Kent County
Medical Examiner

2008
Annual Report

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

2008 Kent County Medical Examiner Annual Report

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

The responsibility of determining the cause and manner of unexpected deaths in Kent County is one that the Medical Examiner staff has always taken very seriously. Through rigorous investigation of the scene of death, the medical and personal history of the deceased, as well as the physical pathology revealed through autopsy, the Deputy Chief Medical Examiner and Medical Examiner Investigators are able to find answers where before there were only questions. Our investigations yield valuable information -- data that can inform the development of public policy, evidence that can assist in the prosecution of a crime, and insight that can bring peace of mind to families of the deceased.

While many regard the Medical Examiner Program as being primarily concerned with the circumstances surrounding the end of life, Medical Examiners are equally concerned with the preservations of life. The Medical Examiner personnel continues to spend many hours with the Child Death Review Team to examine all types of data related to the deaths of children under 18 years of age in our community.

In 2008, there were 5,171 deaths in Kent County. The Medical Examiner's Office was contacted regarding 1,371 of these deaths of which 352 required autopsies.

However, while the high standards to which we adhere provide the foundation for quality investigative practices, it is the practitioners – the Deputy Chief Medical Examiner and Medical Examiner Investigators - who ultimately yield results. Within the frame-work of investigative protocols, the Deputy Chief Medical Examiner and Medical Examiner Investigators must have latitude for judgment and the discretion to exercise it accordingly. I have always sought to direct our Medical Examiner program in a manner that takes full advantage of the professional trainings and experience of the Kent County Deputy Chief Medical Examiner and Medical Examiner Investigators, and continue to be an advocate for their expertise as a critical component of a quality program.

On behalf of the Medical Examiner's Office of Kent County, I would like to thank the Board of Commissioners for their continued support of this program which enables the Medical Examiner staff to provide this valuable and necessary service for the citizens of Kent County. I also wish to express my deepest gratitude to the excellent staff of the Kent County Medical Examiner program – the Deputy Chief Medical Examiner, Medical Examiner Investigators, and the administrative support staff – who keep this program running smoothly. It is my pleasure to present the Kent County Medical Examiner's 2008 Annual Report.

Respectively submitted,

Stephen D. Cohle MD

Stephen D. Cohle, MD
Chief Medical Examiner

Office of the Kent County Medical Examiner

700 Fuller N.E., Grand Rapids, MI 49503
phone (616) 632-7247, fax (616) 632-7088
Medical Examiner Exchange (616) 588-4500

Medical Examiner Personnel

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

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

Jason S. Chatman
Medical Examiner Investigator

John T. Connolly
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

Richard Washburn
Kent County Conveyance Specialist and
Scene Investigator

Dolly M. Olthoff
Medical Examiner Support Staff

Carmen M. Perez
Medical Examiner Support Staff and
Child Death Review Coordinator

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, 2007 and 2008

	2007		2008	
	Amount	Percentage	Amount	Percentage
Medical examiner (compensation)	$182,592	14.3%	$180,000	15.6%
Autopsies	880,579	69.1%	772,062	66.8%
Cadaver transportation	84,448	6.6%	85,624	7.4%
Support services	42,325	3.3%	58,296	5.0%
Administration	85,000	6.7%	60,000	5.2%
Total	$1,274,944	100.0%	$1,155,982	100.0%
Average cost per case investigated		$1,277		$1,163

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.

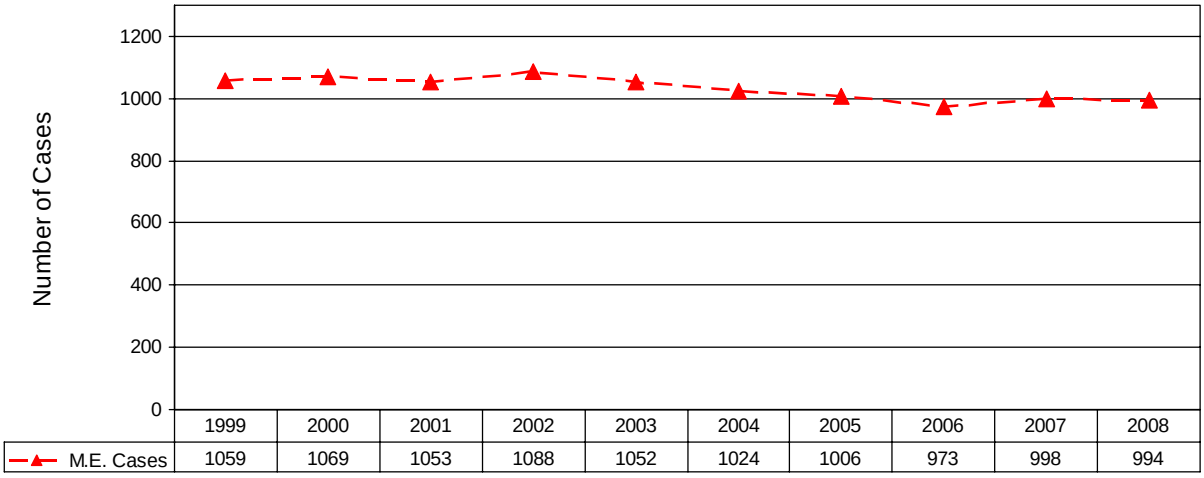
* All trauma related deaths no matter when the trauma occurred.
** The ten (10) day requirement relates solely to physician attendance.
*** The 48 hour requirement triggers an investigation when there has been no medical attendance of any kind (i.e., nursing care, etc.)

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.

