

2025 Annual Report

Office of the Chief Coroner

Government of Nunavut
Department of Justice

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1.0 Introduction

The Nunavut Coroners Service is an independent office that falls administratively within the Government of Nunavut's Department of Justice and its budget and operates in accordance with the *Coroners Act* CSNu c C-180, of Nunavut. Financial details are available through government reporting documents. The Office of the Chief Coroner is in Iqaluit and oversees all death investigations in the territory. As of December 31, 2025, there were 10 "fee-for-service" coroners across the territory that provide coroner services in their respective communities. These Community Coroners are appointed under Section 3(1) of the Coroners Act and compensated as per §7 (1) of the Coroners Act and the *Remuneration and Allowances Regulations*.

In Nunavut, all sudden and unexpected deaths must be reported to a coroner. In the Coroner's Act it is stated that any person is required to notify a coroner or a police officer of any death in circumstances detailed in §8, so that a coroner may proceed with the necessary investigation. The Coroner Service is responsible for the investigation of all deaths reported to them to determine first whether it is a reportable death and proceed to determine the cause of death and the circumstances surrounding the death (§9). The Act applies to all deaths that occur in Nunavut or result from events in Nunavut (§8).

The Coroner Service is supported in its efforts by the Royal Canadian Mounted Police, and works collaboratively with the Fire Marshal's Office, the Workers' Safety and Compensation Commission, the Transportation Safety Board, and other agencies that may provide support or have a valid interest.

1.1 Historical Background on Coroners Service

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

One of the early functions of the office was to enquire into sudden and unexpected deaths. It's the duty of the Crowner to establish the facts relating to the death. There was a rigid procedure enforced for every unexpected death, with any deviation from the rules resulting in heavy fines.

This particular function of the Office of the Coroner has been modified over the centuries and presently exists in common-law jurisdictions. There are two death investigation systems in Canada: the Coroner system and the Medical Examiner system. The Coroner system has four main roles to fulfill: investigative, administrative, judicial, and preventive. The Medical

Examiner system involves medical and administrative elements. The Coroner and the Medical Examiner both collect medical and other evidence in order to determine the medical cause and manner of death. The coroner examines the investigative material, comes to a judicial decision concerning the death, and makes recommendations to prevent a similar death in the future, whether through their initial report, or through the use of the inquest.

1.2 Mission

The Nunavut Coroners Service is an independent, publicly accountable agency for the investigation of deaths. The Coroner Service is mandated by statute to review all reportable deaths and conduct inquests as required in service of the public interest. The Coroners Service does not have a vested interest of any kind in the outcome of death investigations.

1.3 Coroners of Nunavut

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

Candidates must complete an application form outlining any special skills or training they have that would assist them in the role of Coroner. The letter of recommendation for appointment by the Chief Coroner is sent to the Minister of Justice. Coroners are appointed by the Minister of Justice for a period of three years (§ 3(1)).

On December 31, 2025, the Nunavut Coroner Service had 10 community coroners across Nunavut; three of them are Inuit. There are additionally the Chief Coroner and the Deputy Chief Coroner who are the full-time staff for the Nunavut Coroners Service.

1.4 Coroners' Investigations

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

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

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

The Report of the Coroner is a document outlining the result of a coroner's investigation. It provides a classification of the facts and circumstances surrounding the death. The report

establishes the identity of the deceased, the cause of death, and includes recommendations to prevent a similar death. A Report of the is completed for all death investigations, except for cases where an inquest has been called. At the inquest, the jury's verdict takes the place of a Coroner's Report.

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

1.5 Post-mortem Examinations and Autopsy

An initial postmortem examination is conducted by the Coroner, or those ordered to by the Coroner, at the scene or at the local medical facility to which the deceased is transported from the scene. This examination assists in the initial steps of the investigation. During this initial examination it is common for the coroner to draw, or order to be drawn, bodily fluids for toxicological and serological examination when it is possible that the results could be of assistance in determining the cause or manner of death. In cases where the manner of death is not entirely clear when circumstances are considered, or a natural cause is not supported by medical history, an autopsy may be authorized by the investigating coroner. An autopsy may also be ordered when the manner and cause may be clear, but the identity is unclear. Where reasonable given the needs of diligent investigation, the wishes of the family are considered. Due to the remote location of all Nunavut's communities, this procedure is currently performed exclusively at one of two southern facilities under a Memorandum of Understanding (MOU) with the Government of Nunavut's Department of Justice and the Medical Examiners and Forensic Pathologists from the south. There are no facilities in Nunavut where autopsy examinations can be performed. When it is determined an autopsy is needed the remains are placed in a transport container, and arrangements are made for the remains to be transported as Human Remains Cargo by air. Canadian North and Calm Air are the airlines used, depending on the hamlet in which death occurred.

