Principles for Communicating with Next of Kin during Medicolegal Death Investigations

When a death requiring a medicolegal death investigation occurs, families will have many questions and concerns as they assimilate and accept information about the death of their loved one. Families of individuals who died in situations requiring an investigation experience additional challenges and emotions not faced by families following “normal or anticipated” deaths. Sudden deaths exacerbate the experience of grief and loss—regardless of the manner of death. The investigation generally delays and often affects mourning rituals, and thus has the potential to create uncertainty, additional frustration and psychological stress.

How medicolegal professionals communicate with families in the aftermath of a death will have a direct impact on their ability to cope, their view of the medicolegal system, and their willingness to cooperate with the investigation and future proceedings.

Medical Examiners’ and Coroners’ offices vary widely with regard to capacity, resources, and statutory mandates. The principles included here can be adapted by any office in their approach to interacting with Next of Kin (NOK) in any manner of death whether it is: natural, accidental, suicide, homicide or undetermined.

**Principle 1**: No two individuals grieve alike. Sensitivity and respect for cultural, religious and individual preferences should be pursued and accommodated to the extent that the investigation allows.

- Do not assume that ALL NOK will prefer communication in the same way.
- Understand that the detailed experience the NOK has with medicolegal professionals during this traumatic time will become part of their personal and family history forever.

**Principle 2**: Medical Examiners, Forensic Pathologists, Coroners, Medicolegal death investigators and all other Medicolegal Professionals who have the potential to interact with NOK should receive training appropriate to their duties. This training should include but not be limited to: death notification, interacting with people in crisis and trauma, grief education and the management and return of personal effects.

- Additional local resources for possible trainers, in addition to the above mentioned MDI professionals, who may support these training needs include: victim assistance programs,
mental health providers who are involved in trauma intervention, bereavement programs, hospice programs, and various organizations dealing with sudden death.

- Specific topics for training content include, but are not limited to, the basics of effective crisis intervention, communication basics with individuals in crisis (verbal and non-verbal), understanding the basics of grief and loss, and responding to angry reactions/managing hostile situations.
- Recognize that guilt can be a major factor for the NOK in many causes and manners of deaths.
- Appendix A covers some well-intentioned but potentially hurtful statements that medicolegal professionals should be sensitive to avoid.

**Principle 3:** Provide information in multiple formats (verbally, brochure and website) on the basic death investigation process, including why it is necessary and required. Keep the language as simple as possible. Anticipate questions in advance. If a significant segment of your population is non-English speaking, offering similar brochures in commonly spoken languages for your area is appropriate. Access to non-family translators, including sign language for deaf families, should be available.

- Grieving families have difficulty processing information verbally and remembering details. Information may need to be repeated. Provide important information in writing, including but not limited to:
  - A point of contact and their contact information for follow up questions.
  - Why a death investigation is recommended/required
    - Include information about organ/tissue retention (when/where, how, why)
  - What to expect during the death investigation process and time expectations
  - How/when the final cause of death will be communicated
  - How to obtain reports and/or records involving their loved one and the appropriate contact information (e.g., autopsy report, death certificate)
  - Resource List (e.g., for financial assistance, coping with their loss/grief)
    - List Local and National Resources
    - See Appendix C: Abbreviated Listing of National Advocacy/Family Support Programs
    - Note: Do not promote any specific faith-based group
  - Include statutory requirements for investigating sudden deaths
  - How to obtain personal affects
  - See Appendix B: Frequently Asked Questions.
- Provide information in multiple formats as soon as possible (i.e., at scene, during interview…)
- See Appendix D for the following brochure examples/templates
  - Miami-Dade County Medical Examiner Department
• English and Spanish
  o The Sudden Unexplained Death In Childhood (SUDC) Program
  o Clark County Office of the Coroner/Medical Examiner

**Principle 4: Prepare NOK for the condition of the remains.**

• Many people expect to receive an intact body and may not be prepared for decomposition, severe damage, or fragmentation.

