

**Joint Legislative Committee on Performance
Evaluation and Expenditure Review (PEER)**

Report to
the Mississippi Legislature



An Evaluation of Mississippi's Medicolegal Death Investigation Process

Mississippi's medicolegal death investigation system has evolved from a purely local system to a mixed system in which local officials and a central State Medical Examiner's Office share authority. State law makes the State Medical Examiner the state's expert in forensic death investigations. Under the Mississippi Medical Examiner Act, the State Medical Examiner must be a physician board-certified in forensic pathology. The State Medical Examiner is to have authority over physician county medical examiners and non-physician county medical examiner investigators and responsibility for medicolegal death investigation training and rule promulgation.

PEER found that because of the long-time vacancy in the position of State Medical Examiner (since 1995), an insufficient number of staff, and underfunding of the office, the State Medical Examiner's Office has not been able to ensure that all of its statutory responsibilities have been addressed.

- Since 1995, designated pathologists have been performing all autopsies referred to a medical examiner. No state-level oversight of these designated pathologists has been exercised since 1991.
- The office's staff currently does not have the medical expertise to review the reports filed by local medical examiners.
- The office has not effectively fulfilled some of its recordkeeping duties—specifically, reconciliation of local medical examiners' death reports with death certificates from the Department of Health—because some county medical examiners/investigators do not file necessary documents with the office.
- Because the State Medical Examiner's position is vacant, the office has not technically complied with the statutory requirement for the State Medical Examiner to perform autopsies when deaths occur in the correctional system.

The lack of a State Medical Examiner or adequate staffing impairs the state's ability to ensure that issues surrounding deaths affecting the public interest are resolved competently. Also, several sections of the MISSISSIPPI CODE addressing the authority of the State Medical Examiner are unclear as to the office's authority in critical areas of death investigation.

September 16, 2008

PEER: The Mississippi Legislature's Oversight Agency

The Mississippi Legislature created the Joint Legislative Committee on Performance Evaluation and Expenditure Review (PEER Committee) by statute in 1973. A joint committee, the PEER Committee is composed of seven members of the House of Representatives appointed by the Speaker and seven members of the Senate appointed by the Lieutenant Governor. Appointments are made for four-year terms with one Senator and one Representative appointed from each of the U. S. Congressional Districts. Committee officers are elected by the membership with officers alternating annually between the two houses. All Committee actions by statute require a majority vote of four Representatives and four Senators voting in the affirmative.

Mississippi's constitution gives the Legislature broad power to conduct examinations and investigations. PEER is authorized by law to review any public entity, including contractors supported in whole or in part by public funds, and to address any issues that may require legislative action. PEER has statutory access to all state and local records and has subpoena power to compel testimony or the production of documents.

PEER provides a variety of services to the Legislature, including program evaluations, economy and efficiency reviews, financial audits, limited scope evaluations, fiscal notes, special investigations, briefings to individual legislators, testimony, and other governmental research and assistance. The Committee identifies inefficiency or ineffectiveness or a failure to accomplish legislative objectives, and makes recommendations for redefinition, redirection, redistribution and/or restructuring of Mississippi government. As directed by and subject to the prior approval of the PEER Committee, the Committee's professional staff executes audit and evaluation projects obtaining information and developing options for consideration by the Committee. The PEER Committee releases reports to the Legislature, Governor, Lieutenant Governor, and the agency examined.

The Committee assigns top priority to written requests from individual legislators and legislative committees. The Committee also considers PEER staff proposals and written requests from state officials and others.

PEER Committee
Post Office Box 1204
Jackson, MS 39215-1204

(Tel.) 601-359-1226
(Fax) 601-359-1420
(Website) <http://www.peer.state.ms.us>

The Mississippi Legislature

Joint Committee on Performance Evaluation and Expenditure Review

PEER Committee

SENATORS
SIDNEY ALBRITTON
Chair
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MERLE FLOWERS
CINDY HYDE-SMITH
GARY JACKSON
SAMPSON JACKSON
NOLAN METTETAL



Post Office Box 1204
Jackson, Mississippi 39215-1204

Max K. Arinder, Ph. D.
Executive Director

www.peer.state.ms.us

REPRESENTATIVES
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RAY ROGERS
GREG WARD

OFFICES:
Woolfolk Building, Suite 301-A
501 North West Street
Jackson, Mississippi 39201


TELEPHONE:
(601) 359-1226

FAX:
(601) 359-1420

September 16, 2008

Honorable Haley Barbour, Governor
Honorable Phil Bryant, Lieutenant Governor
Honorable Billy McCoy, Speaker of the House
Members of the Mississippi State Legislature

On September 16, 2008, the PEER Committee authorized release of the report entitled
An Evaluation of Mississippi's Medicolegal Death Investigation Process.



Senator Sidney Albritton, Chair

This report does not recommend increased funding or additional staff.

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An Evaluation of Mississippi's Medicolegal Death Investigation Process

Executive Summary

Introduction

Medicolegal death investigations (i. e., investigations that combine gathering and interpreting information about the circumstances and causes of a particular death) serve numerous societal interests. In the face of recent concerns about the quality of death investigations in Mississippi, the PEER Committee evaluated the state's medicolegal death investigation process, focusing on activities of the State Medical Examiner's Office.

Mississippi's medicolegal death investigation system has evolved from a purely local system to a mixed system in which local coroners and a central State Medical Examiner's office share authority. State law makes the State Medical Examiner the state's expert in forensic death investigations. Under the Mississippi Medical Examiner Act (MISS. CODE ANN. § 41-61-55 [1972]), the State Medical Examiner must be a physician board-certified in forensic pathology. The State Medical Examiner is to have authority over physician county medical examiners and non-physician county medical examiner investigators and responsibility for medicolegal death investigation training and rule promulgation. Duties of the State Medical Examiner fall into the following primary categories:

- service (including performing autopsies, consulting, and training);
- regulation (including selecting and overseeing designated pathologists and conducting death investigations);
- recordkeeping; and,
- special statutory duties regarding deaths in state correctional institutions and infant deaths from Sudden Infant Death Syndrome (SIDS).

Has the State Medical Examiner’s Office fulfilled its statutorily prescribed duties with respect to death investigation?

Because of the long-time vacancy in the position of State Medical Examiner, an insufficient number of staff, and underfunding of the office, the State Medical Examiner’s Office has not been able to ensure that all of its statutory responsibilities have been addressed.

State law makes clear that the Legislature created the State Medical Examiner’s Office for the purpose of ensuring that deaths are investigated throughout the state competently and uniformly. PEER concludes that the office has not always been able to fulfill responsibilities placed on it by the comprehensive legislation adopted for death investigations, as evidenced by the following:

- Since 1995, designated pathologists have been performing all autopsies referred to a medical examiner. No state-level oversight of these designated pathologists has been exercised since 1991.
- The office’s staff currently does not have the medical expertise to review the reports filed by local medical examiners.
- The office has not effectively fulfilled some of its recordkeeping duties—specifically, reconciliation of local medical examiners’ death reports with death certificates from the Department of Health—because some county medical examiners/investigators do not file necessary documents with the office.
- Because the State Medical Examiner’s position is vacant, the office has not technically complied with the statutory requirement for the State Medical Examiner to perform autopsies when deaths occur in the correctional system.

Weaknesses in the State Medical Examiner’s program may be attributed primarily to vacancies in the State Medical Examiner’s position, other staffing issues, and historical underfunding of the office.

While the role of State Medical Examiner is one of great importance, the position has been filled only sporadically over the past twenty-three years. The instability in this position has given rise to an environment wherein important regulatory and managerial duties go unattended because there is no person with the statutorily require background to give leadership and direction.

The State Medical Examiner’s Office currently must rely on the Mississippi Crime Laboratory for oversight and staff support. As of June 2008, three positions—two medical examiner assistants and one support technician—in the State Medical Examiner’s

Office were filled, and the incumbent in one of these positions had been on military leave for approximately two years. Currently, two crime lab employees perform support functions for the State Medical Examiner's Office.

In addition to a lack of leadership, the State Medical Examiner's Office has not received funding adequate for the purpose of carrying out the duties and responsibilities set out in statute. Only in the current fiscal year, FY 2009, has there been sufficient funding on hand to hire a State Medical Examiner and other medical doctors who could perform forensic analysis and provide technical and professional support to the death investigation process.

