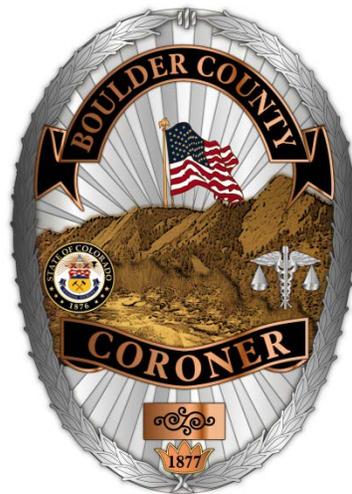




2016 ANNUAL REPORT

BOULDER COUNTY CORONER'S OFFICE



Emma R. Hall
Boulder County Coroner

5610 Flatiron Parkway
Boulder, CO 80301
Phone: 303-441-3535 / Fax: 303-441-4535

www.bouldercounty.org/dept/coroner



Office of the Boulder County Coroner

5610 Flatiron Parkway, Boulder, Colorado 80301 - 303.441.3535 - Fax: 303.441.4535

Mailing Address: P.O. Box 471 - Boulder, Colorado 80306 - www.bouldercounty.org

To the Citizens of Boulder County,

It is my pleasure to present the 2016 annual report for the Boulder County Coroner's Office. The report highlights the activities of the office and offers a valuable resource to understand the obligation of this office. The overall case load scene responses and autopsies for 2016 was fairly consistent with the dramatic increase first seen in the year 2013. Regardless of case load, the priority of the office was, and will always be, to provide the citizens of Boulder County with the highest quality service.

This year, the office did not see a lot of fluctuation from the type, or number of cases like the office had in 2015. Therefore, there does not seem to be any emerging trends or changes in the way deaths are occurring. The office did have three officer involved shootings this year. All three of these cases were ruled homicides. Of note, the office did have one additional homicide for the year creating a total of four homicides in 2016. Any time an officer involved shooting occurs in Boulder County the Coroner's Office works with the Boulder County Shoot Team as well as the District Attorney's Office, the Coroner's Office presents the investigation and autopsy findings to them both.

In 2016 the office continued to make community and professional outreach a priority. Staff provided presentations and trainings for community organizations. This was an opportunity to educate those who have an interest in the general operation of the Coroner's Office. In addition, the office hosted the following trainings and or conferences: the fall annual conference for the Colorado Coroner's Association, the Advanced Forensic Investigations for Hazardous Environments (a statewide training provided through Louisiana State University), and a local training on Cornea Donation and Recovery put on by the Rocky Mountain Lions Eye Bank. Our office organized and participated in victim advocacy training on how to help families, as well as the staff, cope with the day to day affects of a traumatic death. This is very important for all involved in the trauma and tragedy associated with many cases.

Furthermore, the office sits on the North Central Regional Mass Fatality Planning committee and participates in mock mass fatality exercises. The staff also served on the Child Fatality Prevention Team. This is a state-led organization that reviews child fatality cases with the intention of identifying ways to prevent child deaths throughout the state. The office also continued to be represented on the Elder Justice Coalition group. For your knowledge, this is a wonderful group of individuals from varied backgrounds who gather to discuss how best to educate law enforcement and first responders particularly about the needs and rights of our aging population. We also participated in the first annual Missing in Colorado event where we presented three John Doe cases and interacted with families and other interested parties of missing persons. Chief Deputy Coroner, Dustin Bueno, was also appointed by the Commissioners to the Cultural Responsiveness and Inclusion Advisory Committee (CRIAC) to represent the Coroner's Office. This committee is committed to respect, inquiry, truth, listening, shared dialogue and mindfulness as we endeavor to help create a diverse and inclusive Boulder County for all.

I am honored and proud to have had the opportunity to serve the citizens of Boulder County for another year.

A handwritten signature in cursive script that reads "ERHall".

EMMA R. HALL
Coroner

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INTRODUCTION

MISSION STATEMENT

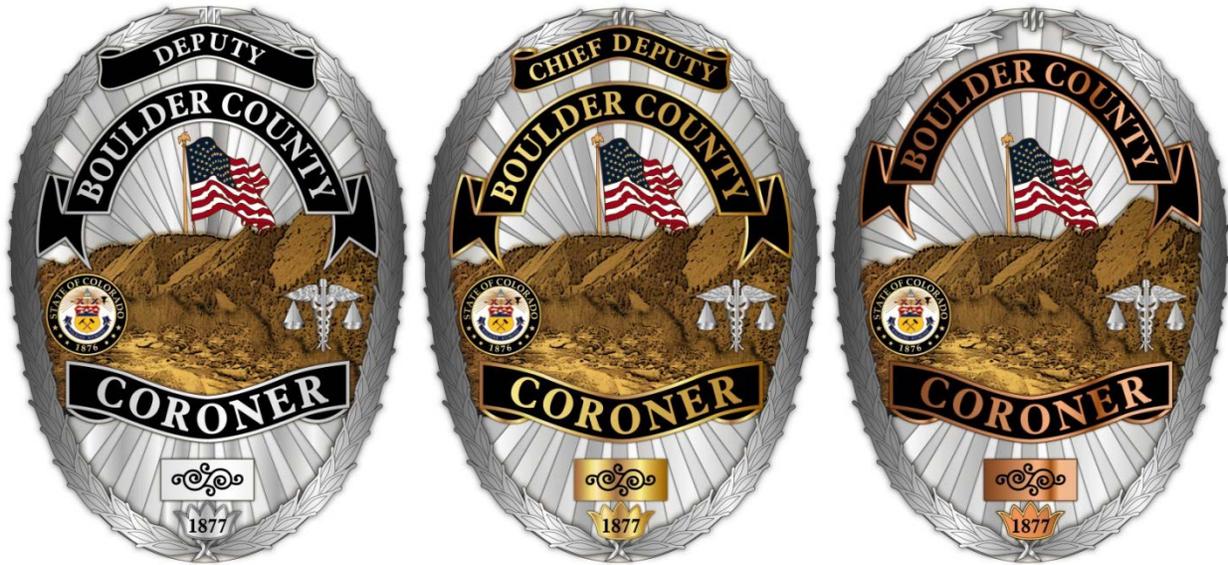
The mission of the Boulder County Coroner’s Office is to conduct thorough and fair investigations into deaths falling under its jurisdiction with professionalism and integrity to determine the manner and cause of death in a timely manner. The core values of the office are integrity, excellence and compassion; the office is committed to maintaining the integrity of the investigations it conducts by setting high standards of accountability and preserving confidentiality, the office is committed to serving with excellence by establishing and preserving community trust through professional conduct, the office is committed to providing compassion, dignity and respect for the deceased and their families.

FUNCTION OF THE OFFICE

The Office of the Boulder County Coroner is a creation of the Colorado Constitution and the Colorado Revised Statutes §30-10-601 through 621. Under those statutes the Coroner is required to make all proper inquiry regarding the cause and manner of death of any person under his/her jurisdiction.

The cause of death may be defined as the disease or injury that resulted in the death of an individual. Examples of causes of death may include: “heart disease”, “pneumonia”, “gunshot wound”, or “blunt force trauma”. The manner of death is a medico-legal term that describes the circumstances of an individual’s death, and is an opinion based on the “preponderance of evidence”. When a natural disease process (such as heart disease or diabetes) causes death, the manner of death typically would be classified as **Natural**. The manner of death is classified as **Accident** when the death is the result of a hostile environment, and the event is not expected, foreseen, or intended. The manner of death is classified as **Suicide** when the person acts with the intent of causing his or her own death. When the death is the result of the killing of one human being by another, the manner of death is classified as **Homicide**. Homicide is a medico-legal term and should not be confused with such terms as “murder” or “manslaughter” which are used by the criminal justice system to describe the degree of criminal intent in a particular homicide. When there is insufficient evidence to determine the cause and/or manner of death, both the cause and manner of death may be classified as **Undetermined**. In other instances, the cause of death may be readily apparent, but the evidence that indicates manner of death may be equivocal, thereby leading to a manner of death of Undetermined. The manner of death is classified primarily to aid survivors in understanding the events surrounding an individual’s death and for statistical purposes.

BOULDER COUNTY CORONER BADGE



Badge Shape: Oval Shield

Border: Laurel Wreath

Sun Rays: In the background of the badge there are 17 distinctive sun rays. The 13 upper rays are a reminder of the responsibilities and the qualities the office holds in the search for the truth: the office has a responsibility to: Investigate deaths for the deceased, their families and community as a whole; the office serves with: professionalism, integrity, excellence, compassion, accountability, confidentiality, dignity and respect. All of these qualities are also represented in the coroner's mission statement. The lower 9 rays represent the cities within Boulder County: Lyons, Longmont, Louisville, Boulder, Superior, Lafayette, Erie, Nederland and Ward.

Banners:

- All banners are black in color.
- The deputy's rank is proudly denoted on a banner at the top of the badge.
- A second banner near the top of the badge prominently displays "BOULDER COUNTY".
- A third banner near the bottom of the badge prominently displays "CORONER".
- The bottom banner personalizes each badge with a badge number assigned by the Coroner.

Crown: In Middle English, the word "coroner" referred to an officer of the crown, derived from the French *couronne* and Latin *corona*, meaning "crown". The crown is represented at the base of the badge with 5 points representing branches of death investigation every coroner and deputy serves to investigate: Natural, Accident, Suicide, Homicide and Undetermined. The year 1877 is inscribed into the crown to represent the year the first Coroner took office in Boulder County, Seth D. Bowker; who served from 1877-1881.

Center Piece: The center piece of the badge is an image of Boulder Creek for which the county was named after; in the background are the Boulder Flatirons which are a popular icon of the Boulder area. There is an American flag atop the flatirons. On the left side of the center piece is the Colorado state symbol and on the right side is a medical legal symbol.

Rank Designation:

- *Deputy*: Silver Borders on each rocker/banner, silver lettering.
- *Chief Deputy*: Gold border on each rocker/banner, gold lettering.
- *Coroner*: Copper border on each rocker/banner, and copper lettering.

STAFF

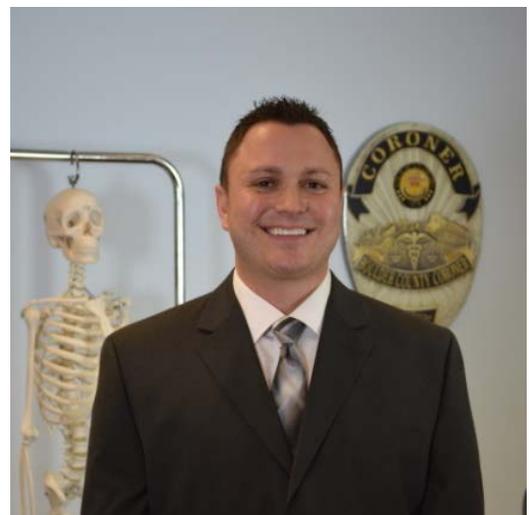
The 2016 staff of the Boulder County Coroner's Office consisted of the following:



Elected Coroner: Emma R. Hall. Ms. Hall is a Boulder County native who grew up in Lyons on Hall Ranch. She comes from a pioneer family that has lived in the county since the 1870s. Ms. Hall is responsible for the day to day administration of the office as well as the daily management of cases. She is ultimately responsible for the determinations of cause and manner of death for the cases in which the office takes jurisdiction. Ms. Hall is a graduate of Niwot High School and Metropolitan State College of Denver, with a degree in Criminalistics (the study of evidence). Her background includes experience and training in death investigation, autopsies and forensic pathology, crime scene investigation, evidence analysis, elder abuse, child death investigation, blood stain pattern analysis, forensic anthropology, mass fatalities and emergency management, aquatic death and homicidal drowning. Ms. Hall is a registered Medicolegal Death Investigator with The American Board of Medicolegal Death Investigators. Ms. Hall is additionally a

Certified Death Investigator with the Colorado Coroner's Association as well as a member of the Colorado Coroner's Association. She co-chairs the Elder Abuse Fatality Review Team with District Attorney Stan Garnett. Ms. Hall attends a number of meetings throughout the county and state to include Boulder County Elected Official/Department Head meetings, mass fatality planning meetings, fire and flood planning meetings, Boulder County Child Fatality Review Team meetings, Boulder County Law Enforcement Chiefs meetings, Metro Area Coroner meetings, and the Colorado Forensic Investigators meetings. Additionally, Ms. Hall serves as the President of the Criminal Justice/Forensics Advisory Board at Arapahoe Ridge High School in Boulder. Emma's true passion in the field is being able to provide answers to as many questions as possible to the family in each investigation and to help the family in their healing process.

Chief Deputy Coroner: Dustin Bueno. Mr. Bueno is responsible for the day to day administration of the office and the management of the investigations and pathology staff. Mr. Bueno has over 15 years of combined experience working in, and managing, the field of medico-legal death investigation and private investigations. Mr. Bueno was previously at the Adams County Coroner's Office where he held positions as a Deputy Coroner, a Supervisor and a Chief Deputy; as a supervisor and field training officer he created a death investigation training program and wrote numerous office policies and procedures still in use today. He has managed and participated in the conception and implementation of two, state of the art, Coroner Facilities in Colorado. Mr. Bueno is experienced in assisting with autopsy procedures and has extensive training in toxicology, radiography, latent fingerprint collection and identification, and photography



to name a few. Mr. Bueno has produced numerous educational presentations for law enforcement and the community, and he has taught on numerous career related topics as well as trained many Deputy Coroner's currently employed across the state of Colorado. Mr. Bueno and his wife are both Colorado natives with two wonderful children. He loves the outdoors and anything involving the Rocky Mountains.

Board Certified Forensic Pathologist: Daniel C. Lingamfelter, D.O., Forensic Pathologist. Dr. Daniel Lingamfelter is a 2004 graduate of University of North Texas Health Science Center. His post graduate training consisted of an Anatomic and Clinical Pathology Residency at the University of Missouri-Kansas City, and a Forensic Pathology Fellowship at the University of Texas Southwest Medical Center. Dr. Lingamfelter is board certified by the American Board of Pathology in Forensic Pathology, Anatomic and Clinical Pathology and has taught at the University of Missouri School of Medicine and at Texas Christian University. Dr. Lingamfelter has published many journal articles and has given many presentations throughout the nation and Canada.

Board Certified Forensic Pathologist: Dawn B. Holmes, M.D., Forensic Pathologist. Dr. Dawn B. Holmes is a forensic pathologist who moved to Colorado in July 2012. She earned her bachelor's degree in Food Science and Human Nutrition from the University of Florida in Gainesville, FL; earned her medical degree at the University of South Carolina in Columbia, SC; completed her Anatomic and Clinical Pathology residency at Rush University Medical Center in Chicago, IL; and completed her fellowship in Forensic Pathology at the Office of the Cook County Medical Examiner in Chicago, IL. Dr. Holmes is board certified in Anatomic, Clinical, and Forensic Pathology and has been practicing since 2011. In her spare time, she enjoys coin collecting, snow skiing, running, traveling, and spending time with her family.

Board Certified Forensic Pathologist: John Carver, J.D., M.D., Forensic Pathologist. Dr. John Carver is a life-long Coloradan who practiced oil and gas law for fourteen years before returning to medical school (C.U., class of 2000). He completed pathology residency training at C.U., and did a fellowship year in forensic pathology in Milwaukee, WI. He is board-certified in anatomic, clinical and forensic pathology, and is an Associate Clinical Professor in the department of pathology at the C.U. School of Medicine. Over the past ten years he has performed autopsies for, and testified in numerous jurisdictions in Colorado, including the Larimer County Coroner's Office, Denver Office of the Medical Examiner, and Jefferson County Coroner's Office.

Deputy Coroner: Wendy Kane. Ms. Kane has a Bachelor's Degree in Business Management and an Associate's Degree in Criminal Justice and Applied Sciences. She has over 9 years of experience in investigations as a police officer and is also a certified massage therapist. Ms. Kane previously worked for the Colorado Bureau of Investigations Unit and is trained in fingerprint identifications. Ms. Kane handles a portion of the caseload, as well as handling various day-to-day operations.

Deputy Coroner: Brandon Dixon. Mr. Dixon grew up in the Golden area and attended college at the University of Colorado at Denver. He graduated with a degree in history and has worked in the investigative field ever since. Mr. Dixon has five years' experience working in the private sector doing financial and insurance based investigative work prior to joining the coroner's office. Mr. Dixon handles a portion of the caseload, as well as, handling various day-to-day operations of the office.

Deputy Coroner: Kimberly Wright. Mrs. Wright has a Bachelor's Degree in Criminal Justice from the University of Wyoming. Throughout her final year at the university, Mrs. Wright worked as a Deputy Coroner with the Albany County Coroner's Office. Upon completing her degree in December 2014, Mrs. Wright joined the Boulder County Coroner's Office. Mrs. Wright handles a portion of the caseload, leads the Child Fatality Prevention and Review Team meetings, as well as handling various day-to-day operations.

Deputy Coroner: Cari Lehl. Mrs. Lehl has a Bachelor's Degree and Master's Degree in Forensic Science and a minor in psychology. During her studies, she interned with the Weld County Coroner's Office, the Arapahoe County Coroner's Office, the Miami-Dade Medical Examiner's Office, and the Denver Police Department. Mrs. Lehl handles a portion of the caseload, as well as handling various day-to-day operations of the office.

Deputy Coroner: Laurissa Weidlich. Ms. Weidlich has a Bachelor's Degree and Master's Degree in Criminal Justice with a minor in Forensic Science. During her studies, she interned for the Bexar County Medical Examiner's Office. After completion of her undergraduate studies, she worked for the Texas Department of Family and Protective Services. She served six years in the United States Air Force as an Arabic Linguist and has two Associate's Degrees in Arabic and Cryptologic Language Analysis. Ms. Weidlich handles a portion of the caseload, as well as handling various day-to-day operations of the office.

Deputy Coroner: Jordan Steiner. Mr. Steiner has a Bachelor's Degree in Anthropology and a minor in Mathematics from the University of Colorado, Boulder. Following college, he attended the Red Rocks Community College Law Enforcement Academy where he graduated with academic and arrest control honors. Mr. Steiner handles a portion of the caseload, as well as handling various day-to-day operations of the office.

Pathology Assistant: Cory Martin. Ms. Martin joined the Boulder County Coroner's office in September of 2011 as an Autopsy Technician Intern and was subsequently hired upon completion of her internship. Ms. Martin holds degrees in opera performance from Indiana University, Bloomington, gemological certifications from the Gemological Institute of America and a bachelor's degree in biology from Metropolitan State University, Denver. Ms. Martin is responsible for the day-to-day operation of the morgue and assists at autopsies.

Administrative Supervisor: Donna Lee. Ms. Lee has an extensive background in office administration. Her career included providing administrative assistance to employers such as the State of Colorado, AT&T/Lucent Technologies/Avaya Communications and the City of Northglenn. Donna is responsible for assisting the Coroner in the administration of the office.

Administrative Technician: Kathy Murray. Mrs. Murray is the Administrative Technician for the Boulder County Coroner's Office. She has been with the coroner's office since December of 2014 and prior to that worked at the Addiction Recovery Center within Boulder County Public Health. Her previous experience includes various administrative support positions in the fields of hospice care and behavioral health. Mrs. Murray enjoys crocheting, reading, her dogs and being a huge Colorado Rockies and Colorado Avalanche fan.

FACILITIES

Groundbreaking for the Boulder County Coroner Facility located at 5610 Flatiron Parkway occurred in March of 2014. The facility was completed in the spring of 2015. The office is designed to welcome and assist those coming to the Boulder County Coroner's Office. The staff is available to law enforcement personnel, community partners and family members, from 8:00 A.M. to 4:30 P.M. (Closed for lunch from 12 P.M. to 1 P.M.). After hours coroner's office staff is available 24/7 through Boulder County Dispatch.



The building is a stand-alone facility which includes a 1060 square foot autopsy suite featuring state-of-the-art amenities to allow for the most safe work environment possible for the staff and for public health in general. The suite includes two full function stainless steel autopsy tables in addition to a 202 square foot Isolation room with independent reverse flow air system. The morgue features a remote controlled body lift system, surgical lamps, natural light for energy conservation, pan/tilt/zoom (PTZ) and fixed security cameras with medical detail zoom capabilities and remote communication with conference rooms, and a walk in freezer and refrigerator capable of storing up to 30 bodies each.

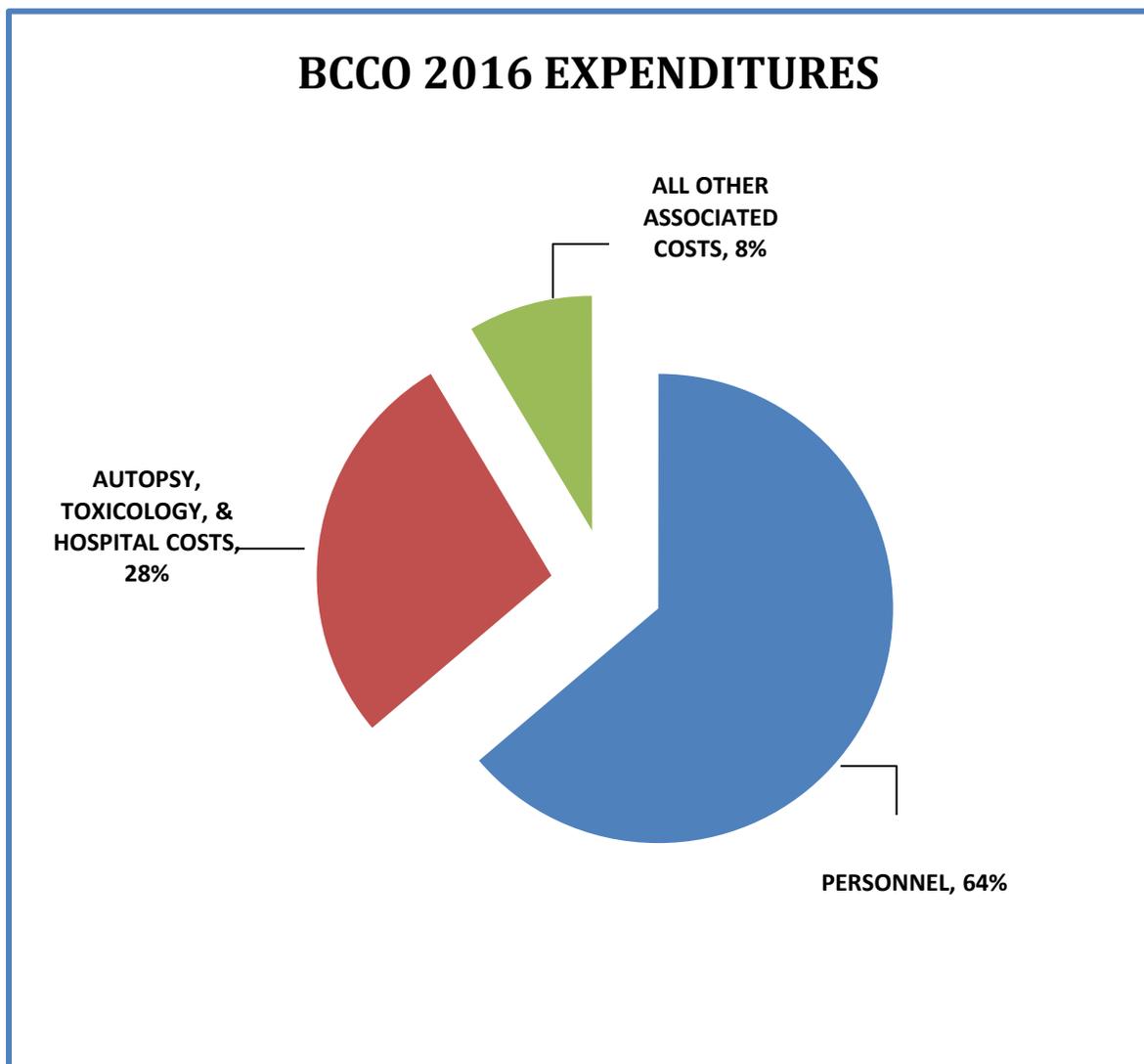


FUNDING

The funding for the coroner's office comes from the general fund. The general fund is the common use fund where the majority of the county's core services are funded. The coroner's office has an appropriation which is split between personnel and operating expenditures. The majority of the revenues that go into the general fund include property tax, motor vehicle fees, recording fees, other fees and charges for service, interest on investments, and intergovernmental revenues. Additional information is available through the Boulder County Budget Office.

EXPENDITURES

The 2016 expenditures for the Boulder County Coroner's Office was \$1,083,696. This is 0.25% of the total adopted 2016 Boulder County budget of \$426,638,902.



DESCRIPTION OF REPORTABLE CASES

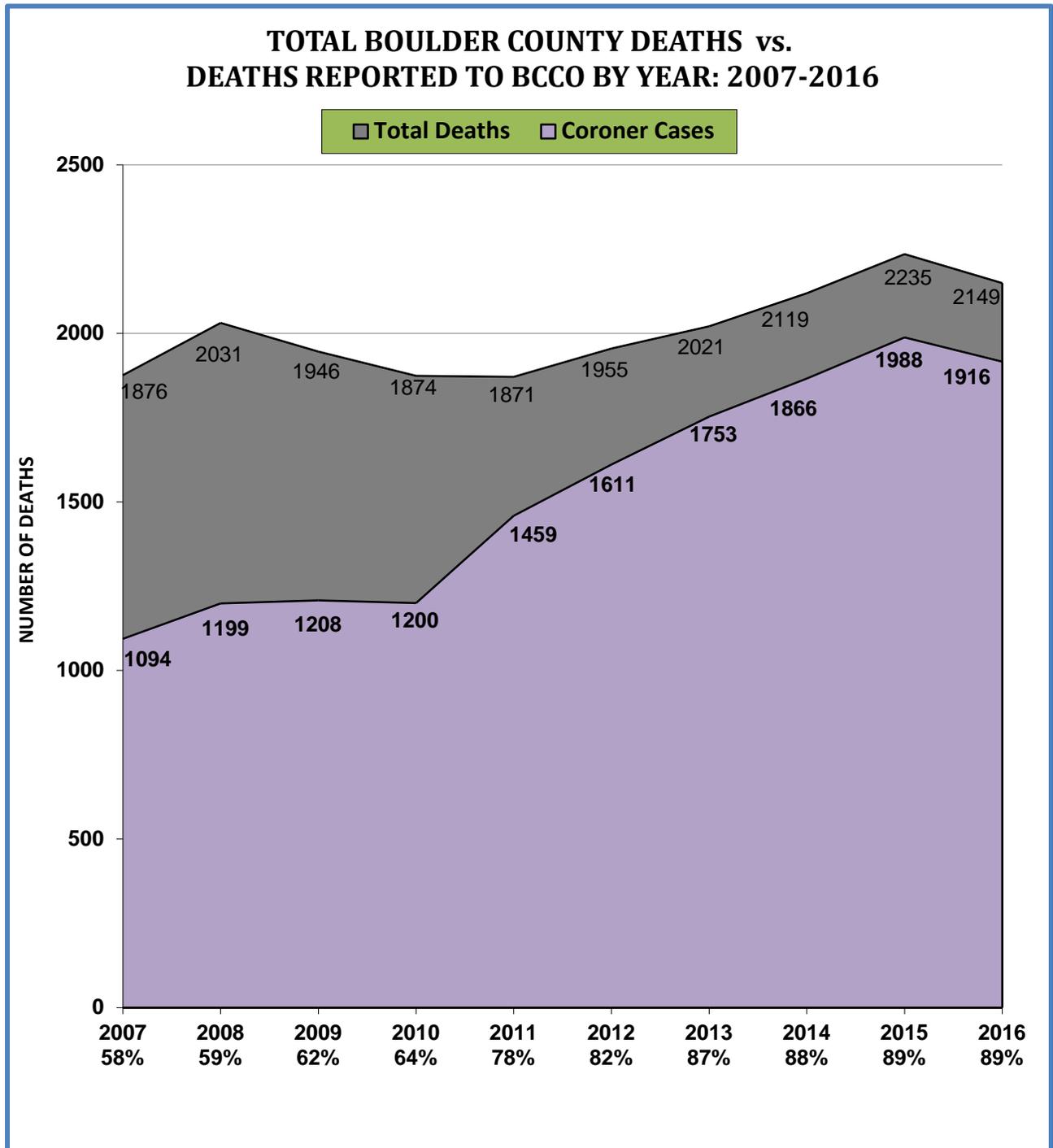
In accordance with Colorado Revised Statute §30-10-606, the following deaths are **reportable** to the Boulder County Coroner's Office:

- If the death is or may be unnatural as a result of external influences, violence or injury;
- Death due to the influence of or the result of intoxication by alcohol, drugs or poison;
- Death as a result of an accident, including at the workplace;
- Death of an infant or child is unexpected or unexplained;
- Death where no physician is in attendance or when, though in attendance, the physician is unable to certify the cause of death;
- Death that occurs within twenty-four hours of admission to a hospital;
- Death from a disease which may be hazardous or contagious or which may constitute a threat to the health of the general public;
- Death occurs from the action of a peace officer or while in custody of law enforcement officials or while incarcerated in a public institution;
- Death was sudden and happened to a person who was in apparent good health;
- When a body is unidentifiable, decomposed, charred or skeletonized;
- Circumstances that the coroner otherwise determines may warrant further inquiry to determine cause and manner of death or further law enforcement investigation.

