

COUNTY OF SPOKANE  
STATE OF WASHINGTON

**OFFICE OF THE MEDICAL  
EXAMINER**

**2016 Annual Report**

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Nationally Accredited Office

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## Section 1: Overview

### **Mission Statement**

*“A regional center dedicated to excellence in public service by providing professional, scientific, and compassionate forensic death investigation.”*

### **Introduction**

*The Spokane County Medical Examiner’s Office has been in existence since January 1, 1999, when the Coroner’s Office was replaced. In April of 2004, the office received full accreditation from the National Association of Medical Examiners (NAME). The office was re-inspected and re-accredited in May, 2009. Another inspection was completed in April 2014 and re-accreditation was obtained a third time. **The National Commission on Forensic Sciences (through the Department of Justice) recommends that all investigation systems whether coroner or Medical Examiner obtain accreditation by 2020. Only 100 of 2342 Medical Examiner/Coroner Offices in the United States are currently accredited.***

*The Spokane County Medical Examiner’s Office is a separate department in Spokane County, and not under the supervision or direction of the Spokane Police Department, the Washington State Patrol, or the Spokane County Sheriff’s Office. The Medical Examiner’s Office is an independent entity.*

*The determination of manner of death (natural, homicide, suicide, accident, or undetermined) is for purposes of the death certificate, only. The Medical Examiner criteria for manner of death is not the same as the prosecutor’s legal determination. For example, most motor vehicle deaths are classified as “accident” by the Medical Examiner. The prosecutor may pursue a legal charge of “vehicular homicide”, if the legal definition is met. Medical Examiner manner of death certification is for generation of public health data. **Any determination by the Medical Examiner of suicide, accident or homicide in no way limits the ability of law enforcement to investigate to whatever extent they deem appropriate or necessary.***

*The office employs two forensic pathologists, an office manager, four full time investigators, two full time administrative staff personnel, one chief autopsy assistant, one half time autopsy assistant, as well as 3 extra help employees who work as investigators on a call-out basis. For more information about the Medical Examiner’s Office, visit our web site at <http://www.spokanecounty.org/807/Medical-Examiner> .*

*The office has been the recipient of six federal Paul Coverdell Forensic Science Improvement grants, totaling approximately \$ 300,000.00. The latest grant was awarded in March 2016. The last two Coverdell grants will provide updated dental x-ray capabilities and new sample storage freezers.*

## Foreword

Information presented in this annual report has been compiled from deaths that were reported to the Spokane County Medical Examiner's Office in 2016. This summarized report presents data in a variety of formats with the objective of providing useful information to diverse groups in the community.

**Referral Caseload:** In addition to assuming statutory responsibility for unexpected death in Spokane County, the Spokane County Medical Examiner's Office performs autopsies for 11 "outside" counties in Eastern Washington and the Idaho panhandle. In 2016 a total of 126 autopsies were performed for the following referral counties, Asotin, Benewah, Bonner, Boundary, Garfield, Kootenai, Lincoln, Nez Perce, Pend Oreille, Shoshone and Stevens. The referral relationship is established by memorandums of agreement. The surrounding counties utilize forensic expertise and an accredited forensic pathology facility, without the necessity of having larger staffs, employing Forensic Pathologists, and maintaining an autopsy facility. Spokane County receives payment from outside counties for these services, revenues for autopsies totaled \$208,656.00 in 2016.

### OUTSIDE COUNTY AUTOPSIES

2016	126
2015	130
2014	139
2013	125
2012	136
2011	186
2010	132
2009	157

### SPOKANE COUNTY AUTOPSIES

2016	415
2015	430
2014	354
2013	408
2012	373
2011	359
2010	410
2009	394

- Note 14 of the Spokane County Cases were external body examinations and not complete autopsies and 1 was a partial examination

### Outside County Autopsies per County

	2016	2015	2014	2013	2012	2011	2010	2009
<i>Asotin</i>	4	7	2	1	4	3	6	3
<i>Benewah</i>	2	2	2	1	1	2	2	2
<i>Bonner</i>	7	19	12	9	14	15	8	19
<i>Boundary</i>	0	4	6	3	6	4	2	4
<i>Clearwater</i>	5	0	0	0	0	0	0	0
<i>FBI</i>	0	0	0	0	0	1	N/A	N/A
<i>Garfield</i>	0	0	1	0	2	1	1	0
<i>Kootenai</i>	46	50	57	49	47	84	69	54
<i>Lewis</i>	N/A	0	0	0	1	1	N/A	N/A
<i>Lincoln</i>	6	4	7	6	5	3	1	8
<i>Nez Perce</i>	11	4	9	10	10	16	10	14
<i>Pend Oreille</i>	10	10	8	8	7	12	5	6
<i>Shoshone</i>	9	3	7	8	10	9	6	9
<i>Stevens</i>	26	24	28	30	29	35	22	34

*In 2016 Spokane County began service to the Clearwater County Coroner.*

*The Spokane County Medical Examiner only periodically performs autopsies at the request of the FBI.*

### Criteria for Reportable Deaths

1. Persons who die suddenly when in apparent good health and without medical attendance within 36 hours preceding death.
2. Circumstances that indicate death was caused in part or entirely by unnatural or unlawful means.
3. Suspicious circumstances.
4. Unknown or obscure causes.
5. Deaths caused by any injury whatsoever, whether the primary cause or contributing cause.
6. Rapidly fatal contagious disease, with public health risk.
7. Unclaimed bodies.
8. Premature and stillborn infants where suspicious circumstances exist.
9. All deaths in children.

### Function of the Medical Examiner's Office

The Medical Examiner's Office serves the living, by investigating deaths that are unnatural and/or unexpected, such deaths have implications to the greater community. This task begins with careful investigation at the scene of death, supplemented when appropriate, by autopsy examination, toxicology and other testing. The Medical Examiner's Office helps the community by determining the cause and manner of death, recognizing and collecting evidence needed for adjudication, defining public health and product safety risks and providing compassionate services to families including direction of efforts to notify next of kin.

## ***Standard Annual Reports Data as Identified by the National Association of Medical Examiners (N.A.M.E.)***

The Spokane County Medical Examiner's Office (SCMEO) achieved the distinction of Accreditation by the National Association of Medical Examiners in April, 2004. In March 2009 the Spokane County Medical Examiner's Office was inspected again and re-accredited by the National Association of Medical Examiners. Re-accreditation was obtained for another 5 year period in April 2014. The National Association of Medical Examiners (NAME) is the national professional organization of forensic pathologists, physician medical examiners, medical death investigators, death investigation system administrators, and consultants who perform the official duties of medicolegal investigation of deaths of public interest in the United States. Most members work as Medical Examiners or Coroners. Accreditation is a rigorous process, and requires a lengthy inspection by an independent Medical Examiner appointed by the organization. The accreditation requirements are 30 pages long, and include more than 300 items covering diverse points of quality, such as how specimens are labeled, and the qualifications of staff members. The Spokane County Medical Examiner's Office is accredited for a 5 year period, until May 2019. Please refer to the following chart for some of the data required for continuing accreditation by the National Association of Medical Examiners.

### ***2016 N.A.M.E. Data***

Deaths in Spokane County	4966
Deaths Reported to the Medical Examiner's Office	4218
Deaths Investigated by the Medical Examiner's Office (JA)	654
Scenes Investigated by the Medical Examiner Office	363
Bodies transported by order of the office via Contract Body Transport	457
○ Total bodies transported to the Forensic Institute	701
Total External Body Examinations	14
Total Partial Autopsies	1
➤ Total Complete Autopsies	526
Hospital Autopsies Retained Under Medical Examiner Jurisdiction	0
Microscopic Studies Performed	526
Neuropathologic Studies Performed	1
Cardiac Pathologic Studies Performed	1
Autopsies Performed for Outside Jurisdictions	126
Bodies Unidentified after Examination	0
▪ Organ Donors	10
Corneal Donors	21
Bone Donors	13
Connective Tissue Donors	14
Heart Valve Donors	5
Skin Donors	11
Unclaimed bodies	20
Exhumations	0

- Some decedents are not transported via contract transport; these include deaths that occur at Holy Family Hospital, where the Forensic Institute is housed; as well as deaths that occur in a referral county.
- Total complete autopsies includes both Spokane County cases and Referral County Cases.

- Organ and tissue donation agencies must seek permission from the Medical Examiner's office before proceeding with donation procedures.

The remaining statistical information includes information regarding Spokane County Deaths only.

### ***Spokane County Medical Examiner Cases in 2016***

In 2016, there were 4,966 deaths in Spokane County. Based on the latest United States Census Bureau data the estimated population of Spokane County is 490,945. The 4,966 deaths thus represent approximately 1% of the population. Of these deaths, 4,218 or 85% of the deaths were reported to the Medical Examiner. Based upon analysis of the scene and circumstances of death, and the decedent's medical history, the Medical Examiner assumed jurisdiction in 654 (16%) of these reported deaths, or in 13% of all deaths in the county. These reporting figures and autopsy percentages are similar to other Medical Examiner jurisdictions nationally.

There were deaths reported to the Medical Examiner in which jurisdiction was released after investigation (termed "jurisdiction released"). The number of deaths reported to the Medical Examiner's Office is significantly greater each year than reported during the years Spokane County has an elected lay Coroner for death investigations (before January 1, 1999). The number of cases which were reported to the Medical Examiner but released after investigation (jurisdiction released) has also generally increased during the Medical Examiners years (1999 to present), reflecting efforts by the Medical Examiner's Office to educate reporting agencies and encourage appropriate reporting of deaths to the Medical Examiner and also partly due to population growth. All nursing home and adult care facilities deaths are reported to the Medical Examiner's Office allowing for appropriate agency analysis. This progressive Spokane County Medical Examiner Policy has been adopted by other Medical Examiner and coroner systems around the state.



## ***Forensic Unit***

The Forensic Unit is part of the Sheriff's department and provides crime scene documentation, fingerprint comparison and scene photo documentation at the direction of the Law Enforcement Agency with jurisdiction. The Medical Examiner's office often partners with this group in the collection and preservation of evidence. The unit also assists the Medical Examiner's Office in providing fingerprint (friction ridge) comparison expertise.

## ***Chaplaincy Services***

While there are no Washington State laws which require the Medical Examiner to identify and locate next-of-kin, by convention and practice in Spokane County, the Medical Examiner has been depended upon for identifying next-of-kin and for facilitating the locating and notifying of next-of-kin. The Medical Examiner's Office is fortunate to have the assistance of the Chaplains from the Spokane County Sheriff's Office and the Spokane Police Department in notifying family members. The staff of the Medical Examiner's Office recognizes that the Chaplains have considerable experience and professional training to help in this difficult endeavor.

## **Section 2: Total Cases**

### ***Total Cases for 2016***

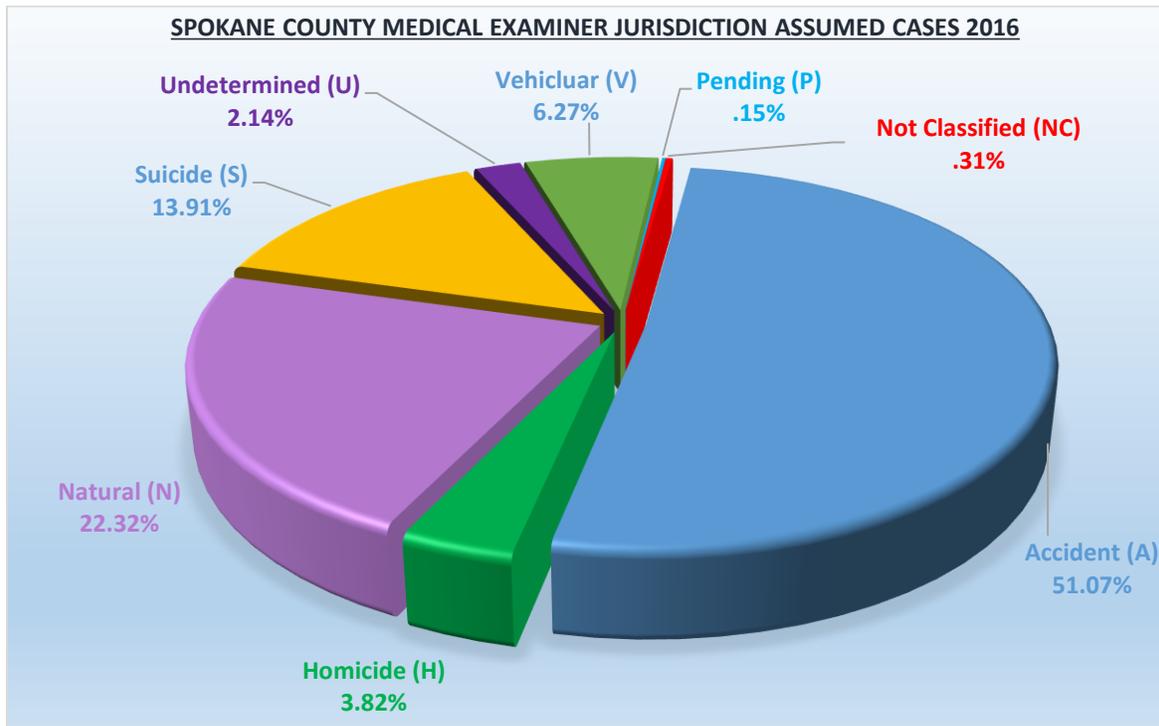
<b>Total Spokane County Population</b>	490,945
<b>Total Deaths in Spokane County</b>	4,966
<b>Total Deaths Reports to the Medical Examiner in 2016</b>	4,218
<b>Total Jurisdiction Released after Investigation</b>	3564
<b>Total Spokane County Jurisdiction Assumed Cases</b>	654
<b>Total Spokane County Autopsies Performed</b>	415
<b>Total Spokane County External Examinations Performed</b>	14

### ***Manner of Death and Death Certification***

The death certificate is a Washington State Health Department document, not a medical examiner or coroner document. The death certification process includes classification of the manner of death (Natural, Accident, Suicide, Homicide, or Undetermined), intended to describe the action associated with a death, if any, for public health department vital statistics purposes. In the vast majority of deaths, Washington State law directs the physician last in attendance to certify the death. The Medical Examiners assist the community and the Health Department with death certifications in some of the deaths reported to the Office of the Medical Examiner, most often in cases of unnatural death. The manner of death as used by the Office of the Medical Examiner does not address presence or absence of intent, culpability or justification of any action associated with a death. Manner of death classification was added to the death certificate by public health officials in 1910 to help clarify the circumstances of death and how an injury causing death occurred, assisting nosologists who code and classify cause-of-death information for statistical purposes.

<b>Jurisdiction Assumed Cases by Manner of Death 2016</b>	<b>Number of Deaths</b>	<b>Percent of Total</b>
Accident (A)	334	51.07%
Homicide (H)	25	3.82%
Natural (N)	146	22.32%
Suicide (S)	91	13.91%
Undetermined (U)	14	2.14%
Vehicular (V)	41	6.27%
Pending (P)	1	0.15%
Not Classified (NC)	2	0.31%
<b>Total</b>	<b>654</b>	

For death certificate purposes, vehicular deaths are classified as accident.



There are two deaths that are Not Classified, one is a case of skeletal human remains reported to the Medical Examiner, which may be Native American or pioneer, likely greater than 100 years old. These remains have been turned over to the Washington State Archaeologist. The second “not classified” case was thought by the reporting individual to be remains, these were determined to be an anatomical study set of bones (typically used in a medical classroom setting such as medical school).

One death is still considered Pending as the Federal Bureau of Investigation (FBI) has not completed its investigation. The FBI has advised it could take as long as one year to complete.

	Jurisdiction Released Cases	Outside Agency Deaths Reported (Adult Care Facilities, Nursing Homes, Hospice, etc)	❖ Spokane County Autopsies Completed	Referral County Autopsies Completed
January	132	195	30	8
February	100	183	32	11
March	108	196	36	9
April	110	203	38	12
May	109	191	38	12
June	103	186	40	11
July	90	173	32	13
August	91	177	37	7
September	102	197	32	9
October	94	193	34	13
November	117	191	34	10
December	129	192	32	11
<b>Total</b>	<b>1286</b>	<b>2278</b>	<b>415</b>	<b>126</b>

- ❖ Includes 400 Spokane County complete autopsies, 14 external only examinations and 1 partial examinations. In addition to the Spokane County autopsies, the Medical Examiner's Office performed 126 complete autopsies for neighboring referral counties, for a total of 526 complete autopsies performed by Spokane County Medical Examiners.

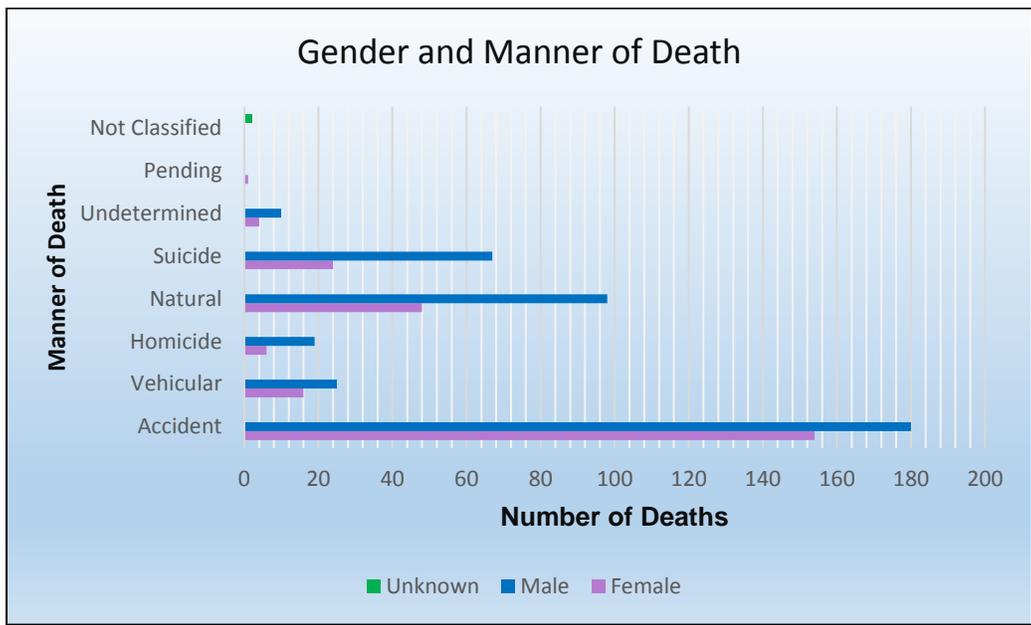
### Total Cases by Gender and Manner of Death

- A – Accident
- V – Vehicular
- H – Homicide
- N – Natural
- S – Suicide
- U – Undetermined
- P – Pending
- NC – Not Classified

### Gender and Manner of Death

Sex	A	V	H	N	S	U	P	NC	Total	Percent
Female	154	16	6	48	24	4	1	0	253	38.69%
Male	180	25	19	98	67	10	0	0	399	61.01%
Unknown	0	0	0	0	0	0	0	2	2	0.31%
<b>Total</b>									<b>654</b>	

The preponderance of males has been the historical norm in Spokane County, and is similar to the experience/practice of nearly all other medical examiner systems.



Predominance of male gender in all categories of death coming under the jurisdiction of the Medical Examiner’s Office reflects the experience of most death investigation systems. This male predominance begins in infancy and extends to near the end of life spans. While females statistically attempt suicide more often than males, males more often succeed.

**Total Jurisdiction Assumed (JA) Cases by Race and Manner of Death**

	Race and Manner of Death								Total	% of 4966 Spokane County Deaths
	A	H	N	S	U	V	P	NC		
Asian	1	1	1	1	0	1	0	0	5	0.10%
Black	1	1	5	3	1	0	0	0	11	0.22%
Caucasian	312	21	132	83	13	36	1	0	598	12.04%
Hispanic	5	1	0	2	0	0	0	0	8	0.16%
Native American	5	0	4	2	0	3	0	0	14	0.28%
Other	2	0	3	0	0	0	0	0	5	0.10%
Unknown	8	1	1	0	0	1	0	2	13	0.26%
	<b>334</b>	<b>25</b>	<b>146</b>	<b>91</b>	<b>14</b>	<b>41</b>	<b>1</b>	<b>2</b>	<b>654</b>	

These data reflect the demographics of Spokane County, where the Caucasian race predominates statistically. Race determination is required on the death certificate.

**Total Jurisdiction Assumed (JA) Cases by Age Group and Manner of Death**

In Jurisdiction Assumed (JA) cases, the Medical Examiner assumes responsibility for signing the death certificate. In 400 cases a complete autopsy was performed, in 14 cases an external body examination was performed, in 1 case a partial autopsy was performed. In 239 cases the death certificate was signed based on death investigation and/or medical records.

<b>Age and Manner of Death</b>									
<b>Age Group (Years)</b>	<b>A</b>	<b>H</b>	<b>N</b>	<b>S</b>	<b>U</b>	<b>V</b>	<b>P</b>	<b>NC</b>	<b>Total</b>
<b>Unknown Age</b>	0	0	0	0	0	0	0	2	<b>2</b>
<b>0-9</b>	5	3	6	0	5	0	0	0	<b>19</b>
<b>10-19</b>	2	0	2	8	0	5	0	0	<b>17</b>
<b>20-29</b>	22	4	6	27	3	6	0	0	<b>68</b>
<b>30-39</b>	24	6	14	13	1	4	0	0	<b>62</b>
<b>40-49</b>	28	5	20	12	0	6	1	0	<b>72</b>
<b>50-59</b>	48	2	35	10	1	7	0	0	<b>103</b>
<b>60-69</b>	37	4	39	14	2	5	0	0	<b>101</b>
<b>70-79</b>	35	1	15	5	1	5	0	0	<b>62</b>
<b>80-89</b>	75	0	8	2	1	3	0	0	<b>89</b>
<b>90-99</b>	55	0	1	0	0	0	0	0	<b>56</b>
<b>100-109</b>	3	0	0	0	0	0	0	0	<b>3</b>
	<b>334</b>	<b>25</b>	<b>146</b>	<b>91</b>	<b>14</b>	<b>41</b>	<b>1</b>	<b>2</b>	<b>654</b>

In the 0-9 age group, sudden unexplained infant deaths (SIDS or SUID) are classified as natural in this jurisdiction. In older Spokane County deaths (age 70 plus) accidents predominate, and most result from falls with fractures or head injuries leading to death.

There are two deaths that are “not classified”, one is a case of skeletal human remains reported to the Medical Examiner, which may be Native American or pioneer, likely greater than 100 years old. These skeletal remains have been turned over to the Washington State Archaeologist. The second “not classified” skeletal remains were determined to be an anatomical study set of bones (typically used in a medical classroom setting).

One death is still considered Pending as the Federal Bureau of Investigation (FBI) has not completed its investigation. The FBI has advised it could take as long as one year to complete.

**Total Jurisdiction Assumed (JA) Cases by Age Group and Gender**

Age Group (Years)		Female	Male	Unknown Gender
** Unknown Age	2	0	0	2
0 to 9	19	7	12	0
10 to 19	17	4	13	0
20 to 29	68	19	49	0
30 to 39	62	18	44	0
40 to 49	72	23	49	0
50 to 59	103	39	64	0
60 to 69	101	28	73	0
70 to 79	62	27	35	0
80 to 89	89	50	39	0
90 to 99	56	36	20	0
10 to 109	3	2	1	0
<b>Total</b>	<b>654</b>	<b>253</b>	<b>399</b>	<b>2</b>

\*\* See explanation above

**Out of Area Incidents Leading to Death in Spokane County**

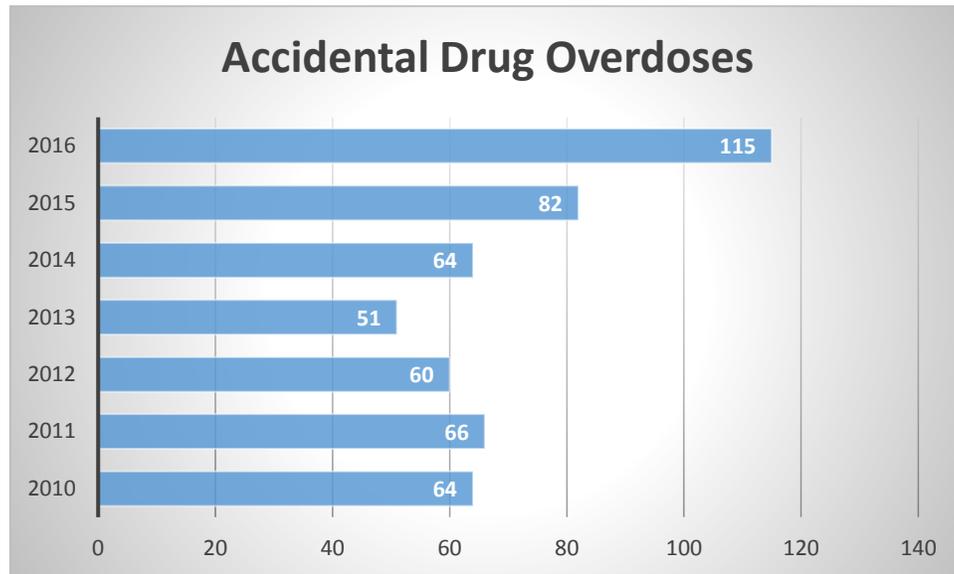
In 2016 there were a total of 53 cases in which an event occurred outside of Spokane County that led to the eventual death in Spokane County. According to Washington State law, Medical Examiner and Coroner jurisdiction is based upon where the death occurs. The majority of these cases were transfers from out of county or out of state hospitals to one of the Spokane County hospitals. The manners of death in these cases are: 33 Accidents, 4 homicides, 10 motor vehicle accidents, 2 natural, 2 suicide and 2 undetermined. Please see the link to the data below:

[Out of Area Incidents Leading to death in Spokane County](#)

**Section 3: Multi-Year Comparison**

The Medical Examiner's Office replaced the coroner's system on January 1, 1999. From 1999 to present, the number of Spokane County deaths which have fallen under the jurisdiction of the Medical Examiner System has ranged from a low of 550 to a high of 680, with the number of Spokane County autopsies performed typically under 450.

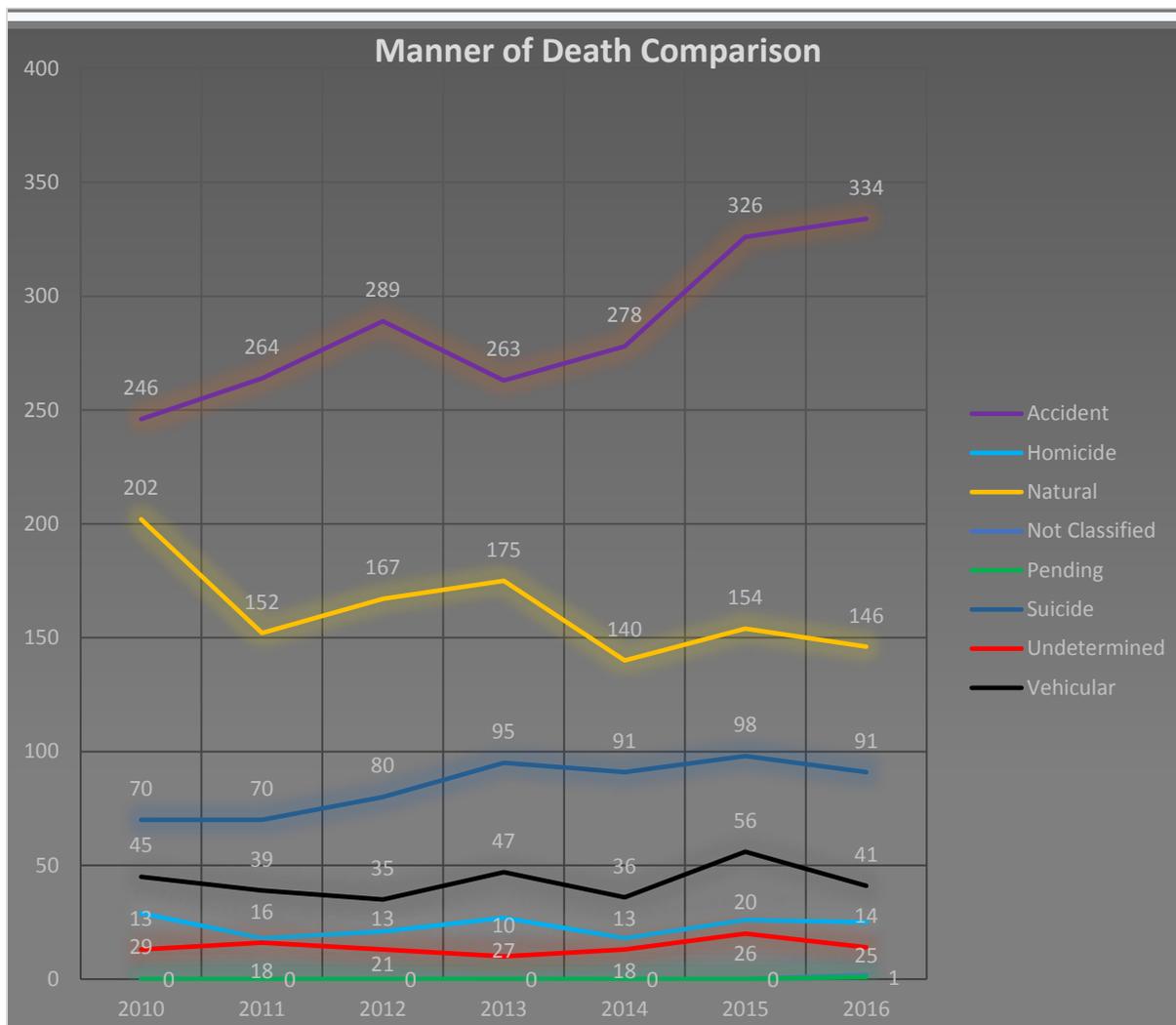
Overdose deaths may be classified as "accidents". The federal government data categorizes overdose deaths as "unintentional poisoning deaths". Federal data indicates that poisoning deaths have increased significantly in the last decade. Most of the poisoning death increases have resulted from prescription medications or a combination of illicit and prescription drugs. Data below shows accidental drug overdose deaths in Spokane County, in which prescription and/or illicit drugs were demonstrated in toxicology.



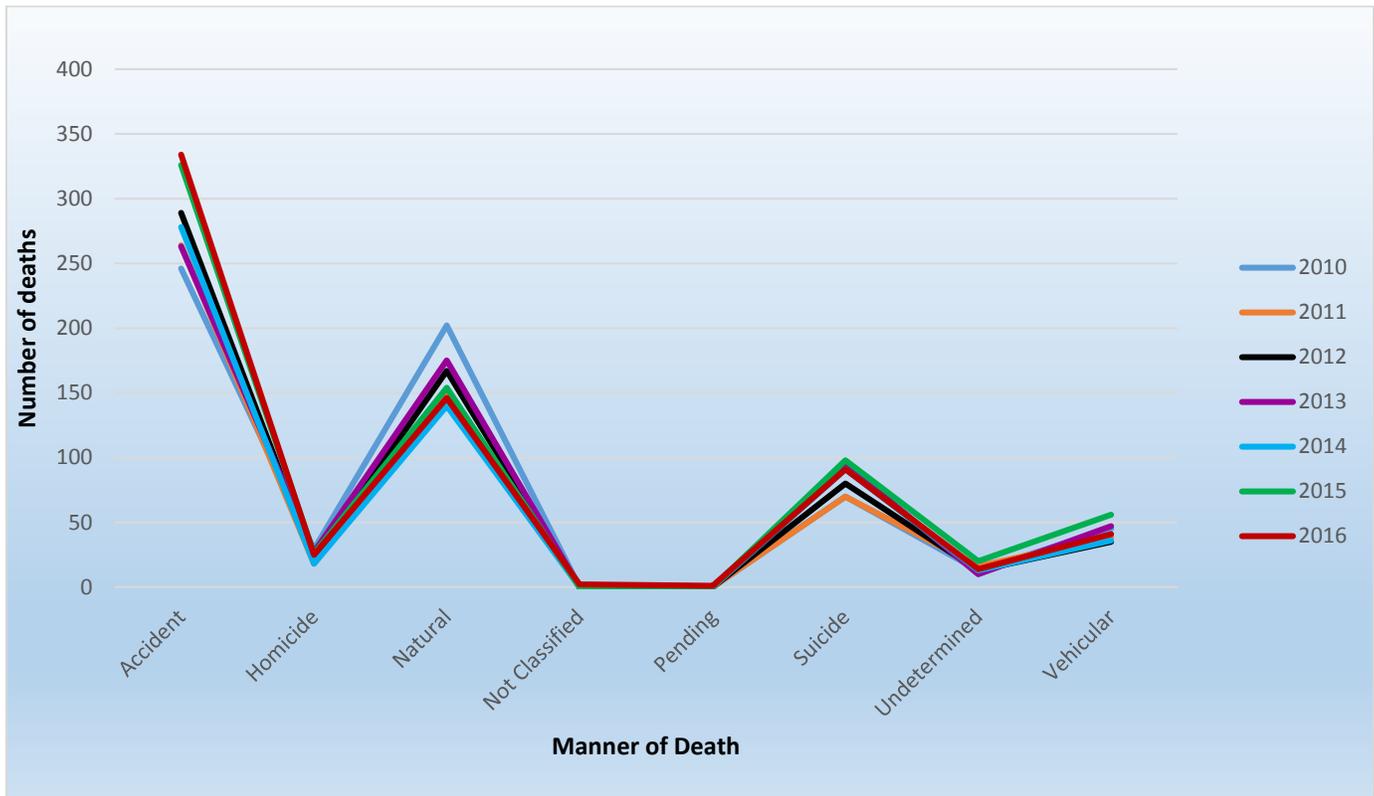
***Manner of Deaths Comparison (Jurisdiction Assumed – JA Deaths)***

**Comparison of Manners of Death 2010-2016**

Manner of Death	2010	2011	2012	2013	2014	2015	2016
Accident	246	264	289	263	278	326	334
Homicide	29	18	21	27	18	26	25
Natural	202	152	167	175	140	154	146
Not Classified	0	0	0	0	0	0	2
Pending	0	0	0	0	0	0	1
Suicide	70	70	80	95	91	98	91
Undetermined	13	16	13	10	13	20	14
Vehicular	45	39	35	47	36	56	41
<b>Total</b>	<b>605</b>	<b>559</b>	<b>605</b>	<b>617</b>	<b>576</b>	<b>680</b>	<b>654</b>



Medical Examiner Homicide numbers may not mirror the Police Department reports of homicide deaths because the Medical Examiner certification of homicide is broader in some situations and more narrow in others. The Medical Examiner is using these classifications for the purposes of statistical analysis based on death certificate classification. As above these categories of death certification remain relatively stable through the years. The office has been releasing jurisdiction more in natural deaths, but assumes jurisdiction for more accidents. Part of the increase in accidents in 2016 is attributed to the 33 additional accidental drug overdose deaths.



The proportions of the manners of death have remained remarkably similar through the years.

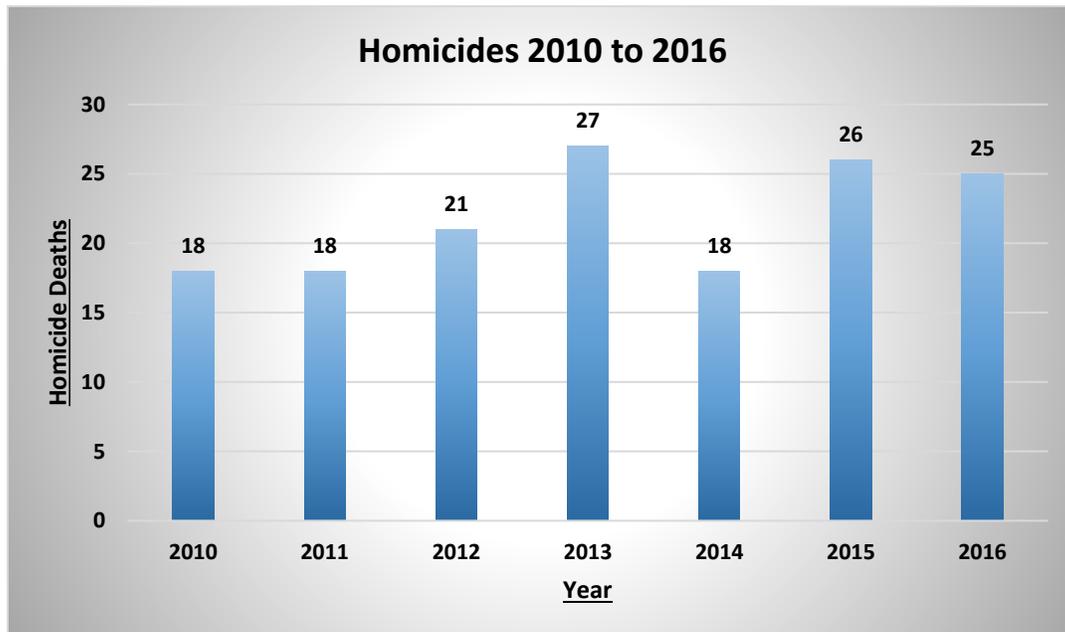
Manner of Death	2010	2011	2012	2013	2014	2015	2016
Accident	40.66%	47.23%	47.77%	42.63%	48.26%	47.94%	51.07%
Homicide	4.79%	3.22%	3.47%	4.38%	3.13%	3.82%	3.82%
Natural	33.39%	27.19%	27.60%	28.36%	24.31%	22.65%	22.32%
Not Classified	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.31%
Pending	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.15%
Suicide	11.57%	12.52%	13.22%	15.40%	15.80%	14.41%	13.91%
Undetermined	2.15%	2.86%	2.15%	1.62%	2.26%	2.94%	2.14%
Vehicular	7.44%	6.98%	5.79%	7.62%	6.25%	8.24%	6.27%

Ideally, a Medical Examiner system strives to keep the percentage of “undetermined” manner of death cases to less than five percent. This requires thorough investigation and autopsy. In the Spokane County Medical Examiner’s Office, every “undetermined” manner case is reviewed by multiple staff members as part of the office Quality Improvement Program.

### *Homicidal Methods Comparison*

Method Used	2010	2011	2012	2013	2014	2015	2016
Asphyxia	1	0	0	0	0	1	1
Blunt Impact	0	1	0	1	0	0	1
Child Abuse	2	1	1	1	0	2	3
Firearms	12	9	11	19	12	12	12
Homicidal Violence	1	2	1	1	2	0	4
Other	1	4	0	3	0	6	1
Stabbing	0	0	3	0	3	3	3
Strangulation	1	1	5	2	1	2	0
<b>Total</b>	<b>18</b>	<b>18</b>	<b>21</b>	<b>27</b>	<b>18</b>	<b>26</b>	<b>25</b>

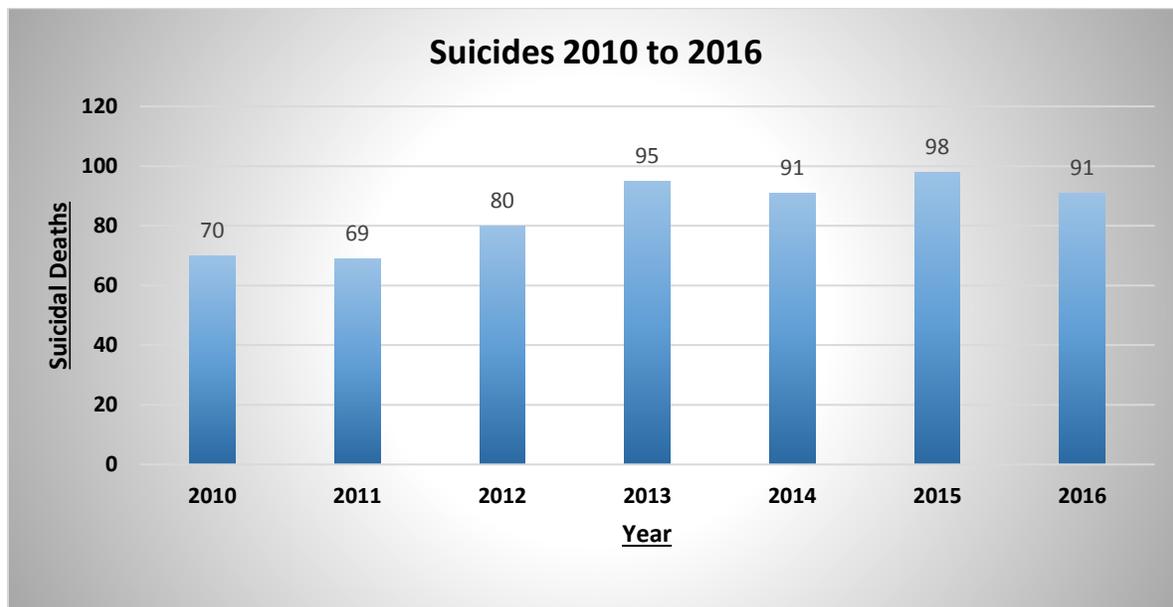
The number of homicides in Spokane County is small enough that collected data cannot be extensively interpreted.



**Suicidal Methods Comparison**

**Comparison of Suicidal Deaths**

Method Used	2010	2011	2012	2013	2014	2015	2016
Carbon Monoxide	1	3	1	4	2	0	6
Drowning	1	0	3	0	5	1	0
Drugs/Poisons	13	12	11	15	7	19	9
Firearms	35	39	42	44	54	46	44
Hanging	13	7	15	23	16	23	19
Jumping	3	3	4	2	1	2	7
Other	2	2	0	3	1	3	3
Plastic Bag	0	2	3	2	3	3	2
Stab/incised wound	2	1	1	2	2	1	1
<b>Total</b>	<b>70</b>	<b>69</b>	<b>80</b>	<b>95</b>	<b>91</b>	<b>98</b>	<b>91</b>

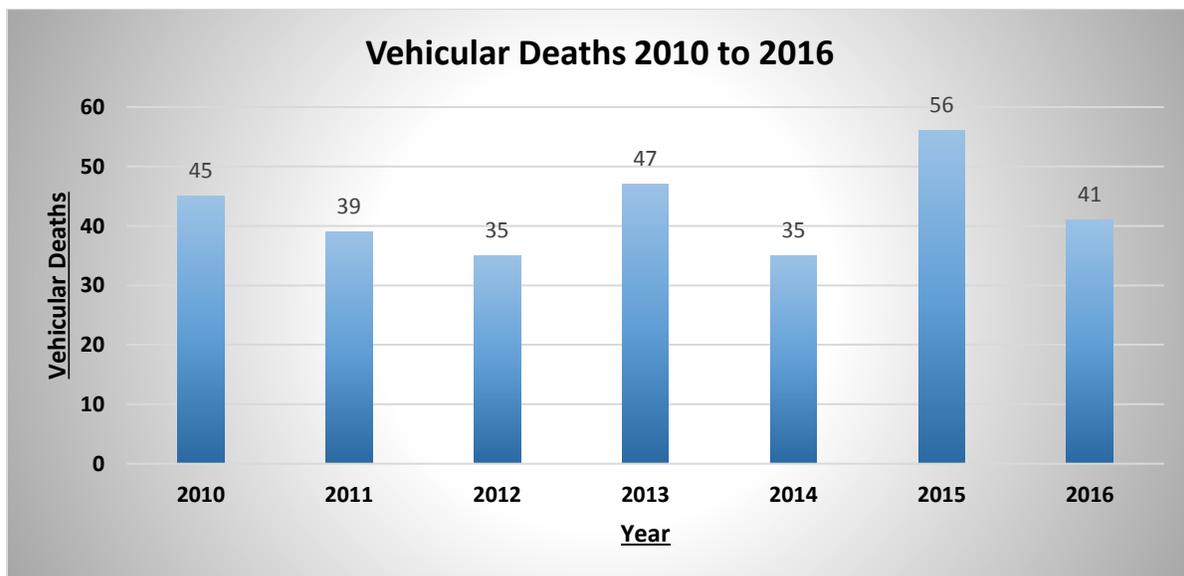


### Vehicular Deaths Comparison

Vehicular-related fatalities are separated from other accidents because some community groups have special statistical interests in examining vehicular-related deaths.

**Comparison of Vehicular Deaths 2010 to 2016**

Vehicle Circumstances	2010	2011	2012	2013	2014	2015	2016
Automobile Driver	19	20	12	19	20	22	17
Automobile Passenger	11	4	3	14	2	11	6
Bicyclist	3	1	1	0	1	1	2
Motorcycle Driver	6	8	6	8	5	6	5
Motorcycle Passenger	1	0	0	0	1	0	0
Pedestrian	2	6	9	5	5	11	5
Other	2	0	1	0	1	2	3
Unknown	1	0	3	1	0	3	3
<b>Total</b>	<b>45</b>	<b>39</b>	<b>35</b>	<b>47</b>	<b>35</b>	<b>56</b>	<b>41</b>



**Accidental Deaths Comparison****Comparison of Accidental Deaths 2010 to 2016**

<b>Accident Circumstances</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Aircraft	1	0	0	0	0	4	0
Alcohol Abuse	1	1	1	8	2	5	1
Anaphylaxis	0	0	0	1	0	0	1
Asphyxiation	2	1	4	3	6	3	5
Aspiration	2	0	4	0	1	2	0
Bicycle Fall	1	1	1	0	2	1	0
Choking	3	5	6	1	7	6	4
Drowning	7	7	8	7	5	7	5
Drugs	24	36	30	33	30	66	81
Prescribed Drugs	40	30	43	24	32	16	34
Electrocution	1	1	0	0	0	0	0
Fall	138	167	172	156	176	179	181
Farm	3	0	0	0	0	1	0
Fire/burns	8	6	3	3	3	5	5
Firearms	2	0	1	3	0	1	3
Hyperthermia	0	0	0	0	1	4	3
Hypothermia	2	2	2	8	3	15	3
Industrial Accident	2	0	1	2	3	1	1
Motorcycle Driver (race track)	0	1	0	0	0	0	0
Other	9	6	13	13	7	9	6
Struck by Object	0	0	0	0	0	0	1
Surgical Procedure	1	0	0	1	0	0	0
Therapy Complication	0	0	0	0	1	1	0
<b>Total</b>	<b>247</b>	<b>264</b>	<b>289</b>	<b>263</b>	<b>279</b>	<b>326</b>	<b>334</b>

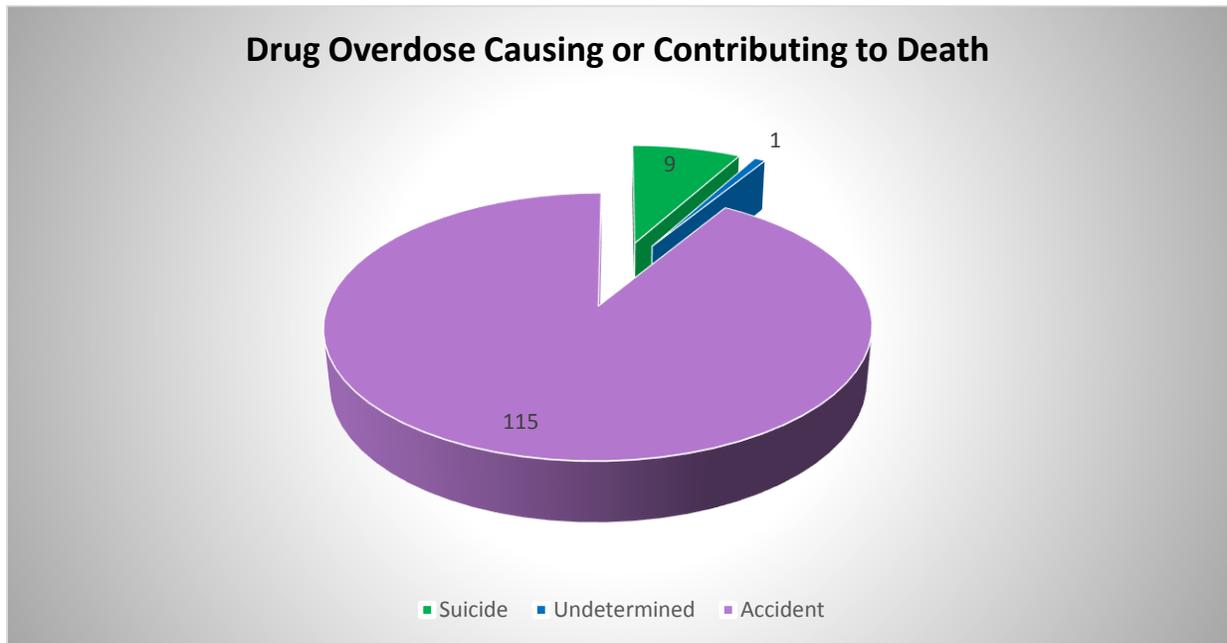
Toxicology may show numerous combinations of medications and illicit drugs, but such deaths are categorized in the chart above as “Drugs”. Prescribed drugs is an exclusive category.

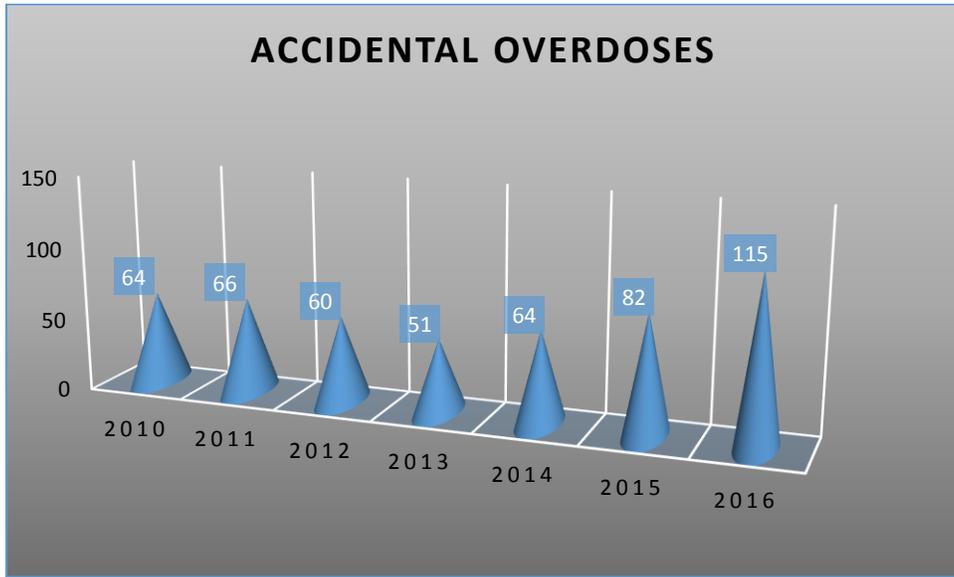
## Drug Overdose Data Summary 2016

In 2016 a total of 125 deaths had prescription /and or illicit drugs listed on the death certificate as causing or contributing to death. Of these, 118 deaths had drugs listed in the primary cause of death, in the others the drugs contributed to death.

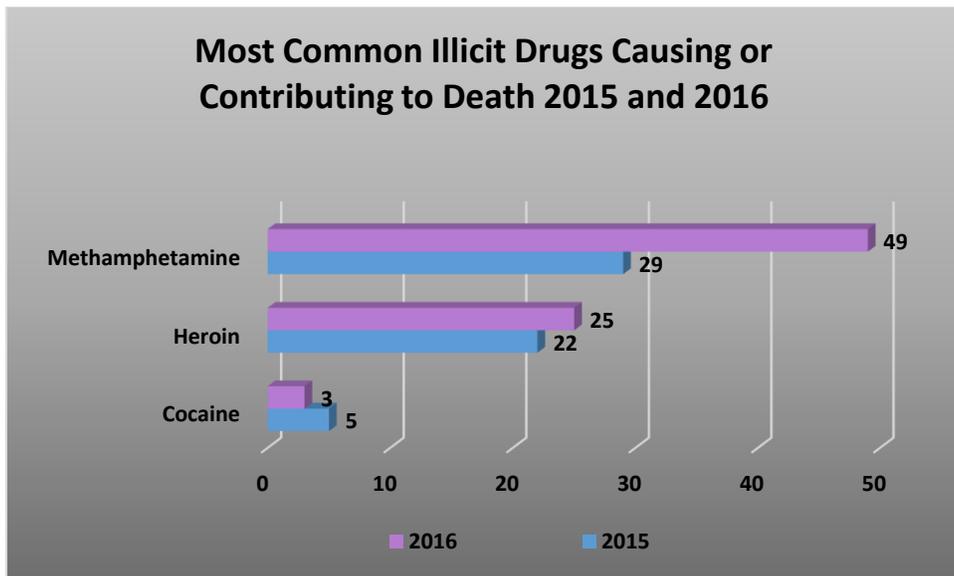
Drug Overdoses causing or contributing to 125 deaths:

- 9 deaths      Suicide
- 1 death      Undetermined (accident vs. suicide)
- 115 deaths    Accident





### Most Common Illicit Drugs In Accidental Death



The above chart represents the most common illicit drugs found in Accidental Deaths in Spokane County in 2015 and 2016. These are listed both as the primary cause of death on the death certificate, as well as listed just as contributing to death on the death certificate.

### ***2016 Most Common Opioids (plus Benzodiazepines) Listed as Causing or Contributing to Accidental Death***

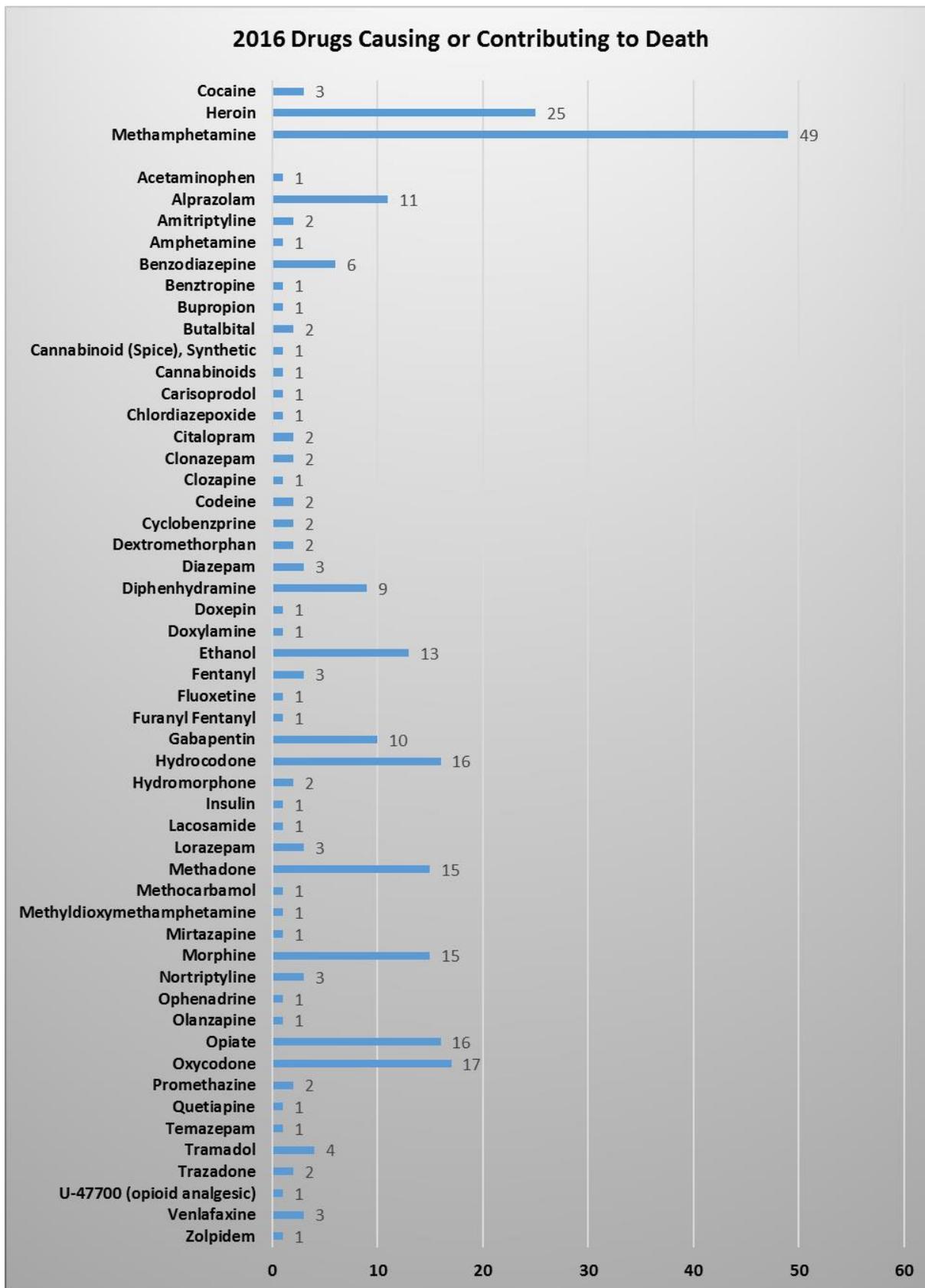
#### **Opioid (plus\*\*benzodiazepine)**

<b>Oxycodone</b>	<b>16</b>
<b>Morphine</b>	<b>15</b>
<b>Methadone</b>	<b>15</b>
<b>Hydrocodone</b>	<b>14</b>
<b>**Benzodiazepines</b>	<b>23</b>

The above table represents the most common opioids found in Accidental Deaths in Spokane County in 2016. These are listed in both the primary cause of death as well as a contributing factor.

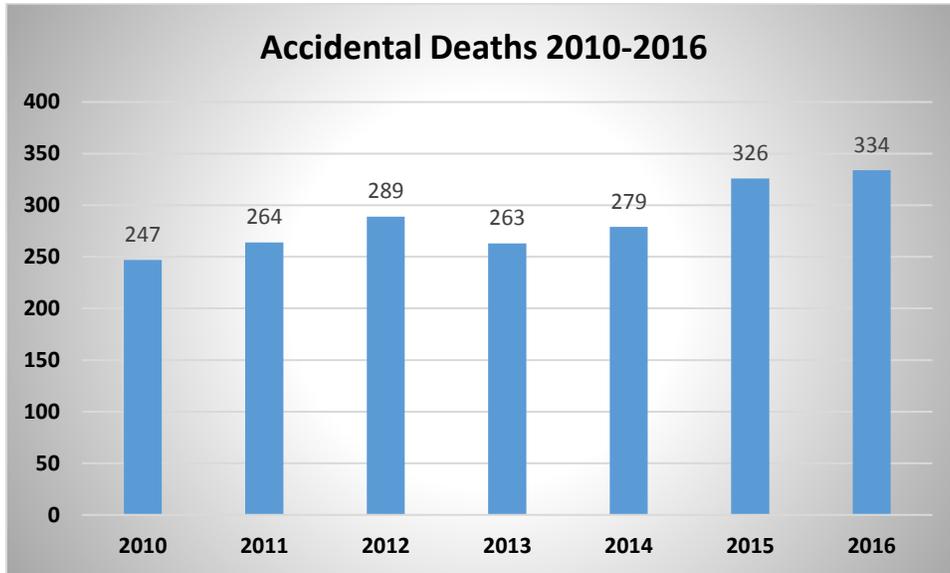
\*\* Though benzodiazepines are not opioids they are included with the opioids as national data which indicates that benzodiazepines are often seen in combination with opioids in prescription medication deaths.

In the chart below, specific benzodiazepines were sometimes listed on the death certificate, such as diazepam (valium). On some death certificates the overriding classification of "benzodiazepine" was used.



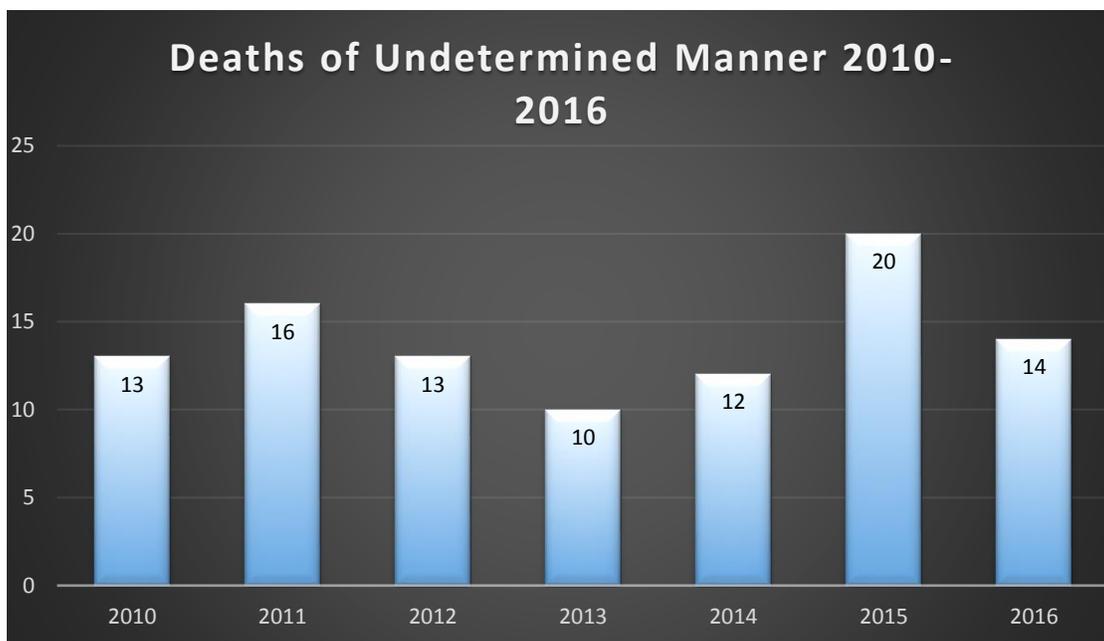
Fentanyl analog deaths are increasing nationally. In Spokane County, only one fentanyl analog death occurred in 2016 (furanyl fentanyl).

**Accidental Deaths Comparison (Jurisdiction Assumed – JA Deaths)**



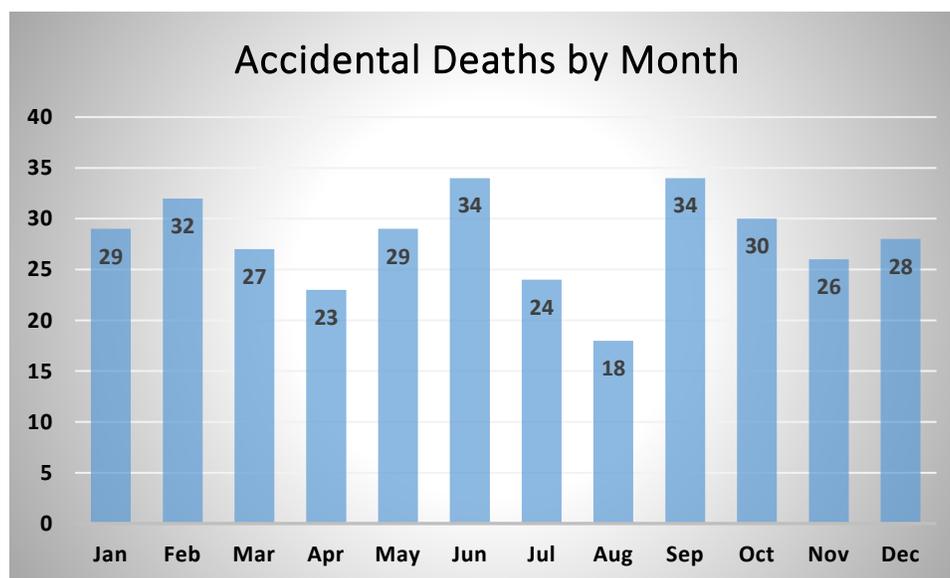
**Natural Deaths Comparison (Jurisdiction Assumed – JA Deaths)**



**Undetermined Deaths Comparison (Jurisdiction Assumed – JA Deaths)**

Ideally Medical Examiner Systems use the undetermined manner of death category in less than five percent of cases. This reflects fullest utilization of investigation and decedent autopsy. In 2016, the undetermined classification was used in 2.14% of Spokane Medical Examiner cases.

Undetermined manner is used in a wide array of circumstance. An example is an “overdose” death, wherein the intent is unknown despite investigation, making the determination of accident versus suicide unclear.

**Accident****Accidental Deaths in Jurisdiction Assumed (JA) Cases by Month**

As noted elsewhere in this report the majority of deaths investigated by the Medical Examiner are in males. Falls resulting in death become more common in women in their 80's and 90's. An example is a fall leading to hip fracture, and resulting death from related complications. See the link to a report from the Spokane Regional Health District regarding falls in Washington's East Region ([Falls in WA E Region](#))

<b>Accident Mode</b>	<b>Female</b>	<b>Male</b>	<b>Total</b>
Alcohol Abuse	0	1	<b>1</b>
Anaphylaxis	1	0	<b>1</b>
Asphyxiation	1	4	<b>5</b>
Choking	0	4	<b>4</b>
Drowning	1	4	<b>5</b>
Drugs	25	56	<b>81</b>
Prescribed Drugs	14	20	<b>34</b>
Fall	104	77	<b>181</b>
Fire/burns	1	4	<b>5</b>
Firearms	2	1	<b>3</b>
Hyperthermia	2	1	<b>3</b>
Hypothermia	2	1	<b>3</b>
Industrial Accident	0	1	<b>1</b>
Other	2	4	<b>6</b>
Struck by Object	0	1	<b>1</b>
<b>Total</b>	<b>155</b>	<b>179</b>	<b>334</b>

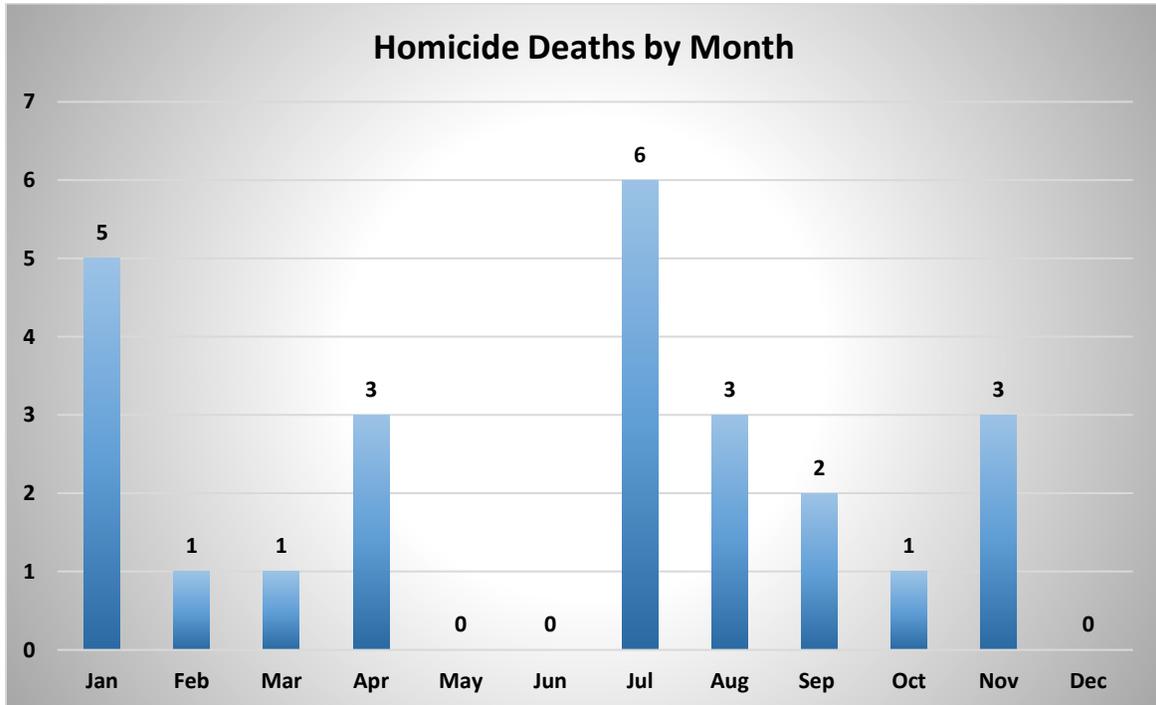
**Accident Mode by Gender and Age Group**

Accident Mode	Sex	>1	1-9	10-19	20-29	30-39	40-49	50-59	60-69	70-79	80-89	90-99	100-109	Total
Alcohol Abuse	Male	0	0	0	0	0	1	0	0	0	0	0	0	1
														1
Anaphylaxis	Female	0	0	0	0	0	1	0	0	0	0	0	0	1
														1
Asphyxiation	Female	1	1	0	0	0	0	0	0	0	0	0	0	2
Asphyxiation	Male	0	0	0	1	0	0	2	0	0	0	0	0	3
														5
Choking	Male	0	0	0	0	1	0	1	2	0	0	0	0	4
														4
Drowning	Female	0	0	0	0	0	0	1	0	0	0	0	0	1
Drowning	Male	0	1	1	0	0	1	1	0	0	0	0	0	4
														5
Drugs	Female	0	0	0	4	3	3	9	5	1	0	0	0	25
Drugs	Male	0	0	0	10	13	11	12	9	1	0	0	0	56
														81
Prescribed Drugs	Female	0	0	0	2	3	2	5	1	1	0	0	0	14
Prescribed Drugs	Male	0	0	1	3	3	4	5	4	0	0	0	0	20
														34
Fall	Female	0	0	0	1	1	0	2	5	15	44	34	2	104
Fall	Male	0	0	0	0	0	0	5	6	16	29	20	1	77
														181
Fire/burns	Female	0	0	0	0	0	0	0	1	0	0	0	0	1
Fire/burns	Male	0	1	0	0	0	0	1	2	0	0	0	0	4
														5
Firearms	Female	0	0	0	1	0	1	0	0	0	0	0	0	2
Firearms	Male	0	0	0	0	0	1	0	0	0	0	0	0	1
														3
Hyperthermia	Female	0	0	0	0	0	1	1	0	0	0	0	0	2
Hyperthermia	Male	0	0	0	0	0	0	1	0	0	0	0	0	1
														3
Hypothermia	Female	0	0	0	0	0	0	1	0	0	0	1	0	2
Hypothermia	Male	0	0	0	0	0	0	0	0	0	1	0	0	1
														3
Industrial Accident	Male	0	0	0	0	0	0	0	1	0	0	0	0	1
														1
Other	Female	0	0	0	0	0	1	0	1	0	0	0	0	2
Other	Male	0	1	0	0	0	1	1	0	1	0	0	0	4
														6
Struck by Object	Male	0	0	0	0	0	0	0	0	0	1	0	0	1
														1
<b>Grand Total</b>		<b>1</b>	<b>4</b>	<b>2</b>	<b>22</b>	<b>24</b>	<b>28</b>	<b>48</b>	<b>37</b>	<b>35</b>	<b>75</b>	<b>55</b>	<b>3</b>	<b>334</b>

Falls that result in mortality are significantly correlated with increasing age. Illicit and prescription drug deaths peak in middle ages in Spokane County.

## Homicide

In 2016 there were 25 recorded homicides, this is a decrease by 1 from the previous year. Firearms accounted for the single largest method of homicide (12 of 25). Firearms also accounted for the largest number of deaths by suicide.

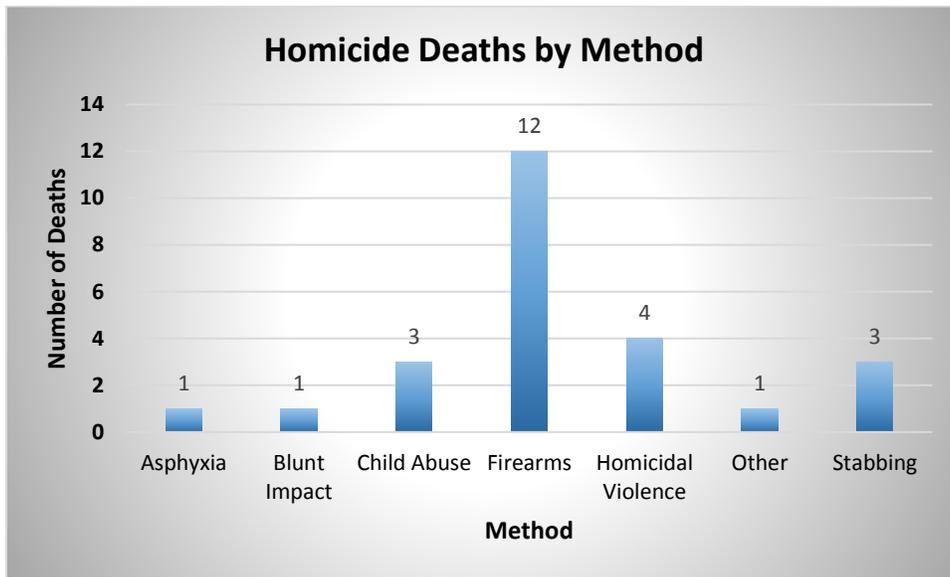


**Homicide Deaths by Method, Gender, and Age Group**

Homicide Method	Sex	>1	1-9	10-19	20-29	30-39	40-49	50-59	60-69	70-79	Total
Asphyxia	Male	0	0	0	0	0	0	0	1	0	1
<b>1</b>											
Blunt Impact	Male	0	0	0	0	0	0	0	1	0	1
<b>1</b>											
Child Abuse	Female	0	1	0	0	0	0	0	0	0	1
Child Abuse	Male	0	2	0	0	0	0	0	0	0	2
<b>3</b>											
Firearms	Female	0	0	0	0	0	1	0	0	0	1
Firearms	Male	0	0	0	2	4	3	1	1	0	11
<b>12</b>											
Homicidal Violence	Female	0	0	0	0	0	1	0	1	0	2
Homicidal Violence	Male	0	0	0	0	0	0	1	0	1	2
<b>4</b>											
Other	Male	0	0	0	0	1	0	0	0	0	1
<b>1</b>											
Stabbing	Female	0	0	0	1	0	0	0	0	0	1
Stabbing	Male	0	0	0	1	1	0	0	0	0	2
<b>3</b>											
<b>Grand Total</b>		<b>0</b>	<b>3</b>	<b>0</b>	<b>4</b>	<b>6</b>	<b>5</b>	<b>2</b>	<b>4</b>	<b>1</b>	<b>25</b>



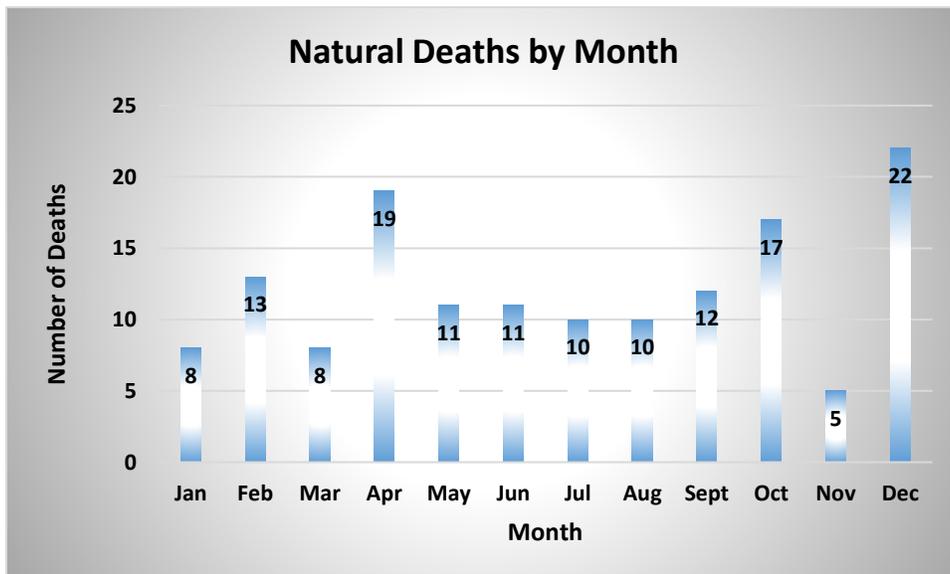
This graph is limited statistically by the small number of total deaths it represents.



**Natural**

Typically, the Medical Examiner’s Office assumes jurisdiction in cases that turn out to be natural death when the death occurs in a young age group without medical history and is therefore unexpected.

**Natural Deaths by Month (Jurisdiction Assumed – JA Deaths)**



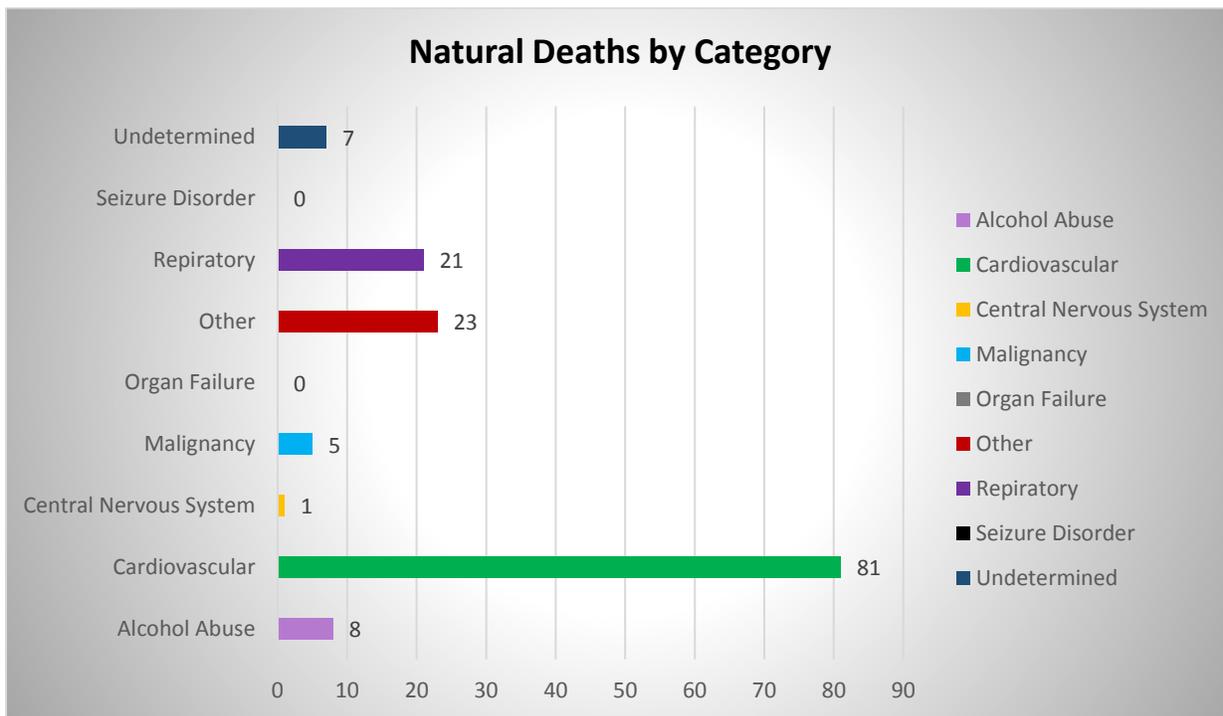
**Natural Deaths by Disease Process**

Natural Disease By Process	Alcohol Abuse	Cardiovascular	Central Nervous System	Malignancy	Organ Failure	Other	Respiratory	Seizure Disorder	Undetermined	Total
Addisons Disease	0	0	0	0	0	1	0	0	0	1
Arrhythmia	0	1	0	0	0	0	0	0	0	1
Asthma	0	0	0	0	0	0	2	0	0	2
Atherosclerotic Cardiovascular Disease	0	46	0	0	0	0	0	0	0	46
Cardiac Dysrhythmia	0	3	0	0	0	0	0	0	0	3
Cardiomyopathy	0	20	0	0	0	0	0	0	0	20
Cerebral Hemorrhage	0	0	0	0	0	1	0	0	0	1
Chronic Alcoholism	5	0	0	0	0	0	0	0	0	5
Chronic Obstructive Pulmonary Disease	0	0	0	0	0	0	3	0	0	3
Cirrhosis of the Liver	3	0	0	0	0	0	0	0	0	3
Diabetes Mellitus	0	0	0	0	0	4	0	0	0	4
Dissecting Aneurysm	0	2	0	0	0	0	0	0	0	2
Enphysema	0	0	0	0	0	0	4	0	0	4
Epilepsy	0	0	1	0	0	0	0	0	0	1
Gastrointestinal Bleed	0	0	0	0	0	1	0	0	0	1
Hypertensive heart disease	0	3	0	0	0	0	0	0	0	3
Hypothyroidism	0	0	0	0	0	1	0	0	0	1
Left Anterior Descending Coronary Artery	0	1	0	0	0	0	0	0	0	1
Lung Cancer	0	0	0	2	0	0	0	0	0	2
Myocardial Infarction	0	1	0	0	0	0	0	0	0	1
Other	0	4	0	3	0	8	1	0	0	16
Peritonitis	0	0	0	0	0	3	0	0	0	3
Phlebothrombosis	0	0	0	0	0	0	1	0	0	1
Pneumonia	0	0	0	0	0	0	5	0	0	5
Pulmonary Embolism	0	0	0	0	0	0	5	0	0	5
SIDS	0	0	0	0	0	3	0	0	0	3
Subarachnoid Hemorrhage	0	0	0	0	0	1	0	0	0	1
Undetermined	0	0	0	0	0	0	0	0	7	7
<b>Total</b>	<b>8</b>	<b>81</b>	<b>1</b>	<b>5</b>	<b>0</b>	<b>23</b>	<b>21</b>	<b>0</b>	<b>7</b>	<b>146</b>

**Natural Deaths by Category (Jurisdiction Assumed – JA Deaths)**

The high proportion of deaths related to the cardiovascular system is typical of national statistics describing natural deaths. By convention, in most Medical Examiner and Coroner’s offices, long term (chronic) alcohol abuse is considered “natural”.

These cancer deaths are usually not diagnosed until autopsy or are investigated for mitigating circumstances such as concern of overdose.



**Natural Deaths by Disease Process and Gender**

Disease Process	Female	Male	Total
Alcohol Abuse	4	4	8
Cardiovascular	25	56	81
Central Nervous System	0	1	1
Malignancy	1	4	5
Other	9	14	23
Respiratory	8	13	21
Undetermined	1	6	7
<b>Total</b>	<b>48</b>	<b>98</b>	<b>146</b>

**Natural Deaths by Gender and Age Group**

Disease Process	Sex	<1	1-9	10-19	20-29	30-39	40-49	50-59	60-69	70-79	80-89	90-99	100-109	Total
Alcohol Abuse	Female	0	0	0	0	0	2	2	0	0	0	0	0	4
Alcohol Abuse	Male	0	0	0	0	1	3	0	0	0	0	0	0	4
<b>Alcohol Abuse Total</b>														<b>8</b>
Cardiovascular	Female	0	0	0	1	2	3	5	9	3	1	1	0	25
Cardiovascular	Male	0	0	1	2	4	5	13	18	8	4	0	0	55
<b>Cardiovascular Total</b>														<b>80</b>
Central Nervous System	Male	0	0	0	1	0	0	0	0	0	0	0	0	1
<b>Central Nervous System Total</b>														<b>1</b>
Malignancy	Female	0	0	0	0	0	0	1	0	0	0	0	0	1
Malignancy	Male	0	0	0	0	0	0	1	3	0	0	0	0	4
<b>Malignancy Total</b>														<b>5</b>
Other	Female	3	0	0	0	2	0	3	1	0	1	0	0	10
Other	Male	2	1	0	2	1	4	3	1	0	0	0	0	14
<b>Other Total</b>														<b>24</b>
Respiratory	Female	1	0	0	0	2	1	2	1	1	0	0	0	8
Respiratory	Male	0	0	0	0	2	2	5	2	1	1	0	0	13
<b>Respiratory Total</b>														<b>21</b>
Undetermined	Female	0	0	0	0	0	0	0	0	1	0	0	0	1
Undetermined	Male	0	0	0	0	0	0	0	4	1	1	0	0	6
<b>Undetermined Total</b>														<b>7</b>
<b>Grand Total</b>		<b>6</b>	<b>1</b>	<b>1</b>	<b>6</b>	<b>14</b>	<b>20</b>	<b>35</b>	<b>39</b>	<b>15</b>	<b>8</b>	<b>1</b>	<b>0</b>	<b>146</b>

Three of the deaths listed as “other” in the <1 age group are attributed to **Sudden Unexplained Infant Death (SUID)**. Sudden unexplained infant death is the death of an infant less than one year of age in which investigation, autopsy, medical history review, and appropriate laboratory testing fails to identify a specific cause of death.

**Natural Deaths by Disease Process (Autopsied)**

AA = Alcohol Abuse

OF = Organ Failure

C = Cardiovascular

O = Other

CNV = Central Nervous System

R = Respiratory

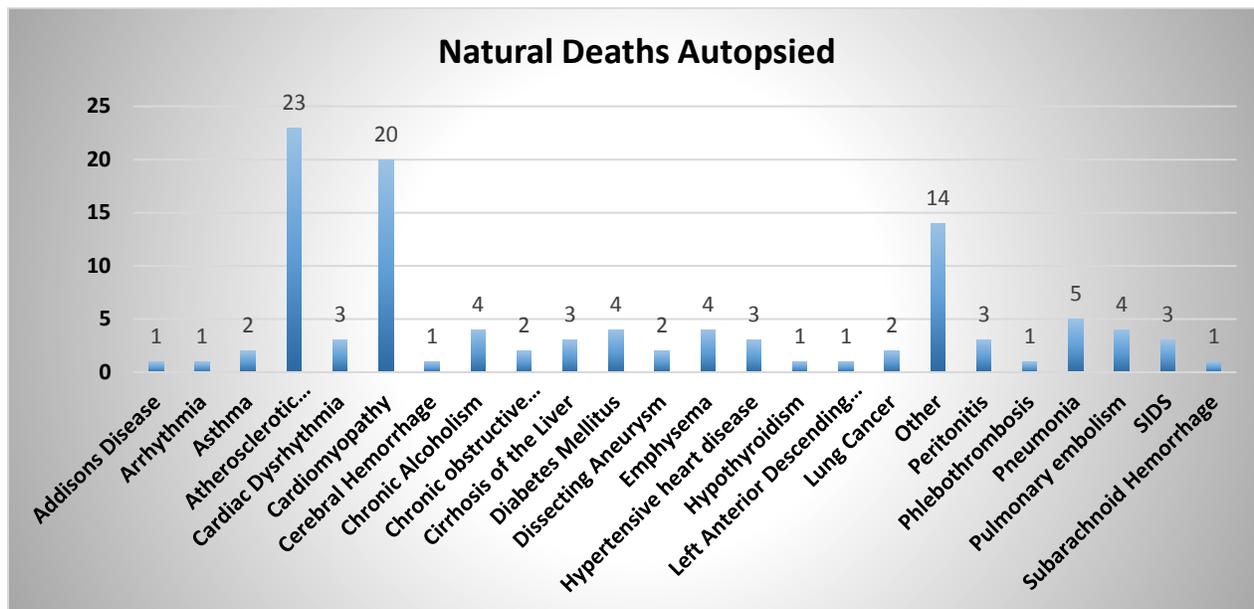
M = Malignancy

SD – Seizure Disorder

U = Undetermined

Natural Deaths Autopsied	AA	C	M	OF	O	R	SD	Total
Addisons Disease	0	0	0	0	1	0	0	1
Arrhythmia	0	1	0	0	0	0	0	1
Asthma	0	0	0	0	0	2	0	2
Atherosclerotic Cardiovascular Disease	0	23	0	0	0	0	0	23
Cardiac Dysrhythmia	0	3	0	0	0	0	0	3
Cardiomyopathy	0	20	0	0	0	0	0	20
Cerebral Hemorrhage	0	0	0	0	1	0	0	1
Chronic Alcoholism	4	0	0	0	0	0	0	4
Chronic obstructive pulmonary disease	0	0	0	0	0	2	0	2
Cirrhosis of the Liver	3	0	0	0	0	0	0	3
Diabetes Mellitus	0	0	0	0	4	0	0	4
Dissecting Aneurysm	0	2	0	0	0	0	0	2
Emphysema	0	0	0	0	0	4	0	4
Hypertensive heart disease	0	3	0	0	0	0	0	3
Hypothyroidism	0	0	0	0	1	0	0	1
Left Anterior Descending Coronary Artery	0	1	0	0	0	0	0	1
Lung Cancer	0	0	2	0	0	0	0	2
Other	0	3	3	0	7	1	0	14
Peritonitis	0	0	0	0	3	0	0	3
Phlebothrombosis	0	0	0	0	0	1	0	1
Pneumonia	0	0	0	0	0	5	0	5
Pulmonary embolism	0	0	0	0	0	4	0	4
SIDS	0	0	0	0	3	0	0	3
Subarachnoid Hemorrhage	0	0	0	0	1	0	0	1
<b>Total</b>	<b>7</b>	<b>56</b>	<b>5</b>	<b>0</b>	<b>21</b>	<b>19</b>	<b>0</b>	<b>108</b>

**Natural Deaths Autopsied**

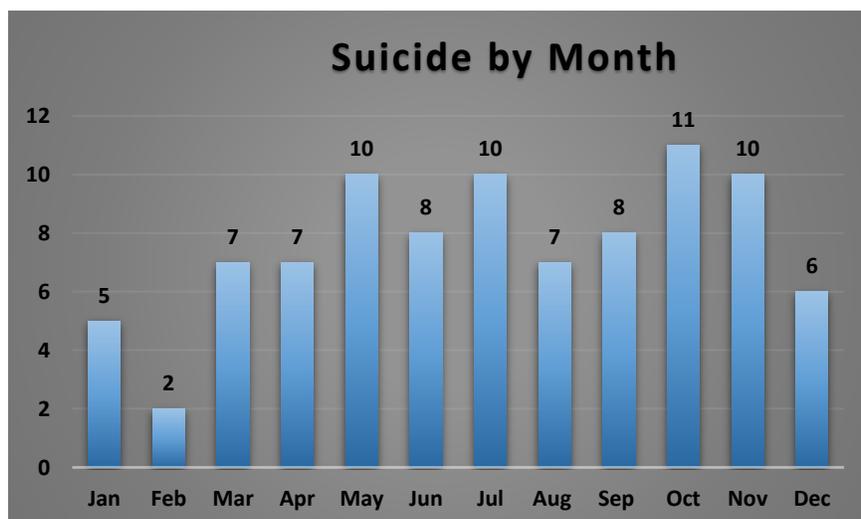


The numbers of cardiovascular deaths reflect the fact that the first symptom of significant heart disease is often a fatal heart attack.

**Suicide**

Suicides are those deaths caused by intentional, self-inflicted injuries. In Spokane County there were (91) suicides in 2016, a decrease of 7 from 2015 which had (98).

The highest number (62/91) of suicides fell within the 20-59 age groups. In the United States, suicide numbers were highest in the 45-54 age range, but the rate by gender was highest in males older than 85 (2008) data. Nationally suicide deaths in older Americans are associated statistically with depression, relationship difficulties, drug and alcohol abuse, and serious physical health problems. Eight suicides occurred in teenagers in Spokane County and 27 in the 20-29 age group.



*Suicide Method by Gender and Age Group*

Suicide Method	Sex	10-19	20-29	30-39	40-49	50-59	60-69	70-79	80-89	90-99	Total
Carbon Monoxide	Female	0	0	0	2	0	0	0	0	0	2
Carbon Monoxide	Male	0	0	1	0	1	2	0	0	0	4
											<b>6</b>
Drugs/Poisons	Female	0	1	1	0	1	1	0	0	0	4
Drugs/Poisons	Male	0	1	2	0	0	1	1	0	0	5
											<b>9</b>
Firearms	Female	0	4	1	2	1	1	0	1	0	10
Firearms	Male	4	12	1	3	3	6	4	1	0	34
											<b>44</b>
Hanging	Female	2	1	1	0	0	0	0	0	0	4
Hanging	Male	1	4	4	2	2	2	0	0	0	15
											<b>19</b>
Jumping	Female	0	0	1	1	1	0	0	0	0	3
Jumping	Male	0	1	1	1	1	0	0	0	0	4
											<b>7</b>
Other	Female	0	0	0	0	0	1	0	0	0	1
Other	Male	0	2	0	0	0	0	0	0	0	2
											<b>3</b>
Plastic Bag	Male	1	0	0	1	0	0	0	0	0	2
											<b>2</b>
Stab/incised wound	Male	0	1	0	0	0	0	0	0	0	1
											<b>1</b>
<b>Total</b>		<b>8</b>	<b>27</b>	<b>13</b>	<b>12</b>	<b>10</b>	<b>14</b>	<b>5</b>	<b>2</b>	<b>0</b>	<b>91</b>

As has been the case in many Medical Examiner years, gunshot wounds remain the most frequent suicide method partly because of the inherent lethality of firearm injuries (44 total). Gunshot wounds are followed by 19 suicidal hanging and 9 intentional overdoses.

The Centers for Disease Control (CDC) report a rise in the U.S. suicide rate, key findings are as follows:

- From 1999 through 2014, the age-adjusted suicide rate in the United States increased 24%, from 10.5 to 13.0 per 100,000 population, with the pace of increase greater after 2006.
- Suicide rates increased from 1999 through 2014 for both males and females and for all ages 10–74.
- The percent increase in suicide rates for females was greatest for those aged 10–14, and for males, those aged 45–64.
- The most frequent suicide method in 2014 for males involved the use of firearms (55.4%), while poisoning was the most frequent method for females (34.1%).

- Percentages of suicides attributable to suffocation increased for both sexes between 1999 and 2014.

Here is a link to the original CDC National Center for Health Statistics (NCHS) report:

<https://www.cdc.gov/nchs/data/databriefs/db241.pdf>.

The suicide rate in Spokane County is 18.5 / 100,000 residents. Spokane County is a medium metro area according to the Centers for Disease Control (CDC). The CDC control graph [CDC MMWR Suicides per 100,000](#) shows Spokane County suicide rate is higher than other medium metro areas.

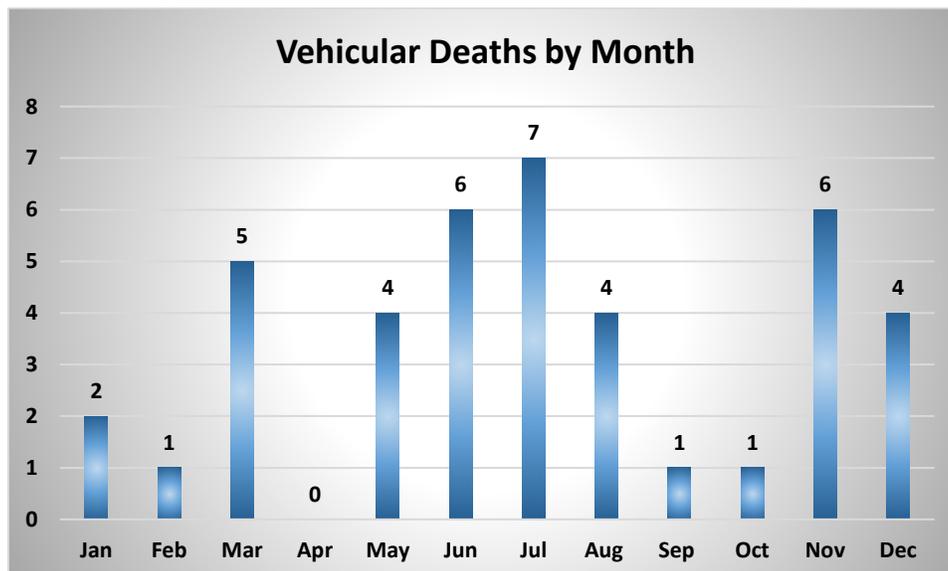
Data Center Report from the Spokane Regional Health District regarding Suicide in Washington's East Region ([Suicide in WA E Region](#)).

## Vehicular

During the calendar year of 2016, The Medical Examiner's Office participated in the investigation of (41) deaths categorized as vehicular. This is a decrease of 15 from 2015 during which (56) deaths were categorized as vehicular..

In vehicle collisions there were 23 deaths, 17 drivers and 6 passengers.

In addition there were 5 deaths among motorcycle operators and 5 pedestrian. There are 2 deaths listed as "other" both were all terrain vehicle (ATV) accidents. There were 4 deaths listed as unknown, 3 were automobile accidents in which it was unknown as to whether the deceased was a driver or a passenger. One of the unknown deaths is the result of a motorcycle accident 23 years prior, it was unknown as to whether the deceased was a driver or a passenger. Finally there were 2 deaths involving bicyclists.



***Vehicular Deaths by Method, Gender, and Age Group***

<b>Vehicular Method</b>	<b>Sex</b>	<b>10-19</b>	<b>20-209</b>	<b>30-39</b>	<b>40-49</b>	<b>50-59</b>	<b>60-69</b>	<b>70-79</b>	<b>80-89</b>	<b>Total</b>
Automobile Driver	Female	1	1	0	0	1	0	1	2	6
Automobile Driver	Male	2	2	0	2	1	2	2	0	11
										<b>17</b>
Automobile Passenger	Female	0	1	0	0	1	1	1	0	4
Automobile Passenger	Male	0	0	0	1	0	0	0	1	2
										<b>6</b>
Bicyclist	Female	0	1	0	0	0	0	0	0	1
Bicyclist	Male	0	0	0	0	0	1	0	0	1
										<b>2</b>
Motorcycle Driver	Male	0	1	0	2	1	1	0	0	5
										<b>5</b>
Other	Male	0	0	2	0	1	0	0	0	3
										<b>3</b>
Pedestrian	Female	1	0	0	0	2	0	1	0	4
Pedestrian	Male	1	0	0	0	0	0	0	0	1
										<b>5</b>
Unknown	Female	0	0	1	0	0	0	0	0	1
Unknown	Male	0	0	1	1	0	0	0	0	2
										<b>3</b>
<b>Total</b>		<b>5</b>	<b>6</b>	<b>4</b>	<b>6</b>	<b>7</b>	<b>5</b>	<b>5</b>	<b>3</b>	<b>41</b>

***Traffic Fatalities and Use of Restraint***

<b>Circumstances</b>	<b>Restrained</b>	<b>Unknown</b>	<b>Unrestrained</b>	<b>Total</b>
Automobile Driver	3	6	2	11
Automobile Passenger	2	1	1	4
<b>Total</b>	<b>5</b>	<b>7</b>	<b>3</b>	<b>15</b>

When traffic victims are flown / transported to Spokane for advanced medical care, it becomes more difficult to collect use of restraint information.

***Undetermined***

“Undetermined” manner is used to designate a death that does not exactly fit the categories natural, suicide, homicide, accident or overlaps between two categories. An example is a death due to medication overdose. In some such deaths, the determination between accident and suicide cannot be made as the decedent’s intent is not clear. Information concerning the circumstances may be lacking because of the absence of background information, or because of a delay between death and the discovery of the body. If an extensive investigation and autopsy cannot clarify the circumstances, the death is placed in this category. There were (14) undetermined manner deaths in Spokane County in 2016.

Although the cause of death was established in almost all of these deaths, the manner still could not be established. Again, the reason for undetermined manner is lack of information or conflicting information.

### ***Undetermined Deaths***

<b>Number</b>	<b>Cause of Death</b>	<b>Month</b>	<b>Sex</b>	<b>Age Yrs</b>	<b>Age Mos</b>	<b>Age Days</b>	<b>Race</b>
1	Drowning	January	M	31	6	27	Caucasian
2	Drowning	March	M	23	2	14	Caucasian
3	Basilar skull fractures with subtotal transection of brainstem due to blunt impact to head	April	M	56	9	28	Caucasian
4	Multi-organ system failure due to septic shock due to peritonitis due to cecal perforation	May	F	0	0	29	Caucasian
5	Drowning	June	M	68	9	24	Caucasian
6	Probable drowning	June	M	27	5	15	Caucasian
7	Undetermined after complete autopsy	August	M	0	0	24	Caucasian
8	Sudden unexplained death in infancy (SUIDI)	September	M	0	3	3	Caucasian
9	Complications of pneumothorax due to rib fractures	September	F	84	8	16	Caucasian
10	Intraoral gunshot wound of the head	October	M	66		14	Caucasian
11	Fractures of C-2 and C- 5-6 spinal column with spinal cord contusion due to blunt impact to face with neck hyper-extension	October	F	73	6	13	Caucasian
12	Probable drowning	November	M	24	7	27	Caucasian
13	Death in utero, cause unknown	December	M	0	0	0	Black
14	Death in utero due to maternal drug use [opiate, methamphetamine] with maternal respiratory arrest	December	F	0	0	0	Caucasian

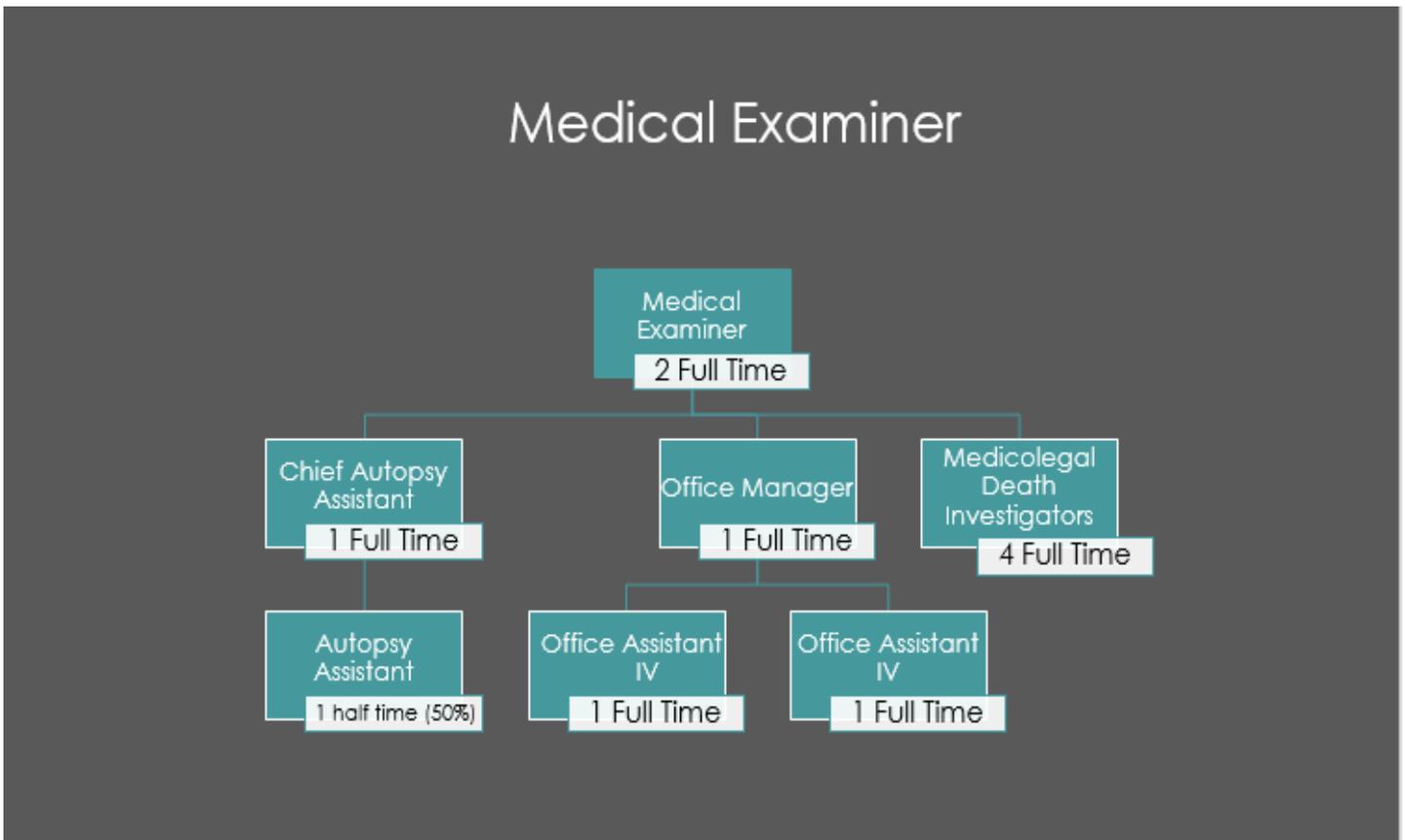
## *Glossary of Terms*

<b>Prescription Drug</b>	Therapeutic drug or Medicine: A substance, other than food, used in the prevention, diagnosis, alleviation, treatment, or cure of disease.
<b>Illicit Drug</b>	A drug used non-medically for personal stimulation/depression/euphoria, use or abuse.
<b>Drug Caused Death</b>	Death directly caused by a drug or drugs in combination with each other, including psychiatric drugs or therapeutic drugs for conditions such as asthma or epilepsy
<b>Jurisdiction</b>	The jurisdiction of the Medical Examiner's Office extends to all reportable deaths occurring within the boundaries of Spokane County, whether or not the incident leading to the death (such as an accident) occurred within the county. Also included are people who are transferred to Spokane area hospitals from surrounding Counties/States, who then expire in Spokane.
<b>Manner</b>	A statistical classification on the death certificate of the way in which the cause of death came about (accident, homicide, suicide, natural, or undetermined).
<b>Manner: Accident</b>	Death other than natural, where there is no evidence of intent, i.e., unintentional. In this report, vehicle accidents are identified separately.
<b>Manner: Homicide</b>	Death due to the acts of another.
<b>Manner: Natural</b>	Death caused solely by organic disease. If natural death is hastened by injury (such as a fall), the manner of death will not be considered natural.
<b>Manner: Suicide</b>	Death as a result of a purposeful action, with intent (explicit or implicit) to end one's life.
<b>Manner: Traffic or Vehicular</b>	Unintentional deaths of drivers (automobile, bicycle or motorcycle), passengers, and pedestrians involving motor vehicles on public roadways. By convention, and at the direction of state vital records, accidents involving motor vehicles on private property (such as driveways) are not included in this category.
<b>Manner: Undetermined</b>	Manner assigned when there is insufficient evidence or information to assign to accident, homicide, suicide, or natural categories, or when two plausible manners are equally likely.
<b>Opioid Drug</b>	A broad class of drugs including morphine, heroin, and synthetic medicines such as methadone.
<b>Poison</b>	Any substance, either taken internally or applied externally, that is injurious to health or dangerous to life.
<b>Race</b>	The racial categories used in this report are: Asian, Black, Caucasian, Hispanic, Native American, Other and Unknown. For public Health purposes, race is included in the Washington State death certificate.

**Sudden Unexplained Infant Death (SUID)**

Applies to the death of an infant less than one year of age, in which (SUID) investigation, autopsy, medical history review, and appropriate laboratory testing fails to identify a specific cause of death. SUID includes cases that meet the definition of Sudden Infant Death Syndrome.

**Medical Examiner Organizational Chart**



The Spokane County Medical Examiner is responsible for death investigation in all of Spokane County to include Federal, State, County and City lands.