

# 2023

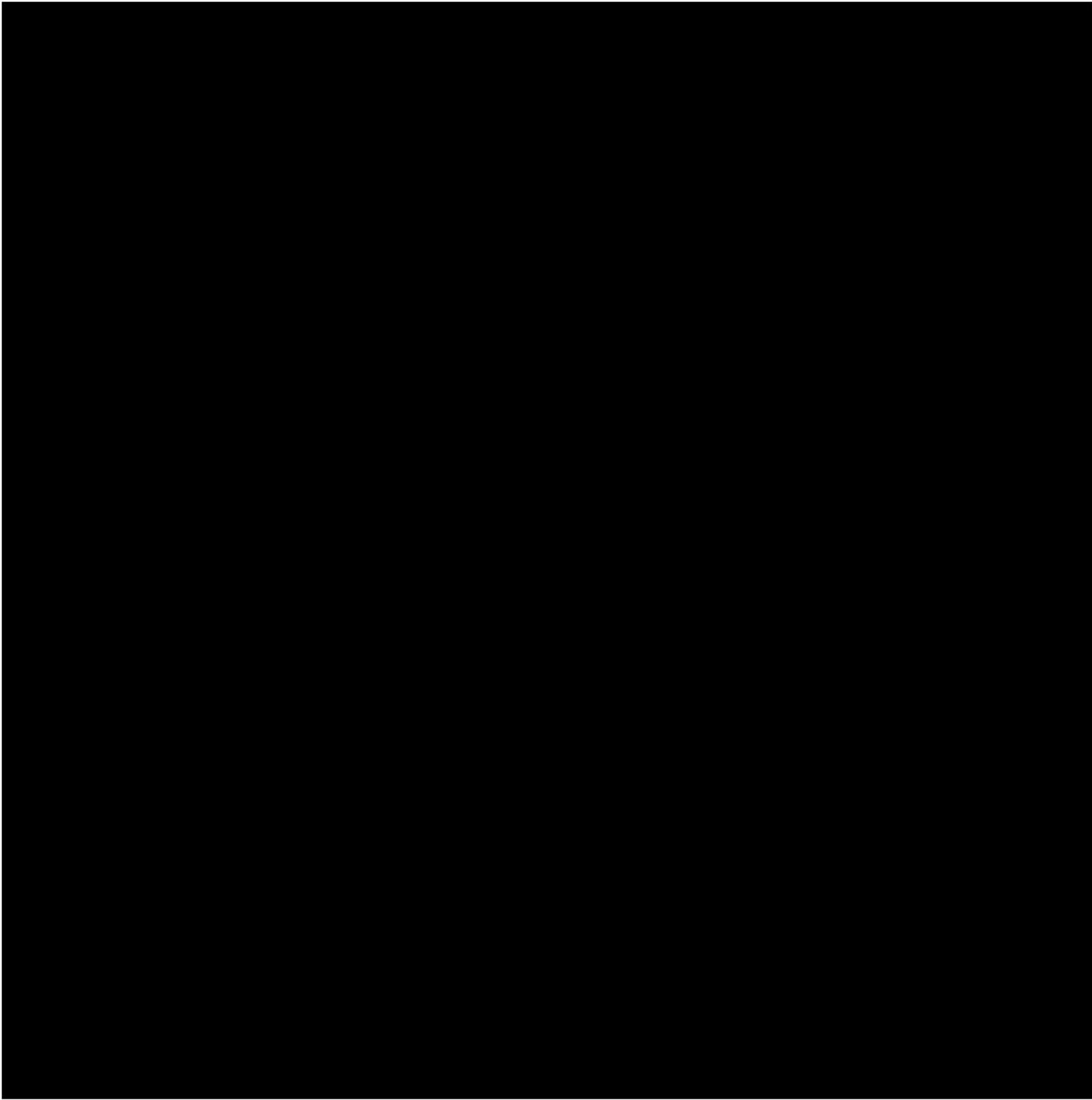
## CORONER'S OFFICE ANNUAL REPORT





# DEDICATION

It is recognized that each in this report represents the death of a person whose absence is grieved by relative and freinds. To those individuals of [REDACTED] who have suffered the loss of a relative or friend, this report is dedicated.



# TABLE OF CONTENTS

Dedication	3
Table Of Contents	4
Introduction	6
Overview	7
Description and purpose of Coroner's Office	7
Reportable deaths	7
Explanation of data	8
Total Cases/Reportable Deaths	9
Statistics Totals (Figure 1)	10
Statistics by Month (Figure 2)	11
Total Cases: Autopsy Status (Figure 3)	12
Total Cases: Case Distribution (Figure 4)	13
Infant Death (Figure 5)	14
Ten-Year Perspective	15
Coroner's Jurisdiction Cumulative Data (Figure 6)	16
Accident	17
Accidental Fatalities-by method (Figure 7)	18
Accidental Fatalities-by location (Figure 8)	19
Accident Fatalities-by Overdose (Figure 9)	20
Accident (Motor Vehicle Crashes)	21
Traffic Fatalities-by age (Figure 10)	22
Traffic Fatalities-by crash mechanism (Figure 11)	23
Traffic Fatalities-by party (Figure 12)	24
Traffic Fatalities-seat belt usage (Figure 13)	25
Traffic Fatalities-by blood alcohol concentration (Figure 14)	26
Traffic Fatalities-by day of week (Figure 15)	27
Homicide	28
Homicides-by method (Figure 16)	29
Homicides-by method and month (Figure 17)	30
Homicides-by age (Figure 18)	31
Homicides-by race (Figure 19)	32
Homicides-by blood alcohol concentration (Figure 20)	33
Homicides-by marital status (Figure 21)	34
Homicides-by location (Figure 22)	35
Homicides-by day of week (Figure 23)	36

Suicide	37
Suicides-by method (Figure 24)	38
Suicides-by method and month (Figure 25)	39
Suicides-by age (Figure 26)	40
Suicides-by suicide note (Figure 27)	41
Suicides-by blood alcohol concentration (Figure 28)	42
Suicides-by location (Figure 29)	43
Suicides-by marital status (Figure 30)	44
Suicides-by day of week (Figure 31)	45
Natural	46
Natural Deaths-by cause (Figure 32)	47
Undetermined	48
Undetermined-by cause (Figure 33)	49
Law Enforcement Agencies	50
Cases by Investigating Agency (Figure 34)	51
Performance Measures/Quality Assurance	52
Performance Measures (Figure 35)	53
Performance Measures by Investigator by Case Type (Figure 36)	54
Coroner Activity	55
Glossary of terms	57
Organizational chart	59

## Introduction

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The Coroner's Office serves the living by investigating sudden and unexpected deaths and in particular, those that occur under violent or suspicious circumstances. The Coroner's Office is tasked by statute with investigating all reportable deaths occurring within the county to subsequently determine the cause and manner of death in such cases, and to provide formal death certification.

The Coroner's staff recognizes the tragedy surrounding an untimely death and performs its investigations, in part, to assist the grieving family. A complete investigation also provides information for implementing criminal and civil litigation and may be used for the expeditious settling of insurance claims and estates. Questions which seem irrelevant in the initial hours after death can become significant in the following months. The surviving family, friends, and general public should have the assurance that a complete investigation was conducted.

When a death occurs on the job or is work related, the results of our investigation are immediately forwarded to the Occupational Safety and Health Administration so that the job site can be thoroughly examined. Private insurance companies also routinely use these findings to settle claims. Whenever a consumer product is implicated in a death, the Consumer Product Safety Commission is notified to ensure that the product is studied and the necessary steps are taken to protect the public. The public health dimension of the Coroner's function is designed to isolate and identify infectious agents or poisons that cause sudden, unexpected death, and when an agent is implicated, the family and persons recently in physical contact with the deceased are notified in order that they might receive any needed medical treatment.

The medical investigation of violent death is frequently required in criminal adjudication. Thus, a prompt medical investigation is conducted to provide the criminal justice system with information and evidence. Although criminal death investigations constitute a small portion of deaths investigated by the Coroner, these deaths are studied in great detail because of the legal consequences involved.

## Overview

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### Description and Purpose of the Coroner's Office

The Coroner's Office is a separate and independent division of the ██████ County Government and is funded through the ██████ County Commissioners by the citizens of ██████ County.

The Coroner is an elected position, voted into office by the citizens of ██████ County; the elected Coroner, ██████, is a physician trained and board certified in Anatomic and Clinical Pathology and Forensic Pathology, which is the branch of medicine concerned with the medical determination of cause of death, particularly in sudden and unexpected, violent, or suspicious deaths. Under the Coroner's direction are Medicolegal Death Investigations, Autopsy Support, and Administrative Support; these sections are responsible for field investigation of scenes and circumstances of death, identification of the deceased, certification of death, notification of next-of-kin, performance of autopsies where indicated, control and disposition of personal property of the deceased, and archiving of related documentation.

### Reportable deaths

Those deaths that occur within the county borders that are to be reported to the Coroner's Office are defined by statute (Colorado Revised Statutes CRS 30-10-606) and include, but are not limited to, the following:

- Any death that occurs suddenly and unexpectedly, when the person has not been under medical care by a physician for significant natural disease.
- Any death suspected to be due to violence (suicidal, accidental, or homicidal injury) regardless of when or where the injury occurred.
- Any death suspected to be due to alcohol, illicit drug, or prescription drug intoxication or exposure.
- Any death related to exposure to toxic agents, environmental extremes (heat or cold), or thermal, chemical or radiation injury.
- Any death of a person in the custody of law enforcement officers or housed in a county or state institution.
- Any death that occurs within 24 hours of admission to a hospital.
- Any death of an infant or child that is unexpected or unexplained.
- Any death related to a person's occupation or occurring at the workplace.
- Any death suspected to be due to infectious or contagious disease that may constitute a threat to the health of the general public.
- Any death where the body is unidentifiable, decomposed, charred or skeletonized.
- Any death occurring under suspicious circumstances.

Any death in which there is doubt as to whether or not it is a Coroner's case should be reported.

Deaths meeting the above criteria will be investigated by Coroner's Office personnel; jurisdiction may or may not be assumed in individual cases and autopsies will be performed as determined necessary by the Coroner; per statute, autopsies must be performed by a Forensic Pathologist (CRS 30-10-606.5).

## Explanation of Data

The information presented in this report was compiled on deaths which were reported to the [REDACTED] [REDACTED] [REDACTED] and occurred during the 2023 calendar year. The report will present routinely collected data in a manner that attempts to answer questions regarding mortality and public health; the role of alcohol, drugs of abuse, and firearm use in violent deaths is emphasized. If the quality of life in [REDACTED] [REDACTED] is to be improved, perhaps this report can serve as an instigator for change. The data included represents only a subset of total mortality figures, representing findings on cases that come to the attention of the Coroner's Office. Complete mortality figures for the county to include deaths not under the jurisdiction of the Coroner's Office can be obtained through the [REDACTED] [REDACTED] Public Health Department.

The geographic area served by the Coroner's Office includes the entire 810 square miles of [REDACTED] [REDACTED], encompassing the southeastern portion of the Denver metropolitan area. Information from the 2020 census from the U.S. Census Bureau lists [REDACTED] [REDACTED] as having a 2020 population of 655,070 and the U.S. Census Bureau estimates that the 2023 population of the county is 656,061, ranking it as the third most populous county in Colorado. The county contains all or parts of the following cities and towns: Aurora, Bennett, Bow Mar, Byers, Centennial, Cherry Hills Village, Columbine Valley, Deer Trail, Englewood, Foxfield, Glendale, Greenwood Village, Littleton, Sheridan, Strasburg and Watkins.

Demographics in this report are summarized from individual cases under the jurisdiction of the Coroner, and presented here in aggregate form. Each manner of death is addressed individually with appropriate data displayed relating to each category; the variables displayed such as race, gender, age, etc. have been selected as those most likely to assist and interest individuals utilizing this report.

Blood alcohol data included here represents the blood concentrations at the time of death or injury/hospitalization, when available. Alcohol is metabolized at a rate of 0.015 to 0.018 grams/deciliter per hour. Thus, if there is a significant interval between injury and death, there will be discrepancies between blood concentrations at the time of injury and the time of death. Tables will reflect blood alcohol at the time of injury whenever appropriate samples were available for testing. When representative samples from the time of injury are not available (due to prolonged hospitalization or other circumstance), blood alcohol testing may not be performed on autopsy samples or if performed, may show significantly decreased blood alcohol level not reflective of that present at the time of the actual incident.

## Total Cases/Reportable Deaths

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In 2023, there were a total of 4,931 deaths in [REDACTED] [REDACTED]. Of these deaths, 4,304 were reported to the [REDACTED] [REDACTED] [REDACTED] by medical and law enforcement personnel and the office provided various degrees of investigative services for each of these deaths. Based on an analysis of the scene, circumstances surrounding the death, and the deceased's medical history as gathered by the medical investigators, the Coroner assumed jurisdiction in 949 (22%) of reported deaths. Examinations were carried out in 83% (789/949) of the cases. Autopsies are not performed in deaths where the scene, circumstances, medical history, and external examination of the body provide sufficient information for death certification. In cases where jurisdiction was relinquished by the [REDACTED] Coroner, a local physician certified the death based on knowledge of the deceased's state of health and medical conditions. Deaths certified by local physicians primarily encompass natural deaths in individuals with a known disease process, and include deaths within nursing homes and assisted care facilities. In addition, under CRS 30-10-606, jurisdiction was transferred to a different County Coroner's Office in 272 deaths that were initially reported to [REDACTED] County.

The following tables and figures summarize the manner of death in all cases reported to the Coroner's Office. Of the cases that fell under the Coroner's jurisdiction, a majority (47%) were under the accidental category, followed by natural deaths (31%) and suicides (14%). Homicidal deaths, while comprising only 6% of the cases, usually garner a disproportionate amount of attention and effort by the Office.

