

From Tragedy to Action: *Strengthening Communities Through Overdose Fatality Reviews*

2026 Kentucky Overdose Prevention Summit

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Overdose Response Strategy

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By the End of This Session, You Will Be Able To...

- 1 Describe the purpose and process of Overdose Fatality Reviews (OFRs) in overdose prevention.
- 2 Explain how multidisciplinary collaboration through OFRs strengthens community overdose response.
- 3 Identify gaps and prevention opportunities revealed through the OFR case review process.
- 4 Apply OFR strategies to develop actionable recommendations for overdose prevention in your community.

The Overdose Crisis: Why This Work Matters

Record High
Overdose Deaths
in the United States
in recent years

Record high 2,257 overdose
deaths in Kentucky (2021)

*One of the most pressing public health
challenges in America today*

The Silo Problem

Traditional prevention approaches have operated in silos, limiting the ability to address complex, intersecting factors.

Missed Opportunities

Without cross-sector collaboration, critical intervention moments go unidentified.

A Promising Practice

OFRs convene diverse partners to examine cases, identify gaps and recommend systemic change.

What Is an Overdose Fatality Review?

Definition

A nationally recognized model, OFRs involve the analysis and review of aggregate data and a series of individual death reviews by a multidisciplinary team.

The goal is to effectively identify system gaps and innovative, community-specific overdose prevention and intervention strategies.

Key Insight

- Combines community data with decedent life history
- Reveals risk factors, circumstances and missed prevention opportunities
- Allows jurisdictions to see patterns of need across agencies
- Generates recommendations to prevent future deaths

Purpose of an OFR

Prevention

1

Determine prevention strategies targeting opioids and other substances.

Gap Analysis

2

Recognize and address gaps and barriers in existing services and systems.

Root Causes

3

Identify underlying causes of substance use disorders in the community.

Collaboration

4

Build a community of multi-disciplinary partners to work across agencies and sectors.

Policy Change

5

Develop recommendations for program and policy changes at local and state levels.

Who Participates in OFRs?

1

**Medical
Examiner
or Coroner**

2

**Public Health
Professionals**

3

**Public
Safety/First
Responders**

4

**Criminal Justice
Agencies**

5

**Healthcare
Providers**

6

**Behavioral
Health
Providers**

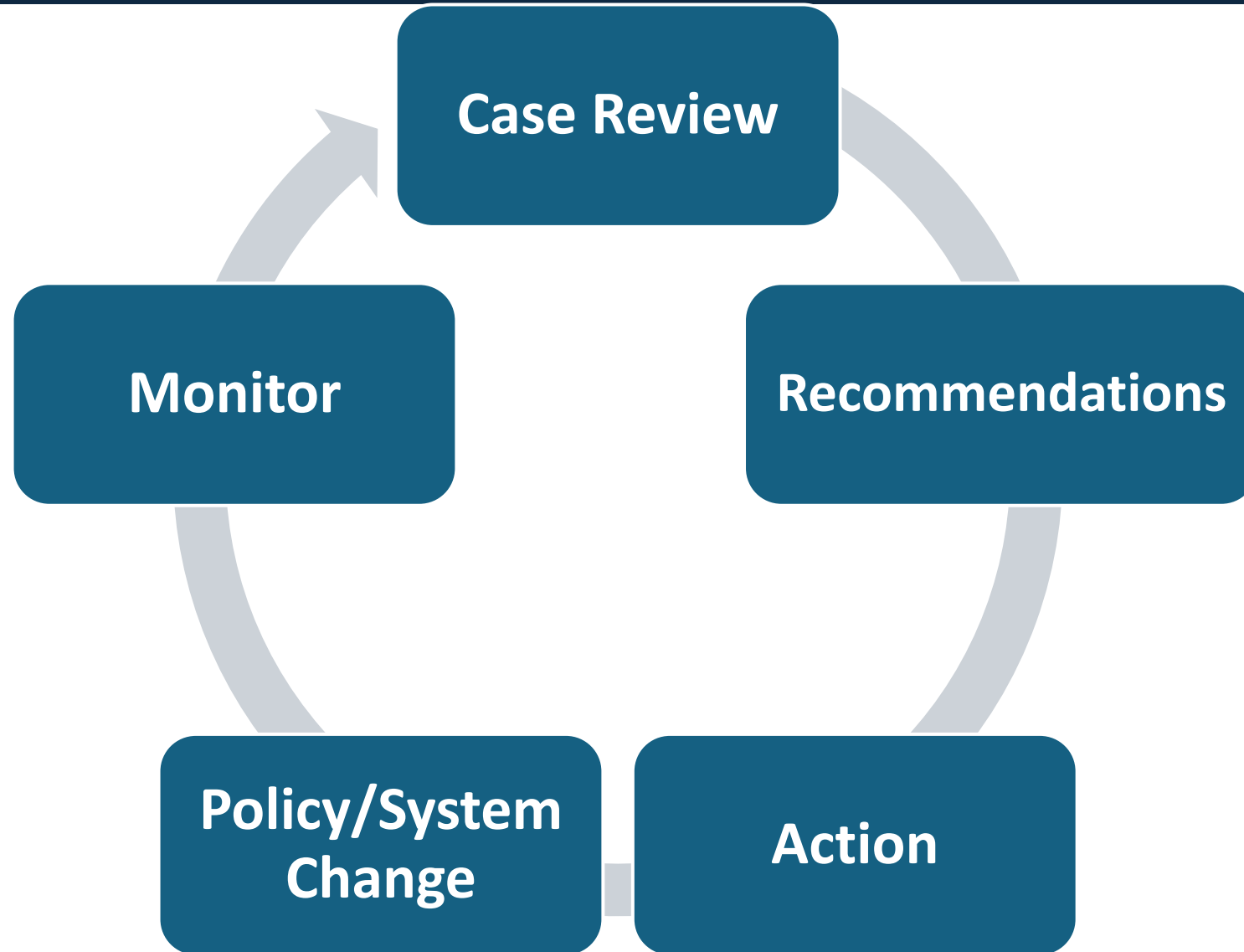
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**Child
Services**

