1	SENATE FLOOR VERSION		
2	April 11, 2018 AS AMENDED		
3	ENGROSSED HOUSE		
4	BILL NO. 2798 By: Downing, McCall, Sanders, West (Tammy), Blancett,		
5	Bush, Frix and O'Donnell of the House		
6	and		
7	Griffin of the Senate		
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10	[public health and safety - Opioid Overdose Fatality Review Board - codification - effective date]		
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14	BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:		
15	SECTION 1. NEW LAW A new section of law to be codified		
16	in the Oklahoma Statutes as Section 2-1001 of Title 63, unless there		
17	is created a duplication in numbering, reads as follows:		
18	A. There is hereby created until July 1, 2023, in accordance		
19	with the Oklahoma Sunset Law, the Opioid Overdose Fatality Review		
20	Board within the Office of the Attorney General. The Board shall		
21	have the power and duty to:		
22	1. Conduct case reviews of deaths of persons eighteen (18)		
23	years of age or older due to licit or illicit opioid use in this		
24	state;		

2. Collect, analyze and interpret state and local data on
2 opioid overdose deaths;

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- 3. Develop a state and local database on opioid overdose deaths;
- 4. Improve policies, procedures and practices within the agencies in order to prevent fatal opioid overdoses; and
- 5. Enter into agreements with other state, local or private entities as necessary to carry out the duties of the Opioid Overdose Fatality Review Board.
- B. In carrying out its duties and responsibilities, the Board shall:
- 1. Promulgate rules establishing criteria for identifying cases involving an opioid overdose death subject to specific, in-depth review by the Board;
 - 2. Conduct a specific case review of those cases where the cause of death is or may be related to licit or illicit use of opioid drugs;
 - 3. Establish and maintain statistical information related to opioid overdose deaths including, but not limited to, demographic and medical diagnostic information;
 - 4. Establish procedures for obtaining initial information regarding opioid overdose deaths from law enforcement agencies;
- 5. Review the policies, practices and procedures of the medical system and law enforcement system and make specific recommendations

1 to the entities comprising the medical and law enforcement systems for actions necessary for the improvement of the system; 6. Review the extent to which medical and law enforcement 3 systems are working together and evaluate whether the state is 4 5 efficiently discharging its drug overdose prevention responsibilities; 7 7. Request and obtain a copy of all records and reports pertaining to an adult whose case is under review including, but not limited to: 10 the report of the medical examiner, a. 11 b. hospital records, 12 C. school records, d. court records, 13 prosecutorial records, 14 e. f. local, state and federal law enforcement records 15 including, but not limited to, the Oklahoma State 16 Bureau of Investigation (OSBI) and Oklahoma State 17 Bureau of Narcotics and Dangerous Drugs Control (OBN), 18 fire department records, 19 q. State Department of Health records, including birth 20 h. certificate records, 21 i. medical and dental records, 22 Department of Mental Health and Substance Abuse 23 j.

Services and other mental health records,

- k. emergency medical service records, and
- 2 l. files of the Department of Human Services.

- Confidential information provided to the Board shall be maintained by the Board in a confidential manner as otherwise required by state and federal law. Any person damaged by disclosure of such confidential information by the Board or its members which is not authorized by law may maintain an action for damages, costs and attorney fees pursuant to The Governmental Tort Claims Act;
- 8. Maintain all confidential information, documents and records in possession of the Board as confidential and not subject to subpoena or discovery in any civil or criminal proceedings; provided however, information, documents and records otherwise available from other sources shall not be exempt from subpoena or discovery through those sources solely because such information, documents and records were presented to or reviewed by the Board;
- 9. Conduct reviews of specific cases of opioid overdose deaths and request the preparation of additional information and reports as determined to be necessary by the Board including, but not limited to, clinical summaries from treating physicians, chronologies of contact and second-opinion autopsies;
- 10. Report, if recommended by a majority vote of the Board, to the Governor, the President Pro Tempore of the Senate and the Speaker of the House of Representatives any gross neglect of duty by any state officer or state employee or any problem within the

1 medical and law enforcement system discovered by the Board while 2 performing its duties; and

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- 11. Exercise all incidental powers necessary and proper for the implementation and administration of the Opioid Overdose Fatality Review Board.
- The review and discussion of individual cases of an opioid С. overdose death shall be conducted in executive session. All other business shall be conducted in accordance with the provisions of the Oklahoma Open Meeting Act. All discussions of individual cases and any writings produced by or created for the Board in the course of determining a remedial measure to be recommended by the Board, as the result of a review of an individual case of an opioid overdose death, shall be privileged and shall not be admissible in evidence in any proceeding. The Board shall periodically conduct meetings to discuss organization and business matters and any actions or recommendations aimed at improvement of the medical system or law enforcement system which shall be subject to the Oklahoma Open Meeting Act. Part of any meeting of the Board may be specifically designated as a business meeting of the Board subject to the Oklahoma Open Meeting Act.
- D. The Board shall submit an annual statistical report on the incidence and causes of opioid overdose deaths in this state for which the Board has completed its review during the past calendar year including its recommendations, if any, to the medical and law

