



When murder is not enough: Toward a new definition of community violence[☆]

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Abstract

Homicide classification is classic criminological preoccupation, but criminology and criminal justice are only really ever concerned with the willful kind, which are murder and nonnegligent manslaughter. Other disciplines, such as epidemiology, do not operate such a differentiation and consider all homicides together, as one type of death, a violent one. This study adopts a broader, epidemiological approach to homicide, in order to understand classification effects at the death certification level. In order to achieve this goal, this article presents a procedural analysis of the classification of violent deaths based on systematic observations conducted in a medical examiner's office in an urban area. The ethnographic data show the many different procedural stages leading to death classification. They also uncover the complex web of informal rules, individual influences, institutional limitations, etc., making the classification system based more on “degrees of certainty” rather than a “true/false” statement.

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Keywords: Homicide; Violent death; Classification; Manner of death; Criminology; Public health

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1. Introduction

Homicide research had long been preoccupied with typologies, whereas they concerned themselves with characteristics of the event, the victim, the offender, his or her motivation, etc. However, one can also look at homicide as one category in a broader typology, a typology of deaths.

Homicide is the termination of someone's life by someone else, whether it is willful (nonnegligent) or by negligence (FBI, 2006). Criminology and criminal justice are only really ever concerned with the willful kind, which are murder and nonnegligent manslaughter (Riedel & Welsh, 2002). Other disciplines, such as epidemiology, do not operate such a differentiation and consider all homicides together, as one type of death, a violent one (Holinger, 1987). Homicides can thus be taken into consideration from different perspectives, namely criminology/criminal justice or epidemiology/public health (Moore, 1995; Riedel & Welsh, 2002).

Going further, a criminological view purports that homicide should be studied alongside aggravated assaults as they can be considered homicide attempts and therefore allow for a better understanding of criminal violence (Block, 1977; Harries, 1989; Pittman & Handy, 1964; Pokorny, 1965; Riedel & Welsh, 2002). A public health approach would then, also continuing along the line previously identified, consider homicide as an intentional lethal injury and therefore look at it not only in the context of other violent deaths, but of all injuries, as they are attempts at violent deaths (HIRCR, 2006; Ludwig & Cook, 2003; Wright, Rossi, Daly, & Weber-Burdin, 1981).

The purpose of this study is to participate to the public health perspective on a criminological matter by offering a procedural look at how violent deaths are identified as such. This article will thus examine some of the factors coming into play in the decision-making process leading to classifying violent deaths as accidental, suicidal, and particularly homicidal. In order to achieve this goal, this article will present a procedural analysis of the classification of violent deaths based on systematic observations conducted in a regional medical examiner's office in an urban area of the Northeast.

2. Literature review

2.1. *Classifying homicide*

There are several classifications under which homicides can fall. One can classify homicides legally, as part of the general class of crimes against the person, and further elaborate from there, differentiating between murder in the first degree, voluntary or involuntary manslaughter, and justifiable homicide (Adler, Mueller, & Laufer, 2003). One can also classify homicide as per its motive, differentiating between domestic homicides, drug homicides, escalating disputes gone awry, stranger homicides, gang homicides, homicides committed in conjunction with another felony, primary versus non-primary homicides, etc. (Decker, 1993; Flewelling & Williams, 1999; Loftin, 1986; Loftin, Kindley, Norris, & Wiersema, 1987; Maxfield, 1989; Smith & Parker, 1980). One can also analyze homicide as the lethal outcome of an assault, for they share some very similar characteristics (Block, 1977; Harries, 1989; Pittman & Handy, 1964; Pokorny, 1965; Riedel & Welsh, 2002). Finally, one can see homicide as one type of death, as opposed to natural deaths, suicides or lethal accidents (Holinger, 1987; Vollum & Brewer Titterington, 2001).

Depending on the angle according to which homicides are analyzed, the operating factors of categorization vary. When looking at homicides from a legal standpoint, one is interested in the intent or *mens rea*. When differentiating between the different types of homicides, one is focusing on the motivation behind the act as well as the circumstances surrounding it. When looking at homicides as an outcome, one is focusing on the differences between a lethal and a non-lethal assault. Finally, when looking at homicide from an epidemiological or behavioral perspective as one type of death, one focuses on identifying the existence and locating the source of the lethal intent.

2.2. *Violent deaths and intent*

According to a medico-legal or epidemiological perspective, a death can be natural, accidental, suicidal or homicidal. The factors operating the differentiation between those four types are the lethal intent and its locus (Vollum & Brewer Titterton, 2001). The classification does seem quite clear cut. However, it could be argued that it is more like a continuum rather than a mutually exclusive categorization system. Attributing intent is indeed always a difficult matter, but even more so when the main subject of inquiry is no more.

