

## 2025 ANNUAL REPORT



This annual report presents a transparent and accountable summary of the activities, case data, and emerging trends of the Skagit County Coroner's Office, demonstrating our commitment to public service, community trust, and the fulfillment of our statutory responsibilities.

# Skagit County Office of the Coroner

Hayley Thompson, D-ABMDI

1700 CONTINENTAL PLACE, MOUNT VERNON, WA 98273

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# SKAGIT COUNTY CORONER'S OFFICE 2025 ANNUAL REPORT

## MISSION STATEMENT

The mission of the Skagit County Coroner's Office is to serve our community through independent, compassionate, and professional medicolegal death investigations. We are dedicated to finding the truth in every case while honoring the decedent and supporting their families and loved ones.

## VISION STATEMENT

Our vision is to be a trusted partner to the Skagit County community by providing compassionate, professional service and collaborating with local agencies to reduce preventable deaths and promote community well-being.

## DEDICATION

We acknowledge that each case in this report represents the loss of a person whose absence is deeply felt by family, friends, and our community. We dedicate this report to those individuals, their loved ones, and the citizens of Skagit County whom we are honored to serve with compassion each day.

## ABOUT THE CORONER'S OFFICE

The Skagit County Coroner's Office investigates the circumstances surrounding a person's death independently of any law enforcement agency with the primary role of determining the *cause* and *manner* upon notification of deaths that are unexpected, unexplained, suspicious, violent, or in which the cause and/or manner of death is unknown. In addition to this role, the coroner is responsible for identifying decedents, locating and notifying next of kin, and ensuring appropriate disposition in cases where remains are unclaimed. The Coroner's Office strives to provide every individual in need of our services with factual direction, professionalism, commitment, and care.

## CORE VALUES

### INTEGRITY:

Honesty in everything we do; knowing it is critical to do the best we can for all decedents and their families to arrive at the most accurate conclusion of each death we investigate.

### COMPASSION:

To be able to recognize and respond with sincerity to the needs, concerns, and fears of those experiencing a loss.

### SERVICE:

To be available anytime we are needed, and to respond to provide our services quickly and with an emphasis on thoroughness. Assist other agencies, both public and private, in gathering and sharing information with them relative to their participation in the cases we investigate.

### PREVENTION:

Provide timely and accurate information on causes and manners of death and engage with community partners to support proactive strategies aimed at reducing preventable deaths, including drug-related fatalities and suicides.

### Role of the Coroner

Determining cause and manner of death	Through medical and investigative review
Confirming identification of the decedent	Using scientific and forensic methods
Locating and notifying next of kin	Verifying legal priority, ensuring timely outreach, and delivering the message with professionalism and compassion
Returning personal property	Ensuring proper documentation and custody
Sharing findings with partner agencies	Helping prevent future deaths

**Figure 1:** Responsibilities of the Coroner's Office

## ACCREDITATION



In 2022, the Skagit County Coroner's Office embarked on a journey to achieve accreditation through the International Association of Coroners and Medical Examiners (IACME). This rigorous process ensures that our office meets the highest standards in medicolegal death investigations, reflecting our commitment to excellence, integrity, and the community we serve.

In January 2024, we proudly completed the accreditation process, becoming the 39th coroner's office in the nation and the 7th in Washington State to achieve this distinction. This milestone is a testament to our dedication to providing Skagit County residents with compassionate, professional, and trusted service every day.



## SKAGIT COUNTY



Skagit County spans over 1,730 square miles, encompassing coastal, agricultural, and mountainous regions. Its communities include: Mount Vernon, Burlington, Anacortes, Guemes Island, La Conner, Bow, Alger, Sedro-Woolley, Lyman, Hamilton, Concrete, Rockport, and Marblemount. The county is also home to (3) Native American tribes: the Swinomish Tribe, Upper Skagit Tribe, and Sauk-Suiattle Tribe.

According to the 2024 U.S. Census Bureau, Skagit County has an estimated population of approximately 132,736

residents, reflecting a modest growth rate of 2.5% since 2020. The county ranks as the 11th largest in Washington State. Skagit County's population is diverse, with 71.7% identifying as Caucasian, 20.3% Hispanic or Latino, 2.9% American Indian or Alaska Native, 2.8% Asian, 1.3% African American, and 3.5% identifying as two or more races. Approximately 23.6% of the population is aged 65 years or older, while 20.4% is under the age of 18 years.

### AREA HOSPITALS

Skagit County is served by three hospitals that provide a range of emergency, trauma, and specialty medical services to county residents and surrounding communities.

- **SKAGIT VALLEY HOSPITAL**, located in Mount Vernon, Washington, is a **137-bed Level III Trauma Center**. The hospital provides a full range of medical services, including surgical services, renal dialysis, advanced diagnostic imaging, and comprehensive heart and vascular care.
- **PEACEHEALTH UNITED GENERAL HOSPITAL**, located in Sedro-Woolley, Washington, is a **25-bed Level III Critical Access Hospital**. It serves residents of Burlington, Sedro-Woolley, Bayview, Samish Island, Concrete, Marblemount, Clear Lake, and portions of Mount Vernon, offering essential medical and emergency services to rural and outlying communities.
- **ISLAND HOSPITAL**, located in Anacortes, Washington, is a **43-bed Level III Trauma Center** providing emergency and inpatient care to residents of Anacortes and surrounding island and coastal communities.



**Figure 2.** Skagit County Population Growth

## CAUSE AND MANNER OF DEATH CLASSIFICATION

Per the *Guide for Manner of Death Classification, 1st Edition*, prepared by the National Association of Medical Examiners (NAME), deaths investigated by the Coroner/Medical Examiner are classified by both cause of death and manner of death.

### CAUSE OF DEATH

The **CAUSE OF DEATH** is the official medical determination of the disease or injury and the sequence of events that directly results in an individual's death.

### MANNER OF DEATH

The **MANNER OF DEATH** describes the circumstances under which the death occurred and the conditions that led to the fatal outcome. This determination is based largely on the medicolegal investigation and is used primarily for statistical and public health purposes. The classification of manner of death has **no direct bearing** on criminal prosecution, insurance determinations, or judicial proceedings.

Under the Coroner/Medical Examiner system, certain deaths- such as controlled substance-related deaths and vehicular fatalities- may be classified as accidents when there is no evidence of intent to harm another person, even if criminal charges are pursued separately.

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IN WASHINGTON STATE THERE ARE (5) MANNERS OF DEATH, LISTED BELOW

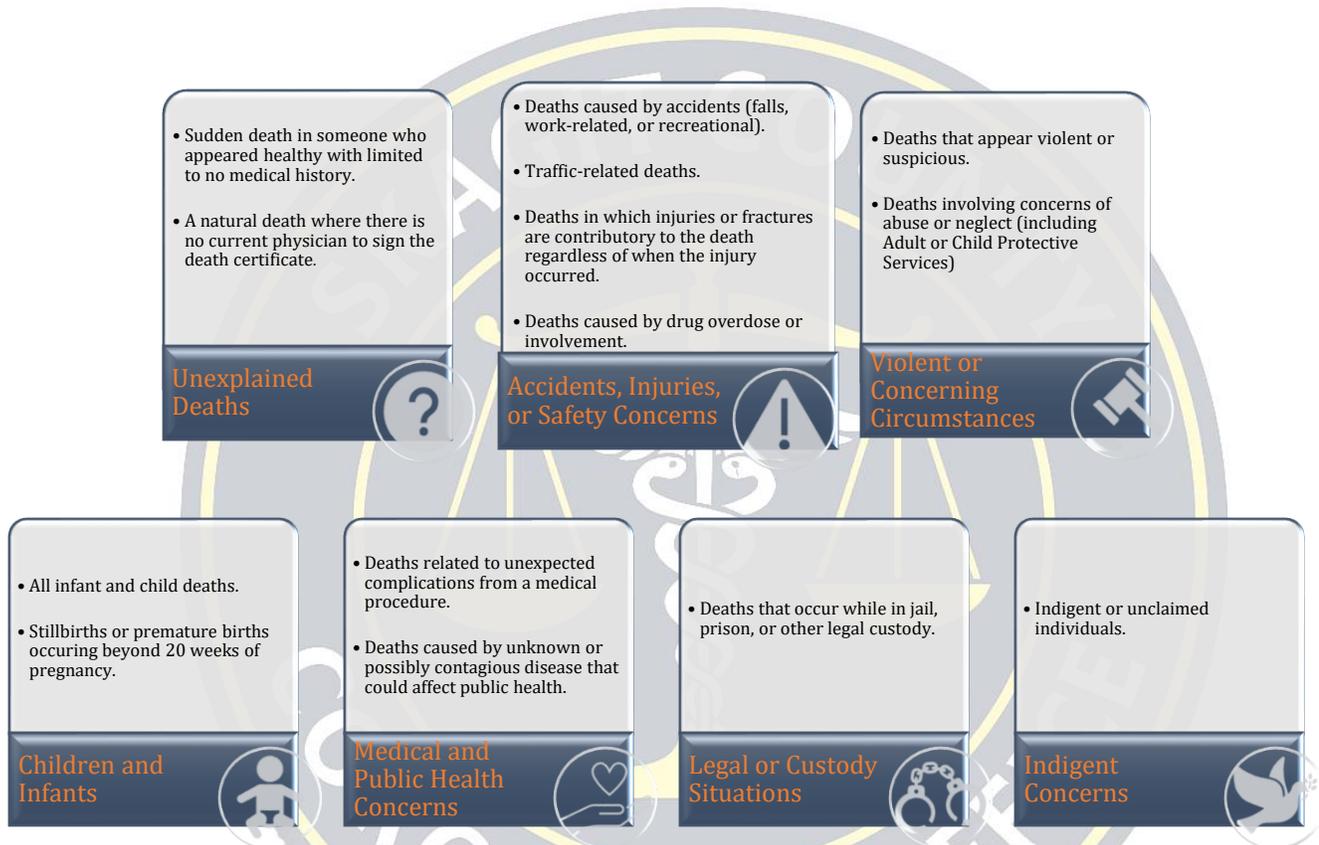
Natural	Accident	Suicide	Homicide	Undetermined
<ul style="list-style-type: none"><li>•Death caused by disease and/or aging process</li></ul>	<ul style="list-style-type: none"><li>•Death resulting from an injury or poisoning where there is little to no evidence of intent to cause harm or death.</li></ul>	<ul style="list-style-type: none"><li>•Death resulting from an intentional self-inflicted injury or poisoning carried out to cause self-harm or death.</li></ul>	<ul style="list-style-type: none"><li>•Death resulting from a volitional act committed by another person to cause fear, harm, or death.</li></ul>	<ul style="list-style-type: none"><li>•Used when after thorough investigation, the available information does not clearly support one manner of death over one or more competing classifications.</li></ul>

**Figure 3.** Manners of Death

## JURISDICTION

The Coroner's Office has investigative authority only within Skagit County, regardless of the decedent's county or state of residence. If a Skagit County resident dies outside the county, jurisdiction rests with the coroner or medical examiner in the county where the death occurred.

Under **Revised Code of Washington 68.50 (RCW 68.50)**, the Skagit County Coroner's Office must be notified when a person is found deceased in Skagit County and was not under the direct care of a physician at the time of death. The Coroner is responsible for investigating deaths that meet one or more of the following criteria:



**Figure 4.** Reportable Deaths to Coroner's Office

The Coroner assumes jurisdiction over sudden, violent, traumatic, or otherwise unexpected deaths. This includes certain deaths that appear natural but lack recent medical oversight or a documented medical condition sufficient to explain the death. Deaths that occur under active hospital care, hospice services, or other ongoing medical supervision generally do not require notification unless statutory criteria are met.

The Coroner is the only official legally authorized to certify deaths that are not natural in manner, including those classified as accident, suicide, homicide, or undetermined. In such cases, the Coroner's Office conducts a thorough investigation into the facts and circumstances surrounding the death to determine both cause and manner of death. When available information is insufficient to make this determination or documentation is necessary for judicial purposes, the Coroner may order an autopsy or other postmortem studies.