The body is transported to the Eastern Ontario Regional Forensic Unit in Ottawa, Ontario, or to the Chief Medical Examiner's Office in Edmonton, Alberta. Following the autopsy, the remains are sent to Kelly Funeral Homes in Ottawa or to Connelly-McKinley Funeral Homes in Edmonton for preparation and repatriation. Toxicology services are provided by Dyna Care Lab in Edmonton, Alberta.

1.6 Manners of Death

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

Classifications are as follows:

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

ACCIDENTAL: a death is accidental if it is due to an occurrence, incident, or event that happens without foresight or expectation. An accidental death is caused by an external factor, where death or harm was not foreseen or expected.

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

HOMICIDE: includes any death resulting from injuries caused directly or indirectly by the actions of another person. Homicide is a neutral term that does not imply fault or blame.

UNDETERMINED: is any death which cannot be classified in any of the categories. The actual cause of death may or may not be known in these cases.

A finding of "undetermined" may be a positive and appropriate finding after a full investigation and careful consideration of all the evidence. It should not be considered a failure to reach a conclusion.

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

NOTE: Some data includes deaths noted as UNCLASSIFIED. This indicates that there is a file which is awaiting further investigation such as an inquest.

2.0 Manner of Death

When reviewing the various manners of death investigated and recorded in Nunavut, it is important to keep in perspective the sample being considered. As of December 31, 2025 the population was just over 41900 (per Statistics Canada), and the Nunavut Coroners Service investigated 124 deaths in 2025 (Table 1).

Natural deaths accounted for the largest proportion of cases (n = 47; 37.9%, followed by suicide (n = 38; 30.6%) and accidental deaths (n = 25; 20.2%) (Table 1). Homicide, undetermined, and unclassified deaths each represented less than 5% of all deaths investigated.

Table 1 Deaths Investigated by Coroners, by Manner of Death, Nunavut, 2025

Manner of Death	Count	Percentage of Deaths Investigated
Natural	47	37.9%
Suicide	38	30.6%
Accidental	25	20.2%
Homicide	6	4.8%
Undetermined	5	4.0%
Unclassified	3	2.4%
Total	124	100%

2.1 Manner of Death by Region

Qikiqtaaluk experienced the highest number of deaths investigated by coroners (n = 77), followed by Kivalliq (n = 34) and Kitikmeot (n = 13) (Table 2). Natural deaths and suicides accounted for the majority of investigated cases in all three regions (Kitikmeot = 61.5%, Kivalliq = 70.6%, Qikiqtaaluk = 68.8%) (Figure 1). Due to the different population sizes between regions and because only counts and percentages, not rates, are provided, no direct comparisons can be made between regions. Due to small cell counts, percentages may vary greatly when there is only a difference of one or two counts. Trends should be interpreted with caution.

Table 2 Deaths Investigated by Coroners, by Manner and Region, Nunavut, 2025

	Region		
Manner of Death	**Kitikmeot**	**Kivalliq**	**Qikiqtaaluk**
Natural	5	14	28
Suicide	3	10	25
Accidental	1	4	20
Homicide	1	5	0
Undetermined	2	1	2
Unclassified	1	0	2
Total	13	34	77