What are the policy implications of the weaknesses of the State Medical Examiner's program?

The lack of a State Medical Examiner or adequate staffing impairs the state's ability to ensure that issues surrounding deaths affecting the public interest are resolved competently.

Because of the lack of a State Medical Examiner for the past thirteen years, the office has been unable to regulate effectively. In recent years, the processes of death investigation in Mississippi have come under close and often critical scrutiny, perhaps most notably in the criminal case of *Edmonds v. State*, 955 So. 2d 787 (Miss, 2007). In *Edmonds*, the court reversed a criminal conviction of a defendant convicted of capital murder. One justice concurring in the result was sharply critical of the testimony of a designated pathologist who performs autopsies in Mississippi cases when county medical examiners have concluded that an autopsy is necessary.

While PEER is in no position to opine as to the professional competence of persons performing functions in the medical field, one can note that large numbers of autopsies are being performed by a person who is not board-certified in forensic pathology and that the one position that can regulate or oversee the activities of persons performing forensic work in the state has been vacant since 1995.

Because the Office of the State Medical Examiner has historically been underfunded, the office has been unable to fulfill part of its service role. Inadequate staffing in the State Medical Examiner's Office has caused local death investigators to depend on designated pathologists. The inability of the office to perform the most rudimentary levels of oversight such as records review and reconciliation and meeting with other professionals on updating and overseeing the work of designated pathologists may be attributed to an inadequate number of other staff in addition to the lack of a State Medical Examiner.

Should the Legislature change state laws dealing with death investigation?

Several sections of the MISSISSIPPI CODE addressing the authority of the State Medical Examiner are unclear as to the office's authority in critical areas of death investigation.

Some provisions of current law are ambiguous as to where authority lies for making certain critical decisions regarding death investigations and other provisions regarding the promulgation of rules and regulations for death investigations appear to be contradictory. Also, statutes governing death investigation split authority for conducting death investigations between local and state officials.

Policy Options

Option One: Retain the Current System, Make Technical Corrections to the Law, and Increase Funding

Under this option, the state would commit itself to funding a State Medical Examiner's Office that is capable of providing not only regulation of death investigation, but all services needed to assist local death investigators in the furtherance of their duties. Such a system would provide the office with sufficient numbers of pathologists to perform most autopsies needed to complete death investigations. These pathologists would be regularly reviewed for their work quality.

Under this option, the office would clearly be responsible for regulating the performance of death investigation and would routinely review all filings of local death investigators to insure that their work is being performed professionally. State law would need to clarify the conflicts and ambiguities in law.

Under state law that became effective July 1, 2008 (H.B. 525, Regular Session 2008), the cost of a forensic autopsy will increase from \$550 to \$1,000 per autopsy. Assuming that the State Medical Examiner's Office is able to perform at least 1,000 autopsies per year, this would generate for the office \$1 million in fee-based revenue to support office operations, thereby making the office closer to self-sufficiency.

Option Two: Establish a Pure State Investigation System

Under a pure state investigation system, the state would bear the costs of investigating all deaths affecting the public interest. To facilitate such a system the following would have to occur:

- abolition of the local office of coroner; and,
- creation and funding of a statewide death investigation system.

Abolition of the Coroner's Office: While the statutes refer to the offices of county medical examiner and county medical examiner investigator, the office of coroner is a constitutional office under Section 135 of the MISSISSIPPI CONSTITUTION. While this section provides that the duties of the office may be combined with that of another office, it does not authorize the abolition of any office. Consequently, the office of coroner would have to be abolished through a constitutional amendment.

Funding of a State System: Some states combine the investigative functions that are split between state and local authorities in Mississippi into a single central state agency. In such states, the responsibility for investigating deaths, collecting evidence, as well as performing and overseeing autopsies, is in the hands of the state agency. Such arrangements give the state complete control over the management, selection, and training of staff that work in medicolegal death investigations, unlike our mixed system wherein the local medical examiners control the decision to select local staff. Such an approach insures consistency in the quality of personnel selected.

Centralized models have their drawbacks also. The loss of locally selected medical investigative staff could destroy relations that have been forged over time between local law enforcement agencies. Such impairments could frustrate death investigations. Additionally, centralized systems add costs to the state that under mixed systems are borne by local government.

In the state of Maryland, for example, not only does the state perform autopsies, it also is responsible for field investigation of deaths. Maryland has on staff fifteen investigators who carry out the functions similar to those of Mississippi's county medical examiners and county medical examiner investigators. Salary expenses for these staff are approximately \$500,000 per year. While Maryland does perform about 4,500 autopsies per year, about 2.25 times Mississippi's workload, the state is geographically smaller. (Maryland's total area is 12,407 square miles versus Mississippi's total area of 48,430 square miles.) Thus Maryland's death investigators cover a much smaller area with corresponding reduced travel times than would Mississippi's investigators.

If Mississippi were to utilize such a system, its costs would most likely be greater than 44% of Maryland's costs. Additionally, a larger central staff would also require additional support staff to assist in the management of a fully centralized death investigation system.

Option Three: Eliminate the State Medical Examiner's Office and Revert to a Local System

Under this option, Mississippi would revert to its pre-1974 approach to investigating deaths. The coroner system would operate without the benefit of a centralized support system to ensure effective operations. Such a system would be likely to cost local governments no more than the current system: a death

investigation system in which there is no State Medical Examiner, wherein counties bear the burden of paying for death investigations and autopsies.

Obviously such a system would not cost the state as much as is currently expended on the limited operations of the State Medical Examiner's office. While financially this option would generate savings to the state, non-financial costs related to death investigation would be similar to those discussed earlier in this report. Criticism and concern regarding the quality of the state's forensic investigations would be likely to continue without support from trained oversight personnel.

For More Information or Clarification, Contact:

PEER Committee
P.O. Box 1204
Jackson, MS 39215-1204
(601) 359-1226
<http://www.peer.state.ms.us>

Senator Sidney Albritton, Chair
Picayune, MS 601-590-1845

Representative Harvey Moss, Vice Chair
Corinth, MS 662-287-4689

Representative Walter Robinson, Secretary
Bolton, MS (601) 866-7973

An Evaluation of Mississippi's Medicolegal Death Investigation Process

Introduction

Medicolegal death investigations (i. e., investigations that combine gathering and interpreting information about the circumstances and causes of a particular death) serve numerous societal interests. In the face of recent concerns about the quality of death investigations in Mississippi, the PEER Committee evaluated the state's medicolegal death investigation process, focusing on activities of the State Medical Examiner's Office.

Authority

In conducting this review, PEER exercised authority granted by MISS. CODE ANN. Section 5-3-51 et seq. (1972).

Scope and Purpose

In this evaluation of medicolegal death investigations in Mississippi, PEER focused particularly on the State Medical Examiner's Office, the entity created by law to oversee those practices.

Specifically, PEER sought to answer several questions regarding death investigation in Mississippi. These were:

- Has the State Medical Examiner's Office fulfilled its statutorily prescribed duties with respect to death investigation?
- What are the policy implications of the weaknesses of the State Medical Examiner program?
- Should the Legislature change state laws dealing with death investigation?

In this review, PEER focused on the State Medical Examiner's Office because:

- state law imposes numerous duties and obligations on that office with respect to death investigations;
- PEER's 1988 policy analysis of the office served as a model for proceeding with a follow-up review;

- recent criticism of the state’s death investigation system has centered on the State Medical Examiner’s Office; and,
- initial assessments of the office indicated it would be in the current project’s interest to expend additional scrutiny there in the hopes of making informed recommendations for change.

PEER did not review the operations of the Mississippi Crime Laboratory beyond the extent to which doing so was incidental to the Committee’s overall interest in statewide medicolegal death investigations. The Committee had conducted a comprehensive review of the laboratory in 2004 and released report #476, *A Review of the Department of Public Safety’s Mississippi Crime Laboratory*.

Also, PEER did not review the performance of local death investigation offices, except to the degree that such was necessary to reviewing the operations of the State Medical Examiner’s Office.

