2009 SENATE HUMAN SERVICES

SB 2168

2009 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. SB 2168

Senate Human Services Committee

☐ Check here for Conference Committee

Hearing Date: 1-21-09

Recorder Job Number: 7445, 7465

Committee Clerk Signature Mary K Monson

Minutes:

Senator J. Lee opened the hearing on SB 2168 relating to the confidentiality of autopsy reports.

Senator J. Lee (District #13) introduced SB 2168. This is a rewrite of antiquated statutes. There has been a task force made up of stakeholders of every sort with any kind of involvement with this issue meeting to put this together.

Dr. John Baird (Field Medical Officer for the ND Department of Health) testified in support of SB 2168. Attachment #1.

Senator J. Lee said there are some media that are quick to request a court order for a death report. She asked what protection there is for a family so that what might be considered less official data isn't on the news the next day.

Dr. Baird said his feeling was that if a court orders he would have to release it.

Senator J. Lee asked if he thought there was more protection for the family's privacy in the way this is written now.

Dr. Baird said very much so.

Senator Dever asked if pictures are available to the family if they want them.

Cynthia Feland (Assistant States Attorney in Burleigh County) answered the question by saying that if there isn't an act of criminal prosecution and a family requests photographs they can meet with the medical examiner and view the pictures. The pictures are on slides. She went on to explain the process if there was an act of criminal prosecution.

Senator Dever pointed out the misspelling of the word decedent in the bill.

Senator Heckaman asked if this would increase the county budgets of those counties that don't have an official coroner.

Dr. Baird said that all counties are required to have an official coroner. Some counties have not been able to appoint one and then the sheriff acts as coroner. It would still be possible for the sheriff to act as coroner.

The committee recessed.

Job #7465

Senator J. Lee reconvened the hearing on SB 2168.

Mike Mullen (Assistant Attorney General) talked about how this bill fits in with the HIPA privacy rules. Under current law it is sort of an unequal playing field because the state forensic examiner is an office within the state department of health. The state department of health is a covered entity under the HIPA privacy rule. Therefore, any reports that are created or maintained by the state forensic examiner are confidential and may only be disclosed as permitted in the HIPA privacy rule. The privacy rule specifically provides that a covered entity must comply with the HIPA privacy rule with respect to the protected health information of a deceased individual. Autopsy reports created by a hospital are confidential records. With respect to county coroners, they are not covered entities so their records are not subject to the privacy rule. This legislation attempts to create a level field. He went on to talk about the difference in the autopsy report and the autopsy findings.

Senator J. Lee asked what happens when the media asks for things they really don't need.

Mr. Mullen said that if an act of criminal investigation is going on the courts should look at the structure of this act. It would have to be some exceptional situation where they would order the disclosure for reasons that aren't included in the bill,.

Discussion continued on the disclosure of information.

Jack McDonald (ND Newspaper Assoc. & ND Broadcasters Assoc.) testified that they support the bill. This sets out the ground rules of what is available and what is open and what is not open and who gets the full information. Basically autopsy photos are confidential and can't be released. Even the family can only view the slides.

Senator Dever asked if these restrictions only apply to the autopsy or are pictures taken in the investigation considered to be part of the autopsy report.

Mr. McDonald said it probably depends on who took the pictures.

Cynthia Feland (Burleigh County States Attorneys Office) testified that on the who they support the bill but there are a few provisions they have concerns about. Specifically on page 4 lines 23-24 there is a reference that a death of a minor must be reported to the Dept. of Human Services. She offered a proposed amendment – Attachment #2. She then addressed their concerns.

She provided copies of a completed "Report of Death" (Attachment #3) and a copy of a blank "Report of Autopsy" (Attachment #4) and a completer "Autopsy Report" (Attachment #5). She explained the differences in these reports and what they intend to disclose and what should remain confidential. She said they want the Autopsy Report to remain confidential and explained why.

She asked that the terminology be real clear and to use the terminology that is actually on the documents.

Aaron Birst (Association of Counties) testified in support of SB 2168. This bill moves law enforcement in the right direction, gets better training for the people who do these things (whoever is designated for that position).

Senator Dever. asked if the county commissioners can appoint somebody from an adjacent county.

Mr. Birst said from the Assoc. of Counties standpoint, if that is the most effective and provides the same service, it would be ok.

A short discussion followed on who would serve in the absence of the coroner.

Marlys Baker (Dept. of Human Services) testified in support of SB 2168. Attachment #6.

She also pointed out that she would be opposed to the amendment by Cynthia Feland.

Cindy Willey provided testimony on SB 2168 – Attachment #7.

Opposing Testimony.

John Val Emter – testified as a concerned citizen.

There was no neutral testimony.

Senator J. Lee asked Dr. Baird if there were any comments from the Task Force about the amendment proposed by Cynthia Feland and the way of interpreting the language.

Dr. Baird said he didn't remember any discussions at that time.

Senator J. Lee asked Mr. Mullen and Ms. Feland who agreed to work on an amendment to include Ms. Baker so if she had concerns they could also be addressed.

Senator Dever asked about the amendment and child deaths.

Ms. Baker explained how the process works and the records that are requested and where they are requested from. She explained what problems arise when they can't get the information they need in a timely manner.

Ms. Feland said they have had requests made of their office where they have declined to provide the information. They have a problem disclosing the information until the prosecution is done. They have had cases in the past where information has been disclosed through inadvertent channels (intentional or unintentional). They have no problem providing the initial information or the information listed on the report of death, but the detailed information at this point they have concerns about.

Senator J. Lee asked Ms. Baker if the notice of death without the details is enough information to do some of their work.

Ms. Baker said they aren't. The facts on the face sheet are very little of any more information than what they receive from vital records.

Senator J. Lee asked if a lot of counties won't send in the reports.

Ms. Baker said it is usually 1-3 cases a year. It varies according to the prosecutor. It tends to be the larger counties.

The hearing on SB 2168 was closed.

2009 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. SB 2168

Senate Human Services Committee

☐ Check here for Conference Committee

Hearing Date: 1-28-09

Recorder Job Number: 8048

Committee Clerk Signature Mary K Monson

Minutes:

Senator J. Lee opened SB 2168 for committee work.

An amendment from Cynthia Feland was submitted (Attachment #8).

Mr. Mullen explained that he had seen the amendments and had consulted with the Dept. of Human Services who said they can accept the amendments. He reported that Dr. Baird and the task force signed off on the other amendments. He explained the amendment by Cynthia Feland.

Senator J. Lee said they had three separate amendments in front of them. (1) the Feland amendment (2) the Board of Nursing amendment because that's beyond their scope of practice (attachment #9) and (3) the amendment dated 1/22/09 (attachment #10).

It didn't sound like there were any objections to any of them.

Senator J. Lee asked the intern to combine the three amendments into one amendment for the committee to look at.

Committee work was adjourned.

Additional information – Attachment #11.

2009 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. SB 2168

Senate Human Services Committee

☐ Check here for Conference Committee

Hearing Date: 2-02-09

Recorder Job Number: 8327 (Meter 01:45)

Committee Clerk Signature	Mary K Monson

Minutes:

Senator J. Lee opened SB 2168 for committee work.

There was clarification that the amendment being considered was a combination of three.

The amendment includes (1) concerns of Cynthia Feland (2) clarifying what the report was and (3) eliminating licensed practical nurse and specialty practice nurse and registered nurse because that's outside their scope of practice.

There was also discussion to include in the amendment replacing decendant with decedent in several areas.

Senator Heckaman moved to accept the amendments to SB 2168.

Seconded by **Senator Marcellais**.

Roll call vote 6-0-0. **Amendment adopted**.

Senator Heckaman moved a **Do Pass as amended**.

Seconded by **Senator Marcellais**.

Roll call vote 6-0-0. Motion passed.

Carrier is **Senator J. Lee**.

2-2-09

PROPOSED AMENDMENTS TO SB 2168

Page 3, line 13, replace the first comma with "or" and remove "specialty practice"

Page 3, line 14, remove "registered nurse, or licensed practical nurse"

Page 5, line 23, remove "autopsy"

Page 5, line 24, replace "findings" with "report of death"

Page 6, line 25, replace "Autopsy findings" with "Report of Death"

Page 6, line 28, replace "final findings" with "report of death"

Page 7, line 2, remove "final"

Page 10, line 18, replace "Final autopsy findings" with "Report of death" and after "the" remove "final"

Page 10, line 19, after "death" insert "that is the face page of the autopsy report identifying the decedent and stating the cause of death and manner of death"

Page 10, line 23, remove "Final"

Page 10, line 24, replace "autopsy findings are" with "The report of death is"

Page 10, line 30, remove "final"

Page 11, line 12, after "fault" insert "if there is no active criminal investigation"

Page 11, line 13, after "panel" insert "if there is no active criminal investigation"

Page 11, line 16, remove "final"

Page 11, line 23, after "company" insert "if there is no active criminal investigation"

Renumber accordingly

Adopted by the Human Services Committee
February 2, 2009

2-4-7

PROPOSED AMENDMENTS TO SENATE BILL NO. 2168

Page 3, line 13, replace the first comma with "or" and remove ", specialty practice"

Page 3, line 14, remove "registered nurse, or licensed practical nurse"

Page 5, line 23, replace "autopsy" with "a report of death"

Page 5, line 24, remove "findings"

Page 6, line 25, replace "Autopsy findings" with "A report of death"

Page 6, line 28, replace "final findings" with "report of death"

Page 7, line 2, remove "final"

Page 10, line 18, replace "Final autopsy findings" with "Report of death" and remove "final"

Page 10, line 21, after "examiner" insert "and which is the face page of the autopsy report identifying the decedent and stating the cause of death and manner of death"

Page 10, line 23, replace "Final" with "The report of death is"

Page 10, line 24, remove "autopsy findings are"

Page 10, line 30, remove "final"

Page 11, line 12, after "fault" insert "if there is no criminal investigation"

Page 11, line 13, after "panel" insert "if there is no active criminal investigation"

Page 11, line 16, remove "final"

Page 11, line 17, replace the first "decendent's" with "decedent's" and replace the second "decendent's" with "decedent's"

Page 11, line 22, replace "decendent's" with "decedent's"

