

**SENATE CHAMBER**  
**STATE OF OKLAHOMA**

DISPOSITION

☐ FLOOR AMENDMENT

No. \_\_\_\_\_

\_\_\_\_\_

☐ COMMITTEE AMENDMENT

\_\_\_\_\_  
(Date)

Mr./Madame President:

I move to amend House Bill No. 2798, by substituting the attached floor substitute for the title, enacting clause and entire body of the measure.

Submitted by:

\_\_\_\_\_  
Senator Griffin

Griffin-BHG-FS-Req#3621  
4/16/2018 1:42 PM

(Floor Amendments Only)    Date and Time Filed: \_\_\_\_\_

☐ Untimely

☐ Amendment Cycle Extended

☐ Secondary Amendment

STATE OF OKLAHOMA

2nd Session of the 56th Legislature (2018)

FLOOR SUBSTITUTE  
FOR ENGROSSED

HOUSE BILL NO. 2798

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

and

Griffin of the Senate

FLOOR SUBSTITUTE

[ public health and safety - Opioid Overdose Fatality  
Review Board - codification - effective date ]

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 Department of Mental Health and Substance Abuse  
Services. The Board shall have the power and duty to:

1. Coordinate and integrate state and local efforts to address  
overdose deaths and create a body of information to prevent overdose  
deaths;

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

4        3. Collect, analyze and interpret state and local data on  
5 opioid overdose deaths;

6        4. Develop a state and local database on opioid overdose  
7 deaths;

8        5. Improve policies, procedures and practices within the  
9 agencies in order to prevent fatal opioid overdoses and to serve  
10 victims of unintentional overdose; and

11       6. Enter into agreements with other state, local or private  
12 entities as necessary to carry out the duties of the Opioid Overdose  
13 Fatality Review Board, including but not limited to, conducting  
14 joint reviews with the Child Death Review Board on unintentional  
15 overdose cases involving child death and child near-death incidents.

16       B. In carrying out its duties and responsibilities, the Board  
17 shall:

18       1. Promulgate rules establishing criteria for identifying cases  
19 involving an opioid overdose death subject to specific, in-depth  
20 review by the Board;

21       2. Conduct a specific case review of those cases where the  
22 cause of death is or may be related to overdose of opioid drugs;  
23  
24

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

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

6        5. Review the policies, practices and procedures of medical  
7 systems and law enforcement systems and other overdose protection  
8 and prevention systems, and make specific recommendations to those  
9 entities for actions necessary for the improvement of the system;

10       6. Request and obtain a copy of all records and reports  
11 pertaining to an adult whose case is under review including, but not  
12 limited to:

- 13           a. the report of the medical examiner,
- 14           b. hospital records,
- 15           c. school records,
- 16           d. court records,
- 17           e. prosecutorial records,
- 18           f. local, state and federal law enforcement records  
19 including, but not limited to, the Oklahoma State  
20 Bureau of Investigation (OSBI) and Oklahoma Bureau of  
21 Narcotics and Dangerous Drugs Control (OBN),
- 22           g. fire department records,
- 23           h. State Department of Health records, including birth  
24 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,
- l. files of the Department of Human Services, and
- m. records in the possession of the Child Death Review Board when conducting a joint review in accordance with paragraph 6 of subsection A of this section.

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;

7. 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;

8. 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

1 to, clinical summaries from treating physicians, chronologies of  
2 contact and second-opinion autopsies;

3 9. Report, if recommended by a majority vote of the Board, to  
4 the Governor, the President Pro Tempore of the Senate and the  
5 Speaker of the House of Representatives any information and guidance  
6 regarding the prevention and protection system to advise on changing  
7 trends in overdose rates, substances, methods or any other factor  
8 impacting overdose deaths, including any systemic issue within the  
9 medical, law enforcement or other relevant systems discovered by the  
10 Board while performing its duties; and

11 10. Exercise all incidental powers necessary and proper for the  
12 implementation and administration of the Opioid Overdose Fatality  
13 Review Board.

14 C. The review and discussion of individual cases of an opioid  
15 overdose death shall be conducted in executive session. All other  
16 business shall be conducted in accordance with the provisions of the  
17 Oklahoma Open Meeting Act. All discussions of individual cases and  
18 any writings produced by or created for the Board in the course of  
19 determining a remedial measure to be recommended by the Board, as  
20 the result of a review of an individual case of an opioid overdose  
21 death, shall be privileged and shall not be admissible in evidence  
22 in any proceeding. The Board shall periodically conduct meetings to  
23 discuss organization and business matters and any actions or  
24 recommendations aimed at improvement of the medical system or law

1 enforcement system which shall be subject to the Oklahoma Open  
2 Meeting Act. Part of any meeting of the Board may be specifically  
3 designated as a business meeting of the Board subject to the  
4 Oklahoma Open Meeting Act.

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

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

20 A. The Opioid Overdose Fatality Review Board shall be composed  
21 of eighteen (18) members, or their designees, as follows:

22 1. Eight of the members shall be:

23 a. the Attorney General or designee,

24 b. the Chief Medical Examiner or designee,

- c. the State Commissioner of Health or designee,
- d. the Chief of Injury Prevention Services of the State Department of Health or designee,
- e. the President of the Oklahoma State Medical Association or designee,
- f. the Director of the Oklahoma Bureau of Narcotics and Dangerous Drugs Control or designee,
- g. the Commissioner of the Department of Mental Health and Substance Abuse Services or designee,
- h. the President of the Oklahoma Osteopathic Association or designee,
- i. the Director of the Department of Human Services, or designee, and
- j. the Director of the Oklahoma State Bureau of Investigation or designee; 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,



- b. a chief of a municipal police department selected from a list of three names submitted by the Oklahoma Association of Chiefs of Police,
- c. an attorney licensed in this state who is in private practice selected from a list of three names submitted by the Board of Governors of the Oklahoma Bar Association,
- d. a district attorney selected from a list of three names submitted by the District Attorneys Council,
- e. a physician with emergency medical training selected 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 who currently receives or formerly has been a consumer of addiction recovery services related to opioid use, selected from a list of three names submitted by the Oklahoma Department of Mental Health and Substance Abuse Services, and

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 and the Department of Mental Health and  
9 Substance Abuse Services, pursuant to the State Travel Reimbursement  
10 Act; provided, that the reimbursement shall be paid in the case of  
11 state employee members by the agency employing the member.

12          C.    With funds appropriated or otherwise available for that  
13 purpose, the Office of the Attorney General, jointly with the  
14 Department of Mental Health and Substance Abuse Services, shall  
15 provide administrative assistance and services to the Opioid  
16 Overdose Fatality Review Board.

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

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

1 of death was due to an overdose of licit or illicit drugs including  
2 opioids meeting the Center for Disease Control and prevention  
3 guidelines for opioid related deaths.

4 B. The Office of Chief Medical Examiner shall conduct an  
5 initial review of overdose death certificates in accordance with the  
6 criteria established by the Opioid Overdose Fatality Review Board  
7 and refer to the Board those cases that meet the criteria  
8 established by the Board for specific case review.

9 C. Upon the request of the Board, every entity within the  
10 medical and law enforcement system shall provide to the Board any  
11 information requested by the Board relevant to the discharge of its  
12 duties, unless otherwise prohibited by state or federal law.

13 SECTION 4. This act shall become effective November 1, 2018.

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