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## WISCONSIN LEGISLATIVE COUNCIL

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### POWERS AND DUTIES OF CORONERS AND MEDICAL EXAMINERS

Legislative Council Conference Room, One East Main Street, Suite 401  
Madison, Wisconsin

September 14, 2005

10:00 a.m. – 1:50 p.m.

[The following is a summary of the September 14, 2005 meeting of the Special Committee on the Powers and Duties of Coroners and Medical Examiners. The file copy of this summary has appended to it a copy of each document prepared for or submitted to the committee during the meeting. A digital recording of the meeting is available on our Web site at <http://www.legis.state.wi.us/lc/2004studies.htm>.]

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#### Call to Order and Roll Call

Chair Nischke called the meeting to order. The roll was called and it was determined that a quorum was present.

COMMITTEE MEMBERS PRESENT: Rep. Ann Nischke, Chair; Sens. Alan Lasee and Fred Risser; Reps. Daniel LeMahieu and Amy Sue Vruwink; and Public Members Anthony D'Alessandro, Susan Karaskiewicz, Melanie Ramey, Michelle Rinehart, and Thomas Thelen.

COMMITTEE MEMBER ABSENT: Public Member John E. Stanley.

COUNCIL STAFF PRESENT: Dan Schmidt, Senior Analyst; Don Salm, Senior Staff Attorney; and Julie Learned, Support Staff.

APPEARANCES: Terry C. Anderson, Director, Legislative Council; John Larson, Marathon County Coroner; Dr. Anthony D'Alessandro, Division of Transplantation; Melanie Ramey, The HOPE of Wisconsin; Dr. Lynda Biedrzycki, Waukesha County Medical Examiner; Paul Bucher, Waukesha County District Attorney; Adam Peer, Rock County Supervisor; and Susan Dzubay, Pierce County Coroner.

## **Opening Remarks**

**Terry C. Anderson**, Director of the Legislative Council, welcomed the committee and introduced the Legislative Council staff members assigned to work with the committee. He explained the basic procedures for study committees and noted that the committee's meetings are recorded and available on the Internet.

## **Introduction of Committee Members**

Chair Nischke welcomed all members of the committee and thanked them for their commitment to serve on the committee. She then asked the members of the committee to briefly introduce themselves.

## **Description of Material Distributed**

Don Salm, Legislative Council staff, provided a brief summary of Staff Brief 04-8, *Powers and Duties of Coroners and Medical Examiners*, which will be used as a reference during committee deliberations.

## **Invited Speakers**

**John Larson, Marathon County Coroner**, provided background information on the coroner/medical examiner system in Wisconsin, and described the structure and purposes of the Wisconsin Coroners and Medical Examiners Association (WCMEA). He noted that, for the past few years, the WCMEA has been working on updating and revising ch. 979, Stats., on death investigations. He pointed out that one proposal that has been suggested for providing funding for the currently under-funded coroners and medical examiner offices is to impose a ½ of one percent surcharge on Wisconsin life insurance policies for training and equipment in these offices. He did not know how much money such a surcharge would yield, but noted that the State of Florida had looked into this concept four or five years ago.

**Dr. Anthony D'Alessandro, Division of Transplantation**, discussed a number of issues relating to the role of coroners and medical examiners in organ and tissue donations both within and outside the context of a hospital. He noted that out-of-hospital deaths account for a majority of deaths that occur in a county. He described the situation nationally and in Wisconsin with reference to requirements and practices relating to donations, including recent instances in which coroners and medical examiners have: (1) denied such donations based on prosecution and other concerns; and (2) redirected hospital tissue donations to tissue banks outside of the tissue bank chosen by the hospital. He explained that some of the key problem areas are a lack of federal, state and local oversight; the denial of life-saving organ transplants; the circumvention of the hospital's choice of a tissue bank; and the lack of oversight and transparency in the tissue referrals. He then described some possible approaches for dealing with these issues.

