

Drug Overdose Prevention–Coroners' Study  
Deliverable 2: Survey Results and Analysis

# Assessing Coroners' Needs

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## Research Purpose

The Nebraska Department of Health and Human Services (DHHS) partnered with Support and Training for the Evaluation of Programs (STEPS) at the University of Nebraska at Omaha to assess the needs of Nebraska county coroners in conducting drug overdose death investigations. This is the second year DHHS has partnered with STEPs to assess coroners' needs.

To develop a clear understanding of Nebraska county coroners' needs, STEPs conducted an online survey of the 91 county coroners who are serving 93 Nebraska counties, according to Nebraska DHHS's internal data. STEPs administered the survey on June 25, 2020 and closed it on July 24, 2020. 21 coroners completed the survey in its entirety, providing a response rate of 23%. At least three responses came from each of the Behavioral Health Regions 1–5. No responses came from Behavioral Health Region 6.



## Summary of Findings

1. Nebraska's county coroners continue to report low drug overdose death rates in their counties. The drug most frequently cited in overdose cases continues to be prescription pain relievers.
2. The county coroners reported several partnering agencies that assist in their drug overdose death investigations, including the county sheriff's department and Nebraska State Patrol. These agencies could be a great asset to DHHS' DOP efforts to increase awareness of drug overdose deaths and resources.
3. While most county coroner participants reported having 10 or more years of experience, practices for drug overdose death investigations vary from county to county. Most county coroners reported requesting toxicology reports only if they suspected a crime occurred.
4. The greatest area of need for the Nebraska county coroners is increased financial resources for investigations, including the cost of pathology, toxicology and autopsy.



## Recommendations

To meet the needs of Nebraska's county coroners, STEPs recommends that DHHS:

1. Increase drug-involved death investigation training and capacity building for coroners and provide outreach to counties/law enforcement not participating in DHHS' free toxicology program.
2. Allocate additional financial support to coroners based on the need in their county.
3. Consider partnering with local law enforcement to increase drug overdose death awareness.
4. Develop a state-level medicolegal group of death investigators to support county coroners.
5. Continue conducting coroner surveys on a regular basis to assess the needs of coroners. Also, including interviews or focus groups of county coroners in future studies would provide richer data on the needs and practices of Nebraska coroners in conducting drug overdose death investigations.



## Sampling

STEPs located names and contact information for all of Nebraska’s attorneys via the Nebraska County Attorney Association (NECAA) website. There are presently 91 county attorneys serving 93 counties in Nebraska. Throughout the course of this study, STEP s obtained updated contact information for counties with new attorneys.

The original research plan included STEP s staff attending the NECAA conference in May 2020 to encourage participation in the coroner survey. Due to the COVID-19 pandemic, this conference was cancelled, and STEP s administered the survey via Qualtrics, an online survey software.<sup>2</sup> NE DHHS approved changes from the original methodology prior to survey administration.

STEP s collected survey responses from June 25, 2020 through July 24, 2020 and sent an email reminder to county attorneys on July 14, 2020, along with follow up calls, to encourage participation from July 14–24, 2020.



## Survey Items

The 26-item survey was a combination of closed-ended, open-ended, and scaled questions that focused on four topic areas:

1. Current policy and procedure in determining and investigating drug overdose deaths.
2. Capacity to investigate drug overdose deaths.
3. Needs for improving the drug overdose death investigations.
4. Demographic characteristics.

STEP s and Nebraska DHHS collaboratively developed the survey questions, all items of which can be found in the [Appendix](#) to this report.



## Differences between 2019 and 2020 Survey Items

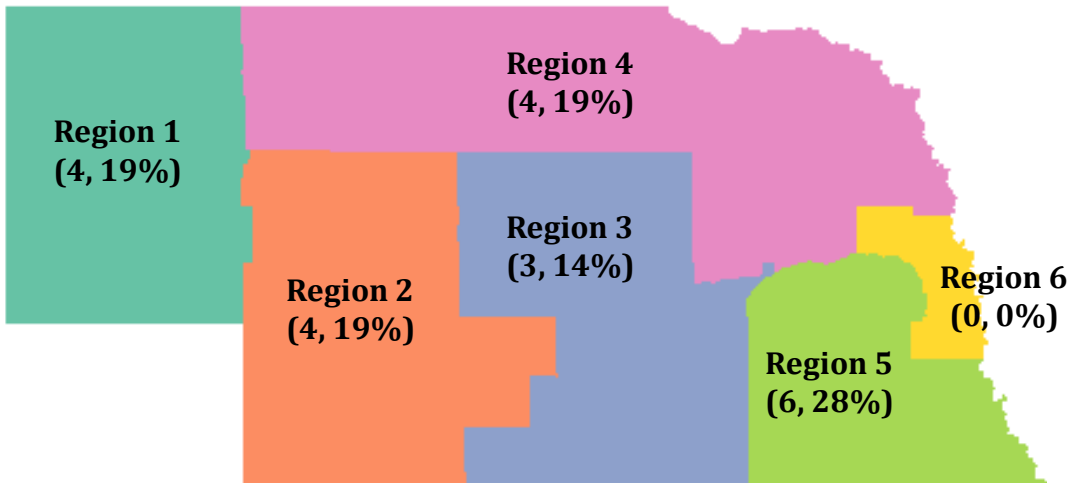
The principle for designing the 2020 survey questionnaire was to maintain the continuity of the survey by utilizing as many of the previous year’s survey items as possible. However, STEP s did revise some survey items to make them more readable and understandable based on the findings and comments of the 2019 survey items. The summary of the significant changes are listed here:

1. Question Q34 was added to determine scope of coroner jurisdiction as some coroners may serve more than one county.
2. Question P1 was added to confirm that the respondent oversees the completion of death investigations. The 2019 survey found that there would be exceptional cases in which the county attorney would not take charge to avoid role conflict in the courtroom. Therefore, question P1: 1) checks if a county attorney works as a county coroner, 2) investigates who completes the death investigation if a county attorney recuses themselves, and 3) provides further detail of which parties future studies should consider reaching.
3. Question Q27 was added to assess Nebraska county coroners’ awareness of NE DHHS programs.

