Stephen P. Nonn

Office Of The Coroner
Madison County, Illinois

This annual report is submitted to you so that you may better measure the services the Office of the Coroner provides in return for your tax dollar

2010 Annual Report

April 27, 2011

Mr. Alan Dunstan
Chairman of the County Board
Madison County Administration Building
157 North Main Street
Edwardsville, Illinois 62025

RE: 2010 Annual Report

Dear Chairman Dunstan,

Please allow me to present the 2010 Annual Report for the Madison County Coroner's Office. The economy and budgetary restraints continue to pose difficulties in our operations as we continue to operate in a short-staffed environment while calls for service continue to increase in volume and complexity.

We continue to work on issues of emergency and disaster preparedness and planning as funding allows and this office is playing a major role in the development of regional mass fatality planning through the St. Louis Area Regional Response System (STARRS). Due to an unusual increase in overdose deaths, specifically heroin related deaths, we moved to the forefront with initiatives in training, multi-agency investigation, and collaboration in prosecution of criminal activity associated with deaths. Training of personnel continues to play a prominent part in the agency's professional development. Along with the essential technical skills continuing education for staff, Chief Deputy Coroner Roger Smith and I completed a three month long, 200 hour law enforcement executive training program, provided at no cost by the Illinois Law Enforcement Training and Standards Board Executive Institute.

Please feel free contact me with any questions concerning the annual report or office operations. I hope that I can count on your support for restoration of funding as the economy allows in order to further capitalize on the services this agency provides to Madison County and our residents.

Sincerely,

Stephen P. Nonn, D-ABMDI
Coroner of Madison County

INTRODUCTION

The duties and responsibilities of the County Coroner are many and varied, but in essence can be described as the investigative arm of Madison County Government concerning deaths of an unexpected, violent or criminal nature. The main functions of this office include:

- Respond to and investigate deaths that occur outside of hospital or clinical settings with such investigations including scene analysis, photography, sketching, witness interviews, body examination, and utilization of other forensic tests as indicated.
- Convene coroner's inquest to determine cause and manner of deaths involving homicides, suicides, and accidents, natural and or unexplained and suspicious deaths.
- Under mandate of law, investigate the death of any ward of the State of Illinois.
- Operate and maintain the Madison County Morgue for the purpose of conducting scientific and forensic post-mortem examination of human remains and for holding of unidentified/unclaimed human remains pending disposition.
- Maintain the property, monies, and personal effects of decedents processed through the coroner's office.
- Conduct public and community education programs regarding topics such as: Drinking and Driving, Traffic Safety, Substance Abuse, and Crime/Death Scene Response.
- Training and maintaining a cadre of reserve, volunteer deputy coroners for the management of disaster or mass casualty events.
- To report to the State of Illinois all child deaths, boating fatalities, traffic fatalities, work-related fatalities.
- Service of legal process when the Sheriff is party to a suit or when such process by the sheriff would be a conflict of interest.
- Enforcement of Grave Robbery Act. As promulgated by Illinois Historical Preservation Agency per Illinois Compiled Statutes.
- Issue Death Certificates and Cremation Permits

Mission Statement

The Madison County Coroner's Office serves as a bridge between the living and the dead. We give voice to the departed and, with all due diligence, strive to provide answers to the survivors. Utilizing the resources available by the application of science and under the principles of law we strive to assure that justice prevails for those deprived of our most precious possession ---- LIFE.

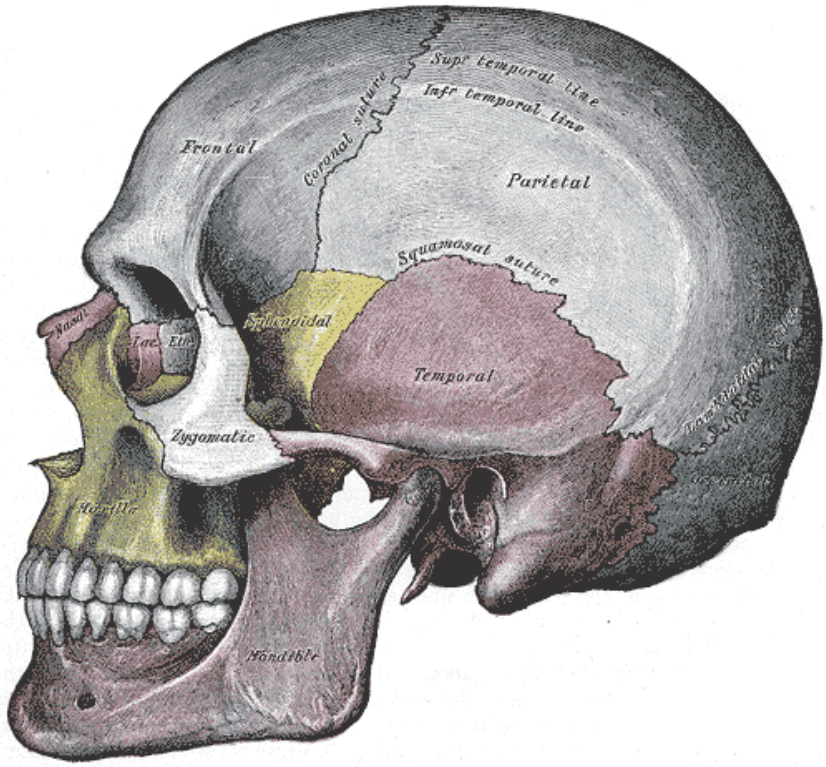
As Coroner of Madison County,

Stephen P. Nonn, D-ABMDI

And a member of the Law Enforcement community, it is my goal is to provide professional death investigations to determine the manner and cause in cases where the Coroner has jurisdiction and to provide critical services to surviving families with compassion and dignity.

