Office of the Medical Examiner  
State of Kentucky  
Physician/Doctorate Staff

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Office of the Associate Medical Examiner Frankfort, KY
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Victoria Graham, MD

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DeDe Schluckebier, MD (Through May 2011)

Office of the Medical Examiner Ft. Thomas, KY
Charles Stephens, MD  
Gregory Wanger, MD
Office of the Medical Examiner
2011 Annual Report

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Introduction

The Office of the Medical Examiner investigates deaths occurring in the state of Kentucky, as authorized by Kentucky’s elected coroners. The staff assists Kentucky coroners and law enforcement agencies in all aspects of death investigations by determining the cause and manner of death, identification of the deceased, and collection and interpretation of trace evidence. The Medical Examiner Division performed services for approximately 2,378 deaths. A detailed summary of the case distribution is delineated in this report.  It should be noted that this annual report does not include all deaths occurring in Kentucky, but rather those cases investigated by the Kentucky Medical Examiner Program. For total numbers of deaths occurring in the state, please contact:

Office of Vital Statistics
275 E. Main St. 1EA
Frankfort, KY 40621
(502) 564-4212

The following report is presented in two sections. The first section summarizes the activity of the Medical Examiner’s Office. The second section presents data routinely collected by the Medical Examiner’s Office in regards to medicolegal death investigations performed. The graphs and figures presented are designed to be self-explanatory and provide the reader with a brief understanding of the types of cases completed within this Division.

Overview—Office of the Medical Examiner—2011

The Medical Examiners Office performs death investigations and postmortem examinations at four separate regional offices around the state:

• The Office of the Chief Medical Examiner in Louisville, KY
• The Office of the Associate Chief Medical Examiner in Frankfort, KY
• The Western Kentucky Regional Medical Examiners Office in Madisonville, KY
• The Northern Kentucky Regional Medical Examiners Office in Ft. Thomas, KY

There are six basic functions of the Office of the Medical Examiner:

• determine the cause and manner of death of individual decedents in a timely fashion
• identify the dead with a high degree of certainty and written documentation
• prepare and maintain accurate, thorough and timely reports regarding examinations and opinions
• safeguard and account for evidence and personal property
• maintain confidentiality of case information
• base expert opinions on logical conclusions after considering all historical and physical evidence available, in light of current scientific and medical knowledge

All medical examiner offices in Kentucky are staffed by board certified and/or board eligible forensic pathologists. These forensic pathologists are physicians who have undergone at least five years of postgraduate training to become proficient in the subspecialty of forensic pathology. The forensic pathologists routinely perform postmortem examinations; consult with law enforcement officials and attorneys regarding aspects of investigations including blood spatter analysis, crime scene investigation and toxicology interpretation; meet with decedents’ families; and provide expert testimony in courts throughout Kentucky.

**OUR MISSION**

The mission of the Kentucky Medical Examiners Office is to serve the public by:
• providing accurate, thorough and efficient medical legal investigations of death, thereby,
• insuring justice, and
• providing solace, comfort and protection to the living

**Reportable Deaths**

**KRS 72.025 Circumstances requiring post-mortem examination to be performed by coroner.**

Coroners shall require a post-mortem examination to be performed in the following circumstances:

1. When the death of a human being appears to be caused by homicide or violence;
2. When the death of a human being appears to be the result of suicide;
3. When the death of a human being appears to be the result of the presence of drugs or poisons in the body;
4. When the death of a human being appears to be the result of a motor vehicle accident and the operator of the motor vehicle left the scene of the accident or the body was found in or near a roadway or railroad;
5. When the death of a human being occurs while the person is in a state mental institution or mental hospital when there is no previous medical history to explain the death, or while the person is in police custody, a jail or penal institution;
6. When the death of a human being occurs in a motor vehicle accident and when an external examination of the body does not reveal a lethal traumatic injury;
7. When the death of a human being appears to be the result of a fire or explosion;
8. When the death of a child appears to indicate child abuse prior to the death;
9. When the manner of death appears to be other than natural;
10. When human skeletonized remains are found;
11. When post-mortem decomposition of a human corpse exists to the extent that external examination of the corpse cannot rule out injury or where the circumstances of death cannot rule out the commission of a crime;
12. When the death of a human being appears to be the result of drowning;
When the death of an infant appears to be caused by sudden infant death syndrome in that the infant has no previous medical history to explain the death;
(14) When the death of a human being occurs as a result of an accident;
(15) When the death of a human being occurs under the age of forty (40) and there is no past medical history to explain the death;
(16) When the death of a human being occurs at the work site and there is no apparent cause of death such as an injury or when industrial toxics may have contributed to the cause of death;
(17) When the body is to be cremated and there is no past medical history to explain the death;
(18) When the death of a human being is sudden and unexplained; and
(19) When the death of a human being occurs and the decedent is not receiving treatment by a licensed physician and there is no ascertainable medical history to indicate the cause of death.