2008 Medical Examiner Caseload

Figure 1: Accepted Kent County Medical Examiner Cases, 1999-2008



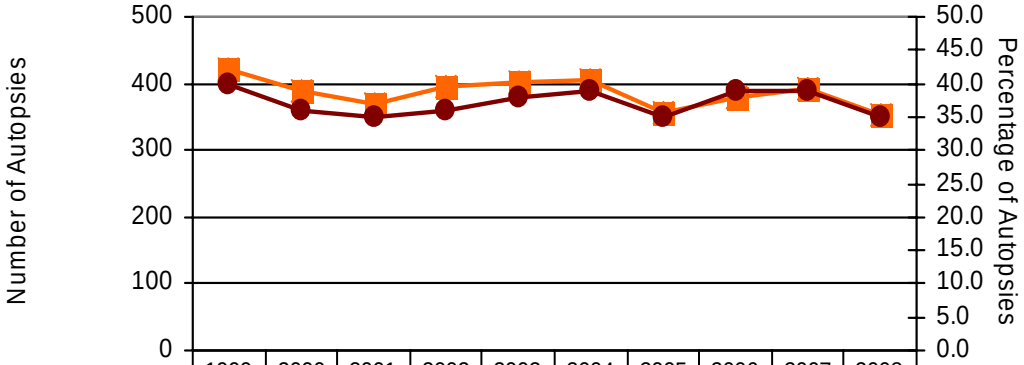
	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
M.E. Cases	1059	1069	1053	1088	1052	1024	1006	973	998	994

Total Referred Medical Examiner Cases in 2008: 1,371

Accepted	994	72.5%
Declined	377	27.5%

In 2008, there were 5,171 deaths in Kent County. The medical examiner was contacted regarding 1,371 of these deaths. Only 994 cases were accepted for investigation, while 377 were declined and did not fall within the requirements for investigation by the Medical Examiner's Office.

Figure 2: Medical Examiner Cases with Autopsy, 1999-2008

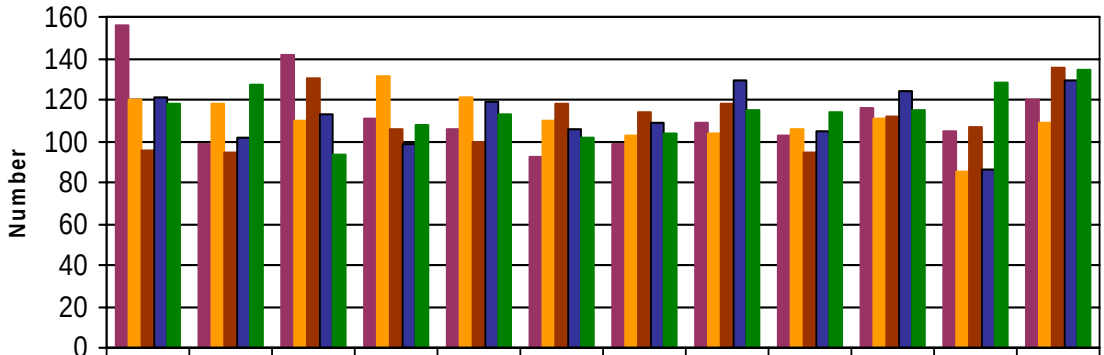


	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Number of Autopsies	422	390	369	394	401	404	356	379	391	352
Percentage of Autopsies	40.0	36.0	35.0	36.0	38.0	39.0	35.0	39.0	39.0	35.0

Of the 352 autopsies performed, 328 were charged to Kent County. The remaining 24 autopsies were performed either by a request from the family or another county.

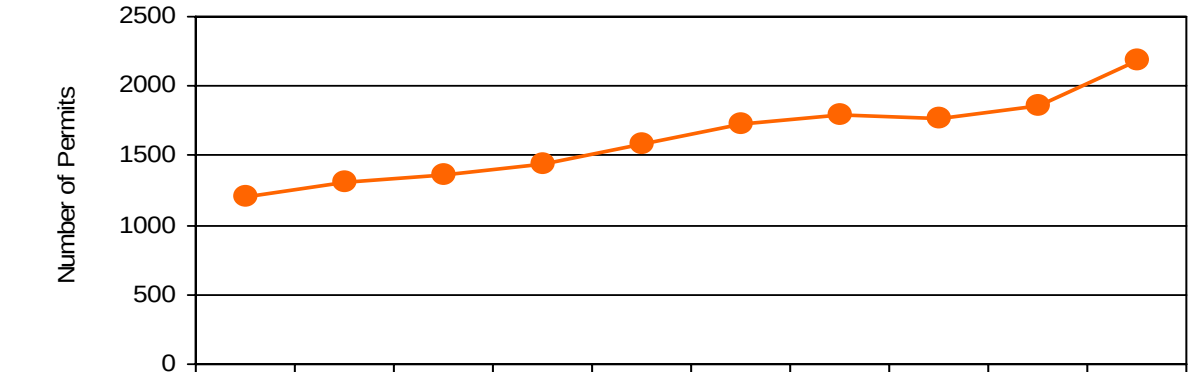
2008 Medical Examiner Caseload

Figure 3: Referred Medical Examiner Caseload by Month, 2004-2008



Year: Deaths	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2004: 1356	156	98	142	111	106	92	98	109	103	116	105	120
2005: 1328	120	118	110	131	121	110	103	104	106	111	85	109
2006: 1322	95	94	130	106	99	118	114	118	94	112	107	135
2007: 1341	121	102	113	98	119	106	109	129	105	124	86	129
2008: 1371	118	127	93	108	113	102	104	115	114	115	128	134