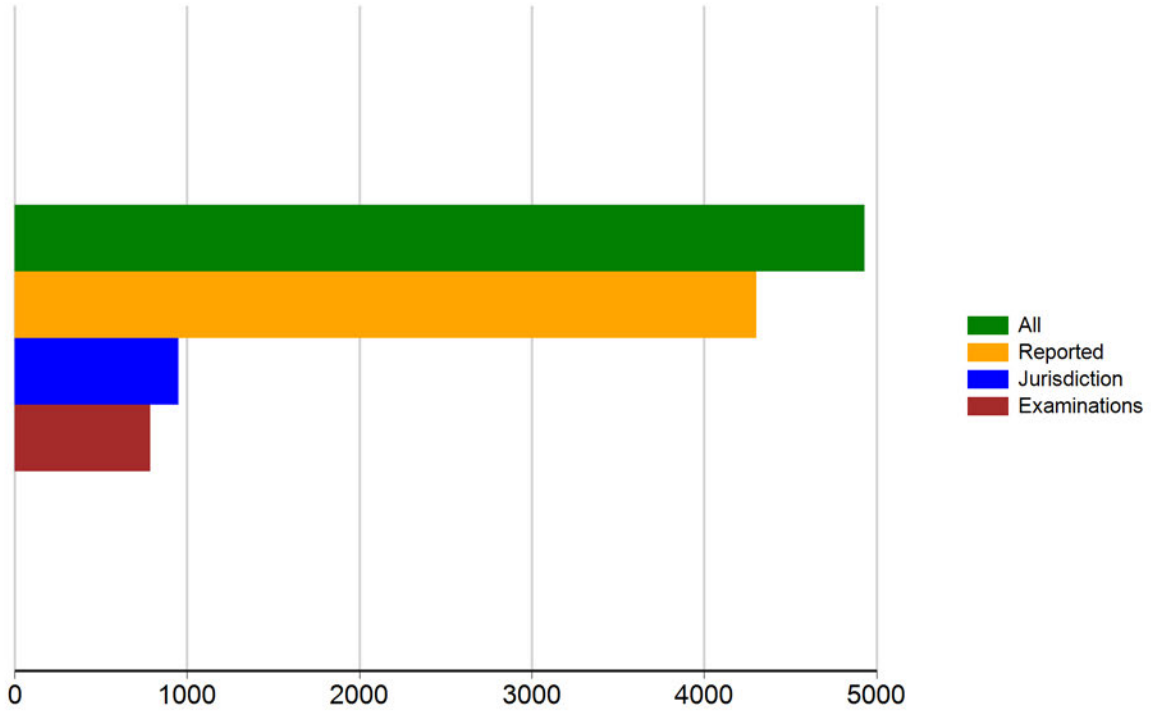
# STATISTICS TOTALS

Figure 1

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All ██████ County Deaths	4,931
Reported to ██████ County Coroner	4,304
Jurisdiction Assumed by County Coroner	949
Examinations by ██████ County Coroner	789

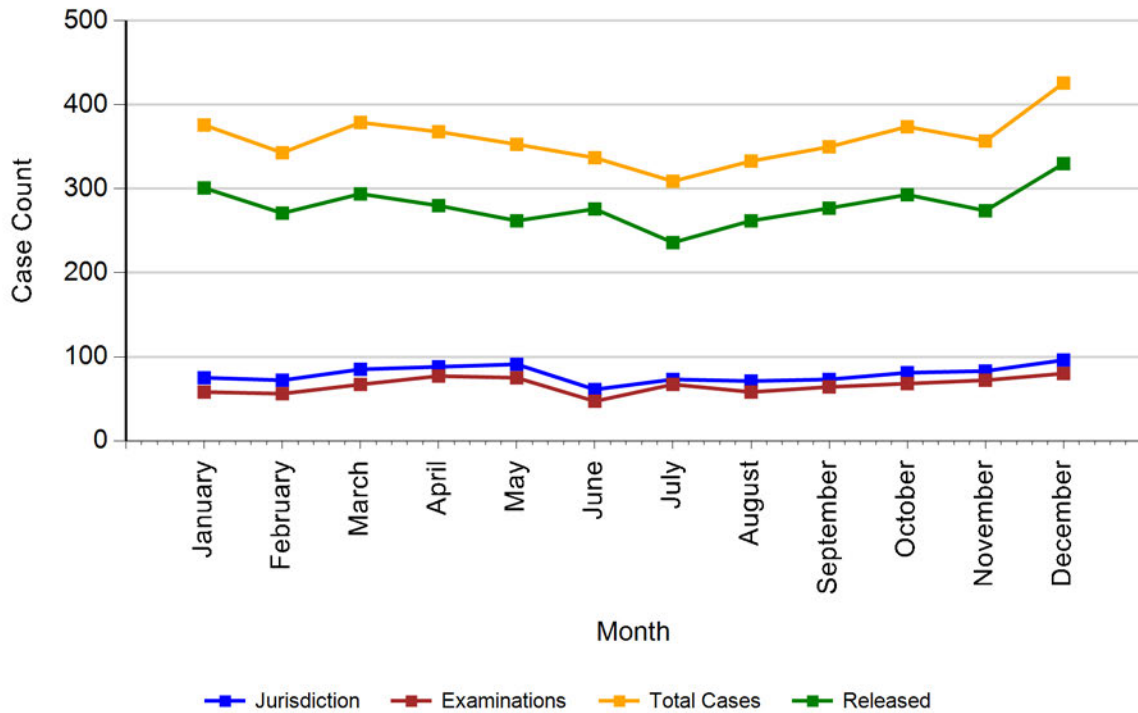
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# STATISTICS BY MONTH

Figure 2

Month	Total Cases	Released	Jurisdiction	Examinations
January	376	301	75	58
February	343	271	72	56
March	379	294	85	67
April	368	280	88	77
May	353	262	91	75
June	337	276	61	47
July	309	236	73	67
August	333	262	71	58
September	350	277	73	64
October	374	293	81	68
November	357	274	83	72
December	426	330	96	80
<b>Total</b>	<b>4,305</b>	<b>3,356</b>	<b>949</b>	<b>789</b>



# TOTAL CASES AUTOPSY STATUS

Figure 3

Type of Case Manner of Death	Examinations			Percent Autopsied	Total
	Autopsy	External	No		
<b>Coroner Jurisdiction</b>					
<b>Accident</b>	300	32	116	67%	448
<b>Fetal Demise</b>	1			100%	1
<b>Homicide</b>	59			100%	59
<b>Natural</b>	156	98	42	53%	296
<b>Suicide</b>	66	64	2	50%	132
<b>Undetermined</b>	12	1		92%	13
	594	195	160		949
<b>Jurisdiction Terminated</b>					
<b>Coroner OK</b>	1,316				1,316
<b>Non Reportable</b>	1,767				1,767
	3,083				3,083
<b>Jurisdiction Transferred</b>					
<b>Accident</b>	70				70
<b>Homicide</b>	1				1
<b>Natural</b>	74				74
<b>Undetermined</b>	3				3
<b>Not Given</b>	124				124
	272				272
<b>Reported Deaths</b>	3,355	594	195	160	4,304

# TOTAL CASES: CASE DISTRIBUTION

Figure 4

## Cases by Manner of Death by Age

Gender	Age	Accident		Fetal Demise	Homicide	Natural	Suicide	Undetermined	Total
		*MVC	Non-*MVC						
Female	<1	0	1	0	0	0	0	1	2
	1-4	0	0	0	1	0	0	0	1
	5-9	0	0	0	1	0	0	1	2
	10-14	0	0	0	0	0	1	0	1
	15-19	1	2	0	1	1	1	0	6
	20-24	3	5	0	0	1	2	0	11
	25-34	2	8	0	0	8	5	1	24
	35-44	3	16	0	9	12	6	1	47
	45-54	1	12	0	3	13	9	0	38
	55-64	2	10	0	2	14	5	0	33
	65-74	2	16	0	1	20	2	0	41
	75-84	4	18	0	0	9	1	0	32
	85-94	1	13	0	0	5	1	1	21
	95+	0	7	0	0	4	0	0	11
<b>Subtotal</b>		<b>19</b>	<b>108</b>	<b>0</b>	<b>18</b>	<b>87</b>	<b>33</b>	<b>5</b>	<b>270</b>
Male	<1	0	2	1	0	0	0	1	4
	1-4	0	0	0	1	3	0	1	5
	5-9	1	0	0	1	1	0	0	3
	10-14	1	0	0	2	1	0	0	4
	15-19	8	5	0	3	0	2	1	19
	20-24	9	8	0	8	4	7	0	36
	25-34	11	44	0	11	13	27	2	108
	35-44	12	55	0	8	27	21	2	125
	45-54	10	38	0	4	34	11	1	98
	55-64	5	41	0	3	52	11	0	112
	65-74	9	20	0	0	42	13	0	84
	75-84	2	17	0	0	21	4	0	44
	85-94	0	22	0	0	10	2	0	34
	95+	0	1	0	0	1	1	0	3
<b>Subtotal</b>		<b>68</b>	<b>253</b>	<b>1</b>	<b>41</b>	<b>209</b>	<b>99</b>	<b>8</b>	<b>679</b>
<b>Total</b>		<b>87</b>	<b>361</b>	<b>1</b>	<b>59</b>	<b>296</b>	<b>132</b>	<b>13</b>	<b>949</b>

\*MVC=Motor Vehicle Crash

# Infant Death

Figure 5

Cause Of Death	Certified	Autopsied	Natural	Accident	Homicide	Fetal Demise	Undetermined	Total
	6	6						
Fetal demise						1		1
Mechanical/positional asphyxia				3				3
Unexplained sudden death in infants and children							2	2
Total				3		1	2	6

## Ten-Year Perspective

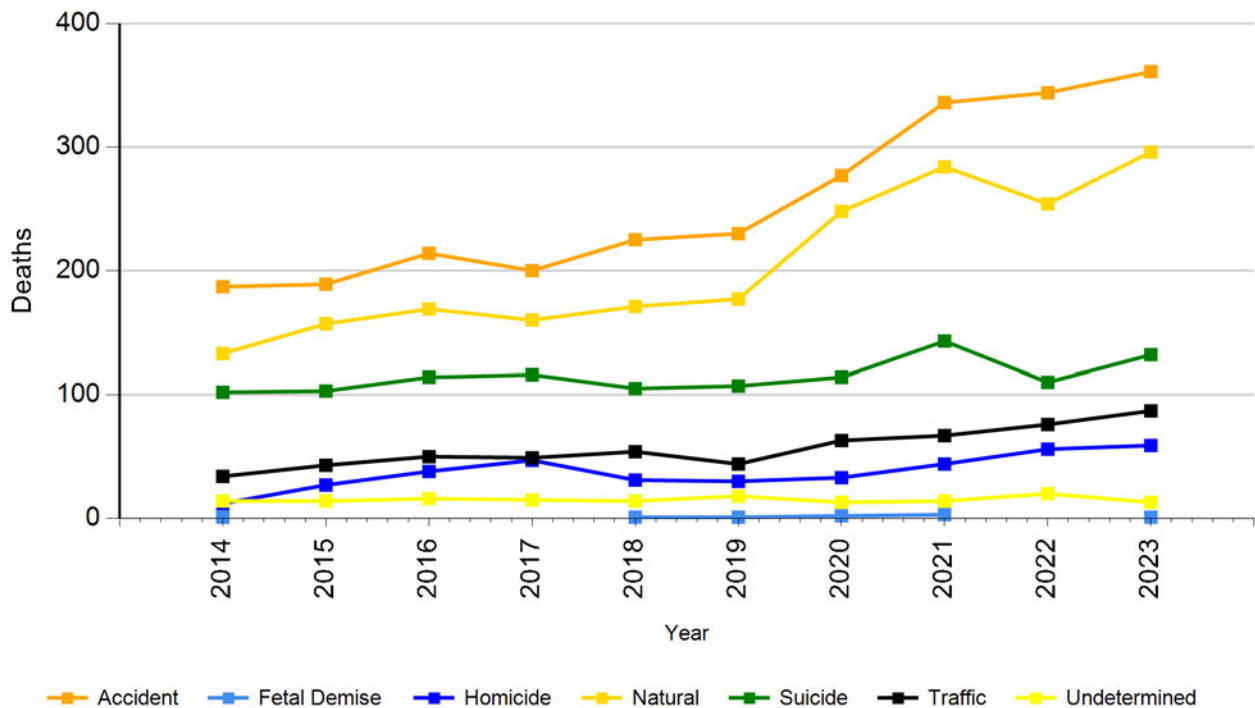
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A ten-year perspective on deaths investigated by the Coroner is presented, illustrating data variation from year to year to provide trends over time. The total number of deaths for 2023 in which jurisdiction was retained increased over the 2022 total (89 more cases), an increase similar to that which we experience most years. Most of these increases were distributed across all categories (excluding undetermined) as further detailed in the following corresponding sections.

# CORONER'S JURISDICTION CUMULATIVE DATA (PAST 10 YEARS)

Figure 6

Year	Accident	Traffic	Fetal Demise	Homicide	Natural	Suicide	Undetermined	Total
2023	361	87	1	59	296	132	13	949
2022	344	76	0	56	254	110	20	860
2021	336	67	3	44	284	143	14	891
2020	277	63	2	33	248	114	13	750
2019	230	44	1	30	177	107	18	607
2018	225	54	1	31	171	105	14	601
2017	200	49	0	47	160	116	15	587
2016	214	50	0	38	169	114	16	601
2015	189	43	0	27	157	103	14	533
2014	187	34	1	12	133	102	14	483
<b>Total</b>	<b>2,563</b>	<b>567</b>	<b>9</b>	<b>377</b>	<b>2,049</b>	<b>1,146</b>	<b>151</b>	<b>6,862</b>



## Accident

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448 deaths were certified as accidental during the 2023 calendar year (a rate of 68 per 100,000 population), including traffic fatalities which are further subdivided in the following pages. Drug-related deaths including overdoses accounted for the largest single group of accidental fatalities (47%, 211/448). This increase continues to be noted locally and nationwide, predominantly driven by fentanyl-related deaths (seen alone or in combination with other drugs) as illustrated in Figure 9. Accidental falls were the second largest category (22%, 99/448), and the third largest group was motor vehicle crashes (19%, 87/448).

# ACCIDENT FATALITIES - BY METHOD

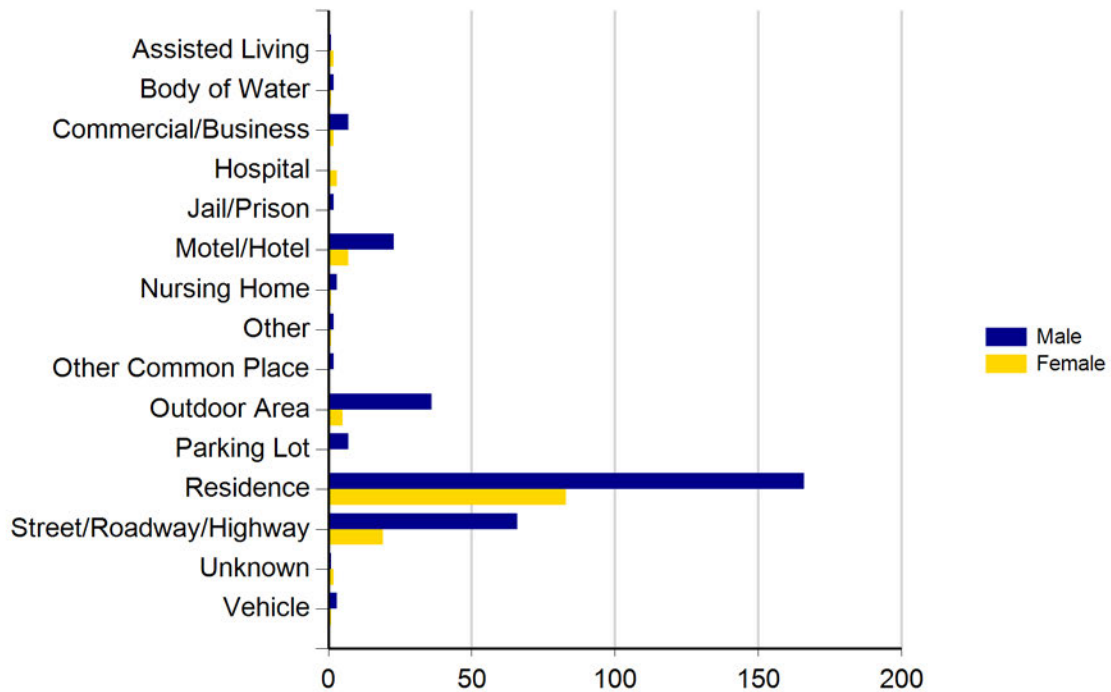
Figure 7

Cause	Male	Female	Total
Anaphylaxis	0	2	2
Blast injuries	1	0	1
Bowel obstruction	1	0	1
Choking	1	2	3
Drowning	6	3	9
Drug overdose	144	44	188
Exsanguination	1	0	1
Fall down stairs	10	10	20
Fall from short distance height	43	35	78
Fall from significant height	1	0	1
Gunshot wound of head	1	0	1
Hanging	1	0	1
Hyperthermia	0	1	1
Hypothermia	8	2	10
Inhalation of products of combustion	0	1	1
Mechanical/positional asphyxia	8	3	11
Natural disease exacerbated by drug use	19	4	23
Pulmonary embolism	1	1	2
Seizure disorder	3	0	3
Sharp force injury (stabbing or cutting)	1	0	1
Thermal injury/burns	3	0	3
Traffic-multivehicle crash	31	4	35
Traffic-pedestrian struck by vehicle	12	11	23
Traffic-single vehicle crash	24	4	28
Traffic-unknown circumstances	1	0	1
<b>Total</b>	<b>321</b>	<b>127</b>	<b>448</b>

