



King County Medical Examiner's Office

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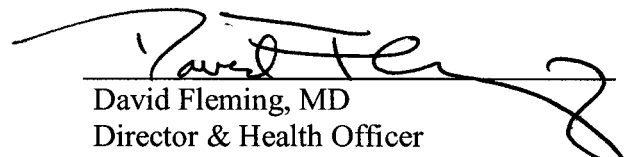
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Public Health 
Seattle & King County

DEDICATION

We recognize that each case in this report represents the death of a person whose absence is grieved by friends and relatives. To those people who have suffered the loss of a friend or relative, we dedicate this report.


David Fleming, MD
Director & Health Officer
Public Health - Seattle & King County

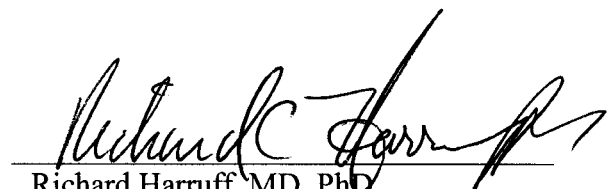

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FOREWORD

The King County Medical Examiner's Office serves the community by investigating sudden, unexpected, violent, suspicious, or unnatural deaths. Medical Examiner staff recognize the tragedy surrounding an untimely death and perform 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 that the Medical Examiner 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 that the family can gain the full benefit of our findings. Private insurance companies also routinely use our findings to settle claims. Whenever a consumer product is implicated in a death, we notify the Consumer Product Safety Commission to ensure that the product is studied and the necessary steps are taken to protect the public. The public health dimension of the Medical Examiner's function is designed to isolate and identify causes of sudden, unexpected death. When an infectious agent or poison is implicated in a 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 Medical Examiner provides an important level of surveillance for such possibilities.

Civil or criminal judicial proceedings frequently require the medical investigation of violent death. Thus, the King County Medical Examiner's Office conducts a prompt medical 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 Medical Examiner, these deaths are studied in great detail because of the issues and legal consequences involved. In this way, the King County Medical Examiner's Office offers the criminal justice system the best support that medical science can provide.

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

DESCRIPTION AND PURPOSE
of the
Public Health – Seattle & King County
King County Medical Examiner's Office

In 1968, the Home Rule Charter abolished the King County Office of the Coroner, which was replaced with the King County Medical Examiner's Office. The Medical Examiner's Office is within the Prevention Division of Public Health – Seattle & King County. Although the Department of Public Health is a combined City-County department, the King County Medical Examiner's Office is funded by King County and is under the King County Executive.

The Chief Medical Examiner is a physician trained and certified in Forensic Pathology - the branch of medicine concerned with the scientific investigation of sudden, unexpected, violent, suspicious, or unnatural deaths. There are four sections under the Chief Medical Examiner's direction: Forensic Pathology, Scene Investigation, Autopsy Support and Administrative Support. The duties of these four sections include the performance of autopsies when indicated, certification of death, field investigation of scene and circumstances 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 Medical Examiner are defined by state statute (RCW 68.50) and include, but are 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, lightning, radiation, chemical or thermal injury, starvation, environmental exposure, or neglect. (2) Unexpected death during, associated with, or as a result 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 agents, 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. (3) 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 whatsoever, 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
Public Health – Seattle & King County
King County Medical Examiner's Office

The mission of the King County Medical Examiner's Office (KCMEO) is to investigate sudden, unexpected and unnatural deaths in King County with the highest level of professionalism, compassion and efficiency and to provide a resource for improving the health and safety of the community consistent with the general mission of Public Health.

To achieve this mission, KCMEO 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 investigations and autopsies professionally, scientifically, and conscientiously; and complete reports expeditiously with regard for the concerns of family members, criminal justice, and public health and safety.

Provide compassion, courtesy, and honest 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 disseminate information regarding deaths in a manner consistent with the laws of Washington State and consistent with the mission of Public Health.

Provide medical and scientific testimony in court and in deposition as well as medicolegal consultation for prosecuting attorneys, defense attorneys, and attorneys representing surviving family members.

Promote and advance, through education and research, the sciences and practices of death investigation, pathology, and anthropology within KCMEO and in collaboration with educational institutions.

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

Expand communication throughout Public Health and the community at large regarding the roles, responsibilities, and objectives of KCMEO.

EXPLANATION OF DATA

The information presented here was compiled on deaths in which the King County Medical Examiner assumed jurisdiction during the calendar year 2006. *(Please refer to Pages 2 and 3 which outline this jurisdictional definition.)* This report emphasizes the role of alcohol, drugs, and firearm use in violent deaths. Health agencies, safety councils, and lawmakers may find these statistics useful. If the quality of life in King County is to be improved then perhaps this report can serve as a basis for change.

The Medical Examiner serves the geographic area that includes all 2,130 square miles of King County, bounded by Pierce County to the south, Snohomish County to the north, Kittitas and Chelan Counties to the east, and Puget Sound to the west. In 2006 the King County population was estimated to be 1,835,300¹. Included within King County are 42 cities and towns including Seattle, the state's largest city. Mercer Island, Vashon Island, two major airports and several colleges and universities are all in the geographic area served by the Medical Examiner's Office. In King County more than 20 hospitals and a major trauma center serve the entire Pacific Northwest region.

This report summarizes demographics from individual cases in which the Medical Examiner assumed jurisdiction, and presents them in aggregate form. The location (Nearest Incorporated City to the Fatal Incident, Table 1-8, page 17) represents the location of the incident to the nearest city, not the residential address of the individual. Each manner (category) of death is subdivided into the various sub-groupings (methods) appropriate to that manner, which together form a more detailed description of the cause and manner of death.

The variables displayed in the tables such as race, sex, age, etc., have been selected as those most likely to assist and interest individuals using these data in assembling a profile of death statistics on deaths examined by the Medical Examiner's Office for 2006. According to 2004 Office of Financial Management (OFM) estimates, the racial distribution of King County is 77.7% White, 5.8% Black, 3.3% two or more races indicated (new category in the year 2000), 12.2% Asian (including Hawaiian and other Pacific Islanders), and 1.0% Native American. Information on Hispanic ethnicity of the decedent is not available for every case, and will not be presented in this report.

Medical Examiner figures cannot be directly compared to the racial distribution of King County residents. The main reason for this is that, as emphasized in Table 1-9 on page 19, in 17% of the Medical Examiner cases the incident leading to death occurred outside of King County and the decedent likely was not a resident of King County. However, as a rough estimate, the only manner of death that varies from the racial distribution of the county by a large percentage is Homicide (see discussion on page 43).

¹ State of Washington, Office of Financial Management, June 27, 2007 estimate.

Age groups are divided into youth and adult. The youth groups are infants (newborn to 11 months), toddlers (1-5 years), grade school (6-12 years), junior high (13-15 years), and high school (16-19 years). Adult age groups are in corresponding decades with the last being 90 years old or older.

Blood alcohol (ethanol) data included here represent the blood level at the time of death. Alcohol is metabolized at a rate of 0.015 to 0.018 grams percent per hour. Thus, if there is a significant survival interval, the blood alcohol at the time of death will be lower than at the time of incident. Consequently, blood alcohol tests are not performed in cases where death occurs more than 24 hours after the fatal injury. For these reasons, an unknown number of cases not tested or showing no blood alcohol may actually have had a measurable alcohol concentration at the time of the incident.

Three sections are included that review specific issues. Data are presented which highlights deaths due to drugs, firearms, and among children and youth. The firearm data pertain to the victim because data relating to the shooter are not included in the Medical Examiner's investigation. On deaths among children and youth, the analysis focuses on violent, non-natural causes of death.

Data on natural deaths are included. However, these deaths due to natural causes are not representative of all natural deaths in King County. Natural deaths that the Medical Examiner investigates are those that occur suddenly and unexpectedly with no physician in attendance, or under suspicious circumstances. Such natural deaths comprised 37% (752/2,055) of all deaths that the Medical Examiner investigated in 2006.

The "Undetermined" category includes deaths in which the manner could not be clearly determined. In some cases, serious doubt existed as to whether the injury occurred with intent or as a result of an accident. In others, lack of witnesses or prolonged time between death and discovery precluded the accurate determination of the circumstances surrounding death. Moreover, it may be difficult to assess street drug or medication overdose deaths as showing enough features to reasonably determine the manner of death. Also included in the "Undetermined" category are Fetal Deaths, which, according to the State of Washington death certification guidelines, are not assigned a manner of death.

Those interested in obtaining more specific information and data from the King County Medical Examiner's Office should contact (206) 731-3232, extension 1.

MEDICAL EXAMINER CASES IN 2006

The following provides a summary of the raw data from the Medical Examiner's cases for the year 2006.

In 2006 there were an estimated 12,966 deaths in King County² (0.71% of a 2007 population estimate of 1,835,300). Of these deaths, 8,791 (68%) were reported to the Medical Examiner's Office by medical and law enforcement personnel. Based on analysis of the scene and circumstances of death and the decedent's medical history gathered by the medicolegal investigators, the Medical Examiner's Office assumed jurisdiction in 2,119 of these reported deaths, of which 64 were either ultimately found to be non-human remains or were anthropology or contract cases. Throughout the discussion of data that follows, except where stated, the non-human, anthropology, and contract cases are excluded. The number of applicable cases used in this report is 2,055 deaths.

Of note is the fact that the Medical Examiner declined jurisdiction in 6,672 of the deaths that were reported. The Medical Examiner's Office applies a strict interpretation of the legislative language in terms of "persons who die suddenly when in apparent good health and without medical attendance within thirty-six hours preceding death" (RCW 68.50). The Medical Examiner assumes jurisdiction only if both conditions (lack of medical care and apparent good health) apply, and there is no attending outside physician with sufficient knowledge of the individual's natural disease condition to certify the death.

The Medical Examiner's Office performed autopsies in 67% (1,385/2,055) of the cases in which jurisdiction was assumed. Autopsies by a Medical Examiner pathologist were not performed in deaths where scene, circumstances, medical history, and external examination of the body provided sufficient information for death certification. In 2006 there were 411 such deaths, accounting for 20% (411/2,055) of the total deaths. In addition, there were 255 deaths (12%) (255/2,055) certified by attending private physicians after review by and consultation with the Medical Examiner.

Several factors appear repeatedly in the unnatural deaths. Of all traffic fatalities in which tests were performed, 37% (63/171) tested positive for presence of alcohol (ethanol) in the blood. In recognition of the importance of safety devices in traffic accidents, Medical Examiner data indicate that of the 141 vehicle occupants who died, 55% (77/141) were wearing restraints.

In the 28 deaths involving motorcyclists, all 28 (100%) were wearing helmets.

² Death certificates filed in King County, (Vital Statistics, Public Health - Seattle & King County, 2007).

Firearms were the most frequent instrument of death in homicides and suicides, accounting for 57% (52/91) of the homicides and 43% (98/227) of the suicides.

While the discussion here tends to depict the more violent types of death, the reader should be reminded that 37% (752/2,055) of Medical Examiner cases involve natural deaths. Specific discussion and presentation of relevant tables regarding 2006 cases follow this brief summary.

Table 1-1 Deaths Occurring in King County / Medical Examiner Cases / 2006

CASES BY MANNER OF DEATH ³			NUMBER OF KCME DEATHS	PERCENT OF KCME DEATHS
Accident Other	(A)		721	35.1%
Accident Traffic	(T)		211	10.3%
Homicide	(H)		91	4.4%
Natural	(N)		752	36.6%
Suicide	(S)		227	11.0%
Undetermined ⁴	(U)		53	2.6%
Total KCME general cases			2,055	100%
Non-applicable cases where jurisdiction was assumed ⁵			64	
Total KCME jurisdiction cases			2,119	
Total KCME general cases ⁶			2,055	
Deaths reported to KCME but no jurisdiction was assumed (NJA)			6,672	
All other deaths in King County not reported to KCME			4,239	
ALL KING COUNTY DEATHS ⁷			12,966	

³The letters following each manner of death will be used in most tables throughout this report (A = Accident (Non-Traffic), T = Traffic, H = Homicide, N = Natural, S = Suicide, U = Undetermined).

⁴Includes nine fetal deaths, which, according to Washington State death certification procedures, are not assigned a manner, and two cases pending investigation.

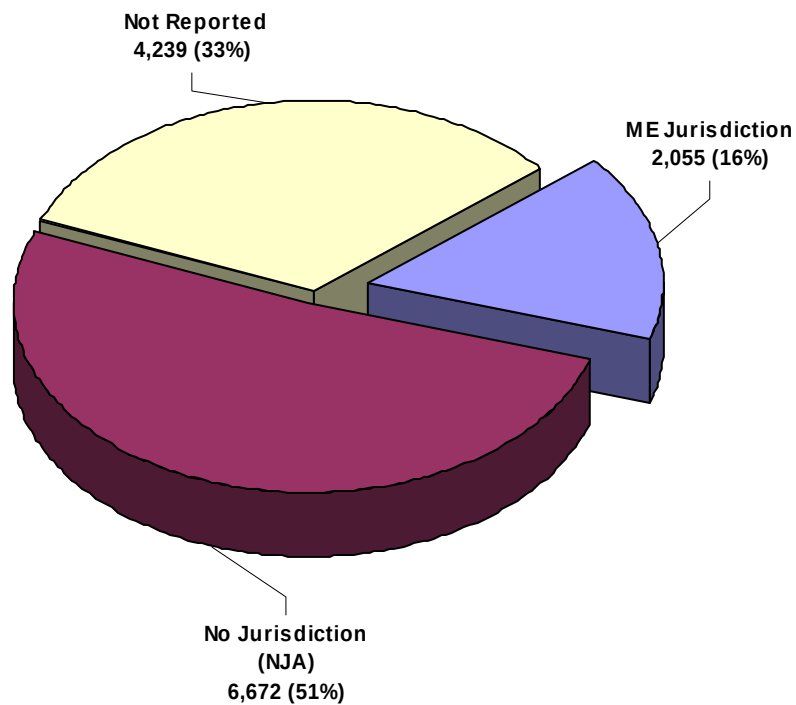
⁵Non-applicable includes 48 non-human bones/tissue, and 16 anthropology/contract cases.

⁶This is the total number of cases that will be referred to throughout this report unless otherwise noted.

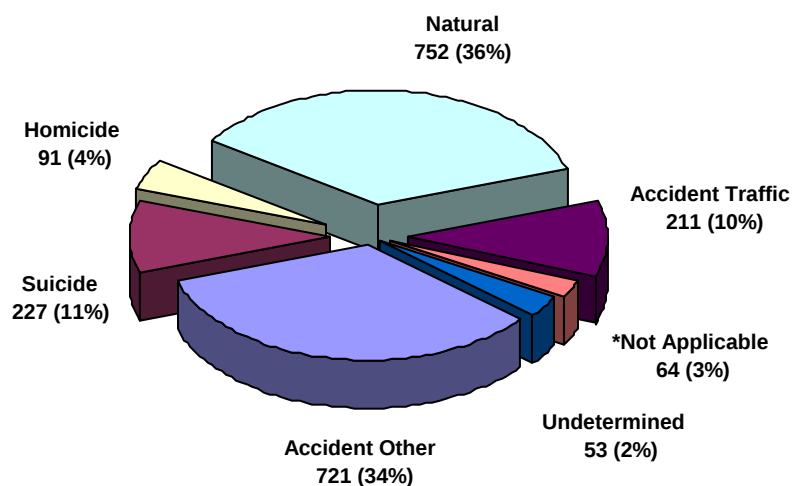
⁷Death certificates filed in King County (Vital Statistics, Public Health – Seattle & King County, 2007)

Graph 1-1 All King County Deaths with Medical Examiner Jurisdiction Shown / 2006

There were 12,966 deaths in King County in 2006.

**Graph 1-2 Manner of Death for All Medical Examiner Jurisdiction Cases / 2006**

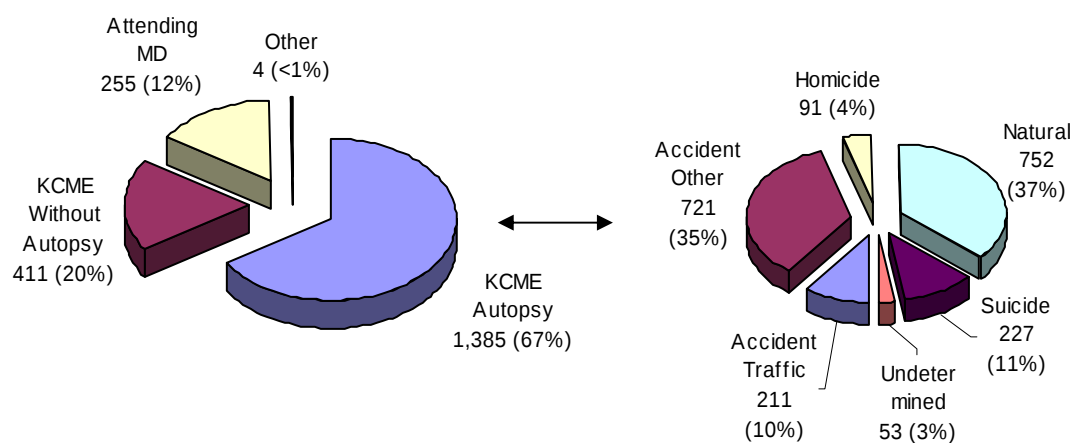
Jurisdiction assumed in 2,119 cases⁸.



⁸This number includes 64 non-applicable cases (non-human tissue/bones and anthropology/contract cases).

Table 1-2 Method of Certification / Manner of Death / KCME / 2006

CERTIFICATION	MANNER OF DEATH						TOTAL	%
	A	T	H	N	S	U		
KCME Autopsies	460	151	88	448	191	47	1385	67.4%
KCME External Exams	153	59	0	160	36	3	411	20.0%
KCME Other	0	0	3 ⁹	1	0	0	4	0.2%
Attending Physician	108	1	0	143	0	3	255	12.4%
Totals	721	211	91	752	227	53	2,055	100%

Graph 1-3 Method of Certification for all King County Medical Examiner Jurisdiction Cases / 2006

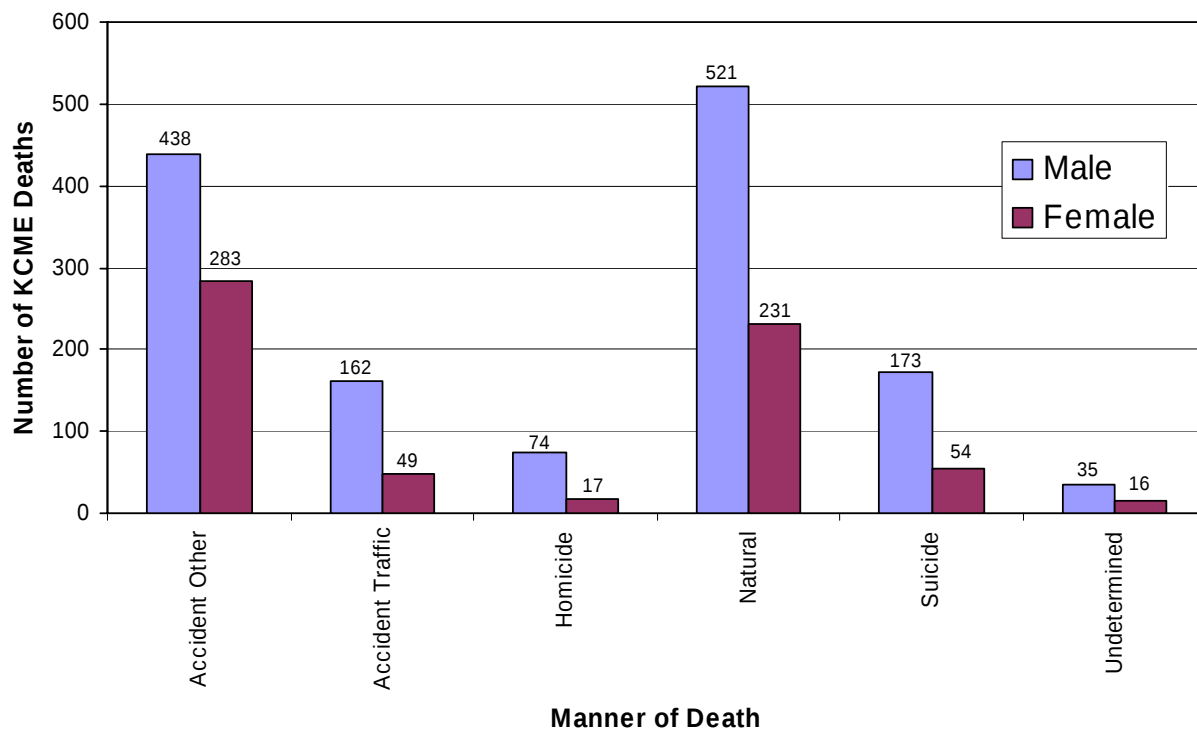
⁹ The remains of three (3) victims whose deaths were classified as Homicide were returned to the county(s) where the original injuries occurred. Because Harborview Medical Center is a regional trauma center, the King County Medical Examiner's Office often receives victims of violence from surrounding counties. By prior agreement, the remains of some of these victims are returned to the originating county for autopsy by the Medical Examiner of record.

Manner of Death in 2006 King County Medical Examiner General Cases

Table 1-3 Sex / Manner of Death / King County Medical Examiner / 2006

SEX	MANNER OF DEATH						TOTAL	%
	A	T	H	N	S	U		
Male	438	162	74	521	173	35	1403	68%
Female	283	49	17	231	54	16	650	32%
Totals	721	211	91	752	227	53¹⁰	2,055¹¹	100%

Graph 1-4 Sex / Manner of Death / King County Medical Examiner / 2006¹²



¹⁰Includes two fetal deaths of undetermined sex.

¹¹Includes two fetal deaths of undetermined sex.

¹²Does not include two fetal deaths of undetermined sex.

Table 1-4 Age / Sex / Manner of Death / King County Medical Examiner / 2006

AGE / SEX	MANNER OF DEATH						Sub-Total	TOTAL	%
	A	T	H	N	S	U			
Under 1 year	2	1	4	25	0	9		41	2.0%
Male	1	0	3	18	0	5	27		
Female	1	1	1	7	0	2	12		
Unknown	0	0	0	0	0	2	2		
1 - 5 years	11	1	2	8	0	0		22	1.1%
Male	6	1	2	4	0	0	13		
Female	5	0	0	4	0	0	9		
6- 12 years	3	2	0	1	0	0		6	0.2%
Male	3	1	0	1	0	0	5		
Female	0	1	0	0	0	0	1		
13-15 years	5	4	2	0	1	1		13	0.7%
Male	4	3	0	0	0	1	8		
Female	1	1	2	0	1	0	5		
16-19 years	10	23	7	5	10	0		55	2.6%
Male	9	17	7	3	9	0	44		
Female	1	6	0	2	1	0	10		
20- 29 years	57	46	29	12	40	3		187	9.1%
Male	46	39	26	10	33	3	158		
Female	11	7	3	2	7	0	30		
30- 39 years	63	27	14	50	39	5		198	9.6%
Male	41	19	13	35	29	2	139		
Female	22	8	1	15	10	3	59		
40- 49 years	104	36	19	107	45	16		327	15.9%
Male	68	28	15	84	33	13	241		
Female	36	8	4	23	12	3	86		
50- 59 years	140	25	9	186	47	10		417	20.3%
Male	100	20	7	145	34	5	311		
Female	40	5	2	41	13	5	106		
60 - 69 years	57	16	2	152	18	5		250	12.2%
Male	43	14	1	118	16	3	195		
Female	14	2	1	34	2	2	55		
70 - 79 years	68	9	0	89	12	2		180	8.8%
Male	40	5	0	48	9	2	104		
Female	28	4	0	41	3	0	76		
80 - 89 years	142	17	2	76	12	0		249	12.1%
Male	62	12	0	40	8	0	122		
Female	80	5	2	36	4	0	127		
90+ years	59	4	1	41	3	1		109	5.3%
Male	15	3	0	16	2	1	37		
Female	44	1	1	25	1	0	72		
Unknown	0	0	0	0	0	1		1	0.1%
Male	0	0	0	0	0	0	0		
Female	0	0	0	0	0	1	1		
Totals	721	211	91	752	227	53		2,055	100%

Table 1-5 Race / Sex / Manner of Death / King County Medical Examiner / 2006¹³

RACE / SEX	MANNER OF DEATH						Sub-Total	TOTAL	%
	A	T	H	N	S	U			
White								1662	80.9%
<i>Male</i>	359	125	38	416	148	28	1114		
<i>Female</i>	249	39	12	186	49	12	547		
<i>Unknown</i>	0	0	0	0	0	1	1		
Black								204	9.9%
<i>Male</i>	51	13	18	65	9	5	161		
<i>Female</i>	15	3	4	18	2	1	43		
Asian								120	5.8%
<i>Male</i>	16	17	13	23	13	1	83		
<i>Female</i>	14	5	1	14	3	0	37		
Native American								43	2.1%
<i>Male</i>	10	7	4	7	2	1	31		
<i>Female</i>	5	1	0	5	0	1	12		
Other								25	1.2%
<i>Male</i>	2	0	1	10	1	0	14		
<i>Female</i>	0	1	0	8	0	2	11		
Unknown								1	0.1%
<i>Male</i>	0	0	0	0	0	0	0		
<i>Female</i>	0	0	0	0	0	0	0		
<i>Unknown</i>	0	0	0	0	0	1	1		
Totals	721	211	91	752	227	53		2,055	100%

¹³A = Accident (Non-Traffic), T = Traffic, H = Homicide, N = Natural, S = Suicide, U = Undetermined.

Table 1-6 Marital Status / Sex / Manner of Death / King County Medical Examiner / 2006¹⁴

MARITAL STATUS / SEX	MANNER OF DEATH						Sub-Total	TOTAL	%
	A	T	H	N	S	U			
Never Married	200	91	62	230	100	23		706	34%
Male	148	71	55	182	85	16	557		
Female	52	20	7	48	15	5	147		
Unknown	0	0	0	0	0	2	2		
Married	194	60	8	175	52	9		498	24%
Male	132	46	6	130	41	8	363		
Female	62	14	2	45	11	1	135		
Divorced	147	43	13	178	54	14		449	21%
Male	94	35	8	124	33	8	302		
Female	53	8	5	54	21	6	147		
Widowed	156	13	3	105	17	3		297	14%
Male	44	7	0	38	12	1	102		
Female	112	6	3	67	5	2	195		
Unknown	24	4	5	64	4	4		105	5%
Male	21	3	5	47	2	2	80		
Female	3	1	0	17	2	2	25		
Totals	721	211	91	752	227	53		2,055	100%

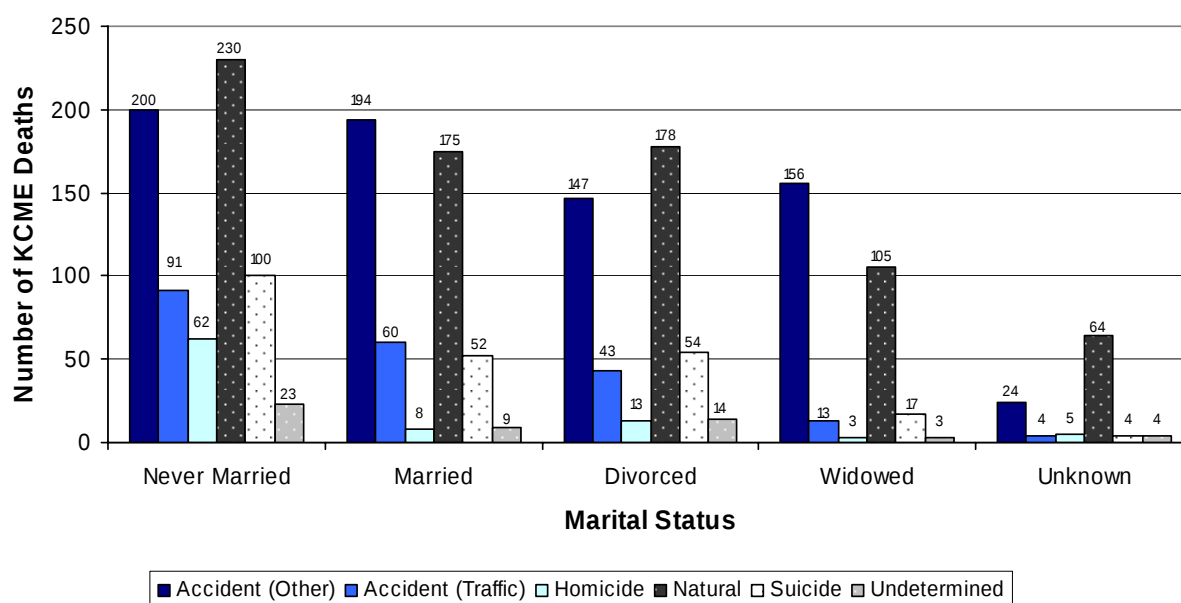
Graph 1-5 Marital Status / Manner of Death / King County Medical Examiner / 2006¹⁴A = Accident (Non-Traffic), T = Traffic, H = Homicide, N = Natural, S = Suicide, U = Undetermined.

Table 1-7 Month / Manner of Death / King County Medical Examiner / 2006¹⁵

MONTH	MANNER OF DEATH						Total	%
	A	T	H	N	S	U		
Prior to 2005	0	0	1	0	0	4	5	0.2%
2005	5	0	0	3	2	3	13	0.6%
January	61	17	8	56	17	0	159	7.8%
February	63	9	6	68	14	2	162	7.9%
March	58	17	11	62	19	6	173	8.4%
April	55	18	2	56	23	4	158	7.7%
May	72	12	5	61	15	7	172	8.4%
June	67	16	9	62	18	3	175	8.5%
July	66	22	11	64	22	3	188	9.2%
August	47	27	5	50	24	4	157	7.6%
September	50	25	12	51	16	1	155	7.5%
October	53	20	9	66	22	5	175	8.5%
November	71	13	4	80	12	9	189	9.2%
December	53	15	8	73	23	2	174	8.5%
Totals	721	211	91	752	227	52	2,055	100%

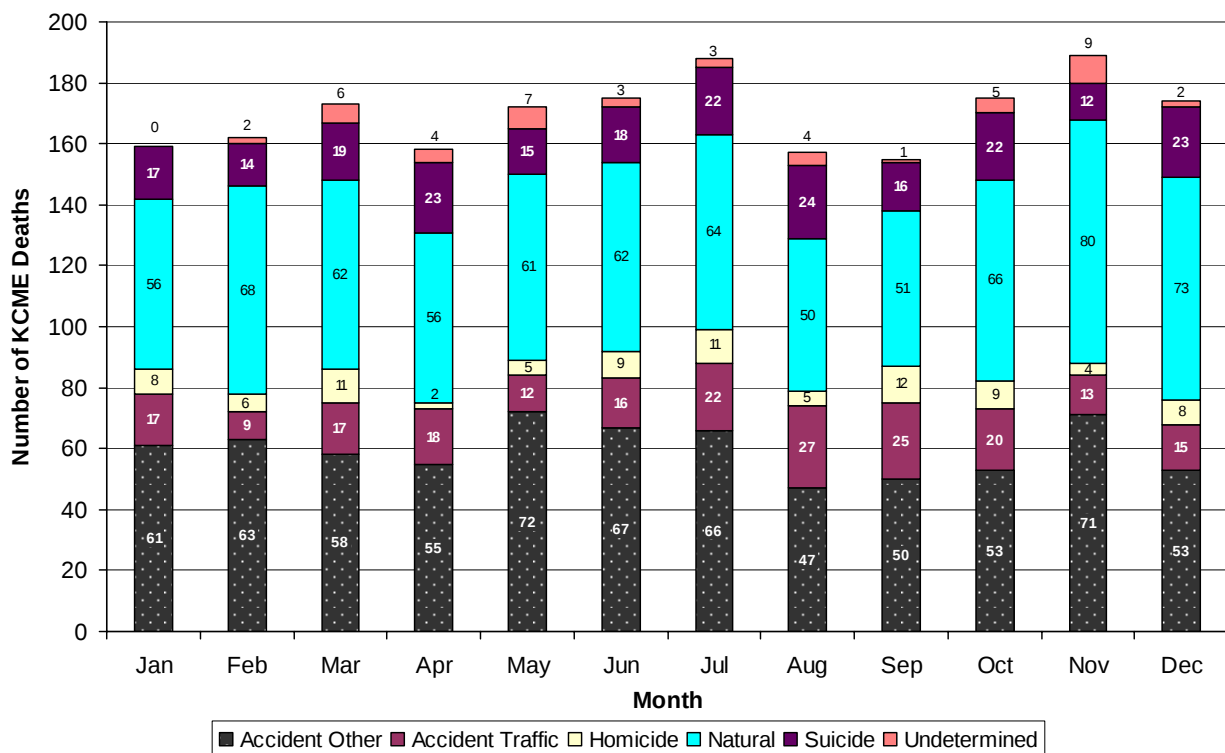
Graph 1-6 Month / Manner of Death / King County Medical Examiner / 2006¹⁵A = Accident (Non-Traffic), T = Traffic, H = Homicide, N = Natural, S = Suicide, U = Undetermined.

