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IN-BRIEF

Medicolegal Death Investigation Partnerships on Overdose Fatality Reviews

"The importance of death investigation cannot be underestimated. Data collected during a death investigation provides more information than just cause and manner of death. It can shed light on what happened and why. The information we bring to OFRs is a critical piece of the puzzle for identifying innovative strategies that address fatal drug overdose."

—Megan Broekemeier, MPH, CHES
Opioid Fatality Research Coordinator
Office of the Medical Examiner,
Utah Department of Health

Introduction

Drug overdoses are a leading cause of death in the United States.[1] In fact, based on recently released provisional data from the Centers for Disease Control and Prevention (CDC), there were an estimated 100,306 drug overdose deaths in the United States from April 2020 to April 2021.[2] This was an increase of 28.5% from the same period the prior year.[2] To combat this epidemic and help prevent future overdoses, states, counties, and municipalities have formed multi-disciplinary teams to review overdose fatality cases. These teams serve to identify system gaps and create innovative community-specific overdose prevention and intervention strategies.[1]

The makeup of the teams vary based on jurisdiction but are typically made up of partnerships between health departments, law enforcement, social service providers, medical examiner and corner offices, and others. These groups are commonly referred to as Overdose Fatality Review (OFR) teams.

Objectives

- Provide an overview of OFR teams.
- Highlight six examples of OFRs with various geographic size, population counts, and MDI systems.
- Discuss the engagement of MDI systems with OFRs.
- Offer ideas or recommendations for improving or implementing OFRs.

	Medicolegal Death Investigation System	Legislation	Created	Approximate Cases Reviewed Per Year	Overdoses (confirmed 2020)
Winnebago County, WI	County-based Coroner's Office	None	2018	12 (one per month)	37
Milwaukee County, WI	County-based Medical Examiner's Office	None	2016	24 (two per month)	544
Rhode Island	Centralized State Medical Examiner System	Rhode Island General Laws 23-4-3	2016	32 (4-8 per quarter)	384
Delaware	Centralized State Medical Examiner System	Delaware Code Title 16, § 4799	2016	190 (7-8 per month)	450
Cuyahoga County, OH	County-based Medical Examiner's Office	None	2013	20 (1-2 per month)	549
Charleston County, SC	County-based Coroner's Office	None	2021	12 (one per month)	180

Exhibit 1. This figure displays facts regarding the six OFRs highlighted.[5-12,13]

OFR teams conduct detailed case reviews that examine a decedent's life from a holistic perspective and focus on information gleaned from the death scene, medical records, law enforcement reports, and use of social services, to name a few. Some OFR teams even contact next of kin or others who were close to the decedent for a more personal and comprehensive examination of the decedent's life. Reviewing these data helps inform the team of potential missed opportunities for intervention or prevention and allows them to develop recommendations to assist others in similar circumstances. The understanding that overdose deaths are preventable remains the guiding strategy behind the review process.[1]

OFR teams build on similar long-established case review models for child death and suicide. The basic structure includes a lead agency, which helps select cases for review, provides administrative support, and coordinates meetings as well as a team of community partner representatives. OFR teams can also include subcommittees tasked with dedicated focus areas. Some OFR teams are created based on legislation whereas others have been formed because of departmental regulations or requests. These laws or regulations are used to guide the composition of the team and to set parameters for release of records and other confidentiality concerns.

There are more than 2,000 medical examiner (ME) and coroner offices in the United States, and these offices performed over 600,000 medicolegal death investigations (MDIs) in 2018.[3] In addition, there are several different types of MDI systems across the country. For example, some states operate under a centralized or state ME system whereas others have a county/district-based ME system.[4] Still, some states have a county/district-based coroner system whereas other states have a county-based system with a mixture of coroner and ME offices.[4] Many jurisdictions have legislation or guidelines that require a coroner or ME to review a suspected overdose death. This puts those MDI entities at the helm of information gathering for understanding an individual's death in addition to potential overdose trends and occurrences that are affecting their communities.

