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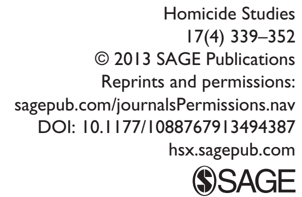

Putting the Public Back in Public Health: An Argument for the Articulation of Fatality Reviews and Coroners' Inquests

Melanie-Angela Neuilly[1]

Abstract

Fatality reviews are part of the public health arsenal to mortality prevention. As such they rely on medico-legal practitioners' participation. Yet medico-legal practice in the United States is still divided between the scientific approach of medical examiners systems and the political approach of coroners systems. I argue that this is related to the public's reluctance to let go of its jurisdiction over death as a social fact. I posit that attempts at systematizing coroners' inquests, as in Washington State, illustrate such resistance, yet could be conceived as a compromise between the political and the scientific, benefiting public health and the goal of fatality reviews.

Keywords

forensic technology, policing, investigation, policing, public policy, courts, methodology

Introduction

The evolution of death investigation systems in the United States from coroners to medical examiners follows a general switch from the political to the scientific, and from the public eye to the expert eye, with the goal of continually improving the quality of death investigation and related products such as mortality statistics. Indeed recommendations at the national level have favored the professionalization of death investigation since the beginning of the 20th century (National Research Council, 1928), leading to the multiplication of medical examiners offices, particularly starting

[1]Washington State University, Pullman, WA, USA

Corresponding Author:
Melanie-Angela Neuilly, Assistant Professor, Department of Criminal Justice and Criminology, Washington State University, Johnson Tower 721, P.O. Box 644872, Pullman, WA 99164-4872, USA.
Email: m.neuilly@wsu.edu

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after the National Municipal League's 1951 *A Model State Medico-legal Investigative System*. Yet, close to a century after the 1928 report, coroners' systems maintain jurisdiction over roughly half of the American population (Hanzlick, 2003), questioning the inevitability of the scientific takeover (Gieryn, 1999; Johnson-McGrath, 1995). In addition, the development of fatality review teams, initiated in Los Angeles in 1978 for cases involving the unexpected deaths of children (Durfee, Gellert, & Tilton-Durfee, 1992; Shanley, Risch, & Bonner, 2010), and now spanning a wide range of cause-specific or population-specific deaths adds another layer of complexity to the evolution of death investigation. Indeed, such fatality review teams put the emphasis on multidisciplinarity as best practice (National MCH Center for Child Death Review, n.d.), instead of focusing on the role of medically trained personnel.

I argue here that the persistence of coroners systems in the United States is related to the public's reluctance to let go of its jurisdiction over death as a social rather than medical fact. I further posit that attempts at systematizing coroners' inquests, such as those taking place in Washington State, illustrate such resistance, yet could be conceived as a compromise between the political and the scientific. Finally, I propose that such a movement could be a beneficial tool to be added to the public health arsenal, including fatality reviews.

I will start with a brief presentation of the history of the American death investigation system, contrasting the nature of medical examiners' and coroners' jurisdiction over death investigation, specifically with regard to their role in public health. I will discuss the American systems in comparison with other systems that incorporate death investigation and certification with dimensions of public health, specifically, coroners systems in Commonwealth countries and the role of inquests and recommendations. In such light, I will examine ongoing legislative efforts to systematize coroners' inquests in the State of Washington as an example of jurisdictional appropriation, and will draw on the extant literature to offer suggestions regarding the potential use of inquests in fighting domestic violence and preventable child deaths in a manner complementary to fatality reviews.

From the Public Sphere to the Expert Eye: Coroners' and Medical Examiners' Jurisdictions in the United States

The story is well-known and many times told: Inherited from colonial times, death investigation in the United States remained dominated by coroners until the second half of the 20th century. It is, however, often told in a one-sided manner, proposing the evolution as an inevitably beneficial one. I endeavor here to briefly retell the story using a critical lens in order to later highlight how seemingly opposite viewpoints can be reconciled.

