



SUICIDE SPECIALIST INVESTIGATIONS

ANNUAL REPORT

— 2023 —

Franklin County Coroner
Nathaniel R. Overmire, D.O.

Suicide Specialist
Dallas Allen

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2090 FRANK ROAD
FRANKLIN COUNTY
FORENSIC SCIENCE CENTER
Nathaniel R. Overmire, D.O.
FRANKLIN COUNTY CORONER

ABOUT THE OFFICE

The Franklin County Coroner's Office serves a community of 1.3 million people, including the city of Columbus. There were approximately 11,800 deaths in 2022.

The Coroner's Office investigates all deaths by violence, criminal means, suicide, infant deaths, and prisoner deaths or any unattended death whatever the cause.

The Coroner's Office provides identification, performs autopsies or medical examinations, and carries out any other requirements in regard to deaths which fall in the categories mentioned above.



CORONER'S MESSAGE

My training as a family doctor accentuates my curiosity in ways to help people live happy and healthier lives. While we often focus on an individual's physical health, we cannot minimize a person's mental health. Some people may be hesitant to ask for help, but it's okay to seek help. Each of us should encourage friends and loved ones to use the suicide and crisis lifeline 988.

Our suicide specialist investigator alerted us to a significant increase in black suicides in mid-2023. We were able to take steps to respond by convening and facilitating a discussion with leaders of agencies that provide direct community services. Together, we can continue to combat the stigma associated with mental health and save lives.

NATHANIEL R. OVERMIRE, D.O.
FRANKLIN COUNTY CORONER

MISSION



The mission of the Franklin County Coroner's Office is to serve and protect the interests of the community by maintaining the highest standard of professionalism and integrity in determining the cause and manner of death.



We are dedicated as a team to provide services in an efficient and courteous manner, respecting the needs of the families involved. We want the citizens of Franklin County to know, by our words and actions, that we are sincere and loyal to them, and will deal respectfully with each and every death.

OUR INVESTIGATOR

DALLAS ALLEN
SUICIDE SPECIALIST
INVESTIGATOR



Dallas Allen is the Suicide Investigations and Postvention Specialist at the Franklin County Forensic Science Center, Office of the Coroner in Columbus, Ohio. Dallas conducts full psychosocial investigations and provides grief support to individuals who have lost loved ones to suicide. As of July 2021, Dallas became the first person in the nation to hold this title within a medicolegal office.

Dallas is a suicide loss survivor who believes lifting the stigma surrounding suicide will create more prevention possibilities for individuals who struggle with mental health and suicidal ideation. Dallas has garnered most of his experience from working with adolescents in a mental health setting. Dallas has a Bachelor of Arts degree in Criminal Justice from Muskingum University in New Concord, Ohio.

In addition to his position at the Coroner's office, Dallas is also a board member for LOSS Community Services, a volunteer member of the Franklin County Suicide Prevention Coalition, and a Resource and Care Connections Committee member for the Attorney General's Task Force on Criminal Justice and Mental Illness.

OUR SERVICE

PSYCHOSOCIAL INVESTIGATION

The Suicide Investigations Specialist has two primary functions. The first function is to interview suicide loss survivors for the psychosocial history of the decedents who died by suicide within Franklin County. The second function is to provide those loved ones with resources that are focused on the unique grief related to suicide loss.

Although the specialist completes scene investigation work, the specialist brings a unique perspective to the investigative unit by focusing more on psychosocial factors that could have contributed to the decedent's fatal self-injury incident. The specialist completes full psychosocial reports that are presented in a suicide fatality review.

The full report is completed with information gathered from interviews, public records, social media, medical records, and any additional outlet that is available to obtain information to better understand the decedent and their life experiences. The specialist investigates stressors that could be present within an individual's social dynamics, religion, education/employment, substance use history, physical/mental health history, criminal history, and many others.

Ultimately, having suicide fatalities viewed through the lens of a specialist is going to inform public health initiatives and will aid in community intervention.



