The Regional Emergency Medical Services Council (REMSCO) of New York City has researched and clarified how EMS Providers can determine death in the prehospital environment. This advisory has been approved by the Regional Emergency Medical Services Council for use in the NYC region.

Owners/operators of Ambulance and ALS First Response Services providing prehospital medical treatment within the five boroughs of the City of New York are responsible to provide copies of this Operational Advisory to personnel and Service Medical Director.

Jeffrey Horwitz, DO
Chair, Regional Emergency Medical Services Council of New York City
The Regional EMS Council of NYC, Ambulance Operations / Systems Committee, formed a Technical Advisory Group (TAG) to develop an information guideline – not a policy or standard – to help EMS Agencies orient their personnel regarding Determination of Death by Prehospital Providers. Below is a listing of frequently asked questions that can assist EMS Agencies in the development of policies and procedures regarding the determination of death by prehospital providers. EMS Agencies are encouraged to orient their personnel with regards to determination of death in the field.

**INITIATION OF RESUSCITATIVE MEASURES AND THE PRESUMPTIVE DIAGNOSIS OF DEATH**

**Types of Death & Pronouncement**

There are two types of death: natural and unnatural. Natural is defined by an Office of the Medical Examiner’s memorandum dated April 12, 1990 (Attachment 1). The memorandum states, “death occurring at home, attended by a physician, does not fall under the jurisdiction of the medical examiner. A natural death is a death caused entirely by disease.”

Unnatural deaths include, but are not limited to: criminal violence, all accidents (i.e., motor vehicle, industrial, home, public place, etc.), all suicides, sudden death of a person in apparent good health, etc.

1. **Who can pronounce a death?**
   
   Only a physician may pronounce a patient’s death.

2. **Who may sign the Death Certificate?**

   The death certificate may be signed by the attending physician who has been providing medical care to the patient, has treated the patient for the disease causing death, and has examined the patient at appropriate intervals relative to the patient’s disease and condition.¹

**Initiation of Resuscitative Measures**

1. **When should Cardiopulmonary Resuscitation (CPR) be initiated by the EMT/Paramedic?**

   The Regional Emergency Medical Advisory Committee (REMAC) of New York City, Prehospital Transport and Treatment Protocols, General Operating Procedures, page A.8 (Attachment 2), states CPR should be initiated on all patients who are not breathing (apneic) and pulseless, unless one of the following conditions exists:

   - Extreme dependent lividity; or
   - Rigor mortis; or
   - Tissue decomposition; or
   - Obvious mortal injury; or
   - A valid Do Not Resuscitate (DNR) order is present.

2. When should Cardiopulmonary Resuscitation (CPR) be stopped by the EMT/Paramedic?

The Regional Emergency Medical Advisory Committee (REMAC) of New York City, Prehospital Transport and Treatment Protocols, General Operating Procedures, page A.8, states CPR should be continued until one of the following occurs:

- Spontaneous circulation has been restored; or
- Resuscitative efforts have been transferred to providers of equal or higher level of training; or
- A qualified, licensed physician assumes responsibility for the outcome of the patient; or
- The crew is exhausted to the point of not being able to continue resuscitative efforts.

NOTIFICATION OF PRESUMPTIVE DIAGNOSIS OF DEATH

1. Who must be notified?

In the case of death, there are many people that may need to be notified, such as the New York City Police Department (NYPD), private physicians, family members, funeral homes, etc. However, EMS personnel are not equipped to handle those tasks and should not be required to do so.

In order to avoid unnecessary complications, it is recommended that NYPD attend each and every case of natural OR unnatural death, as NYPD is well equipped to make notifications, etc. EMTs/Paramedics must comply with the agency guidelines under which they operate, however, if certain conditions apply (see ‘Special Situations Concerning Presumptive Diagnosis of Death’, page 5) it may not be necessary to contact NYPD.

2. Under what circumstances must NYPD and the Office of the Chief Medical Examiner be notified?

EMS providers must call NYPD if there is any suspicion of foul play or if they question the validity of a supposed natural death.

In the event of a crime scene, NYPD must be notified and asked to respond. EMS Personnel are not to handle crime scenes alone.

a) Under what special circumstances are notifications made to agencies other than NYPD? This includes other law enforcement agencies, family members, press, etc.

