Priority Action Report

Medicolegal Death Investigation Subcommittee

Crime Scene / Death Investigation SAC

J. Keith Pinckard, MD PhD

February 13, 2017

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Subcommittee Leadership

Position	Name	Organization	Term	Email
Chair	Keith Pinckard	Travis County Medical Examiner		drkpinckard@yahoo.com
Vice Chair	Laura Crandall	NYU Langone Medical Center		laura.crandall@nyumc.org
Executive Secretary	Kelly Keyes	Orange County Sheriff's Coroner Office		kakeyes@ocsd.org

Subcommittee Members

#	Name	Organization	Email
1	Baker, Andy	Hennepin County Medical Examiner's Office	Andrew.Baker@co.hennepin.mn.us
2	Carter, David	Chaminade University of Honolulu	david.carter@chaminade.edu
3	Fowler, David	Maryland Office of the Chief Medical Examiner	fowlerd@ocmemd.org
4	Fudenberg, John	Clark County Office of the Coroner Medical Examiner	FUD@clarkcountyNV.gov
5	Hensley, Tom	Jackson County (Missouri) Medical Examiner's Office	mo_reb@yahoo.com
6	Howe, Julie	Franklin, Jefferson, and St. Charles Counties (Missouri) Medical Examiner Offices	howej@slu.edu
7	Lunn, Matthew	Arapahoe (Colorado) County Coroner's Office	mlunn@arapahoegov.com
8	McGivern, Lauri	Vermont Office of the Chief Medical Examiner	lauri.mcgivern@state.vt.us
9	Nashelsky, Marcus	University of Iowa Carver College of Medicine Department of Pathology and Johnson County (Iowa) Medical Examiner	marcus-nashelsky@uiowa.edu
10	Oliver, William	Brody School of Medicine at East Carolina University (North Carolina)	oliverw@ecu.edu
11	Sampson, Barbara	Office of the Chief Medical Examiner, New York City	bsampson@ocme.nyc.gov
12	Thomas, Lindsey	Hennepin County (Minnesota) Medical Examiner 's Office	lindsey.thomas@hennepin.us
13	Warner, Margaret	U.S. Centers for Disease Control and Prevention, National Center for Health Statistics	mwarner@cdc.gov

Resource Committee Liaisons

Name	FSSB Committee
William Oliver	Human Factors Committee
Lindsey Thomas	Legal Resource Committee
?	Quality Infrastructure Committee
Kelly Keyes	Kavi Liaison

Discipline Description

Medicolegal Death Investigation:

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.

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Subcommittee Core Values

- Values shared by all stakeholders on Subcommittee
  - Medical Examiners
  - Coroners
  - Medicolegal Death Investigators
- FORENSIC PATHOLOGY IS THE PRACTICE OF MEDICINE
- Issue of “cognitive bias”

Summary of Priority Projects

Priority	OSAC Process	Working Title of Document
1	With SAC prior to SDO (RA-300)	Competent Medicolegal Death Investigation

Standards/Guidelines Development Priority 1 Document

Document Title: **SDO-1- Competent Medicolegal Death Investigation**

Scope: Broad

Objective/rationale: Define the components of all aspects of competent death investigation, including organizational/structural independence, and from scene through autopsy

Issues/Concerns: applicability of field to standards development

Task Group Name: Entire subcommittee
Task Group Chair Name: Keith Pinckard MD PhD
Task Group Chair Contact Information:
drkpinckard@yahoo.com
Date of Last Task Group Meeting: July 2016

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Standards/Guidelines Development Priority 1 Document

Key Components of Standard:

- Independence
- Inspection/Accreditation of offices
- Certification of personnel
- Adherence to existing guidelines and standards

Priority 1:
Competent Medicolegal Death Investigation

Task Group/Subcommittee Action Plan

Planned Actions	OSAC Process Stage (e.g., SDO 100)	Assignee	Estimated Completion Date
Review by SAC prior to SDO	RA-300	Greg Davis MD	?

Summary of Standards/Guidelines Priority Actions

Priority	OSAC Process	Working Title of Document
1	With SAC prior to SDO (RA-300)	Competent Medicolegal Death Investigation

Repeat of the Priority Actions Summary slide

Standards/Guidelines Reviewed For Technical Merit

Title	Developing Organization	Status*	OSAC Process Stage (e.g., RA 100)
A Guide to Death Scene Investigation	NIJ	pending	RA-100
Forensic Autopsy Performance Standards	NAME	pending	RA-100
Sudden, Unexplained Infant Death Investigation: Guidelines for the Scene Investigator	CDC	pending	RA-100
Guidelines for Communication with Next of Kin During Medicolegal Death Investigation	SWGMDI	pending	RA-100
Standards for Interactions Between Medical Examiner/Coroner Offices and Organ and Tissue Procurement Organizations and Eye Banks	SWGMDI	pending	RA-100

Research Needs Identified

- Improved surveillance of drug-related deaths by medical examiners and coroners

- Detection and surveillance of fentanyl and fentanyl analogue related deaths

Research Needs Identified

- Postmortem naloxone testing to provide valuable insight into the prevalence and geographic distribution of lay naloxone rescue attempts as well as help characterize its utility as distributed to the public and help guide public health toward overdose death prevention

Research Needs Identified

- Obstacles to accreditation in medicolegal death Investigation offices, especially in rural areas
- Obstacles to certification of medicolegal death investigators, especially in rural areas
- Formally submitted; status pending

Additional Items of Interest

- Issues in cognitive bias in Medicolegal Death Investigation

Additional Items of Interest

- Draft Recommendations for Medical Examiner/Coroner Drug-related Death Investigations

- Strategy Statement for Medical Examiner/Coroner Drug Death Investigations

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