WISCONSIN LEGISLATIVE COUNCIL
AMENDMENT MEMO

2003 Assembly Bill 152	Assembly Substitute Amendment 1, as Amended by Assembly Amendment 1
Memo published: **September 12, 2003**	*Contact*: **Philip G. Cardis, Staff Attorney (267-0683)**

Assembly Bill 152 creates a Prison Mortality and Morbidity Board composed of 12 members attached to the Department of Corrections (DOC). The board will have the authority to investigate the death of an inmate in a state correctional institution. Under the bill, within 72 hours after the death of an inmate, DOC must notify each member of the board of the death, and provide them with all of the information available to DOC regarding the death.

Under the bill, DOC is required to provide any assistance the board needs to investigate the death, including providing the board with the inmate's prison records, information obtained as the result of any internal investigation of the death, and any medical records of the inmate in DOC's custody. The bill allows the board to review any medical records of the inmate; information from a law enforcement agency, district attorney, or attorney general related to the death; and information obtained by the coroner or medical examiner regarding the death. The bill allows the board to ask a court to subpoena documents related to the death, to order an autopsy, and to request the district attorney or court to order an inquest into the inmate's death.

The bill requires the board to issue a report of the board's investigation and submit that report to the district attorney, if appropriate; to a relative of the deceased inmate; to the Speaker of the Assembly and President of the Senate, or their designees; to members of the appropriate standing committees of the Senate and Assembly; and to the Secretary of DOC. The bill authorizes the board to make recommendations to DOC regarding medical and other prison procedures, and to make recommendations regarding possible disciplinary action against DOC staff. If the board determines during its investigation of an inmate's death that a medical provider failed to provide proper and necessary medical care, the board is required under the bill to prepare and forward a complaint to the appropriate credentialing board.

Assembly Substitute Amendment 1 creates the Inmate and Resident Mortality Board composed of 12 members and attached to DOC. The board is given authority to review circumstances of the death of a person who is in the custody of DOC and who is an inmate in an in-state or out-of-state correctional

One East Main Street, Suite 401 • P.O. Box 2536 • Madison, WI 53701-2536
(608) 266-1304 • Fax: (608) 266-3830 • Email: leg.council@legis.state.wi.us
http://www.legis.state.wi.us/lc

institution, a county jail, or a house of corrections, or who is a resident of a secured correctional facility. Under the substitute amendment, within three business days after the death of an inmate or resident, DOC must send a written notice to each member of the board of the death, and provide them with a summary of information regarding the death, including the date, time, and place of the death. DOC is also required to provide the board, at its next scheduled meeting, with the records that are in the custody of DOC regarding the person who died and with any information obtained as the result of DOC's internal review of the death.

The substitute amendment requires the coroner or medical examiner to also notify the attorney general of the death of a person in the custody of DOC who is in an institution if the death is one that would permit the district attorney to order an inquest.

Upon notification of the death of a person in DOC's custody, the district attorney may order and conduct an inquest. The substitute amendment also gives the attorney general the authority to order and conduct an inquest when notified of that death.

Under the substitute amendment, DOC is required to provide any assistance the board needs to review the circumstances of the death. The substitute amendment allows the board to review any medical records of the inmate or resident in the custody of a medical provider; with the approval of the district attorney or attorney general, medical records in the custody of a law enforcement agency; information obtained by the coroner or medical examiner regarding the death; and information collected as a result of the autopsy.

The substitute amendment requires the board to issue a report of the board's review within 30 days after the meeting at which the board completes its review of the death and to submit that report to a relative of the deceased person; to the chair and the ranking minority member of the appropriate standing committees of the Assembly and Senate; to the Secretary of DOC; and to the district attorney or attorney general, if appropriate. The substitute amendment authorizes the board to make recommendations to DOC regarding medical and other prison procedures, including rules, based on the board's review of the death. If the board determines during its review of a person's death, that a medical provider failed to provide appropriate, proper, and necessary medical care, the board is required under the substitute amendment to prepare and forward a complaint to the appropriate credentialing board.

Summary of Major Changes in Assembly Substitute Amendment 1

Assembly Substitute Amendment 1 makes the following major changes to Assembly Bill 152:

- Changes the title of the board from the "Prison Mortality and Morbidity Board" to the "Inmate and Resident Mortality Board."

Attorney General

- Allows the attorney general, in addition to the district attorney, to order and conduct inquests of deaths.

Board Membership

- Staggers the appointment of board members so that five are appointed for a four-year term; four are appointed for a three-year term; and three are appointed for a two-year term.

- Board membership appointed by the Governor includes two *physicians* from the University of Wisconsin Hospitals and Clinics Authority and two *physicians* from the Medical College of Wisconsin. In the original bill, two *representatives* of each of those entities is required.

- The Governor must appoint one *registered* nurse employed by a private health maintenance organization, one registered *nurse employed by a private hospital*, and one member who does not represent any of the foregoing entities and *who is not employed by a state agency*. In the original bill, one nurse employed by a state agency is a member of the board. Also, a nurse employed by a private hospital is not on the board in the original bill.

- The Secretary of DOC must appoint *a health care provider who is employed by DOC, and an employee of DOC who works in a correctional facility.* In the original bill, a registered nurse from a correctional institution and a correctional officer are members of the board.

- One member of the board must be a physician who is a pathologist with subspecialty training in forensic pathology and who is certified by the American Board of Pathology. In the bill, a licensed forensics pathologist must be appointed.

Board Review

- Grants the Inmate and Resident Mortality Board the authority to review circumstances of the death of a person who is in the custody of DOC and who is an inmate in an in-state or out-of-state correctional institution, a county jail, or a house of corrections, and of juveniles in secured correctional facilities. In the original bill, the board has the authority to investigate only the deaths of inmates in state correctional institutions.

- Requires DOC to send *written* notice to each member of the board of the death within *three "business" days* after the death of an inmate or resident, and provide them with a summary of information regarding the death, including the date, time, and place of the death. In the original bill, DOC is required to notify each member of the board of the death within 72 hours, and provide them with all of the information available to DOC regarding the death.

- DOC must provide the board with the records that are in the custody of DOC regarding the person who died and with any information obtained as the result of DOC's internal review of the death at the board's *next scheduled meeting.*

- Allows the board to review a law enforcement agency's medical records relating to the inmate or resident only *with the approval of the district attorney or attorney general.*

- Allows board members to disqualify themselves from any discussion regarding a specific death if they determine that they cannot act in an impartial manner regarding that death.

- Removes the board's authority to ask a court to subpoena documents related to the death, to order an autopsy, and to request the district attorney or court to order an inquest into the inmate's death.

Board's Report and Submittal to Certain Persons

- Requires the board to issue a report of the board's review *within 30 days after the meeting at which the board completes it's review of the death* and to submit that report to a relative of the deceased person; to the chair and the ranking minority member of the appropriate standing committees of the Assembly and Senate; to the Secretary of DOC, and to the district attorney or attorney general, if appropriate. In the bill, the board is not required to issue a report in a specified amount of time.

- Allows the board to refer concerns or recommendations to DOC relating to the performance or work rule violations regarding staff who did not follow departmental policies or procedures relating to the circumstances surrounding the death. In the bill, the board may make recommendations to DOC regarding *possible disciplinary action against staff* who did not follow departmental policies or procedures relating to the death.

Assembly Amendment 1 to Assembly Substitute Amendment 1

Assembly Amendment 1 modifies board membership appointed by the Secretary of DOC relating to correctional officers.

Under Assembly Amendment 1, the Secretary shall appoint a "correctional officer who shall be from a list provided to the secretary by the labor organization recognized or certified to represent the employees in the collective bargaining unit that represents correctional officers."

Legislative History

On September 10, 2003, the Assembly Committee on Corrections and the Courts introduced Assembly Substitute Amendment 1 and Assembly Amendment 1 by unanimous consent.

The Assembly Committee on Corrections and the Courts recommended Assembly Substitute Amendment 1, as amended by Assembly Amendment 1, for adoption and passage of the bill, as amended, by a vote of Ayes, 9; Noes, 2.

PGC:jal;tlu

Tommy G. Thompson
Governor

on E. Litscher
Secretary

State of Wisconsin
Department of Corrections

Mailing Address

149 East Wilson Street
Post Office Box 7925
Madison, WI 53707-7925
Telephone (608) 266-2471
Fax (608) 267-3661

EXECUTIVE DIRECTIVE # 56

September, 2000

SUBJECT: Accessibility of Rescue Inhalers for Treatment of Asthma Attacks

I. Background

Asthma is a chronic inflammatory disease of the airways that causes temporary blockages of the airways. The prompt provision of prescribed inhalers to persons having an asthma attack can prevent permanent airway damage or death.

II. Policy

Inmates / youth shall have immediate access to prescribed rescue (short acting, fast relief) inhalers including while in segregation status and during non-housing unit activities (school, work, recreation). Inhalers may be kept under staff control as determined by a health care prescriber: physician, physician's assistant, or nurse practitioner.

III. Procedure

Inmates / youth will be allowed to have in their possession prescribed rescue inhalers.

The prescriber will determine and write an order if the inmate/youth is not to have possession of the prescribed inhaler.

- Some inhalers are not prescribed for asthma attacks but for daily treatment of asthma. If inmates/youth have more than one inhaler, a health professional from the Health Services Unit shall identify which inhaler(s) must be immediately available to the inmate / youth.
- If staff believe the inmate/youth should not be allowed to retain possession of the inhaler, the prescriber will be consulted.
- During off-hours, the on-call nurse shall be called for direction and the nurse will consult with the on-call physician for a determination.
- If an agreement regarding possession of the inhaler cannot be reached, the Responsible Physician will make the final decision.
- If it appears an inmate / youth is overusing an inhaler, the Health Services Unit shall be notified to initiate interventions (medical assessment, counseling or education).

When it is determined an inhaler will be retained by security staff

- If the inhaler is retained by security, the inhaler shall be kept in a location that will allow staff to deliver the medication immediately.
- While in segregation, an inmate / youth not allowed to possess an inhaler shall be placed in a cell which allows close monitoring by staff.
- Staff shall respond immediately to any call for help from the inmate / youth.