Method

In conducting this evaluation, PEER:

- reviewed relevant sections of state law and the State Medical Examiner’s Office’s policies and procedures regarding the fulfillment of statutory duties and responsibilities for medicolegal death investigations;
- reviewed the State Medical Examiner’s Office procedures, records, budget requests, fiscal information, management documents, medicolegal death investigation materials, and other agency-specific materials;
- reviewed Attorney General’s opinions; audits of the Department of Public Safety; Ethics Commission opinions; and prior PEER reports related to the State Medical Examiner, coroners, and medicolegal death investigations;
- reviewed state and national statistics related to medicolegal death investigations;
- reviewed requirements for accreditation by the National Association of Medical Examiners and similar medical and forensic professional organizations;
- interviewed selected personnel of the State Medical Examiner’s Office, Department of Public Safety, Department of Health, Legislative Budget Office, and other individuals;
- examined reports, documents, rules, regulations, and other information compiled by the State Medical Examiner’s Office concerning accountability, performance, organizational structure, and medicolegal death

investigations, including responses to PEER interrogatories and requests for information;

- conducted a literature review of secondary sources such as forensic and medical scholarly journals, social science studies and research on medicolegal death investigations, law and information on forensic practices in other states, and local and national press coverage; and,
- inspected the State Medical Examiner's Office, Mississippi Crime Laboratory, and state morgue.

Background

What are Medicolegal Death Investigations?

Medicolegal death investigations—which combine the tasks of obtaining and interpreting information about the circumstances and causes of death—fulfill fundamental responsibilities of government and serve important societal interests.

A medicolegal death investigation involves the combined tasks of obtaining and interpreting information about the circumstances and causes of a particular death. It includes steps such as observing the death scene, collecting relevant evidence, conducting an external body examination, performing an autopsy, completing sample testing, and certifying the death.

From the prosecution of criminals to the protection of the innocent, a medicolegal death investigation system fulfills a fundamental responsibility of government: establishing a fair and accurate criminal justice system to guard citizens against the willful and wanton loss of life. In the process, through various services such as the maintenance of vital statistics, it also furthers important societal interests in public health.

In 2004, sixteen states in the U. S. had a centralized statewide medical examiner system. Although the degree of centralization varies tremendously, each falls into one of three basic types of medicolegal death investigation systems: (1) medical examiner, (2) coroner, or (3) mixed examiner-coroner. For the most part, coroners tend to be elected laypersons. Medical examiners, in contrast, typically possess medical degrees; some also have specialized training in forensic pathology.

Evolution of Medicolegal Death Investigation in Mississippi

Mississippi’s death investigation system has evolved from a purely local system to a mixed system in which local coroners and a central state medical examiner’s office share authority.

Until 1974, Mississippi’s elected county coroners directed death investigation in each county.

Until 1974, Mississippi’s elected county coroners directed death investigation in each county. Under the local system, the coroner convened a “coroner’s jury” for the investigation of any “violent, sudden, or causal death.” Lay and expert witnesses provided testimony to the jury on the cause and manner of death, including autopsy findings from forensic pathologists, when such evidence was available.

The Mississippi Medical Examiners Act of 1974

The enactment of 1974 legislation establishing a State Medical Examiner replaced a purely local medicolegal death investigation system in Mississippi with a centralized mixed one.

In 1974, the Legislature created a State Medical Examiner's position in Mississippi.

Mississippi moved toward creation of a mixed system when it adopted Chapter 398, *Laws of 1974*, known as the Mississippi Medical Examiners Act of 1974. MISS. CODE ANN. §§ 41-61-1 to -21 (1972) created a State Medical Examiner's position (hereafter referred to as SME) under the authority of the University of Mississippi School of Medicine. Without affecting coroners' responsibilities, this law authorized the SME to investigate sudden, violent, or suspicious deaths and to conduct autopsies when in the public interest.

The first of two revisions followed in 1981, when MISS. CODE ANN. § 41-61-23 (1972) required the SME to investigate violent, sudden, or suspicious deaths and to develop a plan for the uniform distribution of services to all counties in the state. In addition to authorizing statewide death investigations and the creation of operational rules, a second revision in 1984 placed the SME under the supervision of the Department of Public Safety's Crime Laboratory.

Mississippi's 1986 Death Investigation Legislation

Mississippi's 1986 death investigation laws ushered in a complete overhaul of medicolegal death investigations in the state and made the State Medical Examiner a key leadership position in the death investigation process.

The Mississippi Medical Examiner Act of 1986 (MISS. CODE ANN. §§ 41-61-51 to -79 [1972]) and the Mississippi Coroner Reorganization Act of 1986 (MISS. CODE ANN. §§ 19-21-101 to -109 [1972]) repealed earlier provisions providing for a coroner's jury, reclassified coroners as physician county medical examiners (referred to here as CMEs) or non-physician county medical examiner investigators (referred to here as CMEIs), and required each to complete mandatory training in order to hold office. The Mississippi Medical Examiner Act of 1986 also elaborated on the types of deaths to be investigated.

The 1986 act reclassified coroners as physician county medical examiners or non-physician county medical examiner investigators and required mandatory training.

Medical examiners, defined by MISS. CODE ANN. § 41-61-53 (1972) to include the State Medical Examiner, CMEs, and CMEIs collectively, maintain authority over a body in a death affecting the public interest. Under CODE Section 41-61-59 (1), deaths affecting the public interest include those in which "the circumstances are sudden, unexpected, violent, suspicious, or unattended." CODE Section 41-61-59 (2) contains additional examples of such deaths.

Under the Mississippi Medical Examiner Act of 1986 and the Mississippi Coroner Reorganization Act of 1986, the process of death investigation is as follows:

1. A death is investigated by local authorities.

2. If it appears to the local authorities that the death might fall within the definition of a death affecting the public interest, the coroner (now known as a county medical examiner) or a county medical examiner investigator becomes involved in the case.
3. The coroner (now known as a county medical examiner) investigates the matter and prepares the mandatory ME-1 form.
4. The State Medical Examiner may review the ME-1 form and determine if his/her office should become involved.
5. The County Medical Examiner/Investigator contacts the State Medical Examiner if in his opinion an autopsy should be performed.
6. The State Medical Examiner or a designated pathologist performs the autopsy and completes all necessary forms regarding the death.

In Mississippi, the law contemplates that the State Medical Examiner will serve a leadership role in the death investigation system. This leadership is to extend to oversight of the processes followed by local death investigators, approval of persons who may perform autopsies for the state, and as needed, a professional who can perform autopsies and investigate deaths when necessary.

The chapter beginning on page 8, "Role of the State Medical Examiner in Mississippi's Medicolegal Death Investigation Process," discusses the requirements in state law for the SME and the statutory responsibilities of the position.

PEER's 1988 Policy Analysis of the State Medical Examiner Program

PEER's 1988 policy analysis of the State Medical Examiner's Office found heavy workloads that exceeded available resources, a lack of local cooperation among CMEs and CMEIs, inadequate facilities, and inconsistent state laws that deprived Mississippi of the benefits of a medicolegal death investigation system overseen by a State Medical Examiner.

PEER's 1988 report found that the State Medical Examiner's Office was significantly underfunded, with inadequate staffing and facilities.

In 1988, following concerns about vacancies in the Office of the State Medical Examiner, PEER conducted a policy analysis of the State Medical Examiner's Office. The report found that the office was significantly underfunded, thereby forcing the medical examiner to emphasize some functions to the detriment of others. The most recent State Medical Examiner at the time of that report had placed considerable emphasis on the performance of autopsies. PEER noted that the support staffing of the office was inadequate at that time, as were the facilities.

PEER presented several options to the Legislature in 1988 for correcting the problems at the State Medical Examiner's Office. These included:

- maintaining the system as currently staffed and funded;
- eliminating the State Medical Examiner position and returning to a locally managed death investigation system;
- maintaining the system and funding upgrades in staffing and infrastructure;
- downgrading the system to a set of duties that could be carried out effectively with prevailing levels of funding; or,
- creating a centralized state system for death investigation.

The report recommended upgrading the current system through additional resources and improved facilities. PEER warned in the report that if changes were not made in the funding and operations of the State Medical Examiner's Office, the system could degrade into a locally managed system without the resources to ensure that forensic work was performed with the necessary degree of quality.

Role of the State Medical Examiner in Mississippi's Medicolegal Death Investigation Process

State law makes the State Medical Examiner the state's expert in forensic death investigations.

