YAKIMA COUNTY CORONER ANNUAL SUMMARY 2019

FOREWORD

The Yakima Coroner's Office serves the community by investigating sudden, unexpected, violent, suspicious, or unnatural deaths. The Coroner's staff recognizes the tragedy surrounding any untimely death and performs investigations, in part, to assist the grieving family. A complete investigation provides for the expeditious settling of estates and insurance claims, as well as for implementing civil and criminal actions. Questions which seem irrelevant in the initial hours after death can become significant in the following months. The surviving family, friends, and general public can have the assurance the Coroner conducted a comprehensive investigation.

When a death occurs on the job or is work related, we immediately forward the results of our investigation to the State Department of Labor and Industries so family can gain the full benefits of our findings. Private insurance companies also routinely use our finding to settle claims. Whenever a consumer product is implicated in a death, we notify the Consumer Product Safety Commission to ensure the product is studied and the necessary steps taken to protect the public. One of the Coroner's functions is to isolate and identify causes of sudden, unexpected death. When an infectious agent or poison is the cause of death, we notify the family and contacts of the deceased so they may receive any needed medical treatment. In this era of concern regarding bioterrorism, the Coroner provides an important level of surveillance for such possibilities.

Civil or criminal judicial proceedings frequently require the medical investigation of violent death. The Yakima County Coroner's Office conducts a prompt medico legal investigation to provide the criminal justice system with medical information and evidence required for adjudication. Although criminal death investigations constitute a small portion of deaths investigated by the Coroner's Office, these deaths are studied in great detail due to the legal issues and consequences involved. In this way, The Yakima County Coroner's Office offers the criminal justice system the best support that medical science can provide.

In summary, the Yakima County Coroner's Office brings trained medical legal evaluation to the investigation of deaths that are of concern to the health, safety, and welfare of the community.

DESCRIPTION AND PURPOSE
OF THE
Yakima County Coroner's Office

Washington State utilizes three systems for the investigation of deaths. The Medical Examiner's system is used for county populations of more than 250,000; the Coroner's system is used for county populations of 40,000 to 250,000, and in counties with a population less than 40, 000, the Prosecuting Attorney assumes the responsibilities of the Coroner.

Yakima County is under the ***Coroner System*** with a population of 247,681, which is the 8th largest county population in Washington State and encompasses 4,312 square miles, making it the second largest county in the State of Washington. There are 39 Counties in the State of Washington.

The Coroner is an elected position. The Coroner is responsible for the investigation of sudden, unexpected, violent, suspicious, or unnatural deaths. The key functions under the Coroner's direction are: forensic pathology, scene investigation & circumstances of death, autopsy support, and when indicated, certification of death, identification of the deceased, notification of next-of-kin, and control and disposition of the deceased's personal property.

Deaths that come under the jurisdiction of the Yakima County Coroner are defined by state statute (RCW 68.50) and include, but not limited to, the following circumstances:

1. Persons who die suddenly when in apparent good health and without medical attendance within thirty-six hours, preceding death. This category is reserved for the following situations: (1) Sudden death of an individual with no known natural cause for the death. (2) Death during an acute or unexplained rapidly fatal illness, for which a reasonable natural cause has not been established. (3) Death of an individual who was not under the care of a physician. (4) Death of a person in a nursing home or other institution where medical treatment is not provided by a licensed physician.

2. Circumstances which indicate death was caused in part or entirely by unnatural or unlawful means. This category includes but is not limited to: (1) Drowning, suffocation, smothering, burns, electrocution, lighting, radiation, chemical or thermal injury, starvation, environmental exposure, or neglect. (2) Unexpected death during, associated with, or as results of diagnostic or therapeutic procedures. (3) All deaths in the operating room whether due to surgical or anesthetic procedures. (4) Narcotics or other drugs including alcohol or toxic exposure. (5) Death thought to be associated with, or resulting from, the decedent's occupation, including chronic occupational disease such as asbestosis and black lung. (6) Death of the mother caused by known or suspected abortion. (7) Death from apparent natural causes during the course of a criminal act, e.g., a victim collapses during a robbery. (8) Death that occurs within one year following an accident, even if the accident is not thought to have contributed to the cause of death. (9) Death following all injury producing accidents, if recovery was considered incomplete or if the accident is thought to have contributed to the cause of death (regardless of the interval between the accident and death).

