2024

Tennessee Department of Health
Office of the State Chief Medical Examiner

County Medical Examiner Handbook

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TN Department of Health

FOREWARD

The mission of the Tennessee Office of the State Chief Medical Examiner (OSCME), operating within the Department of Health, is to assist county medical examiners in creating consistent, high-quality, and professional medicolegal death investigation and forensic autopsy services. The purpose of the office is to serve its fellow citizens by protecting the public's health and safety, participating in the criminal justice system, and providing reliable mortality data for vital statistics.

Tennessee has a mixed medical examiner death investigation system, with the OSCME primarily responsible for providing guidelines and training for the county medical examiners and their investigators and collecting and maintaining records of deaths investigated under medical examiner jurisdiction. County medical examiners, along with their medicolegal death investigators, are responsible for conducting death investigations in coordination with various professionals and providing opinions about cause and manner of death. Five regional forensic centers provide forensic autopsy services for the county medical examiners when autopsies are requested.

This handbook provides Tennessee county medical examiners and medicolegal death investigators a guide for death investigation and death certification in the performance of their duties under §TCA 38-7-104. This document it is not intended to be a comprehensive encyclopedia of death investigation, but rather is presented as a handy reference guide for common situations and questions that may arise during death investigations. References and foundation documents for further study and reading are included at the end of this guide.

The OSCME is committed to providing support, education and training, and consultation to each of the county medical examiners and medicolegal death investigators to assist them in improving death investigation throughout Tennessee.

Dr. Adele Lewis
Chief Medical Examiner, State of Tennessee
January 2024

ACKNOWLEDGMENTS

The State Medical Examiner would like to acknowledge and thank the Medical Examiner Advisory Council for their input and review of these guidelines.

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DEFINITIONS AND ABBREVIATIONS

Accreditation: Formal recognition by an independent accreditation body that a medicolegal office, person, or agency meets or exceeds a prescribed set of standards

Accident: Medical examiner manner of death classification for an unexpected or unforeseen death due to injury

American Board of Medicolegal Death Investigators (ABMDI): A voluntary national, not-for-profit, independent professional certification board that has been established to promote the highest standards of practice for medicolegal death investigators (see www.abmdi.org)

Autopsy: Diagnostic medical procedure, conducted by a pathologist, consisting of postmortem external examination, internal examination, and other ancillary tests of a decedent

Cause of Death: Medical opinion about the disease or injury that set into motion the chain of events that ultimately resulted in the death.

- Arteriosclerotic cardiovascular disease, gunshot wound of head, and multiple blunt force injuries are examples of causes of death.
- Cardiopulmonary arrest and shock are examples of mechanisms of death and should not appear alone, for the most part, in the cause of death section of the death certificate.

Certification of Death: Completing cause and manner of death on the death certificate; only a physician may certify the cause of death and manner of death in Tennessee. TCA §68-3-502(1)

Child: A person of one year of age and up to, but not including eighteen years of age.

County Medical Examiner (CME): Medical or osteopathic physician, licensed in the state of Tennessee and appointed by the county mayor. TCA §38-7-104(a)

County Medical Examiner Investigator (CMI): An individual who is serving their county to assist in death investigations, working directly under the supervision of a physician county medical examiner for that county and is a licensed emergency medical technician (EMT), paramedic, nurse, physician assistant, or a person registered by or a diplomate of the American Board of Medicolegal Death Investigators (ABMDI); may also be referred to as a medicolegal death investigator (MDI). TCA §38-7-108; see MDI.

Cremation: The reduction to ashes of a human body.

Death Certificate: Formal vital statistics document certifying the identification, cause and manner of death of a particular individual.

Death Affecting the Public Interest: Any death of a human being where the circumstances are sudden, unexpected, violent, suspicious, or unattended.

Decedent: Deceased person or any suspected human remains

Embalming: The disinfecting or preserving of human remains, entire or in part, by the use of chemical substances, fluids, or gases in the body, or by the introduction of same into the body by vascular or hypodermic injections, or by direct application into the organs or cavities for the purpose of preservation or disinfection.

External examination: Diagnostic medical procedure, conducted by a pathologist, consisting of physical inspection and ancillary tests of a decedent without internal examination.

External evaluation: Physical assessment of the decedent by a medicolegal death investigator or county medical examiner

Forensic pathologist: Physician who is board-certified in forensic pathology by an accredited credentialing body, currently the American Board of Pathology and American Osteopathic Board of Pathology

Homicide: Medical examiner manner of death classification as a result of a volitional act by another person

Immediate Next-of-kin: Any available member of the following classes of person, in the order of priority listed, who may make funeral arrangements and order the final disposition of the decedent (TCA §62-5-703):

1. The attorney-in-fact pursuant to a durable power of attorney for health care.
2. The spouse of the decedent.
3. The decedent's surviving adult children. The adult child making the arrangements should make a reasonable effort to contact all other adult children and ensure agreement among those contacted on the choice for funeral arrangements.
4. A parent of the decedent.
5. An adult sibling of the decedent.
6. An adult grandchild of the decedent.
7. The grandparent of the decedent.
8. A guardian of the decedent at the time of the decedent's death.

Infant: A person of less than one year of age.

Manner of Death: The circumstances under which the cause of death occurred (includes Natural, Accident, Suicide, Homicide, and could not be determined as the only five possible final choices). "Pending" may be used when it is reasonably expected that additional forthcoming information will further clarify the circumstances. A "pending" cause or manner of death must be changed to one of the five classifications once the investigation is complete.

Mass Fatality Incident: Any incident where the number of fatalities overwhelms and exceeds local resources.

Mechanism of Death: A physiologic derangement in the body through which the cause of death ultimately produces death (e.g., congestive heart failure, exsanguination, cardiac arrest, shock, etc.). Mechanisms of death need not be included in investigative reports, except in the narrative summary.

Medical Examiner (ME): Refers to the county medical examiner and/or deputies, or to the state medical examiner and/or deputies.

Medicolegal death investigator (MDI): An individual who is serving their county to assist in death investigations, working directly under the supervision of a physician county medical examiner for that county and is a licensed emergency medical technician (EMT), paramedic, nurse, physician assistant, or a person registered by or a diplomate of the American Board of Medicolegal Death Investigators (ABMDI); may also be referred to as a medicolegal death investigator (MDI). TCA §38-7-108; see CMI.

Natural: Medical examiner manner of death classification of death due solely to natural cause(s)

Pronouncement of Death: The statement of opinion that life has ceased for an individual.

Regional Forensic Center (RFC): A facility accredited by the National Association of Medical Examiners (NAME) in Tennessee where autopsies and other post-mortem examinations are performed. TCA 38-7-105

State Chief Medical Examiner (SCME): The board-certified forensic pathologist/physician appointed by the Commissioner of the Department of Health to direct the post-mortem examination division or service. TCA 38-7-103

Suicide: Medical examiner manner of death classification resulting from intentional/volitional self-inflicted act

Undetermined: Medical examiner manner of death classification when evidence for one manner of death is more compelling than another or when there is insufficient information to classify the manner of death

INTRODUCTION

Medicolegal death investigations are the basis for certifying the cause of death and manner of death for unnatural and unexplained deaths. Ultimately, death investigations have broad importance for the criminal justice system and public health. They provide details about a death for family and loved ones, document the circumstances of a death for legal purposes, both civil and criminal, provide important public health information, and are the foundation of state and national mortality statistics. The importance of competent medicolegal death investigation has been highlighted by the National Research Council of the National Academies, the National Commission on Forensic Science, and the National Science and Technology Council.

In Tennessee, county medical examiners and medical examiner investigators have primary, important roles in investigating unnatural or unexplained deaths, including homicides, suicides, drug-related deaths, unintentional injuries, and deaths due to natural causes (see Figure 1). Since the authority for the medicolegal death investigation rests at the county level, it is imperative that investigations and death certifications by county medical examiners be professional, thorough, accurate, and based on accepted death investigation standards. Best practice operations and processes for county medical examiners, in consideration of jurisdictional mandates and resources, are presented here and in a comprehensive list of resources and foundational documents.

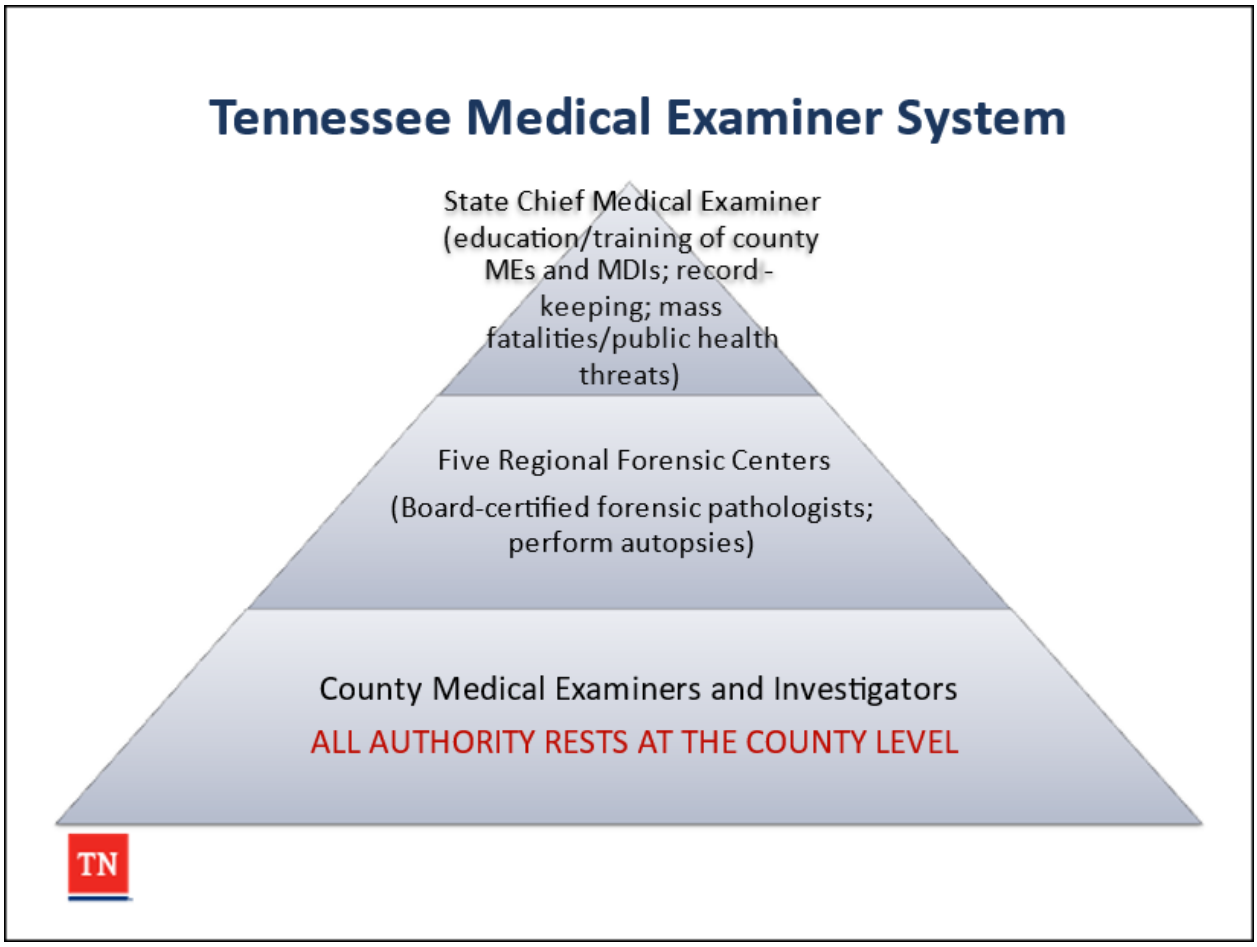

Figure 1: Structure of Tennessee Medical Examiner System

GENERAL CONSIDERATIONS FOR COUNTY MEDICAL EXAMINER OPERATIONS

This section provides a broad overview of operations of a county medical examiner's office. Additional specific procedures, statutes, and other considerations are discussed in detail below in separate sections.

Each county has a physician county medical examiner (CME) who is the primary agent of medicolegal death investigation in a county and is the "gatekeeper" for the referral-based autopsy system.

The physician CME is appointed by the county legislative body. The physician must have an unrestricted medical license (M.D. or D.O.) (T.C.A. § 38-7-104 (a). Appointments are for a five-year term with eligibility for reappointment by the county mayor with confirmation by the county legislative body. If a physician cannot be found within the county to serve, a physician from a neighboring county may be appointed. A physician may serve as CME for more than one county if necessary.

The CME has ***three primary functions as defined by statute***:

1) Investigation of deaths under suspicious, unnatural, or unusual circumstances (TCA §38-7-108) and,
2) The county medical examiner shall record and store the findings and transmit copies according to the death investigation guidelines developed by the Tennessee medical examiner advisory council (TCA § 38-7-109 and §38-7-102) and
3) Permits as required by the county and/or state which are necessary for the disposition of a dead body, including cremation permits and transit permits (TCA §38-7-108)

County medical examiner offices must have availability to provide consultations and receive reports of death 24 hours a day, seven days a week. Since most county medical examiners also maintain a full-time clinical practice, it is recommended that a county medical examiner appoint medicolegal death investigators (MDIs) to assist the CME with medical examiner operations. Under the authority of the CME and with appropriate training, an MDI may assist with many of the CME functions, including determining case jurisdiction, ordering autopsies, pronouncement of death, death scene investigations, and completing reports of investigations. Required qualifications and responsibilities of MDIs are discussed in separate sections below.

The CME is also strongly encouraged to appoint one or more deputy CMEs to assist with the CME duties and provide coverage when the CME is temporarily unavailable or unable to perform his or her duties (vacations, extended illness, etc.). Deputy CMEs may be appointed from a neighboring or nearby county if one is not available in the same county. Deputy CMEs and MDIs will help ensure the timeliness of jurisdictional determination and scene investigation, when necessary.

Immediately after appointment, the CME should initiate contact with law enforcement agencies, a regional forensic center, hospitals, nursing homes, hospice, funeral directors, emergency preparedness agencies, and public health agencies within the jurisdiction. The CME should disseminate routine and emergency contact phone numbers for reporting deaths in that jurisdiction. In addition, the CME should notify the OSCME with any contact numbers and email addresses for the CME and CME personnel. Procedures for how reports of death will be handled should be established and disseminated to county agencies and law enforcement. In addition, CMEs and MDIs shall be required to receive initial training and regular continuing education through the chief medical examiner and to operate according to the death investigation guidelines adopted by the department of health. (T.C.A. § 38-7-104(g)

Figure 2 summarizes the initial important tasks for a CME after appointment.

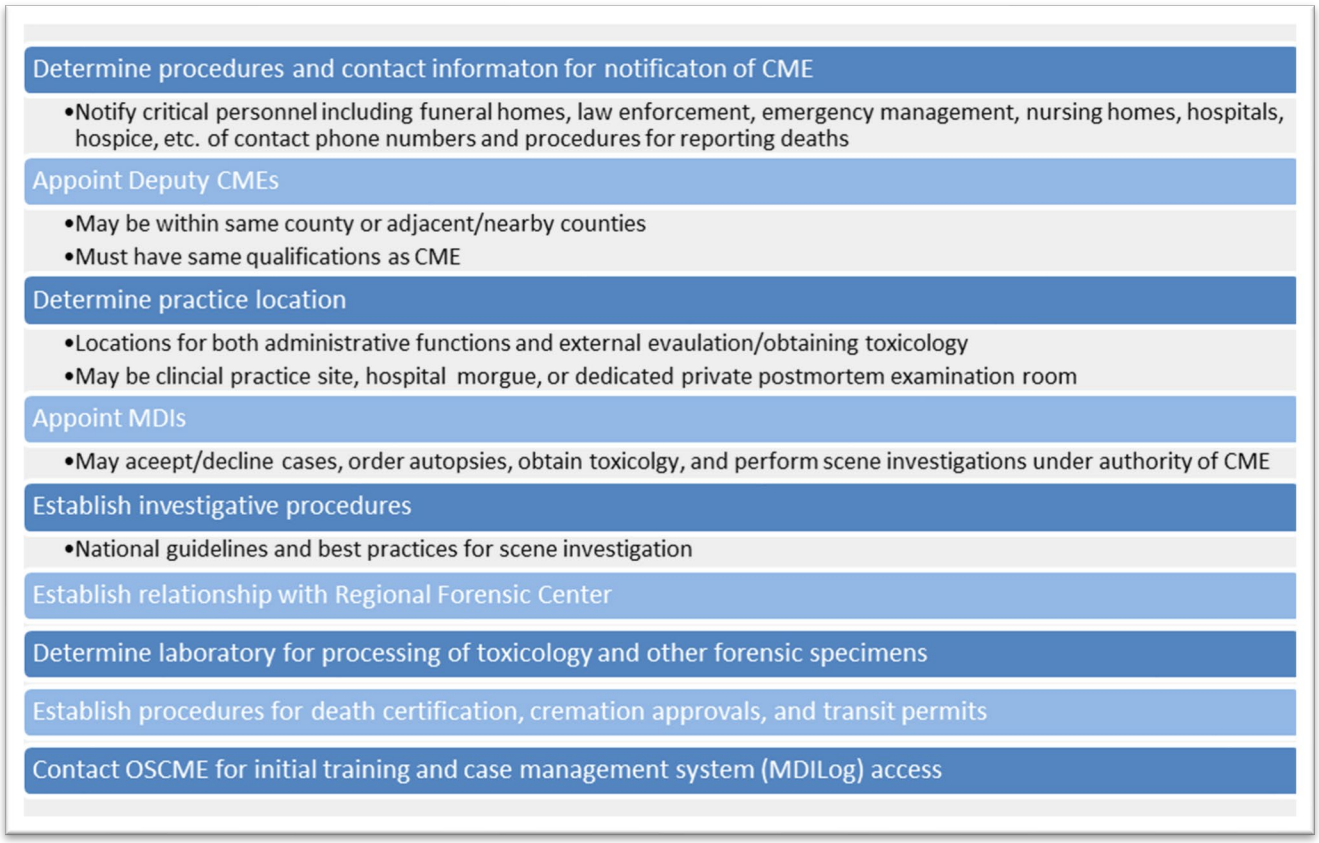

Figure 2: Overview of administrative considerations/procedures of CME office

Because not every deceased individual whose death falls under medical examiner jurisdiction will require an autopsy (discussed in detail below), a CME should establish an appropriate location for body evaluation if the CME intends on performing external body evaluations and/or collecting toxicology when an autopsy is deemed not necessary. Such practice sites may include a hospital morgue or funeral home. In such cases, the CME or MDI may perform a brief

body evaluation to document and photograph postmortem changes, injuries, general body habitus, etc., and collect toxicology specimens.

If an autopsy is ordered, the medicolegal autopsy must be performed at a Regional Forensic Center (RFC) accredited by the National Association of Medical Examiners (NAME). Since each of the five RFCs is independently operated, each has its own policies and procedures for reporting cases, autopsy ordering, body transport, etc., and the CME should establish a relationship with an RFC and familiarize themselves with these procedures prior to referring cases for autopsy. A CME may choose any accredited RFC for autopsy referral for any case, although many choose the RFC based on geographic location or service cost.

The CME should establish procedures with funeral homes and local vital records offices for the cremation approval process and how to facilitate any other body transport letters, as needed.

Finally, the county medical examiner should expect competent legal assistance through the county attorney for issues related to his or her official duties. The county medical examiner should also become acquainted with the local district attorney and feel comfortable in requesting professional assistance from that office in any investigations, especially with forensic issues for which the county medical examiner has direct responsibilities (i.e., disinterment, autopsy order).

MEDICOLEGAL DEATH INVESTIGATORS

A CME should consider using MDIs (also known as county medical investigators, or CMIs) to assist the CME with medical examiner operations. Under the authority of the CME and with appropriate training, an MDI may assist with many of the CME functions, including determining case jurisdiction, ordering autopsies, pronouncement of death, death scene investigations, and completing reports of investigations.

An MDI shall be a licensed emergency medical technician (EMT), paramedic, registered nurse, physician's assistant, or a person registered by, or a diplomate of the American Board of Medicolegal Death Investigators (ABMDI) approved by the county medical examiner to serve as medical investigator. The appointed MDIs should contact the OSCME for initial training and for access to MDILog, the statewide medicolegal case management system. Medical death investigators should also register with the Controlled Substances Monitoring Database (CSMD) as a delegate of the CME, which allows them to ascertain any controlled substances prescribed to a decedent.

"The county medical investigator may conduct investigations when a death is reported, as provided in T.C.A. § 38-7-108, under the supervision of the county medical examiner. The county medical investigator may make pronouncements of death and may recommend to the county medical examiner that an autopsy be ordered. However, the county medical investigator shall not be empowered to sign a death certificate. The county medical examiner

may delegate to the county medical investigator the authority to order an autopsy." T.C.A. § 38-7-104 (f) (3)

"County medical examiners and medical investigators shall be required to receive initial training and regular continuing education through the chief medical examiner and to operate according to the death investigation guidelines adopted by the department of health." T.C.A. § 38-7-104(g)

CASE RECORDS AND CASE MANAGEMENT

The CME is responsible for maintaining copies of all records and documents generated during an investigation. This includes all cases reported to the CME, whether jurisdiction is accepted or not. Types of documents generated by the CME include, but are not limited to, report of investigation (ROI), medication log, scene investigation report and photographs, body evaluation report, body evaluation photographs, order for autopsy, toxicology report, etc. According to statute, "the county medical examiner shall record and store the findings and transmit copies according to the death investigation guidelines developed by the Tennessee medical examiner advisory council." T.C.A. § 38 -7-109 (a). The county may be reimbursed $25 per completed ROI submitted to the OSCME.

To facilitate maintaining and transmitting required documents, the OSCME provides MDILog, a web-based medicolegal case management software, to all CME personnel. MDILog is provided free of charge by the OSCME. MDILog is the preferred method for maintaining all investigation related documents and transmitting the ROI to the OSCME, as required by statute. MDILog is a comprehensive system for all aspects of medicolegal case management, including tracking of reported cases, ordering and reporting of autopsies, evidence management, toxicology ordering and reporting, office administration, communication tracking, and cremation approvals. In addition, MDILog input of case information is structured to assist with collecting pertinent information about a particular type of death and will aid in collecting comprehensive investigative information.

MDILog has no requirements for on-site software installation, servers, or any equipment other than internet accessible computers, tablets, and phones. MDILog user accounts can be set-up and fully functional within an hour. Employee activations are requested through OSCME staff. Because MDILog is based on national guidelines and standards for death investigations, the learning curve for individuals currently working in the medical examiner/coroner environment is short.

OSCME personnel will coordinate and assist with group and individual training, employee activations, and assigning role permissions. To register as a user call 615-837-5039 or toll free 844-860-4511.

REPORT OF INVESTIGATION (ROI)

The ROI is one of the most important documents a CME is required to complete and transmit to the OSCME. A ROI should be completed for every death reported to the CME, regardless of whether jurisdiction is accepted or declined. The ROI is the first record of investigation by the CME and provides all the pertinent information about an investigation including demographic information, scene investigation, narrative summary of the pertinent facts of the death, documents the next-of-kin information, and the cause of death and manner of death.

In MDILog, the ROI is also named the "MDI Worksheet." The easiest and most expeditious way to complete and transmit a ROI is to enter the basic investigative case information into MDILog and it will populate the necessary fields in the MDI Worksheet.

A signed copy of the ROI may also be sent directly to the OSCME via traditional means of fax (615-401-2532) and email (OSCME.ROI@TN.GOV).

CME GENERAL INVESTIGATIVE PROCEDURES

OVERVIEW OF PROCEDURES

There are many different sources of information which must be considered in a medicolegal death investigation, and the investigation usually requires multiple steps and different types of information from varied agencies. In consideration of best practices, and to meet the requirements of the Tennessee CME statute, the overall steps of a medicolegal death investigation include:

- Notification of death to county medical examiner
- Determination of medical examiner jurisdiction by CME or medicolegal death investigator (MDI)
- Scene investigation, if applicable
- Body examination or evaluation, if applicable
- Determination of whether autopsy is needed
- Ordering autopsy and coordinating with RFC
- Collecting and ordering toxicology, if needed and no autopsy is ordered
- Entering preliminary and final report of investigation and case information in MDILog (TN OSCME case management system)
- Death certification
- Arranging for final dispensation of remains
- Cremation approval and other transit permits, as needed

The determinations at each investigative step will be based on the totality of the evidence available for each specific case, including review of scene information, investigative information, medical history, etc., and in consultation with law enforcement, the district attorney, or public health agencies.

Cause and manner of death are medical determinations which may be different from the law enforcement or judicial determination of the manner of death. While a medicolegal death investigation will typically rely on investigative facts from other agencies, the death investigation should be objective, independent, and separate from any law enforcement investigation. Medical examiner investigations and findings should be free of undue influence or external pressure from the public, law enforcement, family members, or district attorneys.

NOTIFICATION OF COUNTY MEDICAL EXAMINER

Early notification and screening of a reported case by knowledgeable individuals (CME and MDI) will ensure that appropriate deaths are accepted and investigated in a timely manner. The CME may delegate receiving notifications to an MDI (as defined above) who acts as the county medical examiner's agent.

The CME for the county in which the death occurred should be notified in "any case involving a homicide, a suspected homicide, a suicide, or a violent, unnatural, or suspicious death" (TCA § 38-7-106). In such cases, the CME "shall investigate and certify the death certificate" (TCA § 68-3-502-d). The county medical examiner is to be notified immediately upon the discovery of death that legally requires his or her review. Deceased bodies cannot be moved without the county medical examiner's permission (T.C.A. § 38 -7-108 (b)) except to preserve the body from loss or destruction or to maintain the flow of traffic on a highway, railroad, or airport.

Any physician, undertaker, law enforcement officer, hospital, outpatient facility, nursing home, treatment resource, clinic, district attorney, or other individuals having knowledge of deaths which may fall under medical examiner jurisdiction, or in which the body is going to be cremated shall notify the county medical examiner (T.C.A. § 38 -7-108 (a)). These entities should be provided with a general knowledge of notification protocols established above, and the local standards of practice. Please see the appropriate portions of the death investigation section for information on establishing these policies. The appendices contain a printable document for easy reference for healthcare facilities to use when deciding if medical examiner notification is indicated.

Whenever law enforcement is involved in the investigation of any death the CME should be notified. One of the services the CME can provide the community is to ensure all deaths are properly certified either by a physician who is knowledgeable of the deceased's medical history or by the CME.

When determining if a death is reportable to the county medical examiner, keep in mind that many natural deaths should be reported, but **ALL** deaths in which the manner of death is **NOT** natural must be reported. Simply put, any death in which a discrete identifiable event or object external to the decedent (e.g., methamphetamine, in the case of acute methamphetamine toxicity; the floor, in the case of a residential fall) is not natural. The interval elapsed between the time of the injury or poisoning event and death is irrelevant. Some CMEs will ask all hospitals and other medical facilities in their jurisdiction to report every death for evaluation so that no reportable case goes unreported and are "missed".

Usually, the dispatch center of the local law enforcement or ambulance service can perform the notification of the CME. However, the physician's own private answering service or the county hospital's 24-hour switchboard can suffice. These entities should be provided with all

appropriate contact information and an updated ongoing schedule of availability of medical examiner personnel.

ACCEPTING OR DECLINING MEDICAL EXAMINER JURIDICTION

Determination of jurisdiction is the professional assessment by the CME or MDI of whether the medical examiner is required to determine the cause of death or take charge of a deceased person. This is usually the first investigative determination after a death is reported to the CME. The decision of jurisdiction should be made by the CME or by CME personnel knowledgeable about statutory requirements for investigation and death certification.

If a death meets the legal criteria for a reportable case as set forth in T.C.A. § 38 -7-108 (a) the county medical examiner may establish jurisdiction. The county medical examiner will direct the extent of their investigation based on the type, circumstances, and location of death and the protocols established for their county.

In Tennessee, CMEs should *accept* jurisdiction in the following circumstances:

1. Death resulting from violence or trauma of any type;
2. Sudden death when in apparent good health;
3. Sudden unexpected death of infants and children;
4. Deaths of prisoners or persons in state custody;
5. Deaths on the job or related to employment;
6. Deaths believed to represent a threat to public health;
7. Deaths where neglect or abuse of extended care residents are suspected or confirmed
8. Deaths where the identity of the person is unknown or unclear;
9. Deaths in any suspicious/unusual/unnatural manner;
10. Found dead;
11. Unidentified human remains; or
12. For cremation permits for deaths occurring in the county of the CME.

Once jurisdiction is accepted, the county medical examiner must decide whether a scene investigation is necessary and what type of body examination or toxicology is needed (discussed further below). If no further investigation is necessary, or an examination is not requested at an RFC, the CME may issue the death certificate. If a body is sent for examination by a forensic pathologist, then it is preferred and considered best practice for the forensic pathologist to sign the death certificate.

“Jurisdiction declined” cases may be defined as: 1) deaths that are reported to the CME/CMEI but do not meet the criteria for medical examiner jurisdiction set forth as reportable by the T.C.A. § 38 -7-108; and 2) the CME declines to pursue the case any further and relinquishes death certification to another physician.

Tennessee does not have a "24-hour" rule requiring hospitals to notify the medical examiner when a death occurs within 24 hours after hospital admission, unless the death occurred due to unusual, unnatural, suspicious, or unexpected circumstances (T.C.A. § 38-7-108 (a)). If the death is reportable to the medical examiner, despite the length of the hospital admission, hospital personnel are required to immediately notify the county medical examiner. Appendix E contains a printable flyer for hospitals delineating specific deaths which must be reported to the medical examiner of the county in which death occurred.

The CME should complete a report of investigation (ROI) for all deaths reported, whether jurisdiction is accepted or declined. The ROI should be maintained by the CME and submitted to the OSCME as described above in CASE MANAGEMENT, CASE RECORDS, AND REPORTING section.

AUTHORITY TO OBTAIN MEDICAL RECORDS

It may be desirable or necessary to obtain medical records before CME jurisdiction is determined or before a death certificate is certified. "An authorized post-mortem official acting under the control or direction of the chief medical examiner or a county medical examiner or performing an investigation pursuant to a court order or an order of a district attorney general is authorized to obtain, upon written request, or may subpoena through the appropriate district attorney general, all medical or hospital records maintained by individuals licensed under title 63 or by facilities licensed under title 68 that pertain to a case under investigation." T.C.A. § 38 -7-117 (a sample records request form may be found in Appendix F or at https://www.tn.gov/content/dam/tn/health/documents/officeofthestatechiefmedicalexaminersoffice/resourcesforthemedicalexaminer/REQUEST_FOR_MEDICAL_RECORDS.pdf)

PUBLIC ACCESS TO RECORDS

Tennessee Code Annotated §38-7-110(c) states that the reports of the county medical examiners, toxicological reports, and autopsy reports shall be public documents unless restricted by court order (See T.C.A. § 38 -7-110(d)). The public can obtain these reports from the OSCME, the county medical examiner, or the Regional Forensic Center, depending on facility protocols.

The OSCME and county medical examiner / Regional Forensic Center may charge a fee for copies of the autopsy report, toxicology report, and ROI. The T.C.A. Open Records Act does not stipulate a fee for records but does advise the fee should be "reasonable." T.C.A. § 10-7-503 (C)(i).

HIPAA

The Health Insurance Portability and Accountability Act (1996) regulates the use and disclosure of protected health information (PHI), such as medical records, medication logs, and psychotherapy notes of an individual for 50 years following their date of death. 45 CFR §160.103 specifically permits the release of PHI by covered entities to coroners or medical examiners and funeral directors (HHS.GOV, §164.512(g)(2) without any signed consent or prior authorization of the decedent or next-of-kin. Any coroner, medical examiner, or funeral director who receives PHI becomes an agent of the covered entity and cannot release the protected information except through the covered entity.

DEATH SCENE INVESTIGATION

GENERAL CONSIDERATIONS

It is recommended that a CME/MDI go to the scene of the death whenever possible if a death occurs outside of a medical facility. An inspection of the scene, and the body within that environment, can be of importance in determining if jurisdiction should be accepted, if an autopsy is necessary, and in establishing the cause and manner of death. The scene investigation has several important functions:

- Assisting with determination of jurisdiction
- Official pronouncement of death
- Information gathering (demographic data, circumstances of death, medical history, speaking with family and first responders, coordinate with other investigating agencies)
- Examination of body and its relationship to other elements of the scene (postmortem changes, scene temperature and conditions, any evidence of injury, collection of any trace evidence, etc.)
- Documentation of scene findings with photography and diagrams
- Determining if an autopsy is necessary
- Collection of toxicology if no autopsy is ordered

While a death scene is typically under the jurisdiction of law enforcement, a deceased body will be within the jurisdiction of the CME. In many smaller jurisdictions the CME/MDI will be well known to local law enforcement agencies so formal introductions may not be necessary. This, however, may not be true statewide. It is best practice for the CME to introduce themselves and their personnel (CMEIs, transport) to local law enforcement and other key officials in the county prior to arriving at their first death scene. This multi-agency cooperation and understanding of the role of the CME is necessary to ensure a full and complete death investigation.

