

**American Board  
of  
Forensic Odontology**

**Diplomates Reference**

**Manual**

**Section IV  
Standards & Guidelines**

**February 2018 Edition**

# **American Board of Forensic Odontology, Inc.**

## **DIPLOMATES REFERENCE MANUAL**

### **SECTION IV STANDARDS & GUIDELINES**

#### **TABLE of CONTENTS**

##### DEFINITIONS of GUIDELINES, STANDARDS and POLICIES STANDARDS AND GUIDELINES for EVALUATION BITEMARKS

Preface

Standards

Guidelines

Linkage Terminology

Evidence Collection

Bitemark Analysis

Bitemark Comparisons

ABFO Bitemark Analysis and Comparison Algorithm

Bitemark Evidence Reports

Appendices

Glossary of Terms

Factors Influencing the Interpretation of Bitemarks on Human Skin

Uses of Bitemark Evidence

Checklist for Evidence Collection from Questioned Bitemarks

Checklist for Evidence Collection from Dentitions of Persons of Interest

Checklist for Second Opinions in Bitemark Evidence Cases

##### ABFO BODY IDENTIFICATION INFORMATION

##### BODY IDENTIFICATION GUIDELINES

Collection and Preservation of Postmortem Dental Evidence

Comparison of Antemortem and Postmortem Evidence

Categories and Terminology for Body Identification

##### ABFO STANDARDS & GUIDELINES for DENTAL AGE ASSESSMENT

Purpose and Value

General Principles

Definitions

Standards

Guidelines

Dental Age Assessment Reports

Summary

Resources

## **SECTION IV**

### **Standards & Guidelines**

#### **Definitions of Guidelines, Standards and Policies**

**Guidelines:**

- Suggested but not mandatory
- Recommended, but not required

**Standards:**

- A model to be followed; establishes protocol; a benchmark
- Strictly defined and to be followed by all based on its correctness
- Compulsory minimal level of practice
- More restrictive than guidelines; more enforceable

COMMENT: a failure to follow a standard may be defensible if it can be justified by proof that the standard is not worthy or that the departure is equivalent.

**Policy:**

- A predetermined, selected and planned prescription of conduct.
- Policies define beliefs and philosophy
- A principle, plan, or course of action as pursued by an organization

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## **AMERICAN BOARD OF FORENSIC ODONTOLOGY (ABFO)**

### **Standards and Guidelines for Evaluating Bitemarks**

Revised 2-19-2018

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#### **Preface**

ABFO standards and guidelines are dynamic and can be modified in response to developments in the field following ABFO policies and bylaws. These standards and guidelines were developed with consideration of the current status of the discipline. The appendices to this document include a glossary of terms (Appendix 1), factors influencing the interpretation of

bitemarks on skin (Appendix 2), lists of potential uses of bitemark evidence (Appendix 3), and checklists for specific procedures (Appendices 4, 5, and 6).

These Standards and Guidelines are not intended to be contrary to any jurisdiction's laws and statutes.

## **1. Standards**

- a. An ABFO Diplomate shall be familiar with and adhere to ABFO Standards.
- b. An ABFO Diplomate shall document, review, and consider all evidence received and collected.
- c. An ABFO Diplomate shall be familiar with the current literature, and use established analytical methods for pattern, patterned injury, and bitemark evidence. These can be supplemented with other techniques or methods.
- d. Final reports shall include the results of all analyses.
- e. Terms used in a manner different from the guidelines shall be explained in reports and in testimony.
- f. An ABFO Diplomate shall not express conclusions unconditionally linking a bitemark to a dentition.
- g. An ABFO Diplomate shall not give expert testimony outside her/his recognized area(s) of expertise.

## **2. Guidelines**

### **a. Guiding Principles**

#### **i. Objectivity (see Appendix 1)**

Odontologists should remain objective in all phases of investigation, analysis, comparison, and reporting of their casework, including minimizing all forms of bias.

#### **ii. Nature, Value, and Limitations of Bitemark Evidence**

Odontologists should discuss and explain the nature, value, and limitations of bitemark evidence with investigative and legal authorities involved, including the relationship of the bitemark evidence to the presence or absence of other physical evidence.

#### **iii. Blinding**

- 1) Whenever possible, the same odontologist should not collect evidence from both persons with patterned injuries purported to be bitemarks and persons of interest whose dentitions may or may not

have caused the bitemark. Another dentist should be engaged to collect such evidence in order to minimize bias.

- 2) When only one person of interest is proffered, the odontologist should engage another dentist to produce a “dental line-up” of dentition evidence. If utilized, the dental line-up evidence should include evidence from the person or persons of interest and from other individuals as foils. (see Foil in Appendix 1)
  - a) The dental line-up evidence should be similarly produced, developed, and presented to avoid disclosing identifying information.
  - b) There should be no gross discrepancies in the general arrangement and number of teeth present for selected foils.
- 3) When multiple persons of interest are proffered, the odontologist should include one or more foils to supplement the dental line-up.
- 4) When comparing dentition evidence and bitemark evidence, the odontologist making the comparison should not have access to dentition information disclosing the identity of a person of interest. All comparison dentition evidence within the dental line-ups should be anonymized.

iv. Independent Verification

- 1) Before submitting a final report, odontologists should seek independent verification in the form of a second opinion from a minimum of one ABFO Diplomate.
- 2) Odontologists engaged for independent verifications should be blinded to the conclusions of the referring odontologist and blinded to information that would reveal identifying information regarding persons of interest.

b. Terms indicating a pattern or patterned injury is or is not a bitemark

i. Human Bitemark – human teeth caused the pattern

Criteria:

- 1) The pattern demonstrates class characteristics of human teeth, including prosthetic replacements when present.
- 2) The discernable features are sufficient such that other causes for the pattern were considered unlikely or excluded.
- 3) A curvilinear pattern or patterned injury generally circular or oval and often consisting of two opposing arches that may or may not be

separated at their bases by unmarked space. Sometimes only one arch is clearly visible.

- 4) Individual marks, impressions, abrasions, contusions, striations, or lacerations from specific teeth may be found within the pattern.
- 5) A central area of contusion is sometimes present.
- 6) In severe human bitemarks, material may be forcefully removed from the medium bitten.
- 7) The marks present reflect the size, shape, arrangement, and distribution of the contacting surfaces of teeth. (The contacting surfaces of human teeth include the incisal and occlusal surfaces of teeth and may also include the lingual surfaces of anterior teeth.)
- 8) Some marks made by individual teeth can be recognized and identified based on the class characteristics and location relative to other features.
- 9) The size and shape of each visible arch conforms to the varying ranges of size and shape of the human dentition.

ii. Not a Human Bitemark – human teeth did not cause the pattern.

Criteria: The pattern or patterned injury does not include features demonstrating the class characteristics of human teeth.

iii. Inconclusive – There is insufficient information available to support a conclusion of whether or not a pattern or patterned injury is a human bitemark.

Criteria: Features demonstrating the class characteristics of human teeth are incomplete, distorted, or otherwise insufficient.

c. Terms relating or linking a dentition to a human bitemark

i. Excluded as Having Made the Bitemark

Criteria: The bitemark demonstrates class characteristics or individual characteristics that could not have been caused by the dentition.

ii. Not Excluded as Having Made the Bitemark

Criteria: The bitemark demonstrates class characteristics or class and individual characteristics that could have been caused by the dentition. There are no unexplainable discrepancies between the features of the bitemark and the dentition. The dentition is not excluded from the population of dentitions that could have caused the bitemark.

iii. Inconclusive

Criteria: There is insufficient information to support a conclusion whether or not the bitemark could have been caused by the dentition.

d. Bitemark: Definition, Characteristics, and Evidentiary Value

i. Bitemark definition

A physical alteration or representative pattern recorded in a medium caused by the contact of the teeth of a human or animal. (see 2.b.1. *supra* for a comprehensive definition of a human bitemark)

ii. Characteristics of human bitemarks

1) Class characteristic

A feature, trait, shape, or array that distinguishes a bitemark from other patterns or patterned injuries. An expected finding within a class or group.

2) Individual characteristic

A feature, trait, shape, or array that represents an individual variation within a group rather than an expected finding within that group.

a) Arch characteristic

An arch characteristic is a type of individual characteristic that is displayed in a pattern representing the arrangement of multiple teeth in a dentition or bitemark. (e.g. arch shape, arch size, rotated teeth, teeth displaced toward the facial or lingual, teeth drifted toward the mesial or distal, diastemata).

b) Dental characteristic

A dental characteristic is a type of individual characteristic seen in a bitemark that represents an individual tooth variation (e.g. wear pattern, chips, notches, fractures, dental anomalies).

iii. Evidentiary value of human bitemarks

1) General considerations:

a) After a pattern or patterned injury has been determined to be a human bitemark, an odontologist should evaluate the information in the bitemark for forensic significance or evidentiary value. The evidentiary value of the information should be determined to be sufficient before initiating comparisons to dentitions (see criteria at iv.2 *infra*).

- b) Induced distortion of the skin from biting action and other factors related to the nature of human skin can affect the recording of the dental features, arch size, and arch shape in the bitemark.
  - c) Certain factors influence the interpretation of bitemarks on human skin. (see Appendix 2)
- 2) Criteria for Determining Evidentiary Value

Conditions and features of bitemark evidence that indicate sufficient evidentiary value for comparisons to dentitions include but are not limited to these criteria:

- a) The bitemark pattern was adequately photographed both without and with a reference scale a) in place, and b) on the same plane as the pattern or injury. (Note: Image management software cannot correct for deficiencies in this criterion.)
- b) Images used for comparison are properly focused, adequately illuminated, suitably exposed, and made with the plane of the image receptor either a) parallel to the plane of the portion of the bitemark being imaged, or b) not parallel to the portion of the bitemark being imaged but the images can be corrected for the angle known as theta ( $\theta$ ) using image-management software.  
  
