

ISO/IEC 17020

7.2-7.4

7.2 Handling inspection items and samples

7.2.1 Individual Case Numbers: Every death reported to the Spokane County Medical Examiner's Office is given a unique, sequential case number at entry into the database. The case number begins with the last two digits of the year followed by a unique 4-digit sequential number, 18-XXXX. The first case reported in any calendar year is XX-0001. The only exception to this is for mass fatality events. In order to more easily track such events, the numbering system used is DD-XXXX, with the Xs being sequential numbers beginning with DD-0001. Disaster fatalities are entered into a separate database, to allow for easier tabulation of statistics, and for separate tracking and identification of such decedents for public health purposes.

Labeling of Decedents: Whenever the Medical Examiner's Office takes custody of remains, and the decedent is to be transported to the office, the body must have an identification band placed prior to transport. An identification band is secured to an extremity, usually the right ankle. The band is permanently labeled with the decedent's name, date, security tag number (uniquely numbered evidence tag used to secure body pouch), and the Medical Examiner case number. If the decedent is not identified, the same information is placed on the morgue band, except that the name is inscribed UDR (F or M) date, excluding year, and street name where body was discovered: UDR 0304, Sprague. (UDR for unidentified remains, UDF for unidentified female, UDM for unidentified male) The year is excluded in this name designation, as it is implied by the case number itself.

If two or more unidentified decedents are found at the same location, they are further labeled A, B, etc.: "UDF 0301, E. Sprague A". In the case narrative the exact location of discovery of each decedent is to be documented, as in decedent A is located in the passenger seat, and B is found in the rear driver's seat.

After the identification (morgue) band is affixed, and the body pouch sealed, identifying information is to be placed on the outside of the body pouch, including decedent NAME (or UDR, UDM, UDF designation), date, security tag number, and Medical Examiner case number.

In certain circumstances the Medical Examiner case number will not have been established at the time of scene investigation, for example when an investigator stays in the field traveling from scene to scene. In these decedents the Medical Examiner case number will be temporarily left off the body pouch, and morgue band as the last two digits of the year, followed by a hyphen and blank. As early as possible, after receipt in the office, the body pouch

will be updated with the complete case number. When the seal on the body pouch is broken at autopsy, the morgue band will be immediately updated with the case number digits.

If body tissues are to be examined, such as a bone, the bone is packaged at the scene in a suitable wrap, such as a paper bag, which is labeled on the outside as above for body pouches and sealed with evidence tape. The case number is written directly on the bone. If a soft tissue is to be examined, the tissue is labeled with an affixed identification tag, with information as described for morgue bands.

Transportation of Bodies and Sign-in/Sign-out: Appropriately banded bodies are transported to the Medical Examiner's Office in security-tag sealed body pouches that are also labeled as per policy. Upon arrival to the Medical Examiner's Office, the body information is entered into both the digital and hard copy logs. The body transport service personnel complete the "Clothing and Body Transfer" form, including decedent name, date and time of arrival to morgue, delivering agency and name of agent, body tag number, signature, and verification of body tag being present. The "Clothing and Body Transfer" form is placed on the "in board". The body is placed in the refrigerator in the secured facility. (See "Body Transport and Handling" policy)

At the time of autopsy, photographs are taken of the security tag on the body pouch, and labeling of the pouch. As the pathologist opens the pouch, by breaking the security tag, identification is verified by the morgue band on the decedent. The morgue band is photographed. The unique case number must correspond with the case number in the investigative report.

At body sign-out, the log book is completed for sign-out date. The removal portion of the "Clothing and Body Transfer" form is completed with date, time, agency, clothing released, and signatures. After body release the form is placed in the permanent case file for the decedent, which is filed by case number.

