Kent County
Medical Examiner

2016
Annual Report

Office of the Medical Examiner
700 Fuller N.E.
Grand Rapids, Michigan 49503

2016 Kent County Medical Examiner Annual Report

To the Kent County Board of Commissioners
and to the Citizens of Kent County:

I am pleased to present the Kent County Medical Examiner 2016 Annual Report. I would like to highlight several aspects of this report. First, our total cost for 2016 was $1,363,204.00, a more than $13,000 decrease from 2015. This is a bargain given that the calculated mean budget/capita in the United States is $3.02 compared to approximately $2.10 for Kent County.

A continuing challenge for our office is the large number of drug overdoses. In particular, the large number of novel drugs, particularly analogs of fentanyl, presents a diagnostic challenge. Fentanyl and its analogs are not identified on most routine drug screens employed by hospitals and, thus, remain unidentified unless a hospital requests the laboratory to check for such drugs in the patient. Our office has requested and usually received cooperation from law enforcement in submitting syringes and material that may contain drugs to our office or to the State Police Crime Lab for identification. Unfortunately, the same cannot be said for Grand Rapids area hospitals. All too often, patients are evaluated in the emergency department for suspected drug overdose. A urine drug screen, which is very crude and gives no information as to the amount of drug in the patient's blood, will be done. Many important drugs, such as fentanyl, are not identified on these screens. Regardless, no attempt to determine a blood level of drugs of abuse or of prescription narcotics is undertaken. There is simply an a priori assumption that the patient has overdosed on something. The patient is admitted to the intensive care unit where he or she may survive for four or five days or longer. Meanwhile, the laboratory discards any blood that was drawn from the patient on admission, blood which could be used to determine a level of a drug on which the patient overdosed. By the time the case is reported to us, we have a dead patient and no way to determine how the death occurred, in particular, whether the patient died from a drug overdose.

The unfortunate outcome of this is: (1) the family will never know the true cause of death of their loved one, (2) cause of death statistics are inaccurate because such deaths will have to be certified as "indeterminable", and (3) law enforcement cannot prosecute the supplier of drugs that may have caused the overdose because we cannot provide them with a definitive cause of death. Despite numerous efforts to request that hospitals and emergency departments assist us by either quantitating a level of drug in the blood or at least saving us a specimen so that we can determine the level, this problem remains.

The number of unclaimed bodies has decreased due to both the diligent efforts of the Medical Examiner Office staff and local funeral homes in assisting with burial or cremation of such bodies.

The number of deaths of children as reviewed by the Child Death Review Team has decreased with a steady downward trend from 33 cases in 2012 to 21 cases in 2016.

The Medical Examiner Office will continue its efforts to serve the public and hope that assistance and cooperation with these efforts will be rendered.

Respectively submitted,

Stephen D. Cohle, MD
Kent County Chief Medical Examiner

Office of the Kent County Medical Examiner

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Medical Examiner Personnel

Stephen D. Cohle, MD
Chief Medical Examiner and
Forensic Pathologist

David A. Start, MD
Deputy Chief Medical Examiner and
Forensic Pathologist

Elizabeth L. Brown, D-ABMDI (2016)
Medical Examiner Investigator

Judy A. Chamberlain
Medical Examiner Investigator

Paul R. Davison, F-ABMDI
Medical Examiner Investigator

Cynthia L. Debiak, RN
Medical Examiner Investigator

Peter J. Noble
Medical Examiner Investigator

Theodore E. Oostendorp
Medical Examiner Investigator

Daniel Hopkins
Kent County Conveyance Specialist

Carmen D. Marrero-Perez
Office Administrator and
Child Death Review Coordinator

Dolly M. Olthoff
Medical Examiner Support Staff

Board Certification
The American Board of Medicolegal Death Investigators (ABMDI) sets quality and process standards for death investigators. Medical examiners who pass the certification requirements of the ABMDI are designated as registered Diplomats (D-ABMDI). Medical examiners with continued time in investigation and who pass required tests are designated as certified Fellows (F-ABMDI).

Medical Examiner Program Expenditures, 2015 and 2016

	2015		2016	
	Amount	Percentage	Amount	Percentage
Medical examiner (compensation)	$ 179,584	13.0%	$ 226,772	16.6%
Autopsies	1,001,575	72.7%	951,695	69.8%
Body transport	87,924	6.4%	85,838	6.3%
Support services	47,503	3.5%	38,899	2.9%
Administration	60,000	4.4%	60,000	4.4%
Total	$1,376,586	100.0%	$1,363,204	100.0%
Average cost per case investigated	$1,173		$1,180	

Medical Examiner Reportable Deaths and Autopsy

The Michigan County Medical Examiners Law, P.A. 181 of 1953, as amended, and the Michigan Public Health Code, P.A. 368 of 1978, as amended, mandates that specific types of deaths (listed below, left) be referred to the medical examiner for investigation. Medical examiner investigation of a death may also be ordered by the county's prosecuting attorney, the Michigan Attorney General or, upon the filing of a petition, signed by six (6) electors of a county. Not all deaths referred to the medical examiner for investigation necessarily result in an autopsy; however, an autopsy is generally ordered in certain circumstances (listed below, right), to determine more accurately the cause and manner of death.

Types of Deaths Reportable to the Medical Examiner, P.A. 368 of 1978

1. Sudden deaths and unexpected deaths (all deaths occurring in operating room, in recovery room, anesthesia related, natural death but not expected, occupational related deaths, subdural hematoma, intracerebral hemorrhage, etc.)*

2. Accidental deaths (motor vehicle, burns, drowning, falls, broken bones, drug overdose, drug toxicity, subdural hematoma, recent or past trauma, etc.)

3. Violent deaths (homicide, gunshot, stabbing, suicide, subdural hematoma, etc.)*

4. Suspicious circumstances surrounding a death.*

5. Deaths occurring as a result of an abortion.

6. Upon written order of the prosecuting attorney or the attorney general or upon the filing of a petition signed by six (6) electors of a county.

