



Priority Action Report

Medicolegal Death Investigation

Crime Scene/Death Investigation SAC

John Fudenberg

Jan 29, 2016





Subcommittee Leadership

Position	Name	Organization	Term	Email
Chair	John Fudenberg	Clark County Office of the Coroner/Medical Examiner	2 yrs (Oct 2016)	fud@clarkcountynv.gov
Vice Chair	Keith Pinckard	Travis County Medical Examiner's Office	4 yrs (Oct 2018)	drkpinckard@yahoo.com
Executive Secretary	Laura Crandall	NYU School of Medicine, The SUDC Foundation	3 yrs (Oct 2017)	Laura.crandall@nyumc.org



Subcommittee Members



#	Name	Organization	Term	Email
1	Matt Lunn	Binghamton University	4 (Oct 2018)	mlunn@binghamton.edu
2	William Oliver	Brody School of Medicine at East Carolina University	4 (Oct 2018)	oliverw@ecu.edu
3	Margaret Warner	Centers for Disease Control, National Center for Health Statistics	4 (Oct 2018)	mwarner@cdc.gov
4	David Carter	Chaminade University of Honolulu	3 (Oct 2017)	david.carter@chaminade.edu
5	Stephen Cina	Cook County Medical Examiner's Office	2 (Oct 2016)	stephen.cina@cookcountyil.gov
6	Julie Howe	Franklin, Jefferson and Saint Charles Counties Medical Examiner Offices	3 (Oct 2017)	howej@slu.edu
7	Lindsey Thomas	Hennepin County	4 (Oct 2018)	lindsey.thomas@hennepin.us
8	Tom Hensley	Jackson County Medical Examiners Office - Kansas City, MO	3 (Oct 2017)	mo_reb@yahoo.com
9	Barbara Sampson	New York City Office of Chief Medical Examiner	3 (June 2018)	bsampson@ocme.nyc.gov
10	Lauri McGivern	Office of the Chief Medical Examiner NH	3 (Oct 2017)	lauri.mcgivern@state.vt.us
11	David Fowler	Office of the Chief Medical Examiner Maryland	4 (Oct 2018)	fowlerd@ocmemd.org
12	Kelly Keyes	Orange County Sheriff-Coroner	3 (Oct 2017)	kakeyes@ocsd.org
13	Gary Watts	Richland County	2 (Oct 2016)	wattsg@rcgov.us
14	James Gill	State of Connecticut	2 (Oct 2016)	jgill@ocme.org
15	William Oliver	Brody School of Medicine at East Carolina University	4 (Oct 2018)	oliverw@ecu.edu



Discipline Description



The Subcommittee on Medicolegal Death Investigation will focus on standards and guidelines related to deaths reportable to coroners and medical examiners including sudden, unattended, unexpected, or suspicious deaths and deaths due to violence (accidents, suicides and homicides). This subcommittee will also focus on education, research, certification, accreditation, systems administration, and the value of medicolegal death investigation to public health.



Summary of Standards/Guidelines Priority Actions

Priority	Working Title of Document
High	1. Communicating findings, including final cause and manner of death and access to autopsy reports, to the next of kin of decedents.
High	2. Documentation of Medicolegal Death Investigator Findings
High	3. Jurisdictional determination by certified medicolegal death investigators
High	4. Collection of blood or other appropriate samples for potential genetic testing in sudden, unexplained deaths that remain unexplained at the completion of the autopsy.
High	5. Determination of Cause of Death



Summary of Standards/Guidelines Priority Actions

Priority	Working Title of Document
High	6. Evaluation of Circumstances Surrounding Death
High	7. Medical Examiner and Coroner Independence
High	8. Recognition of the NAME Forensic Autopsy Standards as the National Practice Model
High	9. Forensic Pathology as the Practice of Medicine
High	10. Medicolegal Death Investigation offices shall participate in local or state level child fatality review teams.



Priority 1-10: Documents



Planned Actions	OSAC Process Stage (e.g., SDO 100)	Assignee	Estimated Completion Date
Submit and receive approval from SAC	SDO-100	Will be assigned once SAC approval obtained	TBA





Existing Documents for Registry Process Consideration to Standards/Guidelines Priority Actions

Priority	Working Title of Document
High	1. Principles for Communicating With Next of Kin during Medicolegal Death Investigations- Submit for Approval
High	2. Recommendations for Certification and Training of Medicolegal Death Investigation Personnel- Submit for Approval
High	3. SWGMIDI's Standards for Interactions Between Medical Examiner/Coroner Offices and Organ and Tissue Procurement Organizations and Eye Banks- Submit for Approval





Standards/Guidelines Reviewed For Technical Merit

Title	Developing Organization	Status*	OSAC Process Stage (e.g., RA 100)
None			



Research Needs Identified

- Assessing the utility of autopsy in contentious medicolegal categories of death
- Pediatric Forensic Pathology to improve the accuracy of cause and manner of death certification
- Death Investigation, workload, mixed methods, investigations
- Geographic and Seasonal Variation in Postmortem Changes



Additional Items of Interest

- Response by MDI Sub-committee regarding Cognitive Bias Issues to be shared with Human Factors Committee and other interested parties





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