SCIENTIFIC WORKING GROUP FOR
MEDICOLEGAL DEATH INVESTIGATION

Status of and *Perceived* Need for Regional Medicolegal Death Investigation Centers

A Report and Recommendations Prepared by the System Infrastructure Committee of the Scientific Working Group on Medicolegal Death Investigation (SWGMDI)

Executive Summary

Recommendation 11a of the National Research Council (NRC) report, *"Strengthening Forensic Science in the United States: A Path Forward,"* is that funds be provided to build regional medical examiner offices (1). As a follow up to that recommendation, the SWGMDI embarked on a process to establish the *perceived* need for regional centers in the United States. Following analysis of survey results, the following recommendations are made:

- **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, as well as the types of services that may be needed to serve the region.**
- **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.**
- **Consideration should be given to establishing a federally funded armamentarium of forensic pathologists.**
- **Generic plans should be developed for regional centers that could be the model for all newly constructed regional centers.**
- **Further study of state-specific needs should be conducted.**
- **Consider regional centers that may serve jurisdictions in adjacent states, especially in areas near state lines.**
- **Federal support should be provided.**
- **Criteria for regional centers need to be developed.**

This report contains the methodology, background methodology, and survey results that were used in developing the above recommendations. It is important to realize that this report describes perceived need, which may not correspond to real need or be justifiable. The SWGMDI is undertaking other projects related to regional center construction and staffing and forensic pathologist workforce locations. It is critical for more study to be conducted within states and among states before the idea of regional centers is seriously planned or implemented.

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Regional Medicolegal Death Investigation Centers

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INTRODUCTION

Recommendation 11a of the NRC Report, *"Strengthening Forensic Science in the United States: A Path Forward,"* is that funds be provided to build regional medical examiner offices (1). As a follow up to that recommendation, the Scientific Working Group on Medicolegal Death Investigation (SWGMDI) embarked on a process to document the perceived need for regional centers in the United States.

METHODS

On April 17, 2012, email notification of the National Association of Medical Examiners (NAME), American Board of Medicolegal Investigators (ABMDI), and International Association of Coroners and Medical Examiners (IAC&ME) members was made regarding an on-line survey to collect information about the status and perceived need for regional medicolegal death investigation centers in each state.

The number of email notifications to each organization numbered 1103, 1295, and 600, respectively. There is a small overlap in membership among those organizations, so the number of people receiving notification probably numbered less than 2998. Information requested included:

- Name of the responder's state
- Whether or not regional centers currently exist in the state
- Whether there is a perceived need for additional regional centers
- The suggested locations for future regional centers
- The approximate number of counties that would be served by each center
- The approximate number of additional forensic pathologist FTEs that would be needed to staff the regional centers
- Whether these centers would need autopsy services, on-site investigators, toxicology services, and/ or a more extensive crime lab
- Open ended comments/clarifications

The on-line survey was closed on May 13, 2012. The Presiding Officer of the SWGMDI System Infrastructure Committee tabulated the survey results and prepared an initial draft report. The draft report was reviewed by members of the Committee and appropriate edits were made to the draft. The entire SWGMDI Board of Directors then reviewed the draft and approved it for public review and comment.

Assuming that "medical examiners" will eventually work in any regional centers that are established, and that the term "medical examiner" is variably used among states, the SWGMDI defines a medical examiner as a physician certified in forensic pathology by the American Board of Pathology or its international equivalent, and who performs or oversees official medicolegal autopsies for a coroner or medical examiner death investigation system.

RESULTS AND COMMENTS

There were 110 responses. At least one response was obtained from each state except Hawaii. The number of responses per state ranged from 1 to 8 (see Table 1). Sixty-eight (62%) of responders were forensic pathologists; the remaining responders included coroners (n=22), administrators (n=9), and death investigators (n=6). (See Table 2)

Although the response rate of 4% may seem very low, it is quite possible that a single responder could fully understand the need or lack of need for regional centers in a given state. For example, for the 26 states with a state medical examiner, it could be assumed that the state medical examiner would have a good perception of need. In fact, the SWGMDI conducted a separate survey of the 26 State Medical Examiners to determine their perceptions about need for additional facilities, and the results were concordant with those presented in this report (2). In other states, a single coroner, death investigator, or forensic pathologist might be quite familiar with needs in the state. Thus, the low response rate does not necessarily undermine the validity of the results.

Although in some states there was disagreement about whether additional regional centers were needed, in 30 states at least one respondent perceived a need for at least one regional center (see Figure 1 and Appendix 1). In 16 states, multiple respondents agreed that one or more regional centers were needed.

It must be remembered, however, that the survey reflects the perceived need by responders of various types and with various perspectives, without regard to the logistics of implementation. In some cases, it is possible that a responder had a desire for a regional center near his/her area, but for one or more reasons, actually having a regional center in that area may not be practical or feasible. For example, seven different locations in Wyoming were suggested as needing a regional center, yet the population is sparse and funding and caseload may not support such a large number of regional centers.

In some states, the need for regional centers indicated that new facilities would need to be built in selected cities/towns. Others indicated that existing county or regional centers needed to be more formally organized within a state to serve specific groups of counties. Further, at least two states reported regional centers that exist but are not open because of budget and staffing problems (GA, MS) (See Figure 1 and Appendix 1).

