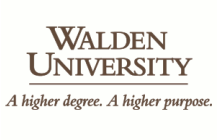

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Regulating Medicolegal Death Investigations

Antoinette Vicks
Walden University

Walden University

College of Social and Behavioral Sciences

This is to certify that the doctoral dissertation by

Antoinette Vicks

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee
Dr. Carolyn Dennis, Committee Chairperson,
Criminal Justice Faculty

Dr. Michael Klemp-North, Committee Member,
Criminal Justice Faculty

Dr. Joseph Pascarella, University Reviewer,
Criminal Justice Faculty

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Abstract

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Antoinette Vicks

Dissertation Proposal Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Medicolegal death investigators (MDIs) are a crucial part of the death investigation process but the profession remains unregulated and lacks a required accreditation or licensing process that many other professions use. Research shows the current medicolegal death investigations system, though a crucial government function, has existing deficits in its functionality that affect service delivery. The current study was based on an educational theory and utilized open ended survey questions. Data from 16 investigators was collected through surveys where relevant information was asked in the context of their situation and questions were specific to the phenomenon being studied. The data was analyzed by identifying individual and group descriptions of the experience to understand the overall meaning of their experience. The investigators interviewed had different experiences and varying beliefs in the importance of their role as an investigator. They were confident in their roles and provided detailed descriptions of their responsibilities. Additionally, investigators do not appear to have any direct issues due to educational differences but did embrace their roles as death investigators with a desire toward ensuring both their personal safety and that of society. Although many have acquired training as a result of their employment, they did not feel that the lack of prior training was a hindrance. This study contributes to the literature by providing data for consideration when developing regulations promoting standards within the system. This includes the health and safety of medicolegal death investigators and filling the gap of recognizing the need for standardized regulations by identifying the need for uniform training and safety practices.

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Chapter 1: Introduction to the Study

Defining Medicolegal Death Investigations

Medicolegal death investigation is the terminology used to define investigations to determine the cause and manner of death for the medical examiner and indicates a merger of both law and medicine. The medicolegal death investigator investigates reported death in the jurisdiction of the medical examiner such as homicides, suicides, suspicious deaths, unexpected deaths, and unexplained deaths. Investigators conduct crime scene investigations focusing on data obtained or derived from inspecting decedent remains and assessing if further investigation is warranted. The medicolegal death investigator possesses authority over the decedent remains and what happened to them while law enforcement focuses on the scene and who may have committed an offense. It is important that these distinctions are made to aid in determining the direction and extent of regulations for any further or continued investigation.

The Need to Regulate Medicolegal Death Investigations

The United States has different death investigative systems, the main four used are: the county medical examiners system, county coroner system, centralized state medical examiner system, and mixed county, which is composed of a coroner and medical examiner system (Hanzlick, n.d.). However, these systems vary per county and state resulting in irregularities within the death investigation system. The irregularities associated with the varying death investigation system lends itself to regulatory gaps and a lack of health and safety protection in the medicolegal death investigators (MDIs) including federal and government standards that monitor the inaccuracies of death

investigations (Pearsall, 2010). MDIs are vital to the death investigation process and though many professions require an accreditation process that ensures the consistency of the services delivered and increases the quality of standard operating procedures, medicolegal death investigators do not (Kelsall and Bowes, 2016). The National Institute of Justice, the National Association of Medical Examiners, and United States Congress have recognized that medicolegal death investigations play a crucial government role but shortages in funding, qualified personnel, and technological advancements have resulted in irregularities in service delivery (Boyd, 2016). Performance standards in death investigations vary drastically, especially in offices within rural locations, diminished resources, and with varying local policies (Wade, 2013). Regulating medicolegal death investigation will provide high quality medicolegal death investigative services that support employees, public safety and health, and the criminal justice systems (National Institute of Standards and Technology, 2016). This study will contribute to the literature by providing data for legislators to consider when developing regulations that promote and encourage uniform standards for medicolegal death investigations systems.

Accreditation helps ensure not only the reliability of the investigations performed but it also improves the operating procedures and quality of investigations (Kelsall &Bowes, 2016). The National Association of Medical Examiners, United States Congress, and the National Institute of Justice have acknowledged that MDIs perform a vital role in the government however, lack of qualified personnel, funding deficits, and technological developments have caused irregularities in death investigations (Boyd, 2016). Irregularities when conducting death investigations tend to differ considerably

especially in rural locations who have varying policies and reduced resources (Medical Examiner System under its purview, 2013). Nonetheless, regulating investigations offers improved quality during investigative services that strengthens the criminal justice system, public safety and health, and support employees (National Institute of Standards and Technology, 2016). This study contributes to the literature by offering information that policymakers can contemplate during the creation of guidelines that endorse the public's health and safety and that of medicolegal death investigators. However, there is limited literature on the topic of regulating medicolegal death investigations and the need of standardizing the profession.

History of Medicolegal Death Investigation

Standardizing the medicolegal death investigation system strengthens the overall system and improves investigator precision and the dependability of investigated results during investigations. There is a profound need to implement and administer policy changes while emphasizing the professionalism of the medicolegal death investigations system, encouraging improvements toward public consciousness of health problems, and streamlining principles that align with the criminal justice system (Draft Report on Strengthening the Medicolegal Death Investigation System, 2016). Researchers have conducted studies suggesting that applying comprehensive and standardized investigation methods and practices among all jurisdictions and states increases not only the knowledge of etiology but improves the knowledge of the protective and risk factors (Landi et al, 2005). According to Miller and Braswell (2010), effective death investigation means using scientific and physical evidence in collaboration with

knowledgeable investigators thus basic investigative tools equates to successful investigations since death scenes are different, investigators should negotiate the scene using a methodical and rational approach. While Ribaux et al. (2010) believed that establishing conditions which encourage the development of forensic intelligence that lead to efficiency in death investigations should be a framework that links forensic science and investigations to intelligence-led policing.

Over the decades, medicolegal death investigators have become valuable members of the death investigation team. Until recently, these individuals received on-the-job training with no specified educational background or curriculum required. However, the required or needed skills of a death investigator have now been defined and are the basis for the professional certification by the American Board of Medicolegal Death Investigators (ABMDI) which currently has approximately 800 registered death investigators (The National Association of Medical Examiners, 2014). Unfortunately, the greatest challenge that persists is the absence of adequate scene investigators due to the lack of adequate staffing and the funds to train them. Any person performing the task of death investigations should receive adequate and uniform training to conduct their duties and align with professionally accepted standards. The federal government can help improve this process by providing funding or grants for training and professional certifications of death investigators.

Problem Statement

Increasing irregularities in death investigations cause investigators to believe that unregulated death investigations effects medicolegal death investigators, their personal

health and safety, and repercussions on the health and safety of the public. Medicolegal death investigators have not been studied in this capacity; nonetheless I believe there is a positive correlation between unstandardized death investigations and the investigators levels of education, training, experience, and skills of investigators issues. The various expectations within death investigations vary drastically especially in offices within rural locations, diminished resources, and with varying local policies (Wade, 2013). Thus, in order to maintain integrity within the medicolegal death investigations field, establishing regulations and developing standards within the profession will positively affect the quality of death investigations conducted and improve public health implications. This concept was measured using medical examiner offices in Northern Texas. The U.S. Constitution states that each state should implement laws that determine the minimum requirements for death investigations (Jentzen, 2009). This research provided data that encourages the implementation of regulations for how medicolegal death investigations impact public health and safety which is important to determine the societal impact if any, on the health and safety effects for investigators while they are in the field conducting investigations.

Research Questions

1. What standards of practice, if any, should be adopted when conducting medicolegal death investigations? Why?
2. Does varying volumes of medicolegal death investigations performed per jurisdiction have any effect on investigative standards and case outcomes? How?

Purpose of the Study

The purpose of this qualitative case study was to understand how the unregulated profession of death investigations impacts not only the investigation but the medicolegal death investigators, their personal health and safety, and repercussions on the health and safety of the public. Establishing regulations and standardizing the profession will positively affect the quality of death investigations conducted and improve public health implications using medical examiner offices in Texas (Kelsall & Bowes, 2016). Requiring medical examiner offices to comply with the National Association of Medical Examiners NAME standards and required training to receive government funding is also a viable option to aid in strengthening the medicolegal death investigations system. The U.S. Constitution states that each state should implement laws which determine the minimum requirements for death investigations (Jentzen, 2009). The data collected in this research also encourages regulations for how medicolegal death investigations impact societal health and safety. It is also important to ascertain whether health and safety issues have caused a prevalent effect on investigators while they are in the field conducting investigations.

Theoretical Framework

For this study's framework, I chose the advocacy coalition framework (ACF) and the social organization theory. The ACF offers a theoretical approach for initiating policy change and stability and accounts for ongoing policy debates among advocacy coalitions concerning value conflicts throughout various geographical locations. The ACF provides a detailed theoretical proposal with both a dynamic and comprehensive approach (Sotirov

& Memmler, 2012), so I was able to look at the interactions among medicolegal death investigators and the connection among political and socioeconomic environment. The ACF was the most appropriate theoretical framework for my study and aligns with the problem statement because it helped to link both the practical and theoretical significance of my research for policymakers and key stakeholders to encourage death investigation standards. Additionally, after I evaluated my problem statement it was apparent that the ACF offers policy assessment encourages the development of policy of different subsystems such as those on the local, state, and federal level. This framework is important to help guide the implementation of regulations that standardize operations of medicolegal death investigations by engaging the behavior and involvement of key stakeholders and the challenges to impact the policy-making process directly or indirectly.

I also used social organization as a framework for this study. Possessing the ability to communicate efficiently with colleagues, superiors, and all individuals on all levels through the exchange of information among all organizational affiliates is imperative to organizational growth and success (Papa, Daniel & Spiker, 1997). Elevating communication surrounding and within organizations in social organization framework aids in heightening both administrators and employees, which is necessary to ensure the regulation of the profession. Furthermore, the social organization framework allows researchers to incorporate several aspects to use in the evaluation, assessment, and analysis of medicolegal death investigations. The desired changes I proposed regarding the standardization of death investigations and using the social organization framework

will motivate changes geared toward improving death investigation policy. The development and implementation of the new policy recommendations should incorporate the involvement of societal stakeholders. These stakeholders are those responsible for initiating changes and include government entities, employees, and most importantly those in society who are most affected and benefit from structuring the regulation of medicolegal death investigations. Death investigations are a social organization because it conceptualizes how individuals behave and helps to identify role perceptions as well as the physical environment investigators work in. The use of social organization in death investigations leads to understanding the need for regulating operating procedures throughout the profession.

Operational Definitions

American Board of Medicolegal Death Investigators (ABMDI): Developed as an independent professional certification, The American Board of Medicolegal Death Investigators is nationally recognized, voluntary, and not-for-profit organization that encourages Medicolegal Death Investigators to exude the highest standards of practice.

Forensic Investigators: Attend crime scenes to collect evidence while performing a variety of tasks in conjunction with working alongside medical examiners and coroners. Forensic investigators can also interview witnesses, family members of suspects, and friends who bear witness to the questioned event. Forensic investigators can also be referred to as forensic technicians, crime scene analysts, or even crime scene investigators.

Medicolegal Death Investigation (MDI): Dual representation of either the act of Medicolegal Death Investigation or the actual investigators who are known as Medicolegal Death Investigators. Frequently used interchangeably, a medicolegal death investigator researches suspicious, unknown or trauma related deaths that fall under the jurisdiction of the medical examiner by collecting and analyzing evidence, developing reports from evidence obtained and when required testifying in court. Medicolegal Death Investigation is the act of investigating these deaths that falls under the medical examiners' jurisdiction. For the purpose of this study, MDI will refer to medicolegal death investigators.

Medical Examiner's Office (MEO): A medical examiner's office is one that houses a pathologist and usually medicolegal death investigators or forensic investigators who are trained to investigate deaths that fall under their jurisdiction, perform post-mortem examinations (autopsies), and may also be required to initiate inquests.

National Association of Medical Examiners (NAME): National professional organization of medical examiners and medicolegal death investigators who perform the official duties of the medicolegal death investigations by providing expertise that is essential to the effective functioning of the civil and criminal justice systems. NAME seeks to improve the day to day investigation of cases while cultivating the interaction of death investigation systems with other agencies and political entities during the death investigation process.

Regulating: to adjust so as to ensure accuracy of operation: to bring into conformity with a rule, principle, or usage (Regulate, n.d.).

Society of Medicolegal Death Investigators, Inc (SOMDI): Established March 2011 in St. Louis, MO and created by experienced, veteran medicolegal death investigators who identified the need for medicolegal death investigators to have an organization geared toward educating, training, monitoring, representing, and advocating for the profession.

Assumptions, Limitations, Scope, and Delimitations

Assumptions

I assumed that access to death investigators may be difficult to establish except for those investigators I work with. I needed to identify investigators willing to participate in the study and coordinate meeting locations throughout the North Texas area. Willingness of death investigators to participate was difficult to obtain for those investigators I worked with due to fear of breach in confidentiality. Investigators (MDI) did not want to participate in the study because they did need see the relevance or importance of the study. Participants were open and honest with the survey questions presented.

Limitations

The limitations for this study were the various medical examiner offices in North Texas and how they presented barriers to identifying participants. This was primarily an issue because many offices targeted were small entities and remotely located making it difficult to meet face to face with participants. The results of this study were also limited to Northern Texas medical examiner offices which is a small group of individuals and limited response possibilities.

Scope and Delimitations

The scope and delimitations of this study were limited to the Northern region of Texas. Thus, expanding the research to include the entire state of Texas or even to include two states would have been beneficial in gaining a broader perspective regarding issues surrounding the challenges investigators encounter.

Results were not generalized to all medical examiner offices because of the unique nature of varying crimes and investigative techniques applied at different medical examiner offices. MDIs typically work in one geographical area throughout the duration of their careers resulting in persistent conditioning of death investigation techniques. Death investigators are enthralled in a unique environment oppose to other types of investigators, so it was important to remember this difference when writing the questionnaire.

The education theory provided the qualitative structure since there were no previous studies to gage or compare. Accurate descriptions for the role of an MDI were identified by exploring how the MDIs think using the interpretations gathered from their questionnaires. The study findings were limited to interpretation rather than data analysis thus ignoring the social context.

Significance of the Study

The study of forensic science is frequently regarded as the use of science practices to answer questions and solve law related issues. Surprisingly, the rigidness of this view restricts the effects of science while endeavoring to lower conceivable risks geared toward insufficiencies and breakdowns of justice. My study objective is to theorize the overall impact the lack of uniformed training has on the long-term effect of medicolegal

death investigators. These contributing factors and support from government entities are imperative to build communities, improve policing strategies, and incorporating plans that guides the information and intellect for the groundwork of the death investigation systems. The collaboration of forensic science and medicolegal death investigations has a characteristic of analysis for security adjusted models deterring a well-recognized process. This process is considered a form of forensic intelligence which stems from both accurate and timely processing of forensic data when conducting investigations. The results of forensic analysis can be used just like any other relevant information to improve the ability of the crime analyst to generate leads and solve crimes. Establishing and identifying optimum conditions that develop forensic intelligence will build efficiency in the area of conducting death investigations. In addition, using the idea of forensic intelligence as a framework to establish links between medicolegal death investigations, forensic science, and the relationship with intelligence-led policing will continue to strengthen the field. The social change implications are to have policy makers work cooperatively in developing uniform standards for investigators when conducting medicolegal death investigations. It is important that policy makers understand the association with medicolegal death investigation and the impact medicolegal death investigations have on societal health and safety.

Summary

An important facet of creating standards and regulating the medicolegal death investigations is to encourage positive outcomes and enhances the quality of investigations performed in conjunction with improving public health in Texas medical

examiner offices. In addition, creating and regulating death investigations will also require a need for medicolegal death investigation compliance with National Association of Medical Examiners (NAME) which has established trainings and standards for medical examiner's offices geared toward enhancing government funding and improving equality for all medical examiner's offices. The above collaboration is important because there is so little consistency between offices, thus mandating minimum requirements was suggested by the U.S. Constitution stating individual states beholden that obligation for death investigations (Jentzen, 2009). Death investigators are essential to the process of death investigation process; unfortunately, this profession does not necessitate an accreditation process. Due to the lack of accreditation of many medical examiner offices lack standardizations designed to safeguard MDIs while working in the field. The absence of government standards to alleviate inaccuracies during death investigations could lead to potential public safety and health problems (Pearsall, 2010). Accreditation helps ensure not only the reliability of the investigations performed but it also improves the operating procedures and quality of investigations (Kelsall & and Bowes, 2016).

Chapter 2 includes a review of pertinent literature. Chapter 3 contains descriptions of the study design such as procedures, participants, assessments used, and the assessment of the information gathered. Please state what is in Chapters 4 and 5.

Chapter 2: Literature Review

Introduction

Medicolegal death investigators investigate the deaths that fall under the jurisdiction of the medical examiner. The task of the medicolegal death investigator is to gain knowledge and understanding with regard to the varying mechanisms of death. Death investigators are not concerned with arrests or convictions but focus on the crime scenes and human remains. It is imperative that investigators understand forensics and its applications, have a good grasp on what questions to ask, and know how to assimilate the data collected in order for the pathologist to mesh these findings to determine a cause and manner of death. Knowledge of how to effectively accomplish these tasks results in a medicolegal death investigator who is highly effective in the methods of participating in and solving these investigations.

Regardless of the geographic location, the medical examiner's office is assigned to investigate deaths of a specific nature that fall under their jurisdiction. The seriousness involved with performing death investigations warrants consistency and a collaborative effort among policy makers and the death investigation system to improve the quality of services within the medicolegal death investigation system. Regrettably, a common theme persists within the act of conducting death investigations which is manifested through restricted resources either through training, education, or lack of standardization and reinforces egregious outcomes within the unstructured and unregulated system. Additionally, many medical examiner's offices experience instances of monetary shortages, however, these shortages vary substantially per capita by jurisdiction thus

affecting how and which cases are investigated and autopsied (National Research Council, 2009). Furthermore, the lack of qualified investigators is another issue within smaller jurisdictions and remote locations (National Research Council, 2009). Strengthening the medicolegal death investigations system is vital to enhance the precision, trustworthiness, and reliability of death investigators and their investigations. Developing these systems will have an overall benefit to law enforcement and public programs (health, safety, and prevention) nationally.

Below, I present a review of the research strategies that I used to capture the effects of non-standardized death investigations on the death investigation system. I will also provide data that gives a rational for implementing regulations for how unstructured death investigations impact public health and safety.

Research Strategy

I conducted the literature search using several data sources for information. I used the following search terms: *death, investigation, investigators,* and *training* as the root of my inquiries. Additionally, I used other search words such as *medicolegal investigators*, *crime scene investigators*, *death investigator requirements*, *becoming a death investigator*, and *forensic investigator training* were used to narrow the search. I used the articles that I obtained from the above search terms to find additional resources that I did not discover in the initial search. I also used the Walden online library, which helped in providing several beneficial articles for my review as well as Google Scholar, Criminal Justice Database, and the National Criminal Justice Reference Service. Unfortunately, I was unable to locate any research literature referring specifically to the

training a MDI received and correlation of this training to job performance. The contents of this review are limited to the impact training has on MDIs and how their job performance is affected.

Literature Review

Unstandardized processes throughout the death investigation system have implications for inconsistent training for medicolegal death investigators and a far-reaching effect on the partner agencies, the criminal investigation, and society. The following literature reviews provide insight into what investigators experience when conducting a crime scene investigation and the skills, experience, and training necessary to successfully perform the function of a medicolegal death investigator.

No standards: medicolegal investigation of deaths

In Canada, approximately 230,000 individuals die an unexpected, unexplained, or violent death and require either a coroner or medical examiner to determine the cause and manner of their death (Kelsall & Bowes, 2016). Depending on the jurisdiction, there are annually 7%-45% of deaths investigated and autopsy which raises concerns about potential misclassification of deaths (Kelsall & Bowes, 2016). Unfortunately, with many deaths in Canada, there have been concerns regarding the misclassification of deaths and whether this has any bearing on the quality of their medicolegal investigations of deaths. This poses specific issues because the precise classification of deaths and quality of death reporting possess both significant legal inferences and extensive public health consequences.

Information from death certificates is contained in national records, archives, and databases. In addition, the information garnered from death certificates offers relevant information on preventable deaths while directing and updating public health policies. Thus, when it is conveyed that a death investigation is undetermined due to a poorly performed investigation or the lack of an investigation, this could preclude future death investigations resulting in a potential breakdown of justice in Canada from inadequate forensic evidence.

The above article references how dealing with so many death investigations increases the probability for error and the misclassification during the death investigation process. The referenced article also listed potential issues associated with jurisdictional constraints and the likelihood of diminished quality in the delivery of death investigations. This diminished quality is exhibited in a weakened death investigation system and has been displayed by loss of integrity, standards, and ethics of death investigators and the investigations they conduct. Furthermore, the article No standards, provides information regarding the negative impact misclassifying mortality rates has on the public's safety and health. In addition to the negative effect misclassifying deaths has on public health, there can also be issues with how deaths are classified (homicide, suicide, accidental, etc.) as well as how deaths are reported to various entities. Obtaining accurate information is important to society to maintain public health and safety but the information obtained from death investigations is also gathered and placed on death certificates that go on national records, databases, and archives (Kelsall & Bowes, 2016). Thus, it is easy to make a correlation between flawed and inadequate death investigations

and how that results in possible breakdowns and even gaps within the Canadian criminal justice system.

Strengthening the Medicolegal Death Investigation System

Within the United States, there are approximately 2,400 medical examiner and coroner jurisdictions charged with investigating over 500,000 deaths annually by performing examinations and autopsies to render the cause and manner of death (Draft Report on Strengthening the Medicolegal Death Investigation System, 2016). Although every state has different specific organizational functions and structure, these differences do not negate the obligation of the medicolegal death investigator to investigate the deaths that fall under their purview. In order to help improve and increase both the accuracy and reliability in the process of death investigations, the system must be restructured and strengthened with uniform standards. Furthermore, there are societal benefits associated with developing and implementing improvements in the death investigation system. Changes in the system are resonated through better-quality public safety and health programs allowing for a better application of intervention methods for deaths considered preventable. Notably, developing and applying policy changes will reinforce professionalism of medicolegal death investigations, while increasing public awareness of health issues and fortifying the principles of the criminal justice system (Draft Report on Strengthening the Medicolegal Death Investigation System, 2016). Once a connection is made between effective policy changes in the process of death investigations, then the relationship with other states and their organizational functions and structures can be formed to nationally reinforce the death investigation system.

In the article, Strengthening the Medicolegal Death Investigation System, there are examples given regarding the logic for implementing mandates to standardize requirements for MDIs. Moreover, there are explanations regarding how jurisdictional changes modify how investigators respond to and investigate deaths. While the Draft Report on Strengthening the Medicolegal Death Investigation System (2016) provides examples that offer reasons why developing cohesiveness in the medicolegal death investigation system will have a positive impact on the entire profession. However, there are benefits to having one uniform medicolegal death investigation system oppose to the dual system which is currently in place causing confusion and discord throughout the death investigation system because of the organizational inconsistencies. Creating an overhaul in the death investigation system will improve the accurateness of investigations performed and increase dependability of results for case outcomes and findings obtained during death investigations process. Furthermore, Draft Report on Strengthening the Medicolegal Death Investigation System (2016) provides argument toward the connection between increased deaths, a lack of uniformity when conducting death investigation, and the negative impact on society.

Coroners Seek Consistency for Death Investigations

In Wisconsin, each county has the option to elect either a coroner system (elected official) or a medical examiner system (county official appointed by the County Board); they both possess the same authority to protect the interests of deceased individuals and the communities they serve (Kleefisch, n.d.) However, current law fails to specify qualifications for either position and do not require death investigators to hold a license,

complete continuing education courses, or partake in training (Kleefisch, n.d.). The medicolegal death investigation system has irregularities thus making it a necessity to petition legislators and policy makers with mandating qualification standards and investigative standards. Establishing consistent standards throughout the system will help build and reinforce integrity in the death investigation system especially since only a forensic pathologist is trained in determining the cause and manner of death and the county coroner is usually an elected official who may depend on the investigator for direction (Sathyavagiswaran & Rogers, 2018). This lack of uniformity goes beyond individual pedigree in nomination or elected officials; qualification requirements are important, even more important is making sure that the work being done by these important offices is performed both uniformly and accurately (Kleefisch, n.d.). An effective justice system relies on the concept that every death investigation, regardless of region or death investigation system; adheres to uniform investigative protocols across all death investigation systems. The type of uniformity that is being requested for death investigators is one that is commonly mandated for many professionals such as lawyers, doctors, nurses, plumbers, and teachers.

Criminal investigations rely on attention to detail, reliability, and the discovery of forensic evidence during a death investigation plays an integral role (Ruslander, 2019). For this reason, death investigations should also be handled with the same focus on consistency as any other profession. There are several professionals that are required to obtain and maintain credentialing. Not only does this display to others that you possess fundamental knowledge in a specific area but that you are devoted to your professional

development. This credentialing and licensure requirement is true for barbers, nurses, lawyers, and social workers to name a few. The Assembly Bill 530 will create a professional examining board for the implementation of statewide standards in death investigations, create a death investigation license, and stipulate training and continuing education requirements to ensure death investigations are conducted properly throughout Wisconsin (Kleefisch, n.d, p. 2). Furthermore, according to Kleefisch (n.d.) the criminal justice system should consider petitioning states to impose death investigation standards on all aspects of the death investigation system.

