DEATH INVESTIGATION:

An Analysis of Laws and Policies of the United States, Each State and Jurisdiction

[as of January 31,1977]

ON, AND WELFARE
on

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The research herein was performed by the Sheehan, Phinney, Bass & Green Prof. Ass'n., Manchester, New Hampshire pursuant to contract 240-76-0021 with the Bureau of Community Health Services, Health Services Administration, Department of Health, Education, and Welfare. The opinions expressed herein are those of the authors and should not be construed as representing the opinions or policies of any agency of the United States Government.

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Of Death Investigation Systems

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This study has been prepared pursuant to Contract No. HSA 240-76-0021 between Sheehan, Phinney, Bass & Green Prof. Ass'n and the Bureau of Community Health Services (BCHS), Health Services Administration, U.S. Department of Health, Education and Welfare (DHEW).

The Project Director for the study is Attorney Alan P. Cleveland. The legal research and analysis of all relevant statutory law has been done by Attorneys Ronald E. Cook and Raymond W. Taylor, assisted by Mr. Daniel J. Scanlon and Ms. Paula R. MacDonald, and under the supervision of Mr. Cleveland and the law firm of Sheehan, Phinney, Bass & Green.

The study is designed to assemble and analyze existing State and Territorial law, policies and regulations governing medico-legal death investigation. Its purpose is to assist the BCHS Office of Maternal and Child Health in developing a systematic surveillance of national medico-legal investigation of death in relationship to the sudden and unexplained death of infants.

In addition to the 50 States, this study covers the District of Columbia, American Samoa, Guam, Puerto Rico, Panama Canal Zone, and the U.S. Virgin Islands. Local ordinances or regulations and policies adopted by governmental bodies below the State level are not included except in occasional instances where cited to clarify State law. The study speaks as of January 31, 1977, although in a few instances later developments are included.

Introduction

On April 22, 1974, the SIDS Act of 1974 (P.L. 93-270) was signed into law and codified as an amendment to the Public Health Services Act (42 U.S.C. 300c-11). In pertinent part, the Act authorizes start-up federal funding of:

> programs providing information and counselling services to families and other persons affected by infant death;
>
> programs designed to develop public information and professional educational materials relating to infant death, and to disseminate such information and materials to persons providing health care, to public safety officials, and to the general public.

Although the Act, by its terms and funding, seeks to foster programs which would alleviate the family dislocation and remorse resulting from infant death, Federal law itself cannot be expected to fully resolve all issues attendant to this special public health problem. The fact of the case is that the ultimate providers of professional counselling services to those affected by infant death must be found at the State level. It is State law which expressly requires medico-legal investigative agencies to take initial and exclusive investigation over any sudden, unexplained or unattended death. It is State law which legally mandates investigative procedures that operate to either support or erode family unity in facing an infant death.

Whether or not a given State agency may effectively participate in a family counselling program at all remains a function of those State laws prescribing local death investigative procedure--since nothing in the Act compels State, county or municipal authority to modify administrative norms to accommodate a trained and sensitive handling of infant deaths.

Recognizing the dispositive effect certain State and Territorial law exercises on programs relating to public health deaths, this study offers a concise and uniform overview of the legal framework underpinning a national medico-legal system of death investigation.

Any endeavor to create the proper context within which this study might be utilized should include a statement characterizing the present status of death investigation and its evolving national purpose. Historically, the medico-legal system adopted an accusatory approach to the investigation of sudden and unattended death: The purpose of a death investigation was merely to collect evidence, first, to determine whether the subject death resulted from a criminal act, and, if so, to aid in the conviction of the alleged perpetrator. Today, there is an increasing awareness of the importance of medico-legal death investigation for programs of disease and accident prevention, medical research, and other public health programs.

The growth of highly sophisticated medical technology and the introduction of public health issues as a matter of social priority have resulted in a wholesale reevaluation of the traditional function of death investigation. This progress has fostered a redefinition and extension of the medico-legal role beyond the criminal justice system to meet the greater public health expectations of the general populace.

