OHIO Violent Death Reporting System

Part of CDC's National Violent Death Reporting System

Operated by the Ohio Department of Health, Violence & Injury Prevention Program

Collecting data since 2010

ESTABLISHING OHIO'S VIOLENT DEATH REPORTING SYSTEM

PARTNERSHIPS

EDUCATE PARTNERS such as Coroners & Law Enforcement about benefits of a state violent death reporting system & how it works

ESTABLISH ADVISORY BOARD that includes partners who will provide data to – & use data from – the state violent death reporting system

PARTNERS CAN ADVOCATE through their professional organizations for the new system

CHALLENGES

NO CENTRALIZED SOURCE FOR CORONER & LAW ENFORCEMENT DATA

- 88 county coroners
- 900+ law enforcement agencies

EXISTING STATE CONFIDENTIALITY LAWS

- Public Records Law & Open Meeting Acts
- Parts of Coroner reports considered confidential
- Law enforcement records confidential while death under investigation (can take years)

LINKED DATA in the OH-VDRS provide a more **COMPLETE PICTURE** of violent deaths in Ohio

LEGAL COUNSEL & GOVERNMENT AFFAIRS STAFF for the state health department can provide assistance

BENEFITS OF LEGISLATION

EASED CONFIDENTIALITY CONCERNS

- Law supports OH-VDRS when it ***requests*** data
- Law supports coroners & law enforcement when they ***provide*** data

Ensures data will be used for **VALID PUBLIC HEALTH REPORTING PURPOSES**

LOCAL-LEVEL VIOLENT DEATH DATA AVAILABLE for partners to use in their communities

HIGH PARTICIPATION RATES from coroners & law enforcement

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A LEGISLATIVE APPROACH TO ESTABLISHING THE OH-VDRS

To establish the Ohio Violent Death Reporting System (OH-VDRS), the Ohio Department of Health determined that legislation that mandates reporting by key data providers – including coroners and law enforcement agencies – was a necessary first step.

CHALLENGES

Like many states, Ohio has no centralized coroner or law enforcement data systems. Prior to the OH-VDRS, a request for data about a death had to be made to one of 88 county coroners, and at least one of the state's 900+ local law enforcement agencies.

Existing state laws regarding confidentiality presented challenges for establishing the OH-VDRS, including Ohio's Sunshine Laws (Public Records Law & Open Meeting Acts), which allow any person to make a request for information; **law enforcement records** that remain confidential while a death is under investigation (for homicides, this may take years); and **coroner records**, which include investigative notes that may remain confidential, while other coroner data are made public.

PARTNERSHIPS

Partnerships with coroners, medical examiners and law enforcement agencies – and the professional associations representing these partners – were central to the successful passage of the legislation.

To educate partners, the Violence & Injury Prevention Program (VIPP) provided information about the OH-VDRS to coroners, law enforcement and others. Partners supported the OH-VDRS and recommended a legislative approach once they understood how their data would be **kept confidential** and **used for violence prevention efforts** (not typical prior to the OH-VDRS). They also valued being able to **share county-level data from the OH-VDRS with prevention partners in their communities**.

The OH-VDRS Advisory Board included representatives from coroner and law enforcement associations, who spoke on behalf of the OH-VDRS during legislative hearings.

Legal counsel from the Ohio Department of Health helped the VIPP to draft model language. Staff from the department's Office of Government Affairs helped to identify potential legislative paths for the OH-VDRS legislation (e.g. state biennium and mid-biennium budget bills) and respond to requests about the legislation.

LEGISLATION

After multiple attempts over two years, legislation was passed that (1) **established** the OH-VDRS, (2) **authorized** the Ohio Department of Health to study and collect violent death data, (3) **mandated** reporting from key data sources relevant to the OH-VDRS, and (4) deemed all data collected and subsequent work products to be **confidential and exempt from public record requests**.

IMPACT OF LEGISLATION & MANDATED REPORTING

Ohio's legislation requiring confidential, mandated reporting contributed to the credibility and effectiveness of the OH-VDRS. The legislation:

- **supports the OH-VDRS** when it *requests* data from coroners, medical examiners and law enforcement, and **supports coroners and law enforcement** when they *release* data to the OH-VDRS;
- ensures that data collected for the OH-VDRS will be **used for valid public health reporting purposes**; and
- has resulted in **high participation rates** – almost 100% among coroners and about 80% among law enforcement – which in turn help ensure **OH-VDRS's long-term**

THE BIG PICTURE

Prior to establishing the OH-VDRS, the Violence & Injury Prevention Program (VIPP) had little data to support its assumptions about different kinds of violent deaths. Now the state has important information about violent deaths. For example:

- In 2010, there were 2,192 violent deaths in Ohio.
- 65%, or nearly two-thirds, of these violent deaths were suicides.
- About 25% of these deaths were homicides.

OH-VDRS data also includes information about the circumstances of violent deaths. With these data, the VIPP has evidence that:

Among women who died from homicide

- 54.2% of these deaths were related to intimate partner violence.

Among persons who died from suicide

- 41.3% were currently depressed,
- 53.1% had a current mental health problem,
- 21.7% had a previous suicide attempt, and

54%

of homicide deaths among women were related to intimate partner violence