**Melanie Ramey, The HOPE of Wisconsin**, noted that among the most serious problems with the current coroner system in Wisconsin are: (1) no qualifications are required for the position, which is often occupied by persons with insufficient knowledge to carry out the duties; (2) because it is an elected, constitutionally specified office, there is no oversight of the office, with county boards basically

powerless to question any matters relating to the operation of the office; (3) issues relating to pronouncement of death and the use of “hospice advance notice registries” by some coroners; and (4) various other practices of some coroners, including demanding an on-site visit for every death. She urged the committee to replace the current system with a single statewide system under the direction of a professional medical examiner and accountable to an appropriate state agency such as the Department of Health and Family Services.

**Dr. Lynda Biedrzycki, Waukesha County Medical Examiner**, gave an overview of the coroner-medical examiner systems in the United States and in Wisconsin, and provided substantial detail about the staffing, funding, caseload, and operation of the medical examiner system in Waukesha County. She pointed out that her office engages in multi-county cooperation for contractual and vacation autopsy coverage, investigator training, purchasing arrangements, and information sharing. She explained that an ideal death investigation agency would involve: (1) forensic pathologist medical direction; (2) educated death investigators; (3) continuing training for death investigators; (4) adequate funding for operations and facilities; (4) being locally-based; (5) regional cooperation; and (6) independence (i.e., not linked to law enforcement). She suggested, as models for the committee to consider, the Indiana Coroner Training Board and a State of California requirement for 80 hours of training for peace officers in coroner’s offices. She also suggested that an ideal system would: (1) require written guidelines for the coroner-medical examiner offices; and (2) establish a problem resolution system with broad representation of interested parties.

**Paul Bucher, Waukesha County District Attorney**, said that coroners and medical examiners need to know what the role of the prosecutor is in the death investigation system. He suggested that the provisions relating to coroners and medical examiners need to be placed in one specific area of the statutes (or in administrative rules) so it is clear what their powers and duties. He added that there should be minimum training and qualifications for coroners and medical examiners, developed by looking at best practices in Wisconsin counties or other states with excellent systems. He suggested that since coroners and medical examiners have to testify in court, there should be a required certification or licensing process to ensure that they know what they are doing in that context. He added that minimum qualifications, minimum education, and minimum continuing education should all be required.

**Adam Peer, Rock County Supervisor**, discussed the recent difficulties experienced in the Rock County coroner’s office. He explained that issues relating to the office of coroner, in general, revolve around the independent constitutional status of the office and the fact that it is a partisan elected office. For short-term reforms, he suggested: (1) giving counties true oversight over the office, by allowing county boards to remove coroners in the same manner as certain other county officers and to determine policy as to that office similar to the way it determines policy for other administrative county departments; (2) providing for uniform statewide standards and qualifications for the office; (3) allowing reorganization of the office amongst counties; and (3) making the office nonpartisan. As to long-term reform, he suggested that the office would be better administered on a statewide basis, with the scope, standards, and qualifications of the office uniform across the state.

**Susan Dzubay, Pierce County Coroner**, noted that the key issues relating to the office of coroner are accountability, liability (e.g., consequences of the coroner being hurt or infected at a death scene), and the limited resources provided to offices in many of the smaller counties. She suggested that: (1) the office of coroner be for a four-year term for purposes of continuity and stability; and (2) there be mandatory training at the beginning of a coroner’s experience in the office and continuing

education requirements thereafter. She added that, among other things, the fees relating to coroners need to be raised (e.g., the \$25 fee applicable to cremation permits), that information needs to be shared amongst various offices on a more immediate and regular basis, and that various definitions and other provisions in the statutes need to be clarified.

### **Discussion of Committee Assignment**

Chair Nischke reiterated the committee's scope and reminded committee members of the September 28 deadline for submitting suggestions to Legislative Council staff.

### **Other Business**

There was no other business brought before the committee.

### **Plans for Future Meetings**

The next meeting of the Special Committee will be held on *Wednesday, October 12, 2005, at 10:00 a.m., in the Legislative Council Conference Room, One East Main Street, Suite 401, Madison.*

### **Adjournment**

The meeting was adjourned at 1:50 p.m.

DLS:jal