



OVERDOSE REVIEW PANELS
Issue Brief

Fatal Overdose Review Panels: Overview of Laws in Six States

Introduction

The overdose crisis continues unabated. While the epidemic was originally fueled largely by prescription opioid pain relievers, around 2010 a dramatic increase in heroin-related overdoses began.¹ After remaining essentially stable for years, overdose deaths involving heroin spiked rapidly, more than tripling between 2010 and 2014.² Starting in 2014, the epidemic began another transformation. Black market drug products—both heroin and counterfeit pills - became increasingly adulterated with illicitly—manufactured synthetic opioids, mainly fentanyl analogues. In the span of a single year, from 2014 to 2015, deaths attributed to fentanyl and related drugs spiked by over 70%.³

Because the contours of the epidemic are shifting so rapidly, it is vital that governments, clinicians, and the public have access to timely, comprehensive data regarding overdose decedents. Unfortunately, such data are rarely available in a timely manner. Medical examiner or coroner data are often incomplete and, in many states, not available for months after the date of death.⁴ In part to address this problem, a handful of states have established bodies that specifically review overdose deaths to provide additional data regarding overdose decedents and, typically, make recommendations for policy improvements. This report briefly explains and contrasts the specifics of panels in the six states that have established such panels as of late 2017.

Arizona

The Arizona legislature created a drug overdose fatality review team in August 2017. The team is administratively housed in the Department of Health Services and is composed of the head of each of the following entities: the Attorney General; the Department of Health Services; the Arizona Health Care Cost Containment System; the Department of Economic Security; the Governor's Office of Youth,



Faith and Family; the Administrative Office of the Courts; the State Department of Corrections; the State Council of Human Services Providers; and the Department of Public Safety.⁵ Additionally, the Director of the Department of Health Services is responsible for appointing a medical examiner who is a rural forensic pathologist; a medical examiner who is a metropolitan forensic pathologist; a representative of a tribal government; a public member; a representative of a professional emergency management system association; a health care professional from a statewide association representing nurses; a health care professional from a statewide association representing physicians; a representative of an association of county health officers; a representative of an association representing hospitals; a health care professional who specializes in the prevention, diagnosis and treatment of substance use disorders; and a county sheriff, or designee, who represents a county with a population of less than five hundred thousand persons and a county sheriff, or designee, who represents a county with a population of more than five thousand persons.⁶ The team designates a member to serve as the chairperson.⁷ All members serve without compensation.

Arizona statute requires the review team to: develop a drug overdose fatalities data collection system; conduct an annual analysis on the incidence and causes of drug overdose fatalities during the preceding fiscal year; encourage and assist in the development of local drug overdose fatality review teams; develop standards and protocols for local drug overdose fatality review teams and provide training and technical assistance to these teams; develop protocols for drug overdose investigations, including protocols for law enforcement agencies, prosecutors, medical examiners, health care facilities and social services agencies; study the adequacy of statutes, ordinances, rules, training and services to determine what changes are needed to decrease the incidence of preventable drug overdose fatalities and take steps to implement these changes; and educate the public regarding the incidence and causes of drug overdose fatalities as well as the public's role in preventing these deaths.⁸

The team Chairperson may request information and records from a provider of medical, dental or mental health care as well as the State of Arizona or a political subdivision that might assist the team in reviewing the fatality.⁹ These records "shall be provided" within five business days.¹⁰ The statewide team and local teams may contact, interview, or obtain information by request or subpoena from a family member of an overdose decedent.¹¹ All information and records acquired by the teams are confidential and are not subject to subpoena, discovery or introduction into evidence in any civil or criminal proceeding.¹²

Delaware

Delaware passed legislation creating a statewide Drug Overdose Fatality Review Commission in April 2016.¹³ By statute, The Commission is composed of the state Attorney General, the Secretary of the Department of Health and Human Services, the Director of the Delaware Division of Forensic Science, the Secretary of Safety and Homeland Security, the Director of the Division of Public Health, the Commissioner of the Delaware Department of Corrections, and eight members appointed by the Governor.¹⁴ The members serve without compensation, and the Commission is staffed by the Department of Justice. The legislation requires the Commission to create three regional review teams,



each of which is authorized to review “overdose deaths involving opiates, fentanyl and/or heroin.” The legislation creating this Commission appears to be modeled after that creating state commissions on child deaths and deaths of domestic violence victims.

