Wisconsin Legislative Council
COMMITTEE RECOMMENDATIONS

STUDY COMMITTEE ON
UNIFORM DEATH REPORTING STANDARDS

Prepared by Amber Otis, Senior Staff Attorney, and
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CR-2023-02

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 document summarizes committee activity and presents study committee recommendations to the Joint Legislative Council.

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PART I | EXECUTIVE SUMMARY

The Study Committee on the Uniform Death Reporting Standards, chaired by Senator Joan Ballweg, was created in the 2022 interim and tasked with reviewing the current protocols for investigating causes of death and reporting deaths, as well as options to implement more comprehensive uniform death reporting standards across Wisconsin. The study committee completed its assignment in December 2022 and recommends six bill drafts for introduction during the 2023-24 legislative session.

BACKGROUND

Wisconsin's death reporting system relies on information from various actors, such as funeral directors, physicians, and county coroners or medical examiners, all of whom may 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 publicly available as vital statistics.

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 that certain types of deaths 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.

Discussions have arisen in recent legislative sessions regarding the uniformity of information included in a death record, as well as the manner in which that information is submitted to DHS. Beyond death records and vital statistics, many counties in Wisconsin are creating mechanisms, such as fatality review teams and standardized forms, to gather more comprehensive data on certain kinds of deaths, particularly suicides, with the goal of assisting stakeholders in understanding risk factors to better inform preventative efforts.

STUDY COMMITTEE'S MEETINGS AND RECOMMENDATIONS

The study committee met five times throughout the summer and fall of 2022, and heard testimony from DHS, medical examiners, law enforcement, funeral directors, groups advocating for issues relating to child health and mental health, and national and state public health personnel specializing in data collection. The committee discussed numerous policy options, weighing the need for uniform data against the burdens associated with additional requirements imposed on stakeholders. The committee also analyzed the utility of using a multi-disciplinary approach to studying deaths in order to support public health initiatives. Part II provides a summary of the testimony and committee discussion at each meeting.

In concluding its work, the committee recommends that the Joint Legislative Council introduce the following six bill drafts, with Part III describing their provisions in more detail:

- LRB-0460/1, relating to providing additional information fields regarding occupation on death records.

- LRB-0523/1, relating to requiring use of the electronic system of vital records for medical certifications of death.
- LRB-0458/1, relating to requiring notification to the medical examiner or coroner of any death that occurs within 24 hours of presentment at or admission to certain facilities.
- LRB-0524/1, relating to requiring DHS to establish and encourage best practices for coroners and medical examiners.
- LRB-0555/1, relating to recommended training for persons who complete and sign medical certifications of death.
- LRB-0521/1, relating to fatality review teams and granting rule-making authority.

PART II | COMMITTEE ACTIVITY

The Joint Legislative Council established the Study Committee on Uniform Death Reporting Standards and appointed the chairperson by a mail ballot dated April 8, 2022. The study committee was directed to review the current protocols for investigating causes of death and reporting death, and the uniformity of those protocols, with a focus on 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 was tasked with developing 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 assist in completing this charge, the Joint Legislative Council appointed the study committee's membership by mail ballot dated May 31, 2022. The final committee membership consisted of two senators, two representatives, and seven public members. **Appendix 1** lists the committee members.

SUMMARY OF MEETINGS

The study committee held five meetings on the following dates at the State Capitol in Madison:

- July 18, 2022.
- August 17, 2022.
- October 17, 2022.
- November 15, 2022.
- December 15, 2022.

July 18, 2022

At its first meeting on July 18, 2022, the committee received an overview of background information by Legislative Council staff and invited testimony from several speakers.

Amber Otis, Senior Staff Attorney, and **Kelly McGraw**, Staff Attorney, Legislative Council staff, provided an overview of state and federal law relevant to the committee's scope, as provided in the Legislative Council Staff Brief 2022-01, *Study Committee on Uniform Death Reporting Standards* (July 11, 2022).