As previously noted, many of the states and counties around the country are familiar with the concept of fatality review teams. A foundation of all fatality review teams is the reliance on the expertise and available records provided by the MDI community. This necessary partnership between health departments, law enforcement, and other collaborating agencies with the MDI community has helped pave the way for increased cooperation and involvement with the MDI community in OFRs.

This in-brief will discuss OFRs and the importance of engaging partnerships with the MDI community by highlighting six established OFR teams. The teams are not only geographically and jurisdictionally diverse but also vary in the way they have been established (e.g., legislation, lead agency, funding). This in-brief will also offer recommendations for implementing or improving OFRs and will discuss the role MDIs have within OFRs.

Milwaukee & Winnebago: A Comparison of Two County-Level OFR Teams in Wisconsin with Different MDI Systems

Wisconsin's state-level OFR program was established in 2016[7] as a collaborative effort between the Wisconsin Department of Health Services and the Wisconsin Department of Justice (DOJ).[14] Currently, the Wisconsin OFR Program encompasses 18 separate OFR teams, which represent 21 out of the 72 counties within the state.[15] The OFR program is funded through the CDC Overdose Data to Action (OD2A) and Bureau of Justice Assistance (BJA) Comprehensive Opioid, Stimulant and Substance Abuse Program (COSSAP) grants.[14] The Medical College of Wisconsin is contracted to provide training and technical assistance to all local OFR teams.[14] Wisconsin OFR teams are not regulated by state legislation,[6] and Wisconsin operates as a county-based MDI system with a mixture of coroner and ME offices.[4]

"[The Medical Examiner's Office] sees things through a certain lens but getting information from other entities with different perspectives is refreshing."

—Sara Schreiber, BS, D-ABFT-FT
Forensic Technical Director,
Milwaukee County Medical Examiner's Office

Milwaukee County

The Milwaukee County OFR team was established in 2016, meets monthly, and reviews two cases per meeting.[7] The county-level team also collaborates with four municipal OFR teams run by local health departments to review additional deaths in the county.[7] Some of the partners on the county-level team include child protective services, behavioral health and treatment, public health agencies, law enforcement agencies, the county school district, district attorney's office, and the Department of Corrections.[7]

The Milwaukee County OFR team works collaboratively with the ME's office to review cases. In 2020, a combined team from the Milwaukee County ME's Office and the Medical College of Wisconsin were awarded a U.S. DOJ grant to form an Overdose Public Health and Safety team to initiate drug overdose prevention planning.[5] Some of the benefits noted by the ME's office in their OFR participation include gaining access to information on harm reduction and counseling, and insight into why certain drugs may have been prescribed.[16]

One of the main recommendations from this team for prospective or newly formed OFR teams is the importance of building trust among partner agencies and team members to increase the comfort level needed to point out gaps in systems.[7] Facilitators have indicated they are continuing to work on improving collaboration with member agencies and attempting to find gaps in service.[7] Regarding this process of constant improvement, the organizers define the program's ultimate success as not simply a statistical measurement reflecting a reduction in overdose deaths but also the expansion of partnership and collaboration in the prevention of both fatal and nonfatal overdoses.[7]

"The resources and contacts that I have made through the OFR team are some that I would never have had without my participation."

—Cheryl Brehmer
Coroner, Winnebago County Coroner's Office

Winnebago County

The Winnebago County OFR team was established in 2018 under the Winnebago County Health Department and reviewed its first case in May of that year.[6] Participating partners include various health agencies, the coroner's office, law enforcement, child welfare, ambulance services, counseling centers, treatment and recovery, education, faith-based organizations, city and county services, and more.[5] The team reviews one case per month, and the results and recommendations of the meetings are compiled in a yearly report that is publicly available on their website.[6] The Winnebago County OFR

team operates a COSSAP Peer Mentor Site and has provided training to teams across the country.[5] One of the unique facts about the Winnebago County OFR is their facilitator is unaffiliated with any agency within the OFR team.[6]

