

Coroner Duties in North Dakota



Connie Kadrmas, MSN, RN

Objectives:

- ✎ Discuss who can be a coroner in North Dakota
- ✎ Explain what constitutes a coroners case
- ✎ Expound on duties while investigating a scene
- ✎ Present details of a physical examination
- ✎ Review importance of medical and social history
- ✎ Describe compilation of death records
- ✎ Entail the ways a coroner acts as a counselor
- ✎ Provide a summary of coroner duties

Who Can Be a Coroner In North Dakota?

- ☞ Licensed Physician (N.D.C.C. 43.17)
- ☞ Advanced Practice Registered Nurse or Registered Nurse (N.D.C.C. 43.12.1)
- ☞ Physician Assistant (N.D.C.C. 43.17)
- ☞ Any other individual determined by the State Forensic Examiner to be qualified to serve as coroner

What Constitutes a Coroner Case?

- ✎ Homicide, suicide, or accidental injuries
- ✎ Firearm injuries
- ✎ Unexplained injuries
- ✎ Occupant or pedestrian motor vehicle injuries
- ✎ Any death of a minor, including abuse or neglect
- ✎ Fire, chemical, electrical, or radiation injuries
- ✎ Starvation deaths
- ✎ Unidentified or skeletonized human remains
- ✎ Drownings
- ✎ Suffocation, smothering, or strangulations
- ✎ Poisoning or illegal drug use
- ✎ Victims in custody of human services, social services, correctional facilities, or law enforcement
- ✎ Unexplained, undetermined, and unattended deaths
- ✎ Suspected victim of sexual assault
- ✎ Any suspicious factor

Scene Investigation:

- ✎ Initial verbal report (who, when, where, why, how)
- ✎ Determining which agencies are involved
- ✎ Evidence of last life or illnesses
- ✎ Discussing possibilities of organ procurement
- ✎ Ensuring death notification
- ✎ Investigation of witnesses
- ✎ Determining if case should be evaluated by the medical examiner
- ✎ Maintaining scene safety
- ✎ Pronounce time of death
- ✎ Assist as needed
- ✎ Develop diagrams or reconstruction of scene
- ✎ Having proper equipment
- ✎ Multiple fatalities?
- ✎ Maintaining dignity of deceased
- ✎ Safeguarding personal property
- ✎ Determining if scene matches injury

Examining the Deceased:

- ✎ Obtaining toxicology kit (eye, heart, and bladder if available) if needed
- ✎ Identifying features
- ✎ Estimate time of death
- ✎ Manner of death
- ✎ Identifying and collecting evidence on the body
- ✎ Physical characteristics
- ✎ Traumatic injuries

Obtaining Medical and Social History:

- ☞ Determining medical provider/facility
- ☞ Requesting medical records
- ☞ Recent health complaints
- ☞ Frequent or recent medical visits
- ☞ Demographical information collection
- ☞ Mental health status
- ☞ Understanding cultural and religious concerns
- ☞ Medication evaluation, identification, and count

Recordkeeping:

- ☞ Death Investigation forms, other narratives, and diagrams
- ☞ Report of Coroner's Investigation
- ☞ Death certificate
- ☞ Request for Examination/Autopsy
- ☞ Sudden Unexplained Infant Death Investigation Reporting Form (SUIDI)
- ☞ Paperwork for organ procurement
- ☞ Auditor billing forms

Counselor:

- ∞ Family
- ∞ Law enforcement
- ∞ Other responding agencies
- ∞ Fair and impartial
- ∞ Dealing with personal stress and establishing coping mechanisms

In Conclusion...

Death is observed or reported → Law enforcement is notified



Coroner is notified, then acts as a liaison throughout case progression



References:

- ∞ Clark, S., Ernst, M. F., Haglund, William, & Jentzen, J. (1996). *Medicolegal Death Investigator: A Systematic Training Program for the Professional Death Investigator*. Big Rapids Michigan: Occupational Research and Assessment, Inc.
- ∞ North Dakota Century Code 11-19.1 (2016).
- ∞ North Dakota Department of Health, State Forensic Examiner. (2015). *Report of Coroner's Investigation (SFN 58713)*. Retrieved from: <https://eforms.nd.gov/lfservlet/SFN58713>
- ∞ North Dakota Department of Health, State Forensic Examiner. (2015). *Request for Examination/Autopsy (SFN 59166)*. Retrieved from: <https://eforms.nd.gov/lfservlet/SFN59166>
- ∞ North Dakota Department of Health, Vital Records. (2013). *North Dakota Certifier's Worksheet for Completing a Medical Certification of Death (SFN 58646)*. Retrieved from: <http://ndhealth.gov/vital/forms/58646.pdf>
- ∞ Saint Louis University School of Medicine, Medicolegal Death Investigator Training Course. *Investigation of Hanging Deaths Fact Sheet*.
- ∞ Saint Louis University School of Medicine, Medicolegal Death Investigator Training Course. *Investigative Questions for Hanging Victims*.
- ∞ Centers for Disease Control and Prevention, Division of Reproductive Health Maternal and Infant Health Branch. *Sudden Unexplained Infant Death Investigation (SUIDI) Reporting Form*. Retrieved from: <http://www.ndhealth.gov/NDME/Resources/SUIDI-Form.pdf>

INVESTIGATION OF HANGING DEATHS - FACT SHEET

PAGE 2

VICTIM: (continued)

areas of lividity will appear in back and buttocks.

GROOVE IN NECK: The groove can suggest the type of ligature used by examination of the imprint. A noose of soft material may not leave a groove, eg. silk. Skin folds of obese people and small children may resemble a noose mark after refrigeration. An abraded area of skin often marks the location of the knot.

Any NAILMARKS, SCRATCHES or other INJURIES about the neck region suggest the possibility of manual strangulation - Was this a homicide?

SUICIDAL INDICATORS:

- 1) Absence of signs of struggle
- 2) Presence of suicide note
- 3) History of previous threats and/or attempts
- 4) Reliable history of emotional depression or alcoholism

HOMICIDAL HANGINGS are rare. Usually homicidal hangings can only be accomplished if the victim is young or person is incapacitated by drink, drugs or disease. It is very difficult to accomplish by one perpetrator. ALWAYS inspect victim for evidence of defense wounds, bruises, scratches, etc.