7. Death of a prisoner in any county or city jail who dies while so imprisoned.

8. If a fetal death occurs without medical attendance at or after the delivery.

In terms of a physician attendance: for the purposes of the medical examiner program, we consider that an investigation is required when:

A. The deceased was last seen by a physician more than **ten (10) days before his or her death, if the cause of death appears to be other than the illness or condition for which the deceased was being treated.
B. The attending physician cannot accurately determine the cause of death.
C. When the deceased has not received any medical attention during the ***48 hours prior to the hour of death unless the attending physician, if any, is able to accurately determine the cause of death.

* All trauma related deaths no matter when the trauma occurred.
** The ten (10) day requirement relates solely to physician attendance.
***The 48 hour requirement triggers an investigation when there has been no medical attendance of any kind (i.e., nursing care, etc.)

Types of Medical Examiner Cases for which Autopsy is Generally Ordered

1. Sudden deaths and unexpected deaths only when in the medical examiner's judgment, sufficient medical history is not available to determine cause and manner of death.

2. Accidental deaths such as motor vehicle, burns, drowning, etc. If an individual has been hospitalized for a length of time, it is the medical examiner's decision to order an autopsy.

3. Violent deaths such as homicide, suicide, gunshot, stabbing, etc.

4. Suspicious circumstances surrounding death, including unidentified bodies.

5. Death related to an abortion.

6. Sudden infant deaths (SIDS) and deaths of children 18 and under without significant medical history.

7. Death of a prisoner imprisoned at any county or city jail.

8. In a fetal death occurring without medical attendance at or after delivery.

9. An autopsy may be ordered at the discretion of the medical examiner if the cause of death appears to be other than the illness or condition for which the deceased was being treated, or if the attending physician cannot accurately determine the cause of death.

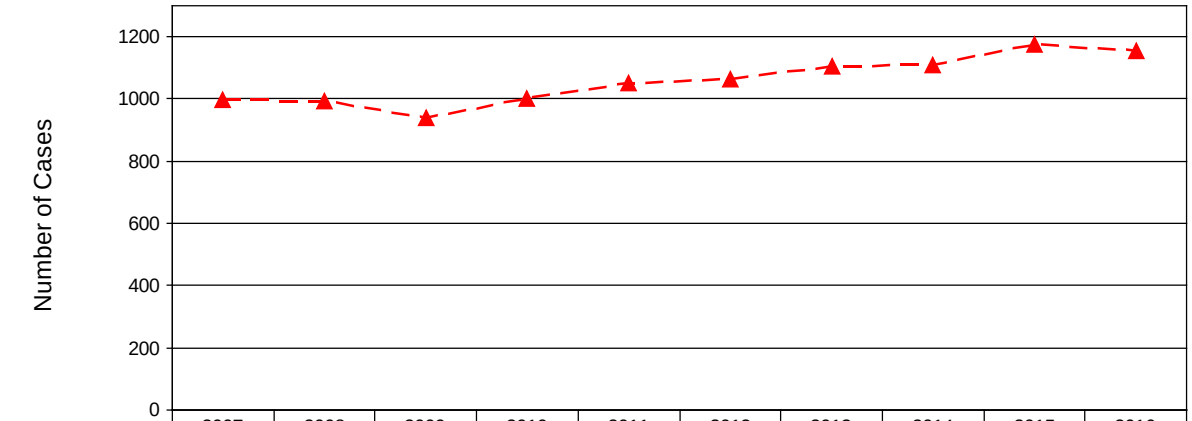
10. Anesthesia-related and unexpected deaths of patient in health care institutions.

11. Partial autopsies are not done because it is not best practice.

12. Views are performed in cases in which there is adequate history to explain the death, but there are external findings, such as injuries, that require direct examination to determine whether they maybe significant injuries that mandate full autopsy.

2016 Medical Examiner Caseload

Figure 1: Accepted Kent County Medical Examiner Cases, 2007-2016



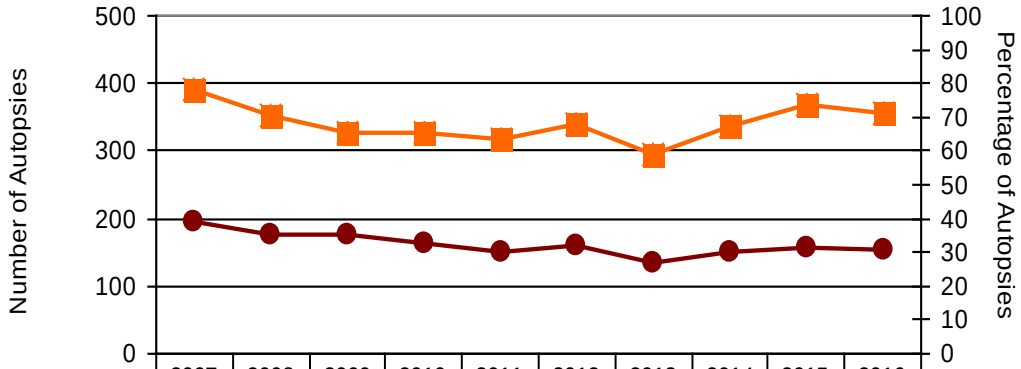
	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
M.E. Cases	998	994	938	1001	1053	1066	1105	1110	1174	1155

Total Referred Medical Examiner Cases in 2016: 1,727

Accepted	1,155	67.0%
Declined	572	33.0%

In 2016, there were 5,934 deaths in Kent County. The medical examiner was contacted regarding 1,727 of these deaths. 1,155 cases were accepted for investigation, while 572 were declined and did not fall within the requirements for investigation by the Medical Examiner's Office. There were no exhumations in 2016. In 2016, there were 162 referrals to Gift of Life and Eversight resulting in 45 tissue donors and 41 eye donors.