• It is important for Medical Examiner/Coroner personnel to take responsibility for addressing the viewability of their loved one with the NOK. Taking time to prepare the NOK for what will be/will not be viewable will allow them to craft realistic expectations.
  o The funeral home chosen by the family may be an additional resource in fostering this communication to NOK. In cases of trauma, some reconstruction may be possible by funeral home professionals. The extent of reconstruction possible may be difficult to assess by many medical examiners/coroners. The medical examiner/coroner may direct the family to work with the funeral home to optimally set expectations.

**Principle 5: When possible and requested by NOK, medicolegal professionals should consider allowing the NOK to view the decedent prior to transportation. Separate policies should be created to handle requests to view the decedent after transportation to morgue.**

Considerations may include:

• **The condition of remains** - Is it appropriate for NOK the view the decedent? Most traumatic deaths are best viewed after some funeral home preparation. This is particularly true with head trauma or traumatic injury in children, where family members may want to hold or touch their loved one. It is very difficult (at times impossible) to stop blood or other fluids (including brain tissue) from flowing from a body with significant head trauma prior to funeral home preparation. The family may also be unprepared for dislocation / fractures of long bones or other significant traumatic defects. These can readily be ameliorated with simple preparation by funeral home professionals and avoid additional emotional trauma to the family.

• **Maintaining Integrity of the Investigation** - Determine if allowing the family to view or have contact with the decedent **legitimately** jeopardizes the integrity of the investigation. Ensure the integrity of the investigation while remaining sensitive to the needs of NOK.
  o Ex: If trace evidence is not being collected, then compromising trace evidence is not sound rationale for preventing NOK to view the decedent.

• **Environment that is safe and conducive to viewing** - Due to the emotional crisis that sudden deaths create, creating an environment that is safe and conducive for viewing by the NOK can vary due to the location itself. NOK should be assessed for their ability to follow the directions of MDI professionals in viewing the decedent to ensure the integrity
of the investigation (i.e., “you can see your loved one, but cannot touch them” or “you can hold your baby, but for safety, you need to stay sitting in this chair while you do so”, etc.)

- **Supporting the grief process** - Allowing the NOK, when they request to view the decedent immediately after death, allows them to begin to face the reality of the death and promote healthy grieving. It also allows them the opportunity for goodbye rituals that contribute to a healthy grieving process. This is especially important in child deaths, where parents are faced with the unanticipated and unnatural order of death by surviving their own children and the tremendous disbelief that ensues.
  - Allowing the NOK, when they desire it, to be with the deceased for even a short time, and even with supervision, can be a lasting benefit to them that can reduce additional trauma, maladaptive coping behaviors and more complicated grief.

- **There may be cultural or religious rituals and ceremonies important to NOK that traditionally should be performed as soon as possible following death. Accommodation of these practices should be a goal while maintaining case investigation integrity.** Families should be aware and counseled on the need/rationale for investigation protocols; families should also be heard and cultural/ritual ceremonies accommodated to the extent possible in an individual case.

**If the decedent has already been transported to the morgue**, a request to view the decedent by NOK may create hardships on the medicolegal office. It may interrupt and delay the medicolegal investigation process, and offices are often not set up to easily accommodate this request.

- However, if viewing is a policy or available practice in a particular jurisdiction, or utilized on a specific case, consider the following:
  - When feasible, a small and private room should be set aside for families. The room should be furnished comfortably and can be equipped with a closed circuit monitor for viewing.
  - Brochures and other literature explaining the benefits of the autopsy process, legal issues, and grief assistance resources can be available in the room.
  - The areas of the body to be seen or touched may be limited.
  - Time should be allowed afterwards for families to ask questions.

- Encourage families to postpone viewing remains until it can be done at the funeral home. However, staff should not assume NOK will agree to delay viewing the remains; each family’s request should be considered individually and with cultural sensitivity.
**Principle 6: Provide NOK with reasonable expectations**

Initially the NOK can be informed that an “investigation” will be conducted. However, on some cases, what that investigation will specifically entail (i.e., external, toxicology, autopsy) may not be known initially.

- Convey what is known and not known, including timeframes (if known), what may occur, how they will find out and who they can contact if they have questions.