8

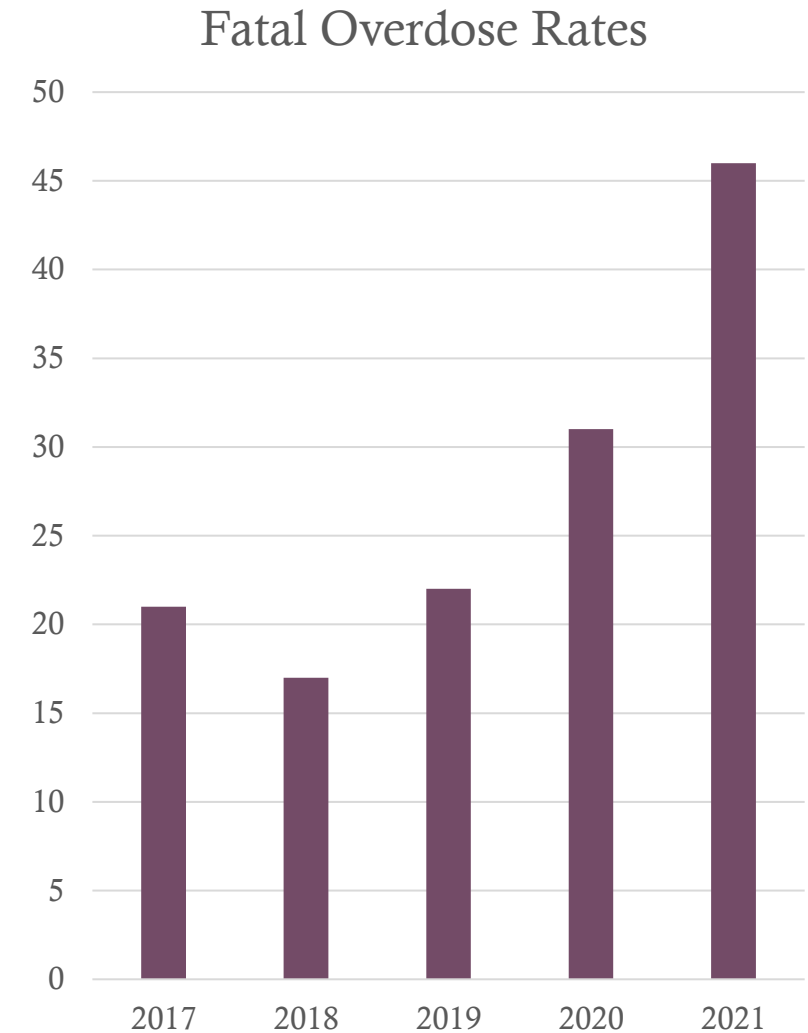
**People with
Lived Experience**

The OFR Review Process



OUR STORY

- 2017 – 2021: Hardin County experienced a consistent rise in fatal overdoses
- 2021: Tragic overdose of a local teen
- Initial call: Local hospital's Chief Medical Officer



BRINGING IT ALL TOGETHER



SITE INFORMATION



- **County:** Hardin County
- **Year started:** 2021 with case reviews starting in 2022
- **Size of jurisdiction:** 112,000 residents
- **Funding sources:** Currently Hardin County OFR does not have a funding source

KEY CHALLENGES FACED

Limited ability to hold in-person meetings due to COVID-19 restrictions

Uncertainty about how and where to begin addressing the issues

Disconnected communication between essential agencies, including law enforcement, hospital staff, and detention centers