(see Theta ( $\theta$ ) in Appendix 1)
- d) Either the maxillary or mandibular arch or both arches can be located and the midline of one or both arches can be determined.
- e) Some marks caused by individual teeth can be seen and recognized based on their class characteristics and/or location relative to other features.
- f) The size and shape of each arch conforms to the variations of the size and shape of the human dentition.

e. Bitemarks made by Permanent, Mixed, and Primary Dentitions

- i. The criteria used to distinguish bitemarks made by an adult's teeth *versus* bitemarks made by a child's teeth should be based not on size alone, but also on the differences of the class characteristics of the permanent dentition and the primary dentition. Class characteristic features should be visible in the bitemark.

Bitemarks made by children and adolescents during their mixed dentition phase may exhibit characteristics of permanent and primary dentitions.



### **3. Linkage Terminology**

The ABFO standards and guidelines indicate that if sufficient information is available to support conclusions, bitemark linkage conclusions should only a) exclude or b) not exclude (*include*) a dentition. The specific terms found in 2.c. are: a) for exclusion, Excluded as Having Made the Bitemark, and b) for inclusion, Not Excluded as Having Made the Bitemark. Stronger terms of attribution are not condoned by the ABFO (see Standard 1.f.)

*The following guidelines sections comprise the Best Practices for evidence collection, analysis, comparison and reports. Best Practices should be followed by odontologists whenever possible and practical.*

#### **4. Evidence Collection**

From Questioned Patterns, Patterned Injuries, Bitemarks, Persons of Interest, and Dentitions

a. General considerations

- i. A questioned bitemark is a pattern or patterned injury that may or may not be a bitemark.
- ii. A dentition or subject dentition refers to the teeth of a known person of interest that may or may not have caused a bitemark.
- iii. The odontologist who collects the evidence from a questioned pattern, patterned injury, or bitemark should not also collect evidence from the dentitions of known persons of interest (see 2.a.iii.1).
- iv. If only one person of interest is proffered, then a line-up of dentition evidence from persons of interest and foils should be employed. (see Foil in Appendix 1) Foils should be persons unrelated to the case but with similar dentitions. (see 2.a.iii.2).
- v. An odontologist performing comparisons should be blinded to the identities of persons of interest and their dentitions (see 2.a.iii.4)
- vi. Evaluation of bitemark evidence includes:
  - 1) Examination of questioned patterns and patterned injuries to form conclusions, if the evidence allows, of whether or not they are bitemarks
  - 2) Interpretation and analysis of those questioned patterns or patterned injuries that are concluded to be bitemarks
  - 3) Comparison of evidence from bitemarks containing sufficient evidentiary value to evidence from subject and foil dentitions, and
  - 4) Formation of opinions, if the evidence allows, of whether a bitemark is excluded or not excluded as being caused by the subject and foil dentitions
- vii. Following evidence-based evaluation and analysis and if the evidence is sufficient, comparisons of bitemarks to subject and foil dentitions can be undertaken. These steps should follow established guidelines. Together they constitute a forensic physical comparison.

viii. Because bitemark evidence evaluations, analyses, and comparisons fall within the knowledge spectrum described in state and federal rules of evidence as “scientific, technical, or other specialized knowledge that can be helpful to the court,” the admissibility of bitemark evidence in a legal proceeding is a determination made solely by the court.

b. Case information

- i. Case agency, case number, and date of examination should be noted and can also appear on the reference scale utilized for photographs.
- ii. The names of subjects should be recorded, if available, as well as the place of examination. However, information produced for blinded second opinions or independent verifications of conclusions should omit names or other identifying information
- iii. The medical or legal authority that requested or provided authorization for the odontology examination should be documented.

c. Chain of custody

- i. Receipt of any evidence by the odontologist should be clearly documented using appropriate chain of custody, including the case name and number, time and date of delivery, an inventory of the evidence delivered, and from whom the evidence was received, along with the recipient’s signature.
- ii. Release of evidence by the odontologist should be similarly documented.
- iii. A copy of the chain of custody should be retained as part of the case record.
- iv. The odontologist should place his/her mark and date of examination on each item of physical evidence, such as dental casts, CDs, DVDs, photographs, etc. in a non-diagnostic area using a method that does not materially alter the item or evidence.

d. Evidence collection from questioned bitemarks

- i. General considerations
  - 1) In the context of this section the terms questioned bitemark, pattern, and patterned injury can be used interchangeably.
  - 2) Initial evidence collection from a questioned bitemark can be a one-time event without the possibility of a follow-up examination. When the odontologist is involved in the initial examination, collection of evidence from the site(s) should include the methods of documentation described below.

- 3) Evidence that was collected by others may be provided. Odontologists should assess such evidence and proceed only if the forensic significance or evidentiary value of the evidence justifies continuing the analysis.
- 4) Legal permission in the form of a written consent, search warrant, subpoena, or court order should be obtained from the appropriate authority prior to investigative procedures and should be noted in the reports.

ii. Documentation

1) General descriptors

- a) Case agency
- b) Case number
- c) Examiner
- d) Age, sex, and race of bite mark recipient

2) Pattern location

- a) Anatomical location of patterned injuries
- b) Surface contour
- c) Tissue characteristics
- d) Object (medium) description, if not human skin

3) Pattern or injury features

- a) Size
- b) Shape
- c) Nature (abrasion, contusion, laceration, avulsion)
- d) Other (indentations, incisions, unusual features)

4) Pattern description

- a) Orientation of maxillary/mandibular dental arches
- b) Locations of midlines
- c) Individual tooth marks
- d) Unmarked areas
- e) Tooth rotations, translations or anomalies
- f) Summary

iii. Orientation photographs

Prior to other evidence collection procedures, orientation images should be exposed to document the identity of the object or person, case information, and clearly demonstrate the location(s) of the questioned bite marks.

iv. Swabbing

If not already accomplished, each questioned bitemark should be swabbed for biological evidence following the proper protocols for the jurisdiction.

v. Photography

- 1) Under normal circumstances the pattern or patterned injury should be photographed using a high quality digital camera. Whenever possible the photographic procedures should be performed by or under the direction of the forensic odontologist.
- 2) Once the orientation images have been exposed as recommended in 5.d.iii. progressively closer photographs should be sequentially exposed of each questioned bitemark.
- 3) Images should be of sufficient resolution to allow for enlargement to life-sized dimension without pixilation.
- 4) Photographs of the pattern or patterned injury should be exposed without and with a properly placed and labeled reference scale (e.g. ABFO No.2<sup>®</sup> or similar).
- 5) In some cases, it can be beneficial to obtain serial photographs of the patterned injury over time.
- 6) Both ambient and artificial lighting can be used, as well as infrared (IR), reflective ultraviolet (UVA), and alternate light source (ALS) imaging when indicated.
- 7) Video imaging can be used *in addition* to conventional still photography.

vi. Impressions

- 1) Impressions should be taken of the surface containing questioned bitemarks, especially when three-dimensional properties are present. The impression materials used should meet American Dental Association (ADA) specifications and should be documented by name, including lot number and expiration date, in the report.
- 2) Impressions should be taken of the dentition of a person with a questioned bitemark to assess the possibility of a self-inflicted bitemark. Or, in case the person with the questioned bitemark may have bitten another person that was involved in the incident.
  - a) Adequate support should be provided for the impression material.
  - b) Impressions should be poured with appropriate ADA listed materials following the manufacturer's directions. The resulting casts should be labeled and stored following appropriate chain of custody.

vii. Checklist – A checklist for Evidence Collection from Questioned Bitemarks is at Appendix 4

e. Evidence collection from persons of interest

i. General Considerations

- 1) Subject dentitions are the teeth of persons of interest.
- 2) Prior to collecting evidence from persons of interest, the odontologist should ensure that a written search warrant, court order, or other legal consent has been obtained from the appropriate authority, or the subject person in the case of informed consent.
- 3) Court documents or consent as in 2) above provide legal authority for the collection of the evidence listed below. Copies of these documents should be retained as part of the case record.
- 4) Whenever practical, the odontologist who collects the evidence from a questioned bitemark should not also collect evidence from the dentitions of persons of interest. An exception exists if, in the judgment of the odontologist, a questioned bitemark could have been self-inflicted. In these cases, the odontologist should also collect evidence from that person's dentition.
- 5) Similarly, whenever practical, a second odontologist or another dentist should collect evidence from persons of interest following the guidelines below.
- 6) If only one person of interest is proffered, in order to produce a dental line-up a second odontologist or dentist should collect or provide evidence from other individuals who are foils with similar dentitions to the person of interest.

ii. Evidence collected should include:

- 1) Demographic and other identifying information
- 2) Dental treatment records, if available

iii. Photography

To the extent possible, photographic documentation should include:

- 1) Extraoral photographs
- 2) Full face
- 3) Right and left three-quarter profiles
- 4) Right and left full profiles
- 5) Intraoral photographs (with retractors and mirrors as needed):
  - a) Anterior view with teeth closed

- b) Anterior view with teeth slightly parted
  - c) Anterior view with mandible protruded
  - d) Anterior view demonstrating maximal opening
    - i) with reference scale
    - ii) without reference scale
  - e) Lateral views, both left and right sides
  - f) Occlusal views of each arch
  - g) Additional photographs that may provide useful information
  - h) Images of surfaces of test bites with and without reference scales
- 6) Video imaging can be used *in addition to* conventional still photography
- iv. Intraoral examination

The dentist performing the intraoral examination should document the condition of the teeth, including the following:

- 1) Missing teeth
  - 2) Fractured teeth
  - 3) Mobile teeth
  - 4) Condition of the periodontium
  - 5) Maxillary and mandibular tori
  - 6) Tongue and lip piercings and/or jewelry
  - 7) Other unusual intraoral features or anomalies
- v. Impressions
- 1) Maxillary and mandibular impressions should be taken. Both conventional and digital impression techniques utilized in clinical dentistry are acceptable.
  - 2) For conventional impressions, ADA-listed materials should be used following established dental impression techniques. Dental casts should be produced from impressions following established techniques.
  - 3) For digital impressions ADA-listed optical scanner and laser scanner techniques are acceptable.
    - a) The digital files from the scans can be used for digital analyses utilizing appropriate software techniques.
    - b) Alternately, the digital files can be used following established techniques to produce physical dental casts
  - 4) If removable prostheses are present, impressions should be made both with and without the prosthetic appliances *in situ*.