**Principle 7: Avoid direct visual identification of remains by NOK whenever possible.**

Although a forensic or contextual identification is preferred; there are some cases when a visual identification may be necessary. It is not uncommon for NOK to assume they must identify the decedent or directly observe the body to do so. This misconception can be avoided by explaining the medical examiner’s or coroner’s protocols for identification.

- Information should be provided to the NOK about how the identification was accomplished.
- When necessary, consider showing the NOK a photograph at a neutral or separate location.
- NOK can also play a role in obtaining information useful in the identification process (e.g. dental records, medical records, etc.), so consideration should be given to discussing the need for such information and how it will be used.
- Be aware of what can and cannot be legally communicated to NOK among decedents whose identities have not yet been confirmed, especially those involving victims of crime.
- Refer to SWGMDI Decedent Identification Committee for additional information about this topic.

**Principle 8: Provide information on resources available to the NOK to assist them in their grief early in investigation.**

- Develop and maintain resource networks with local and national advocacy/family support programs, to include crime victims’ assistance, bereavement counseling and support groups, crime victims’ compensation and burial assistance, COD specific organizations and community crisis intervention programs.
- The individual(s) in the medical examiner’s or coroner’s office who interacts most with NOK should liaise with these organizations and maintain a resource file, including brochures or applications for these programs. Some programs may provide volunteer support on-site on a regular or as needed basis.
- Refer to Appendix C for an introductory listing of national advocacy/family support programs. Many of these national organizations will have local chapters or may act as clearinghouse to refer to known local resources.
**Principle 9**: Ensure that families understand their rights to access the final autopsy report, that they understand how to obtain the autopsy report, and that the reports are provided in the most meaningful and compassionate manner.

- NOK should be informed how to obtain a copy of the autopsy report and to whom they should address questions about the contents of the report.
  - Unsolicited mailing to NOK of autopsy reports/cause of death information/final death certificate is highly discouraged.
  - Autopsy reports are best understood when explained by the pathologist or another medical expert.
  - NOK may also ask for photographs, and a policy should be developed to handle such requests if statutory requirements do not already exist.

**Principle 10**: Inform NOK regarding issues related to public information and the media.

- Inform the NOK what is considered public record in your jurisdiction
  - Autopsy reports? Photographs?
  - If appropriate, explain what an open records request is.
  - Include how they might affect what is released by an open records request (i.e., court orders or other means to stop release). Consider effects of special populations or poorer populations who may not have access to legal counsel in this regard.
- Inform the NOK of media relations issues before made public
  - If press release is generated or information released to media- communicate information to NOK beforehand.

**Principle 11**: Recognize and respect that families have a right and need to understand how and why their loved one died. The worst news can be delivered with sensitivity and compassion. The method of communicating the final COD to the NOK should be communicated early on in the investigation. If the NOK has a specific preference for this method (i.e., scheduled call vs. unanticipated call, letter, or meeting etc.), considerations should be given to attempt to comply with their wishes.

Most people will visualize the death and surrounding circumstances and create a narrative in an attempt to make sense of it. What families imagine is often worse than the reality. Even when the facts are terrible, the majority of people can eventually accommodate or come to terms with them.

- Family members who lack information on how their loved one died tend to experience maladaptive coping behaviors and more complicated grief. Families undergoing a “pending investigation” are at great risk for additional stress and anxiety as they live with a constant sense of uncertainty. Communicating timelines and a direct liaison to the
Office for these families are especially important to deal with their ongoing need to try to understand the death, and their prolonged anticipation of the investigation findings.

- Delivering the Final Cause of Death (FCOD) and Manner of Death (MOD) to the NOK: When the FCOD an MOD are NOT already known to the NOK due to the circumstances of death, they should be delivered to the NOK via the established point of contact at the office, or by a staff member most appropriate to answer the NOK’s questions and respond to their anticipated concerns.
  - How? - In a manner that has been outlined to the NOK early on in the investigation.
    - A form letter or phone call via the NOK’s point of contact stating the FCOD/MOD is available and who they can contact via phone or to set up meeting to discuss is appropriate and usually adequate.
    - An additional option is to have the autopsy report sent to a personal physician. NOK could then review the report with their doctor, who would also be prepared to help the family members cope with distress and answer their questions. However, all personal physicians may not be able to decipher all autopsy information or answer all the family’s questions and therefore the pathologist should be available to the family or personal physician in this instance.
  - When? – As soon as possible after the FCOD/MOD is determined.
  - Exception: Unless the NOK has communicated they do not want to be informed of the FCOD, or if the initial COD/MOD has been communicated and is already known to NOK.

