State of Wisconsin
2023 - 2024 LEGISLATURE

LRB-0521/P2
SWB:skw

PRELIMINARY DRAFT - NOT READY FOR INTRODUCTION

AN ACT ***to amend*** 48.396 (1), 48.396 (2) (a), 48.78 (2) (a), 48.981 (7) (a) 15., 938.396 (1) (a), 938.396 (2) (a) and 938.78 (2) (a); and ***to create*** 51.30 (4) (b) 29., 146.82 (2) (d), 250.22 and 961.385 (2) (cm) 5. of the statutes; **relating to:** fatality review teams and granting rule-making authority.

Analysis by the Legislative Reference Bureau

This bill is explained in the NOTES provided by the Joint Legislative Council in the bill.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

JOINT LEGISLATIVE COUNCIL PREFATORY NOTE: This bill was prepared for the Joint Legislative Council Study Committee on Uniform Death Reporting Standards.

Current law does not address fatality review teams, though several types of such teams currently exist in Wisconsin based on voluntary efforts primarily organized by counties, with state-level technical assistance available for certain types of teams.

The bill establishes fatality review teams under state law, and generally governs a fatality review team's responsibilities, ability to access certain records, requirements related to confidentially and disclosure of information. Under the bill, the Department of Health Services (DHS) is generally required to establish a fatality review program comprised of a state fatality review team, and local fatality review teams established at the option of a county, a local health department, or a combination of counties or local health departments.

Fatality Review Team Program

Under the bill, a fatality review team is a multidisciplinary and multiagency team reviewing one or more types of unexpected death among children and adults and developing recommendations to prevent future deaths of similar circumstances. The bill identifies examples of the types of deaths that may constitute an unexpected death, including those caused by unintentional injury, suicide, and homicide, among other causes.

The bill contains general provisions governing all types of fatality review teams. Under the bill, state and local fatality review teams have the purpose of gathering information about unexpected deaths to examine risk factors and understand how deaths may be prevented, through identifying recommendations for cross–sector, system–level policy and practice changes, and promoting cooperation and coordination among the agencies involved in understanding causes of unexpected deaths or in providing services to surviving family members.

If established, each fatality review team must: (1) establish and implement team protocols; (2) collect and maintain data as requested by DHS or its contracted agency; (3) create strategies and track implementation of prevention recommendations; and (4) evaluate the team's process, interagency collaboration, and implementation of recommendations. Teams must enter data regarding each unexpected death under review into a secure database.

Record Access and Confidentiality

The bill authorizes a fatality review team to access records from a variety of sources, such as certain state agencies, law enforcement, medical examiners and coroners, health care providers, human service agencies, and schools, among others, subject to certain restrictions under the bill and current law. Information and records provided to or created by a fatality review team are confidential, subject to limited exceptions provided under the bill, and are not subject to Wisconsin's public records laws. The bill requires DHS or its contracted agency to create a confidentiality agreement for use by fatality review teams, and further requires team members, and other individuals invited to attend a team meeting, to sign a copy of that agreement before participating in, or attending, a review of an unexpected death. The bill exempts fatality review team meetings from Wisconsin's open meetings law. However, the bill allows for public meetings to share summary findings and recommendations, but limits the types of information that may be disclosed in public meetings.

The bill prohibits team members, persons in attendance at team meetings, and others providing records to teams from testifying in any civil or criminal actions as to the information specifically obtained through participation in the fatality review team's meeting. The bill authorizes disclosure of information if such disclosure serves a team's purpose and certain other conditions are met, such as the information does not allow for identification of individuals and does not contain conclusory information attributing fault, with the exception of certain findings or judgments.

The bill further specifies that a team's information and records are not subject to discovery or subpoena, or admissible as evidence, in a civil or criminal action or administrative proceeding, unless obtained independently from a team's review. The bill also provides that a person participating in a fatality review team is immune from civil or criminal liability for any good faith act or omission in connection with providing information or recommendations.

