SCIENTIFIC WORKING GROUP FOR MEDICOLEGAL DEATH INVESTIGATION

PRC#7. Status of and Perceived Need for Regional Medicolegal Death Investigation Centers

Public Comment Report

Created by SWGMDI's Systems Infrastructure Committee
Open for Public Review and Comment January 2, 2013 to March 3, 2013
Total responses received= 11 (Counting National Association of Medical Examiners' response as 1 response)
60% endorsed the draft as is.

Comments Received from 10 individuals and the National Association of Medical Examiners (NAME)

Commenter #1
The regional center concept was ill defined in this document making the concept difficult to evaluate. The basic parameters of regional centers were not delineated such as the functions to be performed (autopsies, externals, investigations, toxicology, radiology, histology, neuropathology, anthropology, etc.), organizational structure of the facility, funding, etc.
Response: The ill-defined nature of the regional center concept in this document was intentional. We did ask what responders did perceive (perceive being the operative word) as necessary components in their vision of a regional center. We did not want to put preconceived notions in the heads of responders. Rather, we took an open approach to determine what responders viewed as being needed in their areas. Note that we specifically cited the need for further study. *We will make it clearer in the document that this is a study of perceived need, not necessarily real need, and that follow up studies will be needed.*
It would be useful if the SWG could give a more robust discussion of the ideal minimum size of a jurisdiction based on jurisdictional cases & autopsies per population, NAME accreditation standards. Such a discussion should also include the benefits of an economy of scale including access to expensive technology (CT and other imaging modalities, digitization and completely electronic databases), personnel (critical mass for coverage without overwhelming on-call responsibilities, peer review), administration (uniform procedures and lines of authority), service to public health and public safety communities (population-based surveillance).
Response: These issues are topics of ongoing SWGMDI projects and the current PRC7 document was not meant to address them. The relevant issues mentioned will be thoroughly addressed in subsequent SWGMDI documents. No changes are needed in the current document.
Organization of autopsy and investigations systems into regional, comprehensive centers is a good idea. Though the value of regional autopsy centers is understood, if one goes to all the work of regionalization, it would be best to be inclusive of all aspects of death investigation, not

just autopsies. It seems as though states that indicated a need for autopsy centers are states where the respondents would be opposed to loss of or consolidation of county level investigative operations.
Response: Again, these concerns are relevant but need to be studied further as we cite in the report. Specifically at the state and even inter-state level. The SWGMDI understands that one size will probably not fit all, which is why a more detailed study will be conducted. No changes are needed in the current document.
The term Medical Examiner (ME) was not adequately defined given the myriad combinations of death investigative systems found in the U.S. with a mix of MEs, Coroners, and Forensic Pathologists present within city, county, regional, and state systems.
Response: We will more specifically define "medical examiner" in the context of this document.
There is a typo on page 2; line 82 – report was review***ed***
Response: This correction will be made.
The legend for figure 1 should clearly define what each color dot indicates. It would be valuable if the report focused on regionalization from the standpoint of both consolidation and decentralization of jurisdictions.
Response: We will modify the legend to make the Figure more meaningful. We will edit the document to include the concepts of consolidation and decentralization.
Line 23-24- **The Coroner Summit proposed for 2013 should include agenda time and further information collection to better identify the need for regional centers in states with coroners.** Consider deleting or rephrasing this bullet item because for coroners, a regional medicolegal death investigation center would really be a regional autopsy center, while the investigative component would remain in the hands of non-pathologist county coroners. It would be better to stand up centers that offer comprehensive investigative services, not just autopsies.
Response: This is a valid suggestion. We will modify the recommendation to include consideration of the scope of services that may be needed. This will vary among states, undoubtedly.
Lines 188 & 189- **1) Consider regional centers that may serve jurisdictions in adjacent states, especially in areas near state lines.** The laws and regulations governing death investigation differ greatly between states, even those adjacent to one another. It will be problematic for a regional center offering full death investigation services to operate properly across state lines given the differences in state laws and regulations. Regional centers may be a more feasible concept in coroner states if "autopsy only" services are offered that follow NAME autopsy guidelines as a national standard. This too may be problematic as most states also have laws and regulations governing the performance of autopsies and they differ between states. The differing laws concerning autopsies that may be particularly challenging include those that address religious objection to autopsy, organ/tissue retention by a pathologist, organ/tissue donation, next of kin rights, etc. Those of us working in well run and well-funded statewide systems with regional offices have a difficult enough time managing remote district offices when the laws, regulations and expectations are uniform statewide.
Response: The SWGMDI fully recognizes these issues. They are topics that need further study as the concept of regional centers evolves, as we state in the document. For the purpose of PRC7,