If the CME has accepted jurisdiction, the body should not be moved from the scene of death or embalmed until the county medical examiner has been notified and determined if an autopsy or further investigation is necessary to determine the cause and manner of death.

Well-established and peer-reviewed guidelines for death scene investigation are readily available and included in appendices. In 2011, the National Institute of Justice updated their protocol, *Death Investigation: A Guide for the Scene Investigator*. The guidelines are considered best practices for medicolegal death investigation and ensure comprehensive and standardized practices. The guidelines can be found in their entirety at the website listed below.

Death Investigation: A Guide for the Scene Investigator, Technical Update (ojp.gov).

The OSCME recommends following the NIJ protocol for death scene investigation. The scene protocol is very generally outlined as:

a. Ascertain the essential facts preceding and the circumstances surrounding the death. Obtain personal medical, social, psychiatric, or criminal history.

b. Photograph the body and the scene, document pertinent descriptive information, and establish identification.

c. Record the names and pertinent information of witnesses present.

d. Take custody of any evidence directly associated with the body with the exclusion of firearms, live ammunition, illicit drugs, or drug paraphernalia that may aid in the determination of the cause and manner of death. Ensure chain of custody.

e. Take custody and document prescription medication using the Medication Log. Ensure medication that has been prescribed to the decedent does not remain at the scene.

In addition, guidelines for response to death scene locations published by the Organization of Scientific Area Committees for Forensic Science (OSAC) in 2022 are available at OSAC 2022-N-0027 MDI Response to Scenes Best Practice Recommendations. OPEN COMMENT VERSION.pdf (nist.gov)

Investigators should utilize universal precautions at every death scene if contact with blood or other body fluids is likely. In the case of an exposure to a first responder, law enforcement, or on-scene ME personnel the CME/MDI may be requested to draw a blood sample for testing for blood-borne pathogens. If the body is to be sent for autopsy the request should be communicated to the regional forensic center. The release of results from such blood work to the health officer for the exposed employee is covered under the Health Insurance Portability and Accountability Act, HIPAA, 45 CFR §164.512(b)(1)(v), *Uses and disclosure for which an authorization or opportunity to agree or object is not required.*

BASIC SUPPLIES FOR DEATH SCENE INVESTIGATION

The following items, at a minimum, are recommended to be immediately available for scene investigation and documentation. Additional items and specialized equipment may be necessary depending on case circumstances.

- Digital camera with memory card
- Small, medium, and "L" shaped rulers for scale in photographs
- Laptop computer or tablet
- Clipboard and pens, permanent markers
- Clean, unused envelopes for possible trace evidence collection
- Writable tags for body (ankle or wrist)
- Body bags – clean and unused
- Numbered lock tag seals for body bag
- Clean, unused paper sacks for bagging hands (or feet) when indicated
- Roll of tape (masking tape) to secure paper sacks over hands or feet
- Flashlight or penlight (with extra batteries)
- Indoor/outdoor thermometer for recording environmental temperature
- Measuring tape
- Personal Protection Equipment:
    - Disposable gloves
    - Mask (N-95 or better)
    - Face shield
    - Shoe covers
    - Apron, disposable gown, or jumpsuit
    - Hair cover
- Cotton or disposable sheet to wrap body to protect evidence when indicated
- Toxicology Supplies:
    - 20 cc to 30 cc plastic syringe
    - Large bore needles
    - Sharps container
    - Various tubes for fluid and blood collection (check with toxicology lab for preferences)

SCENE PHOTOGRAPHY

Documenting a death scene photographically is an essential component of a death investigation. Scene photographs provide a detailed permanent visual record for documentation and to allow for review by other independent experts, if necessary. Quality, detailed scene photographs will provide information and context for interpreting other investigative information, such as autopsy findings. The following recommendations are from Death Investigation: A Guide for the Scene Investigator, Technical Update (ojp.gov).

Photographs of the scene and body should be done as a systematic procedure. Non-essential personnel and extraneous objects should be removed from the photographic field, if possible.

First, an overall orientation photograph should locate the specific scene to a surrounding area (for example, outside of a dwelling at street-level view, outside of a vehicle in the street with adjacent surroundings). Next, more detailed areas of the scene should be photographed within the larger scene. Then, photographs of the scene from different angles may also be helpful. Photographs should include scales and should be taken even if the body and other evidence has already been removed or moved.

Digital cameras dedicated for death investigation activities should be used. External light sources and ring light camera attachments may be useful in certain scene settings. Cell phones should not be used for photography or storage of photographs.

BODY EVALUATION AND ORDERING AN AUTOPSY

The county medical examiner acts as "gatekeeper" to determine if an autopsy is needed, if an external examination on scene is sufficient, or if no body examination is necessary. The CME may "order an autopsy on the body of any person in a case involving a homicide, suspected homicide, a suicide, a violent, unnatural or suspicious death, an unexpected apparent natural death in an adult, sudden unexpected infant and child deaths, deaths believed to represent a threat to public health or safety and executed prisoners." T.C.A. § 38-7-106 (a). This decision will be based on the totality of the circumstances and investigative information about a case, and in consultation with law enforcement and/or a district attorney.

If an autopsy is ordered, the medicolegal autopsy must be performed at a Regional Forensic Center (RFC) accredited by the National Association of Medical Examiners (NAME). Since each of the RFCs is independently operated, each has its own policies and procedures for reporting cases, autopsy ordering, body transport, etc., and the CME should establish a relationship with an RFC and familiarize themselves with these procedures prior to referring cases for autopsy. A CME may choose any accredited RFC for autopsy referral for any case, although many choose the RFC based on geographic location or service cost.

An Order for Autopsy Form (OFA) may be downloaded at OSCME - Order for Autopsy.pdf (tn.gov) or may be completed as a part of the case record in MDILog. Specific procedures for autopsy ordering should be reviewed with the RFC where the autopsy is requested.

To assist county medical examiners, the following guidelines for determining when to order an autopsy have been established by the OSCME. There are deaths in which an autopsy must be performed so that each county provides a minimum service and meets national guidelines and best practices. In other instances, an autopsy may be recommended but not required. CMEs must establish policies and procedures for consistency in which cases will necessitate autopsy.

AN AUTOPSY MUST BE REQUESTED IN THE FOLLOWING CASES:

- All cases of homicide or suspected homicide must be autopsied, including apparent "accidental" shootings. This includes homicide victims that may have lived for days, weeks, months, or years prior to succumbing to their injuries.

- All cases in which the manner of death is listed as "Could not be determined" must have an autopsy. Note that this refers to *manner* of death rather than *cause* of death. The cause of death is the anatomic abnormality which initiated the events which eventually led to death; the manner of death is the circumstances under which that abnormality occurred.

- All child and infant deaths in which there is no previously known diagnosis to reasonably account for death must be autopsied. The diagnosis of Sudden Infant Death Syndrome (SIDS) or Sudden Unexpected Infant Death (SUID) requires an autopsy to exclude all other causes of death. Child abuse or neglect may also be difficult to detect and document without a complete autopsy. Chronically ill or special needs children are at higher risk for physical abuse or neglect and may have a combination of natural disease and physical injury which can only be adequately documented and determined through autopsy.

- Most deaths in prison, jail or correctional institution or police custody, or involving police intervention, in the presence or suspicion of injury must have an autopsy. Deaths of long-term prisoners or those in state custody who have well-documented disease processes known to cause death (e.g., cirrhosis due to hepatitis C virus infection) do fall under medical examiner jurisdiction and at a minimum should have an external examination with photography performed by the county medical examiner or his or her investigator.

AN AUTOPSY IS RECOMMENDED IN THE FOLLOWING CASES:

- All suicides unless the circumstances are very clear, no questions are pending, and the family has no reasonable objection.

- All deaths resulting from opiate, illegal or illicit drug overdose (Rule 1200-36-01-01), poison, or alcohol intoxication.

- All cases that involve drivers of a motor vehicle crash, unless it is a single motor vehicle accident, or the injuries have been clearly documented radiographically or by a hospital stay. An accident victim who has had a hospital stay will most likely have ample documentation of injuries in the medical records. An autopsy may not provide any additional information, although it may be of benefit to test blood taken at the time of admission for common drugs of abuse.

- Deaths of celebrities or high-profile persons: The autopsy serves a public health purpose, and many questions or speculations arising after the death has occurred can be addressed if an autopsy has been performed.

- Deaths related to electrical/electrocution and lightning-related deaths because the circumstances are often not straightforward, and because the external physical signs are very subtle or even undetectable.

- Burn victims or victims of smoke inhalation who are unidentified or who die at the scene of the fire should be autopsied. Questions arise as to identification of the decedent, time of death with respect to the time of the fire, and whether the death occurred before the fire started (the fire may be masking another type of death, such as a homicide).

- Deaths related to environmental exposure, such as hypothermia and hyperthermia.

- Persons who die in their workplace from obvious injury should be autopsied. Many legal questions may arise because of such a death on the job, and deaths at the workplace or related to employment clearly fall under medical examiner jurisdiction (T.C.A. § 38 -7-108 (a)). These cases should always be reported to Tennessee Occupational Safety and Health Administration (TOSHA; 844-224-5818; www.tn.gov/workforce/section/tosha).

- Deaths due to a possible public health hazard, such as meningitis or rabies, when the disease has not been confirmed, should be autopsied.

- Deaths that may be related to failure of a consumer product should be autopsied, and if confirmed, a report made to the U.S. Consumer Product Safety Commission (800-638-2772; www.cpsc.gov).

Most deaths in any community are natural, and most deaths reported to and accepted for investigation by the medical examiner are due to natural causes. In cases where there is sufficient documentation of natural disease, an autopsy may not be needed. Whether or not an autopsy is ordered in these circumstances is at the discretion of the of the CME in consultation with family or legal next of kin.

In most cases the death of a person of advanced age of apparent natural causes, with or without a known medical history and when non-natural factors have been ruled out, does not warrant a medical examiner requested autopsy. An external evaluation or examination with toxicology is usually sufficient. The cause of death in these instances usually may be certified as atherosclerotic cardiovascular disease. This designation is intended to include deaths from atherosclerosis, coronary artery disease, ischemic cardiomyopathy, peripheral vascular disease, cerebrovascular accidents, ruptured aneurysms, and aortic or other vessel dissections. Although a complete autopsy might better define the specific nature or mechanism of the immediate cause of death, determining the precise mechanism of death may not provide adequate justification for the expenditure of public funds to perform a forensic autopsy.

EXTERNAL EVALUATION BY CME or MDI

If a body examination if not practical or possible at the scene of a death outside of a medical facility, and/or an autopsy is not ordered, the body may be transported to another location for examination with the permission of the CME. Each CME should have a practice site to allow for body evaluation and collection of toxicology specimens if an autopsy is not ordered. Location and contact information should be provided to the county executive, local law enforcement, local health care facilities, and the state chief medical examiner. Care should be taken to perform the external evaluation in a private area that is not accessible or visible to the public.

If an autopsy is not ordered, the external evaluation findings should be documented by the CME or MDI with full-body photographs, front and back of the body, with additional photographic documentation of any pertinent findings or injuries. General body descriptions, postmortem changes (rigor mortis, livor mortis, etc.), and identifying marks, tattoos, and scars should be recorded. The external examination should include inspection of the surface of the eye orb, inner aspect of the upper and lower eyelids, inner aspect of the lips, and inside the mouth when possible.

It is recommended that CMEs and MDIs familiarize themselves with common postmortem changes. There are multiple standard sources of information about postmortem changes, such as Spitz and Fisher's Medicolegal Investigation of Death: Guidelines for the Application of Pathology to Crime Investigation:

> **Rigor mortis** is the stiffening of muscles after death and is due to a chemical process by which the actin and myosin fibers of the muscles are chemically cross-linked after death. The development and lysis of rigor mortis is extremely variable, and may be slowed or

hastened by many factors including ambient temperature, body mass, clothing, etc. Because of the variability, it is often very difficult to estimate a time since death based on rigor mortis or other postmortem changes. Rigor mortis begins throughout the body at the same time but can be appreciated first in the smaller muscles of the fingers and hands, neck, jaw, and elbows. Rigor mortis is usually noted later in the larger muscle groups. Rigor mortis may onset at short at 30 minutes after death. The process will usually reach a maximum stage, or full rigor, between 12 and 24 hours and will then begin to lyse over the next 12 to 24 hours. When rigor is present, it may be "broken" by forcibly flexing or contracting the muscle, after which it will move freely. The external inspection should include noting the intensity and distribution of rigor mortis, and whether it is appropriate for the position of the body.

Livor mortis is the discoloration of the body due to the settling of blood due to gravity after death. The presentation and development of livor mortis can be extremely variable and subjective. In general, in early postmortem period, livor mortis is not "fixed", meaning that if the body is repositioned, the distribution of lividity will change. Livor mortis will eventually become "fixed" and will not redistribute if the body is moved.

To evaluate livor mortis, apply digital pressure to the area of lividity. If the livor blanches where pressure has been applied, then it is not "fixed". As the postmortem interval increases, Tardieu spots, pinpoint focal areas of livor similar in appearance to petechiae or small purpura within areas of lividity may occur. The color and appearance of livor mortis can be dependent on the cause of death and time elapsed since death. For example, in the case of carbon monoxide poisoning, livor mortis may be cherry-red in the skin and the organs of the body. As livor progresses it will deepen in color and take on a marbled appearance.

Algor Mortis is the cooling of the body after death until ambient temperature is reached. Both external factors and variables intrinsic to the body can have a significant effect on the rate of cooling introducing a large and incalculable margin of error. In most cases tactile perception of whether the body is hot, warm, cool, or cold is all that is required. In those few cases in which a temperature reading should be taken, generally homicide cases where law enforcement has time sensitive questions about time of death or suspected hyperthermia cases, a rectal temperature reading should be obtained using a specialized digital thermometer. The rectal temperature cannot be obtained using standard thermometers used for live patients. A rectal temperature should never be attempted in cases involving suspected sexual assault.

COLLECTING AND ORDERING TOXICOLOGY

Appropriate samples of bodily fluids and/or tissues should be obtained by the CME or MDI for toxicological analysis unless the body will be sent for autopsy, *in which case the collection will be performed at the time of autopsy.* The method of collection and containers used should be guided by the lab chosen to provide analysis of the specimens. The lab should be provided with enough information about the case to guide the process of analysis. The lab chosen should be made aware of any suspected poisons or toxins involved in the case.

The county medical examiner must establish a working relationship with a toxicology lab for collection, shipment, and processing of appropriate samples. The Tennessee Bureau of Investigation Crime Lab will perform forensic drug and alcohol testing free of charge whenever law enforcement is involved in the case. For cases requiring accelerated handling, arrangements with a private lab meeting forensic specifications for performance of tests and testimony may facilitate expeditious evaluation of cases. Since the use of a private forensic laboratory will involve an additional cost, the county medical examiner should consult with the agency providing funding for the office for approval. If an autopsy is to be performed, the specimen should and will be obtained by the pathologist performing the autopsy at the regional forensic center.

A clean, unused, large bore needle with a clean, unused, syringe and various tubes are needed for specimen collection. It is important to have a conversation with your toxicology service concerning the type of tubes/ preservative acceptable for testing, as different labs have different abilities and requirements. Ask the toxicology service if coagulated or hemolyzed blood can be used for postmortem toxicology.

Toxicological testing is usually performed on whole blood that is not clotted, so the test tubes will require some type of preservative that stabilizes the specimen. For example, the Tennessee Bureau of Investigation requests blood and vitreous fluid for toxicology testing be placed in grey top (sodium fluoride) tubes, and urine to be collected in a sealable, leak-proof, container without preservative.

TOXICOLOGY SPECIMENS

Blood is often the specimen of choice for detecting, quantifying, and interpreting drugs and other toxicants. The best source of blood for toxicology is the femoral vessels. The second-best source for blood is the subclavian vein, although subclavian blood may be contaminated with pleural fluid. Blood should never be collected externally from the heart for toxicology testing, as the location makes it difficult to collect without contamination or dilution, and because the phenomenon of postmortem redistribution can confound the interpretation of toxicology results obtained from central blood.

Vitreous humor is the fluid within the eye and is a good specimen for toxicology (especially confirmation of blood alcohol level) because of its isolation from blood and other body fluids

that are more readily affected by postmortem changes, including redistribution. Vitreous humor can also be useful in measuring some of the pre-terminal electrolytes. Again, it is prudent to establish with the laboratory performing the testing the preferred type of tube for electrolyte testing. Vitreous fluid can usually be collected from the eye up to four days post-death and can be collected from embalmed bodies where the eyes have remained intact. Vitreous humor can be obtained by inserting a needle at the lateral margin of the eye and using gentle suction on the syringe to draw the fluid up. A slow, steady suction will allow the collection of the clear, colorless fluid, free of contaminants. One (1) to two (2) milliliters of vitreous should be easily obtainable from each eye.

Urine can be obtained by inserting a needle over the top of the pubic symphysis and aspirating (a suprapubic tap), or by catheterizing the patient. If there is urine in the bladder, it should be collected for toxicology. Urine samples can be used to screen for a relatively large number of drugs that could be cost- and sample-prohibitive using blood; however, urine toxicology is usually not determinative of whether drugs were present in the blood at the time of death. Any positive result from urine screening should be confirmed by another method.

If the deceased has spent time in the hospital prior to death and is to be sent for autopsy, obtain admission blood and urine specimens if available. Most hospital labs, due to storage constraints, do not keep specimens for more than a few days. Blood banks are required by the College of American Pathologists to retain specimens for ten days; if a decedent has been evaluated for a blood transfusion, the blood bank is the most likely source for antemortem blood for toxicology testing.

POSTMORTEM TOXICOLOGY INTERPRETATION

Interpretation of postmortem toxicology should be accomplished by forensic pathologists, toxicologists, or other personnel with knowledge and understanding of principles of forensic toxicology such as postmortem redistribution. The staff of the Office of the State Chief Medical Examiner is available for consultation by county medical examiners in the interpretation of postmortem toxicology results, as well as for any other concerns regarding medical examiner investigation of deaths, jurisdictional questions, and assistance in certification of death.

PRESERVATION AND COLLECTION OF EVIDENCE

The CME and MDI, in conjunction with law enforcement, should safeguard evidence directly related to medicolegal investigations. This evidence will generally fall into three (3) categories: medical examiner evidence, death scene evidence, and personal property.

Personal property and evidence are important items in a death investigation. Evidence associated with the body must be protected and collected properly to ensure its availability if needed for future evaluation and litigation. Personal property must be safeguarded to ensure its eventual distribution to appropriate agencies or returned to the legal next of kin.

It is important to remember that what is evidence to be collected is different on a case-by-case basis, from law enforcement agency to law enforcement agency, and between regional forensic centers. Often facilities do not have a "standard" evidence collection protocol. It is the responsibility of the CME/CMEI to communicate with their local law enforcement agency as to their expectations at autopsy.

Evidence located at the scene of a death not directly in contact with the body, in general, is the responsibility of law enforcement and should remain in their custody and control. The county medical examiner (CME) / investigator (CMEI) should cooperate with law enforcement's efforts to safeguard evidence. Death scene evidence which might be especially important to note in your report of investigation (ROI), and document with photography, would include suicide notes, illicit drugs, drug paraphernalia, weapons, and any item thought to be related to the cause of death (e.g., frayed electrical cord in suspected electrocution).

Prescription medications located at the scene may be treated differently than other related evidence. In many jurisdictions, the prescription medication prescribed specifically to the decedent is collected by the CME/CMEI for documentation, inventory, and disposal. Prescription medications, especially controlled substances, should be disposed of through safe, approved methods. Many area pharmacies and police departments now have drug/pill drop boxes which are approved for disposal. Prescription medications specifically prescribed for the decedent should always be included in the medication inventory and should not be left at the death scene. Law enforcement should be aware that prescription medication removed from the scene goes through a disposal process. Depending on the preliminary cause and manner of death, the CME/CMEI may release the prescription medication, once documented and inventoried, to law enforcement as evidence.

Evidence associated with the body at a death scene, in general, will stay with the body and is under the control of, and is the responsibility of, the CME/CMEI. Law enforcement should cooperate with your efforts to maintain the integrity of the body and any associated evidence contained on the body until the body is transported to the regional forensic center if autopsy is requested. Evidence on the body which might be especially important for the case forensic pathologist could include, but is not limited to, clothing of known or suspected homicide victims, ligatures, or any evidence of medical intervention. It is recommended that a body sent for autopsy receive minimal manipulation. In some instances the hands may need to be "bagged" in paper bags (See Preparing a Body for Transport pg. 36). It is recommended that evidence such as fingernail clippings, scrapings, or other invasive types of evidence be collected at autopsy.

CHAIN OF CUSTODY

The chain of custody is a chronological documentation or paper trail that documents the collection, transfer, custody, testing, or disposition of any items considered evidence. The

integrity of evidence and admissibility in court is predicated upon an unbroken chain of custody. It is important to demonstrate that the evidence introduced at trial is the same evidence collected at the death scene, and that access was controlled and documented. Retain a copy of a signed chain of custody for the transfer of evidence either to the CME/MDI, or from the CME/MDI to the regional forensic center or law enforcement. Local law enforcement or the district attorney should have appropriate evidence transfer forms available.

PREPARING A BODY FOR TRANSPORT

Proper preparation of the body for transport is crucial in preserving any evidence that might be associated with the body. If a body is being sent for autopsy, please contact the RFC to confirm the specific procedures for body transport and receiving.

When medical examiner jurisdiction has been accepted, every decedent should receive some form of identification tag listing known information such as name, date of birth, county of death, etc. Unidentified remains should be tagged as unknown male/female, county of death, date of death (or whatever verbiage is recognized and in use by the county). To maintain the chain of custody of the decedent, untagged bodies should not be transported to the regional forensic centers.

The body should be sealed in a clean, unused body bag for transportation to the examination facility or regional forensic center if autopsy is ordered. Clothing and other personal effects that are on the body of the deceased should be left on the body and transported with the body. Seal the body bag with a tamper proof, locking seal (numbered plastic zip ties/lock) to ensure that the body has not been disturbed during transport and storage prior to examination.

In cases of homicide, suspected homicide, or other suspicious deaths, the hands should be “bagged” to preserve evidence. Use paper bags only (plastic does not breathe and moisture can develop inside of the bag and ruin any evidence that may be present). Secure the bags with tape about the forearms, wrapping tape at the level of the top of the bag without touching the skin. Sometimes it may be necessary to bag the feet as well. When in doubt, bag the hands to preserve any evidence or suspected evidence during transport, and communicate with the RFC what evidence is to be collected. For cases of homicide or suspicious deaths, wrapping the body in a clean, white cotton or disposable sheet is recommended. Minimal handling of the body in these cases is crucial for preservation of evidence. Emphasis should be on maintaining the body and associated evidence for collection in a proper facility where trace evidence can be more easily visualized and collected.

DISPOSITION OF PERSONAL PROPERTY

Personal effects or valuables that are on the decedent fall under the same jurisdiction as the body. Pictures of the body as found, including clear views of jewelry and other valuables, provide documentation that can protect medical examiner personnel, law enforcement,

transport, funeral home personnel, and other family members if accusations of missing property arise. Property removed from the decedent, prior to transport to a regional forensic center or funeral home, and released to law enforcement, legal next of kin, or others, should be accompanied by a receipt of the transaction. Personal property could include clothing of decedents not sent for autopsy, jewelry, currency, wallet, purse, and/or other papers and personal items. Personal property does not include illicit drugs, controlled substances, or drug paraphernalia. A chain of custody form would suffice for this transaction. Note in the Report of Investigation (ROI) any property removed and released at the scene, especially if an autopsy is being requested.

NEXT-OF-KIN NOTIFICATION

Often the next-of-kin are present at the scene of death or have already been notified of the death prior to the medical examiner establishing jurisdiction. If not, the medical examiner can help facilitate the death notification process. The responsibility of notification of death rests with law enforcement; however, it is the responsibility of the CME to notify next-of-kin of an impending autopsy.

If the body is to be autopsied, "the authority ordering the autopsy shall notify the next of kin about the impending autopsy if the next of kin is known or reasonably ascertainable. The sheriff or other law enforcement agency of the jurisdiction shall serve process containing such notice and return such process within twenty-four (24) hours," T.C.A. § 38 -7-106(a).

The county medical examiner must make sure that the document containing the notice to the next-of-kin goes with the body to the regional forensic center.

T.C.A. § 62-5-703 defines next-of-kin in order of the following:

1. The attorney-in-fact pursuant to a durable power of attorney for health care.
2. The spouse of the decedent.
3. The decedent's surviving adult children.
4. A parent of the decedent.
5. An adult sibling of the decedent.
6. An adult grandchild of the decedent.
7. The grandparent of the decedent.
8. A guardian of the decedent at the time of the decedent's death.

If there is more than one adult child, the adult child making the arrangements should make a reasonable effort to contact all other adult children and ensure agreement among those contacted on the choice for funeral arrangements.

In addition to notification of the next-of-kin, the county medical examiner must also notify the district attorney and the state chief medical examiner whenever he or she decides to order an autopsy. T.C.A. § 38 -7-106 (a)

DECEDENT IDENTIFICATION

Identification of unidentified bodies is an important function of the CME. Bodies should be identified using one or more scientific methods accepted by medicolegal guidelines, as detailed below. Specific procedures for tagging the body of a decedent prior to sending for autopsy are established by individual forensic centers.

If a decedent cannot be positively identified prior to transportation for autopsy, the tag or band placed on the body should indicate UNKNOWN MALE/FEMALE, COUNTY OF DEATH, and any other information routinely used by the CME or MDI. If the decedent's identity is reasonably presumed, but unconfirmed, the presumed name may be included on the body tag (written as "presumed to be OR believed to be"). The method by which the decedent is identified should be documented in the Report of Investigation (ROI).

Identification of the decedent can be accomplished through use of one or more of the following methods:

Visual/Photographic Identification: Visual identification is the most common method currently used; however, visual identification alone is considered the least reliable method of identification. Identification of the body may be made by showing either the body or a photograph of the body/face to a member of the family, a friend, or other individual who knew the decedent. This method should only be used when the decedent is visually recognizable and not in cases of extensive facial trauma, decomposition, or any other circumstance that would obscure the facial features. Information about the person who confirmed the decedent's identification (including name, address, contact phone number, and relationship to the decedent) should be documented by the CME or MDI.

When a decedent is either positively or presumptively identified by a photograph from a driver's license or other official documents with a photograph, it is encouraged that this document be sent with the body to the RFC. The CME or MDI should not use "identified by family" or "known to law enforcement" in their reports but should document with specific information who was the identifier and their contact information.

While visual identification is the most common method used for positive identification, it has the greatest potential for error. Persons, even close family members, can make errors in identifying a deceased body. It is advisable to include at least other circumstantial information such as "decedent found in own residence, or vehicle" in the instance of a visual identification.

Tattoos may also be an acceptable method of visual identification. The tattoos must be distinctive enough in location and appearance to allow discrimination, and the tattoos should be confirmed via family members or by photographic comparison and documentation.

Fingerprint Identification: Fingerprint comparison is an excellent method of identification if the deceased has a fingerprint record on file for comparison. It is inexpensive, easy to obtain, and usually will have a short time for confirmation of results. Law enforcement records provide the most common sources for retrieving comparison fingerprints. The FBI fingerprint database contains a criminal file, a civil file for government employees, and a military file that covers the armed forces. When the decomposition process is advanced fingerprints may be difficult or impossible to obtain. Local law enforcement or the regional forensic center may be able to aid in printing difficult cases.

Fingerprints for homicide, suicide, or suspicious cases should not be collected prior to autopsy as the process of fingerprinting may destroy evidence. The RFC and/or forensic pathologist should be consulted prior to fingerprinting a decedent of suspected foul play.

Dental Identification: This method requires the presence of antemortem dental records and/or dental images. The record of the known person can be compared to the dentition of the deceased for positive identification by a forensic odontologist. As soon as it is suspected that dental identification may be required, a search for antemortem dental records should begin. Antemortem dental information should be forwarded to the regional forensic center performing the postmortem examination.

Radiographic Identification: Radiograph comparison may be used when antemortem x-rays are available and show remote skeletal fracture(s), unique skeletal anomalies or patterns, lesions, old and un-recovered projectiles, prior medical or surgical intervention and prostheses. Antemortem x-ray information should be forwarded to the regional forensic center performing the postmortem examination. Radiographic comparison may be performed by the forensic pathologist or forensic anthropologist depending on case circumstances.

DNA Identification can be used to establish the positive identification of a deceased person. Specimens considered suitable for DNA comparison include dried blood, hair with roots, tissue, bone marrow, and sometimes teeth. Blood dried on DNA blotter paper or an FTA bloodstain card is the specimen of choice. DNA identification is expensive and is susceptible to contamination and degradation. Rapid DNA technology is now available from the OSCME in certain circumstances when other methods of identification have failed.

ANDE Rapid DNA

The OSCME has obtained an ANDE system for use by our office on behalf of the county medical examiner cases. The ANDE system is a portable, easy-to-use, and deployable system for rapid DNA identification of deceased individuals who cannot be identified by other scientific means or in the event of a mass casualty. County medical examiners and regional forensic centers will be able to submit decedent samples and comparison samples to the OSCME for rapid DNA identification.

- Cases appropriate for rapid DNA comparison include cases which are submitted for autopsy and all other means of identification (fingerprinting, dental comparison, radiograph comparison, etc.) have failed.
- The ANDE system can also be deployed on-site throughout the State for rapid decedent identification in the event of a mass casualty.
- If a decedent's identity is unknown with no presumed identity, ANDE can create a DNA profile for storage and comparison should potential family relations be found for comparison.
- Employees of the OSCME are trained for ANDE use. The unit will be housed at one of the RFCs unless deployed in the field.

DNA identification can be requested by the RFC where the autopsy was performed after all other means of identification have been exhausted or are untenable. Samples submitted can include fresh muscle or liver tissue, bone, or teeth. Contact the OSCME for information on what samples would be best submitted as this is often case dependent. All ANDE cases must be entered into the state database.
The RFC or investigating law enforcement agency should also submit buccal swab samples from potential family members along with the known relationship between the decedent and that family member. A donor consent form (Appendix G) should be submitted with each comparison buccal swab.

PRESUMED IDENTIFICATION

If positive identification cannot be made via visual or scientific means, then a presumptive or circumstantial identification may be possible. Circumstantial evidence may include, but is not limited to, identification on the body, unique jewelry, scars, and tattoos, location of body within a residence or vehicle, and anthropological data. Circumstantial evidence alone is rarely used alone for decedent identification; however, if circumstantial information is the only means available for identification, the decedent's name should include "presumed to be" on official CME and vital record name documentation.

DEATH CERTIFICATION

Electronic death registration in Tennessee is now the only method for death certification. The certification is accomplished through the TN Vital Record Information System Management (VRISM). If not already registered, CMEs should register at https://apps.health.tn.gov/VRISMUserAgreement/UserAgreement/UserAgreement. Procedures for completing the medical death certification can be found at UPDATED: Medical Certifier VRISM Training - YouTube, ¬Position paper (thename.org), and https://www.tn.gov/content/dam/tn/health/documents/vital-records/vrism/EDRS-Guide-for-Medical-Certifiers.pdf.

GENERAL CONSIDERATIONS

Death certificates are the source of data for regional, state, and national mortality statistics and are used to allocate funding for scientific research, direct public health efforts, and assess the efficacy of preventative initiatives. In addition, a completed death certificate is required before a body can be buried or cremated, and is necessary for survivors to collect insurance benefits, transfer property, and the like. Erroneously completed death certificates may result in denial of payments to the decedent's heirs.

Certification of death by the county medical examiners and treating physicians should follow the guidelines established by the Tennessee Department of Health and the National Center for Health Statistics (NCHS). The NCHS keeps statistics on all deaths that occur in the United States. There are numerous resources for proper certification of death by physicians and medical examiners (Medical Examiners' and Coroners' Handbook on Death Registration and Fetal Death Reporting (cdc.gov), Improving Medical Death Certification CME - TNMED; More on Manner of death (memberclicks.net).

Standard language for specific examples for completing cause of death and "how injury occurred" sections of the death certificate are provided in Appendices C and D.

Tennessee law dictates that the "physician in charge of the patient's care for the illness that resulted in death" in non-medical examiner cases complete and sign the death certificate if that physician had treated or evaluated the deceased within the four months prior to death. This holds true even if that physician was not physically present at the time of death. Of course, a treating physician may also certify deaths of patients which occur more than four months after the decedent was last seen by him or her. Supervising physicians are responsible for certifying natural deaths of patients treated by nurse practitioners or physicians' assistants under their supervision, even if the physician never treated the patient. Failure to comply can result in disciplinary action by the Board of Medical Examiners.

