SCIENTIFIC WORKING GROUP FOR MEDICOLEGAL DEATH INVESTIGATION

PRC#12: SWGMDI Autopsy Performance Criteria:

Standards, Guidelines and Best Practices

Public Comment Report

Created by SWGMDI's Autopsy Committee
Open for Public Review and Comment June to November, 2013
Total Commenters= 55
7% endorsed the draft as is.

Comments Received from

Commenter #1
First, I question the wisdom and utility of promoting more than one set of separately evolving and potentially conflicting standards/guidelines/best practices -- those of NAME as well as those of SWGMDI -- in the same document.
Second, I doubt the utility of including "best practices" at all, as these are more likely to evolve and change rapidly while also being impossible or highly impractical for any given office to implement. As written some of these are unproven wish-list items, not well evidenced best practices.
Third, the document appears to exclude the role of contracted services in lines 83-88 by focusing unnecessarily on statutory roles, which of course are highly variable across the country, and do not necessarily include service to the civil justice system.
Response:
Lines 93-95: I do not think every jurisdictional case requires investigation as detailed here.
Response:
Lines 94-95: The parenthetical inclusions are not necessary to specify. Some of those items may not be available for a given case, and in other cases different information may be important. I think standards should not micromanage.
Response:
Lines 96-99: Religious and/or cultural concerns should not be the provenance of federal standards in regards to medical or scientific issues. They should be separate.
Response:
Line 124: Common influenza is a threat to public health, but not much of a threat, and almost certainly should not require "additional investigation" as a matter of routine. The same could be said for numerous natural diseases: infections, obesity, ASCVD, cancer, etc. Perhaps add "..as determined by the Chief Medicolegal Officer and/or the jurisdiction's local public health agency" or something of the kind.
Response:
Line 125: The term "physician" is becoming less applicable as more physician assistants and other so-called mid-levels are involved in care, and may be allowed to manage care and sign death certificates in some jurisdictions. Perhaps just "health care practitioner who is qualified.."
Response:
Lines 127-129: I do not think every death certificate presented for cremation authorization requires investigation as defined in lines 93-95, as a "standard". Reviewed perhaps, but not necessarily investigated as defined there. If appropriately filled out with a reasonable natural diagnosis, it is not unreasonable to allow a death certificate to stand as self explanatory, having been filled out and signed by a licensed medical professional. This would not apply if cremation requests are not being considered "reported" for investigation, but other items on this list usually would be.
Response:

Lines 134-137: Stillbirths generally will have no death certificate, and therefore may fall outside statutory responsibilities of an office. I am not aware of much data supporting definitive outcomes in the setting of maternal drug use, and the general role of medicolegal death investigation systems is not academic research.
Response:
Lines 138-139: Deaths related to therapeutic complications may be classified as natural, related to the underlying disease. There's no reason to become involved in a case solely because they were under active care of a physician who was treating them, as opposed to being under care of a physician but happened to be at home at the time of death. Were that the case we should investigate EVERY death in the jurisdiction, medically expected or not. Possible complications related to therapy do not always need to be reported or investigated as a universal standard, when there is no universal standard that, for example, a nicked bowel during the course of a complicated surgery, etc., is not "natural".
Response:
Lines 138-139: These are medical standard of care/complications of treatment issues with recognized risks, and need not be relevant to a given jurisdiction. Physicians should retain the ability to determine the need to report; there is no good reason a ruptured AAA who happens to die during emergency surgery for same automatically should *require* reporting. In general that's a waste of perfectly good resources both on the clinician's side and the medicolegal office's side.
Response:
Lines 144-145: This is already addressed in lines 116-118, no need to duplicate.
Response:
Lines 154-155: In many jurisdictions this is what the office of Vital Statistics is for.
Response:
Lines 161-167: Editorializing.
Response:
Lines 180-181: Delayed non-natural deaths with extensive medical documentation could be a very reasonable exclusion.
Response:
Line 183: Why? Certainly many electrical related deaths provide little to no visible evidence of injury, but others are extremely severe and involve massive charring. While an autopsy might be advisable, why absolutely mandated?
Response:
Lines 184: Again, a delayed death with extensive medical documentation need not require an autopsy.
Response:
Lines 188-190: "Compromised" is perhaps not the best term. Death alone compromises normal visual identification, if only a little. Perhaps "such that personal identification and/or reasonable assessment for possible injuries is not effective without autopsy" or similar. I appreciate what I think the item intends, but I do not think every decomp needs an autopsy just because they're decomposed, as this almost implies as written; history, scene, and circumstances matter, as does the experience and confidence of whoever is at the scene or does the external examination.
Response:
Line 190: "deemed insufficient by the Chief Medicolegal Officer."
Response:
Lines 194-195: duplication of lines 192-193 and therefore unnecessary.
Response:
Lines 197-200: Probably better at the beginning of the section, not the end.
Response:
Lines 218-220: Performance of the autopsy need not include every step of evisceration, as this somewhat implies.
Response:
Lines 227-228: Arbitrary number based on what? Occasionally it takes 48 hrs to even determine jurisdiction, and small offices may not be able to staff routine autopsies on the weekends. As a best practice, perhaps, but not as a mandated standard. Similar applies to lines 236-237.
Response:

Lines 262-273: Mostly editorializing.
Response:
Lines 292-293: Scene and circumstances can be considered scientific, they just happen to have a higher rate of error than, say, fingerprints. But even fingerprints, radiography, and odontology have a rate of error which are not best described as "unequivocal" (as the term "scientific identification" is defined in lines 923-924). They are simply more reliable than certain other methods of identification.
Response:
Lines 309-310: It doesn't require a forensic odontologist, per se, to chart dentition.
Response:
Lines 309-310: Not convinced a "forensic odontologist" per se is required.
Response:
Line 313: There aren't that many board certified forensic anthropologists out there. I think it unwise to confuse terminology. Anthropologists with forensic experience can and often do perform this task very well. There is no glossary entry for "forensic anthropologist."
Response: We will add a glossary entry for forensic anthropologist.
Line 320: This is generally not under the control of the pathologist, and is therefore odd to make it that specific person's responsibility.
Line 320: The final disposition of remains upon release from the office is rarely in the control of that office, and really has no bearing on the medicolegal death investigation once the office has completed its examination and documentation.
Response:
Line 321: The pathologist has no control over whether CODIS will accept a DNA profile, and the DNA data may not be the pathologist's to submit, such as when other organizations pay for such testing.
Response:
Line 351: This may not be best managed by the pathologist, but by law enforcement in conjunction with the medicolegal office.
Response:
Lines 361 and 382: Perhaps add the word "relevant".
Response:
Lines 460-481: Confusing list. Typo line 461.
Response:
Lines 496-497: Lateral midline is also a useful descriptor in some circumstances.
Response:
Lines 582 & 601: Why include "(forensic technician)" here when only "qualified designee" is used everywhere else in the document?
Response:
Lines 608 & 610: Many subdurals & subarachnoids are not amenable to photography, and when not photographing every other hemorrhage during the internal examination, why mandate doing so for these?
Response:
Line 609: There is no need to always collect a sample of any epidural or subdural hemorrhage.
Response:
Line 610: There is no need to always photograph and measure subarachnoid hemorrhage.
Response:
Line 639: While preferable, there is no need to always only examine the neck after removal of all other organs including the brain.
Response: This is one of the basic tenets of forensic autopsies.
Line 644: An anterior neck dissection may not always be necessary in all neck trauma cases. For example, it is probably not necessary in a MVC with obvious severe neck trauma -- if an autopsy might not even be necessary as a standard, why should an anterior neck dissection be?
Line 644: Layered neck dissection is probably not necessary in an MVC with massive cervical spine injury, or similar cases. Examination yes, layered dissection no.
Response:
Line 652: Why is this not replacing & consolidating the separate sections for these injury types?

Response:
Line 703: Lack of intact skin does not equal presence of a deep/penetrating defect. An abrasion involves loss of "intact" skin, as does skin slippage and blistering. This seems better suited as a "best practice".
Response:
Line 709-710: This is already described in 698-699 as a standard. Why re-word it as also a best practice, and include the undefined term "pediatric trauma survey"?
Response:
Lines 732-733: Wasteful and thoughtless to mandate tox on pediatric MVC and certain related deaths, in the absence of a realistic suspicion.
Response:
Lines 761-764: ...or with no circumstantial cause of death. Some deaths have an obvious cause related to the circumstances, but which have no gross anatomic or toxicologic finding.
Lines 761-764: Should include "or circumstantial" cause of death.
Response:
Lines 766-767: Interesting to make this a "standard", when a definitive positive finding I think is extremely low probability, particularly with a postmortem specimen and without special staining or ultrastructural examination. Just not sure I'm comfortable with it as a "standard."
Line 766-767: Plain postmortem H&E of skeletal muscle is very low yield; reasonable results from extremely fresh samples and specialized staining can be useful, but mandating plain histology as a standard seems poorly evidenced. And of course, unexpected is not the same as unexplained -- it may be unexpected that an infant is found wedged between bed and wall, or with significant trauma after an MVC, but it certainly can explain the death in the absence of low yield skeletal muscle H&E.
Response:
Line 771: Not sure where this comes from. Many jurisdictions have a 1 year hold. Why 2?
Response:
Line 858: There is no need to repeat (and potentially distort) information placed elsewhere in the case file, such as investigative information and autopsy findings, as a matter of standard. Interpretations can also change over time while objective findings should not. This should be a matter of preference to include, not a standard.
Response:
Line 859-861: Elsewhere in this document the forensic pathologist need not attend the scene, so why would the forensic pathologist prepare a report of the scene? This should be qualified designee or medicolegal death investigator, unless the forensic pathologist did indeed go to the scene.
Response:
Line 867-869: This is often not appropriate, and a data dump of possible missed diagnoses is misleading and inevitably incomplete.
Response:
Line 868: The work product of the medicolegal death investigation system is rarely brought to the attention of a clinician. This line as at best applicable to few cases, or those with direct clinical involvement such as hospital autopsy cases, and could be confusing rather than clarifying in difficult cases or certain homicides.
Response:

Commenter #2
Line 191: In accidental fire deaths when the carbon monoxide level is in the fatal range, I don't think an autopsy is needed.
Response:
Line 892: Definition of a forensic pathologist should include pathologists who have attended an accredited program in forensic pathology and have been practicing forensic pathology for more than 10 years.
Response:

Commenter #3

As one who was very involved in the development of the NAME Forensic Autopsy Performance Standards, I wish to congratulate you on your efforts. I know what a difficult and tedious process it can be. You have obviously gone through each word of each existing standard carefully and the fact that you adopted so much of the previous document is a validation to some extent of the original NAME standards. I wholeheartedly agree with almost all the changes that you have made. I do believe that it is advantageous to have added "Best Practices" and have suggested this previously in discussions while on the NAME committee.
Response:
Line 396-397/877-879: The numbering system must include the titled divisions. It is simply too awkward and inconsistent with other standards to say: "External Examinations:Patterned Injuries, 1.a." It is a little unclear if the term Certified Medicolegal Death Investigator is appropriate, rather than ABMDI registered MDI. See: P. 15, L. 396-397 (BP); P. 37, L.877-879 (Glossary #2), comment #3 & 7 below.
Response:
Line 104: Medicolegal Death Investigation: Responsibilities: I think the Best Practice would be an FP or a "certified MDI"…
Response:
Line 144-145: Medicolegal Death Investigation: Initial Inquiry: I think deaths from fractures are covered under deaths from violence, unexpected or unexplained deaths, or occurring under unusual or suspicious circumstances; but at any rate, if retained, should be a best practice
Response:
Line 157: Medicolegal Death Investigation: Initial Inquiry: I recommend consideration for adding to the best practices: "3. The Chief Medicolegal Officer shall ensure that the investigations are catalogued in an electronic database for archival, retrieval, and summary statistical purposes."
Response:
Line 205: Forensic Autopsies: Selecting Deaths Requiring Forensic Autopsies, I recommend consideration for adding to the best practices: "2. The Chief Medicolegal Officer shall ensure that the cases requiring forensic autopsies are catalogued in an electronic database for archival, retrieval, and summary statistical purposes."
Response:
Lines 283-284: Identification: Identification Procedures: You might consider the "shall ensure" phraseology rather than the "or designee" phraseology for the accomplishment of fingerprints. The FP may have no say in who from LE does the print, if LE does do the print [of course, most such personnel will be qualified].
Response:
Line 368: External Examinations:Physical Characteristics, "gender" is used by anthropologists as a cultural characteristic and "sex" is a biological characteristic—which is more appropriate here (see for example: http://www.who.int/gender/whatisgender/en/).
Response:
Lines 367-374: External Examinations:Physical Characteristics: I would suggest combining them all under FP or designee, with the possible exception of item #8. It seems to me if there is one thing on this list that is commonly not performed by the FP, it is #6 tattoos.
Response:
Line 418: External Examinations:Specific Procedures for Suspected Sexual Assault: It seems to me that if you called for a certified MDI in the preceding sections BP for postmortem changes (P.15, L396), then you should call for it here as a BP for sexual assault examinations.
Response:
Line 438: External Examinations:Injuries (General) "Color" is out of order here and should be moved up, probably after "type" or "location". [My preference would also be to move "course" to after "depth"]
Response:
Line 506-507: External Examinations:Firearm Injuries: The phrase/notion "and collect and save it for analysis, when appropriate" should be separate from the phrase/notion "document it photographically". Specifically, the "collect and save" notion should be its own item and not as a standard, but rather as a best practice.
Response:

Lines 535-537 External Examinations:Burn Injuries: #4 describe the appearance of the body hair associated with the burn should be a best practice and maybe also #4 TBSA estimation. #5 describing soot inhalation requires an autopsy. Although I am personally in favor of autopsying all burn victims, it is not the practice in many jurisdictions. Thus, this might be a best practice. Would a swabbing of the back of the throat suffice as evidence of inhalation?—I believe that we should document soot or not below the vocal cord and thus I would answer this question "no"—but if the answer is "yes" then an autopsy may not have to be performed. If the fire injury burned through the neck and exposed the trachea, then is an autopsy still necessary?
Response:
Lines 551-552: External Examinations:Patterned Injuries: I had difficulty and gave up trying to find the ABFO reference from the given link. I assume that the required method of swabbing referenced here is the double swab—wet & dry technique described by David Sweet for DNA collection. I would suggest rewording the standard to include "…the wet and dry double swabbing technique for DNA collection…". I would also suggest splitting out the "…and documented [according to ABFO standards] ..." phrase/notion to a separate best practices bullet [or combine it with BP1]. DNA swabbing should be retained as a standard.
Response:
Line 628: Internal Examination: Head and Spine: Append to the end "…as determined by the forensic pathologist".
Response:
Lines 748-749: Ancillary Tests and Support Services: Specimens for Laboratory Testing, I would suggest reversing the thought here as "Autopsies should be performed in all cases in which toxicology testing is performed" which is what I think is the true intent of the BP.
Response:
Line 826: Ancillary Tests and Support Services: Evidence Processing: The phrase/notion "…photographed" should be a separate bullet from the phrase/notion "and inventoried in an electronic database".
Response:
Line 852: Documentation and Reports:Postmortem Examination Report: I would recommend adding "and diagnoses" after "objective findings". It is unrealistic to believe that objective findings can be completely separated from subjective opinions. All medicine, including forensic medicine, involves application of medical judgment--some diagnoses are somewhat subjective or uncertain, but we are asking the professional his/her medical opinion. The objective findings and subjective diagnoses are somewhat intertwined. Is cirrhosis of the liver a mere objective finding? --what about hepatic fibrosis or hepatomalacia? I am more likely to call the liver brownish discolored if I am thinking of hemochromatosis. It is fantasy to say our "objective findings" are not influenced by our opinions. At any rate, I personally prefer that the concluding list be of Postmortem Diagnoses.
Response:

Commenter #4 [NAME, CAP, ASCP]
The Standards and Executive Committees of the National Association of Medical Examiners, the American Society for Clinical Pathology, and the Forensic Pathology Committee of the College of American Pathologists have carefully reviewed and considered the Scientific Working Group for Medicolegal Death Investigation (SWGMDI) draft document "PRC-12 Autopsy Performance Criteria: Standards, Guidelines and Best Practices." This letter represents the official response of the National Association of Medical Examiners, the American Society for Clinical Pathology, and the College of American Pathologists. The National Association of Medical Examiners (NAME) is the national professional organization of physician medical examiners, medicolegal death investigators, and death investigation system administrators who perform the official duties of the medicolegal investigation of deaths of public interest in the United States. NAME was founded in 1966 with the dual purposes of fostering the professional growth of physician death investigators and disseminating the professional and technical information vital to the continuing improvement of the medical investigation of violent, suspicious and unusual deaths.

Growing from a small nucleus of concerned physicians, NAME has expanded its scope to include physician medical examiners and coroners, medicolegal death investigators, and medicolegal system administrators from throughout the United States and other countries. NAME serves as a resource to individuals and jurisdictions seeking to improve medicolegal death investigation by continually working to develop and upgrade national standards for death investigation. NAME aims to involve competent professional medicolegal death investigators in every jurisdiction in the United States.

The American Society for Clinical Pathology (ASCP) is a nonprofit medical specialty society representing more than 100,000 members. Its members are board certified pathologists, other physicians, clinical scientists, certified medical technologists and technicians, and educators. ASCP is one of our nation's largest medical specialty societies and is the world's largest organization representing the field of laboratory medicine and pathology. As the leading provider of continuing education for pathologists and medical laboratory personnel, ASCP enhances the quality of the profession through comprehensive educational programs, publications, and self-assessment materials. The mission of ASCP is to provide excellence in education, certification and advocacy on behalf of patients, pathologists and laboratory professionals across the globe.

The College of American Pathologists (CAP) is a medical society serving 18,000 physician members and the global laboratory community. It is the world's largest association composed exclusively of board-certified pathologists and is the worldwide leader in laboratory quality assurance. CAP members practice in many subspecialties of pathology including forensic pathology. As the leading organization of board-certified pathologists, CAP serves patients, pathologists, and the public by fostering and advocating excellence in the practice of pathology and laboratory medicine worldwide. The CAP advocates accountable, high-quality, and cost-effective patient care. The CAP's Laboratory Accreditation Program is responsible for accrediting more than 7,000 clinical laboratories worldwide.

The NAME Forensic Autopsy Performance Standards—publicly available at www.thename.org—were first approved by the NAME general membership in 2005 and have been revised and amended multiple times in the ensuing years. NAME has a rigorous method of assessing and vetting proposed standards changes or amendments, which ultimately must be approved by the majority of members in attendance at a NAME business meeting before being adopted. Thus, the NAME standards are—by definition—the product of the very practitioners who seek to uphold and disseminate the standards.

In a 2010 letter to the National Institute of Justice (NIJ), NAME provided considerable input to the NIJ on the composition and objectives of the SWGMDI. In that letter, NAME described the NAME Forensic Autopsy Performance Standards and asked that the NIJ task the SWGMDI with *developing recommendations to encourage widespread implementation of these* ***existing standards***. (emphasis added)

NAME, ASCP, and CAP recognize the voluminous and valuable work that has been performed by the SWGMDI on a number of fronts, ranging from reports on physical facility recommendations to recommendations regarding pathology workforce issues. We also note that many of NAME's already published standards were imported wholesale into the SWGMDI Autopsy Performance Criteria draft. We further recognize that many of the newly proposed standards proffered in the SWGMDI draft document might, if implemented, be valuable additions to the practice of forensic pathology. However, with regard to the SWGMDI's Autopsy Performance Criteria, ***NAME, ASCP, and CAP unequivocally believe that only one set of forensic autopsy performance standards should exist, and these should be the standards developed and promulgated by NAME***. There are good reasons why this should be the case:

As noted above, the NAME Forensic Autopsy Performance Standards are developed, amended, and produced through consensus by the very professional society to which the standards apply. A mechanism for altering the NAME standards exists, and NAME has a committee dedicated to reviewing proposed changes to the standards. In contrast, the SWGMDI Autopsy Performance Criteria were developed by a relatively small committee, of which several members are not forensic pathologists. This

latter set of standards, if published, would be regarded as an outside dictate to the discipline of forensic pathology and infringement upon the practice of medicine.

The existence of a SWGMDI set of forensic autopsy standards introduces redundancy into forensic pathology and death investigation. Any proposed standard desired by the SWGMDI can be brought to NAME—a considerable subset of the SWGMDI consists of NAME members—and the standard in question can be voted upon for inclusion into the NAME standards.

Two published sets of forensic autopsy performance standards would create unacceptable ambiguity in the fields of forensic pathology and death investigation, confusing practitioners, law enforcement, families, the legal system, the public, our clinical colleagues, and our fellow forensic scientists.

The performance of forensic autopsies is the practice of medicine. The standards to which forensic autopsies are performed, therefore, are solely the purview of the qualified medical practitioners who perform them.

In summary, ***NAME, ASCP, and CAP cannot and will not endorse or recognize forensic autopsy standards that are not the product of NAME***. NAME will unapologetically defend itself as the leading authority on forensic autopsy performance standards and the practice of forensic pathology, and will actively and publicly oppose forensic autopsy standards authored or promulgated by any other organization or agency. ASCP and CAP fully supports NAME's position. For the reasons noted above, NAME, ASCP, and CAP strongly encourage the SWGMDI to simply endorse the NAME standards as the leading set of forensic autopsy standards in the field and recognize that NAME has a mechanism for reviewing proposed forensic autopsy performance standards changes.

Thank you in advance for your time and your consideration.

Response:

Commenter #5
Line 134: I do not believe it appropriate to take jurisdiction in every case of stillbirth in which there was (reportedly) maternal drug use. To take all of these cases would serve no rational purpose. Much discussion needed here.
Response:
Lines 224-226: Is this standard to mean that cases performed by our fellow under my supervision count against my "325 maximum cases?" This would be both novel and inappropriate and surely is not found in the current NAME inspection materials.
Response:
Lines 304-313: Given all the specificity here regarding processing of unidentified remains with respect to radiographs and dental charting, it seems odd that there is mention neither of fingerprints nor of DNA sampling
Response:
Line 368: Gender is a grammar term. Humans have sex. Personally, I resolve the difficult issue of s/p sex reassignment surgery as "genotypic male" or "genotypic female," such terms cannot be incorrect or negotiable based on next-of-kin whim.
Response:
Line 507: Collect and save gunshot residue for analysis? What analysis would that be, in 2013?
Response:
Lines 617-628: Brain and spinal cord to the neuropathologist in all of these cases? You must be kidding.