Specific Types of Fatality Review Teams

In addition to the bill's general provisions governing all types of fatality review teams, the bill contains specialized provisions that apply to specific types of fatality review teams, if established. Specifically, the bill addresses the following types of fatality review teams: (1) child death review teams; (2) fetal infant mortality review teams; (3) overdose fatality review teams; and (4) suicide review teams.

Child Death Review Teams

A child death review team reviews unexpected deaths of infants, children, and adults up to the age of 25, and identifies risk factors and circumstances surrounding such deaths to identify prevention opportunities. The bill requires team members be drawn from various entities and areas of expertise, to the extent available, such as public health, law enforcement and emergency personnel, medical examiners and coroners, health professionals, education professionals, and the district attorney, along with any other member requested by the team.

With respect to child death review teams, the bill requires DHS, in coordination with the Department of Justice (DOJ) and the Department of Children and Families (DCF) to do all of the following: facilitate local team development; identify training needs and make available training resources; provide technical assistance and support; assign review of deaths to a state fatality review team upon request or in the absence of a local team; educate the public on causes and recommendations for prevention of child deaths; and provide information to the legislature, state agencies, and communities on the need for modifications to law, policy, or practice.

Fetal Infant Mortality Review Teams

A fetal infant mortality review team reviews stillborn deaths with a birth weight of 350 grams or more, or 20 weeks gestation, and infants who die suddenly and unexpectedly before one year of age, and identifies the risk factors and circumstances surrounding infant and stillborn deaths in order to identify prevention opportunities. The bill requires team members to reflect a broad community representation of those who have an interest in, or the ability to affect, infant mortality, and be drawn from various entities and areas of expertise, such as public health, health systems, medical and academic professionals, community agencies, and health maintenance organizations, along with any other member requested by the team. The bill requires fetal infant mortality review teams to perform a de–identified review, in which only one person knows the decedent's name and birth date, and is tasked with collecting information from multiple sources, such as vital records, medical records and a maternal interview, and summarizing such information for team review.

With respect to fetal infant mortality death review teams, the bill requires DHS, in coordination with DOJ and DCF, to do all of the following: facilitate local team development; identify training needs and make available training resources; provide technical assistance and support; educate the public on causes and recommendations for prevention of fetal and infant deaths; and provide information to the legislature, state agencies, and communities on the need for modifications to law, policy, or practice.

Overdose Fatality Review Teams

An overdose fatality review team reviews deaths of individuals 18 years of age or older whose death resulted from a drug overdose and the manner of death is determined to be an accident or undetermined, and identifies risk factors and develops policy and program recommendations to prevent future overdose fatalities. The bill requires team members be drawn from various entities and areas of expertise, to the extent available, such as public health, tribal health centers, law enforcement and emergency personnel, medical examiners and coroners, the Department of Corrections (DOC), medical professionals, individuals with personal experience relating to overdoses or overdose deaths, along with any other member requested by the team. In addition to records available to all fatality review teams, the bill authorizes an overdose fatality review team to obtain records from the state's prescription drug monitoring program.

With respect to overdose fatality review teams, the bill requires DHS, in coordination with DOJ, to review issues regarding causes and circumstances of fatal overdoses and receive recommendations from local teams; provide information on potential modifications to law, policy, or practice to prevent future deaths; and educate the public regarding overdose death trends, including policy changes or actions to prevent future deaths; and identify areas for further data inquiry and analysis.

Suicide Review Teams

A suicide review team reviews deaths of individuals 18 years of age or older whose manner of death is determined to be suicide, and identifies risk factors and develops policy and program recommendations to prevent future suicides. The bill requires team members be drawn from various entities and areas of expertise, to the extent available, such as public health, tribal health centers, law enforcement and emergency personnel, medical examiners and coroners, DOC, medical professionals, schools, crisis centers, chamber of commerce members and employers, and individuals with personal experience relating to suicide, along with any other member requested by the team. In addition to records available to all fatality review teams, the bill authorizes a suicide review team to obtain records from the state's prescription drug monitoring program.

Under the bill, DHS must promulgate administrative rules to develop and implement a standardized suicide investigation form for use by suicide review teams, and further directs suicide review teams to assign a team member to complete that form when reviewing specific fatalities. The bill also requires DHS to receive recommendations from local suicide teams and provide updates to the steering committee of Prevent Suicide Wisconsin.

