2021 ANNUAL REPORT

BOULDER COUNTY CORONER'S OFFICE

Emma R. Hall

Boulder County Coroner

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Office of the Boulder County Coroner

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To the Citizens of Boulder County,

It is my pleasure to present the 2021 annual report for the Boulder County Coroner's Office. This report highlights statistical information from the office over the past calendar year and the last 10 years and serves as a valuable resource to understand our responsibility within Boulder County.

Coming out of the initial phases of the COVID-19 pandemic, 2021 was a year to re-focus and re-structure many internal processes and communications. Just as we were beginning to start this work the Boulder community suffered the Table Mesa Mass Shooting. Once we heard the news of the shooting, our staff immediately pulled together, quickly devised staffing plans and strategies on how our office would respond for the recovery of victims, make identifications, notify families, complete the required autopsies and work with all our partner agencies through the course of the investigation. Our hearts go out to the victims whose lives were tragically taken and their families for the incredible loss they continue to suffer.

From this event our office has learned a great deal and one of the biggest priorities coming out of this was to create a Family Assistance Division in the office. Therefore, a request for a full-time Family Assistance Coordinator was brought forth to the Boulder County Commissioners. In November we were very fortunate to gain their approval for this key position to start in 2022. We are excited to have their support and the ability to create the Family Assistance Division in the coming year!

Providing the citizens of Boulder County with the highest quality service continues to be the priority of this office.

Boulder County Coroner,

ERHall

EMMA R. HALL
Coroner

TABLE OF CONTENTS

INTRODUCTION

MISSION STATEMENT

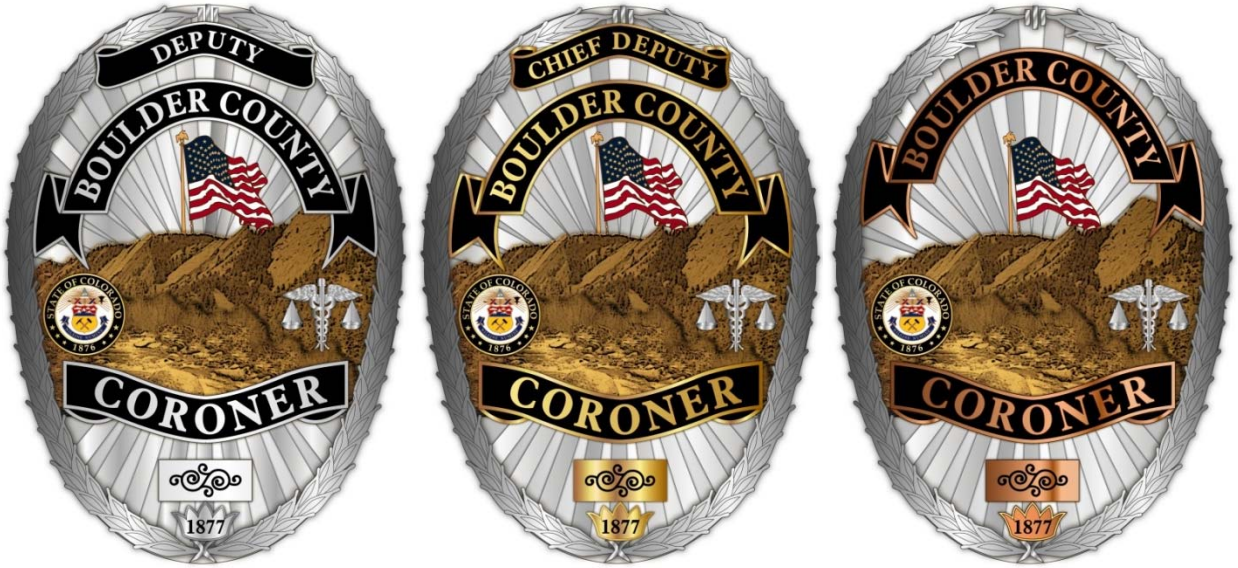
The mission of the Boulder County Coroner's Office is to conduct thorough and fair investigations into deaths falling under its jurisdiction with professionalism and integrity to determine the manner and cause of death in a timely manner. The core values of the office are integrity, excellence and compassion; the office is committed to maintaining the integrity of the investigations it conducts by setting high standards of accountability and preserving confidentiality, the office is committed to serving with excellence by establishing and preserving community trust through professional conduct, the office is committed to providing compassion, dignity and respect for the deceased and their families.

FUNCTION OF THE OFFICE

The Office of the Boulder County Coroner is a creation of the Colorado Constitution and the Colorado Revised Statutes §30-10-601 through 621. Under those statutes the Coroner is required to make all proper inquiry regarding the cause and manner of death of any person under their jurisdiction.

The cause of death may be defined as the disease or injury that resulted in the death of an individual. Examples of causes of death may include: "heart disease," "pneumonia," "gunshot wound," or "blunt force trauma." The manner of death is a medicolegal term that describes the circumstances of an individual's death, and is an opinion based on the "preponderance of evidence." When a natural disease process (such as heart disease or diabetes) causes death, the manner of death typically would be classified as **Natural**. The manner of death is classified as **Accident** when the death is the result of a hostile environment, and the event is not expected, foreseen, or intended. The manner of death is classified as **Suicide** when the person acts with the intent of causing their own death. When the death is the result of the killing of one human being by another, the manner of death is classified as **Homicide.** Homicide is a medicolegal term and should not be confused with such terms as "murder" or "manslaughter" which are used by the criminal justice system to describe the degree of criminal intent in a particular homicide. When there is insufficient evidence to determine the cause and/or manner of death, both the cause and manner of death may be classified as **Undetermined**. In other instances, the cause of death may be readily apparent, but the evidence that indicates manner of death may be equivocal, thereby leading to a manner of death of Undetermined. The manner of death is classified primarily to aid survivors in understanding the events surrounding an individual's death and for statistical purposes.

BOULDER COUNTY CORONER BADGE



Badge Symbolism: The Boulder County Coroner badge is displayed to symbolize the authority to act under public trust and the duty to serve. The oval shaped shield dates back to medieval times and the laurel wreath is made of connected branches and leaves of the bay laurel, it is used as a symbol of honor.

Sun Rays: In the background of the badge there are twenty-two distinctive sun rays. The thirteen upper rays are a reminder of the responsibilities and the qualities the office holds in the search for the truth. The office has a responsibility to investigate deaths for the deceased, their families and community as a whole. The office serves with professionalism, integrity, excellence, compassion, accountability, confidentiality, dignity and respect. All of these qualities are also represented in the Coroner's mission statement. The lower nine rays represent the cities within Boulder County: Lyons, Longmont, Louisville, Boulder, Superior, Lafayette, Erie, Nederland and Ward.

Banners:

- All banners are black in color
- The deputy's rank is proudly denoted on a banner at the top of the badge
- A second banner near the top of the badge prominently displays BOULDER COUNTY
- A third banner near the bottom of the badge prominently displays CORONER
- The bottom banner personalizes each badge with a badge number assigned by the Coroner

Crown: In Middle English, the word "coroner" referred to an officer of the crown, derived from the French *couronne* and Latin *corona*, meaning "crown". The crown is represented at the base of the badge with 5 points demonstrating the branches of death investigation every coroner and deputy serves to investigate: Natural, Accident, Suicide, Homicide and Undetermined. The year 1877 is inscribed into the crown to represent the year the first Coroner took office in Boulder County, Seth D. Bowker, who served from 1877-1881.

Center Piece: The centerpiece of the badge is an image of Boulder Creek for which the county was named after; in the background are the Boulder Flatirons which are a popular icon of the Boulder area. There is an American flag atop the flatirons. On the left side of the center piece is the Colorado state symbol and on the right side is a medical legal symbol.

Rank Designation:

- *Deputy:* Silver Borders on each rocker/banner, silver lettering
- *Chief Deputy:* Gold border on each rocker/banner, gold lettering
- *Coroner:* Copper border on each rocker/banner, and copper lettering

STAFF

The 2020 staff of the Boulder County Coroner's Office consisted of the following:

Elected Coroner: Emma R. Hall. Ms. Hall is a Boulder County native who grew up in Lyons on Hall Ranch. She comes from a pioneer family that has lived in the county since the 1870s. Ms. Hall is responsible for the day to day administration of the office as well as the daily management of cases. She is ultimately responsible for the determinations of cause and manner of death for the cases in which the office takes jurisdiction. Ms. Hall is a graduate of Niwot High School and Metropolitan State College of Denver, with a degree in Criminalistics (the study of evidence). Her background includes experience and training in death investigation, autopsies and forensic pathology, crime scene investigation, evidence analysis, elder abuse, child death investigation, blood stain pattern analysis, forensic anthropology, mass fatalities and emergency management, aquatic death and homicidal drowning. Ms. Hall is a registered Medicolegal Death Investigator with The American Board of Medicolegal Death Investigators. Ms. Hall is additionally a Certified Death Investigator with the Colorado Coroner's Association as well as a member of the Colorado Coroner's Association. She co-chairs the Elder Abuse Fatality Review Team with District Attorney. Ms. Hall attends a number of meetings throughout the county and state to include Boulder County Elected Official/Department Head meetings, mass fatality planning meetings, fire and flood planning meetings, Boulder County Child Fatality Review Team meetings, Boulder County Law Enforcement Chiefs meetings, Metro Area Coroner meetings, and the Colorado Forensic Investigators meetings. Additionally, Ms. Hall has served on many boards including the International Association of Coroner's and Medical Examiner's, the Colorado Coroner's Association, the Criminal Justice/Forensics Advisory Board at Arapahoe Ridge High School in Boulder and the Inn Between on Longmont. Ms. Hall's true passion in the field is being able to provide answers to as many questions as possible to the family in each investigation and to help the family in their healing process.

Chief Deputy Coroner: Jeff Martin. Mr. Martin is responsible for the day to day administration of the office and the management of the investigations and pathology staff. Mr. Martin has over 30 years of combined experience in the field of medicolegal death investigation and law enforcement investigations. Mr. Martin was previously at the District 1 Medical Examiner's Office in Florida, the State of Oklahoma Medical Examiner's Office in Tulsa and the Tulsa County Sheriff's Office. He has held various positions to include Deputy, Investigator, Chief Investigator, Internal Affairs, Chief Operating Officer and Director of Operations; as the Chief Deputy he has fostered an environment of teamwork by creating new procedures which make the office operate with a higher level of efficiency. Mr. Martin has experience in all divisions of the office to include pathology, investigations and administration. Mr. Martin has re-invented the post-COVID internship program with a more formal approach to teaching and immersion into the office. Mr. Martin, and his wife moved to Colorado in June of 2021. They have four children and two grandchildren. He loves the Rocky Mountains, and anything related to the "Old West Era".

ADMINISTRATION DIVISION

Assistant to the Coroner: Noelle Mockler. Ms. Mockler has a Master's Degree in Forensic Psychology from Marymount University in Arlington, VA and Bachelor's Degree in Criminal Justice and Criminology from Metropolitan State University. After completion of her graduate degree, she worked primarily in the human service field in the DC area for approximately 5 years before moving back to Colorado. Noelle is the Assistant to the Coroner as well as the operational oversight of the administrative department

Administrative Specialist: Angela Euresti. Ms. Euresti is the Administrative Specialist for the Boulder County Coroner's Office. She joined the Coroner's Office in April of 2020 after previously working as an Executive Logistics Event Planner and Executive Assistant for a global technology company hosting events and providing support to Fortune 500 presidents and CEOs. She is responsible for administrative and accounting duties for the office. A forever Coloradan, Ms. Euresti loves to spend her free time in genealogy and connecting families.

INVESTIGATION DIVISION

Investigations Supervisor: Michelle Montonera. Mrs. Montonera has a Bachelor's Degree in Photography with a specialization in Biomedical/Forensic Photography and a Master's Degree in Forensic Science. During her studies, she interned for the Miami-Dade Medical Examiner's Office in the Forensic Imaging Department. Following her studies, Mrs. Montonera spent 6 years working for the District 20 Medical Examiner in Naples, Florida performing the duties of forensic photographer, death investigator, autopsy technician, and cold case coordinator for the State of Florida. Mrs. Montonera then worked in Austin, Texas with the Travis County Medical Examiner. She spent 5 of her 9 years at Travis County as the Chief Autopsy Technician, leading a department of 7 technicians, creating an autopsy technician internship program, and participating in the development and planning of their new facility and policy and procedure manual prior to joining Boulder County in 2021. Mrs. Montonera is responsible for the operational oversight of the investigations department, as well as handling various day-to-day operations of the office and general managerial duties.

Deputy Coroner: Cari Lehl. Mrs. Lehl has a Bachelor's Degree and Master's Degree in Forensic Science and a minor in psychology. During her studies, she interned with the Weld County Coroner's Office, the Arapahoe County Coroner's Office, the Miami-Dade Medical Examiner's Office, and the Denver Police Department. Mrs. Lehl handles a portion of the caseload, leads the Child Fatality Prevention and Review Team meetings, as well as handling various day-to-day operations.

Deputy Coroner: Tahlia Goff. Mrs. Goff has a Bachelor's Degree in Biology and a Minor in Criminalistics from Metropolitan State University of Denver. She started her forensic education at a young age and went through a Forensic Science vocational school while in high school. While in college, Mrs. Goff completed an internship with the Boulder County Coroner's Office. This experience then led to her full-time employment with Boulder County as a Deputy Coroner. Mrs. Goff handles a portion of the caseload, as well as handling various day-to-day operations of the office.

Deputy Coroner: Andy Melvin. Mr. Melvin has a Bachelor's Degree in Psychology and a minor in History from Colorado State University. Following college, he spent time developing his investigative skills in the private sector with a focus on financial and insurance-based work across the state of Colorado. Mr. Melvin handles a portion of the caseload, as well as handling various day-to-day operations of the office.

Pathology Assistant: Kayci Vigil. Ms. Vigil has Bachelor's Degrees in Anthropology and Sociology with emphases in Biology and Criminal Justice from Colorado State University. While in college, Ms. Vigil completed an internship with the Boulder County Coroner's Office. This experience then led to her full-time employment with Boulder County as a Pathology Technician and subsequently as a Medicolegal Death Investigator. Ms. Vigil handles a portion of the caseload, as well as handling various day-to-day operations of the office.

Deputy Coroner: **Rachel Goodman.** Ms. Goodman has a Bachelor's Degree in Criminology and Criminal Justice with minors in Psychology, Sociology, and Forensic Science from Northern Arizona University. During her studies, she completed an internship with the Coconino County Medical Examiner's Office. Ms. Goodman handles a portion of the caseload, as well as handling various day-to-day operations of the office.

Deputy Coroner: **Jessica Filipeli.** Ms. Filipeli has dual Bachelor's Degrees in Anthropology and Criminal Justice and Criminology from Metropolitan State University of Denver. As part of her continuing education, she has assisted with biological anthropology, historical anthropology, and forensic archaeology. Prior to joining Boulder County Coroner's Office, she worked as a researcher and field support for Colorado Forensic Canines, assisting handlers in the field conducting searches and gathering information on missing persons. Ms. Filipeli handles a portion of the caseload, as well as handling various day-to-day operations of the office.

PATHOLOGY DIVISION

Board Certified Forensic Pathologist: Daniel C. Lingamfelter, D.O., Forensic Pathologist. Dr. Daniel Lingamfelter is a 2004 graduate of University of North Texas Health Science Center. His post graduate training consisted of an Anatomic and Clinical Pathology Residency at the University of Missouri-Kansas City, and a Forensic Pathology Fellowship at the University of Texas Southwestern Medical Center. Dr. Lingamfelter is board certified by the American Board of Pathology in Forensic Pathology, Anatomic and Clinical Pathology and served for a year as a deputy medical examiner in Kansas City, MO, before moving to Colorado in 2010. He has taught at the University of Missouri School of Medicine and at Texas Christian University, currently he is a clinical assistant professor for Rocky Vista University Medical School in Parker, CO. Dr. Lingamfelter has published many journal articles and has given many presentations throughout the nation. Dr. Lingamfelter is a Fellow of the College of American Pathologists, National Association of Medical Examiners, and the American Society for Clinical Pathology.

Board Certified Forensic Pathologist: Meredith Frank, M.D., Forensic Pathologist. Dr. Frank obtained her medical doctorate at the University of Texas in San Antonio and completed her residency training at the University of Colorado Denver. She then completed a Forensic Pathology fellowship at the Southwestern Institute of Forensic Sciences in Dallas, Texas. Dr. Frank is board certified by the American Board of Pathology in Anatomic and Clinical Pathology and Forensic Pathology. Since 2010, she has served as a Medical Examiner in Dallas TX, Anchorage AK, and Denver, CO. Dr. Frank is Faculty and Director for the Forensic Pathology Fellowship program at the University of Colorado Denver School of Medicine. She is active with the American Academy of Forensic Sciences and National Association of Medical Examiners and serves on the Colorado Maternal Morbidity and Mortality Review Committee.

Pathology Supervisor: **Katie Becker.** Ms. Becker grew up in the Thornton area and attended college at Colorado State University. She graduated with a Bachelor's Degree in Sociology with an emphasis in Criminal Justice. Following her graduation Ms. Becker started with the Coroner's office as a part time Pathology Technician. This experience then led to her full-time employment as the Pathology Supervisor, where she is responsible for the operational oversight of the pathology department. In addition, Ms. Becker assists with autopsies and is responsible for the day-to-day operations of the morgue. Ms. Becker is also the office representative for the North Central Region Mass Fatality Committee.

Pathology Assistant: **Paul Xenos.** Mr. Xenos has a Bachelor's Degree in Criminal Justice from the University of West Florida. While in college, Mr. Xenos completed an internship with the District One Medical Examiner's Office in Pensacola, Florida where he was later hired and held positions in Pathology including morgue supervisor and eventually Operations Manager. Mr. Xenos moved to Boulder County in 2021 and currently assists with autopsies, as well as handling various day-to-day operations of the morgue. A Pisces, he enjoys spending his free time traveling and attending the opera.

HISTORICAL COMMITTEE

Boulder County Coroner's Office established a Historical Committee in 2018. The objective of this committee is to review, organize, and electronically preserve paper files and all legacy data in the Coroner's Office. In addition to electronic preservation, the Committee is reviewing all data for historical significance to Boulder County. The Historical Committee is comprised of both volunteers and hourly employees both aiding to the overall goal of the project. The Historical Committee was put on hold in 2020 during the COVID-19 pandemic.

FACILITIES

Groundbreaking for the Boulder County Coroner Facility located at 5610 Flatiron Parkway occurred in March of 2014. The facility was completed in the spring of 2015.

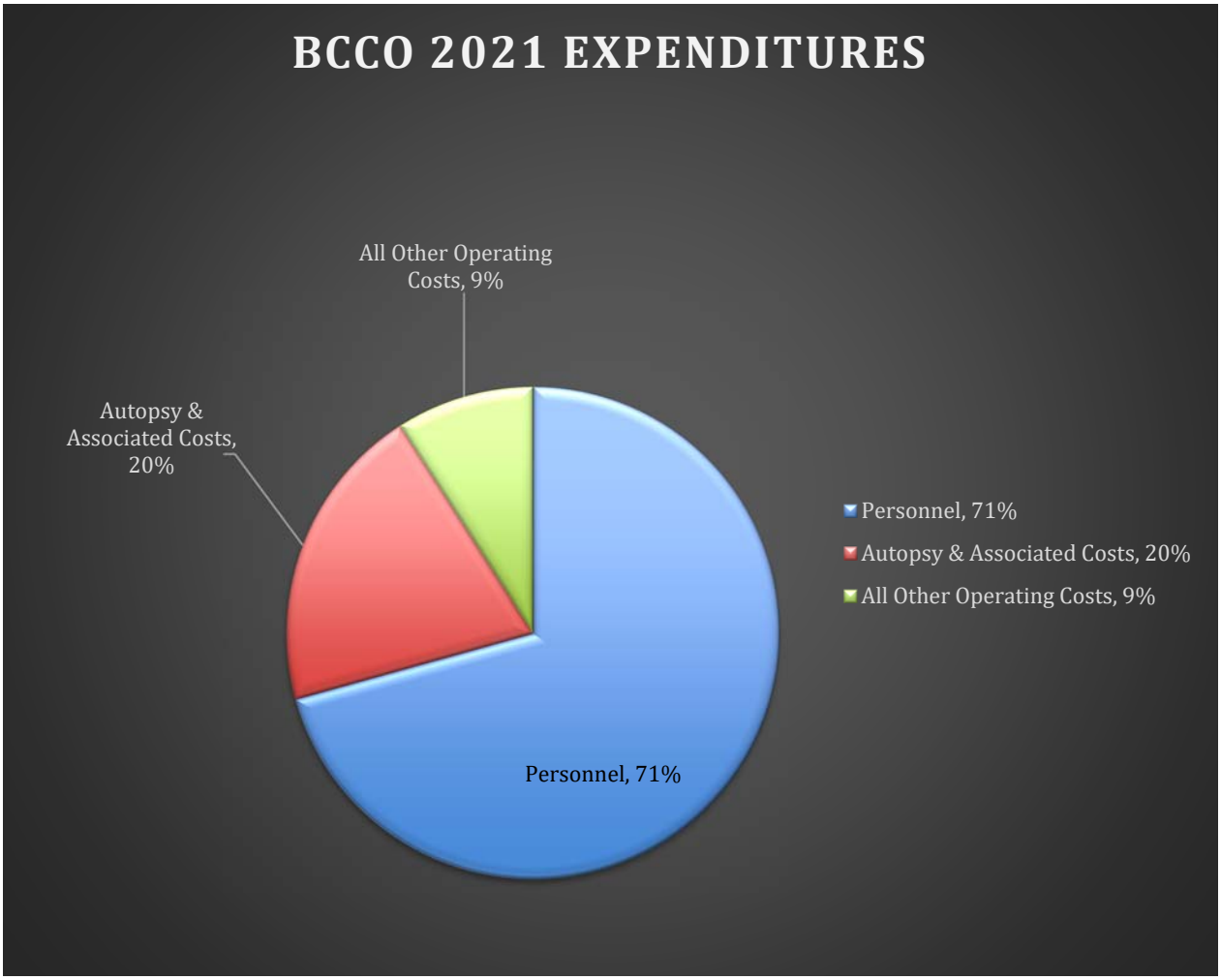
The building is a stand-alone facility which includes a 1060 square foot autopsy suite featuring state-of-the-art amenities to allow for the safest work environment possible for the staff and for public health in general. The suite includes two full function stainless steel autopsy tables in addition to a 202 square foot isolation room with an independent reverse flow air system. The morgue features a remote-controlled body lift system, surgical lamps, natural light for energy conservation, pan/tilt/zoom (PTZ) and fixed security cameras with medical detail zoom capabilities and remote communication with conference rooms, and a walk-in freezer and refrigerator capable of storing up to 30 bodies each.

FUNDING

The funding for the coroner's office comes from the general fund. The general fund is the common use fund where the majority of the county's core services are funded. The coroner's office has an appropriation which is split between personnel and operating expenditures. The majority of the revenues that go into the general fund include property tax, motor vehicle fees, recording fees, other fees and charges for service, interest on investments, and intergovernmental revenues. Additional information is available through the Boulder County Office of Financial Management.

EXPENDITURES

The 2021 expenditures for the Boulder County Coroner's Office were $1,822,582.90. This is 0.37% of the total adopted 2021 Boulder County budget of $493,200,000.



DESCRIPTION OF REPORTABLE CASES

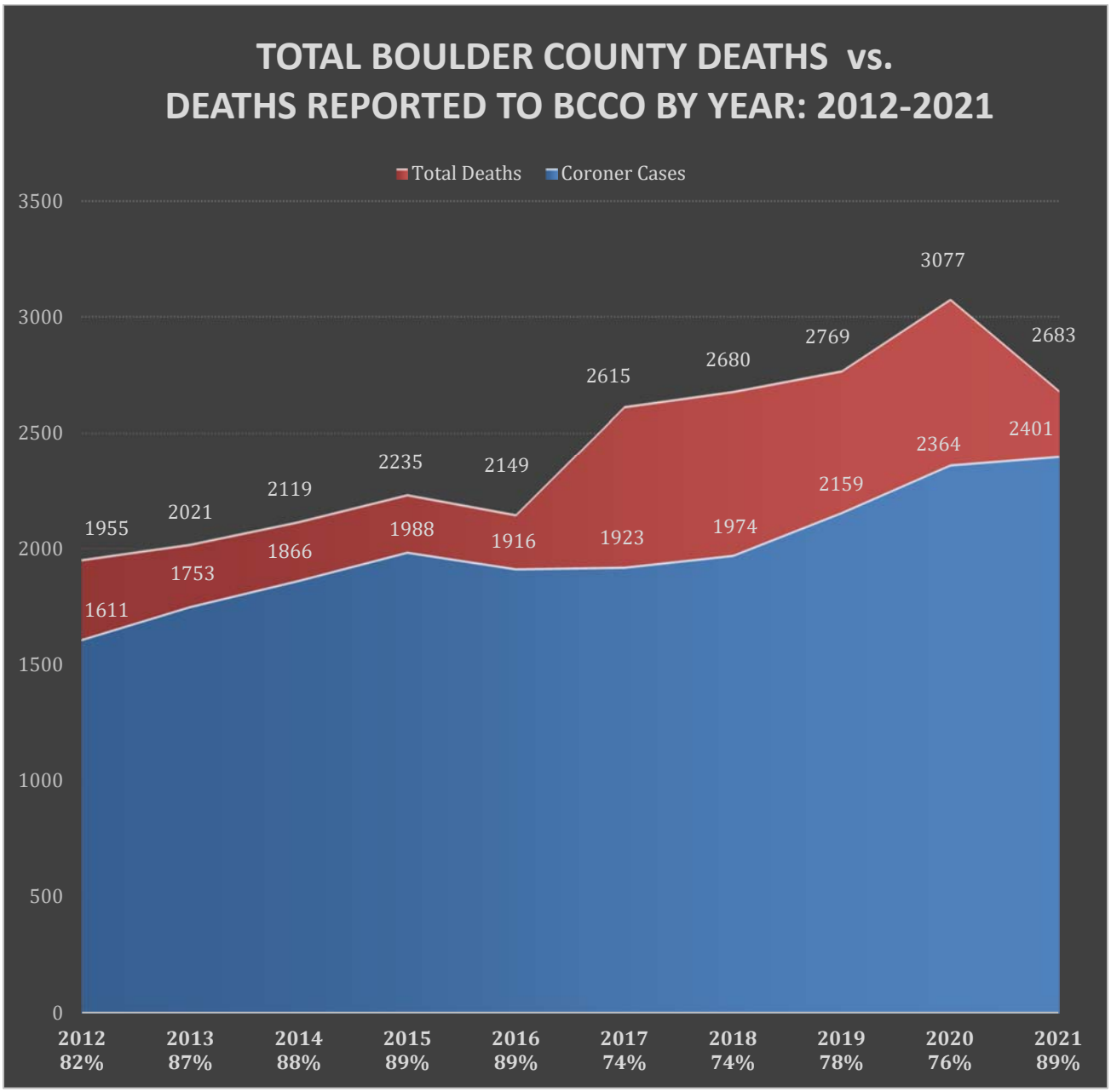
In accordance with Colorado Revised Statute §30-10-606, the following deaths are **reportable** to the Boulder County Coroner's Office:

- If the death is or may be unnatural as a result of external influences, violence or injury;
- Death due to the influence of or the result of intoxication by alcohol, drugs or poison;
- Death as a result of an accident, including at the workplace;
- Death of an infant or child is unexpected or unexplained;
- Death where no physician is in attendance or when, though in attendance, the physician is unable to certify the cause of death;
- Death that occurs within twenty-four hours of admission to a hospital;
- Death from a disease which may be hazardous or contagious or which may constitute a threat to the health of the general public;
- Death occurs from the action of a peace officer or while in custody of law enforcement officials or while incarcerated in a public institution;
- Death was sudden and happened to a person who was in apparent good health;
- When a body is unidentifiable, decomposed, charred or skeletonized;
- Circumstances that the coroner otherwise determines may warrant further inquiry to determine cause and manner of death or further law enforcement investigation.

It should be emphasized that, although a particular death may be "reportable" to the coroner's office; an autopsy may not be necessary depending upon the circumstances.

PERCENTAGES OF BOULDER COUNTY DEATHS REPORTED TO THE CORONER

Per the US Census, the 2021 estimated population of Boulder County was 329,543. A death certificate is filed with the Boulder County Public Health Department for each death that occurs in Boulder County. The Public Health Department keeps track of the total number of deaths that occur in Boulder County. A portion of the deaths that occur in Boulder County are reported to the Boulder County Coroner's Office. The chart below shows a yearly total of all deaths that occurred in Boulder County and a yearly total of all deaths reported to the Boulder County Coroner.



AUTOPSIES BY YEAR

In approximately 13% percent of the deaths that were investigated by the Boulder County Coroner's Office in 2021, an autopsy or skeletal examination was performed to aid in the determination of the cause and manner of death, to document disease, to identify injury patterns, or to recover evidence. Included in almost all autopsies are toxicology tests that may be helpful in determining the cause and manner of death. Toxicology testing and histology review is performed on various specimens collected at autopsy. Several laboratories are used for drug testing. Screening tests include alcohol, illicit drugs, commonly abused prescription and non-prescription drugs, and other substances as needed.