Added in 1910 to the U.S. Standard Death Certificate, the concept of manner of death is an American invention (Hanzlick, Hunsacker, & Davis, 2002), differentiating between Natural, Accidental, Homicidal, Suicidal, or Undetermined deaths.

Hanzlick et al. (2002) seem to tackle the heart of the classification dilemma when they write: “It must be realized that when differing opinions occur regarding manner-of-death certification, there is often no “right” or “wrong” answer or specific classification that is better than its alternatives.” The decision therefore rests most often in the hands of the examiner or coroner, implying individual differences between certifiers (DeJong & Hanzlick, 2000), but is also influenced by other factors such as the manner of death itself, suicide being more likely to be misidentified (Linsley, Schapira, & Kelly, 2001), or the combination between the manner of death and socio-ethno-demographic characteristics of the decedents (Sorenson & Haikang, 1997; Stanistreet, Taylor, Jeffrey, & Gabbay, 2001).

The intent can sometimes be a delicate matter (Beskow, Runeson, & Asgard, 1990), and Hanzlick et al. (2002) devise a schema of “degrees of certainty” required in order to determine each of the manners of death. Following this schema, the undetermined manner should be checked whenever the level of certainty is below 50%. For most everything else, the authors advise a “reasonable probability” which translates into a more likely than not statement. However, for suicide, “case law or prudence may require a ‘preponderance’ of evidence [greater than 70%]- or in homicide-‘clear and convincing evidence’ [greater than 90%] may be required or recommended” (Hanzlick et al., 2002, p. 4).

As underlined in the literature presented above, the certification of the manner-of-death can often be matter to debate. This becomes especially problematic for the use of mortality statistics.

2.3. *The production of death records, their compilation and computation into vital statistics*

As with the classification and collection of any type of official records, mishaps as well as discretionary decision making or gaps in standardization can happen at every step. Concerning death records, two major sources of discrepancies exist. The establishment of the cause-of-death is a first source of errors in the reporting of death statistics. This will not be further explored within the context of this article.

The establishment of the manner-of-death is the second source of possible variation discussed above and the aspect this study is most interested in. As presented prior, even though guidelines have been developed (Hanzlick et al., 2002), the core of manner determination rests with individual certifiers. In a series of articles, Goodin and Hanzlick (1997), and Hanzlick and Goodin (1997) report the results of their survey of 700 medical examiners/coroners. Their goal was to assess individual differences in manner-of-death certification in usual but often contentious scenarios. Results show a considerable lack of majority agreement, with a wide variation in the manner-of-death statements for those controversial death scenarios. DeJong and Hanzlick (2000) then examined correlations between medical examiner investigators (with a law enforcement background) categorizations and forensic pathologists medical examiners conclusions as to manner-of-death statements in Fulton County, Georgia, and concluded that discrepancies existed in 12% of the cases reviewed. It is therefore interesting to realize that certification of the manner of death does not seem to be a matter of assessing the truth of a situation, but rather be the relative interpretation of the possible intent of the deceased. This is hypothesized to be in part due to the fact that forensic pathologists are not particularly trained in psychology and other social sciences (O’Carroll, 1989). One possible solution is argued to be the systematization of psychological autopsies (Beskow et al., 1990) carried out by professional psychologists.

Illustrating this fact, an important segment of the manner-of-death literature focuses on the underestimation or misallocation of suicides, using a various range of approaches, the general consensus being that suicides are under- and poorly reported. The following is by no means an exhaustive look at the prolific literature on the topic. O’Carroll (1989) tests the quality of information contained in cases concluded to be suicides, and finds that it varies copiously. Phillips and Ruth (1993) examine the characteristics of official suicide data in order to decide of their appropriateness for social science research. Linsley et al. (2001), Ohberg and Lonnqvist (1998) and Sorenson and Haikang (1997) focus

on identifying suicides hidden in undetermined or open-verdict deaths, comparing the characteristics of both categories. Lee, Collins, and Burgess (1999) tackle on the topic of adolescents and children suicide, whereas Palermo et al. (1997), Prahlow, Long, and Barnard (1998), and Stanistreet et al. (2001) aim at disentangling murder–suicide, suicides concealed as murders, or the factor coming into play in the differentiation between accidents and suicides. Finally, Kleck (1988) argues that suicides might sometimes be underestimated, they also are sometimes over counted, and therefore it is all much ado about nothing.

This controversy surrounding the validity and reliability of the determination of the manner of death and its reporting is similar in many respects to the criminological literature on the reporting of homicide circumstances and other complex variables. According to this literature, the level of possible discrepancies, variation, or construction involved is inversely proportionate to the straightforwardness of the situation (Decker, 1993; Petee, Weaver, Corzine, Huff-Corzine, & Wittekind, 2000). It is also important to note that this process is influenced by the organization of the police institution itself (Innes, 2002; Maxfield, 1989), element which could then possibly be extended to medical examiners' and coroners' offices and the certification of the manner of death.

