Wisconsin Legislative Council
STAFF BRIEF

STUDY COMMITTEE ON
UNIFORM DEATH REPORTING STANDARDS

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The Wisconsin Legislative Council is a nonpartisan legislative service agency. Among other services provided to the Wisconsin Legislature, staff of the Wisconsin Legislative Council conduct study committees under the direction of the Joint Legislative Council.

Established in 1947, the Joint Legislative Council directs study committees to study and recommend legislation regarding major policy questions facing the state. Study committee members are selected by the Joint Legislative Council and include both legislators and citizen members who are knowledgeable about a study committee's topic.

This staff brief was prepared by the Wisconsin Legislative Council staff as an introduction for study committee members to the study committee's topic.

INTRODUCTION

Wisconsin's death reporting system relies on information from physicians, as well as the work of county coroners or medical examiners, who report various death-related information to the Wisconsin Vital Records Office (office of vital records) within the Department of Health Services (DHS). Certain data, including the cause and manner of death, are then compiled by DHS's office of vital records and available for public viewing.

As a general matter, when a death occurs in Wisconsin, a death record – which includes a certification from a physician, coroner, or medical examiner as to the cause of death and other medically related data – must be filed with the state. For many deaths, a physician certifies the cause and manner of death, and the reporting does not involve a county coroner or medical examiner. However, state law specifies certain types of deaths that invoke the jurisdiction of the county coroner or medical examiner, who is then required to undertake an investigation to determine the cause and manner of death, by using certain investigatory tools, such as accessing records and ordering autopsies.

The process for investigating and reporting deaths is governed by various constitutional provisions and statutes, which have not been modified in many years. Some Wisconsin counties maintain an office of coroner, an elected constitutional officer, while others have instituted a medical examiner system for death investigations.

Discussions have arisen in recent legislative sessions regarding the uniformity of county-level work, as has interest in more comprehensive reviews of certain kinds of deaths, particularly suicides, to help stakeholders understand risk factors to better inform preventative efforts. For example, many counties use child death review teams, which employ a multi-disciplinary approach to conduct in-depth reviews of individual deaths. Some adult suicide death review teams have recently been created and use the same multi-disciplinary approach.

With this background, the Joint Legislative Council (JLC) has directed the Study Committee on Uniform Death Reporting Standards to review the current protocols for investigating causes of death and reporting death, and the uniformity of those protocols among counties. Specifically, the JLC directed the committee to review options to implement more comprehensive uniform death reporting standards across Wisconsin, including the advantages and barriers to implementation of such standards. Following review, the committee is instructed to develop legislation to provide minimum requirements for death investigations and reporting, particularly deaths involving homicide, suicide, child or infant death, domestic violence, maternal mortality, and substance use.

To support committee members in accomplishing this charge, this staff brief describes current state law relevant to analyzing legislative options related to death reporting. Specifically, this staff brief contains the following parts:

- **Part I** summarizes the procedure and requirements for creating death records with the state's office of vital records, as well as examples of the ways in which death record data may be disclosed and used.
- **Part II** describes the role of a coroner or medical examiner and their investigations of the types of deaths that categorically invoke the jurisdiction of a coroner or medical examiner.

PART I | DEATH RECORDS

WISCONSIN VITAL RECORDS OFFICE

State law requires that DHS establish an office of vital records and appoint a state registrar, who is tasked with numerous duties, including supervising the office of vital records, directing the system of vital records, and acting as custodian of vital records. [ss. 69.02 (1) (b) and 69.03, Stats.]

The system of vital records encompasses the filing, registration, collection, preservation, amendment, and certification of vital records, as well as other activities relating to the analysis and publication of vital statistics. Vital records include records of birth, death, divorce or annulment, domestic partnership, and marriage, while vital statistics reflect the data derived from those types of records or other related reports. [s. 69.01 (25) to (27), Stats.]

The state registrar and the office of vital records work with and oversee local registrars, city registrars, and registers of deeds, who in turn are authorized by statute to accept the filing of vital records and certify such records to the state registrar. [ss. 69.05, 69.06, and 69.07, Stats.]

RECORDING DEATHS

When a person dies, a death record, comprised of certain factual and medical data, must be filed with the state, a task most commonly performed by a funeral director. Very generally, the filing party must obtain certification from a physician, coroner, or medical examiner as to the cause of death and other medically related data, and then ensure the death record is presented to the state. This process is outlined in more detail below.