Labeling of Body Fluid Samples, tissues, slides, blocks, cultures, evidence removed from decedents: All such items are labeled with the unique Medical Examiner case number, with various other identifiers depending on the sample/item. (See Medical Examiner Policies "Collection of Evidence at Autopsy in Cases of Suspicious Death", and "Collection of Body Fluids, Samples, and Tissues at Autopsy/Transfer for Toxicologic Testing")

Chain of Custody: Medical Examiner's policies describe and detail where samples and items of evidence are stored in the facility and for how long. When any items of evidence or any autopsy samples are removed from the facility for testing, or any other reason Chain of Custody is maintained and a chain of custody form is completed. (See policy: "Chain-of-Evidence")

Photographic Documentation: At scenes of investigation photographic documentation is used to establish the position of the decedent, and decedent surroundings. Photographs are taken liberally at autopsy for documentation of the examination. (See policy “Photographs and Digital Images”)

7.2.2, Establishment of whether the body has been prepared: Washington State Law (RCW 68.50.010 Coroner’s jurisdiction over remains), establishes Medical Examiner responsibility for decedents who die via a broad range of circumstances. At investigative scenes law enforcement is responsible for directing scene processing, with the exception of the body itself. If because of practical considerations, the decedent must be moved, or manipulated at the investigative scene, this information must be provided to representatives of the Medical Examiner’s Office. Likewise, no item will be removed from the body without the permission and without direct observation of Medical Examiner staff. Any such manipulation of the body, or of personal effects or clothing will be documented in the database investigator narrative.

Preparing the body for autopsy involves multiple steps, defined in several Medical Examiner Policies:

1. The body is removed from refrigeration and weighed.
2. The decedent, still in the body pouch is taken into the examination room, and the pouch is photographed. (See Medical Examiner Policies: Postmortem Examination, Photographs and Digital Images)
3. The security seal on the body pouch is broken.
4. Photographs are taken, to include the morgue identification band.
5. Evidence is collected, if appropriate.
6. Clothing is removed, medical intervention is documented
7. Photographs are repeated.
8. The body is cleaned, and photographed again.
9. The inspection (autopsy) begins.

7.2.3 Recording of abnormalities, such as the body labeling not conforming to the investigator narrative identification: Any discrepancy in things such as name spelling, regarding body description, or identification of the decedent will be resolved prior to autopsy. If events such as the need to replace a security seal occur prior to autopsy these will be documented in the narrative of the database. If identification or body description raise concerns during initial examination of the body, the discrepancy and resolution of the discrepancy will be detailed in the autopsy narrative. Almost all bodies and tissues, such as bone, are suitable for inspection, except for frozen bodies, which typically must be thawed prior to inspection (examination). If a body is frozen, the thawing progress is documented in the narrative of the database.

7.2.4: Documented Procedures to avoid deterioration or damage to inspection items: Such procedures are documented and in place in the Spokane County Medical Examiner's Office. Inspection items that are included in the scope of medical examiner work include: the body of the decedent, any items of evidence removed from the body, photographs, microscopic slides and blocks, retained body tissues and organs, and body fluid samples for testing. Proper secure storage of these is necessary to prevent damage and deterioration. The chief autopsy assistant is responsible for maintenance of the examination area, to include monitoring and recording of temperatures in all freezers and refrigerators. All inspection items must also be kept secure in the facility.

Medical Examiner's Policies that address safeguarding of inspection items:

1. Postmortem Examination
2. Collection of Evidence at Autopsy in Cases of Suspicious Death
3. Collection of Body Fluids, Samples, and Tissues at Autopsy/Transfer for Toxicologic Testing
4. Storage Retention and Disposal of Items of Evidence, body Fluids, and Tissues Removed at Autopsy
5. Body Transport and Handling
6. Photographs and Digital Images
7. Security

7.3 Inspection records

7.3.1 Record system (See 8.4) The Spokane County Medical Examiner's Office maintains autopsy reports and worksheets, photographs etc. in accordance with two policies:

1. Case Records, Case Files, and Paperwork Flow
2. Records Management and Archiving

Each reported death is assigned a number by the database, and records are maintained for each case according to that number. The record-keeping includes hard copy files, and a database with photographs. The policies describe in detail what is to be maintained in the case files. By Washington State Law, all case files are maintained in perpetuity by eventual archiving.

7.3.2 Each investigation/Death Report is reviewed by one of the Forensic Pathologist Medical Examiner's within 24 hours. The reviewing medical examiner determines whether jurisdiction is released after investigation, or jurisdiction is assumed. That decision is recorded in the

database, which automatically records and assigns the decision to the specific medical examiner.

Autopsy Report: Every autopsy and the direction of any additional investigation becomes the responsibility of the assigned Forensic Pathologist-Medical Examiner. That physician is designated on all autopsy sample labeling, all evidence labeling, all worksheets, the database, and the autopsy report. When complete, the autopsy report is signed and dated by the autopsy physician.