Page 11, line 23, after "company" insert "if there is no active criminal investigation"

Page 11, line 27, replace "decendent's" with "decedent's"

Renumber accordingly

Date: 2-2-09

Roll Call Vote #: 1

2009 SENATE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. SB 2168

Senate Human Services Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number Amendment

Action Taken ☐ Do Pass ☐ Do Not Pass ☒ Amended ☐ Rerefer to Appropriations

Motion Made By Sen. Heckaman Seconded By Sen. Marcellais

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee, Chairman	✓		Senator Joan Heckaman	✓	
Senator Robert Erbele, V.Chair	✓		Senator Richard Marcellais	✓	
Senator Dick Dever	✓		Senator Jim Pomeroy	✓	

Total (Yes) 6 No 0

Absent 0

Floor Assignment

If the vote is on an amendment, briefly indicate intent:

Date: 2-2-09

Roll Call Vote #: 2

2009 SENATE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. SB 2168

Senate Human Services Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number 90275.0201 Title .0300

Action Taken ☒ Do Pass ☐ Do Not Pass ☒ Amended

Motion Made By Sen. Heckaman Seconded By Sen. Marcellais

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee, Chairman	✓		Senator Joan Heckaman	✓	
Senator Robert Erbele, V.Chair	✓		Senator Richard Marcellais	✓	
Senator Dick Dever	✓		Senator Jim Pomeroy	✓	

Total (Yes) 6 No 0

Absent 0

Floor Assignment Senator J. Lee

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SB 2168: Human Services Committee (Sen. J. Lee, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (6 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). SB 2168 was placed on the Sixth order on the calendar.

Page 3, line 13, replace the first comma with "or" and remove ", specialty practice"

Page 3, line 14, remove "registered nurse, or licensed practical nurse"

Page 5, line 23, replace "autopsy" with "a report of death"

Page 5, line 24, remove "findings"

Page 6, line 25, replace "Autopsy findings" with "A report of death"

Page 6, line 28, replace "final findings" with "report of death"

Page 7, line 2, remove "final"

Page 10, line 18, replace "Final autopsy findings" with "Report of death" and remove "final"

Page 10, line 21, after "examiner" insert "and which is the face page of the autopsy report identifying the decedent and stating the cause of death and manner of death"

Page 10, line 23, replace "Final" with "The report of death is"

Page 10, line 24, remove "autopsy findings are"

Page 10, line 30, remove "final"

Page 11, line 12, after "fault" insert "if there is no criminal investigation"

Page 11, line 13, after "panel" insert "if there is no active criminal investigation"

Page 11, line 16, remove "final"

Page 11, line 17, replace the first "decendent's" with "decedent's" and replace the second "decendent's" with "decedent's"

Page 11, line 22, replace "decendent's" with "decedent's"

Page 11, line 23, after "company" insert "if there is no active criminal investigation"

Page 11, line 27, replace "decendent's" with "decedent's"

Renumber accordingly

2009 HOUSE HUMAN SERVICES

SB 2168

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. **SB 2168**

House Human Services Committee

☐ Check here for Conference Committee

Hearing Date: **3 March 2009**

Recorder Job Number: 10107

Committee Clerk Signature

Minutes:

Chairman Weisz opened the hearing of SB 2168.

Senator Judy Lee, District 32, introduced the bill. This updates the statutes by changing some of the terms used reporting timelines that are outdated, clarifies the state forensic examiner's role in oversight of the state's death investigation system and protect confidentiality of personal medical information.

Dr. John Baird, Field Medical Officer for the ND Department of Health and Cass County Coroner, testified in favor the bill. **(Attachment 1)** His testimony contained proposed amendments.

Representative Conrad: Do you have trouble finding coroners?

Dr. Smith: Yes, it can be a real problem especially in some of the smaller counties. The statutes say that in the absence of a coroner the sheriff acts as the coroner. The sheriffs find that very difficult because they don't medical experience.

Representative Conrad: Do you have any suggestions on how we can improve that system?

Dr. Smith: The training aspect is one part of it. Others things that we have been doing besides this bill is the coroner in Minot and myself have been polling the coroners in the state

and we are looking at ways to have training session and have an association to communicate with each other.

Chairman Weisz: You said the state examiner performs 240 autopsies. Are all of those in small counties?

Dr. Smith: Those are from all over the state because even in Fargo the local pathologists don't like doing coroner autopsies because they don't want to get involved in legal matters. Oftentimes, especially if it's an accident, suspicious circumstance, or we are not sure what happened, we get a better legal autopsy done by the forensic medical examiner who is looking for things a medical pathologist wouldn't look for because they are just looking for disease not for suspicious causes.

Chairman Weisz: Have you a breakdown of counties smaller than 8,000 or greater than 8,000. That might be helpful.

Unidentified: I can tell you that Cass County has probably around 60-70, McKenzie about 50-60, Stark about 22. The larger counties have more deaths so they have more autopsies.

Representative Nathe: In your testimony on the second page you talked about the coroner's record reports deaths is the state forensic examiner but they are not doing it routinely. Why is that?

Dr. Smith: It has never been enforced and there is no way to really enforce it. The forensic examiner's office has attempted to go through death certificates and try to get a picture of what is going on. They are developing a reporting form that would be given to all the coroners and give them a better avenue as to how to submit those reports. It is more of a coroner's worksheet outlining details of the death.

Representative Nathe: As far as the report of death—the public record, how does somebody access that information.

Smith: The request can go to the coroner or to the forensic examiner and anyone can ask for it. It is public record.

Representative Damschen: This has language that says the minor must be reported to the Department of Human Services, does that mean every death or just that might be suspected abuse. What is the procedure now?

Smith: Any death of a minor should be reported to the Department of Human Services or their designee which is Child Protective Services in the counties. It is a repetition in statue but it is to remind coroners that it needs to be done. Coroners don't always think about reporting it to the Department of Human Services, they are looking at the death from legal aspect and not considering abuse or other children in the family. It's just to remind them to not forget to do that reporting.

Representative Damschen: What does the department do when they receive these reports?

Smith: Marlis Baker from Department of Human Services is here. She is in charge of the child fatality review board that looks at all the child fatalities to see if there was anything in the system, should something have done differently so the child wouldn't have died, or were there some other things that should be changed to prevent child deaths. It's an ongoing review board. This is just to remind coroners about that because it is often forgotten from a coroner's perspective.

Representative Porter: A couple of questions: In section 2 the extension from 2 to 5 years that the County Commission has to appoint the coroner.

Smith: Many coroners serve long terms this makes it easier than to go back to the commission every two years to be reappointed and just gives it a longer period of time. They can always resign at any time. It's just easier mechanics to approach the commission every five years.

Representative Potter: On both sides then they can be unappointed within that 5-year time frame and they can also resign.

Smith: That's correct.

Representative Porter: In section 3 we start talking about an almost centralized system where we are really close to these individuals being employees of the state rather than employees of the county. The counties have the financial responsibility but now we are putting things in there like setting up training and continuing education requirements and qualifications that we are walking a fine line by most certainly putting a mandate of property tax increases out these counties and especially those counties under 8,000 people that didn't have this requirement in the past.

Smith: With these changes we were trying to balance having good investigation done by the counties. We didn't change it to a state system or a regional system. We left it at a county coroner's system. But there were no requirements for any training or expertise by coroners. To not miss deaths that should be investigated, we granted that the forensic examiner would set out some qualification requirements. It was just to be sure that the investigations were done properly to have people get some training. There is already in the medical examiners statute that the forensic examiner should do training, but there is no where that there were any requirements especially in smaller counties as to who could be coroner. I will give you this testimony from **Cindy Willy** whose parents appeared to have died in a fire, but it was found out it was actually a double homicide by a forensic pathologist. **(Attachment 2)**

Representative Porter: Section 14 requires a consultation under a lot of new circumstances. In side of the requirement now if the body had already been released and if not, is the state forensic examiner available 24 hours, seven days a week to all of the county coroners?

Smith: Yes, they have a call system of investigators that are call from his office and they also call him as necessary through state radio. The consultation is often done right at the scene at the time of death or when the body is found or even the next day.

Representative Porter: So it is not the MD it is whoever would be on call out of that office.

Smith: It would be the Office of the State Forensic Examiner because he has given instructions to the investigators as to when to consult him further but investigators field the initial questions.

Representative Porter: There may be a conflict but in Section 15 where we are stating who the state forensic examiner is and on Section 14 we aren't saying that duty can given to anybody else we are saying it is that individual because of the definition is Section 15.

Smith: There is no time frame in Section 14. All of the contacts to the forensic medical examiner's office are reported to him by the next morning if happens to be in the middle of night so he is able to review and follow up on any particulars. If the coroner wants to speak directly to him, there's no problem with that. By the next day he will be available and aware of what happened.

Representative Porter: It's Friday night at midnight and someone dies in a car crash. The forensic examiner is on vacation and has some one on call for the weekend and is unavailable. There is no way to do that notification that way this is set up. The body has already been turned over to the local funeral home and on Monday the forensic examiner looks at it and says we should have that person in here for an autopsy.

Smith: The mechanics of how it works and the many consultations required by statute have not been a problem. We only have one forensic pathologist and when he is not available he does designate someone to cover for him. If something happens on the weekend he can be notified—or his designee.

Representative Porter: It doesn't say designee in here. The reason I bring that up is because we have substantially increased the number of deaths that require notification. Now the chance of going through a weekend where someone hasn't died of an accidental death is going to be more difficult.

Smith: The required consultation is to actively consult with the state forensic examiner. We have clarified it more so that suspicious circumstances will noted and consultation will be requested. The time frame is not noted in there but the consultation will be done.

Chairman Weisz: The way this is written it has to be the state forensic examiner and only him. It could not be any designee or staff. While the language doesn't state when the consultation has to occur, it seems a rather moot point. I would think it occur when the accident or homicide or suspicious, you know. Are you saying that it has to be the forensic examiner and only him or can it be staff or a designated that could do the consult with the coroner?

Smith: All we are trying to do with this and all the revisions is to better utilize the expertise of the forensic pathologist we have available to us and to involve that expertise with our investigations and to not miss things. It could be consult with his office and he eventually reviews it. The state forensic "office" could be used to.