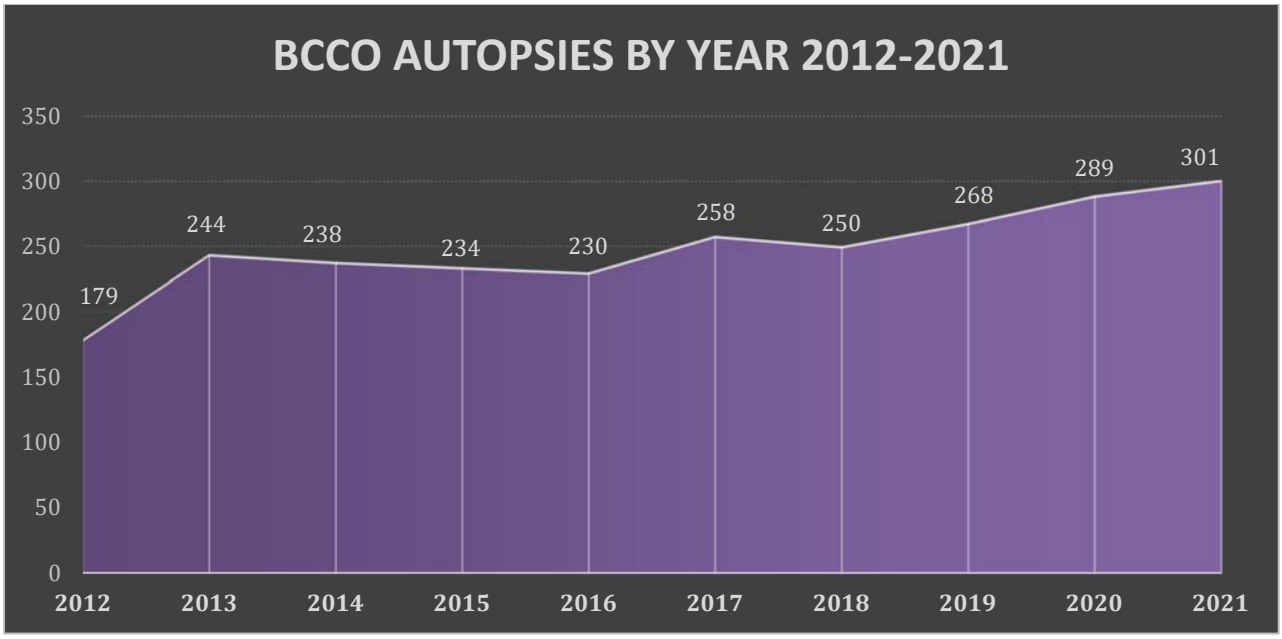
In 2011, House Bill 11-1258 was passed. The bill states that the coroner shall perform forensic autopsies with the most recent version of the "Forensic Autopsy Performance Standards" adopted by the National Association of Medical Examiners (NAME). And that all forensic autopsies must be performed by a board-certified forensic pathologist.

The "Forensic Autopsy Performance Standards" listed by NAME are as follows:

Medicolegal death investigation officers are appointed or elected to safeguard the public interest. Deaths by criminal violence, deaths of infants and children, and deaths in the custody of law enforcement agencies or governmental institutions can arouse public interest, raise questions, or engender mistrust of authority. Further, there are specific types of circumstances in which a forensic autopsy provides the best opportunity for competent investigation, including those needing identification of the deceased and cases involving bodies of water, charred or skeletonized bodies, intoxicants or poisonings, electrocutions, and fatal workplace injuries. Performing autopsies protects the public interest and provides the information necessary to address legal, public health, and public safety issues in each case. For categories other than those listed below, the decision to perform an autopsy involves professional discretion or is dictated by local guidelines. For the categories listed below, the public interest is so compelling that one must always assume that questions will arise that require information obtainable only by forensic autopsy.

A forensic pathologist shall perform a forensic autopsy when:

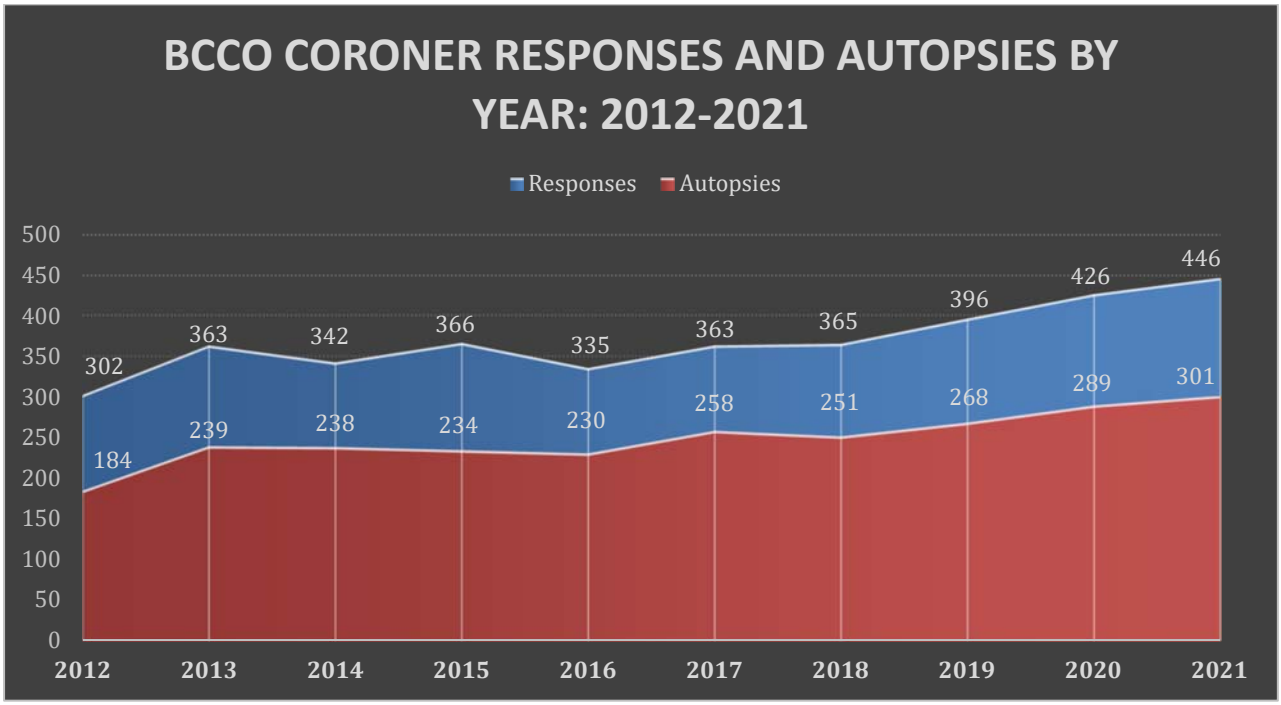
- The death is known or suspected to have been caused by apparent criminal violence
- The death is unexpected and unexplained in an infant or child
- The death is associated with police action
- The death is apparently non-natural and in custody of a local, state, or federal institution
- The death is due to acute workplace injury
- The death is caused by apparent electrocution
- The death is by apparent intoxication by alcohol, drugs, or poison, unless a significant interval has passed, and the medical findings and absence of trauma are well documented
- The death is caused by unwitnessed or suspected drowning
- The body is unidentified, and the autopsy may aid in identification
- The body is skeletonized
- The forensic pathologist deems a forensic autopsy is necessary to determine cause or manner of death, or document injuries/disease, or collect evidence
- The deceased is involved in a motor vehicle incident and an autopsy is necessary to document injuries and/or determine the cause of death



Note: *The Boulder County Coroner's Office performed 301 autopsies (including one skeletal examinations) in 2021.

CORONER RESPONSE AND AUTOPSY TOTALS

The Boulder County Coroner's Office makes a physical response to a low percentage of its total case load and performs an autopsy on an even lower percentage of its total case load. The chart below shows the annual trend lines for both the responses and the autopsies.



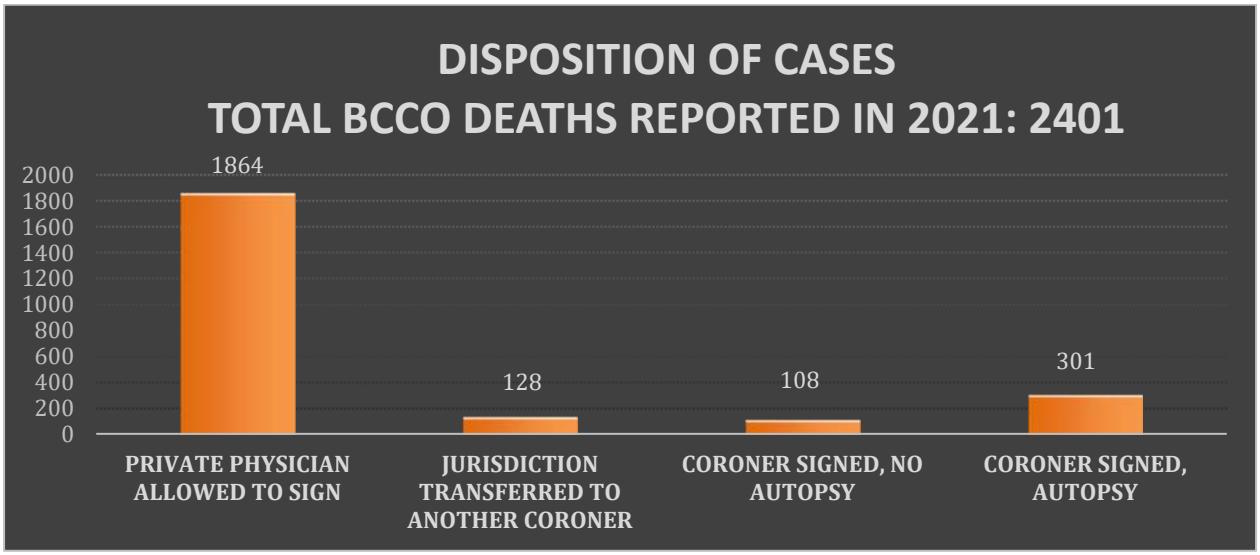
Note: * There were 303 cases in 2021 that required an autopsy, 2 of the autopsies were performed in 2022.

CASES BY MONTH

Note: *The total number of cases reported includes 128 cases that were transferred to other coroners. See **Transfer of Jurisdiction** section of this report for further explanation.

DISPOSITION OF CASES

Deaths that fall under the jurisdiction of the coroner are handled in one of four ways. Most commonly, if the death is due to natural disease and if a private physician who has treated the decedent is able to certify the cause of death, the coroner may allow the private physician to sign the death certificate. Or the coroner may assume jurisdiction over the death and conduct an investigation and an autopsy to determine cause and manner of death and then issue a death certificate. Or the coroner may assume jurisdiction of a death and conduct an investigation, but not perform an autopsy. Or, even though a death may have occurred in the county, a "transfer of jurisdiction" may occur to the coroner of the county where the initiating event causing death occurred or where the decedent was transported from (i.e. by ambulance) prior to death. The transfer of jurisdiction is allowed according to Colorado Revised Statute §30.10.606.



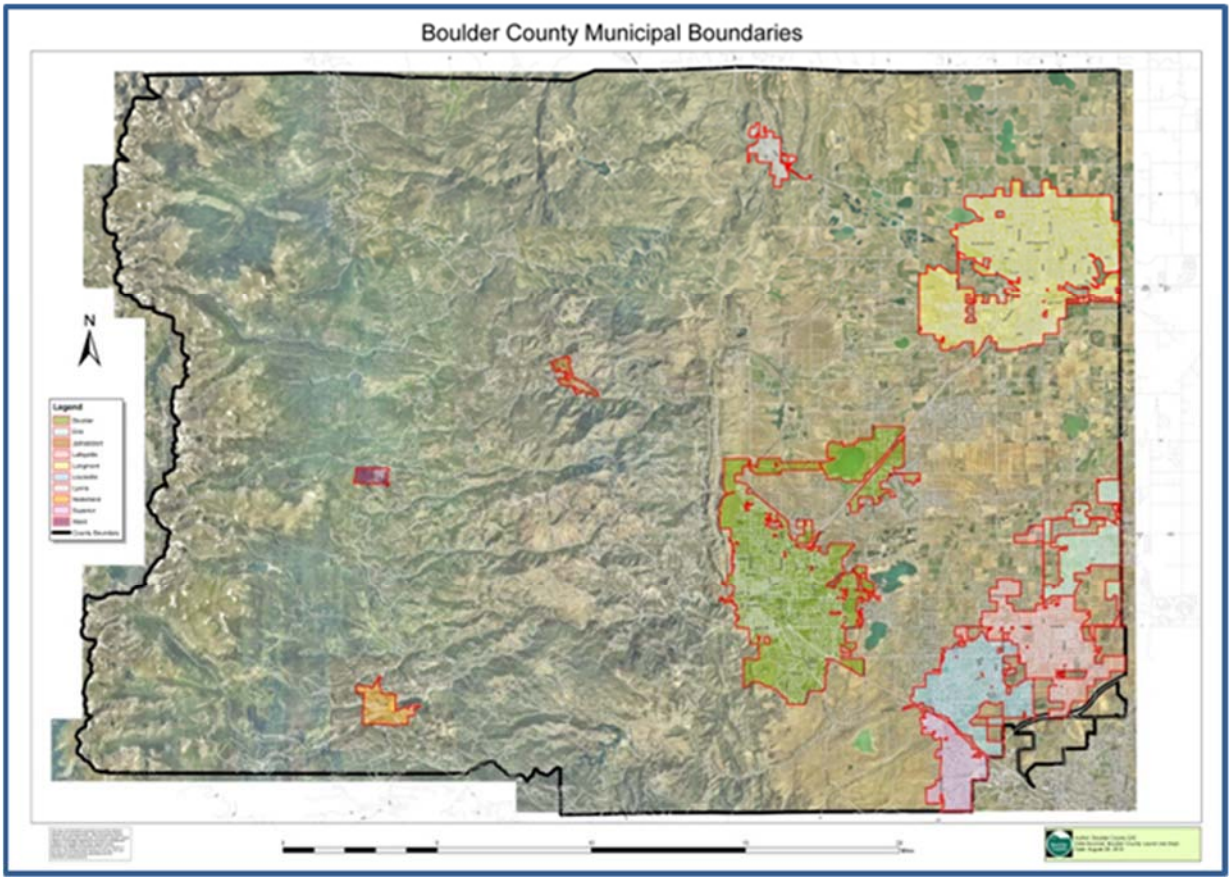
TRANSFER OF JURISDICTION

Occasionally, deaths that occur in Boulder County are due to an "initiating event" that occurred in another county. For example, an individual may die in a hospital from injuries that they sustained in an incident that occurred in another county, or an individual may collapse at their residence (in another county), be transported to a hospital in Boulder County, and subsequently die in that hospital. In these cases, the Boulder County Coroner will transfer jurisdiction (subsequent investigation and certification) to the coroner of the county in which the "initiating event" occurred.

In 2021, the jurisdictions of 128 cases were transferred to other coroners in surrounding counties. Eighty-four cases were natural deaths, 10 were traffic incidents, 23 were non-traffic accidents, 5 were suicides, and 5 were homicide. 1 case was unclassified. Cases were transferred to the following counties: Adams/Broomfield County (47), Weld County (37) and Jefferson County (33), Larimer (2), Grand (1), Arapahoe (1), Morgan (1), Gilpin (1), Mesa (1), Garfield (1), Mineral (1), Rio Blanco (1) and Delta (1).

114 of the transferred cases were deaths that occurred in a hospital and 14 were in a long-term care center, an assisted living facility or rehabilitation center. Fifty-five of the transferred cases were deaths that occurred in an emergency department. Thirty-nine of them occurred at Good Samaritan Medical Center, 1 occurred at Avista Hospital, and 15 occurred at Longs Peak Hospital in Longmont.

For statistical purposes, in the sections to follow, transferred cases will not be counted among the deaths investigated by Boulder County, unless otherwise noted.

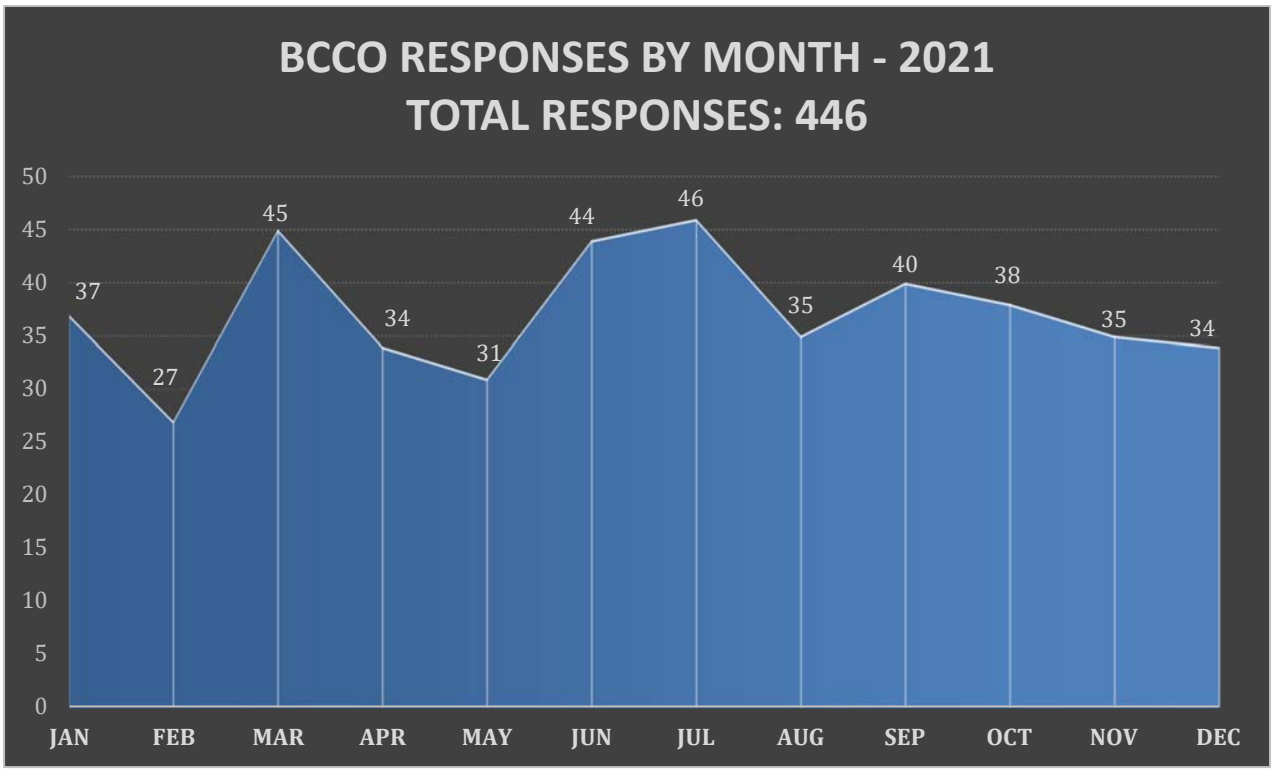


CORONER RESPONSES BY MONTH

The Boulder County Coroner's Office is called to action by either receiving a phone report of a death or by receiving a notification and response request from law enforcement. When a death is reported to the office by phone it is typically being reported by a hospice agency, a care center or a hospital. The coroner's office will make a determination if a response is necessary; if not, a phone report is taken, and the office may follow up with attaining additional medical records and conducting further interviews as needed. A response is made by the coroner's office to the care center or hospital if further information is needed at the time of death.

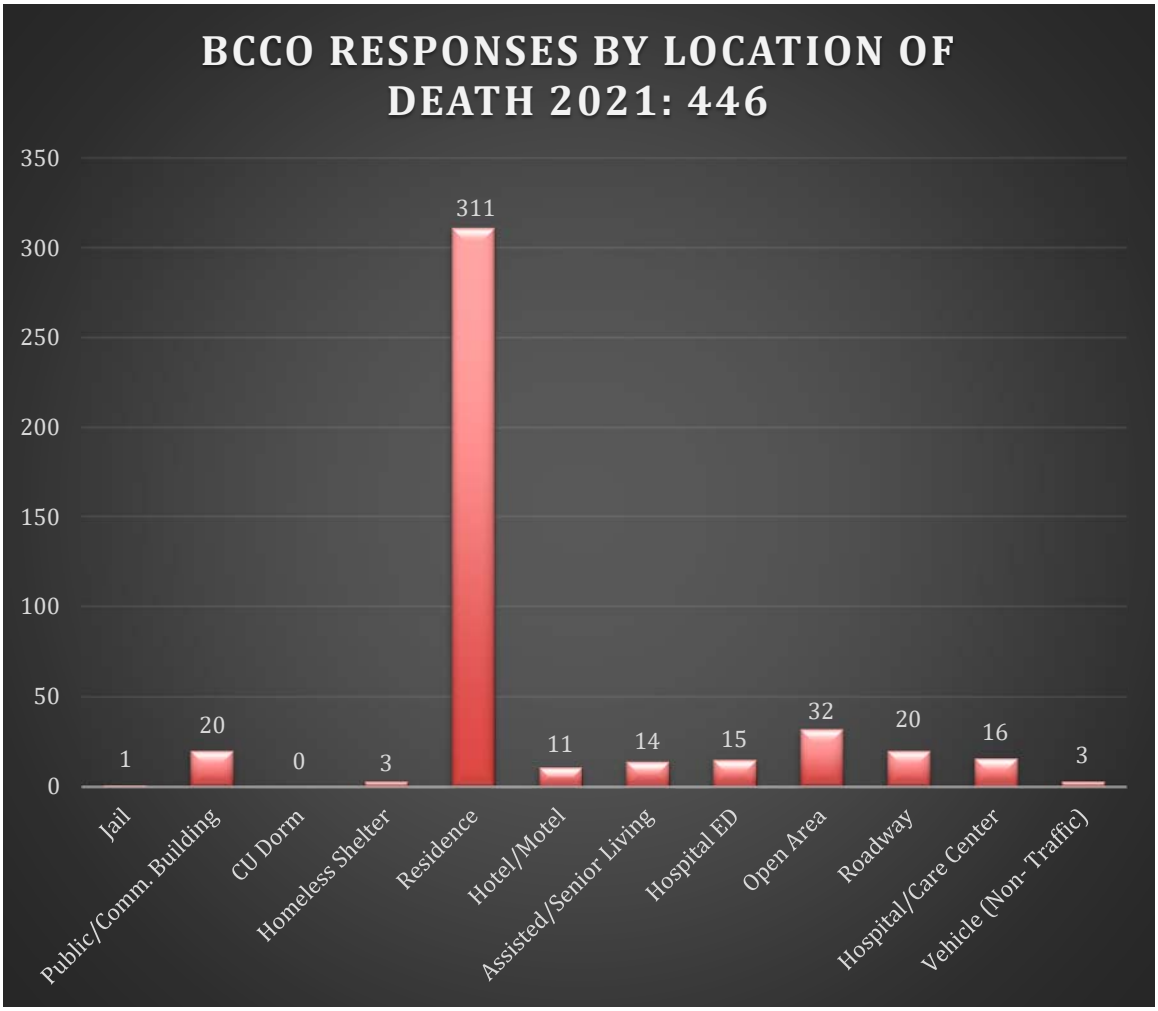
Most responses made by the coroner's office are to death scenes where law enforcement was notified and requested the coroner's office. Law enforcement has jurisdiction over the scene, while the coroner's office has jurisdiction over the body, therefore, both agencies work together to accomplish their individual responsibilities. The coroner's office is responsible for determining manner and cause of death, identifying the decedent and notifying the next of kin. Law enforcement's responsibility is to determine and document any crime that may have occurred or the lack thereof.

In 2021, 446 scene responses were made which was 19% of all the deaths reported to the Boulder County Coroner's Office.



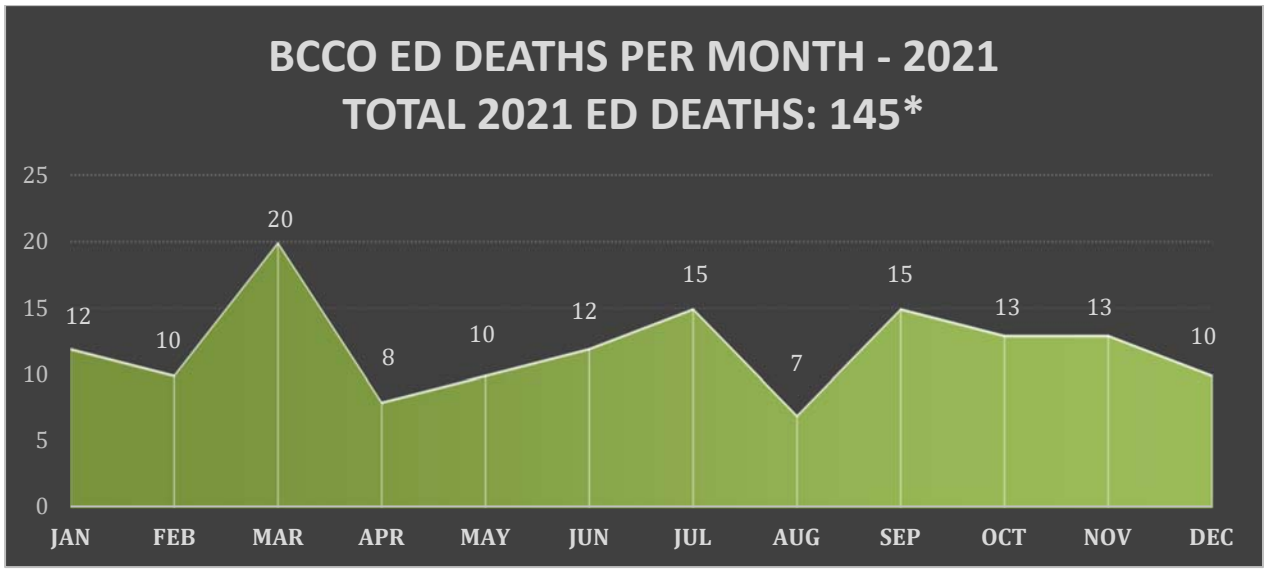
CORONER REPONSES BY LOCATION OF DEATH

Boulder County Coroner's Office all-terrain response vehicle equipped for mountain responses.



EMERGENCY DEPARTMENT CALLS BY MONTH

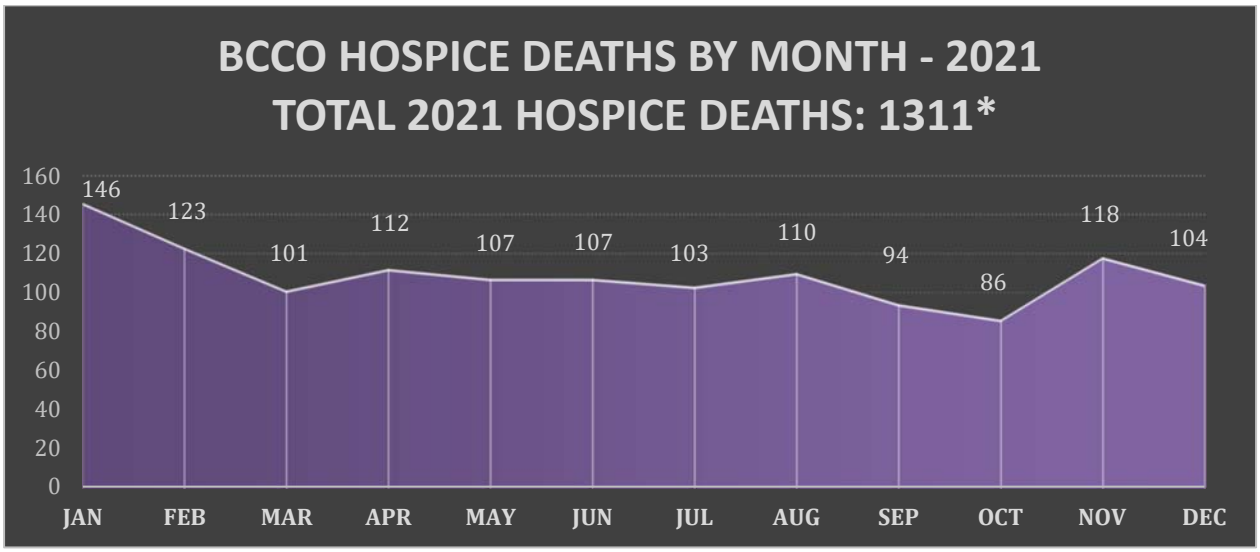
Deaths that occur in an Emergency Department (ED) are required to be reported to the coroner's office. Hospitals in Boulder County include Boulder Community Hospital Foothills, Longmont United Hospital, Good Samaritan Medical Center, Avista Adventist Hospital, and Longs Peak Hospital.



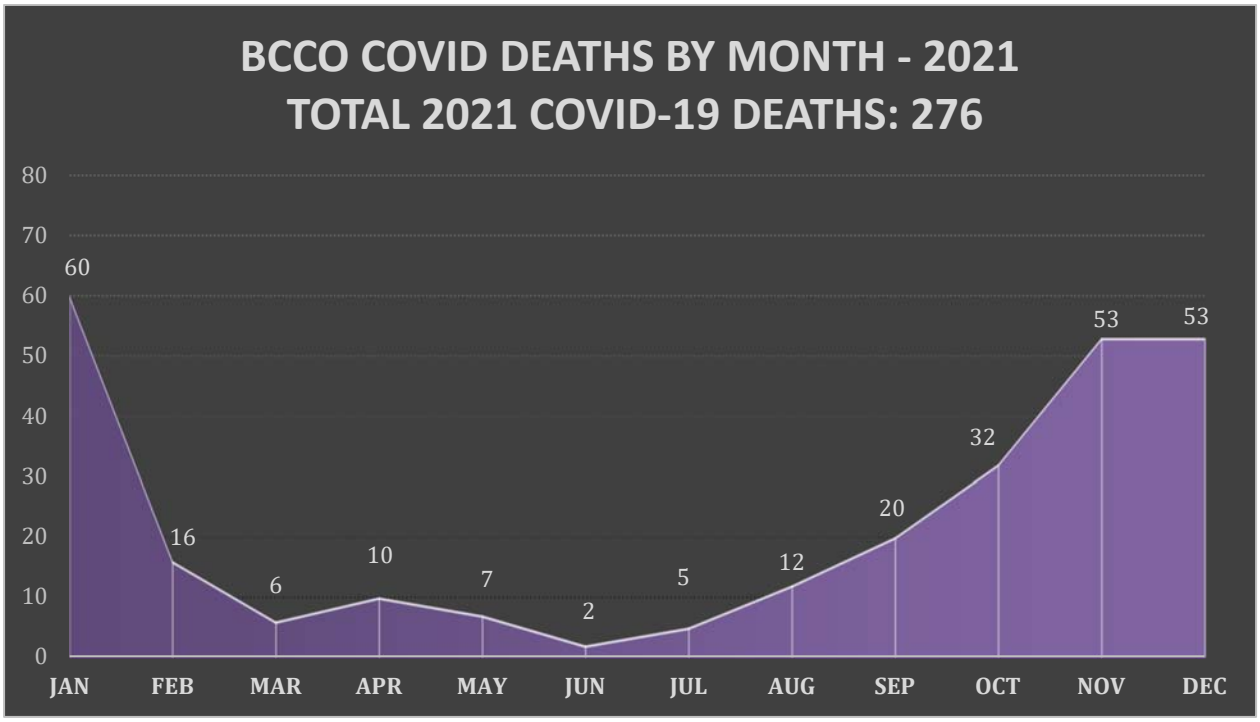
Note: *The total number of cases reported includes 55 cases that were transferred to other coroners. See **Transfer of Jurisdiction** of this report for further explanation.