SECTION 1. 48.396 (1) of the statutes is amended to read:

48.396 **(1)** Law enforcement officers' records of children shall be kept separate from records of adults. Law enforcement officers' records of the adult expectant mothers of unborn children shall be kept separate from records of other adults. Law enforcement officers' records of children and the adult expectant mothers of unborn children shall not be open to inspection or their contents disclosed except under sub. (1b), (1d), (5), or (6) or s. 48.293 ~~or~~, 250.22, or 938.396 (2m) (c) 1p. or by order of the court. This subsection does not apply to the representatives of newspapers or other reporters of news who wish to obtain information for the purpose of reporting news without revealing the identity of the child or adult expectant mother involved, to the confidential exchange of information between the police and officials of the public or private school attended by the child or other law enforcement or social welfare agencies, or to children 10 years of age or older who are subject to the jurisdiction of the court of criminal jurisdiction. A public school official who obtains information under this subsection shall keep the information confidential as required under s. 118.125, and a private school official who obtains information under this subsection shall keep the information confidential in the same manner as is required of a public

school official under s. 118.125. This subsection does not apply to the confidential exchange of information between the police and officials of the tribal school attended by the child if the police determine that enforceable protections are provided by a tribal school policy or tribal law that requires tribal school officials to keep the information confidential in a manner at least as stringent as is required of a public school official under s. 118.125. A law enforcement agency that obtains information under this subsection shall keep the information confidential as required under this subsection and s. 938.396 (1) (a). A social welfare agency that obtains information under this subsection shall keep the information confidential as required under ss. 48.78 and 938.78.

SECTION 2. 48.396 (2) (a) of the statutes is amended to read:

48.396 **(2)** (a) Records of the court assigned to exercise jurisdiction under this chapter and ch. 938 and of courts exercising jurisdiction under s. 48.16 shall be entered in books or deposited in files kept for that purpose only. Those records shall not be open to inspection or their contents disclosed except by order of the court assigned to exercise jurisdiction under this chapter and ch. 938 or as required or permitted under this subsection, sub. (3) (b) or (c) 1g., 1m., or 1r. or (6), or s. 48.375 (7) (e) or 250.22.

SECTION 3. 48.78 (2) (a) of the statutes is amended to read:

48.78 **(2)** (a) No agency may make available for inspection or disclose the contents of any record kept or information received about an individual who is or was in its care or legal custody, except as provided under sub. (2m) or s. 48.371, 48.38 (5) (b) or (d) or (5m) (d), 48.396 (3) (bm) or (c) 1r., 48.432, 48.433, 48.48 (17) (bm), 48.57 (2m), 48.66 (6), 48.93, 48.981 (7), 250.22, 938.396 (2m) (c) 1r., 938.51, or 938.78 or by order of the court.

SECTION 4. 48.981 (7) (a) 15. of the statutes is amended to read:

48.981 **(7)** (a) 15. A fatality review team established under s. 250.22, a child fatality review team recognized by the county department, or, in a county having a population of 750,000 or more, the department or a licensed child welfare agency under contract with the department.

SECTION 5. 51.30 (4) (b) 29. of the statutes is created to read:

51.30 **(4)** (b) 29. To an authorized member of a fatality review team established under s. 250.22. The recipient of any treatment records under this subdivision shall keep the records confidential in accordance with s. 250.22.

SECTION 6. 146.82 (2) (d) of the statutes is created to read:

146.82 **(2)** (d) Notwithstanding sub. (1), patient health care records shall be released, upon request, to a fatality review team, as defined in s. 250.22 (1) (a), acting as a public health authority for the purpose of reviewing a death as described under s. 250.22. Records required to be released under this paragraph for the public health purposes under s. 250.22 may be disclosed to a fatality review team only in accordance with that section, and the recipient of any records released shall keep the records confidential.