This is accomplished with the most cost-effective methods available.

The statistics compiled for this annual report will provide the public, medical profession, and law enforcement agencies with beneficial information. If you have any questions regarding this office or any material contained in this report, please contact my office at any time.



BIRTH
AND DEATH
ARE THE
ONLY TWO
UNIVERSAL
HUMAN
EXPERIENCES.

Illinois Coroner's Creed

Birth and death are the only two universal human experiences.

Birth is the most important biological event in the life of any human being. If it does not occur, there is no being. If there is no person, no legal rights and duties arise, for the law relates to the rights and the duties of living people, no inanimate objects.

Death, on the other hand, is the most important legal event for all human beings. When it occurs, all legal rights and duties devolving upon the person during his life span in a civilized jurisdiction are terminated. All persons with whom the deceased had legal relations at that moment in time are also directly affected by the occurrence of death. Moreover, both the deceased and the survivors may be greatly affected legally by how death occurred, what actually happened, why it occurred, and precisely when it occurred. Above all who died must be absolutely determined, and where death occurred is positively required for jurisdiction over the descendent is based upon a geographical location. The law becomes extremely active when a person dies. Wealth is redistributed. Contacts are altered. A wrongful death may give rise to tortuous claims. Tax obligations are always present. Public social benefits and private insurance policies are paid. Criminal laws may be involved. Creditors must be satisfied, and debtors located. Spouse and children, heirs and next-of-kin have their attachments rearranged. It is not surprising that for centuries the sovereign state has had an overriding interest in the death of its subject or citizens. The office of the Coroner, or the Office of the Medical Examiner, along with the state-licensed physician is legally charged with significant duties answering the pertinent questions relating to death: Who, Where, When, What, How, Why. Only when these questions have been answered correctly can all the proper legal issues arising at death be effectively handled for the proper administration of justice.

Although the legal aspects of death are most important, certainly the religious and humanitarian heritages of a civilized society also command a deep concern over the death of a human being. The spiritual faith in a religion as well as the humanitarian concern for a fellow human being demand correct answers to the questions of death: Who, Where, How, When and Why? Human death obligates the living to acquire accurate facts on which to apply just laws for each deceased member of the human race.

The obligation for proper death investigation is mandatory for legal and religious/humanitarian satisfactions in the human society. Let those responsible for death investigations take heed that they labor not only for the State, but also for God.

2010

Coroner's Statistical Report

Madison County, Illinois

Total Death Investigations:

"Medical Cases" – Natural cause deaths screened or investigated and returned to the medical community for certification – including deaths while in hospice, long-term care, or during hospitalization where a definitive diagnosis was made.	1,772
Coroner Cases - Total	356
Natural Cause	182
Accident	135
Suicide	26
Homicide	11
Undetermined Verdicts	2
Miscellaneous Reports	36
Non-Human Remains	10

Coroner's Inquest Verdicts*

HOMICIDE	8
SUICIDE	9
ACCIDENT	21
NATURAL	1
UNDETERMINED	2

Administrative Review Verdicts*

HOMICIDE	0
SUICIDE	20
ACCIDENT	91
NATURAL	0
UNDETERMINED	0

* Verdicts include year 2009 cases that were resolved and closed in 2010.

Cremation Permits Issued	694
Toxicology Cases	205
Autopsies Performed	140
Inquest Cases	41
Administrative Reviews	111

1954

NATURAL DEATHS JANUARY-DECEMBER 2010

	MALE	FEMALE	TOTAL
Abdominal Aneurysm	1	5	6
Acute Myocardial Infarction	146	105	251
Abdominal Cancer	1	3	4
Adrenal Hemorrhage	1		1
Adeno Carcinoma		2	2
ALS			0
Alzheimer's Disease	20	40	60
Anemia		1	1
Anoxic Brain Death		2	2
Aortic Aneurysm			0
Aortic Stenosis	1	2	3
Appendix Cancer			0
Arteriosclerotic Heart Disease	5	3	8
Asbestosis			0
Aspiration		1	1
Asthma			0
Bacteremia			0
Biliary Cancer		2	2
Bladder Cancer	10	4	14
Blood Disorder	1		1
Bone Cancer		6	6
Bowel Obstruction	2	1	3
Brain Cancer	9	7	16
Breast Cancer		33	33
Cardiac Arrhythmia	9	14	23
Cancer of Head & Neck	5		5
Cancer of Spine	1		1
Cerebral Palsy			0
Cardiomyopathy	10	4	14
Cerebral Vascular Hemorrhage	38	54	92
Cervical Cancer		4	4
Chronic Obstructive Pulmonary Disease	73	61	134
Cirrhosis	4	7	11
Clostridium Difficile			0
Colitis		2	2
Colon Cancer	20	23	43
Congenital Disorder			0
Congestive Heart Failure	79	100	179
Coronary Artery Disease	17	10	27
Crohns Disease			0
Debility	16	26	42
DVT (Deep Vein Thrombosis)		1	1
Dehydration		1	1
Dementia	25	74	99
Diabetes Mellitus			0
Diabetes Type II	2	2	4