1	enforcement system. The Board shall also prepare and make available			
2	to the public, on an annual basis, a report containing a summary of			
3	the activities of the Board relating to the review of opioid			
4	overdose deaths, the extent to which the state medical and law			
5	enforcement system is coordinated and an evaluation of whether the			
6	state is efficiently discharging its responsibilities to prevent			
7	opioid overdose deaths. The report shall be completed no later than			
8	February 1 of the subsequent year.			
9	SECTION 2. NEW LAW A new section of law to be codified			
10	in the Oklahoma Statutes as Section 2-1002 of Title 63, unless there			
11	is created a duplication in numbering, reads as follows:			
12	A. The Opioid Overdose Fatality Review Board shall be composed			
13	of eighteen (18) members, or their designees, as follows:			

- 1. Eight of the members shall be:
 - a. the Attorney General,
 - b. the Chief Medical Examiner,
 - c. the State Commissioner of Health,
 - d. the Chief of Injury Prevention Services of the State Department of Health,
 - e. the President of the Oklahoma State Medical Association,
 - f. the Director of the Oklahoma State Bureau of Narcotics and Dangerous Drugs Control,

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1	g.	the Commissioner of the Department of Mental Health
2		and Substance Abuse Services, and
3	h.	the President of the Oklahoma Osteopathic Association;
4		and
5	2. Ten	of the members shall be appointed by the Attorney
6	General, sh	all serve for terms of two (2) years and shall be
7	eligible fo	r reappointment. The members shall be persons having
8	training an	d experience in matters related to opioid abuse and
9	prevention.	The appointed members shall include:
10	a.	a county sheriff selected from a list of three names
11		submitted by the executive board of the Oklahoma
12		Sheriffs' Association,
13	b.	a chief of a municipal police department selected from
14		a list of three names submitted by the Oklahoma
15		Association of Chiefs of Police,
16	C.	an attorney licensed in this state who is in private
17		practice selected from a list of three names submitted
18		by the Board of Governors of the Oklahoma Bar
19		Association,
20	d.	a district attorney selected from a list of three
21		names submitted by the District Attorneys Council,
22	е.	a physician with emergency medical training selected
23		from a list of three names submitted by the Oklahoma

State Medical Association,

- f. a physician with experience in drug addiction

 treatment and recovery selected from a list of three

 names submitted by the Oklahoma Osteopathic

 Association,
 - g. a nurse selected from a list of three names submitted by the Oklahoma Nurses Association,
 - h. two individuals, at least one of whom shall be a person in recovery from an addiction to licit or illicit opioids, selected from a list of three names submitted by the Oklahoma Department of Mental Health and Substance Abuse Services, and
 - i. a member of the Judiciary selected from a list of three names submitted by the Oklahoma Supreme Court.
 - B. Every two (2) years the Board shall elect from among its membership a chair and a vice-chair. The Board shall meet at least quarterly and may meet more frequently as necessary as determined by the chair. Members shall serve without compensation but may be reimbursed for necessary travel out of funds available to the Office of the Attorney General pursuant to the State Travel Reimbursement Act; provided, that the reimbursement shall be paid in the case of state employee members by the agency employing the member.
 - C. With funds appropriated or otherwise available for that purpose, the Office of the Attorney General shall provide

- 1 administrative assistance and services to the Opioid Overdose 2 Fatality Review Board.
- 3 SECTION 3. NEW LAW A new section of law to be codified 4 in the Oklahoma Statutes as Section 2-1003 of Title 63, unless there 5 is created a duplication in numbering, reads as follows:
 - A. Beginning November 1, 2018, the Center for Health Statistics of the Department of Health shall forward to the Office of the Chief Medical Examiner on a monthly basis copies of all death certificates of persons over eighteen (18) years of age received by the Center for Health Statistics during the preceding month whereby the cause of death was due to an overdose of licit or illicit drugs including opioids meeting the Center for Disease Control guidelines for opioid related deaths.
 - B. The Office of Chief Medical Examiner shall conduct an initial review of overdose death certificates in accordance with the criteria established by the Opioid Overdose Fatality Review Board and refer to the Board those cases that meet the criteria established by the Board for specific case review.
 - C. Upon the request of the Board, every entity within the medical and law enforcement system shall provide to the Board any information requested by the Board.
- SECTION 4. This act shall become effective November 1, 2018.
- 23 COMMITTEE REPORT BY: COMMITTEE ON APPROPRIATIONS
 April 11, 2018 DO PASS AS AMENDED

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