Office of the Coroner
Skagit County

Hayley L. Thompson, D-ABMDI
Coroner

2018 Annual Report

The Skagit County Coroner's Office is an independent agency who serves the residents of Skagit County by investigating the facts and circumstances concerning the deaths of those who have died suddenly, violently, or unexpectedly while in apparent good health within the geographic boundaries of the county. The goal of this office is to serve the citizens of Skagit County with the highest degree of compassion, professionalism, and integrity regarding those who have died within Skagit County.

To achieve this mission, the Skagit County Coroner's Office will:

- Treat decedents and their property with dignity and respect and without discrimination.
- Conduct investigations and autopsies professionally, scientifically, and conscientiously.
- Research and implement new procedures to better investigate death scenes.
- Promote and maintain adequate staffing levels in order to provide all mandated services.
- Promote and maintain an emotionally and physically healthy and safe working environment for all staff.
- Promote and provide adequate equipment, training, and support to all staff.
- Provide assistance, training, and education to all agencies requesting our services.
- Provide a statistical annual report of deaths within the county.
- Prepare and plan for mass casualty incidents.
- Provide for disposition of unclaimed, indigent citizens in accordance with RCW 36.39.030.
- Strive to increase proficiency and professionalism of all staff members through training.

The Skagit County Coroner's Office has an important public health role in bringing causes and manners of deaths to the attention of the public and many involved agencies. The Coroner's Office works with community partners to adopt a proactive approach to reducing preventable deaths such as drug-related deaths as well as suicides.

Introduction

A Description of Skagit County and its Population

Skagit County encompasses an area over 1,920 square miles which consists of coastal, agricultural and mountain areas. 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 Tribe, Upper Skagit Tribe, and Sauk Suiattle Tribe.

Skagit County is home to approximately 128,206 people (per the United States 2018 Census). This was a 9.7% increase in growth since April 2010. The number of residents residing in Skagit County increases every year with a growth rate of 1.81%. Skagit County's population is made up of 74% Caucasian, 18.7% Hispanic or Latino, 2.7% American Indian/Alaska Native, 2.4% Asian, 1.1% African American, 0.4% Native Hawaiian and other Pacific Islander, and 3.2% identifying with two or more races (United States 2018 Census).

As of July 2018 (US 2018 Census), Skagit County had 21.8% of the population under the age of 18. And 20.7% of the population was 65 years and over.

Skagit County has three hospitals:

* Skagit Valley Hospital (137 bed) level III Trauma Center. This hospital offers a full range of services including surgical services, renal dialysis, and advanced diagnostics. The hospital also offers advanced heart and vascular care.

* Peacehealth United General Hospital located in Sedro Woolley, WA is a 25 bed critical access hospital serving those in Burlington, Sedro-Woolley, Bayview, Samish Island, Concrete, Marblemount, Clear Lake, and areas of Mount Vernon.

* Island Hospital in Anacortes WA is a level III trauma center and has 43 beds.

Jurisdiction and State Statutes

The Skagit County Coroner's Office assumes jurisdiction on certain categories of deaths that occur within the geographical boundaries of the county. This is regardless of whether the decedent is a resident of the county. Those Skagit County residents who die in another county do not fall under the jurisdiction of the Skagit County Coroner. Only the Coroner can certify a death that is not considered to be natural (accident, suicide, homicide, or undetermined).

In accordance with the Revised Code of Washington (RCW 68.50), the following categories of deaths fall under the Coroner's jurisdiction:

* Sudden death of an apparent healthy person with no known or significant medical history
* Suspected natural deaths in which there is no current physician to certify the death
* Deaths in which there are abuse or neglect concerns (Adult Protective Services or Child Protective Services involvement)
* Violent or suspicious circumstances
* Traffic-related deaths
* Suicides
* All child deaths
* All premature births and still births over 20 weeks gestation
* All accidental deaths (falls, industrial, recreational)
* Deaths attributed to drug overdose or drug-related
* Deaths that occur while in legal/court/jail/prison custody
* Deaths due to unforeseen complications of therapy, surgery, or diagnostic procedures
* Deaths due to an injury or fracture that either was directly or contributory to decline to death, this includes those injuries that occurred years earlier.
* Deaths due to contagious disease that may be a public health hazard
* Indigent or unclaimed bodies

The role of the Coroner in such deaths is to investigate the facts and circumstances concerning the death for the purpose of determining the cause and manner of death. 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.

In addition to this role, the Coroner is required by law to determine the identity of the deceased and notify the legal next of kin of the death. A scientific method of identification is

required for all homicides as well as in cases in which visual identification is not able to be performed or is not confirmatory. The following scientific methods are used for identification: fingerprint comparison, dental comparison, imaging comparison, and DNA comparison.

Coroner's Office Staff and Facilities

The scene, the examination of the body (external examination or internal examination), along with researching the history/background of the decedent all work together to provide the most accurate cause and manner of death. This can only be accomplished with a devoted team of investigators.

In 2018, the Coroner's Office staff included the Coroner, (1) full time Senior Deputy Coroner, (4) on-call part-time deputy coroners, and (1) reserve deputy. The office also had 2-3 interns to assist from time to time. The Coroner or Senior Deputy Coroner, along with an on-call deputy coroner are on duty 24/7/365. The Coroner's Office is contracted with (2) board certified forensic pathologists.

Staff:

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

The office utilizes (2) county vehicles: Ford Transit Van and a newly purchased 2018 Chevrolet Suburban that can be used in cases where terrain is difficult.

The administrative office is located at 1700 Continental Place in Mount Vernon, WA. The Skagit County Morgue and autopsy suite are located at the Skagit Valley Hospital. This space is shared with the hospital. Morgue capacity is 6 and is routinely at capacity.

The Skagit County Coroner's Office staff are involved in a variety of activities in order to fulfill the required state statutes involving this office. These include responding to and investigating various death scenes, performing postmortem examinations, confirming identification, certifying the cause and manner of death, and providing information and assistance to families. Deputy Coroner's as well as the Coroner and Senior Deputy Coroner work to communicate directly with the families which includes reviewing the findings and answering the many questions that accompany a sudden or traumatic loss of life.

In all cases, the identification and establishing and locating next-of-kin is necessary. In certain cases, the identification process can be extensive requiring outside assistance from

an odontologist, pathologist, or out of state lab to analyze DNA. Finding the next of kin can be complicated as some individuals may have died leaving no next of kin or next of kin to be located. The Skagit County Coroner's Office ensures that all leads regarding next of kin are exhausted before establishing the case as indigent. This can be very time consuming but ultimately rewarding.

All autopsies are performed by a contracted board certified forensic pathologist at the direction of the Coroner. If an autopsy is required in order to determine the cause and manner of death, then various body fluids (blood and vitreous), tissues for microscopic and toxicological analysis will be taken in addition to the anatomical examination. Photographs are taken during autopsy and are essential to the case and the pathologist. Autopsy reports and related data from individual investigations are provided to law enforcement agencies, prosecuting attorneys, and other agencies such as Occupational Safety and Health Administration, Federal Aviation Administration, National Transportation Safety Board, Board of Consumer Product Safety, and Labor and Industries if they are involved in the case.

The Coroner provides information to local law enforcement and medical personnel as well as various community groups on a regular basis regarding the role and function of the Coroner's Office. In addition, the Coroner's Office collects and analyzes data on various cases to assist the community with prevention. Media releases regarding cases of interest are updated as requested on the Coroner's website.