Filing Party's Role

State law specifies that a death record must be filed whenever a death occurs in this state or a corpse is found in this state, among other circumstances. The death record may be filed by certain parties authorized by statute. A funeral director typically serves as the filing party.[1] [s. 69.18 (1) (a) and (b), Stats.]

The filing party must obtain information required for the death record from the next of kin or the best qualified person or source available. In addition, within 24 hours of being notified of a death, the filing party must present the record to the physician, coroner, or medical examiner responsible for completing and signing the medical certification. The medical certifier has six days from the pronouncement of death to complete the medical portion of the death record, as described in more detail below. Within two days after receipt of the medical certification, the filing party must file the death record in the county[2] of the place of death or in which the corpse was found, if the place of death was not in Wisconsin or is unknown. [s. 69.18 (1) (bm) and (2), Stats.]

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[1] A death record may also be filed by a member of the decedent's immediate family who personally prepares for and conducts the final disposition of the decedent, or by persons authorized by statutes in various circumstances, such as unclaimed human bodies at certain institutions, donated human bodies, and religious burial customs. [ss. 69.18 (1) (a) 2. and 3., 157.02, and 445.16, Stats.]

[2] Specifically, filing must occur in the "registration district" in which the death occurred or the corpse was found. This term generally refers to a county, though the state registrar may approve a city to function as a registration district for purposes of death record filings, if the city has the staff, office space, and other resources for proper administration of death records. [ss. 69.01 (21), 69.04, and 69.18 (1) (bm), Stats.]

A hospital, nursing home, or hospice that is the place of death may prepare a death record for the deceased and give the record to the filing party. The statutes specify various medical professionals who are authorized to pronounce the date, time, and place of a patient's death, if certain conditions are met. [s. 69.18 (1) (c), (cj), (ck), and (cm), Stats.]

Medical Certification

The medical certification refers to those portions of a death record that provide the cause of death, manner of death, injury-related data, and any other medically related data that is collected as prescribed by the state registrar. As previously mentioned, the filing party will select the medical certifier responsible for completing and certifying the medical portion of the death record. The medical certifier could be a physician, coroner, or medical examiner, depending on the circumstances of the death.

Information in Medical Certification

A person signing a medical certification must do all of the following:

- Describe, in detail, the cause of death.
- Show the duration of each cause, the sequence of each cause if the cause of death was multiple and, if the cause was disease, the evolution of the disease.
- For any disease, describe the disease in medical terms and not limit the description to symptoms or conditions resulting from the disease.
- If being certified by a coroner or medical examiner (as explained below), describe any violence related to the cause of death, its effect on the decedent, and whether it was accidental, suicidal, homicidal, or undetermined.

[s. 69.18 (2) (f) 1., Stats.]

If a person signing a medical certification fails to satisfy these requirements, the medical certification must be deemed incomplete and may be returned to the person for completion. The medical certifier must note on the record if the cause of death of the subject of the record is unknown, undetermined, or if the determination of the cause of death is pending. In those cases, the medical certifier must submit an amendment to the medical certification that satisfies the requirements above within 30 days after the pronouncement of death, subject to limited exceptions. [s. 69.18 (2) (f) 2. and 3., Stats.]

Certification by Physician

A physician must complete and sign the medical certification if a person under his or her care dies from an illness or a condition for which care is given, and a coroner or medical examiner does not certify the cause of death, as described below. If that physician is absent or provides written approval, one of the following professionals with access to the decedent's medical history may complete and sign the medical certification: (a) any other physician who assisted in attending the decedent; (b) the chief medical officer of the hospital or nursing home in which the death occurred; or (c) the physician who performed an autopsy on the decedent. [s. 69.18 (2) (b) and (c), Stats.]

Certification by Coroner or Medical Examiner

If a death is the subject of a coroner's or medical examiner's determination under the laws governing death investigations (as described in Part II), then the coroner or medical examiner in the county where the event that caused the death occurred must complete the medical

certification. A physician supervised by a coroner or medical examiner may also fulfill this function. [s. 69.18 (2) (d) 1., Stats.]

Even if no death investigation occurred, the coroner or medical examiner in the county of the place of death may still be responsible for completing the medical certification. Specifically, if the decedent was not under the care of a physician for the illness or condition from which the person died, the coroner or medical examiner in the county of the place of death is responsible for completing the medical certification. The statutes also authorize a physician supervised by a coroner or medical examiner to complete the medical certification in this context. [s. 69.18 (2) (d) 2., Stats.]