3. Suspicious circumstances. This category includes, but is not limited to, deaths under the following circumstances: (1) Deaths resulting from apparent homicide or suicide. (2) Hanging, gunshot wounds, stabs, cuts, strangulation, etc. (4) Alleged rape, carnal knowledge, or Sodomy. (4) Death during the course of, or precipitated by, a criminal act. (5) Death that occurs while in a jail or prison, or while in custody of law enforcement or other non-medical public institutions.

4. Unknown or obscure causes. This category includes: (1) Bodies that are found dead. (2) Death during or following an unexplained coma.

5. Deaths caused by any violence whatever, when the injury was the primary cause or a contributory factor in the death. This category includes but is not limited to: (1) injury of any type, including falls. (2) Any death due to or contributed to by any type of physical trauma.

6. Contagious disease. This category includes only those deaths wherein the diagnosis is undetermined, and the suspected cause of death is a contagious disease which may be a public health hazard.

7. Unclaimed bodies. This category is limited to deaths where no next of kin or other legally responsible representatives can be identified for disposition of the body.

8. Premature and stillborn infants. This category includes only those stillborn or premature infants whose birth was precipitated by maternal injury or drug use, criminal or medical negligence, or abortion under unlawful circumstances.

MISSION STATEMENT
OF THE
YAKIMA COUNTY CORONER'S OFFICE

The mission of the Yakima County Coroner's Office is to investigate sudden, unexpected and unnatural deaths in Yakima County with the highest level of professionalism, compassion, accuracy, and efficiency and to provide a resource for improving the health and safety of the community consistent with the general mission of Public Health Department.

To achieve this mission The Yakima County Coroner's Office will:

Coordinate investigative efforts with law enforcement, hospitals, and other agencies in a professional and courteous manner.

Treat decedents and their effects with dignity and respect, and without discrimination.

Conduct investigation and autopsies professionally, scientifically, and conscientiously; and to complete reports expeditiously with regard for the concern of family members, criminal justice, and public health and safety.

Provide compassion, courtesy, and accurate information to family members and, with sensitivity for cultural differences, make appropriate efforts in assisting with their grief, medical and legal questions, disposition of decedents and effects, and other settlements.

Collect, compile, and provide scientific testimony in court and depositions, as well as medical legal consultation for prosecuting attorneys, defense attorneys, and attorneys representing surviving family members.

A goal of the Yakima County Coroner's Office is to promote and advance, through education and research, the sciences and practices of death investigation, pathology, and anthropology in collaboration with educational institutions.

Promote and maintain an emotionally and physically healthy and safe working environment for employees, following Public Health Department policies for standards of conduct, management, and support for employee diversity, training and development.

Expand communication with public health agencies and the community at large regarding the roles, responsibilities, and objectives of The Yakima County Coroner's Office.

This report is dedicated to those people in Yakima County who have suffered the loss of a relative or friend.

YAKIMA COUNTY CORONER ANNUAL SUMMARY 2019

Coroner Cases in 2019

In **2019,** there were a total of **1918** deaths recorded in Yakima County by the Department of Vital Statistics. Based on the analysis of the scene and circumstances of death, and the decedent's medical history, the Coroner assumed jurisdiction over **595** of these deaths. Of these **595** deaths, it was deemed necessary to perform **53** autopsies. There were a total of **291** cases when the Coroner's Office was notified but did not assume jurisdiction (Non-Jurisdiction Cases). There were a total of **1032** Hospice deaths reported to the Coroner.

It is the goal of this office to provide quality death investigation which may, in turn, benefit the living. Through data collected by our office and shared with valley agencies, we attempt to find answers, explanations and preventive measures. This report breaks down the data so as to assist individuals in assembling a profile of death statistics.

TOTAL HOSPICE DEATH REPORTED:1032
TOTAL ALL CORONER CASES FOR 2019:595
TOTAL NON-JURISDICTION CASES:291
TOTAL NUMBER OF DEATHS IN YAKIMA COUNTY FOR 2019:1918

YAKIMA COUNTY CORONER ANNUAL SUMMARY 2019

CORONER CASES 2019

ACCIDENTAL
Suffocation - Asphyxia - 1
Head Trauma/Subdural Hematoma -2
Foreign body aspiration -2
Fall - 1
Carbon Monoxide - 2
Fresh Water Drowning -1
Climate Exposure - 1
Blunt Force Trauma/ Crush - 1
Spinal Cord Injury -1
Asphyxia, smoke inhalation -1
Pulmonary Fibrosis –1
Gunshot Wound-2
Accidental Opioid Overdose-1
Train – 2
Fireworks-1