ACCIDENTAL HANGINGS FALL into 2 categories- (a) hangings that occur during play or when at work, in circumstances which are essentially accidental: and (b) SEXUAL ASPHYXIAL HANGINGS.

SEXUAL ASPHYXIAL HANGING: A ligature is placed about the neck and the constriction of the neck is used to create a state of ecstatic sexual euphoria as result of cerebral hypoxia.

Participants are almost exclusively male, young and predominantly Caucasian. Body is usually found at home in a "private place". Door is frequently locked from the inside.

VICTIM: Occasionally found either naked or partially clothed, may be transvestite attired - genitals may be exposed.

Feet are oftentimes touching the floor. Hands, feet and genitals may exhibit some features of bondage.

LIGATURE: ****PADDING**** between the ligature and neck, eg. towel, sock, etc. often found on body. This is to avoid detection of the neck groove by others after sexual ecstasy has been accomplished.

SCENE: Usually pornographic materials are in view of the subject.

Mirrors are sometimes found in a location that would allow subject to view act.

Oftentimes, evidence of previous sexual hanging incidents can be found at the scene, eg. hooks indoors in bedroom, other ligatures, bondage materials. Knot of ligature often of a fail-safe type.

JUDICIAL HANGINGS: The victim is dropped several feet-proportional to his body weight -

INVESTIGATION OF HANGING DEATHS - FACT SHEET

HANGING - Death is caused by the ligature either stopping the arterial blood supply to the brain or blocking the venous return from the brain. Loss of consciousness occurs rapidly which adds increased tension to the neck structures by the added weight of the limp, suspended body. It is NOT necessary for the ligature to completely surround the neck as long as it is applied under the chin so as to compress the sides of the neck.

Deaths are usually suicidal (90%), occasionally accidental (sexual asphyxia), and rarely homicidal.

Hanging can take place in ANY POSITION, provided the pressure on the neck is maintained above that necessary to cause vascular occlusion, eg. kneeling, squatting, seating, suspended, etc.

Hanging can be accomplished from ANY HEIGHT - of those incompletely suspended: 2/3 have both feet touching the ground/floor.

THE SCENE OF A HANGING:

-Hanging usually occurs at home or place of work.

LIGATURE: Almost any type of ligature can be used, eg. rope, wire, sheet, etc.

-will produce a groove in the neck if ligature has a rough surface. An imprint on the neck surface may be seen.

-the COURSE of the groove will depend upon whether a fixed or running ligature is used:
-FIXED ligature is knotted at the point where the ligature encircles the neck. The side of the noose nearest the suspended portion will be pulled upwards, assuming the shape of an inverted V. The groove of the skin will then have a corresponding course of unmarked skin at the apex of the V because the head has fallen away from the rope/ligature area.

-RUNNING ligature does not have a knot. The noose end passes through a loop of itself. The weight of the body will cause the noose to tighten in a HORIZONTAL position - with a corresponding HORIZONTAL groove. There may be a vertical mark in addition that has been caused by the suspending portion of the ligature.

POINT OF SUSPENSION: Usually one which can be easily reached with or without the aid of a platform, eg. hook, nail, shower curtain rod, support beam.

PLATFORM: Any surface from which a subject can step down to tighten the ligature, eg. stool, chair, table, appliance, ladder, etc (Failure to find a platform at the scene of a completely suspended subject must arouse suspicion - check to see if anything has been moved prior to your arrival.)

VICTIM:

Face is usually dusky purple, congested and slightly swollen above ligature. Tongue may protrude from mouth and be dark in color due to drying effect. Bloody mucous may be seen about the nose and under the body due to rupture of engorged blood vessels..

Tiny, pin-point hemorrhages (Tardieu's spots) may be present in the face, particularly in the eyelids and conjunctivae.

LIVIDITY: In a suspended body, the livor mortis is usually limited to the lower half of the body and the hands and forearms. NOTE: If body is cut down within 4-5 hours of

INVESTIGATIVE QUESTIONS FOR HANGING VICTIMS:

* Use this page WITH Scene Investigation Form

Location where body was found: _____

Was door locked from inside? Yes ___ NO ___ Type of lock: _____

Position of body: Suspended completely off floor/ground ____, partially resting on floor/ground ____, kneeling ____, sitting ____, squatting ____, reclining ____, other _____

Were feet on ground? Yes ___ NO ___ Both feet ___ one foot ___

LIGATURE:

Type: Rope ___ Wire ___ Other _____

Knot: Running: ___ Fixed ___ Describe: _____

Was knot of a fail-safe configuration? Yes ___ No ___

Source from which ligature obtained: _____

Texture of ligature: Coarse ____, Patterned ____, Soft ____, Other _____

Ligature Length: _____ Number of times encircles neck _____

Ligature attached to: Hook ____, Nail ____, Support beam ____, Other _____

Describe attachment: _____

Height of point of suspension from floor/ground: _____

Location of ligature knot: Right side of neck ____, Left ____, Front ____, Back ___ N/A ___

Any PADDING between neck and ligature? Yes ___ No ___ Describe: _____

PLATFORM:

Chair ____, Table ____, Bench ____, Appliance ____, Ladder ____, Other _____

Height of platform from ground/floor: _____ Distance from body: _____

Is platform overturned: Yes ___ No ___ Any skuff marks on platform? Yes ___ No ___

If any signs of struggle noted, describe thoroughly: _____

NOTE: If subject is fully suspended and there is no platform found at the scene, check to see if the platform had been moved prior to your arrival.

Condition of Premises: _____

Any evidence of struggle? Yes ___ No ___ Describe: _____

Any pornographic materials near body? Yes ___ No ___ Where: _____

Any mirror near body? Yes ___ No ___ Could subject view himself from it? Yes ___ NO ___

Any evidence that "suspension incident" had been attempted previously? Yes ___ NO ___

If yes, explain: _____

Was a suicide note found? Yes ___ No ___ Where: _____

Note found by: _____ Was handwriting identified? Yes ___ NO ___
(Enclose a copy of the note with your final report)

Subject was found by (name): _____ at (time): _____

*Body was cut down by (name): _____ at (time): _____

Cut ligature below point of suspension and above point where encircles neck; tie with string or tape ligature to illustrate original ligature position. DO NOT untie knot).

