauma Incl. Late Effects	0	3	0	0	3
Asphyxia	0	0	1	0	1
Fight	0	1	0	0	1
Motor Vehicle Other	1	0	0	0	1
Pushed in Front of Train	0	1	0	0	1
Fire	0	0	1	0	1
Unknown	0	1	0	0	1
<b>Total</b>	<b>36</b>	<b>14</b>	<b>34</b>	<b>6</b>	<b>90</b>



\*Other includes: Infant Cranial Trauma, Asphyxia, Fight, Other Motor Vehicle, Pushed in Front of Train, Fire and Unknown

## Suicides

In 2007 there were 473 suicides investigated by the Alberta Office of the Chief Medical Examiner, 5 of which were from out of province or of no identifiable address. Any of the data below that presents regional data or rates will be based only on the 468 Albertans. The remaining data will include all cases investigated.

### Gender and Regional Distribution

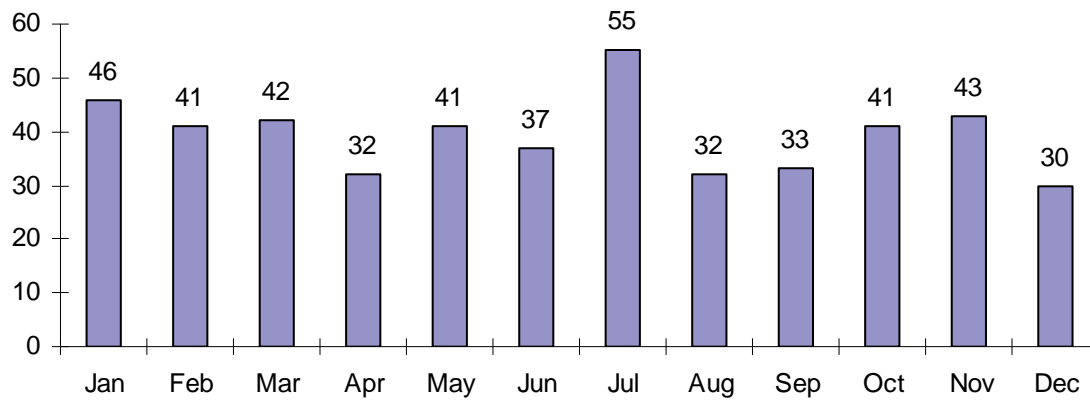
Region	Female	Male	Total
Calgary	36	66	102
South Rural	41	101	142
Edmonton	44	74	118
North Rural	16	95	111
<b>Total</b>	<b>137</b>	<b>336</b>	<b>473</b>

### Suicide Rates by Age and Gender per 100,000 Population

Age Range	Female	Male	Total	Rate/100,000 Population
Age 10-14	1	2	3	1.3
Age 15-19	8	11	19	7.9
Age 20-24	16	38	54	21.6
Age 25-29	11	30	41	16.6
Age 30-34	5	21	26	10.9
Age 35-39	10	34	44	18.2
Age 40-44	15	38	53	20.3
Age 45-49	15	44	59	21.1
Age 50-54	16	46	62	24.9
Age 55-59	19	21	40	20.6
Age 60-64	8	11	19	13.0
Age 65-69	4	13	17	16.0
Age 70-74	3	8	11	12.7
Age 75-79	3	6	9	12.4
Age 80-84	2	6	8	16.0
Age 85-89	0	2	2	6.9
Age 90 +	0	1	1	6.9
<b>Total</b>	<b>136</b>	<b>332</b>	<b>468</b>	<b>14.0</b>

\* Rate calculated as per 100,000  
Populations based on Alberta Health and Wellness Population Projections for 2007 by Age Group

