This document has been accepted by the **Academy Standards Board (ASB)** for development as an American National Standard (ANS). For information about ASB and their process please refer to asb.aafs.org. This document is being made available at this stage of the process so that the forensic science community and interested stakeholders can be more fully aware of the efforts and work products of the Organization of Scientific Area Committees for Forensic Science (OSAC). The documents were prepared with input from OSAC Legal Resource Committee, Quality Infrastructure Committee, and Human Factors Committees, as well as the relevant Scientific Area Committee. The content of the documents listed below is subject to change during the standards development process within ASB and may not represent the contents of the final published standard. All stakeholder groups or individuals are strongly encouraged to submit technical comments on this draft document during the ASB’s open comment period. Technical comments will not be accepted if submitted to the OSAC Scientific Area Committee or Subcommittees.

Organizational and Foundational Standard for Medicolegal Death Investigation

Foreword

Medicolegal death investigation systems, including the public health, public safety, and law enforcement communities that support them, are responsible for conducting death investigations and certifying the cause and manner of deaths in the United States and abroad. The importance of medicolegal death investigation has been highlighted by the National Research Council of the National Academies1, the National Commission on Forensic Science2,and the National Science and Technology Council3. The role of the medicolegal death investigator, the medical examiner, or coroner is to investigate any death falling under their jurisdictional authority. Jurisdictional authorities vary based on state and national legal mandates, but generally include deaths that are unattended, known or suspected to be of unnatural means, unexplained, or of public health interest. Unnatural and unexplained deaths include homicides, suicides, unintentional injuries, drug-related deaths, and other disease-related deaths that are sudden or unexpected. These deaths have important national public health and public safety implications.  Processes followed by fully competent medicolegal death investigation systems optimize public health and public safety engagement, while bringing comfort and answers to the newly bereaved. The educational frameworks, operational roles, and processes for competent medicolegal death investigation are described here. This standard articulates the use and applicability of a comprehensive compilation of existing standards and guidelines.

**Keywords:** medicolegal death investigation; autopsy; forensic pathologist; medicolegal death investigator; forensic pathology; death certification; cause of death; manner of death; coroner; medical examiner; professional certification

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**Organizational and Foundational Standard for Medicolegal Death Investigation**