This article, Coroners Seek Consistency for Death Investigations, is aligned with my research since it relates to the need for standardization in the death investigation system and how the lack of standards negatively effects death investigations. The lack of standards within death investigations can cause an array of issues throughout the system. These impacts can negatively affect criminal justice outcomes for potential offenders and the way cases are solved including the outcomes they produce. Uniformity creates equality of service delivery and strengthens the role of the death investigator and the investigations they conduct. Slotting mandatory requirements for investigator training, continuing education, and performances ensures investigations are held to standard and regardless the offense, the investigative techniques and outcomes could be achieved.

Implementing Case Management within a Large Medicolegal Death Investigation Agency

In the process of conducting a medicolegal death investigation, both the coroner and the medical examiner's office must generate autopsy reports, these reports provide a

detailed report of findings from the death investigation and the physical findings (Drake, Harper, & Hudson, 2016). However, to ensure these death investigative agencies maintain any accreditations they have or allow them to be eligible to obtain accreditations such as NAME, they have an expectation to finalize autopsy reports in a timely manner. Considering the need to manage the turnaround time of autopsy reports, brought about the need to implement case management principles to manage the autopsy report process especially in large jurisdictional areas. Often, larger metropolitan jurisdictions have a more difficult responsibility of overseeing quick responses and efficient turnaround times because they cover larger territories. However, the complexity of forensic autopsies coupled with related supplementary studies such as forensic histology, toxicology, and a variety of other specialty consults make it an increased challenge to expeditiously complete autopsy reports (Drake, Harper, & Hudson, 2016). Thus, the implementation of forensic case management services was initiated in 2013 to assist forensic pathologists by decreasing the time it took for autopsy reports to be finalized and conforming with accreditation policies (Drake, Harper, & Hudson, 2016). Despite case increases in 2014, the Houston metropolitan area maintained a 90% accreditation standard of turn around within 90 days and the case management service offered process improvement, technology to track and trend, and increased interdisciplinary collaboration (Drake, Harper, & Hudson, 2016). Proving the case management implementation system for forensic autopsies can improve processes and decrease report turnaround times.

The introduction of case management in the medicolegal death investigation field could provide substantial benefits for investigations and investigators by improving

standards and increasing investigative outcomes. Implementing this process equates to a checks and balances within medicolegal death investigations by promoting and supporting investigation outcome optimization. Many of the proposed scenarios range from investigators answering death calls and determining jurisdiction to forensic examiners focusing on autopsies thus creating an environment conducive for a case manager to initiate family follow-ups, obtaining additional information from policing agencies, health care professionals, and handling inquest for autopsy reports (Drake, Harper, & Hudson, 2016). Realizing the need for case management within the medicolegal death investigation system could help bridge gaps between pathologists, medicolegal death investigators, policing agencies, and any other vested entities. Another positive reinforcement for implementing case management for death investigations is to aid in promoting investigatory process improvements and streamline organizational change. Furthermore, utilizing case management throughout the investigation process will diminish instances of investigative division among agencies collaborating with the medical examiner's office and decrease potential inconsistencies in death investigation case results. Unfortunately, when the medical examiner's or coroner's office experiences delays distributing autopsy reports, not only does this delay affect the agency's performance, but also contributes to issues with accreditation and possible negative impacts on the criminal justice system.

The implementation of a case management model will give the medical examiner's office a smooth transition and adaptable way to improve their death investigation processes by helping to ensure standards and quality are met using this

quality assurance method. As an additional quality assurance method, case management can lessen instances of service duplication in case reporting, ensure case follow-ups are performed, and expedite the review of pending reports. This process can also aid in identifying organizational deficits, areas where the investigation process can be improved, and the need for additional case follow up either by the pathologist of the MDI. The necessity to identify areas for follow-up is crucial to reducing criminal justice malfeasance, improving, recognizing, and reporting public health outbreaks, and improve collaborative efforts both intra and inter agencies thus maximizing case outcomes efficiency.

Capture the Crime Scene

Crime scenes like crimes are usually as unique as DNA and differ from each other. This uniqueness can bring about challenges regarding the ways crimes scenes are documented due to time constraints, evidence oversight, physical barriers, and scene disruptions. Nonetheless, the technique for investigating most crime scenes remains similar for most cases and investigators. Thus, if investigators could use a tool that would help streamline the investigative procedure, the process would be less challenging and produce effective scene documentation results. Many antiquated tools of crime scene investigation are no longer considered reliable such as photogrammetry, total stations, and tape measurements and their effectiveness is heavily dependent upon the investigator's ability to determine evidentiary relevance (Investigations, 2017). Innovation and technology have helped to alleviate issues associated with crime scene documentation such as the use of 3D scanning and similar laser equipment. The use of

this tool has slowly been introduced into crime scene technology and has aided in scene documentation investigation by capturing the entire crime scene a lot better than just standard photography. A notable benefit is how little time it takes to scan a scene and document it completely allowing the scanner to capture millions of evidence data points that form a photographic point cloud (Investigations, 2017).

The application of the 3-D laser scanner helps with crash reconstruction providing the ability to not only document more information but to document the information more completely in a shorter timeframe. Then the FARO Focus Laser Scanner, designed for outdoor crime scene use is lightweight, small, and long-range scanning capability with remote scanning and data sharing abilities (Investigations, 2017). This scanner provides a bird's eye view allowing the investigator to target specific items and has proven to provide accuracy, promptness, and deliver professional data results. When working homicides, the investigator can target the area where the victim(s) are located and work outward while documenting and preserving positioning. In shooting related incidents, projectile strikes and its path are easily documented for range and accuracy regardless of weather or temperature in a panoramic view. Another example of technological advancement in investigations is the OSCR360, which is not only a camera with tripod that takes panoramic photos and geospatial relationships, but it is also a tablet that has real-time photo viewing (Investigations, 2017). The ability to obtain close-up details during crime scene investigations is not always concerning or referencing the scene investigated but includes the body being examined. The capability of this scanner is phenomenal and can make major strides in the outcome of cases. Investigators can scan

victims of baby shaken syndrome, photograph and record injuries both internal and external during autopsies which aids in the pathologists' determination of death and proving additional opportunities to attain evidence. Additionally, the x-rays taken with this handheld scanner can be hyperlinked and attached to their associated photos and later used in courtrooms to corroborate investigative testimony. These technological investigative tools are all designed to expedite the efficiency and effectiveness of the investigative process and can be used to complete the death investigative process as well. However, to ensure uniformity in the delivery of investigative services, it is important that these tools are accessible to investigative agencies and training is provided on their uses and benefits resulting in consist and uniform outcomes.

New NY Law Requires Medical Training for Elected Coroners

The governor of New York signed a new law requiring elected coroners, before taking office, to complete courses in medical-legal investigations thus placing New York as the 17th state to require training for coroners (Magazine & Aug, 2017). The specifications for the required courses have yet to be determined but the Department of Health, Commission on Forensic Science, the N.Y. State Division of Criminal Justice Services, the N.Y. Department of State and other professional groups, will collaborate to determine the curricula (Magazine & Aug, 2017). Since dealing with death and crime scenes tends to be inherently difficult both mentally and physically, it is imperative that crime scenes and evidence discovery are handled appropriately thus warranting state mandates toward coroner training. Nonetheless, there are still concerns regarding the need for coroner training, what entity or who will manage and provide training, and

mandated costs associated. Though there have been some offers to begin preparations for providing coroner instructions, some initial steps are needed such as proctors and the organization of a yearly coroner beginner or introductory class.

The new law requires coroners to pay for the courses themselves, with counties having the option to reimburse the officials but there are also concerns about the cost imposing undue expenses on counties due to lack of funding (Magazine & Aug, 2017). Additionally, there are apprehensions with whether mandating coroner training will transform the duties and responsibility of coroners making them something that they are not and changing their job descriptions. However, imposing training courses for this specific area of a coroner's responsibilities will not make them experts in death investigations nor will it make them pathologists so if any suspicious circumstances occur, they would still be advised and expected to contact an expert.

Unlike medical examiners, coroners do not have to possess any precise education or professional background unless mandated by law and they are usually elected or appointed into their positions. Throughout the United States, approximately 20 states operate under a medical examiners system and 30 states use a coroner system. In New York if a coroner is not licensed to practice medicine then they must work with a coroner's physician, but this should not negate the need for coroners to have some training (Magazine & Aug, 2017). There is no expectation for coroners to become medical examiners but only that they hold basic primitive points of carrying out a medicolegal death investigation. Ultimately, the intent is to ensure death scenes are investigated properly.

As with medicolegal death investigators, there are also inconsistencies within the coroner and medical examiner systems. Nonetheless, this article, New NY Law Requires Medical Training for Elected Coroners and provides rational for reasons to regulate the proposed standards and streamline the death investigation system. Furthermore, since many coroner offices also employ medicolegal death investigators or forensic investigators, consistency is key to the assurance that cases are conducted in a routine manner.

European Council of Legal Medicine (ECLM) accreditation of forensic pathology services in Europe

Throughout the legal process in the criminal justice system, forensic experts are an integral aspect of the process and the evidence they gather during the criminal justice processing and their professional expertise helps to build a better system. The criminal justice system mediates either the perceived guilt or innocence of an accused individual. Thus, the process of medicolegal investigation is also an essential aspect of the criminal justice process by aiding in the scientific determination of cause and manner of death in deaths that fall under the medical examiner's jurisdiction. Additionally, death investigations provide case evidence that provides evidence in cases dealing with psychological, physical, or sexual abuse and the evidence obtained should remain effective, independent, and prompt during service delivery. It is highly preferable that forensic pathologist conduct death investigations. Forensic pathologists are preferred since they have specialized in forensic medicine, have no hierarchical relationships with policing agencies or prosecutorial authorities, and provide high quality forensic reports of

their findings. It is additionally important that forensic pathologist have resources available with private, public, national, or international authorities at their disposal and have built a network of working professionals. Forensic pathologist and other specialists who work in accordance with high standards of professional performance and have submitted to an official accreditation/certification process using valid and acceptable criteria are able to establish themselves as experts in their field (Mangin, et al., 2015). NAME, an organization designed to support the accomplishment of ensuring the expertise of medical examiner's, has developed an accreditation/certification checklist that serves as a decision-making tool for inspectors selected to gauge applicants (Mangin, et al., 2015). Furthermore, NAME Accreditation Standards and the European Council of Legal Medicine (ECLM) board established an ad hoc working group tasked with the goal of developing and implementing an accreditation/certification procedure similar to the NAME's but taking into account the realities of forensic medicine practices in Europe and restricted to post-mortem investigations (Mangin, et al., 2015). The difference in the NAME accreditation process opposed to any other is that the focus of this accreditation is geared toward the act or services provided oppose to the individual conducting the act. Policies and procedures are highlighted and emphasized in a NAME proposal and considered as the minimum standards needed to get the recognition of consistency and performance in forensic pathology.

National Commission on Forensic Science

In 2013, the National Institute of Standards and Technology (NIST) and the US Department of Justice (DOJ) began a collaboration forming the National Commission on

Forensic Science (NCFS) and what is now the Organization of Scientific Area Committees (OSAC) (DOJ, 2015). To date, the NCFS has implemented several tools and resources geared at strengthening the forensic system process by offering resources for professionals. The NCFS is comprised of a diverse group of stakeholders from various federal, state, and local entities who are all involved and vested either directly or indirectly in the forensic science process. Additionally, there ae subject matter experts in the forensic field who provide their expertise for the development of NCFS programs and advancements. The subject matter experts serving on NCFS committees do so on a two-year term, during which time they are slotted to discuss and approve agendas that are aimed at positively impacting the forensic science system. An example of a recommendation established by the NCFS is regarding a National Code of Professional Responsibility for Forensic Science and Forensic Medicine Service Providers (DOJ, 2015). These recommendations include pretrial discovery, a request for NIST to perform developmental validation studies, accreditation of digital and multimedia forensic science service providers, and formation of a national disaster call center (DOJ, 2015).

The primary responsibility of the NCFS is to promote the fair and impartial application of forensic evidence in the determination of criminal justice findings. The NCFS is devoted to ensuring foundational improvements are made to advance the basic aspect of science and legitimize both forensic techniques and evidence collection. The application of these practices is important because it promotes a better understanding of the process and encourages clarity of forensic evidence within the forensic science system. Lastly, the NCFS strives toward the improvement of the management and

operation of organizations that offer forensic services to ensure quality and consistent service from the beginning until the end of the investigative process.

Bill would require training for death investigators

Rock County has changed from a coroner system to a medical examiner system consequently requiring extensive training beyond the minimal standards for their death investigators. This change stemmed from the case of a 91-year-old whose death was originally deemed an accidental death and later ruled a homicide or if could be due to the rash of heroin overdoses that are missed and underreported (Tca, News, & May, 2015). Unfortunately, with the 91 -year old, an autopsy was not performed, and it was not until the body was exhumed that the case was reclassified. During the initial death investigation process, the MDIs did not obtain the evidence they normally would have during a homicide death investigation since the death was originally investigated as a natural death. This error during the death investigation process was thought to have been the fault of an untrained deputy coroner thus causing many to request legislative support mandating that those involved in the death investigation process receive a minimal amount of training to conduct death investigations. Regrettably, the legislation has encountered reluctance in passing due to lawmakers not wanting to mandate training for coroners (elected officials) (Tca, News, & May, 2015). Furthermore, this new proposal would require MDIs to get 40 hours of death investigative training, obtain certifications through the state and the American Board of Medicolegal Death Investigators (Tca, News, & May, 2015). These new requirements are an insignificant change in comparison to the hundreds of hours police officers undergo to learn about death investigations or the

training required for hair stylists or tattoo artists experience to effectively perform job functions (Tca, News, & May, 2015). Requiring consistency in training for MDIs is an issue that affects everyone, but it is not discussed, is difficult to get legislative attention due to the lack of high-profile issues and no apparent correlation between any hot button issues and errs in death investigations.

The proposal requires $1.5 million for training in the first biennium and then $500,000 every two years to keep investigators up to date and train new ones (Tca, News, & May, 2015). Nonetheless, Wisconsin is one of four states that does not dictate the need for training of its coroners or death investigators and of the 600 death investigators and six coroners, more than half do not possess that specific training (Tca, News, & May, 2015). The lack of training for those who investigate death has resulted in instances of unprofessional conduct by coroners and death investigators. Thus, the proposed mandates for training will not only help during the death investigation but will cover all other aspects of the criminal justice and investigative process. During testimonies, once they have completed their training, death investigators are considered trained professionals or an expert in the field. Investigators trained beyond the current minimum standards were surveyed during the preliminary process and they believe that the proposed training requirements would be a great addition to the death investigation system and only prove to add value to both the system and the process.

Overdose Deaths Overwhelm Medical Examiner, Coroner Offices

An increasingly high number of death due to overdoses are causing a snowball effect on the already troubled coroner and medical examiner offices, leading to issues

with body storage as well as delays with providing toxicology and autopsy reports. Such as the Connecticut medical examiner's office is considering the use of rented refrigerated trucks to accommodate body storage concerns, Milwaukee County medical examiner's office often runs out of gurneys and uses Army-style cots for their deceased, or the Hamilton County coroner's whose 100-day DNA backlog has caused delays for police drug investigations (Worldstream, York, & York, 2016). The various coroners and medical examiners offices are faced with the added strain on their services. This strain is primarily due to increased overdose deaths, monetary constraints, surges in violence, shortages in qualified investigators, and inadequate facilities (Worldstream, York, & York, 2016). Several counties and varying jurisdictions are encountering this same problem, 47,055 people in the U. S. died from drug overdoses in 2014, spurred by heroin and opioid deaths with the recidivism of overdoses continuing to increase (Worldstream, York, & York, 2016). The problems associated with the increases in deaths have also resulted with delays in criminal investigations and court proceedings.

Several medical examiner and coroner offices are risking their accreditation because pathologists are nearing the limit of allowable autopsies established by the National Association of Medical Examiners' accrediting program. Many counties have stated how issues with understaffing has left them unable to perform death investigations in conjunction with complaints of overloaded bodies in morgue coolers and testing backlogs for toxicology and histology. Dr. James Gill, Connecticut's chief medical examiner, said the rash of deaths has caused his office to no longer perform toxicology tests for deaths clearly caused by trauma thus leaving the expense to police departments

and families if they want the tests done (Worldstream, York, & York, 2016). Additionally, the Milwaukee County office is having more issues than investigative shortages, they are also dealing with budget cuts resulting in unfilled toxicologist position. The White House's National Science and Technology Council has been looking into how to improve the nation's coroner and medical examiner system. Many of the proposed changes will include recommendations to increase investments in training pathologists and better report death investigation data needed to inform lawmakers and monitor public health (Worldstream, York, & York, 2016).

Death Investigation in Maryland

Death investigations in Maryland dates back to 1634 as a coroner system; aside from being used to train the Office of Chief Medical Examiner's (OCME) forensic investigators, Scarpetta House has been employed to train members of the Disaster Mortuary Operations Response Team (D-MORT), Baltimore City Police Department homicide detectives, attendees of the Frances Glessner Lee Homicide Seminar, and other groups (Fowler & Goldfarb, 2015). By the 1930's the coroner system in Baltimore had progressed into one that was untrustworthy, dissatisfactory, and susceptible to corruption and abuse within the death investigation system. The old system was chockfull of hearsay, guesses, and snapshot diagnoses comprised without personal investigation where discrepancies and inaccuracies were so common on death certificates that often they were worthless for accurately giving immediate causes of death (Fowler & Goldfarb, 2015). Currently the OCME is thought to be a forensic model both in the U.S. and internationally and has hosted visits from various medicolegal death investigative

agencies to observe the building for their design process as well as maintaining a role in resident training for local medical schools. Additionally, the OCME has structured educational relationships in China, formed an international study agreement with Ningbo University medical school, launched a forensic science master's program, and hosted two visiting scholars from Fudan University (Fowler & Goldfarb, 2015). In addition, the OCME investigates more than 9,000 deaths, conducts about 4,400 autopsies annually, and adheres to a strong institutional lineage of excellence (Fowler & Goldfarb, 2015). The OCME facility is a cohesive system which houses laboratories, training, autopsies, records, and supervision departments. Unlike many forensic facilities, the OCME implements a multifaceted quality assurance practices with peer reviews of death investigation cases in the morning and conferences in the afternoon designed to certify that findings are as factual as possible.

The OCME has proven to be not only effective but efficient stewards of public funds. While other accredited forensic medical centers have an operational cost of $3 per taxpayer per year, the OCME is at $1.97 and the $10 million annual budget is still less than the State's Fisheries Service (Fowler & Goldfarb, 2015). The fiscal accountability displayed is just one of the reasons why OCME is considered a great professional and modern example of a medicolegal death investigation system. Furthermore, the OCME has set examples of ways to optimize MDI resources as well as how to emphasize a teaching model when conducting death investigations and thus regarded as the gold standard for other forensic systems to model.

An overview of the challenges facing death investigation systems in certain resource limited countries

An appropriate and well-run death investigation system (DIS) serves multiple stakeholders who can be described as the public, law enforcement agencies, and public health departments. The data collected during a death investigation should be done methodically and competently to ensure the integrity of the data retrieved is maintained. In conjunction, the system should be amenable enough to respond to the various pressures place on investigative resources especially since the responsibilities on an investigation necessitate an investment of public money through taxes. However, countries such as the Sub-Saharan Africa and the Caribbean face several difficulties that prohibit the appropriate functioning of the DIS. Yet, in Western countries the world economic crisis has resulted in a public service deficit affecting both the healthcare system and related to death investigation services. Pathologists and other stake holders (judiciary, police agencies, families) prefer that death investigations were conducted by international standards, unfortunately policy makers in resource limited countries face additional population health and socio-political pressures which generally result in very little funding for investigative service (Obenson & Enow Orock, 2017).

Summary

This chapter focused on identifying and isolating gaps within current literature regarding current standards and the regulation of medicolegal death investigations. The importance of creating a standardized process serves as a foundation that encourages positive outcomes while enhancing the quality of investigations performed as well as

refining implications of public health within the Texas medical examiner offices. This includes reinforcing the need for compliance with programs such as NAME or ABMDI especially because the process and profession of investigating deaths does not necessitate accreditation credentials. This lack of mandated this credentialing process can make things challenging for MDIs. Meanwhile, issues persist while conducting investigations with the absence of government standards thus increasing inaccuracies in death investigations performed and leading to public safety and health problems.

The implementation of uniform standards during investigations will improve the quality of services within the medicolegal death investigation system, however, restricted resources through training, education, monetary shortages, the lack of qualified investigators, or uniformity reinforce irregularities throughout the system. Thus, to gain more insight regarding death investigations, articles were chosen by conducting an exhaustive literature review using words and terms that would help with the identification process. The gap identified was in the area that is under-explored, developing standards within the medicolegal death investigation system. This was realized by recognizing areas where a contribution toward new research can be implemented. Additionally, research strategies highlighted research categorizing the effects of unstructured death investigations on the medicolegal death investigation system.

Since a gap in research has been identified regarding medicolegal death investigations, transitioning to chapter 3 will contain descriptions of the study design such as procedures, participants, assessments used, and the assessment of the information

gathered. Thus, the use of a qualitative method and the education theory may best shed light on and assist in understanding experiences of MDI and this phenomenon.

Chapter 3: Research Method

Introduction

In the previous chapters, I described how unstandardized procedures in medicolegal death investigations can affect the delivery of investigative services. The change in standards that I have proposed included differences concerning investigator training, education, and work experiences. The focus and primary concerns of standardizing medicolegal death investigations is to reduce negative health implications as well as issues with death investigations that may result in miscarriages of justice in the criminal justice system. During the death investigation process, MDIs encounter and are subjected to several situations and scenarios that have the potential to affect their service delivery. However, what is not known is how these factors and inconsistencies impact the medicolegal death investigation procedure. Thus, an educational theory may shed light on this unknown phenomenon of interest experience. In this chapter I outlined the qualitative method used to assist in understanding the experiences of MDIs.

Research Methodology

Qualitative methodology is exploratory in nature and allows for broader knowledge and understanding of issues and underlying problems affecting the various outlooks, motives, and inspirations of society (Johnson, Onwuegbuzie, &Turner, 2007). However, due to the absence of research and investigation of MDIs, it is difficult to define variables to examine. The use of a qualitative method provides not only more insight but encourages the development of both theories and ideas toward the research being engaged. Qualitative research provides a basis for theory construction a mere

explanation of itself using usually a small sample size to fulfill the stated quota. In this research I compared educational, work experiences, and training experiences of MDIs currently employed by medical examiners' offices in the North Texas Region. Additionally, the research conducted in this study dealt with the experience's investigators had while conducting death investigations and whether these experiences caused a lack of understanding for the profession and the expectations of investigators. Furthermore, I discussed whether the investigators experience had negative impacts on how they conducted their investigations, impacted societal health and safety, and potentially caused hazardous working conditions for investigators. My research also gaged if changes and improvements to the system will have any profound affect; possibly errors are part of the job and have no bearing on personnel performance.

Research Design

The use of a qualitative approach in this research allowed for me to use several research designs approaches that were beneficial for this research. The education approach is the approach that allows society who are the stakeholders, to concentrate on understanding the relationship between medicolegal death investigation and how the investigations they conduct impact society. In my research, the education theory explained not only the purpose of my research but also helped with the interpretation, application, and learning about death investigations and education. Though the educational theory is composed of several theories, this theory helped to clarify not just a singular explanation but also how information should be delivered to provide greater understanding of what is being researched. Using the education theory investigators

detailed their knowledge, including any issues faced or experienced when they were conducting death investigations, times they felt inadequate to handle their jobs due to training, and educational issues experienced. Thus, in order to evaluate the experiences of MDIs this research involved the dissemination, collection, and interpretation of surveys given to investigators that involved their experiences as death investigators.

I used educational theory to offer insight in research related to criminal justice and allowing for focus on stakeholders including the investigators geared primarily toward the processes involved in medicolegal death investigations. I used this theory to incorporate the use of interviews and coding since several investigators are going to be contacted throughout various districts in the North Texas Region. Additionally, the educational theory was more appropriate for my research because the gender role strain theory or other existing theories did not allow for investigators to share their experiences as effectively. According to Creswell (1998), such as with ethnographical studies that are used to provide a "description or interpretation of a cultural group or system the same can be said for the use of the educational theory when used in the right context. However, an ethnographical approach would be possible if the participant population was much greater and perhaps confined to a population in a specific location. Unfortunately, the population of MDIs used in this research was not large, they were concentrated in the North Texas Region, and are not considered a cultural group or system. The use of case studies was also a consideration for my study, case studies are "an exploration of a bounded system or cases over time to gather information (Creswell, 1998)." Though the use of a case studies may be applicable to this research, this approach was not chosen

because the focus of this research was to gauge the current experiences of investigators and not the experiences, they have over time. Additionally, my research focused on exploring how MDIs learned and processed information and how to best apply research findings thus making the educational theory the most appropriate theory for me to use.