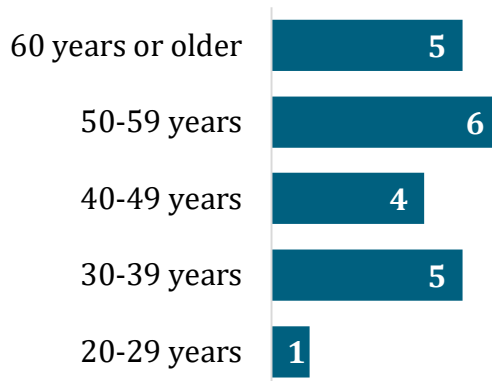


## Sample Description

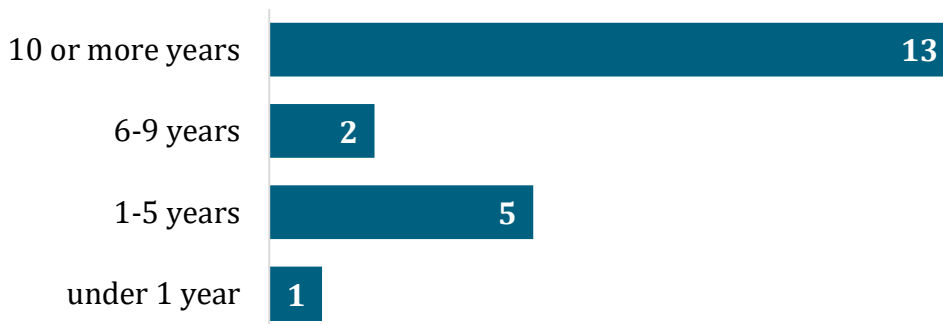
The survey received 21 complete responses. Each behavioral region had at least three responses, except for Region 6, which had zero. This map shows the number of respondents in each region and the percentage of the survey respondents that they represent.



Survey responses were from 14 males (67%), 6 females (29%), and 1 who preferred not to provide their sex (5%), with ages ranging from “20-29 years” to “60 years or older.”



Most respondents (62%) had 10 or more years of experience as a coroner.





## County Responsibilities

Of the 21 respondents who answered this question, 20 (95%) were responsible for coroner duties in one county. Because of small county populations, some county attorneys have jurisdiction in multiple counties. In this survey, only one county attorney reported having multiple county responsibilities. This question differed from the 2019 survey, which did not ask about jurisdiction.



## Role of County Coroner

Though Nebraska county attorneys are required by law to act as county coroners, respondents also reported involving deputy county attorneys and sheriffs in their decisions about whether to conduct death investigations. In 2019, STEPs found that law enforcement frequently consulted on or took a more prominent role in death investigations. This question was added to the 2020 survey to determine which counties may need targeted outreach for their law enforcement.



## Drug Involved Death Investigation Practices

County attorneys answered that they completed an average of 21 death investigations over the past 12 months (n=21), with responses ranging from 0–200 death investigations per year.

Of those deaths investigated, county attorneys answered that, on average, only 17% were related to a drug overdose (n=14). This is consistent with 2019’s findings, which showed that county attorneys reported drug overdoses lower than the national average. The following table displays the average number of deaths reported in the 2020 survey, and of those deaths, how many were reported to be drug related.

Region	Average Number of Deaths	% of Drug-Related Deaths
Region 1	11	5%
Region 2	7	30%
Region 3	4	0%
Region 4	23	5%
Region 5	44	30%
Region 6	unknown	unknown



## Substances Found in Drug-Involved Death Investigations

The substances most frequently found in the drug-involved death investigation process were prescription pain relievers (9), methamphetamines (6), fentanyl (5), and antidepressants (5). Other substances mentioned were prescription drugs (non-specific), marijuana, morphine, and drugs mixed with alcohol. These findings are consistent with the 2019 survey, which found prescription pain relievers, methamphetamine, and fentanyl as the most common substances in drug overdose deaths.

Name of Drug	# of Respondents
Prescription Pain Relievers	9
Methamphetamine	6
Fentanyl	5
Antidepressants	5
Other	4
Cocaine	2
Heroin	2
Benzodiazepines	2
Unknown Drugs	2



## Toxicology Reports

**On average, the 19 responding county attorneys requested toxicology reports 62% of the time.** Responses ranged widely from requesting a toxicology report 0–100% of the time. Most respondents reported that their driving force to request a toxicology report was a death related to a crime (79%). Other reasons included the deceased’s history of drug abuse (74%), identifying which drug caused the overdose (68%), no obvious cause of death (68%), and a death related to a car accident (63%). Other reasons included cases of suicide, to properly determine cause of death, and to eliminate a suspected drug overdose.

STEPS found similar results in 2019, when most attorneys reported they only request toxicology reports if the death is related to a crime. Because of the small sample size, bivariate analysis could not determine if there are major differences in requesting toxicology reports among county attorneys.

Reason	# of Respondents
It is related to a crime	15
The deceased has a history of drug abuse	14
I am certain it is a drug overdose, but do not know which drug	13
There is no obvious cause of death	13
It is related to a car accident	12
The family requested a toxicology report	5
Other reasons	3

## Why Not Request a Toxicology Report?

**Most of the 17 responding county attorneys answered they do not request a toxicology report if the death is not related to a crime (71%).** County attorneys also reported that it is too expensive to request a toxicology report (29%), and it takes too long to receive toxicology results (24%). Other reasons for not requesting a toxicology report included not needing detailed toxicology information (18%). Due to the small sample size, this study was unable to determine if any differences exist between those who request more often and those who do not.