Representative Kilichowski: All counties have to have their own coroner. Right? May they contract with other counties?

Smith: Yes, it may be possible that they not be a resident of a county. We have such situations where they serve a neighboring county.

Representative Potter: In section 5, part 3, says it needs to be reported for stillborns to law enforcement.

Smith: Any birth that would be eligible to receive a birth certificate. That would include a stillborn. Of hand I don't know the statute of how many weeks of gestation are needed to get a birth record. It is a death at a point where a birth record would be filed for that infant.

Representative Potter: We have had several abortion bills pass through the house that define a human being, is that going to fit in with this.

Smith: I haven't seen the exact wording of that bill and I don't know how that bill would apply to birth records.

Representative Nathe: A stillborn at 22 weeks or less and we file a fetal death certificate, does that pertain to this?

Smith: Not a fetal death certificate, just a birth record.

Representative Nathe: The decedents relatives get access to the autopsy report, is that correct? That is provided there is no criminal trial going on? Where does the media fit in here?

Smith: Correct, if requested—until there is no active criminal investigation going on. The media gets public records so they would not get the full autopsy reports.

Chairman Weisz: What happens if a county doesn't appoint a coroner?

Smith: Then the sheriff is the acting coroner.

Representative Nathe: Why not set up a state system? Too cumbersome? Too expensive?

Smith: It is a possibility but we wanted to leave the responsibility with the counties. It is a system we have had and are used to. It would be a huge change and a huge expense. It could be looked at.

Aaron Birst, Association of Counties, spoke in favor of the bill. We do support this legislation. I was on the committee that went through this in the interim. Thank you for your concerns about the unfunded mandate aspect. That still concerns the counties somewhat as

this allows the medical examiner to create a professional system and the requirements the counties would have to fulfill. However, the way we look at it is that it is very important and we feel comfortable that we already have the expertise to try to work on these. If they come up with a 1,000 hour training requirement, we may have to come back to this legislature and ask for some help on that. What we thought was that it was better to advance the ball and come back next session if there is a problem. What this bill is attempting to do is those people who have the expertise working with the medical examiner would be able to be appointed as the coroner to make sure we find the right answers. That's why we support this.

Chairman Weisz: Do you have any idea on average what it costs the counties for an autopsy?

Birst: I can get back to you on that. It does become a dispute too because a number of counties have to pay for the transportation costs which are huge. The state picks up the tab on the autopsies, but the transportation and training costs are the counties.

Representative Porter: How many counties are using just the sheriff as the coroner?

Birst: We have a list but off the top of my head I will say 10.

Representative Porter: Is there a list of the amount of money spent by each county for their county coroner line item for their budget. Is there a possibility that we could have the cost not of not only the people, but the services and the transportation and autopsy costs?

Birst: I can try to get that for you. It is a bit problematic because it not consistent.

Chairman Weisz: Your county coroner sends the bill to the state when they perform an autopsy.

Smith: If it is determined that an autopsy is necessary, the body is delivered to Bismarck where the autopsy takes place. The only cost will be the transportation.

Chairman Weisz: So none of the counties perform autopsies.

Smith: Grand Forks had the medical college and has done a few. The standard practice is to send them to Bismarck. In Fargo we do a few and for those the county pays for. If you send a body from Fargo to Bismarck the transportation cost is about $450 and the medical examiner does it at no cost. If I do it in Fargo, it costs about $1,000. I'm not sure who pays for the body to be transported back. Each county makes their own deal regarding transport. It varies.

Jack McDonald, representing the ND Newspaper & Broadcasters Association and also the ND Funeral Directors Association. The funeral directors do support this and one of them participated in the task force. They support the bill. From the Newspaper Association standpoint there has been long-standing controversy in the state over access to autopsy reports. It has been a grey and murky area. This bill goes a long way to establish what a public record is and what is not. We are very glad this has been established.

There being no further testimony, Chairman Weisz closed the hearing of SB 2168.

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. 2168

House Human Services Committee

☐ Check here for Conference Committee

Hearing Date: March 9, 2009

Recorder Job Number: 10529

Committee Clerk Signature Vicky Crabtree

Minutes:

Chairman Weisz: Let's take up 2168 committee.

Rep. Porter: What did we do with amendments?

Chairman Weisz: The department has some.

Rep. Porter: There's something we need to do in there to make it work.

Chairman Weisz: Section 14 you are concerned with, right?

Rep. Porter: End of line 16 where it says, "they shall actively consult with the state forensic examiner or designee".

Chairman Weisz: You want to reiterate your rational for that?

Rep. Porter: It is pretty obvious that we have one state forensic examiner and that individual isn't available 24 hours, 7 days a week. There is also other staff out there that takes call. The way that this reads, it must be that person. You could change it and say, "the state (inaudible) examiner's office" too. There hasn't to be something other than what is worded currently otherwise it is just that individual.

Rep. Kilichowski: Could it be (inaudible) designee?

Rep. Porter: It could be designee (inaudible) or it could be the office. It could be the state's forensic examiner's office.

Rep. Conrad: On line 18, (inaudible) designee. And also line 27.

Rep. Porter: That's exactly why the other one needs to change also because this is saying that the designee can assume jurisdiction over the deceased person so the state medical examiner doesn't have to be there to admit every person.

Chairman Weisz: I think I'd be more inclined to go with the language of the office.

Rep. Kilichowski: That only deals with the jails and the child.

Rep. Porter: No. (Everyone talking at once.)

Chairman Weisz: It's under conditions if you ask for an autopsy. It's in all cases, but I think the language, office, would be better because Section 12 we are looking at the authority and in 14 you just want them to consult with the state forensic examiner's office. Either way will work.

Rep. Holman: (Inaudible) would allow the examiner the ability to designate someone in advance.

Chairman Weisz: (Coughing, inaudible) whoever is in the office at night would be able to take care. If the coroner calls the office at 2 a.m., whoever's in charge automatically because it is the office they have to contact the office automatically would be in charge. If you say designee then in theory I don't think it is a big deal either because the examiner would just say (inaudible) designee at 2 a.m. The language either way works. (Chatter back and forth, inaudible). My suggestion is to say, "the state forensic examiner's office". We are not looking at authority (inaudible).

Rep. Conklin: Motion to move amendment.

Rep. Porter: After examiner insert the word office.

Chairman Weisz: Right.

Rep. Porter: Second.

Voice Vote: Motion Carried.

Rep. Porter: On the record, this is a huge expansion of our current system. There's a huge potential unfunded mandate back to counties for training on this. There is a lot of trust being placed into the state health department that they are going to stay within the assembly's definition of reasonable when it comes to the training of the person who is the county coroner. The one area was in relation to the county where the funeral director is currently the coroner. He is not specifically (inaudible) as being able to continue those duties in this bill, but it does have that sub d, Section 3, on page 3 that says, (reads from bill). There is that ability to continue that, but in some counties it is impossible to have a physician, nurse or physician's assistance, so if they do have the ability to have somebody else be the coroner. A funeral home director or sheriff. I don't necessarily disagree with a lot of this, but I think we are putting a lot of blind faith into the health department.

Rep. Conrad: We are at a point where we need to address it (inaudible) and we need some direction from the state.

Chairman Weisz: Are we potentially going to have more counties that have no one and it will fall to the sheriff?

Rep. Conrad: I wish people could specialize in this more because there would be (inaudible).

Rep. Porter: If you have courses Monday through Friday in Bismarck, you will have people saying this is too much for me. Burleigh County spends $60,000 a year for one doctor. Stark County is like $11,000-$12,000 a year. It's a wide range.

Rep. Kilichowski: Maybe counties can contract with each other to cover coroner duties.

Chairman Weisz: The question is if the county just refuses, then it is a sheriff and he has no choice. Does raise some questions.

Rep. Frantsvog: Just because you have a county coroner doesn't necessarily mean that they always use the county coroner in the event of a death.

Rep. Porter: Duties between the county coroner and the autopsy performed by the state medical examiner's office differ greatly.

Chairman Weisz: The vast majority of the coroners in the state do the autopsy.

Rep. Hofstad: Is the coroner not required to initially visit the scene of death?

Chairman Weisz: Yes.

Rep. Hofstad: Can you transfer unless in a hospice situation a dead person unless he's been (drops sentence).

Rep. Porter: (Inaudible). The Burleigh County Sheriff had an amendment and I can have this information tomorrow for everyone.

Rep. Conklin: Motion withdrawn.

Rep. Porter: Second.

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. 2168

House Human Services Committee

☐ Check here for Conference Committee

Hearing Date: March 11, 2009

Recorder Job Number: 10663

Committee Clerk Signature Vicky Crabtree

Minutes:

Chairman Weisz: Let's take up SB 2168.

Rep. Porter: Mr. Burst's excel sheet from the Association of Counties is an explanation of how much is each county spending for their county coroner system. You can a wide range of costs. Some of the smaller counties understand there is not a physician in that position. That amount will go up as you start saying that it has to be the nurse practitioner and the registered nurse or someone else approved by the state. Just want everyone to be aware of the range of costs. Les Withcowski. from the Burleigh County Sheriff's department was looking through the bill while we were hearing it and on page 4, line 21, was looking through the wording and thought that instead of the "and" that it say "or" so only one notification be done. Typically the coroner and the law enforcement work in conjunction with each other. So that was a recommended amendment from him. And then on page 5, line 2, there isn't inside of the definitions of this bill the words "medical deputy" so his suggestion the words "assistant or deputy coroner". These are the two suggestions he has made. Amendment change on page 9, but we already made that change.

Chairman Weisz: He wants both assistant or deputy? Not one or the other?

Rep. Porter: The way that it was worded in other areas of the bill, that both of those terms would fit. I did talk to Mr. Mullen this morning and he explained to me that his involvement in this bill was from the standpoint of the records and HIPPA things. He thought there were a couple of those areas wouldn't hurt (inaudible) coincided as we moved it forward.

Rep. Porter: Motion to propose the further amendments

Rep. Holman: Second.

Chairman Weisz: On page 21, change the "and" to an "or" and on page 5, line 2 it will say the coroner or assistant coroner or deputy coroner shall notify the parent.

Voice Vote: 13 yeas, 0 nays, 0 absent.

MOTION CARRIED.