It should be emphasized that, although a particular death may be "reportable" to the coroner's office; an autopsy may not be necessary depending upon the circumstances.

PERCENTAGES OF BOULDER COUNTY DEATHS REPORTED TO THE CORONER

Per the US Census, the 2016 estimated population of Boulder County was 322,226. A death certificate is filed with the Boulder County Public Health Department for each death that occurs in Boulder County. The Public Health Department keeps track of the total number of deaths that occur in Boulder County. A portion of the deaths that occur in Boulder County are reported to the Boulder County Coroner’s Office. The chart below shows a yearly total of all deaths that occurred in Boulder County and a yearly total of all deaths reported to the Boulder County Coroner.



AUTOPSIES BY YEAR

In approximately twelve percent of the deaths that were investigated by the Boulder County Coroner's Office in 2016, an autopsy or skeletal postmortem examination was performed to aid in the determination of the cause and manner of death, to document disease, to identify injury patterns, or to recover evidence. Included in almost all autopsies are toxicology tests that may be helpful in determining the cause and manner of death. Toxicology testing and histology review is performed on various specimens collected at autopsy. Several laboratories are used for drug testing. Screening tests include alcohol, illicit drugs, commonly abused prescription and non-prescription drugs, and other substances as needed.

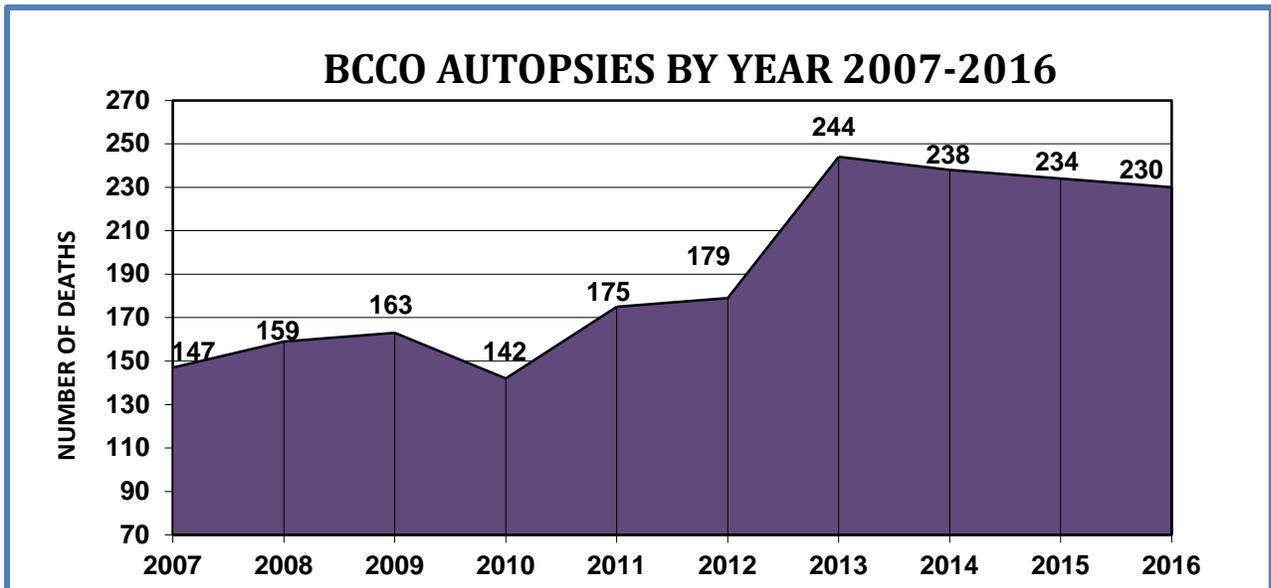
In 2011, House Bill 11-1258 was passed. The bill states that the coroner shall perform forensic autopsies with the most recent version of the "Forensic Autopsy Performance Standards" adopted by the National Association of Medical Examiners (NAME). And that all forensic autopsies must be performed by a board-certified forensic pathologist.

The "Forensic Autopsy Performance Standards" listed by NAME are as follows:

Medicolegal death investigation officers are appointed or elected to safeguard the public interest. Deaths by criminal violence, deaths of infants and children, and deaths in the custody of law enforcement agencies or governmental institutions can arouse public interest, raise questions, or engender mistrust of authority. Further, there are specific types of circumstances in which a forensic autopsy provides the best opportunity for competent investigation, including those needing identification of the deceased and cases involving bodies of water, charred or skeletonized bodies, intoxicants or poisonings, electrocutions, and fatal workplace injuries. Performing autopsies protects the public interest and provides the information necessary to address legal, public health, and public safety issues in each case. For categories other than those listed below, the decision to perform an autopsy involves professional discretion or is dictated by local guidelines. For the categories listed below, the public interest is so compelling that one must always assume that questions will arise that require information obtainable only by forensic autopsy.

A forensic pathologist shall perform a forensic autopsy when:

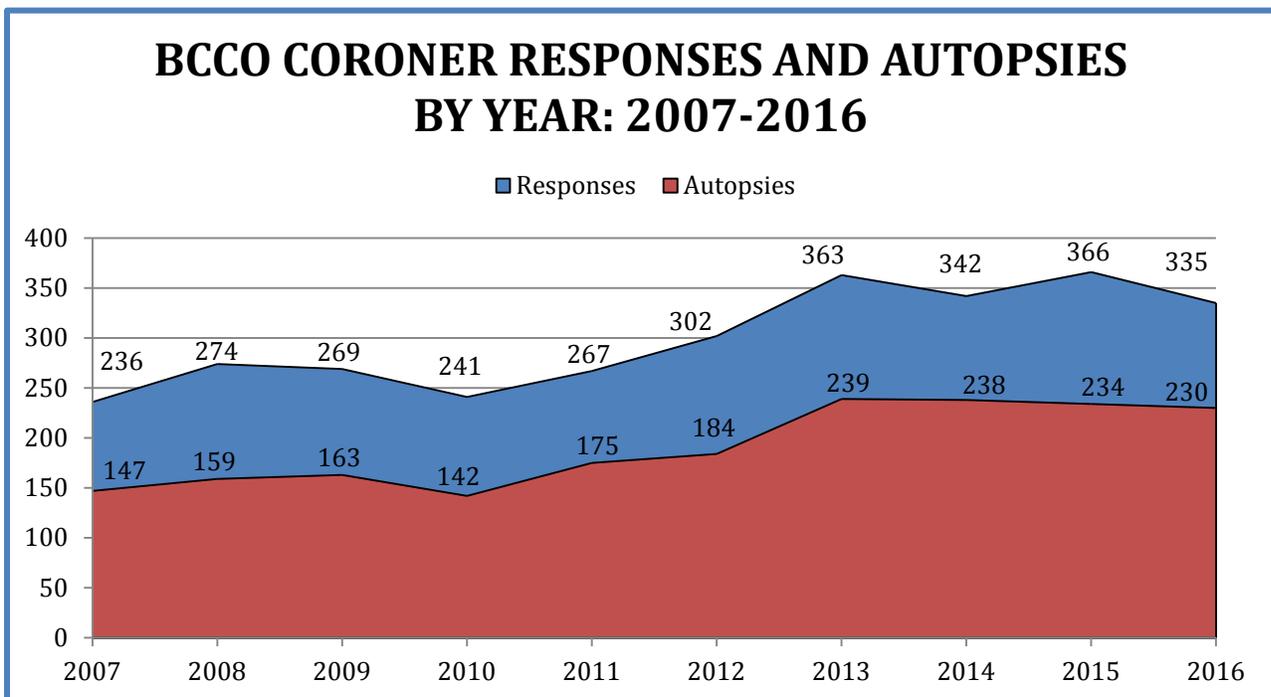
- The death is known or suspected to have been caused by apparent criminal violence.
- The death is unexpected and unexplained in an infant or child.
- The death is associated with police action.
- The death is apparently non-natural and in custody of a local, state, or federal institution.
- The death is due to acute workplace injury.
- The death is caused by apparent electrocution.
- The death is by apparent intoxication by alcohol, drugs, or poison, unless a significant interval has passed, and the medical findings and absence of trauma are well documented.
- The death is caused by unwitnessed or suspected drowning.
- The body is unidentified and the autopsy may aid in identification.
- The body is skeletonized.
- The forensic pathologist deems a forensic autopsy is necessary to determine cause or manner of death, or document injuries/disease, or collect evidence.
- The deceased is involved in a motor vehicle incident and an autopsy is necessary to document injuries and/or determine the cause of death.



Note: *The Boulder County Coroner’s Office performed 230 autopsies in 2016, one of which was a 2015 case, additionally there was one 2016 case in which the autopsy was performed in 2017.

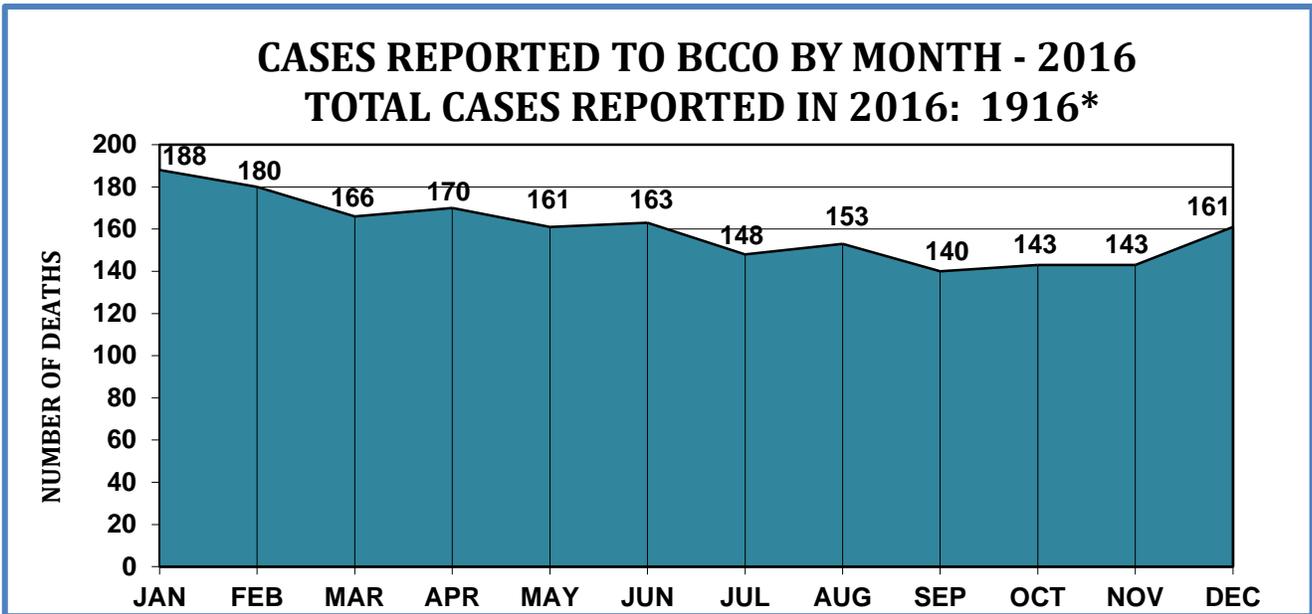
CORONER RESPONSE AND AUTOPSY TOTALS

The Boulder County Coroner’s Office makes a physical response to a low percentage of its total case load and performs an autopsy on an even lower percentage of its total case load. The chart below shows the annual trend lines for both the responses and the autopsies.



Note: * There were 230 cases in 2016 that required autopsies; however one of the autopsies was performed in 2017 (one autopsy performed in 2016 was a 2015 case).

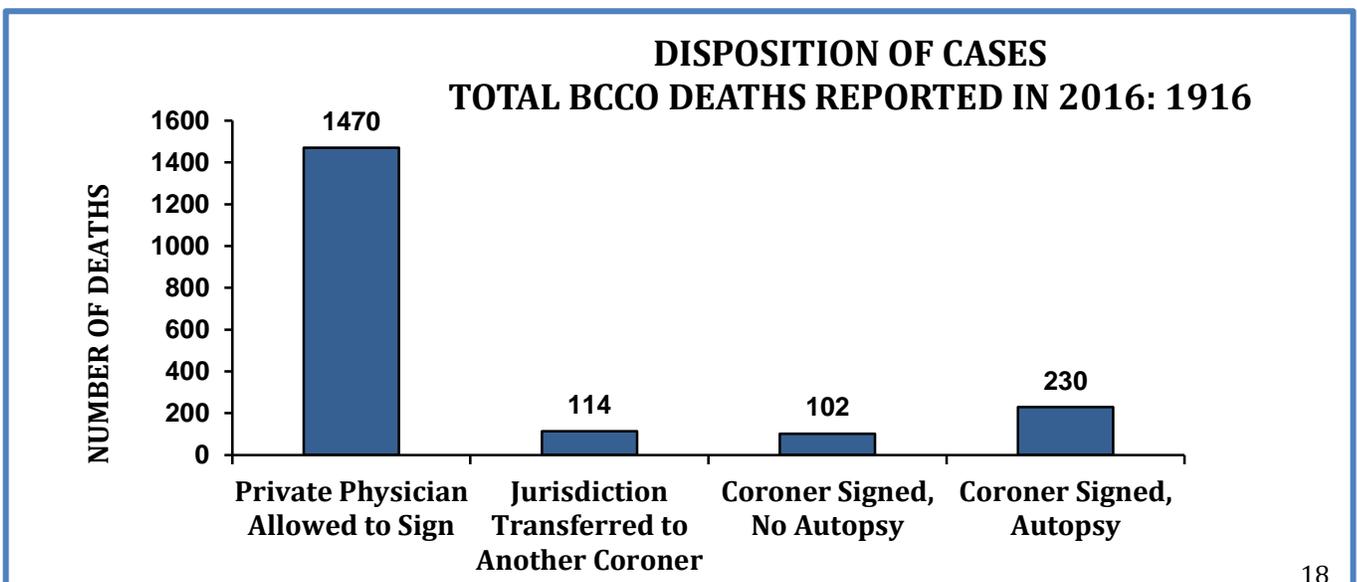
CASES BY MONTH



Note: *The total number of cases reported includes 114 cases that were transferred to other coroners. See **Transfer of Jurisdiction** section of this report for further explanation.

DISPOSITION OF CASES

Deaths that fall under the jurisdiction of the coroner are handled in one of four ways. Most commonly, if the death is due to natural disease and if a private physician who has treated the decedent is able to certify the cause of death, the coroner may allow the private physician to sign the death certificate. Or the coroner may assume jurisdiction over the death and conduct an investigation and an autopsy to determine cause and manner of death and then issue a death certificate. Or the coroner may assume jurisdiction of a death and conduct an investigation, but not perform an autopsy. Or, even though a death may have occurred in the county, a “transfer of jurisdiction” may occur to the coroner of the county where the initiating event causing death occurred or where the decedent was transported from (i.e. by ambulance) prior to death. The transfer of jurisdiction is allowed according to Colorado Revised Statute §30.10.606.



TRANSFER OF JURISDICTION

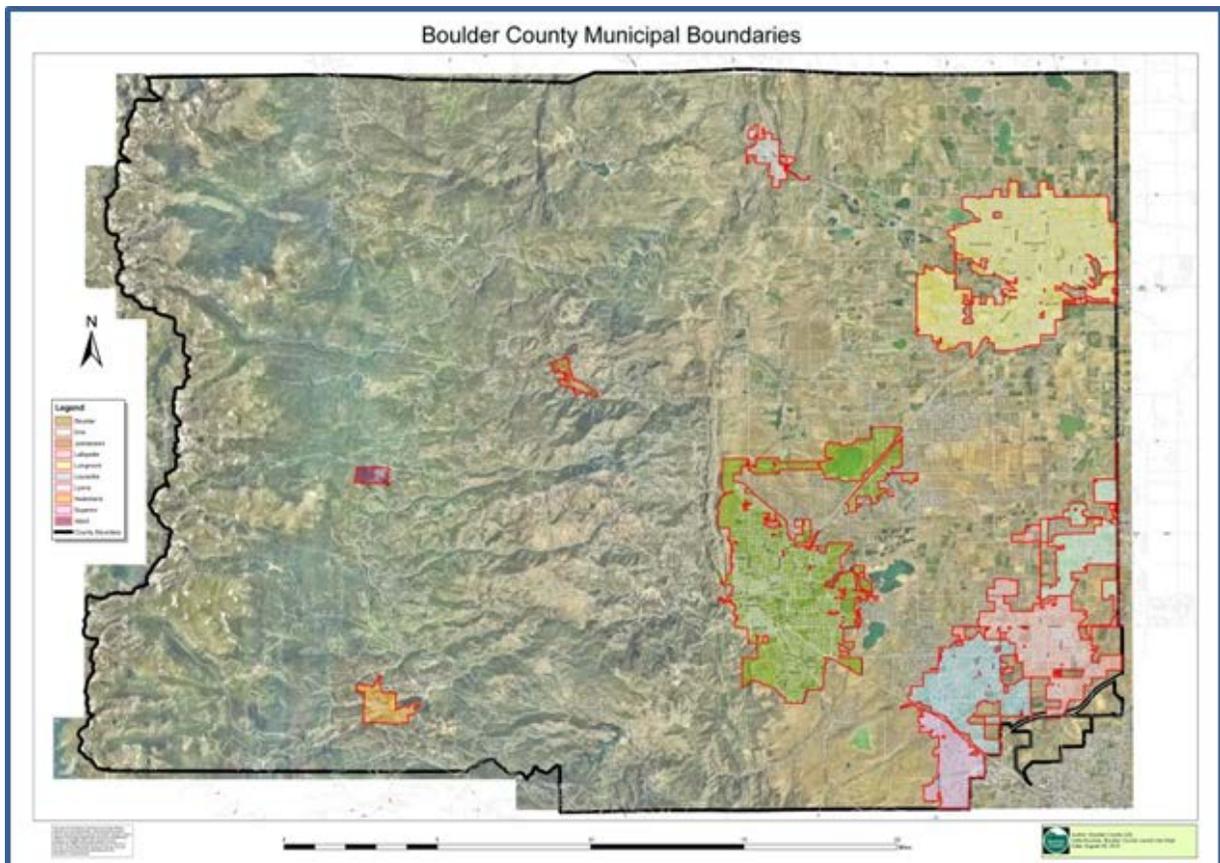
Occasionally, deaths that occur in Boulder County are due to an “initiating event” that occurred in another county. For example, an individual may die in a hospital from injuries that they sustained in an accident that occurred in another county, or an individual may collapse at their residence (in another county), be transported to a hospital in Boulder County, and subsequently die in that hospital. In these cases, the Boulder County Coroner will transfer jurisdiction (subsequent investigation and certification) to the coroner of the county in which the “initiating event” occurred.

In 2016, the jurisdictions of 114 cases were transferred to other coroners in surrounding counties. Sixty-seven cases were natural deaths, twelve were traffic accidents, twenty-five were non-traffic accidents, seven were suicides, one was undetermined, two were homicide. Seventy-one of the cases were transferred to Adams/Broomfield County, twelve were transferred to Weld County, thirty were transferred to Jefferson County, and one was transferred to Pueblo County.

Fifty-two of the transferred cases were deaths that occurred in an emergency department. Forty-eight of them occurred at Exempla Good Samaritan Medical Center (EGSMC), one occurred at Avista Adventist Hospital and three occurred at Longmont United Hospital.

In 82% of the cases (93 total) that were transferred to other coroners, the decedents were transported to Exempla Good Samaritan Medical Center from areas outside of Boulder County (this includes the 48 EGSMC ED deaths).

For statistical purposes, in the sections to follow, transferred cases will not be counted among the deaths investigated by Boulder County, unless otherwise noted.

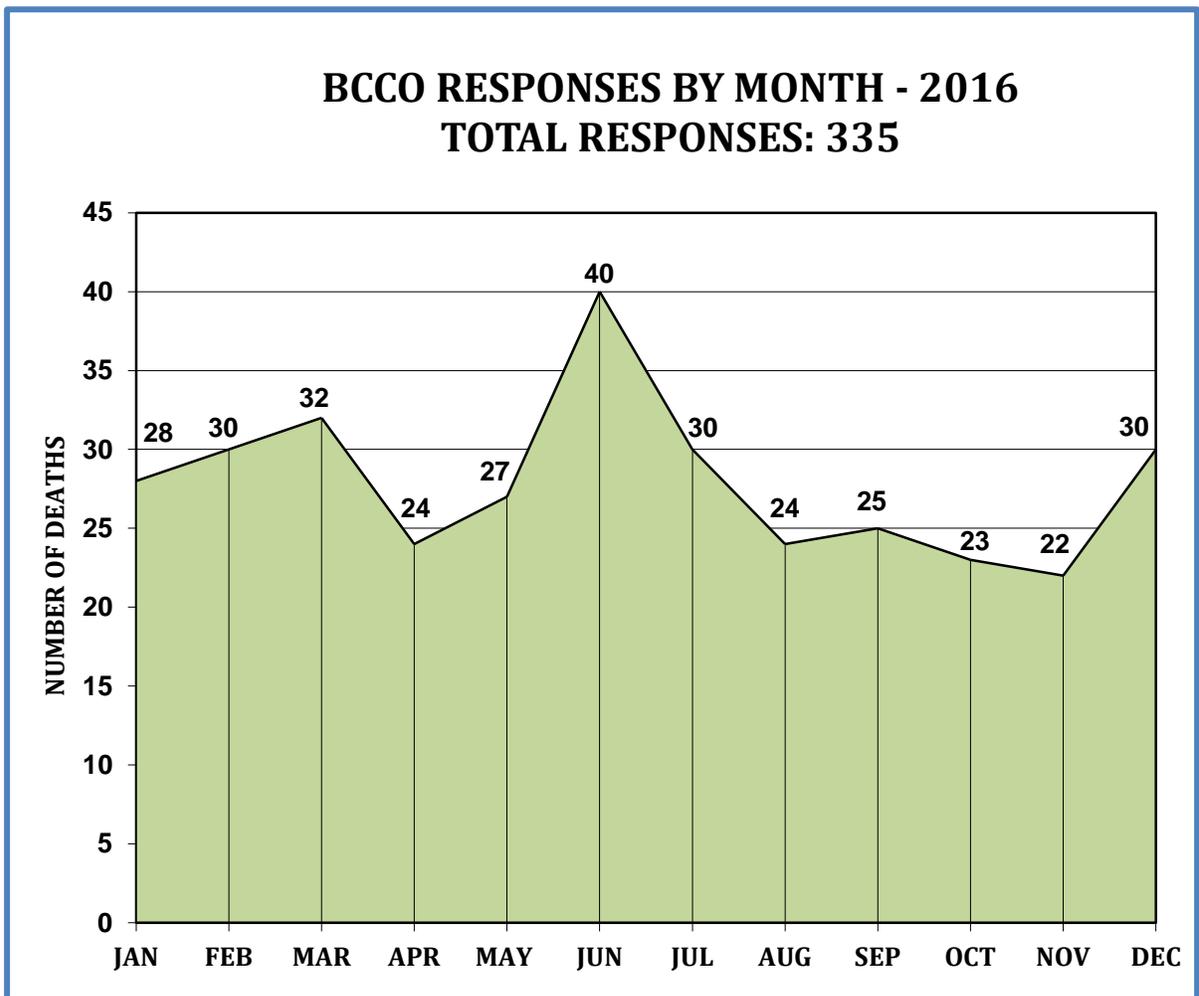


CORONER RESPONSES BY MONTH

The Boulder County Coroner's Office is called to action by either receiving a phone report of a death or by receiving a notification and response request from law enforcement. When a death is reported to the office by phone it is typically being reported by a hospice agency, a care center or a hospital. The coroner's office will make a determination if a response is necessary; if not, a phone report is taken and the office may follow up with attaining additional medical records and conducting further interviews as needed. A response is made by the coroner's office to the care center or hospital if further information is needed at the time of death.

Most responses made by the coroner's office are to death scenes where law enforcement was notified and requested the coroner's office. Law enforcement has jurisdiction over the scene, while the coroner's office has jurisdiction over the body, therefore, both agencies work together to accomplish their individual responsibilities. The coroner's office is responsible for determining manner and cause of death, identifying the decedent and notifying the next of kin. Law enforcement's responsibility is to determine and document any crime that may have occurred or the lack thereof.

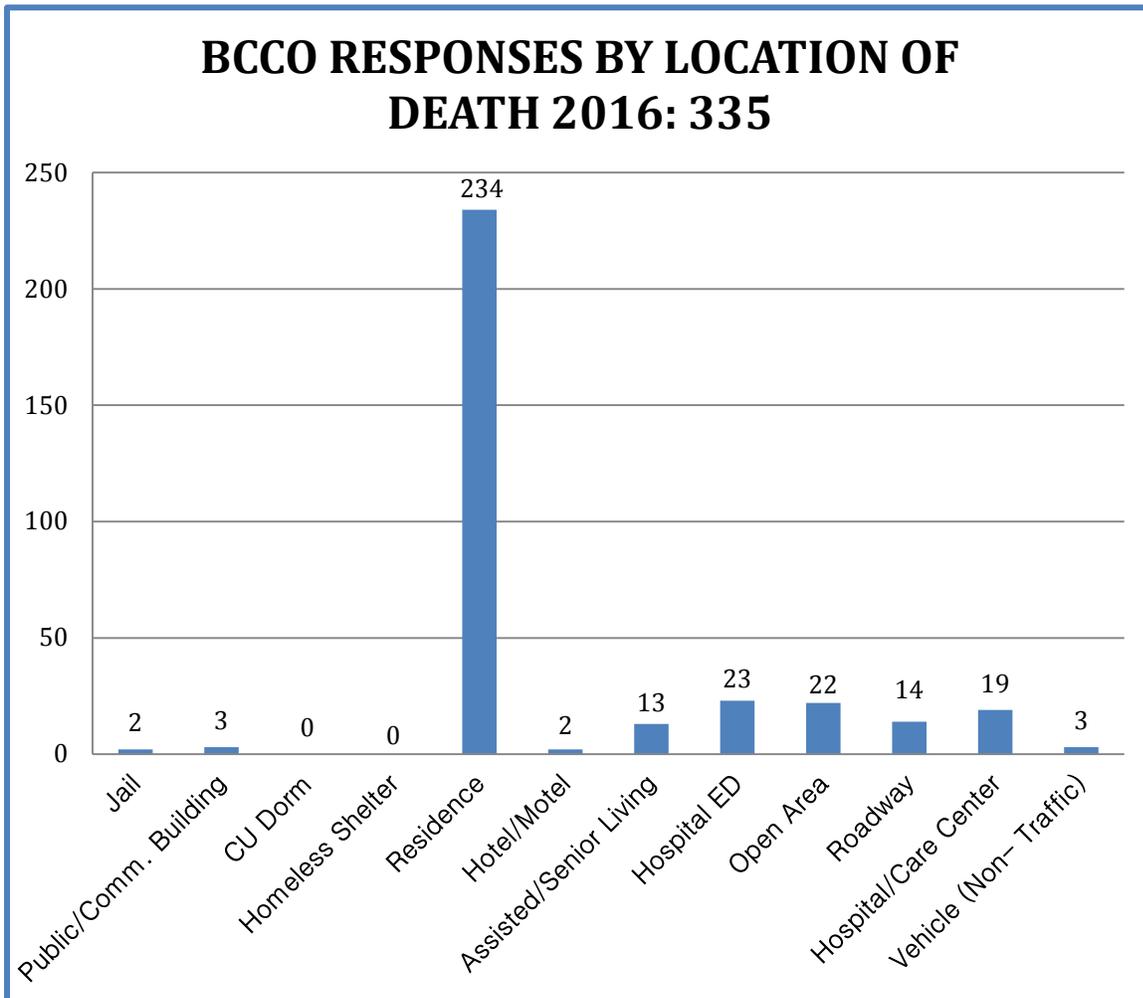
In 2016, 335 scene responses were made which was 18% of all of the deaths reported to the Boulder County Coroner's Office.



