LEGISLATIVE ANALYSIS AND PUBLIC POLICY ASSOCIATION

OVERDOSE FATALITY REVIEW BOARDS: STATE LAWS

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OVERDOSE FATALITY REVIEW BOARDS: STATE LAWS

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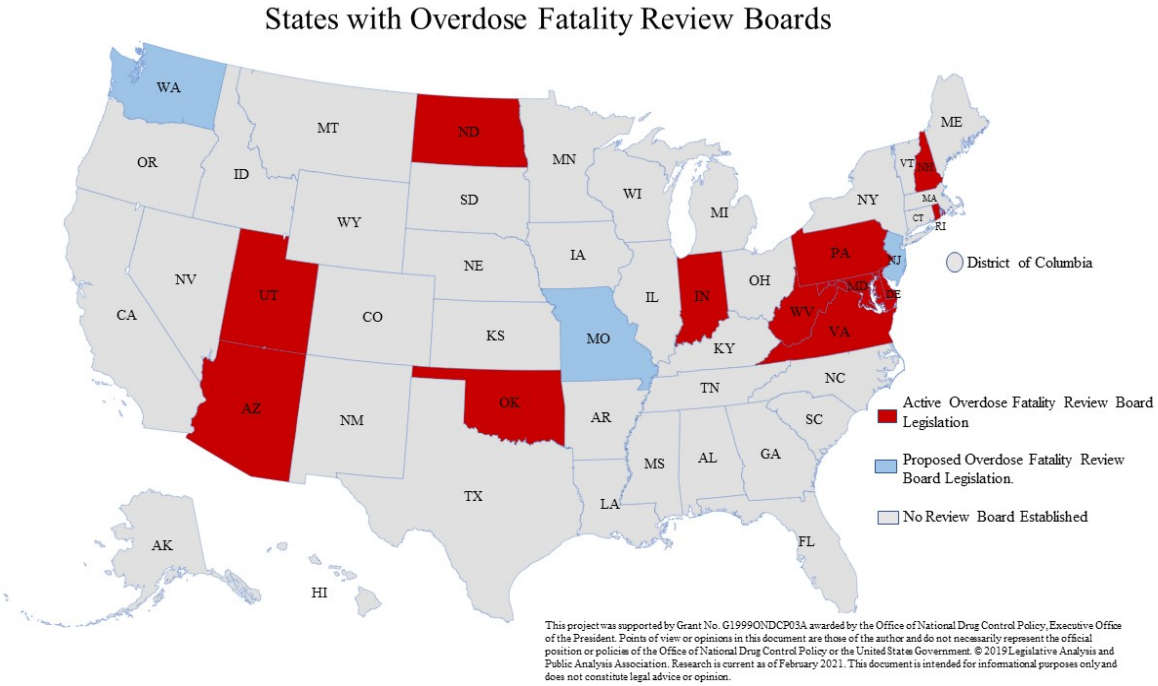
SUMMARY

Overdose fatality review boards are multidisciplinary teams that are established on the state, city, or county level "to examine and understand the circumstances surrounding fatal drug overdoses."[1] These teams review fatal drug overdose cases within their jurisdictions in order to determine what factors and characteristics may lead to a possible overdose. By understanding what influences a fatal overdose, the review board can recommend changes in law and policy that will better allow the state, city, or county to prevent future overdose deaths. As of this writing, 12 states have authorized overdose fatality review boards. Moreover, bills that would establish an overdose fatality review board have been proposed in New Jersey[2],Missouri[3], and Washington[4].

The goal of this research document is to provide accurate and complete information that is free of omissions. If you believe that this document contains misinformation or errors, please email LAPPA at info@thelappa.org.



[1] "More States Authorizing the Use of Overdose Fatality Review Teams," *Association of State and Territorial Health Officials*, August 23, 2018, https://www.astho.org/StatePublicHealth/More-States-Authorizing-the-Use-of-Overdose-Fatality-Review-Teams/08-23-18/.
[2] Assembly bill 798, 219th Leg., 2020-2021 Regular Sess. (N.J. 2020) and Senate bill 52, 219th Leg., 2020-2021 Regular Sess. (N.J. 2020).
[3] House bill 1153, 100th Leg., 2019 Regular Sess. (Mo. 2019).
[4] House bill 1074, 67th Leg, 2021-2022 Regular Sess. (Wash. 2021).

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ARIZONA	
Created by	Legislation
Statute(s) and/or regulation(s)	A.R.S. §§ 36-198 and 36-198.01
Effective date	August 9, 2017
Drugs or substances of focus	Not specified.
Team members	The Arizona Drug Overdose Fatality Review Team is composed of representatives from the following entities or that person's designee: (1) the Office of the Attorney General; (2) the Department of Health Services; (3) the Arizona Health Care Cost Containment System; (4) the Department of Economic Security; (5) the Governor's Office of Youth, Faith, and Family; (6) the Administrative Office of the Courts; (7) the State Department of Corrections; (8) the Arizona Council of Human Services Providers; and (9) the Department of Public Safety. The Director of the Department of Health Services will also appoint the following members to serve on the review team: (1) a medical examiner who is a rural forensic pathologist; (2) a medical examiner who is a metropolitan forensic pathologist; (3) a representative of a tribal government; (4) a public member; (5) a representative of a professional emergency management system association; (6) a health care professional from a statewide association representing nurses; (7) a health care professional from a statewide association representing physicians; (8) a representative of an association of county health officers; (9) a representative of an association representing hospitals; (10) a health care professional who specializes in the prevention, diagnosis, and treatment of substance use disorders; and (11) a county sheriff, who represents a county with a population of less than 500,000 persons and a county sheriff, or the sheriff's designee, who represents a county with a population of more than 5,000 persons.
Duties, tasks, and objectives	The review team is responsible for developing a drug overdose fatalities data collection system and conducting an annual analysis on the incidence and causes of drug overdose deaths in the state that occurred the preceding year. Additionally, the review team works to encourage and assist the development of local drug overdose fatality review teams by developing standards and protocols for these local teams, as well as providing training and technical assistance. Moreover, the team develops protocols for drug overdose investigations and studies the adequacy of statutes, ordinances, rules, training, and services to determine what changes are needed to decrease the incidence of preventable drug overdose fatalities. Finally, the team has the task of educating the public about the incidence and causes of drug overdose deaths and what the public can do to prevent these deaths.

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ARIZONA	
Access to information	The chairperson of the team may request, as necessary to carry out the team's duties, information and records from: (1) a provider of medical, dental, or mental health care, and (2) the state or a political subdivision of the state that might assist the team in reviewing the fatality. Access to the information requested is to be provided to the chairperson within five days.

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DELAWARE	
Created by	Legislation
Statute(s) and/or regulation(s)	16 Del.C. §§ 4799A through 4799D
Effective date	April 21, 2016
Drugs or substances of focus	Opiates, fentanyl, and/or heroin.
Team members	The Delaware Drug Overdose Fatality Review Commission is composed of the: (1) the Delaware Attorney General; (2) the Secretary of the State Department of Health and Social Services; (3) the Director of the Delaware Division of Forensic Science; (4) the Secretary of Safety and Homeland Security; (5) the Director of the Delaware Division of Public Health; and (6) the Commissioner of the Delaware Department of Correction. Additionally, the Governor appoints the following members to the Commission: (1) two representatives of the Medical Society of Delaware; (2) a representative of the Delaware Nurses Association; (3) a representative of the Police Chiefs Council of Delaware who is an active law enforcement officer; (4) a representative of the Delaware Fraternal Order of Police who is an active law enforcement officer; (5) two advocates from statewide nonprofit organizations; and (6) a representative of the Delaware Healthcare Association.
Duties, tasks, and objectives	The Commission is tasked with investigating and reviewing the facts and circumstances of all overdose deaths involving opiates, fentanyl or heroin that occur in the state. At least annually, the Commission is to make recommendations to the Governor and General Assembly regarding practices or conditions that impact the frequency of overdose deaths and steps that can be taken to reduce the number of those deaths.
Access to information	The Commission has access to the medical records of the deceased. Additionally, the Commission can compel the production of any records related to the death or that are pertinent to the Commission's investigation.

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INDIANA	
Created by	Legislation
Statute(s) and/or regulation(s)	IC 16-49.5
Effective date	July 1, 2020
Drugs or substances of focus	Not specified.
Team members	A Suicide and Overdose Fatality Review Team may be established in a county or in multiple counties. Member of a team must be appointed by the county health officer or another entity approved by the State Department and may include local represents from the following disciplines: (1) public health; (2) primary health care; (3) mental health; (4) law enforcement; (5) behavioral health; (6) parole or probation; (7) addiction medicine; (8) emergency medical services; and (9) social work. Members may also include (1) a coroner or deputy coroner; (2) an epidemiologist; and (3) a pathologist.
Duties, tasks, and objectives	The team is required to meet at least quarterly and is tasked with (1) determining the factors contributing to suicides and overdose fatalities; (2) identifying public health and clinical interventions to improve systems of care and enhance coordination; and (3) developing strategies for the prevention of suicides and overdose fatalities. With each review the team should (1) identify the factors that contributed to the fatality; (2) determine whether similar fatalities may be prevented; (3) identify any agencies or resources that may be used to assist in the prevention of a similar fatality; and (4) identify any solution to improve practice and policy between the agencies, entities, and resources. Before July 1 of each year, a team must submit a report to the State Department that includes a summary of the data collected during the previous year and any actions recommended by the team to improve systems of care and community resources.
Access to information	A team may review the following records if the records pertain to a person or incident within the scope of the team's review: (1) records held by the (a) local or state health department; (b) the Indiana scheduled prescription electronic collection and tracking program; and (c) department of child services; (2) medical records; (3) law enforcement records; (4) autopsy reports; (5) coroner records; (6) mental health reports; (7) emergency medical services provider records; (8) fire department run reports; (9) disciplinary or health records generated by a local school system, and (10) any other record

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INDIANA	
	concerning the assessment, care, fatality, diagnosis, near fatality, or treatment of the person subject to a team review.

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MARYLAND	
Created by	Legislation
Statute(s) and/or regulation(s)	MD Code, Health - General, §§ 5-901 through 5-906
Effective date	October 1, 2014
Drugs or substances of focus	Not specified.
Team members	Maryland counties can establish Local Overdose Fatality Review Teams. State law requires the teams to include the following members or their designee: (1) the county health officer; (2) the Director of the local Department of Social Services; (3) the State's Attorney; (4) the Superintendent of Schools; (5) a state, county, or municipal law enforcement officer; (6) the Director of Behavioral Health Services in the county; (7) an emergency medical services provider in the county; (8) a representative of a hospital; (9) a health care professional who specializes in the prevention, diagnosis, and treatment of substance use disorders; (10) a representative of a local jail or detention center; (11) a representative from parole, probation, and community corrections; (12) the Secretary of Juvenile Services; (13) a member of the public with interest or expertise in the prevention and treatment of drug overdose deaths, appointed by the County Health Officer; and (14) any other individual necessary for the work of the local team, recommended by the local team and appointed by the County Health Officer.
Duties, tasks, and objectives	The teams are required to meet at least quarterly to review drug overdose death cases and to recommend actions to improve coordination of services and investigations among the member agencies, as well as recommend actions to prevent drug overdose deaths. Teams will also provide recommendations to the state Department of Hygiene and Mental Health on needed changes to state and local laws, policies, or practices.
Access to information	The chair of the local team may request, as necessary, the following information: 1. Health care records, including information about physical health, mental health, and treatment for substance use disorder for a. An individual whose death or near fatality is being reviewed; or b. An individual convicted of a crime that caused a death or near fatality; 2. Records maintained by the state or local government agency, including death certificates, law enforcement investigative information, medical examiner investigative information, parole and probation information and records, and information and records of a social services agency for

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MARYLAND	
	a. An individual whose death or near fatality is being reviewed; b. An individual convicted of a crime that caused a death or near fatality; or c. The family of an individual described in (a) or (b). Once a record is requested by the team, the team should be immediately provided with the information.

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NEW HAMPSHIRE	
Created by	Legislation. New Hampshire had a Drug Overdose Fatality Review Committee established by executive order in 2016 prior to legislation being passed. (N.H. Exec. Order No. 2016-05) The executive order can be found here.
Statute(s) and/or regulation(s)	N.H. Rev. Stat. Ann. § 126-DD:1
Effective date	September 27, 2020 (statute). October 12, 2016 (Executive order).
Drugs or substances of focus	Not specified.
Team members	The New Hampshire Drug Overdose Fatality Review Committee is composed of the following people or their designee: (1) one member of the senate, appointed by the president of the senate; (2) three members of the house of representatives, appointed by the speaker of the house of representatives; (3) the Attorney General; (4) the chief medical examiner; (5) the Commissioner of the Department of Health and Human Services; (6) The Commissioner of the Department of Safety; (7) the Chairperson of the Governor's Commission on Alcohol and Drug Abuse Prevention, Treatment, and Recovery; (8) a representative of the New Hampshire Association of Chiefs of Police, appointed by the association; (9) a representative of the New Hampshire Association of Fire Chiefs, appointed by the association; (10) a health official from a city health department, appointed by the governor; (11) a victim/witness advocate, appointed by the attorney general; (12) a representative of the New Hampshire Hospital Association, appointed by the association; (13) a representative of the recovery community, appointed by the governor; (14) a representative of the treatment community, appointed by the governor; (15) a representative of the prevention community, appointed by the governor; (16) a representative of New Futures, appointed by that organization; (17) a representative from American Medical Response, appointed by that organization. (18) a representative of the Drug Enforcement Administration, appointed by the administration; (19) the Governor's advisor on addiction and behavioral health; (20) a suicide prevention specialist, appointed by NAMI-New Hampshire; and (21) a representative of the New Hampshire Medical Society, appointed by the society.
Duties, tasks, and objectives	The Committee is tasked with (1) reviewing trends and patterns of overdose-related fatalities in New Hampshire; (2) identifying high-risk factors, current practices, and gaps in system responses; (3) recommending policies, practices, and services that will encourage collaboration and reduce overdose fatalities; (4) improving sources of

NEW HAMPSHIRE	
	data collection by developing a system to share information between agencies and offices that work with individuals struggling with addiction; (5) educating the public, policy makers, and funders about overdose-related fatalities and about strategies for intervention and effective prevention, treatment, and recovery; and (6) reviewing laws and programs enacted in other states, counties, or municipalities.
Access to information	Upon the request of the chairperson of the commission and as necessary to carry out the commission's duties, the chairperson shall be provided, within 5 days excluding weekends and holidays, with access to information and records regarding a drug overdose fatality that is being reviewed by the commission or regarding the person who overdosed on drugs. The commission may request the information and records from any of the following: (1) a provider of medical, dental, or behavioral health care; and (2) any state or a political subdivision of this state that might assist the commission in reviewing the fatality.

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NORTH DAKOTA	
Created by	Legislation
Statute(s) and/or regulation(s)	NDCC, 23-50-01 through 23-50-03
Effective date	August 1, 2019
Drugs or substances of focus	Prescription drugs, illicit drugs, and alcohol.
Team members	The forensic pathology department of the University of North Dakota School of Medicine and Health Science appoints individuals to serve as members on the drug fatalities review panel. The panel must include representation from multiple disciplines and services. Membership may include (1) a forensic pathologist; (2) a pharmacist with knowledge in pharmacogenomics; (3) representatives of rural and urban healthcare facilities; (4) a licensed addiction counselor; (5) a physician; and (6) representatives of nonregulatory divisions of the state Department of Health and Department of Human Services.
Duties, tasks, and objectives	The Drug Fatalities Review Panel is tasked with providing outcome data on drug-related fatalities in the state as a basis for policy, intervention, and other program effectiveness. Additionally, the panel promotes interagency communication and training for individuals and agencies that share a responsibility in responding to or preventing drug-related fatalities. Moreover, the panel promotes the use of intervention and education programs to prevent drug-related fatalities. When conducting a review, the panel should identify factors that may have contributed to a preventable fatality and make recommendations to identify whether a fatality was preventable.
Access to information	Not addressed by statute.

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OKLAHOMA	
Created by	Legislation
Statute(s) and/or regulation(s)	63 Okl.St.Ann. §§ 2-1001 through 2-1003
Effective date	November 1, 2018
Drugs or substances of focus	Opioids.
Team members	The Oklahoma Opioid Overdose Fatality Review Board is composed of the following people or their designees: (1) the Attorney General; (2) the Chief Medical Examiner; (3) the State Commissioner of Health; (4) the Chief of Injury Prevention Services of the State Department of Health; (5) the President of the Oklahoma State Medical Association; (6) the Director of the Oklahoma Bureau of Narcotics and Dangerous Drugs Control; (7) the Commissioner of the Department of Mental Health and Substance Abuse Services; (8) the President of the Oklahoma Osteopathic Association; (9) the Director of the Department of Human Services; and (10) the Director of the Oklahoma State Bureau of Investigation. Additionally, the Attorney General will appoint the following people to the Board: (1) a county sheriff selected from a list of three names submitted by the executive board of the Oklahoma Sheriffs' Association; (2) a chief of a municipal police department selected from a list of three names submitted by the Oklahoma Association of Chiefs of Police; (3) a licensed attorney who is in private practice selected from a list of three names submitted by the Board of Governors of the Oklahoma Bar Association; (4) a district attorney selected from a list of three names submitted by the District Attorneys Council; (5) a physician with emergency medical training selected from a list of three names submitted by the Oklahoma State Medical Association; (6) a physician with experience in substance use disorder treatment and recovery selected from a list of three names submitted by the Oklahoma Osteopathic Association; (7) a nurse selected from a list of three names submitted by the Oklahoma Nurses Association; (8) two individuals, at least one of whom currently receives or formerly has been a consumer of 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 (9) a member of the judiciary selected from a list of three names submitted by the Oklahoma Supreme Court.
Duties, tasks, and objectives	The Board is tasked with coordinating and integrating state and local efforts to address overdose death. The Board is to conduct case reviews of opioid overdose deaths of persons 18 years or older in the state and to collect, analyze, and interpret state and local data on opioid overdose deaths. Additionally, the Board makes recommendations on how to

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	improve policies, procedures, and practices within the agencies to prevent fatal opioid overdoses. Each year, the Board is required to submit an annual statistical report on the incidence and causes of opioid overdose deaths in the state for which the Board has completed its review during the past calendar year.
Access to information	The Board can request and obtain a copy of all records and reports pertaining to an adult whose case is under review including: (1) the report of the medical examiner; (2) hospital records; (3) school records; (4) court records; (5) prosecutorial records; (6) local, state, and federal law enforcement records including the Oklahoma State Bureau of Investigations and Oklahoma Bureau of Narcotics and Dangerous Drug Control; (7) fire department records; (8) State Department of Health records; (8) medical and dental records; (9) Department of Mental Health and Substance Abuse Services and other mental health records; (10) emergency medical service records; (11) files of the Department of Human Services, and (12) records in the possession of the Child Death Review Board when conducting a joint review.

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PENNSYLVANIA	
Created by	Legislation
Statute(s) and/or regulation(s)	71 P.S. §§ 1691.1 through 1691.9
Effective date	When initially established on January 22, 2013, the statute was referred to as the "Methadone Death and Incident Review Act," and the team only reviewed deaths in which methadone was a primary or secondary cause of death or may have been a contributing factor. A November 25, 2020 amendment to the statute, which went into effect on February 23, 2021, changed the name to the "Medication Death and Incident Review Act," and broadened the focus of the team to deaths where a medication approved by the U.S. Food and Drug Administration for the treatment of opioid use disorder was the primary or secondary cause of death or may have been a contributing factor.
Drugs or substances of focus	Medications approved by the U.S. Food and Drug Administration for the treatment of opioid use disorder.
Team members	The Pennsylvania Methadone Death and Incident Review Team is composed of the following people or their designee: (1) the Secretary of Drug and Alcohol Programs; (2) the Director of the Bureau of Drug and Alcohol Programs; (3) a representative from an opioid-assisted treatment program; (4) a representative from a licensed drug and alcohol treatment program that is not defined as an opioid-assisted treatment program; (5) a representative from law enforcement recommended by a statewide association representing members of law enforcement; (6) a representative from the medical community recommended by a statewide association representing physicians; (7) a district attorney recommended by a statewide association representing district attorneys; (8) a coroner or medical examiner recommended by a statewide association representing county coroners and medical examiners; (9) a member of the public; (10) a patient or family advocate; (11) a representative from a recovery organization; (12) An office-based agonist treatment provider who is assigned a waiver from the Drug Enforcement Administration, including a special identification number, commonly referred to as the "X" DEA number, to provide office-based prescribing of buprenorphine; (13) a representative of the Department of Health who is affiliated with the Achieving Better Care by Monitoring All Prescriptions Program (ABC-MAP)[5]; (14) and a toxicologist.
Duties, tasks, and objectives	The team is tasked with reviewing each death where a medication approved by the United States Food and Drug Administration for the treatment of opioid use disorder was either the primary or secondary cause of death and determining what role a medication approved by the

[5] Achieving Better Care by Monitoring All Prescriptions Program (ABC-MAP) Act, 35 PA. STAT. AND CONS. STAT. ANN. § 872.1 through 872.40 (2015).

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	United States Food and Drug Administration for the treatment of opioid use disorder played in each of those deaths. Additionally, the team communicates concerns to regulators and helps to facilitate communication between health care and the legal system about health and public safety issues. Moreover, the team develops best practices to prevent future medication-related deaths and medication-related incidents.
Access to information	When necessary, the team may review and inspect the following information: (1) coroner's reports or postmortem examination records; (2) death certificates and birth certificates; (3) law enforcement records and interviews with law enforcement officials; (4) medical records from hospitals, other health care providers, and narcotic treatment programs; (5) information and reports made available by the county children and youth agency; (6) information made available by firefighters or emergency services personnel; (7) reports and records made available by the court; (8) EMS records; (9) traffic fatality reports; (10) opioid-assisted treatment program incident reports; (11) opioid-assisted treatment program licensure surveys from the program licensure division; and (12) any other records necessary to conduct the review.

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RHODE ISLAND	
Created by	Legislation
Statute(s) and/or regulation(s)	Gen.Laws 1956, § 23-4-3
Effective date	June 28, 2018
Drugs or substances of focus	Not specified.
Team members	Rhode Island's multidisciplinary team review of drug-related overdose deaths may include, as determined by the Director of the Department of Health, the following individuals: (1) a representative from the Department of Health; (2) a representative from the Office of the Attorney General; (3) a representative from the Rhode Island state police; (4) a representative from the Department of Corrections; (5) a representative from the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals; (6) a representative from the Rhode Island Police Chiefs Association; (7) a representative from the Hospital Association of Rhode Island; (8) an emergency department physician; (9) a primary care physician; (10) an substance use disorder medicine/treatment provider; (11) a mental health clinician; (12) a toxicologist; (13) a recovery coach or other representative of the recovery community; (14) and others as may be determined by the Director of the Department of Health.
Duties, tasks, and objectives	The Team is tasked with the goal of reducing the prevalence of overdose deaths by examining emerging trends in overdoses, identifying potential demographic, geographic, and structural points for prevention, and other factors. Each year the Team is to report a summary of its activities, as well as its findings, progress towards reaching its goals, and recommendations for any needed changes in legislation or otherwise.
Access to information	Details about what records and information the team can request or access is not addressed by the statute.

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UTAH	
Created by	Legislation
Statute(s) and/or regulation(s)	U.C.A. 1953 § 26-7-10
Effective date	Originally chartered in 2017. H.B. 295 (authorizing statute) was signed by the Governor on March 28, 2020.
Drugs or substances of focus	Opioids and substances that closely resemble opioids. The committee Will review non-opioid overdose deaths if there are a substantial number of overdose deaths in the state caused by the use of a non-opioid.
Team members	The Department of Health (Department) will establish the Opioid and Overdose Fatality Review Committee. The committee is to consist of (1) the Attorney General; (2) a state, county, or municipal law enforcement officer; (3) the manager of the Department's Violence Injury Program; (4) an emergency medical services provider; (5) a representative from the Office of the Medical Examiner; (6) a representative from the Division of Substance Abuse and Mental Health; (7) a representative from the Office of Vital Records; (8) a representative from the Office of Health Care Statistics; (9) a representative from the Division of Occupational and Professional Licensing; (10) a health care professional who specializes in the prevention, diagnosis ,and treatment of substance use disorders; (11) a representative from a state or local jail or detention center; (12) a representative from the Department of Corrections; (13) a representative from Juvenile Justice Services; (14) a representative from the Department of Public Safety; (15) a representative from the Commission on Criminal and Juvenile Justice; (16) a physician from a Utah-based medical center; and (17) a physician from a non-profit vertically integrated health care organization. The President of the Senate may also appoint one member of the Senate and the Speaker of the House of Representatives may appoint one member of the House of Representatives to serve on the committee.
Duties, tasks, and objectives	The committee is tasked with reviewing available information regarding a descendant of an opioid overdose death and identifying any specific factors that put the decedent at risk for an opioid overdose. The committee is also required to make recommendations for changes to law or policy that may prevent opioid overdose deaths and inform public health and public safety entities of emerging trends in opioid overdose deaths. The committee can meet up to eight times each year.
Access to information	The Department must give the committee access to all reports, records, and other documents that are relevant to the committee's responsibilities, including reports, records, or documents that are private. The committee may interview or request information from a staff member, a provider, or any other person who may have

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	knowledge or expertise that is relevant to the review of an opioid overdose death.

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VIRGINIA	
Created by	Legislation
Statute(s) and/or regulation(s)	VA Code Ann. § 32.1-283.7
Effective date	July 1, 2018
Drugs or substances of focus	Not specified.
Team members	Any county or city may establish a local or regional overdose fatality review team. The teams may be composed of the following persons from the localities represented on a particular board or their designees: (1) a medical examiner; (2) a local social services official; (3) a director of the relevant local or district health department; (4) a chief law-enforcement officer; (5) an attorney for the Commonwealth; (6) an executive director of the local community services board or other local mental health agency; (7) a local judge; (8) the local school division superintendent; (9) a representative of a local jail or detention center. Additional members that can be appointed by the chair of the team may include: (1) representatives of local human services agencies; (2) local health care professionals who specialize in the prevention and treatment of substance abuse disorders; (3) local emergency medical services personnel; (4) a representative of a hospital; (5) experts in forensic medicine and pathology; (6) local funeral services providers; and (7) representatives of the local bar.
Duties, tasks, and objectives	The Team is tasked with reviewing the death of any person who lives in the commonwealth and whose death was or is suspected to be due to overdose. Additionally, the Team promotes cooperation and coordination among agencies involved in investigations of overdose deaths or providing services to surviving family members. Moreover, the Team recommends changes within the agencies represented on the local team and advises the state agencies on changes to law, policy, or practice to prevent overdose deaths.
Access to information	Details about what records and information the team can request or access is not addressed by the statute.

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WEST VIRGINIA	
Created by	Legislation
Statute(s) and/or regulation(s)	W. Va. Code St. R. § 64-29-7
Effective date	July 12, 2013
Drugs or substances of focus	Prescription drugs.
Team members	West Virginia's Unintentional Pharmaceutical Drug Overdose Fatality Review Panel consists of the following members or their designees: (1) the Chief Medical Examiner in the Bureau for Public Health; (2) the Director of the West Virginia State Board of Pharmacy; (3) the Commissioner of the Bureau for Public Health; (4) the Director of the Division of Vital Statistics; (5) the Superintendent of the West Virginia State Police; (6) one representative who is a physician nominated by the West Virginia State Medical Association; (7) one representative who is a registered nurse nominated by the West Virginia Nurses Association; (8) one representative who is a doctor of osteopathy nominated by the West Virginia Society of Osteopathic Medicine; (9) one licensed physician or doctor of osteopathy who practices pain management as a principal part of his or her practice; (10) one representative who is a Doctor of Pharmacy, with a background in prescription drug abuse and diversion, selected by the West Virginia Pharmacists Association; (11) one representative who is a licensed counselor selected by the West Virginia Association of Alcoholism and Drug Abuse Counselors; (12) one representative of the United States Drug Enforcement Administration; (13) one representative who is a prosecuting attorney selected by the West Virginia Prosecuting Attorneys Institute; (14) a person who is considered an expert in bioethics training; (15) one representative who is a licensed dentist recommended by the Board of Dental Examiners; and (16) any additional persons that the chairperson of the panel determines is needed in the review and consideration of a particular case.
Duties, tasks, and objectives	The Panel is tasked with reviewing and analyzing all deaths occurring within the state where the cause of death was determined to be due to an unintentional pharmaceutical drug overdose and determining what trends, patterns, and risk factors are related to unintentional pharmaceutical drug overdose fatalities. Additionally, the Panel develops and implements standards for the uniform and consistent reporting of unintentional pharmaceutical drug overdose deaths by law enforcement or other emergency service responders and provides statistical information and analysis regarding the causes of unintentional pharmaceutical drug overdose fatalities.
Access to Information	The panel may request the following information and records as necessary to carry out its responsibilities: (1) medical, dental, and mental health records; (2) substance abuse records; and (3) information

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	and records maintained by any state, county, and local government agency.

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ABOUT THE LEGISLATIVE ANALYSIS AND PUBLIC POLICY ASSOCIATION

Based in Washington D.C., and led by and comprised of experienced attorneys, the Legislative Analysis and Public Policy Association is a 501(c)(3) nonprofit organization whose mission is to conduct legal and legislative research and analysis and draft legislation on effective law and policy in the areas of public safety and health, substance use disorders, and the criminal justice system.

LAPPA produces timely model laws and policies that can be used by national, state, and local public health, public safety, and substance use disorder practitioners who want the latest comprehensive information on law and policy as well as up-to-the-minute comparative analyses, publications, educational brochures, and other tools ranging from podcasts to fact sheets. Examples of topics on which LAPPA has assisted stakeholders include naloxone laws, law enforcement/community engagement, alternatives to incarceration for those with substance use disorders, medication-assisted treatment in correctional settings, and the involuntary commitment and guardianship of individuals with alcohol or substance use disorders.


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