

# Autopsies in Child Death Cases

Updated September 2011

This compilation contains legislation, session laws, and codified statutes. All statutes, laws, and bills listed in this compilation have been signed by the pertinent governor and enacted into law. This report was compiled using Westlaw. This compilation is up-to-date as of the month it was created. However, please note we recommend checking both case law and current legislation for any possible modifications to the statutes listed below.

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## **ALABAMA**

### **ALA. CODE § 26-16-91 (2011). Definitions**

The following words and phrases have the following meanings unless the context clearly indicates otherwise:

- (1) Autopsy. An external and internal examination, medical history, and record review.
- (2) Child. A person who has not yet reached his or her eighteenth birthday.
- (3) Child deaths to be reviewed. Those deaths which are unexpected or unexplained.
- (4) Community. The people and area within the local team jurisdiction.
- (5) County. The county in which a deceased child resided prior to his or her death.
- (6) Investigation. In the context of child death, includes all of the following:

a. A postmortem examination which may be limited to an external examination or may include an autopsy.

b. An inquiry by law enforcement agencies having jurisdiction into the circumstances of the death, including a scene investigation and interview with the child's parents, guardians, or caretakers and the person who reported the child's death.

c. A review of information regarding the child from relevant agencies, professionals, and providers of medical care.

(7) Local team. A multidisciplinary, multiagency child death review team established for a county or judicial circuit pursuant to Section 26-16-96.

(8) Meeting. In-person meetings and conferences as well as those through telephone and other live electronic means. Individual participation in meetings through electronic conferencing may be authorized through the state team chairperson or designee. Local teams may not meet by electronic means.

(9) Person acting in a professional capacity. A health practitioner, law enforcement officer, employee of a local department of social services, undertaker, funeral home director or employee of a funeral home, or firefighter, who is acting in the course of his or her professional duties.

(10) Provider of medical care. Any health practitioner who personally provides, or a facility through which is provided, any medical evaluation or treatment, including dental and mental health evaluation or treatment.

(11) State team. The State Child Death Review Team.

(12) Unexpected/Unexplained. In referring to a child's death, includes all deaths which, prior to investigation, appear possibly to have been caused by trauma, suspicious or obscure circumstances, child abuse or neglect, or other agents or Sudden Infant Death Syndrome.

ALA. CODE § 26-16-92 (2011). State policy

It is the policy of this state that responding to unexpected/unexplained child deaths is a state and a community responsibility and must include an accurate and complete determination of the cause of death.

ALA. CODE § 26-16-93 (2011). State Child Death Review Team -- Created

(a) There is hereby created the State Child Death Review Team, referred to in this article as the state team.

(b) The state team shall be situated within the Alabama Department of Public Health for administrative and budgetary purposes.

(c) The state team shall be a multidisciplinary, multiagency review team, composed of 28 members, the first 7 of whom are ex officio. The ex officio members may designate representatives from their particular departments or offices to represent them on the state team who may vote and exercise all other prerogatives of the appointment. The members of the state team shall include all of the following:

(1) The Jefferson County Coroner, Medical Examiner.

(2) The State Health Officer who shall serve as chair.

(3) One member appointed by the Alabama Sheriff's Association.

(4) The Director of the Alabama Department of Forensic Sciences.

(5) The Commissioner of the Alabama Department of Human Resources.

(6) The Commissioner of the Alabama Department of Mental Health.

(7) The Director of the Alabama Department of Public Safety.

(8) A pediatrician with expertise in SIDS appointed by the Alabama Chapter, American Academy of Pediatrics.

(9) A health professional with expertise in child abuse and neglect appointed by the Alabama Department of Public Health.

(10) A family practice physician appointed by the Alabama Academy of Family Physicians.

(11) A pediatric pathologist appointed by the Alabama Department of Forensic Sciences.

(12) Eight private citizens appointed by the Governor.

- (13) A member of the clergy appointed by the Governor.
  - (14) A representative of the Alabama Coroner's Association.
  - (15) A representative of the Alabama Network of Children's Advocacy Centers.
  - (16) A representative of the Alabama Sheriff's Association.
  - (17) A representative of the Alabama District Attorney's Association.
  - (18) A specialist in pediatric emergency medicine appointed by the Alabama Medical Association.
  - (19) A representative of the Alabama Association of Chiefs of Police.
  - (20) Chair of the Senate Health Committee or his or her designee and the Chair of the House Health Committee or his or her designee.
- (d) Members who are not ex officio shall serve for a three-year term and shall not serve more than two consecutive terms. Terms for these members shall be staggered.
- (e) Staffing for the state team shall be provided through the Alabama Department of Public Health using funds appropriated for this article.
- (f) The initial meeting of the state team shall be held within 60 days of September 11, 1997. Meetings shall be held at least quarterly thereafter.
- (g) Fifteen members shall constitute a quorum for conducting all activities of the state team which may require a vote among the members. A simple majority of members present constituting a quorum shall be required for any affirmative vote.

**ALA. CODE § 26-16-94 (2011). State Child Death Review Team – Purposes; duties**

The purpose of the state team is to decrease the risk and incidence of unexpected/unexplained child injury and death by undertaking all of the following duties:

- (1) Identifying factors which make a child at risk for injury or death.

- (2) Collecting and sharing information among state team members and agencies which provide services to children and families or investigate child deaths.
- (3) Making suggestions and recommendations to appropriate participating agencies regarding improving coordination of services and investigations.
- (4) Identifying trends relevant to unexpected/unexplained child injury and death.
- (5) Reviewing reports from local child death teams and, upon request of a local team, individual cases of child deaths.
- (6) Providing training and written materials to the local teams to assist them in carrying out their duties. Such written materials shall include model protocols for the operation of the local teams.
- (7) Developing a protocol for child death investigations, and revising the protocol as needed. The protocol for child death investigations shall not include any activity that causes public scrutiny of the family circumstances surrounding the subject death.
- (8) Undertaking a study of the operations of local teams considering training needs and service gaps. If the state team determines that changes to any statute, regulation, or policy is needed to decrease the risk and incidence of child injury and death, it shall propose and recommend changes to such statute, regulation, or policy in its annual report.
- (9) Educating the public in Alabama regarding the incidence and causes of child injury and death and the public role in aiding in reducing the risk of such injuries and deaths. The state team shall enlist the support of civil, philanthropic, and public service organizations in its performance of its education duties.
- (10) Developing and implementing such procedures and policies as are necessary for its own operation.
- (11) Providing the Governor and the Legislature with an annual written report which shall include, but not be limited to, the state team's findings and recommendations for each of its duties; and providing copies of such report to the public.
- (12) Determining, by consent of state team members, what protocols should be followed by team members for providing data and/or information to the state team as a whole.
- (13) Examining confidentiality and access to information laws, regulations, and policies for agencies with responsibilities for children, including health, public welfare, education,



social services, mental health, and law enforcement agencies, and determining whether those laws, regulations, or policies impede the exchange of information necessary to reduce the risk of injury and death. If the state team determines that such laws, regulations, or policies do impede the necessary exchange of information, it shall take prompt steps to propose and recommend changes to the appropriate state agencies.

#### ALA. CODE § 26-16-95 (2011). Liability of team members

State and local team members shall be immune from any and all civil and criminal liability in connection with their good faith participation on the state or local team and all activities associated therewith, provided however, this immunity shall not be available in the event any state or local team member violates the provisions of confidentiality enumerated in this article.

#### ALA. CODE § 26-16-96 (2011). Local child death review teams

(a) There are hereby created local child death review teams.

(b) Each county of the state shall be included in a local multidisciplinary, multiagency child death review team's jurisdiction. The district attorney shall initiate the establishment of local teams by convening a meeting of potential team members within 60 days of September 11, 1997. In the absence of the initiation of a child death review team by the district attorney within 60 days of September 11, 1997, the local public health representative will initiate the first team meeting. During this meeting, participants shall recommend whether to establish a team for that county alone or to establish a team with and for the counties within that judicial circuit.

(c) The local team shall include, but not be limited to, all of the following members, the first five of whom are ex officio. The ex officio members may designate representatives from their particular departments or offices to represent them on the local team who may vote and exercise all other prerogatives of the appointment. The members of the local team include the following:

- (1) The county health officer.
- (2) The director of the county department of human resources.
- (3) The county district attorney.
- (4) The medical examiner.
- (5) The local coroner.

(6) An investigator with a local sheriff's department who is familiar with homicide investigation.

(7) An investigator with a local police department who is familiar with homicide investigation.

(8) A pediatrician, or if no pediatrician is available a primary care physician, appointed by the county medical society.

(9) A representative from a local child advocacy center, if one exists.

(d) The local team shall select a chair from among its members. The chair shall serve a term of three years and may serve more than one consecutive term.

(e) Members who are not ex officio shall serve for a three-year term and may succeed themselves but shall not serve more than two consecutive terms. Terms for these members shall be staggered.

(f) The initial meeting of the local team shall be held within 60 days of September 11, 1997.

(g) A quorum for conducting all activities shall be determined by the local team. A simple majority of members present constituting a quorum shall be required for any affirmative vote.

(h) The purpose of the local team is to decrease the incidence of unexpected/unexplained child injury and death by the following means:

(1) Identifying factors which make a child at risk of injury or death.

(2) Sharing information among the agencies which provide services to children and families or which investigate child deaths or provide services.

(3) Improving local investigations of unexpected/unexplained child deaths by participating agencies.

(4) Improving existing services and systems and assisting in the establishment of additional services and systems to fill in gaps in the community.

(5) Identifying trends relevant to unexpected/unexplained child injury and death.

(6) Educating the local public regarding the incidence and causes of child injury and death and the public role in aiding and reducing the risk of such injuries and deaths.

(i) To achieve its purpose, the local team shall perform all the following duties and functions:

(1) Establish and implement a protocol for the local team within two months of receipt of the model protocols from the state team as required by Section 26-16-93.

(2) Respond by recording all child deaths and reviewing individual unexpected/unexplained child deaths in accordance with protocols from the state team.

(3) Meet as deemed necessary by the local chair, but not less than annually, to review the status of unexpected/unexplained child death cases, propose recommendations for improving coordination of services and investigations between member agencies, and propose changes within the member agencies which shall reduce the risk and incidence of unexpected/unexplained child injury and death.

(4) Collect data as required for submittal to the state team.

(5) Provide reports to the state team following each team meeting which shall include data on child deaths, steps taken to improve coordination of services and investigations, steps taken to implement changes within member agencies, and advice on needed changes to law, policy, and practice which shall aid in reducing the risk and incidence of child injury and death.

(j) At a local team meeting to review unexpected/unexplained child deaths, information shall be provided as specified below, except where otherwise protected by statute, to carry out each of the following of the local team's purpose and duties:

(1) The providers of medical care, the physician representative, or the medical examiner, shall provide pertinent health and medical information regarding a child whose death is being reviewed by the local team.

(2) State, county, or local government agencies shall provide all of the following data on forms developed by the state team for reporting to local child death review teams:

a. Birth information for children who died at less than one year of age including confidential information collected for medical and health use.

b. Death information for children who have not reached their eighteenth birthday.

c. Law enforcement investigative data, medical examiner investigative data, parole and probation information, and records.

d. Medical care, including dental, mental, and prenatal health care.

e. Pertinent information from any social services agency that provided services to the child or family.

**ALA. CODE § 26-16-97 (2011). Meetings; disclosure of information; violation; penalties**

(a) Meetings of the state team and of local teams shall be closed to the public and not subject to the State Sunshine Law when the state team or local team is discussing a specific child death.

(b) Information identifying a deceased child, a family member, guardian or caretaker of a deceased child, or an alleged or suspected perpetrator of abuse or neglect upon a child, may not be disclosed during a meeting which is open to the public.

(c) Information regarding the involvement of any agency with the deceased child or family may not be disclosed during a public meeting.

(d) Nothing in this section shall be construed as preventing the state team or a local team from requesting the attendance at a team meeting of a person who has information relevant to the team's exercise of its purpose and duties.

(e) Any person who intentionally violates any portion of this section commits a Class C misdemeanor and shall be punished as prescribed by law.

Any person who violates the provisions of confidentiality in any proceedings conducted by either a local team or the state team shall be removed from the team in addition to any other penalty.

**ALA. CODE § 26-16-98 (2011). Confidentially of information and records**

(a) All information and records acquired by the state team or by a local team, in the exercise of its purpose and duties pursuant to this article, are confidential, exempt from disclosure under Section 41-13-1, and may only be disclosed as necessary to carry out the team's duties and purposes.

(b) Reports of the state team and of a local team which do not contain any information that would permit the identification of any person to be ascertained shall be public information.

(c) Except as necessary to carry out a team's purpose and duties, members of a team and persons attending a team meeting may not disclose what transpired at a meeting which is

not public under Section 26-16-97, nor shall they disclose any information the disclosure of which is prohibited by this section.

(d) Members of a team, persons attending a team meeting, and persons who present information to a team may release information to such government agencies as is necessary for the purpose of carrying out assigned team duties.

(e) Information, documents, and records of the state team or of a local team are not subject to subpoena, discovery, or introduction into evidence in any civil or criminal proceeding, except that information, documents, and records otherwise available from other sources are not immune from subpoena, discovery, or introduction into evidence through those sources solely because they were presented during proceedings of the team or are maintained by a team.

(f) Moreover, notwithstanding subsections (a) and (b), those criminal records, court records, and other records that have been open to public inspection before September 11, 1997, shall remain open.

#### ALA. CODE § 26-16-99 (2011). Duties of Coroner/Medical Examiner

The duties of the coroner/medical examiner shall include the following:

(1) Except in locations where a county medical examiner has jurisdiction, the coroner or a person acting in a professional capacity shall report the death of a child by telecommunications to the medical examiner or his or her representative as soon as possible upon discovery.

(2) Upon receipt of a report of a child death, the county medical examiner or state medical examiner shall determine whether the death appears to be unexpected/unexplained. If the death appears to be unexpected/unexplained, the county medical examiner or state medical examiner shall commence an investigation of the death consisting of a postmortem examination conducted by a state or county medical examiner. Upon the recommendation of the state medical examiner, with authorization from a district attorney, an autopsy may be conducted. A county medical examiner may conduct an autopsy at his or her discretion as authorized by existing statutes. This section should not be interpreted as mandating an autopsy. In a case where an autopsy is not performed, the postmortem examination shall consist of an external examination.

## **ALASKA**

#### ALASKA STAT. § 12.65.015. (2011). Duties of Coroner/Medical Examiner

(a) The commissioner of health and social services shall appoint a state medical examiner to perform the duties set out in AS 12.65.015--12.65.025. The commissioner shall also appoint a deputy medical examiner, and may appoint assistant medical examiners, to perform or assist the state medical examiner in performing these duties. To be eligible for the position of medical examiner, deputy medical examiner, or assistant medical examiner, a person must be a physician licensed to practice in this state or, if the physician is licensed in another jurisdiction, the physician must be employed by the state or by an agency of the United States government within the state. The state medical examiner, deputy medical examiner, and assistant medical examiners are in the exempt service under AS 39.25.110.

(b) The state medical examiner and the deputy medical examiner must be physicians licensed to practice in the state who have education and experience in forensic pathology.

(c) The state medical examiner and deputy medical examiner shall perform the duties assigned to the medical examiner and deputy medical examiner under AS 12.65.020 and regulations implementing that section, and other duties as assigned by the commissioner of health and social services.

(d) The state medical examiner may, through contracts for services, appoint local, regional, and district medical examiners throughout the state to perform or assist in performing the duties assigned to the state medical examiner. To be eligible for appointment as a local, regional, or district medical examiner, a person must be a physician licensed to practice in this state or, if the physician is licensed in another jurisdiction, the physician must be employed by the state or by an agency of the United States government within the state. An appointment under this subsection may be for a term of up to two years.

(e) The state medical examiner shall facilitate the formation of local, regional, or district child fatality review teams to assist local, regional, and district medical examiners in determining the cause and manner of deaths of children under 18 years of age. If a team is formed under this subsection, the team shall have the same access to information, confidentiality requirements, and immunity as provided to the state child fatality review team under AS 12.65.140. A meeting of a team formed under this subsection is closed to the public and not subject to the provisions of AS 44.62.310 - 44.62.319 (Open Meetings Act). A review by a local, regional, or district child fatality review team does not relieve the state child fatality review team under AS 12.65.120 of the responsibility for reviewing a death under AS 12.65.130. A person on a local, regional, or district child fatality review team is not eligible to receive compensation from the state for service on the team, but is eligible for travel expenses and per diem from the Department of Health and Social Services under AS 39.20.180. A person on a team formed under this subsection serves at the pleasure of the state medical examiner.

ALASKA STAT. § 12.65.120. (2011). State child fatality review team

(a) The state child fatality review team is established in the Department of Health and Social Services to assist the state medical examiner. The team is composed of

(1) the following persons, or that person's designee:

(A) the state medical examiner;

(B) a state prosecutor with experience in homicide prosecutions, appointed by the attorney general;

(C) an investigator with the state troopers who has experience in conducting investigations of homicide, child abuse, or child neglect, appointed by the commissioner of public safety;

(D) a social worker with the Department of Health and Social Services who has experience in conducting investigations of child abuse and neglect, appointed by the commissioner of health and social services;

(2) the following persons, or that person's designee, appointed by the commissioner of health and social services:

(A) a physician licensed under AS 08.64 who

(i) specializes in neonatology or perinatology; or

(ii) is certified by the American Board of Pediatrics;

(B) a municipal law enforcement officer with experience in conducting investigations of homicide, child abuse, or child neglect;

(C) other persons, including educators, whose experience and expertise would, as determined by the commissioner of health and social services, contribute to the effectiveness of the team.

(b) A team member is not eligible to receive compensation from the state for service on the team. A member appointed under (a)(2) of this section

(1) is eligible for travel expenses and per diem from the Department of Health and Social Services under AS 39.20.180; and

(2) serves at the pleasure of the commissioner of health and social services.

(c) In addition to the persons specified in (a) of this section, the team may invite a person to participate as a member of the team if the person has expertise that would be helpful to the team in a review of a specific death. A person participating under this subsection is

eligible only for travel expenses and per diem from the Department of Health and Social Services under AS 39.20.180.

(d) The state medical examiner serves as chair of the team.

ALASKA STAT. § 12.65.130. (2011). State child fatality review team

(a) The state child fatality review team shall

(1) assist the state medical examiner in determining the cause and manner of the deaths in this state of children under 18 years of age;

(2) unless the child's death is currently being investigated by a law enforcement agency, review a report of a death of a child within 48 hours of the report being received by the medical examiner if

(A) the death is of a child under 10 years of age;

(B) the deceased child, a sibling, or a member of the deceased child's household

(i) is in the legal or physical custody of the state under AS 47 or under similar custody of another state or political subdivision of a state; or

(ii) has been the subject of a report of harm under AS 47.17 or a child abuse or neglect investigation by the Department of Health and Social Services or by a similar child protective service in this or another state;

(C) a protective order under AS 18.66.100 or 18.66.110 has been in effect during the previous year in which the petitioner or respondent was a member of the deceased child's immediate family or household; or

(D) the child's death occurred in a mental health institution, mental health treatment facility, foster home, or other residential or child care facility, including a day care facility;

(3) review records concerning

(A) abuse or neglect of the deceased child or another child in the deceased child's household;

(B) the criminal history or juvenile delinquency of a person who may have caused the death of the child and of persons in the deceased child's household; and

(C) a history of domestic violence involving a person who may have caused the death of the child or involving persons in the deceased child's household, including records in the



central registry of protective orders under AS 18.65.540;

(4) if insufficient information exists to adequately determine the cause and manner of death, recommend to the state medical examiner that additional information be obtained under AS 12.65.020; and

(5) if a local, regional, or district child fatality review team has not been appointed under AS 12.65.015 or is not available, be available to provide recommendations, suggestions, and advice to state or municipal law enforcement or social service agencies in the investigation of deaths of children.

(b) The state child fatality review team may

(1) collect data and analyze and interpret information regarding deaths of children in this state;

(2) develop state and local data bases on deaths of children in this state;

(3) develop a model protocol for the investigation of deaths of children; and

(4) periodically issue reports to the public containing statistical data and other information that does not violate federal or state law concerning confidentiality of the children and their families involved in the reviews; these reports may include

(A) identification of trends, patterns, and risk factors in deaths of the children;

(B) analyses of the incidence and causes of deaths of children in this state;

(C) recommendations for improving the coordination of government services and investigations; and

(D) recommendations for prevention of future deaths of children

**ALASKA STAT. § 12.65.140. (2011). Records; information; meetings; confidentiality; immunity**

(a) The state child fatality review team and its members shall have access to all information and records to which the state medical examiner has access under this chapter. The state child fatality review team and its members shall maintain the confidentiality of information and records concerning deaths under review, except when disclosures may be necessary to enable the team to carry out its duties under this chapter. However, the team and its members may not disclose a record that is confidential under federal or state law.

(b) Except for public reports issued by the team, records and other information collected by the team or a member of the team related to duties under this chapter are confidential and not subject to public disclosure under AS 40.25.100--40.25.295.

(c) Meetings of the state child fatality review team are closed to the public and are not subject to the provisions of AS 44.62.310 - 44.62.319 (Open Meetings Act).

(d) The determinations, conclusions, and recommendations of the state child fatality review team, or its members, are not admissible in a civil or criminal proceeding. Members may not be compelled to disclose their determinations, conclusions, recommendations, discussions, or thought processes through discovery or testimony in any civil or criminal proceeding. Records and information collected by the state child fatality review team are not subject to discovery or subpoena in connection with a civil or criminal proceeding.

(e) Notwithstanding (d) of this section, the state medical examiner may testify in a civil or criminal proceeding even though the death was reviewed by the state child fatality review team under AS 12.65.130 and information received from the review formed a basis of the state medical examiner's testimony.

(f) A person who is a member or an employee of, or who furnishes services to or advises, the state child fatality review team is not liable for damages or other relief in an action brought by reason of the performance of a duty, a function, or an activity of the review team.

## **ARIZONA**

ARIZ. REV. STAT. § 11-597 (2011). Autopsies; reports; exemption from liability

**A.** The county medical examiner or alternate medical examiner shall conduct a death investigation to determine whether or not the public interest requires an external examination, autopsy or other special investigation.

**B.** An external examination or autopsy is not required for deaths due to natural diseases that occur during surgical or anesthetic procedures unless the medical examiner or alternate medical examiner determines that an external examination or autopsy is necessary.

**C.** In the determination of the need for an autopsy, the county medical examiner or alternate medical examiner may consider the request for an autopsy made by private persons or public officials. If the county attorney or a superior court judge of the county

where the death occurred requests an autopsy, the county medical examiner shall perform the autopsy, or, in the case of an alternate medical examiner, an autopsy shall be performed by a forensic pathologist.

