By Senator DiCeglie

18-00921C-26 20261752__

A bill to be entitled

An act relating to suicide and drug overdose prevention; creating ss. 394.47893 and 394.47894, F.S.; providing legislative intent and purpose; creating the Drug Overdose Death Review Committee and the Suicide Death Review Committee, respectively, within the Department of Health for specified purposes; requiring local public health departments to establish local review committees for a specified purpose; providing for membership of the committees and duties of the Drug Overdose Death Review Committee and the Suicide Death Review Committee, respectively; authorizing external stakeholders to review specified information; providing for stakeholder participation; requiring the Drug Overdose Death Review Committee and the Suicide Death Review Committee, respectively, to annually submit a report to the Department of Health and the Statewide Drug Policy Advisory Council by a specified date; providing requirements for the report; authorizing the chair of the committees to access certain records; authorizing the committees to access certain records and information; authorizing providers to charge a specified fee for records; providing requirements for and prohibitions on the use of such records and information; authorizing the chair of the Drug Overdose Death Review Committee and the Suicide Death Review Committee, respectively, to issue subpoenas for records; providing construction; providing that persons who attend a committee meeting

or otherwise participate in committee activities may not be required to testify in any proceeding as to any records or information related to such meetings or activities; providing certain entities and persons immunity from liability for participating in or furnishing records or information to a committee; providing applicability; authorizing the Department of Health, or any political subdivision of the state operating a local review committee, to administer certain funds for the operation of the committees, apply for grants and accept donations, and, to the extent funds are available, hire staff or consultants and reimburse reasonable expenses; authorizing the State Surgeon General or a county or city administrator to substitute certain existing entities for purposes of carrying out the responsibilities of the committees; requiring each regional managing director of the Department of Children and Families to appoint a local review committee representative; providing requirements for the representative; requiring the Department of Health to adopt rules; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 394.47893, Florida Statutes, is created to read:

394.47893 Drug overdose review; Drug Overdose Death Review Committee; local review committees.—

(1) LEGISLATIVE INTENT; PURPOSE.—It is the intent of the Legislature to establish multidisciplinary, multiagency, epidemiological drug overdose death review committees. The local committees shall review the facts and circumstances of drug-related deaths that occur within each committee jurisdiction. The local review committees shall work cooperatively. The primary function of the local review committees is to conduct individual case reviews of drug overdose deaths; identify factors contributing to those deaths; make recommendations for system, policy, and practice improvements at the local and state level; promote interagency collaboration and data sharing consistent with federal and state confidentiality protections; and inform prevention initiatives through accurate, timely, and comprehensive data. The purpose of the local review committees is to:

(a) Achieve a greater understanding of the causes and contributing factors of deaths resulting from drug overdose.

(b) Whenever possible, develop a communitywide approach to address the causes and contributing factors.

(c) Identify any gaps, deficiencies, or problems in the delivery of services to individuals by public and private agencies which may be related to deaths that are the result of drug overdose.

(d) Recommend changes in law, rules, and policies at the state and local levels, as well as develop practice standards that support the safe and healthy stabilization of individuals and reduce preventable deaths.

(e) Following internal review of identified cases, engage community stakeholders as part of a deidentified review of case

findings from the review group for broader insights about gaps, deficiencies, or observed themes that identify problems or prevention practices.

(f) Implement such recommendations, to the extent possible.

(2) DRUG OVERDOSE DEATH REVIEW COMMITTEE.—The Drug Overdose Death Review Committee is established within the Department of Health to review deaths resulting from drug overdose. Local public health departments shall establish local review committees, which shall provide review results to the Drug Overdose Death Review Committee.

(a) *Membership*.—

1.a. The Drug Overdose Death Review Committee shall, at a minimum, include representatives appointed by the State Surgeon General from all of the following:

(I) The Department of Health.

(II) County and city health and human services departments or divisions.

(III) The medical examiner's office.

(IV) Local managing entities that are contracted by the Department of Children and Families.

(V) Emergency medical services.

(VI) Next of kin of persons whose deaths resulted from drug overdose.

b. The members of the Drug Overdose Death Review Committee shall be appointed to staggered terms not to exceed 2 years each, as determined by the State Surgeon General. Members may be appointed to no more than three consecutive terms. The Drug Overdose Death Review Committee shall elect a chair from among its members to serve for a 2-year term, and the chair may

appoint ad hoc committees as necessary to carry out the duties of the committee.

2.a. Local committees may include representatives appointed by county health department directors, to the extent available, from:

(I) The Agency for Health Care Administration.