Participants of the Study

I targeted medicolegal death investigators (MDIs) in the state of Texas specifically in the North Texas region. Investigators were contacted to participate in surveys, questionnaires, interviews, and MDI shadowing if possible. There are 11 medical examiner offices in however, the invitations were extended to offices in the North Texas region which was approximately five offices for a target of 15 medicolegal death investigators. The purpose of conducting job shadowing with investigators was to compare how each office handles their field investigations and whether these offices have their own internal regulatory standards. I aimed to accomplish with this study a goal of determining whether regulations existed within offices and highlight whether these variations made a difference in the delivery of investigative services. Additionally, I focused on identifying if differences impacted service delivery and performance for MDI. According to Kelsall & Bowes (2016), establishing regulations and standardizing medicolegal death investigations positively affects the quality of death investigations conducted and serves to improve implications toward public health. This is further complicated because the U.S. Constitution gives the responsibility of determining the minimum law requirements for death investigators to each individual state to implement (Jentzen, 2009). Thus, as a medicolegal death investigator, I personally reached out to the

targeted medical examiner offices and requested that my flyers were allowed to be placed in public areas for MDI participation in my questionnaire/interview. I also contacted medicolegal death investigators that I had connections with through my social media accounts such as LinkedIn and Twitter to request the assistance of their participation. I sent a letter describing my research study to all potential volunteers. This letter can be found in Appendix A.

Measures

The purpose of this study was to identify how an unstandardized medicolegal death investigation system referencing MDIs work experience, training, and educational backgrounds affect MDIs and their service delivery. Standard requirements for investigators were addressed in my research and how these factors as well as varying differences impacted medicolegal death investigation procedures. This research provided insight into the unregulated profession of medicolegal death investigations, any effects created by differences between MDIs, and the impact on the medicolegal death investigation system. Investigators were identified as those who were currently employed by any North Texas region medical examiner's office either as a full-time or part-time MDI. My research questions were designed to better understand the experiences of MDIs and their work conditions as it related to performing medicolegal death investigations.

Research Questions

1. What standards of practice should be adopted, if any, when conducting medicolegal death investigations?

2. What would be the benefit of implementing new procedural practices for investigators?
3. To what extent do varying volumes of medicolegal death investigations performed per jurisdiction have a direct effect on investigative standards and case outcomes?

Ethical protection of participants

The participants in this study were adult volunteers who made an uncoerced choice regarding their desire to participate in my research. There was no known harm associated with participating in this study. However, if participants did encounter harm or difficulty due to their study participation, a referral to local services would have been provided. Each member received and completed a consent form as well as an assurance that their confidentiality would be protected. Any associated research audiotapes, transcripts, surveys, and files were stored in a secured keyed location in the researcher's home. Access to surveys were limited to the researcher and were numbered to protect participant identities. All identifying materials and data were removed from transcripts before I validated the data.

Procedures

The following procedures will serve as a chronological guide to recruiting and informing participants, collecting and analyzing data, and validating findings.

1. Contacted, via direct message on LinkedIn, Twitter, and telephone, current death investigators in the North Texas region and provided them with information about the study.
2. Informative letters detailing the nature of the study were sent to participants.
3. I scheduled informative meetings with the identified adult participants to present research and to provide a copy of a letter describing the study.
4. Requested that interested participants contact me to schedule interviews. I made follow-up telephone calls to participant when no contact was made within one week of the informative meeting.
5. Before the survey, each participant was given a copy of a letter describing the proposed study and participants were asked to either sign the consent forms or return by email as a sign of consent.
6. Surveys were transcribed and analyzed according to steps outlined at the end of this chapter.

Data Collection

I used purposive sampling, which entails selecting certain persons, settings, or activities that provide both relevant information to the research questions and goals which cannot be obtained through other forms. Medicolegal death investigators are a small professional population, so the most appropriate selection is purposeful because it ensures the conclusion obtained represents the preset variables and show the relationships that answers the research questions.

During the data collection process, the contiguous relationship between the needed information and the information collected involves a process of revisiting both the research problem and question, while confirming the best data for the research is gathered (Creswell, et al., 2003). This data collection process allowed time for constant revisions and highlighted possible issues in my research related to participant representation and during the survey questionnaire response. The surveys I disseminated focused on the backgrounds of the participant, the participant's experiences in context with the study, and their job responsibilities. Additionally, the pre-survey interaction involved building a rapport with participants, ensuring the consent forms were signed, and clarifying research objectives. This included describing the nature of the study and sharing my personal experiences related to medicolegal death investigations, if appropriate. This information was shared with MDIs in an effort to build rapport and hopefully develop credibility towards listening to their experiences objectively.

Last, ensuring my research question was addressed entailed me surveying each participant with questions designed to identify how they perceived their effectiveness as an investigator. Furthermore, notes will be taken to transcribe survey responses. Data was organized by creating files of the transcribed surveys. Interview questions are listed in Appendix B.

Data Analysis

Once the data was obtained, constant note taking during the analysis phase focused on my thoughts while generating new research awareness. Data was analyzed using coding and categories to identify patterns and themes in the research that would

help develop the conclusion. Once the data from the surveys was compared, it was then be coded and categorized using CAQDAS analysis. The data collected primarily entailed the use of surveys which were coded, and memos were used to identify similarities in the data collected. A matrix helped maintain alignment and bridged gaps to show relationships from research questions to the collected data.

It was important to list or highlight statements that contain specific text relevant to my study. Various statements were extracted to understand the role of the medicolegal death investigator and the inconsistencies in the profession. The assertion of a reduction and elimination process occurred during data analysis since the extracted text produced numerous possibilities. Nonetheless, parallel experiences that contained necessary facets of a MDIs skill was labeled.

Labeling statements allowed for greater understanding of the effects of unstandardized death investigations was a crucial step in understanding the experiences of MDIs. The expressions identified represented the emotions, feelings, and actions regarding how participants (MDIs) experienced the phenomena. Statements were later defined with a psychological meaning and described the typical language regarding the phenomena studied.

Finally, the data obtained from the surveys was analyzed by developing both individually and by group descriptions of the experience and created the meaning for participants which was another important aspect of the analysis process. Once formed, individual descriptions were made, and the connections of each participants were grouped

to develop descriptions of their meanings to reflect and translate the experiences, representing the group.

Verification of Findings

A verification process was used, commonly used qualitative studies and helps maintain the essence of its own standing while keeping the qualitative inquiry intact (Creswell, 1998). This process is comprised of two of eight recommended steps which includes triangulation, persistent observation, clarifying researcher bias, peer review, member checks, negative case analysis, external audits, or rich and thick description, (Creswell, 1998). Of these steps, my research employed rich and thick description and clarifying researcher bias.

The purpose of having a rich and thick description allows the readers to transfer information to other settings and to ascertain whether my findings can be transferred based on shared characteristics (Creswell, 1998). This study possesses verbatim transcripts which provide both descriptive and contextual information. This process consisted of marginal notes on surveys that highlighted meaning units and directed statements from participants. In conjunction with completing these steps, I also identified and clarified any researcher bias which is extremely important in my study since I am employed as a MDI. According to Creswell (1998), it is imperative that the reader understands the researchers' relationship to this topic. As the researcher in this study, I was a medicolegal death investigator in the North Texas region. Additionally, the I have firsthand experiences with discrepancies of unstandardized death investigations. During investigations I have experienced discord when collaborating with various entities due to

inconsistent practices among other medicolegal death investigators as well as medical examiners' offices. Having experienced feelings of incompetence, having outdated skills, and even being over or under qualified were often common themes. When conducting this study, I was expecting to find that other investigators experienced similar issues or feeling, so I made a dedicated effort prior to any communication with participants to heighten my awareness and keep in mind that the experiences shared were to solely be those of the participant's. Surveys were evaluated objectively, and I avoided clarifying questions that may have led participants to respond in a fashion that was consistent with my personal experiences. This approach was also used during each step of the data analysis process as well. Thus, I was cognizant of any relevant experiences that fell under these scenarios and these experiences were documented accordingly.

The final form of verification stems from having a rich, thick description. The purpose of detailed description "allows the readers to transfer information to other settings and to determine whether the findings can be transferred based on shared characteristics" (Creswell, 1998). This study has verbatim transcripts providing contextual and descriptive information. This type of verification provides a richness of information because multiple data points are identified by using verbatim quotes in the text regarding the theme as it relates to multiple participants. There are notes in margins of the transcript highlighting meaning units or horizons, and direct quotes from participants beneath psychological expressions. Thus, each of these methods of analysis are important in providing a rich, thick description.

Summary of Chapter Three

An educational method of inquiry was chosen for this study because it provided a way for the investigators in this study to share their education, training, and work experiences and how their backgrounds related to how they perform their jobs. The participants selected for this study were all medicolegal death investigators or forensic investigators, who worked either full-time or part-time as an investigator, and all were in the Northern Texas area without regard to their specific length of employment. Data was collected through surveys where relevant information was asked to the context of their situation and questions were specific to the phenomenon being studied. The data was analyzed by identifying individual and group descriptions of the experience to understand the overall meaning of their experience. Verification consisted of using clarifying researcher bias and having a rich, thick description. Chapter 4 provides rationale for modifying the recruitment process; participant profiles; and an explanation of how data was collected, managed, analyzed, and verified. It also provides findings relevant to the research questions.

Chapter 4: Results

Introduction

Medicolegal death investigators are considered experts in the field of their trade with an expectation that they be well versed in forensic science especially with the investigation of deaths under the jurisdiction of the medical examiner. The role of the MDI is very specific, however a lot of their knowledge and understanding of the job is gained from on the job training and prior investigative experience. MDIs deal with varying degrees of death and a primary focus on the crime scenes as it relates only to human remains present. The skills needed to be successful as a MDI consist of an understanding in forensics and its applications, effective and efficient interview techniques, and collecting pertinent data that the forensic pathologists uses to determine cause and manner of death (Kelsall & Bowes, 2016). However, what was not documented is how an unstandardized medicolegal death investigation system focusing only on the experience of the MDI and their work experience, training, and educational backgrounds may influence how they conducted death investigations.

This study is the first step in filling a void in the literature to better understand and recognize the need for standardized regulations in medicolegal death investigations by concentrating on the need for uniform training and safety practices. In this study, 16 investigators completed surveys and provided detailed information regarding their experience. In this chapter I detailed the process in which participants were recruited; the participants profiles; how data was obtained, securely stored, and analyzed. I also provide

information regarding the steps of verification used to ensure accurate and quality data that was collected and the identification of themes.

Recruitment

MDIs form medical examiner offices in the North Texas region were recruited for participation. This approach allowed for access to participants by identifying those medical examiners offices that are in the North Texas region. After identifying qualified investigators, letters were provided to them detailing the purpose of the study as well as offering an option to complete either a survey or an interview. This letter is in Appendix A.

Flyers were placed in public medical examiner county buildings, sent to the public county email addresses of MDIs and flyers were posted on my personal social media forums both Twitter and LinkedIn informing MDIs of the nature of my study and the profile of needed participants in an effort to recruit participants . Respondents were professional colleagues of which more than half of them I worked with. This approach in identifying recruits also posed barriers to identifying individuals willing to participate. Many investigators stated they were too busy to dedicate 30 minutes to complete a survey. No investigators wanted to participate in an interview because they felt that it would be too time consuming. There were investigators who were in other states willing to participate; however, they were outside of the target area. There were also investigators that simply declined the invitation for no stated reason. Ultimately, 16 qualified participants were identified and agreed to participate.

Of the 16 participants, 10 were my work colleagues, four were friends of colleagues that are also investigators whom the researcher met during this process, one was by word of mouth, (a snowball sample) and one by online recruitment efforts. The participants were contacted via email regarding the study, during this communication they were given information regarding the research, asked about their interest in participating, and their qualification to participate in the research was determined.

Participant Profiles

Participant Number 1, B. P., a medicolegal death investigator in the North Texas region was recruited as a colleague. He possesses a bachelor's degree in an unspecified field, had no previous training in conducting death investigations and he does not belong to any professional organizations. This participant chose to participate in this research by completing a survey.

Participant Number 2, C. J., a medicolegal death investigator in the North Texas region was recruited as a friend of a colleague. She possesses a bachelor's in forensic science and a masters in anthropology. She had no prior training in conducting death investigations and she does belong to a professional organization. This participant chose to complete the survey option of the research.

Participant 3, C. P., a medicolegal death investigator in North Texas was recruited by word of mouth after discussing the research with a friend of a colleague who completed a survey. She has bachelor's in an unspecified field. She has had no previous training in conducting death investigations and has no affiliations with any professional

organizations. This participant resides over an hour away from any agreeable meeting location and is taking online classes thus she chose to complete the research via survey.

Participant 4, C. S., a medicolegal death investigator in North Texas was recruited as a colleague. She has a bachelor's degree in criminal justice and a master's degree in forensic science. She had no previous training in conducting death investigations and no professional affiliations. Due to personal time constraints and family dynamics, this participant chose to complete the survey option of the research.

Participant 5, E. D., a medicolegal death investigator in North Texas was recruited as a colleague. She possesses a bachelor's in an unspecified field and a master's degree in criminology and criminal justice. Her previous hospital experience and military career provided her with previous training in conducting death investigations. Additionally, she has professional affiliations and chose to complete the survey because she felt it was more anonymous.

Participant 6, J. H., a medicolegal death investigator in North Texas was recruited as a colleague who is now in a different county. She has a bachelor's degree in criminal justice and has completed coursework toward a master's degree in forensic science. She had no previous training in conducting death investigations and does not belong to any professional organizations. She declined to participate in an interview but agreed to complete a survey at her leisure.

Participant 7, J. J., a medicolegal death investigator in North Texas was recruited by online recruiting through social media. She possesses a bachelor's degree in police science and stated her previous work as an intern provided her with training that prepared

her for conducting death investigations. However, she does not have any professional organization affiliations. She elected to complete a survey and was not interested in participating in an interview.

Participant 8, K. A., a medicolegal death investigator in North Texas was recruited as a colleague and possesses a bachelor's degree in forensic science with a minor in chemistry. She had under 2 years of prior experience conducting death investigations and she does have professional organizational affiliations. She only opted to participate in completing a survey.

Participant 9, K. C., a medicolegal death investigator in North Texas was recruited as a colleague. She has an associate's in science, a bachelor's in business, and a master's in forensic science. She stated she has had extensive investigative training which prepared her for conducting death investigations and she does have affiliations with professional organizations. She elected to complete the survey and declined an interview.

Participant 10, K. N. a medicolegal death investigator in North Texas was recruited as a colleague. He has a bachelor's degree in an unspecified field and has completed some coursework toward a master's degree. He had not obtained any previous training prior to conducting death investigations and he does have affiliations with professional organizations. He offered no explanation but only agreed to participate in completing a survey.

Participant 11, L. H., a medicolegal death investigator in North Texas was recruited as a colleague. She has a bachelor's in criminal justice and no prior training in conducting death investigations. However, she does have affiliations with professional

organizations. She was unable to arrange a time via in-person or on the telephone to participate in an interview, so she completed a survey.

Participant 12, M. F., a medicolegal death investigator in North Texas was recruited by word of mouth after discussing the research with a friend of a colleague who completed a survey. He has a bachelor's in premed, prelaw, and psychology and has completed some graduate coursework in public health. He has had prior training in law enforcement which he stated prepared him for conducting death investigations. Additionally, he also belongs to affiliated professional organizations. He reached out to me via email requesting to complete a survey.

Participant 13, N. H., a medicolegal death investigator in North Texas was recruited as a colleague. She has obtained an associate degree in criminal justice; she has had no prior training in conducting death investigations and belongs to no professional organizations. She only agreed to conduct the survey and not to participate in an interview.

Participant 14, S. F., a medicolegal death investigator in North Texas was recruited as a colleague. He has obtained a bachelor's degree in psychology with emphasis in criminal justice, a master's degree in applied cognition and neuroscience, and a certificate in forensic science. He stated he has obtained prior training from a law enforcement background and does not belong to any professional organizations. Due to time constraints and prior obligations, we were unable to arrange an agreeable interview time, so he completed a survey instead.

Participant 15, S. M., a medicolegal death investigator in North Texas was recruited as a colleague. He has obtained a bachelor's in criminal justice and an MBA. He has no prior experience in conducting death investigations and he does not belong to any professional organizations. He was only willing to participate in completing a survey.

Participant 16, T. E., a medicolegal death investigator in North Texas was recruited as a colleague. She has obtained an associate degree in forensic science and psychology, a bachelor's in criminal justice, a master's in forensic psychology, and completed some coursework toward a PhD. She has had no prior training in conducting death investigations, but she does belong to affiliated professional organizations. She opted to participate in the survey aspect of the research.

Data Collection and Storage

Each of the 16 participants completed a survey via email, as described in Chapter 3. I personally delivered consent forms to each participant via email. Once the participants were in receipt of the forms, they were tasked with reviewing them for clarity and understanding then confirming that they were willing to participate. Once each participant notified me of their intent to participate, they were then sent a survey to complete. After surveys were completed and received, they were then filed and saved in a secure database on my private computer. Additionally, a secured password protected flash drive was also used. I then transcribed each survey and stored in a locked filing cabinet in my home office. I ensured all identifying information was removed from the transcripts prior to the verification procedures.

Data Analysis

Reduce number of times you use I. The survey transcripts were analyzed through a multi-step process once they were organized and printed in large font with triple-spaced lines. I read each transcript in its entirety to ensure I had a general understanding of the data obtained, which is typically the first step in data analysis. Then any statement made by participants that contained relevance to my research topic was highlighted and underlined. Furthermore, specific statements that were relevant to my research that referenced education, training, and work experiences of MDIs was labeled and reframed into descriptive expressions. This process also required me to development themes that were pertinent to my research topic. Once specific themes were identified, individual descriptions were formed by listing the general themes for each participant at the end of every transcript. Once individual descriptive experiences were consolidated by similar themes, I was able to create an overall group description. Individual and group descriptions are provided later in this chapter. However, it was appropriate to develop a set of subcategories which were designed to be inclusive opposed to being exclusive.

Data Verification

In order to start the verification process, the surveys had to first be completed, transcribed, and then analyzed. I verified the data for my study by clarifying researcher bias, peer review, and rich, thick description as suggested by Creswell (1998). However, a rich, thick description is demonstrated using direct quotes from transcribed surveys to provide support for the expressions listed, which follows in the next section.

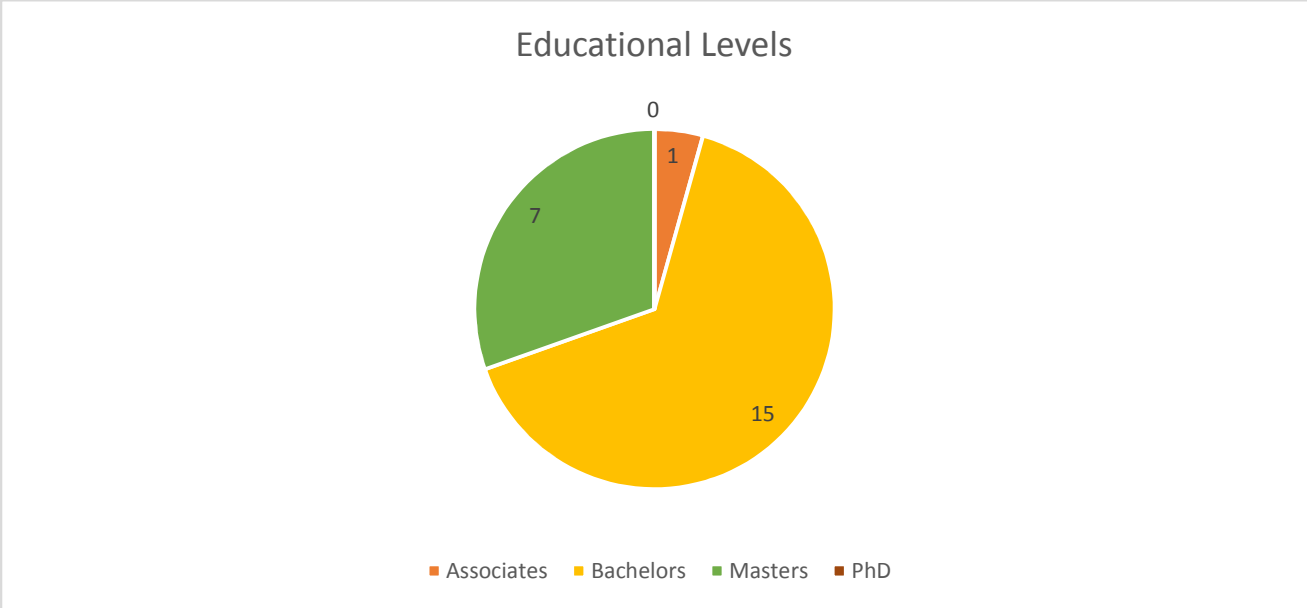
Additionally, transcribed verbatim responses from the interviews are provided in Appendix D.

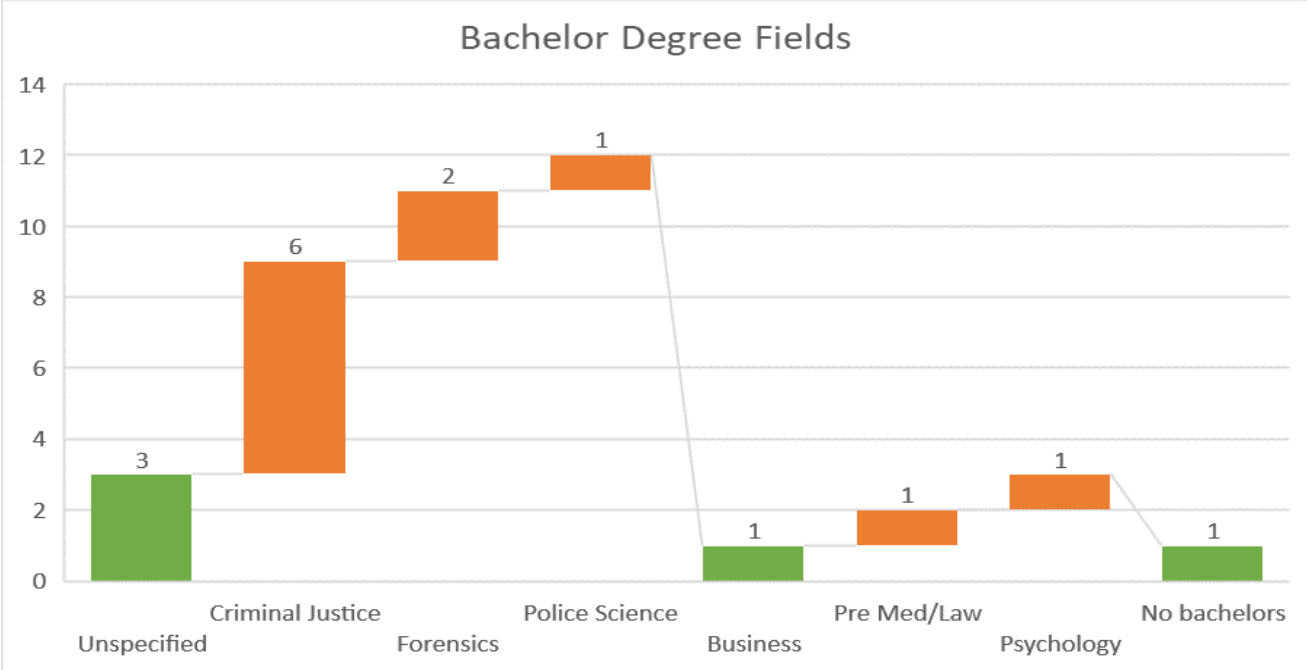
As part of clarifying researcher bias it is known that I was a medicolegal death investigator in the North Texas region and had herself experienced inconsistencies in work performance due to prior work experiences and training. I found similar experiences regarding developing stronger training for investigators and came to appreciate the need to develop structure and routine so death investigations could be correctly and effectively performed. Additionally, I experienced firsthand discrepancies of unstandardized death investigations while working as a MDI. During death investigations I have experienced discord with collaborative entities due to inconsistent practices among other medicolegal death investigators as well as medical examiners' offices. Having feelings of incompetence, having outdated knowledge, and even feeling overqualified at times were often common themes. I was expecting to find that other investigators experienced similar feelings and was cognizant of this expectation prior to and during the transcribing of surveys. I made a dedicated effort prior to each interview to heighten awareness of my own experiences to lessen bias. My role was to interpret each participants response objectively and avoid clarifying questions and translations that may lead to participants replying in a fashion that coincided with my experience. I was sure to conduct each step of the data analysis in my research with the same consistency and without bias.

Themes Identified

In this study my goal was to determine whether an unstandardized medicolegal death investigation system relating to the MDIs differences in work experience, training, and educational backgrounds had any effect on the criminal justice system. Additionally, I aimed to identify if the differences in how MDIs conducted their investigations has any bearing on death investigation case outcome. This study sought to discover if the varying experiences of investigators impacted the medicolegal death investigation procedure and the investigators processes. The findings below are presented by stating the term used to label their experiences, which stemmed from the analysis process, and are followed by what findings meant for the investigators in this study. The findings are then followed by an analysis of the research questions. The research questions concerned procedural differences in conducting death investigations, training, and education. Finally, discrepant findings are discussed.