**D.** A forensic pathologist shall perform an autopsy in cases of sudden and unexplained infant death in accordance with protocols adopted by the director of the department of health services. If the medical examiner or forensic pathologist determines that the infant died of sudden infant death syndrome, the medical examiner or forensic pathologist shall notify the department of health services. The medical examiner or forensic pathologist may take tissue samples for diagnostic purposes.

**E.** If an autopsy is performed, a full record or report of the facts developed by the autopsy in the findings of the person performing the autopsy shall be properly made and filed in the office of the county medical examiner or the board of supervisors. If the person performing the autopsy determines that the report should be forwarded to the county where the death occurred or the county in which any injury contributing to or causing the death was sustained, the report shall be forwarded to the county attorney.

**F.** A county attorney may request and upon request shall receive from the county medical examiner or alternate medical examiner a copy of the report on any autopsy performed.

**G.** The county medical examiner or alternate medical examiner may perform other tests deemed necessary to determine identity and the cause and manner of death and may retain tissues, specimens and other biological materials for subsequent examination.

**H.** When an autopsy or other tests are performed by a forensic pathologist, no cause of action shall lie against the physician or any other person for requesting the autopsy, for participating in the autopsy or for retaining specimens or tissues.

**ARIZ. REV. STAT. § 36-3501 (2011). Child fatality review teams; membership; duties**

**A.** The child fatality review team is established in the department of health services. The team is composed of the head of the following departments, agencies, councils or associations, or that person's designee:

1. Attorney general.
2. Office of women's and children's health in the department of health services.
3. Office of planning and health status monitoring in the department of health services.

4. Division of behavioral health in the department of health services.
5. Division of developmental disabilities in the department of economic security.
6. Division of children and family services in the department of economic security.
7. Governor's office for children.
8. Administrative office of the courts.
9. Parent assistance office of the supreme court.
10. Department of juvenile corrections.
11. Arizona chapter of a national pediatric society.

**B.** The director of the department of health services shall appoint the following members to serve staggered three year terms:

1. A medical examiner who is a forensic pathologist.
2. A maternal and child health specialist involved with the treatment of native Americans.
3. A representative of a private nonprofit organization of tribal governments in this state.
4. A representative of the Navajo tribe.
5. A representative of the United States military family advocacy program.
6. A representative of the Arizona sudden infant death advisory council.
7. A representative of a statewide prosecuting attorneys advisory council.
8. A representative of a statewide law enforcement officers advisory council who is experienced in child homicide investigations.
9. A representative of an association of county health officers.
10. A child advocate who is not employed by or an officer of this state or a political subdivision of this state.
11. A public member. If local teams are formed pursuant to this article, the director of the department of health services shall select this member from one of those local teams.

**C. The team shall:**

1. Develop a child fatalities data collection system.
2. Provide training to cooperating agencies, individuals and local child fatality review teams on the use of the child fatalities data system.
3. Conduct an annual statistical report on the incidence and causes of child fatalities in this state during the past fiscal year and submit a copy of this report, including its recommendations for action, to the governor, the president of the senate and the speaker of the house of representatives on or before November 15 of each year.
4. Encourage and assist in the development of local child fatality review teams.
5. Develop standards and protocols for local child fatality review teams and provide training and technical assistance to these teams.
6. Develop protocols for child fatality investigations, including protocols for law enforcement agencies, prosecutors, medical examiners, health care facilities and social service agencies.
7. Study the adequacy of statutes, ordinances, rules, training and services to determine what changes are needed to decrease the incidence of preventable child fatalities and, as appropriate, take steps to implement these changes.
8. Provide case consultation on individual cases to local teams if requested.
9. Educate the public regarding the incidence and causes of child fatalities as well as the public's role in preventing these deaths.
10. Designate a team chairperson.
11. Develop and distribute an informational brochure which describes the purpose, function and authority of a team. The brochure shall be available at the offices of the department of health services.
12. Evaluate the incidence and causes of maternal fatalities associated with pregnancy in this state. For the purposes of this paragraph, "maternal fatalities associated with pregnancy" means the death of a woman while she is pregnant or within one year after the end of her pregnancy.

**D.** Team members are not eligible to receive compensation, but members appointed pursuant to subsection B are eligible for reimbursement of expenses pursuant to title 38, chapter 4, article 2. [FN1]

**E.** The department of health services shall provide professional and administrative support to the team.

**F.** Notwithstanding subsections C and D, this section shall not be construed to require expenditures above the revenue available from the child fatality review fund.

**ARIZ. REV. STAT. § 36-3502 (2011). Local teams; membership; duties**

**A.** If local child fatality teams are organized, they shall abide by the standards and protocol for local child fatality review teams developed by the state team and must have prior authorization from the state team to conduct fatality reviews. Local teams shall be composed of the head of the following departments, agencies or associations, or that person's designee:

1. County medical examiner.
2. Child protective services office of the department of economic security.
3. County health department.

**B.** The chairperson of the state child fatality review team shall appoint the following members of the local team:

1. A domestic violence specialist.
2. A psychiatrist or psychologist licensed in this state.
3. A pediatrician certified by the American board of pediatrics or a family practice physician certified by the American board of family practice. The pediatrician or family practice physician shall also be licensed in this state.
4. A person from a local law enforcement agency.
5. A person from a local prosecutors office.
6. A parent.

**C.** If local child fatality teams are authorized, they shall:

1. Designate a team chairperson who shall review the death certificates of all children who die within the team's jurisdiction and call meetings of the team when necessary.
2. Assist the state team in collecting data on child fatalities.
3. Submit written reports to the state team as directed by that team. These reports shall include nonidentifying information on individual cases and steps taken by the local team to implement necessary changes and improve the coordination of services and investigations.

**ARIZ. REV. STAT. § 36-3503 (2011). Access to information; confidentiality; violation; classification**

**A.** On request of the chairperson of a state or local team and as necessary to carry out the team's duties, the chairperson shall be provided within five days excluding weekends and holidays with access to information and records regarding a child whose death is being reviewed by the team, or information and records regarding the child's family and records of a maternal fatality associated with pregnancy pursuant to § 36-3501, subsection C:

1. From a provider of medical, dental or mental health care.
2. From this state or a political subdivision of this state that might assist a team to review a child fatality.

**B.** A law enforcement agency with the approval of the prosecuting attorney may withhold investigative records that might interfere with a pending criminal investigation or prosecution.

**C.** The director of the department of health services or the director's designee may apply to the superior court for a subpoena as necessary to compel the production of books, records, documents and other evidence related to a child fatality or a maternal fatality associated with pregnancy investigation. Subpoenas issued shall be served and, on application to the court by the director or the director's designee, enforced in the manner provided by law for the service and enforcement of subpoenas. A law enforcement agency is not required to produce the information requested under the subpoena if the subpoenaed evidence relates to a pending criminal investigation or prosecution. All records shall be returned to the agency or organization on completion of the review. Written reports or records containing identifying information shall not be kept by the team.

**D.** All information and records acquired by the state team or any local team are confidential and are not subject to subpoena, discovery or introduction into evidence in any civil or criminal proceedings, except that information, documents and records otherwise available from other sources are not immune from subpoena, discovery or

introduction into evidence through those sources solely because they were presented to or reviewed by a team.

**E.** Members of a team, persons attending a team meeting and persons who present information to a team may not be questioned in any civil or criminal proceedings regarding information presented in or opinions formed as a result of a meeting. This subsection does not prevent a person from testifying to information that is obtained independently of the team or that is public information.

**F.** A member of the state or a local child fatality review team shall not contact, interview or obtain information by request or subpoena from a member of a deceased child's family, except that a member of the state or a local child fatality review team who is otherwise a public officer or employee may contact, interview or obtain information from a family member, if necessary, as part of the public officer's or employee's other official duties.

**G.** State and local team meetings are closed to the public and are not subject to title 38, chapter 3, article 3.1 [FN1] if the team is reviewing individual child fatality cases or cases of maternal fatalities associated with pregnancy. All other team meetings are open to the public.

**H.** A person who violates the confidentiality requirements of this section is guilty of a class 2 misdemeanor.

#### **ARIZ. REV. STAT. § 36-3504 (2011). Child fatality review fund**

**A.** The child fatality review fund is established consisting of appropriations, monies received pursuant to § 36-342, subsection E and gifts, grants and donations made to the department of health services to implement subsection B of this section. The department of health services shall administer the fund. The department shall deposit, pursuant to §§ 35-146 and 35-147, all monies it receives in the fund.

**B.** The department of health services shall use fund monies to staff the state child fatality review team and to train and support local child fatality review teams.

**C.** Monies spent for the purposes specified in subsection B of this section are subject to legislative appropriation. Any fee revenue collected in excess of one hundred thousand dollars in any fiscal year is appropriated from the child fatality review fund to the child abuse prevention fund established pursuant to § 8-550.01, subsection A, to be used for healthy start programs.

## **ARKANSAS**



ARK. CODE ANN. § 12-12-315 (2008). Notification of certain deaths.

(a)(1) The county coroner, prosecuting attorney, and either the county sheriff or the chief of police of the municipality in which the death of a human being occurs shall be promptly notified by any physician, law enforcement officer, undertaker or embalmer, jailer, or coroner or by any other person present or with knowledge of the death if:

(A) The death appears to be caused by violence or appears to be the result of a homicide or a suicide or to be accidental;

(B) The death appears to be the result of the presence of drugs or poisons in the body;

(C) The death appears to be a result of a motor vehicle accident, or the body was found in or near a roadway or railroad;

(D) The death appears to be a result of a motor vehicle accident and there is no obvious trauma to the body;

(E) The death occurs while the person is in a state mental institution or hospital and there is no previous medical history to explain the death, or while the person is in police custody or jail other than a jail operated by the Department of Correction;

(F) The death appears to be the result of a fire or an explosion;

(G) The death of a minor child appears to indicate child abuse prior to death;

(H) Human skeletal remains are recovered or an unidentified deceased person is discovered;

(I) Postmortem decomposition exists to the extent that an external examination of the corpse cannot rule out injury, or in which the circumstances of death cannot rule out the commission of a crime;

(J) The death appears to be the result of drowning;

(K) The death is of an infant or a minor child under eighteen (18) years of age;

(L) The manner of death appears to be other than natural;

(M) The death is sudden and unexplained;

(N) The death occurs at a work site;

(O) The death is due to a criminal abortion;

(P) The death is of a person where a physician was not in attendance within thirty-six (36) hours preceding death, or, in prediagnosed terminal or bedfast cases, within thirty (30) days;

(Q) A person is admitted to a hospital emergency room unconscious and is unresponsive, with cardiopulmonary resuscitative measures being performed, and dies within twenty-four (24) hours of admission without regaining consciousness or responsiveness, unless a physician was in attendance within thirty-six (36) hours preceding presentation to the hospital, or, in cases in which the decedent had a prediagnosed terminal or bedfast condition, unless a physician was in attendance within thirty (30) days preceding presentation to the hospital;

(R) The death occurs in the home; or

(S)(i) The death poses a potential threat to public health or safety.

(ii) Upon receiving notice of a death that poses a potential threat to public health or safety, the county coroner shall immediately notify the Department of Health.

(2) Nothing in this section shall be construed to require an investigation, autopsy, or inquest in any case in which death occurred without medical attendance solely because the deceased was under treatment by prayer or spiritual means in accordance with the tenets and practices of a well-recognized church or religious denomination.

(b) With regard to any death in a correctional facility, the county coroner and the State Medical Examiner shall be notified, and when previous medical history does not exist to explain the death, the Department of Arkansas State Police shall be notified.

(c) A violation of the provisions of this section is a Class A misdemeanor.

**ARK. CODE ANN. § 12-12-318 (2008). Cause of death; examinations; investigations or post-mortems**

(a)(1) When death occurs in such a manner or under such circumstances as described in § 12-12-315, the State Crime Laboratory shall have the power and authority to perform such functions and duties as may be provided by this subchapter.

(2)(A) The laboratory shall make examinations, investigations, or perform postmortem examinations to determine the cause of death as the Executive Director of the State Crime

Laboratory or his or her staff deems necessary or as may be requested by the:

- (i) County coroner of the county in which death occurs or is discovered;
- (ii) Prosecuting attorney of the jurisdiction in which death occurs or is discovered;
- (iii) Prosecuting attorney of the jurisdiction in which death occurs or is discovered; [FN1]
- (iv) Chief of police of the city in which death occurs or is discovered;
- (v) Board of Corrections or its designee, or the Director of the Department of Correction or his or her designee if the person was in the care, custody, or control of the Department of Correction at the time of death; or
- (vi) Director of the Department of Arkansas State Police or his or her designee.

(B) Deputies of elected officers enumerated in subdivision (a)(2)(A) of this section shall have no authority to request a postmortem examination by the laboratory.

(b)(1) In cases of sudden death in children between the ages of one (1) year and six (6) years with no previous major medical health problems, the State Medical Examiner, on a case-by-case basis, may delegate authority to the Arkansas Children's Hospital to perform postmortem examinations to determine the cause of death.

(2)(A) Should any such postmortem examination determine that death occurred from foul play or a criminal act, the hospital will immediately notify the chief law enforcement officer of the jurisdiction in which the death occurred and the examiner.

(B) In addition, the examiner will be responsible for developing guidelines to assure that proper evidentiary procedures are followed.

(3) For purposes of this section, the hospital's staff pediatric pathologist, meeting the criteria prescribed in § 12-12-307, shall be considered assistant medical examiner and, notwithstanding any other provisions in this section, may perform postmortem examinations as directed by a duly constituted authority.

(c) Postmortem examinations or investigations authorized in this section may be conducted without consent of any person.

(d) The executive director and his or her staff shall not, as a part of their official duties, perform any postmortem examination at the request of any private citizen or any public official other than those enumerated in this section.

(e) The provisions of this section shall supersede any and all other laws relating to the power and authority of the executive director or his or her staff, including the examiner,

to conduct examinations, investigations, or postmortem examinations.

(f)(1) The executive director shall have the final authority on any ruling of manner of death which may become a matter of dispute between those persons authorized by this section to request a post mortem examination as described in § 12-12-315 and the examiner or his or her associates.

(2) The executive director shall use any and all material accumulated by the laboratory, interview all parties necessary, and consult with any medical authority necessary for him or her to make his or her decision as to the manner of death, and his or her ruling shall be final and binding as that ruling affects any documents generated and signed by any employee of the laboratory relating to manner of death.

(3) This subsection and the executive director's decision in no way affects or prohibits any person or agency to seek any other relief that may be available through legal channels.

## CALIFORNIA

### CAL. PENAL CODE § 11174.2 (2011). Interagency child death teams; Autopsy protocols; Records exempt from disclosure; Report

(a) Each county may establish an interagency child death review team to assist local agencies in identifying and reviewing suspicious child deaths and facilitating communication among persons who perform autopsies and the various persons and agencies involved in child abuse or neglect cases. Interagency child death review teams have been used successfully to ensure that incidents of child abuse or neglect are recognized and other siblings and nonoffending family members receive the appropriate services in cases where a child has expired.

(b) Each county may develop a protocol that may be used as a guideline by persons performing autopsies on children to assist coroners and other persons who perform autopsies in the identification of child abuse or neglect, in the determination of whether child abuse or neglect contributed to death or whether child abuse or neglect had occurred prior to but was not the actual cause of death, and in the proper written reporting procedures for child abuse or neglect, including the designation of the cause and mode of death.

(c) In developing an interagency child death review team and an autopsy protocol, each county, working in consultation with local members of the California State Coroner's

Association and county child abuse prevention coordinating councils, may solicit suggestions and final comments from persons, including, but not limited to, the following:

- (1) Experts in the field of forensic pathology.
  - (2) Pediatricians with expertise in child abuse.
  - (3) Coroners and medical examiners.
  - (4) Criminologists.
  - (5) District attorneys.
  - (6) Child protective services staff.
  - (7) Law enforcement personnel.
  - (8) Representatives of local agencies which are involved with child abuse or neglect reporting.
  - (9) County health department staff who deals with children's health issues.
  - (10) Local professional associations of persons described in paragraphs (1) to (9), inclusive.
- (d) Records exempt from disclosure to third parties pursuant to state or federal law shall remain exempt from disclosure when they are in the possession of a child death review team.
- (e)(1) No less than once each year, each child death review team shall make available to the public findings, conclusions and recommendations of the team, including aggregate statistical data on the incidences and causes of child deaths.
- (2) In its report, the child death review team shall withhold the last name of the child that is subject to a review or the name of the deceased child's siblings unless the name has been publicly disclosed or is required to be disclosed by state law, federal law, or court order.

CAL. PENAL CODE § 11174.33 (2011). Interagency child death team protocol

Subject to available funding, the Attorney General, working with the California Consortium of Child Abuse Councils, shall develop a protocol for the development and implementation of interagency child death teams for use by counties, which shall include relevant procedures for both urban and rural counties. The protocol shall be designed to facilitate communication among persons who perform autopsies and the various persons and agencies involved in child abuse or neglect cases so that incidents of child abuse or neglect are recognized and other siblings and nonoffending family members receive the appropriate services in cases where a child has expired. The protocol shall be completed on or before January 1, 1991.

**CAL. PENAL CODE § 11174.34 (2011). Coordination and integration of state and local efforts; sharing of data and other information; California State Child Death Review Council**

(a)(1) The purpose of this section shall be to coordinate and integrate state and local efforts to address fatal child abuse or neglect, and to create a body of information to prevent child deaths.

(2) It is the intent of the Legislature that the California State Child Death Review Council, the Department of Justice, the State Department of Social Services, the State Department of Health Services, and state and local child death review teams shall share data and other information necessary from the Department of Justice Child Abuse Central Index and Supplemental Homicide File, the State Department of Health Services Vital Statistics and the Department of Social Services Child Welfare Services/Case Management System files to establish accurate information on the nature and extent of child abuse- or neglect-related fatalities in California as those documents relate to child fatality cases. Further, it is the intent of the Legislature to ensure that records of child abuse- or neglect-related fatalities are entered into the State Department of Social Services, Child Welfare Services/Case Management System. It is also the intent that training and technical assistance be provided to child death review teams and professionals in the child protection system regarding multiagency case review.

(b)(1) It shall be the duty of the California State Child Death Review Council to oversee the statewide coordination and integration of state and local efforts to address fatal child abuse or neglect and to create a body of information to prevent child deaths. The Department of Justice, the State Department of Social Services, the State Department of Health Services, the California Coroner's Association, the County Welfare Directors Association, Prevent Child Abuse California, the California Homicide Investigators Association, the California Emergency Management Agency, the Inter-Agency Council on Child Abuse and Neglect/National Center on Child Fatality Review, the California Conference of Local Health Officers, the California Conference of Local Directors of Maternal, Child, and Adolescent Health, the California Conference of Local Health

Department Nursing Directors, the California District Attorneys Association, and at least three regional representatives, chosen by the other members of the council, working collaboratively for the purposes of this section, shall be known as the California State Child Death Review Council. The council shall select a chairperson or cochairpersons from the members.

(2) The Department of Justice is hereby authorized to carry out the purposes of this section by coordinating council activities and working collaboratively with the agencies and organizations in paragraph (1), and may consult with other representatives of other agencies and private organizations, to help accomplish the purpose of this section.

(c) Meetings of the agencies and organizations involved shall be convened by a representative of the Department of Justice. All meetings convened between the Department of Justice and any organizations required to carry out the purpose of this section shall take place in this state. There shall be a minimum of four meetings per calendar year.

(d) To accomplish the purpose of this section, the Department of Justice and agencies and organizations involved shall engage in the following activities:

(1) Analyze and interpret state and local data on child death in an annual report to be submitted to local child death review teams with copies to the Governor and the Legislature, no later than July 1 each year. Copies of the report shall also be distributed to public officials in the state who deal with child abuse issues and to those agencies responsible for child death investigation in each county. The report shall contain, but not be limited to, information provided by state agencies and the county child death review teams for the preceding year.

The state data shall include the Department of Justice Child Abuse Central Index and Supplemental Homicide File, the State Department of Health Services Vital Statistics, and the State Department of Social Services Child Welfare Services/Case Management System.

(2) In conjunction with the California Emergency Management Agency, coordinate statewide and local training for county death review teams and the members of the teams, including, but not limited to, training in the application of the interagency child death investigation protocols and procedures established under Sections 11166.7 and 11166.8 to identify child deaths associated with abuse or neglect.

(e) The State Department of Health Services, in collaboration with the California State Child Death Review Council, shall design, test and implement a statewide child abuse or neglect fatality tracking system incorporating information collected by local child death review teams. The department shall:

(1) Establish a minimum case selection criteria and review protocols of local child death review teams.

(2) Develop a standard child death review form with a minimum core set of data elements to be used by local child death review teams, and collect and analyze that data.

(3) Establish procedural safeguards in order to maintain appropriate confidentiality and integrity of the data.

(4) Conduct annual reviews to reconcile data reported to the State Department of Health Services Vital Statistics, Department of Justice Homicide Files and Child Abuse Central Index, and the State Department of Social Services Child Welfare Services/Case Management System data systems, with data provided from local child death review teams.

(5) Provide technical assistance to local child death review teams in implementing and maintaining the tracking system.

(6) This subdivision shall become operative on July 1, 2000, and shall be implemented only to the extent that funds are appropriated for its purposes in the Budget Act.

(f) Local child death review teams shall participate in a statewide child abuse or neglect fatalities monitoring system by:

(1) Meeting the minimum standard protocols set forth by the State Department of Health Services in collaboration with the California State Child Death Review Council.

(2) Using the standard data form to submit information on child abuse or neglect fatalities in a timely manner established by the State Department of Health Services.

(g) The California State Child Death Review Council shall monitor the implementation of the monitoring system and incorporate the results and findings of the system and review into an annual report.

(h) The Department of Justice shall direct the creation, maintenance, updating, and distribution electronically and by paper, of a statewide child death review team directory, which shall contain the names of the members of the agencies and private organizations participating under this section, and the members of local child death review teams and local liaisons to those teams. The department shall work in collaboration with members of the California State Child Death Review Council to develop a directory of professional experts, resources, and information from relevant agencies and organizations and local child death review teams, and to facilitate regional working relationships among teams. The Department of Justice shall maintain and update these directories annually.



(i) The agencies or private organizations participating under this section shall participate without reimbursement from the state. Costs incurred by participants for travel or per diem shall be borne by the participant agency or organization. The participants shall be responsible for collecting and compiling information to be included in the annual report. The Department of Justice shall be responsible for printing and distributing the annual report using available funds and existing resources.