For operational and reporting purposes, the Skagit County Coroner's Office classifies death reports into two categories:

### I. Non-Jurisdictional Cases

These cases typically involve attended natural deaths in hospitals, licensed care facilities, or hospice settings. While reporting to the Coroner's Office is not required, when such cases are reported, no further investigation is needed if a qualified healthcare provider can certify the death as due to natural causes and the circumstances do not suggest an unnatural cause. If the circumstances or cause of death appear unnatural, or if no provider is available or able to certify the death, the case is treated as jurisdictional.

### II. Jurisdictional Cases

These include deaths—natural or non-natural—that meet statutory reporting requirements and require further investigation to establish cause and manner of death. This classification ensures compliance with state law while allowing the Coroner's Office to allocate investigative resources effectively and maintain thorough, professional standards in every case.

## IDENTIFICATION AND LOCATING NEXT OF KIN

In every case, confirming the identity of the decedent and locating the legal next of kin is a critical and time-sensitive responsibility of the Skagit County Coroner's Office. Accurate identification is essential to ensure proper certification of death, facilitate notification of family members, and uphold the integrity of the investigative process.

Although these responsibilities are urgent, the process of establishing a positive identification or locating legal next of kin can require a significant amount of time. Complex cases may involve limited available records, unrecognizable remains, estranged family relationships, or out-of-state and international inquiries, all of which can extend the investigative timeline.

The identification process may require coordination with forensic specialists or accredited out-of-state DNA laboratories. Depending on the condition of the remains and the availability of antemortem records, identification methods may include dental record comparison, fingerprint analysis, forensic anthropology, or DNA testing.

## UNCLAIMED AND INDIGENT CASES

In accordance with RCW 68.50.230 and 36.39.030, the county is responsible for the disposition of unclaimed remains 45 days after death. The Skagit County Coroner's Office participates in two donation programs that return remains at no cost to the county as well as maintains contracts with local funeral homes to provide county cremations. The office makes extensive efforts to locate next of kin and discuss disposition options with families. When remains become legally unclaimed, a remembrance ceremony is held to honor those individuals.

In May 2025, in partnership with Kern Funeral Home, the Coroner's Office held the second indigent ceremony in its history, the first having been held in 2019. The ceremony honored 53 unclaimed cremains, providing a respectful and dignified farewell. Unclaimed remains were dispersed at sea, while cremains of identified veterans were transported to Tahoma National Cemetery for proper honors and interment. Going forward, the Coroner's Office will conduct an indigent ceremony every two years, with the next scheduled for May 2027. This biennial observance ensures that every individual is remembered with care and respect, regardless of circumstances.

## AUTOPSY SERVICES

All autopsies are performed by a board-certified forensic pathologist under the direction of the Coroner. The Skagit County Coroner's Office contracts with (2) board-certified forensic pathologists, as well as the Snohomish County Medical Examiner's Office to provide autopsy services. These pathologists adhere to the professional standards set by the International Association of Coroners and Medical Examiners (IACME) and the National Association of Medical Examiners (NAME).

When an autopsy is necessary to determine or document the cause and manner of death, the examination may include:

- Collection of body fluids and tissues for microscopic and toxicological analysis
- A comprehensive external and internal anatomical examination
- Photographic documentation to support investigative and medical findings
- Preparation of a detailed autopsy or consultation report outlining findings, cause of death, and manner of death

## RECORDS AND CONFIDENTIALITY

All records maintained by the Coroner's Office, including autopsy and investigative reports, are confidential and not subject to public disclosure under Washington law (RCW 68.50 and RCW 42.56). Access is limited to agencies involved in the case—such as law enforcement, prosecuting attorneys, attending physicians, and other relevant agencies (e.g., OSHA, FAA, NTSB, Labor & Industries, Adult or Child Protective Services)—as well as the legal next of kin and immediate family. Requests for reports from outside parties require authorization from the legal next of kin.

The Coroner's Office works closely with law enforcement, medical personnel, and community groups, providing information on its role and sharing case data to support prevention and public safety.

Revised Code of Washington 68.50.300 governs the release of information concerning a death. When the media inquires about a death investigation, only authorized information is released and is provided in written form on the Skagit County Coroner's Office website under Media Releases.

Current statistics, annual reports, confirmation of death lists by year, and informational guides for the public and families are also available on the Coroner's website to promote transparency and public access to information.

## CORONER'S OFFICE FACILITIES AND VEHICLES

The Skagit County Coroner's Office, located at 1700 Continental Place, Mount Vernon, WA, operates from a fully equipped facility supporting all aspects of medicolegal death investigations. The facility includes administrative and investigative office space, as well as a morgue and autopsy suite for thorough on-site examinations. The facility is equipped to provide appropriate refrigerated storage, maintain evidentiary integrity, and ensure respectful care of the deceased while investigations, identification, next-of-kin notification, and final disposition arrangements are completed.

The office utilizes two county vehicles to support operations: a 2016 Ford Transit Van and a 2018 Chevrolet Suburban.



Coroner's Office



Secure Morgue with storage capacity of 12 decedents.



Autopsy suite equipped with two autopsy stations, allowing for the simultaneous examination of decedents.



2018 Chevrolet Suburban with four-wheel drive configured to transport one decedent.



2016 Ford Transit Van is configured to transport two decedents

## CORONER'S OFFICE STAFF

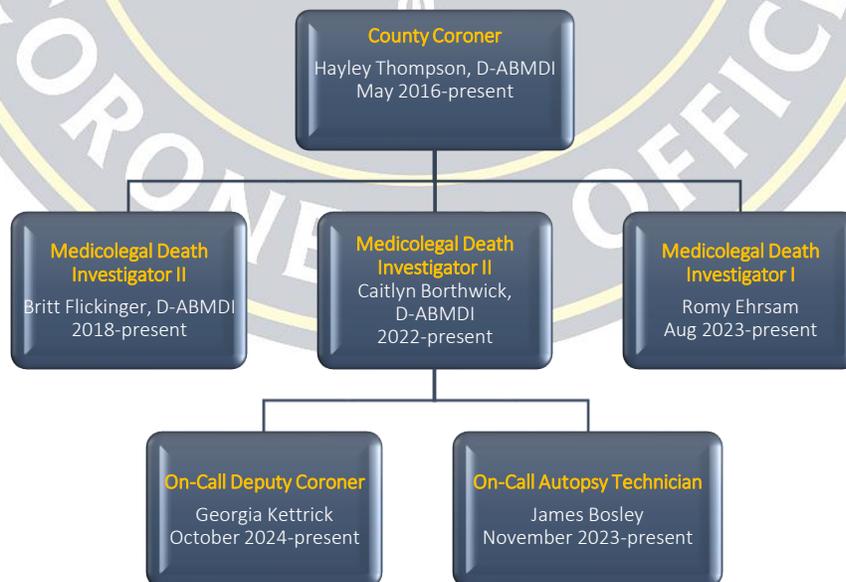


The staff of the Skagit County Coroner's Office bring diverse backgrounds, training, and experience that greatly enhance the quality of our investigations. Coroner staff engage in a wide range of activities to fulfill the responsibilities mandated by state law. These duties include responding to and investigating death scenes, performing postmortem examinations, confirming decedent identification, certifying cause and manner of death, and providing information and support to families. Staff communicate directly with families, reviewing findings and addressing questions that often accompany sudden or traumatic losses.

In 2024, the Skagit County Coroner's Office reorganized its staff to strengthen leadership and career development. Full-time deputy coroners were reclassified as Medicolegal Death Investigators (MDI) I and II, with opportunities for promotion and supervisory responsibilities. A full-time MDI I was added, and the office continues to be supported by an on-call deputy coroner and on-call autopsy technician.

All full-time and on-call deputy coroners are required to obtain state and national certifications, reflecting the office's commitment to professional excellence. By the end of 2025, the Coroner and nearly all full-time investigators had achieved both certifications, with remaining staff actively completing the certification process.

Since the end of 2016, the Skagit County Coroner's Office has managed an internship program offering students and individuals interested in the field the opportunity to gain hands-on experience in medicolegal death investigations. Since its inception, the office has hosted over 75 interns. In 2025, the program was transformed into a more structured and professional learning opportunity with specific requirements for participation. Throughout the year, the office hosted 2–5 interns per quarter, providing valuable practical experience while supporting the operations of the Coroner's Office.



**Figure 5.** 2025 Skagit County Coroner Organization Chart

## STAFFING

County Coroner

**Hayley Thompson, D-ABMDI**

*(Left to Right)*

**Britt Flickinger, D-ABMDI**

Medicolegal Death Investigator II

**Romy Ehrsam**

Medicolegal Death Investigator I

**Caitlyn Borthwick, D-ABMDI**

Medicolegal Death Investigator II

**Georgia Ketrick**

On-Call Deputy Coroner



## STRATEGIC GOALS OF THE CORONER'S OFFICE

The Skagit County Coroner's Office is committed to serving the community with integrity, professionalism, and compassion. Our strategic goals ensure that every death investigation is conducted thoroughly, ethically, and with respect for the families we serve.

### Professional Development

Support the professional growth of all Medicolegal Death Investigators by ensuring that ABMDI certification and Washington State Medicolegal Forensic Investigation Certification are achieved by all current staff by December 2026.

### Community Engagement

Keep the community informed by sharing monthly death statistics and updates on the Coroner's Office website.

### Transparency and Accountability

Promote transparency and accountability by publishing an annual report before June of each year.

### Education and Outreach

Educate and engage the community, partner agencies, and the public about the role and work of the Coroner's Office, while offering career development opportunities such as internships. Participate in at least five presentations or events per year and provide opportunities for at least three interns per quarter.

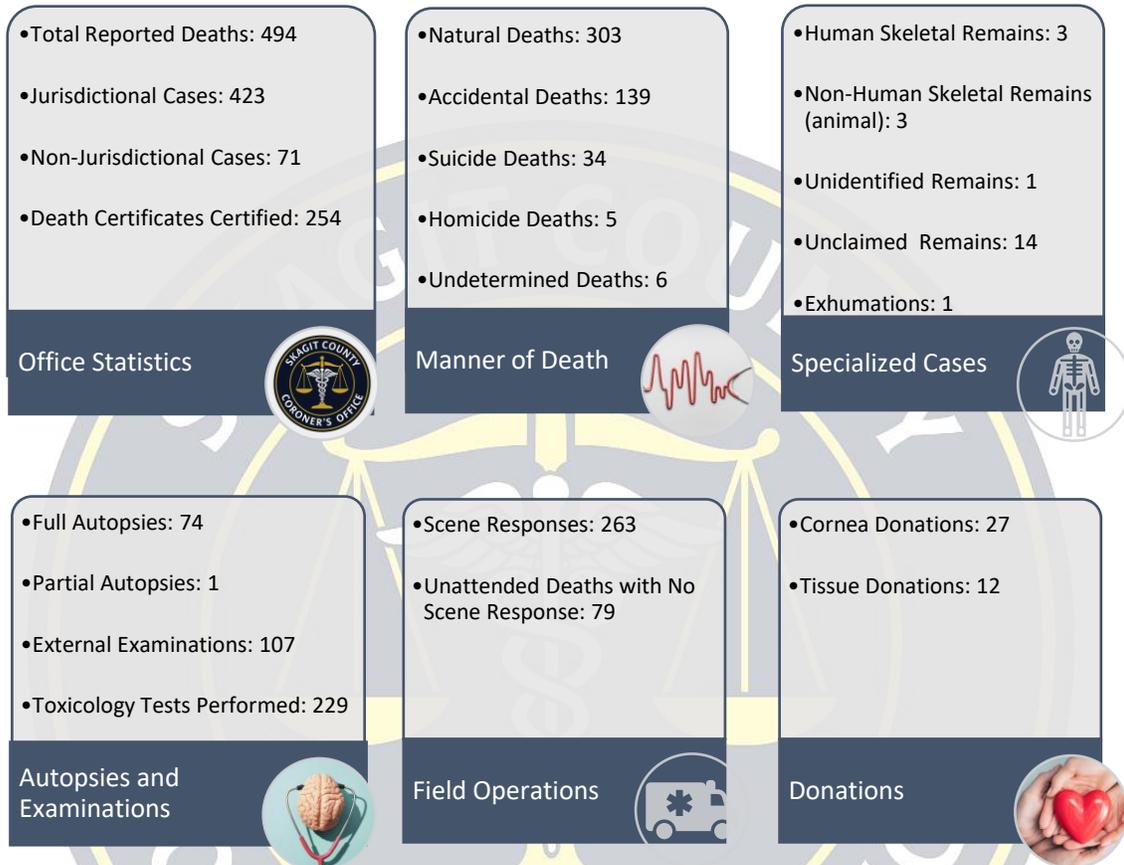
### Operational Excellence

Maintain excellence in operations by reviewing and updating all policies and procedures annually, ensuring that best practices are consistently applied.

