Wisconsin Legislative Council

MINUTES

STUDY COMMITTEE ON UNIFORM DEATH REPORTING STANDARDS

411 South, State Capitol
Madison, WI
July 18, 2022
10:00 a.m. – 3:10 p.m.

CALL TO ORDER AND ROLL CALL

Chair Ballweg called the meeting to order and determined that a quorum was present.

COMMITTEE MEMBERS PRESENT:	Sen. Joan Ballweg, Chair; Rep. Jesse James, Vice Chair; Sen. LaTonya Johnson; Rep. Steve Doyle; and Public Members Lynda Biedrzycki, Tim Candahl, Sara Kohlbeck, Brian Michel, Teresa Paulus, and Tara Steininger.
COMMITTEE MEMBERS EXCUSED:	Public Member Kerry Riemer.
COUNCIL STAFF PRESENT:	Anne Sappenfield, Director; Amber Otis, Senior Staff Attorney; Kelly McGraw, Staff Attorney; and Annie Gonring, Legislative Intern.
APPEARANCES:	HJ Waukau, Legislative Director, Lynette Childs, State Registrar, State Vital Records Office, Michelle Smith, System Administrator, Statewide Vital Records Information System, Chelsea Boekhoudt, Vital Records Program Supervisor, Department of Health Services; Sarah Bassing-Sutton, Community Suicide Prevention Coordinator, N.E.W. Mental Health Connection; Karen Ordinans, Retired, Former Executive Director of Children's Health Alliance of Wisconsin, and Karen Nash, Program Leader, Injury Prevention and Death Review, Children's Health Alliance of Wisconsin; and Adam Covach, M.D., Chief Medical Examiner, Fond du Lac County.

OPENING REMARKS FROM ANNE SAPPENFIELD, DIRECTOR, LEGISLATIVE COUNCIL STAFF

Anne Sappenfield, Director of the Legislative Council staff, welcomed committee members and thanked them for their service. She introduced the Legislative Council staff assigned to the committee. She then presented a video featuring remarks from Wisconsin legislators, including the current co-chairs of the Joint Legislative Council, regarding the work of interim study committees. In closing, Ms. Sappenfield briefly described the procedures followed throughout the study committee process.

Introduction of Committee Members

Chair Ballweg introduced herself and welcomed the committee members. At her invitation, committee members introduced themselves and briefly explained their backgrounds and interest in the committee's topic.

Description of Distributed Materials by Legislative Council Committee Staff

Amber Otis, Senior Staff Attorney, and Kelly McGraw, Staff Attorney, provided an overview of information provided in Legislative Council Staff Brief 2022-01, *Study Committee on Uniform Death Reporting Standards* (July 11, 2022). Ms. Otis described the committee's scope and the role of committee staff, and then summarized current laws governing the filing of death records with the Office of Vital Records in the Department of Health Services (DHS). Ms. McGraw then summarized the current state statutes addressing death investigations by a county coroner or medical examiner, as well as the difference between those two types of county offices. A copy of their PowerPoint presentation is available on the committee's website.

Presentation by the Wisconsin Department of Health Services

HJ Waukau, Legislative Director; Lynette Childs, State Registrar, State Vital Records Office; Michelle Smith, System Administrator, Statewide Vital Records Information System; and Chelsea Boekhoudt, Vital Records Program Supervisor

Mr. Waukau, Legislative Director, introduced the panel of DHS staff presenting to the committee. A copy of DHS's PowerPoint presentation is available on the committee's website.

Ms. Childs, State Registrar, provided an overview of the following topics: (1) key definitions and acronyms used in the context of vital records; (2) the definition of, purposes for, and laws governing vital records in Wisconsin; and (3) the core functions of the state vital records office (SVRO). She then described in more detail the role of the SVRO with respect to death records.

Specifically, Ms. Childs outlined the basic steps of filing a death record, commonly beginning with a funeral director initiating the record in the Statewide Vital Records Information System, and then selecting a medical certifier to enter cause-of-death information. Once the cause of death is medically certified, the death record is returned to the funeral director, who then signs and routes the death record to the local vital records office. The local vital records office accepts the death record and it is then registered with the SVRO.