Figure 2: Medical Examiner Cases with Autopsy, 2007-2016

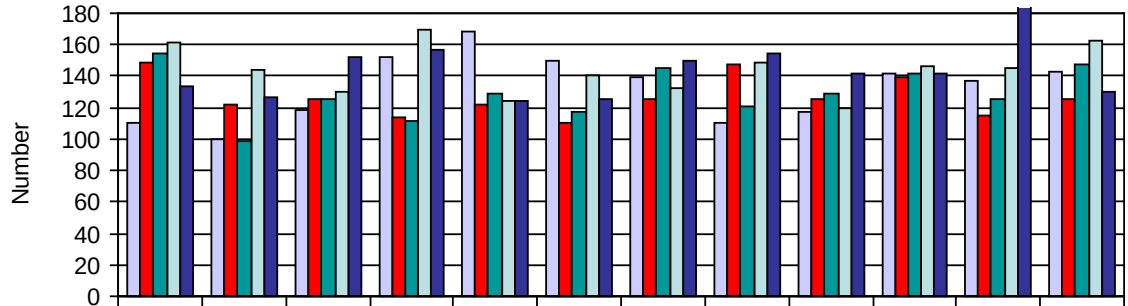


	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Number of Autopsies	391	352	327	328	317	340	296	337	368	355
Percent Autopsied	39.0	35.0	35.0	33.0	30.0	32.0	27.0	30.4	31.3	30.7

Of the 355 autopsies performed, 345 were charged to Kent County. The remaining 10 autopsies were performed at the request of other counties. Toxicology was performed on 375 cases with 15 of those being views (85) and 19 where only toxicology was performed. There were no partial autopsies performed.

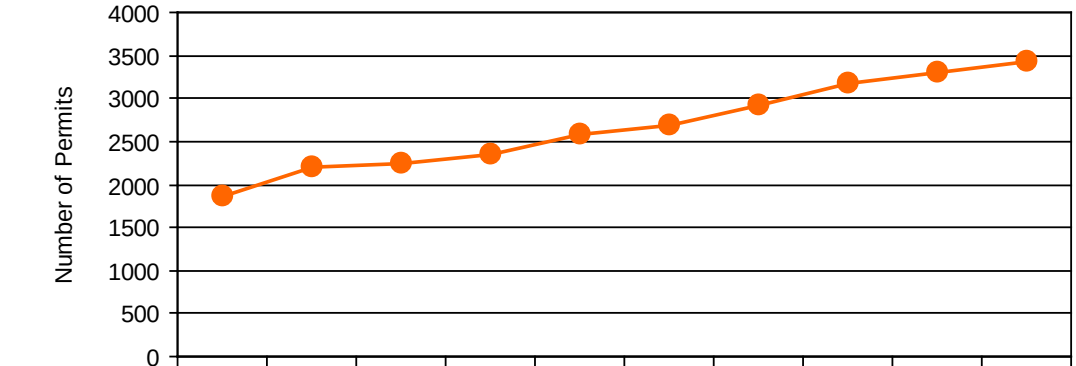
2016 Medical Examiner Caseload

Figure 3: Accepted Medical Examiner Caseload by Month, 2012-2016



Year: Cases	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2012: 1586	110	100	118	152	168	150	139	110	117	142	137	143
2013: 1518	149	122	125	114	122	110	125	147	125	139	115	125
2014: 1547	155	99	126	112	129	117	145	121	129	142	125	147
2015: 1726	162	144	130	170	124	141	132	149	120	146	145	163
2016: 1727	134	127	152	157	124	125	150	155	142	142	189	130

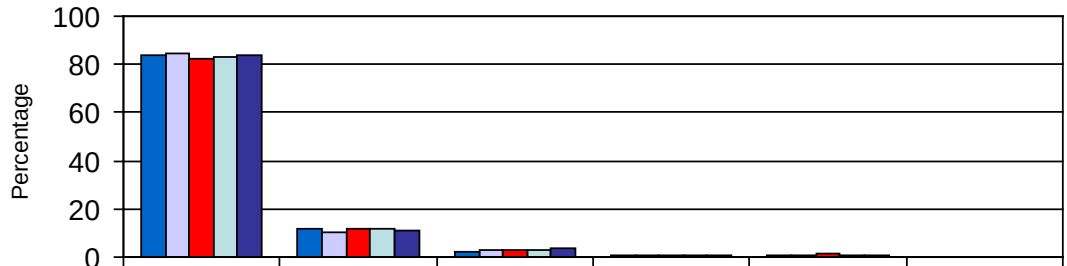
Figure 4: Cremation Permits Issued, 2007-2016



	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
# of Permits	1864	2191	2245	2356	2583	2687	2912	3166	3310	3433

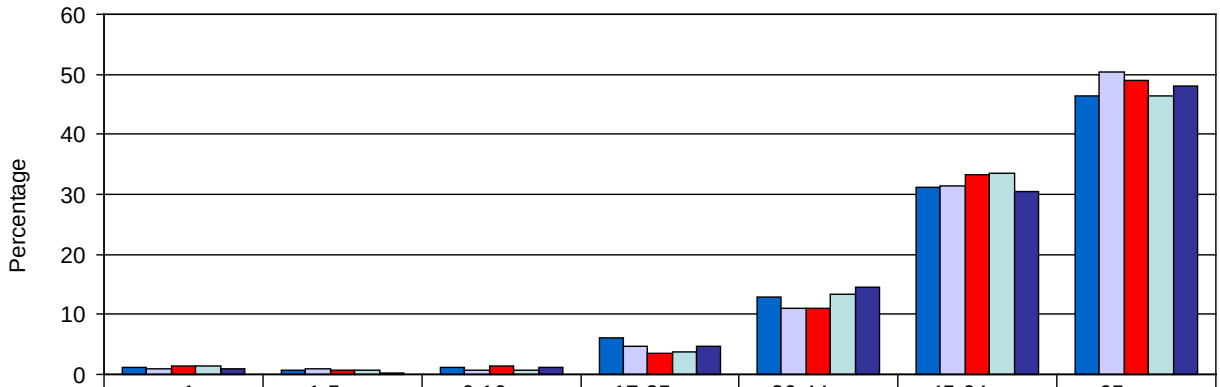
Demographics of Medical Examiner Cases

Figure 5: Medical Examiner Cases by Race/Ethnicity, 2012-2016



Year: Cases	White	Black	Hispanic	Native American	Asian/Pacific Islander	Other
2012: 1066	84.1	11.5	2.4	1.0	0.7	0.3
2013: 1105	84.5	10.4	2.9	1.0	0.9	0.3
2014: 1110	82.7	11.7	3.1	0.9	1.3	0.3
2015: 1174	83.4	11.8	3.2	0.8	0.6	0.2
2016: 1155	83.5	11.0	3.8	1.1	0.5	0.1