we only intended to mention interstate cooperation as something that needs to be considered. No changes needed in regard to this comment.
Line 202- **Under 2) The vast majority of states for which a perceived need for regional centers was expressed are coroner states.** For the most part, it seems the coroner states do not have much experience with the regional office concept that those working in statewide medical examiner systems have. Coroners may not have an appreciation for the challenges of running regional offices, particularly those that cross state lines.
Response: This problem is understood. It is the reason that a Coroner Summit and other further study are needed. PRC7 only lays the groundwork to describe perceived need and to point to the need for further study. No changes needed at this time.
Line 207- **3) Accredited forensic pathology training positions that are not currently funded should be funded with a combination of state and federal funds, and efforts are needed to fill those positions** Agree wholeheartedly with this concept as most offices have current challenges funding fellowship positions. In Virginia, though we have slots for 4 FP fellows we will only be able to fund 2 of the 4 slots for 2013-2014. There should be a very strong connection between this document and the FP training document when both are finalized.
Response: This comment is supportive. No changes needed.
Lines 218-224- **4) Consideration should be given to establishing a federally funded armamentarium of forensic pathologists. Federal funds could be used to fund forensic pathology training positions and to provide incentives to trainees such as low cost loans or loan forgiveness. Perhaps a corps of forensic pathologists could be established, analogous to the Armed Forces Medical Examiner (but non-military), that could be deployed to regional centers in states but be federal employees or state employees funded, at least in part, with federal dollars. Such persons would live and work in the area to which they are assigned.** This suggestion of a federally funded armamentarium of forensic pathologists is intriguing. There are many details to be considered, such as licensure, oversight, quality assurance, and type of regional center in which these FPs practice. SWG might want to discuss how a potential federal forensic pathology workforce could be tied to existing federal programs (e.g., CDC- Infectious Disease Pathology Branch and the former CDC Medical Examiner/Coroner Information Sharing System, DMORT, the National Violent Death Reporting System and the Armed Forces Medical Examiner system.)
Response: Yes, these thoughts need to be considered in conjunction with increasing forensic pathologist manpower as discussed in the SWGMDI report on increasing the supply of forensic pathologists in the United States. Future studies and reports will address these issues, which go beyond the current PRC7 document's scope. No change needed.
Though this idea does sound feasible on the surface, if implemented, these federally funded forensic pathologists should all be trained in medical examiner systems and not trained in coroner systems. Over the years when hiring forensic pathologists into a statewide medical examiner's system I have found that forensic pathologists trained in coroner systems can have difficulty transitioning to work in a medical examiner's system. In coroner systems, the coroner usually determines which cases to accept, which cases to autopsy, what to put on the death certificate, etc. while the forensic pathologist is expected to only provide autopsy services with

evidence recovery and toxicology. When faced with working in a medical examiner system, some coroner office trained forensic pathologists have difficulty performing the case triage and death certification duties expected of medical examiners as these duties were typically performed by coroners where they trained. These pathologists also tend to be unaccustomed to withstanding the pressure that an unpopular determination can cause, because in a coroner system the coroner ultimately makes the determination of manner of death, generally the determination most likely to raise the ire of the decedent's family. On the other hand, FP fellows trained in medical examiner systems do not seem to have any trouble transitioning to work in a coroner system except that they may feel they are not working up to their potential, if they are not allowed to triage cases and sign death certificates.

Response: Again, these are good thoughts, but they go beyond the purpose of PRC7 and need to be considered in future SWGMDI studies and reports. No change needed.

Lines 230-231- **5) Generic plans should be developed for regional centers that could be the model for all newly constructed regional centers.**
Agree with the model plans for regional centers. These model plans should all be required to meet the NAME facilities standards for accreditation, particularly if any federal funding is planned.

Response: Supportive comment. No change needed.