(j) The California Emergency Management Agency, in coordination with the State Department of Social Services, the Department of Justice, and the California State Child Death Review Council shall contract with state or nationally recognized organizations in the area of child death review to conduct statewide training and technical assistance for local child death review teams and relevant organizations, develop standardized definitions for fatal child abuse or neglect, develop protocols for the investigation of fatal child abuse or neglect, and address relevant issues such as grief and mourning, data collection, training for medical personnel in the identification of child abuse or neglect fatalities, domestic violence fatality review, and other related topics and programs. The provisions of this subdivision shall only be implemented to the extent that the agency can absorb the costs of implementation within its current funding, or to the extent that funds are appropriated for its purposes in the Budget Act.

(k) Law enforcement and child welfare agencies shall cross-report all cases of child death suspected to be related to child abuse or neglect whether or not the deceased child has any known surviving siblings.

(l) County child welfare agencies shall create a record in the Child Welfare Services/Case Management System (CWS/CMS) on all cases of child death suspected to be related to child abuse or neglect, whether or not the deceased child has any known surviving siblings. Upon notification that the death was determined not to be related to child abuse or neglect, the child welfare agency shall enter that information into the Child Welfare Services/Case Management System.

**CAL. PENAL CODE § 11174.35 (2011). Child death cases; investigation and findings; abuse and neglect; plan to track and maintain data**

The State Department of Social Services shall work with state and local child death review teams and child protective services agencies in order to identify child death cases that were, or should have been, reported to or by county child protective services agencies. Findings made pursuant to this section shall be used to determine the extent of child abuse or neglect fatalities occurring in families known to child protective services agencies and to define child welfare training needs for reporting, cross-reporting, data integration, and involvement by child protective services agencies in multiagency review in child deaths. The State Department of Social Services, the State Department of Health Services, and the Department of Justice shall develop a plan to track and maintain data on child deaths from abuse or neglect, and submit this plan, not later than December 1, 1997,

to the Senate Committee on Health and Human Services, the Assembly Committee on Human Services, and the chairs of the fiscal committees of the Legislature.

## **COLORADO**

Lacks specific provisions for automatic autopsy of children fatalities.

*For general autopsy or death reporting requirements, see Colo. Rev. Stat. Ann. § 30-10-606 (2011).*

## **CONNECTICUT**

Lacks specific provisions for automatic autopsy of children fatalities.

*For general autopsy or death reporting requirements, see Conn. Gen. Stat. Ann. §§ 19A - 406 (2011) and 19A – 407 (2011)*

## **DELAWARE**

Lacks specific provisions for automatic autopsy of children fatalities.

*For general autopsy or death reporting requirements, see 29 Del. Code. Ann. § 4706 (2011)*

## **DISTRICT OF COLUMBIA**

D.C. CODE ANN. § 5-1405 (2011). Deaths – determinations and investigations; cremations

(a) The CME, other medical examiners, and medicolegal investigators (physician assistants or advanced practice registered nurses) licensed under subchapter V of Chapter 12 of Title 3, are authorized to make determinations of death.

(b) Pursuant to regulations established by the Mayor, the following types of human deaths occurring in the District of Columbia shall be investigated by the OCME:

(1) Violent deaths, whether apparently homicidal, suicidal or accidental including deaths due to thermal, chemical, electrical or radiation injury and deaths due to criminal abortion, whether apparently self-induced or not;

(2) Sudden, unexpected or unexplained deaths not caused by readily recognizable disease, including sudden infant deaths or apparent sudden infant death syndrome (SIDS) for infants one year of age and younger;

(3) Deaths under suspicious circumstances;

(4) Deaths of persons whose bodies are to be cremated, dissected, buried at sea or otherwise disposed of so as to be thereafter unavailable for examination;

(5) Deaths related to disease resulting from employment or on-the-job injury or illness;

(6) Deaths related to disease which might constitute a threat to public health;

(7) Deaths of persons who are wards of the District of Columbia government;

(8) Deaths related to medical or surgical intervention, including operative, peri-operative, anesthesia, medication reactions or deaths associated with diagnostic or therapeutic procedures;

(9) Deaths of persons while in legal custody of the District;

(10) Fetal deaths related to maternal trauma including substance abuse, and extra-mural deliveries;

(11) Deaths for which the Metropolitan Police Department, or other law enforcement agency, or the United States Attorney's Office requests, or a court orders investigation; and

(12) Dead bodies brought within the District of Columbia without proper medical certification.

(c) Clearances by the CME shall be required for all deaths occurring in the District of Columbia for which cremations are requested regardless of where the cremation will occur.

(d) The Mayor shall, by regulation, prescribe procedures for taking possession of a dead body following a death subject to investigation under subsection (b) of this section and for obtaining all essential facts concerning the medical causes of death and the names and addresses of as many witnesses as it is practicable to obtain.

## FLORIDA

**FLA STATE. ANN. § 383.3362 (2011).** Sudden Infant Death Syndrome

**(1) Findings and intent.--**The Legislature recognizes that Sudden Infant Death Syndrome, or SIDS, is a leading cause of death among children under the age of 1 year, both nationally and in this state. The Legislature further recognizes that first responders to emergency calls relating to such a death need access to special training to better enable them to distinguish SIDS from death caused by criminal acts and to appropriately interact with the deceased infant's parents or caretakers. At the same time, the Legislature, recognizing that the primary focus of first responders is to carry out their assigned duties, intends to increase the awareness of SIDS by first responders, but in no way expand or take away from their duties. Further, the Legislature recognizes the importance of a standard protocol for review of SIDS deaths by medical examiners and the importance of appropriate followup in cases of certified or suspected SIDS deaths. Finally, the Legislature finds that it is desirable to analyze existing data, and to conduct further research on, the possible causes of SIDS and how to lower the number of sudden infant deaths.

**(2) Definition.--**As used in this section, the term “Sudden Infant Death Syndrome,” or “SIDS,” means the sudden unexpected death of an infant under 1 year of age which remains unexplained after a complete autopsy, death-scene investigation, and review of the case history. The term includes only those deaths for which, currently, there is no known cause or cure.

**(3) Training.--**

(a) The Legislature finds that an emergency medical technician, a paramedic, a firefighter, or a law enforcement officer is likely to be the first responder to a request for assistance which is made immediately after the sudden unexpected death of an infant. The Legislature further finds that these first responders should be trained in appropriate responses to sudden infant death.

(b) After January 1, 1995, the basic training programs required for certification as an emergency medical technician, a paramedic, a firefighter, or a law enforcement officer as defined in s. 943.10, other than a correctional officer or a correctional probation officer, must include curriculum that contains instruction on Sudden Infant Death Syndrome.

(c) The Department of Health, in consultation with the Emergency Medical Services Advisory Council, the Firefighters Employment, Standards, and Training Council, and the Criminal Justice Standards and Training Commission, shall develop and adopt, by rule, curriculum that, at a minimum, includes training in the nature of SIDS, standard procedures to be followed by law enforcement agencies in investigating cases involving sudden deaths of infants, and training in responding appropriately to the parents or caretakers who have requested assistance.

**(4) Autopsies.--**

(a) The medical examiner must perform an autopsy upon any infant under the age of 1 year who is suspected to have died of Sudden Infant Death Syndrome. The autopsy must be performed within 24 hours after the death, or as soon thereafter as is feasible. When the medical examiner's findings are consistent with the definition of sudden infant death syndrome in subsection (2), the medical examiner must state on the death certificate that sudden infant death syndrome was the cause of death.

(b) The Medical Examiners Commission shall develop and implement a protocol for dealing with suspected sudden infant death syndrome. The protocol must be followed by all medical examiners when conducting the autopsies required under this subsection. The protocol may include requirements and standards for scene investigations, requirements for specific data, criteria for ascertaining cause of death based on the autopsy, criteria for any specific tissue sampling, and any other requirements that the commission considers necessary.

(c) A medical examiner is not liable for damages in a civil action for any act or omission done in compliance with this subsection.

(d) An autopsy must be performed under the authority of a medical examiner under s. 406.11.

**(5) Department duties relating to Sudden Infant Death Syndrome (SIDS).**--The Department of Health shall:

(a) Collaborate with other agencies in the development and presentation of the Sudden Infant Death Syndrome (SIDS) training programs for first responders, including those for emergency medical technicians and paramedics, firefighters, and law enforcement officers.

(b) Maintain a database of statistics on reported SIDS deaths, and analyze the data as funds allow.

(c) Serve as liaison and closely coordinate activities with the Florida SIDS Alliance, including the services related to the SIDS hotline.

(d) Maintain a library reference list and materials about SIDS for public dissemination.

(e) Provide professional support to field staff.

(f) Coordinate the activities of and promote a link between the fetal and infant mortality review committees of the local healthy start coalitions, the local SIDS alliance, and other related support groups.

**FLA STATE. ANN. § 383.402 (2011).** Child abuse death review; State Child Abuse Death Review Committee; local child abuse death review committees

(1) It is the intent of the Legislature to establish a statewide multidisciplinary, multiagency child abuse death assessment and prevention system that consists of state and local review committees. The state and local review committees shall review the facts and circumstances of all deaths of children from birth through age 18 which occur in this state as the result of verified child abuse or neglect. The purpose of the review shall be to:

(a) Achieve a greater understanding of the causes and contributing factors of deaths resulting from child abuse.

(b) Whenever possible, develop a communitywide approach to address such cases and contributing factors.

(c) Identify any gaps, deficiencies, or problems in the delivery of services to children and their families by public and private agencies which may be related to deaths that are the result of child abuse.

(d) Make and implement recommendations for changes in law, rules, and policies, as well as develop practice standards that support the safe and healthy development of children and reduce preventable child abuse deaths.

(2)(a) The State Child Abuse Death Review Committee is established within the Department of Health and shall consist of a representative of the Department of Health, appointed by the State Surgeon General, who shall serve as the state committee coordinator. The head of each of the following agencies or organizations shall also appoint a representative to the state committee:

1. The Department of Legal Affairs.
2. The Department of Children and Family Services.
3. The Department of Law Enforcement.
4. The Department of Education.
5. The Florida Prosecuting Attorneys Association, Inc.
6. The Florida Medical Examiners Commission, whose representative must be a forensic pathologist.

(b) In addition, the State Surgeon General shall appoint the following members to the state committee, based on recommendations from the Department of Health and the agencies listed in paragraph (a), and ensuring that the committee represents the regional,

gender, and ethnic diversity of the state to the greatest extent possible:

1. A board-certified pediatrician.
2. A public health nurse.
3. A mental health professional who treats children or adolescents.
4. An employee of the Department of Children and Family Services who supervises family services counselors and who has at least 5 years of experience in child protective investigations.
5. The medical director of a child protection team.
6. A member of a child advocacy organization.
7. A social worker who has experience in working with victims and perpetrators of child abuse.
8. A person trained as a paraprofessional in patient resources who is employed in a child abuse prevention program.
9. A law enforcement officer who has at least 5 years of experience in children's issues.
10. A representative of the Florida Coalition Against Domestic Violence.
11. A representative from a private provider of programs on preventing child abuse and neglect.

(3) The State Child Abuse Death Review Committee shall:

- (a) Develop a system for collecting data on deaths that are the result of child abuse. The system must include a protocol for the uniform collection of data statewide, which uses existing data-collection systems to the greatest extent possible.
- (b) Provide training to cooperating agencies, individuals, and local child abuse death review committees on the use of the child abuse death data system.
- (c) Prepare an annual statistical report on the incidence and causes of death resulting from child abuse in the state during the prior calendar year. The state committee shall submit a copy of the report by December 31 of each year to the Governor, the President of the Senate, and the Speaker of the House of Representatives. The report must include recommendations for state and local action, including specific policy, procedural, regulatory, or statutory changes, and any other recommended preventive action.

- (d) Encourage and assist in developing the local child abuse death review committees.
  - (e) Develop guidelines, standards, and protocols, including a protocol for data collection, for local child abuse death review committees, and provide training and technical assistance to local committees.
  - (f) Develop guidelines for reviewing deaths that are the result of child abuse, including guidelines to be used by law enforcement agencies, prosecutors, medical examiners, health care practitioners, health care facilities, and social service agencies.
  - (g) Study the adequacy of laws, rules, training, and services to determine what changes are needed to decrease the incidence of child abuse deaths and develop strategies and recruit partners to implement these changes.
  - (h) Provide consultation on individual cases to local committees upon request.
  - (i) Educate the public regarding the provisions of chapter 99-168, Laws of Florida, the incidence and causes of child abuse death, and ways by which such deaths may be prevented.
  - (j) Promote continuing education for professionals who investigate, treat, and prevent child abuse or neglect.
  - (k) Recommend, when appropriate, the review of the death certificate of a child who died as a result of abuse or neglect.
- (4) The members of the state committee shall be appointed to staggered terms of office which may not exceed 2 years, as determined by the State Surgeon General. Members are eligible for reappointment. The state committee shall elect a chairperson from among its members to serve for a 2-year term, and the chairperson may appoint ad hoc committees as necessary to carry out the duties of the committee.
- (5) Members of the state committee shall serve without compensation but are entitled to reimbursement for per diem and travel expenses incurred in the performance of their duties as provided in s. 112.061 and to the extent that funds are available.
- (6) At the direction of the State Surgeon General, the director of each county health department, or the directors of two or more county health departments by agreement, may convene and support a county or multicounty child abuse death review committee in accordance with the protocols established by the State Child Abuse Death Review Committee. Each local committee must include a local state attorney, or his or her designee, and any other members that are determined by guidelines developed by the State Child Abuse Death Review Committee. The members of a local committee shall be appointed to 2-year terms and may be reappointed. The local committee shall elect a chairperson from among its members. Members shall serve without compensation but are



entitled to reimbursement for per diem and travel expenses incurred in the performance of their duties as provided in s. 112.061 and to the extent that funds are available.

(7) Each local child abuse death review committee shall:

(a) Assist the state committee in collecting data on deaths that are the result of child abuse, in accordance with the protocol established by the state committee.

(b) Submit written reports at the direction of the state committee. The reports must include nonidentifying information on individual cases and the steps taken by the local committee and private and public agencies to implement necessary changes and improve the coordination of services and reviews.

(c) Submit all records requested by the state committee at the conclusion of its review of a death resulting from child abuse.

(d) Abide by the standards and protocols developed by the state committee.

(e) On a case-by-case basis, request that the state committee review the data of a particular case.

(8) Notwithstanding any other law, the chairperson of the State Child Abuse Death Review Committee, or the chairperson of a local committee, shall be provided with access to any information or records that pertain to a child whose death is being reviewed by the committee and that are necessary for the committee to carry out its duties, including information or records that pertain to the child's family, as follows:

(a) Patient records in the possession of a public or private provider of medical, dental, or mental health care, including, but not limited to, a facility licensed under chapter 393, chapter 394, or chapter 395, or a health care practitioner as defined in s. 456.001. Providers may charge a fee for copies not to exceed 50 cents per page for paper records and \$1 per fiche for microfiche records.

(b) Information or records of any state agency or political subdivision which might assist a committee in reviewing a child's death, including, but not limited to, information or records of the Department of Children and Family Services, the Department of Health, the Department of Education, or the Department of Juvenile Justice.

(9) The State Child Abuse Death Review Committee or a local committee shall have access to all information of a law enforcement agency which is not the subject of an active investigation and which pertains to the review of the death of a child. A committee may not disclose any information that is not subject to public disclosure by the law enforcement agency, and active criminal intelligence information or criminal investigative information, as defined in s. 119.011(3), may not be made available for

review or access under this section.

(10) The state committee and any local committee may share any relevant information that pertains to the review of the death of a child.

(11) A member of the state committee or a local committee may not contact, interview, or obtain information by request or subpoena directly from a member of a deceased child's family as part of a committee's review of a child abuse death, except that if a committee member is also a public officer or state employee, that member may contact, interview, or obtain information from a member of the deceased child's family, if necessary, as part of the committee's review. A member of the deceased child's family may voluntarily provide records or information to the state committee or a local committee.

(12) The chairperson of the State Child Abuse Death Review Committee may require the production of records by requesting a subpoena, through the Department of Legal Affairs, in any county of the state. Such subpoena is effective throughout the state and may be served by any sheriff. Failure to obey the subpoena is punishable as provided by law.

(13) This section does not authorize the members of the state committee or any local committee to have access to any grand jury proceedings.

(14) A person who has attended a meeting of the state committee or a local committee or who has otherwise participated in activities authorized by this section may not be permitted or required to testify in any civil, criminal, or administrative proceeding as to any records or information produced or presented to a committee during meetings or other activities authorized by this section. However, this subsection does not prevent any person who testifies before the committee or who is a member of the committee from testifying as to matters otherwise within his or her knowledge. An organization, institution, committee member, or other person who furnishes information, data, reports, or records to the state committee or a local committee is not liable for damages to any person and is not subject to any other civil, criminal, or administrative recourse. This subsection does not apply to any person who admits to committing a crime.

(15) The Department of Health shall administer the funds appropriated to operate the review committees and may apply for grants and accept donations.

(16) To the extent that funds are available, the Department of Health may hire staff or consultants to assist a review committee in performing its duties. Funds may also be used to reimburse reasonable expenses of the staff and consultants for the state committee and the local committees.

(17) For the purpose of carrying out the responsibilities assigned to the State Child Abuse Death Review Committee and the local review committees, the State Surgeon General may substitute an existing entity whose function and organization include the function

and organization of the committees established by this section.

(18) Each district administrator of the Department of Children and Family Services must appoint a child abuse death review coordinator for the district. The coordinator must have knowledge and expertise in the area of child abuse and neglect. The coordinator's general responsibilities include:

- (a) Coordinating with the local child abuse death review committee.
- (b) Ensuring the appropriate implementation of the child abuse death review process and all district activities related to the review of child abuse deaths.
- (c) Working with the committee to ensure that the reviews are thorough and that all issues are appropriately addressed.
- (d) Maintaining a system of logging child abuse deaths covered by this procedure and tracking cases during the child abuse death review process.
- (e) Conducting or arranging for a Florida Abuse Hotline Information System (FAHIS) record check on all child abuse deaths covered by this procedure to determine whether there were any prior reports concerning the child or concerning any siblings, other children, or adults in the home.
- (f) Coordinating child abuse death review activities, as needed, with individuals in the community and the Department of Health.
- (g) Notifying the district administrator, the Secretary of Children and Family Services, the Deputy Secretary for Children's Medical Services, and the Department of Health Child Abuse Death Review Coordinator of all child abuse deaths meeting criteria for review as specified in this section within 1 working day after verifying the child's death was due to abuse, neglect, or abandonment.
- (h) Ensuring that all critical issues identified by the local child abuse death review committee are brought to the attention of the district administrator and the Secretary of Children and Family Services.
- (i) Providing technical assistance to the local child abuse death review committee during the review of any child abuse death.

## GEORGIA

GA. CODE. ANN. § 45-16-24 (2011). Notices of death to coroners or county medical examiners; orders to conduct medical examiner's inquiries

(a) When any person dies in any county in this state:

(1) As a result of violence;

(2) By suicide or casualty;

(3) Suddenly when in apparent good health;

(4) When unattended by a physician;

(5) In any suspicious or unusual manner, with particular attention to those persons 16 years of age and under;

(6) After birth but before seven years of age if the death is unexpected or unexplained;

(7) As a result of an execution carried out pursuant to the imposition of the death penalty under Article 2 of Chapter 10 of Title 17;

(8) When an inmate of a state hospital or a state, county, or city penal institution; or

(9) After having been admitted to a hospital in an unconscious state and without regaining consciousness within 24 hours of admission,

it shall be the duty of any law enforcement officer or other person having knowledge of such death to notify immediately the coroner or county medical examiner of the county in which the acts or events resulting in the death occurred or the body is found. For the purposes of this Code section, no person shall be deemed to have died unattended when the death occurred while the person was a patient of a hospice licensed under Article 9 of Chapter 7 of Title 31.

(b) A coroner or county medical examiner who is notified of a death pursuant to subsection (a) of this Code section shall order a medical examiner's inquiry of that death.

(c) Whenever an affidavit is made and filed with a court having criminal jurisdiction attesting that a person came to his death by foul play, that court may interrogate and examine witnesses, if any exist, as to the necessity of a medical examiner's inquiry. Should the court decide that a medical examiner's inquiry is essential to the ends of justice, such inquiry shall be ordered by that court.

(d) A medical examiner's inquiry required under this Code section shall be reduced to writing and filed as provided in Code Section 45-16-32. At the time of such filing, a copy of the medical examiner's inquiry into a death reported to a coroner or county medical examiner pursuant to paragraph (6) of subsection (a) of this Code section shall also be transmitted to the department of family and children services of the county in which the

child resided at the time of death.

## HAWAI'I

Lacks specific provisions for automatic autopsy of children fatalities.

*For general autopsy or death reporting requirements, see Haw. Rev. Stat. Ann. § 841-3 (2011).*

## IDAHO

IDAHO CODE ANN. § 19-4301 (2011). County coroner to investigate deaths

(1) When a county coroner is informed that a person has died, the county coroner shall investigate that death if:

(a) The death occurred as a result of violence, whether apparently by homicide, suicide or by accident;

(b) The death occurred under suspicious or unknown circumstances; or

(c) The death is of a stillborn child or any child if there is a reasonable articulable suspicion to believe that the death occurred without a known medical disease to account for the stillbirth or child's death.

(2) If a death occurs that is not attended by a physician and the cause of death cannot be certified by a physician, the coroner must refer the investigation of the death to the sheriff of the county or the chief of police of the city in which the incident causing the death occurred or, if such county or city is unknown, to the sheriff or chief of police of the county or city where the body was found. The investigation shall be the responsibility of the sheriff or chief of police. Upon completion of the investigation, a written report shall be provided to the coroner of the county in which the death occurred or, if such county is unknown, to the coroner of the county where the body was found.

(3) A coroner in the county where the incident causing the death occurred or, if such county is unknown, the coroner in the county where the body was found, may conduct an inquest if there are reasonable grounds to believe as a result of the investigation that the death occurred as provided in subsection (1) of this section.

(4) If an inquest is to be conducted, the coroner shall summon six (6) persons qualified by law to serve as jurors for the inquest.

(5) Nothing in this section shall be construed to affect the tenets of any church or religious belief.

## ILLINOIS

### 55 ILL. COMP. STAT. ANN. 5/3-3015 (2011). Circumstances under which autopsy to be performed

§ 3-3015. Circumstances under which autopsy to be performed. (a) Where a death has occurred and the circumstances concerning the death are suspicious, obscure, mysterious, or otherwise unexplained and in the opinion of the examining physician or the coroner the cause of death cannot be established definitely except by autopsy, and where a death has occurred while being pursued, apprehended, or taken into custody by or while in the custody of any law enforcement agency, it is declared that the public interest requires that an autopsy be performed, and it shall be the duty and responsibility of the coroner to cause an autopsy to be performed, including the taking of x-rays and the performance of other medical tests as the coroner deems appropriate.