- 5) The inter-occlusal relationship should be recorded using ADA-listed materials and techniques.
- vi. Sample or test bites should be recorded using ADA-listed materials and appropriate techniques. These items should be labeled, photographed, and retained.
- vii. Dental casts
  - 1) If physical casts from either conventional or digital impressions are produced, master casts should be prepared. For master casts produced from conventional impressions, ADA-listed Type III dental stone prepared according to manufacturer's instructions should be used following established dental techniques. Master casts may also be made from digital files from digital 3D scans using fit for purpose ADA-listed materials.
  - 2) Additional casts can be poured from polyvinylsiloxane or polyether impressions or fabricated from digital files. Each subsequent model poured should be sequentially labeled to indicate the order of production.
  - 3) If the original conventional impressions are taken using alginate or similar materials, duplicate casts can be produced from an impression of the master cast made using ADA-listed materials for duplication.
  - 4) Duplicate casts should be appropriately labeled and the master cast utilized to produce the duplicate should be noted.
  - 5) Master casts should not be altered. All tests and experiments should be performed using duplicate casts.
- viii. Other evidence

Upon request, additional reference samples can be collected and stored with appropriate authorization and following established protocols.
- f. A checklist for dentition evidence collection is at Appendix 5

## **5. Bitemark Analysis**

### **a. General considerations**

- i. Bitemark analysis in the context of this section refers to the analysis of patterns or patterned injuries that may or may not be bitemarks, as well as the continued analysis of patterns or patterned injuries that in the opinion of the odontologist are bitemarks.



- ii. Once an odontologist forms an opinion that a pattern is a human bitemark, the odontologist should complete the analyses of that bitemark before making any comparisons to the dentitions of persons of interest.
  - iii. Comprehension of dental and oro-facial anatomy and morphology, plus an understanding of dental treatment modalities, are required for evaluation and interpretation of a pattern or patterned injury caused by human teeth.
- b. Interpretation of a Pattern or Patterned Injury as a Bitemark
- i. Assessment of a pattern
    - 1) Determining the orientation of the marks caused by maxillary and/or mandibular teeth. The relative size and morphological differences visible in the pattern may support differentiation between marks from the maxillary and mandibular arches. Assessments may include, but are not limited to:
      - a) Locating within the marks the position(s) of the midline(s) of the maxillary and/or mandibular arches. Midline(s) of the maxillary and mandibular arches may be determined either by noting the central incisors visible in the mark, or by determining the midpoint of each arch.
      - b) Locating marks caused by specific teeth by examining the anatomical morphology of the incisal edge and occlusal surface patterns.
      - c) Locating areas without marks potentially due to missing, fractured, unerupted, partially erupted, malformed, or ectopic teeth.
      - d) Locating features that indicate rotations, translations, or other anomalies caused by specific teeth.
      - e) Performing a manual or computer-assisted metric analysis of the overall and specific features of the questioned bitemark.
      - f) Locating drag marks (e.g. abrasions, striations) in relation to specific teeth induced by motion during the act of biting.
    - 2) Summarize the features that form the pattern including:
      - a) Class characteristics of:
        - i) Primary dentition
        - ii) Mixed dentition
        - iii) Permanent dentition
      - b) Individual characteristics

- i) Individual arch characteristics
- ii) Individual dental characteristics
- c) Anomalies or other unusual features
- 3) Form conclusion

ii. **Graphic aids**

Odontologists can use graphic aids to assist in the analyses or to demonstrate features of a questioned bite mark. For example, a software program can be used to optimize an image or to create demonstrative graphics.

c. **Conclusions and Opinions**

Following completion of the bite mark analyses, conclusions should be made following ABFO terminology guidelines (see 2.b and 2.c). A list of features that support the conclusion(s) should be included.

**6. Bite mark Comparisons**

a. **General considerations**

- i. An unknown exhibit (i.e. questioned bite mark), for which the odontologist is attempting to identify the origin, should be compared to the known reference exhibit(s) (i.e. dentition evidence).
- ii. Only patterns and patterned injuries that the odontologist has concluded are human bite marks should be compared to the dentitions of persons of interest.
- iii. Patterns and patterned injuries the odontologist has concluded are animal bites can be compared to the dentitions of animals of interest.
- iv. Bite mark analyses should be completed before comparisons to dentitions are undertaken.
- v. To the greatest extent possible, odontologists should be blinded to information about the dentition evidence that would disclose the identity of a person of interest.
- vi. Whenever possible, a second odontologist or other dentist should collect the dentition evidence from persons of interest and from foils and then provide that evidence in a manner that allows odontologists performing comparisons to be blinded to the source.

- vii. Bitemark comparison conclusions are odontologists' opinions derived from evaluations and analyses based on education, training, knowledge, skill, and experience.
- viii. An odontologist should recognize that many human dentitions are similar and that bitemarks are not always accurately recorded in human skin. Opinions that exclude or do not exclude persons of interest should only be made in cases in which information is sufficiently clear and distinctive to allow those opinions.

b. Methods of comparison

i. Overlays

- 1) Overlays are tools useful for comparing a dentition to a pattern or patterned injury determined to be a bitemark. Overlays can be hollow volume, solid volume, semi-transparent, or other representations of the biting surfaces of subject or foil dentitions.
- 2) Overlays can be computer generated from 2D or 3D scans of the subject or foil dentitions, 2D photographic images of the teeth or dental casts or 2D or 3D scans of dental casts.
- 3) Odontologists should confirm that the overlays and the images to which they will be compared are identically sized.

ii. Test bites

- 1) Test bites are made by producing simulated bites in a medium using dental casts. The medium used for the test bites can be dental wax or other ADA-listed dental materials, animal skin, human skin, or other media. Test bites can be made in more than one medium.
- 2) Test bites can be used to produce overlays. The overlays can be manually or computer generated and compared to or superimposed over same-sized images of the bitemark.
- 3) Test bites can be useful to analyze similarities or differences between the test bites and the bitemark. Analyses can be completed side-by-side or utilizing an overlay technique.

iii. Additional comparison techniques may include, but are not limited to:

- 1) Exemplars of the subject's dentition compared to corresponding-sized images of the bite pattern
- 2) Life-sized casts of subject's dentition compared to life-sized images or 3D casts of bitemark patterns
- 3) Manual or computer-generated comparisons

- 4) Digitization and computer enhancement of images
- 5) Use of computer software to assist in performing comparisons
- 6) Stereomicroscopy
- 7) Scanning Electron Microscopy

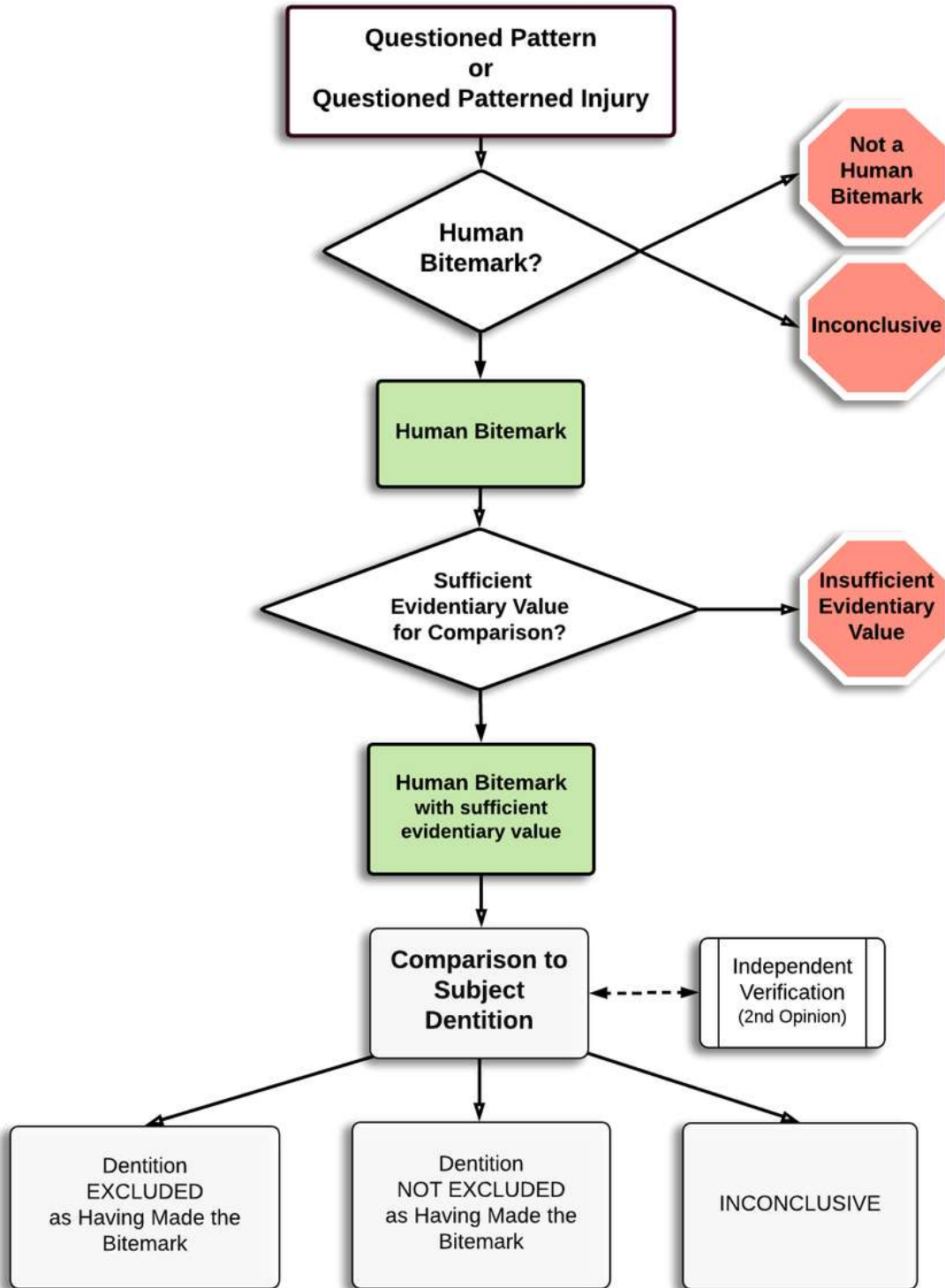
c. Conclusions

Conclusions should be expressed following ABFO Standards and Guidelines. A list of features supporting conclusions should be included.

d. ABFO Bitemark Analysis and Comparison Algorithm

The algorithm is intended as a graphic aid to odontologists. See following page.

