

Beyond the  
Surface: Delving  
into Medicolegal  
Death  
Investigations of  
Suicides



# Introductions

Medicolegal Death Investigator since 2006

Ada County Coroner from 2014-2023

Masters Degree

ABMDI Certified since 2011

Name Accredited

IACME Accredited

IACME Accreditation Committee Chair

Advocate



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# Receiving/ Reporting Critical Data

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The death investigator is responsible for documenting every death reported to the office according to the State Statutes.

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It is important that a thorough and scientific investigation takes place for every SINGLE case, regardless of age and HX.

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A professional investigator will gather all information before reaching a conclusion about the possible cause and manner of death



# ME/Coroner Limitations

- Personal information pertaining to Mental Health Hx, Medical HX is protected by HIPPA
- Budgets and resources restrain ME/Coroners in rural jurisdictions
- Determining suicide vs accident. Very small numbers leave a note- At times, it is hard to determine
  - Suicide-Must have the self-harm intent
  - Accident –No intent present
- Social Stigma-Information is limited to what families disclose- we only know what we know



# Death/Forensic Investigation Impacts....

Personal  
Liability and  
Freedoms

Financial Well  
Being

Injury  
Prevention  
and Control

Mortality  
Analysis

Assessment of  
Medical Care

# Why is Medicolegal Death Investigation Important

## □ Detailed Death Investigation

Detail and Document lifestyle, health, mental health & prescription hx

## □ Fatality Reviews- Data is essential for mortality prevention. Suicides, Overdoses, Infant, Maternal, Epidemic/Pandemic

## □ Data

Death Certificates- accurate/inaccurate information

Lack of investigation leads to misleading data & funding



# Coroners are the Arsenal to Public Health

## Detailed Death Investigation Data

- ✓ Assists a state in prevention efforts
- ✓ Age groups susceptible
- ✓ Identification of drugs that have infiltrated our communities
- ✓ Suicide Prevention, Infant/Child Mortality, Product recalls etc.

## Prosecution of Dealers-Federally

Must have two key elements-**AUTOPSY AND TOXICOLOGY**

*Monitoring deaths from drug overdose helps us understand the epidemic's impact on the U.S. population and tell us how the crisis is evolving – for better or worse. “CDC”*





# Medicolegal Investigation

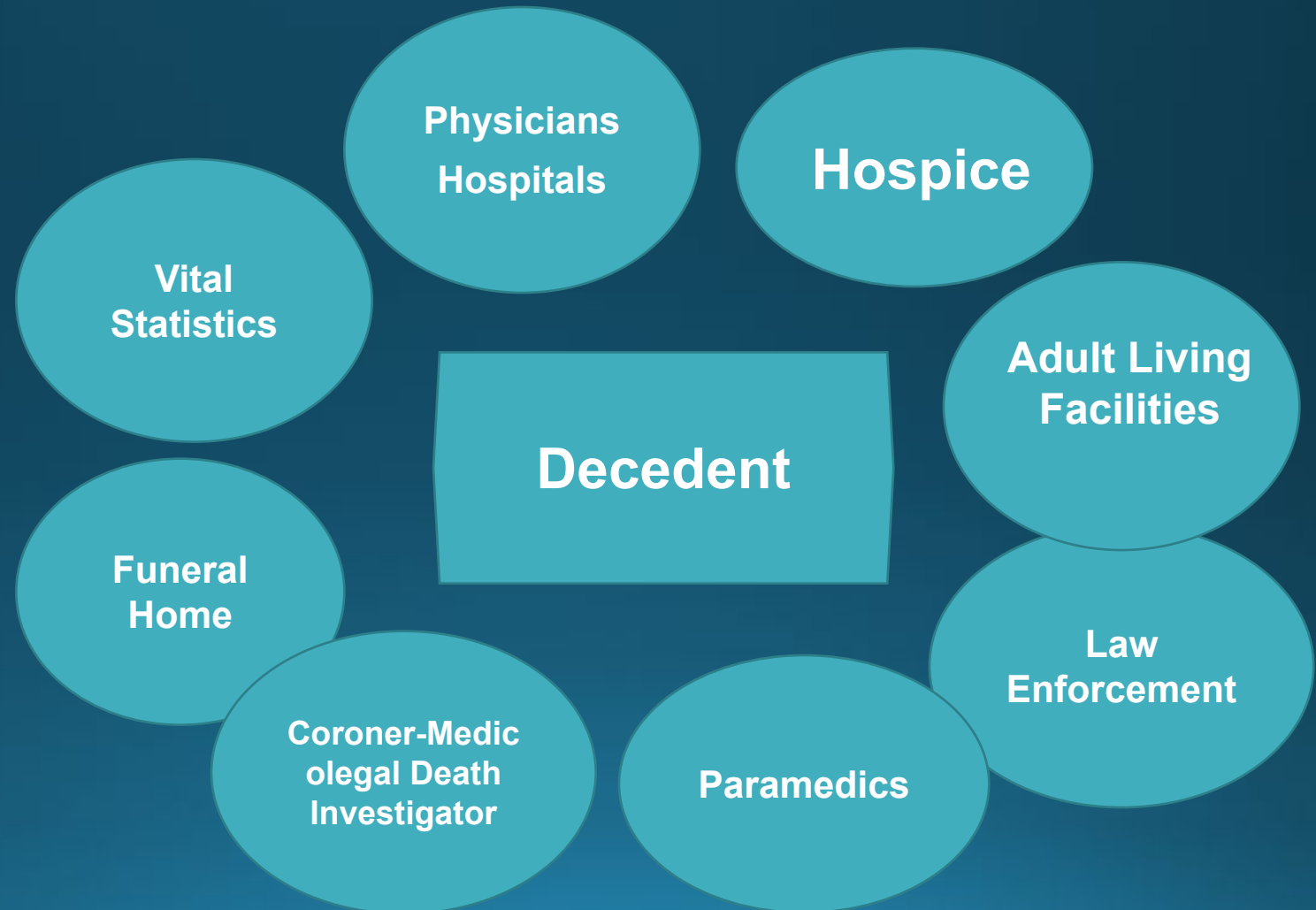
The Role and Responsibilities of



# Working Together- A Medicolegal Investigative Approach

Many groups depend on each other to perform their jobs well and accurately.