Ms. Childs noted that the SVRO reviews cause-of-death statements for legal acceptability consistent with the statutes governing Wisconsin vital records. While the SVRO provides direction on the manner in which records are filed, she noted the SVRO's has limited oversight on the determination of cause and manner of death. Rather, death investigations are a function of county coroner and medical examiner offices, meaning oversight of investigation standards and policies occurs at a county level.

DHS responded to questions from committee members on various topics, including: the standardized data fields in the federal U.S. Standard Certificate of Death form; the circumstances in which a family member, rather than a funeral director, would serve as the filing party; the limits on accessing death record information; when and how a death record may be amended; and the ability for other state

agencies, such as the Department of Veterans Affairs or the Department of Corrections, to access death record information.

PRESENTATION BY SARAH BASSING-SUTTON, COMMUNITY SUICIDE PREVENTION COORDINATOR, N.E.W. MENTAL HEALTH CONNECTION

Ms. Bassing-Sutton presented to the committee on the importance of uniform death reporting standards to suicide prevention. Her PowerPoint presentation is available on the committee's website.

First, Ms. Bassing-Sutton described her work with the N.E.W. Mental Health Connection, which currently serves Calumet, Outagamie, and Winnebago Counties. She noted that data greatly varies among counties with respect to deaths requiring an investigation, particularly suicides. She specified that the lack of a standardized reporting or investigative tool hampers the quality of data collected.

She then outlined her work, along with other community partners, in creating a Suicide Investigation Form (SIF), a ready-to-use tool that guides a coroner or medical examiner in gathering comprehensive information that can help identify risk factors with the ultimate goal of effective prevention efforts. She noted that vital records statistics are useful, but may take years to compile and release, and may not include specific data fields that adequately capture certain risk factors.

She explained that the typical SIF process involves a coroner or medical examiner completing the SIF based on conversational interviews with the decedent's family and friends, who often trust the coroner or medical examiner due to presence on site near the time of death. She also provided a summary of data collected using the SIF in the last several years. She closed her presentation by explaining how the SIF can provide valuable information to adult suicide death review teams by showing high-level trends across a county, or an in-depth look at events leading up to a death that may not have been contained in other sources, such as police reports or medical records.

Ms. Bassing-Sutton addressed questions from committee members on several topics, including: (1) the difference between the SIF and psychological autopsies, an investigatory practice typically offered by outside organizations; (2) the ability of coroner or medical examiners to engage with family to complete the SIF; (3) access to information when completing the SIF; (4) examples of prevention efforts resulting from the SIF data; (5) challenges for coroners or medical examiners in using the SIF with current staffing levels and caseloads.

PRESENTATION BY CHILDREN'S HEALTH ALLIANCE OF WISCONSIN

Karen Ordinans, Retired, Former Executive Director, and Karen Nash, Program Leader, Injury Prevention and Death Review

Ms. Ordinans and Ms. Nash described the work of the Children's Health Alliance of Wisconsin (CHAW). The committee's website provides a copy of their PowerPoint presentation and distributed materials. Generally, CHAW provides technical assistance to local child death review (CDR) teams under its *Kids Alive in Wisconsin* program, with the goal of preventing future deaths by understanding how and why a child dies and identifying the need for policies and programs to improve child health.

Ms. Nash explained that CDR teams meet regularly in a confidential setting and review individual unexpected child deaths, such as those resulting from abuse, neglect, accidents, homicides, SIDS, or suicides. CDR teams have multidisciplinary membership and typically include a representative from the county's public health department, law enforcement, the district attorney's office, the medical examiner or coroner, the child protective services (CPS) agency, and the local school district, among others.

Teams complete a data form about the incident, which then is sent to the National Center for Fatality Review & Prevention.

Ms. Ordinans noted that, though a voluntary endeavor, 45 CDR teams currently exist in Wisconsin. She provided a statewide map of fatality review teams implemented across Wisconsin counties, including not only CDR teams, but also fetal infant mortality review teams, overdose fatality review teams, and suicide review teams. CDR teams served as a model for these other types of fatality review teams.

Ms. Ordinans identified challenges facing CDR teams, including the capacity of professionals to serve and complete the data form, the inability to access certain records, and an inconsistency among death investigations, in part due to varying county resources. She recommended creation of a state statute codifying the current practice of fatality review teams, which would provide a comprehensive fatality review system, ensure uniformity of data reported, and allow the opportunity to learn from past deaths and prevent future deaths. Ms. Ordinans specified that, ideally, such legislation would: (1) recognize the establishment of fatality review teams; (2) define the purpose, structure, and confidentiality of the review process; (3) resolve barriers on information sharing; and (4) provide the resources to capture data appropriately. She noted that many states address fatality review teams by statute.

