NEW YORK STATE | Department of Health

SHINE A BRIGHTER LIGHT

A White Paper on Improving the Reporting of Drug Overdose Fatalities in New York State

The people of New York State deserve a more consistent and collaborative Coroner and Medical Examiner system to ensure high quality, accurate, and timely death information. To that end, the New York State Department of Health Office of Drug User Health and the New York State Coroner/Medical Examiner Workgroup embarked on a variety of projects to better understand the issues and identify opportunities to improve the reporting of drug overdose deaths.

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ABSTRACT

The death certificate is the primary source of information on fatal drug overdoses, including the type of drug or drugs involved. However, there is an inconsistency throughout New York State in death investigations, toxicology testing, and death certification. This has significantly affected the quality, accuracy, and timeliness of the information on the death certificate, ultimately resulting in a lack of knowledge and underreporting of the drug epidemic for deaths outside of a clinical setting. The issues uncovered by this project are very likely to exist in other aspects of death reporting, including but not limited to infant, cardiac, motor vehicle, and consumer product safety.

Although Coroners and Medical Examiners are often aware of these challenges, changes that could streamline their work are not always rapidly accepted. The need for complete, accurate, and timely data requires the perspective and interventions by everyone at the local, state, and national level.

Therefore, the New York State Department of Health Office of Drug User Health embarked on a variety of projects to better understand the issues and improve the identification and reporting of drug overdose deaths certified by Coroners and Medical Examiners. New York State deserves a more unified and collaborative Coroners and Medical Examiners system to ensure high quality, accurate, and timely death information.

PROBLEM STATEMENT

The State Unintentional Drug Overdose Reporting System is an important tool to capture, monitor, and measure overdose deaths. A pilot project was launched in 2019 with twenty-one counties in New York State to collect and abstract data for drug overdose deaths from death certificates and Coroners and Medical Examiners' reports for entry into this web-based Centers for Disease Control and Prevention platform that is shared with the National Violent Death Reporting System. New York State and local jurisdictions are increasingly informed by systems like the State Unintentional Drug Overdose Reporting System, which present comprehensive information on the characteristics and circumstances surrounding drug overdose deaths to inform prevention and response efforts.

While the New York State Department of Health is meeting the reporting deadline for State Unintentional Drug Overdose Reporting System data to the Centers for Disease Control and Prevention, New York State struggles to meet the goal for the percentage of records that contain Coroners and Medical Examiners' reports, and all the reporting content therein, such as death scene, autopsy, toxicology, medical history, and more. For example, for the period January – June 2022, only 47 percent of the records the New York State Department of Health submitted contained a Coroner and/or Medical Examiner report. This prevents the Centers for Disease Control and Prevention from being able to publish our data on the Centers for Disease Control and Prevention State Unintentional Drug Overdose Reporting System dashboard.

CORONERS AND MEDICAL EXAMINERS AT THE CENTER

Coroners and Medical Examiners are a crucial part of the public health infrastructure in New York State because they investigate sudden and unexpected deaths, including drug overdose deaths. High-quality morbidity data obtained by Coroners and Medical Examiners are a key source of drug overdose death data and essential to public health surveillance and response efforts. These data help to enable the Centers for Disease Control and Prevention, New York State Department of Health, and Local Health Departments in New York State to understand the changing nature of the drug overdose epidemic at the state and local levels, deploy resources where they are needed the most, and identify emerging drug trends.

