SENATE COMMITTEE ON PUBLIC SAFETY

Senator Aisha Wahab, Chair
2023 - 2024 Regular

Bill No:	AB 2871	**Hearing Date:**	June 18, 2024
Author:	Maienschein		
Version:	April 24, 2024		
Urgency:	No	**Fiscal:**	Yes
Consultant:	JD		

Subject: ***Overdose fatality review teams***

HISTORY

Source: San Diego County

Prior Legislation: AB 271 (Quirk-Silva) Chapter 135, Statutes of 2023.
SB 863 (Min) Chapter 986, Statutes of 2022.
AB 2654 (Lackey, 2021) held in Assembly Appropriations.
AB 2660 (Maienschein, 2021) vetoed by Governor.

Support: California State Association of Counties; City and County of San Francisco; County Behavioral Health Directors Association of California; County Health Executives Association of California (CHEAC); County of Riverside; San Diego County District Attorney's Office; Urban Counties of California (UCC)

Opposition: None known

Assembly Floor Vote: 71 - 0

PURPOSE

The purpose of this bill is to allow counties to establish an interagency overdose fatality review team to assist local agencies in identifying and reviewing overdose fatalities, facilitate communication, and integrate local prevention efforts.

Existing law defines "state summary criminal history information" as the master record of information complied by the Attorney General regarding the identification and criminal history of a person (Penal Code §11105).

Existing law defines "criminal offender record information" as records and data compiled by criminal justice agencies for purposes of identifying criminal offenders and of maintaining summaries of arrests, criminal proceedings and its results, and incarceration (Penal Code §11075).

Existing law defines "local summary criminal history information" as the master record of information compiled by any local criminal justice agency pertaining to the identification and criminal history of any person (Penal Code §13300).

Existing law requires probation officers to report and record antecedents, character, history, family environment, and offense of any person receiving a guilty verdict, this record shall be kept as a record of the court and can be accessed by specified an appointed or designated person or profession (Penal Code §1203.10).

Existing law provides, pursuant to the California Constitution, that all people have inalienable rights, including the right to pursue and obtain privacy. (Cal. Const., art. I, § 1.)

Existing law states that the "right to privacy is a personal and fundamental right protected by Section 1 of Article I of the Constitution of California and by the United States Constitution and that all individuals have a right of privacy in information pertaining to them." Further states these findings of the Legislature:

- The right to privacy is being threatened by the indiscriminate collection, maintenance, and dissemination of personal information and the lack of effective laws and legal remedies.

- The increasing use of computers and other sophisticated information technology has greatly magnified the potential risk to individual privacy that can occur from the maintenance of personal information.

- In order to protect the privacy of individuals, it is necessary that the maintenance and dissemination of personal information be subject to strict limits. (Civil Code §1798.1.)

Existing law establishes under federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which sets standards for the privacy of individually identifiable health information and security standards for the protection of electronic protected health information, including, through regulations, that a HIPAA-covered entity may not condition the provision of treatment, payment, enrollment in a health plan, or eligibility for benefits on the provision of an authorization, except under specified circumstances. Provides that if HIPAA's provisions conflict with state law, the provision that is most protective of patient privacy prevails. (42 U.S.C. § 1320d, et seq.; 45 Code Fed. Regs. Part 164.)

Existing law prohibits, under the state Confidentiality of Medical Information Act (CMIA), a health care provider, a health care service plan, a contractor, a corporation and its subsidiaries and affiliates, or any business that offers software or hardware to consumers, including a mobile application or other related device, as defined, from intentionally sharing, selling, using for marketing, or otherwise using any medical information, as defined, for any purpose not necessary to provide health care services to a patient, except as expressly authorized by the patient, enrollee, or subscriber, as specified, or as otherwise required or authorized by law. States that a violation of these provisions that results in economic loss or personal injury to a patient is a crime. (Civil Code §56, et. seq.)

Existing law defines, for purposes of the CMIA, medical information to mean any individually identifiable information, in electronic or physical form, in possession of or derived from a provider of health care, health care service plan, pharmaceutical company, or contractor regarding a patient's medical history, mental health app information, mental or physical condition, or treatment. (Civil Code §56.05 (i).)

