

Drug Overdose Prevention—Coroners' Study

# Assessing Coroners' Needs

August 2021

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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 third 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 13, 2021 and closed it on August 17, 2020. 22 coroners fully or partially completed the survey, resulting in a response rate of 22%. Coroners from each behavioral health region submitted responses.



## 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 varied 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.



## Overview of Recommendations

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

1. Continue outreach efforts to educate NE coroners on available services, resources, and supports.
2. Provide targeted training on drug-involved death investigations and evaluate those trainings for effectiveness and usefulness.
3. Continue to seek out financial support for coroners, including funding to support administrative or medicolegal investigation expenses, costs of autopsies, and other related items.
4. Advocate for a medicolegal work group to support state efforts on overdose death investigations.



## Sampling

STEPs located names and contact information for Nebraska's attorneys via the Nebraska County Attorney Association (NECAA) website. At the time of the survey, there were 91 county attorneys serving 93 counties in Nebraska. Throughout the course of this study, STEPs obtained updated contact information for counties with new attorneys and resent surveys.

The research plan included advertising for the survey at a DHSS Coroner Training via flyers. Based on prior experiences implementing surveys with county coroners, this year's survey included an incentive lottery to increase participation. STEPs implemented the survey online in Qualtrics and sent multiple reminder messages to gain responses.

STEPs administered the survey on June 13, 2021 and closed it on August 17, 2021. During this period, 22 coroners completed or partially completed the survey, resulting in a response rate of 22%. Respondents represented each of the behavioral health regions, although only one respondent represented Region 6.



## Survey Items

The 34-item survey was a combination of close-ended, open-ended, and scaled questions that focused on six topic areas, including two new topics this year (in bold):

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.
5. **Toxicology program utilization.**
6. **Community of Practice (CoP) participation and recommendations.**

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



## Differences between the 2021 and Prior Survey Items

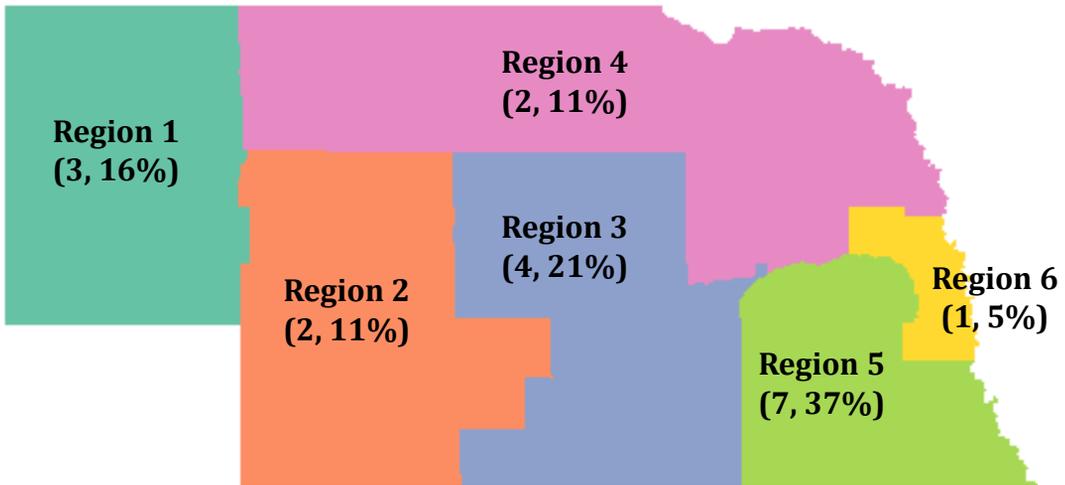
The principle for designing the 2021 survey questionnaire was to maintain the continuity of the survey by utilizing as many of the previous year's survey items as possible. STEPs revised some survey items to make them more categorical (from open response) and to include new items on the topic of toxicology services and the Community of Practice (CoP). The summary of the significant changes are listed here:

1. Two questions were added to capture information on toxicology program utilization.
2. Four questions were added to investigate CoP participation and recommendations for future meetings.
3. Several questions on death investigations and autopsies were new or expanded, including, categorical questions about reasons for not requesting autopsies.
4. A few items were removed that had not produced relevant findings or were captured using other altered questions.

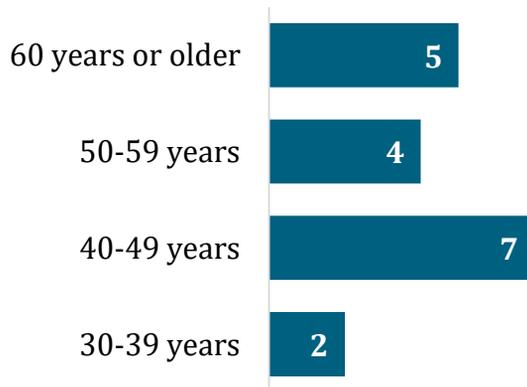


## Sample Description

The survey received 19 complete responses. Each behavioral region was represented in the survey, however Region 6 only had one respondent. This map shows the number of respondents in each region and the percentage of the survey respondents that they represent.



Survey responses were from 11 males (58%), 7 females (37%), with ages ranging from “30–39 years” to “60 years or older.”



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





## County Responsibilities

Because of small county populations, some county attorneys have jurisdiction in multiple counties. Of the 21 respondents who answered this question, 20 (95%) were responsible for coroner duties in one county. Only one county attorney reported having multiple county responsibilities.



## Role of County Coroner

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. 20 coroners (100%) responded that the county attorney was acting as the county coroner, and 7 (35%) indicated that the deputy county attorney was also acting as the county coroner.

Role	# of Respondents
County attorney acting as county coroner	20
Deputy county attorney acting as county coroner	7



# DHHS Post-Mortem Toxicology Testing Program

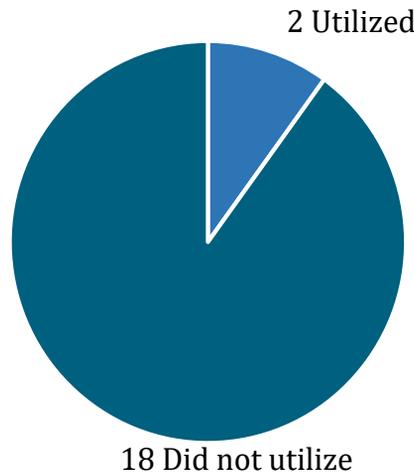




## DHHS Post-Mortem Toxicology Testing Program—NEW

18 of the 20 responding county coroners (90%) said they have not utilized DHHS' free Post-Mortem Toxicology Testing program, for any/all toxicology report request. Only two county coroners reported they had utilized the program. The following question responses shows that not all respondents were aware or had used the program.