Educational Minimums



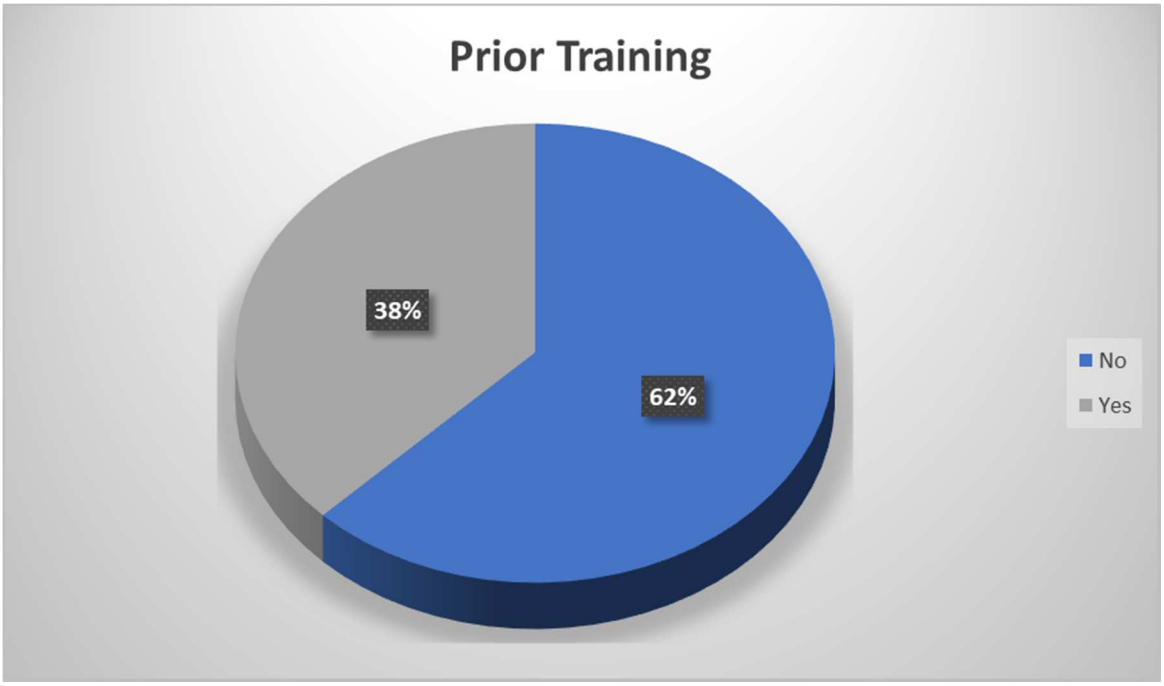


Many of the investigators shared they had at a minimum of a bachelor's degree.

Of the investigators surveyed, all but one investigator had a bachelor's degree, while the

others had bachelors in varying topics. Three investigators stated they had a bachelor's degree but did not specify the field, six had a bachelor's degree in criminal justice, two in forensic science, one in police science, one in business, one in psychology, and one in a combination of pre-law, pre-med, and psychology. Of these same investigators, one had a master's degree in anthropology, two had a masters in forensic science, there was one masters in criminal justice, three had some graduate work, one had masters in forensic psychology, one masters in neuroscience, one master's in business, and the other ten investigators had no masters degrees nor did they mention any graduate work. Of all the investigators surveyed, only one shared having completed some coursework toward a PhD program, however, there they failed to mention the field.

Establish Training Programs



Each of the investigators who participated in this survey had varying levels of relevant training related to death investigations or investigative work. However, ten investigators expressed not having any prior relatable investigative training while the remaining six investigators shared training that was relevant to their position as a medicolegal death investigator.

> Investigator #5 stated, *I have more indirect prior training and experience. I worked as a Multi Skilled Tech II (MST II) for 5 years. I performed wound care and bandage changes, blood draw on children and adults and took patient medical histories. I worked in the ER, on Med-Surge floor with infectious diseases and psych patience and in the surgical department (pre and post-op). I as have 10 years of military experience.*

Investigator #7 shared, "*Intern Medicolegal Death Investigator for the Maricopa County Medical Examiner's Office in Phoenix, Arizona."*

> Investigator #8 stated, *Before I started this position, I worked for about a year and a half at the Abilene TX Police Dept as a Forensic Specialist. I attended a few death scenes in that time period and was able to observe and learn some evidence collection procedures and information gathering regarding death investigations from my coworker, who had been working in the position for years. I also sat in on a Death Investigation course during my last semester in college.*

Investigator #9 shared their training experience as, *"I worked for some private criminal defense attorneys doing investigation and then I was a police officer for 3 years prior to this job."* However, investigator #12 stated that their experience was, *"40-hour death*

investigation school initially along with crime scene search, homicide investigation, and other related criminal justice academics.

Lastly, investigator #14 had the most extensive training of all the investigators surveyed. Investigator #14 prior training consisted of, *"Forensic Science Diploma from the American Institute of Applied Science, Coursework in the following: Peace Officer Standards and Training, International Association of Identification, Basic and Advanced Crime Scene Certifications, Latent fingerprint examination training, Certified Forensic Investigator, Marijuana Identification Technician, Field Identification Drug Officer, as well as Forensic Investigator for medium sized metropolitan police department.*

Transferrable Prior Work Experience/Skills

Many of the investigators surveyed had their own idea of what they felt were transferrable work skills and experience. However, they were are asked about their previous/prior work experience with a follow-up question of whether they felt this experience prepared them for their assignment as a death investigator. Investigator #1 responded by stating, he worked in "*Molecular Psychiatric Research and Brain Collection Agency. Yes, it allowed me to become familiar with DCME procedure and reports by allowing me access to the investigators."*

Investigator #2 worked for *2 years in loss prevention and 8 years in social services. Yes, my experience working as a loss prevention officer taught me to have attention to detail, obtain information, and prepare reports documenting*

events and details. My experience in social services gave me the knowledge I needed to work with different policing entities, co-workers, and families.

Investigator #3 was a prior "*Police Officer and stated that yes, was assigned to the Homicide Unit and years of death investigations from a criminal aspect."* Investigator #4 was employed as "*an investigator for child protective services. Yes, it prepared me in my dealings with families of all backgrounds/religions. I learned how to build a rapport with families, especially during high stress and often emotional circumstances."*

Investigator #5 was a *Multi Skilled Tech II (MST II) and had 10 years of military experience. Yes. While working in the hospital as a MST II, I was able to see the disease process and trauma injuries in the ER as well as the surgical department. My experience also includes working and speaking with the public during highly emotional situations, while giving and receiving information. While working as an MST II in a county hospital, I had the opportunity to work and interact with law enforcement that accompanied patience that were in custody.*

Investigator #6 stated they, *worked as an intern at CID on army base, 911 dispatcher, loss prevention officer, and a medicolegal death investigator for another agency. Yes, working under pressure; having jobs that required attention to detail; having to work with different personalities (coworkers + agencies) – having to be a team player. Loss prevention gave me the skills to know when someone was lying – it's very useful when talking to families/friends + witnesses at death scenes. I am also more perceptive to body language + details that most people overlook.*

Investigator #7 had experience working as a *Case Information Coordinator with a medical examiner's office, 911 Dispatcher with the Department of Public Safety, and 911 Dispatcher-PHI/Air Evac. Yes, my intern experience prepared me the most and was the most valuable. However, being a Case Information Coordinator prepared me for the administrative duties involved and gave me exposure to decedents. Being a 911 dispatcher gave me the experience to communicate well with the public in times of stress along with communicating with law enforcement, which is a vital part of my current job.*

Investigator #8 shared her experience as a prior, *forensic specialist with a Police Dept. Yes, but only slightly because I did not attend many death scenes. The population of that city is much smaller that Dallas, and our Forensics unit was not contacted by patrol officers for every single death that took place. I would say that my previous job prepared me in that I was able to be introduced to the basics of evidence collection, scene processing, and photography, and I was able to be a part of those things for the few death scenes I did attend.*

Investigator #9 stated, *I worked for some private criminal defense attorneys doing investigation and then as a police officer for 3 years. My prior work and educational history prepared me for this job. I knew I could handle decedents. I knew I could interact with people in a state of shock and anger. The interaction with multiple socioeconomic layers of society prepared me well for this job.*

Investigator #10 had previous experience as "*Autopsy Technician and DNA*

Sequencing technician. As an autopsy technician I was able to go out on some death scenes with investigators which allowed me to gain experience in scene processing. Also performing autopsies helped in learning different disease processes and acquiring knowledge on how the medical examiner determines cause and manner of death.

Investigator #11 stated, *I worked for CPS (Child Protective Services) as an investigator but prior to that, I worked in restaurants throughout college. Absolutely, you need to have a thick skin as well as a demeanor that does not provoke those around you. When you work for tips, you learn quickly to keep an even temperament. Working for the state provided another reality, exposure to poverty and all that encompasses.*

Investigator #12 was previously an "*EMT-Paramedic and Texas Peace Officer. Yes. There is a great overlap between the pre-hospital medical and law enforcement fields; hence, the general term "medicolegal" investigator."*

Investigator #13 shared their prior experience as *Emergency Room (nurse technician), Home Health Care (medical assistant), Psych Ward (mental health tech), Burn Acute Care and Burn ICU (burn technician), and a Transplant Services (transplant technician). Yes. My prior experience prepared me in dealing with other agencies such as law enforcement and medical personnel. My prior experience also gave me a wide medical background that helps in obtaining proper information for when performing an investigation.*

Investigator #14 shared that they previously *worked as a 911 dispatcher,*

forensic investigator, and secondary assignments with child abduction response team, EOC liaison, union board member, and intelligence team member. Also, as an EMT in pre-hospital and emergency room care and part time experience in armed security, collections, and customer service. Yes. Forensic Investigations included evidence collection and scene work at deaths, both attended and unattended. EMS experience helped with medical knowledge.

Investigator #15 had prior work experience in "*Corporate security management, primarily in hospitals. No, it did not."*

Investigator #16 had performed prior work with an *electronics retailer as an operations senior/supervisor + hiring + training coordinator. Somewhat. I was investigating financial variances as the operations senior which I believe helped me become a better investigator. I had to learn to look at things from different angles in order to find variances and/or reasons for them. It was also a collaborative effort, which I believe is important in all aspects on investigation. Also, my experience as a nurse tech, taught me about some of the medical as well as HIPPA + confidentiality laws.*

Procedural Clarification

For many, obtaining clarity, especially at work, means that there is understanding and a belief in a common goal with a direct focus. Thus, if you do not know what you are working toward, your actions will have little context and you can struggle to stay focused. However, clarity does not mean that you know what you are doing but only why you are doing what you are doing. When referencing procedural processes with many of

the MDIs, the questions were geared around procedures, initial death questioning, reportable deaths, and deaths that investigators would respond to. Though most of them agreed with what the steps were, unfortunately, these were some slight variances in opinions.

> Investigator #2 Stated that *required protocols were: contact the required personnel for information exchange, begin processing the scene by performing a walk-through of the scene, collect evidence (bag, tag, or record as appropriate), photograph scene, and prepare case report. Initial death call questions were: has the deceased experienced any trauma, where is the deceased physically located, does the deceased have any medical history, does the deceased have a record of drug abuse or excessive alcohol use, has the deceased been hospitalized in the last 24 hours, any signs of decomposition? Deaths were investigators should respond to the scene: if the deceased is found outside, if the deceased is decomposing, if the deceased is suspected of overdosing, if the deceased has experienced any trauma, if there is no known health issues, if the deceased has been under a doctor's care for more than 24 hours. Non-reportable deaths: If the individual has substantial medical history and has a prescribing doctor that will sign their death certificate. They have not experienced any trauma or have died in a nursing home or hospice without trauma.*
>
> Investigator #4 Relayed that *required protocols were: remember you jurisdiction meaning allow crime scene to process scene before you enter (work together), wear personal protection equipment (PPE) to protect yourself + crime scene, and*

be professional (remember family and media may be present on scene). Initial death call questions were age of the decedent, location where he/she expired, circumstances, medical history, any trauma, and/or decomposition. Deaths were investigators should respond to the scene: unexplained – especially anyone under the age of 50 (considering medical history), accidents, suicides, homicides, and essentially anything that could be un-natural. Non-reportable deaths: decedent was admitted to hospital for less than 24 hrs. (no trauma and no surgeries), medical staff often has an idea as to why person expired, and stillbirths are also non-reportable due to no breath or heartbeat.

Investigator #6 Relayed that *required protocols were: photograph scene, document everything, bag hands for all homicides/gunshot wounds (GSW) victims, wear gloves, use PPE (investigator safety should be #1 priority). Initial death call questions were: if there is any trauma, bleeding, weapons, drugs, etc., age of person and medical history, and position/location where person was found. Deaths were investigators should respond to the scene: children under the age of 6 with no prior medical history, decomposing bodies, persons found outside, any death involving trauma, unexplained deaths of persons with no attending physician or no medical history. Non-reportable deaths: that is does not fall under the ME's requirements for reporting the death (i.e. natural hospital death where the patient has been in the hospital for more than 24 hrs.*

Investigator #9 Relayed that *required protocols were: I don't understand this question. There are protocols for PPE and for recovery of evidence. It is best to*

go into a scene with the crime scene investigator and walk through together. It is necessary to allow the crime scene investigators to recover evidence sometimes before the removal of the body in order to prevent the destruction of evidence. Initial death call questions were: The determination needs to be made if there is trauma and/or if the decedent is decomposing. Deaths were investigators should respond to the scene: homicide, suicide, undetermined, decomposing, infant deaths, accident, sometimes natural deaths in order to determine whether or not the decedent needs to come to the office. Sometimes those scenes need to be looked at by a trained MDI. Non-reportable deaths: It means that the death was not required by law to be reported to the ME.

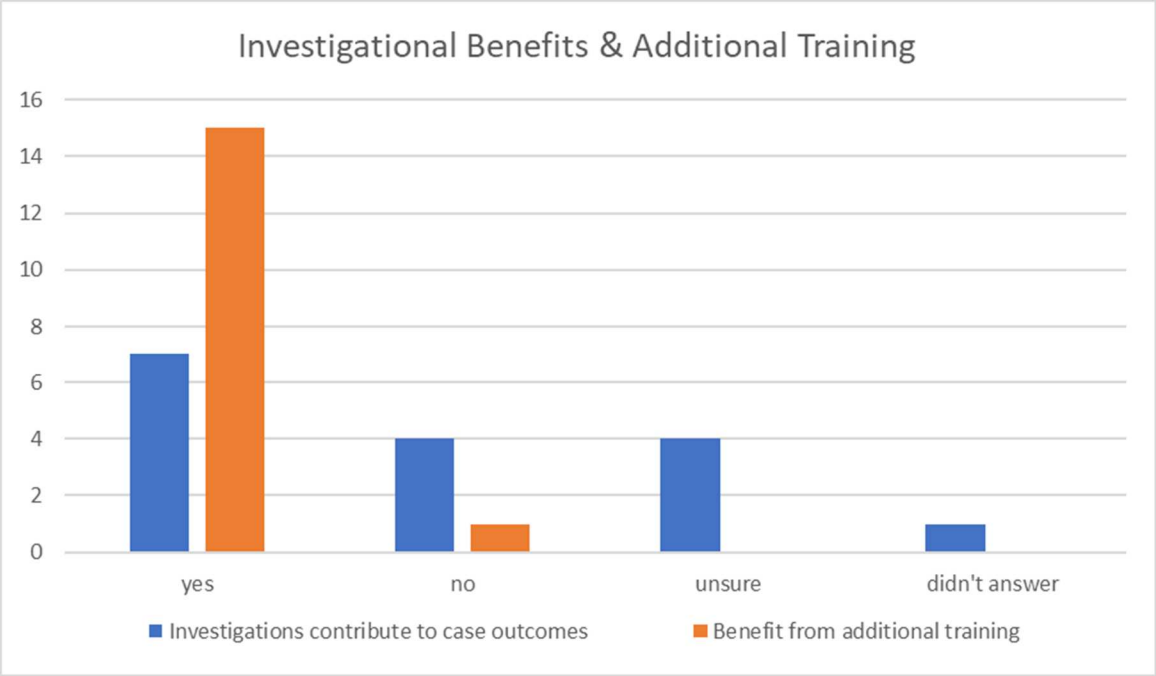
Investigator #11 stated that *the protocols are required at all crime scenes were: PPE (personal protective equipment). Initial death call questions were: Who, what, where and when. Death were investigators should respond to the scene: anyone outside, unsecured residential deaths, suspected overdoses (with or without drugs on scene), any deaths where no medical history is known in the decease, suspicions voiced by police, violent/traumatic deaths, suicides, and all children (unless they have a terminal illness). Non-reportable deaths: if an individual is being treated and monitored in the hospital by a physician and medical staff for over 24 hours after admission and their medical history does not include trauma or illicit drug use, then their death is non-reportable.*

Investigator #13 shared what they felt were *protocols are required at all crime scenes: We do not attend crime scenes at this facility. Initial death call questions*

were: We do not attend crime scenes at this facility. Death were investigators should respond to the scene: We do not attend crime scenes at this facility. Non-reportable deaths: A death that is expected and has an identifiable cause without criminal activity would be a non-reportable death.

Investigator #16 Stated that *required protocols were: wear proper PPE (required but not technically enforced). Initial death call questions were: last known alive time, time found, any decomposition, decedents identity, next of kin (NOK), where found (location, secured or unsecured, open access), trauma (type), history, scene observation (weapons, suicide note, drugs, EtOH, at the club, outside, and temperature). Death were investigators should respond to the scene: traumatic, homicide, suicide, accidents (vehicular, falls, drugs/EtOH), undetermined deaths of a young person under 30 where there is suspicion of trauma due to no documented history, substance abuse (where nothing is found on scene). Non-reportable deaths: death should not be reported because the person has been in a medical facility for less than 24 hrs. with no concerns of death, documented history/diagnostic/and lab cultures results, and no trauma.*

Discrepant Findings



Analysis of the data found that MDIs have relatively inconsistent views on how they feel their investigations contribute to case outcomes. Of the investigators surveyed 7 felt that their investigations and actions contributed while 1 investigator stated occasionally, and 4 investigators felt their investigations did not affect case outcomes. Additionally, 3 investigators were unsure what affect if any their investigations had on case outcomes and 1 investigator did not give an answer to this question. However, when the death investigators were asked if they felt they would or could benefit from additional death investigation training; fifteen of the surveyed investigators stated yes and 1 investigator replied no.

Summary of Chapter Four

In chapter four, I provided information regarding the processes in which participants were recruited, participant profiles were given; and how data was obtained, securely stored, and analyzed. Moreover, the steps of verification used to ensure accurate and quality data was collected and how themes developed and were identified were also included. The investigators in my research were employed as medicolegal death investigators either part-time or full-time. There were no considerations given regarding the investigators length of time employed as a death investigator. Results of this study indicated that there should be training programs established for death investigators and that there is a need for investigators to have transferrable prior work experience or skills. Furthermore, research also showed that job specific clarification is needed to execute procedural processes when conducting death investigations. There was no evidence of a direct correlation between investigators and so their educational levels were not evident based on the data collected. Chapter 5 will provide an interpretation of the findings, implications for social change, recommendations, and research conclusions.

Chapter 5: Interpretations and Conclusions

Introduction

Medicolegal Death Investigations are characterized as investigators tasked with assisting the forensic pathologist with determining cause and manner of death in cases that fall under the medical examiner jurisdiction. Those who work as MDIs come from various backgrounds and often their circumstances differ in the areas of education, previous training, and employment history. Traditionally, there are no formal requirements to become a medicolegal death investigator since every office has different hiring practices and requirements. However, my research indicated that there should be mandatory training programs for death investigators and that when investigators possess prior work skills and experience that is transferrable, they are better able to perform investigations. It was also determined that medical examiner and coroner offices need to have procedural processes clarified when conducting death investigations. Kelsall and Bowes (2016) stated that there are annually 7%-45% of deaths investigated and autopsy which raises concerns about potential misclassification of deaths with many deaths, there have been concerns regarding the integrity of morality as well as the quality of medicolegal investigations of deaths. Prior to this research study, the impact unstandardized medicolegal death investigations had on death investigations referencing the work experience, training, and educational backgrounds of MDIS had not been previously documented in literature.

Though most medical examiner offices want investigators to have investigative experience, many offer on-the-job training, so investigators learn while actively

conducting crime scene investigations. Furthermore, any additional training MDIs receive beyond on-the-job is usually done on their own and not a requirement of continued employment. Though not the focus of my study, there is an uncertainty whether the type and source of training MDIs received is beneficial to them. I used my research as a starting point to assess the support offered to investigators to better understand the need for additional training and to ensure MDIs have relevant work experience and relevant skills prior to employment.

I used the educational theory to help understand and offer insight into research related to criminal justice. Hopefully lawmakers will focus on including MDIs in legislation geared primarily toward the processes involved in medicolegal death investigations and creating regulations. The education theory was chosen because medicolegal death investigations is relatively new to study. Moreover, the educational theory offers the ability for investigators to learn through reading and listening as well as the idea that people are responsible for developing their own understanding of the world and using this information based on prior experiences and linking this information to their experiences. Additionally, the educational theory gives rise to the thought that MDIs will process data by forming connections during the process of conducting their investigations.

The use of social media sites and my professional colleagues was primarily how investigators for this study were solicited and where 16 investigators were identified. Each investigator worked either full or part-time as a medicolegal death investigator in Northern Texas regardless of their length of employment. The research questions I

developed focused on identifying the investigators educational levels, training programs they have taken, and if they have relatable previous work experience or skills. I also focused on whether their education, training, and work history affected their ability to conduct death investigations.

The findings from the surveys revealed that there should be training programs established for death investigators because ten of the sixteen investigators interviewed felt they should have more training. Furthermore, research showed that there is a need for investigators to have skills and work experience that they can transfer into their ability to conduct death investigations as well as the need for exact procedural processes when conducting death investigations.

Each of the investigators who participated in this survey had varying levels of relevant training related to death investigations or investigative work. However, ten investigators expressed not having any prior relatable investigative training while the remaining six investigators shared training that was relevant to their position as a medicolegal death investigator. Discrepant cases found that of the investigators surveyed 7 felt that their investigations and actions contributed while 1 investigator stated occasionally, and 4 investigators felt their investigations did not affect case outcomes. Additionally, 3 investigators were unsure what affect if any their investigations had on case outcomes and 1 investigator did not give an answer to this question.

Interpretations

In this study I intend to provide insight into the area of medicolegal death investigations and the irregularities associated with the varying death investigation

systems and how they lend to regulatory gaps and a lack of health and safety protection in the medicolegal death investigators (MDI); according to Pearsall (2010), developing standards includes federal and government standards that would monitor the inaccuracies of death investigations. I found, after conducting this study, that many investigators in this study had no prior training before beginning their careers as medicolegal death investigators, had few transferrable skills or work experience, and their educational backgrounds had little to no proven effect on conducting investigations. Acquired training since employment and membership with professional organizations for death investigators are points of consideration when interpreting the study findings.

Educational Minimums

In addressing the first research question, what standards of practice should be adopted when considering medicolegal death investigations, several themes emerged. I was unable to demonstrate a correlation that linked the educational level of medicolegal death investigators with their capability in conducting investigations. Educational requirements for investigators varied per employing Office of the Medical Examiner, however, investigator educational levels varied from an associate degree to master's degrees as well as varying degree fields. In my research, investigators that established internships in medicolegal death investigations prior to their employment showed to have benefited from those experiences. The MDIs that I surveyed believed themselves at an advantage to those investigators who did not have prior training or training in another investigative area.

Need for Training Programs

Investigators were mostly unanimous in their belief that there is a need for additional training. Although one investigator did not feel that they needed additional training, they did feel that training would overall be beneficial to ensure uniformity in things such as taking death calls, attending death scenes, and the proper operational definitions. For most investigators, they felt that because the profession is constantly changing and the procedures and best practices are always updating due to changes in technological advances, they would absolutely benefit from additional training. One investigator felt that without continuous training, their investigations may suffer because they are using outdated practices that could have a direct effect on the ultimate outcome of a criminal or civil case as a result of their investigation.

Transferable Prior Work Experience/Skills

Each of the investigators had their own opinion regarding what they felt were transferrable work experience and skills for conducting death investigations. This also included them explaining how this experience prepared them to for a career as a medicolegal death investigator. Of all the investigators surveyed, only one stated they did not see how their previous employment prepared them for conducting investigations as a medicolegal death investigator.

Procedural Clarifications

My research was unable to identify, support, or answer the research question; does varying volumes of medicolegal death investigations performed per jurisdiction have a direct effect on investigative standards and case outcomes. However, the research

did identify that depending on the jurisdiction where the investigator was employed dictated what deaths were investigated and how or whether the MDI responded to that death. For example, some jurisdictions responded to all death scenes, including hospitals, to rule out trauma, thus altering their investigative volume. Among the investigators surveyed, there did not appear to be a connection between the amount of investigations they performed and the integrity of investigative standards and case outcomes.

Additionally, investigators were asked about the characteristics of a death investigator and important aspects of conducting death investigations, their answers were wide-ranging. Some of the answers regarding desirable characteristics of what is described as an effective MDI included the ability to maintain confidentiality, stay calm, remain unbiased, be ethical and honest, communicating with both the public and law enforcement, as well as the ability to gather as much relevant case information as possible. Other characteristics were MDIs who possessed knowledge of anatomy, basic medical terminology and those who were able to be detail-oriented both in attention to scene assessment and their final work product. The MDIs surveys felt that there were key aspects that MDIs should know when conducting death investigations. Some of the aspects the MDIs mentioned was the knowledge to effectively secure crime scenes, record what is observed both through photography and written documentation, not contaminating the crime scene, and staying focused. Additionally, MDIs felt that other important skills should be critical thinking, scientific knowledge, interviewing witnesses, being thorough, patient, open-mindedness, ability to handle extreme environments which

can include safety hazards, visual and olfactory hazards, and any other associated scene hazards, and unbiasedly serving as the eyes and ears for the medical examiners.

However, many of the investigators shared several varying answers when asked about the protocols required at all crime scenes. While one investigator stated they did not understand the question, another stated that their office follows guidelines rather than protocols as there are variations from scene to scene and circumstance to circumstance. Nonetheless, many investigators shared similar answers regarding their routine and structure when conducting death investigations. Prioritizing tasks and organizing their responsibilities appeared to be key factors in managing their work caseloads.