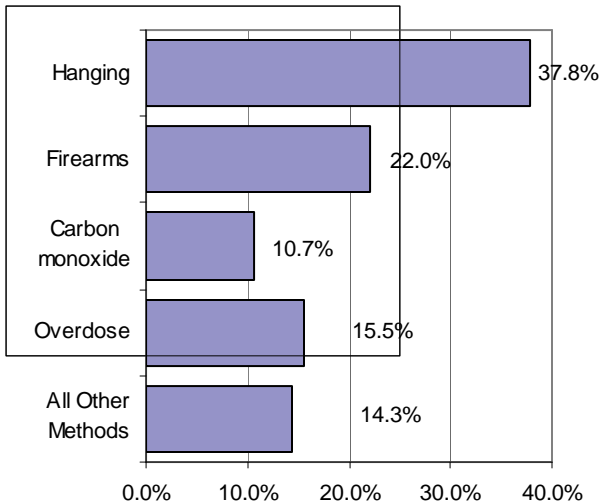
## Suicides by Month



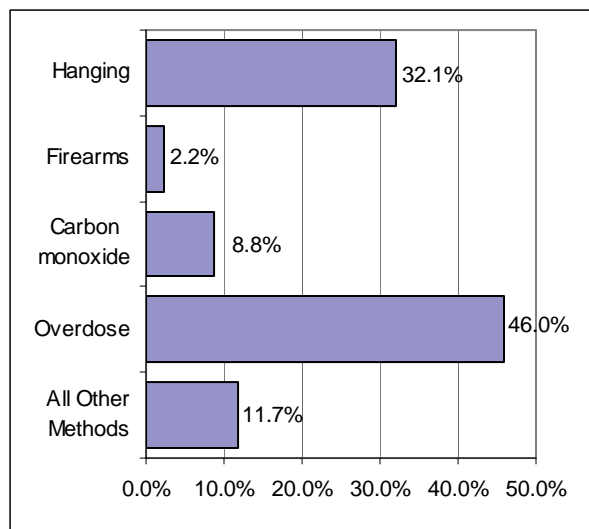
## Suicides by Cause of Death

Method	Female	% Female	Male	% Male	Total	% Total
Hanging/Strangulation	44	25.7%	127	74.3%	171	36.2%
Overdose	63	54.8%	52	45.2%	115	24.3%
Firearm	3	3.9%	74	96.1%	77	16.3%
Carbon Monoxide	12	25.0%	36	75.0%	48	10.1%
Jump From Height/Fall	2	15.4%	11	84.6%	13	2.7%
Stab/Slash	6	35.3%	11	64.7%	17	3.6%
Drowning	2	28.6%	5	71.4%	7	1.5%
Other*	2	28.6%	5	71.4%	7	1.5%
Plastic Bag Suffocation	2	33.3%	4	66.7%	6	1.3%
Other Poisoning	1	25.0%	3	75.0%	4	0.8%
Pedestrian (Train)	1	25.0%	3	75.0%	4	0.8%
Pedestrian Motor Vehicle	0	0.0%	3	100.0%	3	0.6%
Motor Vehicle Crash—Driver	0	0.0%	1	100.0%	1	0.2%
Hypothermia	0	0.0%	1	100.0%	1	0.2%
Motor Vehicle Crash Into Train	0	0.0%	1	100.0%	1	0.2%
<b>Total</b>	<b>137</b>	<b>29.0%</b>	<b>336</b>	<b>71.0%</b>	<b>473</b>	<b>100.0%</b>

Cause of Suicidal Deaths — Males



Cause of Suicidal Deaths — Females

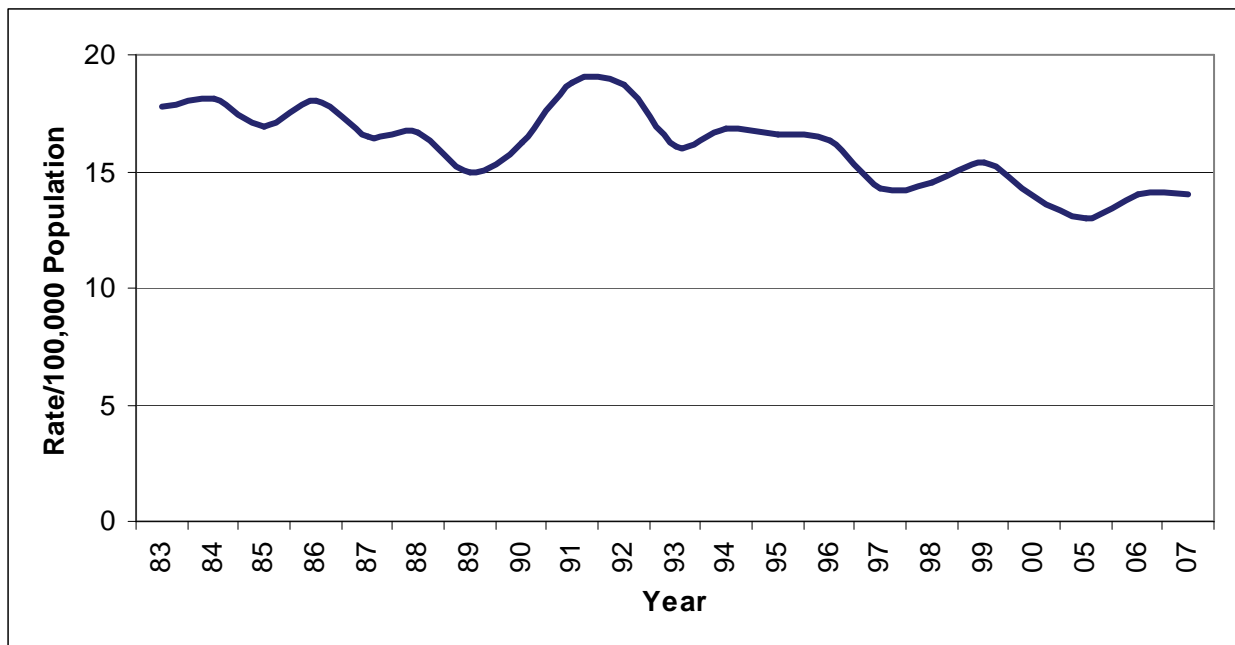


\*Other includes: crossbow, electrocution, multiple combined methods

## Alberta Suicides from 1975 - 2007

Region	1975	1980	1985	1990	1995	2005	2006	2007
Calgary	78	103	105	93	110	101	98	102
South Rural	69	91	88	83	101	100	112	142
Edmonton	68	99	102	115	114	124	116	118
North Rural	72	107	100	109	132	102	132	111
<b>Total</b>	<b>287</b>	<b>400</b>	<b>395</b>	<b>400</b>	<b>457</b>	<b>427</b>	<b>458</b>	<b>473</b>