CORONER REPOSSES BY LOCATION OF DEATH

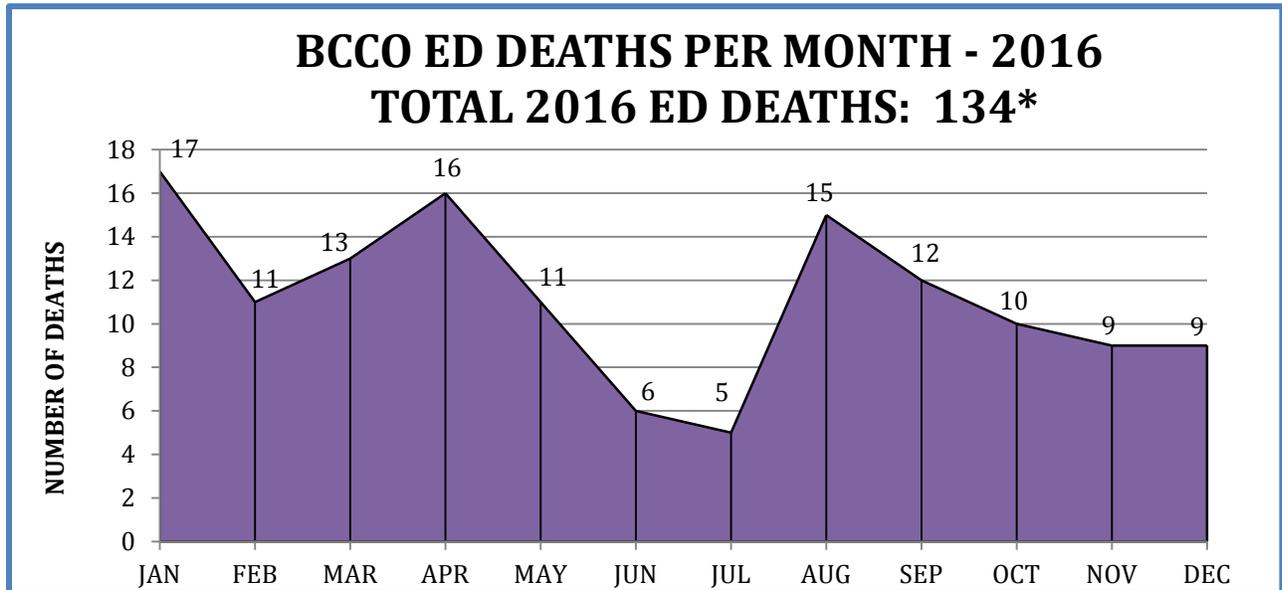


BCCO all-terrain response vehicle, equipped for mountain responses.



EMERGENCY DEPARTMENT CALLS BY MONTH

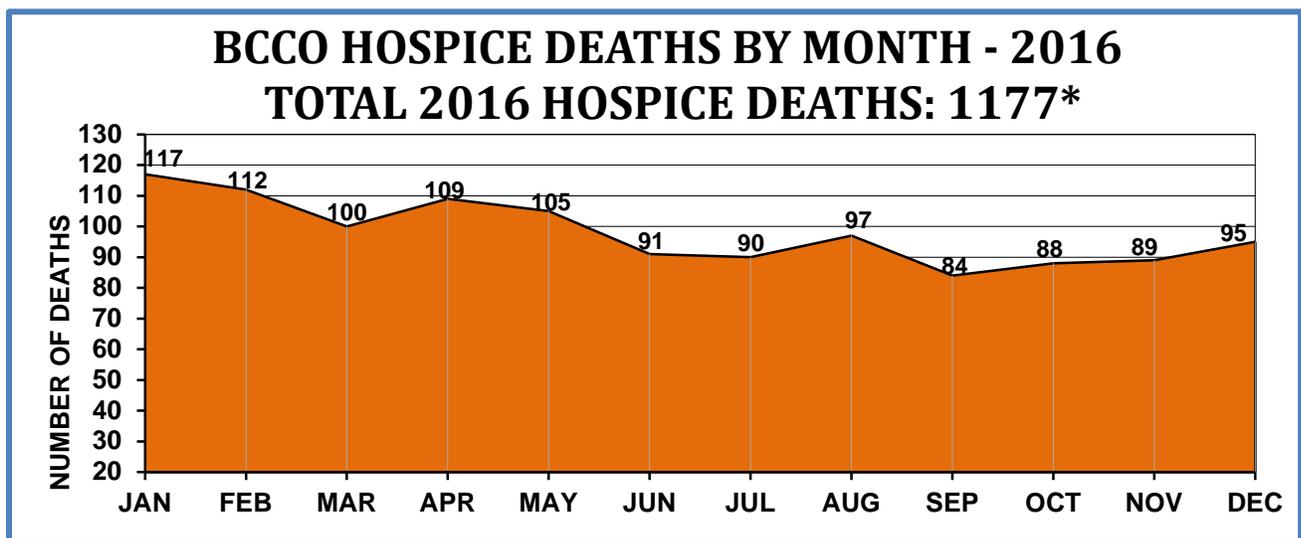
Deaths that occur in an emergency department are required to be reported to the coroner's office. Hospitals in Boulder County include Boulder Community Hospital Foothills, Longmont United Hospital, Exempla Good Samaritan Medical Center, and Avista Adventist Hospital.



Note: *The total number of cases reported include 52 cases that were transferred to other coroners. See **Transfer of Jurisdiction** of this report for further explanation.

HOSPICE CASES BY MONTH

Deaths occurring under hospice care in Boulder County are reported to the Boulder County Coroner's Office. There are several hospice organizations operating throughout Boulder County. Of the 1177 hospice cases, reported to the Boulder County Coroner's Office, 1126 (96%) were natural deaths, 49 (4%) were accidental deaths and 2 (<.01%) were suicides. Of the 1177 hospice cases, three of them included an autopsy (one due to reports of abuse and the other two due to indications of suicide).



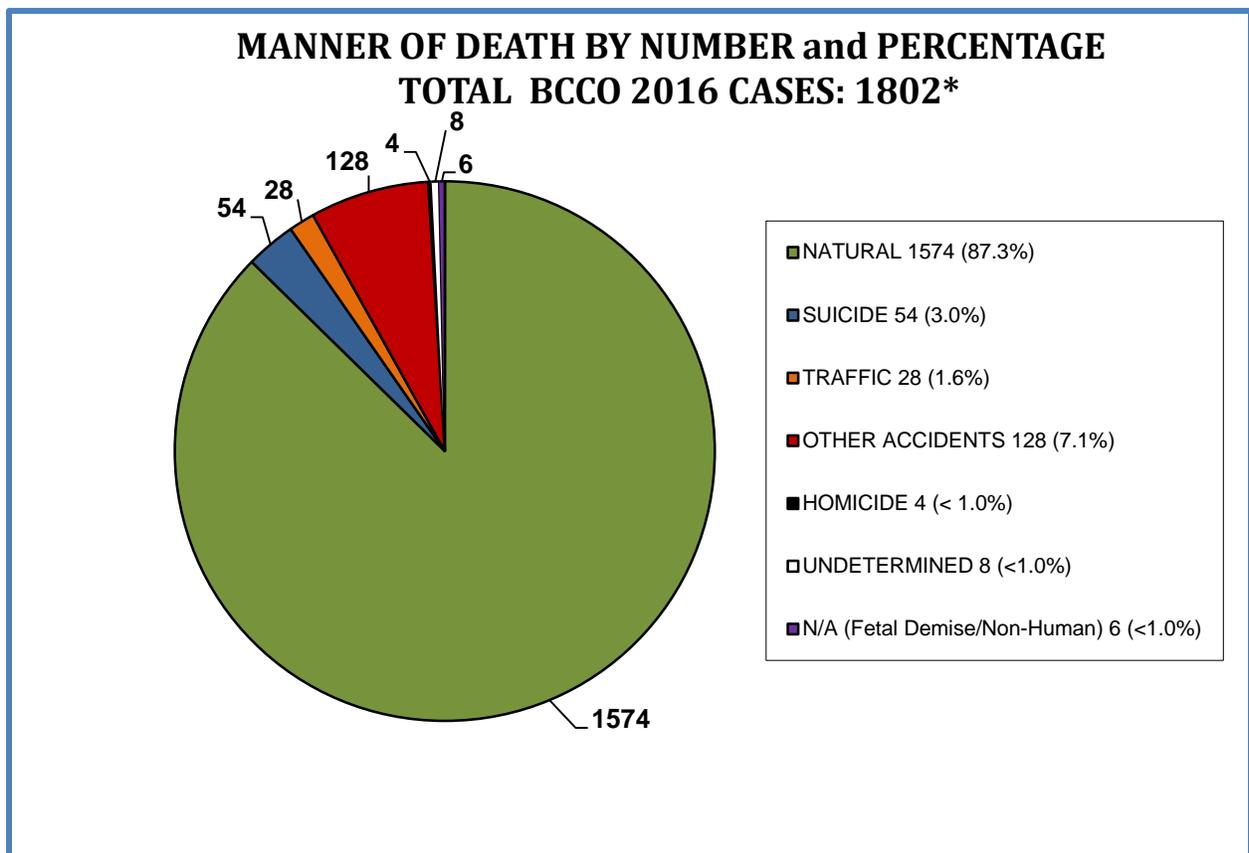
Note: *This total excludes the 11 hospice cases that were transferred to other coroners.

MANNER OF DEATH

One of the main responsibilities of the coroner's office is to determine the manner of death. The manner of death is a classification of death based on the circumstances surrounding the cause of death and how that cause came to be. There are five manners of death: Natural, Suicide, Accident, Homicide and Undetermined. The manner of death is one of the items that must be reported on the death certificate. The manner of death was added to the US Standard Certificate of Death in 1910; it was added by public health officials as a way to code and classify cause of death information for statistical purposes. It should be noted that the medicolegal definition of Homicide means death caused by another, and is not based on intent. A ruling of Homicide does not indicate or imply criminal intent.¹

MANNER OF DEATH BY NUMBER AND PERCENTAGE

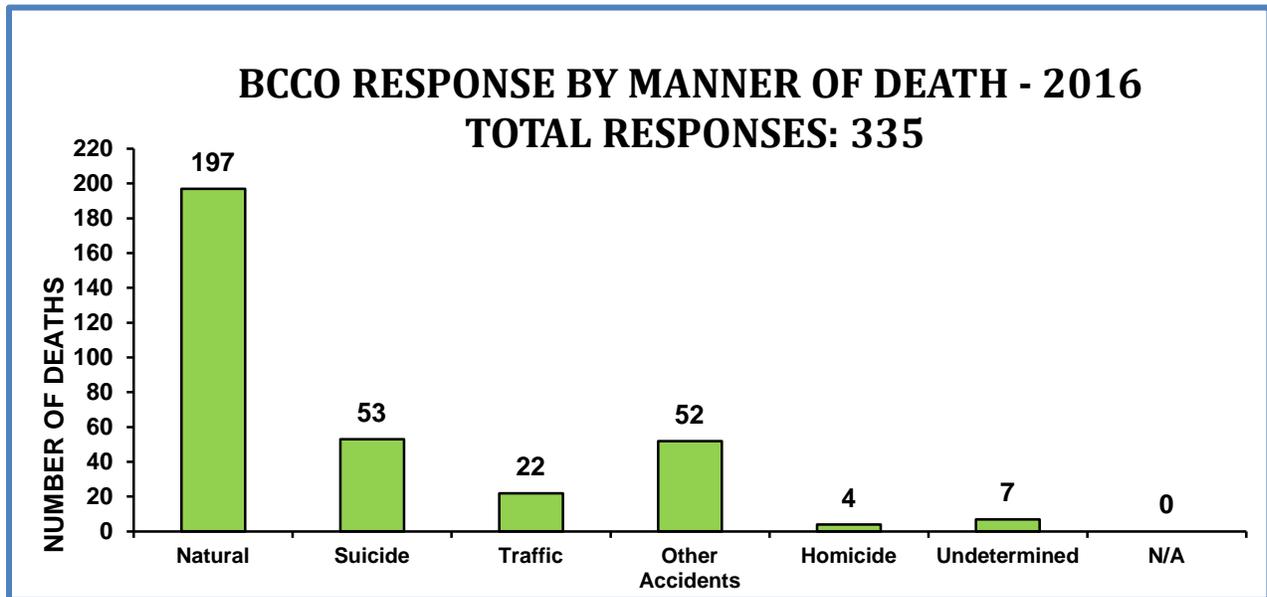
A large majority of the cases investigated by any medical examiner or coroner's office are natural deaths. In Boulder County that figure was 1574 cases, or 87.3% in 2016. Included within these natural deaths were 1126 hospice cases.



Note: *The 114 cases transferred to other coroners are not included in this total.

Note: Statistical information may not coincide with information available from the Colorado Health Department. The State Health Department tracks death statistics by the county of residence, not by the county where the injury or death occurred.

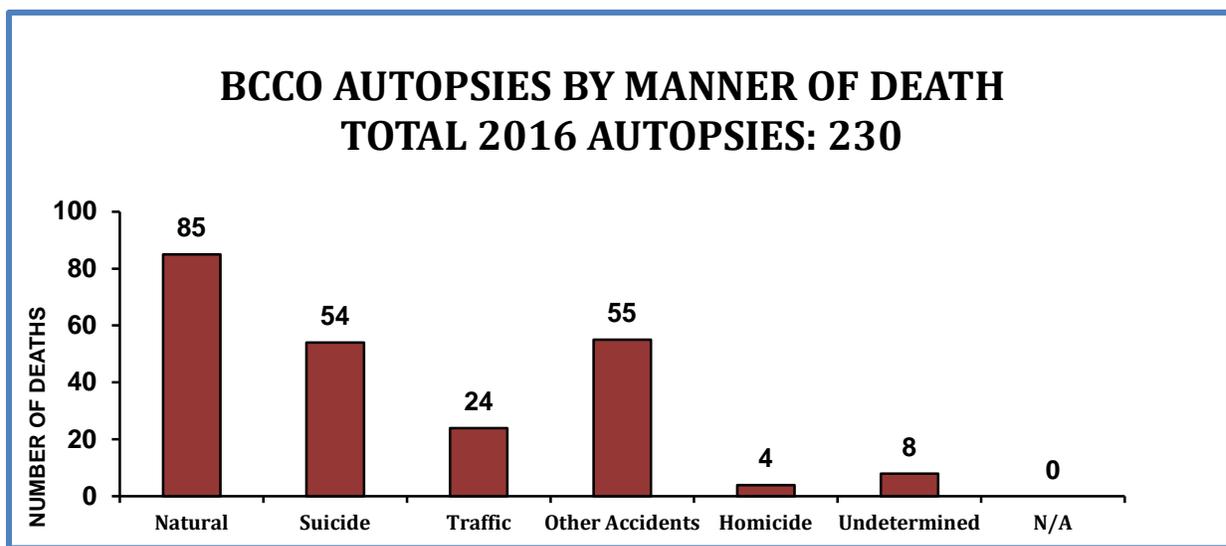
CORONER RESPONSE BY MANNER



Note: The apparent absence of a scene investigation in some suicides, motor vehicle, and other accident cases may be due to the extended survival of the victim in a hospital, or because the victim was transported by emergency personnel to a hospital outside the county and subsequently died away from the scene.

AUTOPSIES BY MANNER OF DEATH

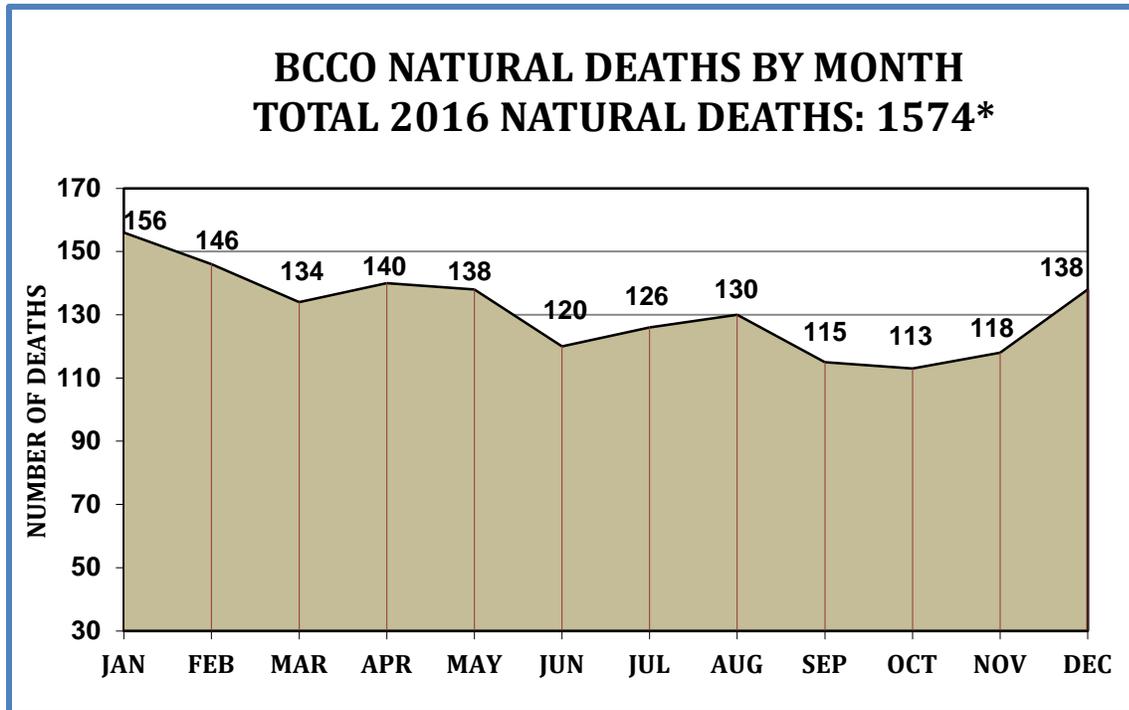
In addition to following the “Forensic Autopsy Performance Standards” adopted by the National Association of Medical Examiners (NAME), the Coroner weighs many factors in order to determine whether an autopsy should be performed. Autopsies are performed in all homicides, most infant deaths, most deaths of individuals without an established medical history, deaths involving possible criminal action, most motor vehicle accident deaths, and most suicides.



NATURAL DEATHS

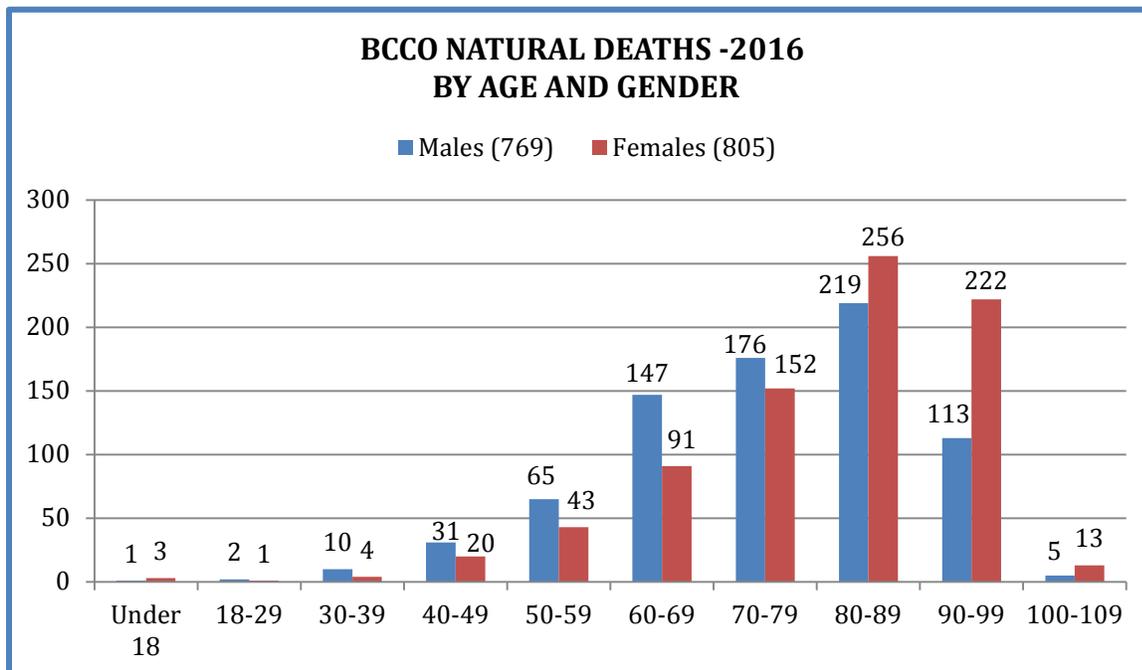
NATURAL DEATHS BY MONTH

Natural deaths comprise the majority of all deaths nationwide and holds true for the cases handled by the Boulder County Coroner's Office.



Note: *This total does not include the 67 natural deaths transferred to other coroners.

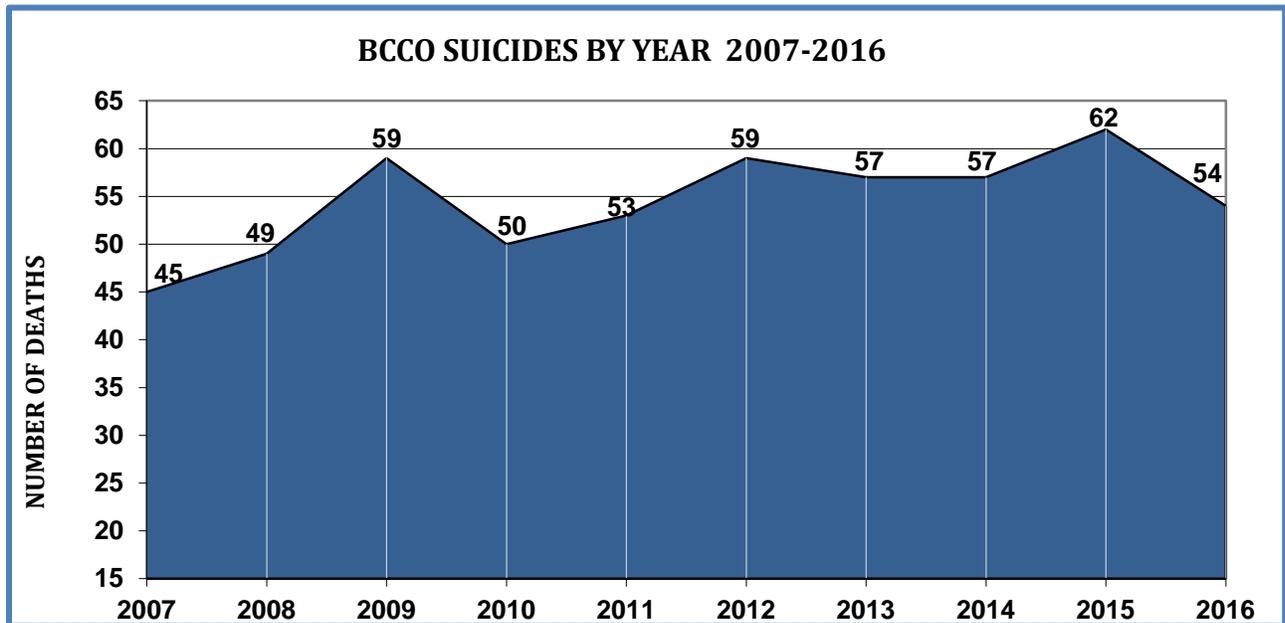
NATURAL DEATHS BY AGE AND GENDER



SUICIDES

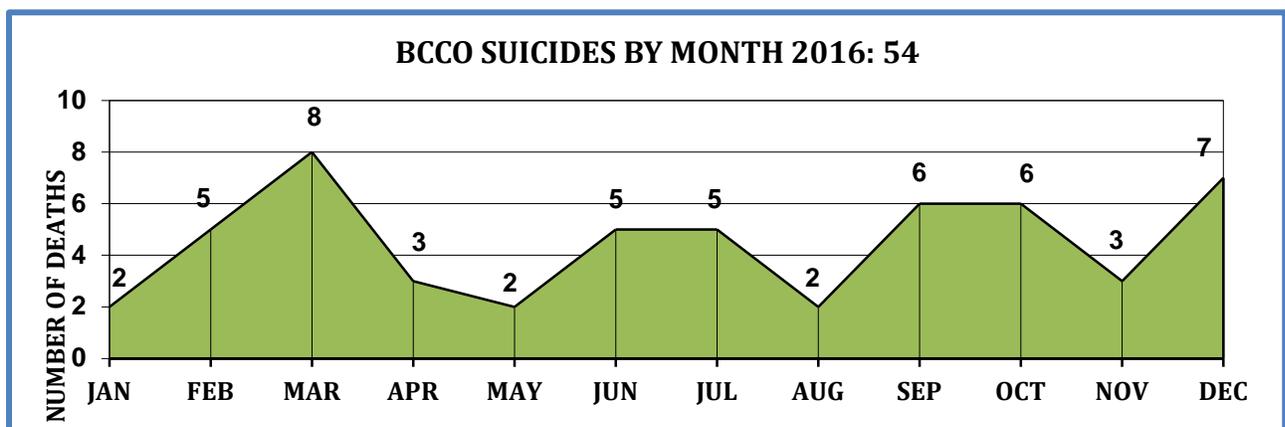
Suicide is defined as the intentional act of killing oneself. Nationally, men are three to five times more likely to commit suicide than women, but women attempt suicide more frequently than men. The most common method of committing suicide is with firearms, followed by hanging, suffocation, and ingestion of poisons.² In 2016 in Boulder County, the most common method used was a firearm, followed by hanging and then by suffocation.

SUICIDES BY YEAR



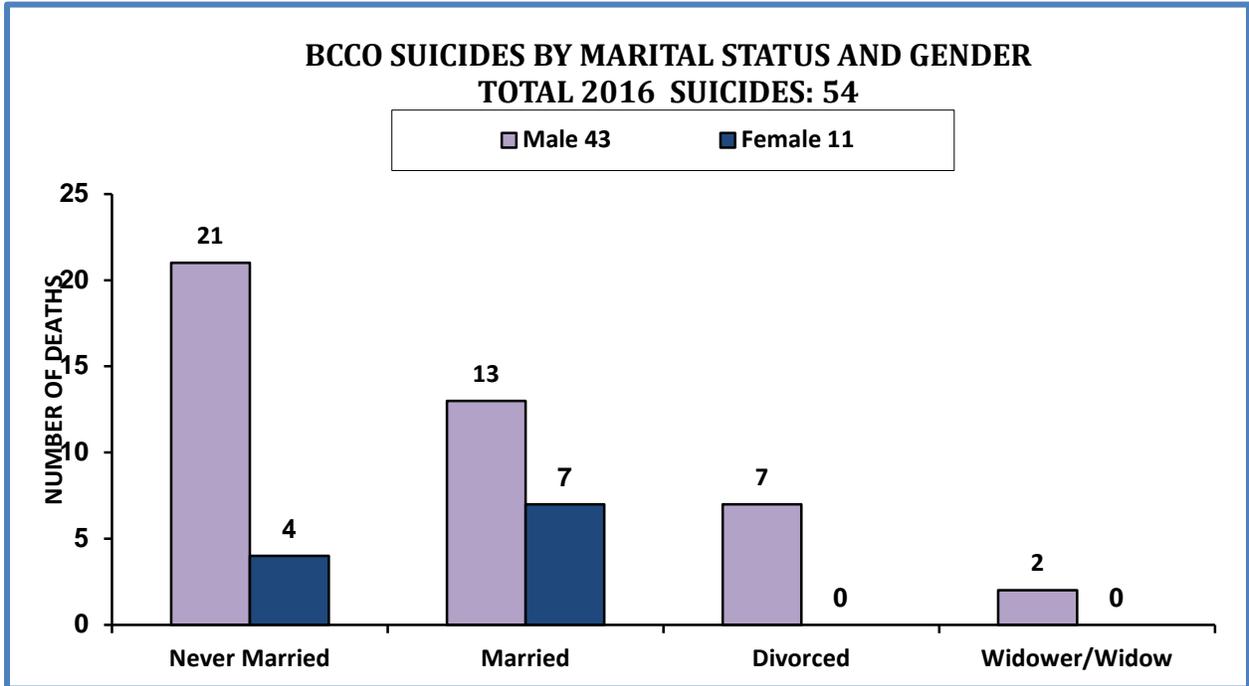
Note: There were a total of 61 suicides reported to the Boulder County Coroner's Office in 2016. The Boulder County Coroner's Office investigated 54 of those cases and transferred jurisdiction of seven cases to other coroners.