Building trust between agencies to share critical information

**CASE EXAMPLE:
KEY ISSUES IN
JUSTICE-
INVOLVED
PATIENT CARE**

Scenario: Individual had ingested bag of presumed illicit substances before arrest

Communication Breakdown: Police officers transporting patients with limited medical training

Unclear Expectations: Ambiguity around the term "medical clearance"

Why It Mattered: Life-threatening gaps in care for justice-involved patients

Outcome: Resulted in overdoses, emphasizing critical safety concerns

RESPONSE: IMPLEMENTING A NEW PROTOCOL

Medical Report Form



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graph TD; A[Medical Report Form] --> B[Complete Visit Record]; B --> C[Direct Communication Line];
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Complete Visit Record

Direct Communication Line

LESSONS LEARNED

Collaboration is Key

Transparent Communication

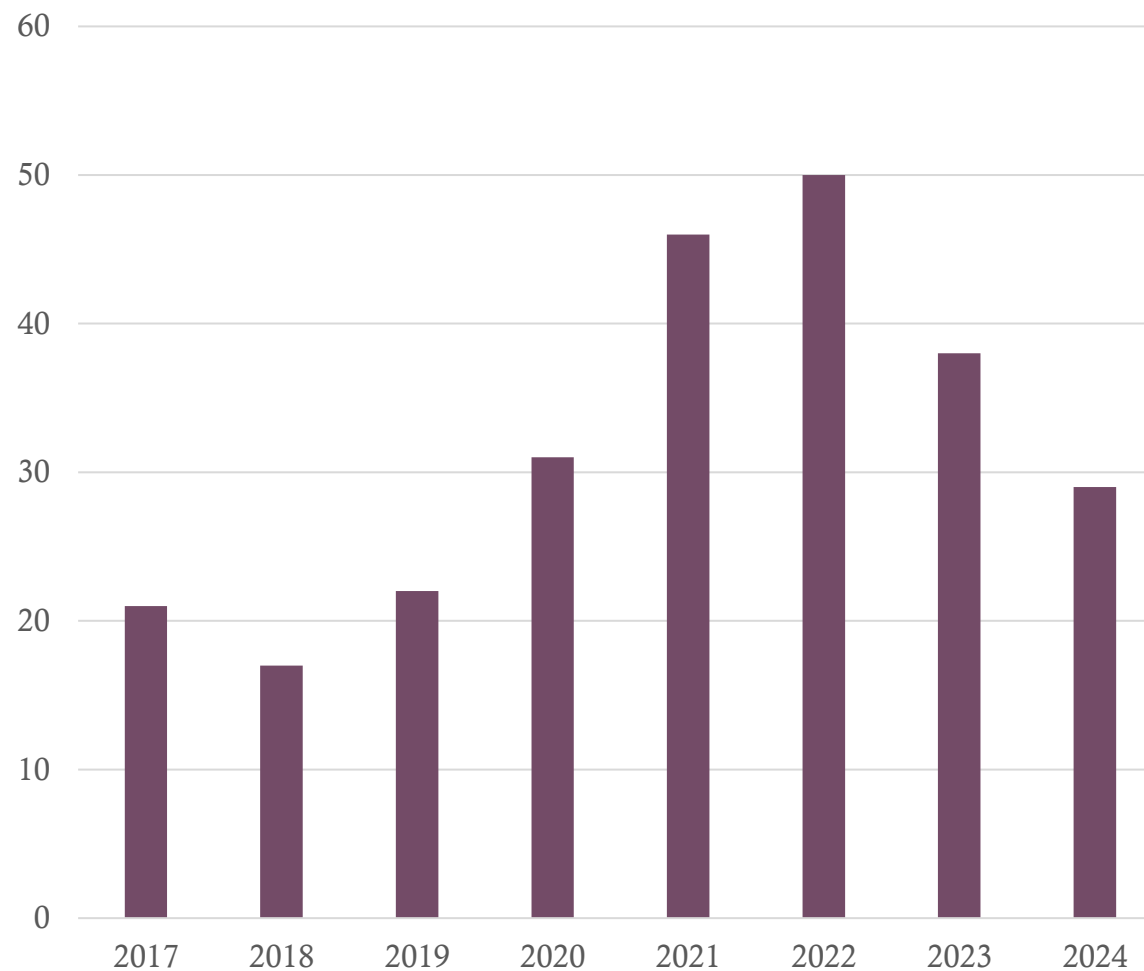
Flexibility and Trust

Small Steps, Big Impact



RESULTS

Fatal Overdoses Occurring in
Hardin County



* Data from Drug Overdose Fatality Report produced
Kentucky's Office of Drug Control Policy

OTHER ITEMS TO COME FROM HARDIN COUNTY'S OFR

Quick Response Team

Increased access to naloxone

Youth Task Force

OD prevention education in local schools

Observation by other jurisdictions

ED peer support (still in discussion)

