

Grand County Coroner's Office



2019 Annual Report

Brenda L. Bock

Coroner

1003 Eagle Avenue | PO BOX 828 | Kremmling, CO 80459
970-724-0083 | co.grand.co.us/124/coroner

GRAND COUNTY CORONER'S OFFICE

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Brenda L. Bock, Coroner

We at the Grand County Coroner's office recognize that each death in this report represents the death of a person whose absence is grieved by family and friends.

To those individuals in Grand County who have suffered the loss of a relative or friend, this report is dedicated.



**Brenda Bock
Coroner**



**Tawnya Bailey
Chief Deputy Coroner**

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FOREWORD

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

When a death occurs on the job, or is work related, the results of our investigation are immediately forwarded to the State Department of Labor and Industry so that the family can gain the full benefit of our findings. Private insurance companies also routinely use these 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 Coroner's function is designed to isolate and identify causes of sudden, unexpected death. When an infectious agent or poison is implicated in a death, the family and persons recently in physical contact with the deceased are notified in order that they might receive any needed medical treatment.

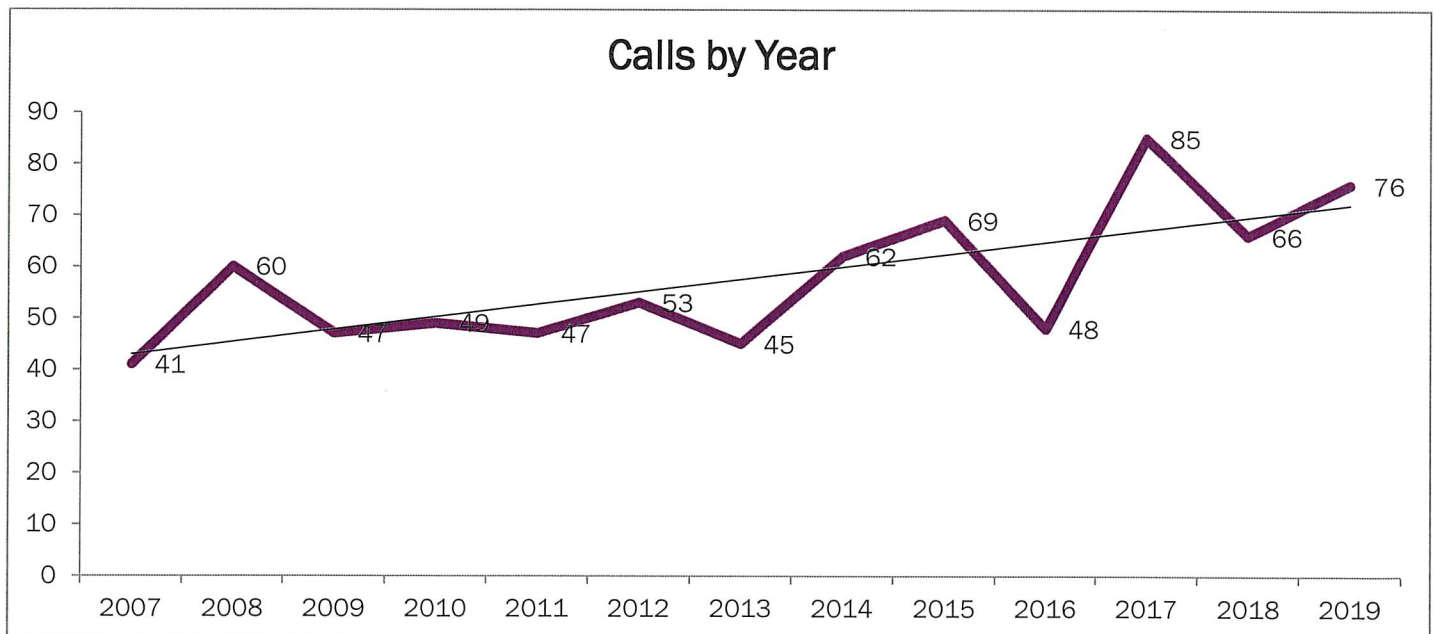
The medical investigation of violent death is frequently required in civil or criminal adjudication. Thus, a prompt medical investigation is conducted to provide the criminal justice system with medical information and evidence required for adjudication. Although criminal death investigations constitute a small portion of deaths investigated by the Coroner, these deaths are studied in great detail because of the issues and legal consequences involved. In this way, the criminal justice system is offered the best support.

CORONER CASES IN 2019

This report provides a summary of the raw data from the Grand County Coroner's 2019 cases.

In 2019, there were an estimated 85 deaths from Grand County. Of these deaths, 76 were reported to the Coroner's Office by medical and law enforcement personnel. Based on an analysis of the scene, the circumstances of death, and the deceased's medical history gathered by the medical investigators, the Coroner assumed jurisdiction in most of these reported deaths. Autopsies were carried out in 41% of the cases. In cases where jurisdiction was not assumed by the Coroner, a local physician, with knowledge and awareness of the deceased's state of health, certified the death. These were primarily natural deaths, predominantly individuals in medical facilities with a known fatal disease process. Autopsies were not performed in deaths where scene, circumstances, medical history, and external examination of the body provided sufficient information for death certification.

The accompanying tables and figures summarize the manner of death in all cases where jurisdiction has been assumed by the Coroner. The majority of cases fall into the natural category (64%). High profile deaths, out of state, out of country and OSHA involved deaths, usually garner a disproportionate amount of attention and effort by the Coroner. All of the categories are further analyzed in subsequent sections of the report.



DEFINITION OF MANNERS OF DEATH

The **Manner of Death** is a classification of the way in which the Cause of Death came about, whether by force of natural events, accidental means, self-inflicted wounds, or other external forces. There are only five (5) manners of death, listed below.

NATURAL: Death caused solely by disease. If natural death is hastened by injury or any other non-natural event (ex: fall), the manner of death will not be considered natural. If the terminal disease process is caused by a non-natural event (ex: pneumonia due to long term bed confinement as a result of a motor vehicle accident), the manner of death will not be considered natural.