## Alberta Suicide Rates/100,000 Population (1983 - 2007)



## Accidental Deaths

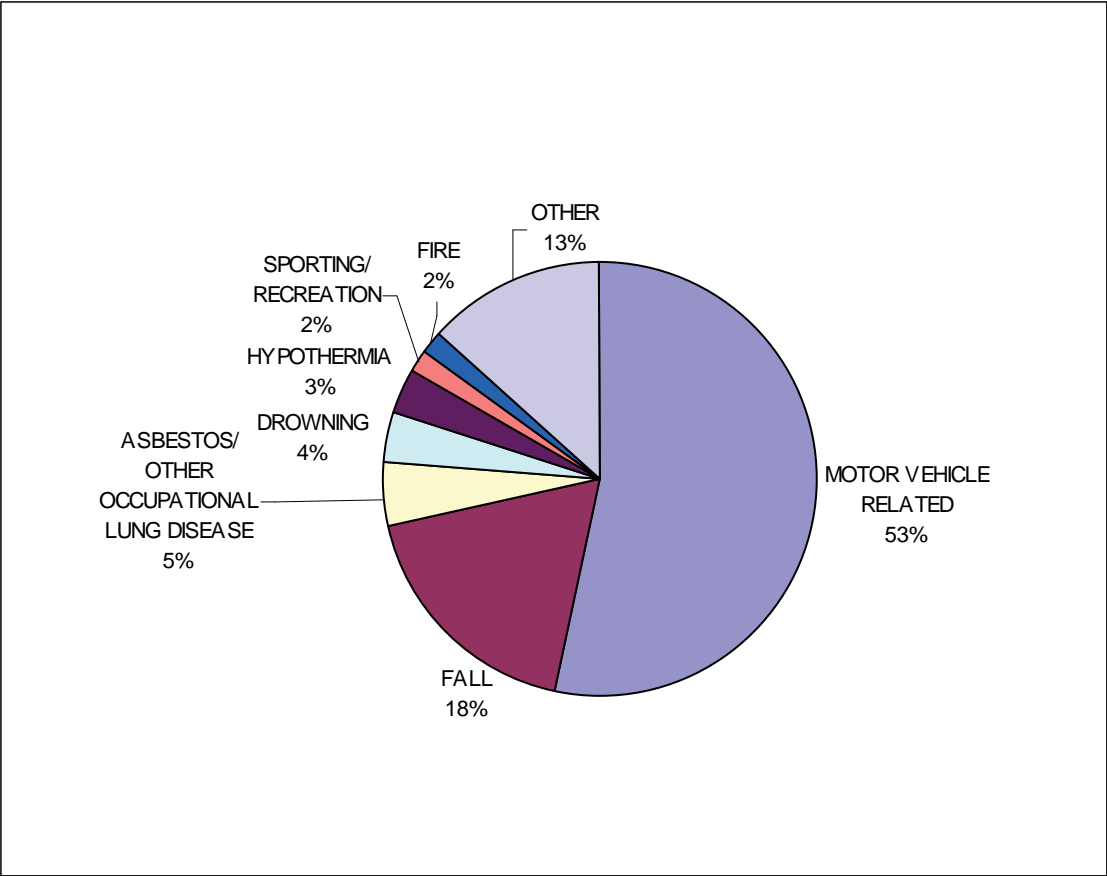
### Accidental Deaths by Cause and Region

Accident Type	Calgary	South Rural	Edmonton	North Rural	Total
Motor Vehicle Related	74	113	68	233	488
Fall	77	20	55	14	166
Asbestos/Other Occupational Lung Disease	20	9	11	3	43
Drowning ( <i>excludes motor vehicle related</i> )	8	12	2	13	35
Hypothermia	2	4	4	21	31
Sporting/Recreation ( <i>excludes drowning, atv, snowmobiling</i> )	3	11	1	1	16
Fire ( <i>excludes motor vehicle related</i> )	3	2	6	4	15
Unintentional Carbon Monoxide	4	7	0	1	12
Medical/Surgical/Drug Misadventures	2	2	7	1	12
Late Effects	5	3	2	2	12
Aspiration	5	0	3	2	10
Farm ( <i>not all deaths occurring on a farm only those related to farming excluding drowning and atv</i> )	1	3	2	4	10
Head Injury of Unknown Etiology	2	2	5	1	10
Struck by Falling or Moving Object	2	1	1	4	8
Asphyxia	3	0	0	5	8
Electrocution	2	1	1	2	6
Aircrash	0	1	0	4	5
Caught in Machinery/Equipment ( <i>does not include farming related</i> )	2	1	1	1	5
Crush Injury	0	2	0	3	5
Other Unclassifiable Injury	0	1	3	1	5
Struck by Falling Tree	1	2	0	1	4
Autoerotic Asphyxiation	0	1	1	1	3
Explosion	1	2	0	0	3
Firearms	0	0	0	2	2
Animal Attack	0	1	0	0	1
<b>Total</b>	<b>217</b>	<b>201</b>	<b>173</b>	<b>324</b>	<b>915</b>

## Details of Motor Vehicle Related Accidental Deaths

	Calgary	South Rural	Edmonton	North Rural	Total
<b>Occupant of a moving vehicle</b>					
Driver	22	58	18	125	223
Passenger	21	31	16	41	109
Unknown if decedent was driver or passenger	0	2	0	13	15
<b>Subtotal</b>	<b>43</b>	<b>91</b>	<b>34</b>	<b>179</b>	<b>347</b>
<b>Struck by a moving vehicle</b>					
Pedestrian	11	4	15	13	43
While bicycling	1	3	4	4	12
<b>Subtotal</b>	<b>12</b>	<b>7</b>	<b>19</b>	<b>17</b>	<b>55</b>
<b>Train-related accidents</b>					
Pedestrian struck by a train	4	1	0	2	7
Occupant of vehicle struck by a train	0	0	0	3	3
<b>Subtotal</b>	<b>4</b>	<b>1</b>	<b>0</b>	<b>5</b>	<b>10</b>
<b>Other motor vehicle accidents</b>					
Motorcycle	11	9	7	7	34
Snowmobile	1	0	0	2	3
All terrain vehicle	0	2	3	12	17
Crushed by vehicle	2	2	3	6	13
Other vehicle related	1	1	2	5	7
<b>Subtotal</b>	<b>15</b>	<b>14</b>	<b>15</b>	<b>32</b>	<b>76</b>
<b>Total motor vehicle accidents</b>	<b>74</b>	<b>113</b>	<b>68</b>	<b>233</b>	<b>488</b>

