COMMITTEE SUBSTITUTE

FOR

Senate Bill No. 283

(By Senators Laird, Miller, Stollings, Unger, Jenkins, Foster, Plymale, Klempa, Yost and Kessler (Acting President))

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[Originating in the Committee on Health and Human Resources; reported February 18, 2011.]

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A BILL to amend the Code of West Virginia, 1931, as amended, by adding thereto a new article, designated §61-12A-1, §61-12A-2, §61-12A-3 and §61-12A-4, all relating to the creation of the Unintentional Pharmaceutical Drug Overdose Fatality Review Team; setting forth membership of the team; setting forth responsibilities of the team; requiring the examination and the provision of preventative education in cases that involve unintentional pharmaceutical drug overdose deaths; providing for an annual report; setting forth record-keeping requirements; requiring other state agencies to cooperate with the team; and granting rule-making authority.

Be it enacted by the Legislature of West Virginia:

That the Code of West Virginia, 1931, as amended, be amended by adding thereto a new article, designated §61-12A-1, §61-12A-2, §61-12A-3 and §61-12A-4, all to read as follows:

ARTICLE 12A. UNINTENTIONAL PHARMACEUTICAL DRUG OVERDOSE FATALITY REVIEW TEAM.

§61-12A-1. Legislative findings.

The Legislature finds:

(1) That pharmaceutical drug abuse and addiction has become an increasingly serious public health and law enforcement problem throughout the State of West Virginia, affecting the quality of life in the communities in which we live;

(2) That the increased and growing number of unintentional overdose deaths associated with the nonmedical use and diversion of pharmaceutical drugs, primarily opioid analgesics, is unacceptable and requires further public policy consideration and action;

(3) That problems related to pharmaceutical drug abuse and addiction, the nonmedical use and diversion of pharmaceutical drugs, and unintentional pharmaceutical drug overdose deaths are complex problems requiring multidisciplinary review, study and planning to assist in the identification and further development of public policies intended to address these problems in the future.

§**61-12A-2. Unintentional Pharmaceutical Drug Overdose Fatality Review Team.**

(a) The Unintentional Pharmaceutical Drug Overdose Fatality Review Team is hereby created under the office of the chief medical examiner. The Unintentional Pharmaceutical Drug Overdose Fatality Review Team is a multidisciplinary team created to examine, review and analyze the deaths of all persons in the State of West Virginia

who die as a result of unintentional prescription or pharmaceutical drug overdoses.

(b) The Unintentional Pharmaceutical Drug Overdose Fatality Review Team shall consist of the following members appointed by the Governor:

(1) The Chief Medical Examiner in the Bureau for Public Health, who is to serve as the chairperson and who is responsible for calling and coordinating all meetings;

(2) The Director of the West Virginia State Board of Pharmacy or his or her designee;

(3) The Commissioner of the Bureau for Public Health or his or her designee;

(4) The Director of the Division of Vital Statistics or his or her designee;

(5) The Superintendent of the West Virginia State Police or his or her designee;

(6) One representative who is a physician nominated by the West Virginia State Medical Association;

(7) One representative who is a registered nurse nominated by the West Virginia Nurses Association;

(8) One representative who is a doctor of osteopathy nominated by the West Virginia Society of Osteopathic Medicine;

(9) One representative who is a physician specializing in addiction medicine nominated by the West Virginia Society of Addiction Medicine;

(10) One representative who is a Doctor of Pharmacy, with a

background in prescription drug abuse and diversion nominated by West Virginia Pharmacists Association;

(11) One representative who is a licensed counselor nominated by the West Virginia Association of Alcoholism and Drug Abuse Counselors;

(12) One representative of the United States Drug Enforcement Administration;

(13) One licensed physician or doctor of osteopathy who practices pain management as a principal part of his or her practice;

(14) A person who shall be considered an expert in bio-ethics training; and

(15) Any additional persons that the chairperson of the team determines is needed in the review and consideration of a particular case.

(c) Each member of the Unintentional Pharmaceutical Drug Overdose Fatality Review Team shall serve for a term of three years, unless otherwise reappointed to a second or subsequent term. Members shall continue to serve until their respective terms expire or until their successors have been appointed.