Effective: July 15, 1998

1. The coroner determines whether the case becomes a medical examiner case.
2. The medical examiner and the coroner may discuss whether a complete autopsy, a focused examination, or external inspection with toxicology specimen acquisition is warranted on certain cases. The Medical Examiner makes a MEDICAL DECISION regarding the type and amount of examination done to render a medicolegal opinion and thus provide assistance to the coroner. In all cases submitted by a coroner with an authorization, a report including a final opinion is generated.
3. In the rare event that the coroner declines to authorize an examination by the Medical Examiner’s office in a case in which law enforcement investigators conclude that ME involvement is crucial, then law enforcement may obtain and authorize an examination by the ME office by procuring a court order through the Commonwealth Attorney’s Office.

Statutory Duty

72.210 Purpose of Division of Kentucky State Medical Examiners Office.
In enacting legislation establishing a Division of Kentucky State Medical Examiners Office for the Commonwealth of Kentucky, it is not the intention of the General Assembly to abolish or interfere with the coroner in his role as a constitutionally elected peace officer. It is the intention of the General Assembly for the office to aid, assist, and complement the coroner in the performance of his duties by providing medical assistance to him in determining causes of death.

Effective: July 15, 1998
Summary Highlights

Aforementioned above, the four regional medical examiner offices together performed 2,378 postmortem examinations in 2011. The Western Kentucky Medical Examiner’s Office performed cases January through May 2012. Beginning in mid-May, all Western Kentucky cases were performed by the Louisville Medical Examiner’s Office.

Training and Education

The Medical Examiner’s Division provides educational instruction in death investigation to coroners, law enforcement, medical, and social service agencies throughout the state. The Office of the Chief Medical Examiner plays an active role in the University of Louisville Department of Pathology educational programs and activities. Staff pathologists participate in the training of medical students, residents and fellows.

Forensic Pathologist Fellowship Program

The University of Louisville Division of Forensic Pathology Fellowship program is a one-year extensive training program in the subspecialty of forensic pathology. The trainee works with all of the attending physicians, gaining exposure to a wide spectrum of cases with various histories, causes, manners and mechanisms of death. The trainee is always staffed by one of the attending physicians in the autopsy room. The gross findings are discussed during the dissection, dictated at the table, and are signed out at the end of dissection. Case discussions are initiated prior to autopsy, and continued with staff and investigators through the multi-step process to the final report. The trainee is supervised throughout the process of interpretation of radiographs, microscopic slides, and toxicologic analysis. The trainees’ dictations are critiqued and modified as needed by the attending physicians. Early in training, the trainee accompanies the attending physician to death scenes as requested by coroners. As the training year progresses, the fellow may accompany coroners to death scenes without an attending physician; even when the fellow conducts a scene visit without an attending physician, an attending physician remains available to provide telephone consultation regarding scene findings, or go to the scene as circumstances indicate.
Office of the Medical Examiner
Organizational Chart

Figure 1

Justice and Public Safety Cabinet Secretary
J. Michael Brown
(502)564-7554

Office of the Chief Medical Examiner
Chief Medical Examiner
Tracey S. Corey, MD
(502)852-5587

Frankfort M.E. Office
(502)564-4545

Ft. Thomas M.E. Office
(859)572-3559

Madisonville M.E. Office
(270)824-7048
The remainder of this report will present data routinely collected by the Medical Examiner Offices. The graphs summarize data collected on all cases performed throughout the four regional offices.
Statewide Medical Examiner Case Totals 2011
The totals listed below do not represent all deaths occurring in Kentucky but rather the total cases undergoing autopsy by the Kentucky Medical Examiner Offices.

