

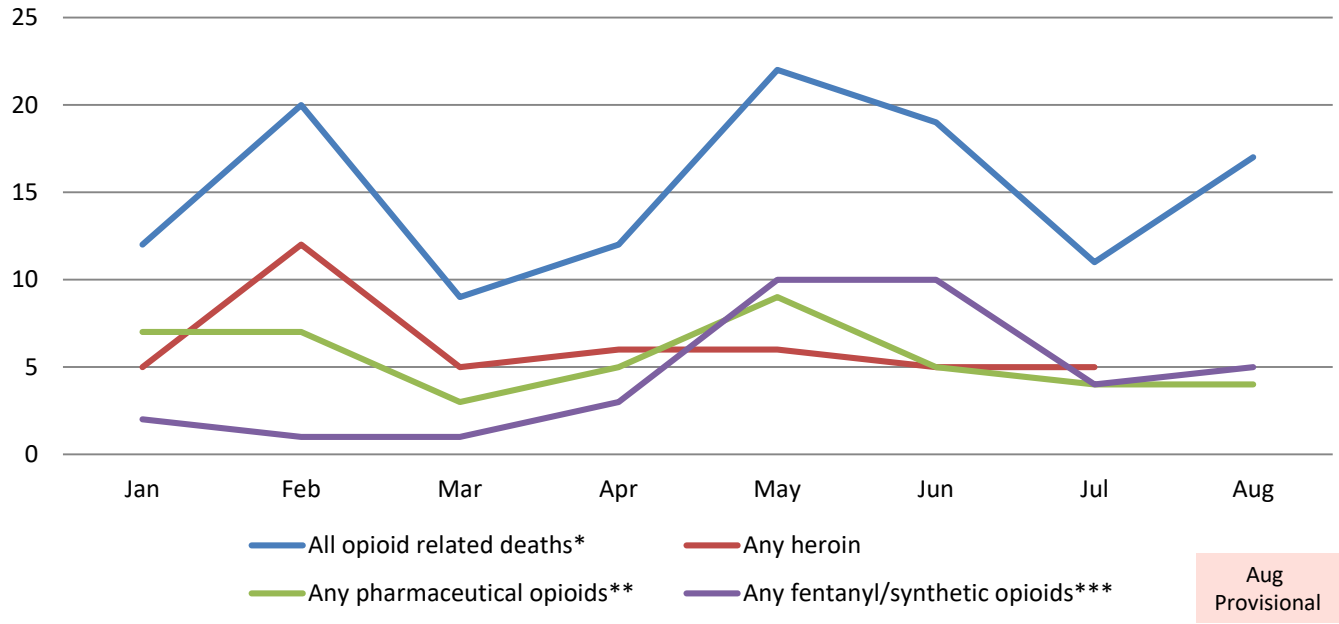
**Fatal Opioid Overdoses**  
**January 2017 – August 2017**

**Background**

The State Medical Examiner’s Office maintains a database for all deaths investigated under its jurisdiction. These data are considered an effective source for rapidly collecting information about overdose deaths due to opioids.

Data are considered provisional and counts may increase based on pending toxicology.

**Opioid Deaths Investigated by Medical Examiner by Drug Type and Month**  
**Clackamas, Multnomah, and Washington Counties: Jan-Aug 2017**

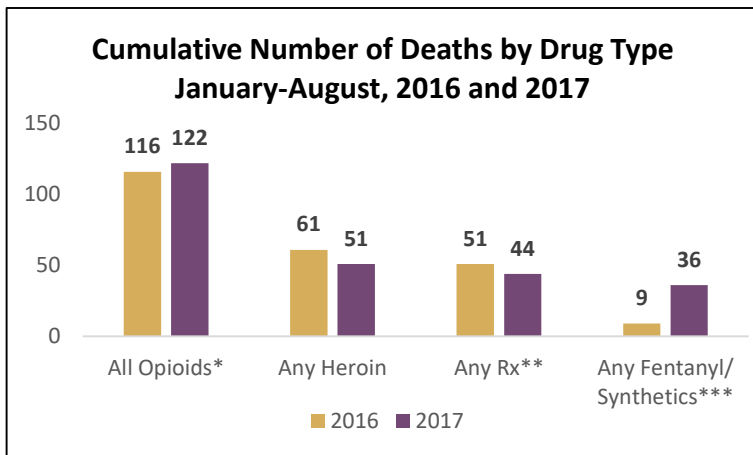
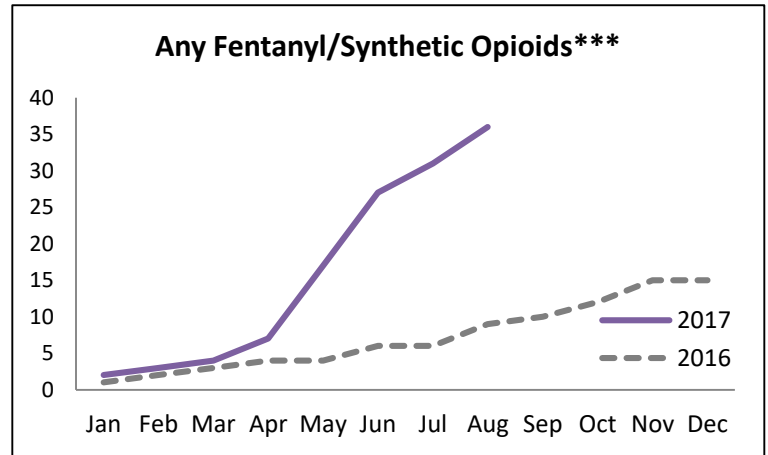
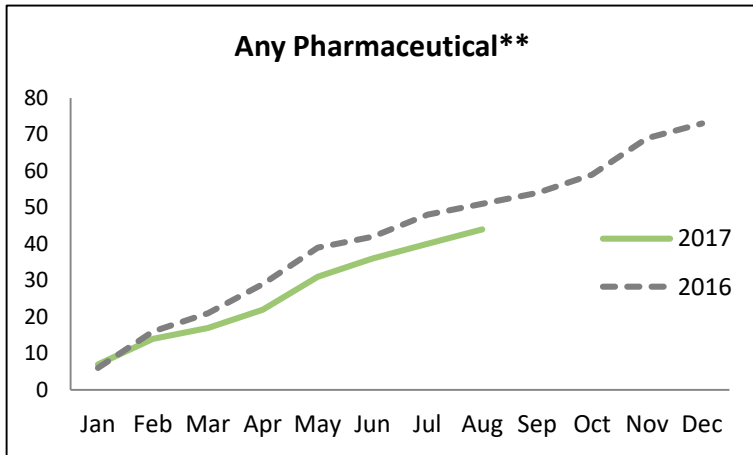
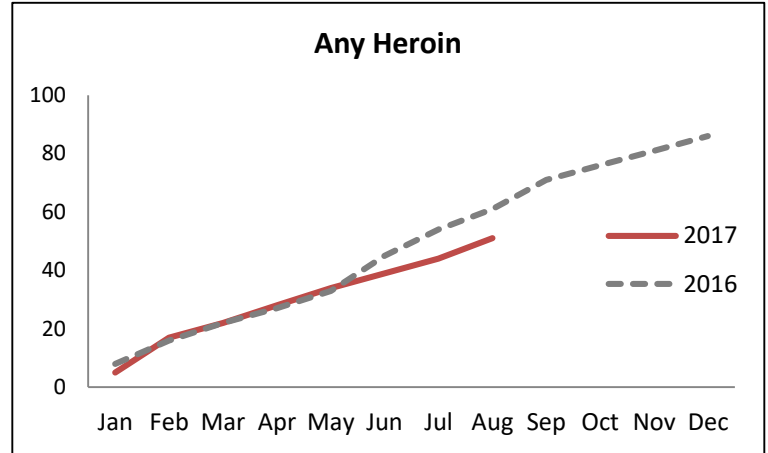
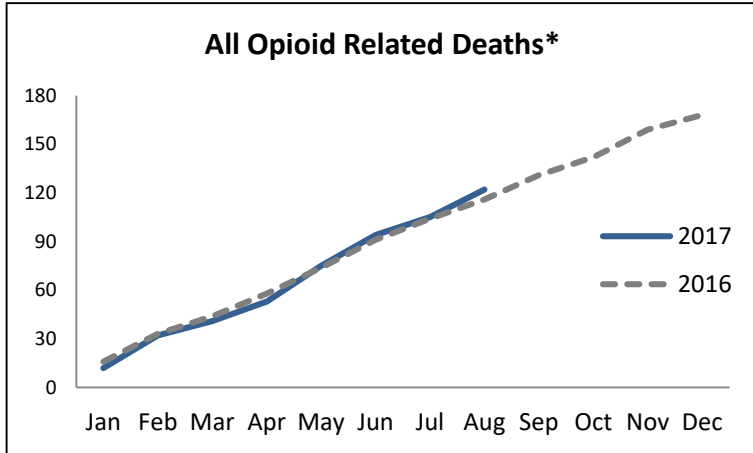


\* Includes any substance where pharmacologic type is opioid, including heroin, and any death where a specific opioid was not listed (e.g., “opioid”, “opiate”)  
 \*\* Pharmaceutical opioid refers to specific brands of prescription opioids as well as methadone  
 \*\*\* Includes any mention of fentanyl or derivatives plus illegal opioids such as U-47700, 4-ANPP, kratom/mitragynine  
 SOURCE: Oregon Medical Examiner Database



The Tri-County Opioid Safety Coalition coordinates efforts to decrease the harms and overdose deaths from opioids, improve the quality of life for people living with chronic pain, and improve the quality of life for people with opioid use disorder in Clackamas, Multnomah, and Washington counties.

Year-to-Date Cumulative Number of Fatal Opioid Overdoses by Drug Type and Month  
Clackamas, Multnomah, and Washington Counties  
2016 and 2017



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SOURCE: Oregon Medical Examiner Database

## Methods

Cases were identified using a literal text search of electronic Medical Examiner data for search terms including specific drugs, categories of drugs, and ICD-10 codes. This method was validated by case reviews. Data were included if the primary or contributing causes of death involved at least one of the following: prescription opioid, heroin, fentanyl/illicit opioids, or an unspecified opioid. All manners of death (i.e., accident, suicide, homicide, and unspecified) were included. Some deaths involve multiple substances and categories are not mutually exclusive.

## Limitations

Medical Examiner data are provisional and counts are likely to increase based on pending toxicology results. This surveillance report will generally update counts monthly with a 3-4 month lag based on the ratio of pending to confirmed cases. Counts will increase in subsequent reports if additional pending cases are confirmed.

While the Medical Examiner should be involved in all drug-related deaths, the Medical Examiner does not conduct an investigation in some rare cases, generally due to reporting errors. Overall, for capturing information on opioid-related deaths, Medical Examiner data are considered an effective source for rapidly collecting this information.

It is not possible to calculate death rates by county due to 1) deaths investigated by the Medical Examiner are assigned to a county based on where the death occurred rather than the residence of the deceased and 2) that address information for the deceased is sometimes incomplete. As a result, the denominator, or the population at risk for a death investigated by the Medical Examiner, is unknown, preventing calculation of a rate.

## Contact

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