The Winnebago County Coroner, Cheryl Brehmer, participates in meetings and helps select the cases while being invested in creating and implementing team recommendations.[6] She has been a member since the inception of the OFR and has seen tangible benefits as a result.[17] For example, she has developed a means to refer families to the health department (or other OFR partner) for assistance with offering professional grief services.[17] Additionally, the coroner's office is working with other OFR members to either expand the current rapid response team (a specialty unit designed to bring resources directly to a scene) or create a new rapid response team to assist in the county's largest metropolitan area (Oshkosh, WI).[17]

Some recommendations from Winnebago County for other OFR teams are to customize the process to fit your community, build trust and good working relationships with your partners, and have an understanding that the way the team looks today may not be how it looks tomorrow—flexibility is essential.[6]

"Our OFR team is a success because of the coroner. She helps pick the cases, shows up and actively participates at meetings, listens and learns, and helps lead change in our community to save lives. We're extremely grateful for her leadership to make this team a success."

—Jennifer Skolaski, PhD
Facilitator, Winnebago County Overdose Fatality Review

Rhode Island & Delaware: A Comparison of Two State-Level OFR Teams with a Centralized ME System

Rhode Island and Delaware share similar population sizes of approximately 1 million residents. Each state has OFR legislation and a centralized ME system that plays a significant role within the respective OFR teams.

Rhode Island

The Rhode Island OFR team was piloted in 2016 and officially established based on legislation passed in 2018 (Rhode Island General Laws § 23-4-3). The legislation established a temporary multi-disciplinary review team of health and public safety professionals to review overdose deaths in Rhode Island to examine trends and provide an annual report to the governor and the General Assembly. In June 2021, the law was amended to make the OFR permanent "…with the goal of reducing the prevalence of these deaths by examining emerging trends in overdose, identifying potential demographic, geographic, and structural points for prevention and other factors." [18] Funding for Rhode Island's OFR is entirely provided through the CDC's Overdose Data to Action grant. OFR partners include the ME, health department, law enforcement, attorney general's office, hospital association, emergency room physician, and more.

Rhode Island's OFR team is led by the state's Department of Health, which also includes the State Center for the Office of Medical Examiners. Before the onset of the COVID-19 pandemic, meetings were held quarterly in the ME's office but have since transitioned to a virtual format where participants view information prepared by the Department of Health officials. Cases for review are chosen based on trends and are a randomized sample of the most recent data. Eight cases are prepared for each meeting; however, depending on the theme and the information available, the exact number varies. Rhode Island's OFR work product is protected under state law and is not subject to "…subpoena, discovery, or introduction into evidence in any civil or criminal proceeding..."[18]

Separate from the OFR team, Rhode Island also has a Governor's Overdose Prevention and Intervention Task Force, which is geared toward prevention, treatment, rescue, and recovery. This task force meets monthly and is co-chaired by the Directors of the Department of Health and the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals. A representative of the state ME's office is also a member. Some of the individuals from the OFR team, including the

state ME's office are on the task force. Their meetings serve as a venue for presenting the OFR reports and recommendations.

Delaware

In Delaware, state legislation (Delaware Code Title 16, § 4799) passed in 2016 formed the Delaware Drug Overdose Fatality Review Commission (DOFRC).[8] The DOFRC is seated under the Delaware DOJ, which has full subpoena power to retrieve medical and law enforcement records. The DOFRC specifically looks at opioid deaths around the state; however, new legislation is anticipated to widen the range of drug overdoses that the DOFRC can review. After starting with unfunded legislation, the DOFRC was able to secure a grant from the Delaware Department of Social Services to hire a management analyst and a data analyst. Delaware currently has two regional review teams, each of which are tasked with case review. The regional teams ten comprise the same types of members as the Commission, which include representatives from public health, non-profit, law enforcement, corrections, substance abuse/mental health, health and social services, safety and homeland security, and the ME's office.[8]