3. Research questions

As stated in the Introduction, it is the goal of this article to examine the process leading to the classification of a death as homicidal as opposed to natural, accidental or suicidal. Based on the literature review presented above, the author posits that the classification of deaths relies on a complex combination of factors, whether legal, institutional, individual, etc. This complexity in turn has to be taken into consideration by criminologists who study homicide and maybe lead to a different classification approach.

The questions addressed here are centered on the organizational and medical practices leading to the certification of the manner of death, in order to understand homicide in its broader epidemiological context. The end result of the study will thus consist of a flowchart illustrating the process leading to the certification of the manner of death following a number of stereotypical scenarios.

4. Methods

4.1. Design

The research presented in this article is part of a larger, comparative project, articulating elements of ethnography with systematic data extraction. As mentioned earlier, this section of the research is a case study of a medical examiner's office in an urban area. Observations were conducted for a period of 6 months. Observations are defined as systematic observations of autopsies, systematic observations of death scene investigations, and observations of institutional and organizational structure and functioning. Archive sampling was also conducted, and is defined as the collection of information on stored deaths records.

4.2. Measurement

Measurement focuses on the description of institutional organization, roles and processes, including but not limited to the size of the institutions, the distribution of professional roles and corresponding duties, the circulation of paperwork, the spatial and temporal organization of the work, the collaboration with outside agencies, and all other elements leading to a better understanding of the death certification process.

Systematic observations followed a pre-established and site-approved code sheet. Variables covered by the code sheet fall under one of five categories: incident characteristics, decedent's characteristics, death scene characteristics, post-mortem examination characteristics, and case narrative. Incident characteristics include the case number, the case status, whether or not this was a hospital death, therefore implying no death scene, and the reason for investigation by a medical examiner. Decedent's characteristics include demographic information such as age, race, and gender as well as the city in which the decedent was a resident of. It also includes information on when the decedent was last seen alive, who in relation to him or her, made the identification, when the incident happened, when death was pronounced, by what type of professional and where. Finally, elements concerning the apparent instrument of death as well as the circumstances (i.e. whether the body was found, it was an injury, or an illness onset) are included. Scene

characteristics include the scene address for potential mapping purposes, the type of setting (residence, street, commercial building, etc.) and the police jurisdiction it falls under. The post-mortem examination information identifies who performed it (codes are used instead of names), the type of examination performed, its date and duration.

4.3. Data

Systematic observations aim at establishing a typical classification of the manner of death process. Those focused on the two main stages of the certification process: the death scene investigation and the post-mortem examination. Because death is an unpredictable event, systematic observations had to be conducted whenever the occasion arose as the researcher was on-site. During the semester spent on site, the researcher averaged one data collection day per week, spending a total of 13 days, observing 65 post-mortem examinations and 10 death scene investigations.

Following this period of observation, the researcher returned to the study site to complete the data extraction phase of the research. During this phase, the researcher randomly sampled 245 death records investigated by the site and covering a period of two years. Descriptive elements of these data are found in [Table 1](#).

5. Results

5.1. Description of the study site

The study site is located in a highly urban area. Its jurisdiction covers a population of over two million. The site investigates about 6000 deaths per year, over 1000 of which result in an autopsy. At the time of the study, the site employed 9 full-time medical examiners, 3 medical examiners on a per diem basis in case of heavy workload, 13 morgue technicians, and 13 medical examiner investigators.

The facility has three refrigerated storage areas: one with a capacity of 120 bodies; one with subzero temperatures (to store bodies, for example for indigent people whose family cannot afford a funeral, or for people who are not claimed), which holds 16 bodies; and one for decomposed bodies, which also holds 16 bodies. There are two autopsy suites: the main suite has 4 work stations; and the second suite is smaller, with only two work stations, but with a special ventilation system which makes it adequate for decomposed bodies or public health threats. HIV/AIDS decedents are also usually examined in this suite. There are also a stationary and portable X-ray machines. The two-story building also houses the State Toxicology Laboratory, a well as administrative offices, archives and evidence storage.

Morgue technicians work from about 8 am to 4 pm, therefore post-mortem examinations have to take place during that time. The site is opened 24 h a day, seven days a week: at night, investigators are present to go on scene or investigate if necessary, and there is always a pathologist on call; during holidays and weekends, autopsies are carried on even though the personnel is restricted.

The day starts at 8:30 am, when the day's cases are presented during the morning conference. The day's cases are usually from the day and night before. After the presentation, each case is attributed a pathologist and a technician, and a decision is made on the type of examination to be conducted.

