



# Office of the Medical Examiner 2016 Calendar Year Annual Report

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State of Kentucky  
2016 Physician/Doctorate Staff**

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*Chief Medical Examiner*

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**Northern Kentucky Medical Examiner's Office (NKY) Ft. Thomas, KY**

**Michael Belenky, MD (Through April 26<sup>th</sup>, 2016)**  
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# Overview

## 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 determination of 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 2,835 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—2016

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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 Eastern Kentucky Regional 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;
- (13) 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



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## *Kentucky's Combined Coroner-Medical Examiner System*

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1. The coroner determines whether the case becomes a medical examiner case.
2. "Post-mortem examination" as discussed in KRS 72, is not defined as an autopsy. Not all circumstances defined by KRS 72.025 will be referred to the State Medical Examiners System, rather they will be investigated solely by the Coroner.
3. 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.
4. 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.
5. In any case undergoing examination by a Kentucky ME, the ME performing the examination renders an official opinion regarding both cause and manner of death.

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### *Statutory Duty*

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#### *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

**History:** Amended 1998 Ky. Acts ch. 65, sec. 4, effective July 15, 1998. -- Created 1968 Ky. Acts ch. 114, sec. 1.

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### *Summary Highlights*

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Kentucky has 4 regional medical examiner offices throughout the Commonwealth:

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

These four regional medical examiner offices (OCME, EKME, WKME and NKME) together performed 2,835 postmortem examinations in 2016.

The Western Kentucky Regional Medical Examiners Office was not fully staffed until July 18<sup>th</sup>, 2016. Prior to that date, the office accepted cases only a few days a month in which forensic pathologists travelling from the OCME performed the examinations. All other days, cases were sent to the Office of the Chief Medical Examiner in Louisville for examination.

The Northern Kentucky Regional Medical Examiners Office was fully staffed from January 1st through April 26<sup>th</sup>, 2016. For the remainder of 2016, the office accepted cases only a few days a month in which the Chief Medical Examiner performed the examinations. All other days, cases were sent to the Eastern Kentucky Regional Medical Examiner in Frankfort or the Office of the Chief Medical Examiner in Louisville for examination.

## **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. Furthermore, the EKY plays an active role in the University of Kentucky, Department of Pathology.

### *Forensic Pathologist Fellowship Program*

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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 supervised 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. An attending pathologist always co-signs the final autopsy report with the trainee.

### *Accreditations*

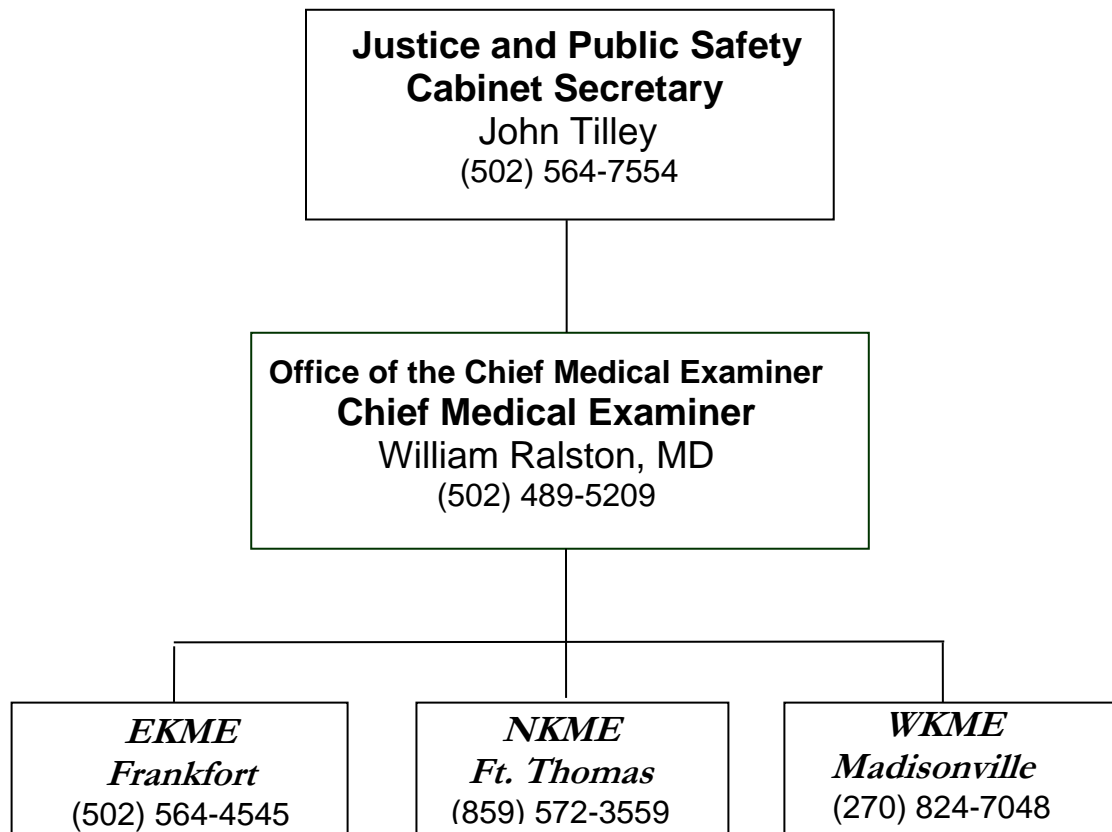
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The Kentucky State Office of the Chief Medical Examiner in Louisville, KY is fully accredited by the National Association of Medical Examiners (NAME) through December 2017.

The University of Louisville Division of Forensic Pathology Fellowship Program at the Office of the Chief Medical Examiner in Louisville, KY is fully accredited by The Accreditation Council for Graduate Medical Education (ACGME) through April 2018.

## Office of the Medical Examiner 2016 Organizational Chart

Figure 1



# Statewide Medical Examiner Data



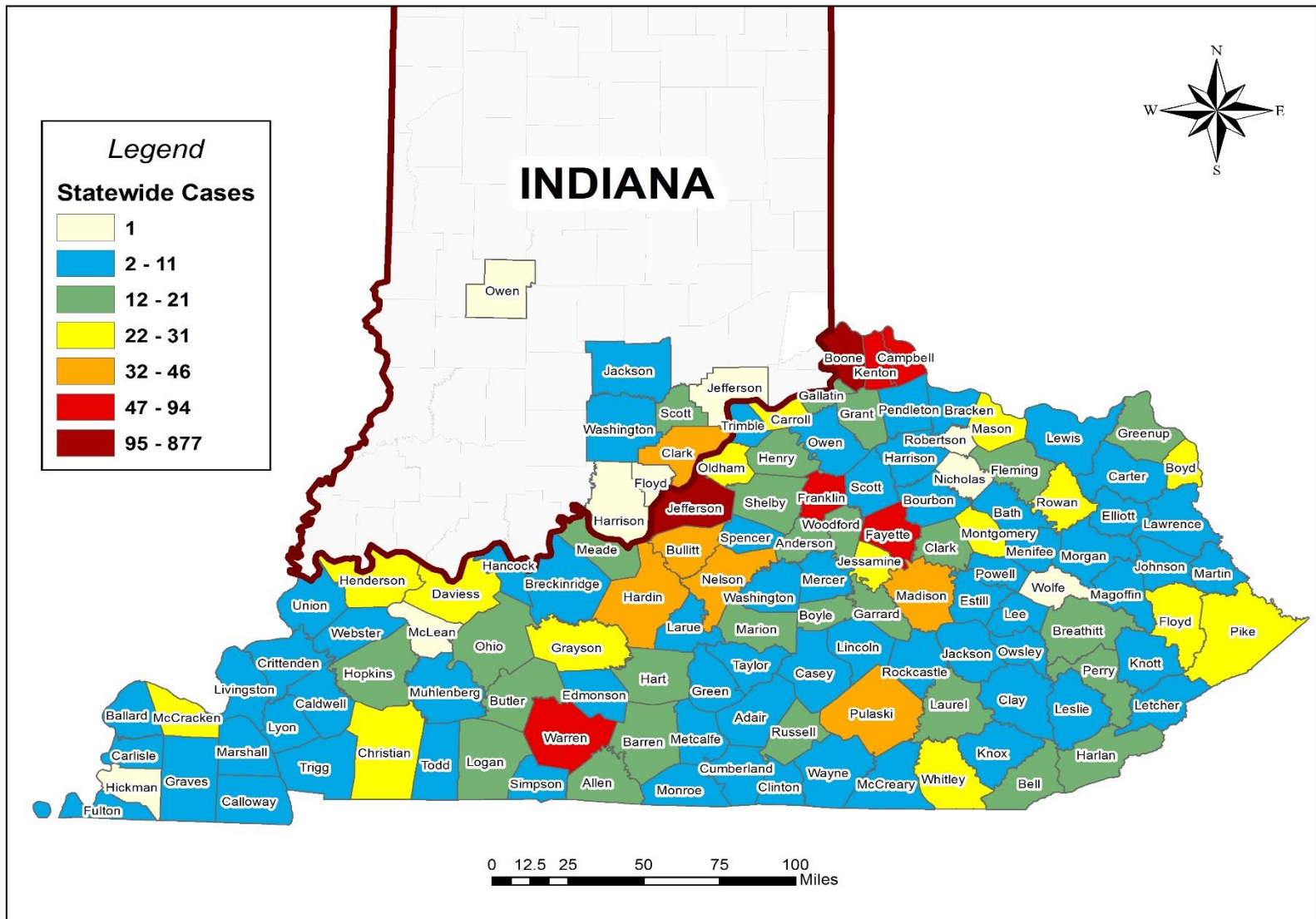
### *Total Cases*

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.

The totals listed in this report do not represent all deaths occurring in Kentucky, but rather the total cases undergoing autopsy by the Kentucky Medical Examiner Offices.

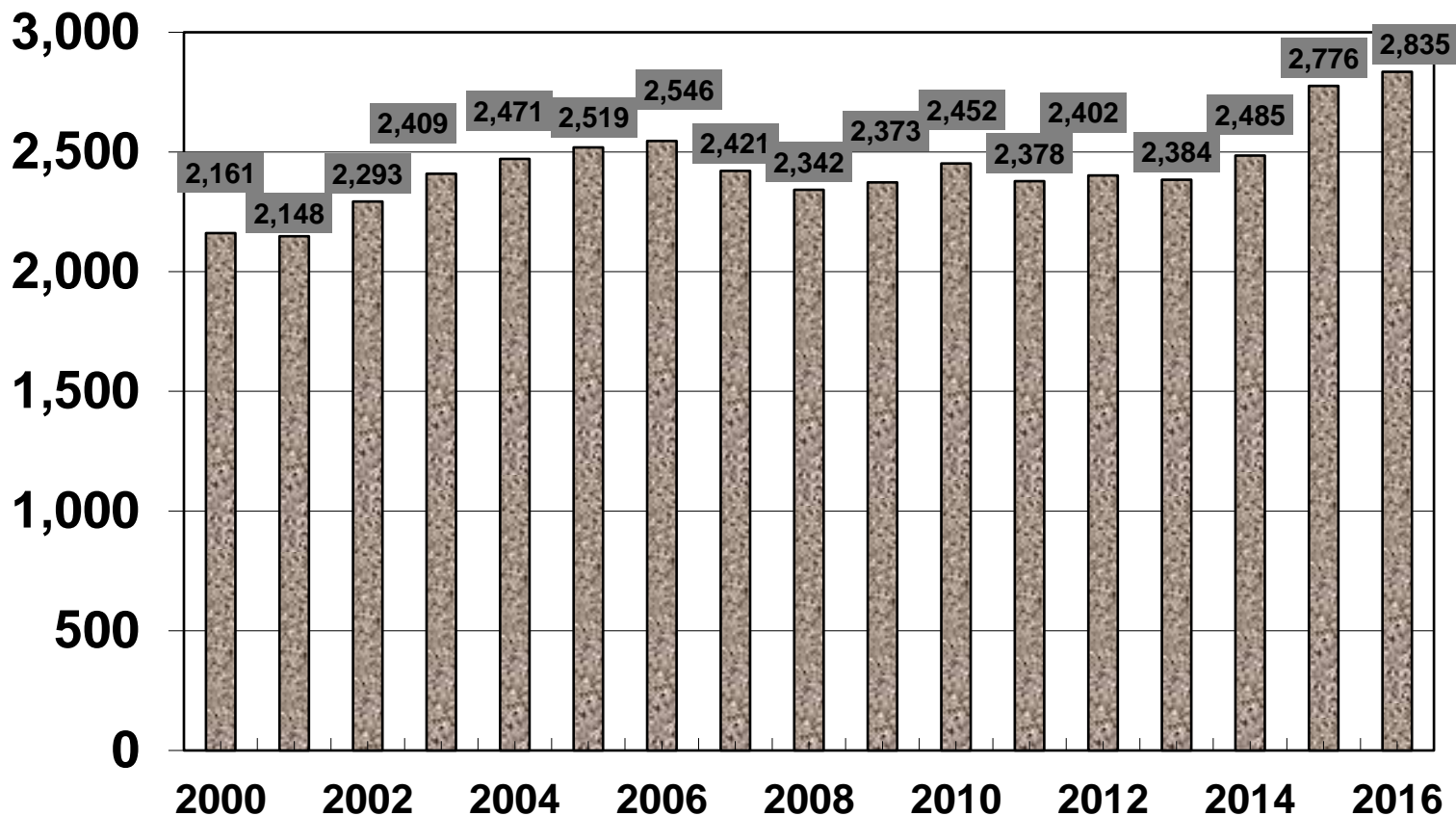
<b>ME CASES 2016</b>	
Table 1	
<b>Total</b>	<b>2,835</b>
<b>OCME Louisville</b>	<b>1,608</b>
<b>EKME Frankfort</b>	<b>975</b>
<b>WKME Madisonville</b>	<b>102</b>
<b>NKME Ft. Thomas</b>	<b>150</b>

*Statewide Cases Sent for Autopsy  
by  
Locality of Death, 2016*  
**Figure 2**



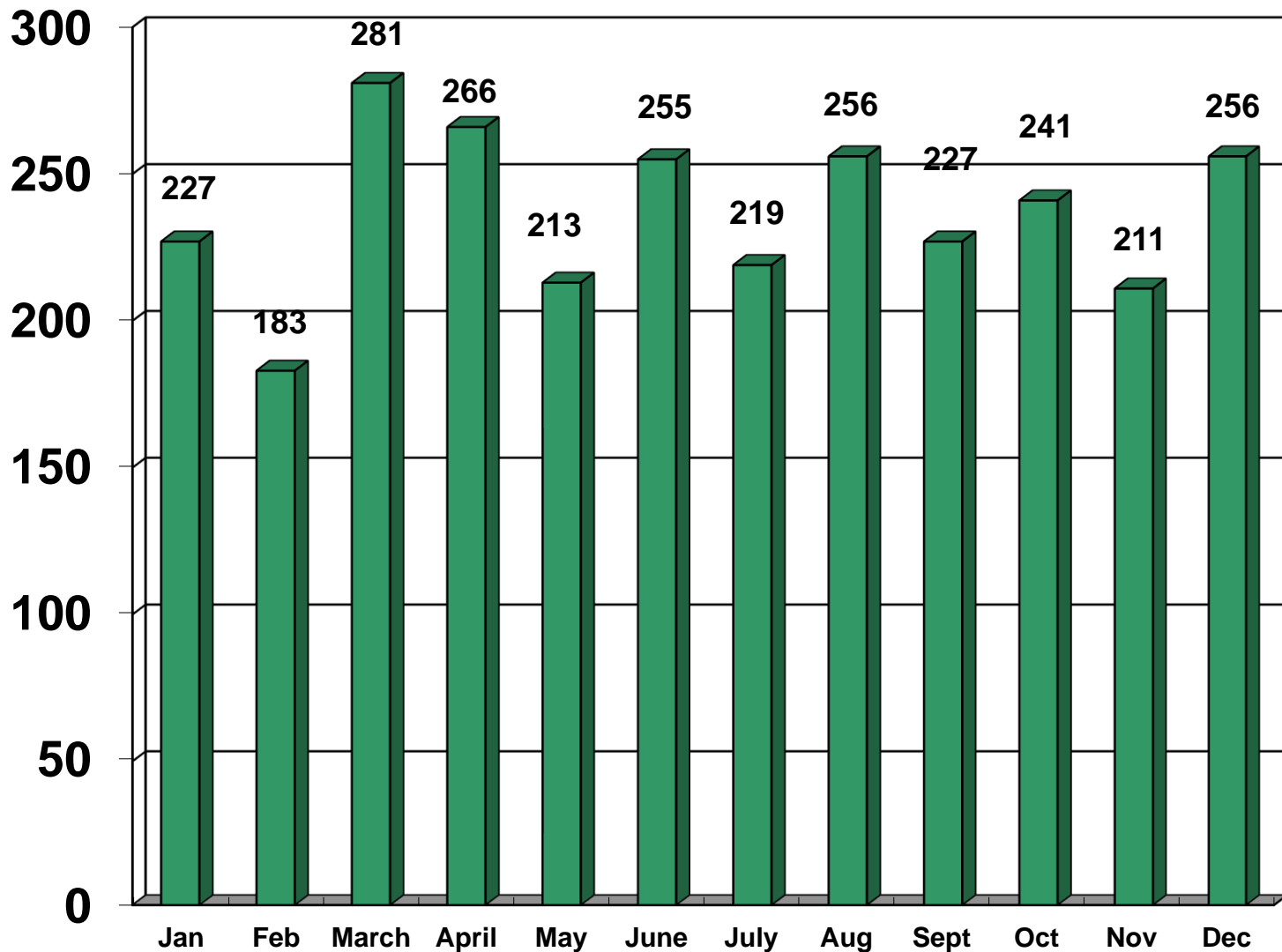
## Statewide Cases by Year of Autopsy, 2000-2016

### Figure 3



## Statewide Cases by Month of Autopsy, 2016

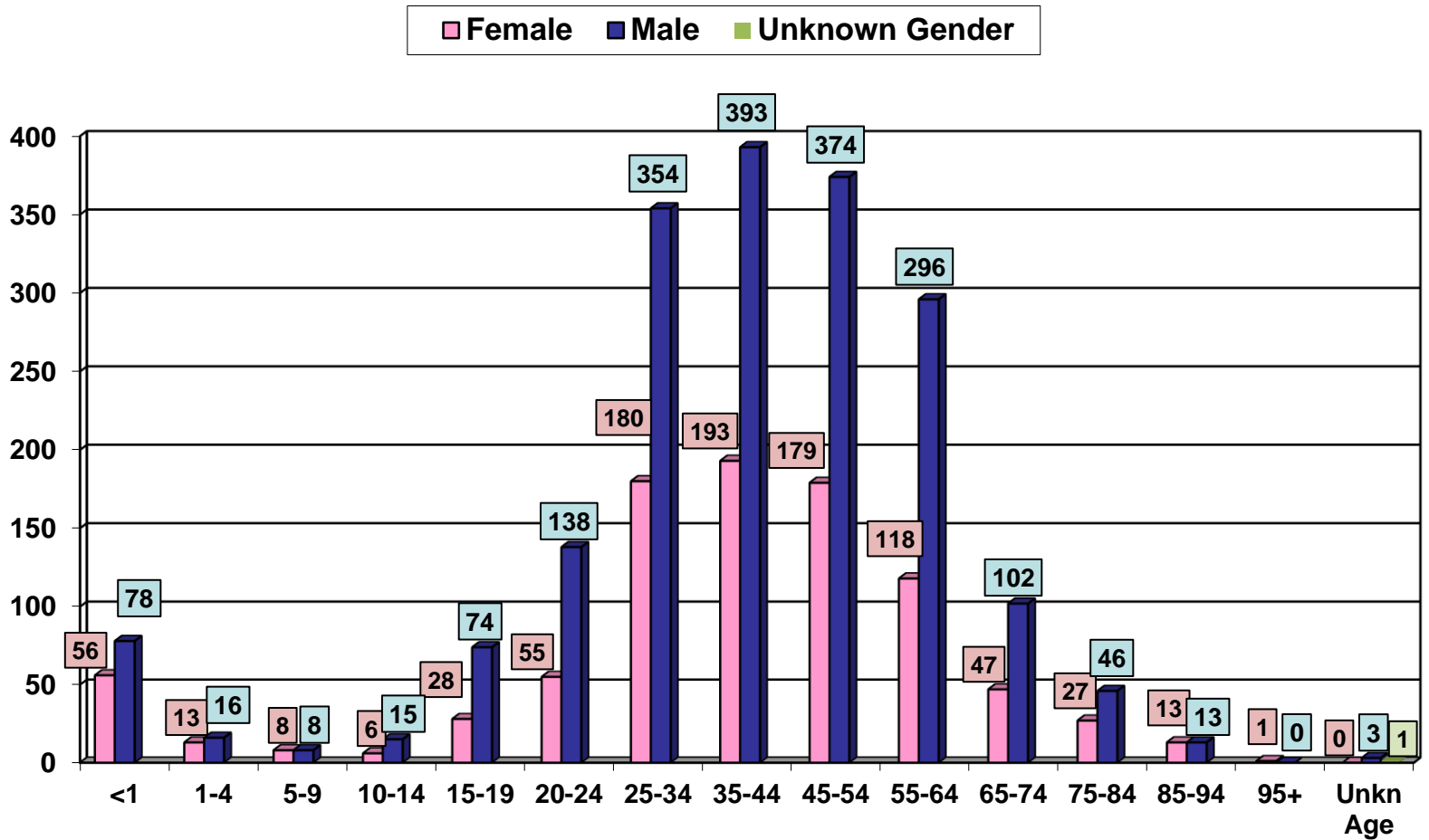
### Figure 4





## 2016 Statewide Cases by Age and Gender

### Figure 5

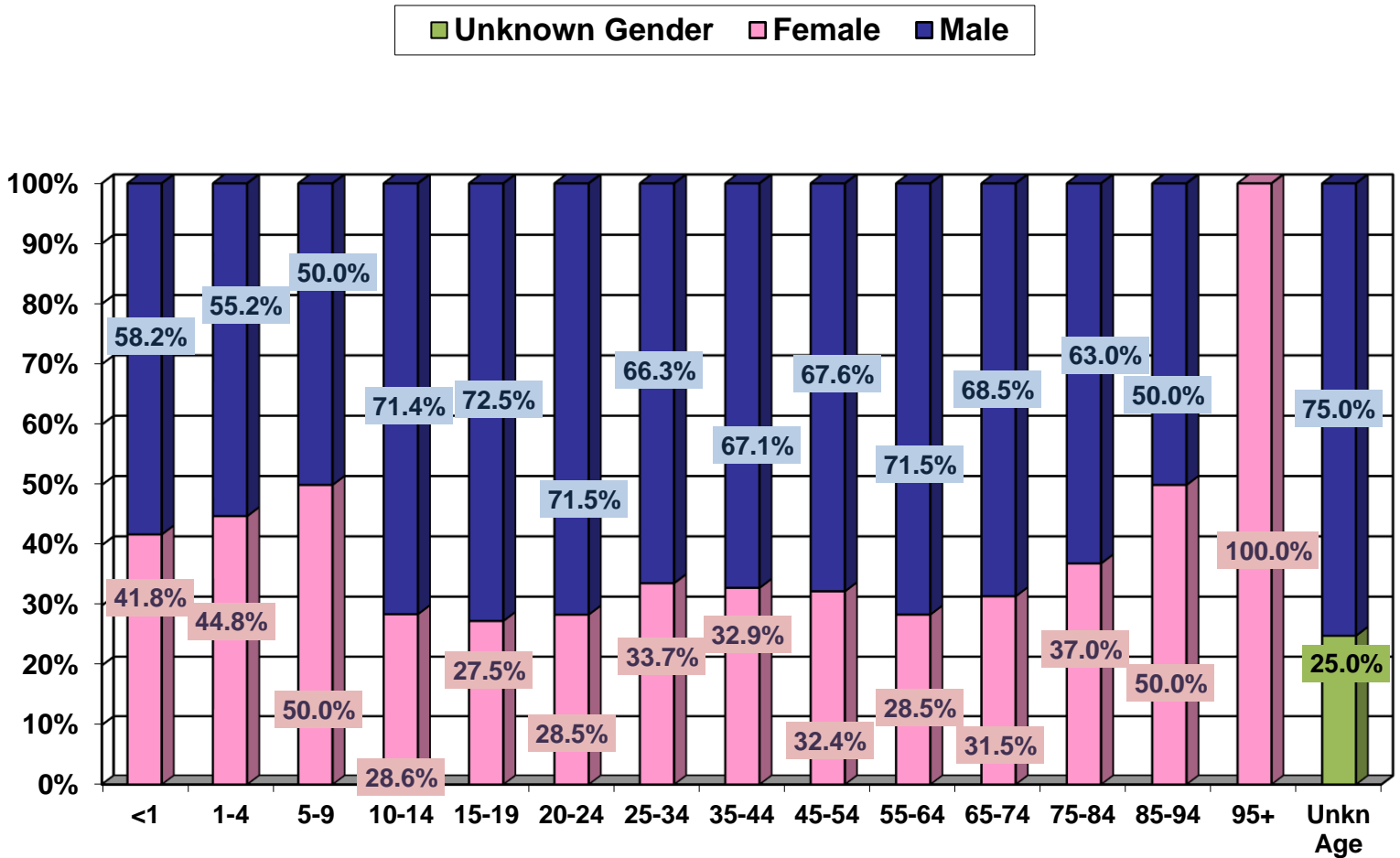


\*\*1 unknown gender/unknown age consisted of unidentified skeletonized adult remains

\*\*3 known gender/unknown age consisted of unidentified skeletonized adult remains

## 2016 Statewide Percentages by Age and Gender

### Figure 6



\*\*1 unknown gender/unknown age consisted of unidentified skeletonized adult remains

\*\*3 known gender/unknown age consisted of unidentified skeletonized adult remains

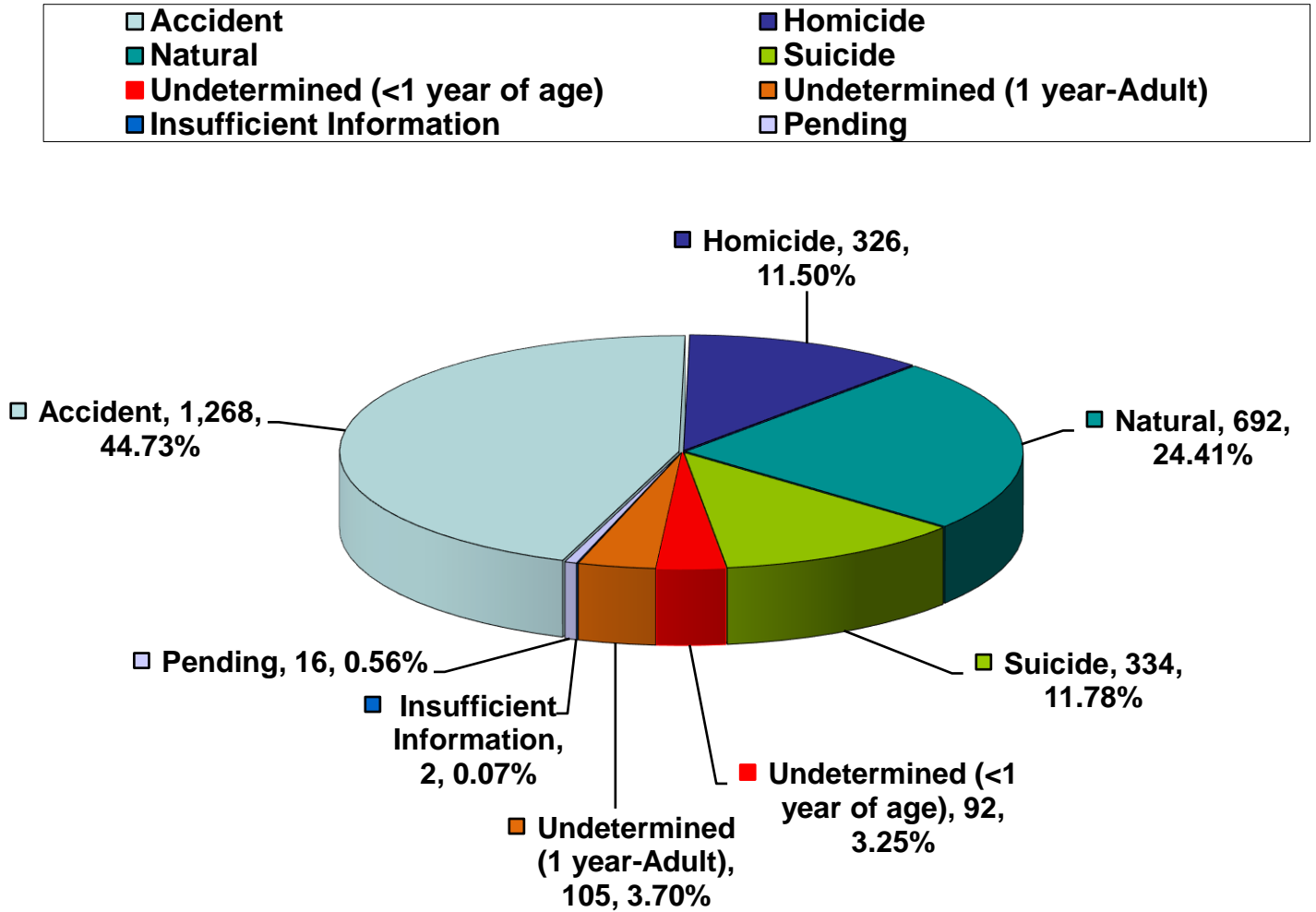
STATEWIDE MEDICAL EXAMINER CASES BY MANNER Table 2		
Manner	Total	Percentage
Accidents	1,268	44.76%
Homicides	326	11.51%
Naturals	692	24.43%
Suicides	334	11.79%
Undetermined (<1 year of age)	92	3.25%
Undetermined (1 year – Adult)	105	3.70%
Pending	16	0.56%
Insufficient Information Provided	2	0.07%
Skeletal Remains of No Forensic Significance	2	0.07%
<b>TOTAL</b>	<b>2,835</b>	

\*Skeletal Remains of No Forensic Significance are not included in the total forensic case load

## 2016 Statewide Cases by Manner of Death

Figure 7

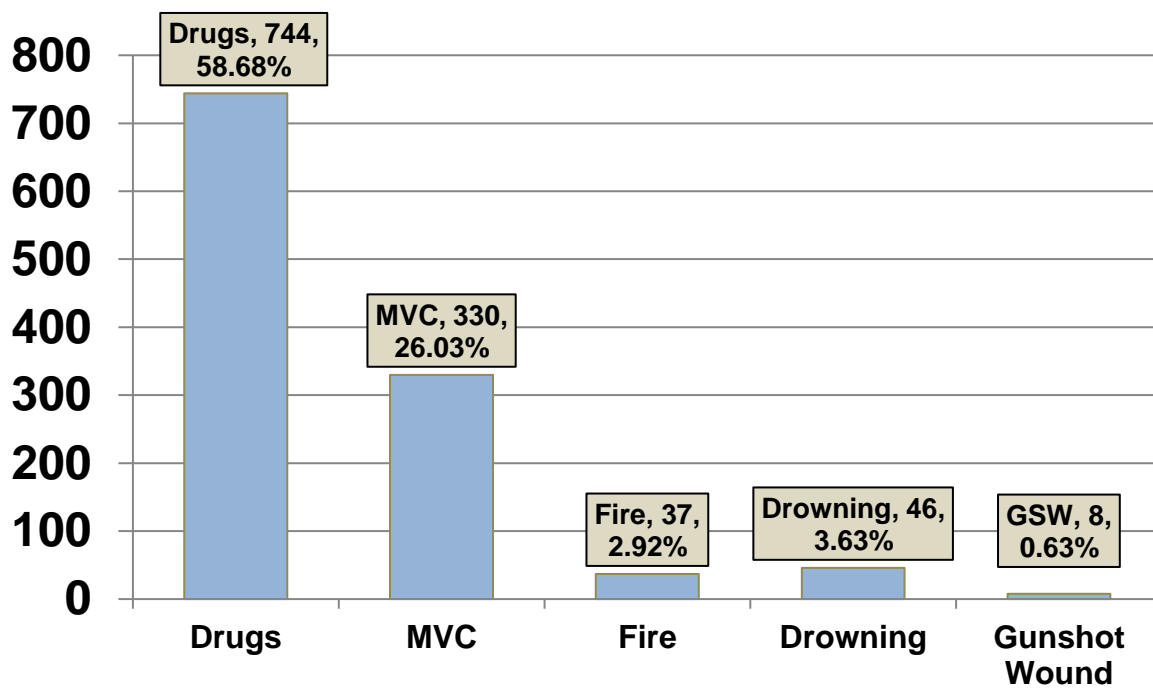
TOTAL=2,835





## 2016 Statewide Accidents by Major Causes of Death

### Figure 8

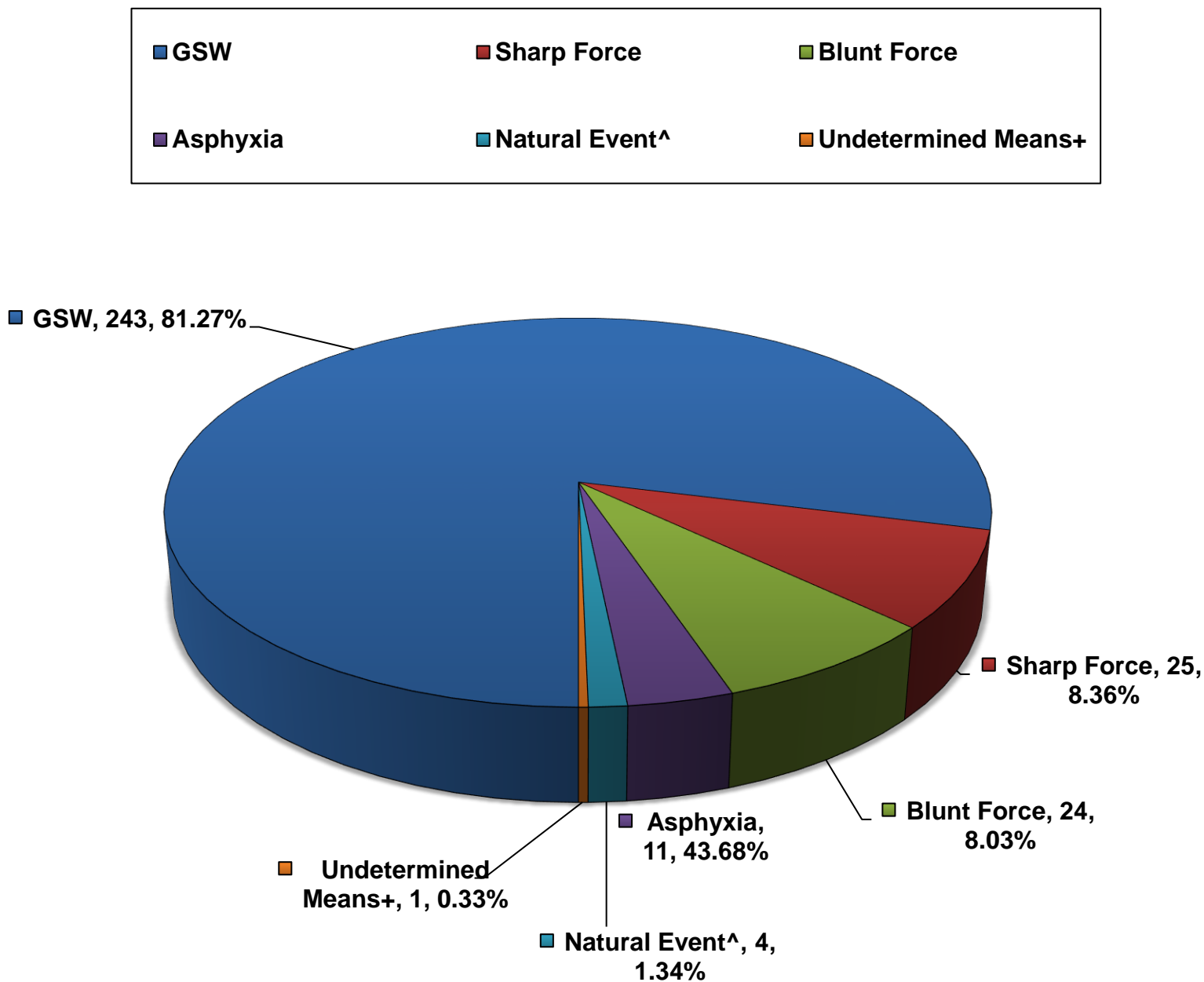


\*Only Major Categories of accidents are illustrated

\*\*Any manner of death other than "accident" are not included in above totals\*

## 2016 Statewide Homicides by Cause of Death, Adults (Age 18+)

Figure 9  
Total=299



\*\*Percentages may be > than 100%, as some decedents may have more than one (1) type of injury