Commenter #6
Line 154-155: All death certificates on decedents must be reviewed by a Chief Medical Officer or designee prior to cremation, non-medicolegal dissection or removal from state. (This should also be a standard not a best practice). Reviewing all death certificates filled in a jurisdiction is a massive waste of taxpayer money.
Response:

Line 248: In this section I would add a best practice as "The forensic pathologist who determines the cause of death shall also determine the manner of death."
Response:
Lines 649-650: There is no literature that supports taking out of spinal cord and nerve roots en bloc in all suspected neck injuries. All or almost all standard posterior neck dissections will elucidate the injuries. I would remove this best practice procedure.
Response:
Lines 774-775: This best practice of performing microscopic exams on every autopsy is actually bad practice. It wastes a massive amount of taxpayer money for no useful information on most cases. Microscopic exam should be done at the discretion of the forensic pathologist on all cases that have a gross anatomic or toxicological cause of death. I would remove this best practice.
Response:
Lines 799-801: Another best practice that should be eliminated because the cost is prohibitive for the amount of use that many of these scientific services supply. For high volume offices, it is probably practical to have on-site toxicological and histological services. The rest should be supplied by private contractors.
Response:

Commenter #7
I cannot support this draft at all. It goes above and beyond those standards endorsed and approved by NAME which represent many practicing forensic pathologists, rather than the opinions of few. I would suggest that this SWG simply reflect that all offices should abide by the NAME standards with the best practice being accreditation. I do not see a reason to reinvent the process, we have on one in place in the NAME standards and those should be utilized.
Response:

Commenter #8
Any Standards produced by this group should be identical to those produced and maintained by the NAME, wherein practicing FPs within the organization are able, via specified procedures, amend and/or change the standards as deemed appropriate.
Response:

Commenter #9
Line 317: Include NCIC which is more inclusive of dental conditions. Namus is insufficient and inadequate for any reliability as it was intended for non professional utilization.
Response:

Commenter #10
Line 506: Gunshot Residue Kits are not supplied by my agency for use, regardless of whether testing is deemed "appropriate' by the Forensic Pathologist. Rather, the law enforcement agency having jurisdiction in the case provides the kit to the Medical Examiner when they determine the necessity for testing. This line should reflect that the Forensic Pathologist obtains gunshot residue for testing based on requests for same by the criminal justice system.
Response:

Commenter #11
I thank the committee for their work, but I have one specific concern. The most important change must be the removal of all the "Best Practices" from the document. The legal system can not differentiate between a minimal standard, guideline, and best practice in court. The nature of adversarial court in my jurisdiction is such that best practices become minimal standards, and no amount of education or explaining will change that. The focus becomes not if the autopsy and cause of death are accurate and properly performed, but the de facto standards, which will include your best practices that are beyond my control. Expert witnesses will capitalize on this to create confusion. Everyone wants the "best" but few of us can afford it, unfortunately. NAME specifically only made minimal Standards for this very reason. Florida and IL both have their own autopsy practice standards/guidelines that apparently were

not considered. I respectfully ask that you publish the Best Practices as a separate document for utopian jurisdictions with unlimited resources and funding, which clearly IL does not have. Two previous SWG documents pointed out the severe shortage of FPs, especially in the Midwest region. Please check the IL number of FPs to population compared to the rest of the country. Your document neglects this important information. Please publish the Best Practices separately, so they do not appear as mandatory standards or guidelines. Thank you for your consideration of my request.
Response:

Commenter #12
Lines 67-68: are what we need to be addressing because 66 is not vigorous enough to achieve a scientific certainty. I am acutely aware that a major forensic center no longer obtains tissue sections and does no histology whatsoever. Additionally the photographs are taken by dieners or in-house "M.E. Investigators" that have not been professionally trained. It is my practice to have all of those functions to be the work product of the physician.
Response:
Lines 152 and 154: This should be a mentor relationship, the "Chief" in some jurisdictions may be under the influence or politics, illegal drugs or some other aspect. As an example, there is ample evidence in one jurisdiction, where the Chief Medical Examiner for a large portion of a state had uniformly redacted all vital diagrams by 40% in order to make them illegible to the public, the prosecution, and defense atty's in order to gain an advantage in court, where the true and exact document is finally made available in court, but only via projector, not a hard copy.
Response:
Line 221: This is an absolute must, beginning with the opening of the body bag.
Response:
Line 236: This consideration is important, but there should be exceptions for certain cases where rushing this autopsy may be detrimental to the investigation, which may still be incomplete within this time constraint. Examples are when the circumstances of the event are delayed, unknown, or suspicious for radiological, biological or toxic chemical events. Providing a "standard" autopsy may defeat the end result.
Response:
Line 287: I would recommend some judgment here regarding palm prints. DNA should be the first choice. The recent odontology debacle is no different than palm prints.
Response:
Line 347: "Qualified Designee" is loose cannon. Set Standards.
Response:
Lines 351-353: This opens the door to real trouble. It introduces the concept of what is, or is not: important to a tech, who cannot testify as an expert, vs. the remains of what the tech left the pathologist to see. Blood spatter is best appreciated when first found and not second hand, so is soot and GSR.357: Any photography MUST be through the hands of the pathologist. One of the strongest statements for the pathologist to make is: "This photograph was taken by my own hand at the time of the autopsy, and depicts what I saw, as "True and Exact"
Response:
Line 375: Another pitfall. Perhaps it can be described to the pathologist, but the pathologist is the ONLY professional to memorialize the finding.
Response:
Lines 390-394: Another mistake, just waiting to impeach your testimony.
Response:
Lines 409-416: These are things that can only be done right ONCE. This is the pervue of the pathologist.
Response:
Line 450: Ibid
Response:
Line 459: Ibid
Response:
Line 506: Ibid

Response:
Line 554: I think forensic odontology needs to be cleaning up their shop.
Response:
Line 668: It is of great value to excise GSW's for histologic analysis indicating what foreign materials are present and the sequence of the materials, including polarization for retained fragments of glassI have also found it of great value to examine the airways in cases of drowning and inhalation of soot and superheated gases.
Response:

Commenter #13
Line 231: Given the shortage of FP's, there is no way we can limit FP's to this number currently. While it may be ideal, attorneys could potentially use this against the FP during testimony. This could have an adverse effect and cause the FP to decline cases past the 250 mark. Then, we would be in dire straits. Thank you.
Response:

Commenter #14
Line 127: #9 - I do not have state given legal jurisdiction or investigate the deaths listed here. I have no way to legally require this. This should be addressed since you have it as a "standard".
Response:
Line 139: #13 - I do not have state given legal jurisdiction or investigate the deaths listed here. I have no way to legally require this. This should be addressed since you have it as a "standard."
Response:
Line 283: #5 - I do not feel that obtaining fingerprints is necessary when the decedent's identification is not in question. I agree they should be taken if the identification is in question. This should not be considered a "standard" for all cases examined. It also creates a storage issue since no time frame is given as to how long the prints should be maintained.
Response:
Line 641: #3 - I do not feel it is necessary to examine the tongue in every case. I agree when the Forensic Pathologist is concerned with neck trauma the tongue should be examined.
Response:
Line 724: #3 - what if long term storage capability is not available to the Coroner office. The NAME paper makes allowance for the office capability. Does this "standard" do the same?
Response:
Line 807-813: How does a Coroner office their toxicology company to include the listed information? Some allowance should be made for this issue.
Response:

Commenter #15
There is a serious lack of specifying arterial damage. This may not be the direct cause or manner of death but is essential in the assault in cases of death from blunt for trauma to the head. Some court jurisdictions limit testimony from bloodstain pattern analysts to blood outside the body, thus requiring explanation of arterial rupture via aneurysm to come from the autopsy physician. To require this being brought out separate from the autopsy makes the pathologist look like they are hiding evidence. Should be required examination whether a pinhole tear occurred or not.Secondly, there is no mention of cadaveric spasms. If autopsies must be completed within 24 hours it's possible that the pathologist be aware of such. This can help position the body at the moment of traumatic death. Such information will assist in reconstruction.Bite mark evidence is mentioned although there are presently challenges to admissibility. Arterial damage is extremely important and should be considered at least as evidential if not more so than bite mark.
Response:

Commenter #16

The autopsy standard already exists under NAME organization. The committee is headed by a non-physician. The "best practice" section should be removed.
Response:

Commenter #17
Line 907: correct terminology for this allied health professional is Pathologists' Assistant More information on this professional may be found at http://www.pathologistsassistants.org/ You may reference details in the 'About Us' tab at the top of the page, and 'What is a PA?' section within that area. Typically, a Pathology Assistant is synonymous with "Diener", "Autopsy Assistant" or "Autopsy Technician." Thank you for the opportunity to comment on the draft publication.
Response:

Commenter #18
I endorse with comments/questions to consider: Line 409: What about swabs to grab marks for touch DNA? & floss teeth for presence of semen in oral penetration? Also will photos include internal & external genital injuries in sex assault?
Response:
Line 532: Burns: Should there be a statement on pattern burns in children? i.e. sock and glove? Also splash, & run burns? Also is the statement consistent with injury, developmental age and ability, and is there a developmental milestone present such as toilet training, etc?
Response:
Line 630: Should there be a statement concerning hyoid bone for strangulation?
Response:
Can there be a definition of a forensic nurse, since there was a statement about the forensic nurse in crime scene investigation? Many FNs work in autopsy too. One other question is, unless I missed this somewhere; is there a statement addressing Chain of Custody and the body in forensic autopsies? Thank you for the opportunity to read your hard work!
Response:

Commenter #19
No comments. Yes for endorsement.
Response:

Commenter #20
Line 202: I do not think all MVAs must be autopsied. All must have careful external examination and documentation of injuries by diagram and photos. MVA drivers should be autopsied if: Unwitnessed Mechanics unexplained by investigation, No apparent lethal injuryFire/burned, Tox not easily available, Possible MV suicide or homicide, Obvious MV accidents do not require autopsies on passengers and some drivers. E.g. driver of auto hit by dump truck.
Response:
Line 224: 325 is too many complete autopsies for any pathologist unless you mean 250 plus 75 that the staff forensic pathologist supervised.
Response:
Line 236: Not feasible if the body has to travel great distances and arrangements must be made.
Response:
Line 257: The cause and manner of death must be certified as listed by the forensic pathologist. C & M should not be overruled by a Chief Medical Officer who is not a forensic pathologist.
Response:
Line 283: Two sets of prints should be taken – one for police to routinely run through AFIS and one original set that should remain as part of the permanent case record and never be yielded. Prints get lost in police records that are sometimes purged.
Response:

Line 351: clothing should be retained and carefully dried. Examination for subtle trace should be by forensic scientist – i.e tape lifts for fine hairs, paint, etc is best carried out in forensic science lab.
Response:
Line 357: Body should be photographed as received and before and after cleaning. The hands in particular should be photographed.
Response:
Line 413: Add body and extremity hairs. Document and swab any apparent or questionable bite marks in accordance with standards set by ABFO.
Response:
Line 418: A competent sexual assault exam should be carried out in a morgue with good light not at the scene. May need fuming for fingerprints
Response:
Line 551: Should be taken care of earlier on in the exam.
Response:
Line 593: There is no need to photograph obviously normal organs.
Response:
Line 679: Blunt force (and any other) injuries to the hair bearing head should have the margins shaved to see the shape and edges, also any trace in the wounds.
Response:
Line 745: Nails should only be pulled if poisoning suspected. It is disfiguring and not necessary.
Response:
Line 748: All views should have toxicology drawn and submitted for testing and the samples of blood, vitreous and urine retained. This must be a MISPRINT!
Response:
Line 752: This is a cost issue and is blind testing. It may be worthwhile if the death is to be certified as undetermined but appears natural and the decedent is young
Response:
Line 761: I favor heart, lungs, liver kidney and brain on all. Especially if drug screen is not completed on all.
Response:
Line 863: The jurisdiction should make provision for archiving and ensuring retrievability of the case report, including the autopsy and photographs permanently.
Response:
Line 869: The pathologist cannot simply record risk in a record and assume someone else will communicate it to family. If the risk is real he/she must be sure the risk is communicated directly. NOK may not contact the office, the FP may not receive, read or act on the record. The responsibility for communication lies with the pathologist.
Response:

Commenter #21
I endorse draft, but with a few clarifications: Line 30: Could the term: "animal models" be changed? Animal Rights Activists could see this as offensive
Response:
Lines 223-225: Should a line be included which notes that contacting a next of kin will be priority? These lines could make the assumptions that these populations have no next of kin in any circumstances, which, of course, is not correct.
Response:
Lines 233-234: Add a "volunteering parent"?
Response:
Line 289: Drowning in bath tub vs. natural waters (eg. boat) - both covered here? - in Canada, boat drownings are difficult to determine as homicide, suicide or accident. These are my comments, I think the draft is a terrific piece of work!
Response:

Commenter #22
No comments. Endorses draft.
Response:

Commenter #23
Line 127: Deaths of persons to be cremated: This is unnecessary if to be investigated if only because cremation will occur.
Response:
Line 144: Deaths in which a fracture: This is too vague and should be eliminated or re-written. Treated fractures of reasonable age are not relevant. It does not clearly state that if the fracture may have contributed, then investigate.
Response:
Line 175: Shall perform autopsy when: This section should address multiple fatalities/mass fatality such as those caused by nature - there needs to be decisions as to who receives an autopsy in that case.
Response:
Lines 275-293, Line 350, Lines 452-457: Regarding autopsy photographs: There should be a minimum set of photographs for all autopsies - I'd recommend at least 13 - 3 overlapping photos of anterior, laterals, and posterior surfaces of the body, and 1 ID photo. Further - there should be guidance regarding deleting or altering a poor quality digital photograph in the procedural standard.
Response:
Line 593: concerning a certified forensic photographer. This qualification and practice is unnecessary of every organ system, only those of forensic value. Negative photos are generally not useful.
Response:

Commenter #24
As an outsider reading the document, I provide the following comments or suggestions: Line 185: clarification - eg. boat drowning
Response:
Lines 250-251: If forensic autopsy is only part of .... (include what is)
Response:
Line 269: DNA storage for future criminalistics is a threat to individual privacy rights and that of their families especially if there is not apparent criminal link - this would need clarification as this contravenes with SWGDAM
Response:
Line 279: DNA archived indefinitely without a criminal link contravenes with preservation of DNA guidelines
Response:
Line 290: DNA storage indefinitely - see previous response
Response:
Line 321: DNA profiles can only be submitted to CODIS in cases related to violent criminal matters. If remains are unidentified - but CODIS is set up for criminal matters - should say so here or at least clarify that this is in matter of a criminal nature - otherwise maybe DNA should be put into NDIS - National DNA Index System
Response:
Line 367: bone dentition by anthropologist
Response:
Line 377: does this include retinal hemorrhages
Response:
Line 595: in title spine is mentioned, but not throughout the section
Response:
Line 617: should this include nerve roots used in cases of SBS
Response:
Line 644: including nerve roots used in cases of SBS

Response:

Commenter #25
Referencing Lines 290-91 and 724-28>>>HOORAYI am a clinician dealing with families who have suffered the sudden death of a family member, and the recommendation to preserve DNA specimens for future evaluation is a BIG step. An associated thought >>notwithstanding the lack of funds for genetic testing, the family should be offered the information that such testing exists and a list of companies who perform such test so that they can choose to pursue if desired.
Response:

Commenter #26
This whole document seems VERY medical examiner focused and not compatible with a Coroner system and in fact very opposite of a coroner system and not representative of the training that goes into many of those systems. Especially lines 104 & 154, the references to NAME standards, P.10
Response:
Lines 91-92: Given that many chief medicolegal officers ARE law enforcement or part of the law enforcement (LE) community can this be better worded? In my case, being LE, of course I'm influenced by LE since they are who makes the rules. Maybe it should say OUTSIDE LE agencies or other LE investigations?
Response:
Line 127: We have nearly 19,000 deaths a year in my jurisdiction. I think that standards also needs to be put in a framework of reality. This would require umpteen more investigators OR, as we know would happen in government, just over burden those already working so they can't focus on actually "important" death investigations.
Response:
Line 134: In item #12 I would also include due to maternal trauma
Response:
Line 224: What is the basis for this number? It appears random. I know it is a NAME standard but why? Is there going to be a limit on the number of investigations an investigator may oversee in a year?
Response:
Line 227: Why 95%? That seems random, especially given the volume that a larger office might have OR the difficulty of finding an available FP and coordinating for a smaller jurisdiction. Additionally, sometimes having additional time for investigation can aid an autopsy.
Response:
Line 396: Define "certified"?
Response:

Commenter #27
Perhaps this could be reframed as a document for coroner systems? This might at least partially address concerns about potential conflicts with already existing NAME Standards (which are mainly those of medical examiners even though they are titled "Forensic Autopsy Performance Standards." Also, Line3 590-593. I do not think that either of these are best practices. Having to eviscerate is not a good use of FP time. It is also unnecessary to photograph all dissected organ systems. Not needed.
Response:
I have no problem with the concept of best practices. If challenged on the stand for not meeting them, people should be able to explain why they can't meet them. But some people seem afraid of the term and its possible consequences in court. Could we retitle them to "goals?" That's really what they are, are they not?
Response:

Commenter #28
Here is what I wrote on the NAME mailing list: OK, pet peeve time. I was going to write this a month ago, but was banned from the NAME mailing list for a few weeks (due to technical issues, not a policy thing), and then got caught up in getting ready for my vacation. But here it is. SWGMDI has decided

that NAME is not the place for autopsy standards. It is. So screw NAME. I suggest that everybody look at the SWGMDI autopsy standards -- soon to be imposed on you. Unfortunately, there's only about a week left to comment, so look soon.
But it's a disaster. Oh sure, they have *incorporated* many of the ideas of NAME. But big deal. What they have done is decided not to *defer* to NAME standards, but instead to *supplant* them. The difference? In five years when, for political purposes, those SWGMDI standards get changed, it won't matter one rat's ass what the NAME standards are. The difference between:

"SWGMDI defers to the NAMEW standards for autopsy performance," (a short, sweet and perfectly adequate statement) and presenting a modified (and much worse) version of it as the word of God from mount Washington is vast. SWGMDI chose the latter. Henceforth, we no longer establish our own standards. Instead, we must submit them to a political panel for adoption. SWGMDI has declared war on NAME.

I remember Vince Di Maio saying that if we don't create standards, the feds will do it for us. Vince was right in that they would do so. He was wrong in that the feds would allow us any self-governance once it decided that all things in the world must be regulated from Washington, the mantra of the Progressive world.

So, here it is. And, unfortunately, as all elitists do, they forget that intellect is not wisdom, and made the mistake common to all central planners -- the reason why Soviet five year plans don't work, why one-size-fits-all regulations don't work, and why Washington is ruled by unintended consequences rather than rational policy. In order to have a central plan, all the world must fit a particular model. And if it doesn't fit that model, it must be destroyed. Hence SWGMDI.

The problems are manifold. Succinctly, there is no validation, there is no accountability, the standards they present are capricious and arbitrary, and they are *necessarily* arbitrary because of the politically-imposed structure that the current Administration has enforced; they have surrendered correctness for conformity.

Back when the SWGs were started, when their purpose was to provide cover for the FBI and support admission of forensic evidence in court, each SWG had its own by-laws and structure, determined in large part by the peculiarities of each discipline involved. Thus, SWGDOC (the Scientific Working Group devoted to questioned documents) was very different in structure and output than SWGIT (the SWG devoted to forensic imaging). When the feds decided to use the SWGs as the tool for imposing top-down regulation of the forensic world, they decided to enforce a uniform structure and format to both the SWGs and the documents they produced. They also changed the mandate from proposing guidelines for the purpose of providing defense against challenges about admissibility to dictating standards for the purpose of punishing practitioners.

One of those top-down requirements is that one have guidelines, standards and "best practices." Thus, having a well-thought out set of standards that had been vetted by the community is simply not enough. It is *dictated* that *additional* requirements be pulled out of the asses of the committee members without that vetting, that discussion, or that voluntary acceptance by the community. But of course, the idea of "voluntary acceptance" is no longer operational.

And that is what has happened. If you look over the SWGMDI document, you might be tempted to say "Hey, these look a lot like the NAME standards. What can go wrong?"

The answer is simple. On top of the NAME standards, SWGMDI has imposed capricious and inappropriate "best practices" for no other reason (as far as I can see) than they *have* to.

And that is deadly. The response by SWGMDI might be that "best practices are optional." But, of course, that is bullshit when it comes to testifying on the stand. On the stand, it goes like this:

Q. Is it not true, Doctor Oliver, that the Scientific Working Group has said that it is a best practice to do such and such?
A.Yes.
Q.Did you do this?
A.No.
Q.Why not, Doctor?
A. I did not believe it was necessary (or we were not funded, or we were not staffed, or whatever).
Q.So you did not believe it was important enough to do the best possible job in this case? and it goes downhill from there. Trust me, I know. I've been there in Daubert hearings regarding forensic imaging. There is no good answer to the "Yes this is the best practice, but I didn't do it" problem. So this claim that the "best practices aren't standards" is simple bullshit. There is a desire of folk who write guidelines to put in their pet peeves and secret desires of what would happen in a perfect world where reality was unimportant. But we really shouldn't write standards that way.

I proposed, when the NAME standards were being written, that each new standard should be accompanied by a formal estimate of *what difference it would make.*In other words, if you want to say that all MVAs must be autopsied, then you should be able to provide an estimate of how many otherwise unsuspected homicides per year you expect that to show up. It's not enough to remember that one case from 20 years ago, and then decide that it's malpractice not to do it on all cases. That's just bullshit. And that's what the SWGMDI "best practices" is all about. There is *no* quantitative estimate of what difference it would make. Because if there was one, it would be clear how ludicrous these are.

And look at those "best practices" when you read the document. For instance, it is a "best practice" that all autopsies be done within 24 hours *of notification.* Safety be damned. Now I can think of at least ten instances where it is *better* to wait, and doing a case within 24 hours is *not* a best practice. But, Washington will say it is, and you are screwed on the stand.

It is a "best practice" that the forensic pathologist performing the autopsy must do all scene investigations (though later it's expanded to include medicolegal investigators). Yep, *every* death -- none of this taking the cops or EMT word on anything when it comes to those 60 year-olds with chest pain and witnessed death.

You *must* go to the scene in *all* cases. Oh, and it gets better -- they want you to do your rape kit at the scene!

It is a "best practice" that a lay Coroner overrule the pathologist regarding taking jurisdiction.

It is a "best practice" that a lay Coroner overrule the pathologist regarding cause and manner of death.

It is a "best practice" that *all* MVAs be autopsied, no matter how much a waste of time and resources it (they just won't give up on that, will they?)

All identifying marks must be photographed, even when identification is not an issue.

Fingerprints must be taken on *all* cases.

Confirmatory "scientific" identification must be done on *all* cases, no matter whether or not it is needed -- there is clearly no room for individual professional judgment when it comes to SWGMDI!

A Forensic Pathologist personally must document *all* physical characteristics -- how much is "all."

Your investigator must be certified by the IAI to take photographs!! The AMBDI isn't good enough any more. (As if the IAI should dictate what we do!)

A cast must be made by a board certified forensic odontologist of every possible bite mark.

The forensic pathologist must do every evisceration himself or herself!!! Just think of the fun you are going to have on the stand with that one.

A certified forensic photographer must photograph every organ!!!

The spinal cord must be removed on every case -- even those gunshot wounds to the head and myocardial infarctions. Once again, screw that stupid professional judgment stuff. Washington knows what you need to do!

In all cases of neck trauma -- even those MVAs that we are all now autopsying -- we must remove the neck en bloc! **Every case.**

All wound pathways must be photographed, whether its practical or not.

All pathologists must have access to postmortem MRI.

All children, even natural deaths, must have full body x-rays.

Fingernails must be obtained and saved. Good grief.

Bowel contents will be saved in all oral drug deaths -- yeah, that's *always* useful.

Screw the protocol at your tox lab, the SWGMDI knows what's best. You should centrifuge your samples whether your tox lab wants it that way or not.

Histology should be done on all cases, regardless of whether or not it has any relevance to cause and manner of death.

You must store all tissue blocks on all those useless cases in perpetuity. And it goes on. NAME should not endorse this.