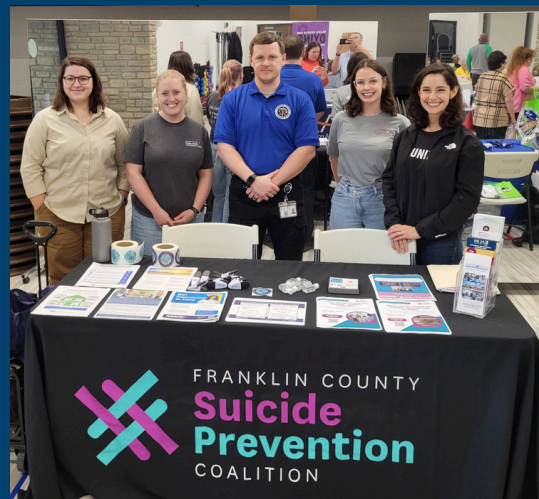
OUR SERVICE

FATALITY REVIEW COMMITTEE

The purpose of the Suicide Fatality Review (SFR) Committee is to decrease the incidence of preventable suicide deaths by promoting cooperation, collaboration, and communication between all groups and professions engaged in suicide prevention, education, and treatment efforts.

The SFR is backed by legislation (Ohio HB 110, ORC Section 3701.0411) which grants agencies the ability to share appropriate information with each other in a closed review setting. The committee includes various mandated agencies that must be in attendance for each review. The mandated agencies include local law enforcement, a public health official, the executive director of a local ADAMH board, and a physician that is authorized to practice medicine. Additional individuals and agencies can be added at the discretion of the SFR facilitator.

During the SFR meeting, a suicide death that was investigated by the Franklin County Coroner's Office is presented in detail. The meeting is then opened for a collaborative discussion about the case and recommendations are created with the idea of preventing a similar situation from happening again. Although resources exist in Franklin County, they are sometimes complex and difficult to access, therefore the SFR process is designed to make that gap smaller.



OUR SERVICE

OVERVIEW OF RECOMMENDATIONS

Throughout 2023 there were around 70 recommendations created by the Franklin County Suicide Fatality Review Committee. This section will act as an overview of common themes that were presented within the recommendations throughout the year.

Common themes for the year include increasing education, promotion of continuous care, and awareness of first responder/veteran mental illness. Increasing community education related to suicide prevention is an idea that was mentioned in each review. Messaging related to the evidence-based Question, Persuade, and Refer suicide prevention training and guidelines on how to create a safety plan could lead to earlier detection of mental health complications and help individuals de-escalate when in a moment of crisis.

Members of the committee also felt that increased professional cross-training for physicians and therapists could better equip them to handle clients with comorbidities. Messaging regarding safe storage of lethal means should be advertised and readily available to the public. Additionally, it is important that community leaders support the general public with acquiring firearm lock boxes.

Numerous cases reviewed by the committee revealed that families often knew their loved one was struggling but keeping their loved one connected with services was difficult. Promoting continuous care will increase the likelihood that an individual is successful in their mental health journey. The “disjointed” healthcare system and turnover rates for mental health professionals are challenges that the committee believes need to be addressed.

Lastly, many of us know that the first responder/veteran community is at a greater risk for suicide compared to the average individual. As a community, we must come together to better understand issues that are prevalent within this at-risk population. The review committee highlighted limitations to time off for first responders which often leads to burnout and depression and recommended the promotion of unique types of therapy outside of clinical settings.