Response of staff to inmates/youth having an asthma attack

- If the condition of the inmate/youth appears life threatening, staff shall activate the EMS system and also contact the Health Services Unit.
- If the symptoms do not improve or worsen after use of the rescue inhaler as prescribed, the inmate / youth must be immediately evaluated by a health professional.
- If Health Services staff is not on site, the local emergency medical service will be activated immediately for evaluation of the inmate / youth.

IV. Originated By

Division of Adult Institutions, Bureau of Health Services

Dated this 30 day of August, 2000.

Jon E. Litscher, Secretary

DOC-864 (Rev. 9/98)

INTERNAL MANAGEMENT PROCEDURES	PROCEDURE NUMBER: DOC 306 IMP 1	PAGE NUMBER: 1 of 4 + 3 page attachment
	ORIGINAL EFFECTIVE DATE: 12/01/77	NEW EFFECTIVE DATE: 01/01/02
STATE OF WISCONSIN DEPARTMENT OF CORRECTIONS DIVISION OF ADULT INSTITUTIONS	SUPERSEDES NUMBER: DOC 306 IMP 1	DATED: 10/15/01
SUBJECT: INMATE DEATHS	Signed by Steven B. Casperson	

POLICY:

Institutions will process inmate deaths consistent with Wisconsin Statutes and with respect for / sensitivity to the concerns of next-of-kin.

REFERENCES:

Wisconsin State Statutes: 979.01; 157.02; 445.14; 867.03; 301.32; 973.045; 51.05; 302.14; 146.82(2)(a)18
Department of Corrections Administrative Codes 306 and 309
Administrative Directive 1.9, Reporting Serious Incidents, Events of Special Interest, Media Contacts and Legislative Inquiries
Executive Directive 58, Department of Corrections Committee on Inmate/Youth Deaths
Division of Adult Institutions, Bureau of Health Services: 100:04:01
Division of Adult Institutions, Bureau of Health Services: DCI - Infirmary #18
DOC 306 SIMP 20, Protection, Gathering, and Preservation of Evidence
Department of Corrections Records Office Procedures 035, Deaths
Webster's II Dictionary

DEFINITION:

Direct Burial: includes casket, embalming, vault and cemetery charges.

REQUIREMENTS/NOTES:

- After assessment and resuscitation efforts are complete, the body of the deceased inmate *shall not be moved* until the coroner or medical examiner or any involved law enforcement personnel grants authorization to move the body.
- All infectious disease control procedures shall be followed when handling the body and when cleaning up blood and other body fluids that may be present.
- Bodies may not be donated to medical schools due to the requirement for an autopsy. Medical schools will not accept autopsied bodies.
- Unclaimed bodies may not be cremated.
- DCI-Infirmary staff should follow DAI BHS DCI-Infirmary #18.

PROCEDURE:

A. **Security Director/Designee Responsibilities**

1. Immediately notify the warden or the designated on-call administrative staff person of the death.

2. Ensure routine crime scene security measures shall be employed to preserve evidence.

B. **Warden/Designee Responsibilities**

1. Develop institution policies and procedures regarding death of inmates and ensure compliance.

2. Receive notice of imminent death and ensure appropriate notification (i.e., DAI, next-of-kin)

3. Receive notification of inmate death.

4. Notify appropriate Health Services staff.

5. Notify the coroner or medical examiner in the county in which the death occurred.

6. Ensure Division of Adult Institution (DAI) notification.

   a. Immediately notify the DAI Administrator or the DAI staff person on call.

   b. The following information will be provided to the DAI Administrator via e-mail as soon as possible after the death occurs:

      i. Date and time of the incident;

      ii. Place of the occurrence;

      iii. Description of the incident and action taken;

      iv. Information on inmate(s) involved;
      - Inmate name and number
      - County of commitment
      - Current offense
      - Sentence structure
      - Parole eligibility date
      - Mandatory release date
      - Discharge date
      - Latest parole action
      - Date received at DCI
      - Transfer date to current institution

   c. Immediately compile and forward all reports related to the inmate's death to the DAI Administrator.

7. Immediately report the inmate's death to the sheriff or police chief of the jurisdiction in which the death occurred and/or in which the institution having responsibility is located.

8. Notify the Office of Victim Services.

9. Notify the inmate's agent of record.

10. Notify the Next of Kin

    a. Notify the next of kin.

    b. Provide a written notification to the next of kin informing them that they may request a copy of the autopsy from the coroner or medical examiner.

    c. Determine if the next of kin wish to claim the body and provide the burial.

    d. When the next of kin claim the body, the institution bears no responsibility for funeral expenses.

    e. If the next of kin does not claim the body, arrangements shall be made for burial at institution expense, following established Business Office procedures.

11. Autopsy and Autopsy Report

    a. A request for an autopsy and a copy of the autopsy report shall be made to the coroner or medical examiner.

    b. Forward the autopsy report to Central Medical Records at Dodge Correctional Institution (DCI) for filing in the deceased inmate's medical record.

    c. Central Medical Records will forward a copy of the autopsy report to the Director of the Health Services.

12. Certified Copy of the Death Certificate

    a. Request at least two (2) certified copies of the death certificate from the Department of Health & Family Services, Division of Health, Section for Vital Statistics, PO Box 309, Madison, WI. 53701-0309.

    b. Forward a copy of the death certificate to the institution Records Office for filing in the deceased inmate's legal file.

    c. Forward the certified death certificate to Central Medical Records at DCI for filing in the deceased inmate's medical record.

    d. If the next of kin request a certified copy of the death certificate, the requester should be instructed to contact the Department of Health and Family Services and the address listed in section B subsection 10a.

13. Disbursement of Property and Funds

    a. Upon the death of an inmate, the next of kin shall receive a written notice of the inmate's personal goods and money currently in trust to the warden.

b. Follow the procedures of disbursing property and funds established in §302.14 and §867.03 Wis. Stats.

c. If the money remains unclaimed for one (1) year after the inmate's death, the funds shall be deposited in the general fund. Unclaimed personal property shall be disposed of or sold after one (1) year and any proceeds deposited in the general fund. See §301.32(1) and IMP 309 #3(c).

The sale of unclaimed personal property shall be arranged through the Department's purchasing officer.

C. **Health Services Unit Responsibilities**

1. Health Services staff should follow BHS policies and procedures.

2. Provide information to the coroner, deputy coroner, medical examiner or medical examiner assistant.

3. Make two (2) certified copies of the entire medical file. One (1) copy is sent with the body and the other copy is forwarded to the Health Services Unit Manager.

4. Receive the autopsy report and a certified copy of the death certificate from the Warden/designee for filing in the deceased inmate's medical record.

5. Refer all deaths to the DOC Committee on Inmate/Youth Deaths.

D. **Institution Records Office Responsibilities**

1. Follow Records Office Procedures 035, Deaths.

2. Receive a certified copy of the death certificate from the Warden/designee for filing in the deceased inmate's legal file.

E. **Business Director/Designee Responsibilities**

1. Inform the warden/designee of the inmate's personal property and money currently in trust.

2. If the next of kin does not claim the body, the institution business office will arrange for and pay for the funeral and internment costs.

a. An honorably discharged veteran of the U.S. Armed Forces is entitled to certain burial expenses. The institution will claim these benefits when appropriate to defray its expenditures.

b. There is no provision in state law for the institution to recover funeral and internment cost from the funds of a deceased inmate.

c. The institution shall provide for an immediate "direct" burial.

DOC-3007 (Rev. 9/99)

WISCONSIN Department of Corrections Health Services	EFFECTIVE DATE April 8, 2003	NUMBER
	UNITS AFFECTED DAI/DJC/DCC	SUPERCEDES NO.
Chronic Disease Management		DATE REVISED
SUBJECT **Asthma Program**		PAGE 1 Of 3

Asthma is a chronic inflammatory disorder of the airways characterized by recurrent episodes of wheezing, breathlessness, chest tightness, and cough. These episodes are usually associated with variable airflow obstruction that is often reversible either spontaneously or with treatment. The condition of a patient with asthma will change over time depending on the environment, patient activities, management practices and other factors. Therefore, even when a patient's condition is stable, monitoring and treatment are needed to maintain control.

Resources and Materials:

Standards

- Practical Guide for the Diagnosis and Management of Asthma (1997, October). National Institutes of Health (NIH) http://www.nhlbi.nih.gov/health/prof/lung (go to Guidelines)
- Practical Guide for the Diagnosis and Management of Asthma - Update on Selected Topics (2002). NIH
- Asthma Nursing Protocol

Asthma Documentation Forms

- DOC - 3443 Assessment; DOC – 3444 Treatment Care Plan; DOC - 3445 Education Flow Sheet
- DOC – 3446 -Asthma Self Management Control Plan for patient

Education Materials - (adult and adolescent) http://www.nhlbi.nih.gov/health/prof/lung/ (go to Lung Information for Patients and Public)

Management of Asthma

1. Identification
   - Asthma is classified according to symptom frequency "Mild Intermittent-Step I, Mild Persistent-Step 2, Moderate Persistent-Step 3, Severe Persistent-Step 4" as described on p. 10 of the guidelines. Diagnosis of asthma is based on establishing symptom frequency, history, and excluding alternative diagnosis (DOC Form 3443) and is important in determining appropriate treatment.
   - Appropriate treatment can minimize or prevent asthma morbidity and mortality such as preventable hospitalizations and deaths.

2. Initial treatment plan of care
   - The goal of treatment is to reduce symptoms and prevent exacerbation's.
   - The treatment plan will be developed by a physician, nurse practitioner, or physician assistant and documented in the medical record on the appropriate treatment documentation form, flow sheet, and progress notes.
   - The plan will be developed for a classification of Step 2, 3, and 4 in partnership with the patient and include an initial classification, pharmacological therapy as appropriate, education regarding the goals of therapy, and a written action plan for self-management (DOC - 3446 Form. .outlook:\\Public Folders\All Public Folders\DOC\Forms\DAI -use "asthma" in the find option to locate this and other asthma forms)

3. Routine Follow-up Clinic Visits
   - Patients classified with Mild, Moderate, or Severe Persistent asthma will be scheduled two times or more each year according to disease severity for routine reevaluations to the health services unit to appropriately monitor and adjust the treatment plan as needed. These focused examinations will include a review of treatment goals,

effectiveness of self-management measures, check of inhaler use and peak flow technique, environmental triggers, medication, and frequency of follow-up. These visits must be documented on DOC 3444 - Asthma Treatment Care Plan Form.