Strategic Goals of the Coroner's Office

The Skagit County Coroner's Office has identified the following goals and objectives necessary for the Coroner's office to continue to provide timely and legally defensible death investigations over the next 5 years:

* All part-time on-call staff will be certified with the American Board of Medicolegal Death Investigators (ABMDI)
* Shifts will be staffed to handle the daily caseload with little to no effect on the devised budget.
* 100% of the decedents under the Coroner's jurisdiction will be stored in a modern refrigerated County Morgue
* A Mass Fatality Plan will be completed and reviewed annually.
* Achieve accreditation with the International Association of Coroner and Medical Examiner's
* Improve communication by providing monthly death statistics which will be added to the Coroner website every month. Annual report will be completed before the end of July each year. Continue to provide presentations to hospitals, schools, health care providers, criminal justice agencies, and other community organizations on the role and function of the Coroner's Office.

Death Investigations- An Overview

Death Investigations are categorized into 2 different categories: non-jurisdictional and jurisdictional. Non-jurisdictional cases are natural deaths which are reported to the Coroner's Office where a physician has knowledge and awareness of the decedent's health and will certify the death certificate. These type of cases occur in nursing homes, hospitals, and in-home hospice. Jurisdictional cases are deaths where the Coroner certifies the cause and manner of death. All non-natural deaths must be certified by the Coroner.

Table 1. 2018 Statistical Summary

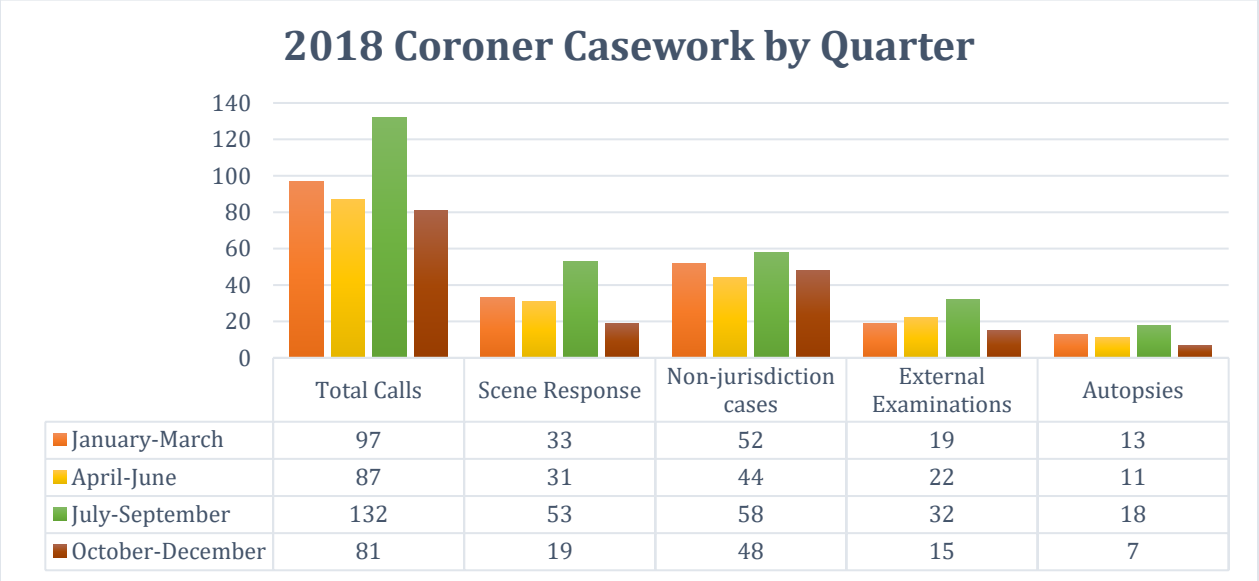
Reported Cases	399
Non-jurisdictional Cases	202
Jurisdictional Cases	197
Natural Causes	73
Accidental	89
Suicide	22
Homicide	1
Undetermined	13
Non-Human Remains	7
Full Autopsies	48
Partial Autopsies	1
External Examination Only	88
Toxicological Tests Performed	137
Transport Cases	136
Unidentified Bodies	2
Exhumations	1

Per the Skagit County Vital Records Department, in 2018 there were 1,237 deaths in Skagit County. Of these 1,237 deaths, 399 deaths were investigated by the Coroner's Office and 197 of these deaths were certified by the Coroner's Office. It is important to note that the cause and manner of death as well as the decisions for non-jurisdictional and jurisdictional cases are often a matter of judgment and strict comparisons across years are not valid.

In 2018, 49 autopsies were performed by the Skagit County Coroner's Office. The percentage of jurisdictional cases that had an autopsy performed in 2018 was 13.75%. The number of autopsies performed each year has varied from 49 to 65. The possible reason for a lower number of autopsies for 2018 would be due to the advancement in medical diagnostics which allows the cause of death to be determined to a reasonable degree of medical certainty without an autopsy. The ability for the Coroner's Office to have access to medical records has also streamlined the investigation into a decedent's medical history and if there are concerns that should be known about the decedent.

The Skagit County Coroner's Office provides reports on all violent deaths to the Washington State Violent Death Reporting System. This includes all deaths where the

manner of death was determined to be a homicide, accident, or suicide. Accidents are the second most common manner of death after natural deaths for Skagit County. Accidental deaths include all motor vehicle accidents, falls, and drug overdoses.



	Total Calls	Scene Response	Non-jurisdiction cases	External Examinations	Autopsies
January-March	97	33	52	19	13
April-June	87	31	44	22	11
July-September	132	53	58	32	18
October-December	81	19	48	15	7