SECTION 7. 250.22 of the statutes is created to read:

250.22 Fatality review teams. (1) In this section:

(a) "Fatality review team" means a multidisciplinary and multiagency team reviewing one or more types of unexpected death among children and adults and developing recommendations to prevent future deaths of similar circumstances.

(b) "De–identified review" means a review in which a fatality review team is not provided information that would link the unexpected death being reviewed to a specific individual.

(c) "Local fatality review team" means a fatality review team that reviews unexpected deaths from a specific county or counties. A "local fatality review team" may include a team formed by a collaboration of two or more counties or local health departments.

(d) "State fatality review team" means a fatality review team that reviews unexpected deaths of residents across the state.

(e) "Unexpected death" includes a death for which any of the following has been determined to be the cause of death:

1. Undetermined.

2. Unintentional injury.

3. Suicide.

4. Homicide.

5. Motor vehicle incident.

6. Child abuse or neglect.

7. Sudden unexpected death.

8. Stillbirth.

9. Fetal death or infant death.

****NOTE: Because fatality review teams review "unexpected deaths," the types of unexpected deaths above provide a non–exhaustive list of which deaths are reviewable by the teams. Does this list reflect the types of deaths the committee intends to be reviewed by fatality review teams?

(2) (a) The department shall establish a fatality review program comprised of a state fatality review team and local fatality review teams established at the option of a county, a local health department, or a combination of counties or local health departments. The state and local teams shall have the purpose of gathering information concerning unexpected deaths to examine the risk factors and

circumstances leading to unexpected deaths and understand how the deaths could have been prevented through all of the following:

1. Identification of recommendations for cross–sector, system–level policy and practice changes to address the identified risk factors and prevent future unexpected deaths.

2. Promotion of cooperation and coordination among agencies involved in understanding the causes of unexpected deaths or in providing services to surviving family members.

(b) The department may enter into a contract with an entity to perform any of the department's duties under this section.

(c) 1. If established, each fatality review team shall do all of the following:

a. In consultation with the department or its contracted entity, establish and implement a protocol for the fatality review team.

b. Collect and maintain data as requested by the department or its contracted entity.

c. Create strategies and make and track the implementation of recommendations for the prevention and reduction of unexpected deaths in the area served by the fatality review team.

d. Evaluate the team's review process, interagency collaboration, and development and implementation of recommendations to ensure adherence to the purpose of the program described in sub. (2) (a).

****NOTE: Paragraph (b) requires fatality review teams to engage in various activities in consultation with the department, at the request of the department, or independently. Are these requirements consistent with the committee's intent?

2. A fatality review team may address an unexpected death that occurred in the area served by the fatality review team or that relates to a resident of the area

served by the fatality review team if the incident involved or death occurred elsewhere in the state.

(3) (a) When conducting a fatality review under this section, a fatality review team may be provided with information from the records held by any of the following, if the records pertain to a person or incident within the scope of the review:

1. The department of health services or a local health department.

2. The department of children and families.

3. A law enforcement agency.

4. A medical examiner or coroner.

5. A treatment provider for substance use or mental health.

6. A hospital or health care provider.

7. Emergency medical services, including a fire department.

8. A Women, Infants, and Children program under s. 253.06.

9. The department of corrections.

10. A district attorney's office.

11. A circuit or municipal court.

12. A social services agency.

13. Child protective services.

14. A school or university.

15. An agency or organization identified in subs. (5) to (8) necessitated by the specific review type.

****NOTE: A fatality review team may obtain information from records held by any of entities listed in paragraph (a), if the records pertain to a team's review. Is this consistent with the committee's intent?

(b) A fatality review team shall enter data regarding each unexpected death under review into a secure database designated by or in consultation with the department or its contracted entity.

(c) Information and records provided to or created by a fatality review team are confidential, except as otherwise provided in this section, and are not subject to inspection or copying under s. 19.35. The department or its contracted entity shall create and make available to fatality review teams a confidentiality agreement to be used by fatality review team members to ensure confidentiality consistent with this section. Before a member of a fatality review team may participate in the review of an unexpected death, the member must sign a copy of the confidentiality agreement and review the purpose and goals of the fatality review team. Any person who is invited to a fatality review team meeting must sign a confidentiality agreement before attending or participating in the meeting.