The Commission is charged with investigating and reviewing all relevant overdose deaths and making recommendations to the Governor and the legislature “regarding those practices or conditions which impact the frequency of overdose deaths involving opiates, fentanyl or heroin, and steps that can be taken to reduce the frequency of such overdose deaths.” The statute does not specify how the review process will operate, but does provide that meetings are not open to the public and all records are confidential and cannot be released via subpoena or discovery. The Commission and regional review teams are given the authority to administer oaths and to compel the attendance of witnesses and the production of records related to a death under review, with the caveat that where a criminal investigation is underway the Commission must wait until its conclusion before questioning, deposing, or interviewing any potential witness to the criminal prosecution. All members are provided criminal and civil immunity for good faith acts made while in the service of the Commission. As of March 2017, the Commission had yet to investigate a case.

Maryland

The Maryland legislature passed a law in 2014 that allows, but does not require, Maryland counties to establish Local Overdose Fatality Review Teams (LOFRT).¹⁵ These teams are modeled after existing statewide mortality review programs, the Maryland Child Fatality Review Team (CFR) and the Maryland Fetal and Infant Mortality Review (FIMR).¹⁶ They may serve a single county, but counties are also permitted to enter into agreements with other counties to create multicounty teams. There are currently 19 operational teams across the state, and over 200 deaths have been reviewed. The state does not provide funding or other direct support to these teams.

State law requires that the teams include the following members: the county health officer (or a designee); the director of the local department of social services (or a designee); the state's attorney (or a designee); the superintendent of schools (or a designee); a state, county, or municipal law enforcement officer; the county director of behavioral health services; an emergency medical services provider in the county; a representative of a hospital; a SUD healthcare professional; a representative of a local jail or detention center; a representative from parole, probation and community corrections; the Secretary of Juvenile Services (or a designee); a member of the public with interest or expertise in prevention and treatment of overdose deaths; and any other individual necessary for the work of the local team, recommended by the local team and appointed by the county health officer.¹⁷ Local teams elect a chair from among their members.

The teams are tasked with promoting cooperation and coordination across agencies involved in overdose investigations; developing an understanding of the causes and incidence of drug overdose deaths in the county; developing plans and recommending changes within the agencies on the local team; and providing recommendations to the state Department of Hygiene and Mental Health (DHMH)



on how to address the epidemic, which may include changes to law or regulations. Each team is required to meet at least quarterly, although in practice most teams meet more often. According to DHMH, the teams are designed not so much to find additional information about previous deaths, but to prevent future ones.¹⁸

The legislation provides the teams with a great deal of authority to access otherwise confidential information. The statute requires that, on the request of the chair of a local team, the team is to be “immediately provided with” all relevant medical records regarding an individual whose death is being investigated and of an individual convicted of a crime that caused a death or near fatality so long as those records are “necessary to carry out its official functions.”¹⁹ Similarly, the statute requires that the team be provided, on the same terms, “access to information and records” maintained by state or local agencies, including but not limited to death certificates, law enforcement investigative information, medical examiner information, probation and parole records, and social services information.²⁰ Government records concerning the family of a decedent or person convicted of a crime are also available to the team. All identifying records developed or requested by the team are confidential, and members cannot be compelled to testify regarding information presented in or opinions formed as a result of team meetings.

The Office of the Chief Medical Examiner provides data on each overdose decedent in each team’s jurisdiction on a quarterly basis. This includes information on the decedent and the incident, the medical examiner’s investigative notes, and toxicology results. The teams also have access to records from the prescription drug monitoring program and health information system, in addition to all records and information that can be obtained from local sources, as outlined above.

