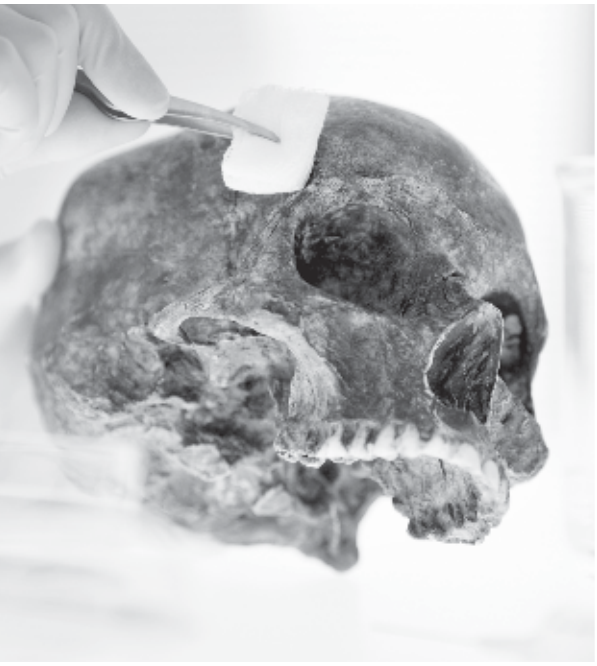

Improving Forensic Death Investigation

by Beth Pearsall

The death investigation community searches for solutions for a fragmented system.

In its 2009 report, *Strengthening Forensic Science in the United States: A Path Forward,* the National Academy of Sciences (NAS) stated that, "Death investigations in the United States rely on a patchwork of coroners and medical examiners" and that "these vary greatly ... in the quality of services they provide."[1] Forensic death investigation, the report stated, took place in the context of a "fragmented," "deficient" and "hodgepodge" system that made it difficult to standardize performance.

J.C. Upshaw Downs, coastal regional medical examiner for the Georgia Bureau of Investigation, acknowledged as much at the Forensic Death Investigation Symposium in June 2010.

"Currently, there is a disjointed patchwork of medical examiners, coroners and mixed offices," Downs said. He added, "The field must come together to have a clear, unified message," if it hopes to set goals and improve the quality of forensic death investigations. "The lack of uniformity is having a negative impact on justice, on public health and on public safety."

At the symposium, convened by the National Institute of Justice and the National Center for Forensic Science, the findings of the NAS report spurred participants' discussion about the forensic death investigation field.

While *Strengthening Forensic Science in the United States: A Path Forward* provided an objective, external review of forensic sciences as a whole, the Academy highlighted a number of long-standing issues within the medicolegal death

community in Chapter 9, "Medical Examiner and Coroner Systems: Current and Future Needs."

Like the rest of the report, the findings in Chapter 9 received considerable attention from the press. For those in the forensic death investigation community, however, the report's findings were anything but surprising.

The Forensic Death Investigation Symposium brought members of that community together for three days to discuss the field's current and future needs, many of which were highlighted in the Academy's report. Coroners, medical examiners, forensic pathologists, death investigators, law enforcement officers and members of the legal community gathered to explore and develop suggestions for improving the field. In particular, they sought to address enhancing communication; legal and ethical issues; education, training and certification programs; technology; and areas for future research in death investigation.

Medical Examiners or Coroners?

One of the most controversial sections in Chapter 9 of the NAS report calls for the elimination of coroner systems.

The United States has several different systems for handling death investigation. The four main systems in the U.S. are centralized state medical examiner systems, county coroner systems, county medical examiner systems, and mixed county medical examiner and coroner systems.[2]

State statute determines whether a medical examiner or coroner delivers death investigation services. Coroners — often elected officials who fulfill state requirements — may or may not be physicians or have medical training. Some serve as administrators, while others are responsible for determining the cause and manner of death. Medical examiners, on the other hand, are almost always physicians, are appointed and are often pathologists or forensic pathologists.