5.2. Training

Medical examiners are M.D.s who have completed their residency in pathology, and a one-year fellowship in forensic sciences. During that year, future medical examiners usually perform a required number of autopsies, but also sometimes get trained in field investigation, forensic photography, and other types of related forensic fields.

Morgue technicians are not required to have any sort of formal education besides a high school diploma. They get on the job training.

Investigators are not required any specific education either, but their usual background is either medical (mostly Registered Nurses) or law enforcement. The training is mainly conducted on the job even though St. Louis University offers an expedited training certificate. Investigators to be then have to get certified by the American Board of Medicolegal Death Investigators.

Table 1
Descriptive statistics of the random sample of death records extracted at the study site ($n=245$)

Decedents' age	Mean	45.40	
Decedents' race	Caucasian	53.5%	
	African origin	24.9%	
	Hispanic	16.7%	
	Asian	2.4%	
	Other	2 %	
	Unknown	0.4%	
Decedents' gender	Male	73.9%	
	Female	25.7%	
Circumstances	Found	58.4%	
	Injury	26.9%	
	Illness	14.3%	
Instrument	Hanging	3.7%	
	Blunt force	3.3%	
	Fall	5.7%	
	Suffocation	0.8%	
	Environment	0.8%	
	Firearm	9 %	
	Drugs/alcohol	15.1%	
	Drowning	1.2%	
	Motor vehicle	10.6%	
	Fire	0.8%	
	Exhaust and other fumes	1.6%	
	Other ingestible poisons	0.8%	
	Sharp force	2.9%	
	Unknown	8.2%	
	Not applicable	35.5%	
	Body condition	Intact	88.6%
		Decomposed	9 %
Remains		1.2%	
Charred		0.8%	
Exhumation		0.4%	
Setting	Residence	60.4%	
	Street	22.4%	
	Commercial building	3.7%	
	Liquor licensed est.		
	Parking lot	2.4%	
	Countryside	1.6%	
	Institutional facility	3.7%	
	Other	1.2%	
	Unknown	2 %	
	Not applicable	2.4%	
	Agency	Municipal police	73.1%
State police		2.9%	
Prosecutor's office		2 %	
Hospital		2.4%	
Other		2 %	
Unknown		4.9%	
Not applicable		12.7%	
Examination	View	33.1%	
	Full autopsy	66.5%	
Reason for investigation by a medical examiner	Suspicious	10.2%	
	Violent	37.1%	
	Medically unattended	0.8%	
	Unwitnessed	25.3%	
	Witnessed	13.1%	
	Within 24 h of admission	2 %	
	Unrecognizable	1.2%	

(continued on next page)

Table 1 (continued)

Reason for investigation by a medical examiner	SIDS	2 %
	Child under 3 years-old	0.8%
	Institutional facility	0.4%
	Legal custody	2.4%
	Other	4.5%
County	1	30.6%
	2	24.5%
	3	24.1%
	4	20.4%
Manner of death	Natural	42.4%
	Accident	31.4%
	Suicide	11.8%
	Homicide	12.2%
	Undetermined	1.6%

Figures in bold represent the largest percentage for each category.

5.3. How does it work?

Whether or not a case is reportable (i.e. falls within the jurisdiction of the medical examiner's office), as soon as it enters the site system, it is attributed a case number. Cases are numbered by county, year, and in order of incidence. The investigators then screen out the non-reportable cases, as well as those reportable cases which do not need to be investigated further, and this mostly through telephone communications with family members, hospitals, police departments, primary care physicians, etc. (Fig. 1).

The medical examiner's office investigates deaths that are: violent, environmental, sudden/unexpected (in adults), unrecognizable, Sudden Infant Death Syndrome (SIDS), children under 13 years of age, that happen in detention, inmates (prison or psychiatric hospital), job-related, threat to public health, at home unattended, criminal abortions, within 24 h of admission to hospital, and therapeutic misadventure.

Cases identified as warranting an investigation can be differentiated by whether or not there was a death scene. As a matter of fact, hospitals do not constitute a scene. Therefore whether or not there is a scene influences the investigators' strategy. When a death happens in a hospital, they conduct their more in-depth investigation over the phone, whereas when a death happens "on scene," they physically go to the scene and investigate in part there, and then in part over the phone. On scene, investigators do not look for the same sort of evidence as the police do. They tend to look for medical clues, prescriptions, time of death elements, but they also evaluate the possibility of foul play. Investigators also try and establish the past social, mental, and medical history of the decedent.

The investigator's role is to rule out foul play and trauma, as well as to identify the medical history.

On her first scene observation, the researcher notes:

"On the scene, we meet up with one detective and one uniformed officer. They have already taken pictures. Later on, the person in charge of removing the body and taking it to the morgue arrives and the body is removed. The investigator takes notes, takes the body's temperature, inspects the pockets. The scene is clean, only one little glassine bag of heroine is found by the body."