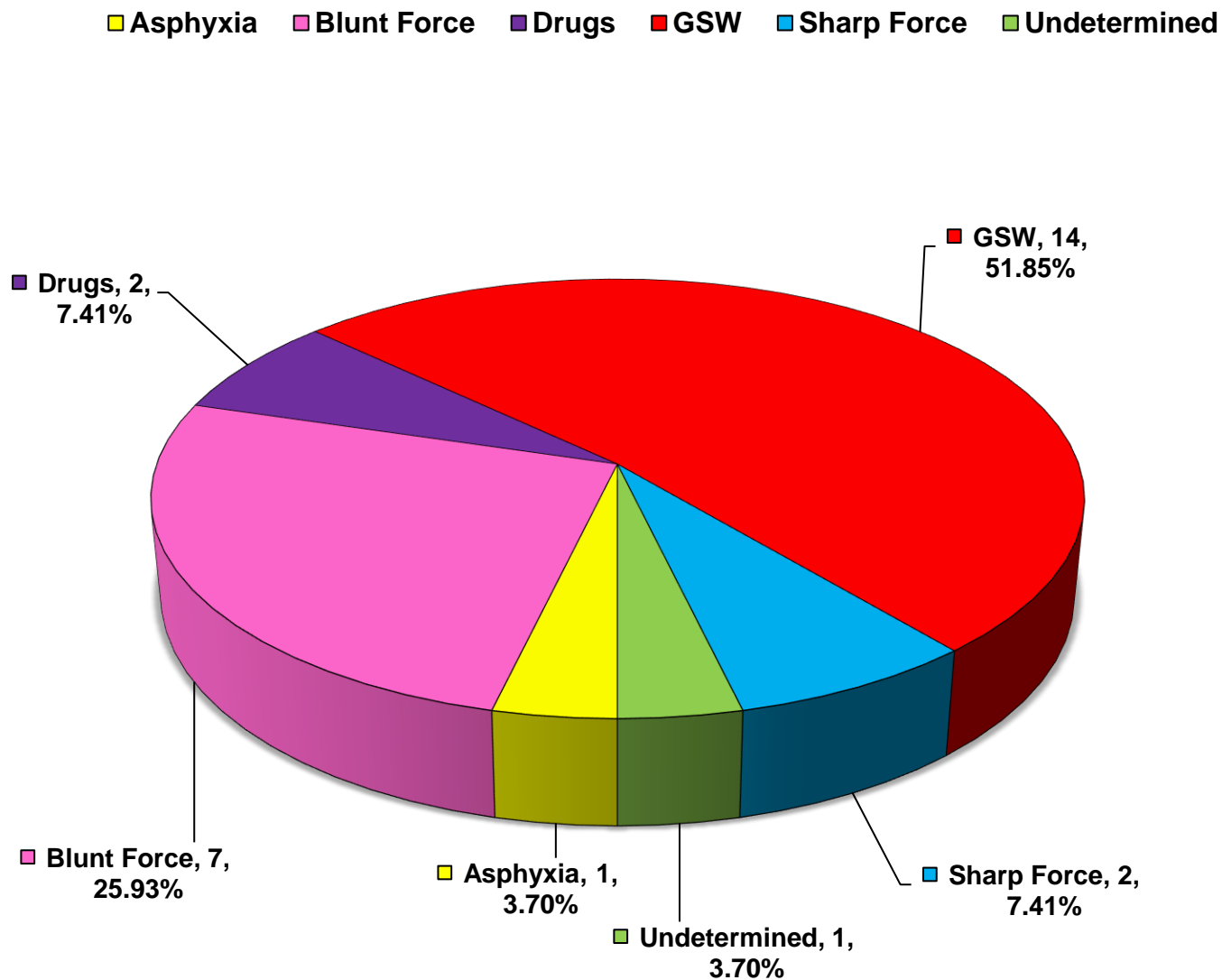
^Natural event occurring after physical altercation

+Undetermined Means in a skeletonized decedent

## 2016 Statewide Homicides by Cause of Death, Children (Birth-17)

Figure 10

Total=27

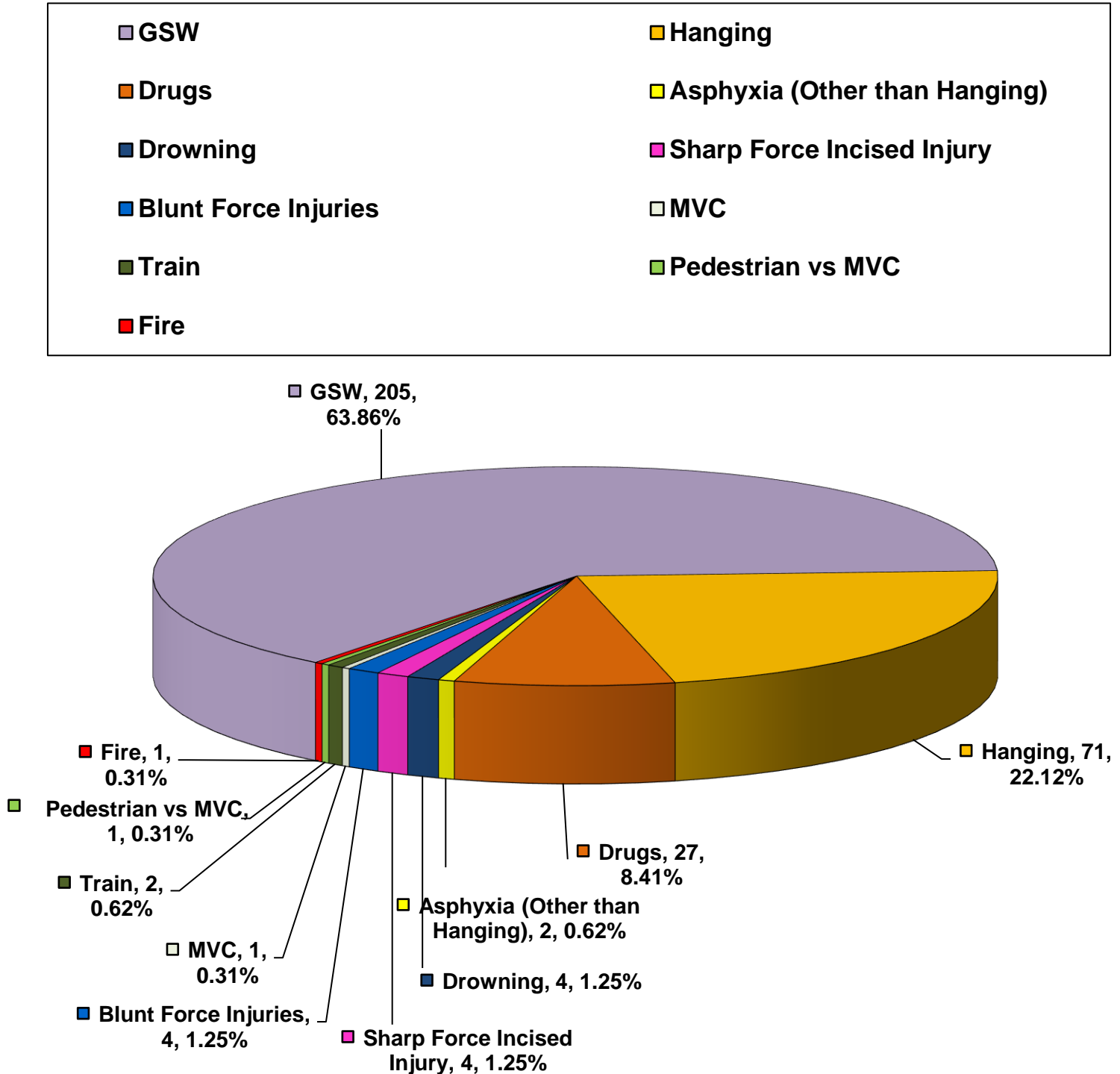


\*\*Percentages may be > than 100%,  
as some decedents may have more than one (1)  
type of injury.

## 2016 Statewide Adult Suicides by Cause of Death

**Figure 11**

Total=321



\*\*Percentages may be > than 100%,  
as some decedents may have more than one (1)  
type of injury.



**2016 STATEWIDE MEDICAL EXAMINER  
TOTALS BY SPECIFIC CASE TYPES**

Table 3

Type	Total	Percentage of Statewide Total
Drug Related	919	32.42%
MVCs	337	11.89%
GSWs	489	17.25%
Fire-Related	80	2.82%
Drowning	54	1.90%
Infants <1yr ALL Causes	136	4.80%
SUID	56	1.96%
Children >1yr ≤ 12yrs, ALL Causes	54	1.90%

<b>2016 STATEWIDE MEDICAL EXAMINER DRUG RELATED DEATHS</b>		
<b>Table 4</b>		
<b>Manner</b>	<b>Total</b>	<b>Percentage</b>
Accidents	744	80.96%
Homicides	2	0.22%
Suicides	27	2.94%
Undetermined	41	4.46%
Insufficient Information	1	0.11%
Pending	1	0.11%
Complications of Chronic Use	103	11.21%
<b>TOTAL</b>	<b>919</b>	

<b>2016 STATEWIDE MEDICAL EXAMINER DRUG RELATED DEATHS CONTAINING HEROIN</b>		
<b>Table 5</b>		
<b>Manner</b>	<b>Total</b>	<b>Percentage</b>
Accidents	216	93.51%
Suicides	2	0.87%
Undetermined	12	5.19%
Complications of Chronic Use	1	0.43%
<b>TOTAL</b>	<b>231</b>	<b>25.14%</b>

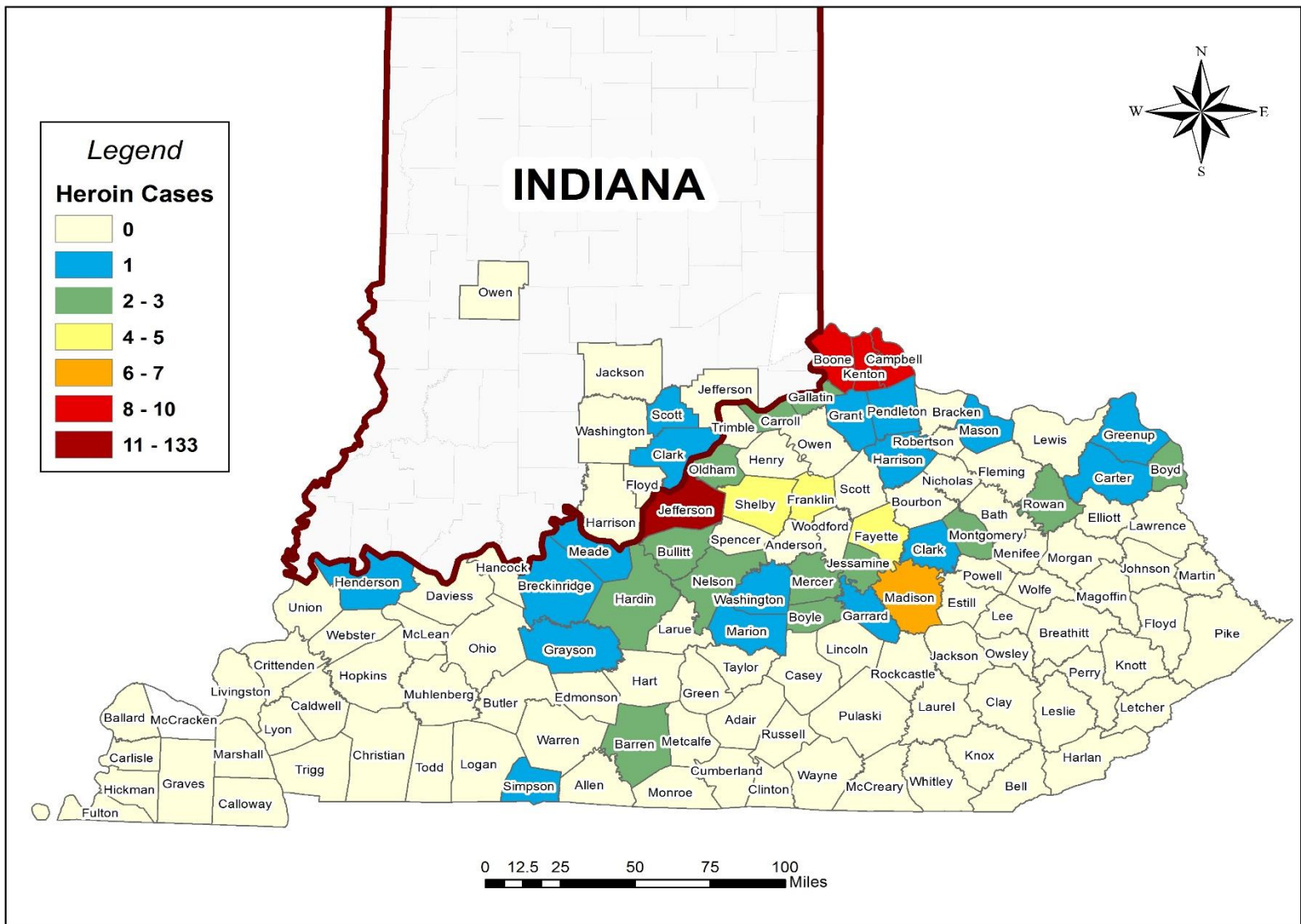
<b>2016 STATEWIDE MEDICAL EXAMINER DRUG RELATED DEATHS CONTAINING FENTANYL</b>		
<b>Table 6</b>		
<b>Manner</b>	<b>Total</b>	<b>Percentage</b>
Accidents	326	93.14%
Suicides	4	1.14%
Undetermined	12	3.43%
Insufficient Information	1	0.29%
Complications of Chronic Use	7	2.00%
<b>TOTAL</b>	<b>350</b>	<b>38.08%</b>

## Figure 12



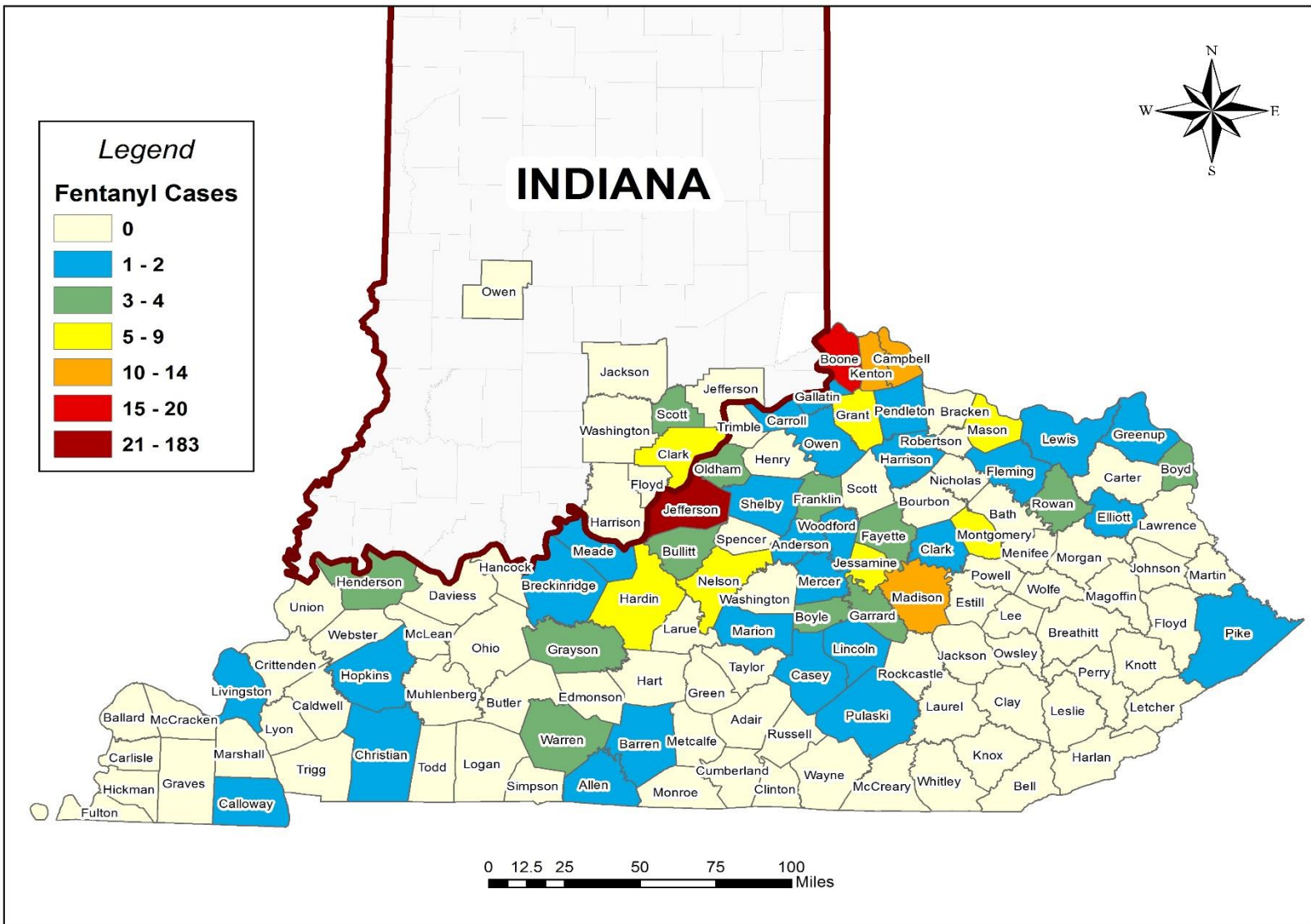
# *Statewide Drug Related Deaths Containing Heroin Sent for Autopsy by Locality of Death, 2016*

**Figure 13**





# Statewide Drug Related Deaths Containing Fentanyl Sent for Autopsy by Locality of Death, 2016 Figure 14





## Statewide Medical Examiner Drug Related Deaths

### By Demographics

#### Table 7

	Total Cases	Percentage
<b><i>Age</i></b>		
<17	7	0.76%
18-24	65	7.07%
25-34	229	24.92%
35-44	283	30.80%
45-54	201	21.87%
55-64	119	12.95%
65-74	13	1.41%
75-84	2	0.22%
85-94	0	0%
95+	0	0%
<b><i>Race</i></b>		
White	839	91.29%
Black	66	7.18%
Hispanic	9	0.98%
Asian	1	0.11%
Other	4	0.44%
<b><i>Sex</i></b>		
Male	588	63.98%
Female	331	36.02%
Unknown	0	0%

\*Statewide Drug Related Deaths includes Indiana cases

## Statewide Medical Examiner Drug Related Deaths Containing Heroin By Demographics

### Table 8

	Total Cases	Percentage
<b><i>Age</i></b>		
<17	0	0%
18-24	19	8.23%
25-34	68	29.44%
35-44	76	32.90%
45-54	49	21.21%
55-64	16	6.93%
65-74	3	1.30%
75-84	0	0%
85-94	0	0%
95+	0	0%
<b><i>Race</i></b>		
White	202	87.45%
Black	21	9.09%
Hispanic	5	2.16%
Asian	1	0.43%
Other	2	0.87%
<b><i>Sex</i></b>		
Male	161	69.70%
Female	70	30.30%
Unknown	0	0%

\*Statewide Heroin Related Deaths includes Indiana cases

## Statewide Medical Examiner Drug Related Deaths Containing Fentanyl By Demographics

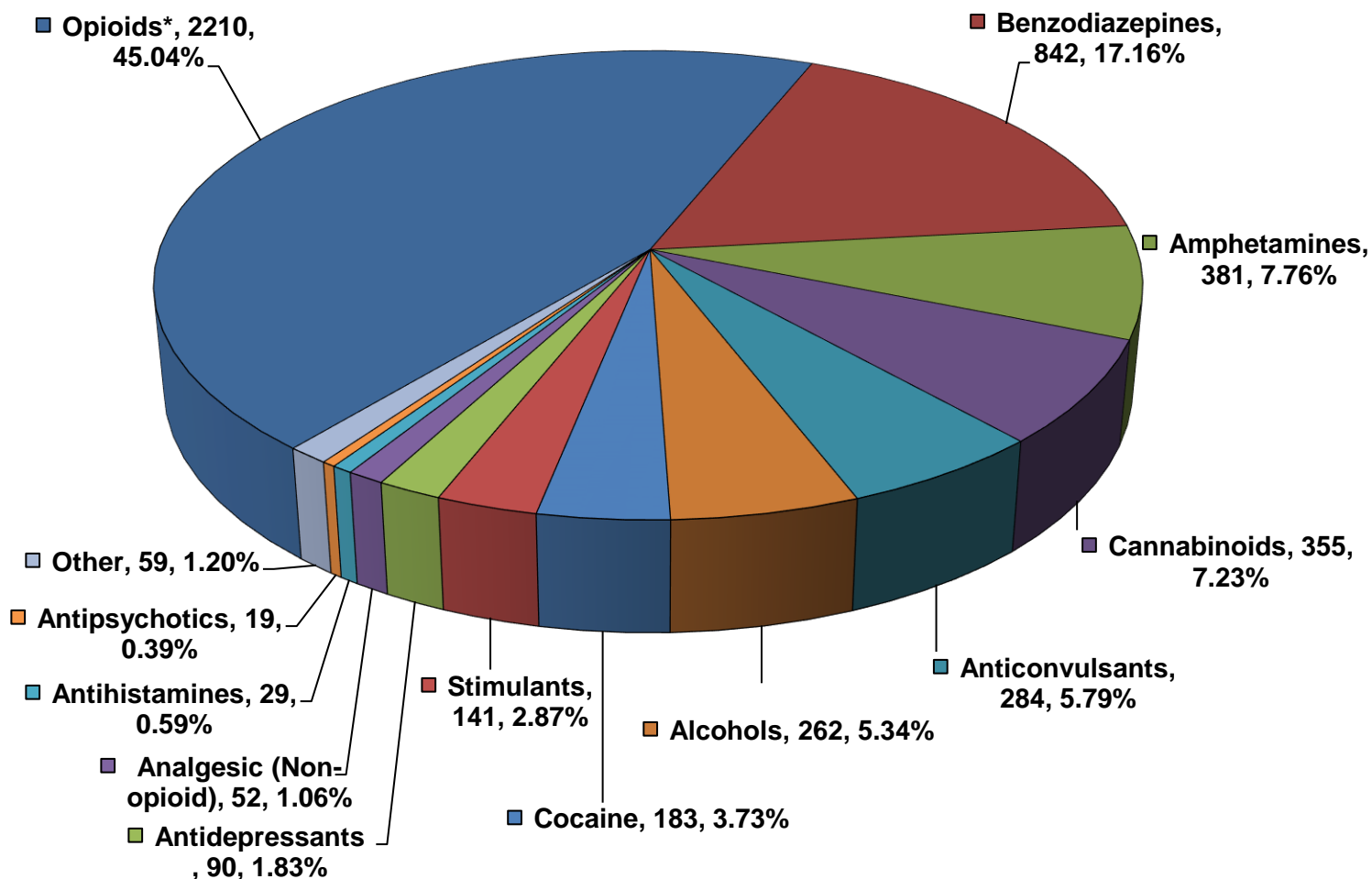
### Table 9

	Total Cases	Percentage
<b><i>Age</i></b>		
<17	1	0.29%
18-24	32	9.14%
25-34	107	30.57%
35-44	113	32.29%
45-54	67	19.14%
55-64	28	8.00%
65-74	2	0.57%
75-84	0	0%
85-94	0	0%
95+	0	0%
<b><i>Race</i></b>		
White	202	87.45%
Black	21	9.09%
Hispanic	5	2.16%
Asian	1	0.43%
Other	2	0.87%
<b><i>Sex</i></b>		
Male	237	67.71%
Female	113	32.29%
Unknown	0	0%

\*Statewide Fentanyl Related Deaths includes Indiana cases

## 2016 Statewide Most Common Drug Classes Detected in Drug Related Death Victims

### Figure 15



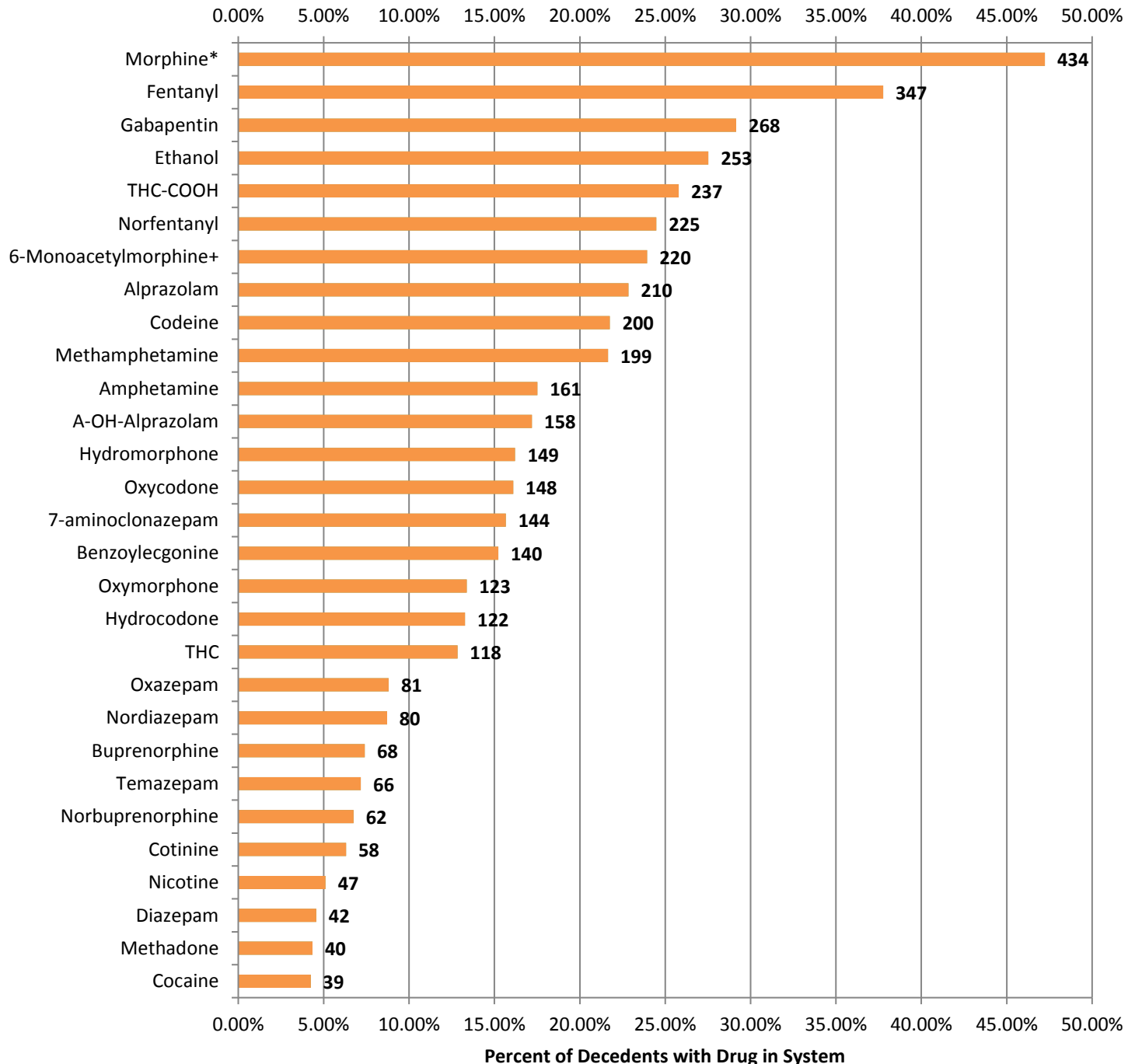
\*Opioids includes all opium-like substances (including natural opiates and synthetic opioids)

^Percent is based off of n=4907, the total drug count across all Statewide drug overdoses

⌘Detected drugs were found in blood, urine, and/or vitreous fluids.

## 2016 Statewide Most Frequent Drugs Detected in Drug Related Death Victims

Figure 16



\*Morphine represents true drug and/or metabolite of Heroin

+11 Heroin Cases do not have 6-Monoacetylmorphine present in postmortem toxicology

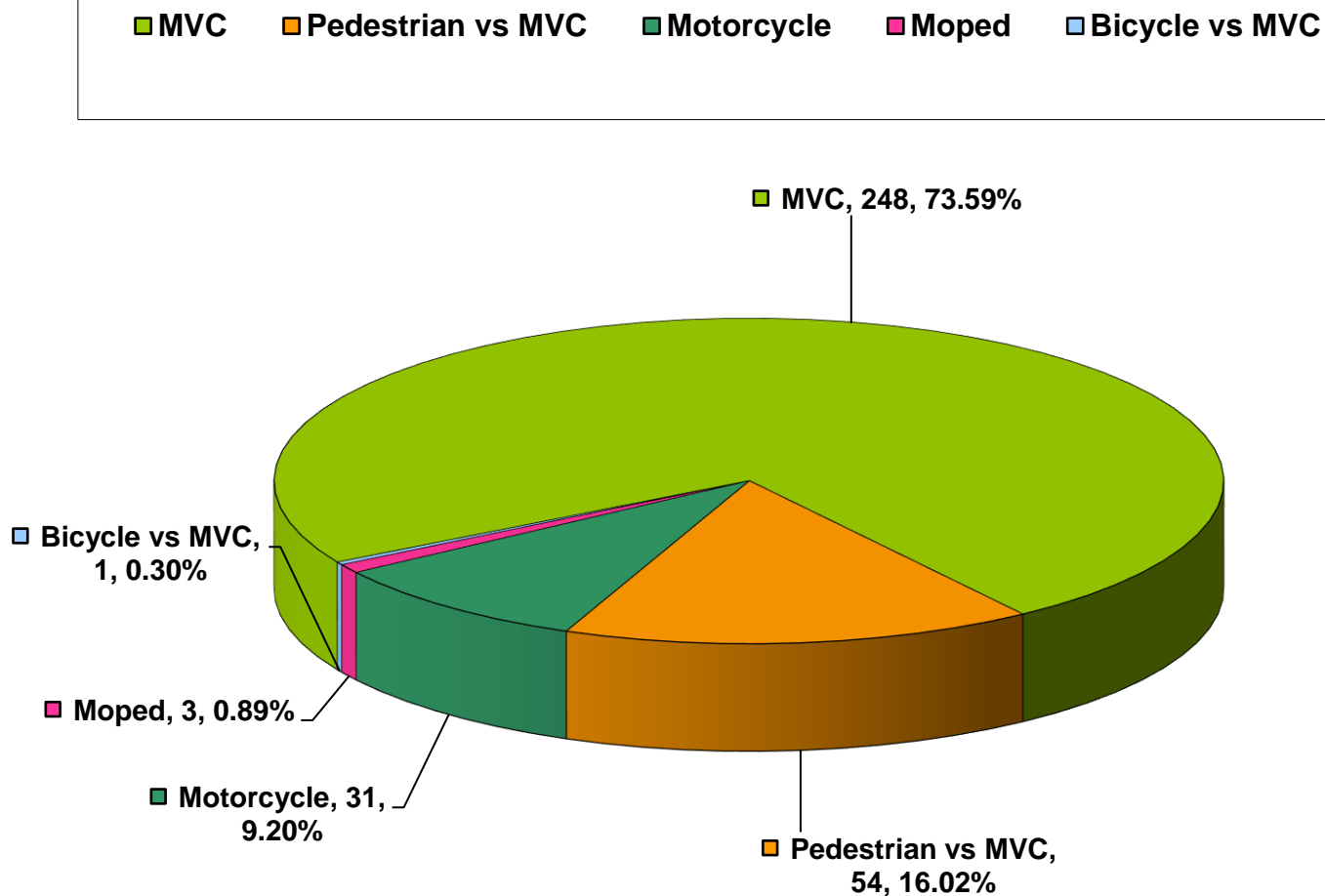
^Total Percentages >100% due to more than 1 drug being present in many decedents

¤Detected drugs were found in blood, urine, and/or vitreous fluids.

## 2016 Motor Vehicle Collisions by Type

Figure 17

Total=337





## Statewide Totals by Special Circumstances and Subsequent Manners of Death

### Table 10

<b>Fatal Event</b>	<b>Total</b>	<b>Percentage</b>
<b><i>Work Related</i></b>	<b>29</b>	<b>1.02%</b>
Accident	21	72.41%
Suicide	1	3.45%
Homicide	2	6.90%
Natural	5	17.24%
<b><i>Jail</i></b>	<b>19</b>	<b>0.67%</b>
Accident	4	21.05%
Suicide	4	21.05%
Homicide	1	5.26%
Natural	10	52.63%
<b><i>Prison</i></b>	<b>9</b>	<b>0.32%</b>
Accident	1	11.11%
Suicide	1	11.11%
Homicide	3	33.33%
Natural	4	44.44%
<b><i>Arrest-Related</i></b>	<b>34</b>	<b>1.20%</b>
Accident	6	17.65%
Suicide	10	29.41%
Homicide	17	50%
Undetermined	1	2.94%
<b><i>Home Incarceration</i></b>	<b>11</b>	<b>0.39%</b>
Accident	7	63.64%
Suicide	2	18.18%
Undetermined	2	18.18%
<b><i>Domestic</i></b>	<b>28</b>	<b>0.99%</b>
Homicide	22	78.57%
Suicide	5	17.86%
Undetermined	1	3.57%
<b><i>Child Abuse</i></b>	<b>6</b>	<b>0.21%</b>
Homicide	5	83.33%
Undetermined	1	16.67%
<b><i>Nursing Home</i></b>	<b>4</b>	<b>0.14%</b>
Accident	2	50%
Natural	2	50%

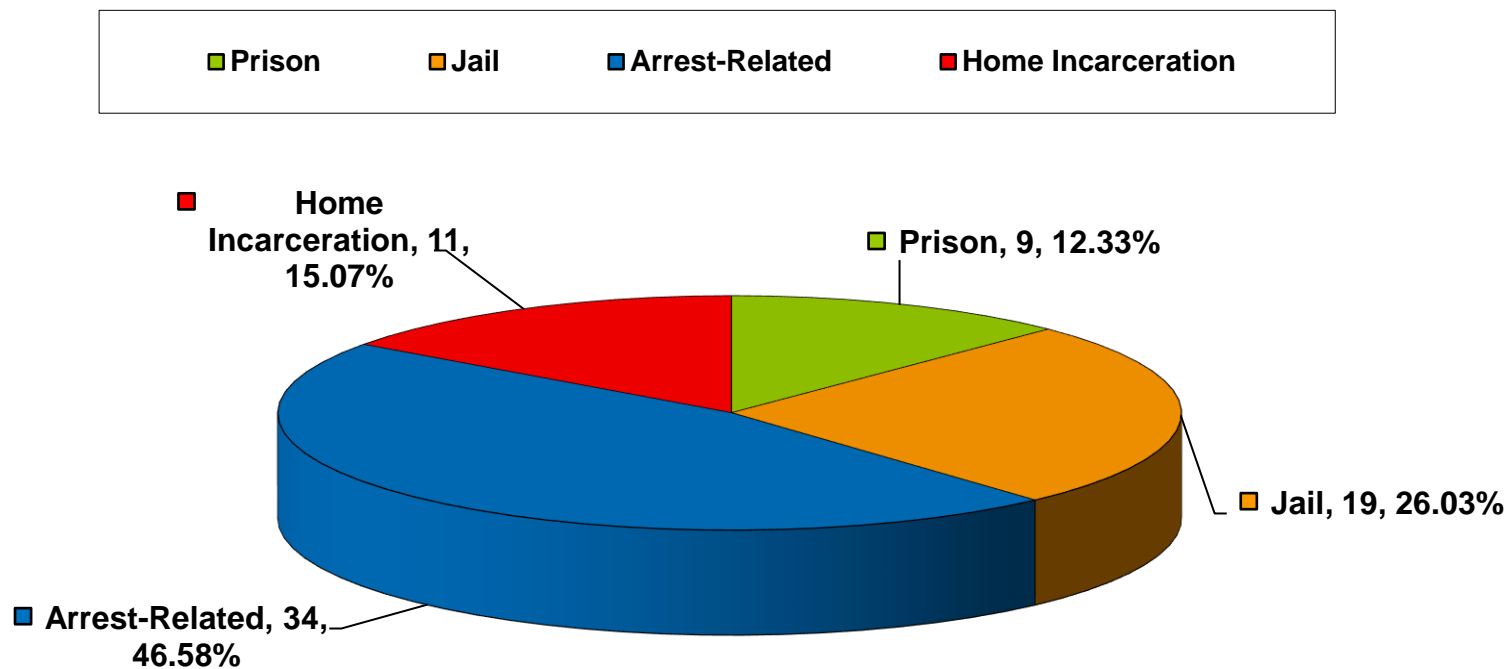
**Statewide Police-Involved Cases by Demographics and Involvement**  
**Table 11**

<b>Demographic</b>	<b>All Police Involved</b>	<b>All Police %</b>	<b>Jail Deaths</b>	<b>Jail %</b>	<b>Prison Deaths</b>	<b>Prison %</b>	<b>Arrest- Related Deaths</b>	<b>Arrest- Related %</b>	<b>Home Incarc Deaths</b>	<b>Home Incarc %</b>
<i>Age</i>										
24 and younger	10	13.70%	2	10.53%	1	11.11%	5	14.71%	2	18.18%
25-34	28	38.36%	9	47.37%	5	55.56%	9	26.47%	5	45.45%
35-44	17	23.29%	3	15.79%	2	22.22%	9	26.47%	3	27.27%
45-54	10	13.70%	1	5.26%	0	0%	8	23.53%	1	9.09%
55-64	7	9.59%	3	15.79%	1	11.11%	3	8.82%	0	0%
65 and older	1	1.37%	1	5.26%	0	0%	0	0%	0	0%
<i>Race</i>										
White	55	75.34%	16	84.21%	6	66.67%	26	76.47%	7	63.64%
Black	16	21.92%	2	10.53%	3	33.33%	7	20.59%	4	36.36%
Hispanic	1	1.37%	0	0%	0	0%	1	2.94%	0	0%
Other	1	1.37%	1	5.26%	0	0%	0	0%	0	0%
<i>Sex</i>										
Male	65	89.04%	14	73.68%	9	100%	34	100%	8	72.73%
Female	8	10.96%	5	26.32%	0	0%	0	0%	3	27.27%
<b>Total</b>	<b>73</b>	<b>100%</b>	<b>19</b>	<b>26.03%</b>	<b>9</b>	<b>12.33%</b>	<b>34</b>	<b>46.58%</b>	<b>11</b>	<b>15.07%</b>