Autopsy Report Corrections or Addendums: Any new information, pertinent test results, etc. that are received after the autopsy report is signed, will be documented in an addendum report, that then becomes part of the permanent autopsy report. Every addendum report is signed and dated by the physician responsible for the autopsy. Any need for a correction (such as name spelling) to an autopsy report made after the report is signed and issued will be documented in the database and the report will be resigned, and redistributed. An error that results in a significant change to the autopsy report will be described in a “corrected report” statement, that will be signed and dated by the autopsy physician and added permanently to the autopsy report.

Death Certificate: The death certificate is created in the Washington State Electronic Death Registration System (EDRS), by the funeral home. The EDRS death certificate is signed by a Forensic Pathologist Medical Examiner and the signature is electronically recorded and tracked. The EDRS is password protected, and physician credentials are verified by the WA Department of Health before access to the EDRS is granted.

Technical Review: Daily, monthly, and quarterly review of cases is described in Spokane County Medical Examiner Policy “Quality Assurance and Performance Review”. To summarize, the office performs multiple types and levels of peer review.

Daily review: All deaths reported to the Medical Examiner’s Office generate a case report in the database. With the exception of faxed reports from nursing homes and like agencies with nursing staff, all reports are first entered into “review”. One of the Medical Examiners reviews all entered cases on a daily basis. Errors in the reports, unclear or incomplete information, and need for follow-up are addressed at review. For faxed reports, the medicolegal death investigators screen for any information of concern, and finding injury or other reportable condition enter a full report in review.

Monthly peer review of investigator reports: Two reports from each investigator (one jurisdiction assumed death, and one jurisdiction released death), are peer reviewed each

month. The review is rotated on a schedule between the investigators, chief autopsy assistant, and medical examiners.

Autopsy report review at completion: After the physician responsible for the autopsy signs the completed report, it is given to the other medical examiner. This is a brief review, the purpose of which is to make the partner pathologist aware that the autopsy report is complete and communicate how the death certificate was signed. A check is made of the summary of case findings for spelling and cohesiveness. The reviewing pathologist initials and dates the “reviewed by” box on the signature page. This review is primarily a communication tool between medical examiners.

Pathologist formal review: All cases that are certified as manner homicide or undetermined are reviewed by another medical examiner. On a monthly basis, 2 autopsy reports produced by each medical examiner (accidents, natural, or suicide manners) are peer reviewed. This review includes the entire case file, microscopic slides and photographs, and completion of a “Monthly Autopsy Quality Assurance” form that are placed in the case file. Each medical examiner receives a copy of the peer review forms generated on his/her cases.

Formal Quarterly Case Review: Quarterly an investigator is responsible for coordinating a review of cases, 6 total (two natural, two suicides, two accidents), 3 from each pathologist. This comprehensive review evaluates all office functions, including record-keeping, photography, scene investigation, the autopsy report. All staff departments participate (Office manager, administration, pathologists, investigator, autopsy assistant). A “Quarterly Quality Assurance Case Review” form accompanies records and materials being reviewed. When the review is complete the investigator responsible for the quarter issues a report to all office staff with a summary of findings and any corrective actions taken following the review.

In a given year, via the monthly pathologist review, review of all homicides and undetermined manner deaths, and the quarterly review, an average of 67 autopsy reports and related materials are peer reviewed, approximately 25% of Spokane County autopsies performed. Both the monthly and quarterly quality assurance forms include direct questions about whether the case file material is complete and supports the conclusions made in the autopsy report and on the death certificate.

In Washington State Medical Examiners are required by statute to be physicians certified by the American Board of Pathology in Forensic Pathology. Medical Examiner peer review is performed by another Medical Examiner. Death Investigators in the office are registered in the American Board of Medicolegal Death Investigators (ABMDI). Medical Examiners and Death Investigators perform peer review on other investigators, and complete the “investigator”

section of the Quarterly Quality Assurance Case Review form. Administrative and autopsy staff complete their corresponding sections of the Quarterly form.

Errors and Disagreements Identified via Peer Review: As per the Quality Assurance and Performance Improvement policy, any comments made on the monthly or quarterly quality assurance forms are reviewed by the pathologist responsible for the case. Any errors are corrected by an addendum, corrected, or amended report, as appropriate.

