Making Elder Care Better Since 1975

Kansas Advocates for Better Care

*Founded in 1975 as **Kansans for Improvement of Nursing Homes** by concerned citizens like you.*

March 20, 2013

Chairman Pilcher-Cook and Members of the Senate Public Health and Welfare Committee:

Thank you for the opportunity to comment on SB 236 which would cause reporting of deaths of adults in adult care homes to the county coroner. I am Mitzi McFatrich, executive director of Kansas Advocates for Better Care (KABC). KABC is a not-for-profit organization, beholden to no commercial interests and is supported almost entirely by donations from citizens who support our mission of improving the quality of care in all long-term settings. KABC's only interest is in *good quality long-term care* for older and disabled adults.

SB 36 would require that all deaths of adults in adult care homes and long-term care units be reported to the county coroner. While we support this change we would further recommend that the coroner shall accept the report for investigation and upon finding reasonable cause to suspect that an adult has died as a result of abuse, sexual abuse, or negligence shall report his findings to the police, and the appropriate prosecuting attorney. The second step would provide the avenue for the coroner to act upon the report. Kansas has such a model in KSA 22a-242 regarding the death of a child.

In 1999 Arkansas passed similar legislation and included the language we are recommending. I spoke with the Pulaski County, Arkansas Coroner, Mark Malcolm on March 19, 2013. He stated to me that the Arkansas legislation "Allowed for an investigation to be done at the time of death, so that there were, either no questions about correct and appropriate levels of care, or there were answers to those questions. The reports made at the time of death, allowed the coroner to see the environment, the body, look at the record of medications, look for signs of abuse or neglect. In most cases there were no problems but when there were problems the coroner could get a toxicology report or order an autopsy and the questions were resolved. There was a direct, undisturbed line of evidence." He further said, "We saw immediate good results from this legislation. There was better protection for the patient and for the facilities." In his opinion, "Facility staff are not qualified to determine unnatural death. And by reporting all deaths to the coroner immediately, it removes 100% of the burden from the facilities and places it where it belongs with totally qualified professionals."

We certainly do not think providers of long-term care are wrong doers, and yet we do know of specific instances of wrong-doing that have resulted in death for adults living in long-term care facilities and that have not been reported to the coroner, and that in fact, on occasion attempts have been made to cover up the wrong-doingby misrepresenting the circumstances surrounding the death. If one thinks about organization at the scene of death, and if there was harm that resulted in death whether intentional or unintentional, then asking the facility to report the wrong doing, is rather like asking the fox to guard the hen house.

Kansas Advocates for Better Care 913 Tennessee, Suite 2 Lawrence, KS 66044
785-842-3088 / 800-525-1782 info@kabc.org www.kabc.org

In Kansas Statute 22a-242. (a) When a child dies, any law enforcement officer, health care provider or other person having knowledge of the death shall immediately notify the coroner of the known facts concerning the time, place, manner and circumstances of the death. If the notice to the coroner identifies any suspicious circumstances or unknown cause, as described in the protocol developed by the state review board under K.S.A. 22a-243 and amendments thereto, the coroner shall immediately: (1) Investigate the death to determine whether the child's death included any such suspicious circumstance or unknown cause; and (2) direct a pathologist to perform an autopsy.

(b) If, after investigation and an autopsy, the coroner determines that the death of a child does not include any suspicious circumstances or unknown cause, as described in the protocol developed by the state review board under K.S.A. 22a-243 and amendments thereto, the coroner shall complete and sign a nonsuspicious child death form.

(c) If, after investigation and an autopsy, the coroner determines that the death of a child includes any suspicious circumstance or unknown cause, as described in the protocol developed by the state review board under K.S.A. 22a-243 and amendments thereto, the coroner shall notify, within 30 days, the chairperson of the state review board and shall notify, within 24 hours, the county or district attorney of the county where the death of the child occurred.

There are areas that are analogous in the reasoning applied to child protection and elder protection. There are parallels related to the reporting of child abuse and elder abuse. There are issues of capacity for children and with adults who have Alzheimers, intellectual disabilities or severe mental illness. There are issues of inability to protect oneself due to size for children and frailty for elders. So it seems reasonable to look to KSA 22a-242 as we attempt to implement an adequate statute to address reporting deaths of elders or adults with disabilities living in adult care facilities.

While you may think that because a facility has a medical director, he/she is the attending physician for adults living in the facility and is in the facility daily, but that is not the case. The medical director would not be called to come into the facility at the time of a resident’s death to check the body or the circumstances of their death.

Thank you for your consideration of these issues and I hope you will act to amend the bill and empower the coroner to investigate deaths of elders in adult care facilities.

Mitzi McFatrich, Executive Director
Kansas Advocates for Better Care
On behalf of members and volunteers