HOSPICE CASES BY MONTH

Deaths occurring under hospice care in Boulder County are reported to the Boulder County Coroner's Office. There are several hospice organizations operating throughout Boulder County. Of the 1325 hospice cases reported to the Boulder County Coroner's Office there were 14 cases transferred to another coroner's office. Of the 1311 hospice cases reviewed by the office 1274 (97%) were natural deaths, 35 (3%) were accidental deaths, one was suicide, and one was a homicide. Three of the hospice cases involved an autopsy.



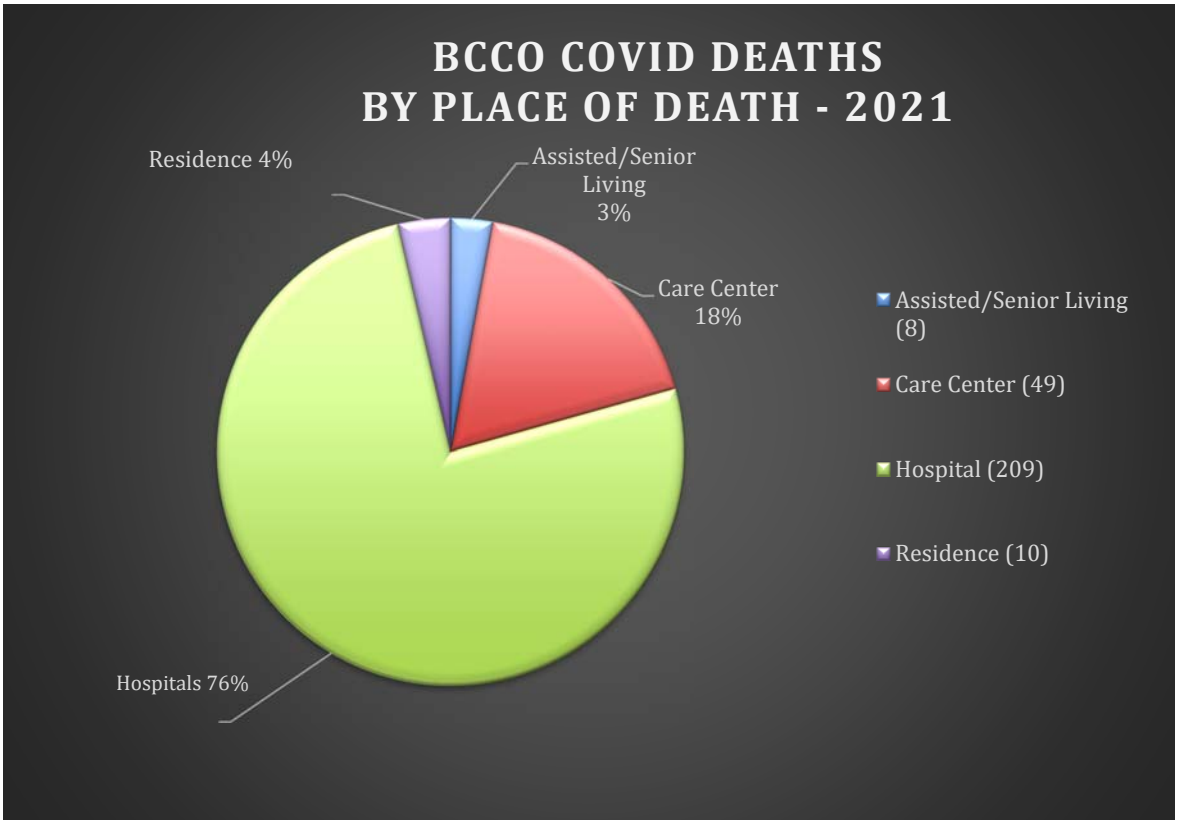
Note: *The total number of cases reported does not include 14 cases that were transferred to other coroners.

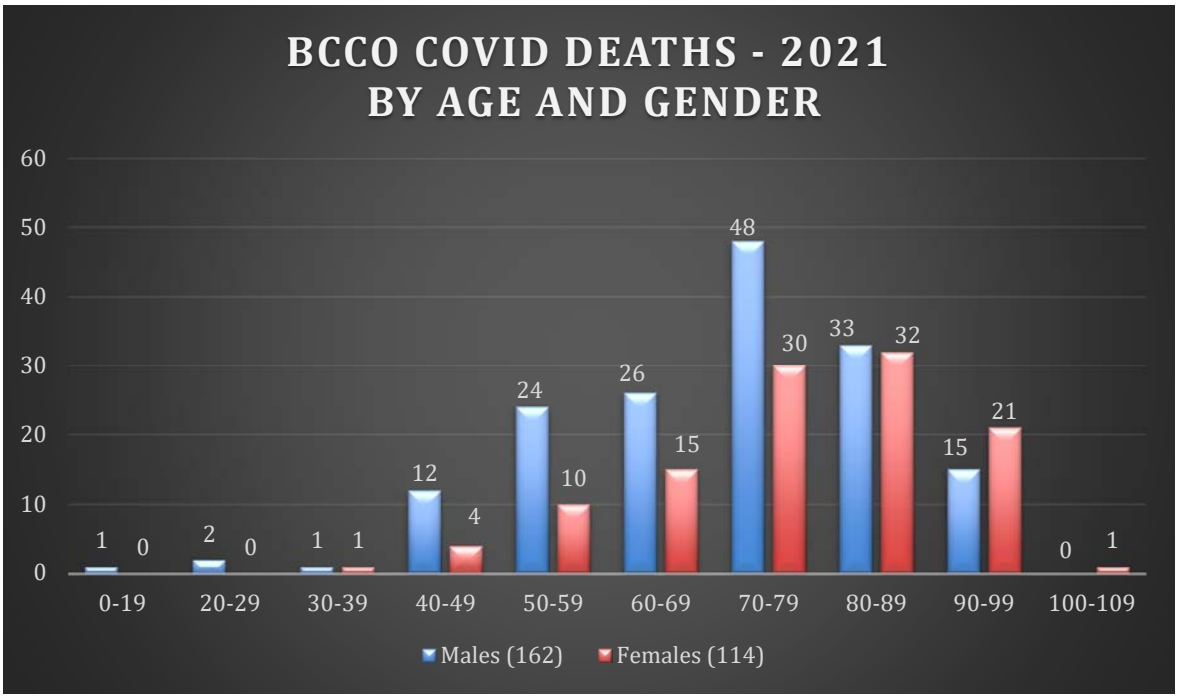


Note: Statistical information may not coincide with information available from the Colorado Health Department. The State Health Department tracks death statistics by the county of residence, not by the county where the injury or death occurred. The 276 cases included cases where the cause of death was due to COVID. Of the above 276 cases, 165 of them were not registered as Boulder County residents at the time that their death occurred, however they died in Boulder County.

Boulder County Courthouse lit in magenta to honor lost lives

On Friday evening, March 5, the Boulder County Courthouse was lit up in magenta in remembrance of the nearly 6,000 Coloradans who lost their lives over the last 12 months to #COVID-19. Let's continue to honor our neighbors by continuing to mask up and maintain safe social distancing so we can prevent further losses. #doyourpart


BCCO COVID DEATHS
BY PLACE OF DEATH - 2021
Residence 4%
Assisted/Senior Living 3%
Care Center 18%
Hospitals 76%
Assisted/Senior Living (8)
Care Center (49)
Hospital (209)
Residence (10)

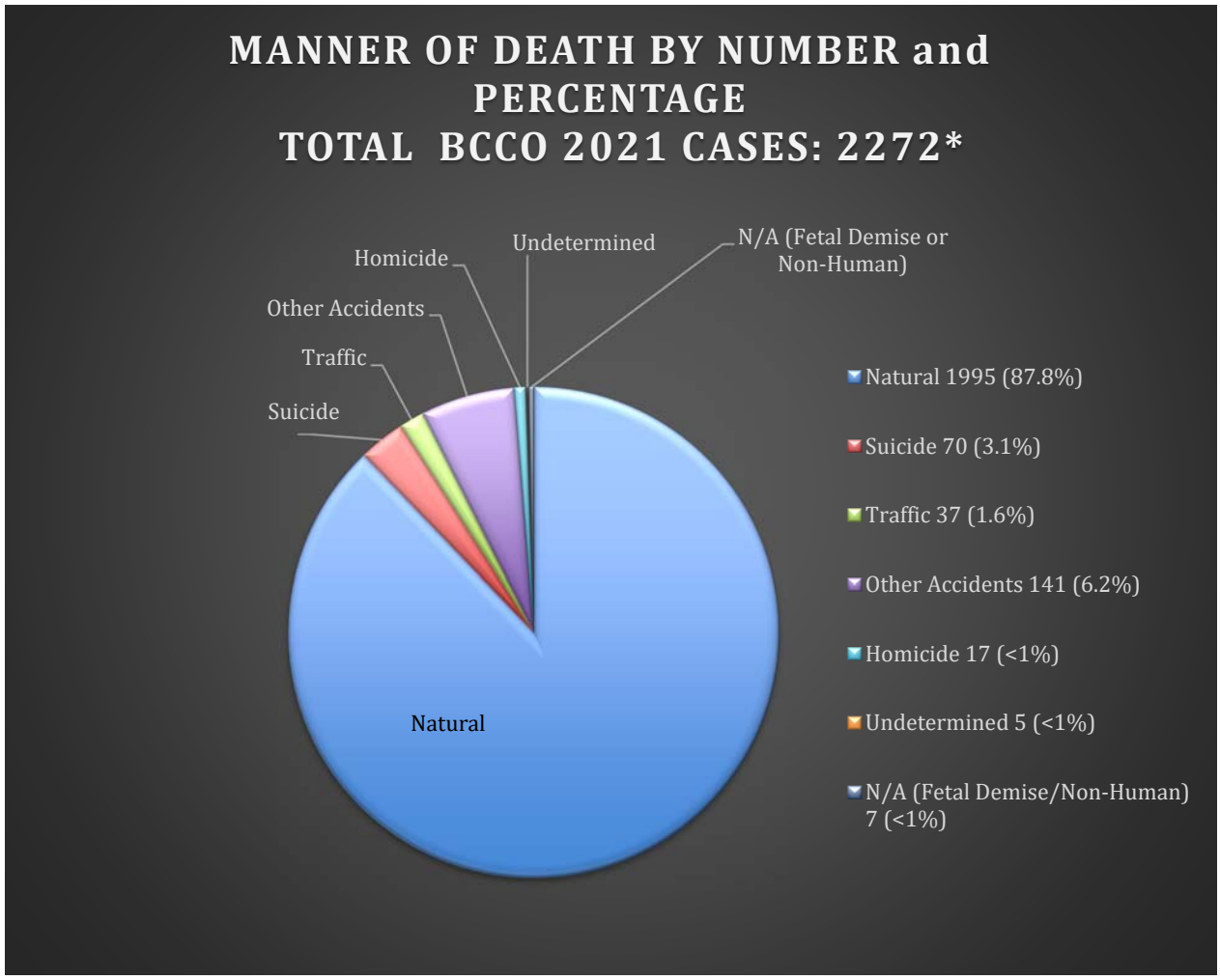

BCCO COVID DEATHS - 2021
BY AGE AND GENDER
60
50
40
30
20
10
0
1 0
2 0
1 1
12 4
24 10
26 15
48 30
33 32
15 21
0 1
0-19
20-29
30-39
40-49
50-59
60-69
70-79
80-89
90-99
100-109
Males (162)
Females (114)

MANNER OF DEATH

One of the main responsibilities of the coroner's office is to determine the manner of death. The manner of death is a classification of death based on the circumstances surrounding the cause of death and how that cause came to be. There are five manners of death: Natural, Suicide, Accident, Homicide and Undetermined. The manner of death is one of the items that must be reported on the death certificate. The manner of death was added to the US Standard Certificate of Death in 1910; it was added by public health officials as a way to code and classify cause of death information for statistical purposes. It should be noted that the medicolegal definition of Homicide means death caused by another and is not based on intent. A ruling of Homicide does not indicate or imply criminal intent.[1]

MANNER OF DEATH BY NUMBER AND PERCENTAGE

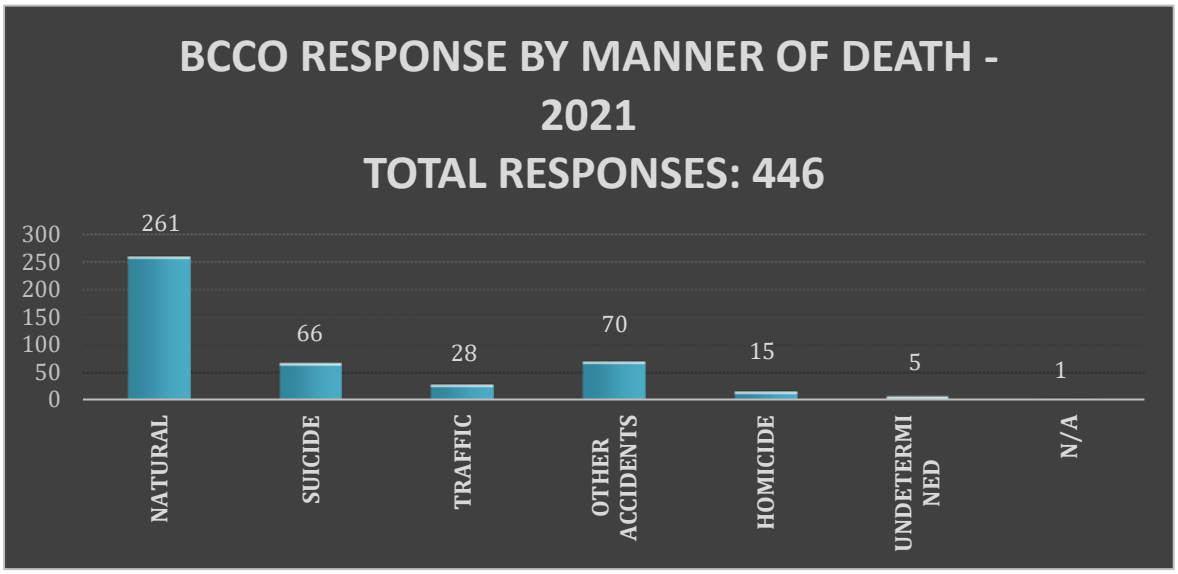
A large majority of the cases investigated by any medical examiner or coroner's office are natural deaths. In Boulder County that figure was 1995 cases, or 87.8% in 2021. Included within these natural deaths were 1274 hospice cases.



Note: *The 128 cases transferred to other coroners are not included in these totals.

Note: Statistical information may not coincide with information available from the Colorado Health Department. The State Health Department tracks death statistics by the county of residence, not by the county where the injury or death occurred.

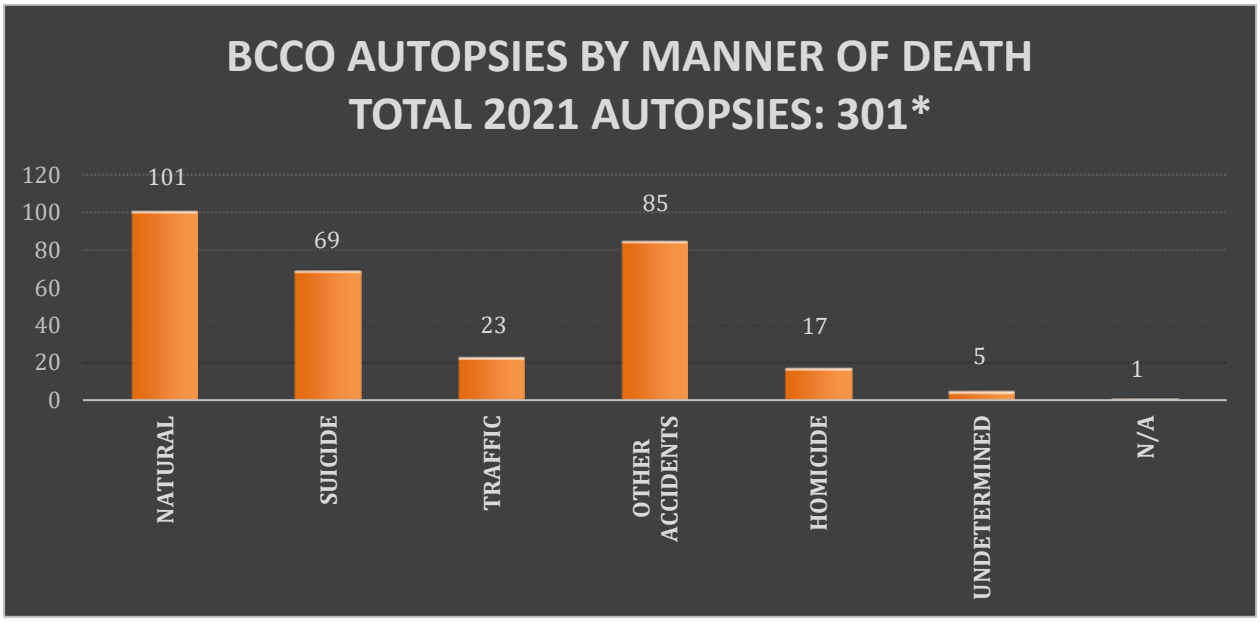
CORONER RESPONSE BY MANNER



Note: The apparent absence of a scene investigation in some suicides, motor vehicle, and other accident cases may be due to the extended survival of the victim in a hospital, or because the victim was transported by emergency personnel to a hospital outside the county and subsequently died away from the scene.

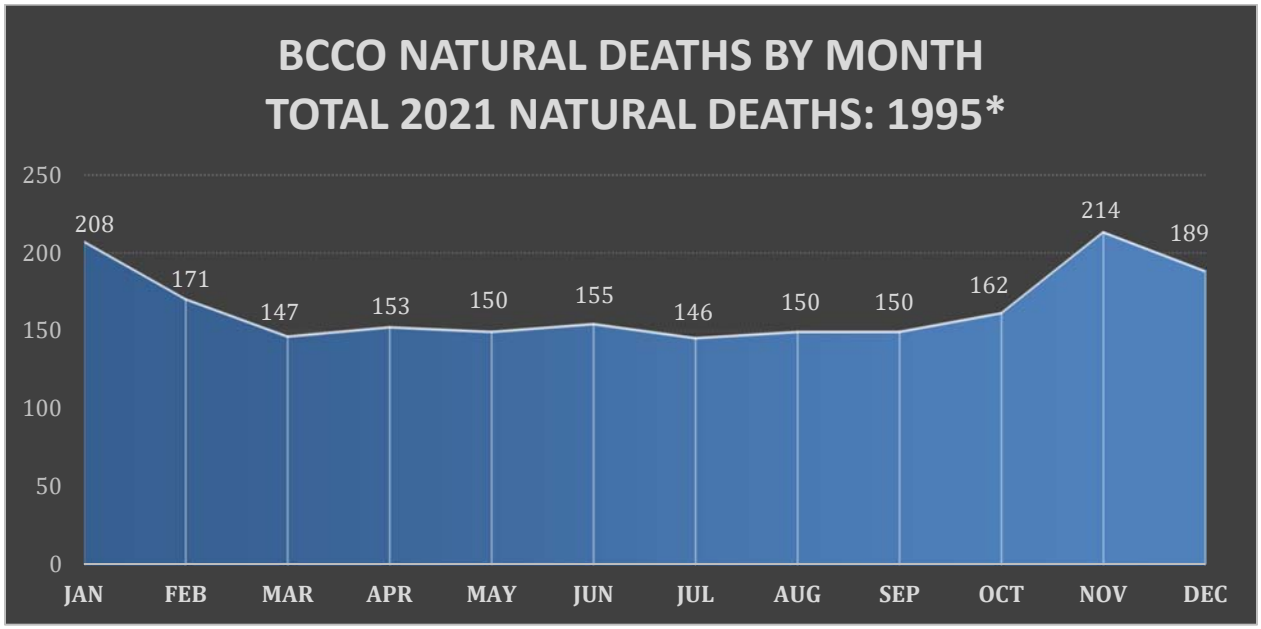
AUTOPSIES BY MANNER OF DEATH

In addition to following the "Forensic Autopsy Performance Standards" adopted by the National Association of Medical Examiners (NAME), the Coroner weighs many factors in order to determine whether an autopsy should be performed. Autopsies are performed in all homicides, most infant deaths, most deaths of individuals without an established medical history, deaths involving possible criminal action, most motor vehicle accident deaths, and most suicides.



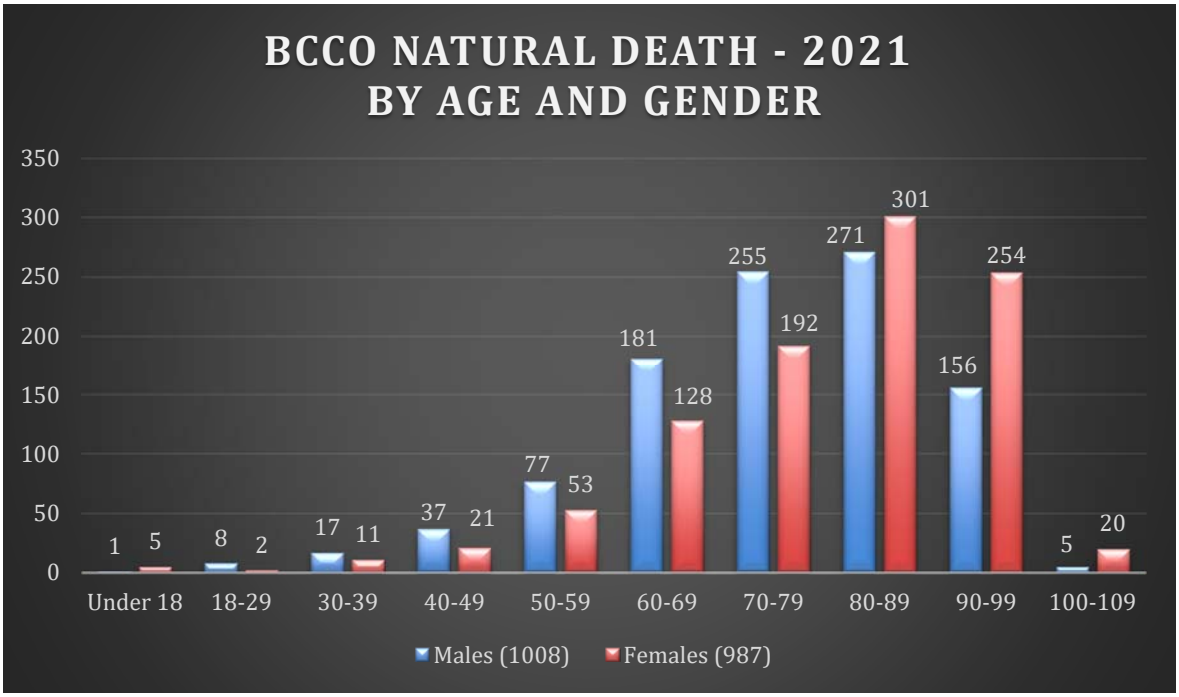
NATURAL DEATHS BY MONTH

Natural deaths comprise the majority of all deaths nationwide and holds true for the cases handled by the Boulder County Coroner's Office.



Note: *This total does not include the 84 natural deaths transferred to other coroners.

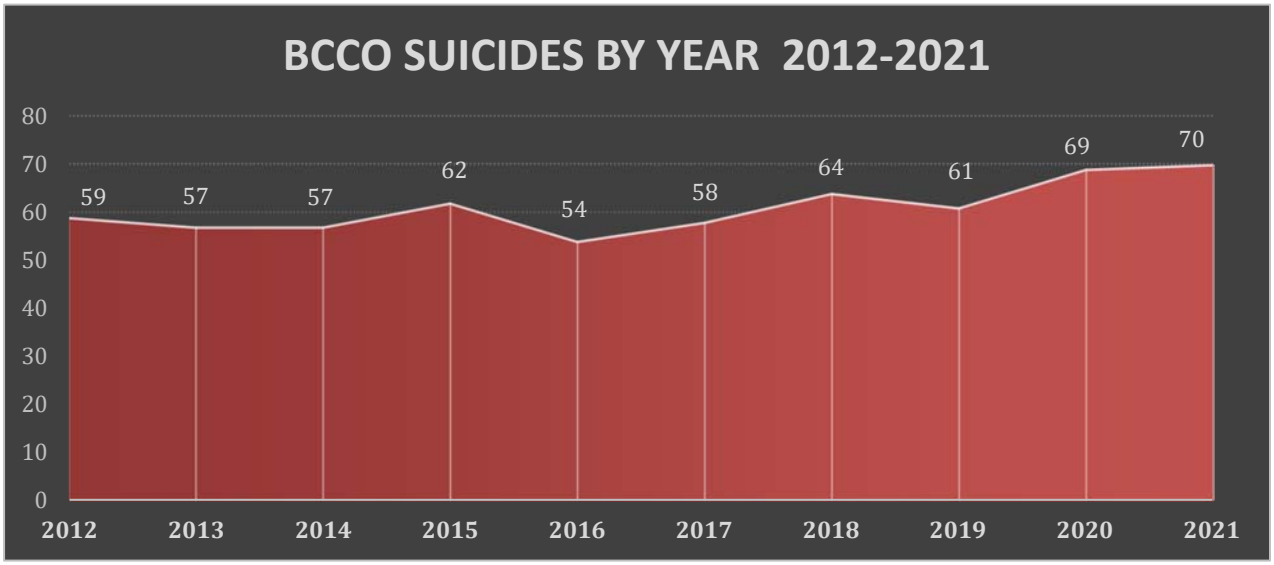
NATURAL DEATHS BY AGE AND GENDER



SUICIDES

Suicide is defined as the intentional act of killing oneself. Nationally, men are 3.56 times more likely to commit suicide than women[2] but women attempt suicide more frequently than men. The most common method of committing suicide is with firearms, followed by hanging, suffocation, and ingestion of poisons.[3] In 2021 in Boulder County, the most common method used was a firearm, followed by hanging and then by prescription medication.

SUICIDES BY YEAR

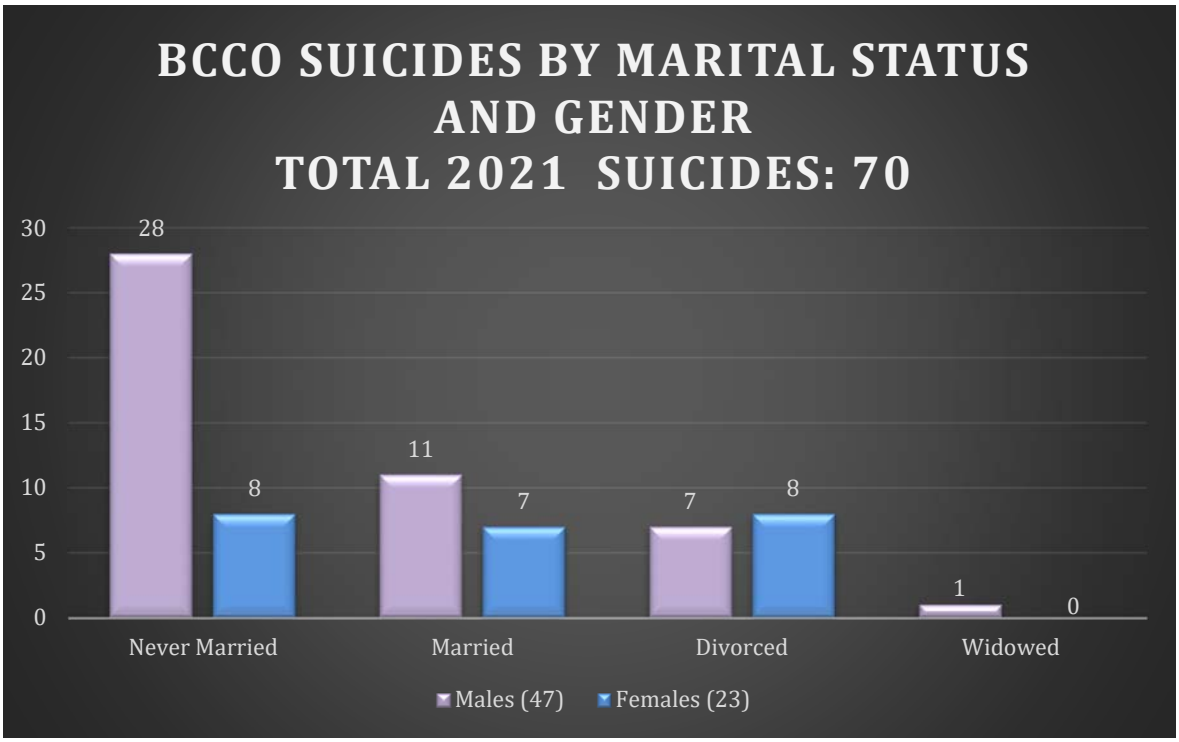


Note: There were a total of 75 suicides reported to the Boulder County Coroner's Office in 2021. The Boulder County Coroner's Office investigated 70 of those cases and transferred jurisdiction of 5 cases to other coroners.