As a side note, it was discovered, during the autopsy, that there was a needle still stuck in the decedent's groin area, on which the investigator could have injured himself while searching the decedent's pockets.

The preservation of scenes is a crucial element in the reliability of the investigators' findings. Through conversations with investigators, the topic of scene tampering by police, emergency medical services, decedents' families, or others emerges as a major problem.

The problem of priming also seems to be somewhat of a concern in the sense that emergency medical services or the police call cases into the study site, referring to them as a suicide, a homicide, an accident, even before any type of medicolegal assessment has been carried out.

Medical examiners can be requested to go on scenes for some homicides, and they also have to go to mass fatalities or disaster scenes. In all other cases, it is within their discretionary power to elect to go.

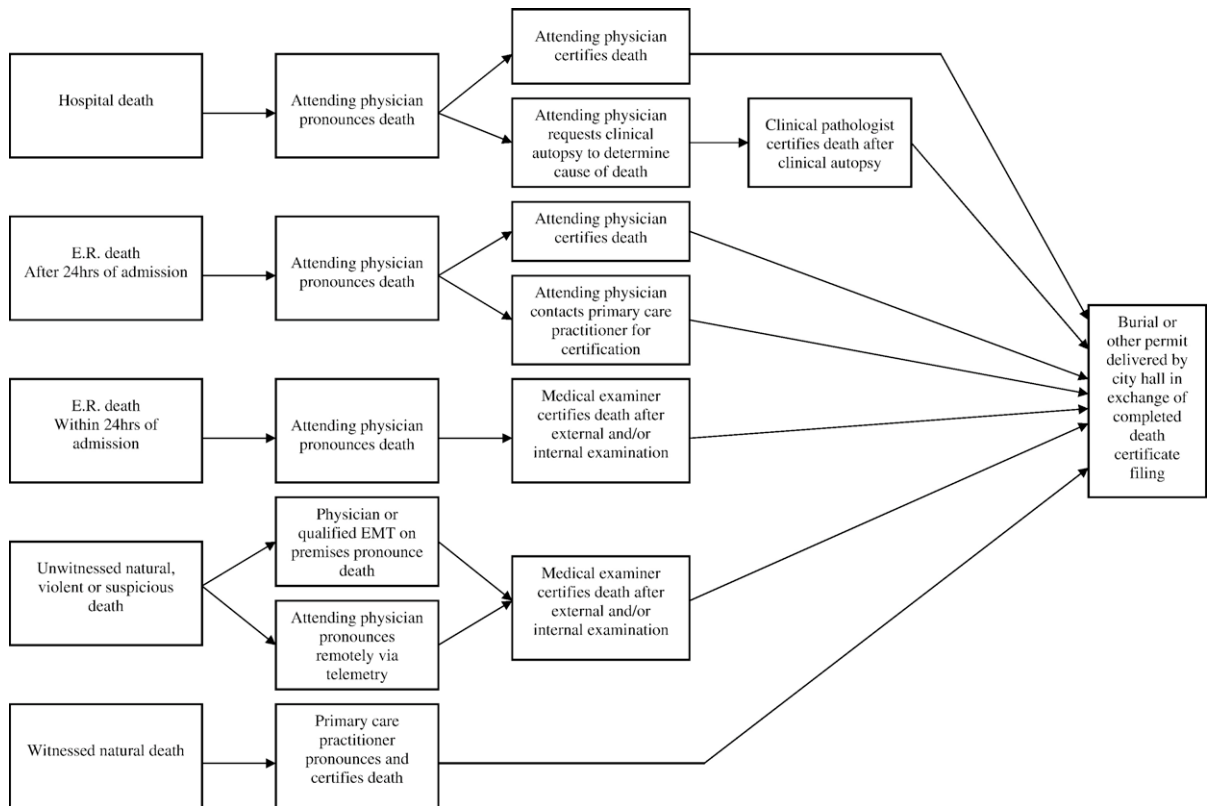


Fig. 1. Schematic overview of potential typical death case scenarios and their certification processes in the study site as an example.

Once the “field” and “background” part of the investigation are complete, the file is passed along to the medical examiners, who, through post-mortem examination, have to determine the cause and manner of death. The role of the medical examiner is not limited to certifying the death, she also has to collect evidence, document the process through which she has reached her conclusions, and be able to provide an expert testimony in case of a trial. A side note to the role of the medical examiner involves life insurance claims, and the necessity to have reached a final, determined, conclusion for any claim to go through.

The public often associates medical examiners’ offices and other forensic facilities with the glamour and high tech images presented in the entertainment media. The reality is much more focused on practicality issues:

“The autopsy suite is a relatively large space, but a little crowded. There are 4 stations there, on the wall opposite from the door. They are composed of big sinks and slabs. Everything is in stainless steel, even the walls above the sinks, where the MEs write the information they gather during the autopsies.”