**Figure 6.** Strategic Goals of Skagit County Coroner's Office

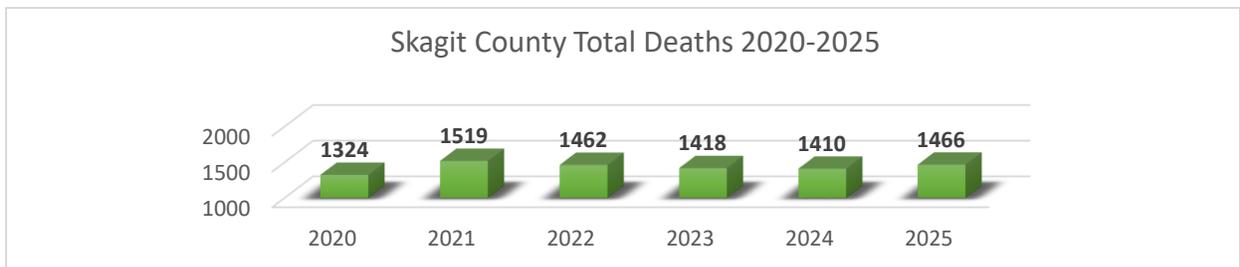
## DEATH INVESTIGATIONS- AN OVERVIEW

The Skagit County Coroner’s Office Annual Report only includes deaths investigated by our office. It does not reflect all deaths that occur in Skagit County. For information on all deaths in the county, please visit the Washington State Department of Health, Bureau of Vital Records.

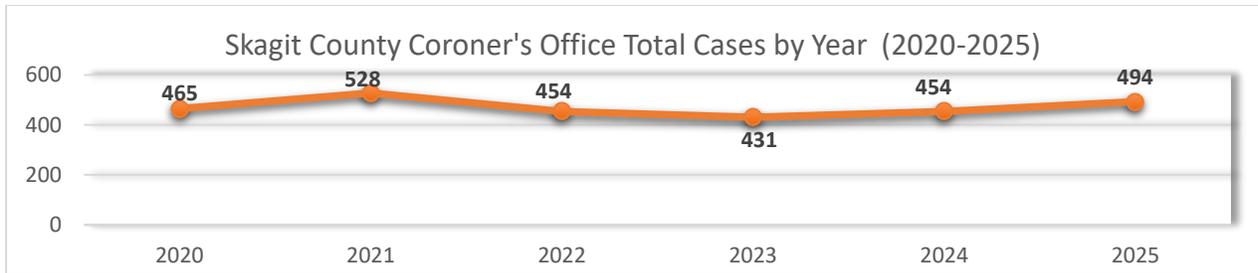


**Figure 6.** 2025 Stats

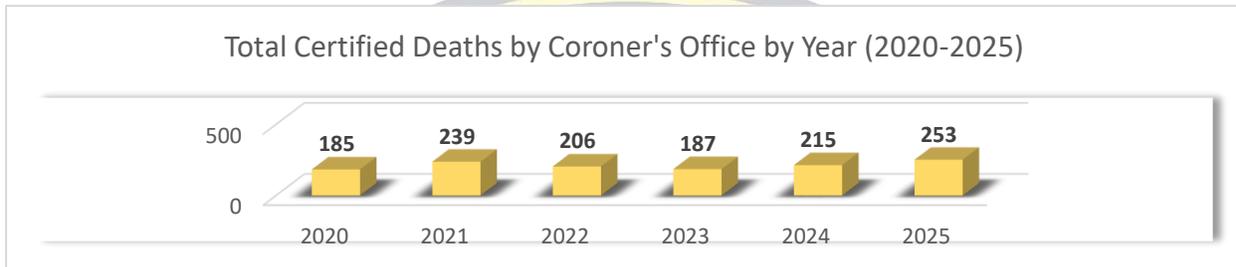
In 2025, Skagit County recorded a total of 1,466 deaths. The Coroner’s Office investigated 494 of these cases, representing 33.7% of all deaths, and assumed jurisdiction in 423 cases. Of the jurisdictional cases, 253 (59.8%) were certified by the Coroner. At the Skagit County Coroner’s Office, each case is reviewed carefully, and decisions about the cause of death and whether the office assumes jurisdiction are based on the unique circumstances of that case. Because every case is different, year-to-year comparisons should be interpreted with caution. See Figures 8-12.



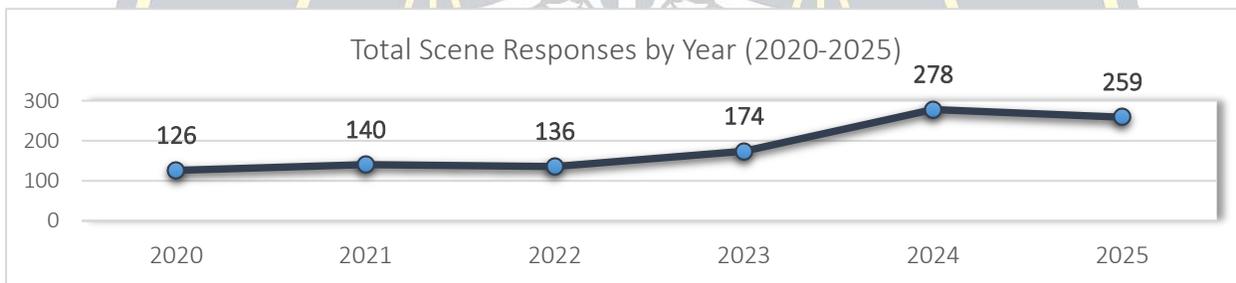
**Figure 7.** Skagit County Total Deaths per Year (2020-2025)



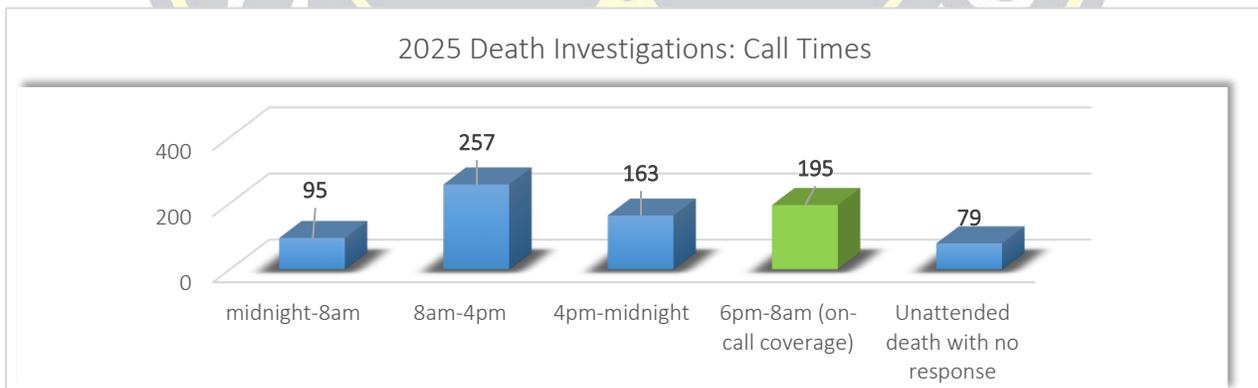
**Figure 8.** Skagit County Coroner Total Cases (2020-2025)



**Figure 9.** Skagit County Coroner Certified Deaths by Year (2020-2025)



**Figure 10.** Total Scene Responses by Year (2020-2025).



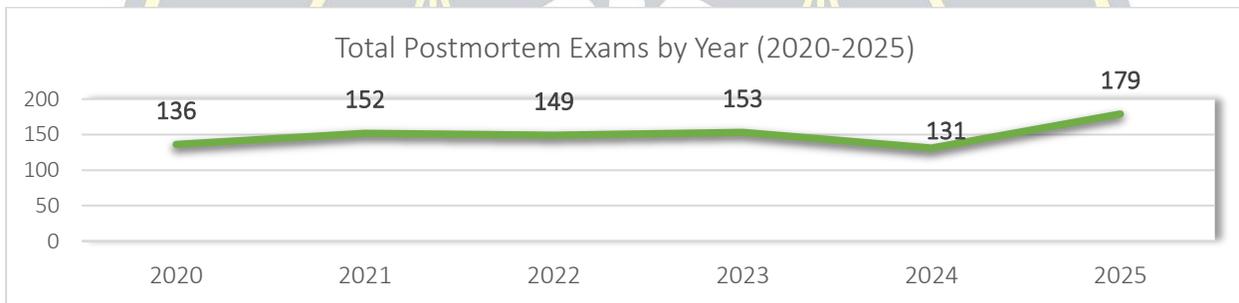
**Figure 11.** Timing of Death Reports in 2025

A review of deaths reported to the Coroner's Office from 2020–2025 shows that annual case volumes have remained relatively steady, ranging from 431 to 528 cases. In 2025, the office received 494 death reports, the second-highest total during this period (see Figure 8). The busiest hours for calls were 8:00 a.m. to 4:00 p.m. (257 calls), accounting for 52% of the total deaths reported, while 39.5% of deaths occurred during the current on-call hours of 6:00 p.m. to 8:00 a.m. (see Figure 11).

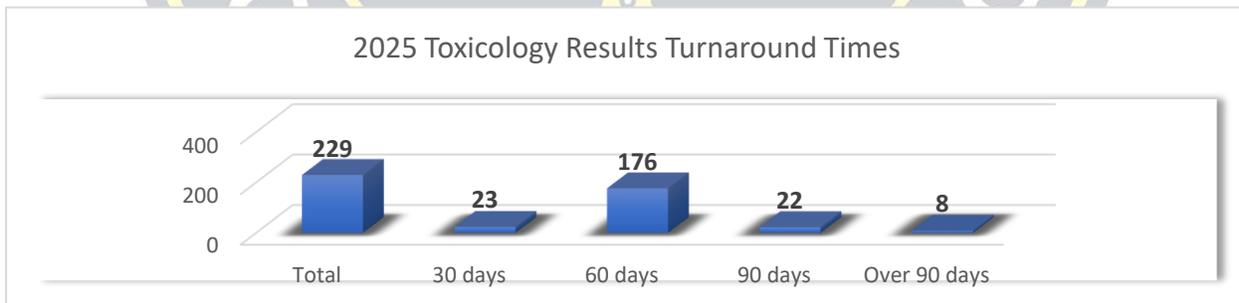
With current staffing, the Skagit County Coroner’s Office operates from 8:00 a.m. to 6:00 p.m., providing coverage for scene responses, office work, follow-up, and body examinations while ensuring staff receive adequate days off. Staff alternate being on-call overnight from 6:00 p.m. to 8:00 a.m. Due to coverage limitations, the office is currently unable to implement a dedicated 4:00 p.m. to midnight shift, which would cover approximately 33% of calls and reduce overnight on-call hours to eight per night.

As the county population grows and social dynamics change, the demands on the Coroner’s Office are expected to increase, including a higher number of deaths requiring investigation. To address these future needs, the office aims to add a fourth full-time investigator. This additional staffing would better align coverage with call volumes, reduce overtime, and help prevent burnout, while ensuring staff can continue to respond safely and efficiently to the community’s needs.