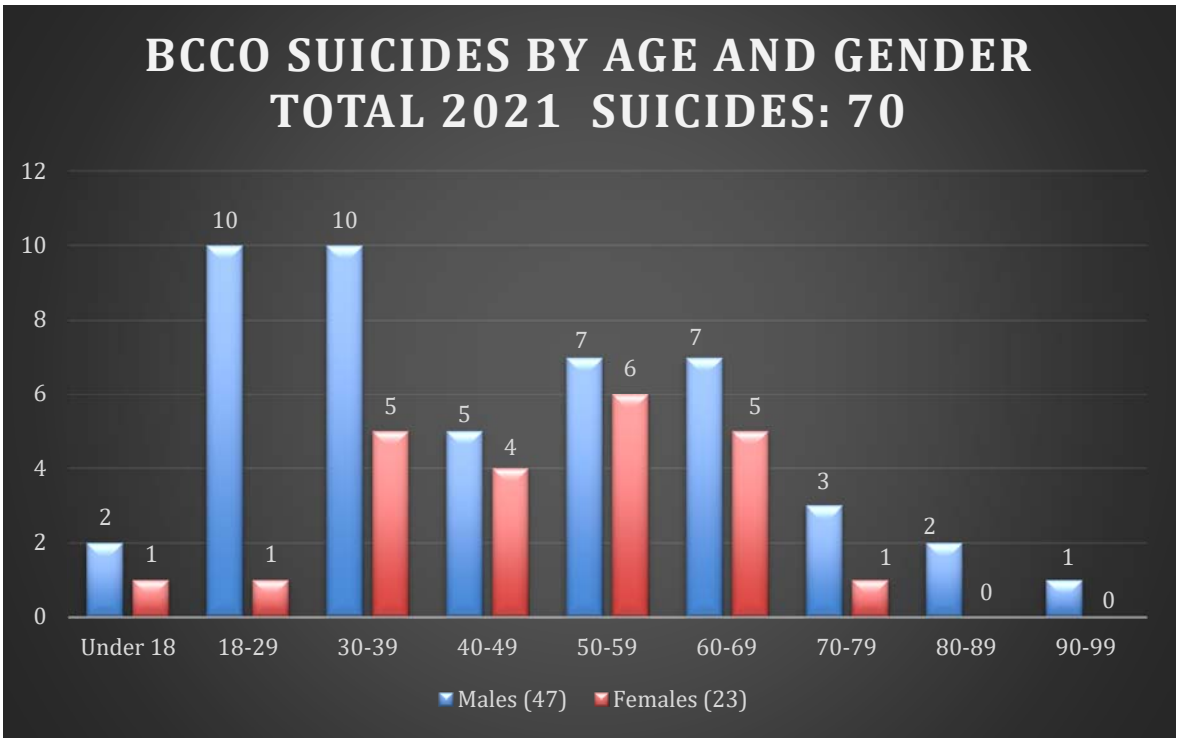
SUICIDES BY MONTH

Note: Nine of the suicides were non-Boulder County residents.

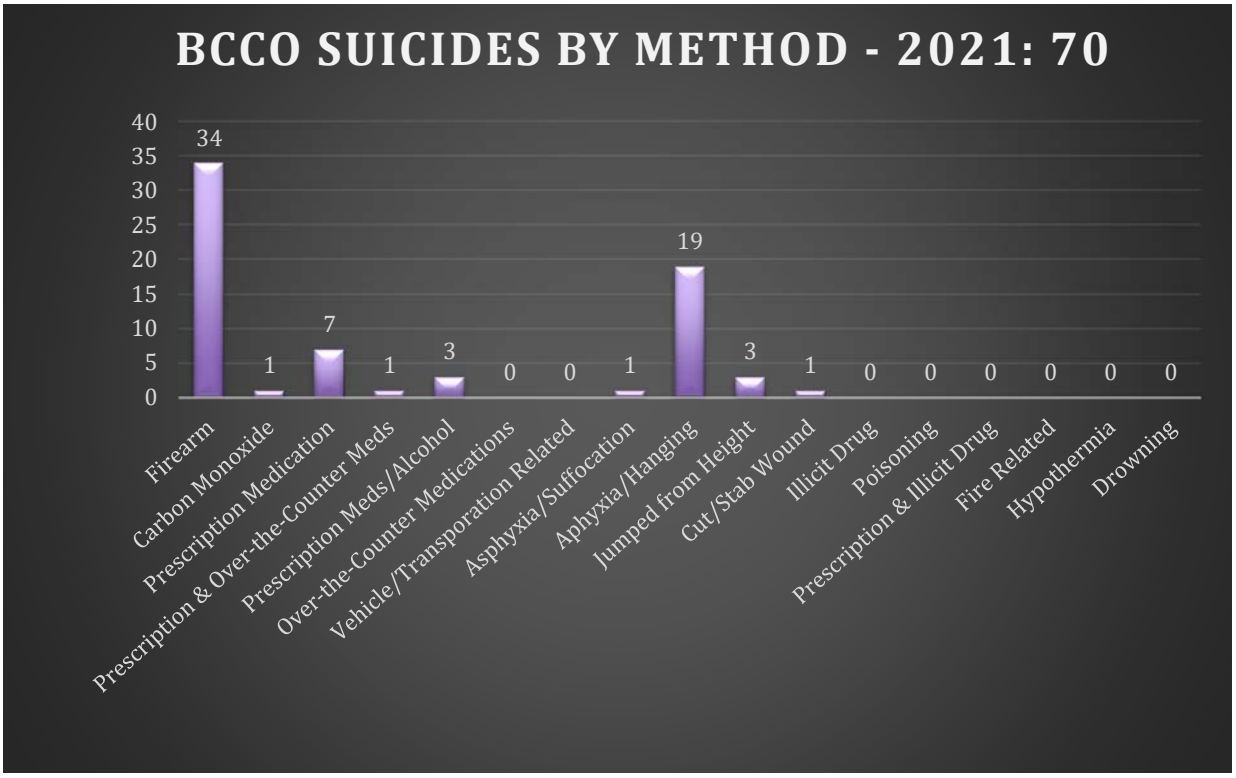
SUICIDES BY MARITAL STATUS AND GENDER



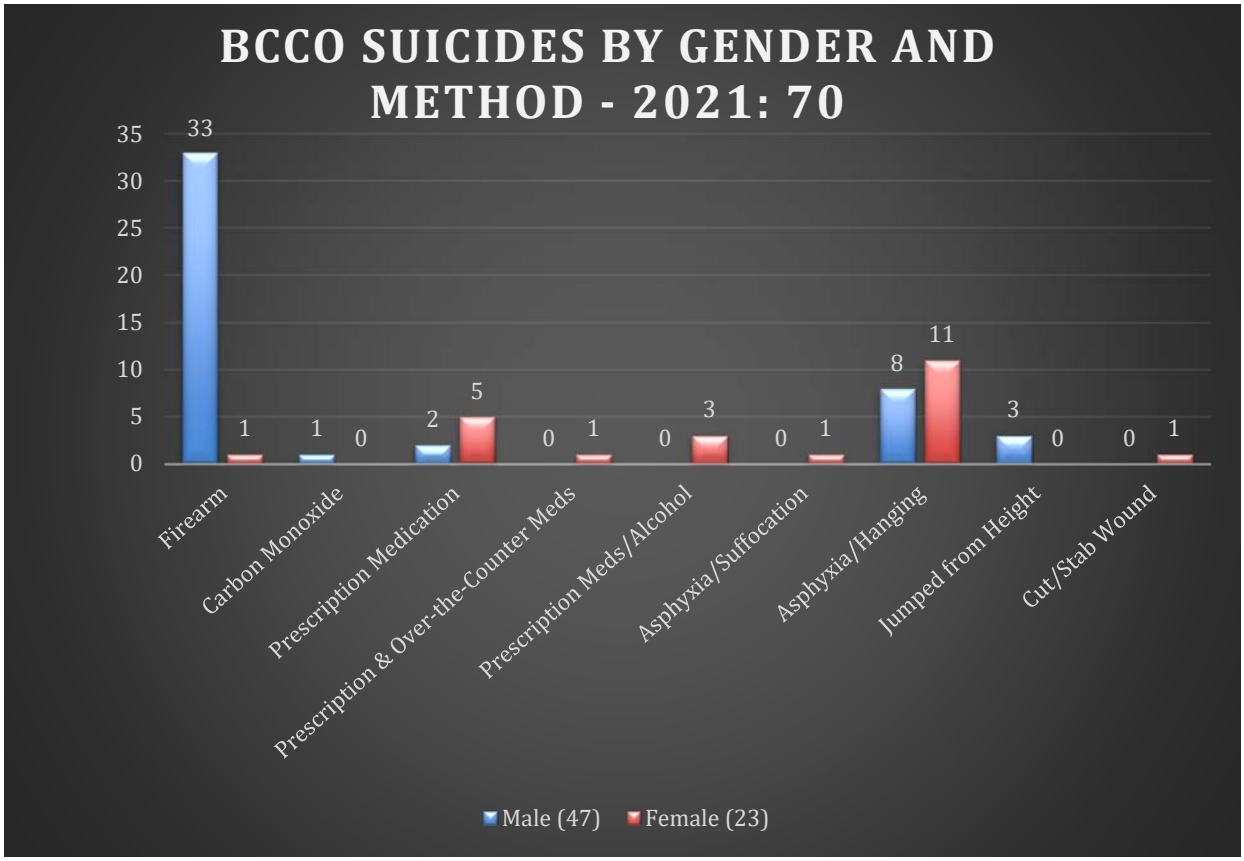
SUICIDES BY AGE AND GENDER



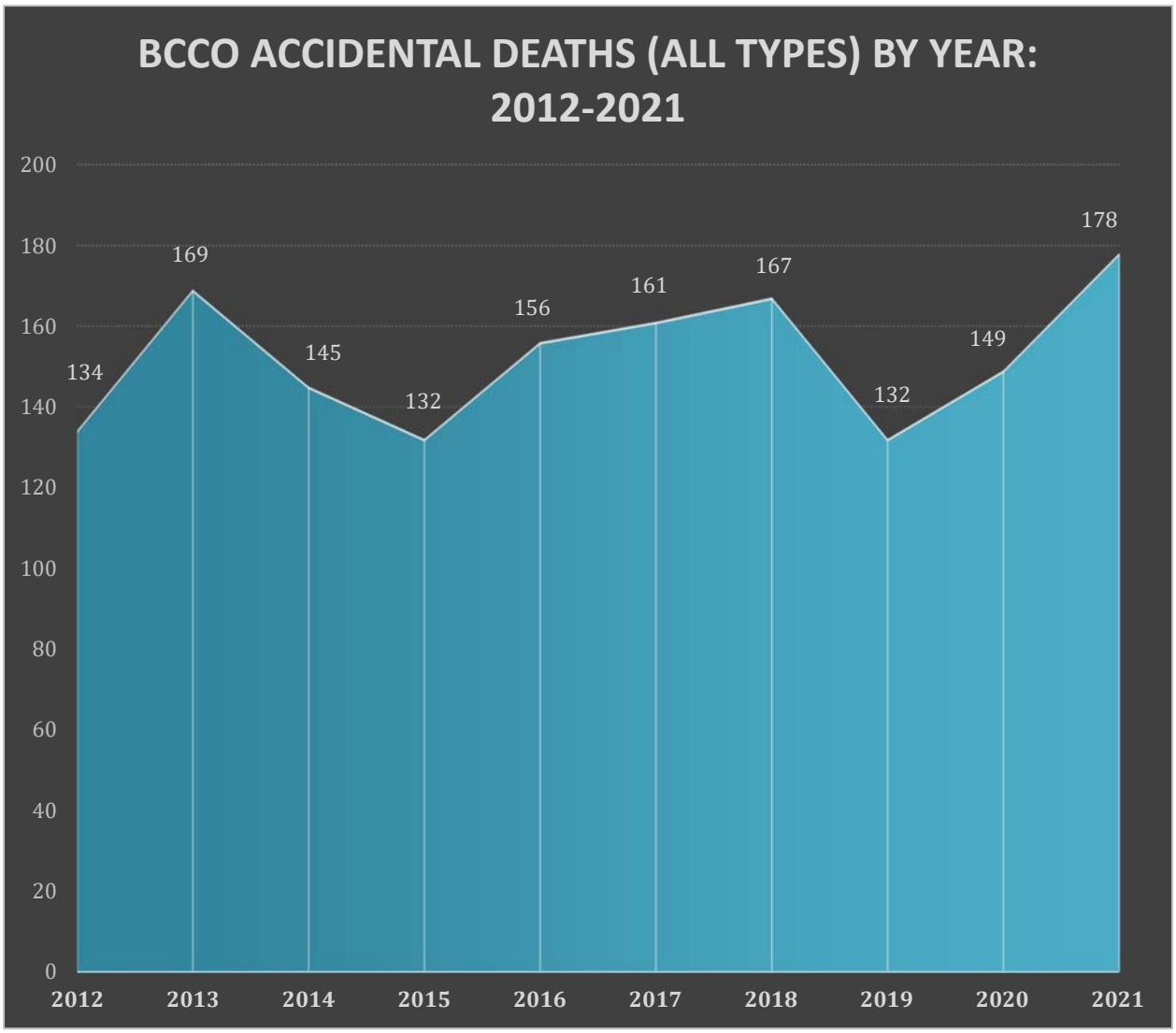
SUICIDES BY METHOD



SUICIDES BY GENDER AND METHOD



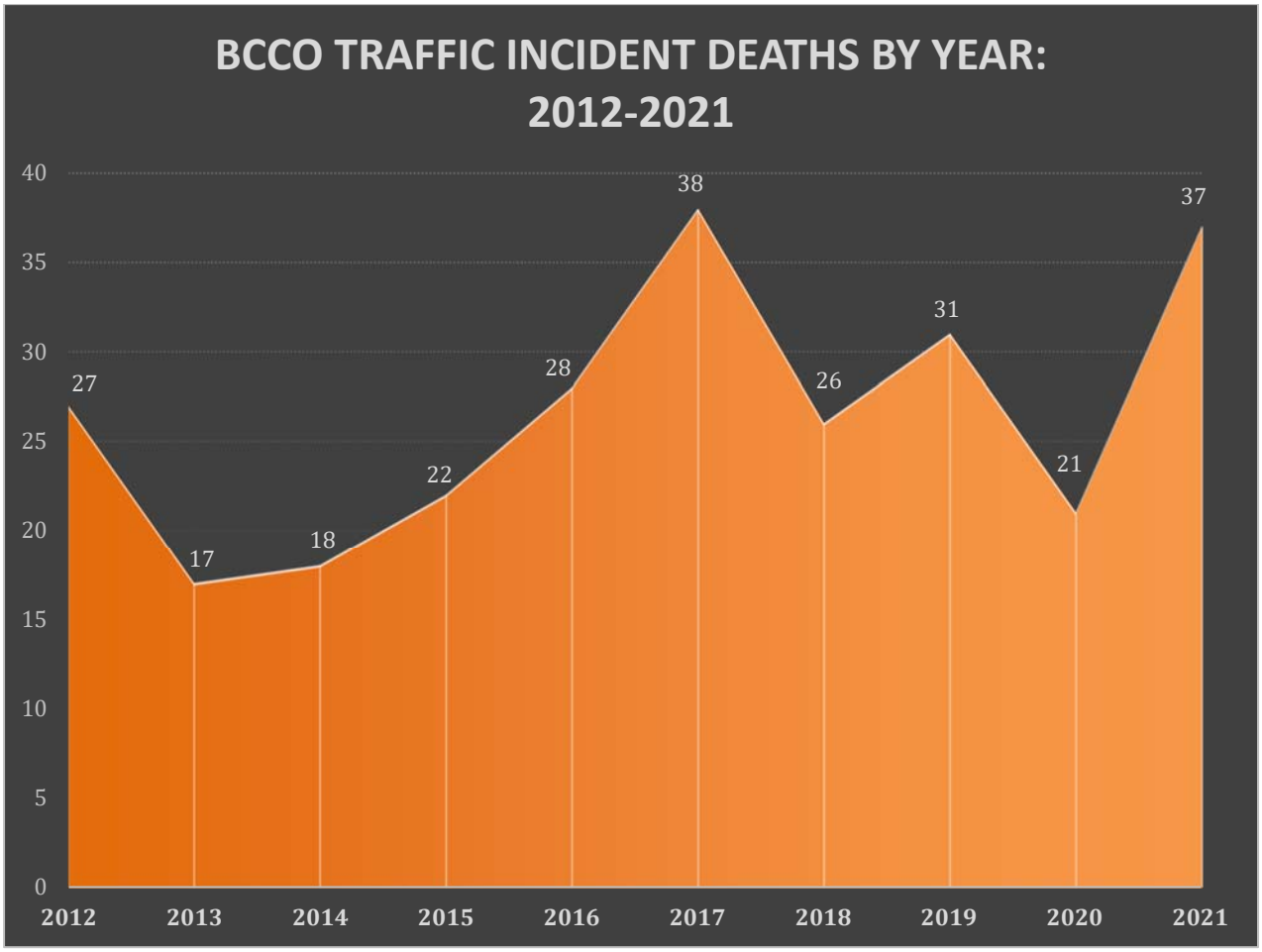
ACCIDENTAL DEATHS BY YEAR, ALL TYPES



Note: In 2021, a total of 212 accidental deaths were reported to the Boulder County Coroner, 34 of those cases were transferred to other coroners.

TRAFFIC INCIDENT DEATHS BY YEAR

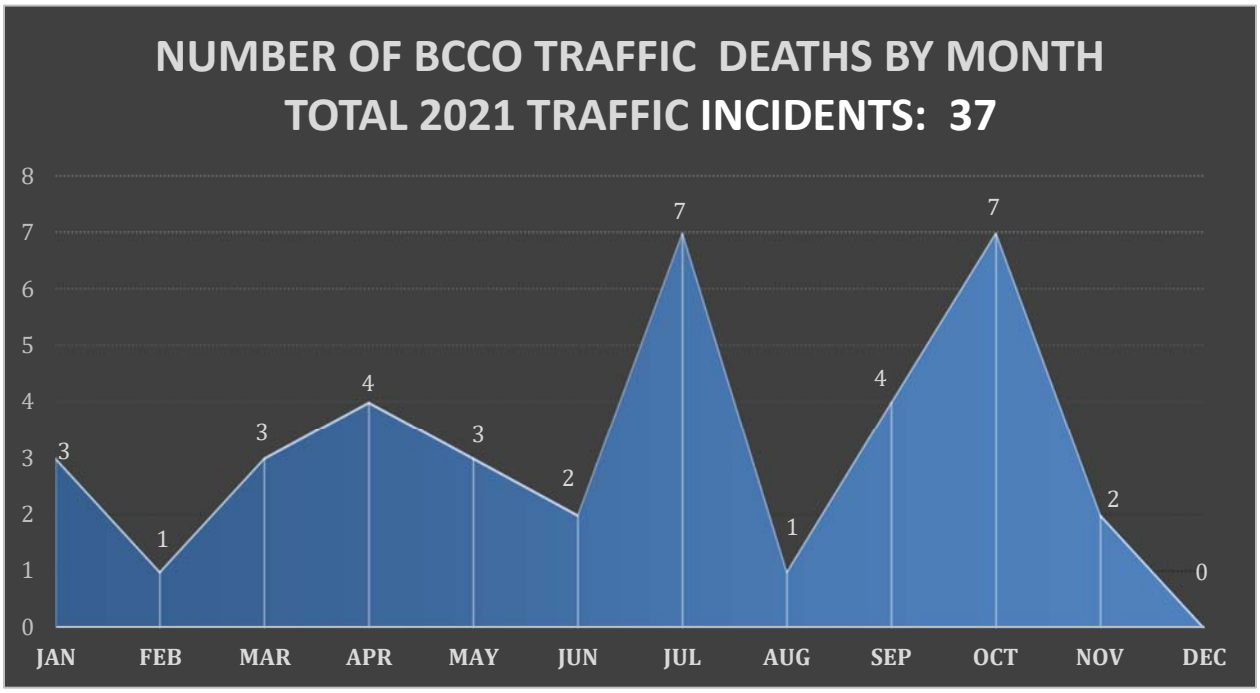
For the purpose of this report, deaths involving a motor vehicle, motorcycle, bicycle-vehicle incidents, all-terrain vehicles, trains, and vehicle-pedestrian incidents, are considered to be traffic incident deaths.



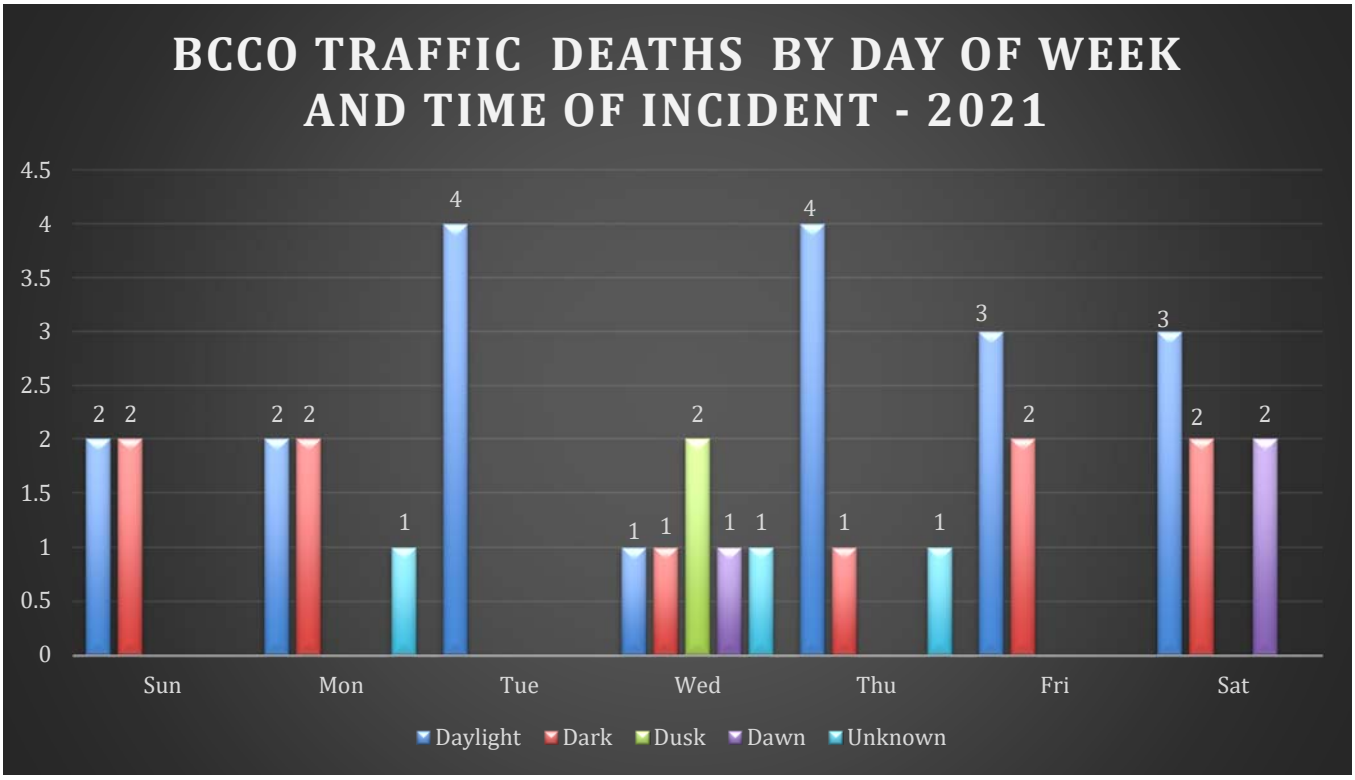
The Boulder County Coroner's Office investigated 37 deaths resulting from traffic incidents in 2021. Of the 37 deaths, 32 were male and 5 were female. Their ages ranged from 16 to 93 years of age. Twenty-two people died due to injuries or complications from injuries sustained in motor vehicle incidents (including automobiles, pickup trucks, SUVs and vans), 4 people died as a pedestrian struck by a motor vehicle, 6 people that died were bicyclists involved in a collision and 5 were motorcyclists. Among the 22 vehicle fatalities, 19 were drivers and 3 were passengers. Seven of the 19 drivers were wearing seatbelts and 1 of the 3 passengers were wearing seatbelts. Of the 6 bicycle deaths, 4 were wearing a helmet. Of the 5 motorcycle deaths, all 5 were drivers and 3 were wearing a helmet.

Note: There were a total of 47 traffic incident deaths reported to the Boulder County Coroner's Office in 2021. The Boulder County Coroner's Office investigated 38 of these cases; the other 10 cases were transferred to another coroner's jurisdiction.

TRAFFIC DEATHS BY MONTH



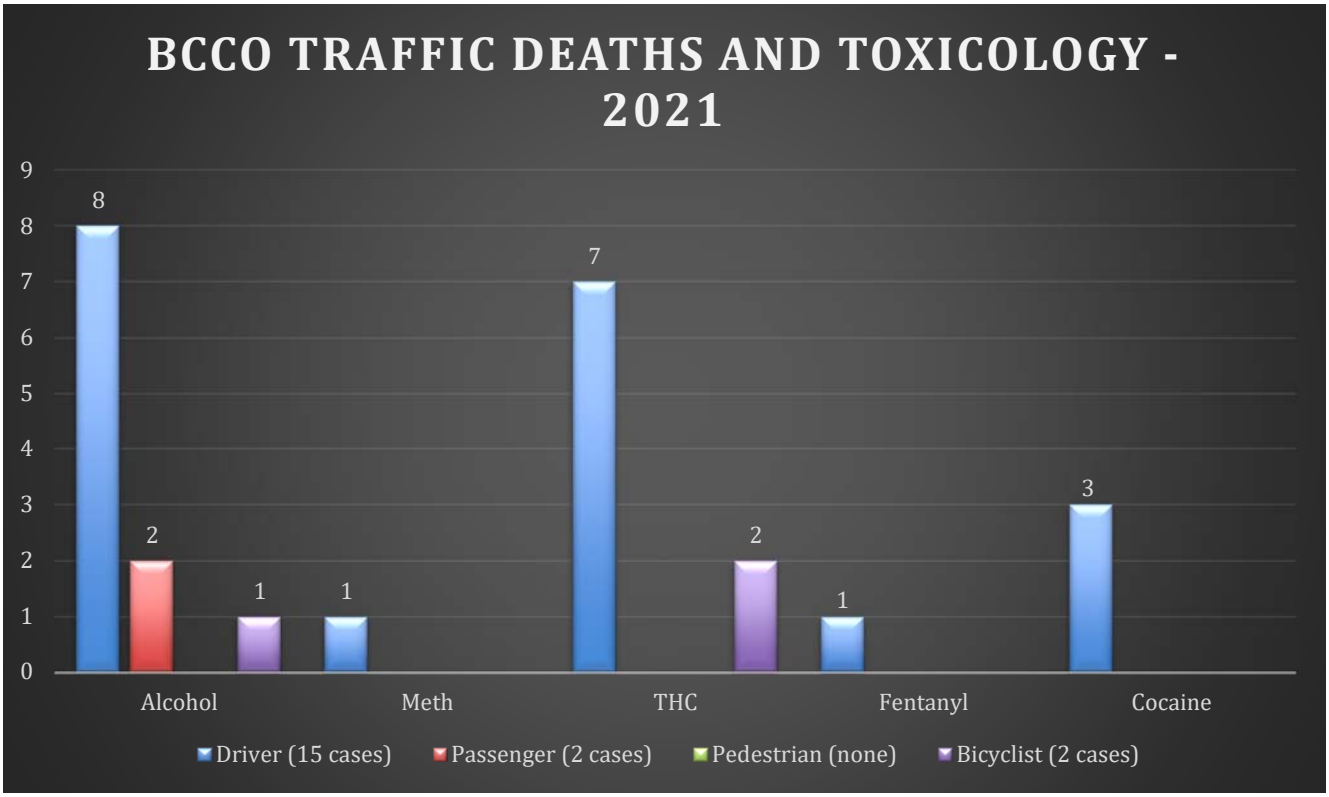
TRAFFIC DEATHS BY DAY OF WEEK AND TIME OF INCIDENT



Note: The graph displays the information based on the time of incident, which may differ from the time of death.

ALCOHOL AND TRAFFIC DEATHS

In the toxicology testing of the traffic fatality cases, there were 9 cases in which toxicology testing was positive, the following substances were detected.

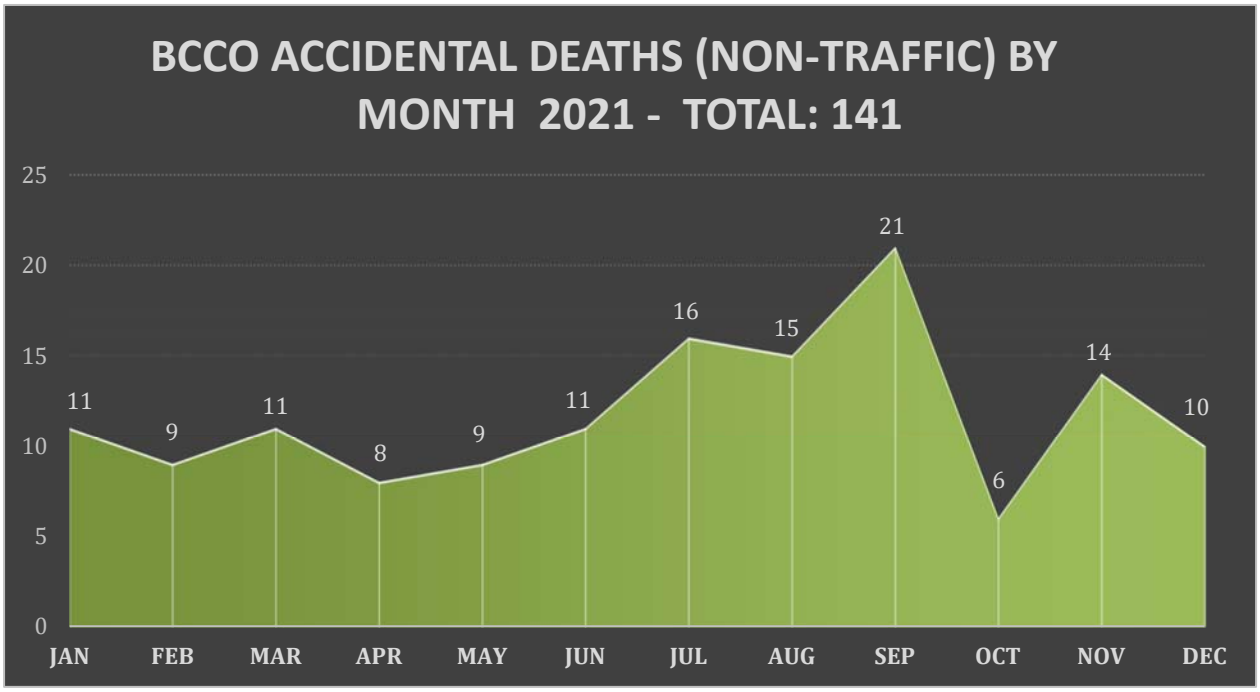


In Colorado in 2021, a driver is presumed to be Driving While Ability Impaired (DWAI) when a blood alcohol or breath concentration (BAC) is between .050% and .079%. Prior to July 1, 2004, the blood alcohol concentration threshold was .10% to be considered Driving Under the Influence (DUI). As of July 1, 2004, a driver is presumed to be Driving Under the Influence when the BAC is 0.080% or higher. The legal drinking age is 21.