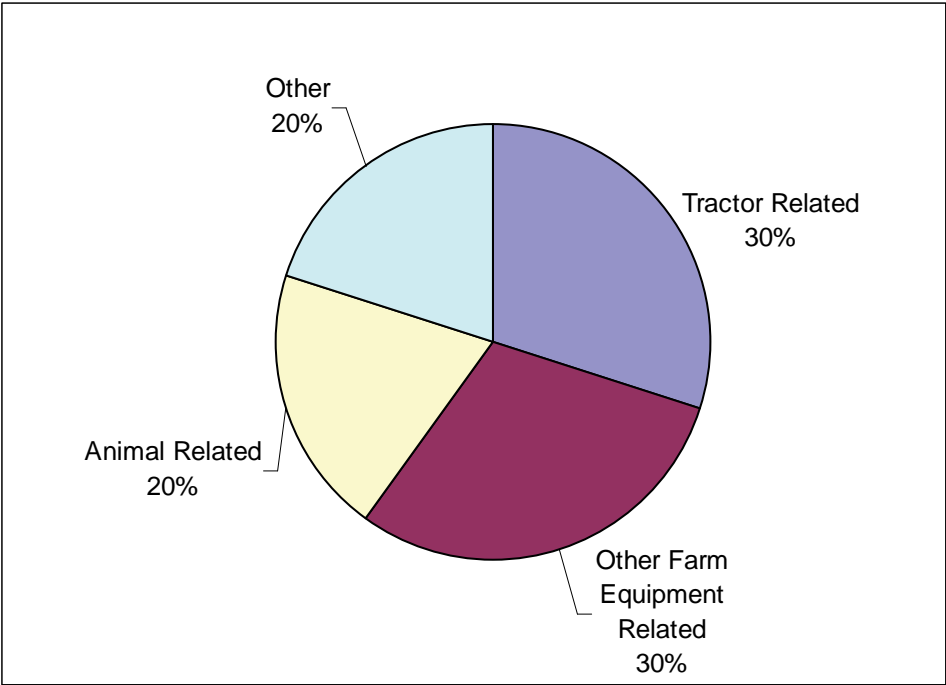
# Accidental Deaths by Cause



**Details of Selected Groups of Accidental Death**

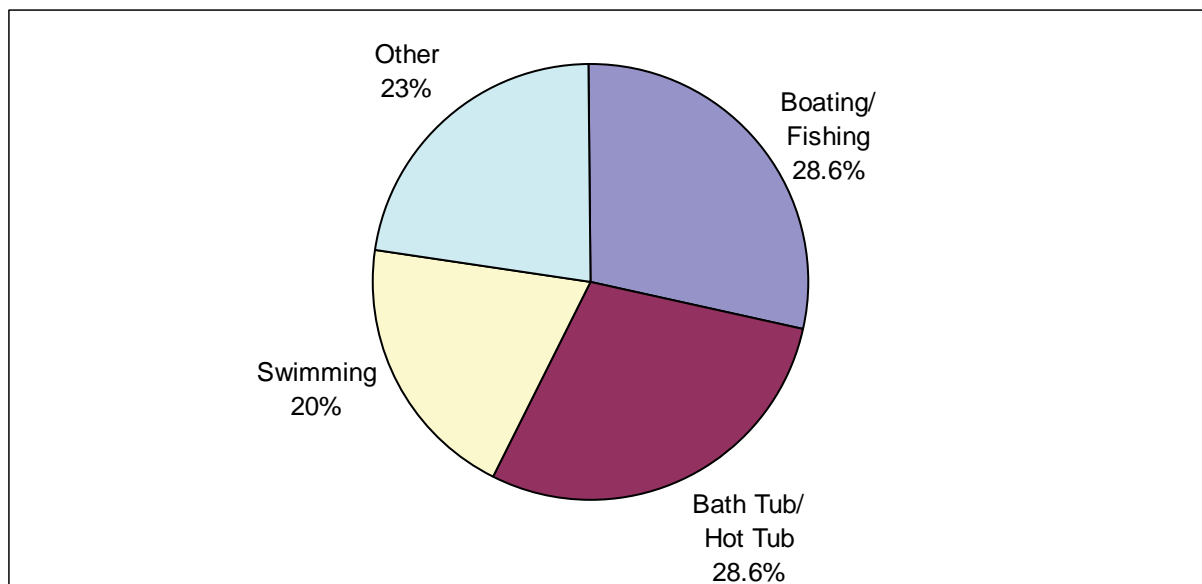
**Farm Deaths**

Type of Death	#
<b>Animal Related</b>	<b>2</b>
<b>Equipment Related</b>	<b>6</b>
<i>Tractor—Rollover/Runover/Flip</i>	3
<i>Bobcat Flip</i>	1
<i>Caught in Power Take Off (PTO)</i>	1
<i>Pinned Between Machines</i>	1
<b>Other Farming Related</b>	<b>2</b>
<i>Struck by Bale</i>	1
<i>Smothering from Grain</i>	1
<b>Total</b>	<b>10</b>