- The national standards addressing specific areas of asthma evaluation and treatment can be found in the Practical Guide for the Diagnosis and Management of Asthma and update:
  - Initial Assessment & Diagnosis of Asthma p.4
  - Pharmacological Therapy Managing Asthma Long Term p. 7
  - Control of Factors Contributing to Asthma Severity p. 17
  - Periodic Assessment and Montiroing p. 20
  - Education for a Partnership in Asthma Care p. 23
  - Managing Asthma Exacerbations p.26

- Follow-up appointments will be scheduled as clinically indicated and more frequent if poorly controlled.

- Routine visits are conducted by a qualified health care professional. The patient will be seen by a physician, nurse practitioner, or physician assistant at least twice annually, or more often as clinically indicated. Adjustments to the treatment plan will be made by a nurse practitioner, physician assistant or physician.

4. Monitoring is an integral part of the treatment plan and assessment parameters such as vital signs, peak flow readings, and compliance with treatment will be noted. These will be provided by health care staff as ordered and recorded in the medical record.

5. Patient education is a vital part of chronic illness management and should be done at each visit. Providing reasonable opportunities for patients to participate in self-care prepares them to manage their conditions during their incarceration and upon discharge from custody.

   - Specific education points to be emphasized are listed in the DOC – 3445 Patient Education Flow Sheet (outlook:\\Public Folders\All Public Folders\DOC\Forms\DAI) and are detailed on p.23 of the NIH Guidelines.

   - Additional education tools include a packet from the NIH, age appropriate handouts from the American Lung Association, and a video "Wheeze World" for adolescents,

6. Quality Improvement
   - Chart reviews will be performed periodically
   - Performance indicators for chart review include:
     1. Severity classification present
     2. Presence of a self-management control plan
     3. Peak flow before and after an acute attack
     4. Severe persistent asthma – one consultation with a pulmonologist or allergist
     5. Flu and pneumococcal immunizations were given
     6. Education Flow Sheet completed

APPROVED:

James Greer, Director
Bureau of Health Services

DATE

Dr. Dave Burnett, Medical Director
Bureau of Health Services

DATE

DEPARTMENT OF CORRECTIONS
Division of Adult Institutions
DOC-3443 (4/03)

WISCONSIN

ASTHMA ASSESSMENT

OFFENDER NAME | DOC NUMBER | DATE | TIME

Subjective

History: ☐ Allergies

Have you ever been diagnosed with asthma? ☐ Yes ☐ No

Are you on medication now or have you ever been on medication for asthma? ☐ Yes ☐ No

If yes, how often do you use the medication? _____ Name/Description of medication: _____

What triggers your asthma? _____ What makes it better/ worse? _____

Have you ever gone to the hospital for asthma? ☐ Yes ☐ No Intubated? ☐ Yes ☐ No

If yes, when? _____ Length of stay? _____ Records sent for? ☐ Yes ☐ No

Asthma symptoms/severity:

	Mild Intermittent	Mild Persistent	Moderate Persistent	Severe Persistent
Symptom Frequency:	☐ ≤2x/week no symptoms between exacerbations	☐ >2x/week but <1x/day	☐ Daily	☐ Continual
Nighttime Symptoms:	☐ ≤2x/month	☐ >2x times per month	☐ >1x/week	☐ Frequent
Physical Activity:	☐ Activity not affected	☐ Symptoms may affect	☐ Symptoms may affect activity	☐ Symptoms limit activity
Lung Function	☐ PEF ≥ 80% predicted	☐ PEF ≥ 80% predicted	☐ PEF>60% - < 80% predicted	☐ PEF ≤60% predicted

Objective

Vital Signs: BP: ____/____ Pulse _____ Resp. rate _____ Temp. _____ Skin Color _____

Continue recording VS on reverse if repeat measurements taken.

Peak flow meter (3 consecutive readings) 1st: _____ 2nd: _____ 3rd: _____

Do you know your peak flow? ☐ Yes ☐ No If yes, value: _____ Predicted value: _____

Spirometry done ☐ Yes ☐ No Last done _____

Auscultate lung and heart sounds Wheeze ☐ Insp ☐ Exp ☐ Crackles ☐ Rhonchi

Respiratory exam (use of accessory muscles, air flow, etc) Describe _____

Cough ☐ Productive ☐ Non Productive Sputum ☐ Yes ☐ No

Describe: If yes, describe:

Dx.

Plan

Interventions _____

Referrals: ☐ Stat ☐ Urgent ☐ Routine

STAFF SIGNATURE

Distribution: Program Notes of the Medical Record
Put Chart Notes on Back of Form

DEPARTMENT OF CORRECTIONS
Division of Correctional Programs
DOC-3444 (3/03)

ASTHMA TREATMENT CARE PLAN

WISCONSIN

OFFENDER NAME | DOC NUMBER | DATE OF BIRTH

Diagnosis: ____/____/____

Classification: ___Step (4) - Severe Persistent see every 1 to 3 months; ____ Step (3) -Moderate Persistent see every 3 to 6 months ; ____ Step (2) -Mild Persistent see every 3 to 6 months; ____ Step (1) - Mild Intermittent - see very 6 months ---A written control plan is required for Steps 1, 2, & 3.

INSTRUCTIONS: Indicate date of visit, enter data and the actual results, as indicated (e.g. peak flow value, trigger), "D" if done elsewhere, and "R" if reviewed, NC for no change from last visit. Or NA if not applicable. Enter "PN" for additional explanations written in the patient's progress notes.

DATE						
General Office Visits	**Results**	**Results**	**Results**	**Results**	**Results**	**Results**
Enter Classification Step each visit						
Goals of therapy reviewed each visit - Circle one	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
Assessment						
Disease Control – Enter one - Good, Fair, Poor						
Any exacerbations (urgent care since last seen?)	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
Lung auscultation						
Vital signs done						
Peak Flows – enter value of personal best						
Spirometry measurements - if done						
Triggers: List those that apply - allergens, GERD, OTC sensitivity, smoke, environmental, infection						
Prevention						
Smoking status each visit						
Reduce exposure to triggers						
Medications - List						
Quick relief inhaler - List						
Long term control (e.g. Maintenance inhalers						
Compliance	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
If no, counseled						
Asthma Control Plan						
Written action plan with:						
Activities/restrictions						
Environmental controls						
Peak flow frequency						
Emergency plan (zones)						
Plan Adjusted this visit?	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
If yes, specify changes in progress notes						
Immunizations						
Influenza yearly						
Pneumococcal						
FOLLOW-UP DATE SCHEDULED(List Date)						
STAFF INITIAL						
INSTITUTION						

DISTRIBUTION: Original – Care Plan Section of the Record
USE REVERSE SIDE TO CHART ADDITIONAL FINDINGS

DEPARTMENT OF CORRECTIONS
Division of Correctional Programs
DOC-3445 (4/03)

ASTHMA EDUCATION FLOW SHEET

WISCONSIN

OFFENDER NAME	DOC NUMBER	DATE OF BIRTH

Date of Diagnosis: ____/____/____Classification - __Step (4) – severe persistent, __ Step (3) – Moderate Persistent, __ Step (2) – Mild Persistent, __Step (1) - Mild Intermittent

INSTRUCTIONS: Please indicate program skill level, teaching method - **Chart additional pertinent comments in progress notes.**

Education evaluation key: 1 =needs instruction; 2 =needs review/assistance; 3 verbalizes/demonstrates competence; N/A = not applicable; PN =progress notes.

Teaching Method: L = lecture/discussion; D = demonstration; AV = AV presentation; R = return demonstration; H = handout.

DATE						
	EDUCATION EVALUATION KEY & TEACHING METHOD					
	Codes	Codes	Codes	Codes	Codes	Codes
Disease Process						
Inflammation of airways, obstruction, and disease reversibility						
Signs & symptoms of exacerbation						
Potential Triggers						
Psychosocial						
Maintain normal activity levels						
How to manage therapies in daily routine						
Prevention						
Recognize & avoid triggers						
Adverse effects of OTC medications (ASA, NSAIDS)						
Exercise induced bronchospasm						
Monitoring						
Vital Signs (BP, P., T, R)						
Weight						
Compliant (check medication usage - # of canisters)	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
If no, counseled	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
Peak Flows x 3 (enter values)						
Medication						
Quick acting Inhaler (purpose & technique)						
Maintenance Inhaler (purpose & technique)						
Side effects	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
If yes, specify						
Use of spacers (if applicable)						
Self Management Plan						
Written action plan from practitioner reviewed						
Use of Peak Flow Meter (how, when, & zones)						
Actions to take in an acute exacerbation (when to get help)						
Identification of symptoms and when to get help						
FOLLOW-UP DATE SCHEDULED (List Date)						
STAFF INITIAL						
INSTITUTION						

DISTRIBUTION: Copy – Flow Sheet Section of the Medical Record

DEPARTMENT OF CORRECTIONS
Division of Correctional Programs
DOC-3446 (4/03)

WISCONSIN

ASTHMA SELF-MANAGEMENT CARE PLAN

OFFENDER NAME	DOC NUMBER	STAFF SIGNATURE

ASTHMA SEVERITY	PERSONAL BEST PEAK FLOW	DATE PREPARED

MY DAILY ASTHMA MEDICATION IS

NAME	TYPE	NAME	TYPE
DIRECTIONS:		DIRECTIONS:	
NAME	TYPE	NAME	TYPE
DIRECTIONS:		DIRECTIONS:	
NAME	TYPE	NAME	TYPE
DIRECTIONS:		DIRECTIONS:	

The Green Zone: All clear…*I should be here everyday.*

My peak flow is: _____ (80-100% of personal best)

- I am able to do my usual activities.
- I can sleep without having symptoms.
- I have few if any symptoms during waking hours.

I should:

- Continue my maintenance inhalers as outlined above.
- Continue my rescue inhaler as needed.

The Yellow Zone: Caution…*this is not where I should be.*

My peak flow is: _____ (50-80% of personal best)

- My symptoms may be mild or moderate.
- I am not able to do my usual activities.
- My symptoms may keep me awake at night.

