OPERATIONAL GUIDELINES

Wisconsin Coroners and Medical Examiners Association

Submitted by:

Jeffrey Jentzen – Chairman

Susan Casper – Fond du Lac County

Marion Cumming – Manitowoc County

John Larson – Marathon County

John Taggetz – Milwaukee County

June 1992

Revised by:

Al Klimek – Brown/Door County

Traci England – Oneida County

John Stanley – Dane County

John Larson – Marathon County

October 2005

PREAMBLE

Medical examiners and coroners perform the duties of medicolegal death investigation as a service to law enforcement agencies, the legal system of government, the decedent's family, and the community at large. The competent practice of medicolegal death investigation depends on appropriate financial, personnel and physical resources. There is a strong commitment among coroners and medical examiners within the State of Wisconsin towards excellence in regards to medicolegal death investigation system. Towards that end, the Wisconsin Coroners and Medical Examiners Association (WCMEA) have established these guidelines.

INTRODUCTION

Realizing the unique characteristics and demands of each jurisdiction, the coroners and medical examiners of Wisconsin are generally governed by Wisconsin Statutes concerning medicolegal death investigation which includes portions of ss. 979, 59.34, 69.18, 135, 155, and others.

The duties consist of the examination, evaluating and study of deceased persons, biological and physical substances and materials, in order to provide information and opinions concerning the mechanism, cause and manner of death. These duties impact upon the needs of public health organizations, public safety, and the administration of justice, with the highest goal being the prevention of death and injury.

The practice of medicolegal death investigation, in addition to what is ethical and competent, is in many respects a team effort with the participation of a variety of professionals and agencies involved in the investigation of disease, injury and death. Responsibility may be supported or constrained by governing statutes, budgets, law enforcement agencies, and local criminal justice and legal systems and other whose expertise is integrate into the interpretation of cause, manner, time and circumstances of disease, injury and death and may provide variable amounts and quality of input.

These guidelines represent the current recommended practice guidelines of a modern medicolegal death investigation system. These guidelines are dynamic, based on professional experience, expertise and scientific advances, and as such are subject to continual change and revision.

The modern death investigation system has, in addition to service responsibilities, educational and research functions which seek to improve the level of knowledge of other medical investigators as well as develop a reference of experience and data to promote the public health and safety within the guidelines provided for by the statutory regulations.

METHODOLOGY

The opinions and observations by which these guidelines serve to provide to the coroner and medical examiner are established by standards developed by State and National professional organizations of medicolegal death investigation.

Expert clinical judgment and review is accomplished by the formulation of the guideline by active practitioners of forensic pathology, criminalistis, toxicology, practitioners of medicolegal death investigation, other experts within the framework of their particular professional organization and adherence to the standards of care set forth by the individual professional organization. The body of knowledge for the medicolegal death investigator is broad based involving all aspects of medicine, law enforcement, and criminalistic techniques.

Methods of evaluation of the standards include the consensus of the practitioners that a practice or procedure has utility and validity from practical scientific experience.

PRACTICE GUIDELINES

I. Credentials and Qualifications

A coroner is an elected state officer who oversees the administrative duties of the Office of the Coroner and serves as the chief medicolegal death investigator of each county jurisdiction. The administrative duties include: the determination and documentation of the cause and manner of death with proper certification and completion of the death certificate, the ordering of autopsies and diagnostic tests to assist in the determination and documentation of the cause and manner of death, the consultation and rendering of objective investigative information to local law enforcement and legal authorities; the proper securing and storage of documents and evidence and the responsible dispersal of public funds in providing for the budgetary administration of the Office.

A Medical Examiner is an appointed county officer who oversees the administrative duties of the Office of the Medical Examiner and serves as the chief medicolegal death investigator of each county jurisdiction. The functions and responsibilities of the Medical Examiner mimic that of the Coroner and are different only in the manner in which they obtain their position.