Acquired Training

Those who chose to participate in this study may have adjusted better to their positions as medicolegal death investigators due to the additional training they acquired after being hired. Therefore, they may have felt more comfortable talking about their experience and wanted to share their role and perceived expectations. This may have been attributed to these investigators feeling more comfortable in their assignments due to supplemental training. The amount of training each investigator had varied greatly and may contribute to a redefinition of what it means to be an effective investigator.

Membership with Professional Organizations

The surveyed investigators were asked about their professional membership affiliations, they replied stating only 10 of the 16 investigators belonged to professional organizations. Unfortunately, of those 10, only eight were members of an organization that was related to medicolegal death investigations. However, those who have affiliation

with professional organizations are provided with an advantage since member usually become both active and knowledgeable within their industry. In addition, those who are member of professional organizations benefit by staying abreast of any new technological advances in the field, legislation changes, as well as variances in industry trends.

Theoretical Considerations

The results of this study do not suggest that these investigators experienced no negative effects while conducting death investigation due to their educational level. Transformative and social cognitive theory provide some insight into the results of this study. Mezirow (1997) defined transformative learning as a process of effecting change in a frame of reference. It can be argued that the investigators in this study were able to acquire experience with frames of reference that have been defined by their previous employment. These frames were structured assumptions through which investigators were able to understand the experiences of their position. This transition created the correlational experience of their previous employer to conduct their responsibilities as an investigator. A frame of reference incorporates an emotional component, cognitive, and conative as well as including both a point of view and habits of mind dimensions (Mezirow,1997). Thus, facilitating transformative learning, will require supervisors and/or employers to help investigators become aware and critical of not just their own but also the assumptions of others when conducting investigations. It would benefit the MEO to practice in recognizing frames of reference and directing investigators to use critical thinking to redefine investigative issues from various perspectives. Finally, investigators are encouraged to participate in discourse to authenticate both how and what they have

understood relating to their responsibilities, or to arrive at a best judgment regarding a role.

Social cognitive theory is for the implementation of employee-training programs that utilize processes designed to significantly increase success and include retention processes, attentional processes, reinforcement processes, and motor reproduction processes (Kritsonis, 2005). Attentional processes consider that investigators will learn easier from an example especially in situations where they can recount the situation and are able to record the details. It is important that the MEO develop examples for investigators to learn that are compelling, neat, attention grabbing, and relatable to their current knowledge set. In addition, retention processes will come into play when investigators complete training and are able to demonstrate their ability to not only remember key elements of conducting investigations but imperative characteristics. Thus, the investigator should be able to demonstrate their aptitude by translating what they observe into report writing and scene observation to relay to the medical examiner. Finally, the process of reinforcement should be used to encourage changes in the investigators behavior by executing a rewards and positive incentives initiative. These targeted changed behaviors, once properly applied, will aid in strengthening the medical examiners system, and could help to maintain any organizational affiliations such as NAME accreditations.

Though each of the above models provided some insights into the results of this study, it was the opinions expressed in the participant descriptions of feeling that there was a need for both more and continuous training. The investigators in this research often

find themselves in various investigative situations and many of them believe they are well prepared and capable of performing their jobs. One investigator shared that a proper and thorough scene investigation is often key to the correct cause and manner of death determination (particularly the manner). Additionally, stating that a good scene investigation with ample salient information can allow a pathologist to avoid having to perform anything other than an external inspection of the body to rule out trauma rather than having to waste expensive resources conducting needless and unwarranted internal examinations.

As referenced in Kelsall & Bowes (2016), despite the importance of medicolegal death investigation, there is no accreditation system for coroner or medical examiner offices, no nationally recognized training program or credentialing system for coroners and medical examiners, no national standards for the investigations, investigators, or classifications of death, and no agreement on common outcome measures against which to evaluate performance. Some valuable traits identified were the investigators sharing their reasons for wanting to become MDIs, "ability to help families at the worst moments of their lives, giving myself, and bringing some peace to them." The invaluable traits were, investigators expressing that if a mistake is made while conducting a death investigation, the least consequence the investigator could experience from the Medical Examiner's/Coroner's Office is that "it goes completely un-noticed." This study has helped to highlight medicolegal death investigators as well as the professionalism and decorum they exhibit in their interactions with families, law enforcement agencies, and healthcare professionals. They have embraced their roles as the silent partners in the

community of death investigations and have found a level of mutual understanding as a result of this acceptance.

Implications of Social Change

Medicolegal death investigators are tasked with the crucial responsibility of performing scene investigations stressing evidence developed from the decedent and determining if additional investigation is needed and if so, how much. This is often a thankless, underappreciated, and underacknowledged job but incredibly necessary. Investigators must work under various conditions and environments often without complaint. Additionally, there is often no relationship made between the importance of the medicolegal death investigator and society. However, MDIs contribute information obtained from their investigations that contributes to the CDC and mortality rates within their jurisdictions which effect public health. This relates to tobacco use, obesity, alcohol related deaths, contagious and toxic agents, firearms related deaths, sexual related deaths, motor vehicles deaths, sudden infant deaths (SIDs) and illicit use of drugs.

The social change implications are imparting medical examiner's offices and coroner's offices to work cooperatively in developing uniform standards for conducting medicolegal death investigations. The goal is that these agencies would use the information provided by the investigators and create programs geared toward uniform mandatory training, networking, educational, and internship standards to embrace, strengthen, grow, and positively impact the profession. The medicolegal death investigation system must find a way to offer educational and training opportunities to agencies with limited resources. Furthermore, coordination efforts involving Federal

initiatives could aid in strengthening the medicolegal death investigation system and support death investigation services practiced by both medical examiner and coroner offices first in Texas and ultimately throughout the United States. Practitioners and policy makers need to understand the importance of developing and understanding the association with medicolegal death investigation and how negative impacts on death investigations and on society effect public health and safety. This can be initiated by identifying and developing goals that encourage the implementation of programmatic activities that support the medicolegal death investigation system as well as supporting public health and safety on local and national policies and initiatives.

Recommendations

The medical examiner and coroner offices should consider the results of this study. Despite the longevity already displayed in the system, these agencies should consider developing collaborations to improve the delivery of services. Though the investigators in this study experienced the need for training, consistency, and the need to know how their investigations effect the bigger picture they all had knowledge in their skills and a strong desire to work in this field. Thus, these agencies Department of Health and Human Services, CDC, state legislators, Homeland Security, NAME, ABMDI, and local universities can use this information to structure collaborative programs to help death investigative efforts. Offering regular death investigator training programs with online capabilities for office who cannot afford to attend, encouraging investigators to join professional organizations, and promoting tuition assistance and offering other incentive for advanced degrees in related fields could prove to be effective avenues to

build the death investigations system. This could also be an effective tool to lure newly qualified death investigator hopefuls into the field.

A focus on the investigator's length of employment as an investigator and their work conditions including environment in future studies may not only provide insight into death investigators but also help understanding their experiences. Focusing studies in this area will bring attention to unique needs of the MEO and the death investigators they employ. Identifying potential investigators earlier in their professional careers, could eliminate the resounding need for training reinforcing the pool of qualified candidates.

The scope of this study was limited to the Northern region of Texas. Expanding the research to include the entire state of Texas or even to include two states would be beneficial in gaining a broader perspective regarding issues surrounding the challenges investigators encounter. Additionally, future studies should examine whether geographical locations make a difference in job specific requirements of the investigators which may add understanding to the different expectations of investigators. Other issues to discuss in future studies could consider even questioning how comfortable or competent investigators felt when conducting death investigations.

Previous research has documented the impact society faces because current laws does not require death investigators to hold a license, complete continuing education courses, or partake in training and irregularities exist within this system necessitating legislation to reinforce the integrity within the MEO pertaining to death investigations (Kleefisch, n.d.). There were no findings in this study denoting irregularities within the system, only the need for consistency in processes and procedures of conducting death

investigations. Thus, future studies concentrating on specific irregularities as a result of death investigation irregularities may find opposing results.

Lastly, several of the investigators in this study had skills or work experience that they felt qualified as prior experience. With a focus on prior experience, future studies may find it beneficial to question whether the levels of prior experience regarding varying feelings of being overwhelmed or stressed when conducting investigations and number of cases worked per shift.

Conclusions

MDIs are vital to the death investigation process and though many professions require an accreditation process to ensure consistency in services delivered while also increasing the quality of standard operating procedures, unfortunately medicolegal death investigators do not (Kelsall & Bowes, 2016). For many of the investigators interviewed, becoming a medicolegal death investigator has been a life-long career dream. As more people have become interested in this profession, popularity has grown. Traditionally, MDIs have not had any formal requirements to be employed with hiring practices varying between offices, jurisdictions, counties, and states. Until now, research has not documented the experiences of MDIs and the relationship of their training, educations, and prior experience in conducting death investigations. Previous research of medicolegal death investigations had focused more on the medical examiners and found that the system was chockfull of hearsay, guesses, and snapshot diagnoses with discrepancies and inaccuracies common on death certificates that were worthless for accurately giving immediate causes of death (Fowler & Goldfarb, 2015). Research also found that

regulating medicolegal death investigation will create quality investigative services that support employees, public safety and health, and the criminal justice systems (National Institute of Standards and Technology, 2016). The current investigators shared their knowledge and experience as an investigator and were connected in their desire for more training.

Though there is limited literature on this topic of regulating medicolegal death investigations and the need to standardize the profession, the findings in this study were consistent. The fact that these investigators have been currently working in the field for an unknown time frame, may have led to the likelihood of them not seeing a connection in the inconsistencies of their backgrounds. They likely share different experiencing based on their length of employment and varying caseloads of investigations. Despite the various jurisdictions the investigators came from, they shared similar backgrounds in their roles and likely encounter the same experiences. The experience of investigators differed but they all were confident in their roles, provided detailed descriptions of their responsibilities, but varied in the belief of the importance of their roles.

These investigators did not appear to have any direct issues due to their educational backgrounds. They embraced their roles as death investigators with a desire and a tendency to lean toward the common theme of ensuring their personal safety. Although many have acquired training as a result of their employment, they did not feel that the lack of prior training was a hindrance. The experiences of this select group of professional investigators should be further explored and evaluated in consideration to

bring to the forefront the often-overlooked role of the medicolegal death investigators, while toiling to assist the families of those left behind.

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Appendix A: Letter to Participants

Date:

Name of Participant

Work Location

Dear (Name),

My name is Antoinette Vicks and I am a doctoral candidate at Walden University. I am conducting dissertation research on the effects of the non-standardized medicolegal death investigation system as it pertains to investigators and their work experience, training, psychological issues, and educational backgrounds. There are very few studies conducted concerning medicolegal death investigations and of those few, none address standard requirements for investigators. Thus, what is not known is how these factors and the nonexistence of standards impact the medicolegal death investigation procedure and the death investigation system. This research will provide insight into the unregulated profession of death investigations and the effects, if any, of investigator differences and the impact on the medicolegal death investigation system.

I realize that your time is important to you and I appreciate your consideration to participate in this study. To fully understand your experience, we need to meet for approximately one hour at a location of your choosing and will not require you to do anything you do not feel comfortable doing. The meetings are designed to simply get to

know you and learn about your experience as a death investigator. All information gathered during our meetings will be kept strictly confidential.

Please contact me at your earliest convenience to schedule a date and time that we can meet. My telephone number is (XXX) XXX-XXXX. You can also email me at my.lastname@waldenu.edu. I look forward to hearing from you.

Antoinette Vicks

Doctoral Candidate

Walden University

Appendix B: Interview Protocol

Date: _____
Location: _____
Name of Interviewer: _____
Name of Interviewee: _____

1. What is your typical case load per week in your office for all cases, reportable and nonreportable?

2. What are the types of cases reported (please list both reportable and non-reportable by each) to your office and what is the office procedure for responding to these cases?

3. Considering your current knowledge, training, and education why or how do you feel adequately equipped to conduct investigations?

4. What standardized requirements for medicolegal death investigators should be implemented in the areas of experience, training, or education?

5. Does varying levels of education, training, experience, and skills effect an investigators ability to conduct death investigations and effectively document case findings?

How?

6. How do you feel your expertise compares to that of your peers locally, statewide, nationwide? Please select your appropriate response.

1. Below Average _____locally _____statewide _____nationwide

2. Slightly Below Average _____locally _____statewide _____nationwide

3. Average _____locally _____statewide _____nationwide

4. Slightly Above Average _____locally _____statewide _____nationwide

5. Above Average _____locally _____statewide _____nationwide

7. How long have you worked as a medicolegal death investigator or forensic investigator? What is your current educational level, what training classes have you had, and what continuing education courses have you taken specific to death investigations?

Appendix C: Regulating Medicolegal Death Investigations Survey Questionnaire

Date: _____

Location: _____

Interviewee initials: _____

*Please answer all questions completely and honestly. If a question does not apply to you, please state N/A or don't use. All information obtained in this research will be kept confidential.

1. What is your official title and job description?

2. What is your current educational background?

3. What prior/previous training have you had in conducting death investigations?

4. What is your previous work history?

5. Did your prior work experience prepare you for your assignment as a death investigator? If so, please explain.

6. What training have you acquired since working as an investigator?

7. Are you a member of any professional organizations? If yes, what are they?

8. Tell me 3 important characteristics of a death investigator.

9. Tell me 3 key aspects of conducting death investigations.

10. What factors influenced your decision to become a death investigator?

11. In your opinion, how do the investigations you work effect, if at all, autopsy outcomes?

12. Define your role as a death investigator.

13. When working cooperatively with law enforcement, do you think that the work you perform as a death investigator has a profound effect on case outcomes? If so, how?

14. Hypothetically speaking, if an investigator makes a mistake while conducting a death investigation what is the least consequence the investigator could experience from the Medical Examiner's/Coroner's Office?

    14a. What is the most severe reprimand, except firing, that the investigator could experience from the Medical Examiner's/Coroner's Office?

    14b. Referencing question (14), could the investigator experience any consequences from
    any other agencies?

15. What protocols are required at all crime scenes?

16. What questions are asked during the initial death call which determines if an investigator will respond to the crime scene?

17. In your opinion, please list the deaths where an investigator should respond to the scene.

18. What does it mean for a death to be non-reportable?

19. In your opinion, does not responding to the initial crime scene have any impact on your investigation and/or the official death ruling?

20. Do you think you would/could benefit from additional death investigation training?
    If so, how?

21. Do you handle the death investigation of an unknown decedent differently than a known decedent? If so, how?

22. What factors influence how an unknown decedents' remains are disposed of?

23. In your opinion, what is the most important thing to do when first arriving on a scene?

Appendix E: Survey Transcripts

Regulating Medicolegal Death Investigations
Survey Questionnaire #1

Date: _____1-24-19

*Please answer all questions completely and honestly. If a question does not apply to you, please state N/A or don't use. All information obtained in this research will be kept confidential.

1. What is your official title and job description?

   Medicolegal Death Investigator

2. What is your current educational background?

   BS

3. What prior/previous training have you had in conducting death investigations?

   0

4. What is your previous work history?

   Molecular Psychiatric research and Brain Bank Collection

5. Did your prior work experience prepare you for your assignment as a death investigator? If so, please explain.

   Yes, it allowed me to become familiar with the medical examiner's procedures and reports by allowing me access to the investigators.

6. What training have you acquired since working as an investigator?

   7 years' experience

7. Are you a member of any professional organizations? If yes, what are they?

   No

8. Tell me 3 important characteristics of a death investigator.
   - Observation

- Empathy
- Attention to detail

9. Tell me 3 key aspects of conducting death investigations.
   1. Observing body and scene
   2. Collecting information
   3. Summarizing details

10. What factors influenced your decision to become a death investigator? N/A

11. In your opinion, how do the investigations you work effect, if at all, autopsy outcomes?

    I believe the information obtained by the MDI informs the ME of the history/circumstances of the decedent to allow for them to make informed choices during the autopsy and for further tests.

12. Define your role as a death investigator.

    Obtain info by examining the scene/body, gather information/circumstances on the dead and leading to the death and relay that info to the ME's in a clear and concise manner.

13. When working cooperatively with law enforcement, do you think that the work you perform as a death investigator has a profound effect on case outcomes? If so, how?
    Yes, by providing pertinent case info to the ME's for informed decision during the autopsy that can bad to effects on the case.

14. Hypothetically speaking, if an investigator makes a mistake while conducting a death investigation what is the least consequence the investigator could experience from the Medical Examiner's/Coroner's Office?
    Reprimand/write-up

    14a. What is the most severe reprimand, except firing, that the investigator could experience from the Medical Examiner's/Coroner's Office?
    Suspension

    14b. Referencing question (14), could the investigator experience any consequences from any other agencies?
    Yes, strained working relationship or refusal to work with the investigator.

15. What protocols are required at all crime scenes?

    PPE, observe scene/body
    Communicate with officer/detective
    Collect evidence (photo, property, etc)
    Examine body
    Speak with family if needed

16. What questions are asked during the initial death call which determines if an investigator will respond to the crime scene?

    Circumstances prior to death, how decedent found, apparent trauma/drugs

17. In your opinion, please list the deaths where an investigator should respond to the scene.

    Homicide, suicide, traumatic death, outside death, car accident, drug use suspected, decomposition, infant death

18. What does it mean for a death to be non-reportable?

    That the cause of death is natural, there is no drugs suspected, no trauma, and doctor have a firm idea of what caused the decedent death

19. In your opinion, does not responding to the initial crime scene have any impact on your investigation and/or the official death ruling?

    Sometimes, being there allows us to document and observe the scene for better references and information for the ME

20. Do you think you would/could benefit from additional death investigation training?

    If so, how?

    Yes, learn more procedures, strengthen observation skills, more information on what to look for on scene, and evidence on body as to cause of death

21. Do you handle the death investigation of an unknown decedent differently than a known decedent? If so, how?

    Yes, attend to get more info to confirm ID

22. What factors influence how an unknown decedents' remains are disposed of?

    Finding NOK

23. In your opinion, what is the most important thing to do when first arriving on a scene?
    Observe scene and speak with detectives

Regulating Medicolegal Death Investigations
Survey Questionnaire #2

Date: _____February 10, 2019

*Please answer all questions completely and honestly. If a question does not apply to you, please state N/A or don't use. All information obtained in this research will be kept confidential.

1. What is your official title and job description?
   Medicolegal Death Investigator
   As an investigator, I gather and examine evidence to help in determining the cause of death in criminal, unnatural or unattended death cases. I ensure that collected evidence gets safely transported to the office for analysis. I am responsible for obtaining medical records from hospitals and healthcare personnel for evaluation by the pathologist. Once investigations are completed, I summarize findings in writing and give reports along with photographs, when applicable, to the pathologist. I can also be called as an expert witness and testify in pre-trial and court hearings.
2. What is your current educational background?

   BS in Forensic Science
   Masters in Anthropology
3. What prior/previous training have you had in conducting death investigations?

   N/A

4. What is your previous work history?

   2 years in loss prevention and 8 years in social services

5. Did your prior work experience prepare you for your assignment as a death investigator? If so, please explain.
   Yes. My experience working as a loss prevention officer taught me to have attention to detail, obtain information, and prepare reports documenting events and details. My experience in social services gave me the knowledge I needed to work with different policing entities, co-workers, and families.

6. What training have you acquired since working as an investigator?
   On the job training and classes through the University of North Dakota in Death Investigations

7. Are you a member of any professional organizations? If yes, what are they? Yes. National Association of Criminal Justice and Southern Criminal Justice Association
8. Tell me 3 important characteristics of a death investigator.
   1. Maintain confidentiality

2. Remain unbiased
3. Be ethical and honest

9. Tell me 3 key aspects of conducting death investigations.
    1. Secure crime scene
    2. Record everything you observe either thru photography or written documentation
    3. Refrain from contaminating the crime scene

10. What factors influenced your decision to become a death investigator?

    I love being in the know of events, attending crime scenes, and seeing the natural effects that the human body undergoes after death. I have always had a love for science, but I do not have the passion to deal with living patients and would be too bored being confined to an office.

11. In your opinion, how do the investigations you work effect, if at all, autopsy outcomes?
    Absolutely, if I miss something on the crime scene and mistakenly document something seen or observed, it could impact autopsy outcomes. However, the pathologist does an independent report and the information I provide is used as a supplement. So, if the pathologist does their job then my report should not have an effect.

12. Define your role as a death investigator.

    Investigate any death that falls under the jurisdiction of the medical examiner including all suspicious, violent, unexplained and unexpected deaths. I perform scene investigations emphasizing information developed from the decedent and determines further investigation is necessary. At scenes of death, I collect physical evidence to bring back to the laboratory to be analyzed. I photograph the crime scene, including the body and those pictures accompany my official crime scene reports.

13. When working cooperatively with law enforcement, do you think that the work you perform as a death investigator has a profound effect on case outcomes?
    If so, how? Yes, if I miss evidence on scene or the correct information is not processed with the crime scene then that could mean individuals could escape prosecution. Additionally, if we do not collaborate with law enforcement, we could miss pertinent information needed to help with the processing of the crime scene.

14. Hypothetically speaking, if an investigator makes a mistake while conducting a death investigation what is the least consequence the investigator could experience from the Medical Examiner's/Coroner's Office?

    Verbal coaching

    14a. What is the most severe reprimand, except firing, that the investigator could experience from the Medical Examiner's/Coroner's Office?
    Permanente documentation in your employee file

    14b. Referencing question (14), could the investigator experience any consequences from any other agencies?
    They could possibly request that the investigator not attend their crime scenes

15. What protocols are required at all crime scenes?
    1. Contact the required personnel for information exchange
    2. Begin processing the scene by performing a walk-through of the scene
    3. Collect evidence (bag, tag, or record as appropriate)
    4. Photograph scene
    5. Prepare case report

16. What questions are asked during the initial death call which determines if an investigator will respond to the crime scene?
    1. Has the deceased experienced any trauma?
    2. Where is the deceased physically located?
    3. Does the deceased have any medical history?
    4. Does the deceased have a record of drug abuse or excessive alcohol use?
    5. Has the deceased been hospitalized in the last 24 hours?
    6. Any signs of decomposition?

17. In your opinion, please list the deaths where an investigator should respond to the scene.
    1. If the deceased is found outside
    2. If the deceased is decomposing
    3. If the deceased is suspected of overdosing
    4. If the deceased has experienced any trauma
    5. If there is no known health issues
    6. If the deceased has been under a doctor's care for more than 24 hours

18. What does it mean for a death to be non-reportable?
If the individual has substantial medical history and has a prescribing doctor that will sign their death certificate. They have not experienced any trauma or have died in a nursing home or hospice without trauma.

19. In your opinion, does not responding to the initial crime scene have any impact on your investigation and/or the official death ruling? It is possible that it could have an impact if the policing agency that does respond does not collect all evidence because they did not know it was relevant or if they accidently miss something. Missed evidence may mean a delay in resolving the case.

20. Do you think you would/could benefit from additional death investigation training?
If so, how? Yes, it could strengthen my skills as an investigator, and I could also learn any new techniques or procedures.

21. Do you handle the death investigation of an unknown decedent differently than a known decedent? If so, how? No, the investigation itself is the same, however, we perform an extensive next of kin search for unknown decedents.

22. What factors influence how an unknown decedents' remains are disposed?
Whether or not family is located and whether they can or will pay for final disposition arrangements.

23. In your opinion, what is the most important thing to do when first arriving on a scene?
Locate the lead detective and obtain the initial scene information from them.

Regulating Medicolegal Death Investigations
Survey Questionnaire #3

Date: _____03/19/2019

*Please answer all questions completely and honestly. If a question does not apply to you please state N/A or don't use. All information obtained in this research will be kept confidential.

1. What is your official title and job description?

   Medicolegal Death Investigator

2. What is your current educational background?

   Bachelor's degree

3. What prior/previous training have you had in conducting death investigations?
   None

4. What is your previous work history?
   Police Officer

5. Did your prior work experience prepare you for your assignment as a death investigator? If so, please explain.
   Yes, was assigned to the Homicide Unit and years of death investigations from a criminal aspect.

6. What training have you acquired since working as an investigator?
   None
7. Are you a member of any professional organizations? If yes, what are they?
   No
8. Tell me 3 important characteristics of a death investigator.
   a. Detail Oriented
   b. Articulate
   c. Team Player

9. Tell me 3 key aspects of conducting death investigations.
   a. Preliminary Investigation – Victimology
   b. Scene – Viewing the premises of the death
   c. Reporting – Preparing the formal findings

10. What factors influenced your decision to become a death investigator?
    This was a position that would enable me to be part of a team that could bring closure to families after emotional experiences.

11. In your opinion, how do the investigations you work effect, if at all, autopsy outcomes?
    The preliminary work done by the medicolegal investigator has an enormous impact on the autopsy. The actual report and photographs give me the doctor performing the autopsy a firsthand account of what occurred and lets him/her visualize the crime scene. These items will potentially answer questions regarding the condition of the body that is observed during the autopsy.

12. Define your role as a death investigator.
    I see my role as a death investigator as the eyes and ears of the Medical Examiner's Office. I believe my role is essential because I am the boots on the ground that should be asking the questions that may come up during the autopsy.

13. When working cooperatively with law enforcement, do you think that the work you perform as a death investigator has a profound effect on case outcomes? If so, how?

    Having done both jobs, I'm not sure how much our work has on the case outcome; however, a thorough investigation by the death investigator will give the doctor a better understanding of how an individual died.