Recent activities of leading medico-legal professional associations [such as the National Association of Medical Examiners, the International Association of Coroners and Medical Examiners, and the American Academy of Forensic Science among others] indicate a commitment of those organizations setting professional medico-legal standards to design policies and protocols geared to existing public health demands. Among the most encouraging aspects of this trend include the regionalization and modernization of medico-legal facilities and services, the widespread dissemination of new techniques and technologies through programs of continuing professional education, and a movement away from the confines of strictly forensic investigation toward a more comprehensive public health approach.

Perhaps the foremost example of an increasing involvement of the medico-legal community with extra-forensic public health death is that of the sudden and unexpected infant death. It is from the standpoint of the public health death, and, in particular, infant death, that this study views the national medico-legal system of death investigation.

Although the purpose of this report is to objectively characterize those individual medico-legal systems at the State and Territorial level relevant to the investigation of infant death, it is perhaps helpful for a general understanding of the subject to typify death

investigation procedure as it exists in the United States today. The following is a descriptive summarization of, not necessarily an ideal standard for, those standard procedures commonly adopted by most systems in the conduct of post-mortem investigations:

When a death is discovered to have occurred unattended by a physician, it must be reported to a law enforcement officer, who in turn notifies the medico-legal system exercising jurisdiction in the locale where the body is found.

An agent of that office is immediately delegated the responsibility for conducting an on-site preliminary investigation to determine whether the manner of death is actually subject to the jurisdiction of the system. [The definition of a "subject death" is set forth in each jurisdiction by statute, varying in detail from a multitude of particularized situations to merely any suspicious, unnatural or unattended demise.] This preliminary investigation includes: verification of the reported death; collection of personal and medical data on the deceased; review of all observeable circumstances surrounding death, such as place, time, witnesses, and causal agents; and, of course, a view, which consists of a visual examination of the body. It is standard procedure that in any subject death the body may not be moved without the permission of the responsible investigating medico-legal officer.

After completion of the view, the case officer is obligated to make a recommendation to his superiors within the medico-legal system. This recommendation takes the form of either a call for additional investigation or for certification of death. The latter results in official identification of the cause of death and, normally, closes the file on the case as a matter warranting no further investigation by the medico-legal office.

However, if a recommendation for additional investigation is acted upon, the case officer initiates such investigation on two levels: First, the responsible law enforcement agency is notified, which then conducts an independent circumstantial inquiry into the death. Second, either an inquest or a forensic investigation is ordered, which may entail further external examination, chemical and toxicological testing. Should the investigation yield no persuasive grounds for certifying the cause of death, further recommendation for gross or partial autopsy will be made and decided upon within the medico-legal system. All avenues of forensic investigation would be utilized by the medico-legal system for the ultimate purpose of determining cause of death. Only certification of death properly concludes a post-mortem investigation.

Throughout the investigation records are maintained regarding its conduct and conclusions, including the results of all tests, examinations, and circumstantial investigation. Upon certification, the complete report is issued by the case officer to certain designated authorities within the criminal justice system and, in an increasing number of jurisdictions, to certain State agencies involved with Public Health.

Within this broadly described medico-legal procedure a great deal of discretion, judgment and experience is exercised by each system in carrying out the jurisdiction's statutory mandate to investigate death. This same discretion is implicit in the preparation of investigative reports and the certification of death. It is the element of investigatory discretion, as channelled by the overall character of the system, which lends itself to an adjustment of the medico-legal function to accommodate contemporary considerations in the medico-legal investigation of infant death.

Leaving aside the substance of the report, the development of the present study can be characterized as in two main parts - research and production.

The initial, or research, aspect of the project's methodology can be further divided into five steps: (1) Collection of all pertinent statutory material relative to death investigation and registration in each of the fifty-six jurisdictions examined; (2) Verification of such material for accuracy and currency by independent staff research and review; (3) Identification of collected material by reference to topical sub-categories; (4) Summarization and digesting of all relevant statutory material; and (5) Development of a list of official field contacts in each jurisdiction for competent and authoritative outside review of statutory research and analysis.

