HB

383

Alaska State Legislature

Interim:
145 Main St. Lp., 223
Kenai, Alaska 99611
907/283-7095
907/283-3075 fx
907/262-7574 hm

Session:
State Capitol
Juneau, AK 99801
907/465-2693
fx 907/465-3835
800/463-2693

Representative Gary Davis

MEMORANDUM

DATE: March 5, 1998

TO: Representative Joe Green, Chair
House Judiciary Committee

FROM: Representative Gary Davis

RE: Request for Hearing on HB 383 "An Act relating expected deaths that occur at home or in a health care facility"

This is to request that a hearing be scheduled on House Bill 383 "An Act relating expected deaths that occur at home or in a health care facility." Attached are the following items for inclusion in the committee files.

- Sponsor Statement;
- Sectional Analysis;
- current Alaska statutes that will be modified by HB 383; and
- background information on expected home death procedures in Anchorage and Juneau, and correspondence from personnel with the Hospice of the Central Peninsula.

Thank you for considering this request. Please contact Deb Davidson of my staff if you have any questions.

GLD/dld

Attachments

Representing House District 8
Cooper Landing, Funny River, Hope, Moose Pass, Seward, Sterling, Soldotna

Representative_Gary_Davis@legis.state.ak.us

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Representative Gary L. Davis

SPONSOR STATEMENT

House Bill 383

"An Act relating to expected deaths that occur at home or in a health care facility"

Expected home death describes a circumstance whereby a person who has a limited life expectancy and wants to die at home completes an "Expected Home Death Case Report" signed by the attending physician and files a copy of this form with the State Medical Examiner. Alaska statutes list the criteria necessary for a circumstance to be considered an expected home death and specify conditions under which a registered nurse may make a determination and pronouncement of death in these circumstances.

House Bill 383 amends statutes pertaining to expected home deaths by removing perceived contradictions in law regarding whose responsibility it is to sign the death certificate in these cases. It also adds a new section that states it is not necessary to notify a peace officer in the event of a properly documented expected home death.

Current law requires that both law enforcement officials and the state medical examiner be notified in all instances of death regardless of cause. The law is somewhat unclear as how and when peace officers are to be involved in an expected home death situation; however it is explicit in its requirement that the person's body may not be moved without the permission of the state medical examiner. This lack of clarity has caused some confusion and discrepancies in the way expected home deaths are handled throughout the state.

Experiencing the death of a family member is a difficult and emotionally charged event, and requiring additional personnel to the situation can cause unnecessary stress. House Bill 383 removes the requirement that peace officers be notified in the event of an expected home death provided that the procedure for filing an expected home death case report has been followed, and the person authorized to pronounce death believes the death occurred as anticipated.

Death from a terminal illness or natural causes is a normal life event and should be treated as such. House Bill 383 amends current statutes to allow this to happen without undue intrusion, while still providing that the interests of the state and the deceased are protected.

HB383/SS/2/12/98

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SECTIONAL ANALYSIS

House Bill 383

"An Act relating to expected deaths that occur at home or in a health care facility"

Section 1 Amends AS 08.68.395 "Determination of death by registered nurse," subsection (a) to specify that the required documentation for anticipated death include the physician's agreement to sign the death certificate if the death occurs as anticipated.

Section 2 Amends AS 08.68.395(b) to specify that the registered nurse who pronounced death in an anticipated death circumstance shall provide to the person signing the death certificate the required information.

Section 3 Adds a new section to AS 12.65, "Death Investigations and Medical Examiners," stating that a peace officer does not have to be notified in cases of expected home deaths where a person authorized to pronounce death is in attendance or has knowledge of the death.

SB383/SA/2/11/98

Chapter 65. Death Investigations and Medical Examiners.

Cross references. — For inquests, see AS 09.55.062 — 09.55.069.

Collateral references. — 18 Am. Jur. 2d, Coroners or Medical Examiners, § 1 et seq.

18 C.J.S., Coroners, § 1 et seq.; 80 C.J.S., Sheriffs and Constables, § 38.

Liability for wrongful autopsy, 18 ALR4th 858.

Sec. 12.65.005. Duty to notify state medical examiner. (a) Unless the person has reasonable grounds to believe that notice has already been given, a person who attends a death or has knowledge of a death, in addition to notifying a peace officer, shall immediately notify the state medical examiner when the death appears to have

(1) been caused by unknown or criminal means, during the commission of a crime, or by suicide, accident, or poisoning;

(2) occurred under suspicious or unusual circumstances or occurred suddenly when the decedent was in apparent good health;

(3) been unattended by a practicing physician or occurred less than 24 hours after the deceased was admitted to a medical facility;

(4) been associated with a diagnostic or therapeutic procedure;

(5) resulted from a disease that constitutes a threat to public health;

(6) been caused by a disease, injury, or toxic agent resulting from employment;

(7) occurred in a jail or corrections facility owned or operated by the state or a political subdivision of the state or in a facility for the placement of persons in the custody or under the supervision of the state;

(8) occurred in a foster home;

(9) occurred in a mental institution or mental health treatment facility; or

(10) occurred while the deceased was in the custody of, or was being taken into the custody of, the state or a political subdivision of the state or a public officer or agent of the state or a political subdivision of the state.

(b) A person who attends a death or has knowledge of a death occurring in circumstances other than those enumerated in (a) of this section may notify the state medical examiners of the death if, in the person's opinion, a death investigation under AS 12.65.020 — 12.65.025 may be appropriate.

(c) The body of a person whose death has been or should be reported to the state medical examiner under this section may not be moved or otherwise disturbed without the permission of the state medical examiner. (§ 2 ch 103 SLA 1996)

Effective dates. — Section 2, ch. 103, SLA 1996, which enacted this section, took effect on September 23, 1996.

Article 5. Miscellaneous Provisions.

Section
395. Determination of death by registered nurse

Sec. 08.68.395. Determination of death by registered nurse. (a) A registered nurse licensed under this chapter may make a determination and pronouncement of death of a person under the following circumstances:

(1) an attending physician has documented in the person's medical or clinical record that the person's death is anticipated due to illness, infirmity, or disease; this prognosis is valid for purposes of this section for no more than 120 days from the date of the documentation;

(2) at the time of documentation under (1) of this subsection, the physician authorized in writing a specific registered nurse or nurses to make a determination and pronouncement of the person's death; however, if the person is in a health care facility and the health care facility has complied with (d) of this section, the physician may authorize all nurses employed by the facility to make a determination and pronouncement of the person's death.

(b) A registered nurse who has determined and pronounced death under this section shall document the clinical criteria for the determination and pronouncement in the person's medical or clinical record and notify the physician who determined that the prognosis for the patient was for an anticipated death. The registered nurse shall sign the death certificate, which must include the

(1) name of the deceased;

(2) presence of a contagious disease, if known; and

(3) date and time of death.

(c) Except as otherwise provided under AS 18.50.230, a physician licensed under AS 08.64 shall certify a death determined under (b) of this section within 24 hours after the pronouncement by the registered nurse.

(d) In a health care facility in which a physician chooses to proceed under (a) of this section, written policies and procedures shall be adopted that provide for the determination and pronouncement of death by a registered nurse under this section. A registered nurse employed by a health care facility may not make a determination or pronouncement of death under this section unless the facility has written policies and procedures implementing and ensuring compliance with this section.

(e) Notwithstanding AS 08.68.400(a)(1), this section applies to a qualified nurse described in AS 08.68.400(a)(1) who is employed by a federal health care facility.

(f) The Department of Health and Social Services may adopt regulations to implement this section.

(g) In this section,

(1) "determination of death" means observation and assessment that a person is dead, as defined in AS 09.68.120;

(2) "health care facility" means a private, municipal, state, or federal hospital, psychiatric hospital, tuberculosis hospital, skilled nursing facility, kidney disease treatment center (excluding freestanding hemodialysis units), intermediate care facility, or Alaska Pioneers' Home administered by the Department of Administration under AS 47.55. (§ 1 ch 6 SLA 1991)

STATE OF ALASKA

TONY KNOWLES, GOVERNOR

DEPARTMENT OF HEALTH & SOCIAL SERVICES
Division of Public Health
OFFICE OF THE MEDICAL EXAMINER

5700 East Tudor Road
Anchorage, Alaska 99507-1264
Phone: 269-5090/Fax: 269-5069

MEMORANDUM

TO: Persons Registering Expected Home Deaths

FROM: Michael T. Propst, M.D.
Chief Medical Examiner

SUBJECT: Procedure Change for Registration of Expected Home Deaths

Effective immediately the agency registering an expected home death will send (fax) the notification to two places:

1. Office of the State Medical Examiner - fax 269-5069

2. Anchorage Fire Dispatch - fax 344-6180

The Fire Department requires copies of the form authorizing the pronouncement of death by an R.N., when that is elected by the treating physician. It is not necessary to supply that form to the Medical Examiner.

The Medical Examiner's Office is not able to forward information or to fax back confirmation of registration.

EXPECTED HOME DEATH PROCEDURE FOR ANCHORAGE

The Anchorage Fire Department EMS Division (paramedics), the State Medical Examiner's Office and other concerned persons have developed this procedure for handling Expected Home Deaths.

To Initiate a Listing

If you are making the arrangements for an Expected Home Death, we ask you to follow this standard procedure:

1. The treating physician completes and signs an Expected Home Death registration form and return it by fax to the State Medical Examiner's Office at 269-5069 and to Anchorage Fire Dispatch at 344-6180. (You may contact the Medical Examiner's Office at 269-5090 to obtain a blank copy of this form).

    a. The form will contain the following information on the patient
    Name
    Date of birth
    Social security number
    Residential address of patient (and directions if necessary)
    Phone number at residence
    Next-of-kin/contact and phone number
    Nature of the illness
    Treating physician's signature, license number and phone number
    Name of home nursing service, if any
    Whether the patient has a pacemaker

    b. The treating physician must confirm the nature of the illness and that he/she is willing to sign the death certificate if this patient dies at home.

2. After the Medical Examiner's Office has reviewed the Expected Home Death form, it will be kept on file.

To Report a Death at the Home of a Listed Person

1. If this is an Expected Home Death in which the patient's treating physician has responded to the home to pronounce the death, there is no requirement for paramedics or police officers to be involved Upon arriving in the home and pronouncing death, the physician shall contact the Medical Examiner by calling the Anchorage Police Department Dispatch at 786-8900 The Medical Examiner will give permission to remove the body.

2 If this is an Expected Home Death in which a specific Registered Nurse has current written authority to pronounce death, the Home Nursing Service Agency will provide a written procedure for the family to follow upon the death of the patient.

3. In all other cases, when an Expected Home Death occurs, the procedure set forth on the next page should be followed by persons in the home:

a. Call Anchorage Fire Department Paramedic Dispatch at 522-1122. This is a 24 hour number.

b. The caller must identify who they are and state "this is an Expected Home Death".

c. The caller must give the nature of the call; that is, the patient is dead.

d. The caller must give Dispatch the patient's full name.

e. The caller must give Dispatch the residence phone number, street address and directions, if needed

If the above procedure is followed, a paramedic and police officer will be dispatched without lights and sirens to the residence.