I should:

- Use my rescue inhaler 2 to 4 puffs every 20 minutes up to 1 hour, or use my nebulizer every 20 minutes for up to 1 hour. Recheck my peak flow after 1 hour. If I am still in the Yellow Zone, I will repeat my rescue inhaler (2 to 4 puffs) or nebulizer (1 treatment) every 4 to 6 hours, continue checking my peak flows, and send a note to the health care system if I am not back in the green zone within 24 hours.
- Increase my maintenance inhaler (_____) to _____ puffs _____ times a day.
- Other things to do: _____

The Red Zone: Medical Alert…*this is an emergency!!*

My peak flow is: _____ (Less than 50% of personal best)

- My symptoms are severe.
- I am having difficulty breathing even at rest.
- The muscles in my neck/chest are pulled tight.
- My symptoms are worse after 24 hours in the Yellow Zone

I should:

- Use my rescue inhaler 4 to 6 puffs every 20 minutes up to 1 hour, or use my nebulizer every 20 minutes for up to 1 hour. Recheck my peak flow after 1 hour
- **Ask an officer to contact the health care system NOW!** *I may need emergency treatment if my breathing does not improve.*
- Increase or start my prednisone or other prescribed steroid pill at _____ tablets.
- Other things to do: _____

DISTRIBUTION: Copy – Care Plan Section of Medical Record

WISCONSIN
STATE
ASSEMBLY

SHELDON
WASSERMAN
STATE REPRESENTATIVE

April 9, 2003

Testimony of Representative Sheldon Wasserman
Before the Assembly Committee on Corrections and the Courts
In Favor of Assembly Bill 152

Good afternoon, Chairman Bies and fellow committee members. I appreciate the chance to testify in favor of Assembly Bill 152 today.

I am sure that you all remember the story of Taycheedah inmate Michelle Greer from a few years ago. Ms. Greer was born in Taycheedah, and she died there in February 2000 of an asthma attack on a cafeteria floor. The questionable circumstances surrounding her death spurred numerous newspaper reports and legislative inquiries into the delivery of health care and emergency response protocol in Wisconsin's prisons.

Last session former Representative Scott Walker and I co-authored a bill to address public concerns about prison death investigations in particular. The legislation, AB 170, came before this committee. A substitute amendment was adopted, but in my view it took most of the teeth out of the original proposal.

AB 170 never advanced past the committee stage. However, the Department of Corrections was compelled to make some needed improvements since Ms. Greer's passing and the debate over the legislation. I have toured four prisons since then and have been impressed with many of the things I have seen and the people I have met.

Nevertheless, I continue to believe that an internal panel cannot truly and independently review inmate deaths, and that it invites public distrust. It would serve both the inmate population and the department well—politically, legally and ethically—to form an external review board.

The current DOC internal panel is called the Committee on Inmate/Youth Deaths. It meets quarterly and has been known to consider as many as 30 cases at a time. Outgoing DOC Secretary Jon Litscher signed a revised executive directive defining its makeup, purposes, policies and procedures in December 2002. I have provided each of you with a copy. Again, improvements have been made. But in my view the panel's membership lacks necessary independence, and its investigative and advisory capabilities still fall short.

AB 152 combines parts of last session's legislation and the substitute amendment. It creates a new board within DOC made up of 12 members appointed to 2-year terms:

MADISON:
POST OFFICE BOX 8953
MADISON, WISCONSIN 53708
(608) 266-7671
TOLL-FREE NUMBER: 1-888-534-0022
FAX: (608) 266-7038
E-MAIL: rep.wasserman@legis.state.wi.us
WEB PAGE: http://www.legis.state.wi.us/assembly/asm22/news/

HOME:
3487 NORTH LAKE DRIVE
MILWAUKEE, WISCONSIN 53211
(414) 964-0663

- 8 members appointed by the governor, including 2 representatives from the UW Hospital and Clinics, 2 from the Medical College of Wisconsin, one physician from a health care provider other than the UW or MCW, a nurse employed by a state agency, a nurse employed by a private HMO or preferred provider plan, and one member who does not represent any of the aforementioned entities.

- 4 members appointed by the DOC secretary, including a warden, a manager of a Health Services Unit, an RN from a correctional institution and a correctional officer.

- At least one of these members must be a board-certified forensics pathologist.

The board's duties and abilities would include:

- The power to order an autopsy, request an inquest by the district attorney, and ask a court to issue a subpoena of documents or witnesses.

- The responsibility of preparing reports on every inmate death to be submitted to a relative of the deceased, the DOC secretary and the district attorney, if appropriate, as well as the speaker of the assembly, president of senate, and each member of the appropriate standing committees in each house.

- Make recommendations to the department regarding medical and other prison procedures based on its investigations, including advising disciplinary action against staff.

- Forward a complaint to the appropriate credentialing board if a medical provider does not provide proper and necessary care.

The board must be notified within 72 hours of an inmate death.

Administrative staff at the Department of Corrections called a meeting AB 152 on April 1st. But due to the department's current focus on state budget deliberations, it has not yet formulated a position on the legislation for the committee to consider. I am told that the department will issue an opinion in the near future.

I look forward to working with all of you to pass a bill for which we can all be proud. I will be happy to answer any questions you may have, and in DOC's absence today I will do my best to address inquiries about its current procedures.

Thank you for your time.

Scott McCallum
Governor

Jon E. Litscher
Secretary

Mailing Address

3099 East Washington Avenue
Post Office Box 7925
Madison, WI 53707-7925
Telephone (608) 240-5000
Fax (608) 240-3300

State of Wisconsin
Department of Corrections

Executive Directive 58

SUBJECT: Department of Corrections Committee on Inmate/Youth Deaths

I. Policy

The DOC Committee on Inmate/Youth Deaths (Committee) is to provide the Secretary with an objective peer review of inmate/youth deaths in conformity with Sec. 146.37 and 146.38 Wis. Stats., so as to help the facilities and the Department continually improve the quality of health care.

II. Purpose of Committee

A. The Committee shall:

1. Conduct reviews of inmate/youth deaths occurring at adult correctional facilities, juvenile correctional facilities, correctional centers, and private out-of-state contracted facilities housing Wisconsin offenders.

2. Review the causes and circumstances surrounding deaths with particular attention to those considered to be unusual or unexpected.

3. Make recommendations for changes in policies or procedures designed to improve the quality of health care given.

4. Ensure that information relating to deaths is properly communicated so that health care can be improved.

5. Conduct its reviews in the interest of public safety and the effective health care of inmates/youths.

6. Look at issues relating to the deaths of DOC inmates/youths from a systemic point of view.

B. Committee composition and organization.

1. The Committee shall be composed of no more than seven persons, three of which are appointed by the Secretary. The Secretary will appoint a Warden, facility Health Services Manager, and a member of the general public. The Secretary will identify four external agencies and request that each agency select a person to serve on the committee. For example, a physician from the University of Wisconsin Hospital, a physician from a private health care organization such as Marshfield Clinic, a nurse clinician from another state agency such as Division of Care and Treatment Facilities, and a Registered Nurse from a health maintenance organization. The four persons selected by the external agencies shall be licensed health care providers.

2. The Secretary shall designate a Bureau of Health Services Nursing Coordinator to act as a facilitator and advisor to the committee. The Secretary may designate other individuals to serve as advisors to assist the Committee in the performance of it's functions.

3. Members are appointed for staggered terms of three years, except the chair who is selected by the full Committee for a term of two years. Members chosen to fill vacancies created other than by expiration of term shall be appointed for the unexpired term of the member for whom she/he is to succeed.

4. A quorum shall consist of two-thirds of the members then in office. While most actions are determined by consensus, a majority of those voting shall be required to adopt motions and approve actions. If a quorum is not present, the Committee members present may proceed with the meeting as specified by the agenda and recommend actions to be ratified by the Committee, if it has a quorum, at the next meeting. If the chair is absent from a committee meeting, the Committee may designate one of its members to be the acting chair during that meeting.

5. Committee members must be present personally to count for a quorum and to participate in decision-making. Members may not send alternates or designees without the prior approval of the Chair.

C. Confidentiality.

1. All information generated by the Committee, including but not limited to, Committee reports (except its annual report), proceedings of the Committee regarding the cases it reviews, and deliberations, shall be kept confidential by members in accordance with Sec. 146.37 and 146.38 Wis. Stats., and the confidentiality agreements signed by each committee member. Consultants, advisors, committee staff and other individuals with specialized expertise who participate in a review or otherwise provide support to the Committee shall be required to sign a confidentiality agreement.

2. All information, including but not limited to reports, DOC-3356A-C forms, records, memos, and other documents generated by the fact gathering team, consultants, advisors or others acting at the request of the Committee, shall be kept confidential by said individuals in accordance with Sec. 146.37 and 146.38 Wis. Stats., and any confidentiality agreements signed by said individuals.

D. Procedures of the Committee.

1. The Committee shall meet at least quarterly unless there were no deaths in the previous quarter. The Secretary or Chair may call additional meetings.

2. Minutes shall be kept at each meeting and shall include:

   a. Records of all death reports reviewed by the Committee.

   b. Records of all actions taken by the Committee.

   c. The status of all pending reviews.

3. Minutes shall be ratified by the Committee.

4. The Committee shall establish independent fact gathering teams in the Division of Adult Institutions and Division of Juvenile Corrections respectively, for the purpose of collecting information on behalf of the Committee regarding the cause and circumstances of inmates/juvenile deaths.

5. Members of the Committee may visit and inspect any DOC facility and shall have access to all records and data necessary to conduct a review.

6. The Committee may request other persons having relevant information to appear before the Committee as part of a review.

7. The Committee shall establish the format for all fact gathering reports, including the information to be included, and the timelines under which the fact gathering team will present its reports regarding the cause and circumstances of death.

8. The Committee may request persons with specialized expertise to serve as consultants and participate in a review. If the consultant requires compensation, that must be pre-approved by the Secretary.

9. The Committee shall review all documents and information deemed relevant for purposes of conducting its review, including but not limited to reports, if any, from external agencies.