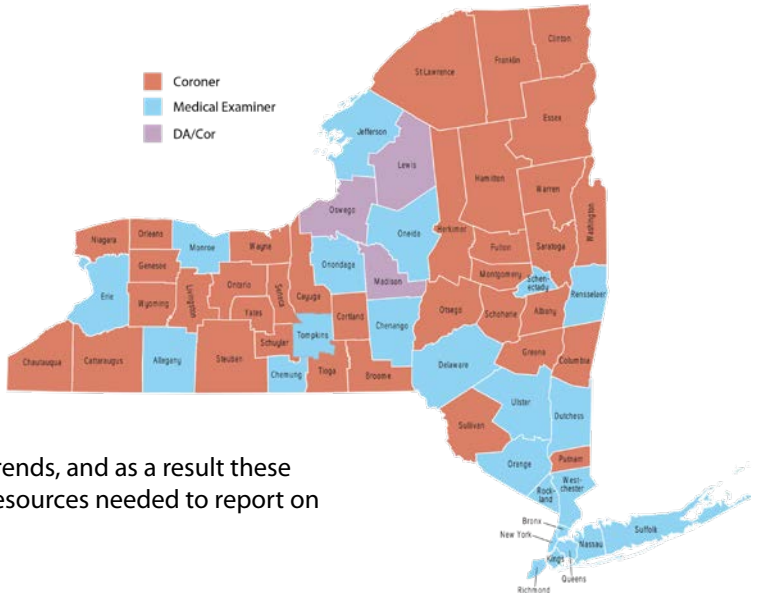
METHODOLOGIES

We have engaged the Coroners and Medical Examiners community via several qualitative methodologies:

- Thirty-seven in-depth interviews were conducted statewide with Coroners, Medical Examiners, Death Investigators, Administrative Assistants, Project Administrators, Local Health Department Commissioners and Public Health Directors, and more.
- Interviews with our peers in Ohio and Pennsylvania Departments of Health to learn about evidence-based solutions and best practices.
- Interviews with staff from Bureau of Occupational Health and Injury Prevention and Bureau of Vital Records.
- Interviews with New York State-based Association leadership from New York State Association of Counties.
- Formation of a statewide workgroup (See addendum 1 – Participants) representing different roles and perspectives that contribute to death reporting across New York State. Founded in 2021, the workgroup meets about seven times per year to identify the trends and challenges that hinder quality reporting of drug overdose deaths, learn best practices, and guide the solutions that will enhance the Coroners and Medical Examiners profession and ultimately improve the quality and consistency of drug overdose fatality reporting in New York State.
- Web-based research on trends, practices, and more.

Background

According to a 2018 report by the New York State Association of Counties, there are presently 35 counties with a Coroner's Office and 20 counties with a Medical Examiner's Office, including the five counties making up New York City. Three counties in New York operate under a coroner model, but their District Attorney serves as the elected coroner. In general, coroners are independently elected officials while medical examiners are appointed and are required to be physicians. Their roles vary from county to county.



An analysis of county adopted 2018 budgets shows that there are over 1,100 people working in medical examiner or coroner offices across New York State. There are over 114 elected coroners and deputy coroners in New York State — the vast majority of which serve in a part-time capacity. In 2018, counties across New York State budgeted over $122M for coroner and medical examiner services.

Coroners and Medical Examiners are occasionally supported by a staff administrative person who helps with case tracking, financial accounting, and reporting. That said, staffing levels have not kept pace with increasing case load trends, and as a result these departments struggle to make the time and budget for the resources needed to report on cases, in particular fatal overdose deaths, in a timely manner.

We know from firsthand research and interviews that there are a number of factors contributing to the delays and quality of data reporting. Chief among them are:

Therefore, the New York State Department of Health embarked on a variety of projects to better understand the issues and improve the identification and reporting of drug overdose deaths certified by Coroners and medical examiners.

CHALLENGES IDENTIFIED

Although Coroners and Medical Examiners are often aware of these challenges, changes that could streamline work are not always rapidly accepted and are often met with legislative policy obstacles or confusion. The need for complete, accurate, and timely data requires statewide interventions. Therefore, the New York State Department of Health embarked on a variety of projects to better understand the issues and improve the identification and reporting of drug overdose deaths certified by Coroners and Medical Examiners.

