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Testimony on AB 867

Thank you Chairman Swearingen, Vice Chair Craig and members of the committee for allowing me to provide testimony on this legislation dealing with coroner and medical examiner reforms and training.

Coroners, medical examiners, and those who assist them in their duties perform a crucial function in our communities. Currently, Wisconsin has no training or licensure requirements for these individuals. There are some coroners and medical examiners across the state that already have training, but many do not. Currently, there are roughly 550 coroners, medical examiners, and other death investigation staff working across the state, and about 350 of them have little or no training in death investigations. Wisconsin is one of four states without any minimal requirements for death investigation training. Most other states require initial and ongoing training, or they require a coroner or medical examiner to be a medical doctor. This bill establishes a requirement that anyone performing the duties of a medical examiner or a person assisting a coroner or medical examiner must be licensed and trained under a newly created Medicolegal Investigation Examining Board. Coroners and accredited medical examiners are exempt from this requirement under the bill.

The creation of a new licensing and training board under this bill is not intended to keep individuals out of the profession, or protect the jobs of those currently serving. Coroners and Medical Examiners play a crucial role in both our criminal justice and public health systems. Making sure the individuals investigating the cause and manner of deaths in our state are trained properly is crucial to death certificate accuracy. Accurate death investigations provide important evidence in trials to convict criminals, protect the innocent, and help in civil litigation. Without any training, it is more likely a coroner or medical examiner could miss crucial details that might allow a murder to go unsolved, or a drug overdose to be misdiagnosed.

Because we require no minimal level of training, Wisconsin is lagging behind other states. At one of the most vulnerable and sensitive times in a family's life, it is vitally important to have someone who is properly trained conducting the death investigating. The changes made in this bill will help coroners, medical examiners, and their staff do their jobs more efficiently and effectively.

In addition to the creation of the examining board and training and licensure requirements, this bill makes changes to the statutes governing death investigations, notification of deaths,

reporting requirements, and the disposition of remains. Many of these statutes have not been reformed for many years. We worked with stakeholders that would be impacted by the changes proposed in our initial draft of this bill and had a healthy discussion. We will be introducing a substitute amendment to address some of the concerns that were raised. Some of the language changes will be removed from the bill and negotiated next session.

We are also working with the Department of Safety and Professional Services and the Department of Health Services on tweaks to the funding model in the bill.

The creation of the examining board, training and licensure requirements, and statutory reforms outlined in this bill come at the request of the coroners and medical examiners from across Wisconsin. Moving forward, they believe it is crucial that the individuals performing these important death investigation roles are properly trained and educated.

STATE REPRESENTATIVE
Katrina Shankland
ASSISTANT DEMOCRATIC LEADER
71st ASSEMBLY DISTRICT

Testimony in Support of Assembly Bill 867

Assembly Committee on State Affairs and Government Operations
February 10, 2016

Chairman Swearingen and members of the committee, I appreciate this opportunity to testify in support of Assembly Bill 867, legislation to update standards and training requirements for coroners and medical examiners.

Under current law, coroners are elected officials who are not required to have specialized knowledge or training in death investigations. Yet coroners and medical examiners carry a tremendous responsibility when they carry out their duties. They discover evidence that is used in criminal cases and civil litigation, uncover safety violations, and influence public health statistics through the death certificates they complete.

Just as it is required that District Attorneys hold a law degree, so should it be that coroners undergo basic training upon election so they may adequately perform their job duties to the best of their ability as they serve the public. While it's important to recognize that most of Wisconsin's coroners and medical examiners are professional and take their job seriously, in some cases, we have seen irresponsible and dangerous behavior.

In 2011, the Rock County coroner ruled a death an accident that was later ruled a homicide by a forensic pathologist. Unfortunately, the case is unresolved. In addition, a colleague of the coroner was convicted of stealing medication from the deceased. Another example is even more shocking: a former Oneida County medical examiner was found guilty of two counts of misconduct in public office for taking a cadaver spine and human tissue from autopsies to train her dog.