Figure 1. 2018 Skagit County Coroner Quarterly Casework

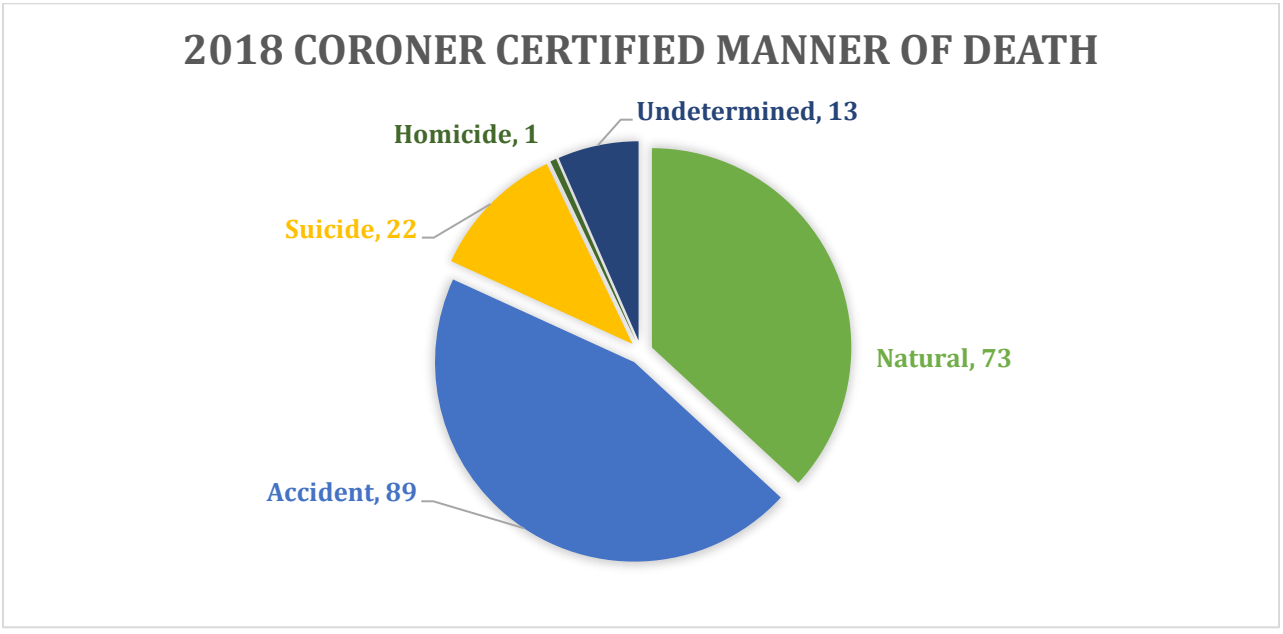


Figure 2. 2018 Skagit County Manner of Death

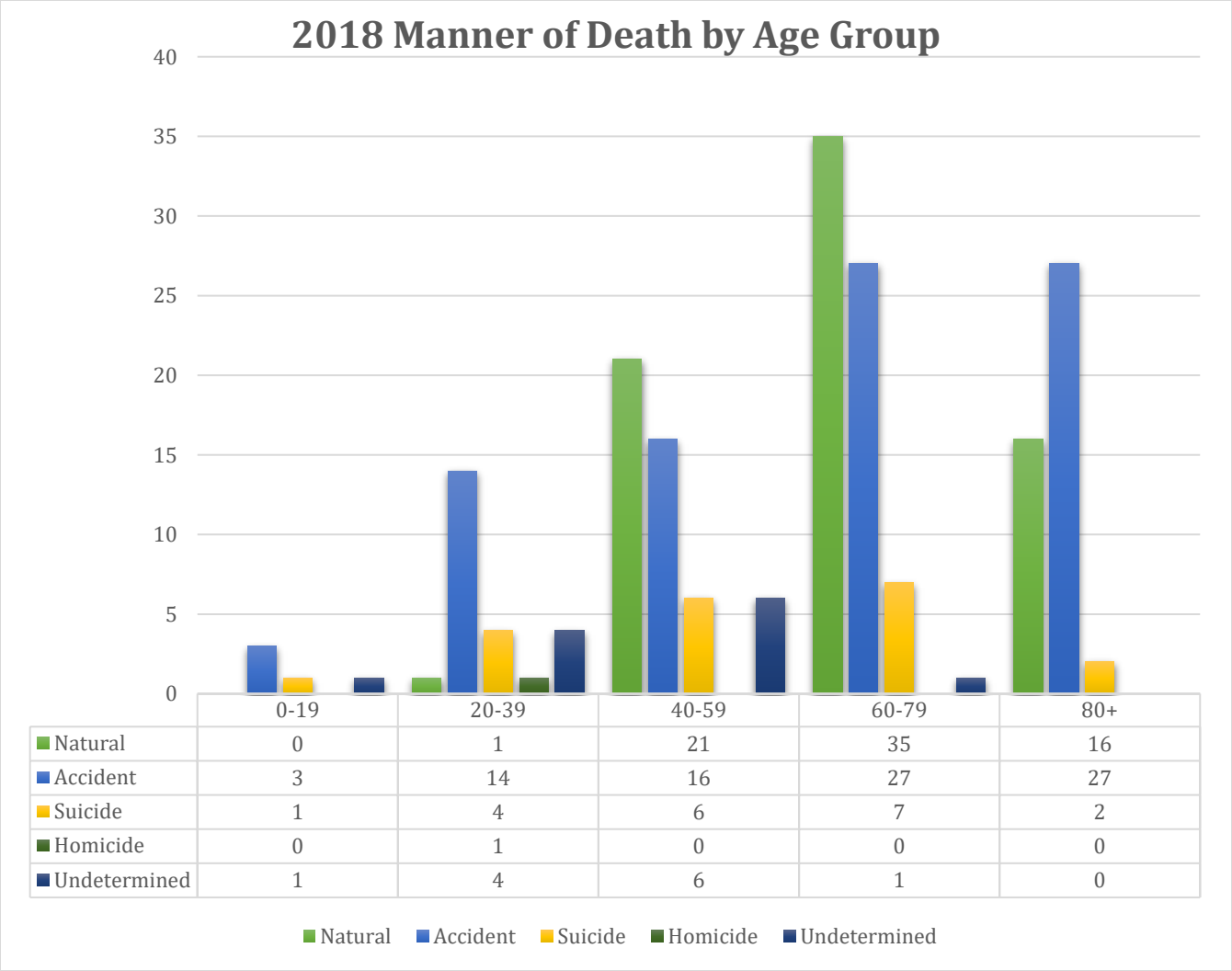


Figure 3. 2018 Skagit County Manner of Death by Age Group

Manner of Death: Natural

The Coroner may certify natural deaths under many circumstances. These include a sudden and unexpected death in an apparently healthy individual, when there is no physician able or willing to certify the death, when there is no next of kin, or when there are suspicious circumstances surrounding the death.

In 2018, there were 275 natural deaths investigated by the Coroner's Office. A total of 73 cases were assumed under jurisdiction of the Coroner. Of these 73 deaths, the primary cause of death was cardiac-related (44/73, 60%) followed by neurologic (8/73, 10%), pulmonary (8/73, 10%), gastrointestinal (6/73, 8%), cancer (2/73,2%), and other/unspecified causes (5/73, 6%). Thirty-eight (38/73, 52%) of these cases received an external examination as well as toxicological analysis. Nine (9/73, 12%) of these cases underwent an autopsy with toxicological analysis.

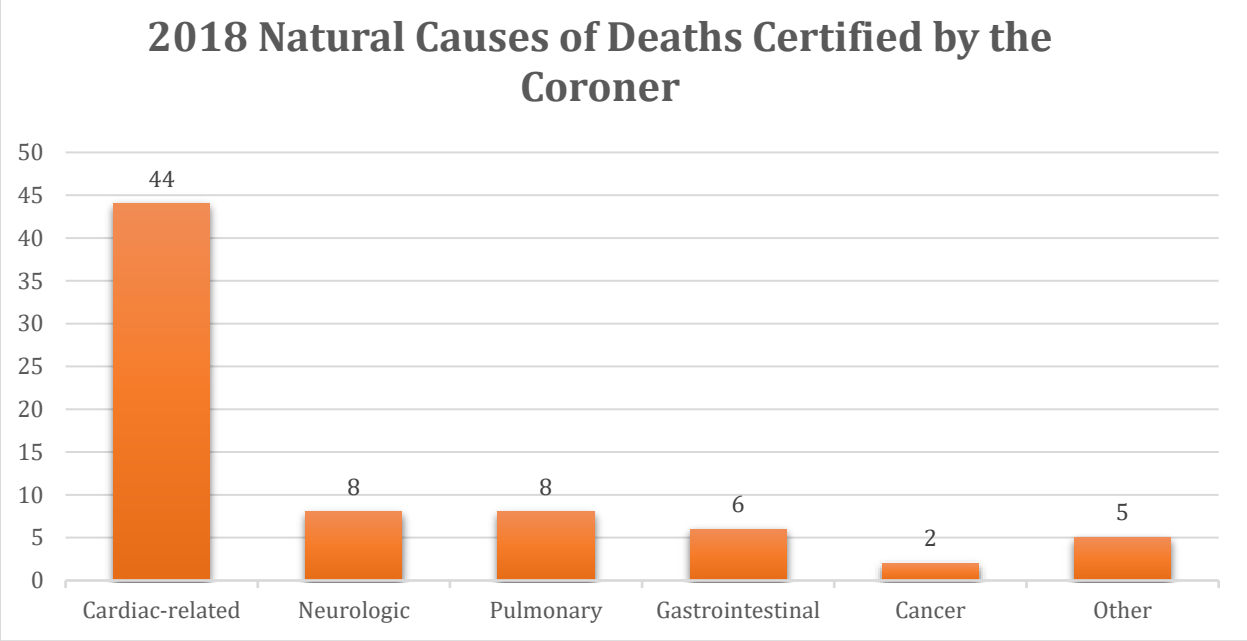


Figure 4. 2018 Skagit County Certified Natural Causes of Death

Manner of Death: Accident

The Coroner certified 89 deaths as accidental in 2018 accounting for 22% of the total deaths reported to the Coroner's Office. Of these 89 accidental deaths, 28% were due to drug overdose. Motor vehicle accidents made up 22% of accidental deaths. Falls resulting in trauma including those deaths in which elderly patients had fallen resulting in trauma were 21% of accidental deaths. Since all accidental deaths are theoretically preventable, each such death is investigated for public health purposes.