BODY:

Describe clothing: _____

Was clothing appropriate for this individual, this time and this place? Yes ___ No ___

Was clothing in place? Yes ___ No ___ Describe any variations noted: _____

Describe any ropes/tapes/bondage materials found on subject and include areas of the body involved: _____

Was the subject right handed? ___; left handed ___; ambidextrous ___; Unk. ___

**** BE SURE TO PHOTOGRAPH BODY WHILE SUSPENDED. ALSO PHOTOGRAPH LIGATURE AND GROOVE IN NECK PRIOR TO CUTTING THE BODY DOWN!**

GROOVE IN NECK: Is a groove present in the neck? Yes ___ No ___

Describe areas where groove is seen: _____

Is there any padding between ligature and neck? Yes ___ No ___ Describe: _____

Is there any pattern seen in the groove? Yes ___ No ___ Describe: _____

Are any abrasions or scratches seen about the neck? Yes ___ No ___ If yes, describe fully

Location of the knot in relation to the neck: _____

Location of the apex of the ligature: _____

FACIAL DESCRIPTION: Cyanotic ___; bloated ___; other _____

Was tongue protruding from mouth? Yes ___ No ___ Color of tongue: _____

Any blood or bloody fluid seen about face or body? Yes ___ No ___ Describe: _____

**Are pinpoint hemorrhages present in eyelids or conjunctivae? Yes ___ No ___

LIVOR MORTIS found in the following areas: Right foot and leg ____, left foot and leg ____,

buttocks ____, abdomen/pelvic area ____, back ____, chest ____, right hand/forearm ____,

left hand/forearm ____, other _____



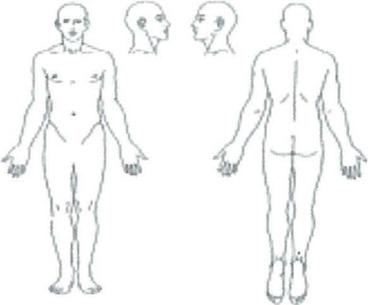
REPORT OF CORONER'S INVESTIGATION
 NORTH DAKOTA DEPARTMENT OF HEALTH
 STATE FORENSIC EXAMINER
 SFN 58713 (6-2015)

2637 East Main Avenue
 Bismarck ND 58501
 701.328.6138 FAX 701.328.6228
 After Hours: 701-220-6692

Name of Decedent (Last, First Middle)			Date of Birth		
Address		City		State	Zip Code
Age	Sex	Race	Occupation		

County of Death	Reported by	Date	Time
County Coroner		Law Enforcement Agency	Telephone Number
Type of Injury or Illness		Date of Incident	Time of Incident
Place of Incident (i.e., residence, work site)		Location of Incident (address)	

Circumstances (if necessary, add additional sheet)

Description of Body and/or Injuries 	
--	--

Death Pronounced By	Date Pronounced	Time Pronounced
---------------------	-----------------	-----------------

Place (i.e., ER, Residence, work site)	Location of Pronouncement (Address)
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Coroner's Case: <input type="radio"/> Yes <input type="radio"/> No	Autopsy: <input type="radio"/> Yes <input type="radio"/> No	Toxicology Submitted: <input type="radio"/> Yes <input type="radio"/> No
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Name of Pathologist

Cause of Death

Manner of Death (Check only one) Natural Accident Suicide Homicide Undetermined Pending

Signature of Coroner/Investigator	Date
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Please print the form for your records prior to clicking the submit button.

SFN 58713 (6-2015)
Page 2 of 2

Narrative of Circumstances (continued)

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NORTH DAKOTA CERTIFIER'S WORKSHEET FOR COMPLETING A MEDICAL CERTIFICATION OF DEATH

NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS
SFN 58646 (10-2013)

1. Decedent's Legal Name (First, Middle, Last)		2. Actual Date of Death	Actual Time of Death (Military Time)
3. Pronounced Date of Death, if different from Actual	Pronounced Time of Death, if different from Actual		4. Was the State Medical Examiner or County Coroner Contacted? <input type="checkbox"/> Yes <input type="checkbox"/> No
5. Date of Birth	6. Name of Funeral Home		
7. Social Security Number*	8. Place of Death		

* Based on federal law (42 U.S.C. §§ 652(a)(7) and 666(a)(5)(C)(iv)), the social security number has been determined to be a mandatory data element for this form and will be used for identification purposes. Failure to disclose this information will not affect the validity of this form.

9. Cause of Death

Part I. Enter the Chain of Events – diseases, injuries, or complications – that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT abbreviate. Enter only one cause on a line. Add additional lines if necessary.		Approximate Interval Between Onset and Death	
Immediate Cause (Final Disease or condition Resulting in death)	a.		
Sequentially list conditions, if any, leading to the cause listed on line a. Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST	b.		
	c.		
	d.		
Part II. Enter other significant conditions contributing to death but not resulting in the underlying cause given in PART I			
10. Autopsy Performed <input type="checkbox"/> Yes <input type="checkbox"/> No	11. Autopsy Findings Available to Complete the Cause of Death <input type="checkbox"/> Yes <input type="checkbox"/> No	12. Tobacco Use Contributed to Death <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknow	13. Decedent a Diabetic <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
14. If Female, Decedent was: <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Not Pregnant, but pregnant 43 days to 1 year before death <input type="checkbox"/> Not Pregnant within past year <input type="checkbox"/> Not Pregnant, but pregnant within 42 days of death <input type="checkbox"/> Unknown if pregnant within the past year			
15. Manner of Death. If the Manner of Death is not natural (i.e. the Cause of Death is attributable, at least in part, to an external event and does not solely represent the effects of a natural disease process), the case should be forwarded to a County Coroner for certification. <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could Not Be Determined			

If the decedent's death was not due to an injury, skip to question 22.

16. Date of Injury	Time of Injury (Military)	17. Place of Injury (i.e. Decedent's home, construction site, restaurant, wooded area)	18. Injury at Work <input type="checkbox"/> Yes <input type="checkbox"/> No
19. Address Where the Injury Occurred		Apartment Number	Inside City Limits <input type="checkbox"/> Yes <input type="checkbox"/> No
City	County	State	ZIP Code
20. Describe How the Injury Occurred			
21. Transportation Injury <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, Please Specify <input type="checkbox"/> Driver Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other. Specify:		
22. Signature of the Certifier			
23. Name of Certifier			
Address		City	State ZIP Code
24. Title of Certifier		25. License Number	26. Date Certified

Mail completed form to: Division of Vital Records; 600 E. Boulevard Ave.; Bismarck, ND 58505-0200

Instructions for Certifier's Worksheet

ITEM 2 - ACTUAL OR PRESUMED TIME OF DEATH

Enter the exact hour and minutes according to a 24 hour clock. If the exact time of death is unknown, enter the **approximate** time. If the time cannot be approximated enter the time the body is found and identify the **date found**.