EMTs/Paramedics are not required to make any notifications, other than notifying NYPD (when required to do so). Once NYPD has arrived at the scene, the EMT/Paramedic has no further responsibilities. Each agency should have a written policy in place regarding any additional responsibilities (if any) it wishes its employees to assume.

3. How is notification made?

When a notification is required, notification should be made to NYPD only. There should be no notifications made to any private physicians, family members, or others who are not on the scene.

Volunteer Ambulance Agencies should be directed to contact their neighborhood NYPD precinct.
4. What information should pre-hospital providers give NYPD?

In agreement with the FDNY Operating Guide Procedure, “Cancellation of Ambulance Response to DOAs”, June 15, 1999 (Attachment 3), the appropriate information for presumptive diagnosis of death incidents shall include:

- name, certification number and expiration date of the EMT determining death,
- name of the EMS Agency,
- patient’s name, address, age and sex, and
- most obvious cause of death.

5. How long must the EMT/Paramedic remain on the scene?

Each Agency must have its own policy, however, if NYPD has been called, an EMS provider must remain on scene until a police officer is present.

6. To what agency or to whom can the body be released?

In agreement with the FDNY Operating Guide Procedure, “Removal of the Deceased from the Scene of an Assignment” (Attachment 4), March 24, 2005, the body cannot be removed from a scene without the presence of NYPD and a report made (by NYPD) to the Office of the Chief Medical Examiner. EMS providers should not move decomposing bodies; this is to be done by mortuary units. Remember, the Office of the Chief Medical Examiner is the primary agency responsible for the removal of the deceased from the scene of an assignment regardless of location.

7. When and where can a body be left (i.e., situations when bodies must be removed)?

The only circumstance in which EMS providers should ever be involved in transporting the deceased is in cases of obvious death where the dead body is in public view. In these cases, law enforcement is on-scene; therefore, EMS providers should follow the instructions of NYPD on-scene.

To ensure chain of custody of forensic evidence, all removals should be made by the Office of the Chief Medical Examiner. However, there are special exceptions made for public safety personnel at the discretion of the incident commander.
SPECIAL SITUATIONS CONCERNING PRESUMPTIVE DIAGNOSIS OF DEATH

1. How does an EMT/Paramedic handle the notification of Presumptive Diagnosis of Death for Home Hospice Patients?

An EMT or Paramedic is not required to report a death at home or in a home hospice program to the police if all of the following conditions are satisfied:

- The EMT or Paramedic is told by a physician that:
  - the death was due to disease or medical condition capable of causing such death;
  - the physician or the physician’s associate has been providing medical care to the decedent;
  - such physician or associate has treated the decedent for the disease or medical condition causing death;
  - such physician or associate has examined the decedent within the 31 days proceeding death;
  - such physician or associate is willing to sign a death certificate certifying that the death was caused by such disease or medical condition;
- The evidence at the scene is, in the reasonable opinion of the EMT or Paramedic, consistent with death due to such disease or medical condition; and
- The EMT or Paramedic sees no evidence of criminal violence, accident, suicide, or death in any suspicious or unusual manner.

If any of the forgoing are not satisfied, there is a risk that the EMT or Paramedic could be charged with a misdemeanor for failure to notify the police.

In addition, if the EMT or Paramedic becomes aware of any evidence that the death was caused by criminal violence, by accident, by suicide, suddenly when in apparent health, or in an suspicious or unusual manner, the EMT or Paramedic is required to report such death to the police—even if the decedent is in a home hospice care program for a chronic terminal illness. Also, if the attending physician or his associate refuse to certify death due to disease or medical condition, the police and the OCME need to be notified even if the family or hospice object.² (Attachment 5)

2. How do we inform NYPD that non-municipal EMTs can make a presumptive diagnosis of death in the field?

A copy of this information guideline, in addition to a letter will be sent to the NYPD representative to the Regional EMS Council and to the NYPD Commissioner by the Regional EMS Council.

Attachment 1
A natural death occurring at home, attended by a physician, does not fall under the jurisdiction of the medical examiner. A natural death is a death caused entirely by disease.

A person attended by a physician shall mean that a physician has been providing medical care to the patient, has treated the patient for the disease causing death, and has examined the patient at appropriate intervals relative to the patient's disease and condition. Generally, the physician should have seen the patient within thirty-one days of death, but that period of time may be enlarged in a particular case by the approval of the Chief Medical Examiner or a Deputy Chief Medical Examiner.