While *CSI* and every other prime-time murder mystery television show position death neatly within the realm of hard science, the origins of death investigation in Common Law systems tell us a different story. Death is indeed more than the end of cellular life. It is a social fact (Neuilly, 2007, 2011; Timmermans, 2006), and the very role of the coroner is a reminder that with death comes political questions. As agents

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of the British crown starting in the 12th century, coroners (or "crowners") were tasked with a broad range of powers (inquests, pardons, confessions, seizures, along with various investigations) but mostly focused on elucidating homicides and suicides (Davis, 1997; Hanzlick, 2003; Hunnisett, 1961; Timmermans, 2006). Indeed it was their role to ensure that no debt to the crown would remain unpaid, including fines pertaining to killing oneself or another, making death a political responsibility. The role of course evolved from agent of coercion to participant in the democratic representation system in the United States where most coroners are elected (Jentzen, 2009; Timmermans, 2006). Yet throughout this evolution, the core responsibility of coroners (and later medical examiners) has remained the same: to "broker" (Timmermans, 2005, 2006) deaths falling outside the realm of what is understood as the socially normal way to die, to elucidate potential crimes and thus restore social order.

The medical push against coroners starting during the Progressive Era has been articulated around two central issues. First is the coroners' lack of scientific knowledge and thus inadequate death investigation skills leading to botched verdicts. Second, and possibly most importantly, is the corrupt nature of coroner systems, seen as a result of their being part of the political machine (Jentzen, 2009; Johnson-MacGrath, 1995; LeBrun, 1962; Timmermans, 2006). That push was initially focused solely on requirements for medical knowledge, at the expense of integrating the legal aspects of death investigation, using the campaign as part of the American Medical Association's larger push to increase medical authority in American society (Johnson-McGrath, 1995). This was met with resistance both from the courtroom workgroup and the public, because it was perceived by the former as an encroachment onto their jurisdiction. Furthermore, the latter rejected it as less relatable than a layperson's witness account (Johnson-McGrath, 1995; Mohr, 1993). This position can seem difficult to fathom nowadays, in an era dominated by the "*CSI* effect" (Cather, 2004; Jentzen, 2009; Roane & Morrison, 2005; Tyler, 2006), in which science can be perceived as conferring moral authority (Cavender & Deutsch, 2007), while impeding the pursuit of justice by distorting the real abilities of the vast field of forensics (Cather, 2004; Tyler, 2006). The difference in perceptions of forensic science by the public and thus juries between the Progressive Era and today can be seen as the result of a successful public relations and education campaign (Johnson-McGrath, 1995). This underscores the important role the public plays in shaping expectations with regard to death investigation.

While medical examiners were successful in overcoming resistance and establishing forensic pathology as the gold standard of death investigation, the criticism pertaining to coroners' corruption was met with a different set of challenges. As stated before, the Progressive Era push to eradicate coroners systems initially focused solely on the medical aspects of death investigation (Johnson-McGrath, 1995), neglecting the legal, administrative, and managerial sides of the job description. Medical examiners were thus trained solely scientifically, making their performance as heads of death investigation systems open to criticism (Jentzen, 2009; Johnson-McGrath, 1995). It also became apparent that forensic pathologists could simply replace the untrained coroners' physicians, and work under the old system, allowing a "best of both worlds" type of approach: politically savvy managers and scientifically prepared experts

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(Johnson-McGrath, 1995). This partially explains the end of the trend away from coroners toward medical examiners systems in the mid-1980s (Hanzlick, 2003).

Medico-Legal Investigations as the Crossroads Between Criminal Justice and Public Health: The Role of Fatality Review Teams

What is fascinating about the history of death investigation in the United States is that despite over a century's worth of push from the medical and scientific communities (American Medical Association, 1958; Committee on Identifying the Needs of the Forensic Science Community, 2009; Hanzlick, 2003; National Research Council, 1928; National Municipal League, 1951) for more systematization and professionalization of the system in order to increase accuracy and reliability of death investigation and related mortality statistics products, relatively little seems to have been achieved (ProPublica/PBS/NPR, 2011). Warnings continually resound as per the appropriateness of mortality statistics for theory building and injury prevention (DeJong & Hanzlick, 2000; Douglas, 1967; Goldsmith, et al., 2002; Goodin & Hanzlick, 1997; Hanzlick & Goodin, 1997; Hanzlick, Hunsacker, & Davis, 2002; Sainsbury & Jenkins, 1982). Factors such as demographic characteristics of the decedents (Platt, Backett, & Kreitman, 1988; Rockett, Wang, Stack, De Leo, Frost, Ducatman, Walker, & Kapusta, 2010; Sorenson & Haikang, 1997; Stanistreet, Taylor, Jeffrey, & Gabbay, 2001), method of death (Linsley, Schapira, & Kelly, 2001; Platt et al., 1988), training of death-certifying personnel (Douglas, 1967; O'Caroll, 1989; Varnik, et al., 2010), or institutional characteristics of death-certifying organizations (Best, 2001; Bogdan & Ksander, 1980; DeJong & Hanzlick, 2000; Douglas, 1967; Davis & Spelman, 1968) have been identified as sources of variation in the identification of the manner of death, thus affecting the reliability of mortality statistics. As a result, specific types of deaths have been identified as regularly undercounted, including suicides (Platt et al., 1988; Rockett, 2010), but also homicides of children (Crume, DiGuiseppi, Byers, Sirotnak, & Garrett, 2002; Herman-Giddens, Brown, Verbiest, Carlson, Hooten, Howell, & Butts, 1999; Levene, & Bacon, 2004), only to cite a few of the systemic problems linked to death certification, and impacting mortality statistics.