(b) The coroner shall instruct involved parties that embalming of the body is not to be conducted until the toxicology samples are drawn. If a child dies from suspicious or unexplained circumstances, the coroner shall secure the services of a pathologist. The Department of Public Health shall provide coroners and pathologists with a child death autopsy protocol.

(c) If the coroner determines it advisable to exhume a body for the purpose of investigation or autopsy or both, and the coroner would have been authorized under this Section to perform an investigation or autopsy on the body before it was interred, the coroner may exhume the body after consulting on the matter with the state's attorney and upon the order of the circuit court directing the exhumation upon the petition of the state's attorney.

### 55 ILL. COMP. STAT. ANN. 5/3-3016 (2011). Sudden Infant Death Syndrome

§ 3-3016. Sudden infant death syndrome. Where an infant under 2 years of age has died suddenly and unexpectedly and the circumstances concerning the death are unexplained, an autopsy shall be performed by a physician licensed to practice medicine in all of its

branches who has special training in pathology. When an autopsy is conducted under this Section, the parents or guardian of the child shall receive a preliminary report of the autopsy within 5 days of the infant's death. All suspected Sudden Infant Death Syndrome cases shall be reported to the Statewide Sudden Infant Death Syndrome Program within 72 hours.

Death certificates shall list the cause of death as Sudden Infant Death Syndrome where this finding is medically justified pursuant to the rules and regulations of the Department of Public Health. Copies of death certificates which list the cause of death of infants under 2 years of age as Sudden Infant Death Syndrome shall be forwarded to the Department of Public Health within 30 days of the death with a report which shall include an autopsy report, epidemiological data required by the Department and other pertinent data.

## **INDIANA**

IND. CODE ANN. § 36-2-14-6.3 (2011). Notification of death of child in suspicious, unexpected or unexplained manner

Sec. 6.3. (a) A coroner shall immediately notify:

(1) the county office of the department of child services by using the statewide hotline for the department; and

(2) either:

(A) the local child fatality review team; or

(B) if the county does not have a local child fatality review team, the statewide child fatality review committee;

of each death of a person who is less than eighteen (18) years of age, or appears to be less than eighteen (18) years of age and who has died in an apparently suspicious, unexpected, or unexplained manner.

(b) If a child less than eighteen (18) years of age dies in an apparently suspicious, unexpected, or unexplained manner, the coroner shall consult with a child death pathologist to determine whether an autopsy is necessary. If the coroner and the child death pathologist disagree over the need for an autopsy, the county prosecutor shall determine whether an autopsy is necessary. If the autopsy is considered necessary, a child death pathologist or a pathology resident acting under the direct supervision of a child

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death pathologist shall conduct the autopsy within twenty-four (24) hours. If the autopsy is not considered necessary, the autopsy shall not be conducted.

(c) If a child death pathologist and coroner agree under subsection (b) that an autopsy is necessary, the child death pathologist or a pathology resident acting under the direct supervision of a child death pathologist shall conduct the autopsy of the child.

**IND. CODE ANN. § 36-2-14-6.7 (2011). Autopsy required for death of child under three years of age**

Sec. 6.7. (a) This section applies to a child who:

- (1) died suddenly and unexpectedly;
- (2) was less than three (3) years of age at the time of death; and
- (3) was in apparent good health before dying.

(b) A child death pathologist or a pathology resident acting under the direct supervision of a child death pathologist shall conduct an autopsy of a child described in subsection (a).

(c) A county coroner may not certify the cause of death of a child described in subsection (a) until an autopsy is performed at county expense.

(d) The county coroner shall contact the parent or guardian of a child described in subsection (a) and notify the parent or guardian that an autopsy will be conducted at county expense.

(e) The child death pathologist shall:

- (1) ensure that a tangible summary of the autopsy results is provided;
- (2) provide informational material concerning sudden infant death syndrome; and
- (3) unless the release of autopsy results would jeopardize a law enforcement investigation, provide notice that a parent or guardian has the right to receive the preliminary autopsy results;



to the parents or guardian of the child within one (1) week after the autopsy.

(f) If a parent or guardian of a child described in subsection (a) requests the autopsy report of the child, the coroner shall provide the autopsy report to the parent or guardian within thirty (30) days after the:

(1) request; or

(2) completion of the autopsy report;

whichever is later, at no cost.

(g) A coroner shall notify:

(1) a local child fatality review team; or

(2) if the county does not have a local child fatality review team, the statewide child fatality review committee;

of the death of a child described in subsection (a).

## IOWA

### IOWA CODE § 331.802 (2011). Deaths--reported and investigated

1. A person's death which affects the public interest as specified in subsection 3 shall be reported to the county medical examiner or the state medical examiner by the physician in attendance, any law enforcement officer having knowledge of the death, the embalmer, or any other person present. The appropriate medical examiner shall notify the city or state law enforcement agency or sheriff and take charge of the body.

2. a. If a person's death affects the public interest, the county medical examiner shall conduct a preliminary investigation of the cause and manner of death, prepare a written report of the findings, promptly submit the full report to the state medical examiner on forms prescribed for that purpose, and submit a copy of the report to the county attorney.

b. Except as provided in section 218.64 or as otherwise provided by law, for each preliminary investigation and the preparation and submission of the required reports, the county medical examiner shall receive from the county of appointment a fee determined by the board plus the examiner's actual expenses. The fee and expenses paid by the

county of appointment shall be reimbursed to the county of appointment by the county of the person's residence. However, if the person's death is caused by a defendant for whom a judgment of conviction and sentence is rendered under section 707.2, 707.3, 707.4, 707.5, or 707.6A, the county of the person's residence may recover from the defendant the fee and expenses.

c. The fee and expenses of the county medical examiner who performs an autopsy or conducts an investigation of a person who dies after being brought into this state for emergency medical treatment by or at the direction of an out-of-state law enforcement officer or public authority shall be paid by the state. A claim for payment shall be filed with the Iowa department of public health. If moneys are not appropriated to the Iowa department of public health for the payment of autopsies under this paragraph, claims for payment shall be forwarded to the state appeal board and, if authorized by the board, shall be paid out of moneys in the general fund of the state not otherwise appropriated.

3. A death affecting the public interest includes, but is not limited to, any of the following:

- a. Violent death, including homicidal, suicidal, or accidental death.
- b. Death caused by thermal, chemical, electrical, or radiation injury.
- c. Death caused by criminal abortion including self-induced, or by sexual abuse.
- d. Death related to disease thought to be virulent or contagious which may constitute a public hazard.
- e. Death that has occurred unexpectedly or from an unexplained cause.
- f. Death of a person confined in a prison, jail, or correctional institution.
- g. Death of a person who was prediagnosed as a terminal or bedfast case who did not have a physician in attendance within the preceding thirty days; or death of a person who was admitted to and had received services from a hospice program as defined in section 135J.1, if a physician or registered nurse employed by the program was not in attendance within thirty days preceding death.
- h. Death of a person if the body is not claimed by a person authorized to control the deceased person's remains under section 144C.5, or a friend.
- i. Death of a person if the identity of the deceased is unknown.
- j. Death of a child under the age of two years if death results from an unknown cause or if the circumstances surrounding the death indicate that sudden infant death syndrome may

be the cause of death.

k. Death of a person committed or admitted to a state mental health institute, a state resource center, the state training school, or the Iowa juvenile home.

4. The county medical examiner shall conduct the investigation in the manner required by the state medical examiner and shall determine whether the public interest requires an autopsy or other special investigation. However, if the death occurred in the manner specified in subsection 3, paragraph “j”, the county medical examiner shall order an autopsy, the expense of which shall be reimbursed by the Iowa department of public health. In determining the need for an autopsy, the county medical examiner may consider the request for an autopsy from a public official or private person, but the state medical examiner or the county attorney of the county where the death occurred may require an autopsy.

5. a. A person making an autopsy shall promptly file a complete record of the findings in the office of the state medical examiner and the county attorney of the county where death occurred and the county attorney of the county where any injury contributing to or causing the death was sustained.

b. A summary of the findings resulting from an autopsy of a child under the age of two years whose death occurred in the manner specified in subsection 3, paragraph “j”, shall be transmitted immediately by the physician who performed the autopsy to the county medical examiner. The report shall be forwarded to the parent, guardian, or custodian of the child by the county medical examiner or a designee of the county medical examiner, or through the infant's attending physician. A copy of the autopsy report filed with the county attorney shall be available to the parents, guardian, or custodian upon request.

6. The report of an investigation made by the state medical examiner or a county medical examiner and the record and report of an autopsy made under this section or chapter 691, shall be received as evidence in any court or other proceedings, except that statements by witnesses or other persons and conclusions on extraneous matters included in the report are not admissible. The person preparing a report or record given in evidence may be subpoenaed as a witness in any civil or criminal case by any party to the cause. A copy of a record, photograph, laboratory finding, or record in the office of the state medical examiner or any medical examiner, when attested to by the state medical examiner or a staff member or the medical examiner in whose office the record, photograph, or finding is filed, shall be received as evidence in any court or other proceedings for any purpose for which the original could be received without proof of the official character of the person whose name is signed to it.

7. In case of a sudden, violent, or suspicious death after which the body is buried without an investigation or autopsy, the county medical examiner, upon being advised of the facts, shall notify the county attorney. The county attorney shall apply for a court order requiring the body to be exhumed in accordance with chapter 144. Upon receipt of the

court order, an autopsy shall be performed by a medical examiner or by a pathologist designated by the medical examiner and the facts disclosed by the autopsy shall be communicated to the court ordering the disinterment for appropriate action.

8. Where donation of the remains of the deceased to a medical school or similar institution equipped with facilities to perform autopsies is provided by will or directed by the person authorized to control the deceased person's remains under section 144C.5, any autopsy under this section shall be performed at the direction of the school or institution, and in such a manner as to further the purpose of the donation, while serving the public interest.

## KANSAS

KAN. STAT. ANN. § 22A-242 (2010). Child death, notification of coroner; autopsy; notification of state review board; notification of parent or guardian; SIDS death; fee for autopsy

(a) When a child dies, any law enforcement officer, health care provider or other person having knowledge of the death shall immediately notify the coroner of the known facts concerning the time, place, manner and circumstances of the death. If the notice to the coroner identifies any suspicious circumstances or unknown cause, as described in the protocol developed by the state review board under K.S.A. 22a-243 and amendments thereto, the coroner shall immediately: (1) Investigate the death to determine whether the child's death included any such suspicious circumstance or unknown cause; and (2) direct a pathologist to perform an autopsy.

(b) If, after investigation and an autopsy, the coroner determines that the death of a child does not include any suspicious circumstances or unknown cause, as described in the protocol developed by the state review board under K.S.A. 22a-243 and amendments thereto, the coroner shall complete and sign a nonsuspicious child death form.

(c) If, after investigation and an autopsy, the coroner determines that the death of a child includes any suspicious circumstance or unknown cause, as described in the protocol developed by the state review board under K.S.A. 22a-243 and amendments thereto, the coroner shall notify, within 30 days, the chairperson of the state review board and shall notify, within 24 hours, the county or district attorney of the county where the death of the child occurred.

(d) The coroner shall attempt to notify any parent or legal guardian of the deceased child prior to the performance of an autopsy pursuant to this section and attempt to notify any such parent or legal guardian of the results of the autopsy.

(e) A coroner shall not make a determination that the death of a child less than one year of age was caused by sudden infant death syndrome unless an autopsy is performed.

(f) The fee for an autopsy performed under this section shall be the usual and reasonable fee and travel allowance authorized under K.S.A. 22a-233 and amendments thereto and shall be paid from the district coroners fund.

## KENTUCKY

### KY. REV. STAT. ANN. § 72.025 (2011). Circumstances requiring post-mortem examination to be performed by coroner

Coroners shall require a post-mortem examination to be performed in the following circumstances:

- (1) When the death of a human being appears to be caused by homicide or violence;
- (2) When the death of a human being appears to be the result of suicide;
- (3) When the death of a human being appears to be the result of the presence of drugs or poisons in the body;
- (4) When the death of a human being appears to be the result of a motor vehicle accident and the operator of the motor vehicle left the scene of the accident or the body was found in or near a roadway or railroad;
- (5) When the death of a human being occurs while the person is in a state mental institution or mental hospital when there is no previous medical history to explain the death, or while the person is in police custody, a jail or penal institution;
- (6) When the death of a human being occurs in a motor vehicle accident and when an external examination of the body does not reveal a lethal traumatic injury;
- (7) When the death of a human being appears to be the result of a fire or explosion;
- (8) When the death of a child appears to indicate child abuse prior to the death;
- (9) When the manner of death appears to be other than natural;

- (10) When human skeletonized remains are found;
- (11) When post-mortem decomposition of a human corpse exists to the extent that external examination of the corpse cannot rule out injury or where the circumstances of death cannot rule out the commission of a crime;
- (12) When the death of a human being appears to be the result of drowning;
- (13) When the death of an infant appears to be caused by sudden infant death syndrome in that the infant has no previous medical history to explain the death;
- (14) When the death of a human being occurs as a result of an accident;
- (15) When the death of a human being occurs under the age of forty (40) and there is no past medical history to explain the death;
- (16) When the death of a human being occurs at the work site and there is no apparent cause of death such as an injury or when industrial toxics may have contributed to the cause of death;
- (17) When the body is to be cremated and there is no past medical history to explain the death;
- (18) When the death of a human being is sudden and unexplained; and
- (19) When the death of a human being occurs and the decedent is not receiving treatment by a licensed physician and there is no ascertainable medical history to indicate the cause of death.

**KY. REV. STAT. ANN. § 213.161 (2011). Sudden Infant Death Syndrome Program**

- (1) In order to obtain information which may be useful to research organizations studying the causes and incidence of the sudden infant death syndrome, a program is hereby established in the Cabinet for Health and Family Services. The purpose of this program shall be to obtain factual information concerning the characteristics, incidence, and distribution of the sudden infant death syndrome throughout the Commonwealth and to provide a means of public education concerning any research findings which may lead to the possible means of prevention, early identification, and treatment of children susceptible to the sudden infant death syndrome.

(2) In instances where an ostensibly healthy child dies suddenly and unexpectedly with no known or apparent cause as determined by a physician or a coroner, an autopsy with the written approval of the parents or legal guardian of the child shall be performed within forty-eight (48) hours and the results reported to the cabinet and to the parents or legal guardian of the child.

(3) In order to implement the provisions of this section, the secretary of the Cabinet for Health and Family Services shall:

(a) Promulgate administrative regulations as may be necessary in order to obtain in proper form all information relating to the occurrence of sudden infant deaths which is relevant and appropriate for the establishment of a reliable statistical index of the incidence, distribution, and characteristics of cases of the sudden infant death syndrome;

(b) Collect such factual information from physicians, coroners, medical examiners, hospitals, and public health officials who have examined any child known or believed to have the sudden infant death syndrome;

(c) Make such factual information available to physicians, coroners, medical examiners, hospitals, public health officials, and educational and institutional organizations conducting research as to the causes and incidence of the sudden infant death syndrome;

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

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

## LOUISIANA

LA. REV. STAT. ANN. § 40:2019 (2011). Child death investigation

### **A. Findings and purpose.**

(1) The legislature hereby finds and declares that:

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

(b) Collecting data on the causes of unexpected deaths will better enable the state to protect some infants and children from preventable deaths and will help reduce the incidence of such deaths.

(c) 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 will help reduce the incidence of such deaths.

(d) Multidisciplinary and multiagency reviews of child deaths can assist the state in the investigation of child deaths, in the development of a greater understanding of the incidence and causes of child deaths and the methods for preventing such deaths, and in identifying gaps in services to children and families.

(2) The purpose of this Section is to identify the cause of death of children fourteen years of age and below, and thereby reduce the incidence of injury and death to infants and children by requiring that a death investigation be performed in the case of all unexpected deaths of children fourteen years of age and below, and establishing the Louisiana State Child Death Review Panel to collect data from such investigations and report to the legislature regarding the causes of such deaths and share information among local and regional panels, health care providers, and state agencies which provide services to children and families.

**B. Definitions.** For the purpose of this Section, the following terms shall have the following meaning:

(1) “Autopsy” means a post-mortem external and internal physical examination conducted in accordance with accepted medical practice and the laws of this state using a standardized child death investigation protocol performed by a forensic pathologist or, if a forensic pathologist is unavailable, a pathologist licensed or otherwise appointed to conduct such an examination under such laws.

(2) “Death investigation” means the process of determining the cause and manner of death and shall include the following:

(a) A postmortem examination which may be limited to an external examination or may include an autopsy.

(b) An inquiry by any law enforcement agency having jurisdiction into the circumstances of the death, including a death scene investigation and interview with the child's parent, legal guardian, or caretaker, and the person who reported the child's death.

(c) A review of information regarding the child from any other relevant agency, professional, or health care provider.



(3) “Unexpected death” means a death which is a result of undiagnosed disease, or trauma in which the surrounding circumstances are suspicious, obscure, or otherwise unexplained, or other death the circumstances of which are suspicious, obscure, or otherwise unexplained. A clinical diagnosis of death due to Sudden Infant Death Syndrome (SIDS) shall be deemed an unexpected death.

**C. Child Death Review Panel.** There is established within the Department of Health and Hospitals the Louisiana State Child Death Review Panel, hereinafter referred to as the “state panel” which shall be composed of twenty-five persons. Members of the panel shall include:

- (1) The state health officer or his designee.
- (2) The secretary of the Department of Health and Hospitals or his designee.
- (3) The secretary of the Department of Children and Family Services or his designee.
- (4) The superintendent of the office of state police or his designee.
- (5) The state registrar of vital records in the office of public health or his designee.
- (6) The attorney general or his designee.
- (7) A member of the Senate appointed by the president of the Senate.
- (8) A member of the House of Representatives appointed by the speaker of the House of Representatives.
- (9) The commissioner of the Department of Insurance or his designee.
- (10) The executive director of the Highway Safety Commission of the Department of Public Safety and Corrections or his designee.
- (11) The state fire marshal or his designee.
- (12) A representative of the injury research and prevention section of the office of public health appointed by the assistant secretary of the office of public health.
- (13) The executive director of the Louisiana Maternal and Child Health Coalition.
- (14) A district attorney appointed by the Louisiana District Attorneys Association.
- (15) A sheriff appointed by the Louisiana Sheriff's Association.

- (16) A police chief appointed by the Louisiana Association of Chiefs of Police.
- (17) A forensic pathologist certified by the American Board of Pathology and licensed to practice medicine in the state appointed by the chairman of the Louisiana State Child Death Review Panel subject to Senate confirmation.
- (18) A pathologist experienced in pediatrics appointed by the Louisiana Pathology Society.
- (19) A coroner appointed by the president of the Louisiana Coroner's Association.
- (20) Six persons appointed by the governor, subject to Senate confirmation, for a term of three years as follows:
- (a) A health professional with expertise in Sudden Infant Death Syndrome appointed from a list of three names submitted by the Louisiana State Medical Society.
- (b) A pediatrician with experience in diagnosing and treating child abuse and neglect appointed from a list of three names submitted by the state chapter of the American Academy of Pediatrics.
- (c) Four citizens from the state at large who represent different geographic areas of the state.

**D. Functions and duties of panel.**

- (1) The state panel shall:
- (a) Establish a standardized child death investigation protocol which shall require at a minimum that all death investigations be completed within thirty working days of the report of the death. The protocol shall include procedures for all law enforcement agencies and local departments of social services to follow in response to a child death.
- (b) Establish criteria for information that must be included in a death investigation report and provide such information to the appropriate agencies and medical providers to be used as a guideline in preparing the death investigation report.
- (c) Collect, review, and analyze all death investigation reports prepared in accordance with this Section, and such other information as the state panel deems appropriate, to use in preparation of reports to the legislature concerning the causes of and methods of decreasing unexpected deaths of infants and children.
- (d) Recommend changes within the agencies represented on the state panel which may prevent child deaths.

(2) The state panel may:

(a) Establish local and regional panels to which it may delegate some or all of its responsibilities under this Section.

(b) Analyze any data available through any state systems that may decrease the incidence of injury and unexpected death to infants and children below the age of fourteen.

#### **E. Child death investigation.**

(1) In each unexpected death of a child fourteen years of age and below, a death investigation shall be performed in accordance with the child death investigation protocol established by the Louisiana State Child Death Review Panel which may include, at the discretion of the coroner but not be limited to, a complete autopsy performed by the coroner of the parish where the death occurred pursuant to the death investigation procedure established by R.S. 33:1563. The death investigation findings shall be reported to appropriate authorities including the police, health care providers, and the child protective services if appropriate, within three days of the conclusion of the death investigation.

(2) A copy of the death investigation report, or any portion thereof, including law enforcement, coroner, fire department, and medical providers, or any other information relative to the death investigation shall be provided to the state panel within thirty days from the date the state panel requests such information.

(3) Nothing in this Section shall be construed to change, alter, or restrict the authority or jurisdiction of a coroner as established in R.S. 33:1551 et seq.

(4) Nothing in this Section shall be construed as requiring a finding of negligent treatment or maltreatment when the state panel determines that the parents or guardians were treating the child solely according to the tenets and practices of a well-recognized religious method of treatment which has a reasonable, proven record of success.

#### **F. Records; confidentiality; prohibited disclosure and discovery.**

(1) Notwithstanding any other provision of law to the contrary, the state panel, and any local or regional panel or its agent thereof, shall be authorized to access medical and vital records in the custody of physicians, hospitals, clinics, and other health care providers, and the office of public health, and to any other information, documents, or records pertaining to the completed investigation of unexpected deaths of infants and children below the age of fourteen in the custody of any law enforcement agency or child protective service agency in order that it may perform its functions and duties as provided in Subsection D. All such records obtained by the state panel or any local or regional panel or its agent in accordance with the provisions of this Subsection, as well as the results of any child death investigation report, shall be confidential and shall not be

available for subpoena nor shall such information be disclosed, discoverable, or compelled to be produced in any civil, criminal, administrative, or other proceeding nor shall such records be deemed admissible as evidence in any civil, criminal, administrative, or other tribunal or court for any reason.

(2) The furnishing of confidential information, documents, and reports in accordance with this Section by any person, agency, or entity furnishing such information, documents, and reports shall not expose such person, agency, or entity to liability and shall not be considered a violation of any privileged or confidential relationship, provided the participant has acted in good faith in the reporting as required in this Section.

(3) Nothing in this Subsection shall prohibit the publishing by the state panel of statistical compilations relating to unexpected child deaths of infants and children fourteen years of age or below which do not identify individual cases or individual physicians, hospitals, clinics, or other health care providers.

**G. Report.** The state panel shall report to the legislature annually concerning the causes of unexpected deaths of infants and children below the age of fourteen. The report shall include analysis of factual information obtained through review of death investigation reports required in Subsection D of this Section.