TOTAL STATEWIDE CASES UNDERGOING AUTOPSY BY KENTUCKY MEDICAL EXAMINER OFFICES = 2,378

<table>
<thead>
<tr>
<th>Manner</th>
<th>Total</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accidents</td>
<td>1,032</td>
<td>43.40%</td>
</tr>
<tr>
<td>Homicides</td>
<td>198</td>
<td>8.33%</td>
</tr>
<tr>
<td>Naturals</td>
<td>605</td>
<td>25.44%</td>
</tr>
<tr>
<td>Suicides</td>
<td>310</td>
<td>13.04%</td>
</tr>
<tr>
<td>Undetermined</td>
<td>205</td>
<td>8.62%</td>
</tr>
<tr>
<td>Pending Further Information</td>
<td>28</td>
<td>1.18%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>2,378</td>
<td>100%</td>
</tr>
</tbody>
</table>
### SUMMARY OF TOTAL STATEWIDE OVERDOSES UNDERGOING AUTOPSY BY KENTUCKY MEDICAL EXAMINER OFFICES

<table>
<thead>
<tr>
<th>Manner</th>
<th>Total</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accidents</td>
<td>558</td>
<td>81.58%</td>
</tr>
<tr>
<td>Homicide</td>
<td>1</td>
<td>0.15%</td>
</tr>
<tr>
<td>Suicides</td>
<td>31</td>
<td>4.53%</td>
</tr>
<tr>
<td>Undetermined</td>
<td>37</td>
<td>5.41%</td>
</tr>
<tr>
<td>Pending Further Information</td>
<td>13</td>
<td>1.90%</td>
</tr>
<tr>
<td>Complications of Chronic Use</td>
<td>44</td>
<td>6.43%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>684</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>
2011 Statewide Medical Examiner Cases

Figure 2

Louisville, 1,179
Frankfort, 706
NKY, 407
WKY, 86
### Louisville Totals by Some Specific Fatal Event

<table>
<thead>
<tr>
<th>Fatal Event</th>
<th>Total Cases</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overdoses</strong></td>
<td>336</td>
<td>28.50%</td>
</tr>
<tr>
<td>Accidental</td>
<td>244</td>
<td>72.62%</td>
</tr>
<tr>
<td>Homicide</td>
<td>1</td>
<td>0.30%</td>
</tr>
<tr>
<td>Suicide</td>
<td>15</td>
<td>4.46%</td>
</tr>
<tr>
<td>Complications of Chronic Use</td>
<td>35</td>
<td>10.42%</td>
</tr>
<tr>
<td>Pending Further Information</td>
<td>13</td>
<td>3.87%</td>
</tr>
<tr>
<td>Undetermined</td>
<td>28</td>
<td>8.33%</td>
</tr>
<tr>
<td><strong>MVC</strong></td>
<td>117</td>
<td>9.92%</td>
</tr>
<tr>
<td>Accident</td>
<td>116</td>
<td>99.15%</td>
</tr>
<tr>
<td>Pending Further Information</td>
<td>1</td>
<td>0.85%</td>
</tr>
<tr>
<td><strong>GSW</strong></td>
<td>203</td>
<td>17.22%</td>
</tr>
<tr>
<td>Homicide</td>
<td>77</td>
<td>37.93%</td>
</tr>
<tr>
<td>Suicide</td>
<td>120</td>
<td>59.11%</td>
</tr>
<tr>
<td>Undetermined</td>
<td>3</td>
<td>1.48%</td>
</tr>
<tr>
<td>Pending Further Information</td>
<td>3</td>
<td>1.48%</td>
</tr>
<tr>
<td><strong>DROWNING</strong></td>
<td>38</td>
<td>3.22%</td>
</tr>
<tr>
<td>Accident</td>
<td>31</td>
<td>81.58%</td>
</tr>
<tr>
<td>Homicide</td>
<td>1</td>
<td>2.63%</td>
</tr>
<tr>
<td>Suicide</td>
<td>4</td>
<td>10.53%</td>
</tr>
<tr>
<td>Pending</td>
<td>1</td>
<td>2.63%</td>
</tr>
<tr>
<td>Undetermined</td>
<td>1</td>
<td>2.63%</td>
</tr>
<tr>
<td><strong>FIRE</strong></td>
<td>17</td>
<td>1.44%</td>
</tr>
<tr>
<td>Accident</td>
<td>14</td>
<td>82.35%</td>
</tr>
<tr>
<td>Pending Further Information</td>
<td>2</td>
<td>11.76%</td>
</tr>
<tr>
<td>Suicide</td>
<td>1</td>
<td>5.88%</td>
</tr>
<tr>
<td><strong>SUID</strong></td>
<td>23</td>
<td>1.97%</td>
</tr>
<tr>
<td>Undetermined</td>
<td>23</td>
<td>100</td>
</tr>
<tr>
<td><strong>All other Louisville Accidents</strong></td>
<td>52</td>
<td>4.41%</td>
</tr>
</tbody>
</table>