Treating physicians, including consultants (e.g., cardiologists, oncologists) and emergency room physicians, may also certify death given knowledge of the medical history of the deceased. **Completion of the death certificate is the final act of care a treating physician can deliver to a**

patient; avoidance or failure to do so in a timely, accurate manner will cause undue distress to surviving family members. The medical certification of death is to be completed within 48 hours of pronouncement of death. Physicians acting in good faith when completing death certificates are immune from civil suit. T.C.A. § 68-3-513

County medical examiners are responsible for completing the medical certification of death for cases falling under medical examiner jurisdiction as detailed in T.C.A. § 38-7-108(a), as well as for natural deaths in which the treating physician refuses to sign a death certificate because more than four months have elapsed since the decedent was last evaluated by him or her. The county medical examiner is not responsible for certifying deaths in cases in which a treating physician has failed to arrange coverage for clinical responsibilities while on vacation and is not to be used as a death certification service for natural deaths which do not fall under medical examiner jurisdiction.

The medical examiner is responsible for completing the medical certification portion of the death certificate for cases investigated in accordance with the medical examiner statute. County medical examiners are not responsible for certifying deaths in cases not under their jurisdiction, though they may opt to do so if the certificate would not otherwise be signed. In such a case, the medical examiner should complete a Report of Investigation (ROI) by County Medical Examiner as well as the medical certification of the death certificate and file the ROI as required with the Office of the State Chief Medical Examiner.

It is recommended and considered best practice that the death certificate for cases referred to the RFCs be completed by the forensic pathologist who performed the examination.

In Tennessee, the date and time of death are determined by the date and time in which death is pronounced. That is, if a person is discovered in a state of advanced decomposition, the official date and time of death will be when death is officially pronounced and should not be estimated or otherwise approximated based on postmortem changes. Similarly, the place in which a body is found dead is to be listed as the place of death, even if the fatal injury or event occurred elsewhere. In cases in which a person is pronounced brain dead, the date and time of brain death is the official date and time of death. T.C. A. § 68-3-501 et seq.

The county medical examiner shall issue permits as required by the county and/or state which are necessary for the disposition of a dead body (to include cremation permits). The county medical examiner may be called upon to issue a letter certifying that a decedent had no known contagious disease prior to transport of the body to a foreign country.

CAUSE OF DEATH VERSUS MECHANISM OF DEATH

The cause of death statement is used to indicate the medical cause of death and should list the anatomic disease(s), injury or injuries that caused death. The cause of death and the mechanism of death, the physiologic process leading to death, are often incorrectly used interchangeably on the death certificate. Mechanisms of death are not specific to any given

disease process. For example, the *mechanism* of death for a person who is shot in the head may be exsanguination or hypoxic brain injury or ventricular dysrhythmia; the *cause* of death is simply gunshot wound of the head. A middle-aged cystic fibrosis patient may die with septic shock or right heart failure or a mucus plug; however, the underlying cause of death is correctly listed as cystic fibrosis. Many, if not most or all, cases of "aspiration pneumonia" occur in neurologically compromised patients; in this population, the disease process causing the neurologic impairment should be listed as the underlying cause of death (e.g., dementia, Alzheimer's type; amyotrophic lateral sclerosis; cerebrovascular accident due to atherosclerotic cardiovascular disease). "Natural causes" without an underlying specific disease is not an acceptable cause of death. In cases of drug overdose, all drugs contributing to death should be listed on the death certificate in Part I.

According to the Centers for Disease Control and Prevention, the below-listed diagnoses ***should not be listed on a death certificate as the underlying cause of death***. If listed in Part I of the death certificate, an underlying cause of death must follow.

Abscess
Abdominal hemorrhage
Adhesions
Adult respiratory distress syndrome
Acute myocardial infarction
Altered mental status
Anemia
Anoxia/anoxic encephalopathy
Arrhythmia
Ascites
Aspiration
Atrial fibrillation
Bacteremia
Bedridden
Biliary obstruction
Bowel obstruction
Brain injury
Brain stem herniation
Carcinogenesis
Carcinomatosis
Cardiac arrest
Cardiac dysrhythmia
Cardiomyopathy
Cardiopulmonary arrest
Cellulitis
Cerebral edema
Hepatorenal syndrome
Hyperglycemia
Cerebrovascular accident
Cerebellar tonsillar herniation
Chronic bedridden state
Cirrhosis
Coagulopathy
Compression fracture
Congestive heart failure
Convulsions
Decubiti
Dehydration
Dementia (when not otherwise specified)
Diarrhea
Disseminated intravascular coagulopathy
Dysrhythmia
End stage liver disease
End stage renal disease
Epidural hematoma
Exsanguination
Failure to thrive
Fracture
Gangrene
Gastrointestinal hemorrhage
Heart failure
Hemothorax
Hepatic failure
Hepatitis
Pleural effusions
Pneumonia

Hyperkalemia
Hypovolemic shock
Hyponatremia
Hypotension
Immunosuppression
Increase intracranial pressure
Intracranial hemorrhage
Malnutrition
Metabolic encephalopathy
Multi-organ failure
Multisystem organ failure
Myocardial infarction
Necrotizing soft tissue infection
Old age
Open (or closed) head injury
Pancytopenia
Paralysis
Perforated gallbladder
Peritonitis
Pulmonary arrest
Pulmonary edema
Pulmonary embolism
Pulmonary insufficiency
Renal failure
Respiratory arrest
Seizures
Septic shock
Shock
Starvation
Subdural hematoma
Subarachnoid hemorrhage
Sudden death
Thrombocytopenia
Uncal herniation
Urinary tract infection
Ventricular fibrillation
Ventricular tachycardia
Volume depletion

MANNER OF DEATH

The manner of death represents the county medical examiner's opinion as to which category the death best fits into and is based on the circumstances surrounding the death. The manner of death is an assessment of the event(s) leading to death based upon facts of the individual case and the professional experience of the county medical examiner The manner of death classification should not be construed as a moral, ethical, or judicial opinion of the decedent by the certifier. The medical examiner should be consistent in manner classification and follow accepted guidelines rather than alter classification based on subjective individual case circumstances or demands by the next-of-kin.

The five manner of death classifications are natural, accident, suicide, homicide, and undetermined (could not be determined). Pending Investigation, a sixth option on the Tennessee death certificate, should be considered only a temporary assignment of manner and should be changed as soon as the case investigation is complete. It is not necessary or appropriate to choose "Pending investigation" if the only information unavailable at the time of certification is whether criminal charges will be brought in each case.

A comprehensive discussion of manner of death with case examples may be found at More on Manner of death (memberclicks.net)

NATURAL

Natural deaths are those due *exclusively* (100%) to disease. A death in which a discrete, unnatural act contributes in any way towards the death, regardles of the interval elapsed between the event and demise, cannot be considered a natural death. In general, if death is a result of a combination of natural disease and non-natural factors, preference is given to the non-natural factors in determining manner of death (e.g. cerebral hemorrhage associated with acute cocaine use would be considered an accidental death).

Deaths due to chronic substance abuse (e.g. endocarditis associated with intravenous drug user; cirrhosis from chonic ethanol use) in which a single or discrete intoxication event cannot be identified as directly leading to death are classified as natural.

ACCIDENT

Accidental death is defined as an unnatural death resulting from an inadvertent chance happening. Motor vehicle fatalities are considered an accident unless the driver deliberately uses the vehicle as a weapon or to commit suicide. Classification of motor vehicle fatalities as accidents is done in the interest of uniformity for vital statistical purposes and bears no relation to the presence or absence of criminal charges arising from the motor vehicle fatality. Specifically, even in instances of driving while intoxicated, reckless driving, or hit-and-run fatalities when the driver bears criminal responsibility, the county medical examiner should still classify such deaths as accidents in the interest of uniformity. Such a classification will not preclude criminal prosecution or civil charges.

Deaths due to acute drug intoxication or alcohol poisoning, absent clear evidence of suicide, should be classified as accident. Manner determination of drug-related deaths may be complex, but guidelines dictate classifying deaths from drug use without any apparent intent of self-harm as accident.

SUICIDE

Suicide is defined for medical examiner purposes as a death from self-inflicted injury with some form of explicit or implicit evidence of intent to harm oneself. The burden of proof need not be “beyond any reasonable doubt” but should be more than “more likely than not.”

Death cases involving “Russian Roulette” (spinning the cylinder of a revolver loaded with one cartridge, pointing the muzzle at one’s own head, and pulling the trigger) can be highly controversial as the legal view of intent may differ from that of the medical examiner. These types of behaviors are most often ruled suicide because the act of placing a loaded gun to the head and pulling the trigger is a volitional act that carries a high risk of death.

HOMICIDE

Medical examiner classification of homicide is simply defined as “death at the hands of another.” The medical examiner classification of homicide may or may not be the same as the legal or judicial classification. According to the “Guide for Manner of Death Classification”, a publication of the National Association of Medical Examiners (NAME), available at: More on Manner of death (memberclicks.net):

> “Homicide occurs when death results from a volitional act committed by another person to cause fear, harm, or death. Intent to cause death is a common element but is not required for classification as homicide (more below). It is to be emphasized that the classification of Homicide for the purposes of death certification is a “neutral” term and neither indicates nor implies criminal intent, which remains a determination within the province of legal processes.”

COULD NOT BE DETERMINED (UNDETERMINED)

Could not be determined should be a category that is rarely used and reserved for those cases in which an exhaustive investigation, including forensic autopsy, has been performed. An effort to develop sufficient information to classify an unnatural death as homicide, suicide, or accident should be made in every death case. If there is little available information about the circumstances surrounding the death, or the known information equally supports more than one manner of death, then it can be appropriate to use could not be determined. This category should not be used for cases that are controversial to avoid a dispute or publicity caused by a more appropriate ruling on manner.

PENDING INVESTIGATION

“Pending” manner of death classification may be used for cases where the results of the investigation, autopsy, and/or laboratory studies are not quickly available. This will fulfil the T.C.A. requirement that a death certificate be filed within five (5) days of death and will allow the next of kin to arrange burial or cremation, and to begin the legal and administrative routines when a death occurs. After completion of the investigation, a delayed report of death should be completed in VRISM within six months of the death.

CREMATION APPROVAL AND BODY TRANSIT PERMITS

The CME is required to approve all deaths in which cremation is the final disposition of the body in the jurisdiction where the death occurred. The CME should be prepared to sign all cremation approvals for his or her jurisdiction in a timely manner and should establish procedures to accomplish this. Cremation approval is important as a final assurance that all deaths that potentially require investigation have been reported to the CME before cremation of the body.

In addition, the CME will occasionally be required to sign a body transit or letter certifying the absence of infectious disease when a body is to be transferred to another state or country. Please contact the OSCME or RFC where an autopsy is performed if assistance is needed with this process.

SPECIFIC CASE TYPE AND CIRCUMSTANCE GUIDELINES

The CME should be familiar with the general medicolegal case investigation best practices as well as guidelines for specific case types. The following is not intended to provide a comprehensive review of all case types which may be encountered but is a brief reference for common case types a CME is likely to encounter. If a CME or MDI has specific case questions, they should contact an RFC, forensic pathologist, or the OSCME for guidance and assistance.

ALL-TERRAIN VEHICLES (ATV)

Investigation of ATV vehicle accidents is like other types of motor vehicle collisions. The main duty of the CME/MDI is documentation of injuries sustained by the collision, gathering circumstantial information, and collecting specimens for toxicology testing.

When investigating an ATV collision, consider the following:

- Was the operator or passenger(s) of the ATV wearing a helmet or protective clothing or safety restraints (if applicable)?
- What were the road (trail) conditions? (visibility, weather, etc.)
- What type of roadway or trail was the individual operating on? Was the trail maintained?
- What was the direction of travel for the vehicle(s)?
- What was the operator's experience level?
- Are there any signs of alcohol/drug use?
- Were there any passengers? How many passengers is the vehicle rated for?
- Was the vehicle pulling anything (sprayer, yard cart, a trailer for rock or dirt, etc.)?
- If the accident occurred on the roadway, was the vehicle rated for highway use (lights, turn signals, etc.)?
- Does the ATV have any roll bars, seatbelts, other safety features?
- What is the year, make, model, and serial number? Consumer Product Safety Commission may need to be notified.

BLUNT FORCE/BLUNT TRAUMA INJURY

Blunt force injury is a general classification of injury resulting from when a body strikes an object or when an object strikes a body. Blunt force injuries include abrasions, contusions, lacerations, and fractures. The most common forces that cause blunt trauma injuries are motor vehicle accidents, falls, and assaults.

When investigating a death due to blunt force injuries, consider the following:

- Is trauma from impact with a moveable object, or a fixed object such as a wall?
- Document the size, shape and nature of the moveable object including any artifact found on the object.
- Are there blunt objects present at the scene that could have been used as a weapon or associated with the death? Document their location relative to the body.
- Does the object have fresh or dried blood on it?
- Does the body of the decedent display any obvious pattern injuries?
- Is there a large pool of blood around the decedent? Estimate volume.
- Is the blood in several locations? Are there droplets that may represent cast-off?
- Is the weapon still at the scene? Any suspected weapon should be collected as evidence by law enforcement. The case forensic pathologist may request to view the suspected weapon at the time of autopsy. When collecting and transporting the weapon, it is imperative that it is handled carefully and correctly to preserve any latent prints and/or DNA evidence.

CARBON MONOXIDE

Carbon monoxide (CO) is a colorless, odorless gas that results from incomplete combustion of materials containing carbon. CO is produced when fuel is burned in cars, small engines, furnaces, grills, fireplaces, gas ranges, and in house fires. A deceased individual found within a closed space in a vehicle with the motor running may be readily identified as a CO poisoning. The more subtle cases, possibly due to a faulty heating system or an improperly vented gas generator, can be harder to diagnose and investigate.

In cases where the CO levels are markedly elevated (in the range of approximately 50% to 80% saturation), pink or cherry red livor mortis becomes noticeable on the external examination. Much lower carboxyhemoglobin concentrations can be lethal in certain circumstances, including the presence of other toxic gases from combustion (cyanide), flash fires, and in individuals who are more susceptible due to natural disease. The very young, the very old, and individuals with cardiac and pulmonary disease fit into the category of susceptible individuals. Investigators should not enter the scene until professional personnel have assessed the safety of the environment through utilization of a carbon monoxide monitor, if appropriate.

In deaths due to carbon monoxide poisoning, consider the following:

- If the individual is in a motor vehicle, is the ignition on? Could the vehicle be restarted? Is the gas tank empty? Is the vehicle in a garage with the door closed? Is there stuffing around the garage doors? Is an apparatus connected to the tailpipe? Are there any vehicle defects to the exhaust system, holes in floorboard or firewall?

- Were resuscitation efforts (CPR) performed?

- Are any of the indicators of suicide present, such as a suicide note, comfort items, beverages, previous suicide attempts or threats, history of depression, financial or marital difficulties, etc.?

- If the individual is found in a residence, is the heater on? Does the heater involve combustion? Is the residence in need of repairs, including the gas appliances or heater? Are any pets dead? Is there an attached garage with a running vehicle?

- Is there a charcoal barbecue grill in a confined space near the decedent?

- Is there evidence of medications, drugs, or alcohol at the scene that may indicate the individual had increased susceptibility to carbon monoxide poisoning?

- Testing for carbon monoxide in the blood at autopsy remains the most reliable and efficient way to determine whether a fire victim died from smoke inhalation.

- An apparent carbon monoxide death may represent a homicide; thorough investigation is essential.

CHILD AND INFANT DEATH INVESTIGATIONS

Tennessee Code Annotated, §68-1-1101 to 1103, the Sudden, Unexplained Child Death Act, defines and directs the investigation into child and infant deaths in Tennessee. The county medical examiner shall investigate the circumstances surrounding any death of an infant or child in which the medical history does not document a previous diagnosis of natural disease that could account for the death. Very often there will be multiple agencies involved in a child death investigation, increasing the logistical challenges surrounding an already complex investigation. Also contributing to the difficulty of the investigation are the high emotions associated with an infant or child death and possible multiple scene locations (e.g., at the hospital and where the child was discovered unresponsive or ill).

When the CME is notified of the death of an infant or child within a healthcare setting, he or she should ascertain prior or ongoing law enforcement or child services (DCS) involvement with the family or caregivers. Information provided by these agencies about circumstances prior to admission or transport to the hospital can direct the investigation and determination of jurisdiction for legal purposes. Hospital response by the CME is dependent on circumstances of death and whether medical examiner jurisdiction is accepted. If the CME accepts jurisdiction for the death, and initiates an investigation, the location of death pronouncement is where the investigation should initiate. However, if injury occurred at another location or the infant or child was found unresponsive at another location, that scene should also be investigated.

In cases due to trauma, the investigation focuses on correlating the history of how the injury was reported to have occurred to the findings at the scene, the child's developmental abilities, and the injuries identified at autopsy. A high degree of suspicion for child abuse should be maintained, as evidence of external trauma on the body is often minimal to none.

All hospital records, including radiology, laboratory, and any consultation reports, should accompany the body to the regional forensic center for review by the case pathologist. Antemortem blood samples taken at the time of hospital admission should be acquired if available.

Sudden Infant Death Syndrome (SIDS), a subtype of Sudden Unexpected Infant Death (SUID), is defined as a death in a child below the age of one year whose death occurs suddenly and unexpectedly, with no known or apparent cause, and which remains unexplained after the performance of a complete investigation, including a thorough scene investigation, review of medical history, and an autopsy.

Neglect versus failure to thrive due to natural causes can be difficult to discern based solely on autopsy findings, except in extreme cases. Determination of neglect often entails investigation into the home environment, health of siblings, and reviewing the medical chronology of growth and medical interventions.

CME/MDI interviews with family, caregivers, etc. should be completed in conjunction with law enforcement's investigation. Two fillable reporting forms, the SUIDI (Sudden Unexplained Infant Death Investigation) (Appendix J) and SUCD (Sudden Unexplained Child Death Investigation) (Appendix K) are available on the OSCME website: https://www.tn.gov/health/health-program-areas/oscme/resources-for-the-county-medical-examiner

When investigating a child/infant death, and completing the SUIDI or SUDC, consider the following:

- Attend all scenes (emergency room, home of decedent, etc.) in partnership with law enforcement.
- Obtain medical and social history of decedent.
- Locate medical records for both decedent and mother, including labor / delivery, prenatal care records, well baby records, pediatrician/vaccination records, and newborn metabolic screening results.
- Document any history of Child Protective Services involvement with the family.

- Be familiar with developmental milestones of infants and children and at what age or stage of development these occur. Remember some children achieve some of the milestones earlier than others. Review of pediatrician records is important.

- Consider whether the explanations, history, and information obtained from caregivers, mother, father, significant other of parents, and grandparents, etc. are all consistent, and whether they corroborate with the clinical history and findings of how an injury occurred. Caregivers should be interviewed separately.

- Consider whether any injuries on the child corroborate with the findings at the scene. Scene photographs and diagrams can be very important.

- Document any evidence of drug or alcohol abuse at the scene.

- In cases of failure to thrive, documentation of medical consultations and follow-up should be recorded. Presence or absence of formula or food in the cabinets, refrigerator, or freezer should be documented.

- Infants can be significantly more sensitive to infections, toxins (carbon monoxide), and environmental extremes than older children and adults. The proximity of the infant to heating sources should be noted.

- Perform a doll re-enactment, preferably as soon as possible after the death. Photographs should be taken to document the doll re-enactment and should include images of the position of the child when last seen alive and when found.

- In a possible SIDS/SUID/SUCD investigation, the bedding should be examined along with the sleep surface, and a complete history of sleep position, bed sharing, recent illnesses, and/ prior sibling death(s) documented.

T.C.A. § 68 -1-1101 *et seq.* specifies that a "certified child death pathologist" must perform any autopsy on an infant or child under the authority of the postmortem act. The child death pathologist is a board-eligible or board-certified forensic pathologist who agrees to follow the autopsy protocol for child death investigation as prescribed by the state chief medical examiner. At a minimum, the autopsy and report should include:

- Complete external examination;
- Radiographs of the body prior to autopsy in cases of sudden unexpected death in infants;
- Complete autopsy, defined as at a minimum:

    - *In situ* examination and removal and dissection of organs from the cranial cavity, neck, thoracoabdominal cavities, and pelvis;

- Completion of a written narrative autopsy report, which must include:
    - descriptions of pertinent positive and negative external and internal findings;
    - external and internal injuries;
    - a review of organ systems, including histologic examination of major organ systems;
    - a summary of case findings or list of diagnoses, including review of medical record;
    - opinion regarding cause and manner of death; and
    - completed Sudden Unexplained Infant Death Investigation (SUIDI) reporting form or Sudden Unexplained Death of a Child (SUDC) reporting form as is appropriate for the age of the decedent

These guidelines are based on the Forensic Autopsy Performance Standards issued by the National Association of Medical Examiners, which can be accessed below:

https://www.thename.org/assets/docs/2016%20NAME%20Forensic%20Autopsy%20Standards%209-25-2020.pdf

CONSUMER PRODUCT RELATED DEATHS

A death scene that involves a product that may have caused or contributed to a death of an individual should be documented and reported to the **United States Consumer Product Safety Commission (CPSC)** and the OSCME. It is recommended that an autopsy be performed on such cases.

The CPSC is an independent federal regulatory agency that was created in 1972 by Congress in the Consumer Product Safety Act. In that law, Congress directed the Commission to "protect the public against unreasonable risks of injuries and deaths associated with consumer products."

Examples of common products that should be reported include toys, ATVs, bicycles, cigarette/charcoal lighters, cribs, fireworks, mattresses, portable generators, Pack-n-Plays, etc. Visit www.cpsc.gov and click on the tab titled "Regulations, Laws & Standards," Voluntary Standards" for an alphabetized list of product categories.

When investigating a death involving a consumer product consider the following:

- Did the product contribute to or cause the death?
- Does this product fall under the U.S. Consumer Product Safety Commission's jurisdiction?

- Who is the manufacturer, and what is the model brand name and serial number of the product?
- Is the product available for examination? If so, where is it located?

To report an unsafe consumer product or a product-related death:

A report can be filed electronically with the CPSC at www.saferproducts.gov

U.S. Consumer Product Safety Commission
4330 East West Highway
Bethesda, MD 20814
Phone: (800) 638-2772; TTY (301) 595-7054
Fax: (301) 504-0124 or (301) 504-0025

DECOMPOSED REMAINS

Decomposition may make injury recognition difficult and may delay decedent identification. It is best practice for decomposed remains to be autopsied or examined by a forensic pathologist based on case circumstances.

The rate of decomposition changes is dependent on a number of factors, including environmental temperatures and humidity, insect activity, and the presence of injuries. Documentation of pertinent facts that help estimate the postmortem interval, such as the time the individual was last seen alive, is necessary.

While the time frame may be variable the body will go through some typical changes during the decomposition process. Early in the decomposition process, the superficial layers of the skin may slough off from the body producing "skin slippage." "Marbling" is a green/purple discolored branching pattern due to decomposition of blood within dilated subcutaneous blood vessels. Green/black discoloration of the skin will begin. Gas-producing bacteria can cause the abdomen and other areas to be distended, which is termed "bloating." Brown or red decomposition fluid ("purge") may exude from the nose and mouth. In drier climates, the skin may become dark and dried resulting in "mummification." In cool wet environments, fatty acids in the body convert to soaps, forming a white or tan waxy substance called "adipocere." After several weeks to months, the remains are reduced to the skeleton.

Since less may be learned from a decomposed body at autopsy, circumstantial evidence from the scene becomes important both in the investigation as well as identification. However, confirmation of the identity with scientific methods such as fingerprints, antemortem clinical radiographs, or dental comparison is often necessary. It should be determined whether there are antemortem fingerprints on file. The most recent dental X-rays should be obtained as soon as possible and sent to the pathologist/investigator. In the event that there are no dental records, medical X-rays revealing fractures or anomalies may be utilized.

Consider the following when investigating a decomposed body:

- Document the scene environmental information; temperature, clothed/unclothed, position of body, wet/dry, direct sun/shade, etc.
- Document the degree of decomposition.
- Are blowflies or maggots present?
- Is there evidence of postmortem insect or animal scavenging?
- Is the residence secured and valuables intact?
- Is there a history of depression, suicide attempts, or threats?
- Are medications at the scene appropriate for the prescribed doses? Complete a Medication Log.
- Note the last time the individual was last seen alive.

DISASTER-RELATED DEATHS

It is important to correctly certify deaths that may be related to a natural, human-induced, or chemical/radiological disaster. Deaths due to disasters should include information about the name and type of event on the death certificate for accurate disaster event mortality statistics and for planning and targeted interventions for future events.

Deaths may be directly or indirectly related to a disaster. An extensive discussion of disaster-related deaths can be found at A reference guide for certification of deaths in the event of a natural, human-induced, or chemical/radiological disasters (cdc.gov)

- A directly related death is directly attributable to the forces of a disaster or by the direct consequences of the forces, such as a building collapse, flying debris, or radiation exposure. Common causes include burns, blunt trauma, electrocution, falls, fire or smoke inhalation, radiation or chemical poisoning, suffocation, etc.
- An indirectly related death is when unsafe or unhealthy conditions during any phase of a disaster (pre-event preparations, during the event, or post-event cleanup after a disaster). The death may be caused or contributed to by evacuation, loss or disruption of health care, preparation for the disaster, loss, or disruption of transportation, etc.

Key points:

- When certifying a death, ask if the death occurred during a natural disaster, associated event, or human-induced event.
- If yes, consider if the death was directly or indirectly related to the event.
- If yes, please ensure that the disaster name and type are listed on the death certificate, either in Part I, Part II, or how injury occurred section
- Use the “but-for” principle: “But-for” the disaster (or hostile environment), would the person have died when he or she did?

- If any component of the death is due to trauma or injury, please ensure the case is reported/investigated by the CME.

DROWNING

The diagnosis of drowning is based on the circumstances surrounding the death in combination with the absence of any other intervening cause of death identified at autopsy. Information gathered at the scene is crucial to the correct determination of drowning as the cause of death because findings at autopsy are often minimal and non-specific. A complete autopsy is recommended in cases of suspected drowning.

The following should be considered in the investigation of drowning deaths:

- Is it logical that the decedent was in the water?
- Do scene findings and findings on the body make sense with the history (wetness of body, injuries or lack of injuries, postmortem changes, etc.)?
- How was the body found? Floating? Submerged? How deep is the water where the body was recovered?
- Could the decedent swim? How well? Was there a lifeguard?
- Did the decedent have a history of seizures or cardiac conditions? Is there a family history of sudden death?
- What is the type of body of water? Lake? Pool? River? What are the conditions of the water, including temperature, waves, and currents? Document weather at the time (electrical storms, etc.).
- What factors are present that could contribute to injuries or artifacts on the body (marine life predation, boat activity, etc.)?
- If the drowning is in a pool, are there lights or other electrical equipment that should be checked by an electrician?
- Is there a pool suction filter system? Where was the body found in relation to the components of the system?
- Had the decedent participated in any type of sport or activity such as jumping from a diving board or water skiing?
- What was the decedent wearing at time of incident (personal floatation device, swimming suit, etc.)?
- How did the decedent get to the body of water (car, walk, pool ladder, etc.)?

DRUG RELATED

Investigation of a possible drug-related deaths requires integration of multiple types of investigative information. Below is a summary of investigative practices recommended for a potential drug related death taken from the NAME position paper "Recommendations for the Investigation, Diagnosis, and Certification of Deaths Related to Opioid and Other Drugs." The full recommendations from NAME may be found at ¬PosiRusty5.18!tion paper (thename.org)

1. Autopsy provides the best information about a decedent's medical condition for optimal interpretation of toxicology results, circumstances surrounding death, medical history, and scene findings. The panel considers autopsy an essential component of investigating apparent overdose deaths.

2. Scene investigation includes reconciling prescription information and medication counts. Investigators should note drug paraphernalia or other evidence of using intoxicating substances.

3. Retain blood, urine, and vitreous humor whenever available. Blood from the ilio-femoral vein is preferable to blood from more central sites. For in-hospital deaths, request the blood and other body fluids be retained by the hospital for medical examiner pick-up and testing.

4. A toxicological panel should be comprehensive, including potent depressant, stimulant, and antidepressant medications. Detecting novel substances present in the community may require special testing.

5. When death is attributed to a drug or combination of drugs (as cause or contributing factor), the certifier should list the drugs by generic name in the autopsy report and death certificate.

6. The best classification for manner of death in an overdose without any apparent intent of self-harm is "accident."

In a possible overdose death, consider the following:

- In evaluation of medications found at the scene, to who are they prescribed? The date(s) of the prescription(s), the quantity prescribed, and the number remaining should be catalogued.
- Is the residence secured? Is there evidence of a struggle?
- Is there a history of drug or alcohol abuse?
- Is there drug paraphernalia at the scene? If so, send it with the body. The pathologist may want to send the paraphernalia for toxicological testing.
- Are there needle marks or track marks on the extremities?

- Are any of the indicators of suicide present (suicide note, previous suicide attempts or threats, history of depression, financial or marital difficulties, etc.)?
- Are there indicators of remedy revival such as ice packs or the decedent having been placed in the shower or bathtub?
- Is there paint or glue on the hands or at the scene (huffing)? Are cans of compressed air (keyboard cleaner) near the body?
- Complete a Medication Log by listing all medications, including herbal or alternative remedies and over-the-counter medication.
- If sending for autopsy, check with Regional Forensic Center to determine if medications should be sent with the body.

ELDERLY / DEPENDENT ADULT

Unexpected or unattended death of dependent adults and the elderly requires a complete death investigation. Although most of these cases are natural deaths, other non-natural conditions must be excluded. Autopsy is recommended whenever the manner of death is in question.

Types of elder or dependent adult abuse include physical abuse, sexual abuse, financial exploitation, psychological abuse, and neglect. The investigation of the death of a dependent adult should include a complete scene investigation with inquiry as to the degree of dependence of the decedent, understanding of the roles and responsibilities of the caretaker(s), analysis of the living conditions with review of the decedent's activities of daily living, and evaluation of the decedent's access to food and proper shelter. The scene should be documented by photographs, and in some instances, scene re-creation.

Evaluate the role of the caretaker(s), their capabilities, and resources. Determine the degree of the decedent's independence. Self-neglect may complicate interpretation of scene and physical findings. Individuals who can make their own decisions have the right to refuse care and transport to a medical facility for care.

Questions concerning the need for autopsy or other concerns should be directed to a forensic pathologist.

In addition to what is asked for on the ROI form, consider the following:

- With whom did the decedent live and what is their relationship?
- Has there been a recent change in living conditions or caretaker?
- What is the condition of the residence?
- Are utilities in working order?
- Did the decedent have access to food and drink? If yes, by what means?

- Where, how, and how regularly did the decedent eat? Who prepared the meals?
- Where did the decedent sleep? Describe condition of decedent's clothing and bedding.
- Was the decedent able to communicate and have access to computer or telephone?
- Was the decedent diagnosed with dementia or other cognitive impairment?
- Does the decedent have a physical disability? If yes, describe.
- Did the decedent require the assistance of a wheelchair, walker, cane, eyeglasses, or hearing aids? Were they available to the decedent?
- Who managed the decedent's finances?
- Were any unemployed adults living with the decedent?
- Is there a history of law enforcement or Tennessee Department of Human Services/ Adult Protective Services involvement?
- Is there a history of domestic violence involving the decedent?

ENVIRONMENTAL EXPOSURE

Autopsy is recommended in cases of suspected hypothermia or hyperthermia. The findings at autopsy in cases involving both extremes of temperature can be supportive, but not necessarily diagnostic, of the role of those extremes in the death. Therefore, the diagnosis depends on history and scene investigation combined with autopsy findings.

Invasive documentation of body temperature is not recommended, although documentation by external methods can be helpful. Confer with the forensic pathologist before checking core or rectal temperature.

In cases of hypothermia, documentation of weather conditions and exposure of the individual is very important. An autopsy can rule out most other natural disease and trauma.
Similarly, hyperthermia also relies on environmental conditions and evidence that the individual was exposed to high temperatures. Testing of the vitreous fluids during autopsy can support the diagnosis of dehydration. Documentation of body temperature using a rectal thermometer in cases in which sexual assault is not suspected can help support the diagnosis.

When investigating exposure deaths consider the following:

- Is the individual properly clothed for the conditions? Paradoxical undressing is sometimes seen in cases of hypothermia.
- Is there a psychiatric history?
- Is there evidence of drug or alcohol use?
- Is the individual homeless?
- Is there evidence of a struggle?
- Is there a significant past medical history that would make the individual more susceptible to environmental conditions?