Overall, approximately 46 locations were suggested to host regional centers in the various states (See Figure 1 and Appendix 1), while renovation, restructuring, or re-opening of existing centers was mentioned for approximately 20 additional areas.

Results indicate that up to 160 forensic pathologists would be needed to staff the new regional centers. The actual number may be somewhat less because some responders appear to have reported the total number of FPs that would be needed in the state, including some who are already working in the state. At a minimum, it appears that at least 125 FP FTE's would be needed (see Table 2).

For the 30 states whose responders perceived a need for regional centers, responders in 10 states expressed need for centers that had autopsy services and on-site investigators, responders in 7 states expressed need for autopsy services only, responders in 9 states indicated that need varies by location, responders in 3 states expressed need for autopsy services, toxicology, and/or crime lab services, and responders in 2 states said the state could benefit from reopening existing centers (See Appendix 1).

Some relevant generalizations from data in Appendix 1 include:

- In some states, there are discrepant opinions about whether additional regional centers are needed. (CA, KY, MI, MO, NV, OH, TN, TX, WA)
- In some states, there are existing facilities that serve multiple counties, but they do not formally function as regional centers via a state-level organization. (CA, IL, MN, MO, NE, NY, SC, TX, WA)
- In some states, there is a recognized need for regional centers, but their possible locations have not been identified. (CA, LA, MN, NE, PA)
- Small states with State ME offices, in general, do not see a need for regional centers. (VT, NH, CT, DE etc.)
- Even some large states with State MEs see no need for regional centers. (NM, UT)
- In some states, regional centers exist, but they are not open because of budget issues. (GA (2), MS (1))
- In some states, regional centers exist, but they need renovation/expansion, or reorganization of the counties served. (ND, NV, NY)

A variety of comments were received. (See Appendix 2.)

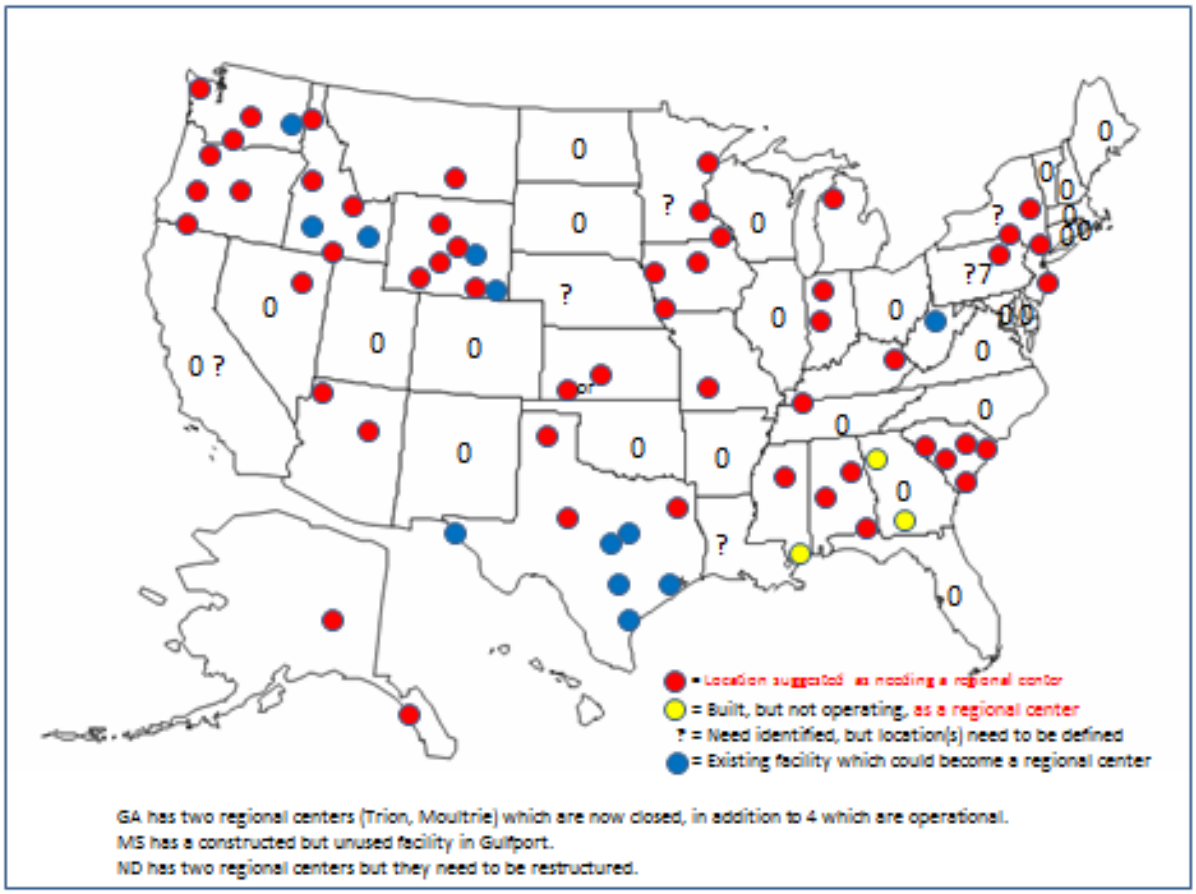
From these data, it may be possible to produce estimates for facility costs and forensic pathologist and other salaries.

