

CME Database

1109.1 PURPOSE AND SCOPE

Documentation and tracking of accurate and complete information is vital to the performance of a thorough death investigation. The Coroner Division Facility accomplishes this tracking via the CME database, which contains a compilation of information input by members of all Division units. This policy establishes general guidelines and requirements for use of this database.

1109.2 GENERAL EXPECTATIONS

All members shall complete their respective sections of CME pages and fields, to document actions taken or information obtained on a given case. All members shall complete their respective sections of CME as soon as practical and prior to case closure. For CME data to qualify as an "official record," entries must be made "at or near the time" of the event referenced in the record. Any entry made into CME shall accurately reflect your actions in relation to the investigation (example: Do not make an entry that property was collected and booked into evidence, until it has actually occurred).

1109.2.1 LATE ENTRIES

Entries may be added following closure of the case for reasons including, but not limited to, specimen disposition, release of property and evidence, report request tracking, or subpoenas. These entries shall be made immediately at the time the action is taken.

1109.3 MINIMUM REQUIREMENTS

For any death requiring Coroner death certification, the assigned Deputy Coroner shall be responsible for completing, at a minimum, the following CME sections prior to the start of autopsy examination and/or Sign Out – No Autopsy (SONA) review:

- (a) Possible Manner
- (b) Decedent's Name and Date of Birth
- (c) Date and Time of Death
- (d) Identified By and Identification Method
- (e) Marital Status
- (f) Autopsy Code
- (g) Billing Code
- (h) Next-of-Kin Name and Contact Information
- (i) Location of Death
- (j) Injury Date, Time, Location and Description (when applicable)
- (k) Detailed Circumstances

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(l) Property Collected

(m) Any Follow-Up Requests