The paramedic will determine that the patient has died. The paramedic will then provide his/her name to the person in charge at the residence or to the police officer.

The police officer will conduct an initial investigation. Usually, this will consist of a visual inspection of the deceased and the surrounding area, a determination of the name of those persons present in the home at the time of death, discussion with the person in charge at the home as to times and events leading up to the death, and a consultation with the paramedic.

The police officer will call the Medical Examiner's Office for permission to remove the body. The funeral home of the family's choice may then be called to request their personnel remove the body.

If this is an Expected Home Death in which a Registered Nurse has current authority to pronounce death, the nurse will contact the Anchorage Fire Department Paramedic Dispatch at 522-1122. Dispatch will notify the appropriate police agency. The police officer will follow the same investigation procedure as above.

It is important that families be aware of the following information:

1 If the 911 emergency number is called, there will be a full coded response with lights and sirens by the paramedics and the police.

2. If the patient still has vital signs when the paramedics arrive at the residence and the family requests transport without resuscitation, the medics will comply with the family's request. If the family makes specific treatment requests, the medics will contact an appropriate physician for direction.

3. In all cases, the police officer has the right to institute a full investigation. This should not be construed to mean anyone is suspected of wrongdoing.

4. The Expected Home Death list is not a "no code" or "do not resuscitate" list. It only relates to the type and level of paramedic and police response after an expected home death has occurred.

REGISTERED NURSE DIRECTIVE
PRONOUNCING DEATH FOR EXPECTED HOME DEATHS

1. Standard procedure for setting up an Expected Home Death through the Medical Examiner's Office will be followed.

2. If a Registered Nurse will be authorized to pronounce death, the Home Nursing Service (this includes Hospice) must provide Anchorage Fire Dispatch with written authorization from the treating physician.

   a. Per A.S. 08.68.395, this written authorization must designate a specific registered nurse or nurses.

   b. The authorization is only valid for 120 days.

3. The Home Nursing Service will provide the family with directions to be followed upon the death of the patient. These directions must be very specific as to what hours and days the R.N. will be available to pronounce death, and what the family is to do if death occurs during the time frames they are not available.

4. The proper authorized Registered Nurse will determine the patient has died. The nurse will then call the proper law enforcement agency for law enforcement response. The number to call at Anchorage Police Department is 786-8900. The number to call the Alaska State Troopers is 428-7200. If the nurse is unsure of jurisdiction, the call should be placed to the Anchorage Police Department. They will direct the call to the proper agency.

The law enforcement response in these cases will be the same. The law enforcement officer will confirm with the Medical Examiner's Office that the registered nurse has current authority to pronounce death.

It is the responsibility of the Home Nursing Service to:

1. Provide the Medical Examiner's Office with written authority from the doctor for the registered nurses to pronounce death. The Medical Examiner's Office will accept a facsimile of that authorization.

2. Track the 120 day limit and insure a current authorization is always on file with the Medical Examiner's Office.

3. Advise the Medical Examiner's Office if they terminate services to a patient, and therefore, would not be authorized to pronounce death.

EXPECTED HOME DEATH REGISTRATION FOR THE ANCHORAGE AREA

To add a patient to the Medical Examiner's Expected Home Death List for 12 months the attending physician must sign the completed form and fax it to 269-5069 and to Anchorage Fire Dispatch at 344-6180

PATIENT NAME_____ TELE#_____

DATE OF BIRTH_____ SS#_____

PATIENT PHYSICAL LOCATION (no P.O. Box)_____

FAMILY/CONTACT (name/relationship)_____ TELE#_____

FACILITY NAME_____ TELE#_____

Will RN be authorized to pronounce death?_____
If yes, then a list of those RN's authorized to pronounce must be sent to A.F.D.

RN Expiration if authorized to pronounce _____ (120 from the physician's date of signature)

ILLNESS_____ PACEMAKER?_____

PHYSICIAN_____ TELE#_____

As the attending physician for this patient, I confirm the illness listed above, that death is anticipated, and I agree to sign the death certificate if death occurs out of my presence, and as a consequence of the above illness.

PHYSICIAN SIGNATURE_____ DATE_____
License #_____

****

Please fax the following information after pronouncement has been made.

DATE OF DEATH_____ TIME OF DEATH_____

PARAMEDIC/PRONOUNCING NURSE_____

OFFICER_____ AGENCY CASE #_____

FUNERAL HOME_____ M.E. NOTIFIED_____

01/02/97 This form supersedes all previous Expected Home Death Registration forms for the Anchorage area.

HOSPICE AND HOME CARE OF JUNEAU
PROCEDURE FOR EXPECTED DEATH REPORTING

DRAFTED BY: **Jan Young, RN**

DATE REVIEWED/REVISED: **11/04/96**

1. **UPON ADMITTING A CLIENT TO HOSPICE, THE NURSE WILL COMPLETE A *EXPECTED HOME DEATH CASE REPORT* FORM AND FAX TO THE OFFICE OF THE STATE MEDICAL EXAMINER (OSME) AT: 1-907-269-5089.**

2. **AT THE TIME OF DEATH, THE NURSE CALLS THE *DEATH REPORTING NUMBER* TO REPORT TIME OF DEATH AND OBTAIN PERMISSION TO RELEASE THE BODY TO THE MORTICIAN. REMEMBER, THE BODY CANNOT BE REMOVED FROM THE HOME UNTIL PERMISSION HAS BEEN GRANTED BY THE OSME. IF YOU HAVE ANY SUSPICION THAT THE DEATH DID NOT OCCUR IN THE EXPECTED MANNER, REPORT THAT ALSO. THE APPROPRIATE POLICE AGENCY WILL NEED TO BE CALLED UPON TO INVESTIGATE.**

OSME DEATH REPORTING NUMBER:

1-888-332-3273 (1-888-DECEASE) (TOLL FREE NUMBER)

(back up no. if 888 doesn't work: 1-907/227-2882)

THERE IS ALSO AN ANCHORAGE OFFICE NUMBER AVAILABLE DURING NORMAL WORKING HOURS: 1-907-269-5090 (THIS IS A L.D. CALL)

3. **IF THE NURSE CANNOT REACH THE OSME AT TIME OF DEATH, SHE MAY CONTACT THE JUNEAU POLICE DEPT. (586-2780). AN OFFICER WILL COME INSPECT THE SCENE AND EITHER REPORT TO THE OSME OR GIVE PERMISSION TO RELEASE THE BODY TO THE MORTICIAN.**

This was our local coroner's Policy for Juneau in general

SMC Substitute office of the State medical Exam. - anywhere "coroner" is referred to.

1992

JUNEAU
HOME DEATH POLICY

Introduction

The purpose and intent of this policy and procedure for expected home deaths is to achieve the dignity and rights of the deceased, the privacy and confidentiality of the family, and the safety and welfare of the public. You are advised to follow this policy when assisting with an expected home death.

Before Death

1. Contact the Office of the ~~Coroner~~ SMC to make the necessary arrangements to facilitate this process. Be ready to provide the necessary patient information, including: name, address, date of birth, social security number, next of kin, diagnosis, "certifying physician", supervising "licensed professional", and whether the JFD/EMS has a "Do Not Resuscitate Order".

2. If you are not the "certifying physician" who intends to sign the certificate of death, then it may be necessary for the Office of the ~~Coroner~~ SMC to confirm the diagnosis and the expected cause of death with the certifying physician. The SMC ~~Office of the Coroner~~ after authorizing removal of the body from the scene will reconfirm the certifying physician's opinion before the body is released to the mortuary.

After Death With Licensed Professional

3. If the case is being supervised by a physician, registered nurse, or other "licensed professional" person licensed in Alaska to make a determination and pronouncement of death, then the individuals on the scene are instructed upon death to call this supervising individual. However, if the "licensed professional" can not be reached immediately, then the people on the scene are instructed to call 911. The EMS will respond in accordance with their "Do Not Resuscitate Protocol" and will wait on the scene until the arrival of the "licensed professional" if contact reasonably can be made.

4. The "licensed professional" will arrive on the scene, will assess the situation, will contact the Office of the SMC ~~Coroner~~, will advise whether the death occured in the expected manner and will provide the following information: the patient's name, date of birth, date and time of death, and the "certifying physician" who intends to sign the certificate of death.

5. If in the unusual case the death occured under circumstances which justifies further inquiry, then the appropriate police agency will be called upon to investigate. If in the normal case the death appears to have occured as expected, then the coroner will give the authorization for the "licensed professional" to arrange for removal of the body without further on-scene investigation. The body will be released to the mortuary only after the coroner reconfirms the availability of the "certifying physician."

After Death Without Licensed Professional

6. If the case is not being supervised by such a person licensed in Alaska to make a determination and pronouncement of death or this "licensed professional" can not be reached immediately by the people on the scene, then the individuals on the scene are instructed upon death to call 911.

7. Dispatch of paramedic/police will occur. If and only if the patient has executed a "Do Not Resusitate Order" (DNR) with the JFD/EMS, then the paramedic unit will be dispatched on a non-emergency basis without lights and siren. If there is no DNR or it can not be confirmed, then an ambulance will be dispatched on an emergency response basis.

8. With a DNR on the scene the EMS personnel will follow the DNR protocol. If death is obvious without signs of foul play, then ambulance personnel will wait on the scene until the arrival of the police and advise the police officer of their findings. The EMS personnel may not remove the body until the police officer arrives and authorization is obtained from the Office of the ~~Coroner~~ Sme If death has not occured, then EMS personnel may elect to leave, administer care, or transport in accord with the DNR protocol.

9. Without a DNR on the scene the EMS personnel will administer appropriate emergency life support in accordance with departmental standard operating procedure.

10. If emergency transport is not done, then the police officer after arrival on the scene will notify the Office of the ~~Coroner~~ SME of the unattended death before the body is removed. If emergency transport is done, then the hospital personnel will notify the Office of the ~~Coroner~~ SME before the body is taken to the morgue. The hospital personnel will advise the ~~coroner~~ SME of the date, time and by whom the death was determined and pronounced. The body will be released to the mortuary only after the ~~coroner~~ SME reconfirms the "certifying physician's" opinion.

Proviso

The "certifying physician" will accept full responsibility for the determination of the medical cause of death and the conduct, judgment and supervision of the "licensed professional." If the "certifying physician", "licensed professional", paramedics, police officers, or coroner feel uncomfortable with any aspect of the situation, then they are authorized to and shall request a further investigation. Any such further investigation is not an indication of any wrongdoing, but rather that a request is being made to handle the case as a normal unattended death.

Drafted by The CORONER for all medical Personnel

Juneau's own CBJ DNR form

CODE STATUS ORDER SHEET

All patients are considered to be Full Code Status unless the following are indicated. Please check the treatment options you wish for this patient.
Check one of these two:

1. _____ Do Not Attempt Resuscitation (DNR)

2. _____ Individualized Resuscitation Attempt (CHECK TREATMENTS TO BE WITHHELD)

- _____ Cardiopulmonary resuscitation (CPR)
- _____ ACLS Medications (with a cardiac monitored patient)
- _____ Defibrillation
- _____ Endotracheal intubation
- _____ Mechanical ventilation
- _____ Others _____

INSTRUCTIONS:

1. Telephone orders for code status are not acceptable.
2. Whenever a change in code status is made, the outdated Code Status Order Sheet will be marked "VOID" and dated across the front at the time of code status change. New order sheets must be filled out whenever a change in code status is required.