If the attending physician is available and willing to sign the death certificate, the family or friends in attendance may then call the funeral director of their choice. The attending physician does not have to see the body in order to sign the death certificate. If the attending physician is not available, a physician associated with the attending physician may sign the death certificate as long as he or she examines the body prior to signing the death certificate.

We want to avoid unnecessarily taking jurisdiction when a death occurs at home or in a home hospice program in cases where the decedent has been under long-term care for a chronic terminal illness, such as AIDS or cancer. In these situations, the patient may have been attended in the terminal stages of disease by friends, members of the family, health care or hospice workers, or home health attendants. If a person who has been attending a decedent under these circumstances contacts the OCME, they should be instructed to do the folllows: (1) to call the attending physician (or a physician
associated with the attending physician if the attending is unavailable; (2) that there is no need for a representative of the OCME to be present unless a death certificate cannot be obtained from the attending physician or his or her substitute; (3) if the attending physician or his or her associate is not available, the police should be called, who then will respond to the scene and notify the OCME. The OCME will respond and certify the death.

Attending physicians may also continue to sign the death certificates of persons who die unexpectedly at home if they have been under prior medical treatment for a disease or condition capable of producing sudden death, such as a heart attack occurring in a patient with coronary artery disease or hypertension. Under any circumstance, if there is any question about whether the person is dead or alive, the family or friends in attendance must call for emergency help.

After arrangements have been made to obtain a signed death certificate for the decedent, the funeral director may come to the place of death and remove the body to the funeral home. The funeral director should obtain the signed death certificate from the attending physician and file it with the New York City Bureau of Vital Statistics within forty-eight hours of death. If the funeral director has any reason to believe the death may have occurred from, or was contributed to, by other than natural causes, the funeral director shall not proceed further, and shall immediately notify the OCME.

This policy supersedes any other policy of the OCME on natural deaths occurring at home.

CSH/ES/ema
Attachment 2
NOTE: PATIENTS WHO BECOME CRITICAL OR UNSTABLE MUST BE TRANSPORTED TO THE NEAREST NEW YORK CITY 911 SYSTEM AMBULANCE DESTINATION EMERGENCY DEPARTMENT.

CARDIOPULMONARY RESUSCITATION

Basic Cardiac Life Support in adults, children, infants, and newborns should conform to the current guidelines set by the American Heart Association and the American Red Cross. The following guidelines apply to the initiation and termination of CPR:

CPR should be initiated on all patients who are not breathing (apneic) and pulseless unless one of the following conditions exists:

- Extreme dependent lividity;
- Rigor mortis;
- Tissue decomposition;
- Obvious mortal injury; or
- A valid Do Not Resuscitate (DNR) order is present. (See Appendix C.)

NOTE: TERMINAL ILLNESS IS NOT A CONTRAINDICATION TO CPR.

CPR should also be initiated in newborns, infants, and children under 9 years of age with heart rates less than 60 (severe bradycardia) and signs of inadequate central (proximal) perfusion (decompensated shock).

NOTE: CPR IS NECESSARY IN NEWBORNS, INFANTS, AND CHILDREN UNDER 9 YEARS OF AGE WITH EXTREMELY SLOW HEART RATES AND POOR VITAL ORGAN PERFUSION TO ENSURE ADEQUATE CIRCULATION TO THE HEART, LUNGS, AND BRAIN.

CPR should be continued until one of the following occurs:

- Spontaneous circulation has been restored;
- Resuscitative efforts have been transferred to providers of equal or higher level of training;
- A qualified, licensed physician assumes responsibility for the outcome of the patient;
- The crew is exhausted to the point of not being able to continue resuscitative efforts.

AIRWAY MANAGEMENT

All patients require continuous monitoring of their airways to ensure airway patency. Wherever the term “Monitor Airway” is used throughout these protocols, the following elements shall be utilized:

- Position of the patient's head
- Need for airway adjuncts
- Need for oropharyngeal suctioning
Attachment 3
1. PURPOSE

1.1 To establish a procedure for non-response, or cancellation, of an EMS Command response to incidents in which a presumptive diagnosis of death has been made by a NYS certified EMT, operating under the direct authority of a pre-hospital care provider agency, other than the FDNY EMS Command.