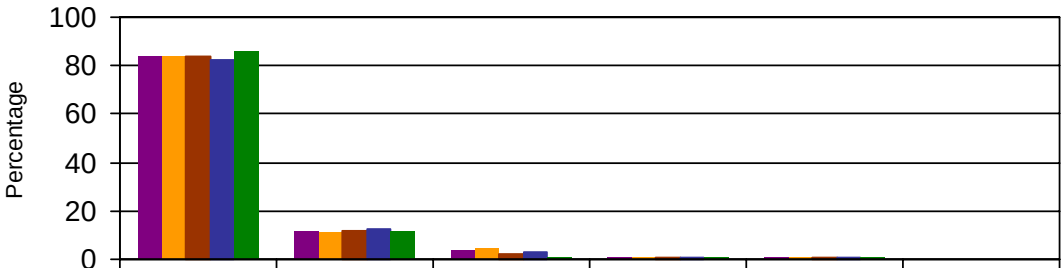
Figure 4: Cremation Permits Issued, 1999-2008



	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
# of Permits	1210	1313	1362	1441	1585	1724	1789	1761	1864	2191

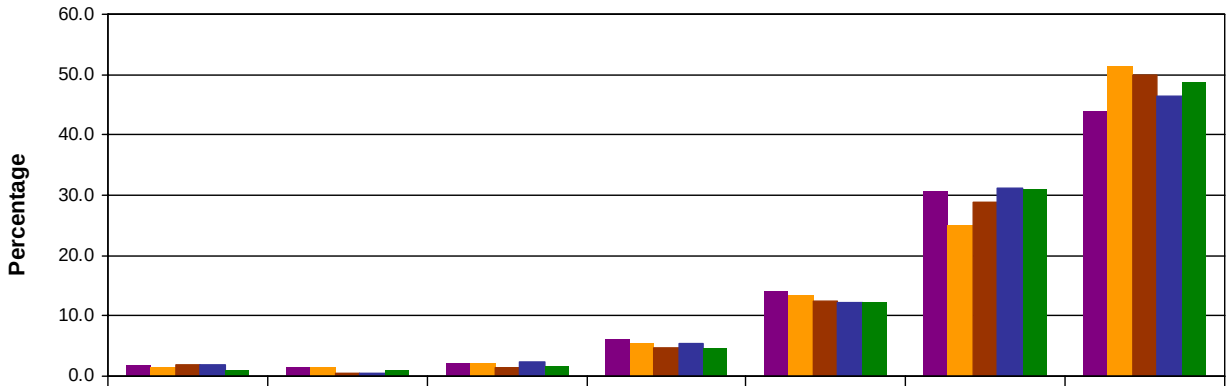
Demographics of Medical Examiner Cases

Figure 5: Medical Examiner Cases by Race/Ethnicity, 2004-2008



Year: Deaths	White	Black	Hispanic	Native American	Asian/Pacific Islander	Other
2004: 1023	83.5	11.6	3.7	0.8	0.4	N/A
2005: 1006	83.6	10.8	4.2	0.6	0.8	N/A
2006: 973	84.1	11.7	2.5	0.9	0.5	0.3
2007: 998	82.6	12.8	2.8	0.8	0.8	0.2
2008: 994	85.8	11.7	0.6	0.9	0.7	0.3

Figure 6: Medical Examiner Cases by Age at Death, 2004-2008



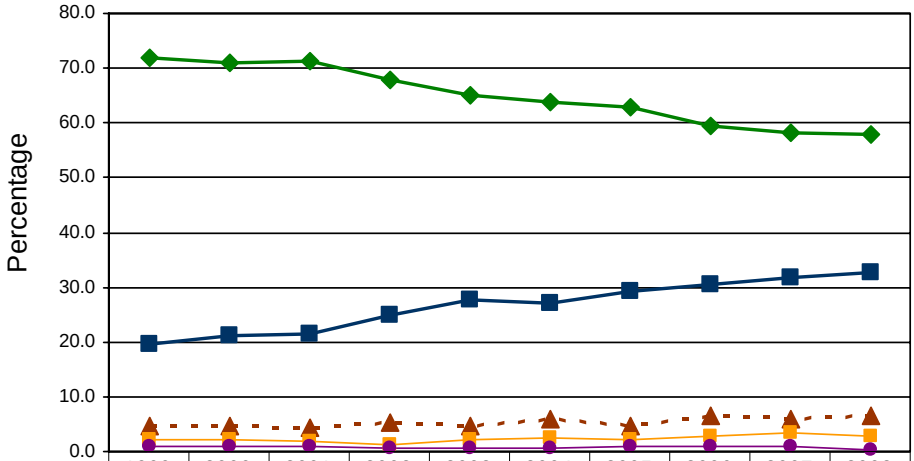
Year: Deaths	<1	1-5 yrs	6-16 yrs	17-25 yrs	26-44 yrs	45-64 yrs	65+ yrs
2004: 1023	1.9	1.3	2.2	6.1	14.1	30.7	43.9
2005: 1006	1.3	1.5	2.0	5.4	13.4	25.1	51.3
2006: 973	1.8	0.5	1.4	4.8	12.5	28.9	49.9
2007: 998	1.8	0.4	2.4	5.4	12.3	31.2	46.5
2008: 994	0.9	1.0	1.6	4.6	12.2	30.9	48.8

Table 1: Medical Examiner Cases by Gender, 2004-2008

	2004	2005	2006	2007	2008
Female	38.5%	39.7%	39.5%	38.6%	36.5% (363 cases)
Male	61.5%	60.5%	60.5%	61.3%	63.5% (631 cases)
Unknown (fetus)				0.1%	