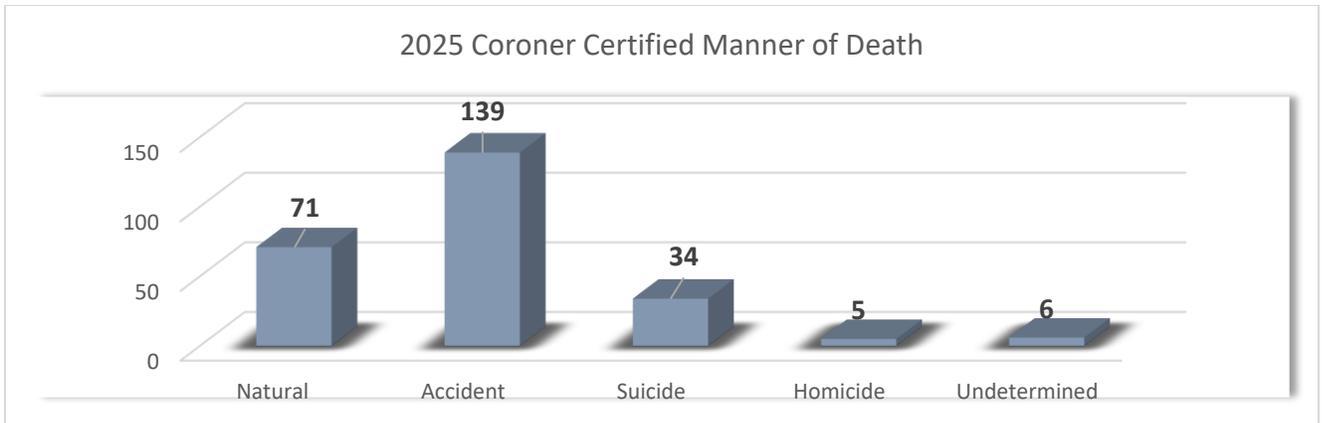
In 2025, 43.1% of Coroner cases (182 cases) underwent a post-mortem examination, including both full autopsies and external examinations. Of these, 75 cases required full autopsies to determine or confirm the cause and manner of death, while 107 cases involved external examinations for documentation purposes (see Figure 12). Toxicological testing was conducted in 229 cases, representing 54% of all Coroner cases. Turnaround times for toxicology results typically ranged from 30 to 60 days, with more complex cases requiring 61 days or longer (see figure 13). Overall, the majority of Coroner cases were completed within 45 to 90 days, reflecting the thorough review and careful documentation performed by the office.



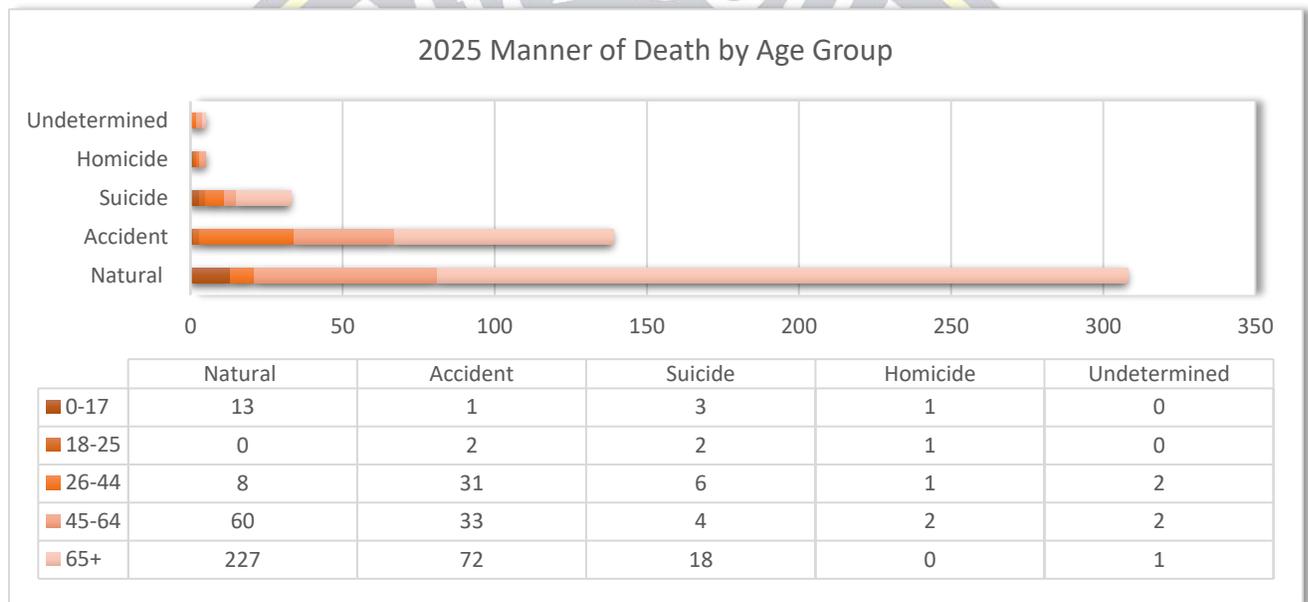
**Figure 12.** Total Postmortem Exams by Year (2020-2025)



**Figure 13.** 2025 Toxicology Results Turnaround Times



**Figure 14.** 2025 Coroner Certified Deaths by Manner

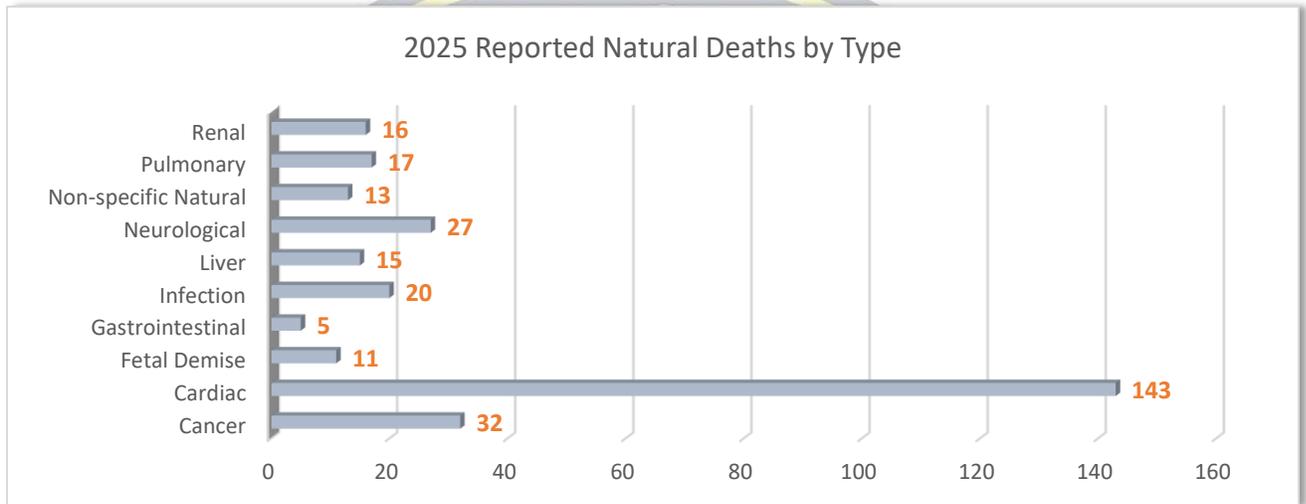


**Figure 15.** 2025 Manner of Death by Age Group

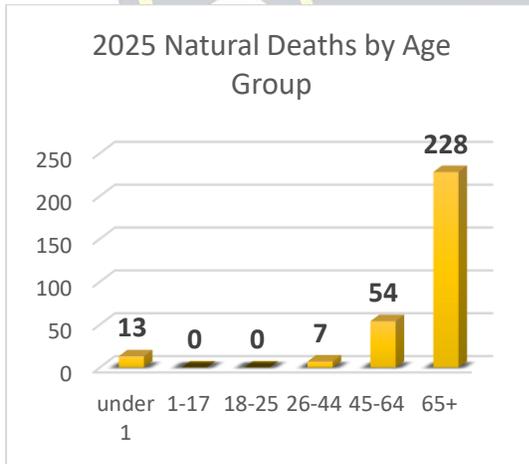
## MANNER OF DEATH: NATURAL

The Coroner may certify deaths due to natural causes under a variety of circumstances, including sudden and unexpected deaths in individuals without a known physician to certify the death, as well as cases in which the circumstances of death require further evaluation despite an apparent natural cause.

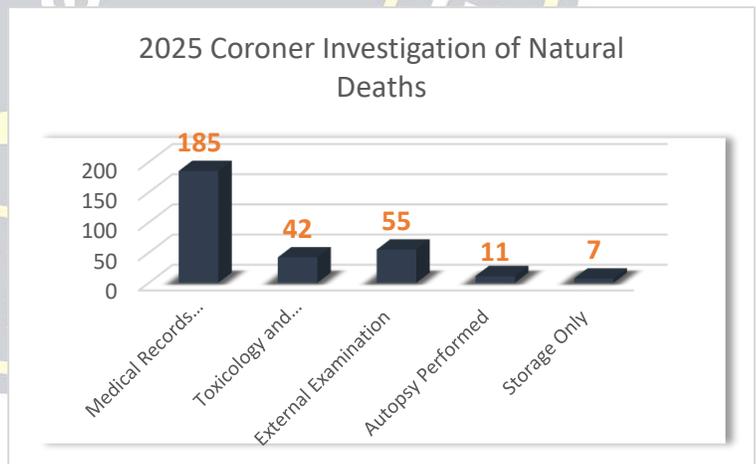
In 2025, the Coroner’s Office investigated 303 deaths determined to be due to natural causes, accounting for approximately 61% of all deaths reported to the office. Of the 253 death certificates signed, 69 cases (27%) were certified as natural deaths by the Coroner’s Office. Among the 69 certified natural deaths, the leading cause of death was cardiac-related disease (39 cases, 56%). Figure 16 illustrates the distribution of natural causes of death for all reported natural deaths in 2025.



**Figure 16.** 2025 Skagit County Certified Natural Causes of Death by Coroner’s Office



**Figure 17.** Reported natural deaths by age group (those under 1 year of age were stillborn births which are legally required to be reported).



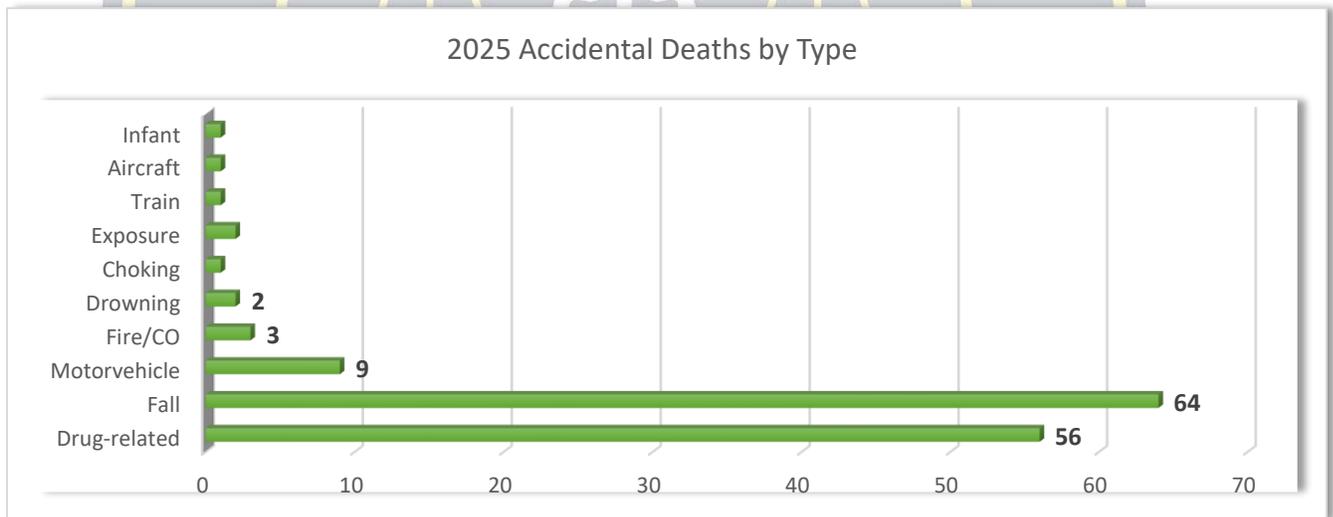
**Figure 18.** Coroner involvement type for reported natural deaths in 2025