- What were the high and low temperatures during the interval that the decedent might have been exposed to the environment?
- What is the immediate temperature in the environment? Has the heat in the residence recently been turned off?

FIRE

Investigation of fire deaths requires close collaboration between fire and arson investigators, death investigators, and law enforcement. Determining cause and manner of death can be difficult in fire deaths due to the possibility of extensive burning of the decedent, determination of how the fire started, and whether the decedent was alive when the fire started.

All fire-related deaths should be autopsied with skeletal x-rays performed as needed. Toxicological analysis for the presence of alcohol, drugs, and carbon monoxide should be performed. A majority of deaths from fires are due to smoke inhalation. Testing for carbon monoxide in the blood will confirm the diagnosis. Depending on fuel load and contents being burned, hydrogen cyanide may also be tested for in the blood.

A major issue in any fire death is confirmation of identity of the decedent. By interviewing the NOK and other witnesses, information concerning the decedent's medical and social history may give clues to information that can be used to positively identify the decedent. Valuable information that needs to be collected for every fire death to help with identification includes:

- Name and location of decedent's dentist.
- Name and location of decedent's primary medical provider.
- History of any prior arrests to help locate fingerprints on file.
- Description of the decedent's tattoos, scars, marks, piercings, clothing, or jewelry.

If information concerning the above items is very limited, then with the assistance of law enforcement, the collection of buccal swabs of the decedent's immediate biologically-related NOK may be necessary to perform DNA analysis.

If the use of an accelerant is suspected in starting a fire, clothing should be collected at the time of autopsy, and submitted for the detection and analysis of ignitable and flammable liquids.

When investigating fire related deaths consider the following:

- Can the body be visually identified or will scientific or circumstantial methods need to be employed to confirm identity?
- What are the circumstances of the fire (hence manner)? Investigation by the fire investigator is needed for this determination.
- Are there physical or medical impairments that would hinder the individual from escaping the fire? Were there structural alterations to the home or car preventing escape (bars on windows, doors locked, etc.)
- What is the location and position of the body in the house, car, etc.? Document the position of the body at the scene.
- Examine area around and under body for weapons, gasoline cans, lighters, etc.

GUNSHOT WOUNDS

Gunshot wound deaths are one of the most common types of death investigated by a CME.

Determining entrance and exit wounds may be difficult in certain cases, especially during scene examination when the wound(s) may be bloody or the scene may have poor lighting. If there is any uncertainty about which wound is the entrance and which is the exit, it is best practice to simply describe the wounds and refrain from identifying the wounds as entrance/exit.

- **Avoid touching or manipulating the wound. Do not clean the wound.**
- **Do not take possession of any firearm at the scene or send a firearm with the body. Document the type of weapon, type of ammunition, and any evidence indicating how many times the weapon may have been fired.**
- **Ensure law enforcement secures and takes possession of any firearm found on scene.**
- **When moving the body for external examination or placing into a body bag, ensure projectiles do not fall from the decedent's clothing or possible exit wounds.**

When investigating gunshot wound deaths consider the following:

- Document the type and caliber of firearm.
- Do the number of casings found at the scene correlate with the number of entrance wounds and/or recovered bullets at the scene?
- Based on witness accounts, room dimensions, blood stain patterns, etc. is there an estimated range of fire?
- In cases of suicide: Where is the weapon in relation to the body? How many spent casings are in the cylinder or on the floor? Was the weapon owned by the decedent? Was the decedent familiar with the suspected firearm? Are there any known mechanical

defects to the firearm? Does there appear to be a contact gunshot wound? Is the entrance wound in a location that could be reached by the decedent? Was the decedent right- or left-hand dominant?

- In cases of homicide: Are there multiple gunshot wounds? Are multiple shooters/weapons involved? Is there an intermediary target?
- Cover the hands with paper bags and secured with tape prior to transport
- Does evidence of medical intervention exist? If so, ensure medical devices are not removed.
- Were clothes removed? If so, every effort should be made to retrieve the clothing and transport them with the body so that they may be examined by the pathologist at the time of autopsy.

HANGING

The overwhelming majority of hanging deaths are suicides. Accidental hangings can occur at work, but the more common "accidental" hangings are due to sexual or autoerotic asphyxia. The presence of an escape mechanism in the case of a decedent with pornographic material nearby could indicate a sexual asphyxia death. Though it is very difficult to hang someone against their will, special circumstances that should make the investigator suspicious of a homicide include an extremely intoxicated individual (i.e., BAC in coma range), a history of domestic abuse, or evidence of a struggle. Hangings can take place in any position (e.g., fully suspended, standing kneeling, seated, etc.) and at any height. The body does not have to be fully suspended.

Transport the body to the morgue with the ligature remaining around the neck and send any remainder of the ligature with the body. **The ligature should not be removed unless there is any possibility of resuscitation.** If it is necessary to remove the ligature for this reason, the ligature should be preserved. This is best done by cutting the ligature away from the knot at the suspension point and securing the ends with string or masking tape.

The usual indicators of suicide still apply:

- Absence of signs of a struggle.
- Suicide note or suicidal ideation.
- Previous suicide attempts.
- History of depression, stressors, or substance abuse.

Consider the following when investigating a hanging death:

- Are the grooves and marks in the neck consistent with the way the body is suspended? A horizontal or downward sloping groove on the lateral neck could indicate the possibility of ligature strangulation.

- How is the body suspended (fully or partially)?
- Are livor patterns consistent with the position of the body? Measure the height of the feet from the ground and the height of the structure supporting the ligature from the ground. Document any furniture or boxes that may have been used as a platform.
- Are there any scratch marks around the ligature to indicate a struggle?
- Is there an escape mechanism, pornographic material, or previous markings where the ligature was secured (scratches on structural beam) to indicate sexual asphyxia?
- Has the body been cut down prior to arrival of CME personnel? If so, it is imperative to interview the person who found the body to document suspension information discussed above. If the person is obviously dead, do not cut the ligature from the supporting structure until photographs have been taken and the scene documentation is complete.

HOME DEATHS

It is best practice for a CME/MDI to conduct a scene investigation of a death outside of a medical facility. The extent of the investigation, and whether an autopsy is ordered, will be based on the overall case circumstances, including the decedent's medical history, evidence of drug use or foul play at the scene, or any indication the death was due to anything other than natural causes.

A natural death occurring at home in which the decedent has been seen by a physician within the last four months for the condition resulting in death does not fall under the jurisdiction of the medical examiner. A natural death in which the decedent has a documented medical history and a physician willing to certify the death is not a medical examiner case, and may not require a scene visit (jurisdiction dependent) unless there are suspicious or unusual circumstances. Personal physicians should sign the death certificate of persons who die at home if they have been under prior medical treatment for a disease or condition capable of producing death, such as a cardiac arrhythmia or myocardial infarction occurring in a patient with coronary artery disease or hypertension.

An apparent natural death occurring at home when there is no physician who attended the decedent in the past 4 months, the decedent was not under hospice care, the death is unexpected, or when there is no available medical history may require a scene investigation. Many of these cases may be able to be released directly to the funeral director from the deceased person's home if examination of the body and investigation of the scene can exclude the possibility of any trauma or other factor that would make the death unnatural.

HOMICIDE

Homicide as a manner of death as classified by medical examiners means death at the hands of another person. According to the National Association of Medical Examiners, "[i]ntent to cause death is a common element but is not required for the classification of homicide (More on Manner of death (memberclicks.net). Classification of homicide for death certification neither implies or indicates criminal intent, which much be determined by legal processes.

In the case of a homicide in which the cause of death is relatively obvious, the investigation concentrates on determining the course of events that led up to the death. Evidence is collected; the scene is documented by both law enforcement and medicolegal death investigation personnel. The CME/MDI on the scene should identify the major areas of external trauma, document body position, and provide basic information for postmortem interval estimation from rigor and livor mortis. In homicide scene investigation, it is very important to accurately document scene findings and circumstances in an objective manner. It is also important to refrain from documenting speculative or inferred findings or information.

With all homicide or potential homicide investigations, consider the following (some of these answers will be attainable through discussion with the investigating law enforcement agency):

- Have the circumstances and events (as they are understood at the time) leading up to the death been documented?
- Have the specific types and numbers of weapons as they are known been documented? Examples might include number and type of ammunition casings or recovered bullets at the scene, types of possible blunt instruments present at the scene that could have been used as a weapon or associated with the death (bat, fire extinguisher, etc.).
- Is there evidence of the body having been moved? Be sure to ask whether the body has been moved.
- Is livor pattern consistent with body position? Had EMS moved the body to initiate resuscitative measures or confirm death?
- Describe possible blood at the scene. What are the dimensions, quantities, and the location relative to the body? Is there possible blood on clothing?
- Is there evidence of a struggle? Examples might include knocked over furniture, possible defensive wounds of the hands, or broken fingernails.
- Has the body been inspected for trace evidence? If there is trace evidence that could be damaged or lost in transport, collect it and document specifically from where on the body or clothing it was recovered.
- Has another investigating agency or emergency medical personnel removed or collected any clothing? If so, this should be documented and every effort should be made to have the clothing available for examination by the pathologist at the time of autopsy.

- Are the hands or feet covered in paper bags prior to moving the body into the body bag?

HOSPICE DEATHS

The death of a patient while under the care of a hospice program, in which the decedent has been under long-term care for a chronic terminal illness, does not automatically fall under the jurisdiction of the medical examiner. Often in these cases the attending physician or hospice medical director has previously agreed to certify the death after the patient dies. A registered nurse within a hospice program may make the actual determination and pronouncement of death of a hospice patient. (T.C.A. § 68 -3-511)

If this type of death is reported and the investigation does not reveal any non-natural factors that may have contributed to the death (for example, remote trauma), the death does not fall under medical examiner jurisdiction.

HOSPITAL DEATHS

In larger counties with multiple hospitals, specialized treatment centers, and level one trauma centers, patients will frequently be transported directly from an out of county incident or transferred from a local hospital or emergency department. The CME responsible for case investigation is the CME in the county where the death occurred, NOT the county in which the injury or illness leading to death occurred. Best practice is for the CME in the county of death to communicate with the CME and investigative personnel in the location where the initial incident or injury occurred.

In a death in which a natural disease is the presumed cause of death, and there are no non-natural processes contributing to death, the physician treating the patient for that disease should complete and sign the death certificate. However, if the patient has not been seen or treated in the physician's practice within the four months prior to death, the clinician may by statute refuse to sign the death certificate. Emergency room physicians may also sign death certificates in apparent natural deaths. The chief medical officer of the facility in which the death was pronounced may be held responsible for certification of death in cases which clearly do not fall under medical examiner jurisdiction, yet the practicing physician refuses to sign the death certificate.

When a death occurs in a nursing home or long-term care facility, it is rarely reported to the county medical examiner. If a person dies while in a nursing home or care facility they are under the care and supervision of a physician, even if the physician was not there at the time of the death. The death is considered "attended." If the death is exclusively due to natural causes, the attending physician has the responsibility of death certification.

Care must be taken when eliciting the history of the terminal illness from the reporter of death. Deaths of many elderly people are the result of a gradual decline in health following a hip fracture. A good rule of thumb is to ask oneself, "Did this person return to their pre-injury level of function prior to death?" If the answer is no, the manner of death cannot be considered natural. In these instances, the county medical examiner can decline to take custody of the decedent but, to ensure that the death certificate is appropriately certified as an "accident," should assume that responsibility. The best method to preserve the integrity of death statistics is for the county medical examiner to sign and complete the death certificate based on medical records review and/or the history provided by the reporter.

Rarely is a scene response necessary in deaths occurring in healthcare facilities. One notable exception is in cases of sudden unexpected deaths of infants or children, in which caregiver and witness interviews are best carried out in concert with law enforcement at both the scene in which the child was found ill or unresponsive and at the hospital. Protocols between the county medical examiner, healthcare facilities, emergency medical services, law enforcement, and the district attorney's office should be clearly established in advance. The county medical examiner should reach out to facility administrators, risk management, or chief medical officers and provide them with the relevant sections of the Tennessee Code. Appendix E contains a flyer developed by the OSCME which may be distributed to healthcare facilities detailing cases in which the county medical examiner must be notified.

If a CME or MDI accepts jurisdiction on a hospital death, he or she has several choices regarding the next most appropriate course of action. For example, he or she could order an autopsy and relay relevant scene and medical findings to a regional forensic center; review medical records without examining the body and issue a death certificate; perform an external examination of the body, with or without ancillary testing; or order toxicology testing on an admission blood specimen in a person who dies in a healthcare facility hours or days after an acute drug intoxication, with or without examining the body. If medical examiner jurisdiction is accepted for a death occurring in a healthcare facility and an examination by the county medical examiner and/or a forensic pathologist at a regional forensic center is planned, all medical therapies should be left in place in the body unless removal is expressly permitted by the medical examiner or investigator. This practice minimizes the possibility of confounding therapeutic artifact with inflicted injury.

IN-CUSTODY DEATHS

The County Medical Examiner must be notified of all in-custody deaths (T.C.A. § 38 -7-108). Deaths that occur while a person is being pursued, apprehended, or incarcerated by law enforcement or involve medical detainees are usually considered high profile cases. These deaths require thorough and objective investigations. These cases have a high likelihood for civil and criminal litigation, and they often have the potential for creating allegations of police or institutional misconduct.

Any in-custody death that is other than natural should be sent to and autopsied by a forensic pathologist.

The duties of the CME/CMEI in investigating in-custody deaths should include the following:

- Visit the scene (jail cell, prison yard, patient room, etc.) where the incident occurred, even if the decedent was removed and taken to a local hospital.
- Document the scene through photographs and scene sketches with dimensions.
- Obtain copies of reports from police, the institution (jail, prison, etc.), EMS reports, time logs, statements from fellow inmates/patients, and any hospital/medical records of the decedent.
- Ascertain the decedent's location, position, actions, and the timing of actions leading up to the death.
- If the decedent was removed prior to arrival, request officials who were present at the time of the incident or when the decedent was found to reenact what was observed.
- If a conducted electrical weapon (Taser, etc.) was used by law enforcement to help subdue the decedent, leave the barbs in place. If the barbs need to be removed for medical care or for other reasons, circle in permanent marker the location of the barbs, and initial and date the areas.
- Obtain copies of any police car dash cam videos, police body camera videos, and/or jail, prison and institutional videos documenting the scene and incident.
- Leave any clothing and other personal effects on the body, as they are considered evidence.
- Leave any ligatures in place unless ***attempts are made to start life-saving procedures***. Do not disturb any knots along the entire length of the ligature.
- Obtain any antemortem (admission) specimens immediately for toxicological analysis.
- If death occurred in a jail, prison, or mental health institute, obtain copies of all recent patient logs, medication administration logs, incident reports and medical records pertaining to the decedent.
- Examine the body and document rigor mortis, livor mortis, and any trauma to the body.
- In cases where drug-induced excited delirium is expected, a rectal temperature should be taken immediately (consult forensic pathologist performing the autopsy before doing so). Also, note the room or environmental temperature.
- Place and transport the body in a labeled and sealed body bag.

INSTITUTIONAL DEATHS

Institutionalized adults may not be under the care of a physician and the death may fall under the jurisdiction of the county medical examiner. In Tennessee, the death of a person committed or admitted to a state mental health institute, a state resource center, a state training school, or other comparable institution, should be reported to and investigated by the county medical examiner. In addition to issues commonly investigated, concerns may arise with regard to the institution and their practices and processes involving care.

Consider the following for these investigations:

- Was the facility secure or non-secure?
- Did the decedent have any recent visitors just prior to death? If yes, who were the visitors?
- Immediately obtain copies of medical records, observation, and medication logs from the facility.
- Secure and obtain video/security camera recordings from the facility (indoor and outdoor), if available.
- Describe clothing and living conditions of the decedent.
- Describe the degree of cleanliness and orderliness of the facility.
- Note any use of restraints with other residents, as well as the decedent.
- Inquire about use of any procedure(s) or equipment to restrain the decedent (has the equipment been removed?)
- Was the institution/facility staff cooperative or evasive? Do they have concern for the decedent?
- What levels of training and education do care providers have? What certifications do they have?
- Is the institution or facility licensed? If yes, by who and is licensing current? Obtain copies of the most current inspection record.
- Has the institution or facility been reported to Tennessee Department of Mental Health & Substance Abuse Services in the last few years? If so, describe any founded and unfounded reports.

MOTOR VEHICLE COLLISIONS

The involvement of the county medical examiner at the scene of a motor vehicle collision should be part of a team approach with law enforcement investigators. It is the duty of the law enforcement agency to reconstruct the scene or accident per individual jurisdiction policies.

The main duty of the medical examiner is the evaluation and documentation of injuries sustained in the collision. Evaluating injuries sustained in a motor vehicle collision requires the ability to recognize and distinguish different types of blunt trauma. Blunt force injuries sustained by occupants of a motor vehicle can be complex. Many victims of motor vehicle accidents, particularly drivers, should be autopsied. This is especially relevant when the collision is the result of illegal activity, collision in the course of employment, or when the cause of the accident is unknown, as well as when the cause of death is not externally obvious. An effort should be made to correlate injury patterns diagnosed at autopsy with object(s) impacted in or on the vehicle.

When investigating a motor vehicle collision, consider the following:

- Who was the driver of the vehicle? In some cases, the distinction is not clear. Some impaired or at-fault drivers have been known to report a deceased passenger as having been the driver.
- What were the road conditions (visibility, weather, etc.)?
- What type of roadway (concrete, asphalt, gravel, dirt, mud, etc.)?
- What type of traffic controls were in use (stop sign, electric signal, yield sign, etc.)?
- What was the speed limit? What was the speed of surrounding traffic? Was there sudden congestion or stop-and-go traffic?
- What was the direction of travel for the vehicle(s)?
- Is there evidence of alcohol/drug use?
- Were seatbelts in use?
- Was the decedent extricated from the vehicle?
- Was decedent ejected from the vehicle?
- Did airbags deploy?
- Was there evidence of distraction, such as a phone?

NATURAL DEATHS

Certification of natural as manner of death means the death is only due to natural causes. If non-natural circumstances or injuries contribute to the death in any way, the manner of death should reflect the circumstances in which the injury occurred (e.g., accident, homicide, or suicide).

Natural death investigations should consider the following:

- Was the death witnessed or unwitnessed?
- Is there any trauma to the body?
- If found at home, was the residence secured? Signs of forced entry? Evidence of a struggle?
- If at work, what was the decedent doing at the time of death? Are there any potential dangers (potential electrical contacts, etc.) in the vicinity?
- Is there significant family or medical history? If so, what is that history?
- Are the medications present with the decedent appropriate in numbers for the prescribed dosage? To whom are the medications prescribed?
- Any recent complaints about pains or illnesses?
- Is the body decomposed? If so, autopsy may be necessary to confirm identification of decedent.

- Is there a history of domestic violence?

If an individual is found deceased outside a healthcare setting (e.g., home, yard, etc.), it is considered best practice for the CME/MDI to attend the scene of death. A medical examiner or investigator should respond to the scene, perform an investigation, and complete the investigative form or ROI. The subsequent investigation will determine whether an autopsy is required.

If a person died while in a healthcare setting and they were under the care of a healthcare provider (e.g., emergency room, hospital inpatient, nursing home, hospice, etc.), the death may be reportable to the medical examiner depending on the circumstances of the admission and underlying disease or injuries.

OCCUPATIONAL DEATHS

An occupational fatality is any fatal event that occurs at work, including death on a farm. The decedent may be an employer, employee, or self-employed person, farmer, or family member helping with a business. Any death, natural or otherwise, that occurs during work should be reported to the CME. Many factors can contribute to the cause of death of an individual on the job (thermal injuries, electrocution, drowning, etc.).

Employers are required to report any on the job death the **Tennessee Occupational Safety and Health Administration (TOSHA) at (800) 249-8510**. This information is used to research and identify common hazards in workplaces and on farms.

In deaths that occur on the job, consider the following:

- Where was the decedent found with reference to any equipment in the area?
- Was the decedent moved by anyone? Who?
- What safety gear is generally required for working around this particular machinery or equipment? Was the proper equipment in use and secured properly?
- What was the decedent supposed to be doing at the time of the incident?
- Was the incident observed?
- Was the decedent performing a task he/she was trained to do?
- Were safety precautions posted in or around the machinery or equipment? Were precautions being followed?
- What was the decedent's medical history?
- Was any other person injured?
- Was there thought to be any medication, drug, or alcohol involvement?
- What was the current work schedule? Was the decedent working long hours or overtime that would cause fatigue?

- Was this the usual type of work for the decedent? Were any unconventional shortcuts utilized that would be considered dangerous?

Any involved equipment should be documented, including the year, make, model, and serial number for Consumer Product Safety Commission report. In some circumstances, the equipment should be sent with the decedent for autopsy; the forensic pathologist should be consulted in this regard.

PEDESTRIAN / BICYCLIST

Vehicular crashes involving pedestrians and bicyclists can often be reconstructed by law enforcement with considerable accuracy by knowing characteristics of the person and the vehicle involved in the collision. Pedestrians and bicyclists struck by motor vehicles should be autopsied. There may be transferred paint, plastic, glass, or imprints from the suspect vehicle to the decedents clothing, skin, or bicycle. Pedestrians will commonly have blunt force contusions and crushing injuries of their legs, torso, and buttocks. An autopsy will help to provide information on whether the vehicle was braking or not at the time of impact and may correlate injury patterns with the suspect vehicle.

When investigating a pedestrian fatality consider the following:

- Was the pedestrian walking, standing, or lying on the road at the time of the collision?
- What was the direction of travel of the vehicle? Of the pedestrian?
- For a bicyclist note the direction of travel and final position of the bicycle.
- Were the vehicles brakes being applied at the moment of impact?
- Did the driver see the pedestrians/bicyclist prior to the collision?
- Is there evidence from the vehicle on the body or clothing of the decedent, such as paint or grease?
- Is there evidence that the pedestrian was thrown up onto the vehicle (broken windshield, etc.)?
- Are there probable impact sites on the vehicle?
- Where did the pedestrian end up relative to the vehicle? Was he/she moved?
- What type of clothing was the pedestrian wearing? Were high visibility/reflective clothing worn?
- Did the vehicle stop at the scene? Are charges pending against the driver of the vehicle?
- If a bicyclist, were they wearing a helmet? Was the helmet damaged? Reflective clothing?
- If at night, was the bicycle equipped with front and rear lights/reflector?
- Was the bicycle using a bike lane?
- How badly was the bicycle damaged?

SKELETAL REMAINS

The medical examiner must assume jurisdiction after the discovery of skeletal remains. The CME should seek assistance from a forensic pathologist or forensic anthropologist to determine if the remains are human. The OSCME staff can assist in determining human versus non-human skeletal remains. In addition, it must be ascertained whether the skeletal remains are of medicolegal significance. Prehistoric bones and anatomical teaching specimens are generally not in the interest of law enforcement or the medical examiner. The location of the remains and any artifacts associated with them can be helpful in the determination of medicolegal significance.

The Regional Forensic Center in your area should be contacted if skeletal remains are determined to be human or suspected to be human and can assist with arranging for anthropological assistance, scene recovery and interpretation of human remains, as may be appropriate. It is important that law enforcement or other investigative agencies do not attempt to recover or remove the skeletal remains without first contacting the CME or RFC.

When investigating skeletal remains consider the following:

- An anthropologist may be available for consultation, identification of remains/burial site, and collection or excavation of the remains.
- The scene must be defined and documented. This could be confined to a single burial or cover a large surface scatter of skeletal remains.
- Systematic and comprehensive search techniques must be utilized to ensure maximal evidence recovery.
- Construction of a grid will assist in the systematic excavating and documentation of the area.
- Articles of clothing (buttons, zippers, man-made fabrics, etc.) and personal artifacts should be sought.
- Soil samples under fairly intact remains should be collected for potential toxicology testing.
- Document the location of a retrieved bone or piece of evidence photographically and by mapping, or scene sketch with measurements referenced to the location of at least two permanent fixtures, such as a large boulder, roadway, or telephone pole.
- Bones may be brittle, and should be cushioned and packaged with care for transport.
- Aerial photography may also be employed when human skeletal remains are found. This technique is used to document surface terrain / topography and the scene's relationship to the surrounding area and environment.

SPORTS RELATED

Sports-related deaths usually occur suddenly and without warning and are almost certainly unexpected. These deaths usually occur in young and/or healthy individuals and therefore should be autopsied.

When investigating a sports related death, consider the following:

- What type of sport was the decedent involved in?
- Was the sport played indoors or outdoors?
- Describe the playing surface.
- If outdoors, describe the weather.
- Was the accident or injury caused by an instrument or piece of equipment used by the decedent or another player?
- Did the death occur while in contact with another player?
- If safety equipment is required for this sport, describe in detail, and indicate whether the decedent was dressed appropriately at the time of incident.
- What was the level of experience of the decedent in this sport?
- Was the decedent ever injured previously in this or any other sport? If yes, were they seen and released by a physician to continue activity? Specify dates and injuries.
- What is the school or team policy for post-injury re-entry?
- Was the decedent taking any medication, either legal or illegal?
- Was the decedent taking any homeopathic or natural supplements, using steroids, or consuming high-energy sports drinks?
- If this is a water sport, refer to section on drowning for further information if needed.
- Was protective clothing or gear used? Obtain make, model, and description.

SHARP FORCE INJURIES

“Sharp force injuries” is a general classification of wounds including stab, incised, and chop wounds. In general, stab wounds are typically deeper than they are long. Incised wounds are usually longer than deep. Chop wounds will often have characteristics of both sharp wounds (from the cutting blade) and blunt injuries from the edges of the instrument. When investigating sharp force injuries, consider the following:

- Are there defensive cuts on the arms or hands?
- Are there multiple superficial hesitation marks on the wrists or around the fatal wound?
- Is there a large pool of blood around the decedent? Estimate volume.
- Is the blood in several locations? Are there droplets that may represent cast-off?

- If there was emergency medical intervention, were clothes removed and were stab wounds altered or sutured (did a thoracotomy incision go through a stab wound, was a stab wound used for a chest tube insertion site, etc.)? Obtain all medical records that document the intervention and the location of the original wounds. Every effort should be made to retrieve the clothing and transport them with the body so that they may be examined by the pathologist at the time of autopsy.
- Is the weapon still at the scene? If so, it should be collected as evidence either by law enforcement or by the medical examiner and brought to the autopsy. When collecting and transporting the weapon, it is imperative that it is handled carefully and correctly to preserve any latent prints or DNA evidence.
- Cover the hands with paper bags and secure with tape to preserve evidence prior to transport

SUICIDE

Determining the manner of death as suicide relies on implicit evidence the individual had the means and intent to kill themself. In general, after a complete investigation, there should be a preponderance of the evidence to indicate that an individual from an intentional act that was meant to, or has an inherently high risk of, causing death. A note indicating suicidal intent ("suicide note") is found in only a minority of all suicide deaths. Additionally, evidence that contradicts the manner being suicide should be sought.

Consider the following when investigating a presumed suicide:

- Is there evidence of a struggle (room disarray, knocked over furniture, etc.)?
- Is the building or room secure? Document presence or absence of locks on doors and windows. Did police have to break in to gain entry into the room or building?
- Are weapons near the body? Document the position of any weapon in relation to the body.
- Is there a past psychiatric history? Be specific about recent versus remote histories of depression. Was the individual ever treated for depression or other psychiatric illness?
- Have there been any previous suicide attempts or threats? Method? Look for linear scars or hesitation marks on the wrists for physical evidence of previous suicide attempts.
- Is there a social history of financial difficulties, marital problems, poor work or school review, or anniversary of the death of a loved one?
- Is there a suicide note? Suicide notes may not necessarily be in the immediate vicinity or same address as the body. Consider the location of suicide notes on electronic devices,

such as computers or cell phones. Be sure to make a copy of the note to retain. If necessary, the signature and writing may be compared with other known documents.

- Examine and photograph the hands. Bag the hands at the scene if necessary to preserve evidence.
- In the case of an overdose, are there paraphernalia or prescription medicine containers? Send paraphernalia with law enforcement so that the contents can be tested. Document all prescription drugs and determine whether pills remaining are appropriate for the prescription. Complete a Medication Log.

SUSPECTED SEXUAL ASSAULT

In cases of suspected sexual assault, it is critical to preserve evidence on the body. In order to do so, additional steps taken at the scene include:

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-the hands should be placed in paper bags secured around the wrists;

-oral or rectal temperature should NOT be taken;

-manipulation of the body should be kept to a minimum; and

-the body should be wrapped in a clean white sheet prior to being placed in the body bag for transport.

If a CME/MDI wishes for a sexual assault kit to be collected, it is paramount that this be relayed to the regional forensic center when the death is initially reported to them to avoid inadvertent loss of evidence.

If law enforcement wishes to retrieve fragile evidence from the body at the scene (e.g. a hair grasped in the hand; a paint chip on the clothing), the item to be collected should first be photographed as it was found on the body, then placed into a sealed evidence container with proper documentation of chain of custody.

The regional forensic center to which the decedent is sent is the best location for the collection of hair and body fluids from the decedent. It is not appropriate to perform an examination for sexual assault at the scene. The clothing is considered evidence and should remain as it is on the body for transport.

The sexual assault kit typically consists of swabs to collect fluid from the mouth, anus, and vagina or penis; glass slides made using those swabs; pulled and combed head and pubic hairs; a blood sample from the decedent; and clippings and scrapings of the fingernails. These are collected by the forensic pathologist at the regional forensic center and appropriately handled and stored. Law enforcement may then submit the kit for analysis to a laboratory, again with strict documentation of the chain of custody.

SPECIAL TOPICS

FETAL DEATHS

Tennessee Code requires investigation by the county medical examiner of a fetal death occurring after 20 weeks' gestation or if the fetus weighs 350 grams or more without medical attendance at or immediately after the delivery, or when inquiry is required. T.C.A. § 68-3-504

A Report of Fetal Demise is to be filed in cases of spontaneous intrauterine fetal demise, meaning the fetus was born without any signs of life, if the body weighs 350 grams or more or is of 20 completed weeks of gestation or more. If a stillbirth as defined above occurs outside a medical institution, the physician in attendance at or immediately after the delivery shall prepare and file the report. However, if there is no medical attendance at or immediately following delivery, the county medical examiner shall investigate the case and file the report. T.C.A. § 68-3-504

Authorization for final disposition of a dead fetus requires a cremation permit only if the fetus meets the definition and criteria listed above. Below 350 grams and/or 20 weeks the remains are considered products of conception and do not require a Report of Fetal Demise nor a cremation permit. T.C.A. § 68 -3-506

GUNSHOT RESIDUE TEST COLLECTION

Testing of swabs for collection of gunshot residue from a decedent's hands is no longer considered determinative nor helpful in deciding if a gunshot wound is self-inflicted or inflicted by another person. Forensic science literature indicates that gunshot residue testing on the hands of deceased person may be positive simply by being near a gun when it is fired. Therefore, it is no longer recommended that swabs for gunshot residue testing swabs be collected from a deceased victim's hands.

OBJECTION TO AUTOPSY

Cultural, religious, and other objections to autopsy are occasionally encountered by a CME during an investigation. If a family expresses an objection to autopsy, the CME or MDI should discuss the objection with the next-of-kin and document the specific nature of the concern or objection. Often, the objection may simply be a misunderstanding that an autopsy procedure will preclude a viewing of the decedent after funeral preparation. The CME may be able to defer an autopsy depending on the details of an individual case if the family expresses firm objections. If the CME deems an autopsy is necessary despite family objections, the CME should consult with the personnel at the RFC where the autopsy is to be performed and/or the district attorney general to determine if special considerations may be made to accommodate the next-of-kin. It is prudent for a CME to work with and communicate with religious and

community leaders to accommodate cultural and religious traditions while fulfilling the CME responsibilities.

ORGAN AND TISSUE DONATION

Medical examiners and investigators play a crucial role in the donation process. It is the position of the National Association of Medical Examiners medical examiners and organ/tissue procurement organizations "should work cooperatively together to establish prospective agreements, protocols, or memoranda of understanding to ensure that both parties get what is needed and that procurement of organs and/or tissues form cases falling under [medical examiner] jurisdiction can be maximized". (NAME Position Statement: Medical Examiner Release of Organs and Tissues for Transplantation Organ and Tissue Statement July 2019.pdf (thename.org).

The Organ Procurement Organizations (OPOs) in Tennessee are committed to collaborating with the medical examiners to ensure that all requirements for a medicolegal investigation are met while honoring the donation decisions of individuals and their families. OPOs in Tennessee will work directly with county medical examiner offices to develop procedures to ensure that medical examiner concerns and needs are addressed while still preserving the opportunity for organ and tissue donation.

Criteria for tissue donation eligibility changes frequently due to changes in tissue processor requirements and regulations. What may rule out donation today may not rule out donation tomorrow. Tissues can be recovered up to 24 hours after death when the body is cooled within 12 hours.

