POLICY: GENERAL PROCEDURES FOR PRODUCTION, STORAGE AND RELEASE OF RECORDS

**Policy:** OCME provides accurate certification of the cause and manner of death, which may require production of documents, radiographs and photographs. To comply with Sec. 19a-401-12 of regulations established by the Commission on Medicolegal Investigations, it is the policy of this office to:

1. Maintain an organized system to file records, including sequential numbering of cases, use of standard forms and format for reports, and storage mechanism for ready retrieval;
2. Maintain security and storage protocols to restrict access to records and preserve the confidentiality of information;
3. Release information in a manner described by COMLI regulations, State law and court decisions;
4. Follow procedures defined by the State Library for storing and disposing of records.

**Procedure:**

1. Initiating a case and producing records for release and storage
2. Notification of a case received for investigation and/or examination prompts Telephone Accessions (TA) personnel to assign a case number, using the Case Manager Information system, and produce a Verbal Report of circumstances of death.
3. Before autopsy is performed, TA personnel prepare a case folder to store the Verbal Report, the Removal Authorization form, and the Receipt of Evidence form.
4. The folder is pre-labeled with the Case Number (last 2 digits of the year followed by a 5-digit number generated from I in sequence through the last case number of the year).
5. After autopsy, TA personnel print the Death Certificate, and other applicable forms such as ME-110, ME-111, cremation or burial certificate.
6. The original Death certificate is signed, provided to the Funeral Director and then filed with the Assistant Registrar of Vital Statistics. A photocopy is placed in the case folder.
7. The case folder goes to Medical Records
8. The autopsy diagrams and other case pertinent reports are maintained with the Pathologist until the case is finalized.
9. After the autopsy report is complete and signed by the examining pathologist, the Medical Secretary gathers all reports and forms belonging with the case and files them in the folder, then marks the autopsy report as final. Completed folder is scanned and all necessary documents are uploaded to Document Management within CaseManager. The file is then forward to Medical Records.
10. In addition to the autopsy report, other reports include toxicology, consultations, police reports and medical records.
11. In addition to ME-II0 and ME-Ill, other forms include ME-l02 and ME-l03.
12. The autopsy report is finalized in Case Manager so the case does not appear on the Pending Case (overdue) list.
13. Medical Records (MR) personnel review the folder for accuracy and completeness.
14. If a folder is missing completed documents or the documents indicate discrepant information, it is returned to the Medical Secretary for completion or correction.
15. If a folder is complete and accurate, the contents are scanned for attachment to the Case Manager file for electronic storage.
16. Completed folder is reviewed to determine if there is a request made to receive a copy of the report. The procedure for releasing reports is described in section F sub-section 2 "Release of Information."
17. Completed folders are filed in number sequence on shelves in the Medical Records department on the main floor of the building.
18. The Medical Records department resides behind locked doors, accessible only to staff who have a reason to retrieve records (secretaries, pathologists, Investigators).
19. Original folders and documents do not leave the premises; pathologists are given photocopies of folder contents when requested to review for testimony in court.
20. Folders are stored on-site for five years, when the contents are microfilmed; original microfilms are stored at William B. Myers, copy is stored at OCME and a copy prepared for the State Library.
21. After folders are microfilmed, their contents are shredded on-site by a shredding service when OCME receives permission from the State Library to do so.
22. Beginning in 2016 all case pertinent documents are scanned and attached to the case of record in Case Manager. PDF files will be transferred to a contracted microfilm vendor for creation of two sets of microfilm.

B. Form# and title of standard forms used:

ME-1 Telephone Notice of Death

ME-102 Report of investigation

ME-103 Hospital Report of Death

ME-104 Report of investigation/Case Review

ME-105 Supplemental Report of investigation

ME-106 Identification Form

ME-110 Receipt of Evidence/Personal Property

ME-110.2(rev 3111) Receipt of Evidence/Police

ME-110.3(rev 3/11) Receipt of Evidence/All Purpose

ME-111 Receipt of Body by Funeral Director

ME-123 Notification to Police

C. The case file, having a unique case number, can contain any of the following documents: NOTE: photographs are taken by digital cameras and stored with the case by electronic means described in section F sub-section 6 "Photographic Records and Practices."

1. Autopsy report (described in section F sub-section 4 "Reports of Postmortem Exams") and any relevant charts or drawing constructed by pathologist during autopsy
2. Copy of Death Certificate
3. Copy of cremation report and certification
4. Any of the standard forms listed in section B. of this procedure
5. Toxicology report produced by the OCME Toxicology Laboratory, NMS Laboratory or Division of Scientific Services Laboratory
6. Consultative reports, including Neuropathology, Anthropology, Division of Scientific Services Evidence, Microbiology results, Perkin Elmer results.

D. Reports and records are stored in electronic format as well as hard copy files.

1. All autopsy reports are available at the transcription service website and also saved in house in the designated folder.
2. Every pathologist has a folder, connected to the local intranet, for storing files. The audio files of reports dictated by pathologists are saved to their designated folder.
3. All folders connected to the intranet are backed-up every day by the office Information

Technology department during off-shift hours.

1. The entire contents of the office system, including Case Manager Information system, are backed-up every Sunday onto tapes and stored off-site at Iron Mountain Archive Service.

E. Death Certificates are completed and filed in accordance with C.G.S. Sec. 7-45 and Sec. 7-62b.

1. The Death Certificate for an individual autopsied at OCME is signed by the examining pathologist and given to the Funeral Director upon release of the body.
2. The Death Certificate issued by OCME pathologists for an individual not autopsied is signed by the pathologist and delivered by receipted mail to the Funeral Director, or picked up at OCME by the Funeral Director.
3. Amended Death Certificates are signed only by the pathologist and co-signed by the Chief Medical Examiner or Deputy Chief Medical Examiner and sent directly to the Registrar of Vital Statistics in the town of death.
4. The office maintains an electronic log of cases for postmortem exam. The log lists case number, decedent name, date of death, date of autopsy, examining pathologist, age/race/gender of the decedent, presumptive cause and manner of death, and the TA-person assigned to the case (see A.2 of this procedure).
5. Standardized terminology of recognized disease nomenclature is used to complete Death Certificates. Staff at the Department of Public Health convert the terms into ICD9/10 codes.

F. The procedure for disclosing information and/or releasing documents contained in case folders is described in section F sub-section 2 "Release of information."

G. The procedure for storing and reproducing digital photographs is described in section F sub-section 6 "Photographic Records and Practices."