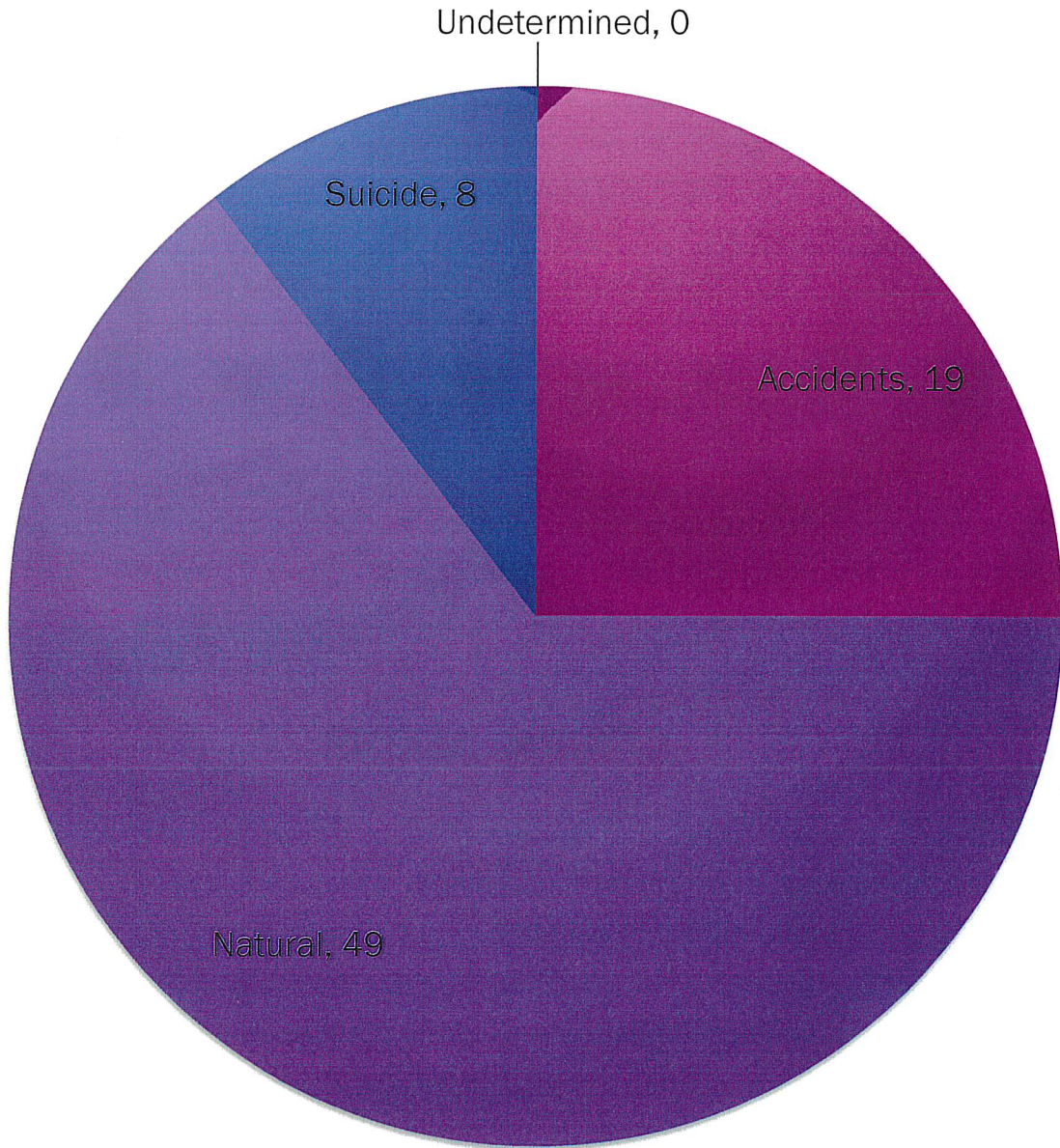
SUICIDE: Death as a result of a purposeful action set in motion (explicit or implicit) to end one's life.

ACCIDENT: Death other than natural where there is no evidence of intent; i.e. an unintentional event or chain of events. This category includes motor vehicle accidents, falls, drowning, accidental drug overdoses, etc.

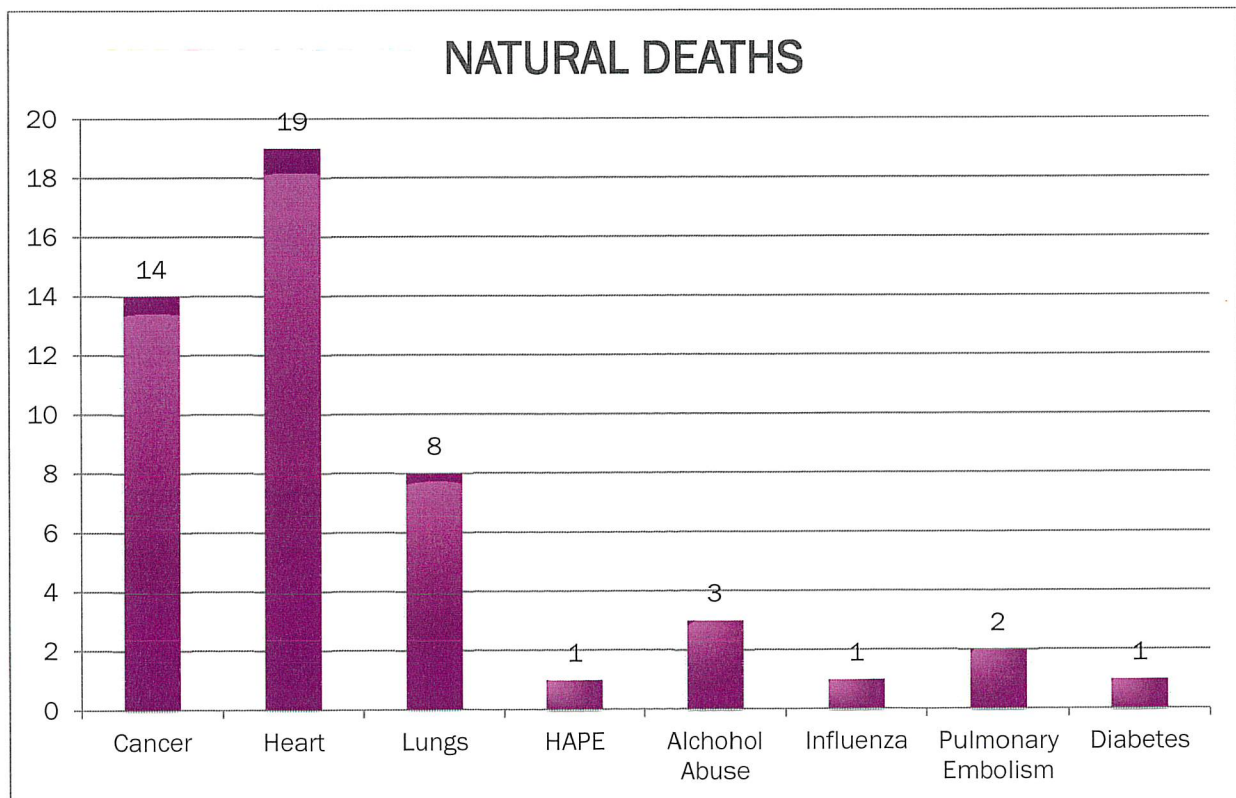
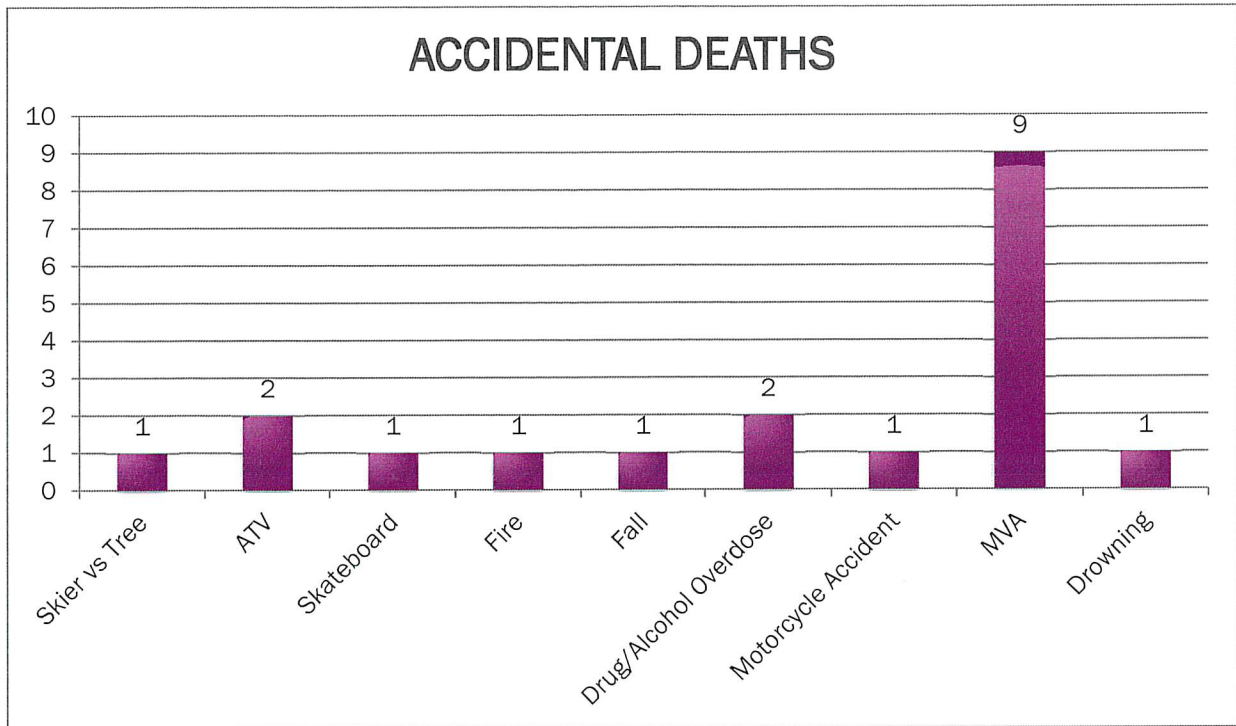
HOMICIDE: Death resulting from injuries intentionally inflicted by another person (explicit or implicit), or inflicted on another by one's grossly reckless behavior.