Diverticulitis	1	1	2
Emphysema	1		1
Endometrial Cancer		2	2
Encephalapathy		3	3
Endocarditis	1		1
Esophageal Cancer	11	1	12
Failure to Thrive	11	46	57
Fetal Death			0
Gastric Cancer			0
G.I. Bleeding	8	8	16
Gleoblastoma	1	1	2
Gynecological Cancer			0
Heart Disease	8	13	21
Heart Failure	2	1	3
Hemophelia		2	2
Hepatic Cancer	2		2
Hepatitis			0
HIV / AIDS	1	1	2
Hunters Syndrome	1		1
Hyperkalemia	1		1
Hypertension	1	3	4
Hypernatremia		1	1
Hypoxemia			0
Intracerebral Bleed		5	5
Ischemic Bowel Disease	1		1
Jaw Cancer	1		1
Ketoacidosis		2	2
Kidney Disease	2	13	15
Kidney Failure	31	57	88
Larynx Cancer		1	1
Leukemia	6	7	13
Liver Cancer	20	4	24
Liver Disease	6	6	12
Lung Cancer	88	88	176
Lymphoma	10	7	17
Malignant Melanoma	1		1
Malignant Neoplasm Endometrium		1	1
Malnutrition		1	1
Melanoma	6	8	14
Meningitis	2	1	3
Mesothelioma	1	1	2
Metastic Cancer	2	1	3
Mitral Valve Prolapse	1		1
Mouth Cancer	1		1
Multiple Sclerosis		2	2
Myelodioplasia	2	4	6
Myeloma	2		2
Myocarditis		1	1
Neck Cancer			0
Neoplasm		1	1
Oligodemdroglioma			0
Omentum Cancer			0

Organ Failure	2	3	5
Ovarian Cancer		12	12
Pancreatic Cancer	21	19	40
Parkinsons	11	8	19
Peritonitis		3	3
Pneumonia	22	36	58
Pelvic Cancer		2	2
Premature			0
Prostate Cancer	21		21
Pulmonary Embolism	8	5	13
Pulmonary Fibrosis	5	2	7
Rectal Cancer	4	2	6
Renal Cancer	7	6	13
Respiratory Arrest			0
Respiratory Distress	1		1
Respiratory Failure	8	13	21
Scleroderma			0
Seizure			0
Septic Shock	7	4	11
Sepsis	15	34	49
SIDS			0
Skin Cancer	2		2
Stomach Cancer	1	2	3
Stroke	5	10	15
Sudden Cardiac Death			0
Testicular Cancer			0
Thoracic Aneurysm	1		1
Throat Cancer	5		5
Uterine Cancer		4	4
Uterus Cancer		1	1
Vaginal Cancer		1	1
Vulva Cancer		1	1
Open Cases	12	5	17
TOTAL	**887**	**1067**	**1954**

135

ACCIDENTAL DEATHS JANUARY - DECEMBER 2010

	MALE	FEMALE	TOTAL
Asphyxiation/Suffocation	4	1	5
Anoxic Brain Injury			0
Agitation / Custodial Death			0
Aspiration / Choking	3		3
Blunt Trauma / Industrial			0
Bowel Obstruction			0
Cardiac Arrest			0
Carbon Monoxide	1		1
Complications of a Hip Fracture	7	15	22
Complications of Fracture	4	3	7
Crushing			0
Drowning	2	1	3
Electrocution			0
Fall	7	6	13
Fire	1		1
Gunshot			0
Hanging			0
Heat Stroke			0
Open Cases			0
Overdose / Abuse (Drugs/Alcohol)	40	16	56
Overlay			0
Pneumonia			0
Positional Asphyxia			0
Post-Operative Complications	1		1
Respiratory Failure		1	1
Skull Fracture			0
Stabbing			0
Vehicular	16	5	21
Environmental (Heat)			0
Environmental (Cold)	1		1
TOTAL	87	48	135

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SUICIDES JANUARY-DECEMBER 2010

	MALE	FEMALE	TOTAL
Asphyxiation			0
Suffocation			0
Carbon Monoxide Poisoning			0
Gunshot	10	2	12
Crushing			0
Drowning			0
Electrocution			0
Exsanguination			0
Fall			0
Fire			0
Lacerations			0
Hanging	6	1	7
Open Cases			0
Overdose / Intoxication (Alcohol)			0
Overdose / Intoxication (Drugs)	6	1	7
Poisoning			0
Stabbing / Cutting			0
Vehicular			0
TOTAL	22	4	26

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HOMICIDES JANUARY-DECEMBER 2010

	MALE	FEMALE	TOTAL
			0
Suffocation/Asphyxia		1	1
Battered	2		2
Fetal Demise/Maternal Demise			0
Gunshot	2	3	5
Blunt Force Trauma	1	1	2
Crushing			0
Drowning			0
Electrocution			0
Fall			0
Fire			0
Hanging			0
Overdose / Intoxication (Alcohol)			0
Overdose / Intoxication (Drugs)			0
Poisoning			0
Stabbing	1		1
Vehicular / Recless Homicide			0
TOTAL	6	5	11

17

INFANT DEATHS JANUARY - DECEMBER 2010

	MALE	FEMALE	TOTAL
Congenital Disorder	2		2
Cord Accident	1	1	2
Encephalopathy			0
Fetal Death	2	3	5
No Cause			0
Overlay	1		1
Potter Syndrome	1		1
Placental Abruption	1		1
Positional Asphyxia	1		1
Premature	3		3
SIDS			0
Stillborn	1		1
TOTAL	13	4	17