(d) Each appointment of a physician, whether for a full term or to fill a vacancy, is to be made by the Governor from among three nominees selected by the West Virginia State Medical Association. Each appointment of a registered nurse, whether for a full term or to fill a vacancy, is to be made by the Governor from among three nominees selected by the West Virginia Nurses

Association. Each appointment of a doctor of osteopathy, whether for a full term or to fill a vacancy, is to be made by the Governor from among three nominees selected by the West Virginia Society of Osteopathic Medicine. With respect to all other appointments not specified herein, the Governor may make the appointments without nomination.

(e) Each member of the Unintentional Pharmaceutical Drug Overdose Fatality Review Team shall serve without additional compensation and may not be reimbursed for any expenses incurred in the discharge of his or her duties under the provisions of this article.

§**61-12A-3. Responsibilities of the Unintentional Pharmaceutical Drug Overdose Fatality Review Team.**

(a) The Office of the Chief Medical Examiner, in consultation with the Unintentional Pharmaceutical Drug Overdose Fatality Review Team shall promulgate legislative rules pursuant to article three, chapter twenty-nine-a of this code. Those rules shall include, at a minimum:

(1) The standard procedures for the conduct of the Unintentional Pharmaceutical Drug Overdose Fatality Review Team; and

(2) The processes and protocols for the review and analysis of unintentional pharmaceutical drug overdoses resulting in fatalities of those who were not suffering from mortal diseases shortly before death.

(b) The Unintentional Pharmaceutical Drug Overdose Fatality Review Team shall:

(1) Review and analyze all deaths occurring within the State of West Virginia where the cause of death was determined to be due to unintentional pharmaceutical drug overdose, specifically excluding the death of persons suffering from a mortal disease or instances where the manner of the overdose death was suicide;

(2) Ascertain and document the trends, patterns and risk factors related to unintentional pharmaceutical drug overdose fatalities occurring within the State of West Virginia;

(3) Ascertain and document patterns related to the sale and distribution of pharmaceutical prescriptions by those otherwise licensed to provide said prescriptions, including the application of information included within the database kept and maintained by the West Virginia Board of Pharmacy;

(4) Develop and implement standards for the uniform and consistent reporting of unintentional pharmaceutical drug overdose deaths by law enforcement or other emergency service responders;

(5) Provide statistical information and analysis regarding the causes of unintentional pharmaceutical drug overdose fatalities; and

(6) Promote public awareness of the incidence and causes of unintentional pharmaceutical drug overdose fatalities, including recommendations for their reduction.

(c) The Unintentional Pharmaceutical Drug Overdose Fatality Review Team shall submit an annual report to the Governor and to

the Legislative Oversight Commission on Health and Human Resources Accountability concerning its activities within the state. The report is due annually on December 1. The report is to include statistical information concerning cases reviewed during the year, trends and patterns concerning these cases, and the team's recommendations to reduce the number of unintentional pharmaceutical drug overdose fatalities in the state.

(d) The Unintentional Pharmaceutical Drug Overdose Fatality Review Team, in the exercise of its duties as defined in this section, may not:

(1) Call witnesses or take testimony from individuals involved in the investigation of a pharmaceutical drug overdose fatality;

(2) Contact a family member of the deceased;

(3) Enforce any public health standard or criminal law or otherwise participate in any legal proceeding; or

(4) Otherwise take any action which in the determination of a prosecuting attorney or his or her assistants, impairs the ability of the prosecuting attorney, his or her assistants or any law-enforcement officer to perform his or her statutory duties.

(e) Proceedings, records and opinions of the Unintentional Pharmaceutical Drug Overdose Fatality Review Team are confidential and are not subject to discovery, subpoena or introduction into evidence in any civil or criminal proceeding. Nothing in this subsection is to be construed to limit or restrict the right to discover or use in any civil or criminal proceeding anything that is available from another source and entirely independent of the

proceedings of the Unintentional Pharmaceutical Drug Overdose Fatality Review Team.

(f) Members of the Unintentional Pharmaceutical Drug Overdose Fatality Review Team 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. This subsection may not be construed to prevent a member of the Unintentional Pharmaceutical Drug Overdose Fatality Review Team from testifying to information obtained independently of the team or which is public information.

§61-12A-4. Other agencies of government required to cooperate.

State, county and local agencies, hospitals and other health agencies shall provide the Unintentional Pharmaceutical Drug Overdose Fatality Review Team with any information requested in writing by the team as allowable by law and upon receipt of a certified copy of the circuit court's order directing said agencies to release information in its possession relating to the deceased. The team shall assure that all information received and developed in connection with this article remain confidential.

This article is new; therefore, strike-throughs and underscoring have been omitted.