SUICIDE SPECIALIST INVESTIGATIONS

ANNUAL REPORT

— 2024 —

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

Suicide Specialist
Dallas Allen

614-525-5290 coroner.franklincountyohio.gov coroner@franklincountyohio.gov

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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 11,000 deaths in 2023.

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 provides the most accurate real time data which continues to show concern in the black community. We are able to use this informaiton to take steps to respond by convening and facilitating discussions 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 2024 there were 44 verbatim recommendations created by the Franklin County Suicide Fatality Review Committee (SFRC). After assessment and categorization, there were 20 actionable recommendations that are included within this report. This section will act as an overview of common themes that were present within the recommendations throughout the year. The Franklin County Coroner's Office (FCCO) and the Franklin County Suicide Prevention Coalition (FCSPC) have been working together since 2021 to prevent suicide and promote health equity through data-driven, evidence-based initiatives. FCCO's goal for 2024 was to expand on this partnership. Aligning with best practices promoted by the Ohio Department of Health (ODH), the SFRC has designated the FCSPC as the implementation body to ensure the SFRC recommendations are actionable. As the "actionable arm" of the SFRC, the FCSPC's Data & Research Action Team (DRAT) has developed a system for categorizing and assessing SFRC recommendations to increase digestibility and stakeholder buy-in and are then shared with the public expeditiously. In alignment with the CDC's categorization of risk and protective factors for suicide, the DRAT reviews SFRC recommendations and identifies the social-ecological levels at which the recommendations would impact local suicide risk: individual, relationship, community, and societal. The DRAT identifies both target audiences (i.e., agencies who would most likely implement the proposed recommendation) and target populations (i.e., community members whose suicide risk could be reduced with implementation of the recommendation). The hope for this process is to promote thorough data-driven community action.

OUR SERVICE

OVERVIEW OF RECOMMENDATIONS

Common themes for 2024 include increasing education, promotion of continuous care, and awareness of suicide risk for youth and individuals who identify with the LGBTQIA+ community. Increasing community education related to suicide prevention is an idea that was mentioned in each review. Implementing suicide prevention training at every school level could lead to earlier detection of mental health complications and can build resiliency among our youth. Members of the committee also felt that increased professional cross-training for physicians and therapists could better equip them to handle clients with comorbidities. Additionally, messaging regarding safe storage of lethal means should be expanded to speak about abusable medication and poisons in addition to firearms. Any lethal means restriction messaging should be advertised and readily available to the public. 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. Lastly, many of us know that individuals who identify with the LGBTQIA+ community are at a greater risk to experience suicidal ideation compared to the average individual. As a community, we must come together to better understand issues that are prevalent within this at-risk population so that we can build a more supportive community for all individuals who live, work, or play here no matter their race, sex, or gender identity.

REVIEWED CASE DEMOGRAPHICS

207 total suicide fatalities reported to FCCO including 25 out of county injuries.
*Out of county injury represents cases where the individuals died at a hospital within our jurisdiction, but the self-injury event occurred in a different county.

Age	2023	2024
≤ 19	2	1
20-29	-	1
30-39	-	-
40-49	1	-
50-59	-	-
60+	-	-

Race	2023	2024
Non-Hispanic White	3	1
Non-Hispanic Black	1	–
Other	-	1

Gender	2023	2024
Male	3	-
Female	-	1
Transgender Female	1	1

RECOMMENDATIONS

2024 Suicide Fatality Review Committee Recommendations

• Increase community awareness surrounding general lethal means restriction. Promote educational campaigns that focus on obscure types of lethal means (i.e., prescription medication). The creation of a community guide/tool could educate community members about how to have difficult conversations with at-risk individuals regarding temporary removal of lethal means during times of crisis or increased stress.

• Implement peer-to-peer support services for youth. Promote these services in alternative community locations (i.e., Barber shops, community centers, gyms).

• Suicide is self-directed violence. There is a need to support Homeland Security's work with implementing family treatment programs for those with violent tendencies rather it be self-directed or directed at others.

• Promote programming that supports continuous care for transition aged youth (i.e., Revamp juvenile court programming).

• Partner with local high schools/universities to promote and implement educational programs on social health of students; increase messaging to students about "what it looks like to be a good friend." Increase the number of students/faculty that are trained in suicide prevention.