Without clear and direct communication, we are working blindly.



# Partnerships Are Important

An open line of communication: EMS, Law Enforcement, Hospitals, Physicians?

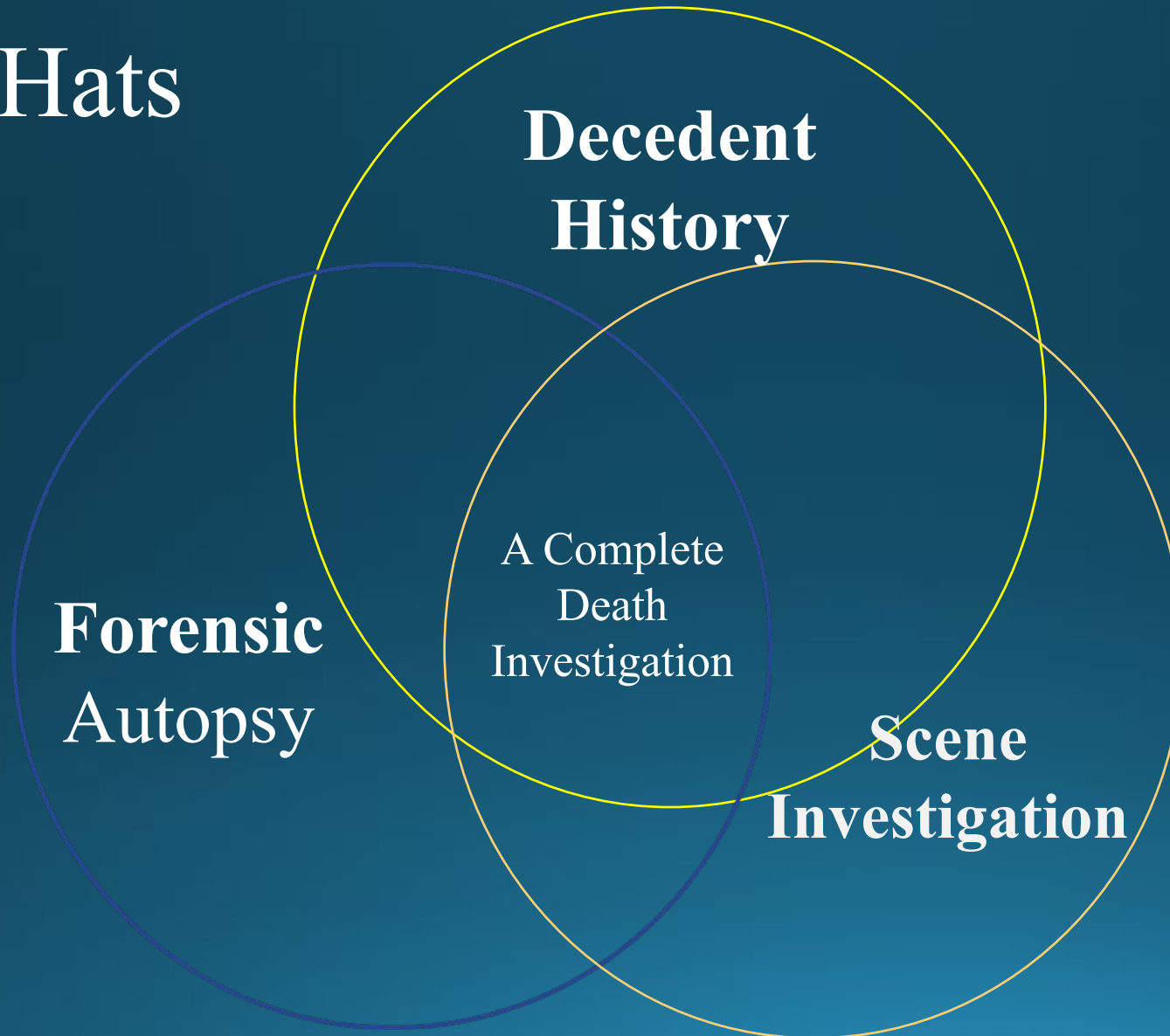
Is your jurisdiction reporting deaths to proper school authorities?

Real-Time Reporting = Real-Time Response



# All Jurisdictions, Regardless of Statutes

Many Hats



# General Responsibilities. What do we do??

Respond to calls relating to SUDDEN death

Partnerships with police, doctors, hospital staff, lawyers, etc.