36

MISCELLANEOUS JANUARY-DECEMBER 2010

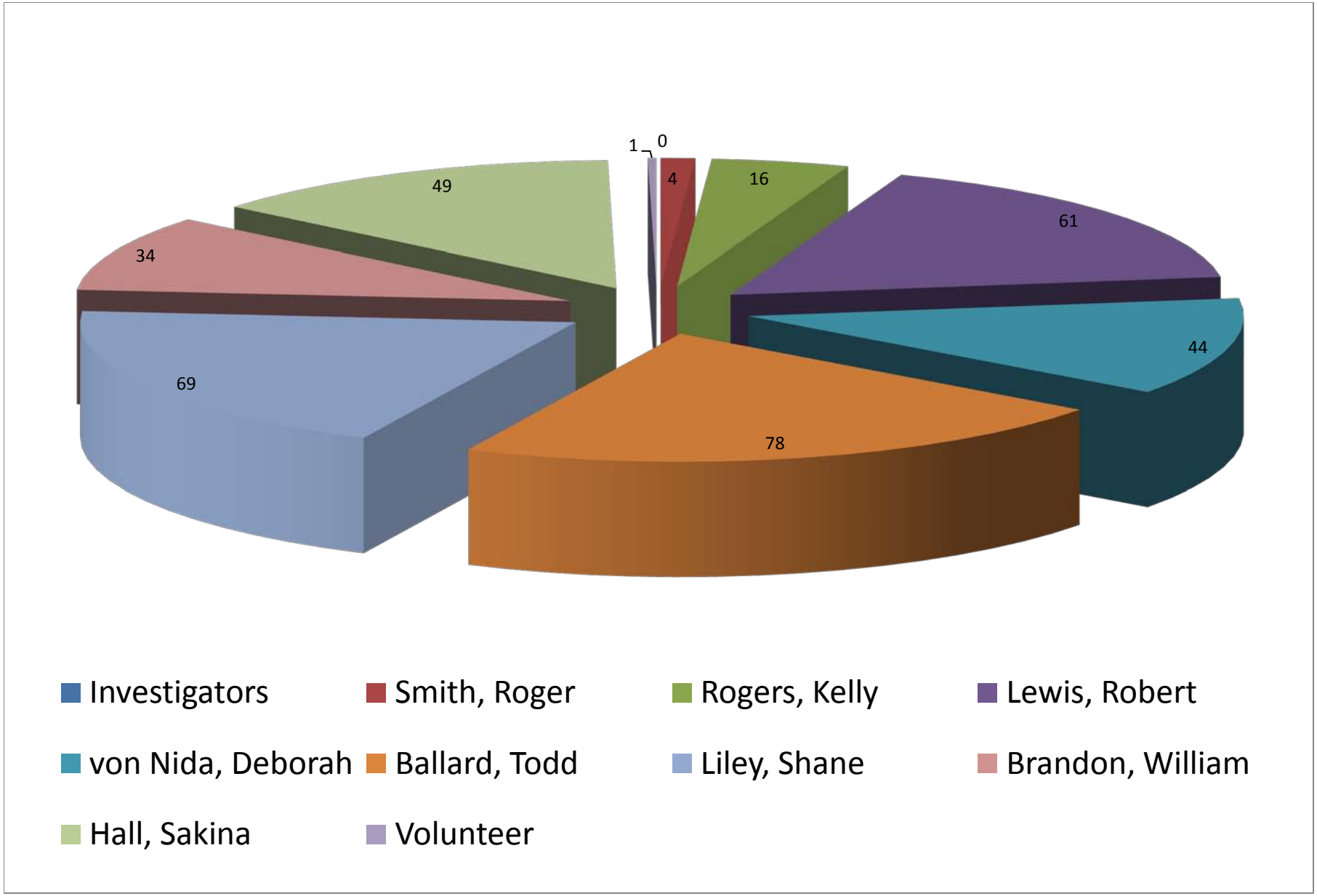
	MALE	FEMALE	TOTAL
Animal Remains/Bone Case	6		6
Assist Police Agency			0
Evidence Storage	1		1
Misc. Report	3		3
Morgue Use	12	8	20
Death Notification	4	2	6
TOTAL	26	10	36

Madison County Coroner 2010 Totals

Name	Total Cases	Coroner	Medical	Hospice	Bone Cases	Miscellany
Investigators						
Smith, Roger	79	4	36	38	0	1
Rogers, Kelly	124	16	43	61	2	2
Lewis, Robert	262	61	61	129	3	8
von Nida, Deborah	266	44	82	133	1	6
Ballard, Todd	357	78	108	162	3	6
Liley, Shane	365	69	118	174	0	4
Brandon, William	347	34	114	198	0	1
Hall, Sakina	360	49	107	196	0	8
Volunteer	14	1	12	0	1	0
Totals	2174	356	681	1091	10	36

Total Autopsy Cases

2010 Coroner's Cases



2009

Coroner's Statistical Report

Madison County, Illinois

Total Death Investigations: 2,148

"Medical Cases" – Natural cause deaths screened or investigated and returned to the medical community for certification – including deaths while in hospice, long-term care, or during hospitalization where a definitive diagnosis was made.	1,759
Coroner Cases - Total	348
Natural Cause	203
Accident	94
Suicide	35
Homicide	13
Undetermined Verdicts	3
Miscellaneous Reports	12
Non-Human Remains	29

Coroner's Inquest Verdicts*

HOMICIDE	17
SUICIDE	4
ACCIDENT	32
NATURAL	3
UNDETERMINED	3

Administrative Review Verdicts*

HOMICIDE	0
SUICIDE	28
ACCIDENT	73
NATURAL	15
UNDETERMINED	2

* Verdicts include year 2008 cases that were resolved and closed in 2009.