Line 243- **6) Further study of state-specific needs should be conducted.**
Agree with this proposal. Regional centers within each state seem to be far better than regional centers extending across state lines. The Virginia model of a statewide death investigation system with four regional population-based centers serving about 2 million people each works exceedingly well and is very cost efficient. The Virginia Office of the Chief Medical Examiner with four equal district offices costs each state citizen only $1.25/citizen/year. The report should also discuss the ultimate in regionalization, which is the statewide centralized medical examiner office (e.g., MD, NM, VT, UT, NH, CT) and the variables that favor a centralized office.

Response: Good thoughts that are more important to consider as state-specific study gets further along. No changes needed in this document.

Line 255- **7) Federal support should be provided.**
Agree with this proposal. Federal funding should be restricted to accredited systems or should be tied with future accreditation so that federal funding will be used to only stand up accredited offices. The feds should consider providing funding only for accredited ME systems in an effort to force the demise of coroner systems.

Response: Supportive comment. No changes needed in this document. This idea should be considered as further study of regional systems is conducted.

Line 265- **8) Criteria for regional centers need to be developed.**
Agree there should be criteria. Not sure if the numbers stand up (250 mile catchment area, population of at least 500,000), but criteria do need to be established (Wyoming is a good example of why). It is also important to look at what is currently in place re: transportation costs and who is paying. In some states/systems, this is picked up by the state, and in others, it may be the county or other local jurisdiction. This may also change, as it did in New Mexico.

Response: Supportive comment. No change needed in this document. These are concepts that will be further studied and reported in ongoing SWGMDI projects related to workforce locations and regional needs.

Commenter #2

A consideration for regionalized interstate forensic pathology service needs to include a needs assessment of criminal court trial management among the various states. Forensic pathology staffing, and skill sets for expert testimony in criminal cases, are vastly different among the states. My own limited experience working criminal trials in various states is that an autopsy resulting in a murder trial in California is automatically going to require me to budget 5 to 10 times more hours just for the increased load of proceedings and phone calls, over what I would need to budget for the same trial in Indiana. This certainly means that an autopsy for one state should cost a lot more than that same autopsy done for a different state jurisdiction, and it requires a different staffing level for the regional morgue facility when the pathologist sits with a subpoena, unable to be fully responsible for the autopsy service load. Lacking the authority to standardize criminal procedure among the states, this project should seek to minimize impact on the current procedural idiosyncrasies that are so vastly divergent across state boundaries, and cause tremendous variation in pathologist work load for court cases. Working with criminal law procedure experts in each state, to get information on their state court needs for pathologist time as required by their local procedures, is the only way to produce a map that locates viable places to provide interstate services. Holding the prosecutors, defense bar, and courts responsible for the down time may not ever be practical, but budgeting those costs allows us to begin to understand how much it really costs when cases are continued at the last minute, or when the court allows a motion for depositions or discovery even though written reports are available. That information needs to be superimposed on the map of jurisdiction over criminal cases, so that the locations for interstate facilities could be based not only on where the bodies end up, but on how much time the morgue staff has to spend traveling and sitting for criminal court cases. It is entirely possible that an interstate facility would best end up quite remote from a dense population area, just because it becomes cost-effective for reducing travel time and down time for morgue staff when they also provide service for a less dense but procedurally-complex court area. These variations could be tempered by locating interstate services in areas where the criminal court procedure is similar among the effected states, and may need to avoid boundaries where the procedures are vastly different. Also, some consideration should be made for federal service for Indian Country and for states which overlap districts with significant exclusive federal jurisdiction, as in DC, PG County, and Fairfax. There is enormous savings potential, and enormous opportunity for overall system improvement by federal oversight of regionalized facilities, but the available plan has relied too much on input from local elected public officials who too often have a conflict of interest in interstate regionalization.

Response: These are concepts that need to be considered in further study of regionalization. They go beyond the intended scope of PRC7. No changes needed in document.

Commenter #3

1. The future need for FPs far outstrips the perceived need for regional centers. Focus on training programs. 2. Each state should devise a plan for adequate FP coverage (# and locations) of its population. 3. For interstate programs (e.g., Rapid City) find out what it will take for the involved states to legitimize the concept.

Response: These are concepts that need to be considered in further study of regionalization. They go beyond the intended scope of PRC7. No changes needed in document.

Commenter #4

Appendix II, in reference to that State of Iowa, says, "Iowa City has only autopsy services. IOSME has MDIs but they are usually not used by the 99 ME counties. Polk is the only county to use both BC-FP and ABMDI certified MDIs. Current system does not control the local county MEs on how they do investigations, what cases are autopsied or where the autopsies are done."