Talking about post autopsy cleanup, the researcher writes:

“Each station is cleaned after the autopsy is performed. The technician in charge of the case does the cleaning. Stations are cleaned with big sponges. There are buckets full of foamy liquid, which smells like bleach. Technicians also use big white sheets and small washcloths-like items to wipe bodies and other things off. [...] There are hoses at each tap of each station. The bodies are hosed down before and after the procedures, as well as during, to get rid of the blood. Before each picture taken, the technician makes sure the part photographed is clean.”

Post-mortem examinations can be autopsies or external views. The former can be either “full” or “partial,” whereas the latter can include drawing fluids or not. External views can be conducted on relatively simple cases, or because the

decedent's family objects to an autopsy, or even to having fluids drawn. Objections can be overruled through a judge's warrant, notably in case of a suspected homicide.

The overall impression of the decision-making process very closely fits the schema of "degrees of certainty" devised by Hanzlick et al. (2002) and described above. Even though the lay person's perspective, reinforced by the popular culture on detective novels and forensic driven investigative shows, is focused on the intensive and always triumphant search for the truth, medical examiners, along with detectives and others, are not always able to reach those solid conclusions, or neither do they always see the need for it. An example is such as the story of this nonsuspicious death for which the mother maintained her objection to an autopsy.

The medical examiner therefore ruled the case as undetermined. In this case scenario, there is nothing at stake, but the wish of a mother to preserve her son's body integrity. Differentiating between what could have been an accident but most likely was a natural death is not a matter taken into consideration at the individual level, and mortality statistics are thus futile.

Autopsies are mandatory in the following cases: homicide, suspicious, threat to public health, inmates, SIDS, child abuse, request by assignment judge, prosecutor, and State medical examiner. Autopsies are discretionary, but predominant, for: suicide/accident, all other violent deaths, sudden natural death, job-related, and motor vehicle accidents.

The routine toxicology tests ran for each non-objecting death can be an integral part of the conclusion reached by the pathologist, it is therefore not unusual to leave a case open until toxicology results are obtained. All cases are tested for a standard cocktail of drugs as well as alcohol. Because of the amount of toxicology tests going through the State Laboratory, it takes approximately three weeks for routine results to come back. However, high profile cases or homicides get a priority. On that topic, the researcher transcribes a discussion amongst medical examiners and toxicologists about the number and types of tests required at the study site.

An interesting informal rule of thumb in place at the research site concerns drug overdoses. Indeed those are systematically classified as accidents, unless a note is found, or a clear suicidal intent is indicated during the investigation, or the toxicology results show abnormally high levels of drugs in the fluids and tissues. The implications of this rule of thumb are important in a highly urban area, with a large population suffering from a variety of social ills, including drug addiction.

Cases in which the distinction between one manner of death and another did not seem quite so clear abounded during the observation period. For example, talking about a woman who died in a nursing home, presumably from choking on a peanut butter sandwich, the medical examiner explains that he is probably going to classify the case as an accident even though she had a history of heart disease, considering the amount of food that was removed and still remain in her airway.

Finally, decedents are also routinely DNA typed as well as fingerprinted, and sections of organs are preserved in slides for pathology examination.

5.4. Following the paper trail

Once the post-mortem examination completed, the death certificate can be completed. If additional test results are necessary in order to come to a conclusion, then the case is left as pending within the site's record keeping system and the certificate is amended when results become available (Fig. 2).

The death certificate is the document allowing for the further processing of the body. Once completed, the death certificate is again collected by the funeral director, who then transmits it to the municipal or local office of the registrar in exchange for a burial permit. Vital statistics are then compiled at the local level, and passed along to the state level, which in turn passes them to the Center for Disease Control, which establishes national vital statistics. Those are finally transmitted to the World Health Organization and incorporated into international vital statistics.

A various stages of this process, precision or correction queries are fed back to the study site, in case of incomplete or inconsistent certification information.

5.5. Some examples

In order to further illustrate the complex manner of death classification process, here are a few examples of some typical cases, as well as some more atypical but significant cases.

In a fairly typical natural death case scenario, the medical examiner leaves herself room for change in manner:

“The decedent had a pulmonary embolus (they found it in his right lung). So they are looking for clots in his legs. The technician has a hunch that it would be in the left leg, and the medical examiner thinks it would be in the other. The technician is right. The embolus is thus the cause of death, but the medical examiner says he will wait until the toxicology results come back to close the case, because the decedent had a history of drug use.”