## MANNER OF DEATH: ACCIDENT

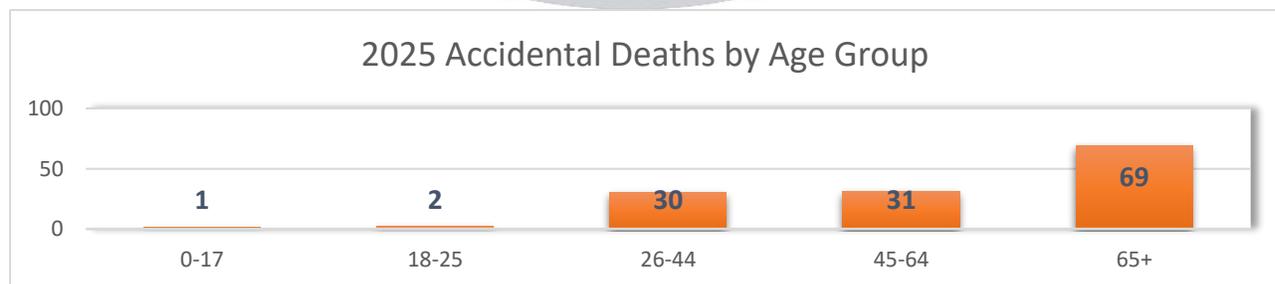
In Skagit County, accidental deaths represent the second most common manner of death, following natural causes. These deaths encompass a broad range of circumstances, including motor vehicle collisions, falls, industrial incidents, drownings, choking or other forms of asphyxiation, structural fires, and drug overdoses. Because accidental deaths are, by definition, potentially preventable, each case is comprehensively investigated to ensure accurate certification and to contribute meaningful data for public health surveillance, injury prevention strategies, and community safety initiatives. The Skagit County Coroner’s Office reports all violent deaths—including homicides, suicides, and accidental deaths—to the Washington State Violent Death Reporting System (WA-VDRS), supporting statewide data collection and evidence-based prevention efforts.

In 2025, the Coroner certified 139 deaths as accidental, accounting for 28% of all deaths reported to the Coroner’s Office and 32.8% of cases in which jurisdiction was assumed. Males represented 59.7% of accidental deaths (83 cases). The highest number of accidental deaths occurred among individuals aged 65 or older (72 cases, 51.7%), followed by those aged 45-64 (33 cases) and 26-44 years of age (31 cases).

Falls were the leading cause of accidental death in Skagit County, accounting for 46% of all accidental. Most involved older adults who sustained injuries from ground-level falls that resulted in a subsequent decline in health. Drug-related deaths (56) were the second leading cause (40%), followed by traffic-related incidents (14)—including motor vehicle, motorcycle, pedestrian, aircraft, and train—accounting for 10% of all accidental death cases. Other accidental causes: (3) fire-related, (2) drowning, (1) asphyxia from co-sleeping with infant, (1) choking on food, and (2) hypothermia.



**Figure 19.** 2025 Accidental Deaths

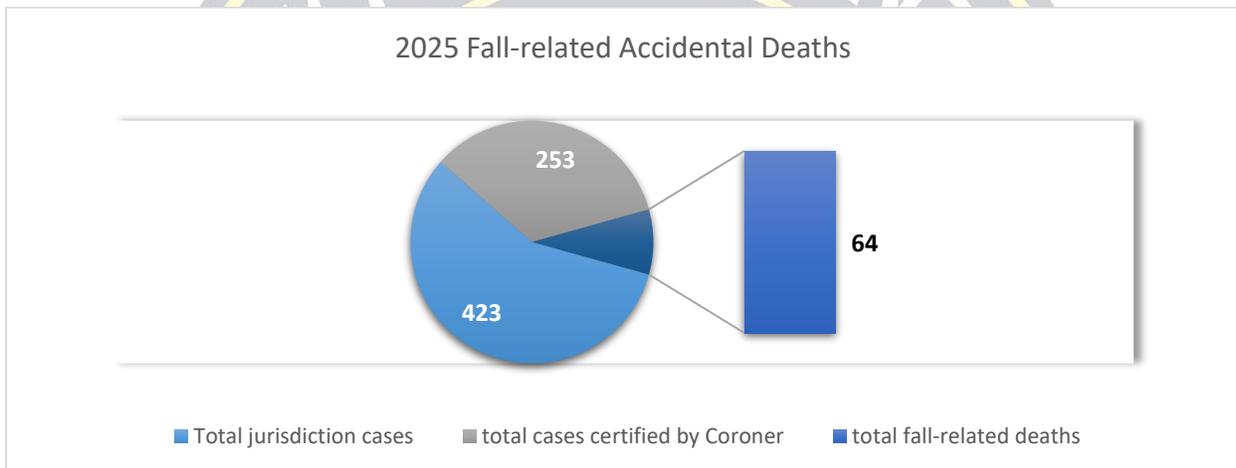


**Figure 20.** 2025 Skagit County Accidental Deaths by Age Group

## FALLS

Falls can be a direct or indirect cause of death. Directly, a fall may cause fatal injuries such as head trauma resulting in a subdural hemorrhage. Indirectly, particularly among older adults, a fall can trigger a cascade of events leading to death. Older adults often have medical conditions such as Alzheimer’s dementia, gait instability, osteoporosis, or other chronic conditions that increase fall risk. For example, a fall may cause a hip fracture requiring surgery, which can limit mobility, lead to being bedbound, and result in complications such as pneumonia or sepsis. While the immediate cause of death may be listed as natural causes, the injury substantially contributes to the decline in health, supporting classification of the manner of death as accidental.

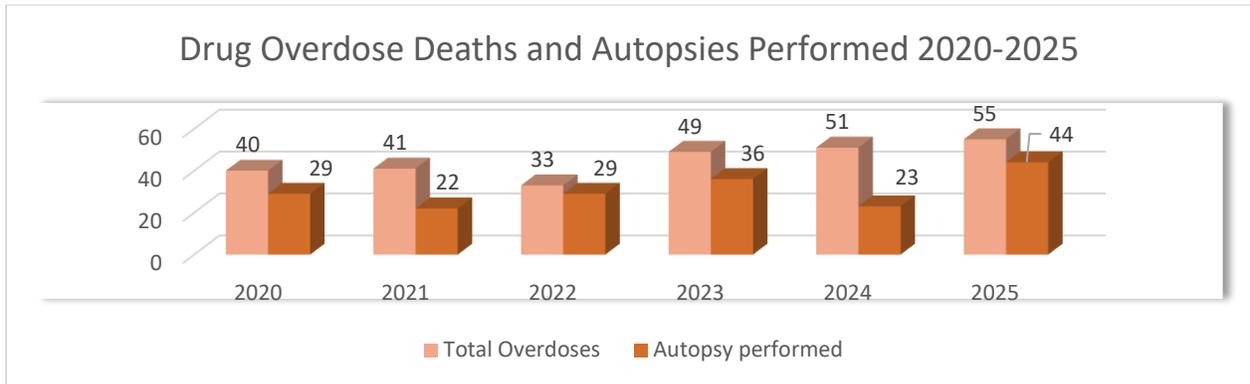
In 2025, 64 deaths were certified as fall-related, representing 15% of jurisdictional deaths and 46% of all accidental deaths in Skagit County. All but one case involved ground-level falls; the exception was a hiker who fell on a trail. Nearly all decedents were aged 65 or older, with an overall age range of 52–104 years.



**Figure 21.** Fall-Related Accidental Deaths

## DRUG OVERDOSE DEATHS

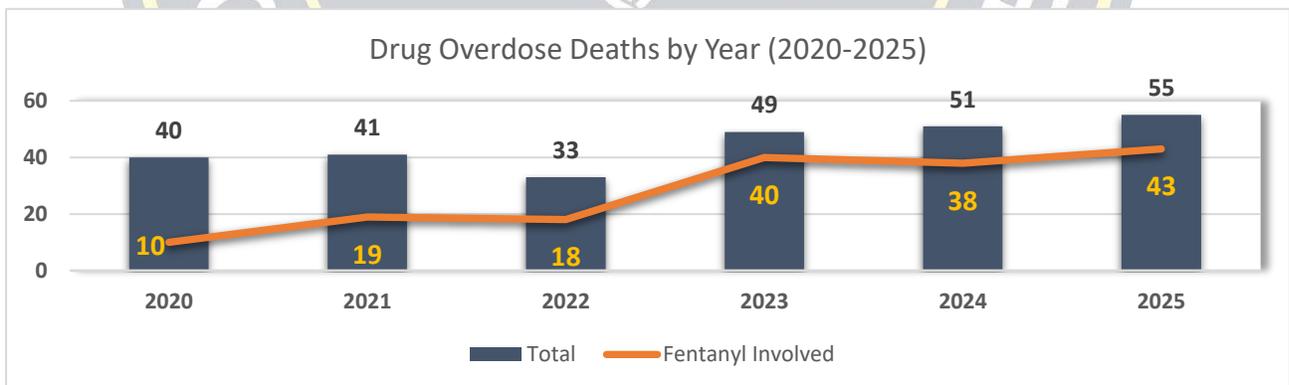
Drug overdose deaths are thoroughly investigated, as there are no specific autopsy findings that can independently confirm an overdose. For this reason, overdose is considered a diagnosis of exclusion and often requires an autopsy, particularly in cases with limited or no documented medical history, to rule out other possible causes of death. See Figure 22 regarding number of autopsies performed on overdose deaths from 2020-2025.



**Figure 22.** 2020-2025 Drug Overdose Deaths and Autopsies

Expanded forensic toxicology testing is performed on all suspected overdose cases. This testing not only supports determination of the cause of death but also helps identify trends in illicit and prescription drug use within Skagit County. The Skagit County Coroner’s Office shares these findings with county agencies and external partners to support public health surveillance, prevention efforts, and community safety initiatives.

In 2025, the Coroner’s Office certified 55 deaths as accidental drug overdoses, representing a 9.2% increase from 2024 and the highest number of overdose deaths recorded in Skagit County to date.



**Figure 23.** 2020-2025 Drug Overdose Deaths and Fentanyl involvement.

Fentanyl is a synthetic opioid approximately 50 times more potent than heroin and 100 times more potent than morphine. It is produced legally for medical use and illicitly for the illegal drug market. In Skagit County, fentanyl-related deaths involve illicitly manufactured fentanyl, which is seen both powder and pill form.

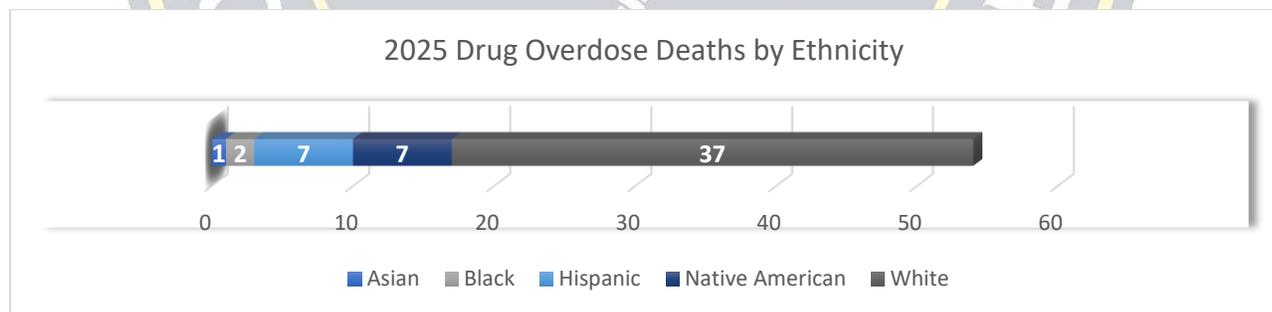
Illicit fentanyl is frequently combined with other substances, increasing overdose risk due to unpredictable potency and compounded effects. In 2025, methamphetamine and cocaine were the most common co-occurring substances. In January 2025, Skagit County recorded its first and only overdose involving carfentanil, a synthetic opioid approximately 100 times more potent than fentanyl.