SUICIDES BY MONTH

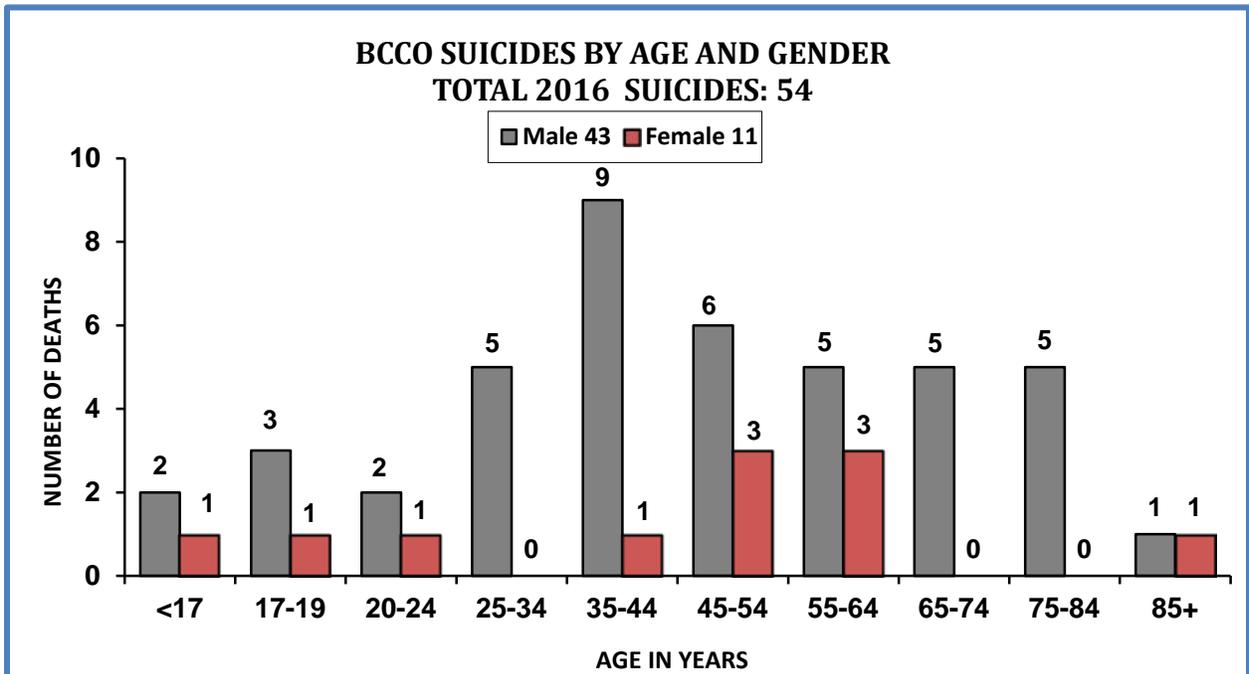


Note: Six of the suicides were non Boulder County residents and one of the suicides was a transient.

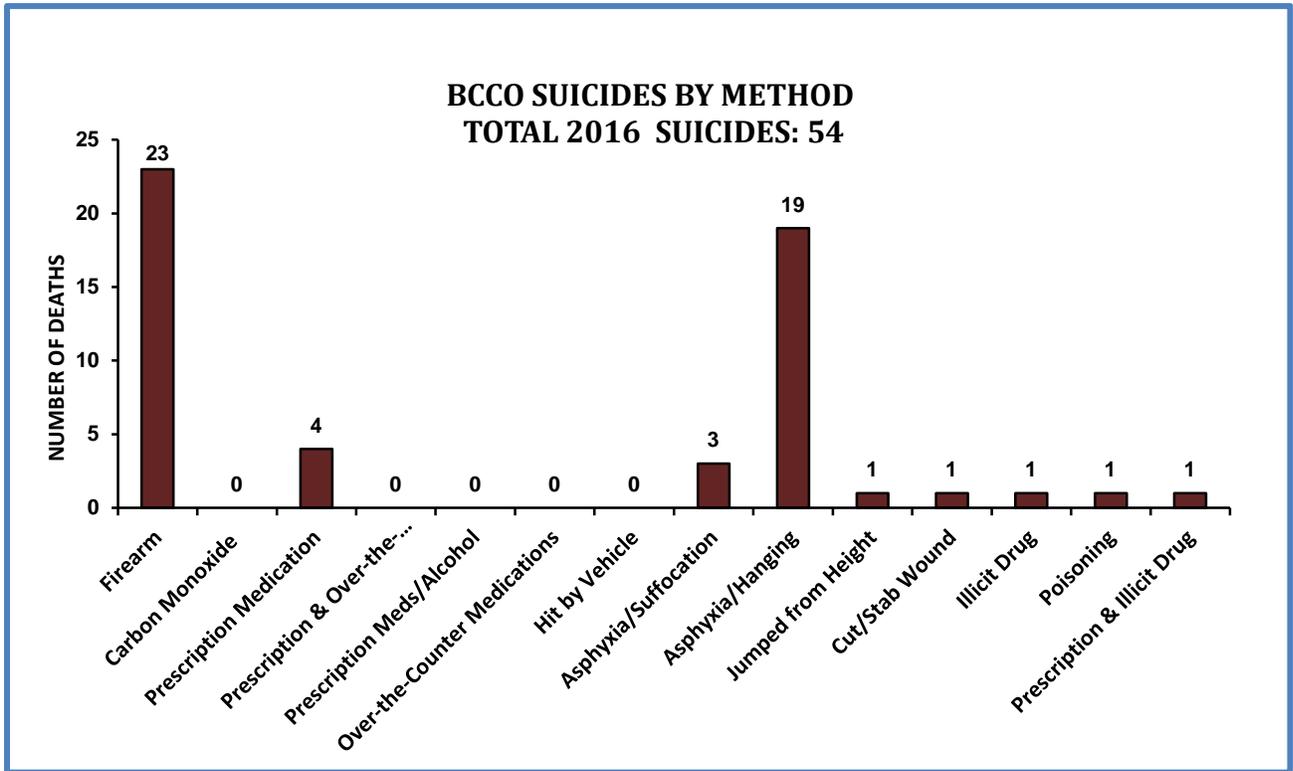
SUICIDES BY MARITAL STATUS AND GENDER



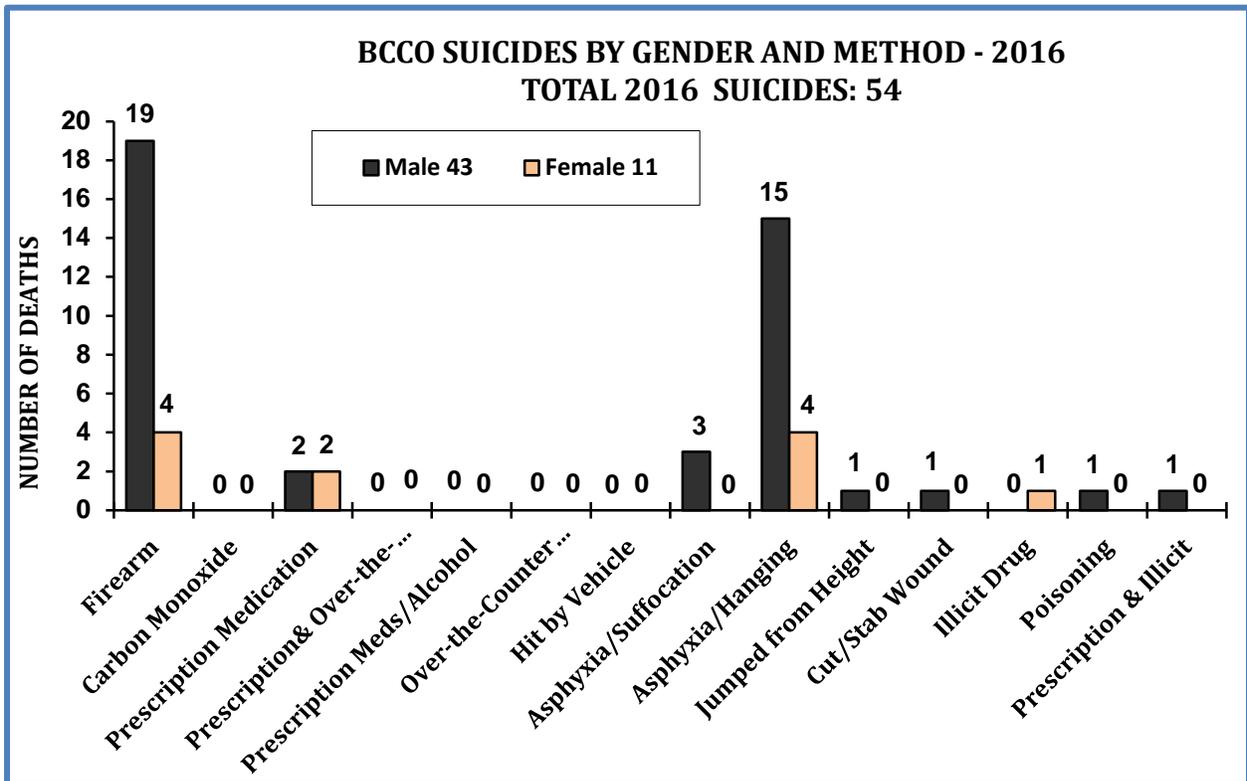
SUICIDES BY AGE AND GENDER



SUICIDES BY METHOD

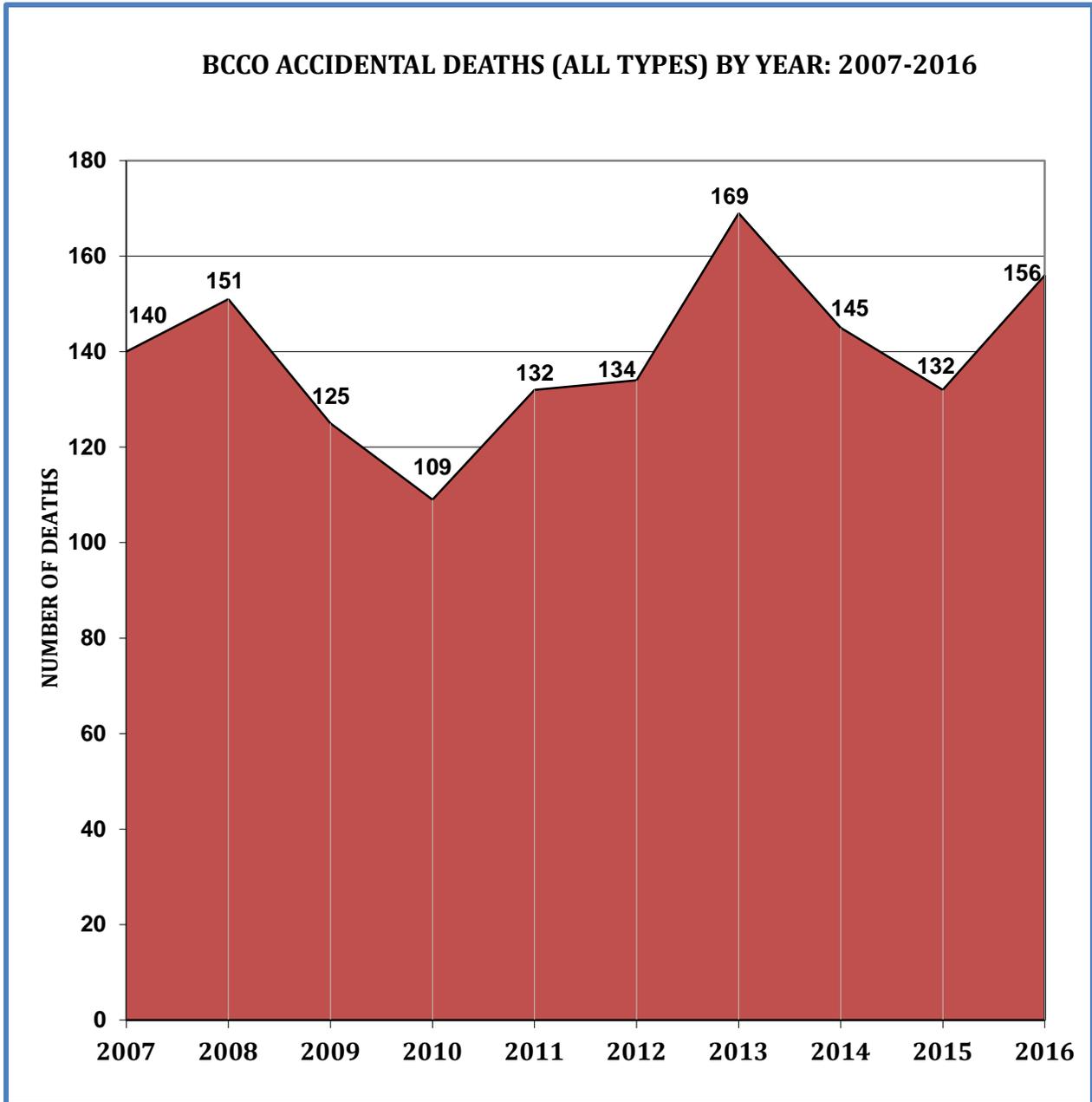


SUICIDES BY GENDER AND METHOD



ACCIDENTAL DEATHS

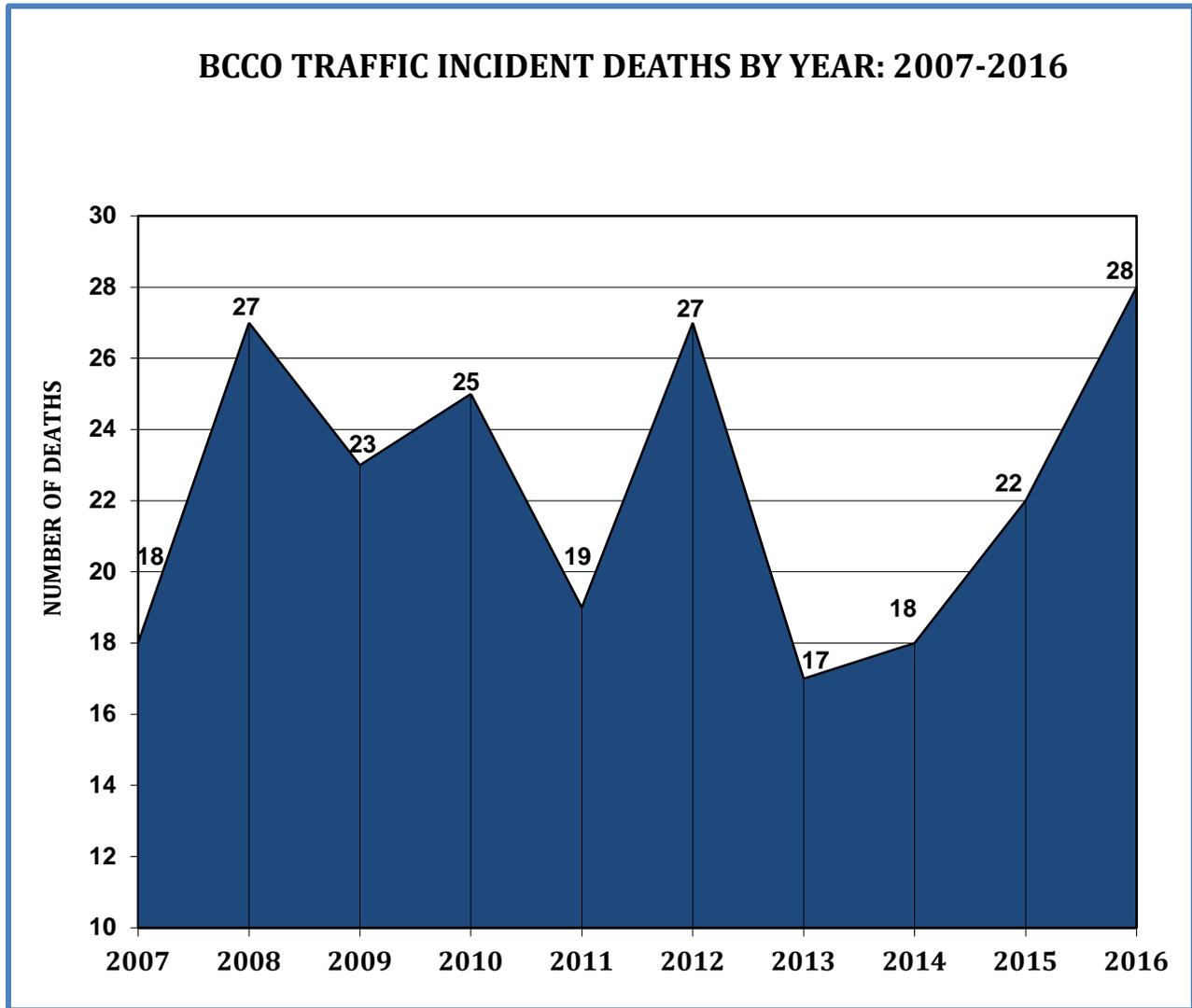
ACCIDENTAL DEATHS BY YEAR, ALL TYPES



Note: In 2016, a total of 193 accidental deaths were reported to the Boulder County Coroner, thirty-seven of those cases were transferred to other coroners.

TRAFFIC INCIDENT DEATHS BY YEAR

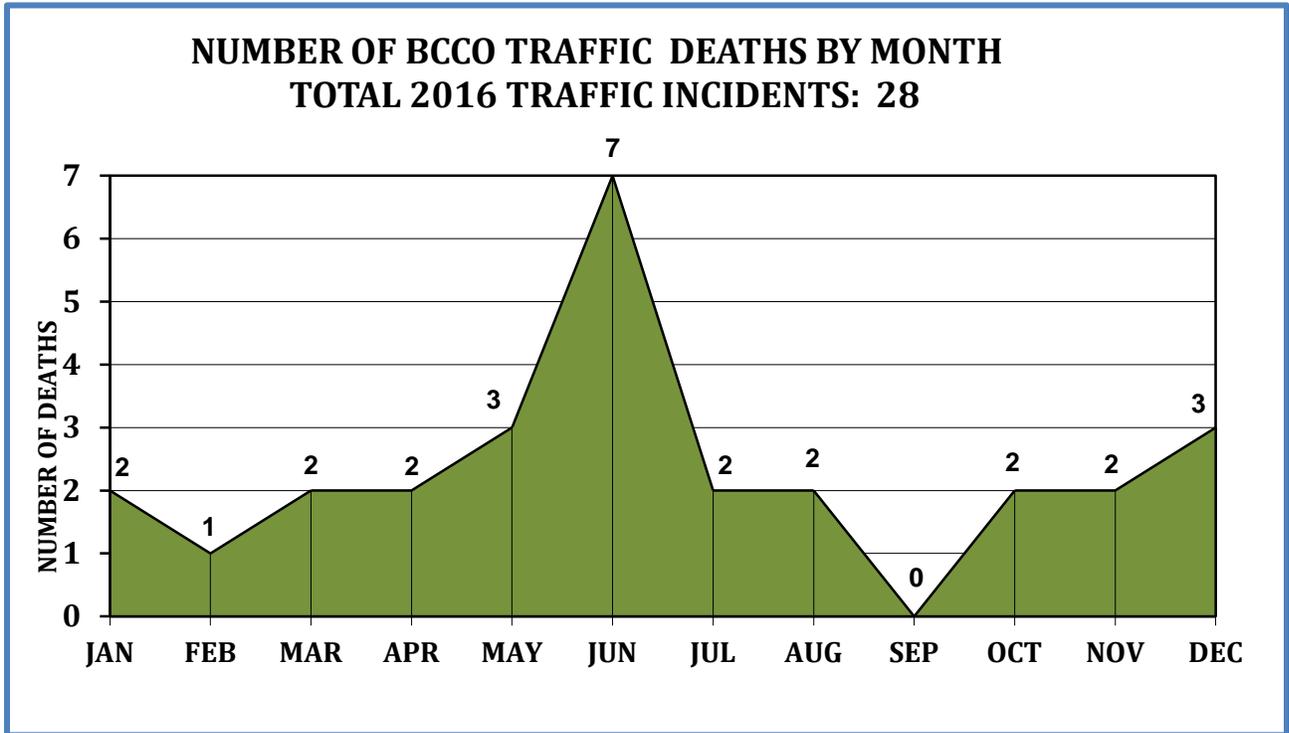
For the purpose of this report, deaths of occupants of a motor vehicle, motorcycle, bicycle-vehicle incidents, or all-terrain vehicle, and vehicle-pedestrian incidents, are considered to be traffic incident deaths.



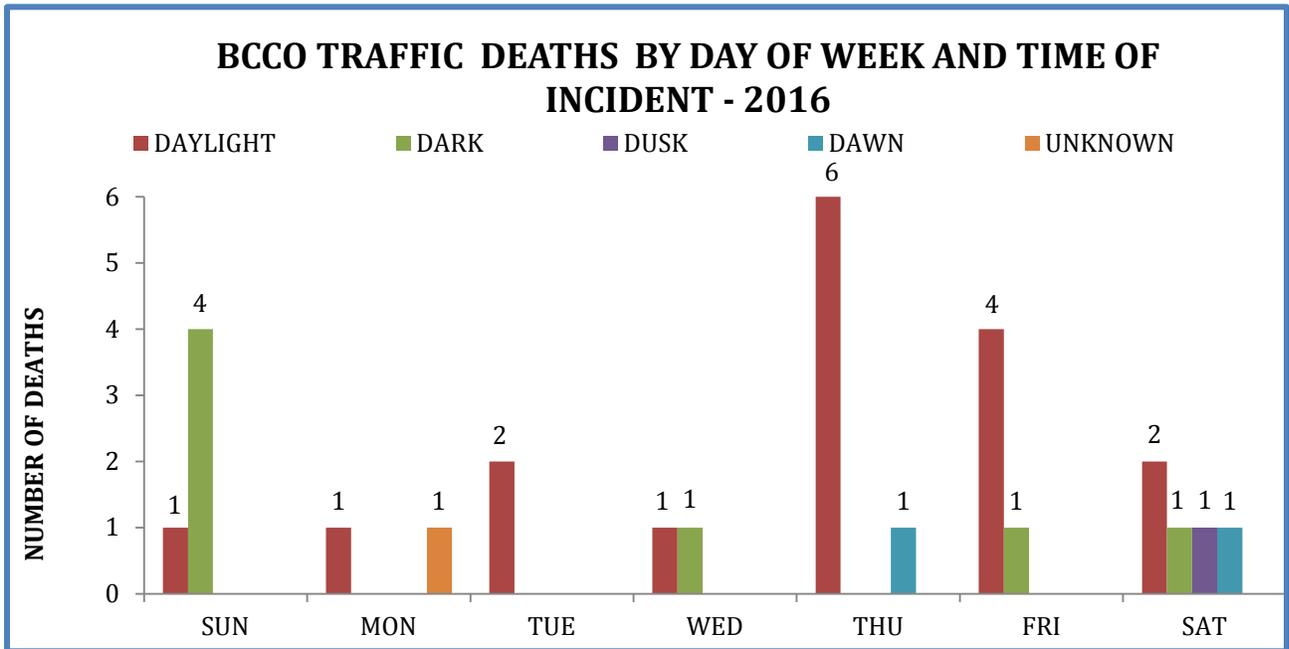
The Boulder County Coroner's Office investigated twenty-eight deaths resulting from traffic incidents in 2016, all of which occurred in Boulder County. Of the twenty-eight cases, eighteen of the victims were male and ten were female. Their ages ranged from eight to eighty-five years of age. Fourteen people died due to injuries or complications from injuries sustained in motor vehicle incidents (including automobiles, pickup trucks, SUVs and vans), five people died in motorcycle incidents, four people died as a pedestrian struck by a motor vehicle, five people that died were bicyclists involved in a collision with another vehicle. Among the fourteen vehicle fatalities, ten were drivers and four were passengers. Five of the drivers were wearing seatbelts. Of the motorcycle deaths, all five were drivers and were wearing a helmet.

Note: There were a total of 40 traffic incident deaths reported to the Boulder County Coroner's Office in 2016. The Boulder County Coroner's Office investigated 28 of these cases; the other twelve cases were transferred to another coroner's jurisdiction.

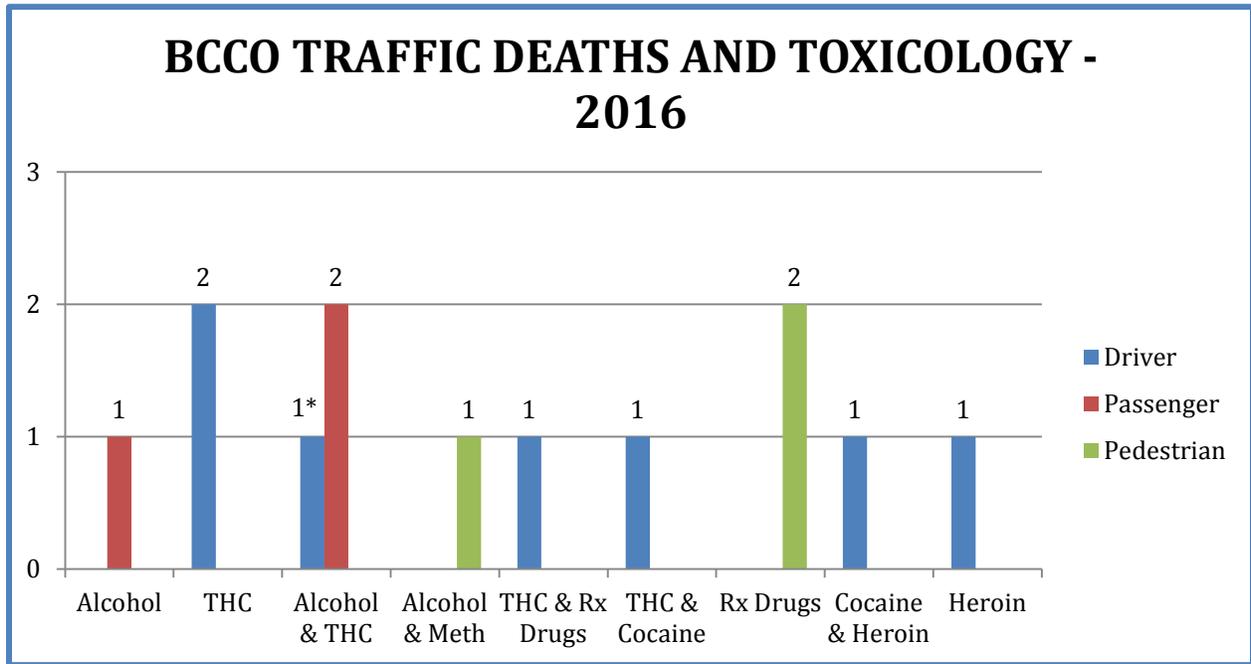
TRAFFIC DEATHS BY MONTH



TRAFFIC DEATHS BY DAY OF WEEK AND TIME OF INCIDENT



Note: The graph displays the information based on the time of incident, not the death.



In Colorado in 2016, a driver is presumed to be Driving While Ability Impaired (DWAI) when a blood alcohol or breath concentration (BAC) is between .050% and .079%. Prior to July 1, 2004, the blood alcohol concentration threshold was .10% to be considered Driving Under the Influence (DUI). As of July 1, 2004, a driver is presumed to be Driving Under the Influence when the BAC is 0.080% or higher. The legal drinking age is 21.