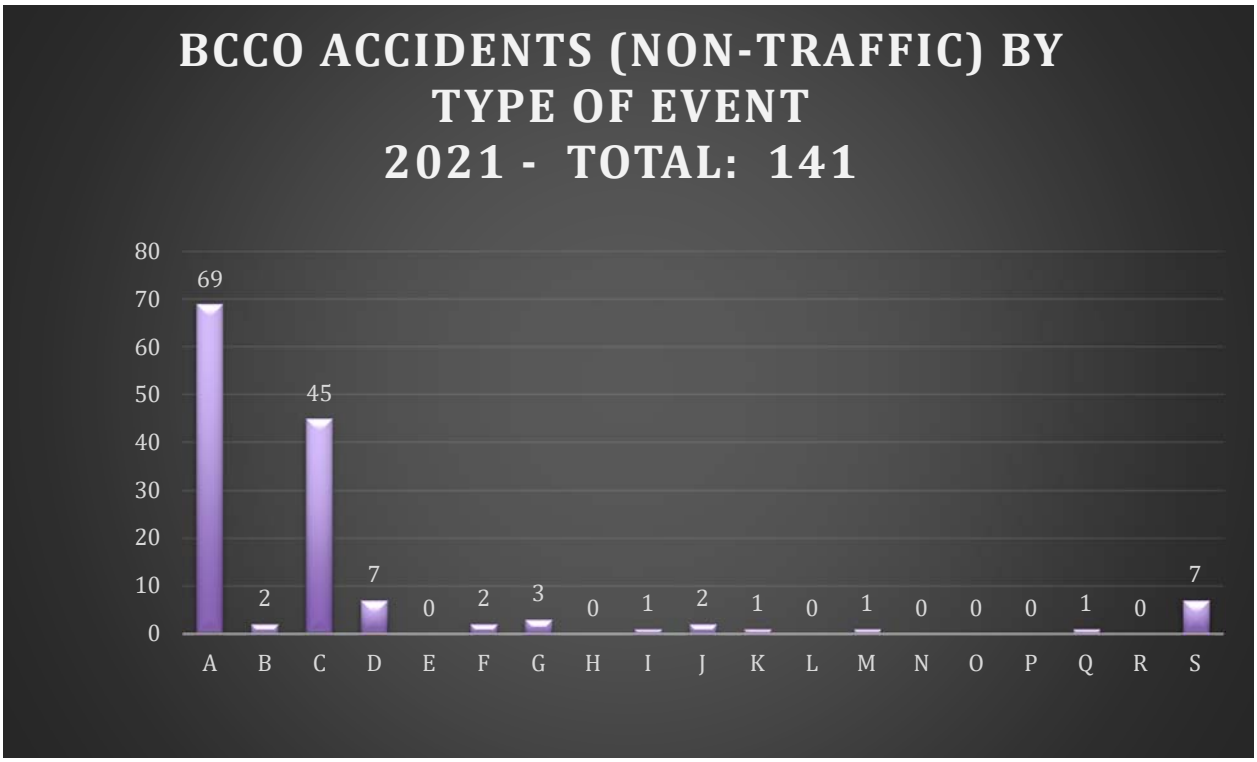
NON-TRAFFIC ACCIDENTAL DEATHS

Note: There were a total of 165 non-traffic accidents reported to the Boulder County Coroner's Office in 2021. The Boulder County Coroner's Office investigated 141 of those cases and transferred jurisdiction of 24 cases to other coroners.

NON-TRAFFIC ACCIDENTS BY MONTH



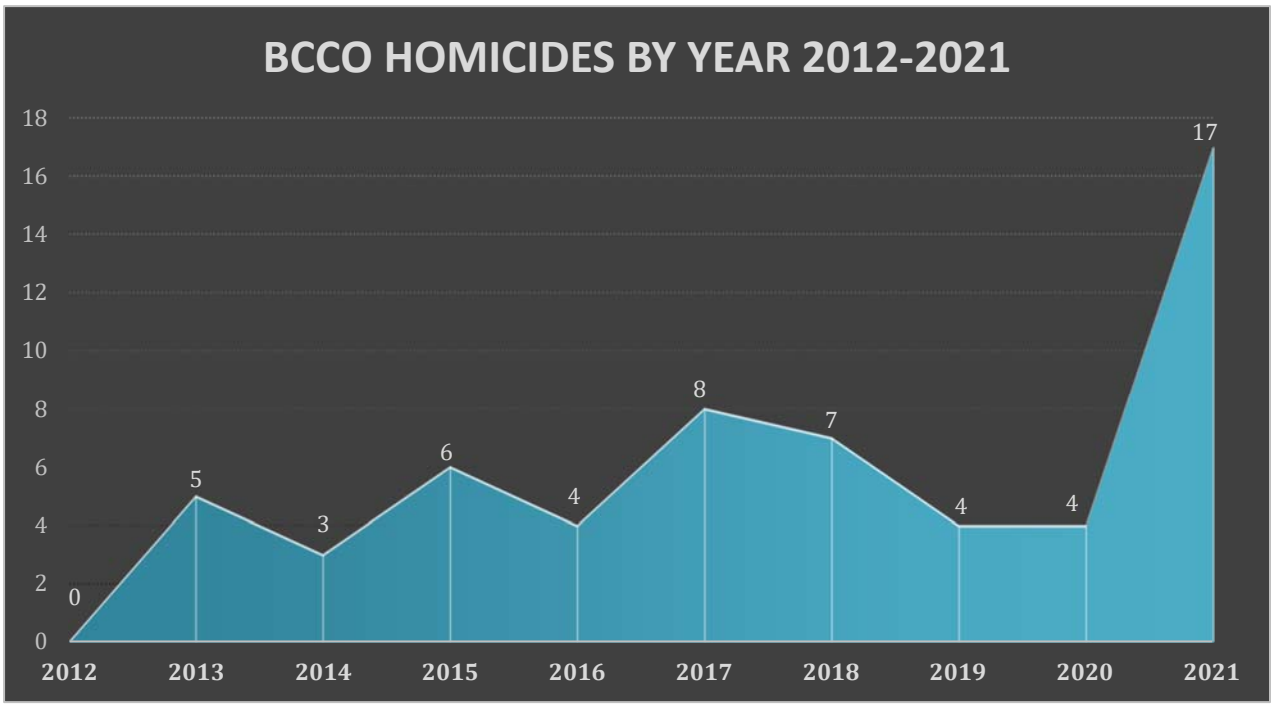
NON-TRAFFIC ACCIDENTAL DEATHS BY TYPE OF EVENT



LEGEND:

A - Fall (Non-Recreational)
B - Fall/Recreational
C - Drug Overdose/Intoxications (All Types)
D - Drug Overdose in combination with Alcohol
E - Alcohol
F - Asphyxia
G - Drowning
H - Electrocution
I - Fall from Height
J - Aspirated on Food
K - Medical Misadventure
L - Airplane Crash
M - Environmental
N - Thermal Injuries
O - Blunt Force/Sharp Force Injuries
P - Injury due to Animal
Q – Industrial
R – Firearms Related
S - Other

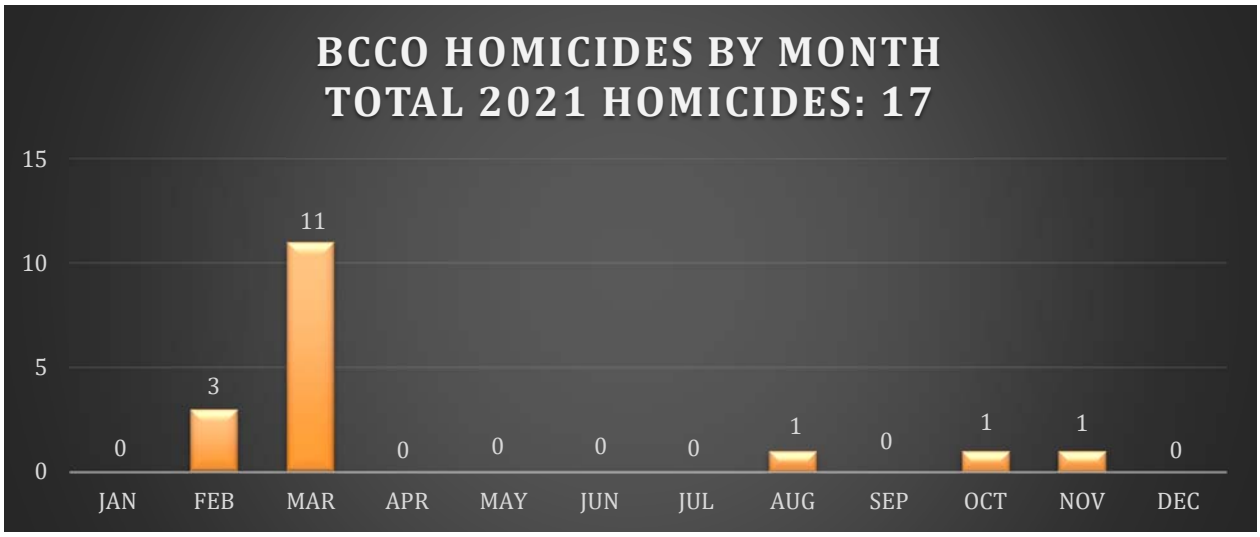
HOMICIDES BY YEAR



Note: In 2021, the Table Mesa mass shooting event accounted for 10 of the homicides for the year.

Note: There were a total of 22 homicides reported to the Boulder County Coroner's Office in 2021. The Boulder County Coroner's Office investigated 17 of those cases and transferred jurisdiction of 5 cases to other coroners.

HOMICIDES BY MONTH

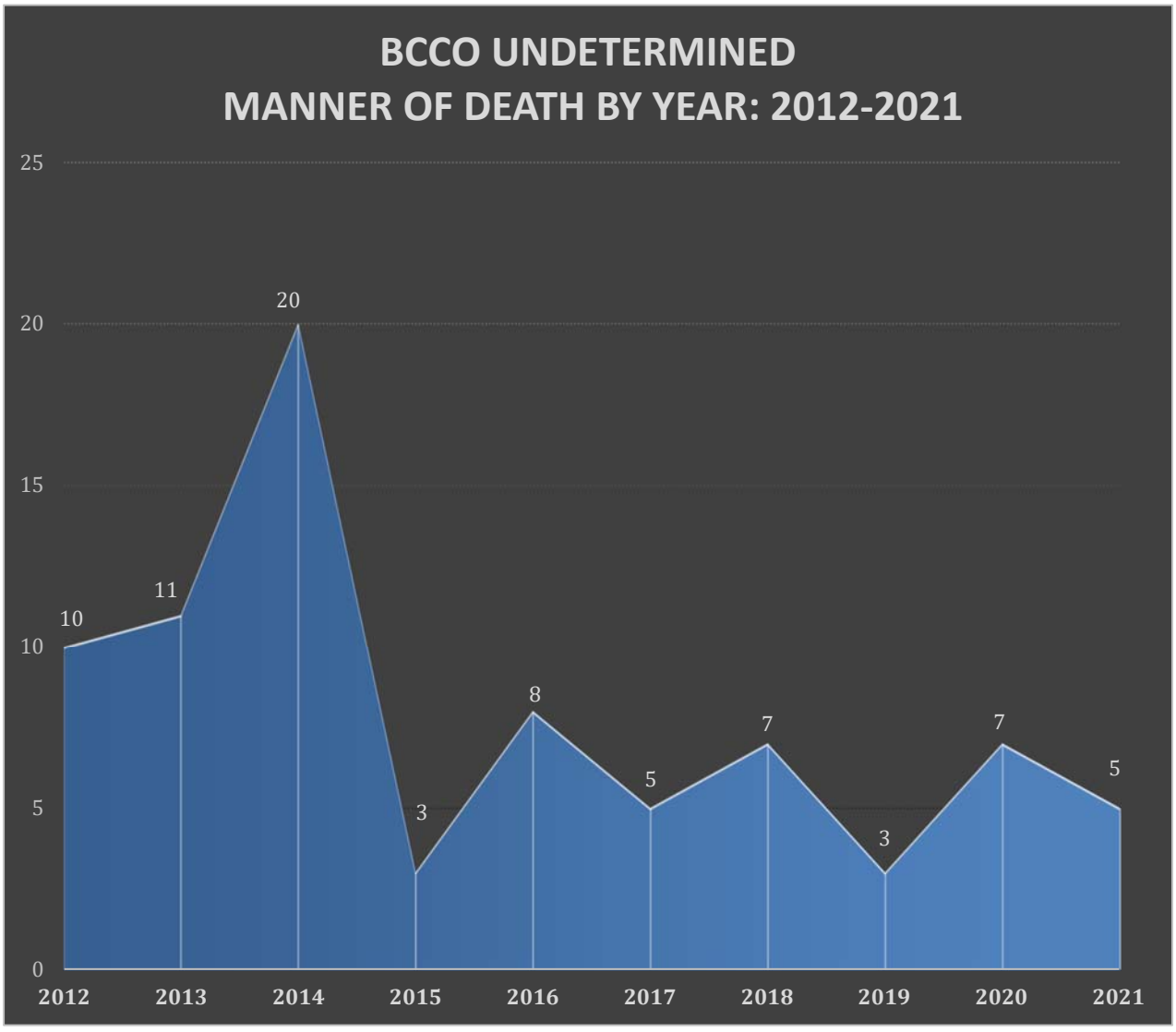


Note: In 2021, 11 of the victims of homicide were male and 6 were female. Four of the victims died of blunt and/or sharp force injures, 13 died of a gunshot wound.

DEATHS OF UNDETERMINED MANNER

Occasionally, medical examiners and coroners encounter cases that, despite a complete autopsy, comprehensive toxicology tests, and a thorough scene investigation, no cause of death can be determined. Medical examiners and coroners also encounter cases where the cause of death is quite apparent; but the evidence supporting the manner of death is equivocal or insufficient to make a determination. The determination of manner of death is an opinion based on the "preponderance of evidence." An example might be a case in which the cause of death is a drug overdose, but, from the information available, it is not certain whether the manner of death is accident or suicide. Therefore, the manner of death may be certified as undetermined.

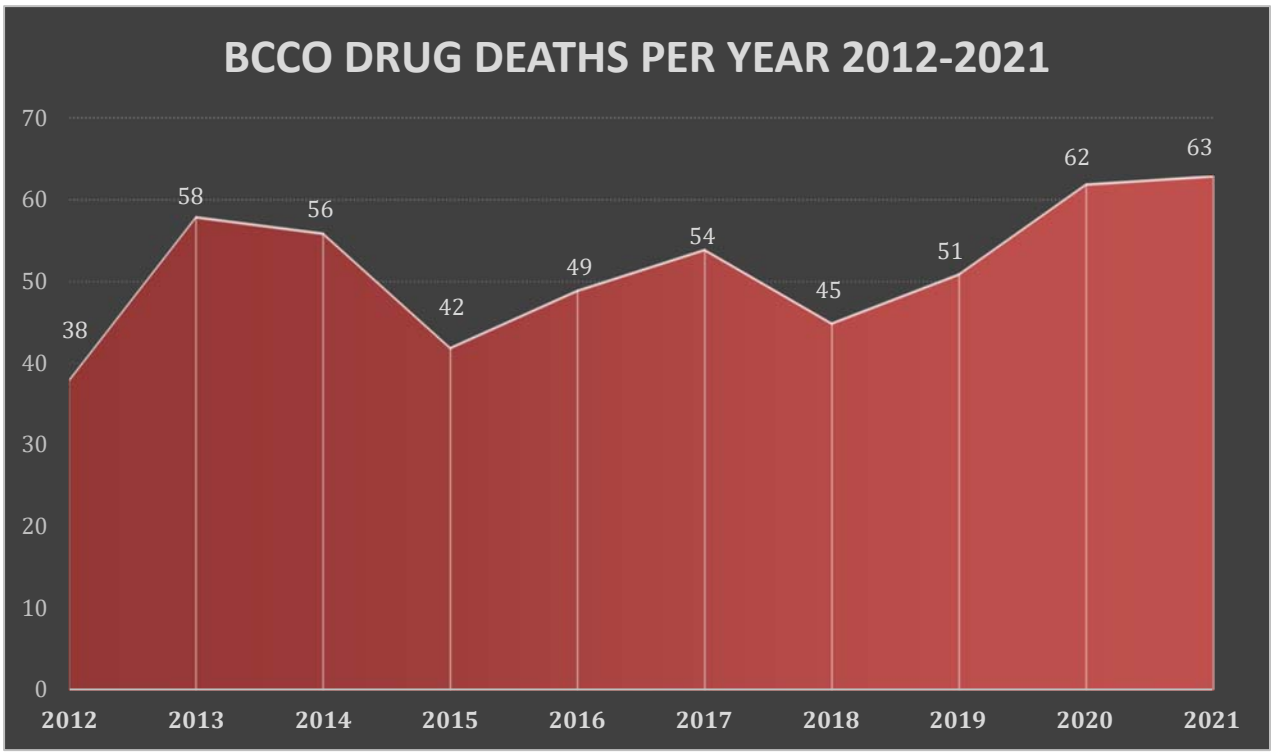
UNDETERMINED MANNER BY YEAR



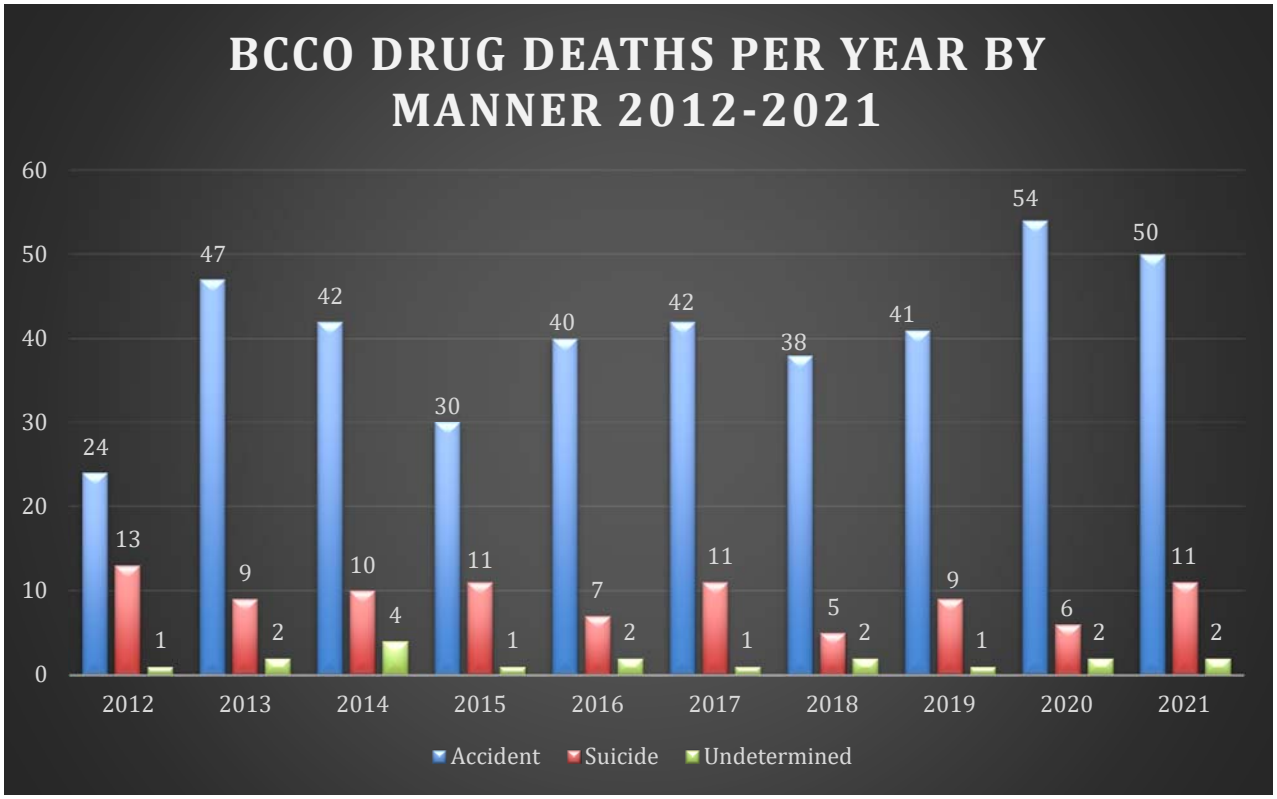
Note: There were a total of 5 cases reported to the Boulder County Coroner's Office in 2021 that were ruled with an undetermined manner of death. There were no additional undetermined deaths that were transferred in 2021.

While the office ruled undetermined for the manner of death in these 5 cases in 2021, 1 of the cases listed an undetermined cause of death as well because a specific cause of death could not be interpreted.

DRUG DEATHS BY YEAR 2012-2021

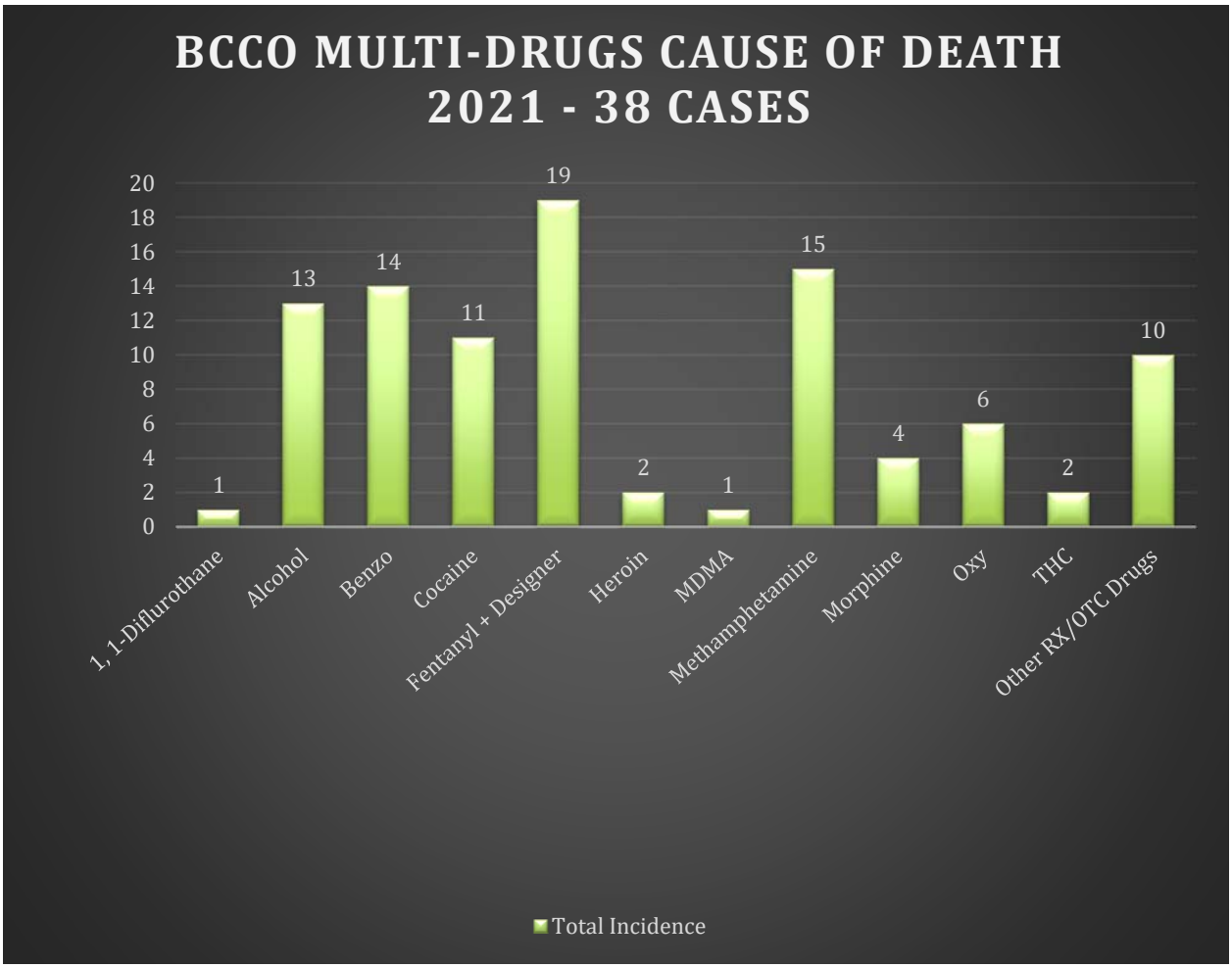


DRUG DEATHS BY MANNER 2012-2021



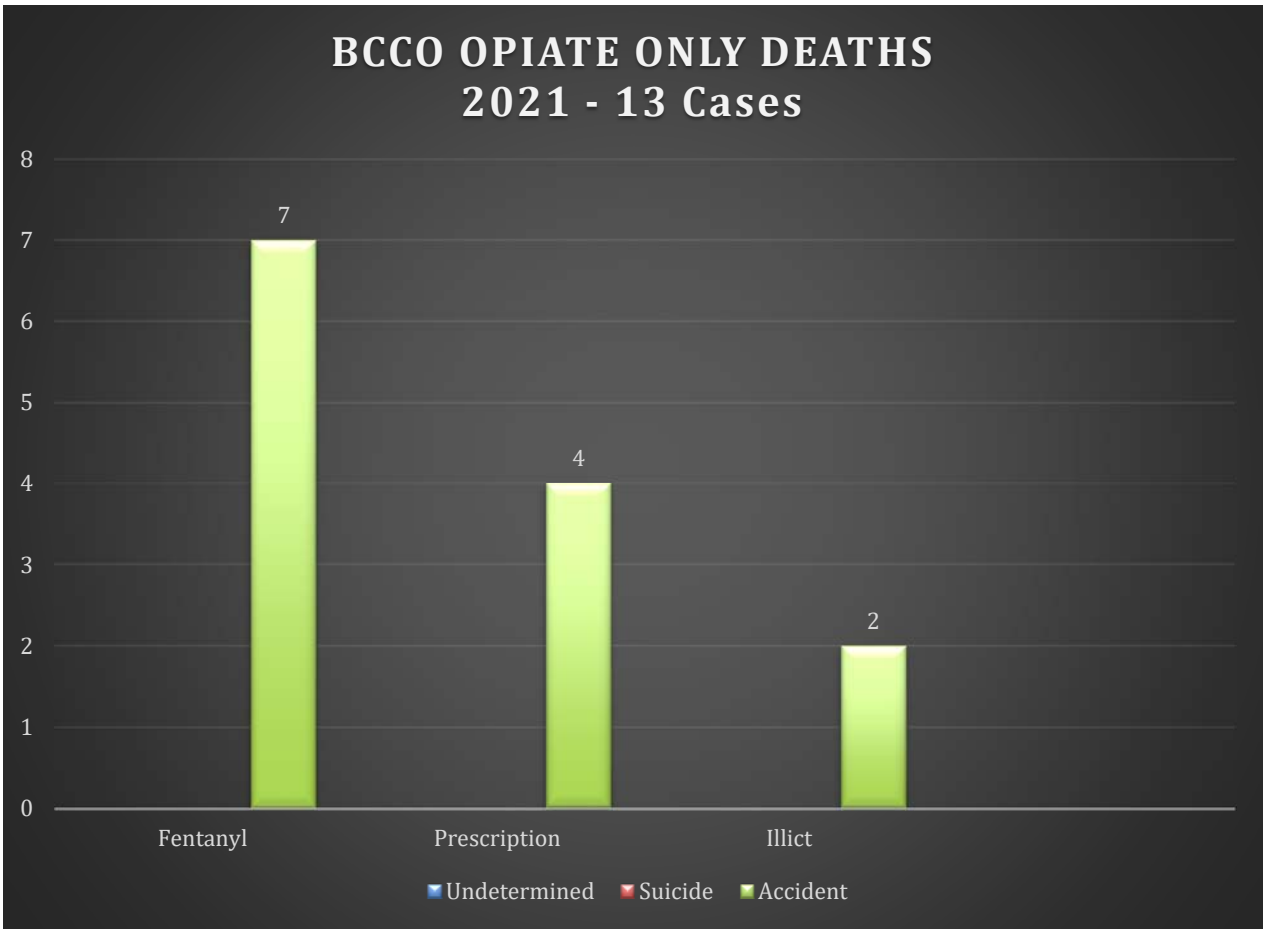
DRUGS OF ABUSE: MULTI-DRUG DEATHS

Many drug abuse deaths are listed with multi-drug intoxication for the cause of death; this is due to the complications that come from interpreting the use of more than one drug at a time, their individual levels and the combined effects of the varying levels. The chart below indicates the drugs that were found in the 38 multi-drug deaths the county had in 2021.



DRUGS OF ABUSE BY OPIATES

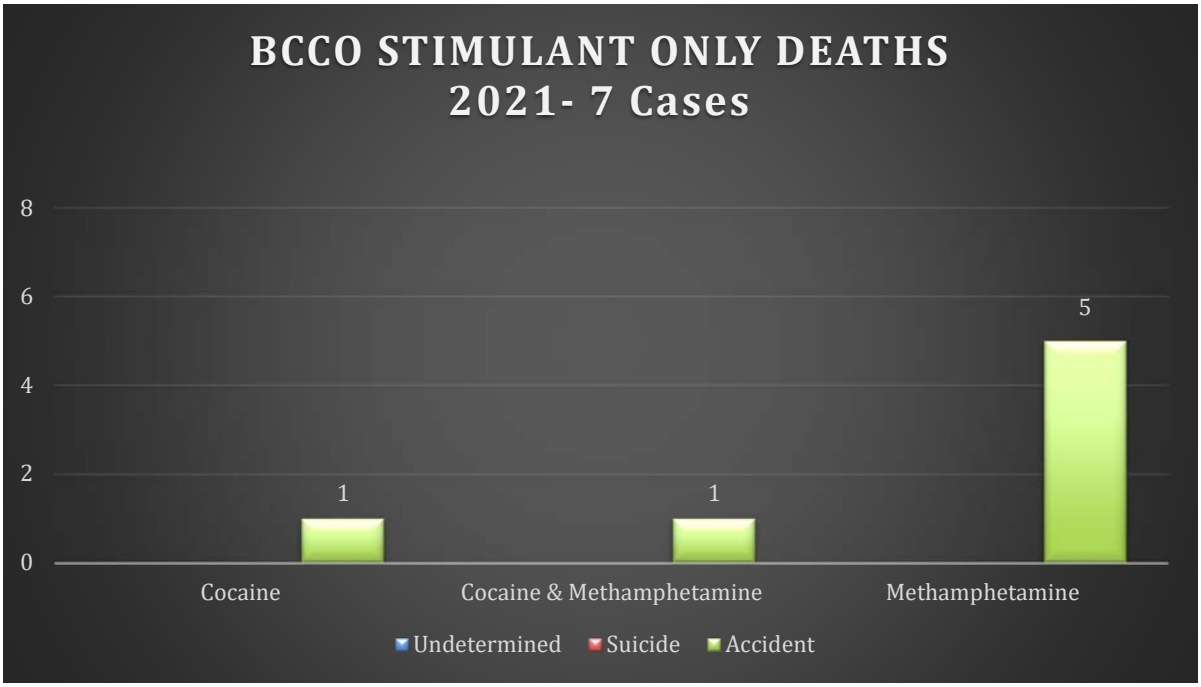
Opioid is used to designate all substances, both natural and synthetic, that bind to opioid receptors in the brain. The psychoactive compounds found in the opium plant include morphine and codeine. Heroin is one of several semi-synthetic opioids derived from the morphine. Examples of opioids include Heroin, Morphine, Methadone, Merpidine, Codeine, Tramadol, Oxycodone, Hydrocodone, Hydromorphone, and Fentanyl.