(II) County and city health and human services departments or divisions.

(III) Hospitals and health systems.

(IV) Behavioral health service providers and recovery organizations.

(V) Judges and public defenders from the judicial circuit.

(VI) Poison control centers.

b. The members of a local committee shall be appointed to 2-year terms and may be reappointed. The local review committee shall elect a chair from among its members to serve for a 2-year term. Members shall serve without compensation but may receive reimbursement for per diem and travel expenses incurred in the performance of their duties as provided in s. 112.061 and to the extent that funds are available.

(b) *Duties.*—The Drug Overdose Death Review Committee shall:

1. Develop standardized protocols and data collection instruments for use by the local review committees.

2. Review selected cases for drug overdose death review.

3. Maintain a protected database of reviewed fatalities to safeguard disclosure of private and protected health information and to inventory the cases reviewed. The chair and vice chair of the review committee shall have access to this protected database. The protected database shall be created by the

Department of Health.

4. Study the adequacy of laws, rules, training, and services to determine what changes are needed to decrease the incidence of drug overdose deaths and develop strategies and recruit partners to implement these changes.

5. Promote continuing education for professionals who review, treat, and prevent deaths related to drug overdose.

6. Recommend, when appropriate, a review of the death certificate of any individual who died as a result of drug overdose.

7. Assist the Department of Health in collecting data on deaths that are the result of drug overdose.

8. Submit written reports as requested by the Department of Children and Families. The reports must include:

a. Nonidentifying information from individual cases.

b. Identification of any problems with the data system uncovered during the review process and the committee's recommendations for system improvements and needed resources, training, and information dissemination, where gaps or deficiencies may exist.

c. All steps taken by the local review committees and private and public agencies to implement necessary changes and improve the coordination of services and reviews.

9. Submit all records requested by the Department of Children and Families at the conclusion of the review of a death resulting from drug overdose.

(3) LOCAL STAKEHOLDER ENGAGEMENT.—Following internal review by the Drug Overdose Death Review Committee, external stakeholders may review nonidentifiable case findings to

generate broader insights into the findings of cases reviewed, to supplement identification of themes and problems, and to develop prevention recommendations. Stakeholder participants shall include representatives, to the extent available, from:

(a) The state attorney's office.

(b) Community-based service agencies.

(c) Persons with lived experience in recovery or loss survivors.

(d) Law enforcement agencies.

(e) Middle schools and high schools.

(f) Physicians.

(g) Social workers.

(4) ANNUAL STATISTICAL REPORT.—The Drug Overdose Death Review Committee shall prepare and submit a comprehensive statistical report by December 1, 2027, and annually thereafter, to the Department of Health and the Statewide Drug Policy Advisory Council which includes data, trends, analysis, findings, and recommendations for state and local action regarding reviewed deaths from drug overdose. The data must be presented on an individual calendar year basis and in the context of a multiyear trend. At a minimum, the report must include all of the following:

(a) Descriptive statistics, including demographic information, regarding victims and the causes and nature of deaths.

(b) A detailed statistical analysis of the incidence and causes of deaths.

(c) Specific issues identified within current policy, procedure, rule, or statute and recommendations to address those

issues from both the state and local committees.

(d) Other recommendations to prevent drug overdose deaths based on an analysis of the data presented in the report.

(5) ACCESS TO AND USE OF RECORDS AND INFORMATION.—

(a) Notwithstanding any other law, the chair of the Drug Overdose Death Review Committee, or the chair of a local review committee, may access any information or records that pertain to an individual whose death is being reviewed by the committee and are necessary for the committee to carry out its duties, including information or records that pertain to a child's family and all of the following:

1. Patient records in the possession of a public or private provider of medical care, dental care, substance use treatment, or mental health care, including, but not limited to, a facility licensed under this chapter, chapter 393, or chapter 395, or a health care practitioner as defined in s. 456.001. Providers may charge a fee for copies not to exceed 50 cents per page for paper records and $1 per fiche for microfiche records.

2. Information or records of any state or local agency or political subdivision which may assist a committee in reviewing a death, including, but not limited to, information or records of the Department of Children and Families, the Department of Health, the Department of Education, the Department of Juvenile Justice, the Agency for Health Care Administration, or any health facility licensed by this state.