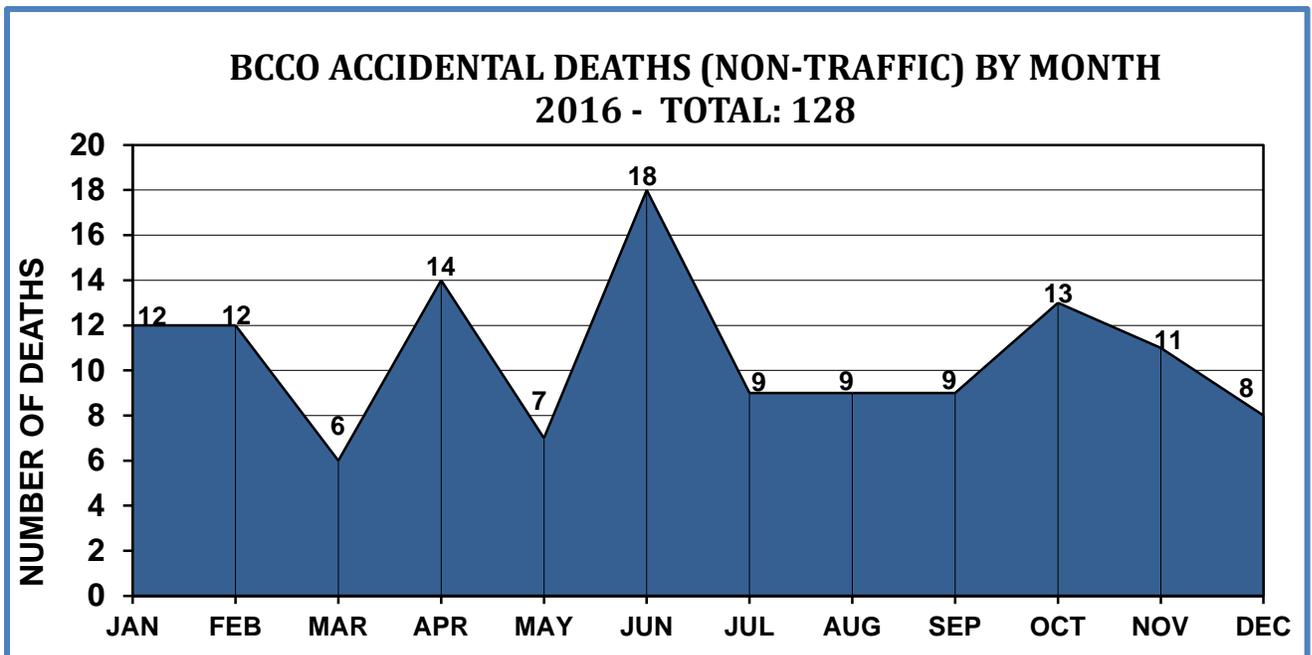
Notes: *The blood alcohol concentration of this driver was 0.15%

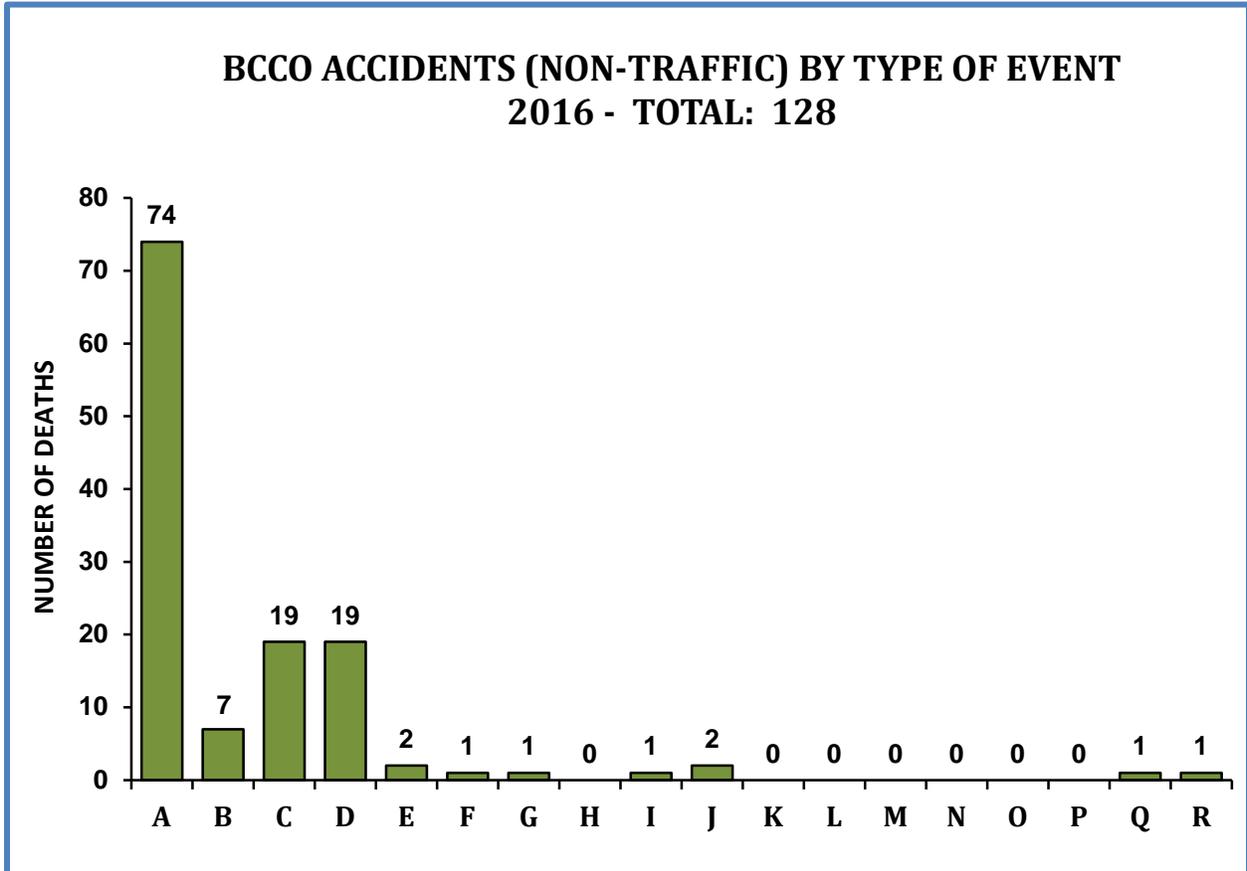
NON-TRAFFIC ACCIDENTAL DEATHS



Note: There were a total of 153 non-traffic accidents reported to the Boulder County Coroner's Office in 2016. The Boulder County Coroner's Office investigated 128 of those cases and transferred jurisdiction of 25 cases to other coroners.

NON-TRAFFIC ACCIDENTS BY MONTH



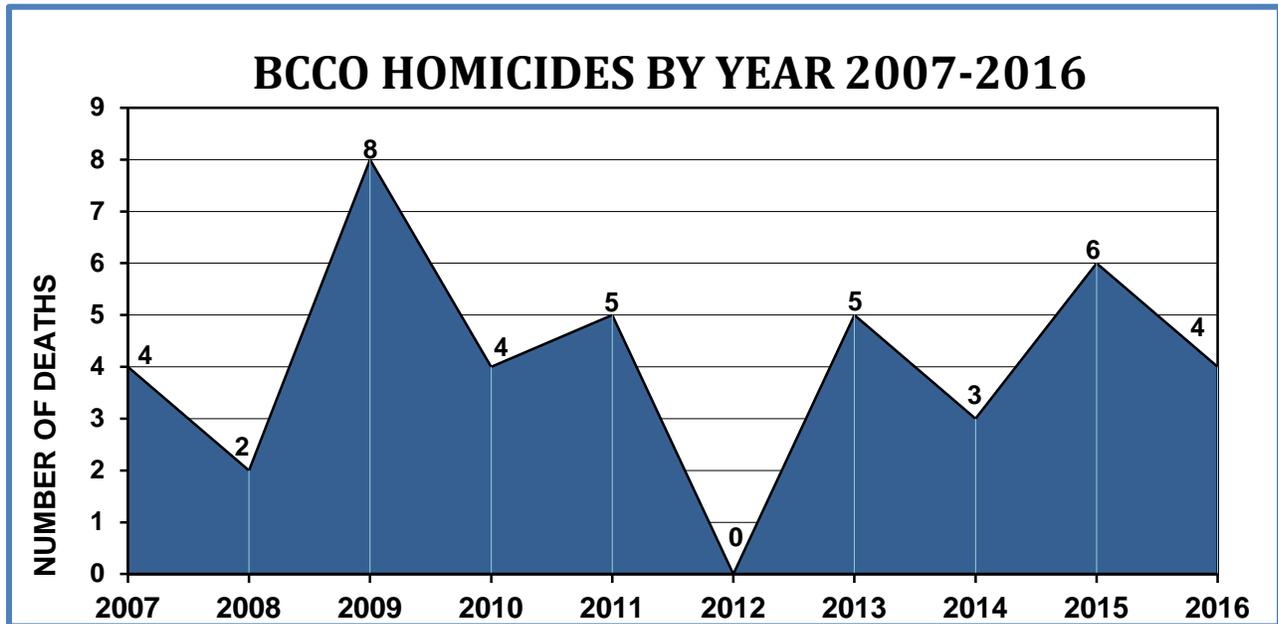


LEGEND:

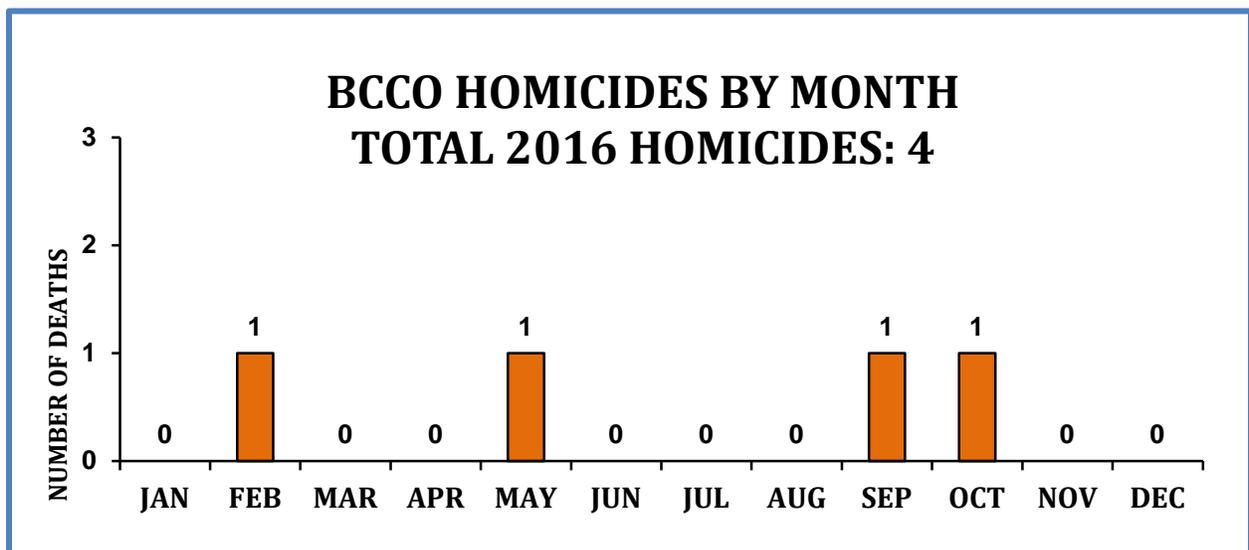
A - Fall (Non-Recreational)
B - Fall/Recreational
C - Drug Overdose (All Types)
D - Drug Overdose in combination with Alcohol
E - Alcohol
F - Positional Asphyxia
G - Drowning
H - Electrocution
I - Fall from Height
J - Aspirated on Food
K - Medical Misadventure
L - Airplane Crash
M - Environmental
N - Thermal Injuries
O - Blunt Force Injuries
P - Injury due to Animal
Q - Industrial
R - Unknown

HOMICIDES

HOMICIDES BY YEAR



HOMICIDES BY MONTH

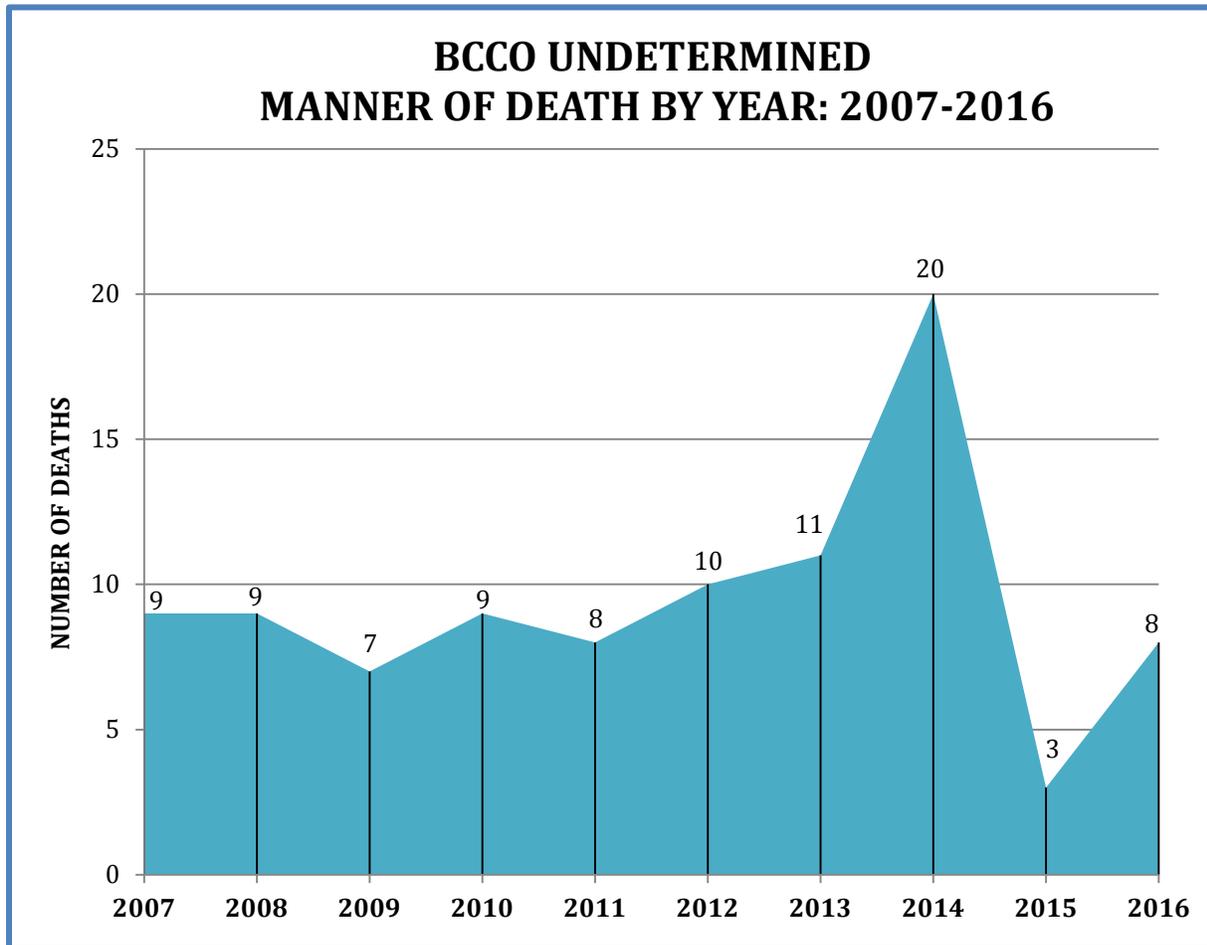


Note: In 2016, all four of the victims of homicide were male. All four homicide victims died of firearm wounds (3 were officer involved shootings). There were a total of six homicides reported to the Boulder County Coroner's Office in 2016. The Boulder County Coroner's Office investigated four of these cases; the other two cases were transferred to another coroner's jurisdiction.

DEATHS OF UNDETERMINED MANNER

Occasionally, medical examiners and coroners encounter cases that, despite a complete autopsy, comprehensive toxicology tests, and a thorough scene investigation, no cause of death can be determined. Medical examiners and coroners also encounter cases where the cause of death is quite apparent; but the evidence supporting the manner of death is equivocal or insufficient to make a determination. The determination of manner of death is an opinion based on the “preponderance of evidence”. An example might be a case in which the cause of death is a drug overdose, but, from the information available, it is not certain whether the manner of death is accident or suicide. Therefore, the manner of death may be certified as undetermined.

UNDETERMINED MANNER BY YEAR

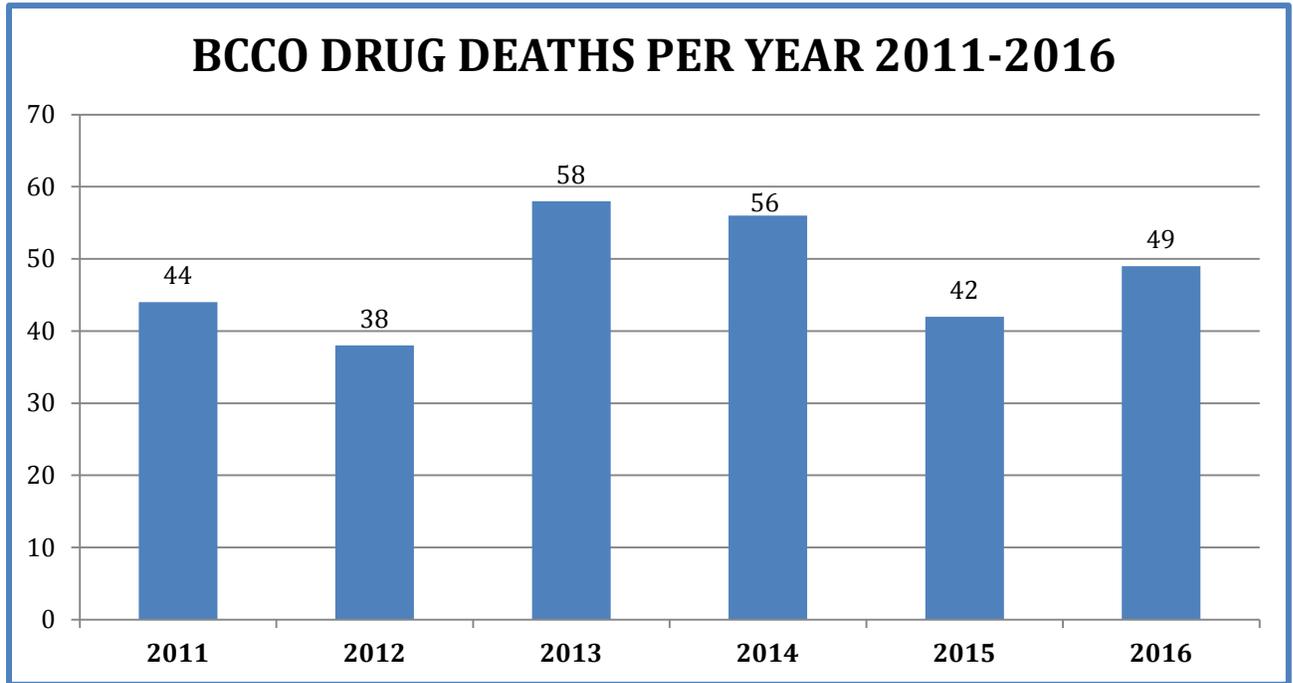


Note: There were a total of 9 cases reported to the Boulder County Coroner’s Office in 2016 that were ruled as an undetermined manner of death; one of these cases was transferred to another coroner’s office which made the undetermined ruling for that case. The Boulder County Coroner’s Office investigated the other 8 cases.

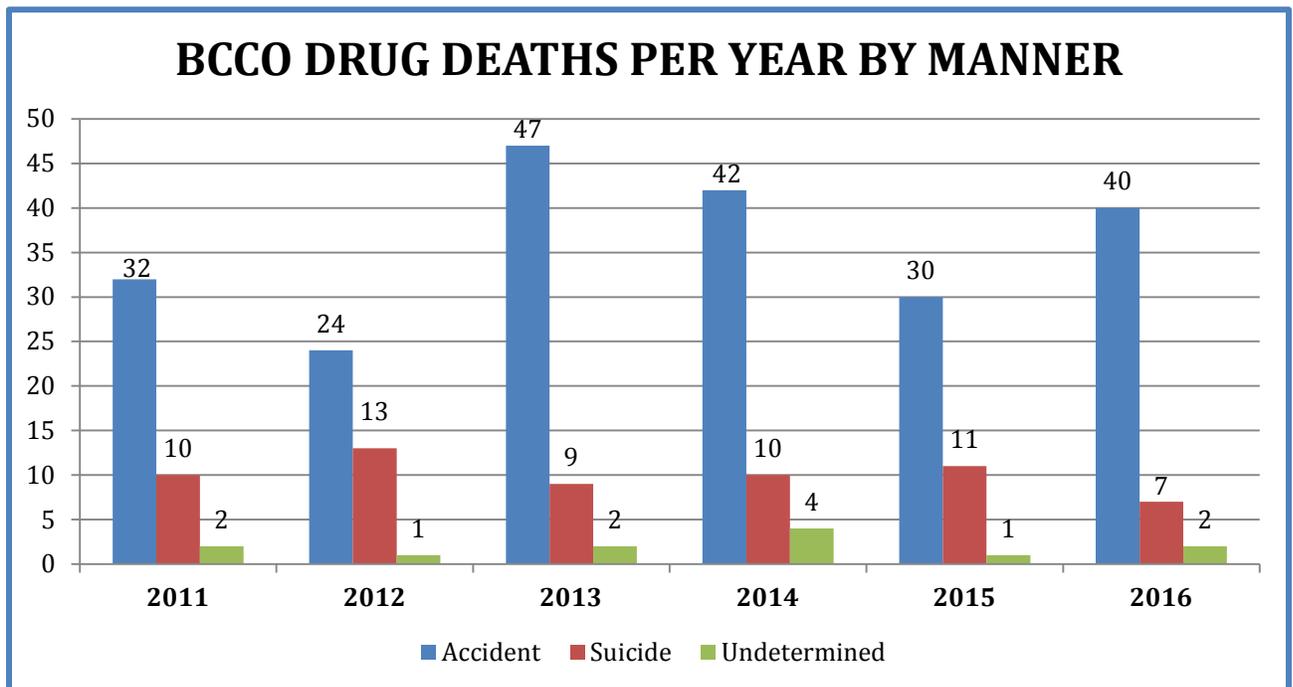
While the office ruled undetermined for the manner of death in these 8 cases in 2016, 4 of the cases listed an undetermined cause of death as well; one presented multiple possible causes of deaths of which not one was able to be ruled out, in one case a specific cause of death could not be interpreted, one case although undetermined was associated with unsafe sleep environment of a 9 month old and the fourth case was skeletal remains where not enough evidence was present for a more accurate cause of death.

DRUG DEATHS

DRUG DEATHS BY YEAR 2011-2016

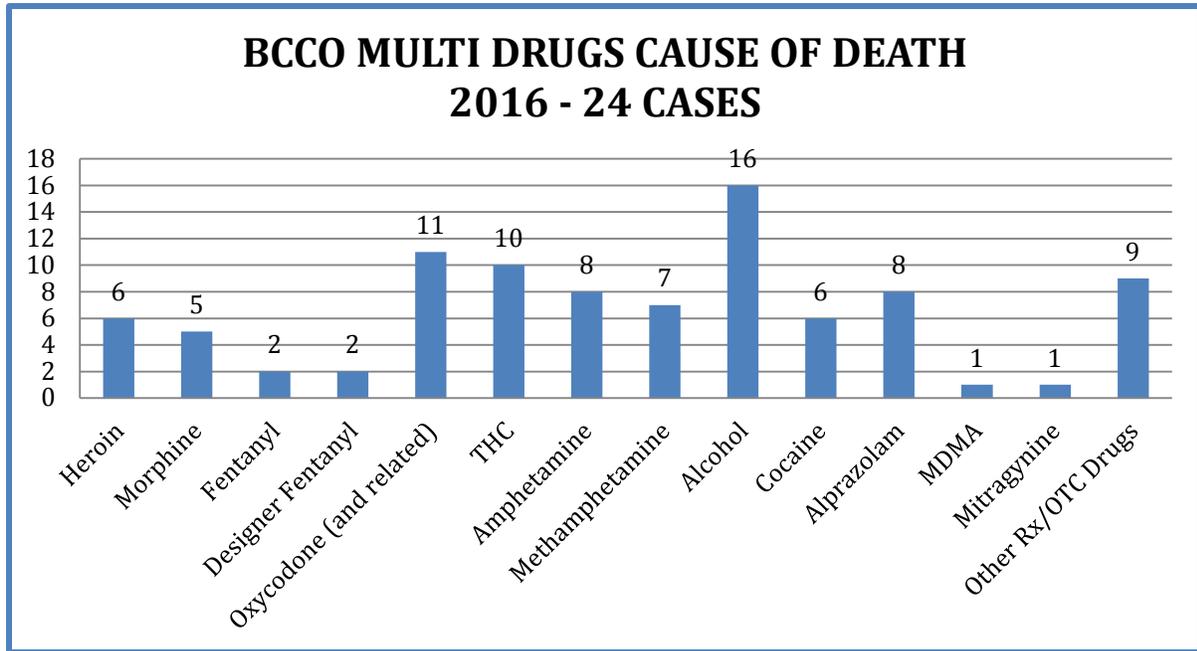


DRUG DEATHS BY MANNER 2011-2016



DRUGS OF ABUSE: MULTI DRUG DEATHS

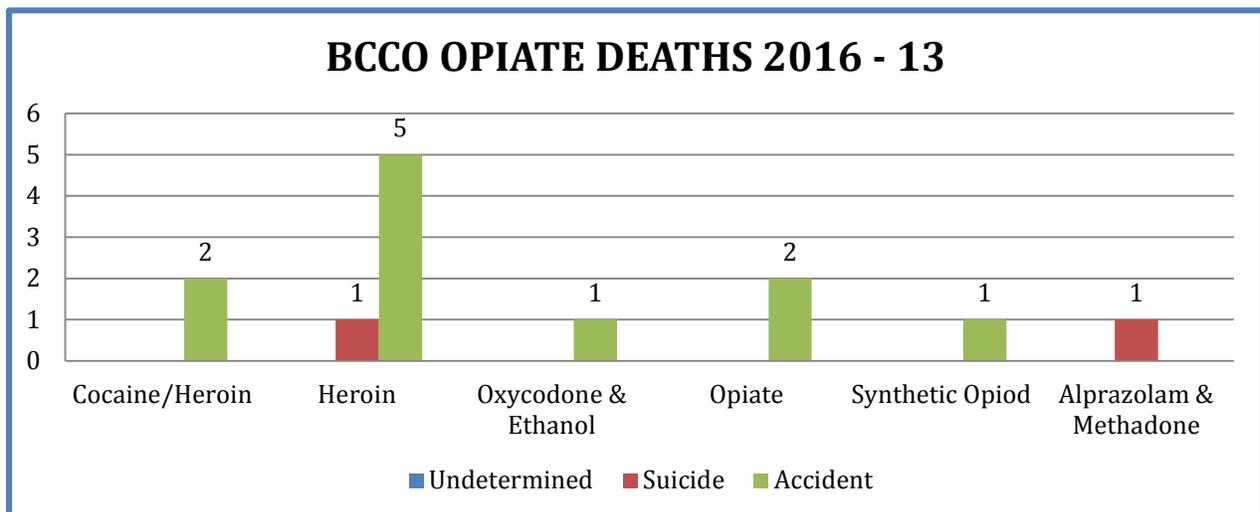
Many drug abuse deaths are listed with multi drug intoxication for the cause of death; this is due to the complications that come from interpreting the use of more than one drug at a time, their individual levels and the combined effects of the varying levels. The chart below indicates the drugs that were found in the 24 multi drug deaths the county had in 2016.



Note: There were also three instances where toxicology tested positive for Naloxone (none of which also tested positive for Heroin).

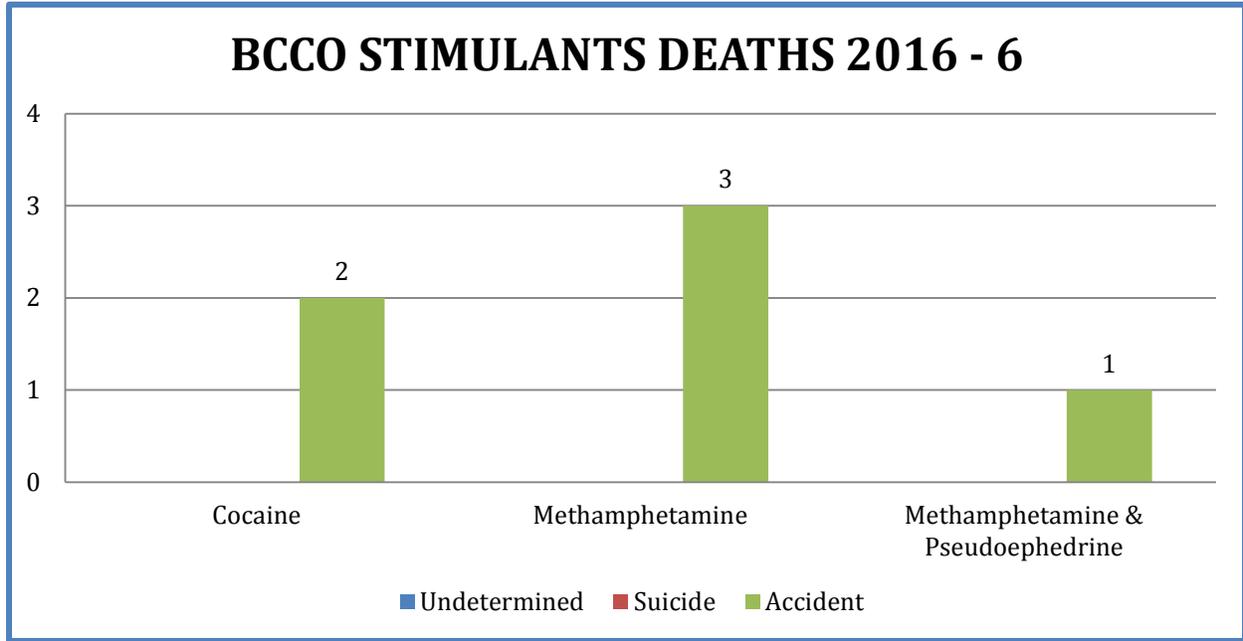
DRUGS OF ABUSE BY OPIATES

Opioid is used to designate all substances, both natural and synthetic, that bind to opioid receptors in the brain. The psychoactive compounds found in the opium plant include morphine and codeine. Heroin is one of several semi-synthetic opioids derived from the morphine. Examples of opioids include Heroin, Morphine, Mepidine, Codeine, Tramadol, Oxycodone, Hydrocodone, Hydromorphone, and Fentanyl.