10. In its review, the Committee may look at the following issues, among others:

    a. The adequacy of health care practices.

    b. Whether clinical judgment was exercised properly.

    c. Whether appropriate expertise was utilized.

    d. Whether appropriate internal polices are in place.

    e. Whether internal policies and procedures were followed appropriately.

    f. Whether appropriate family members were kept fully informed.

    g. Whether external agencies were properly notified.

11. When the Committee is satisfied that it can make no recommendations or no further recommendations, it shall consider the review closed.

12. The Committee shall issue an annual report summarizing its work and make the report available to outside agencies as requested.

E. Fact Gathering Team

1. Upon the death of an inmate/youth, the DOC Division responsible for the custody of the inmate/youth shall have its fact gathering team collect information relating to the circumstances surrounding the individual's death, with emphasis on the health care provided. Each Division responsible for the custody of inmates/youths shall promulgate internal management procedures establishing the makeup and responsibilities of the fact gathering teams.

2. In its review, the fact gathering team may look at the following issues, among others:

    a. The adequacy of care practices.

    b. Whether clinical judgment was exercised properly.

    c. Whether appropriate expertise was utilized.

    d. Whether appropriate internal policies are in place.

e. Whether internal policies and procedures were followed appropriately.

f. Whether appropriate family members were kept fully informed.

g. Whether external agencies were properly notified.

h. Whether the death was fully reported to the investigation team.

3. Upon completion of the fact gathering team's review, the team will report its findings and recommendations to the Committee. The Committee will be responsible to ensure that the fact gathering team report is timely and in a form and with the information it shall prescribe.

4. The Committee may require institution staff to provide additional review or assistance as necessary to ensure full cooperation with the fact gathering team. If the Committee believes there is an attempt to influence or interfere with the fact gathering team the Committee will refer the complaint to the Secretary for immediate review and follow up.

Originated by: Bureau of Health Services

Dated this ------- day of ------- 2002. Effective ---------, 2002

Signed
12/2002

Jon E. Litscher, Secretary

DOC-864 (Rev. 12/98)

INTERNAL MANAGEMENT PROCEDURES STATE OF WISCONSIN DEPARTMENT OF CORRECTIONS DIVISION OF ADULT INSTITUTIONS	PROCEDURE NUMBER: DOC 300 IMP 13	PAGE NUMBER: 1 of 6
	ORIGINAL EFFECTIVE DATE: 6/28/02	NEW EFFECTIVE DATE: 12/3/02
	SUPERSEDES NUMBER: DOC 300 IMP 13	DATED: 6/28/02

SUBJECT: INMATE/YOUTH DEATH REVIEW **Signed by Steven B. Casperson on 12/3/02**

POLICY:

The Division of Adult Institutions upon the request of the DOC Committee on Inmate/Youth Deaths (COIYD) shall provide fact gathering support to the COIYD regarding the health care provided incarcerated inmates/juveniles prior to their deaths for purposes of improving the quality of health care provided by the DOC.

REFERENCES:

Executive Directive 58, Department of Corrections Committee on Inmate/Youth Deaths
DOC 306 IMP 1, Inmate Deaths
Sec. 146.37 and 146.38 Wis. Stats.

DEFINITIONS:

Anticipated Death — Any death where the inmate was in the terminal stage of illness and had an anticipated life expectancy of 12 months or less.

COIYD — Committee on Inmate/Youth Deaths

Short Term Admission — An inmate who is being held for a short time in an institution which may include:

- Violation of Probation Hold
- Violation of Parole Hold
- Felony Drug Offender Alternative to Prison Program (FDOATP)
- Alternative to Revocation (ATR)
- Wisconsin Correctional Center Temporary Lock-Ups
- Unsentenced Inmates
- Intensive Sanctions – ATR
- Intensive Sanctions – Designated Facility Confinement
- Intensive Sanctions – Non-Secure Detention
- Intensive Sanctions – Secure Detention

Unanticipated Death — Any death which occurs where there was no diagnosis by a physician of a terminal medical condition or where the physician had indicated the anticipated life expectancy should be 12 months or longer with a terminal medical condition.

DOC-3356 — Institution/Facility Inmate/Youth Death Review

DOC-3356A — Medical Inmate/Youth Death Review

DOC-3356B — Nursing Coordinator Inmate/Youth Death Review

DOC-3356C — Mental Health Inmate/Youth Death Review

DOC-3356D Committee On Inmate/Youth Death Review

REQUIREMENTS/NOTES:

The fact gathering team will include at a minimum the following members:

- A warden from another institution designated by the Division Administrator
- A security representative
- A physician
- A nursing representative
- Psychological Services (for suicides only-mandatory)
- DOC health care person from another institution (for unanticipated deaths)
- Others as determined by the Division Administrator (i.e. Unit Manager, ICE, Registrar, etc.)

The Department of Health and Family Services Committee on Resident Deaths (CORD) will review deaths that occur at Wisconsin Resource Center or any other DHFS facility.

The staff from the affected facilities shall coordinate with each other to complete the fact gathering process in deaths of temporarily housed inmates (i.e. DCI Infirmary, short-term admission, temporary hold, etc.). The fact gathering process shall be completed by the receiving facility with the assistance of the sending facility.

This same process shall be followed for inmate deaths that occur in private out-of-state contracted facilities except that the warden of the facility shall serve in place of the warden from another institution and for unanticipated deaths the fact gathering team will not include the external DOC person. The DOC contract monitor assigned to that facility and a nursing contract monitor shall review the contracted institution's report.

Deaths occurring at instate jail facilities shall be investigated in accordance with the internal policies and procedures of those facilities.

PROCEDURE:

A. **DAI Division Administrator/Designee Responsibilities**

1. Familiarize DAI staff with IMP requirements.
2. Assign warden and/or other members to fact gathering team as necessary.
3. Maintain confidentiality of recommendations and fact gathering reports received from COIYD.
4. Issue directives as appropriate based upon recommendations from COIYD.
5. Assign appropriate staff to implement directives.

B. DCP Division Administrator/Designee Responsibilities

1. Familiarize DCP staff with IMP requirements

2. Maintain confidentiality of recommendations and fact gathering reports received from COIYD.

3. Issue directives as appropriate based upon recommendations from COIYD.

4. Assign appropriate staff to implement directives.

C. Designated Warden

1. Appoint institution members to form fact gathering team after each death and designate team leader.

2. Select an external DOC health care person from another facility for unanticipated deaths.

3. Coordinate and oversee fact gathering process.

D. Warden of Facility/Designee Responsibilities

1. Develop and implement institution policies and procedures consistent with the IMP.

2. Participate in facility fact gathering process.

E. Fact Gathering Team Leader

1. Convene and initiate the fact gathering process.

2. Complete DOC-3356 and forward to Bureau of Health Services (BHS) Program Assistant Supervisor in central office within 5 working days for an unanticipated death and 30 calendar days for an anticipated death. Attach all applicable institution policies/procedures, incident reports, videotapes, law enforcement reports, investigative reports, other institution documents, external agency reports, etc.

F. Fact Gathering Team Responsibilities

1. Complete the fact gathering process on a timely basis.

2. Make recommendations to COIYD based upon the internal fact gathering process.

3. Maintain confidentiality of information gathered, documents generated and recommendations made during fact gathering process.

G. Medical Director Responsibilities

1. Receive and review health care record.

2. Complete DOC-3356A for review by COIYD within 14 calendar days of the death for unanticipated deaths and 30 calendar days for anticipated deaths.

3. Identify cases where review by COIYD should be expedited. Notify the BHS Nursing Coordinator Advisor.

4. Forward completed DOC-3356A to BHS Program Assistant Supervisor.

5. Maintain confidentiality of information contained in completed DOC-3356A.

H. Bureau of Health Services Nursing Coordinator Advisor Responsibilities

1. Receive and review health care record.

2. Notify COIYD members of all deaths.

3. Notify COIYD of any other investigations or reviews related to death.

4. Notify COIYD chairperson when review by COIYD should be expedited.

5. Ensure COIYD ratifies conclusions/recommendations stated on DOC-3356D prior to transmittal to DOC Secretary and Division Administrators.

I. Bureau of Health Services Nursing Coordinator Responsibilities

1. Receive and review health care record.

2. Complete DOC-3356B for review by COIYD within 14 calendar days of the death for unanticipated deaths and 30 calendar days for anticipated deaths.

3. Identify cases that review by COIYD should be expedited. Notify the BHS Nursing Coordinator Advisor.

4. Forward completed DOC-3356B to BHS Program Assistant Supervisor.

5. Maintain confidentiality of information contained in completed DOC-3356B.

J. Mental Health Director Responsibilities

1. Receive and review health care record.

2. Complete DOC-3356C for review by COIYD within 14 calendar days of the death for suicides.

3. Identify cases that review by COIYD should be expedited. Notify the BHS Nursing Coordinator Advisor.

4. Forward completed DOC-3356C to BHS Program Assistant Supervisor.

5. Maintain confidentiality of information contained in completed DOC-3356C.

K. Bureau of Health Services Program Assistant Supervisor Responsibilities

1. Receive health care record and photocopy from the institution.

2. Provide the health care record to the Medical Director, Nursing Coordinator and Mental Health Director (for suicides only) within two working days of receiving record.

3. Compile information received from the institution, Medical Director, nursing coordinator and Mental Health Director.

4. Forward information and photocopy of health care record to appropriate members of the COIYD.

5. Maintain a system to rotate COIYD member reviews.

6. Develop and maintain a tracking system for review of inmate deaths and appropriate documents.

7. Ensure the health care record is available to the COIYD for their committee process.

8. Maintain file with all pertinent documents used by COIYD, death certificate and autopsy results in secure manner.

9. Take minutes at COIYD meetings and distribute final committee recommendations and fact gathering reports to DOC Secretary and appropriate Division Administrators. The identity of the deceased inmate/youth shall be redacted from any materials distributed to the Secretary and Division Administrators pursuant to Sec. 146.38(3) Wis. Stats.

10. Maintain confidentiality of information gathered and documents generated by fact gathering team, and COIYD's findings, conclusions and recommendations in conformity with Sec. 146.37 and 146.38 Wis. Stats., and requisite confidentiality agreement.

L. Institution Health Services Unit Staff Responsibilities

1. Send original medical record to BHS Program Assistant Supervisor by the end of the first working day after the death via certified mail, registered mail or hand carry only.