ITEM 9 - CAUSE OF DEATH

Take care to make the entry legible. Use a computer printer with high resolution, typewriter with good black ribbon and clean keys, or print legibly using permanent **black** ink in complete the CAUSE OF DEATH section. **Do not abbreviate** conditions entered in section.

PART I (Chain of events leading directly to death)

- Only one cause should be entered on each line. Line (a) **MUST ALWAYS** have an entry. **DO NOT** leave blank. Additional lines may be added if necessary.
- If the condition on Line (a) resulted from an underlying condition, put the underlying condition on Line (b), and so on, until the full sequence is reported. **ALWAYS** enter the **underlying cause of death** on the lowest used line in Part 1.
- For each cause indicate the best estimate of the interval between the presumed onset and the date of death. The terms "unknown" or "approximately" may be used. General terms, such as minutes, hours, or days, are acceptable, if necessary. **DO NOT** leave blank.
- The terminal event (for example, cardiac arrest or respiratory arrest) should not be used. If a mechanism of death seems most appropriate to you for line (a), then you must always list its cause(s) on the line(s) below it (for example, cardiac arrest **due to** coronary artery atherosclerosis or cardiac arrest **due to** blunt impact to chest).
- If an organ system failure such as congestive heart failure, hepatic failure, renal failure, or respiratory failure is listed as a cause of death, always report its etiology on the line(s) beneath it (for example, renal failure **due to** Type I diabetes mellitus).
- When indicating neoplasms as a cause of death, include the following: 1) primary site or that the primary site is unknown, 2) benign or malignant, 3) cell type or that the cell type is unknown, 4) grade of neoplasm, and 5) part or lobe of organ affected. (For example, a primary well-differentiated squamous cell carcinoma, lung, left upper lobe.)
- Always report the fatal injury (for example, stab wound of chest), the trauma (for example, transection of subclavian vein), and impairment of function (for example, air embolism).

PART II (Other significant conditions)

- Enter all diseases or conditions contributing to death that were not reported in the chain of events in Part 1 and that did not result in the **underlying cause of death**. See attached examples.
- If two or more possible sequences resulted in death, or if two conditions seem to have added together, report in Part 1 the one that, in your opinion, most directly caused death. Report in Part II the other conditions or diseases.

CHANGES TO CAUSE OF DEATH

Should additional medical information or autopsy findings become available that would change the cause of death originally reported, the original death certificate should be amended by the certifying physician by **immediately** reporting the revised cause of death to the State Vital Records Office.

ITEMS 10 and 11 - AUTOPSY

- Enter "Yes" if either a partial or full autopsy was performed. Otherwise enter "No."
- Enter "Yes" if autopsy findings were available to complete the cause of death; otherwise enter "No." Leave item blank if no autopsy was performed.

ITEM 12- TOBACCO USE CONTRIBUTED TO DEATH

Check "yes" if, in your opinion, the use of tobacco contributed to death. For example, tobacco use contributes to many deaths due to emphysema or lung cancer. Tobacco use also may contribute to some heart disease and cancers of the head and neck. Tobacco use should also be reported in deaths due to fires started by smoking. For example, tobacco use may contribute to deaths due to a wide variety of cardiovascular, respiratory, neoplastic, metabolic, and other diseases. Check yes, if in your clinical judgment, tobacco use contributed to this particular death.

ITEM 14 - IF FEMALE, WAS DECEDENT PREGNANT AT TIME OF DEATH OR WITHIN PAST YEAR?

This information is important in determining pregnancy-related mortality.

ITEM 15 - MANNER OF DEATH

- Always check Manner of Death, which is important: 1) determining accurate causes of death; 2) in processing insurance claims, and 3) in statistical studies of injuries and death.
- Indicate "Pending investigation" if the manner of death cannot be determined whether due to an accident, suicide, or homicide within the statutory time limit for the death certificate. This should be changed later to one of the other terms.
- Indicate "Could not be Determined" **ONLY** when it is impossible to determine the manner of death.

ITEMS 16 - 21 - ACCIDENT OR INJURY - to be filled out in all cases of death due to injury or poisoning

ITEM 16 - DATE AND TIME OF INJURY

Enter the exact month, day, and year of injury. Spell out the name of the month. **DO NOT** use a number for the month. (Remember, the date of injury may differ from the date of death). Estimates may be provided with "Approx." placed before the date. Enter the exact hour and minutes of injury or use your best estimate. Use a 24-hour clock.

ITEM 17 - PLACE OF INJURY

Enter the general place (such as restaurant, vacant lot, or home) where the injury occurred. **DO NOT** enter firm or organization names. (For example, enter "factory" **not** "Standard Manufacturing, Inc.").

ITEM 18 - INJURY AT WORK

Complete if anything other than natural disease is mentioned in Part I or Part II of the medical certification, including homicides, suicides, and accidents. This includes all motor vehicle deaths. The item **must** be completed for decedents ages 14 years or over and may be completed for those less than 14 years of age if warranted. Enter "Yes" if the injury occurred at work. Otherwise enter "No". An injury may occur at work regardless of whether the injury occurred in the course of the decedent's "usual" occupation. Examples of injury at work and injury not at work follow:

Injury at work

Injury while working or in vocational training on job premises.
Injury while on break or at lunch or in parking lot on job premises.
Injury while working for pay or compensation, including at home.
Injury while working as a volunteer law enforcement official, etc.
Injury while traveling on business, including to/from business contacts.

Injury not at work

Injury while engaged in personal recreational activity on job premises.
Injury while a visitor (not on official work business) to job premises.
Homemaker working at homemaking activities.
Injury while working as a volunteer law enforcement official, etc.
Student in school.
Working for self for no profit (mowing yard, repairing own roof, hobby).
Commuting to or from work.

ITEM 19 - ADDRESS WHERE INJURY OCCURRED

Enter the complete address where the injury occurred, including zip code.

ITEM 20 - HOW INJURY OCCURRED

Enter a brief but specific and clear description of how the injury occurred. Explain the circumstances or cause of the injury. Specify **type of gun** or **type of vehicle** (e.g., car, bulldozer, train, etc.) when relevant to circumstances. Indicate if more than one vehicle included; specify type of vehicle decedent was in.

