Office of the Secretary
Curtis State Office Building
1000 SW Jackson St., Suite 540
Topeka, KS 66612-1367

Kansas
Department of Health and Environment

Phone: 785-296-0461
www.kdheks.gov

Lee A. Norman, M.D., Acting Secretary

Laura Kelly, Governor

Testimony on House Bill 2155

House Health and Human Services Committee

Lee Norman, MD Acting Secretary

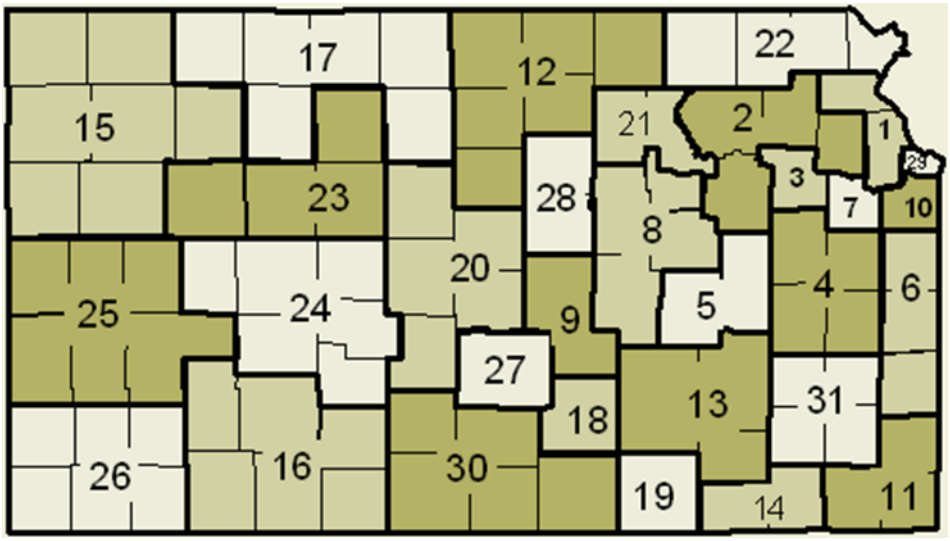
Kansas Department of Health and Environment

February 13, 2019

Chairman Landwehr and members of the committee, thank you for the opportunity to appear before you today and speak in support of HB 2155 and discuss the need to improve the medicolegal death investigation system for Kansas.

Kansas experiences on average 26,000 deaths annually. Approximately 80 % are natural deaths, 20% are not natural--accidents, suicides and homicides. Physicians certify natural deaths while coroners assume additional responsibility to oversee investigations of non-natural deaths. This requires collaboration with law enforcement, county attorneys and others, to investigate and report information about these most disturbing of deaths. An often overlooked and thankless task for a key group of physicians in our communities.

Statutorily, the Kansas coroner system requires physicians to serve in each county as appointed by the county commission. The State is divided into 31 Districts (map below) with a District Coroner overseeing the work of the county needs in the district. Deputy coroners can be appointed and are not required to be physicians.



The opioid epidemic prompted a national review of death investigation and cause of death reporting. Issues surrounding the disjointed way 57 jurisdictions and hundreds of coroners and medical examiners report drug overdose information in this country have been identified. Problems include too few and underpaid forensic pathologists to do the work needed to diagnose overdose deaths, delays in laboratory toxicology reporting and, most concerning to Kansas, the lack of coordination and standardization of death investigation and cause of death reporting among the coroner community.

KDHE commissioned the National Association of Medical Examiners (NAME) to conduct a needs assessment which provided recommendations that, if addressed, could bring Kansas in alignment with the rest of the nation. HB 2155 proposes the State support development for an Office of State Medical Examiner to evaluate gaps and inconsistencies, develop recommendations for best practices and quality improvement and oversee progress. This position will not be performing autopsies but will evaluate the full medicolegal death investigation process for Kansas and utilize collaborative approaches with the local county commissions, coroner, forensic pathology and funeral director communities to better support their needs. In addition, required training and continuing education for coroners is a critical component to assure the latest information is available for better service to families and law enforcement.

Key strengths of Kansas' coroner system:

- Kansas District coroners are appointed locally rather than elected. This eliminates partisan influence in medicolegal death investigation.
- Kansas District coroners are physicians, which brings a level of medical expertise needed for overseeing death investigations.
- Appropriate numbers of death certificates are being certified and filed by coroners based on national expectations.
- Coroners can obtain high quality postmortem examinations performed by board-certified forensic pathologists.
- The multi-disciplinary, systematic review of children's deaths by the State Child Death Review Board serves as a model for other review teams. In addition, written guidelines for child autopsies contribute to standardization for the State.

Weaknesses include:

- No statewide oversight, policies and procedures and annual reports regarding medicolegal death investigations. The lack of statewide coordination creates difficulty in addressing issues of quality and consistency.
- There are no detailed qualifications for the positions of District Coroner, Deputy Coroner or other coroner personnel other than the District coroner be a physician.

- There are no training or continuing education requirements for District and Deputy coroners or coroner personnel. Most coroners are family practice physicians with no experience in death investigation and training is "on the job".

- Delays for finalizing death certificates result in families being unable to settle estates and finalize financial matters.

- Weekend coverage can be an issue, particularly for law enforcement needing information crucial to an investigation.

- Transportation for autopsies has become a driver for autopsy costs due to the long distances needed to reach a forensic pathologist.

- Payment for serving as a coroner is inconsistent and does not meet national benchmarks.

We've heard the stories from families and funeral directors who need to finalize death certificates with information from the coroner and physician community on causes of death for our residents. Kansas needs to evaluate itself, assess the needs of those involved with the medicolegal death investigation process at all levels and address gaps. HB 2155 provides the core infrastructure for Kansas to begin this important work.

Thank you for your time today and I would be happy to address any questions you may have.