DRUGS OF ABUSE BY STIMULANTS

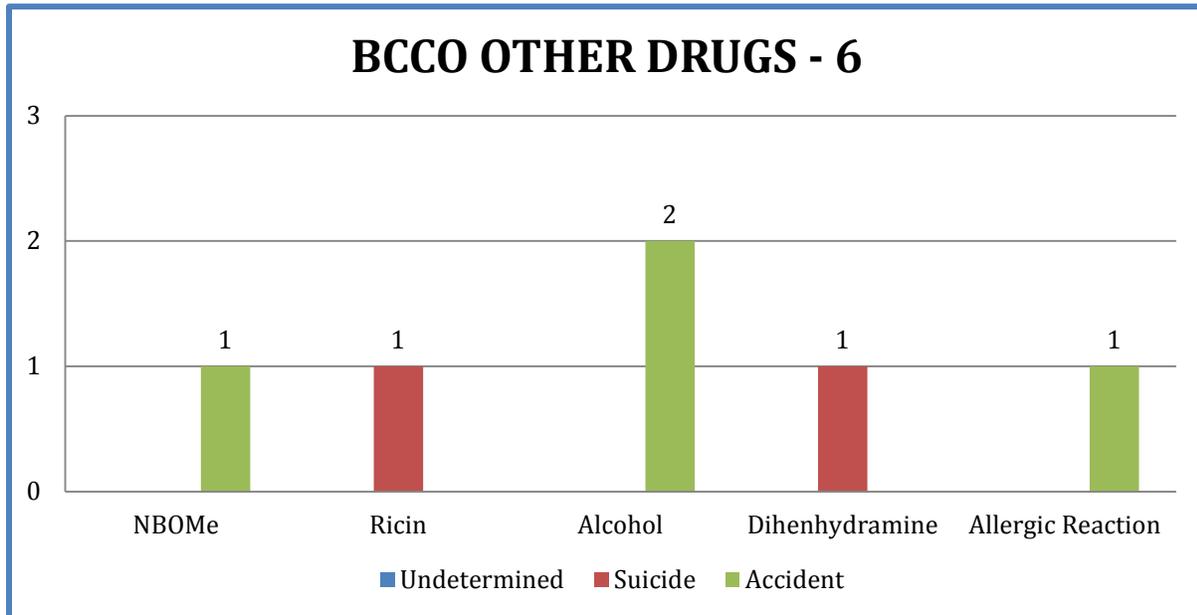
Stimulants (also known as psychostimulants) is a broad term that covers many drugs including those that increase activity of the body, drugs that are pleasurable and invigorating, and drugs that have sympathomimetic effects. Due to their characteristic "up" feeling, stimulants are also occasionally referred to as "uppers". Stimulants are widely used throughout the world as prescription medicines as well as without a prescription (either legally or illicitly) as performance-enhancing or recreational drugs. Examples of stimulants include Cocaine, Amphetamine, Methylene-3,4 dioxymethamphetamine (MDMA), and Methamphetamine.



Note: See above chart for Cocaine/Heroin cases.

DRUGS OF ABUSE: OTHER CATEGORIES

These drugs represent a wide variety of substances abused in Boulder County. Some can be purchased at liquor stores, some require prescriptions from a medical doctor and some are manufactured or purchased elsewhere.



Alcohol is the most commonly abused substance. Examples of alcohols are the following: alcoholic beverages, antifreeze, medical (antiseptics and hand sanitizers), alcohol fuels, preservatives, and solvents. Alcohol beverages are common in most homicides, suicides, many accidents, and can exacerbate normal medical conditions. The most common alcohol causing death was ethanol.

Ricin is a highly toxic substance derived from the castor oil plant. A few grains of ricin can kill a human (1 milligram per kilogram). If someone makes this substance it is a federal offence. This was used in a suicide case.

Diphenhydramine is an over the counter medication with an antihistamine mainly used to treat allergies. In high levels such as an accidental overdose or in a suicide attempt, this medication is lethal.

Hallucinogens are psychoactive substances. These chemicals cause hallucinations, perceptual anomalies and can alter thoughts and emotions. NBOMe was seen in one death this year.

Stimulants - include a host of medications and chemicals which increase the activity of the body. This group is categorized as: prescribed, performance-enhancing, and recreation. The most commonly prescribed stimulants are Focalin, Adderall, and Ritalin. Ephedrine, methylphenidate and amphetamine are common performance drugs. In Boulder County we have found many deaths when decedents mix stimulants with other drugs. Common illegal stimulants found in our toxicology are the following: Methamphetamine, cocaine, MDMA or ecstasy, codeine, and bath salts.

DROWNINGS

Drowning as a cause of death is a diagnosis of exclusion, diagnosis of exclusion is described as a diagnosis of a medical condition that is reached by eliminating all other possible diagnoses. If an individual is found in water and all other possible causes of death have been excluded, one *may* be able to conclude the cause of death is drowning. Presumed drowning cases require complete autopsies, in order to exclude all other causes of death.

In 2016, there was one drowning case, it was ruled an Accident for the manner of death. The drowning occurred in a residential bathtub in combination with ethanol intoxication.

CHILD DEATHS

In 2013 Senate Bill 13-255 passed mandating that starting January 1st, 2015 each county form a local Child Fatality Review and Prevention Team (CFRPT). Moving the reviews to local teams from the state team would create a broader scope, with the state mandating which cases would be reviewed (birth – 17) that involve unintentional injury, violence, motor vehicle incident, child abuse/neglect, sudden unexpected infant death, suicide or undetermined cases. The teams provide the state with individual case findings to develop a community approach to issues surrounding child deaths. They review manner and cause of death and evaluate the means by which the fatality might have been prevented. The teams report case findings to public/private agencies that have responsibilities for children and make prevention recommendations to reduce the number of child fatalities.

Each team must consist of the following:

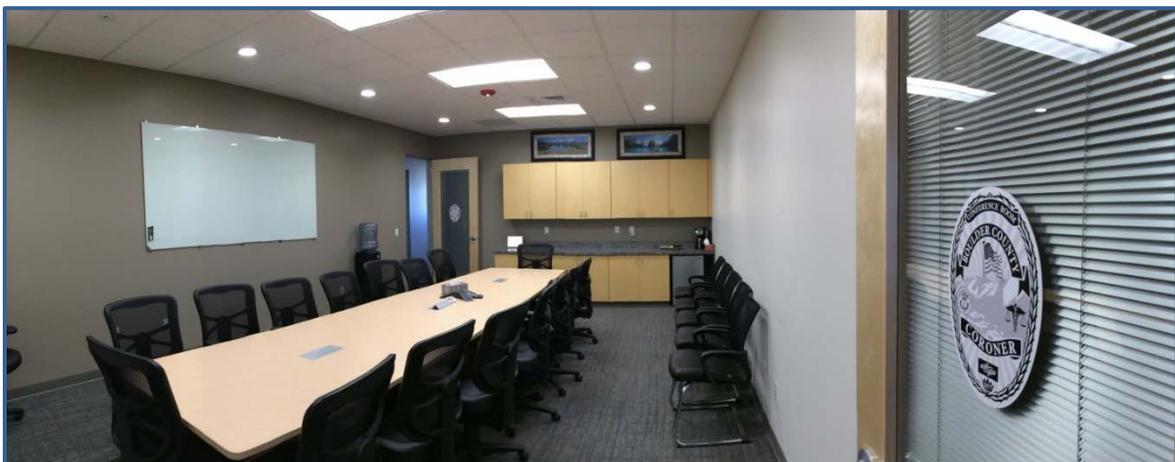
- County department(s) of public health
- Local law enforcement agencies
- District attorney's office
- School districts
- County department(s) of human services
- Coroner's office
- County attorney's office

Additional agencies that may be included are: Hospitals or other emergency medical services, Social services, Mental health professionals, Pediatricians, Child advocacy centers, and Victim advocates.

In 2014, the office worked closely with the Public Health Department to bring the agencies together so that the team could start reviewing the 2014 child deaths starting in January of 2015. Public Health asked the Coroner's Office to become the coordinator for the team; currently Boulder County is the only county in Colorado to participate in this way as the coordinator. In 2016, the team reviewed two 2015 child death cases.

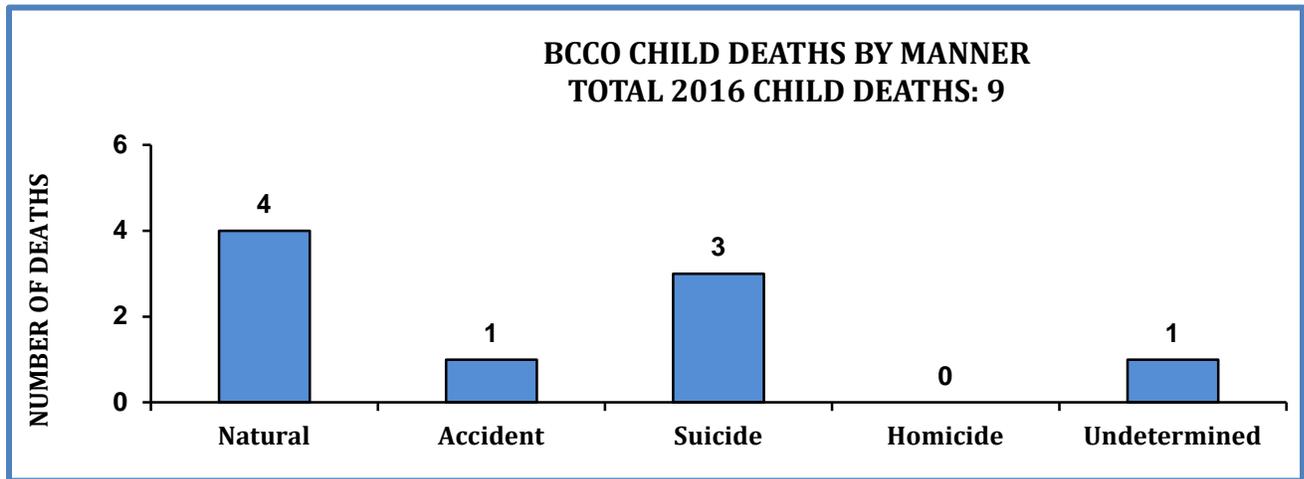
In Boulder County, a total of nine child deaths (<18 years of age) were investigated by the Coroner's Office in 2016. Three additional child death cases were transferred to other coroners. Any of the nine 2016 child death cases selected for review by the state will be reviewed in 2017 by the Boulder County Child Fatality Review and Prevention Team.

Note: Statistical information may not coincide with information available from the Colorado Health Department. The State Health Department tracks death statistics by the county of residence, not by the county in which the injury or death occurred.



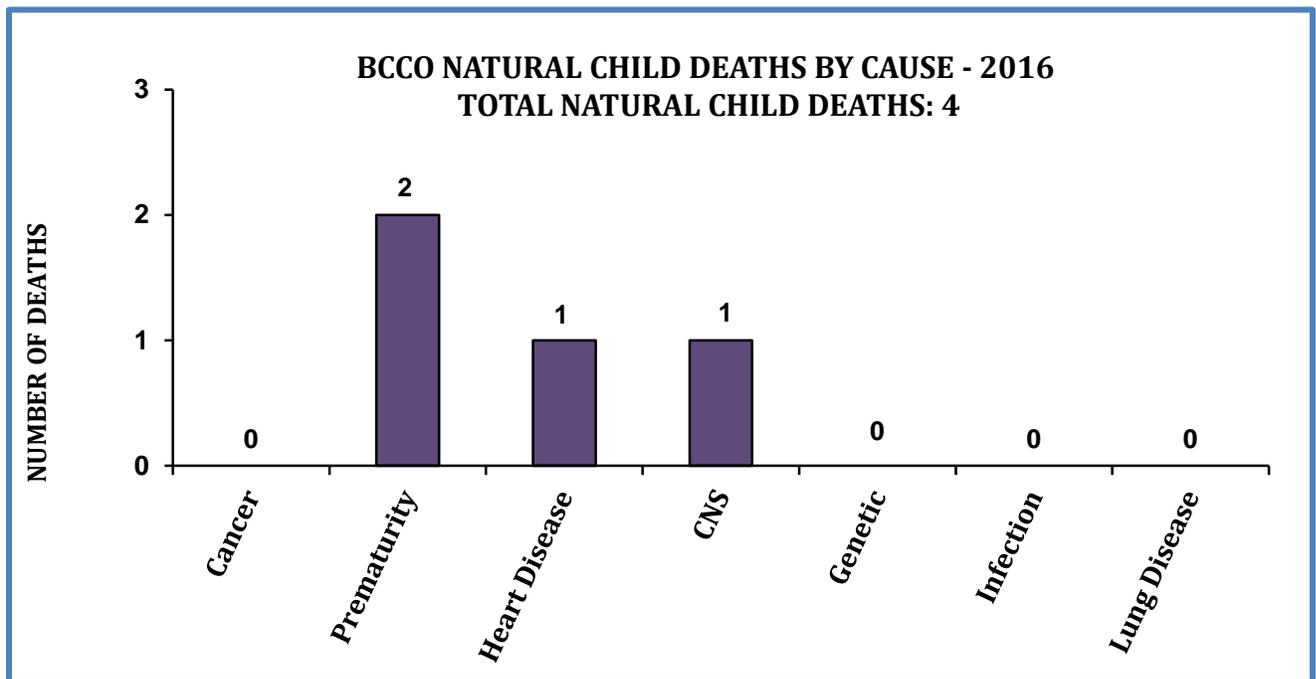
BCCO Conference room where CFRPT meetings are held.

CHILD DEATHS BY MANNER OF DEATH



- **Accident:** The one accidental death was due to trauma resulting from a helmeted bicyclist struck by a vehicle (age 8).
- **Suicide:** All three suicide deaths were a result of hanging (ages 14, 15 and 16).
- **Undetermined:** The undetermined case was ruled undetermined for both manner and cause of death, however unsafe sleep environment cannot be ruled out (age 9 months).

CHILD DEATHS BY CAUSE OF NATURAL DEATHS



SUDDEN UNEXPLAINED INFANT DEATH (SUID) AND SUDDEN INFANT DEATH SYNDROME (SIDS)

The Center for Disease Control and Prevention (CDC) defines sudden unexplained infant death (SUID) as deaths in infants less than 1 year of age that occur suddenly and unexpectedly, and whose cause of death are not immediately obvious prior to investigation. The CDC defines sudden infant death syndrome (SIDS) as the sudden death of an infant less than 1 year of age whose cause of death cannot be explained after a thorough investigation is conducted, including a complete autopsy, examination of the death scene, and review of the clinical history. While the CDC has separate definitions for these two terms, the classification of the manner of death and written description of the cause of death in these types of cases do vary throughout the nation.

SIDS is a diagnosis of exclusion, diagnosis of exclusion is described as a diagnosis of a medical condition that is reached by eliminating all other diagnoses. Therefore, to determine the cause of death is SIDS, a coroner or medical examiner must conduct a thorough case investigation which includes examination of the death scene, including the sleeping environment and bedding, a review of the medical history, perform a complete autopsy and further testing. These cases are a collaborative effort with law enforcement and at times the District Attorney's Office. Once a thorough investigation is conducted and no other possible cause of death is determined only then *may* a determination of SIDS be made. Many times, when a thorough case investigation is conducted, an explanation is found such as natural disease or disorder, positional asphyxia, suffocation, hyper or hypothermia, neglect, homicide, etc. Other times, there may be signs of potential issues but no clear and obvious reason for death, most often the finding of an unsafe sleep environment is found. At times, there may be no indication of potential issues and the cause of death is truly unknown.

The American Academy of Pediatrics (AAP) started its "Back to Sleep" campaign in 1992 informing the public of its recommendation that infants be placed for sleep in a non-prone position on their back, in an effort to prevent SIDS deaths. The CDC makes ongoing efforts to prevent SUID and SIDS deaths and on October 17, 2011 they published a new statement on SIDS, which stated that there has been a major decrease in the incidence of SIDS since 1992, however, the decline has plateaued in recent years. In the 2011 statement, AAP reported that since their previous statement on SIDS in 2005 they have seen an increase in SUID deaths occurring during sleep. Therefore, the AAP expanded its recommendations to focus on safe sleep environments that can reduce the risk of all sleep-related infant deaths including SIDS. Their recommendations include: supine positioning, use of a firm sleep surface, breastfeeding, room-sharing without bed-sharing, routine immunization, consideration of a pacifier, and avoidance of soft bedding, overheating, and exposure to tobacco smoke, alcohol, and illicit drugs.³

The screenshot shows the AAP Policy Statement page. At the top, it features the AAP logo and the tagline "ORGANIZATION TO THE HEALTH OF ALL CHILDREN". Below this, the title "POLICY STATEMENT" is followed by the main title "SIDS and Other Sleep-Related Infant Deaths: Expansion of Recommendations for a Safe Infant Sleeping Environment". A "FREE" badge is visible next to the "abstract" section. The abstract text discusses the AAP's 1992 recommendation and its expansion in 2011. To the right, there is a "TASK FORCE ON SUDDEN INFANT DEATH SYNDROME" section with "KEY WORDS" and "ABBREVIATIONS". At the bottom, there is a copyright notice for 2011 by the American Academy of Pediatrics and a download timestamp: "Downloaded from by guest on April 5, 2016".

Ongoing efforts to encourage safe sleep environments are also being made by the CDC and the National Institute of Child Health and Human Development (NICHD). The NICHD among other literature has published brochures advertising safe sleep. Many of these resources can be found on the CDC's website www.cdc.gov. An example is provided below.

What does a safe sleep environment look like?

Reduce the Risk of Sudden Infant Death Syndrome (SIDS) and Other Sleep-Related Causes of Infant Death




- Use a firm sleep surface, such as a mattress in a safety-approved crib, covered by a fitted sheet.
- Place your baby on his or her back to sleep.
- Make sure nothing covers the baby's face.
- Always place your baby on his or her back to sleep for naps and at night.
- Remove all pillows, blankets, sheepskins, or soft bedding from your baby's sleep area.
- Do not use a baby monitor in your baby's sleep area.
- Keep soft objects, toys, and loose bedding out of your baby's sleep area.
- Do not smoke or let anyone smoke around your baby.
- Do not dress your baby in tight clothing, such as a one-piece sleeper, and do not use a blanket.
- Baby should not sleep in a car seat, stroller, or on a chair alone, with you, or with anyone else.

For more information on crib safety guidelines, contact the Consumer Product Safety Commission at 1-800-633-2772 or <http://www.cpsc.gov>.

Safe Sleep For Your Baby



- Always place your baby on his or her back to sleep, for naps and at night, to reduce the risk of SIDS.
- Use a firm sleep surface, covered by a fitted sheet, to reduce the risk of SIDS and other sleep-related causes of infant death.
- Your baby should not sleep in an adult bed, on a couch, or on a chair alone, with you, or with anyone else.
- Keep soft objects, toys, and loose bedding out of your baby's sleep area to reduce the risk of SIDS and other sleep-related causes of infant death.
- To reduce the risk of SIDS, women should:
 - Get regular health care during pregnancy, and
 - Not smoke, drink alcohol, or use illegal drugs during pregnancy or after the baby is born.
- To reduce the risk of SIDS, do not smoke during pregnancy, and do not smoke or allow smoking around your baby.
- Breastfeed your baby to reduce the risk of SIDS.
- Give your baby a dry pacifier that is not attached to a string for naps and at night to reduce the risk of SIDS.
- Do not let your baby get too hot during sleep.
- Follow health care provider guidance on your baby's vaccines and regular health checkups.
- Avoid products that claim to reduce the risk of SIDS and other sleep-related causes of infant death.
- Do not use home heart or breathing monitors to reduce the risk of SIDS.
- Give your baby plenty of Tummy Time when he or she is awake and when someone is watching.



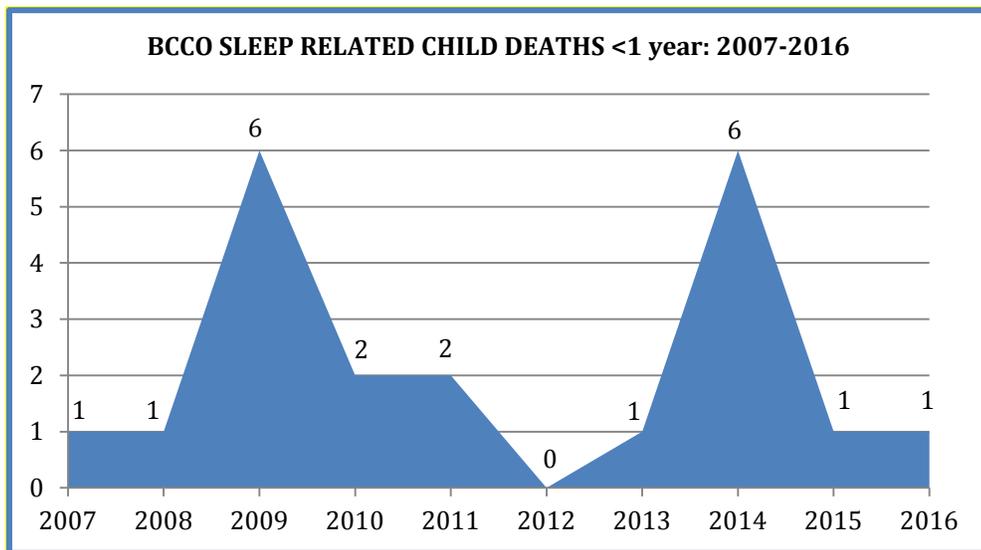
Remember Tummy Time!
Place babies on their stomachs when they are awake and when someone is watching. Tummy Time helps your baby's head, neck, and shoulder muscles get stronger and helps to prevent flat spots on the head.

For more information about SIDS and the safe to sleep campaign:
Mail: 31 Center Drive, 312A32, Bethesda, MD 20892-9425
Phone: 1-800-565-CRIB (2742)
Fax: 1-866-760-5947
Website: <http://www.nichd.nih.gov/sids>
NIH Pub. No. 12-5759 OCF5 Pub 5136
September 2012



10 YEAR CHILD DEATH STUDY

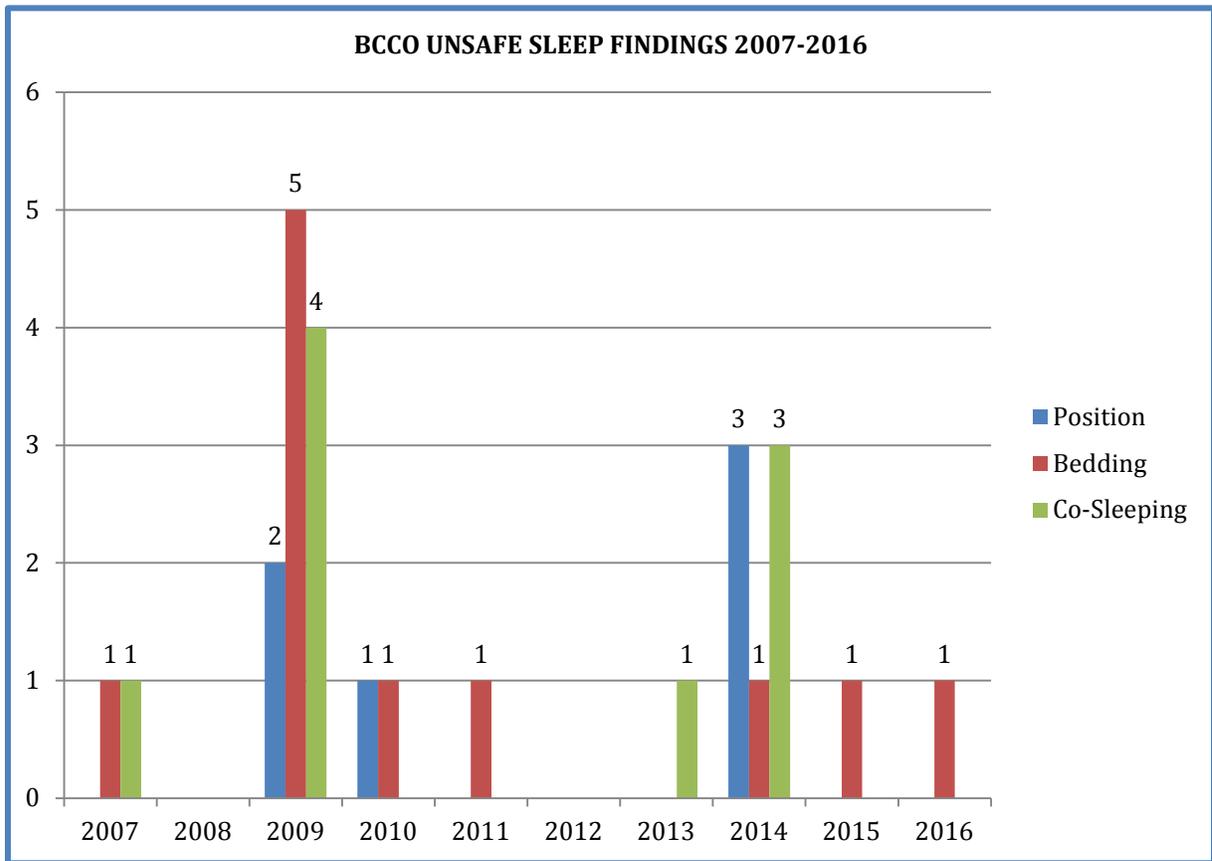
The cases that were included in this study were children under the age of 1 year that died in their sleep. There were a total of 21 cases included in this study.



UNSAFE SLEEP FINDINGS IN 10 YEAR CHILD DEATH STUDY

There were four cases where the unsafe sleep findings were categorized as none, unknown, not ideal, or undetermined; however, the other 17 cases all had at least one finding of an unsafe sleep environment, many of them had more than one finding. The graph below shows the findings, by occurrence, in three types of unsafe sleep categories: position, bedding, and co-sleeping. The non-recommended position the infant was placed in most often was on the stomach.

Of the 21 cases, the investigating law enforcement jurisdictions were as follows: Boulder County Sheriff's Office – 1, Boulder PD – 3, Lafayette PD – 3, Longmont – 10, and Louisville – 4. There were 9 females and 12 males. The ages were as follows: the youngest case was less than 1 month at 13 days, there were 8 cases from 1-3 months, 8 cases from 3-6 months and 4 cases from 6-9 months (the oldest was 9 months). The ethnicities of the children were as follows: Caucasian – 17, African American – 2, Hispanic – 1 and Indian – 1.



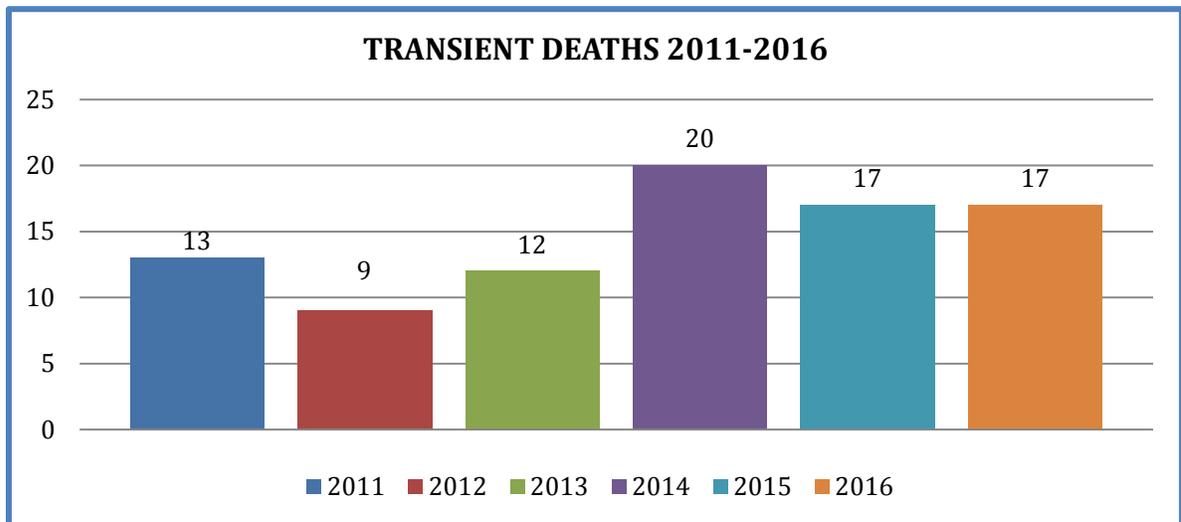
Based on the cases included in this 10 year child death study, Boulder County is a prime location for additional support and promotion of safe sleep environments for infants. As these cases continue to be reviewed by the local Boulder County Child Fatality and Prevention Team, more recommendations will be made to the state on preventing these types of child fatalities.

In the 9 cases where co-sleeping was a finding, the toxicology levels are unknown of the individual whom the infant was co-sleeping with; however, in 4 of the 9 cases there was suspicion or self-reporting of use of alcohol, drugs, prescription drugs or a combination thereof.