2. SCOPE

2.1 This procedure applies to all members of the FDNY EMS Command and the employees of voluntary hospitals who provide pre-hospital emergency medical care through the New York City 911 system.

3. POLICY

3.1 When a notification of a presumptive diagnosis of death has been made by a NYS certified EMT operating under the direct authority of a pre-hospital care provider agency, the FDNY shall:

3.1.1 Exercise the option to respond or not to respond to the incident.

3.1.2 Cancel the FDNY response, if previously initiated.

3.2 Notification of a presumptive diagnosis of death, and actions taken subsequent to the notification, shall be consistent with the criteria set forth in Operating Guide Procedure 106-09, Initiation of Resuscitative Measures and the Presumptive Diagnosis of Death.

3.3 Appropriate CAD information for presumptive diagnosis of death incidents shall include:

3.3.1 The name of the pronouncing EMT.

3.3.2 The EMT certification number and expiration date of the pronouncing EMT.

3.3.3 Name of the pre-hospital care provider for which the EMT provides service.

3.3.4 Patient’s name, address, age, and sex.

3.3.5 Obvious death criteria.
3.3.6 Requests for cancellation of response by the EMS Command may be received either through the 911 system, or directly into Emergency Medical Dispatch (EMD), via the Mutual Aide Radio System (MARS) phone number. The MARS radio may not be utilized for notification.

4. PROCEDURE

4.1 Dispatcher shall:

4.1.1 When a notification of presumptive diagnosis of death is received, enter the following information related to the incident into the CAD system:

A. Call type: PDOD

B. Priority: Segment 9

C. Action Code: Not sent (N)

D. Text: To include, the appropriate CAD information for presumptive diagnosis of death incidents as described in Section 3.3.

NOTE: Use of Not Sent (N) action code will not generate a FDNY unit response. However, it will create documentation pertaining to the incident.

NOTE: If the information provided does not meet accepted criteria for a presumptive diagnosis of death, the call shall be processed for an appropriate FDNY response.

4.1.2 If a call is received, pursuant to this procedure, and a CAD assignment was previously created, the following actions shall be taken:

A. Verify the correct address of incident.

B. Change the call type of the existing CAD assignment as follows:

1. Call type: PDOD

2. Priority: Segment 9

3. Action Code: Change (C)

4. Text: To include the appropriate CAD information for presumptive diagnosis of death incidents as described in Section 3.3.

4.1.3 Cancel the original incident if it has not been dispatched. If a FDNY unit has already been assigned to the incident, notify the appropriate dispatcher to cancel the response to the incident.
5. RELATED PROCEDURES

5.1 OGP 106-09

BY ORDER OF THE CHIEF OF OPERATIONS
1. PURPOSE

1.1 To establish a procedure for the removal of the deceased from the scene of an assignment.

2. SCOPE

2.1 This procedure applies to all members of the EMS Command and to Voluntary Hospital ambulance personnel who provide pre-hospital emergency medical care in the New York City 911 system.

3. DEFINITIONS

3.1 Private Location - shall be defined as those areas to which the public in general does not have access, such as a home, apartment, hotel room, or private office.

3.2 Public Location - shall be defined as those areas, which are open to the public or to public view.

3.3 10-82M, (Location/Borough) – Status signal indicating that a unit is transporting the deceased to the morgue.

4. POLICY

4.1 Office of the Chief Medical Examiner is the primary agency responsible for the removal of the deceased from the scene of an assignment regardless of location.

4.2 Removal of the deceased from any location may be ordered by an on-duty EMS Officer following authorization from the Office of the Chief Medical Examiner.

4.3 When authorized the removal of the deceased shall be performed by ambulance, with the exception of decomposed bodies, which shall only be removed by mortuary units.

4.4 At no time shall the deceased be removed without a NYPD Identification Tag (PD 317-091).
5. **PROCEDURE**

5.1 Prior to removal of the deceased from the scene of an assignment, members shall:

5.1.1 Confirm with the Police that the death has been reported to the Office of the Chief Medical Examiner and a mortuary unit is not responding.

5.1.2 If available, record the M.E. Case Number on the Ambulance Call Report.

5.1.3 Confirm with the Police officer in charge that a search has been conducted and personal property removed.

5.1.4 Confirm that a NYPD Identification Tag (PD 317-091) has been affixed to the body. When confirmed the body shall be placed in a disposable body bag and delivered directly to the Medical Examiner’s Morgue, in the borough of occurrence.