For more information on donation refer to the Revised Uniform Anatomical Gift Act T.C.A. § 68-30-101. (Appendix A)
To contact Tennessee Donor Services visit http://tds.dcids.org , and Mid-South Transplant Foundation visit http://midsouthtransplant.org

The county medical examiner may permit the removal of the cornea or corneal tissues from the body "if a request is received from an authorized official of a not-for-profit corporation chartered under the laws of the state, or authorized to do business in the state and certified by the Eye Bank Association of America to obtain, store and distribute donor eyes and eye tissues to be used for corneal transplants and for other medical purposes," T.C.A. § 38 -7-106 (b).

UNKNOWN OR UNIDENTIFIED DECEDENTS

A body that is unidentified should never be cremated until a positive identification has been established. A body that is unidentified can be embalmed and buried, once information has been collected that may aid in future positive identification. The list of information includes, but is not limited to : height, weight, approximate age, gender, race (ancestry), hair

characteristics (color, length, style, etc.), eye color, description and color photos of all tattoos, amputations, scars, and prosthetics, clothing record (items, colors, labels, sizes) to include color photographs, jewelry descriptions to include color photographs, street names or nicknames, fingerprints, dental exam with chart and dental x-rays, other x-rays (if indicated), DNA specimen(s), and anthropology consultation (if available and indicated). Copies of all information collected should be maintained as a part of the permanent medical examiner record until identification has been established.

Unidentified remains should not be cremated.

UNCLAIMED BODIES

Unclaimed decedents are those whose identification is known, but next of kin is either unknown, unable to be located, or are unable or refuse to make arrangements for final disposition. For clarification, unidentified decedents are those whose identity cannot be established by medical examiners or law enforcement and are different from an unclaimed body.

MEDICAL EXAMINER CASES

Disposition of a decedent whose death was accepted under medical examiner jurisdiction is the responsibility of the county medical examiner in which death occurred or was pronounced. If the body is unclaimed after investigation by the county medical examiner, the body may be cremated or decently buried as directed under T.C.A. § 68-4-113 which requires "(1) proper notice given in accordance with § 68-4-103 (b)(2); and (2) the body is held for the time period provided in § 68-4-103 (c)" (not less than 72 hours).

If the body is unclaimed after investigation by the medical examiner investigator, it may be cremated or decently buried using funds from the county treasury or the proceeds of the sale of property found with the body. T.C.A. § 38-5-118

NON-MEDICAL EXAMINER CASES

A decedent whose death does not meet the criteria as set forth in T.C.A.§ 38-7-108 for medical examiner jurisdiction does not automatically become a medical examiner case if they remain unclaimed by next of kin or if next of kin are unable to be located. T.C.A.§ 68-4-101 provides that if a person dies in a medical facility or public institution, and the next of kin are unavailable, unknown, or fail or refuse to summon an undertaker, after eight (8) hours have elapsed since death, the medical facility or public institution may do so.

If the body remains unclaimed by the next of kin for 96 hours or more the institution is to notify the Office of the State Chief Medical Examiner. The OSCME may make a demand for the body, decline to make a demand for the body or direct the body to be embalmed. The OSCME is

responsible for reasonable compensation of the funeral home or embalmer in this circumstance.

If the OSCME fails to direct that the body be embalmed within 72 hours of notification, then the body may be cremated or buried as directed by T.C.A. § 68-4-113. The expense for burial or cremation is the responsibility of the institution where death occurred.

VETERANS

Honorably discharged veterans, who are unclaimed by next of kin or whose next of kin is unable to be located, regardless of the circumstances or jurisdiction of death, shall be interred as directed by the commissioner of veterans services, or the commissioner's representative, superseding other provisions of T.C.A. § 68-4-102 - - 68-4-109.

NATIONAL MISSING AND UNIDENTIFIED PERSONS SYSTEM (NAMUS)

The National Institute of Justice's National Missing and Unidentified Persons System (NamUS) is a national central database and resource center for missing persons, unclaimed persons, and unidentified decedents. NamUS is a free online system that can be searched by anyone including medical examiners, coroners, law enforcement and the public (NamUS.gov).

NamUS consists of three separate databases that are automatically cross matched for similar cases or matches and can be searched by anyone, including the general public. The Missing Persons database contains information that can be entered by anyone including the families of missing persons. The Unidentified Persons database contains information entered by medical examiner personnel for persons who, after the investigation, remain unidentified. The Unclaimed Persons database contains information entered by medical examiner personnel for person who are identified but next of kin is unknown or not located prior to disposition.

Medical examiner personnel who register for NamUS should register for all three (3) databases. For a decedent sent to a Regional Forensic Center for autopsy, consult with the RFC NamUS representative concerning case entry into the database. A decedent not sent for autopsy can be registered by the RFC NamUS representative or OSCME personnel.

County medical examiner personnel who wish to register for NamUS should contact Amy Dobbs NamUS Regional Systems Administrator (817-304-8873 or Amy.Dobbs@unthsc.edu).

MEDICAL EXAMINER ADVISORY COUNCIL

The Tennessee Medical Examiner Advisory Council (MEAC) was established in 2008 and meets at least annually, with additional meetings as required or requested. The MEAC has three statutory responsibilities:

1) Review candidates and make a recommendation to the Commissioner of Health on the appointment of the Chief Medical Examiner and Deputy State Medical Examiner(s)
2) Assist the Chief Medical Examiner in the development and updating of guidelines for death investigations and forensic autopsies in Tennessee, to be promulgated as rules through the Department of Health
3) Issue an annual report on death investigations in Tennessee

The full MEAC statute (T.C.A § 38-7-201) is included in Appendix A. In short, the MEAC will consist of seventeen members, including: the director of the Tennessee Bureau of Investigation, one district attorney general, one district public defender, three county medical examiners (one from each grand division), one licensed funeral director, and one forensic pathologist from each of the regional forensic centers. In addition, the State Chief Medical Examiner will be ex-officio, voting member of the council. The MEAC appointments are for three years each, with a maximum of two consecutive terms.

STATE CHIEF MEDICAL EXAMINER DUTIES AND RESPONSIBILITIES

The OSCME is based in Nashville and has full-time administrative, record keeping, and educational duties. The State Chief Medical Examiner and OSCME staff are available for consultation and guidance regarding all facets of medicolegal death investigation in Tennessee. This includes, for example, questions concerning autopsies, external examinations, ancillary studies, interpretation of toxicology results, medical record review, other investigative reports, jurisdictional issues, mortality data, assistance with mass fatality planning, and scene responses.

The primary responsibilities of the state chief medical examiner are:

- The keeping of records regarding death investigations by county medical examiners and medicolegal death investigators
- Developing and providing initial training and regular continuing education to county medical examiners and death investigators
- Investigative authority over deaths that are in the interest of the state (e.g., mass fatalities, threats to public health or safety)
- Appointing a county medical examiner if a county legislative body is unable to appoint one in the event of resignation or inability to fulfill duties

Additional duties of the OSCME include consultation with county medical examiners and the public for matters related to death investigation. Families and other agencies frequently request review of deaths and death certification, whether accepted under medical examiner jurisdiction or not. The staff of the OSCME may offer case review in consultation with the relevant county medical examiner and may re-issue death certificates in certain circumstances. Specifically, an amendment to TCA 68-3-502 established a peer review panel convened by the Office of the State Chief Medical Examiner (OSCME) for reconsideration of the suicide ruling upon family request. In addition, the chief medical examiner or the district attorney general may order an autopsy in the absence of the county medical examiner or if the county medical examiner has not ordered an autopsy (TCA 38-7-106(a)).

FORENSIC PATHOLOGISTS AND REGIONAL FORENSIC CENTERS

All medicolegal autopsies ordered by a CME or MDI must be performed in one of the five facilities accredited by the National Association of Medical Examiners (NAME) (T.C.A. § 38 -7-105(a)). The RFCs are in Memphis, Nashville, Chattanooga, Knoxville, and Johnson City. The CME may choose which RFC to utilize for autopsies and the CME should contact the desired RFC (or multiple RFCs) prior to sending decedents for autopsy. Individual counties and CMEs are not required to sign contracts for autopsies exclusive to any RFC, and the CME may choose to utilize any RFC for any particular case based on family wishes, geographic considerations, or budgetary constraints, etc.

Forensic pathologists are physicians who specialize in conducting death investigations to determine cause of death and manner of death. Forensic pathologists must have a medical degree and complete a pathology residency training program, followed by an intensive one-year specialty fellowship in forensic pathology during which forensic principles, advanced autopsy techniques, and death certification are mastered.

After completion of the autopsy the pathologist or regional forensic center may invoice the county for the service, as negotiated between the county executive office, county medical examiner, and RFC. The RFC staff shall forward, preferably in MDILog, to the OSCME the order for the autopsy, a copy of the autopsy report (with any included drawings, narratives, toxicology reports, microscopic reports, etc.) and a claim-for-fee for filing the report with the OSCME. The pathologist or regional forensic center must submit a copy of the autopsy report to the county medical examiner, the office of the state chief medical examiner and to the district attorney or make the report(s) and supportive information available in MDILog or other electronic database.

The county medical examiner must communicate directly with the pathologist (written or orally) or RFC staff to provide clinical details about the case being referred for autopsy. It is the duty of the CME to make the pathologist aware of any specific investigative questions or requests for special tests or evidence collection. Without complete information about the

circumstances of a death, it is difficult and sometimes impossible for the pathologist to provide the most informed cause and manner of death.

In cases referred to a regional forensic center for examination, it is best practice and recommended that the forensic pathologist assigned the case complete the death certificate to ensure the collection of accurate and consistent death statistics.

DISTRICT ATTORNEYS GENERAL

The District Attorney General is an elected Constitutional officer who is under an inherent duty to investigate, prosecute, and insure against all infractions of the public peace and all acts which are against the peace and dignity of the State of Tennessee. As such, and pursuant to T.C.A. § 8-7-103, each District Attorney General has a duty to prosecute in the Courts of his or her respective district all violations of the state criminal statutes, including any and all cases of criminal homicide under T.C.A. § 39-13-201, which is the unlawful killing of another person, and may be first degree murder, second degree murder, voluntary manslaughter, reckless homicide, criminally negligent homicide, aggravated assault resulting in death, or vehicular homicide.

In the performance of these prosecutorial duties and responsibilities, it is necessary in any homicide case for the District Attorney General to obtain evidence and put forth proof beyond a reasonable doubt regarding the facts, circumstances, proximate cause, and manner of death of the homicide victim. Therefore, the District Attorney General will request and expect the County Medical Examiner to order an autopsy on the body of any person and give notice to the District Attorney General in cases involving a suspected homicide, suicide, any violent, unusual, unnatural or suspicious death, an unexpected apparent natural death in an adult, sudden unexpected infant and child deaths, deaths believed to represent a threat to public health or safety, deaths of prisoners or persons in state custody, deaths on the job or related to employment, or deaths where neglect or abuse of extended care residents are suspected. T.C.A. § 38 -7-107 and T.C.A. § 38 -7-108.

The District Attorney General may order an autopsy “in the absence of the county medical examiner or the failure of the county medical examiner to act. The authority ordering the autopsy shall notify the next of kin about the impending autopsy if the next of kin is known or reasonably ascertainable. The sheriff or other law enforcement agency of the jurisdiction shall serve process containing such notice and return such process within twenty-four (24) hours.” T.C.A. § 38 -7-106

The District Attorney General may be asked to petition a judge to order a disinterment of a body falling under medical examiner jurisdiction if the person was buried before an autopsy could be performed, or if disinterment will assist in a pending criminal investigation. Such petition may be made by a state or county medical examiner or by a District Attorney General in the district in which death occurred, or in which the injury leading to death occurred, or in which the body is buried. T.C.A. § 38 -7-107(a) “Upon the presentation of the petition to the judge, the judge shall be authorized to consider the petition and in the exercise of sound judicial discretion, either make

or deny an order authorizing the disinterment and an autopsy to be performed upon the body of the deceased. The cost of disinterment and autopsy shall be paid by the state as provided in T.C.A. § 38 -1-104." T.C.A. § 38 -7-107(b)

Upon written petition by the District Attorney General supported by affidavit and/or testimony under oath from a law enforcement officer that the release of portions of a report of a county medical examiner, toxicological report or autopsy report may seriously impede or impair the investigation of a homicide or felony, a court of record may order that such portions shall not be subject to disclosure as a public document and shall remain confidential, until the indictment and arrest of any and all suspects in the underlying homicide or felony, or upon the closure of the criminal investigation of the same by law enforcement. T.C.A. § 38 -7-110(d)

A County Medical Examiner, through the appropriate District Attorney General, may obtain through judicial subpoena all medical, hospital, or other licensed facility records pertaining to a case under post-mortem investigation or examination. T.C.A. § 38 -7-117

LAW ENFORCEMENT AGENCIES

Law enforcement agents are frequently present at death scenes. Best practices for death investigations require law enforcement and medical examiner collaboration and information sharing. The CME and MDI must take care to not disturb the scene, and to follow directions of law enforcement in negotiating their scene presence. Law enforcement should bear in mind that the body and personal effects are not to be disturbed or moved without the consent of the medical examiner personnel.

FUNERAL DIRECTORS

The Board of Funeral Directors and Embalmers of the Tennessee Department of Commerce and Insurance licenses and regulates funeral directors, embalmers, and funeral establishments in Tennessee. The funeral director may be the first to receive a call about a death that has occurred, especially if prior funeral arrangements have been made. The funeral director is responsible for notification of the medical examiner of any death that meets the criteria set forth in T.C.A. § 38 -7-108 (a) if the death has not already been reported by law enforcement or medical personnel. T.C.A. § 38 -7-108 (b) states that whenever a death meets the criteria set forth by this part the body shall not be moved or embalmed without authorization by the medical examiner for the county in which death occurred.

The funeral director is responsible for obtaining information from the family, initiating the electronic death certificate in VRISM, and filing all completed death certificates and required permits (e.g., cremation permit, burial permit, and transit permit) with the registrar at the department of health of the county in which death occurred. The T.C.A. § 68 -3-502 (b) states, "The funeral director, or person acting as funeral director, who first assumes custody of the dead body shall file the death certificate. The funeral director shall obtain the personal data

from the next of kin or the best qualified person or source available, and shall obtain the medical certification from the person responsible for medical certification, as set forth in subsection (c)." The death certificate should be filed within five (5) days of the death and prior to final disposition (T.C.A. § 68 -3-502 (a) (1)). The funeral director will complete the decedent's data based on information provided by the next of kin or other informant with knowledge of the decedent's personal information.

APPENDICES

APPENDIX A - TENNESSEE STATUTES RELATED TO COUNTY MEDICAL EXAMINERS, DEATH INVESTIGATION, OSCME, ETC.

POST-MORTEM EXAMINATIONS T.C.A. § 38 -7-101 to 201

38-7-101. Short title.

This part shall be known and may be cited as the "Post-Mortem Examination Act."

HISTORY: Acts 1961, ch. 174, § 1; T.C.A., § 38-701.

38-7-102. Post-mortem examination division.

The department of health is authorized and empowered to create and maintain a post-mortem examination division or service. The division or service shall have as its functions the investigation of certain deaths as defined in this part, and the keeping of full and complete records of all reports on investigations and examinations made pursuant to this part. The commissioner of health, acting for the state and with the approval of the governor and considering the recommendation made by the Tennessee medical examiner advisory council, shall appoint a chief medical examiner to direct the division or service, and such other personnel as the commissioner may find appropriate to the enforcement of the duties and powers of this part. The commissioner is authorized and empowered to spend such funds as may be appropriated for the enforcement of this part, and to promulgate rules through the department of health to establish fees for autopsies, guidelines for death investigations and forensic autopsies, and other costs and services associated with this part.

HISTORY: Acts 1961, ch. 174, § 2; 1980, ch. 810, § 2; T.C.A., § 38-702; Acts 2008, ch. 969, § 1.

38-7-103. Chief medical examiner -- Deputies and assistants -- Duties and authority.

(a) The chief medical examiner shall be a physician with an unlimited license to practice medicine and surgery in the state of Tennessee, or who is qualified and eligible for such license, and shall be required to obtain a license within the six-month period after employment. The chief medical examiner shall be a pathologist who is certified by the American Board of Pathology and who holds a certificate of competency in forensic pathology. In addition to the chief medical examiner's other administrative duties, the chief medical examiner's educational duties shall include developing and providing initial training and regular continuing education to all county medical examiners and medical investigators. The chief medical examiner shall be appointed to a five-year term, and may serve unlimited consecutive terms.

(b) The Tennessee medical examiner advisory council shall recommend to the chief medical examiner three (3) deputy state medical examiners, one (1) from each grand division of the state. The chief medical examiner, in consultation with the advisory council and with the approval of the commissioner of health, shall appoint the three (3) deputy state medical examiners and any assistant state medical examiners needed for regional administrative, professional, and technical duties. The deputy medical examiners shall be based in one (1) of the state forensic centers. These state medical examiners shall have the same qualifications as the chief medical examiner. In addition to their other administrative, professional and technical duties, the deputy and assistant state medical examiners may lecture to medical and law school classes and conduct such special classes for county medical examiners and law enforcement officers and other investigators.

(c) The chief medical examiner shall have investigative authority for certain types of death that are in the interests of the state, including mass fatality incidents, for the identification, examination and disposition of victims' remains, and instances that represent a threat to the public health or safety, or both.

HISTORY: Acts 1961, ch. 174, § 3; T.C.A., § 38-703; Acts 1994, ch. 775, §§ 1, 2; 2008, ch. 969, §§ 2-4.

38-7-104. County medical examiner.

(a) A county medical examiner shall be appointed by the county mayor, subject to confirmation by the county legislative body, based on a recommendation from a convention of physicians resident in the county. A county medical examiner shall be a physician who is either a graduate of an accredited medical school authorized to confer upon graduates the degree of doctor of medicine (M.D.) and who is duly licensed in Tennessee, or is a graduate of a recognized osteopathic college authorized to confer the degree of doctor of osteopathy (D.O.) and who is licensed to practice osteopathic medicine in Tennessee, and shall be elected from a list of a

maximum of two (2) doctors of medicine or osteopathy nominated by convention of the physicians, medical or osteopathic, resident in the county, the convention to be called for this purpose by the county mayor.

(b) If it is not possible to obtain an acceptance as a county medical examiner from a physician in a county, authority is given for the election of a county medical examiner from an adjacent or another county. A county medical examiner, when temporarily unable to perform the duties of the office, shall have the authority to deputize any other physician in the area to act as county medical examiner during the absence. If the county legislative body fails to certify a county medical examiner for a county or if the county medical examiner resigns or is unable to fulfill the duties of the office during the interim between county legislative body sessions and a deputy has not been appointed by the county medical examiner, the chief medical examiner shall have the authority to appoint a county medical examiner to serve until the next session of the county legislative body.

(c) A county medical examiner shall serve a five-year term, and shall be eligible for reappointment by the county mayor with confirmation by the county legislative body.

(d) Whenever any county medical examiner shall be called as a witness in any proceedings before the grand jury or in any criminal case, the county medical examiner shall receive from the county as compensation for services as witness a fee as shall be determined by the court before which the proceedings are conducted, unless the fees are paid under provisions of § 38-7-111 [repealed].

(e) The county medical examiner may be suspended by the county mayor for good cause, which shall include, but not be limited to, malfeasance in the performance of the duties of a county medical examiner, criminal conduct, or behavior that is unethical in nature or that is in violation of a relevant code of professional medical responsibility. The suspension shall be for a period of ninety (90) days. At the end of the ninety (90) day period, the suspension shall terminate, unless the county mayor has recommended to the county legislative body in writing that they remove the county medical examiner from office. If the county mayor recommends removal of the county medical examiner, then the county legislative body shall vote on whether to remove the county medical examiner from office within ninety (90) days of the date of the written recommendation. A majority vote shall be required in order to remove the county medical examiner from office. If a majority of the county legislative body does not vote for removal of the county medical examiner from office, then the suspension of the county medical examiner shall terminate immediately.

(f) (1) A medical investigator shall be a licensed emergency medical technician (EMT), paramedic, registered nurse, physician's assistant or a person registered by or a diplomat of the American Board of Medicolegal Death Investigators and approved by the county medical examiner as qualified to serve as medical investigator.

(2) If the county has an elected coroner, the coroner shall serve as the medical investigator for

the county; provided, that such coroner meets the qualifications for a medical investigator set out in subdivision (f)(1). If the coroner is not qualified to serve as medical investigator, then the county legislative body shall, by resolution, either authorize the county medical examiner to appoint a medical investigator subject to confirmation by the county legislative body, or provide for this function through a contract for service approved by the county medical examiner and the county legislative body; provided, however, that, if the county has an elected coroner who has served in that capacity for ten (10) years or more, such coroner shall serve as the medical investigator for the county, regardless of whether the coroner meets the qualifications set out in subdivision (f)(1).

(3) The county medical investigator may conduct investigations when a death is reported, as provided in § 38-7-108, under the supervision of the county medical examiner. The county medical investigator may make pronouncements of death and may recommend to the county medical examiner that an autopsy be ordered. However, the county medical investigator shall not be empowered to sign a death certificate. The county medical examiner may delegate to the county medical investigator the authority to order an autopsy.

(g) County medical examiners and medical investigators shall be required to receive initial training and regular continuing education through the chief medical examiner and to operate according to the death investigation guidelines adopted by the department of health.

HISTORY: Acts 1961, ch. 174, § 4; 1967, ch. 399, § 1; 1969, ch. 21, § 1; 1971, ch. 246, § 1; 1977, ch. 141, § 1; impl. am. Acts 1978, ch. 934, §§ 7, 36; T.C.A., § 38-704; Acts 1983, ch. 12, § 1; 1994, ch. 775, § 3; 2003, ch. 90, § 2; 2004, ch. 651, §§ 1, 2; 2005, ch. 472, § 1; 2008, ch. 969, §§ 5-10.

38-7-105. Facility for performance of autopsies -- Deadline for accreditation in certain counties.

(a) All autopsies must be performed at a facility accredited by the National Association of Medical Examiners (NAME). A facility must receive accreditation from NAME within one (1) year of July 1, 2012, maintain accreditation and operate pursuant to NAME guidelines unless the facility operates in a county which qualifies for an extension under subsection (b).

(b) A facility must receive accreditation from NAME within one (1) year of July 1, 2014, maintain accreditation and operate pursuant to NAME guidelines if the facility is located in any county having a population of not less than three hundred thirty-six thousand four hundred (336,400) nor more than three hundred thirty-six thousand five hundred (336,500), according to the 2010 federal census or any subsequent federal census.

HISTORY: Acts 1961, ch. 174, § 5; 1967, ch. 399, § 2; 1968, ch. 626, § 1; impl. am. Acts 1978, ch. 934, §§ 7, 16, 36; T.C.A., § 38-705; Acts 1994, ch. 775, § 4; 1995, ch. 258, § 1; 2008, ch. 969, § 11; 2009, ch. 392, § 1; 2012, ch. 671, § 1; 2013, ch. 67, § 1.

38-7-106. When autopsies authorized -- Notice to next of kin -- Donor eyes and eye tissues.

(a) A county medical examiner may perform or order an autopsy on the body of any person in a case involving a homicide, suspected homicide, a suicide, a violent, unnatural or suspicious death, an unexpected apparent natural death in an adult, sudden unexpected infant and child deaths, deaths believed to represent a threat to public health or safety, and executed prisoners. When the county medical examiner decides to order an autopsy, the county medical examiner shall notify the district attorney general and the chief medical examiner. The chief medical examiner or the district attorney general may order an autopsy in such cases on the body of a person in the absence of the county medical examiner or if the county medical examiner has not ordered an autopsy. The district attorney general may order an autopsy in such cases on the body of a person in the absence of the county medical examiner or the failure of the county medical examiner to act. The authority ordering the autopsy shall notify the next of kin about the impending autopsy if the next of kin is known or reasonably ascertainable. The sheriff or other law enforcement agency of the jurisdiction shall serve process containing such notice and return such process within twenty-four (24) hours.

(b) Notwithstanding subsection (a), if a request is received from an authorized official of a not-for-profit corporation chartered under the laws of the state, or authorized to do business in the state and certified by the Eye Bank Association of America to obtain, store and distribute donor eyes and eye tissues to be used for corneal transplants, for research and for other medical purposes, the county medical examiner may permit, at any time, the removal of the cornea or corneal tissue from the body of a deceased person in accordance with title 68, chapter 30, part 1.

HISTORY: Acts 1961, ch. 174, § 6; T.C.A., § 38-706; Acts 1984, ch. 917, § 1; 1991, ch. 356, § 1; 1994, ch. 775, § 5; 1995, ch. 258, § 2; 2007, ch. 428, § 2; 2008, ch. 969, § 12.

38-7-107. Disinterment to perform autopsy.

(a) (1) When a person's death occurs under any of the circumstances set out in this part, any of the following persons may request the district attorney general in the district where the body is buried or interred to petition the appropriate circuit or criminal court judge in the district where a body is buried or interred to order a body disinterred:

(A) A state or county medical examiner;

(B) The district attorney general of the district in which it is claimed the death occurred;

(C) The district attorney general of the district in which an act causing the death occurred; or

(D) The district attorney general of the district in which the body is buried or interred, in the general's own discretion.

(2) The grounds for disinterment under this subsection (a) are:

(A) The person's death occurred under one (1) of the circumstances set out in this part;

(B) The person was buried or interred before an autopsy could be performed; or

(C) The disinterment will substantially assist in the collection of evidence for a pending criminal investigation, regardless of whether an autopsy was previously performed, or DNA, scientific, or forensic evidence was collected.

(3) The petition shall specify whether the district attorney general is requesting disinterment for the performance of an autopsy, to collect scientific or forensic evidence, to collect a DNA specimen from the deceased, or any combination of the three (3).

(4) The petition shall set forth the district attorney general's belief that the death in question is subject to post-mortem examination or autopsy as provided by this part and the reasons that support the district attorney general's belief as to the circumstances of the death. When known or reasonably ascertainable, a copy of the petition shall be served upon the next of kin of the deceased.

(5) The petition may be presented during a term of court or in vacation and in:

(A) The county in which it is claimed that the death occurred;

(B) The county in which the act causing the death occurred; or

(C) Any other county of a judicial district in which circumstances leading to the death were likely to have occurred.

(6) The judge hearing a petition under this subsection (a) shall have the power and authority to rule upon the petition in any county in which the judge has jurisdiction.

(b) Upon the presentation of the petition to the judge, the judge shall be authorized to consider the petition and in the exercise of sound judicial discretion, either make or deny an order authorizing the disinterment and an autopsy to be performed upon the body of the deceased. The cost of disinterment and autopsy shall be paid by the state as provided in § 38-1-104.

HISTORY: Acts 1961, ch. 174, § 6; 1965, ch. 136, § 1; 1967, ch. 399, § 3; 1973, ch. 195, § 2; T.C.A., § 38-707; Acts 1994, ch. 775, § 6; 2016, ch. 799, §1

38-7-108. Death under suspicious, unusual, or unnatural circumstances.

(a) Any physician, undertaker, law enforcement officer, or other person having knowledge of the death of any person from violence or trauma of any type, suddenly when in apparent health, sudden unexpected death of infants and children, deaths of prisoners or persons in state custody, deaths on the job or related to employment, deaths believed to represent a threat to public health, deaths where neglect or abuse of extended care residents are suspected or confirmed, deaths where the identity of the person is unknown or unclear, deaths in any suspicious/unusual/unnatural manner, found dead, or where the body is to be cremated, shall immediately notify the county medical examiner or the district attorney general, the local police or the county sheriff, who in turn shall notify the county medical examiner. The notification shall be directed to the county medical examiner in the county in which the death occurred.

(b) Whenever a death occurs under the circumstances as set forth in this part, the body shall not be removed from its position or location without authorization by the county medical examiner, except to preserve the body from loss or destruction or to maintain the flow of traffic on a highway, railroad, or airport. No body subject to post-mortem examination as provided by this part shall be embalmed without authorization by the county medical examiner.

(c) (1) If a body is subject to post-mortem examination under this part, this part shall be suspended to the extent necessary for the preservation of any body or part of the body, as defined in § 68-30-102, where an anatomical gift of the body or part of the body has been made in accordance with the Uniform Anatomical Gift Act, compiled in title 68, chapter 30, part 1.

(2) Any physician, surgeon, undertaker, law enforcement officer, hospital, hospital personnel, or other person who acts in good faith in compliance with this subsection (c) for the purposes established shall be immune from civil or criminal liability for removing, transplanting, or otherwise preserving such body or part of a body.

(3) This subsection (c) shall govern and supersede any conflicting provisions of law.

(4) The chief medical examiner of the state and the organ procurement agencies serving the state shall develop a protocol for those instances in which this subsection (c) is applicable. The protocol shall be filed with the department of health and shall be reviewed and updated as necessary.

HISTORY: Acts 1961, ch. 174, § 7; 1967, ch. 399, § 4; T.C.A., § 38-708; Acts 1983, ch. 84, § 3; 1986, ch. 712, § 1; 2006, ch. 838, § 1; 2008, ch. 969, § 13.

38-7-109. Investigation by county medical examiner.

(a) When a death is reported as provided in § 38-7-108, it is the duty of the county medical examiner in the county in which the death occurred to immediately make an investigation of the circumstances of the death. The county medical examiner shall record and store the findings, and transmit copies according to the death investigation guidelines developed by the Tennessee medical examiner advisory council. In any event the county medical examiner is authorized to remove from the body of the deceased a specimen of blood or other body fluids, or bullets or other foreign objects, and to retain such for testing and/or evidence if in the county medical examiner's judgment these procedures are justified in order to complete the county medical examiner's investigation or autopsy.

(b) When an autopsy is ordered by the district attorney general, the county medical examiner shall notify the chief medical examiner and the county medical examiner may perform the autopsy or shall designate and authorize a pathologist to perform the autopsy as provided in § 38-7-105.

HISTORY: Acts 1961, ch. 174, § 8; 1965, ch. 320, §§ 1, 2; 1967, ch. 399, § 5; T.C.A., § 38-709; Acts 1994, ch. 775, § 7; 1995, ch. 258, § 3; 2004, ch. 595, § 1; 2008, ch. 969, §§ 14-16.

38-7-110. Records received as evidence -- Person preparing report may be subpoenaed as witness -- Reports as public documents -- Release of reports.

(a) The records of the division of post mortem examination, the county medical examiner, or transcripts of the records certified to by the chief medical examiner or the deputy medical examiner or the duly appointed representative of the chief medical examiner, and the reports of the toxicology laboratory examinations performed by the testing laboratory or transcripts of the reports certified to by the director of the testing laboratory or the director's duly appointed representative, shall be received as competent evidence in any court of this state of the facts and matters contained in the records or reports.

(b) The records referred to in this section shall be limited to the records of the results of investigation, of post mortem examinations, of the findings of autopsies and toxicological laboratory examinations, including certified reports of the toxicological laboratory examinations performed by the testing laboratory, and shall not include statements made by witnesses or other persons; provided, however, that persons who prepare reports or records given in evidence pursuant to this section shall be subpoenaed as witnesses, in either civil or criminal cases, upon demand by either party to the cause, or, when unable to appear as witnesses, shall submit a deposition upon demand by either party to the cause.

(c) Subject to subsection (d), the reports of the county medical examiners, toxicological reports and autopsy reports shall be public documents. Medical records of deceased persons, law enforcement investigative reports, and photographs, video and other images of deceased

persons shall not be public records.

(d) (1) Upon written petition by the district attorney general, supported by affidavit or testimony under oath from a law enforcement officer that the release of portions of a report of a county medical examiner, toxicological report or autopsy report may seriously impede or impair the investigation of a homicide or felony, a court of record may order that those portions shall not be subject to disclosure as a public document and shall remain confidential. The court shall cause a record to be kept of any testimony given in support of the petition, which record and all related documentation shall be sealed by the court and open to inspection only by a court reviewing the proceedings.

(2) The court shall order to be held as confidential only those portions of the records the release of which would impede or impair any such investigation. The court may order public disclosure of any record that has previously been protected from disclosure, upon written application of the district attorney general; provided, that the court shall order that the records shall be open to public inspection upon the indictment and arrest of all suspects in the underlying homicide or felony, or upon the closure of the investigation into the underlying homicide or felony. Upon any such closure of the investigation, the law enforcement agency shall immediately inform the district attorney general, who shall, in turn, promptly notify the court of the altered status of the investigation.

(3) Any person aggrieved by an order directing that any portion of a report of a county medical examiner, toxicological report or autopsy report shall remain confidential and not open for public inspection may petition the court having entered the order to set aside or modify the order. A copy of any such petition shall be served on the district attorney general. The court may order disclosure of the records previously sealed, upon the showing of a compelling reason for the disclosure. In any order granting a petitioner access to any such records, the court may make provisions as it deems necessary in the order limiting further disclosure of the records.