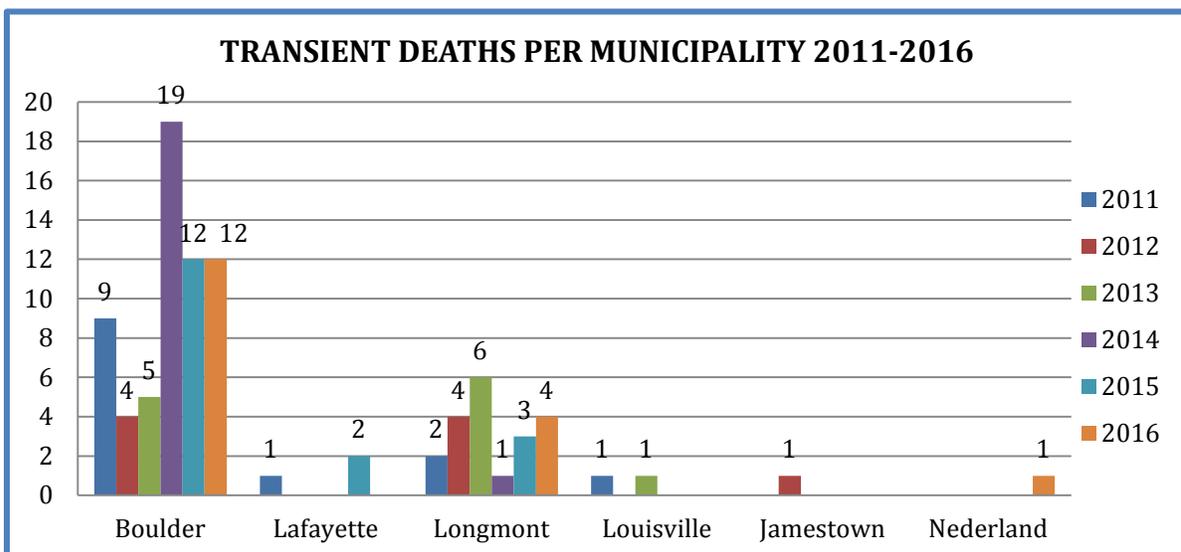
TRANSIENT/HOMELESS DEATHS

The Boulder County Coroner's Office started to notice an increase in the amount of transient/homeless deaths in the city of Boulder mid-year 2014. Due to the increase, a mid-year detailed report was created to offer information to city and county leaders as well as the public on these types of deaths. While the office did its' best to track these kinds of deaths to ensure the best possible information, it should be noted that not all deaths that occur in Boulder County are reported to the Coroner's Office. An example of this would be if a person dies at a nursing home or a person who dies more than 24 hours after being admitted to a hospital, the death may not be reported if the person dies of natural causes. Also, not all transients that die are reported as having lived on the streets at the time of their death. For example, a nurse reporting the death of a person who dies under hospice care or in a care facility may not necessarily know that the person was homeless at a point prior to their admission. Therefore, the total number of transient deaths on file at the coroner's office may vary from numbers on file with other organizations. That being said, the following covers a few statistics on what information is available.

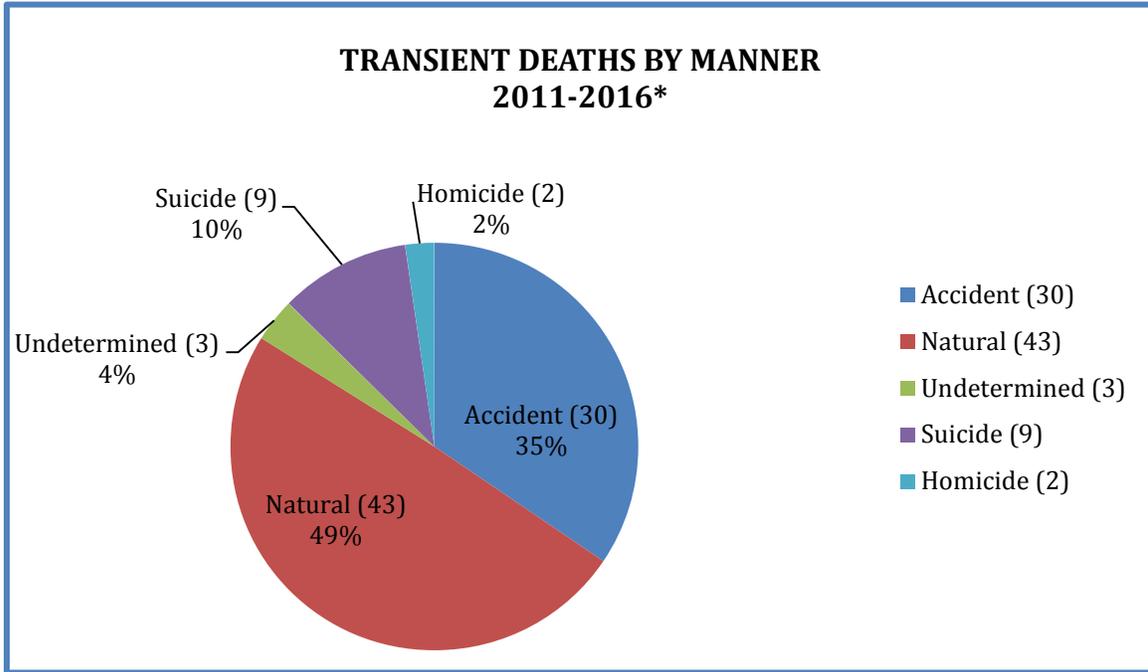
TRANSIENT DEATHS BY YEAR



TRANSIENT DEATHS PER MUNICIPALITY



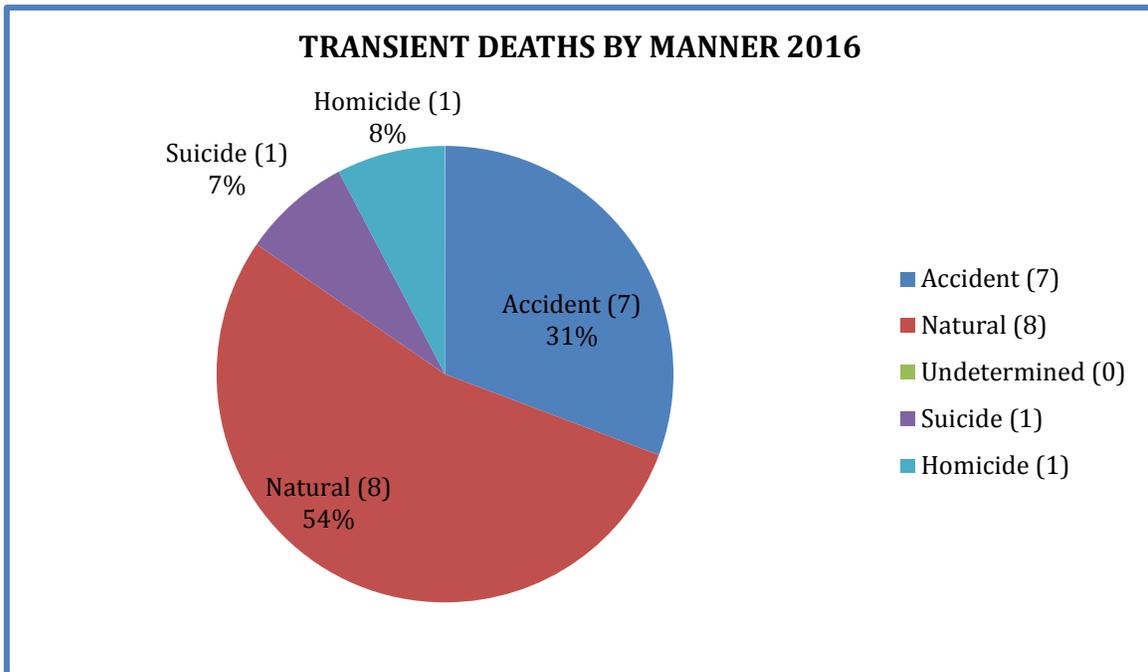
TRANSIENT DEATHS BY MANNER OF DEATH 2011-2016



Note: Of the transient/homeless deaths tracked from 2011 to 2016, 74 were male and 13 were female, one case was a fetal demise of a transient female. Ages of the decedents over the years ranged from 22 to 86.

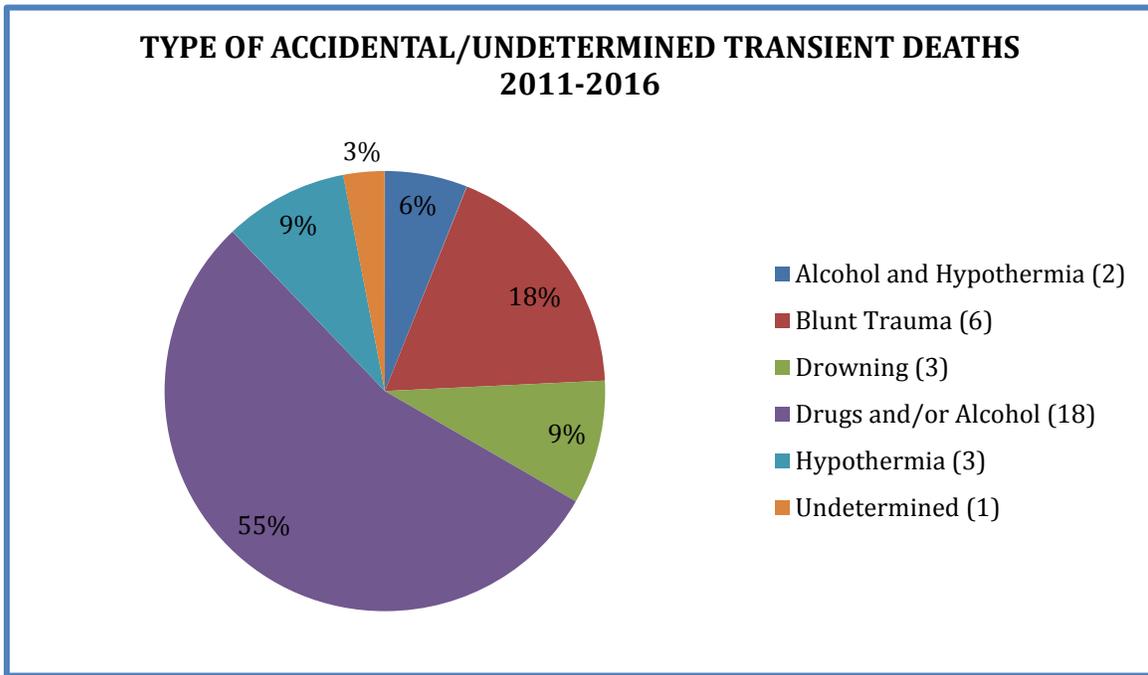
*One case from 2014 was a fetal demise; therefore, no manner of death was assigned.

TRANSIENT DEATHS BY MANNER OF DEATH 2016

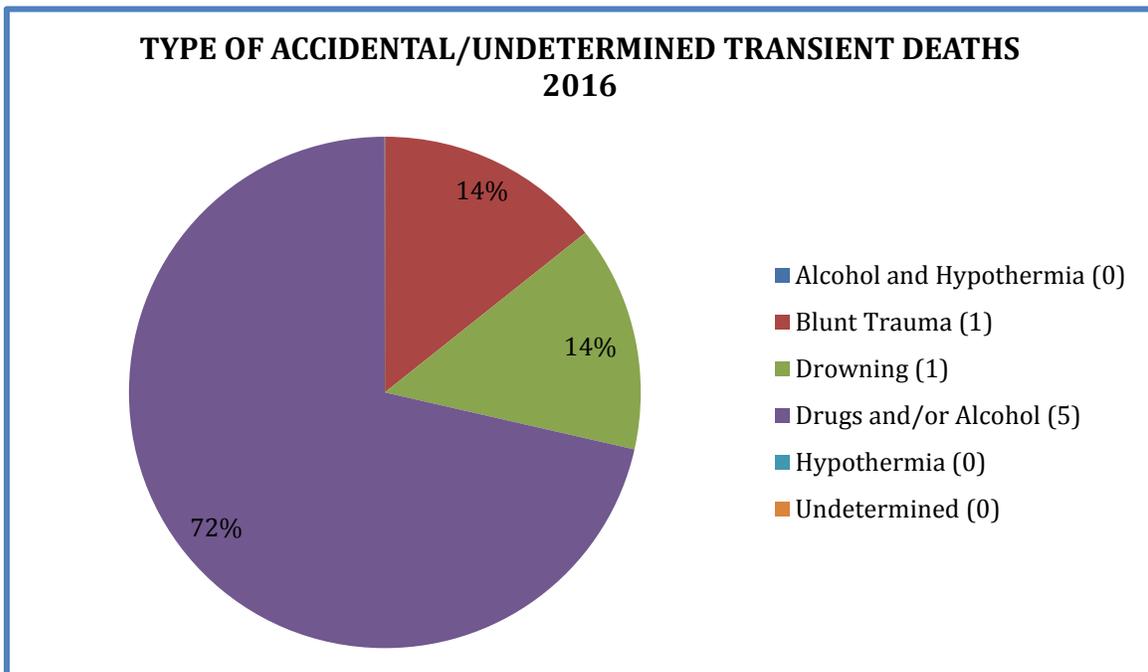


Note: Of the transient/homeless deaths tracked in 2016, 15 were male and 2 were female. Ages of the decedents in 2016 ranged from 28 - 86.

TYPE OF ACCIDENTAL/UNDETERMINED TRANSIENT DEATHS 2011-2016



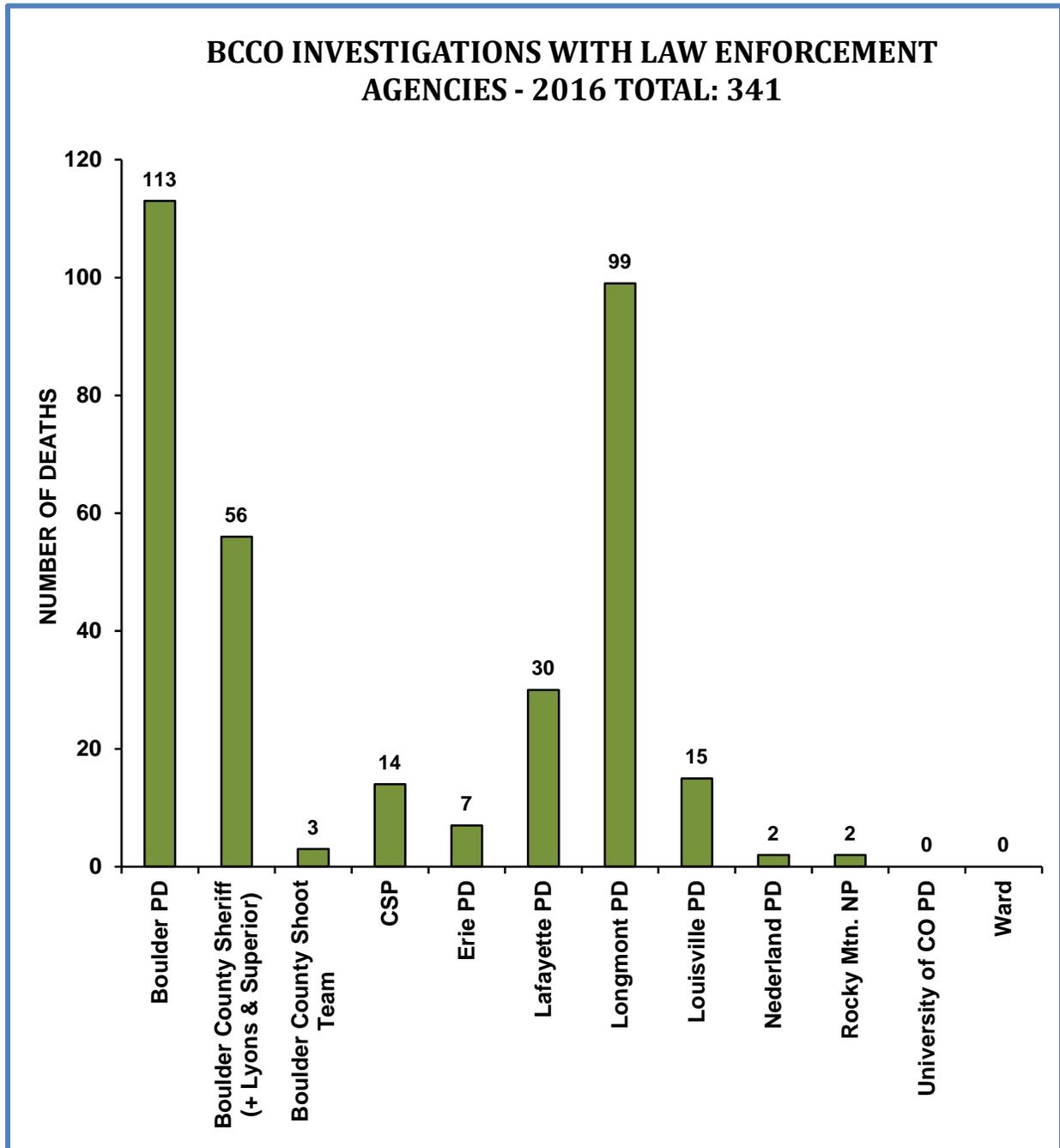
TYPE OF ACCIDENTAL/UNDETERMINED TRANSIENT DEATHS 2016



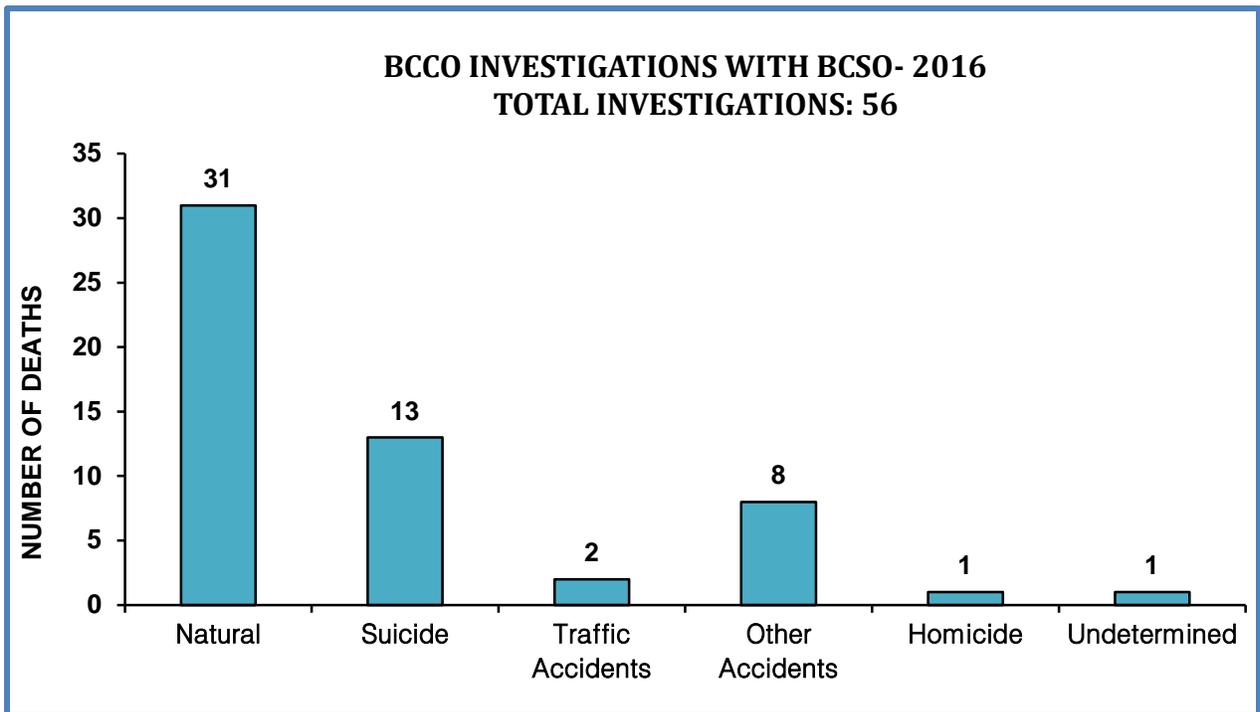
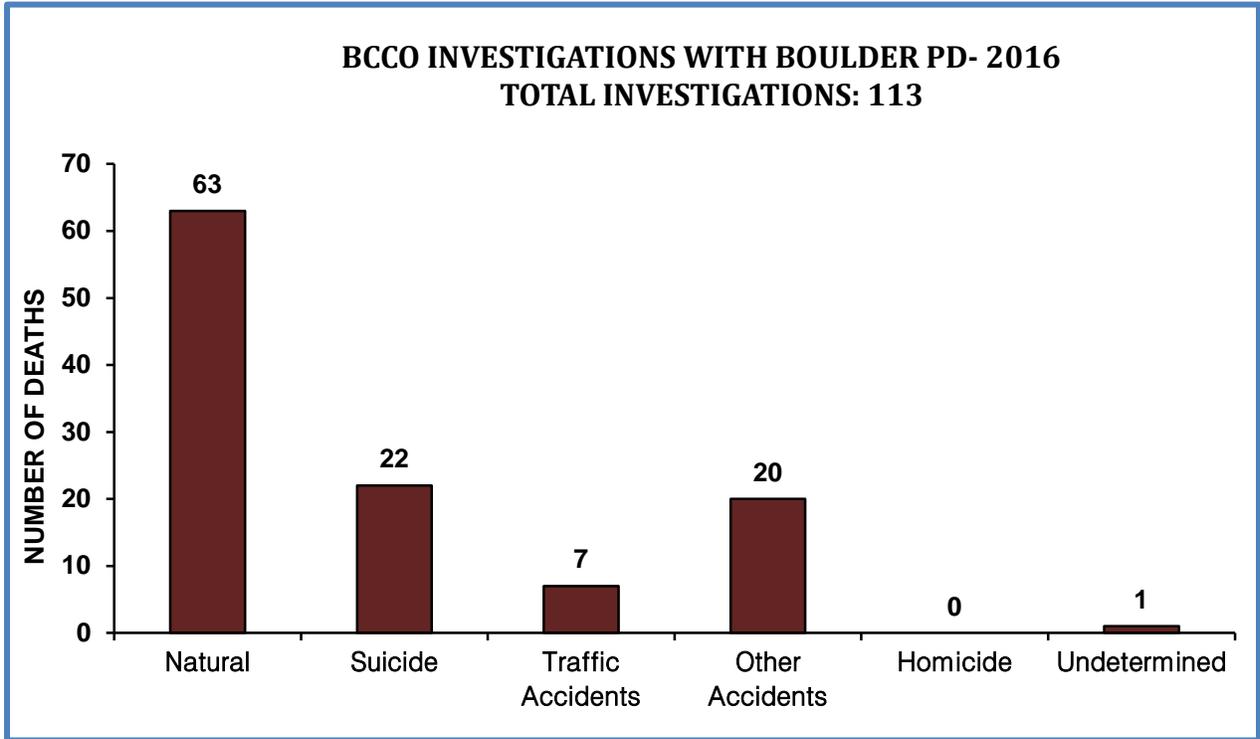
LAW ENFORCEMENT

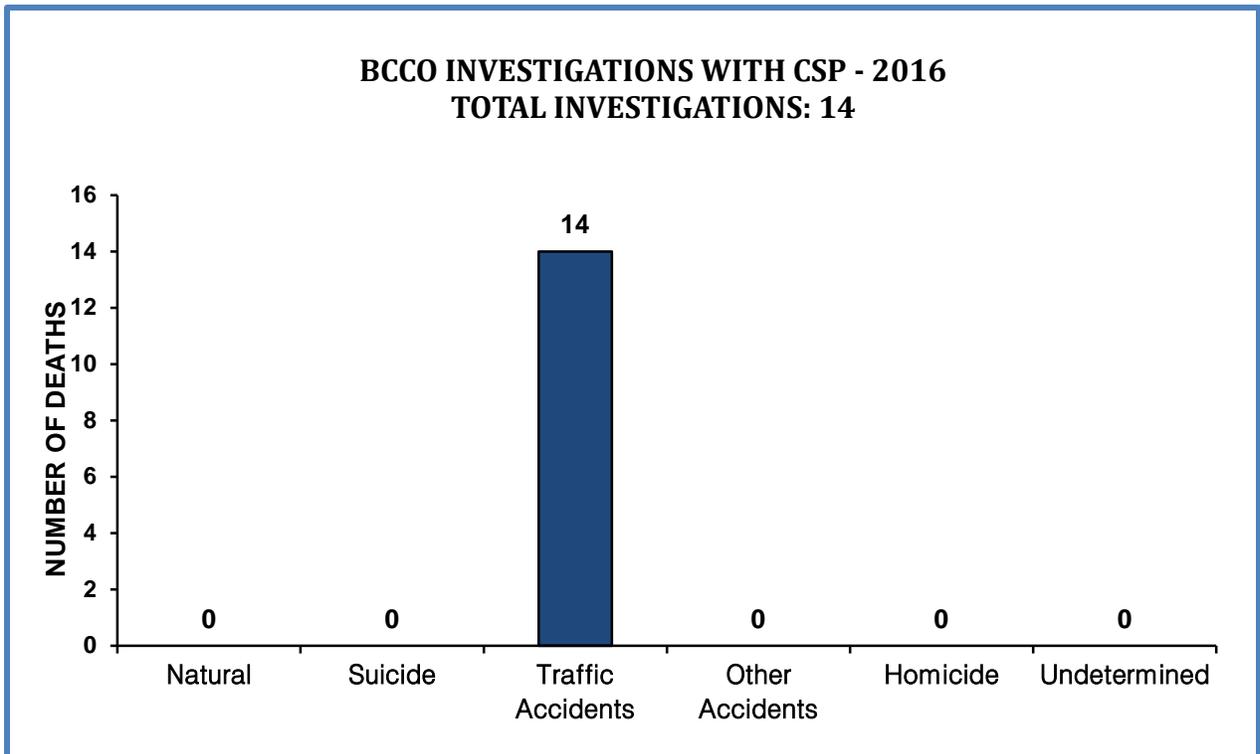
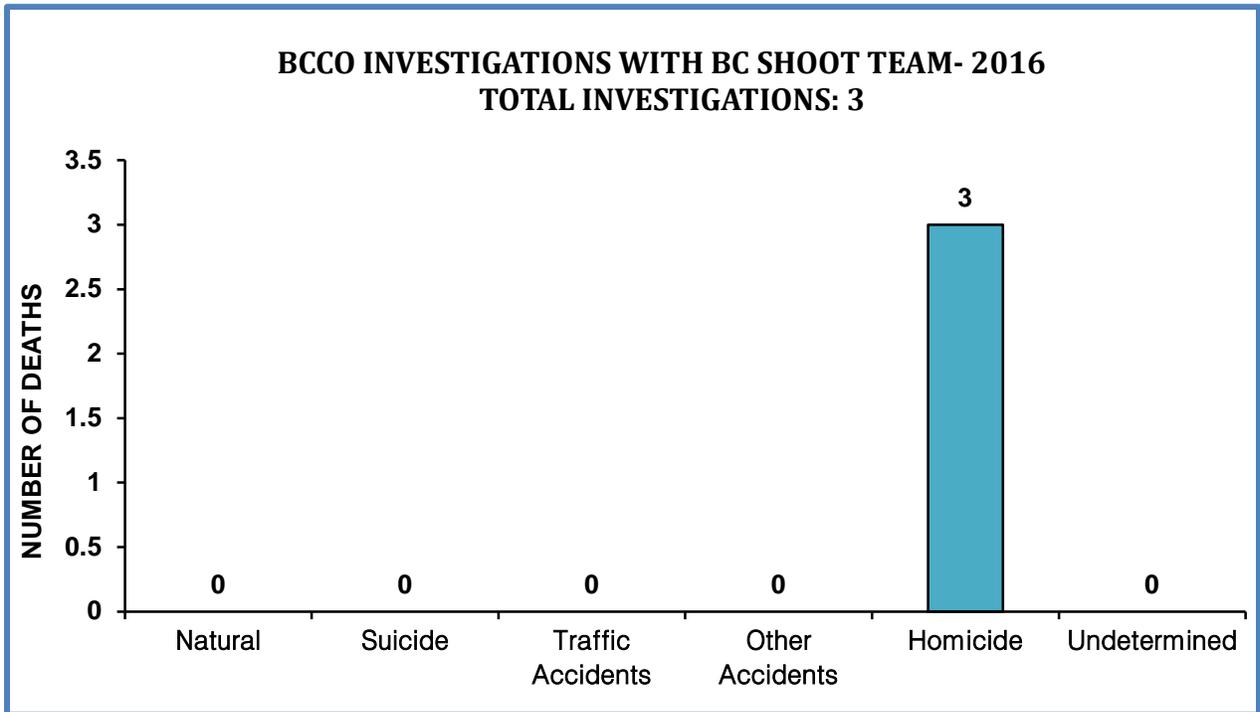
The Boulder County Coroner's Office works with the law enforcement agencies that cover jurisdiction in Boulder County. The charts in this section show the number of cases investigated with these agencies. Please note that the number of investigations listed may differ from those in the "Coroner Response" section of this report because the coroner's office also works with law enforcement on cases in which people die in the hospital as a delayed result of non-natural circumstances (i.e. auto incidents).