### ABFO Bitemark Analysis and Comparison Algorithm



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## **7. Bitemark Evidence Reports**

- a. General considerations
  - i. The guidelines below apply generally to preliminary, interim, and final reports.
- b. Independent verification
  - i. An odontologist investigating a human bitemark case should seek independent verification in the form of a second opinion from a minimum of one ABFO Diplomate before submitting a final report. (see 2.a.iv).
  - ii. A second opinion checklist is at Appendix 6
- c. Components of bitemark evidence reports may include:
  - i. Introduction – Background information for the case. For example, what was requested, by whom, when requested, and why the request was made.
  - ii. Inventory of evidence received – Evidence submitted to the odontologist, including how and when acquired.
  - iii. Inventory of evidence collected – Type, source, and authority for evidence collected by the odontologist, evidence collected, official exhibit number assigned to the items of evidence collected, collection location, and date and time custody of each exhibit was accepted.
  - iv. Findings regarding pattern – Opinion stated using ABFO terminology.
  - v. Analysis – Methods employed, including the times and dates when the analyses took place.
  - vi. Results – Outcomes of analyses and comparisons.
  - vii. Conclusion – Conclusions and opinions of the relationship between each bitemark and dentition using ABFO terminology (see 2.b). Only one term of conclusion should be used for each comparison.
  - viii. Disclaimer – Optional statements can be included to convey that the opinion(s) are based on the evidence examined. For example, the odontologist can reserve the right to file subsequent reports should other evidence become available.

**8. Appendices**

Appendix 1 – Glossary of Terms

Appendix 2 – Factors Influencing the Interpretation of Bitemarks on Human Skin

Appendix 3 – Uses of Bitemark Evidence

Appendix 4 – Checklist for Evidence Collection from Questioned Bitemarks

Appendix 5 – Checklist for Evidence Collection from Dentitions of Persons of Interest

Appendix 6 – Checklist for Second Opinions in Bitemark Evidence Cases

**APPENDIX 1**  
**Glossary of Terms Used in Standards and Guidelines**

**Bite mark** (*bite mark* and *bite-mark* are also acceptable forms)

- A physical alteration with a representative pattern that is registered in a medium caused by the contact of the teeth of a human or animal

**Class Characteristic**

- A general characteristic that defines a category of items or objects but alone is insufficient to establish identity
- A feature, trait, or pattern that distinguishes the human dentition from other items or objects or the dentitions of animals
- A feature, trait, or pattern that distinguishes a bite mark from other patterned injuries

**Dental Prosthesis**

- An artificial replacement of one or more teeth and/or associated structures

**Dentition**

- The teeth in the dental arches

**Excluded**

- In relation to bite mark evidence, a subject or foil dentition that is eliminated as having caused a bite mark

**Exemplar**

- A demonstrative example or model of an item or object(s)
- In bite mark evidence comparisons, exemplars are used to demonstrate the shape, size and position of the biting surfaces of the dentition

**Foil**

- In the context of a dental line-up for bite mark evidence comparisons, an individual or evidence from an individual that is not a person of interest but rather a distractor

**Guideline**

- An item, action, or level of practice or conduct that is recommended or suggested but not mandatory

**Individual Characteristic**

- A characteristic caused by intentional, unintentional, or accidental changes during use, development, etc. that are exceptional and can be used to individualize or identify a specific item or object
- A feature, trait, or pattern that represents an individual variation rather than an expected finding within a defined class or group

**Not Excluded**

- In bite mark evidence comparisons, a dentition that cannot be eliminated from having caused a bite mark



- The dentition is included in the population of dentitions that could have caused the bitemark
- Results of a comparison that determines the absence of unexplainable discrepancies

### **Objective**

- Developing and maintaining neutral and unbiased attitudes, approaches, and opinions that are based on the available evidence

### **Pattern**

- A distinctive shape, form or array
- In the context of bitemark evidence, a distinctive shape, form or array that appears in or on tissue or in or on a medium other than tissue

### **Patterned Injury**

- An injury in tissue with distinctive shape, form or array indicating the characteristics of the contacting surfaces of the object(s) that caused the injury

### **Perimortem**

- Occurring at or about the time of death

### **Person of interest**

- An individual or subject who may or may not be associated with an event
- In the context of bitemark evidence, an individual or subject who had or may have had access to an individual who received a bitemark during a specified time interval

### **Shall**

- The referenced item, action, or proscription is mandatory

### **Should**

- The referenced item, action, or proscription is recommended

### **Standard**

- A compulsory (i.e. mandatory) item, action, or level of practice or conduct

### **Subject Dentition**

- The teeth of a person of interest that may or may not have caused a bitemark

### **Theta ( $\theta$ )**

- In the context of pattern or patterned injury evidence photography, when an image is recorded with the plane of the image receptor not parallel to the portion of the pattern being imaged, theta ( $\theta$ ) is the angle between an imaginary line perpendicular to the image receptor plane extended to a point on the surface imaged and an imaginary perpendicular line from an optimally placed camera's image receptor plane extended to that same point



## **APPENDIX 2**

### **Factors Influencing the Interpretation of Bitemarks on Human Skin**

1. Human skin factors
  - a. Type
  - b. Thickness
  - c. Pigmentation
  - d. Nature of underlying tissues
  - e. Viscoelasticity
  - f. Anisotropy (orientation to skin tension lines)
  - g. Hysteresis (short term only)
  - h. Vital response to injury
2. Injury factors
  - a. Contusion
  - b. Abrasion
  - c. Laceration
  - d. Incision
  - e. Avulsion
3. Biting dynamics factors
  - a. Movement during biting by person biting or person bitten
  - b. Force of the bite
  - c. Positional changes during and after biting
4. Age of the person bitten
  - a. Properties of human skin can change with age
  - b. Skin of older persons can respond to trauma with varying degrees of contusion, abrasion, laceration, and other effects
  - c. Skin of older persons can heal differently compared to the skin of younger persons
5. Health of the person bitten
  - a. Systemic diseases can affect the response of skin to trauma
  - b. Effects or side effects of medications can affect the response of human skin to traumas
6. Other
  - a. Healing process changes in bitemarks on living subjects. Examples:
    - i. Edema presence, progression, and resolution
    - ii. Contusion presence, progression, and resolution
    - iii. Scab formation and resolution
    - iv. Scars, fibrosis, and permanent skin changes
  - b. Postmortem changes in bitemarks on deceased subjects

**APPENDIX 3**  
**Uses of Bitemark Evidence**

Bitemark evidence may be used to:

1. Document aspects of violence
2. Provide a profile of the dentition of a person of interest
3. Compare information from bitemarks to subject or foil dentitions
4. Provide a potential physical and temporal link between a recipient of a pattern or patterned injury and the dentition of the perpetrator
5. Support or refute the history of events that is reported by individuals in a legal proceeding
6. Further potential uses (from Silver, W.E., Souviron, R.R. (2009). *Dental Autopsy*. Boca Rotan, FL: CRC Press.):
  - a. A bitemark can indicate the infliction of pain
  - b. Bitemarks can be offensive, defensive, or consensual
  - c. Bitemarks usually indicate acts of violence
  - d. A bitemark can cause permanent injury; for example, avulsion of an ear, finger, nose or other body part
  - e. Bitemarks of high evidentiary value with distinctive markings can yield clues about the dentition of the questioned dentition – even in the absence of a formal comparison
  - f. Bitemarks in different stages of healing can indicate episodic infliction of injuries or abuse over time
  - g. Absence of any vital skin reaction (e.g. hemorrhage, swelling, etc.) can be indicative of a bitemark caused following death
  - h. Relative positions of the participants in violence involving bitemarks can vary. The location and orientation of bitemarks can provide odontologists with clues to interpret the dynamic interchange
  - i. Anatomical locations of some bitemarks indicate that the bitemarks could not have been self-inflicted
  - j. Presence of a bitemark should prompt medical personnel or members of the death investigation team to collect salivary evidence

**APPENDIX 4**  
**Checklist for Evidence Collection from Questioned Bitemarks**

1. Initial Steps

a. Case data documentation

i. Identification data

- Case agency
- Case number
- Examiner

ii. Pattern location data

- Anatomical location
- Surface contour
- Tissue characteristics
- Object (medium) description, if not human skin

iii. Pattern or patterned injury features data

- Size
- Shape
- Nature (abrasion, contusion, laceration, avulsion)
- Other (3D features, indentations, incisions, unusual features)

iv. Pattern description data

- Orientation of maxillary/mandibular dental arches (if visible)
- Locations of midlines (if visible)
- Individual tooth marks
- Unmarked areas
- Features indicating tooth rotations, translations, or anomalies
- Summary of overall features

b. Orientation photographs

- Orientation images exposed prior to other evidence collection to document characteristics of the person or object, the case number and date, and anatomical location(s)

c. Swabbing

- If not completed by other investigators, each bitemark swabbed for DNA following proper protocols for the jurisdiction. If there is no jurisdictional protocol, the double-swab method is used

2. Photography

- High-quality digital camera used. Photographic procedures are performed by or under the direction of the forensic odontologist
- Appropriate ambient or artificial lighting (or both) utilized

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*Section IV: Standards & Guidelines*

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- Overall orientation images then progressively closer images exposed of each bitemark
- Images of sufficient resolution for enlargement to life-size without pixilation
- Photographs exposed without and with a properly placed and labeled ABFO No.2© or similar reference scale
  - Reference scale is a) in the same plane as, and b) adjacent to the portion of the pattern or patterned injury being imaged
  - Camera sensor and lens face are parallel to both the plane of the reference scale and the plane of the pattern being imaged
  - On curved or compound curved surfaces, multiple images are exposed with the camera sensor, lens face, reference scale, and the pattern in the same plane
- For a living person or person recently deceased, sequential photographs of the injury over time

When indicated, in addition to conventional visible light photographs,  Infrared (IR),  Ultraviolet (UVA), or  Alternative Light Source (ALS) images are exposed

- Video imaging *in addition* to conventional still photography as indicated

3. Impressions

- Impressions of the surface containing the pattern or patterned injury when 3D properties are present using ADA-listed materials and named in the report, including lot number and expiry date
- Impressions of the dentition of the person with the bitemark to assess possibility of self-inflicted bite or to determine if they may have also bitten another person
- Suitable support provided for the impression material
- Impressions are poured using manufacturer's instructions and casts are labeled and retained following appropriate chain of custody

4. Chain of Custody

- Evidence received, collected or developed is clearly documented using appropriate chain of custody showing the case name and number, time and date of delivery, an inventory of the evidence delivered, and from whom the evidence was received along with his/her signature
- Similarly document any release of evidence by the odontologist

**APPENDIX 5**

**Checklist for Evidence Collection from Dentitions of Persons of Interest**

1. General Considerations

- Ensure appropriate search warrant, court order, or legal consent has been obtained
- Copies of these documents are retained as part of the case record
- Impressions of the dentition of the person with the bitemark to assess possibility of self-inflicted bite or to determine if they may have also bitten another person
- Another dentist collects dental evidence from persons of interest and foils. Blinded exemplars are provided to the odontologist for analysis but identities of persons contributing exemplars are not released.