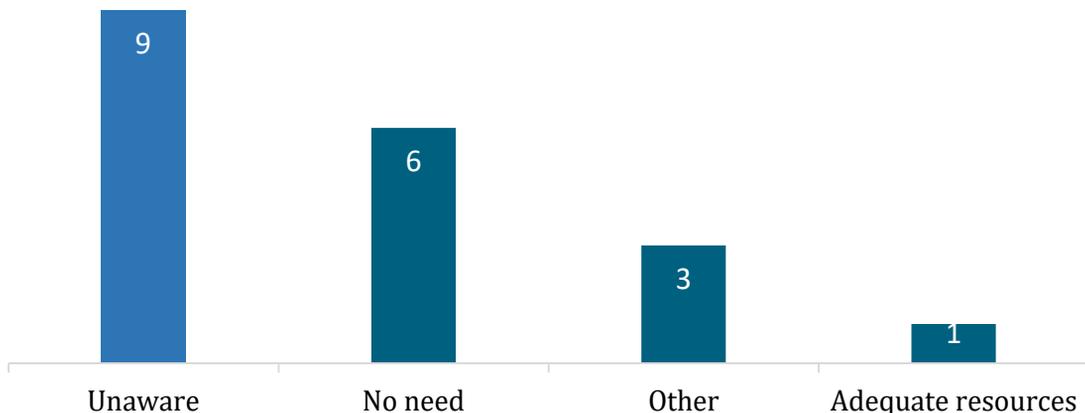
### Utilization of DHHS Toxicology Testing Program



## Reason Not Utilizing DHHS' Toxicology Testing Program—NEW

At this early stage of the program, it is important to understand awareness of services as well as other alternative options that continue to be in use. Coroners who had not used DHHS' Toxicology Testing Program indicated the reason for not utilizing the tool. County coroners reported the main reason they did not use the program was because they were not aware of the program (n=9) or did not have the need or opportunity to use it (n=6). One respondent indicated they have adequate resources for testing. Of coroners who indicated "other," one said, "I do not have anyone who can collect the samples needed for the DHHS program." Another stated, "My pathologist uses a different lab."

### Reason for Not Utilizing DHHS' Toxicology Testing Program





## Toxicology Reports

18 respondents reported that their **top three driving forces** to request a toxicology report was a death related to a crime, car-related deaths, or deaths that have no obvious cause (83%). Other reasons included the deceased’s history of drug abuse (72%), identifying which drug caused the overdose (56%), and the family of the deceased requested further investigation (22%).

Reason	# of Respondents
It is related to a crime	15 (83%)
Car-related deaths	15 (83%)
Deaths with no obvious cause	15 (83%)
Deceased’s history of drug abuse	13 (72%)
Identifying which drug caused the overdose	10 (55%)
Family of deceased requested further investigation	4 (22%)

## Why Not Request a Toxicology Report?

**Most of the 18 responding county attorneys answered they do not request a toxicology report if the death is not related to a crime (67%).** County attorneys also reported not needing detailed toxicology information (22%), families requesting not to investigate further (17%), and other (17%) as reasons to not order toxicology reports. Another reason was toxicology reports take too long to receive (6%).

Reason	# of Respondents
The death is not related to a crime	12 (67%)
There is no need for a detailed toxicology report	4 (22%)
Family requested to not investigate further	3 (17%)
Other	3 (17%)
Reports take too long to receive	1 (6%)

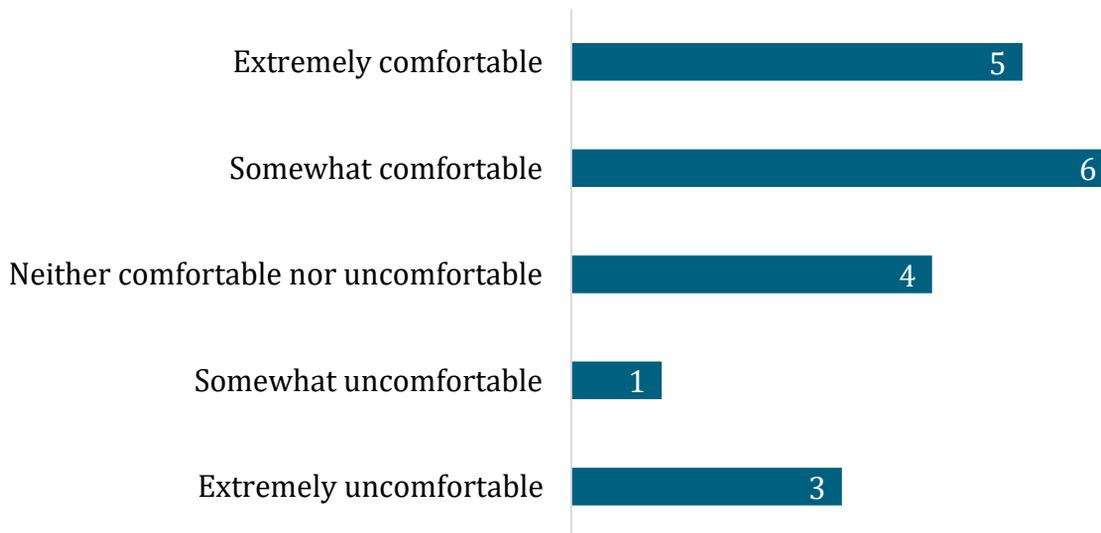


## Coroners' Comfort Level Interpreting Toxicology Results Without Autopsy—NEW

This question was not attributed to a specific testing program (DHHS or other used). While this question was broadly related to toxicology results and not directly to the new program, it provides insight into the needs of coroners surrounding the translation of those results into decision-making.

**When no autopsy is performed, most coroners felt either extremely (n=5) or somewhat (n=6) comfortable interpreting toxicology results.** On the reverse, several were either extremely uncomfortable (n=3) or somewhat uncomfortable (n=1) interpreting those results, while four respondents were neither. Overall, 42% (n=8) indicated that they were in some form not comfortable interpreting the toxicology results.