The number of fentanyl-involved overdose deaths has increased substantially since 2020. In 2025, fentanyl was identified in 78% of all overdose deaths (43 of 55 cases). Of those fentanyl-involved deaths, 20% (9 cases) involved fentanyl as the sole substance detected, while 79% (34 cases) involved fentanyl in combination with one or more additional substances, highlighting the heightened risk associated with polysubstance use.

Demographic analysis of drug overdose deaths in Skagit County indicates that 76% of decedents were male and 67% were Caucasian. Contrary to common perception, overdose deaths among individuals aged 18 and younger remain rare in Skagit County. In 2025, decedents ranged in age from 27 to 70 years. The majority of deaths occurred among working-age adults, with 45% between 26 and 44 years of age and an additional 45% between 45 and 64 years of age. These findings demonstrate that fatal overdoses in Skagit County predominantly affect adult populations rather than adolescents.

Over half of drug overdoses (58%) occurred inside a private residence, though public and outdoor locations were also common. In 65% of cases, the individual was reported to have been using alone and Naloxone (Narcan) was administered in 36% of cases.

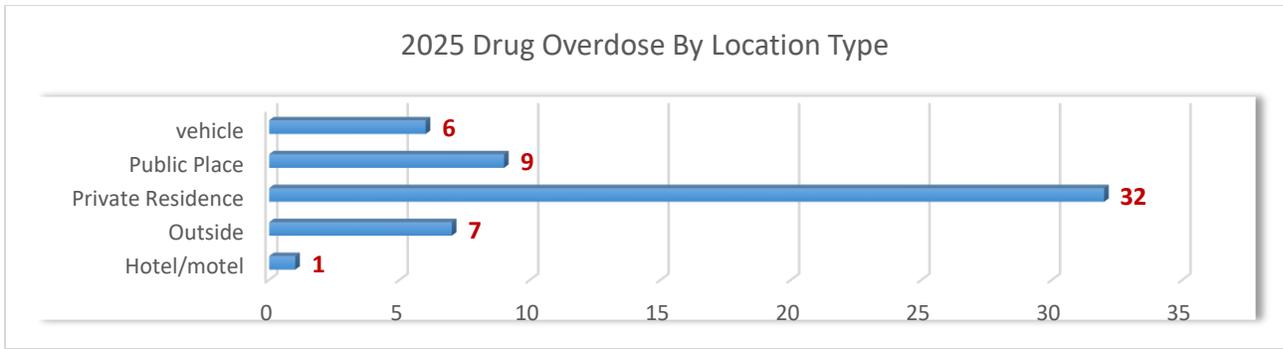
Approximately one-third (32%) of decedents had a documented history of prior overdose, and among those individuals, 50% had experienced an overdose within the previous 12 months. Over one-third (36%) had recently lost someone close to them due to a drug overdose. Additionally, 52% had a documented mental health diagnosis.



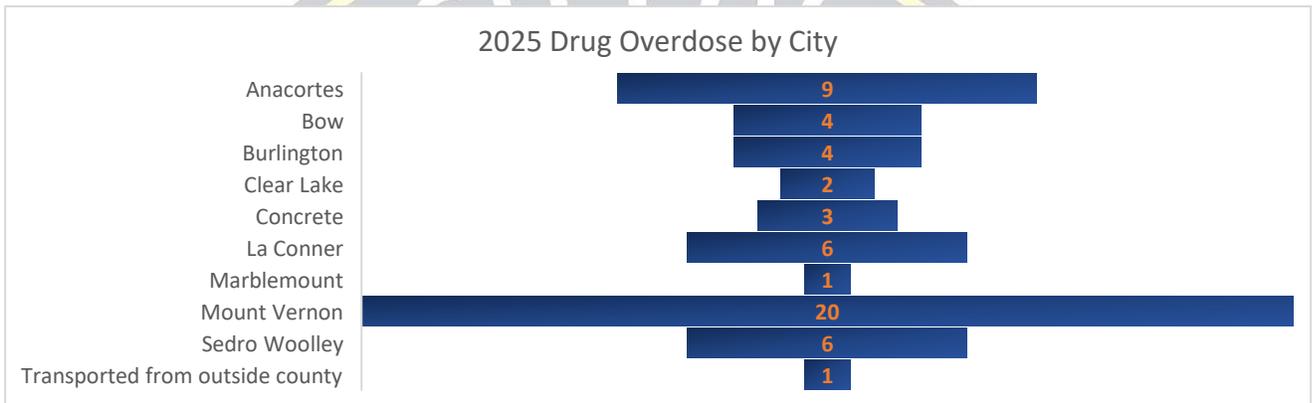
**Figure 24.** 2025 Drug Overdose Deaths by Ethnicity.



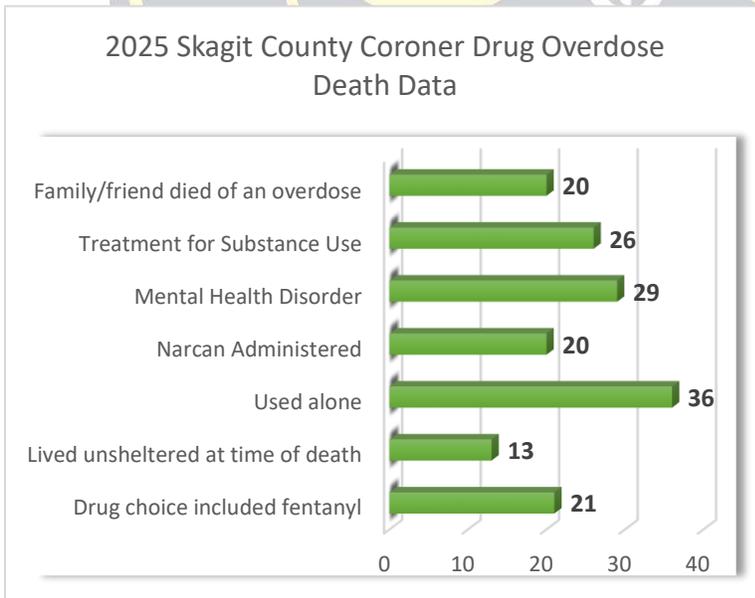
**Figure 25.** 2025 Drug Overdose Deaths by Age Group.



**Figure 26.** 2025 Drug Deaths by Location Type.



**Figure 27.** 2025 Overdose Deaths by City.



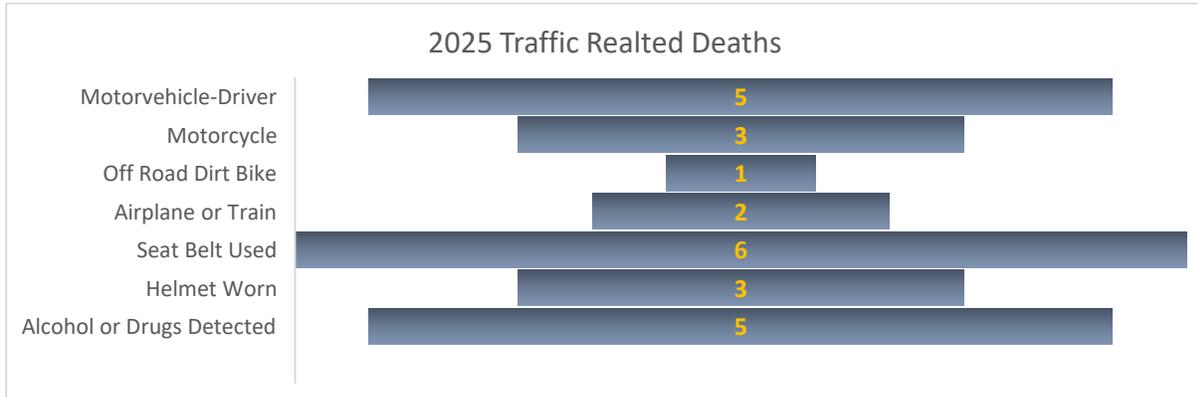
**Figure 28.** 2025 Drug-Related Death Stats



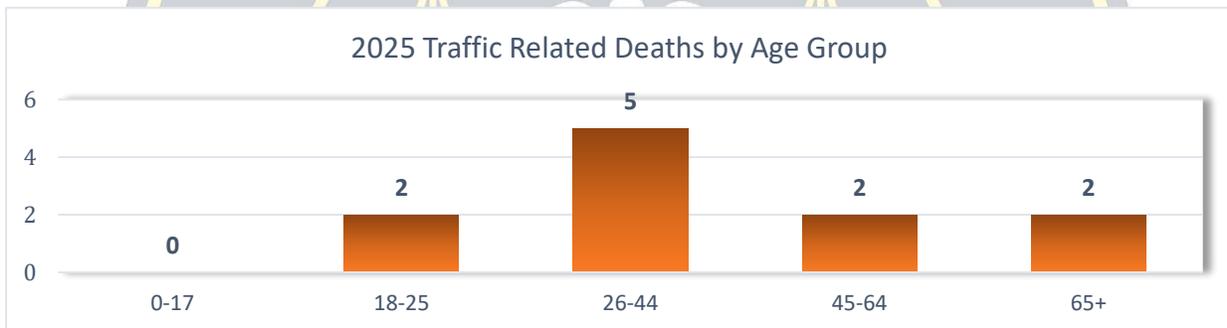
**Figure 29.** 2025 History of Overdose

## TRAFFIC-RELATED ACCIDENTS

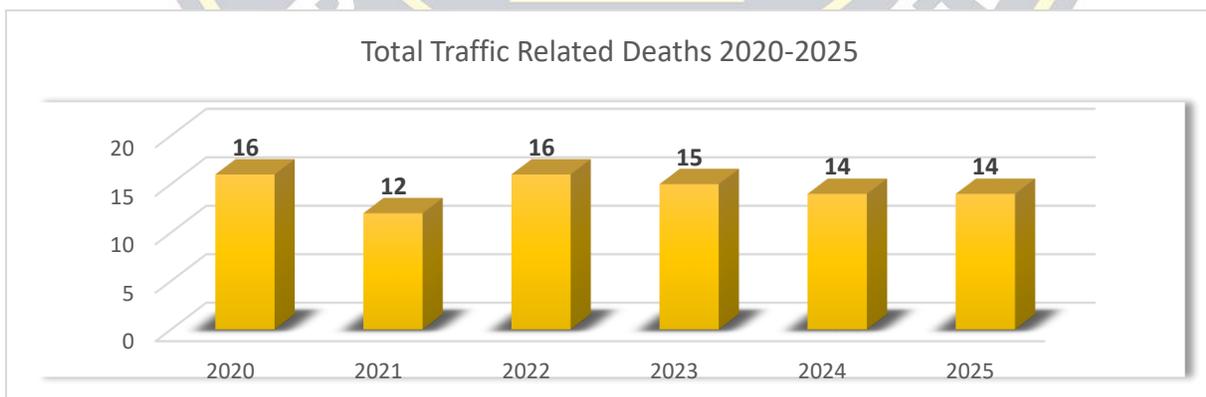
In 2025, there were 14 traffic-related deaths, accounting for 3.3% of all jurisdictional cases and 10% of accidental deaths in Skagit County. Traffic accidents were the third largest category of accidental deaths in the county. See Figures 31-33 for additional statistics related to traffic fatalities in Skagit County.