FOR USE BY BARTLETT REGIONAL HOSPITAL ONLY:

1. Physician must write or dictate a Progress Note to fully document the process by which the resuscitation decision was reached.
2. A new Code Status Order Sheet must be completed with each admission.
3. The active Code Status Order Sheet will be kept in the Advance Directives section of the patient record.
4. The patient will temporarily revert to Full Code status during surgery.
5. Refer to Policy entitled *"Code Status"* for more detail.

This is to inform you that the patient named below is known to me and should be cared for according to the above directions. This order is in accordance with the patient's and/or family's wishes, and/or the Living Will Act of the State of Alaska. I shall sign the patient's death certificate.

Date / Time: _____ Physician Signature: _____

Patient Name: _____ Patient Signature: _____

If patient unable to sign: Patient Representative Signature: _____

Address: _____

Date of Birth: _____ Diagnosis: _____

CITY AND BOROUGH OF JUNEAU
BARTLETT REGIONAL HOSPITAL

Addressograph

BRH / 31 REV. 9/96
Approved SCC: 4/23/98

SME Office Form

EXPECTED HOME DEATH CASE REPORT

To add a patient to the State Medical Examiner's Home Death List the attending physician should sign the completed form and fax it to (907) 269-5069. All information must be typed.

Information Provided By:_____ Facility:_____

Phone:_____ Date:_____

Patient Name:_____ Patient Phone:_____

Date of Birth:_____ SS#_____

Patient Physical Location (no P.O. Box)_____

Family/Contact (Name/Relationship)_____

Address_____ Phone:_____

Funeral Home Choice_____

Physician _____ Phone:_____

Nature of Illness_____

As the attending physician for this patient, I confirm the illness listed above, that death is anticipated, and I agree to sign the death certificate if death occurs at home.

Physician Signature_____ Date:_____

Once the above information has been complete and verified, provide a copy of this form to police, troopers, health aide, or other emergency responders. Be sure the family knows who to call when the death occurs (police, health aide, etc.)

Date of Death._____ Time of Death:_____

Death Pronounced By:_____

Officer:_____ Agency Case Number _____

Copy of SME current Comfort One form

comfort ONE

№ [redacted]

PATIENT INFORMATION

PATIENT NAME: _____ DOB: _____
ADDRESS: _____ GENDER: ☐ M ☐ F

CERTIFICATION OF COMFORT ONE® STATUS

This form constitutes reliable documentation that the above identified patient is certified as a **COMFORT ONE** patient in Alaska under **AS 18 12 and 7 AAC 16.10 and, as such, directs EMS personnel, health care providers, and health care facilities to not resuscitate the patient in accordance with these statutes and regulations**

Patient Signature: _____ Date: _____

My signature below constitutes and confirms a formal order to emergency medical services personnel and other health care providers to follow the Alaska **COMFORT ONE** protocol, as outlined in 7 AAC 16.10.010 - 7 AAC 16.10.090 I affirm that this order is written in accordance with accepted medical, legal, and ethical guidelines.

_____ Phone. _____
Printed Name of Physician

Physician Signature: _____ Date. _____

Questions for State Medical Examiner's Office
(Responses DO NOT Affect Patient Care)

Illness _____

Will the physician named above agree to sign the death certificate if it occurs out of his/her presence and as a consequence of the listed illness? ☐ Yes ☐ No

Does this patient have a pacemaker? ☐ Yes ☐ No

INFORMATION TO PATIENT

This form, when completed, certifies you as a **COMFORT ONE®** patient under Alaska law. If this form or wallet card is presented to, or found by, emergency medical personnel or other health care providers, or you are wearing a **COMFORT ONE** bracelet, they will provide the care described on the reverse side. Emergency medical care will be directed to prevent avoidable suffering and to provide supportive comfort measures. It is understood that as a **COMFORT ONE** patient you will be allowed to die in the natural course of your illness.

REVOCATION

The COMFORT ONE status of the patient may be revoked, by the patient identified or the patient's attending physician, at any time.

If emergency medical services personnel, or other health care providers, do not see this form, the wallet card or the COMFORT ONE bracelet, they will attempt to resuscitate the patient in accordance with their standard procedures.

Form 1572

TONY KNOWLES, GOVERNOR

P.O. Box 110616
Juneau, Alaska 99811-0616

Emergency Medical Services
Telephone: (907) 465-3027
Telefax: (907) 465-4101

Health Promotion
Telephone: (907) 465-3140
Telefax: (907) 465-2770

Primary Care
Telephone: (907) 465-3091
Telefax: (907) 465-6861

Department of Health & Social Services
Division of Public Health
Section of Community Health and Emergency Medical Services

MEMORANDUM

RECEIVED
AUG 2 9 1997

DATE: August 28, 1997

TO: EMS Regions
EMS Services
Hospice Organizations
Home Health Care Organizations

FROM: Doreen Risley
Community Health & EMS

SUBJECT: Comfort One Forms

Several agencies have asked about faxing the Comfort One forms for physician signature when a home death is imminent. While this is not a practice we encourage, we do understand that in some circumstances it is the best alternative for the patient and family. With that said, here is how we would like it handled:

- The patient will sign the form;
- The form will then be faxed to the physician for his/her signature;
- The form is then faxed back to the nurse who annotates the time and date and verifies this with his/her signature,
- The original is routed for signatures by the fastest means;
- If death occurs prior to the arrival of the original form, the responders will contact the physician for verification of enrollment.

Again, this is a practice we would like reserved for those circumstances where the nurse feels the death is likely to occur prior to the arrival of the original form. We encourage physicians to discuss the Comfort One program with terminally ill patients, therefore minimizing the necessity of this procedure. We endorse nurses discussing the DNR option with patients at home and facilitating the process of getting the forms completed. Above all patients need to understand that if at some point he/she changes his/her mind, the DNR may be revoked by destroying all forms and sending back the bracelet, if one was purchased.

As more patients are enrolled in the program I'm sure other questions will arise. Please contact me at 465-8633 so we can address the issue. Thank you for your cooperation.

for pol
& ada
Bracelets

Policies on the Distribution of Comfort One Forms and Bracelets

Overview

The Department of Health and Social Services is responsible, by statute, for the development of a statewide do not resuscitate program. The department has adopted the Montana Comfort One program and is responsible for the development and printing of Alaska Comfort One forms.

The following agencies are responsible for distributing the Comfort One forms to physicians:

Contact	Southern Region EMS Council 6130 Tuttle Place Anchorage, AK 99507-2043	Interior Region EMS Council, Inc. 3522 Industrial Fairbanks, AK 99701	Southeast Region EMS Council, Inc. 207 Moller Drive Room 113 Sitka, AK 99835
Telephone	(907)562-6449	(907)456-3978	(907)747-8005
FAX	(907)562-9893	(907)456-3970	(907)747-1406
e-mail	sremsc@alaska.net	iremsc@alaska.net	serems@ptialaska.net

Form Distribution

The three Regional EMS Offices listed above are the sole sources of Comfort One forms in Alaska. They are authorized to distribute forms to physicians, mid-level practitioners, nurses, and other appropriate staff members, such as discharge planners, who work for an agency responsible for the care of terminally ill patients and which have direct physician oversight.[1] Such agencies include hospitals, nursing homes, medical clinics, Hospice agencies, or home health care agencies.

Individuals receiving the forms are responsible for ensuring they are completed appropriately.

The Regional EMS Office distributing the form should, to the extent possible, ensure that those receiving the forms have been instructed in their proper completion.

Bracelet Distribution

Optional bracelets are available to those enrolled in the Comfort One Program. The Comfort One form is accompanied by a postcard (Comfort One Bracelet Record) for ordering the bracelet. The patient may order the bracelet directly from the Regional EMS Office by mail or the patient, or the patient's agent, may bring the post card to the Regional EMS Office and purchase the bracelet there. In every case, the individual must provide the Comfort One Bracelet Record or

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[1] This is the operational definition of "authorized health care providers" referred to in the brochure for patients and families regarding the Alaska Comfort One program.

Revised 07/97

other unequivocal verification of enrollment, such as a Comfort One form, to purchase a bracelet. The Regional EMS Offices may deny bracelets to those who cannot provide such evidence.

For more information, contact the nearest Regional EMS Office, the Section of Community Health and EMS at (907)465-3027, or visit the program's web site at:

http://www.hss.state.ak.us/dph/ems/ems_dnr.htm

Alaska Comfort One (Do Not Resuscitate) Program
Recommendations for Physicians

On October 10, 1996, regulations (7 AAC 16.10.010 - 7 AAC 16.10.090) went into effect establishing a statewide do not resuscitate (DNR) protocol for physicians, EMS responders, and other health care providers. They also adopt, by reference, the Montana Comfort One© standards for DNR identification, including forms, cards, and bracelets.

Many local communities in Alaska have programs which augment the new statewide DNR system. Emergency Medical Services agencies, for example, may have a system for registering DNR patients with the emergency medical dispatch center. Such a system can result in a much more appropriate medical response to an expected home death. Consequently, physicians are encouraged to become familiar with local DNR programs.

Attached are blank forms for enrolling patients in the Alaska DNR program, also known as the Alaska Comfort One program.

To enroll a qualified patient in the program, you should:

- have the patient read and complete the form, answering any questions that may arise;
- sign and date the form and wallet card;
- give a copy of the form and wallet card to the patient;
- complete and return the DNR program data collection postcard; and
- purchase a DNR identification bracelet for the patient (optional).

.e section of the form containing information for use by the State Medical examiner does not have to be completed for the do not resuscitate order to be effective. However, responding to the questions allows the Medical Examiner and law enforcement personnel to conduct investigations more quickly and with minimal intrusion.

You should make sure the patient signing the form:

- receives an explanation of the expected consequences of withholding or withdrawing cardiopulmonary resuscitation;
- is informed that if the wallet card, form, or bracelet is not apparent and immediately available, resuscitation efforts will be started and will continue until the patient is determined to have a valid DNR status; and
- receives an explanation of how, and by whom, the DNR order may be revoked.

If the qualified patient being enrolled in the program by the physician is unable to sign the form, the signature of others, such as family members, can be of value in demonstrating support of the DNR order. Consequently, physicians are encouraged to obtain such signatures when circumstances warrant. However, the signature of a family member or guardian does not provide legal permission for the do not resuscitate order. That authority is conferred by the signature of the physician.

Distribution of Form Copies:

- The white (original) copy of the form remains with the patient who should be encouraged to keep it in an easily accessible location.
- The second copy of the form is retained by the physician and included in the patient's medical file.
- The third and bottom copies of the form may be used by another agency to confirm enrollment in the Comfort One program. Local fire departments, emergency medical services agencies and hospice organizations are examples of such optional uses.
- A copy of the completed and signed form should be sent via fax to the office of the State Medical Examiner.