Requirements for the State Medical Examiner

Under the Mississippi Medical Examiner Act, the State Medical Examiner must be a physician board-certified in forensic pathology. The State Medical Examiner is to have authority over CMEs and CMEIs and responsibility for medicolegal death investigation training and rule promulgation.

MISS. CODE ANN. § 41-61-55 (1972) creates the position of State Medical Examiner under the supervision of and appointed by the Commissioner of the Department of Public Safety. It also requires the SME to be:

- a physician;
- eligible to practice medicine in Mississippi; and,
- certified in forensic pathology by the American Board of Pathology.

The State Medical Examiner has authority over testing and continuing education of county medical examiners and county medical examiner investigators.

Additionally, CODE § 41-61-57 authorizes the SME to remove a local CME or CMEI for inefficiency or other good cause. CODE § 41-61-57 requires CMEs and CMEIs to attend death investigation training school to be provided by the Mississippi Crime Laboratory and the SME. They must also complete subsequent testing on the subject matter at least once every four years under the SME's authority. Furthermore, this section also requires CMEs and CMEIs to receive twenty-four hours of continuing education units annually as prescribed and certified by the SME.

MISS. CODE ANN. § 41-61-59 (1972) authorizes the SME, in conjunction with the Director of the State Board of Health, Attorney General, President of the Mississippi Coroners Association or their designees, and a certified pathologist appointed by the Mississippi State Medical Association, to "adopt, promulgate, amend, and repeal rules and regulations as may be deemed necessary by them from time to time for the proper enforcement, interpretation, and administration" of the act.

Duties of the State Medical Examiner

The State Medical Examiner's role is to facilitate effective and uniform death investigations through the state by fulfilling the responsibilities assigned by the Mississippi Medical Examiners' Act.

MISS. CODE ANN. § 41-61-63 (1) (1972) imposes specific duties upon the State Medical Examiner. According to that section, the SME shall:

(a) Provide assistance, consultation and training to county medical examiners, county medical examiner investigators and law enforcement officials.

(b) Keep complete records of all relevant information concerning deaths or crimes requiring investigation by the medical examiners.

(c) Promulgate rules and regulations regarding the manner and techniques to be employed while conducting autopsies; the nature, character and extent of investigations to be made into deaths affecting the public interest to allow a medical examiner to render a full and complete analysis and report; the format and matters to be contained in all reports rendered by the medical examiners; and all other things necessary to carry out the purposes of Sections 41-61-51 through 41-61-79. The State Medical Examiner shall make such amendments to these rules and regulations as may be necessary. All medical examiners, coroners and law enforcement officers shall be subject to such rules.

(d) Cooperate with the crime detection and medical examiner laboratories authorized by Section 45-1-17, the University of Mississippi Medical Center, the Attorney General, law enforcement agencies, the courts and the State of Mississippi.

Thus the duties of the State Medical Examiner fall into the following primary categories:

- service;
- regulation;
- recordkeeping; and,
- special statutory duties regarding deaths in state correctional institutions and infant deaths from SIDS.

The following subsections describe the work required by statute that falls into these categories and further discusses what the office is doing to comply with these mandates.

Services to Local Death Investigators

State law empowers the State Medical Examiner to provide certain services to local death investigators. Of critical importance are the performance of autopsies and the provision of training to the individual county medical examiners and county medical examiner investigators.

Autopsies

MISS. CODE ANN. Section 41-61-65 (1) (1972) provides, with respect to the performance of autopsies:

If, in the opinion of the medical examiner investigating the case, it is advisable and in the public interest that an autopsy or other study be made for the purpose of determining the primary and/or contributing cause of death, an autopsy or other study shall be made by the State Medical Examiner or by a competent pathologist designated by the State Medical Examiner. . . .

State law allows designated pathologists, who are private pathologists approved by the State Medical Examiner's Office, to perform autopsies in cases wherein there is a death affecting the public interest.

Thus the statute contemplates the State Medical Examiner's Office providing local death medical examiners with a source of expertise in conducting forensic science to determine the manner and cause of death in certain cases.

The above-cited provision authorizes the use of designated pathologists to perform autopsies. These physicians are private pathologists who are approved by the State Medical Examiner's Office to perform autopsies in cases wherein there is a death affecting the public interest. These pathologists have become of considerable importance in recent years, as there has been no State Medical Examiner.

Consulting and Training

MISS. CODE ANN. Section 41-61-63 (1) (a) (1972) provides:

The State Medical Examiner shall:

(a) Provide assistance, consultation and training to county medical examiners, county medical examiner investigators and law enforcement officials.

Additionally, MISS. CODE ANN. Section 41-61-57 (1972) requires that each county medical examiner and county medical examiner investigator complete a death investigation training program before taking the oath of office.

MISS. CODE ANN. Section 41-61-57 (5) (1972) requires local death investigators to complete training annually. Specifically, the provision requires:

Chief and deputy CME's and CMEI's shall attend the death investigation training school provided by the Mississippi Crime Laboratory and the State Medical Examiner, and shall successfully complete subsequent testing on the subject material by the State Medical Examiner at least once every four (4) years. Room, board and transportation expenses for attending the school shall be borne by the county in which the CME or CMEI is serving. In addition to the above training, the individual shall receive at least twenty-four (24) hours annually of continuing education as prescribed and certified by the State Medical Examiner. If the above requirements for training or continuing education are not met, the individual immediately shall be disqualified and removed from office as CME and/or CMEI. Reapplication for the office may be made the following year after removal.

Thus the State Medical Examiner's Office is critical to ensuring that local death investigators are given essential training to ensure that crime scenes are properly scrutinized.

Regulation

State law places several regulatory responsibilities on the State Medical Examiner, including:

- selecting and overseeing designated pathologists; and,
- conducting death investigations.

Selecting and Overseeing Designated Pathologists

State law contemplates that autopsies may have to be performed by persons other than the State Medical Examiner or his/her staff. MISS. CODE ANN. Section 41-61-65 (1) (1972) provides for the use of designated pathologists for forensic autopsies (see page 10). By this statutory authority, the State Medical Examiner regulates through the power of appointment those persons who may perform forensic autopsies for the support of death investigations.

Regulations of the State Medical Examiner's Office adopted in 1991 require a Designated Pathologist Review Committee to be responsible for a Quality Assurance-Enhancement Program. The committee is to review selected examples of post-mortem examinations and other documents to "recommend selection, retention, probation, or dismissal of pathologists from the designated list." With other professionals as members, the guidelines call for the State Medical Examiner to sit as committee chairman. They also require the State Medical Examiner's Office

to maintain records of the committee. The records are to include files on each designated pathologist, including examples of autopsy audits and other information. Finally, the same rules and regulations require the Designated Pathologist Review Committee to publish an annual report and to meet yearly.

Conducting death investigations

While state law contemplates that local governmental personnel address the investigation of crime scenes, state law does provide in MISS. CODE ANN. Section 41-61-59 (3) (1972) that the State Medical Examiner shall have the authority to investigate deaths in all political subdivisions of the state.

Recordkeeping

Several important provisions of the Mississippi Medical Examiner Act of 1986 pertain to recordkeeping. The records provided for not only are important to the investigation of deaths but also provide the state with methods for ensuring that the work provided by local death investigators can be reviewed by skilled personnel in the State Medical Examiner's Office.

CODE Section 41-61-63 (1972) provides the following with respect to the State Medical Examiner's duty to keep and receive records:

(1) The State Medical Examiner shall: . . .

(b) Keep complete records of all relevant information concerning deaths or crimes requiring investigation by the medical examiners. . . .

(2) In addition, the medical examiners shall:

(a) Upon receipt of notification of a death affecting the public interest, make inquiries regarding the cause and manner of death, reduce the findings to writing and promptly make a full report to the State Medical Examiner on forms prescribed for that purpose. The medical examiner shall be authorized to inspect and copy the medical reports of the decedent whose death is under investigation. However, the records copied shall be maintained as confidential so as to protect the doctor/patient privilege. The medical examiners shall be authorized to request the issuance of subpoenas, through the proper court, for the attendance of persons and for the production of documents as may be required by their investigation. . . .

(e) In all investigations of deaths occurring in the manner specified in subsection (2)(j) of Section 41-61-59, a death investigation shall be performed by the medical examiners in accordance with the child death investigation protocol established by the State

Medical Examiner. The results of the death investigation shall be reported to the State Medical Examiner on forms prescribed for that purpose by the State Medical Examiner and to appropriate authorities, including police and child protective services, within three (3) days of the conclusion of the death investigation.