REVIEWED CASE DEMOGRAPHICS

2023

Certified suicide fatalities: 175

Suspected suicide fatalities: 1

Cases (2022 and 2023) reviewed by committee: 8

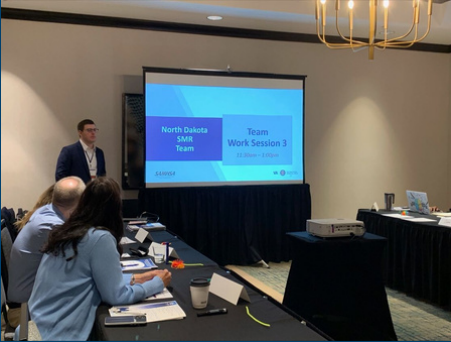


Race	2022	2023
Non-Hispanic White	5	3

Age	2022	2023
20-29	2	0
30-39	2	0
40-49	0	1
50-59	1	2
60+	0	0

Gender	2022	2023
Male	5	2
Female	0	1

RECOMMENDATIONS



Improve Awareness of Current Services

- Promote culturally appropriate education about mental illness and mental health treatment.
- Promotion of suicide prevention trainings such as Question, Persuade, and Refer can lead to earlier detection and increase connection to available resources.
- Increase community awareness of the link between domestic violence and suicide. Promote trainings through the Ohio Domestic Violence Network.
- Promote the national guidelines provided by Workplace Suicide Prevention regarding toxic work environments and how that can impact suicidal behaviors.
- Increase education to the general public regarding negative side effects of medications (e.g., Ketamine, injectable medication, Bactrim, steroid induced psychosis).
- Promote alternative methods of therapy (e.g., Equine Therapy).
- Promote the importance of continuous care for at-risk individuals. Treatment can save lives even if the at-risk individual is not presently in crisis.
- The healthcare system is “disjointed”. Information sharing could lead to better continuity of care. Subject matter experts must work together to increase connection and improve the quality of resources available to the community.

RECOMMENDATIONS

Focused Opportunities

- Public awareness campaigns focused on available mental health treatment and suicide prevention to reduce stigma.
- Improve messaging related to safe storage of medications and firearms. Promote programs such as Life Side Ohio which is bridging the gap between gun owners and safe storage.
- Increase community awareness on suicide risk for neurodivergent individuals (e.g., Autism Spectrum Disorder).
- Increase education on mental illness in public safety, veteran, and medical professional communities. Promote best practices on how to connect these populations to services. More research is needed to identify evidence-based interventions for the first responder community.
- Improve time off limitations for first responders. Being overworked leads to burn out and increases suicide risk.
- Increase community awareness of available services from the Department of Veterans Affairs.
- Increase opportunities for professional cross training. Therapists with the ability to handle a diverse range of complications and life stressors could lead to better overall treatment.
- Promotion of community resource centers for at-risk populations (e.g., Ohio State Nisonger Center, culturally specific resource centers).
- Turnover rates for mental health professionals is a concern for the community with regard to having high quality therapists.
- Having quality patient care leads to properly transitioning patients between therapists to reduce the frequency of traumatic information being shared by patients.
- Early detection of schizophrenia leads to better success in treatment. Focused education on religious delusions surrounding religious ideations can assist in diagnosing schizophrenia.

2023 SUICIDE DEATHS DATA



Franklin County Forensic Science Center

Office of the Coroner

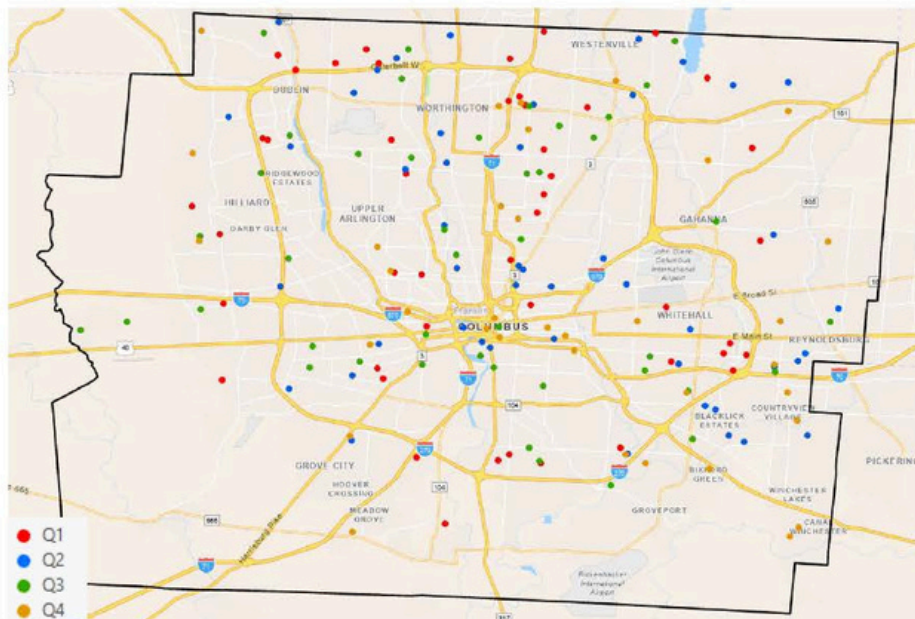
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March 29th, 2024
 Time Period: 2023

Number of Suicide Deaths by Injury Location:

	Q1	Q2	Q3	Q4	2023
Franklin County	46	48	43	35	172
Franklin County - Location Unknown	1	0	0	2	3
Out of County	5	5	6	5	21
OOCLocation - Location Unknown	1	0	1	0	2

2023 Suicide Deaths in Franklin County by Quarter



Source: MDILog 2023.