## 2016 Statewide Police-Involved Cases by Type of Police Involvement

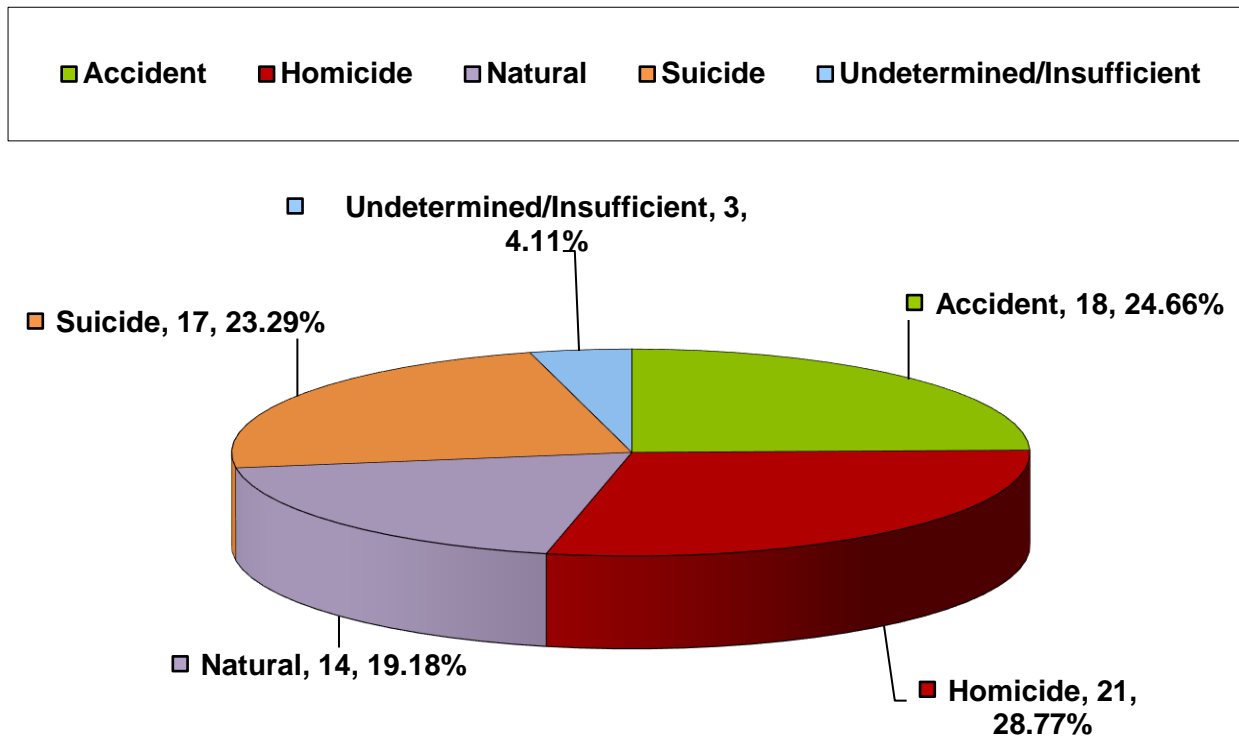
Figure 18

n=73



## 2016 Statewide Police-Involved Cases by Manner of Death

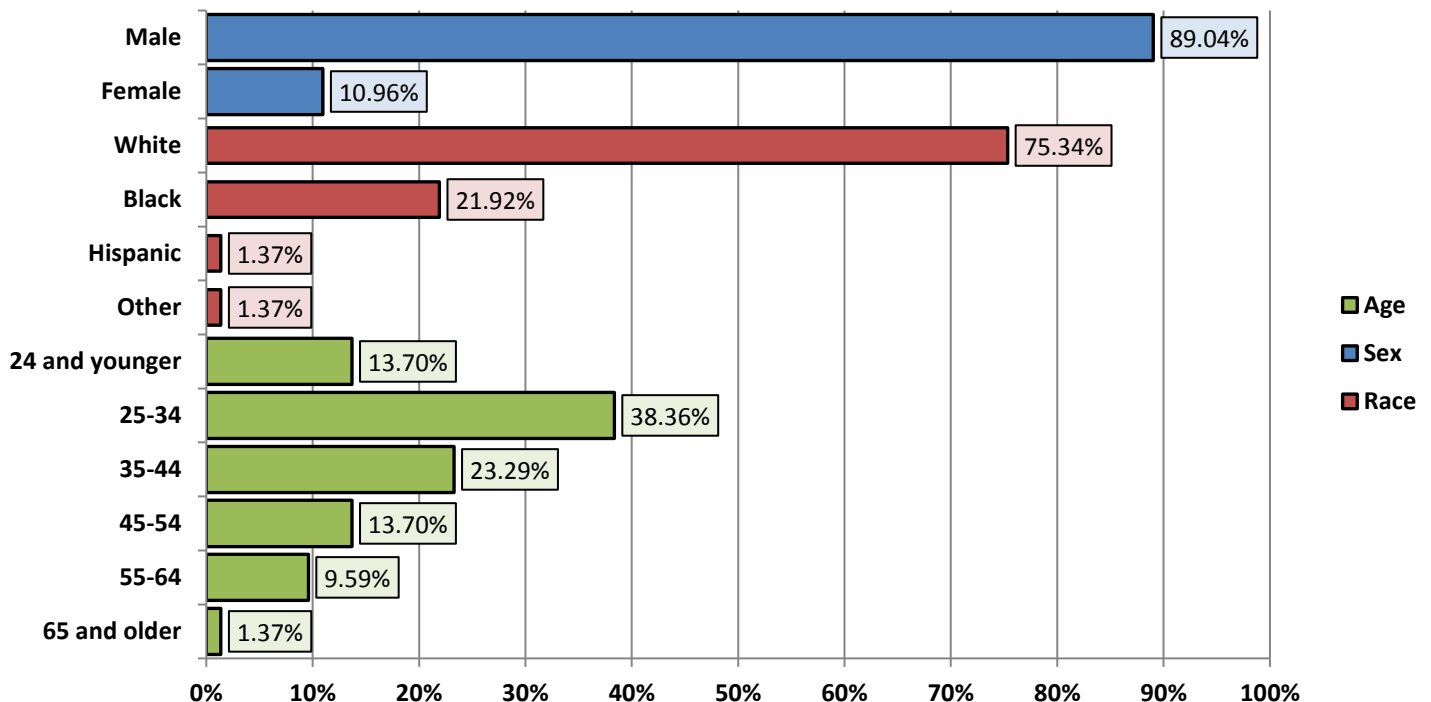
Figure 19



## 2016 Statewide Police-Involved Cases by Demographics

Figure 20

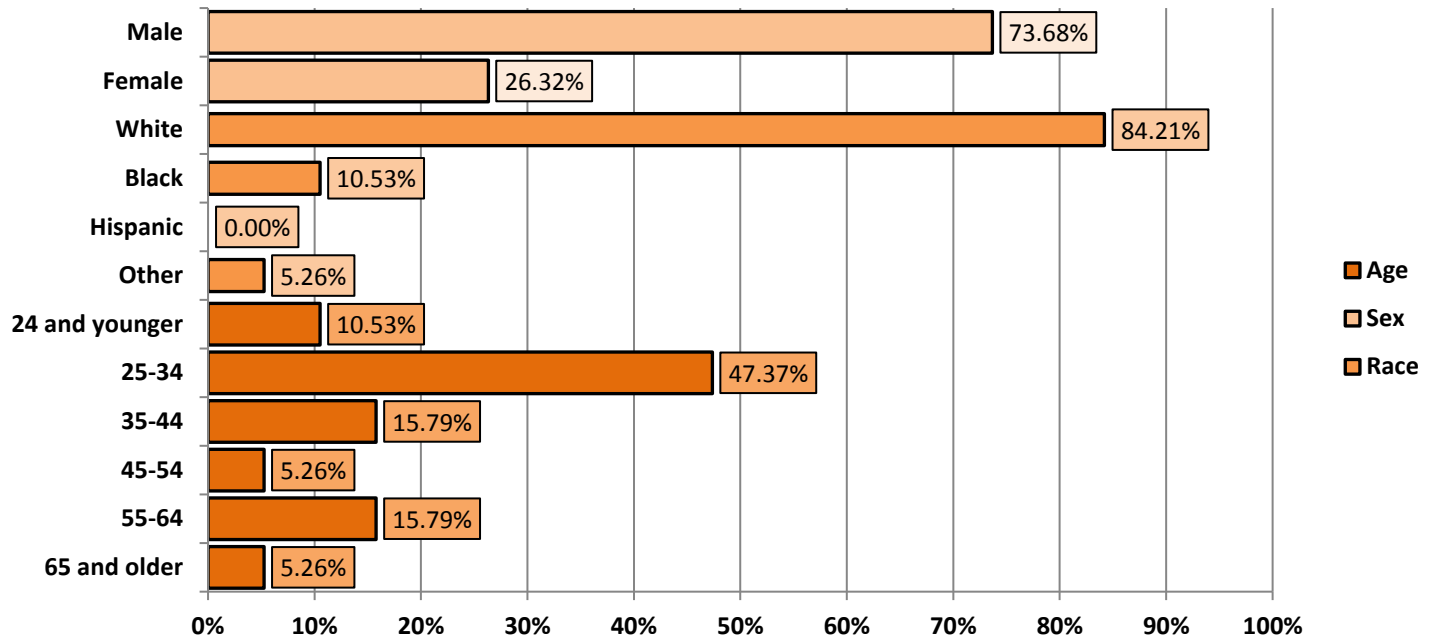
n=73



## 2016 Statewide Jail Deaths by Demographics

Figure 21

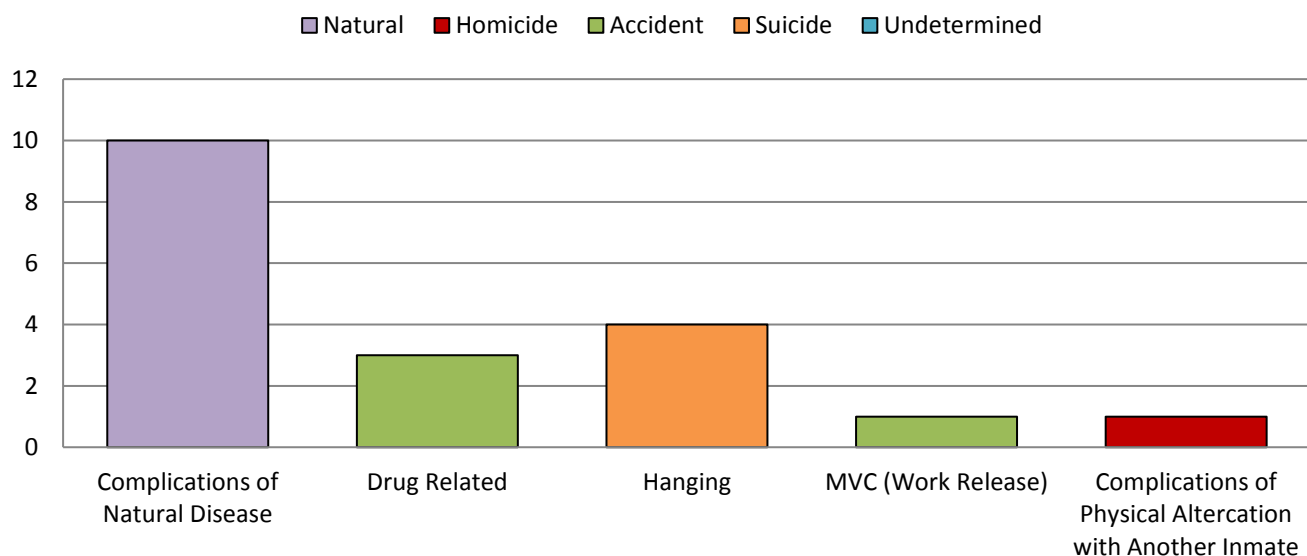
n=19



## 2016 Statewide Jail Deaths by Cause and Manner of Death

Figure 22

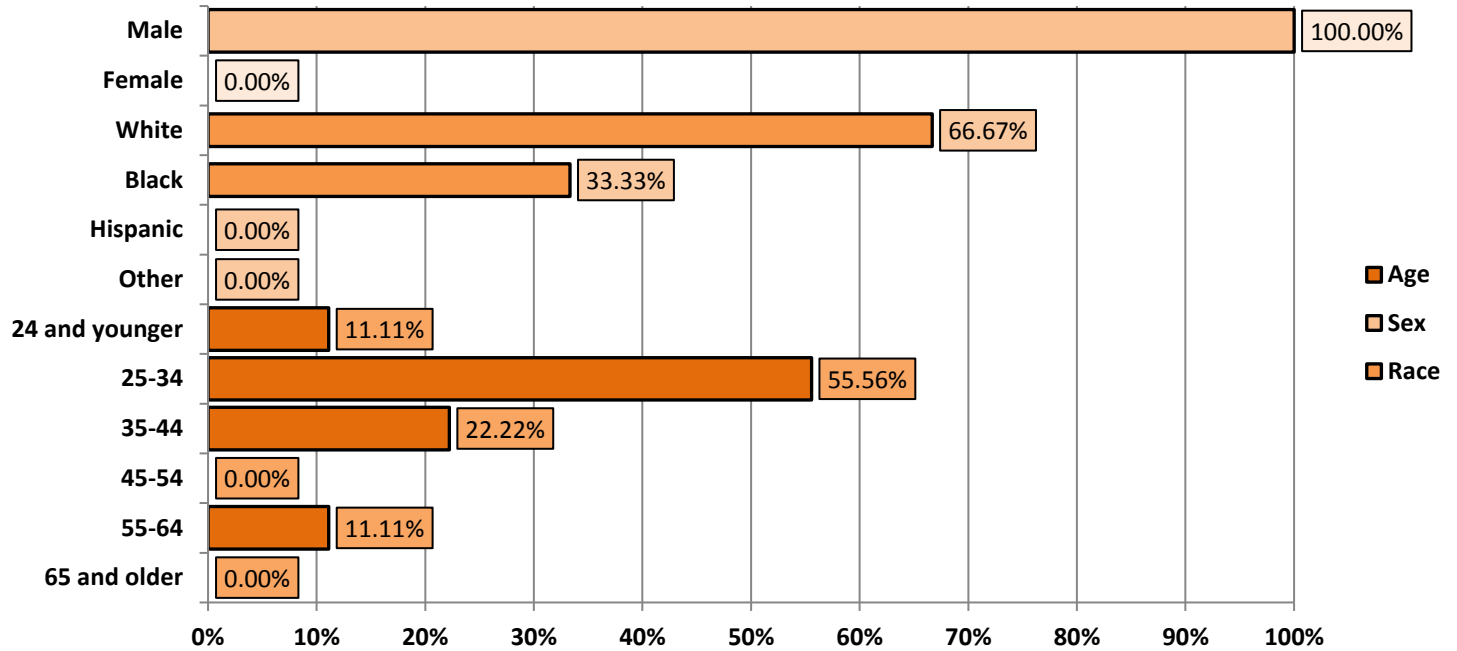
n=19



## 2016 Statewide Prison Deaths by Demographics

Figure 23

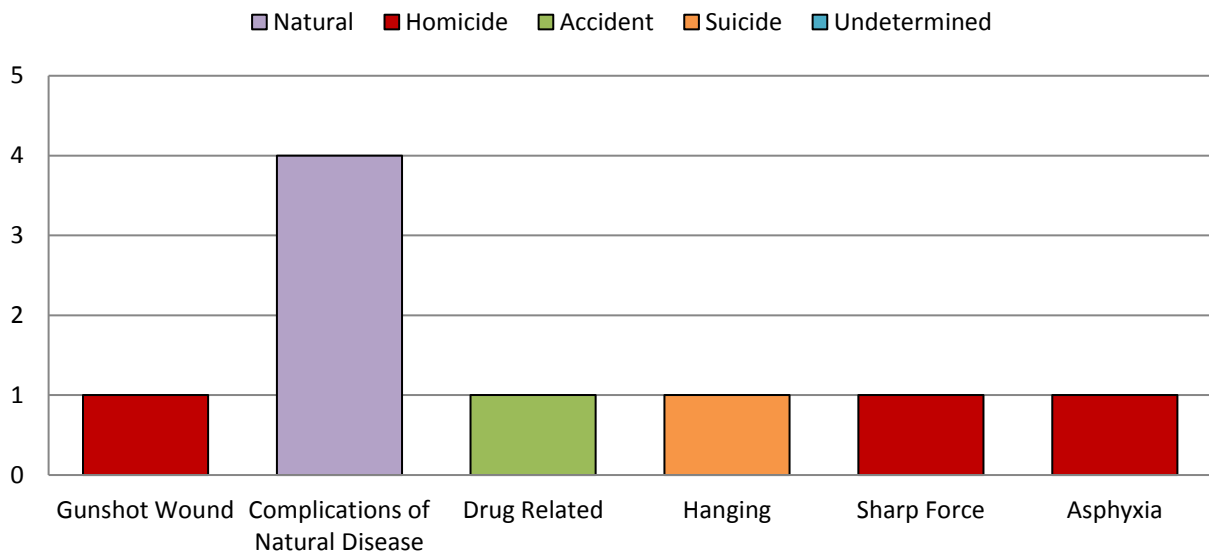
n=9



## 2016 Statewide Prison Deaths by Cause and Manner of Death

Figure 24

n=9

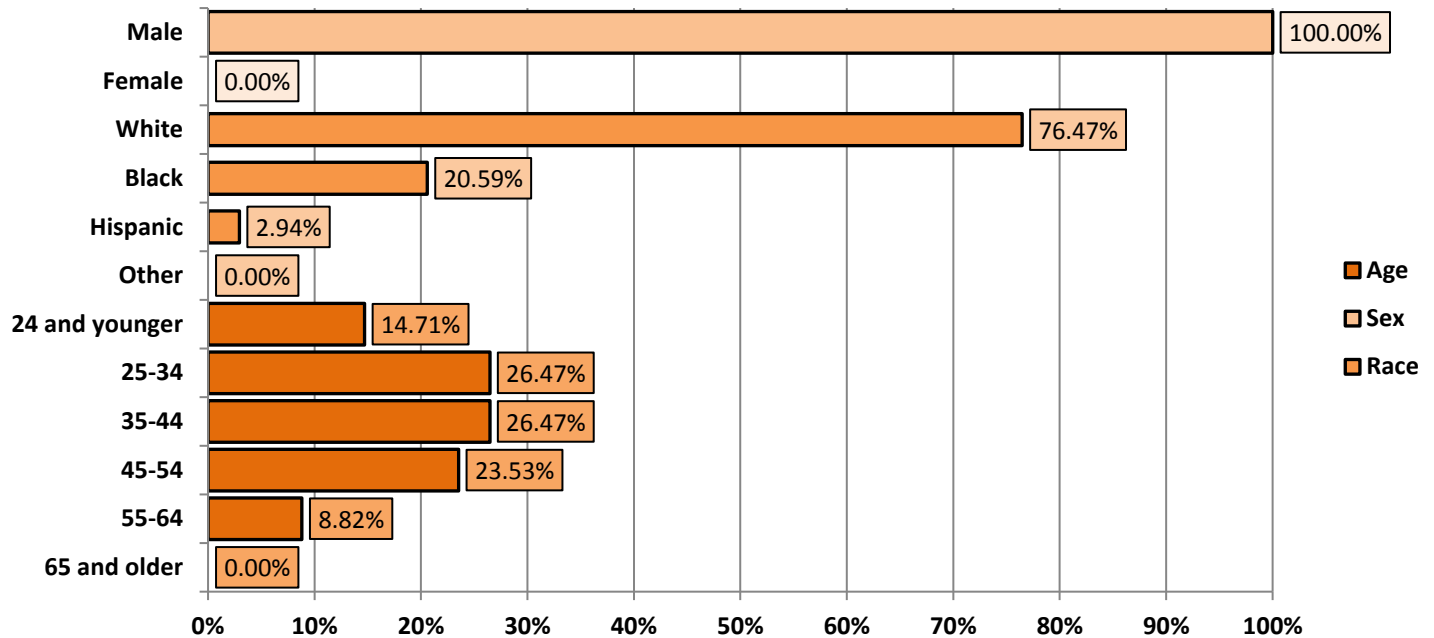




## 2016 Statewide Arrest-Related Deaths by Demographics

Figure 25

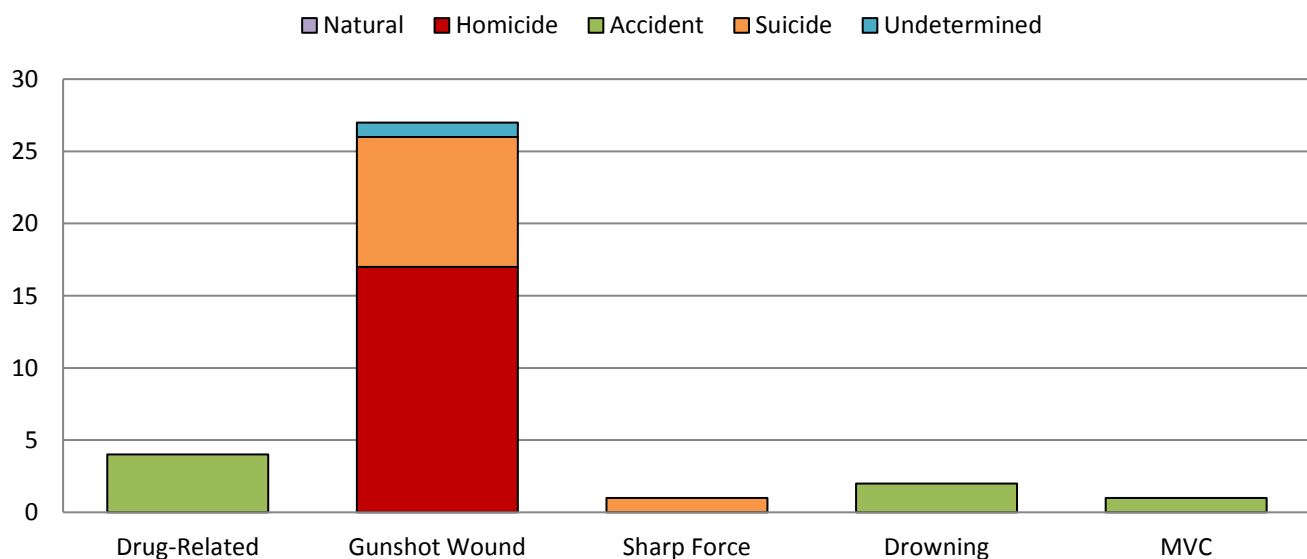
n=34



## 2016 Statewide Arrest-Related Deaths by Cause and Manner of Death

Figure 26

n=34

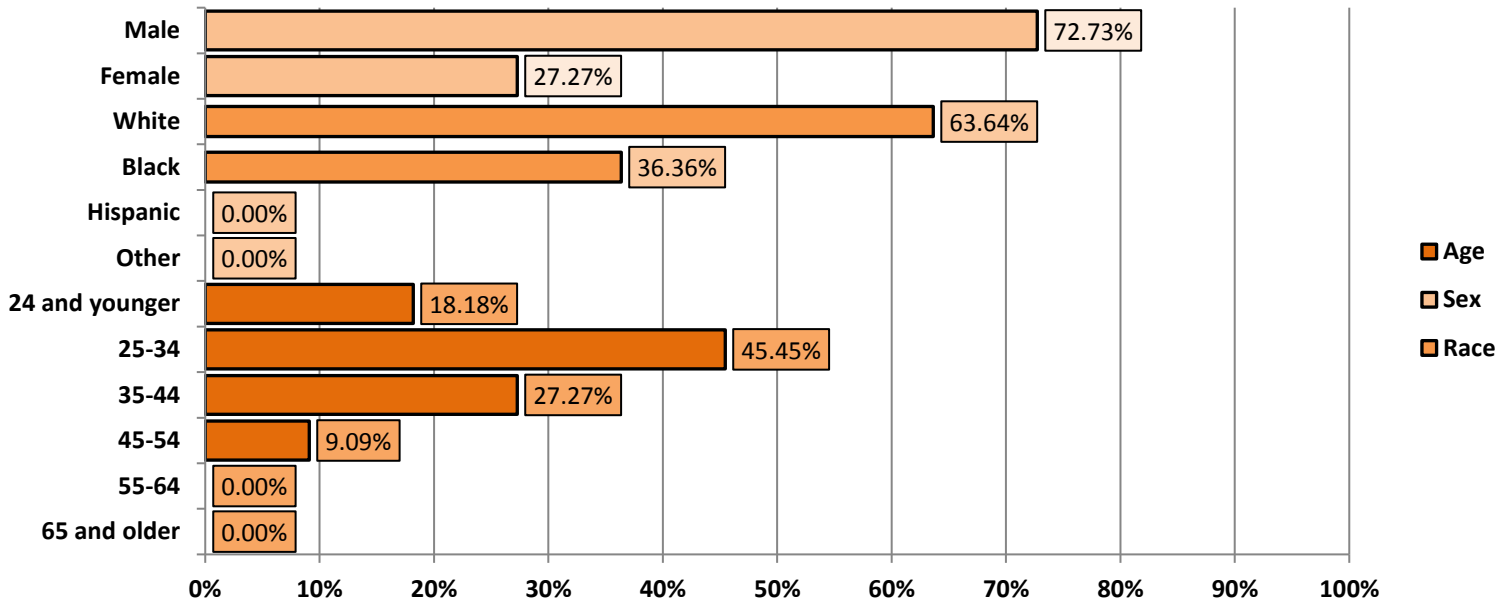


\*1 Multiple Causes of Death (Drowning/Drug-Related)

## 2016 Statewide Home Incarceration Deaths by Demographics

Figure 27

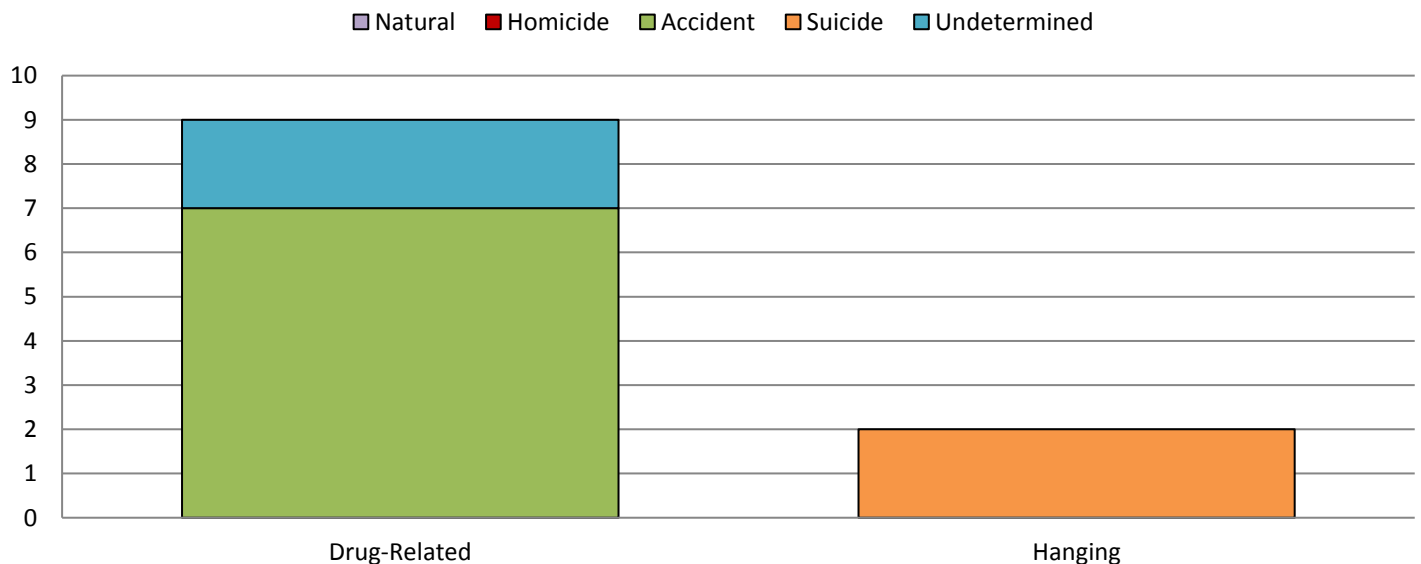
n=11



## 2016 Statewide Home Incarceration Deaths by Cause and Manner of Death

Figure 28

n=11

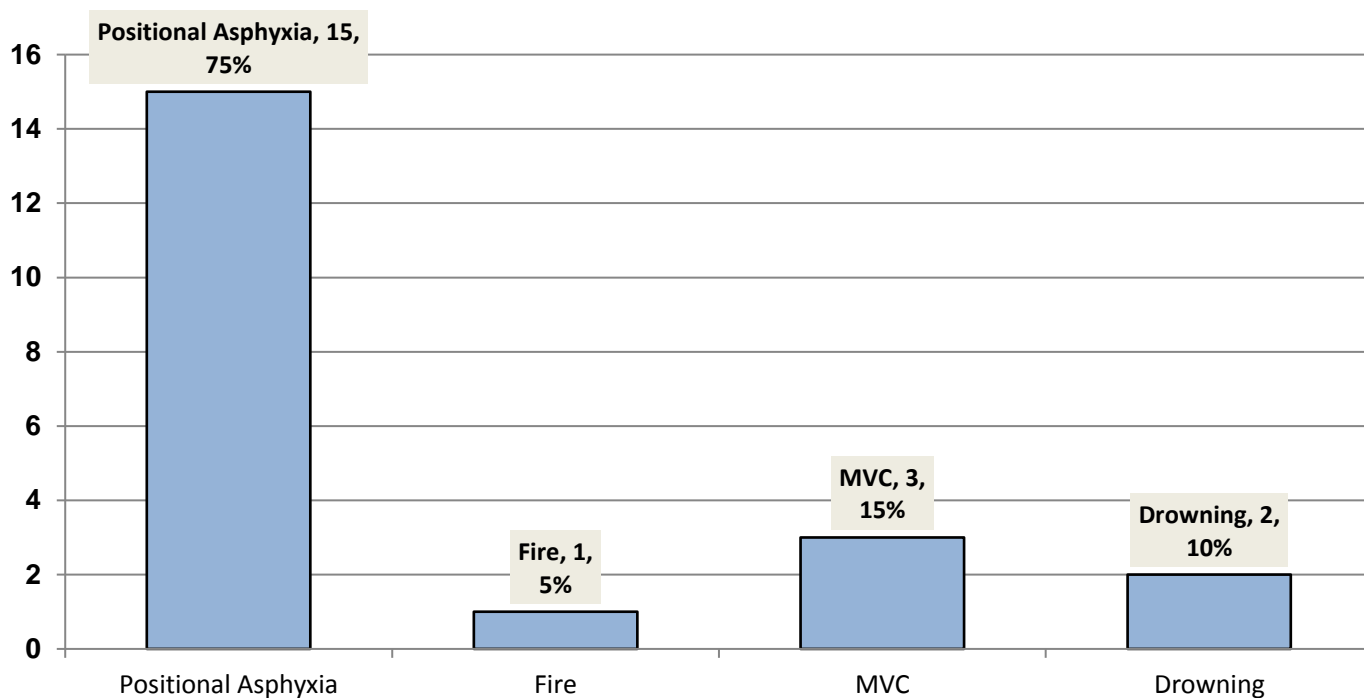


# **Statewide Medical Examiner Data of Children (Birth-17)**

## 2016 Statewide Child (<1) Accidents by Cause of Death

### Figure 29

Total <1 Accidental Deaths=20

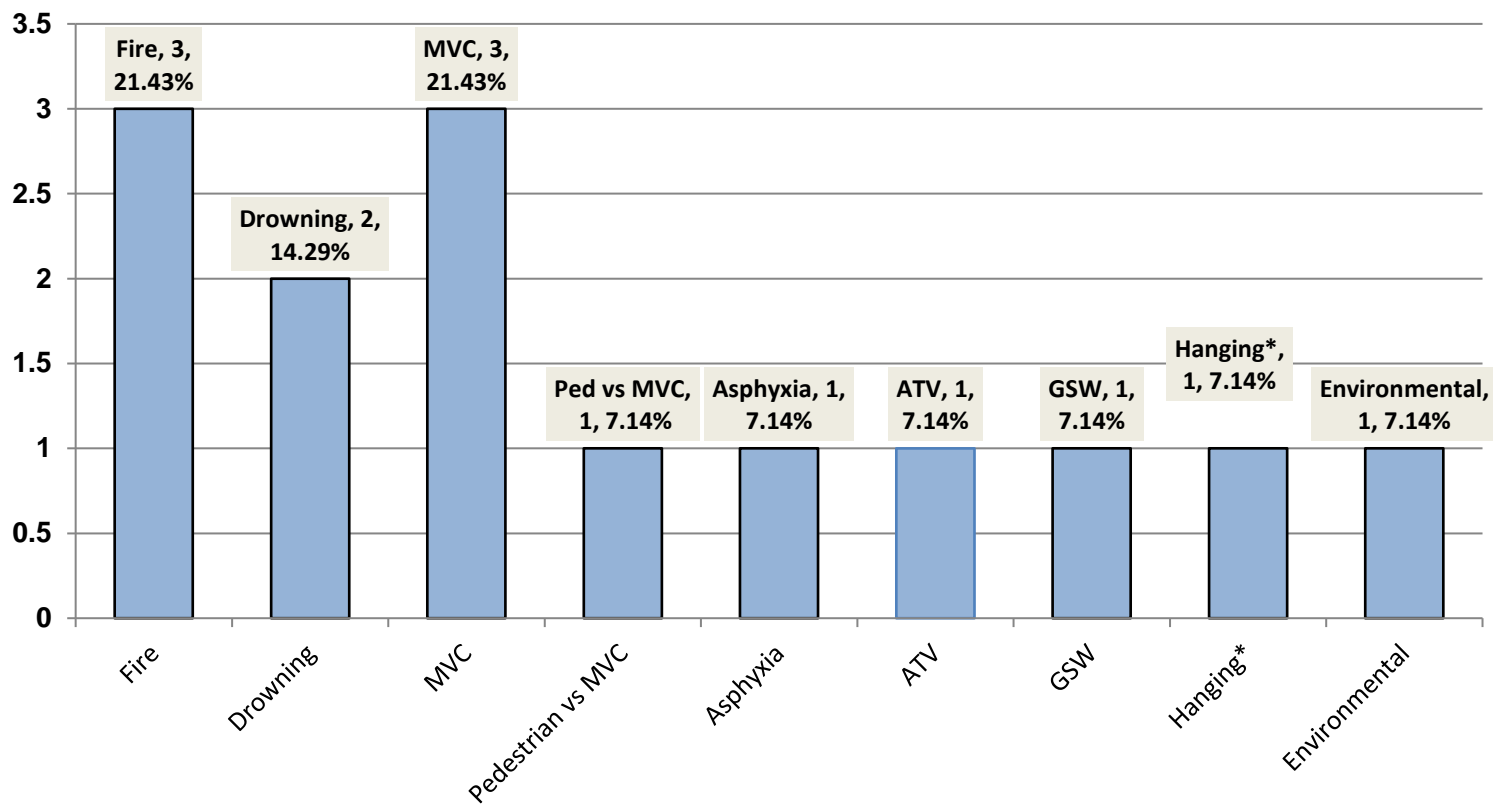


\*\*Percentages may be > than 100%, as some decedents may have more than one (1) type of injury