Response:

Commenter #29

I object to the "Best Practices" sections of all sections. My edit would be to remove all of them. The reasons include:

1. In court they will be misused to discredit competent and qualified forensic pathologists using reasonable judgment on specific cases. The net result will be a miscarriage of justice.
2. Most, if not all of the "best practices" are not, in my opinion, best practices at all. Part of best practices should be evaluation of the validity and need of any particular effort related to an autopsy or death investigation in general. Cost benefit analysis is a Best Practice in my book, but the proposed best practices seem to ignore the cost of time, the cost of materials and the finite limit of man and woman staffing power available to essentially serve the potential needs or whims of the criminal and civil justice system.
3. Much is lost in trying to force the most powerful integrative tool available, an informed brain, into a cookbook approach the complex problem of death investigation and analysis. These standards are an insult to the vast majority of excellent forensic pathologist I know serve in the USA.

Response:

Commenter #30

In brief; I would support this document were all "best practices" to be removed. Most of these are beyond incredible. 236-all forensic autopsies completed within 24 hours of notification (we have to deal with family objections in this county).

Response:

Line 287: All identifying features photographed (what do you mean by "all?").

Response:
Line 288: _palm_ prints on all decedents?! I have never printed palms, ever. I could go on.
Response:
Line 418: Implies that the rape kit must be taken at the scene - that is crazy talk.
Response:
Line 617: Mandates removal of the spinal cord in every autopsy. Get my drift? Eliminate that stuff. Defer to NAME with respect to standards.
Response:

Commenter #31
I have grave concerns about the "best practices" portions of these standards, because many are not going to be able to achieve. Lines 154-155: My county is not particularly large, however, over 5000 people die here each year. I would be reviewing approximately 100 death certificates per week beyond my other duties. There is no definition of what type of follow up needs to be done if any after reviewing the death certificates. If follow up ensues, how am I going to afford to hire the extra staffing needed to make the necessary phone calls and request additional data on these death certificates and is there a time frame in which this needs accomplished. My health department checks death certificates and notifies us of any that appear questionable. If this best practice is instituted, their review would not be deemed adequate.
Response:
Lines 827-828: Storing evidence in an electronically monitored site would require a large expenditure of monies during a tight budget period and would be cost prohibitive. This would require additional staffing to ensure that a person was available to monitor the electronics 24/7. Although we have investigators to cover duties 24/7, they are called out to scenes during afternoons and nights and leave the building vacant.
Response:
Lines 799-801: There are not enough qualified anthropologists available in the US to allow all forensic offices to have on-site personnel in these specialties to assist with cases that occur only sporadically. This is not a practical answer to best practices. Having access to such persons on an as-needed basis is realistic and generally achievable. How do you define "advanced medical imaging"? Is this simply digital x-ray capabilities or are you suggesting that we need to have a CT scanner and MRI available at each forensic office which then requires more stringent inspections and facility specifications than we currently are held to.
Response:
Line 776: Indefinite storage of any specimen is onerous for most facilities. Storage in a true "climate controlled environment" is cost prohibitive particularly in a time when we are all on tight budget constraints due to a poor economy.
Response:
Lines 750-751: What value is there in storing small bowel contents in suspected oral ingestions? There is no standard available to compare values obtained from such samples.The bottom line is that the best practices will be construed as standards when put to the test. The best practices that you have listed here are all fraught with issues for most of the offices that exist due to budgets, personnel and building constraints. Failure to adhere to best practices will erode the value of qualified and diligent forensic pathologists and the decisions and choices we must make on a daily basis to manage our cases. I believe that most forensic pathologists wish to do the best possible job that they can do, but these best practices are beyond the reach of most if not all facilities. Including these is a set up for failure for the profession.
Response:

Commenter #32
My comments concern the draft as a whole. The vast majority of this document is written with an obvious lack of understanding for the variations between offices investigating deaths in this country. Although a degree of uniformity from coast to coast and some type of standards are reasonable expectations, there is no apparent appreciation for the vastly different economic and political differences from one office to the next. It is unfair and unreasonable to expect a one man shop to be able to perform at the same capacity and under the exact same day-to-day guidelines as a large, metropolitan ME office with 8 times

as many forensic pathologists and death investigators. Quality should never be compromised but how one achieves that same level of quality may differ dramatically. There is no "best practice" in our profession because every case is completely different than the next. It would seem the most reasonable approach to developing appropriate autopsy standards would be to mandate individuals performing autopsies be appropriately trained (ie. completion of a forensic pathology fellowship program) and then trust in their well-trained, experienced judgment to do the right thing for each case. The reality though, even with that scenario, is that there is far too much work and far too few appropriately trained forensic pathologists in this country to handle the demand. We need to accept the limitations of work load, staffing and budgets and create standards that allow enough wiggle room for good doctors to continue performing good work.

Response:

Commenter #33

While listing mandates you need to include that the sponsoring county or state is required to provide the necessary staff to allow best practices to be performed. Short of that, most offices will have to shut down in June when they have exceeded the case load requirements.

Those same governing bodies will need to be able to testify in court as to why they failed the people they serve when our testimony is contested because we did not follow the guidelines for best practice for lack of facility and staffing support to handle the demand of our caseloads.

This document should not supersede the NAME Standards. The NAME Standards should be renamed the NAME Guidelines.

Response:

Commenter #34

Line 157: The standards proposed for autopsy cases may reflect the writers opinions, and by putting these in writing, it will make offices who disagree (or don't have the resources to do them) look very bad. For example, a workplace death involving a healthy young man whose harness slips while on a high-up construction site and has obvious lethal blunt force injury externally. What does doing an autopsy add to that investigation? Likewise for a prisoner who hangs themselves on videotape in their one-person cell. While most of the standards are reasonable, some are not in my opinion. Additionally the best practice of autopsying all suicide victims is similarly un-necessary, and does not reflect practice in many, many offices.

Response:

Line 276: Starting around line 276 Identification standards are overly onerous, costly, and likely not necessary in many cases falling under ME/C jurisdiction.

Response:

Line 396: Having a pathologist or investigator attend every death scene is not practical in large jurisdictions with a central office and a huge land mass to cover. Does a pathologist or investigator from Anchorage need to go to Barrow to assess rigor and livor in the case of a 69-year-old man with a history of CABG found dead in his secure home?

Response:

Line 590: Few offices have the pathologists eviscerate their own cases. To do so is a huge waste of resources and time, as it limits the number of cases that can be done per day. This line eliminates the discretion pathologists use to do their own evisceration in cases that may need it, while allowing qualified autopsy techs to do the evisceration in routine cases such as drug/alcohol deaths in young, otherwise healthy persons. This best practice line could be used against a pathologist in court. Likewise, the best practice of photographing every organ in every case is absurd - gross photographs of normal organs would collectively take many, many hours per year with very little benefit

Response:

Line 617: Having a neuropathologist available (and paying them) is a resource all but the largest offices do not have.

Response:

Line 649: En bloc removal of the neck is a procedure rarely taught, let alone done. This best practice suggestion does not reflect real world practice in most offices.
Response:
Line 706: Only a few offices in North America have access to CT or MRI. This best practice recommendation will make many offices look bad because they're not Baltimore, Albuquerque, Toronto, or Dover.
Response:
Line 748: This best practice line is somewhat contradictory, if one's office does not do autopsies in all MVAs.
Response:
Line 752: This line is very vague and does little good in the real world. What testing should be done? By whom? Must we go back to all such cases every few years and submit specimens for new tests? Who pays for these often-expensive genetic screening tests?
Response:
Overall, I cannot endorse this draft as is. Canada is influenced and impacted by US standards, and I think the US and Canada effectively form a single forensic pathology community. I hope there are major revisions, to allow far more jurisdictional variation due to staffing, funding, and desires of the local community.
Response:

Commenter #35
Lines 104-106: A board certified forensic pathologist should not be required to review all of the circumstances for every reported death. In many jurisdictions, a coroner or investigator might do this.
Response:
Line 115: When you say "investigate" does that mean just getting information about these cases is enough, or do bodies have to be brought in and autopsies performed on every one?
Response:
Lines 122-123: Do deaths in custody include people who have monitoring ankle bracelets but die at home/outside of prison (this has actually been the subject of some debate at our office – I am curious as to your opinion)?
Response:
Lines 127-129: Do all persons who are to be cremated need to be viewed/reported? I think different jurisdictions/states have specific laws about this. e.g. in Massachusetts, a medical examiner/investigator must view each body; in NYC reporting them to the office is enough.
Response:
Lines 130-131: Does every person who dies of mesothelioma need to be reported/brought it? How do you enforce this?
Response:
Lines 138-139: Is there a time after surgery it is ok to let people go? Or does every person who ever had surgery in the past need to be always brought in?
Response:
Lines 152-153: Do the coroners in our adjacent jurisdiction have to call us every time someone dies?
Response:
Lines 154-155: Will there be funding provided by the federal government so we can hire an additional 2-3 people to do this full time? Because our county can't afford this.
Response:
Lines 194-195 and 202-204: If a person has been brought in to the hospital and all of their injuries have been documented via imaging, etc and a police investigation has shown nothing out of the ordinary, does this person still need to be brought in? Again, is the federal government going to pay for this? What difference will it make in terms of the cause/manner of death? And why does it say in lines.
Response:
Lines 218-220: Does this mean that a hospital pathologist who has performed thousands of forensic autopsies working for a medical examiner or coroner’s office can now no longer perform autopsies?
Response:

Lines 227-228 and 236-237: Does this mean that a body that comes in with body lice and bedbugs can't be sprayed and left overnight in the cooler before an autopsy is performed? What if there are too many cases to perform all of them within 24 or 48 hours? Will the federal government send someone to help perform autopsies, including technicians, so that they can all be performed in time?
Response:
Lines 256-258: What happens in coroner jurisdictions?
Response:
Lines 283-284: Will there be training available for offices who do not currently fingerprint all decedents? Who will pay for this training? Who will pay for the supplies and storage of the fingerprint cards? Will the fingerprints be entered in a database? Is this even legal? I know that an office I worked in ran into trouble because the police were fingerprinting cases for us (because we had neither the manpower, expertise or supplies) and the police discovered it was technically illegal for them to fingerprint decedents if there was not a specific reason (e.g. for identification purposes).
Response:
Line 287: Do we have to really photograph every scar and tattoo? That could take an hour in itself in certain cases and seems unnecessary if the person has been positively identified.
Response:
Lines 292-293: Scene and circumstances can be considered scientific, they just happen to have a higher rate of error than, say, fingerprints. But even fingerprints, radiography, and odontology have a rate of error which are not best described as "unequivocal" (as the term "scientific identification" is defined in lines 923-924). They are simply more reliable than certain other methods of identification.
Response:
Lines 307-308: How should this be done in jurisdictions where fluoroscopic imaging is employed?
Response:
Lines 309-310: Can a regular dentist be employed, or does it have to be a forensic odontologist? What should happen in jurisdictions where there is no forensic odontologist is available? Should those bodies be shipped to another jurisdiction? Or perhaps a forensic odontologist should be flown in at the county's expense?
Response:
Line 320: How should the body be disposed of if there is nowhere available to bury them? Should the body be held in the morgue cooler indefinitely? Should additional coolers be leased or built for this purpose? Will the federal government pay for this? If there is a place to bury the decedent, who should pay for them to be buried? The county? The state? The federal government?
Response:
Line 346: What should be done in cases where the clothing is not available? If the police have the clothing already in evidence, is it sufficient for the police lab to document such things? What if the police will not give you the clothing for review?
Response:
Line 351: This may not be best managed by the pathologist, but by law enforcement in conjunction with the medicolegal office.
Response:
Lines 350, 357: What if there is no secure server to store such images? What if there is no ability to confirm that the image has not been altered?
Response:
Lines 355-356: Does this include being present while the body is measured and weighed? Often bodies come in overnight – should a forensic pathologist be available in the office 24-7 for each body that is brought in the door?
Response:
Line 382: Is it unacceptable to ask a technician to write the information down for you when your gloves are covered in blood? If there are 2 sets of handwriting on your autopsy diagram, does this call into question whether you "personally documented" the information?
Response:
Lines 396-397: Is this every death? A forensic pathologist has to go to every death? Even a decedent who was on hospice, surrounded by family on his deathbed, with EMS and the police present, with a

