Wayne County
Overdose Fatality Review Board
2023 Annual Summary Report
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Acknowledgements

We would like to thank the Wayne County Board of Commissioners for authorizing the creation of the Wayne County Overdose Fatality Review Board.

We would also like to acknowledge all the people who work to save the lives of Wayne County residents who suffer from substance use disorder. The Wayne County Overdose Fatality Review Board is made up of some of these people who save lives as well as others who have a common goal to work toward interventions to prevent future deaths from overdose.

OFR Overview

Purpose

The purpose of the Wayne County Overdose Fatality Review Board(WCOFR) is to decrease the incidence of overdose deaths. The list of objectives below are the mechanisms by which we strive to meet our purpose.

Objectives

• Improve communication between local and state agencies to enhance coordination efforts.

•Analyze system responses to overdoses within a community to better understand the experiences of persons with substance use disorder, identify points of contact between the decedents and local agencies, and identify improvements to policies and practices that may prevent overdose death.

• Accurately identify and consistently report the circumstances surrounding unintentional overdose deaths and the systems the decedents encountered prior to an overdose.

• Analyze aggregate data to identify trends and patterns of overdose deaths, including common circumstances and risk factors preceding fatal incidents and opportunities for strengthening policies and practices that may reduce future fatalities.

• Initiate recommendations to improve overdose investigation, intervention, and prevention. Identify short- or long-term recommendations for changes in local or state statutes, regulations, policies, and procedures to prevent future overdose deaths.

• Improve delivery of services to families, providers and community members following an overdose death.

• Increase public and systems understanding of substance use disorder and overdose death.

OFR meeting frequency and structure

The WCOFR meets at least twice per year depending on the number of overdose deaths. Since this is our first year of reviewing deaths, a regular cadence has not been established. However, to review the 2023 deaths, we met in December 2023 and March 2024 to review deaths.

Committee Partner Agencies

ANAZAO Community Partners (Local Drug and Alcohol Treatment Provider)
OneEighty (Local Drug and Alcohol Treatment Provider)
Aultman Orrville Hospital
Wooster Community Hospital
MEDWAY (Local Drug Law Enforcement Unit)
Wayne County Sherriff
Wayne County Coroner
Wayne County Adult Probation Department
Wayne County Health Department
Wayne Holmes Mental Health and Recovery Board

Review process and utilization of specific data sources

The WCOFR is facilitated by the Wayne County Health Department. It sends the agenda, sends out information regarding decedent's name and preliminary circumstances surrounding the death that is attainable through the death record. We request from partner agencies to research any potential information on any of the decedents to provide additional insight to achieve the above stated objectives. One of the physicians or other healthcare professionals on the Board will review the death record and explain the cause of death and any health related information from a discharge summary, if applicable. The coroner will also add any information they have on the case. Then as appropriate, the law enforcement, drug and alcohol treatment centers, hospitals and courts will contribute any additional they have information on the decedent(s). We will then discuss any other data sources and any trends or any irregularities associated with each death.

OFR Data & Findings

Provide narratives and data visualizations that represent important data and findings that came out of the OFR process. It is important to provide the annual overdose data for your jurisdiction and it can also be helpful to compare this to Ohio overdose data for the appropriate year. Please make sure to include the following data points and information:

- Total number of unintentional drug overdose deaths in the county - 20
- Total number of unintentional drug overdose deaths involving opioids in the county -18
- Total number of unintentional drug overdose deaths reviewed by the committee. -18
- Total number of unintentional drug overdose deaths involving opioids reviewed by the committee. -16
- Total number of unintentional drug overdose deaths that were not reviewed by the committee. - 2 – pending investigations

- Total number of unintentional drug overdose deaths involving opioids that were not reviewed by the committee. – 2 pending investigations

Demographics of Cases Reviewed

Age (in years)	Deaths
Under 25	2
25-34	2
35-44	9
45-54	3
55-64	2

Sex	Deaths
Male	11
Female	7

Race and Ethnicity

All decedent cases reviewed were White and not Hispanic.

Toxicology of Cases Reviewed

Drug presence	Deaths
Fentanyl	16
Other opiates	3
Methamphetamine	7
Cocaine	5
Benzodiazepines	2
Alcohol	2
Other drugs	2

*Most of the cases reviewed (14 of 18) died with multiple drugs in their system

Identified Trends

- The common trend throughout all of these deaths was that none of the decedents were using in the presence of others when the fatal overdose occurred. Most of the deaths reviewed were between the ages of 35 and 54, 12 of the 18 reviewed.
- Fentanyl was present in an overwhelming majority of deaths reviewed, 16 of 18 reviewed.
- Men were overrepresented as they account for 50% of Wayne County's population but 61% of the overdose deaths.

- Fifteen of the eighteen deaths reviewed died at their home. All three that did not die in their home died out of county. Two of the three that died outside of Wayne County overdosed and died in Akron.
- Half of the deaths reviewed, 9, died were residents of the Wooster zip code. This would include the city of Wooster and areas just outside the city. Orrville's zip code, which includes the city of Orrville and areas just outside of the city saw 4 deaths reviewed.

Recommendations

As indicated in the trend section, many are dying at home and alone. So a couple of recommendations came out of this

- Providers should consider assessing clients' social aspects of their substance use, i.e. are they using alone?
- An awareness campaign targeted to those suffering from substance use disorder to not use alone.

The Board felt the need for more robust data on EMS responses to find out better data on things like whether or not naloxone was administered, any previous EMS dispatch for the person on previous overdoses. While we had some of the data on the previous mentioned items, it was not consistent. So a recommendation of adding someone from a local Fire Department/EMS would be a good to add to the Overdose Fatality Review Board.
Some other data points we are recommending accessing or attempting to access.

- While we had some location data, another data item that might be helpful is to geocode the locations of the deaths.
- OARRS reporting on the decedents. While we had this on some cases, we need to make that part of the process for all decedents, if applicable

Next Steps

This was the first year that Wayne County convened an Overdose Fatality Review Board. In order to improve the Overdose Fatality Review Board, we need to get access to more robust data. One thing we missing was perhaps some information related to EMS interventions. Consequently, we will add some representatives of Fire Departments as they represent the overwhelming majority of EMS presence in Wayne County. While attendance was very good with only one agency missing our first meeting and one agency missing our second meeting, we also would like to establish a regular cadence for meetings as it will hopefully make it easier for Board members and agencies to attend close to 100 percent of meetings.