Cremation Permits Issued	695
Toxicology Cases	182
Autopsies Performed	100
Inquest Cases	59
Administrative Reviews	101

2008

Coroner's Statistical Report

Madison County, Illinois

Total Death Investigations

Medical/Natural	899
Hospice	949
Coroner - **Total**	308
Accidental Deaths	97
Suicides	27
Homicides	19
Infant Deaths	15
Undetermined Verdicts	1
Miscellaneous	21
Non-Human Remains	2

Cremation Permits Issued	625
Toxicology Cases	184
Autopsies Performed	136
Inquest Cases	85
Administrative Reviews	90

2007

Coroner's Statistical Report

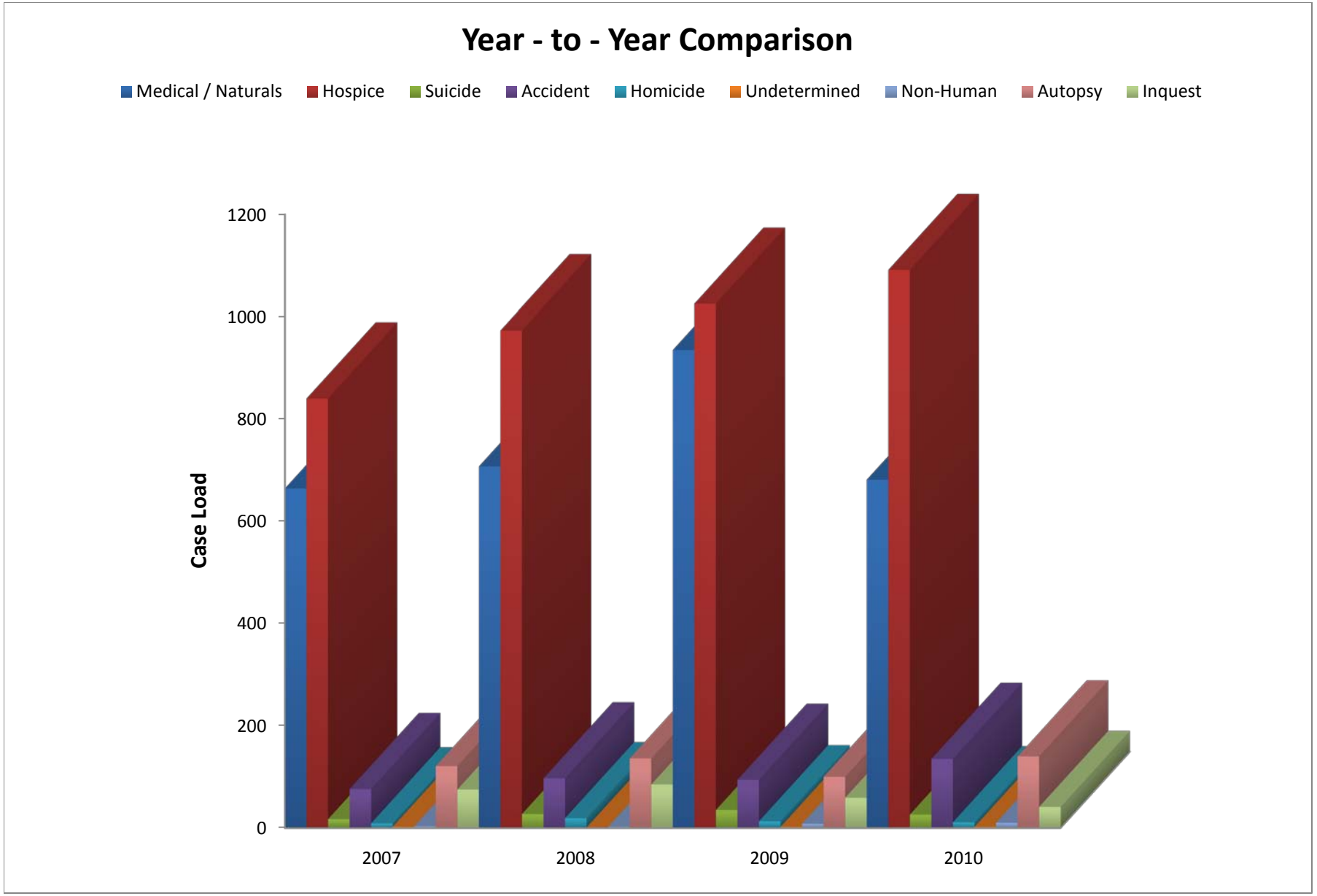
Madison County, Illinois

Total Death Investigations 1,898

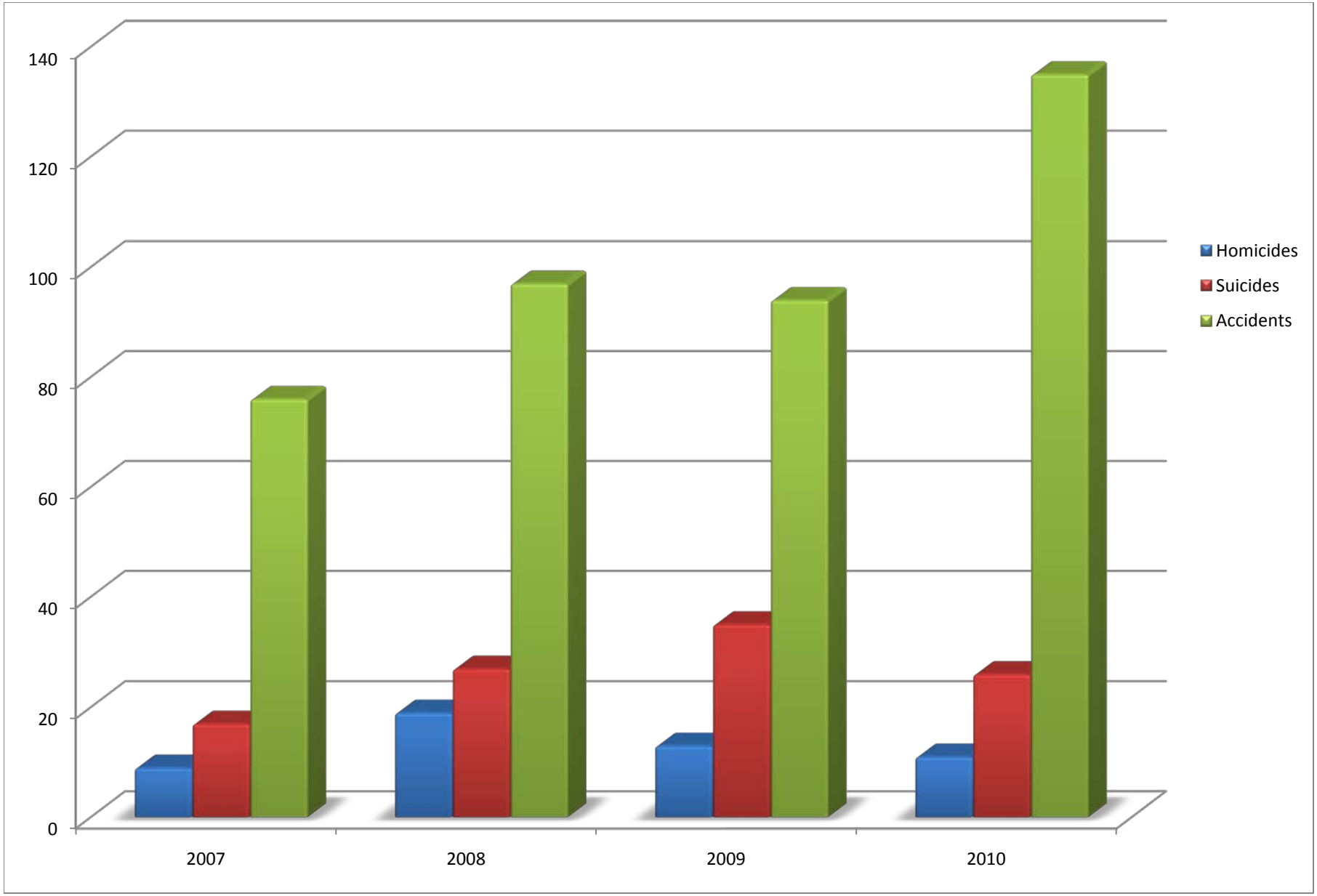
Medical/Natural	651
Hospice	897
Coroner - **Total**	334
Accidental Deaths	76
Suicides	17
Homicides	9
Infant Deaths	8
Undetermined Verdicts	2
Miscellaneous	11
Non-Human Remains	5

Cremation Permits Issued	570
Toxicology Cases	194
Autopsies Performed	121
Inquest Cases	75
Administrative Reviews	35

Manner of Death Statistics 2007 - 2010



Homicides / Suicides / Accidental Deaths 2007-2010



What is an Inquest?

A Coroner's Inquest is neither a civil nor a criminal trial proceeding. It is simply an inquiry into the manner and cause of an individual's death. An inquest is conducted by the Coroner or Deputy Coroner with a court reporter and six jurors present. The jurors are citizens of Madison County, the county in which the death took place.