Table 1-8 **Nearest Incorporated City to the Fatal Incident / KCME / 2006¹⁶**

CITY	MANNER OF DEATH					TOTAL	%
	A	T	H	S	U		
Algona	0	0	0	0	0	0	0%
Auburn	33	17	0	12	1	63	4.8%
Beaux Arts	0	0	0	0	0	0	0%
Bellevue	31	9	4	12	1	57	4.4%
Black Diamond	1	2	0	1	0	4	0.3%
Bothell	16	2	0	2	0	20	1.5%
Burien	13	0	3	3	2	21	1.6%
Carnation	1	1	0	1	0	3	0.2%
Clyde Hill	0	0	0	0	0	0	0%
Covington	1	2	0	1	0	4	0.3%
Des Moines	6	0	0	5	0	11	0.8%
Duvall	0	3	0	1	0	4	0.3%
Enumclaw	11	2	0	2	1	16	1.2%
Fall City	1	0	0	0	0	1	0.1%
Federal Way	17	2	3	12	1	35	2.7%
Hunt's Point	0	0	0	0	0	0	0%
Issaquah	8	3	0	7	0	18	1.4%
Kenmore	6	0	0	1	0	7	0.5%
Kent	30	9	4	14	3	60	4.6%
Kirkland	22	0	6	7	1	36	2.8%
Lake Forest Park	1	0	0	0	0	1	0.1%
Maple Valley	8	1	1	3	1	14	1.1%
Medina	1	0	0	0	0	1	0.1%
Mercer Island	4	0	0	1	0	5	0.4%
Milton	0	0	0	0	0	0	0%
Newcastle	0	0	0	1	0	1	0.1%
Normandy Park	0	0	0	0	0	0	0%
North Bend	4	4	0	3	1	12	0.9%
Pacific	2	0	0	1	0	3	0.2%
Ravensdale	1	2	1	2	0	6	0.5%

¹⁶Table does not include cases where manner of death is classified "Natural." A = Accident (Non-Traffic), T = Traffic, H = Homicide, S = Suicide, U = Undetermined.

Table 1-8 Nearest Incorporated City to the Fatal Incident / KCME / 2006¹⁷ (continued)

CITY	MANNER OF DEATH					Total	%
	A	T	H	S	U		
Redmond	6	3	0	3	0	12	0.9%
Renton	31	8	5	15	3	62	4.8%
Sammamish	4	0	0	0	0	4	0.3%
SeaTac	4	3	3	2	0	12	0.9%
Seattle	322	59	33	89	29	532	40.8%
Shoreline	9	4	2	4	0	19	1.5%
Skykomish	1	3	0	0	0	4	0.3%
Snoqualmie	1	2	0	3	0	6	0.5%
Tukwila	3	3	1	2	2	11	0.8%
Vashon Island	4	0	0	2	0	6	0.5%
Woodinville	2	0	0	0	0	2	0.2%
Yarrow Point	2	0	0	0	0	2	0.2%
Unincorporated King County	0	0	11	0	0	11	0.8%
Outside of King County	114	66	14	15	5	214	16.4%
Unknown Location	0	1	0	0	2	3	0.2%
Totals	721	211	91	227	53	1,303	100%

¹⁷A = Accident (Non-Traffic), T = Traffic, H = Homicide, S = Suicide, U = Undetermined.

OUT OF COUNTY CASES IN 2006

Within King County are several major hospitals and a major trauma center that serve the entire Pacific Northwest and the western United States. Consequently, there are numerous deaths each year where the incident leading to death occurred outside of King County. However, because the death occurred within King County, it comes under the jurisdiction of the King County Medical Examiner. In 2006 there were 217 deaths (17%, 217/1,303) where the incident (excluding deaths classified as “Natural”) occurred out of county. Table 1-9 displays these deaths by incident location and manner.

Table 1-9 Fatal Incident Occurred Outside of King County / KCME / 2006¹⁸

INCIDENT LOCATION	MANNER OF DEATH					TOTAL
	A	T	H	S	U	
Alaska	5	0	0	0	0	5
Idaho	1	0	0	1	0	2
Montana	2	1	0	0	0	3
Oregon	3	0	0	0	0	3
Other States	2	0	1	0	0	3
Washington						
Kitsap County	18	6	1	2	0	27
Pierce County	12	2	2	0	1	17
Skagit County	3	5	1	1	0	10
Snohomish County	24	18	3	4	0	49
Thurston County	2	3	0	2	1	8
Other WA Counties	42	27	6	5	3	83
Washington Sub-Total	101	61	13	14	5	194
Out of Country	0	4	0	0	0	4
Unknown	0	1	0	0	2	3
Totals	114	67	14	15	7	217

¹⁸Table does not include cases where manner of death is classified as “Natural.” A = Accident (Non-Traffic), T = Traffic, H = Homicide, S = Suicide, U = Undetermined.

TEN YEAR PERSPECTIVE

This section provides a ten-year perspective on deaths that the Medical Examiner investigated and variation in data from year to year.

Approximately 68% (8,791/12,966¹) of the deaths that occurred in 2006 in King County were reported to the Medical Examiner. The Medical Examiner's Office, however, did not assume responsibility for certification in all of these deaths. In about 76% (6,672/8,791) of these deaths, the Medical Examiner did not assume jurisdiction and perform an investigation; instead a "No Jurisdiction Assumed" (NJA) number was assigned. In such instances a physician with knowledge and awareness of the decedent's state of health certified the death. These are primarily natural deaths, with a predominance of individuals in nursing homes with a known fatal disease process. Thus, the Medical Examiner assumed jurisdiction in 16% (2,055/12,966) of deaths that occurred in King County in 2006².

The tables on the following pages attempt to give a perspective on the types of deaths that the Medical Examiner investigates. The tables display data by category and year and provide trends over time. More detailed analysis of 2006 data is provided in separate sections for each manner of death (Accident, Homicide, Natural, Suicide, Traffic, and Undetermined).

¹Death certificates filed in King County, (Vital Statistics, Public Health - Seattle & King County, 2007).

²Does not include non-human remains or anthropology/contract cases.

Table 2-1 Comparison of Manners of Death / KCME / 1996 - 2006

MANNER OF DEATH	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Accident (Other)	435	422	404	441	417	472	485	542	602	721
Accident (Traffic)	216	199	200	203	220	203	179	192	226	211
Homicide	97	90	89	73	74	93	93	76	80	91
Natural	518	530	511	522	619	661	770	765	763	752
Suicide	187	202	221	178	185	200	217	229	233	227
Undetermined	37	63	44	90	63	55	71	59	41	53
Totals	1,490	1,506	1,469	1,507	1,578	1,684	1,815	1,863	1,945	2,055

Table 2-2 Comparison of Manners of Death as Percentage of Total Annual Medical Examiner Cases / KCME / 1996 - 2006

MANNER OF DEATH	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
	%	%	%	%	%	%	%	%	%	%
Accident (Other)	29.2	28.0	27.5	29.3	26.5	28.0	26.8	29.1	31.0	35.1
Accident (Traffic)	14.5	13.2	13.6	13.5	13.9	12.1	9.9	10.3	11.6	10.3
Homicide	6.5	6.0	6.1	4.8	4.7	5.5	5.1	4.1	4.1	4.4
Natural	35.2	35.2	34.8	34.6	39.2	39.3	42.4	41.0	39.2	36.6
Suicide	12.6	13.4	15.0	11.8	11.7	11.9	11.9	12.3	12.0	11.0
Undetermined	2.5	4.2	3.0	6.0	4.0	3.2	3.9	3.2	2.1	2.6
Totals	1,490	1,506	1,469	1,507	1,578	1,684	1,815	1,863	1,945	2,055

Graph 2-1 Comparison of Manners of Death / King County Medical Examiner / 1997 - 2006

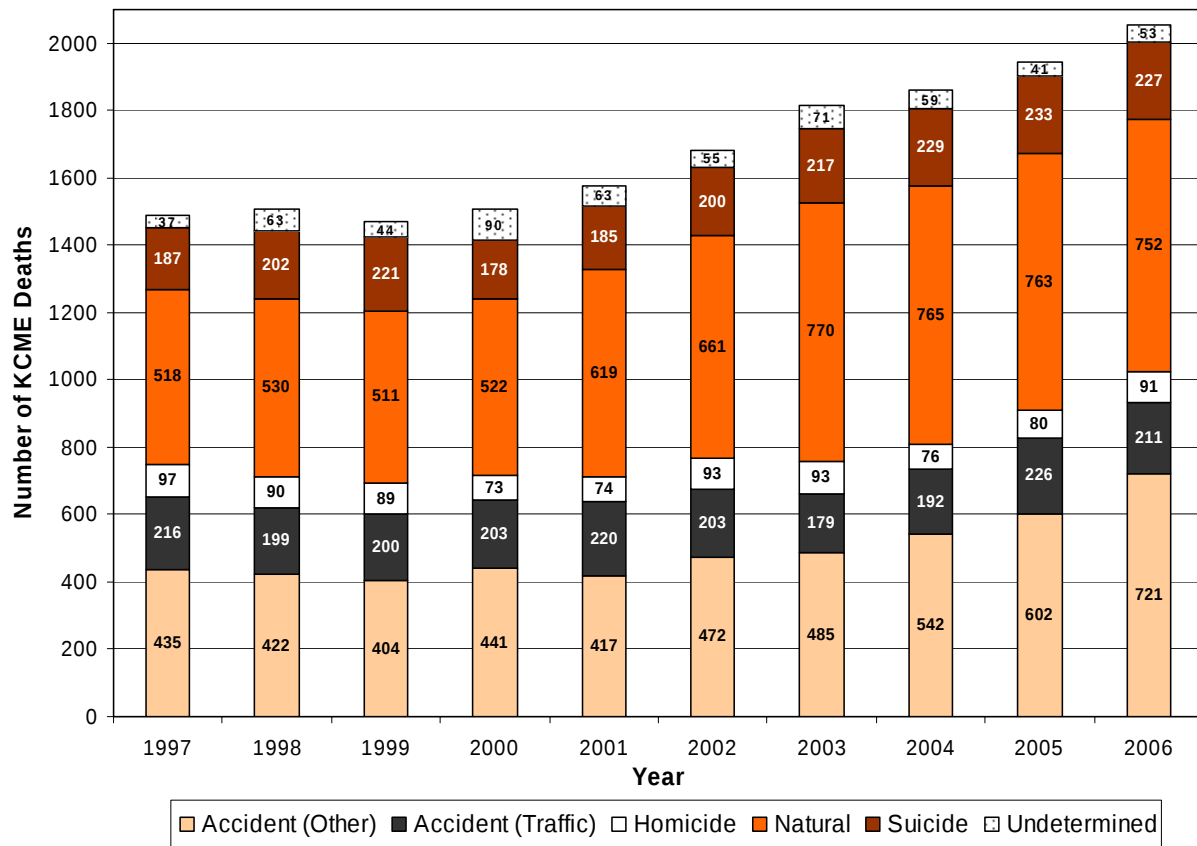


Table 2-3 Ten-Year Perspective of Homicidal Methods / KCME / 1997 - 2006

METHOD USED	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Blunt Force (#)	16	10	9	12	14	14	14	10	12	16
Blunt Force (%)	16%	11%	10%	16%	19%	15%	15%	13%	15%	18%
Firearms (#)	52	55	52	39	43	53	52	46	47	52
Firearms (%)	54%	61%	58%	53%	58%	57%	56%	61%	59%	57%
Hom. Violence (#)	0	0	0	0	0	2	3	3	2	0
Hom. Violence (%)	0%	0%	0%	0%	0%	2%	3%	4%	3%	0%
Stabbing (#)	14	15	19	16	8	17	16	10	14	14
Stabbing (%)	14%	16%	21%	22%	11%	18%	17%	13%	17%	15%
Strangulation (#)	6	5	3	2	3	3	5	1	4	1
Strangulation (%)	6%	6%	3%	3%	4%	3%	6%	1%	5%	1%
Other (#)	9	5	6	4	6	4	3	6	1	8
Other (%)	9%	6%	7%	6%	8%	5%	3%	8%	1%	9%
Totals	97	90	89	73	74	93	93	76	80	91

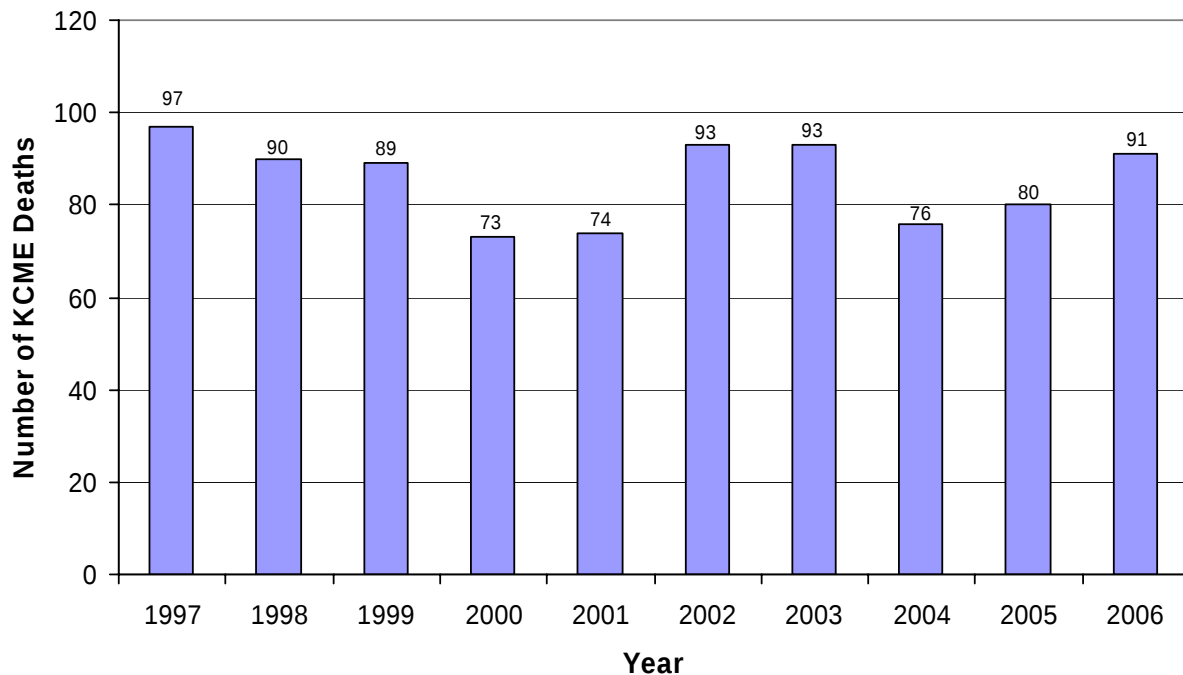
Graph 2-2 Homicide Deaths / King County Medical Examiner / 1997 - 2006

Table 2-4 Ten Year Perspective of Suicidal Injury Modes / KCME / 1997 - 2006

INJURY MODE	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Asphyxia / Plastic Bag	3	6	2	6	9	5	8	7	5	11
Burns / Fire / Heat	0	1	3	1	1	2	1	1	3	3
Carbon Monoxide	14	14	11	5	9	17	12	8	13	11
Drowning	4	3	2	0	1	2	4	5	0	1
Drugs / Poisons	23	29	35	31	21	23	35	41	39	36
Firearms	99	95	106	87	85	98	101	95	96	98
Hanging	28	37	39	31	38	32	36	44	42	31
Incised Wounds / Stabbing	6	3	7	7	9	4	6	8	9	5
Jumped	10	9	15	8	11	14	11	15	22	26
Other	0	5	1	2	1	3	3	5	4	5
Totals	187	202	221	178	185	200	217	229	233	227

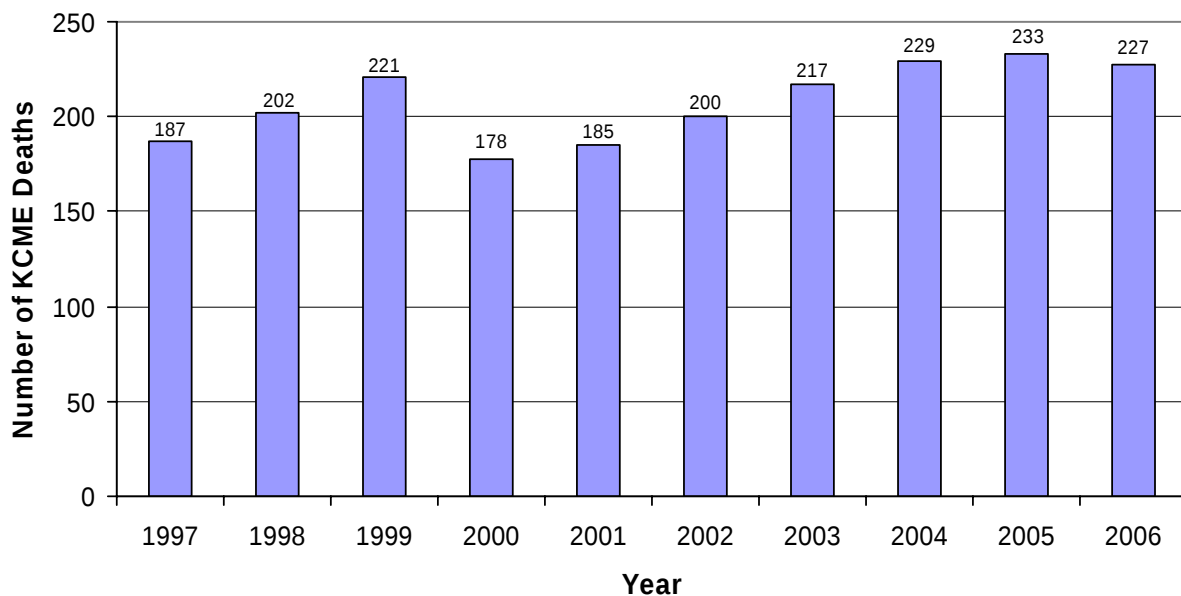
Graph 2-3 Suicide Deaths / King County Medical Examiner / 1997 – 2006

Table 2-5 Traffic Fatality Circumstances / KCME / 1997 - 2006

CIRCUMSTANCES	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Vehicle Driver	88	85	97	90	93	99	75	78	99	92
Vehicle Passenger	58	47	47	52	56	46	36	54	47	44
Vehicle (Undetermined)	0	0	0	2	2	1	2	1	1	5
Bicyclist	9	6	6	8	7	3	3	5	6	8
Motorcycle Driver	14	18	17	9	21	17	21	23	33	27
Motorcycle Passenger	2	2	1	4	0	0	3	0	3	1
Pedestrian	39	40	32	32	40	34	38	30	36	33
Other	6	1	0	6	1	3	1	1	1	1
Totals	216	199	200	203	220	203	179	192	226	211

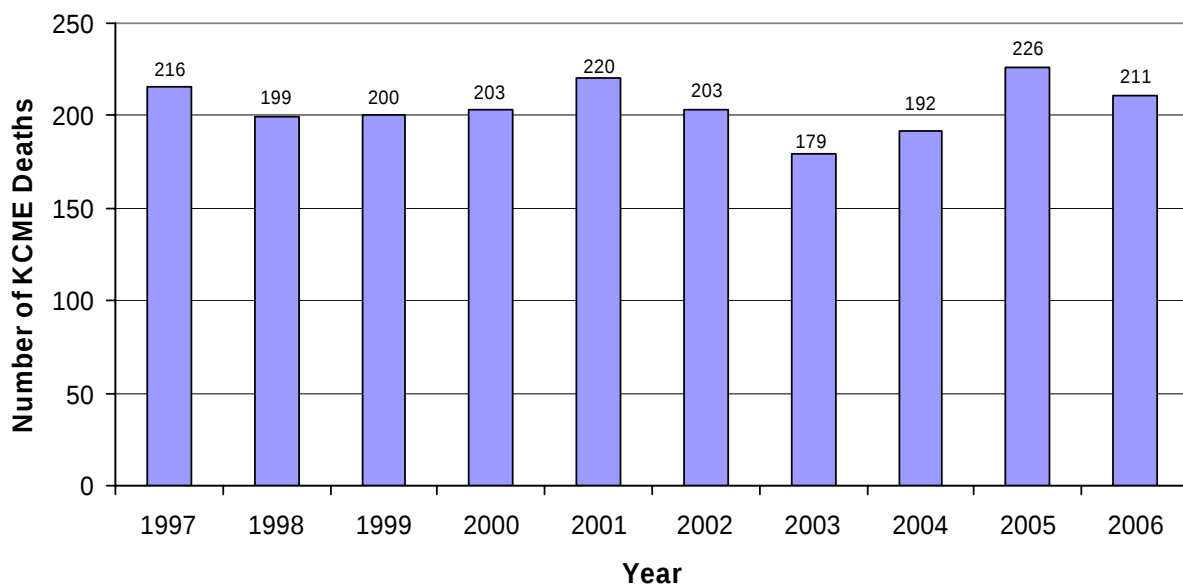
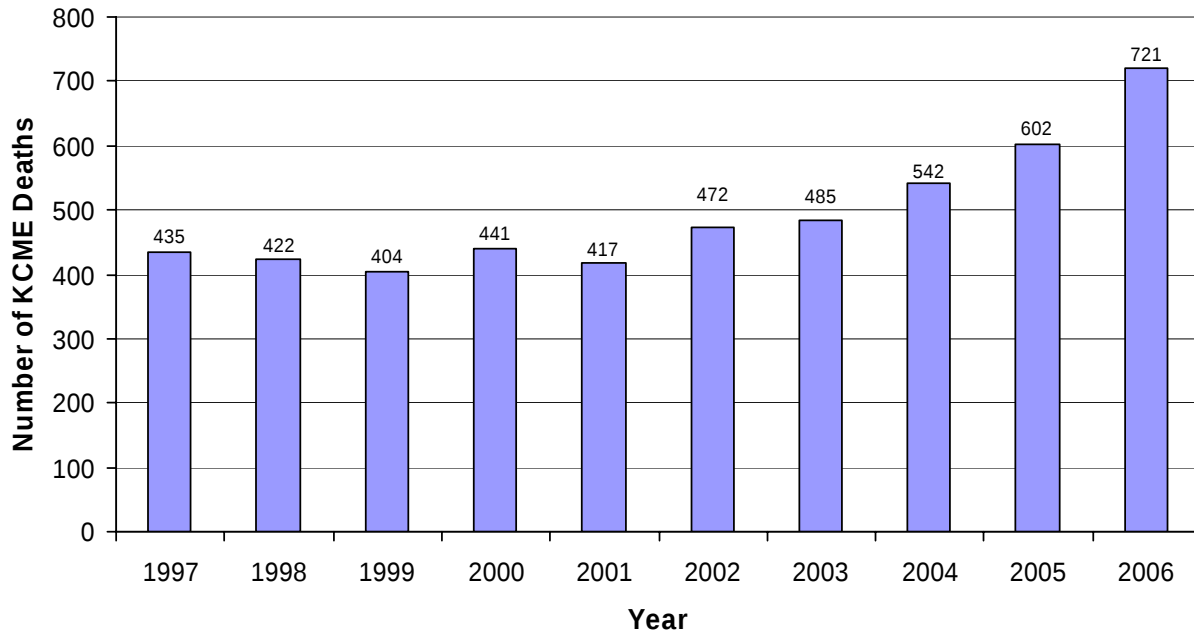
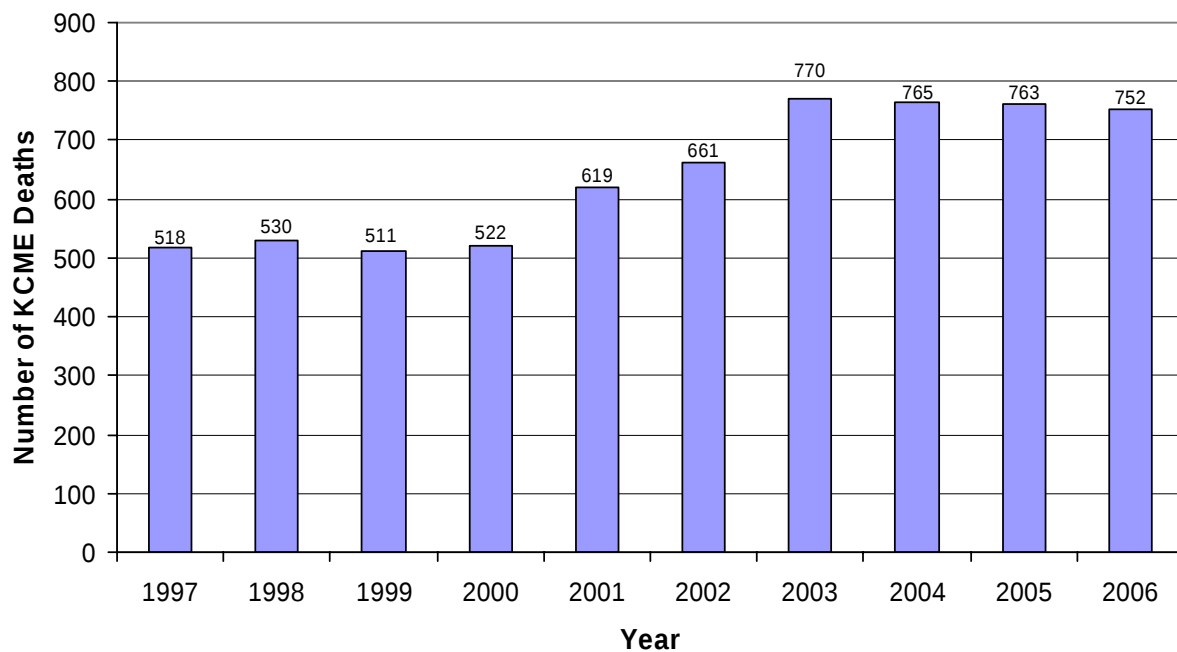
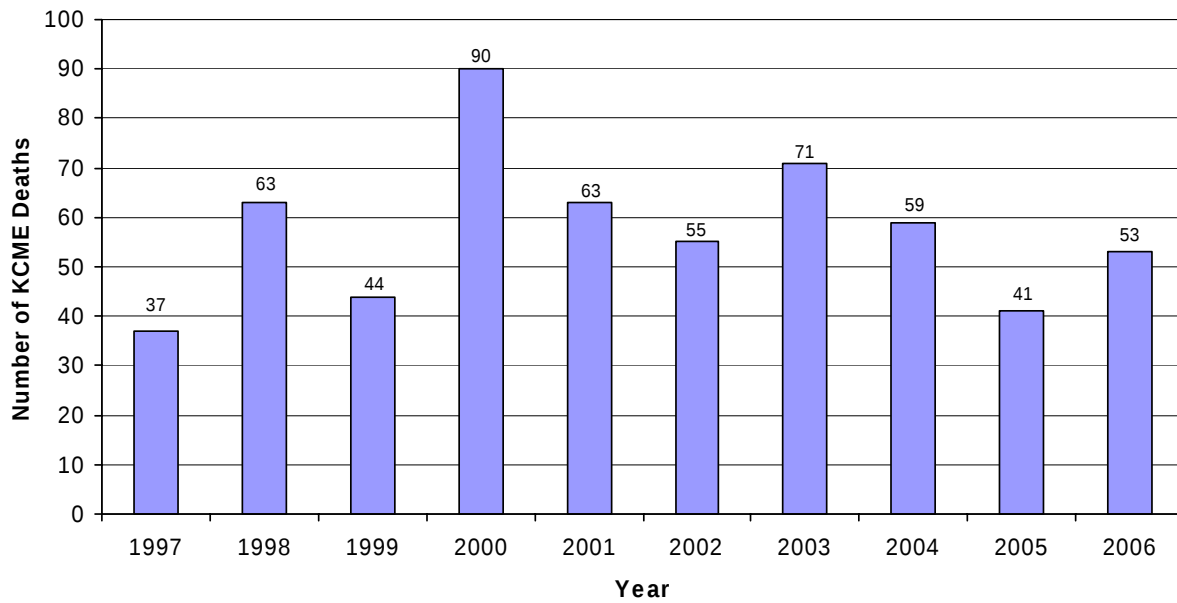
Graph 2-4 Traffic Fatalities / King County Medical Examiner / 1997 – 2006

Table 2-6 **Ten Year Perspective of Non-Traffic Accidental Death Circumstances / KCME / 1997 - 2006**

CIRCUMSTANCES	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Aircraft	3	1	3	3	1	0	0	2	3	3
Asphyxia	2	11	7	7	10	7	4	2	9	12
Aspiration	5	4	1	7	5	5	9	8	10	9
Blunt Force / Crushing	3	8	0	11	7	12	9	8	10	4
Burns / Fire	25	25	25	23	29	22	19	24	26	23
Carbon Monoxide	2	0	0	1	5	0	1	3	4	8
Complication of Therapy	10	10	11	16	17	24	22	18	45	31
Drowning	34	24	23	23	35	32	27	17	19	30
Drugs / Poisons	156	179	164	177	122	173	160	211	216	262
Electrocution	0	1	0	3	1	2	0	2	1	2
Explosion	2	2	2	0	1	0	0	4	1	1
Fall	165	138	147	149	157	171	207	213	230	308
Firearms	1	0	0	0	0	0	1	1	2	0
Hanging	1	0	0	4	0	1	0	2	2	0
Hypothermia	3	5	0	0	8	6	2	2	4	4
Struck by Object	7	6	6	2	5	2	8	7	1	8
Struck by Train	1	1	0	4	3	2	0	3	1	0
Vehicular Non-Traffic	7	3	8	6	6	8	14	10	8	9
Other	8	5	7	5	5	5	2	5	10	7
Totals	435	422	404	441	417	472	485	542	602	721

Graph 2-5 Accidental Deaths / King County Medical Examiner / 1997 – 2006**Graph 2-6 Natural Deaths / King County Medical Examiner / 1997 – 2006**

Graph 2-7 Deaths of Undetermined Manner / King County Medical Examiner / 1997 – 2006



Manner: ACCIDENT

The Medical Examiner certified 721 deaths as non-traffic accidents for the calendar year 2006. The largest group of accidental deaths was those who died as a result of a fall, 43% (308/721). Of the 308 deaths attributed to injury sustained in falls, 75% (232/308) occurred in the age group 70 years and over. A large percentage of these falls were ground-level falls in elderly individuals, which resulted in fractures leading to complications such as pneumonia.

The second largest group of non-traffic accidental deaths was individuals who died as a result of accidental overdoses of drugs and/or poisons, representing 36% (262/721). By age, the largest percentage of these accidental drug deaths, 31% (82/262), occurred among adults between 50-59 years. The second largest group, 29% (76/262), included adults between the ages of 40-49. Seventeen percent (44/262) were adults between 30-39 years of age. Six accidental drug deaths were between the ages of 16-19 years, one was in the age group 13 – 15 years, and one accidental drug death occurred in an infant under one year of age.

The 2006 drug rate number (262) represents a 21% increase compared to the 216 accidental drug deaths in 2005. A more detailed discussion of these deaths is presented in the section "Death Due to Drugs and Poisons" on page 83 and 84.

Twenty-three (23) deaths resulted from fire or thermal injury, a decrease from 26 in 2005 and 24 in 2004. Of the 23 fire-related deaths, 35% (8/23) were the result of accidents that occurred outside of King County. The injured were transported to Harborview Medical Center's Burn Intensive Care Unit where they died.

Another category of accidental deaths worthy of comment is death resulting from drowning. There were 30 drowning deaths in 2006, as compared to 19 drowning deaths in 2005, 17 in 2004, 27 in 2003, and 32 in 2002.

A comment is necessary to clarify the cause of death listed as "aspiration." This type of death results from a person choking on a foreign object, often a bolus of food while eating. In 2006 there were nine (9) deaths due to aspiration of a foreign body compared to ten (10) in 2005, eight (8) in 2004, nine (9) in 2003, and five (5) in 2002.

Of the 721 accidental deaths in 2006, 16% (114/721) were the result of incidents which occurred outside of King County, but the death took place within King County. These deaths were the result of the injured being transported from outside King County to medical facilities within King County where they died. Since these deaths occurred in King County, they fall under King County Medical Examiner jurisdiction.