5.1.5 If a NYPD Identification Tag (PD 317-091) has not been affixed to the body, members shall:

   A. Await the placement of a NYPD ID Tag prior to removing the body from the scene. When this is not possible, the body shall be left in the custody of a Police officer. Bodies shall not be removed from the scene without a NYPD ID Tag.

   B. If police officers are not present at the scene, members shall contact the dispatcher and request the response of the police. Members shall remain on the scene until the arrival of police officers, and the conclusion of a search for personal property.

   C. At no time shall FDNY members sign the NYPD ID Tag. This document must be signed by the accompanying police officer upon arrival at the morgue.

5.4 Between 1600 and 0800 hours when an EMS unit in the borough of Staten Island, needs to transport a body to the Staten Island Medical Examiner’s Office they shall:

5.4.1 Notify the dispatcher that they are removing a body, provide an estimated time of arrival (ETA) to the morgue and request the Medical Examiner’s Office be contacted to ensure an attendant is present to accept the deceased.

5.4.2 If an attendant is not present to accept the body at the morgue, the unit shall:

   A. Request the response of a Conditions Officer.

   B. Request an ETA for a mortuary attendant.
5.4.3 When notified a unit is enroute to the Staten Island morgue, EMD shall contact the Medical Examiner, Office of Communications at (212) 447-2030 and provide the operator with an approximate ETA.

5.5 When the body of a deceased person is transported to the morgue, members shall secure a replacement disposable body bag from the morgue attendant.

6. RELATED PROCEDURE

6.1 OGP 125-04, *Infection Control Program*

BY ORDER OF THE CHIEF OF EMS COMMAND
MEMORANDUM

To:            Nancy A. Benedetto                    Date:  August 1, 2007
               Executive Director, Administration
               Regional Emergency Medical
               Services Council of New York
               City, Inc.

From:         Stephen H. Kinney Jr.
               Arlene Stevens

Subject:       Reporting Deaths

You have asked four questions concerning the duty of an Emergency Medical
Technician (EMT) or a Paramedic to report certain deaths to the police. Your questions were as
follows:

1. Is an EMT or Paramedic required to notify the police if a patient’s death occurs at home or in a home hospice
   program in cases where the patient has been under long-term care for a chronic terminal illness, such as AIDS or
cancer?

   a. Does the above also apply to sudden natural death resulting from a previous medical history such as a
      heart attack occurring from coronary artery disease or hypertension?

   b. What about a cardiac arrest with no known medical history?

2. Are there legal ramifications for not notifying the police when making a presumptive diagnosis of death if the
   patient died at home while under the care of a physician who has seen the patient within the past 31 days and is
   willing to sign a death certificate?
SUMMARY OF FINDINGS

Based upon a review of the authorities described in the Analysis below, an EMT or Paramedic is not required to report a death at home or in a home hospice program to the police if all of the following conditions are satisfied:

1. The EMT or Paramedic is told by a physician that
   a. the death was due to disease or medical condition capable of causing such death;
   b. the physician or the physician’s associate has been providing medical care to the decedent;
   c. such physician or associate has treated the decedent for the disease or medical condition causing death;
   d. such physician or associate has examined the decedent within the 31 days proceeding death;
   e. such physician or associate is willing to sign a death certificate certifying that the death was caused by such disease or medical condition;

2. The evidence at the scene is, in the reasonable opinion of the EMT or Paramedic, consistent with death due to such disease or medical condition; and

3. The EMT or Paramedic sees no evidence of criminal violence, accident, suicide, or death in any suspicious or unusual manner.

If any of the foregoing are not satisfied, there is a risk that the EMT or Paramedic could be charged with a misdemeanor for failure to notify the police.

ANALYSIS

The New York City Administrative Code requires that certain deaths be reported to the police. Administrative code § 17-201, ("Section 17-201"), requires "any citizen who becomes aware of the death of any person, occurring under the circumstances described in subdivision (f) of section five hundred and fifty-seven of the charter to report such death" to the
office of the chief medical examiner and to a police officer. New York City Administrative Code §17-201 (2006) (emphasis added). Section 17-201 also provides that “any person who shall willfully neglect or refuse to report such death...shall be guilty of a misdemeanor.” Id.