For additional information regarding the DNR program in Alaska, contact:

Section of Community Health & EMS
Department of Health and Social Services
Box 110616
Juneau, AK 99811-0616
(907)465-3141/FAX: 465-4101
email: marta@health.state.ak.us

Address of the State Medical Examiner:

Michael Propst, M.D.
State Medical Examiner
5700 E. Tudor Road
Anchorage, AK 99507-1264
(907)269-5090/FAX: 269-5069

This is our own agency Policy – for Hospice

* We do not currently preserve non-Hospice patients

HOSPICE AND HOME CARE OF JUNEAU
POLICY AND PROCEDURE

3 pp

Subject: **EXPECTED CLIENT DEATH (HOSPICE PATIENTS)**

Drafted by: Catherine Cuenin, RN — Date Drafted: 12/20/91

Revised: Jan Young, RN — Date Revised: ~~03/16/95~~ 12/96

Approved: Professional Advisory Committee — Date Approved: 04/11/95

Supersedes Date: 12/07/93 — Revised 1/25/96, 9/25/96

PURPOSE:

1. Establish guidelines for ~~responding~~ reporting an expected death of a patient in the home in a manner which complies with:

   A. Applicable rules and regulations.

   B. The wishes of the patient and/or his/her representative.

2. Promote appropriate response and actions to maintain the patient's and family's dignity and comfort at the time of death.

3. Inform all Team members of the death in a timely manner.

POLICY:

1. The agency establishes a plan for patients who have chosen no intervention (do not resuscitate) through the execution of an advance directive. The process includes:

   A. Notifying the physician.

   B. Obtaining orders.

   add: Reporting Expected Death*

   C. Educating the patient or family.

   D. Establishing a plan for staff.

   * All pts on Hospice Service are expected [illegible]

2. In the situation in which a patient who has executed an advance directive and chosen no intervention ceases respirations or pulse in the home, if:

   A. Professional staff is present, the staff member will
      1. measure the patient's blood pressure, heart rate, respirations and make the determination of death.
      2. notify the ~~coroner's office~~ State Medical Examiner and report the death of the client, providing the client's name, time of death, date of birth, diagnosis, physician's name and responsible family/caregiver's name, address & telephone number.

OSMC

3. notify mortuary or mortician on call, once coroner has released the body, and stay to assist with removal of the body if it is to be within one hour. If the body is to remain in the home, prepares the family for mortician visit, informing them that the gurney must fit through doorways and beside the bed and that the client will be wrapped and removed in a shroud or body bag. The mortician may need some assistance with this procedure. The nurse should ask if he will be bringing an assistant.
4. if the family has not met with the mortician before the death occurs, the nurse gives him the name, address and phone number of the next of kin and what they want done with the body (burial locally, cremation, shipped to another state etc.) when she calls to report the death. This saves the family some time and paperwork when he arrives. An appointment can be set up with the mortician for the next day so the family can complete further paperwork and plans. There will be a blank death certificate in the back of the on-call notebook. RN writes deceased patient's name on the top edge of the certificate above the perforation line), signs own name and records (in black ink) the date and time of death in appropriate boxes for Pronouncing Official.
5. notify the attending physician of client's death if death occurs during day time or evening hours. Physician is notified the following day if death occurs at night unless otherwise directed.
6. clean client, removes unnecessary tubes or equipment and straightens body. If body is to remain in the home, opens the window if possible.
7. dispose of controlled medications with consent of family/caregiver (flushing down the toilet is the recommended method). Instructs the family/caregiver in legal responsibilities if they choose to keep these controlled medications. Document clearly.
8. give support to the client's family.
9. document client's death, the notification of the coroner and attending physician, the disposition of client's body and valuables, and other pertinent information in the client's clinical record within 24 hours.
10. notify the Clinical Supervisor and the Volunteer Coordinator of client's death. If death occurs when the agency is closed, leave a message with the answering service for the office manager, contact anyone who might attempt a visit before being informed of the death by the HHCJ office, and fill out the Bereavement Follow-Up form, returning it to the office manager.
11. contact the Executive Director or Medical Director of Hospice & Home Care if concerns or problems arise that the Registered Nurse and Clinical Supervisor are not able to handle.
12. report the name of client and the time of death to coroner's office the next working day if the coroner himself did not take the call at time of the client's death.

B. No staff member is present, HHCJ on-call RN responds to call from answering service by going to client's home, RN follows procedure defined above.

C. The patient's family member decides to rescind the advance directive at the time of crisis, staff present will activate the emergency medical system and initiate Basic Life Support (BLS) procedures according to established procedure.

D. A home health aide or other nonprofessional is present, that person will call the

answering service to contact HHCJ on-call RN. If possible, the non-professional staff member remains in the home until the RN arrives.

3. In the situation in which a patient who has not executed an advance directive ceases respirations or pulse in the home, if:

   A. A professional staff member is present, he/she will initiate BLS procedure and activate the emergency medical system. Inform the MD who may give orders to stop resuscitation efforts and/or come to the home and pronounce the death himself, or cancel the EMS.

   B. No staff member is present, same as *Unexpected Death Policy* except, notify MD who may give orders to stop resuscitation efforts or cancel the EMS after talking with the family.

   C. A home health aide or other nonprofessional is present, he/she will initiate BLS procedures, activate EMS, and/or call the agency.

   D. The patient dies, notify the coroner and contact the mortuary as in 2.A.3. of this policy.

4. If the emergency medical system is activated

   A. The EMS personnel or physician may decide to transport the patient.

   B. The EMS personnel may terminate measures in the home under physician orders.

5. A HHCJ Registered Nurse may make a determination and pronouncement of death of a patient (as defined in AK statute 08.68.395)

   A. When the attending physician has documented in the client's record that the person's death is anticipated due to illness, infirmity or disease (documentation is valid for up to 120 days); and

   B. When the attending physician authorizes in writing that any HHCJ Registered Nurse may pronounce the person's death.

6. The agency educates staff in the procedures for expected or unexpected death and emergency interventions during orientation and through ongoing education.

DEFINITIONS:

1. Expected Client Death includes only those clients whose names have been previously submitted to the coroner (Hospice patients only).
2. Do not resuscitate (DNR) means those situations when the patient has executed an advance directive and chosen no intervention.
3. BLS means Basic Life Support procedures as defined by the American Heart Association.

Cynthia Elliott, MS, RN
PO Box 2254
Kenai, Alaska
99611
283-6554

August 21, 1997

Dear Mr. Davis,

Pursuant to our conversation Saturday August 9th at the Women's Run, we are enclosing a proposal regarding expected home deaths and how they are handled in this area.

We are working with a Task Force composed of members of the local law enforcement agencies, fire departments, hospice, home health agencies and other interested health care providers in the community to create a process that is everyone can follow when a death occurs at home. Our last meeting included Dr. Michael Propst, the medical examiner for the State of Alaska who came down from Anchorage with Rhonda Burch, an investigator in his office. They feel that it is best to include law enforcement in home deaths because they feel more comfortable being reassured that nothing unusual occurred. Of course law enforcement feels the same way. All of the officers at these meetings feel that the law should be interpreted to mean they have to be called to the home when a person dies there. They consider the home of the recently deceased to be a crime scene and that nothing should be touched until an officer arrives. At this time, we have agreed to handle home deaths this way. But we are greatly opposed to this process.

As I said Saturday when we spoke, I know of one family member who is willing to express her concern about involvement of police and fire department personnel in home deaths. I can and will approach the family member in Nikiski if you think that would be helpful toward changing this process.

Please advise us on how to proceed. Thank you for your interest in this matter.

Sincerely,

Cynthia Elliott, MS, RN
Liz Schubert, Executive Director
Hospice of the Central Peninsula

enclosures: copies of letters from doctors
copies of news articles re: State Troopers
copies of relevant Alaska Statutes
copies of minutes from Task Force Meetings
Proposal

Cynthia Elliott, MS, RN
PO Box 2254
Kenai, AK 99611

January 8, 1997

Dear Drs. Bramante, Crane and Kelley,

I am writing to ask your assistance in handling "expected home deaths." I am a nurse currently working at First Choice Home Health Care, am in the process of joining the Board of Directors of Hospice of the Central Peninsula, and have 5 and ½ years experience at a Hospice in North Carolina. Since my arrival here, I have heard disturbing reports from nurses about the involvement of local police, fire department and/or state troopers in home deaths.

My position is that death at home can be a natural, smooth occurrence, and removing unnecessary steps and personnel from the situation would reduce the trauma to the family and nursing staff involved. Alaska State law only requires that a peace officer be notified of a home death. A registered nurse can pronounce the death and notify the attending physician and funeral director.

I would like to have a discussion with law enforcement agencies about their policies/procedures for responding to notification of a death. Your support would be greatly appreciated. Please let me know your opinions on this matter, and whether or not you would support me in an effort to reduce the confusion at expected home deaths in this area.

Sincerely,

Cynthia Elliott, MS, RN

PENINSULA INTERNAL MEDICINE, P.C.
JOHN P. BRAMANTE, M.D.
CHARLES M. CRANE, M.D.
WILLIAM J. KELLEY, M.D.

January 10, 1997

Cynthia Elliott, MS,RN
PO Box 2254
Kenai, AK 99611

Dear Cynthia,

We would be happy to support your efforts in simplifying expected home deaths. Please let us know specifically what we can do to help you.

Sincerely,

Drs. Crane, Kelley, and Bramante

206 Rockwell Ave., Ste. 101 • Soldotna, Alaska 99669 • Phone: (907) 262-8597 • Fax (907) 262-6516

Cynthia Elliott, MS, RN
PO Box 2254
Kenai, AK 99611

January 8. 1997

Dear Dr. McIntosh,

I am writing to ask your assistance in handling "expected home deaths." I am a nurse currently working at First Choice Home Health Care, am in the process of joining the Board of Directors of Hospice of the Central Peninsula, and have 5 and ½ years experience at a Hospice in North Carolina. Since my arrival here, I have heard disturbing reports from nurses about the involvement of local police, fire department and/or state troopers in home deaths.

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Sincerely,

Cynthia Elliott, MS, RN

MARGUERITE A. McINTOSH, M.D., C.M.

35670 Kenai Spur Hwy., Suite 104B
Soldotna, Alaska 99669
Telephone: (907) 260-3933

February 10, 1997

Cynthia Elliot, M.S.R.N.
PO BOX 2254
Kenai, Alaska 99611

Dear Ms. Elliot:

It is my understanding that unless a person has registered a No Code with the court house that each death at home is a coroner's case. I am interested in seeing some method in which expected home deaths could be handled without the involvement of policemen, picture taking, etc. It would be nice if you could have an understanding with policemen that if a death occurred at home and was expected, the police wouldn't have to be involved.

Sincerely yours,

MARGUERITE A. MCINTOSH, M.D.