Lynette Childs, State Registrar at the State Vital Records Office, DHS, provided an overview of the statutes governing, and core functions of, the office of vital records. 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 and manner-of-death information. Once the death is medically certified, the funeral director routes the death record to the local office of vital records. The local office of vital records accepts the death record and it is then registered with the state office of vital records. The state office of vital records has limited oversight on the determination of cause and manner of death. Death investigations are a function of county coroner and medical examiner offices, meaning oversight of investigation standards and policies occurs at a county level.

Sarah Bassing-Sutton, Community Suicide Prevention Coordinator at N.E.W. Mental Health Connection, provided testimony regarding how the lack of standardized reporting or investigative tools hampers death prevention efforts. She outlined her work in creating a Suicide

Investigation Form, a ready-to-use tool that guides a coroner or medical examiner in gathering comprehensive information that can help identify risk factors.

On behalf of Children's Health Alliance of Wisconsin, **Karen Nash**, Program Leader of Injury Prevention and Death Review, and **Karen Ordinans**, Former Executive Director, presented information on child death review teams. Though a voluntary endeavor, 45 child death review teams currently exist in Wisconsin. Child death review teams meet regularly in a confidential setting to review individual unexpected child deaths. Teams complete a data form about the incident and send the data form to the National Center for Fatality Review & Prevention.

Dr. Adam Covach, M.D., Chief Medical Examiner of Fond du Lac County, 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. Dr. Covach noted that medical professionals receive little, if any, training on how to properly complete a death record.

Following the invited testimony, committee members generally 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. Chair Ballweg noted that the committee's primary goal is to provide a uniform means of reporting so that data can be used to identify trends to inform future prevention strategies.

August 17, 2022

At the meeting on August 17, 2022, Legislative Council staff provided an overview of Memo No. 1, *Information in Response to Committee Requests at July 18, 2022 Meeting* (August 10, 2022). The committee then received testimony from invited speakers.

On behalf of Wisconsin Coroners and Medical Examiners Association (WCMEA), **Dr. Agnieszka Rogalska**, M.D., Chief Medical Examiner, Dane County Medical Examiner's Office, and Acting President, WCMEA, provided information on WCMEA's role in death investigation training. Dr. Rogalska testified that WCMEA educates people who conduct medicolegal death investigations primarily through conferences and printed materials on best practices.

James Klemmer, on behalf of the Wisconsin Funeral Directors Association, and **Nicole R. Krause**, on behalf of the Funeral Service & Cremation Alliance of Wisconsin, presented information on a funeral director's role in creating death records. They discussed how funeral directors acquire information on the cause and manner of death from a medical examiner, coroner, or physician.

On behalf of the National Center for Fatality Review & Prevention (NCFRP), **Heather Dykstra**, Senior Data Analyst, and **Susanna Joy**, Project Coordinator, presented information on NCFRP's efforts to collect data generated from different sources and make it available to develop prevention strategies. They stated that common barriers to death review teams include funding, access to records, and standardization of death scene investigations.

Kate Jankovsky, Childhood Adversity Prevention Manager, Colorado Department of Public Health and Environment, provided testimony regarding Colorado's suicide investigation form, which was implemented to leverage death scene investigator expertise.

Michael J. Staley, Ph.D., Psychological Autopsy Examiner and Suicide Prevention Research Coordinator, Office of the Medical Examiner, Utah Department of Health and Human Services, presented information on Utah's death investigation process. He explained that he conducts

next-of-kin interviews with a team of graduate students and medical residents, and also produces a timely internal report of recent suicide data for stakeholders.

Following the invited testimony, committee members discussed the need for state infrastructure to support efforts to collect and maintain such data. Committee members discussed the role of law enforcement in death investigations and death review teams' ability to access to records. Some committee members raised a concern regarding the impact of fax machine use on data accuracy in death records. Chair Ballweg explained that the study committee does not intend to change the manner in which counties determine whether to have a coroner or a medical examiner system.