2. Evidence Collected Should Include

- Demographic and other information specific to the subject
- Dental treatment records, if available

Photographs – to the greatest extent possible, photo documentation includes:

A. Extraoral photographs

- Full face
- Right and left three-quarter profiles
- Right and left profiles

B. Intraoral photographs (with retractors and mirrors as needed)

- Anterior view with teeth closed
- Anterior view with teeth slightly parted
- Anterior view with mandible protruded
- Anterior view demonstrating maximal opening
  - With reference scale
  - Without reference scale

- Lateral views, both right and left sides
- Occlusal views of each arch

C. Additional images

- Maxillary and mandibular surfaces of test bites with and without reference scale
- Video imaging in addition to conventional still photography as indicated

Intraoral examination

A. Condition of the teeth

- Missing teeth
- Fractured teeth
- Mobile teeth

B.  Condition of the periodontium

C.  Presence of maxillary and/or mandibular tori

D.  Presence of tongue and/or lip piercings and jewelry

E.  Other unusual intraoral features or anomalies\

Impressions

- Maxillary and mandibular impressions taken with ADA-listed materials using appropriate dental impression materials

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*Section IV: Standards & Guidelines*

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- If removable prostheses are present, impressions made both with and without the prosthetic appliances *in situ*
- Inter-occlusal relationship recorded using approved materials and techniques
- Alternate impressions using approved intraoral 3D scanners as needed
- Sample or test bites recorded using appropriate ADA-listed materials and techniques, and these records photographed and retained

Dental casts

- Master casts prepared from impressions using ADA-approved Type III dental stone following manufacturer's instructions and accepted techniques.
- Master casts may also be made using approved materials from 3D scans as needed.

Swabbing

- If not completed by other investigators, buccal swabs should be collected and stored following established protocols

**APPENDIX 6  
Checklist for Second Opinions in Bitemark Evidence Cases**

1. Case identifiers
  - Name and/or identifier recorded of person or object bitten
  - Notation of dentitions of persons of interest and foils blinded
  - Status of recipient of patterned injury noted
    - Alive when injury occurred and alive when evidence collected
    - Alive when injury occurred and deceased when evidence collected
    - Deceased when injury occurred
  
2. Requesting agency
  - Name of agency noted
  - Case contact person and title at agency noted
  - Date of retention noted
  - Chain of custody documented
  
3. Dates
  - Date questioned bitemark made noted, if known
  - Date of initial evidence collection procedures noted
  - Dates of additional evidence collection procedures noted
  
4. Examination and documentation of questioned bitemark
  - Date, Place, & Time of examination noted
  - Others present at examination noted
  - Other experts or consultants used noted
  - Description of the bitemark
    - Anatomic location of mark noted
    - Size and shape of mark noted
    - Type of tissue involved or type of medium if not human tissue noted
  - Documentation (photographic and other) appropriate for the nature of the injury
    - Exceptions noted in case specific comments below
  - ABFO terminology used to describe whether or not the pattern is a bitemark
  - Evidentiary value considered to support proceeding to comparison of bitemark(s)
  - Dentition cast acquisition and production techniques documented
  - Dental line-up utilized
  - Approved comparison technique(s) used
    - Other comparison techniques used
  - ABFO linkage terms used
  - Appropriate blinding procedures used
  - Second opinion written report produced following ABFO report writing guidelines

Case specific comments:

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## **ABFO BODY IDENTIFICATION INFORMATION**

### **The importance of timely identification**

In the United States, the Medical Examiner or Coroner (ME/C) has the statutory responsibility and judicial authority to identify the deceased. The identification of unidentified living individuals is the responsibility of local, state or federal law enforcement agencies. Although it is ultimately these agencies that certify the identification it is the responsibility of the forensic odontologist to provide their opinion on the identity as it relates to forensic odontology. Those opinions are based on a standardized set of guidelines established by the forensic odontology community and are based on scientific best practices.

The positive identification of an individual is of critical importance for multiple reasons that include:

#### **For unidentified living individuals:**

- A positive identification is vital to reunite an unidentified living individual with their family members.

#### **For the human remains:**

- A positive identification is vital to help family members progress through the grieving process, providing some sense of relief in knowing that their loved one has been found.
- A positive identification and subsequent death certificate is necessary in order to settle business and personal affairs. Disbursement of life insurance proceeds, estate transfer, settlement of probate, and execution of wills, remarriage of spouse and child custody issues can be delayed for years by legal proceedings if a positive identification cannot be rendered.
- Criminal investigation and potential prosecution in a homicide case may not proceed without a positive identification of the victim.

## **Scientific Identification**

All methods of identification involve comparing antemortem data to postmortem evidence. Although a presumed identification is often established by contextual evidence, ideally, antemortem biometric data of the individual should be obtained and compared to the postmortem evidence to establish a scientific identification. Currently there are five general methods used to identify deceased human remains of which most require a presumptive identification in order to allow for the direct comparison of antemortem and postmortem biometric evidence. The five methods of identification are visual, fingerprint, DNA analysis, anthropologic/radiology and dental comparison.

### **Visual**

A non-scientific method, but is often used when there is little doubt who the individual is, when the remains are not decomposed, and/or the death was witnessed. However changes in appearance from illness, the circumstances of death, (fire, trauma, disintegration, etc.) and

postmortem taphonomic effects, (decomposition, mummification, saponification, skeletonization, animal predation/scavenging, insect activity, etc.), may render it unreliable. Tattoos, scars, piercings, subdermal body modification, and soft tissue abnormalities are useful for visual identification, especially if the tissue is intact. It is important to note, that although personal effects were exchanged between individuals. However, they may offer important clues for a presumptive identification and assist in obtaining antemortem data on the individual to allow for a scientific are often found with the remains or at the scene (identification cards, jewelry, cell phones, etc.), they should never be used as the sole means of establishing an identification due to the possibility that these items identification.

In the future, the potential to establish a large facial image database based on facial recognition data may be possible; however, currently these databases are extremely limited in size. However, even these limited databases could be utilized to establish a presumptive identification and could assist in obtaining antemortem information in order to establish a more scientific basis of identification.

## **Ridgeology (Fingerprints)**

Ridgeology is an expedient biometric method of human identification, especially if the soft tissue of the fingers are intact, an adequate impression or image of the friction ridges can be obtained, and antemortem fingerprint records are available. Burned, decomposed, skeletonized and fragmented remains may be more difficult, if not impossible to image, however, newer techniques have reduced this problem. This method has the advantage of large known national and international databases and does not required a presumptive identification in order to obtain antemortem information.

## **Anthropology/Radiology**

Anthropology, combined with radiology relies on the unique characteristics of the skeleton to compare with antemortem medical imaging and records. Radiographs of skeletal anatomy, bony anomalies, healed fractures; pathological lesions, medical/surgical hardware and implants, or unusual qualities of the skeleton can be used to confirm identification. However, many individuals do not have antemortem skeletal imaging, or the images may not be available.

## **DNA**

Like other biometric methods of identification, DNA comparison relies on access to antemortem data to make a definitive identification. However, unlike other modalities, familial relationship can be established even when antemortem data is not available. In addition, like ridgeology (fingerprints) large national databases are currently being established that can reduce the need for a presumptive identification especially if the decedent has had contact with the justice system. Direct primary and secondary reference samples from the decedent during life are the best sources for identification and indirect DNA reference samples from biological relatives can prove useful in establishing a relationship. DNA testing requires more time, effort, specialized personnel/equipment, and higher cost than other identification methods. The majority of forensic DNA tests are performed on nuclear DNA using polymerase chain reaction (PCR) amplification of the sample with short tandem repeat (STR) typing. Simultaneous analysis of mitochondrial DNA (mtDNA) may be necessary in order to improve the identification process. Forensic DNA analyses for human identification has seen a tremendous implementation since the President's

DNA Initiative Program began in 2003. This program has facilitated funding, training, and assistance to ensure forensic DNA reaches its full potential to identify missing persons. From this program, the National Institute of Justice now provides funding to have DNA analysis done on unidentified remains and family reference samples, at no cost, by the Center for Human Identification at the University of North Texas, or by the FBI. Once the analysis is complete, the profiles (if they qualify) are entered into the FBI's CODIS system (Combined DNA Index System) and uploaded into the National DNA Index System.

### **Dental Identification**

Dental identification of a deceased person is a primary function of forensic odontology. The comparison of a missing person's antemortem dental records/evidence (i.e., written records, study casts, photographs/digital images and radiographs) with the postmortem dental evidence from unknown human remains has long been recognized as one of the most reliable means of positive scientific identification.

Though an individual's dental characteristics will often change during life (dental disease, restorations, extractions, etc.), changes after death are very slow. In fact, the dental condition at death has been shown to last in some cases for centuries.