The coroner/medical examiner shall have sufficient educational background to perform the duties of the Office. This will include basic training in death investigation to include topics of pharmacology, pathology, physiology, toxicology and anatomy. The coroner/medical examiner shall obtain training in the administrative duties of the Office and have evidence of attendance at the biannual medicolegal death investigation-training course. In addition, the coroner/medical examiner shall complete fifteen (15) hours annually of continuing education pertaining to the medicolegal investigation of death and office administration.

The chief deputy coroner/medical examiner acts as the coroner/medical examiner in his/her absence and as such, shall possess similar qualifications and background.

The coroner/medical examiner shall have all of the right and privileges as specified by state statute to include: consultation with the attorney general, local district attorney, and corporation counsel, a county funded office preferably in the county seat, the right to public funded legal counsel in matters pertaining to the function of the Office, and adequate funding and resources to provide for the proper and competent administration of the Office.

If the coroner/medical examiner deems it advisable and necessary to engage the services of medical specialists, including pathologists, toxicologists, odontologists or other experts, there should be funding available to provide for their services.

II. Jurisdiction

The jurisdiction refers to the governmental jurisdiction and its statute governing the investigation of disease, injury and death.

The coroner/medical examiner functioning in a death investigation system should have the authority to investigate and certify deaths as prescribed in Wisconsin Statute 979.01 etc. all.

(a) All deaths in which there are unexplained, unusual or suspicious circumstances.
(b) All homicides.
(c) All suicides.
(d) All deaths following an abortion.
(e) All deaths due to poisoning, whether homicidal, suicidal, or accidental.
(f) All deaths following accidents, whether the injury is or is not the primary cause of death.
(g) When there was no physician, or accredited practitioner of a bona fide religious denomination relying upon prayer or spiritual means for healing in attendance with 30 days preceding death.
(h) When a physician refuses to sign the death certificate.
(i) When, after reasonable efforts, a physician cannot be obtained to sign the medical certification as required under s. 69.18(2) (b) or (c) within 6 days after the pronouncement of death or sooner under circumstances which the coroner or medical examiner determines to be an emergency.

III. Components of Investigation

The components of death investigation are:

1. To take charge of the dead body upon mandatory and direct notification in accordance with statutory jurisdiction.

2. To personally or by means of a duly authorized representative control the removal of the body from the scene of death.

3. To investigate the circumstances surrounding death such as: on-the-scene investigation, interviews with persons having knowledge of the decedent and events leading to the death, and review of records pertaining to the case including police record, health records and all consultations generated by the investigation.

4. To conduct all necessary examinations of the body to include an autopsy if necessary and the retention of tissues, biological and trace materials as deemed necessary.

5. To take possession of any object, article or record which may be useful in establishing the cause and manner of death.

6. To confirm or determine the identity of unidentified deceased persons.

7. To summarize and record the results of the investigation and examination and to preserve the record for the legitimate use of persons and agencies as determined by statute or regulations.

8. To have the power to subpoena records or cause the subpoena of records by the local judicial court or obtain access to records and information concerning the death.

IV. Identification

All bodies must be positively identified. By signing the death certificate, the coroner/medical examiner indicates that proper identification has been performed within a reasonable degree of medical and/or scientific certainty.

Acceptable means by which an unidentified person may be identified include:

Reliable Visual Identification
Fingerprints
Personal Possessions
Dental Records Comparison
Radiographic Techniques
Tattoos, scars, external anomalies
Autopsy findings of previous surgery, therapy, disease processes, injury or prostheses
Unique anthropological features
Forensic serology utilizing DNA profiling, ABO subgroups or other conventional serological testing methods.

V. External Examination

An external examination includes but is not limited to the following:

1. An examination with photography (film or digital) and evaluation of the clothing that is present on the body and, if possible, the clothing that has been removed from the body during the course of emergency treatment.

2. Protection and preservation of clothing which may be needed to establish and document the cause and manner of disease, injury or death, or the identity of the decedent or the perpetrator of violence.

3. An examination and photographing of all body surfaces noting the features of identification, marks of injury and treatment, if any, and a general examination of the body by regions, with documentation of the cardinal signs of death.

4. May obtain for the purposes of analysis, fluids and any other material from the body that will aid in the determination of the cause and manner of death.