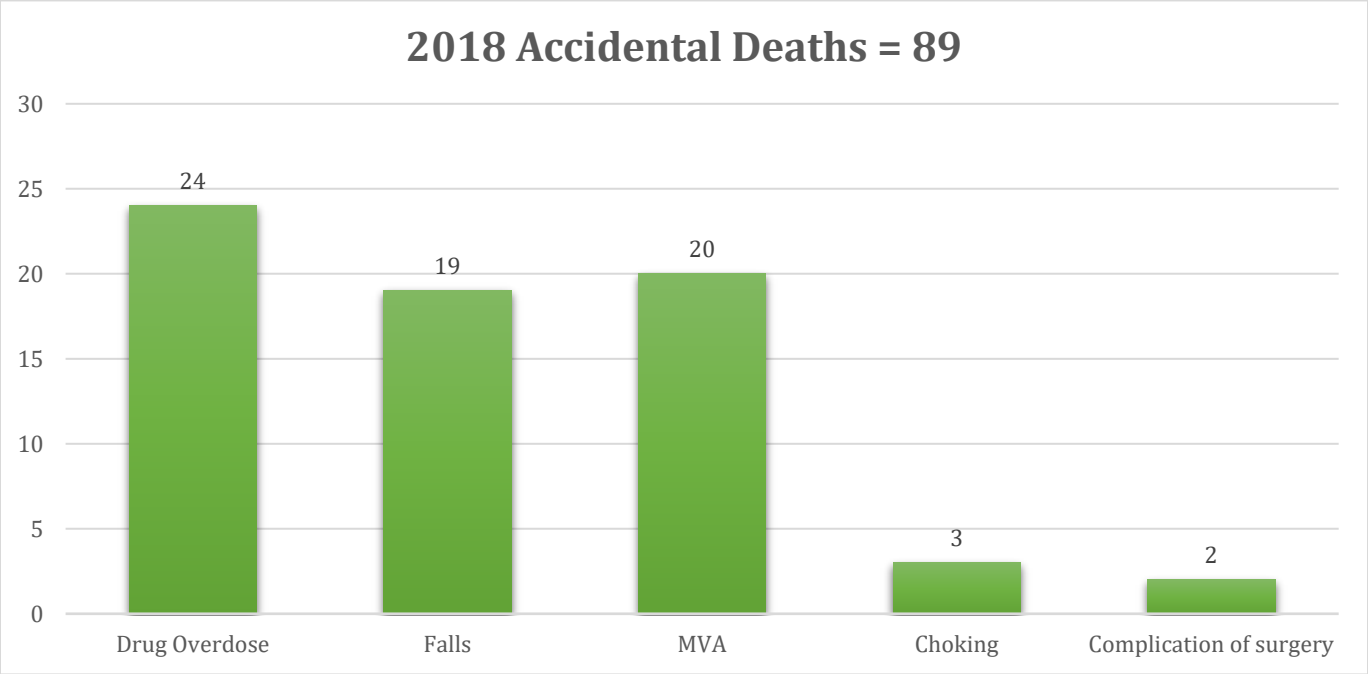


Figure 5. 2018 Skagit County Accidental Deaths

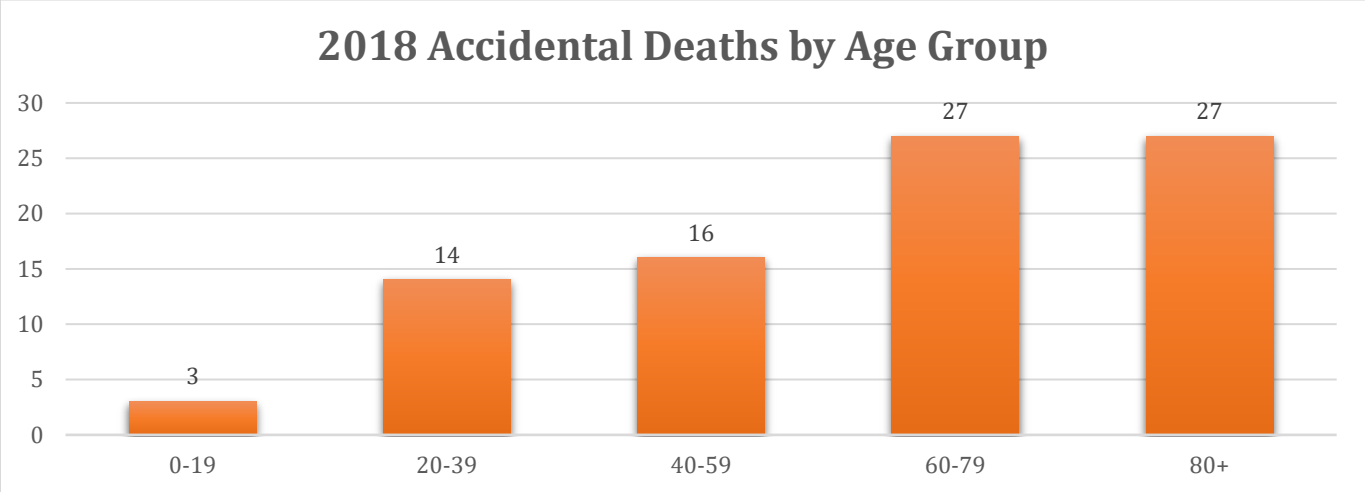
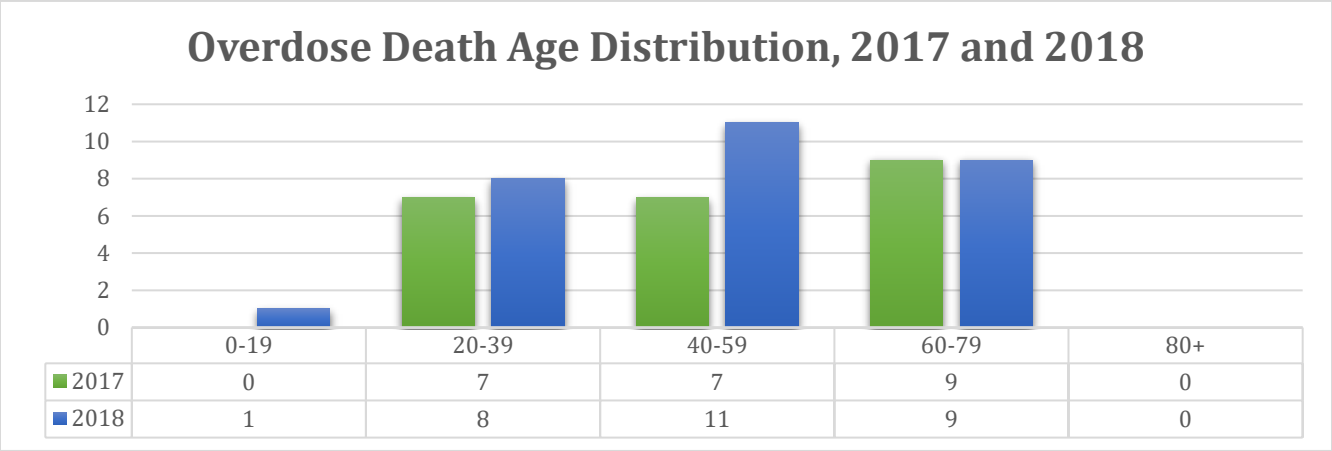


