Wisconsin Legislative Council

MINUTES

STUDY COMMITTEE ON UNIFORM DEATH REPORTING STANDARDS

411 South, State Capitol
Madison, WI
October 17, 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, Kerry Riemer, and Tara Steininger.
COUNCIL STAFF PRESENT:	Amber Otis, Senior Staff Attorney; and Kelly McGraw, Staff Attorney.
APPEARANCES:	HJ Waukau, Legislative Director, Lindsay Emer, Ph.D., National Violent Death Records System Coordinator, and Lynette Childs, State Registrar, State Vital Records Office, Department of Health Services (DHS); Jay Yerges, Special Agent, Division of Criminal Investigation, Steve Wagner, Administrator, Division of Law Enforcement Services, and Stephanie Pederson, Curriculum Staff, Training and Standards Bureau, Division of Law Enforcement Services, Department of Justice (DOJ).

APPROVAL OF THE MINUTES FROM THE AUGUST 17, 2022 MEETING

The committee approved the minutes from the meeting on August 17, 2022, by unanimous consent.

DESCRIPTION OF MATERIALS DISTRIBUTED BY LEGISLATIVE COUNCIL COMMITTEE STAFF

Kelly McGraw, Staff Attorney, outlined the information provided in Legislative Council Memo No. 2, *Information in Response to Committee Requests at August 17, 2022 Meeting* (October 10, 2022), which describes laws governing the disclosure and confidentiality of certain records after death and provides examples of neighboring states' laws governing fatality review teams. Amber Otis, Senior Staff Attorney, provided an overview of Legislative Council Memo No. 3, *Options for Committee Consideration* (October 10, 2022) and explained that this document would serve as the outline for committee discussion later in the meeting.

PRESENTATION BY THE WISCONSIN DEPARTMENT OF HEALTH SERVICES

HJ Waukau, Legislative Director, Lindsay Emer, Ph.D., National Violent Death Records System Coordinator, and Lynette Childs, State Registrar, State Vital Records Office

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

Dr. Emer then presented on the National Violent Death Reporting System (NVDRS), a data collection program specific to violent deaths, such as suicide and homicide, in which all 50 states participate. She explained that NVDRS is an incident-based data system and has the capacity to collect over 600 data elements to gather contextual information regarding an incident's circumstances. While certain information is collected for all violent deaths, NVDRS also collects data elements specific to certain manners of death; for example, for suicide, NVDRS gathers information on history of self-harm and suicidal thoughts or plans, among other topics.

With the goal of educating the community and informing policymakers, NVDRS combines into one program various de-identified data received from the following sources: death record data; reports from law enforcement; and reports from coroners or medical examiners (C/ME), including toxicology reports. Dr. Emer described the general process for collecting and importing the NVDRS data into the CDC's web-based system known as Secure Access Management Services (SAMS). For death certificate information, NVDRS receives data that has been coded by the National Center for Health Statistics and exports the data into the CDC's SAMS system. For reports from law enforcement and C/ME, DHS abstractors request such reports by analyzing which cases are considered violent deaths based on death certificates. Once received, abstractors review them and enter relevant data into the SAMS system.

Dr. Emer also briefly described the State Unintentional Drug Overdose Reporting System (SUDORS), a data collection program specific to overdoses that uses the same SAMS system. Like NVDRS, SUDORs relies on data from death certificates, law enforcement reports, and C/ME reports, with toxicology being an important data element in this context.

Next, Dr. Emer and Ms. Childs responded to a variety of questions from committee members relating to NVDRS and vital records more generally. In response to questions, they noted the following: (1) NVDRS can help public health and other stakeholders identify trends; (2) C/ME generally have one year to update a death record's cause of death that was originally marked as "pending" due to an ongoing investigation; (3) Wisconsin's timelines for submission of death record data is similar to one association's model law, though it can be difficult to enforce those timelines; (4) NVDRS abstractors are well-trained in identifying relevant data within narrative reports from C/ME and law enforcement reports, though a standardized form would help that process; (5) Wisconsin, along with most other states, sends its death record data to the CDC's National Center for Health Statistics for coding, meaning that professionals review the death record's cause-of-death information and apply the appropriate disease classification code; (6) communication and outreach with stakeholders, such as public health and C/ME, can be useful in determining how to present NVDRS data in a meaningful way; (7) NVDRS abstractors defer to C/ME and other experts on the content of their information; (8) NVDRS is not governed by state statute, but rather the data is collected pursuant to a national program in which Wisconsin has participated since 2004 as a condition of certain federal funds; (9) DHS requests NVDRS data from all counties, and most participate, though such participation is not required; and (10) while participation has increased in last five years, a significant majority of physicians continue to use a "fax attestation form" when certifying the cause and manner of natural deaths, rather

than submitting that information as an electronic user of State Vital Records Information System (SVRIS).