Table 1. Number of responders by job title and state, SWGMDI survey on the need for regional forensic autopsy centers, July 2012.

State	Administrator	Death Investigator	Forensic pathologist	Law enforcement	Non-physician Coroner	Toxicologist	Other
AL					2		
AR					1		
AZ			4				
CA	2	1	6		1		
CO			2				
CT			1				
DE	1						
FL			3				
GA			2				
IA			2				
ID		1			3		
IL			1				
IN			1				
KS			1				
KY			2				
LA			2				
MA	1						
MD			1				
ME			1				
MI		1	1				
MN			3 (1 also serves ND)				
MO			3		1		
MS		1	1		1		
NC			1			1	
NE							1
NH			1				
NJ			1				
NM	1		1				
NV			1	1	2		1
NY			2				
OH	1		3				
OK			1				
OR			1				
PA			1		3 (+1 MD coroner)		

State	Administrator	Death Investigator	Forensic pathologist	Law enforcement	Non-physician Coroner	Toxicologist	Other
RI			2				
SC		1	1				
SDX			1				
TN		1	2				
TX			4				
UT			1				
VA	1						
VT			1				
WA			3		2		
WI	1		1		2		
WV			1				
WY	1				4		
TOTAL	9	6	67	1	23	1	2

Figure 1. Locations Suggested by Responders as Places Needing Regional Centers



For most of the suggested regional center locations indicated in Figure 1, the locations correspond to more densely populated areas within the relevant state when compared with U.S. population density maps (3). Idaho is a good example because the dots shown in Figure 1 correspond exactly with the more densely populated areas of the state. For some states in which there was no perceived need for regional centers, already existing district centers (such as FL) or county-based coroner offices (such as CA) may be the explanation. Perceived need for only one regional center in Montana, for example, may reflect sparse population and small numbers of deaths in many areas of the state. A seemingly excessive number of suggested locations in Wyoming, for example, may reflect a responder's desire to have a regional center nearby when, in fact, having so many regional centers in close proximity may not be practical, feasible, affordable, or needed. Finally, some responders perceived a need for regional centers with forensic pathologists but did not perceive a need for additional investigators. This most likely reflects a plan to use the coroners or similar personnel as the investigators. States shown with "0" had at least one responder who indicated that new regional centers were not needed, and states shown with "?" had uncertainty about specific locations for regional centers.

Table 2. Perceived Needs for Forensic Pathologist and Service Types

State	Additional FPs for Regional Centers	Services Needed	Comments
Alabama	4	Autopsy only	
Alaska	2*	Autopsy only	
Arizona	4	Autopsy + Investigators	
California	10	Varies by locale	
Georgia	5	Reopen 2	
Idaho	6	Autopsy+Inv+Tox	
Illinois	8	Autopsy only	One reviewer suggested that at least 10 additional FPs are needed in IL.
Indiana	3	Varies by locale	
Iowa	4	Autopsy + Investigators	
Kansas	10	Autopsy + Investigators	This number may include some FP positions that already exist
Kentucky	4	Autopsy + Investigators	
Louisiana	10	Autopsy + Investigators	This number may include some FP positions that already exist
Michigan	2	Autopsy only	
Minnesota	2	Autopsy+Inv+Tox	
Mississippi	3	Autopsy+Inv+CrimeLab Reopen	
Missouri	2	Autopsy + Investigators	
Montana	2*	Autopsy only	
Nebraska	3	Autopsy only	
Nevada	4	Autopsy + Investigators	
New Jersey	12	Autopsy + Investigators	This number may include some FP positions that already exist
New York	10	Varies by locale	
North Dakota	2	Varies by locale	
Ohio	10	Varies by locale	
Oregon	3*	Autopsy + Investigators	

Pennsylvania	8	Varies by locale	
South Carolina	10	Autopsy + Investigators	This number may include some FP positions that already exist
Texas	5	Varies by locale	
Washington	3	Varies by locale	
Wisconsin	4	Autopsy only	
Wyoming	4	Varies by locale	
TOTAL	160		

*Based on the bare minimum of 1 FP per location.

RECOMMENDATIONS

Based on data derived from the survey and on other existing data, the following recommendations are offered:

1) **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, as well as the types of services that may be needed to serve the region.**

The vast majority of states for which a perceived need for regional centers was expressed are coroner states. The Coroner Summit would be an appropriate venue to more fully discuss status and needs in those states. The Coroner Summit must also include other participants such as, but not limited to, State Medical Examiners from states that also have coroners.

2) **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.**

Recent studies show that the number of forensic pathologists being produced per year is not sufficient to meet projected need and that 25 of 79 approved positions were not funded (4, 5). Funding and filling the positions that are not currently funded could theoretically nearly double the production of forensic pathologists per year. Another SWGMDI report that deals with increasing the supply of forensic pathologists in the United States is available (under review). Although this recommendation may seem unrelated to the topic of regional centers, it is relevant because the establishment of new regional centers would require forensic pathologists to staff them.

3) **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.

Such a program could be initiated with the idea of providing a minimum of 125 forensic pathologists to staff the scores of regional centers for which there is real need.