MAM/wkp

Executive Summary of Proposed Legislation

Expected Home Death

Expected Home Death describes a circumstance whereby a person who has a limited life expectancy and wants to die at home, has completed an Expected Home Death Case Report (see attached) signed by the attending physician and sent a copy to the State Medical Examiner. This document indicates that the person has a condition that limits his or her life and s/he is expected to die at home. When the death occurs as expected at home, with health care personnel in attendance, there is no need for direct involvment of law enforcement.

In order to reduce the cost to the community, expedite procedure for grieving family members, and avoid duplication of services, changes need to be made to Alaska State law to allow expected home deaths to be handled by visiting health professionals in the home with a minimum of police involvment. With the proposed changes, police shall be informed when a death occurs as expected. However, police and EMT attendance at the home shall be avoided when CPR is not being administered and when there is a registered nurse present to pronounce the death. The registered nurse shall obtain the attending physician's agreement to sign the death certificate, based on the nurse assessment at the time of death. The nurse shall notify the Medical Examiner's Office of the occurrence of the death and obtain permission to release the body to the funderal home.

Expected Home Death Case Reports shall continue to be implemented prior to the death, with a copy going to the police and ambulance dispatch center. However, having the police and ambulance service physically respond at the home shall be discontinued. When a nurse is on the scene and has notified the attending physician of the death, there is no need for further personnel to involve themselves in the private affairs of the grieving family. Having police and EMT personnel arrive in the home of a person who has just died in an expected manner represents an unnecessary government intrusion in family life.

Dying peacefully at home is a right that all Alaskans should have without being subjected to expensive, unnecessary investigation by law officers. When Hospice or Home Health professionals are involved in caring for the dying patient under the direction of the attending physician, medical records are kept that indicate the natural decline of the patient. In these instances, death is an expected event after a gradual, generally predictable decline. It is insulting to the health care professional and the family to inject suspicion into the process by involving law inforcement and treating a natural occurrence as a criminal event.

Reduce government spending by allowing the health care team to care for the dying person and the family without intrusion of police and ambulance service. It should not be a crime to die at home in Alaska.

Prepared by Cynthia Elliott, MS, RN
Kenai, Alaska
283-6554

Expected Home Death Meeting May 29,1997 10:00 a.m. - 11:00 a.m.
Central Peninsula General Hospital - Main Conference Room

agenda

I. **Introduction: - Facilitators: C. Elliott, C. Smith, D. Rasmussen.**
-Agency/Personel Introductions.

II. **Objective/Purpose:**
Discuss how to best simplify the procedures surrounding expected in-home deaths, causing the least amount of emotional stress on the bereaved family members.

III. **Goal Proposed:**
Discuss how we can reduce the amount of personnel present at/in the home at the time of death.

IV. Interpretation of AK State Statues: Discussion

V. Present Expected Home Death Case Report Form. Discussion.

VI. Present Do Not Resuscitate Form. Discussion, i.e. exp.ration dates.

VII. Follow-up/Develop Policy and Procedures common to all agencies, (including scheduled II narcotics disposition), Home Health Agencies/Hospice/AST/Police Agencies/EMS/Fire Departments. **NEED FOR FURTHER MEETINGS.**

Expected Home Death Meeting Minutes

May 15, 1997

Present: Diane Rasmussen, RN/CPGH, Gary Kincaid,Sargent/Soldotna City Police, Kenai City Police, Lucie Stanton, SW/CPGH, Lori Brown, Administrator/1st Choice Home Health Care, LeeAnn McGan, RN/Iditaroid Home Care, Pam Kelly, Heritage Place Joe Ray Skhra, Attorney, Connie Smith, Reg. Supervisor/Peninsula Home Health Care Sue Kelly, RN/1st Choice Home Health Care, Craig Ralston, Nikiski EMS, Chuck Conners, Gene Baxter, Tom Bowman, 1st Sargent, Alaska State Troopers, Liz Schubert, Hospice

Purpose of Meeting: Discuss how best to simplify procedures surrounding expected in home deaths, decreasing the amount of trama and stress involved to the bereaved family members, reduce the amount of personnel at the home at the time of death.

Discussion of Alaska State Statues: Determination of death by registered nurse, 120 days-renewals, change of home health agencies - need to redo form with family.

Common form, (Expected Home Death Form), to be used by care provider agencies to decrease number of different forms sent to police, EMS and troopers. Needs futher discussion.

Connie Smith shared some history of no code procedures, system stopped last September 22nd, and reverted over state wide to the medical examiners process. Meeting today helpful because of new system, is a way of looking at some of the problems that have occurred or some of the issues that are a little bit confusing, as an educational process it's helpful that everyone is aware of what piece of the procedure we each are trying to do now, since the change. Question, if there is a format review of this process through the medical examiners office.

Sue Kelly introduced the procedure sheet that was given to agencies in Sept. Question, when does the agency notify a peace officer that a death has occurred?, within 24 hours. Medical examiners office must be notified immediately.

Concern that home health agencies may be taking statute out of context, was raised. Notification of death, strictly means: 1st part/person who attends or has knowledge of a death, must notify a peace officer, state medical examiner - when the death has occurred. Statute then describes when: by unknown or criminal means or under suspicious or unusual circumstances, sets a criteria. Peace officer should be contacted when one of these criteria are met.

Statute says person who attends a death, must immediately notify the peace officers and state medical examiner, AS 12 65 005. Question as to where home deaths fit, unattended

by a physician or in a medical facility for less than 24 hrs? Police department notify ME office for permission to move the body. Peace officers are responsible for making the determination to remove the body, whether or not it is a suspicious death. If body is moved without notifying peace officers, technically means that evidence was tampered with.

Peace officers concern that even with a signed no code, do not resuscitate order and that the doctor has agreed in advance to sign the death certificate - that it doesn't give anyone the right to go in a kill them, no-codes that are suicides. May be a potential for wrong doing.

Concern of home care providers is for families that have been through the gamut of the medical world, peace officers taking pictures, asking questions becomes very difficult.

Need to have a officer who is sensitive, good people skills, understanding of what's going on with the family, do have to view the body to ascertain that the person has died naturally. Peace officers feel more comfortable if they have a relationship with the nurse, home health care agency - this helps, they know nurse is competent, peace officers still have to go to home, but it may limit questioning to have a point of contact at the scene. Needs to be at least one professional person there.

Note that in Fairbanks and Juneau, peace officers are notified but are not dispatched to the scene. Peace officers question how this meets medical examiners policy. ME's office makes the final call, as to whether or not the death is suspicious. Peace officers feel more comfortable going to scene rather than taking someone's word, especially after a long protracted death, money and property issues, possibilities of contested will.
It was noted that in Anchorage, peace officers are called to every death.

Agencies note that since the Sept. change, each death has been handled differently, some times pictures taken, others not. If nurse is present, and signed off on death, why would EMS personnel need to be called?

Peace Officers feel the need for professional trust, point of contact with medical professional at time of death - can limit the amount of handling of the body. Peace officers trained to look for certain injury patterns.

Need for trust understanding/education,-peace officers, home health agencies, hospice and families as to how the procedure for expected home deaths will be responded to. Currently, this procedure varies. Need to take photos, is left to the investigating officer on the scene, may not take a photo, if nurse was present at the time of death.
Troopers are going to stop taking pictures, as a policy, but will still examine body - if they note anything that triggers suspicion - they will take pictures as part of the investigation. Flexibility: depends on trust, sensitivity. Two professional concurring, best scenario for peace officer and RN. Trust.

Need to have future meeting agreed upon. Scheduled for June 19th, 10:00 a.m., CPGH.

Expected Home Death Task Force

Meeting Minutes
June 19, 1997

Present: Tom Bowman, 1st Sargent/AST, LeeAnn McGahn, RN/Iditaroid Home Care, Connie Smith, Reg. Supervisor/Peninsula Home Health, Linda Boyle, Director/Forget-Me-Not Adult Day Care, Craig Ralston/Nikiski EMS, Sue Kelly, RN/1st Choice Home Health, Lucie Stanton, SW/CPGH, Steve O'Connell/Central Peninsula EMS, Dr. W. Cooper/Med.Director-CES, Gary Kincaid, Sargent/Soldotna Police Dept, Gene Baxter,
Kenai Police Dept., Liz Schubert, Director/Hospice

Announcement: Inservice on End-of-Life Decisions, June 30, 8:00 -10:00 a.m. CPGH. Confusion in community as to Living Wills. Living Wills are directives to physicians and not recognized as a expected home death.

Comfort One System: Information was handed out at the end of last month's meeting for participants to review. One need identified in the development of Comfort One was the need for community consistency, i.e. forms. Comfort One is now being used in some area's of Alaska and Outside. Homer is currently using and has been since regulations went in effect Sept. 1996. Southern Regional Emergency Services, are the facilitators of Comfort One for the State of Alaska, DHSS.

It was noted that while EMS services and peace officers had received the regulations, the home care agencies represented had not received this information from the Medical Examiners Office, nor was it believed that the local physicians received any information. There was some confusion as to how patients can obtain the Comfort One bracelets - request needs to come from physician/doctor's telling families to get signed up for Comfort One from home health agencies. Matt Anderson, contact person at M.E.'s office for help putting together educational packet for physicians. ? whether or not to present packets for physicians at inservice June 30th - Lucie will check. ? on DNR orders/No Codes out now - do we need to sign these patients up for Comfort One? Question- Are any current patients enrolled in Comfort One? No one present knew of anyone.

It was noted that a problem arose when no code papers didn't travel with the patient. Some participants felt that the bracelet in Comfort One would help in this situation

According to Dr. Cooper and Steve O'Connell, yes, there is currently a need for EMS to respond to expected home deaths. It would simplify paperwork and is requested that the expected home death form be faxed to the appropriate police/AST dispatch. Peace officers then fax form to the appropriate EMS. Craig Ralston noted that when EMS are at the scene, it helps the family with closure. He noted that the EMS often have a relationship with the patient and family, from providing EMS services to them throughout their illness.

It was noted that included in agencies procedures should be a 120 day "tickler", for the DNR order. The 120 days only applies to the Nurse/HHA and does not effect the No Code status for the patient. Agencies need not resubmit an expected home death request if the patient changes agency - only the DNR order needs to be resubmitted according to agency's procedure. The M.E.'s office doesn't confirm if they received the Expected Home Death Request Form. The M.E.'s office looks at the expected home death list, yearly. Agencies may have to resubmit yearly, if necessary.

Peace Officers question if there is always time for the RN to be on scene when death occurs. Gary Kincaid noted that Peace Officers respond in "no Code" framework. In past, a educational sheet went out to families, letting them know what will happen at the time a death occur. Feels we should incorporate Comfort One now, and follow M.E.'s procedure. It was discussed that there is 2/3 different procedures now are being used.

Craig Ralston shared that it's "in the works to revise the current M.E.'s expected home death form, however, he feels we should be using the Coroners current form - used statewide. This form is signed by physician going to sign the death certificate, describes the nature of the illness, if the patient had a pacemaker. The M.E.'s office needs to OK the physician signing the death certificate. It was noted that some old forms are being used still, (the one that our local magistrate used to sign). it was discussed that it was not clear how the expected home death request, would relate to a person with a terminal illness, that was involved in an accidental death. Need for the Attorney General's Office to make a determination on the limitations of Comfort One - that the expected home death report is for illness only - education of patients and families to the procedure.