**Figure 30.** 2025 Traffic Related Death Data



**Figure 31.** 2025 Traffic Related deaths by Age Group

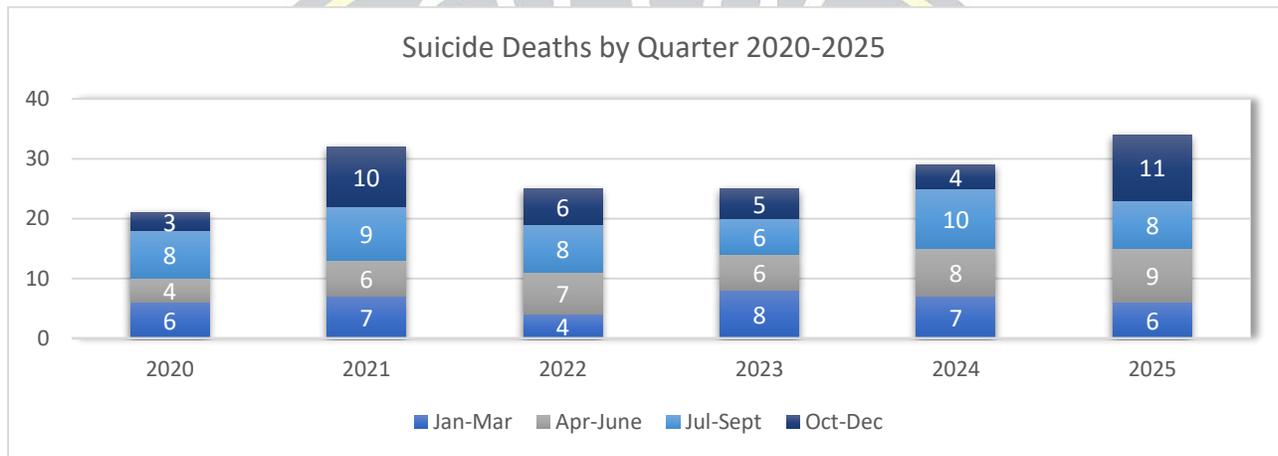


**Figure 32.** Total Traffic-Related Deaths in Skagit County 2020-2025

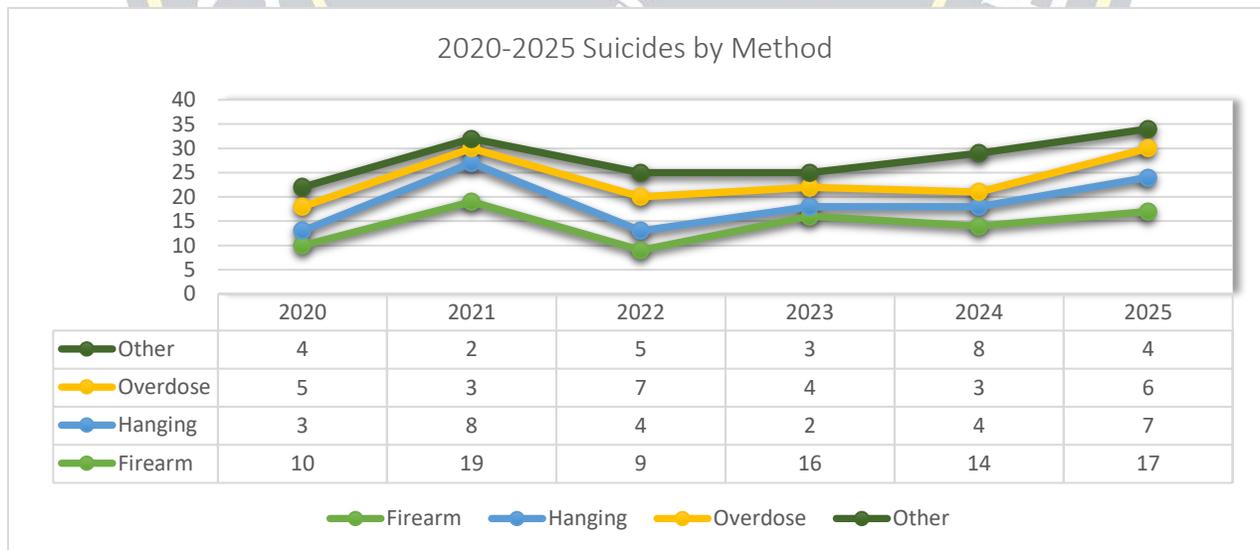
## MANNER OF DEATH: SUICIDE

Suicide refers to a death resulting from intentionally self-inflicted injury or poisoning, supported by evidence of intent to harm or end one’s own life. Evidence of intent may be explicit, such as a suicide note or verbal statement, or implicit, demonstrated through actions clearly intended to cause self-harm or death.

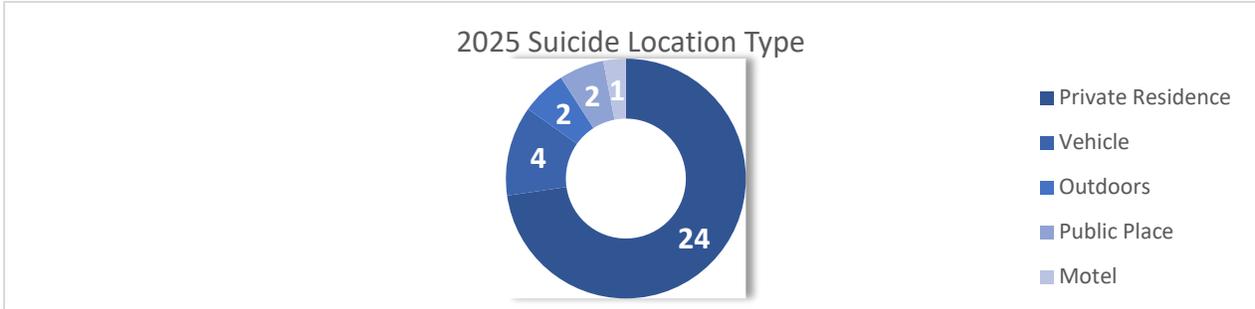
In 2025, there were 34 suicides, representing 6.9% of all deaths reported to the Coroner’s Office and 13.4% of deaths certified by the Coroner’s Office. The most common method of suicide was firearm, accounting for 50% (17 of 34 cases) of suicides in Skagit County. This was followed by asphyxia due to ligature hanging at 20.6% (7 cases). Other methods included intentional drug overdose (6 cases), asphyxia due to inhalant use (2 cases), and drowning (2 cases). Seventy percent of suicides occurred in private residences (24 cases). Other locations included vehicles (4 cases), public places (2 cases), hotels or motels (1 case), and outdoor areas (3 cases).



**Figure 33.** 2020-2025 Skagit County Suicides by Quarter.



**Figure 34.** 2020-2025 Suicides by Method.



**Figure 35.** 2025 Suicides by Location Type.

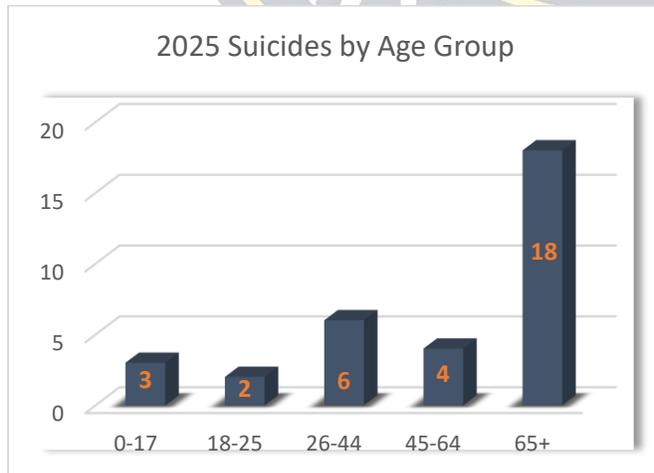
**DEMOGRAPHICS AND CONTRIBUTING FACTORS FOR SUICIDES IN 2025**

The majority of suicides in 2025 involved Skagit County residents, with only 2 cases involving individuals from outside the county. Ages of individuals ranged from 12 to 90 years, with 54.5% (18 cases) aged 65 and older, followed by 18.2% aged 26–45 (6 cases). Males accounted for 72.3% of suicides (24 of 33 cases). Most individuals were Caucasian (87.9%), with other ethnicities represented as follows: Asian (1), Black (1), Native American (1), and Pacific Islander (1).

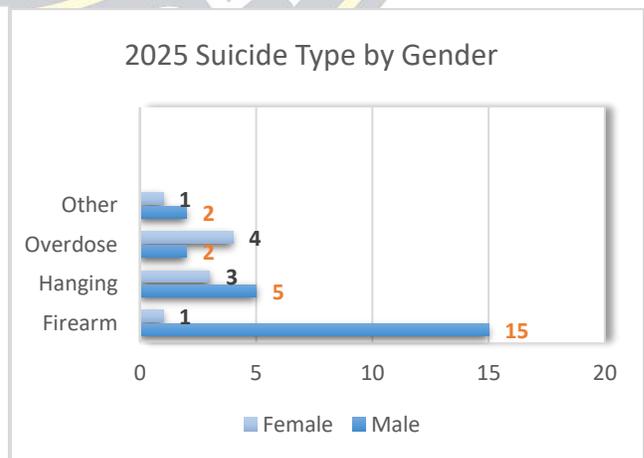
A note or other indication of intent was present in 39% of cases. The primary reasons for suicide were medical conditions (13 cases), followed by multifactorial factors (8 cases).

Regarding mental health and behavioral history:

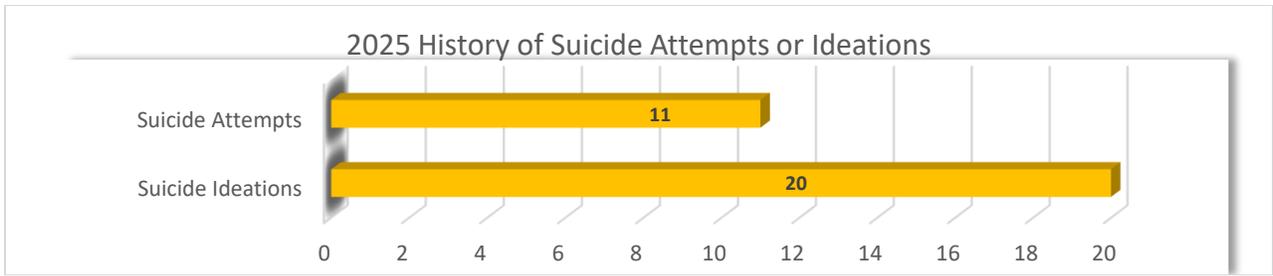
- **60.6%** (20 cases) had a **history of suicidal ideation**, with 15 of these occurring within the past six months.
- **33.3%** (11 cases) had a **history of prior suicide attempts** with 4 having attempted within the last 6 months.
- **33.3%** (11 cases) had a **history of a friend or family member commit suicide**.
- **42.4%** (14 cases) had a **history of substance use**.
- **Over half** (17 cases) had been **diagnosed with a mental health disorder**.



**Figure 36.** 2025 Suicide by Age Group



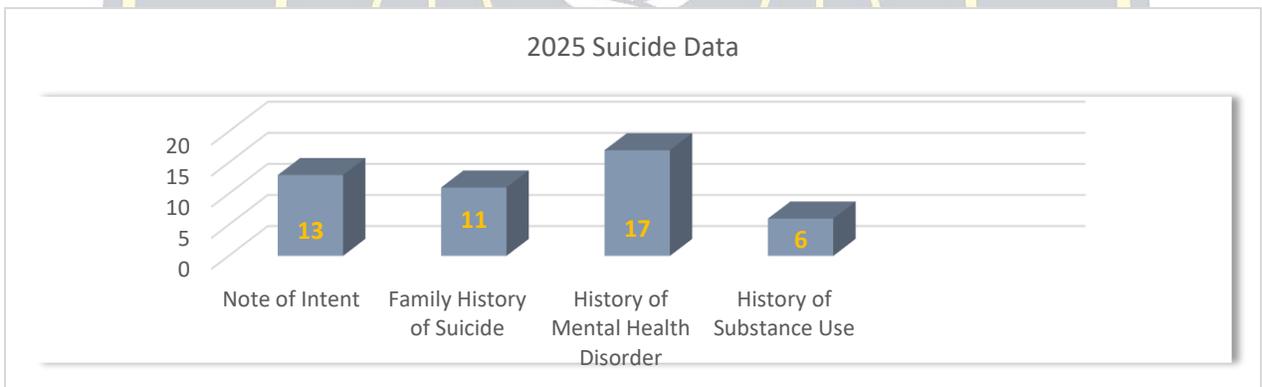
**Figure 37.** 2025 Suicide Type by Gender



**Figure 38.** 2025 History of Suicide Attempts or Ideations



**Figure 39.** 2025 Reason for Suicide.



**Figure 40.** 2025 Suicide Data.

## MANNER OF DEATH: HOMICIDE

The classification of a homicide is determined by the Coroner when a death results from injuries inflicted by another person. This classification does not imply the presence of criminal intent on the part of the individual causing the injury. In some cases, law enforcement may investigate a death as a homicide, but the Coroner may still certify it as an accident.