ITEM 21 - TRANSPORTATION INJURY

Specify role of decedent (e.g. driver, passenger). Driver/operator and passenger should be designated for modes other than motor vehicles such as bicycles. Other applies to watercraft, aircraft, animal, or people attached to outside of vehicles (e.g. surfers).

Rationale: Motor vehicle accidents are a major cause of unintentional deaths; details will help determine effectiveness of current safety features and laws.

REFERENCES

For more information on how to complete the medical certification section of the death certificate, refer to tutorial at <http://www.TheNAME.org> and resources including instructions and handbooks available by request from NCHS, Room 820, 6525 Belcrest Road, Hyattsville, Maryland 20782-2003 or at www.cdc.gov/nchs/about/major/dvs/handbk.htm.



REQUEST FOR EXAMINATION/AUTOPSY
 NORTH DAKOTA DEPARTMENT OF HEALTH
 STATE FORENSIC EXAMINER
 SFN 59166 (6-2015)

2637 East Main Avenue
 Bismarck ND 58501
 701.328.6138 FAX 701.328.6228
 After Hours: 701-220-6692

Decedent (Last, First, Middle)					Race	Sex	Age	Date of Birth
Home Address (Street)					City		State	Zip Code
Next of Kin (Last, First, Middle)					Relationship		Telephone Number	
Address (Street)					City		State	Zip Code
Funeral Home (Name)							Telephone Number	

Coroner	County	Telephone Number
Death Reported By	Investigating Agency	Telephone Number
Death Pronounced By	Date Pronounced	Time Pronounced
Place (i.e., ER, Residence, work site)	Location (Address)	
Identified By	Relationship	Method

CIRCUMSTANCES

Type of Injury or onset of illness	Date of Injury or illness	Time of Injury
Place of Injury	Location (Address)	
Medical History		
Brief narrative of circumstances (continue on additional page if needed)		
An examination/autopsy is requested to be performed by the State Forensic Examiner on the body of		
Signature of Coroner	County	Date

Please print the form for your records prior to clicking the submit button.

SFN 59166 (6-2015)
Page 2 of 2

Narrative of Circumstances (continued)

[Empty text area for narrative of circumstances]

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INVESTIGATION DATA

Infant's Last Name	Infant's First Name	Middle Name	Case Number
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Sex: Date of Birth: Age: SS#:

Race: White Black/African Am. Asian/Pacific Isl. Am. Indian/Alaskan Native Hispanic/Latino Other

Infant's Primary Residence:

Address: City: County: State: Zip:

Incident Address: City: County: State: Zip:

Contact Information for Witness:

Relationship to deceased: Birth Mother Birth Father Grandmother Grandfather

Adoptive or Foster Parent Physician Health Records Other Describe:

Last: First: M.: SS#:

Address: City: State: Zip:

Work Address: City: State: Zip:

Home Phone: Work Phone: Date of Birth:

WITNESS INTERVIEW

1 Are you the usual caregiver?

No Yes

2 Tell me what happened:

3 Did you notice anything unusual or different about the infant in the last 24 hrs?

No Yes Specify:

4 Did the infant experience any falls or injury within the last 72 hrs?

No Yes Specify:

5 When was the infant LAST PLACED?

Date: Military Time: : Location (room):

6 When was the infant LAST KNOWN ALIVE(LKA)?

Date: Military Time: : Location (room):

7 When was the infant FOUND?

Date: Military Time: : Location (room):

8 Explain how you knew the infant was still alive.

9 Where was the infant - (P)laced, (L)ast known alive, (F)ound (write P, L, or F in front of appropriate response)?

<input type="checkbox"/> Bassinet	<input type="checkbox"/> Bedside co-sleeper	<input type="checkbox"/> Car seat	<input type="checkbox"/> Chair
<input type="checkbox"/> Cradle	<input type="checkbox"/> Crib	<input type="checkbox"/> Floor	<input type="checkbox"/> In a person's arms
<input type="checkbox"/> Mattress/box spring	<input type="checkbox"/> Mattress on floor	<input type="checkbox"/> Playpen	<input type="checkbox"/> Portable crib
<input type="checkbox"/> Sofa/couch	<input type="checkbox"/> Stroller/carriage	<input type="checkbox"/> Swing	<input type="checkbox"/> Waterbed
<input type="checkbox"/> Other - describe:			

WITNESS INTERVIEW (cont.)

- 10. In what position was the infant LAST PLACED?** Sitting On back On side On stomach Unknown
 Was this the infant's usual position? Yes No What was the usual position?
- 11. In what position was the infant LKA?** Sitting On back On side On stomach Unknown
 Was this the infant's usual position? Yes No What was the usual position?
- 12. In what position was the infant FOUND?** Sitting On back On side On stomach Unknown
 Was this the infant's usual position? Yes No What was the usual position?
- 13. Face position when LAST PLACED?** Face down on surface Face up Face right Face left
- 14. Neck position when LAST PLACED?** Hyperextended (head back) Flexed (chin to chest) Neutral Turned
- 15. Face position when LKA?** Face down on surface Face up Face right Face left
- 16. Neck position when LKA?** Hyperextended (head back) Flexed (chin to chest) Neutral Turned
- 17. Face position when FOUND?** Face down on surface Face up Face right Face left
- 18. Neck position when FOUND?** Hyperextended (head back) Flexed (chin to chest) Neutral Turned

19. What was the infant wearing? (ex. t-shirt, disposable diaper)

20. Was the infant tightly wrapped or swaddled? No Yes - describe:

21. Please indicate the types and numbers of layers of bedding both over and under infant (not including wrapping blanket):

Bedding UNDER Infant	None		Number		Bedding OVER Infant	None		Number	
Receiving blankets					Receiving blankets				
Infant/child blankets					Infant/child blankets				
Infant/child comforters (thick)					Infant/child comforters (thick)				
Adult comforters/duvets					Adult comforters/duvets				
Adult blankets					Adult blankets				
Sheets					Sheets				
Sheepskin					Pillows				
Pillows					Other, specify:				
Rubber or plastic sheet									
Other, specify:									

22. Which of the following devices were operating in the infant's room?
 None Apnea monitor Humidifier Vaporizer Air purifier Other -

23. In was the temperature in the infant's room? Hot Cold Normal Other -

24. Which of the following items were near the infant's face, nose, or mouth?
 Bumper pads Infant pillows Positional supports Stuffed animals Toys Other -

25. Which of the following items were within the infant's reach?
 Blankets Toys Pillows Pacifier Nothing Other -

26. Was anyone sleeping with the infant? No Yes

Name of individual sleeping with infant	Age	Height	Weight	Location in relation to infant	Imparement (intoxication, tired)

27. Was there evidence of wedging? No Yes - Describe:

28. When the infant was found, was s/he: Breathing Not Breathing
 If not breathing, did you witness the infant stop breathing? No Yes

WITNESS INTERVIEW (cont.)