New Hampshire

In October 2016, New Hampshire Governor Margaret Wood Hassan issued an executive order establishing a state Drug Overdose Fatality Review Committee.²¹ This Committee is comprised of: the Attorney General, or designee; Chief Medical Examiner or designee; the Commissioner of the Department of Health and Human Services or designee; Representatives from the Department of Safety’s Forensic Laboratory, Bureau of Emergency Medical Services, and Information and Analysis Center, Drug Monitoring Initiative, appointed by the Commissioner of the Department of Safety; the Chair of the Governor’s Commission on Alcohol and Drug Abuse, Prevention, Treatment, and Recovery, or designee; a representative of the New Hampshire Association of Chiefs of Police; a representative of the New Hampshire Hospital Association; a representative of the Drug Enforcement Administration; and the Governor’s Advisor on Addiction and Behavioral Health.²² Additionally, the Governor will appoint the following members of the Committee: a representative of the recovery community, a representative of the treatment community; a representative of the prevention community; and a representative from an organization that advocates on substance use issues.²³ The Attorney General, or designee, shall serve as chair.²⁴

The Drug Overdose Fatality Review Committee’s objectives include: to describe trends and patterns of overdose-related fatalities and recommend the efficient use of state resources to combat overdose



deaths based on that data; to identify high-risk factors, current practices, and gaps in systemic responses; to recommend policies, practices, and services that will encourage collaboration and reduce fatalities due to overdoses; to improve the sources of data collection by developing a system to share information between agencies and offices that work with individuals struggling with addiction; and to educate the public, policy makers, and funders about overdose-related fatalities and about strategies for intervention and effective prevention, treatment, and recovery.²⁵

The Drug Overdose Fatality Review Committee “should receive access to existing records on overdose-related fatalities that will advance the goals of the Committee and are legally accessible.”²⁶ The Committee is required to report twice annually to the Governor, the President of the Senate, and the Speaker of the New Hampshire House.²⁷

Pennsylvania

In Pennsylvania, the Methadone Death and Incident Review Act created a statewide team tasked with the investigation of methadone-related deaths and incidents “for the purpose of promoting safety, reducing methadone-related deaths and methadone-related incidents and improving treatment practices.”²⁸ The team is staffed by the Department of Drug and Alcohol Programs (DDAP), which prepares information on suspected cases and provides it to the team. To create case reports, DDAP staff review information such as coroner’s reports, law enforcement records, medical records, court records, and treatment records. In general, suspected cases are originally identified by coroners which are required by the law to forward information on suspected methadone deaths to DDAP, and treatment programs.

The team is composed of the Secretary of DDAP (or a designee); the Director of the Bureau of Drug and Alcohol Programs; and the following individuals, appointed by the Secretary of DDAP: a representative from narcotic treatment programs, a representative from a licensed drug and alcohol addiction treatment program that is not defined as a narcotic treatment program, a representative from law enforcement, a representative from the medical community, a district attorney, a coroner or medical examiner, a member of the public, and a patient or family advocate. The Secretary of DDAP serves as the chairperson of the team.

In 2015, the latest year for which data are available, the Team met seven times and reviewed 59 cases, 56 of which were fatalities. On average, it takes the Team two years to review each case, meaning that some of the cases reviewed in 2015 occurred in previous years. At each meeting, the Team makes determinations about each case and, when appropriate, makes recommendations regarding steps that can be taken to prevent or reduce the likelihood of similar incidents in the future. As with other similar teams, all such meetings are closed to the public and all information presented at the meetings is confidential. The Team also prepares an annual report that is shared on the Department of Drug and Alcohol Program’s website and distributed to legislative officials.²⁹



West Virginia

West Virginia's Fatality and Mortality Review Team was created by the state legislature in 2013.³⁰ The Team is charged with overseeing and coordinating the examination, review, and assessment of, among other things, deaths due to "unintentional prescription or pharmaceutical drug overdoses" in the state (the Team also has authority over other deaths, including those of minors and pregnant women). The review team is required to establish an advisory panel within the team that focuses solely on overdose deaths.