We can prevent these kind of incidents from happening by setting clear standards and requirements for anyone conducting a death investigation in order to maintain the integrity of the investigation and ensure it is medically sound. Assembly Bill 867 would establish standards for death investigations, create a Medicolegal Investigation Examining Board to oversee licensing, and specify training requirements for coroners. These measures would provide coroners and medical examiners with the support and skills to best serve their constituents, which is crucial for criminal investigations and the emotional healing of families with deceased loved ones.

Last legislative session, the Assembly Committee on State Affairs and Government Operations heard from a family who was still haunted by the death of their loved one due to an inadequate death investigation. A man in Monroe County died after a fall the family members deemed suspicious, but the coroner allowed the body to be cremated before the authorities could collect evidence that would be necessary to rule out foul play. For surviving families like theirs who deserve answers and have missed out on financial recourse like life insurance, I ask for your support of this legislation. It's been a long time coming.

For at least a decade, Wisconsin's coroners and medical examiners have been advocating for this needed legislation that will benefit their profession in multiple ways. Rep. Schraa and I have worked closely with the Wisconsin Coroner & Medical Examiner Association and multiple other stakeholder groups to ensure that Assembly Bill 867 addresses the glaring need for uniform medicolegal standards and training requirements without infringing on other professions.

We appreciate the committee's patience as you understand that the substitute amendment – which focuses on the training requirements – is still pending. It's important to know that the stakeholder groups who would be most affected by Assembly Bill 867 are registering neutral on the bill once the substitute amendment is introduced.

Wisconsin is one of only five states that requires no death investigative training for coroners and medical examiners. It's time for this to change – the stakes are too high. I ask for the committee's support of Assembly Bill 867. Thank you.

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Cold Case: Homicide first ruled accidental death

No answers in 2011 Rock Co. woman's death

Author: Jennifer Hoff, jhoff@wisctv.com
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BELOIT, Wis. -

Two years and there are still no answers in a Rock County woman's death.

Marjorie Sands' family found her dead on her bedroom floor. The coroner ruled it an accident, but officials say it wasn't.

The Sands' family said the case might never be solved.

Several days after 91-year-old Sands was buried, her family found something suspicious. It was suspicious enough for authorities to exhume her body. The Rock County coroner never performed an autopsy, and Sands' son said, had she, it would have been clear Marjorie didn't accidentally fall out of her bed and die.

"There were some things that just didn't add up at first, but we figured (the coroner's office) knew what they were doing. They're the ones that should make the call," said Marjorie's son Kenneth Sands.

The coroner, Jenifer Keach, said Marjorie Sands suffered injuries consistent with a fall.

"There was no further investigation of the body, looking for possible injuries or anything like that," said Kenneth Sands. "I just felt like the coroner's office mishandled that right from the start."

"Unfortunately an autopsy wasn't done in this case and it would have shown that it wasn't as it was originally thought to be," said Rock County Sheriff's Office Capt. Todd Christiansen.

Christiansen said it's too expensive to autopsy every death in Rock County. Last year, Keach said her office investigated 783 cases and at $1,450 a piece, that would cost taxpayers more than $1 million. Instead, Keach said she autopsies 10 percent of cases based not on a set of rules, but rather her experience.

The former nurse was elected coroner in 2005 and performs autopsies based on "pertinent information particular to each case," and in Sands' case, that information came too late.

Christiansen refused to explain the new information that came forward five days after Sands' funeral. He said releasing it could jeopardize the case. But its significance could be seen in what happened next.

"You have to have some pretty good reasons why you're going to dig somebody up," said Christiansen.

In a rare move, the sheriff's office exhumed Sands' body.

A Dane County forensic pathologist performed an autopsy that caught inconsistencies in Sands' original cause of death. Kenneth Sands said his mother had severe internal injuries and her death has since been classified as a homicide.

"We do have some physical evidence, but I think had we been able to do a thorough search of the scene the day she was found, we probably would have had more," said Christiansen.

While there have been few leads in two years, Christiansen is still hopeful, since some information came in as early as two weeks ago.

"We want to come to a conclusion," said Christiansen. "It's just going to take that right piece of information to come forward."

As for Marjorie Sands' son, the situation is still unsettling. He said he wants justice, but until this Wisconsin cold case is closed, he'll work to keep his mother's memory alive.

"A lot of people don't make it close to their 90s and when they do, you feel fortunate you've had them that long," said Kenneth Sands. "But it shouldn't end like that."