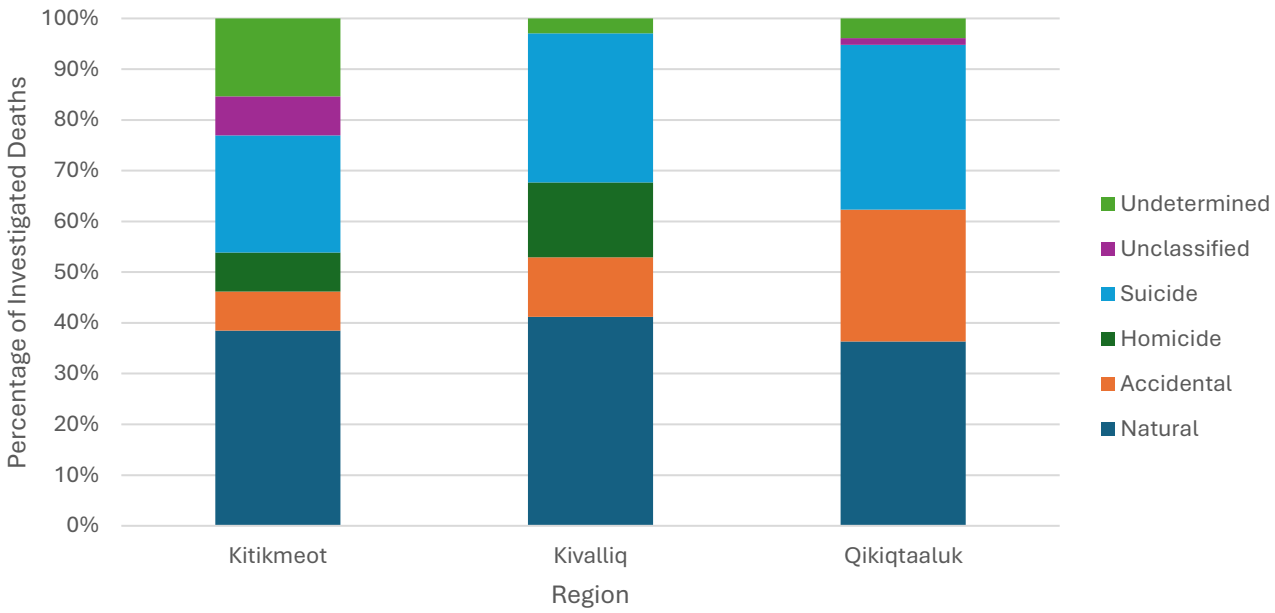


Figure 1 Manner of Death as a Percentage of Deaths within Each Region, Nunavut, 2025

2.2 Manner of Death by Month

Coroners investigated between five and 17 deaths per month in 2025 (Table 3). Natural deaths occur every month, and suicide deaths also occurred most months. Natural deaths accounted for 17.6% to 63.6% of deaths per month, while suicides accounted for 0% to 52.9% of deaths per month (Figure 2). Due to the relatively small number of cases per month, the percentage distributions can shift substantially when counts change by one or two cases. Figure 2 should therefore be interpreted as showing relative composition within each month, not month-to-month trends.

Table 3 Deaths Investigated by Coroners, by Month and Manner of Death, Nunavut, 2025

	Manner of death						
Month of Death	**Natural**	**Suicide**	**Accidental**	**Homicide**	**Undetermined**	**Unclassified**	**Total**
January	3	5	2	0	0	0	10
February	7	1	4	0	1	0	13
March	5	4	0	0	0	0	9
April	7	2	1	1	0	0	11
May	1	2	2	0	0	0	5
June	3	2	0	0	0	1	6
July	3	4	6	1	1	1	16
August	3	2	2	0	0	0	7
September	3	3	1	2	0	0	9
October	3	9	3	0	2	0	17
November	3	4	2	0	1	0	10
December	6	0	2	2	0	1	11
Total	47	38	25	6	5	3	124

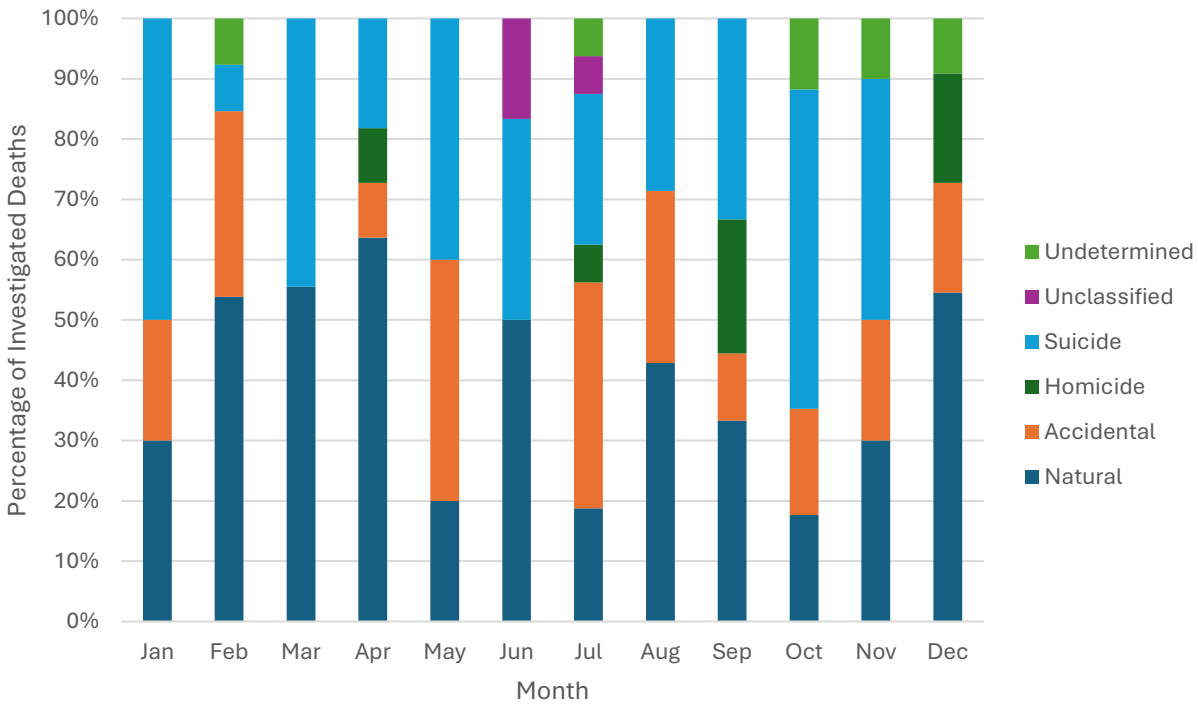


Figure 2 Manner of Death as a Percentage of Deaths within Each Month, Nunavut, 2025