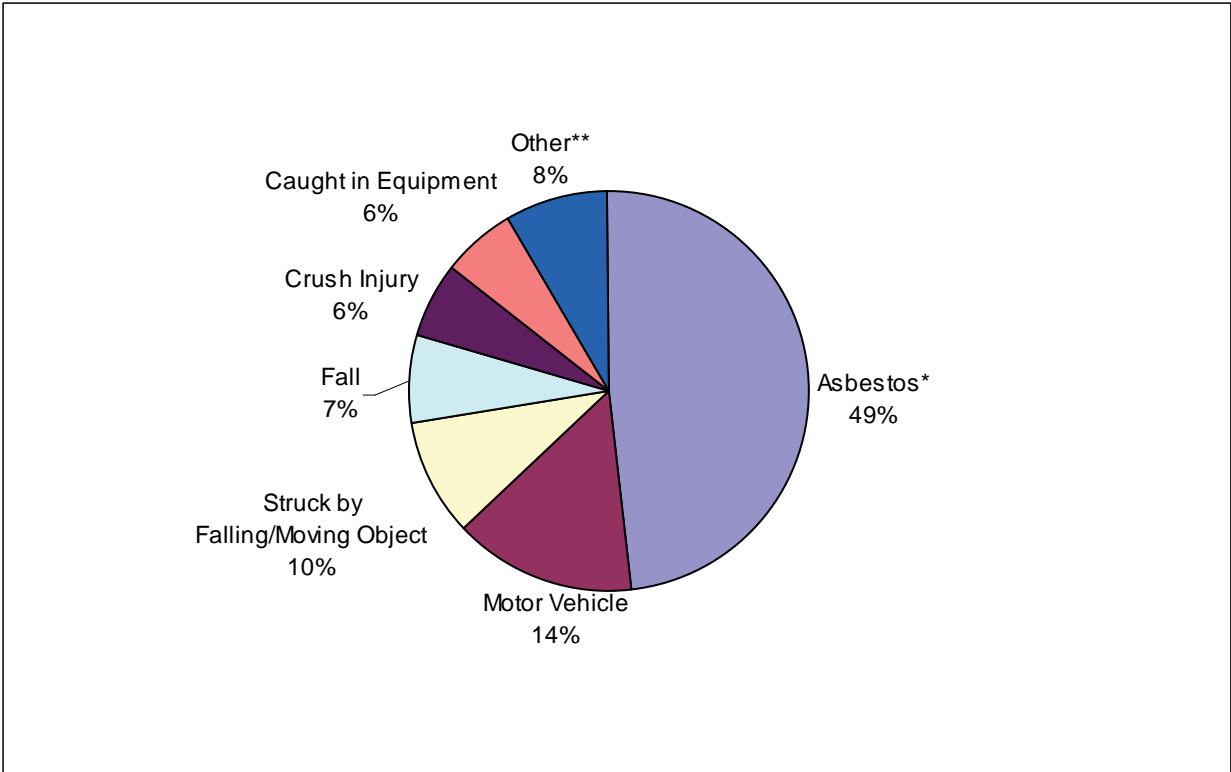
## Accidental Drowning (does not include MVC related drowning)

Drowning Type	#
<b>Bathtub</b>	<b>8</b>
<b>Hot Tub</b>	<b>2</b>
<b>Boating Fishing (Total)</b>	<b>10</b>
<i>Boating, Not Otherwise Specified</i>	2
<i>Canoeing</i>	4
<i>Kayaking</i>	1
<i>Rafting</i>	1
<i>Inflatable Fishing Boat</i>	2
<b>Swimming (Total)</b>	<b>7</b>
<i>Swimming Pool</i>	1
<i>Swimming—Open Body of Water</i>	6
<b>Scuba Diving</b>	<b>2</b>
<b>Fall in Water</b>	<b>3</b>
<b>Fell through Ice</b>	<b>1</b>
<b>Other Drownings (Total)</b>	<b>2</b>
<i>Playing on Beach Chased Ball Into Lake</i>	1
<i>Ran into River (Police Chase)</i>	1
<b>Total</b>	<b>35</b>



# Occupational Deaths

Type of Injury	#
Asbestos/Other Occupational Lung Disease*	40
Motor Vehicle Related	12
Struck by Falling or Moving Object	8
Fall	6
Crush Injury	5
Caught In Equipment	5
Electrocution	3
Explosion	2
Aircrash	1
Other	1
<b>Total</b>	<b>83</b>

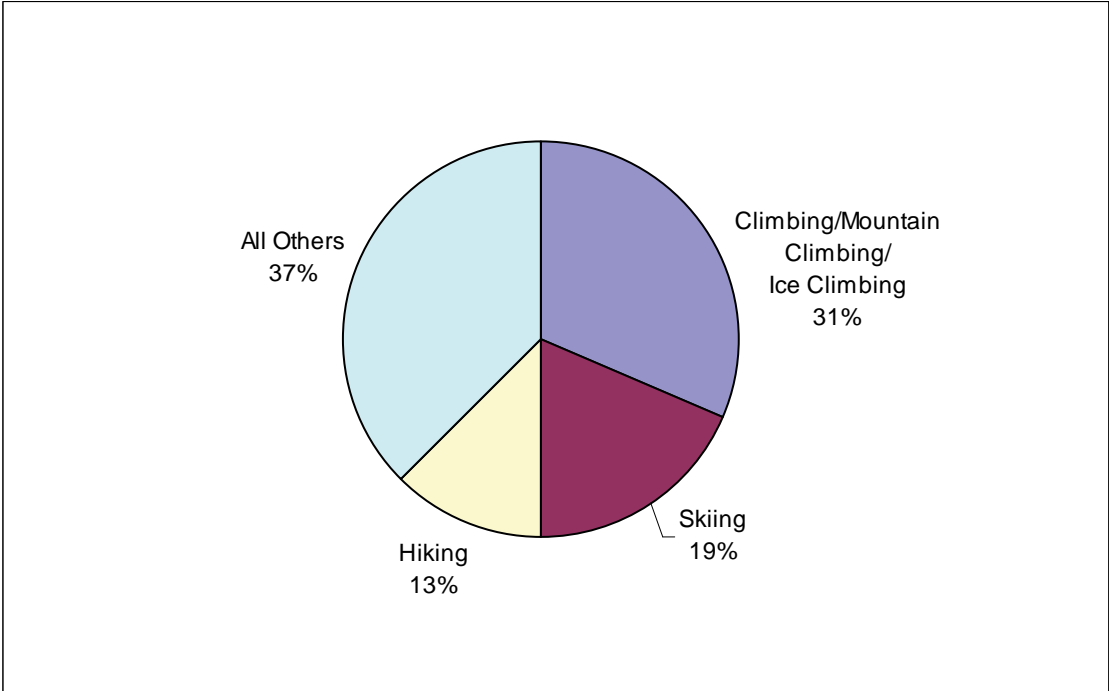


\*\* Other includes: electrocution, explosion, aircrash, other occupational death

