YORK COUNTY OVERDOSE FATALITY REVIEW
ANNUAL REPORT

January 1, 2024 – December 31, 2024

Background

The York County Overdose Fatality Review (OFR) Team was established by a joint initiative between the City of York Bureau of Health, the York Opioid Collaborative, and the County of York Offices of the Coroner and District Attorney. The City of York Bureau of Health received Overdose Data to Action (OD2A) funding in January 2020. Within the first two years of funding, York worked to build capacity with stakeholders interested in collaborating on the OFR Team. York County established its Overdose Fatality Review Team in 2021, with key community members involved and organizations represented.

The OFR Team affiliation agreement, confidentiality agreement, meeting confidentiality acknowledgment, roles and responsibilities, process and procedures, and other templates were finalized before the first case review on Tuesday, June 1, 2021. Stakeholders were recruited, processes and protocols were developed, confidentiality documents were developed, and 4 case review meetings were convened between January 2024 and December 2024. We reviewed three cases each quarterly (two accidental deaths and one suicide), except for December 2024, we increased the total case reviews to four (three accidental deaths and one suicide). During each case review, we identified improvement opportunities in our systems for helping people with substance use disorders and their families.

OFR Overview

Purpose and Objectives

The purpose of this Team is to prevent overdose deaths. We accomplish this purpose by examining individual, organizational, and systems-level factors related to overdose deaths that occur in York County, Pennsylvania.

The OFR purpose is to:

- Develop an understanding of the causes and incidence of overdose deaths in York County.
- Identify risk factors and missed opportunities for prevention and intervention to make policy and programmatic recommendations to prevent future overdose deaths.
- Promote cooperation and coordination among agencies involved in the investigations of overdose deaths and/or provide services to families.
- Define effective localized strategies for coordinating services related to overdose prevention.
- Development and implementation of data-driven prevention and intervention strategies.
- Identify system gaps and innovative community-specific overdose prevention and intervention strategies.
- Develop plans for and recommend changes within the agencies represented on the team in law, policy, and practice to prevent overdose deaths.
- Inform public health and public safety of emerging trends in overdose events.

To fulfill the purposes of the York County Overdose Fatality Review Team, the Team objectives are to:

- Establish policies and procedures for sharing all available information on overdose decedents from local, county, and state government agencies and private entities (including medical examiner investigative records, behavioral health and somatic care treatment records, healthcare payer records, social service records, criminal justice history information, family, and social history, etc.) that maintain confidentiality.
- Conduct multidisciplinary, multi-agency reviews of available information to determine the incidence and prevalence of fatal overdoses and the factors that cause or are correlated with overdoses.
- Identify points of contact between deceased individuals and healthcare, social services, criminal justice, and other systems where prevention/intervention efforts could be implemented.
- Identify the specific factors that put individuals at high risk for overdose.
- Improve coordination and collaboration between member agencies/entities.
- Inform the development of comprehensive local overdose prevention and response plans and identify changes to statutes, regulations, and policies that generally support the implementation of prevention efforts.
- Assist with assessing overdose prevention activities' implementation, impact, and outcomes and developing best practices.

Meeting Frequency and Structure

In 2023, we shifted to quarterly meetings and reviewed three cases, including two accidental drug-confirmed death cases and one suicide death by drug case. By December 2024, we increased our case reviews to include four cases reviewing three accidental drug-confirmed death cases and one suicide death by drug case. A typical meeting will be two hours in length. Given the sensitive nature of the information shared and the need to build trusted relationships, the meetings are closed and not open to the public.

Lead Organization – City of York Bureau of Health: Act 101 outlines categories of individuals who may be selected as a member of a death review team by its "lead organization." In counties with a local health department, the local health department shall be the lead organization to oversee and coordinate the death review team in a form and manner as prescribed by the Pennsylvania Department of Health. The City of York Bureau of Health received funding through the Overdose Data to Action (OD2A) from January 2020- August 2023 to support this initiative. The City of York Bureau of Health received Opioid Settlement funds from January 2024- December 2024 to continue the work of Overdose Fatality Review and hire a full-time Overdose Fatality Review Coordinator. In December 2024, The City of York Bureau of Health received an additional three years of Opioid Settlement Funds which will fund Overdose Fatality Review from January 2025 – December 2027.