A special subset of deaths designated "Complication of Therapy" has been incorporated in the statistical analyses of Accidental deaths but warrants special mention because of an apparent upward trend in incidence and increased public interest. A Complication of Therapy is defined as a death that arises as a predictable consequence of appropriate medical therapy. Circumstances that are excluded from this category include falls and mechanical injuries in hospitals, inadvertent misadministration of drugs, wrong-sided surgeries, and wholly unexpected procedure related injuries, etc.

For example, the manner of death in the case of a person with no known drug allergies and a minor infection who is administered an appropriate dose of penicillin but subsequently develops a fatal allergic reaction to the drug and dies would be Complication of Therapy. Contrast this example with the case of a hospital patient who is written a proper prescription for a heart medication but is administered an overdose of the medication by a healthcare provider, and the manner of death would be Accident, not Complication of Therapy.

It is important to note that the classification of a death as a Complication of Therapy is a non-judgmental means by which the inherent risk of medical therapies can be recognized and tracked. By no means is Complication of Therapy synonymous with malpractice or negligence.

Complication of Therapy deaths have increased in the previous ten years, from ten (10) in 1997 to 31 in 2006 (see table on p. 27, Ten Year Perspective of Non-Traffic Accidental Death Circumstances) and can be divided into three general categories: drug-related, consequence of medical procedure, and consequence of surgery. Drug-related includes anaphylactic/allergic reaction, hemorrhagic complications of anticoagulants, anesthesia related events, and other adverse drug reactions. Consequence of medical procedure refers to complications from procedures that are therapeutic or diagnostic but do not meet the criteria for surgery, such as placement of catheters, penetration of body cavities by needles, or manipulation of body regions, etc. Consequence of surgery refers to direct anatomic damage during a procedure and usually involves a diseased organ system, such as perforation of a viscus or vessel or hemorrhagic complications of surgery.

For 2006, there were 31 deaths classified as Complication of Therapy. Graph 3-4 shows the Complication of Therapy deaths by general category and Graph 3-5 further divides the general category of Surgical Injury into "type of surgery" and "comorbidity" (comorbidity is defined as the coexistence of significant natural disease).

There may be multiple reasons for this apparent upward trend in the incidence of Complications of Therapy over the last ten years but the most important factor is probably the rate at which non-natural deaths are reported to the KCMEO. The medical examiner is dependent on clinical providers to report deaths that may have been a consequence of medical therapy. Recognition of the importance of identifying and reporting these deaths by the medical community has surged since the Institute of Medicine of the National Academy of Sciences published a report in 1999 that estimated that up to 98,000 preventable deaths may occur each year in the United States due to medical errors. The subsequent public interest and efforts by the healthcare system to address issues of patient safety may be resulting in a greater percentage of these cases being reported to the medical examiner.

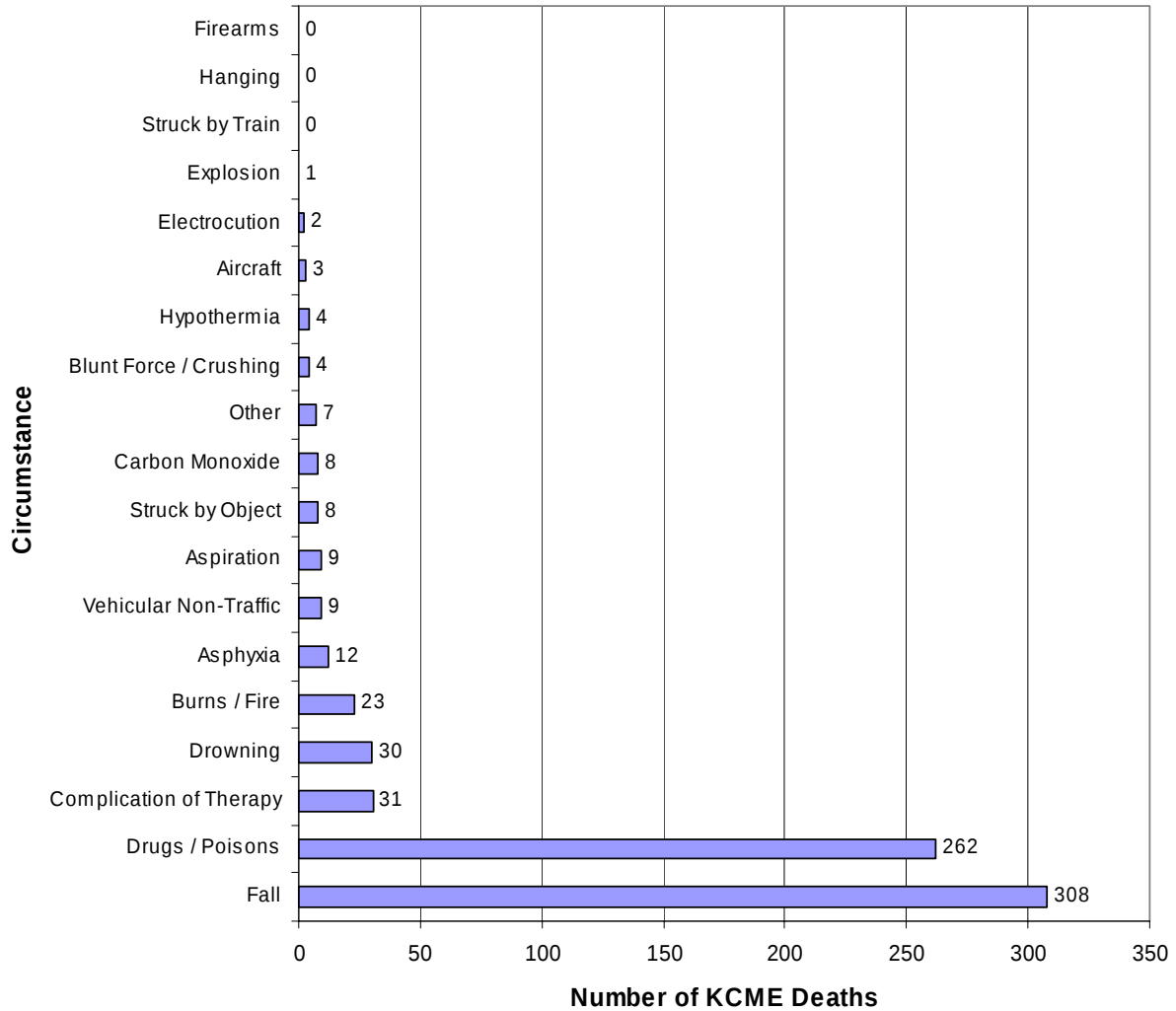
Graph 3-1 Circumstances of Accidental Death / King County Medical Examiner / 2006

Table 3-1 Circumstances of Accidental Death / Race / Sex / KCME / 2006

CIRCUMSTANCES / SEX	RACE					SUB TOTAL	TOTAL
	WHITE	BLACK	ASIAN	NATIVE AMERICAN	OTHE R		
Aircraft	1	2	0	0	0		3
Male	1	2	0	0	0	3	
Female	0	0	0	0	0	0	
Asphyxia (compressional / positional / mechanical)	11	1	0	0	0		12
Male	10	0	0	0	0	10	
Female	1	1	0	0	0	2	
Aspiration	8	0	1	0	0		9
Male	5	0	0	0	0	5	
Female	3	0	1	0	0	4	
Blunt Force / Crushing	4	0	0	0	0		4
Male	4	0	0	0	0	4	
Female	0	0	0	0	0	0	
Burns / Fire	18	1	2	2	0		23
Male	9	1	0	2	0	12	
Female	9	0	2	0	0	11	
Carbon Monoxide	4	0	4	0	0		8
Male	4	0	3	0	0	7	
Female	0	0	1	0	0	1	
Complication of Therapy	28	1	2	0	0		31
Male	13	0	1	0	0	14	
Female	15	1	1	0	0	17	
Drowning	18	6	5	0	1		30
Male	13	6	3	0	1	23	
Female	5	0	2	0	0	7	
Drugs / Poisons	204	46	3	9	0		262
Male	137	34	3	6	0	180	
Female	67	12	0	3	0	82	
Electrocution	2	0	0	0	0		2
Male	2	0	0	0	0	2	
Female	0	0	0	0	0	0	
Explosion	1	0	0	0	0		1
Male	1	0	0	0	0	1	
Female	0	0	0	0	0	0	
Fall	283	8	13	4	0		308
Male	140	7	6	2	0	155	
Female	143	1	7	2	0	153	

Table 3-1 Circumstances of Accidental Death / Race / Sex / KCME / 2006 (continued)

CIRCUMSTANCES / SEX	RACE					SUB TOTAL	TOTAL
	WHITE	BLACK	ASIAN	NATIVE AMERICAN	OTHE R		
Firearms	0	0	0	0	0		0
<i>Male</i>	0	0	0	0	0	0	
<i>Female</i>	0	0	0	0	0	0	
Hanging	0	0	0	0	0		0
<i>Male</i>	0	0	0	0	0	0	
<i>Female</i>	0	0	0	0	0	0	
Hypothermia	4	0	0	0	0		4
<i>Male</i>	2	0	0	0	0	2	
<i>Female</i>	2	0	0	0	0	2	
Struck by Object	8	0	0	0	0		8
<i>Male</i>	8	0	0	0	0	8	
<i>Female</i>	0	0	0	0	0	0	
Struck by Train	0	0	0	0	0		0
<i>Male</i>	0	0	0	0	0	0	
<i>Female</i>	0	0	0	0	0	0	
Vehicular Non-Traffic	7	1	0	0	1		9
<i>Male</i>	5	1	0	0	1	7	
<i>Female</i>	2	0	0	0	0	2	
Other	7	0	0	0	0		7
<i>Male</i>	5	0	0	0	0	5	
<i>Female</i>	2	0	0	0	0	2	
Totals	608	66	30	15	2		721
Percent	84.3%	9.2%	4.1%	2.1%	0.3%		100%

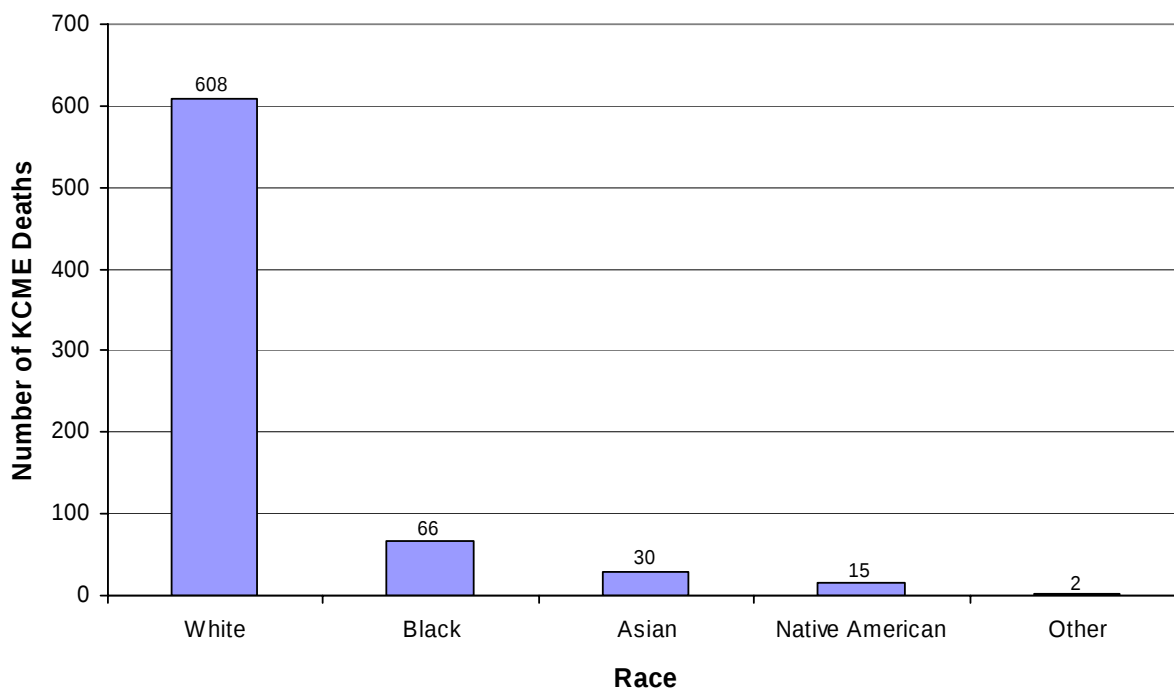
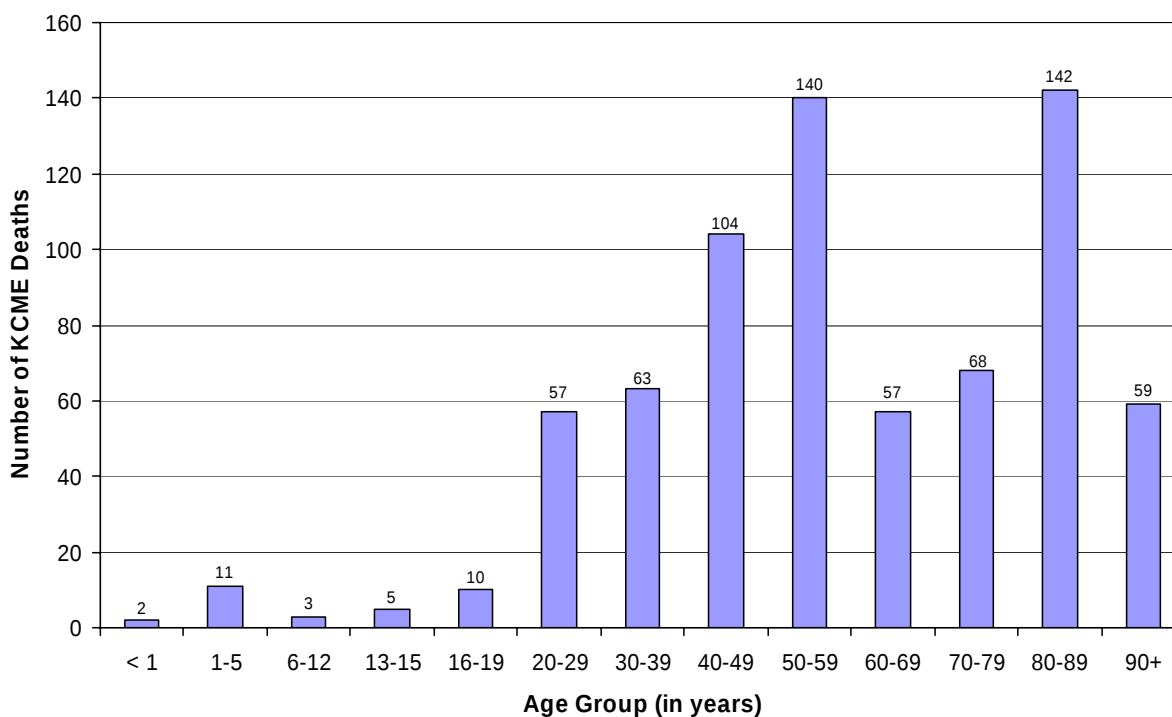
Graph 3-2 Accidental Deaths / Race / King County Medical Examiner / 2006**Graph 3-3 Accidental Deaths / Age Group / King County Medical Examiner / 2006**

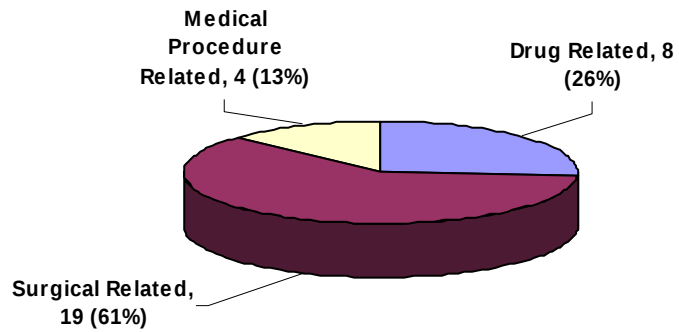
Table 3-2 Circumstances of Accidental Death / Age / Sex / KCME / 2006

CIRCUMSTANCES / SEX	AGE GROUP (YEARS)													SUB TOTAL	TOTAL
	< 1	1 to 5	6 to 12	13 to 15	16 to 19	20 to 29	30 to 39	40 to 49	50 to 59	60 to 69	70 to 79	80 to 89	90 +		
Aircraft	0	0	0	0	0	1	2	0	0	0	0	0	0		3
Male	0	0	0	0	0	1	2	0	0	0	0	0	0	3	
Female	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Asphyxia (compress/positional/mech)	1	0	0	0	1	1	1	0	2	1	2	1	2		12
Male	1	0	0	0	1	1	1	0	2	1	2	1	0	10	
Female	0	0	0	0	0	0	0	0	0	0	0	0	2	2	
Aspiration	0	0	0	0	0	1	0	1	1	1	1	4	0		9
Male	0	0	0	0	0	1	0	0	1	1	0	2	0	5	
Female	0	0	0	0	0	0	0	1	0	0	1	2	0	4	
Blunt Force / Crushing	0	0	0	0	0	0	0	0	4	0	0	0	0		4
Male	0	0	0	0	0	0	0	0	4	0	0	0	0	4	
Female	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Burns / Fire	0	2	0	0	0	2	1	2	5	3	4	4	0		23
Male	0	0	0	0	0	2	0	1	4	1	3	1	0	12	
Female	0	2	0	0	0	0	1	1	1	2	1	3	0	11	
Carbon Monoxide	0	0	0	1	0	2	2	2	0	0	1	0	0		8
Male	0	0	0	1	0	2	2	1	0	0	1	0	0	7	
Female	0	0	0	0	0	0	0	1	0	0	0	0	0	1	
Complication of Therapy	0	2	0	0	2	3	3	2	5	5	6	2	1		31
Male	0	0	0	0	1	0	1	0	3	3	3	2	1	14	
Female	0	2	0	0	1	3	2	2	2	2	3	0	0	17	
Drowning	0	1	3	2	1	7	4	4	4	1	2	1	0		30
Male	0	1	3	1	1	6	2	3	4	1	1	0	0	23	
Female	0	0	0	1	0	1	2	1	0	0	1	1	0	7	
Drugs / Poisons	1	0	0	1	6	32	44	76	82	18	2	0	0		262
Male	0	0	0	1	6	25	29	51	54	13	1	0	0	180	
Female	1	0	0	0	0	7	15	25	28	5	1	0	0	82	
Electrocution	0	0	0	0	0	1	0	0	1	0	0	0	0		2
Male	0	0	0	0	0	1	0	0	1	0	0	0	0	2	
Female	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Explosion	0	0	0	0	0	0	0	0	0	1	0	0	0		1
Male	0	0	0	0	0	0	0	0	0	1	0	0	0	1	
Female	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Fall	0	0	0	1	0	4	2	14	29	26	48	12 8	56		308
Male	0	0	0	1	0	4	1	9	21	21	29	55	14	155	
Female	0	0	0	0	0	0	1	5	8	5	19	73	42	153	

Table 3-2 Circumstances of Accidental Death / Age / Sex / KCME / 2006 (continued)

Circumstance / Sex	AGE GROUP (YEARS)													SUB TOTAL TOTAL	
	< 1	1 to 5	6 to 12	13 to 15	16 to 19	20 to 29	30 to 39	40 to 49	50 to 59	60 to 69	70 to 79	80 to 89	90 +		
Firearms	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Male	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Female	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Hanging	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Male	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Female	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Hypothermia	0	0	0	0	0	0	1	1	1	0	0	1	0	4	
Male	0	0	0	0	0	0	0	1	1	0	0	0	0	2	
Female	0	0	0	0	0	0	1	0	0	0	0	1	0	2	
Struck by Object	0	1	0	0	0	1	2	0	3	1	0	0	0	8	
Male	0	1	0	0	0	1	2	0	3	1	0	0	0	8	
Female	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Struck by Train	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Male	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Female	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Vehicular Non-Traffic	0	4	0	0	0	1	1	1	0	0	1	1	0	9	
Male	0	3	0	0	0	1	1	1	0	0	0	1	0	7	
Female	0	1	0	0	0	0	0	0	0	0	1	0	0	2	
Other	0	1	0	0	0	1	0	1	3	0	1	0	0	7	
Male	0	1	0	0	0	1	0	1	2	0	0	0	0	5	
Female	0	0	0	0	0	0	0	0	1	0	1	0	0	2	
Totals	2	11	3	5	10	57	63	104	140	57	68	142	59	721	
Percent	0.3	1.5	0.4	0.7	1.4	7.9	8.7	14.5	19.4	7.9	9.4	19.7	8.2	100%	

Graph 3-4 Complication of Therapy / General Categories / KCME / 2006



Graph 3-5 Complication of Therapy / Surgical Injuries / KCME / 2006

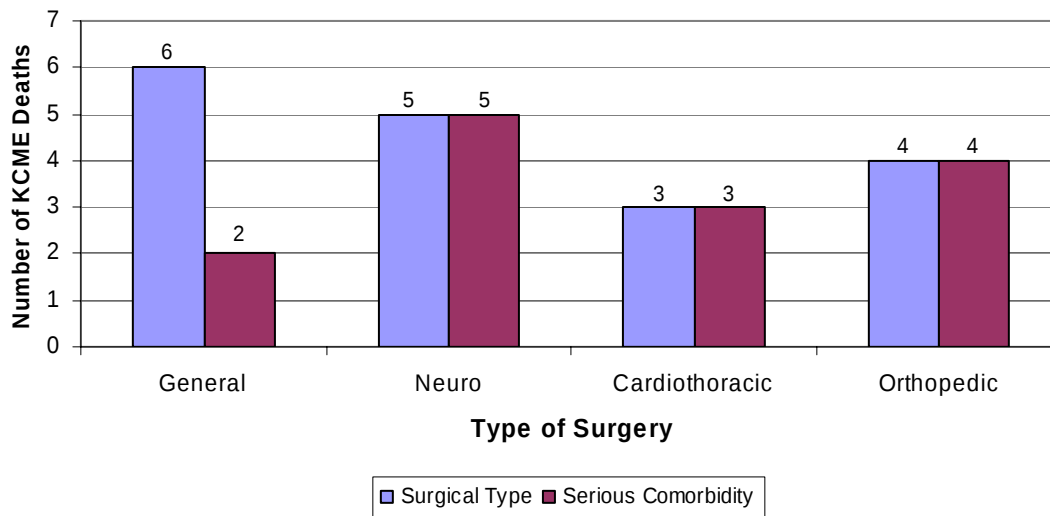


Table 3-3 Circumstances of Accidental Death / Sex / KCME / 2006

CIRCUMSTANCES	SEX		TOTAL
	MALE	FEMALE	
Aircraft	3	0	3
Asphyxia (compressional / positional / mechanical)	10	2	12
Aspiration	5	4	9
Blunt Force / Crushing	4	0	4
Burns / Fire	12	11	23
Carbon Monoxide	7	1	8
Complication of Therapy	14	17	31
Drowning	23	7	30
Drugs / Poisons	180	82	262
Electrocution	2	0	2
Explosion	1	0	1
Fall	155	153	308
Firearms	0	0	0
Hanging	0	0	0
Hypothermia	2	2	4
Struck by Object	8	0	8
Struck by Train	0	0	0
Vehicular Non-Traffic	7	2	9
Other	5	2	7
Totals	438	283	721
Percent	61%	39%	100%

Table 3-4 Circumstances of Accidental Death / Blood Alcohol Results / KCME / 2006

CIRCUMSTANCES	TESTED		NOT TESTED	TOTAL
	TESTED POSITIVE	TESTED NEGATIVE		
Aircraft	0	3	0	3
Asphyxia (compressional/ positional / mechanical)	1	10	1	12
Aspiration	1	4	4	9
Blunt Force / Crushing	0	3	1	4
Burns / Fire	5	13	5	23
Carbon Monoxide	2	6	0	8
Complication of Therapy	0	21	10	31
Drowning	10	15	5	30
Drugs / Poisons	63	190	9	262
Electrocution	0	2	0	2
Explosion	0	0	1	1
Fall	18	94	196	308
Firearms	0	0	0	0
Hanging	0	0	0	0
Hypothermia	1	3	0	4
Struck by Object	0	7	1	8
Struck by Train	0	0	0	0
Vehicular Non-Traffic	1	5	3	9
Other	0	5	2	7
Totals	102	381	238	721
Percent	14%	53%	33%	100%

Manner: HOMICIDE

The Medical Examiner classifies a death as a homicide when the death results from injuries inflicted by another person. The prosecuting attorney may either charge the person responsible for the injuries with murder or manslaughter, or decline to file charges. During 2006, the Medical Examiner classified 91 deaths as homicide. This number represents 4% (91/2,055) of the Medical Examiner death investigations for the calendar year 2006. Of these 91 homicides, 77 were the result of incidents that occurred within King County. For comparison, there were 80 homicides investigated in 2005, of which 72 were incidents in King County. In 2004, 68 of 76 homicides occurred in King County.

The data reflect the weapons or mechanisms responsible for the homicidal deaths in 2006. Firearms were responsible for 57% (52/91), compared to 2005, when 59% (47/80) were due to firearms. Stabbing by a knife or other sharp-edged instrument caused fifteen percent (14/91) of deaths of homicide victims. Blunt force injuries were responsible for eighteen percent (16/91) of the 2006 homicide deaths. There was one (1) death due to strangulation/asphyxia and eight (8) deaths due to other homicidal means.

In 2006, there were six homicide victims under five years of age. There were no homicide victims between 6 - 12 years of age and there were two homicide victims between 13 - 15 years of age. Seven homicide victims were between the ages of 16 and 19 years.

Examining the racial distribution of victims of homicide, 24% (22/91) of the victims were black, compared to 2005, when 32% (26/80) of the victims were black. Whites, while representing 78% of the population, made up 55% (50/91) of the homicide victims. The remaining 21% of homicide victims (19/91) included Asian/Pacific Islanders, Native American, and Other Race. As indicated on page 5, in 17% of the Medical Examiner cases the incident leading to death occurred outside of King County and the decedent was likely not a resident of King County. Therefore, Medical Examiner figures cannot be directly compared to the racial distribution of King County residents (refer to Table 1-9 on page 19).

Males comprised 81% (74/91) and women 19% (17/91) of the homicide victims in 2006. The majority of victims, 68% (62/91), were between the ages of 20 and 49 years. Young people, 19 years old and under, comprised 16% (15/91) of the homicide victims. For comparison, this younger age group represented 16% (13/80) in the year 2004. Ninety-two percent (84/91) of the victims were tested for the presence of alcohol. Of those tested 31% (26/84) showed alcohol present at the time of death.

Of the 91 homicidal deaths in 2006, 85% (77/91) of the fatal incidents occurred within King County, and of these deaths, 33 (36%) occurred within the city limits of Seattle. In fourteen of the 91 homicidal deaths, the incident occurred outside of King County, but death occurred within King County.

The relationship of victim to assailant was not tabulated as part of this report. In order to investigate such associations, additional review of police records would be necessary.

Graph 4-1 Homicide Injury Methods / King County Medical Examiner / 2006

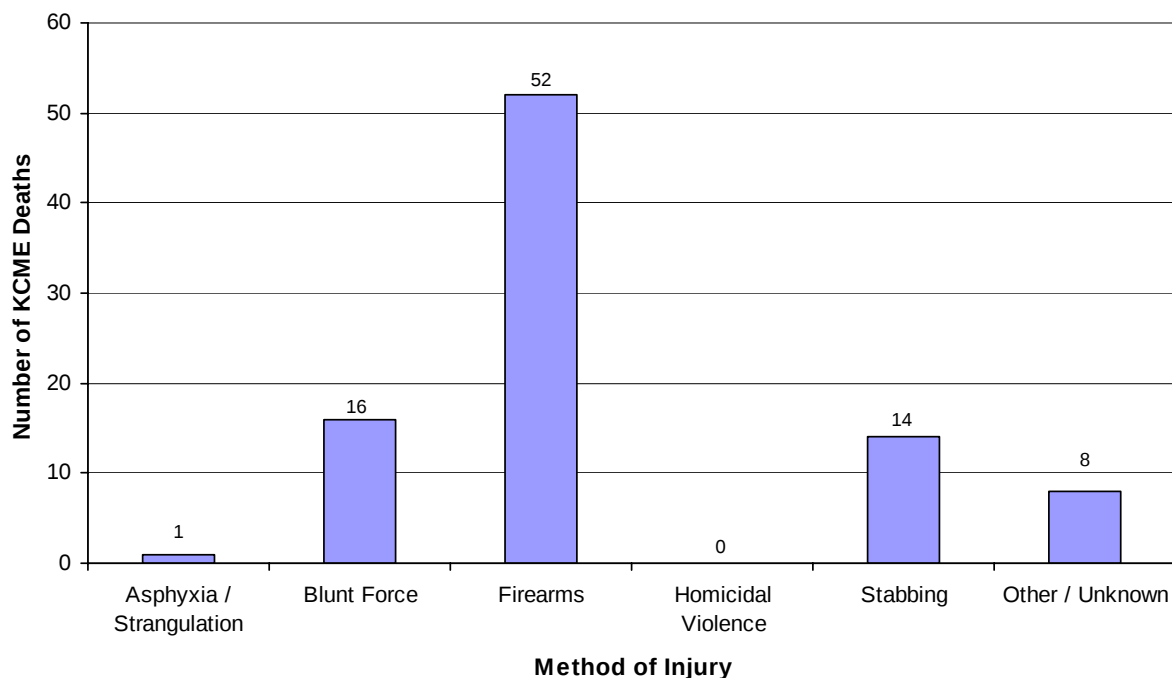


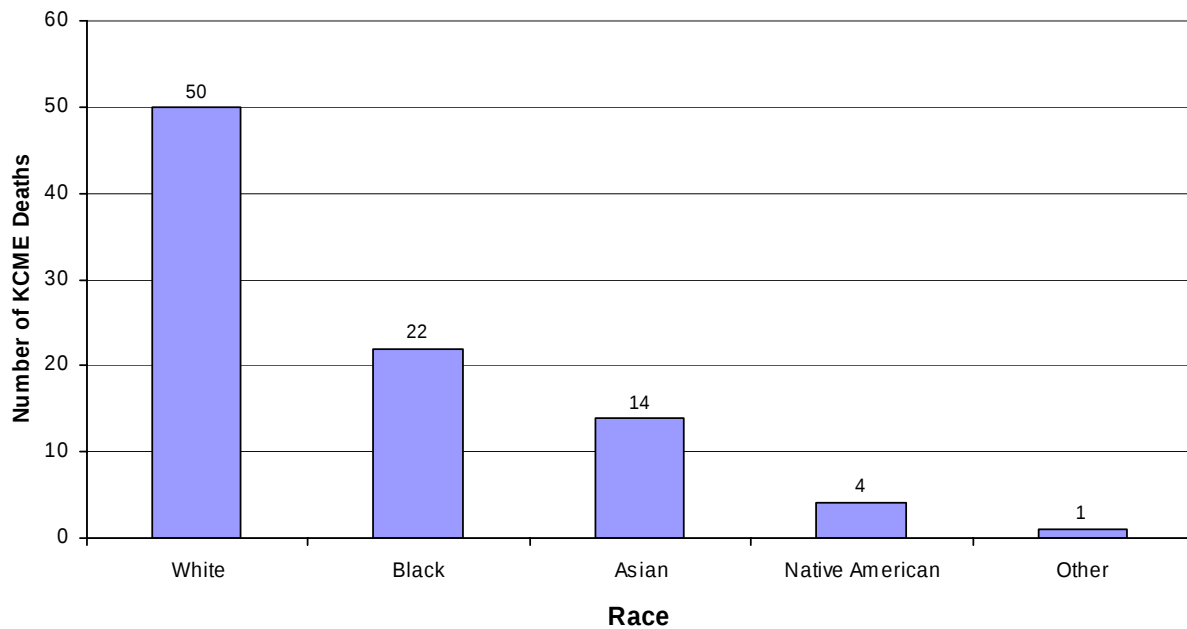
Table 4-1 Homicide Methods / Race / Sex / King County Medical Examiner / 2006

CIRCUMSTANCES / SEX	RACE					SUB TOTAL	TOTAL
	WHITE	BLACK	ASIAN	NATIVE AMERICAN	OTHER		
Asphyxia / Strangulation	1	0	0	0	0		1
<i>Male</i>	0	0	0	0	0	0	
<i>Female</i>	1	0	0	0	0	1	
Blunt Force	8	4	1	2	1		16
<i>Male</i>	6	3	1	2	1	13	
<i>Female</i>	2	1	0	0	0	3	
Firearms	27	11	12	2	0		52
<i>Male</i>	23	11	11	2	0	47	
<i>Female</i>	4	0	1	0	0	5	
Homicidal Violence	0	0	0	0	0		0
<i>Male</i>	0	0	0	0	0	0	
<i>Female</i>	0	0	0	0	0	0	
Stabbing	9	5	0	0	0		14
<i>Male</i>	6	3	0	0	0	9	
<i>Female</i>	3	2	0	0	0	5	
Other / Unknown	5	2	1	0	0		8
<i>Male</i>	3	1	1	0	0	5	
<i>Female</i>	2	1	0	0	0	3	
Totals	50	22	14	4	1		91
Percent	55%	24%	16%	4%	1%		100%