Rep. Conrad: Motion Do Pass.

Rep. Kilichowski: Second.

Chairman Weisz: I do have some concerns of the Health Dept. getting in the middle of determining qualification and everything else.

Rep. Porter: Just to echo your concerns. In a couple of years it will be more money because of the requirements now on there. In the long run is it money well spent to ensure there is a uniform system across the state, I think that is a question that will comes back in front of us in the future.

Chairman Weisz: Probably will.

Roll Call Vote: 10 yes, 3 no, 0 absent.

MOTION CARRIED DO PASS AS AMENDED.

BILL CARRIER: Rep. Conrad.

Date: 3-9-09

Roll Call Vote #: 1

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2168

House HUMAN SERVICES Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken ☐ Do Pass ☐ Do Not Pass ☐ Amended

Motion Made By Rep. Conklin Seconded By Rep. PORTER

Representatives	Yes	No	Representatives	Yes	No
CHAIRMAN ROBIN WEISZ			REP. TOM CONKLIN		
VICE-CHAIR VONNIE PIETSCH			REP. KARI L CONRAD		
REP. CHUCK DAMSCHEN			REP. RICHARD HOLMAN		
REP. ROBERT FRANTSVOG			REP. ROBERT KILICHOWSKI		
REP. CURT HOFSTAD			REP. LOUISE POTTER		
REP. MICHAEL R. NATHE					
REP. TODD PORTER					
REP. GERRY UGLEM					

Total (Yes) _____ No _____

Absent _____

Bill Carrier _____

If the vote is on an amendment, briefly indicate intent:

Motion Carried

Move amendment

Adopted by the Human Services Committee
March 11, 2009

VR
3/12/09

PROPOSED AMENDMENTS TO ENGROSSED SENATE BILL NO. 2168

Page 4, line 21, overstrike "and" and insert immediately thereafter "or"

Page 5, line 2, overstrike "coroner's medical deputy" and insert immediately thereafter "assistant or deputy coroner"

Page 9, line 16, overstrike "examiner" and insert immediately thereafter "examiner's office"

Renumber accordingly

Date: 3-11-09

Roll Call Vote #: 1

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2168

House HUMAN SERVICES Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken ☒ Do Pass ☐ Do Not Pass ☐ Amended

Motion Made By Rep PORTER Seconded By Rep Holman

Representatives	Yes	No	Representatives	Yes	No
CHAIRMAN ROBIN WEISZ			REP. TOM CONKLIN		
VICE-CHAIR VONNIE PIETSCH			REP. KARI L CONRAD		
REP. CHUCK DAMSCHEN			REP. RICHARD HOLMAN		
REP. ROBERT FRANTSVOG			REP. ROBERT KILICHOWSKI		
REP. CURT HOFSTAD			REP. LOUISE POTTER		
REP. MICHAEL R. NATHE					
REP. TODD PORTER					
REP. GERRY UGLEM					

Total (Yes) 13 No 0

Absent 0

Bill Carrier _____

If the vote is on an amendment, briefly indicate intent:

Motion to Further Amend

Date: 3-11-09

Roll Call Vote #: 3

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2168

House HUMAN SERVICES Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken ☒ Do Pass ☐ Do Not Pass ☒ Amended

Motion Made By Rep Conrad Seconded By Rep. Kilichowski

Representatives	Yes	No	Representatives	Yes	No
CHAIRMAN ROBIN WEISZ		✓	REP. TOM CONKLIN	✓	
VICE-CHAIR VONNIE PIETSCH	✓		REP. KARI L CONRAD	✓	
REP. CHUCK DAMSCHEN		✓	REP. RICHARD HOLMAN	✓	
REP. ROBERT FRANTSVOG	✓		REP. ROBERT KILICHOWSKI	✓	
REP. CURT HOFSTAD		✓	REP. LOUISE POTTER	✓	
REP. MICHAEL R. NATHE	✓				
REP. TODD PORTER	✓				
REP. GERRY UGLEM	✓				

Total (Yes) 10 No 3

Absent _____

Bill Carrier Rep. Conrad

If the vote is on an amendment, briefly indicate intent:

DP AS Amended

REPORT OF STANDING COMMITTEE

SB 2168, as engrossed: Human Services Committee (Rep. Weisz, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (10 YEAS, 3 NAYS, 0 ABSENT AND NOT VOTING). Engrossed SB 2168 was placed on the Sixth order on the calendar.

Page 4, line 21, overstrike "and" and insert immediately thereafter "or"

Page 5, line 2, overstrike "coroner's medical deputy" and insert immediately thereafter "assistant or deputy coroner"

Page 9, line 16, overstrike "examiner" and insert immediately thereafter "examiner's office"

Renumber accordingly

2009 TESTIMONY

SB 2168

#1

Testimony
Senate Bill 2168
Senate Human Services Committee
Wednesday, January 21, 2009; 10:45 a.m.
North Dakota Department of Health

Good morning, Madam Chair and members of the Senate Human Services Committee. My name is Dr. John Baird, and I am a Field Medical Officer for the North Dakota Department of Health. I also have been the Cass County Coroner for the past 25 years. I am here today to testify in support of Senate Bill 2168.

About a year ago, I was asked by Dr. Terry Dwelle, our State Health Officer, to bring together a group to examine our current death investigation statutes to see if they needed to be revised or updated. Over the past year, a taskforce of about 16 members met and made recommendations for the purpose of improving the death investigation system in North Dakota. The taskforce's recommendations are contained in Senate Bill 2168. The taskforce members include the state forensic medical examiner, county coroners and members representing law enforcement, the counties, states attorneys, funeral directors, the state Crime Lab, the Department of Human Services, the North Dakota Medical Association, and state legislators.

Goal of NDCC Revision

The revisions to state statutes in SB 2168 are proposed to better utilize the expertise of our forensic examiner, to update antiquated language, to improve the overall functioning of our death investigation system, and to address the issue of confidentiality of autopsy reports.

Background

The North Dakota death investigation system is based on county coroners appointed by the county commissions. Counties with populations greater than 8,000 are required to have a physician serve as their medical coroner. (N.D.C.C. ch 11-19.1) Counties with populations less than 8,000 can appoint a county coroner with no specified qualification or training requirements. (N.D.C.C. ch 11-19) Seventeen North Dakota counties have populations greater than 8,000, and 36 counties are less than 8,000.

Since 1996, a state forensic examiner has been employed by the North Dakota Department of Health as an expert to consult with coroners, investigate and do autopsies when requested, and to provide training. (N.D.C.C. §23-01-05.4) The

state forensic examiner assumes jurisdiction over a dead body when requested to do so by a coroner or states attorney. (N.D.C.C. §11-19.1-18) The coroner is required to report deaths to the state forensic examiner (N.D.C.C. §11-19.1-19), but this is not happening routinely. Coroners are required to actively consult with the state forensic examiner concerning cases involving an inmate, a child younger than 1, or those deaths believed to be due to suicide, homicide, or from child abuse or neglect. (N.D.C.C. §11-19.1-20)

Dr. George Mizell, a forensic pathologist, was North Dakota's first state forensic examiner. Since July 2007, Dr. William Massello, also a forensic pathologist, has served as the state forensic examiner. Excellent morgue and office facilities have been built in Bismarck. The forensic examiner's office has two full-time and three part-time staff besides the pathologist.

In 2007, North Dakota had 5,533 resident deaths. It is estimated that 1,200 of those would have been referred to a county coroner for investigation. Of these cases the state forensic examiner investigated and performed autopsies on 240 cases and was consulted by a coroner on 77 other cases. The mode of death for autopsied cases included 73 natural causes, 79 accidents, 65 suicides, 14 homicides, and 5 undetermined. It should be noted that there were also other autopsies done in the state on coroner cases, estimated at a yearly rate of about 60 cases in Grand Forks, 20 to 25 cases in Williston, and about 12 to 24 cases in Fargo. In 2008, the number of cases investigated and autopsied by the state forensic examiner increased to 274.

Proposed Changes

The changes proposed in Senate Bill 2168 eliminate outdated language, change the coroner chapter so that all counties are covered by one statute, clarify the state forensic examiner's role in oversight of the state's death investigation system, and protect the confidentiality of personal medical information that is included in autopsy reports but not relevant to the death.

As I mentioned, we currently have two chapters that define the role and duties of a coroner. Chapter 11-19 is the county coroner chapter for counties with populations less than 8,000. This chapter contains very antiquated language, such as the following in 11-19-26: "In cases of murder or manslaughter, the fees and mileage allowed to the coroner shall be paid out of the goods, chattels, lands, or tenements of the slayer, if the slayer has any." In this bill, we have repealed Chapter 11-19 and revised Chapter 11-19.1, the medical county coroner chapter, bringing the language into the 21st Century.

The revised Chapter 11-19.1 as proposed will apply to all counties no matter their size. All coroners in the state will need to meet the same qualifications, training and continuing education requirements. They will all have the same requirements for consultation with and reporting to the state forensic examiner. Deaths will be investigated consistently across the state.

Our state death investigation system was greatly enhanced when the legislature added the position of state forensic examiner to the health department 10 years ago. With the proposed revisions, we better utilize that expertise to provide more oversight of the state's death investigation system. The state forensic examiner will determine qualifications, training and continuing education requirements for county coroners. The state forensic examiner will perform autopsies or authorize other pathologists to do them, will be able to order autopsies to be performed, and will maintain records of deaths to keep accurate health statistics.

Senate Bill 2168 also provides for the privacy and confidentiality of autopsy reports, which contain personal medical information. In normal health-care settings, this information is protected by federal law. In the case of a death designated as a coroner case and when a coroner autopsy is performed, all the information is public record and must be provided to anyone who requests it. The proposed section of statute would allow information in an autopsy report to be used for purposes of an investigation, inquest, prosecution, or other specified purposes, as well as in accordance with a court order. The final official autopsy findings indicating the cause of death and manner of death would be public record.

By their nature, the majority of deaths that a coroner investigates are tragedies for families. The deaths are unexpected and can be the result of injury, criminal action or natural causes. The coroner and state forensic examiner function at the junction of medicine and law, applying scientific evaluation to a legal investigation. The confidentiality provisions in this bill are a good compromise to protect private medical information that may have nothing to do with the cause of death. For example, if someone dies in a car accident and an autopsy finds he also had HIV, that medical information currently must be released with the autopsy report, even if it is not pertinent to the cause of death. The final legal autopsy findings of cause and manner of death can potentially be useful information for the good of the general public and are left as public record.