October 17, 2022

At the meeting on October 17, 2022, Legislative Council staff provided an overview of Memo No. 2, *Information in Response to Committee Requests at August 17, 2022 Meeting* (October 10, 2022). The committee then received testimony from invited speakers.

Lindsay Emer, Ph.D., National Violent Death Records System (NVDRS) Coordinator, DHS, provided an overview of NVDRS, a violent death data collection program that gathers de-identified contextual data from all states. NVDRS receives data from various sources including death certificate information and law enforcement reports.

On behalf of the Wisconsin Department of Justice, **Jay Yerges**, Special Agent, Division of Criminal Investigation (DCI), and **Stephanie Pederson**, Curriculum Staff, Training and Standards Bureau, Division of Law Enforcement Services, provided an overview of law enforcement death investigation training course. Special Agent Yerges provided an overview of DCI's specialized death investigation training. Ms. Pederson presented information on new recruit training regarding death investigation. Eight hours of training focus on evidence collection, in which new recruits are trained to secure the scene, protect the evidence, and contact a supervisor or investigator.

Following the invited testimony, Legislative Council staff provided an overview of Legislative Council Memo No. 3, *Options for Committee Consideration* (October 10, 2022), noting that it compiles legislative options that were presented to the committee through testimony, committee discussion, and other correspondence from committee members. Following this overview, Chair Ballweg led the committee through a discussion on Memo No. 3, the options memo, as organized by subject matter categories including: (1) content of and process to create a death record; (2) uniformity among medical certifications; and (3) additional sources of data regarding deaths.

Committee members discussed changes to data collected by DHS's office of vital records. The committee discussed expanding the types of death record data to include multiple occupations and whether substance use contributed to the death. The committee also discussed changes to the method of death record data collection. The committee was generally interested in exploring ways to promote collaboration among governmental agencies to acquire information that the decedent's family may not know. The committee requested more information on this issue.

Second, the committee discussed medical certification of cause and manner of death. The committee expressed support for requiring or recommending training for people who medically certify cause and manner of death. Several committee members expressed support for training or requirements to ensure that deaths under the statutory jurisdiction of coroners and medical examiners are timely reported to them. Further, committee members expressed support of requiring physicians to complete medical certifications electronically in order to reduce error

and increase timeliness, noting that nearly all funeral directors, coroners, and medical examiners use DHS's electronic system of vital records for reporting deaths.

Third, the committee discussed suicide investigation forms used to collect data beyond vital statistics. The committee focused on the types of professionals that may be most appropriate to complete the form in consultation with the decedent's family, such as coroners and medical examiners, law enforcement, funeral directors, and fatality review teams.

Finally, the committee discussed general support for codifying current practice of fatality review teams.

November 15, 2022

At the committee's meeting on November 15, 2022, Legislative Council staff described research on potential collaboration among government agencies to improve the accuracy of death record content. Chair Ballweg then led the committee's discussion of six preliminary bill drafts and the committee's assignment.

First, the committee discussed LRB-0460/P2, relating to providing additional information fields regarding occupation and substance use on death records. Committee members agreed to remove the requirement that a death record identify whether substance use contributed to the death and specify that up to two additional occupations may be included in a death record.

Second, the committee discussed LRB-0524/P2, relating to requiring DHS to promulgate rules regarding death investigations and medical certification of deaths. The committee members agreed to: (1) clarify that the best practices are for medical certifications completed only by coroners and medical examiners; (2) require DHS to consult with forensic pathologist organizations and further permit DHS to consult with other stakeholders; (3) require DHS to periodically update the best practices; and (4) remove the requirement that the best practices be in a checklist format.

Third, the committee discussed LRB-0458/P2, relating to requiring notification to the medical examiner or coroner of any death that occurs within 24 hours of admittance to certain facilities. The committee members agreed to change the term "admission" to language that would encompass outpatient settings, such as emergency rooms or other facilities.