3.0 Suicide Deaths

3.1 Suicide by Age and Sex

Of the 38 suicide deaths investigated in 2025, the highest number occurred among individuals aged 15 to 19 years, with 11 deaths (Table 4). The 10 to 14 and 20 to 24 age groups had the second highest number of deaths, with 6 deaths each. Individuals aged 10 to 24 years accounted for 23 of the 38 suicide deaths investigated.

Most suicide deaths occurred among males (n = 28), with ten deaths among females (Table 4). Among males, the highest number of deaths occurred in the 15 to 19 age group, followed by the 10 to 14 and 20 to 24 age groups. Among females, deaths were the highest in the 15 to 19 age group. Because the number of deaths in each age and gender group is small, these findings should be interpreted as descriptive counts rather than evidence of statistically meaningful differences between groups.

Table 4 Suicide Deaths by Age Group and Sex, Nunavut, 2025

Age-group	All	Male	Female
<10	0	0	0
10 to 14	6	5	1
15 to 19	11	7	4
20 to 24	6	5	1
25 to 29	4	4	0
30 to 34	1	1	0
35 to 39	3	1	2
40 to 44	3	2	1
45 to 49	1	1	0
50 to 54	0	0	0
55 to 59	1	1	0
60 to 64	2	1	1
65 to 69	0	0	0
70 to 74	0	0	0
75 +	0	0	0
Total	38	28	10

3.2 Suicide by Method and Toxicology

Hanging was the most common method of suicide, accounting for 23 deaths (60.5%), followed by gunshot wounds, which accounted for 15 deaths (39.5%). Toxicology was completed in 63.2% of suicide deaths (n = 24).

Among cases with completed toxicology (n = 24), drugs were present in 18 cases (75.0%) and alcohol was present in 11 cases (45.8%) (Table 5). Alcohol and drugs were both present in 9 cases (37.5%).

These findings describe toxicology results among completed tests only and should not be interpreted as representative of alcohol or drug positivity among all suicides investigated. Drugs detected have included cannabis, cocaine and prescription medication, including anti-depressants.

Table 5 Suicide Deaths by Method of Death and Toxicology Findings, Nunavut, 2025

Method Of Death	Deaths* n (%)	Toxicology Completed † n (%)	Drugs Present ‡ n (%)	Drugs NOT Detected ‡ n (%)	Alcohol Present ‡ n (%)	Alcohol NOT Detected ‡ n (%)	Both Alcohol and Drugs Present ‡ n (%)
Hanging	23 (60.5)	17 (73.9)	13 (76.5)	4 (23.5)	7 (41.2)	10 (58.8)	5 (29.4)
Gunshot wound	15 (39.5)	7 (46.7)	5 (71.4)	2 (28.6)	4 (57.1)	3 (42.9)	4 (57.1)
Total	38 (100.0)	24 (63.2)	18 (75.0)	6 (15.8)	11 (45.8)	13 (34.2)	9 (37.5)

Note: "Drugs present" includes cases where drugs were detected with or without alcohol. "Alcohol present" includes cases where alcohol was detected with or without drugs.

**Percentages calculated using all suicide deaths (n=38) as the denominator.*

† *Percentages calculated using cases per method as denominator (hanging: n = 23; gunshot wound: n=15).*

‡ *Percentages calculated using cases with completed toxicology per method as denominator (hanging: n = 17; gunshot wound: n = 7).*

4.0 Accidental Deaths

4.1 Accidental Deaths by Region

Of the 25 accidental deaths in 2025, 20 occurred in Qikiqtaaluk region, while four and one death occurred in Kivalliq and Kitikmeot regions, respectively (Table 6). Due to differences in population size across regions, counts should not be compared between regions

Table 6 Accidental Deaths by Region and Cause of Death, Nunavut, 2025

	Region			
Cause of Death	**Kitikmeot**	**Kivalliq**	**Qikiqtaaluk**	**Total**
Hypothermia	0	2	7	9
Drowning	1	0	4	5
Multiple/blunt force injury	0	1	4	5
Toxicity	0	1	3	4
Asphyxia	0	0	2	2
Total	1	4	20	25

4.2 Accidental Deaths by Cause

The leading cause of accidental deaths in Nunavut in 2025 was hypothermia (n = 9), followed by drowning (n = 5) and multiple/blunt force injury (n = 5) (Table 6; Figure 3). Accidental toxicity and asphyxia accounted for fewer than five deaths each in 2025.