Records of deaths investigated must be reported to the State Medical Examiner on prescribed forms.

Thus records of deaths investigated must be reported to the State Medical Examiner on prescribed forms. The State Medical Examiner estimates that approximately 16,000 ME-1 investigation of death forms are filed by county medical examiners or investigators in a year.

Special Statutory Duties: Deaths in State Correctional Institutions and Infant Deaths from SIDS

State law places a special duty on the office of the State Medical Examiner when a death occurs at a state correctional facility. MISS. CODE ANN. Section 47-5-151 (1972) establishes specific duties for the State Medical Examiner when deaths occur in a state correctional facility. Specifically, this section provides:

It shall be mandatory that the State Medical Examiner cause an autopsy to be performed upon the body of the deceased prisoner. Furthermore, the State Medical Examiner shall investigate any case where a person is found dead on the premises of the correctional system, in accordance with Sections 41-61-51 through 41-61-79. The State Medical Examiner shall make a written report of his investigation, and shall furnish a copy of the same, including the autopsy report, to the superintendent (warden) and a copy of the same to the district attorney of the county in which said prisoner died. The copy so furnished to the district attorney shall be turned over by the district attorney to the grand jury, and it shall be the duty of the grand jury, if there be any suspicion of wrongdoing shown by the inquest papers, to thoroughly investigate the cause of such death. . . .

In Mississippi, deaths affecting the public interest include deaths of children below the age of two for which the circumstances surrounding the death indicate that Sudden Infant Death Syndrome may be the cause of death.

Pages 15 through 22 of this report include a discussion of whether the State Medical Examiner's Office has fulfilled its statutorily prescribed duties regarding death investigation.

While most deaths affecting the public interest involve deaths that occur under suspicious circumstances, state law places one category into the statute that extends beyond the scope of deaths that are usually associated with possible criminal acts. This category includes deaths of children below the age of two for which the circumstances surrounding the death indicate that Sudden Infant Death Syndrome (SIDS) may be the cause of death. These deaths are unexplained by definition. According to a study

by the Mississippi Department of Health, Mississippi's reported SIDS deaths have increased from 1.3 deaths per 1,000 in 2001 to 2.2 deaths per 1,000 in 2005.¹

Because of the unexplained nature of a SIDS death, state law's requirement that a SIDS death be reported to the State Medical Examiner evidences a purpose to ensure that expert medical support is available to review and oversee any finding of SIDS in any case.

¹ J. Graham, S. Hendrix, and R. Schwalberg (2008). "Evaluating the SIDS Diagnosis Process by Coroners in Mississippi." Accepted for publication 2008 - in production.

Conclusions

In conducting this review, PEER focused on issues of resources and resource management to answer the following questions:

- Has the State Medical Examiner’s Office fulfilled its statutorily prescribed duties with respect to death investigation?
- What are the policy implications of the weaknesses of the State Medical Examiner program?
- Should the Legislature change state laws dealing with death investigation?

Has the State Medical Examiner’s Office fulfilled its statutorily prescribed duties with respect to death investigation?

Because of the long-time vacancy in the position of State Medical Examiner, an insufficient number of staff, and underfunding of the office, the State Medical Examiner’s Office has not been able to ensure that all of its statutory responsibilities have been addressed.

Inability to Fulfill Some Statutory Responsibilities

The State Medical Examiner’s Office has not ensured that all of its statutory responsibilities have been fulfilled.

State law makes clear that the Legislature created the State Medical Examiner’s Office for the purpose of ensuring that deaths are investigated throughout the state competently and uniformly. In reviewing the performance of the State Medical Examiner’s Office, PEER has concluded that the office has not been able to consistently fulfill the responsibilities placed on it by the comprehensive legislation adopted for death investigations.

The State Medical Examiner’s Office has not been able to regulate the processes of death investigation in Mississippi effectively as evidenced by the following:

- Since 1995, designated pathologists have been performing all autopsies referred to a medical examiner.
- No state-level oversight of designated pathologists has been exercised since the above-cited policy was adopted in 1991.

- The rules and regulations for death investigation have not been reviewed or revised by a State Medical Examiner since 1991.
- The office’s staff currently does not have the medical expertise to review the reports filed by local medical examiners.
- The office has not effectively fulfilled some of its recordkeeping duties—specifically, reconciliation of local medical examiners’ death reports with death certificates from the Department of Health—because some county medical examiners/investigators do not file necessary documents with the office.
- Because the State Medical Examiner’s position is vacant, the office has not technically complied with the statutory requirement for the State Medical Examiner to perform autopsies when deaths occur in the correctional system.

The following subsections discuss these conditions.

Use of Designated Pathologists

Because Mississippi has not had a State Medical Examiner since 1995, designated pathologists have been performing all autopsies referred to a medical examiner. At least one of these designated pathologists has performed a number of autopsies annually that greatly exceeds professional standards and increases the likelihood of errors.

The position of the State Medical Examiner has been vacant since 1995. Since that time, autopsies referred to the State Medical Examiner’s Office have been performed by designated pathologists. As noted previously, “designated pathologists” are those selected by the State Medical Examiner and placed on a list of persons who are eligible to perform autopsies for the county medical examiners/investigators. This is of particular concern because no oversight of designated pathologists has been exercised since 1991.

In Mississippi, approximately 2,000 autopsies per year are performed by designated pathologists, with approximately 1,700 per year being performed by one particular designated pathologist.

The State Medical Examiner’s Office relies exclusively on a few designated pathologists to perform autopsies on deaths affecting the public interest. According to the Director of the Crime Lab and the State Medical Examiner’s Office, approximately 2,000 autopsies per year are performed by designated pathologists, with approximately 1,700 per year being performed by one particular designated pathologist.

To determine how this number of autopsies performed annually by one individual compared to the recommended professional standard, PEER contacted the National Association of Medical Examiners (NAME), an organization that advocates for professionalism in death investigation. NAME formulates staffing standards and has taken a position on the number of forensic autopsies one person should be expected to perform in a year.

According to NAME standards, a forensic pathologist with no administrative duties should perform no more than 250 autopsies each year. As NAME cautions, over 250 autopsies performed annually corresponds to a tendency for the forensic pathologist, regardless of skill, to engage in shortcuts or to make mistakes, including performing partial autopsies when a full one is warranted, failing to examine an injury or organ, or not completely recording relevant findings.

According to the National Association of Medical Examiners, performing over 250 autopsies annually corresponds to a tendency for a forensic pathologist to engage in shortcuts or make mistakes.

At the threshold of 350 autopsies per year and beyond, a pathologist's mistakes may grow more flagrant and are more likely to involve errors in judgment, such as a case not being autopsied where it should have been, a hasty diagnosis without sufficient basis or thought, or burnout and manpower attrition.

Assuming the information provided by the Acting Director of the State Medical Examiner's Office is accurate regarding the number of autopsies performed, the individual who performs approximately 1,700 autopsies per year (i. e., an overwhelming majority of the autopsies on deaths affecting public interest in Mississippi) performs them at a rate of 580% over NAME recommendations.

No Oversight of Designated Pathologists

Since 1991, no oversight of designated pathologists has been exercised.

According to staff of the State Medical Examiner's Office, even when there was a State Medical Examiner in the mid-1990s, the review committee was not convened to review the work of designated pathologists. Without the review committee or a State Medical Examiner, the state has in place no mechanism to either review the work of designated pathologists for quality or to approve the addition of qualified pathologists to the list when new persons seek inclusion.

Staff Lacks Medical Expertise to Review Reports of Local Medical Examiners

The office's staff currently does not have the medical expertise to review the reports filed by local medical examiners.

The staff of the State Medical Examiner's Office does not have the medical expertise to determine whether the work of local medical examiners is being performed competently or if more professional assistance is needed in a case. At present, the state has no physician in its employ, let alone a forensic pathologist, who can review the work of local death investigators to ensure that proper judgment is being applied in areas in which medical expertise is essential.

Some Recordkeeping Duties Not Effectively Fulfilled

The office has not effectively fulfilled some of its recordkeeping duties. Specifically, it does not routinely reconcile local medical examiner death reports with death certificates from the Department of Health. In some cases, county medical examiners/investigators do not send all necessary documents to the State Medical Examiner's Office, making review problematic.

