

1 ENGROSSED HOUSE  
2 BILL NO. 2798

By: Downing, McCall, Sanders,  
West (Tammy), Blancett,  
Bush, Frix and O'Donnell of  
the House

4 and

5 Griffin of the Senate

6  
7  
8 An Act relating to public health and safety; creating  
9 the Opioid Overdose Fatality Review Board; stating  
10 powers and duties of the Board; providing list of  
11 duties and responsibilities of the Board; requiring  
12 Board to meet in executive session when reviewing and  
13 discussing overdose cases; making certain discussions  
14 and documents privileged and inadmissible in  
15 proceedings; requiring business meetings conducted by  
16 the Board be in compliance with the Oklahoma Open  
17 Meeting Act; directing Board to submit and make  
18 available to the public annual statistical reports  
19 and summary of activities by certain date; providing  
20 for membership of the Board; providing for election  
21 of chair and vice-chair; requiring Board to meet on  
22 quarterly basis; providing for travel reimbursement;  
23 directing Office of the Attorney General to provide  
24 administrative assistance and services to the Board;  
requiring the Center for Health Statistics of the  
Department of Health to forward certain death  
certificates to the Office of the Chief Medical  
Examiner; directing Office of Chief Medical Examiner  
to conduct reviews of overdose death certificates;  
requiring medical and law enforcement entities to  
provide information to the Board upon request;  
providing for codification; and providing an  
effective date.

24 BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

SECTION 1. NEW LAW

A new section of law to be codified in the Oklahoma Statutes as Section 2-1001 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. There is hereby created until July 1, 2023, in accordance with the Oklahoma Sunset Law, the Opioid Overdose Fatality Review Board within the Office of the Attorney General. The Board shall have the power and duty to:

1. Conduct case reviews of deaths of persons eighteen (18) years of age or older due to licit or illicit opioid use in this state;

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

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;

1        2. Conduct a specific case review of those cases where the  
2 cause of death is or may be related to licit or illicit use of  
3 opioid drugs;

4        3. Establish and maintain statistical information related to  
5 opioid overdose deaths including, but not limited to, demographic  
6 and medical diagnostic information;

7        4. Establish procedures for obtaining initial information  
8 regarding opioid overdose deaths from law enforcement agencies;

9        5. Review the policies, practices and procedures of the medical  
10 system and law enforcement system and make specific recommendations  
11 to the entities comprising the medical and law enforcement systems  
12 for actions necessary for the improvement of the system;

13       6. Review the extent to which medical and law enforcement  
14 systems are working together and evaluate whether the state is  
15 efficiently discharging its drug overdose prevention  
16 responsibilities;

17       7. Request and obtain a copy of all records and reports  
18 pertaining to an adult whose case is under review including, but not  
19 limited to:

- 20           a. the report of the medical examiner,
- 21           b. hospital records,
- 22           c. school records,
- 23           d. court records,
- 24           e. prosecutorial records,

- f. local, state and federal law enforcement records including, but not limited to, the Oklahoma State Bureau of Investigation (OSBI) and Oklahoma State Bureau of Narcotics and Dangerous Drugs Control (OBN),
- g. fire department records,
- h. State Department of Health records, including birth certificate records,
- i. medical and dental records,
- j. Department of Mental Health and Substance Abuse Services and other mental health records,
- k. emergency medical service records, and
- 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

1 those sources solely because such information, documents and records  
2 were presented to or reviewed by the Board;

3 9. Conduct reviews of specific cases of opioid overdose deaths  
4 and request the preparation of additional information and reports as  
5 determined to be necessary by the Board including, but not limited  
6 to, clinical summaries from treating physicians, chronologies of  
7 contact and second-opinion autopsies;

8 10. Report, if recommended by a majority vote of the Board, to  
9 the Governor, the President Pro Tempore of the Senate and the  
10 Speaker of the House of Representatives any gross neglect of duty by  
11 any state officer or state employee or any problem within the  
12 medical and law enforcement system discovered by the Board while  
13 performing its duties; and

14 11. Exercise all incidental powers necessary and proper for the  
15 implementation and administration of the Opioid Overdose Fatality  
16 Review Board.

17 C. The review and discussion of individual cases of an opioid  
18 overdose death shall be conducted in executive session. All other  
19 business shall be conducted in accordance with the provisions of the  
20 Oklahoma Open Meeting Act. All discussions of individual cases and  
21 any writings produced by or created for the Board in the course of  
22 determining a remedial measure to be recommended by the Board, as  
23 the result of a review of an individual case of an opioid overdose  
24 death, shall be privileged and shall not be admissible in evidence

1 in any proceeding. The Board shall periodically conduct meetings to  
2 discuss organization and business matters and any actions or  
3 recommendations aimed at improvement of the medical system or law  
4 enforcement system which shall be subject to the Oklahoma Open  
5 Meeting Act. Part of any meeting of the Board may be specifically  
6 designated as a business meeting of the Board subject to the  
7 Oklahoma Open Meeting Act.

8 D. The Board shall submit an annual statistical report on the  
9 incidence and causes of opioid overdose deaths in this state for  
10 which the Board has completed its review during the past calendar  
11 year including its recommendations, if any, to the medical and law  
12 enforcement system. The Board shall also prepare and make available  
13 to the public, on an annual basis, a report containing a summary of  
14 the activities of the Board relating to the review of opioid  
15 overdose deaths, the extent to which the state medical and law  
16 enforcement system is coordinated and an evaluation of whether the  
17 state is efficiently discharging its responsibilities to prevent  
18 opioid overdose deaths. The report shall be completed no later than  
19 February 1 of the subsequent year.

20 SECTION 2. NEW LAW A new section of law to be codified  
21 in the Oklahoma Statutes as Section 2-1002 of Title 63, unless there  
22 is created a duplication in numbering, reads as follows:

23 A. The Opioid Overdose Fatality Review Board shall be composed  
24 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,
  - g. the Commissioner of the Department of Mental Health and Substance Abuse Services, and
  - h. the President of the Oklahoma Osteopathic Association;
- and

2. Ten of the members shall be appointed by the Attorney General, shall serve for terms of two (2) years and shall be eligible for reappointment. The members shall be persons having training and experience in matters related to opioid abuse and prevention. The appointed members shall include:

- a. a county sheriff selected from a list of three names submitted by the executive board of the Oklahoma Sheriffs' Association,

- 1           b.    a chief of a municipal police department selected from  
2               a list of three names submitted by the Oklahoma  
3               Association of Chiefs of Police,  
4           c.    an attorney licensed in this state who is in private  
5               practice selected from a list of three names submitted  
6               by the Board of Governors of the Oklahoma Bar  
7               Association,  
8           d.    a district attorney selected from a list of three  
9               names submitted by the District Attorneys Council,  
10          e.    a physician with emergency medical training selected  
11               from a list of three names submitted by the Oklahoma  
12               State Medical Association,  
13          f.    a physician with experience in drug addiction  
14               treatment and recovery selected from a list of three  
15               names submitted by the Oklahoma Osteopathic  
16               Association,  
17          g.    a nurse selected from a list of three names submitted  
18               by the Oklahoma Nurses Association,  
19          h.    two individuals, at least one of whom shall be a  
20               person in recovery from an addiction to licit or  
21               illicit opioids, selected from a list of three names  
22               submitted by the Oklahoma Department of Mental Health  
23               and Substance Abuse Services, and  
24



1           i.     a member of the Judiciary selected from a list of  
2                   three names submitted by the Oklahoma Supreme Court.

3           B.    Every two (2) years the Board shall elect from among its  
4 membership a chair and a vice-chair. The Board shall meet at least  
5 quarterly and may meet more frequently as necessary as determined by  
6 the chair. Members shall serve without compensation but may be  
7 reimbursed for necessary travel out of funds available to the Office  
8 of the Attorney General pursuant to the State Travel Reimbursement  
9 Act; provided, that the reimbursement shall be paid in the case of  
10 state employee members by the agency employing the member.

11          C.    With funds appropriated or otherwise available for that  
12 purpose, the Office of the Attorney General shall provide  
13 administrative assistance and services to the Opioid Overdose  
14 Fatality Review Board.

15          SECTION 3.       NEW LAW       A new section of law to be codified  
16 in the Oklahoma Statutes as Section 2-1003 of Title 63, unless there  
17 is created a duplication in numbering, reads as follows:

18          A.    Beginning November 1, 2018, the Center for Health Statistics  
19 of the Department of Health shall forward to the Office of the Chief  
20 Medical Examiner on a monthly basis copies of all death certificates  
21 of persons over eighteen (18) years of age received by the Center  
22 for Health Statistics during the preceding month whereby the cause  
23 of death was due to an overdose of licit or illicit drugs including  
24 opioids.

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.

Passed the House of Representatives the 12th day of March, 2018.

Presiding Officer of the House  
of Representatives

Passed the Senate the \_\_\_\_ day of \_\_\_\_\_, 2018.

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Presiding Officer of the Senate