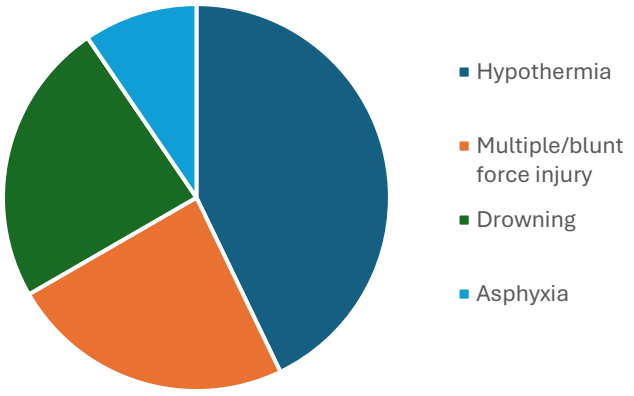


Figure 3 Accidental Deaths by Cause of Death, Nunavut, 2025

4.3 Accidental Deaths by Cause and Sex

Males accounted for 22 of the 25 accidental deaths in Nunavut in 2025 (Figure 4). Hypothermia was the leading cause of death for both sexes, and accounted for all three deaths among females.

Table 7 Accidental Deaths by Cause of Death and Sex, Nunavut, 2025

	Sex	
Cause of Death	**Female**	**Male**
Hypothermia	3	6
Multiple/blunt force injury	0	5
Drowning	0	5
Toxicity	0	4
Asphyxia	0	2
Total	3	22

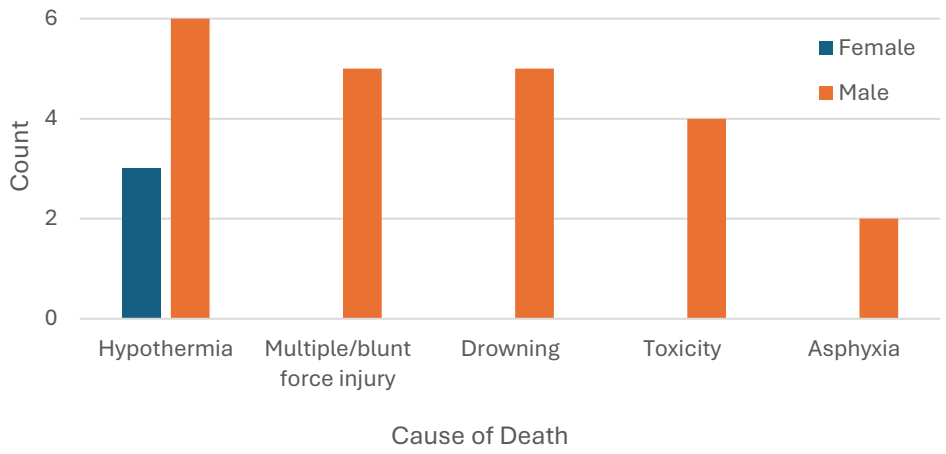


Figure 4 Accidental Deaths by Cause of Death and Sex, Nunavut, 2025

4.4 Substances Detected in Accidental Deaths

Toxicology testing was conducted in 17 (68.0%) of the 25 accidental deaths. Of these 17 deaths, alcohol alone was detected in 35.3% of deaths (n = 6) and neither drugs nor alcohol was detected in 17.6% of deaths (n = 3) (Table 8; Figure 5).

Alcohol, either alone or in combination with drugs, was detected in 64.7% (n = 11) of accidental deaths with toxicology results. Drugs, alone or in combination with alcohol, were detected in toxicology results of 47.1% (n = 8) of accidental deaths with toxicology results.

Results refer only to accidental deaths with completed toxicology (n=17) and should not be interpreted as representative of substance positivity among all accidental deaths (n=25).

Table 8 Substance Detection among Accidental Deaths with Completed Toxicology, Nunavut, 2025

Substance Detected	Count	Percentage
Alcohol only	6	35.3%
Both alcohol and drugs	5	29.4%
Drugs only	3	17.6%
Neither detected	3	17.6%
Total	17	100.0%