UNDETERMINED: Manner assigned when there is insufficient evidence or information, especially about intent, to assign another manner.

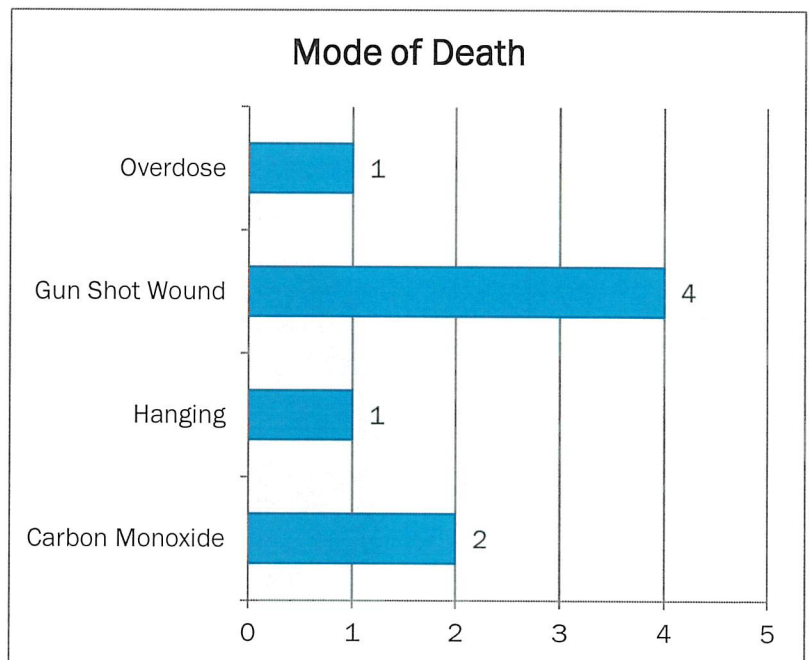
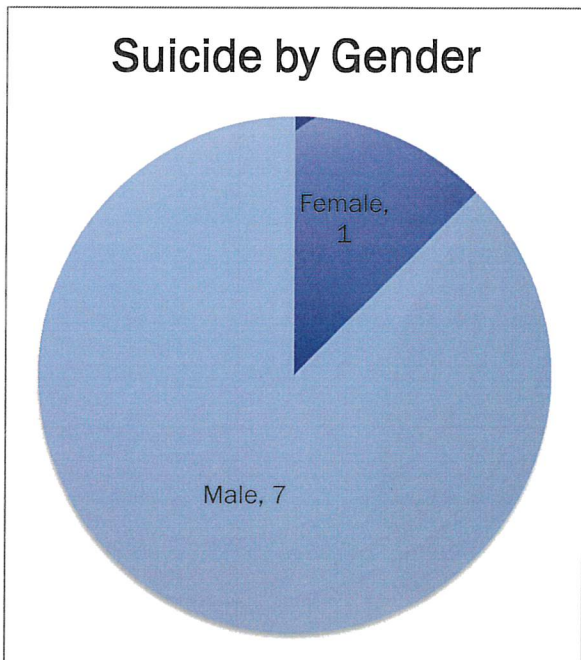
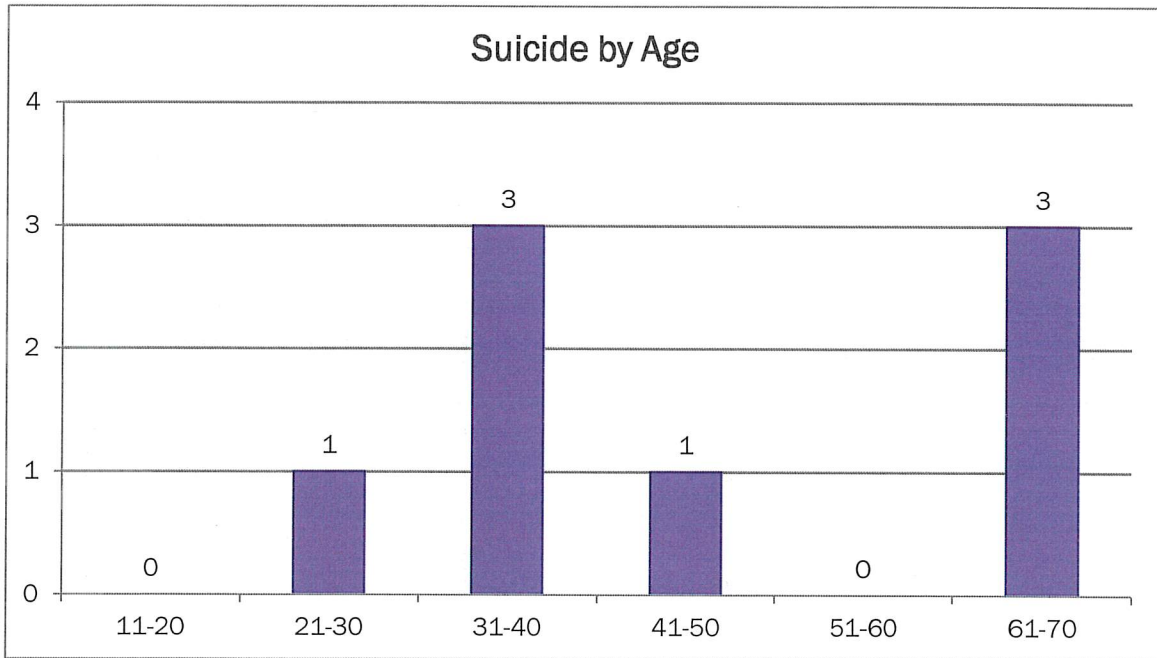
MANNER OF DEATH