Table 4-2 Homicide Methods / Age / Sex / King County Medical Examiner / 2006

METHOD / SEX	AGE GROUP (YEARS)													SUB TOTAL	TOTAL
	< 1	1 to 5	6 to 12	13 to 15	16 to 19	20 to 29	30 to 39	40 to 49	50 to 59	60 to 69	70 to 79	80 to 89	90 +		
Asphyxia / Strangulation	0	0	0	0	0	0	1	0	0	0	0	0	0		1
Male	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Female	0	0	0	0	0	0	1	0	0	0	0	0	0	1	
Blunt Force	4	0	0	0	0	1	4	3	2	0	0	1	1		16
Male	3	0	0	0	0	1	4	3	2	0	0	0	0	13	
Female	1	0	0	0	0	0	0	0	0	0	0	1	1	3	
Firearms	0	0	0	2	5	23	8	9	3	2	0	0	0		52
Male	0	0	0	0	5	23	8	8	2	1	0	0	0	47	
Female	0	0	0	2	0	0	0	1	1	1	0	0	0	5	
Homicidal Violence	0	0	0	0	0	0	0	0	0	0	0	0	0		0
Male	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Female	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Stabbing	0	2	0	0	0	5	1	5	1	0	0	0	0		14
Male	0	2	0	0	0	2	1	3	1	0	0	0	0	9	
Female	0	0	0	0	0	3	0	2	0	0	0	0	0	5	
Other / Unknown	0	0	0	0	2	0	0	2	3	0	0	1	0		8
Male	0	0	0	0	2	0	0	1	2	0	0	0	0	5	
Female	0	0	0	0	0	0	0	1	1	0	0	1	0	3	
Totals	4	2	0	2	7	29	14	19	9	2	0	2	1		91
Percent	4%	2%	0%	2%	8%	32%	16%	21%	10%	2%	0%	2%	1%		100%

Graph 4-2 Homicide Deaths / Race / King County Medical Examiner / 2006



Graph 4-3 Homicide Deaths / Age Group / King County Medical Examiner / 2006

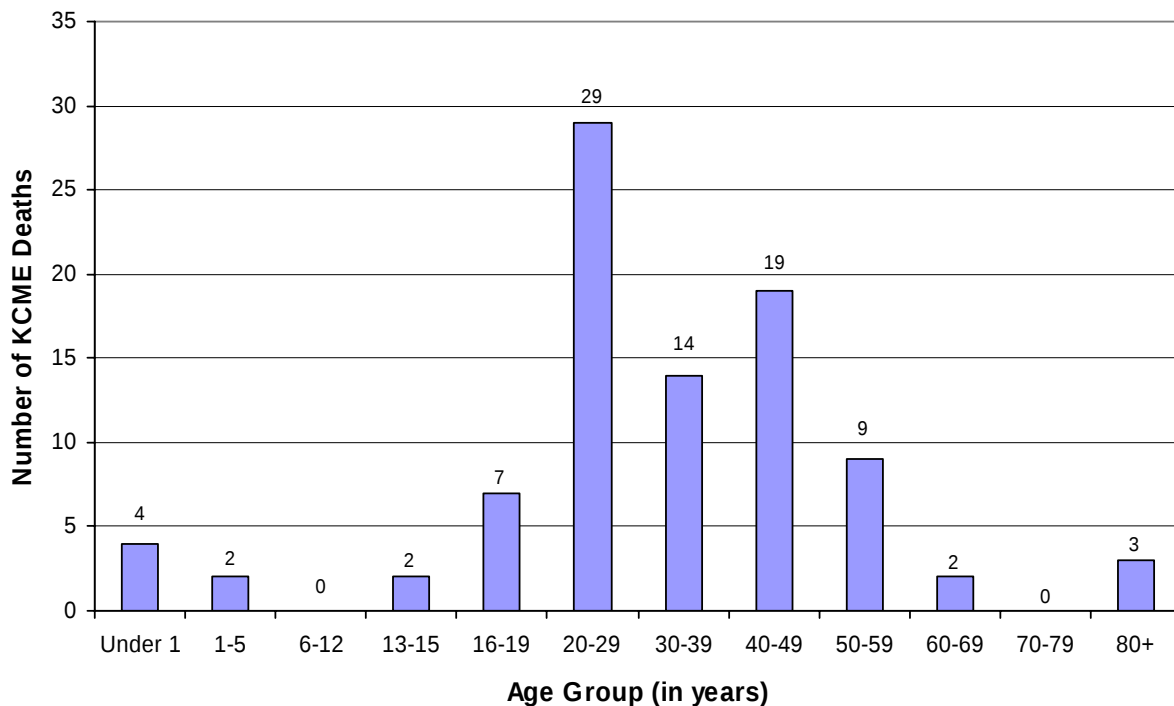


Table 4-3 Homicide Deaths / Age / Race / Sex / King County Medical Examiner / 2006

METHOD		AGE						SUB TOTAL	TOTAL
		< 16	16 to 19	20 to 29	30 to 39	40 to 49	50+		
Asphyxia / Strangulation	White	0	0	0	1	0	0		1
	Male	0	0	0	0	0	0	0	
	Female	0	0	0	1	0	0	1	
Blunt Force	White	2	0	1	2	2	1		8
	Male	1	0	1	2	2	0	6	
	Female	1	0	0	0	0	1	2	
	Black	0	0	0	1	0	3		4
	Male	0	0	0	1	0	2	3	
	Female	0	0	0	0	0	1	1	
	Asian	0	0	0	1	0	0		1
	Male	0	0	0	1	0	0	1	
	Female	0	0	0	0	0	0	0	
	Nat. American	2	0	0	0	0	0		2
	Male	2	0	0	0	0	0	2	
	Female	0	0	0	0	0	0	0	
	Other	0	0	0	0	1	0		1
	Male	0	0	0	0	1	0	1	
	Female	0	0	0	0	0	0	0	
Firearms	White	2	2	10	4	4	5		27
	Male	0	2	10	4	4	3	23	
	Female	2	0	0	0	0	2	4	0
	Black	0	0	7	2	2	0		11
	Male	0	0	7	2	2	0	11	
	Female	0	0	0	0	0	0	0	
	Asian	0	3	5	1	3	0		12
	Male	0	3	5	1	2	0	11	
	Female	0	0	0	0	1	0	1	
Homicidal Violence	None	0	0	0	0	0	0		0
	Male	0	0	0	0	0	0	0	
	Female	0	0	0	0	0	0	0	

Table 4-3 Homicide Deaths / Age / Race / Sex / King County Medical Examiner / 2006

METHOD		AGE						SUB TOTAL	TOTAL
		< 16	16 to 19	20 to 29	30 to 39	40 to 49	50+		
Stabbing	White	2	0	4	1	1	1		9
	Male	2	0	1	1	1	1	6	
	Female	0	0	3	0	0	0	3	
	Black	0	0	1	0	4	0		5
	Male	0	0	1	0	2	0	3	
	Female	0	0	0	0	2	0	2	
Other / Unknown	White	0	1	0	0	1	3		5
	Male	0	1	0	0	0	2	3	
	Female	0	0	0	0	1	1	2	
	Black	0	1	0	0	0	1		2
	Male	0	1	0	0	0	0	1	
	Female	0	0	0	0	0	1	1	
	Asian	0	0	0	0	1	0		1
	Male	0	0	0	0	1	0	1	
	Female	0	0	0	0	0	0	0	
TOTALS		8	7	29	14	19	14		91

Table 4-4 Homicide Methods / Sex / King County Medical Examiner / 2006

METHOD	SEX		TOTAL
	MALE	FEMALE	
Asphyxia / Strangulation	0	1	1
Blunt Force	13	3	16
Firearms	47	5	52
Homicidal Violence	0	0	0
Stabbing	9	5	14
Other / Unknown	5	3	8
Totals	74	17	91
Percent	81%	19%	100%

Table 4-5 Homicide Methods / Blood Alcohol Results / KCME / 2006

METHOD	TESTED		NOT TESTED	TOTAL
	POSITIVE	NEGATIVE		
Asphyxia / Strangulation	0	1	0	1
Blunt Force	3	11	2	16
Firearms	17	31	4	52
Homicidal Violence	-	-	-	0
Stabbing	5	9	0	14
Other / Unknown	1	6	1	8
Totals	26	58	7	91
Percent	28%	64%	8%	100%

Manner: NATURAL

The Medical Examiner assumes jurisdiction over deaths that are classified as natural due to the sudden and unexpected nature of the death in an apparently healthy individual, when there is no physician who has knowledge or awareness of the decedent's condition, when there is no next of kin to make disposition, or when there are suspicious circumstances surrounding the death. In these situations, the Medical Examiner becomes responsible for certification of death. It should be stressed that the natural deaths the Medical Examiner investigates may not be representative of all natural deaths in the general population, due to the possibility that jurisdictional considerations introduce significant bias.

In 2006, the King County Medical Examiner assumed jurisdiction over 752 deaths attributed to natural causes, representing 37% (752/2,055) of the cases investigated. The King County Medical Examiner certified 81% (609/752) of these deaths; attending physicians who had knowledge of the decedent's medical condition certified 19% (143/752). It should be noted that when a death is initially reported, there may be no evidence of an attending physician; a thorough scene investigation often reveals that the deceased did, in fact, have a physician with knowledge of the decedent's medical condition. That physician would then be contacted to certify the death. The King County Medical Examiner performed autopsies in 74% (448/609) of the deaths certified as natural, which included autopsies performed in all 17 deaths from Sudden Infant Death Syndrome (SIDS).

The data presented in this section are derived from the 752 natural deaths in which the King County Medical Examiner assumed jurisdiction. Cardiovascular disease accounted for the greatest proportion of natural deaths. Most deaths in which an autopsy was not performed were certified as due to "probable arteriosclerotic cardiovascular disease."

Table 5-1 Disease Processes Causing Natural Deaths / KCME / 2006

NUMBER OF DEATHS	DISEASE DESCRIPTION
CARDIOVASCULAR	
3	Aortic Aneurysm
11	Aortic Dissection
196	Arteriosclerotic Cardiovascular Disease (ASCVD)
4	Bacterial Endocarditis
3	Cardiac Dysrhythmia
20	Cardiomyopathy
1	Congenital Heart Disease
3	Congestive Heart Failure
59	Hypertensive ASCVD / Hypertensive Heart Disease
4	Myocarditis
11	Probable Arteriosclerotic Cardiovascular Disease
3	Valvular Heart Disease
1	Other
424	TOTAL CARDIOVASCULAR
CENTRAL NERVOUS SYSTEM	
10	Epilepsy (idiopathic & other non-traumatic etiologies)
2	Infarct
2	Meningitis
16	Spontaneous Intracerebral Hemorrhage
15	Spontaneous Rupture of Aneurysm
17	Other
62	TOTAL CENTRAL NERVOUS SYSTEM
ENDOCRINE	
5	Diabetic Ketoacidosis
21	Diabetes Mellitus
1	Pancreatitis
1	Other
28	TOTAL ENDOCRINE
GASTROINTESTINAL	
1	Bacterial Peritonitis
2	Gastrointestinal Hemorrhage
3	Obstruction
4	Perforating Ulcer
3	Other
13	TOTAL GASTROINTESTINAL

Table 5-1 Disease Processes Causing Natural Deaths / KCME / 2006 (continued)

NUMBER OF DEATHS	DISEASE DESCRIPTION
HEPATIC	
3	Cirrhosis
1	Fatty Liver
1	Hepatic Failure
7	Hepatitis
0	Other
12	TOTAL HEPATIC
MALIGNANCY	
5	Breast
4	Colon
11	Lung
0	Pancreas
1	Prostate
2	Rectum
17	Other
40	TOTAL MALIGNANCY
OTHER PROCESSES	
37	Chronic Ethanolism (Alcoholism)
4	Chronic Renal Disease
5	HIV / AIDS
1	Infection
3	Labor / Delivery / Prematurity
17	Necrotizing fasciitis
7	No Anatomic or Toxicologic Cause of Death
12	Sepsis
8	Other
94	TOTAL OTHER PROCESSES
RESPIRATORY	
1	Asthma
19	Chronic Obstructive Pulmonary Disease
24	Pneumonia
13	Pulmonary Thromboembolus
5	Other
62	TOTAL RESPIRATORY

Table 5-1 Disease Processes Causing Natural Deaths / KCME / 2006 (continued)

NUMBER OF DEATHS	DISEASE DESCRIPTION
SUDDEN INFANT DEATH SYNDROME (SIDS)	
17	SIDS
328	TOTAL Non-Cardiovascular Cause of Death
424	TOTAL Cardiovascular Cause of Death
752	Total NATURAL DEATHS under KCMEO Jurisdiction, 2006

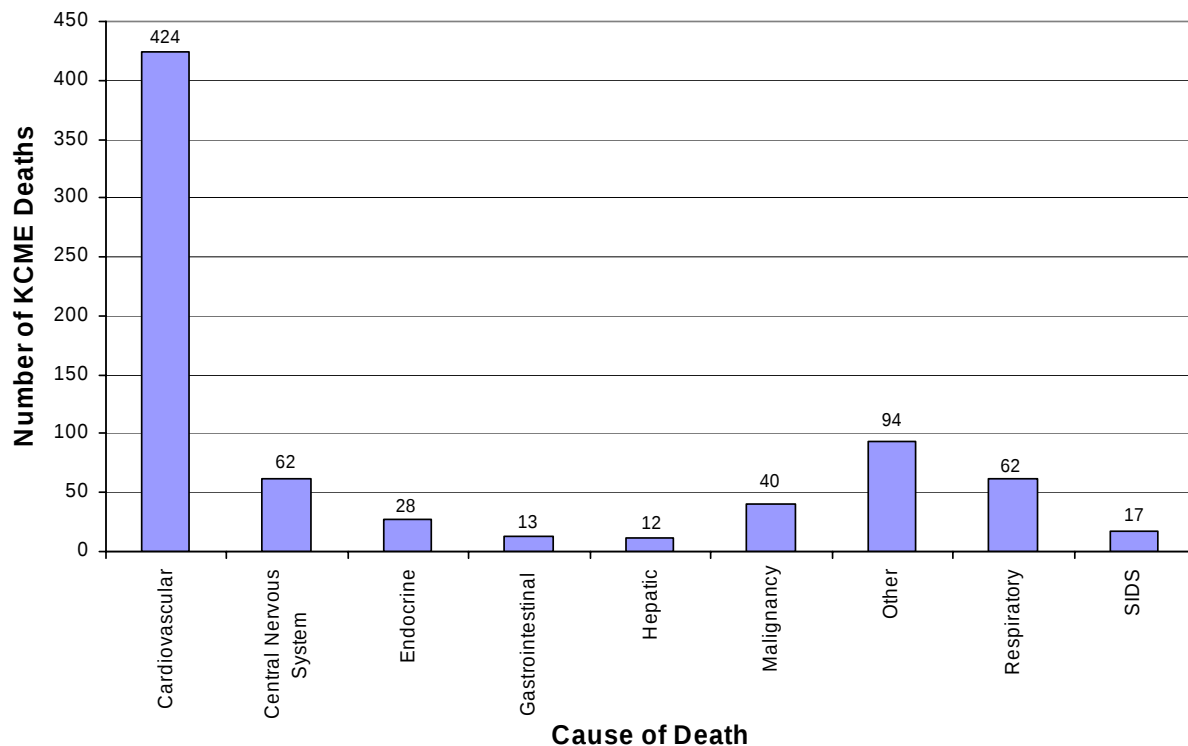
Graph 5-1 Deaths due to Natural Causes / King County Medical Examiner / 2006

Table 5-2 Natural Deaths / Race / Sex / King County Medical Examiner / 2006

DISEASE PROCESS / SEX	RACE					SUB TOTAL	TOTAL
	WHITE	BLACK	ASIAN	NATIVE AMERICAN	OTHER		
Cardiovascular	354	34	22	4	10		424
<i>Male</i>	250	27	15	3	7	302	
<i>Female</i>	104	7	7	1	3	122	
Central Nervous	46	9	3	2	2		62
<i>Male</i>	26	8	1	1	1	37	
<i>Female</i>	20	1	2	1	1	25	
Endocrine	19	8	1	0	0		28
<i>Male</i>	12	8	0	0	0	20	
<i>Female</i>	7	0	1	0	0	8	
Gastrointestinal	11	2	0	0	0		13
<i>Male</i>	9	1	0	0	0	10	
<i>Female</i>	2	1	0	0	0	3	
Hepatic	9	2	1	0	0		12
<i>Male</i>	7	1	0	0	0	8	
<i>Female</i>	2	1	1	0	0	4	
Malignancy	30	4	4	0	2		40
<i>Male</i>	19	3	4	0	0	26	
<i>Female</i>	11	1	0	0	2	14	
Other	72	13	1	4	4		94
<i>Male</i>	51	10	0	2	2	65	
<i>Female</i>	21	3	1	2	2	29	
Respiratory	50	8	3	1	0		62
<i>Male</i>	35	5	2	1	0	43	
<i>Female</i>	15	3	1	0	0	19	
SIDS	11	3	2	0	0		17
<i>Male</i>	7	2	1	0	0	10	
<i>Female</i>	4	1	1	1	0	7	
Totals	602	83	37	12	18		752
Percent	80%	11%	5%	1.6%	2.4%		100%

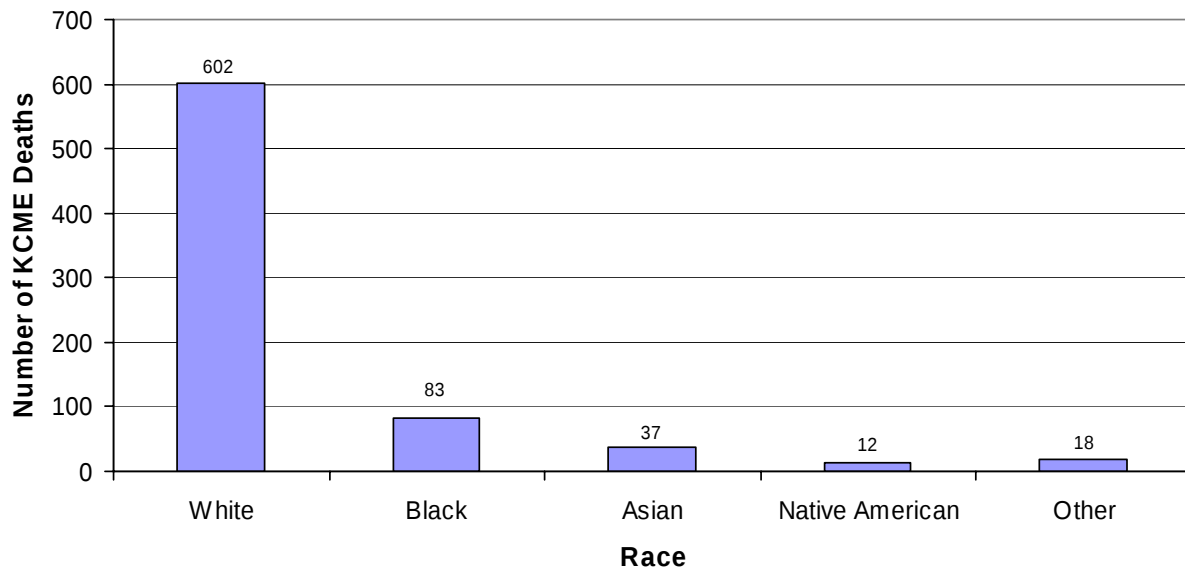
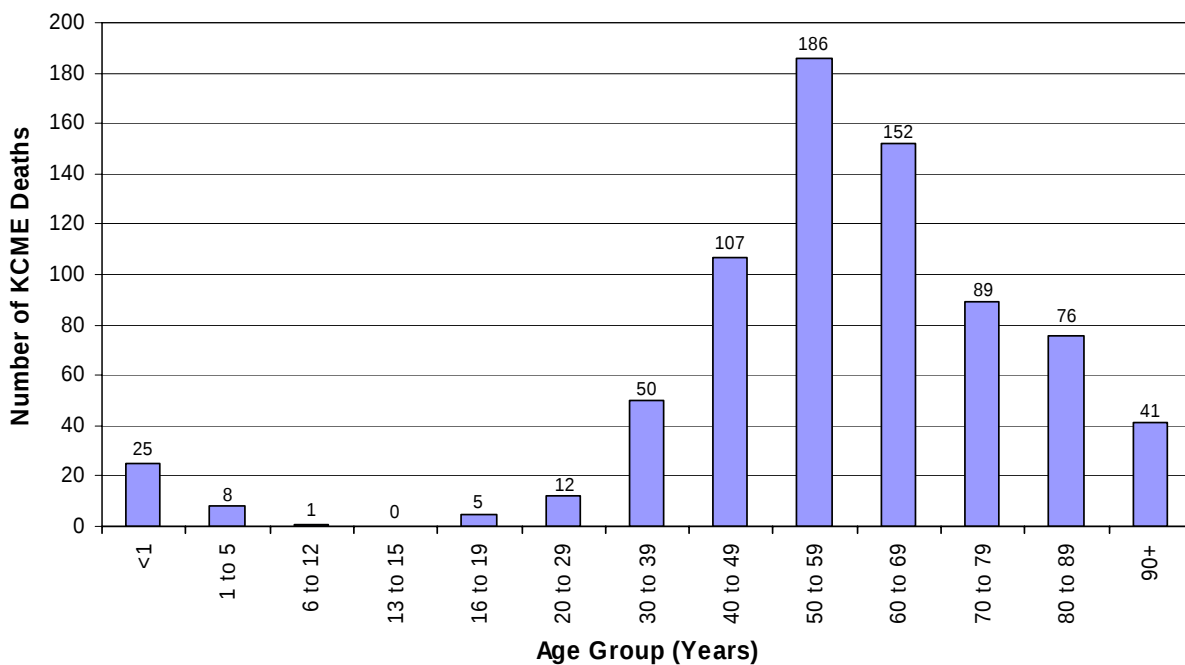
Graph 5-2 Natural Deaths / Race / King County Medical Examiner / 2006**Graph 5-3 Natural Deaths / Age Group / King County Medical Examiner / 2006**

Table 5-3 Natural Deaths / Age / Sex / King County Medical Examiner / 2006

DISEASE PROCESS/ SEX	AGE GROUP (YEARS)													SUB TOTAL	TOTAL
	< 1	1 to 5	6 to 12	13 to 15	16 to 19	20 to 29	30 to 39	40 to 49	50 to 59	60 to 69	70 to 79	80 to 89	90 +		
Cardiovascular	0	0	0	0	1	3	26	51	95	99	67	52	29		424
Male	0	0	0	0	0	2	23	42	80	83	35	29	8	302	
Female	0	0	0	0	1	1	3	9	15	16	32	23	21	12	
Central Nervous	2	2	1	0	3	3	8	11	10	6	4	7	5		62
Male	2	1	1	0	3	2	5	7	8	1	1	2	4	37	
Female	0	1	0	0	0	1	3	4	2	5	3	5	1	25	
Endocrine	0	0	0	0	0	0	3	7	9	4	4	1	0		28
Male	0	0	0	0	0	0	3	5	6	2	4	0	0	20	
Female	0	0	0	0	0	0	0	2	3	2	0	1	0	8	
Gastrointestinal	0	0	0	0	0	0	1	0	7	2	0	1	2		13
Male	0	0	0	0	0	0	1	0	7	2	0	0	0	10	
Female	0	0	0	0	0	0	0	0	0	0	0	1	2	3	
Hepatic	0	0	0	0	0	0	1	2	6	2	1	0	0		12
Male	0	0	0	0	0	0	0	1	5	2	0	0	0	8	
Female	0	0	0	0	0	0	1	1	1	0	1	0	0	4	
Malignancy	0	0	0	0	1	1	0	3	7	17	7	3	1		40
Male	0	0	0	0	0	1	0	3	4	12	4	1	1	26	
Female	0	0	0	0	1	0	0	0	3	5	3	2	0	14	
Other	6	3	0	0	0	1	6	27	33	14	0	1	3		94
Male	6	1	0	0	0	1	1	22	21	10	0	1	2	65	
Female	0	2	0	0	0	0	5	5	12	4	0	0	1	29	
Respiratory	0	2	0	0	0	4	5	6	19	8	6	11	1		62
Male	0	1	0	0	0	4	2	4	14	6	4	7	1	43	
Female	0	1	0	0	0	0	3	2	5	2	2	4	0	19	
SIDS	17	0	0	0	0	0	0	0	0	0	0	0	0		17
Male	10	0	0	0	0	0	0	0	0	0	0	0	0	10	
Female	7	0	0	0	0	0	0	0	0	0	0	0	0	7	
Totals	25	8	1	0	5	12	50	107	186	152	89	76	41		752
Percent	3.3	1.1	0.1	0	0.7	1.6	6.6	14.3	24.7	20.2	11.8	10.1	5.5		100%

Table 5-4 Natural Deaths / Sex / King County Medical Examiner / 2006

CIRCUMSTANCES	SEX		TOTAL
	MALE	FEMALE	
Cardiovascular	302	122	424
Central Nervous	37	25	62
Endocrine	20	8	28
Gastrointestinal	10	3	13
Hepatic	8	4	12
Malignancy	26	14	40
Other	65	29	94
Respiratory	43	19	62
SIDS	10	7	17
Totals	521	231	752
Percent	69%	31%	100%

Table 5-5 Natural Deaths / Blood Alcohol / King County Medical Examiner / 2006

METHOD	TESTED		NOT	TOTAL
	POSITIVE	NEGATIVE	TESTED	
Cardiovascular	52	232	140	424
Central Nervous System	1	34	27	62
Endocrine	2	11	15	28
Gastrointestinal	1	9	3	13
Hepatic	1	4	7	12
Malignancy	0	14	26	40
Other Processes	12	51	31	94
Respiratory	0	35	27	62
SIDS	0	17	0	17
Totals	69	407	276	752
Percent	9%	54%	37%	100%

Manner: SUICIDE

Suicides are those deaths caused by self-inflicted injuries with evidence of intent to end one's life. Evidence of intent includes an explicit expression, such as a suicide note or verbal threat, or an act constituting implicit intent, such as deliberately placing a gun to one's head or rigging a vehicle's exhaust. In 2006 there were 227 suicides, accounting for 11% (227/2,055) of the deaths that the King County Medical Examiner's Office investigated.

Firearms were responsible for forty-three percent (43%, 98/227) of the 2006 suicide deaths. The number of gunshot suicides (98) in 2006 is more than in both 2005 and 2004 when there were 96 and 95, respectively. Hanging accounted for 14% (31/227) of suicidal deaths, while jumping from a height accounted for 11% (26/227). Drugs and poisons accounted for 16% (36/227) of all suicides, while carbon monoxide caused death in 5% (11/227) of the cases. More information regarding drug caused deaths is presented in the section "Deaths Due to Drugs & Poisons" beginning on page 83.

Blood alcohol tests were performed in 96% (218/227) of suicidal deaths and were positive in 33% (72/218) of cases tested.

Suicides in the age group 60 years and older represented 20% (45/227) of all suicides in 2006.

Firearms were the primary method of committing suicide for all age groups in 2006.

In 2006, there were two deaths due to drugs and/or poisons by adults 60 years of age and over. In 2006, there were no suicides attributed to drugs and/or poisons among youths 19 years and younger. This compares to 2005 when there was one.

In 2006, there were 11 suicides among persons 19 years and younger (5% of all suicides, 11/227), which is comparable to 2005 when there were eight suicides in this age group (8/233, 3%). Firearms were the primary method of death (46%, 5/11) for suicide among youth 19 years and younger.