INVESTIGATIONS WITH LAW ENFORCEMENT AGENCIES

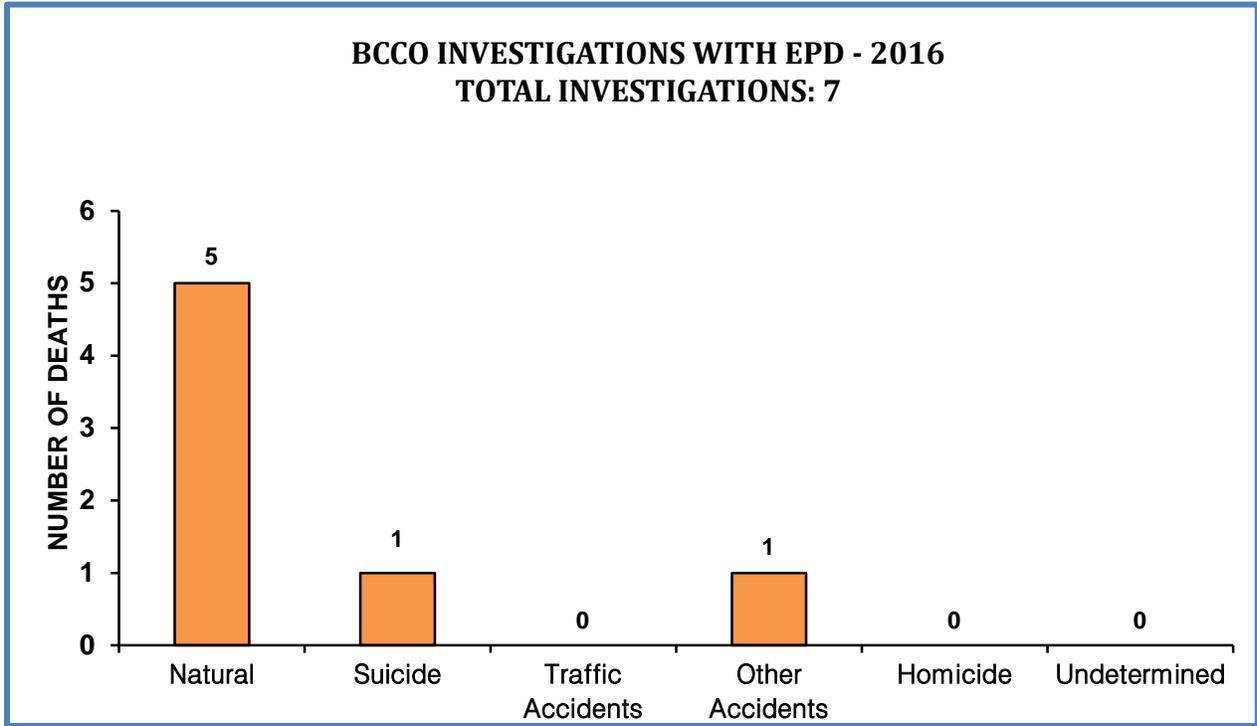


Note: The jurisdiction of the Boulder County Sheriff's Department includes unincorporated areas of Boulder County and the towns of Superior and Lyons.

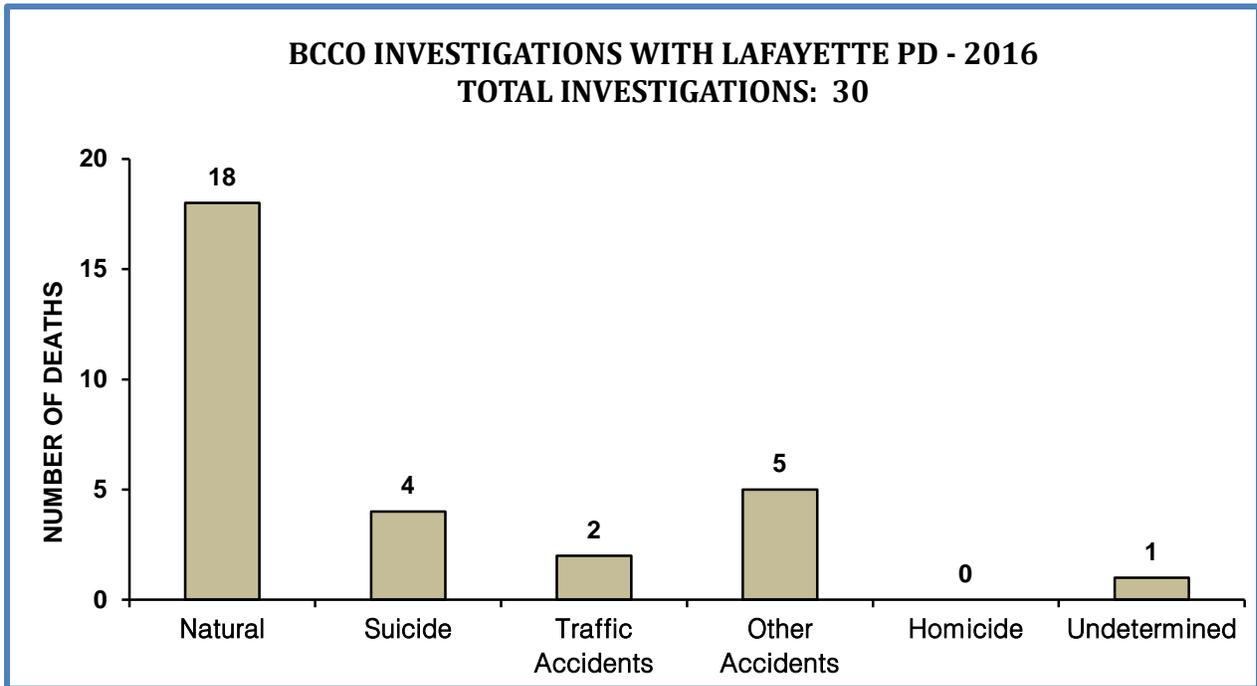




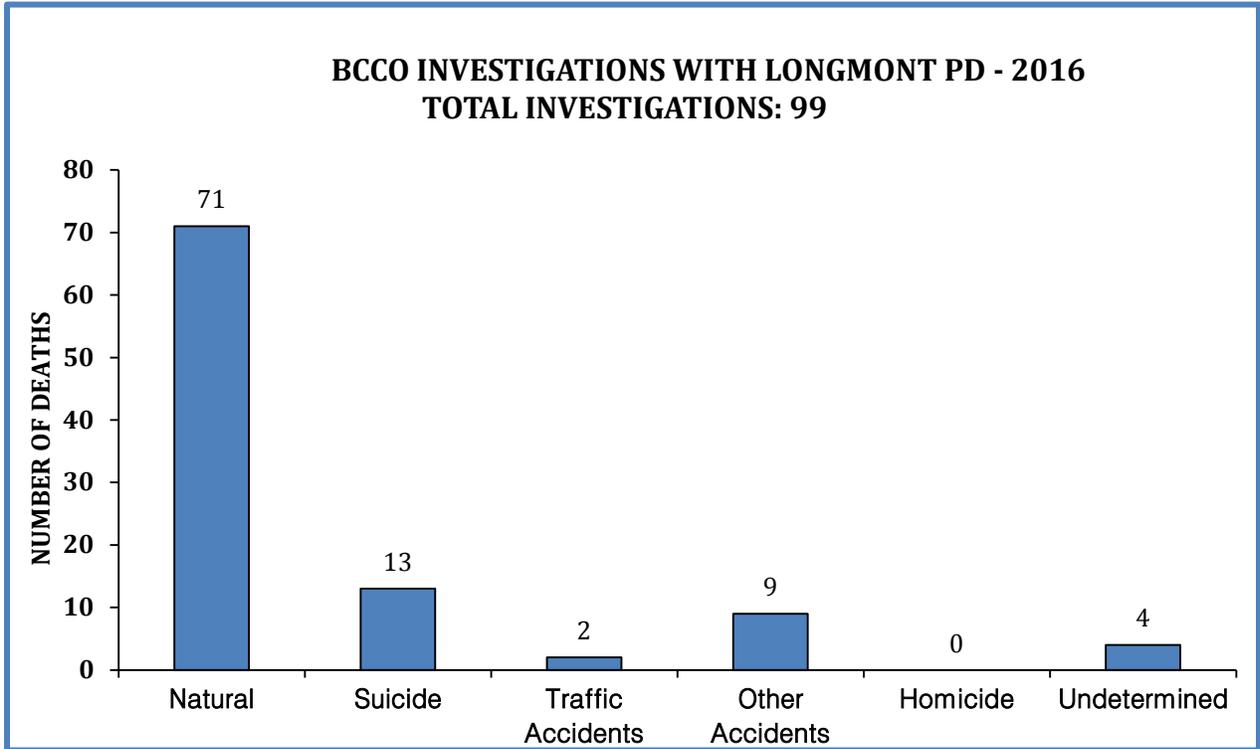
ERIE POLICE DEPARTMENT



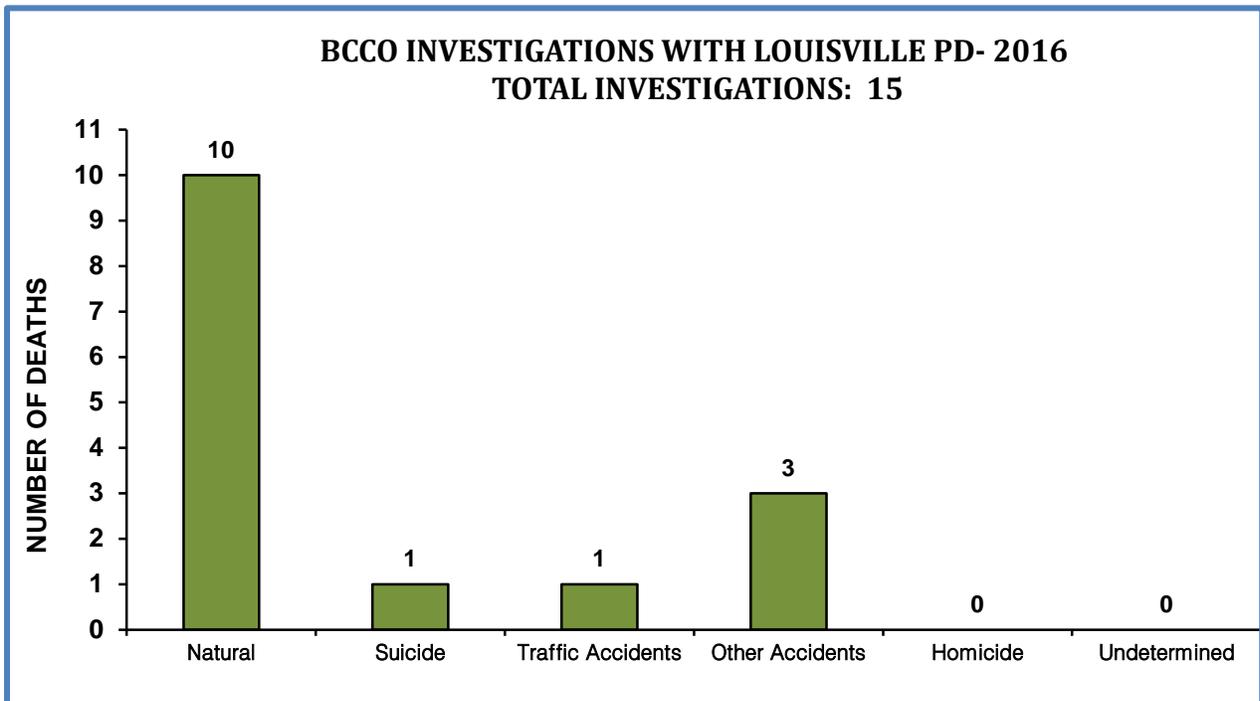
LAFAYETTE POLICE DEPARTMENT

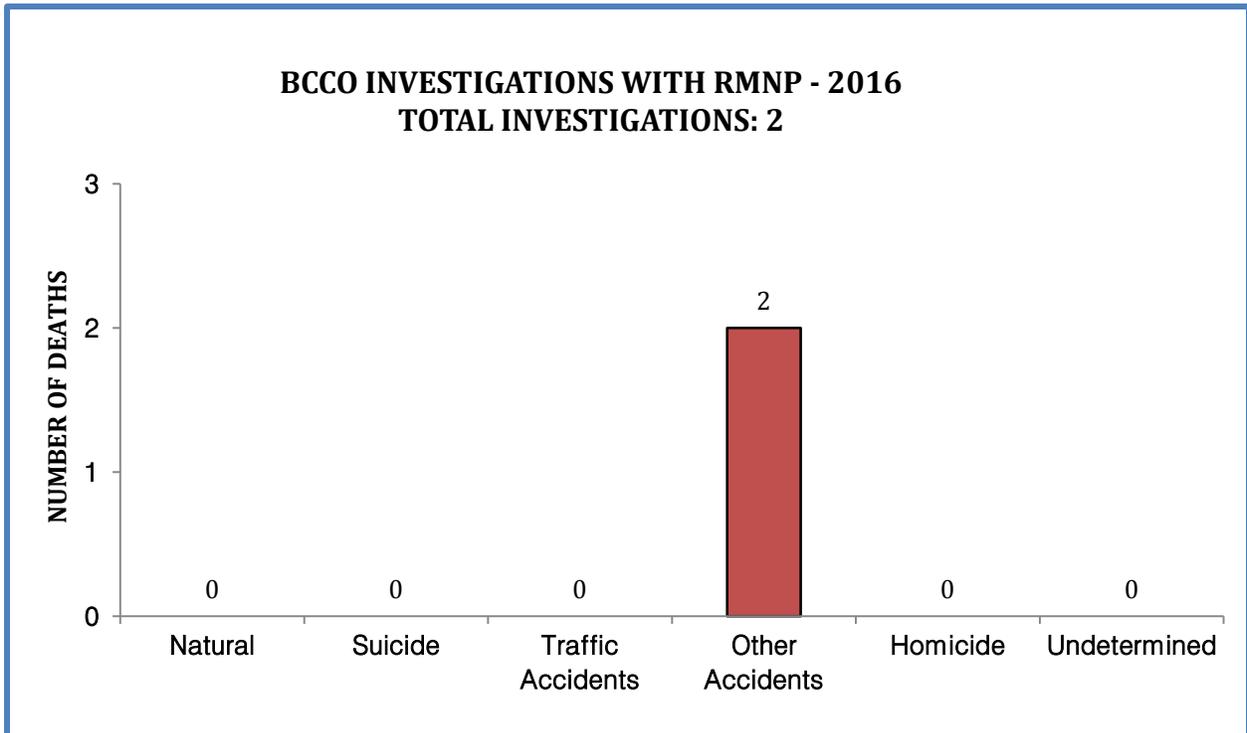
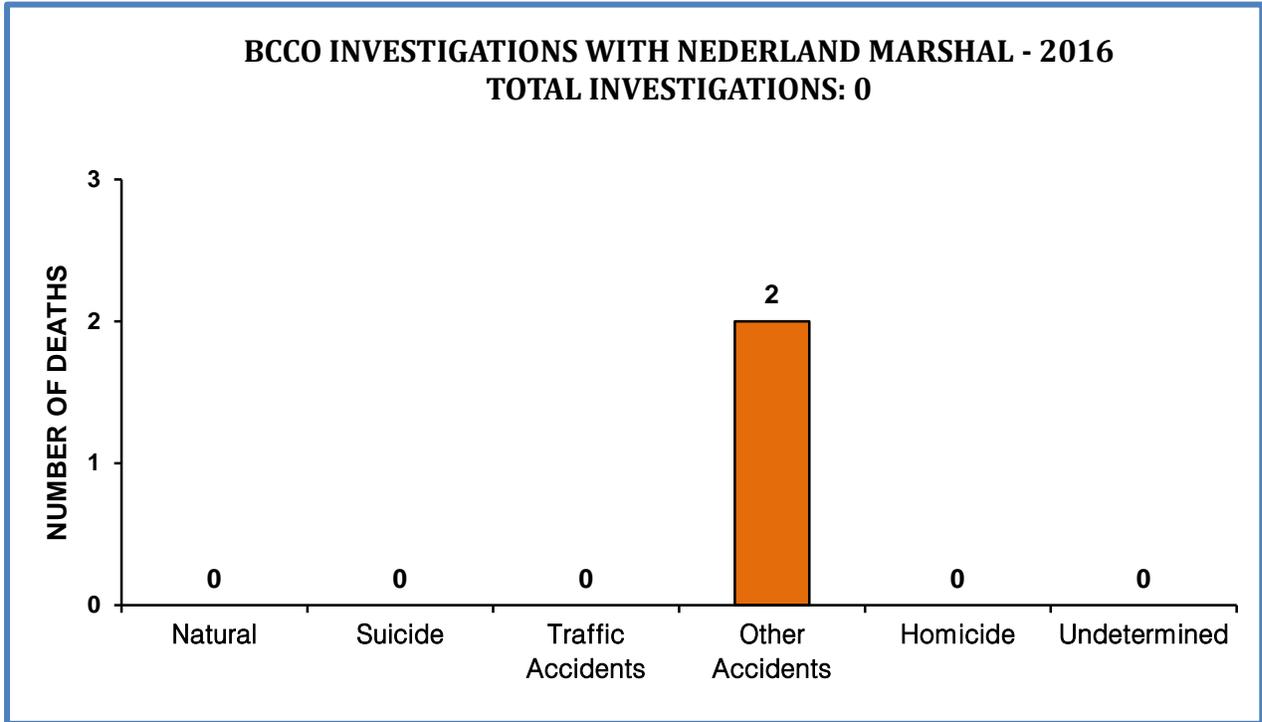


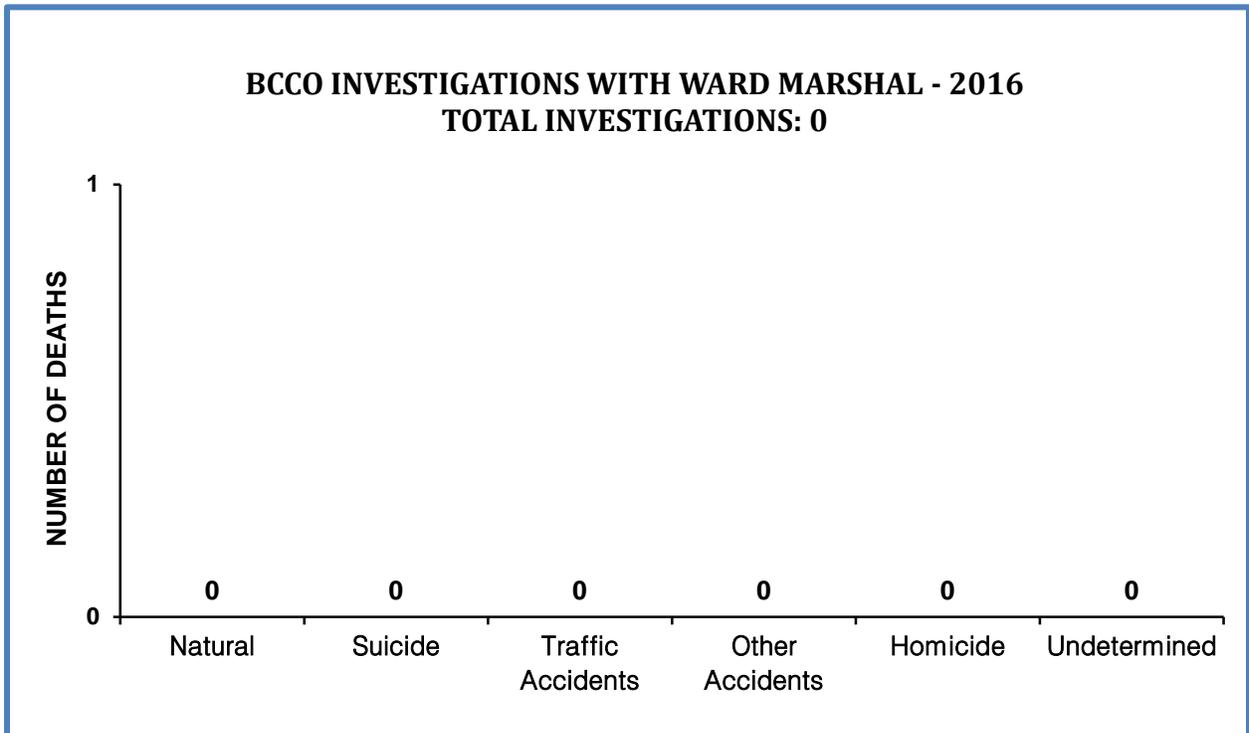
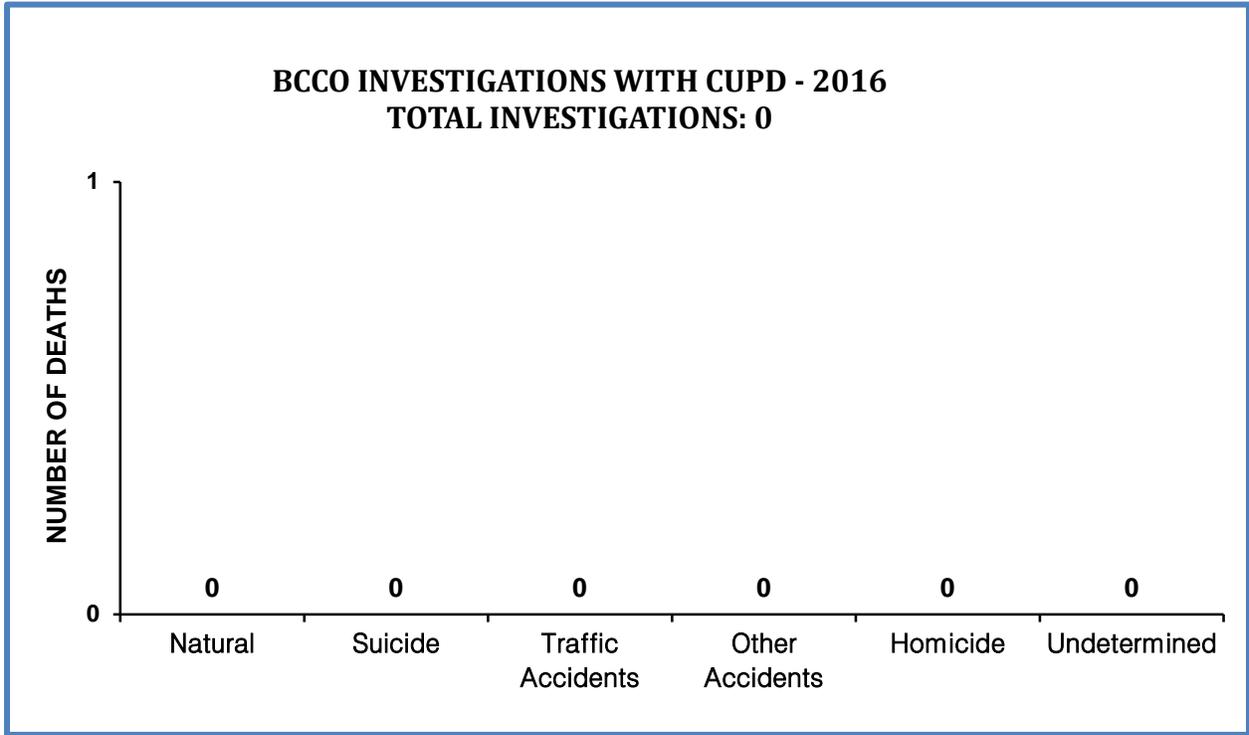
LONGMONT POLICE DEPARTMENT



LOUISVILLE POLICE DEPARTMENT







UNIDENTIFIED REMAINS

Boulder County Coroner's Office has investigated the deaths of the following individuals whose identities remain unknown.

UNIDENTIFIED BLACK MALE

Discovered: October 10, 1993

Approximate Age: 25-35

Height: 5'7"

Weight: 165-175 lbs.

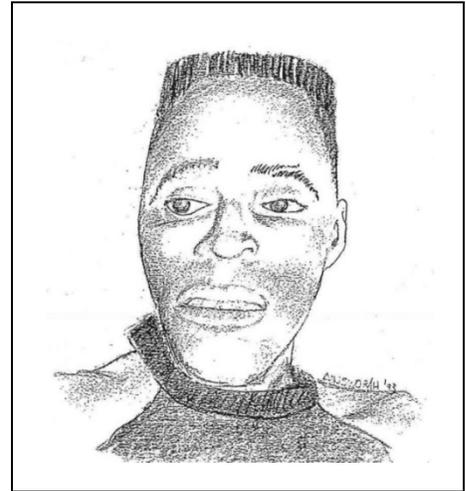
Eye Color: Brown

Hair: short curly black hair with bi-frontal balding.

Scars/Tattoos: On left eyebrow, obliquely oriented, well healed 17mm scar.

Clothing: Black socks; Short black sweat pants, brand name "Pro Spirit", overlaying a pair of long white sweat pants, brand name "Jerzees"; a white windbreaker-type shell with a hood and blue trimmed with zippers half way up front, brand name "Windcrest"; ankle length black hiking-type boots; and a blue mesh baseball cap with a New York Mets logo. Napkin with the logo "Dujour's Casual Café" was also found in his pocket.

Dental: Teeth in excellent repair with no dental work.



A well-nourished male of African descent was found near the base of the second Flatiron in Boulder, CO. Forensic Anthropology and Dentistry suggest he might have been a recent immigrant to America from North Africa. No obvious injury was found. An autopsy did not reveal cause of death. Some clothing and personal effects were found near him, but no camping gear or identification was present. He had a pair of thick-rimmed red prescription glasses.

UNIDENTIFIED CAUCASIAN MALE

Discovered: November 21, 1993

Approximate Age: 25-32

Height: 5'3" - 5'6"

Weight: 150-165 lbs.

Eye Color: Unknown

Hair: Shoulder-length coarse straight dark blond to light brown hair

Scars/Tattoos: None

Clothing: T-shirt, blue denim jeans, white socks and white athletic-type shoes.

Dental: Teeth in extremely poor repair with dental work.

The remains of a mostly skeletonized Caucasian male were found on the North Slope of Gregory Canyon in Boulder County, CO. An autopsy did not reveal a cause of death, but the man may have been suffering from Chronic Iron Deficiency Anemia.

UNIDENTIFIED CAUCASIAN FEMALE INFANT

Discovered: October 12, 2001

Approximate Age: Infant

A Caucasian female infant was found placed in a dumpster behind a grocery store. The investigation is ongoing.

UNIDENTIFIED MALE SKELETAL REMAINS

Reported: November 8, 2013

Skeletal Examination Information:

Ancestry: European descent and/or African ancestry

Approximate Age: 32.59 +/- 5 years

Height: 5' 7.2" +/- 3.3 inches

Weight: N/A

Eye Color: Unknown

Hair: Unknown

Scars/Tattoos: Unknown

Clothing: Unknown

Dental: Maxillary left second premolar and mandibular left second premolar missing post mortem. The right mandibular third molar and both maxillary third molars appear to have never formed. Linear striations indicating possible biological stress during childhood when the adult teeth were forming.

These are skeletal human remains that were turned over to the Boulder County Coroner's Office from the Longmont VFW. The remains were reported to be that of a Native American Female, however an osteological analysis completed by Metropolitan State University of Denver-Human Identification Laboratory has concluded that the remains are that of an adult male approximately 32.59 +/- 5 years at the time of death and that the ancestry analysis indicates that the individual is not of Native American descent, although analysis is not able to definitively identify the ancestry. Analysis suggests that the remains are likely archaeological, although there is no definitive answer as to how long ago the individual died.

The interpretation from the Osteological Report states the following:

"The skeletal remains are consistent with a young adult male with antemortem trauma indicating interpersonal violence at some time in the life of the individual. The discoloration of the skeletal remains and root markings on the bones along with the lack of modern medical intervention for fracture repair and absence of evidence of modern dental work suggest the specimen is likely archaeological. The porotic hyperostosis, which was active at death, and linear enamel hypoplasias indicate biological stress during childhood when the adult teeth were forming. The ancestry analysis indicates the individual is not of Native American descent, though an unambiguous ancestry cannot be identified. Additionally, the postmortem breakage of several teeth, postmortem damage to several bones, and the missing elements (ribs and small bones) are consistent with the story told by the VFW "Last Man Standing Club" that the remains were dug up by one of their members many years ago."

Given that the specimen is likely archeological, it is not probable the identity will be determined, however until such time that an identification or additional information on where the remains originated from, the remains will be kept by the coroner's office.

REFERENCES

- 1 National Association of Medical Examiners, A Guide for Manner of Death Classification First Edition, February 2002, p. 3.
- 2 Colorado Dept. of Public Health and Environment, Violence in Colorado: Trends and Resources, University of Colorado, 1994, p. 123
- 3 Published online October 17, 2011 Pediatrics Vol. 128 No. 5 November 1, 2011 pp e1341-e1367 (doi: 10.1542/peds.2011-2285)