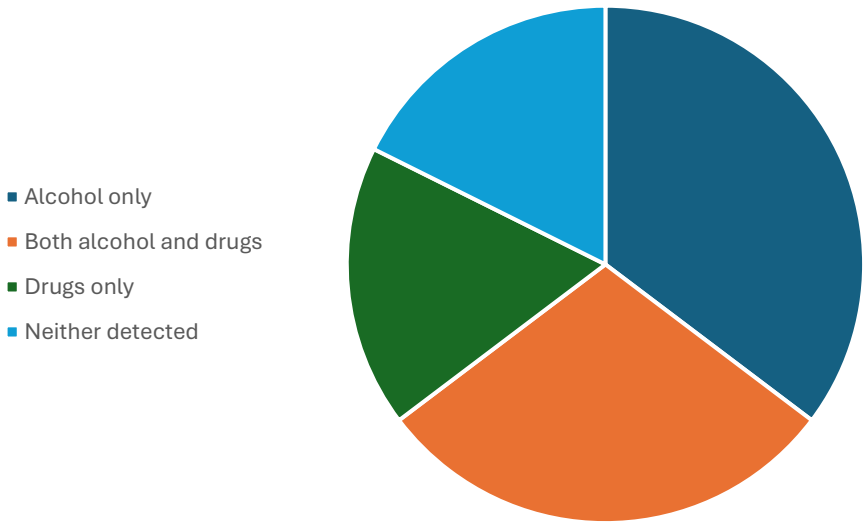


Figure 5 Substance Detection among Accidental Deaths with Completed Toxicology, Nunavut, 2025

5.0 Homicide Deaths

A total of six homicides occurred in Nunavut in 2025. Homicide is defined as any death resulting from injuries caused directly or indirectly by the actions of another person. Homicide is a neutral term that does not imply fault or blame.

5.1 Homicide Deaths by Region

The majority of homicides occurred in Kivalliq (n = 5), and one homicide occurred in Kitikmeot. There were no reported homicides in Qikiqtaaluk for 2025 (Figure 6).

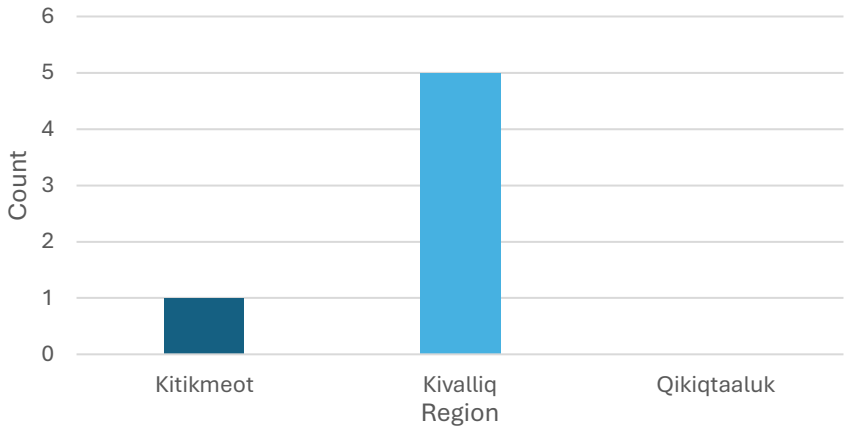


Figure 6 Homicide Deaths by Region, Nunavut, 2025

5.2 Homicide Deaths by Age and Sex

All homicide deaths in 2025 occurred among males between the ages of 20 and 59 (Figure 7). The majority of homicide deaths (66.7%) occurred in the 30-49 age range.

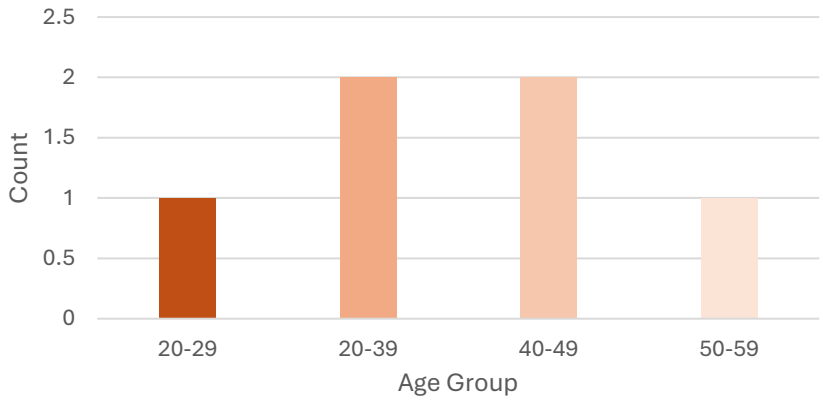


Figure 7 Homicide Deaths by Age Group

5.3 Homicide Deaths by Method

Multiple/blunt force injury accounted for 50.0% (n = 3) of homicide deaths in Nunavut in 2025 (Figure 8). Multiple/sharp force injury accounted for an additional 33.3% (n = 2) of homicide deaths. Smoke inhalation from fire accounted for one death.