Overdose Spike Alert Response Plan (in discussion)



Mock Case Reviews

Interactive Activity

CASE #1

DEMOGRAPHICS

39 -year-old male

Resided with girlfriend in rental home

Did not complete high school

Unemployed at time of death, history of intermittent construction work

No children, no known interaction with other family

Previous diagnosis of Alcohol Use Disorder

Toxicology was positive for alcohol, opioids, and benzodiazepines

CASE #1 TIMELINE

Medical History

- 1/2/24 – ER – Overdose
- 3/4/24 – ER – Chest pain
- 6/1/24 - Urgent Care – Laceration to arm
- 7/27/24 – Primary – Medication refill
- 10/15/24 – Urgent Care – Back pain
- 2/3/25 – ER– Fall from ladder
- 3/7/25 – ER – Back and leg pain
- 6/17/25 – Urgent Care – Medication refill from fall
- 7/1/25 – ER – Back pain
- 12/3/25 – ER – Chest pain

Judicial History

- 6/12/2008 – DUI
- 2/2/2010 – PI, Possession
- 5/27/2015 – Possession, Theft by Deception
- 8/5/2019 – DUI, Possession
- 3/26/2020 – Positive Drug Screen
- 5/16/2023 – PI
- 11/16/2024 – PI
- 12/5/2025 – Theft by unlawful taking – awaiting sentencing at time of death

Date of Death-1/2/26

POTENTIAL RECOMMENDATIONS



Increase awareness of treatment and recovery resources

Community campaign to promote local SUD treatment, recovery meetings, and crisis support services, especially targeting individuals with alcohol misuse and co-occurring mental health needs



Provide education on the risks of mixing substances

Create prevention messaging around the dangers of combining alcohol, prescription pain medications, and other depressants, with outreach through healthcare offices, pharmacies, and community partners



Strengthen screening and referral partnerships

Work with healthcare providers, urgent care centers, and behavioral health partners to encourage routine screening for alcohol and other substance misuse and provide simple referral pathways for treatment and support services



Expand peer support and recovery mentoring

Partner with local recovery organizations to connect individuals with peer support specialists or recovery coaches, especially after substance-related charges, hospital visits, or behavioral health appointments



Provide naloxone and overdose education to household members

Ensure naloxone is distributed to those at highest risk and their family members along with education on overdose warning signs and response

CASE #2

DEMOGRAPHICS

44-year-old female

Divorced, lived alone in an apartment

Completed high school

Employed full-time as a bank teller

Maintained private health insurance through employer

One adult son who lived out of state, last conversation occurred approximately two months prior to her death

No documented history of SUD

Toxicology was positive for methamphetamine, fentanyl, and designer opioids

CASE #2 TIMELINE

Medical History

- 3/16/2021 – Urgent Care – Finger laceration
- 3/26/2021 – Urgent Care – Follow up
- 12/5/2023 – Urgent Care – Influenza

Judicial History

- No Known History

Date of Death-10/18/25

TO CONSIDER

What systems had contact with the decedent prior to death?

Were there any missed opportunities for intervention?

What contributing factors may have increased the overdose risk?

What prevention strategies could have changed the outcome?

What recommendations should this OFR team make?

Which agencies or partners would be responsible for these recommendations?

Are these recommendations individual, system, or community level?

POTENTIAL RECOMMENDATIONS

1

Increase community education on opioid contamination

- Develop overdose prevention messaging

2

Expand naloxone access beyond traditional settings

- Increase naloxone availability in pharmacies, workplaces, apartment complexes and community events

3

Encourage routine screening in urgent care and primary care

- Promote SBIRT or brief screening for substance use, mental health, and social support needs during all patient visits

4

Address social isolation and disconnected support systems

- Develop community outreach and support programs for adults living alone or with limited family contact

5

Improve public messaging that overdose affects all populations

- Use community messaging to reduce stigma and emphasize that overdose can affect anyone including those who are employed, insured, stably housed, etc.
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What OFRs Can Do for Your Community

Nationally Recognized and BJA-Supported: OFR is a supported, evidence-informed model with standardized methodology, national training & technical assistance (TTA) and a growing network of communities committed to implementing the model consistently.

Understand & Analyze

OFRs provide a structured framework to examine overdose deaths and uncover systemic gaps.

Collaborate Across Sectors

Diverse perspectives lead to more comprehensive prevention and intervention strategies.

Generate Real Change

OFR recommendations have led to tangible policy shifts, service expansions and barrier removal.

Scalable & Adaptable

The OFR model can be launched or strengthened in communities of all sizes and contexts.

Thank You

Questions & Discussion

To learn more about implementing OFRs in your community, connect with us after the session or visit <https://www.ofrtools.org/> for more information.

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