1. **Scope**
   1. This document describes the fundamental activities, minimal requirements, procedures, and personnel that are the basic components of a fully competent medicolegal death investigation system.
   2. This document was developed using information sourced from government and professional publications widely accepted in the medicolegal death investigation community as representative of best practice standards.
   3. This document is designed for use by medicolegal death investigators, coroners, and medical examiners and may serve as a reference for law enforcement agencies, the legal community, the medical community, public health officials, and the public at large to holistically define the fundamentals of medicolegal death investigation.
   4. This document may be referenced for inclusion in community resource allocation and planning in order to adequately support medicolegal death investigation responsibilities. This document can be leveraged as a tool for federal, state, local and tribal governments to justify projects, programs, and the development of standard operating procedures backed by sound medicolegal death investigation data.
   5. Actions taken in response to information contained within this document shall only be initiated once such actions are determined to be in full compliance with local, state, and federal laws. Jurisdictional, logistical, or legal considerations may necessarily limit implementation.
   6. This document does not purport to address all of the safety concerns, if any, associated with its use. It is the responsibility of the user of this standard to establish appropriate safety and health practices and determine the applicability of regulatory limitations prior to use.
2. **Normative References**
   1. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics. *Medical examiners’ and coroners’ handbook on death registration and fetal death reporting*. DHHS Publication No. (PHS) 2003-1110. Hyattsville, MD. 2003. Available from: <https://www.cdc.gov/nchs/data/misc/hb_me.pdf>
   2. Department of Health and Human Services, Centers for Disease Control and Prevention, *Sudden, Unexplained Infant Death Investigation; Guidelines for the Scene Investigator.* Atlanta, GA. *2007.* Available at: <https://www.cdc.gov/sids/pdf/curriculumguide_tag508.pdf>
   3. Department of Justice, Office of Justice Programs, National Institute of Justice. *Death investigation: A guide for the scene investigator (technical update)*. Washington, DC. 2011. Available from: <https://www.nij.gov/pubs-sum/234457.htm>
   4. Hanzlick R (ed). Forensic Pathology, Autopsy, and Neuropathology Committees of the College of American Pathologists in conjunction with the National Association of Medical Examiners. *Cause of death and the death certificate: Important Information for Physicians, Medical Examiners, Coroners, and the Public*. College of American Pathologists. Northfield, IL. 2006. Available from: <http://ebooks.cap.org/product/cause-death-certificate>
   5. Luzi SA, et al. *Medical Examiners’ Independence is Vital for the Health of the American Legal System.* Acad Forensic Pathol. 2013 3 (1): 84-92. Available from: <https://doi.org/10.23907/2013.012>
   6. Middleton et. al. *National Association of Medical Examiners Position Paper: Retaining Postmortem Samples for Genetic Testing*. Acad Forensic Pathol. 2013 3 (2): 191-194 Available from: <https://doi.org/10.23907/2013.024>.
   7. Melinek J. et. al. *National Association of Medical Examiners Position Paper: Medical Examiner, Coroner, and Forensic Pathologist Independence.* Acad Forensic Pathol. 2013 3 (1): 93-98. Available from: <https://doi.org/10.23907/2013.013>
   8. National Association of Medical Examiners (NAME), *Forensic Autopsy Performance Standards*. 2016. Available from: <https://name.memberclicks.net/assets/docs/684b2442-ae68-4e64-9ecc-015f8d0f849e.pdf>.
   9. Scientific Working Group for Medicolegal Death Investigation (SWGMDI), *Principles for Communicating with Next of Kin During Medicolegal Death Investigations.* 2012. Available from: <https://www.nist.gov/sites/default/files/documents/2018/04/25/swgmdi_principles_for_communicating_with_next_of_kin_during_medicolegal_death_investigations.pdf>
   10. Scientific Working Group for Medicolegal Death Investigation, SWGMDI’s Guide for Interactions Between Medical Examiner/Coroner Offices and Organ and Tissue Procurement Organizations and Eye Banks. 2013. Available from: <https://www.nist.gov/sites/default/files/documents/2018/04/25/swgmdi_standards_for_interactions_between_medical_examinercoroner_offices_and_organ_and_tissue_procurement_organizations_and_eye_banks.pdf>.
   11. Scientific Working Group for Medicolegal Death Investigation, *Facilities Workplace Locations of Board Certified Forensic Pathologists in the United States who Perform Medicolegal Autopsies for Medical Examiner/Coroner Systems.* Available from: <https://www.nist.gov/sites/default/files/documents/2018/04/25/swgmdi_workplace_locations_of_board_certified_forensic_pathologists_in_the_us_who_perform_medicolegal_autopsies.pdf>.
3. **Terms and Definitions**

For purposes of this document, the following definitions apply:

Accreditation: The formal recognition by an independent body, generally known as an accreditation body, operated according to international standards. [ISO/IEC 17000:2004]

Accreditation Bodies: An organization that provides confidence in the impartiality and competence of conformity assessment bodies by administering accreditation standards. The criteria for accreditation bodies are specified in ISO/IEC 17011:2004. As accreditation bodies are at the top of the confidence pyramid, there is no higher-level body to assess their conformity with the requirements. Instead, accreditation bodies from different countries have formed multilateral agreements through which they carry out peer assessments on each other.

American Board of Medicolegal Death Investigators (ABMDI): A voluntary national, not-for-profit, independent professional certification board that has been established to promote the highest standards of practice for medicolegal death investigators. [see: [www.abmdi.org](http://www.abmdi.org)]

Cause of Death: A medical opinion of the disease or injury that resulted in a person’s death.

Certification: Procedure by which a third party gives written assurance that a person, product, process, or service conforms to specific requirements. [ISO/IEC Guide 2:2016]

Chief Medicolegal Officer: The medical examiner, coroner, justice of the peace or other official who oversees the operation of a medicolegal death investigation office and/or system.

Coroner: An elected or appointed official whose duty is to oversee medicolegal death investigations, usually for a single county, and ensure certification of cause and manner of death; duties vary based on local enabling statutes.

Eye bank: Organization responsible for recovering corneas/eyes from donors.

Forensic Autopsy: An autopsy authorized by law, and typically performed under the jurisdiction of a medical examiner or coroner for criminal justice and public health purposes.

Forensic Pathologist: A physician who is board-certified in Anatomic Pathology or Anatomic and Clinical Pathology, as well as Forensic Pathology.