According to staff of the State Medical Examiner's Office, the office receives approximately 16,000 ME-1 forms in any given year. These forms include the local death investigator's analysis of the manner and cause of death in a case involving a death affecting the public interest, as well as descriptive information regarding the decedent. These forms provide the office with a basis for reviewing the work of local death investigation personnel.

Despite the fact that these records are of importance in reviewing the work of local death investigators, PEER learned that the State Medical Examiner's Office does not routinely review these filings and reconcile them with records provided to the Department of Health. While information PEER received from the Department of Health reflects approximately 16,000 deaths affecting the public interest in the most complete recent fiscal year, a number that closely approximates that provided by the State Medical Examiner, some analysis by the office is necessary to ensure that county-by-county filings of forms are at least consistent with the number reported to the Department of Health.

A recent study conducted by the Department of Health reports that 28% of Mississippi's local death investigators surveyed do not make their required reports to the State Medical Examiner.

In discussing this with the State Medical Examiner's staff, a PEER staffer was told that he could count or review the files himself. While it is understandable that an understaffed office would not be able to catalogue these files routinely, PEER notes that the ability of the office to perform its function is somewhat impaired when it cannot reconcile county-by-county reports with those of the Department of Health.

In one important area, SIDS deaths, records of the State Medical Examiner's Office do not accurately reflect the number of deaths occurring in Mississippi. A recent study conducted by the Department of Health reports that 28% of Mississippi's local death investigators surveyed do not make their required reports to the State Medical Examiner.² These failures to report impair the office's ability to oversee death investigations and the causes could possibly be detected if the office reviewed reports from the State Department of Health and reconciled them with reports filed with the State Medical Examiner's Office.

² Graham et al., 2008.

Technical Noncompliance with the Statutory Requirement for Autopsies following Deaths in the Correctional System

Because the State Medical Examiner's position is vacant, the office has not technically complied with the statutory requirement for the State Medical Examiner to perform autopsies when deaths occur in the correctional system.

The office of the State Medical Examiner has not been able to perform the special duties required by MISS. CODE ANN. Section 47-5-151 (1972) regarding deaths of persons in the correctional system. The provision cited above requires that the State Medical Examiner shall cause autopsies to be performed in deaths occurring in the correctional facilities.

In the strictest sense, the office has not been able to comply with this requirement since 1995 when the State Medical Examiner's position became vacant. Unlike other provisions of law that refer to work being done by the State Medical Examiner or a designated pathologist, this action places the duty squarely on the State Medical Examiner. To PEER's knowledge, designated pathologists perform these autopsies.

Causes for Weaknesses in the State Medical Examiner's Program

Weaknesses in the State Medical Examiner's program may be attributed primarily to vacancies in the State Medical Examiner's position, other staffing issues, and historical underfunding of the office.

Vacancy in the Position of State Medical Examiner

The position of State Medical examiner has been vacant for the past thirteen years.

Throughout the provisions of law set out on page 9 of this report is a requirement that the State Medical Examiner carry out responsibilities with respect to death investigation, from consultation with local officials to approving designated pathologists. While this is a role of great importance, the position has been filled only sporadically over the past twenty-three years, as illustrated below.

Period	Incumbent in State Medical Examiner's Position
1985-1987	Dr. Tom Bennett
1987-1989	Dr. Stephen Hayne (Interim)*
1989-1992	Dr. Lloyd White
1992-1993	vacant
1993-1995	Dr. Emily Ward
1995-present	vacant

* Dr. Hayne served on an interim basis because he is not a board-certified forensic pathologist.

The instability in the position of State Medical Examiner has given rise to an environment wherein important regulatory and managerial duties go unattended because there is no person with the statutorily required background to give leadership and direction.

The instability in the position of State Medical Examiner has given rise to an environment wherein important regulatory and managerial duties go unattended because there is no person with the statutorily required background to give leadership and direction to an important program of state government.

The vacancies in this position could be attributable to many factors. Traditionally, when the position was filled, the staff was not large. Consequently, the State Medical Examiner had to make choices regarding which duties would be fulfilled and which might go unattended. Additionally, as PEER noted in its 1988 report, there was a time when the salary for the position was not competitive. In 1988, only one state paid its medical examiner less than what Mississippi paid.

Regardless of the reasons for vacancy, the lack of a State Medical Examiner has left death investigation leaderless despite the great need for professionalism and direction in this important field.

Other Staffing Issues

The State Medical Examiner's Office, as constituted today, relies on the Mississippi Crime Laboratory for oversight and staff support.

As previously noted, the State Medical Examiner's position has not been filled since 1995. Oversight of the office has been placed in the hands of the crime lab since that time. Currently, designated pathologists perform autopsies in cases referred to a medical examiner. (See page 10 for additional detail.)

As of June 2008, three positions—two medical examiner assistants and one support technician—received salaries and fringes funded through the State Medical Examiner's Office, reflected in Exhibit 1, page 21.

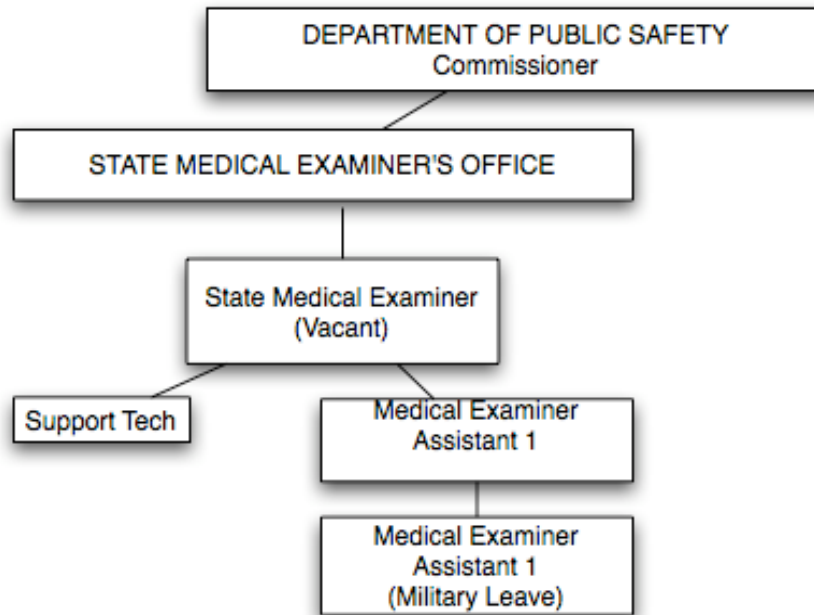
One medical examiner assistant has been on military leave since about 2006. Currently, two crime lab employees perform support functions for the State Medical Examiner's Office.

Underfunding of the State Medical Examiner's Office

The funds made available for the operations of the State Medical Examiner's Office have been inadequate to meet the operational demands of the office and to provide funding for expert medical staff.

In addition to a lack of leadership, the Office of the State Medical Examiner has not received funding adequate for the purpose of carrying out the duties and responsibilities set out in statute. Even if the state had no person qualified to be the State Medical Examiner, the program could be directed on an acting basis by other staff skilled in pathology or in medicine.

Exhibit 1: State Medical Examiner's Office Organizational Chart, June 2008



SOURCE: MERLIN and State Medical Examiner's Office.

Over the past five fiscal years, the State Medical Examiner has received the following in funding:

Fiscal Year	Appropriation	Number of Positions
2005	\$335,454	3
2006	276,648	3
2007	279,006	3
2008	278,505	3
2009	926,225	9

Only in the current fiscal year, FY 2009, has there been sufficient funding on hand to hire a State Medical Examiner and other medical doctors who can perform forensic analysis and provide technical and professional support to the death investigation process.

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Appropriations for the State Medical Examiner's Office for FY 2008 totaled \$278,505. The majority of this amount (59%) came from general funds.

Exhibit 2, page 22, compares funding levels for the State Medical Examiner's Office for FY 2005 through FY 2008. General fund appropriations decreased from FY 2005 to FY 2006 (by \$40,706) and increased slightly from FY 2006 to FY 2007 (by \$2,358). From

FY 2007 to FY 2008, general funds again slightly decreased by \$501.