PRESENTATION BY THE WISCONSIN DEPARTMENT OF JUSTICE

Jay Yerges, Special Agent, Division of Criminal Investigation, Steve Wagner, Administrator, Division of Law Enforcement Services, and Stephanie Pederson, Curriculum Staff, Training and Standards Bureau, Division of Law Enforcement Services

Mr. Wagner introduced himself, described his law enforcement background and current roles at DOJ, and introduced the panel of DOJ representatives presenting to the committee. Materials referenced during DOJ's presentation will be available on the committee's website.

Special Agent Yerges currently serves as a senior special agent with DOJ's Department of Criminal Investigation (DCI), which assists in investigations of certain deaths, such as homicides and suicides. He explained the importance of performing death investigations both timely and methodically, which requires exceptional training. To that end, DCI hosts an annual 80-hour course for death investigators across the state, which costs $200 per person. Last month, DCI hosted its 75th offering of the course, with 64 investigators in attendance. In the past, the course was offered twice annually, but due to costs and other logistics, the course is now offered once annually with a target participant size of 50 to 55 students. Admission is competitive and commonly waitlisted.

Beyond DCI's training, Special Agent Yerges also described a four-day death investigation symposium hosted each April by the Wisconsin Association of Homicide Investigators. The course is open to all certified law enforcement officers serving as death investigators and typically features nationally-recognized experts on certain topics to provide training.

From a death investigator's perspective, Special Agent Yerges views uniform death reporting standards as essential. When teaching about "equivocal deaths" at DCI's training, he obtains statistical data from DHS on leading causes of death, which he believes to be important to quality death investigations, though he noted that the delay in data availability reduces its relevance. Relatedly, he noted that officer suicides have increased in the last calendar year, including among higher-ranking officers.

Given her role of developing police academy curriculum, Ms. Pederson then explained death investigation training received by new recruits as part of the training academy curriculum. Out of the required 720 hours of academy training, eight hours are devoted to evidence collection, in which new recruits are trained to secure the scene, protect the evidence, and contact a supervisor or investigator. Recruits are also trained on proper techniques for notifying family members of a death.

She noted that academy curriculum is designed to focus on an officer's first five years of service, and death investigations are not commonly assigned to new officers. Officers that specialize in death investigations typically obtain additional training on that topic, such as the DCI course, which may count towards an officer's 24 hours of annual training required by state law. While the statutes require a portion of those 24 hours be devoted to specific topics, an officer's employing agency determines the content of the remaining training hours, which allows flexibility for training that supports an officer's specialty or the agency's priorities. Ms. Pederson noted that requiring additional topics as part of the 24 hours could impede on that flexibility and, depending on the required topic, may not apply to an officer's specialized role.

Special Agent Yerges and Ms. Pederson then responded to a variety of questions from committee members regarding law enforcement's role in death investigations, data collection, and suicide

prevention. In response to questions, they noted the following: (1) though law enforcement interacts with funeral directors for certain purposes, law enforcement works most closely with district attorneys, C/ME, and pathologists when investigating a death; (2) the state reimburses law enforcement agencies $160 per officer annually for expenses related recertification training; (3) DCI's death investigation course does not include content on prevention, though the recruit academy curriculum does include 22 hours of crisis management training, which includes suicide prevention, and four hours on officer suicide prevention, and more advanced officers have the option to attend a 40-hour crisis intervention training program; (4) report writing is taught in recruit academy, and narrative reports are necessary to document evidence to support a district attorney's criminal prosecution; (5) a partnership with public health could support the creation of a checklist or guide similar to others already used by law enforcement to assist officers in documenting aspects in the death investigations that would be useful to public health, but all agencies use different software programs so a standardized form or interface could be difficult or costly; (6) officer wellness initiatives, such as peer support groups or teams, are becoming more widely used and are now a topic of discussion at academy and among mid- to upper-level officers; (7) C/ME and district attorneys may attend DCI's death investigation training, as the waitlist permits, or could seek a similar training in a mini-course format at a C/ME conference; and (8) while C/ME and law enforcement work closely in death investigations, their roles are distinct and with different objectives, with a C/ME focusing on "what" and "how" a death occurred, and law enforcement focusing on "who" caused the death and "why."

DISCUSSION OF COMMITTEE ASSIGNMENT

Chair Ballweg explained that the remainder of the meeting would be devoted to discussion of topics that committee members are interested in addressing with legislation. Specifically, the goal would be to determine which topics to request be prepared in the form of a bill draft for committee review at the next meeting. She reminded the committee of the study committee process, in that the study committee will ultimately report its legislative recommendations to the Joint Legislative Council, a legislative committee that will vote on whether to introduce those recommendations as legislation in the 2023-24 Legislative Session. Upon introduction, the legislation will be subject to the regular legislative process.