For context, the following issues were discovered in our fieldwork:

- A Decentralized Model in New York State
- Workflow Productivity:
  - Redundancies
  - Repetitive Requests
- Lack of Industry Leadership Statewide
- Inconsistent County and Local Organization and Reporting Structures
- County and State Laws are Confusing and Misaligned to Support State and National Needs
- Staffing:
  - Department Sizes have not Kept Pace with Caseload Trends
  - Spikes in cases at the county level can easily overwhelm a department for months
  - Attraction of Qualified Workforce
  - Shortage of Qualified Workforce Nationwide
  - Budget and Compensation Challenges
  - Turnover and Personnel
- Toxicology Lab Processing:
  - Timelines
  - Cost
- The Administrative Assistant Plays an Important Role in Managing and Developing Reports
- Lack of Basic Resources
- Funding was cited as a root cause of challenges, directly tied to staffing, training, and maintaining standards

A DECENTRALIZED MODEL IN NEW YORK STATE

Our interviews with the Coroner and Medical Examiner Community indicates that there is an inconsistency throughout New York State in death investigations, toxicology testing, and certification. Specifically, there is a decentralized Coroners and Medical Examiners system in New York State. There are significant variations at the county level, including;

- field investigation tools
- oversight and reporting structure
- full-time and part-time status of Coroners and Medical Examiners
- case tracking and reporting tools
- on-site and off-site toxicology labs funding models

Disparities in reporting may also exist because medical examiner counties are better funded and staffed compared to coroner counties that have part-time positions covering large geographic areas.

LACK OF LEADERSHIP STATEWIDE

There is a lack of leadership of the Coroners and Medical Examiners profession within the public and private sectors to advocate for recruitment and retention, funding, and training which would serve to enhance the overall quality of performance. This is decentralized between several trade associations, county leadership, and even political parties (in the case of coroners are elected to the role).

- It is the published mission of New York State Association of County Coroners and Medical Examiners to serve as the advocacy organization for its profession, however, it is a small nonprofit with an optional annual paid membership. While many Coroners, Medical Examiners and others in related roles maintain membership, numerous people who were interviewed said that they do not participate with this outside of the mandatory Coroner 101 training, demonstrating the need to increase opportunities to improve connectivity among the profession. In the past, organizations like New York State Association of Counties and the New York State Association of County Health Officials have also played an advocacy role on issues related to workforce funding.
- There appears to be no role in New York State government to manage relationships across counties, among Coroners and Medical Examiners, and between the New York State Department of Health, law enforcement agencies, and other relevant partners.
- There is a lack of state standards for fieldwork. For example, Coroners and Medical Examiners described mirroring forms from other counties whose staff they respect, rather than using a template developed by a national or state-level entity.

There currently is no organization designated to work on an ongoing basis to educate and inform county legislative and statewide funding sources about the importance of the role of Coroners and Medical Examiners and the depth of what their job entails.

INCONSISTENT COUNTY AND LOCAL ORGANIZATION AND REPORTING STRUCTURES

The organizational structure varies from county to county, with the Coroners and Medical Examiners working in siloed relationships within their departments, and independent from state and local health departments, law enforcement agencies, etc. This has the potential to hinder collaboration, learning, and trend reporting.

Interviews show Coroners and Medical Examiners typically see themselves as an independent role from public health and law enforcement teams within their counties. They tend to view their role as transactional in nature and often don't see or appreciate their work in a greater context. In some instances, there is even competition within county department teams for the personal revenue derived from cases using a fee-for-service model. Coroners have described monitoring police and Emergency Medical Services calls to be the closest and first available on scene.

COUNTY AND STATE LAWS ARE CONFUSING AND MISALIGNED TO SUPPORT STATE AND NATIONAL NEEDS

The state and county laws applicable to data sharing for Coroners and Medical Examiners (See Addendum 2) are difficult to understand and access. County attorneys are unable at times to interpret and provide guidance to their Coroners and Medical Examiners regarding information that can legally be shared. This leads many Coroners and Medical Examiners to:

- refuse or ignore requests for data from New York State because of the fear of repercussions.
- work only at the task level with no incentive to see trends and public health implications.

DEPARTMENT SIZES HAVE NOT KEPT PACE WITH CASELOAD TRENDS

Caseloads have risen significantly in recent years related to overdose, violent death, and COVID-19, but staffing levels have remained relatively stable. The high volume of deaths and low staffing contributes to difficulty in working and closing cases in a routine and timely manner.