### Comfort Level in Interpreting Toxicology Results without Autopsy





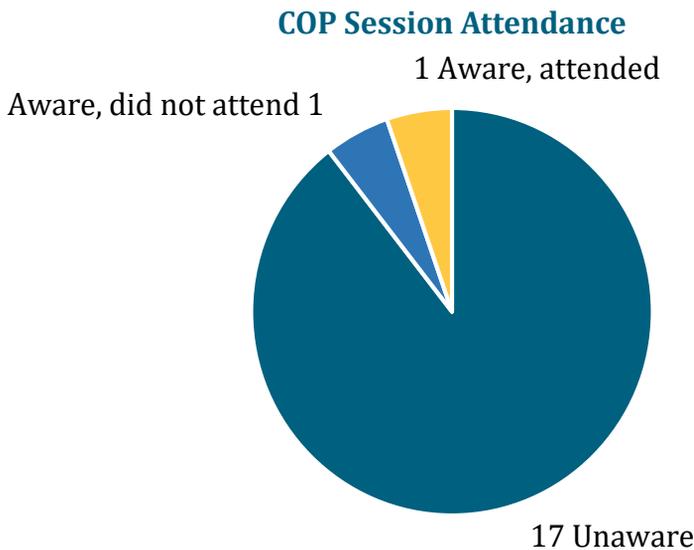
# Community of Practice (CoP) Meetings





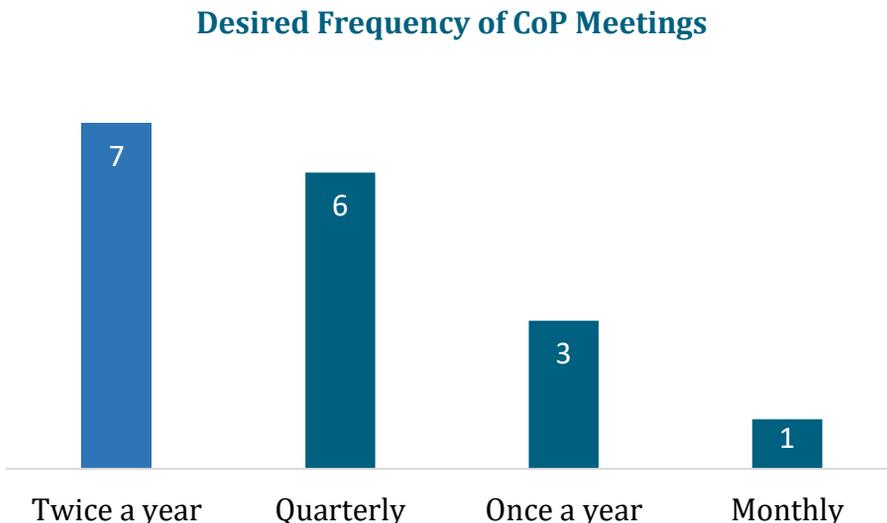
## Community of Practice Session Attendance

Communities of Practice (CoPs) work to strengthen public health as members learn, share expertise, and work together on solving common problems in their communities' focus areas. Through the local health departments in NE, CoPs offer sessions on strategic planning and implementation efforts. When asked if coroners had attended a COP session, almost all participants (n=17) indicated they did not know about the COP sessions. One (5%) coroner reported they were aware of COPs, but had not attended a session, while another (n=1) stated they had attended a COP session.



## Frequency of Future CoP Meetings

When asked about how often they would like COPs to meet, 7 of the 17 responding coroners (41%) reported twice a year and 6 (35%) reported quarterly. Others (n=3) indicated once a year, and 1 (5%) indicated monthly.

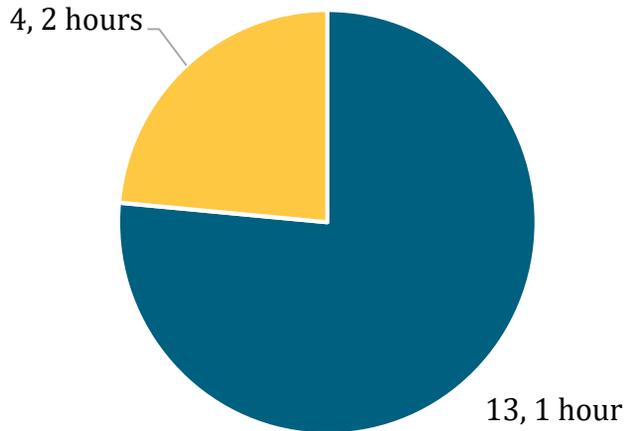




## Length of Future CoP Meetings

13 (76%) of 17 coroners said they would want the meetings to be 1 hour long. Four (24%) indicated 2 hours.

Desired Length of CoP Meetings



## CoP Meeting Topics

When asked if any of these topics or meeting items would be useful to include during CoP meetings, coroners were most interested in receiving some type of training ( $m=71.3, SD=15.9$ ) during the meetings. Less useful to respondents were presentations on relevant topics and informational updates from DHHS, followed by opportunities to network and time to problem solve cases. Answer choices were given from a scale of 1–100, with 100 being the most useful.

Potential Meeting Topic	Usefulness Mean (SD)
Trainings	71.3 (15.9)
Presentations on relevant topics	59.3 (22.5)
Informational updates from DHHS	56.5 (19.2)
Time to problem solve cases	48.9 (28.8)
Opportunities to network	48.3 (30.2)

\*Not at All Useful (0) --- Extremely Useful (100)



# Death Investigation and Autopsy— New Survey Items





## Deaths Routinely Investigated—NEW

County attorneys reported the top three causes of death they routinely investigate are known or suspected non-natural deaths, unexpected or unexplained deaths when in apparent good health, and deaths of persons not in physician care (n=15). Unexpected or unexplained death of infants or children and deaths occurring under unusual or suspicious circumstances (n=14) were reported next, followed by deaths due to violence and deaths of persons in custody (n=13). Eight participants reported they routinely investigate deaths known or suspected to be caused by diseases constituting a threat to public health. Four participants indicated other deaths, mentioning, *All unintended where a physician will not sign certificate* and *unattended deaths*.

Deaths Routinely Investigated	# of Respondents
Non-natural deaths	15
Unexpected deaths when in good health	15
Non-physician care deaths	15
Unexpected deaths of infant/child	14
Suspicious circumstances	14
Deaths due to violence	13
Death of person in custody	13
Death caused by diseases of threat to public health	8
Other	4



## Deaths Autopsies Routinely Ordered—NEW

The most frequent death autopsies routinely ordered were for deaths known or suspected to have been caused by apparent criminal violence, unexplained/unexpected death of an infant or child, deaths apparently non-natural and in custody of a local, state, or federal institution, and in order to determine cause or manner of death, or document injuries/disease, or collect evidence (n=16). More deaths are detailed in the following table below. Four participants indicated other reasons. One said:

*I wouldn't say anything is routine because we do about 2-3 autopsies a year. They have been for a death in the apprehension of a criminal, a drowning, and anything else where there is not a apparent reason for the death (especially if the decedent is "young").*

Another coroner stated, *"Deaths related to underlying health issues [...and] none of these are routine, but would be investigated under those circumstances."* Yet another expressed that, *"None of the above are routine, but would be investigated under those circumstances."*