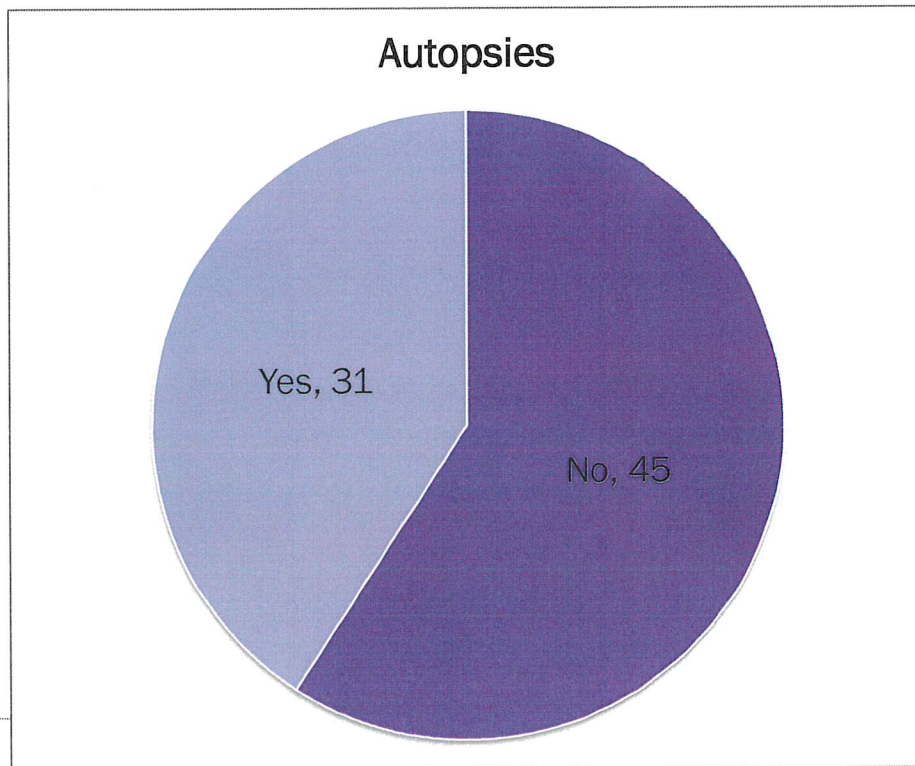
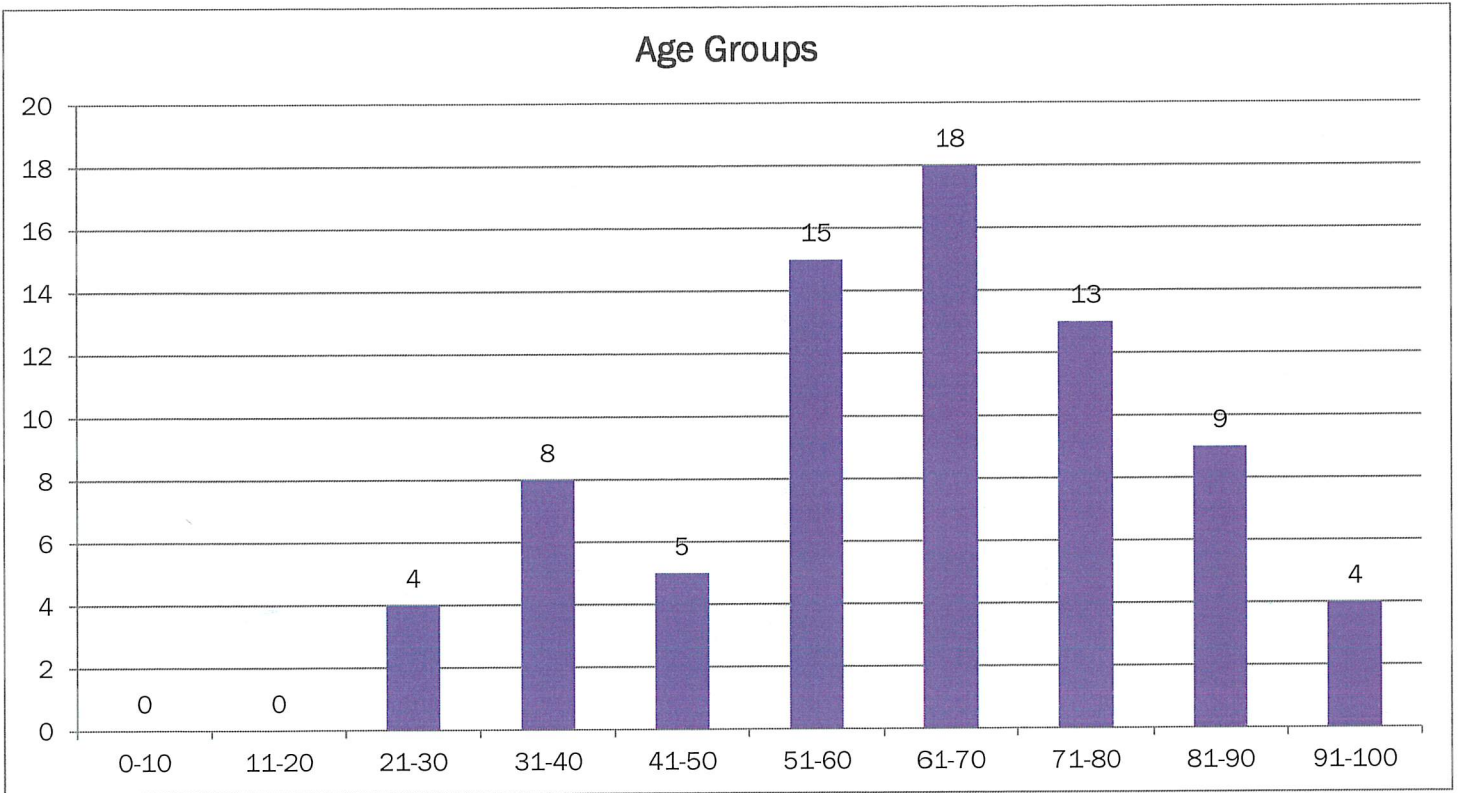