The validity and reliability of these mortality statistics, as it turns out, are foundational for two reasons: First, without appropriate documentation of the cause and manner of death, homicides may not be accurately identified, thus impeding the pursuit of justice and the functioning of the criminal justice system. Second, beyond the importance of adequately classifying individual death cases, each death and its corresponding death certificate, whether filled out as a result of a medico-legal investigation or simply by a nonforensic pathologist physician, gets aggregated in local, state, and national mortality statistics (Neuilly, 2007, 2011). We then use these statistics to ascertain the nature and scope of the various types of deaths, and to develop prevention models aimed at decreasing risk factors and increasing protective factors against certain types of preventable deaths. This is how medico-legal investigations have traditionally been tied to public health (Hanzlick, 2006).

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This model, however, puts quite a bit of distance between medico-legal practitioners and the public health work of epidemiologists, between those who initiate the process of mortality statistics production at their source, and those who use them as a finished product. Some have argued that it is this distance or disconnect between the product and its use that can explain some of the validity and reliability problems identified above (Best, 2001). Indeed, because of this disconnect, medico-legal practitioners and epidemiologists do not answer to the same set of imperatives: the former are focused on individual cases with all the complexity they can involve; the latter are focused on identifying trends from the aggregation, seeing patterns in the swarm of data (Best, 2001; Hanzlick, 2006). Some have further argued that medico-legal practitioners are blind to the public health aspect of their functions due to the overbearing criminal justice focus of the field (McGowan & Viens, 2010) and lack of public health training of medico-legal practitioners (Bugeja, Ibrahim, Ozanne-Smith, Brodie, & McClure, 2012), yet overall, the argument has centered on the difficulty for medico-legal practitioners at the local level to link individual cases to larger trends (Hanzlick, 2006).

Fatality review teams are an attempt at bridging the gap between the micro- and macro-levels in injury and mortality prevention, a way to involve medico-legal practitioners in public health, and thus make more tangible the importance of valid and reliable death classification. Fatality review teams accordingly underscore the need to go beyond the medico-legal investigation, and bring in other actors to "broker" (Timmermans, 2005, 2006) certain types of deaths, such a children's deaths or domestic violence-related deaths. As multidisciplinary endeavors (Durfee et al., 1992; Shanley et al., 2010) fatality review teams contextualize death by bringing together various perspectives to give it meaning—in this case in the form of actionable prevention strategies.

Fatality review teams, however, remain mostly in the domain of the expert eye. They broaden the focus around death from being solely medical to involving, in the case of child death reviews, for example, actors such as prosecutors, law enforcement, or Child Protective Services in addition to pediatricians, medico-legal practitioners, and emergency personnel (Shanley et al., 2010). While the composition of fatality review teams vary greatly by type of review as well as by jurisdiction, it is worth noting that overall they do not bring the public in as actors, as juries do, and if they do, it is more punctual, limited in scope (one person on a panel), and more as liaison (to the victims' families). Rather, they gather a broad range of informed specialists and stakeholders (National Domestic Violence Fatality Review Initiative, n.d.; National MCH Center for Child Death Review, n.d.). Indeed, in public health the public is considered as subject, the population on which prevention strategies are to be acted.

I propose that, in order to productively enhance the well-being of populations through successful public health strategies, understanding the big picture of medico-legal practices and their position at the junction between the political and the scientific is central. As I stated before, I argue that the longevity of the coroners system in the United States in spite of efforts to replace it with the medical examiner system is a testament to the public's unwillingness to relinquish jurisdiction over death as a social fact.