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According to *Strengthening Forensic Science in the United States: A Path Forward,* assessing the dead is a "medical decision," and thus a medical professional — not "a layperson with investigative and some medical training" — should make this decision. The report concluded: "The disconnect between the determination a medical professional may make regarding the cause and manner of death and what the coroner may independently decide and certify as the cause and manner of death remains the weakest link in the process."

Jay Siegel, director of the Forensic and Investigative Sciences Program at Indiana University-Purdue University and member of the NAS committee, told symposium participants that the recommendation to eliminate the coroner system does not come in a vacuum. "This is a system-wide problem," he said. "The NAS report examines the difficulties of the whole forensic science field, including a lack of research, funding, standards and accreditation."

Dr. Lakshmanan Sathyavagiswaran, Chief Medical Examiner-Coroner for the Los Angeles County Department of Coroner and current president of the National Association of Medical Examiners (NAME), presented the NAME resolution which supports the NAS recommendation of providing incentive funds to states and jurisdictions with the goal of replacing coroner systems with medical examiner systems to improve death investigations. He also indicated that this process will take several years and required a dialogue with coroners and law makers. He stated that medical examiners were in a better position to educate and to improve the quality of forensic death investigations.

On the other side of the debate is Dr. O'dell Owens, a previously elected coroner and former president of the International Association of Coroners and Medical Examiners. Dr. Owens disagrees with the notion that an office is necessarily best served by a medical examiner. "It is not about who runs the office," he said. "It is about how well you run the office. And the public should decide this state by state."

"Eighty-four percent of coroners say they want standards and certification, but they lack access to resources and training," Owens said. "We should work to give coroners education and training opportunities."

P. Michael Murphy, coroner for the Clark County (Nevada) Office of the Coroner/Medical Examiner, urged symposium participants not to argue about which system is better. Instead, he asked them to discuss quality and to determine what constitutes a competent medicolegal death investigation.

"All of us have different ideas about what the solution is," Murphy said. "We have an opportunity to air our differences, identify challenges and provide possible solutions. We need a better-coordinated effort. This is our opportunity to make a difference."

A Competent Death Investigation

To help identify solutions for improving death investigation, symposium participants broke into groups to discuss the field's current and future needs. They then made recommendations for moving forward with ways to improve the quality of death investigation.

Communication Breakdown

"Communication — or lack thereof — is the single greatest hurdle to performing our daily work," Murphy said. Communication difficulties with other agencies and with decedents' families hinder the coroner/medical examiner's work.

Clear, well-defined channels of communication between the coroner/medical examiner and the various agencies that play a role in death investigations, from law enforcement to public health, are critical for collaboration, information-sharing and coordinating activities. Participants identified educating other agencies about the role of the coroner/medical examiner as a first step, because many agencies do not understand the coroner/medical examiner's function, much less the importance of his or her involvement and the appropriate stage to initiate that involvement. This lack of communication can lead to delaying notification of coroners/medical examiners of deaths, failing to maintain communication or hindering attempts to collect information.

Sathyavagiswaran discussed the importance of building professional relationships. He emphasized that collaboration among staff in different agencies and acknowledging their expertise can improve communication. He also indicated that developing an official protocol for the involvement of the coroner/medical examiner would help ensure timely communication between agencies and build relationships.

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To address the communication breakdown that occurs too often in death investigations, participants recommended providing education and training to all death investigation professionals and stakeholders, including medical examiners, coroners, law enforcement, EMS personnel, hospitals, the media, elected officials and students.

Symposium participants also recommended encouraging the use of technology to communicate during death investigations. Participants noted that in general, the field does not use potentially valuable tools like teleconferencing, mobile communication technology and social communication platforms that can enhance collaboration, information collection, communication and command.

Proper communication with the family of the deceased is also a primary concern of the death investigation community. Participants recommended creating trainings to enhance communication with the families of the decedent.