The purpose of the Inquest is to present pertinent information concerning the victim's death in order for the jury to arrive at a cause and manner of death. The cause of death is often readily apparent and obvious, based on the facts, circumstances, and medical evidence and in some cases, toxicology and autopsy results. The real essence of the jurors' responsibility is to establish the manner of the death (suicide, homicide, accident, natural, or undetermined)

The Coroner will summon to the Inquest those individuals who have pertinent information concerning the incident. This often includes, but is not limited to, the person who found the deceased, witnesses to the incident, those involved, police officers and investigator, and in some instances, a direct relative. All individuals summoned will present testimony (answer questions) to the jury. Any professional reports (autopsy, toxicology, x-ray, and laboratory reports) will be presented at that time. These reports are not released to the public until the inquest procedures are concluded.

All information and testimony at the inquest is recorded and/or transcribed by a certified court reporter. All such information will be documented verbatim in an inquest transcript available approximately two weeks after the inquest. This transcript may be reviewed in the Coroner's Office at no charge. A copy of the transcript is purchased at $3.00 per page pursuant to the Illinois State Law (Illinois Compiled Statutes, Chapter 55, Act 5, Article 4, Division 4 – 7, Coroner's Fees. 5/4-7001).

The inquest is open to the public and may not be closed pursuant to any requests to do so. Anyone may attend. We publish inquest dates a year in advance, and the times for the inquest docket are set at least a week prior to the Inquest date. Family notifications are sent to the informant, listed on the death certificate.

