Clackamas County

Suicide Fatality Review Annual Report

2025

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 analysis of the seven cases from the 2025 review period in addition to a robust analysis of all 23 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 Disaster Management, Office of the Medical Examiner
- 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 Dept. of Human Services Depts. 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 223 deaths from suicide that occurred between 2020 and 2024, and received authorization to review 32 (14.4%). The SFR committee reviewed five cases in 2022, six cases in 2023, five cases in 2024 and seven cases in 2025 for a total of 23 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
2025	39	7	17.9%	7
Total	**223**	**32**	**14.4%**	**23**

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.[1—3]

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).

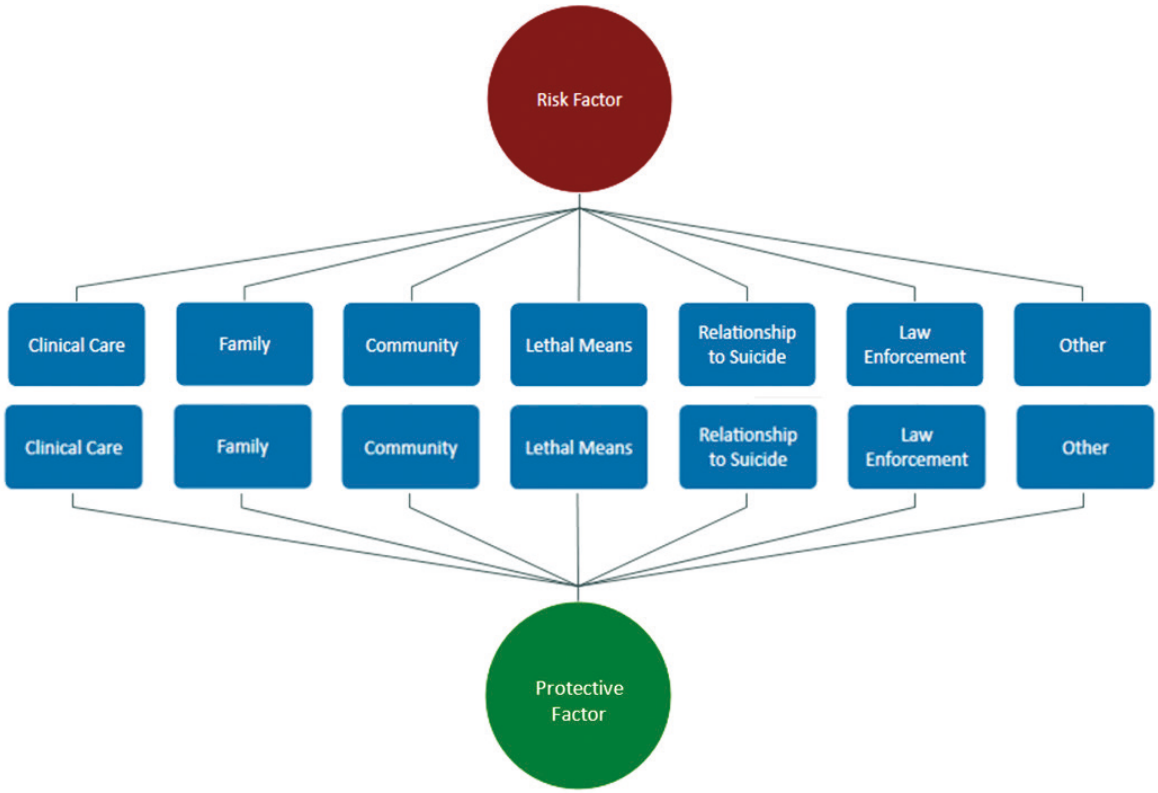


Figure 2

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." Sub-child codes were then applied to further specify the nature of each factor, allowing for more detailed categorization of themes within each child code.

This qualitative approach is based on themes identified in reviewer notes and consensus discussions, rather than a systematic analysis of demographic or clinical variables. For example, sub-child codes such as "young age" and "advanced age" reflect reviewer-identified contextual factors and do not correspond to predefined age thresholds.

This dichotomous 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 excess death, with the goal of bolstering those assets through public health programs and messaging.

Coded notes from the 16 cases from the 2022 – 2024 Suicide Fatality Reviews were appended to this year's review of seven 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 individuals who had died from suicide, also known as decedents.

Previous reports quantified child codes based on the number of times committee members noted a theme during case review. Because multiple members assess each case, this method could result in multiple counts for the same factor within a single decedent. In the current analysis, coding has been standardized to the case level, such that each child code is counted once per decedent when identified and confirmed through consensus review. This approach more accurately reflects the distribution of risk and protective factors across cases.