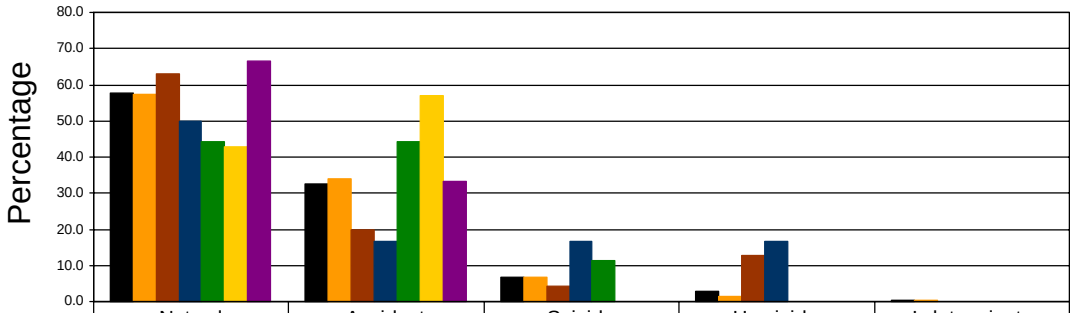
Manner of Death

Figure 7: Medical Examiner Cases by Manner of Death, 1999-2008



	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Natural	72.0	71.1	71.4	68.0	65.0	63.8	62.8	59.4	58.1	57.8
Accident	19.7	21.1	21.6	25.0	27.6	27.1	29.4	30.4	31.9	32.6
Suicide	4.7	4.8	4.3	5.2	4.6	6.0	4.6	6.5	5.8	6.6
Homicide	2.1	2.2	1.8	1.2	2.1	2.5	2.3	2.8	3.3	2.7
Indeterminate	1.0	0.8	0.9	0.6	0.7	0.6	0.9	0.9	0.9	0.3

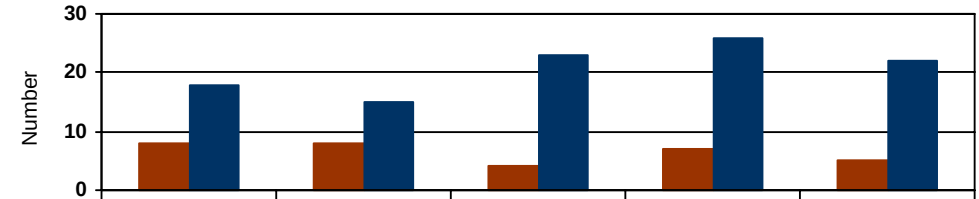
Figure 8: Manner of Death by Race/Ethnicity, 2008



Race: Deaths	Natural	Accident	Suicide	Homicide	Indeterminate
All cases, total: 994	57.8	32.6	6.6	2.7	0.3
White: 853	57.3	34.1	6.9	1.3	0.4
Black: 116	62.9	19.8	4.4	12.9	0.0
Hispanic: 6	50.0	16.7	16.7	16.6	0.0
Native American: 9	44.4	44.4	11.2	0.0	0.0
Asian/Pacific Islander: 7	42.9	57.1	0.0	0.0	0.0
Other: 3	66.7	33.3	0.0	0.0	0.0

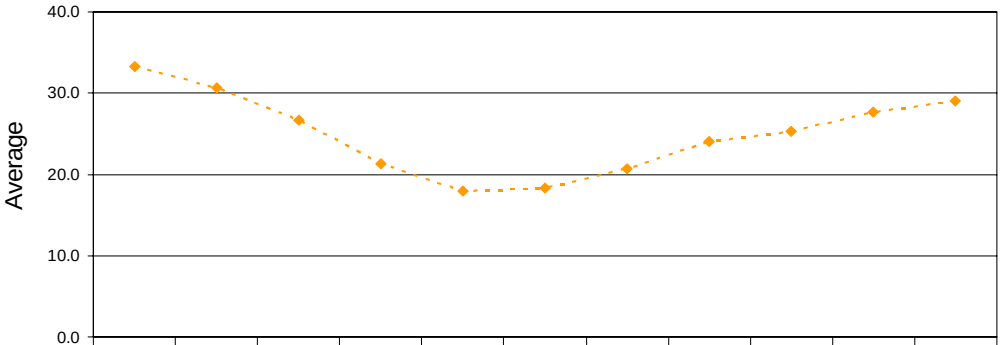
Manner of Death

Figure 9: Kent County Homicides by Gender, 2004-2008



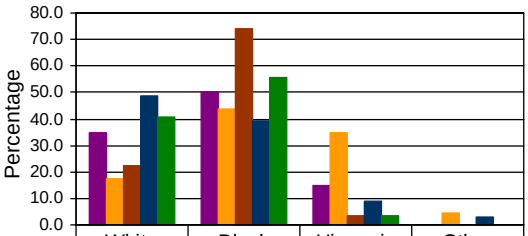
	2004: 26	2005: 23	2006: 27	2007: 33	2008: 27
Female	8	8	4	7	5
Male	18	15	23	26	22

Figure 10: Kent County Homicides, Three-Year Moving Averages, 1996-2008



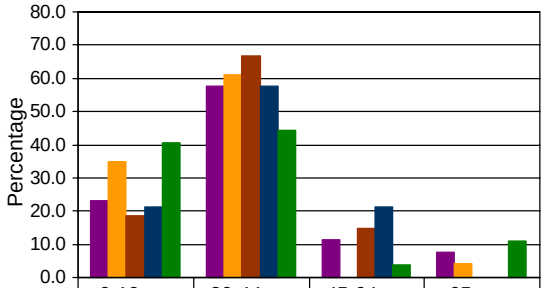
	1996-98	1997-99	1998-00	1999-01	2000-02	2001-03	2002-04	2003-05	2004-06	2005-07	2006-08
Homicides Investigated	33.3	30.7	26.7	21.3	18.0	18.3	20.7	24.0	25.3	27.7	29.0