Figure 6. 2018 Skagit County Accidental Deaths by Age Group

Drug Overdose

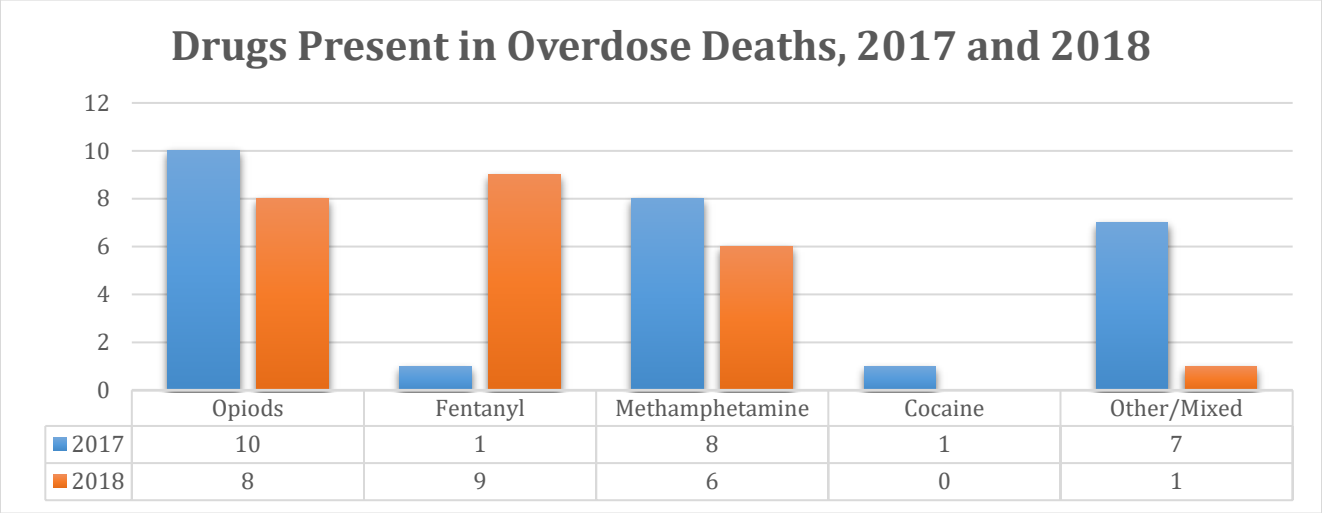
The number of drug overdoses classified as accidental in Skagit County in 2018 was 24. The number of fentanyl related drug overdoses for 2018 was 9. This was an increase from 2017 when there was only 1 case found with fentanyl. The opioid epidemic continued to be a major focus in Skagit County for 2018. Demographic analysis showed males (79% of cases) and Caucasians (83% of cases) to be mostly represented in drug overdose death statistics in Skagit County. The age distribution was 18-71 years with the age group 40-59 having the highest number of deaths.



	0-19	20-39	40-59	60-79	80+
2017	0	7	7	9	0
2018	1	8	11	9	0

Figure 7. 2017-2018 Skagit County Overdose Deaths by Age Groups

Expanded forensic toxicology testing was performed on suspected drug overdose deaths, allowing confirmation of the cause of death and the identification of both illicit and prescription drug abuse trends in Skagit County. Opioids remained the most common category of drugs found on this testing with fentanyl present in 37% of drug overdose deaths.

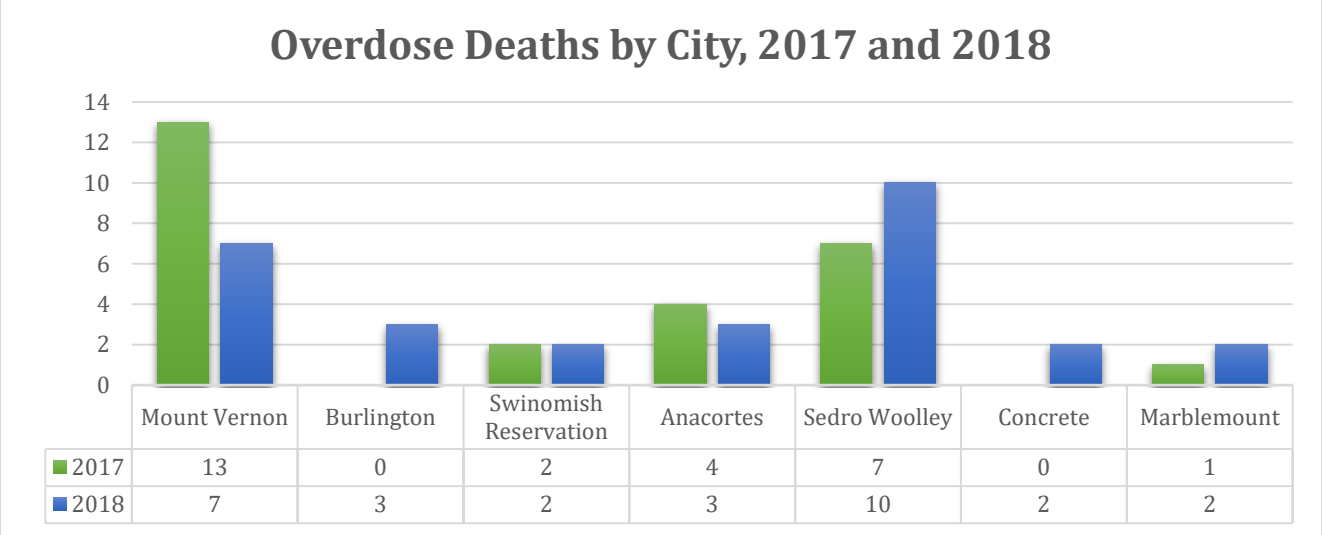


	Opiods	Fentanyl	Methamphetamine	Cocaine	Other/Mixed
2017	10	1	8	1	7
2018	8	9	6	0	1

Figure 8. 2017-2018 Skagit County Overdose Death by Drug Type

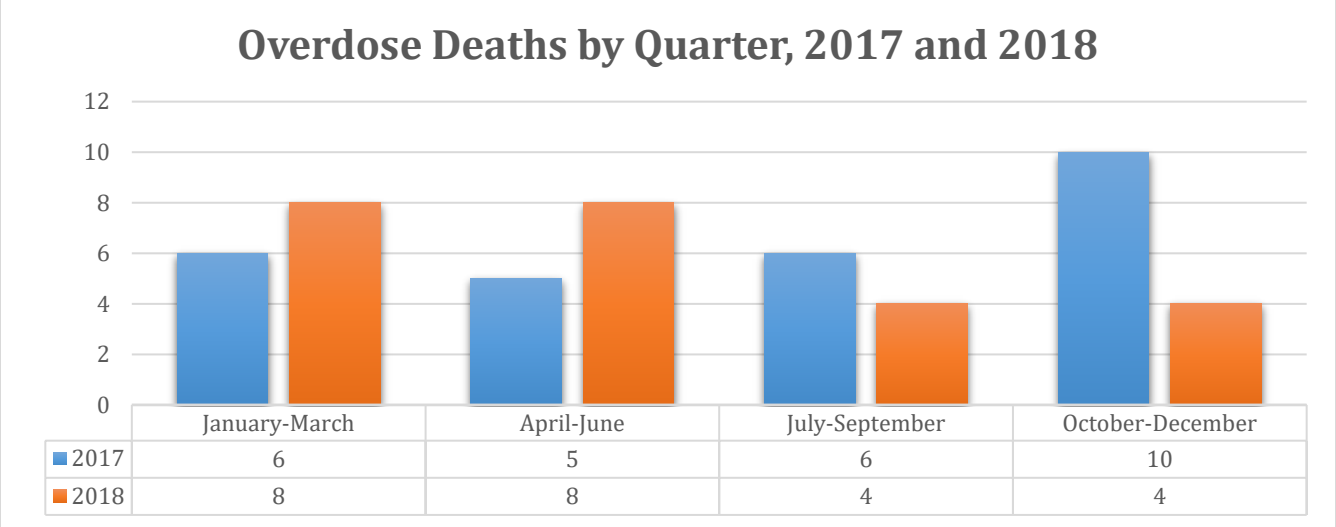
Drug overdose deaths are extensively investigated. It is important to note that a drug overdose is a diagnosis of exclusion requiring an autopsy to be performed on those who have little to no medical history in order to rule out other causes of death.