Note: In addition to the 13 opiate only deaths listed in the chart above, see the DRUGS OF ABUSE: MULTI-DRUG DEATHS section of this report for additional opiate related deaths that were part of a multi-drug death.

DRUGS OF ABUSE BY STIMULANTS

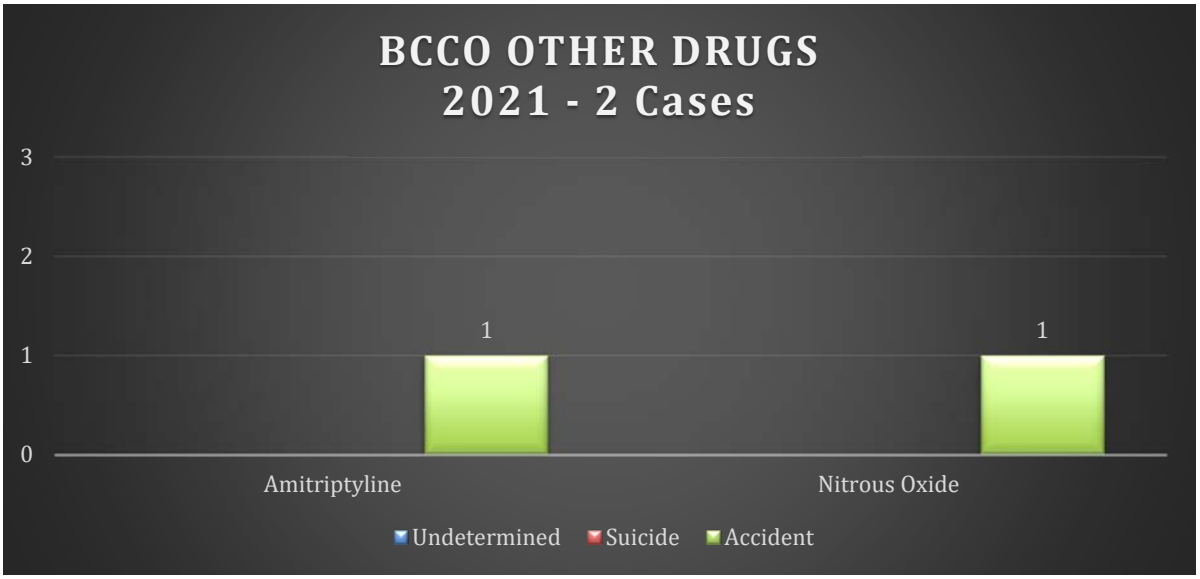
Stimulants (also known as psychostimulants) is a broad term that covers many drugs including those that increase activity of the body, drugs that are pleasurable and invigorating, and drugs that have sympathomimetic effects. Due to their characteristic "up" feeling, stimulants are also occasionally referred to as "uppers". Stimulants are widely used throughout the world as prescription medicines as well as without a prescription (either legally or illicitly) as performance-enhancing or recreational drugs. Examples of stimulants include Cocaine, Amphetamine, Methylene-3,4 Dixoy-Methamphetamine (MDMA), Methamphetamine, ecstasy, bath salts, Focalin, Adderall and Ritalin.



Note: In addition to the 7 stimulant only deaths listed in the chart above, see the DRUGS OF ABUSE: MULTI-DRUG DEATHS section of this report for additional stimulant related deaths that were part of a multi-drug death.

DRUGS OF ABUSE: OTHER CATEGORIES

These drugs represent a wide variety of substances abused in Boulder County. Some can be purchased at liquor stores; some require prescriptions from a medical doctor, and some are manufactured or purchased elsewhere.

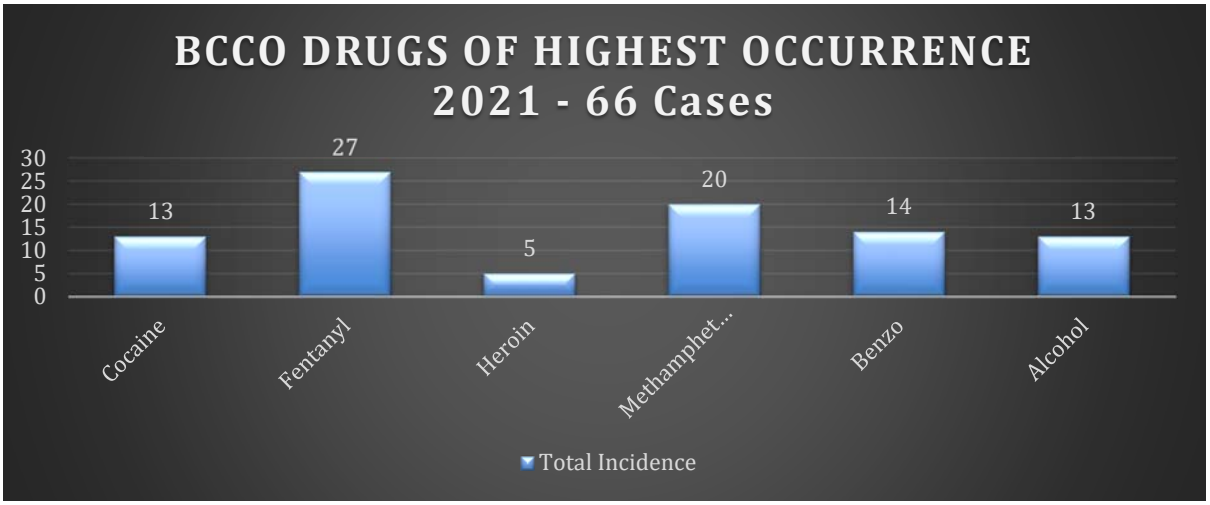


Amitriptyline is a tricyclic compound commonly used to treat depression by acting on neurotransmitters to increase serotonin levels within the brain to maintain mental balance.

Nitrous Oxide is a chemical compound that can be found in an array of common settings from pharmaceutical medications and supplements, to computer cleaners and air guns. Due to its oxidizing agent, when ingested, the chemical limits oxygen transport and distribution in the body causing a lack of oxygen in the blood resulting in hypotension (a drop in blood pressure), cyanosis, hypoxia, altered consciousness, and dysrhythmia.

DRUGS OF ABUSE: HIGHEST OCCURRENCE

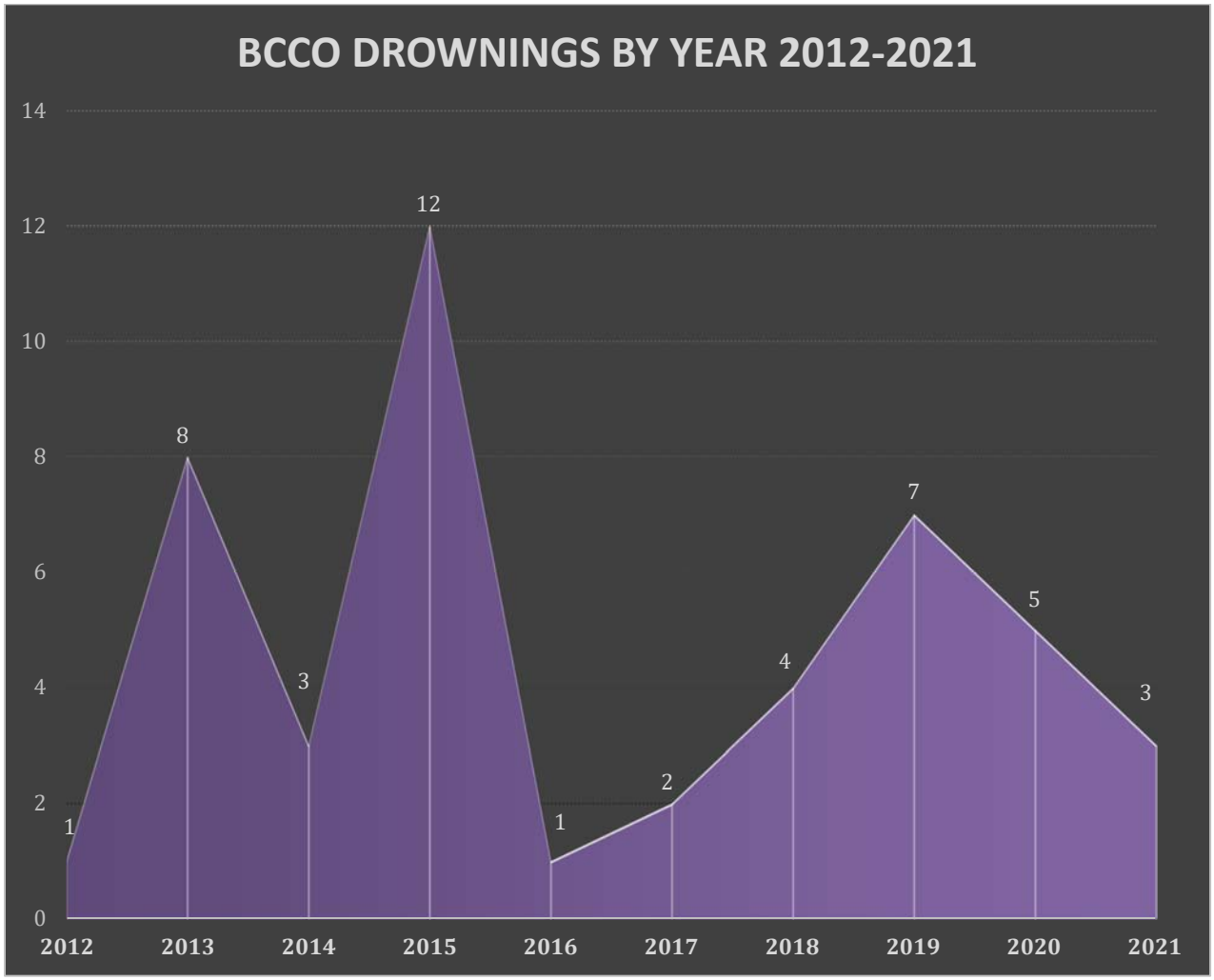
These drugs represent the most commonly found substances in deceased persons who died of a drug related death.



DROWNINGS

Drowning as a cause of death is a diagnosis of exclusion, diagnosis of exclusion is described as a diagnosis of a medical condition that is reached by eliminating all other possible diagnoses. If an individual is found in water and all other possible causes of death have been excluded, one *may* be able to conclude the cause of death is drowning. Presumed drowning cases require complete autopsies, in order to exclude all other causes of death.

In 2021, there were 3 total drowning cases. All 3 cases were ruled accidents. One of the drownings occurred in a creek. Two of the drownings occurred in swimming pools. In 2 of the 3 cases the decedents tested positive for THC and in 1 of the 3 cases the decedent tested positive for alcohol.



Note: Four of the drowning deaths from 2013 were from the September flood.

CHILD DEATHS

In 2013 Senate Bill 13-255 passed mandating that starting January 1st, 2015 each county form a local Child Fatality Review and Prevention Team (CFRPT). Moving the reviews to local teams from the state team would create a broader scope, with the state mandating which cases would be reviewed (birth – 17) that involve unintentional injury, violence, motor vehicle incident, child abuse/neglect, sudden unexpected infant death, suicide or undetermined cases. The teams provide the state with individual case findings to develop a community approach to issues surrounding child deaths. They review manner and cause of death and evaluate the means by which the fatality might have been prevented. The teams report case findings to public/private agencies that have responsibilities for children and make prevention recommendations to reduce the number of child fatalities.

Each team must consist of the following:

- County department(s) of public health
- Local law enforcement agencies
- District attorney's office
- School districts
- County department(s) of human services
- Coroner's office
- County attorney's office

Additional agencies that may be included are hospitals or other emergency medical services, social services, mental health professionals, pediatricians, child advocacy centers, and victim advocates.

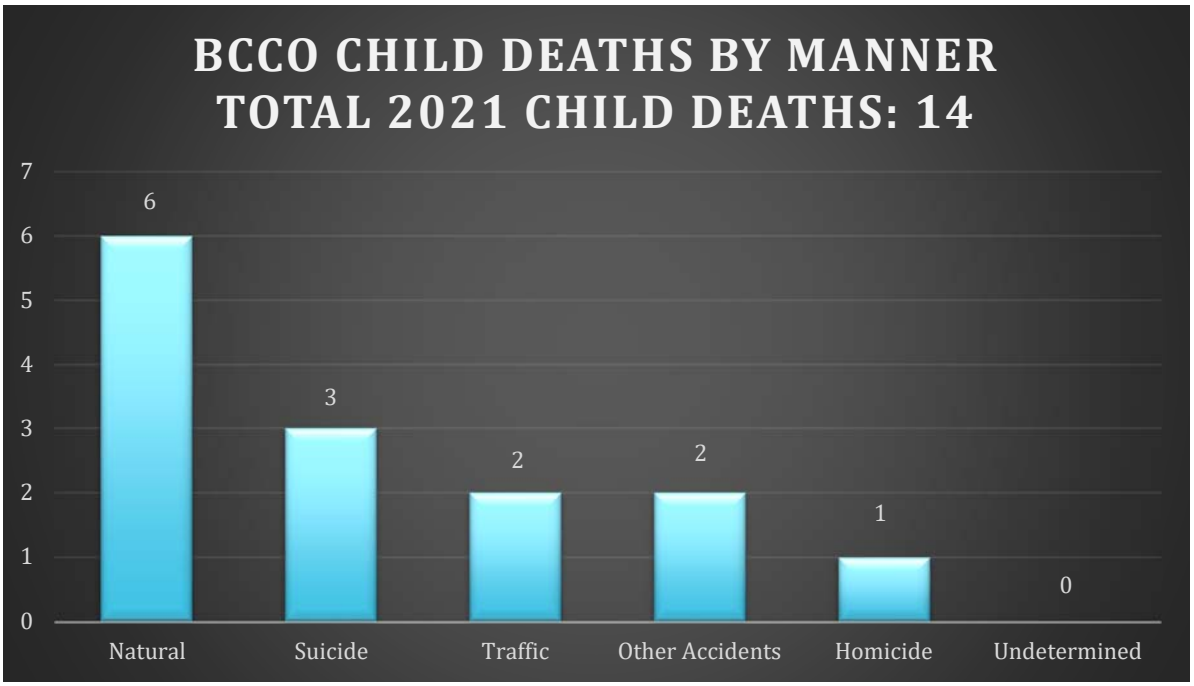
In 2014, the office worked closely with the Public Health Department to bring the agencies together so that the team could start reviewing the 2014 child deaths starting in January of 2015. Public Health asked the Coroner's Office to become the coordinator for the team; currently Boulder County is the only county in Colorado to participate in this way as the coordinator. In 2021, the team reviewed 4 child death cases.

In Boulder County, a total of 14 child deaths (<18 years of age) were investigated by the Coroner's Office in 2021. Two additional child death cases were transferred to other coroners. Any of the 14 child death cases selected for review by the state will be reviewed in 2022 by the Boulder County Child Fatality Review and Prevention Team.

Note: Statistical information may not coincide with information available from the Colorado Health Department. The State Health Department tracks death statistics by the county of residence, not by the county in which the injury or death occurred.

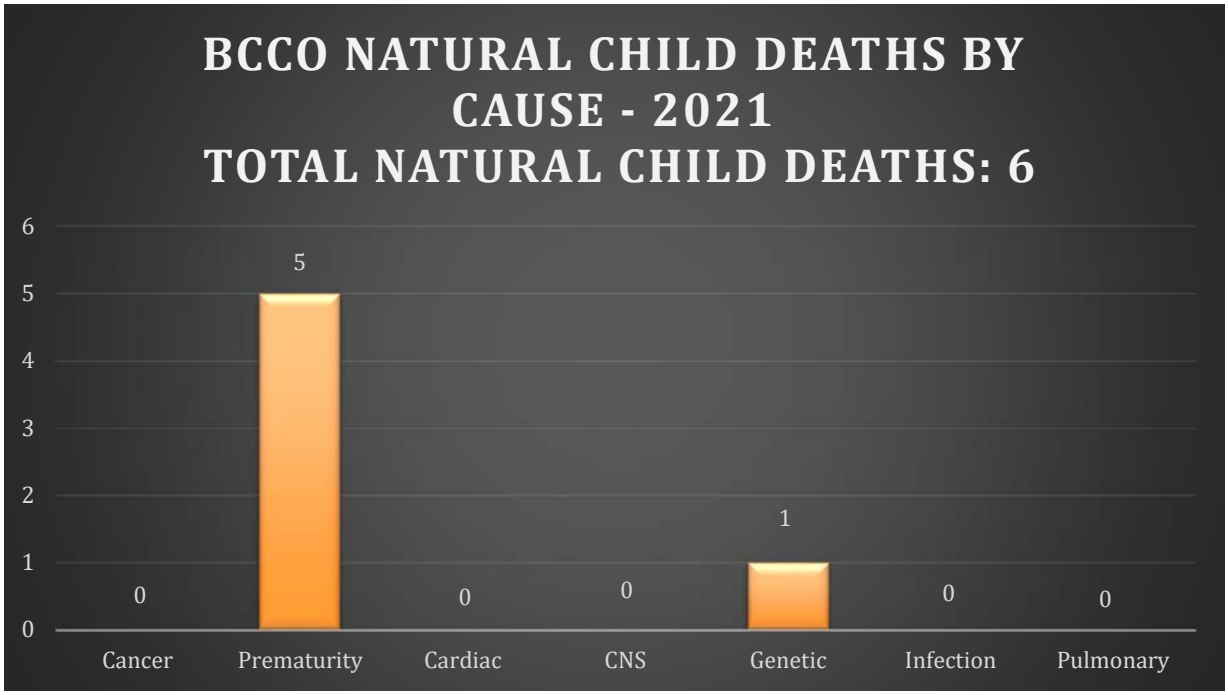
BCCO Conference room where CFRPT meetings are held.

CHILD DEATHS BY MANNER OF DEATH



- **Suicide:** The suicide deaths were a result of hanging, gunshot wound and Asphyxiation (all age 16).
- **Traffic:** The traffic deaths were due to blunt force injuries (age 16, and 17).
- **Accident:** The accidental deaths were due to a drug intoxication and ski accident (age 15, and 17).
- **Homicide:** The homicide death was due to a gunshot wound (age 14).

CHILD DEATHS BY CAUSE OF NATURAL DEATHS



SUDDEN UNEXPLAINED INFANT DEATH (SUID) AND SUDDEN INFANT DEATH SYNDROME (SIDS)

The Center for Disease Control and Prevention (CDC) defines sudden unexplained infant death (SUID) as deaths in infants less than 1 year of age that occur suddenly and unexpectedly, and whose cause of death are not immediately obvious prior to investigation. The CDC defines sudden infant death syndrome (SIDS) as the sudden death of an infant less than 1 year of age whose cause of death cannot be explained after a thorough investigation is conducted, including a complete autopsy, examination of the death scene, and review of the clinical history. While the CDC has separate definitions for these two terms, the classification of the manner of death and written description of the cause of death in these types of cases do vary throughout the nation.

SIDS is a diagnosis of exclusion; diagnosis of exclusion is described as a diagnosis of a medical condition that is reached by eliminating all other diagnoses. Therefore, to determine the cause of death is SIDS, a coroner or medical examiner must conduct a thorough case investigation which includes examination of the death scene, including the sleeping environment and bedding, a review of the medical history, perform a complete autopsy and further testing. These cases are a collaborative effort with law enforcement and at times the District Attorney's Office. Once a thorough investigation is conducted and no other possible cause of death is determined only then *may* a determination of SIDS be made. Many times, when a thorough case investigation is conducted, an explanation is found such as natural disease or disorder, positional asphyxia, suffocation, hyper or hypothermia, neglect, homicide, etc. Other times, there may be signs of potential issues but no clear and obvious reason for death, most often the finding of an unsafe sleep environment is found. At times, there may be no indication of potential issues and the cause of death is truly unknown.

The American Academy of Pediatrics (AAP) started its "Back to Sleep" campaign in 1992 informing the public of its recommendation that infants be placed for sleep in a non-prone position on their back, in an effort to prevent SIDS deaths. The CDC makes ongoing efforts to prevent SUID and SIDS deaths and on October 17, 2011 they published a new statement on SIDS, which stated that there has been a major decrease in the incidence of SIDS since 1992, however, the decline has plateaued in recent years. In the 2011 statement, AAP reported that since their previous statement on SIDS in 2005 they have seen an increase in SUID deaths occurring during sleep. Therefore, the AAP expanded its recommendations to focus on safe sleep environments that can reduce the risk of all sleep-related infant deaths including SIDS. Their recommendations include: supine positioning, use of a firm sleep surface, breastfeeding, room-sharing without bed-sharing, routine immunization, consideration of a pacifier, and avoidance of soft bedding, overheating, and exposure to tobacco smoke, alcohol, and illicit drugs.[4]

American Academy of Pediatrics

Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of all Children

POLICY STATEMENT

SIDS and Other Sleep-Related Infant Deaths: Expansion of Recommendations for a Safe Infant Sleeping Environment

abstract

FREE

Despite a major decrease in the incidence of sudden infant death syndrome (SIDS) since the American Academy of Pediatrics (AAP) released its recommendation in 1992 that infants be placed for sleep in a non-prone position, this decline has plateaued in recent years. Concurrently, other causes of sudden unexpected infant death that occur during sleep (sleep-related deaths), including suffocation, asphyxia, and entrapment, and ill-defined or unspecified causes of death have increased in incidence, particularly since the AAP published its last statement on SIDS in 2005. It has become increasingly important to address these other causes of sleep-related infant death. Many of the modifiable and nonmodifiable risk factors for SIDS and suffocation are strikingly similar. The AAP, therefore, is expanding its recommendations from focusing only on SIDS to focusing on a safe sleep environment that can reduce the risk of all sleep-related infant deaths, including SIDS. The recommendations described in this policy statement include supine positioning, use of a firm sleep surface, breastfeeding, room-sharing without bed-sharing, routine immunizations, consideration of using a pacifier, and avoidance of soft bedding, overheating, and exposure to tobacco smoke, alcohol, and illicit drugs. The rationale for these recommendations is discussed in detail in the accompanying "Technical Report—SIDS and Other Sleep-Related Infant Deaths: Expansion of Recommendations for a Safe Infant Sleeping Environment," which is included in this issue of *Pediatrics* (www.pediatrics.org/cgi/content/full/128/5/e1341). *Pediatrics* 2011;128:1030–1039

INTRODUCTION

Sudden infant death syndrome (SIDS) is a cause assigned to infant deaths that cannot be explained after a thorough case investigation, including a scene investigation, autopsy, and review of the clinical history.[1] Sudden unexpected infant death (SUID), also known as sudden unexpected death in infancy, is a term used to describe any sudden and unexpected death, whether explained or unexplained (including SIDS), that occurs during infancy. After case investigation, SUIDs can be attributed to suffocation, asphyxia, entrapment, infection, ingestions, metabolic diseases, arrhythmia-associated cardiac channelopathies, and trauma (accidental or nonaccidental). The distinction between SIDS and other SUIDs, particularly those that occur during an observed or unobserved sleep period (sleep-related infant deaths), such as ac-

TASK FORCE ON SUDDEN INFANT DEATH SYNDROME

KEY WORDS

SIDS, sudden infant death, infant mortality, sleep position, bed-sharing, tobacco, pacifier, immunization, bedding, sleep surface

ABBREVIATIONS

SIDS—sudden infant death syndrome
SUID—sudden unexpected infant death
AAP—American Academy of Pediatrics

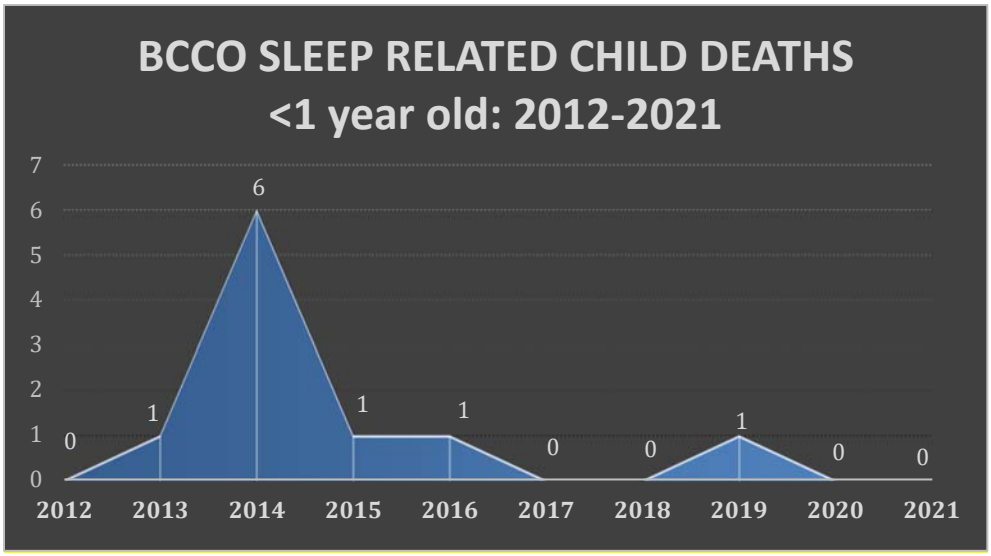
www.pediatrics.org/cgi/doi/10.1542/peds.2011-2284
doi:10.1542/peds.2011-2284

PEDIATRICS (ISSN Numbers: Print, 0031-4005; Online, 1098-4275).

Ongoing efforts to encourage safe sleep environments are also being made by the CDC and the National Institute of Child Health and Human Development (NICHD). The NICHD among other literature has published brochures advertising safe sleep. Many of these resources can be found on the CDC's website www.cdc.gov. An example is provided below.

SLEEP RELATED CHILD DEATHS

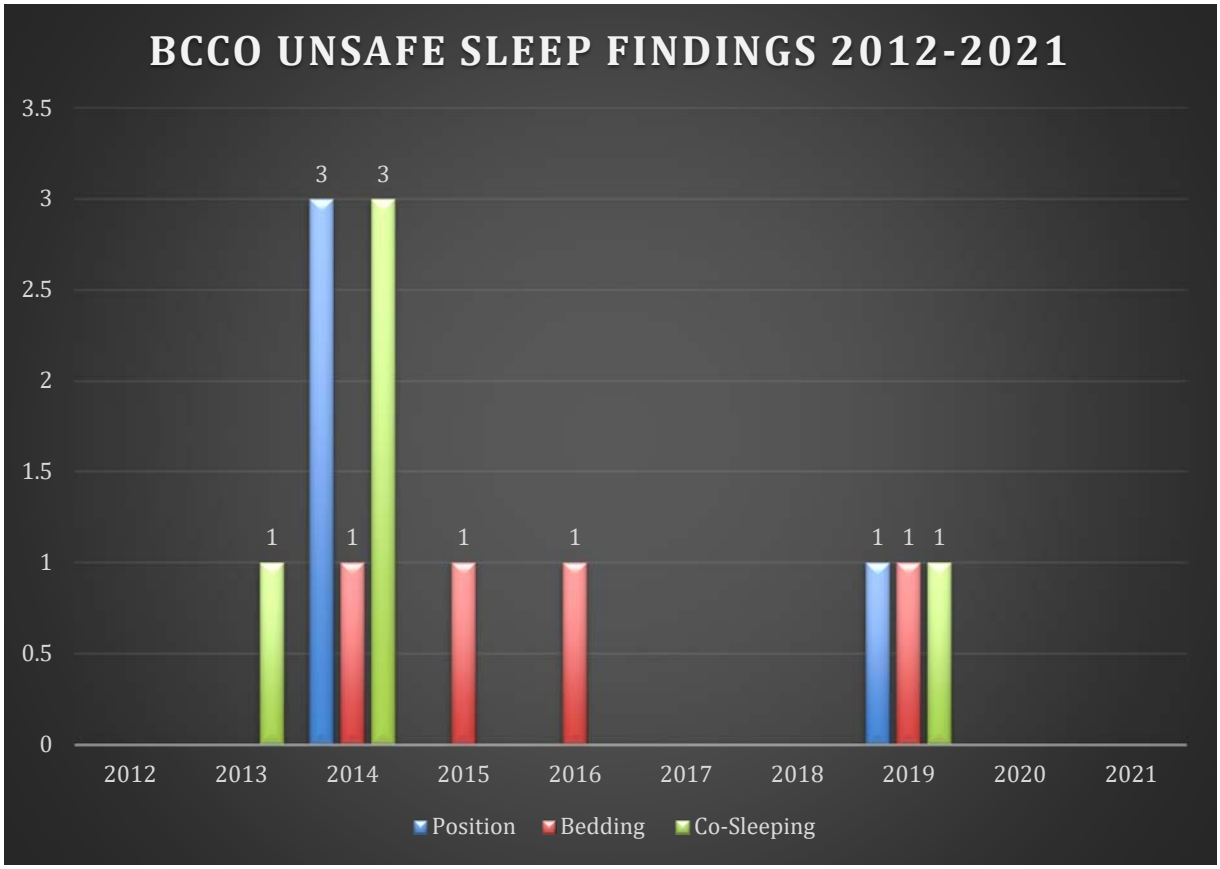
The cases that were included in this study were children under the age of 1 year that died in their sleep. There was a total of 10 cases included in this study.