Reason	# of Respondents
The death is not related to a crime	12
It is too expensive to request a toxicology report	5
It takes too long to receive toxicology report	4
There is no need for a detailed toxicology report	3
Other	2

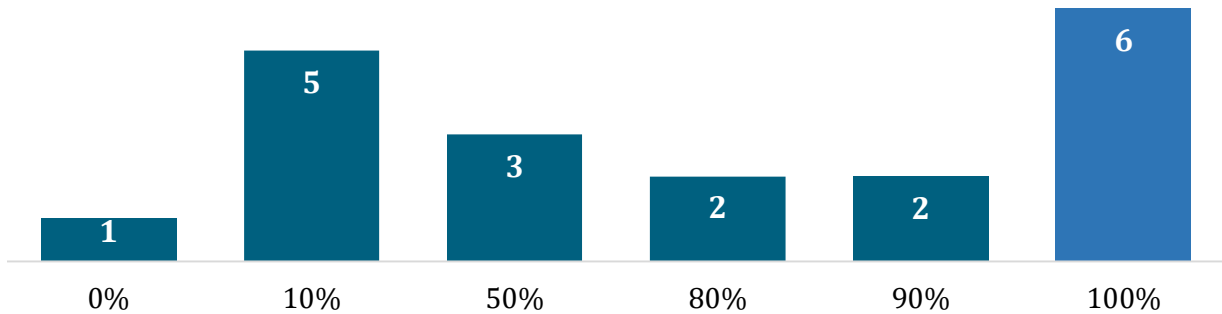




## Autopsy

Nearly one-third of the 19 coroners reported requesting an autopsy 100% of the time. Of the other county attorneys who reported requesting an autopsy, 4 (22%) said they do it 80–90% of the time, 3 (16%) do it half the time, and 6 do it much less often. These results are strikingly similar 2019, in that attorneys vary widely on how often they request autopsies.

**Percentage of the Time Completing Autopsies**



## Non-Mandatory Autopsy Performed

12 of the 18 responding county coroners (67%) said if an autopsy is not required, a non-mandatory autopsy is rarely performed. Two respondents (11%) said non-mandatory autopsies are never performed. However, three respondents (16%) indicated non-mandatory autopsies are sometimes performed, and one respondent (6%) said non-mandatory autopsies are very often performed. As in 2019, most county attorneys explained they do not often perform autopsies if it is not required by law.

**Frequency of Non-Mandatory Autopsies Performed**





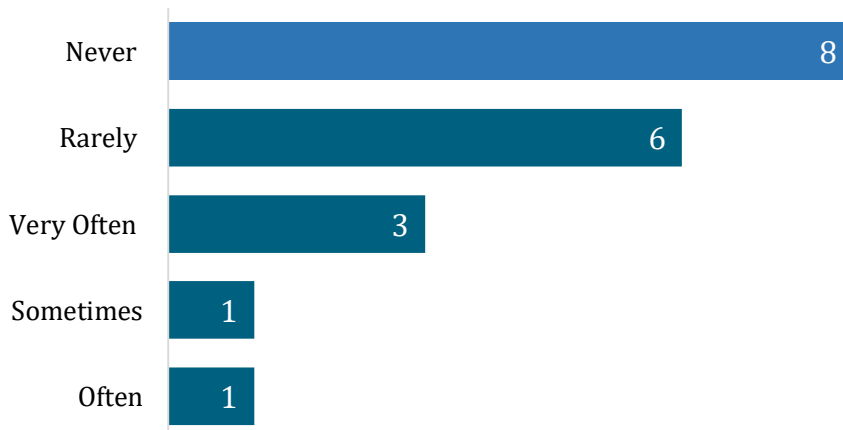
## Non-Mandatory Autopsy Performed Reasoning

The survey then asked coroners who indicated they had performed a non-mandatory autopsy for the main reason they requested an autopsy. Many coroners indicated it was to determine/ rule out the cause of death. Another reason was because it was part of a crime investigation and a crime was committed. One coroner said it was requested for legal reasons, while another mentioned that the family had asked for it. This study did not determine which other factors may be associated with the practice of requesting a complete autopsy.

## Death Certificates

Among the 19 responding coroners, 8 (42%) indicated their office never completed death certificates for (suspected) drug-involved or drug overdose deaths prior to receiving all completed investigation reports (toxicology, medical history, autopsy report). Six respondents (32%) said their office rarely completed them without all necessary data. However, one respondent (5%) said they sometimes completed them, and one respondent (5%) said they often did. Three respondents (16%) said their office very often completed death certificates for (suspected) drug-involved or drug overdose death prior to receiving all investigation reports. These findings are consistent with 2019's data.

**Frequency of the Coroner's Office Completing Death Certificates Prior to Having All Reports**

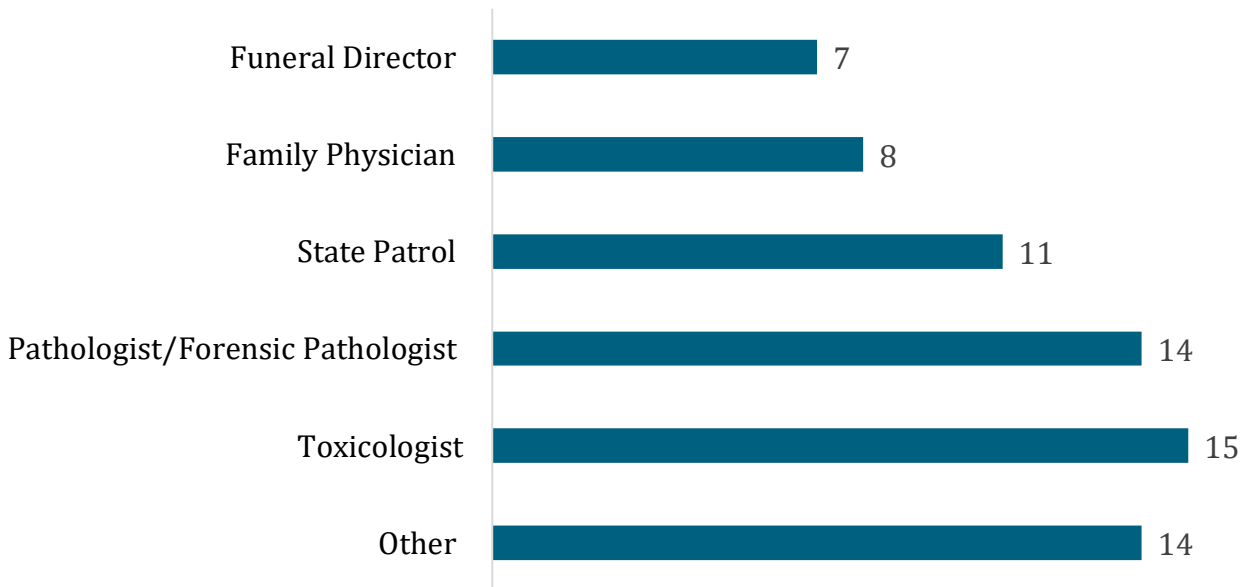




## Other Decision Makers

Among the 19 county attorneys who acknowledged that they consult with other agencies to assist them in drug overdose death investigations, the most frequently named partners were toxicologists (79%), pathologists and forensic pathologists (74%), and others (58%). Of other parties mentioned, county attorneys most frequently named local law enforcement and sheriff departments. In 2019, survey respondents also named local law enforcement as a frequent partner in death investigations.