Exhibit 2: Funding for the State Medical Examiner's Office, FY 2005 through FY 2008

	FY 2005	FY 2006	FY 2007	FY 2008
General	\$202,765	\$162,059	\$164,417	\$163,916
Special	132,689	114,589	114,589	114,589
Total	\$335,454	\$276,648	\$279,006	\$278,505

SOURCE: Appropriations bills for FY 2005 through FY 2008.

Special funds collected by the State Medical Examiner's Office were derived from fees charged for the use of the state morgue. These charges have been \$150 per autopsy. 2008 legislation (H. B. 525, Regular Session 2008) authorizes the State Medical Examiner to charge \$1,000 per autopsy for all services, including use of the facility, its staff, and the State Medical Examiner when one is hired.

What are the policy implications of the weaknesses of the State Medical Examiner's program?

The lack of a State Medical Examiner and adequate staffing impair the state's ability to ensure that issues surrounding deaths affecting the public interest are resolved competently.

Ability to Regulate has Suffered

Because of the lack of a State Medical Examiner for the past thirteen years, the office has been unable to regulate effectively.

A review of the statutes creating the State Medical Examiner's Office makes clear that the Legislature wanted a knowledgeable, qualified person to oversee death investigation in Mississippi. This person was to ensure that autopsies were performed when needed and that decisions made by laypersons serving as coroners could be overseen and, if necessary, be reversed. When the state moved in the direction of approving designated pathologists to carry out the autopsy workload, the State Medical Examiner, and a review committee chaired by the State Medical Examiner, by policy took on the role of ensuring that these were performed competently. Without a State Medical Examiner, the state has no assurance that these things are being done.

In recent years the processes of death investigation in Mississippi have come under close and often critical scrutiny, perhaps most notably in the criminal case of *Edmonds v. State*, 955 So. 2d 787

(Miss, 2007). In *Edmonds*, the court reversed a criminal conviction of a defendant convicted of capital murder. One justice concurring in the result was sharply critical of the testimony of Dr. Stephen Hayne, a designated pathologist who performs autopsies in cases in which county medical examiners/investigators have concluded that an autopsy is necessary. The separate opinion questioned Dr. Hayne's expertise and noted that Dr. Hayne is not a board-certified forensic pathologist. The opinion went further to quote an article in which a medical examiner from Alabama called the system in Mississippi, with no State Medical Examiner, a "mess."

Several articles from the local and national press have raised questions about forensic death investigation in Mississippi.

Several articles from the local and national press have raised questions about forensic death investigation in Mississippi. In an October 2007 article in the *Wall Street Journal*, Radley Balko noted the *Edmonds* decision and raised his own concerns about Dr. Hayne's ability to perform 1,500 to 1,800 autopsies per year. The article cites the standards offered by the National Association of Medical Examiners cited at page 17 of this report that hold that a forensic pathologist should not perform more than 250 autopsies per year. The author further notes that NAME's concern is that fatigued pathologists may make mistakes if they are called upon to perform too many procedures. The article also cites a former police chief from Columbus, Mississippi, who suggests that there may be innocent persons in the State Penitentiary at Parchman due to the testimony of Dr. Hayne. Balko had earlier written a lengthy article in *Reason* magazine that was quoted in the *Edmonds* case.

Other publications and news sources have also raised concerns about the quality of forensic pathology performed in Mississippi. The *Clarion-Ledger* (Jackson) contained an article on July 7, 2008, referring to the forensic work in Mississippi as a "scary CSI episode." The article referred to work conducted by the Innocence Project in uncovering faulty forensic work in criminal cases.

An earlier article regarding Dr. Hayne reported in the *Clarion Ledger* on April 28, 2008, notes that Dr. Hayne failed the examination for certification by the American Board of Pathology, which certifies forensic pathologists and is the board nationally recognized to certify practitioners in forensic pathology.

In response to concerns over the performance of medicolegal investigations in Mississippi, Commissioner of Public Safety Steve Simpson removed Dr. Hayne from the list of designated pathologists on August 5, 2008.

While PEER is in no position to opine as to the professional competence of persons performing functions in the medical field, one can note that large numbers of autopsies are being performed by a person who is not board-certified in forensic pathology and that the one position that can regulate or oversee the activities of persons performing forensic work in the state--the State Medical Examiner--has been vacant since 1995.

Historical Underfunding has Affected Ability to Provide Services

Because the Office of the State Medical Examiner has historically been underfunded, the office has been unable to fulfill part of its service role.

Inadequate staffing in the State Medical Examiner's Office has caused local death investigators to depend on designated pathologists. The reliance on designated pathologists over the past twenty years to conduct autopsies in deaths affecting the public interest and a corresponding increase in the tendency for mistakes and other errors based on the NAME standards has not been closely monitored.

The reliance on designated pathologists over the past twenty years to conduct autopsies in deaths affecting the public interest and a corresponding increase in the tendency for mistakes and other errors based on the NAME standards has not been closely monitored.

A review of the office's funding depicted in Exhibit 2, page 22, establishes this fact. During the periods FY 2005 to FY 2008, the office received appropriations of no more than \$335,454 and had no medical doctor on staff. If the Department of Public Safety had sought the necessary authority to reallocate vacant positions to hire a medical doctor to provide oversight to the death investigation process, at the annual cost of approximately \$110,000 paid to senior physicians in state government, the agency would have been forced to expend from one-third to two-fifths of its appropriated funds for one physician. In view of the fact that the agency also had to purchase other services during the years in question for contractual services and commodities, there simply was insufficient funding on hand to hire the expertise the agency required to support death investigations in Mississippi.

The inability of the office to perform the most rudimentary levels of oversight such as records review and reconciliation and meeting with other professionals on updating and overseeing the work of designated pathologists may be attributed to an inadequate number of other staff in addition to the lack of a State Medical Examiner.

Should the Legislature change state laws dealing with death investigation?

Several sections of the MISSISSIPPI CODE addressing the authority of the State Medical Examiner are unclear as to the office's authority in critical areas of death investigation.

Ambiguity in Law Regarding Decisionmaking Authority

Some provisions of current law are ambiguous as to where authority lies for making certain critical decisions regarding death investigations.

Who determines whether the State Medical Examiner or a designated pathologist will perform an autopsy? MISS. CODE ANN. Section 41-61-65 (1) (1972) provides the following:

If, in the opinion of the medical examiner investigating the case, it is advisable and in the public interest that an autopsy or other study be made for the purpose of determining the primary and/or

contributing cause of death, an autopsy or other study shall be made by the State Medical Examiner or by a competent pathologist designated by the State Medical Examiner.

Personnel of the State Medical Examiner's Office have noted that this provision is unclear as to whether the local death investigators can simply choose a designated pathologist to perform the autopsy or must first contact the State Medical Examiner's Office. While this admittedly seems like an academic point in reviewing recent history when the office has had no State Medical Examiner, when the Department of Public Safety does fill the position of State Medical examiner, some conflict could occur between the State Medical Examiner and local death investigators if the statute does not make clear who decides on the source of forensic expertise.

Apparent Contradiction in Law Regarding Responsibility for Rulemaking

Provisions of state law regarding the promulgation of rules and regulations for death investigations appear to be contradictory.

As cited above, MISS. CODE ANN. Section 41-61-63 (1) (c) (1972) provides:

The State Medical Examiner shall. . . :

Promulgate rules and regulations regarding the manner and techniques to be employed while conducting autopsies; the nature, character and extent of investigations to be made into deaths affecting the public interest to allow a medical examiner to render a full and complete analysis and report; the format and matters to be contained in all reports rendered by the medical examiners; and all other things necessary to carry out the purposes of Sections 41-61-51 through 41-61-79. The State Medical Examiner shall make such amendments to these rules and regulations as may be necessary. All medical examiners, coroners and law enforcement officers shall be subject to such rules.

However, CODE Section 41-63-59 (5) provides:

A body composed of the State Medical Examiner, whether appointed on a permanent or interim basis, the Director of the State Board of Health or his designee, the Attorney General or his designee, the President of the Mississippi Coroners' Association (or successor organization) or his designee, and a certified pathologist appointed by the Mississippi State Medical Association shall adopt, promulgate, amend and repeal rules and regulations as may be deemed necessary by them from time to time for the proper enforcement, interpretation and administration of Sections 41-61-51 through 41-61-79, in accordance with the provisions of

the Mississippi Administrative Procedures Law, being Section 25-43-1 et seq.