Let me briefly walk you through each of the sections of Senate Bill 2168.

Section:

1. Definitions – Chapter 11-19.1-01
   - Revises definition of autopsy to include inspection; addresses issue of retention of organs, tissues, or fluids
   - Updates definition of "reportable circumstances"

2. Term – Chapter 11-19.1-03
   - Increases term of coroner two years to five years; updates language

3. Eligibility – Chapter 11-19.1-04
   - Expands list of those eligible for office of coroner; adds requirements concerning qualifications, training and continuing education as determined by the state forensic examiner
   - Assistant or deputy – adds requirements for the same qualifications as coroner

4. Absence of coroner – Chapter 11-19.1-06
   - Updates language for seeking help of coroner or state forensic examiner if needed

5. Report of death and death of minor – Chapter 11-19.1-07
   - Makes reference to reportable circumstances defined earlier; adds reminder that death of minor must be reported to Department of Human Services.

6. Records of coroner's office – Chapter 11-19.1-08
   - Updates language; references confidential autopsy report

7. Bodies to be held pending investigation – Chapter 11-19.1-10
   - Removes time limit without embalming to allow adequate investigation

8. Autopsies – Chapter 11-19.1-11
   - Specifies that autopsy be done by state forensic examiner or pathologist authorized by the state forensic examiner
   - References confidentiality of autopsy report

9. Cause of death determination – Chapter 11-19.1-13
   - Removes reference to coroner's verdict

10. Notification of next of kin and disposition of body – Chapter 11-19.1-15
    - Updates language to reflect current practice

11. Application – Chapter 11-19.1-17
    - Requires that chapter apply to every county

12. State forensic examiner – authority, costs – Chapter 11-19.1-18
    - Allows state forensic examiner to order an autopsy and exercise powers of coroner
    - More clearly outlines costs that are responsibility of counties.

13. Reports to state forensic examiner – Chapter 11-19.1-19
    - Requires reporting of all coroner cases to state forensic examiner

14. Required consultation with state forensic examiner – Chapter 11-19.1-20
    - Updates language and expands list

15. State forensic examiner section of North Dakota Department of Health – Chapter 23-01-05.4
    - Requires state forensic examiner to be forensic pathologist; gives state forensic examiner same authority as coroners; maintains records so they can be used for health statistics and public health purposes

16. New section Chapter 23-01-05.5
    - Protects confidentiality of autopsy reports, with final autopsy findings (cause and manner of death) as a public record

17. Repeals Chapter 11-19, which refers to counties less than 8,000 population. (The revised Chapter 11-19.1 refers to all counties.) Repeals section 11-19.1-05 since assistant coroner is now addressed in 11-19.1-04.

Conclusion

As I mentioned earlier, the purpose of these changes is to improve the death investigation system in North Dakota. Thank you for your consideration of this bill.

Madam Chair, members of the committee, this concludes my testimony. I am happy to answer any questions you may have.

NDME 09-

STATE FORENSIC MEDICAL EXAMINER
North Dakota Department of Health
PO Box 5520
Bismarck, ND 58506-5520
(701) 328-6138

Same handout given to House.

REPORT OF DEATH

Decedent:
Date of Birth:
Date of Death:
Time of Death:
County:
Place Death Pronounced:
Location Death Pronounced:

Cause of Death:

Other Significant Conditions:

Manner of Death:

Date of Injury:
Time of Injury:
Place of Injury:
Location of Injury:
How Injury Occurred:

Autopsy Performed by: William Massello III, MD Date: Time:

Death Certificate Signed by: William Massello III, MD

Investigating Agencies:

North Dakota Death Investigation System Task Force – Contact Info:

List of individuals who received e-mail information about task force work and attendance at meetings in 2008.

2008 mtgs
11 8/26 11/20

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phone Bev Clayburgh, 1626 Belmont Rd.
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Senator Judy Lee, District: 13 Republican, 1822 Brentwood Court
West Fargo, ND 58078-4204, Phone: 701-282-6512 jlee@nd.gov

Representative Chris Griffin, District: 19 Democrat cdgriffin@nd.gov
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X Representative Gary Kreidt, District 33 Republican
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Home: 843-7074 and Cell 226-2169 gkreidt@nd.gov

#2

PROPOSED AMENDMENTS TO SENATE BILL NO. 2168

Page 12 , after line 10, insert:

"**SECTION 18. AMENDMENT.** Section 50-25.1-04 of the North Dakota Century Code is amended and reenacted as follows:

50-25.1-04. Method of reporting. All persons mandated or permitted to report cases of known or suspected child abuse or neglect shall immediately cause oral or written reports to be made to the department or the department's designee. Oral reports must be followed by written reports within forty-eight hours if so requested by the department or the department's designee. A requested written report must include information specifically sought by the department if the reporter possesses or has reasonable access to that information. Reports involving known or suspected institutional child abuse or neglect must be made and received in the same manner as all other reports made under this chapter. Active criminal intelligence investigation and active criminal investigation information are not subject to disclosure under this section."

Renumber accordingly

06-9753

#3

NDME 06-105

STATE FORENSIC MEDICAL EXAMINER
North Dakota Department of Health
PO Box 937
Bismarck, ND 58502
(701) 328-6138

REPORT OF DEATH

Decedent: Craig, Pamela
Date of Birth: 4/17/59
Date of Death: 6/3/06
Time of Death: 1:01 p.m.
County: Burleigh
Place Death Pronounced: Emergency room
Location Death Pronounced: Medcenter One Health Systems, Bismarck

Cause of Death: Stab wounds of chest

Other Significant Conditions:

Manner of Death: Homicide

Date of Injury: 6/3/06
Time of Injury: Unknown
Place of Injury: Residence
Location of Injury: 2406 E Thayer, Lot 37, Bismarck
How Injury Occurred: Stabbed by another person(s)

Autopsy Performed by: George R. Mizell, M.D. Date: 6/6/06 Time: 8:30 a.m.

Death Certificate Signed by: George R. Mizell, M.D., Forensic Medical Examiner

Investigating Agencies: Burleigh County Coroner, Bismarck Police Department

GRM
6-7-06

E-3

#4

NORTH DAKOTA DEPARTMENT OF HEALTH
STATE FORENSIC EXAMINER
2637 E MAIN AVE, DEPT. 301, PO BOX 5520
BISMARCK, ND 58506-5520
701-328-6138

AUTOPSY NO. NDMF 09-
DATE/DAY
TIME

REPORT OF AUTOPSY

DECEDENT

AUTOPSY AUTHORIZED BY:

BODY IDENTIFIED BY:

PERSONS PRESENT AT AUTOPSY
Dr. Massello:

Rigor: Livor : Color: Distribution:
Age: _ Race: _ Sex: _ Length: _ Weight: _ Eyes: _ Pupils:
Hair: _ Moustache: _ Beard: _ Body heat:

PATHOLOGIC DIAGNOSES:
1.

POSTMORTEM SUMMARY:

CAUSE OF DEATH:

Provisional Report: Final Report:

The facts stated herein are true and correct to the best of my knowledge and belief.

Date Signed	Place of Autopsy	Signature of Pathologist
	ND State Forensic Examiners Office	William Massello III, M. D. State Forensic Examiner

06-9753

#5

STATE FORENSIC EXAMINER
North Dakota Department of Health
PO Box 937
Bismarck, ND 58502

AUTOPSY REPORT

An autopsy is performed on a body identified as Pamela Craig at the North Dakota Forensic Examiner's office on 06/06/06, with the autopsy commencing at 8:30 a.m. At the time of autopsy, the body is identified by tags on the body. The body is received in a sealed body bag.

CIRCUMSTANCES

The decedent is 47-year old white female who reportedly was stabbed at her residence. She was transported from the scene to a local hospital where death was pronounced a short time later.

WITNESSES

Persons present at autopsy are Craig Lahren, Forensic Administrator, Corey Sayler, Autopsy Assistant, Danita Hunke, Autopsy Assistant, Roger Marks, Bismarck Police Department, and Erin Bertsch, Bismarck Police Department.

WEAPON

Brought by Det. Marks in an evidence bag labeled case no. 06-9753, description knife 11 inches overall length 6 inch blade white handle Dexter Russell. It consists of a white handle knife measuring 28 cm in overall length with a 15 cm blade which measures 2.2 cm in width and 0.3 cm in thickness. Blood material is on the surface.

E.4

06-9753

CLOTHING AND PERSONAL EFFECTS

At the time of autopsy, the body is nude. Accompanying the body is a pair of blue shorts and grey t-shirt in 2 pieces. Clothing has been extensively cut per resuscitative practice. On the back part of the t-shirt are two 2 cm slit-like cloth defects.

EVIDENCE OF MEDICAL INTERVENTION

Evidence of medical intervention includes an oral tracheal tube, 2 EKG pads on the chest, needle puncture marks on antecubital and right forearm, and catheters in the right inguinal area and right leg. A sutured 30 cm thoracotomy incision is on the left chest. Hospital bands on the left wrist and left ankle have the name Pamela Craig and the medical record no. 000275146 and the number 7121890.

X-RAYS

Prior to autopsy, head and chest x-rays are obtained which show metal fragments within the head.

EXTERNAL EXAMINATION

The **body** is that of a well-developed well-nourished adult Caucasian female which measures 71 inches in length and weighs 161 pounds, appearing compatible with the stated age of 47 years. The **skin** is cool to touch with normal turgor. Rigidity is well-developed in the upper and lower extremities and moderate in the jaw muscles. Lividity is purple-red, slightly blanching distributed over posterior surfaces of the body.

The **scalp** is covered by reddish-brown hair in a normal female distribution measuring up to 50 cm in length. Irides are blue-hazel. Pupils are bilaterally equal at 0.5 cm. Sclera and conjunctiva are white with no petechial hemorrhages. The nose is normally formed with an intact midline septum. The mouth contains natural dentition in a good state of repair. The face is unremarkable. The ears are normally formed with a cosmetic piercing in the left earlobe. The neck has a midline trachea and no external evidence of injury.