(4) Nothing in this subsection (d) shall be construed as limiting the right of any defendant in any criminal proceeding to obtain discovery of any report of a county medical examiner, toxicological report or autopsy report as provided in Rule 16 of the Tennessee Rules of Criminal Procedure.

(e) (1) If it is necessary to prepare a post-mortem examination report, then an authorized post-mortem official may obtain, in the manner prescribed in § 38-7-117, a needed medical, mental health or hospital record pertaining to a case under investigation pursuant to § 38-7-106.

(2) As used in this subsection (e), "authorized post-mortem official" means:

(A) The chief medical examiner;

(B) A county medical examiner;

(C) A medical investigator;

(D) A coroner;

(E) A deputy or assistant state medical examiner or forensic pathologist under the control or direction of the chief medical examiner; or

(F) A deputy or assistant county medical examiner or forensic pathologist under the control or direction of a county medical examiner.

HISTORY: Acts 1961, ch. 174, § 9; 1967, ch. 399, § 6; 1971, ch. 209, § 1; 1974, ch. 495, § 1; 1980, ch. 810, § 3; T.C.A., § 38-710; Acts 1994, ch. 775, § 8; 2000, ch. 766, §§ 1-3; 2008, ch. 969, §§ 17, 18; 2014, ch. 944, § 1.

38-7-111. [Repealed.]

38-7-112. Immunity of persons performing examinations and autopsies.

A person who in good faith performs a medical examination or an autopsy under this part is immune from civil or criminal liability in performing the authorized service.

HISTORY: Acts 1961, ch. 174, § 11; T.C.A., § 38-712; Acts 1994, ch. 775, § 9.

38-7-113. Refusal or neglect to comply with § 38-7-108 -- Penalty.

Any person who neglects or refuses to comply with § 38-7-108 commits a Class E felony.

HISTORY: Acts 1961, ch. 174, § 12; T.C.A., § 38-713; Acts 1989, ch. 591, § 111; 1994, ch. 775, § 10.

38-7-114. [Repealed.]

38-7-115. [Repealed.]

38-7-116. [Repealed.]

38-7-117. Subpoena of medical and hospital records.

(a) An authorized post-mortem official acting under the control or direction of the chief medical examiner or a county medical examiner or performing an investigation pursuant to a court order or an order of a district attorney general is authorized to obtain, upon written request, or may subpoena through the appropriate district attorney general, all medical or hospital records

maintained by individuals licensed under title 63 or by facilities licensed under title 68 that pertain to a case under investigation.

(b) An authorized post-mortem official acting under the control or direction of the chief medical examiner or a county medical examiner or performing an investigation pursuant to a court order or an order of a district attorney general is authorized, through the appropriate district attorney general, to obtain, by judicial subpoena or through a court order in accordance with § 33-3-105, all records maintained by facilities licensed under title 33 that pertain to a case under investigation.

(c) As used in this section:

(1) "Authorized post-mortem official" means:

(A) The chief medical examiner;

(B) A county medical examiner;

(C) A medical investigator;

(D) A coroner;

(E) A deputy or assistant state medical examiner or forensic pathologist under the control or direction of the chief medical examiner; or

(F) A deputy or assistant county medical examiner or forensic pathologist under the control or direction of a county medical examiner; and

(2) "Case under investigation" means any time during which an authorized post-mortem official conducts an investigation into a case of death.

HISTORY: Acts 1994, ch. 775, § 15; 2014, ch. 944, § 2.

38-7-118. Delivery of remains to family following autopsy.

The body or remains of any dead human subject to an autopsy or pathology examination pursuant to this part shall be delivered to the next of kin as soon as practicable after the completion of the autopsy or pathology examination.

HISTORY: Acts 2004, ch. 643, § 1.

38-7-119. Unauthorized video or audio recordings of autopsies.

(a) (1) Except as provided in subsection (c), it is an offense for the chief medical examiner, a county medical examiner, or pathologist designated pursuant to § 38-7-105, or any agent or employee of the chief medical examiner, a county medical examiner, or pathologist, to contract with or grant authorization to an unauthorized person or an external entity to photograph, videotape, or otherwise capture visual images, or audio recordings in whatever form of a deceased human body, a human autopsy or a body immediately prior to, during or immediately following an autopsy.

(2) No person shall distribute, publish or otherwise disseminate any autopsy photographs, videotape or other visual image or any autopsy audio recording without the written consent of the next of kin or personal representative in the order established pursuant to subdivision (c)(1)(A), unless such use is consistent with subdivision (c)(1)(B), (c)(1)(C) or (c)(1)(D).

(b) Nothing in this section shall prevent the chief medical examiner, a county medical examiner, or pathologist designated pursuant to § 38-7-105, or any agent or employee of the chief medical examiner, county medical examiner, or pathologist, from carrying out training efforts or such person's statutory responsibilities.

(c) (1) A person is not considered "unauthorized" for purposes of subsection (a) if such person photographs, videotapes, or otherwise captures visual images, or audio recordings in whatever form of a deceased human body, human autopsy or a body immediately prior to, during or immediately following such an autopsy, if it is done with the express written consent or at the direction of:

(A) The next-of-kin or personal representative of the deceased in the following order of priority:

(i) Spouse;

(ii) Any adult child;

(iii) Parents;

(iv) Any sibling; or

(v) Administrator or executor, if appointed;

(B) A law enforcement agency or district attorney general, for official use only;

(C) A court order or subpoena; or

(D) An attorney representing a defendant in a criminal case where the original photographs,

images or records of the chief medical examiner, a county medical examiner, coroner or pathologist designated pursuant to § 38-7-105 are not available through discovery or are otherwise not sufficient for the defense of such defendant.

(2) In determining whether the next-of-kin of the deceased is authorized to give consent, the chief medical examiner, county medical examiner, or pathologist designated pursuant to § 38-7-105 shall refer to the priority order in subdivision (c)(1)(A). If a next-of-kin higher on the priority lists consents, the lack of consent of any next-of-kin lower on the list is irrelevant. If a next-of-kin higher on the priority list refuses to give consent, consent by a next-of-kin lower on the list is also irrelevant.

(d) A chief medical examiner, a county medical examiner, or pathologist designated pursuant to § 38-7-105, or any agent or employee of a chief medical examiner, a county medical examiner, or pathologist, shall incur no criminal or civil liability for permitting a person to photograph, videotape, or otherwise capture visual images, or audio recordings in whatever form of a deceased human body or a human autopsy or a body immediately prior to, during or immediately following an autopsy as a result of the consent to such conduct given by the next-of-kin, if such official is presented with the written consent of a next-of-kin of the deceased who is higher on the priority list set out in subdivision (c)(1)(A) than any next-of-kin who does not consent.

(e) To the extent that the chief medical examiner, a county medical examiner, or pathologist designated pursuant to § 38-7-105, or any agent or employee of the chief medical examiner, county medical examiner, or pathologist, is a covered entity under the privacy regulations promulgated pursuant to the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), nothing in this section shall be construed to preempt any provisions of those regulations that provide greater protection of the deceased's privacy than does this section.

(f) (1) A violation of subdivision (a)(1) is a Class A misdemeanor punishable by fine only.

(2) A violation of subdivision (a)(1) is a Class A misdemeanor punishable by fine or imprisonment if the chief medical examiner, a county medical examiner, coroner or pathologist, or an agent or employee of the chief medical examiner, a county medical examiner, coroner or pathologist, receives compensation or other thing of value as an inducement to violate this section.

(3) A violation of subdivision (a)(2) is a Class A misdemeanor.

HISTORY: Acts 2005, ch. 216, § 1; 2009, ch. 276, §§ 1, 2.

38-7-201. Tennessee medical examiner advisory council -- Creation -- Members.

(a)

(1) There is created the Tennessee medical examiner advisory council, referred to in this section as the "council."

(2)

(A) The council shall consist of seventeen (17) members, each of whom shall be a resident of this state. The membership of the council consists of:

(i) Three (3) permanent ex officio voting members, consisting of:

(a) The director of the Tennessee bureau of investigation, or the director's designee;

(b) The speaker of the senate, or the speaker's designee; and

(c) The speaker of the house of representatives, or the speaker's designee;

(ii) The following members appointed by the governor:

(a) One (1) forensic pathologist from each of the five (5) regional forensic centers;

(b) One (1) district attorney general;

(c) One (1) district public defender;

(d) Three (3) county medical examiners, one (1) from each grand division of Tennessee;

(e) One (1) administrator from a non-hospital affiliated regional forensic center;

(f) One (1) licensed funeral director; and

(g) One (1) county mayor; and

(iii) The state chief medical examiner who shall serve as an ex officio voting member of the council.

(B) All regular appointments to the council shall be for terms of three (3) years with a maximum of two (2) consecutive terms. Each member shall serve until a successor is appointed. Vacancies shall be filled by appointment of the governor for the remainder of an unexpired term.

(b) Each member of the council shall receive reimbursement for travel expenses in accordance with the comprehensive travel regulations promulgated by the department of finance and administration and approved by the attorney general and reporter.

(c) If an appointed administrator of the council is absent from more than half of the meetings scheduled in any calendar year without good cause, then a vacancy is created. The vacancy shall be filled by the governor.

(d) The council shall organize annually and shall meet to organize at the call of the prior year's chair. The council shall select the chair of the council. Meetings shall be held at least quarterly with additional meetings as frequently as may be required.

(e) Meetings of the council shall permit members to electronically participate in the meetings.

(f) The council shall have the power and duty to:

(1) Review candidates and make a recommendation to the commissioner of health on the appointment of the chief medical examiner and deputy state medical examiners;

(2) Assist the chief medical examiner in the development and updating of guidelines for death investigations and forensic autopsies in this state, to be promulgated as rules through the department of health;

(3) Submit an annual report on the standards and guidelines of the medical examiners system to the chairs of the health committee of the house of representatives and the health and welfare committee of the senate;

(4) Periodically review standards and guidelines promulgated by the department of health for the medical examiner system; and

(5) Provide reports and recommendations to the commissioner on causes of death which may need public health intervention, funding issues, information technology needs, and any other issues as the council sees fit.

HISTORY: Acts 2008, ch. 969, § 23; 2017, ch. 444, § 3; 2018, ch. 571, § 1; 2019, ch. 353, §§ 1, 2.

ANATOMICAL GIFTS T.C.A. § 68 -30-101 to 402

68-30-101. Short title.

This part shall be known and may be cited as the "Revised Uniform Anatomical Gift Act."

HISTORY: Acts 2007, ch. 428, § 1.

68-30-102. Part definitions.

As used in this part, unless the context otherwise requires:

(1) "Adult" means an individual who is at least eighteen (18) years of age;

(2) "Agent" means an individual:

(A) Authorized to make healthcare decisions on the principal's behalf by a power of attorney for healthcare or an advance directive; or

(B) Expressly authorized to make an anatomical gift on the principal's behalf by any other record signed by the principal;

(3) "Anatomical gift" means a donation of all or part of a human body to take effect after the donor's death for the purpose of transplantation, therapy, research, or education;

(4) "Decedent" means a deceased individual whose body or part, if specified, is or may be the source of an anatomical gift. "Decedent" includes a stillborn infant and, subject to restrictions imposed by law other than this part, a fetus;

(5) "Disinterested witness" means a witness other than the spouse, child, parent, sibling, grandchild, grandparent, or guardian of the individual who makes, amends, revokes, or refuses to make an anatomical gift. "Disinterested witness" does not include a person to which an anatomical gift could pass under § 68-30-110;

(6) "Document of gift" means a donor card or other record used to make an anatomical gift. "Document of gift" includes a statement or symbol on a driver license, identification card, or donor registry;

(7) "Donor" means an individual whose body or part is the subject of an anatomical gift;

(8) "Donor registry" means a database that contains records of anatomical gifts;

(9) "Driver license" means a license or permit issued by the department of safety to operate a vehicle, whether or not conditions are attached to the license or permit;

(10) "Eye bank" means a person that is licensed, accredited, or regulated under federal or state law to engage in the recovery, screening, testing, processing, storage, or distribution of human eyes or portions of human eyes;

(11) "Guardian" means a person appointed by a court to make decisions regarding the support, care, education, health, or welfare of an individual. "Guardian" does not include a guardian ad litem;

(12) "Hospital" means a facility licensed as a hospital under the law of any state or a facility operated as a hospital by the United States, a state, or a subdivision of a state;

(13) "Know" means to have actual knowledge;

(14) "Minor" means an individual who is under eighteen (18) years of age;

(15) "Organ procurement organization" means a person designated by the secretary of the United States department of health and human services as an organ procurement organization;

(16) "Parent" means a parent whose parental rights have not been terminated;

(17) "Part" means an organ, an eye, or tissue of a human being. "Part" does not include the whole body;

(18) "Person" means an individual, corporation, business trust, estate, trust, partnership, limited liability company, association, joint venture, public corporation, government or governmental subdivision, agency, or instrumentality, or any other legal or commercial entity;

(19) "Physician" means an individual authorized to practice medicine or osteopathy under the law of any state;

(20) "Procurement organization" means an eye bank, organ procurement organization, or tissue bank;

(21) "Prospective donor" means an individual who is dead or near death and has been determined by a procurement organization to have a part that could be medically suitable for transplantation, therapy, research, or education. "Prospective donor" does not include an individual who has made a refusal;

(22) "Reasonably available" means able to be contacted by a procurement organization without undue effort and willing and able to act in a timely manner consistent with existing medical criteria necessary for the making of an anatomical gift;

(23) "Recipient" means an individual into whose body a decedent's part has been or is intended to be transplanted;

(24) "Record" means information that is inscribed on a tangible medium or that is stored in an electronic or other medium and is retrievable in perceivable form;

(25) "Refusal" means a record under § 68-30-107 that expressly states an intent to bar other persons from making an anatomical gift of an individual's body or part;

(26) "Sign" means, with the present intent to authenticate or adopt a record:

(A) To execute or adopt a tangible symbol; or

(B) To attach to or logically associate with the record an electronic symbol, sound, or process;

(27) "State" means a state of the United States, the District of Columbia, Puerto Rico, the United States Virgin Islands, or any territory or insular possession subject to the jurisdiction of the United States;

(28) "Technician" means an individual determined to be qualified to remove or process parts by an appropriate organization that is licensed, accredited, or regulated under federal or state law. "Technician" includes an enucleator;

(29) "Tissue" means a portion of the human body other than an organ or an eye. "Tissue" does not include blood, unless the blood is donated for the purpose of research or education;

(30) "Tissue bank" means a person that is licensed, accredited, or regulated under federal or state law to engage in the recovery, screening, testing, processing, storage, or distribution of tissue; and

(31) "Transplant hospital" means a hospital that furnishes organ transplants and other medical and surgical specialty services required for the care of transplant patients.

HISTORY: Acts 2007, ch. 428, § 1.

68-30-103. Applicability.

This part applies to an anatomical gift or amendment to, revocation of, or refusal to make an anatomical gift, whenever made.

HISTORY: Acts 2007, ch. 428, § 1.

68-30-104. Who may make anatomical gift before donor's death.

An anatomical gift of a donor's body or part may be made during the life of the donor for the purpose of transplantation, therapy, research, or education in the manner provided in § 68-30-105 by:

(1) The donor, if the donor is an adult or if the donor is a minor and is:

(A) Emancipated; or

(B) Authorized under state law to apply for a driver license because the donor is at least fifteen (15) years of age;

(2) An agent of the donor, unless the power of attorney for healthcare, advance directive or other record prohibits the agent from making an anatomical gift;

(3) A parent of the donor, if the donor is an unemancipated minor; or

(4) The donor's guardian.

HISTORY: Acts 2007, ch. 428, § 1.

68-30-105. Manner of making anatomical gift before donor's death.

(a) A donor may make an anatomical gift:

(1) By authorizing a statement or symbol indicating that the donor has made an anatomical gift to be imprinted on the donor's driver license;

(2) In a will, any living will, durable power of attorney for healthcare or other instrument, signed by the individual complying with living wills under title 32, chapter 11 with durable powers of attorney for health care under title 34, chapter 6, part 2, or advance directives under chapter 11, part 18 of this title;

(3) During a terminal illness or injury of the donor, by any form of communication addressed to at least two (2) adults, at least one (1) of whom is a disinterested witness; or

(4) As provided in subsection (b).

(b) A donor or other person authorized to make an anatomical gift under § 68-30-104 may make a gift by a donor card or other record signed by the donor or other person making the

gift, or by authorizing that a statement or symbol indicating that the donor has made an anatomical gift be included on a donor registry. If the donor or other person is physically unable to sign a record, the record may be signed by another individual at the direction of the donor or other person and shall:

(1) Be witnessed by at least two (2) adults, at least one (1) of whom is a disinterested witness, who have signed at the request of the donor or the other person; and

(2) State that it has been signed and witnessed as provided in subdivision (b)(1).

(c) Revocation, suspension, expiration, or cancellation of a driver license or identification card upon which an anatomical gift is indicated does not invalidate the gift.

(d) An anatomical gift made by will takes effect upon the donor's death whether or not the will is probated. Invalidation of the will after the donor's death does not invalidate the gift.

HISTORY: Acts 2007, ch. 428, § 1.

68-30-106. Amendment or revocation of anatomical gift before donor's death.

(a) A donor may amend or revoke an anatomical gift, not made by will, by:

(1) A signed statement;

(2) An oral statement made in the presence of two (2) individuals;

(3) Any form of communication by a terminal patient addressed to a physician; or

(4) The delivery of a signed statement to a specified donee to whom a document of gift had been delivered.

(b) A donor who makes an anatomical gift in a will may amend or revoke the gift in the manner provided for amendment or revocation of wills or as provided in subsection (a).

HISTORY: Acts 2007, ch. 428, § 1.

68-30-107. Refusal to make anatomical gift -- Effect of refusal.

An individual may refuse to make an anatomical gift of the individual's body or part by a writing

signed in the same manner as a document of gift or any other writing used to identify the individual as refusing to make an anatomical gift. A terminal patient may refuse to make an anatomical gift by oral statement or other form of communication.

HISTORY: Acts 2007, ch. 428, § 1.

68-30-108. Preclusive effect of anatomical gift, amendment, or revocation.

(a) Except as otherwise provided in this part, in the absence of an express, contrary indication by the donor, a person other than the donor is barred from making, amending, or revoking an anatomical gift of a donor's body. An anatomical gift that is not revoked by the donor before death is irrevocable and does not require the consent or concurrence of any person after the donor's death.

(b) A donor's revocation of an anatomical gift of the donor's body or part under § 68-30-105 is not a refusal and does not bar another person specified in § 68-30-104 or § 68-30-109 from making an anatomical gift of the donor's body or part.

(c) If a person other than the donor makes an unrevoked anatomical gift of the donor's body or part, another person may not make, amend, or revoke the gift of the donor's body or part under § 68-30-109.

(d) A revocation of an anatomical gift of a donor's body or part by a person other than the donor does not bar another person from making an anatomical gift of the body or part under § 68-30-104 or § 68-30-109.

(e) In the absence of an express, contrary indication by the donor or other person authorized to make an anatomical gift under § 68-30-104, an anatomical gift of a part is neither a refusal to give another part nor a limitation on the making of an anatomical gift of another part at a later time by the donor or another person.

(f) If a donor who is an unemancipated minor dies, a parent of the donor who is reasonably available may revoke or amend an anatomical gift of the donor's body or part.

(g) If an unemancipated minor who signed a refusal dies, a parent of the minor who is reasonably available may revoke the minor's refusal.

HISTORY: Acts 2007, ch. 428, § 1.

(a) Subject to subsections (b) and (c), an anatomical gift of a decedent's body or part for purpose of transplantation, therapy, research, or education may be made by any member of the following classes of persons who is reasonably available, in the order of priority listed:

(1) A guardian or conservator of the person of the decedent at the time of death, if the court order authorizes the guardian or conservator to make healthcare decisions;

(2) An agent;

(3) The spouse of the decedent;

(4) Adult children of the decedent;

(5) Parents of the decedent;

(6) Adult siblings of the decedent;

(7) Adult grandchildren of the decedent;

(8) Grandparents of the decedent;

(9) A surrogate identified pursuant to § 68-11-1806;

(10) An adult who exhibited special care and concern for the decedent; and

(11) Any other person having the authority to dispose of the decedent's body.

(b) If there is more than one (1) member of a class listed in subdivisions (a)(4), (a)(5), (a)(6), (a)(7) or (a)(8) entitled to make an anatomical gift, an anatomical gift may be made by a member of the class, unless that member or a person to which the gift may pass under § 68-30-111 knows of an objection by another member of the class. If an objection is known, the gift may be made only by a majority of the members of the class who are reasonably available.

(c) A person may not make an anatomical gift if, at the time of the decedent's death, a person in a prior class under subsection (a) is reasonably available to make or to object to the making of an anatomical gift.

HISTORY: Acts 2007, ch. 428, § 1.

68-30-110. Manner of making, amending, or revoking anatomical gift of decedent's body or part.

(a) A person authorized to make an anatomical gift under § 68-30-109 may make an anatomical gift by a document of gift signed by the person making the gift or by that person's oral communication that is electronically recorded or is contemporaneously reduced to a record and signed by the individual receiving the oral communication.

(b) Subject to subsection (c), an anatomical gift by a person authorized under § 68-30-109 may be amended or revoked orally or in a record by any member of a prior class who is reasonably available. If more than one (1) member of the prior class is reasonably available, the gift made by a person authorized under § 68-30-109 may be:

(1) Amended only if a majority of the reasonably available members agree to the amending of the gift; or

(2) Revoked only if a majority of the reasonably available members agree to the revoking of the gift or if they are equally divided as to whether to revoke the gift.

(c) A revocation under subsection (b) is effective only if, before an incision has been made to remove a part from the donor's body or before invasive procedures have begun to prepare the recipient, the procurement organization, transplant hospital, or physician or technician knows of the revocation.

HISTORY: Acts 2007, ch. 428, § 1.

68-30-111. Persons that may receive anatomical gift -- Purpose of anatomical gift.

(a) An anatomical gift may be made to the following persons named in the document of gift:

(1) A hospital accredited medical school, dental school, college, or university, organ procurement organization, or other appropriate person for research or education;

(2) Subject to subsection (b), an individual designated by the person making the anatomical gift, if the individual is the recipient of the part; or

(3) An eye bank or tissue bank.

(b) If an anatomical gift to an individual under subdivision (a)(2) cannot be transplanted into the individual, the part passes in accordance with subsection (g) in the absence of an express, contrary indication by the person making the anatomical gift.

(c) If an anatomical gift of one (1) or more specific parts or of all parts is made in a document of gift that does not name a person described in subsection (a) but identifies the purpose for which an anatomical gift may be used, the following rules apply:

(1) If the part is an eye and the gift is for the purpose of transplantation or therapy, the gift passes to the appropriate eye bank;

(2) If the part is tissue and the gift is for the purpose of transplantation or therapy, the gift passes to the appropriate tissue bank;

(3) If the part is an organ and the gift is for the purpose of transplantation or therapy, the gift passes to the appropriate organ procurement organization as custodian of the organ; and

(4) If the part is an organ, an eye, or tissue and the gift is for the purpose of research or education, the gift passes to the appropriate procurement organization.

(d) For the purpose of subsection (c), if there is more than one (1) purpose of an anatomical gift set forth in the document of gift but the purposes are not set forth in any priority, the gift shall be used for transplantation or therapy, if suitable. If the gift cannot be used for transplantation or therapy, the gift may be used for research or education.

(e) If an anatomical gift of one (1) or more specific parts is made in a document of gift that does not name a person described in subsection (a) and does not identify the purpose of the gift, the gift may be used only for transplantation or therapy, and the gift passes in accordance with subsection (g).

(f) If a document of gift specifies only a general intent to make an anatomical gift by words such as "donor", "organ donor", or "body donor", or by a symbol or statement of similar import, the gift may be used only for transplantation or therapy, and the gift passes in accordance with subsection (g).

(g) For purposes of subsections (b), (e), and (f), the following rules apply:

(1) If the part is an eye, the gift passes to the appropriate eye bank;

(2) If the part is tissue, the gift passes to the appropriate tissue bank; and

(3) If the part is an organ, the gift passes to the appropriate organ procurement organization as custodian of the organ.

(h) An anatomical gift of an organ for transplantation or therapy, other than an anatomical gift under subdivision (a)(2), passes to the organ procurement organization as custodian of the organ.

(i) If an anatomical gift does not pass pursuant to subsections (a)-(h) or the decedent's body or part is not used for transplantation, therapy, research, or education, custody of the body or part passes to the person under obligation to dispose of the body or part.

(j) A person may not accept an anatomical gift if the person knows that the gift was not effectively made under § 68-30-105 or § 68-30-110 or if the person knows that the decedent made a refusal under § 68-30-107 that was not revoked. For purposes of this subsection (j), if a person knows that an anatomical gift was made on a document of gift, the person is deemed to know of any amendment or revocation of the gift or any refusal to make an anatomical gift on the same document of gift.

(k) Except as otherwise provided in subdivision (a)(2), nothing in this part affects the allocation of organs for transplantation or therapy.

HISTORY: Acts 2007, ch. 428, § 1.

68-30-112. Search and notification.

(a) The following persons shall make a reasonable search of an individual who the person reasonably believes is dead or near death for a document of gift or other information identifying the individual as a donor or as an individual who made a refusal:

(1) A law enforcement officer, firefighter, paramedic, or other emergency rescuer finding the individual; and

(2) If no other source of the information is immediately available, a hospital, as soon as practical after the individual's arrival at the hospital.

(b) If a document of gift or a refusal to make an anatomical gift is located by the search

required by subdivision (a)(1) and the individual or deceased individual to whom it relates is taken to a hospital, the person responsible for conducting the search shall send the document of gift or refusal to the hospital.

(c) A person is not subject to criminal or civil liability for failing to discharge the duties imposed by this section, but may be subject to administrative sanctions.

HISTORY: Acts 2007, ch. 428, § 1.

68-30-113. Delivery of document of gift not required -- Right to examine.

(a) A document of gift need not be delivered during the donor's lifetime to be effective.

(b) Upon or after an individual's death, a person in possession of a document of gift or a refusal to make an anatomical gift with respect to the individual shall allow examination and copying of the document of gift or refusal by a person authorized to make or object to the making of an anatomical gift with respect to the individual or by a person to which the gift could pass under § 68-30-111.

HISTORY: Acts 2007, ch. 428, § 1.

68-30-114. Rights and duties of procurement organization and others.

(a) When a hospital refers an individual at or near death to a procurement organization, the organization shall make a reasonable search of the records of the department of safety and any donor registry that it knows exists for the geographical area in which the individual resides to ascertain whether the individual has made an anatomical gift.

(b) A procurement organization shall be allowed reasonable access to information in the records of the department of safety to ascertain whether an individual at or near death is a donor.

(c) When a hospital refers an individual at or near death to a procurement organization, the organization may conduct any reasonable examination necessary to ensure the medical suitability of a part that is or could be the subject of an anatomical gift for transplantation, therapy, research, or education from a donor or a prospective donor. During the examination period, measures necessary to ensure the medical suitability of the part may not be withdrawn unless the hospital or procurement organization knows that the individual expressed a contrary intent.

(d) Unless prohibited by law other than this part, at any time after a donor's death, the person to which a part passes under § 68-30-111 may conduct any reasonable examination necessary to ensure the medical suitability of the body or part for its intended purpose.

(e) Unless prohibited by law other than this part, an examination under subsection (c) or (d) may include an examination of all medical and dental records of the donor or prospective donor.

(f) Upon the death of a minor who was a donor or had signed a refusal, unless a procurement organization knows the minor is emancipated, the procurement organization shall conduct a reasonable search for the parents of the minor and provide the parents with an opportunity to revoke or amend the anatomical gift or revoke the refusal.

(g) Upon referral by a hospital under subsection (a), a procurement organization shall make a reasonable search for any person listed in § 68-30-109 having priority to make an anatomical gift on behalf of a prospective donor. If a procurement organization receives information that an anatomical gift to any other person was made, amended, or revoked, it shall promptly advise the other person of all relevant information.

(h) Subject to § 68-30-111(i), the rights of the person to which a part passes under § 68-30-111 are superior to the rights of all others with respect to the part. The person may accept or reject an anatomical gift in whole or in part.

(i) Neither the physician who attends the decedent at death nor the physician who determines the time of the decedent's death may participate in the procedures for removing or transplanting a part from the decedent.

(j) A physician or technician may remove a donated part from the body of a donor that the physician or technician is qualified to remove.

(k) Neither the person making an anatomical gift nor the donor's estate is liable for any injury or damage that results from the making or use of the gift.

(*l*) In determining whether an anatomical gift has been made, amended, or revoked under this part, a person may rely upon representations of an individual listed in § 68-30-109(a)(3), (a)(4), (a)(5), (a)(6), (a)(7), or (a)(8) relating to the individual's relationship to the donor or prospective donor, unless the person knows that the representation is untrue.

HISTORY: Acts 2007, ch. 428, § 1.

68-30-115. Immunity.

A person who acts in accordance with this part or with the applicable anatomical gift law of another state, or attempts in good faith to do so, is not liable for the act in a civil action, criminal prosecution, or administrative proceeding.

HISTORY: Acts 2007, ch. 428, § 1.

68-30-116. Law governing validity -- Choice of law as to execution of document of gift -- Presumption of validity.

(a) A document of gift is valid if executed in accordance with:

(1) This part;

(2) The laws of the state or country where it was executed; or

(3) The laws of the state or country where the person making the anatomical gift was domiciled, has a place of residence, or was a national at the time the document of gift was executed.

(b) If a document of gift is valid under this section, the law of this state governs the interpretation of the document of gift.

(c) A person may presume that a document of gift or amendment of an anatomical gift is valid unless that person knows that it was not validly executed or was revoked.

HISTORY: Acts 2007, ch. 428, § 1.

68-30-117. Effect of anatomical gift on advance healthcare directive.

(a) As used in this section, unless the context otherwise requires:

(1) "Advanced healthcare directive" means a power of attorney for healthcare or a record signed or authorized by a prospective donor containing the prospective donor's direction concerning a healthcare decision for the prospective donor;

(2) "Declaration" means a record signed by a prospective donor specifying the circumstances under which a life support system may be withheld or withdrawn from the prospective donor; and

(3) "Healthcare decision" means any decision regarding the healthcare of the prospective donor.

(b) If a prospective donor has a declaration or advance healthcare directive and the terms of the declaration or directive and the express or implied terms of a potential anatomical gift are in conflict with regard to the administration of measures necessary to ensure the medical suitability of a part for transplantation or therapy, the prospective donor's attending physician and prospective donor shall confer to resolve the conflict. If the prospective donor is incapable of resolving the conflict, an agent acting under the prospective donor's declaration or directive, or, if the agent is not reasonably available, another person authorized by law other than this part to make healthcare decisions on behalf of the prospective donor, shall act for the donor to resolve the conflict. The conflict shall be resolved as expeditiously as possible. Information relevant to the resolution of the conflict may be obtained from the appropriate procurement organization and any other person authorized to make an anatomical gift for the prospective donor under § 68-30-109. Before resolution of the conflict, measures necessary to ensure the medical suitability of the part may not be withheld or withdrawn from the prospective donor if withholding or withdrawing the measures is not contraindicated by appropriate end-of-life care.

HISTORY: Acts 2007, ch. 428, § 1.

68-30-118. Uniformity of application and construction.

In applying and construing this part, consideration shall be given to the need to promote uniformity of the law with respect to its subject matter among states that enact it.

HISTORY: Acts 2007, ch. 428, § 1.

68-30-119. Relation to Electronic Signatures in Global and National Commerce Act.

An electronic signature shall be valid as if written. This part modifies, limits, and supersedes the Electronic Signatures in Global and National Commerce Act, compiled in 15 U.S.C. § 7001 et

seq., but does not modify, limit or supersede § 101(a) of the Electronic Signatures in Global and National Commerce Act, codified in 15 U.S.C. § 7001, or authorize electronic delivery of any of the notices described in § 103(b) of the Electronic Signatures in Global and National Commerce Act, codified in 15 U.S.C. § 7003(b).

HISTORY: Acts 2007, ch. 428, § 1.

68-30-120. Gift of entire body to medical school.

Nothing contained in this part shall be construed to supersede or revoke, by implication or otherwise, any valid gift of the entire body to a medical school.

HISTORY: Acts 2007, ch. 428, § 1.

68-30-201 -- 68-30-205. [Repealed.]

68-30-301. Authorization -- Conditions.

In the case of an autopsy performed by or under the authority of the chief medical examiner, county medical examiner or coroner having jurisdiction over the decedent's body, the medical examiner or coroner's physician may, for the purpose of medical research, education or therapy, remove and retain the pituitary gland at the time of autopsy in accordance with the following conditions:

(1) The removal is performed in conjunction with an autopsy under such official's jurisdiction;

(2) The removal will not impede or interfere with the investigation that gave rise to the autopsy, and will not significantly alter post mortem appearance; and

(3) (A) No objection to the removal of the pituitary gland was evidenced by the decedent prior to the decedent's death, nor was there objection on the part of the decedent's next of kin known to the official having jurisdiction over the autopsy.