*The above does not represent the total number of Louisville cases*
## Frankfort Totals by Some Specific Fatal Event

<table>
<thead>
<tr>
<th>Fatal Event</th>
<th>Total</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overdoses</strong></td>
<td><strong>191</strong></td>
<td><strong>27.05%</strong></td>
</tr>
<tr>
<td>Accidental</td>
<td><strong>169</strong></td>
<td><strong>88.48%</strong></td>
</tr>
<tr>
<td>Complications of Chronic Use</td>
<td><strong>7</strong></td>
<td><strong>3.66%</strong></td>
</tr>
<tr>
<td>Suicide</td>
<td><strong>8</strong></td>
<td><strong>4.19%</strong></td>
</tr>
<tr>
<td>Undetermined</td>
<td><strong>7</strong></td>
<td><strong>3.66%</strong></td>
</tr>
<tr>
<td><strong>MVC</strong></td>
<td><strong>60</strong></td>
<td><strong>8.5%</strong></td>
</tr>
<tr>
<td>Accidental</td>
<td><strong>57</strong></td>
<td><strong>95%</strong></td>
</tr>
<tr>
<td>Undetermined</td>
<td><strong>3</strong></td>
<td><strong>5%</strong></td>
</tr>
<tr>
<td><strong>GSW</strong></td>
<td><strong>110</strong></td>
<td><strong>15.58%</strong></td>
</tr>
<tr>
<td>Accident</td>
<td><strong>2</strong></td>
<td><strong>1.82%</strong></td>
</tr>
<tr>
<td>Homicide</td>
<td><strong>51</strong></td>
<td><strong>46.36%</strong></td>
</tr>
<tr>
<td>Suicide</td>
<td><strong>50</strong></td>
<td><strong>45.45%</strong></td>
</tr>
<tr>
<td>Undetermined</td>
<td><strong>7</strong></td>
<td><strong>6.36%</strong></td>
</tr>
<tr>
<td><strong>Drowning</strong></td>
<td><strong>24</strong></td>
<td><strong>3.40%</strong></td>
</tr>
<tr>
<td>Accidental</td>
<td><strong>23</strong></td>
<td><strong>95.83%</strong></td>
</tr>
<tr>
<td>Undetermined</td>
<td><strong>1</strong></td>
<td><strong>4.17%</strong></td>
</tr>
<tr>
<td><strong>Fire</strong></td>
<td><strong>18</strong></td>
<td><strong>2.55%</strong></td>
</tr>
<tr>
<td>Accidental</td>
<td><strong>17</strong></td>
<td><strong>94.44%</strong></td>
</tr>
<tr>
<td>Undetermined</td>
<td><strong>1</strong></td>
<td><strong>5.56%</strong></td>
</tr>
<tr>
<td><strong>SUID</strong></td>
<td><strong>27</strong></td>
<td><strong>3.82%</strong></td>
</tr>
<tr>
<td>Undetermined</td>
<td><strong>27</strong></td>
<td><strong>100%</strong></td>
</tr>
<tr>
<td><strong>All other FFT Accidents</strong></td>
<td><strong>86</strong></td>
<td><strong>12.18%</strong></td>
</tr>
</tbody>
</table>

*The above does not represent the total number of Frankfort cases*
### NKY Totals by Specific Fatal Event