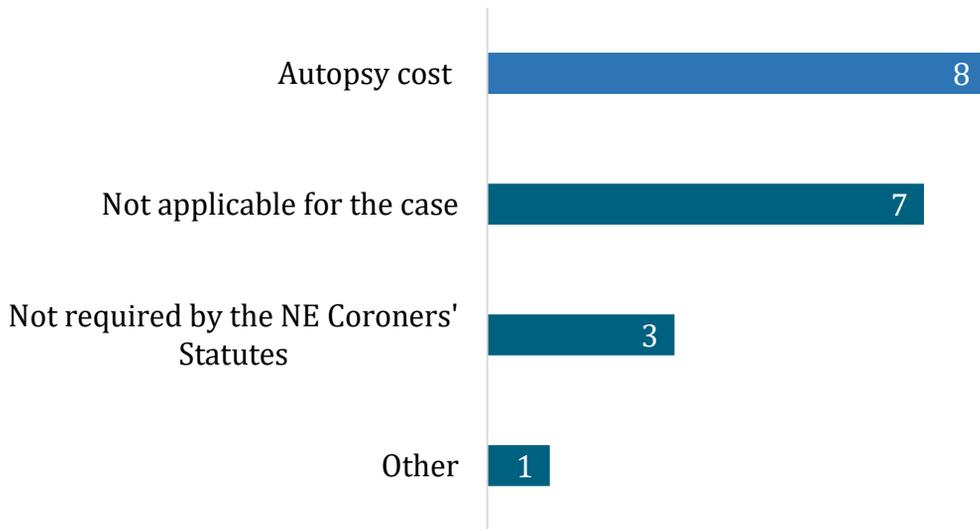
Autopsies Routinely Ordered	# of Respondents
Death due to violence	16
Unexpected deaths of infant/child	16
Death of person in custody	16
To determine cause of death/collect evidence	16
Motor vehicle deaths	15
Document injuries/determine manner of death	15
Deaths associated with police action	14
Death by intoxication by alcohol, drugs, poison	13
Body is charred	11
Body is skeletonized	11
Death by unwitnessed/suspected drowning	11
Acute work injury death	8
Death by apparent electrocution	5
Other	4



### Counties' Primary Barriers to Ordering Autopsies—NEW

When no autopsy is ordered, 8 of 19 responding county coroners (42%) said autopsy cost was a primary barrier that prevented their county from ordering an autopsy. 7 (37%) coroners indicated it was not applicable to the case(s) as primary barriers. Other respondents reported an autopsy is not required by the Nebraska Coroners Statues (n=3, 16%). One county corner indicated "other," stating, "*Cause of death can be determined to a reasonable degree of certainty through investigation.*"

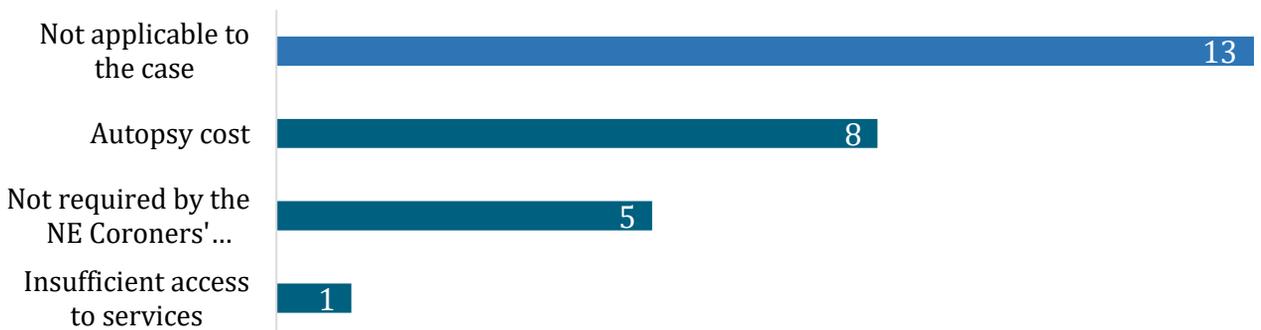
Primary Barriers to Ordering Autopsies



### Other Barriers to Ordering Autopsies—NEW

STEPS asked coroners about other barriers to ordering autopsies. Most county coroners indicated "not applicable to the case(s)" (n=13) as a barrier to ordering autopsies. Other barriers preventing counties from ordering autopsies were cost of autopsy (n=8) and autopsies are not required by the Nebraska Coroners Statues (n=5). 1 participant indicated insufficient access to forensic pathology/autopsy services as another barrier to ordering autopsies.

Other Barriers to Ordering Autopsies

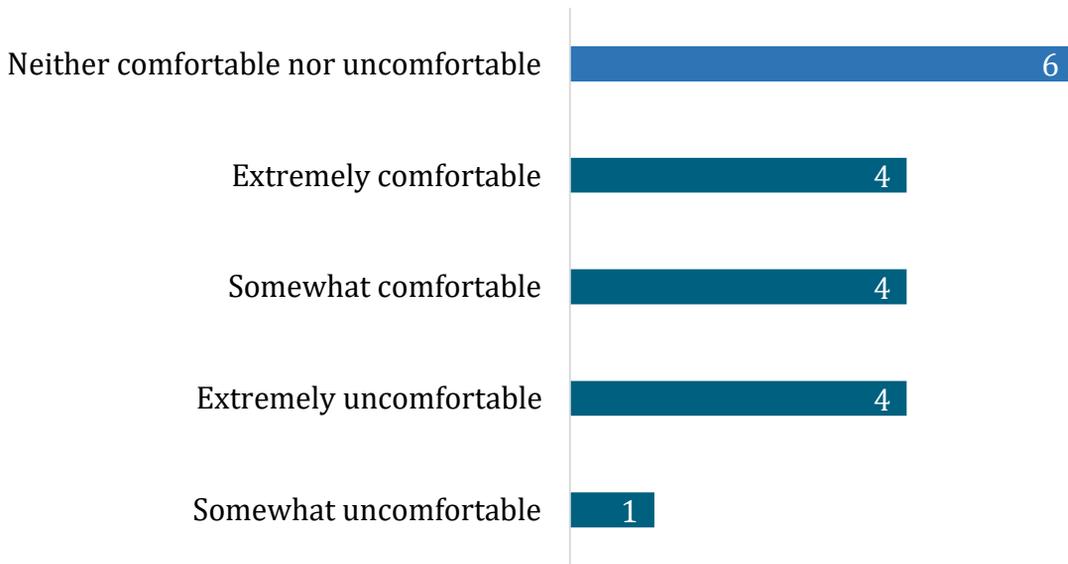




## Coroners' Comfort Level Certifying Cause of Deaths Without Autopsy—NEW

When no autopsy is performed, most county coroners felt neither comfortable nor uncomfortable certifying cause of death (n=6). Four (21%) respondents indicated they felt extremely comfortable certifying the cause of death when no autopsy is performed. Four (21%) coroners reported they were somewhat comfortable. One (5%) county coroner reported they were somewhat uncomfortable, while four (21%) reported they were extremely uncomfortable certifying the cause of death without an autopsy performed. Only 42% were either somewhat or extremely comfortable certifying cause of deaths without autopsy.