2. Make photocopy of the last 6 months (3 months for DCI Infirmary) and send to BHS Program Assistant Supervisor.

M. All Facility Staff Responsibilities

1. Participate in facility fact gathering process as directed.

2. Consult and cooperate with staff from sending facility to complete fact gathering process in deaths of temporarily housed and short term admission inmates.

N. COIYD Responsibilities

1. Meet at least quarterly unless there were no deaths in the previous quarter.

2. Conduct reviews of all inmate/youth deaths in DAI (including contract facilities), and DJC facilities as defined in Executive Directive #58.

3. Maintain minutes of meetings.

4. Review report of fact gathering team.

5. Complete DOC 3356D and make recommendations designed to improve the quality of health care provided.

6. Determine when the review is closed and communicate the closure to the DOC administration.

7. Maintain confidentiality of information gathered and documents generated by fact gathering team, and COIYD's findings, conclusions and recommendations, in conformity with Sec. 146.37 and 146.38 Wis. Stats., and committee member's confidentiality agreements.

O. COIYD Member Responsibilities

1. Review information provided by BHS Program Assistant Supervisor as assigned.

2. Present case review at COIYD meeting.

3. Maintain confidentiality of information gathered and documents generated by fact gathering team, and COIYD's findings, conclusions and recommendations, in conformity with Sec. 146.37 and 146.38 Wis. Stats., and committee member's confidentiality agreements.

P. Nursing Contract Monitor Responsibilities

1. Act as advisor to COIYD regarding private out-of-state contract facilities.

2. Review contracted institution's report prior to transmittal to the COIYD and require additional fact gathering as deemed necessary.

3. Maintain confidentiality of information gathered and documents generated by fact gathering team.

N. Contract Monitor Responsibilities

1. Act as advisor to COIYD regarding private out-of-state contract facilities.

2. Review contracted institution's report prior to transmittal to the COIYD and require additional fact gathering as deemed necessary.

3. Maintain confidentiality of information gathered and documents generated by fact gathering team.

Jim Doyle
Governor

Matthew J. Frank
Secretary

State of Wisconsin
Department of Corrections

Mailing Address

3099 E. Washington Ave.
Post Office Box 7925
Madison, WI 53707-7925
Telephone (608) 240-5000
Fax (608) 240-3300

May 7, 2003

Representative Garey Bies, Chair
Committee on Corrections and the Courts
State Capitol, Room 125 West
Madison, WI 53702

Dear Representative Bies and Committee Members:

I am sorry that we did not have a Department of Correction's representative at the April 9th hearing on AB 152. There was misunderstanding on our part as to what the committee was looking for from the Department of Corrections and I accept responsibility for that. I do look forward to working with the committee in the future on this important issue.

Currently I am in the process of reviewing the inmate death review processes that were in place at DOC prior to my arrival as Secretary. This includes review of internal DOC protocols as well as review of the Committee Inmate/Youth Deaths process. This has been a complicated undertaking and I have not yet reached any definitive conclusions. However, I am committed to a review process that is sound and thorough with appropriate opportunities for oversight, accountability, and identification of possible improvements in medical care. Pending completion of our review, I have not developed a position on AB 152.

I would welcome the opportunity to address the committee once our review is completed. Meanwhile, set forth below are answers to the questions you have posed in your letter of April 16, 2003.

Under s. 979.025 WI Stats; an autopsy is required if an inmate dies in a correctional institution. Our standard operating procedure in the event of an inmate death is described in an internal management procedure (IMP), a copy of which is attached. This IMP is currently under review.

Another question asked was the amount of damages the State paid relating to the death of an inmate in its custody. Since 2000, the Department of Corrections has had three cases. The names of the inmates, amount of settlement and the date of death are as follows:

Michelle Greer	$950,000	2/2/00
Kelvin Jackson	$600,000	7/12/01
Franklin Homesly	$462,000	6/30/02

Offenders who suffer from asthma are mainstreamed into the general population. Individual treatment is addressed according to medical need and physical condition. The Bureau of Health Service's Chronic Disease Asthma Program has implemented procedures to screen and diagnose the disease, develop individualized treatment plans that specify emergency measures, medications, periodic monitoring, and education according to standards promulgated by the National Institute of Health. For those who have severe persistent asthma or acute increase in symptoms, outside specialist evaluations are obtained to ensure optimal management. A Department policy ensures that offenders who need rescue inhalers to manage their chronic disease have ready access in time of need regardless of their security status or location.

Asthma management at DOC has been reviewed in the past and certain changes were implemented. Earlier this year I asked DOC's Medical Director to take yet another look at the asthma issue and make fresh recommendations. Enclosed is an asthma management plan that has recently been approved. We are in the process of taking the steps necessary to implement the plan. Also enclosed are more detailed procedures on how Asthma is treated.

You also had questions concerning the boot camp program. Inmates must volunteer to participate in the boot camp program. As of 11/26/02, DOC implemented changes that prohibited inmates with asthma from participating in the boot camp program The following are the standard operating procedures for admittance into the boot camp:

- Institution social workers/program review staff screen inmates to determine if they meet the program eligibility criteria outlined in statute 302.045.
- Once identified, staff completes a file review and then meets with eligible inmates to describe the program and determine if the inmates want to sign the Memo of Agreement, volunteering for the program.
- If they sign the agreement, social workers/program review staff determine if the inmate is suitable for minimum custody.
- If suitable, they are placed on the waiting list for program entrance.

I hope this adequately answers the Committee's questions. If you or any member needs any additional information, please do not hesitate to contact me.

Sincerely,

Matthew J. Frank
Secretary

cc: Representative Sheryl Albers
Representative Gregg Underheim
Representative Carol Owens
Representative Frank Lasee
Representative Scott Suder
Representative Mark Pocan
Representative Pedro Colon
Representative Tony Staskunas
Representative Sheldon Wasserman

WISCONSIN LEGISLATIVE COUNCIL

Terry C. Anderson, Director
Laura D. Rose, Deputy Director

TO: REPRESENTATIVE SHELDON WASSERMAN

FROM: Philip Cardis, Staff Attorney

RE: Substitute Amendment ___ (LRBs0090/3) to 2003 Assembly Bill 152

DATE: August 11, 2003

In response to your request, the following memorandum highlights the major changes contained in the substitute amendment (LRBs0090/3) to 2003 Assembly Bill 152. 2003 Assembly Bill 152 creates a board to investigate and make recommendations regarding deaths at correctional institutions.

Current Law

Under current law, upon the death of an inmate of a state correctional institution, the person in charge of the institution is required to notify the appropriate relative of the inmate of the death. Currently, the Department of Corrections (DOC) is also required to provide the relative with written notification that DOC, upon request, will provide the relative with a copy of any autopsy performed on the inmate or a copy of any other report or information regarding the inmate's death.

Under current law, if the district attorney has notice that the death of a person may be the result of homicide or suicide, or may have occurred under unexplained or suspicious circumstances, the district attorney may order an inquest to determine the cause of the person's death. If a coroner or medical examiner has similar knowledge about a person's death, the coroner or medical examiner is required to notify the district attorney of the circumstances surrounding the death and may request that the district attorney order an inquest. The district attorney may order an inquest based on that information or may request that the coroner or medical examiner conduct a preliminary examination and report back to the district attorney. If the district attorney does not order an inquest, under current law the coroner or medical examiner may petition the circuit court to order an inquest.

2003 Assembly Bill 152

2003 Assembly Bill 152 creates a Prison Mortality and Morbidity Board composed of 12 members attached to DOC. The board will have the authority to investigate the death of an inmate in a state correctional institution. Under the bill, within 72 hours after the death of an inmate, DOC must

One East Main Street, Suite 401 • P.O. Box 2536 • Madison, WI 53701-2536
(608) 266-1304 • Fax: (608) 266-3830 • Email: leg.council@legis.state.wi.us
http://www.legis.state.wi.us/lc

notify each member of the board of the death, and provide them with all of the information available to DOC regarding the death.

Under the bill, DOC is required to provide any assistance the board needs to investigate the death, including providing the board with the inmate's prison records, information obtained as the result of any internal investigation of the death, and any medical records of the inmate in DOC's custody. The bill allows the board to review any medical records of the inmate; information from a law enforcement agency, district attorney, or attorney general related to the death; and information obtained by the coroner or medical examiner regarding the death. The bill allows the board to ask a court to subpoena documents related to the death, to order an autopsy, and to request the district attorney or court to order an inquest into the inmate's death.

Assembly Bill 152 requires the board to issue a report of the board's investigation and submit that report to the district attorney, if appropriate; to a relative of the deceased inmate; to the Speaker of the Assembly and President of the Senate, or their designees; to members of the appropriate standing committees of the Senate and Assembly; and to the Secretary of DOC. The bill authorizes the board to make recommendations to DOC regarding medical and other prison procedures, and to make recommendations regarding possible disciplinary action against DOC staff. If the board determines during its investigation of an inmate's death that a medical provider failed to provide proper and necessary medical care, the board is required under the bill to prepare and forward a complaint to the appropriate credentialing board.

Substitute Amendment — (LRBs0090/3) to 2003 Assembly Bill 152

The substitute amendment creates the Inmate and Resident Mortality Board composed of 12 members and attached to DOC. The board is given authority to review circumstances of the death of a person who is in the custody of DOC and who is an inmate in an in-state or out-of-state correctional institution, a county jail, or a house of corrections, or who is a resident of a secured correctional facility. Under the substitute amendment, within three business days after the death of an inmate or resident, DOC must send a written notice to each member of the board of the death, and provide them with a summary of information regarding the death, including the date, time, and place of the death. DOC is also required to provide the board, at its next scheduled meeting, with the records that are in the custody of DOC regarding the person who died and with any information obtained as the result of DOC's internal review of the death.

The substitute amendment requires the coroner or medical examiner to also notify the attorney general of the death of a person in the custody of DOC who is in an institution if the death is one that would permit the district attorney to order an inquest.

Upon notification of the death of a person in DOC's custody, the district attorney may order and conduct an inquest. The substitute amendment also gives the attorney general the authority to order and conduct an inquest when notified of that death.