14. Hypothetically speaking, if an investigator makes a mistake while conducting a death investigation what is the least consequence the investigator could experience from the Medical Examiner's/Coroner's Office?

    Coaching from a supervisor

    14a. What is the most severe reprimand, except firing, that the investigator could experience from the Medical Examiner's/Coroner's Office?
    30-day suspension, remedial training and probation

    14b. Referencing question (14), could the investigator experience any consequences from
    any other agencies?

Unless there was something committed by the death investigator that rises to the level of criminal activity. I don't believe the investigator would/should face any consequences from outside agencies.

15. What protocols are required at all crime scenes?
    Safety and preservation of evidence

16. What questions are asked during the initial death call which determines if an investigator will respond to the crime scene?
    Was the person on hospice or expected to die? Was the last breath witnessed by anyone? Did the person die in their home, was it secure or was the person outside? Has the person been under the care of an attending physician?

17. In your opinion, please list the deaths where an investigator should respond to the scene.

    Homicides, suicides, questionable deaths, where the deceased is found outside or in a home or building that is not secure.

18. What does it mean for a death to be non-reportable?
    The person is expected to die (hospice situations), under the care of an attending physician.

19. In your opinion, does not responding to the initial crime scene have any impact on your investigation and/or the official death ruling?
    Depending on the type of death. There are certain procedures that should be conducted regardless if the investigator responds; however, there is still nothing like having a visual of a scene.

20. Do you think you would/could benefit from additional death investigation training?
    If so, how?

    Absolutely, our job is based on the medical profession. That profession is constantly changing, and the procedures and best practices are always updating. Without continuous training, the investigator may use outdated practices that could have a direct bearing on the ultimate outcome of a criminal or civil case.

21. Do you handle the death investigation of an unknown decedent differently than a known decedent? If so, how?

    Yes. You will have unknown variables that can't be answered until the deceased is known. Medical history can't be obtained, family history cannot be obtained or drug history.

22. What factors influence how an unknown decedents' remains are disposed of?
    The County's protocol and S.O.P. The condition of the body will play a factor.

23. In your opinion, what is the most important thing to do when first arriving on a scene?

Survey the scene, speak with the first responders and get a preliminary story. Speak with whoever has firsthand knowledge and then conduct an independent investigation.

Regulating Medicolegal Death Investigations
Survey Questionnaire #4

Date: _____1-28-19

*Please answer all questions completely and honestly. If a question does not apply to you please state N/A or don't use. All information obtained in this research will be kept confidential.

1. What is your official title and job description?

   Medicolegal Death Investigator – respond to death scenes under the direction on the medical examiner

2. What is your current educational background?

   Bachelor of Criminal Justice
   Master of Science – Forensic Science

3. What prior/previous training have you had in conducting death investigations?
   Training included on the job training, online coursework, and participation in death investigation training through the New York Medical Examiner's Office

4. What is your previous work history?
   3 years as an Investigator for Child Protective Services

5. Did your prior work experience prepare you for your assignment as a death investigator? If so, please explain.
   Yes, it prepared me in my dealings with families of all backgrounds/religions. I learned how to build a rapport with families, especially during high stress and often emotional circumstances.

6. What training have you acquired since working as an investigator?
   ON the job training in basic death investigations, excavation, and baby deaths

7. Are you a member of any professional organizations? If yes, what are they?
   N/A
8. Tell me 3 important characteristics of a death investigator.
   - Good communication skills (family, LE, other outside agencies)
   - The investigation must be of ethical character
   - Detail oriented, especially when it comes to your report and associated photographs

9. Tell me 3 key aspects of conducting death investigations.
   4. Obtain initial information
   5. Document everything and photograph according to procedure

6. Interview (obtain social/medical hx)

10. What factors influenced your decision to become a death investigator?
    I had always been fascinated in the filed – was an easy decision for me to apply for the position.

11. In your opinion, how do the investigations you work effect, if at all, autopsy outcomes?
    As an investigator, you are the eyes and ears for the medical examiner – the report you finalize aides in determining the final disposition of the case. Ruling should accurately reflect your investigation.

12. Define your role as a death investigator.
    Assist with the investigation of reported deaths to the Medical Examiner's Office, particularly as it applies to the seeking, gathering, and documentation of pertinent circumstantial, historical, and other medicolegal data. (You are the eyes and ears for the medical examiner)
13. When working cooperatively with law enforcement, do you think that the work you perform as a death investigator has a profound effect on case outcomes?
    If so, how?
    I don't necessarily think my investigation has a profound effect for the law enforcement, as it does for the medical examiner. Law enforcement relies heavily on the outcome of the autopsy and additional testing (such as toxicology).

14. Hypothetically speaking, if an investigator makes a mistake while conducting a death investigation what is the least consequence the investigator could experience from the Medical Examiner's/Coroner's Office?
    Verbal coaching re: situation

    14a. What is the most severe reprimand, except firing, that the investigator could experience from the Medical Examiner's/Coroner's Office?
    The person could be written – up and/or require additional training.

    14b. Referencing question (14), could the investigator experience any consequences from
    any other agencies?
    Yes, there could possibly be repercussions with law enforcement. The investigating agency could report a grievance with a particular investigator and their actions on scene.

15. What protocols are required at all crime scenes?

- Remember to jurisdiction – meaning allow crime scene to process scene before you enter (work together)
- Wear PPE to protect yourself and crime scene
- Be professional (remember family and media may be present on scene)

16. What questions are asked during the initial death call which determines if an investigator will respond to the crime scene?
    - Age of decd
    - Location where he/she expired
    - Circumstances
    - Medical hx
    - Any trauma
    - Decomposition?

17. In your opinion, please list the deaths where an investigator should respond to the scene.
    - Unexplained- especially anyone under age of 50 (considering medical history)
    - Accidents
    - Suicide
    - Homicide

    Essentially anything that could be un-natural

18. What does it mean for a death to be non-reportable?
    - Decd was admitted to hospital for > 24 hrs. (no trauma, no sx)
    - Medical staff often has idea as to why person expired
    - Stillbirths are also non-reportable d/t no breath or heartbeat

19. In your opinion, does not responding to the initial crime scene have any impact on your investigation and/or the official death ruling?
    Yes and no – depends if you are going to gain anything from the scene, thus the reason for the initial screening questions.

20. Do you think you would/could benefit from additional death investigation training?
    If so, how?
    I think everyone could benefit from additional training. It is important to keep your skills sharp and learning new protocols/techniques could always be of benefit on scene.

21. Do you handle the death investigation of an unknown decedent differently than a known decedent? If so, how?

The general investigation is the same however, you are seeking any form of ID on the scene and/or contact information. Anything that will and in an ID. Identify tattoos, surgical scars, etc. Establishing ID is priority.

22. What factors influence how an unknown decedents' remains are disposed of?

23. In your opinion, what is the most important thing to do when first arriving on a scene?
    Meeting w/ the reporting officer and lead detective – this allows you to discuss the case before entering the scene (establish plan)

Regulating Medicolegal Death Investigations
Survey Questionnaire #5

Date: ___February 10, 2019

*Please answer all questions completely and honestly. If a question does not apply to you please state N/A or don't use. All information obtained in this research will be kept confidential.

1. What is your official title and job description?
    a. Medicolegal Death Investigator

2. What is your current educational background?
    a. Master's degree in Criminology and Criminal Justice

3. What prior/previous training have you had in conducting death investigations?

   a. I have more indirect prior training and experience. I worked as a Multi Skilled Tech II (MST II) in John Peter Smith hospital in Fort Worth, Tx for 5 years. During that time, I performed wound care and bandage changes, patient blood draw on children and adults, and took medical histories from patience. I perform these task in the ER, Med-Surge floor with infectious diseases and psych patience and in the surgical department (Pre-Op and Post Op).
   b. I as have 10 years of military experience.

4. What is your previous work history?
   a. See above

5. Did your prior work experience prepare you for your assignment as a death investigator? If so, please explain.
   a. Yes. While working in the hospital as a MST II, I was able to see the disease process and trauma injuries in the ER as well as the surgical department. My experience also includes working and speaking with the public during highly emotional situations, while giving and receiving information. While working as a MST II in a county hospital, I had the opportunity to work and interact with law enforcement that accompanied patience that were in custody.

6. What training have you acquired since working as an investigator?
   a. Death Scene Investigation for Medicolegal Death Investigators by the Director of Forensic Training, NYC Office of the Chief Medical Examiner.
   b. Attended the Crimes Against Children Conference in 2013.
   c. Dallas County Ethics and Building Safety Training- Annual

7. Are you a member of any professional organizations? If yes, what are they?
   a. European Society of Criminology
   b. Candidate for The American Board of Medicolegal Death Investigators

8. Tell me 3 important characteristics of a death investigator.
   a. high levels of intelligence with a method of inner awareness
   b. Good moral character and personal growth
   c. Durable constitution for the macabre

9. Tell me 3 key aspects of conducting death investigations.
    a. Focus
    b. Critical thinking
    c. Scientific knowledge

10. What factors influenced your decision to become a death investigator?
    a. The forensic field as a hole was still new and exciting thanks to entertainment. The entertainment aspect made me seek out fact from fiction.

11. In your opinion, how do the investigations you work effect, if at all, autopsy outcomes?
    a. My investigations can affect the outcome of an autopsy significantly. A deceased person remains are evidence. If the evidence is not preserved or present, then the ruling of the deceased can be delayed. This delay can be as short as a weekend or 20 years or more. The outcome of the autopsy can affect the person that is accused of a crime or family members ability to collect on the life insurance. My investigations into a person's death can affect the deceased as well. If the decease person has not been identified (properly or at all) the decease can be delayed in being laid to rest, which can affect next of kin, court proceedings and insurance payouts.

12. Define your role as a death investigator.
    a. to investigate any death that falls under the jurisdiction of the medical examiner or coroner, including all suspicious, violent, unexplained and unexpected deaths.
    b. Assist the next of kin through the process of a death investigation.
13. When working cooperatively with law enforcement, do you think that the work you perform as a death investigator has a profound effect on case outcomes? If so, how?
    a. Yes, the role of the death investigator is the preserve and collect the evidence at a death scene. The evidence as mentioned before is the deceased. Officers are not trained or equipped to handle the deceased remains. As a Death Investigator, I provide continuity and care for deceased human remain at a death scene.

14. Hypothetically speaking, if an investigator makes a mistake while conducting a death investigation what is the least consequence the investigator could experience from the Medical Examiner's/Coroner's Office?

a. Acknowledgement from their supervisor. As long as the mistake is not done intentionally or with malice intent. Death investigators cannot prepare or plan for every death scene. Some scenes are a learning experience because of environmental factors, juxtaposed to location and condition of the remains as well as other factors.

14a. What is the most severe reprimand, except firing, that the investigator could experience from the Medical Examiner's/Coroner's Office?

a. An official write up that documents the incident and held in an investigators performance report.

14b. Referencing question (14), could the investigator experience any consequences from any other agencies?

b. It is possible for the mere fact that you are working with other law enforcement agencies.

15. What protocols are required at all crime scenes?
    a. Introduction and documentation of lead investigators and others present at the scene. Especially large, high profile scenes that involve multiple agencies.
    b. Injuries of personal
    c. Documentation of personal items that have been removed from the deceased and who they were given to. (Ex. Cell phones given to law enforcement or personal effects given to family.

16. What questions are asked during the initial death call which determines if an investigator will respond to the crime scene?
    a. What type of death scene is this being reported?
        a. Location of the deceased.
        b. Traumatic injuries or any kind.
        c. Condition of the deceased (decomposition)
        d. Age of the deceased.
        e. Multiple deaths

17. In your opinion, please list the deaths where an investigator should respond to the scene.
    a. See above
    b. Anything that cannot be explained as a "natural demise"

18. What does it mean for a death to be non-reportable?
    a. When a deceased person passes away under the care of a doctor, in a medical setting for longer than 24 hours.

19. In your opinion, does not responding to the initial crime scene have any impact on your investigation and/or the official death ruling?
    a. No, law enforcement, Crime Scene Investigators as well lead detective and Justices of the Peace, can give a verbal report to the death investigator.

20. Do you think you would/could benefit from additional death investigation training?
    If so, how?
    a. Yes, with technological advances that have taken place in the field of forensic science, there are a plethora of training that could be taken.
        a. The American Academy of Forensic Sciences is a multidisciplinary professional organization that provides leadership to advance science and its application to the legal system. The objectives of the Academy are to promote professionalism, integrity, competency, education, foster research, improve practice, and encourage collaboration in the forensic sciences.
        b. The International Association of Coroners and Medical Examiners has over 80 years of experience in the presentation of educational seminars for the purpose of assisting Coroners and Medical Examiners in the performance of their duties.
        c. equipment in hospital settings and procedures.
        d. Forensic Anthropology Center at Texas State (FACTS) is a multifaceted center that encompasses a body donation program, the outdoor Forensic Anthropology Research Facility (FARF), the Osteological Research and Processing Laboratory (ORPL), and the Grady Early Building, which houses the Grady Early Forensic Anthropology Research Laboratory (GEFARL).
        e. Firearms and Impression Evidence
        f. Forensic Toxicology
        g. Forensic Photography
        h. Crime Scene Investigation
        i. Firearms and Impression Evidence
        j. Latent Prints
        k. Human Osteology

l. Bloodstain Pattern Analysis Crime scenes from other agencies and locations.
m. Disaster Mortuary Operational Response Teams (DMORT)
n. Federal Emergency Management Agency (FEMA)
o. Death Investigation Training Academy surveyed hundreds of professionals working in various disciplines of the death investigation community. We asked a simple question; what is your biggest obstacle in obtaining quality training in death investigation? The answers were overwhelmingly the same; not enough training options, limited specialized training in death investigation v. general criminal investigations, cost of training is too expensive, limited training in my region or state. These professionals spoke up and we listened. DITA was created to fill the training gap for death investigators around the world.

21. Do you handle the death investigation of an unknown decedent differently than a known decedent? If so, how?
    a. Yes. If a death investigator at Dallas County dies, their autopsy would be done in neighboring Tarrant County and vice versa. Death is challenging profession. It would only be respectful (professional curtesy) to the deceased and the investigator.

22. What factors influence how an unknown decedents' remains are disposed?
    a. Whether there is someone present or willing to identify and bury the deceased after an allotted time if the legal next of kin has been notified.
    b. Whether the ME gives permission for a cremation or not.
    c. Injuries and communicable diseases.

23. In your opinion, what is the most important thing to do when first arriving on a scene?
    Establish communication with officers already present on scene to identify myself, the location of the deceased, the circumstances surrounding the death and any safety concerns.

Regulating Medicolegal Death Investigations
Survey Questionnaire #6

Date: _____2/1/19

*Please answer all questions completely and honestly. If a question does not apply to you please state N/A or don't use. All information obtained in this research will be kept confidential.

1. What is your official title and job description?
Forensic Death Investigator/ Medical Investigator
- Aid in determining identity of decedents + cause of death
- Notify family of deaths + provide necessary information on office protocols

2. What is your current educational background?
Bachelor of Science – Criminal Justice
2 years of Master of Science program in Forensic Science (did not do thesis)

3. What prior/previous training have you had in conducting death investigations?
- Basic Death Investigator Course – (40 hours)
- Advanced Death Investigator Course – (40 hours)
- Blood Spatter Course
- Mass Fatality Training
- Criminal Investigation Training

4. What is your previous work history?
- Intern at CID on Army base
- 911 Dispatcher
- Loss Prevention Officer
- Medicolegal Death Investigator with another agency

5. Did your prior work experience prepare you for your assignment as a death investigator? If so, please explain.
Yes, working under pressure; having jobs that required attention to detail; having to work with different personalities (coworkers) – having to be a team player.

Loss prevention gave me the skills to know when someone is lying – it's very useful when talking to
families/friends + witnesses at death scenes. I am also more perceptive to body language + details that most people overlook.

6. What training have you acquired since working as an investigator?
- Mandatory county employee training (not – job – related)
- PowerPoint presentations from our pathologists
- Suggested reading materials

7. Are you a member of any professional organizations? If yes, what are they?
No, Employer has not scheduled ABMDI testing

8. Tell me 3 important characteristics of a death investigator.
- Detail-oriented
- Team player (works well with coworkers/ agencies)
- Calm/collected during chaos + high anxiety situations

9. Tell me 3 key aspects of conducting death investigations.
- Getting as much information as possible
- Ability to communicate effectively

10. What factors influenced your decision to become a death investigator?
- Ability to mentally do the job + not let it affect personal life
- Interesting cases + experiences daily
- Ability to help families at the worst moments of their lives – giving myself- to bring some peace to them

11. In your opinion, how do the investigations you work effect, if at all, autopsy outcomes?
My investigation is the groundwork or base upon which the doctors start their case. My investigation gives the doctor insight into what testing is needed and if an autopsy will be done.

12. Define your role as a death investigator.
To determine identity of a decedent + to help determine case of death.

13. When working cooperatively with law enforcement, do you think that the work you perform as a death investigator has a profound effect on case outcomes? If so, how?
Yes, many agencies immediately assume a death is a homicide or that a deceased baby is from abuse. My scene investigations can quickly dispel their assumptions. My skills on scene prevent families from being unnecessarily interrogated by police, CPS, etc.

14. Hypothetically speaking, if an investigator makes a mistake while conducting a death investigation what is the least consequence the investigator could experience from the Medical Examiner's/Coroner's Office?

- An email/text/call from boss or coworker to correct the problem, or request for additional information.
- A memo letting everyone know what not to do for future cases

14a. What is the most severe reprimand, except firing, that the investigator could experience from the Medical Examiner's/Coroner's Office?

To receive a written counseling; possible disciplinary and taining to correct the issue

14b. Referencing question (14), could the investigator experience any consequences from any other agencies?

- Loss of reputation; agencies may not trust investigations on scene analysis of death
- Can be called in to court + testify to mistake made – can cause problems during trial

15. What protocols are required at all crime scenes?

- Photograph the scene
- Document everything
- Bag hands for all homicides/GSW victims
- Wear gloves, use PPE (investigator safety should be #1 priority)

16. What questions are asked during the initial death call which determines if an investigator will respond to the crime scene?

- If there is any trauma, bleeding, weapons, drugs, etc.?
- Age of person + medical history
- Position/location where person was found

17. In your opinion, please list the deaths where an investigator should respond to the scene.

- Children under age 6 with no prior medical history
- Decomposing bodies
- Persons found outside
- Any death involving trauma
- Unexplained deaths of persons with no attending physician or medical history.

18. What does it mean for a death to be non-reportable?

Means that it doesn't fall under the ME's requirements for reporting the death. (i.e. Natural hospital deaths where the patient has been in the hospital for more than 24 hours).

19. In your opinion, does not responding to the initial crime scene have any impact on your investigation and/or the official death ruling?
Things can be easily missed if the scene is not attended. Reporting officers/nurses often overlook or fail to report information over the phone that is extremely important to the case.

20. Do you think you would/could benefit from additional death investigation training? If so, how? Of course! Training is always needed in this field. Forensics is always changing – as well as death scenes (i.e. chemical related suicides, etc.)

21. Do you handle the death investigation of an unknown decedent differently than a known decedent? If so, how? Yes, if the person is unknown – extra efforts are made to determine
identity. Tattoos, scars, etc. are extensively documented. Investigators must check cell phones, personal property neighbors, etc. to try to find a tentative identity that can be used for comparison in fingerprints, dental records, or DNA.

22. What factors influence how an unknown decedents' remains are disposed of?

- Size
- Communicable disease
- State of decomposition

23. In your opinion, what is the most important thing to do when first arriving on a scene? Photograph + document everything as it is. (before anything is moved)

Regulating Medicolegal Death Investigations
Survey Questionnaire #7

Date: March 18, 2019

*Please answer all questions completely and honestly. If a question does not apply to you please state N/A or don't use. All information obtained in this research will be kept confidential.

1. What is your official title and job description?
Medicolegal Death Investigator-To investigate all deaths reported to the office and invoke on those that fall under the State Statute for reporting of deaths. Interview law enforcement,
families, and medical personnel. Photograph and document all death scenes. Conduct investigative reports. Enter all donor network information, death certificates, and applicable administrative duties. Assist with autopsies as needed.

2. What is your current educational background?
Bachelor of Science in Police Science, Police Photography, Fingerprint Classification, EMT certified.

3. What prior/previous training have you had in conducting death investigations?
Intern Medicolegal Death Investigator for the Maricopa County Medical Examiner's Office in Phoenix, Arizona.

4. What is your previous work history?
Case Information Coordinator-Maricopa County Medical Examiner's Office
911 Dispatcher-Arizona Department of Public Safety
911 Dispatcher-PHI/Air Evac, Phoenix, Arizona.

5. Did your prior work experience prepare you for your assignment as a death investigator? If so, please explain.

Yes, my intern experience prepared me the most and was the most valuable. However, being a Case Information Coordinator prepared me for the administrative duties involved and gave me exposure to decedents. Being a 911 dispatcher gave me the experience to communicate well with
the public in times of stress along with communicating with law enforcement, which is a vital part of my current job.

6. What training have you acquired since working as an investigator?
In depth anatomy training, how to assist with autopsies, communication, medical terminology and knowledge of diseases, investigative questions.

7. Are you a member of any professional organizations? If yes, what are they?
I am sitting for my ABMDI certification
Arizona Emergency Management

8. Tell me 3 important characteristics of a death investigator.
Communicating with the public/law enforcement.
Gathering as much information as possible, relevant questioning
Knowing anatomy and basic medical terminology.

9. Tell me 3 key aspects of conducting death investigations.
Interviewing witnesses
Thorough on scene investigations…many times things are missed by law enforcement that they may have deemed not relevant.
Documentation

10. What factors influenced your decision to become a death investigator?
Being able to be part of a team that helps in getting answers to the death. Helping families and the public. Doing something that to me is very interesting and intriguing, yet most people could not do my job. It is very rewarding.

11. In your opinion, how do the investigations you work effect, if at all, autopsy outcomes?
Gathering information on the circumstances, medical history, etc. are all very pertinent things. This helps the doctor know what to look for, what to focus on instead going in blindly.
Investigations play a huge role in the autopsy outcomes, however, the findings on the decedent will confirm or deny anything.

12. Define your role as a death investigator.
To obtain pertinent information regarding the decedent's history and events leading up to the death so that the Pathologist can have a clear understanding as to the circumstances about the death.

13. When working cooperatively with law enforcement, do you think that the work you perform as a death investigator has a profound effect on case outcomes?
If so, how?
Yes, because as we work together and collect information and evidence it can make a big difference in addition to what the Pathologist finds. Our investigations in conjunction with the

autopsies are what makes the case. The background information we find can help the Pathologist as far as what to look for, test for, etc.

14. Hypothetically speaking, if an investigator makes a mistake while conducting a death investigation what is the least consequence the investigator could experience from the Medical Examiner's/Coroner's Office?
Being reprimanded by immediate Supervisor and giving a warning, re-teaching of what the proper method should be so it does not happen again.

14a. What is the most severe reprimand, except firing, that the investigator could experience from the Medical Examiner's/Coroner's Office? Being written up for
any type of misconduct, mishandling, or negligence as an Investigator.

14b. Referencing question (14), could the investigator experience any consequences from any other agencies? If we do not conduct ourselves professionally, it is observed by law enforcement agencies and they may not want to conduct business with our office and contract with other Medical Examiner's Offices.

15. What protocols are required at all crime scenes?
Scene safe and secure.
Use of proper personal protective equipment

16. What questions are asked during the initial death call which determines if an investigator will respond to the crime scene?
Medical history, social history (drugs, alcohol, tobacco), trauma, anything suspicious, age. –any many other questions, but those being the most important.

17. In your opinion, please list the deaths where an investigator should respond to the scene.

1. No doctor care for over 18 months
2. Death resulting from violence
3. Suspicious death-drugs involved
4. Homicide
5. In custody
6. Surgical death
7. Decomposed-unidentified
8. Work related death
9. Suicide
10. Possible contagious disease-health threat.

18. What does it mean for a death to be non-reportable?
It does not fall under the state statute to where the death would need to be investigated further by the Medical Examiner's Office.

19. In your opinion, does not responding to the initial crime scene have any impact on your investigation and/or the official death ruling?
Yes, because depending upon the circumstances or questions asked when it was reported, there may be information, pictures, that could turn the investigation into a different direction.

20. Do you think you would/could benefit from additional death investigation training?
If so, how? There is always a need for additional training. Trends change, such as the drug
epidemic and there are always new things to learn, precautions to take and ways of furthering one's knowledge to conduct the most thorough investigations.

21. Do you handle the death investigation of an unknown decedent differently than a known decedent? If so, how? I handle all deaths the same. You must remain professional and keep an emotional disconnect. I have only had one death at my office where I knew the person well, but still remained professional. If it was immediate family, I'm not sure what my response would be, but I definitely handle all deaths the same currently.

22. What factors influence how an unknown decedents' remains are disposed of?
Rate of decomposition, trauma, how long the decedent has been in our coolers.

23. In your opinion, what is the most important thing to do when first arriving on a scene?
Introducing myself to families and law enforcement and explaining what I will be doing and what will be happening. Answering any questions.

Regulating Medicolegal Death Investigations
Survey Questionnaire #8

Date: __02.01.2019_____

*Please answer all questions completely and honestly. If a question does not apply to you please state N/A or don't use. All information obtained in this research will be kept confidential.