### Most Frequent Partners in Death Investigations

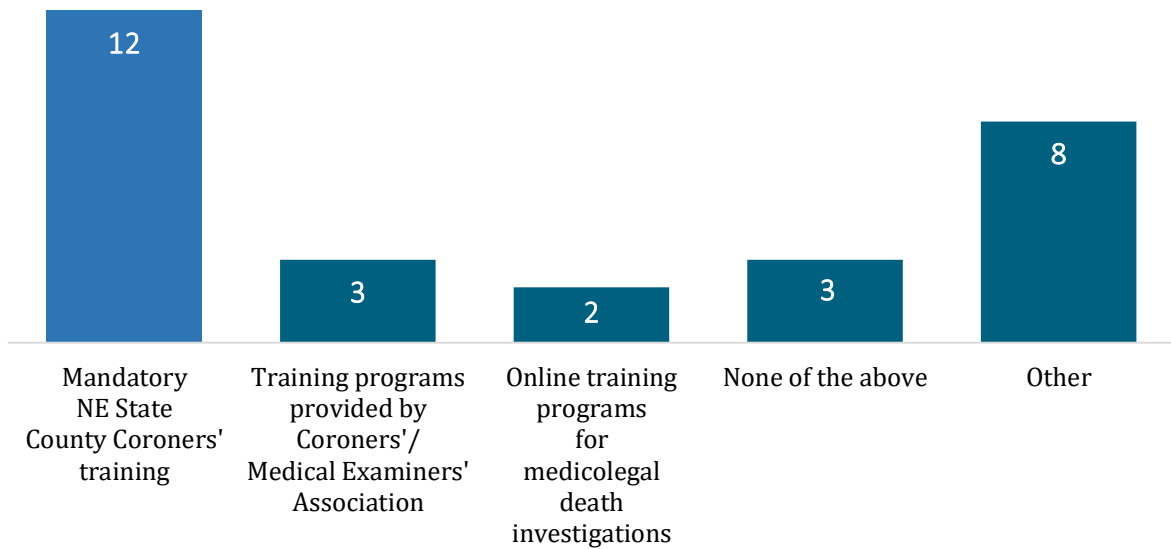




## Death Investigation Trainings

The survey allowed respondents to select multiple responses in naming what types of trainings they had received. Of the 21 responses, 12 respondents (43%) said they participated in the mandatory NE State County Coroners’ training. Other trainings included those provided by coroners’ or medical examiners’ associations (11%), and online programs for medicolegal death investigations (7%). Three respondents (11%) indicated *none of the above*, while eight participants (29%) indicated *other*, which is explored in detail in the following section. Due to the small sample size, key differences in those who had received more than one type of training could not be identified. Future research should examine these differences.

**Types of Trainings Received**



## Other Death Investigation Trainings

STEPS asked the coroners who indicated they had “other” trainings to specify what trainings they had received. Eight coroners had specified which trainings they had received. Many indicated they had training through the Nebraska County Attorney’s Association. Others said networking with experienced pathologists, along with self-guided research and in-person training from Dakota County Sheriff’s Office. These answers are similar to 2019’s responses, which found most attorneys had only received one type of training.

A medicolegal death investigation training for county attorneys had been planned for 2020. However, it was cancelled due to the COVID-19 pandemic and remains to be rescheduled. Because of the limited sample size, STEPS was not able to determine if trainings were related to other factors, including confidence and awareness of pertinent issues.



## Confidence in Factors of Drug-Involved Death Investigations

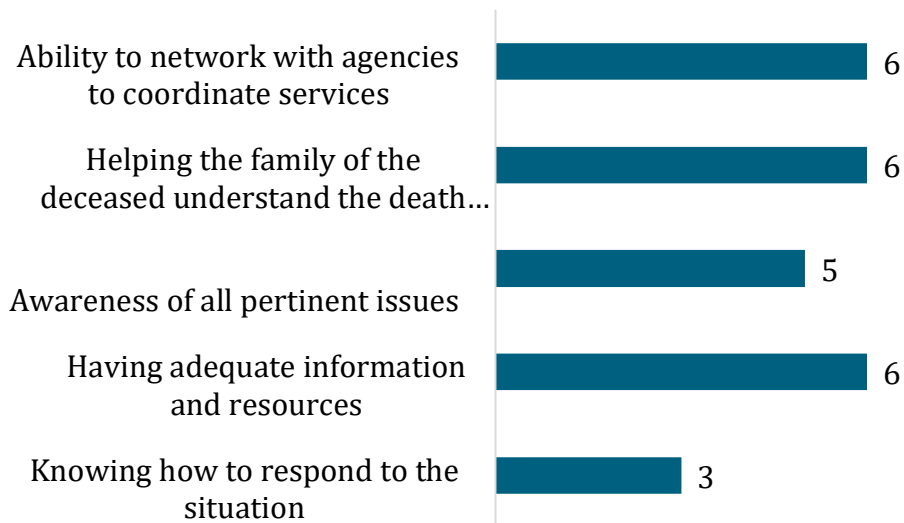
The survey investigated respondents' level of confidence in handling five factors of a suspected drug-involved or drug overdose death investigation:

1. Knowing how to respond to the situation
2. Having adequate information and resources
3. Awareness of all pertinent issues
4. Helping the family of the deceased understand the death investigation process
5. Ability to network with agencies to coordinate services

Overwhelmingly, coroners reported high levels of confidence (very or moderately confident) in each of these five areas. Based on 20 responses, the three areas that reported the lowest confidence were 1) helping the family of the deceased understand the death investigation process (30%), 2) having adequate information and resources (30%), and 3) ability to network with agencies (30%).

Survey results from 2019 found that attorneys with more years of experience had higher confidence than their newer counterparts. Due to the small sample size, analyses could not determine if key differences existed in 2020's sample.