The second, or production, phase of methodology involved: (1) Staff evaluation of each jurisdiction's death investigation system by reference to standard functional and statutory characteristics; (2) Preparation of narrative and abstract summarizations for each system; (3) Categorization of systems into families on the basis of common operational traits; (4) Organization of support data in statistical form; and (5) Preparation of the final written report.

It should be noted at the outset that the primary purpose of this study is to present a view of the individual character of those systems mandated with responsibility for death investigation at the State and Territorial level. Toward this end, certain functional traits were identified as defining a given system. The absence (or presence) of certain of these functional traits in a particular jurisdiction, however, does not of itself provide a basis for critical evaluation of the system in terms of its effectiveness or efficiency in death investigation. The report does not conform to such use.

As it is largely through operations procedure that each death investigation system performs its official mandate, those functional traits identified as common to most systems were selected as criteria for the analyses delineated in Section II of the report. These comparative characteristics include: system structure; method of staff selection and accession; staff qualifications; and authority to order autopsies.

Examination of the statutory foundation for the medico-legal function within these jurisdictions was conducted to determine variables among systems in terms of each of the above major characteristics. Shared traits among systems resulted in the family groupings found appended to the study.

The major principle of the project's surveillance of medico-legal death investigation systems is that the report is premised almost entirely upon legal analysis of each jurisdiction's respective statutes, regulations, and, where applicable, constitutional and decision law. The existence of clear discrepancies between law and practice in the operation of a number of the systems must be a keen and early realization in evaluating the report. With the exception of those items brought to the fore by verification through field representatives, functional deviations from legal mandate have not been generally incorporated in the study. And where they are referenced, it is by footnote and not by amendment or alteration of what otherwise is the required reading of the statute. In the interest of maintaining an objective and constant approach to the study, a strict interpretation of the letter of the law of each jurisdiction relative to death investigation constitutes the mainstay of the report.

A second principle of the project's survey is that the data and analyses presented are not intended to constitute an exhaustive census of each medico-legal death investigation system at every administrative level. For example, several "State" systems prove in fact to be multi-tier systems subordinate to municipalities, counties, classes of counties or specific State agencies. These sub-structures are not individually analyzed by the report.

Another basic premise carried throughout the research phase of the project was that all studied legal authority was considered perishable as subject to material amendment at any time. Consequently, one of the most time-consuming and persistent aspects of the study was the continual review and up-dating of statutory material. As the project neared completion, January 31, 1977 was chosen as the effective date beyond which no new material could be successfully incorporated into the report, and as such represents the terminus of primary material studied.

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SECTION I:

NARRATIVE DESCRIPTION OF OPERATIONS OF DEATH INVESTIGATION SYSTEMS FOR EACH STATE AND TERRITORY

The following is a compendium of the operations of death investigation systems found among the fifty-six studied jurisdictions. The material sets forth in summary fashion the statutory bases for each system written in a manner calculated to be understood by the reader without medico-legal background or training. A more technical approach to the material can be found in SECTION II of this study.

ALABAMA

Alabama's death investigation system consists of county coroners and county health officers. All deaths which occur without medical attendance in a county are required to be investigated by the county coroner or the county health officer.

Each county coroner is elected for a term of four years. When the coroner is informed that a person is dead in the county and that he died without being attended or examined by a legally qualified physician, the coroner is required to immediately proceed to the place where the dead body is lying, examine the dead body to ascertain the cause of death, and make a report. If the coroner is unable to determine the cause of death, he may summon any physician or surgeon to make an external post mortem examination of the dead body and report his opinion of the cause of death to the coroner is writing. If the surgeon or physician is unable to determine the cause of death from an external post mortem examination, and the coroner has reasonable cause to believe that the deceased came to his or her death by unlawful means, the coroner may in such cases order any physician or surgeon to perform an autopsy or internal examination on the dead body and report the findings of the autopsy to the coroner in writing.

A county health officer is required to be elected by the county board of health in each county, subject to the approval of the State committee of public health, for a term of not less than three years. When the county health officer investigates any death which occurs without medical attendance and he suspects suicide or is unable to ascertain the cause of death, or finds circumstances which causes suspicion that the death was caused by the criminal act of another, he is required to refer the case to the coroner or other proper officer for his investigation and certification.