Under the substitute amendment, DOC is required to provide any assistance the board needs to review the circumstances of the death. The substitute amendment allows the board to review any medical records of the inmate or resident in the custody of a medical provider; with the approval of the district attorney or attorney general, medical records in the custody of a law enforcement agency;

information obtained by the coroner or medical examiner regarding the death; and information collected as a result of the autopsy.

The substitute amendment requires the board to issue a report of the board's review within 30 days after the meeting at which the board completes its review of the death and to submit that report to a relative of the deceased person; to the chair and the ranking minority member of the appropriate standing committees of the Assembly and Senate; to the Secretary of DOC; and to the district attorney or attorney general, if appropriate. The substitute amendment authorizes the board to make recommendations to DOC regarding medical and other prison procedures, including rules, based on the board's review of the death. If the board determines during its review of a person's death that a medical provider failed to provide appropriate, proper, and necessary medical care, the board is required under the substitute amendment to prepare and forward a complaint to the appropriate credentialing board.

Highlights of Major Changes Contained in LRBs0090/3

The substitute amendment makes the following major changes to 2003 Assembly Bill 152:

- Changes the title of the board from the "Prison Mortality and Morbidity Board" to the "Inmate and Resident Mortality Board."

Attorney General

- Allows the attorney general, in addition to the district attorney, to order and conduct inquests of deaths.

Board Membership

- Staggers the appointment of board members so that five are appointed for a four-year term; four are appointed for a three-year term; and three are appointed for a two-year term.

- Board membership appointed by the Governor includes two *physicians* from the University of Wisconsin Hospitals and Clinics Authority and two *physicians* from the Medical College of Wisconsin. In the original bill, two *representatives* of each of those entities is required.

- The Governor must appoint one *registered* nurse employed by a private health maintenance organization, one registered *nurse employed by a private hospital*, and one member who does not represent any of the foregoing entities and *who is not employed by a state agency*. In the original bill, one nurse employed by a state agency is a member of the board. Also, a nurse employed by a private hospital is not on the board in the original bill.

- The Secretary of DOC must appoint *a health care provider who is employed by DOC, and an employee of DOC who works in a correctional facility*. In the original bill, a registered nurse from a correctional institution and a correctional officer are members of the board.

- One member of the board must be a physician who is a pathologist with subspecialty training in forensic pathology and who is certified by the American Board of Pathology. In the bill, a licensed forensics pathologist must be appointed.

Board Review

- Grants the Inmate and Resident Mortality Board the authority to review circumstances of the death of a person who is in the custody of DOC and who is an inmate in an in-state or out-of-state correctional institution, a county jail, or a house of corrections, and of juveniles in secured correctional facilities. In the original bill, the board has the authority to investigate only the deaths of inmates in state correctional institutions.

- Requires DOC to send *written* notice to each member of the board of the death within *three* "business" *days* after the death of an inmate or resident, and provide them with a summary of information regarding the death, including the date, time, and place of the death. In the original bill, DOC is required to notify each member of the board of the death within 72 hours, and provide them with all of the information available to DOC regarding the death.

- DOC must provide the board with the records that are in the custody of DOC regarding the person who died and with any information obtained as the result of DOC's internal review of the death at the board's *next scheduled meeting.*

- Allows the board to review a law enforcement agency's medical records relating to the inmate or resident only *with the approval of the district attorney or attorney general.*

- Allows board members to disqualify themselves from any discussion regarding a specific death if they determine that they cannot act in an impartial manner regarding that death.

- Removes the board's authority to ask a court to subpoena documents related to the death, to order an autopsy, and to request the district attorney or court to order an inquest into the inmate's death.

Board's Report and Submittal to Certain Persons

- Requires the board to issue a report of the board's review *within 30 days after the meeting at which the board completes it's review of the death* and to submit that report to a relative of the deceased person; to the chair and the ranking minority member of the appropriate standing committees of the Assembly and Senate; to the Secretary of DOC, and to the district attorney or attorney general, if appropriate. In the bill, the board is not required to issue a report in a specified amount of time.

- Allows the board to refer concerns or recommendations to DOC relating to the performance or work rule violations regarding staff who did not follow departmental policies or procedures relating to the circumstances surrounding the death. In the bill, the board may make recommendations to DOC regarding *possible disciplinary action against staff* who did not follow departmental policies or procedures relating to the death.

DOC Committee on Inmate/Youth Deaths

Presently, DOC has an internal nonstatutory committee on inmate and youth deaths. The purpose of the committee is to:

- Conduct reviews of inmate and youth deaths occurring at adult correctional facilities, juvenile correctional facilities, correctional centers, and private out-of-state contracted facilities housing Wisconsin offenders.

- Review the causes and circumstances surrounding deaths with particular attention to those considered to be unusual or unexpected.

- Make recommendations for changes in policies or procedures designed to improve the quality of health care given.

- Ensure that information relating to deaths is properly communicated so that health care can be improved.

- Conduct its reviews in the interest of public safety and the effective health care of inmates and youths.

- Look at issues relating to the deaths of DOC inmates and youths from a systemic point of view.

The committee is composed of no more than seven persons. The Secretary appoints a warden, a facility health services manager, and a member from the general public. For the remaining members of the committee, the Secretary identifies four external agencies (i.e., University of Wisconsin Hospital, another state agency) and requests that each agency select a person to serve on the committee. The four persons selected by the external agencies should be licensed health care providers.

The committee meets at least quarterly unless there were no deaths in the previous quarter. The secretary or the chair of the committee may call additional meetings.

In its review, the committee may look at the following issues:

- The adequacy of health care practices.

- Whether clinical judgment was exercised properly.

- Whether appropriate expertise was utilized.

- Whether appropriate internal policies are in place.

- Whether internal policies and procedures were followed appropriately.

- Whether appropriate family members were kept fully informed.

- Whether external agencies were properly notified.

The committee must issue an annual report summarizing its work and make that report available to outside agencies as requested. [DOC Executive Directive 58]

If you have any further questions regarding this matter, please feel free to contact me at 267-0683 at the Legislative Council staff offices.

PGC:jal;tlu

12 August 2002

RE: AB 152; Creating a board to investigate and make recommendations regarding deaths at correctional institutions.

The death earlier this year at the Boscobel correctional facility indicates Wisconsin needs to re-examine and improve its health care practices of inmates.

Amnesty International is in favor of investigations into any and all deaths of persons in correctional institutions with the state of Wisconsin.

It is our hope that investigations are conducted, all findings made public and all findings reported, per international law and other human rights documents and standards, in particular the UN High Commission's Standard Minimum Rules for the Treatment of Prisoners.

Basic human rights apply to all people without discrimination or regard to race, colour, sex, language, nationality or social origin, gender, economic status or religion.

Health services shall be accessible to prisoners. These shall be the same as services available in the county, without discrimination on the grounds of prisoners' legal situation. (UN Basic Principles for the Treatment of Prisoners, point 9)

Health services include both physical and mental and each institution shall have at least one qualified medical officer who should have some knowledge of psychiatry. (UN Standard Minimum Rules for the Treatment of Prisoners, point 22(1)). Prisoners who complain of illness should be seen daily by the correctional institute's medical officer who can care for both mental and physical health. (UN Standard Minimum Rules for the Treatment of Prisoners, point 25(1)).

In the case of death of a prisoner, the UN Standard Minimum Rules for the Treatment of Prisoners, point 44(1) is clear. Upon death or serious illness, the director shall at once inform the spouse, if the prisoner is married, or the nearest relative and shall in any event inform any other person previously designated by the prisoner.

Amnesty is encouraged to see Wisconsin take steps to more vigorously investigate deaths in correctional institutions of in-state and out-of-state of Wisconsin prisoners. We hope for the investigative board to be impartial and independent and be staffed with persons in both physical and mental health services. We are encouraged to see this legislation create ground for the board to review records, request subpoena authority for related documents, order an autopsy and make recommendations relating to rules violations and possible disciplinary action where appropriate for delinquency that relates to the death of a prisoner and require the Department of Corrections to provide their assistance in investigations.

Thank you,
Angie Hougas
Coordinator, Amnesty International, WI

Osterberg, Sarah

From: esther heffernan
Sent: Wednesday, August 13, 2003 7:35 AM
To: Sarah.Osterberg@legis.state.wi.us
Subject: AB 152

Dear Sarah Osterberg,

I received a copy of your email yesterday forwarded from Angie Hougas regarding the hearings. Unfortunately I won't be able to attend the hearings, but would like to emphasize my support of the revised bill.

Earlier I emailed the members of the committee on the importance of the original bill, based on my own research and those of others on the critical importance of oversight on deaths in prison. While death occurs with relative infrequency, the fear of death and the sense that a prisoner's life depends on the decisions of others, plays a powerful role in the dynamics of staff-inmate relationships. When there is any question of sources and responsibilty for a death, it is of mutual benefit to the family of the deceased, staff and inmates in the facility, and the administrators of DOC that there be clear accountability through a death review process that includsd responsible oversight beyond the Department of Corrections.

I am grateful that there has been a coooperative effort by Rep. Wasserman and the Department of Corrections to revise the bill in a way that it can be supported by both parties and congratulate them on bringing a bill closer to passage. If this message can be of any help in the hearings, I would appreciate its use.

Esther Heffernan
Department of Social Science
Edgewood College
608-663-2218
heffern@edgewood.edu

WISCONSIN
STATE
ASSEMBLY

SHELDON
WASSERMAN
STATE REPRESENTATIVE

August 13, 2003

Testimony of Representative Sheldon Wasserman
Before the Assembly Committee on Corrections and the Courts
On the Substitute Amendment to Assembly Bill 152

Good morning, Chairman Bies and fellow committee members. Thank you for the chance to testify in favor of Assembly Bill 152 once again.

Back in April I shared with you some key reasons why Assembly Bill 152 is needed. I will review them briefly:

- The Department of Corrections is entrusted with the responsibility of housing Wisconsin inmates and its actions are accountable to the public. Certain circumstances surrounding inmate deaths have occurred that have led to public concern. Assembly Bill 152 and Assembly Substitute Amendment 1 are a comprehensive approach to addressing those concerns.

- The questionable occurrences surrounding the death of Taycheedah inmate Michelle Greer and others spurred improvements in the delivery of health care and emergency response protocol in Wisconsin's prisons. However, there is still more to be done.