Figure 6: Medical Examiner Cases by Age at Death, 2012-2016



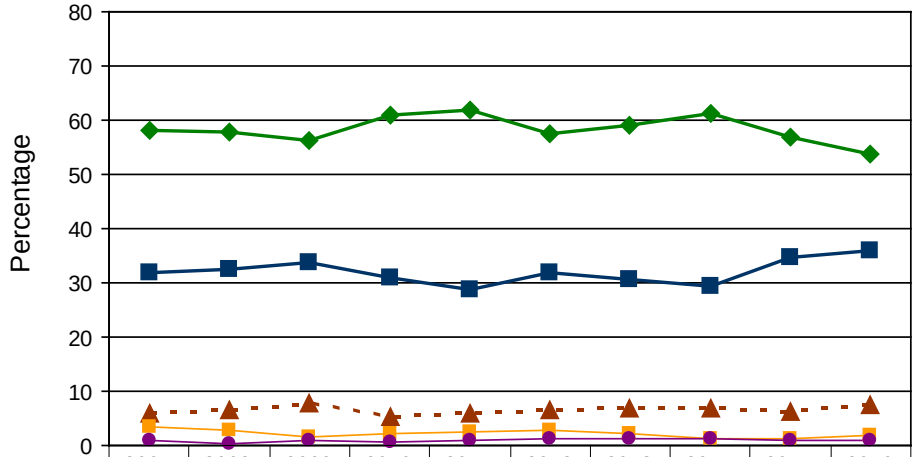
Year: Cases	<1	1-5 yrs	6-16 yrs	17-25 yrs	26-44 yrs	45-64 yrs	65+ yrs
2012: 1066	1.2	0.8	1.2	6.2	13.0	31.2	46.4
2013: 1105	0.9	0.9	0.7	4.6	11.0	31.4	50.5
2014: 1110	1.4	0.6	1.3	3.4	10.9	33.3	49.1
2015: 1174	1.3	0.8	0.7	3.8	13.4	33.5	46.5
2016: 1155	0.9	0.3	1.2	4.6	14.5	30.4	48.1

Table 1: Medical Examiner Cases by Gender, 2012-2016

	2012	2013	2014	2015	2016
Female	35.8%	38.5%	38.8%	37.3%	39.8% (460 cases)
Male	64.2%	61.5%	61.1%	62.7%	60.2% (695 cases)
Unknown			0.1% (bones)		

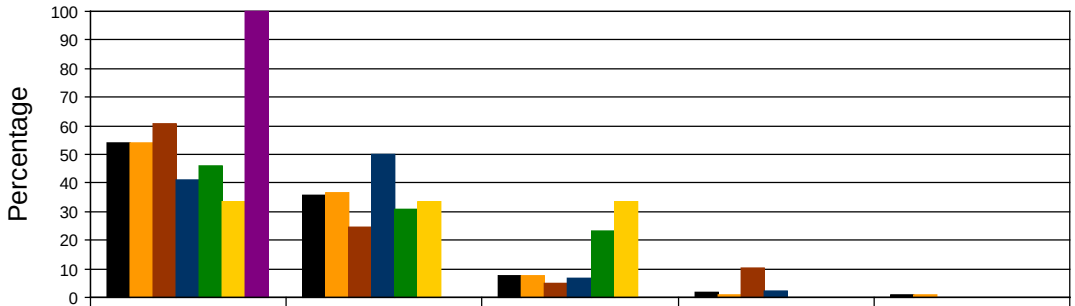
Manner of Death

Figure 7: Medical Examiner Cases by Manner of Death, 2007-2016



	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Natural	58.1	57.8	56.2	60.9	62.0	57.4	59.0	61.2	56.8	53.9
Accident	31.9	32.6	33.6	31.0	28.6	32.0	30.6	29.5	34.7	35.8
Suicide	5.8	6.6	7.9	5.3	6.0	6.5	6.8	6.8	6.4	7.4
Homicide	3.3	2.7	1.5	2.1	2.4	2.8	2.3	1.4	1.3	1.9
Indeterminate	0.9	0.3	0.8	0.7	1.0	1.3	1.3	1.1	0.8	1.0

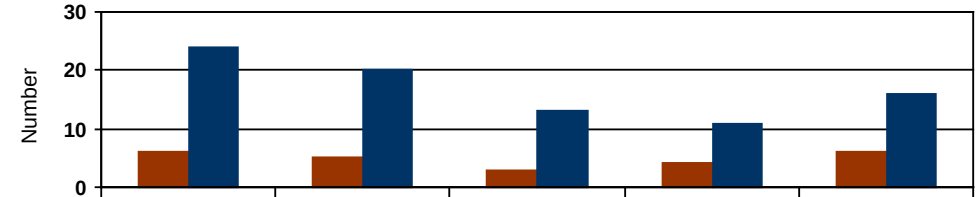
Figure 8: Manner of Death by Race/Ethnicity, 2016



Race: Cases	Natural	Accident	Suicide	Homicide	Indeterminate
All cases, total: 1155	53.9	35.8	7.4	1.9	1.0
White: 964	53.9	36.8	7.5	0.8	1.0
Black: 127	60.6	24.4	4.7	10.3	0.0
Hispanic: 44	40.9	50.0	6.8	2.3	0.0
Native American: 13	46.1	30.8	23.1	0.0	0.0
Asian/Pacific Islander: 6	33.4	33.3	33.3	0.0	0.0
Other: 1	100.0	0.0	0.0	0.0	0.0

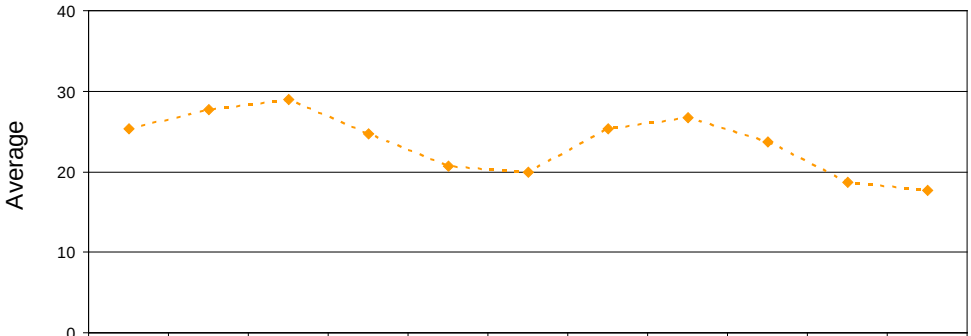
Manner of Death

Figure 9: Kent County Homicides by Gender, 2012-2016



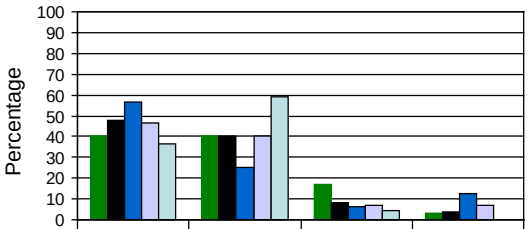
	2012: 30	2013: 25	2014: 16	2015: 15	2016: 22
Female	6	5	3	4	6
Male	24	20	13	11	16