The Centers for Disease Control and Prevention reported that as of Feb. 16, 2022, in addition to the 914,000 United States deaths attributed to COVID-19, there have been another 131,000 deaths since the pandemic started that it classifies as "excess," meaning that they exceed the number that would normally have been expected.

The National Association for Medical Examiners, the accrediting body for medical examiner's offices, recommends that one physician do no more than 325 "autopsy equivalents" per year. Interviews with coroners and medical examiners suggests that this "not to exceed" number is lower than actual workload. These interviews told us that many Medical Examiners that are balancing a caseload nearly 50% above that rate.

SPIKES IN DEATH CASES AT THE COUNTY LEVEL CAN EASILY OVERWHELM A DEPARTMENT FOR MONTHS

From our interviews with Coroners and Medical Examiners, we learned that the increase in death rates from COVID-19, mass killings, and other incidents caused a significant strain on the Coroners and Medical Examiners system, including toxicology lab turnaround times. That trend seems to be waning, though local spikes in caseload and/or a temporary staffing issue such as vacation or sick leave often can result in significant backlogs in work. In some instances, this can mean the difference between one and three cases per day.

STAFFING TURNOVER

Several counties cited staff turnover as an obstacle to the quality and timeliness of their work. The loss of institutional knowledge and time needed to onboard and train replacements can have the same effect on the ability to efficiently process caseload as a spike in cases or staff on leave.

ATTRACTION OF QUALIFIED WORKFORCE

The role of a Coroners and Medical Examiners requires close contact with stressful settings such as homicides, suicides, and overdoses. Attracting staff with the ability and interest in this type of work can be challenging. Additionally, there is the need to interact with the criminal justice system, which is not the norm for most medical disciplines.

SHORTAGE OF QUALIFIED WORKFORCE NATIONWIDE

There also seems to be a significant nationwide shortage of Medical Examiners. The United States has about 500 full-time, board-certified forensic pathologists but our workgroup believes that roughly twice that number are needed. The National Association for Medical Examiners reported about 40 new forensic pathologists graduate each year, which isn't enough to keep up with the needs of the jurisdictions leaving the profession.

STAFFING: BUDGET AND COMPENSATION CHALLENGES

There are several financial factors affecting the ability to attract Coroners and Medical Examiners.

Economics of the degree versus pay scale (clinical pathologist vs forensic pathologist)) present a challenge. It seems clinical pathologists can earn $300 - $350,000 range, but forensic pathologists require an additional year of education and training for positions that pay about $194 - $230,000.

Additionally, it can be harder for counties in New York State to financially compete with other parts of the country that may have lower taxes and a lower cost of living.

TOXICOLOGY LAB PROCESSING: TIMELINES AND COST

The turnaround time from toxicology labs was often cited as a reason for delays in submitting reports in a timely manner. Many participants described turnaround times of 8-12 weeks in 2021 but noted that timelines have improved during the second half of 2022 to 6-8 weeks. Counties with in-house labs seem to have faster turnaround times, although colleagues in Pennsylvania (Pennsylvania and Ohio were interviewed for this project to learn their best practices and chosen based on their decentralized coroner/medical examiner system) described an average two-week turnaround time.

The cost of toxicology reports was often cited as a challenge for Coroners and Medical Examiners. These costs affect the Coroners and Medical Examiners department's overall budget and therefore could affect the ability to invest in staffing, training, and technology. Standard screenings can cost $400 and advanced screenings up to $900, which may disincentivize the search for novel psychoactive substances. Novel psychoactive substances are new substances in the recreational drug market that contain compounds that are either repurposed from pharmaceutical research or chemically modified by other drugs of abuse including synthetic cannabinoids (also known as K2) or bath salts.

WORKFLOW PRODUCTIVITY: REDUNDANCIES, AND REPETITIVE REQUESTS

Statewide, death data are collected and tracked in many ways, with some methods still relying on a paper-based system rather than digital methods. There seems to be a preference for paper forms in the field (which may be less impersonal than a tablet), but data collected on paper need to be manually re-entered when returning from home offices to the County office, causing delays. Additionally, there is an absence of uniform standards for paper record-keeping at home offices, which could result in issues related to the Health Insurance Portability and Accountability Act, loss, and chain of custody.