### Certifying Cause of Death without Autopsy Comfort Level

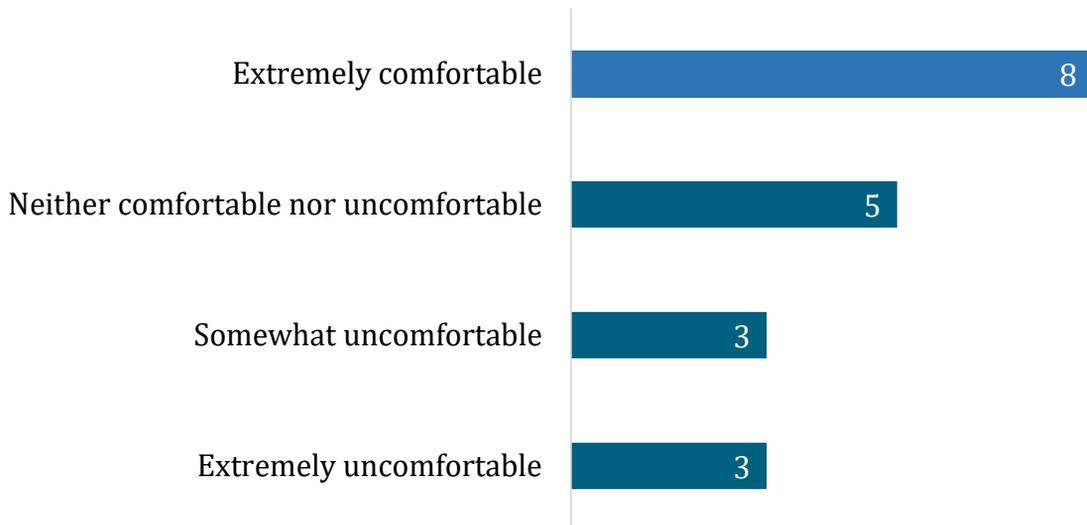




## Coroners' Comfort Level Certifying Manner of Death Without Autopsy—NEW

When no autopsy is performed, the majority of responding coroners indicated they felt extremely comfortable (n=8) in certifying the manner of death. Other coroners reported they felt neither comfortable nor uncomfortable (n=5) when certifying the manner of death without an autopsy. There was a split between coroners stating they felt somewhat (n=3) and extremely uncomfortable (n=3) certifying the manner of death without an autopsy being performed. Only 42% of respondents indicated they were comfortable (somewhat or extremely) in certifying manner of death without an autopsy.

### Comfort Level Certifying Manner of Death without Autopsy





# Survey: Repeat Questions for Annual Comparison of Death Investigations, Needs, and Other Topics





## Drug-Involved Death Investigation Practices

County attorneys answered that they completed an average of just over 10 death investigations ( $m=10.5$ ,  $SD=7.1$ ) over the past 12 months, with responses ranging from 1–25 death investigations per year. This range and average was smaller than the prior report due to a significant outlier in the 2020 data.

Of those deaths investigated, county attorneys answered that, on average, only 11% were related to a drug overdose ( $m=10.8$ ,  $SD=14.4$ ). This is consistent with both prior reports, 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 2021 survey, and of those deaths, the average percent of those that were drug related.

Region	Average Number of Deaths	Average % of Drug-Related Deaths
Region 1	6.5	20%
Region 2	1.5	0%
Region 3	10.3	0%
Region 4	17.5	5%
Region 5	14.0	18%
Region 6	10.0	10%



## Substances Found in Drug-Involved Death Investigations

The substances most frequently found in the drug-involved death investigation process were methamphetamines (8), prescription pain relievers (4), and fentanyl (3). Other substances mentioned were heroin, benzodiazepines, unknown drugs, and other such as alcohol. In the past 12 months, five (71%) coroners had noticed a notable change in substances, two (30%) mentioned increased fentanyl use, and one also mentioned opioids.

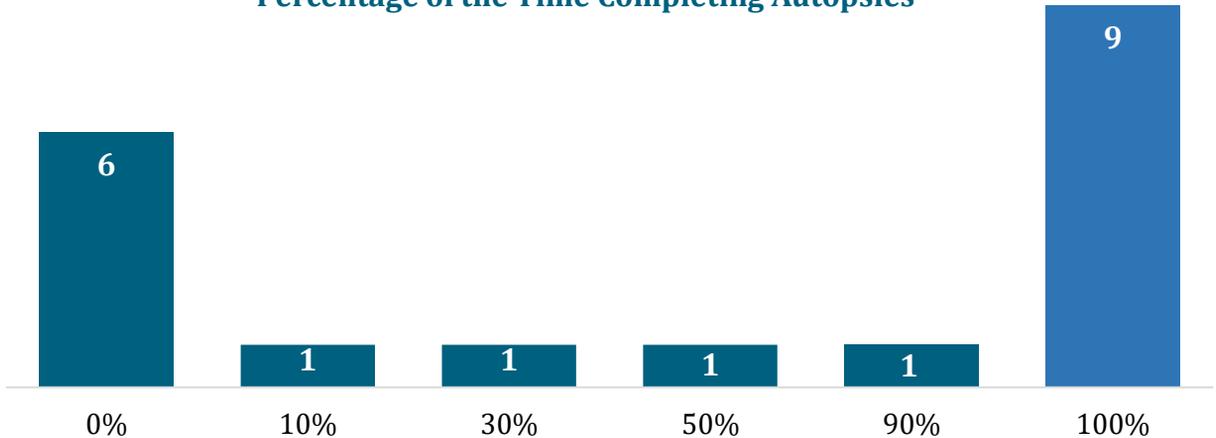
Name of Drug	# of Respondents
Methamphetamine	8
Prescription pain relievers	4
Fentanyl	3
Heroin	1
Benzodiazepines	1
Unknown drugs	1
Other	1



## Autopsy

Half of the 18 coroners reported requesting an autopsy 100% of the time. Of the other county attorneys who reported requesting an autopsy, six (33%) indicated they never request an autopsy, with one response across the rest of the response options ranging 10–90% of the time. These results are strikingly similar to prior surveys in that attorneys vary widely on how often they request autopsies.

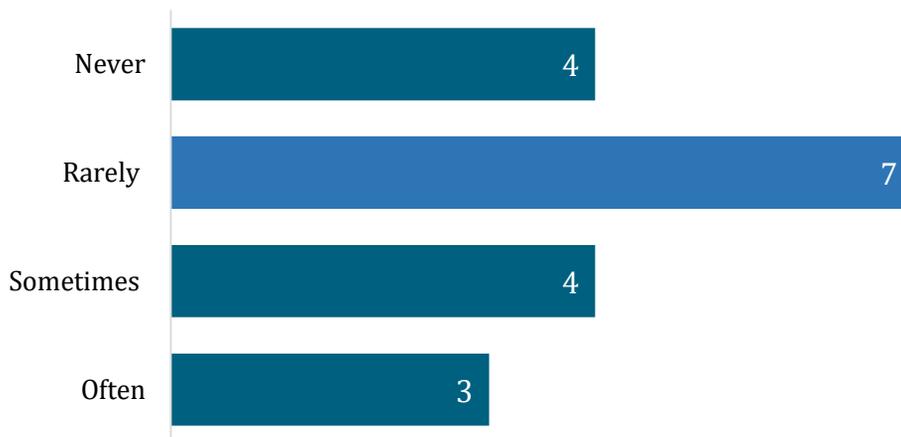
Percentage of the Time Completing Autopsies