(d) Except as otherwise provided in this section, a member of a fatality review team may share information disclosed to the fatality review team regarding an unexpected death with other members of that fatality review team or with another fatality review team conducting a review of the same individual's death, except that the member may not distribute additional, printed copies of any information or record that is disclosed to him or her to other members of the member's fatality review team.

(e) Any person participating in the review of an unexpected death by a fatality review team, including any member of a fatality review team, a person attending a fatality review meeting, or a person who presents information to the fatality review team, and any person providing information or records to the fatality review team for the purpose of reviewing an unexpected death, may not testify in any civil or

criminal action as to the information specifically obtained through the person's participation in the fatality review team's meeting or to any conclusion of the fatality review team regarding an unexpected death. This paragraph does not prohibit a person from testifying to information that is obtained independently of a fatality review team or that is public information.

(f) A person who attends a fatality review team meeting or presents information to a fatality review team is not prohibited under par. (c) or (d) from disclosing information or records obtained independently of the review if that disclosure is otherwise permitted under state or federal law.

(g) 1. A fatality review team may disclose information if the disclosure is made for the purpose of fulfilling a purpose of the fatality review team and if the information meets all of the following criteria:

a. The information does not contain any information that identifies the names or identifying numbers of individuals and does not contain other information for which there is reasonable basis to believe that the information could be used to identify an individual or entity.

b. The information does not contain addresses other than zip codes.

c. The information does not contain dates of birth, death, or incident other than the year.

d. The information does not contain conclusory information attributing fault, not including findings or judgments by law enforcement agencies, courts, or child welfare agencies.

2. Any of the following items, if the item does not contain any information that would allow the identity of an individual to be ascertained, may be disclosed or treated as public information:

a. Statistical or aggregate compilations of data.

b. Reports from fatality review teams.

(h) Information and records provided or obtained in the course of a fatality review under this section are not subject to discovery or subpoena in a civil or criminal action or an administrative proceeding and are not admissible as evidence during the course of a civil or criminal action or an administrative proceeding, except that information and records obtained independently of a review under this section are not immune from discovery merely because the information or records were presented to a fatality review team.

(i) Any person participating in a fatality review team's meeting under this section is immune from any civil or criminal liability for any good faith act or omission in connection with providing information or recommendations relevant to review of an unexpected death to the fatality review team in accordance with this section or any conclusions or recommendations reached by the fatality review team made in good faith. The immunity granted under this paragraph applies to persons conducting the review as well as persons providing information or records to the fatality review team for the meeting. For the purpose of any civil or criminal action, any person participating in a review under this section is presumed to be acting in good faith.

****NOTE: Paragraphs (c) – (i) address the confidentiality of information presented at, or related to, fatality review teams. Are these provisions consistent with the committee's intent?

(4) (a) Meetings of a fatality review team shall be closed to the public and are not subject to subch. V of ch. 19. A fatality review team may hold a public meeting to share summary findings and recommendations of reviews by fatality review teams.

(b) During a public meeting under par. (a), no person may disclose information on or agency involvement with any of the following:

1. A deceased individual.

2. A family member, guardian, or caretaker of a deceased individual.

3. An individual convicted of a crime or adjudicated as having committed a delinquent act that caused a death or near fatality.

(c) This subsection does not prohibit a fatality review team from requesting the attendance at a team meeting of a person who has information relevant to the team's exercise of its purpose and duties, provided that any person attending the meeting sign the confidentiality form as described under sub. (3).

(5) (a) In this subsection, "child death review team" means a fatality review team that reviews the unexpected deaths of infants, children, and adults up to the age of 25.

(b) A child death review team may be established to identify the risk factors and circumstances surrounding child deaths in order to identify opportunities for prevention using data collected from unexpected death reviews.

(c) The department, in coordination with the department of justice and the department of children and families, shall do all of the following:

1. Facilitate the development of local child death review teams under this paragraph.

2. Identify training needs and make training resources available to local child death review teams, statewide professional organizations, advocacy groups, and others.