■ Accidents ■ Natural ■ Suicide ■ Undetermined



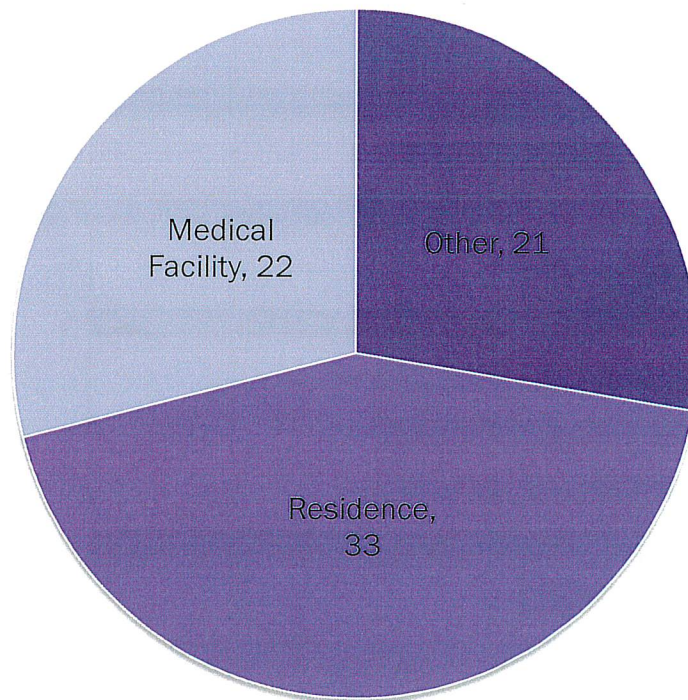
SUICIDE DEATHS





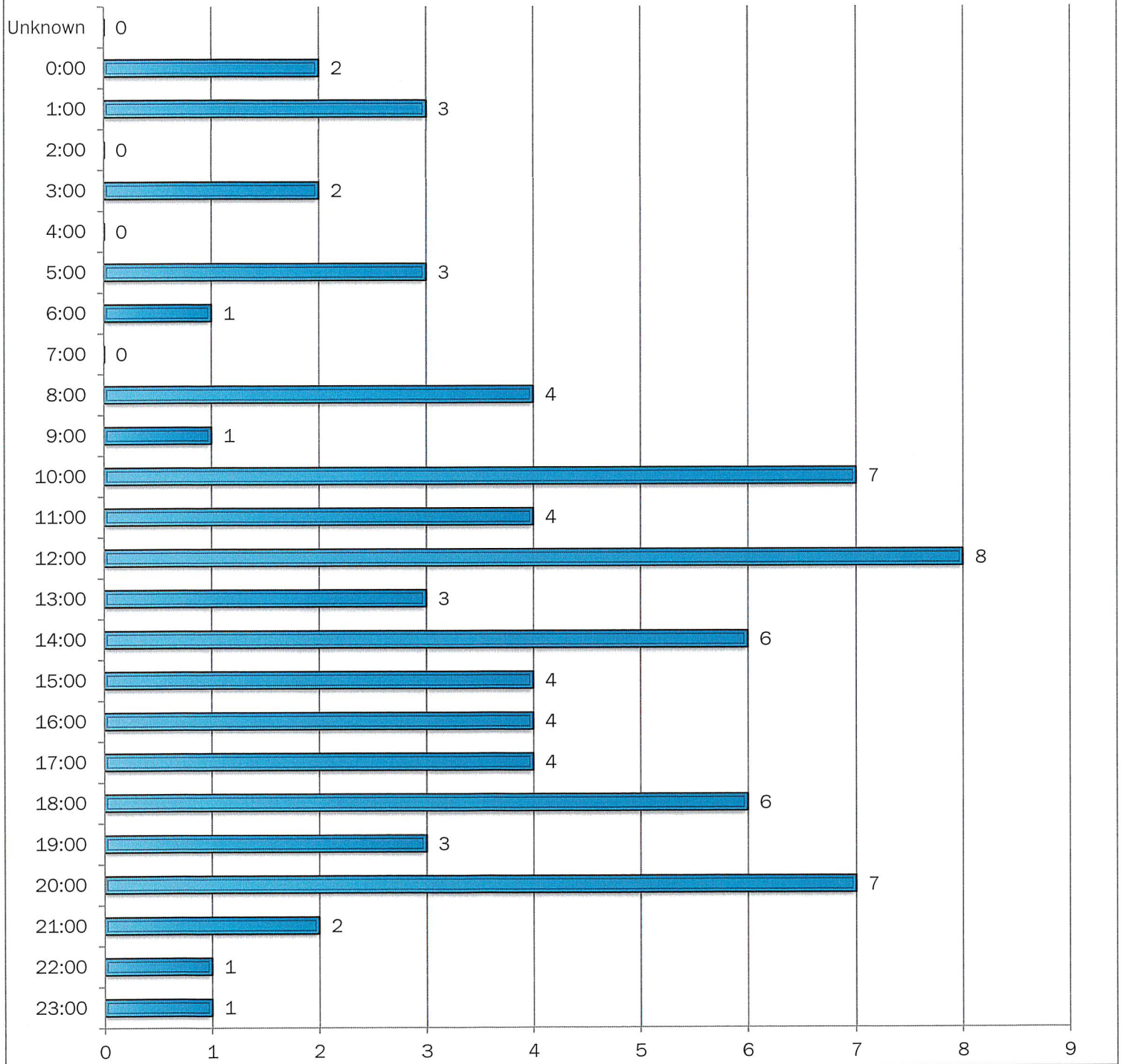
Deaths by Town	Number
Out of County	7
Kremmling	25
Parshall	1
Hot Sulphur Springs	1
Granby	18
Grand Lake	12
Tabernash	4
Fraser	4
Winter Park	4

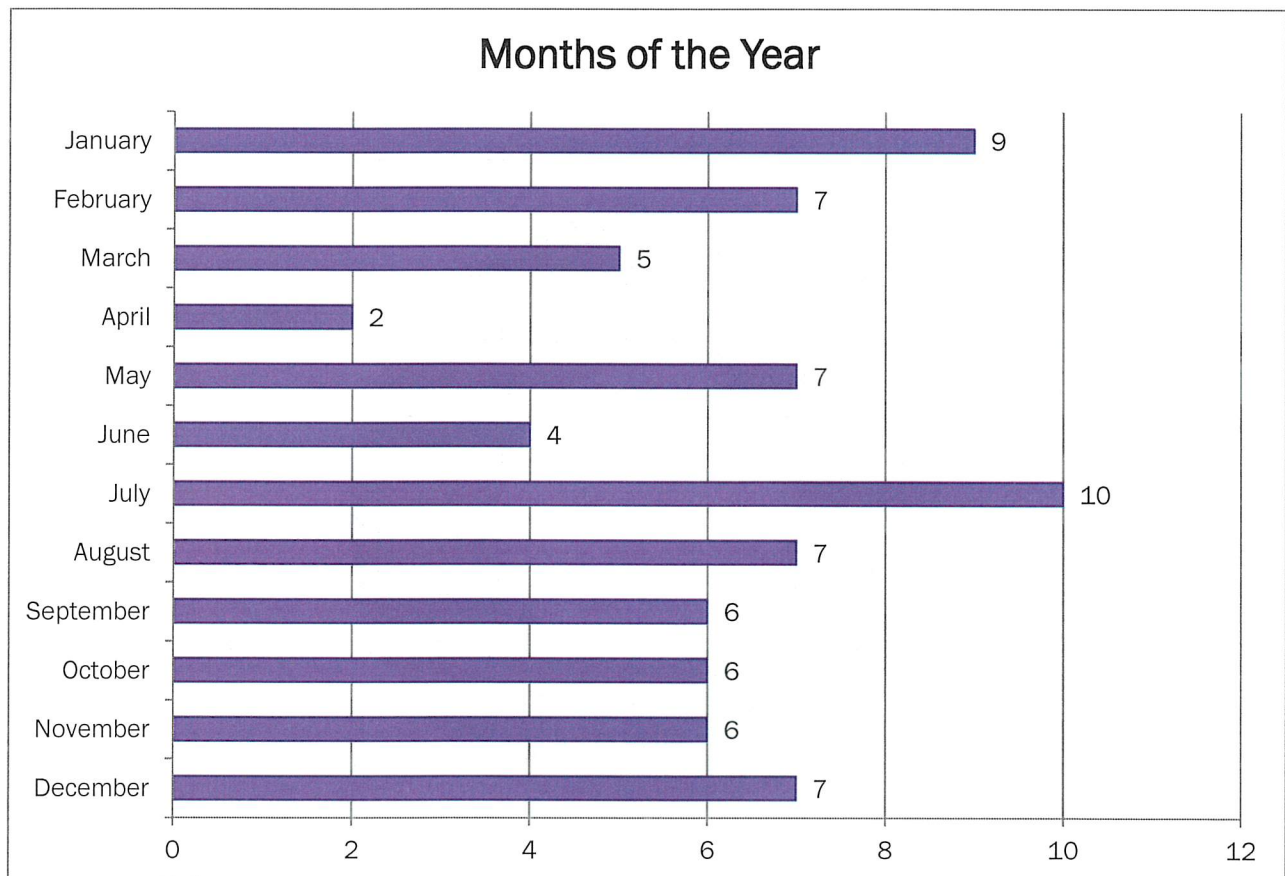
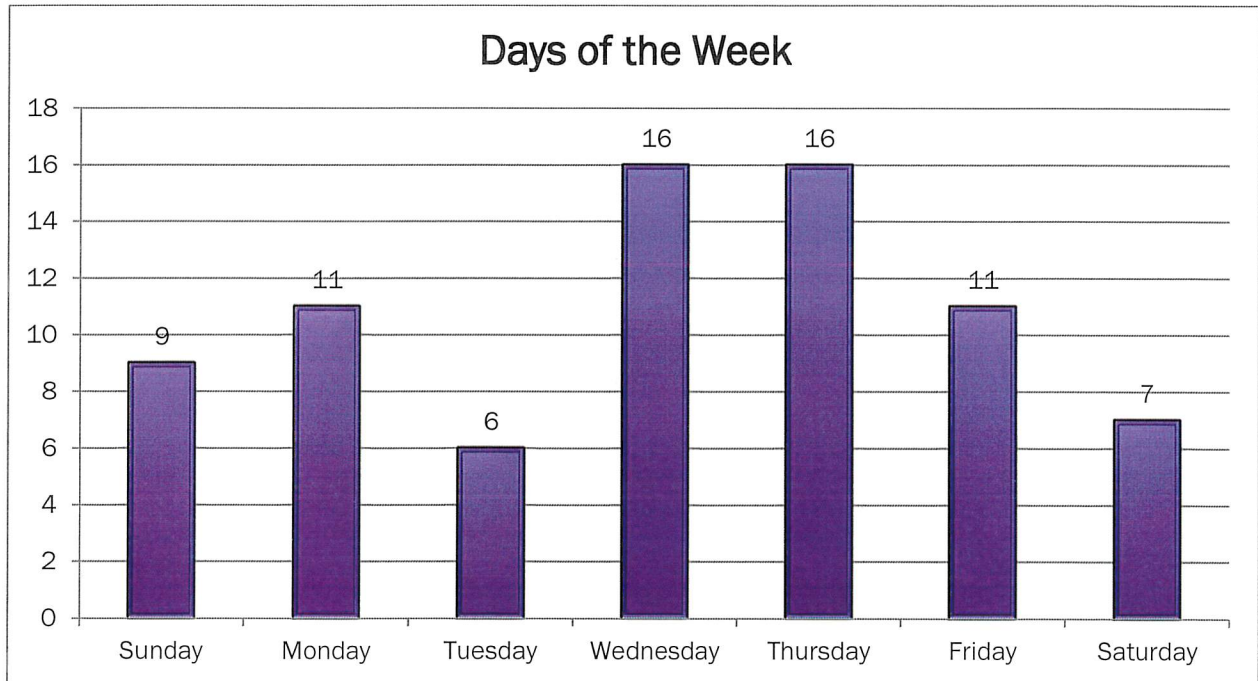
Location