<table>
<thead>
<tr>
<th>Fatal Event</th>
<th>Total</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overdoses</strong></td>
<td>135</td>
<td>33.17%</td>
</tr>
<tr>
<td>Accidental</td>
<td>127</td>
<td>94.07%</td>
</tr>
<tr>
<td>Complications of Chronic Use</td>
<td>1</td>
<td>0.74%</td>
</tr>
<tr>
<td>Suicide</td>
<td>5</td>
<td>3.70%</td>
</tr>
<tr>
<td>Undetermined</td>
<td>2</td>
<td>1.48%</td>
</tr>
<tr>
<td><strong>MVC</strong></td>
<td>34</td>
<td>8.35%</td>
</tr>
<tr>
<td>Accidental</td>
<td>34</td>
<td>100%</td>
</tr>
<tr>
<td><strong>GSW</strong></td>
<td>31</td>
<td>7.62%</td>
</tr>
<tr>
<td>Homicide</td>
<td>7</td>
<td>22.58%</td>
</tr>
<tr>
<td>Suicide</td>
<td>24</td>
<td>77.42%</td>
</tr>
<tr>
<td><strong>Drowning</strong></td>
<td>7</td>
<td>1.72%</td>
</tr>
<tr>
<td>Accident</td>
<td>7</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Fire</strong></td>
<td>4</td>
<td>0.98%</td>
</tr>
<tr>
<td>Accident</td>
<td>3</td>
<td>75%</td>
</tr>
<tr>
<td>Undetermined</td>
<td>1</td>
<td>25%</td>
</tr>
<tr>
<td><strong>SUID</strong></td>
<td>3</td>
<td>0.74%</td>
</tr>
<tr>
<td>Undetermined</td>
<td>3</td>
<td>100%</td>
</tr>
<tr>
<td><strong>All other NKY Accidents</strong></td>
<td>24</td>
<td>27.91%</td>
</tr>
</tbody>
</table>

*The above does not represent the total number of Northern Kentucky cases*
### WKY Totals by Specific Fatal Event

<table>
<thead>
<tr>
<th>Fatal Event</th>
<th>Total</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overdoses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accidental</td>
<td>18</td>
<td>81.82%</td>
</tr>
<tr>
<td>Complications of Chronic Use</td>
<td>1</td>
<td>4.55%</td>
</tr>
<tr>
<td>Suicide</td>
<td>3</td>
<td>13.64%</td>
</tr>
<tr>
<td><strong>MVC</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accidental</td>
<td>5</td>
<td>100%</td>
</tr>
<tr>
<td><strong>GSW</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Homicide</td>
<td>2</td>
<td>22.22%</td>
</tr>
<tr>
<td>Suicide</td>
<td>7</td>
<td>77.78%</td>
</tr>
<tr>
<td><strong>Drowning</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accident</td>
<td>2</td>
<td>66.67%</td>
</tr>
<tr>
<td>Undetermined</td>
<td>1</td>
<td>33.33%</td>
</tr>
<tr>
<td><strong>Fire</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accident</td>
<td>1</td>
<td>100%</td>
</tr>
<tr>
<td><strong>SUID</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Undetermined</td>
<td>2</td>
<td>100%</td>
</tr>
<tr>
<td><strong>All other WKY Accidents</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>3.70%</td>
</tr>
</tbody>
</table>

*The above does not represent the total number of Western Kentucky cases*
Total Statewide Cases Sent for Autopsy

by

Locality of Death, 2011

Figure 3

<table>
<thead>
<tr>
<th>Color</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
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<tr>
<td>ORANGE</td>
<td>21-50</td>
</tr>
<tr>
<td>GREY</td>
<td>51-100</td>
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<tr>
<td>BLUE</td>
<td>101-160</td>
</tr>
<tr>
<td>GREEN</td>
<td>161-550</td>
</tr>
</tbody>
</table>

*539 is highest
Total Statewide Overdoses Sent for Autopsy
by
Locality of Death, 2011

Figure 4

<table>
<thead>
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<th>Range</th>
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</thead>
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<tr>
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<td>11-20</td>
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<tr>
<td>ORANGE</td>
<td>21-30</td>
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<tr>
<td>BLUE</td>
<td>31-40</td>
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<tr>
<td>PURPLE</td>
<td>41-50</td>
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<tr>
<td>YELLOW</td>
<td>51-100</td>
</tr>
<tr>
<td>GREEN</td>
<td>101-180</td>
</tr>
</tbody>
</table>