UNSAFE SLEEP FINDINGS

The graph below shows the findings, by occurrence, in three types of unsafe sleep categories: position, bedding, and co-sleeping. Of the 10 cases included in this 10-year child death study, all 10 cases had at least one finding of an unsafe sleep environment, several cases had multiple findings.

Of the 10 cases, the investigating law enforcement jurisdictions were as follows: Boulder County Sheriff's Office – 1, Lafayette PD – 1, Longmont PD – 6, and Louisville PD – 2. There were 5 females and 5 males. The ages were as follows: the youngest case was 5 ½ weeks, including the youngest case there were 4 cases from 1-3 months, 4 cases from 3-6 months and 2 cases from 6-9 months (the oldest was 9 months). The ethnicities of the children were as follows: Caucasian – 9 and Indian – 1.



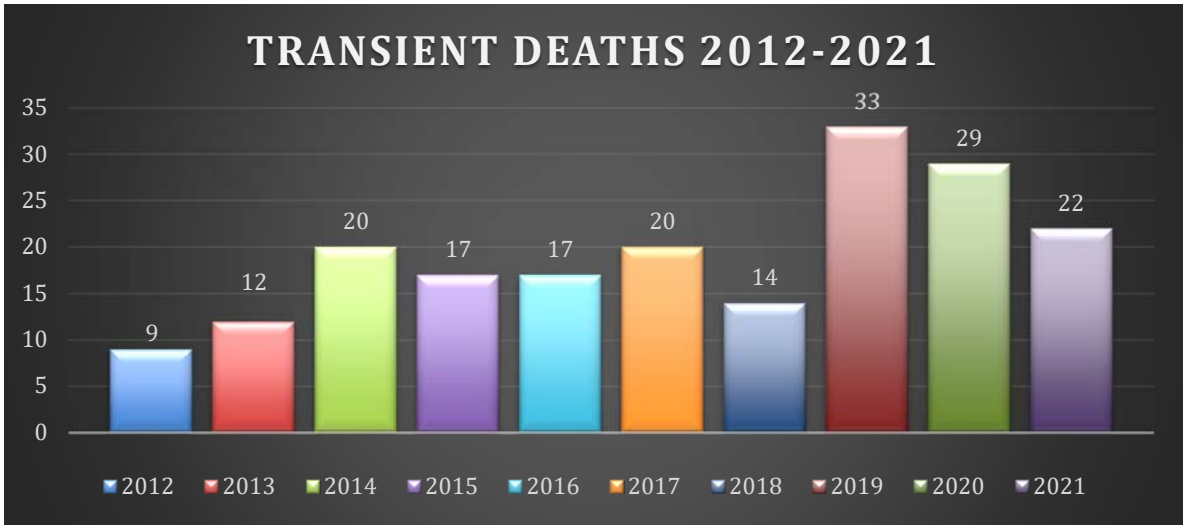
Based on the cases included in this 10 year child death study, Boulder County is a prime location for additional support and promotion of safe sleep environments for infants. As these cases continue to be reviewed by the local Boulder County Child Fatality and Prevention Team, more recommendations will be made to the state on preventing these types of child fatalities.

In the 5 cases where co-sleeping was a finding, the toxicology levels are unknown of the individual whom the infant was co-sleeping with; however, in 3 of the 5 cases there was suspicion or self-reporting of use of alcohol, drugs, prescription drugs or a combination thereof.

TRANSIENT/HOMELESS DEATHS

The Boulder County Coroner's Office started to notice an increase in the amount of transient/homeless deaths in the city of Boulder mid-year 2014. Due to the increase, a mid-year detailed report was created to offer information to city and county leaders as well as the public on these types of deaths. While the office did its' best to track these kinds of deaths to ensure the best possible information, it should be noted that not all deaths that occur in Boulder County are reported to the Coroner's Office. An example of this would be if a person dies at a nursing home or a person who dies more than 24 hours after being admitted to a hospital, the death may not be reported if the person dies of natural causes. Also, not all transients that die are reported as having lived on the streets at the time of their death. For example, a nurse reporting the death of a person who dies under hospice care or in a care facility may not necessarily know that the person was homeless at a point prior to their admission. Therefore, the total number of transient deaths on file at the coroner's office may vary from numbers on file with other organizations. That being said, the following covers a few statistics on what information is available.

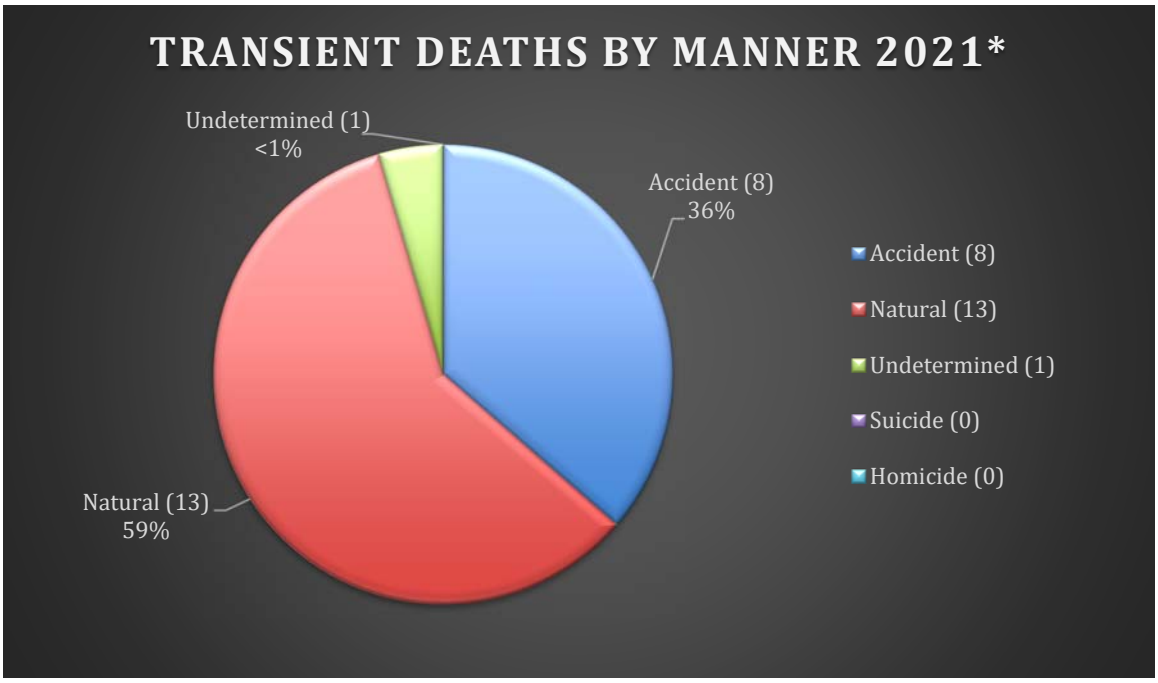
TRANSIENT DEATHS BY YEAR



TRANSIENT DEATHS PER MUNICIPALITY

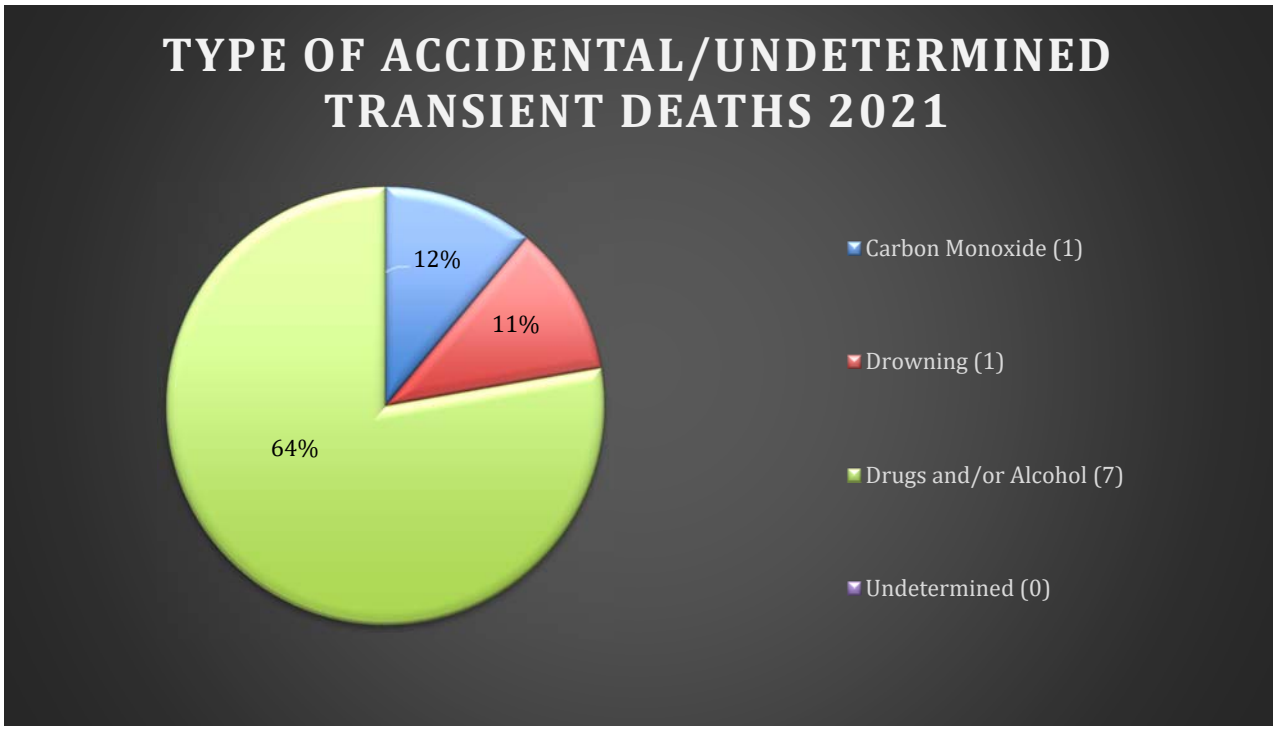
	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Boulder	4	5	19	12	12	12	8	15	13	13
Jamestown	1									
Lafayette				2		1	1	2	3	
Longmont	4	6	1	3	4	7	4	13	11	8
Louisville		1						2	1	
Nederland					1		1	1		1
Ward									1	
Totals	**9**	**12**	**20**	**17**	**17**	**20**	**14**	**33**	**29**	**22**

TRANSIENT DEATHS BY MANNER OF DEATH 2021



Note: Of the transient/homeless deaths tracked in 2021, 19 were male and 3 were female. Ages of the decedents in 2021 ranged from 23-69. *One case from 2021 was a fetal demise; therefore, no manner of death was assigned.

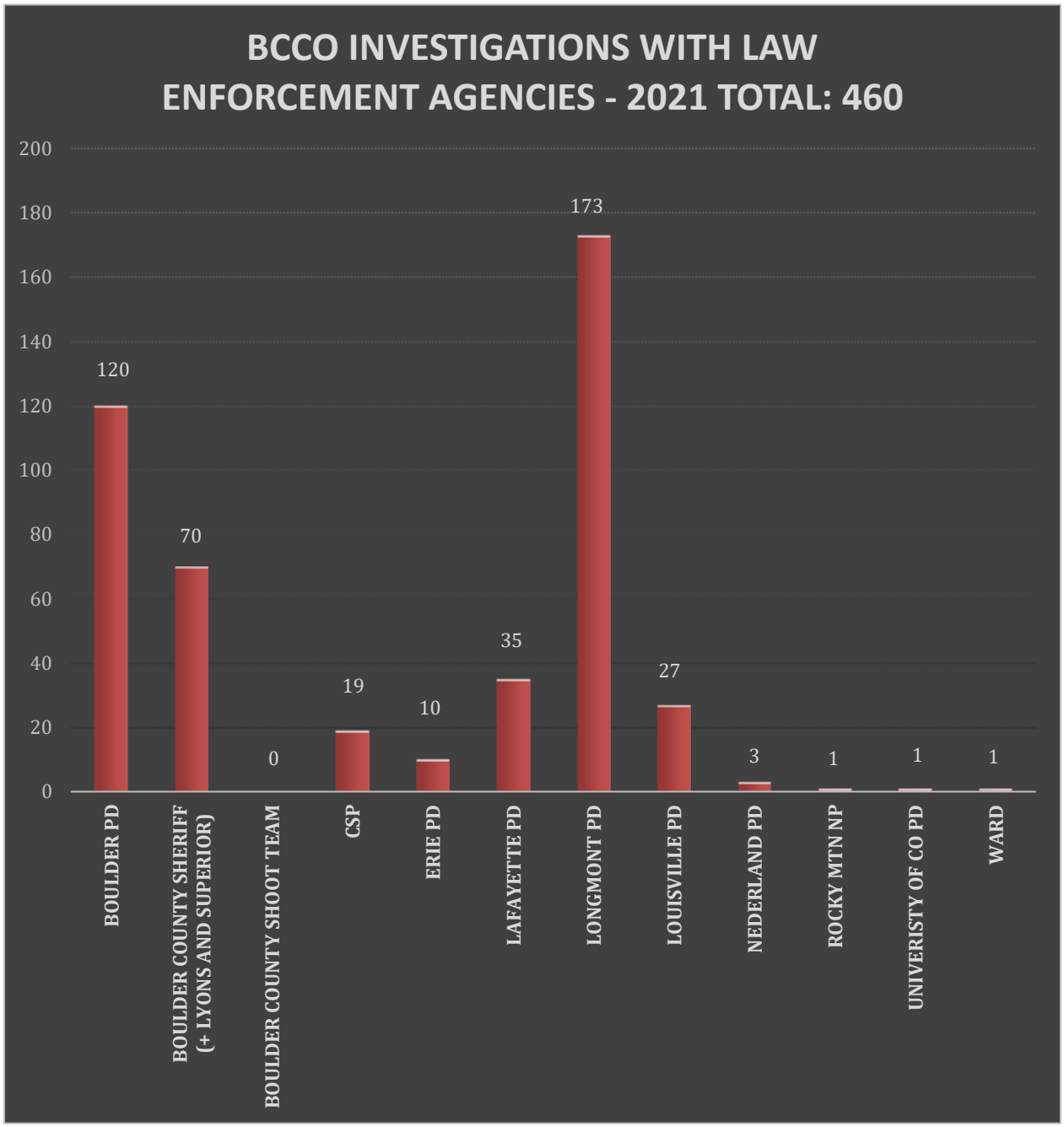
TYPE OF ACCIDENTAL/UNDETERMINED TRANSIENT DEATHS 2021



LAW ENFORCEMENT

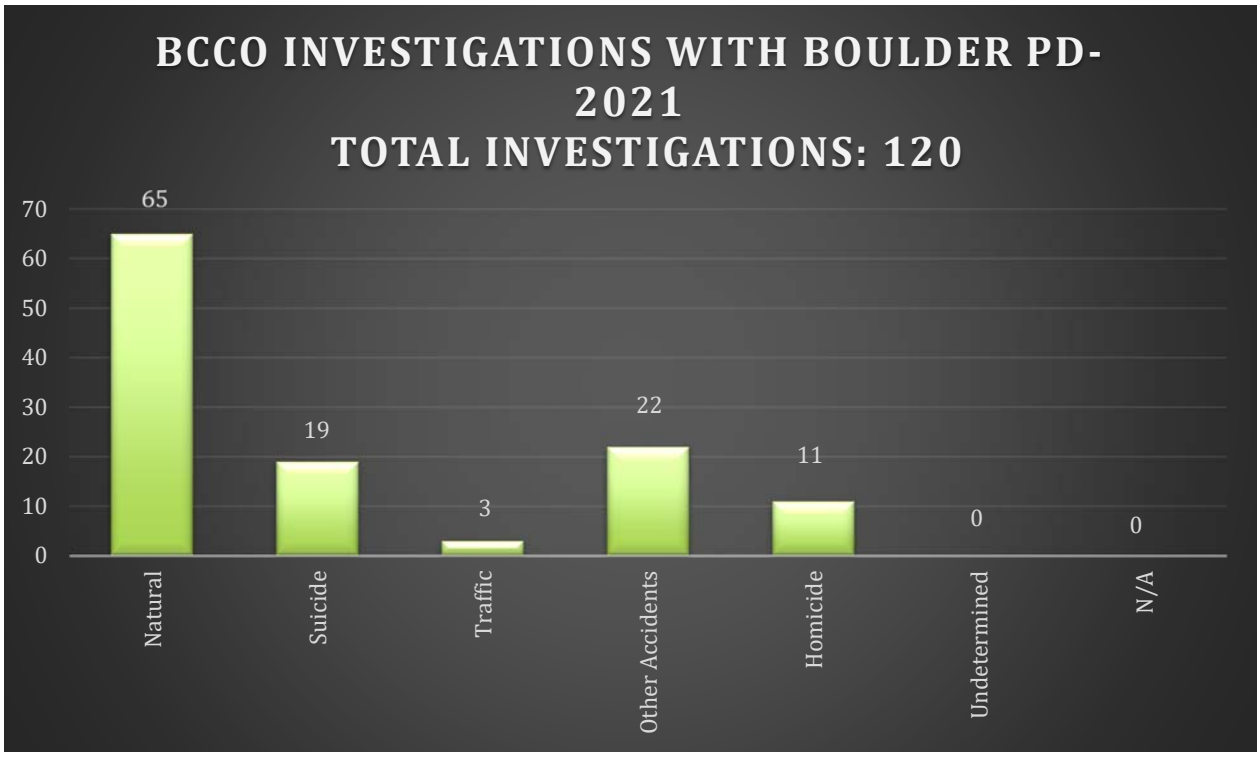
The Boulder County Coroner's Office works with the law enforcement agencies that cover jurisdiction in Boulder County. The charts in this section show the number of cases investigated with these agencies. Please note that the number of investigations listed may differ from those in the "Coroner Response" section of this report because the coroner's office also works with law enforcement on cases in which people die in the hospital as a delayed result of non-natural circumstances (i.e. auto incidents).

INVESTIGATIONS WITH LAW ENFORCEMENT AGENCIES

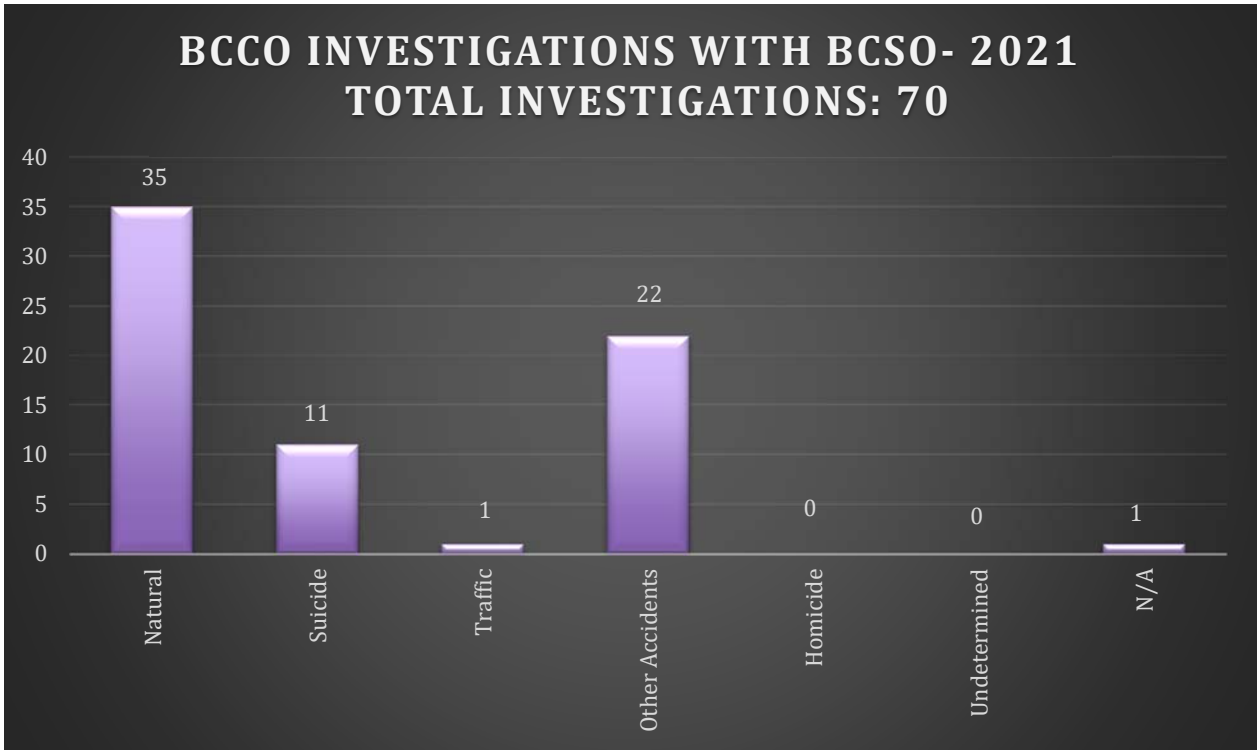


Note: The jurisdiction of the Boulder County Sheriff's Department includes unincorporated areas of Boulder County and the towns of Superior and Lyons.