At Chair Ballweg's request, Legislative Council committee staff provided an overview of Legislative Council Memo No. 3, *Options for Committee Consideration* (October 10, 2022), which compiles background information and options that have arisen in presentations to the committee, as well as committee discussion. Following that overview, Chair Ballweg and Legislative Council committee staff facilitated discussion on the memo's options, as organized by subject matter categories.

Types of Data Collected by State Vital Records System

Ms. Otis provided background information on the current data collected by the state vital records office for death records, which generally mirrors the data fields provided on a form published by the CDC, the federal agency responsible for national vital statistics. Committee members discussed the general purpose of death records, and whether expanding the data collected for vital statistics provides value from a public health perspective, as compared to the purpose and scope of other data systems beyond vital records. Committee members expressed interest in expanding the death record to, for example, allow for more than one occupation to be listed for a decedent or specify whether substance use contributed to the death. Committee members requested information regarding the ramifications of expanding death record data to include fields beyond those currently collected by the CDC.

Method of Collecting of State Vital Records Information

Ms. Otis provided background information on the options identified at previous meetings relating to ways in which data is collected for death record purposes. Committee members expressed support for SVRIS to have the ability to receive information from other governmental agencies that may have information relevant to specific death record data fields, such as the decedent's occupation or history of service in the armed forces. The committee generally discussed that families can often provide this information accurately, though collaboration among governmental agencies would be useful in those circumstances in which the funeral director, or other filing party of the death record, is unable to receive accurate information from the decedent's family. The committee requested additional information on this issue.

Medical Certification of Cause and Manner of Death

Ms. Otis provided background information on the current role of a physician or C/ME in certifying the cause and manner of death as part of the procedure for filing a death record. Committee discussion focused on the manner in which certifiers determine and document the cause and manner of death, as well as the methods by which certifiers submit their determinations.

Committee members expressed support for requiring physicians to receive training on how to properly certify cause and manner of death, and further discussed whether any such training should also apply to C/ME, given that those professionals make the same determination regarding cause and manner of death, despite the possibility of having different educational backgrounds. Some members discussed the possibility of other tools beyond training, such as checklists, that could support better uniformity among C/ME investigations and certifications.

Several committee members also noted the issue of deaths not being reported to C/ME, despite meeting the statutory standard for C/ME jurisdiction. Committee members generally supported the notion that any physician training also address the types of death that must be reported to C/ME. The committee discussed the current practice by some hospitals to notify the C/ME of any death that occurs within 24 hours of the patient's arrival to the hospital to determine whether the C/ME should take jurisdiction of the case, which reduces the likelihood that a C/ME will be required to take those cases later in the timeline required for submission of the medical certification.

With respect to the method for submitting medical certifications, committee members expressed interest in requiring all certifiers to submit the medical certification electronically using SVRIS. The committee discussed that all funeral directors and C/ME are electronic users of SVRIS, and some noted the statistics provided by DHS earlier in the meeting regarding the percentage of physicians continuing to use the fax attestation form. Members noted that electronic filing reduces error, increases timeliness, and could assist in determining which cases should be certified by C/ME rather than a physician.

Suicide Investigation Form

Ms. McGraw summarized the testimony provided at previous meetings regarding some jurisdictions' use of data collection methods beyond vital statistics, such as the use of suicide investigation forms to gather data from families to better inform prevention efforts. Some committee members expressed support for requiring use of the form in all counties, while others noted that the form is a useful tool to guide fatality review discussion.

The committee's discussion centered on which type of professional should be communicating with families to complete the form. Some members viewed C/ME as an appropriate role for this purpose due

to involvement with families at the scene, though others disagreed, citing the C/ME's requirement to provide a neutral determination of cause of death. One member noted the unwillingness of law enforcement in her home county to complete the form, while others inquired whether the form could be incorporated into the documents already used by law enforcement. Other members discussed the possibility of tying completion of the form to the work of a fatality review team. The committee also generally discussed the rapport that funeral directors build with families, making them a natural fit to interview willing families and submit the completed form to a fatality review team.

Fatality Review Teams

Ms. Otis provided background information regarding fatality review teams. The committee discussed the need to clarify the authority of fatality review teams to access records and maintain confidentiality of their meetings. The committee expressed support for creating a state statute governing fatality review teams in a manner codifying current practice, which generally allows counties to determine which type, if any, the county would like to create, based on local preferences and capacity.

Other Discussion

Throughout, and at the close of, the discussion portion of the meeting, Chair Ballweg directed Legislative Council committee staff to identify the areas of consensus for bill development. After the committee concluded discussion on the topics identified in Memo No. 3, Chair Ballweg welcomed other ideas from committee members, and encouraged members to contact her personal staff, or Legislative Council committee staff, if members have additional ideas before the next meeting. Chair Ballweg reminded members that their next meeting is Tuesday, November 15, and that Legislative Council committee staff will be preparing bill drafts for the committee's review at that meeting.

ADJOURNMENT

The meeting adjourned at 3:10 p.m.

AO:ksm