When there is an alteration in an individual's dental condition that change is in one direction. This was described by Lorton and Langley: "The direction of change of status of a tooth is fixed; that is a tooth cannot have a filling on a surface and then proceed to a state in which there is no filling on that surface. It can only go from having no filling on a surface to a state in which there is one".

Likewise, once a tooth is extracted or otherwise missing, it cannot subsequently be present. This unidirectional change is significant during the verification process and must be considered during any comparison/search process

Forensic odontologists are responsible for identifying unknown human individuals by comparative dental analysis. This process requires comprehensive collection and processing of dental data in order to prove or disprove a human identification.

The forensic odontologist will evaluate and compare the two dental records, the postmortem and the antemortem material. It is their task to determine if the two records were made or could have been made from the same individual. Though most will employ similar techniques and routines, there can be some variation in the way that this comparison is executed. In the end however, for there to be a positive match all inconsistencies within the written records must be explained and distinguishing features must be demonstrable in the hard material evidence, i.e. radiographs, dental models, photographs, etc.

## **Body Identification Guidelines**

### **OUTLINE**

#### **I. Collection and Preservation of Postmortem Dental Evidence:**

- A. The Remains - Examination Procedures
- B. Photography
- C. Jaw Resection
- D. Techniques for Dissection/Resection
- E. The Postmortem Dental Record
  - 1. Dental Examination
  - 2. Narrative Description and Nomenclature
  - 3. Dental Impressions
  - 4. Dental Radiology

#### **II. Sources for Antemortem Data:**

- A. Local Agencies
- B. State Agencies
- C. Federal Agencies
- D. International Resources
- E. Insurance Carriers
- F. Other Sources

#### **III. Comparison of Antemortem and Postmortem Evidence:**

- A. Dental features useful in identification

#### **IV. Categories and Terminology for Body Identification:**

- A. Positive Identification
- B. Possible Identification
- C. Insufficient Evidence
- D. Exclusion

Some diplomates may follow alternative techniques that may be equally effective. It is not the purpose of these guidelines to invalidate other methods, but rather to describe methods that a majority of investigators employ.

## **I. COLLECTION AND PRESERVATION OF POSTMORTEM DENTAL EVIDENCE**

The postmortem dental examination is conducted by the authority and under the direction of the coroner/medical examiner or his designee, typically a forensic pathologist. Thus, the protocol for the collection of postmortem dental evidence, particularly decisions to incise the facial tissues for access or resect the jaws, is subject to approval by the regional coroner/medical examiner. The actual procedures to be followed in a dental identification case depend in large part on the condition of the remains (as well as other circumstances of the case).

### **A. Examination Procedures**

#### **1. Visually identifiable body**

- Photographs, radiographs, dental charting
- Dental Impressions, as applicable
- Resection by infra-mandibular dissection

#### **2. Decomposed/incinerated body**

- Photographs, radiographs, dental charting
- Resection and preservation of jaw specimens, if indicated

#### **3. Skeletonized remains**

- Photographs, radiographs, dental charting
- Preservation of jaw specimens, if indicated

### **B. Photography**

Photographic documentation of dental evidence can provide objective data which is often more graphic than the written chart. Photographs (with an accompanying scale) should be taken before and after appropriate cleansing. The ABFO #2™ right angle ruler is recommended. The photographs should be clearly labeled with the case number/name and date. All relevant photographic information should be documented.

#### **1. Recommended Equipment**

- Single lens reflex digital or 35 mm. film based camera
- Electronic flash (preferably point flash or ring light system)
- Cheek retractors
- Intra oral front-surface mirrors

#### **2. Film based photography**

- Color film (slide and/or print format)
- Black and white film, as required

#### **3. Photographic Views**

- Full face, lips retracted
- Close-up view of anterior teeth
- Lateral views of teeth in slightly open position, and in occlusion
- Occlusal views, maxillary and mandibular teeth
- Special views, as required

### **C. Jaw Section/Resection**

Facial dissection and/or jaw sectioning/resectioning, which may be necessary for full access to dental structures are done only with approval of the coroner/medical examiner. Ordinarily, the circumstances dictating decisions to resect are applicable as follows:

#### **1. Viewable Bodies**

Restricted opening due to rigor may require:

Intra oral incision of masticatory muscles, with or without fracture of the condyles

Breaking the rigor with bilateral leverage on the jaws in the retromolar regions

Waiting until the rigor subsides

Infra-mandibular dissection with or without mandibular resection

Removal of the larynx and tongue at autopsy may facilitate the visual examination of the teeth and/or placement of intra oral films. Again, the removal of these tissues should only be performed after the autopsy and with permission of the pathologist.

These tissues should either be retained by the pathologist or replaced with the body.

#### **2. Decomposed, Incinerated, or Fragmented Bodies**

Jaw resection in such cases facilitates dental charting and radiographic examination.

Careful dissection of the incinerated head, in particular, is required to preserve fragile tooth structure and jaws in situ. Radiographs should be made prior to manipulation of badly burned fragments. Mechanical (or chemical) sterilization of such tissue should be instituted where necessary.

#### **3. Skeletonized Remains**

Since the skull and mandible are readily separated from the remainder of the skeleton, resection of the maxilla is not required.

#### **4. Preservation of Evidence**

Jaw resection may be indicated in cases in which:

Body parts are to be transferred, with proper authorization, to other facilities for additional examination and testing.

A homicide victim is to be cremated.

There is other valid justification for preservation of the jaw specimens (state mandated law).

### **D. Techniques for Dissection/Resection**

Selected techniques are described below. Other methods may be employed when indicated.

#### **1. Facial Dissection:**

Bilateral incisions of the face, beginning at the oral commissures and extending posteriorly to the anterior ramus, permit reflection of the soft tissues for better access.

Infra-mandibular Approach: Bilateral incisions are made across the upper anterior neck and extend to points posterior and inferior to the ears. The skin and underlying tissues are then reflected upward over the lower face thereby exposing the mandible.

#### **2. Jaw Resection:**

##### **Stryker Autopsy Saw Method:**

The soft tissue and muscle attachments on the lateral aspect of the mandible are dissected away by incisions which extend through the muco-buccal fold to the lower border of the mandible. Lingual attachments are similarly incised to include the internal pterygoid attachments to medial aspect of the rami and the masseter attachments on the lateral aspect. On the maxilla, facial attachments are incised high on the malar processes

and superior to the anterior nasal spine. Stryker saw cuts are made high on the rami to avoid possible impacted third molars. Alternatively, the mandible may also be removed by disarticulation at the temporomandibular joints. Bony cuts on the maxilla are made high on the malar processes and above the anterior nasal spine to avoid the apices of the maxillary teeth. A surgical mallet and chisel inserted in the Stryker saw cuts in the malar processes and above the anterior nasal spine are used to complete the separation of the maxilla. Remaining soft tissues in the soft palate and fauces are then dissected free.

**Mallet and Chisel Method:**

A mallet and chisel can be used to induce a “Le Fort” Type I fracture of the maxilla. The chisel blows are made below the zygomatic arch, high on the maxillary sinus walls bilaterally. Since it is virtually impossible to fracture the mandibular rami with the mallet and chisel, the mandible can be disarticulated at the temporomandibular joint in such cases.

**Pruning Shears Method:**

An alternative technique for resection of the jaws involves the use of large pruning shears. The soft tissue/muscle dissections are as described on page 10. The small blade of the pruning shears is placed within the nares and forced back into the maxillary sinus. A cut is then made along a plane superior to the apices of the maxillary teeth bilaterally. The mandibular bone cuts are performed by inserting the small blade of the shears high on the lingual aspect of the ramus near the coronoid notch bilaterally.

**E. The Postmortem Dental Record:**

While most morgues will have the standard autopsy equipment, the forensic odontologist may wish to assemble their own forensic kit to include mouth mirrors, explorers, camera equipment, anatomic dental charts, impression materials, cyanoacrylate, etc. Postmortem dental examinations might utilize anatomic dental charts, photographs, radiographs, models, tape recordings and/or narrative descriptions. The data collected should be comprehensive in scope since antemortem records are commonly not discovered until days, weeks or even years later. Accordingly, the post-mortem dental record will include all or most of the items given below.

**1. Basic Data:**

Case Number  
Date/time,  
jurisdiction/authority  
Location  
Putative ID, if any

**2. Body Description, General**

Approximate age  
Race, sex,  
condition

**3. Jaw Fragment(s) Description**



#### **F. Dental Examination:**

The universal tooth numbering system should be used. The record should reflect any missing dental structures or jaw fragments as well as those present and available for evaluation. The chart should illustrate as graphically as possible the following:

1. Configuration of all dental restorations (including prostheses), caries, fractures, anomalies, abrasions, implants (tooth replacement), erosions or other features for all teeth.
2. Materials used in dental restorations and prosthetic devices, when known.
3. Periodontal conditions, calculus, stain.
4. Occlusal relationships, malposed teeth; anomalous, congenitally missing and supernumerary teeth.
5. Intra oral photographs should be used to show anatomic details of teeth, restorations, periodontium, occlusion, lesions, etc.

#### **G. Narrative Description and Nomenclature**

The anatomic dental chart may be supplemented by a narrative description of the postmortem findings with particular emphasis on unusual or unique conditions. Standardized dental nomenclature should be used as follows:

##### **1. Universal Numbering System**

The system of numbering teeth that is used in the United States. The teeth are numbered from 1 to 32. The maxillary right third molar is #1, the maxillary central incisors are #8 and #9, the maxillary left third molar #16, the mandibular left third molar #17 and the mandibular right third molar is #32. The universal tooth numbering system plus the actual name of the tooth should be used (e.g. tooth #3, maxillary right first permanent molar)

##### **2. Dentition Type and Tooth Surfaces**

Primary, permanent, supernumerary, and mixed dentition. Mesial, Occlusal, Distal, Facial and Lingual surfaces (MODFL).

##### **3. Prosthetics and other Appliances**

- Crowns:** full, 3/4, 7/8, or onlay coverage restorations.
- Prosthetics:** Partial, full, or fixed dentures. Orthodontic bands, brackets, appliances, space maintainers and retainers. Mouth guards and night guards.