The regional teams reviewed 190 deaths in 2020 using a sampling criterion of reviewing the cases of odd months (e.g., January-01, March-03) reported on odd days (e.g., 01, 03, 05) and the cases of even months reported on even days. This was done to ensure an unbiased representation of the cases chosen for review and to provide a relatively even number of cases reviewed by each regional team. The data and recommendations from the regional review teams are then brought to the DOFRC, which uses it to create an annual report and then presents these findings to the Governor and General Assembly.

"Forensic Investigators are the lifeline to what I do. Numbers speak, but they only tell a fragment of the story. The goal is to have more of their stories told and to tell a broader story for the victims."

—Julia Lawes, MS
Executive Director, Delaware Drug Overdose Fatality Review Commission

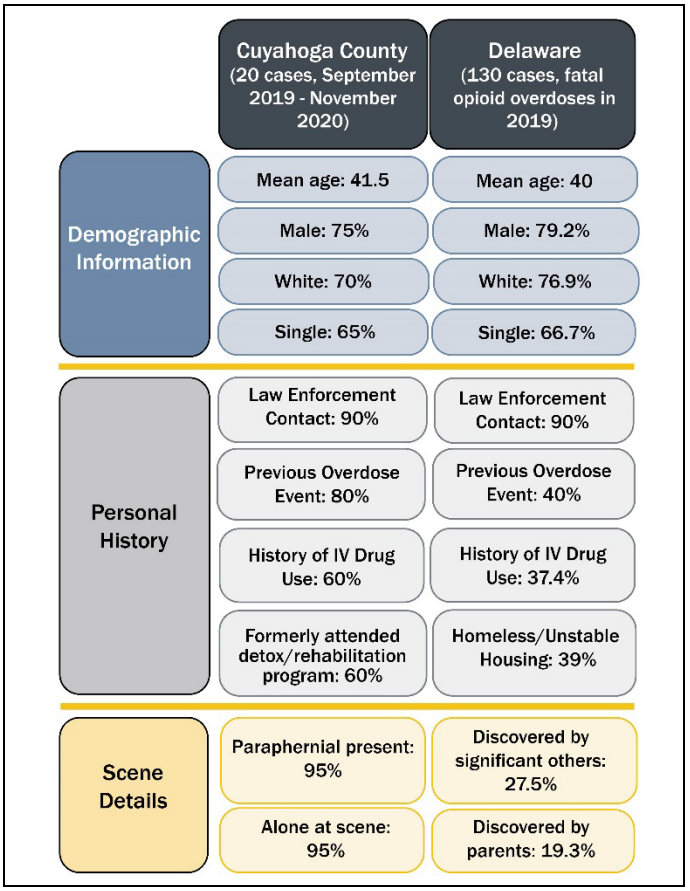

Exhibit 2. This exhibit displays statistics gathered from case reviews for Cuyahoga County[11] and Delaware.[19]

Although, the DOFRC members do not review the individual cases, the DOFRC Executive Director personally reviews each case, choses which cases will be reviewed based on the previously stated sampling criteria, compiles the records, and sends the information packets to the regional teams for review.[8] The whole process begins with a death notification directly from the Division of Forensic Science, where the state ME resides.[8] These notifications are critical to the work of the Commission because without such notification the death is not considered for review.[8]

Cuyahoga County, Ohio & Charleston County, South Carolina: Unique OFR Composition

Cuyahoga County, Ohio, and Charleston County, South Carolina, have unique OFR compositions and MDI systems. In Cuyahoga County, the ME not only co-leads the OFR but also serves as a laboratory director. Charleston County is a coroner-based county, where the coroner is heavily involved in the OFR run by a federal district judge.

"As the ME, I see what drugs are killing people. As the Lab Director (with oversight of the Drug Chemistry Lab, which tests seized drugs) I see what drugs are in the community. These are not always the same."