For example, if a pedestrian is killed in a traffic accident and the driver was negligent, under the influence, or fled the scene, the Coroner may classify the death as an accident because there was no intent to kill. Decisions regarding whether a case meets the legal definition of vehicular homicide or applies to deaths from acute drug intoxication are left to the criminal justice system. As long as there is no evidence of intent to kill, the Skagit County Coroner's Office classifies the manner of death as accident.

In 2025, the Coroner's Office classified 5 deaths as homicides, representing 1.2% of all cases under the Coroner's jurisdiction. The methods of homicide included firearm (2 cases), blunt force (2 cases), and sharp instrument (1 case). Four of the five cases involved males, and individuals ranged in age from 0 to 64 years.



Figure 41. 2020-2025 Skagit County Homicide Cases

## MANNER OF DEATH: UNDETERMINED

The Skagit County Coroner's Office classifies a death as undetermined when available information is insufficient to assign it to one of the other four manners of death: natural, accident, suicide, or homicide. This designation is used in cases with significant uncertainty about whether an injury was intentional or accidental. Contributing factors may include limited background information, absence of witnesses, a prolonged interval between death and discovery, or cases involving only partial human skeletal remains. When a thorough investigation and autopsy do not clarify the circumstances, the death is recorded as undetermined. If credible new information later becomes available, the Coroner's Office may update the manner of death. In 2025, five deaths were certified as undetermined, representing 1.18% of all coroner-involved cases.

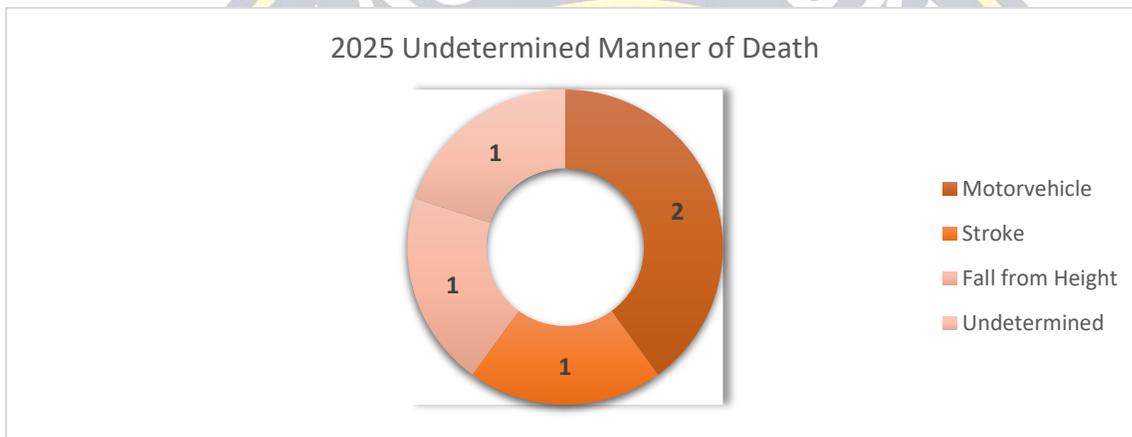


Figure 42. 2025 Undetermined Manner of Death

## CORNEA AND TISSUE DONATION

The Skagit County Coroner’s Office plays a key role in facilitating organ and tissue donation within the Skagit County community. The office utilizes a case reporting system linked directly to Organ Procurement Organizations (OPOs), enabling automatic notification of all potential organ, tissue (including skin, long bones, and heart valves), and cornea donation cases, regardless of whether the decedent passed away in a hospital or another location.

It is important to note that not all cases qualify for donation. Eligibility is determined by several factors, including the time interval between the decedent’s last known alive time and their time of death, as well as the decedent’s age and relevant social history, such as prior drug use.

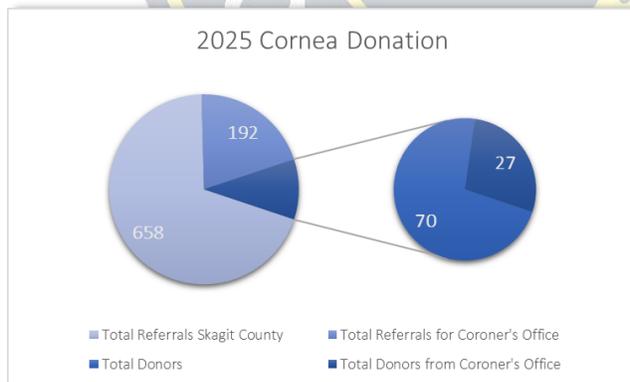
The Skagit County Coroner’s Office autopsy facility is approved for cornea and tissue procurement through formal agreements with Lions World Vision Institute and LifeNet Health. This allows authorized cases to have corneas and other tissues procured directly at the facility, supporting life-saving and life-enhancing donations whenever possible.

### CORNEA DONATION

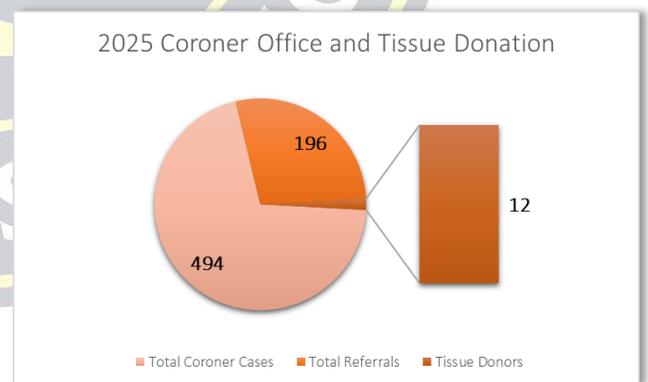
In 2025, the Skagit County Coroner’s Office referred 38% (192 of 494) of reported deaths, up from 171 referrals in 2024. This increase reflects the office’s predominantly full-time staffing, which enhanced case-handling capacity. Of the 192 referrals in 2025, 61 were identified as potential donors, and 27 proceeded to cornea donation, resulting in 41 corneal transplants during the year.

### TISSUE DONATION

In 2025, 39% (196 of 494) of reported deaths were referred by the Coroner’s office for tissue donation. Of these referrals, 12 individuals became tissue donors, positively impacting a total of 900 lives. The office’s timely referral rate improved significantly, rising from 56.3% in 2024 to 85.2% in 2025.



**Figure 43: 2025 Cornea Donation**



**Figure 44: 2025 Tissue Donation**

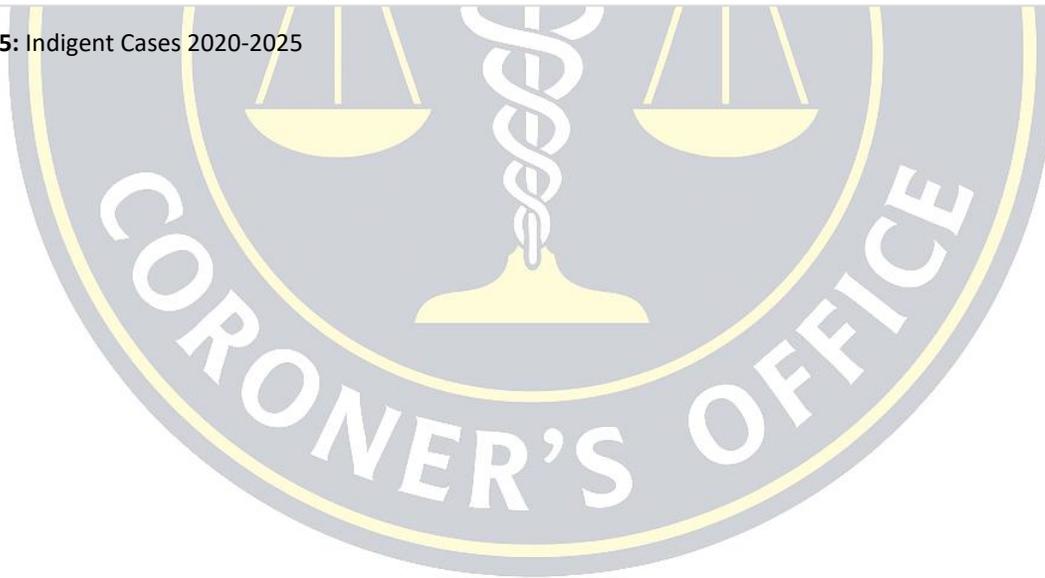
## INDIGENT OR UNCLAIMED

In 2025, 1.2% (6 of 494) of deaths reported to the Coroner's Office were classified as indigent or involved decedents with no next of kin willing to claim them. Through the dedicated efforts of Coroner's Office staff to locate next of kin, four sets of cremains were ultimately claimed by family members or friends during the year.

In early May 2025, the office held its second remembrance ceremony, honoring 53 unclaimed cremains. The cremains were respectfully spread at sea near Deception Pass, followed by a memorial service to honor the unclaimed individuals. The next remembrance ceremony is scheduled for May 2027.



**Figure 45:** Indigent Cases 2020-2025



## UNIDENTIFIED HUMAN REMAINS

Unidentified human remains are cases in which the identity of the decedent cannot be immediately established at the time of discovery. This category includes both recently deceased individuals and unidentified human skeletal remains, which may be recovered from outdoor locations, older investigations, or previously unreported cases. The Skagit County Coroner's Office follows a structured process to investigate, document, and attempt to identify these decedents while ensuring all legal, ethical, and public health considerations are met.

All collected data are entered into local, state, and national databases, including the National Missing and Unidentified Persons System (NamUs) and the Combined DNA Index System (CODIS), to facilitate identification. The Coroner's Office also collaborates with law enforcement agencies, medical examiners, anthropologists, and other relevant organizations to aid in identification.

In 2025, this office had 2 unidentified human remains cases.

## EXHUMATIONS

Exhumations are rare and occur only under specific circumstances, typically when new information or investigative opportunities arise. In 2025, the Coroner's Office was approached by Genetics Uncovered, a nonprofit organization, regarding an unidentified male who was buried at Mount Vernon Cemetery in 1991. This office had not been aware of the case until it was brought forward. Genetics Uncovered raised funds to have the remains exhumed to begin the process of creating a biological profile and ultimately identifying the individual. The skeletal remains will be examined by the state forensic anthropologist and forensic odontologist, with the goal of conducting DNA analysis. This process is expected to take two or more years but represents a significant step toward uncovering the identity of the decedent.

The last exhumation conducted by the Skagit County Coroner's Office occurred in 2018 for an unidentified male who died in 1989. That exhumation was requested by a former detective with the Skagit County Sheriff's Office seeking closure, and all testing costs were covered by the detective and the sheriff's office. In the fall of 2025, DNA analysis led to the formal identification of this previously unidentified individual.

## CONCLUSION

The Skagit County Coroner's Office remains committed to serving the community by providing thorough, professional, and compassionate death investigations. Our work ensures that every decedent is treated with dignity, families receive answers and closure, and public safety is supported through accurate reporting and collaboration with partners. Through these efforts, the Coroner's Office fulfills its mission to protect the health, safety, and well-being of the community while maintaining the highest standards of integrity and accountability.

*Hayley Thompson*

Hayley Thompson, D-ABMDI

Skagit County Coroner