3. Respond to requests from local child death review teams and provide any necessary technical assistance and support.

4. Upon request of a local child death review team, or if a county does not have a child death review team, assign review of deaths to a state fatality review team. The department shall educate the public regarding the incidence and causes of child deaths, including recommendations that identify needed policy changes or action to prevent future deaths.

5. Provide information to the legislature, state agencies, and local communities on the need for modifications to law, policy, or practice.

6. Use prevention–focused data analysis to facilitate the actions in subds. 1. to 5.

(d) The members of a child death review team shall be drawn from the following types of individuals, organizations, agencies, and areas of expertise, to the extent available:

1. Public health.

2. Medical examiners and coroners.

3. Law enforcement.

4. Medical professionals, including physicians, physician assistants, and nurses.

5. Education professionals, including school counselors and school representatives.

6. Emergency medical responders, as defined in s. 256.01 (4p), or emergency medical services practitioners, as defined in s. 256.01 (5).

7. Behavioral health professionals.

8. The district attorney with jurisdiction, or his or her designee.

9. Any other person requested by members of the team.

(6) (a) In this subsection, "fetal infant mortality review team" means a fatality review team that reviews stillborn deaths with a birth weight of 350 grams or more, or 20 weeks gestation, and infants who die suddenly and unexpectedly before one year of age.

(b) A fetal infant mortality review team may be established to identify the risk factors and circumstances, including medical and social circumstances, surrounding infant and stillborn deaths in order to identify opportunities for prevention of future deaths.

(c) The department, in coordination with the department of justice and the department of children and families, shall do all of the following:

1. Facilitate the development of local fetal infant mortality review teams under this paragraph.

2. Identify training needs and make training resources available to local fetal infant mortality review teams, statewide professional organizations, advocacy groups, and others.

3. Respond to requests from local fetal infant mortality review teams and provide any necessary technical assistance and support.

4. Educate the public regarding the incidence and causes of fetal and infant deaths, including recommendations that identify needed policy changes or action to prevent future deaths.

5. Provide information to the legislature, state agencies, and local communities on the need for modifications to law, policy, or practice.

6. Use prevention–focused data analysis to facilitate the actions in subds. 1. to 5.

(d) A fetal infant mortality review team shall review deaths in a de–identified review in which only one person knows the name and birth date of the decedent and is tasked with collecting information from various sources, including from vital records, medical and social service records, and if possible, from a maternal interview. The person that collects the information shall summarize the information and present it for review by the fetal infant mortality review team to identify trends and make prevention recommendations for community action and system change.

(e) A fetal infant mortality review team shall consist of members that reflect a broad community representation of those who have an interest in, or have the ability to affect, infant mortality. The members shall be drawn from the following types of individuals, organizations, agencies, and areas of expertise, to the extent available:

1. Public health.

2. Health systems.

3. Medical professionals, including obstetricians or gynecologists, family physicians, physician assistants, and nurses.

4. Academic professionals.

5. Behavioral health professionals.

6. Community agencies.

7. Health maintenance organizations.

8. Any other person requested by members of the team.

(7) (a) In this subsection, "overdose fatality review team" means a fatality review team that reviews the deaths of individuals 18 years of age or older whose death resulted from a drug overdose and the manner of death is determined to be an accident or undetermined.

(b) An overdose fatality review team may be established to identify risk factors and develop policy and program recommendations to prevent future overdose fatalities.

(c) The department, in coordination with the department of justice, shall do all of the following:

1. Review issues regarding causes and circumstances of fatal overdoses and receive recommendations from local overdose fatality review teams.

2. Provide information on potential modifications to law, policy, or practice to prevent future deaths.

3. Educate the public regarding the incidence and trends among overdose deaths, including policy changes or actions to prevent future deaths.

4. Identify areas for further data inquiry and analysis.

(d) In addition to other records available to fatality review teams, an overdose fatality review team may obtain prescription drug monitoring program records.

