

2025 **ANNUAL REPORT**

Laramie County Suicide Fatality Review Team



Wyoming Institute
of Population Health



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SUICIDE FATALITY REVIEW TEAM

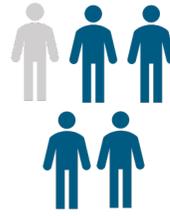
American Medical Response, Member
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Cheyenne Regional Medical Center, Chair
Cheyenne Veterans Affairs Medical Center, Member
Cheyenne Vet Center, Member
Cheyenne-Laramie County Public Health, Member
Cheyenne Police Department, Member
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Laramie County Sheriff's Office, Member
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Volunteers of America, Northern Rockies, Member
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Youth Alternatives, Member

ACKNOWLEDGEMENTS

On behalf of the Suicide Fatality Review Team of Laramie County, we would like to extend our deepest gratitude to those who allowed us to review the death of their loved ones. Their willingness to share information with our team has guided the recommendations developed through this process and would not be possible without their support.

2024 Suicide¹ Statistics

23 ▲ There was an increase in total suicides (17 in 2023).



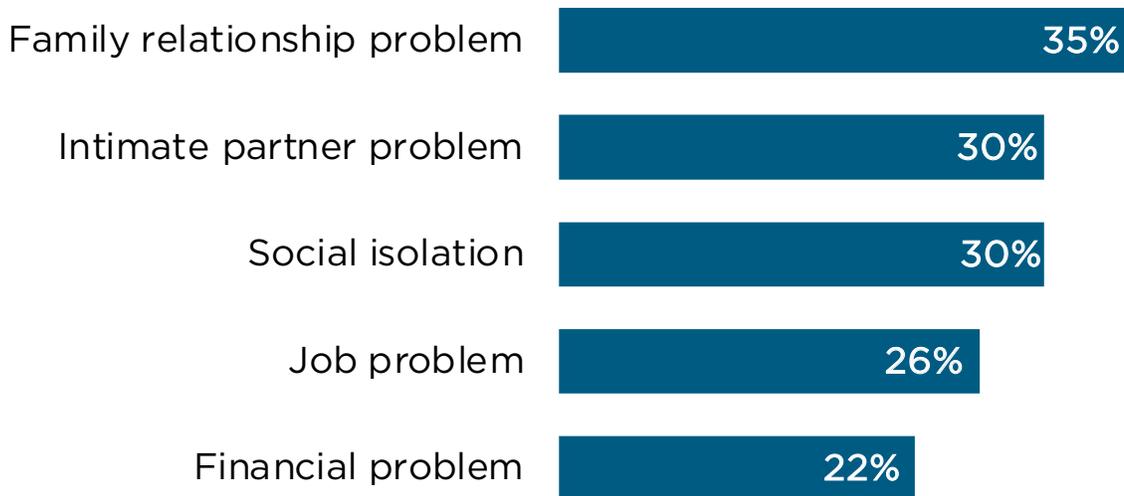
Males accounted for **4 out of 5 suicides** and the average age at death² was **48**.

65% Firearms were used in **two-thirds** of Laramie County suicides.

26% Over **one-fourth** of suicides in **Laramie County** were service members or veterans.

78% of suicides had at least **one social need** identified.

Top five social needs, percent of suicides with social need identified



Just over half (52%) of individuals have a **crisis in the two weeks prior to death**, with the most common crises being a **problem with mental health or alcohol use**.

¹Suicides included on this report include only those suicides investigated by the Laramie County Coroner's Office and may not include deaths that occurred in other Wyoming Counties or States.

² Suicides occurred in these age groups: 19 - 65 and 65 and older.

RECOMMENDATIONS

Recommendations from this process have led to the development of prevention and intervention strategies across a continuum of care designed to reduce suicide and suicidal behaviors in Laramie County. Three suicide fatality reviews were conducted and eight cases were reviewed during the year.

PROVIDE SECTOR-SPECIFIC EDUCATION, TRAINING AND SUPPORT

- Legal professionals
- Realtors
- Clinic staff and primary care providers
- Human Resource professionals

STRENGTHEN SYSTEMS OF CARE AND FOLLOW-THROUGH

- Expand partnerships across county lines
- Engage partners working with individuals and families struggling with chronic conditions (i.e., Dialysis centers, caregiver support, etc.)
- Improve integration of primary care and mental health services, specifically medication management and referrals to additional outpatient Behavioral Health Services

BACKGROUND

Suicide is a preventable public health crisis that impacts every resident of Laramie County, but proven prevention strategies, effective programs and support services are available—and they work. The Laramie County Suicide Fatality Review (SFR) team, a multidisciplinary group of professionals, is dedicated to identifying gaps in the current system of care by examining the circumstances surrounding suicide deaths to strengthen services and reduce risk in the community. The primary goal of the SFR is to uncover unmet needs and systemic challenges while offering informed recommendations that enhance prevention and intervention efforts. With support from the Laramie County Community Partnership (LCCP), the Behavioral Health Action Team and other community partners, the SFR team has gained deeper insight into local factors contributing to suicide, shaping focused strategies to address preventable causes and build a safer, more supportive community for all.

PROCESS

The SFR team follows a structured review process designed to ensure that all relevant questions about the circumstances of a death are addressed. This process is not intended to assign fault to individuals or agencies, but rather to identify opportunities for system improvement and ensure that those impacted by suicide receive needed support. Reviews are conducted for all suicides in Laramie County with next of kin consent. Here are the steps followed during the review process:

- Share, question and clarify all case information
- Discuss the investigation
- Discuss the delivery of services
- Identify risk and protective factors
- Recommend system improvements
- Identify and take action to implement prevention or intervention recommendations
- Determine final steps for concluding the current case review.

IF YOU ARE STRUGGLING OR NEED HELP, PLEASE
TALK TO SOMEONE.

YOU CAN REACH THE 988 SUICIDE & CRISIS LIFELINE BY CALL, TEXT, OR CHAT AT 988. THEY PROVIDE 24/7, FREE, AND CONFIDENTIAL SUPPORT FOR PEOPLE IN DISTRESS AND PREVENTION AND CRISIS RESOURCES FOR YOU OR YOUR LOVED ONES.

988 SUICIDE & CRISIS
LIFELINE





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