Forensic Pathology: The practice of medicine in which the principles of pathology are applied to problems of potential legal, public health, or public safety significance; a common function is the performance of autopsies to determine the cause and manner of death.

Genetic Testing: A type of medical test that identifies changes in chromosomes, genes, or proteins. The results of a genetic test can confirm or rule out a suspected genetic condition.

International Association of Coroners and Medical Examiners (IAC&ME): An international professional organization for medicolegal death investigation offices, coroners, medical examiners, and other practitioners of medicolegal death investigation that provides education and training. IAC&ME offers a voluntary inspection and accreditation program for medicolegal death investigation offices. (see: <https://www.theiacme.com>)

Manner of Death: Classification system based on the circumstances under which death occurred; includes accident, homicide, natural, suicide, and undetermined.

Medical Examiner: An appointed forensic pathologist whose duty is to oversee medicolegal death investigations, perform postmortem examinations, and certify cause and manner of death. In some jurisdictions, individuals with other qualifications hold the title “Medical Examiner”, but for purposes of this document those individuals are considered medicolegal death investigators.

Medicolegal Death Investigation: A formal inquiry into the circumstances surrounding the death of a human being; investigative information is considered with autopsy findings and adjunctive studies (if performed) to determine the cause and manner of death.

Medicolegal Death Investigation System: Medicolegal death investigation office (usually medical examiner or coroner office) within a state or district that is a jurisdictional unit and, which may have a single chief medicolegal officer.

Medicolegal Death Investigator: An individual who performs medicolegal death investigations.

National Association of Medical Examiners (NAME): International professional organization of physician medical examiners, medicolegal death investigators, and death investigation system administrators that promulgates education and professionalism in medicolegal death investigation and establishes national forensic autopsy practice standards. NAME offers a voluntary inspection and accreditation program for medicolegal death investigation offices. (see: [www.thename.org](http://www.thename.org) )

Organ Procurement Organization (OPO): Organization responsible for recovering organs from donors.

Pathologist-in-training (resident/fellow): A physician who has graduated from medical school and is either in a pathology residency or a forensic pathology fellowship program.

Tissue procurement organization (TPO): Organization responsible for recovering tissues from tissue donors.

1. **Requirements**

High quality medicolegal death investigation depends on facilities, personnel (to include training and competencies), resources, and processes. Existing guidance, standards and requirements for each of the elements and their use are presented in this section.

**4.1 Infrastructure**

4.1.1 Any office conducting medicolegal death investigations shall have adequate facilities and equipment to fulfill the office’s statutory mandates and accomplish the office’s mission.

4.1.2 There shall be sufficient information technology infrastructure to support data collection, analysis, and sharing.

4.1.3 Professional organizations have published recommendations for what constitutes an adequate facility.  These include:

4.1.3.1  SWGMDI Regional Medicolegal Autopsy and Death Investigation Centers – Construction, Staffing and Costs4

4.1.3.2  NAME Inspection and Accreditation Checklist5

4.1.3.3  IAC&ME Accreditation Standards6

**4.2 Resourcing the broader medicolegal death investigation mandate**

4.2.1 Medical Examiner and Coroner offices have responsibilities that extend well beyond evaluation of cases from a legal perspective. Public health and policy tasks represent a large and demanding mandate for most modern offices in the United States, particularly in jurisdictions with large catchment areas. Offices shall be provided with the resources, including personnel, time, space, data infrastructure, and funding to meet these needs. Common responsibilities are:

4.2.1.1 Public health surveillance

4.2.1.2 Data sharing with local, state, and federal health agencies

4.2.1.3 Participation in child death reviews

4.2.1.4 Participation in specialty reviews such as elder care and institutional care

4.2.1.5 Participation in product safety reviews

4.2.1.6 Participation in quality improvement programs in local hospitals, such as trauma review boards

4.2.1.7 Participation in policy development, legislation, and process evaluation with local agencies

4.2.2 Medical practice remuneration policies in the United States have evolved in a way that has diminished the performance of autopsies in general medicine. However, the importance of autopsy pathology in general medical practice continues to be demonstrated in the medical literature, and education in autopsy pathology remains an integral part of pathology training. There should be funding that recognizes and supports this role.