(b) The Drug Overdose Death Review Committee or a local review committee may access all information of a medical examiner or law enforcement agency which is not the subject of an active investigation and which pertains to the review of a

death. A committee may not disclose any information that is not subject to public disclosure by the law enforcement agency, and active criminal intelligence information or criminal investigative information, as defined in s. 119.011(3), may not be made available for review or access under this section. The committee may not disclose any information or records that contain personally identifiable information of a decedent or family member; health, treatment, or social service records; law enforcement or medical examiner records related to the decedent; or information that would identify a provider involved in the care of the decedent.

(c) Local review committees may share with each other any relevant information that pertains to the review of the drug overdose death.

(d) A member of the Drug Overdose Death Review Committee or a local review committee may contact, interview, or obtain information by request from a member of a decedent's family as part of a committee's next of kin interview process to inform the review of a death. A member of the decedent's family may voluntarily provide records or information to the Drug Overdose Death Review Committee or a local review committee.

(e) The chair of the Drug Overdose Death Review Committee may require the production of records by requesting a subpoena, through the Department of Legal Affairs, in any county of the state. Such subpoena is effective throughout the state and may be served by any sheriff. Failure to obey the subpoena is punishable as provided by general law.

(f) This subsection does not authorize the members of any committee to have access to any grand jury proceedings.

(g) A person who has attended a meeting of a committee or who has otherwise participated in activities authorized by this section may not be authorized or required to testify in any civil, criminal, or administrative proceeding as to any records or information produced or presented to a committee during meetings or other activities authorized by this section. However, this paragraph does not prevent any person who presents information to the committee or who is a member of the committee from testifying as to matters otherwise within his or her knowledge. An organization, institution, committee member, or other person who participates or furnishes information, data, reports, or records to a committee is not liable for damages to any person and is not subject to any other civil, criminal, or administrative recourse. This paragraph does not apply to any person who admits to committing a crime.

(6) DEPARTMENT OF HEALTH RESPONSIBILITIES.—

(a) The Department of Health, or any political subdivision of the state operating a local review committee, may administer the funds appropriated to operate the review committees and may apply for grants and accept donations.

(b) To the extent that funds are available, the Department of Health, or any political subdivision of the state, may hire staff or consultants to assist a review committee in performing its duties. Funds may also be used to reimburse reasonable expenses of the staff and consultants for the committees.

(c) For the purpose of carrying out the responsibilities assigned to the Drug Overdose Death Review Committee and local review committees, the State Surgeon General or a county or city administrator may substitute an existing entity whose function

and organization includes the function and organization of the committees established under this section.

(7) DEPARTMENT OF CHILDREN AND FAMILIES RESPONSIBILITIES.—Each regional managing director of the Department of Children and Families must appoint a local review representative for the region. The representative must have knowledge and expertise in the area of drug overdose. The representative's general responsibilities include:

(a) Coordinating with the local review committee.

(b) Participating in the implementation of the drug overdose death review process and all regional activities related to the review of drug overdose deaths.

(c) Working with the Drug Overdose Death Review Committee and the contracted managing entity to ensure that the reviews are thorough and that all issues are appropriately addressed.

(d) Ensuring that all critical issues identified by the local review committee are brought to the attention of the regional managing director and the Secretary of Children and Families.

(e) Providing technical assistance to the Drug Overdose Death Review Committee during the review of any drug overdose death.

(8) RULEMAKING.—The Department of Health shall adopt rules necessary to implement this section.

Section 2. Section 394.47894, Florida Statutes, is created to read:

394.47894 Suicide review; Suicide Death Review Committee; local review committees.—

(1) LEGISLATIVE INTENT; PURPOSE.—It is the intent of the

Legislature to establish multidisciplinary, multiagency, epidemiological suicide death review committees. The local committees shall review the facts and circumstances of suicide deaths that occur within each committee jurisdiction. The local review committees shall work cooperatively. The primary function of the local review committees is to conduct individual case reviews of suicide deaths; identify factors contributing to those deaths; make recommendations for system, policy, and practice improvements at the local and state level; promote interagency collaboration and data sharing consistent with federal and state confidentiality protections; and inform prevention initiatives through accurate, timely, and comprehensive data. The purpose of the local review committees is to:

(a) Achieve a greater understanding of the causes and contributing factors of deaths resulting from suicide.

(b) Whenever possible, develop a communitywide approach to address the causes and contributing factors.

(c) Identify any gaps, deficiencies, or problems in the delivery of services to individuals by public and private agencies which may be related to deaths that are the result of suicide.

(d) Recommend changes in law, rules, and policies at the state and local levels, as well as develop practice standards that support the safe and healthy stabilization of individuals and reduce preventable deaths.