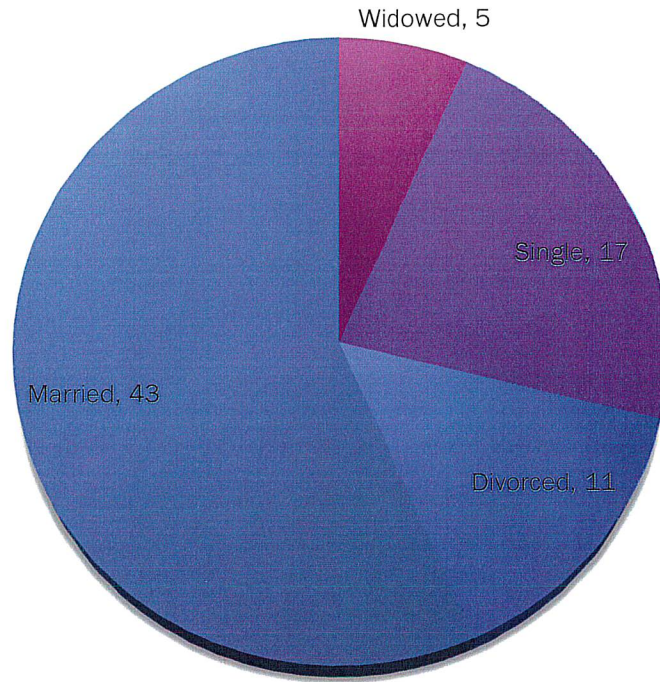
■ Other ■ Residence ■ Medical Facility

Hours of the Day

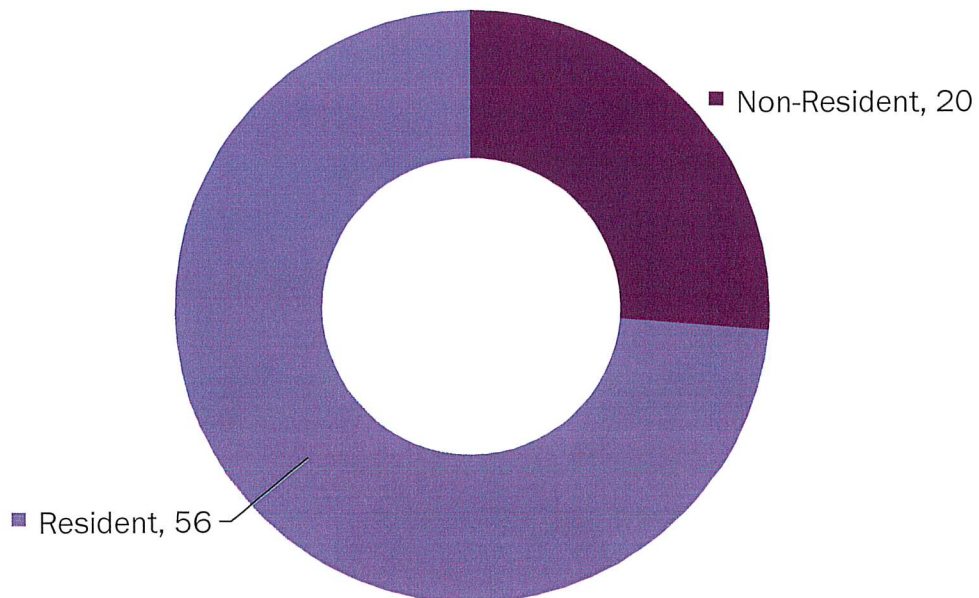




Marital Status



Resident v Non-Resident



THE OFFICE OF THE CORONER

What Are the Statutory Responsibilities of the Coroner in Colorado?

The Coroner's Office is a statutory office, which is mandated to establish the cause and manner of death. The CAUSE OF DEATH is the injury, disease, or combination of the two that was responsible for initiating the train of physiological disturbances (brief or prolonged), which produced the fatal termination. The MANNER OF DEATH refers to the circumstances in which the cause of death arose (suicide, natural causes, accident, and homicide). It is often a misconception that the responsibility for determining these vital questions lies with the law enforcement agency; however, this is the responsibility of the Coroner.

THE TYPES OF DEATHS THAT ARE REPORTED TO THE CORONER:

1. No physician is in attendance.
 2. The attending physician is unable or unwilling to certify the cause of death.
 3. The attending physician has not been in actual attendance within 30 days prior to death.
 4. All cases in which trauma may be associated with the death, such as traffic accidents, gunshots, falls, etc. This includes inpatients who have sustained fractures any time in the past.
 5. Deaths by poison, suspected poisoning, chemical or bacteria, industrial hazardous material, or radiation.
 6. All industrial accidents.
 7. Known or suspected suicides.
 8. Deaths due to contagious disease.
 9. Deaths due to self induced or unexplained abortion.
-

10. Operating room deaths and deaths that occur during a medical procedure.
11. All unexplained deaths – deaths that occur in a healthy individual.
12. Deaths that occur within 24 hours of admission to a hospital or nursing care facility.
13. Deaths in the custody of law enforcement.
14. Deaths of persons in the care of a public institution.