Steering Committee: York County Coroner's Office, York County District Attorney's Office, York Opioid Collaborative, and City of York Bureau of Health

- ✓ **Chair:** Pam Gay, York County Coroner's Office
- ✓ **OFR Facilitator**: Dr. Matthew Howie, WellSpan Health
- ✓ **OFR Coordinators**: Jaime Morris, City of York Bureau of Health
- ✓ **OFR Data Manager**: City of York Bureau of Health

Committee Members/Partner Agencies – As of December 2024, 21 primary team members represented 18 different organizations.

Committee Members/Partner Agencies

City of York Bureau of Health
Emergency Health Services Federation
Person with Lived / Living Experience
Suicide Prevention York
UPMC in Central PA
WellSpan Behavioral Health and Addiction Medicine
WellSpan Health
WellSpan Crisis
York County Children, Youth & Families
York County Coroner's Office
York County District Attorney's Office
York County Health Choices
York County Human Services
York County Prison
York County Probation Department of Adult Services
York Opioid Collaborative
York/Adams Drug & Alcohol Commission
York/Adams Mental Health – Intellectual & Developmental Disabilities (MH-IDD)

Methodology of the Review Process

The York County OFR team is a multidisciplinary team with members who can share case-level data about the decedent and/or contribute to analyzing available data as a subject matter expert. Currently, it is not feasible to review every overdose death in our community. An OFR is a systematic process used to examine the underlying causes of overdose fatalities in real time and problem-solve. This process includes:

1. **CASE SELECTION & GATHER DATA:** Identify cases, gather records, and examine the Coroner's Office Reports
   - ✓ Identifies 2-3 cases based on case selection criteria.
   - ✓ Recruit guest members based on the York County Coroner's Office Death Investigation Report.
   - ✓ Accessing records of the deceased via record request letter*
   - ✓ Secure email sent to team members with Coroner's Office Death Investigation Reports (4-weeks prior).
     - o For virtual meetings: send out Zoom registration information.
   - ✓ Prepare PowerPoint presentation with compiled data into detailed case notes and other visuals.
   - ✓ 2-week Meeting reminder email sent to members.
   - ✓ Agendas and other meeting materials prepared – printed/emailed to members.

2. REVIEW CASES: In-depth case reviews by multi-disciplinary partners to examine case information and identify contributing factors and critical takeaways.
3. MAKE RECOMMENDATIONS: Collectively identify changes within and across existing programs and systems designed to prevent and reduce overdose.
4. CHANGE SYSTEMS: Actionable recommendations to strengthen these programs and systems. Every interaction with a part of the system is an opportunity for intervention.

Case Selection Criteria

York County Coroner Pam Gay began performing autopsies on each individual who overdosed in 2014. The Coroner and District Attorney, David Sunday, spent months persuading York County's 23 police departments, many of which rarely handle significant investigations, to treat every overdose like a crime scene. These efforts were aided in part by a 2011 change in Pennsylvania state law that demoted drug delivery, resulting in death (DDRD) from a murder charge to a first-degree felony. DDRD charges increased 356% statewide in Pennsylvania from 2015 to 2019. York is one of the highest counties with the highest percentage of DDRD offenses. Under current law, prosecutors have five years to charge a person who provided a drug that led to a fatal overdose.

