



Pulaski County

CORONER

ADMINISTRATION BUILDING
201 SOUTH BROADWAY
LITTLE ROCK, ARKANSAS 72201
501-340-8355
501-340-8358 FAX

CITIES

ALEXANDER

CAMMACK VILLAGE

JACKSONVILLE

LITTLE ROCK

MAUMELLE

NORTH LITTLE ROCK

SHERWOOD

WRIGHTSVILLE

UNINCORPORATED AREA

600 SQUARE MILES

MILITARY BASES

LRAFB

CAMP ROBINSON

Testimony of Mark Malcolm Coroner of Pulaski County, Arkansas March 4, 2002

In January of 1994 my office began fielding the first inquiries regarding deaths of nursing home patients. The questions came to us primarily from family members and were generally regarding the level of care or lack thereof, provided by the nursing home facility, or more specifically, did the level of care contribute to or cause the death?

The initial investigations consisted primarily of nursing home and hospital medical record reviews, study of physician' orders, physician interviews, and interviews with both current and former nursing home staff members. In most cases we found that the level of care was adequate and did not contribute to the death. Some cases, however, warranted further scrutiny. From 1994 to 1998 my office conducted six exhumations of nursing home patients. After a full post-mortem examination, all six were determined to have died unnatural deaths. Two cases were ruled and medication errors and four were deaths caused by asphyxia.

The case that drew the most attention was that of a 78 year old man who died on the evening of July 28, 1998. He had been improperly placed in a vest restraint and was discovered

wedged between his mattress and bed rail. He was so tightly compressed in this position that four staff members had to work to free him. He was dead by the time he was finally extricated. Despite the circumstances of the death and a large area of injury to the upper chest, the administrator of the nursing home notified the family of the decedent that he had died naturally in his sleep. An audit by the Arkansas DHS Office of Long Term Care in October of 1998 brought the death to my attention and an investigation began. Following exhumation and autopsy, the death was ruled as positional asphyxia.

Under existing Arkansas law this death and any other case of unnatural death in nursing homes should have been reported to the coroner and law enforcement. Despite the existing statutory requirement to report these deaths, nursing home administrators chose to release the decedents to funeral homes preventing the legally required investigation. Whatever the motive, it was clear that a law directed specifically to long term care patients was necessary.

In January of 1999 I began working with the counsel for the Office of Long Term Care and we authored a bill for consideration by the State Legislature. The bill was passed and signed into law and is included in your packet of information.

Essentially, the law requires that all deaths of nursing home patients be reported to the county coroner for investigation regardless of the cause of death. The law further requires that the death of a nursing home patient who is transferred to a hospital and dies within five days of admission also be reported to the coroner.

Every nursing home patient who dies in Pulaski County, Arkansas, is examined by me or a member of my staff. In addition to the physical examination there are complete reviews of medical records, interviews with physicians, facility staff, and family. We compare pharmacy records to doctors' prescriptions and match that information to nurses' notes to ensure that medications are properly administered.

Since July 1, 1999 my office conducted approximately 2400 nursing home investigations. In the majority of these cases we have found the level of care provided to be adequate. In 56 death investigations we have uncovered a much different story. We have seen dinner plate-sized bed sores with infected and dying tissue, infected feeding tubes, rapid and unexplained weight loss, dehydration, improperly administered medications, and medication errors that resulted in death. We have found basic needs such as general hygiene and dental care neglected, urine and fecal matter dried on bed linens and in diapers left unchanged for hours. We have seen a patient whose care had been so poor that a mucous growth formed on the roof of her mouth and when it finally sloughed off, she asphyxiated and died. When we arrived at the facility to examine this woman, ants were crawling on her bed and body.

Without this law in place, these cases would go unreported and unnoticed, and the decedents would simply be released to funeral homes with families left none the wiser. In sixteen years at the Coroner's Office, I have been active at my State legislature on a variety of issues but none more important than Act 499 of 1999. The intention of the legislation was solely for the protection of the long term care patient. However, independent oversight such as that provided by my office can also provide a modicum of protection to respectable, responsible facilities against frivolous accusations and unwarranted claims. Facilities staffed by competent, conscientious professionals welcome an independent confirmation of good care in the currently litigious atmosphere of their industry.