Determine identity of decedent - dental, fingerprinting, DNA

Investigation of scene, collect evidence

Forensic photography - scene, body and autopsy

Interviews; family, witnesses, friends, physicians

Protect decedent's personal effects

NOK notifications & liaison for the NOK - provide support

Extensive record reviews - medical, mental health and BOP

Create detailed reports - investigations, pathology

Obtain fluids for tox, determine need for autopsy

Certify cause and manner of death

Provide testimony in legal proceedings; both civil and criminal

Public Health/Prevention - Infectious Diseases, Opioids, Suicides, Pandemic



# Types of Deaths Investigated/Standards

Traumatic or Violent: Suicides, Accidents, Homicides

All "Undetermined"

Sudden unexpected deaths –any at home

Hospital Deaths; ER, Less than 24 Hrs., unresponsive

All deaths that occur while under the custody of law enforcement

Anyone without documented medical history

Deaths that may result in a threat to public health (Meningitis)

Any unclaimed, exposed, or unidentified remains

- Skeletal-Bone Fragments

Any at-work death

All children under the age of 18 w/out significant medical issues

Stillbirths with a fetus over 20 weeks – Jurisdictional





# Additional Functions of the MDI's

- Determine events leading up to the death
  - How, When, Where, Why, Why Now
- Determine and document injuries and causation
- Identify natural diseases and report them to the appropriate agency
- Decedent recovery
  - Cliffs, Water, Mountains, etc.

# Unattended/Attended

**Unattended:** An unattended death refers to a situation where an individual passes away without the presence of medical personnel.

- Unattended deaths can present challenges in terms of determining the cause and manner of death.
- Can be natural, accident, suicide, homicide, or undetermined.

**Attended:** Death occurring in the presence of medical personnel, frequently takes place within a hospital environment, nursing home, medical center, or hospice.

- Can be accident, homicide, and suicide (if in a hospital setting such as ICU or CCU).
- If not natural, the death falls under the coroner/medical examiner's jurisdiction despite being in a hospital setting.



# Cause and Manner of Death



# Cause and Manner of Death

The time frame between the incident and death?

Does this matter?





# Manner of Death - Certainty

In many cases, “reasonable probability” will suffice, but in other instances such as suicide, case law or prudence may require a “preponderance” of evidence—or in homicide—“clear and convincing evidence” may be required or recommended (National Association of Medical Examiners <sup>®</sup>, 2002).

While exceptions exist for every “rule,” the majority of rules hold in typical situations. Hence, rules may be adjusted or disregarded in exceptional circumstances, yet they should generally be adhered to for the sake of consistency and orderliness.

Manner-of-death classification should not be formulated based on trying to facilitate prosecution, avoiding challenging publicity, building a political base, or promoting a personal philosophy or agenda.

# Most Important Role- Cause & Manner

- Cause is generally determined by FP through autopsy- Smaller jurisdictions, by the coroner, JP, or Medicolegal Death Investigator.
- Manner is determined through the investigative process (circumstantial)
- At times, disagreements arise regarding the manner
  - FP states the case is Homicide, Law Enforcement rules Accident
- Families can challenge the ruling but has to occur through a court process and with significant evidence

# Cause of death

Must be a direct, continuous sequence of events unbroken by any efficient intervening cause and without which the end result would not have occurred

Must be an etiologically specific disease or injury

The following terminology must be distinguished (BMC Health Serv Res 2007;7:183):

**Immediate cause of death:** final disease or condition that leads to death

**Underlying/proximate cause of death:** other conditions that precede and initiate the train of morbid events that ultimately culminate in the immediate cause of death

**Intervening cause:** any condition that interrupts or exacerbates the chain of proximate causation

**Contributing factors to death:** other conditions that play a role in the death process but are not the primary cause of death

- Autopsy is an essential tool to identify the cause and manner of death correctly



# Cause Examples

- **Immediate Cause of Death:** Respiratory failure due to drug overdose;  
Underlying: Combined toxicity from multiple prescription medications
- **Immediate Cause:** Methamphetamine Toxicity:  
Underlying: Methamphetamine use
- **Immediate Cause :** Positional Asphyxia;  
Underlying: Self-Inflicted Hanging

# Manner

- The MANNER of death (MOD) is the circumstances surrounding the death: Accident, Homicide, Natural, Suicide, or Undetermined.
- MECHANISM of death is something to be considered but is not always discussed. It explains the “how.” For instance, if the COD is a gunshot wound, the typical Mechanism of death is Exsanguination.
- Manners: Natural, Suicide, Accident, Homicide, Undetermined  
“Pending” is not a manner, but a “place holder”

# Manner: Natural

**Natural Death-** when an individual dies as a result of a natural disease process, without the significant influence of injury, drug toxicity, or another significant environmental or non-natural factor.

**Natural death investigated by JP's** frequently involves heart, brain, and lung (PE).

**Examples-** Myocardial infarction, CVA, Cancer, Pulmonary embolism, Cirrhosis, Chronic





# Accidental

- **Accident-** a death resulting from chance or unexpected causes with lack of intention to cause harm.

- Gunshot
- Hanging
- Asphyxiation, positional
- MVA
- Drowning
- Falls

**No Intent Present**

# Homicide vs. Murder

- Homicide is death caused at the hands of another person.
- Murder is decided by the court. Murder- someone is to be held culpable to a death.

## Types;

**Criminal-** Different degrees

**Justifiable-** Law Enforcement, military, self-protection

**Excusable-** Unanticipated and unintended death





# Undetermined



Natural....  
Suicide....  
Accident...





# Undetermined

- Only ruled undetermined when there is insufficient information regarding the circumstances surrounding the death to make a ruling.
- Skeletal remains of a young adult with no evidence of trauma.
- Drug Overdoses
  - 50 yr old male, hx of overmedicating and hx of attempting suicide x2.
  - Suicide or accident?
- The decedent was found deceased outside of his home on concrete steps but had been in a fight at the bar. Intoxicated. Fall at home or stuck head in the commission of the fight? Accident vs Homicide

# Undetermined Manner

## Conflicting Data and Unclear Intent

Such as.....

A salesman of bull semen (for AI) was found dead by nitrous oxide (used to store semen) in the back of his van.

Stockbroker involved in an about-to-collapse Ponzi scheme found drowned in a lake, with cinder blocks tied to his waist.

42-year-old male, no life changes, good job, family, no ideations, found with both arms completely cut from elbow to wrist...

# suicide

suicidal  
grief  
person  
unhappy  
awareness  
desperate  
denial  
preventing  
death  
campaign  
tablets  
lost  
down  
people  
quit  
shame  
drink  
serious  
pill  
dead  
brandy  
warn  
emotions  
communication  
jump  
support  
worry  
worried  
pressure  
hanging  
contemplation  
fail  
hope  
protest  
punishment  
despair  
noose  
lonely  
loop  
idea  
problems  
quitting  
illness  
sadness  
loss  
guilt  
fear  
knot  
life  
help  
caution  
rope  
depressed  
education  
concept  
issues  
abuse  
rejection  
frustration  
pain  
stress  
gun  
prevention  
psychology  
stop  
hopelessness  
desperation  
lifestyle  
warning  
trapped  
hopeless  
anticipating  
danger  
solidarity  
trapped  
trapped





# Manner: Suicide

- Suicide- a death that occurs when an individual deliberately takes his or her own life through a series of deliberate actions.
- Examples- Self-inflicted GSW, OD, Hanging, CO deaths, Jump from Height
- Stabbing? MVA???



# Rare Types of Suicide

- Immolation
- Explosion
- Hypothermia
- Improvised Devices
- Electrocution





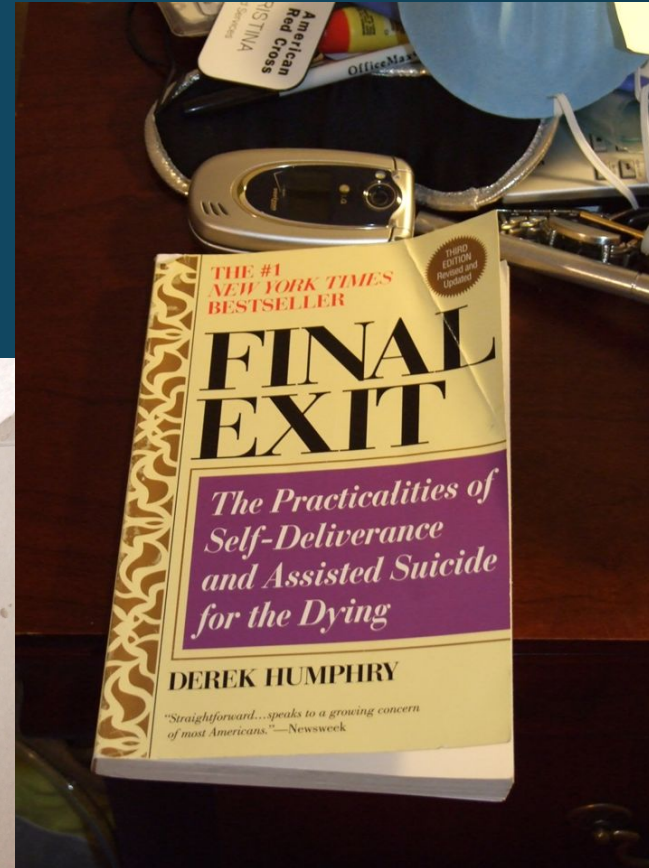
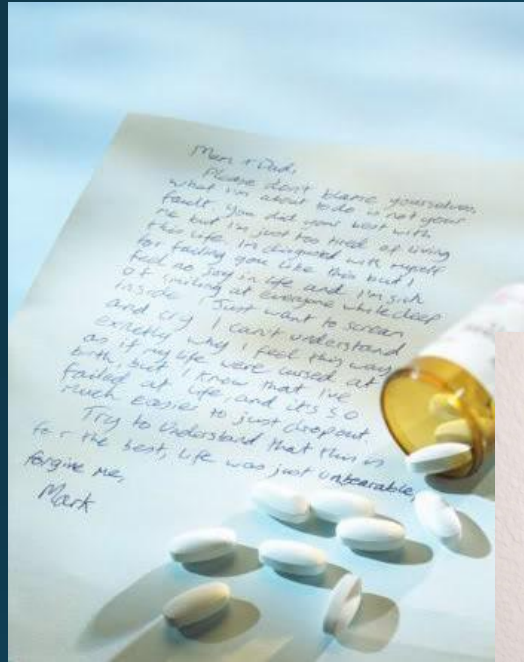


# Complicated Cases

- **Russian Roulette**
  - Accident vs. Suicide
- **Undetermined Deaths**
  - Drownings, falls, etc....
- **“Suicide by Cop”**
  - Suicide vs. Homicide
- **Suicide/Homicide**
- **Autoerotic Asphyxia**



# Letters & Writings; Limited and not always “letters”



SORRY TO BOTHER YOU, BUT

**I**

**AM DEAD**

PLEASE CALL ONE OF THE  
FOLLOWING RELATIVES:



MA + KIDS

I'M SORRY

LOVE  
DAD



# Suicide Notes

- Never determine the manner of suicide based on note or lack thereof...
- Estimated 25-30% of suicides include a suicide note.

And I certainly didn't mean to hurt you  
I truly tried my best and was so close.  
I can't tell you how much I appreciate every  
thing you've done for me. I was sure I was  
one way or the other. I had all the pieces for success  
in front of me. But I just couldn't beat  
Father time. Guess what they say "a day  
late is a dollar short." is true





# Understanding Suicide Deaths

- Suicide is considered a leading “cause” of death in the U.S., with over 47,000 deaths annually (CDC, 2023)
- Focusing on risk and other factors
- Applying investigative processes when examining if a death was related to suicide
- Who died, and who may know about the death event?
- What happened?
- When did it happen?
- Where did it happen?
- How did it happen?
- Why now?



# Suicide Rates Per Year in United States

Suicide rates increased 37% between 2000-2018 and decreased 5% between 2018-2020

However, rates nearly returned to their peak in 2021 ("Suicide Data and Statistics," 2023)

Data table for Figure 1. Age-adjusted suicide rates, by sex: United States, 2001–2021

Year	Total		Male		Female	
	Deaths	Deaths per 100,000 standard population	Deaths	Deaths per 100,000 standard population	Deaths	Deaths per 100,000 standard population
2001.....	30,622	10.7	24,672	18.2	5,950	4.1
2002.....	31,655	10.9	25,409	18.5	6,246	4.2
2003.....	31,484	10.8	25,203	18.1	6,281	4.2
2004.....	32,439	11.0	25,566	18.1	6,873	4.5
2005.....	32,637	10.9	25,907	18.1	6,730	4.4
2006.....	33,300	11.0	26,308	18.1	6,992	4.5
2007.....	34,598	11.3	27,269	18.5	7,329	4.6
2008.....	36,035	11.6	28,450	19.0	7,585	4.8
2009.....	36,909	11.8	29,089	19.2	7,820	4.9
2010.....	38,364	12.1	30,277	19.8	8,087	5.0
2011.....	39,518	12.3	31,003	20.0	8,515	5.2
2012.....	40,600	12.6	31,780	20.4	8,820	5.4
2013.....	41,149	12.6	32,055	20.3	9,094	5.5
2014.....	42,826	13.0	33,162	20.7	9,664	5.8
2015.....	44,193	13.3	33,994	21.1	10,199	6.0
2016.....	44,965	13.5	34,727	21.4	10,238	6.0
2017.....	47,173	14.0	36,782	22.4	10,391	6.1
2018.....	48,344	14.2	37,761	22.8	10,583	6.2
2019.....	47,511	13.9	37,256	22.4	10,255	6.0
2020.....	45,979	13.5	36,551	22.0	9,428	5.5
2021.....	48,183	14.1	38,358	22.8	9,825	5.7

NOTES: Suicide deaths are identified using *International Classification of Diseases, 10th Revision* underlying cause-of-death codes U03, X60–X84, and Y87.0. Age-adjusted death rates are calculated using the direct method and the 2000 U.S. standard population.

SOURCE: National Center for Health Statistics, National Vital Statistics System, Mortality.



# Suicide and age: CDC 2022 provisional data

## Children and Adolescents

- Suicide attempts and deaths among children have increased in the U.S. over the past decade
- Suicide is now the eighth leading cause of death in children aged 5–11
- Suicide is the second-leading cause of death among people aged 15 to 24
- Nearly 20% of high school students report serious thoughts of suicide and 9% have made an attempt to take their lives

## Middle age

- Adults aged 35–64 years account for 46.8% of all suicides in the United States, and suicide is the eighth leading cause of death

## Older Adults

- Adults aged 75+ have one of the highest suicide rates (20.3 per 100,000)
- Men aged 75+ have the highest rate (42.2 per 100,000) compared to other age groups



Investigation

# Medicolegal Role

The medicolegal role at a scene is multifaceted, requiring technical expertise, attention to detail, and collaboration with other professionals to ensure a thorough and accurate investigation of the circumstances surrounding death or injury.



**Initial Assessment:** Upon arrival at the scene, the medicolegal professional assesses the situation to determine the nature and extent of any injuries or fatalities. This assessment includes evaluating the environment for potential hazards and ensuring personal safety





Responsibilities



# Every Case-Every Time

- - Full Medicolegal Death Investigation
  - Body Inspection
  - Scene Photographs
  - Scene Investigation
  - Medical Records Review
  - Mental Health Records Review
  - SBOP Pull and Review
  - Medication Inventory and Counts
  - Review of circumstances and determination of the level of Autopsy & Toxicology

Sudden death takes families by surprise. They may be confused about why the coroner is there. Explaining why you are involved, what is going to happen, and what is expected of them can help relieve unnecessary worry and allow them to anticipate procedures, delays, and future events. The family, at minimum, should be told the following:

- Explain what is believed to have occurred.
- Location of the body
- What procedures will be performed (autopsy, inspection, examined and release from scene)
- Timeline for release
- How personal property will be returned (if possible)
- Timeline for autopsy results, tox results, identification, etc.
- Provide guidance on what they need to do to make arrangements.
  - **\*Do not suggest or refer them to a specific funeral home\***
- Investigator and office contact information in the form of business cards or handouts

**Encourage the family to contact the investigator or office for any questions that may arise.**



# Decedent Inspection

- Throughout the decedent inspection process, the investigator follows established protocols and procedures to ensure the integrity of the investigation and the accurate documentation of findings.
- Pronouncement of Death: If medical personnel have not already pronounced the death, the investigator may pronounce death based on established criteria.
- Initial Assessment: The investigator assesses the body's overall condition and environment. They note any visible signs of trauma, decomposition, or other factors that may be relevant to the investigation.
- External Examination: A systematic external examination of the body is conducted to assess for signs of injury, disease, or other significant findings. This includes documenting injuries, wounds, or any other physical characteristics that may be relevant to the cause or manner of death.

# Conduct the Physical Examination

Visually inspect body

Establish trauma

Establish position of  
body (through  
measurement)

Assess rigor, livor, and  
algor mortis

Assess environmental  
conditions  
(temperature,  
weather, etc.)

Document  
identifying/ unique  
physical  
characteristics

Document clothing  
and items on/in body

Identify and preserve  
trace evidence on  
body

Identify and preserve  
other pertinent  
physical evidence on  
the body

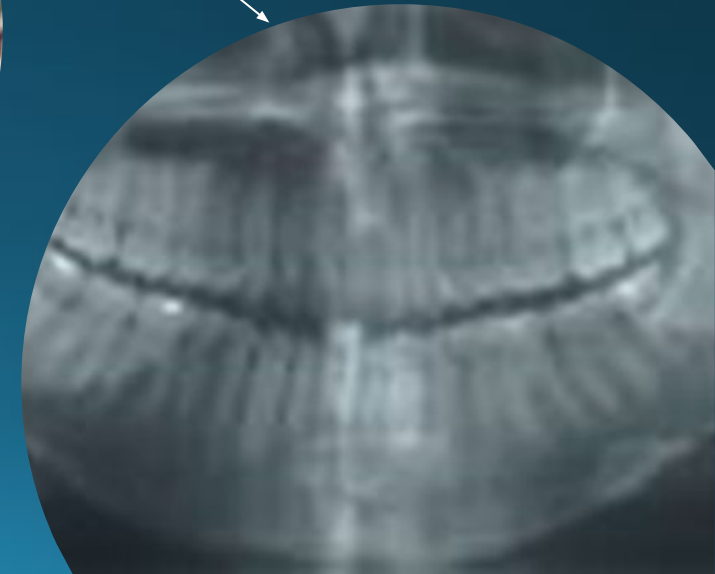
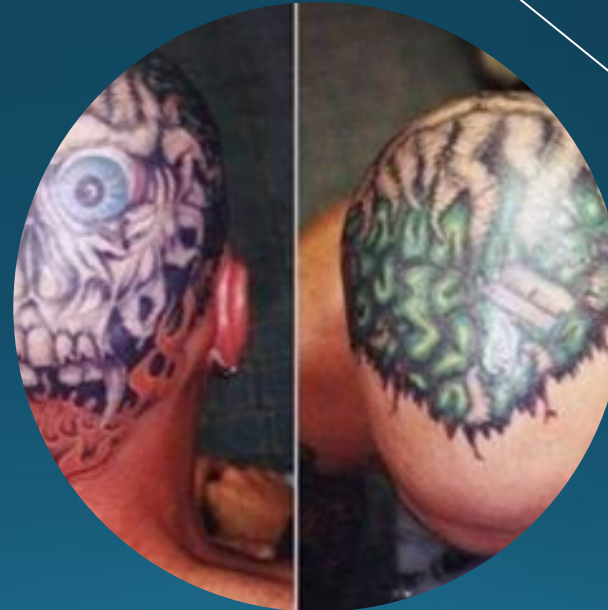
Tag body and body  
bag for identification  
and chain of custody

Place body in  
appropriate container

Arrange for transport

# Identification

- Identify unknown individuals – Is there a photo ID? Does it resemble the individual in front of you?
  - When is scientific Identification required?
  - NEVER ASSUME you think you know who you have. Why?







# Why Scientific?

No vin# Identification

# Interviewing vs. Interrogation

Witness interviews are conducted as soon as possible after the incident to preserve the freshness and accuracy of their recollections.

- **Gathering Information:** Interviews provide an opportunity to collect detailed accounts from individuals who may have knowledge or involvement in the events leading up to the death. This includes witnesses, family members, friends, medical personnel, and other relevant parties.
- **Establishing Timeline:** Witness interviews help establish a timeline of events leading up to the death, including the decedent's activities, interactions, and behaviors. This timeline is crucial for understanding the sequence of events and identifying any potential contributing factors.
- **Corroborating Evidence:** Witnesses may have valuable information about the circumstances leading up to the death, including events, interactions, and behaviors that occurred before, during, or after the incident. Their accounts can provide critical insights into what happened and help establish a timeline of events.
- **Obtaining Context:** Interviews provide context for understanding the decedent's background, lifestyle, relationships, and any relevant factors contributing to their death. This broader context is essential for determining the cause and manner of death accurately.
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This Photo by Ur



# Photos

- JP/MDI Role- Must take your photos
- Scene, Decedent, Medications



# Photograph the Scene/Body/ General

- Establish photographic scene accuracy. Was the body moved? By whom? Why? EMS, Family, Friends, Witnesses?
- Keep all scene processing equipment and investigators out of photos.
- Coroners and Medicolegal Death Investigators MUST take their own photos of the scene and the decedent!
- All photos must be retained and uploaded into the coroner case system- even the bad ones. Do not release to family, friends, etc. You take them, you own them.
- You can share them with Law Enforcement-jurisdiction working cases.
- Attorneys; under subpoena.



# Hospitals, Nursing Homes, Hospice

# Hospital Deaths

- Expired in the ER
- Admit less than 24 hours
- The decedent came in unresponsive and did not regain consciousness
- Did a suicide attempt, accident, or potential homicide result in the admit
  - Does the admission timeframe matter?  
ICU 30 days? 60 days? 90 days??
  - Stillbirths?



# Hospital Deaths



1. When, why, and where was the person admitted to the ER department or hospital?
2. What was the patient's "working diagnosis" (What did they think the patient's problem was?)
3. What procedures were performed when and by whom?
4. If it was a natural death, has the decedent's primary physician been contacted?
5. Will they sign the death certificate?
6. What will they be signing as the cause of death?
7. Private physician needs to be contacted to confirm this information, before releasing the decedent.

# Review hospital records to determine jurisdiction

Anoxic or Metabolic  
Encephalopathy  
Seizures  
End Stage Renal or Liver  
Disease/Failure  
Pulmonary Embolism  
Any Hemorrhages (GI,  
Subdural, Subarachnoid, etc.)  
Respiratory Arrest/Failure  
Heart Failure  
Aspiration/Choking  
Cardiac Arrest/Failure  
Sepsis  
Pneumonia



**WHY????**

# HOSPICE + Medical History

If the reason for Hospice/comfort care/DNR is the result of an accident

- Overdose/Toxicity
- Car accident (any year) left individual on hospice/comfort care
- Individual fell and broke hip placed in hospice
- Individual overdosed and placed in hospice

If injury occurs while on Hospice

- Overdose- Took more medications than prescribed
- An individual is given “too much medication” – directions are misread
- An individual on hospice for cancer falls and gets subdural (or another injury)
- Decedent chokes on food, aspiration pneumonia...



# Suicide Risk Formation

## FACTS

- There is no single cause of suicide
- There is no single TYPE of suicidal person

# Population At Risk

Individuals of all ages, genders, and ethnicities may be at risk, however

- Men more than women
- Middle age white males are the majority
  - Relationship, loss of...
  - Loss of social supports
  - Liquid courage
  - Access to lethal means
- Rural communities more so than urban
  - Lack of social supports
  - Clusters
  - Access to lethal means

Suicide is an outcome that requires several things to go wrong all at once...

# MEANS AND METHOD OF DEATH

- Means reduction is an important part of a comprehensive approach to understanding suicide and suicide prevention
  - Many suicide attempts occur with little planning during a short-term crisis
  - Intent is not all that determines whether a suicide attempter lives or dies; means also matter
  - 90% of attempters who survive do NOT go on to die by suicide later
  - Access to firearms is a risk factor for suicide
  - Firearms used in youth suicide usually belong to a parent



# Perpetuating Risk Factors

**Demographics; Middle Aged Male, White and Native American**

- **Hx of Prior Attempts (90%)**
  - **HX of Prior Ideations**
  - **HX of Self Harm Behavior/Risk Taking**
  - **Hx of Suicide in immediate circle; family and close friends**
  - **Hx of Psychosis**
- 
- **In addition: history of violence, drug and alcohol abuse, divorce, sexual abuse**

## ■ Socio-cultural Risk Factors

- *Lack of social support*
- *Sense of isolation*
- *Stigma associated with seeking help*
- *Barriers to accessing mental health care and substance abuse treatment*
- *Certain cultural and religious beliefs (those that believe suicide is noble)*
- *Exposure to and influence of others who have died by suicide*

# Risk Factors for Suicide...

- Bio-psychosocial Risk Factors:
  - *Previous suicide attempt(s)*
  - *Mental disorders(depression, etc.)*
  - *Alcohol and other substance use disorders*
  - *Hopelessness*
  - *History of trauma or abuse*
  - *Major physical illness*



Signs of  
suicide that  
should be  
documented

Deviations from the normal routine

Evidence of preparations to die

Expressions of a wish to die/ideations

History of previous attempts

History of mental disorder, generally untreated

Recent depressive symptoms

Abusing substances, liquid courage 90%

Recent life stressors; relationship Issues #1

Recent refusal of medical care – elderly or chronic

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Cont. Signs of  
suicide that  
should be  
documented

Expressions of feeling trapped, no way out

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Withdrawing from family/friends

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Abruptly ending personal relationships

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Unusually long grief reaction

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Acting reckless/engaging in risky behavior

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Excessive rage/anger, seeking revenge

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Drastic mood changes

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Cause	Type	Other Significant Conditions	Type	Drugs/Meds/Poison (on board)	Note on Scene	MH Status/Diagnosis	Past SI Hx or Attempts/Hosp	Active Suicidal Ideation	Medical Issues	Active Medical Hx	Relationship Issues	Relationship/Legal/Financial Issues	Employment/Work Hx	DOD Day of week	Vet
Hanging	asphyxia by ligature			methylphenidate 12 ng/ml, ritalinic acid 150 ng/ml, paroxetine 34 ng/ml, desmethylloperidone 150 ng/ml	Y, note in truck	bipolar depression, auditory hallucinations, schizo-affective disorder, PTSD, hypersexual behavior, in tx, on meds	Y, 2 hospitalizations since age 7, psychosocial rehab age 6, reported 3 hanging attempts at age 7		Y	ADHD, fetal alcohol syndrome (in utero narcotics exposure)	Y	father and step-mom separated due to decedent's behavioral issues, shared custody; no known SI per family; no complaints throughout day; possible assault chrg from 6th grade teacher; family and records indicate bio-mom lost parental rights due to physical, emotional abuse of decedent, possible sexual abuse at daycare; family was awaiting residential tx approval	student - Anser Charter	Wednesday	
GSW	head			---		ADHD, anxiety, depression, paranoia, schizophrenia - non-compliant w/ meds	Y, SI stmts, attempted shooting self 15 yrs ago w/ hosp		Y	oxycodone abuse; THC and ETOH use; salvia use	Y	ETOH w/ DUI as juvenile; job loss 12-11-20; in prison 3 yrs; living in motel for a few months; PO reported active paranoia; IDOC reported hitting self in head		Thursday	
Hanging	asphyxia by ligature			ETOH BAC .054, sertraline 180 ng/ml, desmethylsertraline 850 ng/ml, Delta-9 THC >50		Y, anxiety, depression	Y, hx of attempts, most recent attempt 2019 OD,		Y	hx of HTN, allergic rhinitis, migraines, sleep issues, ETOH abuse, on meds		ETOH abuse w/ relapse over Christmas; known distant past heroin, cocaine use and current ETOH abuse; children supportive; ETOH and	Y	Sunday	



# REPORT WRITING

- Upon concluding the investigation and analyzing the evidence, it is imperative to convey the findings through a meticulously prepared report
- Must exemplify clarity and conciseness, devoid of personal opinions, biases or speculations
- Should derive its content strictly from the information and facts garnered from the evidence, adhering to a prescribed format

1. Introduction
2. Investigative Procedure and Process
  - a. General Information
  - b. Collection of Evidence
    - i. Physical and Demonstrative
    - ii. Testimonial
    - iii. Documentary
3. Summary of Evidence
4. Findings and Recommendations

# Discussions with the Family

- #1 rule: Be honest
  - It does not benefit the family to be dishonest about the findings in suicide cases.
- Some questions may seem intrusive but are necessary. Explain why difficult questions are being asked (previous suicide attempts, love affairs, drug use, autoeroticism)
- Ensure the family that their answers will remain confidential as far as the law allows.



# Respond to the Family's Reactions

- Bereaved survivors will exhibit a wide range of emotions
- It is important to remain calm, objective, sympathetic, and focused on the task.
- Reactions usually center around a bereaved person's loss of control
  - Helplessness that the death has occurred
  - Helplessness that the body is inaccessible
  - Helplessness about what is going to be done to the body
- Each of these can be addressed by effective communication and explanation of why things are done the way they are.
- Often times, a family's concerns can be alleviated even if it requires a small change in routine that can be accommodated.



Explain in accurate, concise details what is believed to have happened without using graphic language.



- “Your husband was hit by a car while crossing the street on his way to work.”
- “Your uncle was found dead in his apartment by a neighbor. We are conducting an investigation to determine how he died, but at this time, it appears to be natural.”

If the family desires more information, they will ask, and they should be given correct and concise information. Do not speculate.

# Resources to share with the family

- Develop Family Packets

- Law enforcement contact information
- Funeral home contact information
- Crime scene clean up
- What to expect, why completing the investigation/autopsy
- Time Frames
- Counseling resources

- Man Therapy

- <https://mantherapy.org/explore-topics/gentle-mental-health/368/depression>

## Frequently Asked Questions 11Q. How do I contact the \*\* County Coroner's Office?

The \*\* County Coroner's Office can be reached at 208-287-5556. Investigators are available 24/7, and someone can always be reached. The business office is open Monday through Friday from 8 AM to 5 PM and closed for lunch daily from 12 PM to 1 PM. The office is also closed on holidays. To contact the after-hours on-call Investigator, please call 208-xxx-xxxx and select option #1.

### Q. Where does the Investigator take my loved one?

- Your loved one will be taken to the xxx County Coroner's Office at..... In some cases, your loved one does not need to be taken to the Coroner's Office and will be released directly to your chosen funeral home.

### Q. What funeral home should I use?

- Because the xxx County Coroner's Office is a governmental office, we can't refer families to specific funeral homes. We encourage you to consult with your family and friends for recommendations. If you're unsure which to use, a list of local and surrounding funeral homes is included in this packet in the *Funeral Homes with Phone Numbers* section.
- There are a number of local funeral homes in xxx County that participate in a monthly rotation with the Coroner's Office to work with families when their loved one can be released directly to a funeral home and not taken to the

# Psychological Autopsies

- Forensic technique to establish or specify the causes of a suicide
- It is a process utilized in a medicolegal death investigation to establish the possible causes of suicide, suicidal intentionality, and types of psychological patterns that occurred
- Profile
- Intentionality
- Evidence



# Intentionality

- Evidence: Does the direct and circumstantial evidence support that the death is a suicide? Does the testimony of those interviewed, as well as the physical, demonstrative, and documentary evidence, support the investigatory question? Did this person take their own life?
- Communication: Did the decedent tell anyone that they were going to die by suicide, either directly or indirectly?
- Dire Predictions: A dire prediction is a warning about something terrible that will happen in the future. Perhaps the decedent communicated that he or she will take their own life if they get divorced, fired, or go to prison

# Psychological Autopsies

- Complete extensive report
- Complete thorough interviews of family, friends, and acquaintances
  - Habits, Character, Personality, Personal Relationships
- Complete review of medical records
  - ER Visits, Medical History, Alcohol Abuse, Drug Abuse, etc.
- Complete review of mental health and diagnoses
  - Records and Treatment
- Complete review of the State Board of Pharmacy
  - Suicide vs. Accident vs. Homicide
  - Why, Why Now, Why this Way???

*Suicidal individuals die from accidents and homicides... We need to be as accurate as possible!!*

# BENEFITS SUICIDE REVIEW TEAMS

Ultimately, the overarching goal of a suicide review team is to decrease the prevalence of suicide and promote the overall mental health and safety of individuals at risk within the community. Examining the factors contributing to suicide deaths within a specific area or community.

- Identifying common risk factors and protective measures associated with suicide.
- Analyzing trends and patterns in suicide deaths to inform prevention strategies.
- Evaluating the effectiveness of existing suicide prevention initiatives and interventions.
- Formulating recommendations for targeted actions aimed at reducing the occurrence of suicide.
- Develop resources for individuals, families, and communities impacted by suicide.
- Fostering collaboration among diverse stakeholders, including mental health professionals, law enforcement, public health agencies, and community groups.
- Improving data collection and reporting systems to enhance suicide surveillance and prevention efforts.
- Raising awareness and understanding of suicide as a critical public health concern.



# Last Notes

- MYTH – Suicide happens on a whim and not seasonally.
- Suicide Attempts: Working on the ability to overcome self-preservation.
- People continue to live their lives as they plan their death.
- A decision is made to pull it off the back shelf.
- They believe their death is worth more than life
  - Life Insurance
  - Poor marriage/relationships with family – get on with their lives (family) without having to deal with the issues that the person is going through.



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