## MAINE

### 22 MAINE REV. STAT. ANN. § 3028 (2010). Investigation; autopsy

**1. Authority to conduct investigation.** The medical examiner or the person expressly authorized by the Chief Medical Examiner has authority to conduct an investigation and inquiry into the cause, manner and circumstances of death in a medical examiner case. The medical examiner or authorized person shall, if it is determined necessary, immediately proceed to the scene and, subject to the authority of the Attorney General, assume custody of the body for the purposes of the investigation, and shall retain custody until the investigation has been completed or until the Chief Medical Examiner has assumed charge of the case.

**2. Investigation by law enforcement officer.** When death is not suspected to be the result of physical injury attributable to criminal conduct, the medical examiner may elect not to proceed to the scene, or the Chief Medical Examiner may elect not to dispatch a medical examiner or the person expressly authorized by the Chief Medical Examiner under subsection 1 to the scene. If the medical examiner elects not to proceed to the scene, or the Chief Medical Examiner elects not to dispatch a medical examiner or authorized person to the scene, the law enforcement officer in charge of the scene shall:

**A.** Investigate, take photographs and take possession of useful objects as directed by the medical examiner, authorized person or the Office of Chief Medical Examiner pursuant to subsection 4;

**B. Deleted.** Laws 2001, c. 291, § 2.

**C.** Remove the body in accordance with the instructions of the medical examiner, authorized person or the Office of Chief Medical Examiner; and

**D.** Make a report of the investigation available to the medical examiner, authorized person or the Office of Chief Medical Examiner.

**3. Assistance of law enforcement agency.** The medical examiner, the person expressly authorized by the Chief Medical Examiner or the pathologist as described in subsection 8, may request the assistance and use of the facilities of the law enforcement agency having jurisdiction over the case for the purposes of photographing, fingerprinting or otherwise identifying the body. That agency shall provide the medical examiner, authorized person or pathologist with a written report of the steps taken in providing the assistance.

**4. Possession of useful objects.** Except as otherwise directed by the Attorney General, the Attorney General's deputies or assistants, the medical examiner, the person expressly authorized by the Chief Medical Examiner or the Office of Chief Medical Examiner may direct that a law enforcement officer at the scene make measurements, take photographs and take possession of all objects that in the opinion of the medical examiner, authorized person or the Office of Chief Medical Examiner may be useful in establishing the cause, manner and circumstances of death. For these same purposes, the medical examiner, authorized person or the Office of Chief Medical Examiner may direct that a law enforcement officer take possession of any objects or specimens that have been removed from the victim at the scene or elsewhere while under medical care.

**5. Requests for objects.** Any person having possession of any object or objects, as described in subsection 4, shall at the request of the medical examiner or the person expressly authorized by the Chief Medical Examiner give that object or objects to a law enforcement officer, to the medical examiner, to the authorized person or to the Office of Chief Medical Examiner. Medical personnel and institutions turning over any objects or specimens that have been removed from the victim while under medical care are immune from civil or criminal liability when complying with this subsection. Original written or recorded material that might express suicidal intent must be sent to the Office of the Chief Medical Examiner. The Chief Medical Examiner may elect to accept copies in place of originals.

**6. Examination of body.** In all cases except those requiring a report on a body already disposed of and not to be exhumed for examination, the medical examiner or the person expressly authorized by the Chief Medical Examiner shall conduct a thorough

examination of the body.

**7. Written report.** Upon completing an investigation, the medical examiner or the person expressly authorized by the Chief Medical Examiner shall submit a written report of the investigator's findings to the Chief Medical Examiner on forms provided for that purpose. The investigator shall retain one copy of the report.

If an investigator reports suspected abuse, neglect or exploitation to the Chief Medical Examiner, the Chief Medical Examiner, by reporting that information to the department on behalf of the investigator, fulfills the medical examiner's mandatory reporting requirement under section 3477 or 4011-A.

**8. Autopsy.** If, in any medical examiner case, in the opinion of the medical examiner, the Chief Medical Examiner, the district attorney for the district in which the death has occurred or the Attorney General, it is advisable and in the public interest that an autopsy be made, the autopsy must be conducted by the Chief Medical Examiner or by a physician that the medical examiner, with the approval of the Chief Medical Examiner, may designate. The medical examiner, with the approval of the Chief Medical Examiner, may elect to perform the autopsy. The person who performs the autopsy shall make a complete report of the findings of the autopsy and shall transmit the report to the medical examiner and the Office of Chief Medical Examiner, retaining one copy of the report.

**9. Autopsy of child.** In the case of a child under the age of 3 years, when death occurs without medical attendance or, if attended, without a specific natural cause, the medical examiner shall order an autopsy. The autopsy may be waived by the Chief Medical Examiner, as long as the Chief Medical Examiner includes the reason for the waiver in the record.

**10. Chief Medical Examiner; jurisdiction.** The Chief Medical Examiner may assume jurisdiction over a medical examiner case and may recertify the death when the Chief Medical Examiner finds that it is in the public interest to do so. The Chief Medical Examiner shall include the reasons for so doing in the record.

**11. Final release of body.** In any medical examiner case the body shall not be finally released for embalming or burial except by order of the medical examiner in charge of the case, or by the Chief Medical Examiner. No medical examiner may release a body without first ensuring that the case has been reported to the Office of Chief Medical Examiner.

**12. Report to domestic abuse panel.** If the Chief Medical Examiner determines that a death resulted from criminal conduct and that the victim was pregnant at the time of death, the Chief Medical Examiner shall send a copy of any report prepared under this section to the Domestic Abuse Homicide Review Panel created pursuant to Title 19-A, section 4013.

## MASSCHUSETTS

MASS. GEN. LAWS ANN. 38 § 2A. State and local multidisciplinary child fatality review teams.

(a) As used in this section, the following words shall have the following meanings:-

“Child”, a person under the age of 18.

“Fatality”, any death of a child.

“Local team”, a local child fatality review team established pursuant to subsection (c).

“Near fatality”, an act that, as certified by a physician, places a child in serious or critical condition.

“State team”, the state fatality review team established by subsection (b).

“Team”, the state or a local team.

(b) There shall be a state child fatality review team within the office of the chief medical examiner. Notwithstanding section 172 of chapter 6, members of the state team shall be subject to criminal offender record checks to be conducted by the colonel of the state police, on behalf of the chief medical examiner. All members shall serve without compensation for their duties associated with membership on the state team.

The state team shall consist of at least the following members:- the chief medical examiner, who shall chair the state team; the attorney general or a designee; the commissioner of children and families or a designee; the commissioner of public health or a designee; the commissioner of elementary and secondary education or a designee; a representative selected by the Massachusetts District Attorneys Association; the colonel of the state police or a designee; the commissioner of mental health or a designee; the commissioner of developmental services or a designee; the director of the Massachusetts center for sudden infant death syndrome, located at the Boston Medical Center, or a designee; the commissioner of youth services or a designee; a representative selected by the Massachusetts chapter of the American Academy of Pediatrics who has experience in diagnosing or treating child abuse and neglect; a representative selected by the Massachusetts Hospital Association; the chief justice of the juvenile division of the trial court or a designee; the president of the Massachusetts Chiefs of Police Association Incorporated or a designee; the child advocate appointed under section 3 of chapter 18C or a designee; and any other person, selected by the chair or by majority vote of the members of the state team, with expertise or information relevant to an individual case.

The purpose of the state team shall be to decrease the incidence of preventable child fatalities and near fatalities by: (i) developing an understanding of the causes and incidence of child fatalities and near fatalities; and (ii) advising the governor, the general court and the public by recommending changes in law, policy and practice that will prevent child fatalities and near fatalities.

To achieve its purpose, the state team shall:

- (i) develop model investigative and data collection protocols for local teams;
- (ii) provide information to local teams and law enforcement agencies for the purpose of the protection of children;
- (iii) provide training and written materials to local teams to assist them in carrying out their duties;
- (iv) review reports from local teams;
- (v) study the incidence and causes of child fatalities and near fatalities in the commonwealth;
- (vi) analyze community, public and private agency involvement with the children and their families prior to and subsequent to fatalities or near fatalities;
- (vii) develop a protocol for the collection of data regarding fatalities and near fatalities and provide training to local teams on the protocol;
- (viii) develop and implement rules and procedures necessary for its own operation; and
- (ix) provide the governor, the general court and the public with annual written reports, subject to confidentiality restrictions, which shall include, but not be limited to, the state team's findings and recommendations.

(c) There shall be a local child fatality review team in each of the 11 districts headed by a district attorney. Notwithstanding section 172 of chapter 6, members of a local team shall be subject to criminal offender record checks to be conducted by the district attorney. All members shall serve without compensation for their duties associated with membership on a local team.

Each local team shall be comprised of at least the following members: the district attorney of the county, who shall chair the local team; the chief medical examiner or a designee; the commissioner of children and families or a designee; a pediatrician with experience in diagnosing or treating child abuse and neglect, appointed by the state team; a local police officer from the municipality where the child fatality or near fatality occurred, appointed by the chief of police of that municipality; a state law enforcement



officer, appointed by the colonel of state police; the chief justice of the juvenile division of the trial court or a designee; the director of the Massachusetts center for sudden infant death syndrome, located at the Boston Medical Center, or a designee; the commissioner of public health or a designee; and any other person with expertise or information relevant to an individual case who may attend meetings, on an ad hoc basis, by agreement of the permanent members of each local team. Those other persons may include, but shall not be limited to, local or state law enforcement officers, hospital representatives, medical specialists or subspecialists, or designees of the commissioners of developmental services, mental health, youth services and education.

The purpose of each local team shall be to decrease the incidence of preventable child fatalities and near fatalities by: (i) coordinating the collection of information on fatalities and near fatalities; (ii) promoting cooperation and coordination between agencies responding to fatalities and near fatalities and in providing services to family members; (iii) developing an understanding of the causes and incidence of child fatalities and near fatalities in the county; and (iv) advising the state team on changes in law, policy or practice which may affect child fatalities and near fatalities.

To achieve its purpose, each local team shall:

- (i) review, establish and implement model protocols from the state team;
- (ii) review, subject to the approval of the local district attorney, all individual fatalities and near fatalities in accordance with the established protocol;
- (iii) meet periodically, but at least 4 times per calendar year, to review the status of fatality and near fatality cases and recommend methods of improving coordination of services between member agencies;
- (iv) collect, maintain and provide confidential data as required by the state team; and
- (v) provide law enforcement or other agencies with information for the purposes of the protection of children.

At the request of the local district attorney, the local team shall be immediately provided with:

- (i) information and records relevant to the cause of the fatality or near fatality maintained by providers of medical or other care, treatment or services, including dental and mental health care;
- (ii) information and records relevant to the cause of the fatality or near fatality maintained by any state, county or local government agency including, but not limited to, birth certificates, medical examiner investigative data, parole and probation information records, and law enforcement data post-disposition, except that certain law enforcement

records may be exempted by the local district attorney;

(iii) information and records of any provider of social services, including the state department of children and families, relevant to the child or the child's family, that the local team deems relevant to the review; and

(iv) demographic information relevant to the child and the child's immediate family, including but not limited to, address, age, race, gender, and economic status. The district attorney may enforce this paragraph by seeking an order of the superior court.

(d) Any privilege or restriction on disclosure established pursuant to chapter 66A, section 70 of chapter 111, section 11 of chapter 111B, section 18 of 111E, chapters 112, 123, or sections 20B, 20J or 20K of chapter 233 or any other law relating to confidential communications shall not prohibit the disclosure of this information to the chair of the state team or a local team. Any information considered to be confidential pursuant to the aforementioned statutes may be submitted for a team's review upon the determination of that team's chair that the review of this information is necessary. The chair shall ensure that no information submitted for a team's review is disseminated to parties outside the team. Under no circumstances shall any member of a team violate the confidentiality provisions set forth in the aforementioned statutes.

Except as necessary to carry out a team's purpose and duties, members of a team and persons attending a team meeting may not disclose any information relating to the team's business.

Team meetings shall be closed to the public. Information and records acquired by the state team or by a local team pursuant to this chapter shall be confidential, exempt from disclosure under chapter 66, and may only be disclosed as necessary to carry out a team's duties and purposes.

Statistical compilations of data which do not contain any information that would permit the identification of any person may be disclosed to the public.

(e) Members of a team, persons attending a team meeting and persons who present information to a team may not be questioned in any civil or criminal proceeding regarding information presented in or opinions formed as a result of a team meeting.

(f) Information, documents and records of the state team or of a local team shall not be subject to subpoena, discovery or introduction into evidence in any civil or criminal proceeding; provided, however, that information, documents and records otherwise available from any other source shall not be immune from subpoena, discovery or introduction into evidence through these sources solely because they were presented during proceedings of a team or are maintained by a team.

(g) Nothing in this section shall limit the powers and duties of the chief medical examiner or district attorneys.

## MICHIGAN

MICH. COMP. LAWS. § 52.205A (2011). Death of child under age of 2 years; reports and autopsies; regulations

Sec. 5a. (1) When a child under the age of 2 years dies within this state under circumstances of sudden death, cause unknown, or found dead, cause unknown, that death shall be immediately reported to the county medical examiner or deputy county medical examiner of the county where the body is located. The county medical examiner or deputy county medical examiner shall inform the parents or legal guardians of the child that they may request an autopsy to be performed on the child . The state shall cover the costs of an autopsy requested under this section. The county medical examiner or the deputy county medical examiner shall arrange the autopsy requested under this section and shall promptly notify the parents or legal guardians of the results of that autopsy. The county medical examiner or the deputy county medical examiner shall report the costs of the autopsy performed under this section to the director of the department of community health. If the director determines the claim to be reasonable and proper, he or she shall reimburse the person for the costs incurred under this section out of funds appropriated for this purpose by the legislature. Nothing in this section shall be construed to interfere with the duties and responsibilities of the county medical examiner or deputy county medical examiner as provided in this act.

(2) The department of community health shall promulgate rules and regulations under this act to promote consistency and accuracy among county medical examiners and deputy county medical examiners in determining the cause of death under this section. The department may adopt, by reference in its rules, all or any part of the “State of Michigan Protocols to Determine Cause and Manner of Sudden and Unexplained Child Deaths” published by the Michigan child death review program.

## MINNESOTA

MINN. STAT. § 145.898 (2011). Sudden infant death

The Department of Health shall develop uniform investigative guidelines and protocols for coroners and medical examiners conducting death investigations and autopsies of children under two years of age.

MINN. STAT. § 390.11 (2011). Investigations

**Subdivision 1. Reports of death.** All sudden or unexpected deaths and all deaths that may be due entirely or in part to any factor other than natural disease processes must be promptly reported to the coroner or medical examiner for evaluation. Sufficient information must be provided to the coroner or medical examiner. Reportable deaths include, but are not limited to:

- (1) unnatural deaths, including violent deaths arising from homicide, suicide, or accident;
- (2) deaths due to a fire or associated with burns or chemical, electrical, or radiation injury;
- (3) unexplained or unexpected perinatal and postpartum maternal deaths;
- (4) deaths under suspicious, unusual, or unexpected circumstances;
- (5) deaths of persons whose bodies are to be cremated or otherwise disposed of so that the bodies will later be unavailable for examination;
- (6) deaths of inmates of public institutions and persons in custody of law enforcement officers who have not been hospitalized primarily for organic disease;
- (7) deaths that occur during, in association with, or as the result of diagnostic, therapeutic, or anesthetic procedures;
- (8) deaths due to culpable neglect;
- (9) stillbirths of 20 weeks or longer gestation unattended by a physician;
- (10) sudden deaths of persons not affected by recognizable disease;
- (11) unexpected deaths of persons notwithstanding a history of underlying disease;
- (12) deaths in which a fracture of a major bone such as a femur, humerus, or tibia has occurred within the past six months;
- (13) deaths unattended by a physician occurring outside of a licensed health care facility or licensed residential hospice program;
- (14) deaths of persons not seen by their physician within 120 days of demise;
- (15) deaths of persons occurring in an emergency department;

(16) stillbirths or deaths of newborn infants in which there has been maternal use of or exposure to unprescribed controlled substances including street drugs or in which there is history or evidence of maternal trauma;

(17) unexpected deaths of children;

(18) solid organ donors;

(19) unidentified bodies;

(20) skeletonized remains;

(21) deaths occurring within 24 hours of arrival at a health care facility if death is unexpected;

(22) deaths associated with the decedent's employment;

(23) deaths of nonregistered hospice patients or patients in nonlicensed hospice programs; and

(24) deaths attributable to acts of terrorism.

The coroner or medical examiner shall determine the extent of the coroner's or medical examiner's investigation, including whether additional investigation is needed by the coroner or medical examiner, jurisdiction is assumed, or an autopsy will be performed, notwithstanding any other statute.

**Subd. 1a. Commissioner of corrections; investigation of deaths.** For deaths occurring within a facility licensed by the Department of Corrections, the coroner or medical examiner shall ensure that a forensic pathologist who is certified by the American Board of Pathology reviews each death and performs an autopsy on all unnatural, unattended, or unexpected deaths and others as necessary.

**Subd. 1b. Hospice registration.** Each coroner and medical examiner shall establish a registration policy regarding hospice patients. If a hospice patient is determined to be properly preregistered, the coroner or medical examiner may treat the death as attended by a physician.

**Subd. 2. Autopsies.** The coroner or medical examiner may order an autopsy, at the coroner or medical examiner's sole discretion, in the case of any human death referred to in subdivision 1, when, in the judgment of the coroner or medical examiner the public interest would be served by an autopsy. The autopsy shall be performed without unnecessary delay. A report of the facts developed by the autopsy and findings of the person performing the autopsy shall be made promptly and filed in the office of the coroner or medical examiner. When further investigation is deemed advisable, a copy of

the report shall be delivered to the county attorney. Every autopsy performed pursuant to this subdivision shall, whenever practical, be performed in the county morgue. Nothing herein shall require the coroner or medical examiner to order an autopsy upon the body of a deceased person if the person died of known or ascertainable causes or had been under the care of a licensed physician immediately prior to death or if the coroner or medical examiner determines the autopsy to be unnecessary.

Autopsies performed pursuant to this subdivision may include the removal, retention, testing, or use of organs, parts of organs, fluids or tissues, at the discretion of the coroner or medical examiner, when removal, retention, testing, or use may be useful in determining or confirming the cause of death, mechanism of death, manner of death, identification of the deceased, presence of disease or injury, or preservation of evidence. Such tissue retained by the coroner or medical examiner pursuant to this subdivision shall be disposed of in accordance with standard biohazardous hospital or surgical material and does not require specific consent or notification of the legal next of kin. When removal, retention, testing, and use of organs, parts of organs, fluids, or tissues is deemed beneficial, and is done only for research or the advancement of medical knowledge and progress, written consent or documented oral consent shall be obtained from the legal next of kin, if any, of the deceased person prior to the removal, retention, testing, or use.

**Subd. 2a. Deaths caused by fire; autopsies.** The coroner or medical examiner shall conduct an autopsy or require that one be performed in the case of a death reported to the coroner or medical examiner by the state fire marshal or a chief officer under section 299F.04, subdivision 5, and apparently caused by fire, and in which the decedent is pronounced dead outside of a hospital or in which identification of the decedent has not been confirmed. If the decedent has died in a hospital and identification is not in question, an autopsy may be performed or ordered by the coroner or medical examiner.

**Subd. 3. Exhumation; disinterment.** The coroner or medical examiner may exhume any human body and perform an autopsy on it in the case of any human death referred to in subdivision 1 when the coroner or medical examiner judges that the public interest requires an autopsy. No exhumation shall be conducted unless the surviving legal next of kin consents to it, or the district court of the county where the body is located or buried orders it. Notice of such exhumation shall be given as directed by the district court. Application for an order may be made by the coroner, medical examiner, or county attorney of the county where the body is located or buried, and shall be granted upon a showing that the court deems appropriate.

**Subd. 4. Assistance of medical specialists.** If during an investigation the coroner or medical examiner believes the assistance of pathologists, toxicologists, laboratory technicians, or other medical, scientific, or forensic experts is necessary to determine or confirm the cause or manner of death, identification, time of death, or to address other issues requiring expert opinion, the coroner or medical examiner may obtain their assistance.

**Subd. 5. Inquest.** An inquest into a death may be held at the request of the medical examiner and the county attorney or the coroner and the county attorney. An inquest is optional and the coroner or medical examiner may investigate and certify a death without one. The coroner or medical examiner and county attorney may decide how to empanel the inquest. Inquest records will be made public, but the record and report of the inquest proceedings may not be used in evidence in any civil action arising out of the death for which an inquest was ordered. Whenever the decision is made to hold an inquest, the county attorney may issue subpoenas for witnesses and enforce their attendance. The persons served with subpoenas shall be allowed the same compensation and be subject to the same enforcement and penalties as provided by rule 22 of the Minnesota Rules of Criminal Procedure.

**Subd. 6. Records kept by coroner or medical examiner.** The coroner or medical examiner shall keep full and complete records, properly indexed, giving the name, if known, of every person whose death is investigated, the place where the body was found, the date, cause, and manner of death, and all other available information concerning the death that the coroner or medical examiner considers pertinent. These records of the coroner or medical examiner are the property of the county and subject to chapter 13. These records shall be kept at the coroner's or medical examiner's office, unless no storage space is available. They shall then be kept with official county records and only released in accordance with the Data Practices Act. Records shall be kept in accordance with section 15.17.

**Subd. 7. Duty to report.** Deaths of the types described in this section must be promptly reported for investigation to the coroner or medical examiner and, when appropriate, to the law enforcement agency with jurisdiction, by the law enforcement officer, attending physician, health care professional, mortician or funeral director, person in charge of the public institutions referred to in subdivision 1, or anyone who discovers a deceased person. In a case in which a crime may be involved, the coroner or medical examiner shall promptly notify the law enforcement agency with jurisdiction over a criminal investigation of the death.

**Subd. 7a. Records and other material available to coroner or medical examiner.** Except for health data defined in section 13.3805, subdivision 1, paragraph (a), clause (2), health-related records or data on a decedent whose death is being investigated under this section shall be made promptly available to the coroner or medical examiner, upon the coroner's or medical examiner's written request, by any person, agency, entity, or organization having custody of, possession of, access to, or knowledge of the records or data. This provision includes records and data, whether recorded or unrecorded, including but not limited to, records and data, including medical imaging, concerning medical, surgical, psychiatric, psychological, chemical dependency, or any other consultation, diagnosis, or treatment. In cases involving a stillborn infant or the death of a fetus or infant less than one year of age, the prenatal records on the decedent's mother may also be subpoenaed by the coroner or medical examiner. The coroner or medical examiner shall pay the reasonable costs of copies of records or data so provided under this section.