### Lowest Areas of Confidence Among Coroners

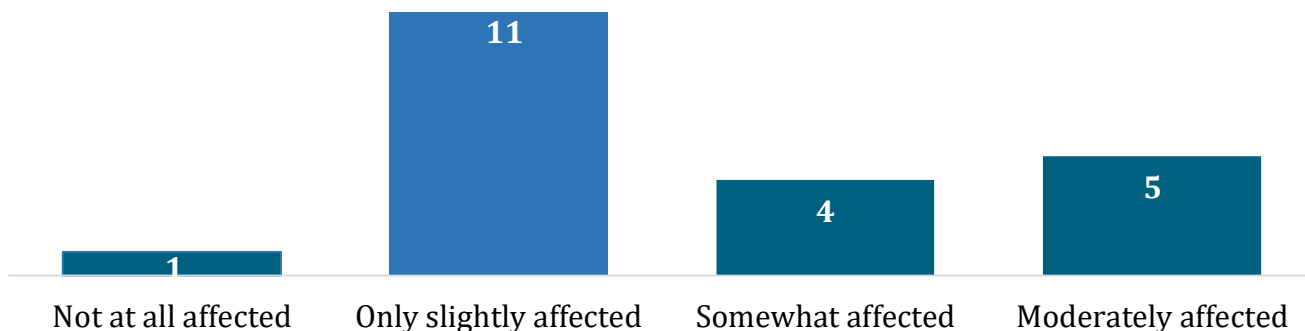




## Needs for Drug-Involved Death Investigation

The survey investigated the level of needs of coroners to conduct and/or improve the current drug-involved death investigation process. **The majority of the 21 responding coroners perceived drug-involved or drug overdose deaths to *only slightly affect* their counties.** Five respondents (24%) reported that drug overdose deaths *moderately affect* their communities. Four county coroners (19%) answered that drug overdose deaths are *somewhat affecting* their communities. However, 11 respondents (52%) indicated that drug overdose deaths *only slightly affect* their communities, while one respondent (5%) said their community was *not at all affected* by drug overdose deaths.

### Perceived Severity of the Drug-Involved or Drug Overdose Death Problem within County



## Perception and Confidence

One question explored was whether perceptions of community impact were related to knowledge, awareness, and resources. For example, the relationship between knowing what response to take when suspected drug-involved death investigations and the perception that their community was impacted by overdose deaths. In this instance the relationship was positively related however not significant ( $r=.35, p>.05$ ). In other words, those who were more confident in what response to take in a drug-related death investigation were also perceiving their community to be more impacted by drug-overdose deaths; however due to a smaller response that trend was not statistically significant.

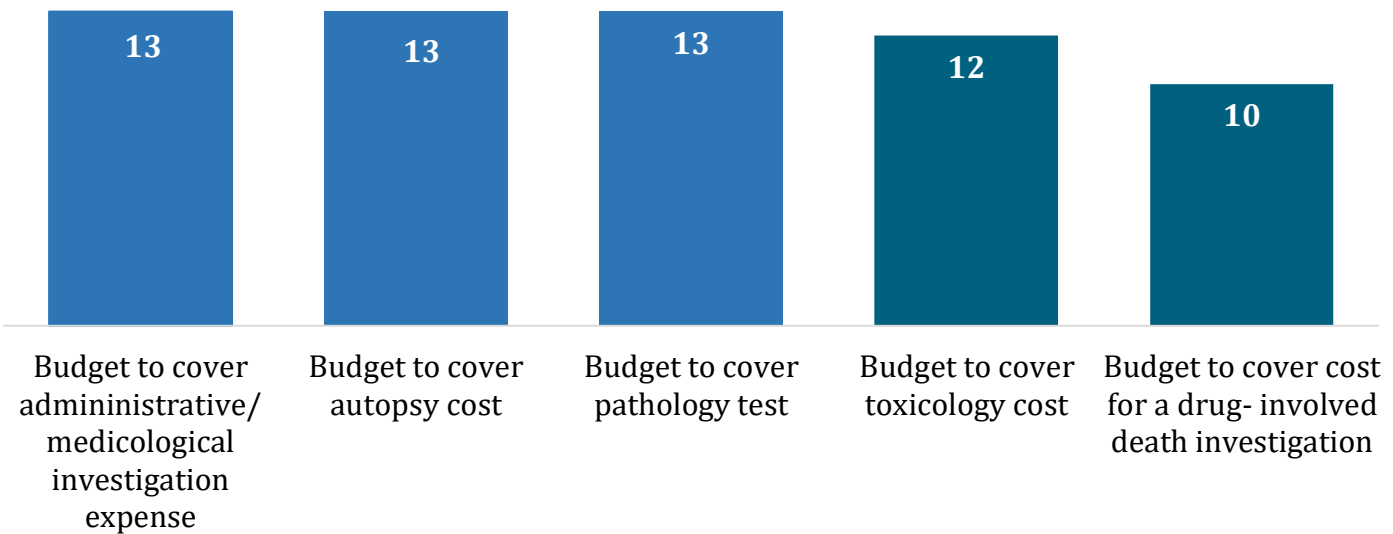
Similarly, confidence in having adequate information and resources to solve these problems ( $r=.25, p>.05$ ) and confidence in being able to help families of the deceased understand the suspicion of drug overdose death ( $r=.29, p>.05$ ) were both positively related with perceptions of community impact; however both were also not significant. Awareness of pertinent issues in their field of practice ( $r=-.07, p>.05$ ) and confidence in network with other agencies for coordination of services ( $r=-.03, p>.05$ ) were not related to perceptions of community impact and not significant.



## Barriers in Completing Drug-Involved Death Investigations

The survey investigated the types of barriers that county coroners face in conducting and/or improving the current drug-involved death investigation process. There were three major barriers identified: 13 (65%) of the 20 coroners indicated budget to cover administrative/ medicological investigation expense along with budget to cover autopsy test. 13 (68%) of 19 coroners said budget to cover pathology tests were a barrier. 12 (60%) of 20 coroners indicated budget to cover toxicology cost as a barrier. 10 (50%) of the 20 coroners said budget to cover cost for a drug-involved death investigation was a barrier they faced.

### Budget Needs for Drug-Involved Death Investigations



### Budget Needs and Regional Differences

Additionally, the survey examined budget issues related to death investigations to determine differences across regions. While responses ranged from “never” to “very often” between respondents, regions, on average, were similar in their response ( $F=1.8, p>.01$ ). It should be noted that Region 6 was not represented in the sample.