# Sport and Recreation Deaths

Excludes: snowmobiling, all terrain vehicles, drowning and bicycling

Activity	#
Climbing (Climbing/Mountain Climbing/Ice Climbing)	5
Skiing	3
Hiking	2
Horseback Riding	1
Inline Skating	1
Sea Doo	1
Swing Set	1
Sky Diving	1
Sledding	1
Total	16



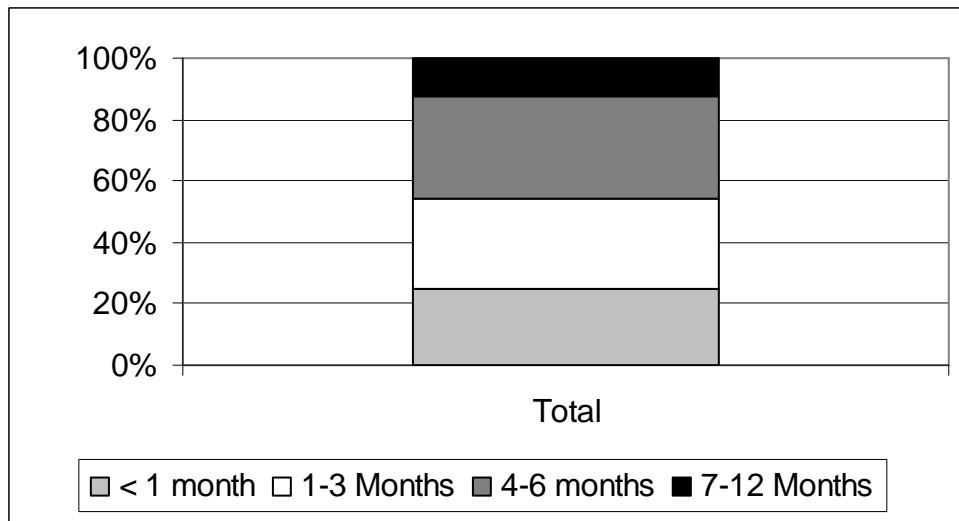
## Sudden Infant Death Syndrome

Sudden Infant Death Syndrome is defined as the sudden death of an infant less than one year of age that remains unexplained after a thorough case investigation, including the performance of a complete autopsy, examination of the scene of death, and review of the clinical history. In Alberta, the Medical Examiner's Office considers the manner of death in SIDS to be natural. If there is any concern that the death is not natural, the cause and manner of death are both classified as undetermined. There has been a world wide decline in the incidence of SIDS since the early 1990s. This trend has also been noted in Alberta.

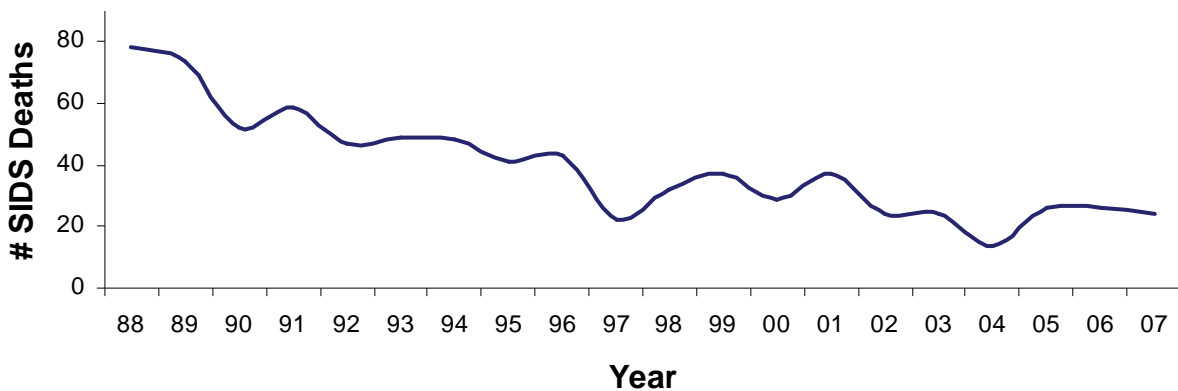
### SIDS Cases by Age and Region

Age	Calgary	South Rural	Edmonton	North Rural	Total
<1 month	1	0	3	2	6
1-3 months	0	2	2	3	7
4-6 months	1	1	1	5	8
7-12 months	1	0	2	0	3
<b>Total</b>	<b>3</b>	<b>3</b>	<b>8</b>	<b>10</b>	<b>24</b>

### SIDS Cases by Age Group



### SIDS



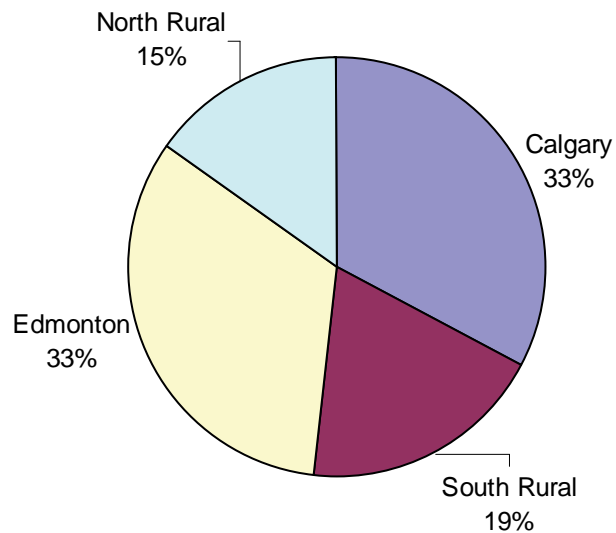
## Unclassified Manner of Death

The unclassified manner of death is used for any death in which a drug of abuse, including alcohol, is the underlying cause of death. This manner does not include deaths where drugs or alcohol contribute to the death, but are not the actual underlying cause of death.