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I therefore offer to tie together the imperatives of best practices in public health such as fatality reviews with the public's demands of accountability over death. In order to do so, I will use a combination of international comparisons with a local example, and further emphasize the intricate relationships between medico-legal practitioners in general and coroners in particular with public health, as well as with the public.

Putting the Public Back in Public Health: Coroners' Inquests

Despite being intrinsic to life, death can appear out of order. Old people die, sick people die, but sometimes, death happens to people who are neither old nor sick. In such cases, death needs explaining, because "out of order" death could be a crime or a threat to public health. As previously stated, making sense of death is thus a social role and not simply within the realm of medicine. As such, coroners' historical power to convene juries to conduct inquests positions death within a social, public sphere, and is thus worthy of closer examination.

As per the previously outlined history, coroners and their apparatus are often perceived as antiquated, stemming from medieval conceptions of the general public as having working medical knowledge (Wear, 2000) and juries acting as direct witnesses (Shapiro, 1991). The system is often contrasted with the continental Europe system of legal medicine, with the assumption that the English coronial system long excluded medical knowledge altogether (Loar, 2010). Examining both the medieval English coronial system, alongside contemporary foreign coronial systems, particularly with regard to inquests, can, however, bring forth a different perspective on the articulation between death investigation and public health in the United States.

In Medieval England and contemporary United States, coroners are faulted for excluding medicine but this criticism can sometimes be misleading. Indeed, Loar (2010) contests the accepted notion that pre-19th century English forensic medicine stayed much behind its continental counterparts and proposes that the coronial system there was not devoid of medical experts' interventions.

> While it is true that there were no statutory requirements in England regarding the inclusion of medical evidence at inquests during this period, coroners' juries commonly considered such evidence; when their verdicts were challenged, they regularly cited that evidence in support of their decisions. (Loar, 2010, p. 476)

The idea that English coroners and their juries would appeal to medical expertise even when the law would not require it before the 19th century resonates with the current situation in the United States where coroners' systems do not usually mean that verdicts are rendered without medical experts lending a hand. As a matter of fact, the partial failure of the medico-legal revolution (Hanzlick, 2003) can be linked to coroners using the services of forensic pathologists (Johnson-McGrath, 1995). Whether such services are used in a systematic enough manner is where the problem lies, not whether coroners and their jury systems stand in the way of medically precise verdicts.

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Critics of coroners systems in the United States, however, often fail to consider definitions and roles of coroners on a larger scale. Commonwealth countries provide an interesting contrast to the coroners' systems in the United States and such a comparison can offer some new perspectives on an old problem. As coroners are an inheritance from Medieval England, they exist in countries other than the United States. Indeed, while Great Britain of course uses coroners, so do Ireland, Canada, Australia, and New Zealand, and all those systems have undergone change over the past decade and operate quite differently from the coroners' systems in the United States. I will focus here on two elements of these systems: the important focus on public health given to coroners in Commonwealth countries, and their use of inquests.

At the heart of any discussion about fatality reviews is the question of public health. In the United States, fatality reviews are one of only a few ways in which medico-legal practitioners get involved in public health (Hanzlick, 2006). In other countries, however, this is not the case and medico-legal practitioners can be tasked with much more direct an involvement in public health. Indeed, through a wave of medico-legal reform in Commonwealth countries, starting in 2006 in New Zealand, followed by the United Kingdom, Ireland in 2007, and Victoria in 2008 (Freckelton, 2008), the role of the coroner as an agent of public health has been emphasized and defined. Specifically, the coroner's role in public health is to make recommendations aimed at impacting preventable deaths (Freckelton, 2008). Such recommendations, which are added to coroners' reports upon their findings, are passed on to interested parties mostly via administrative routes but also sometimes during inquests (Bugeja & Ranson, 2003; Freckelton, 2008). While such recommendations have seldom been studied and remain rare (Brodie, Bugeja, & Ibrahim, 2009; Bugeja, Ibrahim, & Brodie, 2010; Bugeja, Ibrahim, Ozanne-Smith, Brodie, & McClure, 2012; Bugeja & Ranson, 2003), they offer an interesting option for the public health arsenal.