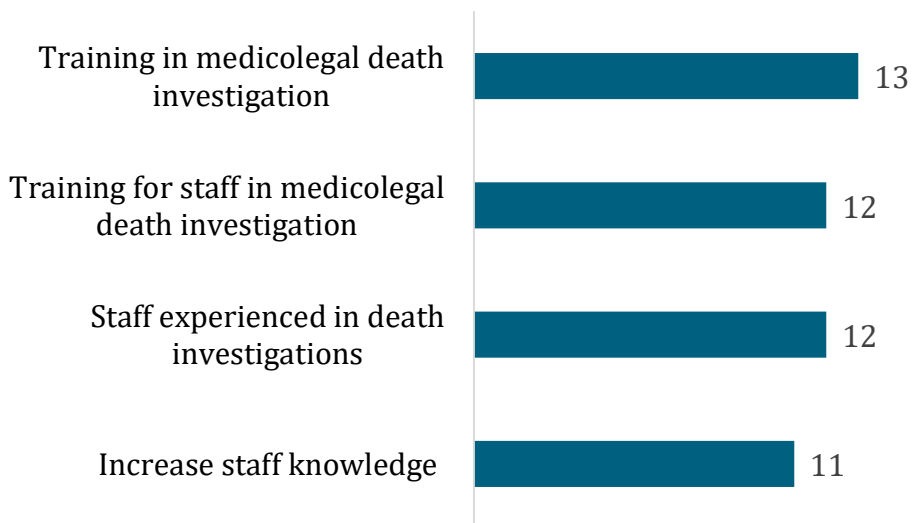
## Needed Resources

The survey investigated which resources county coroners need to conduct and/or improve the current drug-involved death investigation process. Coroners were asked about the frequency of times they encountered various barriers, including training, experience, staffing, funding, access and equipment.

The vast majority of coroners answered they rarely or never encountered issues with access to pathology testing or equipment/instruments for testing. However, as displayed by the following graph, the responses show that the most frequently cited needs for county coroners. 13 (65%) of the 20 county coroners wanted more training in medicolegal death investigations. 12 (60%) indicated they needed training for staff in death investigations. 12 (60%) said they needed staff experienced in conducting death investigations. 11 (55%) county coroners indicated they needed increase staff knowledge about death investigations.

These findings are consistent with 2019's survey, which found that county attorneys most frequently needed additional training, experience and budget to complete drug overdose death investigations more thoroughly.

### Most Frequently Listed Needs for Coroners







## Summary of Findings

Out of 91 coroners, STEPs received 21 responses and made several reminders and attempts to contact other coroners. Respondents consisted of 14 males, 6 females, and 1 person who preferred not to disclose their sex. The ages of responding coroners ranged from their 20s–60s and older. Most respondents had at least 10 years of experience as a county coroner. Most were responsible for only one county. In their role as county attorney, most reported that they alone acted as county coroner, while a few others indicated they utilized their deputy county attorney for coroner duties.

Survey results show that a low number of county coroners perform drug-involved death investigations and most do not perceive that their communities are severely or even moderately impacted by drug overdose deaths. County coroners answered that they completed an average of 21 death investigations over the last 12 months, but the county counts varied widely. Respondents answered that of the deaths which occurred in their county, less than one in five were drug overdose related. Of drug overdose deaths, prescription pain relievers were most frequently cited as the cause of death. Other top drugs were methamphetamine, fentanyl, and antidepressants.

Death investigation practices varied by county coroners. Most requested toxicology reports when related to a crime, when the deceased had a history of drug abuse, or when certain of a drug overdose death but not of the substance. Reasons for not requesting a toxicology report included the death was not related to a crime, the expenses of requesting a toxicology report, and the time it takes to receive a toxicology report. Autopsies were requested less frequently if a crime was not committed, and coroners reported overall that non-mandatory autopsies were rarely completed. However, most coroners answered that they never or rarely complete death certificates prior to receiving all the necessary information.

The survey also revealed county coroners frequently work with other agencies to complete drug overdose death investigations. County coroners stated they most often work with toxicologists, pathologists or forensic pathologists, local law enforcement, and sheriff's departments.

Most county coroners answered they had participated in the mandatory coroner training. Other trainings included coroner/medical examiner association training, workshops for county attorneys, and online trainings. Others mentioned receiving training through local law enforcement. STEPs was unable to conduct further analyses to see if key differences existed among coroners with various trainings.

Confidence was high among county coroners in their ability to respond to drug overdose deaths, access to information and resources, helping the families of the deceased understand the investigation process, and networking with other agencies to coordinate services. While not statistically significant, those who perceived their communities were more impacted by drug overdose deaths did report more confidence in navigating drug overdose death practices.



### **Summary of Findings** (cont.)

Most county coroners reported they most frequently face barriers and insufficiencies in 1) the budget for the cost of toxicology, autopsy, pathology, death investigations and administration of death investigations as well as 2) training and experience for staff in death investigations. On the other hand, most coroners reported rare or few barriers in needing supplies, space, access to lab services or disputes about the need to conduct a drug overdose death investigation. STEPs found no major differences in regions responding to this question.



### Limitations

Like any study, this study has several limitations that need to be considered when reviewing the results and recommendations.

1. Despite STEPs' several efforts to reach county coroners who had not responded, the response rate was fairly low, with some gaps in regional perspectives. STEPs had planned to be present at the NECAA Annual Conference to increase survey participation. Due to COVID-19, this conference had to be cancelled. Additionally, STEPs attempted to gain support from the NECAA leadership team to encourage participation in the survey. However, NECAA did not respond. No responses came from Region 6, which includes Douglas County, Nebraska's most populous county. It is possible responses were limited due to the current COVID-19 pandemic. Drawing general conclusions from such a small sample size is difficult without representation from every region. STEPs recommends collaborating NECAA to reach a greater number of county attorneys to participate in future surveys.
2. The survey was intentionally short in hopes of attracting more respondents, but doing so limited this study's ability to assess a full picture of the problem and listen to the voices of those in the field. Conducting interviews would provide more detailed and context-based stories, giving a better understanding of the problem and resolving unanswered questions.
3. This survey invited respondents to share their own experiences, knowledge, and perceptions through self-report, which is limited by a potential risk of distorted memory. Future studies could include content analysis of death certificate information.
4. Regional differences could not be determined by local health departments due to the small sample size.