The Skagit County Coroner's Office takes an active role in sharing its data and insights regarding overdose deaths with the county as well as with the Skagit County Opioid Workshop Leadership Team established in July 2016.



	Mount Vernon	Burlington	Swinomish Reservation	Anacortes	Sedro Woolley	Concrete	Marblemount
2017	13	0	2	4	7	0	1
2018	7	3	2	3	10	2	2

Figure 9. 2017-2018 Skagit County Overdose Death by City



	January-March	April-June	July-September	October-December
2017	6	5	6	10
2018	8	8	4	4

Figure 10. 2017-2018 Skagit County Overdose Death by Quarter

Motor Vehicle Accidents

Motor vehicle accidents accounted for 22% of the accidental deaths in Skagit County for 2018 (20/89 cases). This was the second largest group of accidental deaths. Four of these traffic accidents resulted in two fatalities (driver and passenger in 3 of the cases). Decedents in the driver's seat accounted for 13 of the 20 deaths (3 of these were motorcycle drivers), while 4 were in a passenger seat, and 3 were pedestrians. All cases had toxicological testing performed. Of the 20 motor vehicle accidents, 6 (30%) of those were positive for alcohol with 5 having levels above the legal limit of BAC 0.08. Presence of marijuana was found in 4 of the cases and only 1 case had mixed drugs in their system.

Falls

There were 19 falls in 2018 accounting for 21% of accidental deaths. The majority of these falls were in those age 75 years or older (15/19, 78%). Falls were sometimes a direct cause of death, such as when the fall results in head trauma leading to a subdural hemorrhage. Falls were also an indirect cause of death, especially in the elderly. For example, a fall may result in a fracture that requires surgery and the decedent later develops pneumonia or sepsis.

Other Causes of Accidental Deaths

In addition to the accidental deaths listed above, there were 10 deaths classified as accidental. Of these 10 deaths, 3 were attributed to drowning, 3 resulted from choking, 2 were due to complications of surgery, 1 was from suffocation/overlay of an infant, and 1 was a result of blunt trauma caused by a falling tree branch.

Manner of Death: Suicide

Suicides are those deaths caused by self-inflicted injuries with the evidence of intent to end one's life. Evidence of intent can include explicit expression such as suicide note or verbal threat, or an act constituting implicit intent, such as deliberately putting oneself on the train tracks in a roadway or placing a gun to one's head.

In 2018, there were 22 suicides, accounting for 5.5% of the total deaths reported to the Coroner's Office. This is slightly lower than the 29 suicides certified in 2017. Individuals who committed suicide were between the ages of 16-88 years. The majority of these suicides were male (16/22, 72%). The primary method of suicide for 2018 was by way of firearm (13/22, 59%). There were 5 deaths attributed to hanging (22%), 2 from mixed drug intoxication, 1 fall from height, and 1 from exsanguination.