## 2016 Statewide Child (1-5) Accidents by Cause of Death

### Figure 30

Total 1-5 Accidental Deaths=14

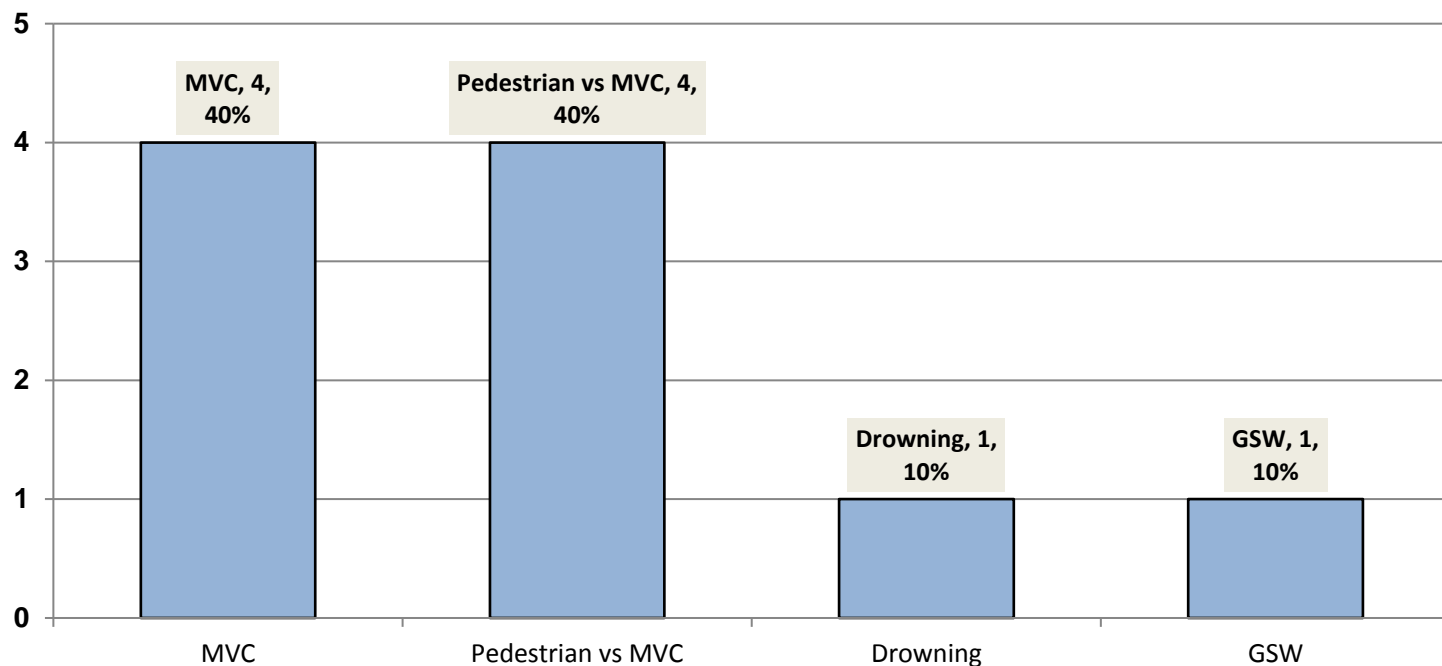


\*entanglement in window blind cord

## 2016 Statewide Child (6-12) Accidents by Cause of Death

### Figure 31

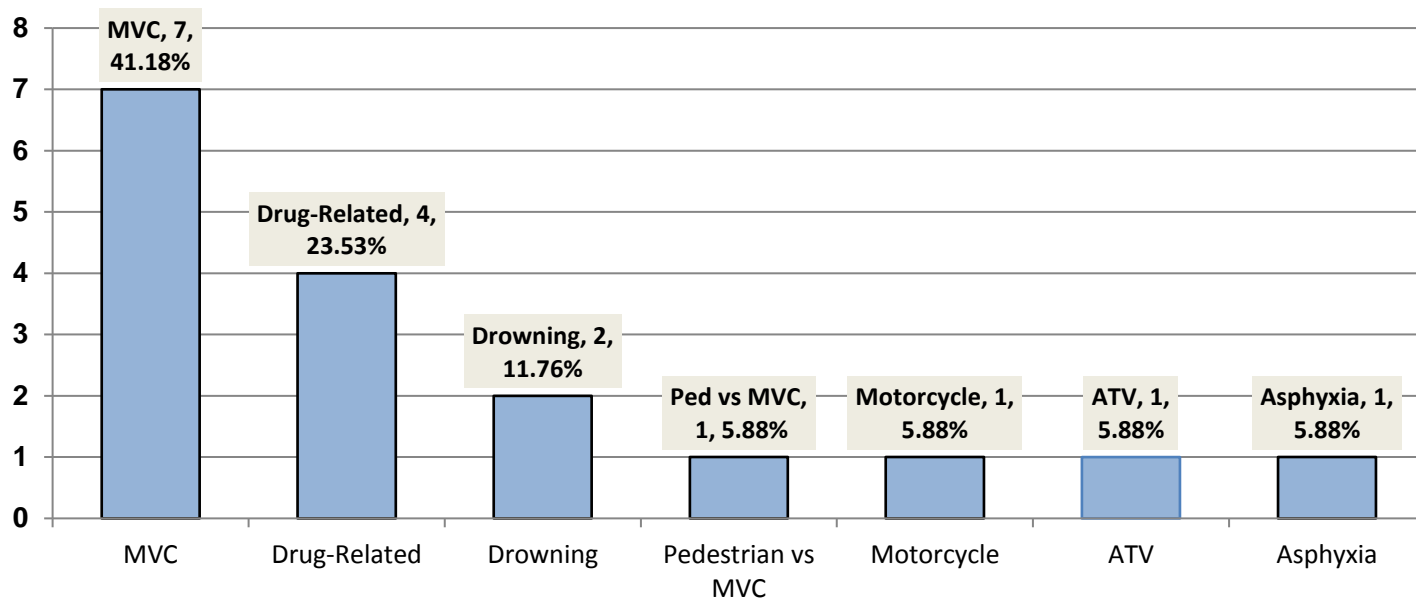
Total 6-12 Accidental Deaths=10



## 2016 Statewide Child (13-17) Accidents by Cause of Death

### Figure 32

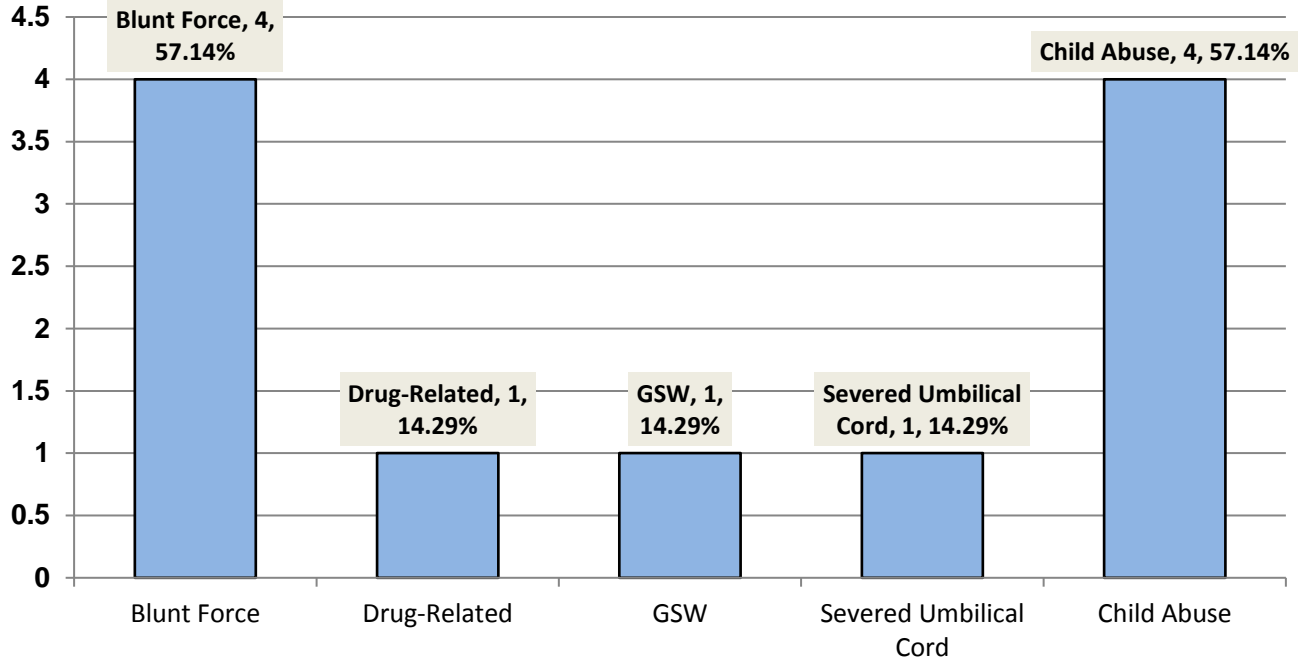
Total 13-17 Accidental Deaths=17





## 2016 Statewide Child (<1) Homicides by Cause of Death Figure 33

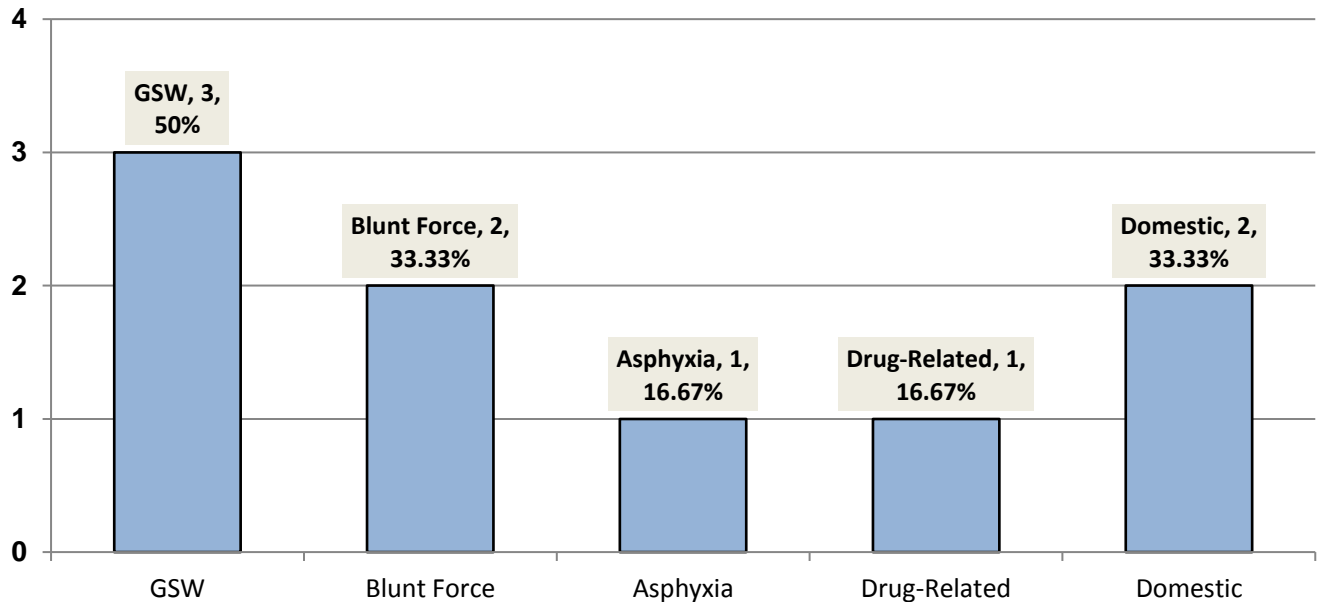
Total <1 Homicide Deaths=7



\*\*Percentages may be > than 100%, as some decedents may have more than one (1) type of injury.

## 2016 Statewide Child (1-5) Homicides by Cause of Death Figure 34

Total 1-5 Homicide Deaths=6

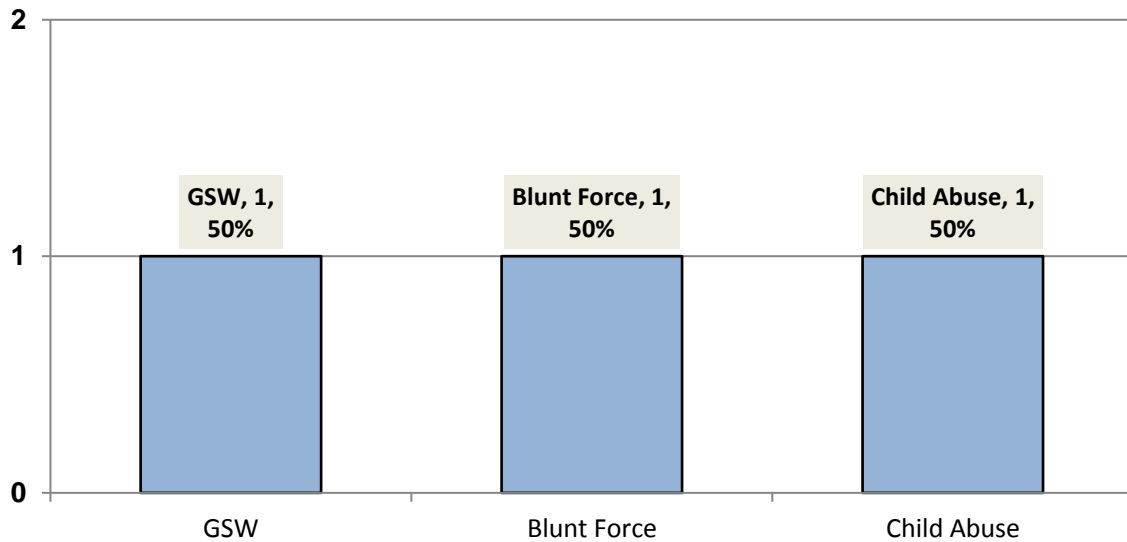


\*\*Percentages may be > than 100%, as some decedents may have more than one (1) type of injury.

## 2016 Statewide Child (6-12) Homicides by Cause of Death

**Figure 35**

Total 6-12 Homicide Deaths=2

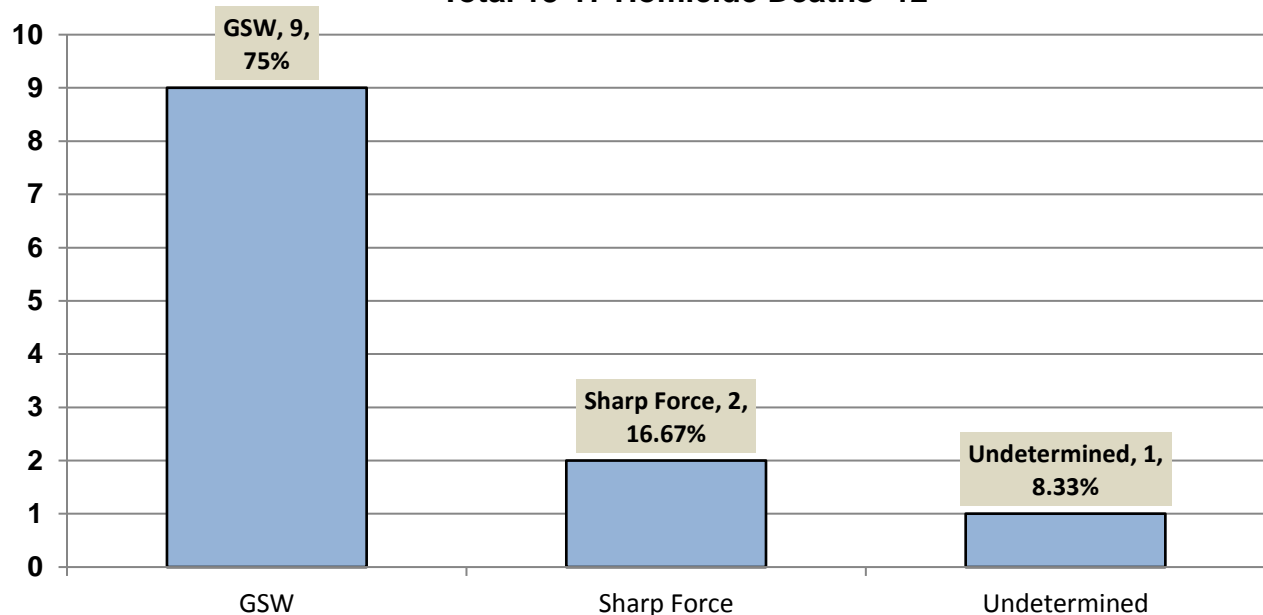


\*\*Percentages may be > than 100%, as some decedents may have more than one (1) type of injury

## 2016 Statewide Child (13-17) Homicides by Cause of Death

**Figure 36**

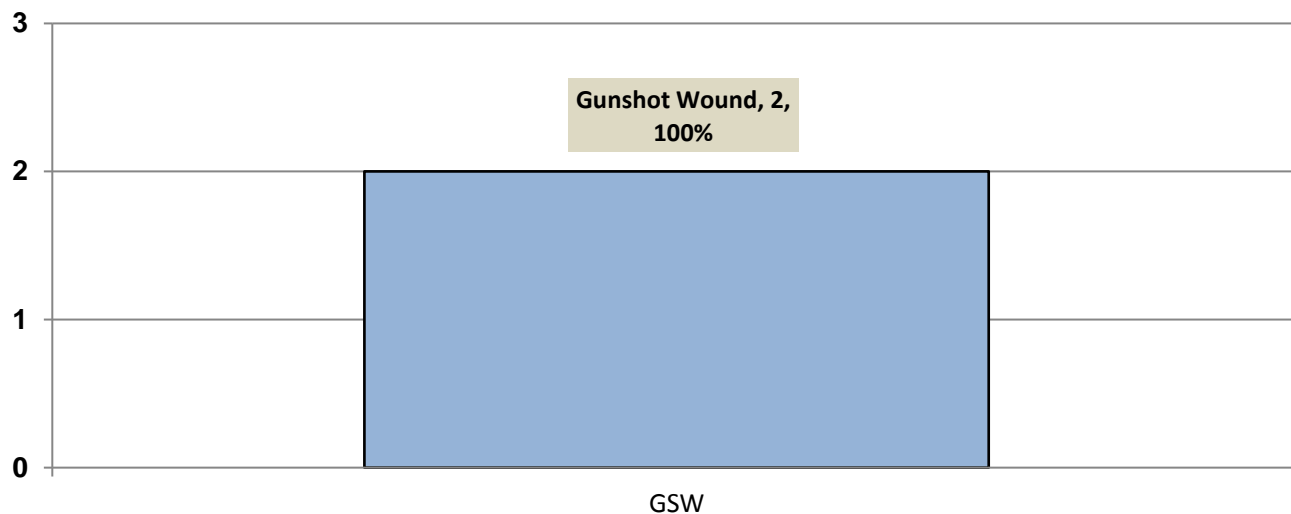
Total 13-17 Homicide Deaths=12



## 2016 Statewide Child (6-12) Suicides by Cause of Death

### Figure 37

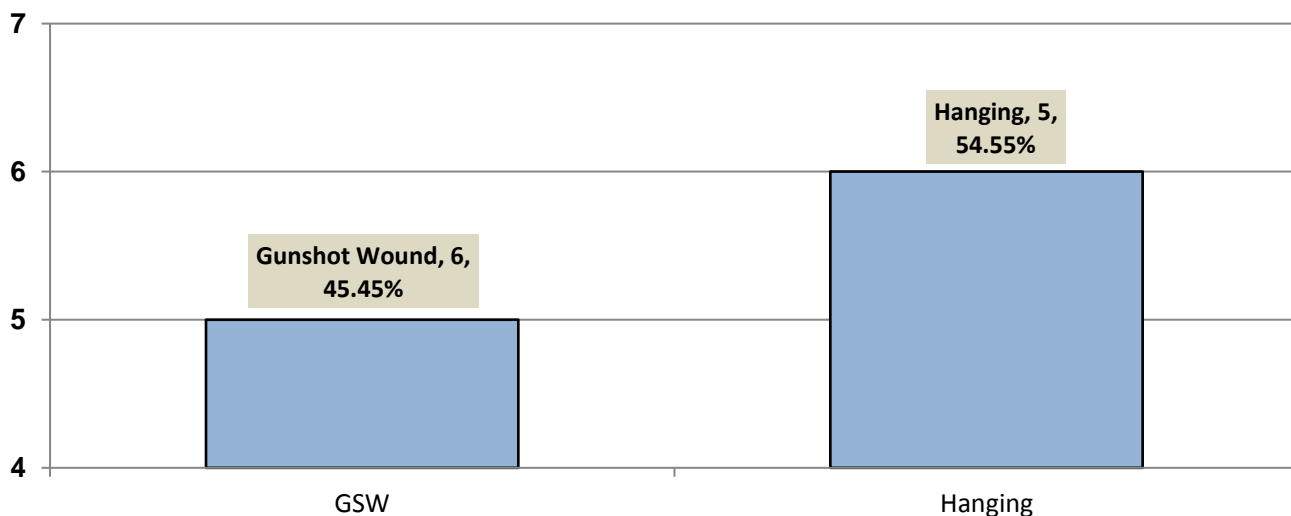
Total 6-12 Suicide Deaths=2



## 2016 Statewide Child (13-17) Suicides by Cause of Death

### Figure 38

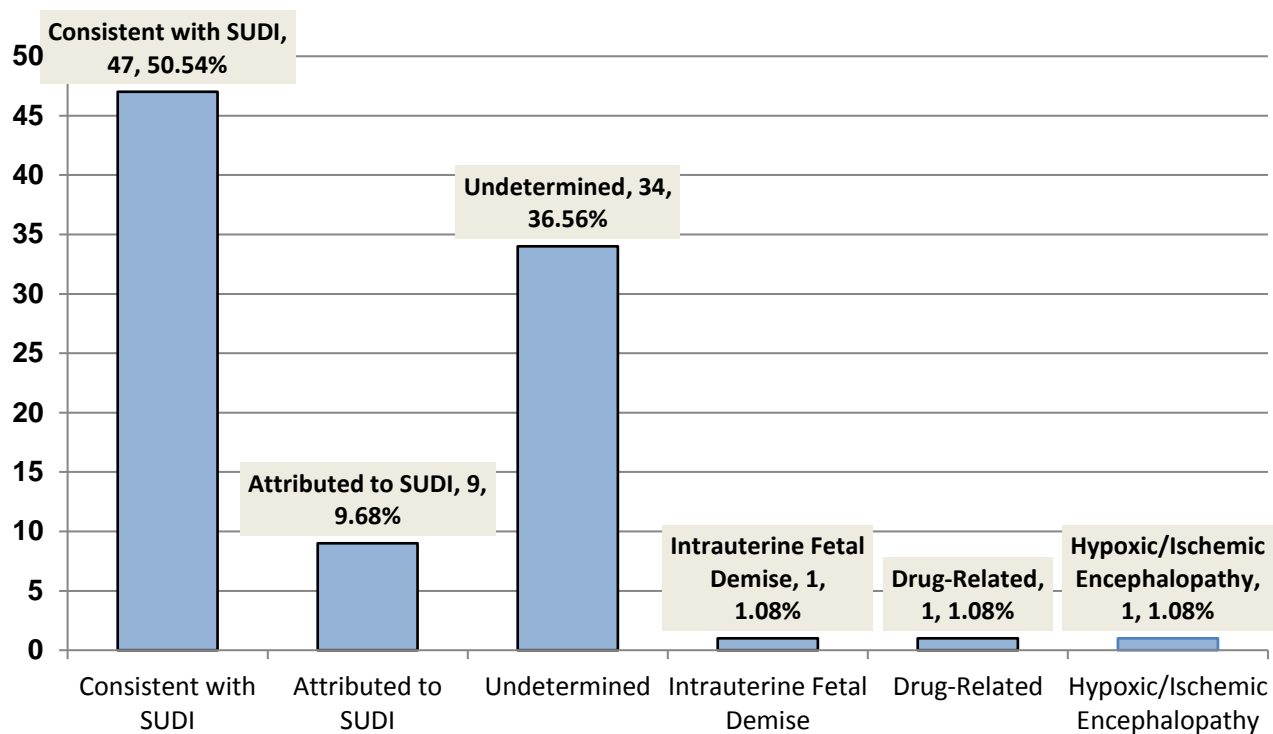
Total 13-17 Suicide Deaths=11



## 2016 Statewide Child (<1) Undetermined Manners by Cause of Death

### Figure 39

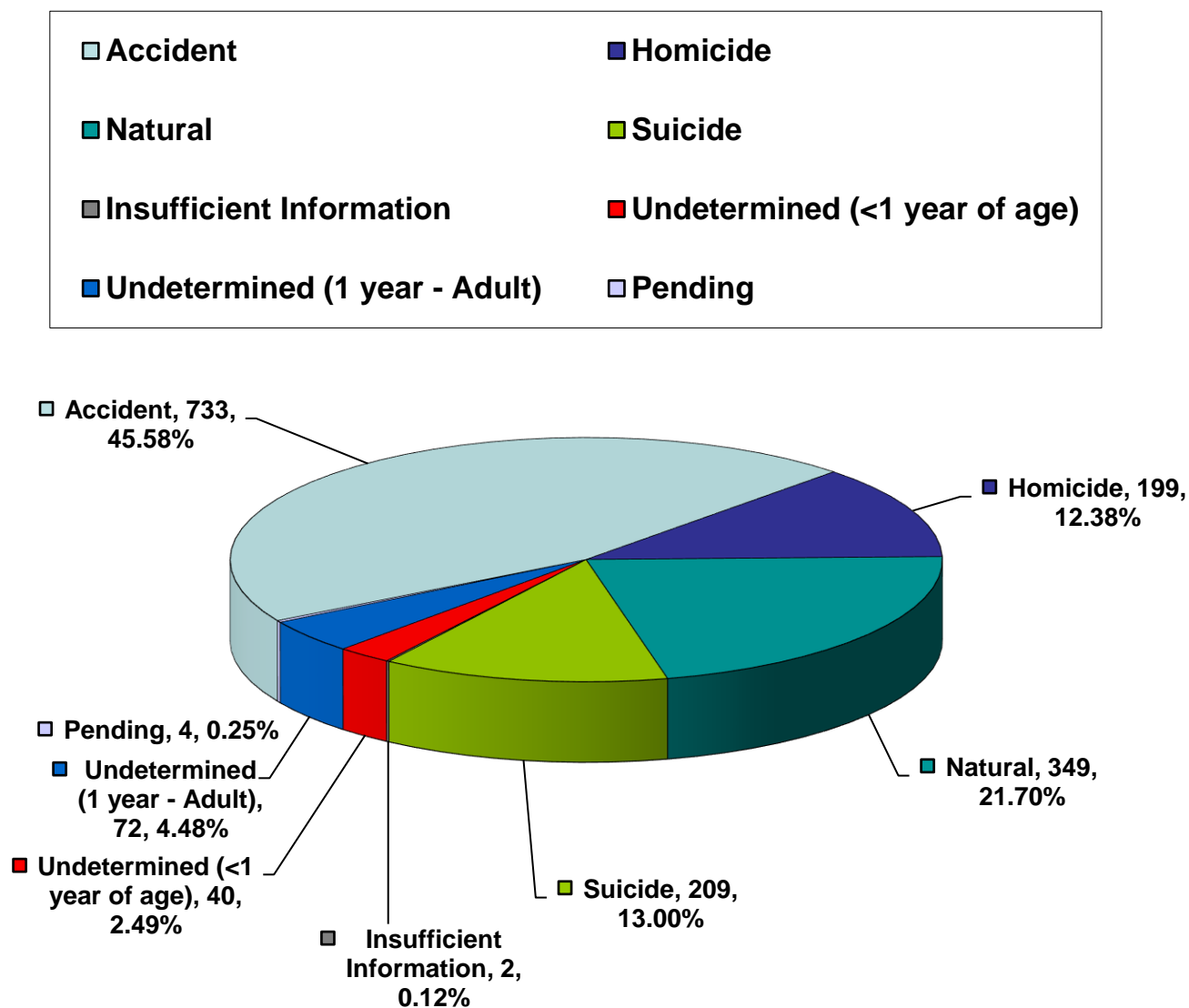
Total <1 Undetermined Deaths=93



# Office of the Chief Medical Examiner Office Data

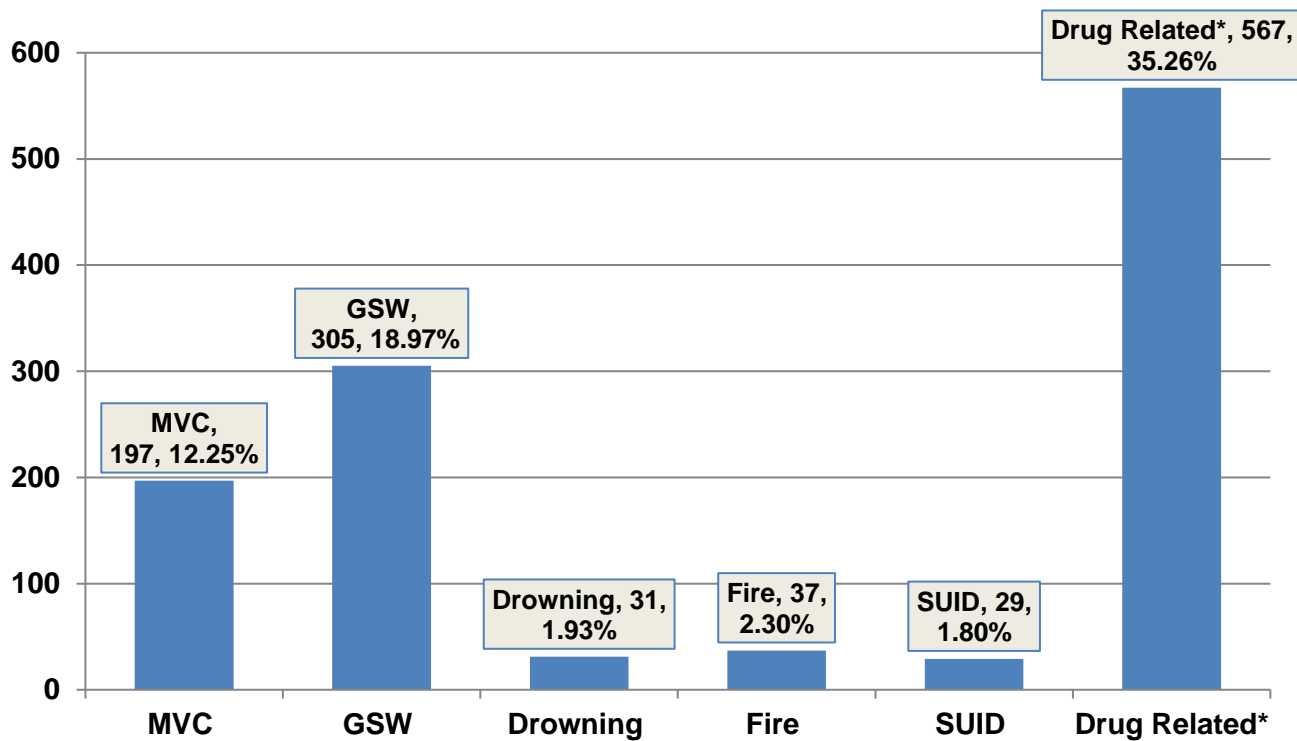
## 2016 OCME Cases by Manner of Death

### Figure 40



## 2016 OCME Cases by Common Causes of Death

### Figure 41



\*Drug Related total includes Indiana



## OCME Totals by Common Causes and Subsequent Manners of Death

**Table 12**

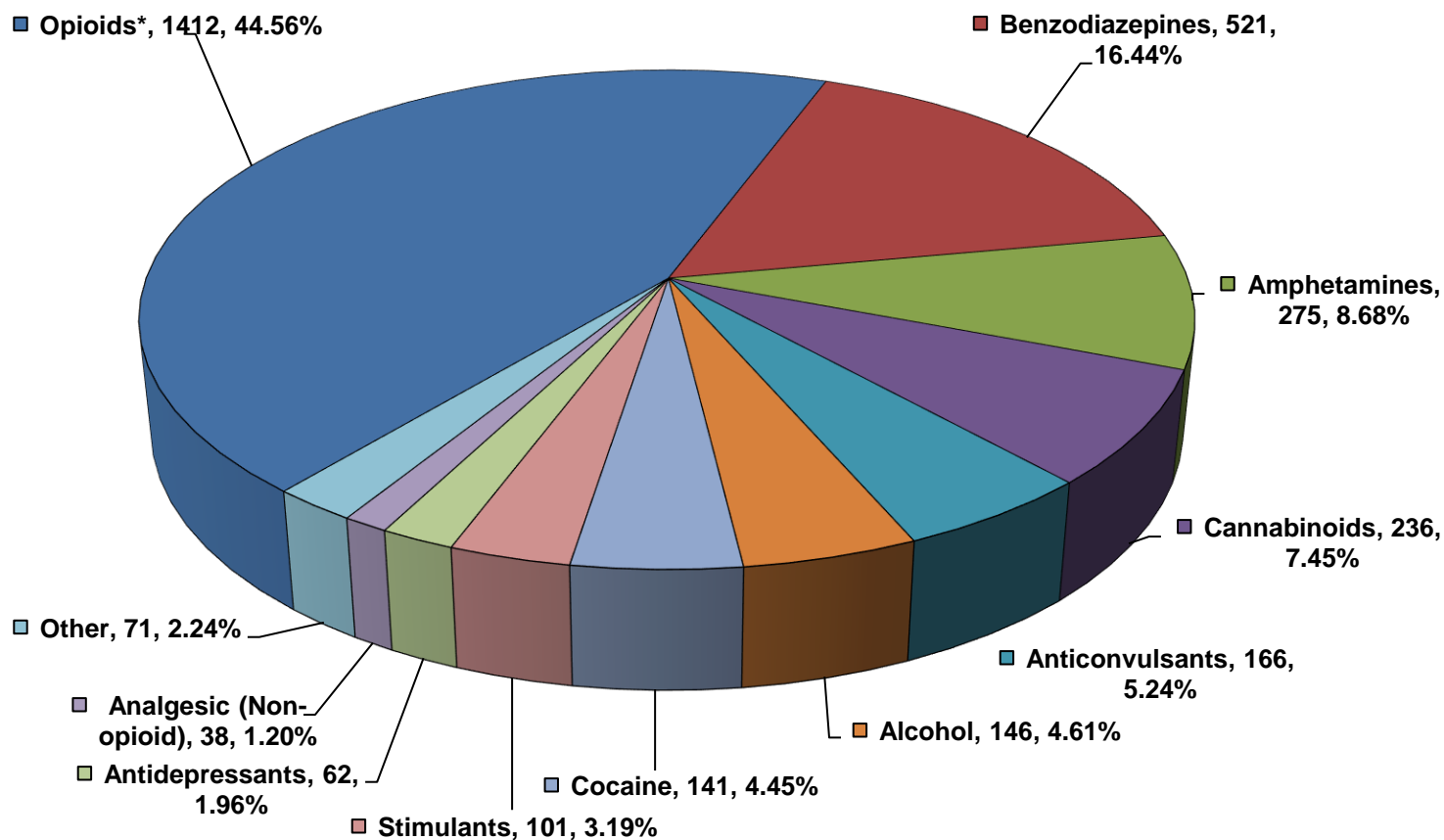
<b>Fatal Event</b>	<b>Total Cases</b>	<b>Percentage</b>
<b><i>Drug Related - Kentucky</i></b>	<b>546</b>	<b>33.96%</b>
Accident	436	79.85%
Homicide	1	0.18%
Suicide	17	3.11%
Natural (Complications of Chronic Use)	57	10.44%
Undetermined/Insufficient	35	6.41%
Heroin Present	166	30.40%
Fentanyl Present	226	41.39%
<b><i>Drug Related - Indiana</i></b>	<b>21</b>	<b>1.31%</b>
Accident	15	71.43%
Homicide	1	4.76%
Natural (Complications of Chronic Use)	1	4.76%
Undetermined/Insufficient	4	19.05%
Heroin Present	2	9.52%
Fentanyl Present	8	38.10%
<b><i>Motor Vehicle Accident</i></b>	<b>197</b>	<b>12.25%</b>
Accident	191	96.95%
Suicide	2	1.02%
Undetermined/Insufficient	4	2.03%
<b><i>Gunshot Wound</i></b>	<b>305</b>	<b>18.97%</b>
Accident	4	1.31%
Homicide	161	52.79%
Suicide	135	44.26%
Undetermined/Insufficient	3	0.98%
Pending	2	0.66%
<b><i>Drowning</i></b>	<b>31</b>	<b>1.93%</b>
Accident	25	80.65%
Suicide	3	9.68%
Undetermined/Insufficient	3	9.68%
<b><i>Fire Related</i></b>	<b>37</b>	<b>2.30%</b>
Accident	32	86.49%
Undetermined/Insufficient	3	8.11%
Pending	2	5.41%
<b><i>SUID</i></b>	<b>29</b>	<b>1.80%</b>
Undetermined	29	100%
<b><i>All other OCME Accidents</i></b>	<b>60</b>	<b>3.73%</b>

\*The above does not represent the total number of OCME cases\*

❑Other than Drug Related Deaths, Indiana cases are included in totals❑

## 2016 OCME Most Common Drug Classes Detected in Drug Related Death Victims

### Figure 42



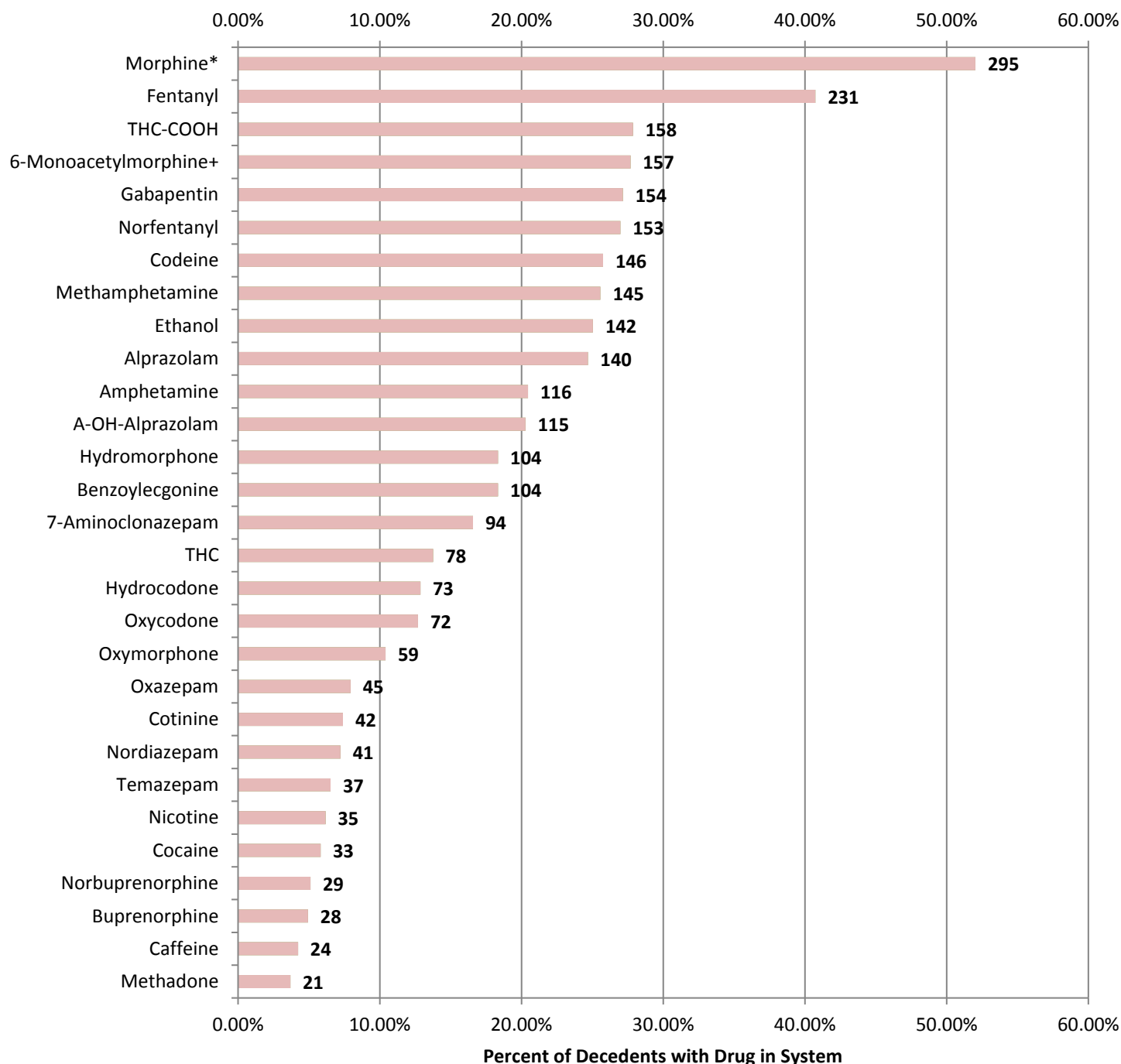
\*Opioids includes all opium-like substances (including natural opiates and synthetic opioids)

^Percent is based off of n=3,169, the total drug count across all OCME drug overdoses

¤Detected drugs were found in blood, urine, and/or vitreous fluids.

## 2016 OCME Most Frequent Drugs Detected in Drug Related Death Victims

### Figure 43



\*Morphine represents true drug and/or metabolite of Heroin

+11 Heroin Cases do not have 6-Monoacetylmorphine present in postmortem toxicology

^Total Percentages >100% due to more than 1 drug being present in many decedents

⌘Detected drugs were found in blood, urine, and/or vitreous fluids.

**2016 OCME Additional Drugs Detected  
in Drug Related Death Victims  
Table 13**

<b>Drug Name</b>	<b>Total</b>	<b>Percentage</b>		<b>Drug Name</b>	<b>Total</b>	<b>Percentage</b>
Diazepam	17	3.00%		Venlafaxine	3	0.53%
Lorazepam	16	2.82%		Acetone	2	0.35%
Naloxone	16	2.82%		Buspirone	2	0.35%
Nortramadol	14	2.47%		Butalbital	2	0.35%
Tramadol	14	2.47%		Carfentanil	2	0.35%
EDDP	13	2.29%		Coumarin	2	0.35%
Clonazepam	12	2.12%		Doxepin	2	0.35%
Diphenhydramine	11	1.94%		Doxylamine	2	0.35%
Pseudoephedrine	11	1.94%		Isopropanol	2	0.35%
Citalopram	10	1.76%		Mirtazapine	2	0.35%
Quetiapine	10	1.76%		O-Desmethylenlafaxine	2	0.35%
Cyclobenzaprine	6	1.06%		Phenobarbital	2	0.35%
Dextromethorphan	6	1.06%		Propranolol	2	0.35%
Acetaminophen	5	0.88%		Salicylates	2	0.35%
Norsertaline	5	0.88%		Topiramate	2	0.35%
Promethazine	5	0.88%		Zolpidem	2	0.35%
Amitriptyline	4	0.71%		1,1-Difluorethane	1	0.18%
Amlodipine	4	0.71%		10-OH-Carbazepine	1	0.18%
Bupropion	4	0.71%		5F-ADB	1	0.18%
Chlorophenylpiperazine	4	0.71%		Alpha-PVP	1	0.18%
Cocaethylene	4	0.71%		Azithromycin	1	0.18%
Fluoxetine	4	0.71%		Baclofen	1	0.18%
Hydroxyzine	4	0.71%		Clindamycin	1	0.18%
Meprobamate	4	0.71%		Demoxepam	1	0.18%
Norfluoxetine	4	0.71%		Dihydrocodeine	1	0.18%
Nortriptyline	4	0.71%		Ephedrine	1	0.18%
Paroxetine	4	0.71%		Ibuprofen	1	0.18%
Amiodarone	3	0.53%		Labetalol	1	0.18%
Carisoprodol	3	0.53%		Levofloxacin	1	0.18%
Chlordiazepoxide	3	0.53%		MDMA	1	0.18%
Chlorpheniramine	3	0.53%		Metoclopramide	1	0.18%
Duloxetine	3	0.53%		Mexiletine	1	0.18%
Lamotrigine	3	0.53%		Nordoxepin	1	0.18%
Levetiracetam	3	0.53%		Olanzapine	1	0.18%
Pregabalin	3	0.53%		Phentermine	1	0.18%
Sertraline	3	0.53%		Ropinirole	1	0.18%
Trazodone	3	0.53%				

^Total Percentages >100% due to more than 1 drug being present in many decedents

¤Detected drugs were found in blood, urine, and/or vitreous fluids.