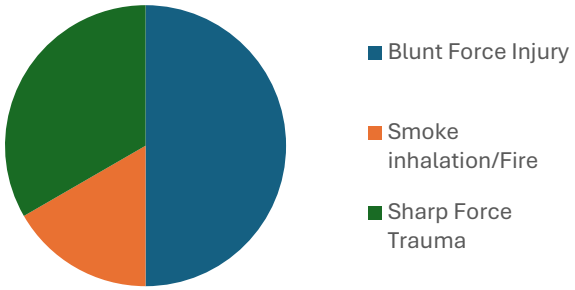


Figure 8 Homicide Deaths by Cause of Death, Nunavut, 2025

6.0 Autopsy Rate

Autopsies were completed in 63 of the 124 investigated deaths (50.8%). All homicide and unclassified deaths received an autopsy. Autopsy rate was also relatively high among natural deaths (65.9%) and accidental deaths (56.0%). Autopsy was lowest in suicide deaths (15.8%). This rate can be seen in Figure 9, which illustrates the percentage and count of autopsies by manner of death.

These findings should be interpreted descriptively and not as trends. The use of an autopsy in an investigation may reflect differences in investigative requirements, case circumstances, available information, and coroner decision-making which must be done on a case-by case basis.

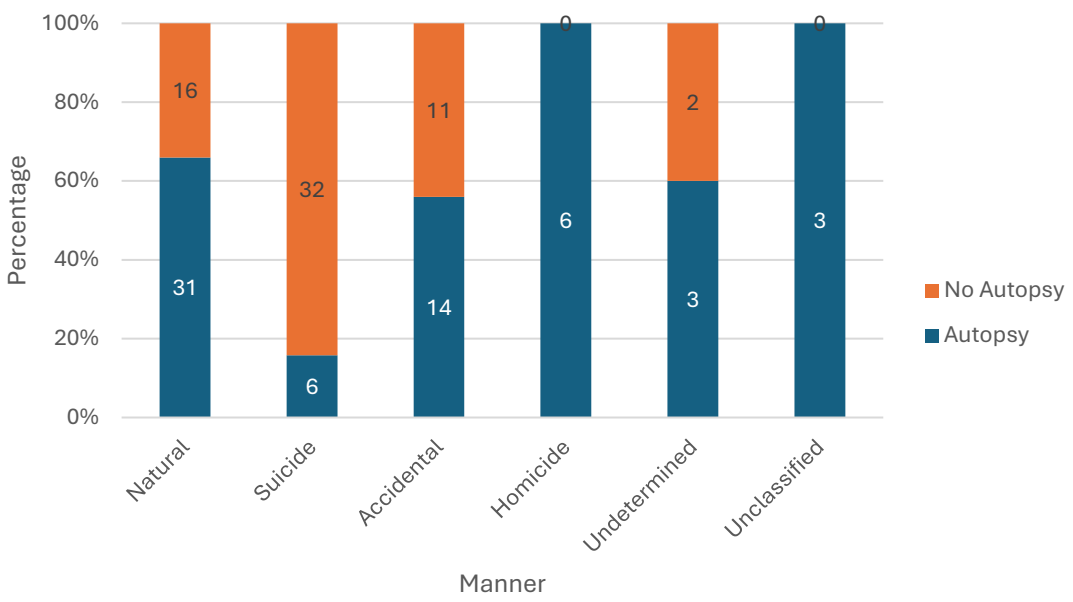


Figure 9 Total counts of autopsy and non autopsy cases by manner of death, in 2025

7.0 Summary of Inquest Recommendations

The Coroner Report prepared in response to each death investigation includes recommendations to different agencies and government departments. These recommendations aim to prevent similar deaths in the future. In the event of an inquest, the inquest jury verdict takes the place of a Coroner Report.

These recommendations may include structural or engineering solutions to help prevent accidents, such as installations of streetlights or signage. Community education to increase knowledge about health, safety, and risks associated with different activities plays an important role in empowering Nunavummiut to protect their health. Recommendations for healthcare service provision identify ways to address healthcare challenges experienced in remote Arctic regions, such as limited emergency care and patient transportation in some communities. Community and Inuit-led responses that emphasize culturally relevant support, and provide opportunities to develop cultural identity and connection, are central to recommendations regarding the development of mental health and wellness resources.

The following summary provides the circumstances and recommendations from the 2025 inquest.

7.1 Coroner's Inquest

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

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

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

Verdict of Coroner's Jury

Date of Inquest:	March 31 to April 4, 2025
Deceased:	George Arlooktoo
Date and time of Death:	February 9, 2019, at 1700 hours
Place of Death:	Kimmirut, Nunavut
Cause of Death:	Stab Wounds of the Neck
Manner of Death:	Suicide

Summary of circumstances under which death occurred:

On February 9, 2019, the Royal Canadian Mounted Police (RCMP) were informed by several people that George Arlooktoo had expressed suicidal ideation. Officers attended Apartment 202-C in Kimmirut, NU, to apprehend George Arlooktoo under the Mental Health Act and bring him to the Health Centre for assessment.

