

OHIO SUICIDE PREVENTION FOUNDATION

Suicide Investigators & Investigations

When someone dies by suicide, the surrounding community often has questions about what happened, why it occurred, and how to prevent similar tragedies in the future. To address these questions, investigations into suicides are sometimes conducted.

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 teams¹ often convened by county mental health boards, local health departments, or the coroner's office. SFRBs generally include 15 to 35 people from different community sectors, 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 population's needs.

Modeled after child fatality review boards, SFRBs conduct case reviews of local suicides.¹ Rather than assigning 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 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 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

For resources about SFRs, visit

<https://www.ohiospf.org/sfr/>

SCAN HERE



Psychological Autopsy Investigator

Another way for communities to examine the circumstances surrounding a suicide is by working with a certified Psychological Autopsy Investigator (PAI). 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.

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.

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 PAIs. 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.

Ohio has invested in Retrospective Fatality Analysis (RFA) as one form of Psychological Autopsy. RFA is a comprehensive analysis of biopsychosocial and environmental factors preceding an individual's death by suicide or other unnatural deaths.³ The process includes data collection, interviews, and data synthesis into a report.

References

- 1 Indiana Department of Health. Things to Know about Suicide and Overdose Fatality Review. <https://www.in.gov/health/safesleep/fatality-review/overdose-fatality-review/>. Accessed June 20, 2025.
- 2 Ohio Revised Code. Section 307.646: Collecting and maintaining information; annual report. Published October 19, 2021. <https://codes.ohio.gov/ohio-revised-code/section-307.646>. Accessed June 18, 2025.
- 3 National Association of Retrospective Fatality Analysis. <https://rfaconsultants.com/>. Accessed June 18, 2025.

ABOUT

OHIO SUICIDE PREVENTION FOUNDATION

Ohio Suicide Prevention Foundation (OSPF) educates, advocates for, and builds connections and support for individuals, families, and communities to prevent suicide.



(614) 429-1528 / OhioSPF.org