4.2.3 Forensic pathology is a scientific discipline that involves aspects of both forensic science and traditional medicine. Many aspects of practice are unique to this specialty, and advancement of medical knowledge in forensic pathology and medicolegal death investigation requires research and scientific inquiry directed specifically to those needs. Moreover, because many Medical Examiner/Coroner offices are not part of academic institutions, they do not have access to traditional research funding mechanisms. Resources and opportunities should be provided for medical research and advancement in the discipline, and participation in this effort should be an integral part of the vision and process of offices that practice forensic medicine.

**4.3 Personnel Roles, Responsibilities, Training Requirements and Competencies.**

Any office conducting medicolegal death investigations shall have an adequate number of specialized, well-trained personnel to fulfill the office’s statutory mandates and accomplish the office’s mission.

4.3.1 Forensic Pathologist

4.3.1.1 A forensic pathologist shall be a physician who is certified in forensic

pathology by the American Board of Pathology (ABP, a member of the American

Board of Medical Specialties), or its international equivalent.

4.3.1.2 Forensic pathologists can hold different titles according to how they are defined by the legal framework mandated by a given jurisdiction. Titles commonly used include medical examiner and coroner, however, regardless of the job title, or method of appointment or employment, all the requirements shall apply.

4.3.1.3 Forensic pathology training and curricula must meet the requirements defined by the Accreditation Council for Graduate Medical Education (ACGME) and ABP for Board Certification.

4.3.1.4 The following are competencies that must be demonstrated by forensic pathologists to meet the requirements for a death investigation system:

4.3.1.4.1 Know of and adhere to professional autopsy standards, such

as NAME’s articulated competencies including those published in the *Forensic*

*Autopsy Performance Standards7*

4.3.1.4.2 Recognize the significance of autopsies to determine the cause and manner of death because they are performed for suspicious, violent, unexplained or unexpected deaths, and data and information gathered from autopsies serve not only the families of the deceased, but also the public, police, and the justice system.

4.3.2 Medical examiner

4.3.2.1 Medical examiners oversee medicolegal death investigations, perform postmortem examinations, and certify cause and manner of death.

4.3.2.2 They are forensic pathologists and are appointed to their position.

4.3.2.3 In some jurisdictions people with other qualifications hold the title “Medical Examiner.” These individuals do not satisfy this document’s definition of medical examiner and for purposes of this document those individuals are considered medicolegal death investigators.

4.3.3 Coroner

4.3.3.1 A coroner’s duty is to oversee medicolegal death investigations, usually for a single county, and ensure certification of the cause and manner of death.

4.3.3.2 They are elected or appointed.

4.3.3.3 Prerequisites and training requirements for coroners are defined by the jurisdiction. Some jurisdictions do not require that a coroner have a medical professional training background, but in other jurisdictions the coroner is required to be a physician, and in others the coroner is required to be a board certified forensic pathologist.

4.3.3.4 Unless they are a forensic pathologist, a coroner who performs the role of medicolegal death investigator shall be certified in medicolegal death investigation by a Forensic Science Accreditation Board (FSAB) accredited certifying board for medicolegal death investigators, such as the American Board of Medicolegal Death Investigators (ABMDI), or international equivalent. Coroners with purely administrative duties who do not perform any medicolegal death investigator role should be certified.

4.3.4 Medicolegal Death Investigator

4.3.4.1 Medicolegal death investigators act on behalf of the medical examiner or coroner to investigate deaths that may fall under the jurisdiction of the office. They determine jurisdiction and extent of initial investigation, and assist with determination of cause and manner of death.

4.3.4.2 They are professionals who shall be certified by a Forensic Science

Accreditation Board (FSAB) accredited certifying board for medicolegal death investigators, such as the American Board of Medicolegal Death Investigators (ABMDI), or an international equivalent. They investigate deaths in the jurisdiction of the medical examiner, coroner, or federal equivalent. A medicolegal death investigator in training for certification shall work under the supervision of a certified medicolegal death Investigator or forensic pathologist.

4.3.4.3 A medicolegal death investigator can have one of many different job titles, the most common being Coroner/Assistant Coroner, Coroner investigator, Deputy coroner, Medical examiner, Medical examiner investigator, Forensic Investigator, Death investigator, or Medicolegal death investigator depending on local convention, type of system and local statutes.