29 What had led you to check on the infant?

30 Describe the infant's appearance when found.

Appearance	Unknown	No	Yes	Describe and specify location
a) Discoloration around face/nose/mouth				
b) Secretions (foam, froth)				
c) Skin discoloration (livor mortis)				
d) Pressure marks (pale areas, blanching)				
e) Rash or petechiae (small, red blood spots on skin, membranes, or eyes)				
f) Marks on body (scratches or bruises)				
g) Other				

31 What did the infant feel like when found? (Check all that apply.)

Sweaty
 Warm to touch
 Cool to touch
 Limp, flexible
 Rigid, stiff
 Unknown
 Other - specify:

32 Did anyone else other than EMS try to resuscitate the infant? No Yes

Who? Date: Military time: :

33 Please describe what was done as part of resuscitation:

34 Has the parent/caregiver ever had a child die suddenly and unexpectedly? No Yes

Explain:

INFANT MEDICAL HISTORY

1 Source of medical information: Doctor Other healthcare provider Medical record Family

Mother/primary caregiver Other:

2 In the 72 hours prior to death, did the infant have:

Condition	Unknown	No	Yes	Condition	Unknown	No	Yes
a) Fever				k) Apnea (stopped breathing)			
h) Diarrhea				e) Decrease in appetite			
b) Excessive sweating				l) Cyanosis (turned blue/gray)			
i) Stool changes				f) Vomiting			
c) Lethargy or sleeping more than usual				m) Seizures or convulsions			
j) Difficulty breathing				g) Choking			
d) Fussiness or excessive crying				n) Other, specify:			

3 In the 72 hours prior to death, was the infant injured or did s/he have any other condition(s) not mentioned?

No Yes - describe:

4 In the 72 hours prior to the infants death, was the infant given any vaccinations or medications? No Yes

(Please include any home remedies, herbal medications, prescription medicines, over-the-counter medications.)

Name of vaccination or medication	Dose last given	Date given			Approx. time (Military Time)	comments:
		Month	Day	Year		
1.						
2.						
3.						
4.						

INFANT MEDICAL HISTORY (cont.)

5 At any time in the infant's life, did s/he have a history of?

Medical history	Unknown	No	Yes	Describe
a) Allergies (food, medication, or other)				
b) Abnormal growth or weight gain/loss				
c) Apnea (stopped breathing)				
d) Cyanosis (turned blue/gray)				
e) Seizures or convulsions				
f) Cardiac (heart) abnormalities				

6 Did the infant have any birth defects(s)? No Yes

Describe:

7 Describe the two most recent times that the infant was seen by a physician or health care provider:
(Include emergency department visits, clinic visits, hospital admissions, observational stays, and telephone calls)

	First most recent visit	Second most recent visit
a) Date		
b) Reason for visit		
c) Action taken		
d) Physician's name		
e) Hospital/clinic		
f) Address		
g) City		
h) State, ZIP		
i) Phone number		

8 Birth hospital name: Discharge date:

Street address:

City: State: Zip:

9 What was the infant's length at birth? inches or centimeters

10 What was the infant's weight at birth? pounds ounces or grams

11 Compared to the delivery date, was the infant born on time, early, or late?

On time Early - how many weeks? Late - how many weeks?

12 Was the infant a singleton, twin, triplet, or higher gestation?

Singleton Twin Triplet Quadrupelet or higher gestation

13 Were there any complications during delivery or at birth? (emergency c-section, child needed oxygen) Yes No

Describe:

14 Are there any alerts to the pathologist? (previous infant deaths in family, newborn screen results) Yes No

Specify:

INFANT DIETARY HISTORY

1 On what day and at what approximate time was the infant last fed?

Date: Military Time: :

2 What is the name of the person who last fed the infant?

3 What is his/her relationship to the infant?

4 What foods and liquids was the infant fed in the last 24 hours (include last fed)?

Food	Unknown	No	Yes	Quantity (ounces)	Specify: (type and brand)
a) Breast milk (one/both sides, length of time)					
b) Formula (brand, water source - ex. Similac, tap water)					
c) Cow's milk					
d) Water (brand, bottled, tap, well)					
e) Other liquids (teas, juices)					
f) Solids					
g) Other					

5 Was a new food introduced in the 24 hours prior to his/her death? No Yes

If yes, describe (ex. content, amount, change in formula, introduction of solids)

6 Was the infant last placed to sleep with a bottle? Yes No - if no, skip to question 9 below

7 Was the bottle propped? (i.e., object used to hold bottle while infant feeds) No Yes

If yes, what object was used to prop the bottle?

8 What was the quantity of liquid (in ounces) in the bottle?

9 Did the death occur during? Breast-feeding Bottle-feeding Eating solid foods Not during feeding

10 Are there any factors, circumstances, or environmental concerns that may have impacted the infant that have not yet been identified? (ex. exposed to cigarette smoke or fumes at someone else's home, infant unusually heavy, placed with positional supports or wedges)

No Yes

If yes, - describe:

PREGNANCY HISTORY

1 Information about the infant's birth mother:

First name: Last name:
 Middle name: Maiden name:
 Birth date: SS#:

Street address: City: State: Zip:

How long has the birth mother been at this address? Years: Months:

Previous Address:

2 At how many weeks or months did the birth mother begin prenatal care? No prenatal care Unknown

Weeks: Months:

3 Where did the birth mother receive prenatal care? (Please specify physician or other health care provider name and address.)

Physician/provider: Hospital/clinic: Phone:

Street address: City: State: Zip:

PREGNANCY HISTORY (cont.)