Existing law prohibits health care providers, health care service plans, or contractors, as defined, from sharing medical information without the patient's written authorization, subject to certain exceptions. (Civil Code §56.10 (a).)

Existing law permits a county to establish an interagency domestic violence death review team to assist local agencies in identifying and reviewing domestic violence deaths and near deaths, including homicides and suicides, and facilitating communication among the various agencies involved in domestic violence cases (Penal Code §11163.3).

Existing law permits a county to establish a homeless death review committee to assist local agencies in identifying the root causes of death of homeless individuals and facilitating communication among persons who perform autopsies and the various persons and agencies involved in supporting the homeless population (Penal Code §11163.72).

Existing law permits a county to establish an interagency child death review team to assist local agencies in identifying and reviewing suspicious child deaths and facilitating communication among persons who perform autopsies and the various persons and agencies involved in child abuse or neglect cases (Penal Code §11174.32).

Existing law permits a county to establish an interagency elder and dependent adult death review team to assist local agencies in identifying and reviewing suspicious elder and dependent adult deaths and facilitating communication among persons who perform autopsies and the various persons and agencies involved in elder and dependent adult abuse or neglect cases (Penal Code §11174.5).

Existing law requires a coroner to inquire into and determine the circumstances, manner, and cause of all violent, sudden, or unusual deaths; unattended deaths; deaths due to drug addiction; deaths in prison or while under sentence; among various other circumstances (Government Code §27491).

Existing law requires coroners to inquire into and determine the circumstances, manner, and cause of various types of deaths, including, but not limited to those that appear to be violent, sudden, or unusual deaths; unattended deaths; and drug addiction (Government Code §27491).

Existing law requires the coroner in all cases in which a person has died under circumstances that afford a reasonable ground to suspect that the person's death has been occasioned by the act of another by criminal means, the coroner, upon determining that those reasonable grounds exist, shall immediately notify the law enforcement agency having jurisdiction over the criminal investigation (Government Code §27491.1).

Existing law allows coroners or their appointed deputy to make inquiries into the circumstances, manner, and means of death (Government Code §27491.2).

This bill authorizes a county to establish an interagency overdose fatality review team to assist local agencies in identifying and reviewing overdose fatalities, facilitate communication among persons and agencies involved in overdose fatalities, and integrate local overdose prevention efforts through strategic planning, data dissemination, and community collaboration.

This bill authorizes a county to develop standardized protocols for postmortem examinations involving an overdose to assist coroners and other persons who perform postmortem

examinations in determining whether drugs contributed to a death or were the actual cause of death.

This bill permits an overdose fatality review team to be comprised of, but not limited to, the following:

- Experts in the field of forensic pathology;
- Medical personnel with expertise in overdose fatalities;
- Coroners and medical examiners;
- District attorneys and city attorneys;
- County or local staff, including, but not limited to, all of the following:
    - Behavioral health services staff;
    - County counsel;
    - Emergency medical services staff;
    - Unhoused services staff;
    - Medical care services staff;
    - Medical examiner staff; and,
    - Public health staff.
- County, state, local, and federal law enforcement personnel;
- Local drug trafficking experts;
- Public health or behavioral health experts;
- Drug treatment providers;
- Representatives of local health plans, nonprofits, religious, or other organizations who work with individuals at high risk of overdose fatalities; and,
- Local professional associations of persons described in this subdivision.

This bill requires an oral or written communication or a document shared within or produced by an overdose fatality review team to be confidential.

This bill requires 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, to be confidential.

This bill permits recommendations of an overdose fatality review team, upon the completion of a review, to be disclosed at the discretion of a majority of the members of the overdose fatality review team.

COMMENTS

1. Need for This Bill:

According to the Author:

> Confronting California's overdose epidemic will take collaboration across all sectors. By providing the specific statutory authorization needed to create Overdose Fatality Review Teams, this proposal would allow counties to look system-wide at individual deaths to find opportunities to increase safety and health in the future. This statutory authorization would increase the likelihood of implementation of opioid fatality reviews by counties. The bill would require all confidential information shared among members of the review team to remain confidential. Other death review teams for children, domestic violence, and elder abuse have yielded tremendous results with opportunities for improvement identified and acted on at both the system-wide and individual levels. Being able to implement drug fatality review teams would allow counties to maximize insights on how they can address the drug and opioid crisis locally for a growing crisis throughout the state.