Effective January 1, 2007, the inquest law was revised that provides that it is permissible, instead of required, for a county coroner to summon eight persons as jurors for inquests in cases involving apparent suicide, homicide, accidental death, or other cases, and the coroner will select six persons to serve as jurors. This new law allows the coroner, at his or her discretion, to sign a death certificate without holding an official inquest.

Attorneys are welcome to attend. The need for an attorney is purely an individual decision. This office neither recommends nor advises attorney attendance, the exception being the Madison County State's Attorney, who is notified of all inquests in Madison County. Attorneys are allowed to ask questions of witnesses as a courtesy only, and such questions are directed to be a maximum of two or three of each witness. The Madison County State's Attorney can question the witness at any time. The family or anyone else will not be permitted to question the witness nor supply their own witnesses; however, the family may testify, if they wish.

Upon completion of the testimony, the Coroner's jury will deliberate in private. They may request additional testimony, evidence or conference, as they deem necessary. When the jury has concluded their deliberations, they will issue a verdict through the foreman as to the cause and manner of death (accident, homicide, suicide, natural or undetermined).

The Coroner's verdict has no civil or criminal trial significance. The verdict and inquest proceedings are merely fact finding in nature and statistical in purpose. However, if a person is implicated as the unlawful slayer of the deceased or accessory thereto, an arrest may be affected. This is extremely rare. This function in now performed by the State's Attorney through grand jury proceedings.

The testimony presented at the inquest is sworn and under oath and properly documented and/or recorded. Because of this, testimony may subsequently be used in perjury proceedings if such testimony should change in future civil or criminal trial proceedings. All such provisions and explanations presented herein are subject to revision at any time.

Types of deaths that must Be reported to the Coroner's Office

ATTENTION:

- **Physicians**
- **Police Officers**
- **Hospitals**
- **Funeral Directors**
- **Embalmers**
- **Ambulance Attendants**
- **Vital Statistics Registrars**
- **Hospice Organizations**

The following information has been compiled for the purpose of acquainting individuals and organizations with the procedures to be followed when they come in contact with the types of deaths described in the following pages.

Conformity with these procedures will prevent unnecessary delay and inconvenience to the family, friends, and those persons having any responsibility to and for the deceased.

Notification in Case of Death by Violence of Suicide

Any person who discovers the body or acquires the first knowledge of the death of any person who died as the result of criminal or other violent means, or by casualty, or by suicide, or suddenly when in apparent health, or in a suspicious or unusual manner, shall immediately notify the office of the Coroner of the known facts concerning the time, place, manner and circumstances of such death, and of any other information which is required by the Coroner.

Notification by Hospital

Any person D.O.A. (Dead on Arrival) at hospitals, these cases are to be reported immediately, and no person shall, without an order from the Coroner, willfully touch, remove, disturb the body or disturb the clothing or any article upon or near such body. This includes any death, which occurs within twenty-four hours after admission.

Notification of Physician in Case of Death by Violence or Suicide

When a person dies as a result of criminal or other violent means, or by casualty, or by suicide, or suddenly when in apparent health, or in any suspicious or unusual manner, the physician called in attendance shall immediately notify the office of the Coroner of the known facts concerning the time, place, manner and circumstances of such death and if a request is made for cremation, the funeral director called in attendance shall immediately notify the Coroner.

I. Accidental Deaths (All forms, including death arising from employment):

1. Anesthetic Accident (Death on the operating table prior to recovery from anesthesia.)
2. Blows or other forms of mechanical violence
3. Crushed beneath falling objects
4. Burns
5. Cutting or stabbing
6. Drowning (actual or suspected)
7. Electric shock
8. Explosion
9. Exposure
10. Firearms

1. Fractures of bones (not pathological). Such cases are to be reported even when the fracture is not primarily responsible for the death. All hip fractures, if patient dies within one year and one month is considered a Coroner's Case and the Coroner must be notified.
2. Falls
3. Carbon Monoxide poisoning (resulting from natural gas, automobile exhaust or other)
4. Hanging
5. Heat Exhaustion
6. Insulation (sunstroke)
7. Poisoning (food poisoning, occupational or other)
8. Strangulation
9. Suffocation (foreign object in bronchi, by bed clothing or other means)
10. Vehicular Accidents (automobile, street car, bus, railroad, motorcycle, bicycle or other)

I. Homicidal Deaths

II. Suicidal Deaths

III. Abortions: Criminal or self-induced

When the manner of death falls within the above classification, such death must be reported to the Coroner even though the survival period subsequent to onset is 12 months.

IV. Sudden Deaths: When in apparent health in any suspicious or unusual manner including:

1. Alcoholism
2. Sudden death on the street, at home, in a public place, at place of employment
3. Death under unknown circumstance whenever there are no witnesses or where little or no information can be elicited concerning the deceased person. Deaths of this type include those persons whose dead bodies are found in the open, in places of temporary shelter, or in their home under condition which offer no clues to the cause of death.