Our case criteria determined include the following inclusion and exclusion criteria described below:

- ✓ INCLUDE: Drug overdose deaths where the death certificate AND/OR the coroner or medical examiner report indicates that acute drug toxicity was directly the cause of death.
  - All drug overdose deaths of unintentional or undetermined intent should be included.
- ✓ INCLUDE: Manner of death[1] —deaths where the manner of death is accident, suicide, or undetermined related to drugs.
  - The manner of death is the circumstance that led to the cause of death. The Commonwealth of Pennsylvania recognizes five manners of death—Homicide, Suicide, Accident, Natural, and Undetermined.
- ✓ EXCLUDE: Age of decedent under 21 years old—excluded cases are being reviewed by the local child death review team under the Public Health Child Death Review Act[2]
- ✓ EXCLUDE: Cases under active investigation and litigation—exclude cases that would hinder the progress of an active investigation or criminal proceeding
  - Accidental cases are reviewed by the York County District Attorney's Office to exclude these cases.

Data & Findings from Case Reviews

York County Overdose Decedent Data, January 2024 – December 2024

13 Total Cases: 9 accidental & 4 suicide by drug were reviewed January 2024 – December 2024

9 Accidental Drug Overdose Fatalities

- ✓ Sex = Males (6) and Females (3)
- ✓ Race = White (9)
- ✓ Average age of decedent at the time of death = 39 years

Majority of the people who died from an accidental drug overdoses were never married or single (66.7%). In addition, the majority of people who died from a drug overdose, died in their own home. Of the 9 accidental overdose fatalities reviewed, 6 (66.7%) occurred at Residence, 1 (11.1%) in a Car/Parking Lot, 1 (11.1%) at Friend's Residence, and 1 (11.1%) at a Public: Establishment.

[1] PA Laws Empowering, Defining and Limiting the Power of the Coroner, http://www.pacoroners.org/Laws.php and Death Investigation: A Guide for the Scene Investigator https://www.ojp.gov/pdffiles/167568.pdf

[2] 11 Pa. Stat. § 2150.20

4 Suicide by Drug Fatalities

- ✓ Sex = Males (1) and Females (3)
- ✓ Race = White (4)
- ✓ Average age of decedent at the time of death = 31 years

In the 4 cases reviewed of individuals who died from suicide by drugs, 100% of them died in their home.

Among the 13 fatalities reviewed, the average age was 37 years old of age:

- 5-19 years old = 1 case
- 20-29 years old = 4 cases
- 30-39 years old = 3 cases
- 40-49 years old = 3 cases
- 50-59 years old = 2 cases

Among the 13 fatalities reviewed, the year of death:

- 2020 = 3 cases
- 2021 = 2 cases
- 2023 = 8 cases

Barriers to an Effective Case Review

Some barriers to an effective case review have been identified during case reviews. Before Act 101 of 2022 was passed, a significant barrier was limited access to case records. Since legislation passed in November 2022 to aid in the efforts, the barrier to accessing records has transitioned to agencies' interpretation and understanding of the legislation. Some agencies continue to lack knowledge and education on the law to release the records, so it prohibits agencies from releasing information until further educated. This was and identified barrier in last year's annual report and continues to be a documented barrier. Additionally, some agencies' interpretation of the legislation continues to impede receiving records. There continues to be difficulty in York County receiving medical records from certain providers.

York County does not have a Next-of-Kin interview process, which also creates limitations regarding effective reviews.

Recommendations Based on Barriers

Eliminating barriers to help OFR teams be more effective and preventative in nature, as intended in the design of OFR, is essential. As a result of the barriers York County faces, the following recommendations are made. Educational materials or bulletins from the state are provided to different types of agencies based on confidentiality guidelines and the release of records to create uniformity in understanding the legislation. For example, the Department of Drug and Alcohol Programs released a bulletin explaining and detailing Act 101 so that treatment facilities understood they could release records despite 42 CFR. Similar bulletins for other agencies would be helpful to share with agencies to educate them. Additionally, it is recommended for the Department of Drug and Alcohol Programs to rerelease the bulletin to the Single County Authorities and Treatment Providers to help aid in compliance with Act 101 of 2022. Similarly, all counties in Pennsylvania handle case review selection differently, and the understanding of whether a review impacts the active investigation of a DDRD case is left up to counties to determine and interpret. OFR is similar in nature to Child Death Review, and these reviews are not delayed due to interference with an active investigation; the legislature for OFR is vague in that the reviews must not interfere with an active investigation; many counties interpret this as an OFR may not be conducted while there is still an open investigation. OFR is not intended to focus on the investigation of the death; it is to look at