## Non-Mandatory Autopsy Performed

Seven of the 18 responding county coroners (40%) said if an autopsy is not required, a non- mandatory autopsy is rarely performed. Four respondents (22%) said non-mandatory autopsies are never performed. However, four respondents (22%) indicated non-mandatory autopsies are sometimes performed, and three respondent (16%) said non-mandatory autopsies are 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

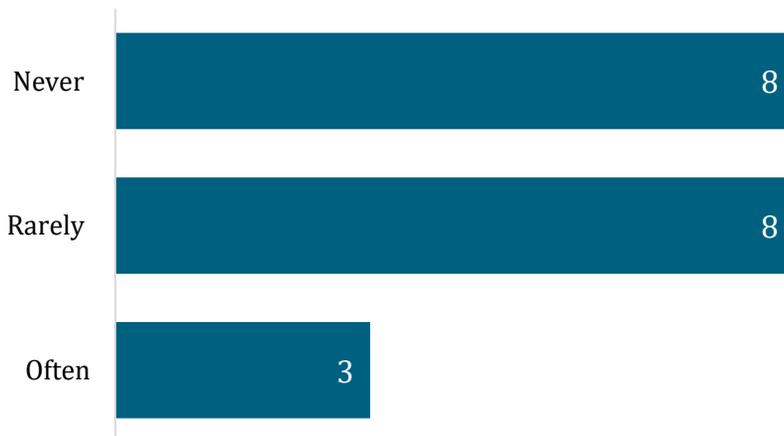




## Death Certificates

Among the 19 responding coroners, eight (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). Eight respondents (42%) said their office *rarely* completed them without all necessary data. However, three respondents (16%) said their office *often* completed death certificates for (suspected) drug-involved or drug overdose deaths prior to receiving all investigation reports. These findings are consistent with 2019 and 2020 data.

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

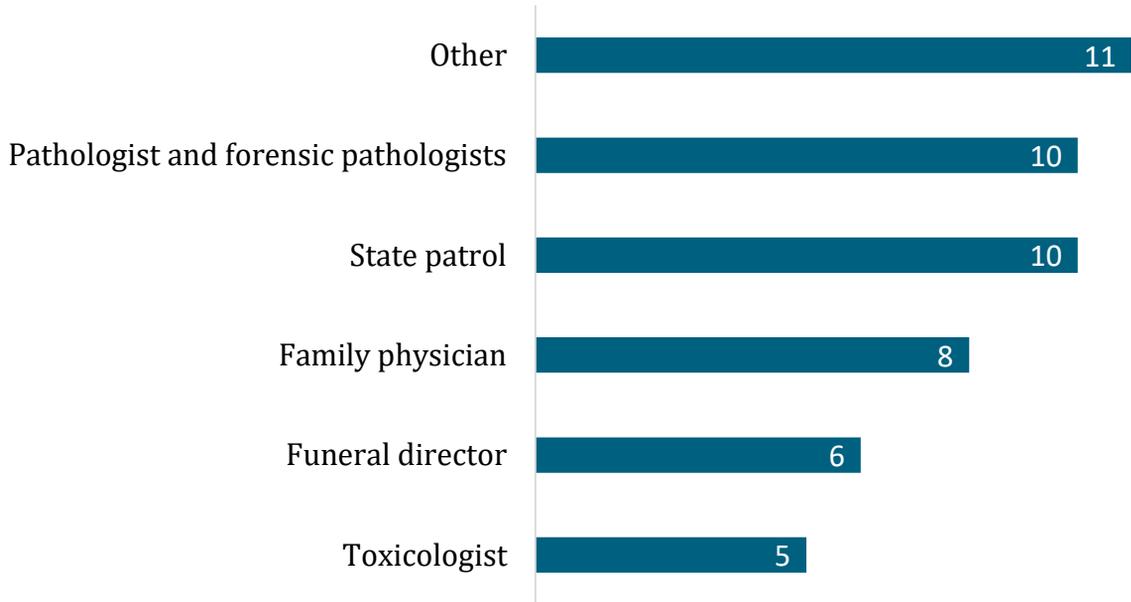




## Other Decision Makers

Among the 19 county attorneys who stated that they consult with other agencies to assist them in drug overdose death investigations, the most frequently named partners were “other” (58%), such as *local law enforcement and sheriff’s office*, pathologists and forensic pathologists (53%), and state patrol (53%). Other parties included family physician, funeral director, and toxicologist.

### Most Frequent Partners in Death Investigations





## 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.

**Based on 18 responses, the two areas that coroners reported the highest confidence (very or moderately confident) were 1) network with agencies to coordinate services (n=13) and 2) network with agencies to coordinate services (n=10).**

### Areas of Confidence Among Coroners

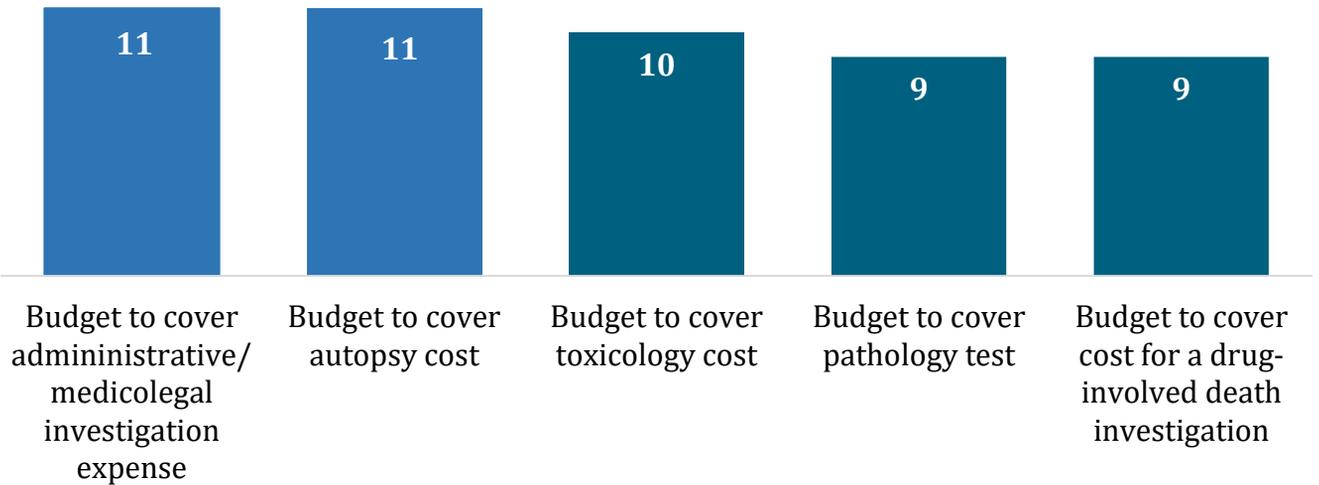




## Barriers in Completing Drug-Involved Death Investigations

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 two major barriers identified: 11 (58%) of the 19 coroners indicated budget to cover administrative/ medicolegal investigation expense along with budget to cover autopsy tests.** Ten (53%) of 19 coroners indicated budget to cover toxicology cost as a barrier. Nine (50%) of 18 coroners said budget to cover pathology tests were a barrier. Nine (47%) of the 19 coroners said budget to cover cost for a drug-involved death investigation was a barrier they faced.