- The current panel that reviews inmate deaths lacks necessary independence, and its investigative and advisory capabilities fall short. An internal panel cannot truly and independently review inmate deaths, and it invites public distrust. It makes sense politically, legally and ethically to form an external review board.

Since the first hearing on AB 152 I have met with Secretary Matt Frank, his staff, the Legislative Reference Bureau and other interested parties. Over the course of the past several months, we developed substitute language that I hope addresses a number of DOC issues, while preserving my goal of forming an independent medical review panel on inmate deaths.

I requested a Legislative Council memo that outlines for the committee the differences between the original bill and the sub. As you will note in the description, it creates a new Inmate and Resident Mortality Board within DOC made up of 12 members appointed to staggered 4-year terms:

- 8 members appointed by the governor, including 2 physicians from the UW Hospital and Clinics, 2 from the Medical College of Wisconsin, one

MADISON:
POST OFFICE BOX 8953
MADISON, WISCONSIN 53708
(608) 266-7671
TOLL-FREE NUMBER: 1-888-534-0022
FAX: (608) 266-7038
E-MAIL: rep.wasserman@legis.state.wi.us
WEB PAGE: http://www.legis.state.wi.us/assembly/asm22/news/

HOME:
3487 NORTH LAKE DRIVE
MILWAUKEE, WISCONSIN 53211
(414) 964-0663

physician from a health care provider other than the UW or MCW, a registered nurse employed by a private HMO, a registered nurse employed by a private hospital and one member who is not employed by a state agency and does not represent any of the aforementioned entities.

- 4 members appointed by the DOC secretary, including a warden, a manager of a Health Services Unit, a health care provider who is employed by the Department of Corrections, and another employee of the department who works in a correctional facility.

- At least one of member of the board must be a board-certified forensics pathologist.

The board's duties and abilities would include:

- The responsibility of preparing reports on every inmate death to be submitted to a relative of the deceased, the DOC secretary, and if appropriate, the district attorney and the attorney general. The chairperson and ranking minority member of the appropriate standing committees in the assembly and senate will also receive these reports.

- Making recommendations to the department regarding medical and other prison procedures based on its investigations, and the work performance of department staff.

- Forwarding a complaint to the appropriate credentialing board if a medical provider is found negligent.

The board must meet at least four times per year, which is the current practice. However, under the sub amendment the chair or a majority of the board may request additional meetings. All findings of the board are, of course, subject to open records law. The department is explicitly required to cooperate with the board and provide any assistance the board requests to review the circumstances of a death. Specific timelines are set for the notification of inmate deaths, and when reports must be submitted.

The substitute amendment also gives the attorney general the power to order an inquest. I think it is critical that this new duty is established so that there is another avenue whereby an inquest may be requested aside from the district attorney.

Having all of this spelled out in the statutes will provide continuity through changes in the administration. It will bring accountability and structure to the process of reviewing inmate deaths, with a focus on the expertise of independent medical professionals. It will serve the government and the public well. I look forward to your questions and suggestions, and your support for this effort.

Thank you.

COMMITTEE ON INMATE/YOUTH DEATHS

Membership Roster

Kathleen Bellaire, RN
Deputy Director
Wisconsin Resource Center
Box 16
Winnebago, WI 54985
(920) 236-4181
Fax (920) 231-6353
bellaks@dhfs.state.wi.us

Sherran Dille, RN
Dean Clinic
1313 Fish Hatchery road
Madison, WI 53713
(608) 252-8212
Fax (608) 283-7314
Sherran.Dille@deancare.com

Shari Heinz, RN
Health Services Manager
Fox Lake Correctional Institution
P.O. Box 147, W10237 Lake Emily Rd.
Fox Lake, WI 53933-0147
Shari.Heinz@doc.state.wi.us

Judy Smith
Warden
Oshkosh Correctional Institution
1730 W. Snell Road
P.O. Box 3530
Oshkosh, WI 54905-3530
(920) 236-2601
Fax (920) 236-2615
judy.smith@doc.state.wi.us

David Titus
Director, Dodge County Department of Human Services
143 E. Center Street
Juneau, WI 53039
(920) 386-3534
Fax (920) 386-3533
dtitus@co.dodge.wi.us

Jeff Wells, MD
University of Wisconsin Hospital
K4/930 CSC
Highland Avenue
Madison, WI 53792
(608) 263-3035
Fax (608) 263-3647
jw2@medicine.wisc.edu

John Williams, MD
Marshfield Clinic
1000 N. Oak
Marshfield, WI 54449
Attn: Occupational Health
1-800-782-8581 Ext. 97415
Fax 715-389-4044
williams.john@marshfieldclinic.org

Non-Members

Kathleen Berkley, RN
Nursing Coordinator
Advisor to COIYD
Bureau of Health Services
P.O. Box 7925
Madison, WI 53707-7925
(608) 240-5126
Fax (608) 240-3311
Kathleen.Berkley@doc.state.wi.us

Robert Pultz, Attorney
Corrections- Office of Legal Counsel
Legal Advisor to COIYD
(608) 240-5045
Robert.Pultz@doc.state.wi.us

Diane Reinen, Program Assistant Supervisor
Dept. of Corrections - Bureau of Health Services
P.O. Box 7925
Madison, WI 53707-7925
Phone (608) 240-5123
Fax (608) 240-3311
Diane.Reinen@doc.state.wi.us

Assembly Committee on Corrections and the Courts

DATE

Moved by Colon Seconded by Poc

AB 152 SB _____ Clearinghouse Rule _____

AJR _____ SJR _____

A _____ SR _____ Other _____

A/S Amdt _____

A/S Amdt _____ to A/S Amdt _____

A/S Sub Amdt _____

A/S Amdt _____ to A/S Sub Amdt _____

A/S Amdt _____ to A/S Amdt _____ to A/S Sub Amdt _____

Be recommended for:

- ☐ Passage
- ☐ Introduction
- ☐ Adoption
- ☐ Rejection
- ☐ Indefinite Postponement
- ☐ Tabling
- ☐ Concurrence
- ☐ Nonconcurrence

	Committee Member	Aye	No	Absent	Not voting
1.	Rep. Garey Bies, chair	1			
2.	Rep. Sheryl Albers, vice-chair		2		
3.	Rep. Greg Underheim	2			
4.	Rep. Carol Owens	3			
5.	Rep. Frank Lasee	4			
6.	Rep. Scott Suder		2		
7.	Rep. Mark Honadel	5			
8.	Rep. Mark Pocan	6			
9.	Rep. Pedro Colon	7			
10.	Rep. Tony Staskunas	8			
11.	Rep. Sheldon Wasserman	9			
	Totals	9	2		

MOTION CARRIED ☑ MOTION FAILED ☐

s:\comclerk\rollcall.1

Assembly Committee on Corrections and the Courts

DATE

Moved by Wasser Seconded by Poc

AB 152 SB _____ Clearinghouse Rule _____

AJR _____ SJR _____

A _____ SR _____ Other _____

A/S Amdt _____

A/S Amdt _____ to A/S Amdt _____

A/S Sub Amdt 1

A/S Amdt _____ to A/S Sub Amdt _____

A/S Amdt _____ to A/S Amdt _____ to A/S Sub Amdt _____

Be recommended for:

- ☐ Passage
- ☐ Introduction
- ☒ Adoption
- ☐ Rejection
- ☐ Indefinite Postponement
- ☐ Tabling
- ☐ Concurrence
- ☐ Nonconcurrence

	Committee Member	Aye	No	Absent	Not voting
1.	Rep. Garey Bies, chair	1			
2.	Rep. Sheryl Albers, vice-chair		1		
3.	Rep. Greg Underheim	2			
4.	Rep. Carol Owens	3			
5.	Rep. Frank Lasee	4			
6.	Rep. Scott Suder		2		
7.	Rep. Mark Honadel	5			
8.	Rep. Mark Pocan	6			
9.	Rep. Pedro Colon	7			
10.	Rep. Tony Staskunas	8			
11.	Rep. Sheldon Wasserman	9			
	Totals	9	2		

MOTION CARRIED ☒ MOTION FAILED ☐

s:\comclerk\rollcall.1

Assembly Committee on Corrections and the Courts

DATE

Moved by Wasserman Seconded by Pocan

AB 152 SB _____ Clearinghouse Rule _____

AJR _____ SJR _____

A _____ SR _____ Other _____

A/S Amdt _____

A/S Amdt _____ to A/S Amdt _____

A/S Sub Amdt _____

A/S Amdt 1:886 to A/S Sub Amdt 1

A/S Amdt _____ to A/S Amdt _____ to A/S Sub Amdt _____

Be recommended for:

- ☐ Passage
- ☐ Introduction
- ☒ Adoption
- ☐ Rejection
- ☐ Indefinite Postponement
- ☐ Tabling
- ☐ Concurrence
- ☐ Nonconcurrence

	Committee Member	Aye	No	Absent	Not voting
1.	Rep. Garey Bies, chair	1			
2.	Rep. Sheryl Albers, vice-chair		1		
3.	Rep. Greg Underheim	2			
4.	Rep. Carol Owens	3			
5.	Rep. Frank Lasee	4			
6.	Rep. Scott Suder		2		
7.	Rep. Mark Honadel	5			
8.	Rep. Mark Pocan	6			
9.	Rep. Pedro Colon	7			
10.	Rep. Tony Staskunas	8			
11.	Rep. Sheldon Wasserman	9			
	Totals	9	2		

MOTION CARRIED ☒ MOTION FAILED ☐

s:\comclerk\rollcall.1

Wasserman Bill

Mary Zahn
414-224-2188

Plans for AB 152

AB 152

Is this necessary?

Do DAs currently have to request an inquest?

Inquire with DOC as to procedure when an inmate dies in custody.

How Much paid out in lawsuits.

Glenn
[redacted]
[redacted] Wavruniek

Matt Frank DOC

↳ Strengthens the commision

~by~

↳ Expands & broadens committee

↳ Additional medical review

↳ Input by those outside Agency

↳ Greater independence from the Agency

↳ Ability to review & provide input as to appropriate modifications to agency procedures

- Committee has ability to refer issues to DA or licensing agency.

Is he ever going to stop talking?

blah-blah-blah