4) Generic plans should be developed for regional centers that could be the model for all newly constructed regional centers.

Developing generic and universally applicable regional autopsy center design and construction plans could reduce architectural and construction costs. Each regional center could have the same layout and vary only in size based on projected case load and needed support staff size. It is conceivable that such centers might even be of the "pre-fab" type in which the building components could be made at a common site, shipped to the location, and assembled. Allowance would be given for exterior treatments so building appearance would conform to local building codes and community design requirements. Sharing of non-generic architectural plans might be an option. Regardless, allowances would have to be made for unique or specific building requirements in the area being served, such as being flood proof, earthquake resistant, etc.

5) Further study of state-specific needs should be conducted.

Data collected in this study suggest locations for regional centers that, as expected, tend to be located near higher populated counties and regions within a given state. However, the number of responses to the survey is small, especially for some states, and further documentation needs to be collected. Also, there are states in which suggestions for regional centers obviously omitted logical places in the state where such a center could be of value (IN, for example), and other states in which perceived need for, and location of regional centers is controversial or complicated (CA , PA, and NY, for example). Much more state-based study is needed to verify data in this report and to collect additional information. Such studies should also include the need for and feasibility of regional centers that serve more than one state.

6) Consider regional centers that may serve jurisdictions in adjacent states, especially in areas near state lines.

It may be advantageous to establish regional centers that can serve areas of two or more states. In some states, referral medical centers may exist in one state very close to the state line, serving areas of an adjacent state. The same model may apply to death investigation. Such arrangements already exist to some extent in western Nebraska, which provides medical examiner services for eastern counties in Wyoming, and in eastern North Dakota, which provides medical examiner services for some western counties in Minnesota. Similar and even more formal regional centers could be appropriate elsewhere.

7) Federal support should be provided.

Although deficiencies within a given state's death investigation system may be state-specific, the collective deficiencies among the states collectively result in a national problem. The current national picture is one of a hodge-podge of death investigation systems of varying quality and inconsistency in practice. The effort of federally directed Scientific Working Groups to establish standards of practice will be fruitless if the substrate on which those standards are imposed is not capable of complying with the standards. Federal support to states and/or regionalized systems serving needs from several states could help rectify such problems.

8) Criteria for regional centers need to be developed.

In addition to identifying perceived need for regional centers, specific criteria should be developed to guide the location of proposed regional centers. For example, the following criteria might be considered as a reasonable starting point for further discussion:

- In those states without a state-wide ME system, no county should be more than 250 miles from a fully staffed, accredited regional medicolegal center.
- Counties within one state should have access to a regional medicolegal center located in an adjacent state, if no intrastate center is located within 250 miles of the county.
- Every regional medicolegal center should serve a geographic "catchment" area with a population of at least 500,000 people. The catchment area, if appropriate, could extend across state boundaries. For example, a center in Rapid City, South Dakota, might serve Western South Dakota, Southeastern Montana, Northeastern Wyoming, and Northwestern Nebraska.
- Concepts of consolidation of multiple small offices and decentralization of single offices need to be explored

FINAL COMMENT

SWGMDI reiterates that this document describes perceived need, which may or may not correspond to real or justifiable need. The potential location of regional centers is a complex issue that needs to consider population, death rates, travel distances, travel times (not all roads allow the same speed limit), availability of forensic pathologists in the area, the nature and location of already existing services, the places where court testimony may be needed, and many other factors. Ongoing SWGMDI projects and related reports will study and make recommendations about estimating generic facility construction, staffing, and ongoing operating costs as well as areas that may need to be identified and addressed as underserved by quality medicolegal death investigation.

Because medicolegal death investigation is typically state-based and performed in conjunction with state laws, policies, funding, and other factors, the SWGMDI cannot make recommendations for specific states without state input. It is imperative that states take it upon themselves to study the issue of regionalization and how that may involve better use of existing facilities, construction of new facilities, decentralization where appropriate, and consolidation of small jurisdictions with inadequate resources.

At the time of this final report, it appeared that the proposed Coroner Summit may not occur in 2013. The SWGMDI still considers such a summit to be potentially useful and will further pursue its organization

SUMMARY

The SWGMDI conducted a survey to establish perceived need for regional medicolegal death investigation centers in the United States. There was a perceived need for approximately 46 regional centers among 30 different states that would require up to 160 forensic pathologists to staff. In some states, the perceived need for regional centers may exceed real need, and in other states, some currently existing medicolegal autopsy centers could be transformed to regional centers but are not currently and formally operating in such a manner. The SWGMDI has offered 10 recommendations for further action.

References

1. National Research Council. Strengthening Forensic Science in the United States: A Path Forward. Committee on Identifying the Needs of the Forensic Sciences Community, National Research Council. National Academies Press. Washington, DC. 2009.

2. State Medical Examiner Survey. SWGMDI. Available at: http://www.swgmdi.org/images/iscommrpt4smeneedsjan2012.pdf Accessed July 25, 2012

3. United States Population Density- Britannica Online Encyclopedia. Available at: http://www.bing.com/images/search?q=us+population+density&view=detail&id=BA4C3423C9250AD1C3BE09D804AC87CC1A75A928&first=1 Accessed July 26, 2012.

