

# Department of Homeland Security



## Special Investigations Report



Report Prepared for Chief and General Counsel  
Brian Abraham

## **Special Investigation In Re: Unreported COVID-19 Deaths**

The following summary is a preliminary overview of findings obtained as part of an ongoing investigation relating to the counting and reporting of COVID-19 deaths by the West Virginia Department of Health and Human Resources (WVDHHR).

This report will show that:

- There were no unreported deaths in the State of West Virginia from COVID-19 as the “Death Certificate” is the official record for tracking for all causes of death.
- Due to the COVID-19 pandemic it was necessary for the State of West Virginia to implement a daily COVID-19 tracking and tracing reporting system which was introduced in March 2020.
- Due to COVID-19 deaths occurring in multiple locations including, but not limited to a residence alone, residence with hospice, assisted living facilities, and hospitals unintentional failure to report COVID-19 deaths occurred to date on 301 occasions.
- Due to the lag time to prepare, submit, and issue a West Virginia Death Certificate it is not possible to use a death certificate for near real-time reporting of a COVID-19 death.
- There was no willfulness and intent by any reporting authority to cause incorrect data being reported or not reported to WVDHHR.

### **Assignment Background**

On Tuesday, 16 March 2021, following the receipt of information indicating a discrepancy between the number of COVID-19 deaths reported to WVDHHR through the administrative Chexout tracking system and the number of official death certificates received from the Bureau of Public Health, Office of Vital Statistics reflecting COVID-19 as the cause of death Governor Justice directed Chief of Staff and General Counsel Brian Abraham to have the West Virginia Department of Homeland Security (WVDHS) Special Investigative Team (SIT) conduct an investigation to determine the reasons behind the inconsistent numbers.

In cooperation with WVDHHR, members of the WVDHS SIT were designated as investigators for WVDHHR pursuant to the provisions of W.Va. Code 16-1-15 for purposes of conducting this preliminary review. Specifically, as part of a quality assurance “linkage” review, through which data from official death certificates is reconciled to corresponding data from provider-prepared *COVID-19 Death Report Forms*, on 22 February 2021, WVDHHR initially identified 168 cases for which a reporting form had not been submitted to WVDHHR. On 10 March 2021, an additional 54 such cases were identified, bringing the total to 222 for purposes of this review. **See Attachment #1** In addition to the 222, as of the date of this report a total of 301 have now been identified. These additional unreported cases will be included in the team’s final report.

Five (5) inter-agency investigative teams were formed and designated as special WVDHHR investigators. To date, over fifty (50) interviews have been conducted, and preliminary analysis has been conducted of underlying data, and supporting documentation. Team members have worked more than 1,000 hours on this investigation.

## Relevant Considerations

A few key concepts are significant for this inquiry.

As stated above with respect to the cases which are the subject of this investigation, there are no missing official death certificates. The death certificate is the official record for information related to a death in West Virginia. The COVID-19 Death Reporting Form is a regulatory form required to be submitted to allow for the timely reporting of information.

The process for reporting COVID-19 deaths takes place in two parallel tracks. **See Attachment #2**

1. *COVID-19 Death Report Forms* are the parallel regulatory tracking forms that healthcare providers are required to complete and submit to the Local Health Department (LHD). The LHD must then submit the *Form* to the WVDHHR. These parallel regulatory forms are a way of getting near real-time information to the health departments more quickly to aid in tracking and for providing more timely information to the public.
2. Death certificates, the traditional long form documenting all state deaths, are issued through the West Virginia Bureau of Public Health, Office of Vital Statistics. The time frame for obtaining a West Virginia death certificate, parts of which must be completed by the person who pronounces or certifies a death, can take up to seven (7) weeks.

While there are no missing death certificates found during the investigation, not every death certificate that notes COVID-19 as a contributing factor, or as the cause of death, has a corresponding regulatory *COVID-19 Death Report Form*.

The *COVID-19 Death Report Forms* that failed to show up in the WVDHHR tracking system are the regulatory *forms*, which were required to be submitted to the WVDHHR, through the various LHD's, pursuant to [West Virginia Rule 64CSR-7](#).

Therefore, all COVID-19 deaths were ultimately accounted for in the State of West Virginia through the traditional death certificate process. However, the near real-time parallel reporting process was disrupted by a variety of operational factors, which led to the lack of corresponding *COVID-19 Death Report Forms* in the cases considered for this present review.