When a coroner is informed that a person has been killed, or suddenly dies under such circumstances as to afford a reasonable ground for belief that such death was occasioned by the act of another by unlawful means, he is required to inquire into the facts and circumstances of the death by taking the sworn statement in writing of the witnesses having personal knowledge of the death and to submit such statements to a judge of a court of record or a solicitor. If, upon the preliminary inquiry, the judge or solicitor is satisfied from the evidence submitted that there is a reasonable ground for believing that the death was occasioned by the act of another by unlawful means, he is required to direct the coroner to summon a jury of inquest to inquire into the cause of death. After inspecting the body and hearing the evidence, the jury is required to render their verdict and certify it by an inquisition in writing signed by them. Each inquisition so taken is required to be returned by the coroner immediately, together with the written statement under oath taken by him on the preliminary investigation, to the clerk of the circuit court of the county.

All county health officers and county coroners are required to correctly make and accurately keep all books, or sets of books, documents, files, papers, letters and copies of letters, as at all times to afford full and detailed information in reference to their duties, and from which the actual status and condition of such duties can be ascertained without extraneous information. County health officers and county coroners are required, in each death investigated, to make and file a certificate of death stating the name of the deceased, if known, the cause of death, or if an external cause, the means of death and whether accidental, suicidal, or homicidal.

Every citizen has a right to inspect and take a copy of any public writing kept by a county health officer or county coroner.

Each record of death is required to be made available by the State Registrar of vital statistics when such recorded information is required for the determination of personal and property rights of the individual, for establishing the age, birth place, parentage, identification, cause of death and similar needs and legitimate uses of such records and then only for such proper purposes. The State Registrar and his authorized representatives are required to furnish any record of death in their custody, or any information relative to such record, unless they are satisfied that the applicant has a valid and tangible interest in the matter recorded.

Alabama has no statutory provision relating specifically to the investigation of sudden and unexplained infant deaths.

Citations: Ala. Code Tit. 12, § 54, Tit. 12, § 57; Tit. 22, § 8; Tit. 15, § 76, Tit. 15, § 78, Tit. 15, § 82, Tit. 15, § 83; Tit. 22, § 26; Tit. 41, § 145; Tit. 22, § 42; Tit. 41, § 139.

ALASKA

Alaska's death investigation system consists of coroners and medical examiners. District judges and magistrates are required to serve as ex officio coroners and perform the duties and exercise the authority of that office. When authorized by the supreme court, the judge in each judicial district is required to appoint a person to act as public administrator of the estates of deceased persons and as coroner.

The commissioner of health and social services is authorized to appoint for a term of one year or less as many medical examiners in each of the judicial districts as, in his opinion, the administration of justice requires. Each medical examiner is required to be a physician licensed to practice in Alaska or a physician employed by the State, or an agency of the United States Government within the State if licensed in a State other than Alaska.

When a person dies unattended by a physician or when no physician is prepared to execute a certificate of death, the district judge or magistrate assigned to serve the place where the death occurs may by written order direct a medical examiner to view the dead body and to perform an examination, including an autopsy, as is, in the opinion of the medical examiner, necessary to make a proper determination of the cause of death and to execute the prescribed death certificate. Upon completing his examination, the medical examiner is required without delay to submit a report of his findings and conclusions to the district judge or magistrate. The judge or magistrate is required to order an inquest if the findings and conclusions of the medical examiner, together with the other information available to the judge or magistrate, so warrant. In holding an inquest, the district judge or magistrate may subpoena and examine an appointed medical examiner when available, or otherwise a physician, who is required to examine the body and give a professional opinion as to the cause of death. If the findings and conclusions of the medical examiner together with other information available to the judge or magistrate do not warrant an inquest, the district judge or magistrate is required to enter an order dispensing with the inquest and to record the certificate of death as prescribed by law.