It was agreed among agencies to plan some education for physicians on the Comfort One program and for patients/families. Still a need to look at forms and procedures. Steve O'Connell, agreed to assist.

April 1, 1998

RE: HB 383

Dear Mr. Chairman and Members of the House Judiciary Committee.

Death at home is not necessarily a case for the Medical Examiner's office and therefore should not be investigated by peace officers in all instances. When terminally ill patients are dying at home with support of a home health agency or hospice, they are receiving medical care outlined in the Plan of Care authorized by the physician. Because these patients have medical assistance at home, have a signed document indicating they do not wish to be resuscitated, are expected to die as a result of the disease documented by the physician, and the physician is willing to sign the death certificate based on the nurse assessment at the time of death, the State Medical Examiner need not be involved, and there need not be any police investigation. We support HB 383.

Sincerely,

Cynthia Elliott RN. MS., Treasurer of the Board
Hospice for the Central Peninsula

Lane Beauchamp, Board Member
Hospice for the Central Peninsula

Liz Schubert, Executive Director
Hospice for the Central Peninsula

First Choice Home Health Care

CS FOR HOUSE BILL NO. 383 ( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTIETH LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): REPRESENTATIVE DAVIS

A BILL

FOR AN ACT ENTITLED

"An Act relating to expected deaths that occur at home."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* Section 1. AS 12.65 is amended by adding a new section to read:

Sec. 12.65.007. No duty for peace officer to respond to the scene of an expected home death.

(a) A peace officer is not required by state law to respond to the scene of an expected home death if

(1) the death was expected to occur due to the dead person's state of health before death;

(2) the death occurred at the dead person's home as expected due to the dead person's state of health;

(3) a person authorized to determine and pronounce death determines and pronounces the death; and

(4) a form signed by the dead person's physician concerning the physician's expectation that the death would occur due to the person's state of health and that it would occur at home was, at the time of death, on file with the law enforcement agency for that jurisdiction.

(b) This section does not

(1) prohibit a person from requesting a peace officer to respond to the scene described in (a) of this section if, in the person's opinion, a death investigation by a peace officer may be appropriate due to suspicious or unusual circumstances; or

(2) relieve a person of the duty to notify the medical examiner and a peace officer of a death that is described in AS 12.65.005(a).

I am in support of HB 383. On January 31, 1998, my 14 year old son died of cancer in our home, in his own bed. I have just experienced a parent's worse nightmare, and feel that this bill could help other family members endure less stress and unnecessary interventions during such an emotional time.

On February 25, 1998, I testified at a teleconference held in Kenai, AK on HB 383. At this time, this bill was being heard in the Labor and Commerce Committee. It wasn't until this Committee was ready to move onto another bill that they realized they had seven (7) people in Kenai that wanted to testify. I was only allowed to speak for less than one minute. I felt it was necessary to testify and did so, but feel that this written testimony will only clarify my testimony and hopefully give you insight into what it was like for me to have to experience the ramifications of this particular law.

In order for you to understand this entire situation, I feel it is necessary to give you a brief summary of my son's medical condition. My son was always a very healthy boy. He just went to the doctor for well physicals until March, 1996. At that time he was having back pain and colds. Finally, after numerous tests, many trips to the doctors, we found out that he Stage IV neuroblastoma. He was diagnosed on May 21, 1996 at Seattle Children's Hospital. This was the beginning of a very long fight for life. He was in Seattle for 3 months receiving chemotherapy before he transferred to New York City to Memorial Sloan-Kettering Cancer Center. He spent nine (9) months there receiving more chemotherapy, three (3) major surgeries, radiation, and immune therapy. It was almost one year to the date of his diagnosis before we returned back home to Alaska. The summer of 1997, we returned to New York for tests, and found out that now he was battling leukemia as well as neuroblastoma. He was to have a bone marrow transplant in Seattle, but his neuroblastoma had reoccurred, so he could not have a transplant. We went to Philadelphia several times for experimental treatment, but that treatment proved ineffective at the doses they were willing to give so we returned home to Alaska in November, 1997. Jared weekly contact with his local doctor and had weekly hospital lab work. The last few weeks of his life he was in contact with his doctor and the hospital lab almost every other day. He was constantly battling infections and was in and out of the Emergency Room. He fought hard to beat this cancer, but it slowly invaded his body, and on January 31st he lost his last battle.

I know this is a very sensitive subject with many emotions on both sides. It has been hard for me to write about, testify, and deal with this issue so soon after my son's death, but if I can make the process of dying at home easier for any other family member, my discomfort will have been rewarded. Two years ago, I would have never thought I would be experiencing or writing about this issue. Life can change very fast in ways we would never have guessed. Because Life is so unpredictable, I hope whoever reads this testimony will think about what it might be like for them to have this happen to their loved ones in their own home. Death doesn't just happen to "old" people.

The first point I would like to make is that the Trooper that arrived at our home in the early morning hours of Saturday, January 31st WAS very empathetic to my husband's and my situation. Trooper Tuckwood was sensitive, polite, and professional. He did, however, have a job to do which was to "investigate a potential crime scene". Treating this situation as a "crime scene" is the memory I have that I rather not think of and feel was totally inappropriate in this situation. No matter how sensitive or empathetic the responding Trooper may be, the fact that he has to be there, ask questions, confiscate the drugs of the deceased, and take pictures is invasive. We had a Home Health Care Registered Nurse, an EMT, a Trooper, and then the mortuary person all in our home, usually at different times, during those early morning hours. They all had their jobs to do while I was feeling a gamut of emotions. I had to take care of business at hand, and answer their questions while realizing that my only child had just died, and soon his body would be taken away and this was the last time I would see him in his room, in his bed.

My son was under constant medical care which many health care providers were a part of. These people are PROFESSIONALS and if anyone knew our son, or my husband, or myself it was these people. These professionals can be the "Check and Balance" that the State Coroner feels he needs. We are a community, and we all need to rely on one another. Agencies need to work together and trust one another. It is not only the law enforcement agencies that are concerned about "foul play". The Medical Community also is concerned, and it is their job and responsibility to alert the police if at any time they suspect someone is being abused. Let these people attend the death and trust them to report if any "foul play" is suspected.

We all have the right to die with dignity and die at home if we choose. It is not a CRIME. We also, as family members, have rights. We are not "possible criminals" because we supported our loved one's wish to die at home in their own bed. I can't explain in words how difficult is was for me to allow the natural process of death to occur in our home in a peaceful, loving, and non-invasive setting. We could do no more and that was very hard to accept.

The State Coroner gave statistics at the same teleconference I attended and there has been NO evidence of any foul play in the last two years in which he said he saw around 1800 deaths. How many unnecessary visits by the police at home deaths did this number reflect? How many home deaths could have just as well been attended by a Registered Nurse or Doctor? I think there is much better use of law enforcement time than investigating home deaths such as my son's.

The State Coroner also stated that law enforcement officers were trained to deal with investigations of death, not doctors or nurses. I would like to point out that when a trooper arrives in a situation such as ours, where a 14 year old boy is dead in his bed, I would guess that red flags would go up. This 14 year old, however, was not healthy . I think it would be very difficult for a law enforcement officer to surmise from looking at him all the medical interventions he had been through, and how his body was riddled with cancer. Now if you asked most hospital emergency room nurses, or

doctors, or numerous other health care professionals, they would know immediately that this 14 year old had fought a long, hard battle, and they were only too well aware that he was losing ground and death was just around the corner. They knew what drugs he was on, what treatments he required, etc. This Trooper had NO clue. Who could do a better investigation? Who could put the family at ease? Who really is needed at a death scene such as this?

I also become very upset when I hear that different law enforcement personnel handle these situations differently. Family members need to know what will happen. I was not prepared prior to the trooper's arrival that he would need Jared's medications and that he would take pictures. I was told that a trooper would need to be called and would come to our house and ask a few questions. That was all I was told. The trooper that arrived at our home explained what he needed and what he had to do once he arrived. I think we could have been better prepared by the health care professionals. Family members need to know what the law is and what the troopers are required to do in these situations.

Please consider all sides to this issue. How many other States require law enforcement officers at home deaths? Why does Alaska need to have law enforcement officers at home deaths when other States do not require this? Is having a law enforcement officer investigate a home death an outdated requirement in Alaska?

Thank you for taking the time to read this.

Sincerely,

Debra Shuey
Kenai

Alaska State Legislature

Please enter into the record my testimony to the Judiciary
committee name

committee on HB383 , **dated** 3/3/98 .
bill # / subject

see Attached testimony - D. Shuey

Signed: Debra L. Shuey
Testifier

Representing (Optional)

HC2 Box 937 Soldotna, AK 99669
Address

907-283-1650
Phone number

Alaska State Legislature

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Kenai, Alaska 99611
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907/283-3075 fx
907/262-7574 hm

Session:
State Capitol
Juneau, AK 99801
907/465-2693
fx 907/465-3835
800/463-2693

Representative Gary Davis

MEMORANDUM

DATE: March 30, 1998

TO: Representative Joe Green, Chair
House Judiciary Committee

FROM: Representative Gary Davis

RE: **House Bill 383, Expected Deaths, Committee Substitute**

Attached is a proposed committee substitute to House Bill 383 that I would like your committee to consider adopting. The bill is scheduled for a hearing in your committee Wednesday, April 1. The committee substitute was drafted after further research was done in response to concerns raised during the House Labor and Commerce Committee hearing on the bill. Below is an explanation of the changes made from the original bill.

Sections 1 and 2 of the original version that amended AS 08.68.395(a) and (b) have been deleted. When originally drafted, these statutes were amended in an attempt to bring uniformity between the wording of the statutes and the information required on the expected death form stating that the physician would sign the death certificate. After reviewing the statutes and forms used, we determined that this was unnecessary.

Existing statutes require the nurse pronouncing death to document the criteria for the determination of death, notify the physician and sign the death certificate. There is also an existing requirement that the physician certify the death within 24 hours. The death certificate has sections for the signatures of both the nurse pronouncing death and the physician certifying the death.

The remaining section of the bill, adding a section to AS 12.65, has been clarified to specify that a peace officer does not need to be notified in the event of an expected home death provided that certain criteria are met. These criteria are:

1. The death was expected to occur;
2. The death occurred at the deceased's home;
3. A person authorized to pronounce death did so; and

4. A form signed by the deceased's physician concerning the expectation that death is expected is on file with the state medical examiner.

If these criteria are met, then only the medical examiner needs to be notified that the death occurred and occurred as anticipated. The intent of this legislation remains the same—to remove the requirement that peace officers respond to the scene of every anticipated home death. As a courtesy, there is nothing to stop the health professionals from providing a copy of the expected death form to local law enforcement, or to informing them when the death occurs.

According to the Division of Legal Services, there does not seem to be a state statute or regulation directly requiring a peace officer to respond to notification that an expected home death has occurred. However, the inference seems to be contained in existing statute because of the types of deaths listed. There may also be municipal ordinances that we are unaware of requiring they respond, or they may feel they need to do so out of a sense of responsibility rather than explicit duty.