Fourth, the committee discussed LRB-0555/P2, relating to recommended training for persons who complete medical certifications of death. The committee expressed support for this bill draft, as written.

Fifth, the committee discussed LRB-0523/P2, relating to requiring use of the electronic statewide vital records information system. The committee agreed to: (1) require any person who completes and signs a medical certification to use the electronic system; (2) remove statutory references to nonelectronic methods for submitting medical certifications; and (3) delay the bill draft's effective date until 24 months after enactment.

Finally, the committee discussed LRB-0521/P2, relating to fatality review teams and granting rule-making authority. The committee agreed to several changes, including to: (1) remove the provisions addressing specific types of fatality review teams; (2) clarify that a team's access to certain records is permissive, rather than mandatory; and (3) grant DHS express rule-making authority to implement the new provisions.

Upon review of the bill drafts, the committee voted unanimously to recommend the following four bill drafts, with certain modifications, to the Joint Legislative Council for introduction:

- LRB-0460/1, relating to providing additional information fields regarding occupation on death records.
- LRB-0523/1, relating to requiring use of the electronic system of vital records for medical certifications of death.
- LRB-0458/1, relating to requiring notification to the medical examiner or coroner of any death that occurs within 24 hours of presentment at or admission to certain facilities.
- LRB-0555/1, relating to recommended training for persons who complete and sign medical certifications of death.

December 15, 2022

At the committee's meeting on December 15, 2022, Chair Ballweg led the committee through a discussion of the remaining two bill drafts.

The committee discussed LRB-0524/P4, requiring DHS to promulgate rules regarding best practices for death investigations and medical certification of deaths and granting rule-making authority. The committee agreed to remove the requirement that the best practices be promulgated as administrative rules, and instead require DHS to establish and encourage such best practices for coroners and medical examiners. The committee also discussed LRB-0521/P4, relating to fatality review teams and granting rule-making authority.

Upon review of the bill drafts, the committee voted unanimously to recommend the following two bill drafts, with certain modifications, to the Joint Legislative Council for introduction:

- LRB-0524/1, relating to requiring DHS to establish and encourage best practices for coroners and medical examiners.
- LRB-0521/1, relating to fatality review teams and granting rule-making authority.

PART III | RECOMMENDATIONS

This Part provides background information on, and a description of, the bill drafts recommended by the Study Committee on Uniform Death Reporting Standards. The bill drafts are organized below based on the following categories: (1) modifying the content of, and the process for creating, a death record; (2) encouraging uniformity among medical certifications; and (3) establishing additional sources of data regarding deaths beyond death records.

CONTENT OF AND PROCESS TO CREATE A DEATH RECORD

LRB-0460/1, Relating to Providing Additional Information Fields Regarding Occupation on Death Records

Background

Current law requires that a death record be filed with the state whenever a death occurs. The death record must include various information about the decedent, including information for statistical use only that is collected on the standard death record form recommended by the federal agency responsible for national vital statistics, along with any other data as directed by the state registrar, including race, educational background, and health risk behavior.

Description

The bill draft requires that, beginning on September 1, 2025, a death record include data on the decedent's usual occupation in a format that allows inclusion of up to two additional occupations, if applicable.

LRB-0523/1, Relating to Requiring Use of the Electronic System of Vital Records for Medical Certifications of Death

Background

Current law requires DHS to establish an office of vital records and appoint a state registrar who, among other duties, directs the system of vital records. DHS currently uses an electronic system of vital records.

Current law requires that a death record be filed by certain parties identified in statute, a function most commonly fulfilled by a funeral director. The filing party must obtain certain factual information for the death record and then, within 24 hours of being notified of a death, present the record to the appropriate individual for completion of the medical certification, which is a portion of the death record providing cause-of-death and other information. Depending on the circumstances of the death, the medical certification may be completed and signed by a medical examiner, coroner, physician, or other specified medical professionals with access to a decedent's medical history.

