Clackamas County

Suicide Fatality Review Annual Report

2024

CLACKAMAS COUNTY

MEDICAL EXAMINER
CLACKAMAS COUNTY OREGON

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Background

Suicide remains a common, and yet largely preventable, cause of death and continues to be a priority health issue in Clackamas County.

Developed in 2021 and with the intent of reviewing as many suicides as possible, the Clackamas County Suicide Fatality Review (SFR) Committee was created to better evaluate the circumstances leading to and causing suicides to improve community and service systems and to take action to prevent suicide. The committee consists of a multidisciplinary group of professionals and community members with lived experience. The SFR functions as a sub-committee of the Clackamas County Coalition to Prevent Suicide which began in 2018.

The objectives of the Clackamas County Suicide Fatality Review are to:

- Identify specific barriers and systems issues involved with suicide deaths.
- Identify risk factors and trends in suicide deaths for future prevention/intervention efforts as well as looking at the enhancement of potential protective factors.
- Develop strategies for increased communication and coordination of delivery of services to survivors of suicide loss.

This report includes an annual, high-level brief analysis of the cases from the 2024 review period in addition to a robust analysis of all 16 cases reviewed by the SFR since its formation.

Confidentiality and Privacy

An integral part of the SFR process is obtaining consent from next of kin. To protect the rights of the deceased and after waiting an appropriate amount of time after the death, permission from the legal next of kin is requested to review their family member's death by sending a formal letter with a release of information request, following up with phone calls if necessary. The SFR committee only reviews those cases in which a release of information has been signed by the legal next of kin.

At the beginning of their service on the committee, and each year thereafter, all SFR members will sign a confidentiality agreement. Additionally, members are asked to sign another confidentiality agreement before every SFR meeting.

Committee Structure

Current SFR membership includes:

- Clackamas County Medical Examiner's Office
- Oregon State Police, Office of the State Medical Examiner
- Clackamas County Health Centers
- Clackamas County Behavioral Health
- Clackamas County Social Services
- Clackamas County Public Health
- Clackamas County District Attorney's office
- Portland VA Health Care System
- Providence Willamette Falls Hospital
- Clackamas County Sheriff's Office
- Oregon City Police Department
- Lake Oswego Police Department
- West Linn Police Department
- State of Oregon Department of Human Services Departments and Programs
- Trauma Intervention Program (TIP)
- Suicide Attempt Survivors
- Suicide Loss Survivors

Methods

Since the SFR's inception, the Chief Medicolegal Death Investigator has contacted the next of kin from a total of 184 deaths that occurred between 2020 and 2024, and received authorization to review 25 (13.6%). The SFR committee reviewed five cases in 2022, six cases in 2023, and five cases in 2024 for a total of 16 cases.

Year	Letters Sent Out	Letters Returned with Permisison	Percent Returned	Cases Reviewed
2022	135	17	12.6%	5
2023	17	4	24%	6
2024	32	4	12.5%	5
Total	**184**	**25**	**13.6%**	**16**

During each fatality review, SFR committee members took notes on the events leading up to the individual's death as well as any life circumstances or experiences deemed relevant to the manner of death. Committee members were given the option of taking notes in a grid format that was intended to help members organize their thoughts; the grid employed the codes that would eventually be used in the final analysis (figure 1). These notes were then coded by a Clackamas County Public Health epidemiologist using a set of pre-identified codes that were selected based on secondary research in suicidality and suicide prevention, mirroring Washington County Public Health Division's SFR methodologies.[2] Coded notes from the 11 cases from the 2022 and 2023 Suicide Fatality Reviews were appended to this year's review of 5 additional cases for a more robust analysis. The data were analyzed using Nvivo QSR International qualitative data analysis software with the purpose of identifying variables of greater or lesser influence as well as patterns among the decedents (persons who have died).

Case Number: **Date:**

	Protective Factors	Risk Factors	Notes on System Improvement
Clinical Care			
Lethal Means			
Community			
Family			
Relationship to Suicide			
Law Enforcement			
Other			

Figure 1

SFR committee members' notes were categorized under one of two parent codes: risk factor or protective factor. From there, findings were subcategorized using a set of child codes under each parent code: clinical care, family, community, lethal means, relationship to suicide, law enforcement, and other (figure 2).