4. Scientific Working Group on Medicolegal Death Investigation. Increasing the Supply of Forensic Pathologists in the United States. 2012. Available at: http://www.swgmdi.org Accessed August 1, 2012

5. Hanzlick R. Work Location and Effort of Forensic Pathology Fellows Who Completed Training in 2012. *Acad For Path*. 2012: 2(3);290-293.

The SWGMDI Infrastructure Committee members who participated in data collection, analysis, and report preparation include:

Barbara Butcher, MPH
John Fudenberg
Randy Hanzlick, MD (Presiding Officer)
R. Gibson Parrish, MD
Mary Ann Sens, MD PhD
Lindsey Thomas, MD
J Scott Denton, MD (Advisor)
Joe Prahlow, MD (Advisor)
Reade Quinton, MD (Advisor)

This document was approved for final publication by the SWGMDI Board on July 19, 2013. At that time, the SWGMDI Board Members were:

Barbara Butcher, MPH
Steve Clark, PhD
Laura Crandall, MA
Tim Davidson, MBA-HA
John Fudenberg
Roberta Geiselhart, BSN
Randy Hanzlick, MD
Marie Herrmann, MD
Julie Howe, MBA
Bruce Hyma, MD
Donald Jason, MD JD
David (Zeb) Johnson
Danielle McLeod-Henning, MFS
R. Gibson Parrish, MD
Keith Pinckard, MD PhD
Lakshmanan Sathyavagiswaran, MD
Mary Ann Sens, MD PhD
Lindsey Thomas, MD
Frederick Upchurch
Margaret Warner, PhD
Amy Wyman

Appendix 1. State, number of responses, and perceived need for regional autopsy centers, SWGMDI survey on the need for regional forensic autopsy centers, July 2012.

State	Responses	Need More	Need No More	Comments/Suggested Locations
Alabama	2	2		Houston County (Dothan) (10 counties) Tuscaloosa (5 counties) Jacksonville/Gadsden (8 counties)
Alaska	1	1		Fairbanks Juneau
Arizona	4	4		Flagstaff (4 or 5 counties)
Arkansas	1		1	
California	8	4	4	No specific recommendations. Further thought is needed.
Colorado	2		2	
Connecticut	1		1	
Delaware	2		2	
Florida	2		2	
Georgia	3	1	2	Regional Centers exist in Trion and Moultrie but are closed because of budget shortfalls. No newly constructed centers are needed.
Hawaii	0			
Idaho	4	2	2	Coeur d'Alene (4 counties) Boise (10 counties) Twin Falls (7 counties) Pocatello (5 counties) Idaho Falls (12 counties) Lewiston (10 counties)
Illinois	1		1	Existing places just need more formal organizations
Indiana	1	1		South Bend (about 5 counties) Lafayette (5-7 counties)
Iowa	2	2		Sioux City (10-15 counties) Council Bluffs (about 5 counties)
Kansas	1	1		Great Bend or Dodge City
Kentucky	2	1	1	East Kentucky Ashland/Pikeville/Hazard/London?) (20 counties) Far West Kentucky (Paducah?) (about 15 counties)
Louisiana	1	1		???
Maine	1		1	

Maryland	1		1	
Massachusetts	1		1	
Michigan	2	1	1	Traverse City (about 20 counties)
Minnesota	2	2		Duluth Minneapolis/St Paul Rochester
Mississippi	3	2	1	Gulfport (Harrison County) is constructed but not open due to budget shortfalls.
Missouri	4	2	2	Springfield
Montana	1	1		Billings. Hope to get a free-standing facility there.
Nebraska	1	1		????
Nevada	4	2	2	Reno needs a new facility. One needed in Elko?
New Hampshire	1		1	
New Jersey	1	1		
New Mexico	1		1	
New York	2	2		Albany (8 counties) Binghamton (8 counties) Valhalla (5 counties) *Existing centers need to expand to cover additional counties
North Carolina	2		2	
North Dakota	1	1		Bismarck* Grand Forks* *These exist but counties they serve need to be restructured
Ohio	4	1	3	Zanesville or Marion
Oklahoma	1		1	
Oregon	1	1		Clackamas (13 counties) Eugene (4 counties) Central Point (5 counties) Bend (13 counties)
Pennsylvania	5	3	2	???? (Need 4- 6) Bradford County
Rhode Island	1		1	
South Carolina	2	2		Greenville/Spartanburg (10 counties) Columbia/Richland (10 counties)

				Charleston (10 counties) Myrtle Beach (6 counties) Florence (10 counties)
South Dakota	1		1	
Tennessee	3	1	2	
Texas	4	3	1	Abilene or San Angelo Amarillo* Dallas/Ft Worth* San Antonio* Corpus Christie* El Paso* NE Texas *Centers exist in these cities but more formal regionalization is needed
Utah	1		1	
Vermont	1		1	
Virginia	1		1	
Washington	5	3	2	Costal/Olympic Peninsula Ellensberg (5 counties) (North central) Tri-Cities (about 6-8 counties) (South Central) Eastern Washington NOS
West Virginia	1		1	Current centers need renovation/replacement
Wisconsin	5	3	2	Current centers need more formal organization
Wyoming	4	3	1	Natrona (12 counties) Laramie (8 counties) Rock Spring (6 counties) Casper (8 counties) Cheyenne (5 counties) Lander /Riverton (5-12 counties) Cody (5 counties)
TOTAL	105	55	50	