TOTAL/ACCIDENTAL: - 20

MOTOR VEHICLE
Driver -14
Passenger -1
Pedestrian -8
Off Road Vehicle -
Motorcycle -
Motor Vehicle Homicide- 11
TOTAL MVF: - 34

NATURAL/TOTAL:420

SIDS/TOTAL -0

FETAL DEMISE: - 11

HOMICIDE
Gunshot Wounds- 24
Stabbing - 1
Heart Attack -
Undetermined -1
Strangulation -1

TOTAL HOMICIDES: -27

ACCIDENTAL ALCOHOL/DRUG TOXICITY
Methamphetamine, Amphetamine - 15
Heroin – Cocaine- 5
Fentanyl – Oxycodone- 18
Alcohol- Ethanol -4
Huffing – 1
Pending - 7
TOTAL DRUG TOXICITY: 50

SUICIDE
Hanging - 8
Gunshot - 19
Jumped from bridge -2
Bag overhead-1

TOTAL SUICIDES: 30

YAKIMA COUNTY CORONER ANNUAL SUMMARY 2019

MANNER: ACCIDENTAL

There were **20** deaths certified as accidental for the year **2019.** Of those, the largest single group was people who died as a result of accidental drug overdose.

INJURY MODE	TOTAL	MALE	FEMALE
Fractures/Fall - 1	1	1	0
Pulmonary Fibrosis -1	1	1	0
Positional Asphyxia - 1	1	1	0
Head Trauma/Subdural Hematoma -2	2	1	1
Spinal Cord Injury-1	1	0	1
Accidental Opioid Overdose -1	1	0	1
Drowning -1	1	1	0
Carbon Monoxide -2	2	2	0
Asphyxia, smoke inhalation -1	1	0	1
Blunt Force Trauma, Crush Injury -1	1	1	0
Foreign body aspiration -2	2	2	0
Climate Exposure - 1	1	1	0
Train – 2	2	2	0
Gunshot Wound - 2	2	2	0
Fireworks - 1	1	1	0

TOTAL: - 20

AGE	TOTAL	MALE	FEMALE
<1	1	1	0
1-9	0	0	0
10-19	1	1	0
20-29	3	3	0
30-39	1	0	1
40-49	4	3	1
50-59	4	4	0
60-69	4	4	0
70-79	0	0	0
80-89	2	2	0
90-99	0	0	0
100	0	0	0

RACE	TOTAL
Hispanic	5
White	11
Native American	4
African American	0
Asian	0

MONTH	TOTAL
January	0
February	3
March	2
April	1
May	2
June	3
July	2
August	1
September	1
October	1
November	1
December	3

TEN YEAR COMPARISON

MANNER: ACCIDENTAL DRUG TOXICITY continued

AGE	TOTAL	MALE	FEMALE
>10	0	0	0
11-19	2	2	0
20-29	8	6	2
30-39	13	10	3
40-49	13	9	4
50-59	9	2	7
60-69	4	2	2
70-79	1	1	0
80-89	0	0	0
90-99	0	0	0

TOTAL: 50

RACE
White - 37
Native American-3
Hispanic - 9
African American- 1

MONTH	TOTAL
January	6
February	1
March	2
April	4
May	2
June	3
July	3
August	5
September	8
October	7
November	2
December	7

TEN YEAR COMPARISON

YAKIMA COUNTY CORONER ANNUAL SUMMARY 2019

MANNER: HOMICIDE

A death is classified as a homicide when the death results from injuries inflicted by another person, regardless of the intent. There are several types of criminal and non-criminal homicides. A non-criminal homicide may be accidental, justifiable or excusable. During **2019, 27** deaths were classified as homicides. The breakdown of agencies that responded to these deaths is as follows:

Yakima PD	Union Gap PD	Selah PD	Sunnyside	Toppenish	FBI	Tribal
8	2			2	8	

Yakima Sheriff's Department
Wapato: 2
White Swan: 1
Yakima:
Toppenish:
Tieton: 1
Sunnyside: 1
Granger: 1
Outlook: 1
YSO TOTAL: 7

METHOD OF HOMICIDE	TOTAL	MALE	FEMALE
Gunshot	24	20	4
Stabbing	1	1	0
Undetermined	1	0	1
Strangulation	1	0	1

TOTAL: 27

AGE	TOTAL	MALE	FEMALE
>1	0	0	0
1-9	0	0	0
10-19	3	3	0
20-29	7	7	0
30-39	6	3	3
40-49	6	5	1
50-59	3	2	1
60-69	2	1	1
70-99	0	0	0

RACE	TOTAL
HISPANIC	16
WHITE	5
NATIVE AMERICAN	6
Unknown	0
African American	

MONTH	TOTAL
January	0
February	0
March	2
April	6
May	9
June	1
July	2
August	1
September	0
October	2
November	1
December	3

TEN YEAR COMPARISON

YAKIMA COUNTY CORONER ANNUAL SUMMARY 2019

MANNER: SUICIDE

Suicide happens when the coping mechanisms for an individual become overwhelmed, and the only way out of perceived pain is via death. Accurate determination of suicidal deaths is necessary in order to identify high-risk groups and develop preventive strategies and interventions.