1. Deaths which follow injuries sustained at place of employment whenever the circumstances surrounding such injury may ultimately be subject of investigation. Deaths of this classification include: Caisson disease (bends), industrial infections (anthrax, septicemia following wounds including gas bacillus infections, tetanus, etc.), silicosis, industrial poisonings (acids, alkalis, aniline, benzene, carbon monoxide, carbon tetrachloride, cyanogens, lead, nitrous fumes, etc.), contusions, abrasions, fractures, burns, (flames, chemical or electrical) received during employment which in the opinion of the attending physician are sufficiently important, either as the cause or contributing factor to the cause of death, to warrant certifying them on the death certificate.
2. All stillborn infants where there is suspicion of illegal interference.
3. Deaths of persons where the attending physician cannot be found or deaths of persons who have not been attended by a physician within two weeks prior to the date of death.
4. All deaths occurring within 24 hours of admission to a hospital.
5. All hip fractures, if the patient dies within one year and one month, will be a Coroner's Case and the Coroner must be notified.
6. All deaths in State institutions and all deaths of wards of the State in private care facilities or in programs funded by the Department of Mental Health and Development Disabilities or the Department of Children and Family Services shall be reported to the Coroner of the County in which the facility is located. If the Coroner has reason to believe that an investigation is needed to determined whether the death was caused by maltreatment or negligent care of the ward of the State, the Coroner may conduct a preliminary investigation of the circumstances of such death as in cases of death under circumstances set forth in the Illinois Compiled Statutes.
7. Any death which occurs within Madison County and not at a hospital or nursing home facility (at any residence, employer, and/or public facility) will immediately be reported to the Coroner.

I. Cremations: All deaths in Madison County where a cremation of the remains is to take place.

Coroner's Staff

These experienced men and women are dedicated to ensuring the professional investigation of all deaths occurring in Madison County, Illinois.

Roger D. Smith F-ABMDI
Chief Investigator

Kelly R. Rogers, D-ABMDI
Chief Deputy

Robert M. Lewis, D-ABMDI
Supervisory Investigator

Deborah B. von Nida, F-ABMDI
Supervisory Investigator

Todd R. Ballard, D-ABMDI
Investigator

Shane P. Liley, D-ABMDI
Investigator

William R. Brandon, D-ABMDI
Investigator

Sakina T. Hall, D-ABMDI
Investigator

Jaclyn M. Kacera
Administrative Aide

What We Do

A Day in the Life of a Madison County Coroner's Investigator

In this particular career there are no such things as "routine call". Every response from this office to a death scene involves the death of a person who was loved and will be greatly missed by their family members.

Some cases however are, by the very nature, more difficult to handle than others and that of course are the children.

I feel that the following communication between an investigator and a supervisor after handling the accidental death of a small child shows a unique insight as to what this office is about and what investigators experience:

Investigator to Supervisor

"All parties have been contacted for the autopsy.

Our ambulance that we had on standby to transport the child to the morgue was called out. No one was available so we decided to take him in my car. We told the parents about the situation. Then we told them that my partner would drive and I would hold the baby in my arms. They were very happy about that. Dad asked if he could carry his son out to the car and we said it was okay with us. I pulled up to the entrance, got in the back and laid an afghan that I carry in my car across my lap. He placed the child in my arms; I covered him up (but not his face) and put one of our little stuffed bears inside the blanket with him. They took comfort in knowing that he would be nearby in Wood River. I drove past the house early in the morning and saw that they have placed a big yellow bow around a tree near where the death occurred. What a tragedy. Still, I think we all made them feel a little more reassured. The entire staff went in the room to pray with them. There wasn't a dry eye in the place. I think a cold beer might be in order now."

Supervisor's Response To Investigator

Excellent job. As long as any comfort measures provided to the survivors will not conflict with the death investigation, this is the type of response that is expected from the entire staff. These are tough situations to deal with for all parties concerned, but if you made the family feel a little better at that given moment you can consider it a "small victory" in the face of tragedy. And with this particular career, the best you can ever hope for is a small victory. Additionally, as "comforting" as a beer may sound, think about this instead….you are part of a select few, who, instead of succumbing to the grief and tragedy around us, rise to the occasion, suck it up, gut it out, put the weight of the whole thing on your shoulders, go forth, speak the truth and shoot straight in order to make sure that justice is served for the dead and the bereaved are comforted. "

American Board of Medicolegal Death Investigators, Inc.℠

As stated in my letter to Madison County Board Chairman Alan Dunstan, it is my goal as Madison County Coroner to have every full time investigator eventually registered with this organization; the information that follows better explains this very fine organization of professional death investigators.

The American Board of Medicolegal Death Investigators, Inc.℠ (ABMDI) is a national, not-for-profit, independent professional certification board that has been established to promote the highest standards of practice for medicolegal death investigators.

The American Board of Medicolegal Death Investigators will certify individuals who have the proven knowledge and skills necessary to perform medicolegal death investigations as set forth in *Death Investigation: A Guide for the Scene Investigator* published in 1999 by the National Institutes of Justice. This is a voluntary certification program.

The American Board of Medicolegal Death Investigators was created, designed, and developed by veteran, practicing medicolegal death investigators who have been involved in the development of *Death Investigation: A Guide for the Scene Investigator.* It will also assist the courts and public in evaluating competency of the certified individual.

Purpose of the American Board of Medicolegal Death Investigators, Inc.℠

- To enhance and maintain professional standards by evaluating knowledge, competency, and skills of medicolegal death investigators based on examination.
- To administer objective and reliable examinations (basic and advanced) in the field of medicolegal death investigation.
- To recognize qualified individuals who demonstrate mastery of basic and advanced skills and knowledge of medicolegal death investigation by granting certificates to those individuals who have met all application requirements and successfully completed rigorous examination
- To recertify individuals every five years according to established recertification criteria including continuing education requirements to ensure that the individual is current in the field.
- To encourage medicolegal death investigators to adhere to high standards of professional practice and ethical conduct when performing medicolegal death investigations.
- To raise the level of professional competency in medicolegal death investigation by identifying appropriate training courses for professional development.
- To maintain a publicly accessible listing of ABMDI certificants in good standing.