However, both the reporting requirements and the criminal penalty are limited to deaths that occur under the circumstances outlined in section 557(f) of the New York City Charter. The Charter gives jurisdiction to the Chief Medical Examiner in instances where death occurs “from criminal violence, by accident, by suicide, suddenly when in apparent health, when unattended by a physician, in a correctional facility or in any suspicious or unusual manner or where an application is made pursuant to law for a permit to cremate the body of a person.” New York City Charter § 557(f) (2006) (emphasis added). Therefore, if the EMT or Paramedic becomes aware of any evidence that the death was caused by criminal violence, by accident, by suicide, suddenly when in apparent health, or in any suspicious or unusual manner, the EMT or Paramedic is required to report such death to the police - even if the decedent is in a home hospice care program for a chronic terminal illness. In addition, if the death occurs when the person is “unattended by a physician,” the EMT or Paramedic must report the death to the police.

While the meaning of “attended by a physician” is unclear from the Administrative Code and the Charter, the Office of the Chief Medical Examiner, (“OCME”), has stepped in and provided clarification. According to a memorandum from Chief Medical Examiner Charles S. Hirsch entitled “Natural Deaths at Home,” a person is “attended by a physician” when “a physician has been providing medical care to the patient, has treated the patient for the disease causing death, and has examined the patient at appropriate intervals relative to the patient’s disease and condition.” Memorandum from Chief Medical Examiner Charles S. Hirsch on Natural Deaths at Home (April 12, 1990). The Hirsch Memorandum
further elaborates by stating that, “[g]enerally, the physician should have seen the patient within thirty-one days of death, but that period of time may be enlarged in a particular case by the approval of the Chief Medical Examiner or Deputy Chief Medical Examiner.” Id. According to the Hirsch Memorandum, the attending physician, or, if the attending physician is unavailable, his associate, is permitted to certify death in such cases. Id.

The OCME has also issued a directive which mirrors the Hirsch Memorandum. Directive 3-08, issued by the OCME and entitled “Natural Deaths At Home Not Requiring A Scene Visit,” states that “[a] natural death occurring at home, attended by a physician, does not fall under the jurisdiction of the medical examiner…this type of case is referred to as ‘no case.’” Office of the Chief Medical Examiner, Policy on Natural Deaths at Home, Directive 3-08. The directive also provides that in such cases the attending physician, or, if the attending physician is unavailable, a physician associated with the attending physician, can sign the death certificate.

In the case of chronic terminal illness, both the Hirsch Memorandum and Directive 3-08 evidence the OCME’s desire to avoid, if possible, causing the decedent’s family and loved ones distress by asserting jurisdiction. The Hirsh Memorandum states, “[w]e want to avoid unnecessarily taking jurisdiction when a death occurs at home or in a home hospice program in cases where the decedent has been under long-term care for a chronic terminal illness, such as AIDS or cancer.” Memorandum from Chief Medical Examiner Charles S. Hirsch on Natural Deaths at Home (April 12, 1990). Directive 3-08 makes this aim even more clear, stating that, “[t]he investigator should have a sensitivity to the trauma caused by unnecessary exercise of medical examiner jurisdiction when a death occurs at home or in a home hospice program in cases where the decedent has been under long-term care for a chronic terminal illness
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such as AIDS or cancer.” Office of the Chief Medical Examiner, Policy on Natural Deaths at Home, Directive 3-08

The EMT or Paramedic arriving at the scene is in a difficult position. Usually, the EMT or Paramedic will have no prior knowledge of the decedent’s medical condition. The family of the decedent may be upset, confused, emotional or, in the case of certain diseases such as AIDS, embarrassed. The attending physician may be difficult to reach. Given these difficulties, we have prepared the following checklist based upon the Administrative Code, the Charter, and the publications of the Office of the Chief Medical Examiner:

1. The EMT or Paramedic is told by a physician that
   a. the death was due to disease or medical condition capable of causing such death;
   b. the physician or the physician’s associate has been providing medical care to the decedent;
   c. such physician or associate has treated the decedent for the disease or medical condition causing death;
   d. such physician or associate has examined the decedent within the 31 days proceeding death;
   e. such physician or associate is willing to sign a death certificate certifying that the death was caused by such disease or medical condition;

2. The evidence at the scene is, in the reasonable opinion of the EMT or Paramedic, consistent with death due to such disease or medical condition; and

3. The EMT or Paramedic sees no evidence of criminal violence, accident, suicide, or death in any suspicious or unusual manner.

