Suicide Investigations and Investigators

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When someone dies by suicide, the surrounding community often has questions about what happened, why, and how to prevent similar deaths in the future. To answer those questions, suicides are sometimes followed by investigations, although who conducts them and how can change from place to place.

Suicide Fatality Review Boards

Suicide Fatality Review Boards (SFRBs), or Suicide Fatality Review Committees, offer one approach to suicide investigation. These boards are multi-disciplinary, multi-agency teams[1] often convened by county mental health boards, local health departments, or the coroner's office. SFRBs generally include fifteen to thirty-five people from different sectors of the community, including law enforcement, education, healthcare, and prevention.[1] They may be formed at the local, county, or regional level, and operate as full committees or within a series of sub-committees depending on the needs of the population.

Modeled after child fatality review boards, SFRBs conduct case reviews of local suicides.[1] Rather than assign blame for a suicide death to a specific person or organization, the goal of case reviews is to uncover gaps in suicide prevention, intervention, or crisis response services. From there, SFRBs use their collaborative approach to draft, implement, evaluate, and monitor solutions to problems identified during case reviews. [1]

Due to the sensitive nature of the cases, reviews are confidential.[2] Meetings are closed to the public, records presented for case reviews can only be used within the context of that review, and information uncovered during the review is rarely released to the deceased's family members to avoid further traumatization. An Ohio law that recently went into effect requires that some information, including cause and geographic location of the death as well as contributing factors to the death must be included in an annual report to the Ohio Department of Health.[2] The department, in turn, produces a publicly available annual report, but information included in the report cannot be traced back to individual decedents.[2]

Suicide Fatality Review Board Members

Members can include (but are not limited to):

- Organizations that work with individuals at higher risk for suicide
- Law enforcement
- Local schools
- Healthcare providers
- Local courts
- County coroner
- Suicide prevention or postvention experts
- A Psychological Autopsy Investigator

Psychological Autopsy Investigator

Another way for communities to examine the circumstances surrounding a suicide is by working with a certified Psychological Autopsy Investigator (PAI).[3] These investigators are trained in psychological autopsy, an evidence-based postmortem procedure designed to reconstruct an individual's death by suicide and resolve uncertainties regarding the death.[3]

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Like Suicide Fatality Review Boards, these investigators generate reports outlining the available facts of how and why an individual died by suicide, but most importantly, how that suicide might have been prevented. Investigators conduct this procedure by reviewing relevant documentation of the decedent, interviewing significant people that interacted with the decedent, and other information that could contextualize the details of the person's death.

"THESE INVESTIGATORS ARE TRAINED… TO RECONSTRUCT AN INDIVIDUAL'S DEATH BY SUICIDE AND RESOLVE UNCERTAINTIES REGARDING THE DEATH."

PAIs do not have to operate as part of SFRBs, nor are SFRBs required to work with PAIs during case reviews, but the intersection of these two types of investigators has the potential to revolutionize local suicide prevention, intervention, and postvention initiatives. While members of an SFRB are rooted in the community they represent, PAIs may not be, meaning they may not be familiar with the community or its resources and may miss crucial connections while investigating the suicide. SFRBs, meanwhile, may not have the capacity or the protocol in place to conduct as rigorous an investigation as Psychological Autopsy Investigators. Working together, however, PAIs and SFRBs can develop a thorough understanding of trends, micro and macro factors impacting suicide in the community, and opportunities to strengthen local suicide prevention activities.

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Resources

For information on how to conduct a case review, check out the Suicide Best Practices National Center Guidance Report from the National Center: https://www.ncfrp.org/wp-content/uploads/Suicide_Guidance.pdf

To learn about Psychological Autopsy Certifications, visit the American Association of Suicidology's website: https://suicidology.org/pact/

For resources after a suicide, visit https://www.ohiospf.org/postvention/.

Reference List

1. Things to Know about Suicide and Overdose Fatality Review. Overdose Fatality Review. https://www.in.gov/health/cfr/files/10-Things-to-Know-about-Suicide-and-Overdose-Fatality.FINAL.pdf. Accessed January 25, 2022.

2. Section 307.646: Collecting and maintaining information; annual report. Section 307.646 - Ohio Revised Code | Ohio Laws. https://codes.ohio.gov/ohio-revised-code/section-307.646. Published October 19, 2021. Accessed January 25, 2022.

3. Psychological autopsy certification training. American Association of Suicidology. https://suicidology.org/pact/. Published November 10, 2021. Accessed January 25, 2022.

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