## OCME Totals by Special Circumstances and Subsequent Manners of Death

### Table 14

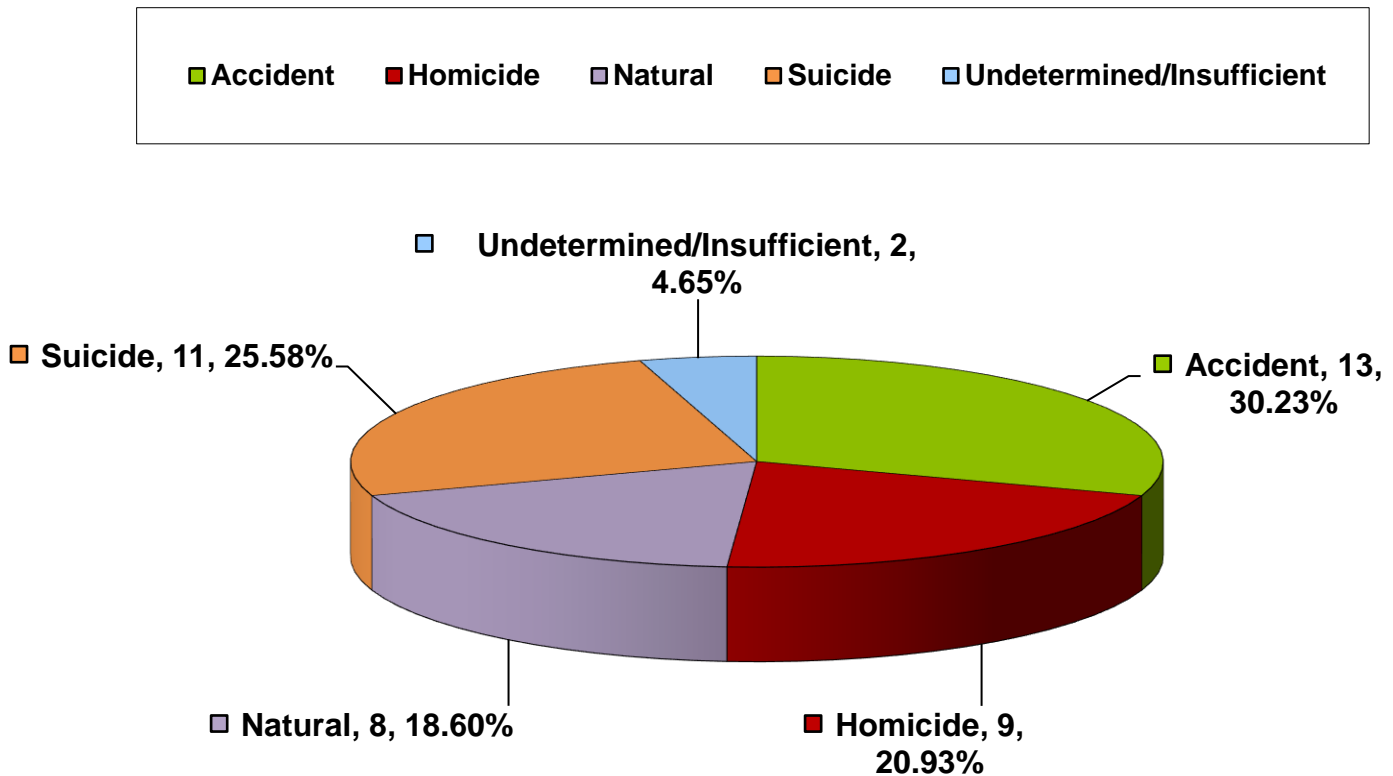
<b>Fatal Event</b>	<b>Total</b>	<b>Percentage</b>
<b><i>Work Related</i></b>	<b>18</b>	<b>1.12%</b>
Accident	12	66.67%
Suicide	1	5.55%
Homicide	2	11.11%
Natural	3	16.67%
<b><i>Jail</i></b>	<b>10</b>	<b>0.62%</b>
Accident	2	20%
Suicide	1	10%
Homicide	1	10%
Natural	6	60%
<b><i>Prison</i></b>	<b>3</b>	<b>0.19%</b>
Homicide	1	66.67%
Natural	2	33.33%
<b><i>Arrest-Related</i></b>	<b>20</b>	<b>1.24%</b>
Accident	5	25%
Suicide	8	40%
Homicide	7	35%
<b><i>Home Incarceration</i></b>	<b>10</b>	<b>0.62%</b>
Accident	6	60%
Suicide	2	20%
Undetermined/Insufficient	2	20%
<b><i>Domestic</i></b>	<b>21</b>	<b>1.31%</b>
Homicide	16	76.19%
Suicide	4	19.05%
Undetermined	1	4.76%
<b><i>Child Abuse</i></b>	<b>2</b>	<b>0.12%</b>
Homicide	2	100%
<b><i>Nursing Home</i></b>	<b>3</b>	<b>0.19%</b>
Accident	1	66.67%
Natural	2	33.33%

**OCME Police-Involved Cases by Demographics and Involvement**  
**Table 15**

<b>Demographic</b>	<b>All Police Involved</b>	<b>All Police %</b>	<b>Jail Deaths</b>	<b>Jail %</b>	<b>Prison Deaths</b>	<b>Prison %</b>	<b>Arrest- Related Deaths</b>	<b>Arrest- Related %</b>	<b>Home Incarc Deaths</b>	<b>Home Incarc %</b>
<i>Age</i>										
24 and younger	7	16.28%	2	20%	0	0%	3	15%	2	20%
25-34	14	32.56%	4	40%	2	66.67%	4	20%	4	40%
35-44	12	27.91%	2	20%	1	33.33%	6	30%	3	30%
45-54	5	11.63%	0	0%	0	0%	4	20%	1	10%
55-64	4	9.30%	1	10%	0	0%	3	15%	0	0%
65 and older	1	2.33%	1	10%	0	0%	0	0%	0	0%
<i>Race</i>										
White	30	69.77%	8	80%	3	100%	13	65%	6	60%
Black	12	27.91%	1	10%	0	0%	7	35%	4	40%
Hispanic	0	0%	0	0%	0	0%	0	0%	0	0%
Other	1	2.33%	1	10%	0	0%	0	0%	0	0%
<i>Sex</i>										
Male	39	90.70%	8	80%	3	100%	20	100%	8	80%
Female	4	9.30%	2	20%	0	0%	0	0%	2	20%
<b>Total</b>	<b>43</b>	<b>100%</b>	<b>10</b>	<b>23.26%</b>	<b>3</b>	<b>6.98%</b>	<b>20</b>	<b>46.5%</b>	<b>10</b>	<b>23.26%</b>

## 2016 OCME Police-Involved Cases by Manner of Death

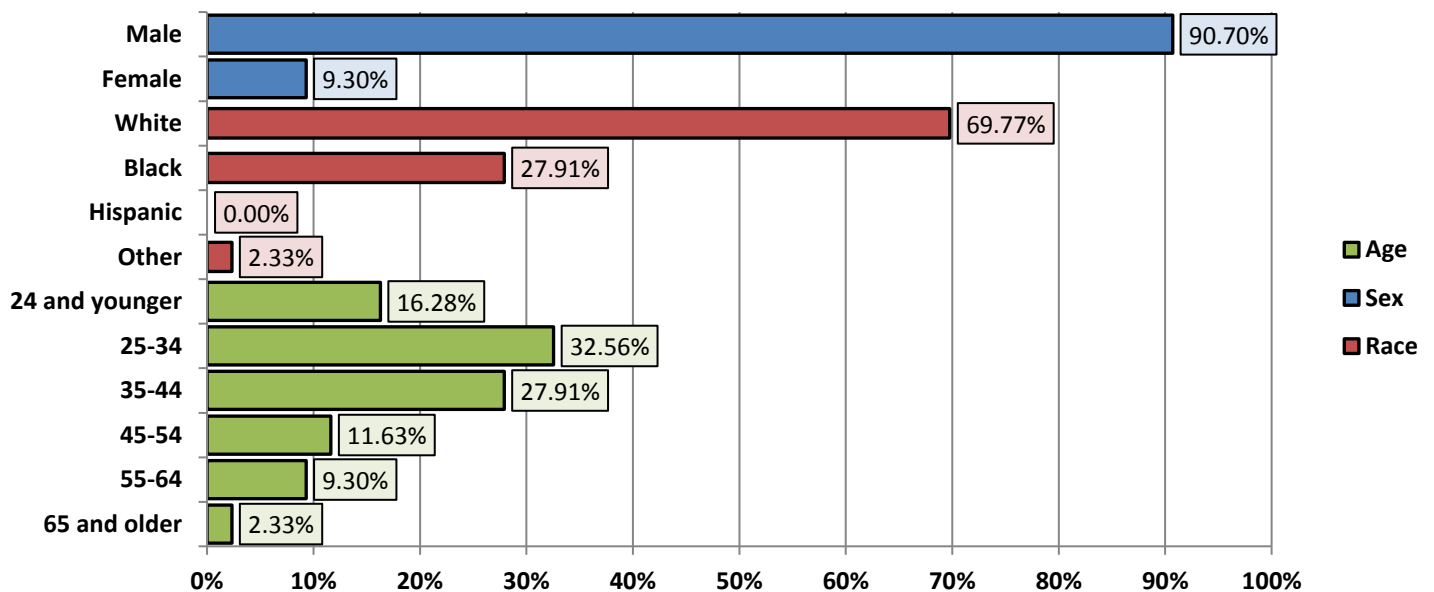
Figure 44



## 2016 OCME Police-Involved Cases by Demographics

Figure 45

n=43

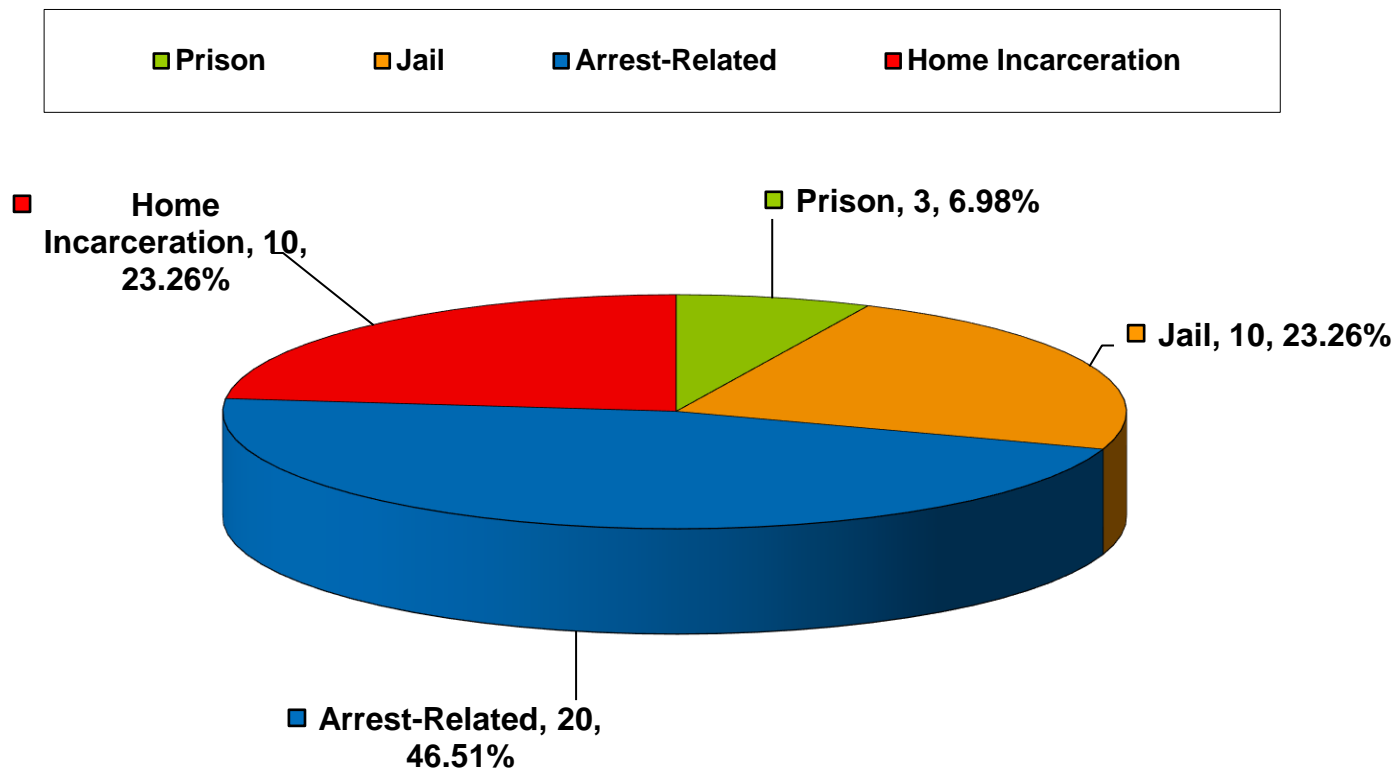




## 2016 OCME Police-Involved Cases by Type of Police Involvement

Figure 46

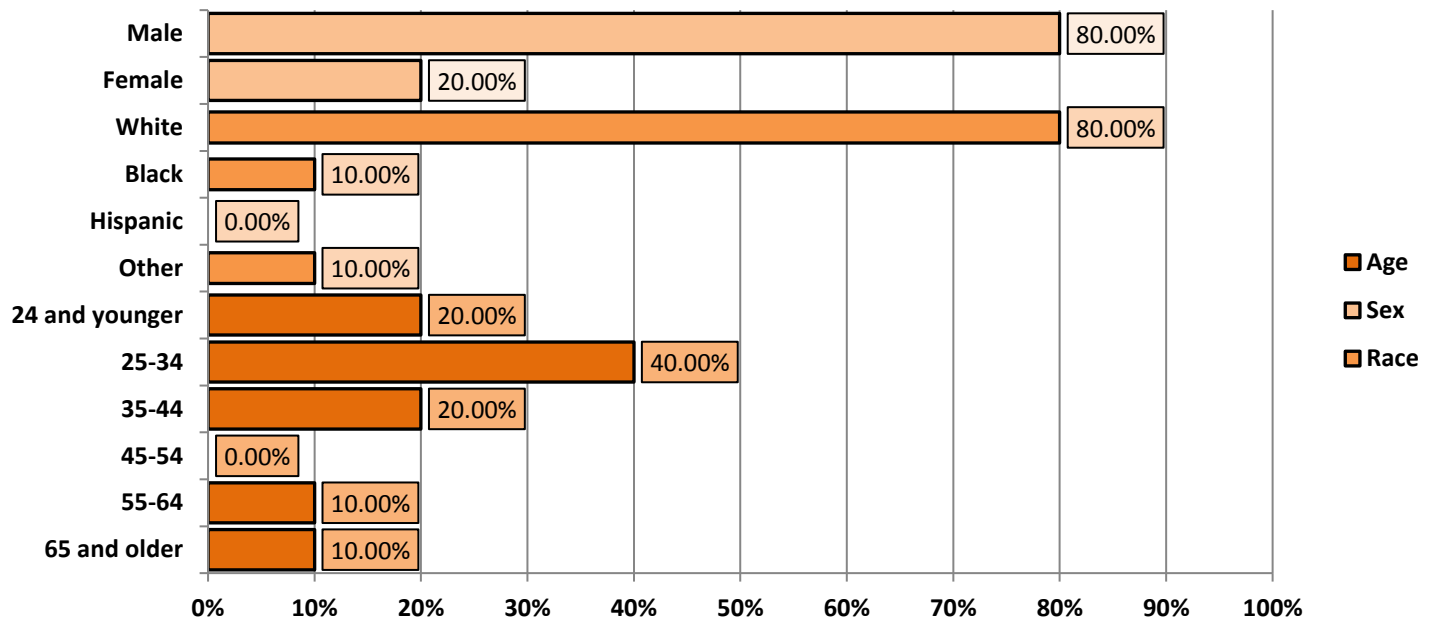
n=43



## 2016 OCME Jail Deaths by Demographics

Figure 47

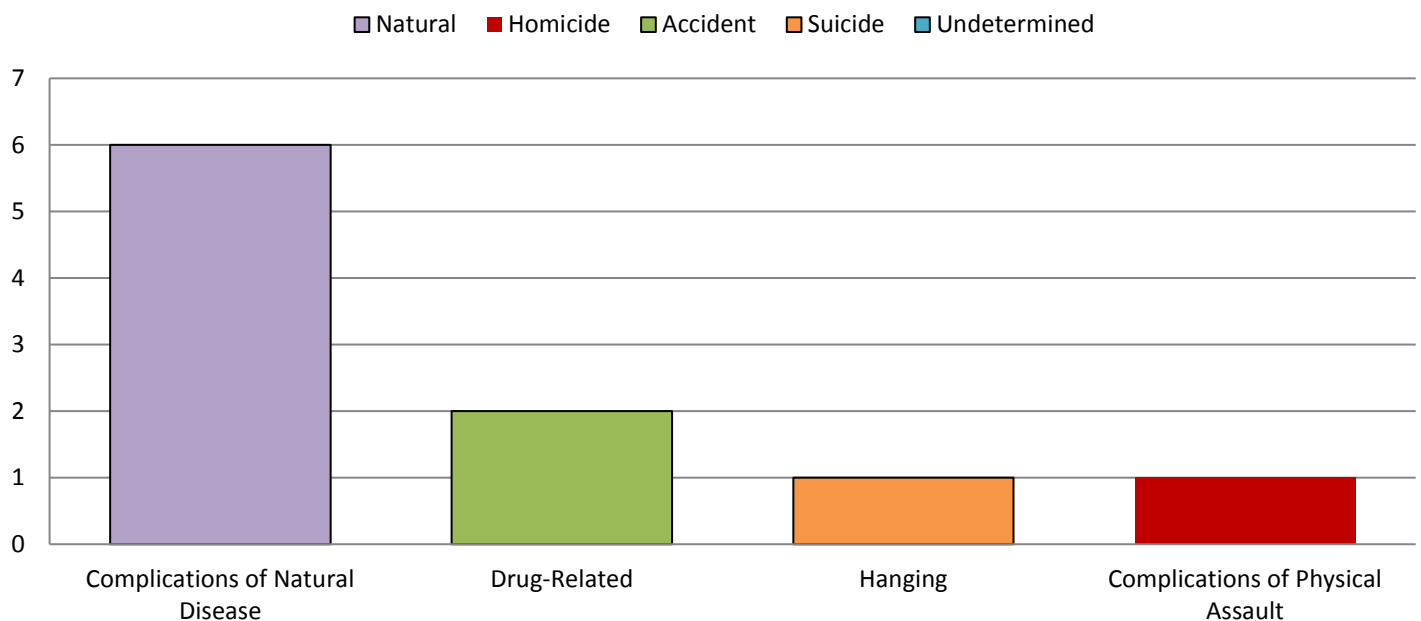
n=10



## 2016 OCME Jail Deaths by Cause and Manner of Death

Figure 48

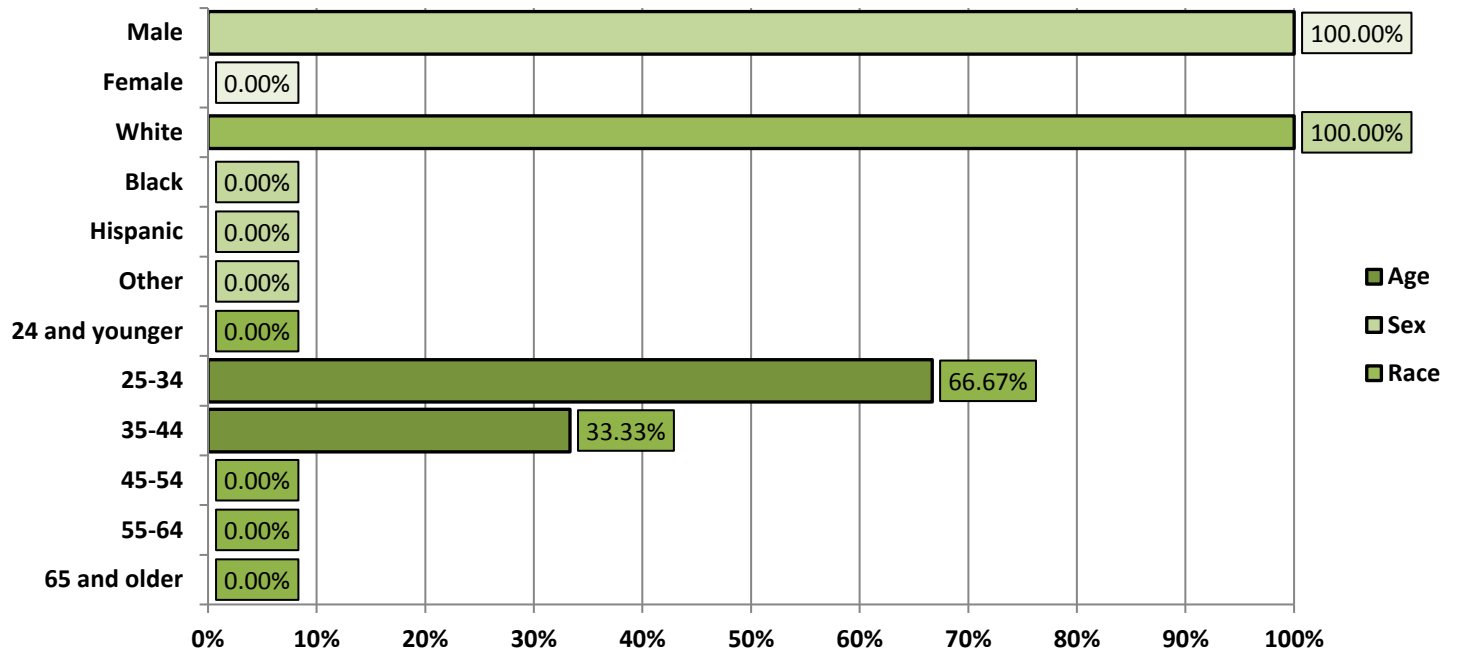
n=10



## 2016 OCME Prison Deaths by Demographics

Figure 49

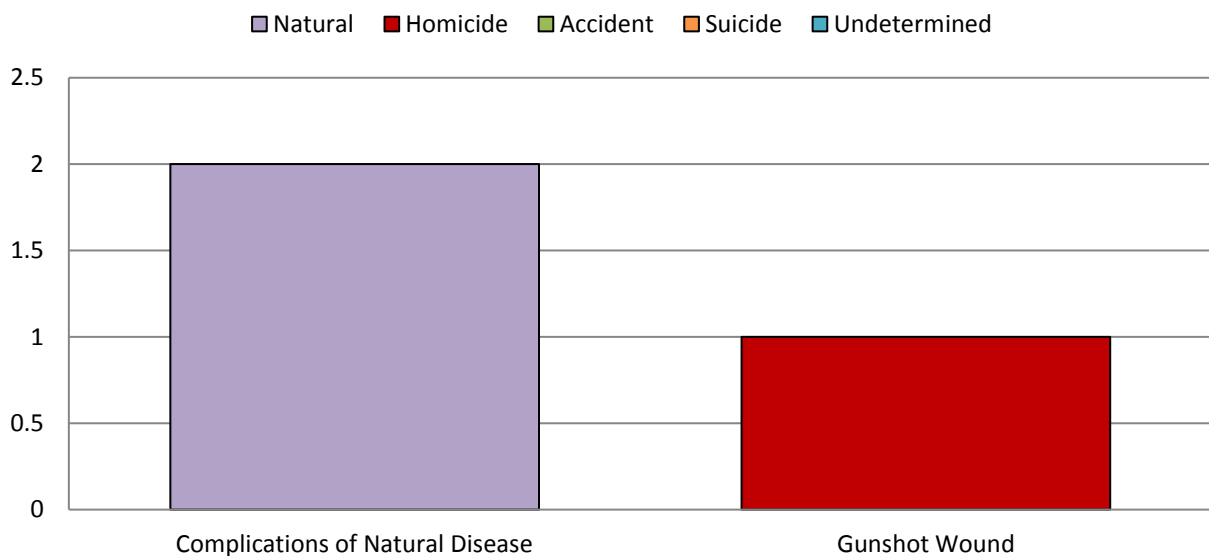
n=3



## 2016 OCME Prison Deaths by Cause and Manner of Death

Figure 50

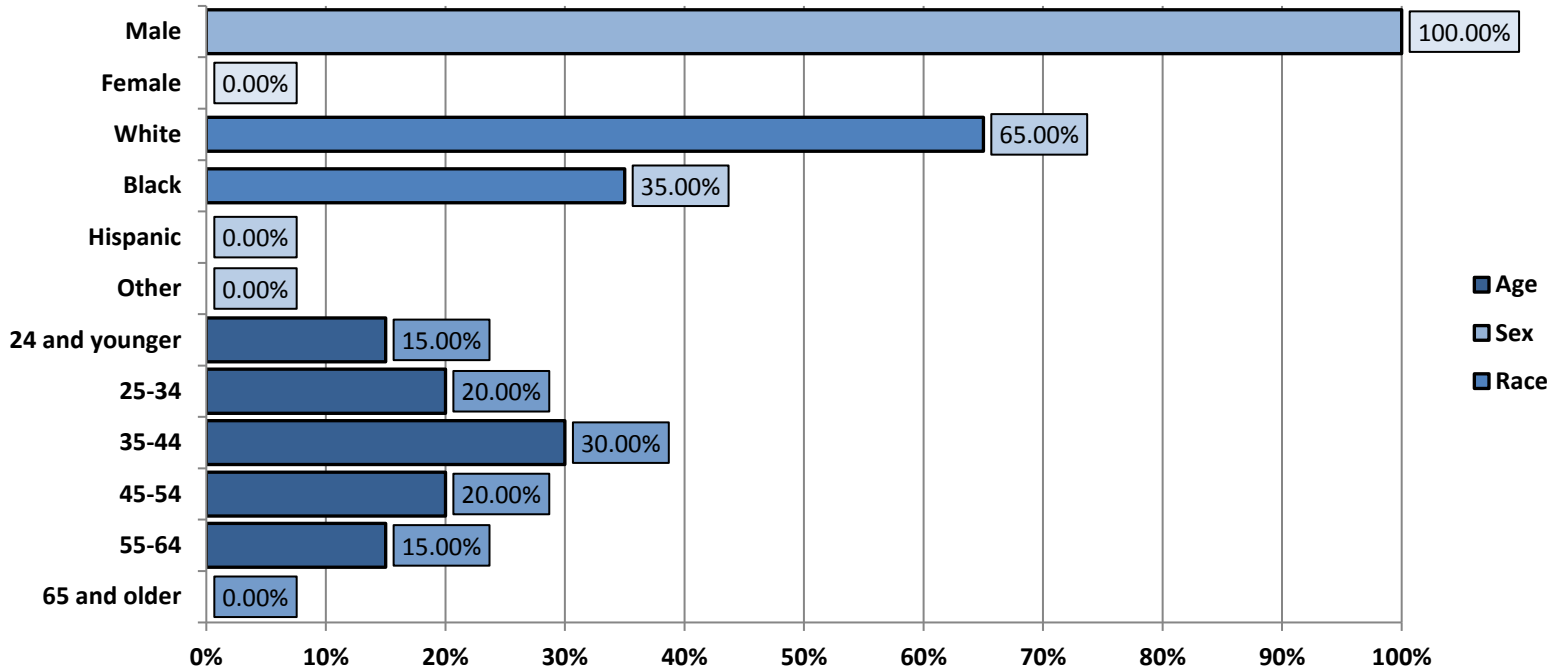
n=3



## 2016 OCME Arrest-Related Deaths by Demographics

Figure 51

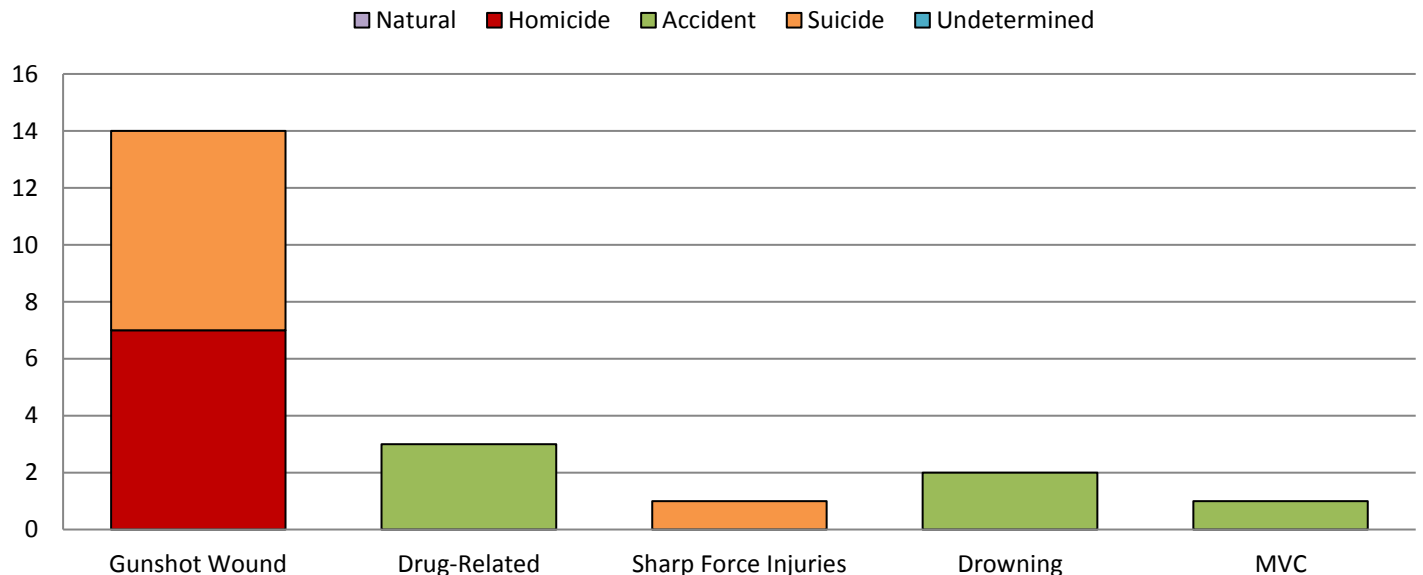
n=20



## 2016 OCME Arrest-Related Deaths by Cause and Manner of Death

Figure 52

n=20

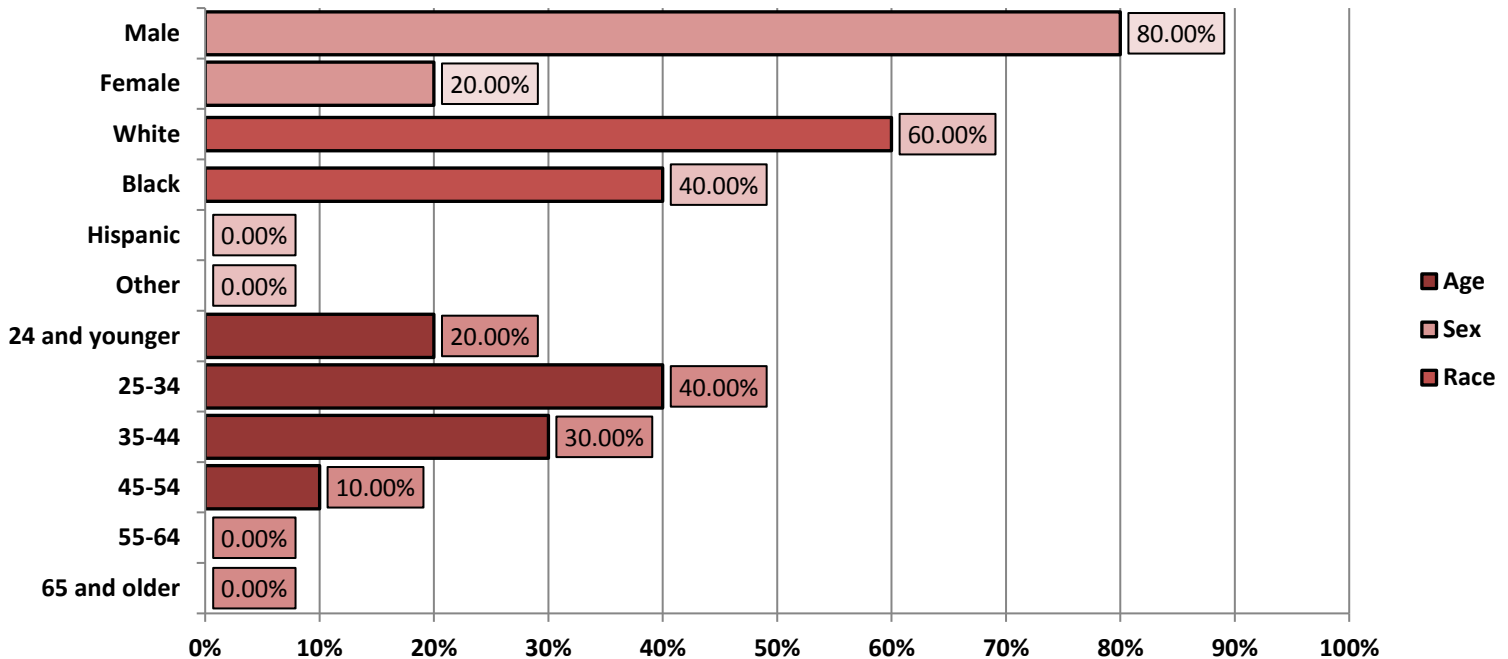


\*1 Multiple Causes of Death (Drowning/Drug-Related)