Under current practice, the electronic system of vital records is widely used by funeral directors, medical examiners, and coroners, and less commonly used by other individuals authorized to complete a medical certification, such as physicians. Those individuals who complete a medical certification without use of the electronic system of vital records instead use a "fax attestation form." Under this method, the medical certification is sent by facsimile to the filing party for manual entry into the electronic system of vital records.

Description

The bill draft requires any person who completes and signs a medical certification to use the electronic system of vital records to complete and sign the medical certification as required under current law. The bill draft also eliminates the option for individuals completing and signing the medical certification to mail the death record to the filing party. Finally, the bill draft delays the effective date of these provisions for 24 months.

LRB-0458/1, Relating to Requiring Notification to the Medical Examiner or Coroner of any Death That Occurs Within 24 Hours of Presentment at or Admission to Certain Facilities

Background

Wisconsin law requires a medical examiner or coroner to determine the cause of death for certain types of deaths. Under current law, physicians, authorities of various medical institutions, and other persons having knowledge of a death must report certain types of deaths, including suicide, to the sheriff, police chief, medical examiner, or coroner of the county where the death took place.

Description

This bill draft creates a requirement to contact a medical examiner or coroner in certain circumstances to determine whether the medical examiner or coroner is required to investigate the death. Specifically, the bill draft requires that, if a physician, authority, or other person required to report deaths has knowledge of a death that occurred within 24 hours after an individual either has presented at or is admitted to a hospital or similar institution, whichever is earlier, that person with knowledge must contact the medical examiner or coroner to determine whether the death is reportable under the current laws requiring a medical examiner or coroner to investigate certain deaths.

TOOLS FOR UNIFORMITY AMONG MEDICAL CERTIFICATIONS

LRB-0524/1, Relating to Requiring DHS to Establish and Encourage Best Practices for Coroners and Medical Examiners

Background

Current law specifies certain types of deaths that require an investigation by a coroner or a medical examiner, who then completes the medical certification. The medical certification is the portion of a death record that provides the cause of death, manner of death, injury-related data, and any other medically related data. Death records are registered with the office of vital records, which is supervised by the state registrar in DHS.

Description

The bill draft requires DHS to establish and encourage best practices for coroners and medical examiners when completing medical certifications and death investigations, in consultation with organizations of coroners, medical examiners, and forensic pathologists, as well as any other organization that DHS determines to be appropriate. The bill draft also requires DHS to make the best practices available to any office of a coroner or medical examiner, and to periodically review and update the best practices, if necessary.

LRB-0555/1, Relating to Recommended Training for Persons who Complete and Sign Medical Certifications of Death

Background

Current law requires a death record to contain a medical certification, which provides the cause of death, manner of death, injury-related data, and any other medically related data that is collected as required by the state registrar at DHS. Depending on the circumstances of the death, the medical certification may be completed and signed by a medical examiner, coroner, or physician, or by certain medical professionals with access to a decedent's medical history. Death records are registered with DHS's office of vital records, which is supervised by the state registrar.

Description

The bill draft requires DHS to promote and encourage appropriate training for any person who is authorized to complete and sign a medical certification under current law. The bill draft requires DHS to compile a recommended set of training materials and resources related to medical certification of deaths, which must be accessible to any person authorized to sign a medical certification.

ADDITIONAL SOURCES OF DATA REGARDING DEATHS

LRB-0521/1, Relating to Fatality Review Teams and Granting Rule-Making Authority

Background

Wisconsin does not currently have a state law governing any type of fatality review team. However, 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. Approximately 45 counties have opted to create fatality review teams, such as child death review teams, fetal infant mortality review teams, overdose fatality review teams, and suicide review teams.

Though each county's approach may vary, teams generally consist of local professionals from various disciplines, such as law enforcement, a coroner or medical examiner, and public health. These teams typically meet regularly in a confidential setting to discuss individual death incidents, with the goal of identifying and discussing risk factors and circumstances surrounding the death, so as to inform future prevention strategies.