—Thomas Gilson, MD
Medical Examiner, Cuyahoga County Medical Examiner's Office

Cuyahoga County

In 2013, Cuyahoga County started to review all cases involving drug overdose; however, this was refined in 2019 to a more selective process.[20] The team meets every other month and discusses approximately three cases per meeting.[20] Cases are selected by the ME's office based on emerging trends; however, individual OFR team members may select cases for review as well.[20] Key partners that participate in the reviews include law enforcement, medical centers, public health, child and family services, universities, drug court, drug addiction, and mental health services.[11]

The Cuyahoga County Board of Health and the ME's office share responsibility for coordinating the OFR team.[20] They are assisted by Case Western Reserve University, which compiles timelines regarding reviewed cases and facilitates the technology for the OFR meetings.[20] Starting in June 2020, meetings have been conducted in a virtual format but were previously held in person at the ME's office.[20]

Because the ME is heavily involved with the OFR, the team has been successful with gathering real-time data.[20] In fact, Cuyahoga County is rather unique in that the ME also serves as the Regional Forensic Science Laboratory Director, which allows for a unique perspective into the region's overdose epidemic. In these roles, Dr. Thomas Gilson notes that it is possible or even likely that MEs can miss certain drugs when testing because of limited access to drug chemistry or not looking for certain drugs in testing.[21]

"The best suggestion is to begin networking with individuals and agencies that have a vested interest. This group then needs to decide how best to use the OFR for their community and make recommendations based on their specific community needs."

—Bobbie Jo O'Neal, RN, BSN
Coroner, Charleston County Coroner's Office

Charleston County

In March 2021, U.S. District Judge Bruce Howe Hendricks and former Obama administration National Drug Control Policy Director Gil Kerlikowske created the Addiction Crisis Task Force with the goal of decreasing overdoses, reducing opioid addiction, and saving lives.[22] Each month, the task force meets and reviews an overdose fatality case presented by a different law enforcement agency.[12] The task force evaluates how systems are operating in the county and compiles recommendations that they would like to see implemented.[12] Some of the task force partners include all law enforcement agencies in Charleston County, hospitals, local EMS, the U.S. Attorney's Office, local solicitors, local schools, a chaplaincy program, and drug abuse services.[22]

The Charleston County Coroner's Office is heavily involved in the task force. The social and medical history of the decedent and the toxicology results are presented at the meetings by a representative of the Coroner's Office, preferably the actual medicolegal death investigator who responded to the death.[12] The Charleston County Coroner, Bobbi Jo O'Neal, suggested that the best way for new OFRs to start is by choosing a team of people who have a vested interest and then deciding how best to use the OFR for their specific community needs.[12] In addition, she also suggested that

