Fatality Review and the Role of the Forensic Psychiatrist

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Multidisciplinary Fatality Review teams have operated for decades in the United States and across the developed world. Goals of these teams include examining individual deaths in the community to determine preventability and to make recommendations for future prevention. Fatality Review teams initially focused on child deaths but have expanded to include deaths from domestic violence, elder abuse, overdose, and maternal mortality. Case reviews include data from various agencies that have had contact with victims and perpetrators prior to the deaths. Cause of death and preventability are analyzed. Preventable deaths often include those with risk from mental illness or addiction. Recommendations made by Fatality Review teams have led to important changes for mental health services and prevention, including the Safe Haven laws for neonaticide prevention, suicide and homicide prevention, child murder prevention, firearm laws, and domestic violence screening. Fatality Review teams, which already include law enforcement and forensic pathologists, can benefit from collaboration with forensic psychiatrists because of their specialized knowledge about the intersection of mental illness and violence, should forensic psychiatrists have an opportunity to join them.

J Am Acad Psychiatry Law 49:396–405, 2021. DOI:10.29158/JAAPL.210027-21

Key words: fatality review; child death; domestic violence; elder abuse; homicide; forensic psychiatry

Fatality Review teams across the United States consider unanticipated child deaths, as well as deaths from domestic violence, elder abuse, and overdose. These multidisciplinary teams, which consist of law enforcement, social services, forensic pathologists, and health services, examine individual deaths to review the cause of death, to determine whether the death was preventable, and to make recommendations for future prevention, including changes in legislation. Recommendations relevant to mental health and violence include Safe Haven laws, firearm laws, changes in domestic violence screening, and suicide and homicide prevention recommendations. In our experience, collaboration with forensic psychiatrists can help these teams understand the relationship between mental illness and violence, as well as preventability. Forensic psychiatrists should consider joining Fatality Review teams, if they have the opportunity.

Published online July 21, 2021.

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Dr. Hatters Friedman is involved in the editorial leadership of The Journal; however, she did not participate in any aspect of this article's review and acceptance.

Disclosures of financial or other potential conflicts of interest: None.

Child Fatality Review Origins

The Fatality Review model, in modern history, began in 1978 in Los Angeles.[1] The child fatality review initially sought to improve the ability to identify child abuse deaths and began informally on a local level. Durfee and colleagues noted that "the value of child death review was understood after the first case reviews, as members discovered that each member was lacking information that others could

provide. The story of the death became more complete and more real" (Ref. 2, p 380).

Each death is conceptualized as a community responsibility, and therefore the response utilizes multidisciplinary participation to prevent future deaths. These Fatality Review teams seek to review information about the person's life and death comprehensively and to understand the circumstances, tabulate the known risk factors, and identify previously unrecognized factors. Recommendations can then be formulated to prevent future tragedies. Criminal investigations and the prosecution of the homicide offenders may be improved,[1] and previously unidentified homicides have also been discovered.[2] Fatality Reviews may occur on state or local levels, with findings and recommendations varying with cultural and geographic differences.

By 2001, all states, as well as the District of Columbia, tribal nations, and Guam, had Child Fatality Review Teams (CFRTs).[2–4] CFRTs initially focused on child abuse deaths but, over time, expanded to include other causes of death.[2] The American Academy of Pediatrics (AAP) noted that "although originally developed to improve identification and prosecution of fatal abuse, the role of CFRTs has expanded toward a public health model of prevention of child fatality through systematic review of child deaths from birth through adolescence" (Ref. 5, p 583). There is national Internet-based data collection, and states issue annual reports, including for over 95% of deaths.[6] The AAP described CFRTs as "a powerful tool" (Ref. 5, p 592) in data accuracy regarding deaths, understanding epidemiology and prevention, and for public health and legislation about prevention.

Other Types of Fatality Review Teams

Domestic Violence Fatality Review Teams

In 1991 the Commission on the Status of Women of San Francisco asked for a public investigation into the murder of Veena Charon.[7] Service gaps for women in abusive relationships were noted, including lack of adequate access, training, communication and coordination of services, and data collection. Subsequently, San Francisco developed a response to intimate partner violence that served as a national model. Performing such inquiries systematically and routinely, Domestic Violence Fatality Review Teams (DVFRTs) "focus on the events leading up to the homicide; they seek to identify gaps in policy, practice, training, resources, information, and collaboration" (Ref. 8, p 5). This was described as a "deliberative process" (Ref. 7, p 539) to prevent future homicides. As of 2019, approximately 200 DVFRTs were in operation in 45 states.[9] While DVFRTs assume that domestic violence perpetrators are the ones responsible for the death, they investigate whether agency involvement and responses could have improved the situation. DVFRTs tend to be based in attorney general or court offices and uniquely tend to analyze the protections for victims prior to their deaths.[1]

As Starr and colleagues noted,

> We draw attention to the loss of life at the hands of abusers for two reasons. First, to recognize and honor the lives lost and insist that the domestic violence victims, their children, and their friends and family members killed by abusers are not forgotten. Second, to direct attention to the struggles and challenges faced by all of the domestic violence victims in our state who are living with abuse and can still be helped by our efforts to respond more effectively to domestic violence (Ref. 8, p 5).

Elder Abuse Fatality Review Team

Elder Abuse Fatality Reviews began in Maine and California in the 1990s and have spread to more than a dozen other states, examining both home and institutional deaths.[1] The goal of an Elder Abuse Fatality Review Team is to identify system gaps and improve victim services.[10] The American Bar Association Commission on Law and Aging has promoted the development of Elder Abuse Fatality Review Teams since 2001.[11] To this end, they provide assistance on creating teams through the publication of a replication manual.

Overdose Fatality Review Team

The newest member of Fatality Reviews considers deaths by overdose, mostly focused on opioids. Recognizing the dramatic increase in unintentional overdoses, by 2018, nine states had Overdose Fatality Review Teams (OFRTs).[12] OFRTs were also described as multidisciplinary teams that shared data and critically examined cases of drug overdose deaths.[13] Haas and colleagues asserted that "Overdose fatality review is an effective means of understanding the opioid epidemic, strengthening coordinated interactions, and informing local and state health department overdose prevention strategic planning" (Ref. 13, p 553).

Maternal Mortality Review Committees

Maternal Mortality Review committees are similarly multidisciplinary, and review deaths of women while pregnant or within a year after delivery.[14] Together, 28 states, Washington D.C., and Puerto Rico have Fetal and Infant Mortality Review teams.[3] Fourteen Maternal Mortality Review committees share information with the Centers for Disease Control and Prevention, allowing for a national perspective of maternal death.[14] Maternal Mortality Review committees are effective in reducing maternal mortality through better data collection and policy advocacy.[15]

International Spread of Fatality Review

By 2009, there were an estimated 1,000 review teams including in the United States, Canada, New Zealand, Australia, the United Kingdom, Ireland, The Netherlands, France, South Africa, Saudi Arabia, China, Japan, the Philippines, and Lebanon.[2,3] In England and Wales, a serious case review is compulsory when a child dies and when child maltreatment is either suspected or known to be a factor in the death.[16] Considering Fatality Review teams from the United States, the United Kingdom, Australia, and New Zealand, Fraser and colleagues noted that concerns have existed regarding the accuracy of data regarding cause of death.[6] Child fatality review processes in multiple nations now seek "to systematically gather comprehensive data for children's deaths, to identify potentially remediable factors, and to make recommendations for system improvement" (Ref. 6, p 894), despite variability in purpose and scope both nationally and internationally.

As of 2015, 71 jurisdictions around the world had Domestic or Family Violence Fatality Review Teams.[17] In addition to the United States, Canada, Australia, New Zealand, and the United Kingdom have teams. These teams examine homicides, and some also examine homicide-suicide cases. Most begin their review after both criminal and coroner investigations are completed.[17]

Multidisciplinary Membership

CFRTs are by design multidisciplinary, include various agencies, and may have a neutral facilitator. Law enforcement, the medical examiner, prosecution, medical services, child protective services, public health, and community stakeholders (such as corrections, education, and human services) are represented.[1,2,5,18] Representatives from public health nursing and juvenile court may be present, as well as unique representatives such as individuals from tribal councils, clergy, or the military.[18] Mental health and addiction services may also be included.[2,3,6,18]

Individual members can provide teams with information regarding an individual victim's experience with services, but they may also provide the team with their own expertise, support the team (e.g., by helping explain procedures and protocols), and help build relationships.[1] Law enforcement may provide expertise regarding death scene investigation and evidence collection. Medical examiners may educate the team on various causes of child death. Emergency medical services may help describe procedures and protocols in their purview. Child abuse pediatricians may offer expert opinions regarding the child's death and the medical evidence, as well as share their background medical knowledge about various childhood diseases and injuries.[1] Representatives from the education system may describe the school progress and interventions for the child and their parents. Child protective services may describe abuse and neglect reports and investigations prior to the death. Juvenile justice representatives may describe the child's or parent's legal history.

Similarly, DVFRTs include medical examiners, criminal justice/law enforcement representatives, partner violence services, attorneys, judges, medical services, mental health and substance abuse services, and citizens (e.g., survivors).[7,9,19] Chanmugam noted, "DVFRT goals are aligned with social workers' goals of eliminating service gaps that prevent those most vulnerable from obtaining critically needed help" (Ref. 19, p 73). In addition to a makeup similar to other Fatality Reviews, Elder Abuse Fatality Reviews also may include financial exploitation experts (e.g., forensic accountants).[1] OFRTs have representation from state and local law enforcement, social services, prosecutors, judiciary, and health care, among others.[20] Many states prevent the release of private information discussed during the review, and some states protect their members from liability related to their work on OFRTs.[12] The makeup of the team allows for insight into all of the determinants that intersect in an overdose, creating thoughtful recommendations by informed partners.

Multidisciplinary team members are each guided by their own professional codes of ethics.[3] McCarroll and colleagues further noted that ethics considerations exist regarding how cases are identified for review, the competencies of various team members, reviewing cases outside a team member's area of expertise, and how case reviews are made into recommendations.[3]

Fatality Review Process

Members may have to sign confidentiality agreements when using identified data in a closed session[6,19,21] or may use de-identified abstracts for the committee.[22,23] Data gathering and sharing about individual cases generally begins with medical examiners' data or public health data, and each case is explored individually.[2]

The various agencies such as health systems, child protective services, and law enforcement, who have had any interaction with the child and family will include their data.[18] For example, records needed for case review for youth homicides include the death scene investigation report, the police report, the crime lab report, child protective services history (for the child, household, and parents), information about other children in the home, firearms information, neighborhood crime records, juvenile records of the teenager and the perpetrators, and information from the gang squad and witness interviews.[1] Information important for reviewing youth suicides includes autopsy findings; toxicology results; scene investigation reports; photos; suicide notes; interviews; emergency medical reports; previous child protective services history regarding the child, information about the caregivers, and the person supervising; mental health history; school records; information about other children in the home; past mental health and suicide attempts; substance use history; significant recent life events; and information about a firearm, if used.[1]

DVFRTs review police records, court documents, medical records, and autopsies, and they conduct interviews where possible.[9] Teams tend to describe the chronology of events leading up to deaths, including medico-legal interventions.[9,19] Typical questions for DVFRTs involve warning signs or red flags; intimate partner violence perpetrators released on bond; history of violence, substance abuse, and mental illness; service providers' relationships with the family; safety provisions; protection orders; opportunities to assess the level of dangerousness and intervention; and prevention, as well as missed opportunities and improvements to the system.[7]

Elder Abuse Fatality Review Teams decide whether to review open or closed cases, the different types of death, and setting (i.e., institutional, etc). Teams can be established at a state or regional level. Even within states, teams may differ on whether they include vulnerable adults in addition to elderly.[24]

OFRTs vary regarding the information that is reviewed. Teams in Oklahoma, for example, review autopsy reports, hospital records, school records, court records, prosecutorial records, law enforcement records, fire department records, social service records, and records from the Department of Human Services.[21] Oklahoma's statute recommends collaboration with other state review boards, specifically the CFRTs.[21] For Maternal Mortality Review committees in California, the main sources of information include the coroner's report and hospital records,[22] while Ohio's Pregnancy-Associated Mortality Review committee reviews medical and social services records.[23]

Through these reviews, socioeconomic concerns, policy concerns, risk factors for the local population, and opportunities for intervention are noted.[3] Teams and states publish reports and recommendations to prevent future deaths on the basis of their findings. It is important that recommendations made by the teams are feasible and actionable.[3] Legal challenges faced by Fatality Review Teams include the fact that ongoing criminal court actions may delay or prevent the review of cases, the need to maintain confidentiality of information discussed during meetings, and the need for protection of members against subpoena or discovery.[3]

Preventability of Death

Because prevention is a priority, the term preventability requires explanation. Many states use a definition of a preventable fatality as "one in which, with retrospective analysis, the team determines that a reasonable intervention (e.g., medical, educational, social, legal, or psychological) might have prevented the death. Reasonable is defined by taking into consideration the condition, circumstances, or resources available" (Ref. 18, p 621). In the United Kingdom, preventable deaths similarly include "those in which modifiable factors may have contributed to the death. These factors are defined as those which, by means of nationally or locally achievable

Table 1 Examples of Fatality Review Team Recommendations of Importance to Forensic Psychiatry

Topic	Example	State
Neonaticide	Development of Secret Safe Place for Newborns,[18] allowing mothers to leave newborns < 3 days old at hospital or emergency departments with no questions asked. Similar Safe Haven programs have since developed in all 50 states.[26]	Alabama
Neonaticide and infanticide	Development of programs for infant homicide prevention and Safe Havens.[18]	North Carolina
Youth homicide	Work with school districts for prevention.[18]	Pennsylvania
Child survivors	Services for child survivors for mourning and grief.[18]	California
Domestic violence fatalities committed with firearms	Collaboration with groups to strengthen the process regarding firearm storage and relinquishment practices in cases where someone had been prohibited from possessing firearms.[9]	Vermont
Domestic violence	Recommendations from Domestic Violence Fatality Review Team include "mental health professionals, suicide specialists, and domestic violence programs should collaborate to provide cross-training to each other and to increase their ability to provide the appropriate range of services to domestic violence victims who are suicidal or have other mental health concerns" (Ref. 8, p 9), and routine screening for domestic violence when women presented as suicidal or depressed.	Washington
Domestic violence risk assessment	Passage of statutes requiring law enforcement officers to utilize the lethality assessment protocol when responding to domestic violence calls,[27] and recommending more medical education regarding warning signs of domestic violence and risk of future homicide in cases of strangulation.[30]	Oklahoma

interventions, could be modified to reduce the risk of future child deaths" (Ref. 6, p 895). This is not dissimilar to a retrospective malpractice analysis completed by a forensic psychiatrist.

In contrast to Child Fatality Reviews, "for the most part, DVFRTs are predicated on the belief that domestic violence deaths are preventable" (Ref. 7, p 539), a belief largely held by ORFTs as well. For example, Oklahoma's Opioid Overdose Fatality Review Board focuses on different types of unintentional overdoses (e.g., heroin, prescription opioids, and opioid and benzodiazepine combinations, etc.), allowing for preventive efforts to be more focused and, therefore, more helpful.

Manner of Death Analysis

Manner of death may be ruled by medical examiners as homicide, suicide, natural, unintentional (i.e., accidental), or undetermined. While Fatality Reviews are generally considered to be within the public health realm, they rely on medico-legal investigation models as well.[3]

One challenge is that members on the team may disagree about classifications.[3] Frasier and colleagues noted that "poor quality death certification practice affects all mortality analysis" (Ref. 6, p 896). Fatality Reviews improved accuracy of death certificate data and interagency coordination and uncovered missed homicides as a result of improved methods.[3,18] Rimsza and colleagues noted that "CFRTs may be able to determine more accurately the cause and manner of death than the physician who completed the death certificate" (Ref. 25, p 1). In Arizona, five of 67 child abuse deaths the team reviewed had been misdiagnosed initially as attributable to either accidental or natural causes.[25] They also identified 16 cases in which the CFRT disagreed with the manner of death first noted by the medical examiner, related to additional information that may not have been available to the medical examiner. Mortality data often are based on the death certificate, which has implications that affect findings in studies of homicide or suicide.

Recommendations of Fatality Reviews

Various Fatality Review team cases, findings, and recommendations have direct relevance for forensic psychiatry, including suicide; homicide; Safe Haven programs for neonaticide prevention; child maltreatment; filicide; intimate partner homicide; homicide-suicide; and familicide (Table 1). The goal of Safe Haven programs is to decrease neonaticides as a result of unsafe abandonment of unwanted children. Neonaticide is a critical area for the involvement of

forensic psychiatry, in light of misunderstandings in the general population about maternal mental health problems and neonaticide.

Child Fatality Reviews have had major impacts on policies and procedures, including "the advocacy and development of programs and litigation addressing: abandoned infants; SIDS [Sudden Infant Death Syndrome]; Shaken Baby Syndrome; daycare licensure; smoke detectors; child passenger, bicycle, water and boating, hunting and firearm safety; graduated driver's licensing; truancy and youth homicide; faith-based services and grief and mourning services" (Ref. 18, p 626). In Ohio, prevention initiatives have focused on child abuse and neglect deaths, youth suicide, substance abuse effects on youth leading to death, vehicular injuries, infant deaths, and sleep-related deaths.[1] New Mexico's CFRT indicated that it was composed of specialized panels, including those that looked at SIDS, child abuse and neglect, suicide, and homicide.[18] The latter three have particular relevance to forensic psychiatrists.

Rimsza and colleagues reported that CFRTs in Arizona considered the majority (61%) of child abuse deaths preventable.[25] In the majority (79%) of deaths due to child abuse, child protective services had not previously been involved with the child's family; this is of importance to forensic psychiatrists evaluating filicide, as well as from a public health perspective. Similarly, 37 percent of homicides were assessed as preventable, as were 69 percent of suicides and all deaths due to unsafe sleep. CFRTs found that more than half (55%) of deaths attributable to firearms were preventable. Rimsza and colleagues recommended early recognition of depression with access to mental health services and elimination of guns from the home for prevention of suicide.[25]

Arizona's Child Fatality Review data were also utilized to consider youth suicide.[28] In four of 153 cases, the CFRT's assessment of manner of death as a suicide was different from the initial assessment of the medical examiner, who had determined three were accidents and one had an undetermined manner of death. The authors summarized that "targeted suicide prevention activities should supplement interventions focused on restricting access to highly lethal means of suicide such as firearms" (Ref. 28, p 36).

Palusci and Covington analyzed the U.S. National Child Death Case Review Reporting System, including data from 23 states.[29] Of the cases where child maltreatment caused or contributed to the death, half (51%) were neglect cases, and 30% involved victims of abusive head trauma. When vital statistics were considered, they found that a considerable number of deaths from child neglect were noted originally as accidental (37%), natural (21%), or undetermined (22%). Strategies for prevention recommended by the CFRTs included education (of providers, parents, and community), agency program and policy changes, changes in law or enforcement of the law, and environmental changes
(e.g., consumer products).[29]

Haas and colleagues studied OFRTs and reported that the most common reported condition in opioid deaths was a mental health diagnosis or treatment, seen in 40 percent of cases.[13] Almost one-fifth of the cases (18%) had a documented history of suicide attempts or suicidal ideation. They noted, "The quality of data and process of case review allowed [OFRTs] to apply a person-centered approach to the improvement of system-level gaps and support for people at risk for overdose" (Ref. 13, p 561).

In summary, various types of Fatality Reviews have led to recommendations of great importance and established collaborative inter-agency relationships. We suggest that forensic psychiatrists can help improve understanding of the intersection of mental illness and violence, should they have the opportunity to join a Fatality Review team, a team which already includes law enforcement and forensic pathologists.

Role for Forensic Psychiatrists

Forensic psychiatrists have a role to play in Fatality Reviews. We would also argue that Fatality Reviews should be seen as a public health role for forensic psychiatry. Both pediatricians and social workers have discussed the importance of their roles in fatality reviews.

The American Academy of Pediatrics policy statement noted, "The pediatrician can influence the child fatality review process for individual patients and, more broadly, for their communities and states" (Ref. 5, p 594). They advocate that pediatricians should serve as expert members in reviewing cases and "should also serve as consultants to the child fatality teams on medical issues that need clarification as well as on social issues and community resources that might contribute to the prevention or causation of preventable child deaths" (Ref. 5, p 595). The AAP further noted, "Pediatricians should work

Table 2 Relevance of Forensic Psychiatry in the Various Types of Fatality Review

Type of Fatality Review Team	Potential Role for Forensic Psychiatry
Child Fatality Review	Sharing knowledge regarding: mental illness in parents and youth, and response to treatment motives for filicide substance use disorders and personality disorders among parents and youth risk factors for suicide and homicide/neonaticide/filicide predictability/foreseeability of suicide and homicide Conceptualizing intentionality versus unintentional or accidental death Developing multi-agency relationships Assisting in developing recommendations that are feasible and logical in our populations
Domestic Violence Fatality Review	Sharing knowledge regarding: mental illness and substance use disorders in both perpetrators and victims, and response to treatment mental illness and substance use and the correlation with domestic violence medical screening for domestic violence different forms of domestic violence, as well as different types of stalking risk factors for intimate partner homicide, suicide, and stalking Developing multi-agency relationships Assisting in developing recommendations that are feasible and logical in our populations
Elder Abuse Fatality Review	Sharing knowledge regarding: geriatric psychiatry related to victims, and mental illness/substance abuse/personality disorders among offenders dementias, diagnosis, and treatment risk factors for physical abuse, physical neglect, and financial exploitation the guardianship process and criteria as well as testamentary capacity predictability/foreseeability of outcomes Developing multi-agency relationships Assisting in developing recommendations that are feasible and logical in our populations
Overdose Fatality Review	Sharing knowledge regarding: substance use disorders and mental illness, and their appropriate treatments appropriate prescribing behaviors physician ethics criminality and criminogenic risk related to drug use suicide among substance abusing populations Conceptualizing intentionality versus unintentional or accidental death Developing multi-agency relationships Assisting in developing recommendations that are feasible and logical in our populations
Maternal Mortality Review	Sharing knowledge regarding: maternal mental health, such as postpartum depression and postpartum psychosis screening for postpartum depression maternal suicide treatment of maternal mental health disorders

collaboratively to ensure that information from child fatality reviews is used to inform local, state, and national policies to reduce preventable child deaths" (Ref. 5, p 595). Similarly, forensic psychiatrists serving on such panels may help interpret psychiatric illness and risk of violence, may help further decrease stigmatization and misunderstandings (such as that all homicides in which a perpetrator allegedly had mental illness are caused by mental illness), and may further assist with legislation.

Chanmugam noted, "Social workers have numerous assets as DVFRT team members . . . skills in group facilitation, inter-professional collaboration, community coordination, and outreach" (Ref. 19, p 77). Similarly, forensic psychiatrists have unique skills which make them appropriate for Fatality Review teams (Table 2), and such service likely would also benefit the profession. The American Academy of Psychiatry and the Law defined forensic psychiatry as "a subspecialty of psychiatry in which scientific and clinical expertise is applied in legal contexts involving civil, criminal, correctional, regulatory or legislative matters, and in specialized clinical consultations in areas such as risk assessment or

employment" (Ref. 31, section 1). This specific scientific and clinical expertise would be well applied to Fatality Review teams as they involve criminal, regulatory, and legislative matters, as well as special areas of risk assessment. Forensic psychiatrists have a stake in similar legislation regarding youth suicide, neonaticide, filicide, and partner homicide, as well as prevention efforts. Smalc and colleagues similarly argued the importance of forensic psychiatry becoming an "interdisciplinary profession in interaction with psychiatry but also with other medical branches just as with judiciary, educational institutions, moral-ethical institutions and religious institutions in producing preventive programs and by participating in individual decision-making process" (Ref. 32, p 429).

Forensic psychiatrists can offer interpretations of mental health records, assist with violence risk prediction and prevention, comment on what is appropriate or inappropriate psychiatric practice, and offer insights into overall prevention mechanisms. For example, while it may appear to those not practicing forensic psychiatry that a psychiatrist should have been able to predict a child suicide two months prior when the child was seen by that psychiatrist, that outcome may have indeed not been predictable on the basis of the data. Without input from forensic psychiatrists, teams may lack appreciation of the dynamic nature of suicide risk and of retrospective bias. Thus, forensic psychiatrists who are experts at analyzing malpractice and causation may be of great utility to a Fatality Review.

Forensic psychiatrists are used to working at the interface of psychiatry and the law, and with severe violence or homicide. Forensic psychiatrists have a specific skill set and an ethics mandate of striving for objectivity in evaluation of cases. Psychiatric patients may be the perpetrators of homicides, the victims, or the parents in cases considered by fatality reviews. Forensic psychiatrists bring their understanding of violence and the complexities of mental illness and addiction, thereby avoiding the simplistic explanations sometimes implied by those without such experience. Forensic psychiatrists, in particular, have expertise explaining risk factors and their interactions in individual cases to diverse audiences.

Forensic psychiatrists have specialized training in assembling and reviewing records to develop a complete picture. Most work requires an examination of the facts to come to an informed opinion. This includes, as examples, applying certain standards to maternal mortality, examining the motives for filicide, conceptualizing the motive in child homicide cases, and recognizing problems with prescribing in an opioid overdose.[33] These skills are uniquely poised to increase the capability and efficacy of Fatality Review teams.

Bloom contended that regulatory and legislative matters "have not been sufficiently emphasized as key components of the specialty of forensic psychiatry" (Ref. 34, p 418). Bloom further argued that, "as subspecialists, forensic psychiatrists have responsibility to all psychiatrists living in their state to be aware of the laws and the proposed changes that may affect the practice of psychiatry in that state" (Ref. 34, p 420). Like the pediatricians described by the American Academy of Pediatrics, psychiatrists, and specifically forensic psychiatrists, may have a similar responsibility to Fatality Review Teams. Bloom further argued that "where laws are involved we should form partnerships with general psychiatrists or other psychiatrist subspecialists to make sure that we are putting together the best combined knowledge to the benefit of our patients and the practice of psychiatry" (Ref. 34, p 420). Fatality Review teams are such a venue to affect local practices, law, roles, and community partnerships.

In a similar vein, psychological autopsies, which originated in the late 1950s, were "conceptualized as a thorough retrospective analysis of the decedent's state of mind and intention at the time of death" (Ref. 35, p 924). For example, in Los Angeles County, equivocal deaths in which the manner of death is either suicide or accident are referred by the medical examiner's office and reviewed by a consulting team of mental health professionals at the University of Southern California.[35,36] This demonstrates the appreciation of the medical examiner's office for the role of forensic psychiatric review of suicide or accident in that locale. Participation as a regular member of a Fatality Review Team takes this several steps further by including a forensic psychiatrist routinely in death cases.

Consider that it is forensic pathologists and coroners in the vast majority of cases nationally, rather than forensic psychiatrists, who make the determination that a death was unintentional versus intentional, or a suicide or homicide versus an accident. These determinations of manner of death are made despite disagreements by forensic pathologists about

how to classify manners of death in specific scenarios.[37–40] Concerns have been raised about the reliability and validity of these classifications. For example, if a parent starves a child to death, the manner might be characterized as a natural death or a homicide. If a parent has a crib, and despite advice upon discharge from the newborn nursery, guidance at pediatric appointments, as well as the Judgment of Solomon story from thousands of years ago, still chooses to leave the infant to sleep on an unsafe mattress with an adult who rolls over on them, this may be determined to be a homicide or an accidental death. An overdose may be ruled a suicide or accidental, without a psychological autopsy. These are difficult determinations for professionals outside of psychiatry and the law.

As standards and knowledge evolve, the psychological autopsy may be a useful tool in these determinations. Highly suspicious deaths may not be ruled as homicide or suicide when there is insufficient forensic pathology evidence. Disagreements between the team and the official ruling have been noted in various aforementioned studies. This may affect the individual family, as well as having an impact on research and public data. The way that a forensic psychiatrist approaches a question is vital in the determination of manner of death, and therefore this perspective can be valuable to a review team. Conceptualizing intentionality and mental state together could help bridge understandings with prosecutors in the future.

Forensic psychiatrists should consider contacting the leader of their local child, domestic violence, elder abuse, or overdose Fatality Review Team to explain their role as forensic psychiatrists and to express their interest in joining such a team. In general, teams have not had forensic psychiatrist members in the past. There may be reticence to such an addition or a misperception that having a social worker fulfills the same role. The roles of a forensic psychiatrist are indeed distinct from the role of social work. The rationales described herein for forensic psychiatrist involvement in Fatality Review teams may help form a blueprint.

Fatality Review and Forensic Trainees

Bloom also suggested that regulatory and legislative matters were relevant for forensic trainees.[34] Forensic trainees learning about participation on Fatality Review Teams from forensic supervisors can lead to further understanding of our role at the intersection of law and health. Fatality Reviews may also provide a way for trainees to see the effective interaction of forensic pathologists, child abuse pediatrics, health, social services, law enforcement, justice, and prosecutors, working toward the common goal of future prevention of violence and deaths.

Conclusions

Fatality Review teams have developed around the world for multi-disciplinary consideration of various types of unnatural death, and these teams have made strides in the prevention of homicides and suicides. Forensic psychiatrists working at the intersection of psychiatry and the law have skill sets and synthesized knowledge relevant to the Fatality Review process, which can help fulfill our public health role. Forensic psychiatrists can demonstrate our value as experts of this body of knowledge by serving on Fatality Review teams. Furthermore, our understanding of malpractice analysis or preventability and our special knowledge about suicide, homicide, risk factors, mental illness, and addiction are important. Forensic psychiatrists could be uniquely positioned to explain perpetrators' and victims' mental health and substance use problems within the Fatality Review process. Knowledge of laws related to mental health and experience regarding legislation can further assist in appropriate recommendations made by Fatality Review teams regarding psychiatric patients. It seems that forensic psychiatry should have a seat at this table and should seek to collaborate on Fatality Review teams.

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