# ACCIDENT FATALITIES - BY LOCATION

Figure 8

Setting	Male	Female	Total
Assisted Living	1	2	3
Body of Water	2	1	3
Commercial/Business	7	2	9
Hospital	0	3	3
Jail/Prison	2	0	2
Motel/Hotel	23	7	30
Nursing Home	3	1	4
Other	2	1	3
Other Common Place	2	0	2
Outdoor Area	36	5	41
Parking Lot	7	0	7
Residence	166	83	249
Street/Roadway/Highway	66	19	85
Unknown	1	2	3
Vehicle	3	1	4
<b>Total</b>	<b>321</b>	<b>127</b>	<b>448</b>



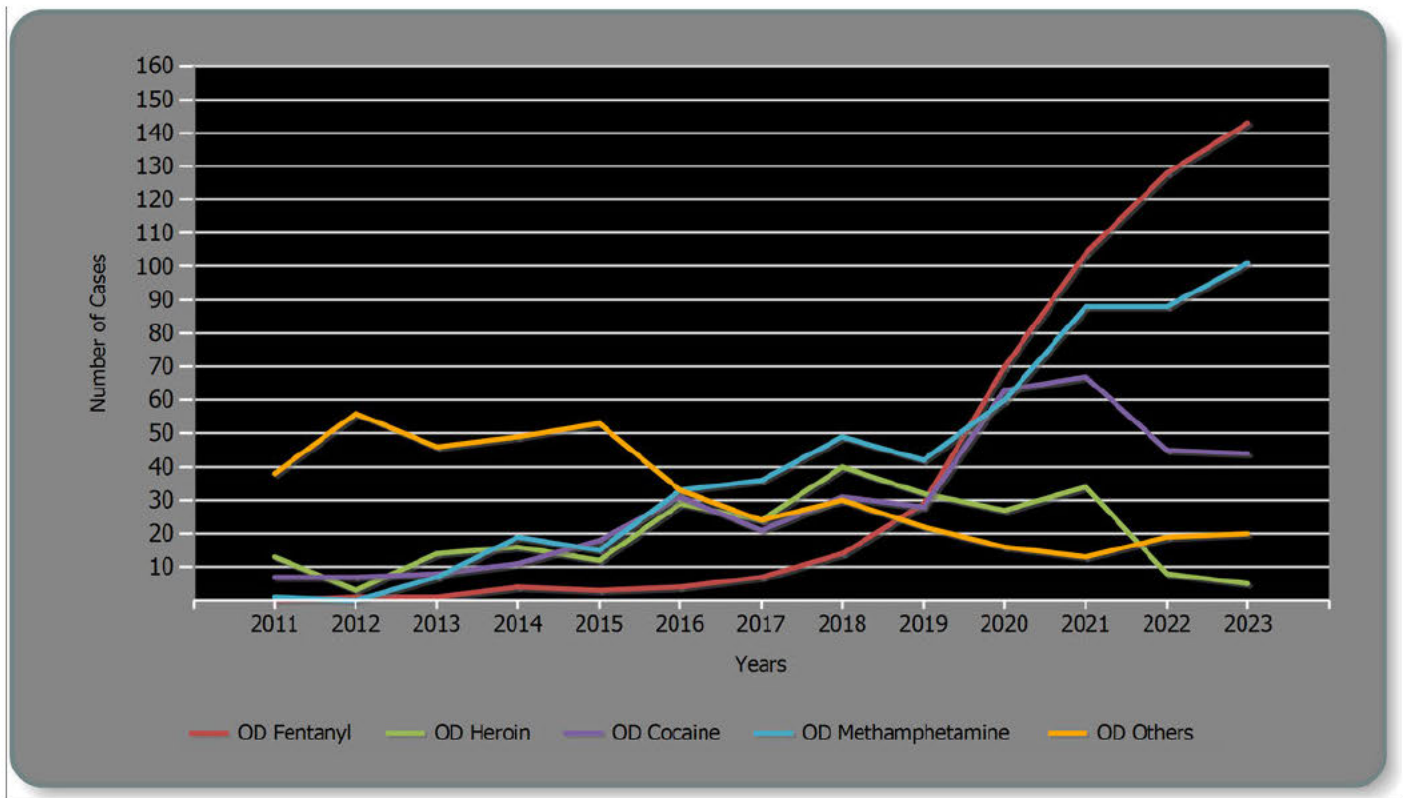
# ACCIDENT FATALITIES - BY OVERDOSE

Figure 9

YEAR	Fentanyl	Heroin	Cocaine	*Meth	Others	Total	Population	*Rate
2011	0	13	7	1	38	55	583443 (est)	9.4
2012	1	3	7	0	56	67	585850 (est)	11.4
2013	1	14	8	7	46	72	607070 (est)	11.9
2014	4	16	11	19	49	91	618821 (est)	14.7
2015	3	12	18	15	53	92	631096 (est)	14.6
2016	4	29	31	33	33	99	634000 (est)	15.6
2017	7	24	21	36	24	87	637000 (est)	13.7
2018	14	40	31	49	30	119	643502 (est)	18.5
2019	29	32	28	42	22	111	649286 (est)	17.1
2020	70	27	63	60	16	153	655070	23.4
2021	104	34	67	88	13	186	660854 (est)	28.1
2022	128	8	45	88	19	201	655808 (est)	30.6
2023	143	5	44	101	20	211	656061 (est)	32.2

\*Meth = Methamphetamine

\*Rate = Rate of Overdose (per 100000)



## Accident (Motor Vehicle Crashes)

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During 2023, the Coroner's Office participated in the investigation of 87 traffic fatalities that were certified as accidental in nature. This excludes any deaths where a motor vehicle was used in a suicidal or homicidal manner. Deaths due to motor vehicle crashes have fluctuated over the past ten years, ranging from 34 to 87 per year. The information in the following tables and graphs shows the age and sex distribution of traffic fatalities; there was a relatively even distribution in the age groups between 11 and 80 years, with the most deaths in the 21 to 30 year age group. Traffic deaths in male drivers were over three times as frequent as those in female drivers.

Operators of motor vehicles, including motorcycles and ATVs, accounted for 55% (48/87) of the traffic fatalities during 2023. Pedestrians, including bicyclists, made up 26% (23/87) of traffic related fatalities.

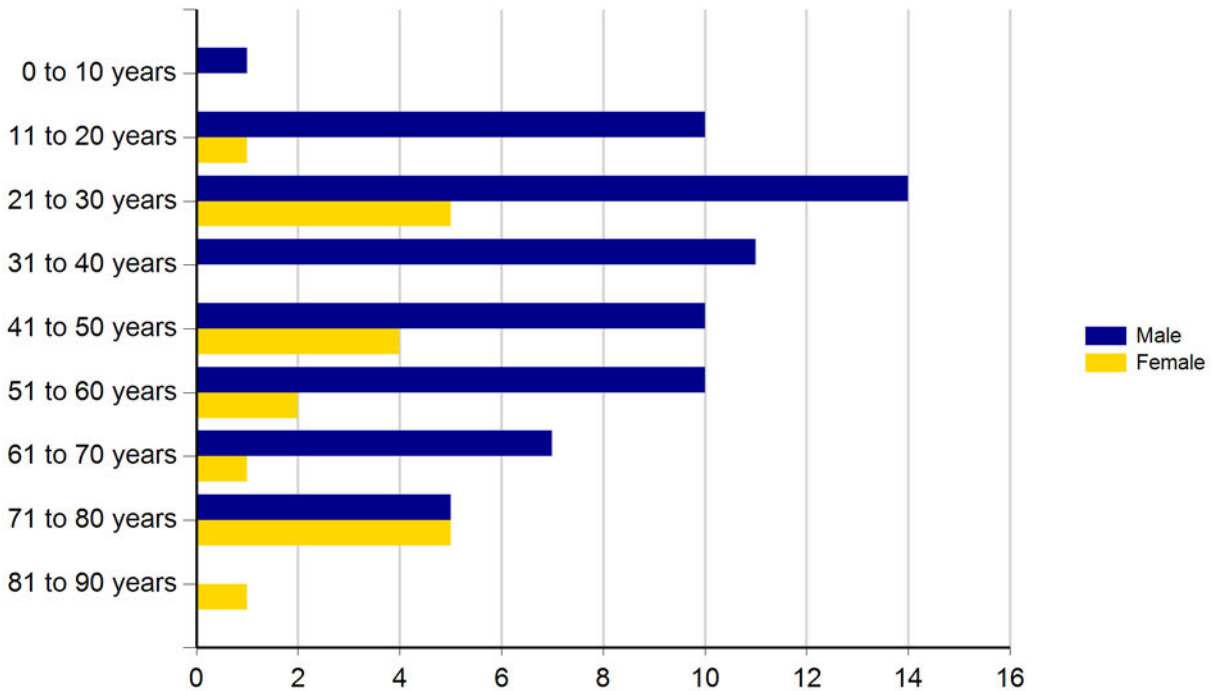
Seat belts were not used in 52% (25/48) of the fatalities in which belt usage was known; this number excludes pedestrians and motorcycle-related deaths. The use of seat belts was unknown in one case.

Blood alcohol concentrations of all traffic fatalities are depicted in Figure 14. When passengers and pedestrians are excluded, of the 48 deaths occurring in operators of vehicles (drivers), there was detectable blood alcohol in 20 cases (53%; 20/38); toxicology testing was not performed in ten drivers due to significant delay between the crash and time of death. Of the drivers tested, marijuana metabolite was detected in 15 cases, fentanyl was identified in three cases, methamphetamine was identified in five, and cocaine metabolite was identified in four; some of these cases overlap with multiple substances coexisting. Blood alcohol levels of surviving drivers involved in motor vehicle crashes in which passengers or pedestrians are killed are not tracked within this report.

# TRAFFIC FATALITIES - BY AGE

Figure 10

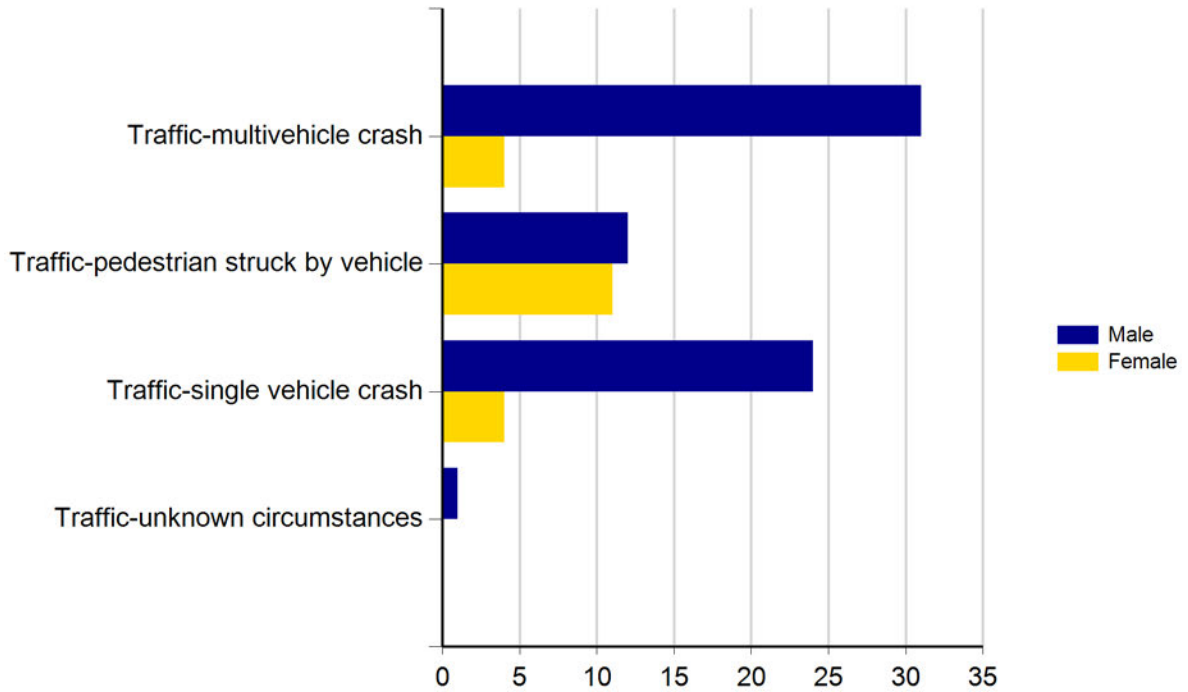
Age	Male	Female	Total
0 to 10 years	1	0	1
11 to 20 years	10	1	11
21 to 30 years	14	5	19
31 to 40 years	11	0	11
41 to 50 years	10	4	14
51 to 60 years	10	2	12
61 to 70 years	7	1	8
71 to 80 years	5	5	10
81 to 90 years	0	1	1
<b>Total</b>	<b>68</b>	<b>19</b>	<b>87</b>



# TRAFFIC FATALITIES - BY CRASH MECHANISM

Figure 11

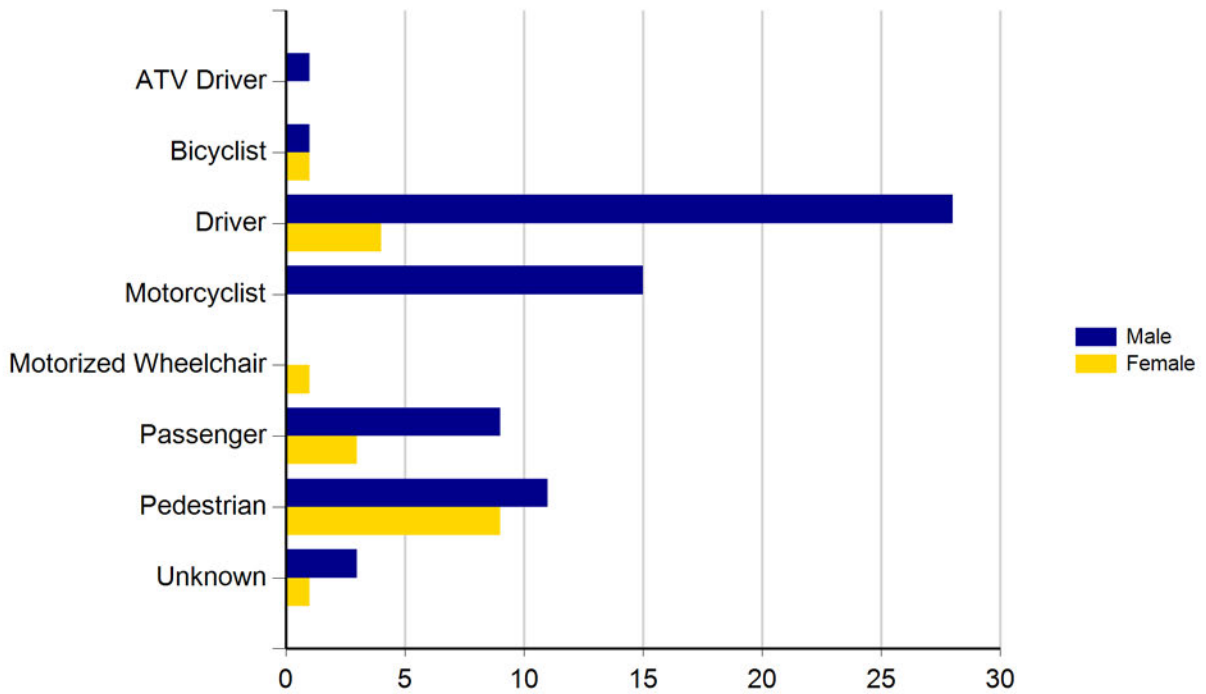
Cause	Male	Female	Total
Traffic-multivehicle crash	31	4	35
Traffic-pedestrian struck by vehicle	12	11	23
Traffic-single vehicle crash	24	4	28
Traffic-unknown circumstances	1	0	1
<b>Total</b>	<b>68</b>	<b>19</b>	<b>87</b>