Figure 10: Kent County Homicides, Three-Year Moving Averages, 2004-2016



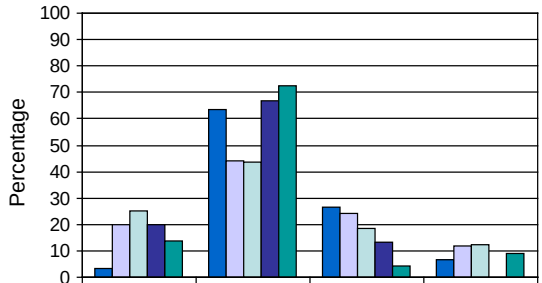
	2004-06	2005-07	2006-08	2007-09	2008-10	2009-11	2010-12	2011-13	2012-14	2013-15	2014-16
Homicides Investigated	25.3	27.7	29.0	24.7	20.7	20.0	25.3	26.7	23.7	18.7	17.7

Figure 11: Homicides by Race, 2012-2016



Year: Cases	White	Black	Hispanic	Other
2012: 30	40.0	40.0	16.7	3.3
2013: 25	48.0	40.0	8.0	4.0
2014: 16	56.3	25.0	6.2	12.5
2015: 15	46.6	40.0	6.7	6.7
2016: 22	36.4	59.1	4.5	0.0

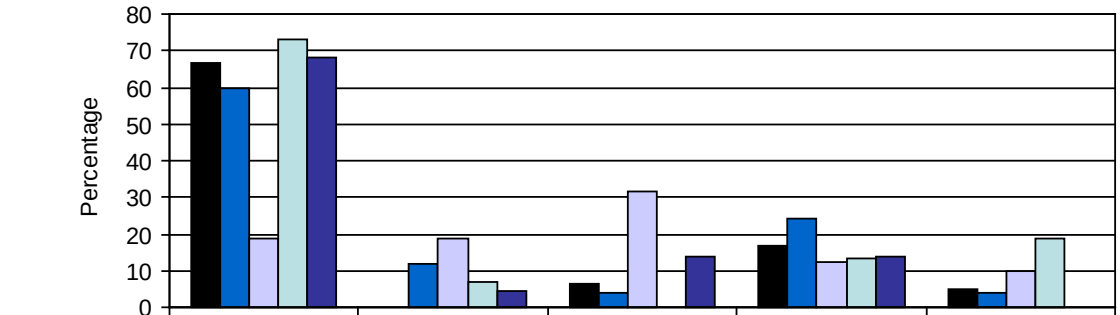
Figure 12: Homicides by Age, 2012-2016



Year: Cases	0-19 yrs	20-44 yrs	45-64 yrs	65+ yrs
2012: 30	3.3	63.3	26.7	6.7
2013: 25	20.0	44.0	24.0	12.0
2014: 16	25.0	43.8	18.7	12.5
2015: 15	20.0	66.7	13.3	0.0
2016: 22	13.7	72.7	4.5	9.1

Manner of Death

Figure 13: Homicide Cases by Method Used, 2012-2016



Year: Cases	Gun	Asphyxia	Stabbed	Assault	Other
2012: 30	66.7	0.0	6.6	16.7	4.8
2013: 25	60.0	12.0	4.0	24.0	4.0
2014: 16	18.7	18.7	31.4	12.5	10.0
2015: 15	73.3	6.7	0.0	13.3	18.7
2016: 22	68.3	4.5	13.6	13.6	0.0

Table 2: Gun Homicides by Age, 2012-2016

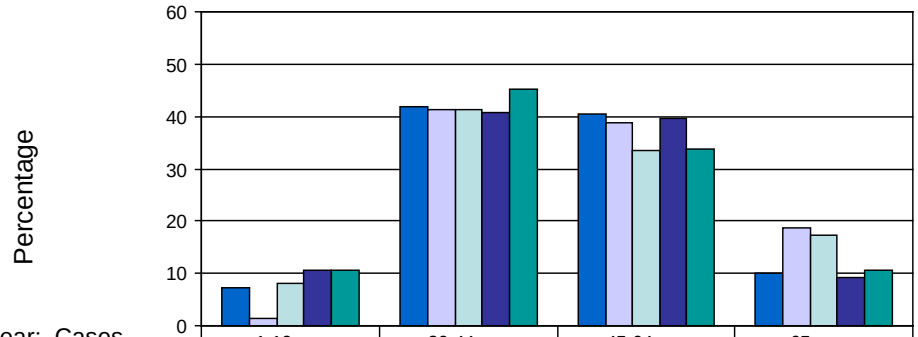
	AGE			
Year: Cases	0-19 yrs	20-29 yrs	30-39 yrs	40+ yrs
2012: 20	1	11	3	4
2013: 15	4	5	1	5
2014: 3	1	1	1	0
2015: 11	1	3	5	2
2016: 15	1	8	3	3

Table 3: Suicide Cases by Race, 2012-2016

	White	Black	Hispanic	Native American	Asian
2012: 69	89.9%	5.8%	2.9%	0.0%	1.4%
2013: 75	90.7%	1.3%	6.7%	0.0%	1.3%
2014: 75	90.7%	8.0%	0.0%	0.0%	1.3%
2015: 76	85.5%	7.9%	5.3%	0.0%	1.3%
2016: 86	83.7%	7.0%	3.5%	3.5%	2.3%