Keach refused our on-camera interview request, but said by phone, it's tragic the family blames anyone but Marjorie's murderer. And said her office did the best it could with what it had.

Keach, though, is out of a job come 2015 after the County Board and voters weighed in to appoint a medical examiner instead.

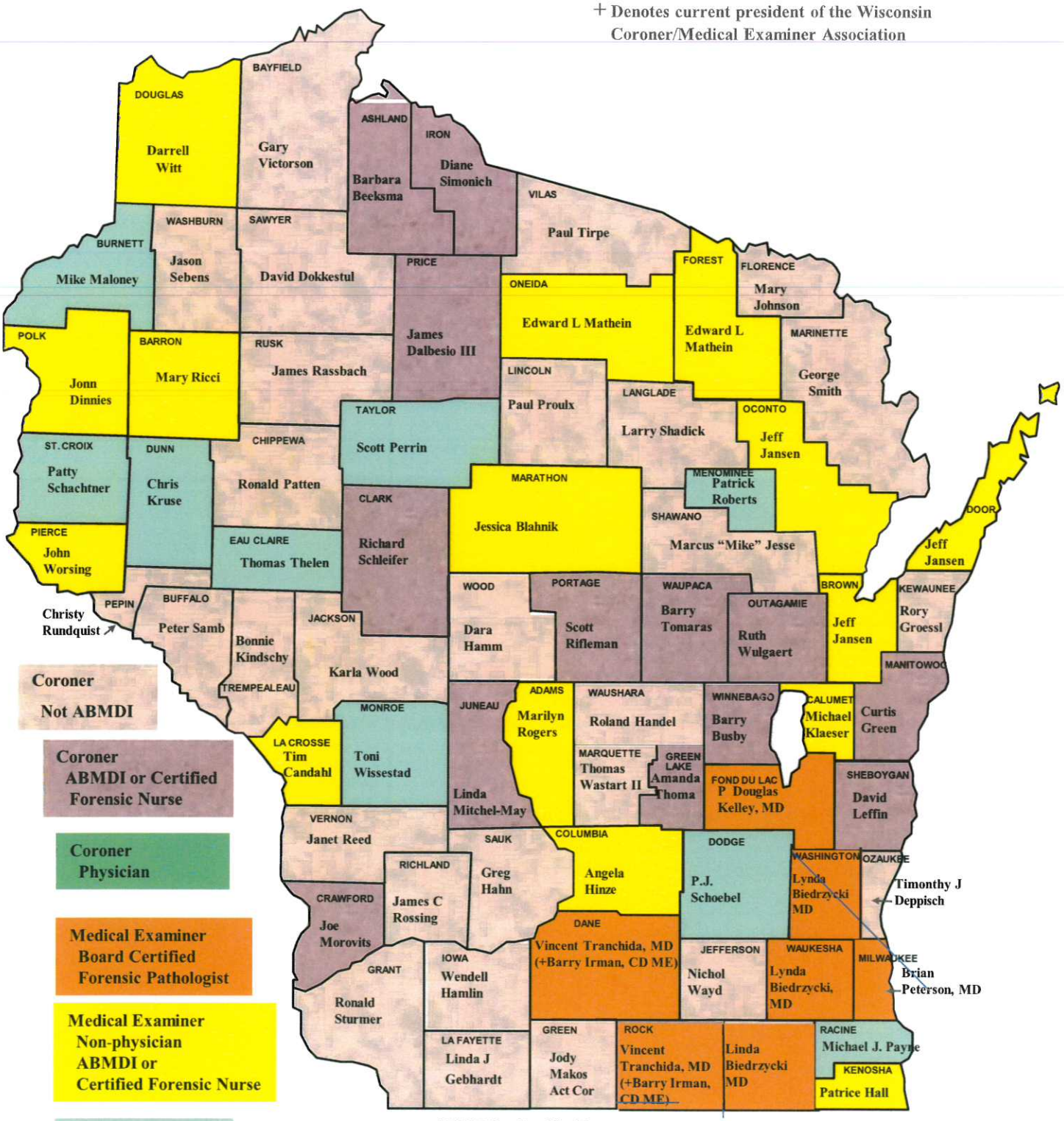
The Sheriff's Office declined to speculate about a motive, but said there weren't any signs of a break-in at Marjorie's house only adding to the mystery.

