Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS Community Health Nursing	

TITLE:		SECTION:	POLICY NUMBER:
Reporting Death to the Coroner		Nursing Practice	07-014-00
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APPLIES TO:			
Community Health Nurses, Nurse Practitioners, Supervisor of Community Health Programs, Licensed Practical Nurses; Acute Care and Primary Care Paramedics			

1. BACKGROUND:

Every province and territory in Canada has a coroner system. The coroner system in Nunavut is housed in the Department of Justice. It is governed by the *Coroners Act* R.S.N.W.T. 1988, c.C-20, as amended by Nunavut Statutes s.NU.2007, c.15, s.177. The Chief Coroner is situated in Iqaluit and operates independently of the government. The Chief Coroner has authority over all community coroners.

The coroner's role is investigative, judicial, preventative and administrative. The coroner can issue a warrant to take custody of the deceased and can order an investigation and an inquest if necessary.

2. POLICY:

2.1 All deaths must be reported to the Coroner to ensure that a reportable death is not missed.

2.2 In most situations, a Community Health Nurse (CHN), Supervisor of Community Health Programs (SCHP), Nurse Practitioner (NP) or Licensed Practical Nurse (LPN) will report a death to the coroner.

2.3 During periods of Health Centre closure if neither CHN, NP nor LPN is available, the Advanced Care (ACP) or Primary Care (PCP) Paramedic must report deaths to the Coroner.

2.4 The Coroner must present a copy of *Information to Obtain* and a *Search Warrant,* signed by a Justice of the Peace in order to obtain a copy of the client record.

3. PRINCIPLES:

3.1 The *Coroners Act* defines the roles and responsibilities of the coroner in Nunavut and outlines the criteria for reportable deaths.

3.2 Under the requirements of the *Coroners Act,* the RCMP, under the authority of the Coroner, become responsible for the body of the deceased in the case of a reportable death.

4. REPORTABLE DEATHS:

4.1 While all deaths must be reported to the coroner to ensure that a reportable death is not missed, the *Coroner's Act,* identifies the following causes of death as reportable:

i. Occurs as a result of apparent violence, accident, suicide or other apparent cause except from disease, sickness or old age.

ii. Occurs as a result of apparent negligence, misconduct or malpractice.

iii. Occurs suddenly and unexpectedly when the deceased was in apparent good health.

iv. Occurs within 10 days after a medical procedure or while the deceased is under or recovering from anesthesia.

v. Occurs during the course of employment.

vi. Is a stillbirth that occurs without the presence of a medical practitioner. (Please see Policy 07-015-00 Stillbirth.)
vii. Occurs while the deceased is detained or in custody involuntarily pursuant to law in a jail, lock-up, correctional facility, medical facility or other institution.
viii. Occurs while the deceased is detained by or in the custody of a police officer.

5. GUIDELINE – REPORTING DEATH TO THE CORONER

5.1 Anyone pronouncing death in the community must immediately report the death to the coroner.

5.2 The coroner is responsible for completing the forms related to a Coroner's case, as outlined in the *Coroners Act* and *Coroner's Forms Regulations.*

5.3 The forms listed below are applicable to the Health Centre; all forms will not necessarily be utilized in each case:

i. Form 1: A warrant to take possession of the body of the deceased
ii. Form 2: An authorization to release the body of the deceased.
iii. Form 3: A certificate that an inquest is unnecessary or necessary.
iv. Form 4: An authorization to a pathologist to perform a post-mortem examination of the body of the deceased.
v. Form 5: An authorization to transport the body of the deceased out of the Territories.
vi. Form 11: An authorization to a nurse or medical practitioner to take a sample of bodily fluids.
vii. Form 12: An authorization to a toxicologist to examine a sample of bodily fluids.

6 RELATED POLICIES, PROTOCOLS AND LEGISLATION:

Policy 05-007-00 Nursing Practice-Employee Responsibilities
Policy 05-011-00 Reduction and Suspension of Core Community Health Nursing Services
Policy 07-012-00 Certification of Death
Policy 07-013-00 Pronouncing Death
Policy 08-004-00 Post Mortem Samples
Policy 08-011-00 Stillbirth

7 **REFERENCES**:

Coroners Act R.S.N.W.T. 1988, c.C-20, as amended by Nunavut Statutes s.NU.2007, c.15, s.177. Available at: https://nunavutcoroner.ca/publications-and-reports/file/1-coroner-act

*Vital Statistics Act (*R.S.N.W.t. 1998, c.17, s.29 as amended by Nunavut Statutes: S.NU. 2012, c.17, s.29. Available at: https://www.nunavutlegislation.ca/en/consolidated-law/vital-statistics-act-consolidation

Coroners Act: Consolidation of Coroners Forms Regulations R.R.N.W.T. 1990,c.C-19. Available at: https://www.nunavutlegislation.ca/en/consolidated-law/coroners-forms-regulations-consolidation .

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