1. What is your official title and job description?

   I am a Medicolegal Death Investigator for the Medical Examiner's Office. I gather information and investigate deaths in order to assist the Medical Examiners in arriving at a correct and truthful cause and manner of death for persons that die. Investigating deaths requires a lot of telephone work and follow-up calls, and also includes attending some death scenes within the county in order to more fully evaluate the circumstances of the involved death. I also help with other daily issues within our office, which include positive identifications of unknown persons, medical records requests, and informational calls from both family members and different agencies.

2. What is your current educational background?

I have a B.S. degree in Forensic Science, with a minor in Chemistry. I have participated in different continuing education courses, both online and in person, since I began this job 12 years ago. I am a board-certified member of the ABMDI.

3. What prior/previous training have you had in conducting death investigations?

Before I started this position, I worked for about a year and a half at the Abilene TX Police Dept as a Forensic Specialist. I attended a few death scenes in that time period and was able to observe and learn some evidence collection procedures and information gathering regarding death investigations from my coworker, who had been working in the position for years. I also sat in on a Death Investigation course during my last semester in college.

4. What is your previous work history?

Before I started this position, I worked for about a year and a half at the Abilene TX Police Dept as a Forensic Specialist.

5. Did your prior work experience prepare you for your assignment as a death investigator? If so, please explain. Yes, but only slightly because I did not attend many death scenes. The population of that city is much smaller that Dallas, and our Forensics unit was not contacted by patrol officers for every single death that took place. I would say that my previous job prepared me in that I was able to be introduced to the basics of evidence collection, scene processing, and photography, and I was able to be a part of those things for the few death scenes I did attend.

6. What training have you acquired since working as an investigator?

I have attended several continuing education courses in the last 12 years and have signed up for numerous online continuing education courses as well, all in topics that deal directly with death investigation, for example Mass Fatality Incident Planning, Infant Death Investigation, and Cultural Competency.

7. Are you a member of any professional organizations? If yes, what are they?

Yes, I have been a member of the International Association for Identification (IAI) and the American Academy of Forensic Sciences (AAFS) since college. I am also a member of the American Board of Medicolegal Death Investigators (ABMDI).

8. Tell me 3 important characteristics of a death investigator.

Patience, medical and disease knowledge/background, and thoroughness

9. Tell me 3 key aspects of conducting death investigations.

Thoroughness, patience, and open-mindedness

10. What factors influenced your decision to become a death investigator?

While I was working towards my B.S. in Forensic Science, I really truly enjoyed the forensics classes we had to take, which included Crime Scene Investigation, Forensic Anthropology, and Forensic Entomology. I knew that in order to have a career I was happy with and a job I enjoyed going to daily, I needed to follow what I was interested in

and what made me happy. I didn't really realize there was a job such as death investigation out there, until college. I have always liked science and have been interested in the circumstances surrounding deaths and high-profile deaths, so I followed that path.

11. In your opinion, how do the investigations you work effect, if at all, autopsy outcomes?
I believe that most autopsy findings correlate with what is seen and found on scene, and with the suspected cause and manner of death that the death scene supports. Every now and then, scene observations are crucial in determining the cause of death, as what can be seen on scene can change something as simple as what appears to be a natural death to a suspected accidental death, for example. I feel that the medical and social background we have to gather from the decedent's friends and family helps the ME know what to look for and confirm, medical-wise, before and during the autopsy.

12. Define your role as a death investigator.
My job is to ultimately assist the Medical Examiner with arriving at the correct cause and manner of death for any cases which we decide to bring into our office or investigate. I need to gather what information I can about the decedent's life, medical history, social history, and sometimes living and family situations, in order to present a picture of that person and a thorough report to the Medical Examiner.

13.When working cooperatively with law enforcement, do you think that the work you perform as a death investigator has a profound effect on case outcomes? If so, how?
A profound effect, no. The rare times when I go out to a scene and discover something either on scene or on the body that the police haven't, that changes the course of the investigation and the presumed cause and manner of death, is important and memorable. I believe that talking with and presenting myself in a caring manner to the decedent's friends and family on scene can at times have a profound effect on them, as I am meeting with them and interacting with them on perhaps one of the worst days of their lives.

14.Hypothetically speaking, if an investigator makes a mistake while conducting a death investigation what is the least consequence the investigator could experience from the Medical Examiner's/Coroner's Office?
I think it depends on what the mistake is, it could range from something simple like forgetting to collect illicit drug paraphernalia that is present on scene, to something like the body being dropped during transport from the scene to the transport vehicle. There are smaller consequences, like the first example, and larger ones, like embarrassment that is experienced either on scene or at the office amongst ones' coworkers and supervisors.

14a. What is the most severe reprimand, except firing, that the investigator could experience from the Medical Examiner's/Coroner's Office?
The most severe issue in my opinion, that I have learned about during my years here, was that an investigator typed some information into her report

that did not match her scene observations and the body condition. This became an issue when the trial for the suspect occurred, as the defense and the prosecution were arguing over the timeline in which the death could've taken place and the decd could've been killed. The issue in the investigator's report, from I can recall, was the description of the rigor and/or livor mortis they typed into their report, either forgetfully or accidentally, which didn't match their scene photos and the true condition of the body. The investigator was called to court and had to explain this discrepancy. I believe a hung jury occurred during the first trial, and it's very possible that other issues played into this as well.

14b. Referencing question (14), could the investigator experience any consequences from any other agencies?
When things like this occur, I feel that when the police detectives involved learn about discrepancies in our reports, it lowers their trust level in us. Their trust in us can also be erased when we are not professional and helpful on scene, and willing to work with them during the death investigation and help answer any questions they might have while on scene.

15. What protocols are required at all crime scenes?
Working professionally with the other agencies involved, staying calm, doing the best job we can, speaking with family and/or friends when they are present, photographing the scene and body, searching for anything that might affect the cause and manner of death, and wearing any appropriate protective gear on scene.

16. What questions are asked during the initial death call which determines if an investigator will respond to the crime scene?
Age of decedent, location of body, if any obvious trauma is noted, if the body is decomposing or not, if and what the decedent's medical history is

17. In your opinion, please list the deaths where an investigator should respond to the scene.
Decomposing bodies (although never fun!), any persons under 50 with no known medical issues, any babies under 1 year of age, any suspected homicides or suicides, any car crashes, any persons who are found outside in the elements

18. What does it mean for a death to be non-reportable?
That means that the death and its circumstances are of no interest to the Medical Examiner, and they do not need to be reported to this office to see if our involvement is needed or not

19. In your opinion, does not responding to the initial crime scene have any impact on your investigation and/or the official death ruling?

For some deaths yes, for some deaths, no. If we have something to gain by going out to a death scene, we will go. I believe we have something to gain when there are scenes were the police see obvious trauma to the body, or the person is of a younger age and has no known medical issues and was just found dead. Also, on scenes where illicit drugs and/or a great amount of pill bottles or loose prescription pills are seen.

20. Do you think you would/could benefit from additional death investigation training? If so, how? Yes, I agree that it is good for investigators in this job to be a part of continuing education courses; it keeps our skills up and introduces us to issues that maybe we had little knowledge of before

21. Do you handle the death investigation of an unknown decedent differently than a known decedent? If so, how? Yes, if I am on scene and an identity is unknown, I will perform a more thorough search, in a residence for example, for any documents or items that could help confirm the identity. Otherwise, the investigations are treated the same.

22. What factors influence how an unknown decedents' remains are disposed?
In our county, if a decedent is never positively identified after a fingerprint search, a dental record search, and a DNA database search, they are buried by the county, instead of cremated, so that if new information comes about in the future, the full remains will be able to be returned to the family once they are located following the positive ID.

23. In your opinion, what is the most important thing to do when first arriving on a scene?
Gathering the basic story and information from the police, or whatever information they have up to that point

Regulating Medicolegal Death Investigations
Survey Questionnaire #9

Date: _____03.17.19_____

*Please answer all questions completely and honestly. If a question does not apply to you please state N/A or don't use. All information obtained in this research will be kept confidential.

1. What is your official title and job description?
Medicolegal death investigator
Attends death scenes and works cooperatively with law enforcement personnel to ensure collection and preservation of evidence related to the death investigation; interviews family of decedent, witnesses, law enforcement personnel, physicians, and other persons to assist with the determination of cause and manner of death; collects, documents, secures, tracks and disposes of decedent's personal property; photographs death scenes

and bodies; assists in establishing identity of decedent and ensures timely notification of next-of-kin; facilitates disposition of body; and prepares and submits detailed, written fact reports to the Medical Examiner.
Receives notification of deaths; makes initial determination regarding scope of investigation including jurisdiction, scene attendance and acceptance of body for physical examination
Provides information and assistance to family members of decedents; assists in providing information and training to staff, interns and other interested parties; responds to general inquiries and requests for information within established guidelines.
Receives and releases decedent bodies; assists with the disposition of indigent and unclaimed bodies
Provides direction and assistance to staff; responds to non-routine situations that occur outside of normal business hour including summoning assistance and taking other actions to safeguard department personnel and property.

2. What is your current educational background?
I have an AS in science, a BS in business, and an MS in forensic science.

3. What prior/previous training have you had in conducting death investigations?
I worked for some private criminal defense attorneys doing investigation and then I was a police officer for 3 years prior to this job.

4. What is your previous work history?
See above

5. Did your prior work experience prepare you for your assignment as a death investigator? If so, please explain.
My prior work and educational history prepared me for this job. I knew I could handle decedents. I knew I could interact with people in a state of shock and anger. The interaction with multiple socioeconomic layers of society prepared me well for this job.

6. What training have you acquired since working as an investigator?
- Crisis Intervention Training, July 2016
- Special Investigative Topics, June 2016
- Investigating Epilepsy Deaths, May 2016
- Mass Disaster Conference, October 2013
- Recreational Asphyxia, Mechanical, June 2012
- Forensic Specialties in Death Investigation, NYC Medical Examiner, March 2012

- National Forensic technology Center, Medicolegal Death Investigation Training Program, October 2010
- Forensic Sciences Training Program, NYC Medical Examiner, March 2010
- FEMA Basic Incident Management, September 2006
- Basic Animal Control Officer, June 2006
- Methamphetamine Conference, February 2006
- Criminal Law Update, November 2005
- Identity Crime Update, September 2005
- Homicide Investigations, March 2005
- Shooting Incident Reconstruction, October 2002

7. Are you a member of any professional organizations? If yes, what are they?
Yes, American Academy of Forensic Science, American Board of Medicolegal Death Investigators, and International Association of Identification.

8. Tell me 3 important characteristics of a death investigator.
Compassion, inquisitiveness, peace/calm in the storm

9. Tell me 3 key aspects of conducting death investigations.
- It is necessary to be detail oriented and thorough.
- It is helpful to be able to speak to the level of the person with whom you are speaking, i.e.
cardiothoracic surgeon vs. special needs child.
-The ability to reconstruct actions that happened and work back logically from that place in
order to retrieve the most appropriate and/or best answer.

10. What factors influenced your decision to become a death investigator?
I thoroughly enjoy the puzzle aspect of this job – trying to determine what happened and/or how it happened

11. In your opinion, how do the investigations you work effect, if at all, autopsy outcomes?
I do not necessarily believe that my investigation effect autopsy outcomes. They certainly effect COD/MOD outcomes. The autopsy is what it is – a physical examination. COD/MOD determination is a concerted and team effort led ultimately by the physician.

12. Define your role as a death investigator.
My role is to provide support and information to the ME so that he/she can make a determination about cause and manner of death.

13. When working cooperatively with law enforcement, do you think that the work you perform as a death investigator has a profound effect on case outcomes? If so, how?
I'm not sure. I know that the things I do on scene, in the midst of an investigation have lasting impact and can come back to cause problems if I do my work poorly or sloppily.

14. Hypothetically speaking, if an investigator makes a mistake while conducting a death investigation what is the least consequence the investigator could experience from the Medical Examiner's/Coroner's Office?
The least consequence would be a conversation – please do not do that again.

14a. What is the most severe reprimand, except firing, that the investigator could experience from the Medical Examiner's/Coroner's Office?
The most severe reprimand would be formal documented "write up" about the incident that went into a permanent file.

14b. Referencing question (14), could the investigator experience any consequences from any other agencies?
Potentially there could be criminal charges if something was done internationally and/or criminally.

15. What protocols are required at all crime scenes?
I don't understand this question. There are protocols for PPE and for recovery of evidence. It is best to go into a scene with the crime scene investigator and walk through together. It is necessary to allow the crime scene investigators to recover evidence sometimes before the removal of the body in order to prevent the destruction of evidence.

16. What questions are asked during the initial death call which determines if an investigator will respond to the crime scene?
The determination needs to be made if there is trauma and/or if the decedent is decomposing.

17. In your opinion, please list the deaths where an investigator should respond to the scene.
Homicide, suicide, undetermined, decomposing, infant deaths, accident, sometimes natural deaths in order to determine whether or not the decedent needs to come to the office. Sometimes those scenes need to be looked at by a trained MDI.

18. What does it mean for a death to be non-reportable?
It means that the death was not required by law to be reported to the ME

19. In your opinion, does not responding to the initial crime scene have any impact on your investigation and/or the official death ruling?
It can depend on the circumstances of the death. It is often very difficult to get accurate information at the hospital – the ER staff is given only what EMS provides. Oftentimes, that information is sketchy and/or just straight inaccurate.

20. Do you think you would/could benefit from additional death investigation training? If so, how?
Yes, more training would NEVER hurt. There is always the possibility to learn something new and to incorporate new things into every day investigation.

21. Do you handle the death investigation of an unknown decedent differently than a known decedent? If so, how?
Well, yes and no. They have to be identified but the investigation will be the same.

22. What factors influence how an unknown decedents' remains are disposed of?
If the decedent remains unknown after fingerprints, dentals, and/or DNA are done, the decedent is buried. If they are eventually identified, then NOK gets to make arrangements. If no NOK is located, the decd (if identified) is cremated.

23. In your opinion, what is the most important thing to do when first arriving on a scene?
Evaluate safety for me and my crew. The second thing is to find the lead with the PD and get information on the specifics of the circumstances.

Regulating Medicolegal Death Investigations
Survey Questionnaire #10

Date: 01.24.19

*Please answer all questions completely and honestly. If a question does not apply to you please state N/A or don't use. All information obtained in this research will be kept confidential.

1. What is your official title and job description?

Medicolegal Death Investigator. The primary job is to gather information to assist the medical examiner in determining the cause and manner of death.

2. What is your current educational background?

Bachelor of Science degree and some post graduate forensic lab coursework

3. What prior/previous training have you had in conducting death investigations?

N/A

4. What is your previous work history?

Autopsy Technician (1 year)
DNA Sequencing technician (2 years)

5. Did your prior work experience prepare you for your assignment as a death investigator? If so, please explain.

As an autopsy technician I was able to go out on some death scenes with investigators which allowed me to gain experience in scene processing. Also performing autopsies helped in learning different disease processes and acquiring knowledge on how the medical examiner determines cause and manner of death.

6. What training have you acquired since working as an investigator?

Continuing education courses in death investigation, fingerprints and DNA profiling

7. Are you a member of any professional organizations? If yes, what are they?

Yes. The American Board of Medicolegal Death Investigators

8. Tell me 3 important characteristics of a death investigator.

Ability to be courteous and respectful to families
Ability to listen and process information
Ability to document well and keep an open mind

9. Tell me 3 key aspects of conducting death investigations.

Note taking
Photography
Report writing

10. What factors influenced your decision to become a death investigator?

I have always been interested in forensics ever since taking several undergrad courses such as anthropology and entomology. I really enjoy talking with families and helping them get through their period of loss

11. In your opinion, how do the investigations you work effect, if at all, autopsy outcomes?

The investigations help the medical examiners gain insight on certain scene factors which help to construct a complete picture when determining cause and manner of death

12. Define your role as a death investigator.

My role incudes going on death scenes and documenting the scene (reports and photographs) which is presented to the medical examiner prior to the autopsy. I also take death reports from hospital deaths which fall under our jurisdiction, death reports of people who are on hospice care, deaths from judges who send decedents to our office for autopsy from different counties.

13. When working cooperatively with law enforcement, do you think that the work you perform as a death investigator has a profound effect on case outcomes? If so, how?

I don't think it helps with the law enforcement side such as prosecuting criminals. But it helps the medical examiner in finding cause of death.

14. Hypothetically speaking, if an investigator makes a mistake while conducting a death investigation what is the least consequence the investigator could experience from the Medical Examiner's/Coroner's Office?

A verbal counseling from supervisors

14a. What is the most severe reprimand, except firing, that the investigator could experience from the Medical Examiner's/Coroner's Office?

Getting a disciplinary write up

14b. Referencing question (14), could the investigator experience any consequences from any other agencies?

If an investigator conducts themselves in an improper manner on scene, law enforcement or even families may notify the supervisor of the investigator or others that are in charge

15. What protocols are required at all crime scenes?

Determining the decedent's medical and social history, determining identification, Inspection of the body/clothing, Consulting with law enforcement and families to gain further circumstantial information or patient history

16. What questions are asked during the initial death call which determines if an investigator will respond to the crime scene?

What is the person's medical history? Is there a history of drug/alcohol smoking? Is there a history of suicidal ideations/attempts? Is there a history of recent trauma? When was the person last known to be alive? Is the person under the care of a physician?

17. In your opinion, please list the deaths where an investigator should respond to the scene.

Any death involving trauma (accidents, homicides, suicides) Child deaths, deaths of inmates in custody that have not been diagnosed with any illness, unexplained deaths of a person with no physician or medical history, deaths of decomposing individuals

18. What does it mean for a death to be non-reportable?

Deaths of individuals that are not children that have well documented medical history and have been in a hospital for 24 hours prior to their death

19. In your opinion, does not responding to the initial crime scene have any impact on your investigation and/or the official death ruling?

Yes. I think being able to attend a scene helps gain knowledge about how the person lived and provides information on social/medical history. Scene attendance also can provide information on trauma.

20. Do you think you would/could benefit from additional death investigation training?

If so, how?

Yes. I think that it is always beneficial to learn new techniques and advances in the field in order to stay current with investigation

21. Do you handle the death investigation of an unknown decedent differently than a known decedent? If so, how?

For unknown decedent's, more efforts are taken to identify the individual by examining personal property, sending off fingerprints/DNA for possible comparison. The overall processing of the investigation outside of trying to determine identity is not any different

22. What factors influence how an unknown decedents' remains are disposed?

If a person is unknown and a thorough search for family has been completed and attempts to identify (fingerprints or DNA if possible) then the person will be buried. Unknowns are not cremated in our jurisdiction

23. In your opinion, what is the most important thing to do when first arriving on a scene?

Communicating with the lead detective/first responding officer on scene

Regulating Medicolegal Death Investigations
Survey Questionnaire #11

Date: _____02/01/2019_____

*Please answer all questions completely and honestly. If a question does not apply to you please state N/A or don't use. All information obtained in this research will be kept confidential.

1. What is your official title and job description?

Medicolegal Death Investigator. I investigate all deaths reported to the office of the Medical Examiner for Dallas County, TX. I determine if the nature or circumstances of the death warrant a forensic autopsy.

2. What is your current educational background?

Bachelor's Degree in Criminal Justice

3. What prior/previous training have you had in conducting death investigations?

None.

4. What is your previous work history?

I worked for CPS (Child Protective Services) as an investigator for about 2 years. Prior to that, I worked in restaurants throughout college.

5. Did your prior work experience prepare you for your assignment as a death investigator? If so, please explain.

Absolutely, you need to have a thick skin as well as a demeanor that does not provoke those around you. When you work for tips, you learn quickly to keep an even temperament. Working for the state provided another reality, exposure to poverty and all that encompasses.

6. What training have you acquired since working as an investigator?

I have attended several forensic training courses and obtained certification AMBDI (American Board of Medicolegal Death Investigators).

7. Are you a member of any professional organizations? If yes, what are they?
AMBDI
8. Tell me 3 important characteristics of a death investigator.
Transparent
Attention to detail (Observant)
Calm

9. Tell me 3 key aspects of conducting death investigations.
- Listening to those involved in the investigation, knowing when and what to ask.
- Learning what to look for on scene, forensic evidence or possible information to help determine cause of death.
- Being flexible with who you come into contact with. First responders, the media, public and family.

10. What factors influenced your decision to become a death investigator?
I am part of the "CSI effect". I saw it in high-school and wanted to pursue this line of work.

11. In your opinion, how do the investigations you work effect, if at all, autopsy outcomes?
It depends on each case, but most Medical Examiners (The good ones) can determine cause of death without a death report, but it certainly helps them solidify their determinations. Death investigators obtain social and medical history regarding the deceased, to help confirm the cause of death or negate it.

12. Define your role as a death investigator.
I provide a service, or the face of the Medical Examiner's Office. I provide valuable information to the family, and obtain critical information to report back to the ME.

13. When working cooperatively with law enforcement, do you think that the work you perform as a death investigator has a profound effect on case outcomes? If so, how?
Yes, developing a working a professional relationship with law enforcement is critical.

14. Hypothetically speaking, if an investigator makes a mistake while conducting a death investigation what is the least consequence the investigator could experience from the Medical Examiner's/Coroner's Office?
It goes completely un-noticed.

14a. What is the most severe reprimand, except firing, that the investigator could experience from the Medical Examiner's/Coroner's Office?
A write up that is added to a personnel file with an understanding (signatures and verbal confirmation) that termination would occur with the next infraction.

14b. Referencing question (14), could the investigator experience any consequences from
any other agencies?
Yes, it could be held against the investigator when going to court. The mistake could be used to discredit the investigators testimony.

15. What protocols are required at all crime scenes?
PPE (personal protective equipment).

16. What questions are asked during the initial death call which determines if an investigator will respond to the crime scene?
Who, what, where and when.

17. In your opinion, please list the deaths where an investigator should respond to the scene.
Anyone outside, unsecured residential deaths, suspected overdoses (with or without drugs on scene), any deaths where no medical history is known in the decease, suspicions voiced by police, violent/traumatic deaths, suicides, and all children (unless they have a terminal illness).

18. What does it mean for a death to be non-reportable?
If an individual is being treated and monitored in the hospital by a physician and medical staff for over 24 hours after admission and their medical history does not include trauma or illicit drug use, then their death is non-reportable.
19. In your opinion, does not responding to the initial crime scene have any impact on your investigation and/or the official death ruling?
Yes, there are plenty of circumstantial evidence that is found by a death investigator that is used by the medical examiner to determine cause of death. Certain things can be missed if an investigator is not on the scene. There are statements made about the deceased that is valuable to the medical examiner.

20. Do you think you would/could benefit from additional death investigation training?
If so, how? Yes, training is always valuable and a great way to refresh and stay up to date on perspective and forensic knowledge.

21. Do you handle the death investigation of an unknown decedent differently than a known decedent? If so, how?
I would say, more work is involved with an indigent person, over someone with family.

22. What factors influence how an unknown decedents' remains are disposed?

DNA, dental, fingerprints and radiological photograph comparisons are used to determine an unknown's identity. If the person is unknown, all forensic means to identify the individual are collected and the unknown decedent is buried. Their likeness and possible tentative ID information is updated in the Namus.gov database.

23. In your opinion, what is the most important thing to do when first arriving on a scene?
Protect yourself.

Regulating Medicolegal Death Investigations
Survey Questionnaire #12

Date: _____March 13, 2019_____

*Please answer all questions completely and honestly. If a question does not apply to you please state N/A or don't use. All information obtained in this research will be kept confidential.

1. What is your official title and job description? Chief Medicolegal Investigator

2. What is your current educational background? Undergraduate degrees in pre-professional medicine, pre-law, and psychology. Nearly completed master's degree in public health. Texas certification as a Master Peace Officer with 1000's of hours of related law enforcement and legal educational training.

3. What prior/previous training have you had in conducting death investigations? 40-hour death investigation school initially along with crime scene search, homicide investigation, and other related criminal justice academics.

4. What is your previous work history? Texas EMT-Paramedic and Texas Peace Officer.

5. Did your prior work experience prepare you for your assignment as a death investigator? If so, please explain. Yes. There is a great overlap between the pre-hospital medical and law enforcement fields; hence, the general term "medicolegal" investigator.

6. What training have you acquired since working as an investigator? Undergraduate degree in pre-law and psychology followed by almost 30 Master's-level hours in Public Health Administration. Also, Diplomate certified by the American Board of Medicolegal Death Investigators (ABMDI).

7. Are you a member of any professional organizations? Yes
If yes, what are they? ABMDI.

8. Tell me 3 important characteristics of a death investigator. Self-starting (the ability to assess and initiate things independently); detail-oriented (both in attention to scene assessment and final work product); and diligent in the pursuit of excellence (arête).

9. Tell me 3 key aspects of conducting death investigations. Personal integrity (honesty and trustworthiness), education (enhances one's ability to understand, describe accurately, and explain one's casework), and effective communication with one's co-workers, a decedent's family, other professionals, the public, etc.

10. What factors influenced your decision to become a death investigator? Personal invitation from a medical examiner (forensic pathologist) combined with an interest on medicine and the law conjointly (although, I never expected necessarily to attain the job).
11. In your opinion, how do the investigations you work effect affect, if at all, autopsy outcomes? A proper and thorough scene investigation is often key to the correct cause and manner of death determination (particularly the manner). Likewise, a good scene investigation with ample salient information can allow a pathologist to avoid having to perform anything other than an external inspection of the body to rule out trauma rather than having to waste expensive resources conducting needless and unwarranted internal examinations.

12. Define your role as a death investigator. To act as the eyes and ears of the forensic pathologist at a scene. To actively participate in the case intake and processing to ensure a timely, accurate outcome for all interested parties (e.g., families, law enforcement and criminal justice systems, medical practitioners, news media, etc.).