Description

The bill draft establishes fatality review teams under state law. Under the bill draft, a fatality review team is defined as a multidisciplinary and multiagency team reviewing one or more types of death among children or adults and developing recommendations to prevent future deaths of similar circumstances. The bill draft generally governs a team's responsibilities, ability to access certain records, confidentiality requirements, and disclosure of information.

DHS's Duties and Authority

Under the bill draft, DHS must establish a fatality review program comprised of local fatality review teams established at the option of a county, a local health department, a tribal health

department, or a combination of these entities. The bill draft also authorizes, but does not require, DHS to create state fatality review teams.

The bill draft requires DHS to perform various duties, in consultation with other state agencies as appropriate, such as: (1) facilitate local team development; (2) identify training needs and make available training resources; (3) provide technical assistance and support; (4) in the absence of a local team or upon request, assign review of deaths to a state fatality review team, if established; (5) educate the public on causes and recommendations for prevention of reviewable deaths; and (6) provide information to the Legislature, state agencies, and local communities on the need for modifications to law, policy, or practice. The bill draft allows DHS to contract with an entity to perform any of its duties under the bill draft.

Under the bill draft, DHS must create and make available to fatality review teams a confidentiality agreement for use by team members to ensure confidentiality consistent with the bill draft's provisions. The bill draft requires DHS to promulgate administrative rules to develop and implement a standardized form for review of suicide deaths, and allows DHS to promulgate rules to develop and implement standardized forms for other types of reviewable deaths. The bill draft further grants general rule-making authority to DHS to implement the bill draft's provisions.

Team Functions

The bill draft contains general provisions governing any type of fatality review team. The bill draft identifies examples of the types of deaths that may constitute a reviewable death, including those caused by unintentional injury, overdose, suicide, and homicide, among other causes. The bill draft also provides a non-exhaustive list of potential team members.

Under the bill draft, a fatality review team has the purpose of gathering information about reviewable 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 reviewable 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; (3) create strategies and track implementation of prevention recommendations; and (4) evaluate the team's process, interagency collaboration, and implementation of recommendations. The bill draft requires teams to assign, as appropriate for a specific review, a team member to complete any standardized form developed by DHS, and to enter data regarding each reviewable death into any secure database designated by DHS or its contracted entity.

Team Record Access and Confidentiality

The bill draft 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, schools, and the prescription drug monitoring program, among others, subject to certain restrictions under the bill draft 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 draft, and are not subject to Wisconsin's public records laws. The bill draft requires team members, and other individuals invited to attend a team meeting, to sign a confidentiality agreement before participating in or attending a fatality review team meeting. The bill draft prohibits team members, persons in attendance at team meetings, and others providing records to teams from testifying in any civil or criminal action as to the information specifically obtained through participation in the team's meeting.

The bill draft 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. The bill draft 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, unless obtained independently from a team's review. The bill draft 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.

The bill draft exempts fatality review team meetings from Wisconsin's open meetings law. However, the bill draft allows for public meetings to share summary findings and recommendations, but limits the types of information that may be disclosed in public meetings.

PART IV | STUDY COMMITTEE VOTES

At the November 15 and December 15, 2022 meetings, the Study Committee on Uniform Death Reporting Standards voted unanimously to recommend the following bill drafts for introduction by the Joint Legislative Council in the 2023-24 legislative session:

- LRB-0460/1, relating to relating to providing additional information fields regarding occupation on death records, passed by a vote of Ayes, 11 (Sens. Ballweg and Johnson; Reps. Doyle and James; and Public Members Biedrzycki, Candahl, Kohlbeck, Michel, Paulus, Riemer, and Steininger); and Noes, 0.
- LRB-0523/1, relating to requiring use of the electronic system of vital records for medical certifications of death, passed by a vote of Ayes, 11 (Sens. Ballweg and Johnson; Reps. Doyle and James; and Public Members Biedrzycki, Candahl, Kohlbeck, Michel, Paulus, Riemer, and Steininger); and Noes, 0.
- LRB-0458/1, relating to requiring notification to the medical examiner or coroner of any death that occurs within 24 hours of presentment at or admission to certain facilities passed by a vote of Ayes, 11 (Sens. Ballweg and Johnson; Reps. Doyle and James; and Public Members Biedrzycki, Candahl, Kohlbeck, Michel, Paulus, Riemer, and Steininger); and Noes, 0.
- LRB-0524/1, relating to requiring DHS to establish and encourage best practices for coroners and medical examiners, passed by a vote of Ayes, 9 (Sens. Ballweg and Johnson; Reps. James and Doyle; and Public Members Kohlbeck, Michel, Paulus, Riemer, and Steininger; Noes, 0; and Absent, 2 (Public Members Biedrzycki and Candahl).
- LRB-0555/1, relating to recommended training for persons who complete and sign medical certifications of death, passed by a vote of Ayes, 11 (Sens. Ballweg and Johnson; Reps. Doyle and James; and Public Members Biedrzycki, Candahl, Kohlbeck, Michel, Paulus, Riemer, and Steininger); and Noes, 0.
- LRB-0521/1, relating to fatality review teams and granting rule-making authority, passed by a vote of Ayes, 9 (Sens. Ballweg and Johnson; Reps. James and Doyle; and Public Members Kohlbeck, Michel, Paulus, Riemer, and Steininger; Noes, 0; and Absent, 2 (Public Members Biedrzycki and Candahl).

APPENDIX 1 | LIST OF COMMITTEE MEMBERS

Study Committee on Uniform Death Reporting Standards

Chair Joan Ballweg, Senator
Markesan, WI 53946

Vice Chair Jesse James, Representative
Altoona, WI 54720

Lynda Biedrzycki, Medical Examiner
Waukesha and Washington Counties
Waukesha, WI 53188

Tim Candahl, Chief Medical Examiner
La Crosse County
La Crosse, WI 54601

Steve Doyle, Representative
Onalaska, WI 54650

LaTonya Johnson, Senator
Milwaukee, WI 53707

Sara Kohlbeck, Director of Suicide Prevention
Comprehensive Injury Center
Medical College of Wisconsin
Milwaukee, WI 53226

Brian Michel, Chief Operating Officer
Mental Health America of Wisconsin
Milwaukee, WI 53204

Teresa Paulus, Public Health Nurse
Winnebago County Health Department
Neenah, WI 54956

Kerry Riemer, Controller
Catholic Financial Life
Milwaukee, WI 53233

Tara Steininger, Funeral Director/Managing Partner
Becker Ritter Funeral Home
Brookfield, WI 53005

STUDY ASSIGNMENT: The study committee is directed to review the current protocols for investigating causes of death and reporting death, and the uniformity of those protocols. The review shall focus on 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 shall 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.

11 MEMBERS: 2 Senators; 2 Representatives; and 7 Public Members.

LEGISLATIVE COUNCIL STAFF: Amber Otis, Senior Staff Attorney, Kelly McGraw, Staff Attorney, Annie Gonring, Legal Intern, and Kelly Mautz, Administrative Staff.

APPENDIX 2 | LIST OF COMMITTEE MATERIALS

July 18, 2022

- Staff Brief 2022-01, Study Committee on Uniform Death Reporting Standards (July 11, 2022).
- Presentation by Amber Otis, Senior Staff Attorney, and Kelly McGraw, Staff Attorney, Legislative Council Staff.
- Presentation by Sarah Bassing-Sutton, Community Suicide Prevention Coordinator, N.E.W. Mental Health Connection.
- Presentation by Adam Covach, M.D., Chief Medical Examiner, Fond du Lac County.
- Presentation by Lynette Childs, State Registrar, State Vital Records Office, and HJ Waukau, Legislative Director, Department of Health Services.
- Presentation by Karen Ordinans, Retired, Former Executive Director, and Karen Nash, Program Leader, Injury Prevention and Death Review, Children's Health Alliance of Wisconsin.
- Handout, Review Team Guidebook, submitted by Karen Nash, Program Leader, Injury Prevention and Death Review, Children's Health Alliance of Wisconsin.
- Handout, CDR Report Form, National Fatality Review Case Reporting System, submitted by Karen Nash, Program Leader, Injury Prevention and Death Review, Children's Health Alliance of Wisconsin.
- Handout, Fatality Review Teams by County, submitted by Karen Nash, Program Leader, Injury Prevention and Death Review, Children's Health of Wisconsin.
- Minutes of the July 18, 2022 meeting.