The investigation of a death by the Coroner's Office is an extremely important function as it is done by an independent agency who does not work for the law enforcement agency, the physician, the nursing home, the hospital, the prosecution or the defense, but works on behalf of the deceased to obtain the truth about their death.

Associated with the responsibility of determining the cause and manner of death, the Coroner has numerous other responsibilities. Listed below are these responsibilities and clarifications.

1. DEATH PRONOUNCEMENT

Pronounce death and determine what time the death occurred. Only a physician or a Coroner may certify a death. The determination of the time of death is critical to a criminal case and may be extremely important with issues related to insurance and beneficiaries.

2. SCENE INVESTIGATION

The Colorado Law is specific that the body of a deceased person may not be moved from its place of death until the Coroner arrives at the scene and performs the investigation. In rural counties the Coroner typically handles most of the scene investigations, and in urban areas, due to the large volume of cases, the Coroner typically has Coroner Investigators who handle the scene investigations.

It is the Coroner's responsibility to be certain that their deputies and investigators are well trained in scene and follow-up investigations.

Scene investigation not only includes evidence collection, scene interviews, and examination of the body and circumstances, but must be followed up with additional interviews of family, friends, physicians, procurement of medical records and other material that might provide the information needed to make the cause and manner of death determinations. The Coroner must correlate the scene findings with clinical history, antemortem medical records, criminal, psychological and family medical history.

3. TAKE CUSTODY OF THE BODY

This is Colorado Law.

It is the Coroner's responsibility to see that the body is removed from the scene. This must be done with extreme skill when there is evidence to preserve. It must be done with sensitivity and respect, as often family members are at the scene. The Coroner must make arrangements to have the body transported to a mortuary, or in cases where an autopsy or other tests must be done, the Coroner must transport the body to their forensic facilities, which may be hundreds of miles away. This responsibility must be carried out in the same professional manner regardless of if the body is in a hospital setting, or is a decomposed, maggot infested, unknown body in the woods.

4. MAKE POSITIVE IDENTIFICATION OF DECEASED

A positive identification is made on all deceased persons whose death is investigated by the Coroner's Office. This can be an extremely time consuming and difficult procedure. Fingerprints, dental records, radiological records, and DNA may all be used for positive identification, but the antemortem records must be found and obtained. Due to Colorado's location and good economy, there are many immigrants, illegal and legal, which often make identifications very difficult.

5. IDENTIFICATION AND NOTIFICATION OF NEXT OF KIN

It is the Coroner's responsibility to determine who the next of kin is. When the determination is made, the person must be located and notification made.

Death notifications should always be made in person and can be one of the most difficult and emotionally charged duties of the Coroner.

Once the next of kin have been notified, the Coroner will be in constant contact with the family to advise them of the results of the investigation and/or autopsy, to obtain other information as needed, and to assist and coordinate the investigation with the funeral plans. The Coroner also makes referrals to specific groups such as the Sudden Infant Death Program and suicide survivors groups as the situation dictates.

If the next of kin are outside the county (maybe in other states or countries), the Coroner connects with out of state Coroners or law enforcement officials so that in person notifications are still facilitated. The Coroner may spend many hours locating these people and many more hours helping them to facilitate disposition of the body and/or understanding and dealing with the death.

6. DISCOVERY OF REMAINS

Often time's skeletal remains, complete or partial, are found in all areas of Colorado. The Coroner is responsible for first determining if the bones are human or animal and if human, are they ancient, or Native American, or have forensic value. If the remains are determined to be Native American, the Coroner must follow certain statutory obligations regarding notification of appropriate State agencies.

7. DEATH CERTIFICATES

At the conclusion of a death investigation, the Coroner issues a death certificate, which is the legal document that states the cause and manner of death. This is an extremely important document as it is used to settle legal matters, criminal and civil, and insurance benefits for survivors often hinge on the rulings.

8. REPORTS

Coroners must keep records and reports of each death investigation. Their records are often subpoenaed into court for criminal or civil purposes, and requested by physicians, insurance companies, and families.

9. OTHER RESPONSIBILITIES OF THE CORONER

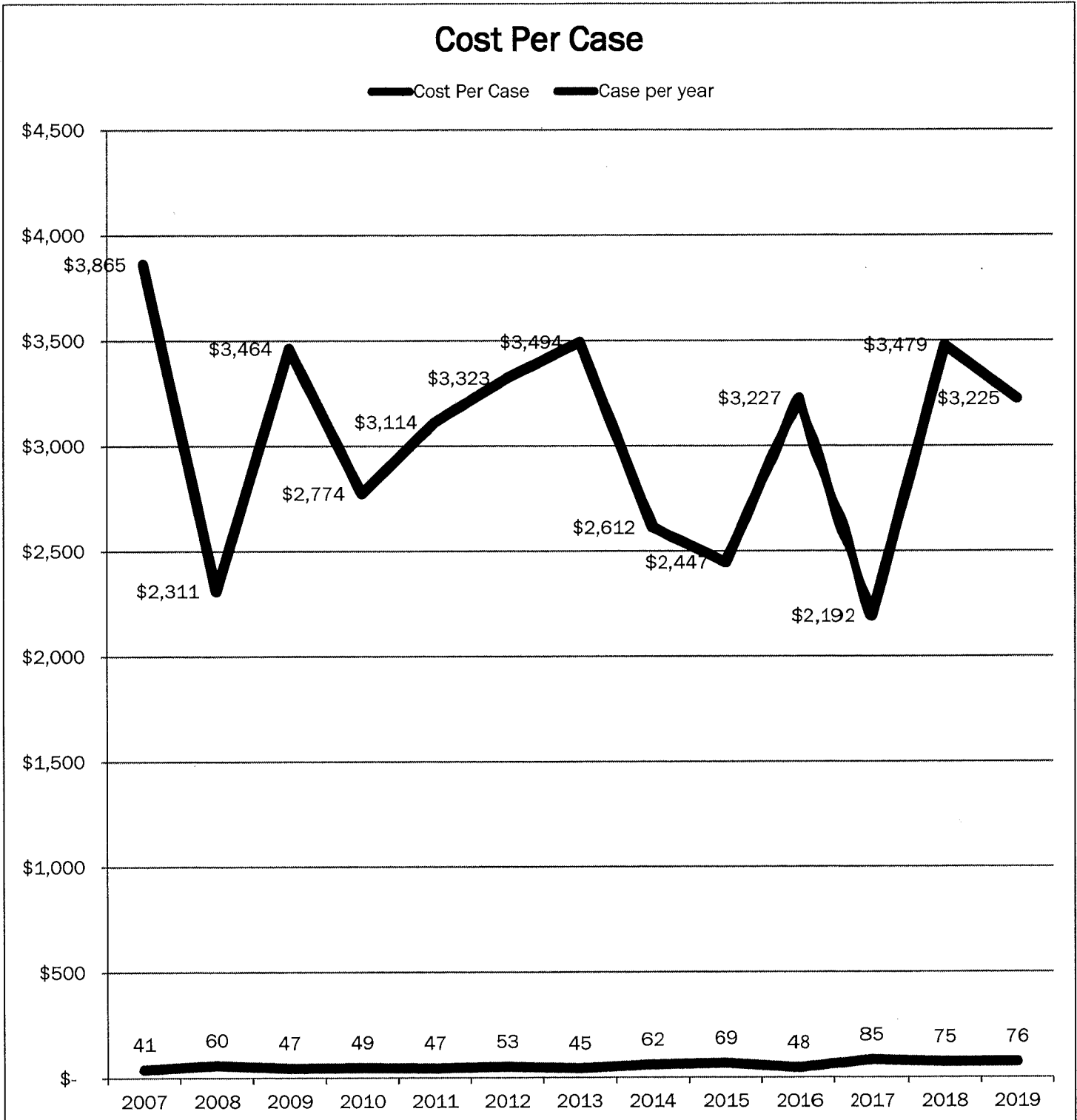
The Coroner's Office provides information, and works closely with other state and federal agencies (Health Department, OSHA, FAA, NTSB, and Consumer Product Safety Commission), local physicians, hospitals, law enforcement agencies, district attorneys, public defenders private attorneys, and insurance companies. The Coroner is also often a member of ambulance, fire department, area trauma councils, and emergency management boards.