##### **4. The FDI Numbering System**

Odontologists should be aware of the FDI/ISO system of numbering teeth. This system is used throughout much of the world other than the United States. Quadrants are numbered from 1 to 4. The maxillary right quadrant is 1, maxillary left 2, mandibular left 3 and mandibular right 4. Teeth are numbered from the midline to the posterior. Central incisors are #1, canines #3 and third molars #8. Teeth are represented by a two digit code with the quadrant first and the tooth second. Thus, the maxillary left first molar is 26 (pronounced 2-6).



## **H. Dental Impressions**

Impressions should be considered when bitemarks, rugae patterns or other evidence warrants the procedure.

### **1. Supplies and Equipment:**

Appropriate trays, plastic or metal, which can be modified to fit the mouth  
Alginate or other American Dental Association approved dental impression material. Type III dental stone is the material of choice for pouring models. Plaster of Paris should not be used.

### **2. Impressions and Preparation of Models:**

Two sets of impressions, both maxillary and mandibular, are obtained in the conventional manner. Models should be trimmed and appropriately labeled with the case number and date. Also it is important to note that dental impressions on autopsy tables take longer to set.

## **I. Dental Radiology**

Postmortem radiographs graphically complement the visual examination/charting of the oral and perioral structures and can provide significant data essential for identification (see section III). In general, radiographs are required in cases where there is no putative ID, antemortem records have not yet been located and/or the jaws cannot be retained. Postmortem radiographs must be considered the prime method of identification. A comprehensive postmortem radiographic examination might include all or some of the following views, depending on the circumstances of the case.

### **1. Intra oral Radiographs**

Digital or analog dental bitewing and periapical radiographs of anterior and posterior teeth comparable in technique to those taken antemortem. (Bitewing views should be taken in the conventional “teeth in occlusion” manner but as an alternative periapical film can be used for separate views of the maxillary and mandibular teeth, using a horizontal bitewing angulation).

### **2. Dental Fragments, Dissociated Teeth**

Appropriate radiographs of all dental fragments, dissociated teeth, bone and restorations should be obtained. Occlusal or lateral plate film may be used for objects larger than a periapical film.

### **3. Edentulous Areas**

Periapical radiographs of edentulous arches or areas, especially the third molars, which may be impacted or previously extracted. Periapical radiographs of sockets of teeth lost postmortem should be taken, since antemortem radiographs of these same teeth may be the only evidence that becomes available.

### **4. Extra oral Radiographs**

Extra oral radiographs (e.g., lateral jaw, maxillary or frontal sinus and panoramic radiographs) are often useful.

### **5. Disposition of Radiographs**

Double pack intra oral film is recommended. One set of films should be retained by the forensic odontologist for his case file. The second set may be mounted and forwarded with a written report to the medical examiner/coroner for the master file. If digital

radiology was utilized, the odontologist should have all the digital files backed up to an external source after electronically submitting the case records.

**NOTE:** *All duplicate/digital films should bear right and left notations.*

## **II. COMPARISON OF ANTEMORTEM & POSTMORTEM EVIDENCE**

This section deals with factors which may be present in both the antemortem and postmortem dental evidence and can be useful for comparison purposes. Most dental identifications are based on restorations, caries, missing teeth and/or prosthetic devices which may be readily documented in the records. It should be noted, however, that the precipitous decrease in caries incidence in recent years will dictate greater reliance on other dental findings in the future. It is emphasized that, given adequate records, a nearly infinite number of objective factors have identification value (see Section IV). Thus, objective findings, particularly those which are unique to the individual, provide the basis for concordance or exclusion. Concomitantly, apparent discrepancies between the antemortem and postmortem evidence (e.g. errors in recording, dental treatment subsequent to the available antemortem record) must be resolved. The following subsections provide examples of objective findings in the teeth, periodontium, and/or jaws, which may be demonstrable in both antemortem and postmortem records. While the factors listed are by no means comprehensive, they may serve as a checklist and demonstrate the range of objective findings that may be applicable in difficult identification cases.

### **Dental Features Useful in Identification:**

#### **Teeth:**

Teeth present-erupted  
Teeth present-unerupted/impacted

#### **Missing Teeth:**

Congenitally missing  
Lost antemortem  
Lost perimortem/postmortem

#### **Tooth Type:**

Permanent mixed dentition  
Retained primary teeth  
Supernumerary teeth

#### **Tooth Position**

Malpositions: facial/lingual version, rotations, supra/infra positions, diastemas, other occlusal discrepancies

#### **Crown Morphology**

Size and shape of crowns  
Enamel thickness  
Location of contact points, cemento-enamel junction  
Racial variations: e.g. shovel-shaped incisors, Carabelli cusp, etc.

### **Crown Pathology**

Caries

Attrition/abrasion/erosion

Atypical variations: e.g. peg laterals, fusion/gemination, enamel pearl, multiple cusps

Dens in dente

Dentigerous cyst

### **Root Morphology**

Size, shape, number, dilaceration, divergence of roots

### **Root Pathology**

Root fracture, hypercementosis, external root resorption, root hemisections

### **Pulp Chamber and Root Canal Morphology**

Size, shape, number, secondary dentin

### **Pulp Chamber and Root Canal Pathology**

Pulp stones, dystrophic calcification

Root canal therapy: e.g. gutta percha, silver points, endo paste, nanoparticulates, posts, and retro-fill procedures

Internal resorption, apicoectomy, periapical pathology, periapical abscess/granuloma/cyst, cementoma, condensing osteitis

### **Dental Restorations**

Metallic restorations: amalgams, gold or non-precious metal crowns/inlays, endo-posts, pins, fixed prostheses, implants

Non-metallic restorations: acrylics, silicates, composites, glass ionomers, porcelain, zirconia, etc.

Partial and full removal prostheses

### **Periodontium**

Gingiva: morphology/pathology

Contour: gingival recession, focal/ diffuse enlargements, interproximal craters

Color: inflammatory changes, physiologic or pathologic pigmentations

Plaque and concretions oral hygiene status, stains, calculus

### **Periodontal Ligament: Morphology/Pathology**

Thickness

Widening (e.g. scleroderma), lateral periodontal cyst

Alveolar process and lamina dura, height/contour/density of crestal bone, thickness of inter-radicular alveolar bone exostoses, tori

Pattern of lamina dura (loss, increased density) periodontal bone loss

Trabecular bone pattern osteoporosis, radio-densities

Residual root fragments, metallic fragments

**Maxilla and Mandible:**

Anatomical landmarks/pathology

Maxillary sinuses: size, shape, retention cyst, antrolith, foreign bodies, oral-antral fistula

Relationship to adjacent teeth, anterior nasal spine, incisive canal, median palatal suture, incisive canal size, shape, cysts

Pterygoid hamulus: size, shape, fracture

Mandibular canal/mental foramen: diameter, anomalous (bifurcated) canal, relationship to adjacent teeth, coronoid and condylar process size and shape, temporomandibular joint size and shape, hypertrophy/ atrophy, ankylosis, fracture, arthritic changes

**Other pathologic processes/jaw bones:**

Developmental/fissural cysts, hemorrhagic (traumatic) bone cyst, salivary gland depression, reactive/neoplastic lesions, metabolic bone disease

Other disorders inducing focal or diffuse radiolucencies or radiopacities, evidence of orthognathic surgery or prior evidence of trauma (e.g. wire sutures, surgical pins, etc.

**III. CATEGORIES & TERMINOLOGY FOR BODY IDENTIFICATION**

**A. Positive Identification**

The antemortem and postmortem data match in sufficient detail to establish that they are from the same individual. In addition, there are no irreconcilable discrepancies.

**B. Possible Identification**

The antemortem and postmortem data have consistent features, but, due to the quality of either the postmortem remains or the antemortem evidence, it is not possible to positively establish dental identification.

**C. Insufficient Evidence**

The available information is insufficient to form the basis for a conclusion.

**D. Exclusion**

The antemortem and postmortem data are clearly inconsistent. However, it should be understood that identification by exclusion is a valid technique in certain circumstances.

NOTE: The forensic dentist is not ordinarily in a position to verify that the antemortem records are correct as to name, date, etc.; therefore, the report should state that the conclusions are based on records which are purported to represent a particular individual.

(Revised 02/2017)

## **ABFO Standards and Guidelines for Dental Age Assessment**

**These standards and guidelines are the collective effort of the American Board of Forensic Odontology, Age Assessment Committee. The use of these standards and guidelines is intended to enhance the quality of forensic dental age assessment and reporting.**

**Use of other age assessment modalities such as anthropologic methodologies should be considered if available. All age assessment methods have advantages and shortcomings, and are dependent upon the availability or existence of suitable population specific reference data.**

### **Purpose and Value**

Forensic dental age assessment results in the estimation of an individual's chronologic age through scientific evaluation of the dentition and surrounding structures. Medico-legal applications in the deceased include estimation of the age at death to narrow search parameters and thereby assist in the identification of missing and unidentified individuals. In situations involving living individuals, dental age assessment has assisted in immigration, legal age of majority and legal age of license cases. Forensic dental age assessment practitioners should utilize the developed guidelines and standards to the fullest extent applicable, practical and appropriate to ensure scientific integrity.

### **General Principles**

Method(s) to be employed depend upon the specific circumstances of each case. The analysis of fetal, infant, child, adolescent and adult dentitions may involve various techniques including gross examination, the use of radiographic analysis, histologic and biochemical evaluation. Forensic age assessment guidelines recommend approaches for estimating age giving consideration to the likely age range of the individual. Thoughtful consideration should be given to sex, ancestry, population specificity and environmental factors.

### **Definitions**

**Standards**: Established protocols that are compulsory minimal level of practice.

**Guidelines**: Recommended procedures that help direct but are not required.

The use of the words “**shall**”, “**should**” and “**must**” follows the 2003 American National Standards Institute (ANSI) ,[https://www.usug.org/answg/pdf/ANSI\\_Style\\_Guidesheet\\_-\\_2003.pdf](https://www.usug.org/answg/pdf/ANSI_Style_Guidesheet_-_2003.pdf), style guidelines on the correct form of requirements and recommendations:

- **Shall** is the correct verb form for indicating a requirement. Use **shall** for indicating a mandatory aspect or an aspect on which there is no option.