If you can help crack the case, you can anonymously call the Rock County Sheriff' Office at (608) 757-2244.

DEPARTMENT OF HEALTH SERVICES
Division of Public Health
State Vital Records Office

Wisconsin Coroners and Medical Examiners, April 2015

+ Denotes current president of the Wisconsin Coroner/Medical Examiner Association



Coroner
Not ABMDI

Coroner
ABMDI or Certified Forensic Nurse

Coroner
Physician

Medical Examiner
Board Certified Forensic Pathologist

Medical Examiner
Non-physician
ABMDI or Certified Forensic Nurse

Medical Examiner
Non-physician
Not ABMDI

ABMDI = Certified by the American Board of Medicolegal Death Investigators

Changes to Rule 979

Currently in Wisconsin an elected coroner is not required to have any death investigation training at all. Many states are moving towards a medical examiner system, but the process has been slowed by the reality that coroners are usually written into a state constitution, are often backed by a local constituency and generally don't have large enough populations nor budgets to support the conversion. Simply put, changing the entire system to a medical examiner system is not practical. Hospitals are accredited. Barbers are accredited, Massage therapist are accredited. But the final safety net to the public and the deceased is required to have no training or accreditation to be able to correctly do their job.

Mortality data are the United States most complete and timely data because the database is comprised from death certificates which are universal in coverage. It is the key database for epidemiologic, demographic, historic research and public policy. It is used to target government resources, justify governmental actions, and monitor the consequences of government action or inaction . State and local policy and resource allocation in the areas of maternal and child health, highway safety, clean air, smoking, and programs involving cancer, diabetes, and heart disease rely extensively on mortality data.

Coroners influence public health by the volume of death certificates they complete. Medical examiners and coroners certify approximately 30% of the deaths in the United States (Hanzlick & Parrish, 2006). In a study completed in 1999 in South Carolina, 40% of the suspicious deaths that coroners investigated listed the cause of death as heart disease. The study showed that the percentage dropped substantially after training was implemented. (Voeker, 1995). This makes one question if coroner error could be inflating coronary disease statistics.

Death investigations provide evidence to convict the guilty, protect the innocent, and aid in civil litigation. They also uncover unsafe conditions that could potentially save lives, expose design flaws, material defect and human error. Results from medicolegal death investigations have led to improvements or creation of products that save lives. Some examples include child car seats, baby cribs, toys, seat belts and air bags.

Wisconsin is one of five states that requires no death investigative training for coroners and medical examiners.

Good Morning [members of the Committee?...]

Thank you for the opportunity to speak before you today. The question being asked today is two-fold: first, does the state of medicolegal death investigation in the WI today warrant legislative mandate for licensure and training of medicolegal death investigators; and second, whether the time, funding and effort to establish and maintain this training will be for the benefit of the people of WI today and in the future. I am here as a representative of the forensic medical community of WI to give a resounding "yes" to both parts of that question.

In their 2009 report, "Strengthening Forensic Sciences in the United States: A Path Forward", the National Research Council insinuated lack of standardized academic rigor in the forensic community through its emphasis on the need for accreditation, certification, training and education. In order to understand the role of medicolegal death investigation in the United States, the SWGMDI conducted a survey of the nation's medical examiner, coroner, justice of the peace, and sheriff-coroner systems to identify the roles of practitioners in each office, their educational background, their certification/accreditation status, and to assess the minimal educational requirements for each job title found.

Their results are not surprising to those of us who work in the field of death investigation. Namely, the SWGMDI reported that there are numerous inconsistencies in the practice of medicolegal death investigation in the country. Not surprisingly, those offices covering large, urban populations, associated with large, well-funded systems tended to have a greater number of certified personnel and to follow established guidelines and best practices. Smaller jurisdictions, on the other hand, were left to

either their own enthusiasm for knowledge, or "on-the-job" training provided by department heads with little to no training of their own.