It is not clear whether the State Medical Examiner or a panel including the State Medical Examiner is to promulgate rules and regulations governing death investigation.

While a court would most likely resolve the conflict by applying the most recent enactment, it is not clear whether the State Medical Examiner or a panel including the State Medical Examiner is to promulgate rules and regulations governing death investigation. If a new State Medical Examiner is hired, the issue of regulatory authority could arise in the near future unless the Legislature addresses this apparent contradiction.

Responsibilities for Death Investigation Split Between State and Local Officials

At present, statutes governing death investigation split the authority for conducting death investigations between local and state officials.

As can be noted from a review of the statutory provisions set out in this report, Mississippi's laws divide the authority for conducting death investigations between state and local government. Locally elected county medical examiners and county medical examiner investigators are responsible for initial investigations of deaths affecting the public interest. At present they rely on the State Medical Examiner's list of designated pathologists to perform autopsies. When the state hires a new State Medical Examiner, that person will have the legal authority to investigate deaths anywhere in the state, thereby having concurrent jurisdiction. Conflicts such as these can only hinder effective death investigation in Mississippi and raise questions as to which legal authority—the State Medical Examiner or some other officer or entity—has responsibility for certain decisionmaking.

Policy Options

PEER suggests that the Legislature consider the following broad policy options for death investigation in Mississippi:

- Retain the current system but make technical corrections to the law and increase funding for the State Medical Examiner's Office.
- Establish a pure state investigation system.
- Eliminate the State Medical Examiner's Office and revert to a local system.

The following sections contain discussions of each of these options.

Option One: Retain the Current System, Make Technical Corrections to the Law, and Increase Funding

Under this option, the state would commit itself to funding a State Medical Examiner's Office that is capable of providing not only regulation of death investigation, but all services needed to assist local death investigators in the furtherance of their duties. Such a system would provide the office with sufficient numbers of pathologists to perform most autopsies needed to complete death investigations. The quality of these pathologists' work would be regularly reviewed.

Under Option One, the state would commit itself to funding a State Medical Examiner's Office that is capable of providing not only regulation of death investigation, but all services needed to assist local death investigators in the furtherance of their duties.

Under this option, the office would clearly be responsible for regulating the performance of death investigation and would routinely review all filings of local death investigators to ensure that their work is being performed professionally. State law would need to clarify the conflicts and ambiguities in law discussed in the preceding chapter (pages 24 through 26).

Under state law that became effective July 1, 2008 (H.B. 525, Regular Session 2008), the cost of a forensic autopsy will increase from \$550 to \$1,000 per autopsy. Assuming that the State Medical Examiner's Office is able to perform at least 1,000 autopsies per year, this would generate for the office \$1 million in fee-based revenue to support office operations, thereby making the office closer to self-sufficiency.

Option Two: Establish a Pure State Investigation System

Under a pure state investigation system, the state would bear the costs of investigating all deaths affecting the public interest. To facilitate such a system the following would have to occur:

- abolition of the local office of coroner; and,
- creation and funding of a statewide death investigation system.

Abolition of the Coroner's Office: While the statutes refer to the offices of county medical examiner and county medical examiner investigator, the office of coroner is a constitutional office under Section 135 of the MISSISSIPPI CONSTITUTION. While this section provides that the duties of the office may be combined with that of another office, it does not authorize the abolition of any office. Consequently, the office of coroner would have to be abolished through a constitutional amendment.

Under Option Two, the state would bear the costs of investigating all deaths affecting the public interest.

Funding of a State System: Some states combine the investigative functions that are split between state and local authorities in Mississippi into a single central state agency. In such states, the responsibility for investigating deaths, collecting evidence, as well as performing and overseeing autopsies, is in the hands of the state agency. Such arrangements give the state complete control over the management, selection, and training of staff that work in medicolegal death investigations, unlike our mixed system wherein the local medical examiners control the decision to select local staff. Such an approach ensures consistency in the quality of personnel selected.

Centralized models have their drawbacks also. The loss of locally selected medical investigative staff could destroy relations that have been forged over time between local law enforcement agencies. Such impairments could frustrate death investigations. Additionally, centralized systems add costs to the state that under mixed systems are borne by local government.

In the state of Maryland, for example, not only does the state perform autopsies, it also is responsible for field investigation of deaths. Maryland has on staff fifteen investigators who carry out the functions similar to those of Mississippi's county medical examiners and county medical examiner investigators. Salary expenses for these staff are approximately \$500,000 per year. While Maryland does perform about 4,500 autopsies per year, about 2.25 times Mississippi's workload, the state is geographically smaller. (Maryland's total area is 12,407 square miles versus Mississippi's total area of 48,430 square miles.) Thus Maryland's death investigators cover a much smaller area with corresponding reduced travel times than would Mississippi's investigators.

If Mississippi were to utilize such a system, its costs would most likely be greater than 44% of Maryland's costs. Additionally, a larger central staff would also require additional support staff to

assist in the management of a fully centralized death investigation system.

Option Three: Eliminate the State Medical Examiner's Office and Revert to a Local System

Under this option, Mississippi would revert to its pre-1974 approach to investigating deaths. The coroner system would operate without the benefit of a centralized support system to ensure effective operations. Such a system would be likely to cost local governments no more than the current system: a death investigation system in which there is no State Medical Examiner, wherein counties bear the burden of paying for death investigations and autopsies.

Under Option Three, Mississippi would revert to its pre-1974 approach to investigating deaths.

Obviously such a system would not cost the state as much as is currently expended on the limited operations of the State Medical Examiner's Office. While financially this option would generate savings to the state, non-financial costs related to death investigation would be similar to those discussed earlier in this report. Criticism and concern regarding the quality of the state's forensic investigations would be likely to continue without support from trained oversight personnel.

Agency Response



STATE OF MISSISSIPPI
HALEY BARBOUR, GOVERNOR
DEPARTMENT OF PUBLIC SAFETY
STEPHEN B. SIMPSON, COMMISSIONER

September 10, 2008



Max K. Arinder, Ph.D.
Executive Director
PEER Committee
Post Office Box 1204
Jackson, MS 39215

Dear Dr. Arinder:

The Department of Public Safety ("DPS") offers the following response to the PEER Committee Review of the Mississippi State Medical Examiner Office:

The PEER Committee prepared an in-depth report of the State Medical Examiner's Office and System in which it opines that the Medical Examiner's Office has been unable to perform specific functions primarily due to the vacancies in the State Medical Examiner's position. As reflected in the PEER report, DPS has not had sufficient funds to hire a State Medical Examiner since 1995.

Despite funding issues, the PEER Committee pointed out that the Mississippi State Medical Examiner's Office continues to perform certain critical functions such as record keeping, training, and monitoring of the coroner's continuing education requirements. This was possible because DPS recognizes the important role of the State Medical Examiner; and thus, the Mississippi Crime Laboratory assigned personnel to assist in fulfilling these critical functions.

Effective July 1, 2008, the Mississippi State Legislature provided additional funding for the position of State Medical Examiner and related staff. DPS immediately began a national search to fill the vacancy. It is the goal of DPS to also fill the vacant positions of associate medical examiners in order to assist the State Medical Examiner in the performance of their duties as soon as possible.

DPS is committed to establishing and maintaining a fully functional quality death investigation system for the State of Mississippi. Thank you for this opportunity to review and respond to the PEER Report.

Sincerely,

A handwritten signature in cursive script that reads "Stephen B. Simpson".

Stephen B. Simpson
Commissioner, DPS

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PEER Committee Staff

Max Arinder, Executive Director
James Barber, Deputy Director
Ted Booth, General Counsel

Evaluation

David Pray, Division Manager
Linda Triplett, Division Manager
Larry Whiting, Division Manager
Chad Allen
Kim Cummins
Brian Dickerson
Lonnie Edgar
Barbara Hamilton
Matthew Holmes
Karen Land
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Sarah Resavy
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Editing and Records

Ava Welborn, Chief Editor/Archivist and Executive Assistant
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Administration

Mary McNeill, Accounting and Office Manager
Amber Ruffin
Rosana Slawson
Gale Taylor

Data Processing

Larry Landrum, Systems Analyst

Corrections Audit

Louwill Davis, Corrections Auditor