Data collected or created pursuant to this subdivision relating to any psychiatric, psychological, or mental health consultation with, diagnosis of, or treatment of the decedent whose death is being investigated shall remain confidential or protected nonpublic data, except that the coroner's or medical examiner's final summary report may contain a summary of, or references to, such data. Where records of a decedent become part of the medical examiner's or coroner's file, they are not subject to subpoena or a request for production directed to the medical examiner or coroner. Body fluids, slides, tissue, organ specimens, radiographs, monitor records, video or other recordings, and any other material or article of diagnostic value obtained from the decedent prior to death shall be made available to the coroner or medical examiner upon request. Notwithstanding the provisions of sections 13.384 and 595.02, the coroner or medical examiner shall have the power to subpoena any and all documents, records, including medical records, and papers deemed useful in the investigation of a death.

**Subd. 7b. Records released by coroner or medical examiner.** Records and reports, including those of autopsies performed, generated, and certified by the coroner or medical examiner shall be admissible as evidence in any court or grand jury proceeding. The admissibility of such evidence under this subdivision shall not include statements made by witnesses or other persons unless otherwise admissible.

**Subd. 8. Investigation procedure; coroner or medical examiner in charge of body.** Upon notification of the death of any person as defined in this section, the coroner or medical examiner staff or their designee may proceed to the body, take charge of it, and arrange for transfer of it, when appropriate. This provision also applies to bones, body parts, and specimens that may be human remains. Discovery of such bones, body parts, and specimens must be promptly reported to the coroner or medical examiner. When necessary, the coroner or medical examiner staff, in coordination with the applicable law enforcement agency, may order that there be no interference with or compromise of the body or the scene of death. In the event a person is transported to an emergency vehicle or facility and pronounced dead, the scene of death shall include the original location of the decedent when first discovered to be ill, unresponsive, or stricken prior to removal by emergency medical personnel. Any person violating such an order is guilty of a gross misdemeanor. The coroner or medical examiner staff shall make inquiry regarding the cause and manner of death and, in cases that fall under the medical examiner's or coroner's jurisdiction, prepare written findings together with the report of death and its circumstances, which shall be filed in the office of the coroner or medical examiner.

**Subd. 9. Criminal act report.** The coroner or medical examiner shall deliver to the county attorney copies of reports or other information created by the coroner's or medical examiner's office in any cases of a potential criminal nature.

**Subd. 10. Infant death.** If a child under the age of two years dies suddenly and unexpectedly, the parents or guardian of the child shall be promptly notified of the availability of counseling services.



Subd. 11. Deleted by amendment, Laws 2006, c. 260, art. 8, § 9, eff. July 1, 2006.

**Subd. 12. Authorized removal of brain.** If the coroner or medical examiner is informed by a physician that a decedent is suspected of having had Alzheimer's disease, the coroner or medical examiner may authorize the removal of the brain for the purposes of sections 145.131 and 145.132.

## MISSISSIPPI

### MISS. CODE ANN. § 41-61-59 (2010). Deaths affecting public interest

(1) A person's death that affects the public interest as specified in subsection (2) of this section shall be promptly reported to the medical examiner by the physician in attendance, any hospital employee, any law enforcement officer having knowledge of the death, the embalmer or other funeral home employee, any emergency medical technician, any relative or any other person present. The appropriate medical examiner shall notify the municipal or state law enforcement agency or sheriff and take charge of the body. When the medical examiner has received notification under Section 41-39-15(6) that the deceased is medically suitable to be an organ and/or tissue donor, the medical examiner's authority over the body shall be subject to the provisions of Section 41-39-15(6). The appropriate medical examiner shall notify the Mississippi Bureau of Narcotics within twenty-four (24) hours of receipt of the body in cases of death as described in subsection (2)(m) or (n) of this section.

(2) A death affecting the public interest includes, but is not limited to, any of the following:

(a) Violent death, including homicidal, suicidal or accidental death.

(b) Death caused by thermal, chemical, electrical or radiation injury.

(c) Death caused by criminal abortion, including self-induced abortion, or abortion related to or by sexual abuse.

(d) Death related to disease thought to be virulent or contagious that may constitute a public hazard.

(e) Death that has occurred unexpectedly or from an unexplained cause.

(f) Death of a person confined in a prison, jail or correctional institution.

(g) Death of a person where a physician was not in attendance within thirty-six (36) hours preceding death, or in prediagnosed terminal or bedfast cases, within thirty (30) days

preceding death.

(h) Death of a person where the body is not claimed by a relative or a friend.

(i) Death of a person where the identity of the deceased is unknown.

(j) Death of a child under the age of two (2) years where death results from an unknown cause or where the circumstances surrounding the death indicate that sudden infant death syndrome may be the cause of death.

(k) Where a body is brought into this state for disposal and there is reason to believe either that the death was not investigated properly or that there is not an adequate certificate of death.

(l) Where a person is presented to a hospital emergency room unconscious and/or unresponsive, with cardiopulmonary resuscitative measures being performed, and dies within twenty-four (24) hours of admission without regaining consciousness or responsiveness, unless a physician was in attendance within thirty-six (36) hours preceding presentation to the hospital, or in cases in which the decedent had a prediagnosed terminal or bedfast condition, unless a physician was in attendance within thirty (30) days preceding presentation to the hospital.

(m) Death that is caused by drug overdose or which is believed to be caused by drug overdose.

(n) When a stillborn fetus is delivered and the cause of the demise is medically believed to be from the use by the mother of any controlled substance as defined in Section 41-29-105.

(3) The State Medical Examiner is empowered to investigate deaths, under the authority hereinafter conferred, in any and all political subdivisions of the state. The county medical examiners and county medical examiner investigators, while appointed for a specific county, may serve other counties on a regular basis with written authorization by the State Medical Examiner, or may serve other counties on an as-needed basis upon the request of the ranking officer of the investigating law enforcement agency. If a death affecting the public interest takes place in a county other than the one where injuries or other substantial causal factors leading to the death have occurred, jurisdiction for investigation of the death may be transferred, by mutual agreement of the respective medical examiners of the counties involved, to the county where the injuries or other substantial causal factors occurred, and the costs of autopsy or other studies necessary to the further investigation of the death shall be borne by the county assuming jurisdiction.

(4) The chief county medical examiner or chief county medical examiner investigator may receive from the county in which he serves a salary of Nine Hundred Dollars (\$900.00) per month, in addition to the fees specified in Sections 41-61-69 and 41-61-75,

provided that no county shall pay the chief county medical examiner or chief county medical examiner investigator less than One Hundred Dollars (\$100.00) per month as a salary, in addition to other compensation provided by law. In any county having one or more deputy medical examiners or deputy medical examiner investigators, each deputy may receive from the county in which he serves, in the discretion of the board of supervisors, a salary of not more than Nine Hundred Dollars (\$900.00) per month, in addition to the fees specified in Sections 41-61-69 and 41-61-75. For this salary the chief shall assure twenty-four-hour daily and readily available death investigators for the county, and shall maintain copies of all medical examiner death investigations for the county for at least the previous five (5) years. He shall coordinate his office and duties and cooperate with the State Medical Examiner, and the State Medical Examiner shall cooperate with him.

(5) A body composed of the State Medical Examiner, whether appointed on a permanent or interim basis, the Director of the State Board of Health or his designee, the Attorney General or his designee, the President of the Mississippi Coroners' Association (or successor organization) or his designee, and a certified pathologist appointed by the Mississippi State Medical Association shall adopt, promulgate, amend and repeal rules and regulations as may be deemed necessary by them from time to time for the proper enforcement, interpretation and administration of Sections 41-61-51 through 41-61-79, in accordance with the provisions of the Mississippi Administrative Procedures Law, being Section 25-43-1 et seq.

#### MISS. CODE ANN. § 41-61-65 (2010). Autopsy or investigation; review

(1) If, in the opinion of the medical examiner investigating the case, it is advisable and in the public interest that an autopsy or other study be made for the purpose of determining the primary and/or contributing cause of death, an autopsy or other study shall be made by the State Medical Examiner, or the State Medical Examiner may choose a competent pathologist who is designated by the State Medical Examiner or the Department of Public Safety as a pathologist qualified to perform postmortem examinations and autopsies to perform the autopsy or study; to be eligible to be designated under this section, a pathologist must be an M.D. or D.O. who is certified in forensic pathology by the American Board of Pathology unless a certified forensic pathologist is not available to perform a postmortem examination or autopsy within a reasonable time. The State Medical Examiner or designated pathologist may retain any tissues as needed for further postmortem studies or documentation. When the medical examiner has received notification under Section 41-39-15(6) that the deceased is medically suitable to be an organ and/or tissue donor, the State Medical Examiner or designated pathologist may retain any biopsy or medically approved sample of the organ and/or tissue in accordance with the provisions of Section 41-39-15(6). A complete autopsy report of findings and interpretations, prepared on forms designated for this purpose, shall be submitted promptly to the State Medical Examiner. Copies of the report shall be furnished to the authorizing medical examiner, district attorney and court clerk. A copy of the report shall be furnished to one (1) adult member of the immediate family of the deceased or the legal

representative or legal guardian of members of the immediate family of the deceased upon request. In determining the need for an autopsy, the medical examiner may consider the request from the district attorney or county prosecuting attorney, law enforcement or other public officials or private persons. However, if the death occurred in the manner specified in subsection (2)(j) of Section 41-61-59, an autopsy shall be performed by the State Medical Examiner or a designated pathologist who is qualified as required by this subsection, and the report of findings shall be forwarded promptly to the State Medical Examiner, investigating medical examiner, the State Department of Health, the infant's attending physician and the local sudden infant death syndrome coordinator.

(2) Any medical examiner or duly licensed physician performing authorized investigations and/or autopsies as provided in Sections 41-61-51 through 41-61-79 who, in good faith, complies with the provisions of Sections 41-61-51 through 41-61-79 in the determination of the cause and/or manner of death for the purpose of certification of that death, shall not be liable for damages on account thereof, and shall be immune from any civil liability that might otherwise be incurred or imposed.

(3) Family members or others who disagree with the medical examiner's determination shall be able to petition and present written argument to the State Medical Examiner for further review. If the petitioner still disagrees, he may petition the circuit court, which may, in its discretion, hold a formal hearing. In all those proceedings, the State Medical Examiner and the county medical examiner or county medical examiner investigator who certified the information shall be made defendants. All costs of the petition and hearing shall be borne by the petitioner.

## MISSOURI

MO. REV. STAT. § 58.452 (2011). Child's death under age eighteen, notice to coroner by persons having knowledge--referral to child fatality review panel, when--procedure for nonsuspicious death, form, duties--autopsy, child death pathologist, when--disagreement on need for autopsy, procedure--violation by coroner, penalty

1. When any person, in any county in which a coroner is required by section 58.010, dies and there are reasonable grounds to believe that such person was less than eighteen years of age, who is eligible to receive a certificate of live birth, the police, sheriff, law enforcement officer or official, health practitioner or hospital or any person having knowledge of such a death shall immediately notify the coroner of the known facts concerning the time, place, manner and circumstances of the death. The coroner shall notify the division of the child's death pursuant to section 210.115, RSMo. The coroner shall immediately evaluate the necessity for child fatality review and shall immediately notify the chairman of the child fatality review panel. The child fatality review panel shall be activated within twenty-four hours of such notice to review any death which

includes one or more of the suspicious circumstances described in the protocol developed by the department of social services, state technical assistance team pursuant to section 210.194, RSMo.

2. If the coroner determines that the death of the person under age eighteen years, who is eligible to receive a certificate of live birth, does not include any suspicious circumstances listed in the protocol, the coroner shall complete a nonsuspicious child death form provided by the department of social services, state technical assistance team and have the form cosigned by the chairman of the child fatality review panel and forward the original to the department of social services, state technical assistance team within forty-eight hours of receiving notice of the child's death.

3. When a child under the age of eighteen years, who is eligible to receive a certificate of live birth dies, the coroner shall notify a certified child death pathologist to determine the need for an autopsy. The certified child death pathologist, in conjunction with the coroner, shall determine the need for an autopsy. If there is disagreement concerning the need for the autopsy, the certified child death pathologist shall make the determination unless the child fatality review panel, within twelve hours, decides against the certified child death pathologist.

4. When there is a disagreement regarding the necessity for an autopsy, the certified child death pathologist shall file a report with the chairman of the child fatality review panel indicating the basis for the disagreement. The pathologist's report on the disagreement shall be included in the report to the department of social services, state technical assistance team. If an autopsy is determined necessary, the autopsy shall be performed by a certified child death pathologist within twenty-four hours of receipt of the body by the pathologist or within twenty-four hours of the agreement by the pathologist to perform the autopsy, whichever occurs later.

5. Knowing failure by a coroner to refer a suspicious death of a child under the age of eighteen years, who is eligible to receive a certificate of live birth, to a child fatality review panel or to a certified child death pathologist is a class A misdemeanor.

MO. REV. STAT. § 194.117 (2011). Sudden infant death--notification--autopsy by certified child death pathologist required, procedure--cost, how paid--department of health and senior services, duties--rules and regulations

Any person who discovers the dead body of, or acquires the first knowledge of the death of, any child under the age of one year and over the age of one week, where the child died suddenly when in apparent good health, shall immediately notify the county coroner or medical examiner of the known facts concerning the time, place, manner, and circumstances of the death. All such deaths shall be autopsied by a certified child death pathologist. The coroner or medical examiner shall notify the parent or guardian of the child that an autopsy shall be performed at the expense of the state. The department of health and senior services shall receive prompt notification of such autopsy results. The

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results from the autopsy shall be reduced to writing and delivered to the state department of health and senior services. The term “sudden infant death syndrome” shall be entered on the death certificate as the principal cause of death where the term is appropriately descriptive of the circumstances surrounding the death of the child. The cost of the autopsy and transportation of the body shall be paid by the department of health and senior services, and the department shall pay, out of appropriations made for that purpose, as a reimbursement to the certified child death pathologist such costs that are within the limitation of maximum rates established by the rules and regulations of the department. Autopsies under this section shall be performed by pathologists deemed qualified to perform autopsies by the department of health and senior services and who agree to perform the autopsy according to protocols developed pursuant to section 210.196, RSMo. The certified child death pathologist shall ensure that a tangible summary of the autopsy results is provided to the parents or guardian of the child and shall provide informational material on the subject of sudden infant death syndrome to the family within one week after the autopsy is performed. A form letter developed by the department of health and senior services shall include a statement informing the parents or guardian of the right to receive the full autopsy results in cases of suspected sudden infant death syndrome. The certified child death pathologist shall, upon request by the parents or guardian, release the full autopsy results to the parents, guardian or family physician in cases of suspected sudden infant death syndrome within thirty days of such request. The tangible summary and full autopsy report shall be provided at no cost to the parents or guardian. The director of the department of health and senior services shall prescribe reasonable rules and regulations necessary to carry out the provisions of this section, including the establishment of a cost schedule and standards for reimbursement of costs of autopsies performed pursuant to the provisions of this section. The provisions of this section shall not be construed so as to limit, restrict or otherwise affect any power, authority, duty or responsibility imposed by any other provision of law upon any coroner or medical examiner. The department of health and senior services may receive grants of money or other aid from federal and other public and private agencies or individuals for the administration or funding of this section or any portion thereof or for research to determine the cause and prevention of deaths caused by sudden infant death syndrome.

## MONTANA

### MONT. CODE ANN. § 50-15-411 (2011). Sudden infant death syndrome--findings--definition

(1) As used in 50-15-412 and this section, “sudden infant death syndrome” means the sudden death of an infant under 1 year of age that remains unexplained after a thorough case investigation, including the performance of a complete autopsy, an examination of the death scene, and a review of the clinical history.

(2) The legislature recognizes that research has shown that sudden infant death syndrome is a leading cause of death among children from 1 month to 1 year of age. The legislature finds and declares that sudden infant death syndrome is a serious problem within Montana and that public interest is served by research and study of sudden infant death syndrome and its potential causes and indications.

## NEBRASKA

NEB. REV. STAT. ANN. § 23-1824 (2011). Minor; autopsy required; when; guidelines; reimbursement

(1) The county coroner or coroner's physician shall perform, at county expense, an autopsy on any person less than nineteen years of age who dies a sudden death, except that no autopsy needs to be performed if (a) the death was caused by a readily recognizable disease or the death occurred due to trauma resulting from an accident and (b) the death did not occur under suspicious circumstances. The Attorney General shall create, by July 1, 2007, guidelines for county coroners or coroner's physicians regarding autopsies on persons less than nineteen years of age.

(2) The county coroner or coroner's physician shall attempt to establish, by a reasonable degree of medical certainty, the cause or causes of the death, and shall thereafter certify the cause or causes of death to the county attorney. No cause of death shall be certified as sudden infant death syndrome unless an autopsy, a death scene investigation, and a review of the child's medical history reveal no other possible cause.

(3) A county may request reimbursement of up to fifty percent of the cost of an autopsy from the Attorney General. Reimbursement requests may include, but not be limited to, costs for expert witnesses and complete autopsies, including toxicology screens and tissue sample tests. The Attorney General shall place an emphasis on autopsies of children five years of age and younger.

NEB. REV. STAT. ANN. § 71-2101 (2010). Sudden infant death syndrome; legislative findings

The Legislature finds that sudden infant death syndrome is the sudden, unexpected death of an apparently healthy infant less than one year of age that remains unexplained after the performance of a complete postmortem investigation, including an autopsy, an examination of the scene of death, and a review of the medical history. The Legislature further finds that, despite the success of prevention efforts, sudden infant death syndrome has been the second leading cause of death for infants in Nebraska for the last twenty

years. Although there are no known ways to prevent sudden infant death syndrome in all cases, there are steps that parents and caregivers can take to reduce the risk of sudden infant death. The Legislature further finds and declares that there is a present and growing need to provide additional programs aimed at reducing the number of cases of sudden infant death syndrome in Nebraska.

## NEVADA

NEV. REV. STAT. ANN. § 440.435 (2010). Death caused by sudden infant death syndrome: Ordinance may authorize postmortem examination; duties of coroner

1. The board of county commissioners of any county may provide by ordinance that in all cases where the cause or suspected cause of a death is sudden infant death syndrome, the coroner may take possession of the body, exhuming the body if necessary, and authorize the performance of a postmortem examination thereon. Such examination may include an analysis of the stomach, stomach contents, blood, organs, fluids or tissues of the body.
2. The findings resulting from the examination performed under subsection 1, including the opinions and conclusions of the examining physician, shall be reduced to writing and included in the coroner's record of death. The coroner shall file a copy of such report with the State Registrar.

## NEW HAMPSHIRE

Lacks specific provisions for automatic autopsy of children fatalities.

*For general autopsy or death reporting requirements, see N.H. Rev. Stat. § 611-B:17 (2011).*

## NEW JERSEY

N.J. STAT. ANN. § 52:17B-88 (2011). Findings; report; autopsy; conclusions; copy to closest surviving relative; transportation of body

If the cause of such death shall be established beyond a reasonable doubt, the county medical examiner shall reduce his findings to writing and promptly make a full report thereof to the State Medical Examiner and to the county prosecutor on forms to be



prescribed by the State Medical Examiner for such purpose. If, however, in the opinion of the county medical examiner, the State Medical Examiner, an assignment judge of the Superior Court, the county prosecutor or the Attorney General, an autopsy is necessary, or if, in cases where the suspected cause of death of a child under one year of age is sudden infant death syndrome or the child is between one and three years of age and the death is sudden and unexpected, and an investigation has been conducted under the provisions of section 9 of P.L.1967, c. 234 (C.52:17B-86), and the parent, parents or legal guardian of the child request an autopsy, the same shall be performed, by (1) the State Medical Examiner, or an assistant designated by him or by (2) the county medical examiner or a deputy or assistant county medical examiner provided either has the recognized training or experience in forensic pathology or by (3) such competent forensic pathologists as may be authorized by the State Medical Examiner; except that when the suspected cause of death of a child under one year of age is sudden infant death syndrome or the child is between one and three years of age and the death is sudden and unexpected, upon the request of the parent, parents or legal guardian of the child, a pediatric pathologist, if available, shall assist in the performance of the autopsy under the direction of a forensic pathologist. The county medical examiner shall notify the parent, parents or legal guardian of the child that they may request that a pediatric pathologist assist in the performance of the autopsy. A detailed description of the findings written during the progress of such autopsy and the conclusions drawn therefrom shall thereupon be filed in the offices of the State Medical Examiner, the county medical examiner and the county prosecutor. The county medical examiner shall make available a copy of these findings and conclusions to the closest surviving relative of the decedent within 90 days of the receipt of a request therefor, unless the death is under active investigation by a law enforcement agency. If the suspected cause of death of a child under one year of age is sudden infant death syndrome or if the child is between one and three years of age and the death is sudden and unexpected, the findings and conclusions shall be reported to the child's parent, parents or legal guardian and the State Department of Health and Senior Services within 48 hours after the death of the child.

It shall be the duty of any county medical examiner to call upon the State Medical Examiner or an assistant State medical examiner, or other person authorized and designated by the State Medical Examiner, to make an examination or perform an autopsy whenever he deems it necessary or desirable, and it shall be the duty of the State Medical Examiner or assistant State medical examiner to perform such examination, except in such cases as a competent pathologist is so authorized by the State Medical Examiner to perform such autopsy. The necessary expenses for transportation of a body for autopsy by the State Medical Examiner or an assistant State medical examiner or an authorized pathologist and such reasonable fee payable to the authorized pathologist as has been approved by the State Medical Examiner for each autopsy such authorized pathologist may perform shall be paid by the State.

N.J. STAT. ANN. § 52:17B-88.10 (2010). Standardized protocol for SIDS autopsies

a. The State Medical Examiner, in consultation with the Commissioner of Health and Senior Services, shall develop standardized protocols for autopsies performed in those cases in which the suspected cause of death of a child under one year of age is sudden infant death syndrome and in which the child is between one and three years of age and the death is sudden and unexpected.

b. The State Medical Examiner shall establish a Sudden Child Death Autopsy Protocol Committee to assist in developing and reviewing the protocol. The committee shall include, but shall not be limited to, the State Medical Examiner or his designee, the Assistant Commissioner of the Division of Family Health Services in the Department of Health and Senior Services or his designee, the Director of the Division of Youth and Family Services in the Department of Children and Families or his designee, the director of the SIDS Resource Center established pursuant to P.L.1987, c. 331 (C.26:5D-4), an epidemiologist, a forensic pathologist, a pediatric pathologist, a county medical examiner, a pediatrician who is knowledgeable about sudden infant death syndrome and child abuse, a law enforcement officer, an emergency medical technician or a paramedic, a family member of a sudden infant death syndrome victim and a family member of a sudden unexpected death victim who was between one and three years of age at the time of death.