Some borderline suicide/natural/accident cases often follow those lines:

“We leave for the scene. The decedent, a 43 years old, Hispanic female, was last seen alive at 10PM the night before, when she ate, witnessed by many people. She never woke up. The subject had a history of depression and anxiety. She was taking Zanax and lithium, and had a history of taking pills by the handful, and then sleep it off. Her doctor stated that she had no significant suicidal history. She also had asthma. Her mother kept her medicine, but she had only one dose left. The investigator and medical examiners seem to be looking at it from an accidental (overdose) perspective. She was a teacher’s aid, so the principal, the board of education, etc., will be calling to know what she died of. She will therefore be autopsied. [...]The investigator talks to the psychiatrist. She says that people never take what they are prescribed. She says that the decedent wasn’t taking her morning pill, etc. But she hadn’t had suicidal ideations lately and she never asked for any particular medications. The psychiatrist mentions that the decedent had a mild heart problem, but nothing bad. [Later on] the medical examiner is inspecting the heart. There is something abnormal in it. The medical examiner says he is going to leave the case pending until they get the toxicology back and depending on the toxicology results he will classify the death as a heart-related or an accident.”

In case of a classic gun homicide (a fairly common occurrence in the site’s jurisdiction):

“They open around the gun shot wounds, based on the X-Rays taken. The victim’s clothes are set up on a white sheet on the floor. One of the technicians is probing the clothes for bullet holes and taking pictures. Another technician is taking samples and looking for more bullets. [...] The first technician puts away the decedent’s clothes in marked brown paper bags. They find one bullet after the other, one through the liver, two through the heart. They try to reconstitute the trajectories. They have to collect all bullets for evidence purposes.”

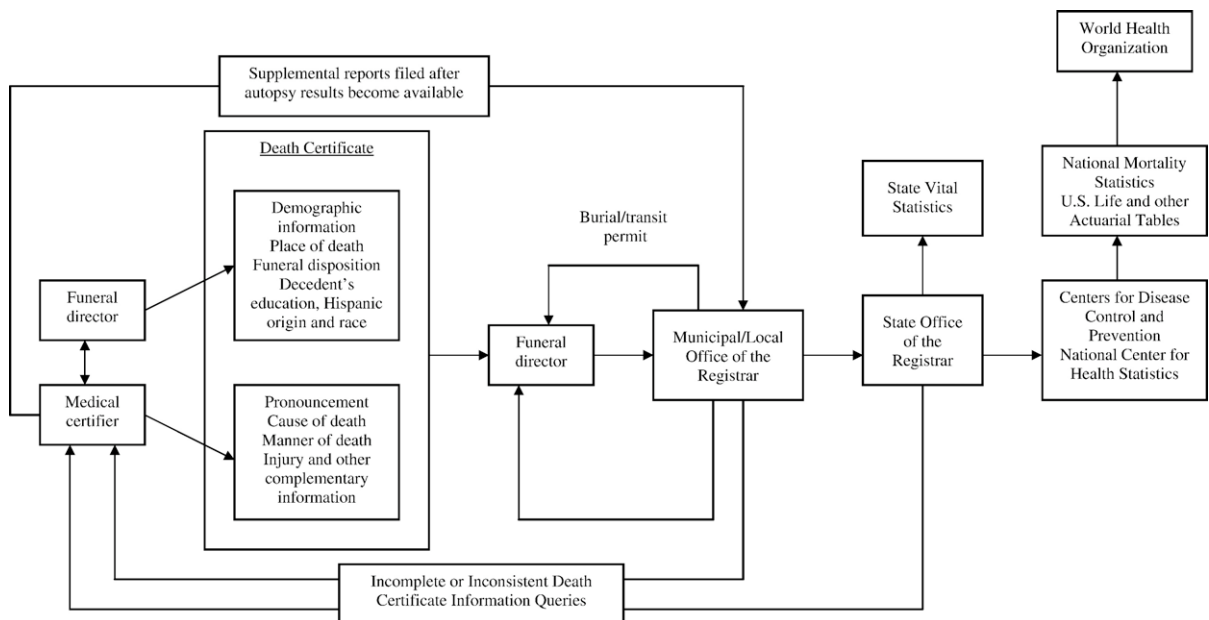


Fig. 2. Schematic overview of the mortality statistics compilation process in the study site state.

In case of a more puzzling scenario: a death by hypothermia, at first identified as a homicide by the emergency rescue personnel:

“At first, the EMS thought that it was a homicide and that the body had been dragged, but the MEs think that there are clearly no marks in the snow. [...] They unbag the hands of the frozen man, which have frostbite. The technician is undressing him. She asked if she should lay out the clothes. The medical examiner said no, unless they found evidence of assault. They take pictures of the hands. [...] Investigators from the prosecutor’s office arrive because a cell phone was found in the decedent’s pocket, and that could lead to identifying him. The investigators say that unless his death looks suspicious, they will not do anything, but they will take the cell phone and try to identify him. They take the originals of the fingerprints, the technician says she will make some more. They have to sign out the evidence for the chain of custody.”