With the assistance of two family members, the RCMP made entry into the apartment, at which point George Arlooktoo ran into the bathroom, grabbed a pocketknife, and stabbed himself repeatedly in the neck. An officer attempted to use a taser to stop him. The two officers, a community member, and Health Centre staff attempted lifesaving measures that were ultimately unsuccessful.

Recommendations of the Jury

1. The alcohol committee in Kimmirut recommends that alcohol orders from Rankin Inlet be divided into 4 weekly shipments, instead of the current system of alcohol orders in one large shipment.

2. We recommend that the RCMP have 3 officers always present in Kimmirut during the time the Iqaluit winter trail (Ittijjagiak) is open.

3. The RCMP will continue to promote professionalism and respectfulness in its dispatch personnel.

4. The RCMP have a bilingual person working with the detachment to assist in interpretation.

5. Recommended to GN that Kimmirut have proper cell service in all parts of Kimmirut, specifically in the Tasilik and Taqaiqsivik area.

6. The GN will promote mental health wellness and hope through public education be taught by mental health professionals, including grade 10-12 students.

7. Recommendation to the GN that Kimmirut should be provided with a women's shelter.

8. The GN will- add defibrillators to various venues and adequate training to use it and advanced first aid.

9. The GN will work with blood banks to equip community health centres with a minimum of four units of blood.

10. The GN will provide all available support, including financial support, to establish and maintain a men's counseling group in Kimmirut. Specifically, the GN will bring Atii Angutiit! to Kimmirut next.

11. The Hamlet of Kimmirut will provide space for Atii! Angutiit! Staff and program participants, including accommodations.
12. The GN will ensure mental health support for mental health and community health nurses in communities.

13. The GN will ensure ambulances and EMTs in every community.

14. The coroner will ensure that inquests happen in a timely manner.

15. The partner agencies involved with Inuusivut Annirnaqtut Action Plan will do more to seek feedback from program participants.

16. The GN and communities, including Kimmirut, will reach out to the RCMP to continue building relationships and ensure continuity. The RCMP will remain receptive to these relationships.

17. The RCMP will work to recruit and retain officers to fill all three positions in Kimmirut and in the interim ensure three officers are always present in the community.

18. The RCMP will invite communities to take a lead role in a co-developing orientation for new members that is specific to the community being served.

19. The Government of Nunavut will equip and train community Health Centre nurses with rapid intravenous (IV) infusers to provide trauma patients with fluids quickly.

20. The GN will ensure community Health Centres are equipped with up-to-date cardiac monitors and defibrillators.

21. The GN will ensure that training for community Health Centre nurses includes regular trauma and wilderness medicine components, including training on how long to continue resuscitation efforts on patients with no vital signs.

22. The GN will deliver greater continuity for mental health support, by recruiting and retaining mental health nurses to serve communities on a long-term basis and by hiring local counsellors directly from the communities.

23. The Hamlet of Kimmirut will make a safe space available for youth programs to develop life skills, cultural identity and hope, and seek funding and support for the group from the GN.
24. The GN will provide all available support, including financial support, to help establish a men's group and youth programming, delivered in safe spaces identified by the community, in Kimmirut and throughout Nunavut.

25. The GN will extend its collection and analysis of suicide data before Nunavut became its own territory in 1999.

26. The GN support the establishment of Inuit-led hotlines throughout Nunavut for people seeking help for gender-based violence, modelled on the hotline recently started in the Kivalliq region.

27. The GN will provide encouragement and financial support for those who deliver suicide prevention training and mental wellness, within communities and in cross-community networks (support for the supporters)

28. The Nunavut housing authority will review design specifications for public housing to ensure porches and back doors are built with enough space for emergency responders to easily access dwellings by using tools and methods available to first responders in Nunavut.

29. The RCMP and the GN ensure finalization and implementation for the education plan to inform frontline workers about changes to the Mental Health Act and Regulations.

30. The RCMP and the GN will continue to advance, publicize, promote and fulfill the action plan items set out in the Inuusivut Annirnaqtut Action Plan 2024-2029

31. The RCMP and the GN will continue to develop weekly inter-agency meetings, in all communities, where police and Health Care providers can coordinate efforts to prevent suicides.

32. The GN will declare a suicide crisis in Nunavut.

8.0 Conclusion

The Office of the Chief Coroner would like to acknowledge the assistance of the Royal Canadian Mounted Police, health care professionals, the Eastern Ontario Forensic Pathology team in Ottawa, the Office of the Chief Medical Examiner in Edmonton, Kelly Funeral Homes in Ottawa, Connely-Mckinley Funeral Homes in Edmonton, and many other investigative partners who assisted us with our death investigations.

The Office of the Chief Coroner would like to express gratitude to the Nunavut community coroners for their dedication and professionalism.