CHAPTER 5
APPARENTLY NATURAL DEATHS

DEFINITION

A definition of apparently is: "seemingly real or true".

INTRODUCTION

Three quarters of all deaths in Ontario are not investigated by coroners because they are due to natural causes. A natural death is not generally reportable to the coroner and does not necessarily require an investigation unless it meets specific criteria under **s. 10** of the ***Act.*** Calls will often be erroneously received from police, ambulance personnel, health care professionals and others about such deaths, because it is part of their standard operating procedure or protocol to report "sudden deaths".

In some apparently natural deaths, it is only the circumstances in which the deceased is found that leads to the reporting of the death to the coroner, i.e. decomposition, unwitnessed, etc. In other situations where there is no medical practitioner available to certify death, the case will, by policy of the OCC, default to the coroner and will have to be investigated.

When an apparently natural death is reported to the coroner, the first responsibility is to assess, as fully as possible, whether this death requires a coroner's investigation. This will require the coroner to obtain adequate information from the reporting person(s) involved in the case. (See **Memos #10-13 and #10-18**)

A) Information About the Circumstances Surrounding the Death

The coroner should obtain as much information as possible to make an informed decision about his/her jurisdiction to accept the case for investigation. Information could include, but not be limited to:

1. What are the known circumstances surrounding the death?
2. When was the deceased last seen alive?
3. When and who found the deceased?
4. Was the death witnessed, and if so, by whom?
5. What was the witness' relationship with the deceased?
6. What is the state of the body?
7. What is the known medical history on the deceased, including any regularly prescribed medication?
8. Is the deceased a palliative patient? Is there any use of narcotics and how did the patient get them?

9. Who is the attending physician?
10. What prior arrangements had been made to contact the physician in an expected death situation?
11. Is there a psychiatric history?
12. Is there any history of drug abuse of prescription or non-prescription medications?
13. Is there any history of causing self-harm or any previous suicide attempts?
14. Is there any history of violence involving an intimate partner/significant other?
15. Can the body be easily identified or will advanced methods be required?
16. Is there any evidence of injury to the deceased?

B) Decision to Accept a Case for Investigation

To assist in deciding on the need for an investigation, the coroner should consider the following 5 questions:

1. Was the death all natural? (*i.e. Was the death entirely due to natural causes without potential contribution from a non-natural condition or event?)*
2. Was the death reasonably foreseeable and does the cause flow logically from a natural disease process?
3. Is there a designated health care practitioner to complete the Medical Certificate of Death?
4. Is the case free from significant care-related concerns from either family or care providers?
5. Are OCC policy and/or **s.10 (2)(3)** statutory obligations excluded? This includes:
    - i) Child with active CAS involvement (direct service in the past 12 months)
    - ii) Threshold case for a long-term care facility
    - iii) Decomposed body
    - iv) Need for identification
    - v) Deaths in:
        - a. Charitable institution
        - b. Children's residence under the *Child & Family Services*
        - c. A supported group living residence under the *Services and Supports to Promote the Social Inclusion of Persons with Development Disabilities Act*
        - d. A psychiatric facility under the *Mental Health Act*
        - e. An institution under the *Mental Hospitals Act.*

        A public or private hospital to which the person was transferred from "a" to "e" above.

If the answer to **all** five of the questions is **YES**, the case does not require investigation and could most likely be declined. The coroner should indicate to the reporting individual that the death does not fall under the jurisdiction of the coroner under the ***Act***, and that he/she should find a health practitioner to pronounce death and issue a Medical Certificate of Death. In some cases, the coroner may have to speak to the health practitioner directly indicating his/her responsibility to the patient and suggest his/her attendance at the location to pronounce and certify death. Where there is no family physician or health practitioner available, or willing to attend, the coroner will be required to take the case. (The reason for investigating a natural death should be recorded both in the Involvements on the Form 3 and in the narrative of the report that is submitted on the case.)

If the answer to one or more of the five questions is **NO**, the death should be accepted as a case requiring investigation. The approach to the investigation into this death is to establish if the death is truly natural or non-natural, to review care related concerns, or to fulfil the required mandate for investigation as defined by the ***Act***.

The investigation should be conducted with an open mind considering all manners of death as an initial possibility and, ruling manners of death out based on the evidence collected. If from the scene investigation and the information obtained from the police, relatives and witnesses the coroner is still unable to answer any of the five questions (who, when, where, how and by what means), then an autopsy is required. If from the information gathered, the death – on the balance of probabilities – appears to be natural and all five questions can be answered, then no autopsy will be required, and a death certificate may be issued.

In any case, where the coroner is not sure, or requires procedural answers about the death, even though it may be apparently natural, then the coroner should consult with the RSC to seek advice.

REFERENCES

i) Memo #10-13 – Investigating Coroners' Acceptance of Natural Deaths for investigation; Best Practice Guideline #4

ii) Memo #10-18 – Best Practice Guideline #5 – Interaction of Investigating Coroners with EMS, Police, Body Removal Services and Funeral Services Arising from Death Investigations