August 17, 2022

- Presentation, Catalyzing Prevention: Through CDR Data Collection, by Heather Kykstra, Senior Data Analyst, and Susanna Joy, Project Coordinator, National Center for Fatality Review & Prevention.
- Handout, Links for Wisconsin Legislative Committee, submitted by Heather Dykstra, Senior Data Analyst, and Susanna Joy, Project Coordinator, National Center for Fatality Review & Prevention.
- Presentation, Legislative Council Study on Uniform Death Reporting, FSCA/WFDA Presentation, by James Klemmer, Heritage Funeral Homes, and Nicole Krause, Krause Funeral Home (August 17, 2022).
- Presentation, Wisconsin Coroner and Medical Examiner Association, by Agnieszka Rogalska, MD, Chief Medical Examiner of Dane, Rock Counties, WCMEA President.
- Memo No. 1, Information in Response to Committee Requests at July 18, 2022 Meeting (August 10, 2022).
- Minutes of the August 17, 2022 meeting.

October 17, 2022

- Memo No. 2, Information in Response to Committee Requests at August 17, 2022 Meeting (October 10, 2022).
- Memo No. 3, Options for Committee Consideration (October 10, 2022).
- Presentation, National Violent Death Reporting system (NVDRS), by Lindsay Emer, PhD, NVDRS Coordinator, Wisconsin Department of Health Services (October 17, 2022).
- Testimony submitted by Department of Justice.
- Minutes of the October 17, 2022 meeting.

November 15, 2022

- LRB-0458/P2, relating to requiring notification to the medical examiner or coroner of any death that occurs within 24 hours of admittance to certain facilities.
- LRB-0460/P2, relating to providing additional information fields regarding occupation and substance use on death records.
- LRB-0521/P2, relating to fatality review teams and granting rule-making authority.
- LRB-0523/P2, relating to requiring use of the electronic statewide vital records information system.
- LRB-0524/P2, relating to requiring the Department of Health Services to promulgate rules regarding death investigations and medical certification of deaths.
- LRB-0555/P2, relating to recommended training for persons who complete medical certifications of death.
- Memorandum, Committee Preliminary Draft Bill Discussion, submitted by HJ Waukau, Legislative Director, Department of Health Services (November 15, 2022).
- Letter from Kyle O'Brien, Senior Vice President Government Relations, Wisconsin Hospital Association (November 14, 2022).
- Minutes of the November 15, 2022 meeting.

December 15, 2022

- LRB-0521/P4, relating to fatality review teams and granting rule-making authority.
- LRB-0524/P4, relating to requiring the Department of Health Services to promulgate rules regarding best practices for death investigations and medical certification of deaths and granting rule-making authority.
- Memorandum, Please Support LRB 0521/P4, Legislation Relating to Fatality Review Teams and Granting Rule-Making Authority, from Matt Crespin, Executive Director, Children's Health Alliance of Wisconsin, and Nathan Berken, Director of Government Relations, Medical College of Wisconsin (December 14, 2022).
- Memorandum, December Committee Preliminary Bill Draft Discussion, from HJ Waukau, Legislative Director, Department of Health Services (December 15, 2022).
- Minutes of the December 15, 2022 meeting.

[Copies of documents are available at www.legis.wisconsin.gov/lc.]