RECOMMENDATIONS

• Encourage direct introductions for high school level mental health providers. High school guidance counselors utilizing a “warm handoff” to college level providers could increase the likelihood that students connect with the appropriate services.

• Create and foster partnerships between social services programs to provide culturally sensitive education on increased suicidal risks for sexual assault survivors.

• Produce educational material to increase community and provider knowledge regarding the risks and ease of access relating specific poisons often used as methods of suicide.

• Promote the “Youth Poisoning Protection Act” which was introduced in the Senate on January 29, 2025, and is currently at S.289, 119th Congress. This act aims to ban consumer sale of sodium nitrite products with a concentration greater than 10%.

• Share and distribute resources from programs (Kaleidoscope, Trans Ohio, etc.) that support LGBTQIA+ youth, especially transgendered youth.

• Implement evidence-based mental health and resiliency programming for young children as a form of prevention (PAX, Signs of Suicide, Yam, etc.).

• Existing research shows a higher prevalence of suicide among individuals who are on the autism spectrum and identify as transgender. Increase frequency of suicidality assessments with high-risk clients.

• Develop recommendations for regular screenings for suicide risk in elementary-age students and partner with school counselors for implementation.

RECOMMENDATIONS

• Promote the Centers for Disease Control and Prevention's (CDC) evidence-based strategies and community programs for mitigating the effect of adverse childhood experiences (ACEs) to build resiliency.

• Increase training to mental health providers regarding suicidal thoughts and behaviors which will lead to more comfortability talking about the subject with at-risk clients.

• Promote and implement best practices on how to treat individuals with an increased suicide risk who suffer from extreme comorbidities.

• Increase awareness to patients and their families when prescribing medications on (1) the strengths of utilizing therapeutic mental and behavioral health treatment services in combination with medication treatment and (2) the importance of medication compliance.

• Partner with health care providers to promote education to patients and their families on the idea of injectable mental health medication, working with patients who are resistant or noncompliant with their medication.

• Develop or update existing referral lists of behavioral healthcare providers (counseling, group therapy, long-term facilities, etc.) for hospitals to utilize when discharging clients experiencing suicidality.

• Advocate for policy that reduces necessary criteria for qualifying for public health insurance coverage for long-term residential mental health facilities which will increase accessibility for eligible high-risk clients.

2024 SUICIDE DEATHS DATA

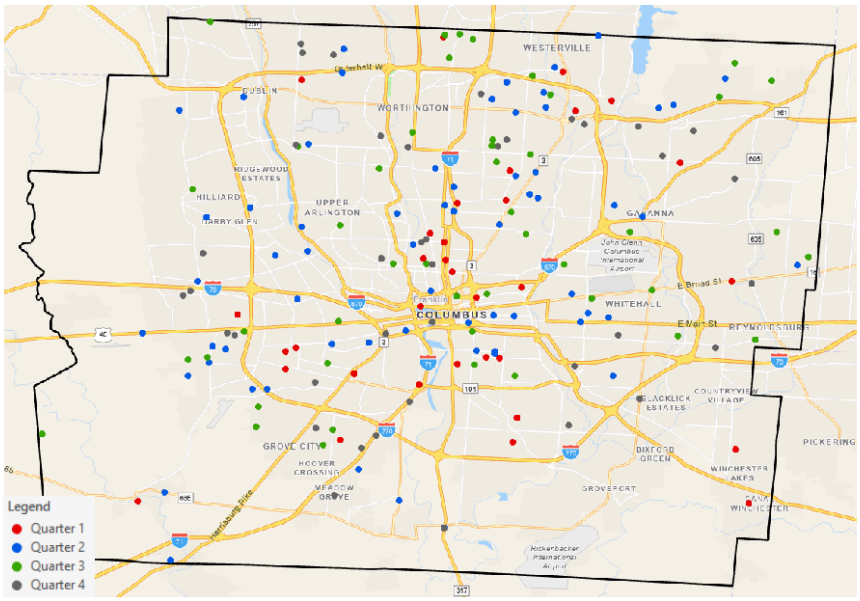
Franklin County Forensic Science Center
Office of the Coroner
Dr. Nathaniel Overmire
2090 Frank Road Columbus, Ohio, 43223
(614) 525-5290 Fax (614) 525-6002

March 20th, 2025
Time Period: 2024

Number of Suicide Deaths by Injury Location:

	Q1	Q2	Q3	Q4	2024
Franklin County	33	63	46	40	182
Out of County	5	5	8	5	23
Location Unknown	1	0	0	2	3

2024 Suicide Deaths in Franklin County by Quarter



Source: MDILog 2024.
Only cases with a precipitating incident occurring inside Franklin County are considered within this report.