Julie Howe, executive director of the American Board of Medicolegal Death Investigators, noted that communicating with families can be a challenge, especially when they expect high-tech investigations and quick answers. "Families often lack understanding of the multi-agency approach to death investigations and are reluctant to talk about the same things to different agencies," Howe explained.

Communicating with families can be even more difficult in the case of a mass disaster. While the National Transportation and Safety Board has a well-organized family communication process for aviation disasters, in most other cases, there are no comparable systems in the U.S. The group recommended creating a centralized mechanism for the public to communicate with responding federal agencies.

Education, Training and Certification Programs

Participants identified a strong need for increased education and training opportunities in all of the disciplines related to medicolegal death investigation, including opportunities for medical examiners, coroners, death investigators, forensic pathologists, forensic anthropologists and forensic toxicologists.

The field must find a way to provide education and training opportunities to those who do not have the resources, participants said. To help do this, they recommended:

- Providing incentive funds to encourage training.

- Developing regional training programs for coroners.
- Funding forensic pathology fellowship programs.
- Establishing leadership and management programs to train death investigation administrators.

But, as Owens pointed out, money drives everything. "We must find a way to increase funding so the field can have better training," he said.

Leveraging R&D and Technology in the Death Investigation Community

According to *Strengthening Forensic Science in the United States: A Path Forward,* investigators do not take full advantage of technology and tools, such as CT scans and digital X-rays, that are routinely used in medical disciplines. Incorporating this technology could assist practitioners in medicolegal death investigations. The report ties this disuse of technology back to the lack of education and training in the field.

The report also states that little research on death investigation and forensic pathology is being conducted in the United States. Forensic pathologists carry heavy caseloads and often lack the time, expertise, facilities or funding for research. According to the report, research is further limited because universities fail to promote research in basic forensic pathology.

To overcome these obstacles, symposium participants recommended:

- Establishing a registry of offices interested in partnering with academic institutions.
- Establishing centers of excellence and partnerships for forensic pathology research.
- Forming an expert panel to evaluate the utility of available technology.
- Offering incentives to draw people to the field, such as loan forgiveness.

Navigating Legal and Ethical Issues in Death Investigation

Finally, participants discussed the ethical and legal issues that can arise during death investigations. They asked: Should conversations between medical examiners and their staff — and any disagreements over the manner of death — be documented? And what happens when the forensic pathologist who originally worked on a case has left the office? Should someone else testify in his or her place?

In addition, symposium participants highlighted a lack of training in courtroom presentation. Medical examiners and coroners must be trained not to use medical and legal jargon in court, they said, because jury members need to understand their statements to make a fair decision.

To address these concerns, they recommended:

- Creating guidelines, best practices and model legislation for the release of records.
- Developing a model discovery packet.
- Offering medical examiners and coroners training with prosecutors and the defense.

Moving Forward

As the symposium drew to a close, Barbara Butcher, chief of staff and director of the Forensic Science Training Program at New York City's Office of Chief Medical Examiner, reminded participants that they are doing "noble work — we speak for the dead and help protect and care for their families. We are the last voice of someone who is gone."

Beth Pearsall is a freelance writer and frequent contributor to the *NIJ Journal.*

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Notes

1. National Academies' National Research Council, *Strengthening Forensic Science in the United States: A Path Forward,* Washington, DC: National Academies Press, 2009, http://www.ncjrs.gov/pdffiles1/nij/grants/228091.pdf.
2. Hickman, M., K. Hughes, J. Ropero-Miller, and K. Strom, *Medical Examiners and Coroners Offices, 2004,* Special Report, Washington, DC: Bureau of Justice Statistics, June 2007, http://bjs.ojp.usdoj.gov/content/pub/pdf/meco04.pdf.

See videos and PowerPoint presentations from the Forensic Death Investigation Symposium: http://www.ncfs.org/Death_Investigation/index.html.