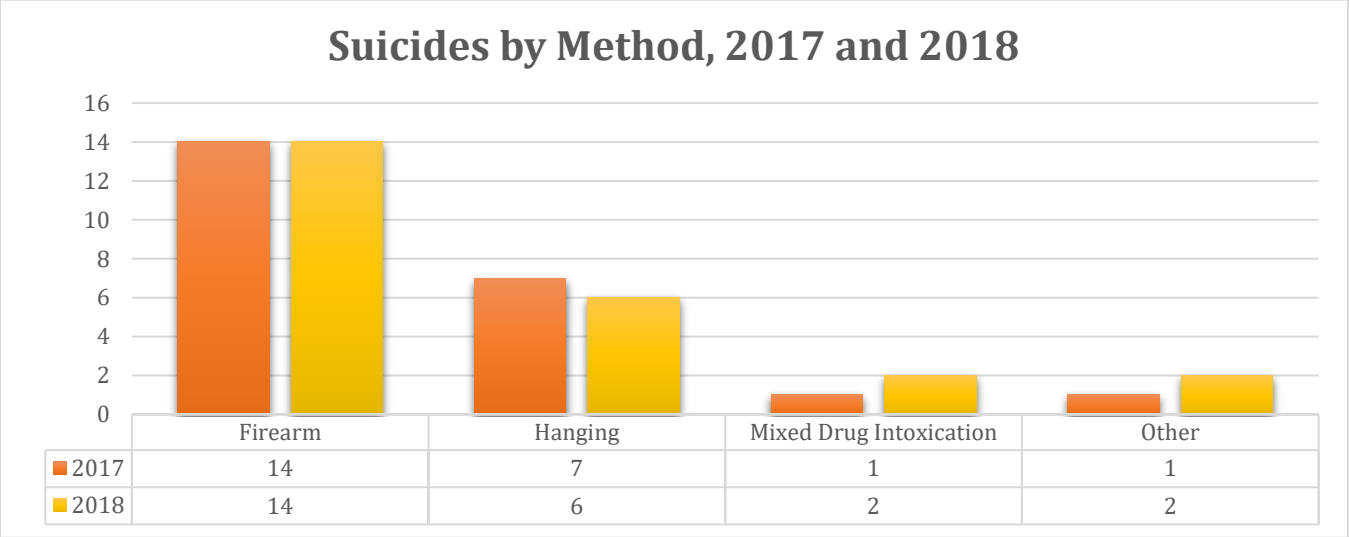


Figure 11. 2017-2018 Skagit County Suicides by Method

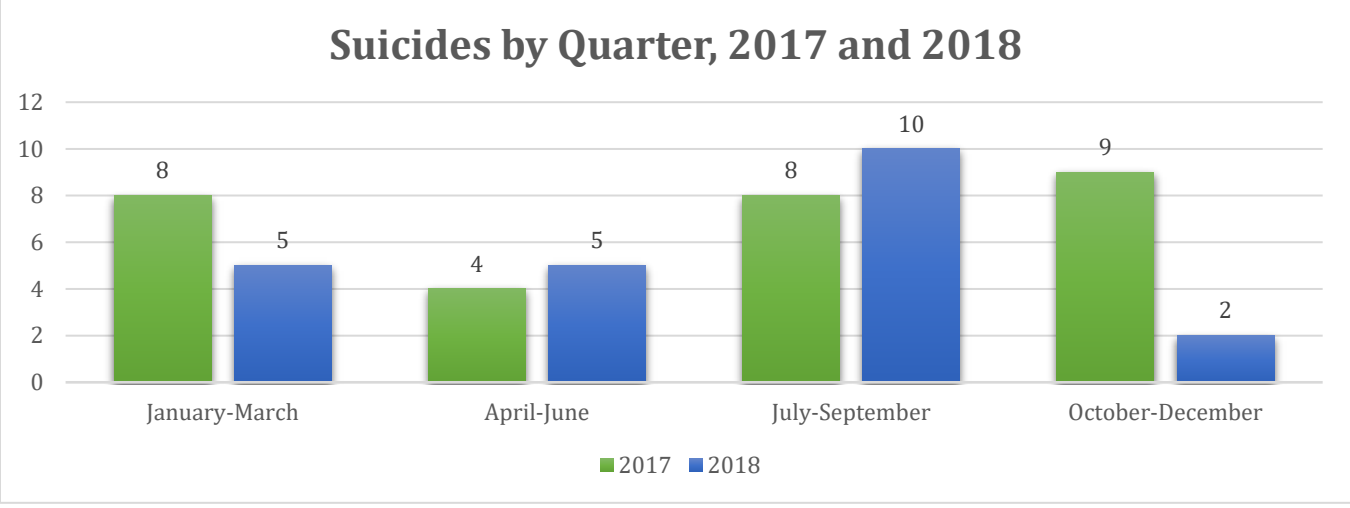


Figure 12. 2017-2018 Skagit County Suicides by Quarter

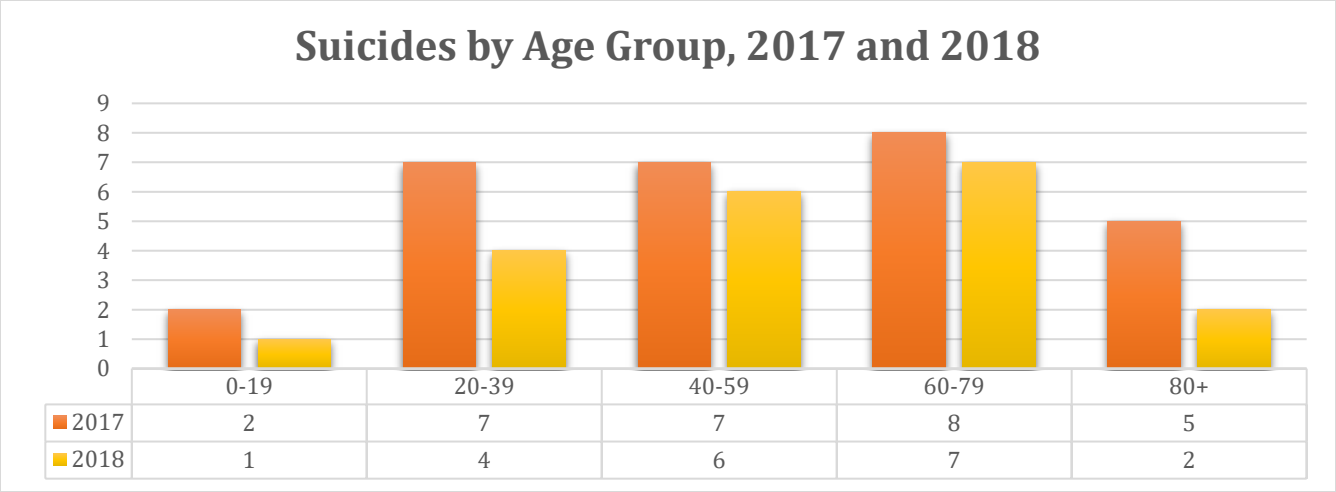


Figure 13. 2017-2018 Skagit County Suicides by Age Group

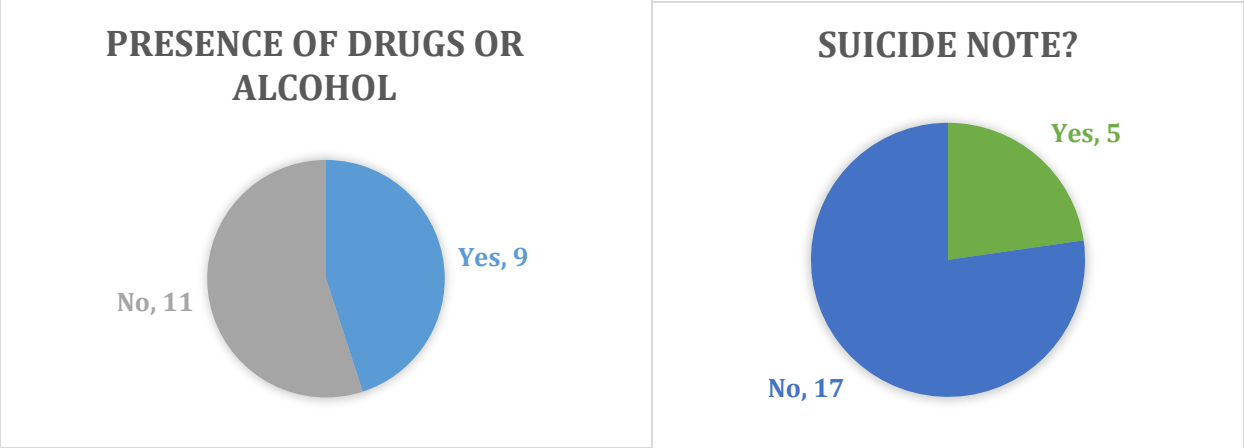


Figure 12. 2018 Skagit County Suicide Presence of Drugs or Alcohol and Suicide Note Left