the gaps and missed opportunities before the death to prevent future overdoses. Clear guidelines from the state for the District Attorney's Office in all counties are recommended to improve uniformity in proceeding with OFR during an active DDRD investigation. Additionally, guidance and direction on sharing data and receiving records from bordering states are essential to improve recommendations. On a local level, York County is continuing to work on establishing a Next-of-Kin interview process to incorporate into OFR to help gather additional data regarding the decedent that other agency records cannot provide or fill in the gaps. The York County Coroner's Office received Opioid Settlement Funds to hire a Family Advocate in 2025. Collaboration between the Family Advocate and the Overdose Fatality Review Coordinator will occur to establish a policy/procedure for Next-of-Kin Interviews after hire.

Recommendations Resulting from Case Review

After a review of overdose-related data, the OFR team develops recommendations to prevent future overdoses and overdose deaths. Recommendations are then shared to be implemented by OFR partners and community agencies. Recommendations to date have focused on communication, information and resource sharing, access to harm reduction services, training, referrals to services, naloxone distribution, and education opportunities. The recommendations generated during the case review meetings are taken to the following Public Health and Safety Team (PHAST) meetings for feedback and support. In addition to recommendations, the OFR team has identified emerging themes during reviews and recurring themes to aid in generating recommendations.

Themes from Deaths Reviewed

- ✓ History of Trauma
- ✓ Mental Health and/or SUD History
- ✓ Comorbidities
- ✓ Access to Services When Experiencing Disabilities
- ✓ Naloxone Access/Stigma
- ✓ Bereavement Support Services

Recommendation Efforts

In the 2023 Annual Report, the prosecution of Drug Delivery Resulting in Death Cases were identified as a barrier to effective case review. In 2024, the Overdose Fatality Review Coordinator worked with the York County Coroner's Office and the York County District Attorney's Office to update the approved cases list for Overdose Fatality Reviews. As a result of this collaborative effort, the agencies were able to compile a significantly larger case review list which increased the ability to review more recent cases. It was discovered cases were missed due to a disconnect and communication was improved to help improve case review selection. In December 2024, two Emergency Medical Stations were purchased that will be placed at the York Fairgrounds to ensure access to include Opioid Reversal Kits with other first aid kits and AED. The Emergency Medical Stations also provide opportunities to share out educational opportunities and reduce stigma through education and messaging utilizing the tablet feature on the medical stations. Additionally, a harm reduction distribution box was purchased to place at the City of York Bureau of Health Clinic location to be placed in the lobby upon delivery. This will allow for distribution of Narcan, test strips, condoms, Deterra medication deactivation pouches, and prescription locking caps. The implementation of this will be a test run to collect distribution data and receptiveness to work toward expansion of this initiative. Monthly Narcan events continued to be held through 2024 from March to October to distribute Narcan to the community. Through Narcan distribution activities, 242 Narcan Kits were distributed to the community to prevent overdose deaths. Additionally, meetings were held to continue working on the Hospitality Health Initiative to distribute Narcan to hotels, motels, bars, and restaurants. This initiative made little progress and will be focused on more during 2025. Educational materials were purchased and distributed with included Timbi Talks About Addiction Books and Coloring Books to help aid in prevention and understanding for children who have been impacted by family members with addiction.

Dissemination Efforts

The 2024 Annual Report for York County was published on the City of York Bureau of Health website[3]The published report contained a review from January 2024 – December 2024. The public can view this annual report. Additionally, printed copies were published to distribute to OFR team members, agencies, and other community stakeholders.

[3] https://www.yorkcity.org/city-services/departments/economic-and-community-development/bureau-of-health/substance-abuse-prevention/