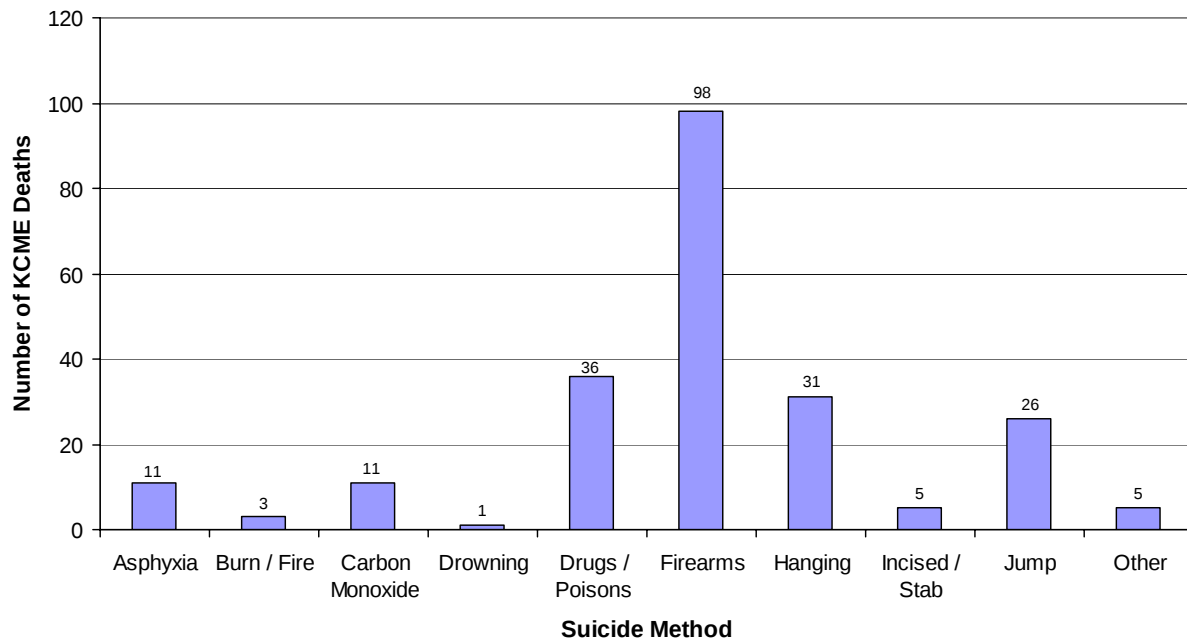
Graph 6-1 Suicide Injury Methods / King County Medical Examiner / 2006

Table 6-1 Suicide Injury Methods / Race / Sex / King County Medical Examiner / 2006

CIRCUMSTANCES / SEX	RACE					SUB TOTAL	TOTAL
	WHITE	BLACK	ASIAN	NATIVE AMERICAN	OTHE R		
Asphyxia	11	0	0	0	0		11
<i>Male</i>	10	0	0	0	0	10	
<i>Female</i>	1	0	0	0	0	1	
Burns/ Fire	2	0	1	0	0		3
<i>Male</i>	0	0	1	0	0	1	
<i>Female</i>	2	0	0	0	0	2	
Carbon Monoxide	10	1	0	0	0		11
<i>Male</i>	8	0	0	0	0	8	
<i>Female</i>	2	1	0	0	0	3	
Drowning	1	0	0	0	0		1
<i>Male</i>	0	0	0	0	0	0	
<i>Female</i>	1	0	0	0	0	1	
Drugs / Poisons	33	2	1	0	0		36
<i>Male</i>	13	1	1	0	0	15	
<i>Female</i>	20	1	0	0	0	21	
Firearms	89	4	4	0	1		98
<i>Male</i>	81	4	4	0	1	90	
<i>Female</i>	8	0	0	0	0	8	
Hanging	23	2	4	2	0		31
<i>Male</i>	17	2	4	2	0	25	
<i>Female</i>	6	0	0	0	0	6	
Incised / Stab Wound(s)	4	0	1	0	0		5
<i>Male</i>	4	0	0	0	0	4	
<i>Female</i>	0	0	1	0	0	1	
Jumping	20	2	4	0	0		26
<i>Male</i>	11	2	2	0	0	15	
<i>Female</i>	9	0	2	0	0	11	
Other	4	0	1	0	0		5
<i>Male</i>	4	0	1	0	0	5	
<i>Female</i>	0	0	0	0	0	0	
Totals	197	11	16	2	1		227
Percent	86.8%	4.9%	7.0%	0.9%	0.4%		100%

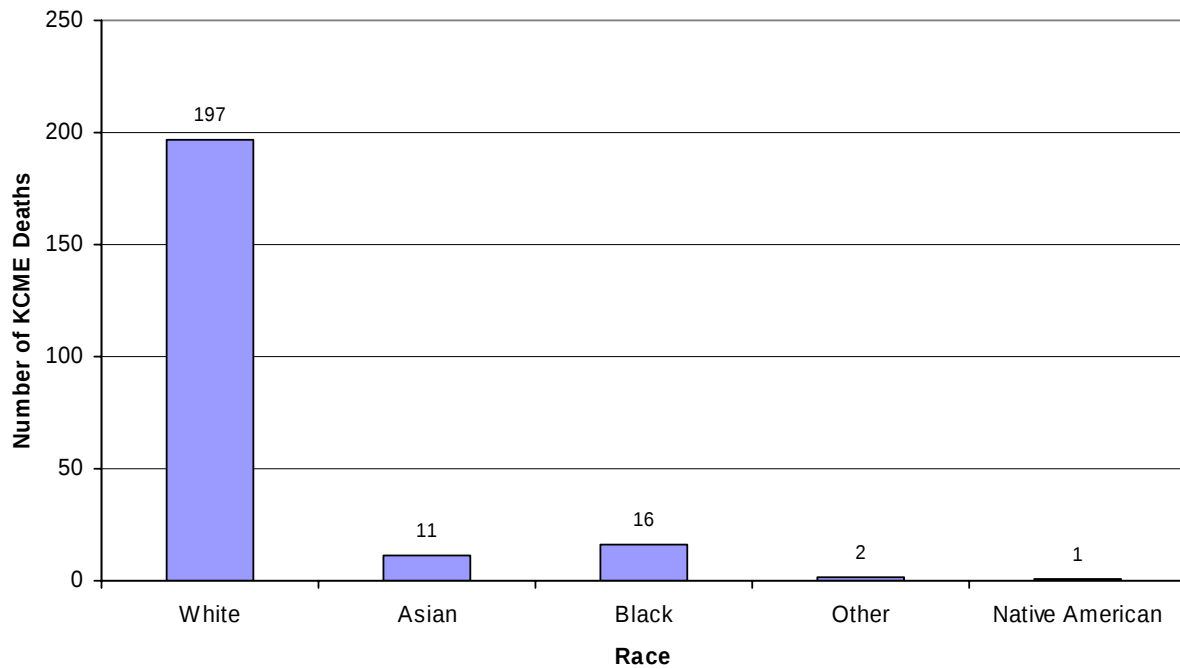
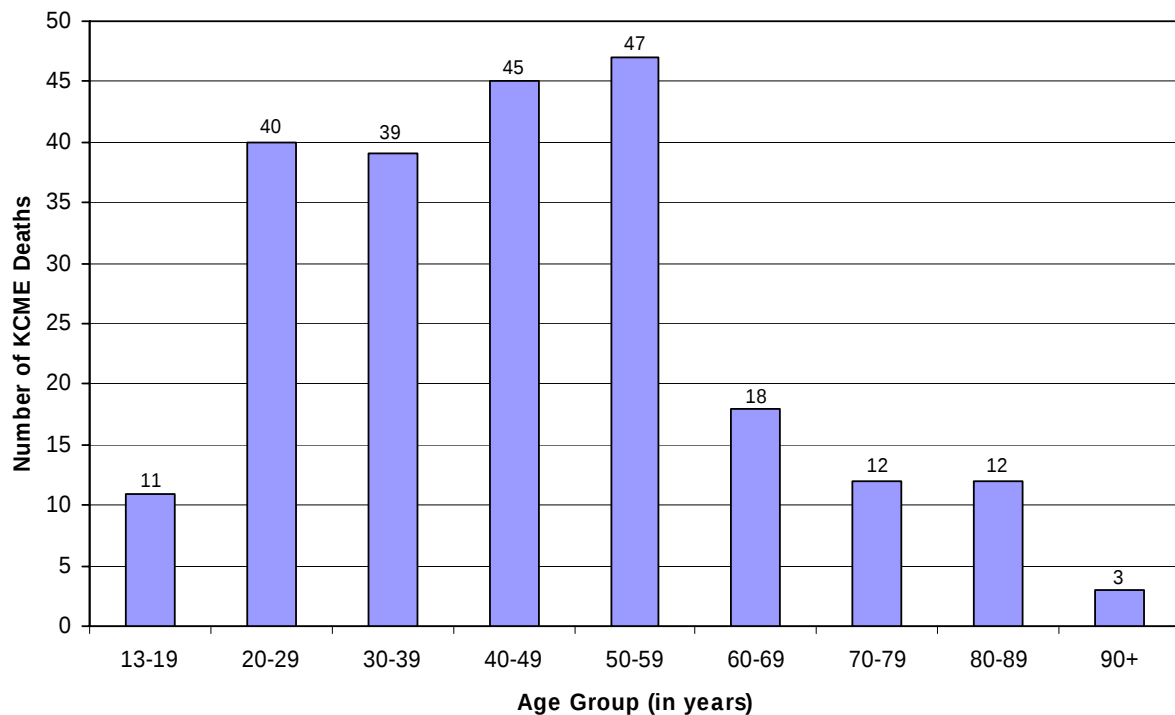
Graph 6-2 Suicide Deaths / Race / King County Medical Examiner / 2006**Graph 6-3 Suicide Deaths / Age Group / King County Medical Examiner / 2006**

Table 6-2 Suicide Injury Methods / Age / Sex / King County Medical Examiner / 2006

INJURY METHOD/ SEX	AGE GROUP (YEARS)									SUB TOTAL	TOTAL
	13 to 19	20 to 29	30 to 39	40 to 49	50 to 59	60 to 69	70 to 79	80 to 89	90 +		
Asphyxia	1	2	3	2	0	1	0	2	0		11
Male	1	2	2	2	0	1	0	2	0	10	
Female	0	0	1	0	0	0	0	0	0	1	
Burns/ Fire	0	1	0	1	1	0	0	0	0		3
Male	0	1	0	0	0	0	0	0	0	1	
Female	0	0	0	1	1	0	0	0	0	2	
Carbon Monoxide	0	1	5	2	0	1	2	0	0		11
Male	0	1	3	2	0	1	1	0	0	8	
Female	0	0	2	0	0	0	1	0	0	3	
Drowning	0	0	0	0	0	0	0	0	1		1
Male	0	0	0	0	0	0	0	0	0	0	
Female	0	0	0	0	0	0	0	0	1	1	
Drugs / Poisons	0	5	6	11	12	0	0	2	0		36
Male	0	2	2	6	5	0	0	0	0	15	
Female	0	3	4	5	7	0	0	2	0	21	
Firearms	5	16	10	15	23	12	8	7	2		98
Male	5	15	10	13	21	11	7	6	2	90	
Female	0	1	0	2	2	1	1	1	0	8	
Hanging	2	9	7	8	4	1	0	0	0		31
Male	2	6	6	7	3	1	0	0	0	25	
Female	0	3	1	1	1	0	0	0	0	6	
Incised / Stab Wound(s)	0	0	2	0	2	0	1	0	0		5
Male	0	0	2	0	1	0	1	0	0	4	
Female	0	0	0	0	1	0	0	0	0	1	
Jumping	2	3	5	6	5	3	1	1	0		26
Male	0	3	3	3	4	2	0	0	0	15	
Female	2	0	2	3	1	1	1	1	0	11	
Other	1	3	1	0	0	0	0	0	0		5
Male	1	3	1	0	0	0	0	0	0	5	
Female	0	0	0	0	0	0	0	0	0	0	
Totals	11	40	39	45	47	18	12	12	3		227
Percent	5%	18%	17%	20%	21%	8%	5%	5%	1%		100%

Table 6-3 Suicide Injury Methods / Sex / King County Medical Examiner / 2006

INJURY METHOD	SEX		TOTAL
	MALE	FEMALE	
Asphyxia	10	1	11
Burns/ Fire	1	2	3
Carbon Monoxide	8	3	11
Drowning	0	1	1
Drugs / Poisons	15	21	36
Firearms	90	8	98
Hanging	25	6	31
Incised / Stab Wound(s)	4	1	5
Jumping	15	11	26
Other	5	0	5
Totals	173	54	227
Percent	76%	24%	100%

Table 6-4 Suicide Injury Methods / Marital Status / Sex / KCME / 2006

CIRCUMSTANCES / SEX	MARITAL STATUS					Sub Total	Total
	Single	Married	Divorced	Widowed	Unknown		
Asphyxia	6	3	1	1	0		11
Male	5	3	1	1	0	10	
Female	1	0	0	0	0	1	
Burns/ Fire	1	1	1	0	0		3
Male	1	0	0	0	0	1	
Female	0	1	1	0	0	2	
Carbon Monoxide	3	1	5	2	0		11
Male	3	1	3	1	0	8	
Female	0	0	2	1	0	3	
Drowning	1	0	0	0	0		1
Male	0	0	0	0	0	0	
Female	1	0	0	0	0	1	
Drugs / Poisons	15	3	15	2	1		36
Male	9	1	5	0	0	15	
Female	6	2	10	2	1	21	
Firearms	42	24	20	10	2		98
Male	40	22	17	9	2	90	
Female	2	2	3	1	0	8	
Hanging	15	12	3	1	0		31
Male	13	8	3	1	0	25	
Female	2	4	0	0	0	6	
Incised / Stab Wound(s)	1	3	1	0	0		5
Male	1	2	1	0	0	4	
Female	0	1	0	0	0	1	
Jumping	11	5	8	1	1		26
Male	8	4	3	0	0	15	
Female	3	1	5	1	1	11	
Other	5	0	0	0	0		5
Male	5	0	0	0	0	5	
Female	0	0	0	0	0	0	
Totals	100	52	54	17	4		227
Percent	44%	23%	24%	7%	2%		100%

Table 6-5 Suicide Injury Methods / Blood Alcohol / KCME / 2006

METHOD	TESTED		NOT TESTED	TOTAL
	POSITIVE	NEGATIVE		
Asphyxia	2	9	0	11
Burns/ Fire	1	1	1	3
Carbon Monoxide	5	5	1	11
Drowning	1	0	0	1
Drugs / Poisons	14	21	1	36
Firearms	27	69	2	98
Hanging	14	15	2	31
Incised / Stab Wound(s)	1	4	0	5
Jumping	6	19	1	26
Other	1	3	1	5
Totals	72	146	9	227
Percent	32%	64%	4%	100%

Manner: TRAFFIC

During the calendar year 2006, the Medical Examiner's Office participated in the investigation of 211 traffic fatalities. There were 144 traffic deaths where the collision occurred in King County, compared to 152 in 2005, 127 in 2004, 112 in 2003 and 121 in 2002. In 2006, 32% (67/211) of the traffic deaths that the Medical Examiner investigated were the result of collisions that occurred outside of King County with the injured transported to hospitals in King County, primarily Harborview Medical Center. Because the death occurred in King County, it came under the jurisdiction of the King County Medical Examiner. This is comparable to 33% (74/226) in 2005, 34% (65/192) in 2004, 37% (67/179) in 2003 and 40% (82/203) in 2002. Although these deaths are classified "accident" for death certification purposes, the more accurate term is "motor vehicle collision."

In 2006, 44% (92/211) of the traffic fatalities were motor vehicle drivers. Teenage drivers (16-19 years of age) were 17% (16/92) of the driver deaths in 2006 compared to 5% (5/99) in 2005, 4% (3/78) in 2004, 15% (11/76) in 2003 and 9% (9/100) in 2002. By age, 13% percent of vehicle driver deaths (12/92) were people between the ages of 20 and 29. Eighteen percent of driver deaths (17/92) were adults between the ages of 30 and 39. Seventeen percent (16/92) were adults between the ages of 40 and 49. Male drivers represented 77% (71/92) of driver deaths as compared to 23% for female drivers (21/92).

Of the 211 traffic fatalities in 2006, 44 were motor vehicle passengers, representing 21% of the total (44/211). In 2006, teenagers (13-19 years old) accounted for 11 motor vehicle passenger deaths. There was one passenger death of an infant (less than one year of age), no deaths of children between the ages of 1-5 years, and one death of a child between the ages of 6-12 years.

Blood ethanol (alcohol) statistics are presented to describe the role of alcohol in traffic deaths. However, it should be noted that in many cases someone other than the person who died was under the influence of alcohol and directly responsible for the accident. The Medical Examiner determines the blood alcohol levels of persons who die, not of everyone involved in the incident. In addition, blood alcohol is not tested in persons who die after surviving more than 24 hours, because in those deaths the alcohol has had time to metabolize¹. Therefore, blood alcohol figures presented in this report are not a total description of the role of alcohol in traffic collisions. In 33% (24/73) of drivers tested, blood ethanol was present. In 19 vehicle driver deaths, no alcohol determination was performed. Passenger fatalities showed the presence of alcohol in 55% (21/38) of victims tested.

¹See "Explanation of Data" for criteria for blood alcohol testing, page 6.

Of cases in which restraint status was known, 35% (29/84) of drivers in vehicle deaths were not restrained. This is comparable to 37% (32/87) in 2005, 37% (25/68) in 2004, 37% (18/49) in 2003 and 43% (30/69) in 2002. Of the vehicle drivers who died at the scene of the collision and who tested positive for blood alcohol, 44% (7/16) were unrestrained.

Motorcycle riders accounted for 13% (28/211) of traffic fatalities. In 2006, there were 27 motorcycle driver fatalities and one motorcycle passenger fatality. Twenty-five of the motorcycle driver deaths were male, and two were female. Of the 28 motorcycle fatalities, 100% (28/28) of the motorcyclists were wearing a helmet. Twenty-three of the motorcyclist fatalities were tested for the presence of blood alcohol. Eight, or 35% (8/23), had a detectable amount of alcohol at the time of autopsy.

Pedestrians constituted 16% (33/211) of traffic fatalities. The majority of pedestrian deaths, 76% (25/33), were male. Of the pedestrian fatalities that were tested, 29% (8/28) had detectable amounts of alcohol present in their blood at the time of death.

There were eight bicyclist deaths in 2006. Four riders were wearing a helmet, one rider was not wearing a helmet, and helmet use by the other three bicyclists is not known.

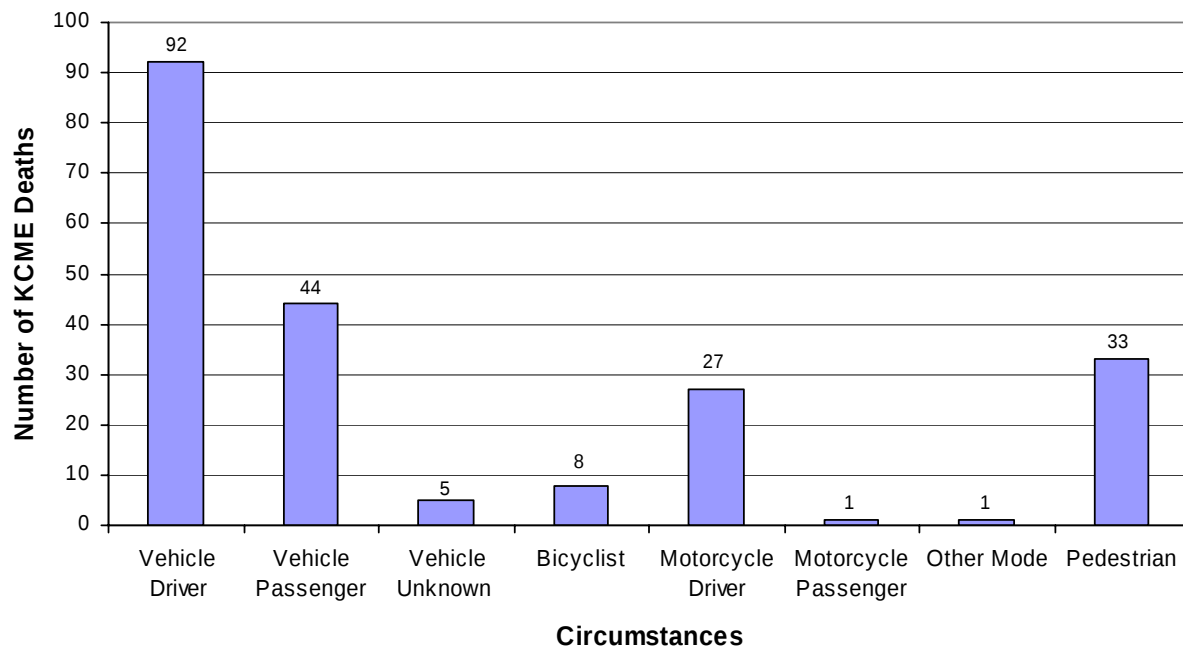
Graph 7-1 Traffic Fatality Circumstances / King County Medical Examiner / 2006

Table 7-1 Traffic Fatality Circumstances / Race / Sex / KCME / 2006

CIRCUMSTANCES / SEX	RACE					SUB TOTAL	TOTAL
	WHITE	BLACK	ASIAN	NATIVE AMERICAN	OTHER		
Vehicle Driver	70	8	10	3	1		92
<i>Male</i>	52	8	9	2	0	71	
<i>Female</i>	18	0	1	1	1	21	
Vehicle Passenger	28	5	7	4	0		44
<i>Male</i>	17	4	4	4	0	29	
<i>Female</i>	11	1	3	0	0	15	
Vehicle Unknown	3	1	0	1	0		5
<i>Male</i>	2	0	0	1	0	3	
<i>Female</i>	1	1	0	0	0	2	
Bicycle	8	0	0	0	0		8
<i>Male</i>	7	0	0	0	0	7	
<i>Female</i>	1	0	0	0	0	1	
Motorcycle Driver	24	1	2	0	0		27
<i>Male</i>	22	1	2	0	0	25	
<i>Female</i>	2	0	0	0	0	2	
Motorcycle Passenger	1	0	0	0	0		1
<i>Male</i>	1	0	0	0	0	1	
<i>Female</i>	0	0	0	0	0	0	
Other Mode	1	0	0	0	0		1
<i>Male</i>	1	0	0	0	0	1	
<i>Female</i>	0	0	0	0	0	0	
Pedestrian	29	1	3	0	0		33
<i>Male</i>	23	0	2	0	0	25	
<i>Female</i>	6	1	1	0	0	8	
Totals	164	16	22	8	1		211
Percent	78%	7.5%	10%	4%	0.5%		100%

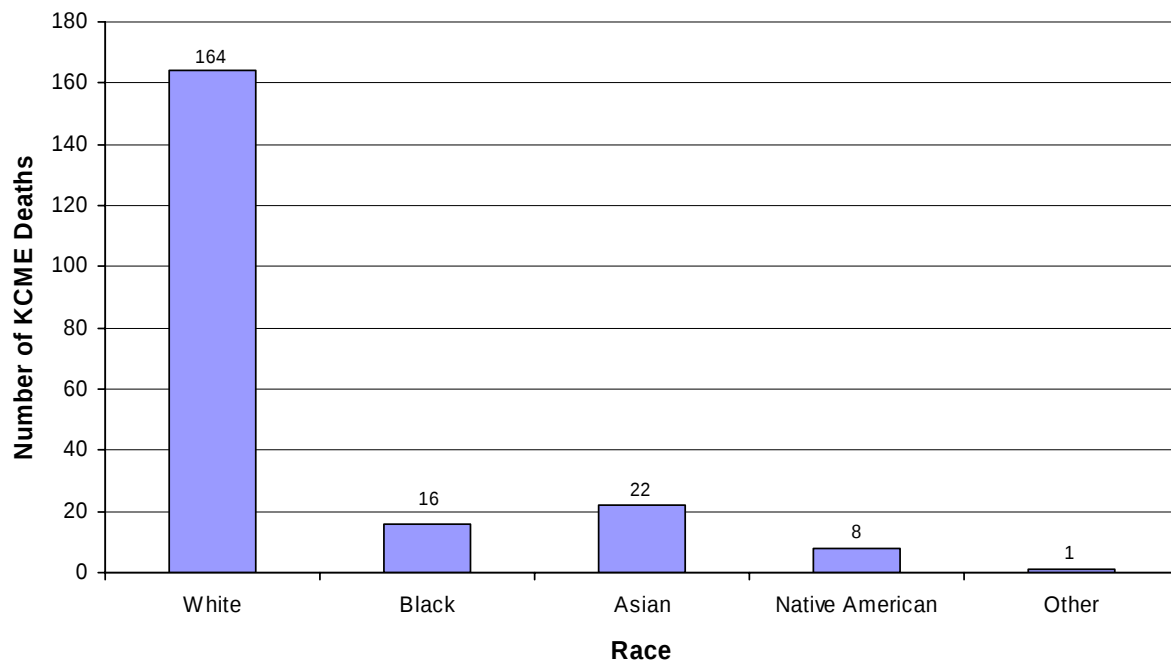
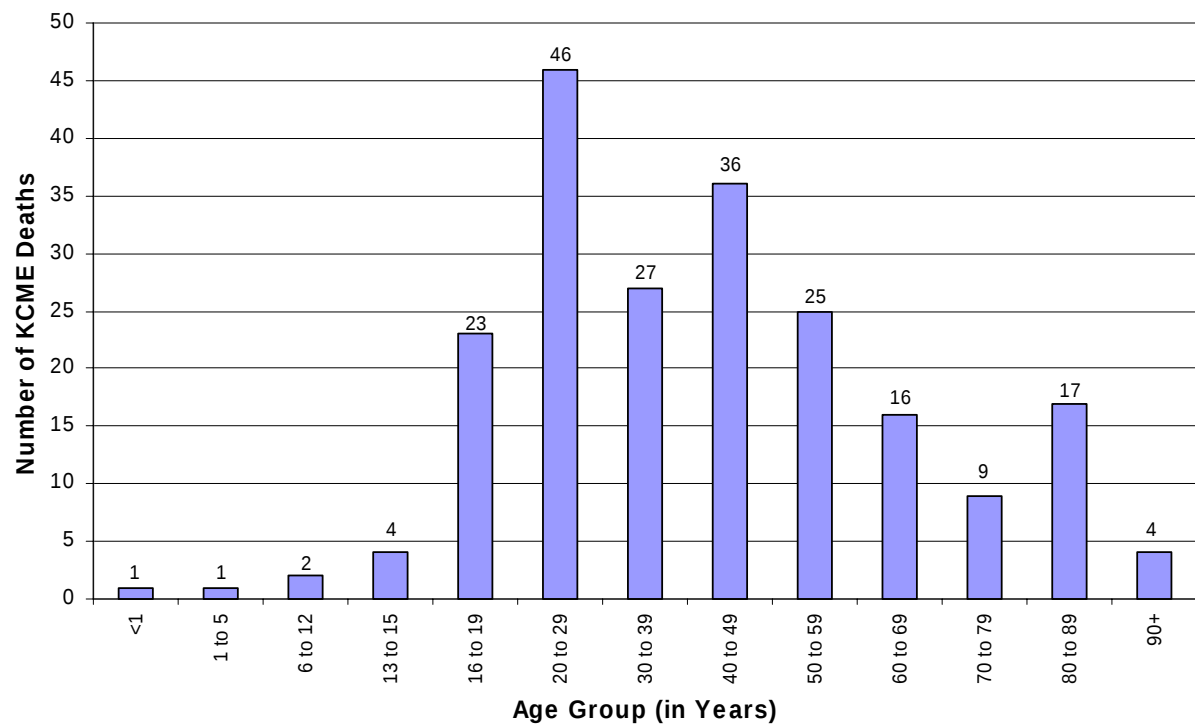
Graph 7-2 Traffic Fatalities / Race / King County Medical Examiner / 2006**Graph 7-3 Traffic Fatalities / Age / King County Medical Examiner / 2006**

Table 7-2 Traffic Fatality Circumstances / Age / Sex / KCME / 2006

Circumstances / Sex	AGE GROUP (YEARS)														SUB TOTAL	TOTAL
	< 1	1 to 5	6 to 12	13 to 15	16 to 19	20 to 29	30 to 39	40 to 49	50 to 59	60 to 69	70 to 79	80 to 89	90 +			
Vehicle Driver	0	0	0	0	16	12	17	16	9	6	4	10	2	92		
Male	0	0	0	0	12	10	11	15	8	5	2	6	2	71		
Female	0	0	0	0	4	2	6	1	1	1	2	4	0	21		
Vehicle Passenger	1	0	1	4	6	19	3	3	1	1	2	3	0	44		
Male	0	0	0	3	4	14	2	2	0	1	1	2	0	29		
Female	1	0	1	1	2	5	1	1	1	0	1	1	0	15		
Vehicle Unknown	0	0	0	0	0	1	2	0	0	1	0	1	0	5		
Male	0	0	0	0	0	1	1	0	0	0	0	1	0	3		
Female	0	0	0	0	0	0	1	0	0	1	0	0	0	2		
Bicyclist	0	0	0	0	0	1	0	2	3	1	0	1	0	8		
Male	0	0	0	0	0	1	0	2	2	1	0	1	0	7		
Female	0	0	0	0	0	0	0	0	1	0	0	0	0	1		
Motorcycle Driver	0	0	0	0	0	9	3	6	6	2	0	1	0	27		
Male	0	0	0	0	0	9	3	5	5	2	0	1	0	25		
Female	0	0	0	0	0	0	0	1	1	0	0	0	0	2		
Motorcycle Passenger	0	0	0	0	0	0	1	0	0	0	0	0	0	1		
Male	0	0	0	0	0	0	1	0	0	0	0	0	0	1		
Female	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
Other Mode	0	0	0	0	1	0	0	0	0	0	0	0	0	1		
Male	0	0	0	0	1	0	0	0	0	0	0	0	0	1		
Female	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
Pedestrian	0	1	1	0	0	4	1	9	6	5	3	1	2	33		
Male	0	1	1	0	0	4	1	4	5	5	2	1	1	25		
Female	0	0	0	0	0	0	0	5	1	0	1	0	1	8		
Totals	1	1	2	4	23	46	27	36	25	16	9	17	4	211		
Percent	0.5	0.5	0.9	1.9	10.9	21.8	12.8	17.1	11.8	7.6	4.3	8.0	1.9	100%		

Table 7-3 Traffic Fatality Circumstances / Sex / King County Medical Examiner / 2006

CIRCUMSTANCES	SEX		TOTAL
	MALE	FEMALE	
Vehicle Driver	71	21	92
Vehicle Passenger	29	15	44
Vehicle Unknown	3	2	5
Bicyclist	7	1	8
Motorcycle Driver	25	2	27
Motorcycle Passenger	1	0	1
Other Mode	1	0	1
Pedestrian	25	8	33
Totals	162	49	211
Percent	77%	23%	100%

Table 7-4 Traffic Fatality Circumstances / Use of Restraint / Helmet / KCME / 2006²

CIRCUMSTANCES	Used Safety Device	No Safety Device Used	Unknown	TOTAL
Vehicle Driver	55	29	8	92
Vehicle Passenger	22	17	5	44
Vehicle Unknown	0	1	4	5
Bicyclist	4	1	3	8
Motorcycle Driver	27	0	0	27
Motorcycle Passenger	1	0	0	1
Other Mode	0	1	0	1
Totals	109	49	20	178
Percent	61%	28%	11%	100%

²Does not include pedestrian deaths.

Table 7-5 Traffic Fatality Circumstances / Blood Alcohol / KCME / 2006

CIRCUMSTANCES	TESTED		NOT TESTED	TOTAL
	POSITIVE	NEGATIVE		
Vehicle Driver	24	49	19	92
Vehicle Passenger	21	17	6	44
Vehicle Unknown	1	3	1	5
Bicyclist	0	4	4	8
Motorcycle Driver	8	15	4	27
Motorcycle Passenger	0	0	1	1
Other Mode	1	0	0	1
Pedestrian	8	20	5	33
Totals	63	108	40	211
Percent	30%	51%	19%	100%

Table 7-6 Blood Alcohol Levels of Traffic Fatalities who died AT THE SCENE of the Collision / King County Medical Examiner / 2006

CIRCUMSTANCES	BLOOD ALCOHOL LEVEL (G%)					TOTAL
	NONE	.01-.09	.10-.19	.20-.29	.30+	
Vehicle Driver	17	2	10	3	1	33
Vehicle Passenger	6	7	3	3	1	20
Vehicle Unknown	0	1	0	0	0	1
Bicyclist	0	0	0	0	0	0
Motorcycle Driver	2	1	3	0	0	6
Motorcycle Passenger	0	0	0	0	0	0
Other Mode	0	0	0	1	0	1
Pedestrian	6	3	0	2	0	11
Totals	31	14	16	9	2	72
Percent	43%	19%	22%	13%	3%	100%

Graph 7-4 Blood Alcohol Levels of Traffic Fatalities who Died AT THE SCENE / King County Medical Examiner / 2006

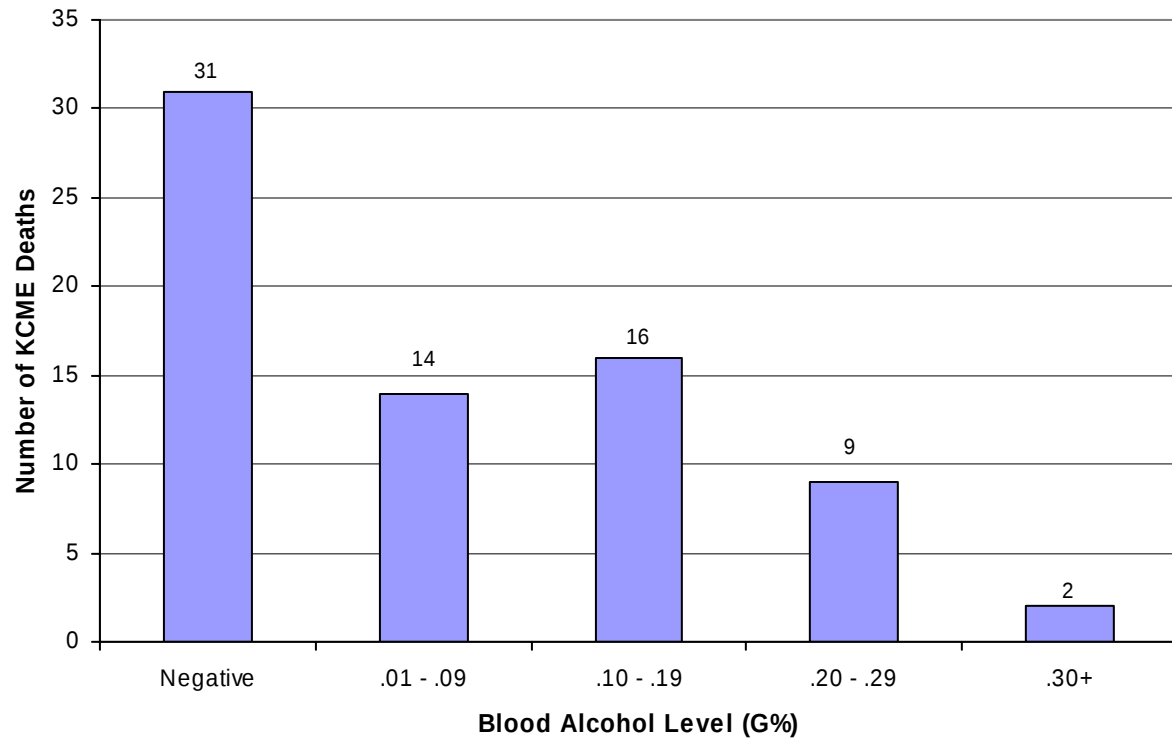
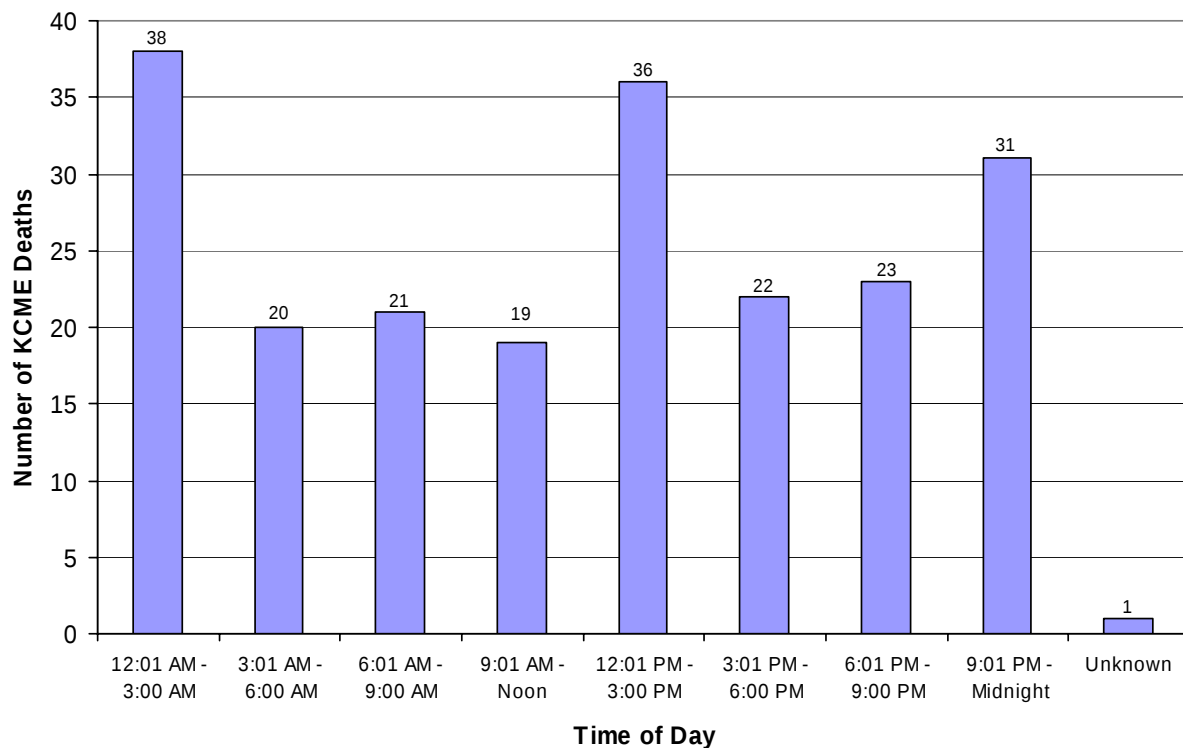


Table 7-7 Time of Fatal Traffic Collision / King County Medical Examiner / 2006

TIME OF DAY	TOTAL	PERCENT
12:01 AM - 3:00 AM	38	18.0%
3:01 AM - 6:00 AM	20	9.5%
6:01 AM - 9:00 AM	21	10.0%
9:01 AM - Noon	19	9.0%
12:01 PM - 3:00 PM	36	17.0%
3:01 PM - 6:00 PM	22	10.4%
6:01 PM - 9:00 PM	23	10.9%
9:01 PM -Midnight	31	14.7%
Unknown	1	0.5%
TOTALS	211	100%

Graph 7-5 Time of Fatal Traffic Collision / King County Medical Examiner / 2006

Manner: UNDETERMINED

The King County Medical Examiner's Office certifies a manner of death as Undetermined when available information regarding the circumstances of death is insufficient to classify the death into one of the specific manners of natural or unnatural death (Accident, Homicide, or Suicide). In some cases, serious doubt existed as to whether an injury occurred with intent or as a result of an accident. Information concerning the circumstances may be lacking due to the absence of background information or witnesses, or because of a lengthy delay between death and discovery of the body. Moreover, it may be difficult to assess street drug or medication overdose deaths as showing enough features to reasonably determine the manner of death. If an extensive investigation and autopsy cannot clarify the circumstances, the death is classified Undetermined.

