2023 ANNUAL REPORT

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This report provides a summary and statistical analysis of the deaths that were investigated by the Shelby County Coroner's Office in the year 2023. We serve an increasing population of 231,406 and responsible for coverage of 800 square miles. Shelby County is the 6th largest county in Alabama. Our staff consists of a total staff of 5; 1 coroner and 4 deputy coroners.

The Coroner and/or Deputy Coroner are on duty 24 hours a day, 365 days a year. The Coroner's mission is to satisfy the legal requirements of the office in an expeditious manner. The primary task of the Coroner's Office is to determine the cause and manner of death of those who have died in Shelby County or in those whose traumatic event originated in Shelby County. An autopsy may be required depending upon the circumstances of the death.

The coroner and all appointed staff have authority through the Alabama Code, Section/Chapter 45-2-61.

The Coroner's Office investigates sudden, unexpected deaths, especially those that occur under violent or suspicious circumstances. Those deaths to be reported to the Shelby County Coroner's Office include all deaths occurring in Shelby County as outlined below regardless of where or when the initial injuring event occurred. In addition, all deaths as outlined below shall be reported that occurred outside of Shelby County but the initiating injuring event occurred in Shelby County.

- From disease which may be hazardous or contagious or which may constitute a threat to the health of the general public
- From external violence, an unexplained cause, or under suspicious circumstances
- Where no physician is in attendance, or where, though in attendance, the physician is unable to certify the cause of death
- From thermal, chemical, or radiation injury
- From criminal abortion
- While in the custody of law enforcement officials or while incarcerated in a public institution
- When the death was sudden and happened to a person who was in good health
- From an industrial accident or any death suspected to involved with the decedent's occupation
- When death occurs in a hospital less than 24 hours after admission to a hospital or after any invasive procedure
- Any death suspected to be due to alcohol intoxication or the result of exposure to drugs or toxic agents
- Any death due to neglect or suspected neglect
- Any stillbirth of 20 or more weeks gestational age unattended by a physician
- Any maternal death to include death of a pregnant woman regardless of the length of the pregnancy, and up to six weeks (or one year) post-delivery, even where the cause of death is unrelated to the pregnancy
- Any death of an infant or child where the medical history has not established a significant pre-existing condition

Staff

Lina Evans F-ABMDI	CORONER
Robert Ingram D-ABMDI	CHIEF DEPUTY CORONER
James Fuller	DEPUTY CORONER
Brandon Harrellson	DEPUTY CORONER
David Lash D-ABMDI	DEPUTY CORONER

General Statistics

Number of Reported Cases

Coroner Cases / Manner of Death	Total Number	Scene Responses
NATURAL	225	205
ACCIDENTAL	37	37
--- DRUG OVERDOSE	47	47
SUICIDE	47	47
HOMICIDE	03	03
UNDETERMINED	02	02
PENDING	05	05

TOTAL AUTOPSIES	33
TOX W/O AUTOPSY	80
ORGAN/TISSUE DONATIONS	10
UNCLAIMED/ABANDON	8
UNIDENTIFIED	0
EXHUMATIONS	0
IN CUSTODY DEATHS	1
DEATH NOTIFICATIONS BY SCCO	186
CREMATION PERMITS	575

Gender of deaths investigated in field

MALES	250
FEMALES	127

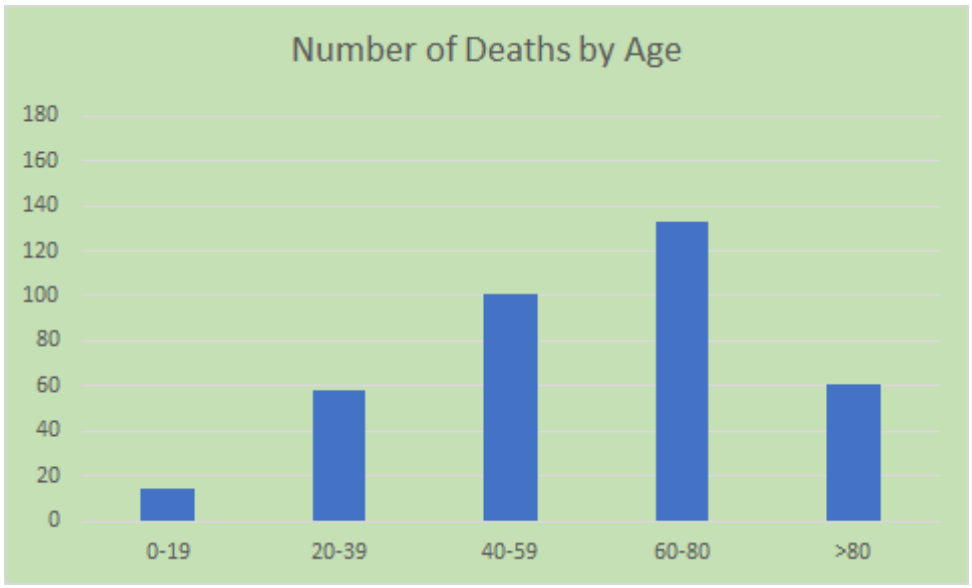
Race of deaths investigated in field

BLACK	49
CAUCASIAN	303
HISPANIC	10
OTHER	4

Body Transport

CORONERS MORGUE	252
MORTUARIES FROM SCENE	98

Age


Number of Deaths by Age
180
160
140
120
100
80
60
40
20
0
0-19
20-39
40-59
60-80
>80

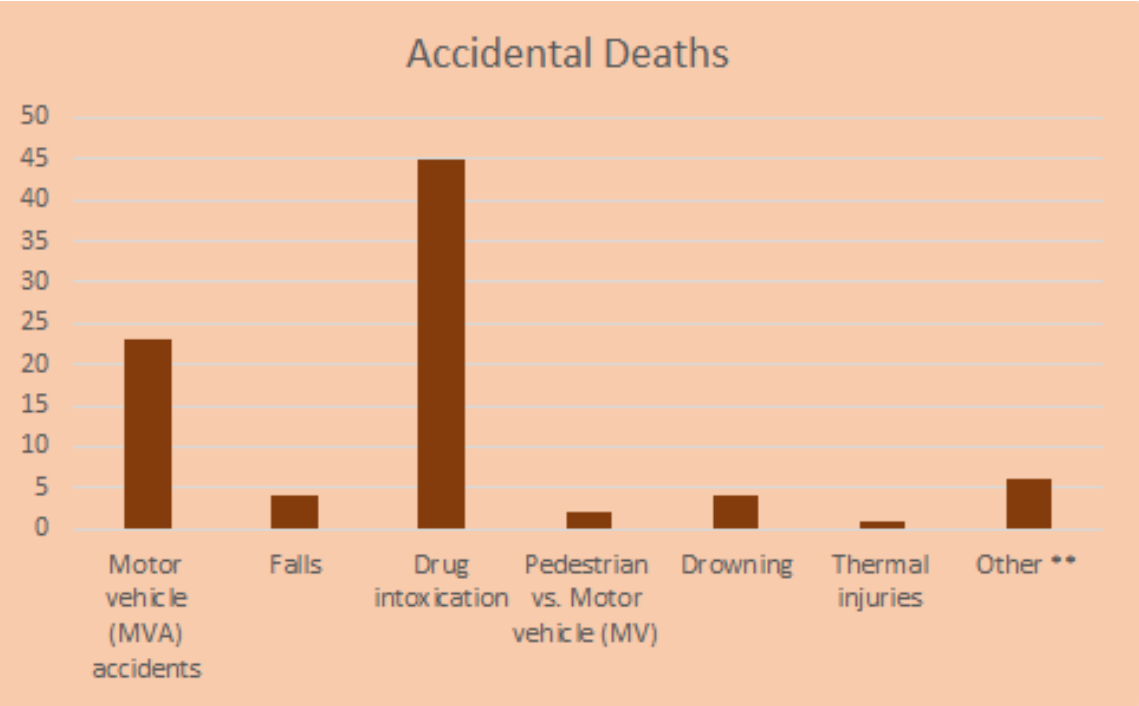
Manner of Death

Manner	# of cases	#of full postmortems at AL DFS	# of partial exams at AL DFS	% receiving full postmortem exam**
Natural	225	4	1	2%
Accident	87	20	1	24%
Suicide	47	2	1	4%
Homicide	03	3	0	100%
Undetermined	1	1	0	100%

** All field investigations receive external exam by SCCO

Accidental Deaths

Type	Number of deaths
Motor vehicle (MVA) accidents	23
Falls	4
Drug intoxication	47
Pedestrian vs. Motor vehicle (MV)	2
Drowning	4
Thermal injuries	1
Other **	6



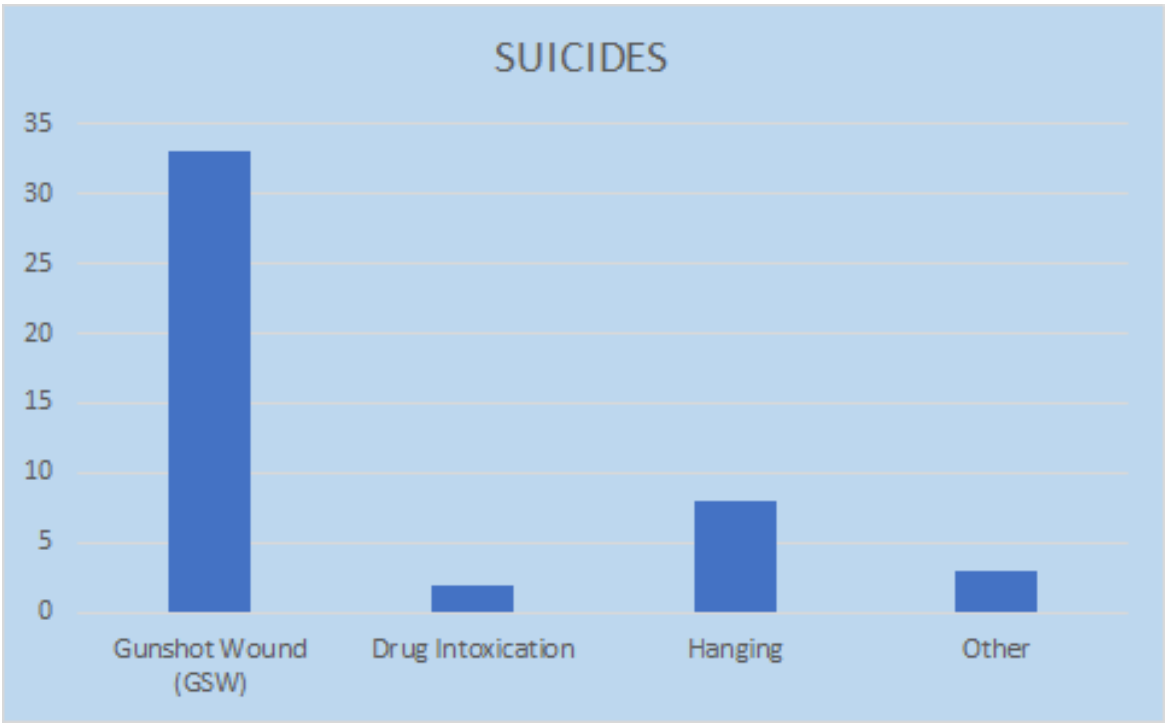
**1 smothering by overlay; 1 heat stoke, 3 BFT, 1 CO2

The 20 motor vehicle collision-related deaths displayed the following characteristics:

- Drivers – 18
- Passengers – 4
- Automobile victims wearing a seatbelt –6
- Automobile victims not wearing a seatbelt – 16

Suicides

Type	Number of deaths
Gunshot wounds (GSW)	33
Drug intoxications	2
Hanging	8
Other	3



The following are some features of the suicide deaths:

- 36 males and 11 females
- Males ages :
  - 0-19 2
  - 20-39 11
  - 40-59 10
  - 60-80 12
  - >80 1
- Females ages:
  - 1-19 2
  - 20-39 11
  - 40-59 10
  - 60-80 12
  - >80 0

Homicides

The 11 homicides had the following characteristics:

- 3 males and 0 females
- Males ages :

0-19	0
20-39	1
40-59	2
60-80	0

- 3 deaths due to gunshot wounds

Natural deaths

Of the natural deaths investigated:

Alzheimers/Dementia Related	4
COVID -19	2
COPD/PE/Lung Related	12
Pancreatits/Pancreatic Cancer	8
Neoplasmas/Cancer Related	20
Chronic ETOH Use Related	16
Diabetes Related	5
Seizure Disorder	4
Infection/Sepsis/Bowel	3
Other Disease Related	4
Renal Failure/ESRF	7
CVD/CVA/CHF - other heart related	140

Undetermined

The 2 undetermined deaths had the following characteristics:

- 1 adult male
- 1 Adolescent female
- both with out medical history
- negative autopsy, toxicology

Other notes of interest:
Most overdose related deaths were due to FENTANYL