13. When working cooperatively with law enforcement, do you think that the work you perform as a death investigator has a profound effect on case outcomes? A profound effect occasionally, with a more general positive effect more commonly. If so, how? Again, assessing a scene thoroughly, interpreting one's observation accurately, and reporting the findings succinctly is paramount to a successful criminal justice outcome

through effective, unbiased, courtroom trial testimony supported by documented facts and conclusions obtained through one's solid work ethic and product.

14. Hypothetically speaking, if an investigator makes a mistake while conducting a death investigation what is the least consequence the investigator could experience from the Medical Examiner's/Coroner's Office? The least consequence is no consequence, but in my office, there is a progressive chain of discipline that is resorted to when prior attempts to educate, train, and guide go unheeded.

> 14a. What is the most severe reprimand, except firing, that the investigator could experience from the Medical Examiner's/Coroner's Office? A formal reprimand filed in one's personnel file through Human Resources. Time off without pay (suspension from duty).
>
> 14b. Referencing question (14), could the investigator experience any consequences from any other agencies? Depending upon the circumstances, yes (e.g., criminal law violations, etc.).

15. What protocols are required at all crime scenes? We have guidelines rather than protocols as there is much variation from scene to scene and circumstance to circumstance. One size does not always fit all, and flexibility is necessary.

16. What questions are asked during the initial death call which that determines if an investigator will respond to the crime scene? Generally, scene visitations are dependent upon the known or anticipated manner of death (e.g., all trauma, foul play, and unnatural manner of death scenes are attended unless the decedent died while hospitalized or the extant case volume is too great to allow for a timely scene visitation), thus, this is one of the first questions asked.

17. In your opinion, please list the deaths where an investigator should respond to the scene. All unnatural deaths. Any apparently natural deaths without any supportive information (e.g., established natural clinical history, prescribed medications, attending doctors, etc.). Any young person (the general, but not fixed, threshold is 50 years of age and dependent upon initially reported case circumstances).

18. What does it mean for a death to be non-reportable? Reportable deaths are enumerated in the Texas Code of Criminal Procedure §49.25 and the Texas Family Code §264.513. Anything not listed therein is considered non-reportable.

19. In your opinion, does not responding to the initial crime scene have any impact on your investigation and/or the official death ruling? There are always exceptions, but not usually.

20. Do you think you would/could benefit from additional death investigation training? Yes.
If so, how? Disciplines evolve and related education and training should likewise advance to maintain one's professional relevancy, knowledge, and acumen. In robust work environments, staff have to rely primarily on in-house educational offerings, free coursework, or take advantage of instructional topics on their own time and at their own expense, which is not necessarily the optimum model.

21. Do you handle the death investigation of an unknown decedent differently than a known decedent? Only as it relates to the decedent being unidentified. If so, how? Unidentified decedent's require additional work to affect a positive identification by scientific means or, less preferably, a visual ID by a family member, friend, or associate. Circumstantial ID is absolutely the weakest form of identification and must be avoided unless there is no other viable option
available.

22. What factors influence how an unknown decedents' remains are
deposed?
Definition of depose (transitive verb)
1: to remove from a throne or other high position // plotting to depose the king // a deposed military leader
2: to put down // deposit // deposing the sacrament in a carved recess
3: [Middle English, from Medieval Latin deponere, from Late Latin]
A: law – to testify to under oath or by affidavit // deposed before the court that he had seen the defendant enter the building
b: law – to affirm, assert
c: law – to take testimony (see testimony sense 1a) from especially by deposition // depose a witness // plaintiffs were entitled to depose experts retained by the defendants

Is this question what you truly intended to ask? How are you defining "depose" in the context of this questionnaire and topical setting?

If you are inquiring as to the methods used for disposition of a decedent's remains post-exam, burial or cremation are the most common options with donation to a research institution or medical school placing a distant third. Considering only those deaths associated with the medical examiner's system, only unidentified bodies cannot be cremated per state law. A quick-thinking district attorney will stretch that restriction to all known homicide cases as well (protects the body as (of) evidence from true or alleged spoliation).

23. In your opinion, what is the most important thing to do when first arriving on a scene? Ensure one's personal safety. An injured or dead investigator helps no one (not to mention the extremely personal aspects of one so involved ☺).

Regulating Medicolegal Death Investigations
Survey Questionnaire #13

Date: February 14, 2019

*Please answer all questions completely and honestly. If a question does not apply to you please state N/A or don't use. All information obtained in this research will be kept confidential.

1. What is your official title and job description?
Medicolegal Death Investigator and Autopsy Technician
As an investigator, I conduct a preliminary investigation of the cause and manner of death by carefully gathering information about the death scene, interview family members, witnesses,
medical and emergency personnel, and law enforcement. I obtain photographs of the death scene and analyze all available information. I prepare detailed reports of each case for review by the
Forensic Pathologist. I work closely with other agencies and medical personnel when conducting investigations.

2. What is your current educational background?
AAS in Criminal Justice
Certifications in Death Scene Investigation, Crime Scene Processing, and Forensic Pathology

3. What prior/previous training have you had in conducting death investigations?
All prior training was obtained in a classroom setting as well as one on one training with a certified ABMDI investigator.

4. What is your previous work history?

5 years - Emergency Room (nurse technician)
3 years – Home Health Care (medical assistant)
1 year – Psych Ward (mental health tech)
5 years - Burn Acute Care and Burn ICU (burn technician)
4 years – Transplant Services (transplant technician)

5. Did your prior work experience prepare you for your assignment as a death investigator? If so, please explain.
Yes. My prior experience prepared me in dealing with other agencies such as law enforcement and medical personnel. My prior experience also gave me a wide medical

background that helps in obtaining proper information for when performing an investigation.

6. What training have you acquired since working as an investigator?
On the job training with ABMDI certified investigators as well as a board-certified forensic pathologist. I have received multiple certifications in death investigation and forensic pathology. I have obtained 400 hours of case experience while I'm currently working on receiving my ABMDI certification.

7. Are you a member of any professional organizations? If yes, what are they? No.

8. Tell me 3 important characteristics of a death investigator.

1. Confidentiality
2. Professionalism
3. Unbiased

9. Tell me 3 key aspects of conducting death investigations.

1. Obtaining a thorough crime scene description
2. Obtaining and communicating correct and accurate information from all involved
3. Maintaining a professional relationship with all involved agencies

10. What factors influenced your decision to become a death investigator?
I have always been passionate about both the medical field and criminal justice. Forensics was the perfect blend of both. I am intrigued by how the human mind and body works and I love being a part of a system such as this one.

11. In your opinion, how do the investigations you work effect, if at all, autopsy outcomes?

I feel that the investigation that I do only supports the autopsy findings. I believe that if the forensic pathologist does a complete job then they should be able to come to a proper conclusion with or without the investigation. It does help to have a back story, however, in order to support all findings. Especially on private cases, if we know the concerns of the family then we are better able to look for answers they are seeking with a proper investigation.

12. Define your role as a death investigator.

As an investigator, I conduct a preliminary investigation of the cause and manner of death by carefully gathering information about the death scene, interview family members, witnesses, medical and emergency personnel, and law enforcement. I obtain

photographs of the death scene and analyze all available information. I prepare detailed reports of each case for review by the Forensic Pathologist. I work closely with other agencies and medical personnel when conducting investigations.

13. When working cooperatively with law enforcement, do you think that the work you perform as a death investigator has a profound effect on case outcomes? If so, how?

No, I do not believe it does in my case, only because we do not visit scenes with this company. I do all of my investigations through phone interviews and I depend on law enforcement to take proper photographs and collect proper evidence on scene. I can only do as good of a job as what law enforcement can bring to my attention. Eventually if we ever do start to go on scene then that will obviously change.

14. Hypothetically speaking, if an investigator makes a mistake while conducting a death investigation what is the least consequence the investigator could experience from the Medical Examiner's/Coroner's Office?

Verbal discipline and re-education

14a. What is the most severe reprimand, except firing, that the investigator could experience from the Medical Examiner's/Coroner's Office?

Permanent record in employees file

14b. Referencing question (14), could the investigator experience any consequences from
any other agencies?
We could potentially lose business and agencies would seek out autopsies elsewhere.

15. What protocols are required at all crime scenes?

We do not attend crime scenes at this facility.

16. What questions are asked during the initial death call which determines if an investigator will respond to the crime scene?

We do not attend crime scenes at this facility.

17. In your opinion, please list the deaths where an investigator should respond to the scene.
We do not attend crime scenes at this facility.

18. What does it mean for a death to be non-reportable?

A death that is expected and has an identifiable cause without criminal activity would be a non-reportable death.

19. In your opinion, does not responding to the initial crime scene have any impact on your investigation and/or the official death ruling?

I feel that I would benefit from being able to respond to a crime scene as opposed to relying on receiving the information from law enforcement, but I do not feel that I do any less of a thorough job because of this.

20. Do you think you would/could benefit from additional death investigation training?
If so, how?
Yes, I feel that additional training of any kind will make me a better and more well-rounded investigator. I try to attend as much additional training as I can.

21. Do you handle the death investigation of an unknown decedent differently than a known decedent? If so, how?

As far as the investigation process, all cases are treated the same. With someone who is unidentified I do tend to focus more on physical characteristics of the decedent with the people that I interview as well as looking into missing persons reports.

22. What factors influence how an unknown decedents' remains are disposed?
Due to the fact that we are a private agency with no legal jurisdiction, all of these decision fall into the hands of the Justice of the Peace overseeing the case. The JP will then relay that information to us.

23. In your opinion, what is the most important thing to do when first arriving on a scene?

We do not respond to scenes, but if I did then my first task would be to find the lead detective or investigator I charge of the scene.

`Regulating Medicolegal Death Investigations
Survey Questionnaire #14

Date: __01/24/2019_____

*Please answer all questions completely and honestly. If a question does not apply to you please state N/A or don't use. All information obtained in this research will be kept confidential.

1. What is your official title and job description?

   Medicolegal Death Investigator. Assists in the investigation of sudden, unnatural, suspicious, or violent deaths. Acts as a liaison between the medical examiner's office, law enforcements agencies, medical agencies, decedent's family, and the general public. Forensic scene work that includes photography, evidence collection, and investigative reporting.

2. What is your current educational background?

   Master of Science in Applied Cognition and Neuroscience
   Bachelor of Arts in Psychology with a Criminal Justice Emphasis
   Forensic Science Diploma from the American Institute of Applied Science
   Coursework in the following:
   Peace Officer Standards and Training
   International Association of Identification

Basic and Advanced Crime Scene Certifications
Latent fingerprint examination training
Certified Forensic Investigator
Marijuana Identification Technician
Field Identification Drug Officer

3. What prior/previous training have you had in conducting death investigations?

   Forensic Investigator for medium sized metropolitan police department
   Training as noted above

4. What is your previous work history?

   7 years with police department. Roles included 911 dispatcher, forensic investigator, and secondary assignments with child abduction response team, EOC liaison, union board member, and intelligence team member
   4 years EMT experience in pre-hospital and emergency room care.
   Part time experience in armed security, collections, and customer service.

5. Did your prior work experience prepare you for your assignment as a death investigator? If so, please explain.

   Yes. Forensic Investigations included evidence collection and scene work at deaths, both attended and unattended. EMS experience helped with medical knowledge.

6. What training have you acquired since working as an investigator?
   On the job training. Several seminars and trainings to better understand the current state of death investigation.

7. Are you a member of any professional organizations? Yes, see question 2 If yes, what are they?

8. Tell me 3 important characteristics of a death investigator.

   Patience
   Ability to adapt and think quickly
   Ability to remain calm under extreme stress and chaos

9. Tell me 3 key aspects of conducting death investigations.

   Ability to convey visual scene information in word/report form
   Ability to effectively communicate and cooperate with multiple law enforcement agencies and the public
   Ability to handle extreme environments which can include safety hazards, visual and olfactory hazards, and any other associated scene hazards

10. What factors influenced your decision to become a death investigator?

Always enjoyed piecing together puzzles, solving complex problems, and had no aversion to death or destruction

11. In your opinion, how do the investigations you work effect, if at all, autopsy outcomes?

    Scene work provides context for injuries. It can explain, confirm, or deny physical injuries. It can lead toward different testing (toxicology) or help confirm or deny self-harm vs. accident.

12. Define your role as a death investigator.
    Assists in the investigation of sudden, unnatural, suspicious, or violent deaths. Acts as a liaison between the medical examiner's office, law enforcements agencies, medical agencies, decedent's family, and the general public. Forensic scene work that includes photography, evidence collection, and investigative reporting.

13. When working cooperatively with law enforcement, do you think that the work you perform as a death investigator has a profound effect on case outcomes? If so, how?

    Yes. Collection and preservation of evidence is vital for court cases. It may be obvious what the cause and manner is in many cases but proving such things can be difficult. Good scene work and documentation help law enforcement clear cases and provides courts with evidence.

14. Hypothetically speaking, if an investigator makes a mistake while conducting a death investigation what is the least consequence the investigator could experience from the Medical Examiner's/Coroner's Office?

    At the very least an informal meeting with a supervisor who can identify the issue and retrain so as not to have it happen again.

    14a. What is the most severe reprimand, except firing, that the investigator could
    experience from the Medical Examiner's/Coroner's Office?

    Permanent letter in file, unpaid days off, or demotion.

    14b. Referencing question (14), could the investigator experience any consequences from any other agencies?
    I am unsure as every department has different policies. I don't think it would be unusual to request that the offending investigator no longer be called that departments scenes.

15. What protocols are required at all crime scenes?

Basic scene safety. Ensuring the scene is safe from any hazards prior to entering. Appropriate donning/doffing of gloves, gown, mask. Appropriate photographic and written evidence. Appropriate interagency cooperation and witness statements. No removal or disruption of items on the decedent. Proper identification of decedent. Proper documentation of medical conditions and medications on scene.

16. What questions are asked during the initial death call which determines if an investigator will respond to the crime scene?

    Any evidence of unnatural death (violence, accident, etc)? Is the decedent still on scene or have they been transported or moved? Infant death for any reason? Anything suspicious that may not fit into these categories but makes you feel like I need to respond?

17. In your opinion, please list the deaths where an investigator should respond to the scene.

    Any death where violence is suspected and any accidental death. Any unexplained death. Any death where decedent has not been under medical care for some time. Individuals that are "hoarders" or look to be neglected. Any time I am dealing with a small department with limited resources and cannot trust the information they are relaying to me. Any death of a child under 18.

18. What does it mean for a death to be non-reportable?

    If it doesn't meet the guidelines for the state, you are in to be reportable. If it doesn't meet criteria of unexplained, unnatural, homicidal, or suicidal violence where an individual is under physician care and in a hospital for more than 24 hours with a physician to sign the death certificate; that is a non-reportable death.

19. In your opinion, does not responding to the initial crime scene have any impact on your investigation and/or the official death ruling?

    Yes, for many of the reasons above. Often law enforcement is not well trained, or trained at all, in medicolegal aspects of death and crime scene evidence collection. Many vital pieces of evidence can be missed or destroyed by an untrained individual. Often times officers may not know what to look for or what questions a pathologist is looking to answer. Scene work is vital to proper death ruling.

20. Do you think you would/could benefit from additional death investigation training?
    If so, how?
    Yes. I am a big proponent of getting as much training in new techniques as well as brushing up on past knowledge.

21. Do you handle the death investigation of an unknown decedent differently than a known decedent? Yes If so, how?

    Only in the way I go about collecting vital statistical data and searching for medical records on scene. Unknown individuals are generally known to someone, somewhere. It's just a matter of locating that person. I will search a home more thoroughly for any identifying information or search a person's wallet for anything that provides clues to who they are. Preservation of fingerprints for identification is vital as well and would be sent to all available databases.

22. What factors influence how an unknown decedents' remains are disposed?

    It generally comes done to identifying an individual and locating next of kin. This can be a very long process but at the end of it our county pays for cremation and the ashes are placed in a common area.

23. In your opinion, what is the most important thing to do when first arriving on a scene?

    Ensuring I am safe.

Regulating Medicolegal Death Investigations
Survey Questionnaire #15

Date: Feb 13, 2019

*Please answer all questions completely and honestly. If a question does not apply to you please state N/A or don't use. All information obtained in this research will be kept confidential.

1. What is your official title and job description?

- Medico Legal Death Investigator
- To review and investigate deaths that may be the result of non-natural or unwitnessed causes.

2. What is your current educational background?

- BS in Criminal Justice
- Master of Business Administration

3. What prior/previous training have you had in conducting death investigations? Passed the examination as a Registered Medico Legal Death Investigator as per ABMDI.

4. What is your previous work history? Corporate security management, primarily in hospitals.

5. Did your prior work experience prepare you for your assignment as a death investigator? If so, please explain. No, it did not.

6. What training have you acquired since working as an investigator? six weeks of on the job training upon hiring.

7. Are you a member of any professional organizations? Yes

   If yes, what are they? ABMDI

8. Tell me 3 important characteristics of a death investigator.

   concerned, curious and thorough

9. Tell me 3 key aspects of conducting death investigations.

Work with law enforcement, validate all critical information, and serve as eyes and ears for the medical examiners.

10. What factors influenced your decision to become a death investigator?
    I was recruited to apply

11. In your opinion, how do the investigations you work effect, if at all, autopsy outcomes? It gives the doctors a complete picture of the case in question.

12. Define your role as a death investigator. To identify and assess factors to determine if the death should be a medical examiner case.

13. When working cooperatively with law enforcement, do you think that the work you perform as a death investigator has a profound effect on case outcomes? If so, how? Medical investigators work to establish decedent identity, as well as cause and manner of death from a medical viewpoint; law enforcement is more focused on determining criminality.

14. Hypothetically speaking, if an investigator makes a mistake while conducting a death investigation what is the least consequence the investigator could experience from the Medical Examiner's/Coroner's Office? The least consequence would be to correct any errors found.

    14a. What is the most severe reprimand, except firing, that the investigator could experience from the Medical Examiner's/Coroner's Office? Suspension and/or probation.
    14b. Referencing question (14), could the investigator experience any consequences from any other agencies? If the death investigator willfully and maliciously altered or destroyed evidence of a criminal nature, she/he could be liable as a coconspirator and subject to prosecution.

15. What protocols are required at all crime scenes Determine the circumstances, photograph the scene, check for identity, collect evidence for the medical examiner, prepare body for transport (bagging, tagging, etc), interview family and witnesses as available, collect medications.

16. What questions are asked during the initial death call which determines if an investigator will respond to the crime scene? was death expected and witnessed; age of patient; history of trauma or suspected trauma; will a doctor sign the death certificate. Has the body been moved to hospital or funeral home?

17. In your opinion, please list the deaths where an investigator should respond to the scene. Evidence or suspicion of trauma; witnessed or not; unexplained or unidentified; decomposing.

18. What does it mean for a death to be non-reportable?
    The death falls outside of the criteria for medical examiner investigation. The death was natural and expected while under medical care.

19. In your opinion, does not responding to the initial crime scene have any

impact on your investigation and/or the official death ruling? Any death that results from criminal activity should be responded to, unless the body has already been moved to a hospital, subject to staff limitations.

20. Do you think you would/could benefit from additional death investigation training?

If so, how? Job specific training is generally a good thing, even if only to refresh one's memory.

21. Do you handle the death investigation of an unknown decedent differently than a known decedent? If so, how? Often establishing identity is as important as establishing cause/manor of death. Fingerprints and dental records can be critical to determine identity.

22. What factors influence how an unknown decedents' remains are disposed? In our office, if the deceased cannot be identified, the remained are held, and eventually buried until family can be found. Bodies that are abandoned by family and/or friends are subject to cremation at county expense.

23. In your opinion, what is the most important thing to do when first arriving on a scene? Assess the scene to determine appropriate action.

Regulating Medicolegal Death Investigations
Survey Questionnaire #16

Date: 01.23. 2019

*Please answer all questions completely and honestly. If a question does not apply to you, please state N/A or don't use. All information obtained in this research will be kept confidential.

1. What is your official title and job description?
(a) Medicolegal Death Investigator
(b) assist w/ the investigation of reported deaths to the Medical Examiner's Office, particularly as it applies to the seeking, gathering, and documentation of pertinent circumstantial, historical, and other medicolegal data in order to determine cause and manner of death.

2. What is your current educational background?
I am currently working on my PhD in Forensic Psychology. I have associate degrees in Forensic Science and Psychology, a Bachelor of Arts in Criminal Justice, and a master's degree in forensic psychology.

3. What prior/previous training have you had in conducting death investigations?
None

4. What is your previous work history? Electronics retailer – Operations Senior/Supervisor and Hiring and Training Coordinator
Texoma Medical Center – nurse technician

5. Did your prior work experience prepare you for your assignment as a death investigator? If so, please explain. Somewhat. I was investigating financial variances as the operations senior with the electronic retailer which I believe helped me become a better investigator. I had to learn
to look at things from different angles in order to find the variances and/or reasons for them. It was also a collaborative effort, which I believe is important in all aspects on investigation. Also,
my experience as a nurse tech taught me about some of the medical aspects as well as HIPPA and confidentiality laws.

6. What training have you acquired since working as an investigator?
On the job. There is no actual set training. Training comes from experience. I network with other agencies and I am constantly asking questions. I learn by doing. There was no real teaching only learning policies/procedures.

7. Are you a member of any professional organizations? Yes
If yes, what are they?
- PsyChi
- Golden Key
- Society of Police and Criminal Psychologists

8. Tell me 3 important characteristics of a death investigator.
- listening skills
- knowing/understanding what to look for
- working in collaboration with various agencies (collaboration)

9. Tell me 3 key aspects of conducting death investigations.
(1) photograph, collect, and preserves evidence @ crime scene locations in order to aid the Mein positive identifications and cause/manner death.
(2) communication, including next-of-kin death notifications, follow-up investigations w/law enforcement agencies, and medical history requests from family, physicians, and hospitals
(3) processing of incoming/outgoing bodies in the morgue

10. What factors influenced your decision to become a death investigator?
I was working toward building my resume in the field of forensics and the medical examiner's office was hiring civilians. I became an intern and one of the doctors suggested I become a field agent.

11. In your opinion, how do the investigations you work effect, if at all, autopsy outcomes?
The autopsy provides the cause of death, such as a gunshot wound to the head (physical cause). However, it does not and cannot determine if that is d/t a suicide or homicide. The investigation, therefore, determines the manner of death (such as hx suicide ideations /attempts, note).

12. Define your role as a death investigator.
To assist the medical examiner in determining identity of decedent and cause and manner of death.

13. When working cooperatively with law enforcement, do you think that the work you perform as a death investigator has a profound effect on case outcomes? If so, how? Sometimes. Because each agency is looking for different pieces to the puzzle (law enforcement

searching for foul play/criminal activity; death investigators – searching for cause/manner of death; CPS/APS – searching for abuse/neglect; medical facilities – medical hx/problem) it
sometimes works out that one agency finds the "critical piece" which is why collaboration is important.

14. Hypothetically speaking, if an investigator makes a mistake while conducting a death investigation what is the least consequence the investigator could experience from the Medical Examiner's/Coroner's Office?
An email

14a. What is the most severe reprimand, except firing, that the investigator could experience from the Medical Examiner's/Coroner's Office? An email or visit to the supervisor's office to go over same information put in an email.

14b. Referencing question (14), could the investigator experience any consequences from any other agencies? A complaint possibly – which results in an email.

15. What protocols are required at all crime scenes?
Wear proper PPE (required but not technically enforced)

16. What questions are asked during the initial death call which determines if an investigator will respond to the crime scene?
- last known alive time, time found? > decomposition
- decedent identity, NOK?
- where found (location, secured or unsecured, open access)?
- trauma, type
- hx
- scene observation (weapons, suicide note, drugs, EtOH, @ the club? Outside? Temperature?

17. In your opinion, please list the deaths where an investigator should respond to the scene.
Traumatic homicide, suicide, accidents (vehicular, falls, drugs/EtOH), undetermined deaths of a
young person <30 where there is suspicion of trauma d/t no documented hx, substance abuse (where nothing is found on scene), etc.

18. What does it mean for a death to be non-reportable

It means that the death should not be reported because the person has been in medical facility >24 hours with no concerns of death, documented hx/diagnostics/ and lab cultures results, and no trauma.

19. In your opinion, does not responding to the initial crime scene have any impact on your investigation and/or the official death ruling? No

20. Do you think you would/could benefit from additional death investigation training?
If so, how? I do not think I would benefit from additional training; however, I do think that proper training for taking death calls scene attendance, and ancillary duties. Verbiage is also a
problem as there is a difference between fired/spent, cartridge case/casing, GSW/SGW, etc. Also, operational definitions and the need to have consistency in reporting.

21. Do you handle the death investigation of an unknown decedent differently than a known decedent? If so, how? No, the death investigation should be the same. If you know who the decedent is, it is easier because you have collateral contacts to interview can determine easier what the decedent was doing before death, etc. If the decedent is unknown, you have to add additional steps to determine identity before collecting collateral information, but you would work the scene the same, but looking for additional info.

22. What factors influence how an unknown decedents' remains are disposed? NOK is responsible for removal of decedent remains. In the case of an unknown decedent, the investigator does a NOK search and if no one is found, the county does a cremation (county
disposition), performed by a supervisor. I do not know what occurs after the supervisor declares it a county disposition.

23. In your opinion, what is the most important thing to do when first arriving on a scene? Getting in contact with the lead investigator on scene and touching base with what is going on.