The King County Medical Examiner's Office certified 53 deaths with manner undetermined, accounting for three percent (53/2,055) of the deaths investigated for the calendar year 2006. Drugs and poisons caused 13 or 25%, of these 53 deaths of undetermined manner. For a more detailed review of drug-caused deaths in 2006, see the discussion in the section on Drugs and Poisons on pages 83 and 84.

The 53 deaths that were classified as Undetermined for 2006 include nine fetal deaths, which, in accordance with the Washington State Department of Health - Center for Health Statistics Fetal Death Certification Guidelines, are not assigned a manner of death. Fetal death certificates must be issued for every fetus of 20 weeks or more gestation. The Medical Examiner assumed jurisdiction over nine fetal deaths in 2006, including one that was related to maternal drug use.

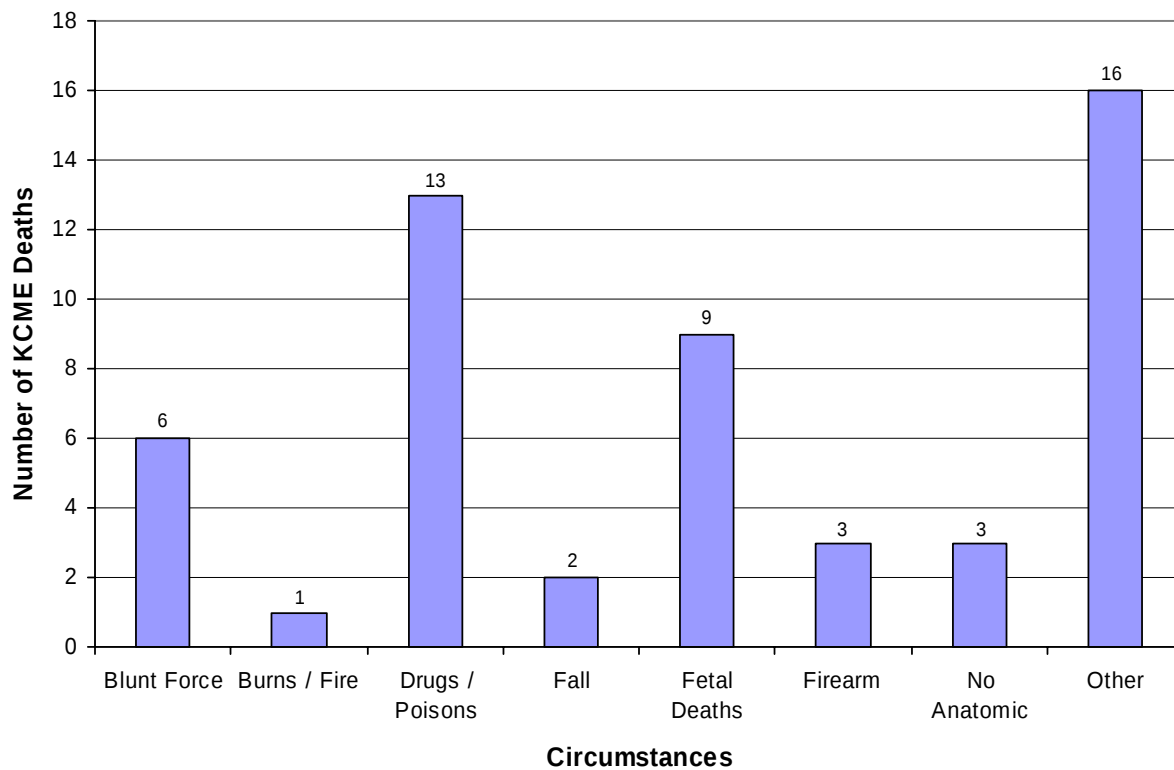
Graph 8-1 Undetermined Manner of Death / King County Medical Examiner / 2006

Table 8-1 Undetermined Manner of Death / Race / Sex / KCME / 2006

CIRCUMSTANCES / SEX	RACE					SUB TOTAL	TOTAL
	WHITE	BLACK	ASIAN	NATIVE AMERICAN	OTHER / UNK		
Blunt Force	3	2	0	1	0		6
<i>Male</i>	2	1	0	1	0	4	
<i>Female</i>	1	1	0	0	0	2	
Burns / Fire	1	0	0	0	0		1
<i>Male</i>	1	0	0	0	0	1	
<i>Female</i>	0	0	0	0	0	0	
Drugs / Poisons	11	0	1	1	0		13
<i>Male</i>	5	0	1	0	0	6	
<i>Female</i>	6	0	0	1	0	7	
Fall	2	0	0	0	0		2
<i>Male</i>	2	0	0	0	0	2	
<i>Female</i>	0	0	0	0	0	0	
Fetal Deaths ¹	5	2	0	0	2		9
<i>Male</i>	3	2	0	0	0	5	
<i>Female</i>	1	0	0	0	1	2	
<i>Unknown</i>	1	0	0	0	1	2	
Firearms	3	0	0	0	0		3
<i>Male</i>	2	0	0	0	0	2	
<i>Female</i>	1	0	0	0	0	1	
No Anatomic or Toxicologic Cause of Death	3	0	0	0	0		3
<i>Male</i>	2	0	0	0	0	2	
<i>Female</i>	1	0	0	0	0	1	
Other	13	2	0	0	1		16
<i>Male</i>	11	2	0	0	0	13	
<i>Female</i>	2	0	0	0	1	3	
Totals	41	6	1	2	3		53
Percent	77%	11%	2%	4%	6%		100%

¹Includes one fetal death related to maternal methamphetamine use. This death is included in the Drugs & Poisons chapter.

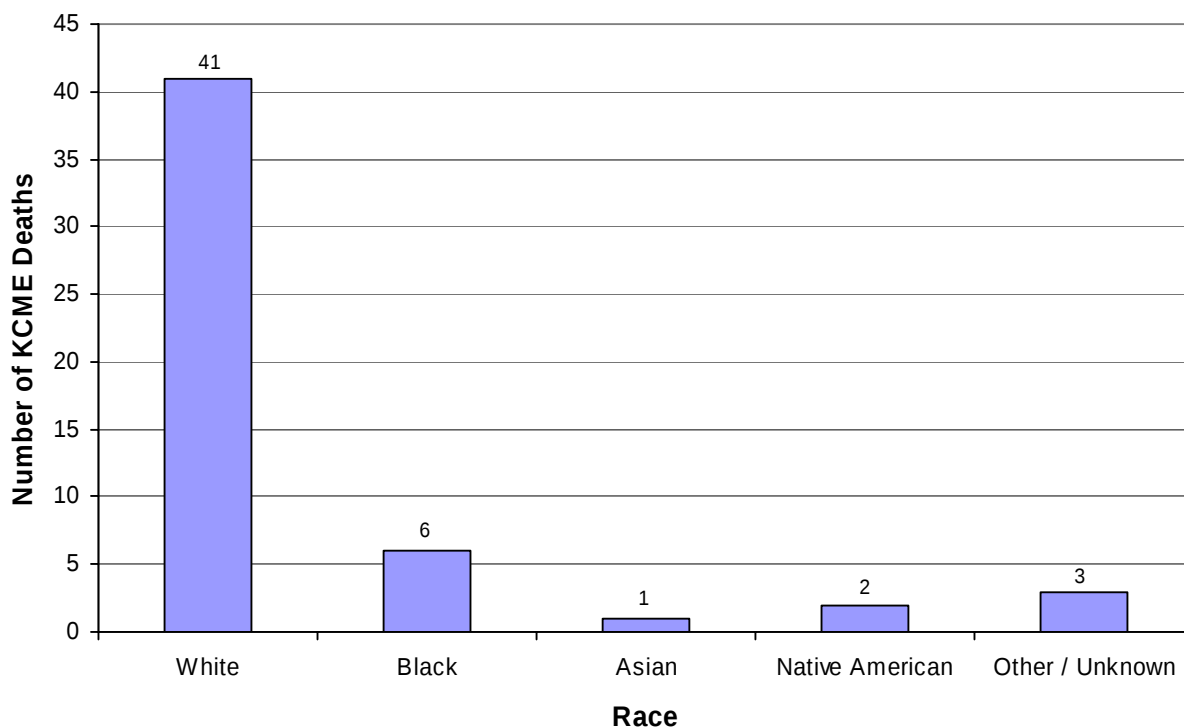
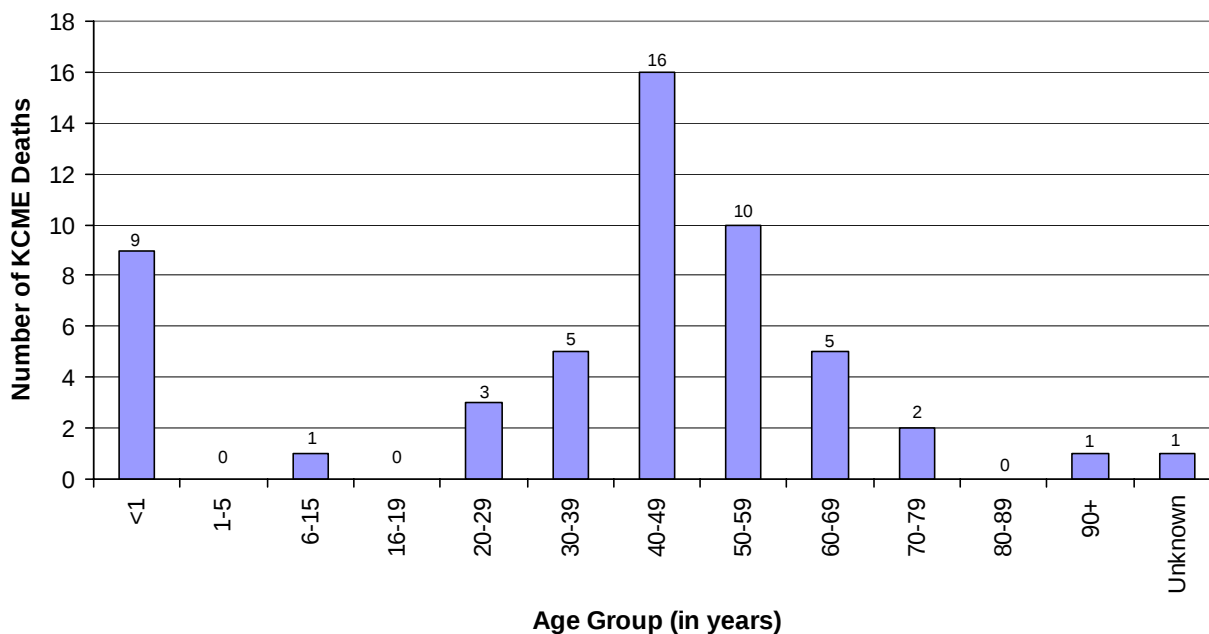
Graph 8-2 Undetermined Manner / Race / King County Medical Examiner / 2006**Graph 8-3 Undetermined Manner / Age Group / King County Medical Examiner / 2006**

Table 8-2 Undetermined Circumstances / Age / Sex / KCME / 2006

INJURY METHOD / SEX	AGE GROUP (YEARS)												SUB TOTAL	TOTAL
	<1	1 to 5	6 to 15	16 to 19	20 to 29	30 to 39	40 to 49	50 to 59	60 to 69	70 to 79	80 to 89	90 +		
Blunt Force	0	0	0	0	0	0	4	1	1	0	0	0		6
<i>Male</i>	0	0	0	0	0	0	3	0	1	0	0	0	4	
<i>Female</i>	0	0	0	0	0	0	1	1	0	0	0	0	2	
Burns / Fire	0	0	0	0	0	0	0	0	1	0	0	0		1
<i>Male</i>	0	0	0	0	0	0	0	0	1	0	0	0	1	
<i>Female</i>	0	0	0	0	0	0	0	0	0	0	0	0	0	
Drugs / Poisons	0	0	0	0	1	1	4	5	1	1	0	0		13
<i>Male</i>	0	0	0	0	1	0	2	2	0	1	0	0	6	
<i>Female</i>	0	0	0	0	0	1	2	3	1	0	0	0	7	
Fall	0	0	0	0	0	0	2	0	0	0	0	0		2
<i>Male</i>	0	0	0	0	0	0	2	0	0	0	0	0	2	
<i>Female</i>	0	0	0	0	0	0	0	0	0	0	0	0	0	
Fetal Deaths	9	0	0	0	0	0	0	0	0	0	0	0		9
<i>Male</i>	5	0	0	0	0	0	0	0	0	0	0	0	5	
<i>Female</i>	2	0	0	0	0	0	0	0	0	0	0	0	2	
<i>Unknown</i>	2	0	0	0	0	0	0	0	0	0	0	0	2	
Firearms	0	0	1	0	1	0	0	1	0	0	0	0		3
<i>Male</i>	0	0	1	0	1	0	0	0	0	0	0	0	2	
<i>Female</i>	0	0	0	0	0	0	0	1	0	0	0	0	1	
No anatomic or toxicological cause of death	0	0	0	0	0	1	1	1	0	0	0	0		3
<i>Male</i>	0	0	0	0	0	0	1	1	0	0	0	0	2	
<i>Female</i>	0	0	0	0	0	1	0	0	0	0	0	0	1	
Other ²	0	0	0	0	1	3	5	2	2	1	0	1		16
<i>Male</i>	0	0	0	0	1	2	5	2	1	1	0	1	13	
<i>Female</i> ³	0	0	0	0	0	1	0	0	1	0	0	0	3	
Totals⁴	9	0	1	0	3	5	16	10	5	2	0	1		53
Percent	17.3	0	1.9	0	5.8	9.6	30.8	19.2	9.6	3.9	0	1.9		100%

²Includes one female of undetermined age.³Includes one female of undetermined age.⁴Includes one female of undetermined age.

Table 8-3 Undetermined Manner / Sex / King County Medical Examiner / 2006

INJURY METHOD	SEX		TOTAL
	MALE	FEMALE	
Blunt Force	4	2	6
Burns / Fire	1	0	1
Drugs / Poisons	6	7	13
Fall	2	0	2
Fetal Deaths ⁵	5	2	7
Firearms	2	1	3
No Anatomic or Toxicologic Cause of Death	2	1	3
Other	13	3	16
Totals⁶	35	16	51
Percent	69%	31%	100%

Table 8-4 Undetermined Manner / Blood Alcohol / King County Medical Examiner / 2006

METHOD	TESTED		NOT	TOTAL
	POSITIVE	NEGATIVE	TESTED	
Blunt Force	4	1	1	6
Burns / Fire	0	1	0	1
Drugs / Poisons	3	7	3	13
Fall	1	0	1	2
Fetal Deaths	0	3	6	9
Firearms	0	3	0	3
No Anatomic or Toxicologic Cause of Death	2	1	0	3
Other	7	3	6	16
Totals	17	19	17	53
Percent	32%	36%	32%	100%

⁵Does not include two fetal deaths of undetermined sex.⁶Does not include two fetal deaths of undetermined sex.

DEATHS DUE TO DRUGS & POISONS: 2006

In 2006, drugs and poisons caused 313 deaths (excluding 19 deaths due to carbon monoxide). This comprised approximately 15% of all deaths investigated (313/2,055). The total number of drug caused deaths has increased compared to 2005 figures when there were 273 drug deaths. In 2004 there were 278 drug caused deaths, in 2003, there were 220, in 2002, there were 216, and in 2001, there were 165. In 2006, deaths due to drugs and poisons comprised 31% (313/1,001) of all suicides, accidents, homicides, and undetermined deaths combined.

Of the drug/poison deaths in 2006, a single drug or poison caused 32% of the deaths (99/313), and drugs or poisons in combination caused 68% (214/313) of the deaths. Multiple drug intoxication continued to cause the majority of drug deaths in 2006 (71% in 2005 and 2004, 72% in 2003, 65% in 2002, and 65% in 2001). Table 9-3 displays the specific drugs that caused death in 2006. Because of their prevalence, ethanol, cocaine (a stimulant), and opiates¹ (a narcotic) are identified as separate drug categories. Data on deaths involving methadone, oxycodone, and methamphetamine are also shown in detail.

The manners of “accident,” “homicide,” “suicide,” and “undetermined” are represented in the deaths due to drugs and poisons. In 2006, there was one homicidal death attributed to drugs/poisons. In the previous five years, there were no homicidal deaths in which drugs or poisons were the primary cause of the death, although the victim may have been under the influence of drugs at the time of the fatal incident.

The classification of undetermined manner is used when the circumstances surrounding the drug death does not allow clarification of whether the fatal intoxication was intentional, unintentional (“recreational”), or involved another person's actions. In the year 2006, drugs and poisons caused 14 deaths of undetermined manner, compared to 18 in 2005, 26 in 2004, 32 in 2003, 20 in 2002, and 21 in 2001. Of the 14 undetermined drug related deaths in 2006, one was a fetal death associated with maternal methamphetamine use.

In 2006, drugs/poisons caused 36 suicides, as compared to 39 in 2005, 41 in 2004, 29 in 2003, 23 in 2002, and 20 in 2001.

Drugs/poisons caused 262 accidental overdoses in 2006 compared to 216 in 2005, 211 in 2004, 159 in 2003, 173 in 2002, and 124 in 2001. In 2006, accidental drug deaths comprised 36% (262/721) of all accidental deaths.

¹ When the term “opiate” is used in this section, the drug detected by analysis is a derivative of opium, usually morphine, the source of which is either pharmaceutical morphine or, much more likely, heroin.

Ethanol (alcohol) is also a drug to be critically examined for its contribution to the circumstances surrounding death. In 2006, eight accidental deaths were attributed to acute ethanol intoxication where ethanol was the single substance used. There were 53 deaths where ethanol, in combination with other drugs, was the cause of death. Blood alcohol (ethanol) tests were performed in 76% (992/1,303) of non-natural deaths. Blood alcohol tests are only performed when death occurs within 24 hours of the initial injury/event, or, in hospital deaths, when an admission blood sample is available for testing. Positive blood alcohol levels were detected in 28% (280/992) of non-natural deaths where tests were performed.

Blood alcohol tests are performed on most persons who die within 24 hours of the incident. It should be noted that in many cases of traffic and homicide deaths, persons responsible for the death other than the decedent were under the influence of alcohol. The blood alcohol data are presented to show the levels of alcohol among those that died, but does not reflect the presence of alcohol among all parties involved.

Table 9-1 Blood Alcohol Testing / Manner / King County Medical Examiner / 2006

Test Results	ACCIDENT	TRAFFIC	HOMICIDE	NATURAL	SUICIDE	UNDETERMINED	TOTAL
Tested	483	171	84	476	218	36	1468
<i>Positive</i>	102	63	26	69	72	17	349
<i>Negative</i>	381	108	58	407	146	19	1119
Not Tested	238	40	7	276	9	17	587
Totals	721	211	91	752	227	53	2,055

Table 9-2 Blood Alcohol Testing / Percentage / Manner / KCME / 2006

Test Results	ACCIDENT	TRAFFIC	HOMICIDE	NATURAL	SUICIDE	UNDETERMINED	TOTAL
Tested	67%	81%	92%	63%	96%	68%	71%
<i>Positive</i>	21%	37%	31%	14%	33%	47%	24%
<i>Negative</i>	79%	63%	69%	86%	67%	53%	76%
Not Tested	33%	19%	8%	37%	4%	32%	29%
Totals	100%	100%	100%	100%	100%	100%	100%

Table 9-3

2006 Drug & Poison Caused Deaths¹

Drug Name	Total Deaths out of 2,055 Cases in which Drug was Present	Overdose Deaths (308) – Drug Present						Overdose Deaths (308) – Drug Causing					
		In which Listed Drug was Present	Single Drug OD in which Drug was Present	Multiple Drug OD in which Drug was Present	Accident	Suicide	Undetermined	In which Listed Drug Caused Death	In which a Single Drug Caused Death	In which Multiple Drugs Caused Death	Accident	Suicide	Undetermined
Acetaminophen	74	45	6	39	31	9	5	24	4	20	13	10	1
Alprazolam	30	23	1	22	19	4	0	21	0	21	17	4	0
Amantadine	1	0	0	0	0	0	0	0	0	0	0	0	0
Amitriptyline	37	21	1	20	15	5	1	20	0	20	15	4	1
Amphetamine	35	12	5	7	7	4	1	2	0	2	1	1	0
Atomoxetine	1	1	0	1	0	0	1	1	0	1	0	0	1
Bromodiphenhydramine	1	0	0	0	0	0	0	0	0	0	0	0	0
Brompheniramine	1	0	0	0	0	0	0	0	0	0	0	0	0
Bupivacaine	2	0	0	0	0	0	0	0	0	0	0	0	0
Bupropion	19	13	1	12	8	4	1	7	0	7	3	3	1
Butalbital	7	7	0	7	4	3	0	7	0	7	4	3	0
Cadmium	1	1	1	0	0	1	0	0	0	0	0	0	0
Caffeine	1	1	1	0	0	1	0	1	1	0	0	1	0
Cannabinoids / THC ²	167	55	15	40	49	5	1	0	0	0	0	0	0
Carbamazepine	9	7	3	4	5	1	1	4	0	4	3	1	0
Carbon Monoxide ³	28	16	16	0	6	10	0	19	19	0	8	11	0
Carisoprodol	14	11	0	11	8	2	1	8	0	8	6	1	1
Chlordiazepoxide	4	3	0	3	2	1	0	3	0	3	2	1	0
Chlorpheniramine	2	0	0	0	0	0	0	0	0	0	0	0	0
Citalopram	37	17	1	16	13	3	1	16	0	16	12	3	1
Clonazepam	4	2	0	2	0	2	0	0	0	0	0	0	0
Clozapine	2	0	0	0	0	0	0	0	0	0	0	0	0
Cocaine ⁴	159	106	36	70	101	4	1	115	44	71	110	4	1
Codeine ⁵	58	46	6	40	41	5	0	8	0	8	6	2	0
Cyanide	1	1	1	0	0	1	0	1	1	0	0	1	0

Table 9-3

2006 Drug & Poison Caused Deaths, page 2

Drug Name	Total Deaths out of 2,055 Cases in which Drug was Present	Overdose Deaths (308)						Overdose Deaths (308)					
		In which Listed Drug was Present	Single Drug OD in which Drug was Present	Multiple Drug OD in which Drug was Present	Accident	Suicide	Undetermined	In which Listed Drug Caused Death	In which a Single Drug Caused Death	In which Multiple Drugs Caused Death	Accident	Suicide	Undetermined
Cyclobenzaprine	14	8	0	8	7	1	0	5	0	5	4	1	0
Desipramine	4	2	0	2	2	0	0	0	0	0	0	0	0
Dextromethorphan	29	14	1	13	13	0	1	8	0	8	8	0	0
Diazepam	96	38	6	32	32	4	2	27	0	27	22	3	2
Diltiazem	13	8	2	6	5	3	0	3	1	2	1	2	0
Diphenhydramine	88	52	3	49	39	12	1	42	0	42	31	10	1
Doxepin	12	9	0	9	5	1	3	8	0	8	5	1	2
Doxylamine	12	6	1	5	4	1	1	3	0	3	3	0	0
Ethanol (Ethyl Alcohol)	350	81	12	69	64	14	3	61	8	53	51	9	1
Ethylene Glycol ⁶	1	1	1	0	0	1	0	2	2	0	0	1	1
Fentanyl	14	7	0	7	7	0	0	8	0	8	8	0	0
Fluoxetine	29	15	0	15	12	3	0	15	0	15	12	3	0
Flurazepam	2	2	1	1	0	2	0	1	0	1	0	1	0
Gabapentin	13	10	0	10	6	3	1	10	0	10	6	3	1
GHB	6	1	0	1	1	0	0	0	0	0	0	0	0
Guaifenesin	2	1	0	1	1	0	0	0	0	0	0	0	0
Hydrocodone	66	28	4	24	24	3	1	20	0	20	17	2	1
Hydromorphone	36	18	1	17	15	3	0	11	0	11	9	2	0
Hydroxyzine	1	0	0	0	0	0	0	1	0	1	1	0	0
Ibuprofen	22	14	3	11	7	5	2	3	0	3	1	2	0
Imipramine	5	2	0	2	2	0	0	2	0	2	2	0	0
Isopropanol	33	3	1	2	1	1	1	0	0	0	0	0	0
Ketamine	3	1	0	1	0	1	0	0	0	0	0	0	0
Lamotrigine	8	1	0	1	1	0	0	0	0	0	0	0	0
Lead	2	1	1	0	0	1	0	0	0	0	0	0	0

Table 9-3

2006 Drug & Poison Caused Deaths, page 3

Drug Name	Total Deaths out of 2,055 Cases in which Drug was Present	Overdose Deaths (308)						Overdose Deaths (308)					
		In which Listed Drug was Present	Single Drug OD in which Drug was Present	Multiple Drug OD in which Drug was Present	Accident	Suicide	Undetermined	In which Listed Drug Caused Death	In which a Single Drug Caused Death	In which Multiple Drugs Caused Death	Accident	Suicide	Undetermined
Levetriacetam	1	1	0	1	1	0	0	0	0	0	0	0	0
Lidocaine	4	1	1	0	1	0	0	0	0	0	0	0	0
Lorazepam	23	6	1	5	5	1	0	2	0	2	2	0	0
Loxapine	1	0	0	0	0	0	0	0	0	0	0	0	0
MDA	1	0	0	0	0	0	0	0	0	0	0	0	0
MDMA	11	3	0	3	0	2	1	1	0	1	0	0	1
Meclizine	2	1	0	1	1	0	0	1	0	1	1	0	0
Meperidine	3	2	0	2	1	1	0	2	0	2	1	1	0
Meprobamate	18	14	0	14	11	2	1	5	0	5	5	0	0
Methadone	125	100	15	85	95	2	3	96	13	83	92	1	3
Methamphetamine	44	19	9	10	15	3	1	21	8	13	16	3	2
Methanol	6	2	2	0	1	1	0	1	1	0	0	1	0
Methocarbamol	2	1	0	1	1	0	0	0	0	0	0	0	0
Methylphenidate	1	1	0	1	1	0	0	1	0	1	1	0	0
Metoclopramide	5	2	0	2	2	0	0	2	0	2	2	0	0
Midazolam	17	2	0	2	1	0	1	0	0	0	0	0	0
Mirtazepine	14	7	0	7	6	1	0	6	0	6	5	1	0
Morphine ⁷	160	79	16	63	73	5	1	76	12	64	70	4	2
Monoacetylmorphine ⁸	20	19	3	16	18	1	0	19	3	16	18	1	0
Nortriptyline ⁹	38	22	0	22	18	3	1	5	0	5	5	0	0
Olanzapine	8	4	0	4	3	1	0	5	0	5	4	1	0
Oxazepam	4	2	0	2	1	0	1	1	0	1	1	0	0
Oxycodone	98	45	1	44	38	7	0	47	1	46	40	7	0
Paroxetine	3	2	0	2	2	0	0	2	0	2	2	0	0
Phencyclidine (PCP)	3	0	0	0	0	0	0	3	0	3	3	0	0

Table 9-3

2006 Drug & Poison Caused Deaths, page 4

Drug Name	Total Deaths out of 2,055 Cases in which Drug was Present	Overdose Deaths (308)						Overdose Deaths (308)					
		In which Listed Drug was Present	Single Drug OD in which Drug was Present	Multiple Drug OD in which Drug was Present	Accident	Suicide	Undetermined	In which Listed Drug Caused Death	In which a Single Drug Caused Death	In which Multiple Drugs Caused Death	Accident	Suicide	Undetermined
Phenobarbital	10	4	1	3	4	0	0	3	0	3	3	0	0
Phentermine	1	1	0	1	1	0	0	1	0	1	1	0	0
Phenytoin	21	3	2	1	1	0	2	1	0	1	1	0	0
Primadone	1	0	0	0	0	0	0	0	0	0	0	0	0
Promethazine	4	3	0	3	3	0	0	10	0	10	8	2	0
Propofol	1	0	0	0	0	0	0	1	1	0	1	0	0
Propoxyphene	10	6	0	6	4	1	1	5	0	5	4	0	1
Pseudoephedrine	7	0	0	0	0	0	0	0	0	0	0	0	0
Quetiapine	5	3	0	3	2	1	0	3	0	3	2	1	0
Quinine/Quinidine	3	1	0	1	1	0	0	0	0	0	0	0	0
Salicylates	3	3	0	3	1	2	0	0	0	0	0	0	0
Sertraline	21	9	1	8	7	2	0	2	0	2	0	2	0
Temazepam	16	7	0	7	5	1	1	3	0	3	1	1	1
Topiramate	9	4	0	4	4	0	0	4	0	4	4	0	0
Tramadol	11	8	0	8	5	2	1	7	0	7	4	2	1
Trazodone	38	20	3	17	17	2	1	14	0	14	12	2	0
Valproic Acid	8	2	0	2	1	1	0	2	0	2	1	1	0
Venlafaxine	20	12	11	1	11	1	0	11	0	11	10	1	0
Verapamil	6	3	0	3	3	0	0	1	0	1	1	0	0
Zolpidem	16	5	0	5	4	1	0	4	0	4	3	1	0
ZZP	1	1	1	0	0	1	0	0	0	0	0	0	0

¹Table 9-3 is constructed on the basis of finding each of the listed drugs by laboratory analysis of the decedent's blood. The first column represents the total number of cases in which the specific drug was detected, regardless of cause and manner of death. The rest of the columns represent only drug overdose deaths and are divided into two parts. The part that lists "Drug Present" represents the number of cases in drug overdose deaths in which the drug was present in quantifiable amounts. The other part that lists "Drug Causing" represents the number of drug overdose deaths in which the specific drug caused or contributed to death in the opinion of the certifying Medical Examiner. In many cases, the numbers in the first part are more than those in the second part

because the drug, although present, was not considered to contribute significantly to death. In a few cases, the column that lists “In which Listed Drug Caused Death” is greater than the column that lists “In which Listed Drug was Present,” because the drug was detected but not in quantifiable levels, and the certifying Medical Examiner considered the drug to have contributed to death. Furthermore, there were 5 additional cases of drug overdose deaths in which no sample was available for analysis. All of these cases represent deaths due to anoxic brain injury that occurred in a hospital after the admission blood sample had been discarded, precluding a confirmatory laboratory analysis. These cases were certified on the basis of the medical records rather than laboratory analysis. These cases included three delayed overdose deaths of the following drugs: (1) acetaminophen; (2) cocaine and ethanol; (3) methadone and methamphetamine; and two delayed overdose deaths of cocaine alone (4) and (5).