This issue has also come to light in multiple states including Kentucky and Ohio.

[Kentucky reports 25 additional COVID-19 related deaths, 166 additional deaths from audit | Coronavirus News | WPSD Local 6](#)

[Ohio auditor: Release separate COVID-19 death category data | Ap | herald-dispatch.com \(herald-dispatch.com\)](#)

## COVID-19 Death Reporting Process and Requirements

On 6 March 2020, [HEALTH ALERT #165](#) was issued by WVDHHR for publication to healthcare providers, hospitals and to LHDs for distribution to community health providers, hospital-based physicians, infection control preventionists, laboratory directors, and other applicable partners categorizing COVID-19 as a Category 1A Reportable Condition and directing that all suspected and confirmed cases be immediately reported to the LHD per the [West Virginia Reportable Disease Rule \(64CSR-7\)](#)

On 3 June 2020, [HEALTH ALERT #166](#) was issued by WVDHHR, requiring providers and health facilities (as defined by Rule 64CSR7 to include “any hospital, nursing home, clinic, cancer treatment center, laboratory, or other facility which provides healthcare or diagnostic services to individuals, whether public or privately owned”) to report deaths related to COVID-19” to the LHD of the patient’s county of residence within 24 hours, by telephone and fax, using the newly developed [COVID-19 Death Report Form](#). A link to the *Form*, and to Instructions for completing it, appear within the Health Alert Notification. Information was also posted on the WVDHHR coronavirus website.

On 13 November 2020, [HEALTH ALERT #172](#) was issued by WVDHHR, reiterating that COVID-19 remained a Category 1A Reportable Condition and that all deaths are immediately reportable to the LHD for the patients county of residence. [See Attachment #3](#)

The instructions set forth the method by which responsibility for tracking and reporting of COVID-19 deaths is to be shared among healthcare providers and facilities, LHDs, and WVDHHR. Facilities and providers, as defined by the Rule, are required to immediately complete the *COVID-19 Death Report Form* and send it to the LHD serving the patient’s county of residence. The LHD is then responsible for submitting the information to the WVDHHR.

Prior to September 2020, the WV Electronic Disease Surveillance System (WVEDSS) was the platform used by West Virginia for the reporting of infectious diseases. Based on a determination that the system was ineffective for handling the volume of cases and information needed for contact tracing and investigations, the decision was made to upgrade the reporting system. In September 2020, Chexout was rolled out as the new platform through which the LHDs were required to submit the reporting *Form* to the WVDHHR.

The Chexout system generates a daily report of all LHD submitted COVID-19 Death Report Forms. The report is reviewed by epidemiologists from the WVDHHR. The daily death report numbers are then published on the WVDHHR website dashboard and forwarded to the Governor’s office for public release.

In January 2021 the WVDHHR implemented a “data linkage” or reconciliation protocol. Epidemiologists now compare the death certificate information received from the Office of Vital Statistics with the information contained on the *COVID-19 Death Report Forms* received from the LHDs to ensure proper reporting reconciliation. The initial comparison was completed on 24 January 2021, and it was through this quality assurance process on 17 March 2021 that the discrepancy was discovered.

Upon discovering the discrepancy, WVDHHR contacted all facilities and LHDs connected with the identified deaths and began working with them to reconcile discrepancies. As of this date, all discrepancies and reporting irregularities in cases which are the subject of this preliminary review have been reconciled, and all the deaths are now reported out publicly as COVID-19 deaths.

### **Executive Summary of Preliminary Findings**

The investigation has preliminarily identified various contributing factors that resulted in failure to provide timely counts of deaths through the *COVID-19 Death Report Form* process ([See Attachment #4](#)):

#### **1. LHD and Healthcare Employees Overwhelmed by the Course and Nature of the Pandemic**

Nearly without exception those interviewed during this preliminary investigation reported that the overwhelming and demanding nature of the responsibilities and workloads faced by the LHD staffs throughout the course of the pandemic as they undertook ongoing duties related to testing, contact tracing, investigations, reporting, record keeping, education for local healthcare providers as reporting and compliance protocols changed, and planning and delivering vaccines, were among the daily

responsibilities faced by exhausted and often overwhelmed staff members. In some instances, LHDs were not notified through the established reporting process, but instead learned of a death through community sources and had to track down information independently. There were also providers who reported that they phoned death reports in to their LHDs, and that later (when the reporting process was changed) they faxed the *Forms* in, but the information was never relayed by the LHDs to WVDHHR. The consensus, as relayed to investigators, appears to be that these occurrences, and others like them, are reasonably attributable to the fact of the pandemic itself and the outgrowth of the intensifying fatigue and challenges arising from it.