Coroners' inquests, the other area of my comparative focus here, do exist in some coroners' systems in the United States. In Commonwealth countries, though, they can take on a more systematized approach and are decidedly more regulated. They also fulfill quite a peculiar role, as inquisitorial hearings in Common Law systems, preoccupied with fact finding instead of assigning guilt. Coroners' inquests can sometimes have as an explicit purpose:

> To make specified recommendations or comments . . . that, in the coroner's opinion, may, if drawn to public attention, reduce the chances of the occurrence of other deaths in circumstances similar to those in which the death occurred. (New Zealand's Coroners Act 2006, s 57(4))

This approach is not a new one, and even in the United States, coroners' inquests in the past have been recognized as potentially playing a role in the public health debate.

> When the coroner's inquest worked well, it was the perfect vehicle for bringing awareness of dangerous situations into the public realm and instituting reform. (Timmermans, 2006, p. 6)

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Since the Progressive Era, the professionalization of medicine and associated supremacy of science in the United States have led to an increasingly distanced and impersonal approach to death and disease, moving away from the public sphere, into the expert sphere (Timmermans, 2005, 2006). Death investigation followed suit and the evolution from coroners to medical examiners meant that death became a matter of specialized knowledge, one about which certainty could be achieved (Jentzen, 2009; Timmermans, 2005, 2006), and about which the public had nothing to say. Fatality reviews, in their multidisciplinary approach, provide a further evolution in the shift from the public to the expert eye by enlarging the expertise beyond that of medical personnel while still mostly keeping the public at bay.

As previously stated, coronial systems in Commonwealth countries use inquests "as truth-telling exercises as distinct from processes concerned with criminal or civil liability" (Scott, 2010, p. 573), which, using all available resources including science, provide a more public and shared type of "death brokering" (Timmermans, 2005, 2006). The key aspect here is that the public sphere is not favored over the expert eye, but rather aims to demystify the medico-legal process and empower laypeople to understand that scientific evidence is circumstantial and should not be isolated from the rest of the social apparatus of death (Johnson-McGrath, 1995). In addition, this approach also empowers medico-legal personnel to work in the light, unencumbered by impossible *CSI* standards of proof (Jentzen, 2009; Johnson-McGrath, 1995), and to participate in the public health mission in a front-and-center rather than behind-the-scenes manner (Scott, 2010).

A Case Example: Washington State

As previously stated, coroners still have jurisdiction over roughly half of the population of the United States. In some of those areas, inquests are part of the coroner's powers. Systematic information as per the extent or frequency of such inquests in the United States is, to my knowledge, nonexistent. Recent examples in Washington State and Clark County Nevada (Clark County Nevada, 2010; King County Washington, 2010), however, provide some anecdotal evidence of an interest in reviving the inquest. I will discuss the situation in Washington State as illustrating the possibility for a new perspective on public health in the United States.

The death investigation system in Washington State includes a mix of coroners and medical examiners offices varying county by county (Washington Association of Coroners and Medical Examines, n.d.). The Revised Code of Washington (RCW), title 36, article 24.020 (Washington State Legislature, 1988) regulates the coronial power to hold inquests, specifying that power to be entirely discretionary. Following high profile incidents of police shootings, King County passed an executive order in 2010 making it mandatory for inquests to be held when a death involves a member of any law enforcement agency within the county in the performance of their duties (King County Washington, 2010, PHL 7-1-1 [AEO]). Similar circumstances in Spokane County prompted the local State Senator to convene a task force and propose legislation systematizing inquests in a number of situations, notably deaths involving law enforcement.[1]

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The situation in Washington State exemplifies the tensions that paralyze death investigation reform. Indeed it stems from a desire (by law enforcement in this case) for more public accountability and scrutiny with regard to manner of death certification, yet it faces opposition from some medico-legal practitioners worried about issues of confidentiality (Washington State Legislature, 2007; R.C.W. 68.50.105). Here we find ourselves at the junction between the public sphere and the expert eye.

The statutes pertaining to the confidentiality of autopsy results stem from a 1994 scandal in which a Pierce County medical examiner's office employee took and kept pictures of Washington's late Governor Dixie Lee Ray's and former Tacoma Mayor Jack Hyde's autopsies (Byrnes, 1996; Seattle Times Staff, 1997). The investigation revealed widespread inappropriate use of autopsy photos (Byrnes, 1996), and led the legislature to intervene and pass R.C.W. 68.50.105 making autopsy reports confidential with access limited to relatives, medical professionals, legal actors, and public health officials.