When a coroner is informed that a person has been killed by another or has suddenly died under such circumstances as to afford a reasonable ground to suspect that his death has been occasioned by criminal means or he has committed suicide, the coroner is required to go to the place where the dead person is, or, in the alternative, arrange for a peace officer to do so and report his findings to the coroner, on the basis of which the coroner may proceed with an inquest if an inquest is warranted.

The inspection, disclosure, and copying of vital statistics records may occur only when the custodian is satisfied that the applicant has a direct interest in the matter and that the information is necessary for the determination of personal and property rights.

Reports of findings and conclusions are submitted to the district judge or magistrate having jurisdiction. No further statutory indication exists relative to the accessibility of such reports to next of kin.

Alaska has no statutory provision relating specifically to the investigation of sudden and unexplained infant deaths.

Citations: Alaska Stat. §§ 12.65.010, 12.65.020, 12.65.030, 12.65.040, 12.65.070; §§ 22.15.110, 22.15.310, 22.15.350; §§ 18.50.310, 18.50.320; §§ 09.25.110, 09.25.120; Alaska Admin. Code § 05.925.

ARIZONA

Arizona has a county medical examiner death investigation system, with the power of appointment in the board of supervisors of each county. Each county medical examiner is required to be a licensed physician in good standing certified in pathology and skilled in forensic pathology. If the board of supervisors of any county determines that the appointment of a medical examiner is not practical, the board of supervisors is required to establish a list of licensed physicians who have agreed to perform the duties required of a county medical examiner on a contract basis. Licensed physicians on such list are not required to be either residents of the county, certified in pathology or skilled in forensic pathology. The county medical examiners are responsbile for the medical examination or autopsy of a human body when death occurs and the deceased is not under the current care of a physician for a potentially fatal illness or when an attending physician is unavailable to sign the death certificate; or when death results from violence; or when death occurs suddenly when in apparent good health, or in prison, or in a suspicious, unusual, or unnatural manner, or during anesthetic or surgical procedures; or when death from disease

or accident is believed to be related to the deceased's occupation or employment; or when death is believed to present a public health hazard; or when death occurs and the deceased is a prisoner.

Whenever any person knows of the death of a human being under any of the above described circumstances, he is required to notify the nearest peace officer who is required to notify the county medical examiner.

Each county medical examiner is permitted to authorize qualified practicing physicians in local areas to perform medical examinations required of the county medical examiner. If no county medical examiner has been appointed, the peace officer is required to notify the county sheriff who in turn is required to notify and secure a licensed physician to perform the medical examination or autopsy.

The county medical examiner or person performing the duties of a county medical examiner is required to take charge of the dead body of which he is notified. After making inquiries regarding the death and the circumstances surrounding it, the county medical examiner or person performing the duties of a county medical examiner is required to conduct such investigation as may be required and to determine whether or not the public interest requires an autopsy or other special investigation. In determining whether an autopsy is needed, the county medical examiner or person performing the duties of a county medical examiner may consider the request for an autopsy made by private persons or public officials, except that he is required to perform an autopsy if he is requested to do so by the county attorney or a superior court judge of the county where the death occurred.

The county medical examiner or the person performing the duties of a county medical examiner is required to reduce his findings to writing and to promptly make a full report. If an autopsy is performed, a full record or report of the facts developed by the autopsy in the findings of the person making the autopsy is required to be made and filed in the office of the county medical examiner or board of supervisors. The county attorney may request and receive from the county medical examiner or person performing the duties of a county medical examiner a copy of the report on any autopsy performed. In those cases in which a medical examination or an autopsy is performed, the county medical examiner or person performing the duties of a county medical examiner is required to execute a death certificate indicating the cause and manner of death. If death is found to be from other than natural causes, or if further investigation appears to be necessary, the county medical examiner or person performing the duties of a county medical examiner is required to notify the county attorney of the appropriate city, town, county or State law enforcement agency.

All death investigation records are public records and at all times during office hours are required to be open to inspection by any person. Any person may request to examine or be furnished copies, printouts, or photographs of any public record during regular office hours.

A certified copy of a death certificate may be obtained by any applicant with a legal or other vital interest in the record or upon order of a court of competent jurisdiction.