If every item in the foregoing checklist is satisfied, the EMT or Paramedic need not notify the police. However, even if every item in this checklist is satisfied, there are risks to the EMT or Paramedic. The person claiming to be a physician might not be a physician. The
death might have been caused by poison, suffocation or conditions other than those for which the
decedent had been treated. If the death later turns out to be reportable, the EMT or Paramedic
could be questioned by the police or even charged, particularly if there were signs that the death
was not natural or the EMT or Paramedic doesn’t recall important details. The EMT or
Paramedic should be alert for suspicious circumstances and, when in doubt, report the death to
the police. The EMT or Paramedic may wish to keep written notes or other evidence that the
checklist was satisfied.

The EMT or Paramedic is generally not required to notify the police or the OCME
where the patient dies a natural death at home or in a home hospice program and the attending
physician or his associate is willing to sign the death certificate. Thus, assuming no other facts,
where a patient, who has been under long term care for a chronic terminal illness, dies at home or
in a home hospice program as a result of such illness, the police do not need to be alerted if the
patient was attended by a physician, as defined in the Hirsch Memorandum, and the attending
physician or his associate is willing to certify death to such illness. A similar rule applies where
a patient dies suddenly at home from a pre-diagnosed disease or medical condition capable of
producing sudden death. For example, assuming no other facts, where the patient dies at home
from a heart attack caused by hypertension or coronary artery disease, the police do not need to
be contacted if the patient was attended by a physician, as defined in the Hirsch Memorandum,
and the attending physician or his associate is willing to certify death to such causes.

However, if the attending physician or his associate refuse to certify death due to
disease or medical condition, the police and the OCME need to be notified even if the family or
hospice object. Unless otherwise permitted by the OCME, a physician should refuse to sign the
death certificate if he or one of his associates has not treated the patient within 31 days preceding
death. See Office of the Chief Medical Examiner, Policy on Natural Deaths at Home, Directive 3-08 (stating that “[g]enerally, the physician signing the death certificate will have seen the patient within thirty-one days of death, but that period of time may be extended in a particular case on a case-by-case basis with the approval of the Chief Medical Examiner or his designee”). Additionally, a physician should refuse to sign the death certificate if he believes that the death occurred from, or was contributed to by, other than natural causes. If the physician is unwilling to sign the death certificate for either reason, Section 17-201 would be triggered and both the police and the OCME would need to be notified. See Memorandum from Chief Medical Examiner Charles S. Hirsch on Natural Deaths at Home (April 12, 1990) (stating that in cases where the patient dies a natural death at home or in a home hospice program and was attended by a physician, the OCME should be contacted only when a death certificate cannot be obtained from the patient’s attending physician or the attending physician’s associate). Where an EMT or Paramedic is called to a home or hospice where the patient has died an apparent natural death, efforts should be made to contact the attending physician. If the attending physician or his associate cannot be located, or are unwilling to certify death due to disease or medical condition, the EMT or Paramedic should ensure that the police and the OCME are notified.

Likewise, there is a duty to report deaths where the patient dies suddenly when in apparent health. The Charter explicitly gives jurisdiction to the chief medical examiner when someone dies “suddenly when in apparent health.” New York City Charter § 557(f)(2006). Since this situation falls under the circumstances of death outlined in the Charter, the reporting requirements of the Administrative Code are applicable. See, New York City Administrative Code §17-201 (2006). Thus, an EMT or Paramedic should ensure that both the police and the
OCME are notified where a patient with no known medical history dies suddenly, whether from cardiac arrest, stroke or otherwise.

CONCLUSION

Based on the assumptions described above, an EMT or Paramedic need not report to the police a death due to disease or medical condition occurring at home or in a home hospice program where the patient is attended by a physician, as defined in the Hirsch Memorandum, and that physician or his associate is able and willing to sign the death certificate. Because Section 17-201 is not applicable to deaths due to disease or medical condition when attended by a physician, there are no legal ramifications for not reporting such deaths to the police. However, an EMT or Paramedic should ensure that the police are notified where the patient dies suddenly when in apparent health, or where the attending physician or his associate is unavailable, unable or unwilling to sign the death certificate. In both instances, Section 17-201 requires the police and the OCME to be notified and provides a criminal penalty for failing to do so.