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Number of Suicide Deaths by Method:

	Q1	Q2	Q3	Q4	2024
Acute Intoxication	6	13	5	4	28
Firearm	22	29	29	24	104
Hanging	3	14	9	8	34
Other	2	7	3	4	16
Total	33	63	46	40	182

Number of Suicide Deaths by Gender:

	Q1	Q2	Q3	Q4	2024
Male	28	49	37	30	144
Female	5	14	9	10	38

Number of Suicide Deaths by Race and Ethnicity:

	Q1	Q2	Q3	Q4	2024
Non-Hispanic White	26	49	29	25	129
Non-Hispanic African American	4	9	11	10	34
Hispanic	0	1	2	2	5
Other	3	4	4	3	14

Number of Suicide Deaths by Race and Gender:

	Q1	Q2	Q3	Q4	2024
White Male	22	38	23	18	101
White Female	4	11	6	7	28
African American Male	4	6	9	7	26
African American Female	0	3	2	3	8

Number of Suicide Deaths by Age Range:

	Q1	Q2	Q3	Q4	2024
<19	3	2	2	5	12
20-39	12	19	15	20	66
40-59	11	25	15	10	61
60-79	6	15	11	5	37
80+	1	2	3	0	6

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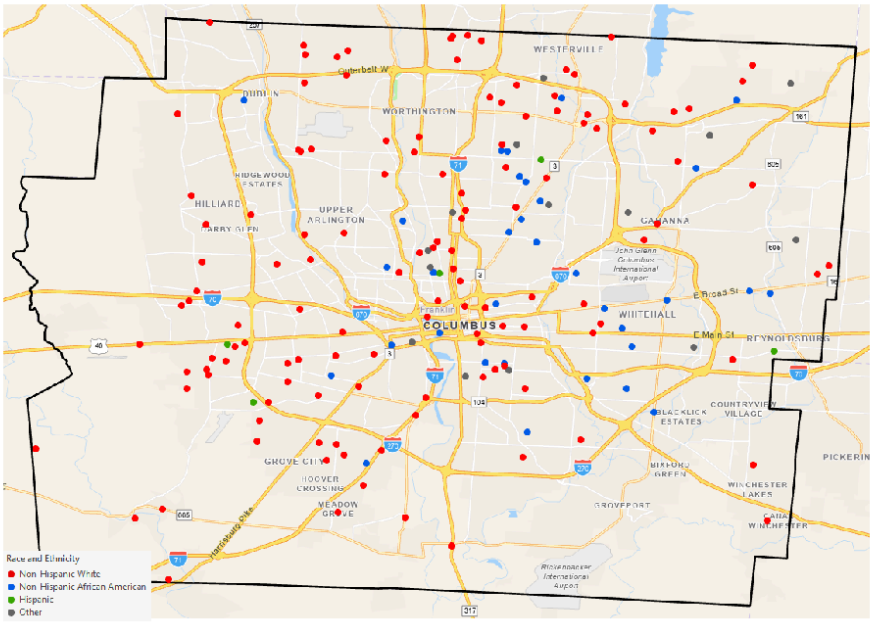
Age-Adjusted Death Rate of Suicide by Race and Ethnicity:

	Q1	Q2	Q3	Q4	2024
All	2.5	4.6	3.4	3.0	13.5
Non-Hispanic White	3.2	5.7	3.4	3.1	15.3
Non-Hispanic African American	1.1	2.8	3.1	3.0	10.0
Hispanic	0.0	0.9	1.9	2.1	4.9

*** Age-adjusted death rate reported in death Per 100,000 Population Count Adjusted to US 2000 Standard Population Weight and 2024 rates are estimated using 2023 Population Data.**

2024 Suicide Deaths in Franklin County by Race and Ethnicity



Source: MDILog 2024.
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2090 Frank Road
Columbus, Ohio 43223
614-525-5290

2024

PREPARED BY

JEREMY BLAKE

SENIOR ADVISOR &
DIRECTOR OF PUBLIC AFFAIRS