4 At how many weeks or months did the birth mother begin prenatal care? No Yes
(ex. high blood pressure, bleeding, gestational diabetes)
 Specify: _____

5 Was the birth mother injured during her pregnancy with the infant? *(ex. auto accident, falls)* No Yes
 Specify: _____

6 During her pregnancy, did she use any of the following?

	Unknown	No	Yes	Daily		Unknown	No	Yes	Daily
a) Over the counter medications					d) Cigarettes				
b) Prescription medications					e) Alcohol				
c) Herbal remedies					f) Other				

7 Currently, does any caregiver use any of the following?

	Unknown	No	Yes	Daily		Unknown	No	Yes	Daily
a) Over the counter medications					d) Cigarettes				
b) Prescription medications					e) Alcohol				
c) Herbal remedies					f) Other				

INCIDENT SCENE INVESTIGATION

1 Where did the incident or death occur? _____

2 Was this the primary residence? No Yes

3 Is the site of the incident or death scene a daycare or other childcare setting? Yes No - If no, skip to question 8

4 How many children (under age 18) were under the care of the provider at the time of the incident or death? _____

5 How many adults (age 18 and over) were supervising the child(ren)? _____

6 What is the license number and licensing agency for the daycare?
 License number: _____ Agency: _____

7 How long has the daycare been open for business? _____

8 How many people live at the site of the incident or death scene?
 Number of adults (18 years or older): _____ Number of children (under 18 years old): _____

- 9** Which of the following heating or cooling sources were being used? *(Check all that apply)*
- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Central air | <input type="checkbox"/> Gas furnace or boiler | <input type="checkbox"/> Wood burning fireplace | <input type="checkbox"/> Open window(s) |
| <input type="checkbox"/> A/C window unit | <input type="checkbox"/> Electric furnace or boiler | <input type="checkbox"/> Coal burning furnace | <input type="checkbox"/> Wood burning stove |
| <input type="checkbox"/> Ceiling fan | <input type="checkbox"/> Electric space heater | <input type="checkbox"/> Kerosene space heater | <input type="checkbox"/> Floor/table fan |
| <input type="checkbox"/> Electric baseboard heat | <input type="checkbox"/> Electric (radiant) ceiling heat | <input type="checkbox"/> Window fan | <input type="checkbox"/> Unknown |
- Other - specify: _____

10 Indicate the temperature of the room where the infant was found unresponsive:
 Thermostat setting Thermostat reading Actual room temp. Outside temp.

11 What was the source of drinking water at the site of the incident or death scene? *(Check all that apply.)*
 Public/municipal water Bottled water Well Unknown Other - Specify: _____

- 12** The site of the incident or death scene has: *(check all that apply)*
- | | | |
|--|---|---|
| <input type="checkbox"/> Insects | <input type="checkbox"/> Mold growth | <input type="checkbox"/> Smoky smell <i>(like cigarettes)</i> |
| <input type="checkbox"/> Pets | <input type="checkbox"/> Dampness | <input type="checkbox"/> Presence of alcohol containers |
| <input type="checkbox"/> Peeling paint | <input type="checkbox"/> Visible standing water | <input type="checkbox"/> Presence of drug paraphenalia |
| <input type="checkbox"/> Rodents or vermin | <input type="checkbox"/> Odors or fumes - Describe: _____ | |
- Other - specify: _____

13 Describe the general appearance of incident scene: *(ex. cleanliness, hazards, overcrowding, etc.)*
 Specify: _____

INVESTIGATION SUMMARY

- 1 Are there any factors, circumstances, or environmental concerns about the incident scene investigation that may have impacted the infant that have not yet been identified?

- 2 Arrival times

Military time

Law enforcement at scene:	:
DSI at scene:	:
Infant at hospital:	:

Investigator's Notes

- 1 Indicate the task(s) performed

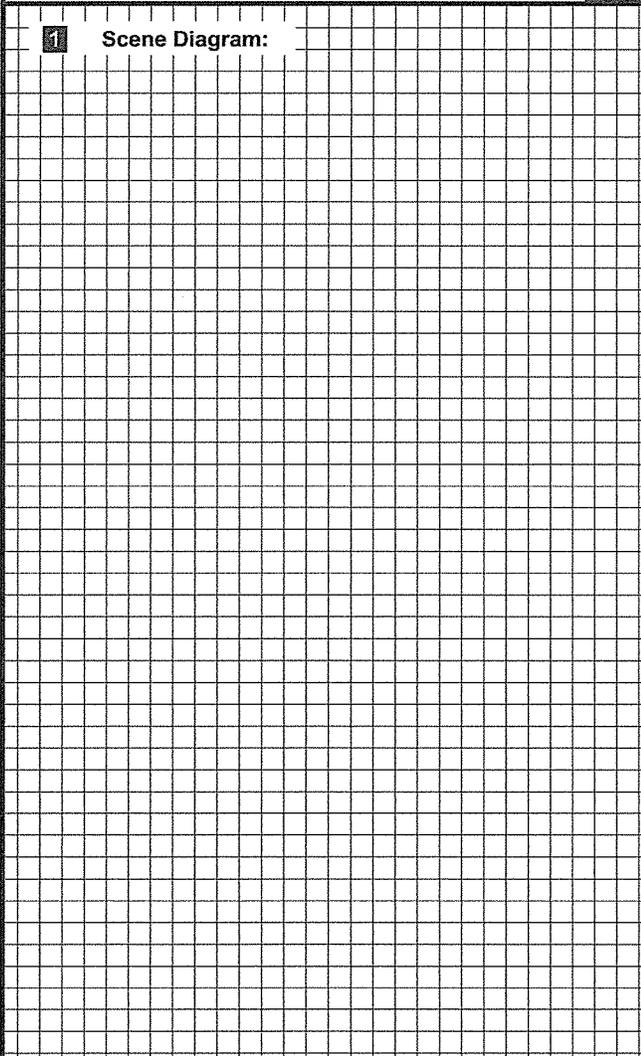
<input type="checkbox"/> Additional scene(s)? (forms attached)	<input type="checkbox"/> Doll reenactment/scene re-creation	<input type="checkbox"/> Photos or video taken and noted
<input type="checkbox"/> Materials collected/evidence logged	<input type="checkbox"/> Referral for counseling	<input type="checkbox"/> EMS run sheet/report
<input type="checkbox"/> Notify next of kin or verify notification	<input type="checkbox"/> 911 tape	

