ST. JOSEPH'S HEALTH
A Member of Trinity Health

301 Prospect Avenue
Syracuse, NY 13203
315.448.5111

sjhsyr.org

DATE

Dear _____,

During a routine mortality chart review, it was noted that you did not notify the Medical Examiner (ME) with a qualifying death.

Patient: *
MRN: *
Discharge date: *

Please recall: **Any death where there is even a remote possibility that the underlying manner of death is unnatural, suspicious, or not the direct result of the progression of a medically recognized disease process MUST be reported to the Medical Examiner's Office. Reporting must occur regardless of the length of time between the initial insult or injury and death.**

The following are deaths that are Reportable to the Medical Examiner:

1. Any death where any form of violence, either criminal, suicidal, accidental, intentional, or unintentional, was directly responsible, or was contributory.
2. Any death caused by an unlawful act or negligence.
3. Any death occurring in suspicious, unusual, or unexplained fashion.
4. Any death where the attending physician is either unable or unwilling, to sign the Death Certificate.
5. Any death of a person confined to a public institution.
6. The death of any prisoner, even though the cause and manner both appear to be natural, regardless of the location of death.
7. Any death caused by, or suspected to be the result of, drug and/or chemical poisoning or overdose.
8. Any sudden death of a person in apparent good health.
9. Any death occurring during diagnostic or therapeutic procedures, resulting from such procedures, or having such procedures play a contributory role.
10. Any fetal stillbirth in the absence of a physician.
11. Any death where there is insufficient medical information to explain the individual's demise.
12. Exposure to extreme heat or cold.
13. Workplace related deaths.
14. Physical, chemical, biological, and radiological injuries.
15. Death of unidentified individuals.

The following are examples of Unnatural Deaths that are also Reportable to the Medical Examiner:

1. Deaths where a motor vehicle was involved.
2. Infectious deaths following an injury.
3. Hip fractures in the elderly, either as a primary or contributory cause of death.
4. Deaths where either the result or contributory cause was due to subdural hematoma.
5. Any death by asphyxiation.
6. Head injuries with a prolonged hospital course.
7. Cases where there is uncertainty or inadequate clinical information at the time of admission or death.
8. Cases transferred from out of county where there may be inadequate information.
9. Deaths from conditions directly related to trauma regardless of the passage of time – e.g., death from a seizure disorder which was the result of a motor vehicle accident, a fall, or being struck on the head.

SJH Policy regarding Reporting Deaths to the Medical Examiner is attached for your reference.

If you have any questions, please contact Anna Talamo in Clinical Quality and/or Zoe Orecki in Risk Management.

Sincerely,

Clinical Quality and Risk Management Teams

Craig T. Montgomery, MD, MQC Peer Review Committee Chair

Cc: Philip A. Falcone, MD, MHL, FACS, Chief Clinical Officer