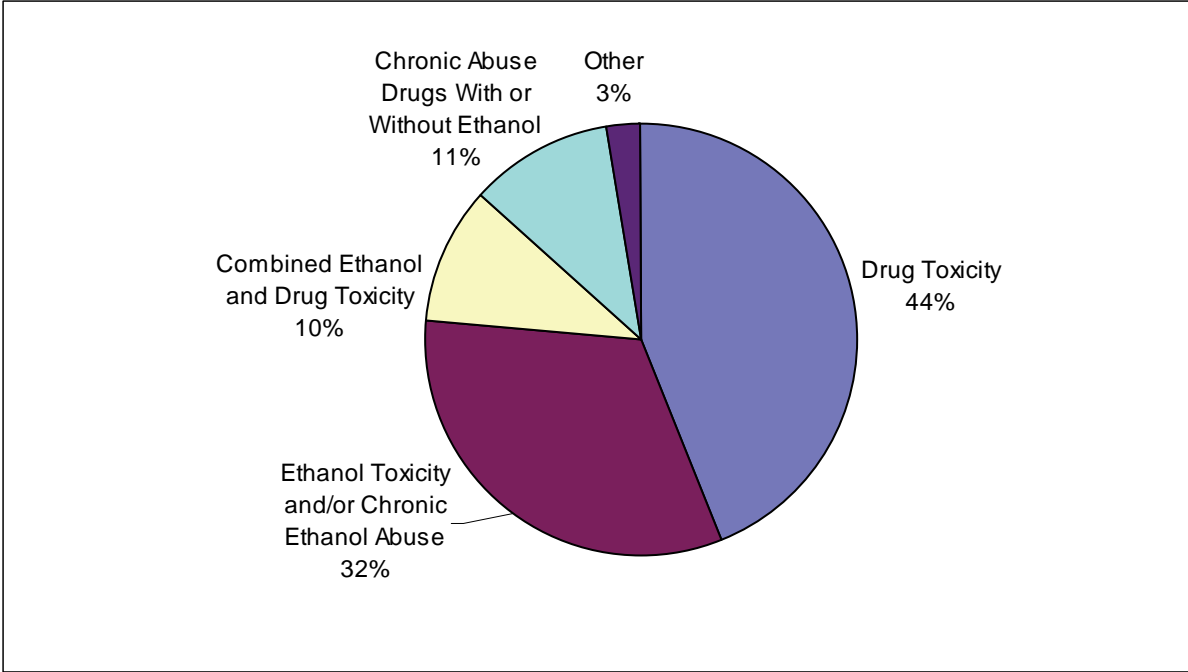
### Unclassified Deaths by Cause of Death and Region

Cause of Death	Calgary	South Rural	Edmonton	North Rural	Total
Drug Toxicity	47	33	71	32	183
Ethanol Toxicity and/or Chronic Ethanol Abuse	64	24	27	20	135
Combined Ethanol and Drug Toxicity	8	7	18	10	43
Chronic Ethanol and Drug Abuse	11	9	5	1	26
Chronic Drug Abuse	4	3	11	1	19
Methanol Toxicity	3	2	1		6
Solvent Toxicity		1	4		5
<b>Total</b>	<b>137</b>	<b>79</b>	<b>137</b>	<b>64</b>	<b>417</b>

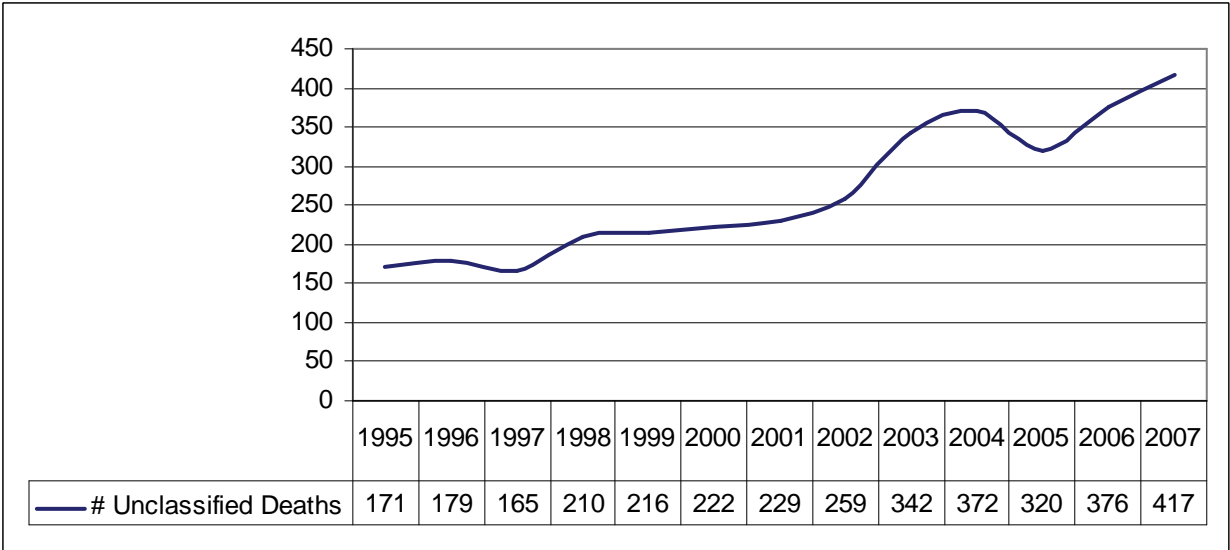
### Unclassified Deaths by Region



### Unclassified Deaths by Cause



### Unclassified Deaths 1995-2003



## Undetermined Manner of Death

The undetermined manner of death is used for cases in which an investigation is unable to establish whether the death was a homicide, suicide, or accident, even though the actual cause of death may be known. In some cases, both the cause and the manner of death cannot be determined.