- **Should** is the correct verb form for indicating a recommendation where it is considered the best among numerous options or there is insufficient scientific evidence to definitively support its mandatory use.
- **Must is NOT a term recognized by ANSI and shall not be used**

**Dental Age Assessment:** The processes used to produce an estimation of an individual's chronologic/biologic age using dental data.

**Dental Age Estimation:** The mean age, age interval, and corresponding measure of the uncertainty that results from Dental Age Assessment.

**Technique:** A method or procedure used for age assessment.

**Study:** A detailed investigation and analysis of a specific population to relate chronologic age to dental development.

**Level of Uncertainty:** The statistical error rate that should minimally reflect 95% of a given population or two (2) Standard Deviations (SD). If SD is not the statistical error rate utilized by a published study, then the appropriate corresponding error rate used by that study should be reported.

**Prenatal/Fetal Dental Age Interval:** That interval in human dental development that occurs prior to birth.

**Infant/Child Dental Age Interval:** That interval in human dental development that includes the postnatal presence of the developing and resorbing primary dentition including the period of mixed primary and secondary dentitions.

**Adolescent Dental Age Interval:** That interval in human dental development that includes the presence of the developed and developing secondary dentition. Retained primary teeth may also be present as a special circumstance during this interval.

**Adult Dental Age Interval:** That interval in human dental development where all teeth present have completed crown/root development and are therefore considered dentally mature.

## **Standards**

1. The odontologist shall provide appropriate and accurate assessments of chronologic age utilizing scientific methodology.
2. The odontologist shall be familiar with currently recommended age assessment methods and shall utilize the appropriate age assessment method(s) for the case at hand.
3. The odontologist shall consider all available information, including sex, ancestry, population specificity, biological information and environmental factors.

4. The odontologist shall utilize the most appropriate statistical data to apply in the assessment of an individual's chronologic age.
5. When practical, the odontologist shall use multiple independent statistical methodologies and shall report the results of each independent statistical method utilized.
6. The odontologist shall precisely follow the specific methodology outlined, including morphologic staging and criteria measurements, within the study being utilized for the selected age assessment technique when estimating chronologic age.
7. When the technique utilized allows, the odontologist shall include a probability statement that the individual has attained the age in question for immigration and legal age of majority cases.

## **Guidelines**

The Odontologist **Should** Record:

1. Case Identification Data:
  - a. Case number
  - b. Referring agency (Person requesting the age estimation)
  - c. Name of the examiner(s)
  - d. Date of the examination
  - e. If known, the individual's name and stated date of birth
  - f. Other pertinent informational data
2. Biographical Information of the Individual:
  - a. Ancestry and geographic population specificity
  - b. Sex
  - c. Nutritional health
  - d. Current and prior systemic diseases
  - e. Socioeconomic status
  - f. Habits and addictions that may affect health or the maxillofacial structures
  - g. Any other environmental factors that may affect morphologic or post-formation dental and skeletal development
3. Dental Evidence Observed, Collected and Measured:
  - a. Specific teeth utilized in the evaluation.
  - b. Age assessment criteria including but not limited to:
    - i. Morphologic developmental staging
    - ii. Eruption Pattern

- iii. Root translucency, Secondary dentin apposition, attrition, periodontal health, or any other measured dental developmental or post-formation characteristics.
  - c. Occlusion
  - d. Oral hygiene
  - e. Pathology
  - f. Photographs (Document Photographer and Agency Affiliation)
  - g. Radiographs (Document Radiographer and Agency Affiliation)
4. Dental Age Assessment Methods/Techniques:

**Atlas**

Atlas dental age assessment techniques utilize diagrammatic representations of the morphologic developing tooth structures with their associated eruption pattern. Atlas techniques are non-sex specific and have a limited number of population specific data sets resulting in a higher degree of variability particularly in mid-childhood through adolescence. In addition, Atlas techniques are often derived from mixed ethnic data. Atlas techniques are particularly useful in mass disaster and clustered victim situations due to their ability to rapidly segregate child, adolescent, and adult remains into age intervals.

**Infant/Child**

Infant/Child dental age assessment techniques utilize radiographic evaluation to stage the degree of morphologic development of the primary and/or secondary dentition as well as resorption of the primary dentition. Infant/Child techniques should consider sex, ancestry, and population specificity. Therefore, these techniques will generally provide a more accurate and reliable estimate of age over eruption and atlas methodologies.

**Adolescent**

Adolescent dental age assessment techniques utilize radiographic evaluation to stage the degree of dental development toward the latter half of dental morphologic maturation. Although, the third molar exhibits the highest degree of morphologic developmental variability, it remains extremely useful in the assessment of age. While teeth other than the third molar continue to undergo morphologic development, early adolescence age assessment methodology should be utilized. Late adolescent age assessment techniques should be utilized when the third molar is the only remaining tooth continuing to undergo morphologic development. These techniques play a useful role in assisting legal authorities in determining the disposition of cases involving immigration, asylum seekers and legal age of majority or license.



## **Adult**

Adult dental age assessment techniques may utilize radiographic morphological evaluation as well as gross and microscopic observation of post-formation changes within the dentition following the cessation of morphologic dental development. Although others have been described, there are six traditional post-formation variables that have been utilized in the assessment of adult chronologic age. They are: root transparency, secondary dentin deposition, periodontal attachment, cementum apposition, attrition and root resorption. The most useful of the criteria are root transparency and secondary dentin deposition. The least valuable criterion is root resorption. Ethical considerations may restrict the use of many adult age assessment methodologies due to the requirement of sacrificing tooth structure.

## **Biochemical**

Biochemical dental age assessment techniques require the sampling of dental tissues for evaluation. Current techniques include analysis of amino acid racemization and determination of the level of radioactive carbon in dental enamel. Racemization techniques estimate age at tooth extraction or death while radioactive carbon analysis estimates the date of birth for individuals born after 1943. These techniques are useful in all age groups and offer a relatively narrow age estimation interval. However, they introduce ethical considerations for tooth sampling in the living and are laboratory procedures that require considerable time and cost to process.

## **The Forensic Dental Age Assessment Report Should Include:**

### **Introduction:**

This section provides background information which should include;

Case Identification Data

Biographical Information regarding the individual

### **Inventory of Evidence:**

This section lists all evidence received, observed and/or collected by the forensic odontologist and details the source of the evidence

### **Method(s) of Analysis:**

This section describes the analytic method(s)/scientific technique(s) and population specific data used in the dental age assessment. A list of anatomic structures analyzed, specific technique(s) utilized, and the published study where statistical data was obtained should be included in the final forensic report.

**Opinion/Conclusions:**

This section summarizes the expert's results which should include: an overall estimate of chronologic age and an estimate of chronologic age for each technique utilized, preferably with an associated age interval at a level of 95% certainty (2 standard deviations). Additionally, when appropriate to the case, a probability statement regarding an individual's attainment of specific age.

**Disclaimer:**

A disclaimer statement indicating that the opinion is subject to review and/or modification if additional information or evidence becomes available.

**Summary**

The final age assessment results from the dental provider's expert judgment by considering all available information. Conclusion statements specific to each methodology employed should include an estimated mean age and age interval and an associated level of uncertainty. When the information is available, the level of uncertainty should statistically consider 95% of the specific population, or two standard deviations. If the peer reviewed published scientific study(s) utilized to assess chronologic age do not provide a two standard deviation statistical level of uncertainty, then, the level of uncertainty defined by that study should be clearly stated in the forensic report.

**Resources:**

ABFO Supplemental Age Assessment Charts: <http://abfo.org> (Located under Resources Tab)

- ABFO Dental Age Assessment Procedures Chart
- ABFO Child/Adolescent Dental Age Assessment Technique Chart
- ABFO Adult Dental Age Assessment Technique Chart

Lewis, J.M., Senn D.R., 2013. Dental age estimation. In: Senn, DR, Weems RA (Eds), Manual of Forensic Odontology, 5<sup>th</sup> Edition. Taylor and Francis Group, Boca Raton, FL, pp. 221-255.

Harris, E.F., Mincer H.H., Anderson K.M., Senn D.R. 2010. Age estimation from oral and dental structures. In: Senn, D.R., Stimpson, P.G. (Eds), Forensic Dentistry, Second edn. Taylor and Frances Group, Boca Raton, FL, pp. 263-303.

Nelson, Stanly J., and Major M. Ash. 2010. Development and eruption of the teeth. In *Wheeler's Dental Anatomy, Physiology, and Occlusion, Ninth edn.*, 21-44. St. Louis: Saunders Elsevier.

V. Gilsanz and O. Ratib 2010. Hand Bone Age: A Digital Atlas of Skeletal Maturity, Second Edition, Springer.

[http://www.chospab.es/biblioteca/DOCUMENTOS/Atlas\\_of\\_Hand\\_Bone\\_Age.pdf](http://www.chospab.es/biblioteca/DOCUMENTOS/Atlas_of_Hand_Bone_Age.pdf)

ABFO Dental Age Assessment Workshop (Check ABFO Website for current dates):  
<http://abfo.org>

Draft Age Estimation Quicksheets™ (Assists the odontologist in calculating age, age range and rate of uncertainty using Excel Spreadsheets):  
[DAEQuicksheets@gmail.com](mailto:DAEQuicksheets@gmail.com)

UT Age Program (Assists the odontologist in calculating age, age range and % probability of having attained a specific age. For use on Adolescents with developing third molars)  
<http://logisys-consulting.com/agesetup.msi>

London Atlas of Tooth Development and Eruption 2010 Interactive Website:  
<https://atlas.dentistry.qmul.ac.uk/>

**Dental Age Research London Information Group (DARLIInG):** This assembly of pages, diagrams, numerical explanations and statistics has been written to provide a detailed and understandable explanation of the theory and practice of Dental Age Estimation. In addition, a library of Dental Age Assessment articles can be located on this web site.  
<http://www.dentalage.co.uk/>

International Organization for Forensic Odonto-Stomatology (**I.O.F.O.S.**):  
<http://www.iofos.eu/>