**Budget Needs for Drug-Involved Death Investigations**





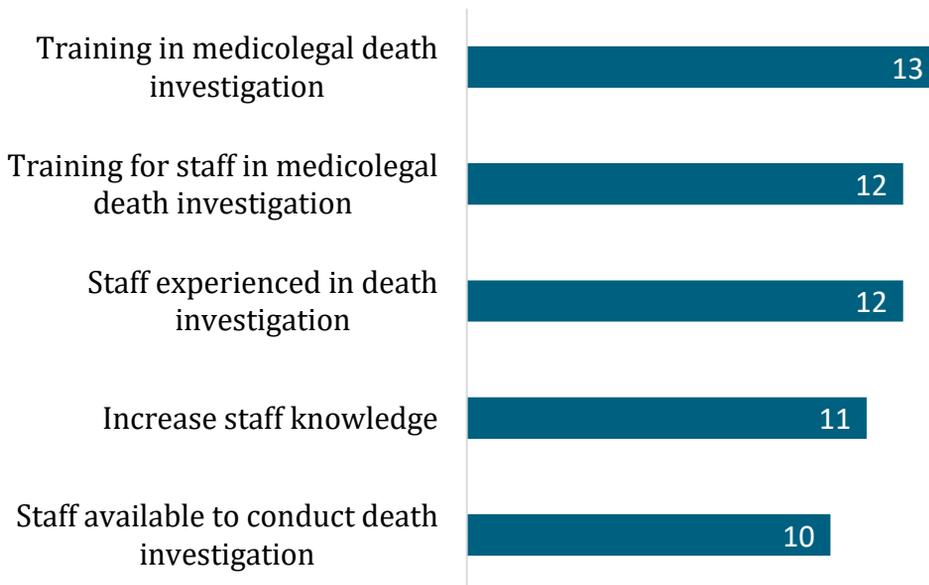
## Needed Resources

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 space/facilities to conduct death investigations.** The responses show the most frequently cited needs for county coroners. Thirteen (68%) of the 19 county coroners wanted more training in medicolegal death investigations. Twelve (63%) indicated they needed training for staff in death investigations. Twelve (63%) said they needed staff experienced in conducting death investigations. Eleven (58%) coroners indicated they needed increase staff knowledge about death investigations. Ten (53%) said they needed staff available to conduct death investigations.

These findings are consistent with prior surveys indicating training and personnel as a constant need in the coroner community.

### Most Frequently Listed Needs for Coroners





### Summary of Findings

Out of 91 coroners, STEPs received 19 complete responses and two partially completed surveys of usable data, thus sample sizes varied from 21 and lower for each item. Of completed responses, respondents consisted of 14 males, 6 females, and 1 person who preferred not to disclose their sex. The ages of responding coroners varied from 30 to 60 years 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 indicated they utilized their deputy county attorney for coroner duties.

The DHHS post-mortem toxicology testing program was only utilized by a few respondents, however, over half were aware of the program. While a significant number were unaware of the program, this survey may have aided in informing those of that program. Unique reasons for not utilizing the service are reported in the summary and will be further explored in a newly developed toxicology survey in 2021–2022. Reasons that respondents utilized toxicology reports were related to a crime, car accident, or no obvious cause of death. A newly developed question helped to show that over 40% of coroners were not comfortable interpreting toxicology test results.

Communities of Practice (CoP) meetings held by local public health departments have grown in Nebraska over the past year. Respondents largely indicated that they were not aware of the meetings, with a few aware and one having attended. When asked to provide input into future meetings, most indicated they would like meetings either twice a year or quarterly, and for those meetings to last about an hour. Respondents also indicated that those meetings would be a good venue for trainings, presentations on relevant topics, or informational DHHS updates.

New survey questions on autopsies and death investigations were also included in this survey. Investigation areas were a newly expanded question, and respondents indicated each of the areas broadly—validating the inquiry about the broad investigative issues that their offices face. Criminal violence, unexplained/unexpected death of a child, non-natural deaths, and others were the main reasons an autopsy were routinely ordered. Respondents indicated barriers to ordering an autopsy were primarily cost, but also not being required by NE coroner statutes. Less than half of respondents were comfortable certifying cause of death or manner of death without an autopsy.

County coroners answered that they completed an average of 11 death investigations over the last 12 months, and the county counts varied less than the prior reporting period. Of the deaths which occurred in their county, respondents indicated about 1 in 10 was drug overdose-related. Of drug overdose deaths, methamphetamines, followed by prescription pain relievers were most frequently cited as the cause of death. Fentanyl was also a noted growth area for specific substances.



### Summary of Findings (cont.)

Like prior surveys, coroner respondents diverged in their frequency of autopsy requests. Nearly half always requested an autopsy while a third or more almost never requested an autopsy. When non-mandatory autopsy is the investigation trajectory, 40% indicated they rarely perform or order an autopsy.

Other features of death investigations were also explored in the survey. Among respondents, most indicated hesitancy in completing a death certificate until all the reports (including toxicology, medical history, or autopsy) were completed. Respondents indicated that others were involved in the decision-making process, most often local law enforcement, pathologists and forensic pathologists.

Confidence continued to be high in five key areas relating to their work. High confidence was noted 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.

Most county coroners reported they most frequently face barriers and insufficiencies in 1) the budget for the cost to cover administrative/medicolegal investigation expenses, 2) budget for autopsies, 3) budget to cover toxicology and pathology tests, and 4) overall costs for drug-involved 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.



### 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 remains low, as in prior years. In the future, further efforts to engage the NECAA for support of the survey may be useful. **Regionally the responses are unbalanced and not necessarily representative of all the counties, particularly those with higher populations and more overdose death investigations (e.g., Region 6 respondents have varied widely across the survey years).** Drawing general conclusions from such a small sample size is difficult without adequate and proportional representation from each region. STEPs recommends collaborating with NECAA to reach a greater number of county attorneys to participate in future surveys.
2. The survey was slightly longer than in the past, however, questions were more diverse in certain areas new to the needs assessment. However, this survey method (i.e., multiple choice or short answer) does limit 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 and fluid situations in funding and overdose deaths. Future studies could include content analysis of death certificate information.
4. Questions about CoP and DHHS' Toxicology Testing Program were new to a significant number of respondents, so some were using their "best guess" in responding. In the future, for example, participants who have utilized the toxicology program services or attended a CoP meetings should be a targeted group for surveys.