(B) As used in this part, "next of kin" includes, in order, the decedent's spouse; or if no competent spouse, the decedent's adult children; or if no competent spouse or adult children, the decedent's parents; or if no competent spouse, adult children, or parents, the decedent's brothers and sisters.

(C) The decedent's next of kin shall be contacted by telephone or otherwise, and unless

there is a specific objection from such kin, a telephone confirmation shall be consent within the requirements of this part.

HISTORY: Acts 1980, ch. 517, § 1; T.C.A., § 53-42-301.

68-30-302. Immunity from liability.

The chief medical examiner, county medical examiner, judge, or coroner permitting such pituitary gland removal, and any donee or agency acquiring such organ, shall be immune from civil or criminal liability incurred as a result of the removal in accordance with this part, if no objection was made by next of kin prior to the autopsy to the official having jurisdiction over the autopsy.

HISTORY: Acts 1980, ch. 517, § 1; T.C.A., § 53-42-302.

68-30-303. Persons excluded.

Persons professing a belief in or practicing the tenets of Christian Science shall be excluded from this part.

HISTORY: Acts 1980, ch. 517, § 1; T.C.A., § 53-42-303.

68-30-401. Restrictions on procuring human organs for consideration and for human transplantation purposes.

(a) It is unlawful for any person to acquire, receive or otherwise transfer any human organ for valuable consideration and for use in human transplantation if the transfer affects commerce.

(b) Any person, firm, board, corporation or association who violates subsection (a) commits a Class A misdemeanor.

HISTORY: Acts 1986, ch. 885, § 3; Acts 1989, ch. 591, §§ 1, 6.

68-30-402. Costs for evaluation and removal of donated organs and tissues.

Any costs incurred at the request of an organ procurement agency or eye bank related to the evaluation of a potential organ and tissue donor, maintenance of organ or tissue viability following a death declaration, and removal of donated organs and tissues will be paid in full by the receiving organ procurement agency or eye bank. The next of kin of the organ and tissue donor will not be responsible for these expenses.

HISTORY: Acts 1986, ch. 885, § 3.

ARCHAEOLOGY T.C.A. § 11-6-107

11-6-107. Discovery of sites, artifacts, or human remains -- Notice to division, contractors, and authorities.

(a) All state agencies, departments, institutions and commissions, as well as all counties and municipalities, shall cooperate fully with the division of archaeology.

(b) Where any sites or artifacts may be found or discovered on property owned or controlled by the state or by any county or municipality, the agency, bureau, commission, governmental subdivision, or county or municipality having control over or owning such property and which is preparing to initiate construction or other earth-moving activities upon such property, or is currently performing work of this type upon such property, the public body having custody of the land shall comply with subsection (d) and is directed to urge supervisors of such works to notify the division of the discovery and location of such sites or artifacts immediately, and to cooperate to the fullest extent practicable with the division, either to prevent the destruction of such sites and artifacts or to allow the division to obtain maximum information and artifacts before these locations are disturbed or destroyed.

(c) It is the responsibility of the state agencies to have the provisions of this chapter made known to contractors who are to perform work upon any such public lands, and contractors shall be required to comply with this chapter.

(d) (1) Any person who encounters or accidentally disturbs or disinters human remains on either publicly or privately owned land, except during excavations authorized under this chapter, shall:

(A) Immediately cease disturbing the ground in the area of the human remains; and

(B) Notify either the coroner or the medical examiner, and a local law enforcement agency.

(2) Either the coroner or the medical examiner shall, within five (5) working days, determine whether the site merits further investigation within the scope of such official's duties.

(3) If the coroner or the medical examiner, and law enforcement personnel, have no forensic or criminal concerns with regard to the site, then the coroner or the medical examiner shall notify the department.

(4) Human remains and burial objects reported to the division shall be treated as provided in §§ 11-6-104 and 11-6-119, and/or title 46, chapter 4, if applicable.

(5) A person who violates subdivision (d)(1)(A) or (d)(1)(B) commits a Class A misdemeanor;

(6) This section does not apply to:

(A) Normal farming activity, including, but not limited to, plowing, disking, harvesting and grazing; provided, that if human remains are discovered or disturbed, a report should be made to the officials specified in subdivision (d)(1)(B); or

(B) Surface collecting.

(7) Nothing in this chapter shall be construed to grant a right of access or occupation to the public without the landowner's permission.

(e) All archaeological site clearance work carried out pursuant to this section shall, in as far as practicable, be scheduled so as not to interfere with construction activities, and such clearance work shall only be conducted at sites which have the potential to yield information significant to the scientific study of Tennessee's aboriginal and historic past.

HISTORY: Acts 1970, ch. 468, § 7; T.C.A., § 11-1507; Acts 1990, ch. 852, §§ 8, 9.

CHILD SEXUAL ABUSE T.C.A. § 37-1-605

37-1-605. Reports of known or suspected child sexual abuse -- Investigations -- Notification to parents of abuse on school grounds or while under school supervision -- Confidentiality of records.

(a) Any person including, but not limited to, any:

(1) Physician, osteopathic physician, medical examiner, chiropractor, nurse or hospital personnel engaged in the admission, examination, care or treatment of persons;

(2) Health or mental health professional other than one listed in subdivision (1);

(3) Practitioner who relies solely on spiritual means for healing;

(4) School teacher or other school official or personnel;

(5) Judge of any court of the state;

(6) Social worker, day care center worker, or other professional child care, foster care, residential or institutional worker;

(7) Law enforcement officer;

(8) Authority figure at a community facility, including any facility used for recreation or social assemblies, for educational, religious, social, health, or welfare purposes, including, but not limited to, facilities operated by schools, the boy or girl scouts, the YMCA or YWCA, the boys and girls club, or church or religious organizations; or

(9) Neighbor, relative, friend or any other person;

who knows or has reasonable cause to suspect that a child has been sexually abused shall report such knowledge or suspicion to the department in the manner prescribed in subsection (b).

(b) (1) Each report of known or suspected child sexual abuse pursuant to this section shall be made immediately to the local office of the department responsible for the investigation of reports made pursuant to this section or to the judge having juvenile jurisdiction or to the office of the sheriff or the chief law enforcement official of the municipality where the child resides. Each report of known or suspected child sexual abuse occurring in a facility licensed by the department of mental health and substance abuse services, as defined in § 33-2-403, or any hospital, shall also be made to the local law enforcement agency in the jurisdiction where such offense occurred. In addition to those procedures provided by this part, § 37-1-405 shall also apply to all cases reported hereunder.

(2) If a law enforcement official or judge becomes aware of known or suspected child sexual abuse, through personal knowledge, receipt of a report or otherwise, such information shall be reported to the department immediately and the child protective team shall be notified to investigate the report for the protection of the child in accordance with this part. Further criminal investigation by such official shall be appropriately conducted.

(3) Reports involving known or suspected institutional child sexual abuse shall be made and received in the same manner as all other reports made pursuant to this section.

(c) Any person required to report or investigate cases of suspected child sexual abuse who has reasonable cause to suspect that a child died as a result of child sexual abuse shall report such suspicion to the appropriate medical examiner. The medical examiner shall accept the report for investigation and shall report the medical examiner's findings, in writing, to the local law enforcement agency, the appropriate district attorney general, and the department. Autopsy reports maintained by the medical examiner shall not be subject to the confidentiality requirements provided for in § 37-1-612.

(d) (1) Notwithstanding § 37-5-107 or § 37-1-612 or any other law to the contrary, if a school teacher, school official or any other school personnel has knowledge or reasonable cause to suspect that a child who attends such school may be a victim of child abuse or child sexual abuse sufficient to require reporting pursuant to this section and that the abuse occurred on school grounds or while the child was under the supervision or care of the school, then the principal or other person designated by the school shall verbally notify the parent or legal

guardian of the child that a report pursuant to this section has been made and shall provide other information relevant to the future well-being of the child while under the supervision or care of the school. The verbal notice shall be made in coordination with the department of children's services to the parent or legal guardian within twenty-four (24) hours from the time the school, school teacher, school official or other school personnel reports the abuse to the department of children's services; provided, that in no event may the notice be later than twenty-four (24) hours from the time the report was made. The notice shall not be given to any parent or legal guardian if there is reasonable cause to believe that the parent or legal guardian may be the perpetrator or in any way responsible for the child abuse or child sexual abuse.

(2) Once notice is given pursuant to subdivision (d)(1), the principal or other designated person shall provide to the parent or legal guardian all school information and records relevant to the alleged abuse or sexual abuse, if requested by the parent or legal guardian; provided, that the information is edited to protect the confidentiality of the identity of the person who made the report, any other person whose life or safety may be endangered by the disclosure, and any information made confidential pursuant to federal law or § 10-7-504(a)(4). The information and records described in this subdivision (d)(2) shall not include records of other agencies or departments.

(3) For purposes of this subsection (d), "school" means any public or privately operated child care agency, as defined in § 71-3-501, preschool, nursery school, kindergarten, elementary school or secondary school.

HISTORY: Acts 1985, ch. 478, § 6; 1987, ch. 145, §§ 2, 11; 1988, ch. 953, § 14; 1993, ch. 439, § 2; 1994, ch. 901, § 2; 2000, ch. 947, §§ 6, 8M; 2008, ch. 1011, § 2; 2009, ch. 283, §§ 4, 5; 2010, ch. 1100, § 54; 2012, ch. 575, § 1; 2014, ch. 761, § 1.

SUDDEN, UNEXPLAINED CHILD DEATH ACT T.C.A. § 68 -1-1101 to 1103

68-1-1101. Short title -- Legislative findings -- Definitions.

(a) This part shall be known and may be cited as the "Sudden, Unexplained Child Death Act."

(b) The legislature finds and declares that:

(1) Protection of the health and welfare of the children of this state is a goal of its people and the unexpected death of a child is an important public health concern that requires legislative action;

(2) The parents, guardians, and other persons legally responsible for the care of a child who dies unexpectedly have a need to know the cause of death;

(3) Collecting accurate data on the cause and manner of unexpected deaths will better enable

the state to protect children from preventable deaths, and thus will help reduce the incidence of such deaths; and

(4) Identifying persons responsible for abuse or neglect resulting in unexpected death will better enable the state to protect other children who may be under the care of the same persons, and thus will help reduce the incidence of such deaths.

(c) As used in this part and in § 68-3-502, unless the context otherwise requires:

(1) "Certified child death pathologist" means a pathologist who is board certified or board eligible in forensic pathology, and who has received training in, and agrees to follow, the autopsy protocol, policies and guidelines for child death investigation, as prescribed by the chief medical examiner for the state of Tennessee;

(2) "Chief medical examiner" means the individual appointed pursuant to title 38, chapter 7; and

(3) "Sudden infant death syndrome" means the sudden death of an infant under one (1) year of age that remains unexplained after a thorough case investigation, including performance of a complete autopsy, examination of the death scene, and review of the clinical history.

HISTORY: Acts 2001, ch. 321, § 1.

68-1-1102. Purpose -- Training -- Notice and investigation -- Autopsy.

(a) The purpose of this part is to help reduce the incidence of injury and death to infants by accurately identifying the cause and manner of death of infants under one (1) year of age. This shall be accomplished by requiring that a death investigation be performed in all cases of all sudden, unexplained deaths of infants under one (1) year of age.

(b) The chief medical examiner shall develop and implement a program for training of child death pathologists. The protocol and policies shall be based on nationally recognized standards.

(c) All emergency medical technicians and professional firefighters shall receive training on the handling of cases of sudden, unexplained child death as a part of their basic and continuing training requirements. The training, which shall be developed jointly by the departments of health and children's services, shall include the importance of being sensitive to the grief of family members.

(d) All law enforcement officers shall receive training on the investigation and handling of cases of sudden, unexplained child death as part of their basic training requirements. The training, which shall be developed jointly by the departments of health and children's services, shall include the importance of being sensitive to the grief of family members and shall be consistent with the death scene investigation protocol approved by the chief medical examiner.

Additionally, whenever changes occur in policies or procedures pertaining to sudden infant death syndrome investigations, the department of health shall promptly notify the various law enforcement associations within the state. Such changes shall then be communicated in a timely manner to the respective law enforcement agencies for dissemination to their enforcement personnel.

(e) In the case of every sudden, unexplained death of an infant under one (1) year of age, the attending physician or coroner shall notify the county medical examiner, who shall coordinate the death investigation.

(f) The county medical examiner shall inform the parent or parents or legal guardian of the child, if an autopsy is authorized.

(g) The county medical examiner shall ensure that the body is sent for autopsy to a child death pathologist as defined in this part. Parents or legal guardians who refuse to allow an autopsy based on the grounds of religious exemption shall personally file a petition for an emergency court hearing in the general sessions court for the county in which the death occurred.

(h) The county medical examiner shall contact the appropriate local law enforcement personnel to conduct a death scene investigation according to the protocol developed by the chief medical examiner. The investigation shall be initiated within twenty-four (24) hours of the time the local law enforcement personnel are contacted by the county medical examiner.

(i) The county medical examiner shall send a copy of the death scene investigation and the medical history of the child to the pathologist conducting the autopsy.

(j) A copy of the completed autopsy, medical history, and death scene investigation shall be forwarded to the chief medical examiner.

(k) The cause of death, as determined by the certified child death pathologist, may be reported to the parents or legal guardians of the child. A copy of the autopsy results, when available, may be furnished to the parent or parents or legal guardian of the child, upon request, within forty-eight (48) hours of the request, except where the cause of death may reasonably be attributed to child abuse or neglect, in the judgment of the certified child death pathologist.

(*l*) Sudden infant death syndrome shall not be listed as the cause of death of a child, unless the death involves an infant under one (1) year of age that remains unexplained after a thorough case investigation, including performance of a complete autopsy, examination of the death scene, and review of the child's clinical history.

(m) Any individual or entity providing information pertinent to the investigation and related autopsy in a suspected case of sudden, unexplained infant death syndrome shall not be civilly liable for breach of confidentiality concerning the release of the information.

HISTORY: Acts 2001, ch. 321, § 2; 2002, ch. 591, §§ 1, 2.

68-1-1103. Implementation.

In order to implement this part, the commissioner of health shall:

(1) Promulgate rules and regulations in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5, as may be necessary to obtain in proper form all information relating to the occurrence of a sudden, unexplained child death that is relevant and appropriate for the establishment of a reliable statistical index of the incidence, distribution and characteristics of cases of sudden, unexplained child death;

(2) Promulgate rules and regulations in accordance with the Uniform Administrative Procedures Act that establish minimum standards for conducting and completing an investigation, including an autopsy if deemed necessary, into the sudden, unexplained death of any child from birth to age seventeen (17). Initial rules promulgated pursuant to this subdivision (2) are authorized to be promulgated as emergency rules, pursuant to § 4-5-208. In promulgating the rules, the commissioner may rely, in whole or in part, on any nationally recognized standards regarding such investigations. Compliance with the rules shall make county governments eligible for reimbursement, to the extent authorized by those rules, of the costs of any autopsy deemed necessary;

(3) Collect factual information from physicians, coroners, medical examiners, hospitals, and public health officials who have examined any child known or believed to have experienced sudden, unexplained death; provided, that no information shall be collected or solicited that reasonably could be expected to reveal the identity of the child;

(4) Make information collected pursuant to subdivision (3) available to physicians, coroners, medical examiners, hospitals, public health officials, and educational and institutional organizations conducting research as to the causes and incidence of sudden, unexplained child death;

(5) Cause appropriate counseling services to be established and maintained for families affected by the occurrence of sudden infant death syndrome; and

(6) Conduct educational programs to inform the general public of any research findings that may lead to the possible means of prevention, early identification, and treatment of sudden infant death syndrome.

HISTORY: Acts 2001, ch. 321, § 3; 2005, ch. 356, § 1; 2009, ch. 566, § 12.

CHILD FATALITY REVIEW AND PREVENTION T.C.A. § 68 -142-101 to 109

68-142-101. Short title.

This part shall be known as and may be cited as the "Child Fatality Review and Prevention Act of 1995."

HISTORY: Acts 1995, ch. 511, § 1; 2007, ch. 588, § 2.

68-142-102. Child fatality prevention team.

There is created the Tennessee child fatality prevention team, otherwise known as the state team. For administrative purposes only, the state team shall be attached to the department of health.

HISTORY: Acts 1995, ch. 511, § 1.

68-142-103. Composition.

The state team shall be composed as provided in this section. Any ex officio member, other than the commissioner of health, may designate an agency representative to serve in such person's place. Members of the state team shall be as follows:

(1) The commissioner of health, who shall chair the state team;

(2) The attorney general and reporter;

(3) The commissioner of children's services;

(4) The director of the Tennessee bureau of investigation;

(5) A physician nominated by the state chapter of the American Medical Association;

(6) A physician to be appointed by the commissioner of health who is credentialed in forensic pathology, preferably with experience in pediatric forensic pathology;

(7) The commissioner of mental health and substance abuse services;

(8) A member of the judiciary selected from a list submitted by the chief justice of the Tennessee supreme court;

(9) The executive director of the commission on children and youth;

(10) A representative from a professional organization working to prevent abuse of children;

(11) A team coordinator, to be appointed by the commissioner of health;

(12) Two (2) members of the house of representatives to be appointed by the speaker of the house of representatives, at least one (1) of whom shall be a member of the health committee;

(13) Two (2) senators to be appointed by the speaker of the senate, at least one (1) of whom shall be a member of the health and welfare committee;

(14) The commissioner of education or the commissioner's designee; and

(15) The commissioner of intellectual and developmental disabilities.

HISTORY: Acts 1995, ch. 511, § 1; 1996, ch. 1079, § 152; 2007, ch. 588, § 3; 2010, ch. 1100, §§ 129, 130; 2011, ch. 410, § 3(hh); 2012, ch. 575, § 2; 2013, ch. 89, § 3; 2013, ch. 236, § 57.

68-142-104. Voting members -- Vacancies.

All members of the state team shall be voting members. All vacancies shall be filled by the appointing or designating authority in accordance with the requirements of § 68-142-103.

HISTORY: Acts 1995, ch. 511, § 1.

68-142-105. Duties of state team.

The state team shall:

(1) Review reports from the local child fatality review teams;

(2) Report to the governor and the general assembly concerning the state team's activities and its recommendations for changes to any law, rule, and policy that would promote the safety and well-being of children;

(3) Undertake annual statistical studies of the incidence and causes of child fatalities in this state. The studies shall include an analysis of community and public and private agency involvement with the decedents and their families prior to and subsequent to the deaths;

(4) Provide training and written materials to the local teams established by this part to assist them in carrying out their duties. Such written materials may include model protocols for the operation of local teams;

(5) Develop a protocol for the collection of data regarding child deaths;

(6) Upon request of a local team, provide technical assistance to such team, including the authorization of another medical or legal opinion on a particular death; and

(7) Periodically assess the operations of child fatality prevention efforts and make recommendations for changes as needed.

HISTORY: Acts 1995, ch. 511, § 2; 2007, ch. 588, § 4.

68-142-106. Local teams -- Composition -- Vacancy -- Chair -- Meetings.

(a) There shall be a minimum of one (1) local team in each judicial district.

(b) Each local team shall include the following statutory members or their designees:

(1) A supervisor of social services in the department of children's services within the area served by the team;

(2) The regional health officer in the department of health in the area served by the team, who shall serve as interim chair pending the election by the local team;

(3) A medical examiner who provides services in the area served by the team;

(4) A prosecuting attorney appointed by the district attorney general;

(5) An employee of the local education agency, to be appointed by the director of schools; and

(6) The interim chair of the local team shall appoint the following members to the local team:

(A) A local law enforcement officer;

(B) A mental health professional;

(C) A pediatrician or family practice physician;

(D) An emergency medical service provider or firefighter; and

(E) A representative from a juvenile court.

(c) Each local child fatality team may include representatives of public and nonpublic agencies in the community that provide services to children and their families.

(d) The local team may include non-statutory members to assist them in carrying out their

duties. Vacancies on a local team shall be filled by the original appointing authority.

(e) A local team shall elect a member to serve as chair.

(f) The chair of each local team shall schedule the time and place of the first meeting, and shall prepare the agenda. Thereafter, the team shall meet no less often than once per quarter and often enough to allow adequate review of the cases meeting the criteria for review.

HISTORY: Acts 1995, ch. 511, § 3; 1996, ch. 1079, § 152; 2007, ch. 588, § 5.

68-142-107. Duties of local teams.

(a) The local child fatality review teams shall:

(1) Be established to cover each judicial district in the state;

(2) Review, in accordance with the procedures established by the state team, all deaths of children seventeen (17) years of age or younger;

(3) Collect data according to the protocol developed by the state team;

(4) Submit data on child deaths quarterly to the state team;

(5) Submit annually to the state team recommendations, if any, and advocate for system improvements and resources where gaps and deficiencies may exist; and

(6) Participate in training provided by the state team.

(b) Nothing in this part shall preclude a local team from providing consultation to any team member conducting an investigation.

(c) Local child fatality review teams may request a second medical or legal opinion to be authorized by the state team in the event that a majority of the local team's statutory membership is in agreement that a second opinion is needed.

HISTORY: Acts 1995, ch. 511, § 4; 2007, ch. 588, § 6.

68-142-108. Powers of local team -- Limitations -- Confidentiality of state and local team records.

(a) The department of health, state team and local teams are public health authorities conducting public health activities pursuant to the federal Health Insurance Portability and Accountability Act (HIPAA), compiled in 42 U.S.C. § 1320d et seq. Notwithstanding §§ 63-2-

101(b) and 68-11-1502, and regardless of any express or implied contracts, agreements or covenants of confidentiality based upon those sections, the records of all health care facilities and providers shall be made available to the local team for inspection and copying as necessary to complete the review of a specific fatality and effectuate the intent of this part. The local team is authorized to inspect and copy any other records from any source as necessary to complete the review of a specific fatality and effectuate the intent of this part, including, but not limited to, police investigations data, medical examiner investigative data, vital records cause of death information, and social services records, including records of the department of children's services.

(b) The local team shall not, as part of the review authorized under this part, contact, question or interview the parent of the deceased child or any other family member of the child whose death is being reviewed.

(c) The local team may request that persons with direct knowledge of circumstances surrounding a particular fatality provide the local team with information necessary to complete the review of the particular fatality; such persons may include the person or persons who first responded to a report concerning the child.

(d) Meetings of the state team and each local team shall not be subject to title 8, chapter 44, part 1. Any minutes or other information generated during official meetings of state or local teams shall be sealed from public inspection. However, the state and local teams may periodically make available, in a general manner not revealing confidential information about children and families, the aggregate findings of their reviews and their recommendations for preventive actions.

(e) (1) All otherwise confidential information and records acquired by the state team or any local child fatality review team in the exercise of the duties are confidential, are not subject to discovery or introduction into evidence in any proceedings, and may only be disclosed as necessary to carry out the purposes of the state team or local teams and for the purposes of the Sudden, Unexplained Child Death Act, compiled in chapter 1, part 11 of this title.

(2) In addition, all otherwise confidential information and records created by a local team in the exercise of its duties are confidential, are not subject to discovery or introduction into evidence in any proceedings, and may only be disclosed as necessary to carry out the purposes of the state or local teams and for the purposes of the Sudden, Unexplained Child Death Act. Release to the public or the news media of information discussed at official meetings is strictly prohibited. No member of the state team, a local team nor any person who attends an official meeting of the state team or a local team, may testify in any proceeding about what transpired at the meeting, about information presented at the meeting, or about opinions formed by the person as a result of the meeting.

(3) This subsection (e) shall not, however, prohibit a person from testifying in a civil or criminal action about matters within that person's independent knowledge.

(f) Each statutory member of a local child fatality review team and each non-statutory member of a local team and each person otherwise attending a meeting of a local child fatality review team shall sign a statement indicating an understanding of and adherence to confidentiality requirements, including the possible civil or criminal consequences of any breach of confidentiality.

HISTORY: Acts 1995, ch. 511, § 5; 2001, ch. 321, §§ 5, 6; 2007, ch. 588, §§ 7, 8.

68-142-109. Staff and consultants.

To the extent of funds available, the state team may hire staff or consultants to assist the state team and local teams in completing their duties.

HISTORY: Acts 1995, ch. 511, § 6.

68-142-110. Immunity from civil and criminal liability.

Any person or facility acting in good faith in compliance with this part shall be immune from civil and criminal liability arising from such action.

HISTORY: Acts 2007, ch. 588, § 9.

68-142-111. Child death investigations and reviews.

Nothing in this part shall preclude any child death investigations or reviews to the extent authorized by other laws.

HISTORY: Acts 2007, ch. 588, § 10.

MATERNAL MORTALITY REVIEW PROGRAM T.C.A. § 68-3-601 *et seq*

68-3-601 Short title.

This part shall be known and may be cited as the "Maternal Mortality and Prevention Act of 2016."

68-3-602 Findings – Definitions

(a) The general assembly finds that:
(1) Maternal deaths are a serious public health concern and have a tremendous family and societal impact;

(2) Maternal deaths are significantly underestimated and inadequately documented, preventing efforts to identify and reduce or eliminate the causes of death;
(3) No processes exist in this state for the confidential identification, investigation, or dissemination of findings regarding maternal deaths;
(4) The centers for disease control and prevention has determined that maternal deaths should be investigated through state-based maternal mortality reviews in order to institute the systemic changes needed to decrease maternal mortality; and
(5) There is a need to establish a program to review maternal deaths and to develop strategies for the prevention of maternal deaths in this state.
(b) As used in this part:
(1) "Department" means the department of health;
(2) "Maternal death" or "maternal mortality" means a:
(A) Pregnancy-associated death;
(B) Pregnancy-related death; or
(C) Pregnancy-associated but not a pregnancy-related death;
(3) "Pregnancy-associated death" means the death of a woman while pregnant or within one (1) year of the end of her pregnancy, irrespective of the cause of death and regardless of the duration or site of the pregnancy;
(4) "Pregnancy-associated, but not pregnancy-related death" means the death of a woman while pregnant or within one (1) year following the end of pregnancy, due to a cause unrelated to the pregnancy; and
(5) "Pregnancy-related death" means the death of a woman while pregnant or within one (1) year of the end of her pregnancy, regardless of the duration or site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.

68-3-603 Maternal mortality review program.

The commissioner of health is authorized to create the Tennessee maternal mortality review program. The intent of the Tennessee maternal mortality review program is to identify and address the factors contributing to poor pregnancy outcomes for women and facilitate state systems changes to improve the health of women before, during and after pregnancy.
68-3-604 Maternal mortality review and prevention team.

There is created the Tennessee maternal mortality review and prevention team, otherwise known as the state team. For administrative purposes only, the state team shall be attached to the department of health.

68-3-605 Composition of state team.

The composition of the state team shall include:
(1) The commissioner of health or the commissioner's designee;
(2) The state maternal and child health director or the director's designee;

(3) A physician licensed or certified under title 63, chapter 6 or 9, with training in obstetrics;
(4) A physician licensed or certified under title 63, chapter 6 or 9, with training in neonatology;
(5) A hospital-based nurse with experience in obstetrics, labor, and delivery, postpartum, or maternity care;
(6) The chief medical examiner or the examiner's designee;
(7) The chair of the health and welfare committee of the senate, or the chair's designee;
(8) The chair of the health committee of the house of representatives, or the chair's designee; and
(9) Additional members as determined by the department, including representatives from multiple disciplines and relevant community-based organizations as necessary to fulfill the intent of this part.

VITAL RECORDS T.C.A. § 68 -3-501 to 504, 507, 513

68-3-501. Uniform Determination of Death Act.

(a) This section may be cited as the "Uniform Determination of Death Act."

(b) An individual who has sustained either:

(1) Irreversible cessation of circulatory and respiratory functions; or

(2) Irreversible cessation of all functions of the entire brain, including the brain stem;

is dead. A determination of death must be made in accordance with accepted medical standards.

(c) This section shall be applied and construed to effectuate its general purpose to make uniform the law with respect to the subject of this section among states enacting it.

68-3-502. Death registration.

(a) (1) A death certificate for each death that occurs in this state shall be filed with the office of vital records or as otherwise directed by the state registrar within five (5) days after death and prior to final disposition, or as prescribed by regulations of the department. It shall be registered, if it has been completed and filed in accordance with this section.

(2) If the place of death is unknown but the body is found in this state, the death certificate shall be completed and filed in accordance with this section. The place where the body is found shall be shown as the place of death. If the date of death is unknown, it shall be determined by the date the body was found.

(3) When death occurs in a moving conveyance in the United States and the body is first

removed from the conveyance in this state, the death shall be registered in this state and the place where it is first removed shall be considered the place of death. When a death occurs on a moving conveyance while in international waters or airspace or in a foreign country and the body is first removed from the conveyance in this state, the death shall be registered in this state; but the certificate shall show the actual place of death insofar as can be determined.

(b) The funeral director, or person acting as funeral director, who first assumes custody of the dead body shall file the death certificate. The funeral director shall obtain the personal data from the next of kin or the best qualified person or source available, and shall obtain the medical certification from the person responsible for medical certification, as set forth in subsection (c).

(c) (1) The medical certification shall be completed, signed and returned to the funeral director by the physician in charge of the patient's care for the illness or condition that resulted in death within forty-eight (48) hours after death, except when inquiry is required by the county medical examiner. In the absence of the physician, the certificate may be completed and signed by another physician designated by the physician or by the chief medical officer of the institution in which the death occurred. In cases of deaths that occur outside of a medical institution and are either unattended by a physician or not under hospice care, the county medical examiner shall investigate and certify the death certificate when one (1) of the following conditions exists:

(A) There is no physician who had attended the deceased during the four (4) months preceding death, except that any physician who had attended the patient more than four (4) months preceding death may elect to certify the death certificate if the physician can make a good faith determination as to cause of death and if the county medical examiner has not assumed jurisdiction; or

(B) The physician who had attended the deceased during the four (4) months preceding death communicates, orally or in writing, to the county medical examiner that, in the physician's best medical judgment, the patient's death did not result from the illness or condition for which the physician was attending the patient.

(2) Sudden infant death syndrome shall not be listed as the cause of death of a child, unless the death meets the definition set forth in chapter 1, part 11 of this title.

(3) (A) In addition to this section, prior to signing medical certification of the cause of death, the physician, chief medical officer or medical examiner shall require screening x-rays of the skull, long bones and chest of any child who was not subject to an autopsy and who died of unknown causes or whose death is suspected to be from sudden infant death syndrome.

(B) The physician, chief medical officer or medical examiner who orders the x-ray examinations pursuant to this section shall be entitled to a reasonable fee as set by the commissioner of health for the costs of the x-ray examinations, to be paid from the funds

allotted to the postmortem examiners program in the department of health.

(d) When inquiry is required, the medical examiner shall determine the cause of death and shall complete and sign the medical certification within forty-eight (48) hours after taking charge of the case. On or before January 1, 2013, the commissioner of health shall establish by rule a protocol for use by medical examiners in cases involving death resulting from opiate, illegal or illicit drug overdose, that requires an appropriate report under § 38-7-108. The commissioner is authorized to promulgate such rules in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5.

(e) If the cause of death cannot be determined within forty-eight (48) hours after death, the medical certification shall be completed as provided by regulation. The attending physician or medical examiner shall give the funeral director, or person acting as funeral director, notice of the reason for the delay; and final disposition of the body shall not be made until authorized by the attending physician or medical examiner.

(f) If the death occurs in a military or veteran's hospital or in a state veteran's home in the state of Tennessee, the death certificate may be signed by the attending physician who holds a license in another state.

(g) In the event a person is dead on arrival at a military or veteran's hospital or at a state veteran's home in the state of Tennessee, the death certificate may be signed by a physician who is employed by one (1) of these institutions and who holds a license in another state.

(h) The form for a certificate of death shall contain a place for the recording of the deceased's social security number and the social security number shall be recorded on the certificate and on any forms necessary to prepare the certificate.