The Team is comprised of the Chief Medical Examiner (or a designee); the Commissioner of the Bureau for Public Health (or a designee); the Superintendent of the State Police (or a designee); and a prosecuting attorney appointed by the Governor. The statute requires county and local government agencies to provide any information requested by the team or panel related to overdose deaths. As with other such committees and teams, all proceedings, records, and opinions are confidential and not subject to discovery or introduction into evidence in any civil or criminal proceeding.

The Commissioner of the Bureau of Public Health is required to propose rules for legislative approval. Many of the particulars of the operation of the Teams were set forth in these rules.³¹ The promulgated rule created the Unintentional Pharmaceutical Drug Overdose Review Panel (UPDORP) within the Fatality and Mortality Review Team.³² The panel's members are: the Chief Medical Examiner (or a designee), who serves as chairperson; the Director of the State Board of Pharmacy (or a designee); the Commissioner of the Bureau for Public Health (or a designee); the Director of the Division of Vital Statistics (or a designee); the Superintendent the State Police (or a designee); a representative who is a physician nominated by the State Medical Association; a representative who is a registered nurse nominated by the State Nurses Association; a representative who is a doctor of osteopathy nominated by the State Osteopathy Association; a licensed physician or doctor of osteopathy who practices pain management; a representative who is a doctor of pharmacy with background in prescription drug abuse and diversion; a representative of the U.S. Drug Enforcement Administration; a representative who is a prosecuting attorney; a person considered an expert in bio-ethics training; a representative who is a licensed counselor selected by the West Virginia Association of Alcoholism and Drug Abuse Counselors; a representative who is a licensed dentist recommended by the Board of Dental Examiners; and any additional person that the chairperson determines is needed in the review and consideration of a particular case.

The UPDORP is charged with reviewing and analyzing all deaths occurring in West Virginia where the cause of death was due to an unintentional pharmaceutical drug overdose. The panel must document the trends, patterns, and risk factors related to unintentional drug overdose fatalities as well as patterns related to the sale and distribution of prescribed drugs by those licensed to provide these prescriptions. Finally, the Panel is responsible for providing statistical information and analysis regarding the causes of unintentional pharmaceutical drug overdose fatalities. To carry out its responsibilities, the Panel has access to medical, dental, and mental health records; substance abuse records; and any other



information maintained by any state, county, or local government agency. The rules also require state, county, and local agencies to provide the Panel with any information requested.

Conclusion

As the causes and intensity of the overdose crisis continue to shift, timely, in-depth information regarding overdose decedents becomes increasingly useful to guiding public health response. At least six states have created specific teams or panels to review overdose-related deaths. While the specifics vary between states, all are multidisciplinary teams tasked with attempting to find causal factors and take steps to reduce overdose fatalities. The trend appears to be towards more comprehensive bodies focused on overdose broadly, as opposed to bodies only focused on a specific drug (methadone in Pennsylvania) or bodies tasked with investigating many causes of death (as in West Virginia). While there are no peer-reviewed studies of these initiatives, they may present a promising avenue for providing additional data and actionable recommendations to reducing the burden of overdose in the United States.