## 2016 OCME Home Incarceration Deaths by Demographics

**Figure 53**

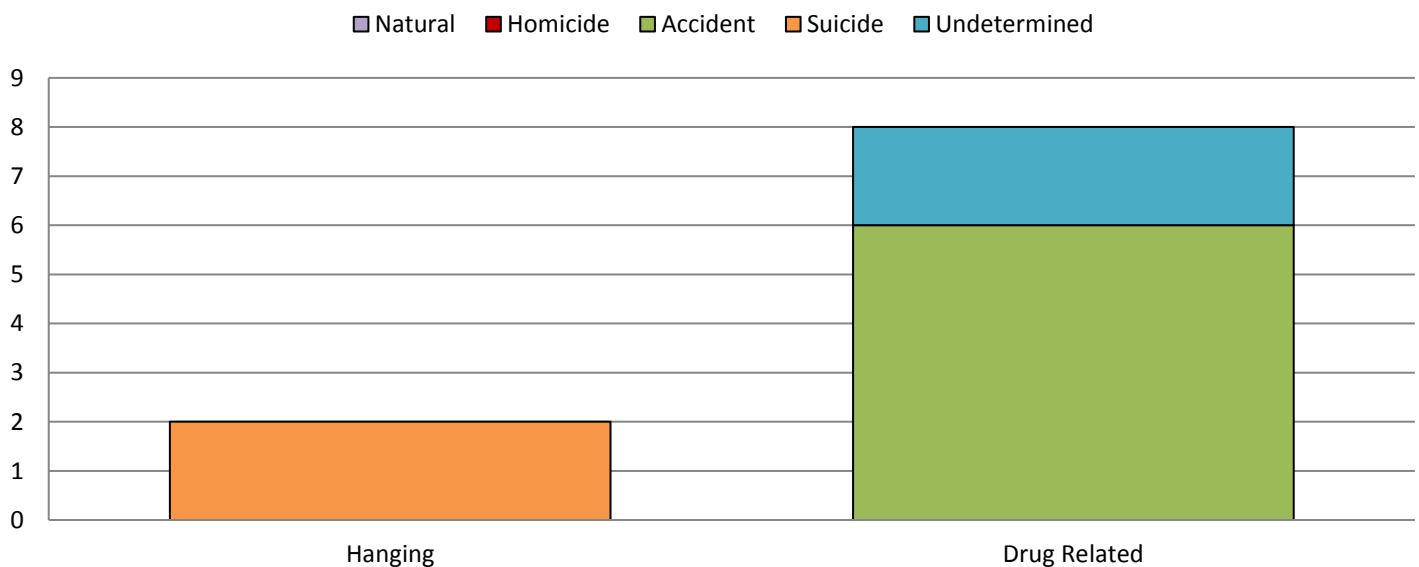
n=10



## 2016 OCME Home Incarceration Deaths by Cause and Manner of Death

**Figure 54**

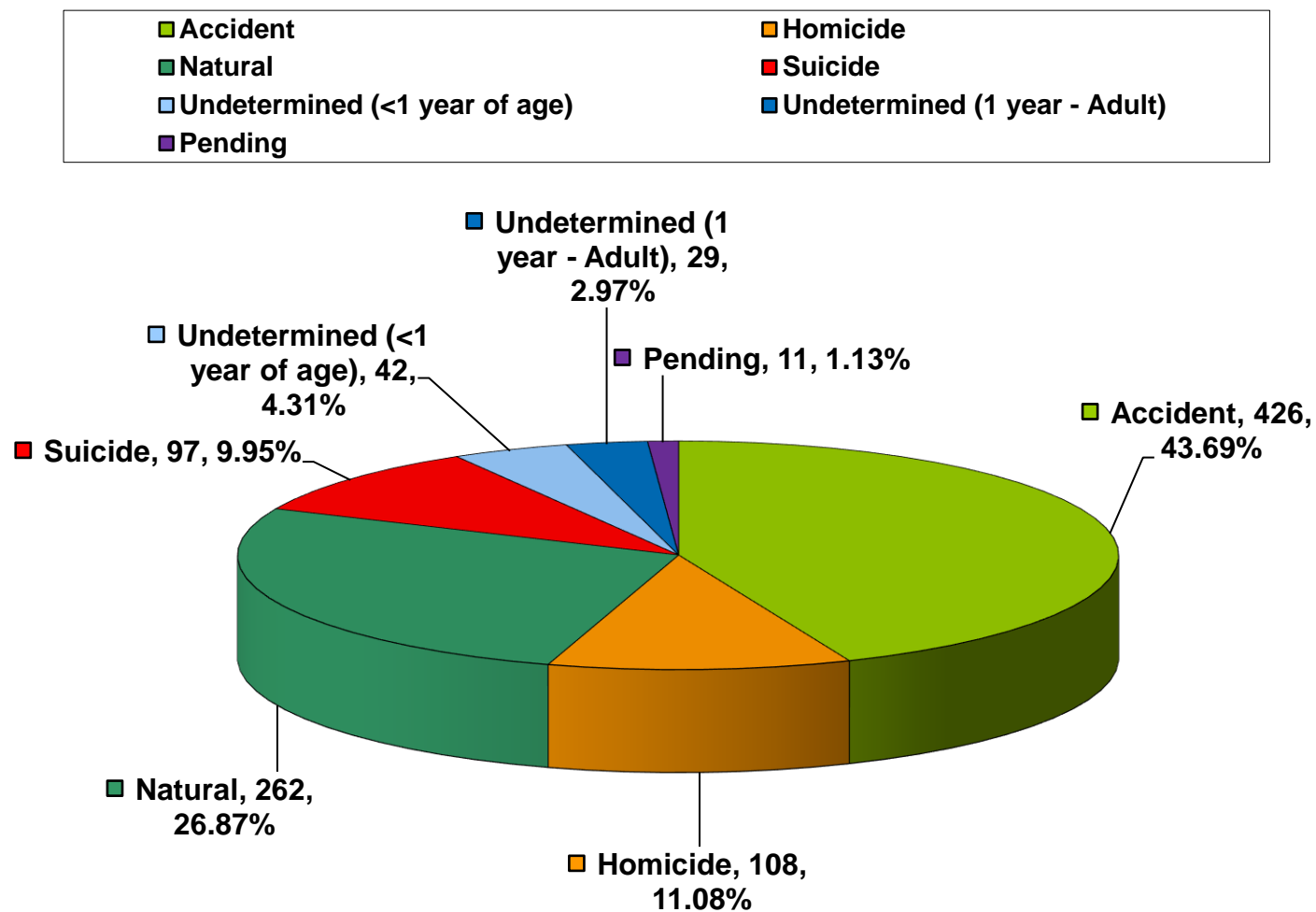
n=10



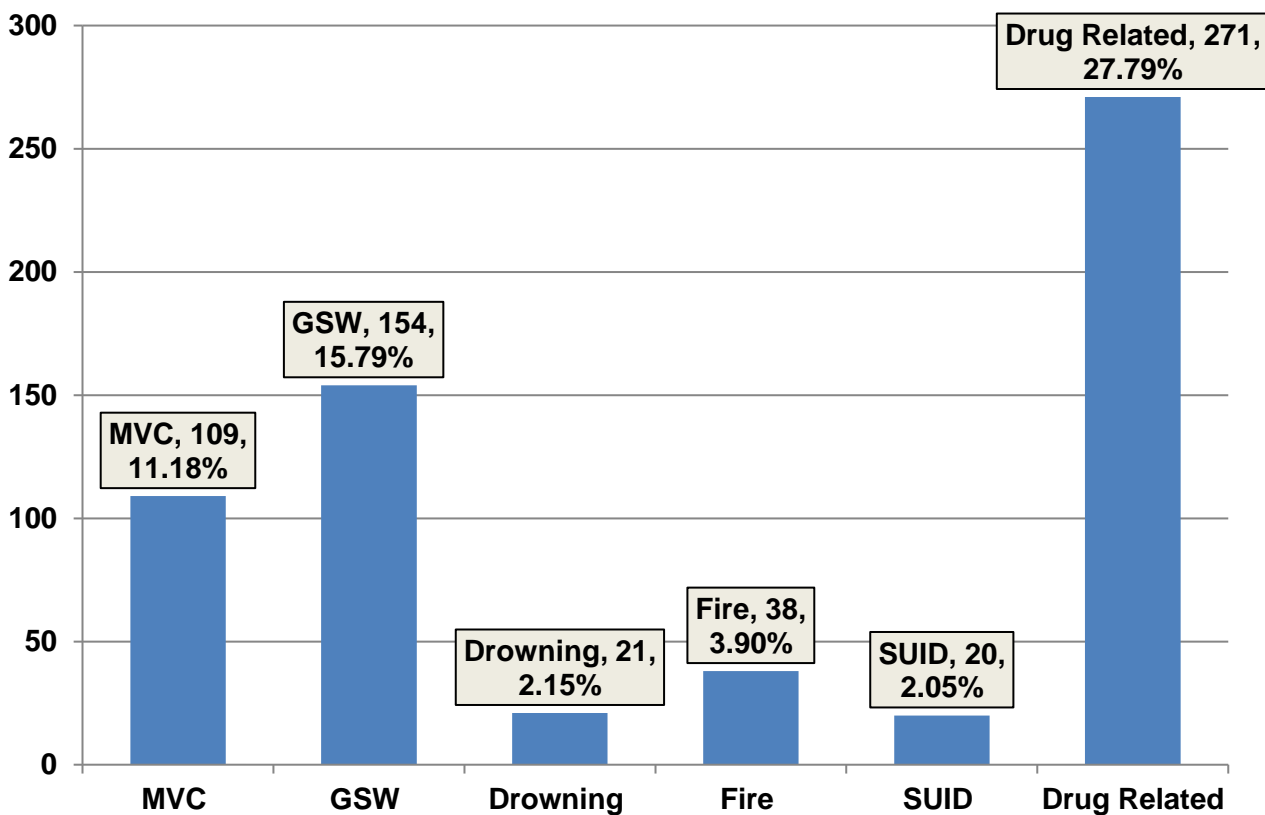
# Eastern Kentucky Regional Medical Examiner Office Data

## 2016 Eastern Kentucky Medical Examiner Cases by Manner of Death

Figure 55





**2016 EKY Cases by Common Causes of Death****Figure 56**

## EKY Totals by Common Causes and Subsequent Manners of Death

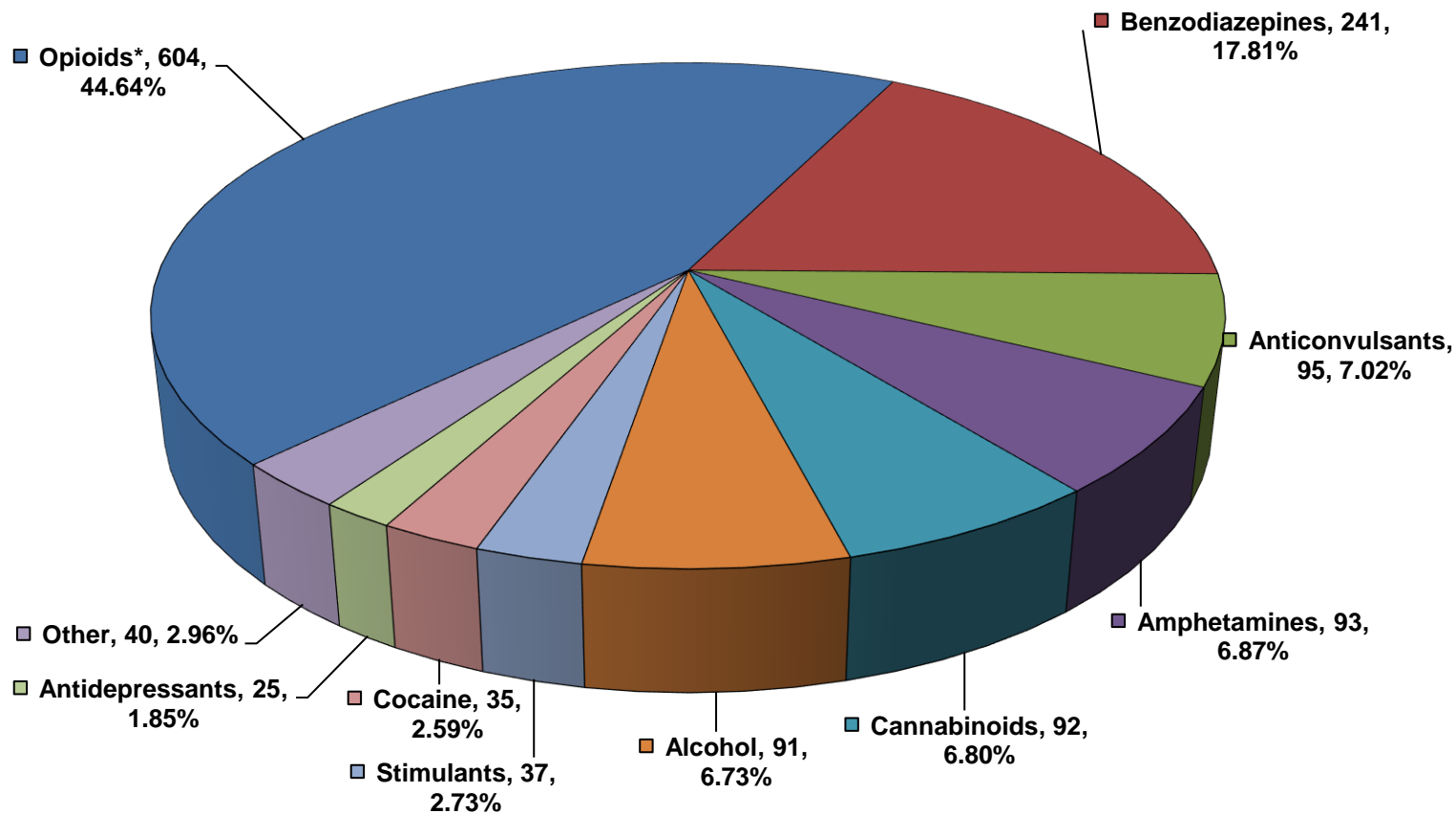
### Table 16

<b>Fatal Event</b>	<b>Total</b>	<b>Percentage</b>
<b><i>Drug Related</i></b>	<b>271</b>	<b>27.79%</b>
Accident	223	82.29%
Natural (Complications of Chronic Use)	37	13.65%
Suicide	7	2.58%
Undetermined	3	1.11%
Pending	1	0.37%
Heroin Present	47	17.34%
Fentanyl Present	84	31.00%
<b><i>Motor Vehicle Accident</i></b>	<b>109</b>	<b>11.18%</b>
Accident	108	99.08%
Undetermined	1	0.92%
<b><i>Gunshot Wound</i></b>	<b>154</b>	<b>15.79%</b>
Accident	4	2.60%
Homicide	82	53.25%
Suicide	61	39.61%
Undetermined	4	2.60%
Pending	3	1.94%
<b><i>Drowning</i></b>	<b>21</b>	<b>2.15%</b>
Accident	19	90.48%
Suicide	1	4.76%
Undetermined	1	4.76%
<b><i>Fire Related</i></b>	<b>38</b>	<b>3.90%</b>
Accident	34	89.48%
Suicide	1	2.63%
Undetermined	2	5.26%
Pending	1	2.63%
<b><i>SUID</i></b>	<b>20</b>	<b>2.05%</b>
Undetermined	20	100%
<b><i>All other EKY Accidents</i></b>	<b>49</b>	<b>5.03%</b>

\*The above does not represent the total number of EKY cases\*

## 2016 EKY Most Common Drug Classes Detected in Drug Related Death Victims

### Figure 57



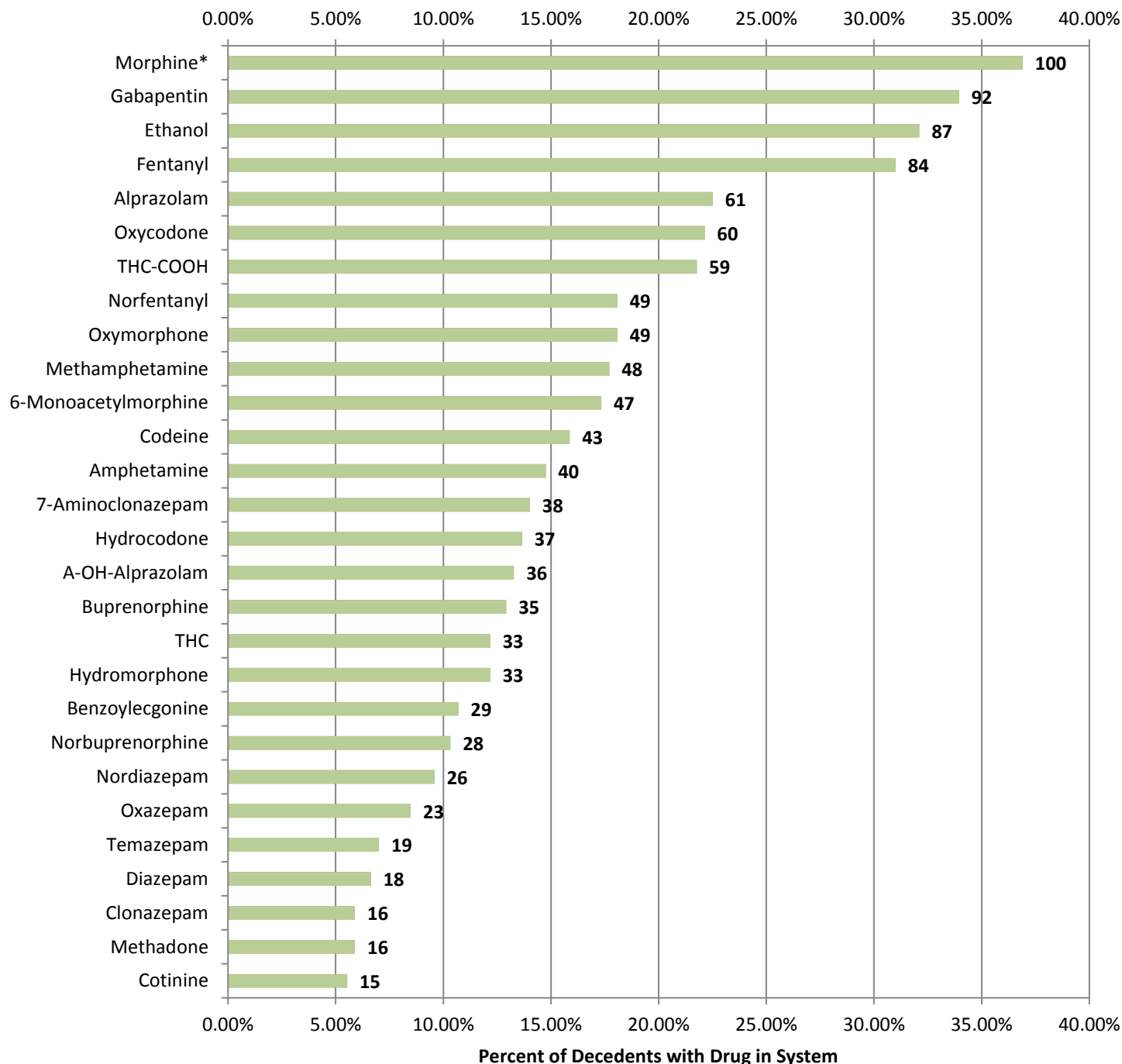
\*Opioids includes all opium-like substances (including natural opiates and synthetic opioids)

^Percent is based off of n=1,353, the total drug count across all EKY drug overdoses

⌘Detected drugs were found in blood, urine, and/or vitreous fluids.

## 2016 EKY Most Frequent Drugs Detected in Drug Related Death Victims

### Figure 58



\*Morphine represents true drug and/or metabolite of Heroin

^Total Percentages >100% due to more than 1 drug being present in many decedents

▣Detected drugs were found in blood, urine, and/or vitreous fluids.

## 2016 EKY Additional Drugs Detected in Drug Related Death Victims Table 17

Drug Name	Total	Percentage
Nicotine	11	4.06%
Caffeine	11	4.06%
EDDP	9	3.32%
Cocaine	6	2.21%
Nortramadol	6	2.21%
Tramadol	6	2.21%
Cyclobenzaprine	4	1.48%
Acetone	4	1.48%
Pseudoephedrine	4	1.48%
Diphenhydramine	4	1.48%
Butalbital	3	1.11%
Dextromethorphan	3	1.11%
Fluoxetine	3	1.11%
Norfluoxetine	3	1.11%
Trazodone	3	1.11%
Hydroxyzine	3	1.11%
Quetiapine	3	1.11%
Carfentanil	2	0.74%
Difluoroethane	3	1.11%
Ibuprofen	2	0.74%
Naloxone	2	0.74%
Levetiracetam	2	0.74%
Amitriptyline	2	0.74%
Bupropion	2	0.74%
Chlorophenylpiperazine	2	0.74%
Norsertaline	2	0.74%
Venlafaxine	2	0.74%
Lorazepam	2	0.74%
5F-AB-PINACA	2	0.74%
Demoxepam	1	0.37%
Sertraline	1	0.37%
Doxylamine	1	0.37%
Aripiprazole	1	0.37%
Pregabalin	1	0.37%
5F-AMB	1	0.37%
Lidocaine	1	0.37%
Promethazine	1	0.37%
Phentermine	1	0.37%
Baclofen	1	0.37%
Salicylates	1	0.37%

## EKY Totals by Special Circumstances and Subsequent Manners of Death

### Table 18

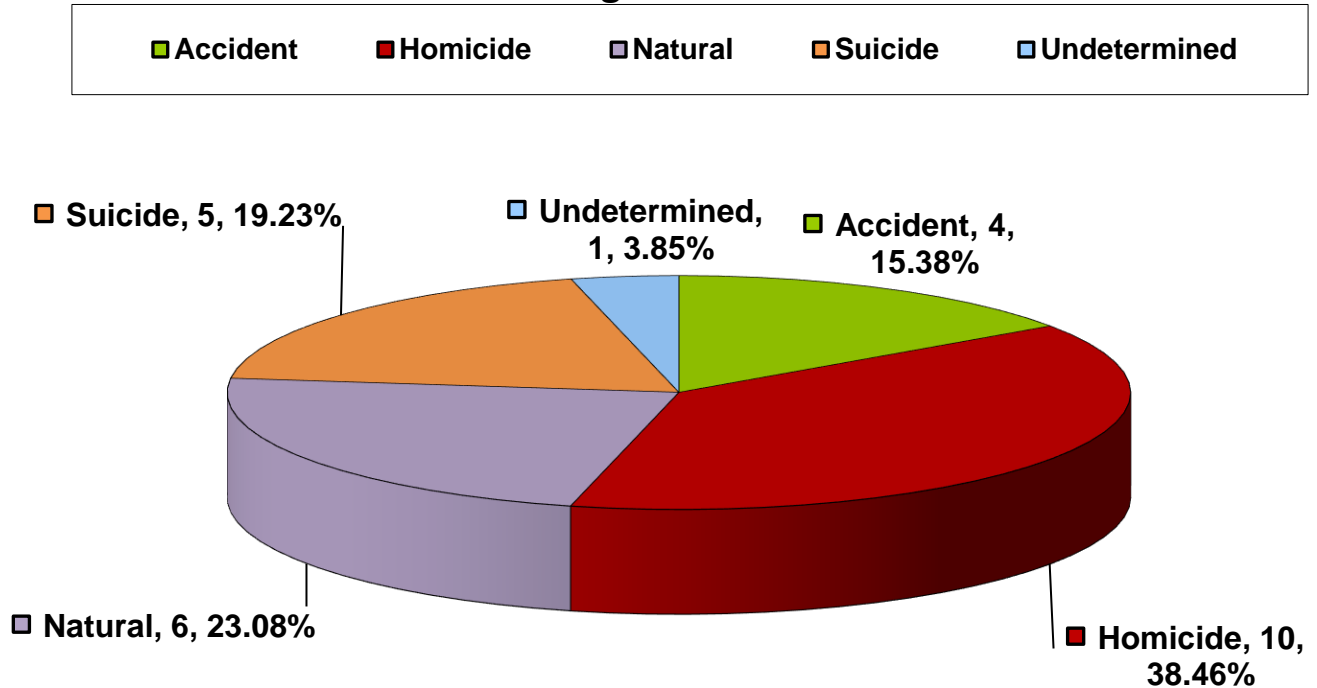
<b>Fatal Event</b>	<b>Total</b>	<b>Percentage</b>
<b><i>Work Related</i></b>	<b>11</b>	<b>1.13%</b>
Accident	9	81.82%
Natural	2	18.18%
<b><i>Jail</i></b>	<b>9</b>	<b>0.92%</b>
Accident	2	22.22%
Suicide	3	33.33%
Natural	4	44.44%
<b><i>Prison</i></b>	<b>5</b>	<b>0.51%</b>
Suicide	1	20%
Homicide	2	40%
Natural	2	40%
<b><i>Arrest-Related</i></b>	<b>11</b>	<b>1.13%</b>
Accident	1	9.09%
Suicide	1	9.09%
Homicide	8	72.73%
Undetermined	1	9.09%
<b><i>Home Incarceration</i></b>	<b>1</b>	<b>0.10%</b>
Accident	1	100%
<b><i>Domestic</i></b>	<b>1</b>	<b>0.10%</b>
Homicide	1	100%
<b><i>Child Abuse</i></b>	<b>3</b>	<b>0.31%</b>
Homicide	3	100%
<b><i>Nursing Home</i></b>	<b>0</b>	<b>0%</b>

**EKY Police-Involved Cases by Demographics and Involvement**  
**Table 19**

<b>Demographic</b>	<b>All Police Involved</b>	<b>All Police %</b>	<b>Jail Deaths</b>	<b>Jail %</b>	<b>Prison Deaths</b>	<b>Prison %</b>	<b>Arrest- Related Deaths</b>	<b>Arrest- Related %</b>	<b>Home Incarc. Deaths</b>	<b>Home Incarc. %</b>
<i>Age</i>										
24 and	2	7.69%	0	0%	1	20%	1	9.09%	0	0%
25-34	14	53.85%	5	55.56%	3	60%	5	45.45%	1	100%
35-44	3	11.54%	1	11.11%	0	0%	2	18.18%	0	0%
45-54	4	15.38%	1	11.11%	0	0%	3	27.27%	0	0%
55-64	3	11.54%	2	22.22%	1	20%	0	0%	0	0%
65 and older	0	0%	0	0%	0	0%	0	0%	0	0%
<i>Race</i>										
White	21	80.77%	8	88.89%	2	40%	10	90.91%	1	100%
Black	4	15.38%	1	11.11%	3	60%	0	0%	0	0%
Hispanic	1	3.85%	0	0%	0	0%	1	9.09%	0	0%
Other	0	0%	0	0%	0	0%	0	0%	0	0%
<i>Sex</i>										
Male	22	85.62%	6	66.67%	5	100%	11	100%	0	0%
Female	4	15.38%	3	33.33%	0	0%	0	0%	1	100%
<b>Total</b>	<b>26</b>	<b>100%</b>	<b>9</b>	<b>31.62%</b>	<b>5</b>	<b>19.23%</b>	<b>11</b>	<b>42.31%</b>	<b>1</b>	<b>3.85%</b>