- NOK should be given the option to meet or communicate with the pathologist to improve their understanding of the final cause of death.

- Inform the family when a situation exists where the cause and manner cannot be released (i.e., homicide of child)

- The pathologist should communicate in their reports and during any conference with NOK and/or their personal physician:
  - If the FCOD/MOD or autopsy findings have any potential health implications for surviving family members
  - What the limitations of the investigation and autopsy include to ensure optimal medical care and follow-up of surviving family members (and/or during subsequent pregnancies).
    - What known disorders were NOT ruled out (in an unexplained death)? Ex: Cardiogenetic arrhythmias

*Best Practice*: Offering a Post Autopsy Family Conference

- Early on in the investigation, the NOK is offered the option of a “Post Autopsy Family Conference” with the pathologist of record to discuss the FCOD/MOD
when it is determined. The conference also serves to address any concerns or questions of the NOK. Upon determination, the NOK is contacted with the FCOD/MOD and again offered the service of the post autopsy family conference.

- The NOK’s timelines will vary for those who choose this service. Some will want the conference to be held ASAP, others may wait several months or perhaps around a significant date (ex: anniversary of death).

- During the conference, the Pathologist will lead the conference but additional staff can be present as appropriate to support the NOK’s understanding and coping of the information provided (i.e., Coroner, Death Investigator, Primary Care Physician, Social Worker or counselor who has been supporting the family). The conference is held in person or via telephone when necessary or preferred by NOK.

- Conferences can be very effective in relaying accurate information about the FCOD/MOD in an understandable way to the NOK. They are also extremely helpful in allaying feelings of guilt by the NOK and responding to their specific concerns that may/may not be specifically addressed in the autopsy report. The benefits of dealing with these concerns directly with the pathologist can be immeasurable to the NOK.
  - “Did they suffer?”
  - “If I had found them sooner, could they have been saved?”
  - “She had a little cough and I think if I would have taken her to the Doctor I could have prevented this. I know the cough killed her.”

References:

**Principle 12:** Ensure that families receive personal effects in a sensitive and timely manner.

- Ensure that families know how to retrieve their loved one’s personal effects, whether it is from the medical examiner or coroner, law enforcement, military officials, funeral home or hospital.
- Ensure that families understand if some personal effects are held for legal reasons or evidence and the expected timeframe / processes needed to return these to the families. Provide the family with an office or individual contact for personal effects that are retained for evidentiary reasons.
- Specific contact information should be provided to NOK to streamline the personal effects retrieval process.
• Maintain a list of local companies that clean and decontaminate personal effects following death.

**Principle 13:** Ensure that families ALWAYS have a single point of contact at the medicolegal office and that questions/calls are responded to in an efficient manner.

• In the event that NOK requests for communication are excessive and/or repetitive to information provided, consider utilizing local or national resources to assist the family in their grief and cope with the investigation process. See Appendix C for some resources.
References:


Baker A, Crandall L. To Hold or Not To Hold. Forensic Science Med Pathol Nov 2009


Adelson L. The Forensic Pathologist “Family Physician” to the Bereaved. JAMA 1977; 237: 1585-8


Appendix A: “WHAT NOT TO SAY…”

Avoid well-intentioned but potentially hurtful statements by NOT saying:

- “I know how you feel…”
- “This will help you get closure…”
  o Although the process may eventually provide the family with information that helps them cope with their loss, insinuating that it will “help them get closure” is inappropriate and insensitive to many.
- “I know what you’re going through…”
  o There is no such thing as true empathy. No two losses are alike.
- “It could have been worse…”
- “It is God’s will…”
  o Do not bring up religion unless they bring it up first. (Hirsch 1984)
- “Sometimes it’s hard to understand the bigger plan for us…”
- “You will be ok”
- “They are in a better place”
- Never refer to the decedent as “the body”
- When describing autopsy procedures, use plain language
  o But be careful to avoid insensitive analogies (Ex: “Microscopic studies are when we chop up an organ and look at it under the microscope.”)