Arizona has no statutory provision relating specifically to the investigation of sudden and unexplained infant deaths.

Citations: Ariz. Rev. Stat. Ann. §§ 11-591, 11-592, 11-593, 11-594, 11-597; 36-340; 39-121, 39-121.01; Reg. of Bureau of Vital Statistics R9-19-401, et seq.

ARKANSAS

Arkansas has a state medical examiner and county coroner death investigation system.

The State Medical Examiner Commission which is composed of the Dean of the University of Arkansas School of Medicine, the Director of the State Board of Health, the Director of the Arkansas State Police, a member to be named by the Arkansas Sheriff's Association, and a member to be named by the Association of the Chiefs of Police of Arkansas, is required to appoint and employ a State Medical Examiner and may remove him only for cause. The State Medical Examiner is required to be a citizen of the United States and a physician or surgeon with an M.D. degree who has been licensed or is eligible for licensure to practice medicine in the State of Arkansas and who has had a minimum of three years post graduate training in human pathology as recognized by the American Medical Association plus at least one year of experience in medico-legal practice. The State Medical Examiner may delegate specific duties to competent and qualified assistants and deputies who may act for the State Medical Examiner within the scope of the express

authority granted by him subject to any rules and regulations prescribed by the State Medical Examiner Commission.

A county coroner is elected by the qualified electors of each county for a term of two years and is commissioned by the Governor. Each coroner may at his discretion appoint deputy coroners.

The State Medical Examiner is authorized to investigate the death of any person from violence, whether apparently homicidal, suicidal, accidental, or industrial, including but not limited to death due to thermal, chemical, electrical or radiation injury and death due to criminal abortion, whether apparently self-induced or not, or suddenly when in apparent good health, or in a prison, jail or penal farm, or in any suspicious or unusual or unnatural manner. When the State Medical Examiner is informed that a death has occurred in any such manner or under any such circumstances, he is authorized to make such examinations, investigations and autopsies as he deems necessary or as may be requested by the Prosecuting Attorney, the Circuit Court, the Sheriff of the County in which death occurs, the Chief of Police of a City in which death occurs, or the Commission of the Arkansas Department of Correction at the time of death. The State Medical Examiner is not required to make such examination, investigation, or autopsy at the request of any private citizen or any public official other than those enumerated above.

Each county coroner is required to investigate the cause of death when death occurs without medical attendance or when the dead body of any person is found and the circumstances of his death are unknown or indicate that he has been foully dealt with. Upon receiving any information that such a death has occurred, the coroner is required to hold an inquest to inquire into the cause, manner and circumstances of the death. The coroner is required to deliver every inquisition, with all the examinations, depositions, and recognizances concerning the case to the clerk of the Circuit Court of his county, who is required to immediately lay the same before the Prosecuting Attorney, prosecuting in and for the county.

The State Medical Examiner or his assistants are required to promptly make and file with the Prosecuting Attorney of the county in which the death occurs a full report of his findings and the facts developed by an autopsy. The State Medical Examiner or his assistants or deputy, is required to make a certificate of death.

All records, files and information kept, retained or obtained by the State Medical Examiner in his examinations, investigations and autopsies are confidential and privileged unless released by a court of competent jurisdiction, the Prosecuting Attorney having criminal jurisdiction over the case, or by the State Medical Examiner, to persons with legal or scientific interests.

The State Registrar is required to permit the inspection of a death record, or issue certified copies from a death record or part of a death record, only when he is satisfied that the applicant has a direct and tangible interest in the content of the death record and that the information contained in the death record is necessary for the determination or protection of a personal or property right.

Arkansas has no statutory provision relating specifically to the investigation of sudden and unexplained infant deaths.

Citations: Const., Art. VII, §§ 46, 48; Ark. Stat. Ann. §§ 12-201, 12-901; §§ 42-611, 42-612, 42-613, 42-615, 42-616, 42-621, 42-622, 42-301, 42-302, 42-325; § 82-520.

CALIFORNIA

California's death investigation system consists of county coroners and medical examiners.