The backup materials provided with the initial request for a hearing contained the Alaska procedures concerning expected home deaths and some correspondence from hospice personnel in Alaska. Since then, I have tried to find out whether peace officers are required to respond to cases of expected home deaths in other states. My staff contacted the National Hospice Association, individuals in several states, and reviewed a 1995 study done by the St. Louis University, School of Medicine. Unfortunately, the majority of information compiled related to whether hospice deaths (expected home deaths) had to be reported to the coroner or medical examiner, rather than whether police needed to respond.

Attached for your review is a summary of what we learned. Oregon recently dealt with the issue of investigations into home deaths and provided some interesting insight into this issue, which is also attached.

Thank you for your time and consideration.

GLD/dld

Attachments

0-LS1220\B
Lauterbach
3/20/98

CS FOR HOUSE BILL NO. 383( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTIETH LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): REPRESENTATIVE DAVIS

A BILL

FOR AN ACT ENTITLED

"An Act relating to expected deaths that occur at home."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

*** Section 1.** AS 12.65 is amended by adding a new section to read:

Sec. 12.65.007. No duty to notify peace officer of an expected home death. (a) Notwithstanding AS 12.65.005(a), a person who attends a death that is described in AS 12.65.005(a) or has knowledge of a death that is described in AS 12.65.005(a) is not required to notify a peace officer of the death if

(1) the death was expected to occur due to the dead person's state of health before death;

(2) the death occurred at the dead person's home;

(3) a person authorized to determine and pronounce death determines and pronounces the death; and

(4) a form signed by the dead person's physician concerning the physician's expectation that the death would occur due to the person's state of health and that it would occur at home was, at the time of death, on file with the state

medical examiner.

(b) This section does not

(1) prohibit a person from notifying a peace officer of a death that is described in (a) of this section if, in the person's opinion, a death investigation by a peace officer may be appropriate due to suspicious or unusual circumstances; or

(2) relieve a person of the duty to notify the medical examiner of a death that is described in AS 12.65.005(a).

Summary of Information Gathered Regarding Expected Home Deaths

Hospice deaths do not have to be reported to the Medical Examiner or Coroner in 19 states.

Arizona	Maryland	North Dakota	Virginia
Delaware	Michigan	Oklahoma	Vermont
Florida	New Hampshire	Pennsylvania	West Virginia
Georgia	New Jersey	Rhode Island	Wyoming
Maine	North Carolina	Utah	

In **California**, the Medical Examiner or Coroner does not have to be called if in hospice situation if death was expected. State law does not require that police respond to an anticipated death, but counties may require differently. The procedures for filling out the death certificate are handled on a county basis (Source: Margaret Clausen, California)

In **New Jersey**, the Medical Examiner or Coroner does not have to be called if in hospice situation is death was expected. (Source Andy Duncan, national Hospice Organization)

Oregon law does not require a death to be investigated when the patient is attended by a physician immediately preceding death. Oregon considers a patient to be attended by a physician if that patient is under the care of the physician, not that the physician is physically present at the time of death. Law Enforcement does not have to be notified. (Source: Ann Jackson, Oregon Hospice Association)

Hospice Deaths must be reported to the Medical Examiner or Coroner in 8 states and the District of Columbia

Alaska	Louisiana	Texas
Connecticut	New Mexico	Washington
Kentucky	Tennessee	

In 8 of these states the reporting person must be at the scene.
In 5 states anyone, including family members can report the death
In 4 states, only the nurse, doctor or law enforcement officer at the scene could report the death

New Mexico has a system where all hospice nurses undergo training at the ME's office prior to reporting a hospice death. The nurse is then certified an extension of the office's investigative staff and is prepared to evaluate the death of a hospice patient.

In **Missouri**, the first licensed medical professional or law enforcement officer notified of a death is required to call the coroner and give a report on whether the death was expected (it occurred in an appropriate timeframe) and whether or not it happened as expected (there was no noticeable trauma). Police do not have to be notified. In fact, the medical professional does not even have to be present. They can tell the coroner that they are not there. (Source: Cindy Newport, Missouri Hospice in Kansas City)

The remaining states seem to have mixed requirements regarding hospice deaths. The majority of these states leave the procedures to be handled on a county-by-county basis. Also, there are varying interpretations of what an "unattended death" is.

Oregon State Medical Examiner Newsletter

Post-it™ Fax Note 7671	Date 3/30	# of pages ▸ 1
To Deb Dalidson	From Larry Lewman	
Co. Dept	Co. OHSU MC	
Phone #	Phone # 503-280-6061	
Fax #	Fax # 503-280-6241	

AUGUST 1991 NEWSLETTER

MEDICAL EXAMINER TRAINING SESSIONS -- ATTENTION PHYSICIANS AND DA'S:
Two eight-hour medical examiner training sessions are scheduled, which will be the last until the Spring of 1992. These death investigation training sessions are open to district attorneys, physician/medical examiners, pathologists and deputy medical examiners throughout Oregon. We would appreciate it if each district attorney and medical examiner in Oregon would make the necessary calls to recruit attendance. These seminars have been scheduled on a Saturday to more easily accommodate the busy schedules of district attorneys, deputy district attorneys and physicians.

One seminar is scheduled for **SATURDAY, SEPTEMBER 7, 1991, FROM 8:00 A.M. UNTIL 5:00 P.M. AT UMPQUA COMMUNITY COLLEGE, WHIPPLE FINE ARTS CENTER, 1140 COLLEGE ROAD, ROSEBURG.** Space is available for 180 persons; as of 8/5/91, 76 persons have signed up.

The final seminar of 1991 is scheduled for **SATURDAY, OCTOBER 19, 1991, FROM 8:00 A.M. UNTIL 5:00 P.M. AT BLUE MOUNTAIN COMMUNITY COLLEGE, ROOM M-130 (MORROW HALL), 2411 NW CARDEN, PENDLETON.** Space is available for approximately 100 persons.

MEMBERS OF THE OREGON BAR: Please note -- These lectures have officially been approved by the Oregon State Bar for 9 continuing legal education credits. Appropriate certificate of completion forms will be available to members of the Bar at these seminars.

PHYSICIAN MEDICAL EXAMINERS: Please note -- In exploring the possibility of getting this seminar approved for continuing medical education credits, we were advised by the OHSU's Division of Continuing Medical Education that physicians can receive credits under Category 2 of the AMA Physician's Recognition Award for the actual hours they are physically in this class. It is your responsibility to report these hours. We will provide documentation to you that you attended.

PLEASE CALL DIANE OR CONNIE AT 280-6061 IN PORTLAND TO RESERVE A SPOT AT ONE OF THESE SEMINARS.

HOSPICE DEATHS:
Occasional inquiries to the State Office relate to the Medical Examiner's policy in investigating hospice deaths. Though the law gives broad authority allowing the counties flexibility in establishing their own death investigation programs, it is the suggestion of the State Office that the vast majority of these deaths be considered as deaths occurring under medical care. Exceptions would be drug overdoses or injuries that clearly fall under ORS 146. It is not necessary that a physician be at the scene. If the patient has a well-established medical history and is being followed by a hospice nurse or physician, the treating physician should be allowed to sign the death certificate without medical examiner investigation.

Rarely counties have been aggressive in investigating these deaths by sending police deputy medical examiners to the scene. Most families do not appreciate a police investigation of these natural deaths and this approach is strongly discouraged.

GUNSHOT WOUND TAPE:
Dr. Lewman presented a one hour lecture on the investigation of gunshot wounds to emergency room and trauma surgery staff at the Medical School. The lecture, including all slides, was professionally taped and the State Office has one standard VCR cassette for use which can be played on your TV. If you wish to use the cassette for small group discussions, medical meetings, etc., please make arrangements through Diane at 280-6061.

LVL:sms

ohca
oregon health care association

Oregon's Association of Nursing Homes, Assisted Living
and Residential Care Facilities

July 31, 1997

Larry Lewman, MD
State Medical Examiner
301 NE Knott
Portland, OR 97212

Dear Dr. Lewman,

We are writing this letter as representatives to The Task Force to Improve the Care of Terminally Ill Oregonians, which was convened by the Center for Ethics in Health Care in January of 1995. (See the attached list of Task Force members.) This Task Force seeks to improve the care of the dying through education, training, and resource development.

The investigation of all hospice deaths in Curry County was brought to the attention of the Task Force out of concern for its adverse impact on family members. The Task Force would like the problem to be resolved in a way that will mitigate the unwanted intrusions on the families. We request your assistance as the State Medical Examiner.

The Task Force members are disturbed by current medical examiner practice in Curry County. Since July 1996, all hospice and home health deaths in Curry County are being investigated by the police, who are deputy county medical examiners. These investigations are done at the direction of the District Attorney, according to his interpretation of the Death Requiring Investigation Statute, ORS 146.090. The investigation includes a visit to the deceased's home, physical examination of the deceased patient, and confiscation of prescription medications. The investigation occurs regardless of the observations made by the hospice/home health nurse, the hospice medical director or the attending physician.

Under ORS 146.090(1)(f) the medical examiner shall investigate and certify the cause and the manner of all human deaths "while not under the care of a physician during the period immediately previous to death." Patrick Foley, the District Attorney of Curry County, has interpreted this phrase to mean that the deceased person must have an attending physician who is physically present at the time of death. In Mr.

15895 S.W. 72nd Avenue Suite 250 • Portland, Oregon 97224-7913 • Phone: 503/620-9300 • Fax: 503/620-9393

Foley's view, only those home deaths in which a doctor is physically present at the time of death are attended.

While the concept of "attended or unattended deaths" is not included in ORS 146.090(1)(f), Mr. Foley uses this concept to justify these death investigations, despite the fact that there are no hospice deaths that have raised suspicions of wrongdoing. Throughout the United States, the concept of "attended or unattended" is generally accepted, both legally and medically, to mean that a patient has or does not have an attending physician.

The death investigation statute authorizes investigations if the person was not under the care of a physician immediately prior to death (ORS 146.090(1)(f). All hospice and home health patients receive care and services under the direction of a physician. Under federal and state laws and regulations for hospices and home health agencies, care must be provided under the direction of an attending physician. See e.g., 42 CFR 410.20, 418.54, 418.68, 418.86; ORS Chapter 443; ORS 410.142.020 (4), 410.142.240(c), and 410.142.020(20). These patients remain under the care of the physician until they die or are discharged from service. Therefore, hospice and home health deaths do not meet the criteria of ORS 146.090(1)(f) because the deceased are under the care of a physician immediately prior to death.

Currently, Curry County is the only county conducting routine in-home investigations of all hospice and home health deaths. Should this practice spread, it could ultimately impact over 7,000 families per year as 25% of Oregonians now die at home under hospice care. The Task Force encourages your prompt intervention.

Under ORS 146.015, the State Medical Examiner Advisory Board shall make policies for the administration of ORS 146.003 to 146.165, and the Department of State Police shall make rules to effectuate such policies. The Task Force requests that you convene an immediate special meeting of the State Medical Examiner Advisory Board to set policies regarding the interpretation of ORS 146.090(1)(f) and that you subsequently request that the State Police adopt an emergency rule to effectuate the policy you adopt.