## **2. Reporting Process Changes**

The new *COVID-19 Death Report Form*, specifically designated for near real-time COVID-19 death reporting, was implemented in June 2020 and announced via **Health Alert #166**. Responsibility for informing and educating providers about the requirements of a *Health Alert* falls to LHDs and created additional strains on LHD workloads. It was relayed to investigators by an employee familiar with the use of *Health Alerts*, such as the ones used to notify the LHDs about the changes in reporting procedures and related information, that even in “normal times” the use of *Health Alerts* often results in a “gap” or lag in “education” or understanding for providers who receive the information from the LHD, but in *this* case, with the LHDs already overwhelmed, and then tasked with the additional responsibility of educating providers, it appears that there was perhaps early confusion about the reporting responsibilities and procedures required of healthcare providers, as “information flow” and assistance was hampered by competing priorities and responsibilities. Providers who were unfamiliar with revised reporting requirements may not have reported deaths to the LHDs. LHD workers also said that sometimes *COVID-19 Death Report Forms* were not forwarded to WVDHHR because they were waiting for doctors/providers to supply a cause of death which didn’t accompany the original report. Staff turnovers, as a result of the pandemic, were common at LHDs and at healthcare facilities, and the resulting unfamiliarity with reporting requirements could also have attributed to reporting breakdowns on both ends.

While there were some concerns expressed regarding the timing and communication surrounding the rollout of the new Chexout electronic surveillance platform, which was implemented in the fall, at the start of the pandemic surge, the numbers, as reflected on the graph on **Attachment #1** and the **Attachment #5** do not necessarily support a claim that unreported *COVID-19 Death Report Forms* can be significantly attributed to perceived difficulties and failures of the Chexout system.

## **3. Hospice and Home Reporting Requirements Perhaps Unclear**

Many LHD representatives reported that there were particular problems in getting *Reports* from providers who attended home deaths, and perhaps hospice and long-term care facility deaths, as well. This was largely attributed to a lack of knowledge or understanding by primary care and other types of healthcare providers regarding their responsibility to report COVID-19 home deaths to the LHD. As a result, while the death certificate information would reflect COVID-19 (when received from the Office of Vital Statistics), there would be no matching provider *COVID-19 Death Report Form* filed with the LHD, and accordingly, no information submitted to WVDHHR. These deaths, therefore, were not recognized as COVID-19 deaths until their death certificates were filed with the Office of Vital Statistics and reconciled by WVDHHR as an earlier death that needed to be added to the COVID-19 death count.

## **4. Uncertainties about what Constituted a COVID-19 Death.**

In some instances, *COVID-19 Death Report Forms* were not submitted to the LHD because providers were of the opinion that a death was not, in fact, a confirmed or probable COVID-19 death. Investigators heard accounts about individuals, who, prior to their death, had been diagnosed with COVID-19, but who may have died weeks or even months later and did not appear to be symptomatic for COVID-19 at the time of their death. In at least one case, the individual had in fact tested negative prior to her death. In other cases, individuals had never had a positive COVID-19 test, so it was not confirmed that they in

fact had ever actually contracted the virus. Some of these individuals, furthermore, were afflicted with serious or incurable underlying conditions and diseases, for which death was considered the inevitable result. Providers may have noted on death certificates in some of these cases that the decedent had either been previously diagnosed with COVID-19, or had been “exposed” to COVID-19, as a condition that possibly “contributed” to the death, although it wasn’t believed by them to be the primary cause and accordingly did not report the death to the LHD. The notation of “COVID-19” or “coronavirus” on the Death Certificate, however, according to national standards, requires that the death be counted as a COVID-19 death. The DHHR must therefore reconcile these death certificates with its “real-time” reporting and add them into the count, since there would not be an initial *Report* filed by the provider with the LHD. The National Center for Health Statistics has published “Guidance for Certifying Deaths Due to Coronavirus Disease 2019” for clinicians making decisions in these situations.