physician willing to sign the death certificate? Does the forensic pathologist need to be there? What is the purpose of being at such a scene? Are we concerned about criminality? Who is paying for this?
Response:
Lines 418-419: What if the scene is not secured? What if the scene is in public view? What if one does not have an on-the-go rape kit? What if family and friends are there – are you really going to start putting swabs in a decedent's vagina? What if the vagina has been swabbed at the scene by someone else – will defense attorneys point out this manipulation could be confused with an injury thought to be caused by sexual assault? What will you do with swabs taken at the scene – they need to be dried before being packaged to avoid degradation of the DNA. Will you bring a hairdryer to the scene to dry the swabs before you package them?
Response:
Line 457: What about very close up photographs? Is it acceptable to leave the label out if it will compromise the photograph being taken?
Response:
Lines 460-481: How does one get IAI certification? If one does not have an IAI certified photographer, is it best to just not take photographs at all? If the police come to take photographs, do you insist that their photographer be IAI certified, otherwise ban them from taking photographs as well?
Response:
Lines 506-507: Who should the gunshot residue evidence be given to? What if the local authorities do not have the ability to do gunshot residue analysis – should you collect it anyway to sit on a shelf in your office forever? Is there a large warehouse somewhere the federal government is making available for the storage of such things?
Response:
Lines 555-559: What if there is no forensic odontologist or tool mark criminalist available? Even if there is, where can one find time and space to allow a tool mark criminalist to sit and make a cast of the bite mark, however long that will take? What if it delays the autopsy by more than 24 hours – a best practice defeated by a best practice?
Response:
Lines 590-592: What about jurisdictions where the technicians routinely eviscerate while the forensic pathologist observes and directs? If you are closely observing and directing the technician, won't your knowledge of what is going on in the body be just as keen?
Response:
Line 593: Are photographs of every normal organ really necessary? Where will all of the terabytes of data created by this requirement be stored? Is the federal government running a server somewhere?
Response:
Line 617: Why would the spinal cord be examined if there is no suspected injury or abnormality? The spinal cord is so rarely abnormal even when you think it should be. Has the time and difficulty associated with the removal of the spinal cord been considered?
Response:
Lines 618-628: What if there is no neuropathologist available? What about formal neuropathology training makes you more able to described traumatic brain injury? In cases of tumors, a hospital neuropathologist could be a help, however, most hospital neuropathologist rarely seen brain trauma. And forensic neuropathologists are a rare breed indeed – will a formal directory of forensic neuropathologists be created and maintained for these cases? Since the examination is supposed to be "with" the neuropathologist, is shipping a brain to a neuropathologist unacceptable? Do you have to go as well, or do you have to force the neuropathologist to come to you?
Response:
Lines 649-650: Is this in adults or just babies? Is this because of that one paper Matches published? You do realize that papers since have shown nerve root hemorrhages in babies who were not shaken.
Response:
Lines 669-670: What is a photograph of a wound pathway? Is that a live action film where the camera is like the bullet traveling through the body? Or just a photo every 2 mm so a flip book can be made? What purpose does that serve?
Response:

Lines 706-708: Where will we get the funds for a CT scanner? How could we convince the hospital next door to allow us to put dead bodied in their CT scanner – particularly decomposed ones? Who is paying for this? Should we ship our bodies to Dover AFB for scanning? Or the handful of other offices with CT scanners? What if this delays the autopsy by more than 24 hours?
Response:
Line 735: What if the lab does not have space to save specimens for 1 year? Why 1 year? What not 6 months? Why not 3 years? What is the logic here?
Response:
Lines 740-742: Does this mean that technicians and students cannot draw vitreous or femoral blood while the forensic pathologist is working on the body diagram?
Response:
Line 745: Again, space for storage. What if the decedent is a victim of a crime and the police want the fingernails? Now the forensic pathologist is failing to meet best practice standards because the police need the fingernails to find a perpetrator's DNA?
Response:
Lines 750-751: If a compound is not in the decedent's blood, what does it matter if it is in the small bowel? They were intoxicated hours before they died – good to know.
Response:
Lines 752-754: Who is paying for this? Do you have any idea how much this costs?! One genetic testing send out and we might have to fire an investigator! This is ridiculous!
Response:
Lines 756,776: CAP requires the retention of glass slides and paraffin blocks for 10 years – why do forensic pathologists need to store them indefinitely?
Response:
Lines 774-775: Why is it necessary to perform histology on cases where it does not contribute to the cause and manner of death, or in some other way help identify what something is? This seems like a waste of time and money.
Response:
Line 792: Again, does a run of the mill dentist suffice, or do they need to have special forensic training?
Response:
Lines 799-801: So few offices have this – you are making it impossible to meet the best practices. How does that serve anyone except defense lawyers?
Response:
Lines 827-828: Does this mean someone has to sit full time in front of the storage closet? You do realize his sounds silly.
Response:
Lines 867-869: Should this appear on homicides too? For the defense lawyers?
Response:

Commenter #36
Lines 154 and 155: All death certificates filed in the jurisdiction are reviewed by the Chief Medicolegal Officer or their designee. Disagree. The best practice would be to educate the healthcare community and vital statistics agencies in the reportable types of deaths, not to serve as a safety net for all death certificates in the jurisdiction. This would be onerous in large jurisdictions (in Harris County for example we investigate approximately 10-12,000 deaths a year, but there are in total approximately 25,000 deaths in the county every year - reviewing all these certificates is in the purvue of vital statistics, not the ME.) This would be an activity of diminishing return.
Response:
Line 288: Suggests that palm prints be taken on all cases within the "custody" of the medicolegal office. I'd be hard pressed to come up with some potential usefulness of palm prints. Fingerprints, fine. But palm prints? On everybody? I realize this is listed as a "best practice" but that should mean there's some rational reason for doing this. What is that?
Response:

Line 419: Performs collection of biological evidence at the scene of death prior to transporting the body. This is not supported by evidence. It may be true in general. However, in many cases, trace (and DNA) evidence collection (including rape kits) is best accomplished after transporting the body (in a secure, sealed enclosure) to the morgue where such evidence can be collected under controlled conditions, with optimal lighting and without interference by adverse weather, public scrutiny, tight confines, etc. We are currently evaluating whether evidence may or may not be lost by transportation, but that's as yet unanswered, and will be difficult to answer conclusively.
Response:
Lines 558 and 559: A tool mark criminalist, forensic odontologist or forensic pathologist shall make a cast exemplar of the pattern injury for documentation, preservation and possible comparison. We certainly agree with this for many injuries, but absolutely not in all. For example...patterned injuries associated with suicidal ligature hangings, contact gunshots, industrial accidents where the implement causing the injury is clearly identified (and may have been examined with the body, at the scene, by the pathologist). Casting may be warranted for patterned injuries if there's a question. But in many cases, there is no question.
Response:
Line 591: et al, In many cases direct examination of intestinal contents is of no utility (eg, homicidal gunshot wounds, car crashes and so forth). Gastric I can see...but intestines? In the same section there is an suggestion that every dissected organ system should be photographed. This is listed as a "best practice." But I can't imagine the rationale for photographing a normal spleen for example, in a suicidal or homicidal gunshot wound of the head. There is no evidence to support that kind of excess.
Response:
Line 621 proposes having a neuropathologist examine the brain in all in-custody deaths. We accept jurisdiction in ALL in custody deaths, including deaths that are clearly natural, and where the decedent has been hospitalized for a prolonged period with heart disease, metastatic cancer, complications of cirrhosis, etc. No need for formal neuropathology consult on ALL these cases. Maybe on in-custody deaths suspected of being non-natural.
Response:
Lines 649-650: In cases of suspected neck trauma, the forensic pathologist shall perform an en-bloc removal and examination of the cervical spine and nerve roots. In many cases of car crashes for example, or pedestrian fatalities, or folks who jump from buildings, the AO joint, or AA joint are so widely separated that this extensive dissection is just not warranted. All questions that could possibly come up in civil/criminal litigation can be answered without disfiguring the body by removing the C-spine.
Response:
Line 698: standard" starting on line 698 suggests that radiographs be done on all children under the age of 5. In many cases this is not warranted. For example, motor vehicle crashes, where there is no suspicion of abuse; witnessed community pool drownings, etc. This is again an activity of diminishing return. Certainly not warranted as a "standard." In general, many of the "best practices" seem to be simply statements of what could be done, if resources were unlimited. They do not however, seem to be justified or warranted, even if resources were unlimited. I agree with most of the items listed as "standards."
Response:

Commenter #37
As a board-certified, practicing forensic pathologist (FP), I object to guidelines/standards being drafted by non board-certified FP's. When best practices/standards are established by CAP, they are written by pathologists and not the technologists.Non-FP's, no matter their background and intention do not have the same education, training and experience as practicing FP's.Paralegals are not permitted to practice law-neither should non FP's practice FP.
Response:

Commenter #38
To list every disagreement with the draft as it stands would require more space and time than I am able to commit.

I strongly object to the very idea of having preemptive autopsy standards drafted by this working group, the majority of whom are not physicians, and those who are only representing a tiny fraction of the forensic pathology community. Standards are already in place in the form of the NAME Forensic Autopsy Performance Standards, and there is no justification for attempting to supplant them with these. The fact that the current standards mirror those from NAME in their current form is not comforting, as that may not always be the case in the future. The NAME standards were formed by practicing forensic pathologists, painstakingly validated, and discussed, debated, and approved by hundreds of forensic pathologists in an open forum. They are periodically re-evaluated in a similar manner. They have far greater legitimacy than the SWG standards can ever hope to achieve.

Additionally, the "best practices" in this document are often nothing of the sort. The true best practice in forensic pathology and in medicine in general is to consider the cost and time involved in a procedure as well as the likelihood of any benefit to be derived from it. Many of these practices fail on both accounts, and constitute the practice of "shotgunning" (utilizing every conceivable procedure or practice that might yield any information at all, regardless of it's costs or demonstrated utility). This is considered inappropriate in clinical practice, and is equally so in our sphere. Some of the best practices are frankly inadvisable and constitute poor practice in my opinion, and anyone who has ever had dealings with the legal system must recognize that practitioners will indeed be held to the "best practices" in this document, not to the standards or guidelines.

Finally, some of the standards and best practices are in opposition to local and state laws. Local statutes should prevail rather than a "one size fits all" federal mandate. The Preface of the NAME Standards has a statement recognizing this local variation and deferring the standards in such conflicting cases. I don't see that type of statement in this document. If I have missed it, I apologize. In any case, attempts to re-invent this wheel should be stopped, and the SWG should simply defer to the expertise of NAME when it comes to forensic autopsy standards.

Response:

Commenter # [39]

I agree with the position of the National Association of Medical Examiners (NAME) that there should be one set of standards, and NAME (the preeminent organization representing the forensic pathology profession) is the organization that should produce, promulgate and (as needed) change them. I also strongly feel that professional standards practice must be developed by the forensic pathology profession. Standards should not be externally imposed on forensic pathologists by those not actually working in the field.

Response:

My biggest problem with this document as it exists currently concerns so-called "Best Practices." "Best Practices" (although defined in the document as dependent upon resources and not "standards" per se) may well create potential legal jeopardy if they are nevertheless NOT followed. In court, they can be held up and misrepresented as being minimum standards. I think the document needs to further clarify (in line 875, but also in line 68) that these are "ideal" practices that may not be possible due to resource limitations, and if they are not followed the death investigation is not necessarily in any way flawed.