(e) Following internal review of identified cases, engage community stakeholders as part of a deidentified review of case findings from the review group for broader insights about gaps,

deficiencies, or observed themes that identify problems or prevention practices.

(f) Implement such recommendations, to the extent possible.

(2) SUICIDE DEATH REVIEW COMMITTEE.—The Suicide Death Review Committee is established within the Department of Health to review deaths resulting from suicide. Local public health departments shall establish local review committees, which shall provide review results to the Suicide Death Review Committee.

(a) *Membership.*—

1.a. The Suicide Death Review Committee shall, at a minimum, include representatives appointed by the State Surgeon General from all of the following:

(I) The Department of Health.

(II) County and city health and human services departments or divisions.

(III) The medical examiner's office.

(IV) Local managing entities that are contracted by the Department of Children and Families.

(V) Emergency medical services.

(VI) Next of kin of persons whose deaths resulted from suicide.

b. The members of the Suicide Death Review Committee shall be appointed to staggered terms not to exceed 2 years each, as determined by the State Surgeon General. Members may be appointed to no more than three consecutive terms. The Suicide Death Review Committee shall elect a chair from among its members to serve for a 2-year term, and the chair may appoint ad hoc committees as necessary to carry out the duties of the committee.

2.a. Local committees may include representatives appointed by county health department directors, to the extent available, from:

(I) The Agency for Health Care Administration.

(II) County and city health and human services departments or divisions.

(III) Hospitals and health systems.

(IV) Behavioral health service providers and recovery organizations.

(V) Judges and public defenders from the judicial circuit.

(VI) Poison control centers.

b. The members of a local committee shall be appointed to 2-year terms and may be reappointed. The local review committee shall elect a chair from among its members to serve for a 2-year term. Members shall serve without compensation but may receive reimbursement for per diem and travel expenses incurred in the performance of their duties as provided in s. 112.061 and to the extent that funds are available.

(b) *Duties.*—The Suicide Death Review Committee shall:

1. Develop standardized protocols and data collection instruments for use by the local review committees.

2. Review selected cases for review of deaths from suicide.

3. Maintain a protected database of reviewed fatalities to safeguard disclosure of private and protected health information and to inventory the cases reviewed. The chair and vice chair of the review committee shall have access to this protected database. The protected database shall be created by the Department of Health.

4. Study the adequacy of laws, rules, training, and

services to determine what changes are needed to decrease the incidence of suicides and develop strategies and recruit partners to implement these changes.

5. Promote continuing education for professionals who review, treat, and prevent deaths related to suicide.

6. Recommend, when appropriate, the review of the death certificate of any individual who died as a result of suicide.

7. Assist the Department of Health in collecting data on deaths that are the result of suicide.

8. Submit written reports as requested by the Department of Health. The reports must include:

a. Nonidentifying information from individual cases.

b. Identification of any problems with the data system uncovered during the review process and the committee's recommendations for system improvements and needed resources, training, and information dissemination, where gaps or deficiencies may exist.

c. All steps taken by the local review committees and private and public agencies to implement necessary changes and improve the coordination of services and reviews.

9. Submit all records requested by the Department of Health at the conclusion of the review of a death resulting from suicide.

(3) LOCAL STAKEHOLDER ENGAGEMENT.—Following internal review by the Suicide Death Review Committee, external stakeholders may review nonidentifiable case findings to generate broader insights into the findings of cases reviewed, to supplement identification of themes and problems, and to develop prevention recommendations. Stakeholder participants shall include

representatives, to the extent available, from:

(a) The state attorney's office.

(b) Community-based service agencies.

(c) Persons with lived experience in recovery or loss survivors.

(d) Law enforcement agencies.

(e) Middle schools and high schools.

(f) Physicians.

(g) Social workers.

(4) ANNUAL STATISTICAL REPORT.—The Suicide Death Review Committee shall prepare and submit a comprehensive statistical report by December 1, 2027, and annually thereafter, to the Department of Health and the Department of Children and Families and the Statewide Drug Policy Advisory Council which includes data, trends, analysis, findings, and recommendations for state and local action regarding reviewed deaths from suicide. The data must be presented on an individual calendar year basis and in the context of a multiyear trend. At a minimum, the report must include all of the following:

(a) Descriptive statistics, including demographic information, regarding victims and the causes and nature of deaths.

(b) A detailed statistical analysis of the incidence and causes of deaths.

(c) Specific issues identified within current policy, procedure, rule, or statute and recommendations to address those issues from both the state and local committees.