## Recommendations

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

1. Continue outreach efforts to educate Nebraska coroners on services, resources, and supports available to them at little to no cost. Further, due to changes in staffing, these outreach efforts should be regular and systemized to promote utilization.
  - a. While Post-Mortem Toxicology Testing Program services may have been thoroughly advertised by this point, ongoing efforts are needed to inform coroners of this program. Critical examination of these services and why or why not they are utilized should continue, for example ensuring that coroners have staffing to collect the necessary samples for the testing.
  - b. CoP meetings have only begun to penetrate regions and using the feedback from survey participants may aid engagement in those meetings. For example, planning future CoP meetings at the timing recommended via the survey, or providing trainings within those meetings might be successful.
2. Provide [targeted trainings](#) on drug-involved death investigations and evaluate those trainings for effectiveness and usefulness. Due to the COVID-19 pandemic, trainings scheduled were delayed, however as these resume, continuous efforts should be made at providing critical trainings to this typically strained group.
  - 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. Virtual training may save time and money for the large number of coroners who live in various parts of Nebraska.
3. Continue to seek out increased financial support for coroners, including funding to support administrative or medicolegal investigation expenses, costs of autopsies, and other related items. As knowledge of the toxicology program expands, and some costs shift in budgets, it will be important to revisit these needs in future surveys.
4. In preparation for this survey, further efforts were made to evaluate the process for creating [a group of medicolegal death investigators](#) or related professionals to support county coroners' personnel needs. Again, this need was identified in the survey and should continue to be sought as a necessary resource to the state's prevention efforts.



### 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 all three years of the survey. Consider inviting STEPs to provide or even present report summaries in order to inform coroners and increase their participation in future research.



1. Wilmore, B., Fraire, L., Ashley, P., Banman, A., & Harder, J. (2020) *Assessing coroners' needs*. Omaha, NE: STEPs
2. Willmore, B., B. Shine, C., & Harder, J. (2019). *Assessing coroners' needs*. Omaha, NE: STEPs.
3. Qualtrics. (n.d.). Qualtrics Online Survey Software. <https://www.qualtrics.com/research-core/survey-software/>
4. National Vital Statistics System. (2019, May 6). Centers for Disease Control and Prevention website: <https://www.cdc.gov/nchs/nvss/index.htm>
5. Willmore, B., B. Shine, C., & Harder, J. (2019). *Drug overdose death investigation*. Omaha, NE: STEPs.
6. CDC. (2019). Death investigation systems. 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. Your input is highly needed!

The survey below will help inform death investigations, toxicology program usage, and future community of practice planning. Please take a few moments to reply!

**\*\*Completion of the survey will enter you into a drawing for 1 of 5 -- \$10 Amazon gift cards.\*\***

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. Survey completion will automatically enter you into the drawing! Funds for the drawing come from STEPs.

Sincerely,

Aaron Banman, PhD

Faculty Fellow at STEPs

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## Questions about Coroner Role

Q2 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 \_\_\_\_\_

Q3 Over the past 12 months, approximately how many death investigations were completed in your county? If none, please enter 0.

Q4 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 DHHS Post-Mortem Toxicology Testing Program

Q6 Did you utilize the DHHS Post-Mortem Toxicology Testing program, available for free, for any/all of those toxicology report requests?

- Yes, all
- Yes, some
- No, none

Q7 If you did not use the DHHS Toxicology Testing program, what may have kept you from doing so? (select any that apply)

- I was not aware of the program
- I have adequate resources for testing
- Did not need/no opportunity to use
- Other

### Questions about Community of Practice (CoP)

Q26 Local Health Departments in NE have been implementing Community of Practice (CoP) sessions surrounding strategic planning and overdose prevention efforts. As defined by the CDC, Communities of Practice (CoPs) are working to strengthen public health as members learn, share expertise, and work together on solving common problems in their communities' focus areas.

With this in mind:

Have you attended a local Community of Practice meeting organized by your local health department?

- I have attended a CoP meeting
- I know about the CoP meetings but have not attended
- I do not know about the CoP meetings

Q27 Thinking about the future of these meetings. How often would you like the Community of Practice to Meet?

- Monthly
- Bi-Monthly
- Quarterly
- Twice a Year
- Once a Year



## Questions about Community of Practice (CoP) (Cont)

Q28 How long would you like each of these Community of Practice meetings to run? (Based on your last response of frequency)

- 1 hour
- 2 hours
- More than 2 hours

Q29 Tell us if any of these topics would be useful to include in the meetings:

Not at all useful    Slightly useful    Moderately useful    Very useful    Extremely useful

	Not at all useful	Slightly useful	Moderately useful	Very useful	Extremely useful
Presentations on relevant topics ()					
Trainings ()					
Opportunities to network ()					
Time to problem solve difficult cases with colleagues ()					
Informational updates from DHHS to inform your work ()					



## Questions about Death Investigation Procedure

Q5 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) \_\_\_\_\_

Q21 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)

Q34 If you indicated substances above, was there a notable change in the particular kind of substance(s) identified in the past 12 months? Please identify and briefly explain. *(e.g. our county noted a substantial increase in heroin related deaths)*

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



Q9 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%)

Q38 If no autopsy is ordered, what is the primary reason or barrier preventing your county from ordering an autopsy

- An autopsy is not required by the Nebraska Coroners Statutes
- Coordination and/or cost of body transport
- Insufficient access to forensic pathology/autopsy services
- Autopsy cost
- Not Applicable for the case(s)
- Other

Q39 If no autopsy is ordered, what are other reasons or barriers preventing your county from ordering an autopsy (select all that apply, if any others):

- An autopsy is not required by the Nebraska Coroners Statutes (1)
- Coordination and/or cost of body transport (2)
- Insufficient access to forensic pathology/autopsy services (3)
- Autopsy cost (4)
- Not Applicable for the case(s) (7)
- Other (6)



## Questions about Death Investigation Procedure (cont)

Q40 When no autopsy is performed, what is your comfort level in

- Certifying cause of death
- Certifying manner of death
- Interpreting toxicology results

Extremely comfortable	Somewhat comfortable	Neither comfortable nor uncomfortable	Somewhat uncomfortable	Extremely uncomfortable
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Q11 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)?

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

## Questions about Confidence

Q13 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



## Questions about Needs

Q15 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

Q16 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

Q18 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

0                      0                      0                      0                      0

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

0                      0                      0                      0                      0

## Additional Questions

Q19 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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## Demographics

Q22 What is your age?

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

Q23 Gender: How do you identify?

- Woman
- Man
- Non-binary
- Prefer to self- describe, below: \_\_\_\_\_

Q24 How many years have you worked as a county coroner?

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