The committee shall annually review the protocol and make recommendations to the State Medical Examiner to revise the protocol, as appropriate.

c. The protocols shall include requirements and standards for scene investigation, criteria for ascertaining the cause of death based on autopsy, criteria for specific tissue sampling, and such other requirements as the committee deems appropriate. The protocols shall take into account nationally recognized standards for pediatric autopsies.

The State Medical Examiner shall be responsible for ensuring that the protocols are followed by all medical examiners and other persons authorized to conduct autopsies in those cases in which the suspected cause of death is sudden infant death syndrome or in which the child is between one and three years of age and the death is sudden and unexpected.

d. The protocols shall authorize the State Medical Examiner, county medical examiner or other authorized person to take tissue samples for research purposes, as provided in section 2 of P.L.2005, c. 227 (C.52:17B-88.11).

e. The sudden infant death syndrome autopsy protocol shall provide that if the findings in the autopsy are consistent with the definition of sudden infant death syndrome specified in the protocol, the person who conducts the autopsy shall state on the death certificate that sudden infant death syndrome is the cause of death.

N.J. STAT. ANN. § 52:17B-88.11 (2011). Legislative findings and declarations; establishment of protocol for participation of medical

## examiners in SIDS research

The Legislature finds and declares that: advances in genetics, biochemistry and other areas of medical research are yielding new information about the specific causes of sudden death in infancy and early childhood; these findings are of great importance because the largest subgroup of these deaths, Sudden Infant Death Syndrome, remains a “rule-out” diagnosis for which the family learns what did not, rather than what did, cause the death of their child; without knowing the actual cause, families are not able to determine if there is a genetic basis that places their other children at risk, and physicians are not able to prevent a death by prospectively diagnosing and treating a potentially fatal medical problem; and if the State is to meet its public health goal of reducing infant mortality, it is in the public interest to accelerate efforts to identify actual causes of death in infants and young children.

a. The State Medical Examiner, in consultation with the Commissioner of Health and Senior Services and the Sudden Child Death Autopsy Protocol Committee established pursuant to section 2 of P.L.2000, c. 24 (C.52:17B-88.10) shall establish, pursuant to this section, a protocol for participation by medical examiners in research activities concerning deaths of children three years of age and younger. The protocol shall be revised as necessary. The research shall include all autopsies in which the suspected cause of death of a child under one year of age is sudden infant death syndrome and the suspected cause of death of a child three years of age and younger is not considered a violent death pursuant to subsection a. of section 9 of P.L.1967, c. 234 (C.52:17B-86).

The protocol shall authorize the State Medical Examiner, county medical examiner or other authorized person to take and transfer tissue samples to an approved research project prior to obtaining the consent of the parent or legal guardian of the deceased infant or young child, but the research project shall not be permitted to use the tissue prior to its obtaining consent as provided in paragraph (3) of this subsection.

Notwithstanding the provisions of this section to the contrary, the protocol shall provide that no tissue sample shall be taken from a deceased infant or young child whose parent or legal guardian has objected to an autopsy because it is contrary to the religious beliefs of the deceased, in accordance with section 2 of P.L.1983, c. 535 (C.52:17B-88.2).

The protocol shall, at a minimum, stipulate that:

(1) the research project first be approved by the institutional review board of the facility at which the research shall be conducted, then by the Sudden Child Death Autopsy Protocol Committee, and finally by the Institutional Review Board of the New Jersey Department of Health and Senior Services. If a research project is submitted by the Department of Health and Senior Services, the final review of the project shall be conducted by an independent review board;

- (2) the research project delineate the information, other than the tissue sample, that will be required from the investigation of the death of the infant or young child;
  - (3) the research project develop a plan for the release by the State Medical Examiner or county medical examiner, as applicable, of a decedent's tissue, as well as obtaining written consent for the use of the tissue and other identifying information from the parent or legal guardian of the deceased infant or young child;
  - (4) the research project develop a plan for the disposal of a decedent's tissue in the event that the parent or guardian does not give consent for use of the tissue, and in cases in which consent is given, upon completion of the research. The plan shall incorporate accepted procedures for disposal of surgical biopsies and biohazardous materials, and shall include procedures to inform the parent or guardian and the Sudden Child Death Autopsy Protocol Committee of the disposal plan;
  - (5) the research project reimburse the State Medical Examiner, county medical examiner or other authorized person participating in the research for reasonable costs incurred in taking, storing and providing tissue samples for the project. The estimated costs subject to reimbursement shall be reviewed and approved by the State Medical Examiner;
  - (6) the research project provide the State Medical Examiner and the Sudden Child Death Autopsy Protocol Committee with periodic updates on the status of the project; and
  - (7) the Sudden Child Death Autopsy Protocol Committee may terminate a research project that is not in compliance with the research project as approved pursuant to this subsection.
- b. Upon receiving notification from the research project that the research project has obtained written consent from the parent or legal guardian of the deceased infant or young child for the use of tissue samples and identifying information, the State Medical Examiner, county medical examiner or other authorized person, as applicable, shall provide the research project with copies of the autopsy reports and any reports generated by the State Medical Examiner or county medical examiner concerning the subject of the research.
  - c. The information and tissue samples provided by the State Medical Examiner, county medical examiner or other authorized person to the research project shall be used by the research project only for the purposes approved by the Sudden Child Death Autopsy Protocol Committee and as specified in the protocol, and shall not otherwise be divulged or made public so as to disclose the identity of any person to whom they relate. The information provided to the research project shall not be considered a public record pursuant to P.L.1963, c. 73 (C.47:1A-1 et seq.) or P.L.2001, c. 404 (C.47:1A-5 et al.).

d. The Sudden Child Death Autopsy Protocol Committee shall oversee the approved research projects.

e. The State Medical Examiner, county medical examiner, their employees and other persons authorized by the State Medical Examiner to provide tissue samples and identifying information to the research project, and the members of the Sudden Child Death Autopsy Protocol Committee shall not be liable for civil damages as the result of any actions or omissions performed in good faith and in accordance with the provisions of this act.

## NEW MEXICO

Lacks specific provisions for automatic autopsy of children fatalities.

*For general autopsy or death reporting requirements, see N.M. Stat. Ann. § 24-12-4 (2011).*

## NEW YORK

N.Y. PUB. HEALTH LAW § 4210 (2011). Cadavers; right to dissect

The right to dissect the body of a deceased person exists in the following cases:

1. In the cases prescribed by special statutes; or,
2. When the dissection is performed by or at the direction of (a) a coroner who is a physician licensed to practice medicine in this state, or (b) a coroner's physician, or (c) a medical examiner of a county, or is performed at the direction jointly of a coroner and coroner's physician, and is performed in the course of an investigation within the jurisdiction of the officer performing or directing the dissection, or is performed upon the written request of a district attorney, or sheriff, or the chief of a police department of a city or county, or the superintendent of state police.

The commissioner shall adopt regulations to establish standard autopsy protocols for any person under the age of one year who dies under circumstances in which death is not anticipated by medical history or the cause is unknown. Such regulations and autopsy protocols shall include but not be limited to (i) requirements for the performance of such autopsies, subject to the limitations provided for in section forty-two hundred ten-c of this title, and (ii) delineation of specific, standardized methods for such autopsies. In developing and implementing such regulations and protocols, the commissioner shall consult with health professionals, families and other persons participating in the implementation of the sudden infant death syndrome program authorized pursuant to

section twenty-five hundred-b of this chapter and at a minimum shall consult with an epidemiologist, a forensic pathologist, a pediatric pathologist, a medical examiner, a county coroner and a pediatrician with expertise in sudden infant death syndrome; or,

3. Whenever and so far as the husband, wife or next of kin of the deceased, being charged by law with the duty of burial, (a) may authorize dissection for the sole purpose of ascertaining the cause of death, or (b) may authorize dissection for any other purpose by written instrument which shall specify the purpose and extent of the dissection so authorized, and when a dissection is so authorized pursuant to this subdivision the person authorizing the dissection also may designate a physician licensed in any state or country to observe such dissection. If the deceased has upon his person an identification card indicating his opposition to the dissection or autopsy of his body no such dissection or autopsy shall be performed except as required by law; or,

4. Whenever any district attorney in this state, in the discharge of his official duties, shall deem it necessary, he may exhume, take possession of, and remove the body of a deceased person, or any portion thereof, and submit the same to a proper physical or chemical examination, or analysis, to ascertain the cause of death, and the same shall be made on the order of any justice of the supreme court of this state, or the county judge of the county in which such dead body shall be, which order shall be made on the application of the district attorney with or without notice to the relatives of the deceased person or to any person or corporation having the legal charge of such body, as the court may direct. Said district attorney shall have power to direct any police officer or peace officer, acting pursuant to his special duties, of this state, or to employ such person, or persons as he may deem necessary to assist him in exhuming, removing, obtaining possession of and examining physically or chemically such dead body or any portion thereof. The expense therefor shall be a county charge, to be paid by the county treasurer on the certificate of the district attorney.

## NORTH CAROLINA

Lacks specific provisions for automatic autopsy of children fatalities.

*For general autopsy or death reporting requirements, see N.C. Gen. Stat. Ann. § 130A-389 (2010).*

## NORTH DAKOTA

N.D. CENT. CODE § 11-19.1-07 (2009). Reports of death--Death of minor

1. Any person who discovers the deceased human body or acquires the first knowledge of the death of any individual, and any physician with knowledge that an individual died as a result of criminal or violent means, died suddenly when in apparent good health in a suspicious or unusual manner, or died as the result of any other reportable circumstance, shall notify immediately the office of coroner or any law enforcement officer of the known facts concerning the time, place, manner, and circumstances of that death, and any other information that may be required pursuant to this chapter. Any person who violates this section is guilty of a class B misdemeanor.

2. Any person who discovers the deceased human body or acquires the first knowledge of the death of any minor who has received or is eligible to receive a birth record, when the minor died suddenly when in apparent good health, shall notify immediately law enforcement or the office of coroner of the known facts concerning the time, place, manner, and circumstances of the death. The death of a minor must be reported to the department of human services as provided under chapter 50-25.1. The coroner shall take custody of the body and immediately consult with a law enforcement agency. The law enforcement agency shall investigate the death and notify the state's attorney of the findings. The coroner shall notify the state forensic examiner of each such death, and shall provide the state forensic examiner the information concerning the death as the state forensic examiner requires. The coroner or the assistant or deputy coroner shall notify the parent or guardian of a child under the age of one year of the right to the performance of an autopsy, at state expense, as provided by this chapter.

#### N.D. CENT. CODE § 11-19.1-11 (2009). Autopsies--Notice of results

1. The coroner or the coroner's medical deputy, if the coroner deems it necessary, may take custody of the deceased human body for the purpose of autopsy. When the coroner does not deem an autopsy necessary, the sheriff or state's attorney may direct an autopsy be performed.

2. The autopsy must be performed by the state forensic examiner or by the state forensic examiner's authorized pathologist at a facility approved by the state forensic examiner.

3. Upon the death of a minor whose cause of death is suspected by the minor's parent or guardian or the coroner or the coroner's medical deputy to have been the sudden infant death syndrome, the coroner or the coroner's medical deputy, after consultation with the parent or guardian, shall take custody of the body and shall arrange for the performance of the autopsy by the state forensic examiner or a pathologist designated by the state forensic examiner, unless the county coroner, sheriff, state's attorney, and the parent or guardian all agree that an autopsy is unnecessary. The parents or guardian and the state health officer must be promptly notified of the results of that autopsy.

4. A report of death, an autopsy report, and any working papers, notes, images, pictures, photographs, or recordings in any form are confidential but the coroner may use or

disclose these materials for purposes of an investigation, inquest, or prosecution. The coroner may disclose a copy of the report of death in accordance with the authority of the state forensic examiner under section 23-01-05.5 and may disclose an autopsy photograph or other visual image or video or audio recording subject to limitations in section 44-04-18.18. The coroner shall disclose a copy of the autopsy report to the state forensic examiner.

## OHIO

### OHIO REV. CODE ANN. § 313.12 (2011). Notification of coroner in case of death by violence, casualty, suicide, or suspicious or unusual manner

(A) When any person dies as a result of criminal or other violent means, by casualty, by suicide, or in any suspicious or unusual manner, when any person, including a child under two years of age, dies suddenly when in apparent good health, or when any mentally retarded person or developmentally disabled person dies regardless of the circumstances, the physician called in attendance, or any member of an ambulance service, emergency squad, or law enforcement agency who obtains knowledge thereof arising from the person's duties, shall immediately notify the office of the coroner of the known facts concerning the time, place, manner, and circumstances of the death, and any other information that is required pursuant to sections 313.01 to 313.22 of the Revised Code. In such cases, if a request is made for cremation, the funeral director called in attendance shall immediately notify the coroner.

(B) As used in this section, “mentally retarded person” and “developmentally disabled person” have the same meanings as in section 5123.01 of the Revised Code.

### OHIO REV. CODE ANN. § 313.121 (2011). Autopsy of child under two years of age dying suddenly when in apparent good health

(A) As used in this section, “parent” means either parent, except that if one parent has been designated the residential parent and legal custodian of the child, “parent” means the designated residential parent and legal custodian, and if a person other than a parent is the child's legal guardian, “parent” means the legal guardian.

(B) If a child under two years of age dies suddenly when in apparent good health, the death shall be reported immediately to the coroner of the county in which the death occurred, as required by section 313.12 of the Revised Code. Except as provided in division (C) of this section, the coroner or deputy coroner shall perform an autopsy on the child. The autopsy shall be performed in accordance with public health council rules adopted under section 313.122 of the Revised Code. The coroner or deputy coroner may



perform research procedures and tests when performing the autopsy.

(C) A coroner or deputy coroner is not required to perform an autopsy if the coroner of the county in which the death occurred or a court with jurisdiction over the deceased body determines under section 313.131 of the Revised Code that an autopsy is contrary to the religious beliefs of the child. If the coroner or the court makes such a determination, the coroner shall notify the health district or department of health with jurisdiction in the area in which the child's parent resides. For purposes of this division, the religious beliefs of the parents of a child shall be considered to be the religious beliefs of the child.

(D) If the child's parent makes a written or verbal request for the preliminary results of the autopsy after the results are available, the coroner, or a person designated by him, shall give the parent an oral statement of the preliminary results.

The coroner, within a reasonable time after the final results of the autopsy are reported, shall send written notice of the results to the state department of health, the health district or department with jurisdiction in the area in which the child's parent resides, and, upon the request of a parent of the child, to the child's attending physician. Upon the written request of a parent of the child and the payment of the transcript fee required by section 313.10 of the Revised Code, the coroner shall send written notice of the final results to that parent. The notice sent to the state department of health shall include all of the information specified by rule of the public health council adopted under section 313.122 of the Revised Code.

(E) On the occurrence of any of the following, the health district or department with jurisdiction in the area in which the child's parent resides shall offer the parent any counseling or other supportive services it has available:

(1) When it learns through any source that an autopsy is being performed on a child under two years of age who died suddenly when in apparent good health;

(2) When it receives notice that the final result of an autopsy performed pursuant to this section concluded that the child died of sudden infant death syndrome;

(3) When it is notified by the coroner that, pursuant to division (C) of this section, an autopsy was not performed.

(F) When a health district or department receives notice that the final result of an autopsy performed pursuant to this section concluded that the child died of sudden infant death syndrome or that, pursuant to division (C) of this section, an autopsy was not performed but sudden infant death syndrome may have been the cause of death, it shall offer the child's parent information about sudden infant death syndrome. The state department of health shall ensure that current information on sudden infant death syndrome is available for distribution by health districts and departments.

## OKLAHOMA

### OKLA. STAT. ANN. TIT. 10, § 1150.2 (2011). Child Death Review Board-- Creation--Powers and duties--Meetings and discussions--Annual report

A. There is hereby re-created until July 1, 2012, in accordance with the Oklahoma Sunset Law, [FN1] the Child Death Review Board within the Oklahoma Commission on Children and Youth. The Board shall have the power and duty to:

1. Conduct case reviews of deaths and near deaths of children in this state;
2. Develop accurate statistical information and identification of deaths of children due to abuse and neglect;
3. Improve the ability to provide protective services to the surviving siblings of a child or children who die of abuse or neglect and who may be living in a dangerous environment;
4. Improve policies, procedures and practices within the agencies that serve children, including the child protection system;
5. Enter into agreements with local teams established by the Child Death Review Board to carry out such duties and responsibilities as the Child Death Review Board shall designate, including reviewing cases assigned by the Board in the geographical area for that local team. The Oklahoma Commission on Children and Youth, with the advice of the Child Death Review Board, shall promulgate rules as necessary for the implementation and administration of the provisions of this paragraph; and
6. Enter into agreements with other state, local, or private entities as necessary to carry out the duties of the Child Death Review Board including, but not limited to, conducting joint reviews with the Domestic Violence Fatality Review Board on domestic violence cases involving child death or child near-death incidents.

B. In carrying out its duties and responsibilities the Board shall:

1. Establish criteria for cases involving the death or near death of a child subject to specific, in-depth review by the Board. As used in this section, the term “near death” means a child is in serious or critical condition, as certified by a physician, as a result of abuse or neglect;
2. Conduct a specific case review of those cases where the cause of death or near death is or may be related to abuse or neglect of a child;

3. Establish and maintain statistical information related to the deaths and near deaths of children including, but not limited to, demographic and medical diagnostic information;
4. Establish procedures for obtaining initial information regarding near deaths of children from the Department of Human Services and law enforcement agencies;
5. Review the policies, practices, and procedures of the child protection system and make specific recommendations to the entities comprising the child protection system for actions necessary for the improvement of the system;
6. Review the extent to which the state child protection system is coordinated with foster care and adoption programs and evaluate whether the state is efficiently discharging its child protection responsibilities under the federal Child Abuse Prevention and Treatment Act [FN2] state plan;
7. As necessary and appropriate, for the protection of the siblings of a child who dies and whose siblings are deemed to be living in a dangerous environment, refer specific cases to the Department of Human Services or the appropriate district attorney for further investigation;
8. Request and obtain a copy of all records and reports pertaining to a child whose case is under review including, but not limited to:
  - a. the report of the medical examiner,
  - b. hospital records,
  - c. school records,
  - d. court records,
  - e. prosecutorial records,
  - f. local, state, and federal law enforcement records including, but not limited to, the Oklahoma State Bureau of Investigation (OSBI),
  - g. fire department records,
  - h. State Department of Health records, including birth certificate records,
  - i. medical and dental records,
  - j. Department of Mental Health and Substance Abuse Services and other mental health records,

k. emergency medical service records,

l. files of the Department of Human Services, and

m. records in the possession of the Domestic Violence Fatality Review Board when conducting a joint review pursuant to paragraph 6 of subsection A of this section.

Confidential information provided to the Board shall be maintained by the Board in a confidential manner as otherwise required by state and federal law. Any person damaged by disclosure of such confidential information by the Board, its local boards or their members, not authorized by law, may maintain an action for damages, costs and attorney fees;

9. Maintain all confidential information, documents and records in possession of the Board as confidential and not subject to subpoena or discovery in any civil or criminal proceedings; provided, however, information, documents and records otherwise available from other sources shall not be exempt from subpoena or discovery through those sources solely because such information, documents and records were presented to or reviewed by the Board;

10. Conduct reviews of specific cases of deaths and near deaths of children and request the preparation of additional information and reports as determined to be necessary by the Board including, but not limited to, clinical summaries from treating physicians, chronologies of contact, and second opinion autopsies;

11. Report, if recommended by a majority vote of the Board, to the President Pro Tempore of the Senate and the Speaker of the House of Representatives any gross neglect of duty by any state officer or state employee, or any problem within the child protective services system discovered by the Board while performing its duties;

12. Recommend, when appropriate, amendment of the cause or manner of death listed on the death certificate; and

13. Subject to the approval of the Oklahoma Commission on Children and Youth, exercise all incidental powers necessary and proper for the implementation and administration of the Child Death Review Board Act.

C. The review and discussion of individual cases of death or near death of a child shall be conducted in executive session and in compliance with the confidentiality requirements of Section 7005-1.2 of this title. All other business shall be conducted in accordance with the provisions of the Oklahoma Open Meeting Act. [FN3] All discussions of individual cases and any writings produced by or created for the Board in the course of its remedial measure and recommended by the Board, as the result of a review of an individual case of the death or near death of a child, shall be privileged and shall not be admissible in evidence in any proceeding. The Board shall periodically conduct meetings to discuss

organization and business matters and any actions or recommendations aimed at improvement of the child protection system which shall be subject to the Oklahoma Open Meeting Act. Part of any meeting of the Board may be specifically designated as a business meeting of the Board subject to the Oklahoma Open Meeting Act.

D. 1. The Board shall submit an annual statistical report on the incidence and causes of death and near death of children in this state for which the Board has completed its review during the past calendar year, including its recommendations, to the Oklahoma Commission on Children and Youth on or before May 1 of each year. The Board shall also prepare and make available to the public, on an annual basis, a report containing a summary of the activities of the Board relating to the review of deaths and near deaths of children, the extent to which the state child protection system is coordinated with foster care and adoption programs, and an evaluation of whether the state is efficiently discharging its child protection responsibilities. The report shall be completed no later than December 31 of each year.

2. The Oklahoma Commission on Children and Youth shall review the report of the Board and, as appropriate, incorporate the findings and recommendations into the annual Commission report and the State Plan for Services to Children and Youth.

## OREGON

### OR. REV. STAT. § 418.785 (2011). Child Fatality Review Teams

(1) Each county multidisciplinary child abuse team shall establish a child fatality review team to conduct child fatality reviews. The purpose of the review process is to help prevent severe and fatal child abuse and neglect by:

(a) Identifying local and state issues related to preventable child fatalities; and

(b) Promoting implementation of recommendations at the county level.

(2) In establishing the review process and carrying out reviews, the child fatality review team shall be assisted by the county medical examiner or county health officer as well as other professionals who are specially trained in areas relevant to the purpose of the team.

(3) The categories of fatalities reviewed by the child fatality review team include:

(a) Child fatalities in which child abuse or neglect may have occurred at any time prior to death or may have been a factor in the fatality;

(b) Any category established by the county multidisciplinary child abuse team;

(c) All child fatalities where the child is less than 18 years of age and there is an autopsy performed by the medical examiner; and

(d) Any specific cases recommended for local review by the statewide interdisciplinary team established under ORS 418.748.

(4) A child fatality review team shall develop a written protocol for review of child fatalities. The protocol shall be designed to facilitate communication and the exchange of information between persons who perform autopsies and those professionals and agencies concerned with the prevention, investigation and treatment of child abuse and neglect.

(5) Within the guidelines, and in a format, established by the statewide interdisciplinary team established under ORS 418.748, the child fatality review team shall provide the statewide interdisciplinary team with information regarding the categories of child fatalities described under subsection (3) of this section.