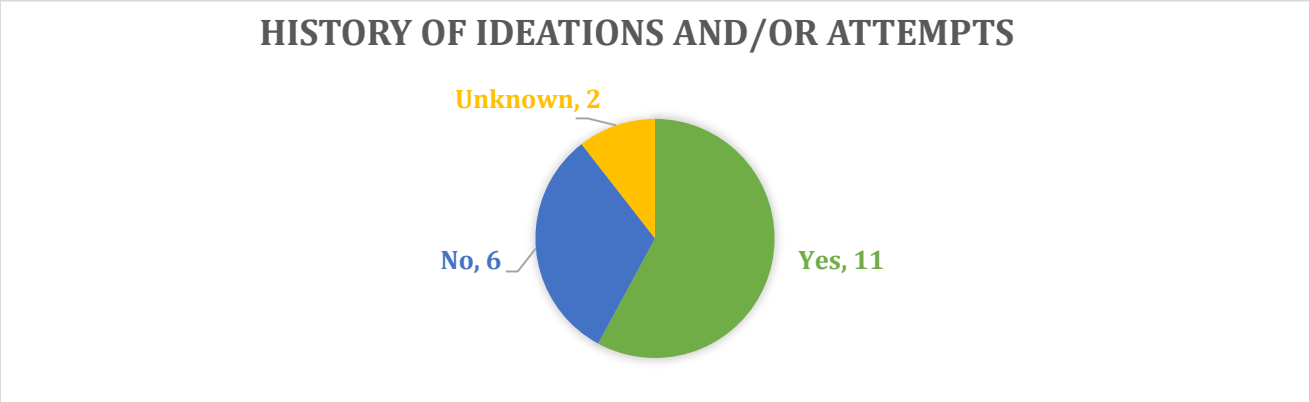


Figure 13. 2018 Skagit County Suicide History of Attempts and/or Ideations

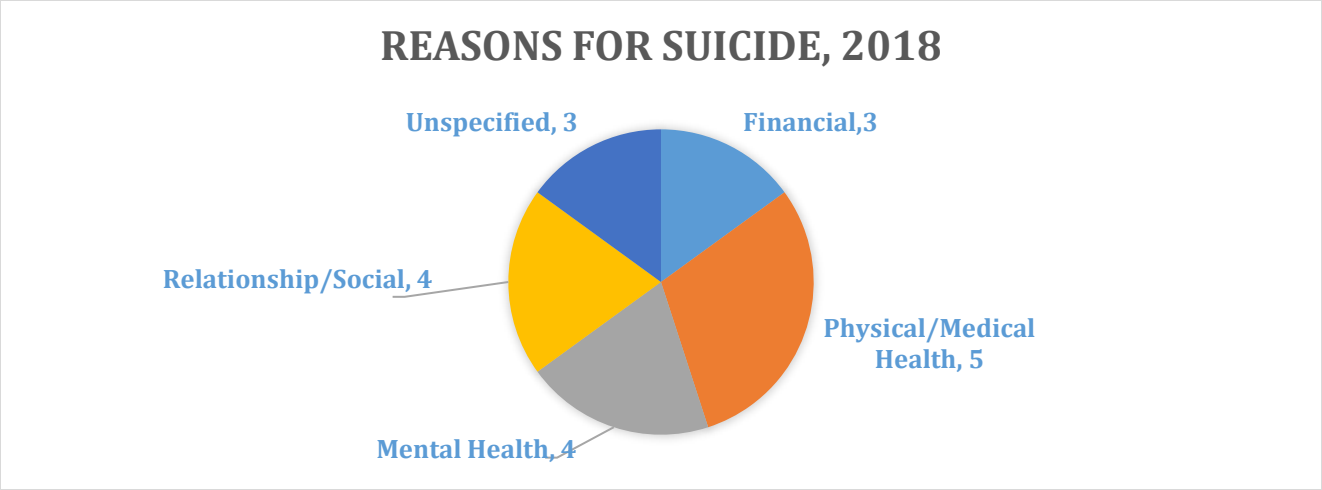


Figure 14. 2018 Skagit County Reason for Suicide

Manner of Death: Homicide

Classification of Homicide is determined by the Coroner when the death results from injuries inflicted by another person. This does not imply the existence of criminal intent behind the action of the other person. In 2018, the Coroner classified (1) death as a homicide.

There are cases in which the investigating law enforcement agency will investigate the case as a homicide. It is important to note, that there are certain cases in which this office will certify the death as an accident even though the case is being looked into as a homicide. Traffic fatalities in which a pedestrian is killed and the driver may show negligent behavior, probable intoxication, or fleeing of the scene will be classified as Accident even though these causes may meet a legal definition of vehicular homicide. This decision is based on the assumption that there was no intent to kill the individual. Whether or not this type of case meets the legal definition of vehicular homicide, it is better left to the criminal justice system to decide. This goes the same for motor vehicle accidents and deaths resulting from acute drug intoxication. As long as there was no intent to kill the individual, then the manner of death will be classified by the Skagit County Coroner's Office as Accident.

Manner of Death: Undetermined

The Coroner's Office certifies the manner of death as undetermined when available information regarding the circumstances of the case is insufficient to classify the death into one of the four manners of death: natural, accident, suicide, homicide. In some cases, serious doubt exists as to whether the injury occurred with intent or as a result of an accident. The information obtained from the case, may be lacking due to absence of background information or witnesses, or because of the lengthy delay between the time of death and the discovery of the body. If an extensive investigation and autopsy cannot clarify the circumstances, the death is classified as undetermined. If new credible information regarding the case is provided at a later time, then the manner of death can be changed.

There were 13 cases in 2018 where the Coroner's Office certified the manner of death as undetermined (13/399, 3%). Six of these cases were discovered skeletal human remains (6/13, 46%). Causes of death were: undetermined (7/13, 53%), smoke inhalation (2/13), sudden infant death (1/13), acute drug intoxication (1/13), pedestrian lying in roadway (1/13), and fall from height (1/13).

Tissue and Cornea Donation

The Skagit County Coroner's Office are adamant supporters of facilitating donation within the Skagit County Community. The Coroner's Office is proud of its partnership with SightLife and LifeNet Health. In late 2017, the Coroner's Office upgraded its case reporting system to a national case management system that is linked to the Organ Procurement Organizations (OPO's). This has allowed the Coroner's Office to automatically notify the OPO's of all potential organ, tissue (skin, long bones, heart for valves), and cornea donation cases regardless if the person died in the hospital or at another location. It is important to note, that there is specific criteria that qualifies cases for donation. The time interval between the last known alive time and the time of death as well as the decedent's age and social history (drug use) are three main determining factors.

Cornea Donation

For 2018, Sight Life received 407 referrals in Skagit County. Out of the 407 referrals, there were a total of 64 cornea donors potentially helping 128 individuals see again. Out of the 64 donors, 9 of these cases were Coroner cases.

Tissue Donation

In 2018, a total of 123 referrals were made from the local hospitals in Skagit County. In addition to the hospital referrals, the Coroner's Office referred 41 cases for potential tissue donation. The total number of cases recovered for donation were 18 from the hospitals and 5 from the Coroner's Office.

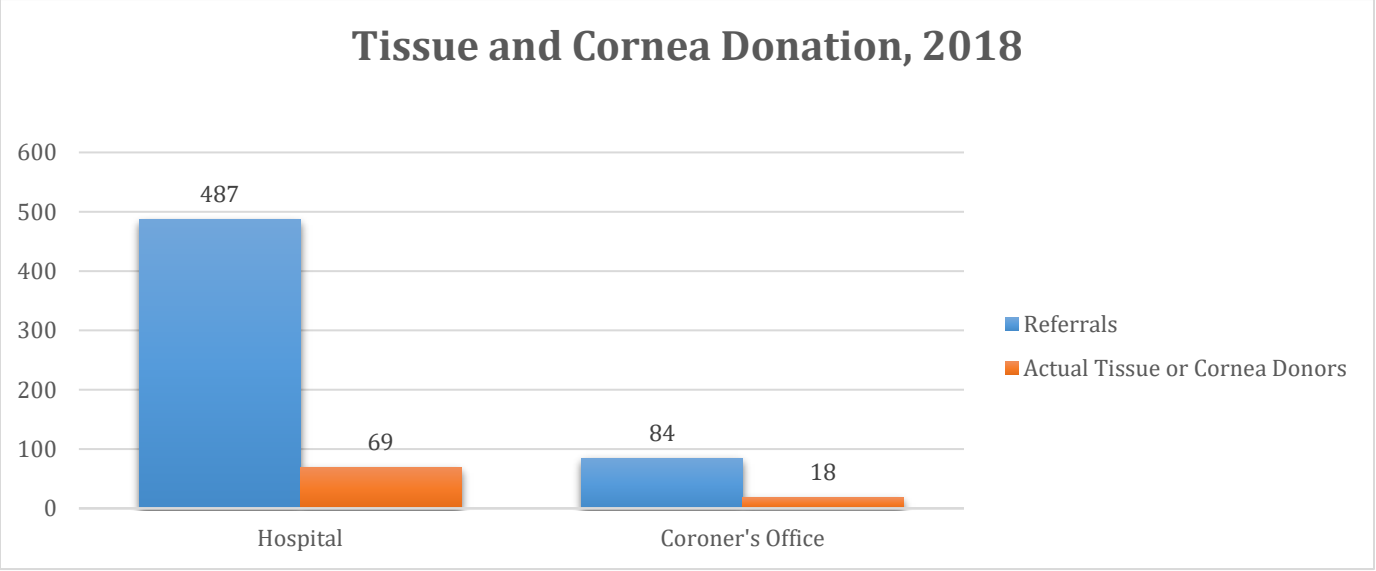


Figure 15. 2018 Skagit County Tissue and Cornea Donation