Comments:

- In some states, there are discrepant opinions about whether additional regional centers are needed. (CA, KY, MI, MO, NV, OH, TN, TX, WA)

- In some states, there are existing facilities that serve multiple counties but they do not formally function as regional centers via a state-level organization. (CA, IL, MN, MO, NE, NY, SC, TX, WA)
- In some states, there is a recognized need for regional centers, but their possible locations have not been identified. (CA, LA, MN, NE, PA)
- Small states with State ME offices, in general, do not see a need for regional centers. (VT, NH, CT, DE etc.)
- Even some large states with State MEs see no need for regional centers. (NM, UT)
- In some states, regional centers exist but they are not open because of budget issues. (GA (2), MS (1))
- In some states, regional centers exist but they need renovation/expansion, or reorganization of the counties served. (ND, NV, NY)

Appendix 2. Comments from responders to SWGMDI survey on the need for regional forensic autopsy centers, July 2012.

State	Comments
AL	Huntsville, AL. Morgue desperately needs renovation! Present equipment is old, heavily worn and rusted.
AZ	NW Arizona or combination of NW AZ and Colorado River Border could utilize a new office and new doctors to cover that area of the state SE Arizona could support about 1.5 doctors Yavapai office could support 1.5 doctors
AZ	major hurdles in Arizona are extremely long travel times and large areas of rural/remote and difficult terrain and many overlapping jurisdictions (large areas of federal lands and very large sovereign Native American reservation lands, both in rural and urban areas). Lack of qualified board certified forensic pathologists.
CA	'different strokes for different folks'. There's no cookie cutter mechanism for stamping out a regional svc. Some counties might require or use more services if available than other counties who might spurn anyone else doing what they consider "their" death investigation. Turf issues not unlike city PD's vs county SO's.
CA	The regional centers in California that I know something about basically like the Sacramento County Coroner Facility that provides autopsy and some related services to near-by smaller population sheriff-coroner counties via individual county by county financial for services rendered contracts.
CA	I am not interested in regional center
CO	CO has a coroner system, and most rural coroners contract (formally or informally) with bigger coroner's offices that are staffed by FP's for autopsy services--not widely distributed data, but each FP would know which counties are covered by their office.
CO	Colorado is served by an archaic coroner system. 5 large autopsy facilities are clustered in adjacent Denver metro counties and most compete for forensic cases from other counties. Many of the pathologists have a financial incentive to do more cases than recommended by NAME guidelines. In my opinion some offices should be consolidated. Some offices should be expanded. The goal should be uniform application of death investigation standards with contemporaneous quality control and utilizing economy of scale where appropriate.
DE	We added a regional (southern) office in 2007. It has met our needs very well.

FL	I think there is a need for regional autopsy centers for non-forensic cases. I think this would improve the current patchwork system that is serviced by ex-ME's, 1-800-CRAPPYAUTOPSY, physician assistants, and other marginal "professionals." Pricing would be more consistent and service (turn-around times, etc) to the customer would improve.
GA	Offices in Trion and Moultrie formerly staffed, but now closed.
GA	Trion and Moultrie have facilities but they are currently closed due to budget problems. DeKalb county performs autopsies for the coroners in White, Hall, Henry, and Rockdale counties). Fulton, Cobb, and Gwinnet counties each have their own medical examiner facilities and do not have coroners.
IA	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 Added after Public Review and Comment: This above statement 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.
ID	Our state has one forensic pathology autopsy lab that we can use. That lab is in Boise and we have to travel anywhere from 30 minutes to 7 hours one way to have an autopsy done. I have to travel .5 hours one way to have an autopsy done. We need at least 3 regional centers to have autopsies done so the travel time is cut down as well as expenses for our counties.
IL	We have too many individual coroner's offices with their own small morgues, especially in Northern Central IL. For coroners, having their own morgue seems important. No coroner wants to take their cases "out of county". There is a state of the art regional facility in South Central IL in Marion, IL but no one will live there. We need more forensic pathologists, not regional autopsy facilities.