²Cannabinoids are listed if they were found at any level in blood or urine, not necessarily in quantified levels. Cannabinoids in levels typically found are not considered lethal agents and, therefore, there are no instances of single drug overdose deaths involving cannabinoids or THC. Although cannabinoids/THC were not considered contributory to death, they were detected in overdose deaths as listed.

³Carbon monoxide fatalities are listed if the level of carboxyhemoglobin was 10% or greater. Suicides due to intentional inhalation of carbon monoxide accounted for 11 of the carbon monoxide deaths. In seven of the 11 carbon monoxide suicides, other drugs may have been present, but they did not contribute to the death. Accidental deaths due to inhalation of carbon monoxide accounted for eight of the carbon monoxide deaths. All of the accidental carbon monoxide deaths were attributed solely to inhalation of carbon monoxide; other drugs may have been present, but they did not contribute to the death. There were no undetermined deaths due to carbon monoxide in 2006. In three of the overdose deaths in 2006, carbon monoxide was listed as causing death, but CO levels were <10%; these deaths were certified on the basis of scene and circumstances, autopsy examination, and toxicology results. Other sources of carbon monoxide involved fire fatalities.

⁴Includes benzoyllecgonine.

⁵Out of the 46 overdose deaths involving codeine, in 35 cases, the source of the drug was likely small quantities of codeine present in heroin used by illicit drug users. In ten (10) cases the source of the drug was pharmaceutical codeine. The source of the codeine in one (1) case was unknown.

⁶The second ethylene glycol poisoning death was delayed, and the cause of death was based on finding oxalate crystals in the kidneys, not by toxicology.

⁷There were 79 overdose deaths involving morphine. In 55 of these cases, the source of the drug was likely the morphine derived from heroin preparations used by illicit drug users. In 17 of these cases the source of the morphine was likely pharmaceutical morphine, and in seven (7) of these cases the source of the morphine was not known.

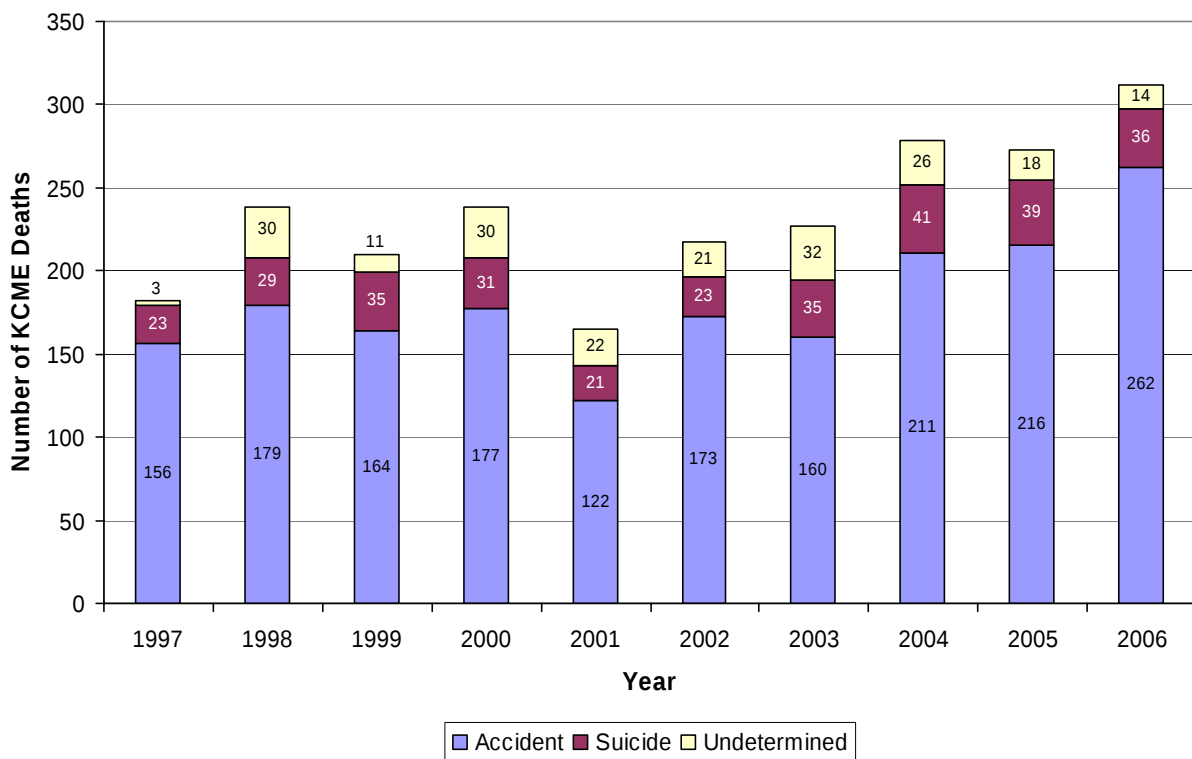
⁸Monoacetylmorphine (MAM) is the first breakdown product of heroin, otherwise known as diacetylmorphine. The presence of MAM, therefore, proves the source of opiate to be heroin. However, the absence of MAM does not imply that the source of the opiate was not heroin.

⁹In five (5) of the 22 total cases, nortriptyline was present without the presence of amitriptyline, indicating that the source of the drug was, in fact, nortriptyline. In the other 17 cases, amitriptyline was also present, indicating that the nortriptyline was present due to the breakdown of amitriptyline. There were a total of five nortriptyline overdose deaths; all accidental multiple drug overdoses.

Table 9-4 Total Overdose Deaths / Accident / Homicide / Suicide / Undetermined / King County Medical Examiner / 1997 - 2006⁹

OVERDOSE DEATHS	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Totals	182	231	210	235	165	216	226	278	273	313

Graph 9-1 Drug & Poison Caused Deaths / Accident / Suicide / Undetermined / King County Medical Examiner / 1997 - 2006¹⁰



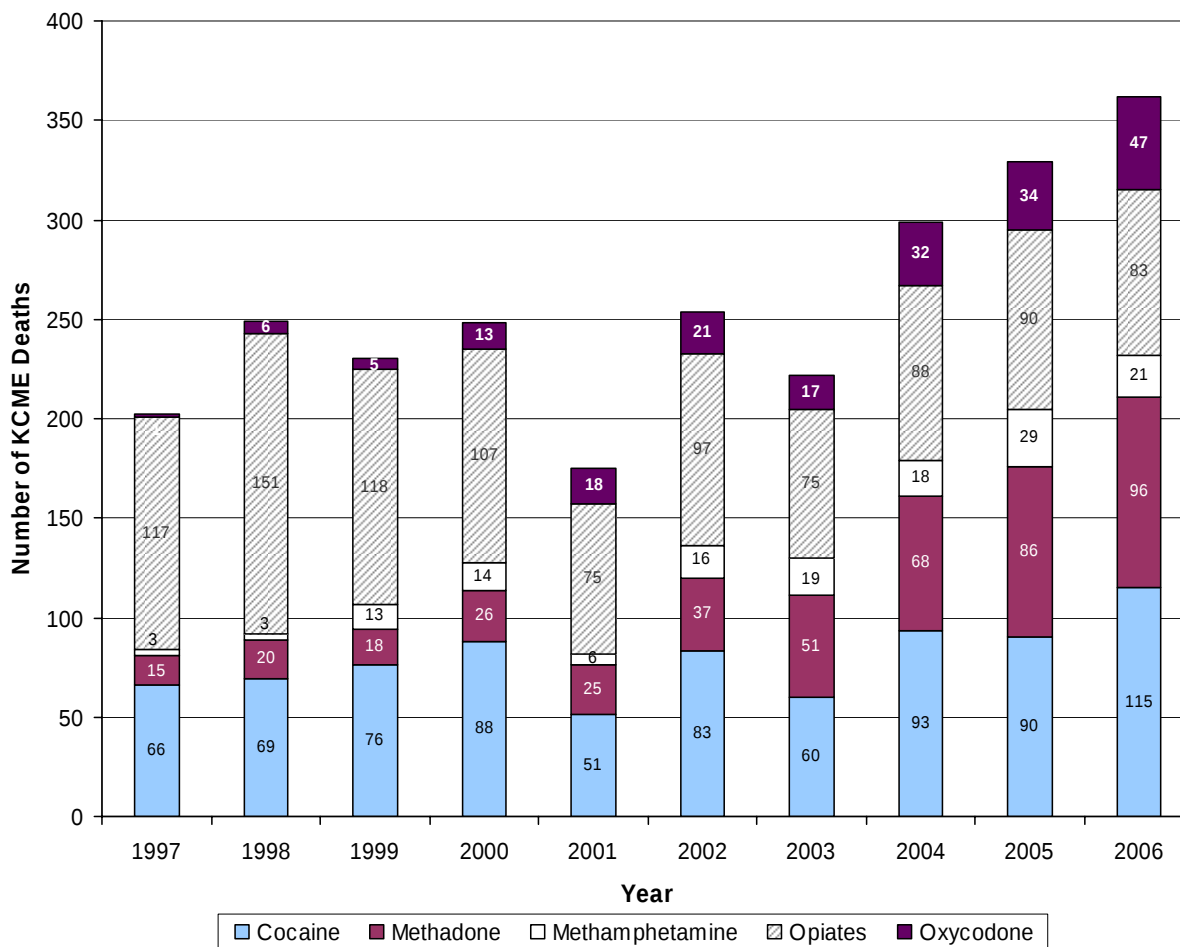
⁹ Includes all deaths classified as overdose, regardless of whether lab samples were available for analysis.

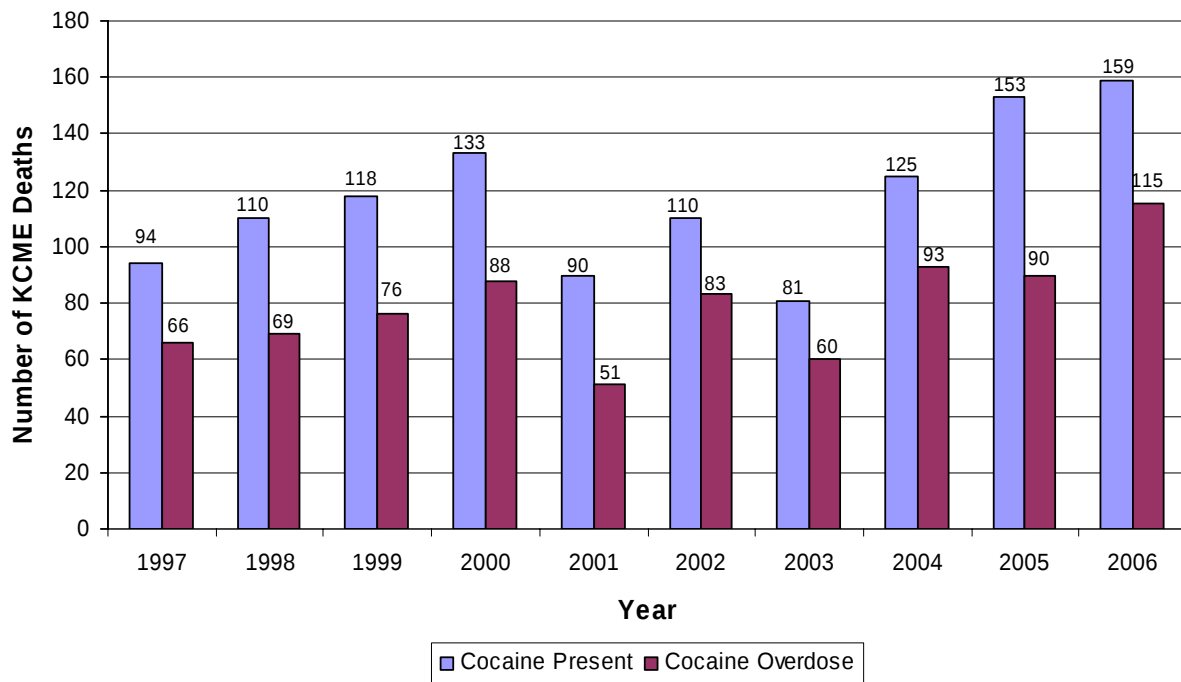
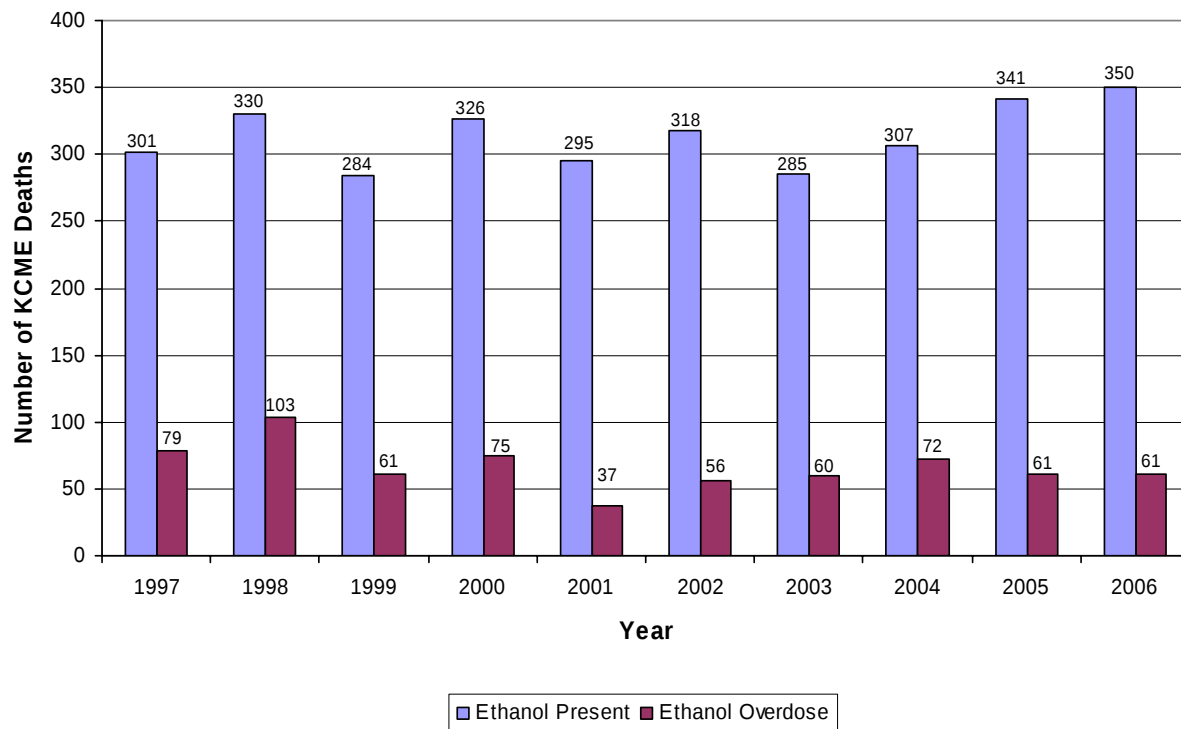
¹⁰ Does not include one drug/poison related homicide for 2006.

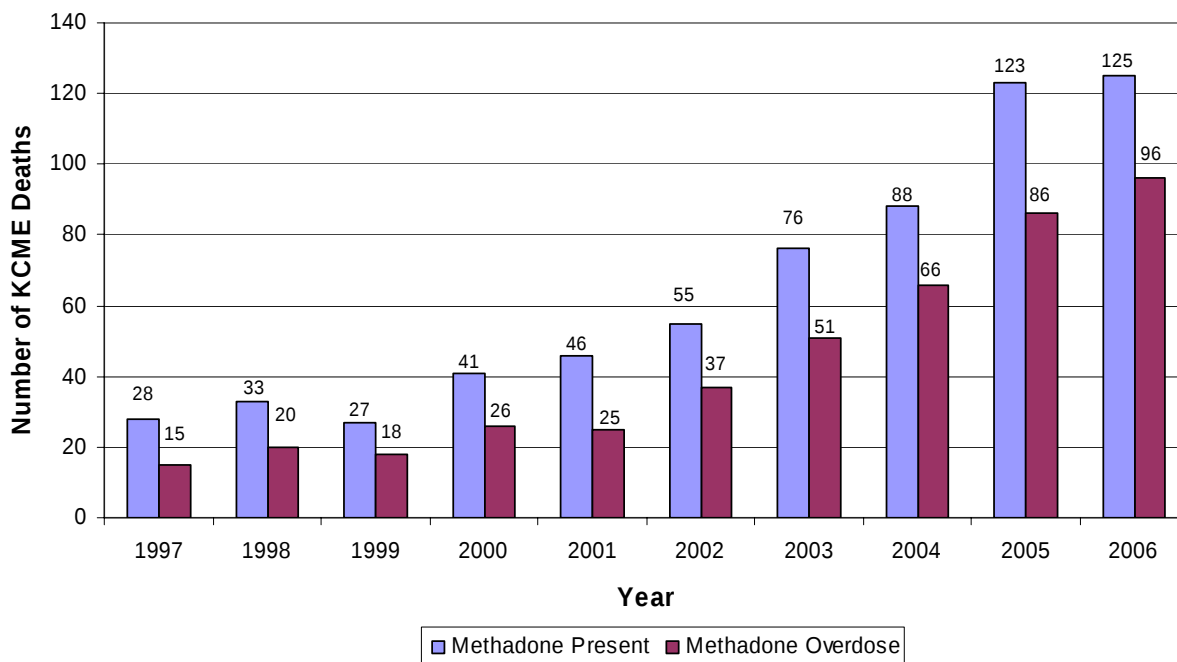
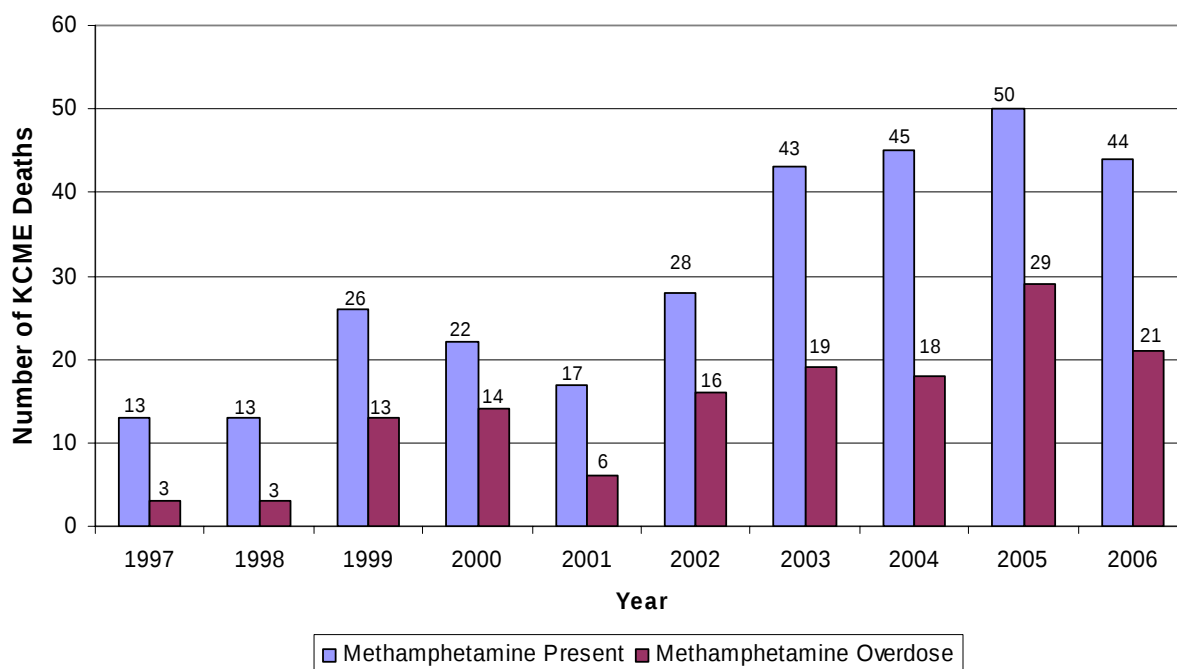
Table 9-5 **Overdose Deaths Involving Cocaine, Methadone, Opiates, Methamphetamine, or Oxycodone / KCME / 1997 - 2006**

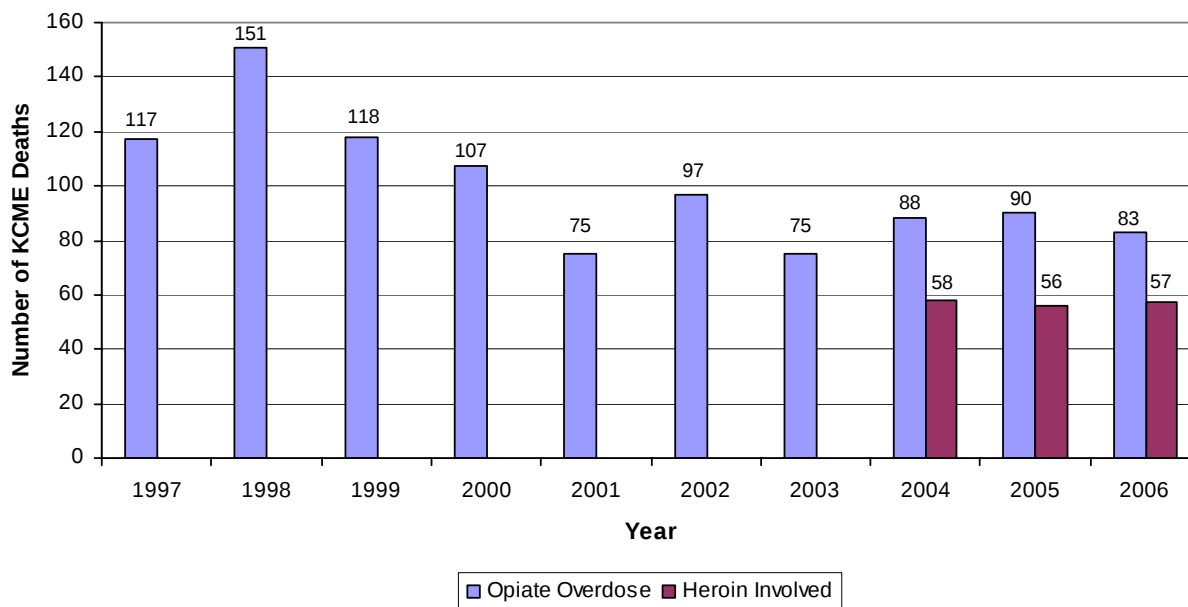
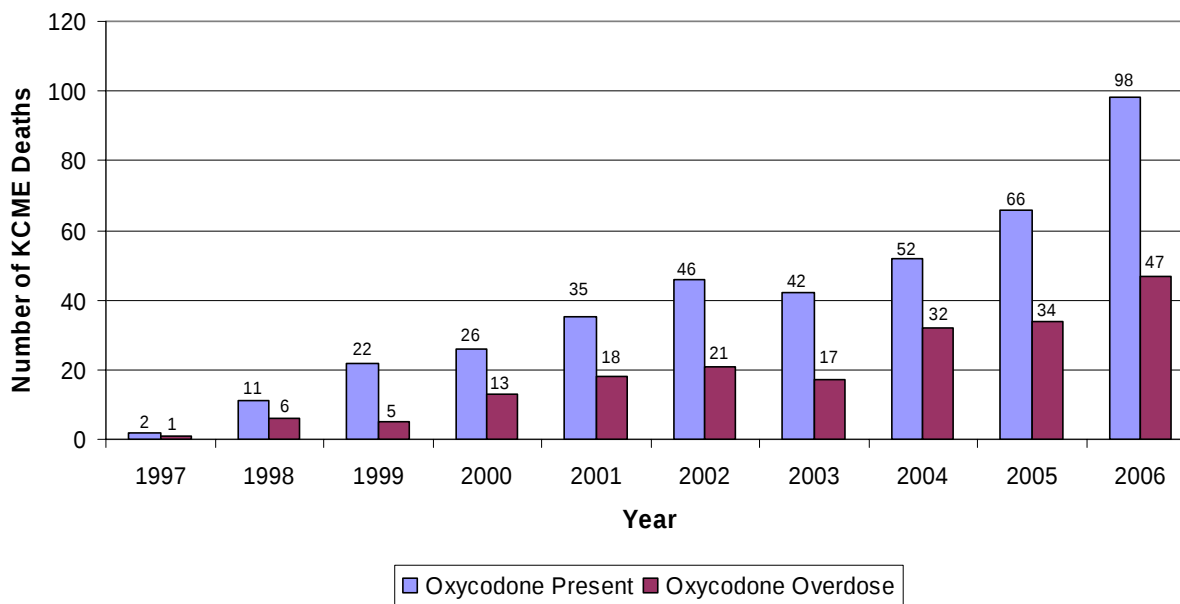
DRUG	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Cocaine	66	69	76	88	51	83	60	93	90	115
Methadone	15	20	18	26	25	37	51	68	86	96
Methamphetamine	3	3	13	14	6	16	19	18	29	21
Opiates	117	151	118	107	75	97	75	88	90	83
Oxycodone	1	6	5	13	18	21	17	32	34	47

Graph 9-2 **Overdose Deaths Involving Cocaine, Methadone, Opiates, Methamphetamine, or Oxycodone / KCME / 1997 – 2006**

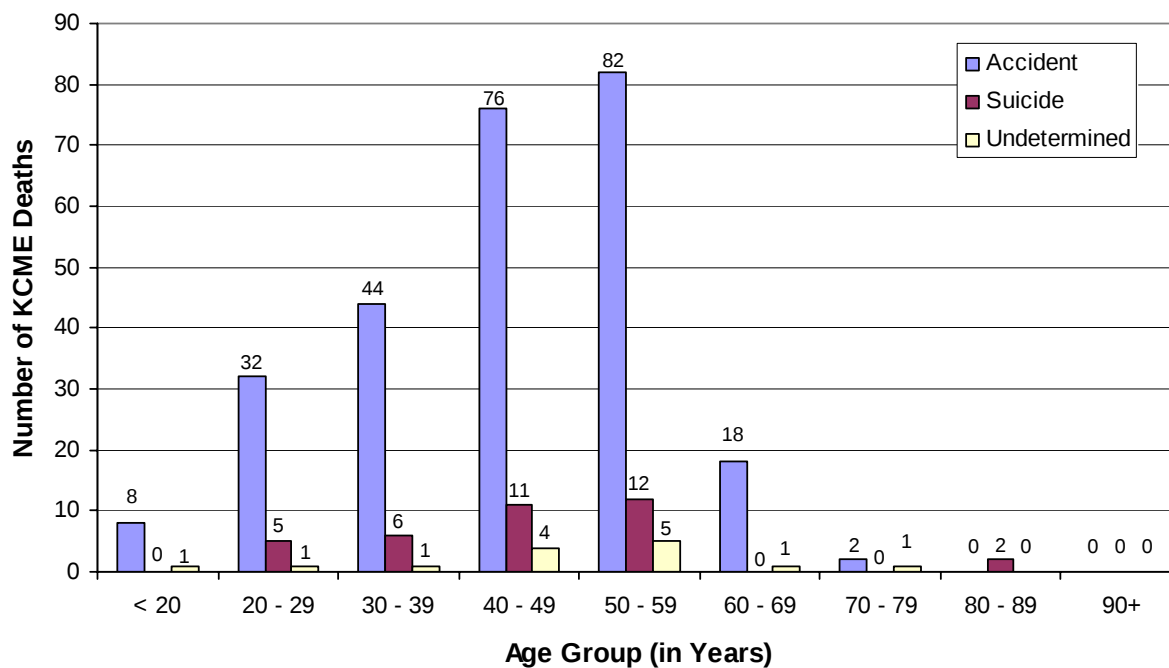


Graph 9-3 Cocaine Involved Deaths / King County Medical Examiner / 1997 - 2006**Graph 9-4 Ethanol Involved Deaths / King County Medical Examiner / 1997 - 2006**

Graph 9-5 Methadone Involved Deaths / King County Medical Examiner / 1997 - 2006**Graph 9-6 Methamphetamine Involved Deaths / KCME / 1997 – 2006**

Graph 9-7 Opiate Overdose Deaths & Heroin-Related Deaths / KCME / 1997 - 2006¹¹**Graph 9-8 Oxycodone Involved Deaths / King County Medical Examiner / 1997 - 2006**

¹¹ In 2004, the King County Medical Examiner's Office began collecting data on probable heroin overdoses based on a combination of scene, circumstances, and toxicology results.

Graph 9-9 Drug / Poison Deaths / Age / King County Medical Examiner / 1997 – 2006¹²

¹² Does not include one drug/poison related homicide in the 50-59 year age group for 2006.

Table 9-6 Drug / Poison Deaths / Age / King County Medical Examiner / 2006

AGE GROUP (YEARS) / SEX	MANNER OF DEATH				TOTAL	TOTAL
	ACCIDENT	HOMICIDE	SUICIDE	UNDETERMINE D		
<20	8	0	0	1		9
Male	7	0	0	1	8	
Female	1	0	0	0	1	
20-29	32	0	5	1		38
Male	25	0	2	1	28	
Female	7	0	3	0	10	
30-39	44	0	6	1		51
Male	29	0	2	0	31	
Female	15	0	4	1	20	
40-49	76	0	11	4		91
Male	51	0	6	2	59	
Female	25	0	5	2	32	
50-59	82	1	12	5		100
Male	54	1	5	2	62	
Female	28	0	7	3	38	
60-69	18	0	0	1		19
Male	13	0	0	0	13	
Female	5	0	0	1	6	
70-79	2	0	0	1		3
Male	1	0	0	1	2	
Female	1	0	0	0	1	
80-89	0	0	2	0		2
Male	0	0	0	0	0	
Female	0	0	2	0	2	
90+	0	0	0	0		0
Male	0	0	0	0	0	
Female	0	0	0	0	0	
Totals	262	1	36	14		313

DEATHS DUE TO FIREARMS: 2006

The Medical Examiner is responsible for investigating all deaths due to firearms that occur in King County. Medical Examiner data relate primarily to the victim because information regarding the weapon and the shooter is often unknown. The following data are specific to the victims of firearm deaths.

In 2006, the Medical Examiner investigated 153 firearm deaths. In 2005, firearms caused 146 deaths; in 2004 firearms caused 144 deaths; in 2003 firearms caused 155 deaths; and in 2002 firearms caused 153 deaths. Of the 153 firearm deaths in 2006, 52 (34%) were homicides and 98 (64%) were suicides. No firearm deaths were classified as accidental in 2006. In 2005 firearms caused two accidental deaths; in both 2004 and 2003 firearms caused one accidental death, and in 2002 there were no accidental firearms deaths. In 2006, firearms caused three deaths that were classified as undetermined. This compares to one in 2005, two in 2004, one in 2003, and two in 2002.

In 2006, gunshot wounds were the leading cause of death for homicides and suicides. Gunshot deaths comprised 57% (52/91) of homicides, compared to 59% (47/80) in 2005, 61% (46/76) in 2004, 56% in 2003 (52/93) and 58% in 2002 (53/92). In 2006, suicides by firearms represented 43% (98/227) of suicide deaths compared to 41% (96/233) in 2005, 42% (95/229) in 2004, 47% in 2003 (101/217), and 49% (98/200) in 2002.

In 2006, of the 52 gunshot homicide victims, 13% (7/52) were 19 years old and younger - a slight decrease from 2005 when 15% of gunshot homicide victims were 19 years old and younger. It is estimated that a disproportionate number of gunshot homicide victims were black (21%, 11/52) compared to the percentage of blacks in the general population. (See discussions on pages 5 and 43.) Of the 11 black gunshot homicide victims, 64% (7/11) were males between 20 and 29 years of age. In comparison, 52% (27/52) of the homicide gunshot victims were white. Of the 27 white homicide victims, 37% (10/27) were males between 20 and 29 years old.

Firearms were also the most common mode of committing suicide (43%, 98/227) in 2006. Of the 98 gunshot suicide victims, 91% (89/98) were white and 92% (90/98) were males. Five of the gunshot suicide victims were 19 years old and under (5%, 5/98). Twenty-six (27%, 26/98) of the gunshot suicide victims were between the ages of 20 and 39 years of age, 38 (39%, 38/98) were between 40 and 59 years, and 29 (30%, 29/98) were 60 years and older.