Ms. Ordinans and Ms. Nash then addressed questions from committee members on a variety of topics, including: (1) whether any of the states with fatality review legislation have a county-based system like Wisconsin; (2) how fatality review teams use data to communicate with other teams; and (3) the entities that oversee and lead the overdose fatality review teams and suicide fatality review teams.

PRESENTATION BY ADAM COVACH, M.D., CHIEF MEDICAL EXAMINER, FOND DU LAC COUNTY

Dr. Covach provided information on a coroner or medical examiner's role in determining the cause and manner of death, as well as issues impacting reporting accuracy. A copy of his PowerPoint presentation is available on the committee's website.

First, Dr. Covach described the history of a coroner's role and the subsequently created medical examiner systems in some jurisdictions. He then described how, in Wisconsin, a coroner is elected, while a medical examiner is appointed by a county board. He then explained that autopsies must be performed by a forensic pathologist, which could be the county's coroner or medical examiner, but not necessarily. Currently, Wisconsin has five offices that can perform autopsies.

Dr. Covach then summarized the duties of a coroner or medical examiner upon a person's death. First, the death must be one of the types reportable to the coroner or medical examiner, thereby invoking their jurisdiction. If the coroner or medical examiner accept jurisdiction, the coroner or medical examiner under takes an investigation as to the cause and manner of death. Dr. Covach noted that often these steps occur simultaneously, in that the investigation determines whether the death is one of the types that invokes jurisdiction. Once determining the cause and manner of death, the coroner or medical examiner signs the death certificate and closes the investigation.

Next, Dr. Covach provided more detail on the process for determining the cause and manner of death and the appropriate way to medically certify that information on the death certificate. With respect to the manner of death, the following five options exist: (1) suicide; (2) homicide; (3) accidental; (4) undetermined; and (5) natural. Dr. Covach then provided examples of varying approaches to completing a death certificate.

Dr. Covach noted that medical professionals receive little, if any, training on how to complete a death certificate. He also noted that coroners and medical examiners are fairly independent and each county may approach this work differently or have different philosophies. He noted that consistency in practice, even within an individual office, is valuable. He closed by identifying possibilities to consider, such as creating a centralized coroner or medical examiner system, but noted that local control is highly valued. He also suggested operating a more centralized system within existing organizations, such as the Wisconsin Coroner and Medical Examiner Association, or by the creation of a "common council" type of model that could reach consensus on certain uniform reporting standards and procedures.

After concluding his presentation, Dr. Covach answered questions from committee members on the following topics: (1) the willingness and capacity of coroners and medical examiners to participate in a common council type model; (2) the requirements to be a coroner or medical examiner; (3) how a centralized system would function; (4) a coroner or medical examiner's obligations if jurisdiction is declined; (5) the authority to conduct an autopsy over objection; (6) guidelines for coroners and medical examiners on how to complete a death investigation and certificate; and (7) the implementation of fatality review teams in his home county.

Discussion of Committee Assignment

Following presentations from invited speakers, the committee discussed the information received, as well as the committee's scope. Some members commented that there seems to be a difference in philosophies and goals, in that some view investigations as a process to determine cause of death, while others view such investigations as an opportunity to understand why the death occurred, and identify prevention efforts. One member noted the importance of determining the purpose for which data, including cause of death, is collected. Chair Ballweg noted that the goal of the committee is to provide a uniform means of reporting, so that data can be used to identify trends to assist in prevention efforts.

At the chair's invitation, committee members requested additional information in the following areas: background information on legislative efforts approximately 20 years ago to create a centralized coroner and medical examiner system; and research on whether any national organizations have published best practices relating to vital records statistics and death investigations.

Adjournment

Chair Ballweg reminded members that the committee's next meeting will be held on Wednesday, August 17, 2022, in Room 411 South, at the State Capitol in Madison. Future meetings are scheduled for October 4, November 15, and December 15, if necessary.

The meeting adjourned at 3:10 p.m.

AO:ksm