*173 is Highest*
Total Statewide Cases by Year of Autopsy 2000-2011

Figure 5
Total Statewide Cases by Month of Autopsy, 2011

Figure 6
2011 Statewide Cases by Age and Gender

Figure 7

- Female
- Male
2011 Statewide Cases by Manner of Death

Figure 8

- **Accident**: 1,033 (44%)
- **Homicide**: 197 (8%)
- **Natural**: 605 (25%)
- **Suicide**: 310 (13%)
- **Undetermined**: 205 (9%)
- **Pending Further Information**: 28 (1%)

![Pie chart showing the distribution of manner of death cases in 2011.](image-url)
2011 Statewide Accidents by Cause of Death

Figure 9

*Overdoses with manner of death other than “accident” are not included in above totals*
**2011 Statewide Homicides by Cause of Death**

*Children = ages 18 and younger*
2011 Statewide Child (Ages 18 and Under)

Homicides by Cause of Death

Figure 11

- Asphyxia: 2
- Blunt Force Trauma: 4
- Drowning: 1
- GSW: 22
2011 Statewide Child (Ages 12 and Under) Homicides by Cause of Death

Figure 12

- Asphyxia: 1
- Blunt Force Trauma: 4
- Drowning: 1
- GSW: 4
2011 Statewide Suicides by Cause of Death

Figure 13

Asphyxia (other than hanging)  |  Blunt Force
CO                               |  Drowning
Drugs                            |  GSW
Hanging                          |  Sharp Force Injuries
Exposure                         |  Thermal Injuries/Smoke Inhalation

- Exposure, 1
- Thermal Injuries/Smoke Inhalation, 1
- Asphyxia (other than hanging), 8
- Blunt Force, 6
- CO, 3
- Drowning, 4
- Drugs, 32
- GSW, 205
- Hanging, 48
- Sharp Force Injuries, 5
2011 Statewide Drugs Most Frequently Detected in the Blood of Overdose Victims

*Alprazolam, 286, 41.81%
*Oxycodone, 213, 31.14%
*Morphine, 99, 14.47%
Hydromorphone, 26, 3.80%
Methadone, 112, 16.37%
Hydrocodone, 187, 27.34%
Fentanyl, 48, 7.02%
Heroin, 22, 3.22%
Alcohol, 134, 19.59%
Clonazepam, 53, 7.75%
Cocaine, 31, 4.53%
Codeine, 20, 2.92%
Diazepam, 108, 15.79%

*Morphine represents true drug and/or metabolite of Heroin
*Total Percentages >100% due to more than 1 drug being present in many decedents
*Total statewide overdose cases = 684
### 2011 Louisville Cases by Manner of Death

**Figure 15**

- **Accident**: 302, 26%
- **Natural**: 107, 9%
- **Homicide**: 185, 16%
- **Suicide**: 457, 38%
- **Undetermined**: 26, 2%
- **Pending Further Information**: 102, 9%

### 2011 Frankfort Cases by Manner of Death

**Figure 16**

- **Accident**: 354, 51%
- **Natural**: 133, 19%
- **Homicide**: 72, 10%
- **Suicides**: 73, 10%
- **Undetermined**: 74, 10%
2011 Northern Kentucky Cases by Manner of Death
Figure 17

- Accident, 195, 48%
- Homicide, 14, 3%
- Natural, 136, 33%
- Suicide, 40, 10%
- Undetermined, 22, 5%

2011 Western Kentucky Cases by Manner of Death
Figure 18

- Accident, 27, 31%
- Homicide, 4, 5%
- Natural, 34, 40%
- Suicide, 12, 14%
- Undetermined, 7, 8%
- Pending, 2, 2%
2011 Specific Common Causes of Death: Louisville Cases by Type

Figure 19

- Overdose (28.50%), 336
- GSW (17.22%), 110
- Drowning (3.22%), 38
- Fire (1.44%), 17
- SUID (1.95%), 23
- MVC (9.92%), 117

2011 Specific Common Causes of Death: Frankfort Cases by Type

Figure 20

- Overdose (27.05%), 191
- GSW (15.58%), 110
- Drowning (3.40%), 24
- Fire (2.55%), 18
- SUID (3.82%), 27
- MVC (8.5%), 60
2011 Specific Common Causes of Death:
Western Kentucky Cases by Type
Figure 21