What TO Say:
  I am so sorry for your loss.
  I am here to help.
  I have some resources that might be of help. They have been helpful to others.

Remember:

Be Truthful. Don’t Ever Lie.
Be Sensitive.
Be Yourself.
Appendix B: FREQUENTLY ASKED QUESTIONS

1. Where is my loved one?
2. Can I see him/her?
3. Do I need to identify him/her? How will they be identified?
4. What do I do now?
   a. Include information on final dispositions i.e. embalming, cremation, funeral home
   b. Advise family that they need to provide the ME/C office with information on their choice of final disposition in order to release their loved one (ie., such as name of funeral home).
   c. Do no promote, endorse or recommend any specific funeral home as to avoid conflict of interest, or accusation of directing business
5. Why is the ME/C involved?
   a. ME/C legal requirements
      1. Homicide, suicide, accidental, traumatic, abuse, suspicious, unattended, in custody, overdose, abortion, medical facility death within 24 hours, surgical death.
      2. Manner of Death
         a. Homicide
         b. Suicide
         c. Accident
         d. Natural
         e. Undetermined
6. Is an autopsy always performed and is there a charge?
7. Can I refuse an autopsy?
8. Why are autopsies performed and who performs them?
9. What are the benefits of an autopsy?
   a. Death Certificate
   b. Cause of Death
   c. Hereditary medical condition
10. How do I recover personal effects and clothing collected by ME/C?
11. When will he/she be released?
12. Who has the responsibility of making arrangements?
13. Who can I contact with questions?
14. How do I learn the COD/MOD?

15. If the identification of my loved one is pending, what information can be shared with me?

16. What does it mean for case to be “pending”? 
Appendix C: Abbreviated Listing of National Advocacy/Family Support Programs and Resources

Compassionate Friends, Inc.
www.compassionatefriends.org
877-969-0010

CJ Foundation for SIDS
www.cjsids.org
888-8CJ-SIDS

The Dougy Center for Grieving Children
www.dougy.org
866-775-5683
(Materials tailored to children and adolescents, will refer to local support resources)

First Candle
www.firstcandle.org
800-221-7437

Mothers Against Drunk Driving (MADD)
www.madd.org
800-GET-MADD

National Organization of Parents of Murdered Children, Inc
www.pomc.com
888-818-POMC

National Center for Victims of Crime
www.ncvc.org
202-467-8700

National Organization for Victim Assistance
www.trynova.org
800-TRY-NOVA

SADS Foundation
www.sads.org
800-STOP-SAD

Sudden Unexplained Death In Childhood Program
www.sudc.org
800-620-7823

Tragedy Assistance Program for Survivors (TAPS) – (for military families)
www.taps.org
800-959-8277
Appendix D: BROCHURE EXAMPLES AND TEMPLATES

Miami-Dade County Medical Examiner Department FAQ brochure (page 1)

Autopsy

Frequently asked questions

What does the law require in regard to an autopsy?
Florida law requires that certain categories of death must be investigated by medical examiner. 850.051 (1) includes deaths in any of these circumstances as requiring such investigation:
- Of criminal violence
- By accident
- By suicide
- Suddenly, when in apparent good health
- Unattended by a practicing physician or other recognized practitioner
- In any place or penal institution
- In police custody
- In any suspicious or unusual circumstances
- By criminal abortion
- By poison
- By disease constituting a threat to public health
- By disease, injury, or toxic agent resulting from employment

In these cases the district medical examiner is authorized by statute to conduct whatever autopsy, examination, or investigation is necessary to determine both the cause and the manner of death. The cause of death refers to the disease or injury that results in the person's death. The manner of death includes the manifestations of homicide, suicide, accident or natural.