(6) Upon the conclusion of a criminal case involving a child fatality, or upon the conclusion of a direct appeal if one is taken, the district attorney may submit a letter to the Governor and the Director of Human Services outlining recommendations for the systemic improvement of child abuse investigations.

## PENNSYLVANIA

11 PA. CONS. STAT. ANN. § 2150.6 (2011). Powers and duties of local public health child death review teams

**(a) Review.**--A local public health child death review team shall review all deaths of children and may review the following information:

(1) Coroner's reports or postmortem examination records.

(2) Death certificates and birth certificates.

(3) Law enforcement records and interviews with law enforcement officials as long as the release of such records will not jeopardize an ongoing criminal investigation or proceeding.

(4) Medical records from hospitals and other health care providers.

(5) Information and reports made available by the county children and youth agency in accordance with 23 Pa.C.S. Ch. 63 (relating to child protective services).

(6) Information made available by firefighters or emergency services personnel.

(7) Reports and records made available by the court to the extent permitted by law or court rule.

(8) Reports to animal control.

(9) EMS records.

(10) Traffic fatality reports.

(11) Any other records necessary to conduct the review.

**(b) Data collection.**--The local public health child death review team shall utilize the child death review data collection system to report its findings in accordance with protocols established by the State public health child death review team. The name and home address of the deceased child shall not be reported to the child death review data collection system.

**(c) Reports.**--A local public health child death review team shall submit annual reports on deaths reviewed to the State public health child death review team. The report shall include the following:

(1) Identification of factors which cause a risk for injury and death, including modifiable risk factors.

(2) Recommendations regarding the following:

(i) The improvement of health and safety policies in this Commonwealth.

(ii) The coordination of services and investigations by child welfare agencies, medical officials, law enforcement and other agencies.

(3) Any other information required by the department.

**(d) Recommendations.**--A local public health child death review team shall make recommendations to local agencies relating to the procedures and other actions to reduce

injury and death of children.

16 PA. CONS. STAT. ANN. § 1237 (2011). Coroner's investigations

(a) The coroner having a view of the body shall investigate the facts and circumstances concerning deaths which appear to have happened within the county, regardless where the cause thereof may have occurred, for the purpose of determining whether or not an autopsy should be conducted or an inquest thereof should be had, in the following cases:

(1) sudden deaths not caused by readily recognizable disease, or wherein the cause of death cannot be properly certified by a physician on the basis of prior (recent) medical attendance;

(2) deaths occurring under suspicious circumstances, including those where alcohol, drugs or other toxic substances may have had a direct bearing on the outcome;

(3) deaths occurring as a result of violence or trauma, whether apparently homicidal, suicidal or accidental (including, but not limited to, those due to mechanical, thermal, chemical, electrical or radiational injury, drowning, cave-ins and subsidences);

(4) any death in which trauma, chemical injury, drug overdose or reaction to drugs or medication or medical treatment was a primary or secondary, direct or indirect, contributory, aggravating or precipitating cause of death;

(5) operative and peri-operative deaths in which the death is not readily explainable on the basis of prior disease;

(6) any death wherein the body is unidentified or unclaimed;

(7) deaths known or suspected as due to contagious disease and constituting a public hazard;

(8) deaths occurring in prison or a penal institution or while in the custody of the police;

(9) deaths of persons whose bodies are to be cremated, buried at sea or otherwise disposed of so as to be thereafter unavailable for examination;

(10) sudden infant death syndrome; and



(11) stillbirths.

(b) The purpose of the investigation shall be to determine the cause of any such death and to determine whether or not there is sufficient reason for the coroner to believe that any such death may have resulted from criminal acts or criminal neglect of persons other than the deceased.

(c) As part of this investigation, the coroner shall determine the identity of the deceased and notify the next of kin of the deceased.

## RHODE ISLAND

Lacks specific provisions for automatic autopsy of children fatalities.

*For general autopsy or death reporting requirements, see R.I. Gen. Laws 1956 §§ 23-4-4 (2010) and 23-4-7 (2010).*

## SOUTH CAROLINA

S.C. CODE ANN. § 17-5-520 (2010). Authority to order autopsy; request in event of child's death.

(A) In addition to the powers vested in other law enforcement officials to order an autopsy, the coroner or medical examiner is authorized to determine that an autopsy be made.

(B) The coroner or medical examiner immediately shall request an autopsy if a child's death occurs as defined in Section 17-5-540. The autopsy must be performed as soon as possible by a pathologist with forensic training.

S.C. CODE ANN. § 63-11-1940 (2010). Purpose and duties of department.

(A) The purpose of the department is to expeditiously investigate child deaths in all counties of the State.

(B) To achieve its purpose, the department shall:

(1) upon receipt of a report of a child death from the county coroner or medical examiner, as required by Section 17-5-540, investigate and gather all information on the child fatality. The coroner or medical examiner immediately shall request an autopsy if SLED determines that an autopsy is necessary. The autopsy must be performed by a pathologist

with forensic training as soon as possible. The pathologist shall inform the department of the findings within forty-eight hours of completion of the autopsy. If the autopsy reveals the cause of death to be pathological or an unavoidable accident, the case must be closed by the department. If the autopsy reveals physical or sexual trauma, suspicious markings, or other findings that are questionable or yields no conclusion to the cause of death, the department immediately must begin an investigation;

(2) request assistance of any other local, county, or state agency to aid in the investigation;

(3) upon receipt of additional investigative information, reopen a SLED case, and request in writing as soon as possible for the coroner to reopen a case for another coroner's inquest;

(4) upon receipt of the notification required by item (1), review agency records for information regarding the deceased child or family. Information available to the department pursuant to Section 63-11-1960 and information which is public under Chapter 4, Title 30, the Freedom of Information Act, must be available as needed to the county coroner or medical examiner and county department of social services;

(5) report the activities and findings related to a child fatality to the State Child Fatality Advisory Committee;

(6) develop a protocol for child fatality reviews;

(7) develop a protocol for the collection of data regarding child deaths as related to Section 17-5-540 and provide training to local professionals delivering services to children, county coroners and medical examiners, and law enforcement agencies on the use of the protocol;

(8) study the operations of local investigations of child fatalities, including the statutes, regulations, policies, and procedures of the agencies involved with children's services and child death investigations;

(9) examine confidentiality and access to information statutes, regulations, policies, and procedures for agencies with responsibilities for children, including, but not limited to, health, public welfare, education, social services, mental health, alcohol and other substance abuse, and law enforcement agencies and determine whether those statutes, regulations, policies, or procedures impede the exchange of information necessary to protect children from preventable deaths. If the department identifies a statute, regulation, policy, or procedure that impedes the necessary exchange of information, the department shall notify the committee and the agencies serving on the committee and the committee shall include proposals for changes to statutes, regulations, policies, or procedures in the committee's annual report;

(10) develop a Forensic Pathology Network available to coroners and medical examiners for prompt autopsy findings;

(11) submit to the Governor and the General Assembly, an annual report and any other reports prepared by the department, including, but not limited to, the department's findings and recommendations;

(12) promulgate regulations necessary to carry out its purposes and responsibilities under this article.

## SOUTH DAKOTA

### S.D. CODIFIED LAWS § 23-14-18 (2011). Deaths to be investigated by coroner

The county coroner shall investigate any human death if a determination of the cause and manner of death is in the public interest. Nothing in the provisions of this section, § 23-14-9.1, 23-14-19, 23-14-20, 34-26-2, 34-26-5, or 34-26-14 supersedes the obligation of any county sheriff to pursue and apprehend all felons pursuant to § 7-12-1. Deaths which are in the public interest, without limitation, are:

(1) All deaths by unnatural means or if there is a suspicion of unnatural means, including all deaths of accidental, homicidal, suicidal, and undetermined manner, regardless of suspected criminal involvement in the death;

(2) All deaths where the identity of the victim is unknown or the body is unclaimed;

(3) All deaths of inmates of any state, county, or municipally operated correctional facility, mental institution, or special school;

(4) All deaths believed to represent a public health hazard;

(5) At the discretion of the coroner, all deaths of children under two years of age resulting from an unknown cause or if the circumstances surrounding the death indicate that sudden infant death syndrome may be the cause of death; and

(6) All natural deaths if the decedent is not under the care of a physician, physician's assistant, or nurse practitioner or if the decedent's physician, physician's assistant, or nurse practitioner does not feel qualified to sign the death certificate. However, the lack of an attending physician may not be construed to require an investigation or autopsy solely because the decedent was under treatment by prayer or spiritual means alone in accordance with the tenets and practices of a recognized church or religious

denomination.

## TENNESSEE

### TENN. CODE ANN. § 38-7-106 (2011). Autopsies; donor eyes

(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 the provisions of 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 the provisions of title 68, chapter 30, part 1.

### TENN. CODE ANN. § 68-1-1102 (2011). Purpose; establishment of program; autopsies; cause of death; liabilities

(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.

## TEXAS

### TEX. FAM. CODE ANN. § 264.514 (2011). Procedure in the Event of Reportable Death

(a) A medical examiner or justice of the peace notified of a death of a child under Section 264.513 shall hold an inquest under Chapter 49, Code of Criminal Procedure, to determine whether the death is unexpected or the result of abuse or neglect. An inquest is not required under this subchapter if the child's death is expected and is due to a congenital or neoplastic disease. A death caused by an infectious disease may be considered an expected death if:

- (1) the disease was not acquired as a result of trauma or poisoning;
- (2) the infectious organism is identified using standard medical procedures; and
- (3) the death is not reportable to the Texas Department of Health under Chapter 81, Health and Safety Code.

(b) The medical examiner or justice of the peace shall immediately notify an appropriate local law enforcement agency if the medical examiner or justice of the peace determines that the death is unexpected or the result of abuse or neglect, and that agency shall investigate the child's death.

(c) In this section, the terms “abuse” and “neglect” have the meaning assigned those terms by Section 261.001.

#### TEX. FAM. CODE ANN. § 264.515 (2011). Investigation

(a) The investigation required by Section 264.514 must include:

- (1) an autopsy, unless an autopsy was conducted as part of the inquest;
- (2) an inquiry into the circumstances of the death, including an investigation of the scene of the death and interviews with the parents of the child, any guardian or caretaker of the child, and the person who reported the child's death; and
- (3) a review of relevant information regarding the child from an agency, professional, or health care provider.

(b) The review required by Subsection (a)(3) must include a review of any applicable medical record, child protective services record, record maintained by an emergency medical services provider, and law enforcement report.

(c) The committee shall develop a protocol relating to investigation of an unexpected death of a child under this section. In developing the protocol, the committee shall consult with individuals and organizations that have knowledge and experience in the issues of child abuse and child deaths.

#### TEX. HEALTH & SAFETY CODE ANN. § 673.002 (2011). Autopsy

(a) The death in this state of a child 12 months old or younger shall be immediately reported to the justice of the peace, medical examiner, or other proper official as prescribed by law if the child dies suddenly or is found dead and if the cause of death is unknown.

(b) The justice of the peace or medical examiner shall inform the child's legal guardian or parents that an autopsy shall be performed on the child. The state shall reimburse a county \$500 for the cost of the autopsy if the primary cause of death of the child is sudden infant death syndrome. The department shall adopt rules that:

- (1) define sudden infant death syndrome; and
- (2) describe the method for obtaining reimbursement for the cost of an autopsy.

(c) Reimbursement required by Subsection (b) of this section is subject to the availability of funds.

(d) After the autopsy is completed, the child's parents or legal guardian shall be notified of the autopsy results.

(e) This section does not affect the duties of the justice of the peace or medical examiner prescribed by other laws.

## UTAH

### UTAH CODE ANN. § 26-4-7 (2011). Custody by medical examiner

Upon notification under Section 26-4-8 or investigation by the medical examiner's office, the medical examiner shall assume custody of a deceased body if it appears that death was:

(1) by violence, gunshot, suicide, or accident unless the accident is a highway accident. If the death was from a highway accident, custody shall only be assumed if an autopsy is required or permitted under the provisions of Section 26-4-13 or if requested by the law enforcement agency with jurisdiction over the highway accident;

(2) sudden death while in apparent good health;

(3) unattended deaths, except that an autopsy may only be performed in accordance with the provisions of Subsection 26-4-9 (3);

(4) under suspicious or unusual circumstances;

(5) resulting from poisoning or overdose of drugs;

(6) resulting from diseases that may constitute a threat to the public health;

(7) resulting from disease, injury, toxic effect, or unusual exertion incurred within the scope of the decedent's employment;

(8) due to sudden infant death syndrome;

(9) resulting while the decedent was in prison, jail, police custody, the state hospital, or in a detention or medical facility operated for the treatment of persons with a mental illness, persons who are emotionally disturbed, or delinquent persons;



(10) associated with diagnostic or therapeutic procedures; or

(11) described in this section when request is made to assume custody by a county or district attorney or law enforcement agency in connection with a potential homicide investigation or prosecution.

## VERMONT

Lacks specific provisions for automatic autopsy of children fatalities.

*For general autopsy or death reporting requirements, see Vermont Stat. Ann. 18 § 5218 (2011).*

## VIRGINIA

VA. CODE ANN. § 32.1-285 (2011). Autopsies

A. If, in the opinion of the medical examiner investigating the death or of the Chief Medical Examiner, it is advisable and in the public interest that an autopsy be made or if an autopsy is requested by the attorney for the Commonwealth or by a judge of the circuit court of the county or city wherein such body is or where death occurred or wherein any injury contributing to or causing death was sustained, an autopsy shall be performed by the Chief Medical Examiner, an assistant chief medical examiner or a pathologist employed as provided in § 32.1-281. Upon petition of a member of the immediate family or the spouse of the deceased in a case of death by injury, such circuit court may, for good cause shown, order an autopsy, after providing notice and an opportunity to be heard to the attorney for the Commonwealth for the jurisdiction wherein the injury contributing to or causing death was sustained or where death occurred. Further, in all cases of death suspected to be attributable to Sudden Infant Death Syndrome (SIDS), an autopsy shall be advisable and in the public interest and shall be performed as required by § 32.1-285.1. A full record and report of the facts developed by the autopsy and findings of the person making such autopsy shall be promptly made and filed with the Chief Medical Examiner and a copy furnished the judge or attorney for the Commonwealth requesting such autopsy. In the discretion of the Chief Medical Examiner or the medical examiner, a copy of any autopsy report or findings may be furnished to any appropriate attorney for the Commonwealth and to the appropriate law-enforcement agency investigating the death.

B. In the case of a child death for which an autopsy is performed and the autopsy indicates child abuse or neglect contributed to the cause of the death, or the child suffered from abuse and neglect, the medical examiner conducting the autopsy shall report the case immediately to the child protective services unit of the local Department of Social

Services.

### VA. CODE ANN. § 32.1-285.1 (2011). Death of infants under eighteen months of age; autopsies required; definition of Sudden Infant Death Syndrome

An autopsy shall be performed in the case of any infant death which is suspected to be attributable to Sudden Infant Death Syndrome (SIDS).

For the purposes of this section, “Sudden Infant Death Syndrome” (SIDS), a diagnosis of exclusion, means the sudden and unexpected death of an infant less than eighteen months of age whose death remains unexplained after a thorough postmortem examination which includes an autopsy.

## WASHINGTON

### WASH. REV. CODE ANN. § 43.103.100 (2011). Sudden infant death syndrome -- Training -- Protocols

(1) The council shall research and develop an appropriate training component on the subject of sudden, unexplained child death, including but not limited to sudden infant death syndrome. The training component shall include, at a minimum:

(a) Medical information on sudden, unexplained child death for first responders, including awareness and sensitivity in dealing with families and child care providers, and the importance of forensically competent death scene investigation;

(b) Information on community resources and support groups available to assist families who have lost a child to sudden, unexplained death, including sudden infant death syndrome; and

(c) The value of timely communication between the county coroner or medical examiner and the public health department, when a sudden, unexplained child death occurs, in order to achieve a better understanding of such deaths, and connecting families to various community and public health support systems to enhance recovery from grief.

(2) The council shall work with volunteer groups with expertise in the area of sudden, unexplained child death, including but not limited to the SIDS foundation of Washington and the Washington association of county officials.

(3) Basic training for death investigators offered by the Washington association of coroners and medical examiners and the criminal justice training commission shall

include a module which specifically addresses the investigations of the sudden unexplained deaths of children under the age of three. The training module shall include a scene investigation protocol endorsed or developed by the council. A similar training curriculum shall be required for city and county law enforcement officers and emergency medical personnel certified by the department of health as part of their basic training through the criminal justice training commission or the department of health emergency medical training certification program.

(4) Each county shall use a protocol that has been endorsed or developed by the council for scene investigations of the sudden unexplained deaths of children under the age of three. The council may utilize guidelines from the center for disease control and other appropriate resources.

(5) The council shall develop a protocol for autopsies of children under the age of three whose deaths are sudden and unexplained. This protocol shall be used by pathologists who are not certified by the American board of pathology in forensic pathology, and who are providing autopsy services to coroners and medical examiners.

#### WASH. REV. CODE ANN. § 68.50.100 (2011). Dissection; when permitted – Autopsy of person under three years of age

(1) The right to dissect a dead body shall be limited to cases specially provided by statute or by the direction or will of the deceased; cases where a coroner is authorized to hold an inquest upon the body, and then only as he or she may authorize dissection; and cases where the spouse, state registered domestic partner, or next of kin charged by law with the duty of burial shall authorize dissection for the purpose of ascertaining the cause of death, and then only to the extent so authorized: PROVIDED, That the coroner, in his or her discretion, may make or cause to be made by a competent pathologist, toxicologist, or physician, an autopsy or postmortem in any case in which the coroner has jurisdiction of a body: PROVIDED, FURTHER, That the coroner may with the approval of the University of Washington and with the consent of a parent or guardian deliver any body of a deceased person under the age of three years over which he or she has jurisdiction to the University of Washington medical school for the purpose of having an autopsy made to determine the cause of death.

(2) Every person who shall make, cause, or procure to be made any dissection of a body, except as provided in this section, is guilty of a gross misdemeanor.

## WEST VIRGINIA

W. VA. CODE ANN. § 61-12-10 (2011). When autopsies made and by whom performed; reports; records of date investigated; copies of records and information

(a) If in the opinion of the chief medical examiner, or of the county medical examiner of the county in which the death in question occurred, it is advisable and in the public interest that an autopsy be made, or if an autopsy is requested by either the prosecuting attorney or the judge of the circuit court or other court of record having criminal jurisdiction in that county, an autopsy shall be conducted by the chief medical examiner or his or her designee, by a member of his staff, or by a competent pathologist designated and employed by the chief medical examiner under the provisions of this article. For this purpose, the chief medical examiner may employ any county medical examiner who is a pathologist who holds board certification or board eligibility in forensic pathology or has completed an American Board of Pathology fellowship in forensic pathology to make the autopsies, and the fees to be paid for autopsies under this section shall be in addition to the fee provided for investigations pursuant to section eight of this article. A full record and report of the findings developed by the autopsy shall be filed with the office of the chief medical examiner by the person making the autopsy.

(b) Within the discretion of the chief medical examiner, or of the person making the autopsy, or if requested by the prosecuting attorney of the county, or of the county where any injury contributing to or causing the death was sustained, a copy of the report of the autopsy shall be furnished to the prosecuting attorney.

(c) The office of the chief medical examiner shall keep full, complete and properly indexed records of all deaths investigated, containing all relevant information concerning the death and the autopsy report if such be made. Any prosecuting attorney or law-enforcement officer may secure copies of these records or information necessary for the performance of his or her official duties.

(d) Copies of these records or information shall be furnished, upon request, to any court of law, or to the parties therein to whom the cause of death is a material issue, except where the court determines that interests in a civil matter conflict with the interests in a criminal proceeding, in which case the interests in the criminal proceeding shall take precedence. The office of chief medical examiner shall be reimbursed a reasonable rate by the requesting party for costs incurred in the production of records under this subsection and subsection (c) of this section.

(e) The chief medical examiner is authorized to release investigation records and autopsy reports to the multidisciplinary team authorized by section three, article five-d, chapter forty-nine of this code. At the direction of the secretary of the department of health and human resources the chief medical examiner may release records and information to

other state agencies when considered to be in the public interest.

(f) Any person performing an autopsy under this section is empowered to keep and retain, for and on behalf of the chief medical examiner, any tissue from the body upon which the autopsy was performed which may be necessary for further study or consideration.

(g) In cases of the death of any infant in the state of West Virginia where sudden infant death syndrome is the suspected cause of death and the chief medical examiner or the medical examiner of the county in which the death in question occurred considers it advisable to perform an autopsy, it is the duty of the chief medical examiner or the medical examiner of the county in which the death occurred to notify the sudden infant death syndrome program within the division of maternal and child health and to inform the program of all information to be given to the infant's parents.

## WISCONSIN

### WIS. STAT. ANN. § 979.03 (2011). Autopsy for sudden infant death syndrome

If a child under the age of 2 years dies suddenly and unexpectedly under circumstances indicating that the death may have been caused by sudden infant death syndrome, the coroner or medical examiner shall notify the child's parents or guardian that an autopsy will be performed, at no cost to the parents or guardian, unless the parents or guardian object to the autopsy. The coroner or medical examiner shall conduct or shall order the conducting of an autopsy at county expense, unless parent or guardian requests in writing that an autopsy not be performed. If the autopsy reveals that sudden infant death syndrome is the cause of death, that fact shall be so stated in the autopsy report. The parents or guardian of the child shall be promptly notified of the cause of death and of the availability of counseling services.

## WYOMING

Lacks specific provisions for automatic autopsy of children fatalities.

*For general autopsy or death reporting requirements, see Wyo. Ann. Stat. § 5218 (2011).*

## FEDERAL LEGISLATION

Lacks specific provisions for automatic autopsy of children fatalities.

*For general autopsy or death reporting requirements, see 30 U.S. Code Ann. § 843 (2011) and 18 U.S.C.A. § 4045 (2011)*

## ***U.S. TERRITORIES***

### **AMERICAN SAMOA**

Lacks specific provisions for automatic autopsy of children fatalities.

*For general autopsy or death reporting requirements, see Am. Samoa Code Ann. 13.0522 (2011)*

### **GUAM**

Lacks specific provisions for automatic autopsy of children fatalities.

*For general autopsy or death reporting requirements, see Guam Code Ann. tit. 10, § 81105 (2010)*

### **PUERTO RICO**

Lacks specific provisions for automatic autopsy of children fatalities.

*For general autopsy or death reporting requirements, see P.R. Laws Ann. tit. 34 §§ 3011-12 (2010).*

### **U.S. VIRGIN ISLANDS**

Lacks specific provisions for automatic autopsy of children fatalities.

*For general autopsy or death reporting requirements, see V.I. Code Ann. tit. 3, 115 (2010).*