Required Information in Death Record

State law specifies the information that must be included in a death record, which is categorized into the following three parts: (a) fact-of-death information; (b) extended fact-of-death information; and (c) statistical-use-only information. [s. 69.18 (1m), Stats.] The chart below sets forth the types of information specified in statute that must be included within each part.

FACT-OF-DEATH INFORMATION	EXTENDED FACT-OF-DEATH INFORMATION	STATISTICAL-USE-ONLY INFORMATION
Decedent's name and other identifiers (including Social Security number, if any)	Information on final disposition, manner, and cause of death	Any other information that is collected on the standard death record form recommended by the federal agency responsible for national vital statistics
Date, time, and place that decedent was pronounced dead	Injury-related data	Other data, as directed by the state registrar, including race, educational background, and health risk behavior
Identity of the person certifying the death		
Dates of certification and filing of the death record		

USE OF DATA

Confidentiality

State law generally limits disclosure of the information included in a death record. Specifically, until 50 years after a decedent's date of death, neither the state registrar nor a local registrar may permit inspection of or disclose "extended fact-of-death information" to anyone except to a person with a direct and tangible interest (such as an immediate family member or a legal representative), or to a direct descendent of the decedent. [s. 69.20 (1) and (2) (c), Stats.]

With respect to death record information designated as "statistical-use-only information," such information may not be disclosed to any person except the following:

- The subject of the information or, if the subject is a minor, his or her parent or guardian.

- Any of the persons who are authorized to apply for disinterment, or an individual who is authorized in writing by one of the persons.

[s. 69.20 (2) (a), Stats.]

The statutes further allow, in specified circumstances, the disclosure of information that would be otherwise prohibited. For example, disclosure is permitted if authorized by a court order and the order specifies the vital record which is to be disclosed, or if, upon written agreement with the state registrar, the information will be used for certain specified research or statistical purposes.[3] [s. 69.20 (3), Stats.]

Reports and Statistical Analysis

State law requires the state registrar to prepare and publish an annual report of vital statistics, which includes data derived from death records. In compliance with this directive, DHS publishes the Annual Wisconsin Death Report, which provides technical notes, data tables, and figures with information on the number and rate of deaths, demographic characteristics of decedents, characteristics of deaths by geographic location, and disposition of bodies. [s. 69.03 (9), Stats.]

In addition to the annual report, DHS also provides further data in a program titled Wisconsin Interactive Statistics on Health (WISH), an online data query system that includes death data for multiple years and geographic areas in Wisconsin.

Beyond use in state publications and analysis, Wisconsin's data is shared for various federal purposes, such as the National Vital Statistics System within the Center for Disease Control and Prevention (CDC)'s National Center for Health Statistics (NCHS). Federal law requires NCHS to collect data from records of births, deaths, marriages, and divorces from states who possess "records affirming satisfactory data in necessary detail and form." [42 U.S.C. s. 242k.] In other words, the legal authority for collection and registration of various vital statistics is the role of the individual states. However, if collected, NCHS must obtain it from the collecting state. To this end, NCHS's collection of vital statistics depends on a cooperative relationship between the states and the federal government, currently accomplished through the Vital Statistics Cooperative Program.

Additionally, data on certain types of deaths, including suicide, are collected in the Wisconsin Violent Death Reporting System. States that receive federal funding for violent death reporting, including Wisconsin, must report de-identified data to the CDC's National Violent Death Reporting System (NVDRS). The data collected under NVDRS includes information on the circumstances surrounding a death, based on death investigation reports and death records. In 2002, Congress first appropriated funds to initiate the NVDRS and, according to the CDC, all 50 states now participate in the NVDRS.

[3] Federal privacy law, particularly the Health Insurance Portability and Accountability Act (HIPAA), impacts the disclosure and use of data, as "protected health information," which includes identifiable health information regarding a person who has been deceased for 50 years after their death. For example, a covered entity may use or disclose protected health information for the public health activities to a public health authority that is authorized by law to collect or receive such information to prevent or control disease, injury, or disability, including death reports. [45 C.F.R. ss. 160.103 and 164.512 (b) (1) (i).]

PART II | DEATH INVESTIGATIONS

As described below, not all deaths prompt involvement by a coroner or a medical examiner. Rather, state law specifies certain types of deaths that require an investigation by a coroner or a medical examiner, who certifies the cause and manner of death in the reported death record after conducting an investigation. If a death occurs that invokes the jurisdiction of a coroner or medical examiner, the statutes afford various tools to assist coroners and medical examiners in determining the cause of death, such as authority to issue subpoenas for records, order autopsies, and request an inquest proceeding. However, some of these tools are far more commonly used than others.