Response:

Parenthetically, even some of the "Standards" are unrealistic for some smaller jurisdictions. For example, see line 227: "95% of forensic autopsies shall be completed within 48 hours of the medicolegal death investigation office being notified of the death." Our office would fail on a number of cases where we may become "notified of" a death at noon or 1 p.m. on a Friday, but where we do not perform the actual autopsy until 9 a.m. on the following Monday morning. We simply do not have the resources to bring both the forensic pathologist and ancillary autopsy staff in on the weekend for routine casework.

Response:

Again, reiterating the consideration that so-called "best practices" may become misrepresented as "minimum standards" (and juries are simply not going to know the difference) a statement such as "100%

of forensic autopsies shall be completed within 24 hours of the medicolegal death investigation office being notified of the death" is obviously problematic.
Response:
Line 766 is sub-optimal in that a more complete examination of the whole range of body tissues should be performed on SUIDI cases.
Response:

Commenter # [40]
I would eliminate all of the best practices section. This will only cause problems in court. Not all offices have access to professional photographers, MRI, etc.
Response:

Commenter # [41]
The definition for "Best Practices" should either be amended or expanded with easily understood caveats. It will only permit the interpretation of "best practice" by attorneys and public where they will be able to contextualize the confusion of properly metered discretion as a failure to perform.
Response:
Line 92: "...interested parties to include families of the deceased."Line 94: "to include but not limited to"
Response:
Line 97: "While maintaining statutory obligations and that criminal malfeasance..."
Response:
Line 103: "...interested parties to include families of the deceased.
Response:
Line 105: "to include but not limited to"
Response:
Lines 138/139: Strike in its entirety...these are civil concerns and will flood the offices with a public wanting free autopsies for perceived medical misadventure
Response:
Line 176: "...by apparent or suspected criminal violence
Response:
Line 195: "...document lethal injuries and/or..."
Response:
Line 203: "injury (where the injury is not readily apparent on external examination), including motor..."
Response:
Lines 227/228 and 236/237: These temporal relationships also depend on the Organ Procurement Organizations and Tissue Banks in an area as well the number of cases an office releases to these organizations.
Response:
Line 276: "...identification, where statutorily permitted."
Response:
Line 536: "100% burned, using rules of nines."
Response:
Line 591: "...contents of the upper gastrointestinal tract..."
Response:
Lines 616 through 629: Strike entirely...cannot be done as either too expensive, redundant, or temporally contraindicated. If it cannot be stricken, at least force the neuropathologist to be board-certified in neuropathology and forensics
Response:
Line 649-650: Strike...funeral homes will complain and cause political upheaval as they pass the cost of restructuring the decedent to the family.
Response:
Line 745: "...shall be saved, where appropriate."
Response:
Line 751: Strike...where is the data on stool drug levels and what would you do with it anyway

Response:
Line 752-755: Strike...cost prohibitive and infinite in scope. There is no known upper limit for the number of genetic disorders which exist.
Response:
Lines 766-767: Skeletal muscle from where and for what purpose?
Response:
All told, this is another example of an organization attempting to devise rules of behavior with no politician, law-maker, or governmental correlative or search for funding to support the compulsory changes fomented here. The ABP did it with time-restricted certificates and now these standards and best practices are being put forth to which we will all be held in court and in deposition. When we cannot agree that we employ best practices, they will ask, "Doctor, are you telling me you do not employ best practices?" to which we will try to tell them how you all are defining best practices to which they will answer "It is a yes or no question, are you or are you not using best practices"...which will create all kinds of problem, the responsibility of which will likely be completely denied by SWIGMDI members as they have done all of this in a vacuum without the promise of Federal, State, or Local support for these ideals.Soon we will all be substandard in the eyes of the court and public because of the impunity with which these "Best practices" were created. Things like this must go hand in hand with the machinations of law-makers to ensure financial support for the changes being suggested. If not, the rules mean nothing, everyone will be embarrassed, the guilty will go free, innocents remain imprisoned, and there will be no justice for the deceased.
Response:

Commenter # 42
No comments. Supports draft document.
Response:

Commenter # 43
Remove all "Best Practices" in all sections as they can be defined by one or more of the following: impractical, costly, time consuming, storage/space problem, require more staffing, potentially disturb/corrupt evidence, and preclude judgment of forensic pathologist. Most importantly, the forensic pathologist will be constantly challenged in court for not adhering to the "Best Practices". Examples: Collection of sexual assault kit at the scene: In a fully clothed individual with layers, or adverse weather conditions rain/snow? -where manipulation and exposure in an uncontrolled environment may disturb or cause the loss of other on-body evidence?
Response:
100% of autopsies completed within 24 hours: Frozen bodies? Body comes in on Saturday autopsies not performed on Sunday? Specifics of chemically hazardous or infectious disease cases, that may need special handling and set-up cases, not immediately known? Waiting for call back from whomever (doctor, family...) for additional relevant history?
Response:
Confirmatory scientific ID on all decedents: Despite the fact that they've been identified by reliable and cheaper means? Costly and an issue of resources to do this.
Response:
Autopsies on every MVA with prolonged hospitalization, often surgical intervention, and clinical record documentation when there's nothing new to be gleaned.
Response:
Take spinal cord in all autopsies: Including the persons with recent chest pain after exertion, no acute or chronic neurological problems, no other relevant history, and thrombosed coronary artery with AMI at autopsy?
Response:
Femoral blood, vitreous fluid, and urine sampling, submission, and testing can be very revealing diagnostically and for cause of death determination in the case with no indication or a need for an autopsy, is otherwise not suspicious, or the family otherwise does not want an autopsy.
Response:

All ancillary services in house? In the perfect well-funded world!

Commenter # 44
Will follow up with line numbers. Unsure of the necessity to accept jurisdiction in all cremations- might be a best practice. CME reviewing all death certificates in a jurisdiction is cumbersome, impractical and not necessary- not a best practice in my opinion. Better training for reporting can address the issue of missed cases as well as rote review of all death certificates. In a reasonable sized jurisdiction like mine this would involve reading 15000 certificates. As it is we review about 40-45% of deaths. This feels more than adequate.Requiring autopsy in all the cases mentioned is not in keeping with my experience and excepting certain types of death mentioned has not noticeably compromised my ability to conduct an adequate investigation. This section also would potentially compromise colleagues in New York who are bound to honor religious objections in cases that many of would prefer to autopsy.
Response:
Commenter # 45
The documents outline practices that seem to reflect the personal opinion of the authors and/or practices of a particular office without any substantive scientific literature to support what they have decided are standards, guidelines and best practices. Issuing this document seems contradict aspects of already approved documents by this group.
Response:

Commenter # 46
This document, like many others by this group is very thoughtful and comprehensive. However, it flies in the face of reality. With an expected public death investigation system autopsy rate of 1 per thousand or 350,000 per year in the US, and at most 700 qualified forensic pathologists nationwide, it would appear unrealistic to limit the number of exams to half the demand (500 per FP) without first addressing the critical shortage of physician specialists.
Response:

Commenter # 47
To myself this makes perfect sense and long over do. I think it is a vital piece of information.
Response:

Commenter # 48
Lines 127-129: The requirement to review the death certificate on every cremated case would be difficult to fulfill without additional staffing. There are approximately 70,000 deaths per year in Los Angeles County. Assuming a 40% cremation rate, the Coroner would be required to review about 28,000 death certificates per year (although we do already review 8,000 of these in the normal course of business).
Response:
Lines 227-228: There is often a delay between notification of the Coroner and the time that the decedent actually arrives at the Coroner's office. Many of these delays are not within the Coroner's control. For example, the body may be delayed at the hospital because of organ procurement or because radioisotopes have been administered to verify brain death. In some cases, investigation may reveal relevant additional information after the Coroner has been notified.
Response:

Commenter # 49
It is really good and except for what I say below I do endorse everything else as is. I do not see in any reasonable spot where the ME is asked to document the perforations in clothing of pen/perf injuries. Besides lining up holes for gunshots and stabs (to make sure that victims real position is documented) there must be mention of at least looking for gunpowder residues on clothing of "indeterminate" entrance wounds on skin. Might also explain shored exit wounds under tight leather belt, etc.
Response:
You probably have it in the document somewhere, but for best practice or even guidelines it should be mentioned in terms of injury description along with external and internal path(s)

Response:

Commenter # 50
Line 192: The forensic pathology and/or the Chief Medicolegal Officer. (There have been many times when our forensic pathologist didn't think it was necessary to do an autopsy and it was ordered anyway and it was determined that was a good decision?
Response:
Line 223: in conjunction with the Chief Mediolegal Officer. In many jurisdictions the cost of the additional testing is paid for by the CMO. They need to make these decisions together.
Response:
Line 283: The FP and/or the Chief Medicolegal Office or their designee.
Response:
Line 310: Again in consultation with the FP and/or the CMO.
Response:
Line 315: Again the FP and/or the CMO. In many jurisdictions the FP doesn't have access to NaMus as they are not the CMO.
Response:
Line 418: Best practice may be having a Sexual Assault Nurse Examiner who is Board Certified perform the sexual assault exam and colposcope exam. They are the ones with the most experience in regards to obtaining evidence from sexual assault victims even more so than an FP or CMO.
Response:

Commenter # 51
The SWG referenced by the NAS report - recommendation (c) page 267 refers to a SWG for forensic pathology AND medico legal death investigation not a SWG for death investigation with forensic pathology as a subsection. The latter having been created implies that standards may be set by persons other than forensic pathologists. The NAS report recognized the difference between these two components of the several involved in death investigation (toxicology, forensic science etc.) Standards, best practices and guidelines for a medical subspecialty should be set by medical practitioners of that subspecialty and not by anyone else or by any other group. Thus the document is garbled with a mixture of investigative components (not entirely medical) and medical components - the autopsy. If the SWG wishes to opine on the autopsy it should adopt the NAME standards as set by the practitioners of the medical specialty of forensic pathology. The SOMDI standards were adopted and the NAME standards should be adopted. This is a confusing document and should not present itself as the standard for the practice of medicine. Thank you for the opportunity to comment.
Response:

Commenter # 52
It is a very optimal piece for comprehensive recommendations for a slandered practice as a minimum requirements for MDI, besides, very realistic guidelines and best practices as an objective plan.
Response:
Yet again, the independence of the forensic pathologist is one of the major problems facing that profession, I believe it should be a stander with clear guidelines. Though the dependence is not only from the political point of view which means the power of the authorities or the media to interfere or peruse a pressure that impacts the expert opinion. Independence means also, on the first place, an efficient personnel's whom are capable for development and having a vision for the future. On the second place, to have financial facilities that allow free decision making in the development and improving the work standards into best practice.
Response:
Line 708: Under the best practice title, we can mention the Virtangio as a very promising postmortem diagnostic tool, appreciating it`s innovative role and inspiring for a real best practice.
Response:
Line 748: I wonder why the forensic pathologist shall "only" submit specimens for toxicology from bodies that have had " Autopsy"!! My point is, the aim for MDI is the objective diagnosis for the cause and manner of death and that is why the standards had been established. The roles are not the holly item

but the goal. In many countries, for example the one I`m working in; there might be only the external examination done by the forensic pathologist with aspiration of peripheral blood and urine, and in many cases, it gave a positive result.
Response:
Lines 807-814: The standards for content of toxicology laboratory report, the toxicology report shall contain the.....I suggest that it would be of value to record the postmortem interval as it might makes sense for the forensic toxicologist considering for example postmortem redistribution or the impact of decomposition and autolysis, and so...
Response:
This is very strong and comprehensive work. Best Regards
Response:

Commenter # 53
The Scientific Working Group for Medicolegal Death Investigation (SWGMDI) draft document "PRC-12 Autopsy Performance Criteria: Standards, Guidelines and Best Practices" has been brought to the attention of our organization, the Association of Pathology Chairs (APC). Having reviewed this document, the APC respectfully submits this letter in response. The APC is already familiar with the Forensic Autopsy Performance Standards crafted by the National Association of Medical Examiners (NAME), publicly available at www.thename.org. These standards were first approved by the membership of NAME in 2005, and have gone through multiple revisions. NAME has a rigorous method of assessing and vetting proposed standards changes or amendments, which ultimately must be approved by the majority of members in attendance at a NAME business meeting before being adopted. Thus, the NAME standards are the product of the very practitioners who seek to uphold and disseminate the standards. It is the opinion of the APC that only one set of forensic autopsy performance standards should exist, and these should be the standards developed and distributed by NAME. The SWGMDI Autopsy Performance Criteria were developed by a relatively small committee, of which several members were not forensic pathologists. This set of standards, if published, would be regarded as an outside dictate to the discipline of forensic pathology and infringement upon the practice of medicine. The performance of forensic autopsies is the practice of medicine. The standards to which forensic autopsies are performed, therefore, should be the purview of the qualified medical practitioners who perform such autopsies. The publication of the SWGMDI forensic autopsy standards would introduce unnecessary redundancy into forensic pathology and death investigation. Two published sets of forensic autopsy performance standards would create unacceptable ambiguity in the fields of forensic pathology and death investigation. Furthermore, the SWGMDI standards outline three "levels" of practice (standards, guidelines, and best practices). While the definitions of these levels are made clear in the document, the APC is concerned that the "best practices" category would be abused, particularly in the courtroom. The SWG defines these "best practices" as "the most rigorous level of performance based on current knowledge without resource limitations." Recognizing that all practices of medicine (particularly forensic pathology) work on limited resources, it is a given that many of these best practices will not be achieved. However, these "best practices" could certainly be used to criticize a forensic pathologist's performance during a trial or in the media, regardless of whether that pathologist adequately performs under accepted standards. In conclusion, the APC will not endorse forensic autopsy standards that are not the product of NAME. The APC strongly encourages the SWGMDI to endorse the NAME standards as the leading set of forensic autopsy standards in the field and recognize that the many SWGMDI members who are also NAME members are welcome to employ NAME's rigorous and democratic process for changing the NAME standards as needed.

Please contact us through the APC office at 301-634-7408, if we can provide further information. Thank you for your kind consideration. Ann Thor, MD, President John Tomaszewski, MD, Advocacy Committee Chair Association of Pathology Chairs
Response:

Commenter # 54
Line 59 - 61: This is a good definition for Forensic Pathologist. However, this document should consider containing a definition for those Medical Doctors who are currently performing forensic pathology services and are not board certified in forensic pathology by the ABP. As you know, there are positions called forensic pathologist where the individual is a physician and not ABP boarded in FP. This introduces confusion with the provided definition of forensic pathologist. See lines 212 - 214 in the current document! Also, it may be good to define in this document a Forensic Pathologist in Training for clarity.As an aside..It may be a good time to consider the term "Medical Examiner" as well, since the disciple in being fine tuned. There is confusion with the term "Medical Examiner" at least in the U.S.. Perhaps a push to call the discipline what it is, "Forensic Pathology" would be best and timely. Office of Forensic Pathology is more descriptive than Office of the Medical Examiner. Those performing the work are forensic pathologists. Fits pretty well.
Response:
Line 134 - 137: The statement of 20 weeks seems to be subject to interpretation. Perhaps consider an "either/or" or preferably changing the statement to a particular "weight and/or length" to make this more uniform and better defined.
Response:
Line 138 - 139: Is this to include known complications of the listed associations?
Response:
Line 144 - 145: Perhaps broaden this to include (certain) head traumas that may have contributed to the death.
Response:
Line 146 - 149: Perhaps something could be included here about Elder Abuse/Neglect and Vulnerable Adult related investigations.
Response:
Line 154 - 155: This can be done easier with systems like the Electronic Death Registration System (EDRS) that many states are going to. However, they may only allow deaths that are assigned to the ME/Coroner as viewable unless there is a requirement for approval of cremations, shipment out of state etc. Can you propose how and through what authority this death certificate review could be undertaken for all certificates filed? Also, the EDRS can flag death certificates that are questionable, so that helps, but not sure how those flags get put in place from state to state.
Response:
Line 208 - 210: Perhaps it was overlooked, but should the forensic pathologist in training be under the direct supervision of the licensed physician (board certified) forensic pathologist?
Response:
Line 212: Here is the term non forensic pathologist. Define this term in the line 59 - 61 area for clarity and include what they are and are not allowed to do as well as suggest or declare a title that differentiates from forensic pathologist as currently defined in this document.
Response:
Line 224 - 226: Some re-evaluation here may be in order. NAME states the 325 is the upper limit while 250 is the standard, this is not currently a best practice, especially for accreditation. Also, since the NAME Standards are mentioned and they include in the autopsy definition a range of 3 - 5:1 for external examinations equaling an autopsy, this should be clarified and included in the standard, again for clarity. Perhaps a discussion with NAME I & A could clarify this matter of 250 and 325 to avoid problems later.
Response:
Line 227 - 228: Could there be a provision of the autopsy being completed within 48 hours of arrival at the office as there could be a time disparity of notification of the death to the body actually being available to autopsy.

Response:
Line 250: Perhaps rewording the line to read "and only after all available or known (necessary) information has been obtained," ...
Response:
Line 254 - 258: is "the forensic pathologist" the assigned case forensic pathologist or "a forensic pathologist" as in an available one or perhaps the chief forensic pathologist? May want to clarify this point.
Response:

Commenter # 55
[A signed PDF version of this response on NAME letterhead was electronically mailed to the SWGMDI leadership on 11/1/13]The Standards and Executive Committees of the National Association of Medical Examiners, the American Society for Clinical Pathology, and the Forensic Pathology Committee of the College of American Pathologists have carefully reviewed and considered the Scientific Working Group for Medicolegal Death Investigation (SWGMDI) draft document “PRC-12 Autopsy Performance Criteria: Standards, Guidelines and Best Practices.” This letter represents the official response of the National Association of Medical Examiners, the American Society for Clinical Pathology, and the College of American Pathologists.The National Association of Medical Examiners (NAME) is the national professional organization of physician medical examiners, medicolegal death investigators, and death investigation system administrators who perform the official duties of the medicolegal investigation of deaths of public interest in the United States. NAME was founded in 1966 with the dual purposes of fostering the professional growth of physician death investigators and disseminating the professional and technical information vital to the continuing improvement of the medical investigation of violent, suspicious and unusual deaths. Growing from a small nucleus of concerned physicians, NAME has expanded its scope to include physician medical examiners and coroners, medicolegal death investigators, and medicolegal system administrators from throughout the United States and other countries. NAME serves as a resource to individuals and jurisdictions seeking to improve medicolegal death investigation by continually working to develop and upgrade national standards for death investigation. NAME aims to involve competent professional medicolegal death investigators in every jurisdiction in the United States.The American Society for Clinical Pathology (ASCP) is a nonprofit medical specialty society representing more than 100,000 members. Its members are board certified pathologists, other physicians, clinical scientists, certified medical technologists and technicians, and educators. ASCP is one of our nation’s largest medical specialty societies and is the world’s largest organization representing the field of laboratory medicine and pathology. As the leading provider of continuing education for pathologists and medical laboratory personnel, ASCP enhances the quality of the profession through comprehensive educational programs, publications, and self-assessment materials. The mission of ASCP is to provide excellence in education, certification and advocacy on behalf of patients, pathologists and laboratory professionals across the globe.The College of American Pathologists (CAP) is a medical society serving 18,000 physician members and the global laboratory community. It is the world's largest association composed exclusively of board-certified pathologists and is the worldwide leader in laboratory quality assurance. CAP members practice in many subspecialties of pathology including forensic pathology. As the leading organization of board-certified pathologists, CAP serves patients, pathologists, and the public by fostering and advocating excellence in the practice of pathology and laboratory medicine worldwide. The CAP advocates accountable, high-quality, and cost-effective patient care. The CAP's Laboratory Accreditation Program is responsible for accrediting more than 7,000 clinical laboratories worldwide.The NAME Forensic Autopsy Performance Standards—publicly available at www.thename.org—were first approved by the NAME general membership in 2005 and have been revised and amended multiple times in the ensuing years. NAME has a rigorous method of assessing and vetting proposed standards changes or amendments, which ultimately must be approved by the majority of members in attendance at a NAME business meeting before being adopted. Thus, the NAME standards are—by definition—the product of the very practitioners who seek to uphold and disseminate the standards. In a 2010 letter to the National Institute of Justice (NIJ), NAME provided considerable input to the NIJ on the composition and objectives of the SWGMDI. In that letter, NAME described the NAME Forensic Autopsy Performance Standards and asked that the NIJ task the SWGMDI with developing recommendations to encourage widespread implementation of these existing

standards.NAME, ASCP, and CAP recognize the voluminous and valuable work that has been performed by the SWGMDI on a number of fronts, ranging from reports on physical facility recommendations to recommendations regarding pathology workforce issues. We also note that many of NAME's already published standards were imported wholesale into the SWGMDI Autopsy Performance Criteria draft. We further recognize that many of the newly proposed standards proffered in the SWGMDI draft document might, if implemented, be valuable additions to the practice of forensic pathology. However, with regard to the SWGMDI's Autopsy Performance Criteria, NAME, ASCP, and CAP unequivocally believe that only one set of forensic autopsy performance standards should exist, and these should be the standards developed and promulgated by NAME. There are good reasons why this should be the case:• As noted above, the NAME Forensic Autopsy Performance Standards are developed, amended, and produced through consensus by the very professional society to which the standards apply. A mechanism for altering the NAME standards exists, and NAME has a committee dedicated to reviewing proposed changes to the standards. In contrast, the SWGMDI Autopsy Performance Criteria were developed by a relatively small committee, of which several members are not forensic pathologists. This latter set of standards, if published, would be regarded as an outside dictate to the discipline of forensic pathology and infringement upon the practice of medicine.• The existence of a SWGMDI set of forensic autopsy standards introduces redundancy into forensic pathology and death investigation. Any proposed standard desired by the SWGMDI can be brought to NAME—a considerable subset of the SWGMDI consists of NAME members—and the standard in question can be voted upon for inclusion into the NAME standards.• Two published sets of forensic autopsy performance standards would create unacceptable ambiguity in the fields of forensic pathology and death investigation, confusing practitioners, law enforcement, families, the legal system, the public, our clinical colleagues, and our fellow forensic scientists.• The performance of forensic autopsies is the practice of medicine. The standards to which forensic autopsies are performed, therefore, are solely the purview of the qualified medical practitioners who perform them. In summary, NAME, ASCP, and CAP cannot and will not endorse or recognize forensic autopsy standards that are not the product of NAME. NAME will unapologetically defend itself as the leading authority on forensic autopsy performance standards and the practice of forensic pathology, and will actively and publicly oppose forensic autopsy standards authored or promulgated by any other organization or agency. ASCP and CAP fully supports NAME's position. For the reasons noted above, NAME, ASCP, and CAP strongly encourage the SWGMDI to simply endorse the NAME standards as the leading set of forensic autopsy standards in the field and recognize that NAME has a mechanism for reviewing proposed forensic autopsy performance standards changes. Thank you in advance for your time and your consideration.Very truly yours,Andrew M. Baker, MDChair, NAME Board of Directors (2013)Chair, NAME Standards CommitteeSteven H. Kroft, MD, FASCPPresident, American Society for Clinical PathologyMichael Graham, MD, FCAPChair, CAP Forensic Pathology Committee

Response: