LEGISLATIVE ANALYSIS AND PUBLIC POLICY ASSOCIATION

OVERDOSE FATALITY REVIEW TEAMS: SUMMARY OF STATE LAWS

SEPTEMBER 2025

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OVERDOSE FATALITY REVIEW TEAMS: SUMMARY OF STATE LAWS

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SUMMARY

Overdose fatality review (OFR) teams are multidisciplinary teams established on the state, county or city level to identify system gaps and innovative community-specific overdose prevention and intervention strategies.[1] OFR teams review fatal drug overdose cases within their jurisdictions to determine what factors and characteristics may lead to a possible overdose. By understanding what influences a fatal overdose, the OFR can recommend changes in law, policy, and agency response and coordination that will better allow the state, county, or city to prevent future overdose deaths.

While the lack of a jurisdiction-wide (*e.g.*, state or territory) law does not prevent an OFR from operating, such laws provide several benefits when compared to OFRs established without them. First, jurisdiction-wide laws can directly authorize OFRs to obtain many types of disclosure-protected information about the decedent. Without such laws, OFRs—and the individuals and entities from which it requests information—are bound to their own interpretations of the confidentiality provisions of the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. § 290dd-2, 42 Code of Federal Regulations (C.F.R.) Part 2, and state or local confidentiality laws. This may result in an unwillingness to provide the requested information due to unduly restrictive interpretations and/or confusion caused by varying conclusions among jurisdictions. Second, OFR legislation helps enhance the legitimacy of OFRs, especially in areas where some community members may be reluctant to establish one. Finally, laws promote uniformity and consistency among the local teams within a state or territory.

Beginning in 2020, the Legislative Analysis and Public Policy Association (LAPPA) undertook an ongoing research project to identify both currently-in-force statutes and recently proposed legislation related to OFR teams, throughout all 50 states, the District of Columbia, and U.S. territories. This document represents the latest iteration of that project. Starting on page 9, LAPPA provides jurisdiction-by-jurisdiction tables describing aspects of each law or regulation in effect as of August 2025, including:

- Statutory citation(s), if any;
- Initial effective date;
- The drugs or substances of focus of the OFR team's review cases;
- The operational level of the OFR team;
- The required or suggested members of the OFR team;
- The duties, tasks, and objectives of the OFR team;
- Provisions governing the OFR team's access to information;
- Confidentiality provisions;
- Reporting requirements;
- The OFR's funding source; and
- Any recently proposed legislation.

[1] "Model Overdose Fatality Review Teams Act," LEG. ANALYSIS & PUB. POL'Y ASS'N. (Feb. 2021). https://legislativeanalysis.org/model-overdose-fatality-review-teams-act/.

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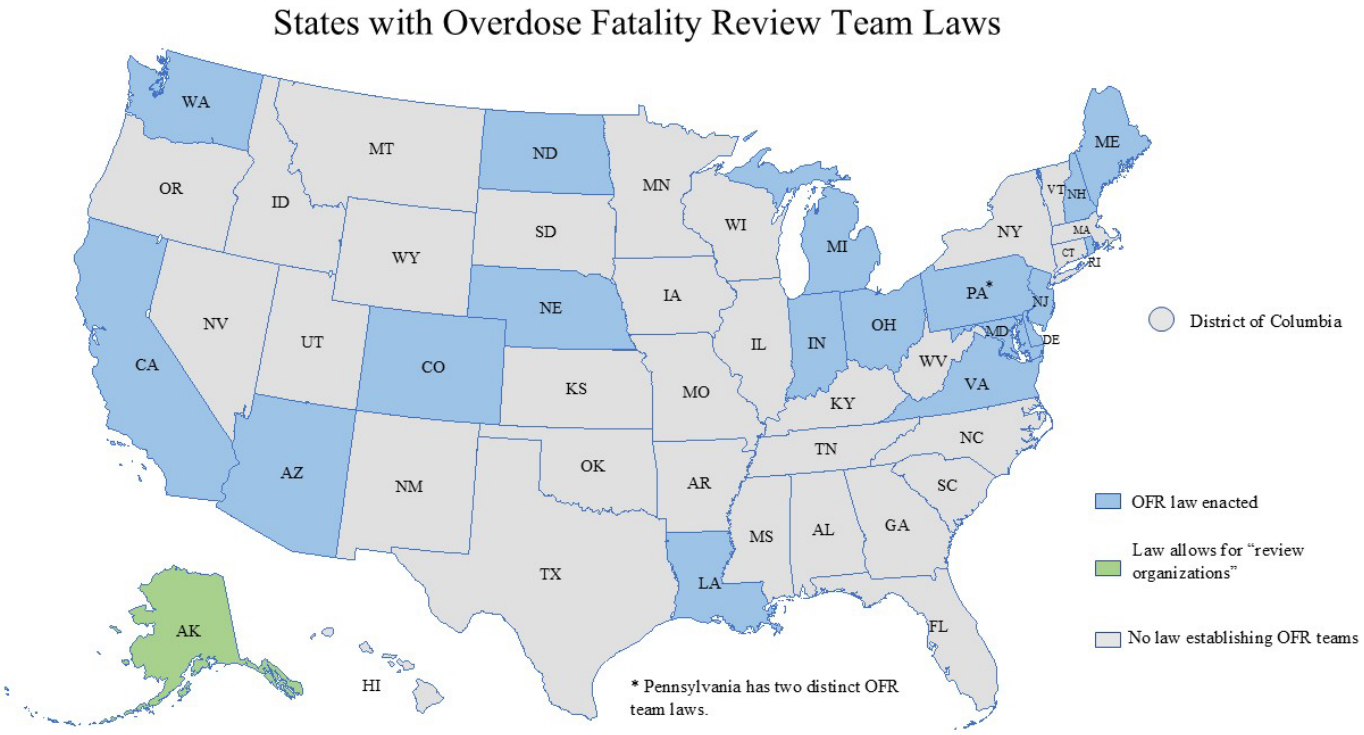
➢ Eighteen states have laws in place authorizing the use of OFR teams.[2] Pennsylvania has two distinct OFR laws in place, one that was enacted in 2013 and one that was enacted in 2022. The 2013 Pennsylvania OFR law focuses on overdose deaths attributed to U.S. Food and Drug Administration approved medications for the treatment of opioid use disorder, while the 2022 Pennsylvania OFR law allows for the review of any type of overdose death. Alaska does not have a specific OFR law in place, but state law allows the commissioner of health and the chief medical officer in the department of health to establish "review organizations" to review public health issues. No U.S. territories have an OFR law in place.



[2] Oklahoma repealed its OFR law in July 2025 and transferred the duties and responsibilities of the former OFR team to the state attorney general. Utah and West Virginia also repealed their OFR laws in May 2025 and May 2024, respectively.

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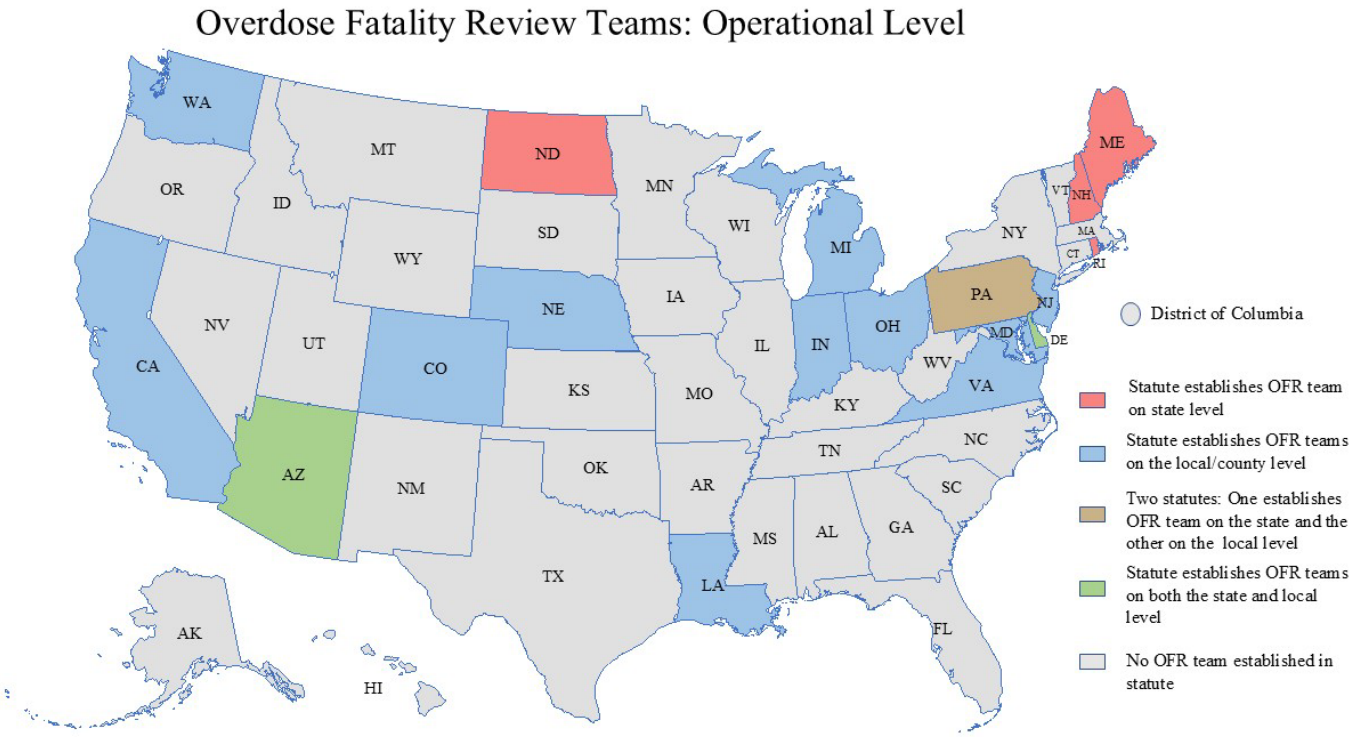
➢ Overdose fatality review team legislation can establish the review team on the state level, local/county level, or a combination of both. In five states (Maine, New Hampshire, North Dakota, Pennsylvania (2013 law), and Rhode Island), legislation establishes the overdose fatality review team on the state level. In 12 states (California, Colorado, Indiana, Louisiana, Maryland, Michigan, Nebraska, New Jersey, Ohio, Pennsylvania (2022 law), Virginia, and Washington), legislation establishes the overdose fatality review team on the local/county level. In Arizona and Delaware, legislation establishes both state and local review teams.



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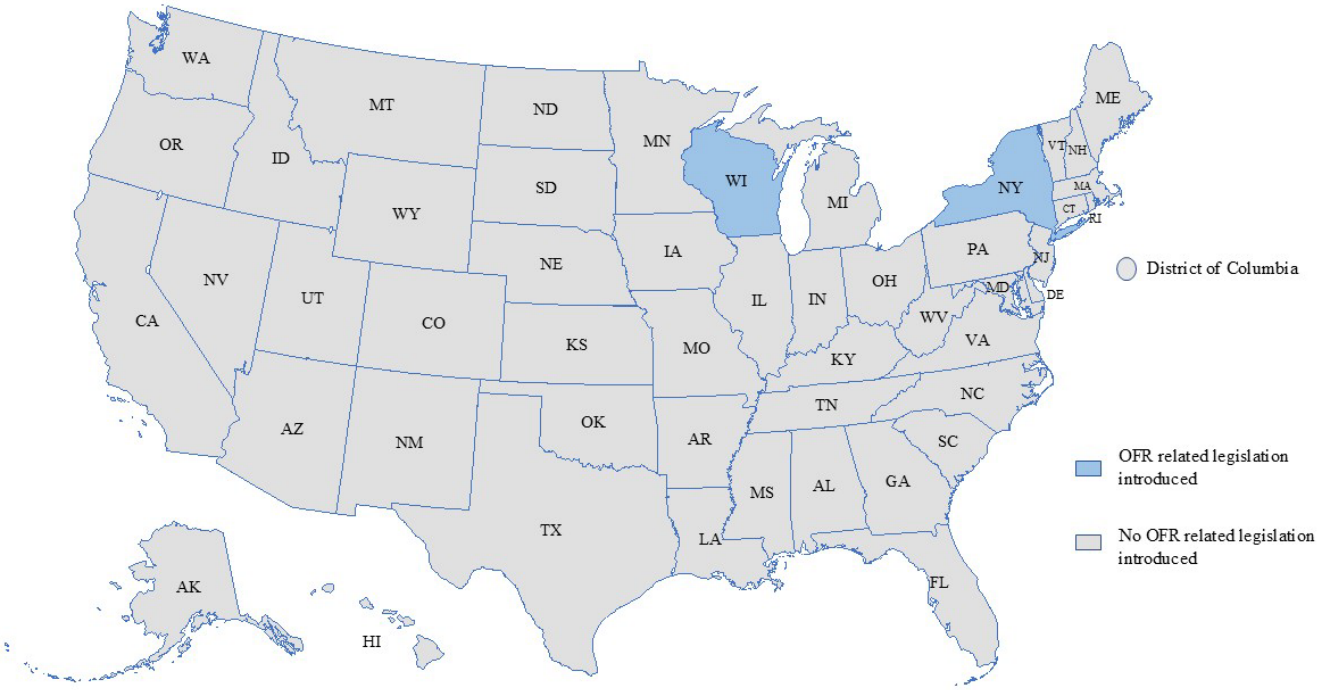
➢ During 2025, two states (New York and Wisconsin) introduced legislation to authorize the use of OFR teams. Both bills establish the OFR teams on the local/county level.

Overdose Fatality Review Teams: Recently Proposed Legislation



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ALABAMA	
Statute(s) and/or regulation(s)	None
Effective date	N/A
Drugs or substances of focus	N/A
Operational level	N/A
Team members	N/A
Duties, tasks, and objectives	N/A
Access to information	N/A
Confidentiality	N/A
Reporting requirement	N/A
Funding source	N/A
Recently proposed legislation	None

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ALASKA	
Statute(s) and/or regulation(s)	ALASKA STAT. ANN. §§ 18.23.005 through 18.23.070 (West 2025) Alaska does not have an explicit OFR law, but state statute does allow for "review organizations," which are defined to include "a committee established by the commissioner of health and approved by the chief medical officer in the department of health to review public health issues regarding morbidity or mortality."
Effective date	1976
Drugs or substances of focus	N/A
Operational level	N/A
Team members	Not addressed by statute
Duties, tasks, and objectives	Not addressed by statute
Access to information	Not addressed by statute
Confidentiality	All data and information acquired by a review organization in the exercise of its duties and functions shall be held in confidence and may not be disclosed to anyone except to the extent necessary to carry out the purposes of the review organization and is not subject to subpoena or discovery. Other than as authorized, a disclosure of data and information acquired by a review committee or of what transpired at a review meeting is a misdemeanor and punishable by imprisonment for not more than one year or by a fine of not more than $500.
Reporting requirement	Not required, however, a review organization may publish a report containing data or information obtained in the exercise of its duties if the report does not violate federal or state law regarding confidentiality of a person or decedent. A report may include: (1) the identification of trends, patterns, and risk factors; (2) an analysis of the rate and cause of death in the state; and (3) methods of intervention or prevention related to causes of death.
Funding source	Not addressed by statute
Recently proposed legislation	None

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ARIZONA	
Statute(s) and/or regulation(s)	ARIZ. REV. STAT. ANN. §§ 36-198 and 36-198.01 (West 2025)
Effective date	The original effective date was August 9, 2017. A sunset provision automatically repealed the statutes, effective January 1, 2023. The legislature reenacted the statutes, effective April 17, 2023.
Drugs or substances of focus	Not specified
Operational level	State and local review teams. The state review team reviews cases in counties without a local team or where the victim's county of residence is unknown.
Team members	The Arizona Drug Overdose Fatality Review Team (DOFR 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 DOFR 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 DOFR Team must develop a drug overdose fatalities data collection system and conduct an annual analysis on the incidence and causes of drug overdose deaths in the state that occurred the preceding year.

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ARIZONA	
Duties, tasks, and objectives (continued)	Additionally, the DOFR 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 DOFR 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 DOFR Team educates the public about the incidence and causes of drug overdose deaths and what the public can do to prevent these deaths.
Access to information	The chairperson of the DOFR Team or local 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 DOFR Team or local team in reviewing the fatality. Access to the information requested is to be provided to the chairperson within five days. Law enforcement agencies shall provide unredacted department reports to the chairperson of a local drug overdose fatality review team on request. A law enforcement agency, with the approval of the prosecuting attorney, may withhold from a review team investigative records that might interfere with a pending criminal investigation or prosecution. A member of the DOFR Team or a local team may contact, interview, or obtain information by request or subpoena from a family member of a deceased person who overdosed on drugs. The director of the Department of Health Services or the director's designee may apply to the superior court for a subpoena as necessary to compel the production of books, records, documents, and other evidence related to the person who overdosed on drugs.
Confidentiality	All information and records acquired by the DOFR Team, or any local team, are confidential and are not subject to subpoena, discovery, or introduction into evidence in any civil or criminal proceeding, except that information, documents and records that are otherwise available from other sources are not immune from subpoena, discovery, or introduction into evidence through those sources solely because they were presented to or reviewed by a team. Members of a team, individuals attending a team meeting, and individuals who present information to a team may not be questioned in any civil or criminal proceeding regarding information presented in or opinions formed as a result of a meeting. Meetings of the DOFR Team or a local team are closed to the public, and not subject to state public meeting law, if the team is reviewing information about an overdose victim. A person who violates the confidentiality requirements is guilty of a class 2 misdemeanor.

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ARIZONA	
Reporting requirement	None
Funding source	Not addressed in statute
Recently proposed legislation	None

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ARKANSAS	
Statute(s) and/or regulation(s)	None
Effective date	N/A
Drugs or substances of focus	N/A
Operational level	N/A
Team members	N/A
Duties, tasks, and objectives	N/A
Access to information	N/A
Confidentiality	N/A
Reporting requirement	N/A
Funding source	N/A
Recently proposed legislation	None

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CALIFORNIA	
Statute(s) and/or regulation(s)	CAL. HEALTH & SAFETY CODE §§ 11675 through 11680 (West 2025)
Effective date	January 1, 2025
Drugs or substances of focus	Not specified
Operational level	Local/county level
Team members	An OFR team may be comprised of, but not limited to, all of the following: (1) experts in the field of forensic pathology; (2) medical personnel with expertise in overdose fatalities; (3) coroners and medical examiners; (4) district attorneys and city attorneys; (5) county or local staff, including, but not limited to, all of the following: (a) behavioral health services staff; (b) county counsel; (c) emergency medical services staff; (d) unhoused services staff; (e) medical care services staff; (f) medical examiner staff; and (g) public health staff; (6) county, local, state, and federal law enforcement personnel; (7) local drug trafficking experts; (8) public health or behavioral health experts; (9) drug treatment providers; (10) representatives of local health plans, non-profits, religious, or other organizations who work with individuals at high risk of overdose fatalities; (11) local professional associations of individuals described in this subdivision; and (12) experts in the field of forensic toxicology.
Duties, tasks, and objectives	The duties of the OFR team include: (1) assisting local agencies in identifying and reviewing overdose fatalities; (2) facilitating communication among the various individuals and agencies involved in overdose fatalities, and (3) integrate local overdose prevention efforts through strategic planning, data dissemination, and community collaboration. Information gathered, and recommendations made, by an OFR team shall be used by the county to develop education, prevention, and intervention strategies that will lead to improved coordination of treatment services and prevent future overdose deaths.
Access to information	A health care provider, as defined by CAL. CIV. CODE § 56.05 (West 2025), or a covered entity, as defined by 45 C.F.R. § 160.103, shall provide to the members of the OFR team any information, including protected health information, and mental health records excluding psychotherapy notes, in its possession that is directly related to the review about the individual involved in the case. The information disclosed shall include substance use disorder patient records only to the extent permitted by 42 C.F.R. Part 2. The following additional information, only to the extent required for carrying out the reviews, may be disclosed:

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CALIFORNIA	
Access to information (continued)	(1) state summary criminal history information, as defined by CAL. PENAL CODE § 11105 (West 2025), criminal offender record information, as defined in CAL. PENAL CODE § 11075 (West 2025), and local summary criminal history information, as defined in CAL. PENAL CODE § 13300 (West 2025); and (2) information provided to probation officers in the course of the performance of their duties, including, but not limited to, the duty to prepare reports pursuant to CAL. PENAL CODE § 1203.10 (West 2025), as well as the information on which these reports are based.
Confidentiality	An oral or written communication or a document shared within or produced by an overdose fatality review team related to an overdose fatality review is confidential and not subject to disclosure or discovery by a third party. An oral or written communication or a document provided by a third party to an overdose fatality review team, or between a third party and an overdose fatality review team, is confidential and not subject to disclosure or discovery by a third party.
Reporting requirement	None
Funding source	Not addressed by statute
Recently proposed legislation	None

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COLORADO	
Statute(s) and/or regulation(s)	COLO. REV. STAT. ANN. §§ 25-20.5-2301 through 2307 (West 2025)
Effective date	August 7, 2024
Drugs or substances of focus	Not specified
Operational level	Local/county level
Team members	Each local team must consist of at least five of the following individuals, organizations, agencies, and areas of expertise, if available, except that there shall not be more than one representative from law enforcement: (1) the county or district health officer, or the officer's designee; (2) the director of the local department of human services, or the director's designee; (3) the local district attorney, or the district attorney's designee; (4) the director of behavioral health services in the county, or the director's designee; (5) a state, county, or municipal law enforcement officer; (6) a representative of a local jail or detention center; (7) the local medical examiner or coroner, or their designee; (8) a health-care provider who specializes in the prevention, diagnosis, and treatment of substance use disorders; (9) a mental health provider who specializes in substance use disorders; (10) a representative of an emergency medical services provider in the county; (11) a representative from parole, probation, and community corrections; (12) a representative from a harm reduction provider; (13) a representative with lived or living experience; and (14) a recovery coach, peer support worker, or other representative of the recovery community. A local team may include the following additional individuals, organizations, agencies, and areas of expertise, if available, as either permanent or auxiliary members: (1) the local superintendent of schools, or the superintendent's designee; (2) a representative of a local hospital; (3) a healthcare provider who specializes in emergency medicine; (4) a healthcare provider who specializes in pain management; (5) a pharmacist with a background in prescription drug misuse and diversion; (6) a substance use disorder treatment provider from a licensed substance use disorder treatment program; (7) a poison control center representative; (8) a mental health provider who is a generalist; (9) a prescription drug monitoring program administrator; (10) a representative from a local drug court; and (11) any other individual necessary for the work of the local team, recommended by the local team and appointed by the chair.
Duties, tasks, and objectives	The purpose of each local team is to: (1) promote cooperation and coordination among agencies involved in the investigation of drug overdose fatalities; (2) develop an understanding of the causes and

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COLORADO	
Duties, tasks, and objectives (continued)	incidence of drug overdose fatalities in the jurisdiction where the local team operates; (3) plan for and recommend changes within the agencies represented on the local team to prevent drug overdose fatalities; and (4) advise local, regional, and state policymakers about potential changes to law, policy, funding, or practice to prevent drug overdoses. To achieve its purpose, each local team shall: (1) establish and implement protocols and procedures; (2) conduct a multidisciplinary review of information received regarding a decedent, which shall include, but not be limited to: (a) consideration of the decedent's points of contact with healthcare systems, social services, educational institutions, child and family services, the criminal justice system, including law enforcement, and any other systems with which the decedent had contact prior to the decedent's death; and (b) identification of the specific factors and social determinants of health that put the decedent at risk for an overdose; (3) recommend prevention and intervention strategies to improve coordination of services and investigations among member agencies to reduce overdose deaths; and (4) collect, analyze, interpret, and maintain local data on overdose deaths.
Access to information	The chair of a local team may request information from individuals, agencies, or entities as necessary to carry out the purposes and duties of the local team. The following individuals, agencies, and entities must comply with a records request by the chair of a local team: (1) a coroner or medical examiner; (2) a fire department; (3) a healthcare facility; (4) a hospital; (5) a state or local law enforcement agency; (6) a state or local governmental agency, including the department of human services, the behavioral health administration, the department of public health and environment, the department of law, the office of state public defendant, the department of corrections, and the state board of parole; (6) a behavioral health entity; (7) a healthcare provider; (8) a substance use disorder treatment provider; (9) a school, including a public or private elementary, middle, junior high, or high school, or a public or private institution of postsecondary education; (10) a social services provider; (11) ground or air ambulance service agencies; and (12) any other individual or entity that is in possession of records that are, as determined by the local team, pertinent to the local team’s investigation of an overdose fatality. Notwithstanding any other provision of state or local law to the contrary, upon written request of the chair of a local team, an individual, agency, or entity shall provide the local team with the following: (1) if the individual , agency, or entity is a healthcare provider, substance use disorder treatment provider, hospital, or other

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COLORADO	
Access to information (continued)	healthcare facility or behavioral health entity, information and records maintained by the individual, agency, or entity regarding the physical health, mental health, and substance use disorder treatment for a person whose death or near death is being reviewed by the local team; and (2) if the agency or entity is a state or local government agency or entity that provided services to a person whose death or near death is being reviewed by the local team or provided services to the family of the person, information and records maintained by the agency or entity about the person, including death investigative information, medical examiner investigative information, law enforcement investigative information, emergency medical services reports, fire department records, prosecutorial records, parole and probation information and records, court records, school records, and information and records of a department of human or social services, including the local human services and public health agencies. An individual, agency, or entity shall provide requested information to the local team within ten business days after receipt of the written request, excluding weekends and holidays, unless an extension is granted by the chair of the local team. Notwithstanding any law to the contrary, the local team does not need an administrative subpoena or other form of legal compulsion to receive requested records. An individual, agency, or entity that provides information or records to a local team is not subject to civil or criminal liability or any professional disciplinary action pursuant to state law as a result of providing the information or record. A member of the local team may contact, interview, or obtain information by request from a family member or friend of a person whose death is being reviewed by the local team.
Confidentiality	Local team meetings in which confidential information is discussed are exempt from the open meetings provisions of the "Colorado Sunshine Act of 1972" (COLO. REV. STAT. ANN. § 24-6-402 (West 2025)) and must be closed to the public. A local team member and any non-member in attendance at a local team meeting shall sign a confidentiality form and review the purpose and goal of the local team before the person may participate in the review of confidential information. The confidentiality form must set out the requirements for maintaining the confidentiality of any information disclosed during the meeting and any penalties associated with failure to maintain confidentiality. Information and records acquired by a local team are confidential and are not subject to subpoena, discovery, or introduction into evidence in a civil or criminal proceeding or disciplinary action. Information and records acquired or created by a local team are not subject to inspection pursuant to the "Colorado Open Records Act"

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COLORADO	
Confidentiality (continued)	(COLO. REV. STAT. ANN. § 24-72-203 (West 2025)). Substance use disorder treatment records requested or provided to the local team are subject to any additional limitations on redisclosure of a medical record developed in connection with the provisions of substance use disorder treatment services pursuant to applicable state or federal law, including a state law listed in Colo. Rev. Stat. Ann. § 25-1-1202 (West 2025), 42 U.S.C. § 290dd-2, and 42 C.F.R. Part 2. Local team members and a person who presents or provides information to a local team may not be questioned in any civil or criminal proceeding or disciplinary action regarding the information presented or provided. Notwithstanding any provision of law to the contrary, law enforcement shall not use information from any overdose fatality review for any law enforcement purpose, including surveillance, increased law enforcement presence, welfare checks, warrant checks, or criminal investigations. An individual who knowingly violates the confidentiality provisions is subject to a civil penalty of up to $1,000.
Reporting requirement	Each local team shall submit an annual report to the county or district public health agency or agencies served by the local team containing de-identified information
Funding source	Not addressed by statute
Recently proposed legislation	None

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CONNECTICUT	
Statute(s) and/or regulation(s)	None
Effective date	N/A
Drugs or substances of focus	N/A
Operational level	N/A
Team members	N/A
Duties, tasks, and objectives	N/A
Access to information	N/A
Confidentiality	N/A
Reporting requirement	N/A
Funding source	N/A
Recently proposed legislation	None

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DELAWARE	
Statute(s) and/or regulation(s)	DEL. CODE ANN. tit. 16 §§ 4799A through 4799D (West 2025)
Effective date	April 21, 2016
Drugs or substances of focus	Not specified (prior to a June 15, 2021 amendment, the Commission only reviewed overdoses involving opiates, fentanyl, and/or heroin.)
Operational level	State level commission and three regional review teams.
Team members	The Delaware Drug Overdose Fatality Review Commission (Commission) is composed of the: (1) Delaware Attorney General; (2) Secretary of the State Department of Health and Social Services; (3) Director of the Delaware Division of Forensic Science; (4) Secretary of Safety and Homeland Security; (5) Director of the Delaware Division of Public Health; and (6) 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 investigates and reviews the facts and circumstances of all overdose deaths involving opiates, fentanyl, or heroin that occur in the state.
Access to information	The Commission may access 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.
Confidentiality	Meetings of the Commission and regional review teams are closed to the public. The records of the Commission and of all regional review teams, including original documents and documents produced in the review process regarding the facts and circumstances of each death, are confidential and not releasable to any person except as expressly provided in state law.

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DELAWARE	
Confidentiality (continued)	Such records shall be used by the Commission, and any regional review team, only in the exercise of the proper function of the Commission or review team and are not public records nor available for court subpoena or subject to discovery. Members of the Commission and regional review teams, and their agents and employees, are immune from, claims, suits, liability, damages, or any other recourse, civil or criminal, arising from any act, proceeding, decision or determination undertaken or performed, or recommendation made, provided such persons acted in good faith and without malice. No person in attendance at a meeting of the Commission or regional review team shall be required to testify as to what transpired during the meeting. No organization, institution or person furnishing information, data, reports or records to the Commission or any regional review team with respect to any subject examined or treated by such organizations, institution, or person, by reason of furnishing such information, shall be liable for damages to any person or subject to any other recourse, civil or criminal.
Reporting requirement	At least annually, the Commission must make recommendations to the Governor and General Assembly regarding practices or conditions that impact the frequency of overdose deaths and steps to take to reduce the number of those deaths.
Funding source	Not addressed in statute
Recently proposed legislation	None

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DISTRICT OF COLUMBIA	
Statute(s) and/or regulation(s)	None
Effective date	N/A
Drugs or substances of focus	N/A
Operational level	N/A
Team members	N/A
Duties, tasks, and objectives	N/A
Access to information	N/A
Confidentiality	N/A
Reporting requirement	N/A
Funding source	N/A
Recently proposed legislation	None

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FLORIDA	
Statute(s) and/or regulation(s)	None
Effective date	N/A
Drugs or substances of focus	N/A
Operational level	N/A
Team members	N/A
Duties, tasks, and objectives	N/A
Access to information	N/A
Confidentiality	N/A
Reporting requirement	N/A
Funding source	N/A
Recently proposed legislation	None

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GEORGIA	
Statute(s) and/or regulation(s)	None
Effective date	N/A
Drugs or substances of focus	N/A
Operational level	N/A
Team members	N/A
Duties, tasks, and objectives	N/A
Access to information	N/A
Confidentiality	N/A
Reporting requirement	N/A
Funding source	N/A
Recently proposed legislation	None

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HAWAII	
Statute(s) and/or regulation(s)	None
Effective date	N/A
Drugs or substances of focus	N/A
Operational level	N/A
Team members	N/A
Duties, tasks, and objectives	N/A
Access to information	N/A
Confidentiality	N/A
Reporting requirement	N/A
Funding source	N/A
Recently proposed legislation	None

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IDAHO	
Statute(s) and/or regulation(s)	None
Effective date	N/A
Drugs or substances of focus	N/A
Operational level	N/A
Team members	N/A
Duties, tasks, and objectives	N/A
Access to information	N/A
Confidentiality	N/A
Reporting requirement	N/A
Funding source	N/A
Recently proposed legislation	None

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ILLINOIS	
Statute(s) and/or regulation(s)	None
Effective date	N/A
Drugs or substances of focus	N/A
Operational level	N/A
Team members	N/A
Duties, tasks, and objectives	N/A
Access to information	N/A
Confidentiality	N/A
Reporting requirement	N/A
Funding source	N/A
Recently proposed legislation	None

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INDIANA	
Statute(s) and/or regulation(s)	IND. CODE ANN. § 16-49.5 Chapters 1 and 2 (West 2025)
Effective date	July 1, 2020
Drugs or substances of focus	Not specified
Operational level	Local/county level
Team members	A suicide and overdose fatality review team may be established in a county or in multiple counties. Members of a team must be appointed by the county health officer or another entity approved by the State Department of Health and may include local representatives 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/or (3) a pathologist.
Duties, tasks, and objectives	Teams must meet at least quarterly and must: (1) determine the factors contributing to suicides and overdose fatalities; (2) identify public health and clinical interventions to improve systems of care and enhance coordination; and (3) develop strategies for the prevention of suicides and overdose fatalities. During 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.
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 concerning the assessment, care, fatality, diagnosis, near fatality, or treatment of the person subject to a team review.
Confidentiality	Before a team member may participate in the review of a suicide or overdose fatality, the member must sign a confidentiality form prepared by the State Department of Health. Individuals who are invited by the team chairperson to attend a team meeting must also sign a confidentiality form before attending or participating in the team meeting. Except as otherwise provided, information and records

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INDIANA	
Confidentiality (continued)	acquired by a team during the execution of the team's duties are confidential and exempt from disclosure. Records, information, documents, and reports acquired or produced by a team are not subject to subpoena or discovery or admissible as evidence in any administrative or judicial proceeding.
Reporting requirement	Before July 1 of each year, a team must submit a report to the State Department of Health 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.
Funding source	Not addressed in statute
Recently proposed legislation	None

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IOWA	
Statute(s) and/or regulation(s)	None
Effective date	N/A
Drugs or substances of focus	N/A
Operational level	N/A
Team members	N/A
Duties, tasks, and objectives	N/A
Access to information	N/A
Confidentiality	N/A
Reporting requirement	N/A
Funding source	N/A
Recently proposed legislation	None

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KANSAS	
Statute(s) and/or regulation(s)	None
Effective date	N/A
Drugs or substances of focus	N/A
Operational level	N/A
Team members	N/A
Duties, tasks, and objectives	N/A
Access to information	N/A
Confidentiality	N/A
Reporting requirement	N/A
Funding source	N/A
Recently proposed legislation	None

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KENTUCKY	
Statute(s) and/or regulation(s)	None
Effective date	N/A
Drugs or substances of focus	N/A
Operational level	N/A
Team members	N/A
Duties, tasks, and objectives	N/A
Access to information	N/A
Confidentiality	N/A
Reporting requirement	N/A
Funding source	N/A
Recently proposed legislation	None

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LOUISIANA	
Statute(s) and/or regulation(s)	LA. STAT. ANN. §§ 40:2025.1 through 2025.6 (West 2025)
Effective date	August 1, 2024
Drugs or substances of focus	Not specified
Operational level	Local/county level
Team members	The local OFR panel shall be comprised of the following members or their designees: (1) the coroner; (2) the director of the regional human services district in which the parish is located; (3) the regional director of the department of children and family services, child welfare division for the region in which the parish is located; (4) the regional medical director for the office of public health, Louisiana department of health for the region in which the parish is located; (5) the parish district attorney; (6) the sheriff; (7) the chief of police; (8) a representative of a local jail or detention center; (9) a healthcare provider who specializes in the prevention, diagnosis, and treatment of substance use disorders; (10) a mental health provider who specializes in substance use disorders; (11) a representative of an emergency medical services provider in the parish; (12) a representative from parole, probation, and community corrections; (13) a representative of the judicial district court or drug court if the parish has a drug court; and (14) the director of the local health department if the parish has a local health department.
Duties, tasks, and objectives	Each OFR panel shall: (1) promote cooperation and coordination among agencies involved in the investigation of drug overdose fatalities; (2) develop an understanding of the causes and incidence of drug overdose fatalities in the jurisdiction where the review panel operates; (3) plan for and recommend changes within the agencies represented on the panel to prevent drug overdose fatalities; (4) advise local, regional, and state policymakers about potential changes to law, policy, funding, or practice to prevent drug overdoses; (5) establish and implement protocols and procedures; (6) conduct a multidisciplinary review of information regarding a decedent, which shall include but not be limited to: (a) consideration of the decedent's points of contact with healthcare systems, social services, educational institutions, child and family services, the criminal justice system, including law enforcement, and any other systems with which the decedent had contact prior to his death and (b) identification of the specific factors and social determinants of health that put the decedent at risk for an overdose; (7) recommend prevention and intervention strategies to improve coordination of services and investigations among member

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LOUISIANA	
Duties, tasks, and objectives (continued)	agencies to reduce overdose deaths; and (8) collect, analyze, interpret, and maintain local data on overdose deaths. An OFR panel may also investigate non-fatal overdose cases that occur within the panel's jurisdiction.
Access to information	Notwithstanding any other provision of law to the contrary, on written request of the chair of an OFR panel and as necessary to carry out the purpose and duties of the review panel, the panel shall be authorized to have access to the following information: (1) information and records regarding the physical health, mental health, and treatment for substance use disorder maintained by a healthcare provider, substance use disorder treatment provider, hospital, or health system for an individual whose death or near death is being reviewed by the review panel; and (2) information and records maintained by a state or local government agency or entity, including but not limited to death investigative information, medical examiner investigative information, law enforcement investigative information, emergency medical services reports, fire department records, prosecutorial records, parole and probation information and records, court records, school records, and information and records of the department of children and family services if the agency or entity provided services to: (a) the individual whose death or near death is being reviewed by the panel, or (b) the family of the decedent being investigated.
Confidentiality	Meetings of the local OFR panel are exempt from the Louisiana open meetings law (LA. STAT. ANN. § 42:11, *et seq*. (West 2025)). An individual, entity, or local or state agency that in good faith provides information or records to the local panel shall not be subject to civil or criminal liability or any professional disciplinary action as a result of providing the information or record. A member of a review panel may contact, interview, or obtain information by request from a family member or friend of an individual whose death is being reviewed by the panel. Information and records obtained by the review panel in accordance with the provisions of this Section and the results of any overdose fatality review report shall be confidential and shall not be available for subpoena, nor shall the information be disclosed, discoverable, or compelled to be produced in any civil, criminal, administrative, or other proceeding, nor shall the records be deemed admissible as evidence in any civil, criminal, administrative, or other tribunal or court for any reason. An individual who appears before, participates in, or provides information to the review panel shall sign a confidentiality notice to acknowledge that any information that the person provides to the review panel shall be confidential.
Reporting requirement	Each OFR panel shall submit no later than November 1st of each year an annual report to the human services district for the parish or parishes

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LOUISIANA	
Reporting requirement (continued)	served by the review panel. The annual report shall include but not be limited to the following information: (1) the total number of fatal overdoses that occurred within the jurisdiction of the overdose fatality review panel; (2) the number of fatal overdose cases investigated by the overdose fatality review panel; (3) any recommendations for state and local agencies or the state legislature to assist in preventing fatal and nonfatal overdoses in the state; and (4) assessable results of any recommendations made by the overdose fatality review panel, including but not limited to changes in local or state law, policy, or funding made as a result of the panel's recommendations. Each human services district shall compile the reports submitted to it from the review panels and submit the compiled report to the Louisiana department of health no later than December 31st of each year. The compiled report shall also include any additional recommendations from the human services district based on the data received for the region. The Louisiana department of health shall analyze each annual report, create a single report containing an aggregate of the data received, and submit the report to the governor and legislature no later than March 15th of each year. Reports submitted are not confidential and are subject to the public records law.
Funding source	Not addressed in statute
Recently proposed legislation	None

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MAINE	
Statute(s) and/or regulation(s)	ME. REV. STAT. ANN. tit. 5, § 200-M (West 2025)
Effective date	June 21, 2021
Drugs or substances of focus	Not specified
Operational level	State level
Team members	The Accidental Drug Overdose Death Review Panel (Panel) consists of the following members: (1) the Chief Medical Examiner; (2) the Commissioner of Public Safety; (3) the Director of the Office of Behavioral Health within the Department of Health and Human Services; (4) the Director of the Maine Center for Disease Control and Prevention within the Department of Health and Human Services; (5) the Chief Justice of the Supreme Judicial Court; (6) a prosecutor nominated by a statewide association of prosecutors and appointed by the Attorney General; (7) a police chief nominated by a statewide association of chiefs of police and appointed by the Attorney General; (8) a sheriff nominated by a statewide association of sheriffs and appointed by the Attorney General; (9) one or more physicians who treat substance use disorder, appointed by the Governor; (10) an emergency medical services representative, appointed by the Commissioner of Public Safety; (11) an expert in harm reduction strategies, appointed by the Governor; (12) an academic research professor with experience in reviewing drug overdose deaths, appointed by the Attorney General; (13) a representative of families affected by drug overdose deaths, appointed by the Governor; (14) a person in recovery from substance use disorder, appointed by the Governor; and (15) the Director of Opioid Response within the Governor's Office of Policy Innovation and the Future.
Duties, tasks, and objectives	The Panel shall examine a subset of the deaths associated with accidental drug overdoses, taking into consideration the racial and ethnic composition of the population of individuals whose deaths are associated with an accidental drug overdose. The deaths selected for review must be recommended by the Chief Medical Examiner or the Chief Medical Examiner's designee or by an individual with whom the Office of the Attorney General contracts for services. Notwithstanding any provision of law to the contrary, the Panel may review information surrounding a non-fatal, accidental drug overdose, as long as review of such a case promotes the purpose of the Panel under this section. The Panel shall recommend to state, county, and local agencies methods of preventing deaths as the result of accidental drug overdoses including modification or enactment of laws, rules, policies, and procedures.

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MAINE	
Access to information	In any case subject to review by the Panel, upon oral or written request of the Panel, and notwithstanding any provision of law to the contrary, any person that possesses information or records that are necessary and relevant to a Panel review shall as soon as practicable provide the Panel with the information and records.
Confidentiality	The proceedings and records of the Panel are confidential and are not subject to subpoena, discovery, or introduction into evidence in a civil or criminal action. The Office of the Attorney General shall disclose conclusions of the Panel upon request, but may not disclose information, records or data that are otherwise classified as confidential.
Reporting requirement	None
Funding source	Not addressed in statute
Recently proposed legislation	None

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MARYLAND	
Statute(s) and/or regulation(s)	MD. CODE ANN., HEALTH-GEN. §§ 5-901 through 5-906 (West 2025)
Effective date	October 1, 2014
Drugs or substances of focus	Not specified
Operational level	Local/county level
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 must 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.
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;

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MARYLAND	
Access to information (continued)	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 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 the team requests a record, the providing entity should immediately provide it to the team.
Confidentiality	All information and records acquired by a local team in the exercise of its purpose and duties under the law are confidential, exempt from disclosure under Title 4 of the General Provisions Article ("Public Information Act"), and may be disclosed only as necessary to carry out the team's purpose and duties. Mental health records are subject to the additional limitations under MD. CODE ANN., HEALTH-GEN. § 4-307 (West 2025) for disclosure of a medical record developed primarily in connection with the provision of mental health services. Substance abuse treatment records are subject to any additional limitations for disclosure or redisclosure of a medical record developed in connection with the provision of substance abuse treatment services under State law or 42 U.S.C. § 290DD-2 and 42 C.F.R. Part 2. Statistical compilations of data and reports of the local team that do not contain any information that would permit the identification of any person to be ascertained are public information. Except as necessary to carry out a local team's purpose and duties, members of a local team and persons attending a local team meeting may not disclose: (1) what transpired at the meeting that is not public; or (2) any information for which the law prevents disclosure. Members of a local team, individuals attending a local team meeting, and individuals who present information to a local team may not be questioned in any civil or criminal proceeding about information presented in or opinions formed as a result of a meeting. Information, documents, or records of a local team are not subject to subpoena, discovery, or introduction into evidence in any civil or criminal proceeding. A person who violates the confidentiality provisions is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $500, imprisonment not exceeding 90 days, or both.

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MARYLAND	
Reporting requirement	Teams must provide requested reports to the Maryland Department of Hygiene and Mental Health, including: (1) discussion of individual cases, (2) steps taken to improve coordination of services and investigations, (3) steps taken to implement changes recommended by the local team within member agencies, and (4) recommendations on needed changes
Funding source	Not addressed in statute
Recently proposed legislation	None

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MASSACHUSETTS	
Statute(s) and/or regulation(s)	None
Effective date	N/A
Drugs or substances of focus	N/A
Operational level	N/A
Team members	N/A
Duties, tasks, and objectives	N/A
Access to information	N/A
Confidentiality	N/A
Reporting requirement	N/A
Funding source	N/A
Recently proposed legislation	None

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MICHIGAN	
Statute(s) and/or regulation(s)	MICH. COMP. LAWS ANN. §§ 330.3021 through 330.3031 (West 2025)
Effective date	February 13, 2024
Drugs or substances of focus	Not specified
Operational level	Local/county level
Team members	Any of the following individuals may be a member of an OFR team: (1) the county health officer; (2) the prosecuting attorney for the county or the attorney's designee; (3) the director of the county's community mental health agency or the director's designee; (4) the county medical examiner or the medical examiner's designee; (5) a law enforcement officer of the department of state police, the participating county, or a municipality within the participating county; (6) a representative of a jail or detection center in the county; (7) a health care provider who specializes in the prevention, diagnosis, and treatment of SUDs; (8) a mental health provider who specializes in the treatment of SUDs; (9) an SUD treatment provider; (10) a representative of an EMS provider in the county; (11) a representative from the department of corrections who has experience with parole, probation, or community corrections; (12) an epidemiologist from a local health department or an organization in the county; (13) a child protective services caseworker; (14) a representative from the department of health and human services who is involved with issues regarding adult protective services; (15) a representative of a hospital with a service area within the county; and (16) any other individual whose membership is necessary for the OFR team to complete the duties required. Any of the following individuals may be invited to participate in an individual overdose review: (1) a prepaid inpatient health plan chief executive officer or that officer's designee, or the prepaid inpatient health plan SUD director; (2) a superintendent of a school in the county, or the superintendent's designee; (3) a representative of a hospital in the participating county; (4) a health care provider who specializes in emergency medicine; (5) a health care provider who specializes in pain management; (6) a pharmacist who has expertise in addressing prescription drug misuse and diversion; (7) a representative from a poison control center; (8) a mental health provider; (9) a prescription drug monitoring program administrator; (10) a representative from a harm reduction provider; (11) a recovery coach, peer support worker, or other representative of the recovery community; (12) a representative from a drug court in the county; (13) an SUD prevention specialist or representative; (14) the director of the department of health and human services office in the county, or the

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MICHIGAN	
Team members (continued)	director's designee; and (15) any other individual necessary to complete the duties of the OFR team.
Duties, tasks, and objectives	An OFR team shall do all of the following: (1) promote cooperation and coordination among agencies involved in the investigation of drug overdose fatalities; (2) identify potential causes and incidences of drug overdose fatalities in the county; (3) recommend and plan for changes within the agencies represented on the OFR team to prevent drug overdose fatalities; (4) propose potential changes to law, policy, funding, or practices to prevent drug overdoses; and (5) recommend prevention and intervention strategies, focusing on evidence-based strategies and promising practices, to improve the coordination of services and investigations among agencies represented by members of the OFR team to reduce drug overdose fatalities.
Access to information	Except as otherwise expressly prohibited by federal or state law, on written request of the chairperson, a health care provider, SUD treatment provider, hospital, or health system shall, not more than 30 business days after receiving the request, provide the chairperson information and relevant records regarding the physical health, mental health, or treatment for the SUD of an individual who is the subject of an individual overdose review of the OFR team. Except as otherwise expressly prohibited by federal or state law, on written request of the chairperson, a person shall, not more than 5 business days after receiving the request, provide the chairperson the following information and records: (1) death investigative information. (2) medical examiner investigative information; (3) law enforcement investigative information; (4) EMS reports; (5) fire department records; (6) prosecuting attorney records; (7) parole and probation information and records; (8) court records; (9) school records; (10) information and records regarding resources provided to the decedent by a social services agency; and (11) information and records regarding resources provided by a social services agency to a family member of the individual who is the subject of an individual overdose review. If a family member or friend of the individual who is the subject of an individual overdose review submits a request to submit information to an OFR team, a member of that team may contact, interview, or obtain the information about the individual from that family member or friend.
Confidentiality	Except as otherwise expressly prohibited by federal or state law, OFR team members and invited individuals may discuss confidential matters and share confidential information during an OFR team meeting. This, however, does not authorize the disclosure of confidential information

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MICHIGAN	
Confidentiality (continued)	outside of the meeting. If an individual has not signed a confidentiality form, that individual must not participate in or observe an OFR team meeting, individual overdose review, or community overdose review. The confidentiality form must summarize the purpose and goal of the meeting or review, the requirements for maintaining the confidentiality of any information disclosed during the meeting, and any consequences for failure to maintain confidentiality. Information obtained or created by or for an OFR team is confidential and not subject to discovery, subpoena, or the Freedom of Information Act (Mich. Comp. Laws Ann. § 15.231 et seq. [West 2023]). Documents and records otherwise available from other sources are not exempt from discovery, subpoena, or introduction into evidence from other sources solely because they were presented to or reviewed by an OFR team. An OFR team shall comply with federal and state laws pertaining to confidentiality and to the disclosure of SUD treatment records, including, but not limited to, 42 U.S.C. 290dd-2 and 42 CFR Part 2. If an OFR team member knowingly discloses confidential information in violation of this act, a person aggrieved by that violation may bring a civil action for damages and any costs and reasonable attorney fees allowed by the court.
Reporting requirement	The OFR team shall submit an annual report to the public, the local health department of the county, and the department of health and human services that contains all of the following information: (1) the total number of drug overdose fatalities that occurred within the participating county; (2) the number of individual overdose reviews conducted by the OFR team; and (3) any recommendations. The report must not contain any identifying information.
Funding source	Not addressed in statute
Recently proposed legislation	None

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MINNESOTA	
Statute(s) and/or regulation(s)	None
Effective date	N/A
Drugs or substances of focus	N/A
Operational level	N/A
Team members	N/A
Duties, tasks, and objectives	N/A
Access to information	N/A
Confidentiality	N/A
Reporting requirement	N/A
Funding source	N/A
Recently proposed legislation	None

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MISSISSIPPI	
Statute(s) and/or regulation(s)	None
Effective date	N/A
Drugs or substances of focus	N/A
Operational level	N/A
Team members	N/A
Duties, tasks, and objectives	N/A
Access to information	N/A
Confidentiality	N/A
Reporting requirement	N/A
Funding source	N/A
Recently proposed legislation	None

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MISSOURI	
Statute(s) and/or regulation(s)	None
Effective date	N/A
Drugs or substances of focus	N/A
Operational level	N/A
Team members	N/A
Duties, tasks, and objectives	N/A
Access to information	N/A
Confidentiality	N/A
Reporting requirement	N/A
Funding source	N/A
Recently proposed legislation	None

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MONTANA	
Statute(s) and/or regulation(s)	None
Effective date	N/A
Drugs or substances of focus	N/A
Operational level	N/A
Team members	N/A
Duties, tasks, and objectives	N/A
Access to information	N/A
Confidentiality	N/A
Reporting requirement	N/A
Funding source	N/A
Recently proposed legislation	None

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NEBRASKA	
Statute(s) and/or regulation(s)	NEB. REV. STAT. ANN. §§ 71-3422 to 71-3437 (West 2025)
Effective date	June 7, 2023
Drugs or substances of focus	Not specified
Operational level	Local/county level
Team members	A local public health department may establish a local team for its jurisdiction or for a group of cities, counties, or districts, pursuant to an agreement among multiple local public health departments. A local team must consist of core members who may include one or more members from the following backgrounds: (1) officials from the local public health department or from another local public health department, or such officials' designees; (2) behavioral health provisions or officials; (3) law enforcement personnel; (4) representatives of jails or detection centers; (5) the coroner or the coroner's designee; (6) health care providers who specialize in the prevention, diagnosis, and treatment of SUDs; (7) mental health providers who specialize in SUDs; (8) representatives of EMS providers in the county; (9) the director of children and family services of the department of health and human services' division of children and family services or the director's designee; and (10) representatives from the board of parole, the office of probation administration, the division of parole supervision, or the community corrections division of the Nebraska Commission on Law Enforcement and Criminal Justice. A local team may also include, either as permanent or temporary members, the following: (1) a local school superintendent or the superintendent's designee; (2) a representative of a local hospital; (3) a health care provider who specializes in emergency medicine; (4) a health care provider who specializes in pain management; (5) a pharmacist with a background in prescription drug misuse and diversion; (6) an SUD treatment provider from a licensed SUD treatment program; (7) a poison control center representative; (8) a mental health provider who is a generalist; (9) a prescription drug monitoring program administrator or such administrator's designee; (10) a representative from a harm reduction provider; (11) a recovery coach, peer support worker, or other representative of the recovery community; (12) a representative from the local drug court; and (13) any other individual necessary for the work of the local team.

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NEBRASKA	
Duties, tasks, and objectives	A local team shall (1) promote cooperation and coordination among agencies involved in the investigation of drug overdose fatalities; (2) examine the incidence, causes, and contributing factors of drug overdose deaths in jurisdictions where the local team operates; (3) develop recommendations for changes within communities, public and private agencies, institutions, and systems, based on an analysis of the causes and contributing factors of drug overdose deaths; (4) advise local, regional, and state policymakers about potential changes to law, policy, funding, or practices to prevent drug overdoses; (5) establish and implement protocols and procedures for overdose investigations and to maintain confidentiality; (6) conduct a multidisciplinary review of information received regarding a person who died of a drug overdose; (7) recommend prevention and intervention strategies to improve coordination of services and investigations among member agencies and providers to reduce overdose deaths; and (8) collect, analyze, interpret, and maintain data on local overdose deaths.
Access to information	Upon written request of the local public health department, and as necessary to carry out the purpose and duties of the local team, the lead organization shall be provided with the following information: (1) nonprivileged information and records regarding the physical health, mental health, and treatment for any SUD maintained by a health care provider, SUD treatment provider, hospital, or health system for an individual whose death is being reviewed by the local team; and (2) information and records maintained by a state or local government agency or entity, including, but not limited to, death investigative information, coroner investigative information, law enforcement investigative information, EMS reports, fire department records, prosecutorial records, parole and probation information and records, court records, school records, and information and records of a social services agency, including the department, if the agency or entity provided services to an individual whose death is being reviewed by the local team. The following persons or entities shall comply with a records request by the local public health department: (1) a coroner; (2) a fire department; (3) a health system; (4) a hospital; (5) a law enforcement agency; (6) a local or state governmental agency, including, but not limited to, the department, local public health authorities, the attorney general, county attorneys, public defenders, the commission on public advocacy, the department of correctional services, the office of probation administration, and the division of parole supervision; (7) a mental health provider; (8) a health care provider; (9) an SUD treatment provider; (10) a school, including a public or private

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NEBRASKA	
Access to information (continued)	elementary, secondary, or post-secondary institution; (11) an EMS provider; (12) a social services provider; and (13) any other person who is in possession of records pertinent to the local team's investigation of an overdose fatality.
Confidentiality	Members of a local team and other individuals in attendance at a local team meeting, including, but not limited to, experts, health care professionals, or other observers (1) shall sign a confidentiality agreement; (2) are bound by all applicable local, state, and federal laws concerning the confidentiality of matters reviewed by the local team but may discuss confidential matters and share confidential information during such meeting; and (3) except as otherwise permitted by law, shall not disclose confidential information outside of the meeting. A member of a local team or an individual in attendance at a local team meeting shall not be subject to civil or criminal liability or any professional disciplinary action for the sharing or discussion of any confidential matter with the local team during a local team meeting. This immunity does not apply to a local team member or attendee who intentionally or knowingly discloses confidential information in violation of the Overdose Fatality Review Teams Act or any state or federal law. A local team is not considered to be a public body for purposes of the Open Meetings Act. Except for reports, information and records acquired or created by a local team are not public records subject to disclosure, pursuant to Neb. Rev. Stat. Ann. §§ 84-712 to 84-712.09 (West 2023), and shall (1) be confidential; (2) not be subject to subpoena; (3) be privileged and inadmissible in evidence in any legal proceeding of any kind or character; and (4) not be disclosed to any other department or agency of the State of Nebraska, except the department of health and human services as specified in the Overdose Fatality Review Teams Act. A person aggrieved by the intentional or knowing disclosure of confidential information in violation of the Overdose Fatality Review Teams Act by a local team, its members, or a person in attendance at a local team meeting may bring a civil action for appropriate relief against the person who committed such violation. A person who intentionally or knowingly violates the confidentiality requirements of the Overdose Fatality Review Teams Act is guilty of a class II misdemeanor.
Reporting requirement	On or before June 1, each local team shall submit a report to the department. The report shall include at least the following for the

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NEBRASKA	
Reporting requirement (continued)	preceding year: (1) the total number of fatal drug overdoses that occurred within the jurisdiction of the local team; (2) the number of fatal drug overdoses investigated by the local team; (3) the causes, manner, and contributing factors of drug overdose deaths in the team's jurisdiction, including trends; (4) recommendations regarding the prevention of fatal and nonfatal drug overdoses for changes within communities, public and private agencies, institutions, and systems, based on an analysis of such causes and contributing factors— such recommendations shall include recommended changes to laws, rules and regulations, policies, training needs, or service gaps to prevent future drug overdose deaths; and (5) a follow-up analysis of the implementation of and results from any recommendations made by the local team, including, but not limited to, changes in local or state law, policy, or funding made as a result of the local team's recommendations. The report must include only de-identified information and must not identify any victim, living or dead, of a drug overdose. The report is not confidential and should be made available to the public.
Funding source	Not addressed in statute
Recently proposed legislation	None

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NEVADA	
Statute(s) and/or regulation(s)	None
Effective date	N/A
Drugs or substances of focus	N/A
Operational level	N/A
Team members	N/A
Duties, tasks, and objectives	N/A
Access to information	N/A
Confidentiality	N/A
Reporting requirement	N/A
Funding source	N/A
Recently proposed legislation	None

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NEW HAMPSHIRE	
Statute(s) and/or regulation(s)	N.H. REV. STAT. ANN. § 126-DD:1 (West 2025) (initially, a 2016 order established the Drug Overdose Fatality Review Commission (N.H. Exec. Order No. 2016-05))
Effective date	September 27, 2020 (statute); October 12, 2016 (executive order)
Drugs or substances of focus	Not specified
Operational level	State level
Team members	The New Hampshire Drug Overdose Fatality Review Commission (Commission) 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 Addiction, Treatment, and Prevention; (8) a representative of the New Hampshire Association of Chiefs of Police; (9) a representative of the New Hampshire Association of Fire Chiefs; (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; (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; (17) a representative from American Medical Response; (18) a representative of the Drug Enforcement Administration; (19) the Governor's advisor on addiction and behavioral health; (20) a suicide prevention specialist, appointed by the National Alliance on Mental Illness New Hampshire chapter; and (21) a representative of the New Hampshire Medical Society.
Duties, tasks, and objectives	The Commission must meet no fewer than six times per year to conduct reviews of overdose fatalities. The Commission must: (1) review trends and patterns of overdose-related fatalities in New Hampshire; (2) identify high-risk factors, current practices, and gaps in system responses; (3) recommend policies, practices, and services that will encourage collaboration and reduce overdose fatalities; (4) improve sources of data collection by developing a system to share information between agencies and offices that work with individuals struggling with addiction; (5) educate the public, policy makers,

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NEW HAMPSHIRE	
Duties, tasks, and objectives (continued)	and funders about overdose-related fatalities and about strategies for intervention and effective prevention, treatment, and recovery; and (6) review 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 five (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 overdose victim. 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.
Confidentiality	Proceedings, records, and opinions of the Commission are confidential, not subject to N.H. REV. STAT. ANN. 91-A (West 2025), and not subject to discovery, subpoena, or introduction into evidence in any civil or criminal proceeding. Members of the Commission may not be questioned in any civil or criminal proceeding regarding information presented in or opinions formed as a result of a meeting of the team. The Commission shall maintain the confidentiality of all records pursuant to N.H. REV. STAT. ANN. 169-C:25 (West 2025), N.H. REV. STAT. ANN. 170-G:8-a (West 2025), and all other related confidentiality laws. The information and records obtained and created in execution of the Commission's official functions are exempt from disclosure pursuant to N.H. REV. STAT. ANN. 91-A (West 2025) and are privileged and exempt from use or disclosure in any criminal or civil matter or administrative proceeding. Any person who knowingly discloses case records or other information obtained from Commission proceedings commits a misdemeanor.
Reporting requirement	The Commission is required to complete an annual statistical report on the incidence and causes of overdose fatalities in the state during the past fiscal year and submit a copy of this report, including its recommendations for proposed legislation and actions, to the governor, the senate president, and the speaker of the house of representatives. The commission is to submit the report on or before December 15 of each year.
Funding source	Not addressed in statute
Recently proposed legislation	None

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NEW JERSEY	
Statute(s) and/or regulation(s)	N.J. STAT. ANN. §§ 26:3A2-20.3 to 20.10 (West 2025)
Effective date	April 18, 2022
Drugs or substances of focus	Not specified
Operational level	Local/county level
Team members	At a minimum, each local overdose fatality review team shall include: (1) the county health officer, or a designee; (2) the regional or county medical examiner, or a designee; (3) a member of the Local Advisory Committee on Alcohol Use Disorder and Substance Use Disorder, if one exists within the local team's jurisdiction; (4) a state, county, or municipal law enforcement officer or county prosecutor; (5) a substance use disorder health care professional; and (6) the county or municipal director of behavioral health services, or a designee. A local OFR team may also include any of the following: (1) the superintendent of schools, or a designee; (2) an emergency medical services provider; (3) a representative of a health care facility, including a hospital, health system, or federally qualified health center; (4) a representative of a county jail, detention center, or corrections department; (5) a representative of a county social services agency; (6) an individual with access to the prescription monitoring program; (7) a representative of the local office of the Division of Child Protection and Permanency in the Department of Children and Families; (8) a representative of a county health care facility; (9) a representative of a harm reduction center, if one is located in a municipality or county over which the local team exercises jurisdiction; (10) a representative of the office of county probation and parole services; and (11) any individual deemed necessary for the work of the local team, as recommended by the chair and approved by a majority vote of the team members and by the Department of Health.
Duties, tasks, and objectives	A local OFR team shall (1) collect, analyze, interpret, and maintain local data on overdose deaths, which information shall be maintained by the local team in accordance with all appropriate and industry-standard technical, administrative, and physical controls necessary to protect the privacy and security of the information; (2) conduct a multidisciplinary review of the information collected regarding a decedent of a confirmed fatal drug overdose, which shall include (a) consideration of the decedent's points of contact with health care systems, social services, educational institutions, child and family services, the criminal justice system, including law enforcement, and any other systems with which the decedent had contact prior to death;

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NEW JERSEY	
Duties, tasks, and objectives (continued)	and (b) identification of the specific factors and social determinants of health that put the decedent at risk for an overdose; (3) recommend prevention and intervention strategies to improve the coordination of services and investigations among member agencies in effort to reduce overdose deaths; (4) produce confidential case reports based on information received; and (5) submit to the Department of Health an annual report containing only de-identified data associated with the jurisdiction served by the local team.
Access to information	The following individuals and entities may disclose, within a reasonable period of time following a request, medical records and information requested by the local team: (1) county medical examiners; (2) paid fired departments or volunteer fire companies; (3) hospitals and health systems; (4) law enforcement agencies; (5) state and local government agencies; (6) mental health providers; (7) health care practitioners; (8) substance use disorder treatment programs and providers; (9) public and private schools and institutions of higher education; (10) emergency medical services providers; (11) social services agencies and providers; and (12) the prescription monitoring program. These individuals or entities may provide a local team with the following information: (1) any relevant information and records maintained by a health care provider related to an individual's physical health, mental health, and substance use disorder treatment; and (2) any relevant information and records maintained by a state or local government agency, including criminal history records and records of probation and parole if the transmission of such records does not imperil ongoing investigations, medical examiner records, social service records, and school records and educational histories.
Confidentiality	A local OFR team shall establish policies and procedures to ensure that all records in their possession containing personally identifiable information are properly handled and retained and are securely and permanently destroyed within one year of, or within a reasonable period of time, after the conclusion of a local team's review of a decedent's case. A local team may only request, collect, analyze, and share information for public health purposes directly related to the review of confirmed fatal drug overdoses and, except as otherwise provided in this act, in compliance with all applicable State and federal laws or regulations. A local overdose fatality review team shall develop a confidentiality policy and from establishing: (1) the requirements for maintaining the confidentiality of any information disclosed during a meeting, during review, or any other time; (2) the responsibilities concerning those requirements; and (3) any penalties associated with

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NEW JERSEY	
Confidentiality (continued)	failure to maintain such confidentiality. Meetings of a local team during which confidential information is discussed shall be closed to the public.
Reporting requirement	The department of health shall analyze and compile reports from each local OFR team and submit one statewide annual overdose fatality report containing information from each local team. The report shall be submitted to the governor and the legislature.
Funding source	The department of health, the office of the chief state medical examiner, applicable county and local health departments, applicable county medical examiner offices, and local OFR teams may pursue all sources of federal funding, matching funds, and foundation funding available to implement the provisions of this act. The department of health, the office of the chief state medical examiner, county medical examiner offices, and local OFR teams may accept such gifts, grants, and endowments, from public or private sources, as may be made, in trust or otherwise, or any income derived according to the terms of a gift, grant, or endowment, to implement the provisions of this act.
Recently proposed legislation	None

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NEW MEXICO	
Statute(s) and/or regulation(s)	None
Effective date	N/A
Drugs or substances of focus	N/A
Operational level	N/A
Team members	N/A
Duties, tasks, and objectives	N/A
Access to information	N/A
Confidentiality	N/A
Reporting requirement	N/A
Funding source	N/A
Recently proposed legislation	None

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NEW YORK	
Statute(s) and/or regulation(s)	None
Effective date	N/A
Drugs or substances of focus	N/A
Operational level	N/A
Team members	N/A
Duties, tasks, and objectives	N/A
Access to information	N/A
Confidentiality	N/A
Reporting requirement	N/A
Funding source	N/A
Recently proposed legislation	Yes, see recently proposed legislation

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NORTH CAROLINA	
Statute(s) and/or regulation(s)	None
Effective date	N/A
Drugs or substances of focus	N/A
Operational level	N/A
Team members	N/A
Duties, tasks, and objectives	N/A
Access to information	N/A
Confidentiality	N/A
Reporting requirement	N/A
Funding source	N/A
Recently proposed legislation	None

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NORTH DAKOTA	
Statute(s) and/or regulation(s)	N.D. CENT. CODE ANN. §§ 23-50-01 to 50-05 (West 2025)
Effective date	August 1, 2019
Drugs or substances of focus	Prescription drugs, illicit drugs, and alcohol
Operational level	State level
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 (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 Panel provides 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	Upon the written request of the presiding officer of the Panel, a health care facility and health care provider shall disclose all patient records of the facility or provider which are requested by the Panel and pertain to an identified drug fatality. The presiding officer may request records from the most recent 36-month period.
Confidentiality	Notwithstanding N.D. CENT. CODE ANN. §§ 44-04-18 to 44-04-19 (West 2025) ("Access to public meetings" and "Access to public records electronically stored information"), (1) all portions of a Panel's meeting that reviews drug fatalities are closed to the public; and (2) all Panel documentation and reports that are related to review of drug fatalities are confidential, except for the annual state report, which may not disclose personally identifiable information of decedents. The confidential records are not discoverable as evidence.
Reporting requirement	Annually, the Panel shall compile a state report of fatalities reviewed. The report must include identification of patterns, trends, and policy issues related to drug fatalities but may not disclose personally identifiable information.

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NORTH DAKOTA	
Funding source	Not addressed in statute
Recently proposed legislation	None

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OHIO	
Statute(s) and/or regulation(s)	OHIO REV. CODE ANN. §§ 307.631 to 307.639 (West 2025)
Effective date	September 30, 2021
Drugs or substances of focus	Not specified
Operational level	Local/county level
Team members	A board of county commissioners may appoint a health commissioner of the board of health of a city or general health district that is entirely or partially located in the county in which the board of county commissioners is located to establish a drug overdose fatality review committee to review drug overdose deaths and opioid-involved deaths occurring in the county. The health commissioner shall select four members to serve on the review committee. The review committee shall consist of the following: (1) the chief of police of a police department in the county, or the county sheriff, or a designee od the chief or sheriff; (2) a public health official or the official's designee; (3) the executive director of the Board of Alcohol, Drug Addiction, and Mental Health Services for the county or the executive director's designee; and (4) a physician who is authorized to practice medicine and surgery or osteopathic medicine and surgery. If two or more counties join to form a joint drug overdose fatality review committee, then the members of the committee shall be representatives from the most populous county served by the committee. The review committee shall invite the county coroner or, in the case of a regional review committee, the county coroner from the most populous county, to serve on the committee. The coroner is not required to accept the invitation.
Duties, tasks, and objectives	The purpose of a local OFR committee is to decrease the incidence of preventable overdose deaths by doing all of the following: (1) promoting cooperation, collaboration, and communication between all groups, professions, agencies, or entities engaged in substance use disorder prevention, education, or treatment efforts; (2) maintaining a comprehensive database of all overdose deaths that occur in the county or region served by the review committee in order to develop an understanding of the causes and incidence of those deaths; (3) recommending and developing plans for implementing local service and program changes and changes to the groups, professions, agencies, or entities that serve local residents that might prevent overdose deaths; and (4) providing the Department of Health (Department) with aggregate data, trends, and patterns concerning overdose deaths.
Access to information	For each drug overdose or opioid-involved death reviewed by a committee, the committee shall collect all of the following: (1) demographic information of the deceased, including age, sex, race, and

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OHIO	
Access to information (continued)	ethnicity; (2) the year in which the death occurred; (3) the geographic location of the death; (4) the cause of death; (5) any factors contributing to the death; and (6) any other information the committee considers relevant.
Confidentiality	In an effort to ensure confidentiality, each local committee shall do all of the following: (1) maintain all records in a secure location; (2) develop security measures to prevent unauthorized access to records containing information that could reasonably identify any person; and (3) develop a system for storing, processing, indexing, retrieving, and destroying information obtained in the course of reviewing a drug overdose or opioid-involved death. Any information, document, or report presented to a drug OFR committee, all statements made by review committee members during meetings of the review committee, all work products of the review committee, and data submitted by the review committee to the department of health, other than the annual report, are confidential and shall be used by the review committee, its members, and the department of health only in the exercise of the proper functions of the review committee and the department of health.
Reporting requirement	By April 1 of each year, the person convening a local committee is required to prepare and submit to the Ohio Department of Health a report that includes all of the following information for the previous calendar year: (1) the total number of drug overdose or opioid-involved deaths in the county or region; (2) the total number of drug overdose or opioid-involved deaths reviewed by the committee; (3) a summary of demographic information for the deaths reviewed, including age, sex, race, and ethnicity; and (4) a summary of any trends or patterns identified by the committee. The report must specify the number of drug overdose or opioid-involved deaths that were not reviewed during the previous calendar year. The report must include recommendations for actions that might prevent other deaths, as well as any other information the review board determines should be included.
Funding source	Not addressed in statute
Recently proposed legislation	None

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OKLAHOMA	
Statute(s) and/or regulation(s)	On July 1, 2025, Oklahoma repealed its Opioid Overdose Fatality Review Board (Board) law in accordance with a sunset provision in the statute. In place of the Board, the Oklahoma legislature gave the attorney general oversight of opioid overdose death control efforts.
Effective date	N/A
Drugs or substances of focus	N/A
Operational level	N/A
Team members	N/A
Duties, tasks, and objectives	N/A
Access to information	N/A
Confidentiality	N/A
Reporting requirement	N/A
Funding source	N/A
Recently proposed legislation	None

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OREGON	
Statute(s) and/or regulation(s)	None
Effective date	N/A
Drugs or substances of focus	N/A
Operational level	N/A
Team members	N/A
Duties, tasks, and objectives	N/A
Access to information	N/A
Confidentiality	N/A
Reporting requirement	N/A
Funding source	N/A
Recently proposed legislation	None

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PENNSYLVANIA (2013 law)	
Statute(s) and/or regulation(s)	71 PA. STAT. AND CONS. STAT. ANN. § 1691.1 to 1691.9 (West 2025)
Effective date	When initially established on January 22, 2013, the statute (termed the "Methadone Death and Incident Review Act") applied only to deaths caused primarily or secondarily by methadone. Effective February 23, 2021, the statute became the "Medication Death and Incident Review Act," and its focus broadened to deaths where a medication approved by the U.S. Food and Drug Administration (FDA) for the treatment of opioid use disorder is the primary or secondary cause of death or may be a contributing factor.
Drugs or substances of focus	Medications approved by the FDA for the treatment of opioid use disorder
Operational level	State level
Team members	The Pennsylvania Medication Death and Incident Review Team (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)[3]; (14) and a toxicologist.

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

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PENNSYLVANIA (2013 law)	
Duties, tasks, and objectives	The Team reviews each death where a medication approved by the FDA for the treatment of opioid use disorder is either the primary or secondary cause of death in order to determine what role that medication plays 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.
Confidentiality	The Team shall maintain the confidentiality of any identifying information obtained relating to the death of an individual or adverse incidents regarding medication, including the name of the individual, guardians, family members, caretakers or alleged or suspected perpetrators of abuse, neglect, or a criminal act. Each member of the Team and any person appearing before the Team shall sign a confidentiality agreement applicable to all proceedings and reviews conducted by the Team. The proceedings, deliberations and records of the team are privileged and confidential and shall not be subject to Right-to-Know laws, discovery, subpoena, or introduction into evidence in any civil or criminal action. Meetings of the Team at which a specific death is discussed shall be closed to the public. A person who violates the provisions of this section commits a misdemeanor of the third degree.
Reporting requirement	The Team is required to prepare an annual report that is to be posted on the department's internet website and distributed to the chairperson and the minority chairperson of the judiciary committee of the senate, the chairperson and the minority chairperson of the health and human services committee of the senate, the chairperson and the minority chairperson of the judiciary committee of the house of representatives, and the chairperson and the minority chairperson of the human services

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PENNSYLVANIA (2013 law)	
Reporting requirement (continued)	committee of the house of representatives. Each report shall (1) provide public information regarding the number and causes of medication-related deaths and medication-related incidents; (2) provide aggregate data on 5-year trends on medication-related deaths and medication-related incidents, when such information is available; (3) make recommendations to prevent future medication-related deaths, medication-related incidents, and abuse and set forth the department's plan for implementing the recommendations; (4) recommend changes to statutes and regulations to decrease medication-related deaths and medication-related incidents; and (5) provide data on medication-related deaths and medication-related incidents and concerns regarding opioid-assisted treatment programs.
Funding source	Not addressed in statute
Recently proposed legislation	None

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PENNSYLVANIA (2022 law)	
Statute(s) and/or regulation(s)	71 PA. STAT. AND CONS. STAT. ANN. §§ 557 to 557.7 (West 2025)
Effective date	December 5, 2022
Drugs or substances of focus	Not specified
Operational level	Local/county level. In counties where there is a local health department, the local health department shall be the lead organization to oversee and coordinate the death review team in a form and manner as prescribed by the department of health for the commonwealth. In counties choosing to establish a death review team, if there is not a local health department, an organization interested in being selected as the lead organization shall submit an application, in a form and manner as prescribed by the department of health, for review and approval.
Team members	Members of the overdose death review team shall be selected from any of the following categories: (1) a coroner or medical examiner, (2) a pathologist, (3) a psychologist, (4) a psychiatrist, (5) a local behavioral health representative, (6) an individual who is a member of the education community with experience regarding existing and potential overdose prevention efforts for students in primary and secondary schools, (7) an individual who is a member of the law enforcement community with experience regarding existing and potential overdose prevention efforts for individuals who are involved with the law enforcement system, (8) a representative of an organization that advocates for individuals with behavioral health issues and their family members, (9) a representative of an organization that advocates for individuals with SUDs and their family members, (10) a representative from a single county authority, (11) the county health officer or the officer's designee, (12) the director of the local office responsible for human services or the director's designee, and (13) the local district attorney or the district attorney's designee. In addition to the members selected above, the lead organization may select additional members for a death review team as deemed necessary by the lead organization to administer the death review team's duties, including individuals with experience and knowledge in the following areas: (1) physical health services, (2) social services, (3) law enforcement, (4) education, (5) emergency medicine, (6) behavioral health services, (7) juvenile delinquency, (8) adult or juvenile probation, and (9) drug and alcohol SUDs.
Duties, tasks, and objectives	Upon receipt of a report of an overdose death, a death review team may perform the following: (1) inquire into cause of death upon receipt of a report of a qualifying death; (2) conduct a multidisciplinary review of

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PENNSYLVANIA (2022 law)	
Duties, tasks, and objectives (continued)	available information collected regarding a deceased individual; (3) establish policies and procedures for collecting and reviewing available information and records regarding the deceased individual from state, county, and local agencies, law enforcement, and private entities; (4) identify points of contact between the deceased individual and health care systems, social services systems, criminal justice systems, and other systems involved with the deceased individual; (5) identify the risk factors that put individuals at risk for an overdose or suicide within the death review team's jurisdiction; (6) promote cooperation and coordination across state, county, and local agencies involved in overdose or suicide investigations; (7) recommend improvements in sources of information relating to investigating reported overdose or suicide deaths, including standards for the uniform and consistent reporting of overdose or suicide deaths by law enforcement or other emergency service responders within the death review team's jurisdiction; and (8) recommend improvements to state laws and local partnerships, policies, and practices to prevent overdose and suicide deaths. The department of health is given the following duties under the law: (1) provide technical assistance; (2) facilitate communication between death review teams; (3) transmit certain available information to the appropriate death review team regarding a fatal suicide or overdose in the death review team's jurisdiction; (4) promulgate regulations as necessary to implement the law; and (5) submit an annual report to the governor and the general assembly by September of each year that includes a summary of reports received from local death review teams and recommendations relating to the reduction of risk of death by suicide and overdose.
Access to information	To the extent permitted by federal law, a death review team may access records as follows: • If deemed necessary for its review, the death review team may petition the court for leave to review and inspect all files and records of the court relating to a deceased individual in accordance with 42 PA. STAT. AND CONS. STAT. ANN. § 6307 (West 2025) (relating to inspection of court files and records). • Individuals or entities that provide SUD treatment services shall provide to an overdose death review team the records of a deceased individual under review without need for authorization of any person, including the executor, administrator, or personal representative of the deceased individual, for purposes of review. • The death review team may review and inspect mental health care service files and records of a deceased individual under review

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PENNSYLVANIA (2022 law)	
Access to information (continued)	without the need for authorization of any person, including the executor, administrator or personal representative of the deceased individual, for purposes of review. Health care facilities and health care providers, pharmacies, and mental health care providers shall provide medical records of a deceased individual under review without the need for authorization of any person, including the executor, administrator or personal representative of the deceased individual, for purposes of review. • Other records pertaining to the deceased under review shall be open to inspection as permitted by law. Notwithstanding any other provision of law, the following shall be provided to a death review team upon written request of the lead organization or chairperson of a death review team: • Records regarding the treatment for SUD, maintained by a federally assisted SUD treatment provider, for a deceased individual under review by a death review team, as permitted to be shared in accordance with federal law, including 42 CFR Part 2. • Records regarding the physical health and mental health—maintained by a health care provider, hospital, or health system—for a deceased individual under review by a death review team. • Records maintained by a state or local government agency or entity, including death investigative information, medical examiner investigative information, law enforcement investigative information, EMS reports, fire department records, prosecutorial records, parole and probation information and records, court records, school records and information and records of a social services agency, including the department of human services, if the agency or entity previously provided services to the deceased individual under review by a death review team. The following shall comply with a records request by a death review team: (1) a coroner or medical examiner; (2) a fire department; (3) a health system; (4) a hospital; (5) a law enforcement agency; (6) a state or local government agency, including the department of health, the department of human services, and the department of corrections; (7) a mental health provider; (8) a health care provider; (9) an SUD treatment provider; (10) a school; (11) an EMS provider; (12) a social services provider; (13) a prescription drug monitoring program representative; and (14) any other person or entity that is in possession of records pertinent to the death review team's investigation of an overdose death.

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PENNSYLVANIA (2022 law)	
Confidentiality	A death review team meeting shall be closed to the public, and information discussed at the meeting shall be confidential. The proceedings, records, and information maintained by and shared with a death review team may not be (1) disclosed under the commonwealth's Right-to-Know Law or (2) subject to discovery, subpoena, or introduction into evidence in a criminal or civil proceeding. Information presented in, or opinions formed as a result of, a meeting of a death review team may not be subject to subpoena or discovery or admissible as evidence in a civil or criminal action. An individual who is not a member of a death review team may, in good faith, provide information to a death review team. A member of a death review team or an individual who, in good faith, provides information to a death review team may not be disciplined, criminally prosecuted, or held administratively or civilly liable for complying with the provisions of this statute.
Reporting requirement	A death review team shall prepare and submit to the department of health an annual report. The team shall publish the annual report on the local department of health's or local government's publicly accessible internet website for the purpose of evaluations, policy considerations, and health care program enhancements. The annual report must comply with all confidentiality requirements and should include all of the following information: (1) a summary of the aggregated, non-individually identifiable findings of the death review team for the previous year; (2) recommendations to improve systems of care and community resources to reduce suicides or fatal overdoses in the death review team's jurisdiction; (3) proposed solutions for inadequacies in the systems of care; (4) recommendations to improve sources of information regarding the investigation of reported suicides and overdose deaths, including standards for the uniform and consistent reporting of suicides and fatal overdoses by law enforcement or other emergency service responders within the death review team's jurisdiction; and (5) recommendations for improvements to state laws and local partnerships, policies, and practices to prevent suicide and overdose fatalities.
Funding source	Not addressed by statute
Recently proposed legislation	None

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RHODE ISLAND	
Statute(s) and/or regulation(s)	23 R.I. GEN. LAWS ANN. § 23-4-3(11) (West 2025)
Effective date	June 28, 2018
Drugs or substances of focus	Not specified
Operational level	State level
Team members	Rhode Island's multidisciplinary team (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) a 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; and (14) others as may be determined by the Director of the Department of Health.
Duties, tasks, and objectives	The Team's goal is to reduce 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 reports 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	State statute does not address details about what records and information the Team can request or access.
Confidentiality	The Team's work product is confidential and protected under all applicable laws, including the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Rhode Island confidentiality of health care information act. The information provided to the Team is exempt from subpoena, discovery, or introduction into evidence in any civil or criminal proceeding, and not subject to disclosure beyond the team members. The team is allowed to gather information from consenting relatives regarding the circumstances of the decedent's death as long as the information gathered remains confidential and is only publicly released as aggregate de-identified information. The information gathered shall not be subject to subpoena, discovery, or introduction into evidence in

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RHODE ISLAND	
Confidentiality (continued)	any civil or criminal proceeding and shall not be subject to disclosure beyond the team members, except to authorized employees of the department of health as necessary to perform its official duties.
Reporting requirement	The team is required to submit a report on or before December 1 of each year to the governor, the speaker of the house of representatives, and the president of the senate. The report should summarize the activities of the team as well as the team's findings, progress toward reaching its goals, and recommendations for any needed changes in legislation or otherwise.
Funding source	Not addressed in statute
Recently proposed legislation	None

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SOUTH CAROLINA	
Statute(s) and/or regulation(s)	None
Effective date	N/A
Drugs or substances of focus	N/A
Operational level	N/A
Team members	N/A
Duties, tasks, and objectives	N/A
Access to information	N/A
Confidentiality	N/A
Reporting requirement	N/A
Funding source	N/A
Recently proposed legislation	None

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SOUTH DAKOTA	
Statute(s) and/or regulation(s)	None
Effective date	N/A
Drugs or substances of focus	N/A
Operational level	N/A
Team members	N/A
Duties, tasks, and objectives	N/A
Access to information	N/A
Confidentiality	N/A
Reporting requirement	N/A
Funding source	N/A
Recently proposed legislation	None

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TENNESSEE	
Statute(s) and/or regulation(s)	None
Effective date	N/A
Drugs or substances of focus	N/A
Operational level	N/A
Team members	N/A
Duties, tasks, and objectives	N/A
Access to information	N/A
Confidentiality	N/A
Reporting requirement	N/A
Funding source	N/A
Recently proposed legislation	None

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TEXAS	
Statute(s) and/or regulation(s)	None
Effective date	N/A
Drugs or substances of focus	N/A
Operational level	N/A
Team members	N/A
Duties, tasks, and objectives	N/A
Access to information	N/A
Confidentiality	N/A
Reporting requirement	N/A
Funding source	N/A
Recently proposed legislation	None

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UTAH	
Statute(s) and/or regulation(s)	On May 1, 2025, Utah repealed its Opioid and Overdose Fatality Review Committee.
Effective date	N/A
Drugs or substances of focus	N/A
Operational level	N/A
Team members	N/A
Duties, tasks, and objectives	N/A
Access to information	N/A
Confidentiality	N/A
Reporting requirement	N/A
Funding source	N/A
Recently proposed legislation	None

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VERMONT	
Statute(s) and/or regulation(s)	None
Effective date	N/A
Drugs or substances of focus	N/A
Operational level	N/A
Team members	N/A
Duties, tasks, and objectives	N/A
Access to information	N/A
Confidentiality	N/A
Reporting requirement	N/A
Funding source	N/A
Recently proposed legislation	None

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VIRGINIA	
Statute(s) and/or regulation(s)	VA CODE ANN. § 32.1-283.7 (West 2025)
Effective date	July 1, 2018
Drugs or substances of focus	Not specified
Operational level	Local/county level
Team members	Any county or city may establish a local or regional overdose fatality review team. The local 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 teams review the death of any person who lives in the Commonwealth and whose death was or is suspected to be due to overdose. Additionally, the teams promote cooperation and coordination among agencies involved in investigations of overdose deaths or providing services to surviving family members. Moreover, the teams recommend changes within the agencies represented on the local team and advise state agencies on changes to law, policy, or practice to prevent overdose deaths.
Access to information	State statute does not detail what records and information a team can request or access.

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VIRGINIA	
Confidentiality	All information and records obtained or created regarding a review of a fatality shall be confidential and shall be excluded from the Virginia Freedom of Information Act. All such information and records shall be used by a team only in the course of its proper purpose and function and shall not be disclosed. Such information and records shall not be subject to subpoena, subpoena duces tecum, discovery, or introduction into evidence when obtained through such other sources solely because the information and records were presented to the team during the fatality review. No person who participated in the review and no member of the team shall be required to make any statement as to what transpired during the review or what information was collected during the review. Upon the conclusion of the fatality review, all information and records concerning the victim and family shall be returned to the originating agency or destroyed. The portions of meetings in which individual cases are discussed by the team shall be closed to the public. All team members, persons attending closed team meetings, and persons presenting information and records on specific fatalities to the team during closed meetings shall execute a sworn statement to honor the confidentiality of the information, records, discussions, and opinions disclosed during any closed meeting to review a specific death. A violation of these provisions is punishable as a Class 3 misdemeanor.
Reporting requirement	None
Funding source	Not addressed in statute
Recently proposed legislation	None

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WASHINGTON	
Statute(s) and/or regulation(s)	WASH. REV. CODE ANN. § 70.05.210 (West 2025)
Effective date	June 9, 2022
Drugs or substances of focus	Not specified
Operational level	Local/county level
Team members	Not specified in statute
Duties, tasks, and objectives	A multidisciplinary overdose, withdrawal, and suicide fatality review team is tasked with reviewing overdose, withdrawal, and suicide deaths and developing strategies for the prevention of overdose, withdrawal, and suicide fatalities. The review process may include (1) a systematic review of medical, clinical, and hospital records related to the overdose, withdrawal, and suicide; (2) confidential interviews conducted; and (3) analysis of individual case information and review of this information by a team of professionals to identify modifiable medical, socioeconomic, public health, behavioral, administrative, educational, and environmental factors associated with each death.
Access to information	A review team has the authority to request and receive (1) all medical records related to the overdose, withdrawal, and suicide; (2) autopsy reports; (3) medical examiner reports; (4) coroner reports; (5) school records; (6) criminal justice records; (7) law enforcement records; and (8) social service records. Upon request by the local health department, (1) health care providers; (2) health care facilities; (3) clinics and schools; (4) the criminal justice department; (5) law enforcement; (6) laboratories; (7) medical examiners; (8) coroners; (9) professions and facilities licensed by the department of health; (10) local health jurisdictions; (11) the health care authority and its licensees and providers; (12) the department of health and its licensees; (13) the department of social and health services and its licensees and providers; and (14) the department of children, youth, and families and its licensees and providers must provide to the local health department all medical records related to the overdose, withdrawal, and suicide; autopsy reports; medical examiner reports; coroner reports; social services records; and other data requested for specific overdose, withdrawal, and suicide fatalities to perform an overdose, withdrawal, and suicide fatality review.
Confidentiality	All health information collected as part of an overdose, withdrawal, and suicide fatality review is confidential, subject to the restrictions on disclosure provided in WASH. REV. CODE ANN. § 70.02 (West 2025). Documents collected may be used solely by local health departments

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WASHINGTON	
Confidentiality (continued)	for the purposes of the review. Information, documents, proceedings, records, and opinions created, collected, or maintained by review teams or the local health department in support of the teams are confidential and are not subject to public inspection or copying nor discovery or introduction into evidence in civil or criminal actions. Any person who attended a meeting of the review team or who participated in the creation, collection, or maintenance of the review team's information, documents, proceedings, records, or opinions may not testify in any civil or criminal action as to the content of such proceedings or the review team's information, documents, records, or opinions. All meetings, proceedings, and deliberations of the review teams are confidential and may be conducted in executive session.
Reporting requirement	None
Funding source	Not addressed by statute
Recently proposed legislation	None

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WEST VIRGINIA	
Statute(s) and/or regulation(s)	On March 1, 2024, West Virginia repealed its Unintentional Pharmaceutical Drug Overdose Review Panel.
Effective date	N/A
Drugs or substances of focus	N/A
Operational level	N/A
Team members	N/A
Duties, tasks, and objectives	N/A
Access to Information	N/A
Confidentiality	N/A
Reporting requirement	N/A
Funding source	N/A
Recently proposed legislation	None

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WISCONSIN	
Statute(s) and/or regulation(s)	None
Effective date	N/A
Drugs or substances of focus	N/A
Operational level	N/A
Team members	N/A
Duties, tasks, and objectives	N/A
Access to information	N/A
Confidentiality	N/A
Reporting requirement	N/A
Funding source	N/A
Recently proposed legislation	Yes, see recently proposed legislation

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WYOMING	
Statute(s) and/or regulation(s)	None
Effective date	N/A
Drugs or substances of focus	N/A
Operational level	N/A
Team members	N/A
Duties, tasks, and objectives	N/A
Access to information	N/A
Confidentiality	N/A
Reporting requirement	N/A
Funding source	N/A
Recently proposed legislation	None

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AMERICAN SAMOA	
Statute(s) and/or regulation(s)	None
Effective date	N/A
Drugs or substances of focus	N/A
Operational level	N/A
Team members	N/A
Duties, tasks, and objectives	N/A
Access to information	N/A
Confidentiality	N/A
Reporting requirement	N/A
Funding source	N/A
Recently proposed legislation	None

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GUAM	
Statute(s) and/or regulation(s)	None
Effective date	N/A
Drugs or substances of focus	N/A
Operational level	N/A
Team members	N/A
Duties, tasks, and objectives	N/A
Access to information	N/A
Confidentiality	N/A
Reporting requirement	N/A
Funding source	N/A
Recently proposed legislation	None

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NORTHERN MARIANA ISLANDS	
Statute(s) and/or regulation(s)	None
Effective date	N/A
Drugs or substances of focus	N/A
Operational level	N/A
Team members	N/A
Duties, tasks, and objectives	N/A
Access to information	N/A
Confidentiality	N/A
Reporting requirement	N/A
Funding source	N/A
Recently proposed legislation	None

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PUERTO RICO	
Statute(s) and/or regulation(s)	None
Effective date	N/A
Drugs or substances of focus	N/A
Operational level	N/A
Team members	N/A
Duties, tasks, and objectives	N/A
Access to information	N/A
Confidentiality	N/A
Reporting requirement	N/A
Funding source	N/A
Recently proposed legislation	None

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U.S. VIRGIN ISLANDS	
Statute(s) and/or regulation(s)	None
Effective date	N/A
Drugs or substances of focus	N/A
Operational level	N/A
Team members	N/A
Duties, tasks, and objectives	N/A
Access to information	N/A
Confidentiality	N/A
Reporting requirement	N/A
Funding source	N/A
Recently proposed legislation	None

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RECENTLY PROPOSED LEGISLATION	
New York S. 976, 2025-2026 Leg., Reg. Sess. (N.Y. 2025)	This bill would authorize an accidental fatality review team to be established at a local or regional level, with the approval of the New York Department of Health, for the purpose of investigating the unexpected or unexplained death of any person, including, but not limited to, deaths suspected to be caused by overdose or suicide.
Wisconsin A.B. 192/S.B. 192, 2025-2026 Leg., Reg. Sess. (Wis. 2025)	This bill would establish fatality review teams under state law. The bill contains general provisions governing any type of fatality review team. The bill identifies examples of the types of deaths that may constitute a reviewable death, including overdose, suicide, maternal death occurring during or within a year of a pregnancy, or any unexpected or unintentional death of a child, among others.

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ABOUT THE LEGISLATIVE ANALYSIS AND PUBLIC POLICY ASSOCIATION

The Legislative Analysis and Public Policy Association (LAPPA) 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 cutting edge model laws and up-to-the-minute comparative analyses, publications, educational brochures, and other tools that can be used by national, state, and local criminal justice and substance use disorder practitioners who want the latest comprehensive information on law and policy. Examples of topics on which LAPPA has assisted stakeholders include naloxone laws, treatment in emergency settings, alternatives to incarceration for those with substance use disorders, medication for addiction treatment in correctional settings, and syringe services programs.

For more information about LAPPA, please visit: https://legislativeanalysis.org/.


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