METHOD OF SUICIDE	TOTAL	MALE	FEMALE
Hanging -	8	6	2
Gunshot Wound -	19	16	3
Drugs & Alcohol -	0	0	0
Carbon Monoxide Poisoning -	0	0	0
Knife -	0	0	0
Drowning -	0	0	0
Death from fall -	2	1	1
Bag over head	1	0	1

TOTAL: 30

AGE	TOTAL	MALE	FEMALE
<19	4	4	0
20-29	8	6	2
30-39	4	2	2
40-49	6	4	2
50-59	3	2	1
60-69	2	2	0
70-79	1	1	0
80-89	2	2	0
90-99	0	0	0

RACE	TOTAL
White	21
Hispanic	5
Native American	4
African American	0

MONTH	TOTAL
January	1
February	1
March	2
April	1
May	5
June	4
July	4
August	2
September	2
October	3
November	4
December	1

TEN YEAR COMPARISON

MANNER: TRAFFIC

Blood alcohol tests were performed for **12** of the **15** traffic fatalities, of the **15, 9** tested positive for alcohol and/or drugs. Of the **14** vehicle drivers, **9** tested positive, of the **1** passengers, 0 tested positive. There were **8** pedestrian fatalities, of those **03** tested positive for alcohol and/or drugs. In the State of Washington, **0.08** grams is considered the legally intoxicated level while driving. Blood Ethanol is measured in grams per 100 ml of blood or grams %. It should be noted that in many cases someone other than the person who died may have been under the influence of alcohol and directly involved in the accident.

CIRCUMSTANCE	TOTAL	MALE	FEMALE
Driver/MVC	14	11	3
Passenger/MVC	1	0	1
Pedestrian	8	6	2
Motor Vehicle Homicide	11	4	7

TOTAL: 34

TOTAL RACE	
Native American	10
White	8
Hispanic	15
Asian	1

AGE	TOTAL	MALE	FEMALE
0-9	1	1	0
10-19	3	2	1
20-29	9	5	4
30-39	6	3	3
40-49	5	2	3
50-59	4	3	1
60-69	4	3	1
70-79	0	0	0
80-89	2	1	1
90-99	0	0	0

MONTH	TOTAL
January	1
February	3
March	2
April	3
May	6
June	4
July	3
August	0
September	3
October	3
November	3
December	3

TEN YEAR COMPARISON

MANNER: SUDDEN INFANT DEATH SYNDROME

The Coroner's Office is required by RCW 43.103.100 (0) to report to the Public Health Department when a sudden unexplained infant death occurs. This is done to achieve a better understanding of such deaths, and to connect families to various community and public health support systems to aid in grief recovery. Autopsies are necessary in all child deaths.

AGE	TOTAL	MALE	FEMALE
	0	0	0

RACE	TOTAL
Hispanic	0
White	0
Native American	0
Africa American	0

MONTH	TOTAL
January	0
February	0
March	0
April	0
May	0
June	0
July	0
August	0
October	0
November	0
December	0

MANNER: FETAL DEMISE

The fetal death certificate is a legal document, although it primarily serves statistical and health research purposes. The information is used to study prenatal care services and obstetrical programs. It is also used to examine consequences to the fetus from possible environmental and occupational exposures to parents. A fetal death certificate must be completed and filed for every fetus 20 or more weeks' gestation.

MONTH OCCURRED	TOTAL	RACE	MALE	FEMALE
January		White	0	0
		Hispanic	0	0
		Nat/American	0	0
February	1	Hispanic	1	0
		Nat/American	0	0
		White	1	0
March	1	Hispanic		1
		Nat/American	0	
April	2	White	0	0
		Hispanic	2	
May	1	Hispanic	0	0
		White	0	0
June		White		0
		Hispanic		0
July		Hispanic	0	0
		White		0
August	3	White	1	1
		Hispanic	1	
September		Hispanic		0
		White	0	0
October		Na/American	0	0
		Hispanic		
November	1	Hispanic	0	0
		White		1
December	2	White	1	0
		Hispanic	1	0

TOTAL: 11

MANNER: NATURAL

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The vast majority of deaths in Yakima County result from natural causes. For most deaths occurring in Yakima County, a physician who has medically attended to the patient, should, and usually will, certify the cause of death. The responsibility of the Yakima County Coroner's Office is to remain focused on the investigation of unnatural deaths.