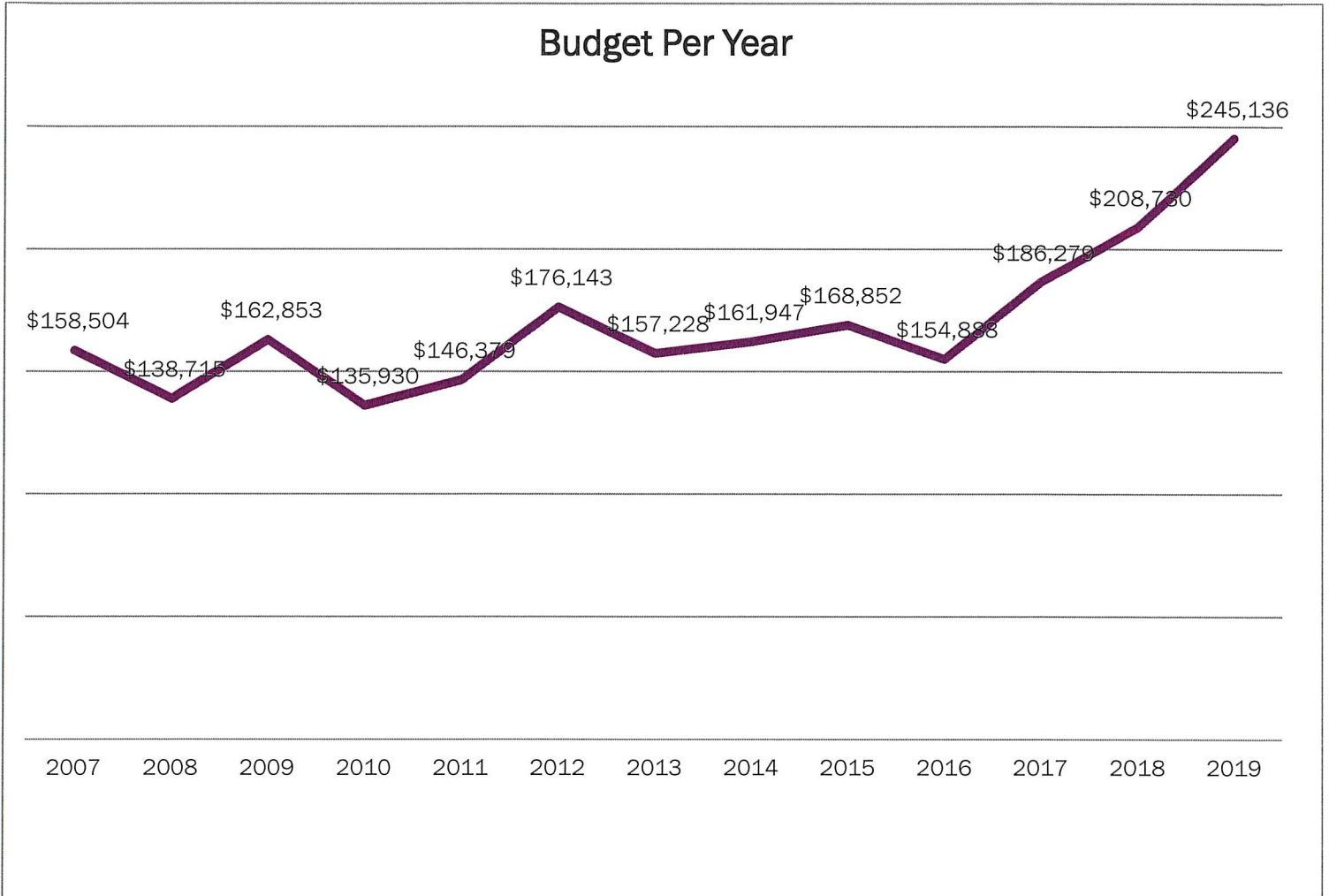
Coroners also provide learning opportunities for many agencies, which facilitates coordinated investigations. Schools and community organizations, as well as hospitals, hospice and nursing care facilities, also receive education about the role of the Coroner's Office.

Coroners in Colorado have the opportunity to become Certified Death Investigators through the Colorado Coroner's Association. The "CCA" was formed in 1988 with the goal of providing continuing education for Colorado Coroners. Colorado Coroners take advantage of continuing education provided by the association's programs as well as numerous other training programs provided on the national level.

CONCLUSIONS

It must be remembered that the medical legal death investigation provided by the Coroner's Office provides the information by which decisions with large monetary issues are connected. These decisions could directly impact the county government particularly in areas of industrial accidents and deaths in custody. A mistake in the identification of a body cost an Alaskan county millions of dollars in the past. The job of the Coroner is not a job that can be taken lightly.





CORONER ACTIVITY

The staff of the Coroner's Office is 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. Members of the Coroner's staff who are familiar with the emotional trauma of an unexpected death communicate directly with the family, as does the Coroner, who reviews the findings with the families in order to clarify the many questions that accompany a sudden loss of life.

Many cases brought to the Coroner's Office are dealt with in a routine manner, because the identity of the deceased is known and next-of-kin can be readily contacted to decide on final arrangements for the deceased and assist in the disposition of personal property associated with the scene of death. However, there are frequent cases which are difficult to resolve. In these deaths at least one of the items above is missing or very difficult to establish: identification of deceased may require tracing of dental, medical or police records; or some individual may have died leaving no next-of-kin or the next-of-kin is 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 toxicological analyses. 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.

The Coroner and investigators provide testimony in court and at depositions. Staff participates in meetings with law enforcement, other interested physicians, and attorneys (both prosecuting and defending) in a variety of criminal and civil cases. Autopsy reports and related data from individual investigations are provided to agencies such as police and Labor Industries, to prosecuting attorneys, and to other agencies including the Drug Enforcement Administration and the Consumer Product Safety Commission. Reports on drug caused deaths are sent to the Drug Abuse Warning Network (DAWN). Case information is entered into annual databases of the Coroner's Office. Our office also works in a cooperative effort with regional organ procurement agencies to facilitate organ and tissue donation for transplantation.

Death investigations require frequent contact between the Coroner's Office and various media personnel. Staff is skilled in responding to media inquiries. The Coroner and staff participate in a variety of medical conferences, and provide information on a regular basis to law enforcement and medical personnel on various aspects of the role and function of the Coroner's Office. The Coroner, in particular, teaches continuing education programs for the Colorado Coroner's Association (CCA). The staff also teaches classes at ski areas and to medical and first responder staff throughout the County.

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