A coroner is required to be elected by the people of each county. The board of supervisors in any county may, by ordinance, abolish the office of coroner and provide instead for the office of medical examiner, to be appointed by the board and to exercise the powers and perform the duties of the coroner. Each medical examiner is required to be a licensed physician and surgeon duly qualified as a specialist in pathology.

Coroners and medical examiners are required to inquire into and determine the circumstances, manner, and cause of all violent, sudden or unusual deaths; unattended deaths; deaths in which the deceased has not been attended by a physician in the twenty days before death; deaths related to or following known or suspected self-induced or criminal abortion; known or suspected homicide, suicide, or accidental poisoning; deaths known or suspected as resulting in whole or in part from or related to accident or injury either old or recent; deaths

due to drowning, fire, hanging, gunshot, stabbing, cutting, exposure, starvation, acute alcoholism, drug addiction, strangulation, aspiration or where the suspected cause of death is sudden infant death syndrome; death in whole or in part occasioned by criminal means; deaths associated with a known or alleged rape or crime against nature; deaths in prison or while under sentence; deaths known or suspected as due to contagious disease and constituting a public hazard; deaths from occupational disease or occupational hazards; deaths under such circumstances as to afford a reasonable ground to suspect that the death was caused by the criminal act of another, or any deaths reported by physicians or other persons having knowledge of death for inquiry by coroner.

Upon being informed that a death has occurred under any of the above described circumstances and finding that it falls into the classification of deaths requiring inquiry, the coroner or medical examiner, or his appointed deputy, may immediately proceed to where the body lies, examine the body, make identification, make inquiry into the circumstances, manner, and means of death, and, as circumstances warrant, order its removal for further investigation or disposition. The coroner or medical examiner has discretion to determine the extent of inquiry to be made into any death occurring under any of the above described circumstances. If in his inquiry he determines that the physician of record has sufficient knowledge to reasonably state the cause of death occurring under natural circumstances, the coroner or medical examiner may authorize that physician to sign the certificate of death.

At the scene of any death, when it is immediately apparent or when it has not been previously recognized and the coroner's examination reveals that police investigation or criminal prosecution may ensue, the coroner or medical examiner may not further willfully disturb the body or any related evidence until the law enforcement agency has had reasonable opportunity to respond to the scene, if their purposes so require and they so request. In all cases in which a person has suddenly died under such circumstances as to afford a reasonable ground to suspect that his death has been occasioned by the act of another by criminal means, the coroner or medical examiner is required to immediately upon receiving notification of the death to report it both by telephone and written report to the chief of police, or other head of the police department of the city or city and county in which the death occurred outside the incorporated limits of a city. When the suspected cause of death is sudden infant death syndrome, the coroner or medical examiner is required to, within 24 hours or as soon as is feasible, unless the infant's physician of record certifies sudden infant death syndrome as the cause of death and a parent objects to an autopsy, and, in all other cases, the coroner or medical examiner, may, in his discretion, take possession of the body, and make or cause to be made a post mortem examination or autopsy on the body.

In any case involving an infant under the age of one year where the gross autopsy results in a provisional diagnosis of sudden infant death syndrome, the coroner or medical examiner is required, within 24 hours of the gross autopsy, to notify the county health officer. The detailed findings resulting from an inspection of the body or autopsy by an examining physician is required to be either reduced to writing or permanently preserved on recording discs or other similar recording media, including all positive and negative findings pertinent to establishing the cause of death in accordance with medico-legal practice. These findings, along with the written opinions and conclusions of the examining physician, are required to be included in the coroner's record of the death.

In those cases in which a coroner or medical examiner is required to conduct an inquiry pursuant to law, he is required to personally sign the certificate of death. The cause of death appearing on such certificate must be in conformity with facts ascertained from inquiry, autopsy and other scientific findings. In case of death without medical attendance and without violence, casualty, criminal or undue means, the coroner or medical examiner may, without holding an inquest or autopsy, make the certificate of death from statements of relatives, persons last in attendance, or persons present at the time of death, after due medical consultation and opinion has been given by one qualified and licensed to practice medicine and so recorded in the records of death, providing such information affords clear grounds to establish the correct medical cause of death within accepted medical practice by the Division of Vital Statistics of the State Department of Public Health.