Coroners and Medical Examiners (and/or their administrative staff) are often burdened with multiple requests for the same autopsy/medical examiner/toxicology reports, often from the same agency

Several agencies that have interest in reports, including but not limited to:

- New York State Department of Health
- Local Health Departments
- New York Department of Labor
- New York State/County Attorneys General
- New York State Department of Motor Vehicles
- State and Local Child & Family Services

LACK OF BASIC RESOURCES

The consensus among workgroup members is a lack of basic resources related to essential job functions including transportation and photography equipment. This may to be tied to funding and more of an issue for rural counties with smaller budgets.

FUNDING WAS CITED AS A ROOT CAUSE OF CHALLENGES, DIRECTLY TIED TO STAFFING, TRAINING, AND MAINTAINING STANDARDS

Prior to 2011, county Coroners and Medical Examiners were reimbursed up to 36 percent with State aid from Article 6 funding to Local Health Departments. In 2011, the New York State Budget shifted the reimbursement for medical examiners from the New York State Department of Health to the New York State Department of Criminal Justice Services and the funding was no longer available to Local Health Departments as New York State deemed this activity to be a public safety and not a public health function.

The overwhelming majority of funding for Coroners and Medical Examiners across New York State comes from the county tax base.

There are additional resources available to some counties, which include:

- **FEE FOR SERVICE.** Providing Coroners and Medical Examiner-related services for other counties as a revenue stream.
- **CORRECTIONS.** The New York State Department of Corrections covers modest expenses for autopsy expenses related to the death of an incarcerated person.
- **FEDERAL GRANTS** such as the **COVERDELL GRANT**, (up to $500,000) are in place, but have restricted use for technology, materials, and support, including services provided by laboratories operated by states and units of local government. However, in order to qualify, the county must be accredited by International Association of Coroners and Medical Examiners (or the funding needs to be used to pursue accreditation). That accreditation is based on caseload and metrics as well as the timeliness of reporting.

POTENTIAL SOLUTIONS

While funding could easily be identified as a root cause, we believe there are several strategies that need to be considered in order to change the organizational dynamic, workflow, and communication in the Coroner/Medical Examiner system to facilitate better outcomes. The following is a list of those strategies that we believe need to be further explored and implemented to create change and improve the quality and timeliness of death reporting:

STATE UNINTENTIONAL DRUG OVERDOSE REPORTING SYSTEM (SUDORS) AWARENESS AND EDUCATION CAMPAIGN

- The State Unintentional Drug Overdose Reporting System was launched statewide in 2019 and continues to be promoted. In spite of past efforts and ongoing outreach to enable use with self-addressed stamped envelopes and other support, there is low awareness and utilization of the State Unintentional Drug Overdose Reporting System program. The New York State Department of Health Office of Drug User Health launched a campaign in 2024 designed to heighten awareness, education and training, and support with a goal of increased participation with the State Unintentional Drug Overdose Reporting System.

The goal of this campaign would be to achieve the following:

- Partner with county and industry leadership
- Raise Awareness of State Unintentional Drug Overdose Reporting System among potential users
- Education and training for potential users
  - Training, including changes to Coroner training curriculum, webinars, and in-service presentations at trade association events
  - Promotion of Technical Assistance and Helpline/Email Enable participation with tools such as self-addressed stamped envelopes

- Explore data partnerships / statewide integration and a shift to Dropbox technology/tools and templates available for us and distributed through industry partners such as New York State Association of Coroners and Medical Examiners
- Develop, implement and distribute funds as part of a Drug Overdose Report Submission Reimbursement Program

DEVELOPMENT OF A COMPREHENSIVE CORONER TRAINING PROGRAM IN NEW YORK STATE

Currently, all new coroners in New York State are only required to attend an eight-hour training session presented once a year by the New York State Association of County Coroners and Medical Examiners. The curriculum is skillful but a one-day training is not comprehensive enough to include all facets of a coroner's responsibilities and ongoing professional development. The development of a consistent training program for all new and existing coroners in New York State is essential in order to ensure accurate and consistent results from death investigations across the state.

We propose the development and deployment of a formal, comprehensive training program for all Coroners and Medical Examiners in New York State. The program would provide a one-stop shop, particularly for Coroners where there is no formal experience and educational requirements, offering up-to-date information on the latest policies and procedures.

The proposed training program in New York State would work with subject matter experts to provide a robust and consistent training program for practitioners in the field. The development of this program based on national standards and in conjunction with an established education and/or workforce development partner would ensure that the curriculum is comprehensive, high-quality, consistent statewide, kept up-to-date, and relevant.

LEGISLATIVE CHANGES TO ENABLE DATA SHARING AND ENHANCED COMMUNICATION

- Legislative changes to New York State law for data sharing that can supersede county law 677 Legislative
- Changes to Data Sharing to protect authors, based on a model developed by Ohio (one of a few states researched and interviewed for this white paper)

ENHANCED LEADERSHIP FOR THE FIELD OF CORONERS AND MEDICAL EXAMINERS, AND THEIR SUPPORT TEAMS:

- Creation of statewide champion/industry relations position within New York State Department of Health (similar to the Funeral Director role) to work directly Coroners and Medical Examiners, and their support teams to communicate, and support their work; this will also minimize reliance on third parties
- Greater support for New York State Association of County Coroners and Medical Examiners's mission by participation in workgroups, training, grant funding, and workforce support
- Strong alignment and organizational reporting with County Local Health Departments in conjunction with the New York State Association of County Health Officials
- Formation of regional or statewide boards of Coroners and Medical Examiners
- Development of Industry Standards
    - Consistent field reporting, case tracking, etc.
    - Dropbox tools for reporting

DEVELOPMENT AND ADVOCACY FOR BEST PRACTICES AT THE COUNTY LEVEL

As we analyze the findings from this research and correlate those with counties that have better performance, a few themes and best practices emerged, including:

- Elasticity in staffing key roles to better respond to spikes in caseload
- Salary vs fee-for-service structure
- Full-time versus part-time positions
- Low turnover within the department
- Strong administrative support for Coroners and Medical Examiners
- On site toxicology labs, and/or retain a private lab for overflow caseload management
- Positive working relationship with Information Technology

FUNDING

- Appeal to federal and state for staffing solutions due to era of mass resignation training/continuing education credits
- Develop, implement and distribute funds as part of a Drug Overdose Report Submission Reimbursement Program to help soften the costs of postmortem toxicology testing and other costs

STAFFING MODELS

- Creation of statewide champion/industry relations position (Part-time, not necessarily a full-time equivalent) within New York State Department of Health (described above)
- Floating forensic pathologist (or Physician Assistant) to cover multiple counties
- Internship programs from accredited colleges and university programs as a feeder to full-time employment, and simultaneously relieve some of the workload for staff

TOXICOLOGY

- Counties should establish overflow contracts with laboratories (if applicable) to ensure they have adequate support for their constituents

AWARENESS AND ADVOCACY CAMPAIGNS/IN-SERVICE PRESENTATIONS TARGETING COUNTY LEADERSHIP AND CORONER/MEDICAL EXAMINERS THEMSELVES

- Staffing recruitment and retention toolkit for counties
- Coroners and Medical Examiners role in public health, why mortality data matters

CONCLUSION

The death certificate is the primary source of information on fatal drug overdoses including the type of drug or drugs involved. However, we have identified a systemic problem with death reporting by Coroners and Medical Examiners in New York State, as well as the key factors contributing to delays, lack of communication, and collaboration.

This has significantly affected the quality, accuracy, and timeliness of the information on the death certificate, ultimately resulting in a lack of knowledge and under reporting of the drug epidemic.

As a result, we believe that not only drug overdose, but other public health issues such as infant mortality, heart disease, motor vehicle, and consumer product safety are also likely underreported.

It is essential that we have timely, accurate information for the purpose of developing stronger intervention and prevention strategies across all public health issues.

Action needs to be taken now to explore and implement the strategies presented in this white paper to affect change in the system and ensure quality reporting of all public health issues.

ADDENDUM 1: RCORONER/MEDICAL EXAMINER WORKGROUP PARTICIPANTS (FROM INCEPTION THROUGH FALL 2023)

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ADDENDUM 2: HTTPS://WWW.NYSENATE.GOV/LEGISLATION/LAWS/CNT/677

SECTION 677

Records; reports

County (CNT) CHAPTER 11, ARTICLE 17-A

§ 677. Records; reports.

1. The writing made by the coroner, or by the coroner and coroner's physician, or by the medical examiner, at the place where he takes charge of the body, shall be filed promptly in the office of the coroner or medical examiner. The testimony of witnesses examined before him and the report of any examination made or directed by him shall be made in writing or reduced to writing and thereupon filed in such office.

2. The report of any autopsy or other examination shall state every fact and circumstance tending to show the condition of the body and the cause and means or manner of death. The person performing an autopsy, for the purpose of determining the cause of death or means or manner of death, shall enter upon the record the pathological appearances and findings, embodying such information as may be prescribed by the commissioner of health, and append thereto the diagnosis of the cause of death and of the means or manner of death. Methods and forms prescribed by the commissioner of health for obtaining and preserving records and statistics of autopsies conducted within the state shall be employed. A detailed description of the findings, written during the progress of the autopsy, and the conclusions drawn therefrom shall, when completed, be filed in the office of the coroner or medical examiner.

3. (a) The coroner or coroners of each county, or the medical examiner, shall keep full and complete records, properly indexed, stating the name, if known, of every person whose death is investigated, the place where the body was found, the date of death, if known, and if not known, the date or approximate date as determined by the investigation, to which there shall be attached the original report of the coroner, or coroner and coroner's physician or physician employed, or medical examiner, and the detailed findings of the autopsy, if any. Such records shall be kept in the office of the county clerk except in those counties having a full-time coroner or medical examiner, in which case such records shall be kept in the office of the coroner or medical examiner.

(b) Such records shall be open to inspection by the district attorney of the county. Upon application of the personal representative, spouse or next of kin of the deceased to the coroner or the medical examiner, a copy of the autopsy report, as described in subdivision two of this section shall be furnished to such applicant. Upon proper application of any person who is or may be affected in a civil or criminal action by the contents of the record of any investigation, or upon application of any person having a substantial interest therein, an order may be made by a court of record, or by a justice of the supreme court, that the record of that investigation be made available for his inspection, or that a transcript thereof be furnished to him, or both.

4. The coroner, coroner's physician or medical examiner shall promptly deliver to the district attorney copies of all records pertaining to any death whenever, in his opinion, or in the judgment of the person performing the autopsy, there is any indication that a crime was committed.

5. The coroner, coroner's physician or medical examiner shall promptly report to the commissioner of motor vehicles, in a form and manner specified by the commissioner, the results of all quantitative tests for alcohol, and for any trace of a controlled substance, as defined in section three thousand three hundred six of the public health law, that the coroner, coroner's physician or medical examiner has reasonable cause to believe is present, performed upon bodies of victims of motor vehicle accidents pursuant to the requirements of subdivision three of section six hundred seventy-four of this chapter.

6. Notwithstanding section six hundred seventy of this article or any other provision of law, the coroner, coroner's physician or medical examiner shall promptly provide the chairman of the correction medical review board and the commissioner of corrections and community supervision with copies of any autopsy report, toxicological report or any report of any examination or inquiry prepared with respect to any death occurring to an incarcerated individual of a correctional facility as defined by subdivision three of section forty of the correction law within his or her county; and shall promptly provide the executive director of the justice center for the protection of people with special needs with copies of any autopsy report, toxicology report or any report of any examination or inquiry prepared with respect to the death of any service recipient occurring while he or she was a resident in any facility operated, licensed or certified by any agency within the department of mental hygiene, the office of children and family services, the department of health or the state education department. If the toxicological report is prepared pursuant to any agreement or contract with any person, partnership, corporation or governmental agency with the coroner

or medical examiner, such report shall be promptly provided to the chairman of the correction medical review board, the commissioner of corrections and community supervision or the executive director of the justice center for people with special needs, as appropriate, by such person, partnership, corporation or governmental agency.

7. (a) Upon the written request of the commissioner of mental health, the commissioner of the office for persons with developmental disabilities, the director of the mental hygiene legal service, the executive director of the justice center for the protection of people with special needs or the director of a mental hygiene facility, as defined in subdivision two of section five hundred fifty of the executive law, at which the deceased was a patient or resident, the coroner, coroner's physician or medical examiner shall provide such person with a copy of all reports and records, including, but not limited to, autopsy reports and toxicological reports related to the deceased prepared by a person, partnership, corporation or governmental agency pursuant to any agreement or contract with the coroner or medical examiner with respect to the death of a patient or resident receiving services at such a mental hygiene facility.

(b) Upon the written request of the commissioner of mental health, or commissioner of developmental disabilities, or a director of a departmental facility as defined in section 1.03 of the mental hygiene law, or the executive director of the justice center for the protection of people with special needs, the coroner, coroner's physician or medical examiner shall transmit to the commissioner, or such director, or any member of the justice center medical review board, original autopsy slides, tissue materials and specimens taken from the body of a deceased patient or resident as defined in paragraph (a) of this section. Such original materials may be used and tested by such office of the department of mental hygiene, or such director, and justice center medical review board pursuant to its authority under section five hundred fifty-six of the executive law. Such slides, materials and specimens may be retained for a reasonable time, and shall be returned to the office of the coroner or medical examiner in good condition allowing for reasonable use for study and testing purposes.

8. The coroner, coroner's physician or medical examiner shall promptly, but in no event later than sixty days from the date of death, absent extraordinary circumstances, provide the office of children and family services with copies of any autopsy report, toxicological report or any report of any examination or inquiry prepared with respect to any death occurring to a child whose care and custody or custody and guardianship has been transferred to an authorized agency, a child for whom child protective services has an open case, a child for whom the local department of social services has an open preventive services case, or a child reported to the statewide central register of child abuse and maltreatment. If the toxicological report is prepared pursuant to any agreement or contract with any person, partnership, corporation or governmental agency with the coroner or medical examiner, such report shall be promptly, but in no event later than sixty days from the date of death, absent extraordinary circumstances, provided to the office of children and family services by such person, partnership, corporation or governmental agency. Where the death involves a child reported to the statewide central register of child abuse and maltreatment, the reports referred to in this subdivision shall also be promptly, but in no event later than sixty days from the date of death, absent extraordinary circumstances, provided to the local child protective service investigating the report pursuant to section four hundred twenty-four of the social services law.

9. When required for official purposes of the state department of health, the state commissioner of health or his or her designee may request copies of all reports and records related to a death, including, but not limited to, autopsy reports and toxicology reports. Upon receipt of the written request of the state commissioner of health or his or her designee, a coroner, coroner's physician or medical examiner, shall, within three business days of their completion, provide to such commissioner or his or her designee a copy of all reports and records, including, but not limited to, autopsy reports and toxicology reports related to the death.

* 10. (a) The coroner, coroner's physician or medical examiner shall report to the division of veterans' services, in a form, and time frame developed by the department of health in a manner that is protective of privacy and contains aggregate, rather than individual data to the extent practicable, any death which appears to be caused by suicide by a person who, to the knowledge of the coroner, coroner's physician or medical examiner, is a veteran.

(b) For the purposes of this subdivision, veteran means a person who served in the United States army, navy, air force, space force, marine corps, coast guard, and/or reserves thereof, and/or in the army national guard, air national guard, New York guard and/or New York naval militia, and/or who served as a member of the commissioned corps of the national oceanic and atmospheric administration or the United States public health service regardless of discharge status.

* NB Effective June 7, 2022