## **5. Surge Phase of the Pandemic**

Another point made by nearly everyone interviewed during this preliminary investigation who was involved in some stage of the reporting and tracking process, was the fact that the highest volume of reportable information was being received by LHDs during the surge in West Virginia cases and deaths, which occurred between December 2020 and February 2021, and which also happened to coincide with the holiday season. A review of the numbers at issue reflect that the largest number of missing *COVID-19 Death Report Forms* occurred during this surge, at which time the rising case and death numbers required a redirecting of focus by the entire healthcare community to patients and their care, rather than the completion of reporting forms. Healthcare facilities were likewise operating at – and at times above – capacity, and often with reduced employee numbers and/or surge staffing who may not have been familiar with reporting requirements. From November 2020 to January 2021, the period of the highest incidence of missing *COVID-19 Death Report Forms*.

## **6. Transition from Testing and Reporting to Vaccination Phase**

It was also during this time that implementation of the vaccine phase began, and this undertaking was likewise a responsibility shared by and coordinated with the LHDs. With the availability of the vaccine LHDs faced mounting priorities of testing, reporting, and getting “shots in arms” with the coordination county-wide efforts to get populations vaccinated, which many believed could have been a contributing factor to incidents of delayed or overlooked reporting.

## **7. Incomplete, Indecipherable Paperwork; Names Transposed or Misspelled, and Jurisdictional Questions about Reporting Out-of-County and Out-of-State Cases**

For the most part, these “clerical” type errors, a number of which were discovered during this inquiry, have been remedied by the WVDHHR’s investigations and reconciliation efforts following their discovery.

## **Conclusion**

Individually, any one of the above-identified factors could account for reports being set aside for later entry, lost, ignored or mis-filed. The WVDHHR put quality assurance protocols in place for the comparison of the parallel reporting systems data, which led the discovery of the discrepancies and are continuing to prove effective.

As stated at the beginning of this report the investigation would show and did show that:

- There were no unreported deaths in the State of West Virginia from COVID-19 as the “Death Certificate” is the official record for tracking for all causes of death.
- Due to the COVID-19 pandemic it was necessary for the State of West Virginia to implement a daily COVID-19 tracking and tracing reporting system which was introduced in March 2020.

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- There was no willfulness and intent by any reporting authority to cause incorrect data being reported or not reported to WVDHHR.

### **Resources**

The West Virginia Department of Homeland Security is proud of the following men and women who diligently worked 11 straight days on this important matter for the Governor of West Virginia.