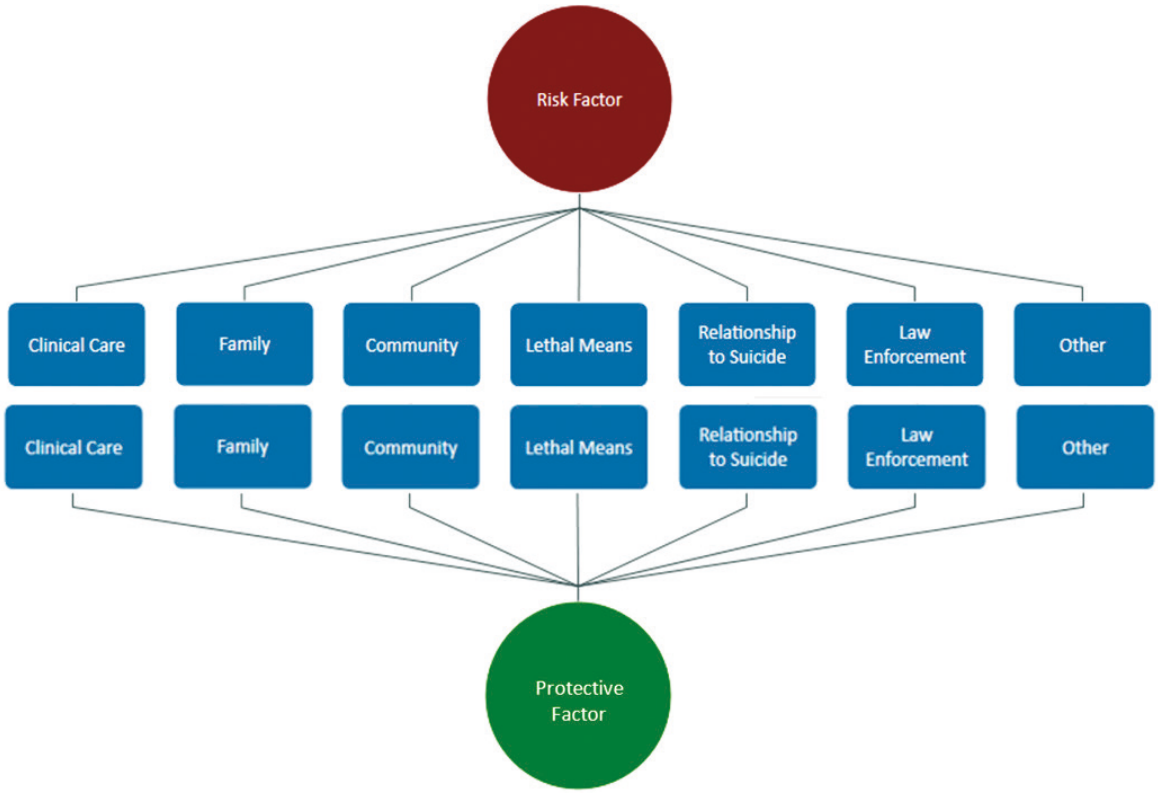

Figure 2

Any mention of a life event, experience, or fact related to the individual's death was categorized using one of the child codes and corresponding parent code. For example, if the SFR committee member stated that the decedent had access to a firearm, that statement would receive the child code of "lethal means" under the parent code of "risk factor."

This method of coding creates a structure that allows for commonalities and patterns to emerge even though each case the committee examined is unique. By classifying the events and circumstances leading up to each person's death as being either potential protective factors or risk factors, public health can better detect and mitigate societal and health system pain points that may contribute to a death by suicide. This information can also assist with identifying any assets that may help prevent deaths, with the goal of bolstering those resources through public health programs and messaging.

There are some shortcomings to this coding method. It requires making some judgements based off the information available, which can impart bias. However, offering the grid format to committee members for taking notes helped control for some of this bias by dispersing categorization of life events across many people. This coding method also does not allow for the existence of gray areas or nuances, which can provide valuable details. As such, this analysis is meant to be paired with narrative findings to offer a more complete understanding of events.

Definitions of Codes

- **Risk factors:** characteristics at the biological, psychological, family, community, or cultural level that precede and are associated with a higher likelihood of negative outcomes. In this case, the outcome is death by suicide[3]
- **Protective factors:** characteristics associated with a lower likelihood of negative outcomes or that reduce a risk factor's impact. Protective factors may be seen as positive countering events[3]
- **Clinical care:** a decedent's interactions with the medical and behavioral health care system as well as any diagnoses and prescriptions
- **Family:** a decedent's relationships with family members, romantic partners, and pets
- **Community:** a decedent's relationships with friends, hobbies, church groups, employment, or any other areas in which personal connection is fostered
- **Lethal means:** a decedent's access to or relationship with items that could act as a mechanism to die by suicide. Examples include: firearms, pills, motor vehicles
- **Relationship to suicide:** a decedent's personal or family history of suicidal ideation, suicide attempts, or death by suicide
- **Law enforcement:** a decedent's relationship to or involvement with police or the legal system
- **Other:** any experience, asset, deficit, or variable that may have acted as a risk factor or protective factor surrounding suicide that does not fit clearly in the aforementioned categories

2024 Analysis Summary

Notes from the five cases reviewed in 2024 were analyzed independently to summarize patterns in risk and protective factors identified during this review year. The five decedents died between 2022 and 2024. More risk factors (174) were mentioned than protective factors (105). Clinical care was mentioned the most as both a suicide risk and protective factor, followed by community and family (figure 3), which is reflective of the 2022-2024 analysis.

Risk Factors

All five decedents were not actively engaged in mental or physical health care, or were having difficulty accessing care (due to lack of insurance, inconsistent follow-up from care providers, etc.). Three out of five had known mental health disorders. All five had expressed suicidal ideation in the past, and three had prior suicide attempts. Four out of five cases lacked support or were estranged from family (i.e., a spouse, child, etc.). Three out of five decedents had mentions of substance or alcohol use disorder diagnoses. Three out of five were experiencing job or financial stress near the time of their death. Three out of five had died by firearm, and three out of five had a firearm in their possession that was not locked.

Protective Factors

All five decedents were known to have relationships with family members. Four out of five were noted to have engaged with mental health care in the past. Four out of five were employed or enrolled in school at the time of death. Four out of five had police welfare checks due to a mental health crisis or expressing suicidal ideation.

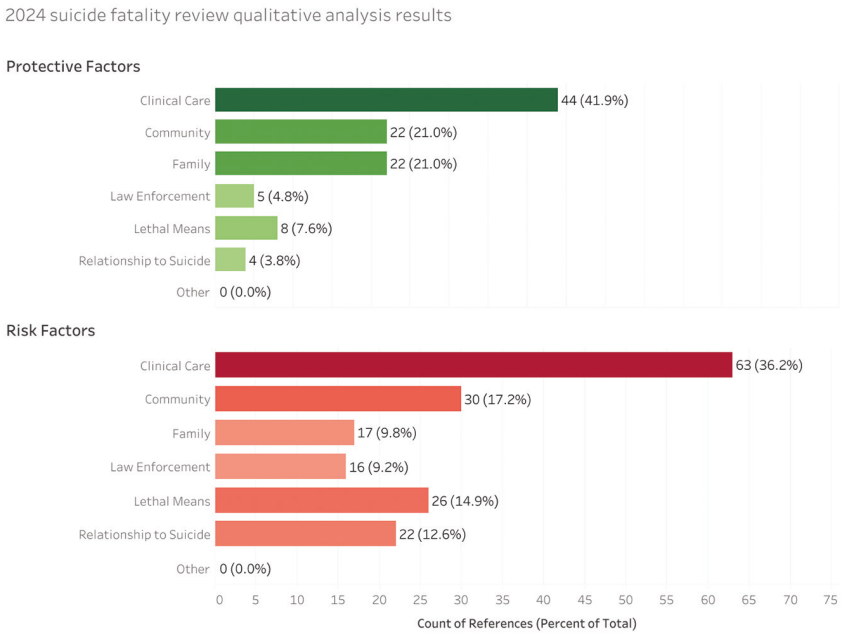

Figure 3

2022–2024 Analysis Summary

High Level Overview

- There were nearly twice as many mentions of suicide risk factors (459) as protective factors (251)
- Clinical care had the most mentions as both risk and protective factors, followed by family, then community (figure 4)
    - 35.9% of protective factors mentioned were related to clinical care compared to 36.6% of risk factors
    - While the number of mentions of family as a protective factor (66) was similar to the number as a risk factor (61), proportionally, nearly twice as many protective factor mentions were related to family (26.3%) compared to risk factor mentions (13.3%)
    - 17.1% of protective factors mentioned were related to community compared to 13.1% of risk factors

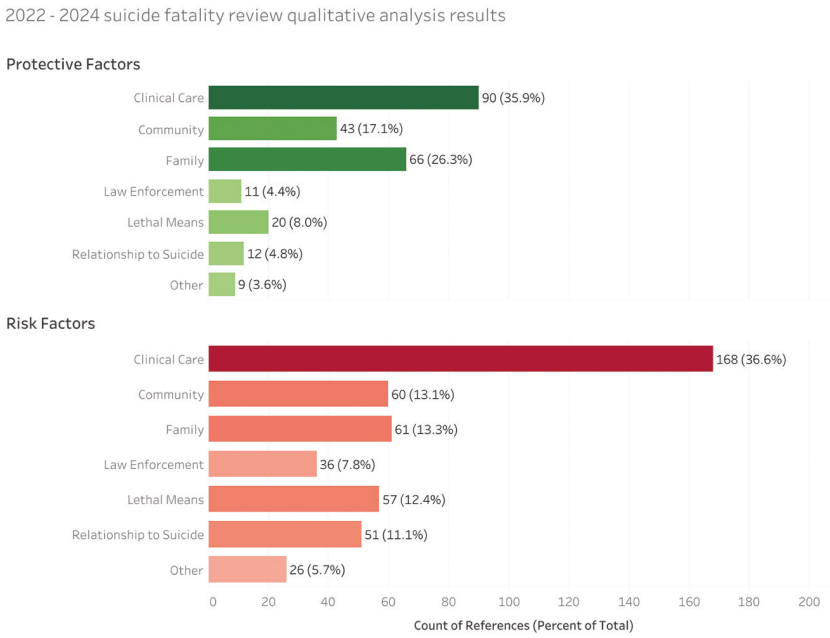

Figure 4

Clinical Care

Risk Factors

- 11/16 decedents had known mental health diagnoses such as depression, anxiety, and schizophrenia
- 10/16 decedents were not actively engaged in mental or physical health care, had no

health insurance, or had difficulty navigating the health care system

- 9/16 decedents had known substance use or alcohol use disorders
- 7/16 decedents had difficulty obtaining medication, were not taking medication as prescribed, or had a recent change in medication for a mental health disorder
- 5/16 decedents were experiencing chronic pain or suffering from a chronic physical illness

Protective Factors

- 11/16 decedents had a known history of engagement in mental health care
- 9/16 decedents had a known history of engagement in physical health care
- 7/16 decedents were compliant with current medication regimens for a mental health disorder

Family

Risk Factors

- 12/16 decedents lacked support or were estranged from one or more family members
- 6/16 decedents were divorced from, separated from, or having recent relationship difficulties with a romantic partner
- 3/16 decedents relied on family members to be their caretakers
- 2/16 decedents expressed a lack of support from a current romantic partner
- 2/16 decedents had a known family history of mental health disorders

Protective Factors

- 16/16 decedents had support from one or more family members
- 5/16 decedents had support from a romantic partner
- 2/16 decedents were known to have pets

Community

Risk Factors

- 8/16 decedents were not working (due to job loss, difficulty finding employment, or retirement) or expressed job or financial stress
- 8/16 decedents reported feeling isolated, lived alone or in an isolated area, or lacked social supports
- 3/16 decedents were experiencing stress from school

Protective Factors

- 6/16 decedents were known to be employed or enrolled in school
- 5/16 decedents were reported to have been engaged with friends or neighbors

- 2/16 decedents were known to be religious or engaged with a faith-based community
- 2/16 decedents were reported to have been engaged in hobbies or sports

Lethal Means

Risk Factors

- 11/16 decedents died by firearm
- 5/11 decedents who died by firearm were known to have recently acquired the firearm
- 5/11 decedents who died by firearm had mentions of the firearm not being in a locked, secured location
- 3/11 decedents who died by firearm did not have the firearm registered to them
- 2/16 decedents died by hanging

Protective Factors

- 3/11 decedents who died by firearm had not acquired the firearm recently
- 2/11 decedents who died by firearm had their firearm(s) previously seized by family or police due to prior suicidal ideation or suicide attempt

Relationship to Suicide

Risk Factors

- 13/16 decedents had expressed suicidal ideation at some point in their lives
- 8/16 decedents were known to have previously attempted suicide
- 3/16 decedents had a friend or family member die by suicide

Protective Factors

- 3/16 decedents had no known history of suicidal ideation
- 3/16 decedents had no known prior suicide attempts

Law Enforcement

Risk Factors

- 11/16 decedents had prior interactions with law enforcement including police officer holds (POH) or arrests
- 2/16 decedents had threatened to attempt “suicide by cop”

Protective Factors

- 5/16 decedents had welfare checks from police due to a mental health episode or suicidal ideation
- 4/16 decedents had mentions of no interactions with law enforcement

Other

Risk Factors

- 3/16 decedents were reported to be using marijuana
- 2/16 decedents had a history of aggression towards others
- 2/16 decedents displayed perfectionist behavior or sensitivity to criticism
- Some uncategorized risk factors mentioned by the committee but did not result in a pattern across multiple decedents were: housing insecurity, trauma, being a survivor of childhood abuse, and running away from home as a child.

Protective Factors

- Some uncategorized protective factors mentioned by the committee but did not result in a pattern across multiple decedents were: active lifestyle, known goals for the future, and having financial means from a source other than a job.

System Recommendations Made

Information collected during the death review process is compiled into the annual report and shared with the larger Suicide Prevention Coalition of Clackamas County. This information will help to direct the Coalition's areas of focus in a variety of areas. SFR committee recommendations will or have already led to system improvements in the community such as:

- Increase care and support to individuals following presentation to an Emergency Department (ED) for a suicide related crisis to improve the likelihood of connection to treatment after discharge.
- Increase education and awareness of how and when an eligible person or entity might consider filing an Extreme Risk Protection Order (ERPO) which prohibits an individual who is determined to be at imminent risk of harm to themselves or others from purchasing, possessing, or receiving firearms for a period of time.
- Educate family members and natural supports about the importance of securing firearms in the home to prevent unauthorized access.

Acknowledgements and Authorship

To the families who have entrusted the Clackamas County Suicide Fatality Review Committee to review the details of their loved one's case, we are incredibly grateful. It is with your permission that we are able to identify risk factors and make recommendations for county wide system improvements as a step toward preventing future suicides.

Clackamas County would also like to thank the members of our Suicide Fatality Review committee:

- Cathy Phelps, Chief Medicolegal Death Investigator, Clackamas County Medical Examiner's Office
- Dr. Rebecca Millius, Deputy State Medical Examiner, State of Oregon
- Tracy Goodrich, Administrative Specialist, Clackamas County Medical Examiner's Office
- Joan Schweizer Hoff, Lived Experience Member
- Elizabeth Chantelle Volk, Lived Experience Member
- Visjna Brooks, Manager of Care Management, Providence Milwaukie Hospital & Providence Willamette Falls Medical Center
- Dr. Martha Carlson, Suicide Prevention Program Manager, Portland VA
- Scott Healy, Senior Deputy District Attorney, Clackamas County District Attorney's Office
    - Amy Hatton, Clackamas County MDT Coordinator, Children's Center
- Jesse Ashby, Undersheriff, Clackamas County Sheriff's Office
- Valentina Muggia, Behavioral Health Specialist, Oregon City Police Department
- Amber Hambrick, Behavioral Health Specialist, Lake Oswego & West Linn Police Departments
- June Vining, Executive Director, Trauma Intervention Program (TIP)
- Kevin Long, Child Welfare Program Manager, State of Oregon, Department of Human Services Departments and Programs
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Sources

1. Clackamas County Medical Examiner's Office; Clackamas County Public Health Division Data and Performance Unit
2. Repp, Kimberly K. PhD, MPH; Hawes, Eva MPH, CHES; Rees, Kathleen J. MSPH; Lovato, Charles AAS; Knapp, Adam BA; Stauffenberg, Michele MD. Evaluation of a Novel Medico-legal Death Investigator–Based Suicide Surveillance System to the National Violent Death Reporting System. The American Journal of Forensic Medicine and Pathology 40(3):p 227-231, September 2019.
3. U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA) Evidence Based Practices Resource Center. Risk and Protective Factors (accessed February 2023).