OPIOID FATALITY REVIEW AMENDMENTS

2019 GENERAL SESSION

STATE OF UTAH

LONG TITLE

General Description:

This bill creates a new position in the Office of the Medical Examiner and creates the Opioid and Overdose Fatality Review Committee.

Highlighted Provisions:

This bill:

- creates the position of an opioid fatality examiner within the Office of the Medical Examiner;
- creates the Opioid and Overdose Fatality Review Committee within the Department of Health; and
- makes technical and conforming changes.

Money Appropriated in this Bill:

None

Other Special Clauses:

None

Utah Code Sections Affected:

ENACTS:

26-4-30, Utah Code Annotated 1953

26-7-10, Utah Code Annotated 1953

Be it enacted by the Legislature of the state of Utah:

Section 1. Section **26-4-30** is enacted to read:

26-4-30. Opioid fatality examiner.

(1) With funds appropriated by the Legislature for this purpose, the department shall provide compensation, at a standard rate determined by the department, to an opioid fatality examiner.

(2) The opioid fatality examiner shall:

(a) work with the medical examiner to compile data regarding opioid related deaths,

including:

(i) toxicology information;

(ii) demographics; and

(iii) source of opioids;

(b) as relatives of the deceased are willing, gather information from relatives of the deceased regarding the circumstances of the decedent's death;

(c) maintain a database of information described in Subsections (2)(a) and (b);

(d) coordinate no less than monthly with the suicide prevention coordinator described in Subsection 62A-15-1101(2); and

(e) coordinate no less than quarterly with the Opioid Fatality Review Committee described in Section 26-7-10.

Section 2. Section **26-7-10** is enacted to read:

26-7-10. Opioid and Overdose Fatality Review Committee.

(1) As used in this section:

(a) "Committee" means the Opioid and Overdose Fatality Review Committee created in this section.

(b) "Opioid overdose death" means a death primarily caused by opioids or another substance that closely resembles opioids.

(2) The department shall establish the Opioid and Overdose Fatality Review Committee.

(3) The executive director of the department shall appoint a committee coordinator.

(4) The committee shall consist of:

(a) the attorney general, or the attorney general's designee;

(b) a state, county, or municipal law enforcement officer;

(c) the manager of the department's Violence Injury Program, or the manager's designee;

(d) an emergency medical services provider;

(e) a representative from the Office of the Medical Examiner;

(f) a representative from the Division of Substance Abuse and Mental Health;

(g) a representative from the Office of Vital Records;

(h) a representative from the Office of Health Care Statistics;

(i) a representative from the Division of Occupational and Professional Licensing;

(j) a healthcare professional who specializes in the prevention, diagnosis, and treatment of substance use disorder;

(k) a representative from a state or local jail or detention center;

(l) a representative from the Department of Corrections;

(m) a representative from Juvenile Justice Services; and

(n) any other individual whom the committee determines is necessary to fulfill the committee's responsibilities under Subsection (7).

(5) The department shall give the committee access to all reports, records, and other documents, including protected health information, that are relevant to the committee's responsibilities under Subsection (7).

(6) The committee coordinator may request records that are relevant to the committee's responsibilities under Subsection (7) through Title 63G, Chapter 2, Government Records Access and Management Act, and by subpoena.

(7) The committee shall:

(a) conduct a multidisciplinary review of available information regarding a decedent of an opioid overdose death, which review shall include:

(i) consideration of the decedent's points of contact with healthcare, social services, criminal justice and other systems; and

(ii) identification of specific factors that put the individual at risk for opioid overdose;

(b) promote cooperation and coordination among government entities involved in opioid misuse, abuse, or overdose prevention;

(c) develop an understanding of the causes and incidence of opioid overdose deaths in the state;

(d) make recommendations for changes to law or policy that may prevent opioid overdose deaths;

(e) inform public health and public safety entities of emerging trends in opioid overdose deaths;

(f) monitor overdose trends on non-opioid overdose deaths; and

(g) review non-opioid overdose deaths in the manner described in Subsections (7)(a) through (7)(e), when the committee determines that there are a substantial number of overdose

deaths in Utah caused by the use of a non-opioid.

(8) A committee may interview a staff member, a provider, or any other person who may have knowledge or expertise that is relevant to the review of an opioid overdose death.

(9) A majority vote of committee members present constitutes the action of the committee.

(10) Each committee member and each individual granted access to a committee proceeding shall sign a confidentiality agreement, created by the department, indicating that the individual agrees to:

(a) keep confidential all information relating to the review of an opioid overdose death; and

(b) not release any information relating to the review of an opioid overdose death, unless required or permitted by law to release the information.

(11) The committee shall meet at least eight times each year.

(12) Committee meetings are closed to the public.

(13) The committee shall record minutes of committee meetings.