Each coroner or medical examiner may, in his discretion, if the circumstances warrant, hold an inquest. If requested to do so by the Attorney General, the district attorney, sheriff, city prosecutor, city attorney, or a chief of police of a city in the county in which such

coroner or medical examiner has jurisdiction, the coroner or medical examiner is required to hold an inquest. Each inquest is required to be open to the public and may be held with or without a jury at the coroner's or medical examiner's discretion.

The coroner or medical examiner may summon a surgeon or physician to inspect the body or hold a post mortem examination and give a professional opinion as to the cause of the death. After hearing the testimony, the jury is required to render its verdict and certify it by an inquisition in writing signed by the members of the jury, or the coroner or medical examiner is required to render his decision if the inquest is held without a jury, setting forth the name of the deceased, the time and place of death, the medical cause of death and whether the death was by natural causes, suicide, accident, or the hands of another person other than by accident. In addition to filing his findings with the county clerk, if the findings are that the deceased met his death at the hands of another, the coroner or medical examiner is required to transmit his written findings to the district attorney, the appropriate police agency, and any other police agency requesting copies.

Each coroner or medical examiner is required to keep an official register or file which includes: the name and any aliases of the deceased, when known; a narrative summary of the circumstances leading to and surrounding the death, together with names and addresses of any witnesses to such events; the cause of death, when known, with reference or direction to the detailed medical reports upon which decision as to cause of death has been based; and persons notified of the death, together with a notation of any unsuccessful attempts at notification.

Records of coroners and medical examiners are public records and are required to be open to inspection by any citizen at all times during office hours. Death certificates are required to be open for inspection by the public in accordance with rules and regulations adopted by the State department of health for local registrars.

Coroners and medical examiners are required to inquire into and determine the circumstances, manner, and cause of those deaths where the suspected cause of death is sudden infant death syndrome. The coroner or medical examiner, within 24 hours or as soon as is feasible, when the suspected cause of death is sudden infant death syndrome unless the infant's physician of record certifies sudden infant death syndrome as the cause of death and a parent objects to an autopsy, is required to take possession of the body, and to make or cause to be made a post mortem examination or autopsy of the body.

The detailed medical findings resulting from an inspection of the body or autopsy by an examining physician is required to be either reduced to writing or permanently preserved on recording discs or other similar recording media, including all positive and negative findings pertinent to establishing the cause of death in accordance with medico legal practice, and along with written opinions and conclusions of the examining physician, are required to be included in the coroner's record of death.

In those cases involving an infant under the age of one year where the gross autopsy results in a provisional diagnosis of sudden infant death syndrome, the coroner or medical examiner is required, within 24 hours of the gross autopsy, to notify the county health officer. Upon receiving such notification, the county health officer or his designated agent, after consultation with the infant's physician of record, is required to immediately contact the person or persons who had custody and control of the infant and explain to such persons the nature and causes of the syndrome to the extent that current knowledge permits.

The State Department of Health is required to keep each county health officer advised of the most current knowledge relating to the nature and causes of sudden infant death syndrome. Annually, on or before April 1 of each year, the State Department of Health is required to submit a report to the legislature specifying the number of autopsies and post mortem examinations performed pursuant to law during the prior year, where the suspected cause of death was sudden infant death syndrome.

Citations: Cal. Gov't Code §§ 6250, 6253, 7113; §§ 24300, 24304, 24306; §§ 24009, 24010; § 24001 (1975 Supp.); Art. 4, § 462; Cal. Admin. Code Tit. 17, §§ 901, 902; Ch. 10, Art. I, §§ 27460 to 27471; Cal. Health & Safety Code § 10250 § 10253; Cal. Vital Statistics Code, § 10066; Cal. Public Health Admin. Code, Art. 1, § 218.

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Colorado has a county coroner death investigation system. A coroner is elected in each county for a term of four years. No person may hold the