- MVC (5.81%)
- GSW (10.47%)
- Overdose (25.58%)
- Fire (1.16%)
- SUID (2.33%)
- Drowning (3.49%)

2011 Specific Common Causes of Death:
Northern Kentucky Cases by Type
Figure 22

- MVC (8.35%)
- GSW (7.62%)
- Drowning (1.72%)
- Fire (0.98%)
- SUID (0.74%)
- Overdose (33.17%)


**Louisville MVC by Manner of Death**

Figure 23

- Accident, 116
- Pending, 1

**Louisville GSW by Manner of Death**

Figure 24

- Suicide, 120
- Homicide, 77
- Undetermined, 3
- Pending Further Information, 3
Louisville Drowning by Manner of Death

Figure 25

- **Accident**: 31
- **Homicide**: 1
- **Suicide**: 4
- **Undetermined**: 1
- **Pending Further Information**: 1

Louisville Fire by Manner of Death

Figure 26

- **Accident**: 14
- **Pending Further Information**: 2
- **Suicide**: 1
Louisville Overdose by Manner of Death

Figure 27

- **Accident**: 244
- **Homicide**: 1
- **Suicide**: 15
- **Complications of Chronic Use**: 35
- **Undetermined**: 28
- **Pending Further Information**: 13
Louisville Most Frequently Detected Drugs in the Blood of Overdose Victims

Figure 28
Total Overdoses = 336

*Morphine represents true drug and/or metabolite of Heroin

*Total Percentages >100% due to more than 1 drug being present in many decedents
Frankfort MVC by Manner of Death
Figure 29

- Accident: 57
- Undetermined: 3

Frankfort GSW by Manner of Death
Figure 30

- Accident: 2
- Homicide: 51
- Suicide: 50
- Undetermined: 11
Frankfort Drowning by Manner of Death

Figure 31

Frankfort Fire by Manner of Death

Figure 32
Frankfort Overdose by Manner of Death

Figure 33

- **Accident**: 169
- **Complications of Chronic Use**: 7
- **Suicide**: 8
- **Undetermined**: 7

The diagram shows the distribution of overdoses by manner of death in Frankfort.
Frankfort Most Frequently Detected Drugs in the Blood of Overdose Victims

Figure 34
Total Overdoses = 191

- Alcohol: 55.50%
- Alprazolam: 13.09%
- Clonazepam: 54.97%
- Cocaine: 4.19%
- Diazepam: 7.85%
- Hydrocodone: 25.13%
- Fentanyl: 12.04%
- Methadone: 4.19%
- Oxycodone: 19.37%
- Oxymorphone: 13.09%
- *Morphine: 9.42%

*Morphine represents true drug and/or metabolite of Heroin
*Total Percentages >100% due to more than 1 drug being present in many decedents
Northern Kentucky MVC by Manner of Death

Figure 35

- Accident, 34

Northern Kentucky GSW by Manner of Death

Figure 36

- Homicide, 7
- Suicide, 24
Northern Kentucky Drowning by Manner of Death
Figure 37

Northern Kentucky Fire by Manner of Death
Figure 38
Northern Kentucky Overdose by Manner of Death

Figure 39

- Accident, 127
- Complications of Chronic Use, 1
- Suicide, 5
- Undetermined, 2
Northern Kentucky Most Frequently Detected Drugs in the Blood of Overdose Victims

Figure 40
Total = 135

Alprazolam, 41 (30.37%)
Morphine, 51 (37.78%)
Oxycodone, 50 (37.04%)
Diazepam, 34 (25.19%)
Hydrocodone, 13 (9.63%)
Methadone, 22 (16.30%)
Alcohol, 18 (13.33%)

* Morphine represents true drug and/or metabolite of Heroin
* Total Percentages >100% due to more than 1 drug being present in many decedents
Western Kentucky MVC by Manner of Death
Figure 41

Western Kentucky GSW by Manner of Death
Figure 42
Western Kentucky Drowning by Manner of Death
Figure 43

Western Kentucky Fire by Manner of Death
Figure 44
Western Kentucky Overdose by Manner of Death

Figure 45

- **Accident**: 18
- **Complications of Chronic Use**: 1
- **Suicide**: 3
Western Kentucky Most Frequently Detected
Drugs in the Blood of Overdose Victims