Table 10-1 Firearm Deaths / Manner / Age / Sex / King County Medical Examiner / 2006

AGE GROUP / SEX	MANNER OF DEATH				SUB TOTAL	TOTAL
	A	H	S	U		
<13 years	0	0	0	0		0
Male	0	0	0	0	0	
Female	0	0	0	0	0	
13-15 years	0	2	0	1		3
Male	0	0	0	1	1	
Female	0	2	0	0	2	
16-19 years	0	5	5	0		10
Male	0	5	5	0	10	
Female	0	0	0	0	0	
20-29 years	0	23	16	1		40
Male	0	23	15	1	39	
Female	0	0	1	0	1	
30-39 years	0	8	10	0		18
Male	0	8	10	0	18	
Female	0	0	0	0	0	
40-49 years	0	9	15	0		24
Male	0	8	13	0	21	
Female	0	1	2	0	3	
50-59 years	0	3	23	1		27
Male	0	2	21	0	23	
Female	0	1	2	1	4	
60-69 years	0	2	12	0		14
Male	0	1	11	0	12	
Female	0	1	1	0	2	
70-79 years	0	0	8	0		8
Male	0	0	7	0	7	
Female	0	0	1	0	1	
80-89 years	0	0	7	0		7
Male	0	0	6	0	6	
Female	0	0	1	0	1	
90+	0	0	2	0		2
Male	0	0	2	0	2	
Female	0	0	0	0	0	
Totals	0	52	98	3		153
Percent	0%	34%	64%	2%		100%

Graph 10-1 Firearm Deaths / Manner / Age Group / King County Medical Examiner / 2006

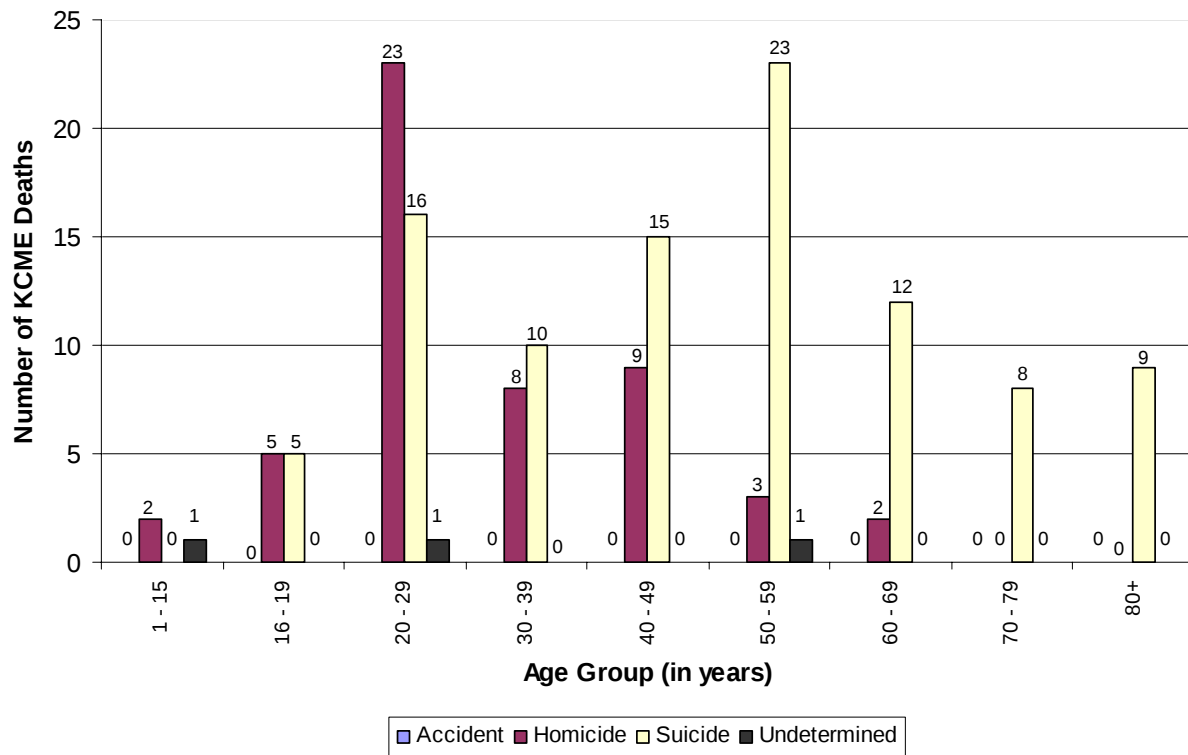


Table 10-2 Firearm Deaths / Manner / Race / Sex / KCME / 2006

RACE / SEX	MANNER OF DEATH				SUB-	
	A	H	S	U	TOTAL	TOTAL
Asian	0	12	4	0		16
Male	0	11	4	0	15	
Female	0	1	0	0	1	
Black	0	11	4	0		15
Male	0	11	4	0	15	
Female	0	0	0	0	0	
Native American	0	2	0	0		2
Male	0	2	0	0	2	
Female	0	0	0	0	0	
White	0	28	89	3		120
Male	0	24	81	2	107	
Female	0	4	8	1	13	
Other	0	0	1	0		1
Male	0	0	1	0	1	
Female	0	0	0	0	0	
Totals	0	53	98	3		153

CAUSES OF DEATH IN CHILDREN AND YOUTH

In 2006, the King County Medical Examiner's Office investigated 128 deaths of children and youth ages 19 years or younger, which represented 6% (128/2,055) of the total deaths investigated. Of these deaths, 30% (39/128) were natural, 23% (30/128) were accidents (non-traffic), 12% (15/128) were homicides, 24% (31/128) were traffic related, 9% (11/128) were suicides, and 0.8% (1/128) were classified as manner undermined. In addition to investigating childhood deaths, the King County Medical Examiner participates in Child Death Review, a process which discusses these deaths in detail and formulates prevention strategies.

Of the 39 natural deaths of children and youth investigated by the Medical Examiner, 64% (25/39) were of infants less than one year of age. Of these 25 infants who died of natural causes, 17 were due to Sudden Infant Death Syndrome (SIDS).

There were 31 children and youth whose deaths were classified as accidental, excluding traffic-related accidents. Another 31 children and youths died in traffic related accidents.

There were 15 homicides among children and youth. Of these 15 homicide victims, 9 were teenagers (13 - 19 years of age) and six were children under 12 years. Forty-seven percent (7/15) of the children and youth homicide victims died by firearms.

There were eleven youth suicides, all between the ages of 13 and 19 years. Males comprised 82% (9/11) of the victims. Regarding the methods used to commit suicide by youth, one was by asphyxia, five were by firearms, two were by hanging, two were by jumping, and one was by vehicle.

Thirty-one (31) children and youth (19 years and under) died in traffic-related accidents, of whom 27 (87%) were teenagers. There were 16 motor vehicle driver deaths and 11 motor vehicle passenger deaths among teenagers. There were no teenage bicycle, motorcycle, or pedestrian deaths in 2006. Of the 29 children and youths who died in motor vehicles, 14 were known to be restrained, eight were found not to be wearing any restraint, and it was unknown or undeterminable if the remaining seven were using seatbelts or any other restraint device.

The following tables list the causes of death among children and youth for all manners in three age groups: less than 1 year, 1-12 years and 13-19 years.

Graph 11-1 Causes of Death in Children & Youth / King County Medical Examiner / 2006

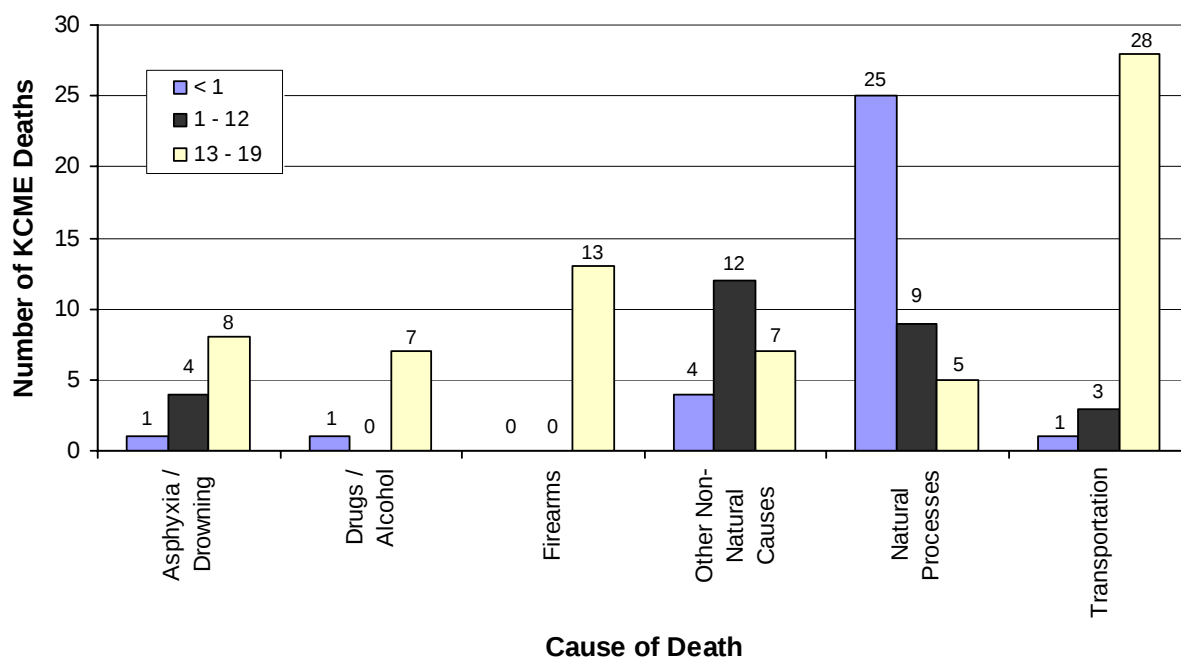


Table 11-1 Causes of Death: Children Under 1 Year of Age / KCME / 2006

CIRCUMSTANCES	MANNER OF DEATH						SUB	
	A	H	S	T	U	N	TOTAL	TOTAL
Miscellaneous	2	4	0	1	0	17		24
Asphyxia	1	0	0	0	0	0	1	
Aspiration	0	0	0	0	0	0	0	
Blunt Force / Crushing	0	4	0	0	0	0	4	
Burns / Fire	0	0	0	0	0	0	0	
Drugs	1	0	0	0	0	0	1	
Homicidal Violence	0	0	0	0	0	0	0	
Motor Vehicle Passenger	0	0	0	1	0	0	1	
Other	0	0	0	0	0	0	0	
SIDS	0	0	0	0	0	17	17	
Other Natural Disease	0	0	0	0	0	8		8
Totals	2	4	0	1	0	25		32

Table 11-2 Causes of Death: Children 1 to 12 Years of Age / KCME / 2006

CIRCUMSTANCES	MANNER OF DEATH						SUB	
	A	H	S	T	U	N	TOTAL	TOTAL
Asphyxia	4	0	0	0	0	0		4
<i>Carbon Monoxide</i>	0	0	0	0	0	0	0	
<i>Drowning</i>	4	0	0	0	0	0	4	
<i>Hanging</i>	0	0	0	0	0	0	0	
<i>Mechanical</i>	0	0	0	0	0	0	0	
<i>Other</i>	0	0	0	0	0	0	0	
<i>Positional</i>	0	0	0	0	0	0	0	
Miscellaneous	9	0	0	0	0	0		9
<i>Complication of Therapy</i>	2	0	0	0	0	0	2	
<i>Drugs</i>	0	0	0	0	0	0	0	
<i>Fire / Explosion</i>	2	0	0	0	0	0	2	
<i>Hyperthermia</i>	0	0	0	0	0	0	0	
<i>Jump</i>	0	0	0	0	0	0	0	
<i>Non Traffic -Vehicle</i>	4	0	0	0	0	0	4	
<i>Other</i>	1	0	0	0	0	0	1	
Physical Trauma	1	2	0	0	0	0		3
<i>Abuse</i>	0	0	0	0	0	0	0	
<i>Blunt Force / Crushing</i>	1	0	0	0	0	0	1	
<i>Burns / Fire</i>	0	0	0	0	0	0	0	
<i>Firearms</i>	0	0	0	0	0	0	0	
<i>Incised / Stab Wound(s)</i>	0	2	0	0	0	0	2	
Transportation Related	0	0	0	3	0	0		3
<i>Bicycle</i>	0	0	0	0	0	0	0	
<i>Motor Vehicle Passenger</i>	0	0	0	1	0	0	1	
<i>Motorcycle</i>	0	0	0	0	0	0	0	
<i>Pedestrian</i>	0	0	0	2	0	0	2	
Natural Disease	0	0	0	0	0	9		9
Totals	14	2	0	3	0	9		28

Table 11-3 Causes of Death: Children 13 to 19 Years of Age / KCME / 2006

CIRCUMSTANCES	MANNER OF DEATH						SUB	
	A	H	S	T	U	N	TOTAL	TOTAL
Asphyxia	5	0	3	0	0	0		8
<i>Carbon Monoxide</i>	1	0	0	0	0	0	1	
<i>Drowning</i>	3	0	0	0	0	0	3	
<i>Hanging</i>	0	0	2	0	0	0	2	
<i>Smothering</i>	0	0	0	0	0	0	0	
<i>Positional</i>	1	0	0	0	0	0	1	
<i>Other</i>	0	0	1	0	0	0	1	
Drugs / Alcohol	7	0	0	0	0	0		7
Miscellaneous	3	2	2	0	0	0		7
<i>Complication of Therapy</i>	2	0	0	0	0	0	2	
<i>Fall</i>	1	0	0	0	0	0	1	
<i>Jump</i>	0	0	2	0	0	0	2	
<i>Non-Traffic Vehicular</i>	0	0	0	0	0	0	0	
<i>Other</i>	0	2	0	0	0	0	2	
Physical Trauma	0	7	5	0	1	0		13
<i>Blunt Force / Crushing</i>	0	0	0	0	0	0	0	
<i>Firearms</i>	0	7	5	0	1	0	13	
<i>Homicidal Violence</i>	0	0	0	0	0	0	0	
<i>Incised / Stab Wound(s)</i>	0	0	0	0	0	0	0	
<i>Strangulation</i>	0	0	0	0	0	0	0	
<i>Struck by Train</i>	0	0	0	0	0	0	0	
Transportation Related	0	0	1	27	0	0		28
<i>Bicycle</i>	0	0	0	0	0	0	0	
<i>Motor Vehicle Driver</i>	0	0	1	16	0	0	17	
<i>Motor Vehicle Passenger</i>	0	0	0	11	0	0	11	
<i>Motorcycle</i>	0	0	0	0	0	0	0	
<i>Pedestrian</i>	0	0	0	0	0	0	0	
Natural Disease	0	0	0	0	0	5		5
Totals	15	9	11	27	1	5		68

MEDICAL EXAMINER ACTIVITY

The staff members of the Medical Examiner's Office are involved in a wide variety of activities commensurate with the mission of the office including responding to and investigating the scene of death, performing postmortem examinations, certifying the cause and manner of death, and providing information and assistance to families. Investigators, who are familiar with the emotional trauma of an unexpected death, communicate directly with the family as do the Medical Examiner pathologists, who review their findings with the families in order to clarify the many questions that accompany a sudden loss of life. The office also provides referrals to grief support services.

In all cases investigated by the Medical Examiner, it is essential that the decedent's identity is established and the next-of-kin is located and notified regarding the death. In addition, property belonging to the decedent must be controlled and released according to legal requirements. In most cases these issues are resolved expeditiously. In certain cases, identification requires additional effort in locating dental, medical or police records. Some individuals may have died leaving no next-of-kin or next-of-kin far removed. Ensuring that all leads have been exhausted in pursuit of next-of-kin can be a very time consuming but ultimately rewarding effort.

The postmortem examination on each decedent includes the preservation of various body fluids and tissues for microscopic and toxicologic analysis. Photographs are taken of the external and internal portions of the examination, which are available for review at a later date if needed. Photographic documentation is also an essential item in those cases where the pathologist must provide court testimony. Forensic anthropology is another important activity necessary to resolve skeletal cases and difficult identification issues.

Medical Examiner pathologists and investigators provide testimony in court and at depositions. Staff participates in meetings with police, medical professionals, and attorneys. A recent addition to the duties of the Chief Medical Examiner is expert medical consultation and testimony in cases involving nonfatal domestic violence assaults.

Autopsy reports and related data from individual investigations are provided to law enforcement agencies, to prosecuting attorneys and to many other agencies including Labor and Industries, the Drug Enforcement Administration, and the Consumer Product Safety Commission. Drug-related deaths are reported to the Drug Abuse Warning Network (DAWN), a national public health surveillance system that monitors drug trends.

Medical Examiner investigations require frequent contact between the Medical Examiner's Office and various media personnel. Staff members are skilled in responding to the media inquiries that occur daily. The Medical Examiner pathologists and other staff participate in a variety of medical conferences, and provide information on a regular basis to law enforcement and to medical personnel on various aspects regarding the role and function of the Medical Examiner's Office.

The data collected and presented in this and other Medical Examiner annual reports also provide baseline information for further analysis. Medical Examiner staff analyzes data to study relevant death investigation topics that have applications in such fields as law enforcement, medicine, law, social sciences, and injury prevention. Examples include infant mortality, teenage suicide, child abuse, law enforcement restraint, investigation of vehicular traffic accidents, and investigation of therapeutic complication deaths. In addition, the office participates in teaching medical students, pathology residents, emergency medical service, and law enforcement personnel.

In 2006, staff participated as speakers at universities, conferences, and training seminars for law enforcement, medical, legal, and social service personnel in the following presentations and lectures:

Richard C. Harruff, MD, PhD, Chief Medical Examiner

Academic Appointment:

- Clinical Associate Professor, Department of Pathology, University of Washington School of Medicine

Associations, Committees and Boards:

- Advisory Board, University of Washington Certificate Program in Forensics
- Community Advisory Board, University of Washington School of Nursing, Advanced Practice Forensic Nurse Specialist Program
- King County Child Death Review Committee
- King County Elder Abuse Council
- Member, Disaster Mortuary Operations Response Team, Region 10
- Member, American Academy of Forensic Sciences
 - Best Resident Paper Award Committee
- Member, National Association of Medical Examiners
 - International Relationships Ad hoc Committee
 - Forensic Pathology Fellowship Training Subcommittee
- Member, Washington Association of Coroners and Medical Examiners
- Member, American Medical Association
- Member, Washington State Medical Association

Preceptorships:

- University of Washington School of Medicine, medical students and pathology residents.
- University of Washington School of Nursing, graduate students in Forensic Nursing.

Professional Meetings:

- National Association of Medical Examiners, Interim Meeting, Seattle, WA, February 21.
- National Association of Medical Examiners, Annual Meeting, San Antonio, TX, October 13-18.

Trainings and Certifications:

- ICS 100, 200 and 700 National Incident Management System Certification, Emergency Management Institute, Federal Emergency Management Agency, September 7, 21; December 27.
- Security and Health Information Privacy Training, Public Health – Seattle & King County, March.

Award:

- Take Action Award Recipient, Seventh Annual Take Action Against Domestic Violence Awards Reception, King County Coalition Against Domestic Violence, Seattle City Hall, October 26.

Scientific Presentations:

- Pathology of environmental and occupational toxic exposures. Workshop: Forensic Toxicology – The World Outside of Drugs. American Academy of Forensic Sciences Annual Meeting, Seattle, WA, February 20-25.
- Necrotizing fasciitis: manifestations, microbiology and connection with black tar heroin. Dunbar NM, Wigren C, Harruff RC, American Academy of Forensic Sciences Annual Meeting, Seattle, WA, February 20-25.
- Measuring misuse of prescription-type opiates: implications for public health. Banta-Green C, Merrill J, Logan B, Harruff RC, Gordon AM. American Public Health Association, 134th Annual Meeting and Exposition, Boston, MA, November 7.
- Intestinal perforations and volvulus in a young child due to swallowed toy magnets. Harruff RC. National Association of Medical Examiners Annual Meeting, San Antonio, TX, October 13-18.

Local and Regional Educational Presentations:

- Automobile Accident Reconstruction
Certificate Program in Forensics, University of Washington
Seattle, WA April 10
- Infant Deaths
Certificate Program in Forensics, University of Washington
Seattle, WA April 10
- Basic Death Investigation

Forensics Sciences Course
Seattle University
Seattle, WA April 13

- Pattern Injuries and Strangulation
Sexual Assault Nurse Examiners (SANE) Core Training
University of Washington
Seattle, WA April 26
- Child Abuse & Neglect, Homicide, and Sudden Infant Death Syndrome
14th Annual Children's Justice Conference
Washington State Convention and Trade Center
Seattle, WA May 1-2
- Investigation of Sudden Unexpected Infant Death
Co-presented with Dr. Kathy Taylor
Federal Bureau of Investigation
Seattle, WA, August 24
- Investigation of Traffic Fatalities
Medicolegal Death Investigator Training
Olympia, WA December 4
- Investigation of Infant Deaths
Medicolegal Death Investigator Training
Olympia, WA December 4

J. Matthew Lacy, MD, Associate Medical Examiner

Associations, Committees and Boards:

- Associate Member, American Academy of Forensic Scientists
- Fellow, College of American Pathologists
- Member, National Association of Medical Examiners
- Member, Washington Association of Coroners and Medical Examiners

Preceptorships:

- Clinical Instructor, Department of Pathology, University of Washington School of Medicine

Publications:

- *Fatal Delayed Posthypoxic Demyelination, An Unsuccessful Trial of Immunomodulatory Therapy.*
Khot S, Walker M, Lacy JM, Oakes P, Longstreth WT. *Neurocritical Care.* 2006; 6:1-4.

Local and Regional Educational Presentations:

- Medical Examiner Testimony
Franklin High School Mock Trial Team
King County Medical Examiner's Office
Seattle, WA January 12
- Opiate Related Deaths in King County
Chronic Pain Management – CME Clinical Course
Public Health Seattle & King County
Renton Community Center
Renton, WA January 24
- Small Cell Carcinoma of the Lung Contributing to Pulmonary Barotrauma with Air Embolism in a Recreational Diver: A Case Report and Review of the Literature
Poster Presentation, American Academy of Forensic Sciences Annual Meeting
Convention Center
Seattle, WA February 20
- Moderator, Best Resident Paper section
American Academy of Forensic Sciences Annual Meeting
Convention Center
Seattle, WA February 23
- Death Certification of Deaths in Custody
King County Medical Examiner's Advisory Committee
Seattle Police Training Facility
Seattle, WA March 21
- Natural Deaths
University of Washington Extension Program in Forensics
UW Campus
Seattle, WA April 10
- Drug Related Deaths in King County
King County Medical Examiner's Advisory Committee
Seattle Police Training Facility
Seattle, WA May 16
- The Medical Examiner and Public Health: Forensic Pathology in Service of the Living.
Grand Rounds, MEDEX Physician Assistant Program, University of Washington
UW Campus
Seattle, WA October 31
- Seattle Police Department TASER Instructor Training
Physician Observer/Commentator
SPD Training Facility
Seattle, WA December 14

Katherine Taylor, Ph.D., Forensic Anthropologist

Associations, Committees and Boards:

- Member, Missing Persons Task Force. Washington Association of Counties
- Board Member, SIDS Foundation of Washington
- Board Member, Department of Criminal Justice Advisory Board, Seattle University
- Member, American Board of Medicolegal Death Investigators
- Fellow, American Academy of Forensic Sciences

Presentations:

- A Career in Forensics
Panel Member for University of Washington Career Day
University of Washington
Seattle, WA, January 23
- Mass Fatality Response
University of Washington Emergency Management
University of Washington
Seattle, WA, January 26
- Outdoor Crime Scenes
Mason County Search & Rescue
Shelton, WA, March 30
- Forensic Anthropology
Annual Conference, American Society of Clinical Laboratory Specialists
Edmonds, WA, April 22
- Processing Outdoor Crime Scenes
Co-presented with the King County Sheriff's Office
Flathead County Search & Rescue
Missoula, MT, May 13 - 14
- Determination of Human versus Non-Human / Outdoor Crime Scenes
Washington State Search & Rescue Conference
Enumclaw, WA, May 19 - 20
- Equipment needed for a Mass Fatality Response
Multidisciplinary Equipment Purchasing Group
Renton, WA, June 4
- Instructor, Buried Body School for Law Enforcement
Lane County Sheriff's Office
Eugene, OR, August 14 - 16
- Processing Outdoor Crime Scenes
Co-presented with the King County Sheriff's Office
Kootenai County Search & Rescue
Coeur d' Alene, ID August 18 - 19
- Investigation of Sudden Unexpected Infant Death
Co-presented with Chief Medical Examiner, Dr. Richard Harruff

Federal Bureau of Investigation
Seattle, WA August 24

- Identifying the Unidentified
Washington Association of Coroners and Medical Examiners
Missing and Unidentified Persons Meeting
Wenatchee, WA October 5 – 6

Greg Hewett, Mdiv, Program Manager IV

Association & Committees:

- Member, Seattle University Advisory Committee, Criminal Justice Program
- Member, Washington Association of Coroners & Medical Examiners
- Washington State Registered Counselor

Presentations:

- Role & Responsibility of the King County Medical Examiner's Office
Seattle Police Department Explorer Post # 943
Seattle, WA, April 17

Alfred Noriega, Lead Forensic Medical Investigator

Association & Committees:

- Diplomate, American Board of Medicolegal Death Investigators
- Member, Washington Association of Coroners & Medical Examiners
- Member, Seattle University Advisory Committee, Criminal Justice Program

Presentations:

- Basic Forensic Death Investigation for Law Enforcement
Washington State Criminal Justice Training Academy, Class # 590
Burien, WA, February 22
- Role and Responsibility of the King County Medical Examiner
King County Sheriff's Office, Ten Print Unit
Seattle, WA, March 22
- Death Investigation, Responsibility of the Seattle Police Department and the KCMEO
Co-presented with Detective Suzanne Moore, Seattle Police Department
Quality Improvement Forum for Licensees/Providers of Adult Family Homes
Washington State Department of Human Health Services / Residential Care Services Region 4
Seattle, WA, April 6
- Role and Responsibility of the King County Medical Examiner's Office
Seattle Police Department Explorer Post 943

Seattle, WA, April 17

- Role and Responsibility of the King County Medical Examiner's Office
Mercer Island High School Career Day
King County Medical Examiners Office
Mercer Island, WA, May 22

Nathan Geerdes, BA Psychology, Medicolegal Death Investigator

Associations:

- Diplomate, American Board of Medicolegal Death Investigators
- Member, Washington Association of Coroners & Medical Examiners

Presentations:

- Role and Responsibility of the King County Medical Examiner's Office
Seattle University
Seattle, WA, January 18
- Role and Responsibility of the King County Medical Examiner's Office
Seattle University
Seattle, WA, January 25
- Role and Responsibility of the King County Medical Examiner's Office
Seattle University
Seattle, WA, April 12
- Role and Responsibility of the King County Medical Examiner's Office
Seattle University
Seattle, WA, April 19

Barry Peterson, Forensic Autopsy Technician

Associations:

- Member, Washington Association of Coroners & Medical Examiners

Presentations:

- Autopsy Procedures & Collection of Evidence at the KCMEO
Seattle Police Department Training Annex
Seattle, WA January 24

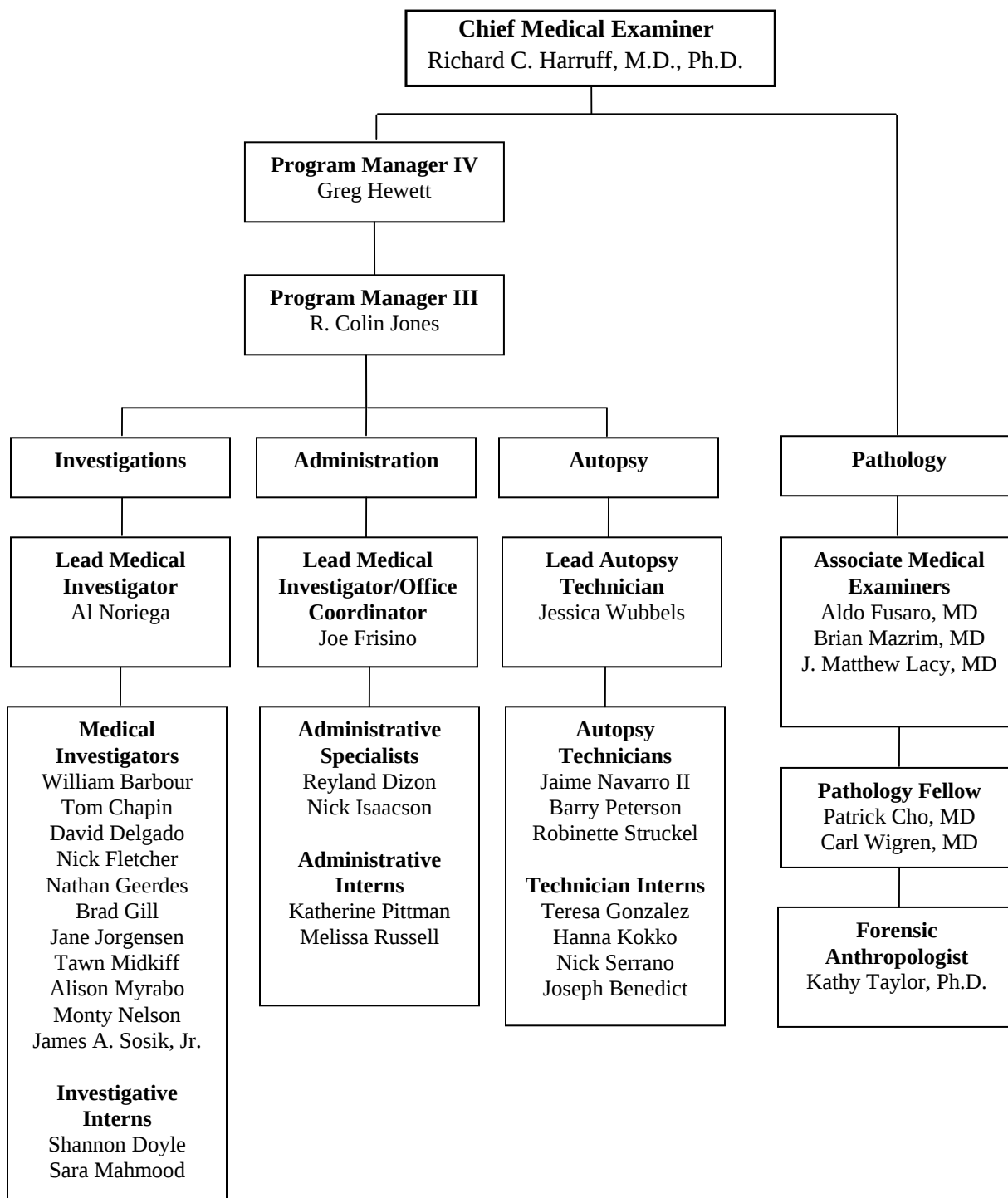
Table 12-1 **Weekly Variation of Deaths Investigated by the King County Medical Examiner's Office**

	TOTAL
Number of weeks studied	52
Mean number of cases assumed	39
Maximum in any one week	53
Minimum in any one week	29

Table 12-2 **Weekly Variation of Autopsies Performed by the King County Medical Examiner's Office**

	TOTAL
Number of weeks studied	52
Mean number of autopsies	27
Maximum in any one week	49
Minimum in any one week	16

Organization of the King County Medical Examiner's Office 2006



GLOSSARY OF TERMS

Blood alcohol level:	The concentration of ethanol (alcohol) found in blood following ingestion. Measured in grams per 100 ml of blood or grams %. In the State of Washington, 0.08 grams % is considered the 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. Recreational 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 Medical Examiner extends to all reportable deaths occurring within the boundaries of King 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 deaths reported fall within the jurisdiction of the Medical Examiner.
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 is 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: Accident	Death other than natural, where there is no evidence of intent, i.e., unintentional. In this report, traffic accidents are classified separately.

¹ DiMaio, Vincent J. & DiMaio, Dominick. 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 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 "Accident" in this report.
Manner: Undetermined	Manner assigned when there is insufficient evidence or information, especially about intent, to assign a specific manner.
Opiate:	Any preparation or 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 Medical Examiner assumes jurisdiction over fetal deaths that meet the criteria specified in RCW 68.50. See pages 2 - 3 of this report for details.
Race:	The racial categories used in this report are: White; Black; Native American; Asian (S.E. Asian/Pacific Islander); and Other.