The **chest** has a normal A-P diameter with symmetrical pendulous breasts and nipples and no palpable masses. The abdomen is flat.

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The upper and lower **extremities** are well developed and symmetrical without absence of digits. Pink nail polish is on the toenails. Hands and fingers are normally formed with irregularly trimmed slightly soiled fingernails. At time of autopsy, hands are bagged.

The **genitalia** is that of a normal adult female. There are no injuries to the external genitalia or introitus. The perianal regions are unremarkable. The back and buttocks have stab wounds to be described.

IDENTIFYING SCARS AND MARKS

Identifying scars include a 20 cm transverse old-healed scar on the mid lower abdomen and a 10 cm old-healed scar on the left thigh. A faint 8 cm old-healed scar is on the forehead at the hairline with palpable bony irregularity of the frontal skull.

EVIDENCE OF INJURY

STAB WOUNDS

Stab wounds are listed arbitrarily.

Stab wound on the left upper back is located 32 cm below the top of the head and 9 cm to the left of midline. It consists of a vertically oriented 1.8 x 0.2 cm skin defect, with a blunt end and a sharp end directed downward. The wound track extends through the posterior chest wall, the posterior left 7th rib interspace and 8th rib, into the left lower lung lobe with a 1.3 cm defect. The wound track is back to front, slightly left to right extending to a depth of about 8 cm.

Stab wound on the left upper back is located 38 cm below the top of the head and 11 cm to the left of midline. It consists of a vertically oriented 1.9 x 0.2 cm stab wound, with a blunt end and a sharp end directed downward. The wound track extends into the left back and chest wall soft tissue. The wound direction is back to front, right to left, and somewhat upward, extending to a depth of about 10 cm.

Stab wound of the mid back is located 50 cm below the top of the head and 3 cm to the left of midline. It consists of a vertically oriented 1.8 x 0.2 cm slit-like defect with a blunt end and a sharp end directed downward and slightly to the right. Wound track extends into the left chest through the posterior 9th rib adjacent to the thoracic spine, into the left lower lung lobe with a 2 cm gaping defect, and into the left lung hilum. A 1 cm incised wound is on the left pulmonary artery near the branch to the left lower lung lobe. Secondary bronchi near the

E.6

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left lung hilum are transected. The wound direction is back to front, somewhat upward with a wound depth of approximately 13 cm.

Left hemothorax consists of 500 ml of liquid and clotted blood material.

OTHER INJURIES

Up to 2 cm red-brown contusions are on the right thigh, knee, and leg, numbering about 6. Two separate 1 cm abrasions are on the left knee and leg. A 2 cm purple to yellow contusion is on the right lower abdomen.

INTERNAL EXAMINATION

BODY CAVITIES

The serosal surfaces are smooth and shiny. A few fibrous adhesions are over the lateral right lung. Organs are in their usual anatomic locations. The subcutaneous fat layer of the abdominal wall is up to 3 cm thick.

CARDIOVASCULAR SYSTEM

The heart weighs 330 grams. The coronary arteries have the usual distribution in a right dominant pattern and are widely patent. The chambers and valves have the usual size, position, and relationship. Valve leaflets are thin and delicate. The myocardium is red-brown with the left and right ventricles measuring up to 1.4 and 0.4 cm in thickness, respectively. Outflow tracts to the aorta and pulmonary arteries are patent. The aorta and major arteries have the usual distribution with no atherosclerosis. Vena cava and major veins have the usual distribution.

RESPIRATORY TRACT

The right and left lungs weigh 500 and 370 grams, respectively. Pleural surfaces are smooth with moderate anthracosis. Cut surfaces are red-tan to purple-red, somewhat mottled over the lower lobes. The trachea and bronchi have the usual distribution and contain some blood material. The pulmonary arteries are patent.

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GASTROINTESTINAL TRACT

The esophagus is lined by white-tan mucosa. The gastric lumen contains about 100 ml of red-tan bloody material and has a grey-tan mucosa. The distal large bowel appears somewhat dilated, containing green stool material. Otherwise, the small and large bowel have no external abnormalities. The appendix is present.

PANCREAS

The pancreas is normal size and has a pink-tan lobulated cut surface.

LIVER

The liver weighs 1730 grams and is covered by an intact capsule. The cut surface is red-tan, homogenous with no fibrosis or focal lesions. The gall bladder contains a single 2 cm light green spherical gall stone and green viscid bile. The extra hepatic biliary tree is patent.

SPLEEN

The spleen weighs 130 grams and is covered by an intact capsule. The cut surface is purple-red with indistinct white pulp.

ADRENALS

The adrenals are normal size and have thin yellow cortices and pale medullae.

URINARY TRACT

The right and left kidneys weigh 100 and 120 grams, respectively. Renal capsules strip easily. Cortical surfaces are finely granular. Cut surfaces are red-tan with well-defined cortices. The collecting system, pelves, and ureters are unremarkable. The urinary bladder is empty and has a white-tan mucosa.

GENITAL ORGANS

The uterus measures 7 cm in greatest dimension and is symmetrical. The ovaries both measure 2 cm and have grey-tan to mottled hemorrhagic cut surfaces. The proximal vaginal and cervical mucosa is unremarkable. The endometrial cavity is lined by a grey-tan to slightly hemorrhagic mucosa.

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HEAD-CENTRAL NERVOUS SYSTEM

The scalp is intact. An 8 cm diameter remote healed craniotomy site is on the mid frontal skull. The brain weighs 1370 grams. Fibrosis is over the dura mater of the frontal skull and over the frontal lobes of the brain. A 5 cm slightly yellow-tan cavitated area involves the mid and left frontal lobe of the brain. The brain stem, cerebellum, and cranial nerves appear intact. Sections of the cerebral hemispheres reveal no additional lesions within the cortex, subcortical white matter, or deep parenchyma of either hemisphere. Sections of the brain stem and cerebellum have the usual architecture. Cerebral blood vessels have the usual distribution with no atherosclerosis.

Recovered from the dura mater and within the mid frontal lobe of the brain are 2 lead colored metallic fragments which have surrounding dense fibrosis. Examination of the hard palate and intra oral mucosa shows a 1 cm diameter apparent callous on the mid hard palate.

NECK ORGANS

The soft tissues of the neck, including strap muscles and large vessels are free of abnormality. The hyoid bone and larynx are intact. The tongue is free of injury. The thyroid is normal size and has a brown-tan cut surface.

HEMATOPOIETIC SYSTEM

Up to 2 cm slightly anthracotic peribronchial lymph nodes are noted. Otherwise, regional lymph nodes are unremarkable. Bone marrow is red-tan.

MUSCULOSKELETAL SYSTEM

The bony framework, supporting musculature, and soft tissues are not unusual.

SPECIMENS

Vitreous, bile, gastric contents, iliac vein blood, aorta blood, and left chest blood are collected.

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EVIDENCE

The following items are collected: fingernail clippings, bags from hands, trace from hands, trace from left arm, pulled scalp hair, blood spot card, fingerprint strips, clothing, and sexual assault kit. Bullet fragments from head, remote, are retained (case file).

MICROSCOPIC EXAMINATION

Lungs - Hemorrhage.
Brain - Loose parenchyma and gliosis with hemosiderin.
Liver - Periportal chronic inflammation.
Heart, spleen, kidney, pancreas, ovary, uterus - Negative.

α-4753

PATHOLOGIC DIAGNOSES

I. Stab wounds (3) of chest.
   A. Stab wound of mid back.
      1) Penetration of chest through posterior 9th rib interspace, left lower lung lobe, left pulmonary artery, and left bronchi.
   B. Stab wound of left upper back.
      1) Penetration of chest through 7th rib interspace and 8th rib into left lower lung lobe.
   C. Stab wound of left upper back into chest wall soft tissue.
   D. Left hemothorax.

II. Remote gunshot wound of head.
   A. Retained bullet fragments within dura mater and brain.
   B. Status post operative craniotomy, remote.

III. Cholelithiasis.

IV. Post operative left thoracotomy.

OPINION

This 47-year old female, Pamela Craig, died of stab wounds of the chest. She was reportedly stabbed at her residence. Autopsy revealed 3 stab wounds on the back which penetrated into the chest with injuries to the left lung and pulmonary artery. Ethanol was not detected in blood. The manner of death is homicide.

GR Mizell MD 8-16-06

George R. Mizell, M.D. Date
Forensic Medical Examiner

#6

Testimony
Senate Bill 2168 – Department of Human Services
Senate Human Services Committee
Senator Judy Lee, Chairman
January 21, 2009

Chairman Lee, members of the Senate Human Services Committee, I am Marlys Baker, Administrator for Child Maltreatment Prevention Services in the Child Protection Program of the Children and Family Services Division, for the Department of Human Services. I appear before you today to support passage of this bill.

My work for the Department includes coordinating the North Dakota Child Fatality Review Panel as well as working within the Child Protection Program. The North Dakota Child Fatality Review Panel, created by North Dakota Century Code Chapter 50-25.1, is a multidisciplinary body charged with responsibility for reviewing the deaths of all children under the age of eighteen years which occur in our state. The Panel is mandated to identify trends or patterns in the deaths of minors and to make recommendations for changes in policy, practice and law.

The membership of the Child Fatality Review Panel has identified concerns about the quality of child death investigations each year since 1996. The training requirements and other provisions related to assuring the quality of services to families following the death of a child contained within this bill will address some of these concerns.

There are many provisions in the current coroner statutes that specifically address the deaths of minors and which reference child abuse and neglect and child protection services. There are two provisions in this bill that I would like to address.

The first is: page four (4), lines twenty-three (23) and twenty-four (24), where the statement, "The death of a minor must be reported to the department of human services as provided under chapter 50-25.1." Chapter 50-25.1, more commonly known as the "child abuse reporting law" contains provisions that mandate the reporting of suspected child abuse and neglect by certain individuals. "Medical examiner or coroner" has been included in this provision for more than twenty years as having a mandate to report suspected child abuse and neglect. Through the work of the Child Fatality Review Panel, it has been identified that many coroners are unaware of this mandate. The intent of the provision within this bill seeks only to direct coroners to the section of the Code where the information is found. It does not reflect a change of any kind to the reporting mandate.