In an August 1991 Medical Examiner's newsletter, you suggested that the vast majority of hospice deaths be considered as natural deaths occurring under medical care. Exceptions include inappropriate or illegal use of drugs or injuries that clearly fall under ORS 146. You stated that it is not necessary that a physician be at the scene. If the patient has a well-established medical history and is being followed by a hospice nurse or physician, the treating physician should be allowed to sign the death certificate without a medical examiner investigation.

The Task Force requests that your August 1991 newsletter recommendation form the basis for the policy that the State Medical Examiner Advisory Board adopt and which the State Police incorporate in the rules.

Please feel free to contact us if we can be of assistance in this matter.

Sincerely,

Margaret M. Carley, RN, JD

Jan Ries, RN, MN
Task Force Member

Ann Jackson, MM
Task Force Member

Patrick M. Dunn, MD FACP, Chair
Task Force to Improve the Care
of Terminally Ill Oregonians

Susan Tolle, MD FACP
Task Force Member

CC: Governor John Kitzhaber,
Attorney General Hardy Meyers
District Attorney Patrick Foley
Chairman Medical Examiners Advisory Board Don Houghton

Enclosure: Membership List of Task Force To Improve the Care of the Terminally Ill

Oregon
John A. Kitzhaber, M.D., Governor

Oregon State Police
Medical Examiner Division
301 NE Knott Street
Portland, OR 97212-3092
(503) 280-6061
FAX (503) 280-6041
TTY (503) 775-0548

Forensic Pathologists:
Larry V. Lowman, M.D.
State Medical Examiner
Karen Gunson, M.D.
Edward F. Wilson, M.D.
Clifford C. Nelson, M.D.
Deputy State Medical Examiners

August 18, 1997

Margaret M. Carley, R.N., J.D.
Oregon Health Care Association
15895 SW 72nd Avenue, Suite 250
Portland, Oregon 97224-7913

Dear Margaret:

My apologies for the delay in responding to your letter of July 31. I thought it wise to first discuss the situation with Don Houghton, M.D., Chairman of the Medical Examiner Advisory Board, and Major Jim Willis, Commander of the Intergovernmental Services Bureau of the Oregon State Police.

Since we last talked, I have had several phone conversations with both Curry County District Attorney Pat Foley and Lori Kent of Curry County Home Health Hospice. Lori has been helpful as the spokesperson for hospice in Curry County and you may wish to contact her at 541-247-7084. The situation in Curry County has improved significantly. DA Foley and Medical Examiner Dr. Pitchford will appoint hospice nurses to serve as deputy medical examiners. The deputy medical examiner nurse will send the report of death (which they currently prepare anyway) to the District Attorney's Office. Law enforcement investigation will cease unless the death clearly falls under ORS 146 (i.e., suicide, accident, etc.). There are some lingering issues regarding the disposal of drugs and training of the nurses which I believe will resolve themselves over time.

It is the opinion of Chairman Houghton, Major Willis, OSP legal advisors and myself that it would be inappropriate to ask the Advisory Board to visit this issue and reiterate a practice which is already in place. The modern version of ORS 146 was passed in 1973 and has served us well for almost 25 years. The language "while not under the care of a physician during the period immediately previous to death" was carefully chosen by the authors and proponents of the law to allow local DA's and medical examiners some latitude in choosing individual deaths to investigate. The Medical Examiner Advisory Board cannot make a policy that is contrary to existing state law or tell district attorneys how to interpret the law.

I prefer to consider the Curry County situation as an anomaly and I do not believe a similar situation will reoccur. If it does, we can deal with it. A similar situation happened in Tillamook County several years ago and it was promptly resolved with a

few phone calls. I am not concerned at all about the practice of investigating hospice deaths spreading throughout the state.

I previously sent you a copy of the August 1991 State Medical Examiner Newsletter which discusses our suggested policy of operation in hospice deaths. Because of the controversy in Curry County, I revisited the issue in the current August 1997 ME Newsletter. Every physician medical examiner, district attorney, pathologist and deputy medical examiner/police officer in the state should receive this information next week.

I hope you had an enjoyable vacation. Please feel free to give either Lori Kent or me a call.

Sincerely,

Larry V. Lewman, M.D.
State Medical Examiner

LVL:dms
cc: Major Jim Willis, Intergovernmental Services Bureau, Oregon State Police
Donald Houghton, M.D., Chairman, Medical Examiner Advisory Board
Lori Kent, Curry County Home Health Hospice

Hospice of El Paso

September 9, 1997

Mr. P trick Foley
District Attorney
Curry County
PO Box 746
Gold Beach, OR 97444

Dear Mr. Foley:

Recently, I became aware that the Oregon Hospice Organization has been working with you related to "unattended" deaths. In Texas, we have a state law which permits nurse pronouncement. I am enclosing a copy of that legislation and our policy related to implementation in El Paso County, Texas, for your information and review.

From a practical standpoint, our local medical examiner and I met several times in 1995-96 to discuss our state nurse license requirements and our state law on pronouncement. Over a period of about four years, we have developed a relationship in which he is confident that our nursing personnel are able to make an appropriate determination of death and to declare death without the presence of an attending physician. The only time a death is investigated by our local medical examiner is when there is an unusual circumstance. In the case of a hospice patient, he might investigate a person who has died in an automobile accident or was found dead in the garage with the car running.

I know that you are interested in assuring that the rights of the citizens living within your community are protected and that your state laws are equitably carried out. I believe that hospice organizations have well established credibility all over the United States. I believe further that you will find that they are able to significantly lighten your staff's burden in dealing with death calls for persons who are known to be terminally ill, have a limited life expectancy, and are so certified by their attending physician and the hospice medical director.

Sincerely,

Charles E. Roark

Charles E. Roark, Ed.D., FACHE
Executive Director

CER/clt

Joint Commission
an Accreditation of Healthcare Organizations

3901 N. MESA • SUITE 400 • EL PASO, TEXAS 79902 • 915 / 532-5699

MONTGOMERY Hospice SOCIETY

1450 Research Boulevard, Suite 310 • Rockville, Maryland 20850 • Phone: (301) 279-2566 • Fax: (301) 309-8791

August 20, 1997

Patrick Foley, Esq.
Curry County District Attorney
PO Box 746
Gold Beach OR 97444

Dear Mr. Foley:

This is written at the behest of Ann Jackson, Executive Director of the Oregon Hospice Association, to respectfully offer comment on "unattended" deaths of hospice patients.

I have, I suspect, a unique perspective or personal background enabling me to make what I hope will be useful remarks in this regard. I am the Medical Director of Montgomery County Maryland's only full-service non-affiliated non-profit hospice. I am also a Deputy Assistant Medical Examiner for the State of Maryland, assigned to Montgomery County. As an attorney and physician, the issue is one with which I have dealt in the past and in other roles.

The hospice physician strives to minimize suffering. As a medical examiner, I make determinations of cause of death and exercise the state medical examiner's authority to the local constabulary. I am careful to keep the roles distinct and do not sign death certificates as medical examiner when my hospice patients die.

Unless "attended" is defined explicitly and uniquely in Oregon's law, ubiquitous usage of that term may be helpful to you. In common professional parlance, a physician caring for a patient is attending on that patient, even when not physically beside the patient. The concept and label of a death as attended or not follows from that usage, *i.e.,* whether or not a patient was being followed by a physician. An unattended death is one wherein the decedent did not have or was not being followed by a doctor, regardless of where that physician was at the time of death. All hospice patients in Medicare certified programs are being followed by a physician.

In other jurisdictions of which I am aware, certifications of cause of death are made by the "attending physician," *i.e.* the physician caring for that patient at the time of death – even if not physically present at the moment of death. Hospice patients are usually easier to certify, given that more is often known about their underlying problem. As medical director, I am often asked to certify the cause of death of patients in our program, to convenience the family, because of the immediate unavailability of the attending physician. This is entirely proper, as long as the medical director can diagnose the cause of death. It is not always clear whether this must be done by a "probability" standard or by "reasonable medical certainty," but it is rare for the higher level of certainty not to be met in hospice.

As medical examiner, when I am asked to approve the certification by another physician of the cause of death of a hospice patient, I apply the same standards as to any death: Is the attending physician's certification reasonable under the circumstances? He or she need not have been at the bedside at the instant of passing. The question often is the degree of contact and the amount of information possessed by the certifying physician – which information is more likely to be adequate for hospice patients.

Ms. Jackson has made us aware that part of the problem relates to nurse declarations of death. This is a matter of state law and the trend has been for legislatures to elongate their lists of who may pronounce death. Diagnosis of death and certification of cause of death are not linked, however; they are separate functions. Oregon has been a national leader in empowering non-physician license holders and may permit nurses to "attend" patients, but this would be unusual. Physicians and possibly nurse practitioners are usually the only professionals who may attend a patient.

Let me offer one other perspective on the terminology that may be of interest. In a teaching hospital, the supervising physician is referred to as the "attending." Thus, when I am teaching resident doctors in the Johns Hopkins Emergency Medicine residency, I am listed as the attending on the case, even when I am not the exclusive source of medical authority. Nurses follow the residents' orders and residents will sometimes declare or even certify death, signing their own names to the appropriate documents. Yet, as their supervisor, they are acting under my dominion.

I hope that at least some of this is interesting or helpful to you. If you care to discuss it or if I can offer other or supporting information, please contact me at the above numbers, or at my consulting offices at The Legal Medicine Center 301 – 530-6577.

Sincereiy,

Hugh F. Hill III, MD, JD
Medical Director

cc: Ms. Jackson

I hope this helps,

LA

Hope Hospice Inc.

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Rib Lake, Wisconsin 54470

August 8, 1997

Patrick Foley, DA - Curry County
P.O. Box 746
Gold Beach, OR 97444

Dear Mr. Foley:

It has come to my attention that hospice deaths are being fairly routinely investigated in your county, being considered "unattended" deaths. I would like to share with you the general understanding we have in Wisconsin regarding hospice deaths.

A hospice patient is always under the care of a physician. I believe home health patients also are always under the care of a physician, although home health is not my field of expertise. In our experience in twelve years of hospice care, the physician is almost never actually physically present at the time of the patient's death. However, the physician is kept informed by the nurse of what is going on, and he continues to give the medical direction for the care. A nurse is legally, in Wisconsin, and I understand also in Oregon, able to communicate her observations to the physician at the time of the patient's death, and from that the physician makes a determination that the patient has indeed died. That type of death is not an unattended death.

To investigate such deaths is to rob family of a great deal of the emotional and spiritual peace, satisfaction, and growth which occur as they care for a dying loved one. It injects into the scene an aura of "something is amiss." The events surrounding a death have a great impact on the grieving of serviving family members. A normal , usual hospice death contributes immeasurably to healthy grieving. An investigation by legal authorities would do just the opposite. I urge you to reconsider your practice of investigating hospice deaths as being "unattended," which they truly are not.

Sincerely,

Barbara J. Meyer

Barb Meyer Hospice Director

BJM/dn
Copy to Ann Jackson