SUPPORTERS

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- ¹ R. A. Rudd, et al., *Increases in heroin overdose deaths - 28 States, 2010 to 2012*, 63 MMWR MORB MORTAL WKLY REP (2014).
- ² R. A. Rudd, et al., *Increases in Drug and Opioid Overdose Deaths--United States, 2000-2014*, 64 MMWR MORB MORTAL WKLY REP (2016).
- ³ R. A. Rudd, et al., *Increases in Drug and Opioid-Involved Overdose Deaths - United States, 2010-2015*, 65 MMWR MORB MORTAL WKLY REP (2016).
- ⁴ See, e.g., Chase Karacostas, *Scale of opioid epidemic in Texas likely obscured by bad data, experts say*, The Daily Texan, (Nov. 17, 2017, 10:04 AM), <http://www.dailytexanonline.com/2017/11/17/scale-of-opioid-epidemic-in-texas-likely-obscured-by-bad-data-experts-say>.
- ⁵ Ariz. Rev. Stat. Ann. § 36-198(A) (2017).
- ⁶ Ariz. Rev. Stat. Ann. § 36-198(B) (2017).
- ⁷ Ariz. Rev. Stat. Ann. § 36-198(C)(8) (2017).
- ⁸ Ariz. Rev. Stat. Ann. § 36-198(C) (2017).
- ⁹ Ariz. Rev. Stat. Ann. § 36-198.01(A) (2017).
- ¹⁰ A law enforcement agency, with the approval of the prosecuting attorney, may withhold investigative records that might interfere with a pending criminal investigation or prosecution. Ariz. Rev. Stat. Ann. § 36-198.01(B).
- ¹¹ Ariz. Rev. Stat. Ann. § 36-198.01(F) (2017).
- ¹² Ariz. Rev. Stat. Ann. § 36-198.01(D) (2017).
- ¹³ Del. Code tit. 16, § 4799A-4799D.
- ¹⁴ The breakdown of the additional eight members is as follows: two representatives of the Medical Society of Delaware; one representative of the Delaware Nurses Association; one representative of the Police Chiefs Council of Delaware who is an active law-enforcement officer; one representative of the Delaware Fraternal Order of Police who is an active law-enforcement officer; two advocates from statewide nonprofit organizations; and one representative of the Delaware Healthcare Association.
- ¹⁵ The relevant legislation, Chapter 650 of 2014, is codified in several places in the state code. An earlier version of the law required the establishment of county teams, but the legislation as passed simply permits their creation. Md. Code Ann., Health-Gen § 5-901 et. seq.
- ¹⁶ The Department of Hygiene and Mental Health has created an informative PowerPoint presentation regarding the teams, which is available at <https://phpa.health.maryland.gov/mch/Documents/FIMR%20Slides%20Training%20Preparing%20Cases%20for%20Review%20DHMH%20Credited.pdf>.
- ¹⁷ Md. Code Ann., Health-Gen § 5-902.
- ¹⁸ *Welcome to the Overdose Fatality Review Program (OFR)*, Maryland Department of Health Behavioral Health Administration, https://bha.health.maryland.gov/OVERDOSE_PREVENTION/Pages/OFR-.aspx (last visited Jan. 25, 2018).
- ¹⁹ Md. Code Ann., Health-Gen § 5-904.
- ²⁰ *Id.*
- ²¹ N.H. Exec. Order No. 2016-05 (Oct. 12, 2016), <http://sos.nh.gov/ExecOrdersHassan.aspx>.
- ²² *Id.*
- ²³ *Id.*
- ²⁴ *Id.*
- ²⁵ *Id.*
- ²⁶ *Id.* It does not appear that the Commission has subpoena authority.
- ²⁷ *Id.*
- ²⁸ The Act is codified at 71 P.S. § 1691.1 et seq. Methadone deaths are defined as “a death where methadone was a primary or secondary cause of death or may have been a contributing factor”. A methadone-related incident is defined “as a situation where methadone may be a contributing factor which does not involve a fatality and involves a serious injury or unreasonable risk of death or serious injury”.
- ²⁹ The most recent report appears to be from 2015. It is available at <http://www.ddap.pa.gov/Reports/MDAIR%20Annual%20Reports/2015%20MDAIR%20Annual%20Report.pdf>.
- ³⁰ W. Va. Code § 61-12A-1 et seq.
- ³¹ W. Va. Code R. § 64-29-1 et seq.
- ³² W. Va. Code R. § 64-29-7.