# TRAFFIC FATALITIES - BY PARTY

Figure 12

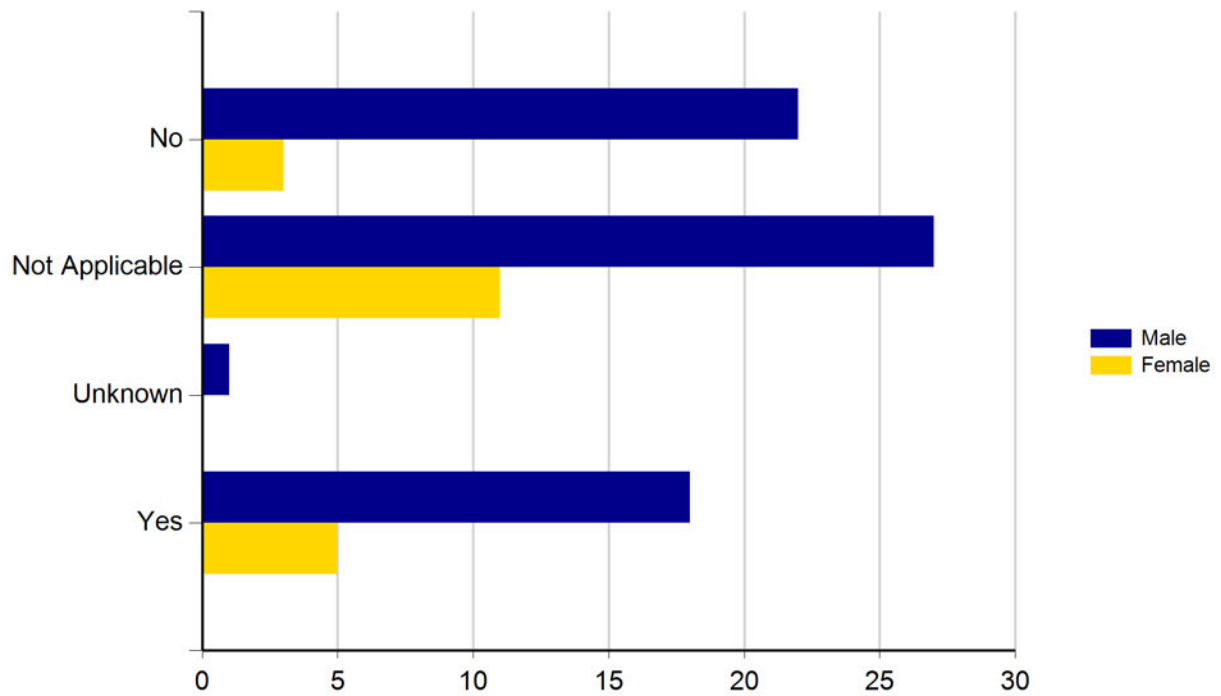
Location	Male	Female	Total
ATV Driver	1	0	1
Bicyclist	1	1	2
Driver	28	4	32
Motorcyclist	15	0	15
Motorized Wheelchair	0	1	1
Passenger	9	3	12
Pedestrian	11	9	20
Unknown	3	1	4
<b>Total</b>	<b>68</b>	<b>19</b>	<b>87</b>



# TRAFFIC FATALITIES - BY SEATBELT USAGE

Figure 13

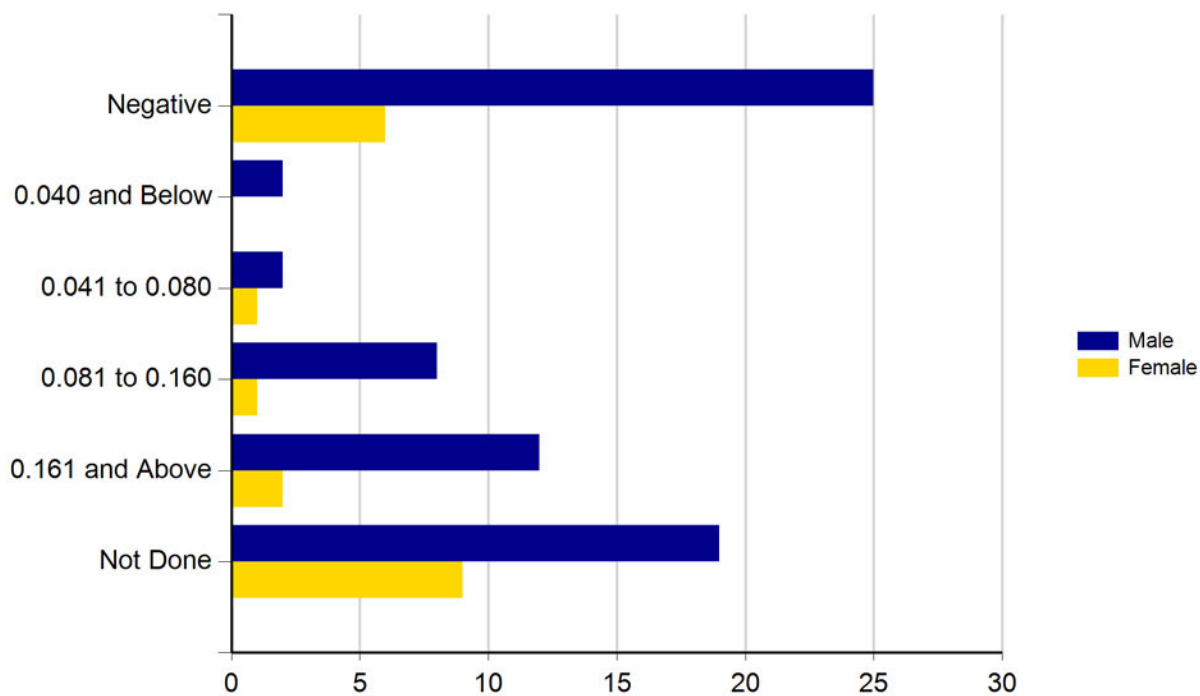
Seatbelt Used	Male	Female	Total
No	22	3	25
Not Applicable	27	11	38
Unknown	1	0	1
Yes	18	5	23
<b>Total</b>	<b>68</b>	<b>19</b>	<b>87</b>



# TRAFFIC FATALITIES - BY BLOOD ALCOHOL CONCENTRATION

Figure 14

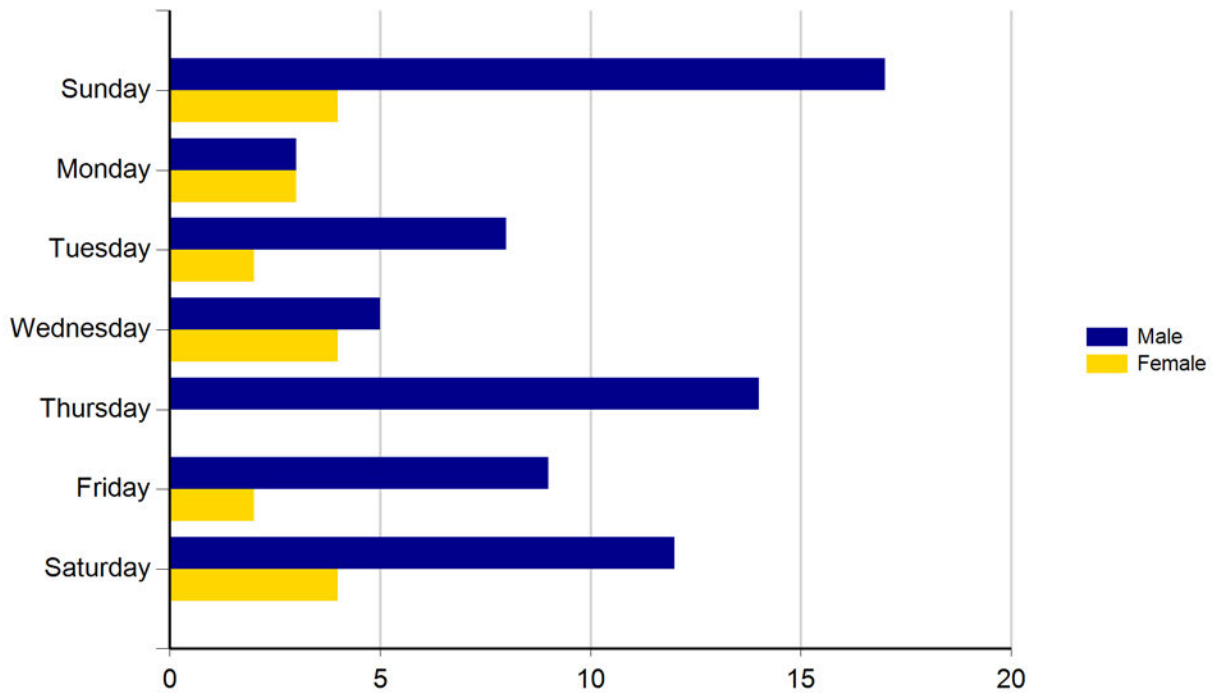
Blood Ethanol %	Male	Female	Total
Negative	25	6	31
0.040 and Below	2	0	2
0.041 to 0.080	2	1	3
0.081 to 0.160	8	1	9
0.161 and Above	12	2	14
Not Done	19	9	28
<b>Total</b>	<b>68</b>	<b>19</b>	<b>87</b>



# TRAFFIC FATALITIES - BY DAY OF WEEK

Figure 15

Setting	Male	Female	Total
Sunday	17	4	21
Monday	3	3	6
Tuesday	8	2	10
Wednesday	5	4	9
Thursday	14	0	14
Friday	9	2	11
Saturday	12	4	16
<b>Total</b>	<b>68</b>	<b>19</b>	<b>87</b>



## Homicide

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A death is classified as homicide when it results from injuries inflicted by another person. The designation of homicide by the Coroner's Office does not reflect specific charges that may or may not subsequently be filed by prosecuting attorneys or the District Attorney's Office. In 2023, 59 deaths were classified as homicide (a rate of 9 per 100,000 population) which represents the highest total number of homicides per year seen by this office, totaling approximately 6% of the death investigations for the year. Over the past ten years, the [REDACTED] [REDACTED] has seen slight variation in the number of homicide deaths from year to year, with these deaths typically comprising 4% to 6% of the caseload.

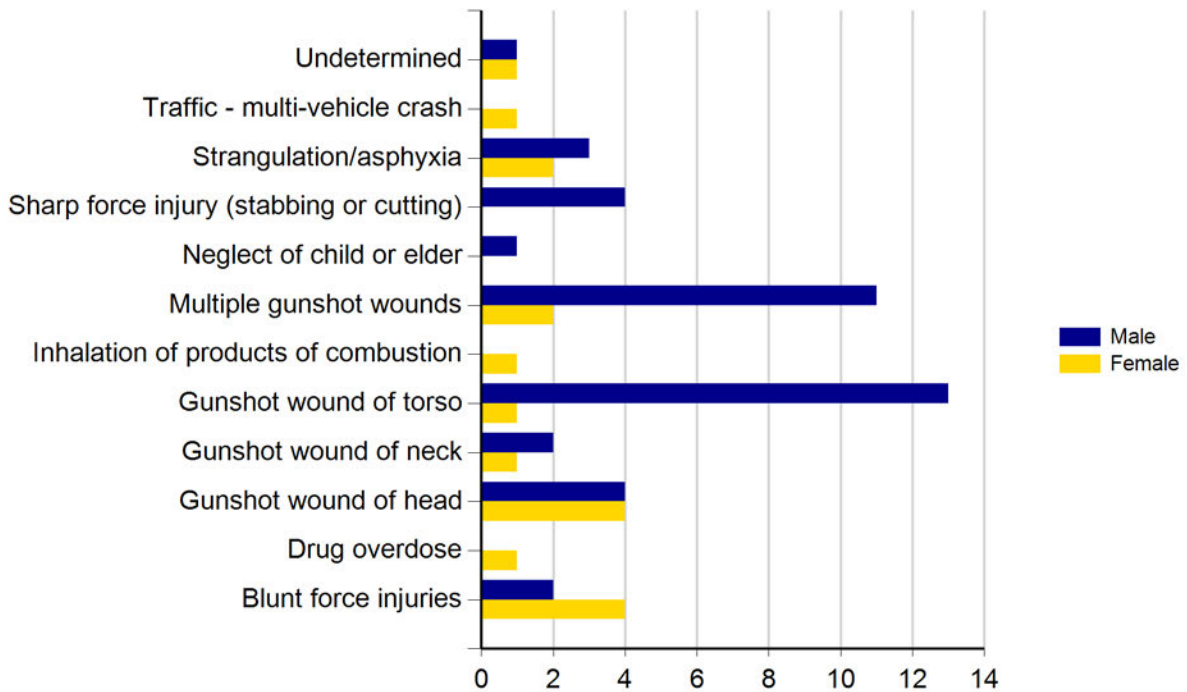
Firearm deaths made up the largest category of all homicides (64%, 38/59) within the county in 2023. The remaining decedents were primarily victims of sharp and blunt force injuries and strangulation/asphyxia. Two cases classified as child abuse or neglect occurred in 2023.

As typically seen in yearly trends for the county and nationwide, male homicide victims (41) outnumbered female victims (18). The largest age groups included the 21 to 50 year old groups, comprising 63% of victims.

# HOMICIDES - BY METHOD

Figure 16

Cause	Male	Female	Total
Blunt force injuries	2	4	6
Drug overdose	0	1	1
Gunshot wound of head	4	4	8
Gunshot wound of neck	2	1	3
Gunshot wound of torso	13	1	14
Inhalation of products of combustion	0	1	1
Multiple gunshot wounds	11	2	13
Neglect of child or elder	1	0	1
Sharp force injury (stabbing or cutting)	4	0	4
Strangulation/asphyxia	3	2	5
Traffic - multi-vehicle crash	0	1	1
Undetermined	1	1	2
<b>Total</b>	<b>41</b>	<b>18</b>	<b>59</b>



# HOMICIDES - BY METHOD AND MONTH

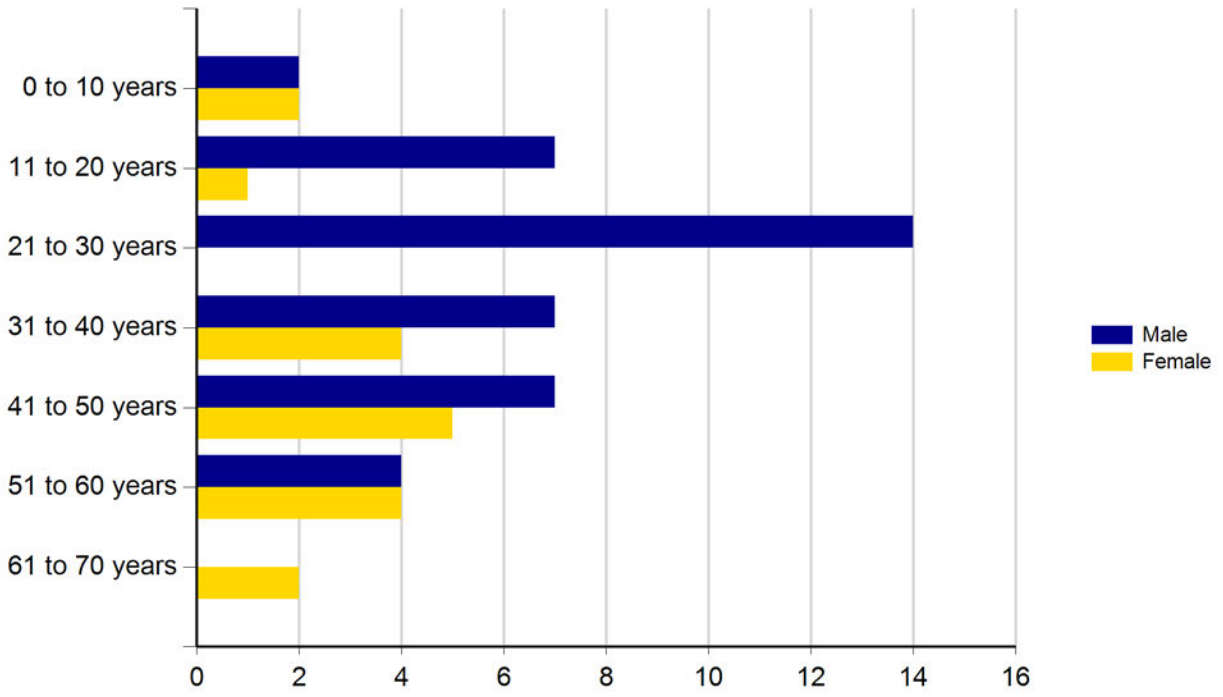
Figure 17

Cause	Gender	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	Total
Blunt force injuries	Female	0	0	2	0	0	0	0	0	2	0	0	0	4
	Male	0	1	0	0	0	0	0	1	0	0	0	0	2
Drug overdose	Female	0	0	1	0	0	0	0	0	0	0	0	0	1
Gunshot wound of head	Female	0	0	0	0	0	0	1	1	1	1	0	0	4
	Male	0	0	0	0	1	0	0	0	1	1	0	1	4
Gunshot wound of neck	Female	0	0	0	0	0	0	0	0	0	0	1	0	1
	Male	0	0	0	1	0	0	0	1	0	0	0	0	2
Gunshot wound of torso	Female	0	0	0	1	0	0	0	0	0	0	0	0	1
	Male	0	2	1	0	1	2	0	3	2	1	1	0	13
Inhalation of products of combustion	Female	0	0	0	0	0	0	0	0	1	0	0	0	1
Multiple gunshot wounds	Female	1	0	1	0	0	0	0	0	0	0	0	0	2
	Male	0	1	2	1	0	0	2	1	1	1	1	1	11
Neglect of child or elder	Male	0	0	1	0	0	0	0	0	0	0	0	0	1
Sharp force injury (stabbing or cutting)	Male	1	0	0	0	0	0	0	0	0	2	1	0	4
Strangulation/asphyxia	Female	0	0	0	0	0	0	0	0	1	1	0	0	2
	Male	0	0	0	0	0	0	1	1	1	0	0	0	3
Traffic - multi-vehicle crash	Female	0	0	0	0	0	0	0	0	0	1	0	0	1
Undetermined	Female	0	0	0	0	1	0	0	0	0	0	0	0	1
	Male	0	0	0	1	0	0	0	0	0	0	0	0	1
<b>Total</b>		<b>2</b>	<b>4</b>	<b>8</b>	<b>4</b>	<b>3</b>	<b>2</b>	<b>4</b>	<b>8</b>	<b>10</b>	<b>8</b>	<b>4</b>	<b>2</b>	<b>59</b>

# HOMICIDES - BY AGE

Figure 18

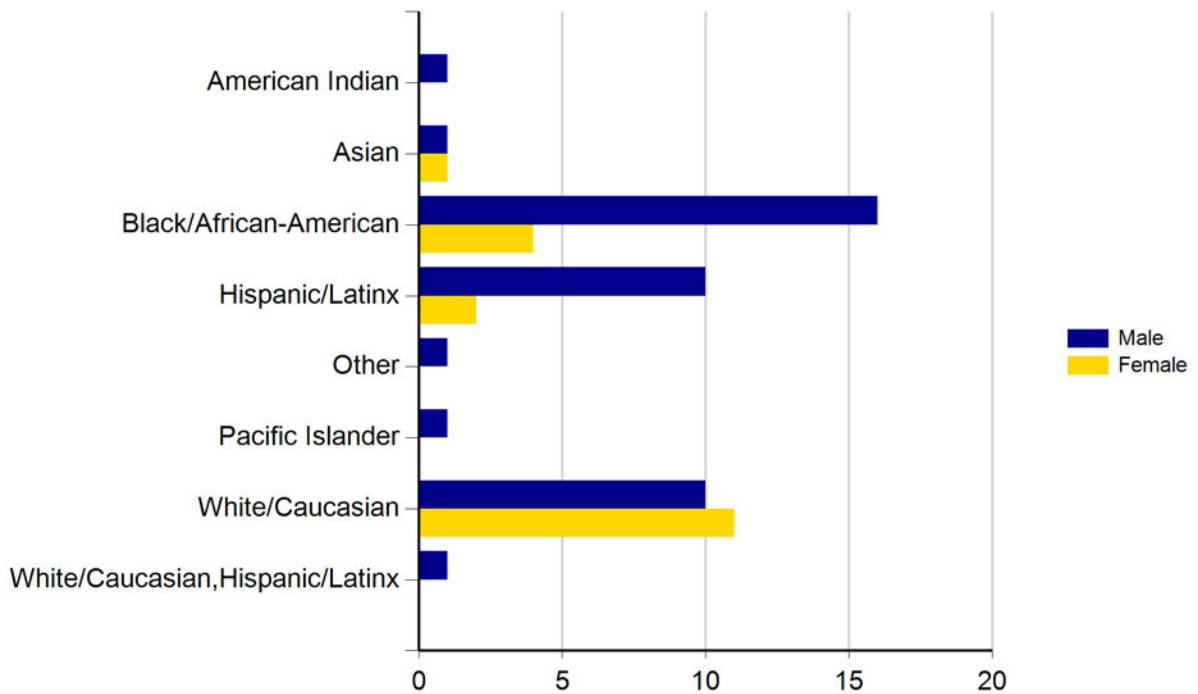
Age	Male	Female	Total
0 to 10 years	2	2	4
11 to 20 years	7	1	8
21 to 30 years	14	0	14
31 to 40 years	7	4	11
41 to 50 years	7	5	12
51 to 60 years	4	4	8
61 to 70 years	0	2	2
<b>Total</b>	<b>41</b>	<b>18</b>	<b>59</b>



# HOMICIDES - BY RACE

Figure 19

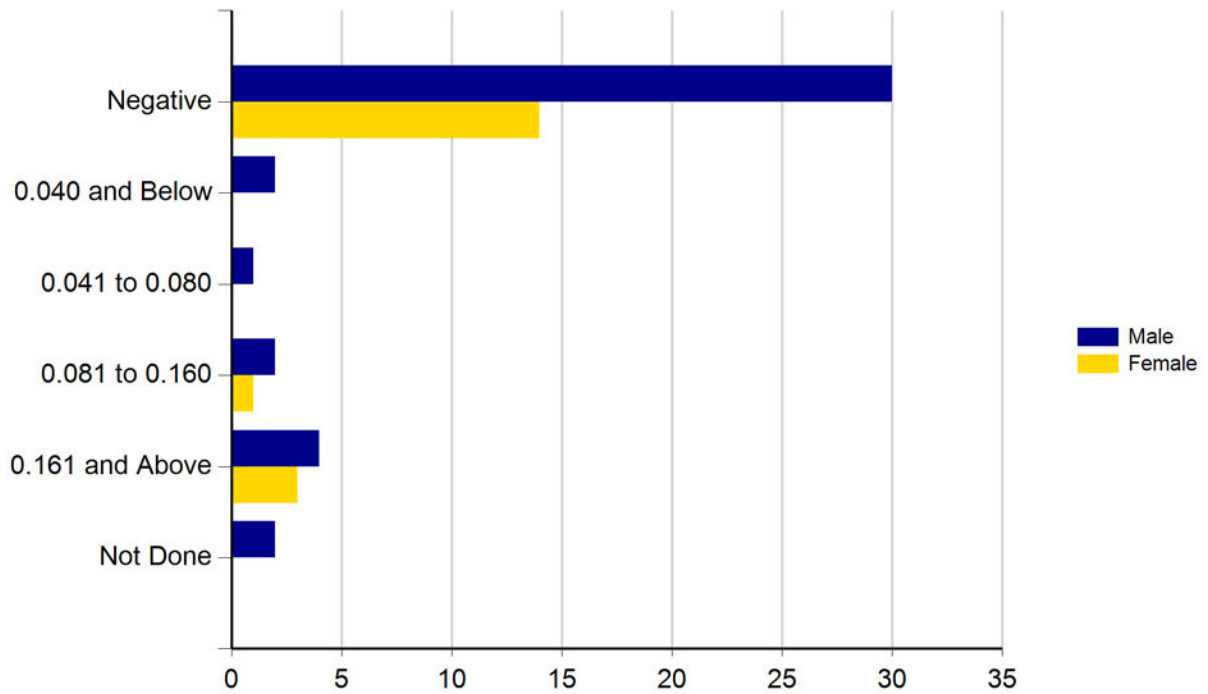
Race	Male	Female	Total
American Indian	1	0	1
Asian	1	1	2
Black/African-American	16	4	20
Hispanic/Latinx	10	2	12
Other	1	0	1
Pacific Islander	1	0	1
White/Caucasian	10	11	21
White/Caucasian,Hispanic/Latinx	1	0	1
<b>Total</b>	<b>41</b>	<b>18</b>	<b>59</b>



# HOMICIDES - BY BLOOD ALCOHOL CONCENTRATION

Figure 20

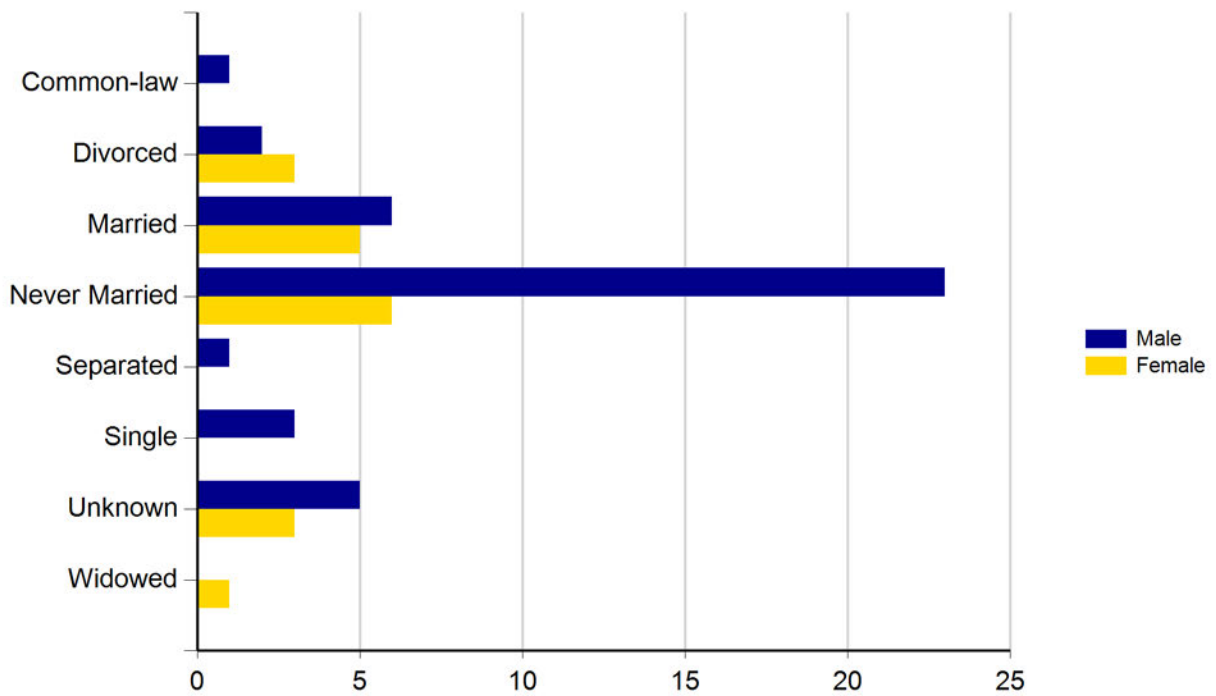
Blood Ethanol %	Male	Female	Total
Negative	30	14	44
0.040 and Below	2	0	2
0.041 to 0.080	1	0	1
0.081 to 0.160	2	1	3
0.161 and Above	4	3	7
Not Done	2	0	2
<b>Total</b>	<b>41</b>	<b>18</b>	<b>59</b>



# HOMICIDES - BY MARITAL STATUS

Figure 21

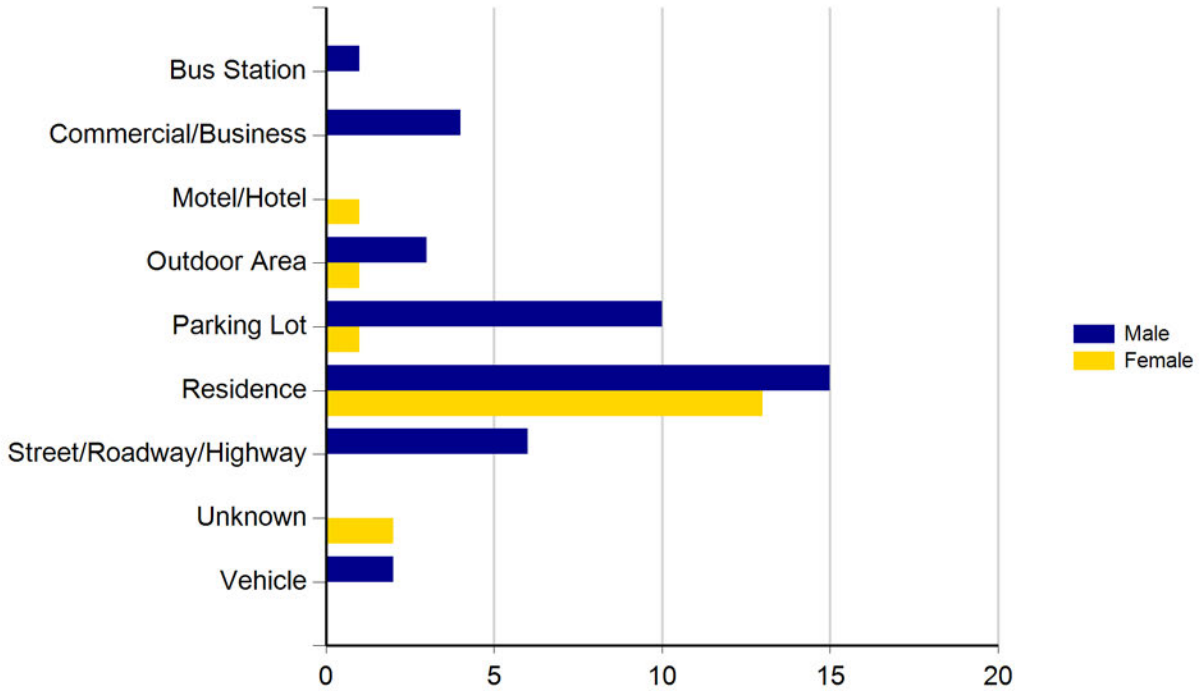
Marital Status	Male	Female	Total
Common-law	1	0	1
Divorced	2	3	5
Married	6	5	11
Never Married	23	6	29
Separated	1	0	1
Single	3	0	3
Unknown	5	3	8
Widowed	0	1	1
<b>Total</b>	<b>41</b>	<b>18</b>	<b>59</b>



# HOMICIDES - BY LOCATION

Figure 22

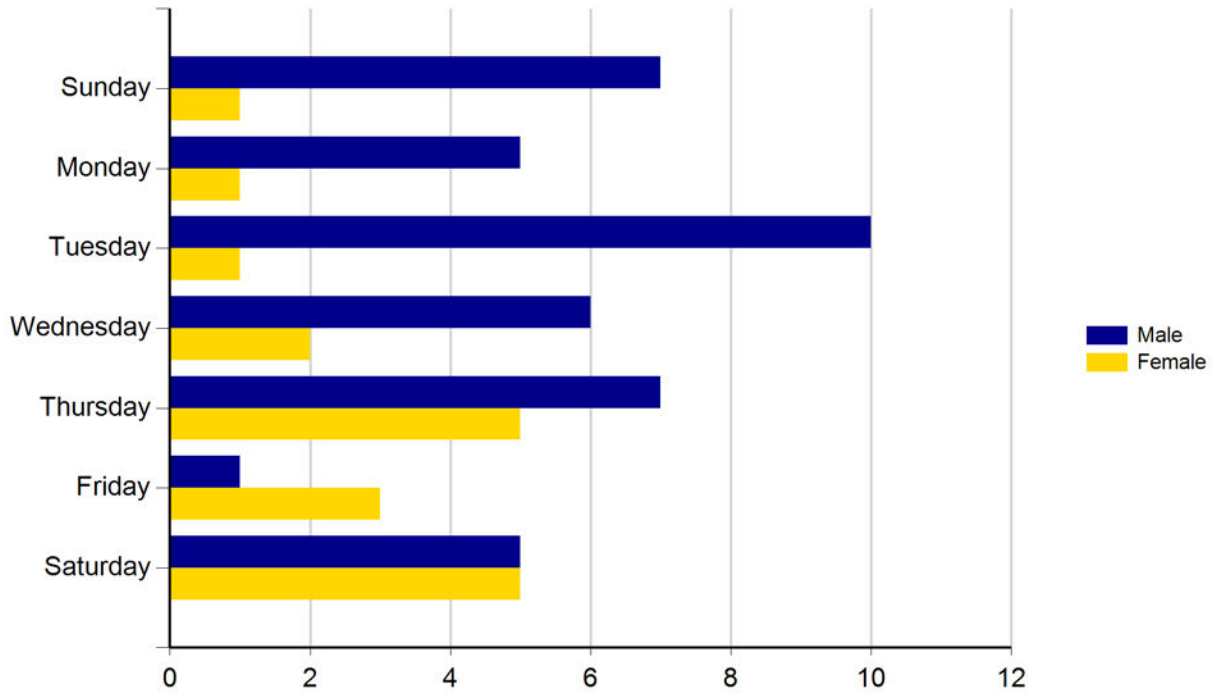
Setting	Male	Female	Total
Bus Station	1	0	1
Commercial/Business	4	0	4
Motel/Hotel	0	1	1
Outdoor Area	3	1	4
Parking Lot	10	1	11
Residence	15	13	28
Street/Roadway/Highway	6	0	6
Unknown	0	2	2
Vehicle	2	0	2
<b>Total</b>	<b>41</b>	<b>18</b>	<b>59</b>



# HOMICIDES - BY DAY OF WEEK

Figure 23

Setting	Male	Female	Total
Sunday	7	1	8
Monday	5	1	6
Tuesday	10	1	11
Wednesday	6	2	8
Thursday	7	5	12
Friday	1	3	4
Saturday	5	5	10
<b>Total</b>	<b>41</b>	<b>18</b>	<b>59</b>



## Suicide

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Suicides are those deaths caused by self-inflicted injuries. During 2023, there were 132 suicidal deaths in ██████ County, accounting for 14% of deaths under the Coroner's jurisdiction (a rate of 20 per 100,000 population). Notes indicating suicidal intent were discovered in 34% (45/132) of the cases. A vast majority (70%) of suicides occurred at a residence (92/132).

In 2023, 52% of all suicides within the county involved firearms (69/132), specifically gunshot wounds of the head (67/132); hanging was the second-most common method used to complete suicide (23%, 31/132) followed closely by drug overdoses (17%, 23/132). The remaining decedents utilized various methods including sharp and blunt injuries and toxic substance exposures.

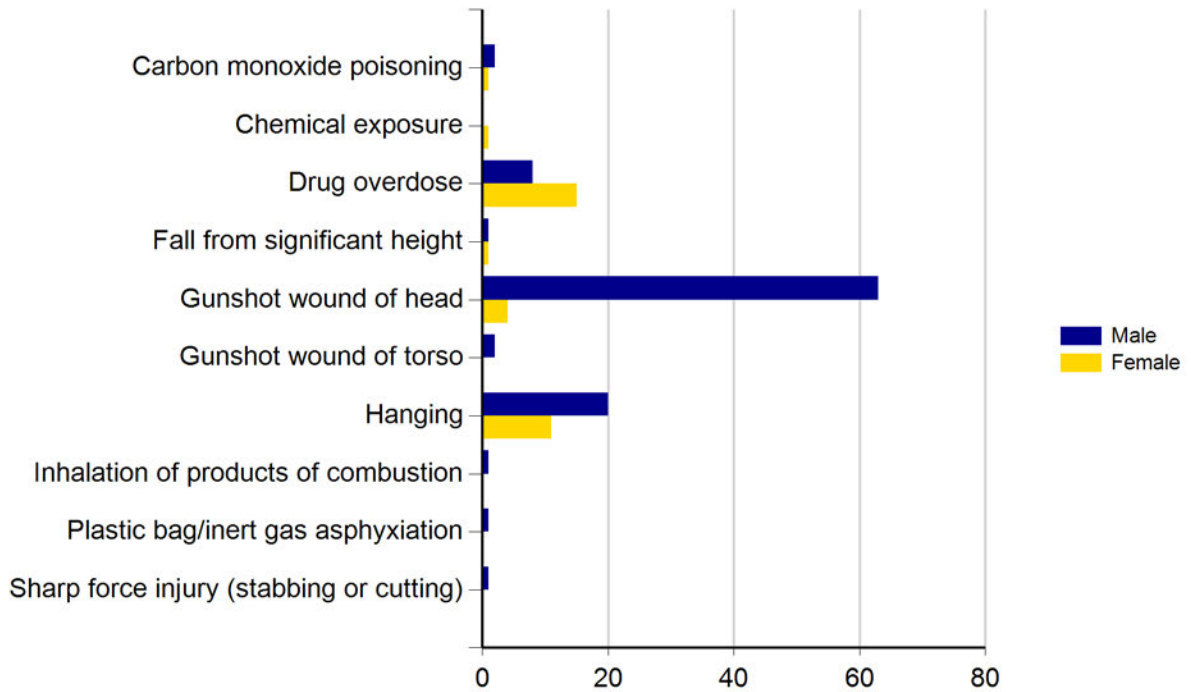
Consistent with nationwide figures, men complete suicide at a higher rate, comprising 75% of the cases within this county. Most victims were relatively evenly distributed between the ages of 21 and 70 with the peak in the 31-40 age group; 2023 had one suicide in youth (17 years and under). Previous years have shown higher numbers of youth suicides, with seven in 2022, five in 2021, nine in 2020, and seven in 2019.

Blood alcohol concentrations of suicides are depicted in Figure 28; however, toxicology testing was only performed in 64% of the cases due to budget constraints, as drug and alcohol concentrations do not change the cause of death when due to physical trauma.

# SUICIDES - BY METHOD

Figure 24

Cause	Male	Female	Total
Carbon monoxide poisoning	2	1	3
Chemical exposure	0	1	1
Drug overdose	8	15	23
Fall from significant height	1	1	2
Gunshot wound of head	63	4	67
Gunshot wound of torso	2	0	2
Hanging	20	11	31
Inhalation of products of combustion	1	0	1
Plastic bag/inert gas asphyxiation	1	0	1
Sharp force injury (stabbing or cutting)	1	0	1
<b>Total</b>	<b>99</b>	<b>33</b>	<b>132</b>



# SUICIDES - BY METHOD AND MONTH

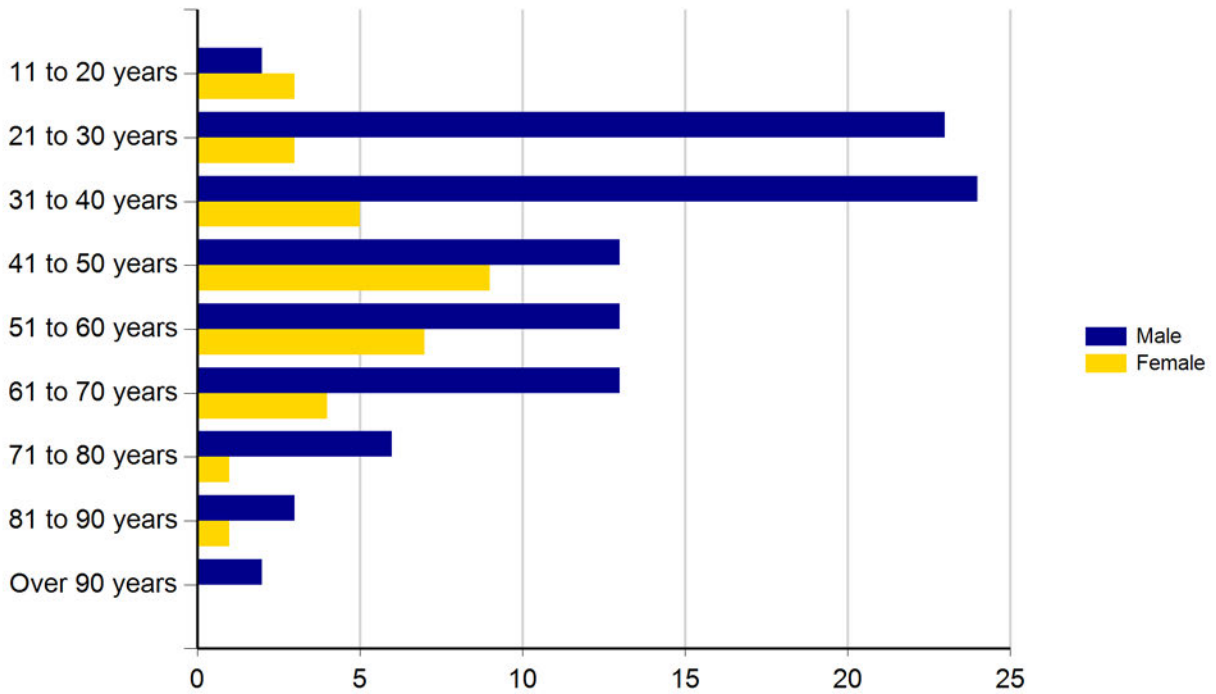
Figure 25

Cause	Gender	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	Total
Carbon monoxide poisoning	Female	1	0	0	0	0	0	0	0	0	0	0	0	1
	Male	0	0	0	0	0	0	0	0	0	0	0	2	2
Chemical exposure	Female	0	0	0	0	0	0	0	1	0	0	0	0	1
Drug overdose	Female	0	0	2	4	1	1	0	4	0	0	1	2	15
	Male	0	0	1	1	0	1	1	0	0	2	0	2	8
Fall from significant height	Female	0	0	0	1	0	0	0	0	0	0	0	0	1
	Male	0	0	0	0	0	0	0	0	0	1	0	0	1
Gunshot wound of head	Female	1	0	0	0	0	0	1	2	0	0	0	0	4
	Male	8	7	2	2	8	3	5	6	8	6	3	5	63
Gunshot wound of torso	Male	1	0	1	0	0	0	0	0	0	0	0	0	2
Hanging	Female	1	0	2	2	1	1	0	1	0	1	1	1	11
	Male	0	0	5	2	0	3	5	1	2	1	0	1	20
Inhalation of products of combustion	Male	0	1	0	0	0	0	0	0	0	0	0	0	1
Plastic bag/inert gas asphyxiation	Male	0	0	0	0	0	0	0	0	0	1	0	0	1
Sharp force injury (stabbing or cutting)	Male	0	0	0	0	0	0	0	0	0	0	0	1	1
<b>Total</b>		12	8	13	12	10	9	12	15	10	12	5	14	132

# SUICIDES - BY AGE

Figure 26

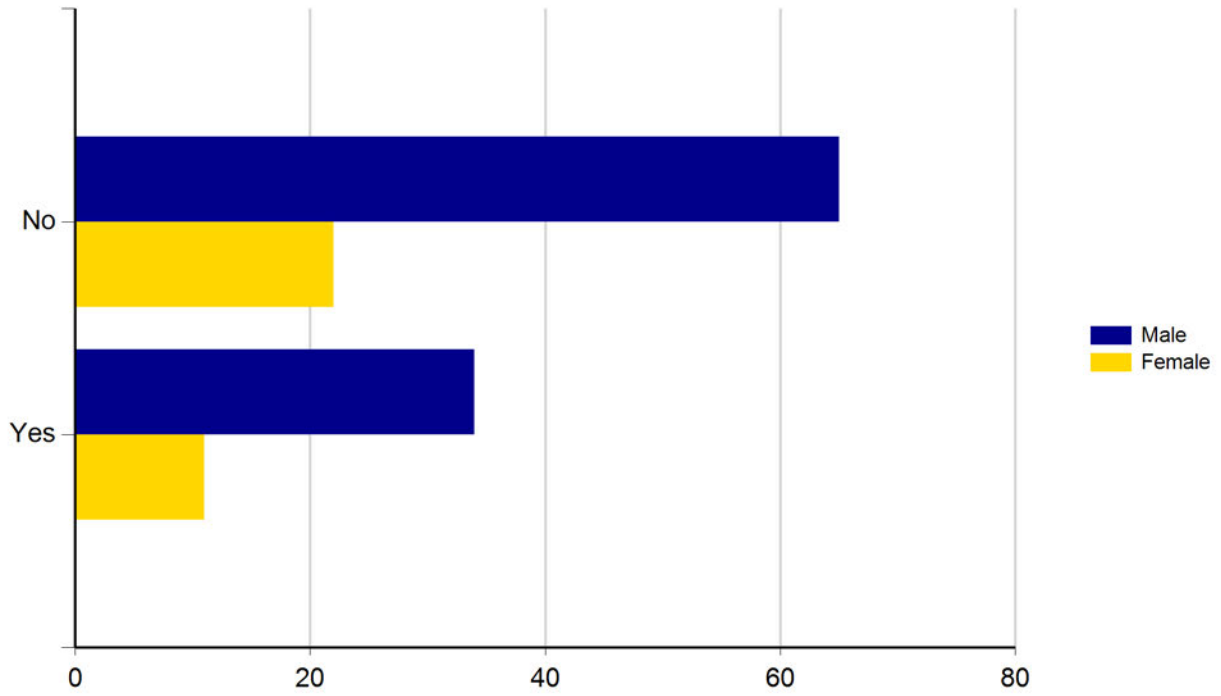
Age	Male	Female	Total
11 to 20 years	2	3	5
21 to 30 years	23	3	26
31 to 40 years	24	5	29
41 to 50 years	13	9	22
51 to 60 years	13	7	20
61 to 70 years	13	4	17
71 to 80 years	6	1	7
81 to 90 years	3	1	4
Over 90 years	2	0	2
<b>Total</b>	<b>99</b>	<b>33</b>	<b>132</b>



# SUICIDES - BY NOTE

Figure 27

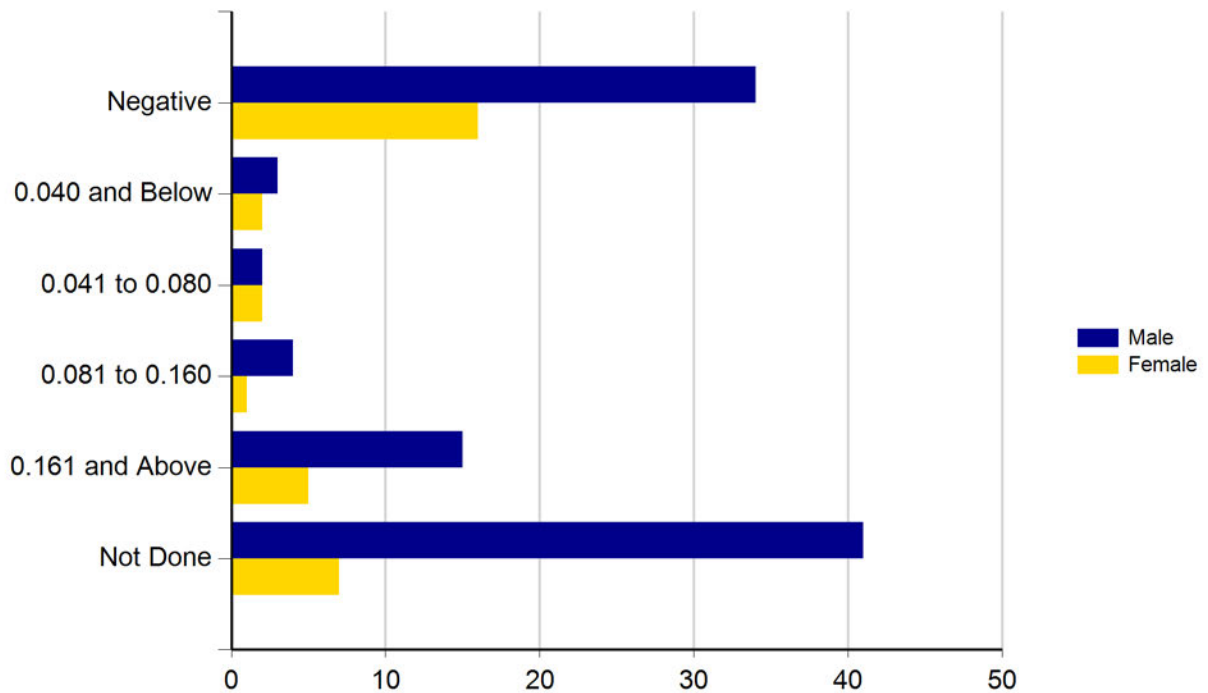
Note	Male	Female	Total
No	65	22	87
Yes	34	11	45
<b>Total</b>	<b>99</b>	<b>33</b>	<b>132</b>



# SUICIDES - BY BLOOD ALCOHOL CONCENTRATION

Figure 28

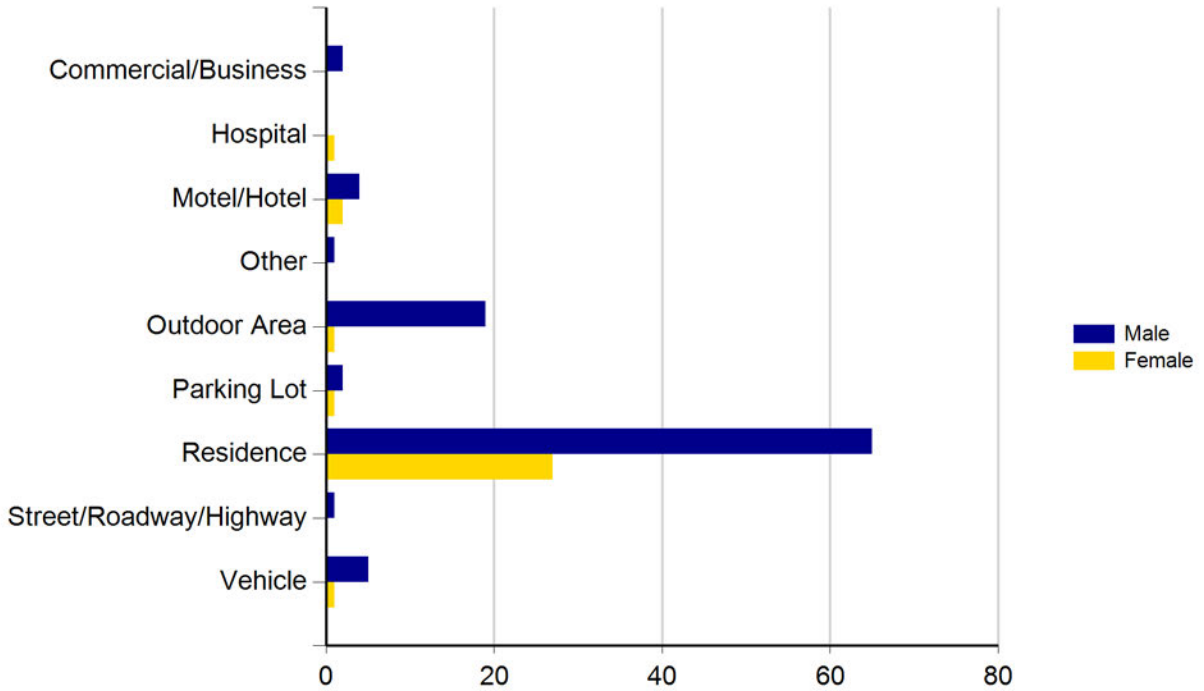
Blood Ethanol %	Male	Female	Total
Negative	34	16	50
0.040 and Below	3	2	5
0.041 to 0.080	2	2	4
0.081 to 0.160	4	1	5
0.161 and Above	15	5	20
Not Done	41	7	48
<b>Total</b>	<b>99</b>	<b>33</b>	<b>132</b>



# SUICIDES - BY LOCATION

Figure 29

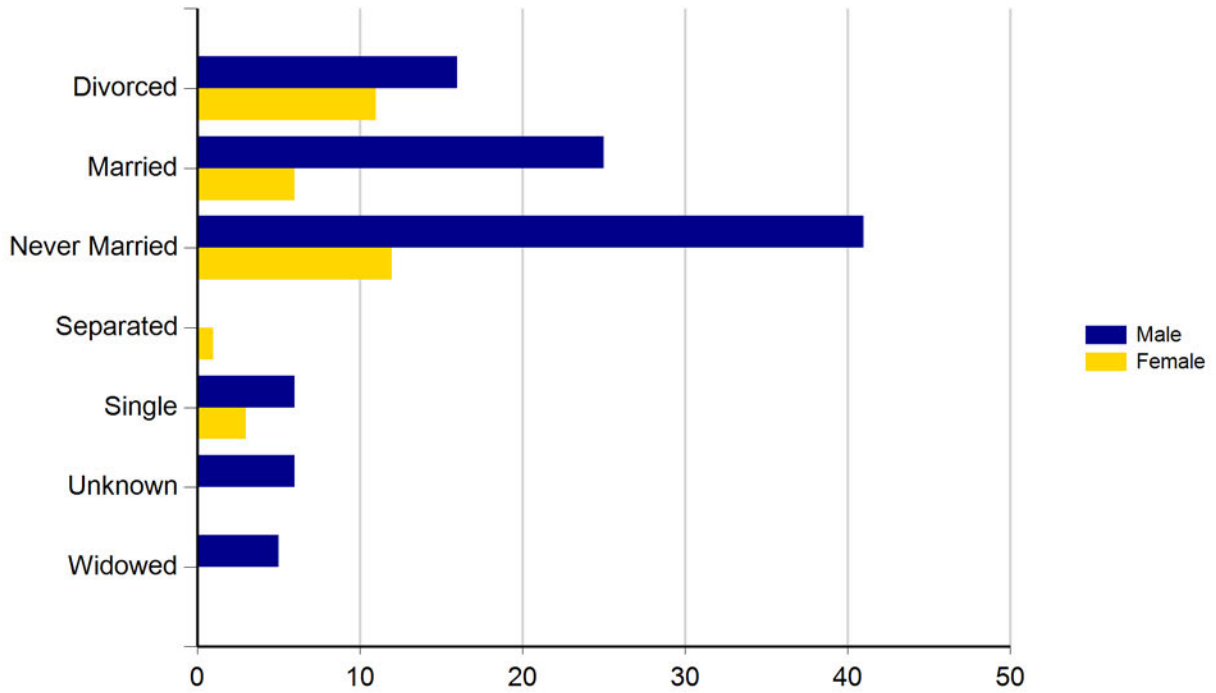
Setting	Male	Female	Total
Commercial/Business	2	0	2
Hospital	0	1	1
Motel/Hotel	4	2	6
Other	1	0	1
Outdoor Area	19	1	20
Parking Lot	2	1	3
Residence	65	27	92
Street/Roadway/Highway	1	0	1
Vehicle	5	1	6
<b>Total</b>	<b>99</b>	<b>33</b>	<b>132</b>



# SUICIDES - BY MARITAL STATUS

Figure 30

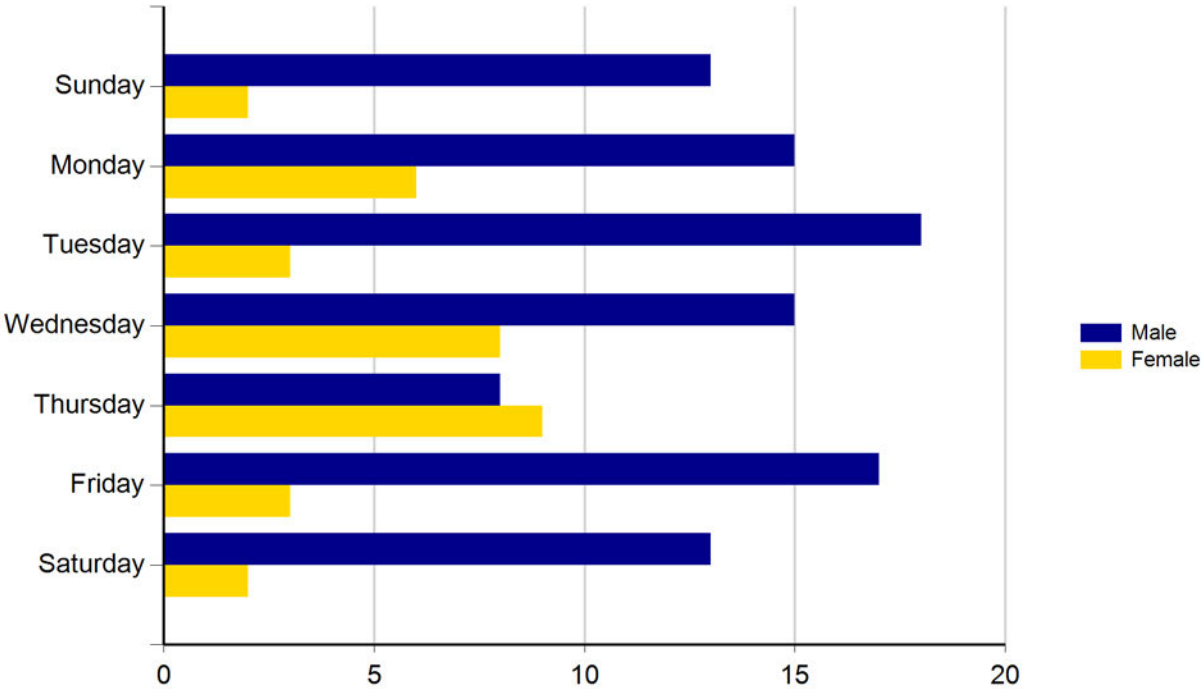
Marital Status	Male	Female	Total
Divorced	16	11	27
Married	25	6	31
Never Married	41	12	53
Separated	0	1	1
Single	6	3	9
Unknown	6	0	6
Widowed	5	0	5
<b>Total</b>	<b>99</b>	<b>33</b>	<b>132</b>



# SUICIDES - BY DAY OF WEEK

Figure 31

Setting	Male	Female	Total
Sunday	13	2	15
Monday	15	6	21
Tuesday	18	3	21
Wednesday	15	8	23
Thursday	8	9	17
Friday	17	3	20
Saturday	13	2	15
<b>Total</b>	<b>99</b>	<b>33</b>	<b>132</b>



## Natural

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Most natural deaths occurring in ██████████ County do not fall under the jurisdiction of the Coroner's Office; many natural deaths are reported to the Office however jurisdiction is waived based on medical history and the presence of a local physician familiar with the decedent. These cases are therefore not represented in this report, creating a significant sampling bias when comparing statistics to the general population.

Natural deaths that are sudden and unexpected in nature are the primary concern of the Coroner's Office; deaths of a natural manner represent one of the largest categories of deaths investigated by the Office (31%). Cardiovascular disease continues to account for the greatest proportion of natural deaths (3%, 158/296) and is primarily grouped under "atherosclerotic and/or hypertensive cardiovascular disease," "congestive heart failure," and "aortic dissection" (among others) in the following figure, which would include causes of death such as coronary artery disease, hypertension, and myocardial infarct.

Deaths due to COVID-19 infections have continued to fall; four deaths directly investigated by this office were certified as due to COVID-19. These deaths represent individuals who died at home and had not been previously diagnosed or tested for COVID-19 and do not include COVID-related deaths occurring in hospital or care facility settings.

## NATURAL DEATHS - BY METHOD

Figure 32

Cause	Male	Female	Total
Acute or chronic kidney disease	2	0	2
Aortic dissection	2	0	2
Atherosclerotic and/or hypertensive cardiovascular disease	113	37	150
Cachexia/inanition	0	1	1
Chronic alcohol abuse	39	15	54
Chronic obstructive pulmonary disease (COPD)	8	2	10
Cirrhosis	0	2	2
Complications of dementia	0	1	1
Congestive heart failure	1	2	3
COVID-19	3	1	4
Diabetes mellitus complications	4	4	8
Gastrointestinal hemorrhage	2	0	2
Infection (local or systemic excluding pneumonia)	5	3	8
Intracranial hemorrhage	2	2	4
Malignancy	3	4	7
Natural causes, not otherwise specified	1	0	1
Neurologic disorder	0	1	1
Obesity	0	1	1
Pneumonia	4	3	7
Probable cardiac arrhythmia	1	2	3
Pulmonary embolism	12	5	17
Reactive airway disease	4	0	4
Seizure disorder	3	1	4
<b>Total</b>	<b>209</b>	<b>87</b>	<b>296</b>

## Undetermined

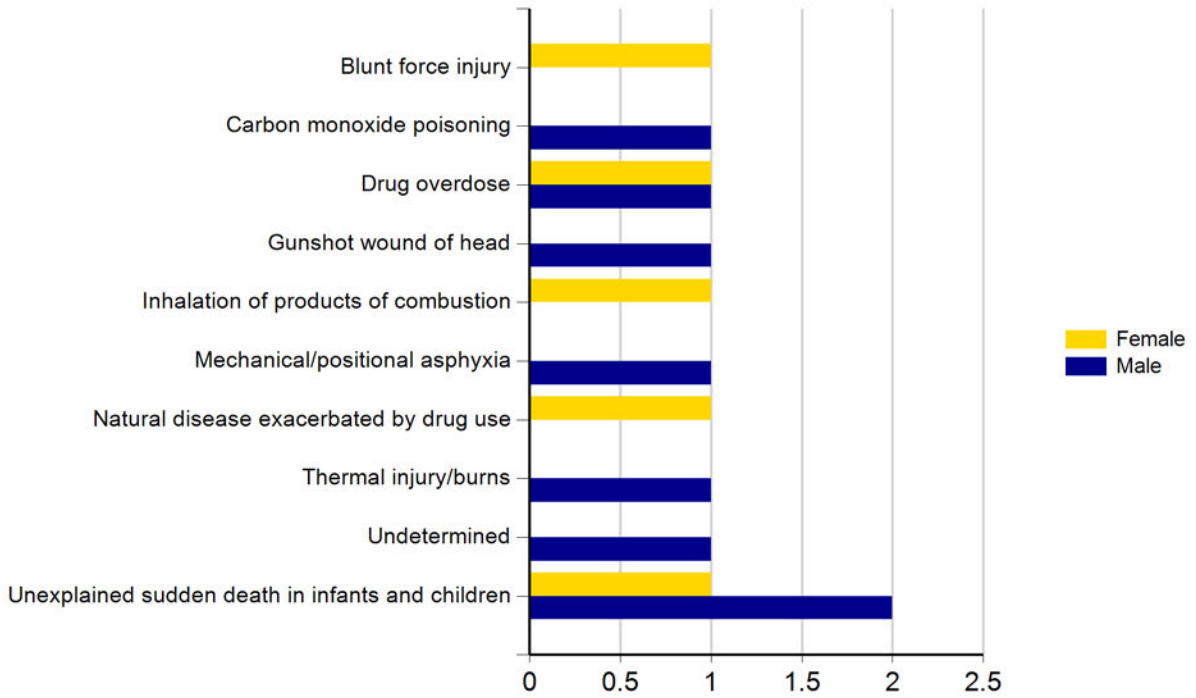
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All possible efforts are made to determine both a manner and cause of death for all deaths investigated by the Coroner's Office. In a small percentage of the total cases (1.4%), the manner of death was unable to be classified, even with a complete autopsy, scene investigation, and toxicology testing. In some of these cases, a cause of death was able to be determined, however there exists continued doubt as to how the death came about (manner of death); these deaths include injuries where it remains unclear if the circumstances were intentional or unintentional. Infant deaths previously termed "SIDS" under death certification practices prior to 2009 typically now fall into the "undetermined" or "unexplained sudden death" categories when suffocation and strangulation in bed or underlying natural disease cannot be confirmed.

# UNDETERMINED - BY METHOD

Figure 33

Cause	Male	Female	Total
Blunt force injury	0	1	1
Carbon monoxide poisoning	1	0	1
Drug overdose	1	1	2
Gunshot wound of head	1	0	1
Inhalation of products of combustion	0	1	1
Mechanical/positional asphyxia	1	0	1
Natural disease exacerbated by drug use	0	1	1
Thermal injury/burns	1	0	1
Undetermined	1	0	1
Unexplained sudden death in infants and children	2	1	3
<b>Total</b>	<b>8</b>	<b>5</b>	<b>13</b>



## Law Enforcement Agencies

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The geographic area served by the Coroner's Office includes the entire 810 square miles of ██████ County. The U.S. Census Bureau lists ██████ County as the third most populous county in Colorado having an estimated 2023 population of 656,061. The county contains all or parts of the following cities and towns: Aurora, Bennett, Bow-Mar, Byers, Centennial, Cherry Hills Village, Columbine Valley, Deer Trail, Englewood, Foxfield, Glendale, Greenwood Village, Littleton, Sheridan, and Strasburg. Figure 34 depicts the distribution of coroner's jurisdiction cases for each law enforcement agency; Aurora Police Department is the largest agency represented (52%; 498/949), followed by the ██████ County Sheriff's Office (20%; 190/949). The Sheriff's Office provides services for unincorporated ██████ County as well as the cities and towns of ██████, ██████, ██████, ██████, ██████, and ██████. Occasionally hospitalized patients are transferred from out-of-state to ██████ County regional trauma centers; at the time of death jurisdiction is retained by ██████ County.

# STATISTICS BY INVESTIGATING AGENCY

Figure 34

Agencies	Accident	Fetal Demise	Homicide	Natural	Suicide	Undetermined	Total
██████████	1	0	0	0	0	0	1
██████████████████	1	0	0	0	0	0	1
████████████████████	88	0	10	53	35	4	190
██████████████	0	0	0	1	0	0	1
██████████████████	221	1	39	163	67	7	498
██████████████	0	0	0	1	0	0	1
██████████████████	1	0	0	0	0	0	1
██████████████	0	0	0	1	0	0	1
████████████████████	2	0	0	1	1	0	4
██████████████████	3	0	0	0	0	0	3
██████████████	1	0	0	0	0	0	1
██████████████	11	0	0	2	0	0	13
██████████████████	0	0	0	1	0	0	1
██████████████████	1	0	0	0	0	0	1
██████████████	0	0	0	1	0	0	1
██████████████	37	0	6	31	12	0	86
██████████████████	0	0	0	1	0	0	1
██████████████	5	0	0	9	1	0	15
██████████████████	18	0	1	5	6	0	30
██████████████	1	0	0	0	0	0	1
██████████████	33	0	2	19	9	1	64
██████████████████	1	0	0	0	0	0	1
██████████████	1	0	0	0	0	0	1
██████████████	0	0	0	0	1	0	1
██████████████	1	0	0	0	0	0	1
██████████████	1	0	0	0	0	0	1
██████████████	19	0	1	7	0	0	27
██████████████████	0	0	0	0	0	1	1
██████████████	1	0	0	0	0	0	1
<b>Total</b>	<b>448</b>	<b>1</b>	<b>59</b>	<b>296</b>	<b>132</b>	<b>13</b>	<b>949</b>

## Performance Measures/Quality Assurance

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The [REDACTED] [REDACTED] [REDACTED] is one of only four coroner's offices in Colorado to be nationally accredited by the National Association of Medical Examiners. As part of this process, the office is held to high standards for medicolegal death investigation and autopsy performance and must maintain certain records and statistics to monitor the quality of service provided. The tables in the following two figures summarize many of our performance measures, including turnaround times for autopsy reports and death certificates, with our goal being a majority of these documents finalized within 60 days and over 80% finalized within 90 days, as well as turnaround times for positive identification of bodies, notification of next-of-kin, histology and toxicology (Figure 35).

In 2023, 14 cases were referred to the public administrator for burial/cremation due to lack of family (unclaimed/abandoned bodies) or families with insufficient funds to arrange final disposition. There were no new unidentified bodies in 2023; the office has four older cases of unidentified bodies or partial remains dating back to 1982. Other unusual circumstances requiring Coroner Office involvement may include examinations of exhumed bodies (none in 2023), and autopsies performed by a hospital pathologist where the Coroner's Office retains jurisdiction (none in 2023).

In 2023, scene visits were performed by medicolegal death investigators representing the Coroner's Office in 1038 of the reported deaths; 1016 bodies were transported to the Coroner's Office. The time between when the death is reported to this office until the arrival of our medicolegal death investigator at the scene is tracked; the scene response time for each medicolegal death investigator, as well as the office total, is provided (Figure 35). For informational purposes and for internal tracking of individual workload, the total numbers by case type for each investigator are also listed (Figure 36).



# PERFORMANCE MEASURES BY INVESTIGATOR BY CASE TYPE

Figure 36

Investigator	Case Type							Total
	Anthro	Autopsy	Coroner OK	External	Non Reportable	Records Review	Transfer	
[REDACTED]	0	0	0	0	1	0	0	1
[REDACTED]	0	57	132	16	173	7	16	401
[REDACTED]	0	50	131	19	172	22	22	416
[REDACTED]	0	63	124	15	121	11	35	369
[REDACTED]	0	52	72	16	85	9	23	257
[REDACTED]	0	60	110	20	138	14	22	364
[REDACTED]	0	6	14	2	19	3	4	48
[REDACTED]	0	0	1	0	0	0	1	2
[REDACTED]	1	65	154	23	217	21	32	513
[REDACTED]	0	58	102	14	158	21	31	384
[REDACTED]	0	78	144	28	169	13	23	455
[REDACTED]	0	0	4	0	2	0	0	6
[REDACTED]	0	6	17	7	24	4	4	62
[REDACTED]	0	55	100	15	139	17	33	359
[REDACTED]	0	16	47	7	102	7	15	194
[REDACTED]	0	28	164	13	247	11	11	474
<b>Total</b>	<b>1</b>	<b>594</b>	<b>1316</b>	<b>195</b>	<b>1767</b>	<b>160</b>	<b>272</b>	<b>4305</b>

## Coroner Activity

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The staff of the Coroner's Office is involved in a wide variety of activities commensurate with the mission of the office; this includes responding to and investigating the scene of death, performing postmortem examinations, certifying the cause and manner of death, and providing information and assistance to families. Members of the Coroner's staff are versed in working with families suffering the emotional trauma of an unexpected death; staff members alert these families to coroner procedure, review the investigative or examination findings with the families, and clarify the many questions that accompany the sudden loss of life.

Many cases brought to the Coroner's Office are dealt with in a customary manner, because the identity of the deceased is known and next-of-kin can be readily contacted to decide on final arrangements and assist in disposition of the personal property of the deceased. However, there are frequent cases which are more difficult to resolve. In certain deaths, the identification of the deceased may not be established or next-of-kin information is not available. These cases require positive identification to be made using dental, fingerprint, medical or DNA records, or for extensive searches to be performed in pursuit of next-of-kin; these efforts can be very time consuming but are ultimately rewarding. In 2023, the Coroner's Office had no new unidentified bodies, but continues to have four older cases of unidentified remains (full skeletonized remains, a decomposed individual, and a skull found during a cemetery remodeling, all three of which have been entered into the NamUs database, as well an abandoned fetus).

The autopsy examination on each decedent involves a thorough external and internal medical exam, and includes the preservation of various tissues and body fluids for microscopic and toxicologic analyses. Toxicology was completed in 65% (616/949) of 2023 cases and is dictated by the availability of funds within the budget; toxicology may not be performed when representative samples from the time of injury are not available or when the results of toxicology testing will not influence further investigation or determination of cause and manner of death. Photographs are taken during the examination for documentation, which is also an essential item in those cases where the pathologist must provide court testimony.

The Coroner and Forensic Pathologist both provide testimony in court and at depositions. Staff participate in meetings with law enforcement and attorneys (both prosecuting and defending), in a variety of criminal and civil cases. Autopsy reports and related data from individual investigations are provided to appropriate agencies, including law enforcement, attorneys, Colorado Department of Public Health (CDPHE), Labor & Industries (OSHA), the Drug Enforcement Administration (DEA), and the Consumer Product Safety Commission (CPSC). Case information on all child deaths (under 18 years old) is provided to local and statewide Child Fatality Prevention Review Teams. The Coroner's Office also works in a cooperative effort with regional organ procurement agencies to facilitate organ and tissue donation for transplantation; the [REDACTED] [REDACTED] [REDACTED] continues to be vigilant in referring cases to Donor Alliance with direct referrals and release of cases referred through the hospital system.

The entire staff participates in a variety of teaching opportunities and conferences, and provides information and education on a regular basis to law enforcement, medical personnel, and other students on various aspects of the role and function of the Coroner's Office. The Coroner and Forensic Pathologist regularly teach at local police academies, first-responder associations, and continuing education conferences of various local and national agencies and organizations. They hold clinical faculty appointments in the Department of Pathology at the University of Colorado School of Medicine and through Rocky Vista University College of Osteopathic Medicine, and regularly participate in teaching medical students and residents.

The data collected and presented in this and other Coroner reports also provides baseline information for further analysis. Coroner staff analyzes data to study relevant death investigation topics which have applications in such fields as law enforcement, medicine, law, social sciences, epidemiology, and injury prevention.

## Glossary of terms

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**Autopsy** – A detailed postmortem external and internal examination of a body to determine cause of death.

**Cause of Death** – The agent of effect that results in a physiological derangement or biochemical disturbance that is incompatible with life. The results of postmortem examination, including autopsy and toxicological findings, combined with information about the medical history of the decedent serves to establish the cause of death. The cause of death can result from different circumstances and manner of death. For example, the same cause of death, drowning, can result from the accidental submersion of a child in a swimming pool or from the homicidal immersion of a child in a bathtub.

**Children** – Individuals 17 years of age or younger.

**Circumstances of Death** – The situation, setting, or condition present at the time of injury or death.

**County of Injury** – The county where the injury leading to death occurred.

**Medical Investigator** – An investigator appointed by the Coroner to assist in the investigation of deaths in the jurisdiction of the [REDACTED] [REDACTED] [REDACTED] [REDACTED]

**External** – A detailed postmortem external examination of a body.

**Drug Toxicity** – A death caused by a drug or combination of drugs. Deaths caused by poisons and volatile substances are excluded.

**Ethanol** – An alcohol, which is the principal intoxicant in liquor, beer and wine. A person with an alcohol concentration in blood of 0.08 grams percent (0.08 g%) is legally intoxicated in Colorado.

**Ethanol Present** – Deaths in which toxicological tests reveal a reportable level of ethanol (0.005% or greater) at the time of death.

**Jurisdiction** – The extent of the Coroner's authority over deaths. The Coroner's authority covers reportable deaths that occur in [REDACTED] County, except for those occurring on federal (military) properties. Colorado Revised Statute 30-10-606 defines reportable deaths. Not all natural deaths are reportable deaths within the jurisdiction of the Coroner.

**Investigation** – An exploration conducted at the scene to determine circumstances surrounding a death, to include a general external examination of the body and the surroundings.

**Manner of Death** – The general category of the condition, circumstances or event, which causes the death. The categories are natural, accident, homicide, suicide and undetermined.

**Manner: Accident** – The manner of death used when, in other than natural deaths, there is no evidence of intent. This category includes motor vehicle crashes which are deemed unintentional in nature.

**Manner: Homicide** – The manner of death in which death results from the intentional harm (explicit or implicit) of one person by another.

**Manner: Natural** – The manner of death used when a disease is the sole cause of death. If death is hastened by an injury (such as incurred in a fall), the manner of death is not considered natural.

**Manner: Fetal** – The designation used for certificates in fetal death which do not receive an actual manner designation (Certificates of Fetal Demise).

**Manner: Suicide** – The manner of death in which death results from the intentional harm (explicit or implicit) of one's self.

**Manner: Undetermined** – The manner of death for deaths in which there is insufficient information to assign another manner.

**Method of Death** – The method of death describes the physical means leading to a cause of death. For example, the cause of death in a case is asphyxia, but an accidental hanging brought on the asphyxia and would be the method of death.

**Motor Vehicle Crash Related Deaths** – An accidental death involving a motor vehicle. Motor vehicles include automobiles, vans, motorcycles, trucks and all terrain vehicles. Excluded are

bicycles, tricycles, and aircraft. The decedent is usually a driver of, a passenger in, or a pedestrian struck by a motor vehicle. The death of a bicyclist struck by a motor vehicle is considered to be a motor vehicle crash related death.

**Opiate** – A class of drugs, including morphine, codeine and heroin, derived from the opium poppy plant (*Papaver somniferum*).

**Place of Injury** – The location where the injury leading to a death occurred. In this report, several categories are used:

**Residence** – Includes areas in and around dwellings, but excludes long-term care facilities and institutions.

**Street/Roadway** – Includes all streets and public areas designed for automotive transportation, to include alleyways.

**Highway** – Includes all designated highways and interstates.

**Railroad or Airport** – Includes all public areas designed for mass transit and motorized transportation via train, light rail, or airplane.

**Body of Water** – Included naturally occurring and man-made bodies of water such as lakes, rivers, ocean, streams, and swimming pools; but excludes small containers holding water, such as bathtubs, pails and toilets.

**Jail/Prison** – Any establishment used to house inmates; other institutions are excluded.

**Motel/Hotel** – Includes any place of lodging rentable by various lengths of time; excludes rooms rented and used as long-term residences.

**Parking Lot** – Includes all areas designed for parking surrounding a place of business, residence, or other area.

**Vehicle** – Includes any automobile, truck, or SUV, regardless of location of vehicle or whether parked or in motion.

**Commercial/Business** – Includes buildings, commercial property and other places of commerce.

**Institution** – Includes hospitals, long-term care facilities, and group homes, but excludes private residences; may be broken down into separate categories including Hospitals and Nursing Homes.

**Outdoor Area** – Includes areas around buildings or structures such as courtyards, and developed outdoor areas such as city parks, golf courses, ski areas, or urban outdoor areas under construction, but excludes undeveloped outdoor areas such as fields or ranches.

**Farm/Ranch** – Includes undeveloped outdoor areas such as farm or ranch fields, or other rural land.

**Unknown** – Insufficient information is available surrounding where an injury occurred.

**Stimulant** – A class of drugs, including cocaine and oral and inhaled amphetamines, whose principal action is the stimulation of the central nervous system. Cocaine is an alkaloid derived from the leaves of *Erythroxylon coca*, a shrub which grows in the Andes Mountains 1000 to 3000 meters (3000 – 9000 feet) above sea level, and can be taken orally, intravenously or by inhalation.

# Organizational Chart

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