Here in Wisconsin, there are 12 – soon to be 13, forensic pathologists practicing in four major Medical Examiner Offices. Three of these are concentrated in the southeastern corner of WI. These offices practice under accreditation standards or best practice guidelines, with continued education through conferences, lectures, and seminars mandated by their credential Boards (NAME or ABMDI). The rest of the state relies on the experience and knowledge of lay medical examiner and coroner lead systems. The funding of these offices is dependent on changing political figures, smaller budgets, a smaller community from which to draw their applicant pool , and limited access to educational resources. And yet, these same people are tasked by the State and their local jurisdiction to perform the same job as forensic pathologists do, on cases of exactly the same level of complexity and importance. I have yet to meet a coroner or medical examiner who has entered this profession out of love of fame or money. The men and women who commit to death investigation do so out of a desire to serve the families of their communities at what is likely the worst time of their lives. And they do so at all hours of the day and night, under extremes of WI weather, to the best of their abilities. And the best of their abilities is the crux of the discussion here today.

Who among us can stand up right now and list, in detail, what they DON'T know? Surely, we can all state what we'd like to learn, or what we feel we could improve on. But the knowledge of one's ignorance requires a level of self-awareness that is by definition absent in any student. We simply don't know what we don't know. And we can't find out unless we have a baseline by which to gauge our knowledge. On the national level, there are Accrediting Boards of medicine, forensic science and death

investigation; the NIST and the OSAC, associations like the NAME which provide those "bumpers". The purpose of this bill, and the introduction of mandatory training for any death investigator in WI, is to ensure that the death scene is not the first place where an investigator discovers s/he does not have the skill set to help the family or law enforcement.

"A" cause of death is not necessarily "The" cause of death. The classic signs of a heart attack due to natural progression of coronary disease can and are mimicked by the classic signs of a heart attack due to cocaine intoxication. It doesn't necessarily require a physician to uncover the underlying causes. But it does require knowing which questions to ask, which medications to look for, the meaning of scratches or punctures on the arms, the significance of a broken pen and some strange ashes, or knowledge that plants don't need those 10 packets of "vitamins" that were bought at the gas station, in order to determine the course and scope of the investigation, and to ensure that a scene is preserved and processed to the benefit of the decedent and family. There is a term in medicine WNL, which stands for Within Normal Limits. One certain forensic television show depicted a disillusioned examiner restating that acronym to her colleagues...We Never Looked. It won't matter how many pathologists, lawyers, or law enforcement officers review a case that was never recognized for what it was at the time is was first encountered. We only have one chance to do things correctly on a death scene. And that requires trained investigators who have a right to be confident in their skill set.

Introducing mandatory training in WI is necessary. Preliminary qualification by means of certification provides the guidelines by which death investigators will assess and process a death scene independent of the information being provided. That ability to assess a death scene facilitates not only proper information gathering, involvement of the proper authorities, and documentation without disturbing

the scene. It allocates precious resources by the law enforcement community to cases which truly require it, while limiting them when natural causes can safely be identified. Proper death investigation promotes cooperation between agencies and instills confidence in the profession from members of the community. Training provides the guidelines by which death investigators can measure unusual circumstances, and provide them with those "bumpers" they would need to uphold a standard of care even when faced with a difficult investigation. And equally importantly, proper death investigation positively affects the families of the decedent. A focused and detailed death investigation facilitates reunification of families with their loved ones. It allows the family to understand the next steps, and be prepared for the logistical challenges of the event. It allows them to grieve for a death they understand, and not one they are afraid of.

In a time of distrust between law enforcement and the community, there is more need than ever to have qualified, trained, and licensed practitioners of death investigation. As technology advances, and as the forensic community develops stringent criteria of investigation to ensure the validity of examinations, the people involved in the investigative process must have the foundational knowledge which will allow them to advance with it. The people of WI deserve the respect of qualified, trained death investigators when such people are needed. And those individual who step up to that role deserve the have the tools to perform that task, as well as the validation for their hard work and experience through credentialed licensure.

Thank you for your time.

Many states have amended their law to address education and continuing education for Coroners. Coroner training is mandated in all but five of the twenty eight states that utilize non- physician coroners. Ten states have a hybrid Coroner Medical Examiner system similar to Wisconsin, of which Texas is the only other state that does not have training within this type of system.

