

April 12, 2023

Bergstrom of the Senate

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;
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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 COMMITTEE REPORT BY: COMMITTEE ON ADMINISTRATIVE RULES
18 April 12, 2023 - DO PASS
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