#### **Office of the Secretary**

Jeff Sandy, Secretary

William Valentino, General Counsel

#### **Division of Corrections and Rehabilitations**

Betsy Jividen, Commissioner

John Frisby, Office of Investigations

Tina Paczewski, Office of Investigations

#### **Division of Emergency Management**

William Minear, Deputy Director Office of Investigations

#### **Fusion Center**

Jack Luikart, Director

Steven Patterson, Deputy Director

Camichelle Spencer, Analyst

Chelsie Cooper, Analyst

Preston McNair, Analyst

#### **Division of Protective Services**

Kevin Foreman, Director

Jack Chambers, Deputy Director

Chad Hess, Investigator

Wallace E. Looney, Investigator

David Sutphin, Investigator

Herb Doss, Investigator

#### **State Fire Marshal Office**

Shawn Petry, Assistant Fire Marshal

#### **State Police**

L.K. Boytek, Investigator

S.E. Wolfe, Investigator

John Smith, Investigator

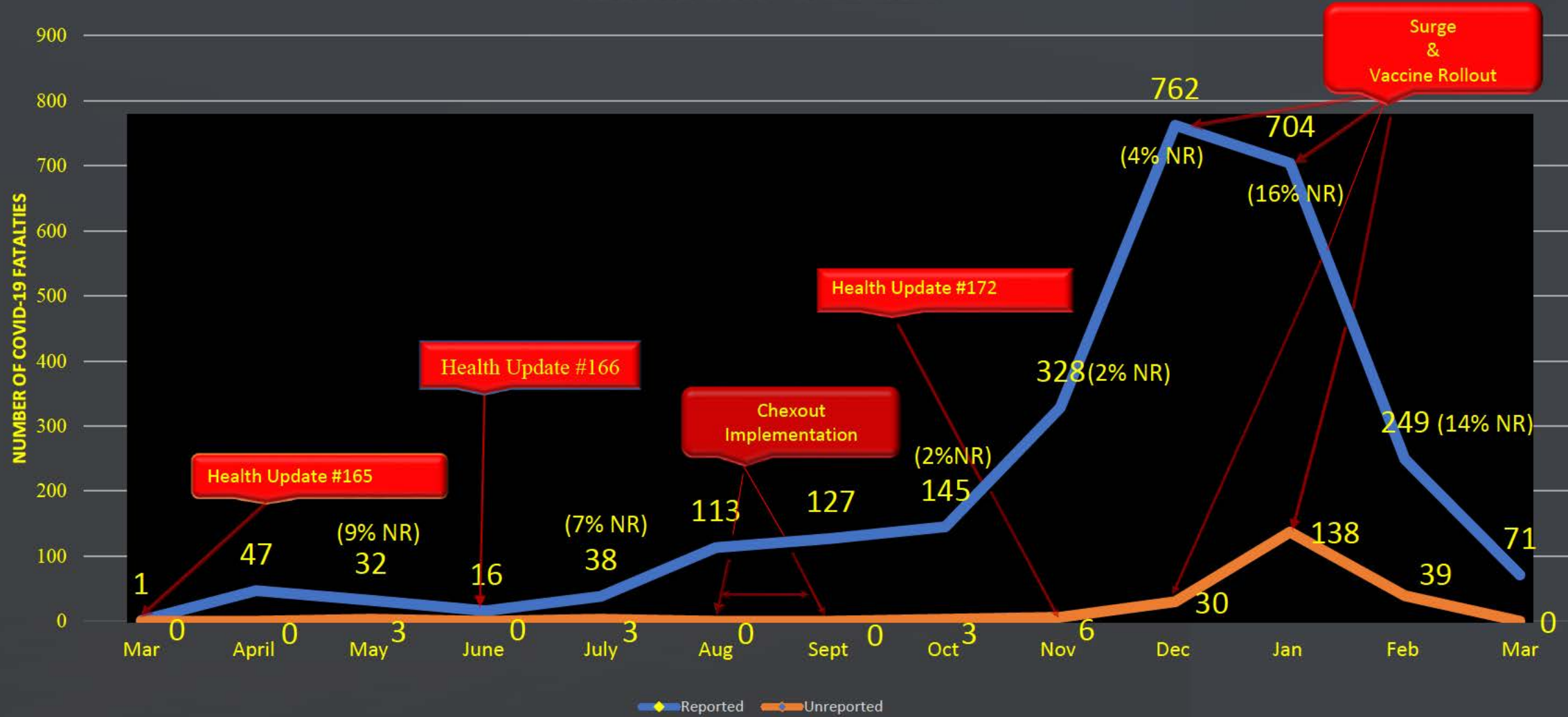
Dean Olack, Investigator

#### **Office of Technology**

James Amos, Computer Investigative Specialist

# Attachment #1

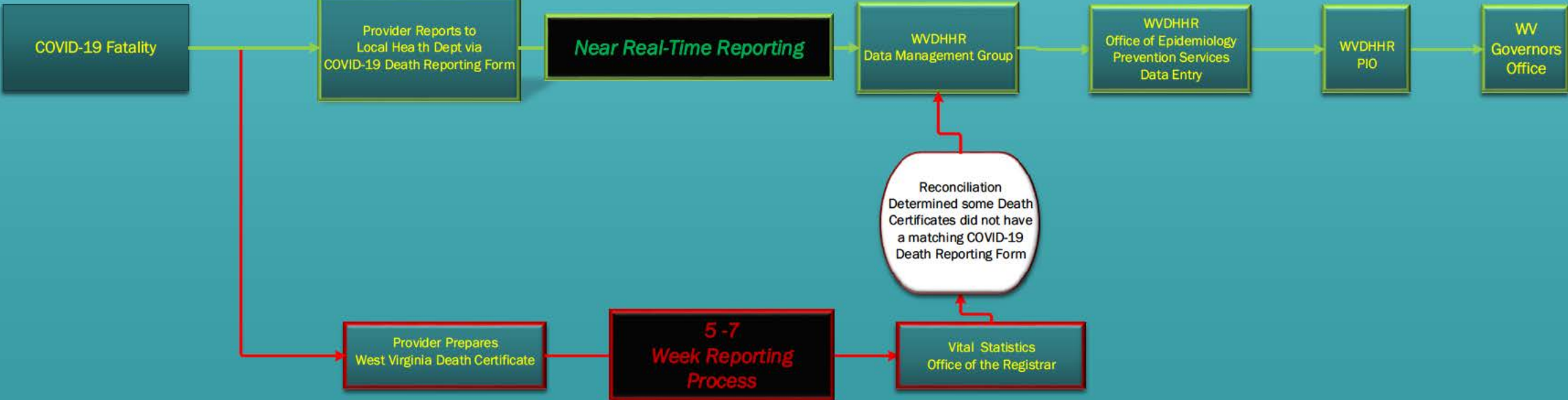
## COVID-19 FATALITIES REPORTED & UNREPORTED MARCH 2020 - FEB 2021





# Attachment #2

## COVID-19 Death Reporting Process



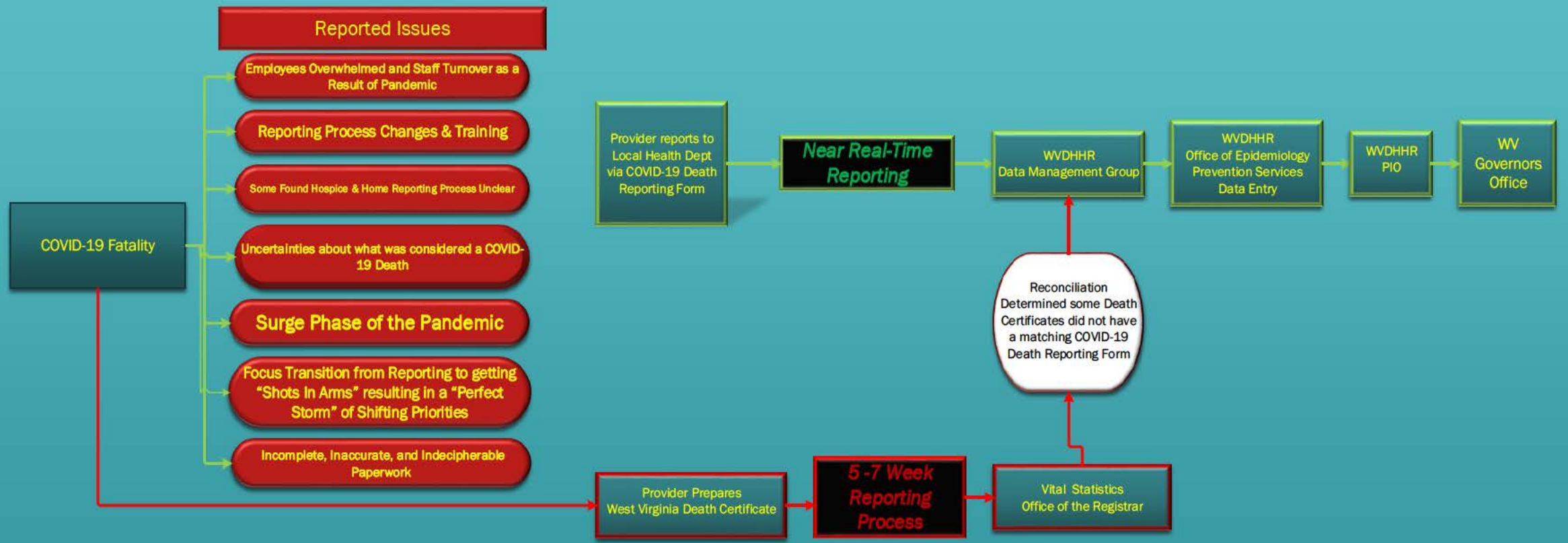
# Attachment #3

## COVID-19 Death Reporting Process Changes 2020



# Attachment #4

## COVID-19 Death Reporting Process Reported Issues



# Attachment #5

## COVID-19 FATALITES REPORTED & UNREPORTED

### MARCH 2020 - FEB 2021

