This report provides a summary and statistical analysis of the deaths that were reported and investigated by the Skagit County Coroner’s Office in the year 2017. Skagit County encompasses an area over 1,920 square miles which consists of coastal, agricultural and mountain areas. Skagit County is home to approximately 124,246 people. Towns include Mount Vernon, Burlington, Anacortes, Guemes Island, La Conner, Bow, Alger, Sedro Woolley, Lyman, Hamilton, Concrete, Rockport, and Marblemount. There are also three Native American Tribes in the county: Swinomish, Upper Skagit Tribe, and Sauk Suiattle Tribe.

The Coroner and/or Full Time Senior Deputy Coroner are on duty 24 hours a day, 365 days a year. There are 4 on-call part-time deputy coroner’s who are called to assist in multiple capacities including responding to and investigating scene calls, transporting cases, assisting with further investigation of cases (such as requesting and reviewing records, speaking with related parties or agencies), assisting with autopsies/external examinations, and offering additional office support when necessary.

Staff:

Hayley Thompson, D-ABMDI   Coroner
Deborah Hollis, D-ABMDI   Senior Deputy Coroner
James Bosley   Part-time Deputy Coroner
Jaci Scheer   Part-time Deputy Coroner
Brittanna Flickinger   Part-time Deputy Coroner
Ethan Greggerson   Part-time Deputy Coroner

The Coroner’s mission is to satisfy the legal requirements of the office in an expeditious manner. The primary task of the Coroner’s Office is to determine the cause and manner of death of those who have died suddenly, violently, or unexpectedly while in apparent good health within the geographic boundaries of Skagit County. An autopsy may be required depending upon the circumstances of the death. Not all deaths that occur in the county are required to be reported to the office, nor are all deaths where jurisdiction is assumed require an autopsy to determine the cause and manner of death. An autopsy is performed only when it is necessary to determine or confirm the cause of death, document injury, or when required by state law.

The Coroner’s office investigates sudden, unexpected deaths that occur under violent or suspicious circumstances. The jurisdiction of the coroner in unexplained or sudden deaths may be exercised only when the manner of death is unexplained. If a diagnostic determination is made that the death is natural its mystery cannot prompt forensic jurisdiction. The failure to know the precise cause or mechanism of death in an otherwise natural death does not activate the coroner’s jurisdiction.
The Coroner’s Office performs on average 50-55 autopsies per year and in 2017 investigated 430 deaths. On average over 200 cases are examined and certified by the Coroner’s Office each year. In 2017, 214 cases were certified by the Coroner’s Office and 217 cases were reported but signed by an outside physician.

In order to provide a comprehensive death investigation, the office works hard to obtain and review records pertinent to the case, obtain toxicology samples, and perform a thorough examination of the body when required or necessary.

General Statistics

Skagit County population (per 2017 census data): **124,246**

Total Skagit County Deaths Reported: **431**

Total Number of Skagit County Deaths for 2017: **1,264**

Number of Scene Investigations: **110**

Number of postmortem examinations (external and autopsy): **122**

* 53 autopsies
* 69 external examinations
* 16 consultations by Forensic Pathologist

Number of Facility Investigations (no scene response): **99**

Jurisdiction declined: **217**
### Reported Cases to Coroner Office by Month 2017

<table>
<thead>
<tr>
<th>Month</th>
<th>Coroner Case</th>
<th>No Jurisdiction Case</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan</td>
<td>22</td>
<td>25</td>
</tr>
<tr>
<td>Feb</td>
<td>10</td>
<td>20</td>
</tr>
<tr>
<td>March</td>
<td>16</td>
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<td>April</td>
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<td>July</td>
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<td>Aug</td>
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<td>Sept</td>
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</tr>
<tr>
<td>Oct</td>
<td>22</td>
<td>22</td>
</tr>
<tr>
<td>Nov</td>
<td>23</td>
<td>14</td>
</tr>
<tr>
<td>Dec</td>
<td></td>
<td>15</td>
</tr>
</tbody>
</table>