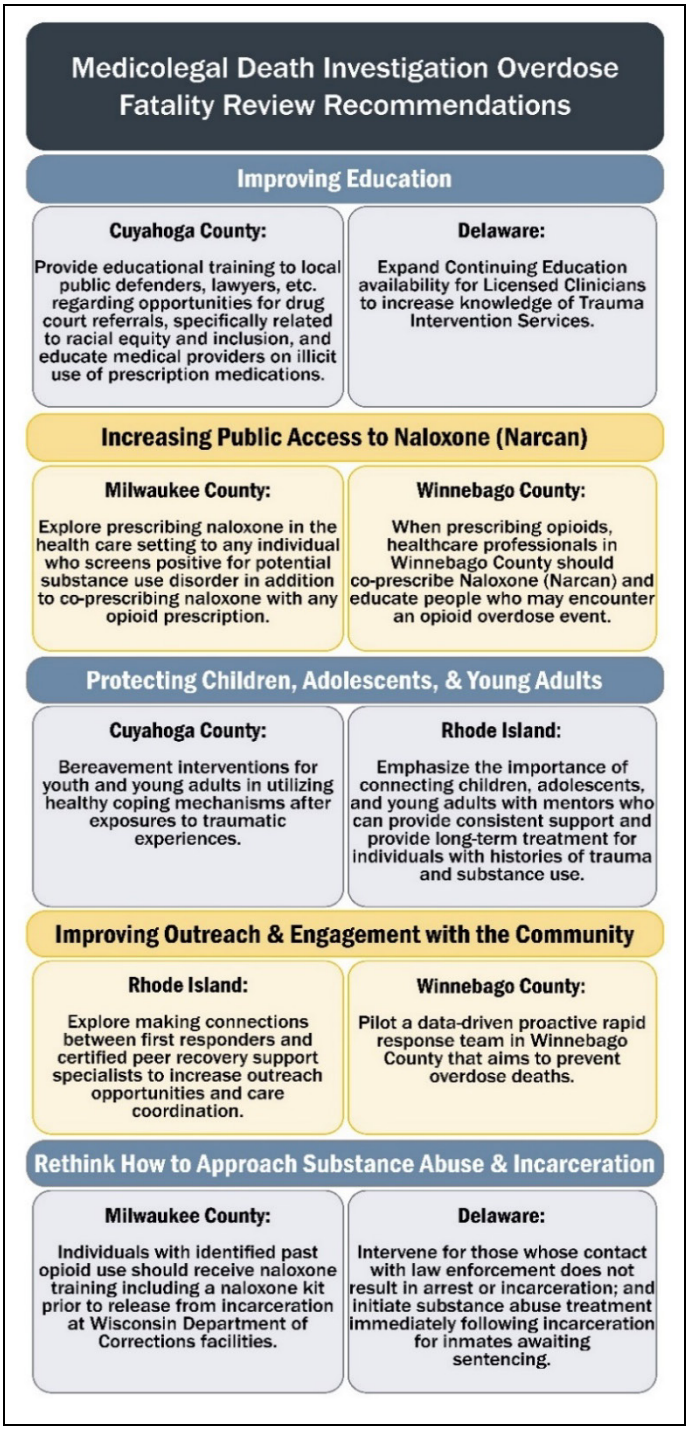

Exhibit 3. Recommendations created by some of the OFRs highlighted. [5, 9, 11, 19]

MEs and coroners should have access to the Overdose Mapping and Application Program (ODMAP) and enter fatal overdose information consistently when toxicology reports become available.[12]

Summary

The main purpose of OFRs is to review overdose fatalities and find gaps in services to help save lives. They rely on a multi-agency approach to information sharing to accomplish this goal. Upon completion of case reviews, OFR teams formulate recommendations to improve services based on the advice from a collaboration of partners, each of whom brings a unique perspective to the team. The six examples here highlight various ways OFR teams have been implemented and how their structure accommodates specific community needs. Some of the common recommendations created by the OFRs discussed above revolve around education, naloxone/Narcan, children, outreach, and incarceration.

Most OFRs rely heavily on the cooperation and assistance from MDI personnel in their jurisdiction. The OFR process begins with a notification of an overdose, which is key to providing a real-time perspective for the deaths reviewed along with insight into community trends. The work of death investigators is critical to understanding how to address the overdose epidemic and the overall process of an OFR. Fostering partnerships with the MDI community and getting them involved in the OFR process is key to sharing information and saving lives. As Dr. Thomas Gilson, the Cuyahoga County ME, notes, “Better communication, better results—it's as simple as that.”

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Additional Resources

- BJA Overdose Fatality Review: A Practitioner's Guide to Implementation
- BJA 2021 Virtual National Forum Overdose Fatality Review
- BJA Partnerships for Prevention: Overdose Fatality Review 101
- BJA Comprehensive Opioid, Stimulant, and Substance Abuse Program Resource Center
- Legislative Analysis and Public Policy Association, Opioid Fatality Review Boards: State Laws
- 10 Tips to to Facilitate a Successful Overdose Fatality Review

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