Figure 11: Homicides by Race, 2004-2008



Year: Deaths	White	Black	Hispanic	Other
2004: 26	34.6	50.0	15.0	0.0
2005: 23	17.4	43.5	34.8	4.4
2006: 27	22.2	74.1	3.7	0.0
2007: 33	48.5	39.4	9.1	3.0
2008: 27	40.7	55.6	3.7	0.0

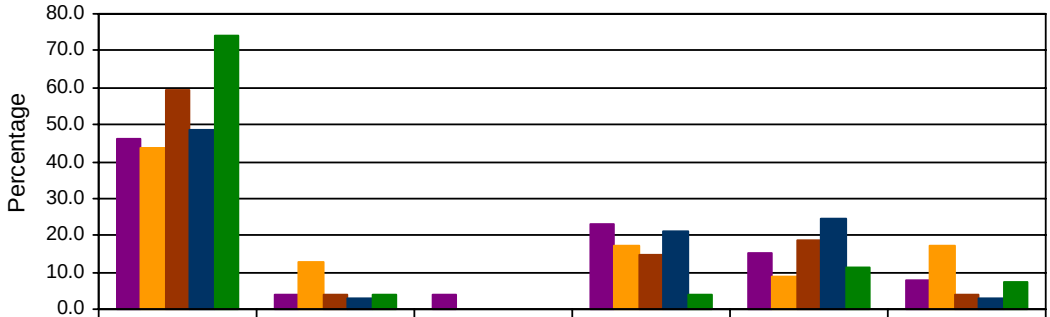
Figure 12: Homicides by Age, 2004-2008



Year: Deaths	0-19 yrs	20-44 yrs	45-64 yrs	65+ yrs
2004: 26	23.1	57.7	11.5	7.7
2005: 23	34.8	60.9	0.0	4.3
2006: 27	18.5	66.7	14.8	0.0
2007: 33	21.2	57.6	21.2	0.0
2008: 27	40.7	44.5	3.7	11.1

Manner of Death

Figure 13: Homicide Cases by Method Used, 2004-2008



Year: Deaths	Gun	Asphyxia	Fire	Stabbed	Assault	Other*
2004: 26	46.2	3.8	3.8	23.1	15.4	7.7
2005: 23	43.5	13.0	0.0	17.4	8.7	17.4
2006: 27	59.3	3.7	0.0	14.8	18.5	3.7
2007: 33	48.5	3.0	0.0	21.2	24.3	3.0
2008: 27	74.1	3.7	0.0	3.7	11.1	7.4

*For 2008, there was 1 homicide where the cause of death was due to shaken baby and 1 due to craniocerebral trauma.

Table 2: Gun Homicides by Age, 2004-2008

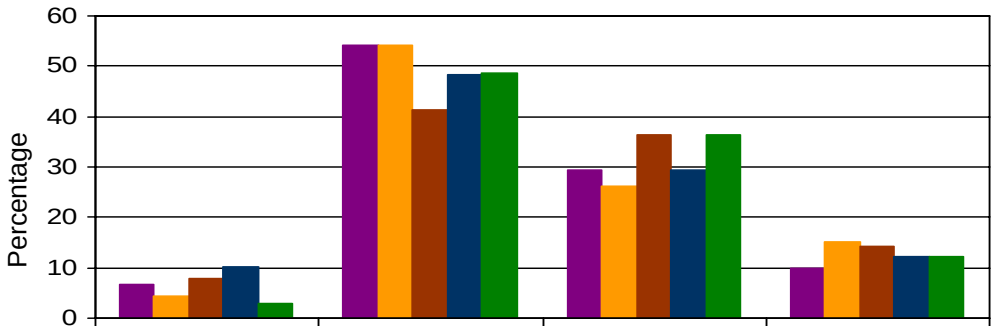
	AGE			
Year: Deaths	0-19 yrs	20-29 yrs	30-39 yrs	40+ yrs
2004: 12	2	5	3	2
2005: 10	2	5	3	0
2006: 16	3	7	2	4
2007: 16	4	8	2	2
2008: 20	8	6	3	3

Table 3: Suicide Cases by Race, 2004-2008

	White	Black	Hispanic	Native American	Asian
2004: 61	83.6%	3.3%	8.2%	0.0%	4.9%
2005: 46	82.6%	6.5%	8.7%	0.0%	1.0%
2006: 63	92.1%	4.8%	3.2%	0.0%	0.0%
2007: 58	89.7%	5.2%	1.7%	1.7%	1.7%
2008: 66	89.4%	7.6%	1.5%	1.5%	0.0%

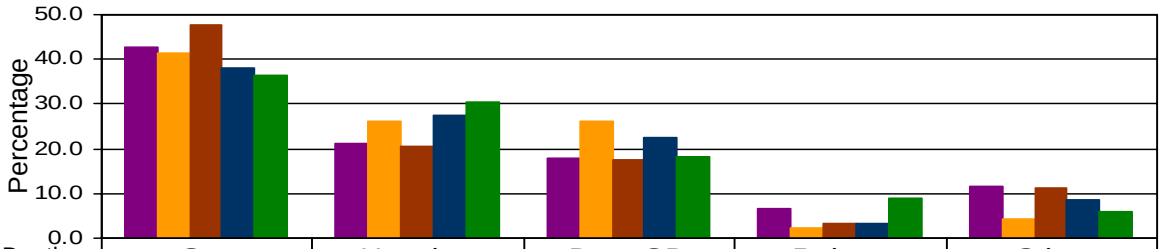
Manner of Death

Figure 14: Suicide Cases by Age, 2004-2008



Year: Deaths	1-19 yrs	20-44 yrs	45-64 yrs	65+ yrs
2004: 61	6.6	54.1	29.5	9.8
2005: 46	4.3	54.3	26.1	15.2
2006: 63	7.9	41.3	36.5	14.3
2007: 58	10.3	48.3	29.3	12.1
2008: 66	3.0	48.5	36.4	12.1