What is an autopsy?
An autopsy is a thorough external and internal examination of a human body after death, using surgical techniques. The procedure is performed by a forensic pathologist, a medical doctor who is specially trained in this type of procedures to recognize the effects of disease and injury in a body.

During the autopsy samples of certain body fluids, such as blood and urine, will be collected from the body as well as tissue samples from the organs. Tests will be conducted on the specimens to identify the presence of any drugs, chemicals or toxic substances. Some of the tissue samples will also be prepared for microscopic study.

Why perform an autopsy?
In many cases, an autopsy is mandated by state statute or is necessary for the medical examiner to make an accurate determination of the cause and manner of death. Determination of the cause of death often requires the medical examiner to correlate the autopsy findings with other sources of information, including the person's medical history (if available), a police scene report, and toxicology and laboratory findings. Because many medical examiner cases will be tried in civil or criminal court, autopsy findings and certification of cause of death must be conducted carefully and accurately under controlled conditions.

What are the benefits of an autopsy?
- May fulfill a legal mandate
- May provide the next of kin with important information in subsequent legal proceedings and in settlement of insurance claims and death benefits
- May bring to light inherited or familial disease that will benefit other members of the family
- May alleviate family concerns and questions by confirming the cause of death
- May protect the community by providing the Department of Health with information regarding communicable diseases

Will I be able to view my loved one at the Medical Examiner Department?
The Medical Examiner Department exists to investigate the cause of death and is not a viewing facility. Many bodies are brought to and are stored in the Morgue each day. Because it is impossible to know what diseases may be present in any of these bodies, body bags are considered to be evidence in a police case. For these reasons, next of kin may not view a body at the Medical Examiner Department.

The Medical Examiner Department will expedite its work in order to release the body as quickly as possible to the designated funeral home, where the family can view the body under appropriate conditions.
Will an autopsy affect funeral plans?
The performance of an autopsy will generally not delay a funeral. Where this may be a concern, family members need to speak with representatives at the Medical Examiner Department so that scheduling can be coordinated.

Are there religious conflicts?
In cases where family members have religious concerns, the medical examiner will explain what considerations can be made.

Where may I obtain a death certificate?
• Professional funeral home
• Florida Department of Health, Office of Vital Statistics
  (850) 215-4285 (toll-free)
  (904) 355-8600 (Jacksonville)

Miami Dade County
Medical Examiner Department
306 646-5400

This brochure was prepared by the Miami-Dade County Medical Examiner Department, which serves the 11th Judicial District of the state of Florida and is accredited by the National Association of Medical Examiners (NAME).
Miami Dade County “Who will help me when a loved one dies” brochure (page 2)
The SUDC Program’s “Help for families when an infant or child dies” brochure (page 1)
* Go to www.sudc.org if you would like request this complimentary personalized brochure be created for your office.
There is no greater loss than the death of your child.

When a baby/child dies suddenly a team of professionals investigate their death. Emergency Medical Personnel, Police Officers, Medical Examiners, Coroners are just a few of the professionals who may be involved on this first day. It can be confusing to understand what is happening during this very overwhelming tragedy.

This brochure was developed to help provide you with a framework of what to expect in the days, weeks and months ahead, as well as provide you with contact information on where you can go for help.

The Medical Examiner

The role of the Medical Examiner is to determine the exact cause of your child’s death and why it occurred. To do this, he/she evaluates the information gathered by the Medical Examiner and performs an autopsy. The Medical Examiner is a medical doctor, with a specialty in forensic pathology (hence they are especially trained to evaluate the cause of death and its relation to (pathology).

Coroner

The Coroner works with pathologists to investigate deaths and determines why and how they died. The Coroner may be trained as a physician but does not have to be. Often they are the elected official and act as the head administrator of their respective office. The Coroner may be a member of the law enforcement in a sheriff/Coroner situation.

What Happens Now...

Your child will be transported to the Medical Examiner/Coroner office for the autopsy and is cared for with respect. The autopsy is an external and internal examination of a body. Licensed physicians, specifically forensic pathologists, acting as medical examiners, will perform forensic autopsies to determine cause of death. After examination, the body is closed. Specimens of body fluids and tissues are retained for diagnostic testing.