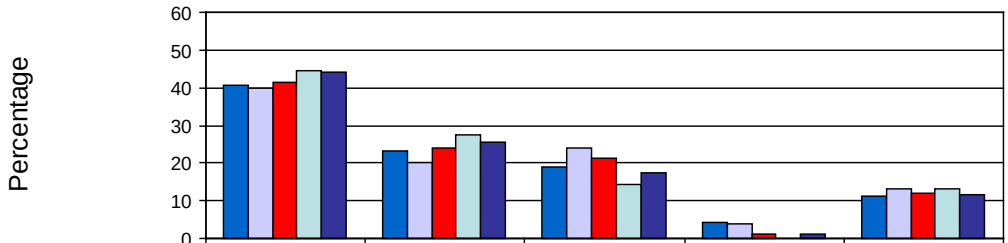
Manner of Death

Figure 14: Suicide Cases by Age, 2012-2016



Year: Cases	1-19 yrs	20-44 yrs	45-64 yrs	65+ yrs
2012: 69	7.3	42.0	40.6	10.1
2013: 75	1.3	41.3	38.7	18.7
2014: 75	8.0	41.3	33.4	17.3
2015: 76	10.5	40.8	39.5	9.2
2016: 86	10.5	45.3	33.7	10.5

Figure 15: Suicide Cases by Method Used, 2012-2016



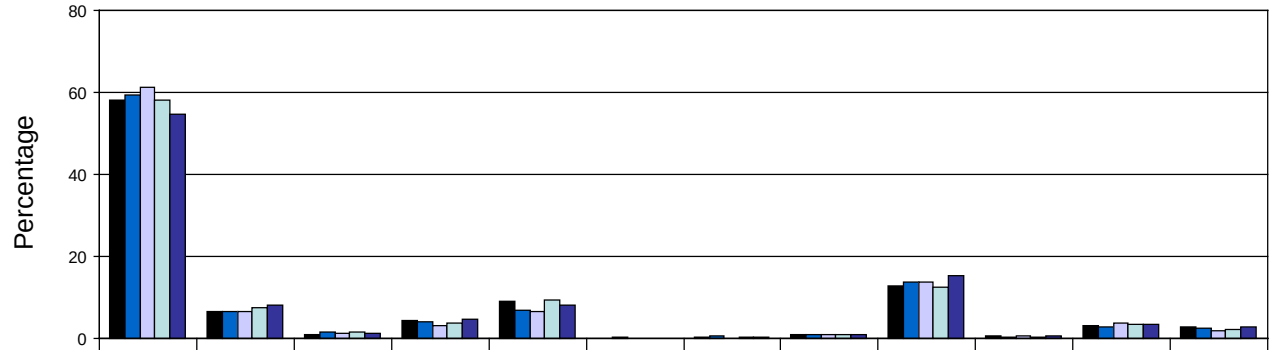
Year: Cases	Gun	Hanging	Drug OD	CO	Other
2012: 69	40.6	23.2	18.8	4.4	11.1
2013: 75	40.0	20.0	24.0	4.0	13.0
2014: 75	41.4	24.0	21.3	1.3	12.0
2015: 76	44.7	27.6	14.5	0.0	13.2
2016: 86	44.2	25.6	17.4	1.2	11.6

In 2016, CO is carbon monoxide poisoning, while Other consists of asphyxia (1), drowning (1), fire (1), falls (3), fire (1), stabbing (1), poison (1) and incised wounds (1).

Of the 86 suicide deaths for 2016, females accounted for 26 (30.2%) deaths, while males accounted for 60 (69.8%).

Cause of Death

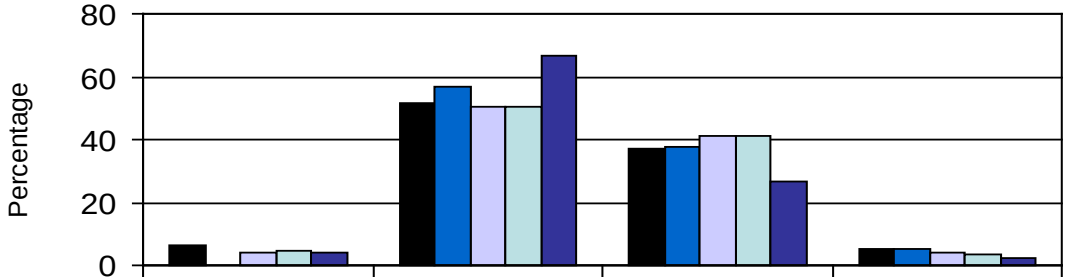
Figure 16: Medical Examiner Cases by Cause of Death, 2012-2016



Year: Cases	Natural Disease*	Vehicle	Bicycle/ Pedestrian	Gun	Drug O.D.	SIDS	Poison**	Fire	Fall	Indeter-minate	Asphyxia***	Other****
2012: 1066	58.2	6.6	0.9	4.5	9.1	0.1	0.4	0.9	12.7	0.7	3.0	2.9
2013: 1105	59.5	6.6	1.7	4.1	7.0	0.2	0.6	0.9	13.7	0.4	2.7	2.6
2014: 1110	61.3	6.5	1.2	3.2	6.7	0.1	0.1	0.8	13.8	0.5	3.8	2.0
2015: 1174	58.2	7.5	1.7	3.8	9.3	0.0	0.2	1.0	12.4	0.4	3.3	2.2
2016: 1155	54.8	8.0	1.2	4.7	8.1	0.0	0.3	0.8	15.3	0.6	3.3	2.9

*Natural: alcohol (37; 5.8%); cancer (25; 4.0%), cardiovascular (446; 70.5%);CNS (33; 5.2%); respiratory (35; 5.5%), and other (57; 9.0%)
**Poison includes carbon monoxide poisoning (3; 75.0%), and herbicide ingestion (1; 25.0%).
***Asphyxia includes deaths from hanging (22; 57.9%), choking on food (6; 15.8%), suffocation with bedding, (2; 5.3%), co-sleeping (4; 10.6%), crushed by object (1; 2.6%), .positional asphyxia (1; 2.6%), Ligature strangulation (1; 2.6%), and suffocation with plastic bag (1; 2.6%).
****Other includes deaths from encephalopathy d/t choking on food (1; 2.9%), drowning (11; 32.5%), stabbed (4; 11.8%), head trauma (2; 5.9%), strangulation (1; 2.9%), hypothermia (3; 8.8%) , electrocution (2; 5.9%), incised wounds (1; 2.9%), sepsis d/ injection (1; 2.9%), crushed by object (2; 5.9%), struck by bull (1; 2.9%), complications from surgery (1; 2.9%),blunt force injuries (2; 5.9%), and quadriplegia (2; 5.9%).