(d) Other recommendations to prevent suicides based on an analysis of the data presented in the report.

(5) ACCESS TO AND USE OF RECORDS AND INFORMATION.—

(a) Notwithstanding any other law, the chair of the Suicide Death Review Committee, or the chair of a local review committee, may access any information or records that pertain to an individual whose death is being reviewed by the committee and are necessary for the committee to carry out its duties, including information or records that pertain to a child's family and all of the following:

1. Patient records in the possession of a public or private provider of medical care, dental care, substance use treatment, or mental health care, including, but not limited to, a facility licensed under this chapter, chapter 393, or chapter 395, or a health care practitioner as defined in s. 456.001. Providers may charge a fee for copies not to exceed 50 cents per page for paper records and $1 per fiche for microfiche records.

2. Information or records of any state or local agency or political subdivision which may assist a committee in reviewing a death, including, but not limited to, information or records of the Department of Children and Families, the Department of Health, the Department of Education, the Department of Juvenile Justice, the Agency for Health Care Administration, or any health facility licensed by this state.

(b) The Suicide Death Review Committee or a local review committee may access all information of a medical examiner or law enforcement agency that is not the subject of an active investigation and that pertains to the review of a death. A committee may not disclose any information that is not subject to public disclosure by the law enforcement agency, and active criminal intelligence information or criminal investigative

information, as defined in s. 119.011(3), may not be made available for review or access under this section. The committee may not disclose any information or records that contain personally identifiable information of a decedent or family member; health, treatment, or social service records; law enforcement or medical examiner records related to the decedent; or information that would identify a provider involved in the care of the decedent.

(c) Local review committees may share with each other any relevant information that pertains to the review of the suicide.

(d) A member of the Suicide Death Review Committee or a local review committee may contact, interview, or obtain information by request from a member of a decedent's family as part of a committee's next of kin interview process to inform the review of a death. A member of the decedent's family may voluntarily provide records or information to the Suicide Death Review Committee or a local review committee.

(e) The chair of the Suicide Death Review Committee may require the production of records by requesting a subpoena, through the Department of Legal Affairs, in any county of the state. Such subpoena is effective throughout the state and may be served by any sheriff. Failure to obey the subpoena is punishable as provided by general law.

(f) This subsection does not authorize the members of any committee to have access to any grand jury proceedings.

(g) A person who has attended a meeting of a committee or who has otherwise participated in activities authorized by this section may not be authorized or required to testify in any civil, criminal, or administrative proceeding as to any records

or information produced or presented to a committee during meetings or other activities authorized by this section. However, this paragraph does not prevent any person who presents information to the committee or who is a member of the committee from testifying as to matters otherwise within his or her knowledge. An organization, institution, committee member, or other person who participates in or furnishes information, data, reports, or records to a committee is not liable for damages to any person and is not subject to any other civil, criminal, or administrative recourse. This paragraph does not apply to any person who admits to committing a crime.

(6) DEPARTMENT OF HEALTH RESPONSIBILITIES.—

(a) The Department of Health, or any political subdivision of the state operating a local review committee, may administer the funds appropriated to operate the review committees and may apply for grants and accept donations.

(b) To the extent that funds are available, the Department of Health or any political subdivision of the state, may hire staff or consultants to assist a review committee in performing its duties. Funds may also be used to reimburse reasonable expenses of the staff and consultants for the committees.

(c) For the purpose of carrying out the responsibilities assigned to the Suicide Death Review Committee and local review committees, the State Surgeon General or a county or city administrator may substitute an existing entity whose function and organization includes the function and organization of the committees established under this section.

(7) DEPARTMENT OF CHILDREN AND FAMILIES RESPONSIBILITIES.— Each regional managing director of the Department of Children

and Families shall appoint a local review representative for the region. The representative must have knowledge and expertise in the area of suicide. The representative's general responsibilities include:

(a) Coordinating with the local review committee.

(b) Participating in the implementation of the suicide death review process and all regional activities related to the review of deaths from suicide.

(c) Working with the Suicide Death Review Committee and the contracted managing entity to ensure that the reviews are thorough and that all issues are appropriately addressed.

(d) Ensuring that all critical issues identified by the local review committee are brought to the attention of the regional managing director and the Secretary of Children and Families.

(e) Providing technical assistance to the Suicide Death Review Committee during the review of any suicide death.

(8) RULEMAKING.—The Department of Health shall adopt rules necessary to implement this section.

Section 3. This act shall take effect July 1, 2026.