IN	This is a very complex issue in Indiana. There are several "regional centers," but for some, they do not necessarily fit the description that you provide. In other words, they serve several counties, but the autopsies are not necessarily performed by FPs. I'm not sure that any of the offices that I listed above have ONLY FPs doing the autopsies. For example, there is a group of 3 pathologists at one center, but only one of them is a FP. In addition to the 3 FPs listed above, I would suggest that Indiana needs another 4-6 FPs at least. There are many counties in Indiana where only some of the autopsies are sent to the FPs at regional centers. Other autopsies are done by local pathologists.
KS	We (Sedgwick County) probably would need additional office (administrative) and storage space. Some of this may be gained by renovation and reconfiguration of certain areas. There is a morgue in Wyandotte County (Kansas City, KS) but I do not think it has very good capacity. Shawnee County (Topeka, KS) has facilities that are adequate. If it became a regional office, it would need additional square footage or be replaced. As far as toxicology and crime labs, there are multiple satellite offices run by the KBI. But they are woefully understaffed (and underfunded) and TAT is very long in most cases.
KY	# of additions depends on how currently assigned FP's might be relocated
KY	Two regional offices (OCME & NKME) need new facilities. Small regional offices in rural areas, especially solo practices, are difficult to staff with competent Board certified forensic pathologists.
LA	Some parishes are using just board certified pathologists or not even pathologists to do minimal *autopsies* such as just looking at the heart in suspected cardiac deaths, just opening head to retrieve bullet, just opening chest if MVC, etc. There is no consistency in either performance of autopsies or death investigation. I trained in a ME system and prefer that but that will never happen in LA in my lifetime. But that's the way to ensure the basics across the state (in my opinion).
LA	The coroner system in LA is not funded at all by the state but by the 64 individual parishes with each parish having their own elected coroner. The state of LA needs to adopt a ME system but I don't see that happening anytime soon.
MA	The number of Forensic Pathologists is the number of additional FTEs that we need to operate based on caseload. The scope of service is not applicable.

ME	The current facility is adequate for the current number of autopsies and the current number of employees. However, the number of autopsies that are currently done is bare minimum and in order to really increase autopsy percentages additional staff, space and equipment would be needed, which would require expansion of the existing facility. Having additional regional facilities might be helpful but the expense of running additional independent facilities with all needed personnel might not make sense in a state with a population of only 1.2 million. I think expanding the current facility and recognizing that we need to do more autopsies, transport more bodies and increase the transportation budget makes the most sense."
MD	Maryland geographically is such that most population is near Baltimore. There are 23 counties and the city served by a single large facility. Bodies are transported up to 3 hours to reach this facility. This provides the economy of scale, and improved QA control inherent within single units.
MI	Michigan has mostly hospital based ME offices/autopsy facilities outside of Detroit metro area. The need is for more hospitals/pathologists to participate, which may occur if community pathologist's income decreases with the changes in healthcare. Forensic pathologists should support our community pathologists by providing consultation, being available to send complex cases, etc. The system should remain as a private, fee for service function, as this provides better quality and efficiency over a government run system.
MN	We are currently trying to merge our office with Hennepin County and are hoping to serve as a model for others in the state as we move to creating a regional center of excellence in medicolegal death investigation.
MN	The MN "system" is a disconnected mix of ME Offices and county coroners that each operate independently. Some natural sites for autopsy services are/have developed, but the specifics of how cases are handled in particular regions of the state are not clear.
MN, ND	In the large rural areas, local death investigation (directed at distance by FP) is needed instead of on site death investigators based in autopsy location. Tox and Forensic services are less critical to offices since send outs are easy and case load modest compared to large systems.
MO	Existing regional centers need to be replaced.
MO	Our regional centers are not official through state government. They involve private pay for service centers working on behalf of county coroners who along with law enforcement provide death investigation of varying levels of expertise.

MS	Mississippi has 82 counties (coroner system) with an OCME & full crime lab in Jackson with 2 FPs serving the entire state. Currently in process of getting two more FP in next few months. Would like to have 5 total FPs. Plan is to staff Gulfport (southern) region with one FP & staff, and have another FP & staff in a northern region facility.
MS	Would be useful to have the regional autopsy facility in use, and to have lab services available there as well.
NC	If you want statewide data, you should probably contact the OCME office in Raleigh. It is not clear that regional medical examiners would be aware of strategic plans of a central office, and perceived needs will represent a bias related to issues that may represent internecine political issues rather than actual needs. For instance, I personally think there should be *fewer* regional offices in NC, because my office would benefit if it could absorb another county or two. I notice that the desire for fewer regional offices is not one of the options. It should be listed -- the argument for regionalization is that some degree of centralization provides benefits from scale and infrastructure. Those same benefits would accrue if there are too many small offices. Thus, a better option other than *more* regional offices would be *bigger* and *better* staffed, but fewer regional offices. Thus, the survey has in inherent bias.
NE	Nebraska is a Coroner State and the County Attorney is the appointed Coroner. The medical autopsies are contracted out to area pathologists with in Omaha/Douglas County. Omaha does have a hospital morgue that the medical autopsies are completed.. It is not defined as a Regional Center, but rather a facility that is designated for Coroner /Medical death autopsies.
NH	The current centralized state office, serving a population of 1.3 million with 2 FTE's could use at least one more.
NJ	There needs to be standardization of the Regional System to allow for uniformity of service.
NM	Even though New Mexico is large geographically (>120,000 sq mi), it has a low population (approx 2,000,000). All medicolegal autopsies (approx 2200/yr) can be managed at our facility in Albuquerque.