(i)
(1) Notwithstanding this section to the contrary, this subsection (i) governs manner of death determinations of death investigations for which suicide is suspected or determined to be the manner of death.
(2) If a county medical examiner suspects that suicide may be a potential manner of death, then the medical examiner shall consult the decedent's treating mental health professional or primary care physician, if known and reasonably able to be identified through the decedent's next of kin, prior to determination of manner of death.
(3)
(A) After inquiry by a county medical examiner pursuant to title 38, chapter 7, part 1, the medical examiner shall enter the manner of death and file the death certificate. If the manner of death is suicide and the next of kin disagrees with the manner of death determination, then the next of kin may contact the county medical examiner who performed the autopsy to request a meeting. The county medical examiner shall meet with the next of kin within thirty (30) calendar days of that initial contact by the requesting next of kin or, if more time is needed to gather documentation, on a mutually acceptable date. The meeting must be either in person

or via teleconference, at the discretion of the requesting next of kin. At the meeting, each party must present the reasons supporting their position with respect to the manner of death, including any relevant documentation.
(B) Within thirty (30) calendar days of the meeting with the next of kin, the county medical examiner shall make a written determination on the manner of death and notify the next of kin. The notification must address the next of kin's specific bases for disagreement, inform the next of kin of their right to seek reconsideration from the office of the state chief medical examiner (OSCME), and include information on how to request the reconsideration. The notification must also inform the next of kin of their right to seek judicial review.
(4)
(A) Within one hundred twenty (120) calendar days of the notification of the manner of death from the county medical examiner, the next of kin may request reconsideration from the OSCME in writing.
(B) Within fifteen (15) calendar days of receiving the reconsideration request, the OSCME shall notify the county medical examiner of the reconsideration request and request all records and documentation from the county medical examiner and the next of kin.
(C) The county medical examiner shall send the requested records and documentation to the OSCME within fifteen (15) calendar days of receiving the request.
(D)
(i)
(*a*) Upon receipt of the records and documentation, the state chief medical examiner shall convene a peer review panel to conduct the reconsideration.
(*b*) The peer review panel must consist of the state chief medical examiner and all chief medical examiners of the regional forensic centers except for the chief medical examiner of the regional forensic center for the region in which the autopsy was performed. The state chief medical examiner shall serve as chair of the peer review panel.
(*c*) The chief medical examiners of the regional forensic centers may each appoint a designee to serve on the peer review panel. The designee must be a forensic pathologist licensed in this state who is employed by the regional forensic center.
(*d*) The state chief medical examiner may distribute records and documentation to the peer review panel members by electronic means. The panel may meet remotely via teleconference or video conference.
(ii) The peer review panel shall complete the reconsideration within ninety (90) calendar days of the date the OSCME receives the records and documentation from the county medical examiner. If the initial review indicates a need for additional investigation, then the peer review panel may use an additional ninety (90) calendar days to finalize their findings and must send written notification to the next of kin that the extra ninety-calendar-day period is necessary.
(iii) Once the members of the peer review panel have completed the review of the records and documentation, the members shall vote on a manner of death determination. The state chief medical examiner shall not vote except in the event of a tie vote among all other panel members. A manner of death that achieves a simple majority of all panel members prevails, at which time a reconsideration investigation is deemed complete.
(iv) The state chief medical examiner shall prepare a written report of the peer review panel's findings and decision and shall detail in the report the panel's reasoning for its decision and an

explanation of any additional investigation that was done. The state chief medical examiner shall send a copy of the report to the next of kin and the county medical examiner within fifteen (15) calendar days of the completion of the investigation.

(5)

(A) If the findings of a reconsideration conducted pursuant to subdivision (i)(4) support the original manner of death determination made by the county medical examiner, then the next of kin may appeal that decision to a court of competent jurisdiction.

(B) If the findings of a reconsideration conducted pursuant to subdivision (i)(4) support a manner of death determination other than suicide, then the state chief medical examiner shall, no later than fifteen (15) calendar days after the date of the written report, amend the manner of death.

(6)

(A) Next of kin may terminate a reconsideration process requested pursuant to this subsection (i) at any time and for any reason by written notice to the OSCME of their intent to terminate the reconsideration.

(B) Next of kin may seek judicial review at any time during the reconsideration process following the receipt of the original death certificate by written notice to the OSCME of their intent to seek judicial review.

(7) By requesting reconsideration under this subsection (i), the next of kin authorizes release of any medical records, hospital records, investigative reports, or other documentary evidence of the deceased that the peer review panel deems necessary to complete the reconsideration.

(8) The department of health shall maintain a notice of decedent's next of kin rights with regard to this subsection (i) on its public website.

(9) As used in this subsection (i), “next of kin” means the person who has the highest priority pursuant to § 62-5-703.

(10) This subsection (i) applies only when the manner of death is suspected or determined to be suicide.

(11) A physician, who acts in good faith to comply with this subsection (i), is immune from individual civil liability in the absence of gross negligence or willful misconduct for actions authorized by this subsection (i).

(12) Unrelated parties have no liability for relying on the original death certificate, without regard to subsequent revision under this part.

(13) OSCME shall maintain statistics on the number of reconsideration requests, the number of manner of death determinations that are upheld or overturned, and the number of next of kin terminations of a reconsideration process before the issuance of final findings. The OSCME may also maintain additional information relative to the reconsideration requests that may assist in carrying out other functions of the office.

(j)

(1) This subsection (j) applies only if an attending physician, chief medical officer, or medical examiner signing the medical certification of the cause of death of a military veteran:

(A) Knows that the deceased person was a United States military veteran; and

(B) Is provided with access to the veteran's medical records.

(2) If the requirements of subdivision (j)(1) have been met, then prior to signing the medical certification of the cause of death of a United States military veteran, the attending physician,

chief medical officer, or medical examiner shall conduct a review of the veteran's medical records, including records made available from the United States department of veterans affairs, to determine if a service-connected disability was the principal or a major contributory cause of death, including when a concurrent or comorbid health condition, such as COVID-19, existed. If a service-connected disability was the principal or a major contributory cause of death, then the attending physician, chief medical officer, or medical examiner shall include the finding on the medical certification.

68-3-503. Delayed registration of death.

(a) When a death occurring in this state has not been registered within the time period prescribed by § 68-3-502, a certificate may be filed in accordance with the regulations of the department. The certificate shall be registered subject to such evidentiary requirements as the department shall, by regulation, prescribe to substantiate the alleged facts of death.

(b) Certificates of death registered six (6) months or more after the date of death shall be marked "delayed."

68-3-504. Reports of fetal death.

(a) (1) Each fetal death of three hundred fifty (350) grams or more or of twenty (20) completed weeks' gestation or more, that occurs in this state, shall be reported to the office of vital records within ten (10) days after delivery.

(2) When a dead fetus is delivered in an institution, the person in charge of the institution, or the person's designated representative, shall prepare and file the report.

(3) When a dead fetus is delivered outside an institution, the physician in attendance at or immediately after the delivery shall prepare and file the report.

(b) The name of the father shall be entered on the fetal death report, in accordance with § 68-3-305.

(c) When a fetal death required to be reported by this section occurs without medical attendance at or immediately after the delivery, or when inquiry is required, the medical examiner shall investigate the cause and shall prepare and file the report.

68-3-507. Moving body from place of death.

With the consent of the physician or medical examiner who is to certify the cause of death, a body may be moved from the place of death for the purpose of being prepared for final disposition.

68-3-513. Immunity from civil suit.

Any physician who in good faith complies with §68-3-502 (c)-(g) shall be immune from civil suit for damages.

Rule 0880-02-.14

Medical certification on death certificates – Any physician who is required to and refuses to or consistently fails to comply with the provisions of TCA §68-3-502 regarding medical certification on death certificates shall be subject to disciplinary action pursuant to TCA §63-6-214(b)(1). ["unprofessional, dishonorable or unethical conduct"]

DISPOSITION OF DEAD BODIES T.C.A. § 68 -4-101 et seq.

68-4-101. Notice of death occurring while receiving medical attention or in institution -- Action taken upon expiration of eight hours -- Penalty.

(a) When any person dies in a doctor's office, or any clinic, hospital or state, county or city institution, it is unlawful for any doctor, nurse, attendant, orderly, janitor or bookkeeper, or anyone, to call an undertaker without first making an effort to contact a relative of the person, if the person has any known kin in the county where the person died, so as to give the kin or relative the right to call an undertaker or crematory of the next of kin's or relative's choice.

(b) In the event kin or relatives are not available or are not known, or should the next of kin fail or refuse to summon an undertaker or crematory or to dispose of the body in some manner within eight (8) hours after the death of the person, then the doctor, hospital, clinic or other institution may summon an undertaker to take over the body.

(c) In the event the next of kin refuses to summon an undertaker or crematory or dispose of the body in some manner immediately, then the doctor, hospital, clinic or institution may summon some undertaker to take over the body.

(d) Any doctor, nurse, attendant, orderly, janitor or bookkeeper or anyone connected with the office, hospital, clinic or institution violating subsection (a) commits a Class C misdemeanor.

HISTORY: Acts 1953, ch. 152, §§ 1-3 (Williams, § 5717.39); T.C.A. (orig. ed.), §§ 53-501 -- 53-503; Acts 1989, ch. 591, § 113.

68-4-102. Disposition of unclaimed bodies of persons dying in charitable or penal institutions or to be buried at public expense.

(a) In order to promote medical and surgical science, and to provide for the disposition of unclaimed bodies of persons who die in any charitable or penal institutions, or are delivered to a public official for the purpose of burial at public expense, the chief medical examiner appointed pursuant to § 38-7-102 shall direct the disposition of unclaimed dead bodies, except those of honorably discharged veterans, which shall be interred as directed by the commissioner of veterans services, or the commissioner's representative, superseding other provisions of §§ 68-4-102 -- 68-4-109.

(b) All reimbursement for travel expenses shall be in accordance with the comprehensive travel regulations as promulgated by the department of finance and administration and approved by the attorney general and reporter.

68-4-103. Persons dying in publicly-supported institutions or to be buried at public expense -- Notice to relatives -- Notice to chief medical examiner -- Removal of body -- Embalming -- Infectious or contagious cases.

(a) Whenever a person dies in any hospital, infirmary, mental health institute, poorhouse, penitentiary, house of correction, workhouse, jail, or other charitable or penal institution that is supported in whole or in part at public expense, or whenever a body is delivered to a public official for the purpose of determining the cause of death or for the purpose of burial of the body or the cremated remains at public expense, it is the duty of the public official or of the custodian, superintendent or active head of such institution to immediately notify the nearest relative of the person, if any relative be known, of the person's death.

(b) (1) After the notification pursuant to subsection (a), the custodian, superintendent or active head of the institution or public official shall then hold the body of the deceased person not less than ninety-six (96) hours, and if at the end of that time no relative claims the dead body and no provision has been made for its interment by burial of the body or the cremated remains other than at public expense, then the custodian, superintendent or active head or public official shall notify the chief medical examiner or the chief medical examiner's representative that the custodian, superintendent or active head or public official has the body, and, upon demand by the chief medical examiner or the chief medical examiner's representative, shall deliver or surrender the body to the chief medical examiner or the chief medical examiner's representative or to either of their order.

(2) Notification shall be made in any manner that the chief medical examiner shall direct and all the expense of notification and delivery or surrender of the body shall be at the expense of and shall be borne by the institution obtaining the dead body.

(c) If the chief medical examiner or the chief medical examiner's representative, upon receipt of the notification, does not, within seventy-two (72) hours, make a demand for the body, then the body or the cremated remains shall be buried as provided by law or cremated in accordance with § 68-4-113. The public official or the custodian, superintendent or active head of such institution as referred to in subsection (a) may, in such person's discretion, choose to have the body cremated prior to burial.

(d) No custodian, superintendent or head of a charitable or penal institution or public official shall charge, receive or accept money or other consideration for any body.

(e) The chief medical examiner may, by proper instructions, have the body embalmed by such person as the chief medical examiner may direct, and, to the person performing this work under the chief medical examiner's instructions the institution receiving the body shall pay a reasonable compensation.

(f) No person who has died of any contagious or infectious disease shall be held to be within §§

68-4-102 -- 68-4-109, unless proper precautions, as prescribed by the chief medical examiner, are taken to prevent the spread of contagions or infections.

68-4-104. Distribution of bodies among medical, dental, and anthropologic institutions -- Receiving institution to pay expense.

(a) The chief medical examiner, upon receiving the bodies or notification of the availability of the bodies as provided in this chapter, shall distribute them among the medical, dental and anthropologic institutions of this state regularly chartered and in active operation as prescribed in §§ 68-4-102 -- 68-4-109, and shall not give, sell or deliver anybody to any other person, firm, society, association or corporation.

(b) Bodies shall be distributed by the chief medical examiner to the institution that is closest to the location of the body and that has indicated a current need for bodies for the purposes authorized by this chapter.

(c) The institution receiving any body shall bear all the expense incident to the transportation of the body from the institution where death occurred, and its delivery to the institution receiving it.

68-4-108. Expenses to be borne by medical, dental, and anthropologic institutions.

No expense that may be incurred in the execution of any part of §§ 68-4-102 -- 68-4-109 shall be a charge upon the state or any county or municipality, or any officer or agent thereof, but all such expenses, whether for compensation, salary, transportation or otherwise shall be borne by the medical, dental and anthropologic institutions as provided in this chapter.

68-4-111. Autopsy by consent of persons having custody of body.

(a) A physician holding an unlimited license to practice medicine under the laws of Tennessee is deemed to have been legally authorized to perform an autopsy upon the body of a deceased person, when the autopsy has been consented to by the person assuming custody of the body for the purposes of burial, such as the surviving spouse, the father, the mother, a child, a guardian, next of kin, or in the absence of any of the foregoing, such governmental agencies as charged by law with the responsibility for burial. If two (2) or more such persons assume custody of the body, the consent of one (1) of them shall be deemed sufficient legal authorization for the performance of the autopsy.

(b) Nothing contained in this section shall be construed as repealing, amending or in any way affecting § 38-1-104, which prescribes the procedure by which district attorneys general may petition for an autopsy, nor § 38-5-107, which prescribes the procedure by which coroners may

summon as a witness a surgeon or physician to make examination of a dead body, including the performing of an autopsy.

68-4-113. Cremation of unclaimed dead body.

Notwithstanding any law to the contrary, the coroner, medical investigator or county medical examiner may direct the cremation of an unclaimed dead body; provided, that:

(1) Proper notice is given in accordance with § 68-4-103; and

(2) The body is held for the time period provided in § 68-4-103.

SEXUALLY TRANSMITTED DISEASES T.C.A. § 68 -10-117

68-10-117: Possible exposure of emergency workers to airborne or bloodborne diseases -- Testing.

(a) If, in the course of performing normal, authorized professional job duties, or rendering emergency care as a good Samaritan under the Good Samaritan Law, codified in § 63-6-218, a member of one of the categories of individuals listed in subsection (d) reasonably believes that the member may have been exposed to potentially life-threatening airborne or bloodborne diseases, including, but not limited to, tuberculosis, HIV or hepatitis B, the person has the right to request, in writing, that the individual who may have exposed the person be evaluated to determine the presence of such disease or diseases. The request shall be made to the designated exposure control officer of the responding agency or county medical examiner, who shall conduct the evaluation pursuant to the rules provided for in subsection (c).

(b) Any evaluation pursuant to subsection (a) shall include all medical records held by the department of health, any health care provider, or health care facility pertaining to the individual who is the subject of the evaluation. Any information provided shall be made available in accordance with the rules provided for in subsection (c) and shall be used only for the purpose of performing the evaluation and shall be otherwise confidential. Any cost related to the evaluation shall be paid by the responding agency.

(c) Any evaluation provided for in subsection (a) shall be conducted pursuant to emergency rules promulgated by the commissioner of health consistent with federal regulations for such determination of exposure experienced by emergency response workers. Any agency, individual, or facility providing any assistance or information necessary for completing the evaluation shall not incur any civil or criminal liability as a result of providing assistance or information consistent with the rules promulgated pursuant to this subsection (c).

(d) The categories of individuals who may request evaluations are paramedics, emergency

response employees, fire fighters, first response workers, emergency medical technicians, and volunteers making an authorized emergency response. The evaluations may also be requested by any person rendering services as a good Samaritan under the Good Samaritan Law.

DISPOSITION OF HUMAN REMAINS T.C.A. § 62-5-704

62-5-704. Circumstances under which rights forfeited.

A person entitled under § 62-5-703 to the right of disposition shall forfeit that right, and the right shall pass on to the next person in accordance with § 62-5-703, in the following circumstances:

(1) Any person convicted of an offense described in § 39-13-202, § 39-13-210, or § 39-13-211, in connection with the decedent's death, and whose conviction or convictions are known to the funeral director; or

(2) Any person who does not exercise the right of disposition within seventy-two (72) hours of notification of the decedent's death or within one hundred and sixty-eight (168) hours of the decedent's death, whichever is earlier.

HISTORY: Acts 2012, ch. 828, § 2.

APPENDIX B

REFERENCE AND FOUNDATION DOCUMENTS

A Guide for Manner of Death Classification, National Association of Medical Examiners:
https://name.memberclicks.net/assets/docs/MANNEROFDEATH.pdf

Medicolegal Death Investigation: Terms and Definitions:
OSAC 2022-N-0026 MDI Terms Definitions.OPEN COMMENT VERSION.pdf (nist.gov)

Luzi SA, et al. Medical Examiners' Independence is Vital for the Health of the American Legal System. Acad Forensic Pathol. 2013 3 (1): 84-92.
Medical Examiners' Independence is Vital for the Health of the American Legal System - Scott A. Luzi, Judy Melinek, William R. Oliver, 2013 (sagepub.com)

Melinek J. et. Al. National Association of Medical Examiners Position Paper: Medical Examiner, Coroner, and Forensic Pathologist Independence. Acad Forensic Pathol. 2013 3 (1): 93-98
National Association of Medical Examiners Position Paper: Medical Examiner, Coroner, and Forensic Pathologist Independence - Judy Melinek, Lindsey C. Thomas, William R. Oliver, Gregory A. Schmunk, Victor W. Weedn, , The National Association of Medical Examiners Ad Hoc Committee on Medical Examiner Independence, The National Association of Medical Examiners Ad Hoc Committee on Medical Examiner Independence, 2013 (sagepub.com)

Organizational and Foundational Standards for Medicolegal Death Investigations. ANSI/ASB Standard 125, First Edition 2021/
Microsoft Word - 125_Std_e1 (aafs.org)

Funeral Directors Handbook:
https://www.tn.gov/content/dam/tn/commerce/documents/regboards/funeral/posts/FuneralDirectorsHandbook-2012.pdf

Tennessee Department of Health Rules (Vital Records):
http://publications.tnsosfiles.com/rules/1200/1200-07/1200-07-01.201506328.pdf

The Centers for Disease Control and Prevention:
https://www.cdc.gov/nchs/nvss/writing-cause-of-death-statements.htm#:~:text=Cause%2Dof%2Ddeath%20statements%20on,it%20on%20the%20death%20certificate.

Winek's Drug and Chemical Blood Level Data 2001
http://www.abmdi.org/documents/winek_tox_data_2001.pdf

NAME I and A checklist
https://www.thename.org/assets/docs/NAME%20Accreditation%20Checklist%202019%20-%202024.pdf

LexisNexis – Tennessee Code Annotated
http://www.lexisnexis.com/hottopics/tncode/

Medical Examiners and Manner of Death. Drs. Amy Hawes and Darinka Mileusnic-Polchan. Tennessee Bar Association Journal Feb. 2019. Medical Examiners and 'Manner of Death' - Articles (tba.org)

Spitz and Fisher's Medicolegal Investigation of Death. Guidelines for the Application of Pathology to Crime Investigation. Werner U. Spitz and Francisco J. Diaz, eds. 2020. Charles C. Thomas.

Disposition of Toxic Drugs and Chemicals in Man. Randall C. Baselt. 2017. Biomedical Publications.

APPENDIX C

EXAMPLES OF STANDARD CAUSE OF DEATH LANGUAGE

Accidental

Acute drug/mixed drug (names of drug(s)) intoxication
Asphyxia due to …
Aspiration of (food bolus, foreign object)
Blunt force injuries of (head, chest, etc.)
Carbon monoxide poisoning
Drowning
Electrocution
Entrapment
Ethanol intoxication
Exsanguination due to…
Gunshot wound of …
Hanging
Head and neck injuries
Hyperthermia due to …
Hypothermia due to exposure
Multiple blunt force injuries
Pulmonary embolus due to deep venous thrombosis
Smoke and soot inhalation
Stab wound
Subdural hematoma
Thermal injuries
Thermal injuries and smoke inhalation

Homicide

Acute drug/mixed drug (type of drug(s)) intoxication
Asphyxia due to (manual strangulation, ligature strangulation, smothering, etc.)
Aspiration of (food bolus, foreign object)
Blunt force injuries of (head, chest, etc.)
Carbon monoxide poisoning
Dehydration
Drowning
Electrocution
Ethanol intoxication
Exsanguination due to (stab wounds, gunshot wounds)
Gunshot wound of …
Hanging

Head and neck injuries
Hyperthermia due to …
Hypothermia due to exposure
Multiple blunt force injuries
Smoke and soot inhalation / Thermal injuries
Stab wound
Subdural hematoma

Natural

Aortic dissection
Aortic aneurysm
Abdominal aortic aneurysm
Acquired Immune Deficiency Syndrome
Alzheimer's
Amyotrophic lateral sclerosis
Arteriosclerotic cardiovascular disease
Asthma
Blood disorders
Cancer of ... (be as specific as possible as to tumor type, stage, grade, and primary site)
Carcinoma
Cardiomegaly
Chronic alcohol abuse
Chronic obstructive pulmonary disease
Complications of ... (pre-existing condition)
Complications of premature birth due to placental abruption, etc.
Congenital defect (be as specific as possible, e.g., DiGeorge's syndrome)
Diabetes
Diabetic ketoacidosis
Emphysema
Hepatic failure due to …
Hodgkin's disease
Hypertension
Hypertensive heart disease
Influenza
Leukemia
Meningitis
Multiple organ failure due to …
Myocardial infarction
Myocarditis
Obesity
Obstruction of …
Pancreatitis
Parkinson's disease

Plague
Pulmonary edema
Pulmonary embolus due to deep venous thrombosis
Renal failure due to…
Reye's syndrome
Spontaneous hemorrhage due to …
Tuberculosis

Other

Non-human remains
Skeletal remains

Pending

Pending Anthropology
Pending Histology
Pending Investigation
Pending Receipt and Review of Medical Records
Pending Microbiology
Pending Neuropathology
Pending Odontology
Pending Other
Pending Police Report
Pending Radiology
Pending Toxicology

Suicide

Acute drug/mixed drug (type of drug(s)) intoxication
Asphyxia due to (suffocation, positional, etc.)
Aspiration of (foreign object)
Blunt force injuries of (head, chest, etc.)
Carbon monoxide poisoning
Drowning
Electrocution
Ethanol intoxication
Exsanguination due to…
Gunshot wound of …
Hanging OR Ligature hanging
Head and neck injuries
Hyperthermia due to …
Hypothermia due to exposure

Multiple blunt force injuries
Self-immolation
Smoke and soot inhalation
Stab wound
Subdural hematoma
Thermal injuries
Thermal injuries and smoke inhalation

Could Not Be Determined

Skeletal/mummified remains
Undetermined
Undetermined after autopsy and/or toxicology

APPENDIX D

EXAMPLES OF STANDARD LANGUAGE OF HOW INJURY OCCURRED BY MANNER OF DEATH

These phrases should satisfy the purposes of item 34 on death certificate in the majority of non-natural deaths, but is not an exhaustive list. In natural deaths, there is by definition no injury, and so this section should be left blank.

Accident

Accidental discharge of (firearm type)
Accidental ligature strangulation
Accident-specify
Bitten/mauled/stung/kicked by (name agent)
Choked on (identify item)
Contacted electrical current via (identify source of current)
Crushed/suffocated by (identify mechanism)
Cut self with (name agent)
Cyclist (explain circumstances briefly)
Cyclist struck by (motor vehicle type)
Drowned in (non-recreational water accidents)
Drowned while swimming (recreational and rescue attempts) in (Center Hill Lake, family pool)
Fall from (identify origin of fall and approximate distance of fall)
Fall from back of pickup
Fall from standing height
Farm or Industrial machinery accident
Fell/thrown from (riding animal)
Ingested alcohol
Ingested and/or injected illicit drug(s)
Ingested and/or injected prescription medications
Inhaled (Name of product/Name of toxic agent) (Substance abused)
Inhaled (Name of product; Name of toxic agent) (Substances inhaled accidentally)
Medical treatment
Pedestrian struck by …
Pilot of (aircraft type) that crashed
Poisoning (name agent)
Received blow/collided with …
Remained outdoors exposed to (cold, heat)
Restrained/Unrestrained/Unknown restraint driver of (auto/truck/motorcycle) in single vehicle collision

Restrained/Unrestrained/Unknown restraint driver of (auto/truck/motorcycle), struck by train
Restrained/Unrestrained/Unknown restraint driver of auto in collision with (other fixed object)
Restrained/Unrestrained/Unknown restraint driver of auto in collision with …(motor vehicle type OR object)
Restrained/Unrestrained/Unknown restraint driver of auto that left roadway
Helmeted/Unhelmeted/Unknown if helmeted driver of motorcycle (explain circumstances briefly)
Helmeted/Unhelmeted/Unknown if helmeted driver of motorcycle in collision with (motor vehicle type)
Restrained/Unrestrained/Unknown restraint driver of pickup in collision with (fixed object)
Restrained/Unrestrained/Unknown restraint driver of pickup in collision with (motor vehicle type)
Restrained/Unrestrained/Unknown restraint driver of pickup that left roadway
Restrained/Unrestrained/Unknown restraint driver of truck in collision with (other fixed object)
Restrained/Unrestrained/Unknown restraint driver of truck in collision with …(motor vehicle type OR object)
Restrained/Unrestrained/Unknown restraint driver of truck that left roadway
Restrained/Unrestrained/Unknown restraint passenger of (auto/truck/motorcycle) in single vehicle collision
Restrained/Unrestrained/Unknown restraint passenger in (aircraft type) that crashed
Restrained/Unrestrained/Unknown restraint passenger in (motor vehicle type) struck by train
Restrained/Unrestrained/Unknown restraint passenger in auto in collision with (other fixed object)
Restrained/Unrestrained/Unknown restraint passenger in auto in collision with …(motor vehicle type OR object)
Restrained/Unrestrained/Unknown restraint passenger in auto that left roadway
Restrained/Unrestrained/Unknown restraint passenger in pickup in collision with (fixed object)
Restrained/Unrestrained/Unknown restraint passenger in pickup in collision with (motor vehicle type)
Restrained/Unrestrained/Unknown restraint passenger in pickup that left roadway
Restrained/Unrestrained/Unknown restraint passenger in truck in collision with (other fixed object)
Restrained/Unrestrained/Unknown restraint passenger in truck in collision with …(motor vehicle type OR object)
Restrained/Unrestrained/Unknown restraint passenger in truck that left roadway
Helmeted/Unhelmeted/Unknown if helmeted passenger on motorcycle
Helmeted/Unhelmeted/Unknown if helmeted passenger on motorcycle in collision with (motor vehicle type)

Restrained/Unrestrained/Unknown restraint passenger who fell from moving (motor vehicle type)
Scalded by (name agent)
Struck by flying/falling (identify moving object)
Struck by lightning
Victim of (type of device) explosion
Victim of (house, car, brush, etc.) fire

Homicide

Assaulted by another person(s)
Beaten by assailant(s)
Ingested/injected/inhaled drugs/poisons
Neglect/Starvation
Pedestrian struck by (vehicle type)
Shot by other person(s) with firearm (specify type, if known)
Stabbed by another person
Strangled by another person
Victim of drowning
Victim of intentionally set fire

Suicide

As pedestrian stepped in front of (truck/car)
Burned self with
Driver of motor vehicle
Drowned self in (lake, swimming pool, etc.)
Hanged self
Ingested or injected medication
Ingested, injected, or inhaled non-prescription medication
Inhaled (vehicle exhaust, etc.)
Jumped from (building, bridge)
Shot self with firearm (type if known)
Stabbed self with …
Suffocated self with …

APPENDIX E

REPORTABLE DEATHS FOR HOSPITALS & NURSING HOMES FLYER

- PDF Attached.

APPENDIX F

REQUEST FOR MEDICAL RECORDS

- PDF Attached

REQUEST FOR MEDICAL RECORDS

Date: ME Case No:

ATTN: Release of Information Patient Information

Name:
DOB:
DOD:
SSN:

The Office of the Medical Examiner is currently investigating the death of the above-named decedent and hereby requests a copy of the decedent's medical records.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) at 45 C.F.R. § 164.512(g) permits release of protected health information without an authorization, subpoena, or court order to coroners and medical examiners acting within the scope of their duties.

Tenn. Code Ann. § 38-7-110(e) and § 38-7-117(a) also authorize post-mortem officials acting within their scope of duty to obtain by written request any medical or hospital records that pertain to a case under investigation.

Please _____the following records to
_____as soon as possible. Thank you for your time.

[ ]Autopsy Report
[ ]H&P and Discharge Summary
[ ]Operative Notes and/or Report
[ ]Progress Notes for (enter length of time requested)
[ ]Other: _____

Signed:

APPENDIX G

DONOR CONSENT FORM

- PDF Attached

PRESUMED IDENTIFICATION OF UNIDENTIFIED REMAINS

RFC: _____ Forensic Pathologist: _____

MDILog Case No: _____

Name: _____ Date of Birth: _____

Age: _____ Race: _____ Sex: _____

DONOR INFORMATION

Sample Provided By (Name): _____

Address: _____

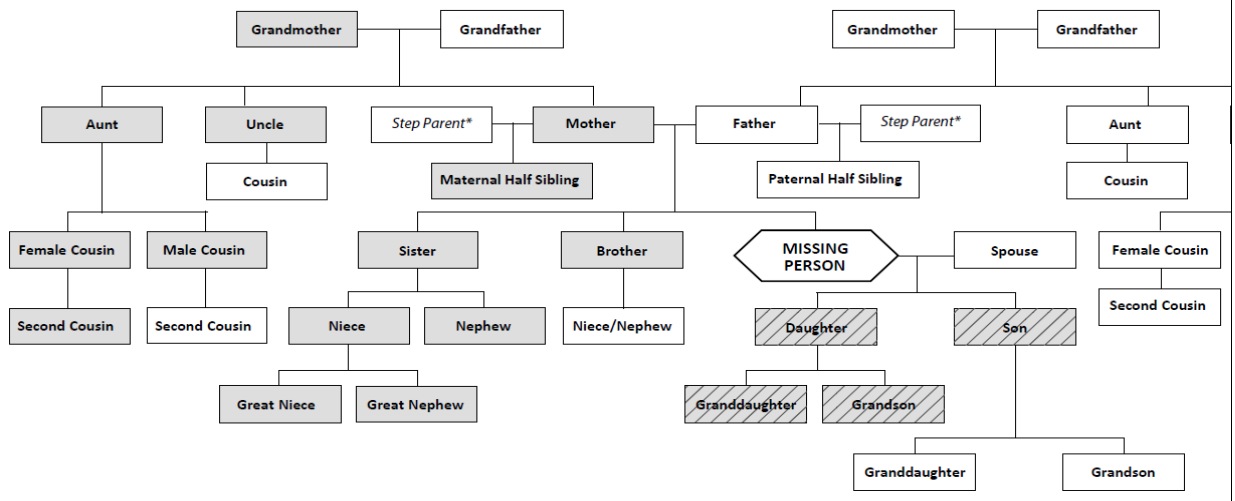
Date of Birth: _____ Race: _____ Sex: _____

Relationship to Unidentified: _____

☐ Maternally Related

☐ Paternally Related

CIRCLE BOX INDICATING RELATIONSHIP TO UNIDENTIFIED PERSON



DONOR CONSENT

I understand that the answers provided on this form are correct to the best of my knowledge. I fully understand that my answers are critical to the process of identifying the decedent.

I freely and voluntarily consent to provide my sample(s) for DNA analysis. I understand that I am not required or obligated to provide a DNA sample, and that my consent to have a DNA sample taken is knowingly and voluntarily made. I also understand that my DNA profile will be destroyed if my family member is positively identified.

I authorize (name of collector) _____ to collect this sample(s) for the purpose of identifying my family member. I have witnessed my sample(s) being collected, and a label with my name has been attached to each sample(s). The sample(s) were placed in the sample collection pouch and sealed.

Signature of Donor or Legal Guardian

X_____ Date: _____

TO BE COMPLETED BY COLLECTOR

I, on the date of _____ at ____:____ a.m./p.m. verified the identity of the individual who is providing the DNA sample. I collected a DNA sample(s) from this individual, attached a label with the donor's name to each sample(s), placed and sealed them in a sample collection pouch.

_____

Printed Name/Signature

APPENDIX H

AFFIDAVIT TO CHANGE DEATH CERTIFICATE

- PDF Attached

APPENDIX I

NON-CONTAGIOUS LETTER

- PDF Attached

APPENDIX J

SUDDEN UNEXPECTED INFANT DEATH INVESTIGATION (SUIDI) FORM

- PDF Attached

APPENDIX K

SUDDEN UNEXPLAINED CHILD DEATH (SUCD) INVESTIGATION REPORT

- PDF Attached

APPENDIX L

AUTOPSY REPORT REQUEST FORM

- PDF Attached