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**PULASKI COUNTY CORONER'S OFFICE
GENERAL ORDER**

**INVESTIGATIONS INTO THE DEATH OF
LONG TERM CARE PATIENTS**

General Order: G.O. 108

Purpose

- A. This General Order establishes the policy and procedures of the Pulaski County Coroner's Office as it pertains to investigations into the deaths of long term care facility residents. The General Order is established in accordance with Act 499 of 1999 and becomes effective June 30, 1999.

Policy

- A. It shall be the policy of the Pulaski County Coroner's Office to conduct thorough and efficient investigations into the deaths of those who die in long term care facilities and those who die in hospitals after being transported from a long term care facility.
- B. Long-term care investigations shall be carried out in the same manner as any other death investigation conducted by the Pulaski County Coroner's Office.

Protocol

- A. When a long term care facility death is reported to the Pulaski County Coroner's Office the deputy coroner on-call shall respond immediately to the notifying facility or appropriate hospital. The on-call deputy shall also contact the supervisor on-call. The supervisor on-call shall respond as well.
- B. Upon arrival the deputy coroner shall contact the reporting party from the long term care facility or hospital. The name of the reporting party and the time the deputy arrived at the facility shall be recorded. The deputy coroner shall inquire as to the circumstances leading to the death and obtain pedigree information of the decedent.

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- C. The deputy coroner shall observe the decedent and conduct an examination of the decedent to include the following:
1. Photographs of the decedent and the room or area where the death occurred.
 2. General cleanliness of room and facility and hygienic observations.
 3. Position of decedent (in bed, chair, on floor, face down, face up).
 4. Restraints (posey vest, buddy belt, arms, legs).
 5. Clothing description.
 6. Medical paraphernalia description.
 7. Body temperature, rigor mortis, and livor mortis.
 8. Hair color.
 9. Eye color.
 10. Eye condition (dry, glazed, bloodshot, petechial hemorrhage).
 11. Dental condition (natural teeth, dentures, gums).
 12. Nutrition (malnourished, emaciated, well nourished).
 13. Bed sores, ulcers (non-bandaged, bandaged, last time dressing changed).
 14. Location of bedsores or ulcers.
 15. Severity of bedsores or ulcers (minor, deep tissue exposure, bone exposure).
 16. Bruising (document location, severity, age of bruise, when and how occurred, report made by staff). The deputy coroner must obtain a copy of the incident report. Bruises must also be inspected for any pattern that may be present. Restraints, hands, fingers, fists, or other blunt objects may cause pattern bruises. The Coroner must be notified immediately if a pattern bruise is suspected.
 17. Broken bones (document location, severity, type of fracture, when and how occurred, report made by staff). The deputy coroner must obtain a copy of the incident report.
 18. Document any insect and rodent bites or infestation. The Coroner must be notified immediately if insect or rodent bites are suspected.
 19. Other cuts, lacerations, abrasions, and contusions.

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20. Completion of body chart and additional photography to document the condition of the decedent.
- D. The deputy coroner shall conduct interviews with the staff to determine the following;
1. Admitting physician and diagnosis including contact number for the physician. The deputy coroner must contact the treating physician.
 2. Current diagnosis if different from admission including any recent hospitalizations or treatments.
 3. Medications. A copy of the medication list must be obtained by the deputy coroner as well as the last medications taken and the time given by staff.
 4. Whether CPR performed?
 5. Whether the patient was DNR?
 6. Last time seen alive, by whom, and what time.
 7. When death occurred. Was the death witnessed and if so by whom? Was the death discovered and if so by whom and what time?
 8. Last visitation by family or others.
 9. Whether the decedent ever "walked away" or attempted to leave the facility without authorized escort or family member? If so, the number of attempts must be obtained as well as dates and times.
 10. Whether the patient was under the care of adult protective services?
 11. Whether any abuse or neglect reports had ever been made regarding the decedent? If so, each incident report must be obtained by deputy coroner as well as dates and times, and who committed or was suspected of the abuse. The deputy coroner must also contact the appropriate law enforcement agency to determine if the long-term care facility contacted police to report suspected abuse or neglect. The Coroner must be notified immediately if an abuse or neglect complaint or report is on file regarding the decedent.