## Recommendations

Based on these survey findings, STEPs offers four overall recommendations for NE DHHS regarding coroners in Nebraska:

1. Provide [targeted trainings](#) on drug-involved death investigations. Efforts were planned for 2020, but due to the COVID-19 pandemic, trainings had to be cancelled.
  - a. Trainings should aim to increase county coroners' knowledge about drug-involved death investigations and to build up experiences in new practices.
  - b. Additionally, these trainings could bring awareness of drug use behaviors which could increase how often coroners consider conducting toxicology or autopsies.
  - c. Consider utilizing existing high-quality online medicolegal training programs, particularly if COVID-19 ceases to resolve soon. Virtual training may save time and money for the large number of coroners who live in various parts of Nebraska.
2. Collaborate with [local law enforcement](#) offices, such as sheriff departments, and Nebraska state patrol and police investigators. Throughout survey responses, participants frequently mentioned local law enforcement as a partner in drug overdose death investigations. Working with these additional agencies may provide DHHS with opportunities to increase drug overdose death awareness and utilization of its free toxicology program.
3. Increase [financial support](#) for coroners' services. Typically, factors such as geographic location, population size, and geographical characteristics (urban or rural areas) are used to allocate financial resources. Most coroners indicated they were not familiar with DHHS' program to cover the cost of toxicology testing for suspected drug overdoses. Outreach to counties that are not currently utilizing this program could assist in identifying drug overdose deaths and free up other funds for the county to redirect to other areas of death investigations such as autopsy or pathology. This could improve drug death reporting in the state.
4. Create [a group of medicolegal death investigators](#) or related professionals to support county coroners' personnel needs. As in 2019, coroners this year reported insufficiencies in the number of professionals trained to investigate drug overdose deaths. While it would be very unlikely to supplement the personnel to all counties in need, a centralized state-level resource to help county coroners successfully conduct drug-involved death investigations may be useful. Several other states have both county coroners and medical examiners, including Texas and Missouri.<sup>5</sup>



### Recommendations for Future Research

STEPs recommends the following for future research endeavors:

1. In addition to the annual survey, conduct in-depth, qualitative interviews or focus groups with county coroners. Particularly, invite those coroners who may not be as confident in their individual capacity or are newer to their role. This type of study would provide richer data on the needs and practices of Nebraska coroners in conducting drug overdose death investigations and aid DHHS efforts to prevent drug overdose deaths in the state of Nebraska.
2. Invite local law enforcement (i.e., sheriff departments, state patrol, local police) to participate in surveys, focus groups, or interviews. Respondents frequently mentioned law enforcement as a partner in drug-overdose death investigations and law enforcement insights could present additional opportunities to learn more about the needs for drug-overdose death prevention in Nebraska.
3. Collaborate with NECAA to gain support for survey, interview, and focus group participation. NECAA may be able to encourage county attorneys and related professionals to continue participating in providing feedback to DHHS about their needs.
4. Invite STEPs to attend and evaluate trainings provided by Nebraska DHHS and/or NCAA to assess training processes and outcomes, increase visibility of STEPs and its reports, and share results from 2019 and 2020 reports. Consider inviting STEPs to provide or even present report summaries in order to inform coroners and increase their participation in future research.



1. Qualtrics. (n.d.). Qualtrics Online Survey Software. Retrieved from <https://www.qualtrics.com/research-core/survey-software/>
2. CDC. (2019). Death investigation systems. Retrieved from Center for Disease Control and Prevention website: <https://www.cdc.gov/phlp/publications/coroner/death.html>



## Invitation to the Survey

Dear Nebraska County Attorneys,

Thank you for your service as a county coroner.

The NE Department of Health and Human Services Division of Public Health (NDHHS DOPH) would like to better understand which drugs are threatening our State's residents and how to strengthen and support drug overdose death investigations. This survey seeks to gather your insights on drug overdose death investigation policies, processes, capacities, and challenges.

NDHHS Division of Public Health has partnered with STEPs (Support and Training for the Evaluation of Programs) at UNO on this survey. STEPs will protect your confidentiality by combining your responses with others. Feel free to contact STEPs if you have any questions.

Please follow this link to complete the survey, which should only take about 10 minutes of your time. We thank you for your participation.

Sincerely,

Brittany Willmore, MPA, PLCSW

Pamela Ashley, M.Ed

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## Questions about Coroner Role

Q34 What is the geographic scope of coroner responsibilities in your jurisdiction?

- Single county
- Multiple counties

P1 Who in your county is in charge of making decisions about whether or not to complete death investigations? Please select all that apply.

- County attorney acting as county coroner
- Deputy county attorney acting as county coroner
- Medical examiner
- Pathologist or forensic pathologist
- Other physician (not pathologist or medical examiner)
- Other, please specify \_\_\_\_\_

Q26 Over the past 12 months, approximately how many death investigations were completed in your county? If none, please enter 0.

P2 Of those death investigations in the past 12 months, approximately what percentage were (suspected) drug-involved deaths or drug overdose deaths?

0    10    20    30    40    50    60    70    80    90    100

Drug Involved Deaths



P10 Please indicate the other parties/office partners that typically influence your decision to determine if a certain death is a drug overdose death. (select all that apply)

- State patrol
- Funeral director
- Family physician
- Toxicologist
- Pathologist or forensic pathologist
- Others (please list) \_\_\_\_\_
- None of above





## Questions about Death Investigation Procedure

P3 Of the drug-involved or suspected drug overdoses deaths you investigated in the past 12 months, approximately what percentage did you request a toxicology report?