Only cases with a precipitating incident occurring inside Franklin County are considered within this report.

2023 SUICIDE DEATHS DATA



Franklin County Forensic Science Center Office of the Coroner

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Number of Suicide Deaths by Method:

	Q1	Q2	Q3	Q4	2023
Acute Intoxication	11	8	4	9	32
Firearm	25	27	27	23	102
Hanging	10	8	6	1	25
Other	1	5	6	4	16
Total	47	48	43	37	175

Number of Suicide Deaths by Gender:

	Q1	Q2	Q3	Q4	2023
Male	34	36	35	33	138
Female	13	12	8	4	37

Number of Suicide Deaths by Race and Ethnicity:

	Q1	Q2	Q3	Q4	2023
Non-Hispanic White	33	25	32	31	121
Non-Hispanic African American	10	16	9	5	40
Hispanic	1	2	1	1	5
Other	3	5	1	0	9

Number of Suicide Deaths by Race and Gender:

	Q1	Q2	Q3	Q4	2023
White Male	27	19	26	28	100
White Female	6	6	6	3	21
African American Male	4	13	7	4	28
African American Female	6	3	2	1	12

Number of Suicide Deaths by Age Range:

	Q1	Q2	Q3	Q4	2023
<19	5	2	4	3	14
20-39	14	23	15	12	64
40-59	17	14	12	13	56
60-79	9	6	11	5	31
80+	2	3	1	4	10

Source: MDILog 2023.

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2023 SUICIDE DEATHS DATA



Franklin County Forensic Science Center Office of the Coroner

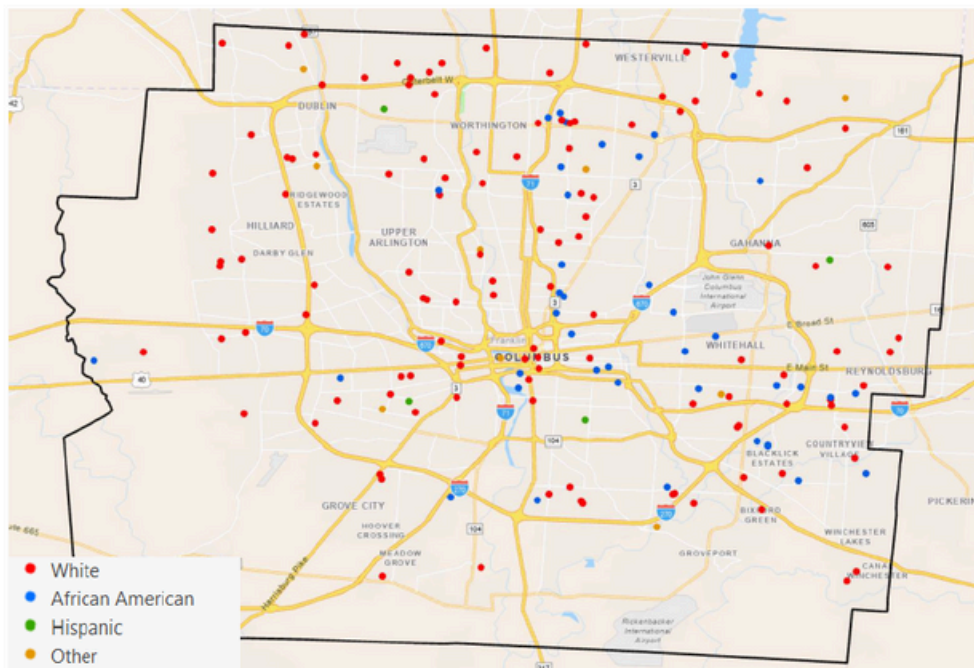
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Age-Adjusted Death Rate of Suicide by Race and Ethnicity:

	Q1	Q2	Q3	Q4	2023
Non-Hispanic White	4.2	3.2	3.9	3.8	15.1
Non-Hispanic African American	3.4	4.8	2.8	1.8	12.8
Hispanic	1.5	3.1	1.4	1.2	6.6

* Age-adjusted death rate reported in death Per 100,000 Population Count Adjusted to US 2000 Standard Population Weight

2023 Suicide Deaths in Franklin County by Race and Ethnicity



Source: MDILog 2023.

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2023

PREPARED BY

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