Figure 46
Total = 22

- Acetaminophen, 7 (31.82%)
- Oxycodone, 5 (22.73%)
- Hydrocodone, 8 (36.36%)
- Ethanol, 7 (31.82%)
- Methamphetamine, 1 (4.55%)
- Methadone, 2 (9.09%)
- Metoprolol, 2 (9.09%)
- Citalopram, 5 (22.73%)
- Diazepam, 6 (27.27%)
- Alprazolam, 5 (22.73%)

*Morphine represents true drug and/or metabolite of Heroin
*Total Percentages >100% due to more than 1 drug being present in many decedents
*Note: No cases performed at this office after May 2012
Glossary

**Accident** – The *manner of death* used when, in other than *natural deaths*, there is no evidence of intent. The death occurs as a result of an unforeseen event.

**Autopsy** – A detailed postmortem external and internal examination of a body to determine cause of death.

**Homicide** – The *manner of death* in which death results from the intentional harm of one person by another. The medical examiner does not determine whether or not a criminal act has occurred.

**Manner of Death** – The general category of the condition, circumstances or event, which causes the death. The categories are *natural, accident, homicide, suicide and undetermined*.

**Natural** – The *manner of death* used when solely a disease causes death. If death is hastened by an injury, the *manner of death* is not considered natural.

**Office of the Medical Examiner** - the Office of the Medical Examiner investigates deaths occurring in the state of Kentucky, as authorized by Kentucky’s elected coroners. The staff assists Kentucky coroners and law enforcement agencies in all aspects of death investigations by determining the cause and manner of death, identification of the deceased, and collection and interpretation of trace evidence.

**Suicide** – The *manner of death* in which death results from intentional act by one’s self.

**Unclassified** – Are cases in which Medical Examiner involvement was for purposes other than for determining the *cause and manner* of death—e.g. tissue where no products of conception were identified; exhumation for DNA sampling only.

**Undetermined** – The *manner of death* for deaths in which there is insufficient information to assign another manner.
MEDICAL EXAMINER DISTRICTS

The Office of the Chief Medical Examiner in Louisville covers the following CENTRAL counties in Kentucky and Southern IN:
   Adair, Allen, Barren, Breckinridge, Bullitt, Butler,
   Carroll, Casey, Clinton, Cumberland, Edmonson,
   Grayson, Green, Hancock, Hardin, Hart, Henry,
   Jefferson, Larue, Marion, Meade, Metcalfe, Monroe,
   Nelson, Oldham, Russell, Shelby, Simpson, Spencer,
   Taylor, Trimbell, and Warren.
Southern Indiana counties: Clark, Crawford, Dearborn,
Dubois, Floyd, Harrison, Jackson, Jefferson, Ohio,
Orange, Perry, Scott, Spencer, Switzerland, Warrick, and Washington.
*Additionally, the OCME provides weekend, holiday, and vacation coverage for the Western counties delineated below.

The Madisonville office covers the following WESTERN counties:
   Ballard, Caldwell, Calloway, Carlisle, Christian,
   Crittenden, Daviess, Fulton, Graves, Henderson,
   Hickman, Hopkins, Livingston, Logan, Lyon,
   Marshall, McCracken, McLean, Muhlenberg,
   Ohio, Todd, Trigg, Union, and Webster.

The Frankfort office covers the following EASTERN counties:
   Anderson, Bath, Bell, Bourbon, Boyle, Boyd, Breathitt,
   Carter, Clark, Clay, Elliott, Estill, Fayette, Floyd, Franklin,
   Garrard, Harlan, Harrison, Jackson, Jessamine, Johnson,
   Knott, Knox, Laurel, Lawrence, Lee, Leslie, Letcher,
   Lincoln, Madison, Magoffin, Martin, McCreary, Menifee,
   Mercer, Montgomery, Morgan, Nicholas, Owsley, Perry,
   Pike, Powell, Pulaski, Rockcastle, Rowan, Scott,

The Northern Kentucky office covers the following NORTHERN counties:
   Boone, Bracken, Campbell, Fleming, Gallatin, Grant,
   Greenup, Kenton, Lewis, Mason, Owen, Pendleton, and Robertson.
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Fax: (502)564-1699

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Fax: (270) 824-7092