Statutes such as this participate in legally establishing the professional dominion of medico-legal professionals over death, and are used as a way to maintain such dominion while keeping professionals' hands tied "for their own good." Yet solutions are being proposed to provide for exceptions in cases in which inquests have to be held, effectively untying medico-legal practitioners' hands. Specifically, Washington State Senate Bill 5256 was passed by the Law and Justice committee in February 2013. It:

> Allows a coroner or a medical examiner to discuss his or her conclusions as to the cause, manner, and mechanism of death in cases where actions of a law enforcement officer have been determined to be a proximate cause of the death or in cases where the death occurs in a penitentiary or institution.

The original language for the bill included all autopsy records, but the Washington Association of Counties, representing Washington coroners and medical examiners, lobbied for the change to be more restrictive (personal communication with task force consultant, February 15, 2013).

While the Washington state examples, along with that of Clark County Nevada, were brought on by high profile cases surrounding use of lethal force by police, they nonetheless open the door to a larger discussion on the role of coroners' inquests in the American death investigation and public health systems in general. As previously stated, maintaining professional dominion can lead to experts having to bear the heavy weight of their indispensible knowledge on their own, while opening it up to the public sphere can empower all parties. This is all the more meaningful when the public's reluctance to let go of coroners' systems in the United States points to the persisting construction of death as a social fact.

With regard to the imperfect American death investigation system, inquests can increase the validity of mortality statistics. While a statistical evaluation of such a claim is not possible currently in Washington considering the lack of data available on inquests, anecdotal evidence points in such a direction, notably with the reversal of a

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coroner's suicide verdict into a homicide in Lewis County (Sky Valley Chronicle Staff, 2011).

With regard to public health, coroners' inquests can be perceived as a way to answer Hanzlick's (2006) call for more involvement of medico-legal professionals in public health. Indeed, finding inspiration in Commonwealth countries' coroners systems, New Zealand's in particular, as well as from the American past (Timmermans, 2006), inquests could be strategically used to publicize findings from fatality reviews, in a pedagogical, yet transparent moment of public accountability. This would not only have potentially positive outcomes for risk prevention campaigns, but would also force medico-legal practitioners to see trends and patterns beyond individual cases, and to understand death investigation as well as certification as more than a mere administrative or even criminal justice act, but as potentially life-saving (McGowan & Viens, 2010).

Conclusion

The state of death investigation in the United States has been garnering frustrated attention since the mid-19th century (AMA, 1958). At the heart of the problem lies the lack of uniformity in the patchwork that is a system regulated at the local level (state and counties, mostly) (Hanzlick, 2003; ProPublica/PBS/NPR, 2011). This patchwork is the result of a century's old tension between seemingly opposite forces: the medical field attempting to achieve total professionalization of death investigation, and the historical inertia of inherited coroners' political power (Jentzen, 2009; Johnson-McGrath, 1995; Timmermans, 2005, 2006). In the midst of all this, public health suffers as mortality statistics remain of questionable validity and reliability (DeJong & Hanzlick, 2000; Douglas, 1967; Goldsmith, Pellmar, Kleinman, & Bunney., 2002; Goodin & Hanzlick, 1997; Hanzlick & Goodin, 1997; Hanzlick, et al., 2002; Sainsbury & Jenkins, 1982) while medico-legal professionals remain mostly unaware of or helpless in the face of their potential role in promoting public health (Hanzlick, 2006). I have attempted here to underscore how criticism directed at coroners' systems can sometimes be rooted in erroneous assumptions and how the professional dominion sought by the medical field over death investigation can be counter-productive and create excessive demands on forensic pathologists. I argue, using the example of Washington State, that coroners' inquests can be advantageous to all by strategically relocating some suspicious deaths within the public sphere and freeing the expert eye from the stifling weight of being solely responsible for "brokering death" (Timmermans, 2005, 2006). This is, in turn, expected to have a positive impact on the quality of death investigations and mortality statistics, as well as public health and the productivity of fatality reviews, by better showcasing and illustrating risk factors in preventable deaths on a public stage.

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1. As a matter of disclosure, it is important to note that I became aware of this situation when I was asked to be an expert witness in front of the task force due to my research interests.

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Author Biography

Melanie-Angela Neuilly is an assistant professor in the Department of Criminal Justice and Criminology at Washington State University. Her research focuses on defining and measuring violent deaths in a comparative framework.

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