A major disagreement between staff members is defined as a difference in interpretation or opinion that could alter the cause or manner of death, or potentially change court testimony. In the case of a major disagreement, the entire case file, microscopic slides, and photographs will be sent to a mutually agreed upon board certified Forensic Pathologist in another office who will render the final opinion.

As part of the **annual management review**, all quarterly summary reports and pathologist's peer review will be re-examined to verify that any corrective action was done, and any preventative suggestions were instituted.

Numbering and Identification of Records: All documents in the case file will be labeled with the unique case number. Each page of the autopsy report will be labeled with the page number, decedent name, and case number. The last page of the autopsy report ends with the office specimen retention schedule, and Washington RCW 68.50.106 providing the legal justification for saving specimens, including organs. Autopsy worksheets and labels have the name (or initials) of the pathologist performing the autopsy, and lists any autopsy assistants. All autopsy forms similarly require identification by case number, decedent name, and pathologist name. The database automatically records the identity of any office member adding an investigative report or narrative note.

Release of Autopsy Report/Records: Washington RCW 68.50.105 addresses the confidentiality of Medical Examiner records, and specifies who is entitled to receive reports. The release of any report is documented and tracked in the permanent case file. Any community member requesting a report must complete a form verifying they can lawfully obtain a copy, according to 68.50.105, including signature, name, relationship to decedent, date of request, and photographic-identification card. When available, the requested records are made available after completing a "Request for Records" form that details what records were released, requires an authorization signature from a staff member, and notes the date when the records were picked up, mailed or e-mailed.

7.4 Inspection reports and inspection certificates

7.4.1 The autopsy report and death certificate serve as the inspection report and certificate in the Medical Examiner's Office. The details of the examination and investigation are documented in the permanent case file, and database. The autopsy reports are signed by the Forensic Pathologist physician that performed the autopsy.

Abbreviations: Any medical or technical abbreviations in the investigative narrative, autopsy report, or any other records will be clearly defined, specifically written out at least once in the narrative, and readily understood.

7.4.2 The autopsy report must include all the following: (reported correctly, accurately, and clearly)

- a. The Spokane County Medical Examiner's name, address, phone number, fax number, and website address
- b. Medical Examiner case number, and date the autopsy report was completed.
- c. Date of death, and date autopsy was performed.
- d. Identification of decedent, or a notation that the decedent is not identified.
- e. Signature of physician that performed the autopsy.
- f. A summary of case findings and opinion
- g. The opinion section includes the cause and manner of death as written on the death certificate
- h. Location where autopsy was performed
- i. Names of autopsy assistant(s) and observers
- j. (A statement of conformity is not applicable)

7.4.3 The information required on the death certificate is established by the Washington State Department of Vital Statistics. The Medical Examiner's Office completes required portions of the death certificate using the Washington Electronic Death Registration System (EDRS), to include the cause and manner of death, date and time of death, accident information, among others. The death certificate is traceable to the autopsy report by the decedent's name, and birthdate, date of death, etc. The death certificate is a public record.

7.4.4 The Examiner's Office frequently relies on reports and information from other accredited laboratories and certified physicians to include: The Washington State Toxicology laboratory, various private medical laboratories, a board-certified anthropologist, board-certified odontologists, board-certified neuropathologists, board-certified entomologists, and board-certified radiologists. Use of expert consultants is described in the policy "Medical Examiner Support Services". All consultants and laboratories issue separate reports identified by decedent name, Medical Examiner case number, and date of issuance. These are maintained in

the database, and permanent case file. If used in forming opinions at autopsy, the consultant conclusions are described in the Summary of Case findings section of the autopsy report, also citing the name of the consultant expert or laboratory providing test results.

7.4.5 Any corrections or changes made on the death certificate, are submitted by formal affidavit to the Washington State Department of Vital Statistics. Copies of such affidavits are retained in the case file.

Corrections or additions to the autopsy report, made after the autopsy report is signed, will be documented by an addendum describing the supporting information or documentation, the correction or addition, with signature and date. Any change in the opinion or in the cause or manner of death will be documented/explained in the addendum. The addendum includes the case number, decedent's name and the other identifying information from the original autopsy report. If the report has already been released, a copy of the addendum report will be sent to all parties who have received the original autopsy report. The addendum is maintained with the original autopsy report in the decedent case file and in the Medical Examiner database, and after completion is to be released as part of the original autopsy report.