5. May order radiology on an as needed basis to assist in the documentation of internal fracture and injury. (i.e. skull fracture or pneumothorax)

6. A detailed written report outlining all pertinent information and observations obtained during the external examination.

VI. The Autopsy

A medicolegal autopsy is a postmortem examination performed by a State of Wisconsin licensed physician whom has specialized in the area of Pathology and has applied his/her expertise to that of the law. (Forensic) This examination will include an external and internal examination in accordance with accepted state and national guidelines for the purposes of the determination and documentation of the cause and manner of death.
A "Clinical Autopsy" may be performed for the purposes of establishing the cause and manner of death when the likelihood of legal involvement is minimal or non-existent. A Forensic or non Forensic Pathologist may perform this examination. This examination may be full or limited to a specific region of the body dependent upon the circumstances. This examination is most likely to be performed when non-criminal incidents result in death.

VII. Ancillary studies:

Ancillary consultations are to be requested at the discretion of the pathologist and/or coroner/medical examiner. Ancillary studies are carried out on a case-by-case basis depending on the circumstances of the death, scene investigation, and other concerns of investigators. Ancillary studies necessary for the appropriate practice of forensic investigations and which should be available are:

1. MEDICOLEGAL AUTOPSY
2. TOXICOLOGY
3. NEUROPATHOLOGY
4. MICROBIOLOGY INCLUDING BACTERIOLOGY, VIROLOGY SEROLOGIC TESITNG FOR MICROBIOLOGICAL DISEASE
5. CLINICAL LABORATORY STUDIES
6. RADIOLOGY: POSTMORTEM RADIOGRAPHS ARE INDICATED TO ASSIST IN IDENTIFICATION, ALL CHILDHOOD DEATHS, GUNSHOT WOUNDS, AND STABBINGS OR WHENEVER TRACE EVIDENCE IDENTIFICATION IS NEEDED.
7. ODONTOLOGY
8. ANTHROPOLOGY
9. ENTOMOLOGY
10. FORENSIC SCIENCES TO INCLUDE FORENSIC SEROLOGY, FIREARMS, FINGERPRINTS, TRACE EVIDENCE EXAMINATION, SCANNING ELECTRON MICROSCOPE, and DNA.
11. ACCESS TO PERTINENT RESEARCH DATA BASES.
12. OTHER PROFESSIONAL OR TECHINCAL EXPERTS AS DICTATED BY A PARTICULAR CASE.

VIII. Reports, records and archives

Proper records shall be maintained either in writing or electronically by the medical examiner/coroner. He/she shall be responsible for all records including written reports, diagrams, photographs, radiographs, and reports of consultants, test results, and other documents.

Records shall be maintained on all death investigations in which jurisdiction was assumed. These should be numbered in a manner that identifies the year as well as the individual case number or otherwise appropriately identified. Authenticated and dated reports of post-mortem examinations should be completed promptly. Original copies shall be under the care, custody, and control of the coroner/medical examiner. Copies of reports shall be available to those individuals having a right to them by authority of statute, regulation, or local custom.

Records must be stored and organized in a manner to provide easy retrieval. The records should be maintained and stored for the minimum period required by local, state, or federal statute or regulation, or by accrediting agencies, or by local custom. Current and archival records should be stored in a manner sufficient to preserve their physical integrity and security.

IX. Expert witness and testimony

A coroner/medical examiner may be requested or required by subpoena to give testimony in matters of fact or to give testimony regarding opinions based upon fact to courts of law, grand juries, public hearing, and inquests, as well as by deposition and interrogatory.

All medical examiners/coroners must be prepared to render factual testimony related to their investigations. The coroner/medical examiner shall limit opinions only to areas within their experience and expertise.

A witness of fact states direct personal observations based upon recollection or records and other methods, but is not permitted to render opinions or to answer hypothetical questions.

An expert witness must be declared qualified by the court based upon training and experience above that of the average person, to render an opinion regarding the facts in evidence, or to answer a hypothetical question, within his/her area of expertise.