Figure 15: Suicide Cases by Method Used, 2004-2008



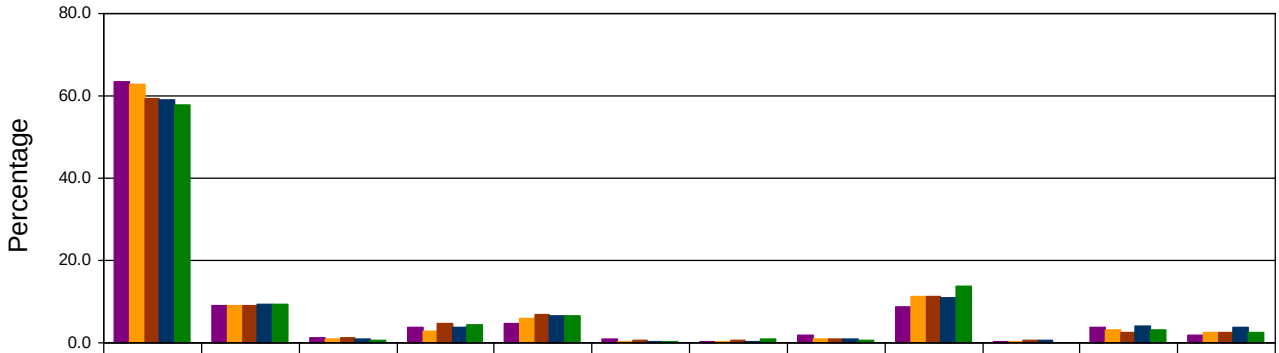
Year: Deaths	Gun	Hanging	Drug OD	Poison	Other
2004: 61	42.6	21.3	18.0	6.6	11.5
2005: 46	41.3	26.1	26.1	2.2	4.3
2006: 63	47.6	20.6	17.5	3.2	11.1
2007: 58	38.0	27.6	22.4	3.4	8.6
2008: 66	36.4	30.3	18.2	9.1	6.0

In 2008, Poison is carbon monoxide poisoning, while Other consists of stabbing (2; 50%), drowning (1; 25%) and fall (1; 25%).

Of the 66 suicide deaths for 2008, females accounted for 12 (18.2%) deaths, while males accounted for 54 (81.8%).

Cause of Death

Figure 16: Medical Examiner Cases by Cause of Death, 2004-2008



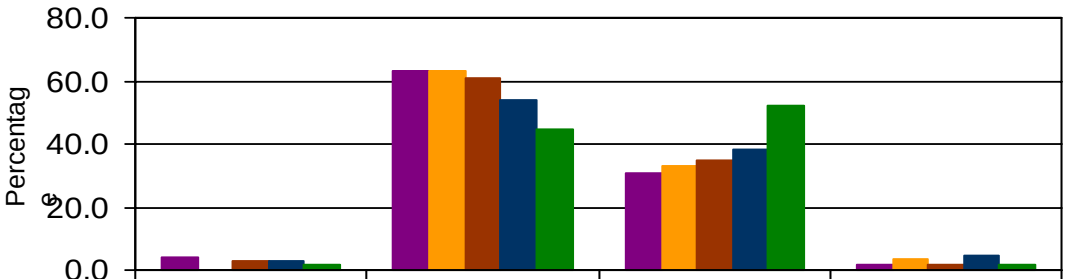
Year: Deaths	Natural	Vehicle	Bicycle/ Pedestrian	Gun	Drug O.D.	SIDS	Poison*	Fire	Fall	Indeter-minate	Asphyxia**	Other***
2004: 1023	63.3	9.0	1.1	3.7	4.8	0.8	0.4	2.0	8.9	0.4	3.9	1.8
2005: 1006	62.9	9.2	0.8	2.9	6.0	0.3	0.2	0.8	11.2	0.3	3.0	2.4
2006: 973	59.5	9.0	1.2	4.7	6.8	0.7	0.5	0.9	11.2	0.5	2.5	2.4
2007: 998	59.1	9.4	1.0	3.8	6.5	0.3	0.2	0.8	10.8	0.5	4.0	3.6
2008: 994	57.8	9.3	0.5	4.5	6.7	0.2	1.0	0.6	13.9	0.0	3.1	2.4

*Poison includes carbon monoxide poisoning (8; 80.0%) and other chemical poisoning (2; 20.0%).

**Asphyxia includes deaths from choking on food (3; 9.7%), drowning (3; 9.7%), hanging (20; 64.5%), strangulation (1; 3.2%), smothering (1; 3.2%) and trapped under object (3; 9.7%).

***Other is comprised of deaths from assault (3; 12.5%), stabbing (3; 12.5%), hypothermia (2; 8.3%), struck by object (3; 12.5%), medical procedure (3; 12.5%), hypoxic encephalopathy d/t choking on food and entanglement in swing set (2; 8.3%), electrocution (2; 8.3%), physical abuse (2; 8.3%) and medical complications (4; 16.8%).