<b>Cause of Death</b>	<b>Calgary</b>	<b>South Rural</b>	<b>Edmonton</b>	<b>North Rural</b>	<b>Total</b>
Undetermined	10	9	6	8	33
Drug Toxicity	6	5	2	2	15
Head Injury - Undetermined Cause	3	1	1	1	6
Fire	0	2	0	2	4
Carbon Monoxide	0	1	0	2	3
Drowning	2	0	0	1	3
Fall	1	1	0	1	3
Motor Vehicle - Driver	1	2	0	0	3
Bronchopneumonia	1	0	0	1	2
Hanging	0	0	1	1	2
Motor Vehicle - Pedestrian	0	0	0	2	2
Abdominal Injury - Undetermined Cause	0	1	0	0	1
Burns - Undetermined Etiology	0	0	1	0	1
Excited Delirium of Undetermined Etiology	0	0	1	0	1
Firearm	0	0	1	0	1
Hypothermia	0	0	0	1	1
Necrotizing Fasciitis of Unknown Etiology	0	1	0	0	1
SUD	0	1	0	0	1
<b>Total</b>	<b>24</b>	<b>24</b>	<b>13</b>	<b>22</b>	<b>83</b>

## Public Fatality Inquiries

### Public Fatality Inquiries Completed During 2007

#### Judicial Recommendations for the Prevention of Similar Deaths

<b>Manner of Death</b>	<b>Given</b>	<b>Not Given</b>	<b>Total</b>
Natural	1	0	1
Homicide	1	2	3
Suicide	1	0	1
Accidental	7	1	8
Unclassified/ Undetermined	4	1	5
<b>Total</b>	<b>14</b>	<b>4</b>	<b>18</b>

### Types of Fatality Inquiries

	<b>Deaths in psychiatric facility or hospital</b>	<b>Deaths involving police</b>	<b>Deaths of children who are in custody of child welfare</b>	<b>Deaths while incarcerated</b>	<b>Other</b>
Natural	0	0	0	1	0
Homicide	0	2	0	1	0
Accidental	1	2	0	0	5
Suicide	0	0	0	0	1
Unclassified/ Undetermined	0	3	1	1	0
<b>Total</b>	<b>1</b>	<b>7</b>	<b>1</b>	<b>3</b>	<b>6</b>

## PEDIATRIC DEATH REVIEW—2007

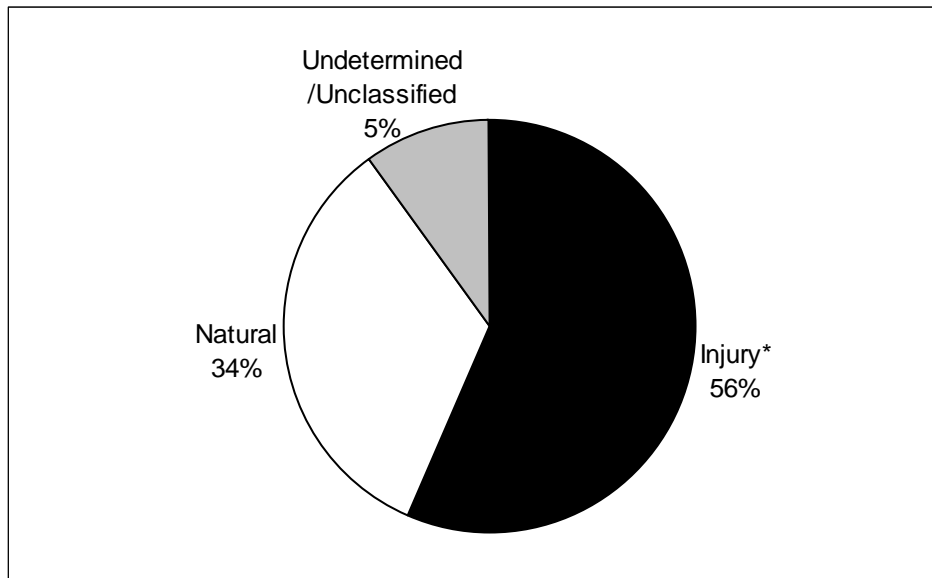
In 2007 the Office of the Chief Medical Examiner investigated the deaths of 160 children and teens aged less than 18 at the time of their death, accounting for 4.3% of all deaths investigated by the OCME. Among injury related deaths (accidental, homicide, suicide) deaths of children accounted for 6.1% of all deaths investigated. Both the Edmonton and Calgary offices host multidisciplinary pediatric death review committees. These committees are committed to comprehensive reviews of child deaths to better understand why children die and to use those findings to prevent other deaths and to improve the health, safety and well-being of all children in Alberta.

### REGIONAL DISTRIBUTION

Region	# Deaths
Calgary	32
South Rural	40
Edmonton	56
North Rural	32
<b>Total</b>	<b>160</b>

### MANNER OF DEATH

Manner of Death	# of Deaths
Accidental	74
Natural	54
Suicide	8
Undetermined	12
Homicide	8
Unclassified	4
<b>Total</b>	<b>160</b>



*\*injury includes: accidental, suicide and homicide*

**PEDIATRIC ACCIDENTAL DEATHS BY CAUSE**

<b>Cause of Injury</b>	<b># Deaths</b>
Motor Vehicle Related Total	53
<i>Driver (1)</i>	
<i>Passenger (32)</i>	
<i>Unknown position in vehicle (2)</i>	
<i>MV Struck by Train (1)</i>	
<i>Motorcyclist (1)</i>	
<i>Other (1)</i>	
<i>Snowmobile (1)</i>	
<i>ATV (5)</i>	
<i>Bicyclist (2)</i>	
<i>Pedestrian (7)</i>	
Asphyxia	7
Drowning	6
Sporting (does not include deaths due to drowning or related to motor vehicle collisions)	2
Aspiration	1
Carbon Monoxide	1
Fall	1
Farm	1
Firearm	1
Hypothermia	1
<b>Total</b>	<b>74</b>