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12. Whether any complaint visit reports or deficiency reports from DHS are on file? If so, a copy of the report must be obtained by the deputy coroner. The Coroner must also be notified immediately. DHS must be contacted by the deputy coroner to determine if there are any complaints regarding the decedent. When the death occurs after business hours, DHS shall be contacted immediately upon the beginning of the next business day.
 13. Funeral home information.
- E. Upon completion of the initial investigation by the deputy coroner a decision on disposition of the decedent must be made. The deputy coroner shall consult the on-call supervisor to determine the following;
1. There is no reason to suspect abuse or neglect of the decedent and the death is of natural causes. If the death is of natural causes the on-call supervisor may release the body to the funeral home.
 2. The presence of abuse or neglect cannot be ruled out without additional information. If the presence of abuse or neglect cannot be ruled out the Coroner must be immediately notified. The Coroner or on-call supervisor shall notify the appropriate law enforcement agency. In addition to the coroner's investigation, coroner's office personnel shall assist the law enforcement agency in whatever way is requested. The Coroner and supervising law enforcement officer shall determine the need for medical examiner notification.
 3. There is reason to suspect abuse, neglect, or foul play in the death. The Coroner and appropriate law enforcement agency must be notified immediately. In addition to the coroner's investigation, coroner's office personnel shall assist the law enforcement agency in any way requested. The decedent shall be transported to the medical examiner.

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- F. If there is no reason to suspect abuse or neglect and the death is determined to be of natural causes the Coroner shall notify the long-term care facility in writing.
- G. If abuse, neglect, or foul play is suspected and the decedent is transported to the medical examiner the Coroner shall notify DHS and the decedent's family.

1 State of Arkansas
2 82nd General Assembly
3 Regular Session, 1999
4

As Engrossed: S2/9/99 S2/11/99

A Bill

ACT 499 of 1999

SENATE BILL 222

5 By: Senator Brown
6 By: Representative Salmon
7
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For An Act To Be Entitled

"AN ACT TO AMEND ARKANSAS CODE 5-28-204 TO REQUIRE THAT ALL NURSING HOME RESIDENT DEATHS BE REPORTED TO THE COUNTY CORONER; AND FOR OTHER PURPOSES."

Subtitle

"TO AMEND ARKANSAS CODE 5-28-204 TO REQUIRE THAT ALL NURSING HOME RESIDENT DEATHS BE REPORTED TO THE COUNTY CORONER."

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

SECTION 1. Arkansas Code 5-28-204 is hereby amended to read as follows:

"5-28-204. Persons required to report abuse.

(a) Any person or official who is required to report cases of suspected abuse of adults under the provisions of this chapter, who has reasonable cause to suspect that an adult has died as a result of abuse, sexual abuse, or negligence, shall report that fact to the appropriate medical examiner or coroner. In all cases of death of a long-term care facility resident, the long-term care facility shall immediately report the death to the appropriate coroner. The report is required regardless of whether the facility believes the death to be from natural causes or the result of abuse, sexual abuse, or negligence, or any other cause. In all cases of death of an individual in a hospital who was a resident of a long-term care facility within five (5) days of entering the hospital, the hospital shall immediately report the death to the appropriate coroner. The report is required regardless of whether the facility believes the death to be from natural cause or the result of abuse.

PRESIDENT OF STATE



1 sexual abuse, negligence, or any other cause.

2 (b) The medical examiner or coroner shall accept the report for
3 investigation and upon finding reasonable cause to suspect that an adult has
4 died as a result of abuse, sexual abuse, or negligence shall report his
5 findings to the police, and the appropriate prosecuting attorney, and, if ~~if~~ If
6 the institution making the report is a hospital, or nursing home, the coroner
7 shall report his findings to the hospital or nursing home unless the findings
8 are part of a pending or ongoing law enforcement investigation."

9
10 SECTION 2. All provisions of this act of a general and permanent nature
11 are amendatory to the Arkansas Code of 1987 Annotated and the Arkansas Code
12 Revision Commission shall incorporate the same in the Code.

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14 SECTION 3. If any provision of this act or the application thereof to
15 any person or circumstance is held invalid, such invalidity shall not affect
16 other provisions or applications of the act which can be given effect without
17 the invalid provision or application, and to this end the provisions of this
18 act are declared to be severable.

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20 SECTION 4. All laws and parts of laws in conflict with this act are
21 hereby repealed.

22 /s/ Brown

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3-9-99

APPROVED Mike Huckabee
GOVERNOR

Robert Win John
Speaker of the House

PRESIDENT
SENATE