Coroners and medical examiners generally perform the same functions with respect to investigating and certifying deaths, though the state constitution and statutes provide different mechanisms for the use of a coroner versus medical examiner system. This Part describes: (a) the manner in which a coroner versus medical examiner is selected; (b) the types of deaths that necessitate an investigation by a coroner or medical examiner; and (c) the functions of, and tools available to, a coroner or medical examiner when determining the cause and manner of death.

COUNTY USE OF A CORONER OR MEDICAL EXAMINER

The office of coroner is a constitutional office under the Wisconsin Constitution, which requires a coroner to be elected in each county (or in more than one county, if combined by the Legislature for that purpose) for a term of four years. As an alternative to electing a coroner for a county or a group of counties, the state's constitution authorizes counties with a population of fewer than 500,000 to institute a medical examiner system or, for two or more counties, a joint medical examiner system. For counties with a population of 500,000 or more, the Wisconsin Constitution expressly abolishes the office of coroner.[4] [Wis. Const. art. VI, sec. 4.]

State statutes supplement these constitutional provisions, and specify that, for those counties with a medical examiner system, the county board appoints the medical examiner, except in Milwaukee County, where the medical examiner is appointed by the county executive and confirmed by the county board. State law also clarifies that, in counties that have instituted the medical examiner system, the duties and powers of the coroner are generally vested in the office of the medical examiner for purposes of investigating deaths.[5] A medical examiner may be appointed on a full-time or part-time basis, with the county board determining compensation. In practice, some medical examiners serve multiple counties, and coroners may act in another county upon request. [ss. 59.34 and 59.38 (5), Stats.]

Under current law, there are no minimum requirements that a coroner or medical examiner must meet. Coroners and medical examiners generally have the same function related to death investigations – namely, administering the office's duties, consulting with local law enforcement and other officials, gathering information and evidence, and determining and certifying the cause and manner of death. To execute these tasks, state law authorizes a coroner to appoint deputy coroners, and further authorizes a medical examiner to appoint assistants as authorized by the county board. [ss. 59.34 (1), 59.35, and 59.38 (1), Stats.]

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[4] Currently, Dane and Milwaukee Counties meet this population threshold. Note that current statutes prohibit election of a coroner in counties having a population of 750,000 or more (currently, Milwaukee County) or in counties in which a medical examiner system is instituted. [s. 59.20 (2) (b), Stats.]

[5] The statutes also list other specific duties for coroners and medicals examiners that are beyond the scope of this staff brief. [See, s. 59.34, Stats.]

TYPES OF DEATHS INVESTIGATED

As mentioned, state law requires the involvement of a coroner or medical examiner when certain types of death occur, which in turn prompts an investigation to determine the cause and manner of death. Specifically, all physicians, authorities of various institutions, and other persons having knowledge of the death of any person, must immediately report the death to the sheriff, police chief, or medical examiner or coroner of the county where the death took place under any of the following circumstances:

- Deaths in which there are unexplained, unusual, or suspicious circumstances.
- Homicides.
- Suicides.
- Deaths following an abortion.
- Deaths due to poisoning, whether homicidal, suicidal, or accidental.
- Deaths following accidents, regardless of whether the injury is the primary cause of death.
- When there was no physician or accredited practitioner of a bona fide religious denomination relying upon prayer or spiritual means for healing in attendance within 30 days preceding death.
- When a physician refuses to sign the death certificate.
- When, after reasonable efforts, a physician cannot be obtained to sign the medical certification as required within six days after the pronouncement of death or sooner under circumstances which the coroner or medical examiner determines to be an emergency.

[s. 979.01 (1), Stats.][6]

If a sheriff or police chief is the official that receives a report of a death, he or she must, in turn, immediately notify the coroner or the medical examiner of the county in which the death took place.[7] The coroner or medical examiner is required to immediately notify the district attorney. [s. 979.01 (1g) and (1m), Stats.]

Any person who violates these reporting requirements is subject to a fine of not more than $1,000 or imprisonment of not more than 90 days, except in some circumstances involving the death or disappearance of a child. [s. 979.01 (2), Stats.]