**Legend:**
- **Coroner Case**
- **No Jurisdiction Case**

![Reported Cases for 2017](image-url)
OUT OF 221 CORONER JURISDICTION CASES

Facility Investigations (no response), 99, 45%

External Examination, 69, 31%

Autopsy, 53, 24%
**Coroner Cases by City/Town 20117**

<table>
<thead>
<tr>
<th>Location</th>
<th>Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Concrete</td>
<td>11</td>
</tr>
<tr>
<td>SEDRO WOOLLEY</td>
<td>26*</td>
</tr>
<tr>
<td>UNITED GENERAL HOSPITAL-SEDRO WOOLLEY</td>
<td>3</td>
</tr>
<tr>
<td>LA CONNER</td>
<td>6</td>
</tr>
<tr>
<td>ANACORTES</td>
<td>43*</td>
</tr>
<tr>
<td>ISLAND HOSPITAL-ANACORTES</td>
<td>10</td>
</tr>
<tr>
<td>BURLINGTON</td>
<td>33</td>
</tr>
<tr>
<td>MOUNT VERNON</td>
<td>86*</td>
</tr>
<tr>
<td>SKAGIT VALLEY HOSPITAL-MOUNT VERNON</td>
<td>27</td>
</tr>
</tbody>
</table>

* Includes hospital deaths within total cases

**Coroner Case Place of Death 2017**

- Other: 3
- Interstate/Highway/Road: 7
- Outdoors: 23
- Motel: 6
- Hospital: 42
- Nursing Home: 34
- Other's Residence: 7
- Residence: 93
CASES REQUIRING SCENE RESPONSES FOR 2017

2017 Autopsy, External Examinations, and Record Review Cases by Month
Manner of Death and Post Mortem Examination 2017

<table>
<thead>
<tr>
<th>Manner of Death</th>
<th># of Cases</th>
<th>External Examination</th>
<th>Autopsy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Natural</td>
<td>80</td>
<td>27</td>
<td>13</td>
</tr>
<tr>
<td>Accident</td>
<td>92</td>
<td>19</td>
<td>25</td>
</tr>
<tr>
<td>Suicide</td>
<td>29</td>
<td>23</td>
<td>5</td>
</tr>
<tr>
<td>Homicide</td>
<td>9</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>Undetermined</td>
<td>5</td>
<td>3</td>
<td>1</td>
</tr>
</tbody>
</table>
Natural Deaths by Age Group and Gender 2017

Natural Types of Death and Gender 2017
Motor vehicle Accidents:

In 2017 there were 15 motor vehicle related deaths along with 2 pedestrian versus motor vehicle deaths.

Motor vehicle Operators: 9
   Restrained: 4 out of 9
Motorcycle Operators: 5
   Helmet used: 5 out of 5
Alcohol and/or drugs involved in 6 out of the 17 cases (35%)
Drug-related deaths means drugs were involved in the death but were not the immediate cause of death.

2017 Drug Deaths by Month

2017 Drug related Deaths by Age Group and Gender

2017 Manner of Death and Drugs Involved
Drug related deaths 2009-2017

Drug related deaths 2009 - 2017

Drug related deaths 2009- 2017
Overdose Deaths versus Drugs Contributing to the Death
2009- 2017

- Overdose
- Drugs contributing to death
- Linear (Overdose)
- Linear (Drugs contributing to death)
Suicides by Method and Sex 2017

Suicide by Age Groups 2017

Presence of Drugs and/or Alcohol on Suicide Cases 2017

Suicide and Location of Death 2017

2017 Suicide Note Left
2017 Suicide-related History

- Attempts only, 5
- Ideations only, 6
- Both, 17

2017 Mental Health History of Suicide Cases

- Yes, 25
- No, 1
- Unknown, 3

2017 Contributing Causes for Suicide

- Multi cause, 5
- Other/unspecified, 8
- Relationship/Social, 9
- Financial, 1
- Medical, 11
- Physical Health, 8
- Mental Health, 3
Suicide by Gender
2000-2017

Suicide by Age Group
2000-2017
HOMICIDES
2017

- Gunshot, 5
- Fire, 2
- Sharp force trauma, 1
- Blunt force trauma, 1