NV	The two existing offices in Nevada, Reno and Las Vegas, would be sufficient as "North and South" regional centers; however, the office facilities should each be replaced with new offices, and supplemented with additional forensic pathologists. Reno operates from an old facility, 55 years old - most recently "renovated" 22 years ago. Based upon case load and service area (most of Nevada outside of Clark County and several north eastern California counties - population 850,000+, > 100,000 sq. mi.) the Reno (Washoe County Medical Examiner's) office should be replaced with a new facility. The location and services provided make Washoe County "a perfect setting" for a Regional Medical Examiner Office. Economic circumstances within the State have prohibited moving forward with establishing a Northern Nevada Regional Medical Examiner Office. Las Vegas has a newer office facility, but is similarly inundated with cases and due for a new facility.
NV	This really is not part in the law enforcement community. While we work closely and efficiently with the coroner's office, I work the police department.
NV	To have a medicolegal autopsy service with on-site crime lab, toxicology lab . Would cut the travel time for the outlying areas to receive this service. if you added an investigator service you could free up the Sheriff's offices in some location. In the bottom your job type. Some of the rural areas do more than one. Like me I investigate and I am the non-physician Coroner. So you should be able to click more than one position. (just a suggestion)
NY	There are numerous coroner counties and some ME counties with only 2 medical examiners. Some of these could be combined into one regional center.
NY	Existing regional centers do not perform field investigations at present. True regional centers should have trained investigators working for the center. This would require additional investigative staff and increased caseload would require pathologists, autopsy techs and toxicologists at these sites with likely expansion of the facilities.
OH	We need better local distribution of quality death investigators, and possibly 6-12 more in the state.
OH	We do not need official regional centers in Ohio. Essentially we presently have de-facto centers. There are several centers in every part of the state except the southeast. If one central county served by a well-respected university medical school began forensic activities, the entire state would be served.
OH	The average age of our Ohio forensic pathologist is approx 58-60 years. There are approximately 28 FP's on Ohio. We need to replace the retiring ones and attract the next generation.

OH	Ohio has an elected Coroner system, and each county has an elected Coroner. They are required to be a physician in good standing, but not a pathologist. Our counties who have pathologists as coroners or on staff provide a professional courtesy to the other counties who do not have pathologists or facilities. It would not be beneficial (financially or logistically) for Ohio to be regionalized.
OK	Renovation plans are underway for both the Central and Eastern Offices. Ok state law mandates that the Central Division Office be moved to Edmond, OK, near the Oklahoma State Bureau of Investigation Laboratories and the Forensic Sciences Institute of the University of Central Oklahoma. A new structure is presently being drawn up, and legislative funding mechanisms are being discussed in the present session.
OR	Bend - new center constructed Eugene - replacement center constructed Central Point - current center added to All regions - satellite outpost offices added
PA	We need forensic autopsy services and on-site toxicology services. In lieu of on-site tox services, we could continue to use an outside lab such as NMS. But forensic autopsy services are critical.
PA	The closet center for Bradford County is 2 1/2 hours driving distance. This is a huge problem for our county.
PA	Scope of services...forensic pathologist AND toxicology. In Pa. Additional investigators NOT needed...each county coroner has several death scene investigators on staff and can and does rely on the assistance of the local Pa. State police crime scene investigators.
PA	There should be an offer of Medicolegal autopsy service & Toxicology Lab. Currently there is no need for regional office but may in the future.
SC	Autopsy and toxicology labs only. Number of FP's needed, I believe that would have to be determined by the case volume.
TN	We are getting a new regional center in Shelby County in 2012.
TN	The regional center in Knoxville is probably in need of replacement/renovation.
TX	Our office has begun plans to convert to a regional forensic center when we open our new facility (~2015)

TX	Texas has a varied death investigation landscape. Some of the existing centers are full ME operations, while others are autopsy services only. In general, there are nearly sufficient forensic pathologists to examine all medicolegal cases in the state, but investigation suffers in the non-ME counties. True regionalization, with formation of ME districts in which a forensic pathologist controlled all investigation in his/her district would greatly improve things. A new West Texas center would preferably be a full ME district, with investigators both on and off-site. In house toxicology would be preferable also.
UT	Although we do not need any additional autopsy centers at this time, we will probably need one more center in the southern part of the state within the next decade.
VA	The Western District OCME needs renovation in the upcoming decade.
WA	Washington State has 39 counties with a mixture of appointed county medical examiners/forensic pathologists (6), and elected coroners (currently all non-physicians) or elected prosecuting attorney-coroner (33) Coroners are responsible for on-site investigations, but refer cases for autopsy to a regional facility or have a private-practice pathologist travel to their county for performance of autopsies (often in a funeral home)
WA	Autopsy facilities are in place. 2 are located in hospitals. Might need to expand cooler space in the hospital facilities.
WA	It is getting more and more difficult to find pathologist's willing to travel to the far reaches of eastern WA to do posts. We really need a pathologist who is based in eastern WA to cover Eastern WA
WA	I really don't have this information as jurisdiction is county by county,
WI	Our regional facility in Milwaukee is surely in need of replacement; renovation is more likely given current fiscal realities.
WV	As above. Our current facilities lack adequate storage and table space. The physical constraints of both facilities prevent adequate expansion. Decomposed bodies that cannot be accepted by our satellite office result in large transportation fees. Subsequent testimony in distant counties incurs additional travel expense.
WY	For the number of FT Pathologists listed - 2 for Casper, 2 for Cheyenne, 1 each for Lander and Cody. These numbers are based on the number of forensic autopsies currently conducted by the counties contained within these proposed regions.
WY	Wyoming has NO board certified forensic pathologists in the entire state who perform autopsies. ALL coroners transport bodies out of state for autopsies.

Note: One reviewer questioned whether comments about private forensic pathology services being of better quality can be substantiated.