Figure 17: Drug Deaths by Age, 2004-2008



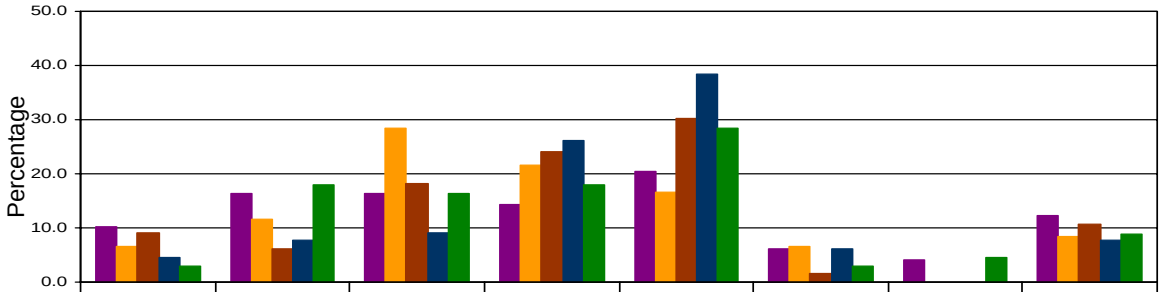
Year: Deaths	<20 yrs	21-44 yrs	45-64 yrs	65+ yrs
2004: 49	4.1	63.3	30.6	2.0
2005: 60	0.0	63.3	33.3	3.3
2006: 66	3.0	60.6	34.9	1.5
2007: 65	3.1	53.8	38.5	4.6
2008: 67	1.5	44.8	52.2	1.5

Table 4: Drug Deaths by Gender, 2008

	Female (22)	Male (45)
Accident	16	38
Suicide	5	7
Indeterminate	1	0

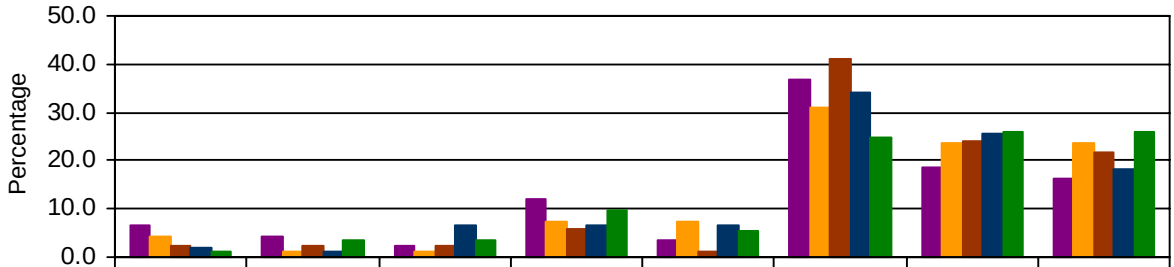
Cause of Death

Figure 18: Drug Deaths by Drug of First Mention, 2004-2008



Year: Deaths	Alcohol	Heroin	Cocaine	Methadone	Narcotic Analgesic	Anti-depressant	Anti-psychotic	Other
2004: 49	10.2	16.3	16.3	14.3	20.4	6.1	4.1	12.2
2005: 60	6.7	11.7	28.3	21.7	16.7	6.7	0.0	8.3
2006: 66	9.1	6.1	18.2	24.2	30.3	1.5	0.0	10.6
2007: 65	4.6	7.7	9.2	26.1	38.5	6.2	0.0	7.7
2008: 67	3.0	17.9	16.4	17.9	28.4	3.0	4.5	8.9

Figure 19: Vehicular Deaths by Age, 2004-2008



Year: Deaths	0-5 yrs	6-10 yrs	11-15 yrs	16-18 yrs	19-20 yrs	21-44 yrs	45-64 yrs	65+ yrs
2004: 92	6.5	4.3	2.2	12.0	3.3	37.0	18.5	16.3
2005: 93	4.3	1.1	1.1	7.5	7.5	31.2	23.7	23.7
2006: 88	2.3	2.3	2.3	5.7	1.1	40.9	23.9	21.6
2007: 94	2.1	1.1	6.4	6.4	6.4	34.0	25.5	18.1
2008: 92	1.0	3.3	3.3	9.8	5.4	25.0	26.1	26.1

Table 5: Vehicular Deaths by Gender, 2004-2008

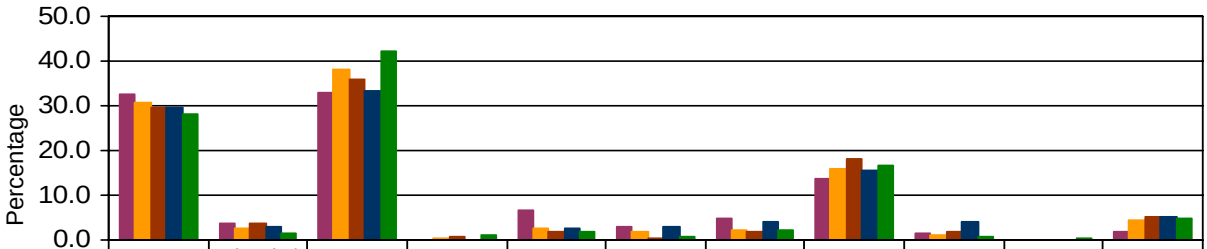
	Female	Male
2004: 92	34.8% (32)	65.2% (60)
2005: 93	31.2% (29)	68.8% (64)
2006: 88	28.4% (25)	71.6% (63)
2007: 94	28.7% (27)	71.3% (67)
2008: 92	29.3% (27)	70.7% (65)

Table 6: Bicycle/Pedestrian Deaths by Age, 2004-2008

	<20 yrs	21-44 yrs	45-64 yrs	65+ yrs
2004: 11	2	5	2	2
2005: 8	3	3	0	2
2006: 11	0	4	5	2
2007: 10	4	2	3	1
2008: 5	1	0	2	2