(e) The members of an overdose fatality review team shall be drawn from the following types of individuals, organizations, agencies, and areas of expertise, to the extent available:

1. Public health.

2. Tribal health centers.

3. Medical examiners and coroners.

4. Emergency medical responders, as defined in s. 256.01 (4p), or emergency medical services practitioners, as defined in s. 256.01 (5).

5. Law enforcement.

6. The department of corrections.

7. The district attorney with jurisdiction, or his or her designee.

8. Medical professionals, including physicians, physicians assistants, and nurses.

9. Behavioral health professionals.

10. Individuals with professional experience relating to drug treatment.

11. Individuals with personal experience relating to overdoses or overdose deaths.

12. Any other person requested by members of the team.

(8) (a) In this subsection, "suicide review team" means a fatality review team that reviews the deaths of individuals 18 years of age or older whose manner of death is determined to be suicide.

(b) A suicide review team may be established to identify risk factors and develop policy and program recommendations to prevent future suicides.

(c) The department shall receive recommendations from suicide review teams and provide updates to the steering committee of Prevent Suicide Wisconsin.

(d) In addition to other records available to a fatality review team, a suicide review team may obtain prescription drug monitoring program records.

(e) If established, the members of a suicide review team shall be drawn from the following types of individuals, organizations, agencies, and areas of expertise, to the extent available:

1. Public health.

2. Tribal health centers.

3. Medical examiners and coroners.

4. Emergency medical responders, as defined in s. 256.01 (4p), or emergency medical services practitioners, as defined in s. 256.01 (5).

5. Law enforcement.

6. The department of corrections.

7. The district attorney with jurisdiction, or his or her designee.

8. Medical professionals, including physicians, physicians assistants, and nurses.

9. Behavioral health professionals.

10. Individuals with professional experience relating to drug treatment.

11. Chamber of commerce members and employers.

12. Representatives of schools and universities.

13. Crisis centers.

14. Individuals with personal experience relating to suicide.

15. Any other person requested by members of the team.

(f) 1. The department shall promulgate rules to develop and implement a standardized suicide investigation form for use by suicide review teams.

2. A suicide review team shall assign a member of the team to complete the form described in this paragraph for unexpected deaths identified for review in which the manner of the individual's death has been determined to be the result of suicide.

SECTION 8. 938.396 (1) (a) of the statutes is amended to read:

938.396 **(1)** (a) *Confidentiality.* Law enforcement agency records of juveniles shall be kept separate from records of adults. Law enforcement agency records of juveniles may not be open to inspection or their contents disclosed except under par. (b) or (c), sub. (1j), (2m) (c) 1p., or (10), or s. 250.22 or 938.293 or by order of the court.

SECTION 9. 938.396 (2) (a) of the statutes is amended to read:

938.396 **(2)** (a) Records of the court assigned to exercise jurisdiction under this chapter and ch. 48 and of municipal courts exercising jurisdiction under s. 938.17 (2) shall be entered in books or deposited in files kept for that purpose only. Those

records shall not be open to inspection or their contents disclosed except by order of the court assigned to exercise jurisdiction under this chapter and ch. 48 or as required or permitted under sub. (2g), (2m) (b) or (c), or (10) or s. 250.22.

SECTION 10. 938.78 (2) (a) of the statutes is amended to read:

938.78 **(2)** (a) No agency may make available for inspection or disclose the contents of any record kept or information received about an individual who is or was in its care or legal custody, except as provided under sub. (2m) or (3) or s. 48.396 (3) (bm) or (c) 1r., 250.22, 938.371, 938.38 (5) (b) or (d) or (5m) (d), 938.396 (2m) (c) 1r., 938.51, or 938.57 (2m) or by order of the court.

SECTION 11. 961.385 (2) (cm) 5. of the statutes is created to read:

961.385 **(2)** (cm) 5. An overdose fatality review team under s. 250.22 (7) (d) or a suicide review team under s. 250.22 (8) (d).

SECTION 12. Effective date.

(1) This act takes effect on the first day of the 7th month beginning after publication.

****NOTE: This version of the draft includes a placeholder for a delayed effective date. Please let us know if you would like to change the date or eliminate the delayed date.

(END)