4.3.4.4 Official guidelines for conducting medicolegal death investigations were established with publication of the *National Guidelines for Death Investigation* and *Death Investigation: A Guide for the Scene Investigator8*.

**4.4 Required Practices**

Every office shall adhere to the following practices:

4.4.1 All reported deaths shall be assessed and investigated by a certified forensic pathologist and/or a certified medicolegal death investigator, to include evaluation of the circumstances of death and determination of jurisdiction.

4.4.2 The cause of death shall be determined by a forensic pathologist.

4.4.3 The manner of death shall be assigned by a forensic pathologist, or the chief medicolegal officer (or designee) in consultation with a forensic pathologist

4.4.4 All forensic autopsies shall be performed by a forensic pathologist, or by a pathologist in training (resident/fellow) who is directly supervised by a forensic pathologist

4.4.5 The chief medicolegal officer or designee(s) shall participate in multi-disciplinary death review teams (e.g., infant/child fatality review teams)

4.4.6 Medicolegal death investigators or appropriate personnel shall collect blood and/or appropriate samples, whenever possible, for potential genetic and toxicological testing in sudden, unexplained deaths that remain unexplained at the completion of the autopsy (see normative reference 2.6)

4.4.7 The office follows the practices and guidelines established by:

4.4.7.1 *Death Investigation: A Guide for the Scene Investigator8*

4.4.7.2 *Principles for Communicating with Next of Kin During Medicolegal Death Investigations9*

4.4.7.3 *Sudden, Unexplained Infant Death Investigation; Guidelines for the Scene Investigator*10

4.4.7.4 *SWGMDI’s Standards for Interactions Between Medical Examiner/Coroner Offices and Organ and Tissue Procurement Organizations and Eye Banks*11

4.4.8 Medicolegal death investigators and medicolegal death investigation offices shall be free from undue influence or coercion by other agencies, offices or any source. (see normative references 2.5 and 2.7).

4.4.9 Medicolegal death investigations shall be parallel to but distinct from investigations by other offices or agencies (e.g. law enforcement, child protective services, state and federal agencies, etc.).

**4.5 Certification**

4.5.1 Forensic Pathology Certifications. All forensic pathologists shall be certified in forensic pathology by a member board of the American Board of Medical Specialties, such as the American Board of Pathology (ABP) or an international equivalent.

4.5.2 Medicolegal Death Investigator Certifications. All persons performing medicolegal death investigations shall be certified in medicolegal death investigation by a Forensic Science Accrediting Board (FSAB) accredited certifying board, such as the American Board of Medicolegal Death Investigators (ABMDI) or an international equivalent.

**4.6 Accreditation**

4.6.1 All organizations conducting medicolegal death investigation shall be accredited by an inspection and accreditation program for medicolegal death investigative offices. Accreditation of medicolegal investigation offices can be performed by third party accreditation organizations (e.g. the National Association of Medical Examiners and the International Association of Coroners and Medical Examiners).

**Bibliography**

1 <https://www.ncjrs.gov/pdffiles1/nij/grants/228091.pdf>

2 <https://www.justice.gov/archives/ncfs/work-products-adopted-commission>

3 <https://obamawhitehouse.archives.gov/sites/default/files/microsites/ostp/NSTC/strengthening_the_medicolegal_death_investigation_system_final.pdf>

4 <https://www.nist.gov/sites/default/files/documents/2018/04/25/swgmdi_regional_medicolegal_autopsy_and_death_investigation_centers_-_construction_staffing_and_costs.pdf>

5 <https://www.thename.org/assets/docs/NAME%20Accreditation%20Checklist%202019%20-%202024.pdf>

6 <https://www.theiacme.com/images/standards.pdf>

7 <https://name.memberclicks.net/assets/docs/684b2442-ae68-4e64-9ecc-015f8d0f849e.pdf>

8 <https://www.nij.gov/pubs-sum/234457.htm>

9 <https://www.nist.gov/sites/default/files/documents/2018/04/25/swgmdi_principles_for_communicating_with_next_of_kin_during_medicolegal_death_investigations.pdf>

10 <https://www.cdc.gov/sids/pdf/curriculumguide_tag508.pdf>

11 <https://www.nist.gov/sites/default/files/documents/2018/04/25/swgmdi_standards_for_interactions_between_medical_examinercoroner_offices_and_organ_and_tissue_procurement_organizations_and_eye_banks.pdf>