The majority of the states provide a one week medicolegal death investigation course for all newly elected coroners within six months to one year of taking office and an average of sixteen hours of annual continuing education. Some state legislation requires their coroners and deputy coroners to become certified. Most state's legislation developed a State Coroner's Board or Training Commission that outlined the powers and duties of the board or commission.

Included in the duties are the provisions to develop coroner training standards for the states, although, Indiana's legislation outlines the specific training topics. There are currently twenty eight states that have coroners in some or all counties. Four states require the coroner to be a physician. The coroner training requirements of the remaining twenty four states are summarized on the following pages. Only five of these twenty eight states do not require training.

The states that border Wisconsin all require training for the person responsible for death investigation in their states. Training has the potential to enhance the mortality trend monitoring and the vital statistics qualities recorded in Wisconsin and in turn enhance the health of Wisconsin. Mass casualty training can provide coroners with the specialized skills and knowledge needed in the event of a natural or man-made disaster, improving the confidence of the citizens of Wisconsin in our government institutions preparedness and ability to respond to disasters. Training will optimally facilitate accuracy of death investigations by providing a standard for coroners. The job of coroner is much more than completing a death certificate. Their role has evolved into a role that serves not only the criminal justice system, but has an enormous effect on public health research, allocation of funds, and prioritizing of programs at the local, state and national levels.

CORONER TRAINING REQUIREMENTS BY STATE

State	System	Coroners Elected/ Appointed	Training Required	Initial	Annual
Alabama	ME in some counties; coroners in others	ELECTED	YES	12 hrs.	12 hrs.
Arkansas	State ME: Coroners in every county	Elected/Appt.	None	0	0
California	Hybrid Coroner/ME	Elected/Appt.	Yes	Basic Course	24 hrs. 2 years
New York	ME/Coroner Hybrid	Elected and Appt.	Yes	54 CEU (36 from State Association) for certification	36 CEU (18 from state Association) for certification
North Carolina	State ME: Coroners in 3 counties others converted to MD serving as ME	Appointed	Yes if not MD	0	0
North Dakota	All Coroners MD's		n/a	n/a	
Ohio	Hybrid Coroner; ME	Elected	Yes	16hr.	36 hrs. over 4 year term
Pennsylvania	Hybrid ME; Coroner	Elected	Yes	32-40 Basic Training before taking office	8hrs.
South Carolina	Hybrid ME; Coroner	Elected	Yes	Basic Training by Law Enforcement	16 hrs.
South Dakota	Coroner Only	Elected	Yes	16 hrs. Basic Training by Law Enforcement	8 hrs.
Texas	Hybrid System (Some are Justice of the Peace)	Elected	None	0	0

Washington	Hybrid Coroner; ME	Elected	Yes	5 day course provided by Association	mandatory training provided by Association
Wisconsin	Hybrid	Elected/Appt.	None	0/Dropped in previous session	0
Wyoming	Coroners	Elected	Yes	40 basic course	16 hrs.
Colorado	Coroners only every county	Elected	Yes	40 hr. Certification	6 hrs.
Georgia	State ME; coroners in some counties	Elected	Yes	Basic Training Course	16 hrs.
Idaho	Coroners in every County	Elected	Yes	Coroner School W/I 1yr	24 hrs.
Illinois	ME Coroner Hybrid	Elected	Yes	40 hrs.	24 hrs.
Indiana	Coroners Only	Elected	Yes	40 hr. certification W/I 6mos. Deputy Certification W/I 12 MO	8 hrs.
Kansas	All Coroners MD's		n/a	n/a	
Kentucky	State ME; Coroner in every county	Elected	Yes	40 hrs. Medical Death Investigative Training	18 hrs.
Louisiana	All Coroners Required MD				
Minnesota	All Coroners MD's				
Mississippi	State ME; Coroner in every County	Elected	Yes	40 hrs. basic 8-16 hrs. advanced every 4 yrs.	24 hrs.
Missouri	Hybrid	Elected	Yes	20 Mediolegal Death Investigation	20 hrs.
Montana	State ME; Coroner in every County	Elected	Yes	40 coroner basic course	24 hrs.

Nebraska	Coroner (County Attorney is Coroner)	Elected	Yes	None	None
Nevada	Sheriff is coroner	Elected/Appt.	Police Training	Police Training	Police Training