Figure 17: Drug Deaths by Age, 2012-2016



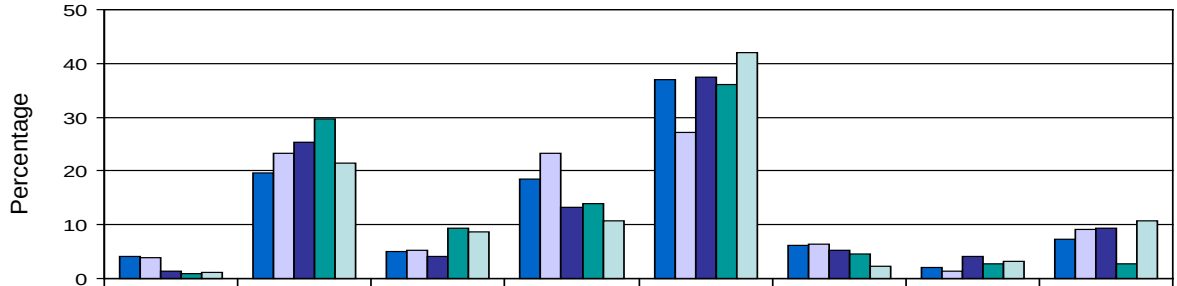
Year: Cases	<21 yrs	21-44 yrs	45-64 yrs	65+ yrs
2012: 97	6.2	51.5	37.1	5.2
2013: 77	0.0	57.1	37.7	5.2
2014: 75	4.0	50.7	41.3	4.0
2015: 109	4.6	50.5	41.2	3.7
2016: 93	4.3	66.7	26.9	2.1

Table 4: Drug Deaths by Gender, 2016

	Female (40)	Male (53)
Accident	28	49
Suicide	11	4
Indeterminate	1	0

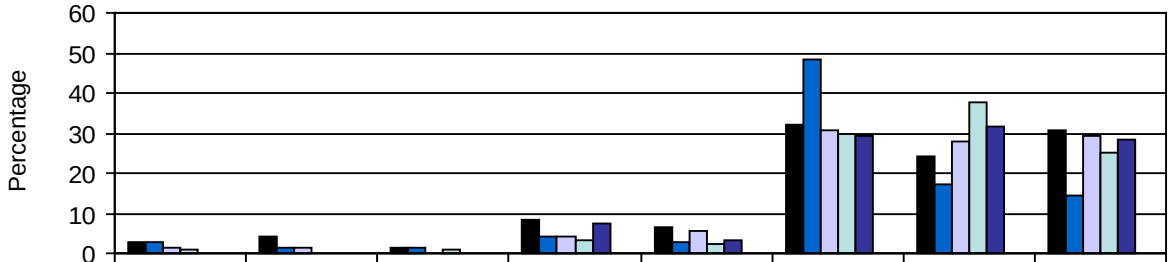
Cause of Death

Figure 18: Drug Deaths by Drug of First Mention, 2012-2016



Year: Cases	Alcohol	Heroin	Cocaine	Methadone	Narcotic Analgesic	Anti-depressant	Anti-psychotic	Other
2012: 97	4.1	19.6	5.1	18.6	37.1	6.2	2.1	7.2
2013: 77	3.9	23.4	5.2	23.4	27.2	6.5	1.3	9.1
2014: 75	1.3	25.3	4.0	13.3	37.5	5.3	4.0	9.3
2015: 109	0.9	29.6	9.3	13.9	36.1	4.6	2.8	2.8
2016: 93	1.1	21.5	8.6	10.8	41.9	2.2	3.2	10.7

Figure 19: Vehicular Deaths by Age, 2012-2016



Year: Cases	0-5 yrs	6-10 yrs	11-15 yrs	16-18 yrs	19-20 yrs	21-44 yrs	45-64 yrs	65+ yrs
2012: 70	2.9	4.3	1.4	8.6	6.5	32.2	24.2	30.6
2013: 73	2.7	1.4	1.4	4.1	2.8	48.6	17.1	14.3
2014: 72	1.4	1.4	0.0	4.2	5.6	30.5	27.7	29.2
2015: 88	1.1	0.0	1.1	3.4	2.3	29.6	37.5	25.0
2016: 92	0.0	0.0	0.0	7.6	3.3	29.3	31.5	28.3

Table 5: Vehicular Deaths by Gender, 2012-2016

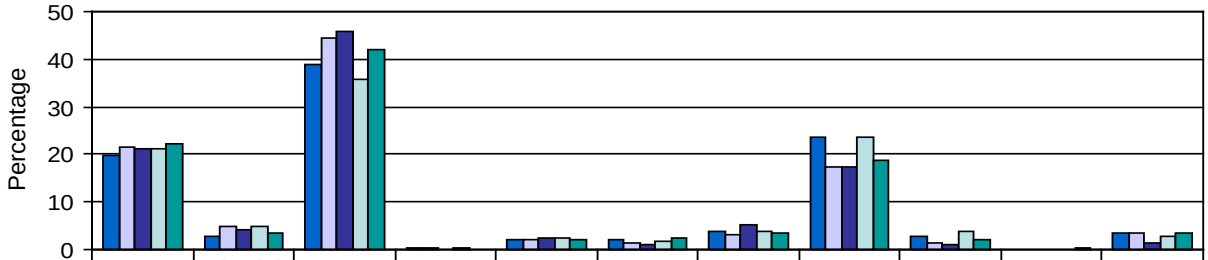
	Female	Male
2012: 70	30.0% (21)	70.0% (49)
2013: 73	28.8% (21)	71.2% (52)
2014: 72	38.9% (28)	61.1% (44)
2015: 88	26.1% (23)	73.9% (65)
2016: 92	40.2% (37)	59.8% (55)