0 10 20 30 40 50 60 70 80 90 100

Toxicology Report Requested



P4 What are the main reasons you may request a toxicology report for a (suspected) drug-involved or drug overdose death? (select all that apply)

- It is a death related to a crime.
- It is a death related to a car accident.
- The deceased has a drug use/misuse history.
- I'm sure it is a drug overdose death, but not sure which drug is used.
- Not an obvious cause of death or contributing factors.
- The family of the deceased requested further investigation.
- Others (please explain) \_\_\_\_\_

P5 What are the main reasons you may not request a toxicology report for a (suspected) drug-involved or drug overdose death? (select all that apply)

- I'm sure it is a drug overdose death, but do not need to have detailed toxicological information.
- The cause of death does not require a toxicology report (not a crime/accident-related death).
- It is too expensive to request a toxicology report.
- It takes too much time to receive a toxicology report.
- The family of the deceased requests not to conduct a further investigation.
- Others (please explain) \_\_\_\_\_

P2-1 What kind of substances were found to be responsible for the drug-involved deaths or suspected drug overdose deaths that you investigated in the past 12 months. (select all that apply)

- Prescription pain relievers
- Fentanyl
- Heroin
- Cocaine
- Methamphetamine
- Benzodiazepines
- Antidepressants
- Others (please list them) \_\_\_\_\_
- Unknown drugs
- Not applicable



### Questions about Death Investigation Procedure (cont)

P6 On approximately what percentage of (suspected) drug-involved or drug overdose deaths you investigated is a complete autopsy performed?

0 10 20 30 40 50 60 70 80 90 100

Complete Autopsy Performed



P7 If a complete autopsy is not required, how often is a non-mandatory autopsy performed?

- Very often (more than 61%)
- Often (41–60%)
- Sometimes (21–40%)
- Rarely (1–20%)
- Never (0%)

P8 If an optional autopsy was performed for a (suspected) drug-involved or drug overdose death, what is the main reason you requested an autopsy? Please explain.

P9 How often does your office complete death certificates for (suspected) drug-involved or drug overdose deaths prior to receiving all completed investigation reports (toxicology, medical history, autopsy report)?

- Very often (more than 61%)
- Often (41–60%)
- Sometimes (21–40%)
- Rarely (1–20%)
- Never (0%)



## Questions about Training & Confidence

C1 What training(s) have you and/or your designated coroner received for completing death investigations? (select all that apply)

- Mandatory NE State Coroner training
- Online training programs for medicolegal death investigations
- Training programs provided by international/national/regional conferences of Coroners/Medical Examiners
- Certification/degree in medicolegal death investigations
- Others (please list) \_\_\_\_\_
- None of above

C2 Consider the times you encountered a suspected drug-involved or drug overdose in performing a death investigation. How confident were you that you could...

- Not at all confident
- Only slightly confident
- Somewhat confident
- Moderately confident
- Very confident

Know what response to take in situations that arise during the investigation.

o o o o o

Have adequate information and resources to solve most professional problems.

o o o o o

Be aware of all the pertinent issues related to my field of practice. o o

o o o

Help the family of the deceased understand the suspicion of drug overdose death and explain the investigation process.

o o o o o

Network with agencies to coordinate services.

o o o o o

Q33 In your opinion, how much has your community been affected by drug-involved or drug overdose deaths?

- Not at all affected
- Only slightly affected
- Somewhat affected
- Moderately affected
- Very affected



## Questions about Needs

Q29 How often does your department face insufficiencies in the following financial resources when completing drug-involved or drug overdose death investigations?

- Never
- Rarely
- Sometimes
- Often
- Very often

Budget to cover cost of death investigations

0 0 0 0 0

Budget to cover cost of autopsies

0 0 0 0 0

Budget to cover pathology tests

0 0 0 0 0

Budget to cover toxicology tests

0 0 0 0 0

Budget for administrative/medicolegal investigation expenses

0 0 0 0 0

## Questions about Human Resources

Q30 How often does your department face insufficiencies in the following human resources when completing drug-involved or drug overdose death investigations?

- Never
- Rarely
- Sometimes
- Often
- Very often

Staff available to conduct death investigations

0 0 0 0 0

Training for staff in death investigations

0 0 0 0 0

Staff knowledgeable about death investigations

0 0 0 0 0

Staff experienced with conducting death investigations

0 0 0 0 0

Training for NE county attorneys/coroners in medicolegal death investigation

0 0 0 0 0



## Questions about Challenges in Completing Drug Overdose Death Investigations

Q32 How often does your department face each of the following challenges in completing drug-involved or drug overdose death investigations?

- Never
- Rarely
- Sometimes
- Often
- Very often

Dispute about whether or not to conduct a drug-involved/drug overdose death investigation

Concerns that the results of drug-involved/drug overdose death investigation will impact our jurisdiction negatively

## Additional Questions

N4 What else would you like to say in regards to the needs of coroners across Nebraska in responding to drug-involved or drug overdose death investigations?

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Q27 DHHS has a program for toxicology screenings on any (suspected) drug-involved or drug overdose death free of cost, regardless of the final results. Select the item that best describes you.

- I am not familiar with the DHHS toxicology screening program.
- I am familiar with the DHHS toxicology screening program, but have not used it.
- I am familiar with and have used the DHHS toxicology screening program.



## Demographics

D1 What is your age?

- 20–29 years
- 30–39 years
- 40–49 years
- 50–59 years
- 60 years and above

D2 What is your gender?

- Male
- Female
- I prefer not to say

D3 How many years have you worked as a county coroner?

- Under 1 year
- 1–5 years
- 6–9 years
- 10 or more years

D4 Which behavioral health regions does your office serve?

- Region 1 – Banner, Box Butte, Cheyenne, Dawes, Deuel, Garden, Kimball, Morrill, Scotts Bluff, Sheridan, Sioux
- Region 2 – Arthur, Chase, Dawson, Dundy, Frontier, Gosper, Grant, Hayes, Hitchcock, Hooker, Keith, Lincoln, Logan, McPherson, Perkins, Red Willow, Thomas
- Region 3 – Adams, Blaine, Buffalo, Clay, Custer, Franklin, Furnas, Garfield, Greeley, Hall, Hamilton, Harlan, Howard, Kearney, Loup, Merrick, Nuckolls, Phelps, Sherman, Valley, Webster, Wheeler
- Region 4 – Antelope, Boone, Boyd, Brown, Burt, Cedar, Cherry, Colfax, Cuming, Dakota, Dixon, Holt, Keya Paha, Knox, Madison, Nance, Pierce, Platte, Rock, Stanton, Thurston, Wayne
- Region 5 – Butler, Fillmore, Gage, Jefferson, Johnson, Lancaster, Nemaha, Otoe, Pawnee, Polk, Richardson, Saline, Saunders, Seward, Thayer, York
- Region 6 – Cass, Dodge, Douglas, Sarpy, Washington