Suicides are often problematic for the families, as explained earlier. This is another example of such cases:

“The investigative report said that the decedent was not depressed, but the police stated that he had lost his job as a postal worker, broke up with his girlfriend, and maybe even lost a baby. The case was on hold from yesterday because he was allegedly a Muslim, and an objection was raised, but the family had changed their minds. The medical examiner, locating information from the prosecutor’s office and the police department, calls the case a suicide. According to him, the investigator’s report was lacking. The investigator states that the family didn’t want to say it was a suicide. They said he had never had suicidal ideas, etc. They even denied the fact that he had lost his job. Additionally, the decedent was right handed but the gun was found on the left side of the body. The family said that was the way it was found. That fact is not cleared.”

Here is a homicide which almost did not get caught because of the stage of decomposition of the body:

“Decomposed at home, possible head wound. He had not been seen for a week. The neighbors found him because of the odor. It is potentially suspicious. The concern about the potential head trauma was difficult to determine because of decomposition. [...] I go in the decomposition room. They found a whole in the decedent’s head. The medical examiner says that it looks like a gunshot wound, but they X-rays did not show anything. There is skin slippage everywhere. The technician says maybe the entry wound is from a screwdriver. He brings the X-Rays in again. There is something that looks like teeth or it might be a bullet. It turns out to be a bullet.”

These examples are of course only anecdotal, but they provide a good illustration of the relative flexibility at play in the manner of death classification process. It is after all a matter of interpreting a scenario without the help of the main actor. Within this framework, it becomes interesting to look at homicide not on its own, but as part of the broader nexus of violent deaths.

6. Conclusion

This study focused on examining the process leading to the certification of the manner of death as natural, accident, suicide, or homicide. It did so by using in-depth qualitative data obtained during six months of observations carried out at a medical examiner’s office in urban area. As mentioned before, this study was part of a larger project that included other types of data collected as well as data collected on another site. Findings obtained during the observations were instructed by the literature and therefore, even though only weak generalizability claims can be made based on a single case study, findings appear to be consistent with elements of the literature review (Maxwell, 1996; Rueschemeyer, 2003; Yin, 2003).

The goal of this study was to provide a different perspective on homicide typologies by looking at the process leading to the classification of the different types of deaths. In this study, homicide was not considered separately from suicides or accidents, but rather identified as being part of a nexus of violent deaths (Holinger, 1987).

Considering homicide as a type of death allows for considerations of the notions of deviance from the norm as well as violence, rather than limiting the discussion to purely criminological elements as defined by the violation of the law.

From a theoretical perspective, crime can be seen as the emerged part of the iceberg that is deviance in society. Homicides, suicides, and accidents can thus be seen as indicators of deviance (Holinger, 1987). In that they represent a relatively small proportion of deaths, non-natural deaths can be seen as a deviation from the norm. In a durkheimian manner, one can thus use death as a social indicator (Durkheim, 1897). Following this argument, one can compare violent mortality rates either across time or across space in order to make criminological inferences, questioning whether death is a social invariant.

From a policy perspective, in that they are not the result of natural causes, violent deaths can be seen as social indicators of violence, whether it is intentional or not, whether it is self-inflicted or not (Holinger, 1987). This approach then emphasizes the necessity of considering crime, and homicide, as part of a greater public health issue (Moore, 1995; Riedel & Welsh, 2002). This, thus, can be considered as part of a broader perception of violence, including not only homicides and other violent deaths, but also intentional (assaults and attempted suicides) and unintentional (accidents) injuries (Wright, Rossi, Daly, & Weber-Burdin, 1981). At the research site, the very thin line between counting toward injury statistics versus mortality statistics was sometimes a bit too palpable due to the proximity of the facility to the local university hospital.

“The police radio is always on in the background in the investigators’ room. I don’t understand anything, but the investigators comment on what’s going on. Someone just got shot in the head. They are waiting to see what is happening on that. The case is probably going to go to the hospital. We hear a siren and see an ambulance driving by fast in the direction of the ER. If I stay long enough tonight, the case might turn up here.”

The role of medical innovations as well as the distance to a medical facility has long been examined as a factor explaining a drop in homicides (Harris, Thomas, Fisher, & Hirsch, 2002; Wolfgang, 1958). For an extensive review of this literature, see Harris et al., 2002. Broadening homicide study to include aggravated assaults, and then all violent deaths and nonfatal injuries is a redefinition of criminal violence to violence. Doing so is particularly necessary in order to address violence as a public health issue within the context of communities.

Further research should thus be articulated on both theoretical and policy implications linked to the consideration of homicide not as a criminological event solely, but as a part of a broad violence nexus, a public health threat at the community level.

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