DETERMINING THE CAUSE OF DEATH

Investigation

Once a death is reported, as required above, the coroner or medical examiner will undertake an investigation to determine the cause and manner of death. The investigation typically involves an on-the-scene investigation, interviews with family members or others with knowledge of the

[6] State law imposes specific reporting requirements for deaths related to certain illnesses or communicable diseases. Specifically, the coroner or medical examiner must report certain information to DHS and the local health department if he or she is aware of the death of a person who, at the time of his or her death, had an illness or a health condition that is believed to be caused by bioterrorism or certain biological agents, or had a communicable disease that must be reported pursuant to DHS's administrative rules. [s. 979.012, Stats.]

[7] If the crime, injury, or event occurred in another county, the coroner or medical examiner of the county in which the death took place must immediately report the death to the coroner or medical examiner of that county as well. [s. 979.01 (1g), Stats.]

incident, consultation with law enforcement, and review of records. Additionally, state law provides various tools to assist coroners and medical examiners in determining the cause of death.

For example, if an autopsy is not performed (as described below), the coroner or medical examiner is authorized to take for analysis any and all specimens, body fluids, and any other material that will assist in determining the cause of death.[8] In addition, if necessary to determine the cause of death, the statutes grant subpoena authority to the coroner or medical examiner. Documents subject to subpoena include the decedent's patient health care records and treatment records.[9] [ss. 979.01 (3) and (3m) and 979.015, Stats.]

The statutes also authorize the use of autopsies and inquest proceedings, if a coroner or medical examiner is unable to determine the cause and manner of death. [ss. 979.02 and 979.04 to 979.08, Stats.] Note, however, that neither autopsies nor inquests necessarily occur in all death investigations. Rather, autopsies are typically ordered only in a subset of the deaths that invoke a coroner or medical examiner's jurisdiction. Moreover, inquests are called very infrequently. That said, because the statutes address these mechanisms, each is discussed in more detail below.

Autopsies

A coroner or medical examiner may order that an autopsy be performed if there is reason to believe from the circumstances surrounding the death that certain crimes have been committed, or the death may have been due to suicide or unexplained or suspicious circumstances. However, state law requires that an autopsy be conducted by a licensed physician who has specialized training in pathology. If qualified, a medical examiner may perform an autopsy and toxicological services. Additional autopsies or examinations may occur if there are unanswered pathological questions concerning the death and the causes of death. [ss. 979.02 and 979.22, Stats.][10]

The statutes require autopsies for deaths of correctional inmates and further require autopsies to be available when a child under two years of age dies suddenly and unexpectedly under circumstances indicating that the death may have been caused by sudden infant death syndrome. [ss. 979.025 and 979.03, Stats.]

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[8] State law requires analysis of such material if requested to do so by a spouse, parent, child, or sibling of the deceased person and not objected to by any of those family members. Whenever a coroner or medical examiner obtains materials, either as authorized or when required, such materials are not admissible in evidence in any civil action against the deceased, or his or her estate, as the result of any act of the deceased. [s. 979.01 (3) and (3m), Stats.]

[9] Wisconsin's statutes governing the confidentiality of patient health care records contain an exception for disclosure of patient health care records, without informed consent, to a coroner, deputy coroner, medical examiner, or medical examiner's assistant, for the purpose of investigating deaths or completing the medical certification described in Part I. Specifically, a health care provider may release information by initiating contact with the office of the coroner or medical examiner without receiving a request for release of the information and must release information upon receipt of an oral or written request for the information from the coroner, deputy coroner, medical examiner, or medical examiner's assistant. However, the recipient of any information must keep the information confidential except as necessary to comply with the statutes governing death records and death investigations. [s. 146.82 (2) (a) 18., Stats.]

[10] The district attorney may request a court order for disinterment of a buried body for autopsy purposes, which the court may grant if any of the criteria to call an inquest exists. [s. 979.02, Stats.]

Inquests

Though rare, a court may conduct an inquest to determine a person's cause of death. Under current law, a district attorney may order an inquest for the purpose of inquiring how the person died if, upon notice to the district attorney, there is reason to believe that, from the circumstances surrounding the death, certain crimes have been committed, or the death may have been due to suicide or unexplained or suspicious circumstances. [s. 979.04, Stats.]

An inquest is conducted by a circuit court judge or a circuit court commissioner. The statutes govern, in detail, various aspects of inquest proceedings, including the examination of jurors and witnesses, the applicable burdens of proof, and the rendering of verdicts. Inquests are conducted before a jury unless the district attorney, coroner, or medical examiner requests otherwise. A jury's verdict makes findings as to the cause of death, though any such findings are advisory, in that the verdict neither precludes nor requires a district attorney to issue criminal charges. [ss. 979.05 to 979.08, Stats.]