Cause of Death

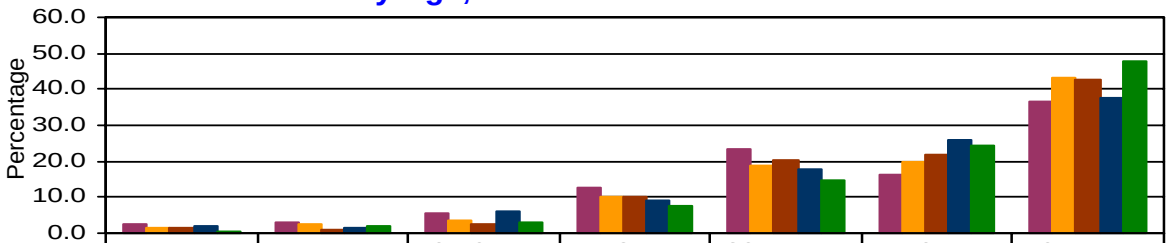
Figure 20: Accidental Deaths by Cause, 2004-2008



Year: Deaths	Vehicle	Bicycle/ Pedes-trian	Fall	Poison	Fire	Drown-ing	Asphyxia	Drug OD	Natural*	Gun	Other
2004: 277	32.5	3.6	32.9	0.0	6.5	2.9	4.7	13.7	1.4	0.0	1.8
2005: 296	30.7	2.7	38.2	0.3	2.7	1.7	2.4	15.9	1.0	0.0	4.4
2006: 296	29.7	3.7	36.1	0.7	2.0	0.3	2.0	18.2	2.0	0.0	5.1
2007: 318	29.6	3.1	33.3	0.0	2.5	2.8	3.9	15.4	4.1	0.0	5.3
2008: 325	28.3	1.5	42.2	1.0	1.8	0.6	2.2	16.6	0.6	0.3	4.9

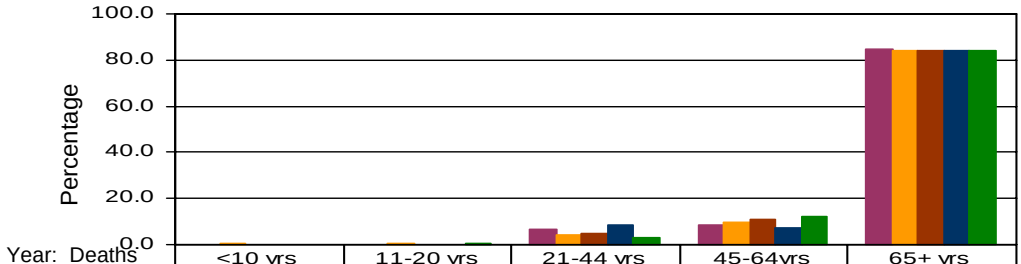
*A natural cause of death can have a contributing factor that determines the death to be accidental. There were 2 deaths that fell into this category in 2008, 1 from drug toxicity and 1 from a vehicle accident.

Figure 21: Accidental Deaths by Age, 2004-2008



Year: Deaths	<1yr	1-5 yrs	6-16 yrs	17-25 yrs	26-44 yrs	45-64 yrs	65+ yrs
2004: 277	2.5	2.9	5.8	12.6	23.5	16.2	36.5
2005: 296	1.4	2.7	3.7	10.1	18.9	19.9	43.2
2006: 296	1.4	1.0	2.7	10.1	20.3	22.0	42.6
2007: 318	1.9	1.3	6.0	9.1	17.9	26.1	37.7
2008: 325	0.3	1.8	3.1	7.4	14.8	24.6	48.0

Figure 22: Deaths Resulting from Falls by Age, 2004-2008



Year: Deaths	<10 yrs	11-20 yrs	21-44 yrs	45-64yrs	65+ yrs
2004: 91	0.0	0.0	6.7	8.8	84.6
2005: 113	0.9	0.9	4.4	9.7	84.1
2006: 107	0.0	0.0	4.7	11.2	84.1
2007: 106	0.0	0.0	8.5	7.5	84.0
2008: 138	0.0	0.7	2.9	12.3	84.1

2008 Child Death Review Meetings

The Child Death Review Team reviews the deaths of those in Kent County who are 18 and younger. In 2008, there were 34 child death cases reviewed. Of these cases, 7 were deaths from 2007, and 27 were deaths from 2008.

Natural Deaths – 9

- SIDS – 2
  - Black – 1
  - White – 1
- Other – 7
  - Medical complications of placental abruption
  - Chronic lung disease due to prematurity
  - Lymphocytic tracheobronchitis with focal broncholitis (viral type)
  - Pulmonary emboli due to deep venous thrombosis
  - Pneumonia – sickle cell/Beta thalussmia
  - Medical complications due to prematurity
  - Gangrene caused by clostridium perfringens

Accidental Deaths – 18

- Vehicular Accidents – 11
  - Driver – 3
  - Passenger – 5
  - Pedestrian – 2
  - Bicyclist – 1
- Drowning – 1
  - Lake
- Suffocations – 3
  - Co-sleeping
  - Pillow
  - Sleeping bag
- Other – 3
  - Ingestion of isopropanol acetone
  - Hypoxic encephalopathy due to neck compression from entanglement in swing set rope
  - Hypoxic encephalopathy due to aspiration from hot dog

Suicides – 1

- Hanging

Homicides – 5

- Gun – 4
- Traumatic brain injury – 1

Indeterminate – 1

- Infant found in bouncy seat

Child Death Cases Reviewed by Year

	2004	2005	2006	2007	2008
Natural	16	11	9	9	9
Vehicular Accidents	8	11	4	10	11
Accidental	16	10	4	11	7
Suicides	1	2	3	4	1
Homicides	1	6	2	5	5
Indeterminate	1	1	3	1	1
Total Cases	43	41	25	40	34

Kent County Medical Examiner 2008 Annual Report

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Created by:
Carmen D. Marrero-Perez
Medical Examiner Support Staff