## 2016 EKY Police-Involved Cases by Manner of Death

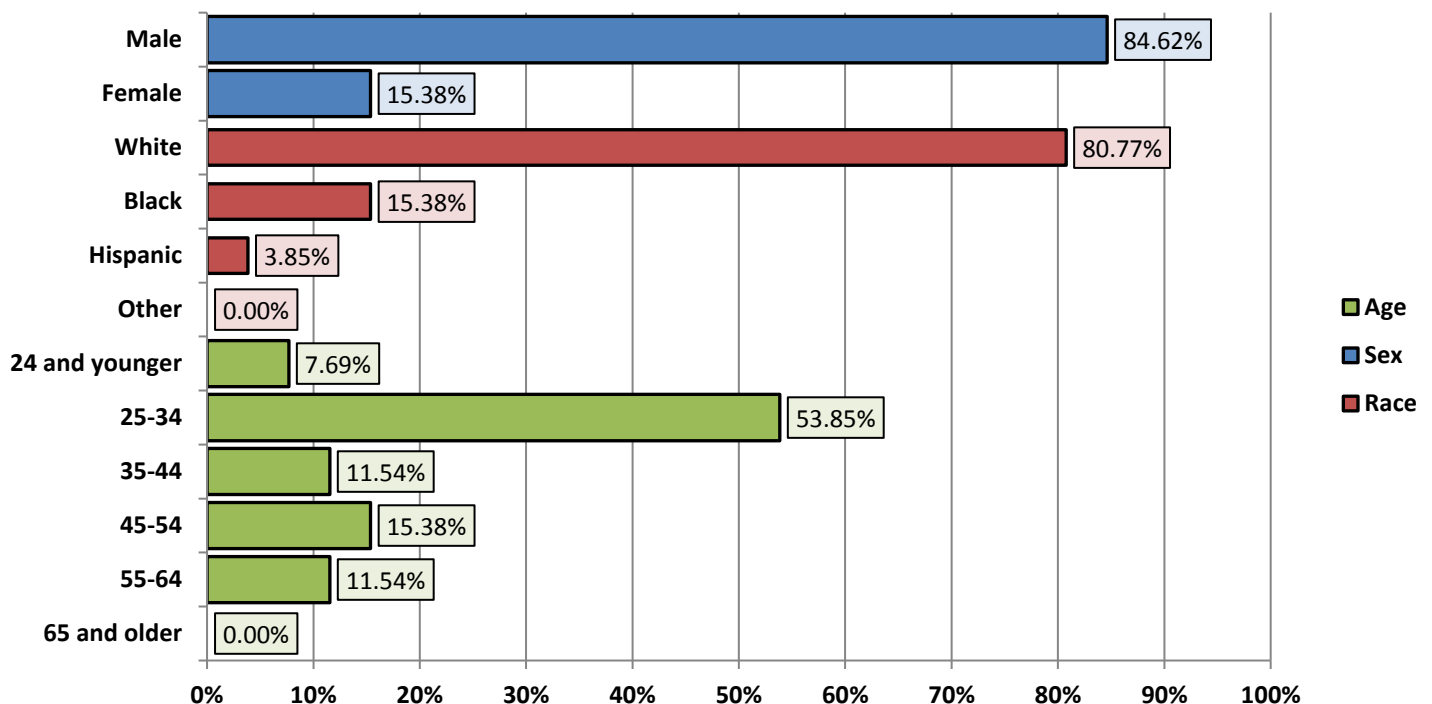
Figure 59



## 2016 EKY Police-Involved Cases by Demographics

Figure 60

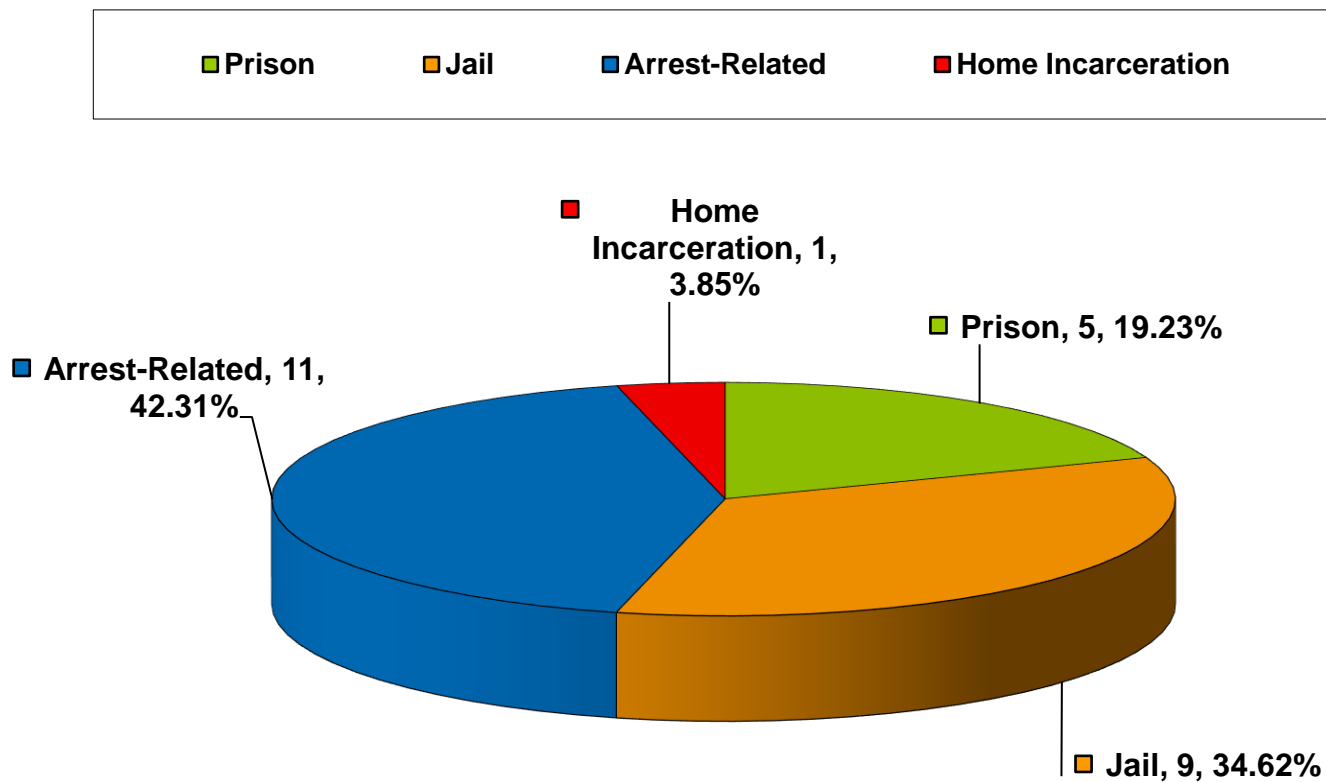
n=26





## 2016 EKY Police-Involved Cases by Type of Police Involvement

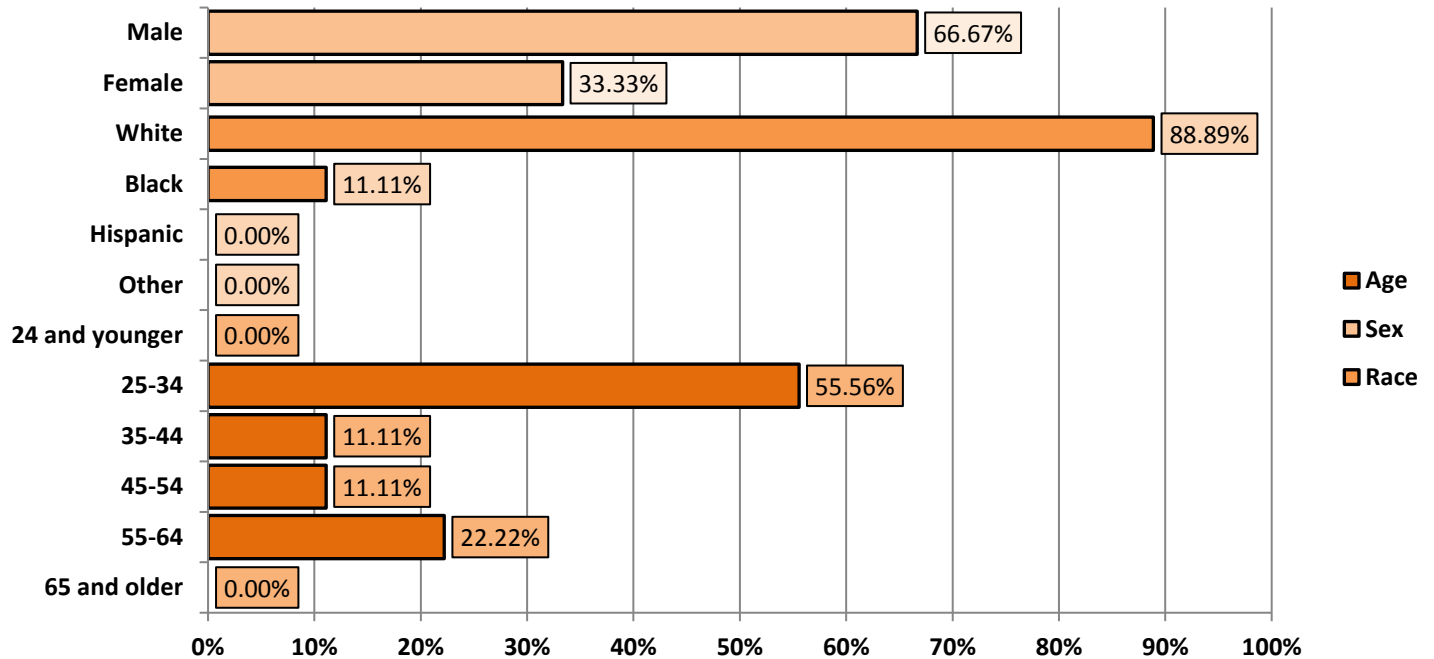
Figure 61  
n=26



## 2016 EKY Jail Deaths by Demographics

Figure 62

n=9

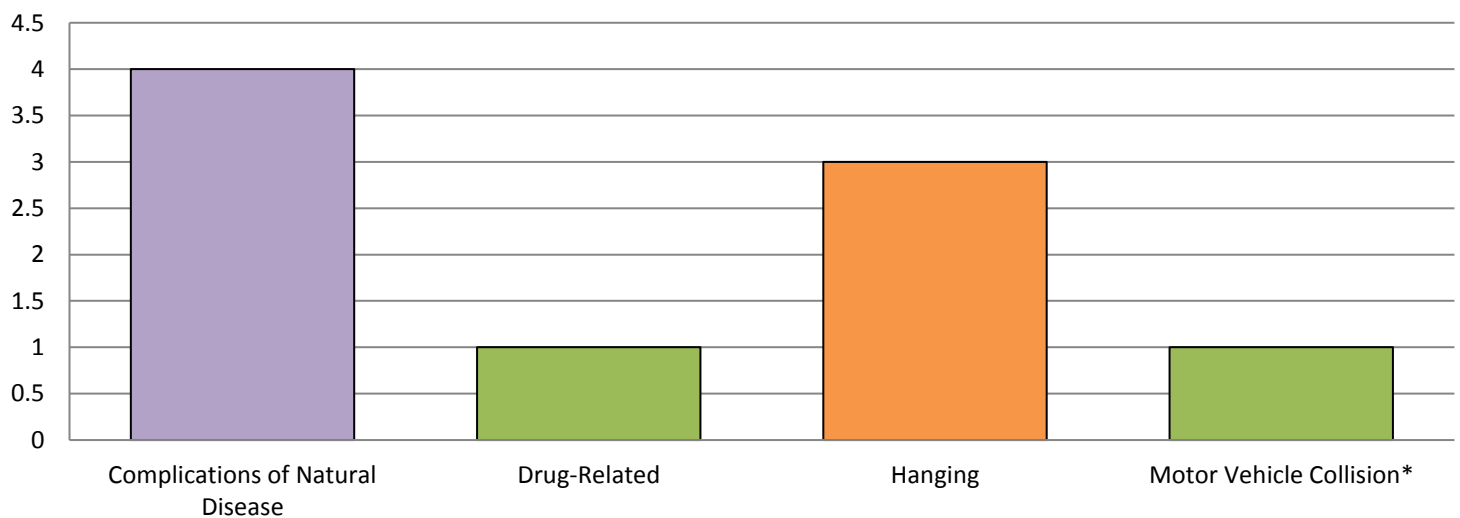


## 2016 EKY Jail Deaths by Cause and Manner of Death

Figure 63

n=9

■ Natural
 ■ Homicide
 ■ Accident
 ■ Suicide
 ■ Undetermined

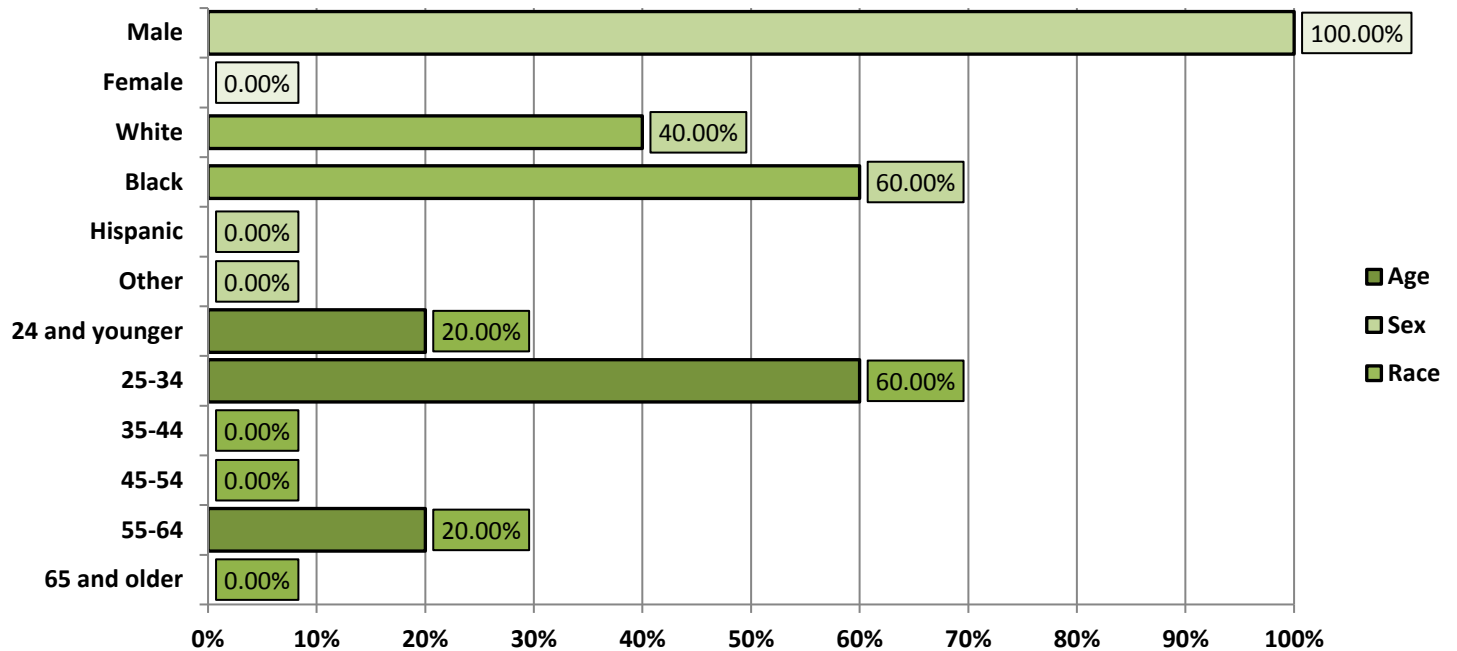


\*MVC, while on work-release duty

## 2016 EKY Prison Deaths by Demographics

Figure 64

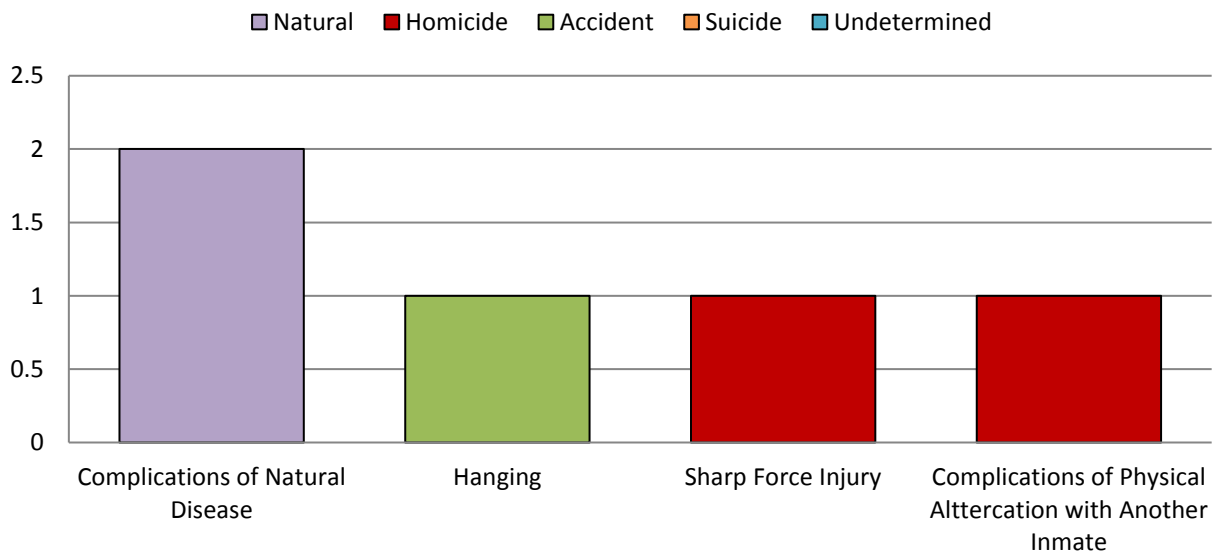
n=5



## 2016 EKY Prison Deaths by Cause and Manner of Death

Figure 65

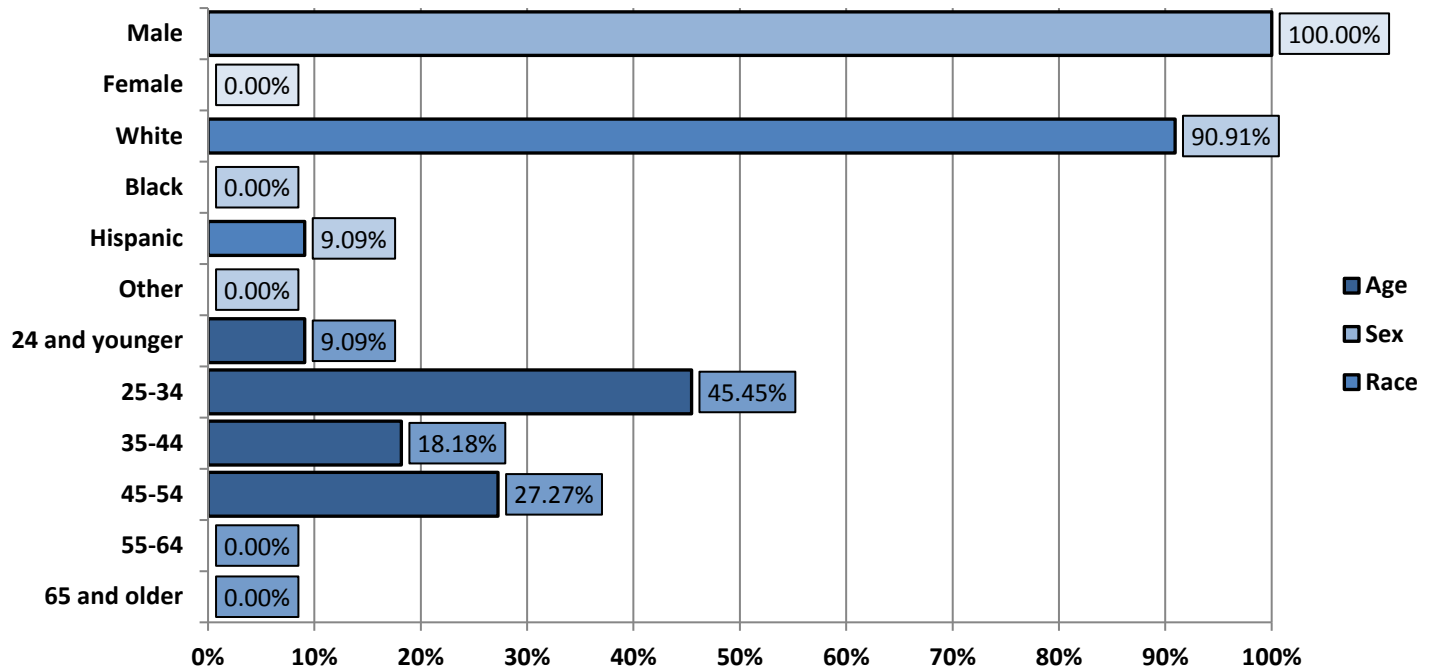
n=5



## 2016 EKY Arrest-Related Deaths by Demographics

Figure 66

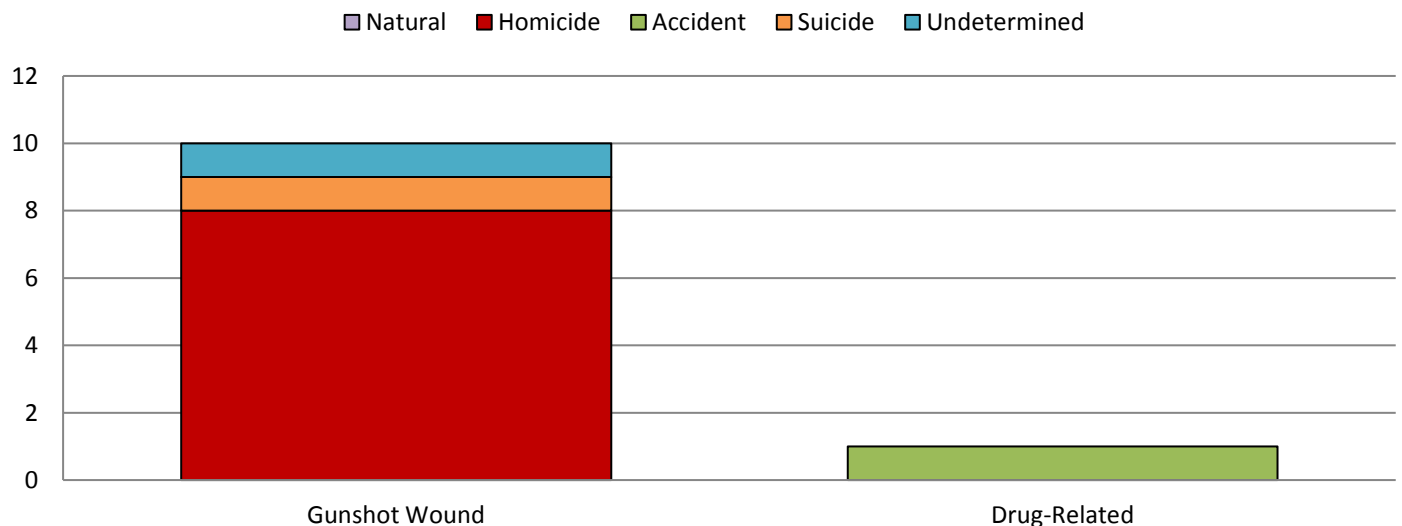
n=11



## 2016 EKY Arrest-Related Deaths by Cause and Manner of Death

Figure 67

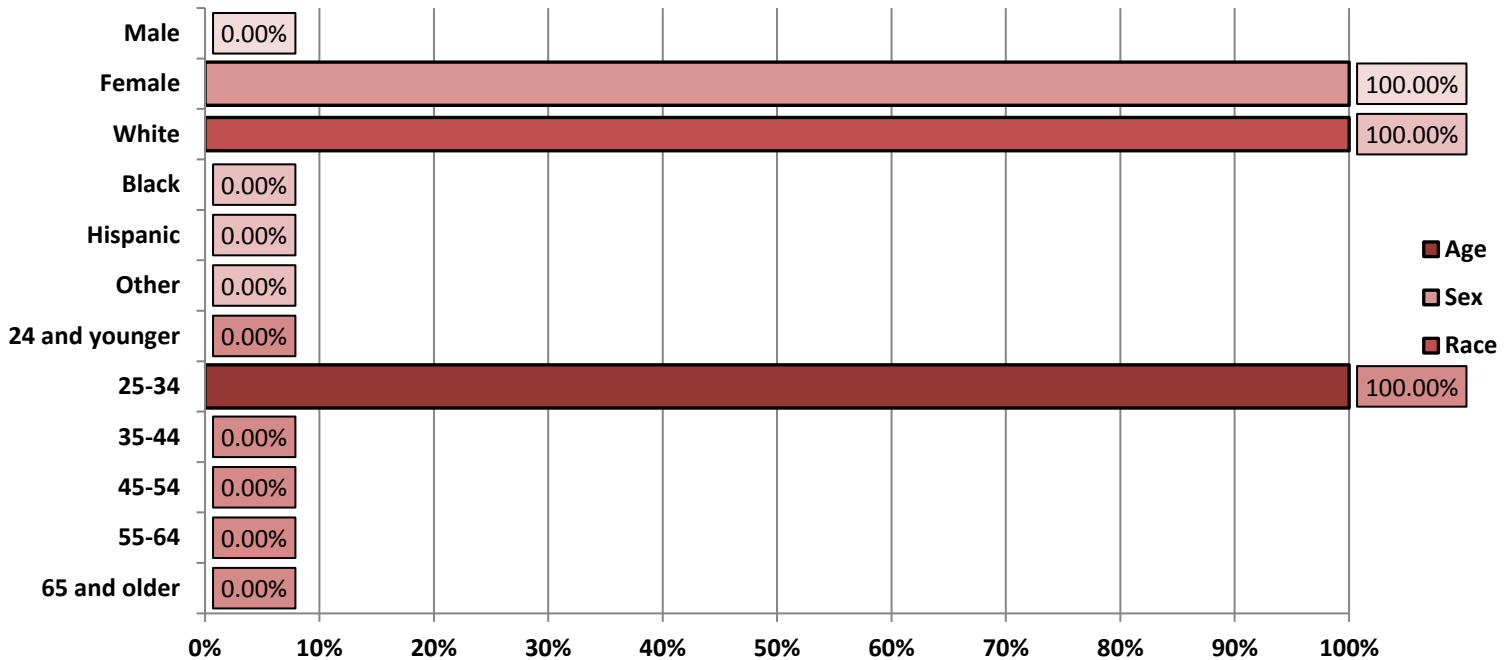
n=11



## 2016 EKY Home Incarceration Deaths by Demographics

Figure 68

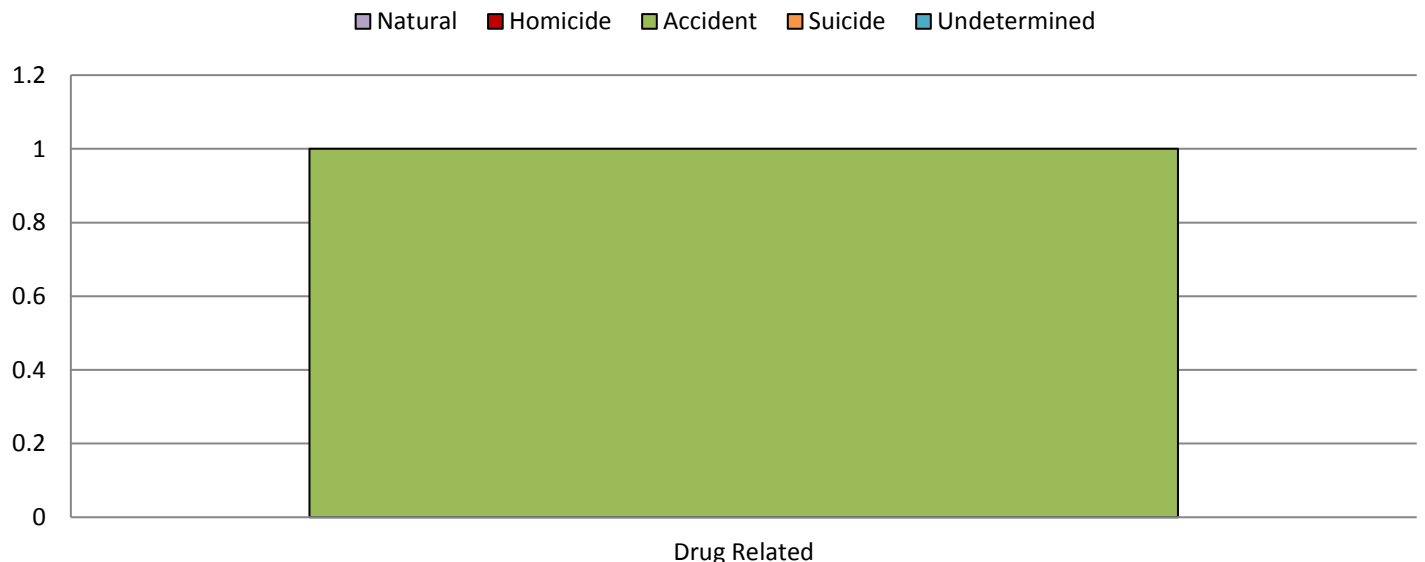
n=1



## 2016 EKY Home Incarceration Deaths by Cause and Manner of Death

Figure 69

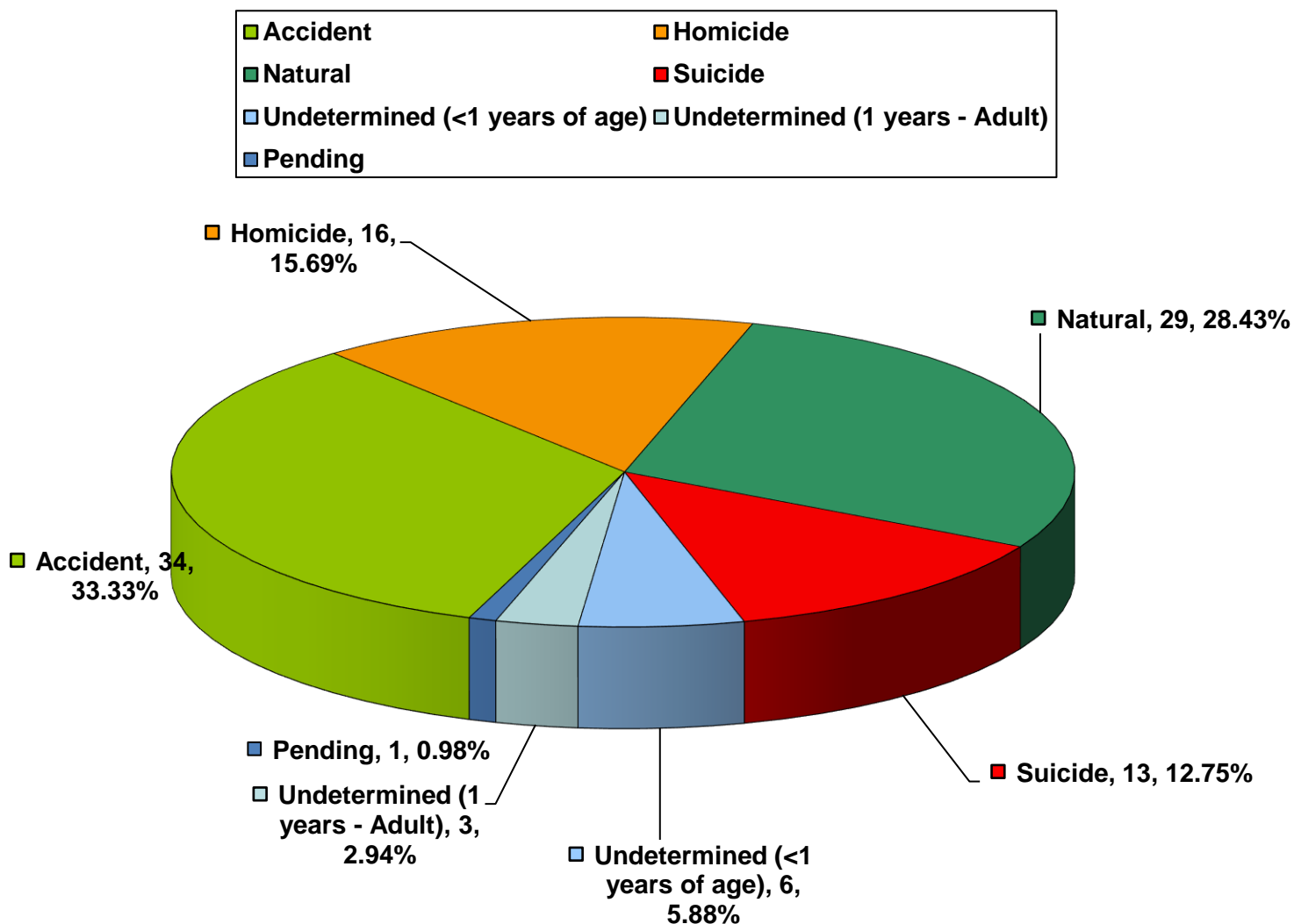
n=1



# Western Kentucky Medical Examiner Office Data

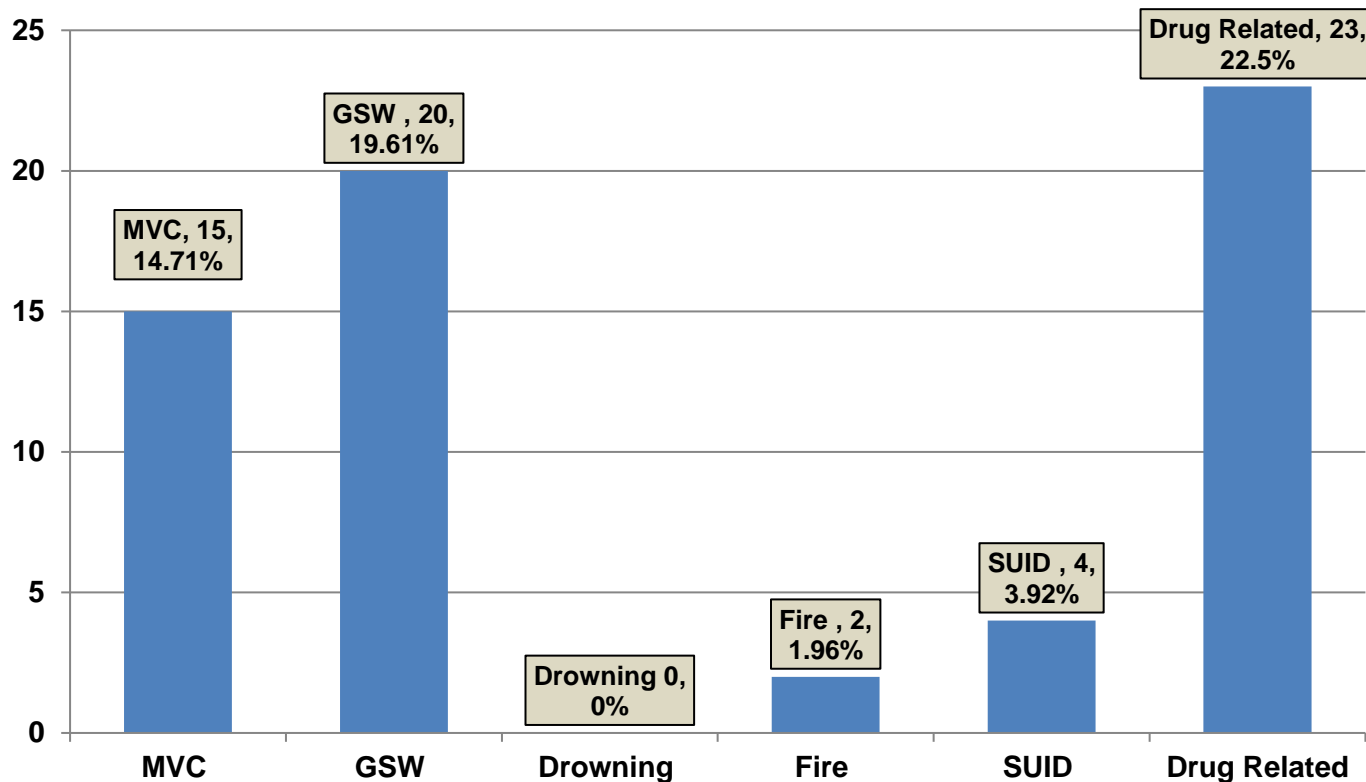
## 2016 Western Kentucky Cases by Manner of Death

### Figure 70



## 2016 Western Kentucky Cases by Common Cause of Death

Figure 71





## Western Kentucky Totals by Common Causes and Subsequent Manners of Death

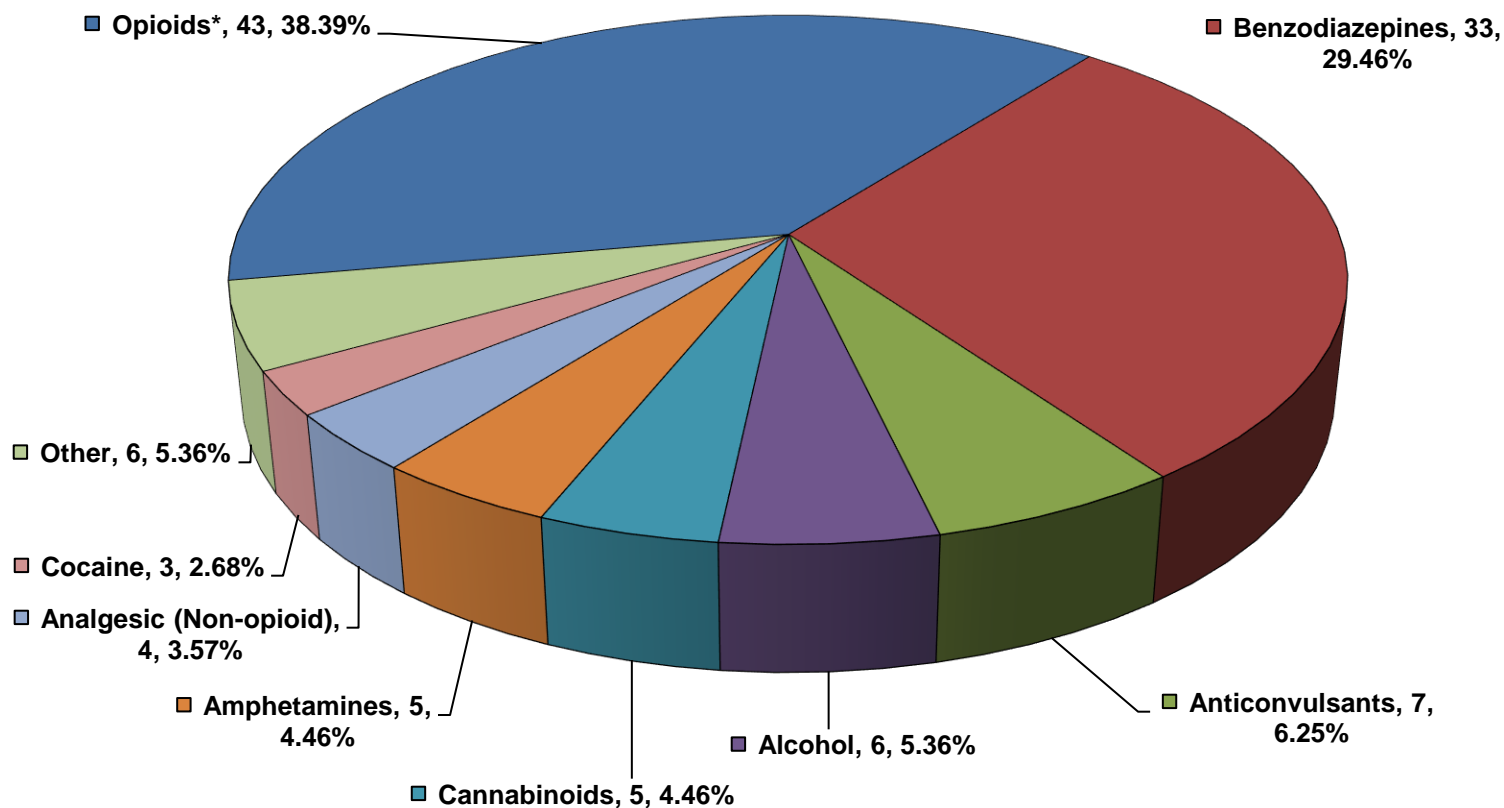
### Table 20

<b>Fatal Event</b>	<b>Total</b>	<b>Percentage</b>
<b><i>Drug Related</i></b>	<b>23</b>	<b>22.55%</b>
Accident	17	73.91%
Natural (Complications of Chronic Use)	4	17.39%
Suicide	2	8.70%
Heroin Present	0	0%
Fentanyl Present	5	21.74%
<b><i>MVC</i></b>	<b>15</b>	<b>14.71%</b>
Accident	15	100%
<b><i>GSW</i></b>	<b>20</b>	<b>19.61%</b>
Homicide	12	60%
Suicide	8	40%
<b><i>Drowning</i></b>	<b>0</b>	<b>0%</b>
<b><i>Fire</i></b>	<b>2</b>	<b>1.96%</b>
Suicide	1	50%
Undetermined	1	50%
<b><i>SUID</i></b>	<b>4</b>	<b>3.92%</b>
Undetermined	4	100%
<b><i>All other WKY Accidents</i></b>	<b>4</b>	<b>3.92%</b>

\*The above does not represent the total number of Western Kentucky cases\*

## 2016 WKY Most Common Drug Classes Detected in Drug Related Death Victims

Figure 72



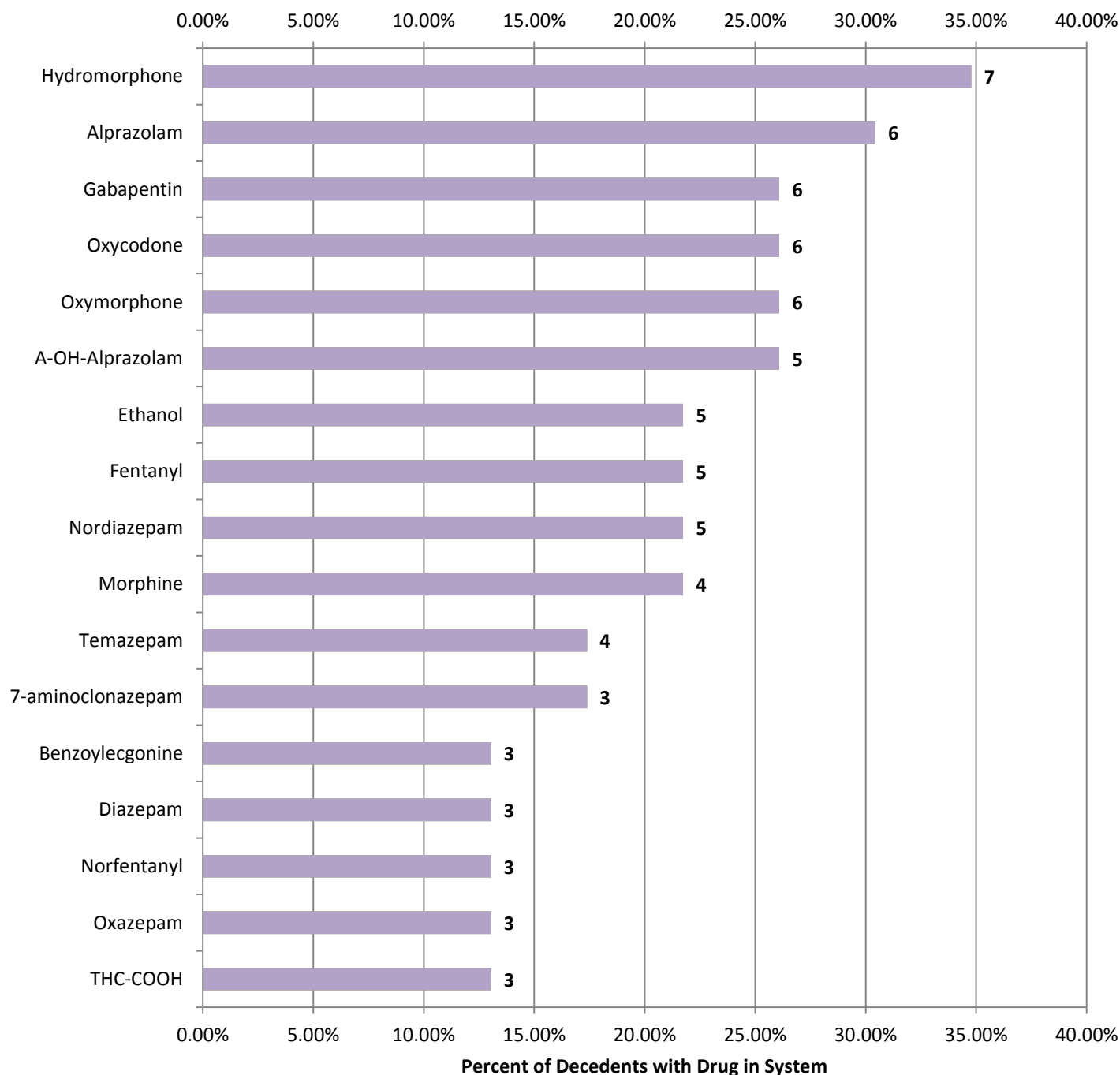
\*Opioids includes all opium-like substances (including natural opiates and synthetic opioids)

^Percent is based off of n=112, the total drug count across all WKY drug overdoses

⌘Detected drugs were found in blood, urine, and/or vitreous fluids.

## 2016 WKY Most Frequent Drugs Detected in Drug Related Death Victims

### Figure 73



^Total Percentages >100% due to more than 1 drug being present in many decedents

¤Detected drugs were found in blood, urine, and/or vitreous fluids.

## 2016 WKY Additional Drugs Detected in Drug Related Death Victims

Table 21

Drug Name	Total	Percentage
Amphetamine	2	8.70%
Clonazepam	2	8.70%
Meprobamate	2	8.70%
Methamphetamine	2	8.70%
THC	2	8.70%
Benzotropine	1	4.35%
Buprenorphine	1	4.35%
Carisoprodol	1	4.35%
Chlordiazepoxide	1	4.35%
Clozapine	1	4.35%
EDDP	1	4.35%
Ephedrine	1	4.35%
Hydroxyzine	1	4.35%
Ibuprofen	1	4.35%
Lorazepam	1	4.35%
Methadone	1	4.35%
Methanol	1	4.35%
Norbuprenorphine	1	4.35%
Norclozapine	1	4.35%
Norsertaline	1	4.35%
Sertraline	1	4.35%
Topiramate	1	4.35%

^Total Percentages >100% due to more than 1 drug being present in many decedents

¤Detected drugs were found in blood, urine, and/or vitreous fluids.

## Western Kentucky Totals by Special Circumstances and Subsequent Manners of Death

### Table 22

<b>Fatal Event</b>	<b>Total</b>	<b>Percentage</b>
<b><i>Work Related</i></b>	<b>0</b>	<b>0%</b>
<b><i>Jail</i></b>	<b>0</b>	<b>0%</b>
<b><i>Prison</i></b>	<b>1</b>	<b>0.98%</b>
Accident	1	100%
<b><i>Arrest-Related</i></b>	<b>3</b>	<b>2.94%</b>
Suicide	1	33.33%
Homicide	2	66.77%
<b><i>Home Incarceration</i></b>	<b>0</b>	<b>0%</b>
<b><i>Domestic</i></b>	<b>6</b>	<b>5.88%</b>
Suicide	1	16.67%
Homicide	5	83.33%
<b><i>Child Abuse</i></b>	<b>1</b>	<b>0.98%</b>
Undetermined	1	100%
<b><i>Nursing Home</i></b>	<b>0</b>	<b>0%</b>

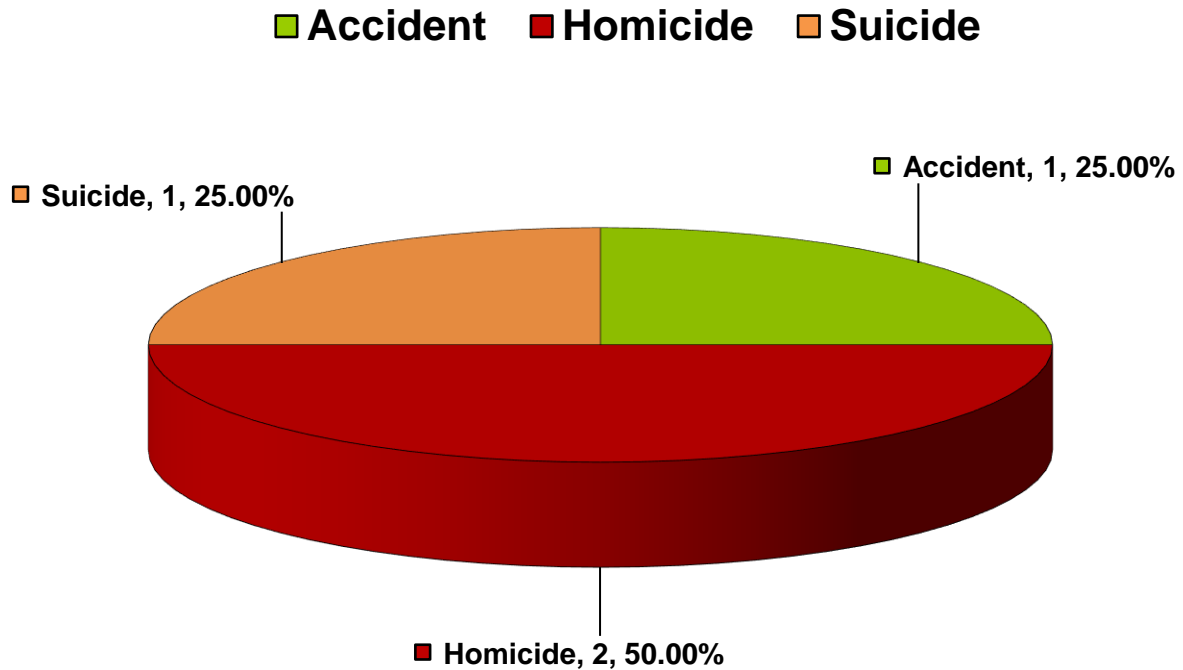
# Western Kentucky Police-Involved Cases by Demographics and Involvement

## Table 23

Demographic	All Police Involved	All Police %	Jail Deaths	Jail %	Prison Deaths	Prison %	Arrest- Related Deaths	Arrest- Related %	Home Incarceration Deaths	Home Incarceration %
<b>Age</b>										
24 and younger	1	25%	0	0%	0	0%	1	33.33%	0	0%
25-34	0	0%	0	0%	0	0%	0	0%	0	0%
35-44	2	50%	0	0%	1	100%	1	33.33%	0	0%
45-54	1	25%	0	0%	0	0%	1	33.33%	0	0%
55-64	0	0%	0	0%	0	0%	0	0%	0	0%
65 and older	0	0%	0	0%	0	0%	0	0%	0	0%
<b>Race</b>										
White	4	100%	0	0%	1	100%	3	100%	0	0%
Black	0	0%	0	0%	0	0%	0	0%	0	0%
Hispanic	0	0%	0	0%	0	0%	0	0%	0	0%
Other	0	0%	0	0%	0	0%	0	0%	0	0%
<b>Sex</b>										
Male	4	100%	0	0%	1	100%	3	100%	0	0%
Female	0	0%	0	0%	0	0%	0	0%	0	0%
<b>Total</b>	4	100%	0	0%	1	25%	3	75%	0	0%