X. Interactions with other agencies

The coroner/medical examiner shall be available for consultation with law enforcement agencies and others having a legitimate interest in a case or as provided by statute or regulation.

The records of medicolegal autopsy shall be available to families, local, State and Federal agencies in accordance with statute and local custom.

The confidentiality of information derived from death investigation and autopsy shall be held in confidence except as provided for by statute or regulation or custom.

Statistical information derived from medicolegal examinations may be provided to authorized persons and agencies for the purpose of advancing medical knowledge and promoting programs for the public health.

The Coroner/Medical Examiner has a duty to educate others about issues pertaining to medicolegal death investigations that promote public health and safety.

XI. Ethics

Members of the WCMEA are governed by the code of ethics present within the constitution and bylaws of the organization.

XII. Administration

The county board should allow the reasonable and necessary expenses of the office of coroner/medical examiner incurred during the usual and customary course of the official business and duties of the coroner/medical examiner. Due to the nature of the position, there shall be at least one qualified coroner/medical examiner or their deputy on call at all times, with due compensation.

Coroner/medical examiners shall be compensated in accordance with Local, State and Federal Guidelines. This compensation should be paid at a similar rate as other elected/appointed officials with comparable duties and responsibilities.

XIII. Organ and Tissue Procurement

Coroners and Medical Examiners in cooperation with law enforcement and the District Attorney should make every attempt to allow for organ and tissue procurement when presented with written directive from the decedent (pre-mortem) or his/her legal representative (post-mortem). In order to protect the integrity of an investigation, certain restrictions and or procurement guidelines may be put in place at the discretion of the Coroner/Medical Examiner. In order to facilitate donation while maintaining investigative integrity, the Coroner/Medical Examiner should establish a working relationship with a procurement agency(s) in advance and the choice of that agency will be that of the discretion of the Coroner/Medical Examiner as outlined in their County Code.

RESOLUTION
OF THE
WISCONSIN CORONERS AND MEDICAL EXAMINERS ASSOCIATION

WHEREAS, the Wisconsin Coroners and Medical Examiners Association continually strives to excel in professionalism; and,

WHEREAS, the duties and responsibilities of the coroner/medical examiner have continually and dramatically evolved; and,

WHEREAS, the public we serve, bodies of government, and our own peers continue to rightfully demand our increased professionalism and accountability; and,

WHEREAS, these guidelines respond to the public's need for quality assurance; and,

WHEREAS, the least populated county's coroners/medical examiners must be as prepared and educated as the most populated; and

WHEREAS, these guidelines attempt to give general definition and management strategies to our practice while providing the latitude necessary to maintain the individuality of each case of each person who has died; and,

WHEREAS, County Boards continue to seek a standardized basis upon which to compensate Coroners and Medical Examiners appropriate to their budgets; and,

WHEREAS, no such common basis for comparison has existed in the past; and,

WHEREAS, proof of standards of practice, accountability, and professionalism should encourage county boards to adequately compensate the office holder, as well as to provide the necessary budgets and equipment necessary to do a good job; and,

WHEREAS, adequate budget, staff, salary, and equipment should afford the office holder the resources to meet the expectations of the office; and,

WHEREAS, adequate budget and staff should allow the Coroner/Medical Examiner to establish a work schedule allowing for adequate rotation of personnel and,

WHEREAS, adequate salary should allow the office holder to end much of the volunteerism which has been our norm; and

WHEREAS, Coroners and Medical Examiners who cannot or will not comply with these operational guidelines may be judged against the standards contained within.

WHEREAS, liability for the Coroner/Medical Examiner and the County Board should diminish as the result of adopting and adhering to these guidelines;

THEREFORE NOW BE IT RESOLVED,

That these Operational Guidelines are duly approved by the members of the Wisconsin Coroners and Medical Examiners Association, and are hereby adopted for recommended use by Coroners and Medical Examiners in the State of Wisconsin as a guide to good practice and excellence in the medico-legal death investigation system.

_____

PRESIDENT DATE
Wisconsin Coroners and Medical Examiners Association

_____

CHAIR DATE
Resolutions Committee