Table 6: Bicycle/Pedestrian Deaths by Age, 2012-2016

	<21 yrs	21-44 yrs	45-64 yrs	65+ yrs
2012: 10	6	3	1	1
2013: 16	2	3	8	3
2014: 14	2	4	8	0
2015: 20	3	4	10	3
2016: 14	2	6	4	2

Cause of Death

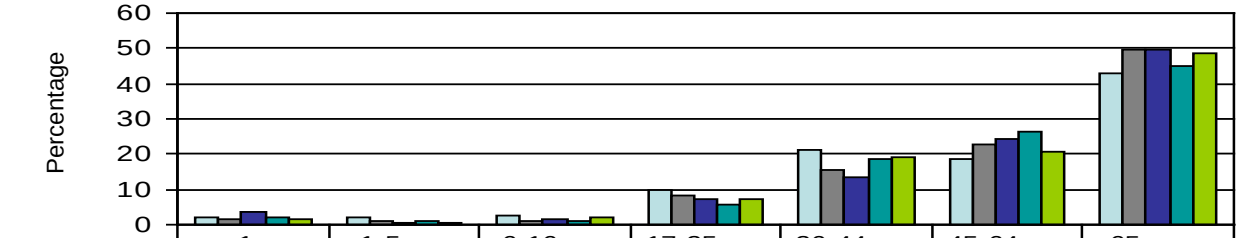
Figure 20: Accidental Deaths by Cause, 2012-2016



Year: Cases	Vehicle	Bicycle/ Pedes-trian	Fall	Poison	Fire	Drown-ing	Asphyxia	Drug OD	Natural*	Gun	Other
2012: 341	19.9	2.9	39.0	0.3	2.1	2.1	3.8	23.5	2.9	0.0	3.5
2013: 338	21.6	4.7	44.3	0.3	2.1	1.5	3.2	17.2	1.5	0.0	3.6
2014: 328	21.3	4.3	45.7	0.0	2.4	1.2	5.2	17.4	1.0	0.0	1.5
2015: 407	21.1	4.7	35.9	0.2	2.5	1.9	3.7	23.6	3.7	0.0	2.7
2016: 414	22.2	3.4	42.0	0.0	2.0	2.4	3.4	18.6	2.2	0.2	3.6

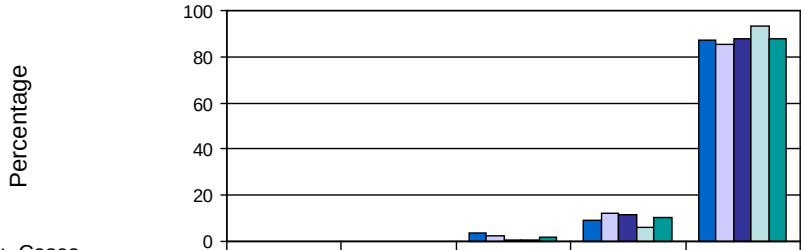
*A natural cause of death can have a contributing factor that determines the death to be accidental. There were 9 deaths that fell into this category in 2016 from falls (2), post traumatic epilepsy/seizure d/t motor vehicle accident (2), mixed drug (1), morphine toxicity (1), cocaine toxicity (1), methamphetamine toxicity (1), and ethanol (1).

Figure 21: Accidental Deaths by Age, 2012-2016



Year: Cases	<1yr	1-5 yrs	6-16 yrs	17-25 yrs	26-44 yrs	45-64 yrs	65+ yrs
2012: 341	2.3	2.1	2.6	10.0	21.1	18.8	43.1
2013: 338	1.5	1.2	0.9	8.3	15.4	23.0	49.7
2014: 328	3.7	0.3	1.5	7.0	13.7	24.4	49.4
2015: 407	2.2	1.0	1.2	5.5	18.4	26.5	45.2
2016: 414	1.7	0.7	1.9	7.5	19.1	20.5	48.6

Figure 22: Deaths Resulting from Falls by Age, 2012-2016



Year: Cases	<11 yrs	11-20 yrs	21-44 yrs	45-64yrs	65+ yrs
2012: 133	0.0	0.0	3.8	9.0	87.2
2013: 150	0.0	0.0	2.7	12.0	85.3
2014: 153	0.0	0.0	0.7	11.3	88.0
2015: 146	0.0	0.0	0.7	6.2	93.1
2016: 177	0.0	0.0	1.7	10.2	88.1

MISCELLANEOUS

Unclaimed Bodies 2012-2016

The Medical Examiner's Office handles all indigent burials in Kent County even if they do not fall under the medical examiner's jurisdiction with the assistance of the Michigan Department of Human Services. In 2016, the office processed 27 unclaimed bodies.

	2012	2013	2014	2015	2016
Medical Examiner Cases	10	18	11	18	9
Not Medical Examiner Cases	20	16	19	18	18
Total Cases	30	34	30	36	27

Deceased are considered unclaimed when they absolutely have no legal next of kin, and others fall under this category when family members either can not afford the expense of a burial/cremation or just do not want anything to do with the funeral arrangements.

Child Death Cases Reviewed 2012-2016

The Child Death Review Team reviews the deaths of those in Kent County who are 17 and younger. In 2016, there were 21 child death cases reviewed. Of these cases, 9 were deaths from 2015 and 12 were deaths from 2016.

	2012	2013	2014	2015	2016
Natural	3	7	5	3	3
SIDS	1	0	2	1	0
Vehicular Accident	7	4	5	2	2
Accidental	14	5	6	11	9
Suicide	5	1	4	4	3
Homicides	1	5	3	1	4
Indeterminate	2	0	2	2	0
Total Cases	33	22	27	24	21

Natural includes deaths from complex congenital heart disease (1); volvulus without malrotation (1); multiple congenital cardiac anomalies (1).
Accidental includes deaths from suffocation: asphyxia d/t smothering-wrapped in bed clothing (1); face down in Pac-n-Play (1); positional asphyxia-face down in air mattress (1); placed on soft bedding (1); co-sleeping (3, anaphylaxis d/t food allergy (1) and acute morphine toxicity (1).
Suicide includes death by gun (1); and hanging (2).
Homicide includes death by gun (1); stabbing & blunt head trauma (1); craniocerebral trauma (1) and asphyxia by smothering (1).

Kent County Medical Examiner 2016 Annual Report

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www.accesskent.com/health/healthdepartment/medicalexaminer

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