2. California's Overdose Epidemic

California is facing an overdose epidemic. According to a California Health Care Foundation report, 9% of Californians have met the criteria for a Substance Use Disorder (SUD) within the last year. While the health care system is moving toward acknowledging SUDs as a chronic illness, only about 10% of people with an SUD within the last year received treatment. Overdose deaths from both opioids and psychostimulants (such as amphetamines), are soaring. This issue, compounded by the increased availability of fentanyl, has resulted in a ten-fold increase in fentanyl related deaths between 2015 and 2019. DPH's Opioid Overdose Dashboard reported 7,385 deaths related to "any" opioid overdose in 2022, with 6,473 (87.7%) of those deaths fentanyl related.

3. County Postmortem Examinations

Post mortem examinations are conducted by a County's coroner's office in California. Specific county processes may differ but California law outlines circumstances that may trigger a coroner to conduct a postmortem evaluation to determine the cause and matter of a death. And if the cause and manner of death is determined to be a result of illegal activity, the coroner must report that information to the County Sherriff's Department for further investigation and handling.

4. Existing Death Review Teams

Los Angeles County established the nation's first Child Death Review Team (CDRT) in 1978. A major role of CDRTs is to function as a case-investigating agency, providing in-depth analysis by many agencies on the possible causes of infant deaths in specific cases. California's CDRTs also assist in identifying agency and systems problems and developing recommendations to prevent future child deaths. According to the National Center for Fatality Review and

Prevention, CDRTs have influenced state and local policy changes on issues ranging from child homicide sentencing, safely surrendered babies, children left alone in cars, child maltreatment reporting, data collection, and more.

Building on the success of CDRTs, in 1995 the California Legislature authorized counties to establish interagency Domestic Violence Death Review Teams to ensure that incidents of domestic violence and abuse are recognized and to develop recommendations for policies and protocols for community prevention and intervention initiatives. In 2001, the Legislature authorized counties to establish interagency elder death teams to examine deaths associated with suspected elder abuse and neglect, identify, and work towards the implementation of prevention strategies to protect our elder population. In 2010 the statute was expanded to allow the review teams to also assist in dependent adult death reviews. Most recently, in 2023 the Legislature authorized counties to establish homeless death review committees to identify the root causes of the deaths of unhoused individuals and facilitate communication among persons and agencies involved in supporting the unhoused population. This bill builds upon these models to authorize overdose fatality review teams.

5. Argument in Support

According to San Diego County:

> California's drug fatality crisis is well-documented. The most recent available data indicates that over 11,000 Californians died from drug overdoses in 2022, more than double the number from 2018. Two-thirds of those deaths are from opioids and 60 percent are from fentanyl alone.
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> Addressing California's drug fatality crisis will require a system-wide effort from local health, social service, and public safety agencies, nonprofits, community groups, and others who have expertise or work with people who are most at risk. While overdose fatality reviews can currently be conducted to a limited degree, the ability to share information about individuals, much of which is confidential by law, is limited. Other death review teams for children, domestic violence, and elder abuse have yielded tremendous results with opportunities for improvement identified and acted on at both the system-wide and individual levels. Being able to implement drug fatality review teams would allow counties to maximize insights on how they can address the drug and opioid crisis locally.
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> For counties interested in doing so, AB 2871 would provide the specific statutory authorization needed to create Overdose Fatality Review Teams. It would detail and protect processes and allow for greater sharing of confidential medical and other information needed to further identify issues and gaps in addressing the overdose fatality crisis. Finally, AB 2871 would require all confidential information shared among members of the review team to remain confidential.
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> The language in this legislation is based on the existing frameworks in law for child, domestic violence, and elder abuse fatality review teams, as well as the homeless adult and family multidisciplinary personnel teams, which allow the sharing within the review team of confidential information.

If signed into law, AB 2871 would unlock the ability for counties and other agencies to better work together to prevent and address future occurrences, as well as to improve coordination and effectiveness of interventions.

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