The second provision I would like to address is found on page eleven (11), line thirteen (13), which requires the disclosure of a copy of the final autopsy report to the Child Fatality Review Panel. This report is currently available to the Child Fatality Review Panel, upon request, under the provisions of 50-25.1-04.4. The provision in this bill would require the report to simply be disclosed, eliminating the need for a request and streamlining the process, since the review of child fatalities is statutorily mandated.

Thank you very much for the opportunity to appear in support of Senate Bill 2168. I am available to answer any questions you have.

Same given to House.

#7

Good Morning, my name is Cindy Willey. I am here to provide testimony regarding Senate Bill 2168 – the Coroner's Bill. I am not a doctor – or a local coroner – but this is my story.

An early morning phone call on April 7, 2007 propelled my family and me on an unimaginable journey. This journey led us through systems that we had never thought about before. Our family home was on fire and our parents, Don and Alice Willey, were missing. It quickly became evident that our parents had not left their home that night and had perished in the fire.

The coroner's system was one of the systems that have touched our lives during this journey. Later that day, the county coroner, a local family practice physician, came to my brother's home along with a sheriff's deputy, to notify us that they had found our parents' bodies. The cause of death – the fire – seemed so obvious. That could easily have been the end of our interaction with that system and so many others. However, due to the tenacious urgings of the sheriff's deputy, our parents' bodies were sent to Bismarck for autopsies.

This was not the typical situation in a small county with a seemingly obvious cause of death. The cause of death seemed so obvious that there seemed no need for autopsies. No one imagined that anything out of the ordinary could have happened. No one wanted to believe that Mom and Dad's deaths could have been suspicious. Thanks God for a Sheriff's Deputy who felt that questionable circumstances must be examined further.

Because of the devastating nature of the fire, there were no easy answers for the local coroner and law enforcement. The fire totally engulfed our childhood home and left little but ashes and debris. This is not a scene that a local coroner typically faces, especially a coroner from a small rural county. External examination of our parents was probably of little value because of the devastating nature of the fire. However, the x-rays that were taken almost immediately when the autopsies were done told a different story.

Fragments of metal in Mom and Dad's bodies, which turned out to be bullets, continued to propel us on this unimaginable journey. The circumstances of Mom and Dad's death had indeed become suspicious. We are very grateful to Dr. Mary Ann Sens, who was providing forensic medical examination services to the state of North Dakota at that time. She and her staff began to uncover the truth about what happened to Mom and Dad. Information provided by the forensic examination played a key role in the prosecution and conviction of two individuals for Mom and Dad's murders.

But this truth might never have been revealed. The system of local coroners depends upon evaluating situations and making judgments to request involvement and an autopsy by the state forensic medical examiner. This system calls for decisions to be made by hard working individuals, who unfortunately, may not always have the education, training and experience, to realize when suspicious circumstances exist.

In a place like North Dakota, we don't want to consider that crime may play a part in the deaths of our family, friends and neighbors. But, unfortunately, that is not the case at times. The true cause of Mom and Dad's deaths was almost not discovered and that is a circumstance that just should not happen.

Senate Bill 2168 begins to address this issue. The bill clarifies reportable circumstances so that coroner and perhaps forensic medical examiners system becomes involved when there are questionable circumstances. There are certainly many situations that require further examination.

The bill also identifies who may serve as a local coroner and gives the state medical examiner the requirement to qualify that person to serve in this role. But more importantly, it provides for the state medical examiner to provide training and continuing education requirements for those local coroners. Most local coroners will probably be family practice physicians with extensive training in medicine, but probably limited training and experience in dealing with questionable or suspicious deaths.

Training and continuing education is vital to help these local coroners identify the circumstances that require further investigation. Opening and strengthening the lines of communication and the connection between the local coroners and the state medical examiner is crucial. Local coroners must feel able to pick up the phone to get questions answered and circumstances reviewed at any time.

It is also very important that local coroners do not feel constrained by the economic realities of this system. Local counties are responsible for costs associated with autopsies and for transportation of the remains to the forensic facility. This needs to not be a factor in making the decision to request an autopsy. If circumstances seem to warrant an autopsy, it needs to happen. We need to make sure that this system works seamlessly to find a reasonable and true cause of death.

We need to have a system that works well to ensure that deaths in questionable circumstances have all of the questions answered. Our family is so grateful that the systems worked to uncover the truth about Mom and Dad's deaths. This journey has changed our lives forever. We, and the state of North Dakota, have been so lucky to have skilled and experienced professionals who made the systems work. Senate Bill 2168 is a good start to strengthening one of these systems – the system of local coroners and the state medical examiner's office.

Thank you for your time and attention.

Cynthia 1-28-09

#8

PROPOSED AMENDMENTS TO SENATE BILL NO. 2168

Page 11, line 12, after "fault" insert "if there is no active criminal investigation"

Page 11, line 13, after "panel" insert "if there is no active criminal investigation"

Renumber accordingly

BON 1-28-09 #9

PROPOSED AMENDMENTS TO SENATE BILL NO. 2168

Page 3, line 13, replace the first comma with "or" and remove "specialty practice"

Page 3, line 14, remove "registered nurse or licensed practical nurse"

Renumber accordingly

#10

Prepared for DOH by MJM
1/21/2009 3:55 PM; *1/22/2009 12:17 PM;* 1/22/2009 4:54 PM

PROPOSED AMENDMENTS TO SENATE BILL NO. 2168

Page 5, line, 23, remove "autopsy"

Page 5, line 24, replace "findings" with "report of death"

Page 6, line 25, replace "Autopsy findings" with "Report of death"

Page 6, line 28, replace "final findings" with "report of death"

Page 7, line 2, remove "final"

Page 10, line 18, replace "Final autopsy findings" with "Report of death" and after "the" remove "final"

Page 10, line 19, after "death" insert "that is the face page of the autopsy report identifying the decedent and stating the cause of death and manner of death"

Page 10, line 23, remove "Final"

Page 10, line 24, replace "autopsy findings are" with "The report of death is"

Page 10, line 30, remove "final"

Page 11, line 16, remove "final"

Page 11, line 23, after "company" insert "if there is no active criminal investigation"

Renumber accordingly

#11

Prepared for DOH by MJM 2/2/2009 8:01 AM; revised2/2/2009 2:05 PM

SB 2168
Explanation of Disclosure of an Autopsy Report to Child Fatality Review Panel

As amended, SB 2168 provides that the state forensic examiner must [is required to] provide a copy of the [complete] autopsy report to the child fatality review panel if there is no active criminal investigation.

On the other hand, the forensic examiner or County coroner is **not automatically required to disclose** immediately a copy of the complete autopsy report to the child fatality review panel, if there is an active criminal investigation.

But it should also be noted that records created by or in the possession of a State's Attorney or a law enforcement official in the course of an active criminal investigation, including an autopsy report, are "exempt records" under the open records law. Consequently, a State's Attorney is authorized – in the state's attorney's discretion – to disclose all or part of an active criminal investigative file relating to a case to the child fatality review panel. See NDCC 44-04-18.7.

Moreover, the child fatality review panel law, NDCC chapter 50-25.1, requires cooperation among "all law enforcement officials... and appropriate State agencies in fulfillment of the purposes of this chapter," i.e.," conducting child fatality review investigations. NDCC 50-25.1-12. And, "if [a] report alleges violation of a criminal statute involving sexual or physical abuse, the department [of human services] and an appropriate law enforcement agency shall coordinate the planning and execution of their investigative efforts to avoid a duplication of factfinding efforts and multiple interviews [of children]." NDCC 50-25.1-05(2).

#1

Testimony
Senate Bill 2168
House Human Services Committee
Tuesday, March 3, 2009; 2 p.m.
North Dakota Department of Health

Good afternoon, Chairman Weisz and members of the House Human Services Committee. My name is Dr. John Baird, and I am a Field Medical Officer for the North Dakota Department of Health. I also have been the Cass County Coroner for the past 25 years. I am here today to testify in support of Senate Bill 2168.

About a year ago, I was asked by Dr. Terry Dwelle, our State Health Officer, to bring together a group to examine our current death investigation statutes to see if they needed to be revised or updated. Over the past year, a taskforce of about 16 members met and made recommendations for the purpose of improving the death investigation system in North Dakota. The taskforce's recommendations are contained in Senate Bill 2168. The taskforce members include the state forensic medical examiner, county coroners and members representing law enforcement, the counties, state's attorneys, funeral directors, the state Crime Lab, the Department of Human Services, the North Dakota Medical Association, and state legislators.

Goal of NDCC Revision

The revisions to state statutes in Senate Bill 2168 are proposed to better utilize the expertise of our forensic examiner, to update antiquated language, to improve the overall functioning of our death investigation system, and to address the issue of confidentiality of autopsy reports.

Background

The North Dakota death investigation system is based on county coroners appointed by the county commissions. Counties with populations greater than 8,000 are required to have a physician serve as their medical coroner. (N.D.C.C. ch 11-19.1) Counties with populations less than 8,000 can appoint a county coroner with no specified qualification or training requirements. (N.D.C.C. ch 11-19) Seventeen North Dakota counties have populations greater than 8,000, and 36 counties are less than 8,000.

Since 1996, a state forensic examiner has been employed by the North Dakota Department of Health as an expert to consult with coroners, investigate and do autopsies when requested, and to provide training. (N.D.C.C. §23-01-05.4) The

state forensic examiner assumes jurisdiction over a dead body when requested to do so by a coroner or state's attorney. (N.D.C.C. §11-19.1-18) The coroner is required to report deaths to the state forensic examiner (N.D.C.C. §11-19.1-19), but this is not happening routinely. Coroners are required to actively consult with the state forensic examiner concerning cases involving an inmate, a child younger than 1, or those deaths believed to be due to suicide, homicide, or from child abuse or neglect. (N.D.C.C. §11-19.1-20)

Dr. George Mizell, a forensic pathologist, was North Dakota's first state forensic examiner. Since July 2007, Dr. William Massello, also a forensic pathologist, has served as the state forensic examiner. Excellent morgue and office facilities have been built in Bismarck. The forensic examiner's office has two full-time and three part-time staff besides the pathologist.