The Coroner assumed jurisdiction on **420** natural deaths in **2019** .The various factors that influence this decision were:

- The physician was unavailable to certify the cause of death within the two-day time frame.
- The physician had not attended to the individual recently and declined to certify the death certificate.
- The decedent had not been under the care of a physician and the cause of death was unknown.
- The decedent was indigent and/or unclaimed and Yakima County contributed to their final disposition.

AGE	TOTAL	MALE	FEMALE
<1	2	1	1
1-09	1	0	1
10-19	2	1	1
20-29	1	1	0
30-39	9	5	4
40-49	31	15	16
50-59	51	37	14
60-69	115	80	35
70-79	109	57	52
80-89	69	33	36
90-99	28	8	20
100+	2	0	2

TOTAL: 420

MONTHS	TOTAL
January	33
February	31
March	30
April	41
May	29
June	18
July	26
August	31
September	32
October	44
November	38
December	57

RACE **TOTAL 420**

White -314
Hispanic - 82
African American - 3
Native American - 21
Asian

TEN YEAR COMPARISON

GLOSSARY OF TERMS

Blood alcohol level:	The concentration of ethanol (alcohol) found in blood following ingestion. Blood ethanol is measured in grams per 100 ml of blood or grams %. In the State of Washington, 0.08 grams % is considered legally intoxicated level while driving.
Cause of Death:	Any injury or disease that produces a physiological derangement in the body that results in the death of an individual. [1]
Drug:	Therapeutic drug: A substance, other than food, used in the prevention, diagnosis, alleviation, treatment, or cure of disease. Recreation drug: A drug used non-medically for personal stimulation/depression/euphoria.
Drug caused death:	Death directly caused by a drug or drugs in combination with each other or with alcohol.
Jurisdiction:	The jurisdiction of the Coroner's Office extends to all reportable deaths occurring within the boundaries of Yakima County, whether or not the incident leading to the death (such as an accident) occurred within the county. Reportable deaths are defined by RCW 68.50, as explained in the "Description and Purpose" section of this report. Not all natural death reported fall within the jurisdiction of the Coroner's Office.
Manner of Death:	A classification of the way in which the events preceding death were causal factors in the death. The manner of death as determined by the forensic pathologist in an opinion based on the known facts concerning the circumstances leading up to and surrounding the death, in conjunction with autopsy findings and laboratory tests. [2]
Manner: Accidental	Death other than natural, where there is no evidence of intent, i.e., unintentional. In this report, traffic accidents are classified separately.

[1] DiMaio, V.J. & DiMaio, D. Forensic Pathology, Second Edition. CRC Press, 2001.

[2] Ibid, p 3.

Manner: Homicide	Death resulting from intentional harm (explicit or implicit) of one person by another, including actions of grossly reckless behavior.
Manner: Natural	Death caused solely by disease. If natural death is hastened by injury (such as a fall or drowning in a bathtub), the manner of death is classified other than natural.
Manner: Suicide	Death as a result of a purposeful action with intent (explicit or implicit) to ends one's own life.
Manner: Traffic	Unintentional deaths of drivers, passengers, and/or pedestrians involving motor vehicles on public roadways. Accidents involving motor vehicles on private property (such as driveways) are not included in this category and are classified non-traffic, vehicular accidents.
Manner: Complication Of Therapy	Death that arises as a predictable consequence of appropriate medical therapy. Although this is a manner of death for death certification purposes, Complication of Therapy statistics are included under the Manner "Accidental" in this report.
Opiate:	Any preparation of derivative of opium, including heroin, morphine or codeine. In this report "opiate deaths" most likely refer to heroin caused deaths.
Poison:	Any substance, either taken internally or applied externally, that is injurious to health or dangerous to life, and with no medicinal benefit.
Fetal Death:	Category of deaths that occur within the uterus. The Coroner's Office assumes jurisdiction over fetal deaths that meet the criteria specified in RCE 68.50. (*See page 13* of this report for details).
Race:	The racial categories used in this report are: White, African American, Native American, Chinese American, and Filipino.