## 2016 WKY Police-Involved Cases by Manner of Death

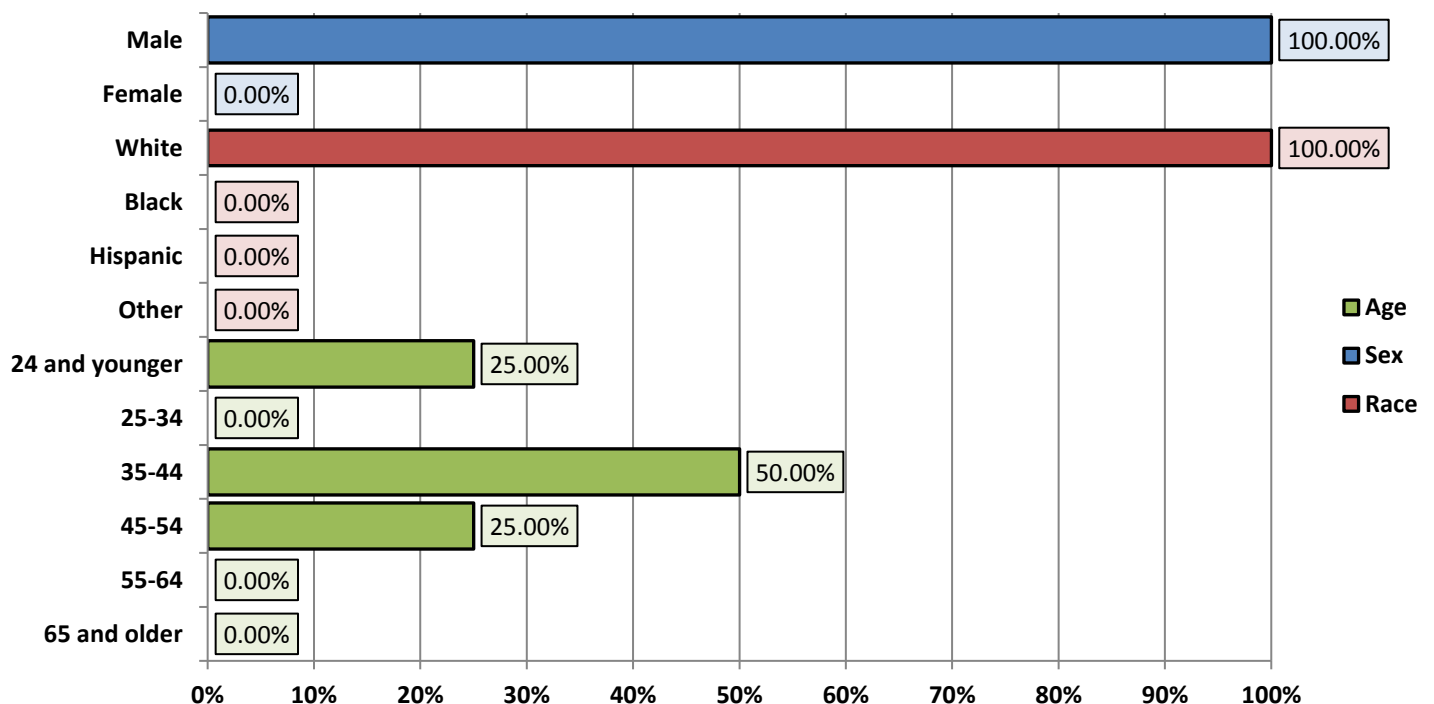
Figure 74



## 2016 WKY Police-Involved Cases by Demographics

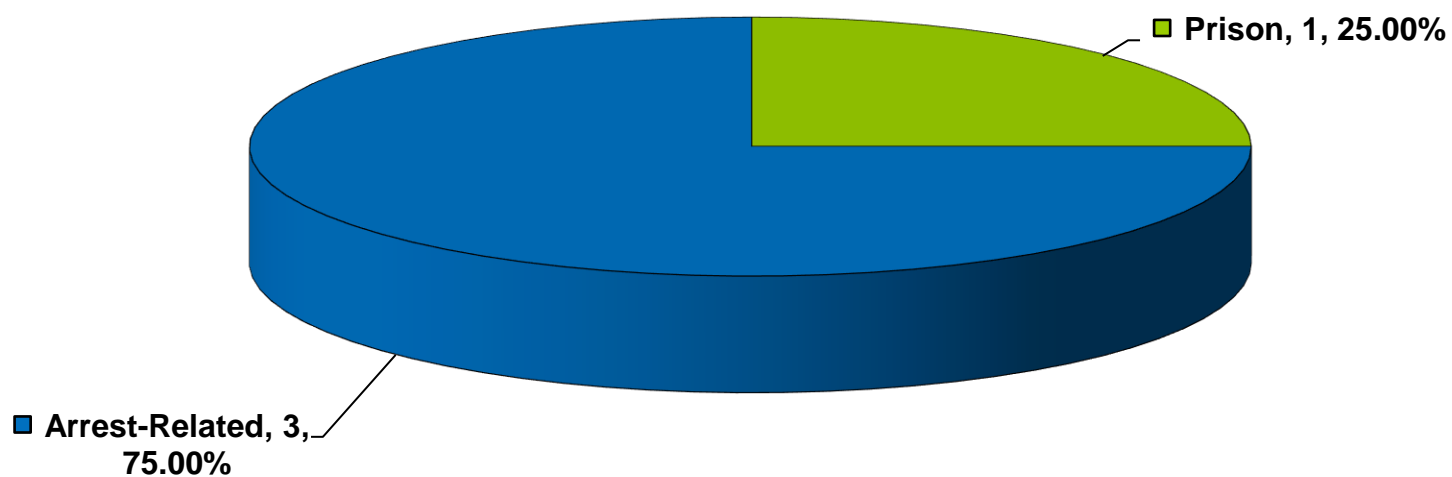
Figure 75

n=4



## 2016 WKY Police-Involved Cases by Type of Police Involvement

Figure 76  
n=4

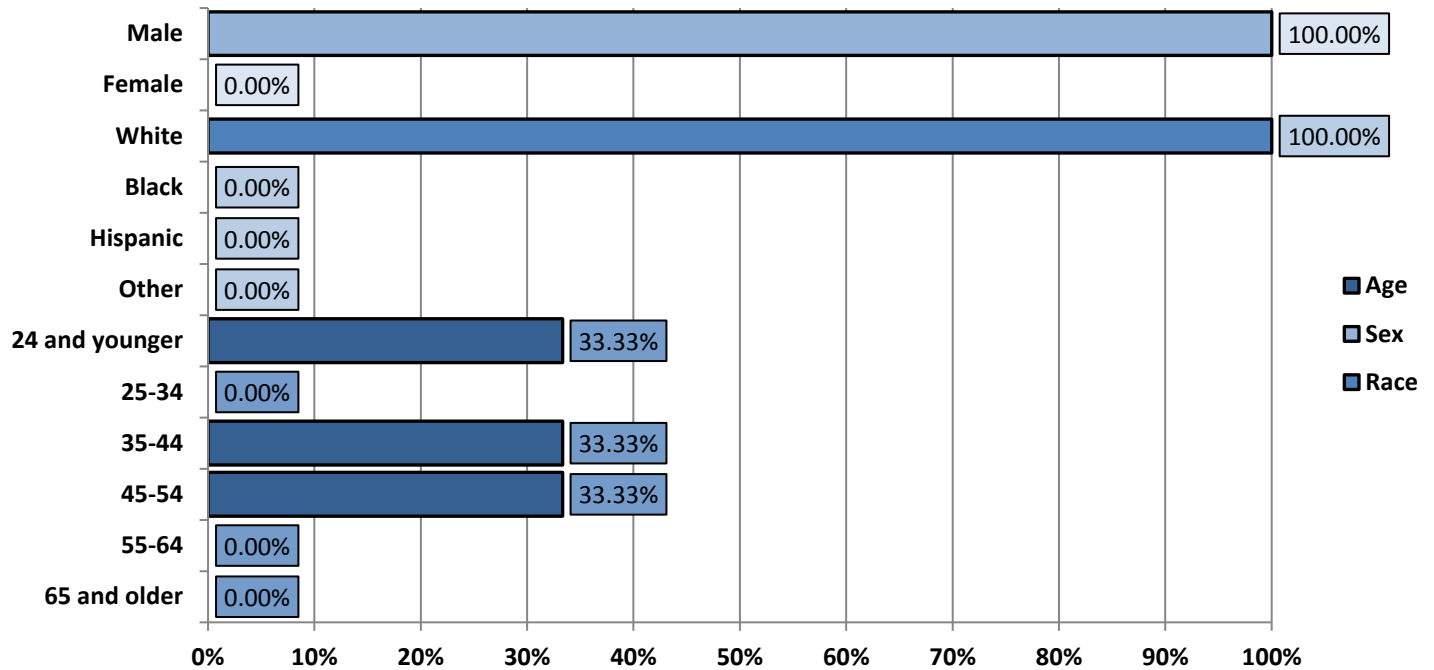




## 2016 WKY Arrest-Related Deaths by Demographics

Figure 77

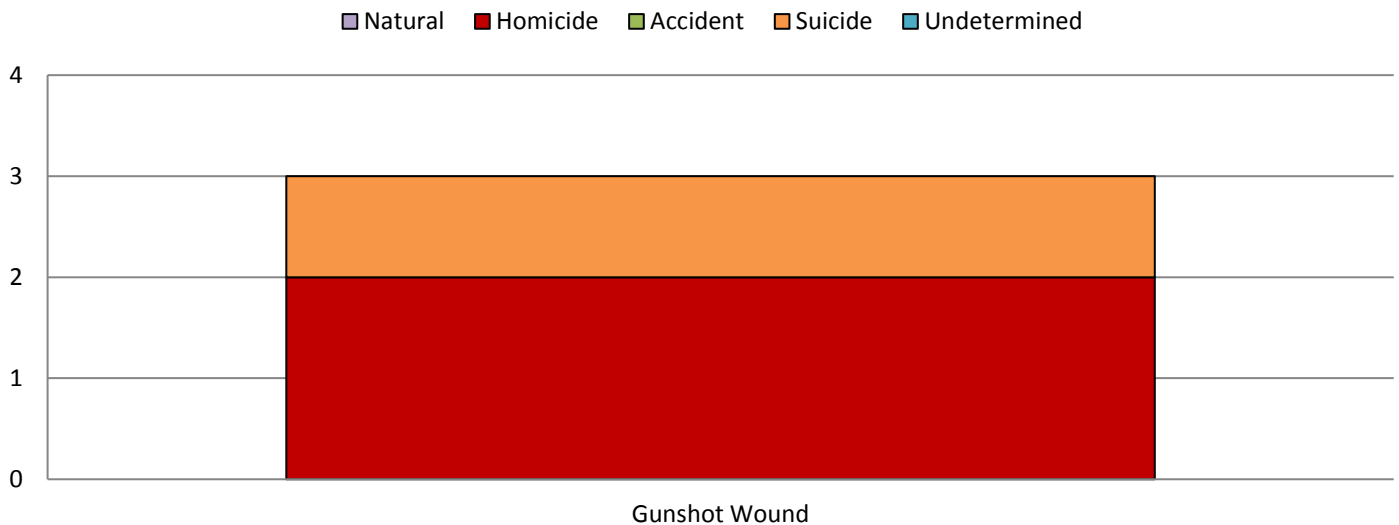
n=3



## 2016 WKY Arrest-Related Deaths by Cause and Manner of Death

Figure 78

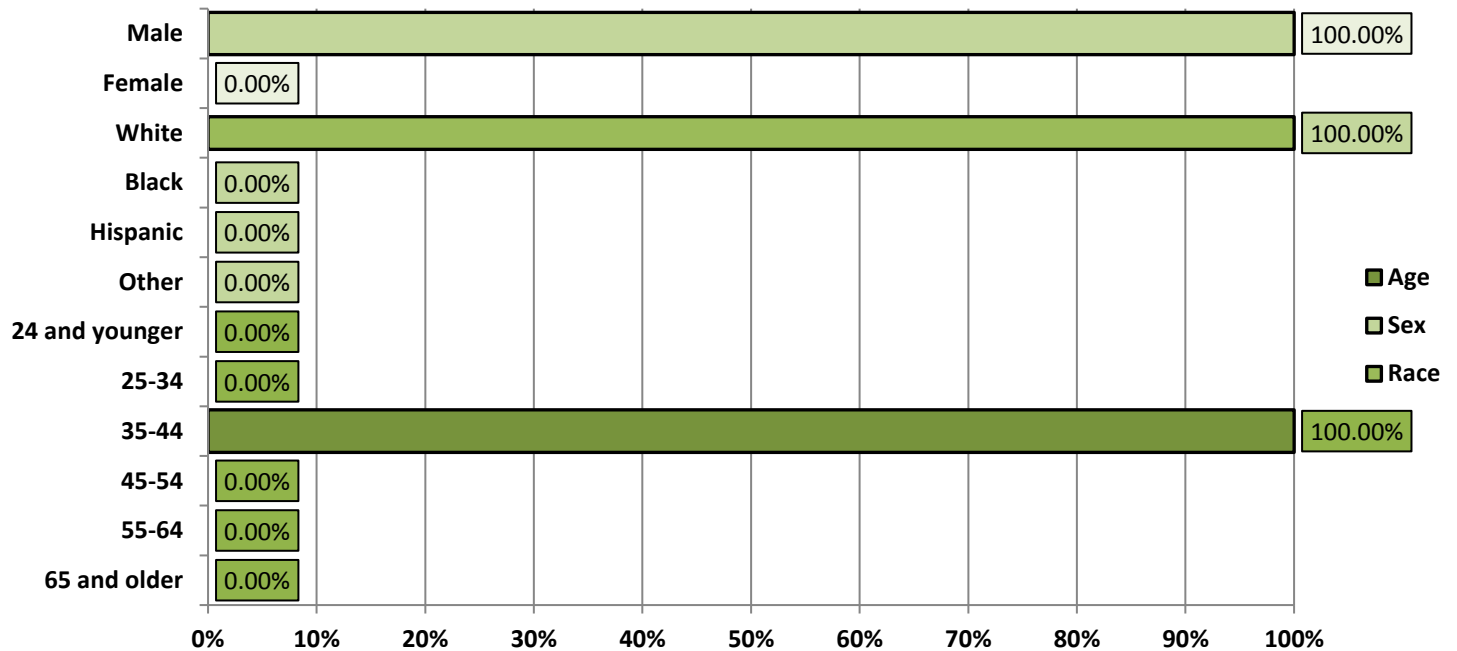
n=3



## 2016 WKY Prison Deaths by Demographics

Figure 79

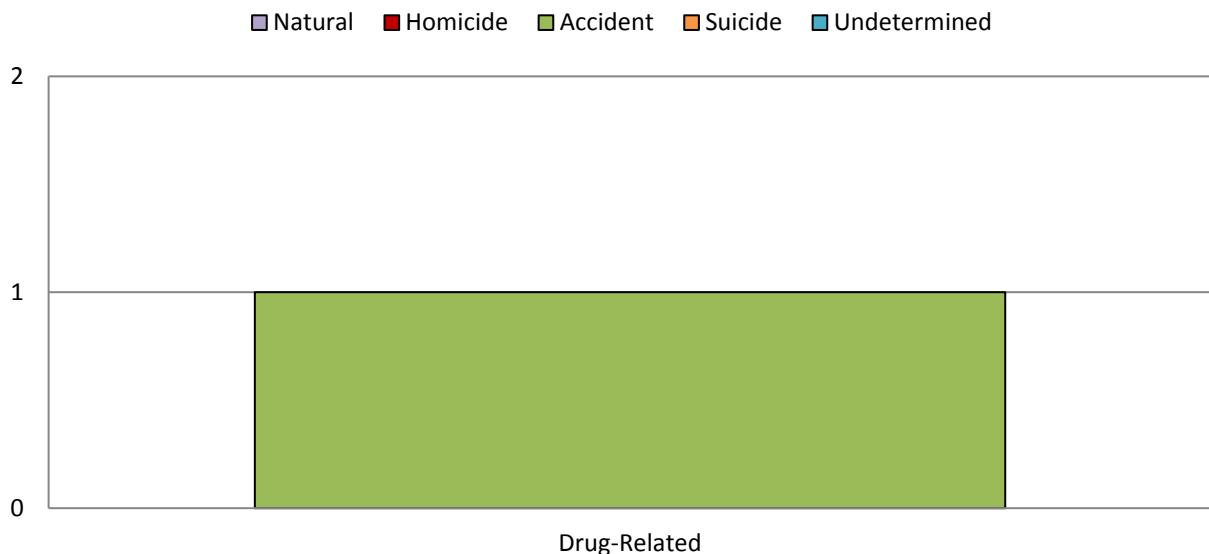
n=1



## 2016 WKY Prison Deaths by Cause and Manner of Death

Figure 80

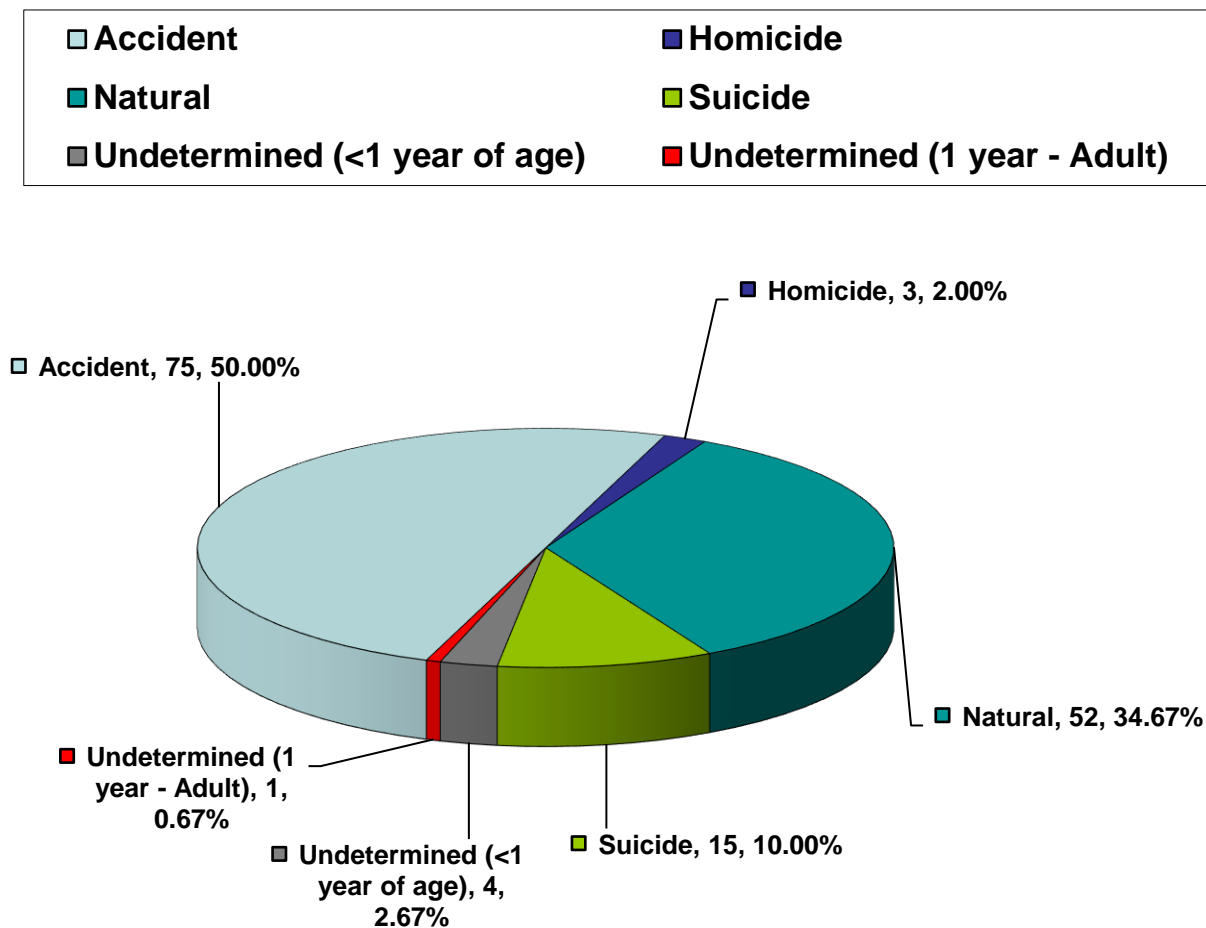
n=1



# Northern Kentucky Medical Examiner Office Data

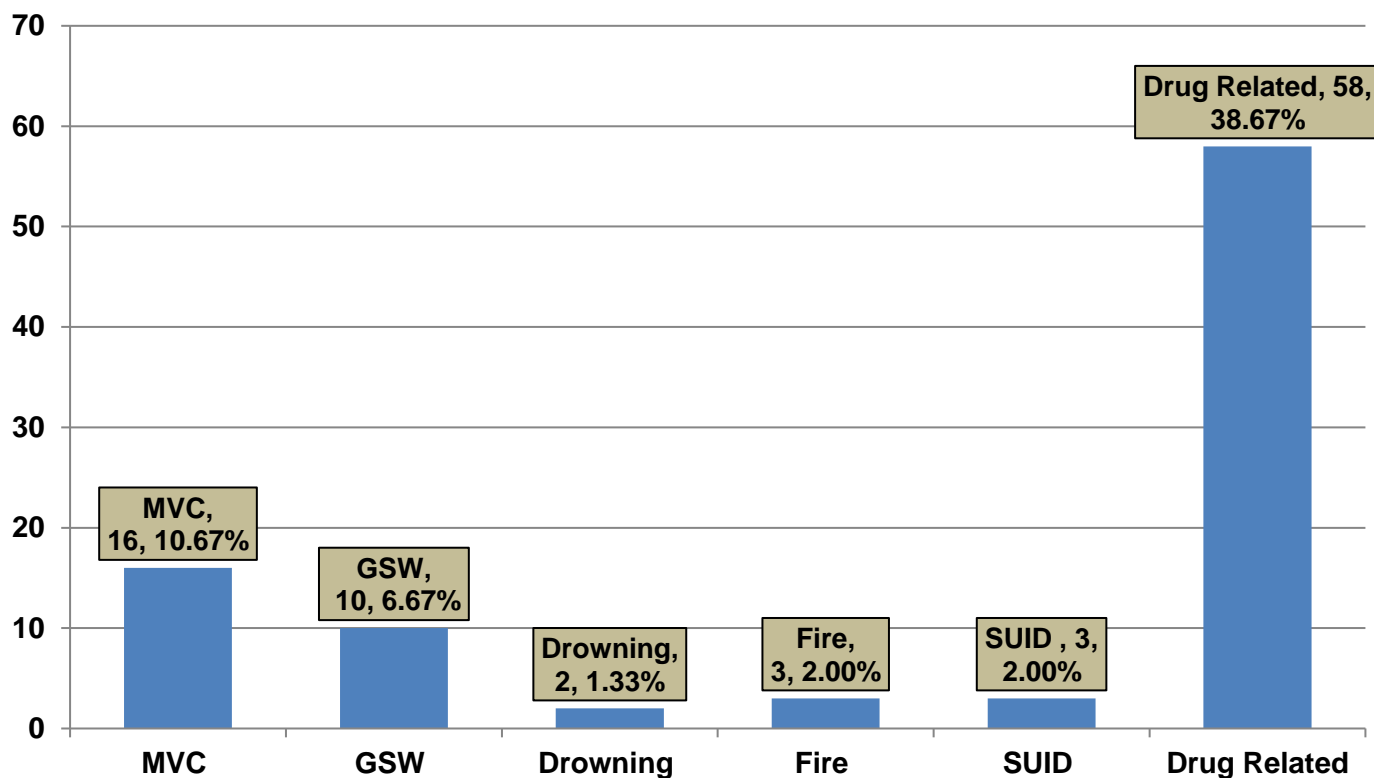
## 2016 Northern Kentucky Cases by Manner of Death

### Figure 81



## 2016 Northern Kentucky Cases by Common Causes of Death

Figure 82



## NKY Totals by Common Causes and Subsequent Manners of Death

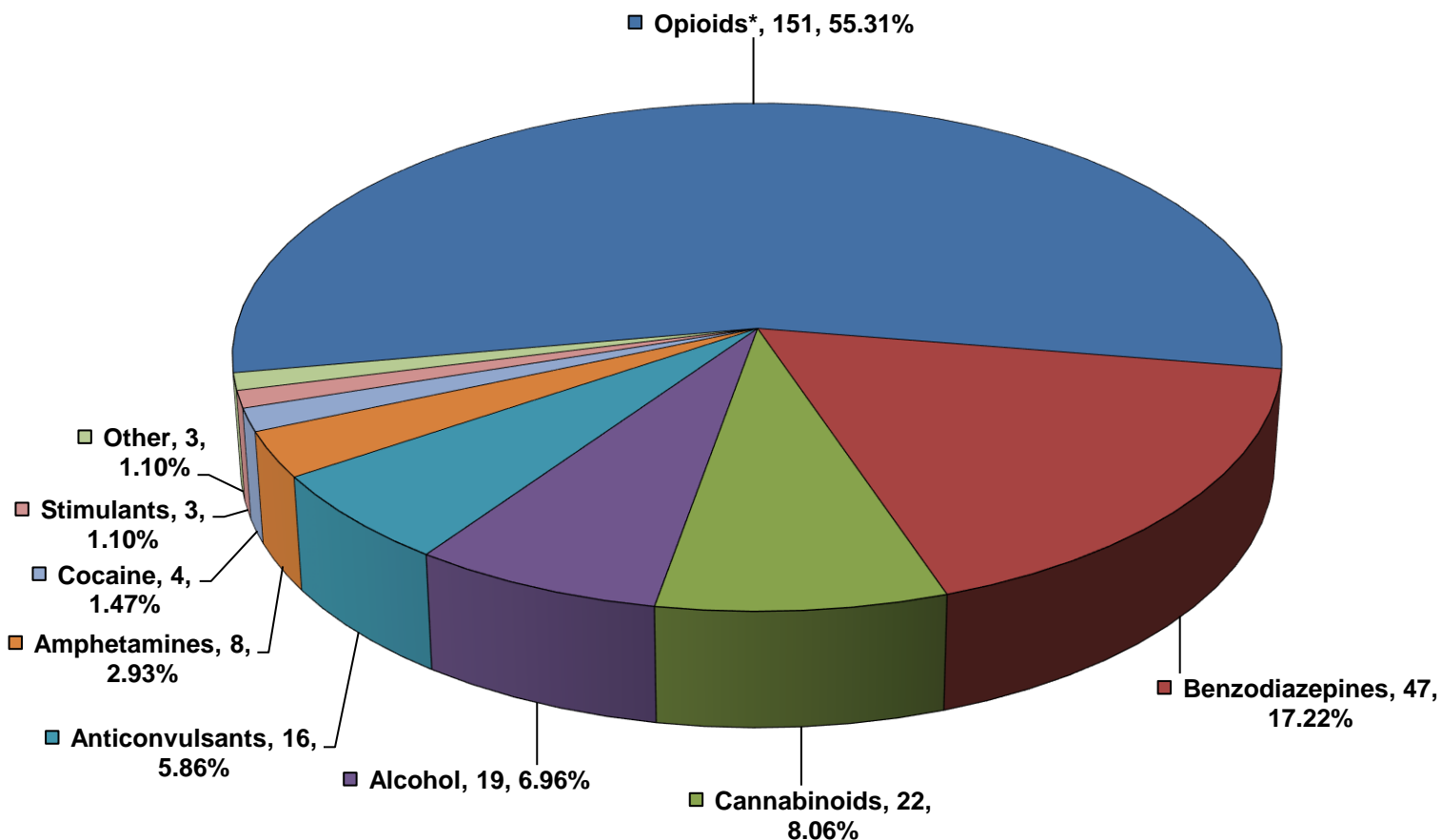
### Table 24

<b>Fatal Event</b>	<b>Total</b>	<b>Percentage</b>
<b><i>Drug Related</i></b>	<b>58</b>	<b>38.67%</b>
Accident	53	91.38%
Natural (Complications of Chronic Use)	4	6.90%
Suicide	1	1.72%
Heroin Present	16	27.59%
Fentanyl Present	27	46.55%
<b><i>MVC</i></b>	<b>16</b>	<b>10.67%</b>
Accident	16	100.00%
<b><i>GSW</i></b>	<b>10</b>	<b>6.67%</b>
Homicide	2	20.00%
Suicide	8	80.00%
<b><i>Drowning</i></b>	<b>2</b>	<b>1.33%</b>
Accident	2	100.00%
<b><i>Fire</i></b>	<b>3</b>	<b>2.00%</b>
Accident	3	100.00%
<b><i>SUID</i></b>	<b>3</b>	<b>2.00%</b>
Undetermined	3	100%
<b><i>All other NKY Accidents</i></b>	<b>4</b>	<b>2.67%</b>

\*The above does not represent the total number of Northern Kentucky cases\*

## 2016 NKY Most Common Drug Classes Detected in Drug Related Death Victims

Figure 83



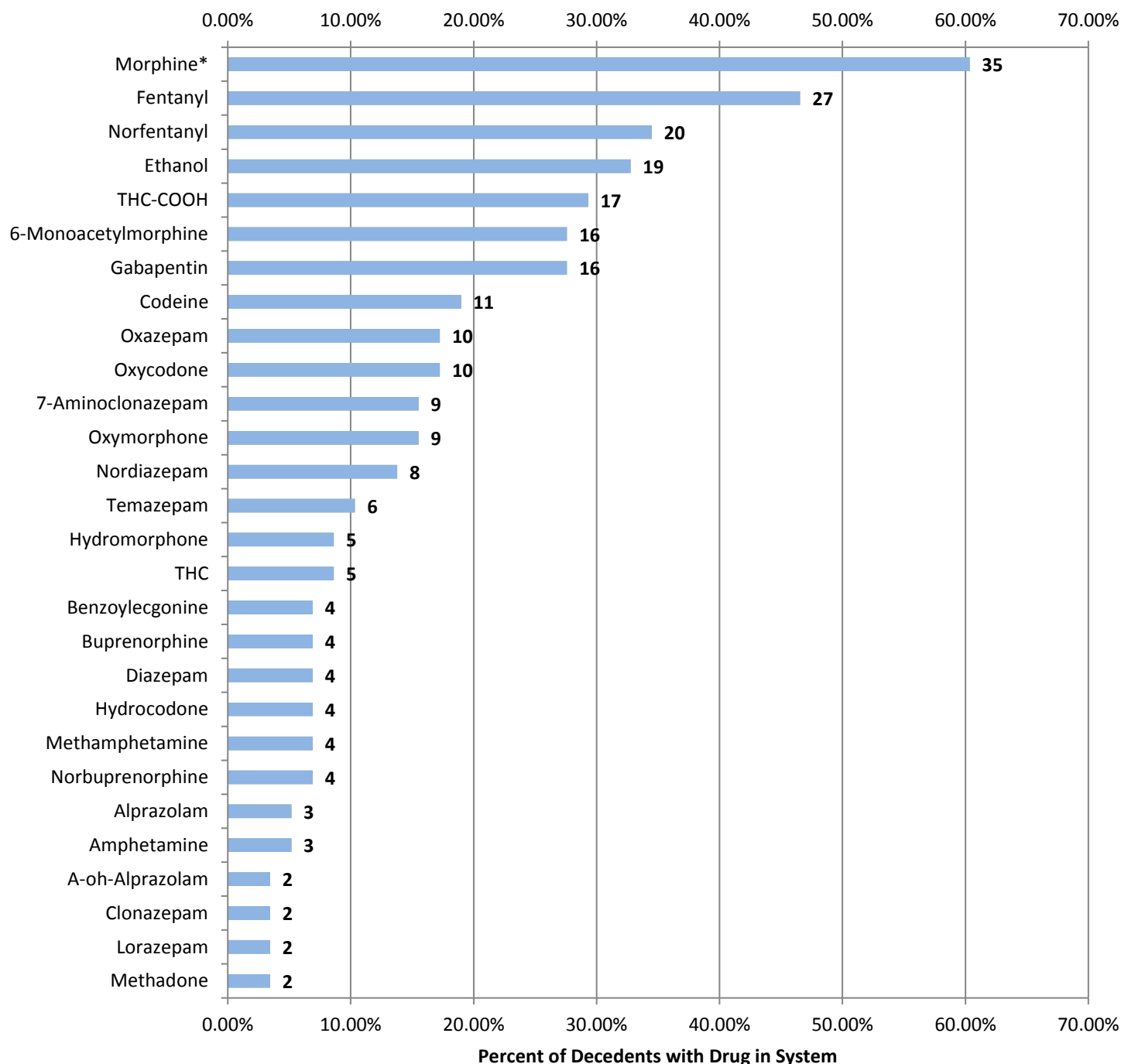
\*Opioids includes all opium-like substances (including natural opiates and synthetic opioids)

^Percent is based off of n=273, the total drug count across all NKY drug overdoses

⌘Detected drugs were found in blood, urine, and/or vitreous fluids.

## 2016 NKY Most Frequent Drugs Detected in Drug Related Death Victims

### Figure 84



\*Morphine represents true drug and/or metabolite of Heroin

^Total Percentages >100% due to more than 1 drug being present in many decedents

▣Detected drugs were found in blood, urine, and/or vitreous fluids.



## 2016 NKY Additional Drugs Detected in Drug Related Death Victims

Table 25

Drug Name	Total	Percentage
Caffeine	1	1.72%
Carfentanil	1	1.72%
Chlordiazepoxide	1	1.72%
Citalopram	1	1.72%
Cotinine	1	1.72%
Dextromethorphan	1	1.72%
EDDP	1	1.72%
Nicotine	1	1.72%
Nortramadol	1	1.72%
Pseudoephedrine	1	1.72%
Tramadol	1	1.72%
Zolpidem	1	1.72%

^Total Percentages >100% due to more than 1 drug being present in many decedents

⌘Detected drugs were found in blood, urine, and/or vitreous fluids.

**Northern Kentucky Totals by Special Circumstances  
and Subsequent Manners of Death**  
**Table 26**

<b>Fatal Event</b>	<b>Total</b>	<b>Percentage</b>
<i>Work Related</i>	<b>0</b>	<b>0%</b>
<i>Jail</i>	<b>0</b>	<b>0%</b>
<i>Prison</i>	<b>0</b>	<b>0%</b>
<i>Arrest-Related</i>	<b>0</b>	<b>0%</b>
<i>Home Incarceration</i>	<b>0</b>	<b>0%</b>
<i>Domestic</i>	<b>0</b>	<b>0%</b>
<i>Child Abuse</i>	<b>0</b>	<b>0%</b>
<i>Nursing Home</i>	<b>1</b>	<b>0.67%</b>
Accident	<b>1</b>	<b>100%</b>

**Northern Kentucky Police-Involved Cases by Demographics and Involvement**  
**Table 27**

Demographic	All Police Involved	All Police %	Jail Deaths	Jail %	Prison Deaths	Prison %	Arrest-Related Deaths	Arrest-Related %	Home Incarc Deaths	Home Incarc %
<i>Age</i>										
24 and younger	0	0%	0	0%	0	0%	0	0%	0	0%
25-34	0	0%	0	0%	0	0%	0	0%	0	0%
35-44	0	0%	0	0%	0	0%	0	0%	0	0%
45-54	0	0%	0	0%	0	0%	0	0%	0	0%
55-64	0	0%	0	0%	0	0%	0	0%	0	0%
65 and older	0	0%	0	0%	0	0%	0	0%	0	0%
<i>Race</i>										
White	0	0%	0	0%	0	0%	0	0%	0	0%
Black	0	0%	0	0%	0	0%	0	0%	0	0%
Hispanic	0	0%	0	0%	0	0%	0	0%	0	0%
Other	0	0%	0	0%	0	0%	0	0%	0	0%
<i>Sex</i>										
Male	0	0%	0	0%	0	0%	0	0%	0	0%
Female	0	0%	0	0%	0	0%	0	0%	0	0%
<b>Total</b>	<b>0</b>	<b>0%</b>	<b>0</b>	<b>0%</b>	<b>0</b>	<b>0%</b>	<b>0</b>	<b>0%</b>	<b>0</b>	<b>0%</b>

# Additional Information

*Additional Data for 2016***Scene Visits at the request of local law enforcement and/or county coroner:**

**Note:** In Kentucky, the scene investigations are conducted by the County Coroners and their deputies who are trained by DOCJT.

The OCME attended five (5) scenes.

The Eastern Kentucky Office attended three (3) scenes.

The Western Kentucky Office attended one (1) scene.

The Northern Kentucky Office attended zero (0) scenes.

**Bodies Transported:** Due to the combined Coroner/Medical Examiner system, no regional Medical Examiner Office transports bodies or arranges/orders the transport of bodies. This duty falls under the purview of the county coroner in which the death occurred. Therefore, zero (0) bodies were transported by any regional office.

**Hospital Autopsies:** Due to the combined Coroner/Medical Examiner system, the Regional Medical Examiner's Offices do not have jurisdiction over hospital deaths and autopsies. There were zero (0) hospital autopsies retained under ME jurisdiction.

**Organ and Tissue Donation**

Of the 1,608 cases undergoing postmortem examinations by the OCME, 6 were organ, 38 were tissue donations, and 0 were both organ and tissue donations.

Of the 975 cases undergoing postmortem examinations by the Eastern Kentucky Office, 11 were organ, 26 were tissue donations, and 0 were both organ and tissue donations.

Of the 102 cases undergoing postmortem examinations by the Western Kentucky Office, 0 were organ, 3 were tissue donation, and 0 were both organ and tissue donations.

Of the 150 cases undergoing postmortem examinations by the Northern Kentucky Office, 0 were organ, 1 was tissue donation, and 0 were both organ and tissue donations.

**Unclaimed Bodies:** Due to the combined Coroner/Medical Examiner system, the Regional Medical Examiner's Offices do not have responsibility over unclaimed bodies. This is the duty of the county coroner in which the death occurred. Therefore, there were zero (0) unclaimed bodies in 2016.

**Exhumations:**

The OCME had zero (0) postmortem examinations from an exhumation in 2016.

The Eastern Kentucky Office had zero (0) postmortem examinations from an exhumation in 2016.

The Western Kentucky Office had zero (0) postmortem examinations from an exhumation in 2016.

The Northern Kentucky Office had zero (0) postmortem examinations from an exhumation in 2016.

**Complete Autopsies**

The OCME performed 1,332 complete autopsies in 2016.

The Eastern Kentucky Office performed 783 complete autopsies in 2016.

The Western Kentucky Office performed 73 complete autopsies in 2016.

The Northern Kentucky Office performed 98 complete autopsies in 2016.

**Focused Examinations**

The OCME performed 96 focused examinations in 2016.

The Eastern Kentucky Office performed 76 focused examinations in 2016.

The Western Kentucky Office performed 12 focused examinations in 2016.

The Northern Kentucky Office performed 8 focused examinations in 2016.

**External Autopsies**

The OCME performed 170 external examinations in 2016.

The Eastern Kentucky Office performed 115 external examinations in 2016.

The Western Kentucky Office performed 15 external examinations in 2016.

The Northern Kentucky Office performed 44 external examinations in 2016.

**Skeletal Remains Examinations**

The OCME performed 10 skeletal remains examinations.

The Eastern Kentucky Office performed 1 skeletal remains examination.

The Western Kentucky Office performed 2 skeletal remains examinations.

The Northern Kentucky Office performed 0 skeletal remains examinations.

## **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, Trimble, 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 provided full-time coverage for the Western Kentucky counties from Jan 1<sup>st</sup>-July 18<sup>th</sup>. From July 19<sup>th</sup>-Dece 31<sup>st</sup>, the OCME provided weekend, holiday, and vacation coverage for the **Western** counties delineated below.

The **WKME in 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 **EKME in 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, Washington, Wayne, Whitley, Wolf, and Woodford.

\*Additionally, the OCME and EKME provided full-time coverage for the Northern Kentucky counties delineated below from April 27<sup>th</sup>-Dece 31<sup>st</sup>.

The **NKME in Ft. Thomas** office covers the following **NORTHERN** *counties*:

Boone, Bracken, Campbell, Fleming, Gallatin, Grant, Greenup, Kenton, Lewis, Mason, Owen, Pendleton, and Robertson.

## Figure 85





**Office of the Chief Medical Examiner (OCME)**

10511 LaGrange Rd  
Louisville, KY 40223  
Tel: (502)489-5209  
Fax: (502)489-5213

**Eastern Kentucky Regional Medical Examiner's Office (EKME)**

Central Laboratory Facility  
100 Sower Blvd, STE 202  
Frankfort, KY 40601  
Tel: (502)564-4545  
Fax: (502)564-1699

**Northern Kentucky Regional Medical Examiner's Office (NKME)**

85 North Grand Avenue  
Ft. Thomas, KY 41075  
Tel: (859)572-3559  
Fax: (859)572-3558

**Western Kentucky Regional Medical Examiner's Office (WKME)**

25 Brown Badgett Loop  
Madisonville, KY 42431  
Tel: (270) 824-7048  
Fax: (270) 824-7092

## ***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.

**Special Circumstances:** When the death occurs in a special location or circumstance, such as deaths occurring in an institution, at the workplace, or in police custody.

**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 no clear determination of one manner over another.

**Insufficient Information Provided** – An opinion regarding the manner of death could not be determined due to insufficient information provided to the prosecuting Medical Examiner.