- 2 If more than one person was interviewed, does the information differ? No Yes

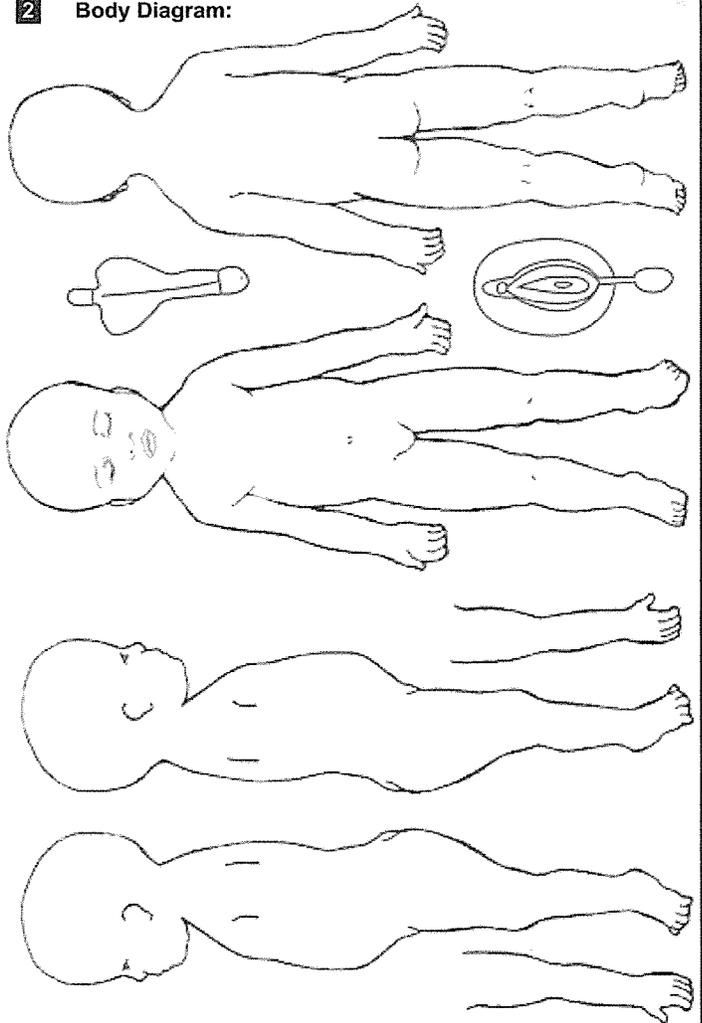
If yes, detail any differences, inconsistencies of relevant information: (ex. placed on sofa, last known alive on chair.)

INVESTIGATION DIAGRAMS

- 1 Scene Diagram:



- 2 Body Diagram:



SUMMARY FOR PATHOLOGIST

Case Information

1 Investigator information Name: Agency: Phone:

	Date	Military time
Investigated:	<input type="text"/>	<input type="text"/>
Pronounced dead:	<input type="text"/>	<input type="text"/>

2 Infant's information: Last: First: M: Case #:

Sex: Male Female Date of Birth: Age:

Race: White Black/African Am. Asian/Pacific Islander

Am. Indian/Alaskan Native Hispanic/Latino Other:

Sleeping Environment

1 Indicate whether preliminary investigation suggests any of the following:

Yes No

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Asphyxia (ex. overlying, wedging, choking, nose/mouth obstruction, re-breathing, neck compression, immersion in water) |
| <input type="checkbox"/> | <input type="checkbox"/> | Sharing of sleep surface with adults, children, or pets |
| <input type="checkbox"/> | <input type="checkbox"/> | Change in sleep condition (ex. unaccustomed stomach sleep position, location, or sleep surface) |
| <input type="checkbox"/> | <input type="checkbox"/> | Hyperthermia/Hypothermia (ex. excessive wrapping, blankets, clothing, or hot or cold environments) |
| <input type="checkbox"/> | <input type="checkbox"/> | Environmental hazards (ex. carbon monoxide, noxious gases, chemicals, drugs, devices) |
| <input type="checkbox"/> | <input type="checkbox"/> | Unsafe sleep condition (ex. couch/sofa, waterbed, stuffed toys, pillows, soft bedding) |

<input type="checkbox"/>	<input type="checkbox"/>	Diet (e.g., solids introduced, etc.)
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<input type="checkbox"/>	<input type="checkbox"/>	Recent hospitalization
--------------------------	--------------------------	------------------------

<input type="checkbox"/>	<input type="checkbox"/>	Previous medical diagnosis
--------------------------	--------------------------	----------------------------

<input type="checkbox"/>	<input type="checkbox"/>	History of acute life-threatening events (ex. apnea, seizures, difficulty breathing)
--------------------------	--------------------------	--

<input type="checkbox"/>	<input type="checkbox"/>	History of medical care without diagnosis
--------------------------	--------------------------	---

<input type="checkbox"/>	<input type="checkbox"/>	Recent fall or other injury
--------------------------	--------------------------	-----------------------------

<input type="checkbox"/>	<input type="checkbox"/>	History of religious, cultural, or ethnic remedies
--------------------------	--------------------------	--

<input type="checkbox"/>	<input type="checkbox"/>	Cause of death due to natural causes other than SIDS (ex. birth defects, complications of preterm birth)
--------------------------	--------------------------	--

<input type="checkbox"/>	<input type="checkbox"/>	Prior sibling deaths
--------------------------	--------------------------	----------------------

<input type="checkbox"/>	<input type="checkbox"/>	Previous encounters with police or social service agencies
--------------------------	--------------------------	--

<input type="checkbox"/>	<input type="checkbox"/>	Request for tissue or organ donation
--------------------------	--------------------------	--------------------------------------

<input type="checkbox"/>	<input type="checkbox"/>	Objection to autopsy
--------------------------	--------------------------	----------------------

<input type="checkbox"/>	<input type="checkbox"/>	Pre-terminal resuscitative treatment
--------------------------	--------------------------	--------------------------------------

<input type="checkbox"/>	<input type="checkbox"/>	Death due to trauma (injury), poisoning, or intoxication
--------------------------	--------------------------	--

<input type="checkbox"/>	<input type="checkbox"/>	Suspicious circumstances
--------------------------	--------------------------	--------------------------

<input type="checkbox"/>	<input type="checkbox"/>	Other alerts for pathologist's attention
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Any "Yes" answers above should be explained in detail (description of circumstances):

Infant History

Family Info

Exam

Investigator Insight

Pathologist

2 Pathologist information Name:

Agency: Phone: Fax: