

COUNTY OF SPOKANE  
STATE OF WASHINGTON

**OFFICE OF THE MEDICAL  
EXAMINER**

**2018 Annual Report**

5901 N. LIDGERWOOD ST. STE 24B  
SPOKANE, WA 99208-1126  
(509) 477-2296

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.”*

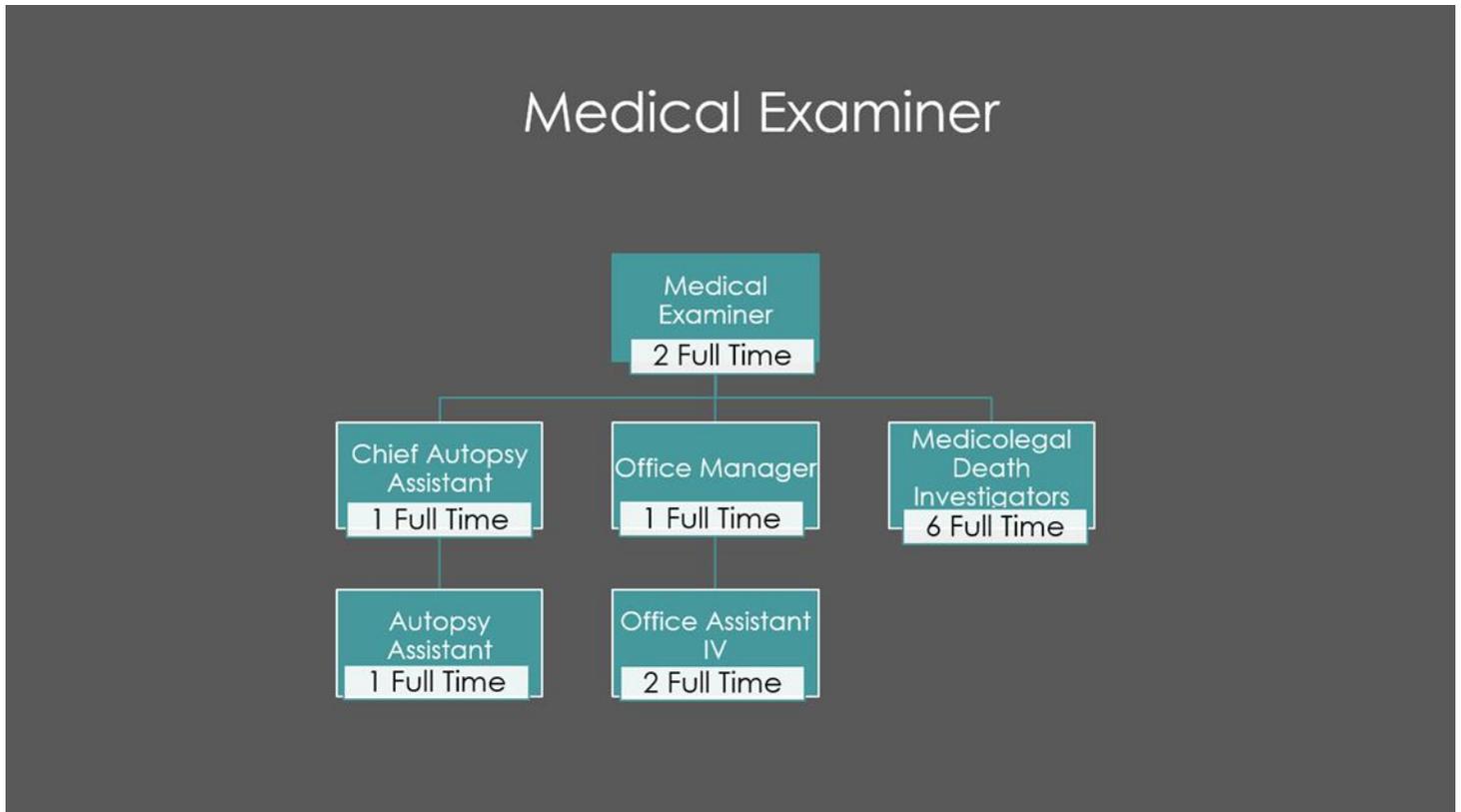
### **Introduction**

*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 88 Medical Examiner/Coroners systems in the United States are currently accredited. There are 1923 Medical Examiner jurisdictions in the United States.***

*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, the Prosecutor’s Office or the Spokane County Sheriff’s Office. The Medical Examiner’s Office is an independent entity.*

*The office employs two forensic pathologists, an office manager, six full time investigators, two full time administrative staff, one chief autopsy assistant, one full time autopsy assistant, as well as 2 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 \$ 570,000.00. The latest grant was awarded in March 2016. The last two Coverdell grants provided updated dental x-ray capabilities and new sample storage freezers and refrigerators. At the time of the writing of this report in 2019, this office learned it was awarded an additional Paul Coverdell Forensic Science grant funds for 2020, in the approximate amount of \$ 270,000 total. These funds will be utilized for full body x-ray scanning equipment in a new state-of-the-art Medical Examiner facility. Spokane County broke ground for the new facility in May 2019 with expected occupancy in June 2020.*

**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.***

## Foreword

Information presented in this annual report has been compiled from deaths that were reported to the Spokane County Medical Examiner's Office in 2018. This summarized report presents data in a variety of formats with the objective of providing useful information to diverse groups in the community. The 2018 report was delayed for many months because of the backlog in the Washington State Toxicology laboratory.

**Referral Caseload:** In addition to assuming statutory responsibility for unexpected deaths in Spokane County, the Spokane County Medical Examiner's Office performs autopsies for 12 "outside" counties in Eastern Washington and the Idaho panhandle. In 2018 a total of 135 autopsies were performed for the following referral counties, Asotin, Benewah, Bonner, Boundary, Clearwater, 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 \$262,808.00 in 2018.

### OUTSIDE COUNTY AUTOPSIES

2018	135
2017	157
2016	126
2015	130
2014	139
2013	125
2012	136
2011	186

### SPOKANE COUNTY AUTOPSIES

2018	396
2017	432
2016	415
2015	430
2014	354
2013	408
2012	373
2011	359

- Note 16 of the 396 Spokane County Cases were external body examinations and not complete autopsies and 2 were partial examinations

### Outside County Autopsies per County

	2018	2017	2016	2015	2014	2013	2012	2011
<i>Asotin</i>	6	3	4	7	2	1	4	3
<i>Benewah</i>	2	2	2	2	2	1	1	2
<i>Bonner</i>	11	15	7	19	12	9	14	15
<i>Boundary</i>	3	4	0	4	6	3	6	4
<i>Clearwater</i>	3	4	5	0	0	0	0	0
<i>FBI</i>	0	0	0	0	0	0	0	1
<i>Garfield</i>	0	2	0	0	1	0	2	1
<i>Kootenai</i>	42	53	46	50	57	49	47	84
<i>Lewis</i>	N/A	N/A	N/A	0	0	0	1	1
<i>Lincoln</i>	3	4	6	4	7	6	5	3
<i>Nez Perce</i>	10	15	11	4	9	10	10	16
<i>Pend Oreille</i>	9	6	10	10	8	8	7	12
<i>Shoshone</i>	9	19	9	3	7	8	10	9
<i>Stevens</i>	37	30	26	24	28	30	29	35

*In 2016 Spokane County began service to the Clearwater County Coroner. Service to Lewis County was discontinued in 2013.*

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

### Criteria for Reportable Deaths (Washington State Law)

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. The office has been continually accredited since, with annual self-inspections, and on-site inspections every 4 years. 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 trained and 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. Please refer to the following chart for some of the data required as part of accreditation by the National Association of Medical Examiners.

### ***2018 N.A.M.E. Data***

Deaths in Spokane County	5295
Deaths Reported to the Medical Examiner's Office	4346
Deaths Investigated by the Medical Examiner's Office (JA)	662
Scenes Investigated by the Medical Examiner Office	352
Bodies transported by order of the office via Contract Body Transport	429
○ Total bodies transported to the Forensic Institute	715
Total External Body Examinations	16
Total Partial Autopsies	2
➤ Total Complete Autopsies	513
Hospital Autopsies Retained Under Medical Examiner Jurisdiction	0
Microscopic Studies Performed	513
Neuropathologic Studies Performed	2
Cardiac Pathologic Studies Performed	3
Autopsies Performed for Outside Jurisdictions	135
Bodies Unidentified after Examination	0
▪ Organ Donors	15
Corneal Donors	25
Bone Donors	17
Connective Tissue Donors	19
Heart Valve Donors	4
Skin Donors	12
Unclaimed bodies	25
Exhumations	0

- Some decedents are not transported via contract transport; these include deaths that occur at Holy Family Hospital (151), where the Forensic Institute is housed; as well as deaths that occur in a referral county (135).
- 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.

### ***Spokane County Medical Examiner Cases in 2018 (Excluding all referral County Autopsies)***

In 2018, there were 5,295 deaths in Spokane County. Based on the latest United States Census Bureau data the estimated population of Spokane County is 506,152. The 5,295 deaths thus represent approximately 1% of the population. Of these deaths, 4,346 or 82% 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 662 (15%) 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 had 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. In 2018 all nursing home and adult care facilities deaths were still reported to the Medical Examiner's Office. Beginning in 2019 only selected nursing home and adult care facility deaths were reported, those meeting hospital reporting criteria.



### ***Next of Kin Notification***

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 office always coordinates next-of-kin notification and typically takes responsibility for notifying next-of-kin of the death.

### ***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.

## **Section 2: Total Cases**

### ***Total Cases for 2018***

<b>Total Spokane County Population</b>	506,152
<b>Total Deaths in Spokane County</b>	5295
<b>Total Deaths Reports to the Medical Examiner in 2017</b>	4,346
<b>Total Jurisdiction Released after Investigation</b>	3682
<b>Total Spokane County Jurisdiction Assumed Cases</b>	662
<b>Total Spokane County Complete Autopsies Performed</b>	378
<b>Total Spokane County External Examinations Performed</b>	16
<b>Total Spokane County Partial Examinations Performed</b>	2

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

The death certificate is a Washington State Health Department document, not a medical examiner or coroner document.

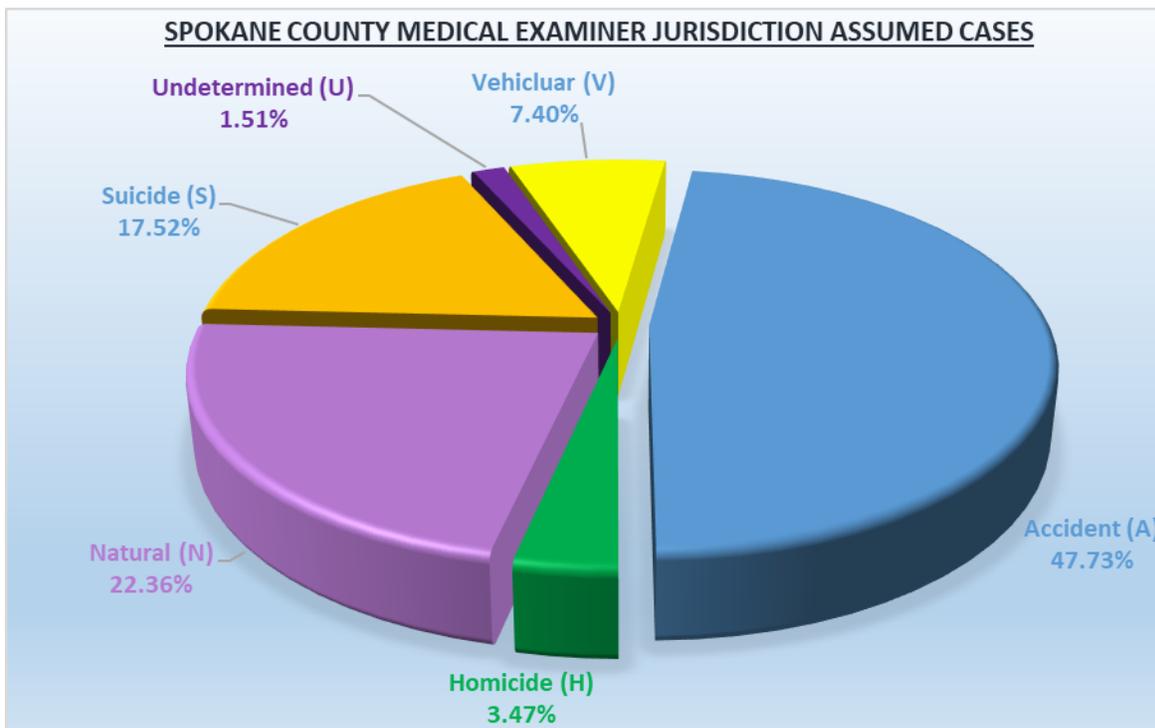
The death certification process includes classification of the manner of death (Natural, Accident, Suicide, Homicide, or Undetermined), intended to describe the action associated with a death, if any, for public health department vital statistics purposes. In the vast majority of deaths, Washington State 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.

*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. No law enforcement agency is bound or limited by the manner of death on a death certificate.***

Jurisdiction Assumed Cases by Manner of Death 2018	Number of Deaths	Percent of Total
Accident (A)	316	47.73%
Homicide (H)	23	3.47%
Natural (N)	148	22.36%
Suicide (S)	116	17.52%
Undetermined (U)	10	1.51%
Vehicular (V)	49	7.40%
<b>Total</b>	662	

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



	Jurisdiction Released Cases	Outside Agency Deaths Reported (Adult Care Facilities, Nursing Homes, Hospice, etc)	❖ Spokane County Autopsies Completed	Referral County Autopsies Completed
January	118	238	28	7
February	112	183	31	10
March	111	201	30	12
April	91	183	38	8
May	95	218	32	13
June	105	178	36	17
July	112	197	34	17
August	118	216	36	14
September	91	167	28	10
October	107	214	35	12
November	95	197	30	7
December	119	215	38	8
<b>Total</b>	<b>1274</b>	<b>2407</b>	<b>396</b>	<b>135</b>

❖ Includes 396 Spokane County complete autopsies, 16 external only examinations and 2 partial examinations. In addition to the Spokane County autopsies, the Medical Examiner’s Office performed 135 complete autopsies for neighboring referral counties, for a total of 513 complete autopsies performed by Spokane County Medical Examiners.

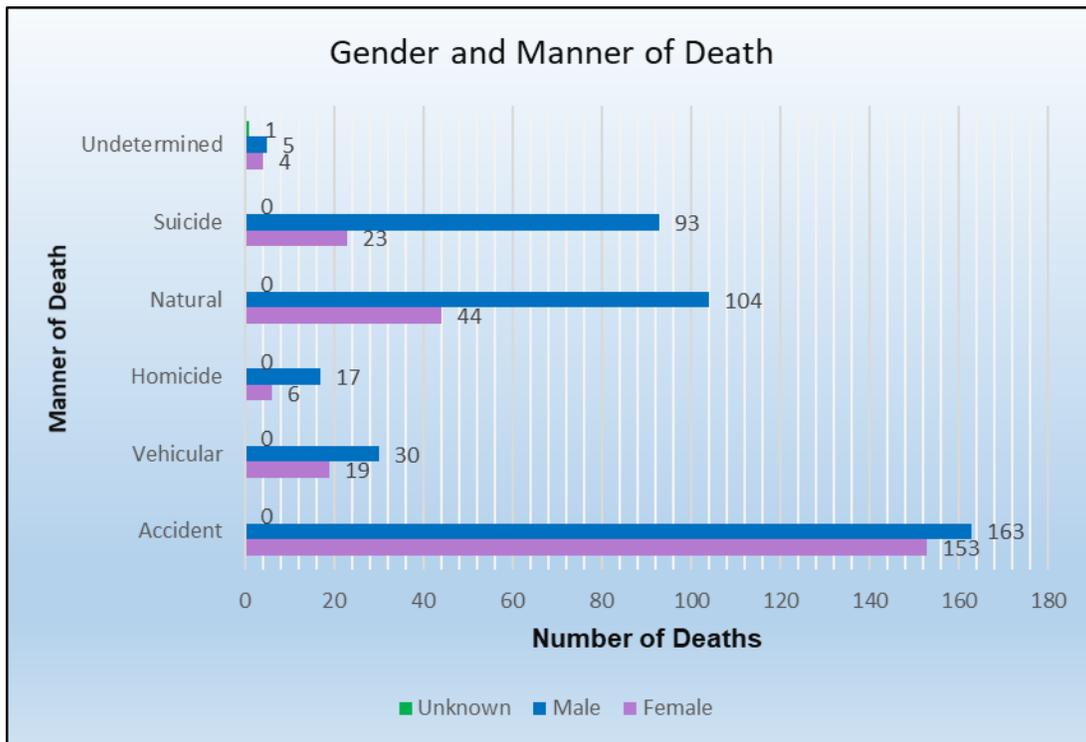
**Total Cases by Gender and Manner of Death (All Jurisdiction Assumed deaths, with or without autopsy)**

- A – Accident
- V – Vehicular
- H – Homicide
- N – Natural
- S – Suicide
- U – Undetermined
- P – Pending

Sex	A	V	H	N	S	U	Total	Percent
Female	153	19	6	44	23	4	249	37.61%
Male	163	30	17	104	93	5	412	62.24%
Unknown	0	0	0	0	0	1	1	0.15%
<b>Total</b>							<b>662</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.

**Gender and Manner of Death**



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 5295 Spokane County Deaths
	A	H	N	S	U	V	P	NC			
Asian	2	0	3	1	0	0	0	0	0	6	0.11%
Black	10	4	8	2	0	0	0	0	0	24	0.45%
Caucasian	284	17	130	109	8	39	1	0	0	588	11.10%
Hispanic	6	0	2	2	0	4	0	0	0	14	0.26%
Native American	11	1	5	1	0	4	0	0	0	22	0.42%
Other	1	1	0	1	0	1	0	0	0	4	0.08%
Unknown	1	0	0	0	2	1	0	0	0	4	0.08%
	<b>315</b>	<b>23</b>	<b>148</b>	<b>116</b>	<b>10</b>	<b>49</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>662</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 378 cases a complete autopsy was performed, in 16 cases an external body examination was performed, in 2 case a partial autopsy was performed. In 266 cases the death certificate was signed based on death investigation and/or medical records.

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.

Age and Manner of Death							
Age Group (Years)	A	H	N	S	U	V	Total
Unknown Age	0	0	0	0	1	0	1
0-9	2	2	14	2	0	0	20
10-19	4	1	1	7	0	4	17
20-29	18	4	1	23	0	9	55
30-39	27	4	15	21	2	9	78
40-49	30	2	14	13	1	4	64
50-59	22	5	41	17	5	10	100
60-69	30	2	33	19	1	7	92
70-79	44	2	18	9	0	3	76
80-89	83	1	8	5	0	2	99
90-99	52	0	3	0	0	1	56
100-109	4	0	0	0	0	0	4
	<b>316</b>	<b>23</b>	<b>148</b>	<b>116</b>	<b>10</b>	<b>49</b>	<b>662</b>

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

Age Group (Years)		Female	Male	Unknown Gender
Unknown Age	1	0	0	1
0 to 9	20	5	15	0
10 to 19	17	4	13	0
20 to 29	55	14	41	0
30 to 39	78	24	54	0
40 to 49	64	22	42	0
50 to 59	100	28	72	0
60 to 69	92	27	65	0
70 to 79	76	31	45	0
80 to 89	99	52	47	0
90 to 99	56	39	17	0
10 to 109	4	4	0	0
<b>Total</b>	<b>662</b>	<b>250</b>	<b>411</b>	<b>1</b>

The 1 case in which gender is unknown is a case in which only a portion of occipital bone (part of a skull) possibly human, was found. This portion of bone was sent to the WA State Forensic Anthropologist for examination.

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

In 2018 there were a total of 51 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: 31 Accidents, 12 motor vehicle accidents, 1 natural, 6 suicides and 1 undetermined. Please see the link to the data below:

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

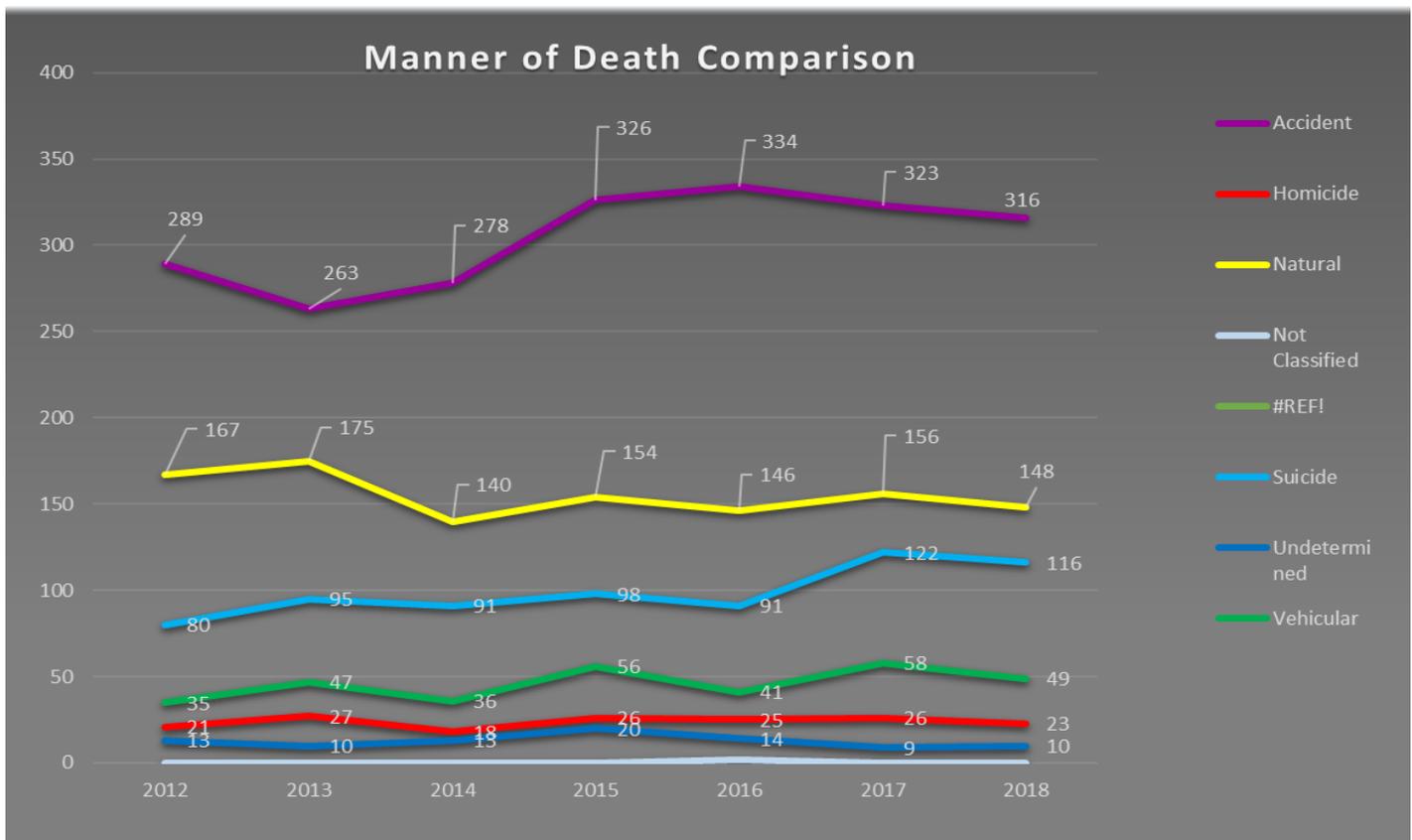
**Section 3: Multi-Year Comparison**

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.

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

**Comparison of Manners of Death 2012-2018**

Manner of Death	2012	2013	2014	2015	2016	2017	2018
Accident	289	263	278	326	334	323	316
Homicide	21	27	18	26	25	26	23
Natural	167	175	140	154	146	156	148
Not Classified	0	0	0	0	2	0	0
Suicide	80	95	91	98	91	122	116
Undetermined	13	10	13	20	14	9	10
Vehicular	35	47	36	56	41	58	49
<b>Total</b>	<b>605</b>	<b>617</b>	<b>576</b>	<b>680</b>	<b>653</b>	<b>694</b>	<b>662</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. The increase in accidents over time is the result of the diligence of the Medical Examiner’s Office in investigating deaths such as hip fractures in the elderly and prescription overdose deaths. The increase in suicides reflects national trends. The

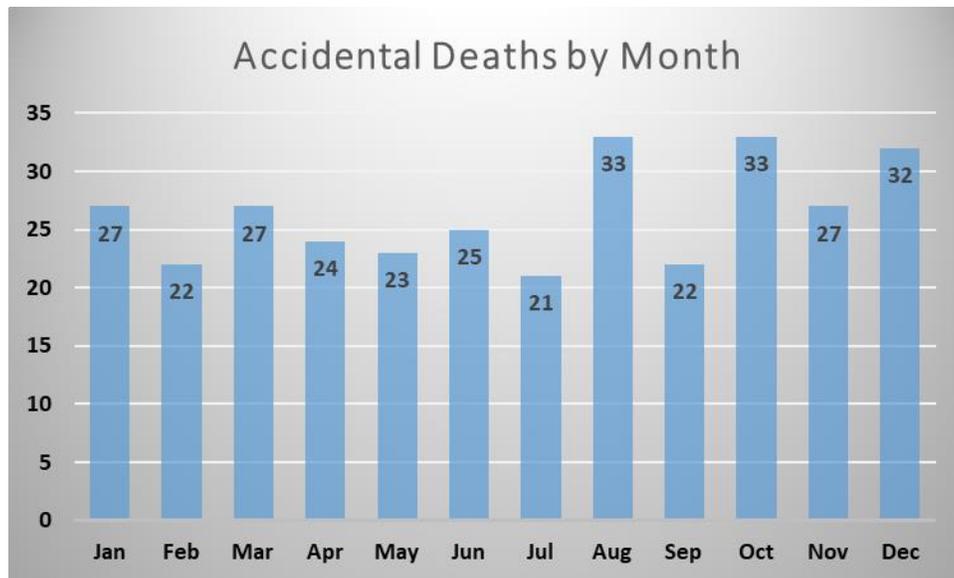
office has been releasing jurisdiction more in natural deaths, but assumes jurisdiction for more accidents.



The proportions of the manners of death have remained remarkably similar through the years, but suicides spiked in 2017 with 6 fewer in 2018.

Manner of Death	2012	2013	2014	2015	2016	2017	2018
Accident	47.77%	42.63%	48.26%	47.94%	51.15%	46.54%	47.73%
Homicide	3.47%	4.38%	3.13%	3.82%	3.83%	3.75%	3.47%
Natural	27.60%	28.36%	24.31%	22.65%	22.36%	22.48%	22.36%
Not Classified	0.00%	0.00%	0.00%	0.00%	0.31%	0.00%	0.00%
Suicide	13.22%	15.40%	15.80%	14.41%	13.94%	17.58%	17.52%
Undetermined	2.15%	1.62%	2.26%	2.94%	2.14%	1.30%	1.51%
Vehicular	5.79%	7.62%	6.25%	8.24%	6.28%	8.36%	7.40%

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.

**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 (About 2/3 of Medical Examiner Jurisdiction Assumed deaths). 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.

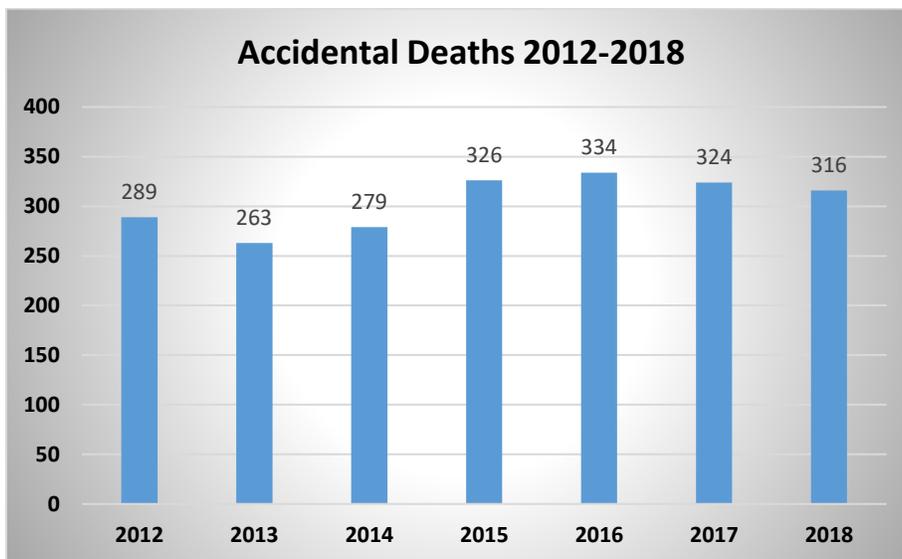
<b>Accident Mode</b>	<b>Female</b>	<b>Male</b>	<b>Total</b>
Alcohol Abuse	3	1	4
Anaphylaxis	0	1	1
Asphyxiation	2	1	3
Aspiration	0	1	1
Bicycle Fall	0	1	1
Choking	2	2	4
Drowning	2	2	4
Drugs	18	53	71
Prescribed Drugs	11	2	13
Fall	106	79	185
Fire/burns	3	3	6
Firearms	1	3	4
Hyperthermia	0	2	2
Hypothermia	0	4	4
Industrial Accident	0	2	2
Motorcycle Driver (race track)	0	1	1
Other	4	5	9
Therapy Complication	1	0	1
<b>Total</b>	<b>153</b>	<b>163</b>	<b>316</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	Female	0	0	0	1	1	1	0	0	0	0	0	0	3
Alcohol Abuse	Male	0	0	0	0	0	0	1	0	0	0	0	0	1
														4
Anaphylaxis	Female	0	0	0	0	0	0	0	0	0	0	0	0	0
Anaphylaxis	Male	0	0	0	1	0	0	0	0	0	0	0	0	1
														1
Asphyxiation	Female	0	0	0	0	0	1	1	0	0	0	0	0	2
Asphyxiation	Male	0	0	0	0	0	0	1	0	0	0	0	0	1
														3
Aspiration	Female	0	0	0	0	0	0	0	0	0	0	0	0	0
Aspiration	Male	1	0	0	0	0	0	0	0	0	0	0	0	1
														1
Bicycle Fall	Female	0	0	0	0	0	0	0	0	0	0	0	0	0
Bicycle Fall	Male	0	1	0	0	0	0	0	0	0	0	0	0	1
														1
Choking	Female	0	0	0	0	0	1	0	0	0	0	1	0	2
Choking	Male	0	0	0	0	0	0	0	1	0	1	0	0	2
														4
Drowning	Female	0	0	0	0	0	0	1	1	0	0	0	0	2
Drowning	Male	0	0	0	0	0	2	0	0	0	0	0	0	2
														4
Drugs	Female	0	0	0	4	3	8	1	2	0	0	0	0	18
Drugs	Male	0	0	2	8	14	11	10	8	0	0	0	0	53
														71
Fall	Female	0	0	0	0	1	1	2	4	16	44	34	4	106
Fall	Male	0	0	0	0	1	0	1	5	24	35	13	0	79
														185
Fire/burns	Female	0	0	0	0	1	0	0	1	1	0	0	0	3
Fire/burns	Male	0	0	0	0	0	0	0	1	1	1	0	0	3
														6
Firearms	Female	0	0	0	0	0	0	0	1	0	0	0	0	1
Firearms	Male	0	0	1	2	0	0	0	0	0	0	0	0	3
														4
Other	Female	0	0	0	0	0	1	0	0	1	1	1	0	4
Other	Male	0	0	0	0	1	0	1	1	0	0	2	0	5
														9
Prescribed Drugs	Female	0	0	0	1	4	1	2	3	0	0	0	0	11
Prescribed Drugs	Male	0	0	0	1	1	0	0	0	0	0	0	0	2
														13
Therapy Complication	Female	0	0	0	0	0	1	0	0	0	0	0	0	1
Therapy Complication	Male	0	0	0	0	0	0	0	0	0	0	0	0	0
														1
Hyperthermia	Female	0	0	0	0	0	0	0	0	0	0	0	0	0
Hyperthermia	Male	0	0	0	0	0	1	0	1	0	0	0	0	2
														2
Hypothermia	Female	0	0	0	0	0	0	0	0	0	0	0	0	0
Hypothermia	Male	0	0	0	0	0	1	1	0	0	1	1	0	4
														4
Industrial Accident	Female	0	0	0	0	0	0	0	0	0	0	0	0	0
Industrial Accident	Male	0	0	0	0	0	0	0	1	1	0	0	0	2
														2
Motorcycle Driver (race track)	Female	0	0	0	0	0	0	0	0	0	0	0	0	0
Motorcycle Driver (race track)	Male	0	0	1	0	0	0	0	0	0	0	0	0	1
														1
<b>Grand Total</b>		<b>1</b>	<b>1</b>	<b>4</b>	<b>18</b>	<b>27</b>	<b>30</b>	<b>22</b>	<b>30</b>	<b>44</b>	<b>83</b>	<b>52</b>	<b>4</b>	<b>316</b>

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

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



Accident Circumstances	2012	2013	2014	2015	2016	2017	2018
Aircraft	0	0	0	4	0	0	0
Alcohol Abuse	1	8	2	5	1	3	4
Anaphylaxis	0	1	0	0	1	0	1
Asphyxiation	4	3	6	3	5	3	3
Aspiration	4	0	1	2	0	0	1
Bicycle Fall	1	0	2	1	0	1	1
Choking	6	1	7	6	4	12	4
Drowning	8	7	5	7	5	3	4
Drugs	30	33	30	66	81	67	71
Prescribed Drugs	43	24	32	16	34	8	13
Electrocution	0	0	0	0	0	0	0
Fall	172	156	176	179	181	192	185
Farm	0	0	0	1	0	1	0
Fire/burns	3	3	3	5	5	7	6
Firearms	1	3	0	1	3	1	4
Hyperthermia	0	0	1	4	3	1	2
Hypothermia	2	8	3	15	3	10	4
Industrial Accident	1	2	3	1	1	4	2
Motorcycle Driver (race track)	0	0	0	0	0	0	1
Other	13	13	7	9	6	7	9
Struck by Object	0	0	0	0	1	3	0
Surgical Procedure	0	1	0	0	0	0	0
Therapy Complication	0	0	1	1	0	1	1
<b>Total</b>	<b>289</b>	<b>263</b>	<b>279</b>	<b>326</b>	<b>334</b>	<b>324</b>	<b>316</b>

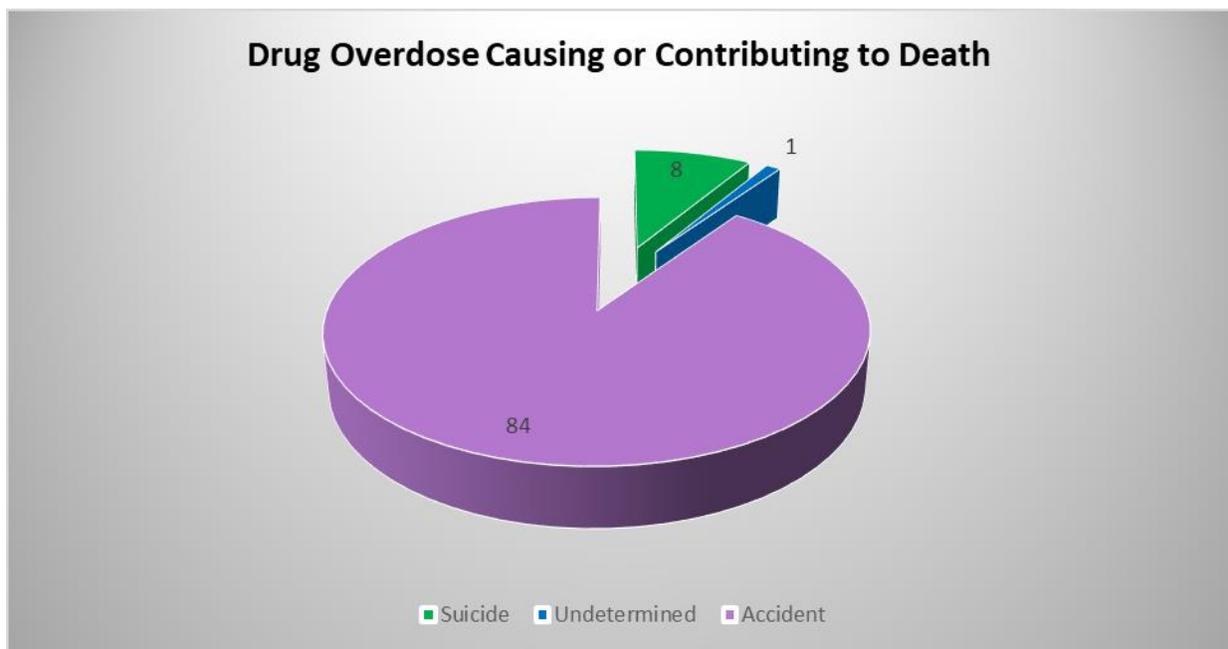
Toxicology may show numerous combinations of medications and illicit drugs, but such deaths are categorized in the chart above as “Drugs”. Prescribed drugs is an exclusive category.

## Drug Overdose Data Summary 2018

In 2018 a total of 84 accidental deaths had prescription / and or illicit drugs listed on the death certificate as causing or contributing to death. Of the 84 deaths 70 had drugs listed in the primary cause of death, in the others the drugs contributed to death.

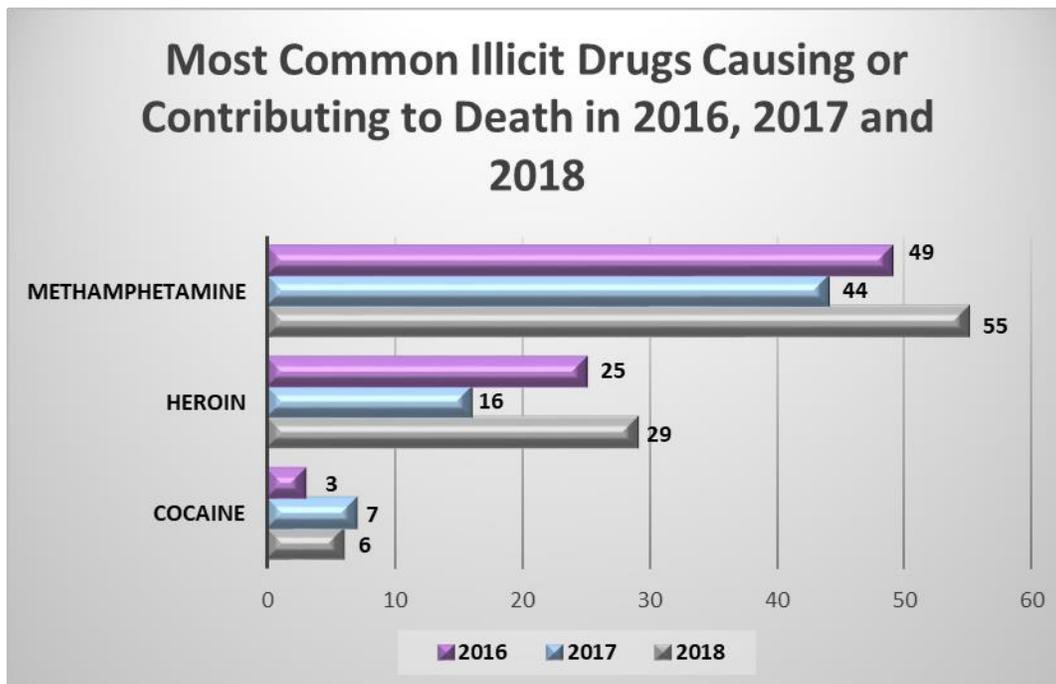
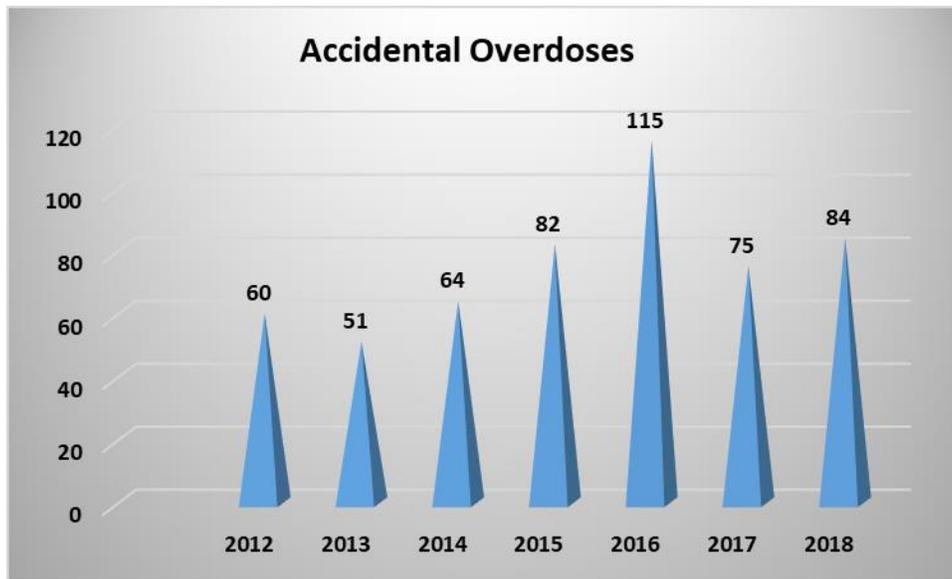
Drug Overdoses causing or contributing to 93 deaths, 8 were intentional (suicide) deaths:

- 8 deaths      Suicide
- 1 deaths      Undetermined (accident vs. suicide)
- 84 deaths      Accident

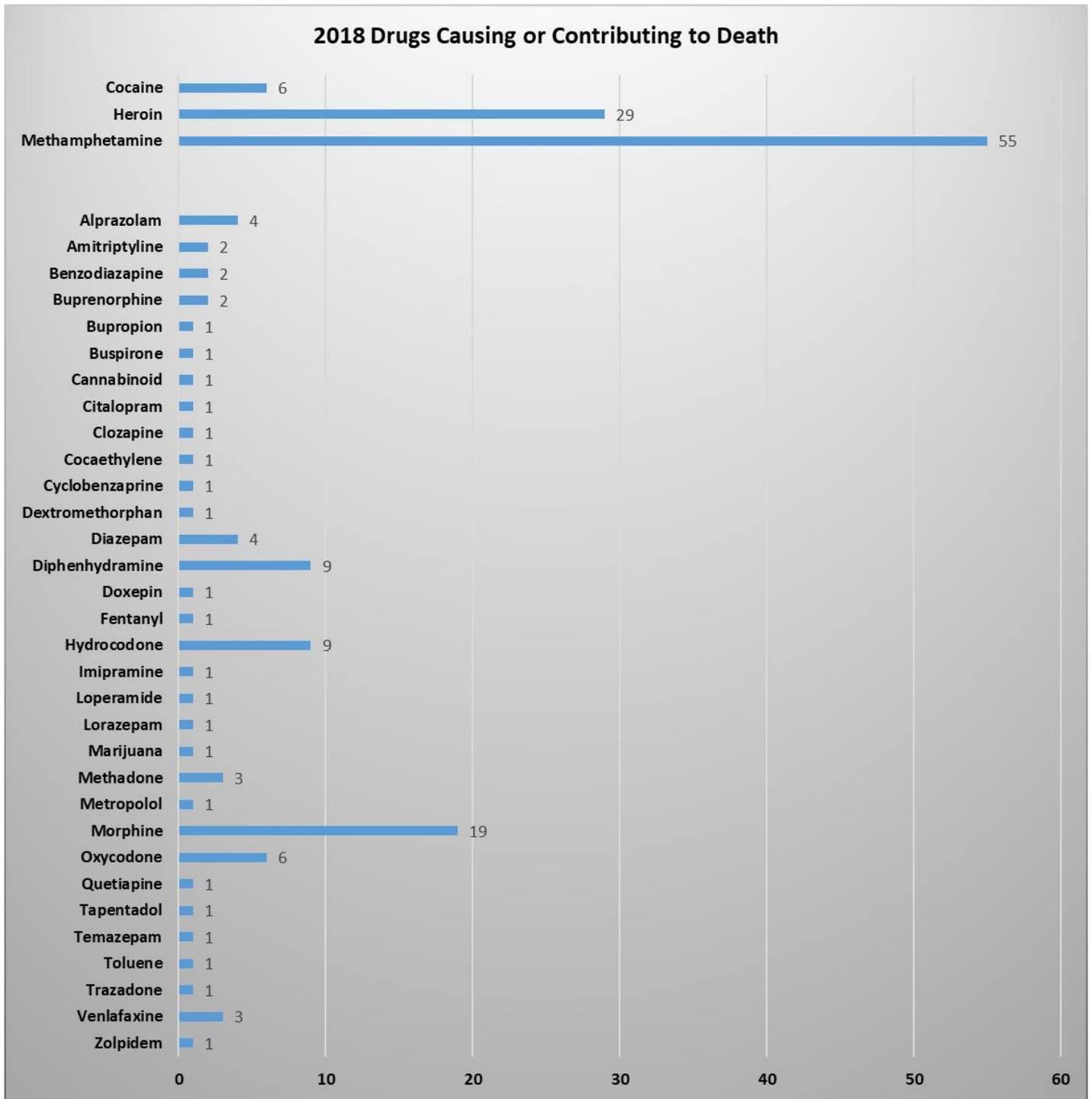


Overdose deaths may be classified as “accidents”. The federal government data categorizes overdose deaths as “unintentional poisoning deaths”. Centers for Disease Control (CDC) data suggests that poisoning deaths have decreased slightly from 2017 to 2018. (See link to CDC Morbidity and Mortality Weekly Report (MMWR) Vol. 68 / No. 34) [MMWR Vol 68 No 34](#) .

Data below shows accidental drug overdose deaths in Spokane County, in which prescription and/or illicit drugs were demonstrated in toxicology.



The above chart represents the most common illicit drugs found in Accidental Deaths in Spokane County in 2016, 2017 and 2018. These are listed either as the primary cause of death or as contributing to death on the death certificate.



The 19 morphine deaths may reflect heroin (rapidly converted to morphine in the body), morphine (a prescription drug) or prescription drugs, such as codeine that are converted to morphine in the body.

Fentanyl deaths are increasing nationally, Spokane saw only one fentanyl death in 2018.

## Homicide

In 2018 there were 23 recorded homicides, this is a decrease of 3 from the previous year. Firearms accounted for the single largest method of homicide (11 of 23). Firearms also accounted for the largest number of deaths by suicide.

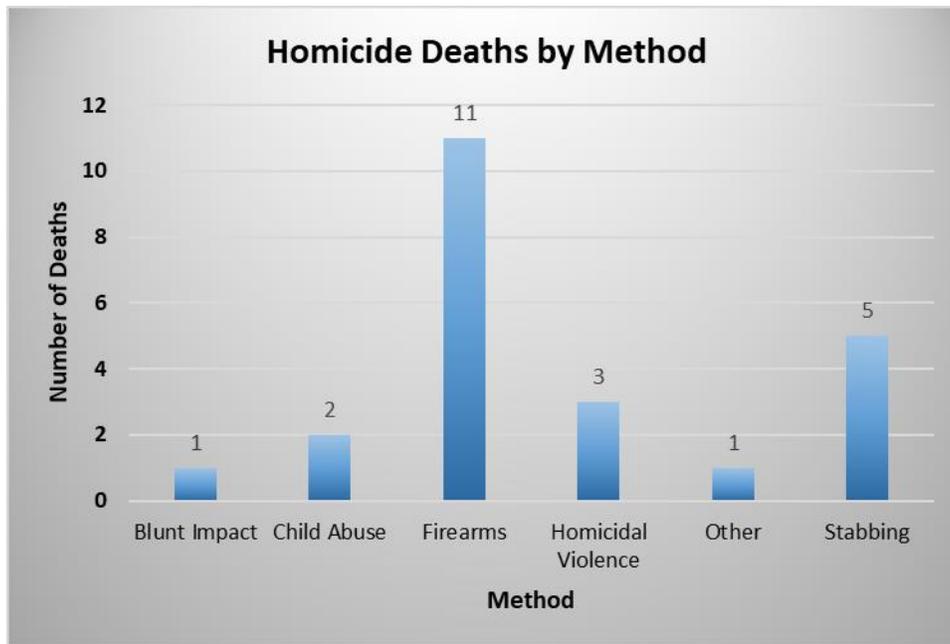


**Homicide Deaths by Method, Gender, and Age Group**

Homicide Method	Sex	<1	1-9	10-19	20-29	30-39	40-49	50-59	60-69	70-79	80-89	Total
Blunt Impact	Male	0	0	0	0	0	0	1	0	0	0	1
												1
Child Abuse	Female	1	0	0	0	0	0	0	0	0	0	1
Child Abuse	Male	1	0	0	0	0	0	0	0	0	0	1
												2
Firearms	Female	0	0	0	0	0	0	1	0	0	0	1
Firearms	Male	0	0	1	3	2	2	2	0	0	0	10
												11
Homicidal Violence	Female	0	0	0	0	0	0	0	0	1	0	1
Homicidal Violence	Male	0	0	0	0	0	0	1	0	1	0	2
												3
Other	Female	0	0	0	0	0	0	0	0	0	1	1
												1
Stabbing	Female	0	0	0	0	0	0	0	2	0	0	2
Stabbing	Male	0	0	0	1	2	0	0	0	0	0	3
												5
<b>Grand Total</b>		<b>2</b>	<b>0</b>	<b>1</b>	<b>4</b>	<b>4</b>	<b>2</b>	<b>5</b>	<b>2</b>	<b>2</b>	<b>1</b>	<b>23</b>



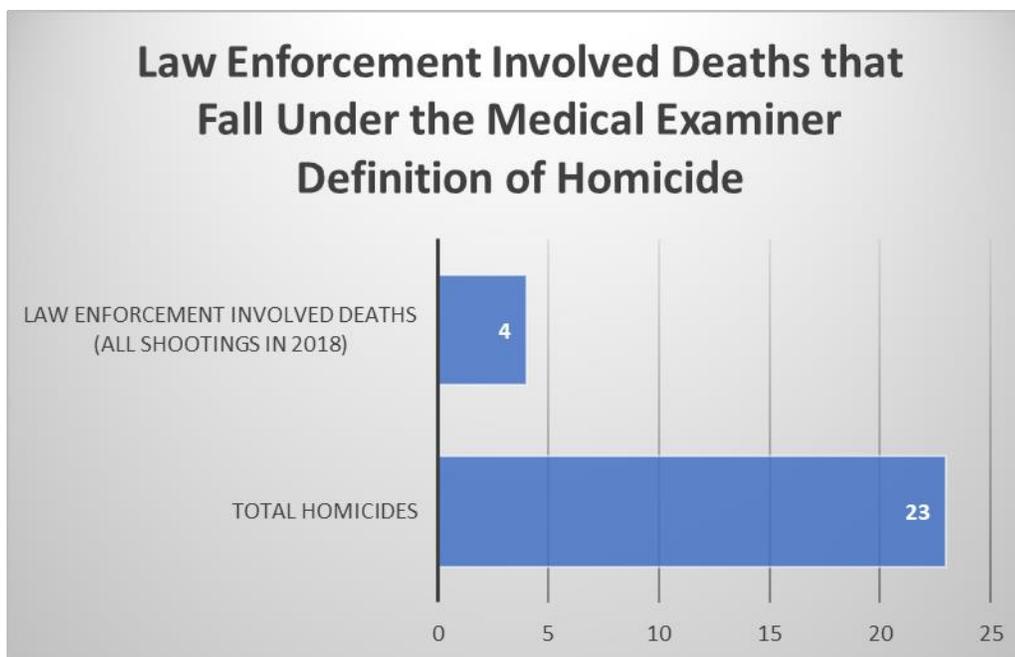
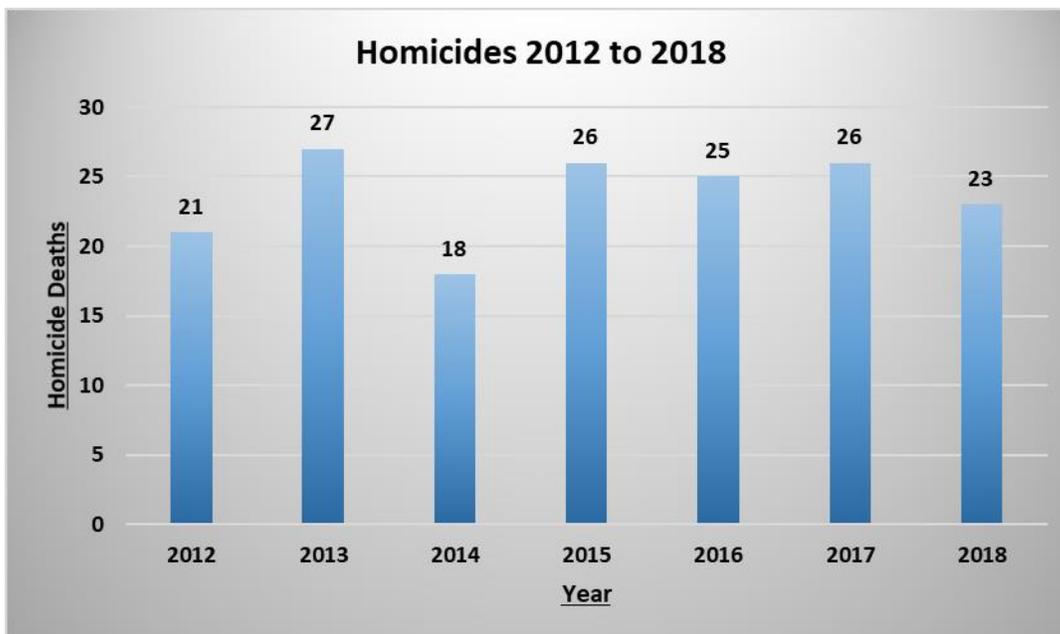
This graph is limited statistically by the small number of total deaths it represents.



**Homicide Methods Comparison**

Method Used	2012	2013	2014	2015	2016	2017	2018
Asphyxia	0	0	0	1	1	0	0
Blunt Impact	0	1	0	0	1	0	1
Child Abuse	1	1	0	2	3	3	2
Firearms	11	19	12	12	12	17	11
Homicidal Violence	1	1	2	0	4	3	3
Other	0	3	0	6	1	0	1
Stabbing	3	0	3	3	3	2	5
Strangulation	5	2	1	2	0	1	0
<b>Total</b>	<b>21</b>	<b>27</b>	<b>18</b>	<b>26</b>	<b>25</b>	<b>26</b>	<b>23</b>

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

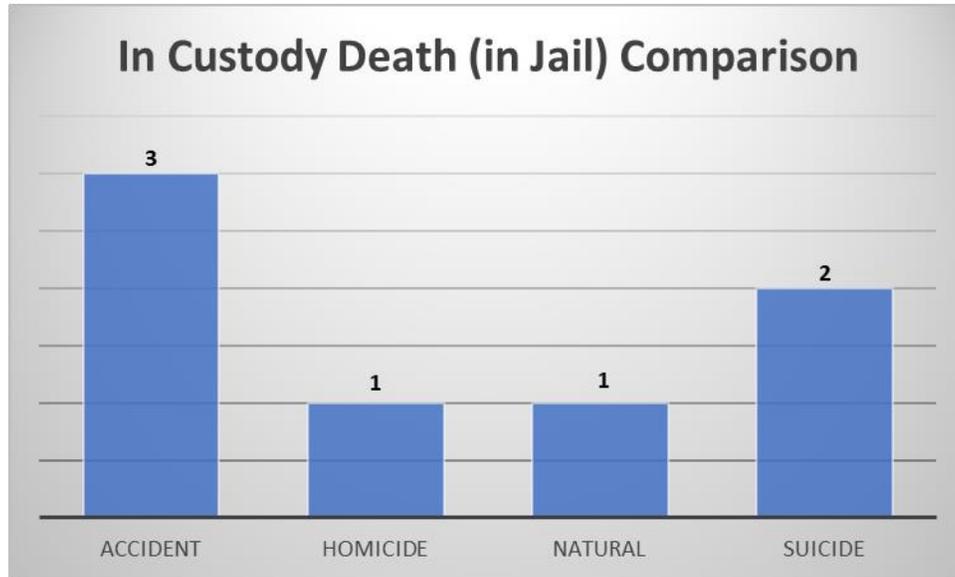


The total number of homicides in Spokane County is 23. Under the Medical Examiner definition of homicide, there were 4 Law Enforcement related deaths (all shootings) categorized as homicide. This equates to 17.4% of homicides.

Homicide is defined as a death due to the acts of another.

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 and therefore 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; nor is the manner of death as determined by a Medical Examiner the same as the prosecutor's legal determination.

***Manner of Comparison of individuals who died while in Law Enforcement Custody (in Jail)***

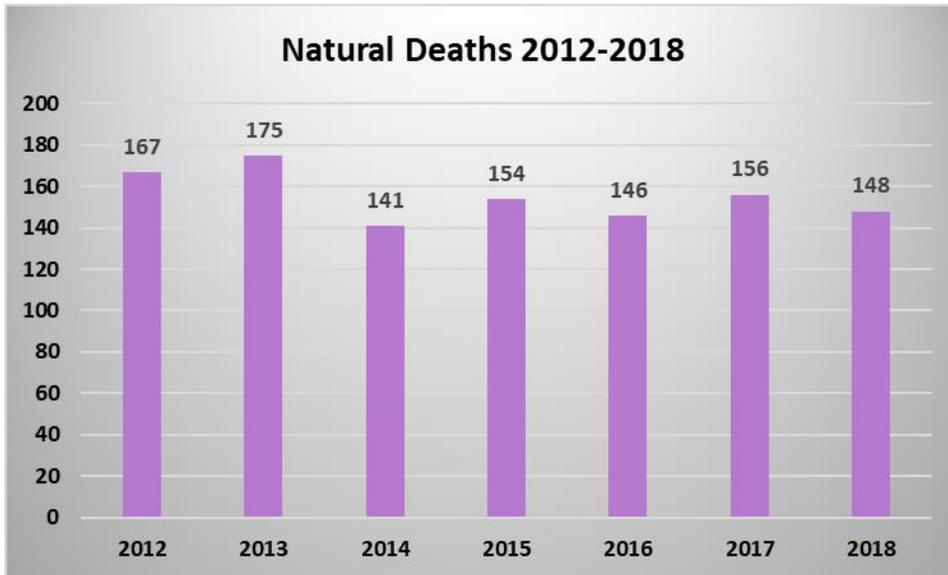


The data above is reflective of deaths that occurred while the individual was in jail.

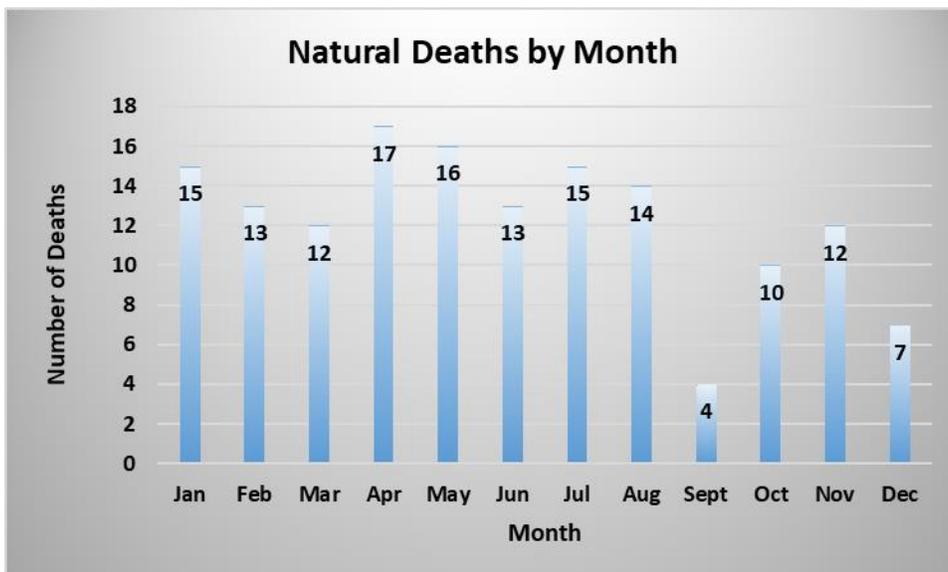
**Natural**

Typically, the Medical Examiner’s Office assumes jurisdiction in cases that eventually are certified as natural deaths when the death occurs in a young age group without medical history and is therefore unexpected.

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



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



**Natural Deaths by Disease Process**

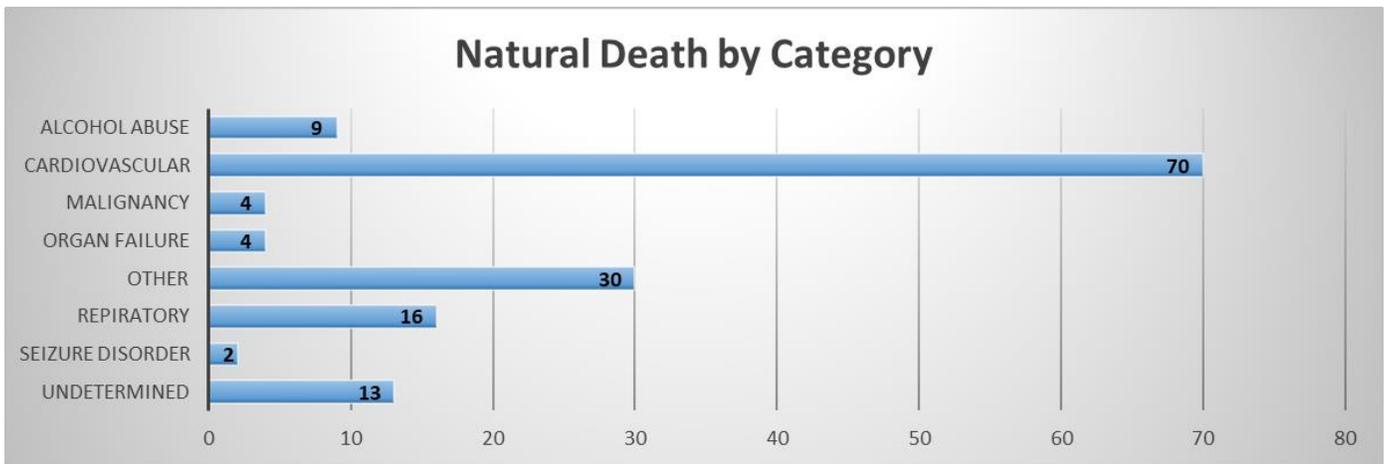
Natural Disease By Process	Alcohol Abuse	Cardiovascular	Malignancy	Organ Failure	Other	Respiratory	Seizure Disorder	Undetermined	Total
Alcohol Abuse	1	2	0	0	0	0	0	2	5
Arrhythmia	0	1	0	0	0	0	0	0	1
Asthma	0	0	0	0	0	2	0	0	2
Atherosclerotic Cardiovascular Disease	0	47	0	0	0	0	0	0	47
Cardiac Dysrhythmia	0	1	0	0	0	0	0	0	1
Cardiomyopathy	0	14	0	0	0	0	0	0	14
Chronic Alcoholism	6	0	0	0	0	0	0	0	6
Chronic Obstructive Pulmonary Disease	0	0	0	0	0	2	0	0	2
Cirrhosis of the Liver	1	0	0	1	0	0	0	0	2
Congenital Abnormality	0	0	0	0	1	0	0	0	1
Coronary Thrombosis	0	1	0	0	0	0	0	0	1
Diabetes	0	0	0	3	0	0	0	0	3
Diabetes Mellitus	0	0	0	0	3	0	0	0	3
Epilepsy	0	0	0	0	0	0	2	0	2
Gastrointestinal Bleed	1	0	0	0	2	0	0	0	3
Hypertensive heart	0	1	0	0	0	0	0	0	1
Influenza	0	0	0	0	3	0	0	0	3
Lung Cancer	0	0	2	0	0	0	0	0	2
Myocardial Infarction	0	2	0	0	0	0	0	0	2
Other	0	1	2	0	13	2	0	0	18
Peritonitis	0	0	0	0	1	0	0	0	1
Phlebothrombosis	0	0	0	0	0	1	0	0	1
Pneumonia	0	0	0	0	0	6	0	0	6
Pulmonary Embolism	0	0	0	0	0	3	0	0	3
SUID	0	0	0	0	6	0	0	0	6
Subarachnoid Hemorrhage	0	0	0	0	1	0	0	0	1
Undetermined **	0	0	0	0	0	0	0	11	11
<b>Total</b>	<b>9</b>	<b>70</b>	<b>4</b>	<b>4</b>	<b>30</b>	<b>16</b>	<b>2</b>	<b>13</b>	<b>148</b>

\*\* Undetermined in this chart means that the exact natural cause of death is unknown (an autopsy may not have been performed), but investigation overwhelmingly indicates a natural manner of death.

**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”.

The 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	5	9
Cardiovascular	19	51	70
Malignancy	0	4	4
Organ Failure	1	3	4
Other	8	22	30
Respiratory	6	10	16
Seizure Disorder	1	1	2
Undetermined	5	8	13
<b>Total</b>	<b>44</b>	<b>104</b>	<b>148</b>

Undetermined in the above charts means that the exact natural cause of death is unknown (an autopsy may not have been performed), investigation overwhelmingly indicates a natural manner of death.

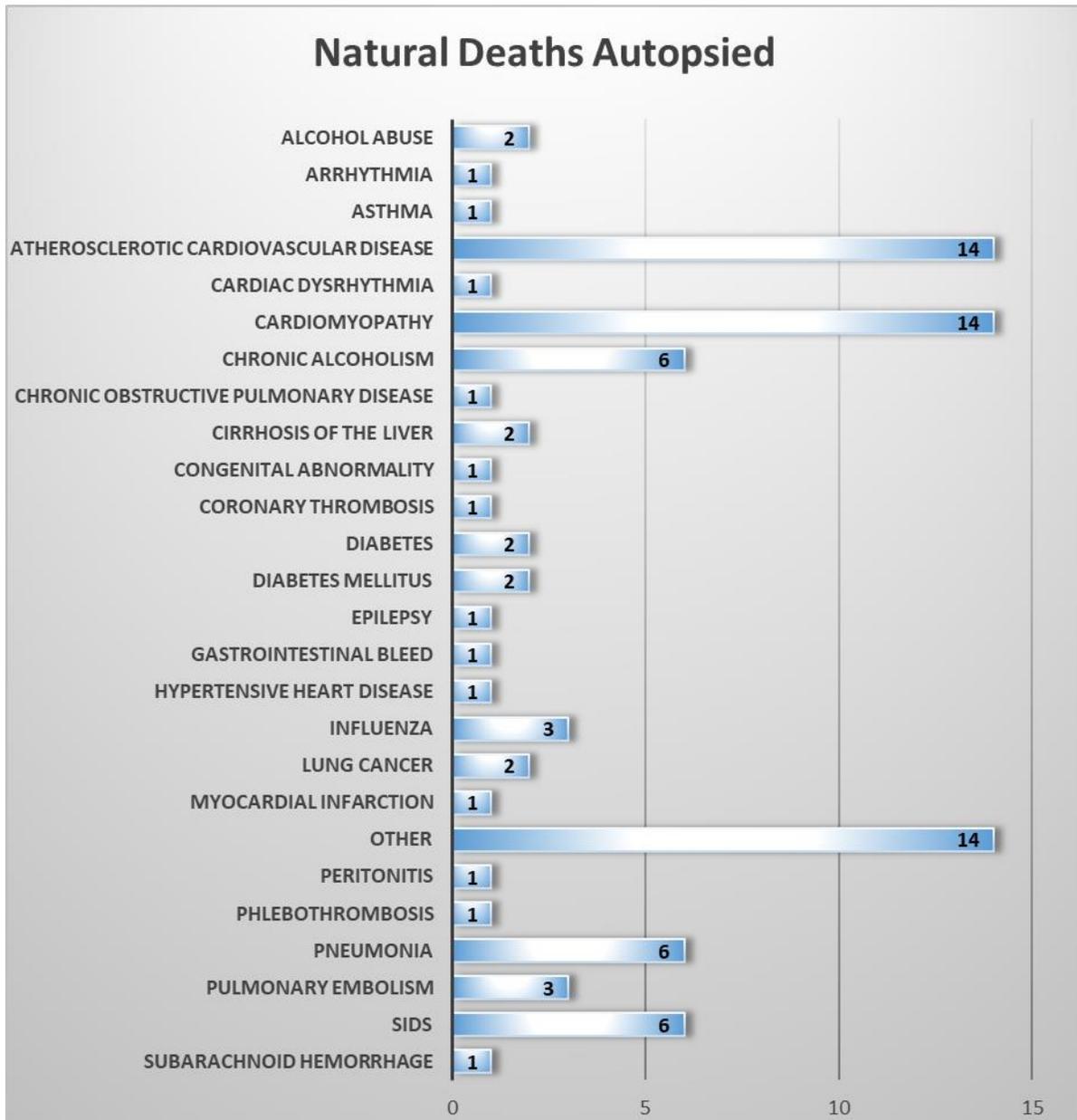
**Natural Deaths by Gender and Age Group**

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	3	0	1	0	0	0	0	0	4
Alcohol Abuse	Male	0	0	0	0	2	0	2	1	0	0	0	0	5
<b>Alcohol Abuse Total</b>														<b>9</b>
Cardiovascular	Female	0	0	0	1	1	0	4	3	5	2	2	0	18
Cardiovascular	Male	0	0	0	0	2	8	15	15	8	2	1	0	51
<b>Cardiovascular Total</b>														<b>69</b>
Malignancy	Female	0	0	0	0	0	0	0	0	0	0	0	0	0
Malignancy	Male	0	0	0	0	0	0	2	2	0	0	0	0	4
<b>Malignancy Total</b>														<b>4</b>
Organ Failure	Female	0	0	0	0	1	0	0	0	0	0	0	0	1
Organ Failure	Male	0	0	0	0	0	1	2	0	0	0	0	0	3
<b>Organ Failure Total</b>														<b>4</b>
Other	Female	3	0	0	0	1	0	2	1	1	0	0	0	8
Other	Male	7	3	0	0	2	2	4	3	0	1	1	0	23
<b>Other Total</b>														<b>31</b>
Respiratory	Female	1	0	0	0	1	1	1	2	0	0	0	0	6
Respiratory	Male	0	0	0	0	1	2	5	2	0	0	0	0	10
<b>Respiratory Total</b>														<b>16</b>
Seizure Disorder	Female	0	0	0	0	0	0	1	0	0	0	0	0	1
Seizure Disorder	Male	0	0	0	0	1	0	0	0	0	0	0	0	1
<b>Seizure Disorder Total</b>														<b>2</b>
Undetermined	Female	0	0	0	0	0	0	0	1	2	2	0	0	5
Undetermined	Male	0	0	0	0	0	0	2	3	2	1	0	0	8
<b>Undetermined Total</b>														<b>13</b>
<b>Grand Total</b>		<b>11</b>	<b>3</b>	<b>0</b>	<b>1</b>	<b>15</b>	<b>14</b>	<b>41</b>	<b>33</b>	<b>18</b>	<b>8</b>	<b>4</b>	<b>0</b>	<b>148</b>

6 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 Autopsied*

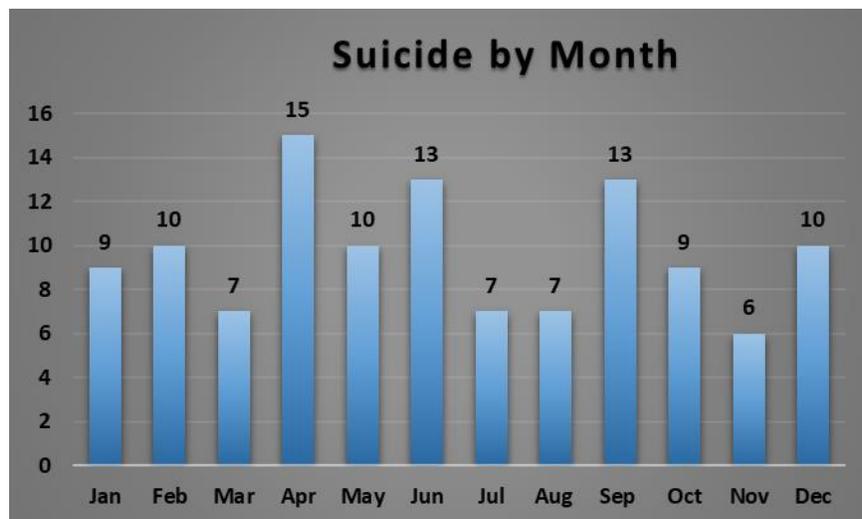


The numbers of cardiovascular deaths reflect the fact that the first symptom of significant heart disease is often a fatal heart attack.

## ***Suicide***

Suicides are those deaths caused by intentional, self-inflicted injuries. In Spokane County there were (116) suicides in 2018, a decrease of 6 from 2017 (122).

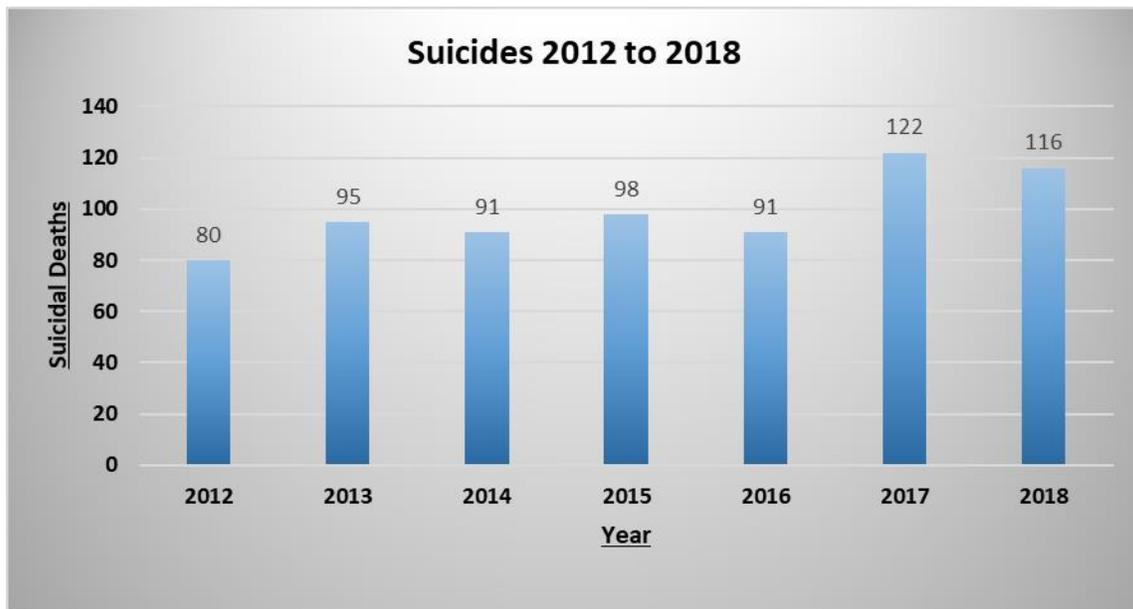
The highest number (93/116) of suicides fell within the 20-69 age range. In Spokane County, suicide numbers were highest in the 20-39 age group. Nationally suicide deaths in older Americans are associated statistically with depression, relationship difficulties, drug and alcohol abuse, and serious physical health problems. Seven suicides occurred in teenagers in Spokane County and 23 in the 20-29 age group. Two suicides occurred in children under 10 years of age.



**Suicide Methods Comparison**

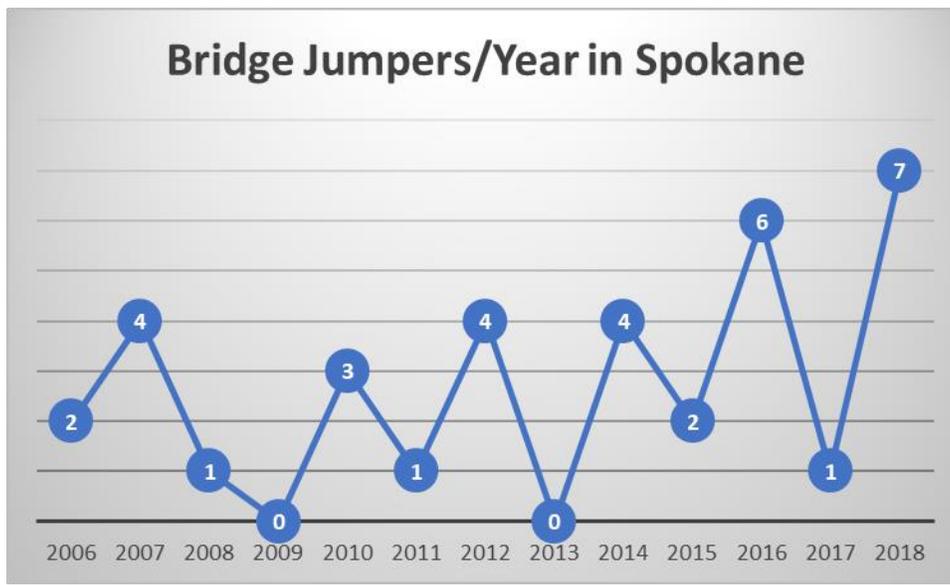
**Comparison of Suicide Deaths**

Method Used	2012	2013	2014	2015	2016	2017	2018
Carbon Monoxide	1	4	2	0	6	2	2
Drowning	3	0	5	1	0	0	1
Drugs/Poisons	11	15	7	19	9	13	8
Firearms	42	44	54	46	44	59	53
Hanging	15	23	16	23	19	37	32
Jumping	4	2	1	2	7	5	10
Other	0	3	1	3	3	2	4
Plastic Bag	3	2	3	3	2	4	4
Stab/incised wound	1	2	2	1	1	0	2
<b>Total</b>	<b>80</b>	<b>95</b>	<b>91</b>	<b>98</b>	<b>91</b>	<b>122</b>	<b>116</b>



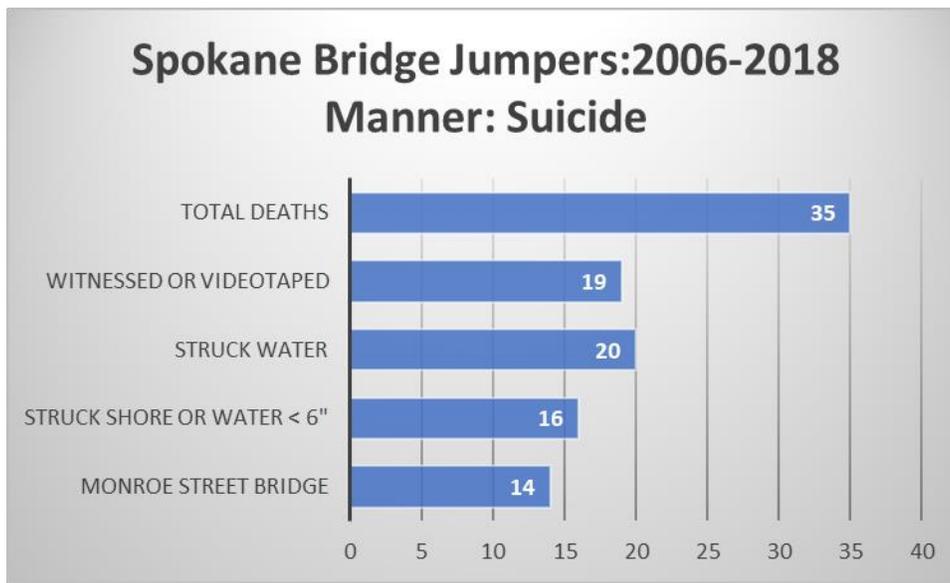
***Suicide Method by Gender and Age Group***

<b>Suicide Method</b>	<b>Sex</b>	<b>1-9</b>	<b>10-19</b>	<b>20-29</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>90-99</b>	<b>Total</b>
Carbon Monoxide	Female	0	0	1	0	0	0	0	0	0	0	1
Carbon Monoxide	Male	0	0	0	0	0	1	0	0	0	0	1
												2
Drowning	Male	0	0	0	0	1	0	0	0	0	0	1
												1
Drugs/Poisons	Female	0	0	0	0	1	1	1	0	0	0	3
Drugs/Poisons	Male	0	0	0	0	1	3	0	0	1	0	5
												8
Firearms	Female	0	0	1	0	1	1	2	3	0	0	8
Firearms	Male	0	1	8	6	5	6	13	4	2	0	45
												53
Hanging	Female	0	1	2	3	1	2	0	0	0	0	9
Hanging	Male	2	2	9	7	2	0	0	0	1	0	23
												32
Jumping	Female	0	0	1	0	0	0	0	0	0	0	1
Jumping	Male	0	1	0	2	1	2	1	1	1	0	9
												10
Other	Male	0	1	1	1	0	0	1	0	0	0	4
												4
Plastic Bag	Female	0	0	0	1	0	0	0	0	0	0	1
Plastic Bag	Male	0	1	0	1	0	1	0	0	0	0	3
												4
Stab/Incised Wound	Male	0	0	0	0	0	0	1	1	0	0	2
												2
<b>Total</b>		<b>2</b>	<b>7</b>	<b>23</b>	<b>21</b>	<b>13</b>	<b>17</b>	<b>19</b>	<b>9</b>	<b>5</b>	<b>0</b>	<b>116</b>



In 2018 there were 7 individuals who jumped from bridges, and 3 additional deaths of individuals (not included in this chart) who jumped from standing structures such as buildings. Of the 7 individuals who jumped from bridges, there were 3 who landed in water and drowned or had blunt impact injury and drowned, the other 4 landed on the solid surfaces beneath the bridge ends.

There were 2 individuals (not included in this chart) found in the Spokane River, it is unknown how they entered the water.



For additional information regarding bridge jumpers, see the link below.

[Facts-about-Bridge-Jumpers](#)

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 (53 total). Gunshot wounds are followed by 32 suicidal hanging and 8 intentional overdoses.

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

- 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.

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 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 (about 16/100,000 in 2015).

Deaths by suicide per 100,000 resident population in the United State 1950-2015 from Statista <https://www.statista.com/statistics/187478/death-rate-from-suicide-in-the-us-by-gender-since-1950/>

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

Trends in state suicide rates from the Centers for Disease Control [CDC-MMWR-Weekly-Vol-67-No-22](#)

## 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 (10) undetermined manner deaths in Spokane County in 2018.

Although the cause of death was established in half 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

Number	Cause of Death	Month	Sex	Age Yrs	Age Mos	Age Days	Race
1	Hypothermia	January	F	58	4	10	Caucasian
2	Undetermined after complete autopsy	May	M	34	7	7	Caucasian
3	Hydrocodone toxicity	June	F	64	4	14	Caucasian
4	Undetermined after complete autopsy	August	M	53	2	15	Caucasian
5	Acute chronic respiratory failure / asthma despite maximal medical management and high dose steroids due to poor air quality secondary to fires, musculoskeletal disabilities, diastolic dysfunction due to right temporal craniotomy, microcephaly, seizure disorders, chronic hyponatremia due to a motor vehicle accident at 6 weeks of age and fell to the floor of the car	September	M	52	9	7	Caucasian
6	Undetermined after complete autopsy	September	F	53	0	5	Caucasian
7	Portion of human cranium, cause of death unknown	September	U				Unknown
8	Undetermined	September	M	46	1	23	Caucasian
9	Undetermined after complete autopsy	October	M	34	3	21	Caucasian
10	Complications including post-traumatic epilepsy due to remote gunshot wound to head	November	F	51	6	9	Caucasian

The undetermined case listed as “Number 8”, has been left undetermined due to the toxicology report not being completed by the WA State Toxicology Laboratory at the time of the writing of this report.

**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 2018, the undetermined classification was used in 1.3% of Spokane Medical Examiner cases.

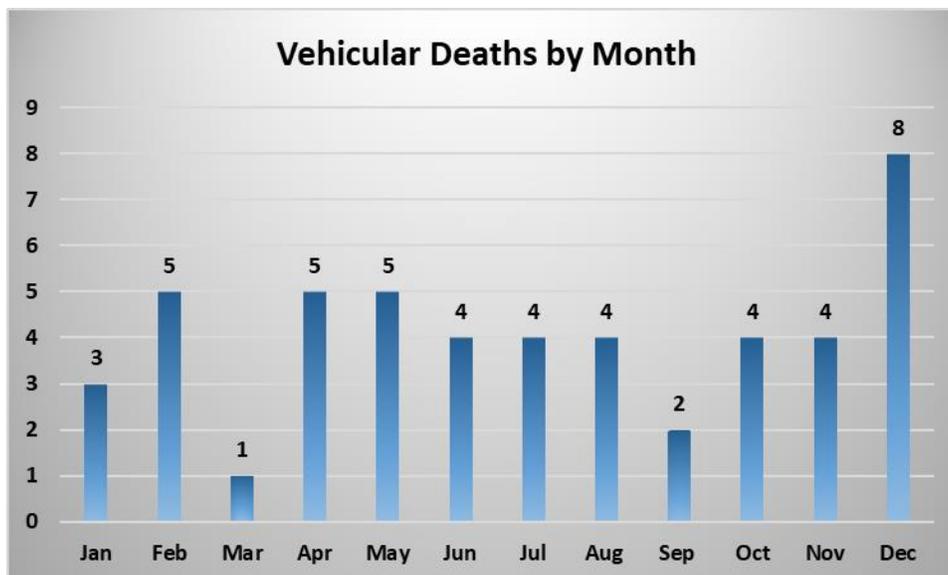
Undetermined manner is used in a wide array of circumstance. An example is an “overdose” death, wherein the intent is unknown despite investigation, making the determination of accident versus suicide unclear.

## ***Vehicular***

During the calendar year of 2018, The Medical Examiner's Office participated in the investigation of (49) deaths categorized as vehicular. This decrease of 9 from 2017 during which (58) deaths were categorized as vehicular.

In vehicle collisions there were 31 deaths, 25 drivers and 6 passengers.

In addition there were 7 deaths among motorcycle operators (6 operators, 1 passenger) and 8 pedestrians. There is 1 death listed as "other" this was an individual riding a skateboard struck by a motor vehicle. Finally there were 2 deaths involving bicyclists.



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

<b>Vehicular Method</b>	<b>Sex</b>	<b>&gt;1</b>	<b>1-9</b>	<b>10-19</b>	<b>20-29</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>90-99</b>	<b>Total</b>
Automobile Driver	Female	0	0	1	2	2	2	1	0	1	0	0	9
Automobile Driver	Male	0	0	1	5	3	0	4	2	1	0	0	16
													<b>25</b>
Automobile Passenger	Female	0	0	1	0	1	0	0	0	0	1	1	4
Automobile Passenger	Male	0	0	0	1	1	0	0	0	0	0	0	2
													<b>6</b>
Bicyclist	Male	0	0	0	0	0	0	1	1	0	0	0	2
													<b>2</b>
Motorcycle Driver	Female	0	0	0	0	0	0	1	0	0	0	0	1
Motorcycle Driver	Male	0	0	0	0	1	1	0	2	1	0	0	5
													<b>6</b>
Motorcycle Passenger	Male	0	0	0	0	0	0	1	0	0	0	0	1
													<b>1</b>
Other	Male	0	0	1	0	0	0	0	0	0	0	0	1
													<b>1</b>
Pedestrian	Female	0	0	0	0	0	1	2	2	0	0	0	5
Pedestrian	Male	0	0	0	1	1	0	0	0	0	1	0	3
													<b>8</b>
<b>Total</b>		<b>0</b>	<b>0</b>	<b>4</b>	<b>9</b>	<b>9</b>	<b>4</b>	<b>10</b>	<b>7</b>	<b>3</b>	<b>2</b>	<b>1</b>	<b>49</b>

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

<b>Circumstances</b>	<b>Restrained</b>	<b>Unknown</b>	<b>Unrestrained</b>	<b>Total</b>
Automobile Driver	7	5	4	16
Automobile Passenger	5	0	0	5
<b>Total</b>	<b>12</b>	<b>5</b>	<b>4</b>	<b>21</b>

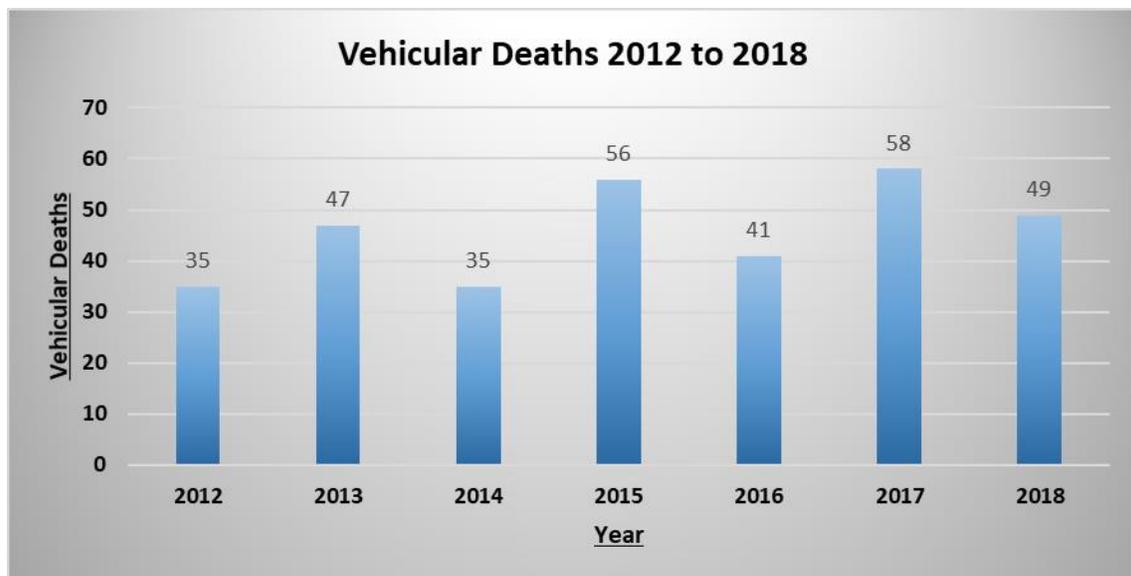
When traffic victims are flown / transported to Spokane for advanced medical care, it becomes more difficult to collect use of restraint information.

### 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 2012 to 2018**

Vehicle Circumstances	2012	2013	2014	2015	2016	2017	2018
Automobile Driver	12	19	20	22	17	25	25
Automobile Passenger	3	14	2	11	6	5	6
Bicyclist	1	0	1	1	2	3	2
Motorcycle Driver	6	8	5	6	5	9	6
Motorcycle Passenger	0	0	1	0	0	0	1
Other	1	0	1	2	3	2	1
Pedestrian	9	5	5	11	5	14	8
Unknown	3	1	0	3	3	0	0
<b>Total</b>	<b>35</b>	<b>47</b>	<b>35</b>	<b>56</b>	<b>41</b>	<b>58</b>	<b>49</b>



## ***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 (self-inflicted), 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 exist.
<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.