This is inaccurate. Iowa City, which is under the jurisdiction of the Johnson County Medical Examiner Department, has 2 board certified forensic pathologists who are also deputy medical examiners and provide autopsy service, 5 D-ABMDI investigators, and 1F-ABMDI investigator/administrator. No one in our office has received any surveys regarding the SWGMDI, and we would appreciate the opportunity to participate.

Response: Appendix II will be modified to include this information. Although SWGMDI has announced its surveys through virtually all national organizations with death investigation interest, we will try to get announcements also directed to the state and local level, such as state medical examiner/coroner associations.

Commenter #5

I do not support Regional Medical Examiner doc. based only on the data about Idaho. Over 60% of the population of the state lives within 150 miles of Boise. Almost 800,000 population. (Total pop. of state 1.3 million) Due to geographical issues it would be very hard to justify six areas in Idaho. We have two FTE FP within the state now and another 6 as the report states. I do not see the numbers being financially justifiable for the case load that would come out of that projection.

Response: This gets to the issue of perceived need versus real need. PRC7 documents perceived need, whether or not it is realistic. Such concerns are exactly what need to be evaluated when further state-specific studies are undertaken. No changes needed in this document.

Commenter #6

Looks good.

Response: Supportive Comment. No change needed.

Commenter #7

One general comment for PRC-7: One of the needs expressed by the National Academy was the need for more formalized training in the Death Scene Investigation process. While the forensic pathologist was by in large the target for this commentary, the entire death scene investigation team (police, investigators, family counselors, etc.) would benefit from the availability of curriculum in the death scene area. The School of Forensic Sciences at OSU, in response to that need, launched a Death Scene Investigator track in our Master's program. Basic forensic curriculum including specialized coursework in Osteology/Archeology and Victimology make up the track. Training culminates with an internship with the State Medical Examiner's Office of Oklahoma (Eastern region) which happens to be located on the CHS campus. We believe this program to be somewhat unique among forensic graduate programs presently available, and the training will enhance death scene investigation for non-pathologist professionals.

Response: This suggestion is appropriate to consider in further studies but goes beyond the scope of the PRC7 document. No change needed.

Commenter #8

My only comment - I completely agree with the need for a single standard in forensic science for death investigation, including autopsy process and procedures. We in the US have to and can do better. I add caution that while standards should be the same, death investigation is and should remain the remit of the State Government, not the Federal Government.

Response: This thought goes beyond the scope of PRC7. No change needed.

Commenter #9

I live and practice pathology in the Peoria/Central Illinois area. There is a definite need for a regional center for addressing forensic issues. The situation in our area is deplorable. My practice covers nine different hospitals in this region and when there is a death in a hospital that meets criteria for which the coroner should take jurisdiction they often decline citing they haven't the staff and facilities to perform these autopsies. This creates a serious medicolegal conflict. The public safety is at risk as our community is not being adequately served. We are in dire need of a proposal such as this!

Response: Supportive comment. No changes needed.

Commenter #10

There is a need for more specific guidelines to help plan for the needs jurisdiction(s) regarding staffing info (How many FP's, Investigators, Admin, Techs, etc.). How much should a full-service center (autopsy plus investigation) cost per capita? What is considered a reasonable price per capita for a system? What is considered a safe autopsy rate? Although the need may be recognized by public officials, we need to be able to answer their questions of "How much will that cost?" to move anything forward past the philosophical stage.

Response: These parameters will be considered in other SWGMDI projects that are underway, such as regional center constructions cost and workforce issues. No changes needed in this document.

Commenter #11

I don't have problems with what is covered, proximity/availability is important. However, one of the key aspects of regional or state MEs is consistency in protocols applied to autopsy/examination. Many states have a patchwork of providers that range from medical examiner's offices with certified forensic pathologists to county coroners that are not medical doctors. I think having standard protocols that are generally accepted in the community is one of the major plusses to having regional/state MEs.

Response: This issue is one that needs to be considered when further study of regional centers is conducted. No change needed in this document.

General Comment: Many of the comments offered are more applicable to projects being undertaken by SWGMDI, but that are not yet completed. The comments will be reviewed in conjunction with ongoing projects to guide the content of further SWGMDI documents.