When necessary, an organ, such as a brain or heart, may also be retained for further testing. None of these tests will prevent the family from being released to the family for funeral arrangements and the autopsy will not interfere with funeral viewing. If organs are held for further testing and should you desire the return of those organs after testing, you should advise the office that performed the autopsy of this request. Otherwise, within a reasonable period, the specimen and organs will be handled consistent with standard practice. Once the Medical Examiner completes the autopsy, the funeral home is contacted. Your child is released to the funeral home of your choice and the process of a funeral can begin.

The Medical Examiner/Coroner’s office may contact you soon after the autopsy is performed. Sometimes they will have specific information to share with you or request additional information. Often, the Medical Examiner/Coroner will explain that more tests need to be performed to understand why your child died. Under this circumstance, their initial cause of death on their death certificate may read “pending further investigation.” This will be amended when further testing and the final report are complete. Further tests will include examining small tissue samples (collected during the autopsy) under a microscope. The health or disease of an organ can be evaluated in this way. It is important that the Medical Examiner/Pathologist do a thorough evaluation of your child to understand their death. The full investigation will take several weeks and frequently a few months before the Medical Examiner/Coroner is ready to complete his/her assessment. At that time, a final autopsy report is completed and can be obtained (as per instructions on back).

If your child is under one year of age and the final cause of death could not be determined, it may be classified as Sudden Infant Death Syndrome (SIDS). If your child is over the age of 12 months and a cause could not be determined, it may be classified as Sudden Unexpected Death in Childhood (SUDC). The Medical Examiner will make this determination.

Autopsy Report Conclusions

The report will list a “cause of death” as well as a “manner of death.” It is the role of the Medical Examiner/Coroner to determine both. The “Cause of Death” is something that is found by autopsy, an infection, cancer or injury that is responsible for the death. In terms of describing the “Manner of Death” (or how the death occurred), the Medical Examiner/Coroner has 3 options for coding purposes: Natural, Homicide, Suicide, Accidental, and Undetermined. The use of “undetermined” manner may be used when environmental and autopsy findings cannot clearly distinguish the manner of death.

Family Services/Child Protective Services

Family Services or an agency of child protective services may be involved to evaluate the safety of other children in the environment.

State Laws

Most states have laws concerning the investigation of all deaths that are sudden and unexpected. Visit your state government’s website to find out about specific laws in your state and how they may pertain to your situation.
Information Guide

On behalf of Clark County and the staff of the Office of the Coroner/Medical Examiner, we would like to extend our condolences to you and your family during this most difficult time. We have received your request for the information guide and wish to inform you that we do not have a specific information guide that addresses all your questions or needs. However, we do have a variety of resources and materials that may be able to provide you with the information you are seeking.

If you have any other questions or need additional assistance, please do not hesitate to contact us at the address and phone number provided below. Our office is open Monday through Friday from 9:00am to 5:00pm. If you have any concerns that cannot be addressed in person or over the phone, please visit our website at www.swgmdi.org, where you can find more information and resources.

If you would like to speak with someone at our office, please call us at (702) 455-3710. Our office is located at 9910 W. Sahara Ave., Las Vegas, NV 89134.

Contact:
John Fudenberg
Assistant Coroner
P. Michael Murphy D.B.A.

Published June 2012

SWGMDI’s NOK Services and Communication Committee
The purpose of this booklet is to provide information about the Clark County Office of the Coroner/Medical Examiner. This office is responsible for determining the cause and manner of death in Clark County, Oregon. The information in this booklet is intended to assist families and friends in understanding the process of identifying and releasing a loved one's body. The booklet includes information on how to contact the office, what to expect during an examination, and how to arrange for the release of the body. It also provides information on the role of the coroner and medical examiner in the investigation and examination of deaths. The booklet emphasizes the importance of respecting the deceased and the emotions of their loved ones during this difficult time. It serves as a guide for those who are navigating the loss of a loved one and the aftermath of a death.