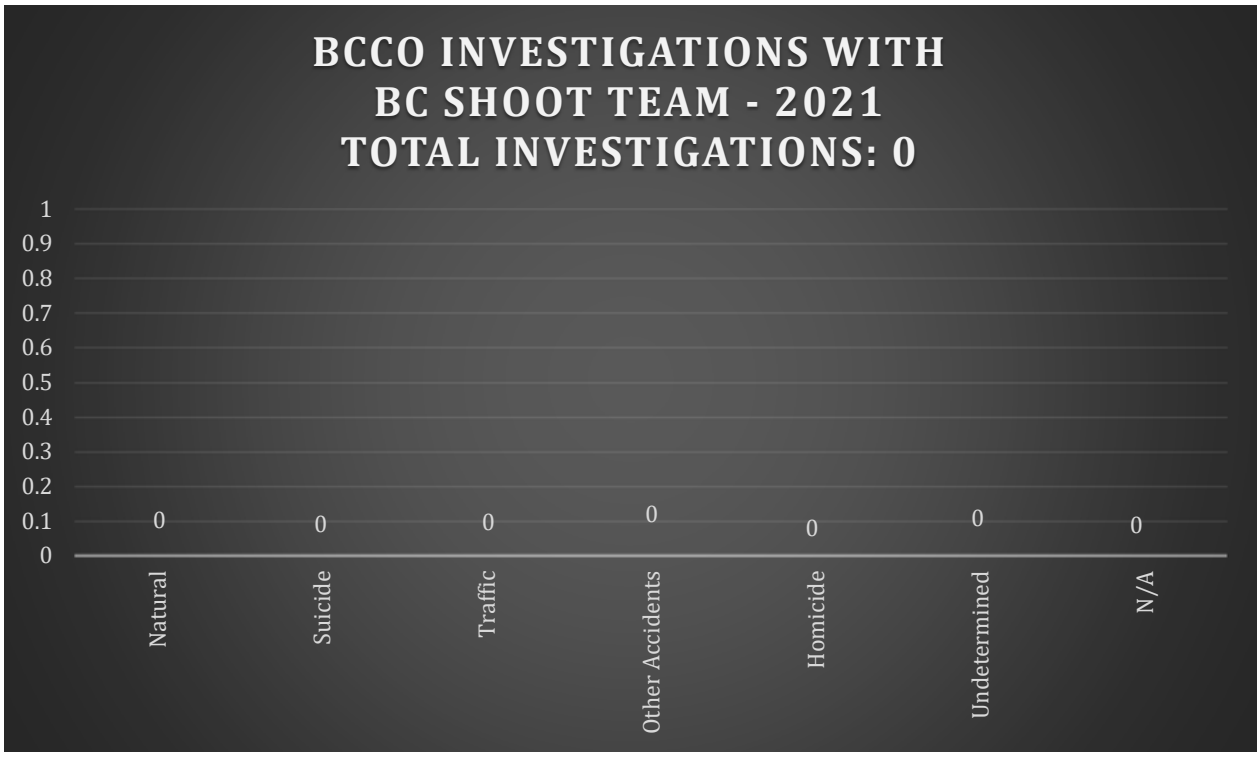
BOULDER POLICE DEPARTMENT



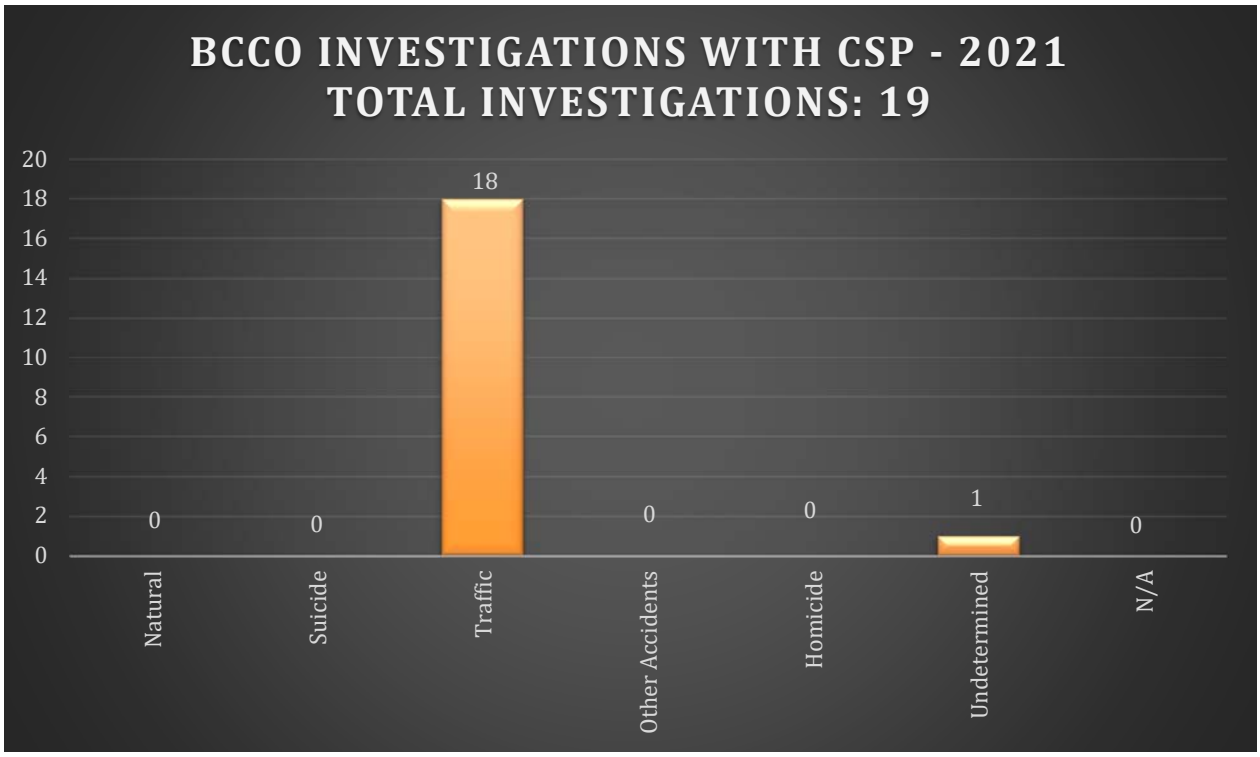
BOULDER COUNTY SHERIFF'S OFFICE



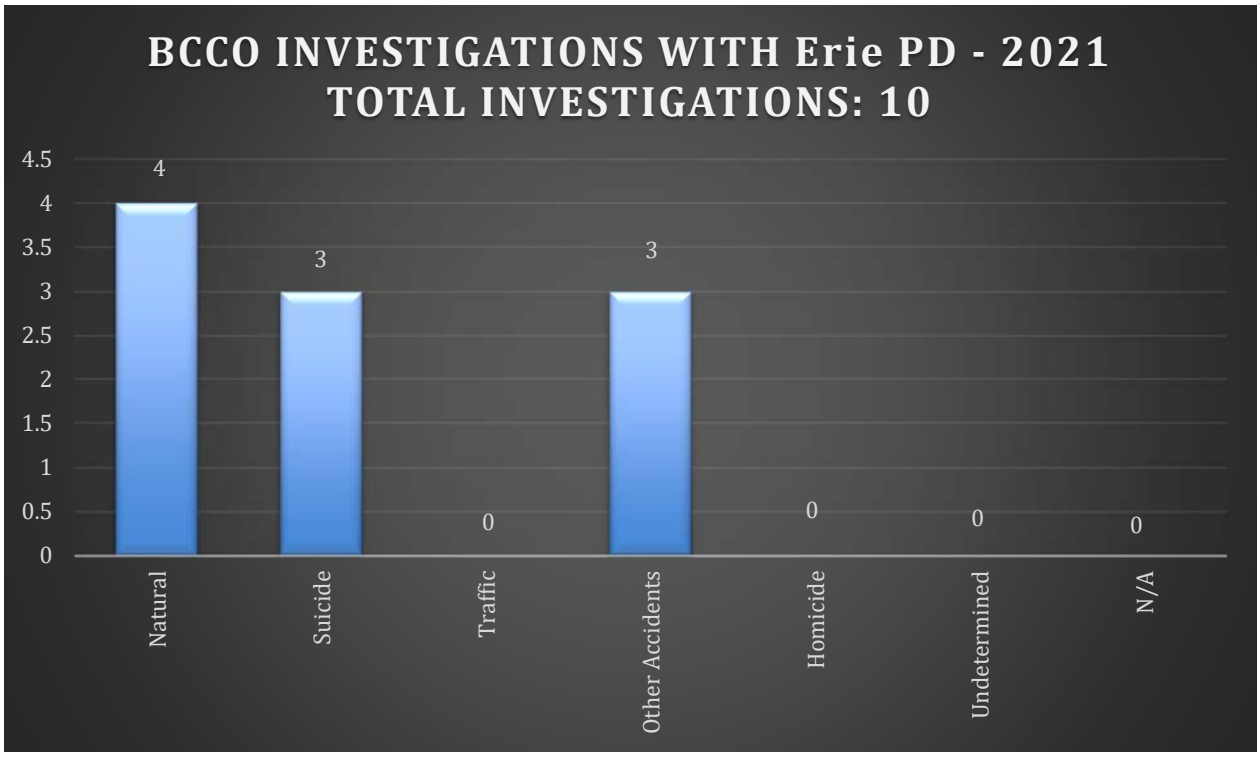
BOULDER COUNTY SHOOT TEAM



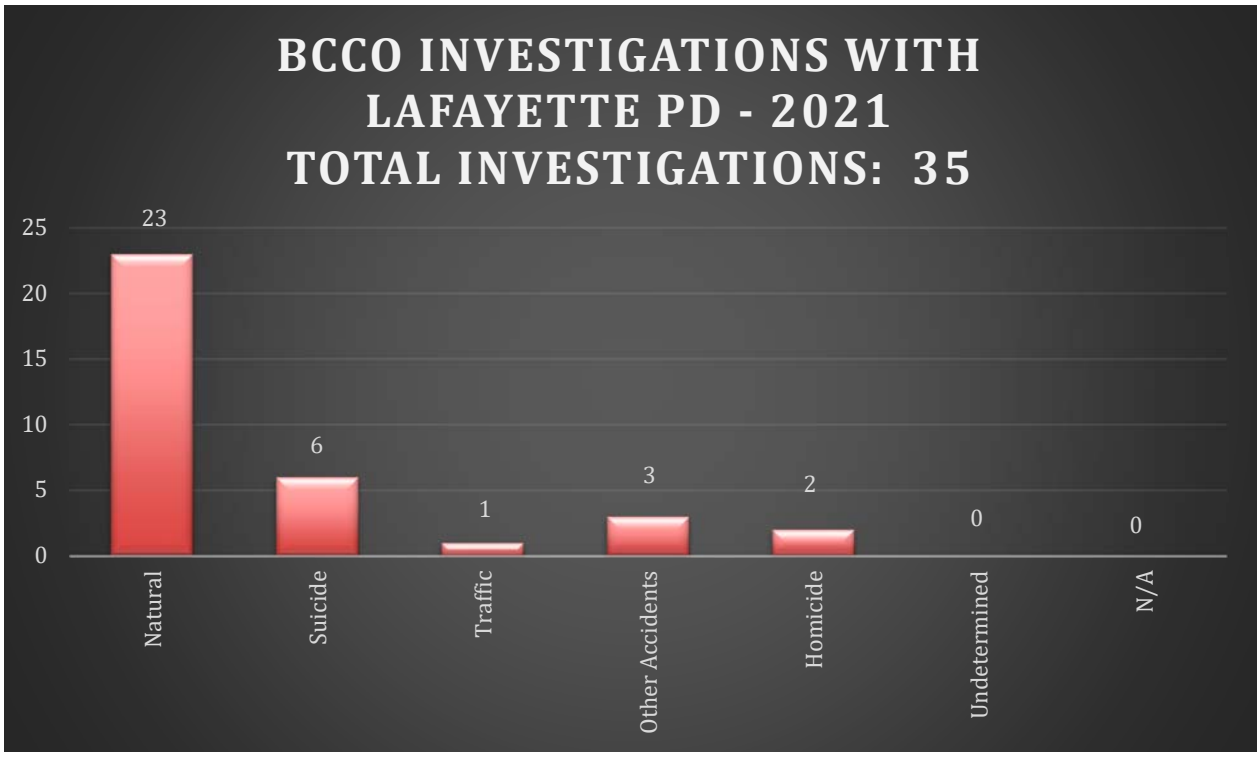
COLORADO STATE PATROL



ERIE POLICE DEPARTMENT

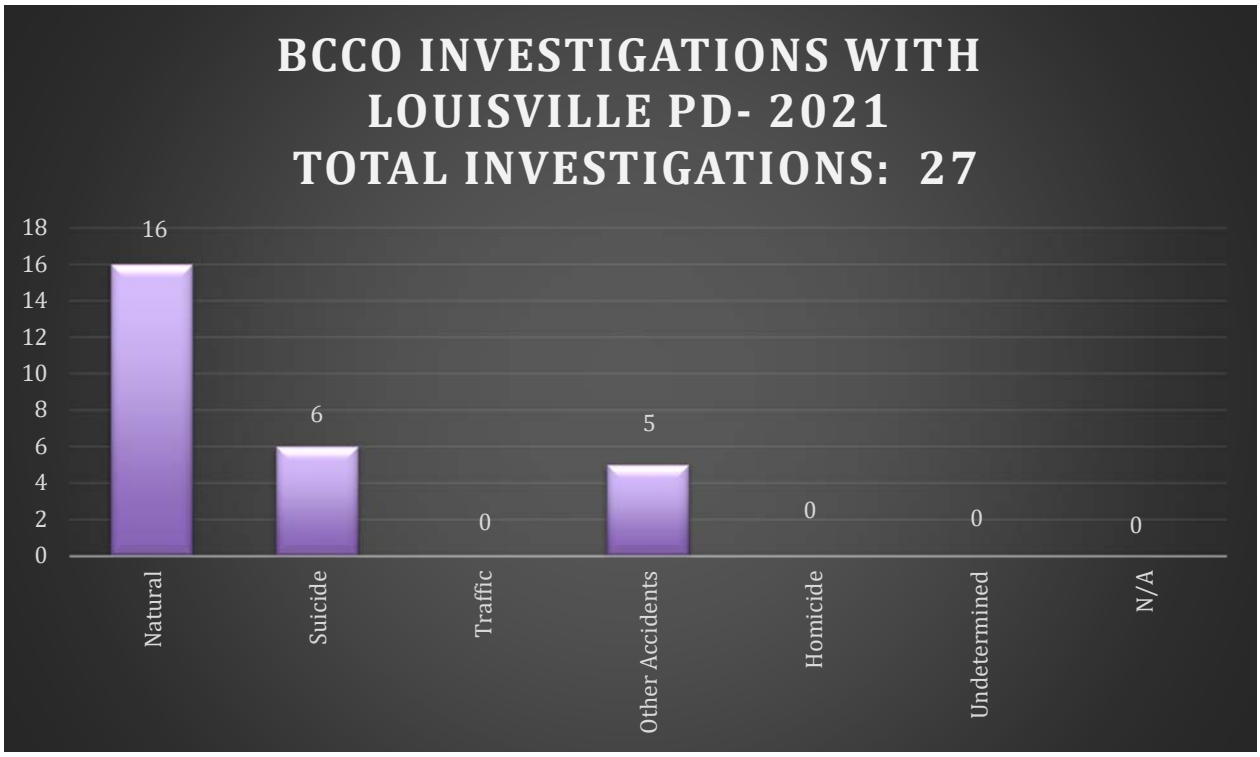


LAFAYETTE POLICE DEPARTMENT

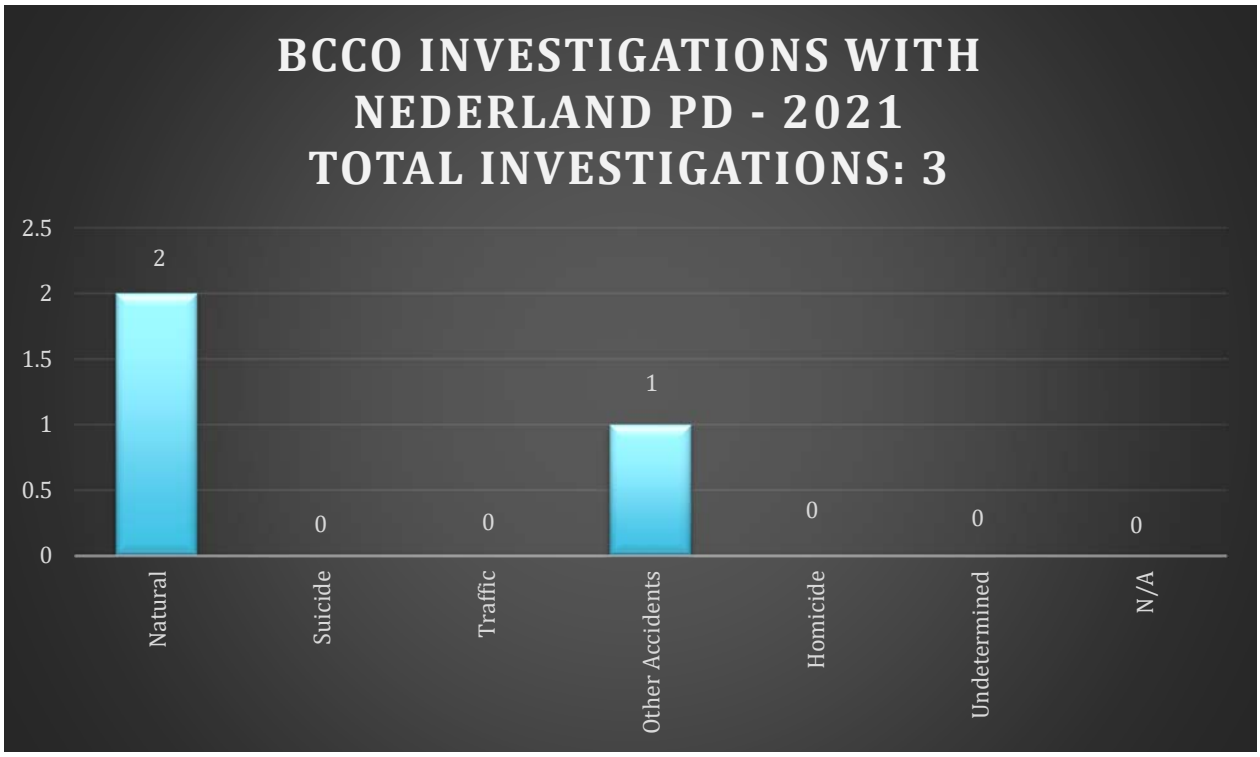


LONGMONT POLICE DEPARTMENT

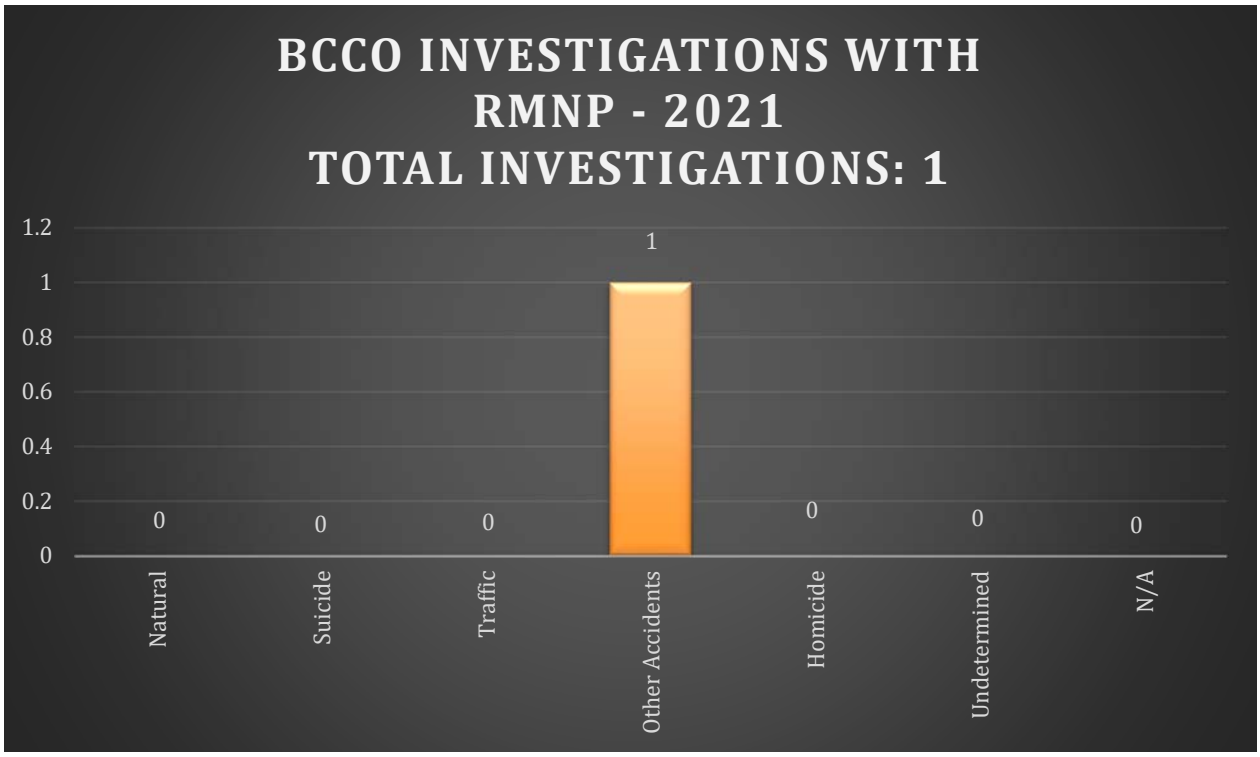
LOUISVILLE POLICE DEPARTMENT



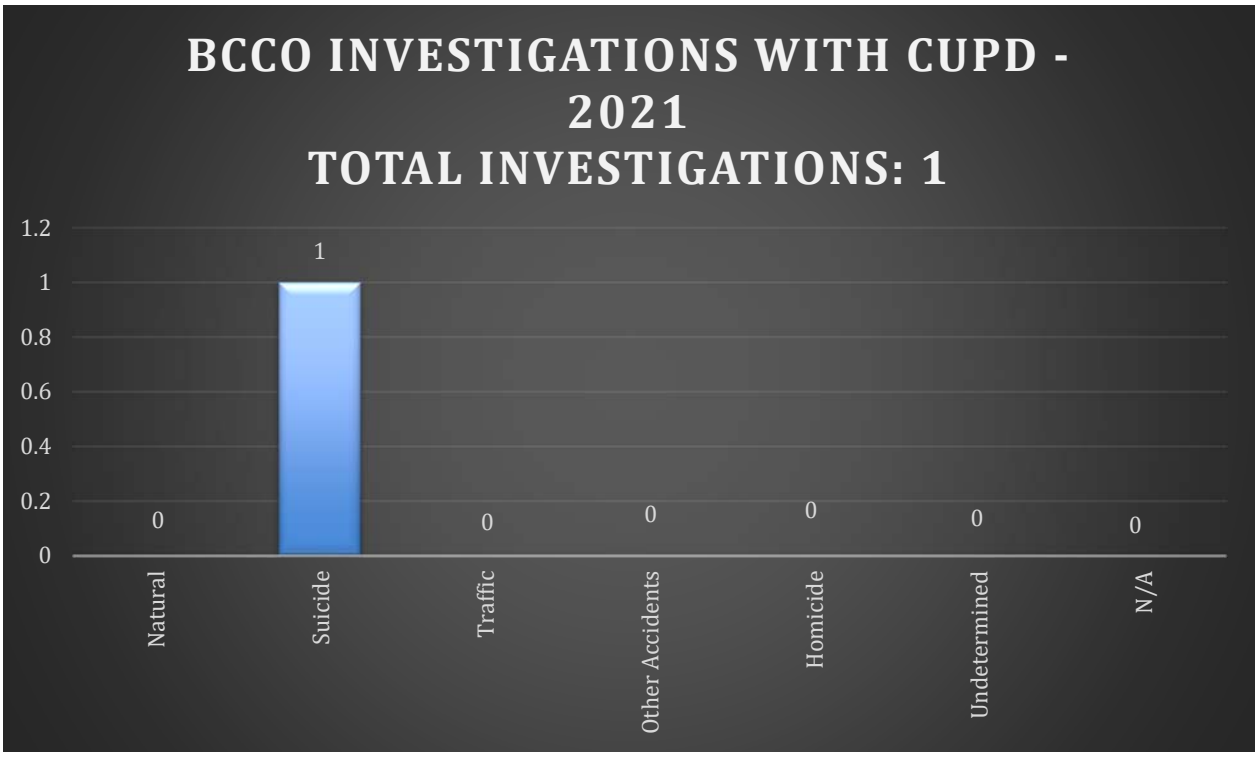
NEDERLAND POLICE DEPARTMENT



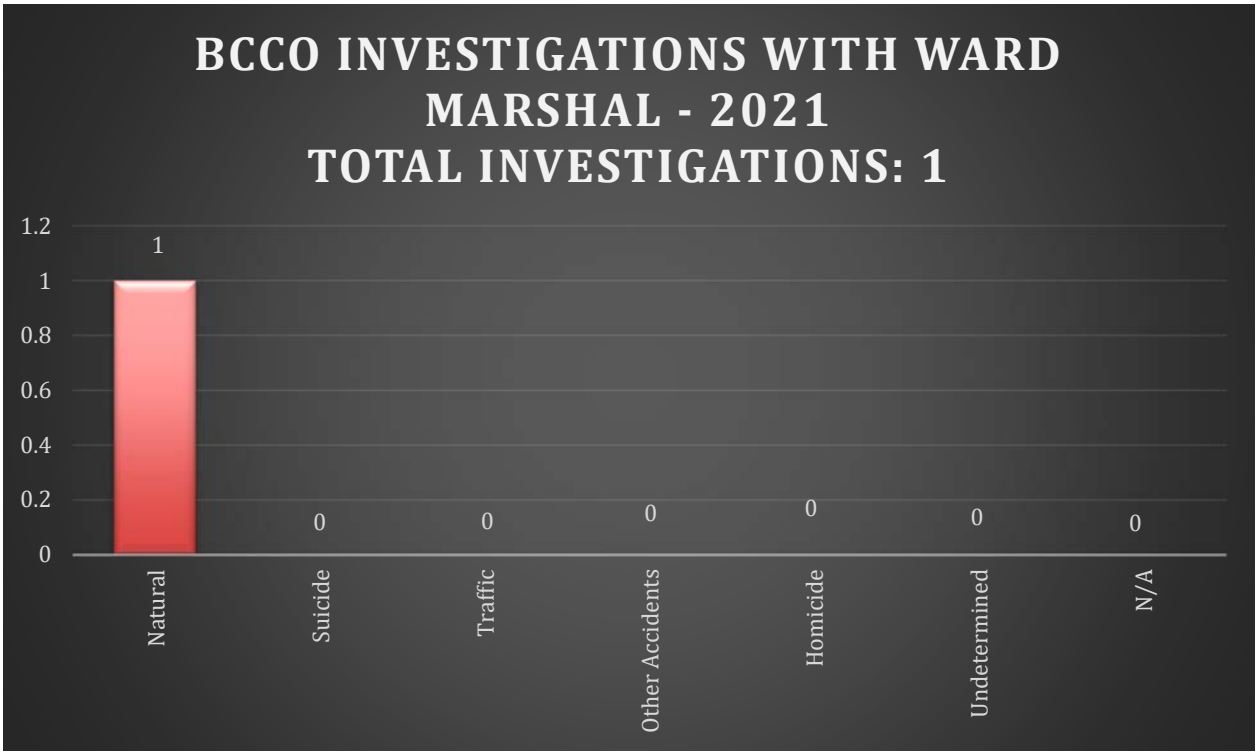
ROCKY MOUNTAIN NATIONAL PARK



UNIVERSITY OF COLORADO POLICE DEPARTMENT



WARD MARSHAL



UNIDENTIFIED REMAINS

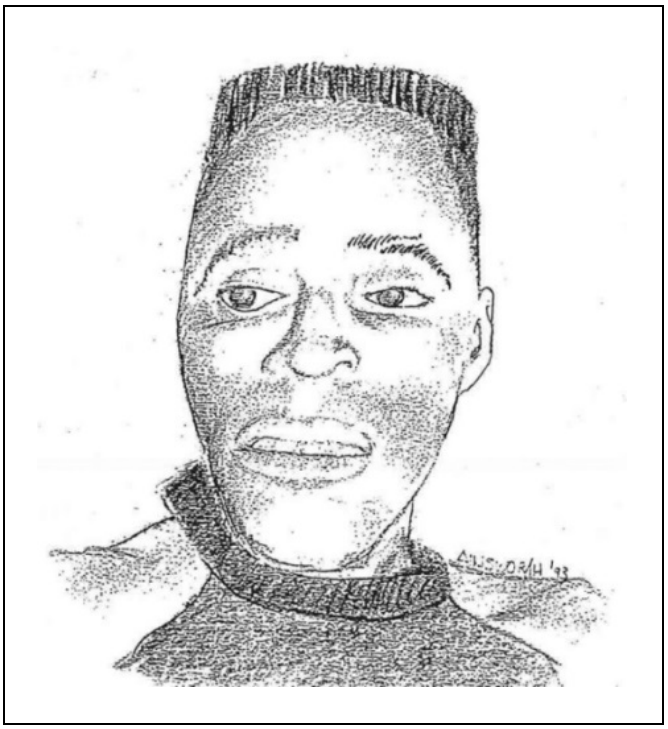
Boulder County Coroner's Office has investigated the deaths of the following individuals whose identities remain unknown.

UNIDENTIFIED BLACK MALE

Discovered: October 10, 1993

NamUs Case Number: UP516
Ancestry: African Descent
Approximate Age: 25-35
Height: 5'7"
Weight: 165-175 lbs.
Eye Color: Brown
Hair: short curly black hair with bi-frontal balding.
Scars/Tattoos: On left eyebrow, obliquely oriented, well healed 17mm scar.
Clothing: Black socks; Short black sweat pants, brand name "Pro Spirit," overlaying a pair of long white sweat pants, brand name "Jerzees"; a white windbreaker-type shell with a hood and blue trimmed with zippers half way up front, brand name "Windcrest"; ankle length black hiking-type boots; and a blue mesh baseball cap with a New York Mets logo. Napkin with the logo "Dujour's Casual Café" was also found in his pocket.
Dental: Teeth in excellent repair with no dental work.

A well-nourished male of African descent was found near the base of the second Flatiron in Boulder, CO. Forensic Anthropology and Dentistry suggest he might have been a recent immigrant to America from North Africa. No obvious injury was found. An autopsy did not reveal cause of death. Some clothing and personal effects were found near him, but no camping gear or identification was present. He had a pair of thick-rimmed red prescription glasses.

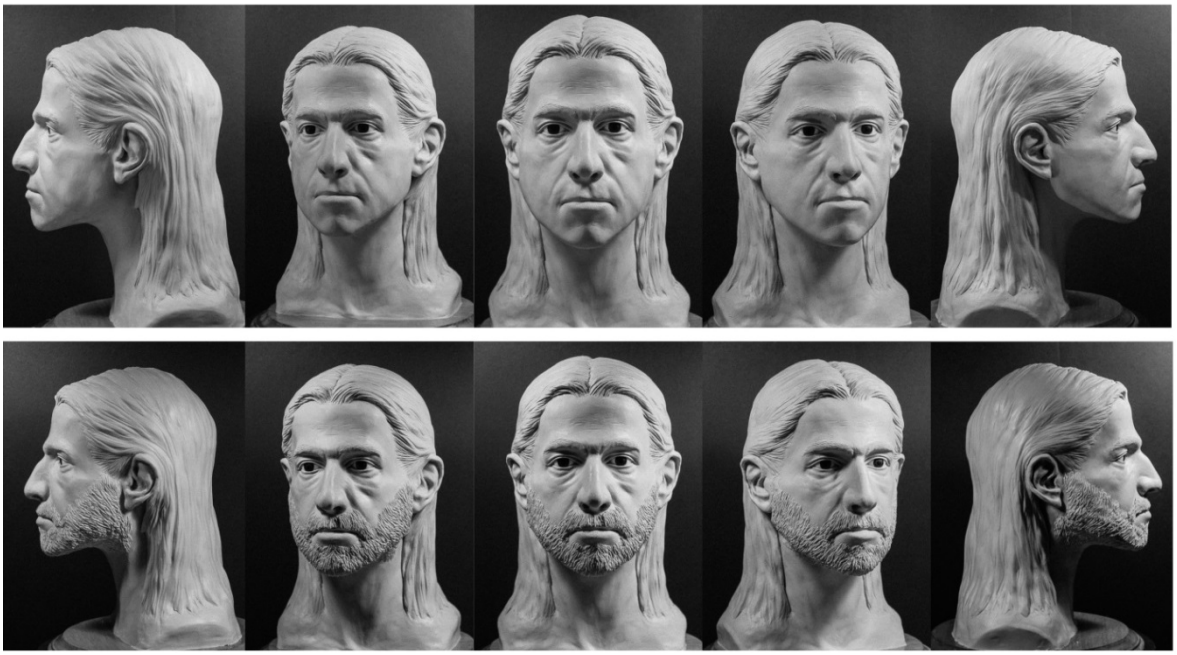


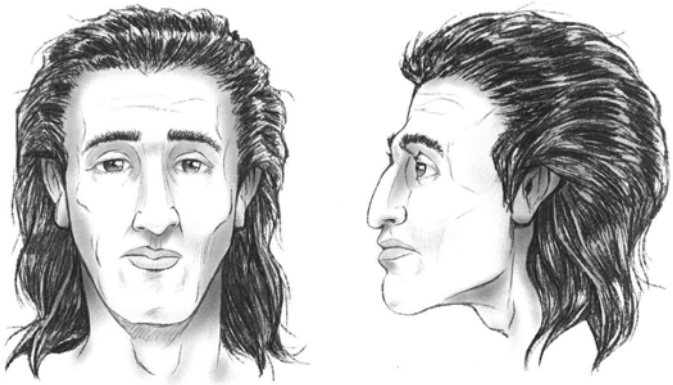
UNIDENTIFIED CAUCASIAN MALE

Discovered: November 21, 1993

NamUs Case Number: UP517
Ancestry: Caucasian
Approximate Age: 25-32
Height: 5'3" – 5'6"
Weight: 150-165 lbs.
Eye Color: Unknown
Hair: Shoulder-length coarse straight dark blond to light brown hair
Scars/Tattoos: None
Clothing: T-shirt, blue denim jeans, white socks and white athletic-type shoes
Dental: Teeth in extremely poor repair with dental work

The remains of a mostly skeletonized Caucasian male were found on the North Slope of Gregory Canyon in Boulder County, CO. An autopsy did not reveal a cause of death, but the man may have been suffering from Chronic Iron Deficiency Anemia.





Facial Approximation

UNIDENTIFIED CAUCASIAN OR MIXED-RACE MALE REMAINS

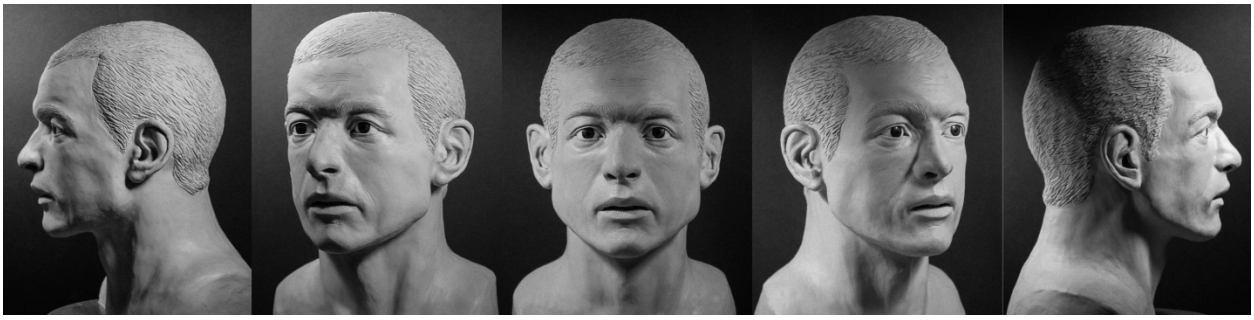
Discovered: October 2, 2017

NamUs Case Number: UP17188
Ancestry: Indeterminate
Approximate Age: 30-60
Height: Unknown
Weight: Unknown
Eye Color: Unknown
Hair: Unknown
Scars/Tattoos: Unknown
Clothing: None found with remains
Dental: Teeth in fair repair with dental work and antemortem extractions

The human skull of a male was found in the area of Mudd Lake in Boulder County, CO. An anthropological examination did not reveal a cause of death. The human mandible of a male was later found in the same general area. The mandible and skull were compared to each other and were found to be from the same decedent.

The interpretation from the Anthropological Report states the following:

"Biological profile: likely male, indeterminate ancestry, broadly estimated at 30-60 years, indeterminate stature. Healed antemortem fractures are noted (left nasal bone, left maxillary frontal process)."



UNIDENTIFIED CAUCASIAN MALE

Discovered: June 6, 1971

NamUs Case Number: UP61119
Ancestry: Caucasian
Approximate Age: 25
Height: 5'8"
Weight: 170-175 lbs.
Eye Color: Brown
Hair: Neck/shoulder length brown hair. Brown beard and mustache
Scars/Tattoos: ½"-1" circular scar on the left forearm
Clothing: Levi jeans, leather belt, one desert boot
Dental: Both upper central incisors were chipped; it is possible this happened postmortem

A Caucasian male was found in Boulder Creek, near the 28th Street bridge, in Boulder, CO. It was estimated that the decedent had been dead for two to three days and had accidentally drowned. All identification attempts at the time were unsuccessful. He was buried in Green Mountain Cemetery on July 23, 1971.

UNIDENTIFIED CAUCASIAN MALE

Discovered: August 21, 1971

NamUs Case Number: UP61120
Ancestry: Caucasian
Approximate Age: 25
Height: 5'11"
Weight: 175 lbs.
Eye Color: Brown
Hair: Shoulder length brown/black hair.
Scars/Tattoos: No identifying marks
Clothing: "Male" brand bell-bottom jeans, blue and white striped long-sleeved shirt, white Keds, gray crew socks with a red stripe on top, "Shapely" 2-button cuff L 16-16 ½
Dental: Right upper central incisor was chipped

A Caucasian male was found by a hiker on the north rim of Blue Mesa, approximately half a mile north of the shelter house in Bluebell Canyon, in Chatauqua Park, Boulder, CO. It was estimated that the decedent had been dead for three to five days. The cause and manner of death are unknown. He may have been associated with Seabrook, TX. All identification attempts at the time were unsuccessful. He was buried in Green Mountain Cemetery on October 1, 1971.

Antemortem photo, believed to be the decedent.

REFERENCES

1 National Association of Medical Examiners, A Guide for Manner of Death Classification First Edition, February 2002, p. 3.

2 American Foundation of Suicide Prevention. (2020, March 1st). *Suicide Statistics*. https://afsp.org/suicide-statistics

3 Colorado Dept. of Public Health and Environment, Violence in Colorado: Trends and Resources, University of Colorado, 1994, p. 123.

4 Published online October 17, 2011 Pediatrics Vol. 128 No. 5 November 1, 2011 pp e1341-e1367 (doi: 10.1542/peds. 2011-2285).