In 2007, North Dakota had 5,533 resident deaths. It is estimated that 1,200 of those would have been referred to a county coroner for investigation. Of these cases the state forensic examiner investigated and performed autopsies on 240 cases and was consulted by a coroner on 77 other cases. The mode of death for autopsied cases included 73 natural causes, 79 accidents, 65 suicides, 14 homicides, and 5 undetermined. It should be noted that there were also other autopsies done in the state on coroner cases, estimated at a yearly rate of about 60 cases in Grand Forks, 20 to 25 cases in Williston, and about 12 to 24 cases in Fargo. In 2008, the number of cases investigated and autopsied by the state forensic examiner increased to 274.

Proposed Changes

The changes proposed in Senate Bill 2168 eliminate outdated language, change the coroner chapter so that all counties are covered by one statute, clarify the state forensic examiner's role in oversight of the state's death investigation system, and protect the confidentiality of personal medical information that is included in autopsy reports but not relevant to the death.

As I mentioned, we currently have two chapters that define the role and duties of a coroner. Chapter 11-19 is the county coroner chapter for counties with populations less than 8,000. This chapter contains very antiquated language, such as the following in 11-19-26: "In cases of murder or manslaughter, the fees and mileage allowed to the coroner shall be paid out of the goods, chattels, lands, or tenements of the slayer, if the slayer has any." In this bill, we have repealed Chapter 11-19 and revised Chapter 11-19.1, the medical county coroner chapter, bringing the language into the 21st Century.

The revised Chapter 11-19.1 as proposed will apply to all counties no matter their size. All coroners in the state will need to meet the same qualifications, training and continuing education requirements. They will all have the same requirements for consultation with and reporting to the state forensic examiner. Deaths will be investigated consistently across the state.

Our state death investigation system was greatly enhanced when the legislature added the position of state forensic examiner to the health department 10 years ago. With the proposed revisions, we better utilize that expertise to provide more oversight of the state's death investigation system. The state forensic examiner will determine qualifications, training and continuing education requirements for county coroners. The state forensic examiner will perform autopsies or authorize other pathologists to do them, will be able to order autopsies to be performed, and will maintain records of deaths to keep accurate health statistics.

Senate Bill 2168 also provides for the privacy and confidentiality of autopsy reports, which contain personal medical information. In normal health-care settings, this information is protected by federal law. In the case of a death designated as a coroner case and when a coroner autopsy is performed, all the information is public record and must be provided to anyone who requests it. The proposed section of statute would allow information in an autopsy report to be used for purposes of an investigation, inquest, prosecution, or other specified purposes, as well as in accordance with a court order. The report of death, indicating the cause of death and manner of death, would be public record.

By their nature, the majority of deaths that a coroner investigates are tragedies for families. The deaths are unexpected and can be the result of injury, criminal action or natural causes. The coroner and state forensic examiner function at the junction of medicine and law, applying scientific evaluation to a legal investigation. The confidentiality provisions in this bill are a good compromise to protect private medical information that may have nothing to do with the cause of death. For example, if someone dies in a car accident and an autopsy finds he also had HIV, that medical information currently must be released with the autopsy report, even if it is not pertinent to the cause of death. The report of death, indicating the legal cause and manner of death, can potentially be useful information for the good of the general public and are left as public record.

Let me briefly walk you through each of the sections of Senate Bill 2168.

Section:

1. Definitions – Chapter 11-19.1-01
   - Revises definition of autopsy to include inspection; addresses issue of retention of organs, tissues, or fluids
   - Updates definition of "reportable circumstances"

2. Term – Chapter 11-19.1-03
   - Increases term of coroner from two years to five years; updates language

3. Eligibility – Chapter 11-19.1-04
   - Expands list of those eligible for office of coroner; adds requirements concerning qualifications, training and continuing education as determined by the state forensic examiner.
   - Assistant or deputy – adds requirements for the same qualifications as coroner

4. Absence of coroner – Chapter 11-19.1-06
   - Updates language for seeking help of coroner or state forensic examiner if needed

5. Report of death and death of minor – Chapter 11-19.1-07
   - Makes reference to reportable circumstances defined earlier; adds reminder that death of minor must be reported to Department of Human Services.

6. Records of coroner's office – Chapter 11-19.1-08
   - Updates language; references confidential autopsy report

7. Bodies to be held pending investigation – Chapter 11-19.1-10
   - Removes time limit without embalming to allow adequate investigation

8. Autopsies – Chapter 11-19.1-11
   - Specifies that autopsy be done by state forensic examiner or pathologist authorized by the state forensic examiner
   - References confidentiality of autopsy report

9. Cause of death determination – Chapter 11-19.1-13
   - Removes reference to coroner's verdict

10. Notification of next of kin and disposition of body – Chapter 11-19.1-15
    - Updates language to reflect current practice

11. Application – Chapter 11-19.1-17
    - Requires that chapter apply to every county

12. State forensic examiner – authority, costs – Chapter 11-19.1-18
    - Allows state forensic examiner to order an autopsy and exercise powers of coroner
    - More clearly outlines costs that are responsibility of counties.

13. Reports to state forensic examiner – Chapter 11-19.1-19
    - Requires reporting of all coroner cases to state forensic examiner

14. Required consultation with state forensic examiner – Chapter 11-19.1-20
    - Updates language and expands list

15. State forensic examiner section of North Dakota Department of Health – Chapter 23-01-05.4
    - Requires state forensic examiner to be forensic pathologist; gives state forensic examiner same authority as coroners; maintains records so they can be used for health statistics and public health purposes

16. New section Chapter 23-01-05.5
    - Protects confidentiality of autopsy reports, with report of death (cause and manner of death) as a public record

17. Repeals Chapter 11-19, which refers to counties less than 8,000 population. (The revised Chapter 11-19.1 refers to all counties.) Repeals section 11-19.1-05 since assistant coroner is now addressed in 11-19.1-04.

Amendments

The Senate adopted amendments to the bill as originally drafted. These are generally agreed to by the taskforce members.

- In section 3, the Board of Nursing asked that specialty practice nurse and licensed practical nurse be removed from the enumerated list of those eligible for the office of coroner.

- In the sections concerning confidentiality of records, language describing the document that will be public record was clarified. In the original bill, "final autopsy findings" was used. The amendment changed this to "report of death," which is the title of the face page of the autopsy report identifying the decedent and stating the cause of death and manner of death. This report of death will be the public record.
- In section 16, paragraphs 4 and 5 list entities that receive a copy of the autopsy report as appropriate. The phrase "if there is no active criminal investigation" was added to three subparagraphs in reference to the disclosure of a completed autopsy report to Workforce Safety and Insurance, the Child Fatality Review Panel, and an insurance company. This was added to avoid any potential compromise of a prosecution. It still will be possible for a State's Attorney, at the state's attorney's discretion, to disclose all or part of an active criminal investigative file, including the autopsy report, to the Child Fatality Review Panel to assist its investigative efforts.

Conclusion

As I mentioned earlier, the purpose of these changes included in Senate Bill 2168 is to improve the death investigation system in North Dakota. Thank you for your consideration of this bill.

Chairman Weisz, members of the committee, this concludes my testimony. I am happy to answer any questions you may have.

NDLA, S HMS

From: Lee, Judy E.
Sent: Tuesday, March 17, 2009 12:37 PM
To: NDLA, S HMS
Subject: FW: SB 2168 - passed house

Mary –
Please make a copy of this message on 2168 for all of our books.

Senator Judy Lee
1822 Brentwood Court
West Fargo, ND 58078
home phone: 701-282-6512
e-mail: jlee@nd.gov

From: John R. Baird, MD, MPH [mailto:jbaird@nd.gov]
Sent: Tuesday, March 17, 2009 9:07 AM
To: Baird, John R.; 'Aaron Birst'; Smith, Arvy J.; 'Bev Clayburgh'; 'Bruce Levi'; 'Chip Thomas'; Griffin, Chris D.; Lahren, Craig H.; 'Dale G. Niewoehner'; Carlson, Dallas L.; Meschke, Darin J.; 'Dennis Wolf'; 'Gary Bitz'; Kreidt, Gary L.; Olson, Hope R.; Kemmet, Jerry C.; Lee, Judy E.; Janke, Kelly J.; Jacobson, LaMonte L.; Jacobson, Lorraine A.; Nelson, Col. Mark A.; Baker, Marlys A.; 'Mary Ann Sens'; Nathe, Mike R.; 'Paul Sannes'; Riha, Richard J.; Hook, Robert S.; Wahl, Tami L.; 'Terrance D. Henrikson'; Dwelle, Terry L.; Massello, William, MD
Cc: Mullen, Mike J.; crolfson@comcast.net; 'Cindy Willey'; 'Steve Stripe'
Subject: RE: SB 2168 - passed house

[redacted]r Task Force,

The House Human Services Committee looked closely at the death investigation bill, made 3 minor changes, and recommended DO PASS with a 10 to 3 vote. Yesterday the House passed the amended bill 71 to 22.

The three amendments made in the House were:

Page 4, line 21, overstrike "and" and insert immediately thereafter "or" – this is in section 11-19.1-07 requiring reporting of certain deaths. Paragraph one says law enforcement **or** coroner must be notified. Paragraph two did say law enforcement **and** coroner must be notified. The change keeps the paragraphs consistent and doesn't make the reporter of the death guilty of a misdemeanor if he or she doesn't report to both offices.

Page 5, line 2, overstrike "coroner's medical deputy" and insert immediately thereafter "assistant or deputy coroner" – this change is in the same section. In the revised statute the term medical deputy is no longer used. This change keeps the language consistent with the rest of the bill.

Page 9, line 16, overstrike "examiner" and insert immediately thereafter "examiner's office" Renumber accordingly – In section 11-19.1-20 describing a coroner's required consultation with the state forensic examiner there was concern that the medical examiner would not be immediately available to personally take [redacted]nsultation calls. The wording change allows the forensic medical examiner to set up procedures in his [redacted]e for the most efficient method of consultation.

My feeling is that the amendments do not change the overall substance of the bill and could be accepted by the Senate without a conference. I am pleased that the bill as now passed fulfills the goals of our taskforce's work. If anyone has any other thoughts, please let me know.

Thank you for all of your contributions to this effort.

John

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