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

2025 Analysis Summary

Notes from the seven cases reviewed in 2025 were analyzed independently to find common themes of risk and protective factors identified during this review year (figure 3). The seven decedents died between 2023 and 2024. The following themes were identified in three or more decedents based on committee review notes:

Protective Factors

- 7/7 decedents were engaged with one or more family members
- 6/7 decedents were engaged in physical healthcare, such as having a primary care provider
- 4/7 decedents were engaged in mental healthcare, such as being under the care of a therapist or psychologist
- 4/7 decedents were employed or in school
- 4/7 decedents had no known interactions with law enforcement (e.g., prior arrests)
- 4/7 decedents had no mentions of prior suicide attempts, or had no known suicidal ideation or threats
- 3/7 decedents were compliant with and/or responding to their prescribed medication regimen

Risk Factors

- 7/7 decedents had one or more known mental health disorders (e.g., major depressive disorder, generalized anxiety disorder, schizophrenia) or neurodivergence (e.g., autism spectrum disorder, attention-deficit/hyperactivity disorder, etc.)
- 7/7 decedents had experienced lack of support from, estrangement from, or a recent loss of a family member(s)
- 7/7 decedents had expressed suicidal ideation or threats at some point in their lives prior to their death
- 6/7 decedents experienced social isolation due to various factors, including but not limited to geographic isolation (i.e., residing in a rural area), limited interaction with peers, and lack of interest in social activities or community groups
- 6/7 decedents were divorced from, separated from, or experiencing significant relationship hardships with a romantic partner
- 6/7 decedents died by or had access to a firearm
- 5/7 decedents had a chronic illness or were experiencing chronic pain that significantly affected their quality of life
- 3/7 decedents had limited access or engagement with mental or physical healthcare
- 3/7 decedents had limited access to, were not compliant with, or had a recent change in a prescription medication(s)

- 3/7 decedents had one or more known substance and/or alcohol use disorder
- 3/7 decedents were considered to be of advanced age by committee reviewers at the time of their death

Category	Common Themes	Number of Decendents
Clinical Care	Engaged in physical healthcare	6 out of 7
	Engaged in mental healthcare	4 out of 7
	Compliant with or responding to medication	3 out of 7
	Given a safety plan by provider after a suicide attempt	2 out of 7
Community	Employed or in school	4 out of 7
	Engaged with friends or neighbors	2 out of 7
Family	Engaged with family	7 out of 7
	Had a supportive partner	2 out of 7
Law Enforcement	No interactions with law enforcement	4 out of 7
	Previous welfare checks or support from police	2 out of 7
Lethal Means	Legal firearm purchase, not recent	2 out of 7
Relationship to Suicide	No history of suicide attempts	4 out of 7

2025 Suicide Fatality Review: Qualitative Analysis of Common Themes — Protective Factors

Category	Common Themes	Number of Decendents
Clinical Care	Mental health disorder or neurodivergent	7 out of 7
	Chronic illness or pain affecting quality of life	5 out of 7
	Limited access to mental or physical healthcare	3 out of 7
	Limited access to or recent change in medication	3 out of 7
	Substance use or alcohol use disorder	3 out of 7
Community	Social isolation	6 out of 7
	Retired	2 out of 7
Family	Lack of support from or loss of family member(s)	7 out of 7
	Divorced, separated, or relationship difficulties	6 out of 7
Law Enforcement	Prior arrests or interactions with law enforcement	2 out of 7
Lethal Means	Died by or had access to a firearm	6 out of 7
	Died by intentional overdose or access to a lethal substance	2 out of 7
	Died by or intended to die by hanging or suffocation	2 out of 7
Other	Advanced age	3 out of 7
	Marijuana use	2 out of 7
	Other traumatic experience	2 out of 7
	Young age	2 out of 7
Relationship to Suicide	Suicidal ideation or threats	7 out of 7 (tied for highest risk factor)

2025 Suicide Fatality Review: Qualitative Analysis of Common Themes — Risk Factors

2022 – 2025 Analysis Summary

Notes from the 23 cases reviewed between 2022 and 2025 were analyzed collectively to identify recurring themes in risk and protective factors since t00he inception of the SFR Committee (Figure 4). The decedents represented in these cases died between 2022 and 2024. The following themes were identified in five or more decedents based on committee review notes:

Protective Factors

- 23/23 decedents were engaged with one or more family members
- 15/23 decedents were engaged in physical healthcare, such as having a primary care provider
- 15/23 decedents were engaged in mental healthcare, such as being under the care of a therapist or psychologist
- 10/23 decedents were compliant with and/or responding to their prescribed medication regimen
- 10/23 decedents were employed or in school
- 8/23 decedents had no known interactions with law enforcement (e.g., prior arrests)
- 7/23 decedents were engaged with friends or neighbors
- 7/23 decedents had a supportive romantic partner
- 7/23 decedents had a history of law enforcement conducting welfare checks or providing supportive services related to suicidal ideation
- 6/23 decedents had no mentions of prior suicide attempts, or had no known suicidal ideation or threats
- 5/23 decedents legally purchased one or more firearms; these were not recent purchases, and there was no evidence to suggest they were made with intent to die by suicide

Risk Factors

- 20/23 decedents had expressed suicidal ideation or threats at some point in their lives prior to their death
- 19/23 decedents had experienced lack of support from, estrangement from, or a recent loss of a family member(s)
- 17/23 decedents had one or more known mental health disorders (e.g., major depressive disorder, generalized anxiety disorder, schizophrenia) or neurodivergence (e.g., autism spectrum disorder, attention-deficit/hyperactivity disorder, etc.)
- 17/23 decedents died by or had access to a firearm
- 14/23 decedents had limited access or engagement with mental or physical healthcare
- 14/23 decedents experienced social isolation due to various factors, including but not limited to geographic isolation (i.e., residing in a rural area), limited interaction with peers, and lack of interest in social activities or community groups

- 13/23 decedents had prior arrests or other interactions with law enforcement other than welfare checks
- 12/23 decedents had one or more known substance and/or alcohol use disorder
- 12/23 decedents were divorced from, separated from, or experiencing significant relationship hardships with a romantic partner
- 10/23 decedents had a chronic illness or were experiencing chronic pain that significantly affected their quality of life
- 10/23 decedents had limited access to, were not compliant with, or had a recent change in a prescription medication(s)
- 9/23 decedents had attempted suicide in the past
- 8/23 decedents were a recent experiencing job loss or financial stress
- 6/23 decedents did not store their firearm in a secure, locked location
- 6/23 decedents were of advanced age at the time of their death (65 years or older)
- 5/23 decedents had purchased or obtained a firearm recently

Category	Common Themes	Number of Decendents
Clinical Care	Engaged in physical healthcare	15 out of 23 (65%)
	Engaged in mental healthcare	15 out of 23 (65%)
	Compliant with or responding to medication	10 out of 23 (43%)
	Given a safety plan by provider after a suicide attempt	4 out of 23 (17%)
	No history of substance or alcohol use disorder(s)	3 out of 23 (13%)
Community	Employed or in school	10 out of 23 (43%)
	Engaged with friends or neighbors	7 out of 23 (30%)
	Religious or part of a faith community	3 out of 23 (13%)
	Hobbies or routine	2 out of 23 (9%)
Family	Engaged with one or more family members	23 out of 23 (100%)
	Has supportive partner	7 out of 23 (30%)
	Owned pet(s) at time of death	2 out of 23 (9%)
Law Enforcement	No interactions with law enforcement	8 out of 23 (35%)
	Previous welfare checks or support from police	7 out of 23 (30%)
Lethal Means	Legal firearm purchase, not recent	5 out of 23 (22%)
	Firearms seized	3 out of 23 (13%)
	Secure firearm storage	2 out of 23 (9%)
Relationship to Suicide	No prior suicide attempts	6 out of 23 (26%)
	No history of suicidal ideation	3 out of 23 (13%)
	Discussed suicidal ideation with friends or family	2 out of 23 (9%)

2022–2025 Suicide Fatality Review: Qualitative Analysis of Common Themes — Protective Factors

Category	Common Themes	Number of Decendents
Clinical Care	Mental health disorder or neurodivergent	17 out of 23 (74%)
	Limited access to mental or physical healthcare	14 out of 23 (61%)
	Substance or alcohol use disorder	12 out of 23 (52%)
	Chronic debilitating illness or pain	10 out of 23 (43%)
	Limited access to or recent change in medication	10 out of 23 (43%)
	No peer support	2 out of 23 (9%)
	Recent acute illness or injury	2 out of 23 (9%)
Community	Social isolation	14 out of 23 (61%)
	Job loss or financial stress	8 out of 23 (35%)
	Job- or school-related stress	4 out of 23 (17%)
	Retired	3 out of 23 (13%)
	War veteran	2 out of 23 (9%)
Family	Lack of support from or loss of family member(s)	19 out of 23 (83%)
	Divorced, separated, or relationship difficulties	12 out of 23 (52%)
	Family as caretaker	3 out of 23 (13%)
	Children or dependents causing stress	2 out of 23 (9%)
	Family history of mental health disorders	2 out of 23 (9%)
	Lack of support from romantic partner	2 out of 23 (9%)
Law Enforcement	Prior arrests or interactions with law enforcement	13 out of 23 (57%)
	Threatened suicide by cop	2 out of 23 (9%)
Lethal Means	Died by or had access to a firearm	17 out of 23 (74%)
	Firearm not locked	6 out of 23 (26%)
	Purchased or obtained firearm recently	5 out of 23 (22%)
	Died by or intended to die by hanging or suffocation	4 out of 23 (17%)
	Died by intentional overdose or access to lethal medication	3 out of 23 (13%)
	Firearm not registered to decedent	3 out of 23 (13%)
Other	Advanced age	6 out of 23 (26%)
	Marijuana use	5 out of 23 (22%)
	History of aggressive behavior	4 out of 23 (17%)
	Young age	4 out of 23 (17%)
	Other traumatic experience	3 out of 23 (13%)
	Sensitive to criticism or perfectionist	3 out of 23 (13%)
	Runaway	2 out of 23 (9%)
	Survivor of assault	2 out of 23 (9%)
Relationship to Suicide	Suicidal ideation or threats	20 out of 23 (87%)
	Prior suicide attempts	9 out of 23 (39%)
	Relative or friend died by suicide	4 out of 23 (17%)

2022–2025 Suicide Fatality Review: Qualitative Analysis of Common Themes — Risk Factors

Acknowledgements

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 can identify risk factors and make recommendations for county-wide system improvements as a step toward preventing future suicides.

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Sources

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