



2019 ANNUAL REPORT

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This report provides a summary and statistical analysis of the deaths that were investigated by the Shelby County Coroner's Office in the year 2019. We serve an increasing population of 213,729 and responsible for coverage of 800 square miles. Shelby County is the 6th largest county in Alabama. Our staff consists of a total staff of 5; 1 coroner and 4 deputy coroners.

The Coroner and/or Deputy Coroner are on duty 24 hours a day, 365 days a year. The Coroner's mission is to satisfy the legal requirements of the office in an expeditious manner. The primary task of the Coroner's Office is to determine the cause and manner of death of those who have died in Shelby County or in those whose traumatic event originated in Shelby County. An autopsy may be required depending upon the circumstances of the death.

The coroner and all appointed staff have authority through the Alabama Code, Section/Chapter 45-2-61.

The Coroner's Office investigates sudden, unexpected deaths, especially those that occur under violent or suspicious circumstances. Those deaths to be reported to the Shelby County Coroner's Office include all deaths occurring in Shelby County as outlined below regardless of where or when the initial injuring event occurred. In addition, all deaths as outlined below shall be reported that occurred outside of Shelby County but the initiating injuring event occurred in Shelby County.

- From disease which may be hazardous or contagious or which may constitute a threat to the health of the general public
- From external violence, an unexplained cause, or under suspicious circumstances
- Where no physician is in attendance, or where, though in attendance, the physician is unable to certify the cause of death
- From thermal, chemical, or radiation injury
- From criminal abortion
- While in the custody of law enforcement officials or while incarcerated in a public institution
- When the death was sudden and happened to a person who was in good health
- From an industrial accident or any death suspected to involved with the decedent's occupation
- When death occurs in a hospital less than 24 hours after admission to a hospital or after any invasive procedure
- Any death suspected to be due to alcohol intoxication or the result of exposure to drugs or toxic agents
- Any death due to neglect or suspected neglect
- Any stillbirth of 20 or more weeks gestational age unattended by a physician
- Any maternal death to include death of a pregnant woman regardless of the length of the pregnancy, and up to six weeks (or one year) post-delivery, even where the cause of death is unrelated to the pregnancy
- Any death of an infant or child where the medical history has not established a significant pre-existing condition

Staff

| | | |
|----------------|---------|----------------------|
| Lina Evans | F-ABMDI | CORONER |
| Robert Ingram | D-ABMDI | CHIEF DEPUTY CORONER |
| Keith Berry | | DEPUTY CORONER |
| Justin Roberts | | DEPUTY CORONER |
| James Fuller | | DEPUTY CORONER |

General Statistics

| | |
|--------------------------|-----|
| Number of Reported Cases | 446 |
|--------------------------|-----|

Coroner Cases / Manner of Death

Natural - 337

Accidental - 74 Drug Overdose - 36

Suicide - 24

Homicide - 8

Pending - 5

Undetermined - 4

Total Autopsies - 74

Tox w/o Autopsy - 72

Unclaimed/Abandon - 6 Unidentified Bodies - 0 Exhumations - 0

Organ/Tissue Donation - 61 Eye Donations - 54

Gender of those deaths investigated in field

| | |
|---------|-----|
| Males | 261 |
| Females | 185 |

Race of those deaths investigated in field

| | |
|-----------|-----|
| Caucasian | 394 |
| Hispanic | 3 |
| Black | 47 |
| Other | 2 |

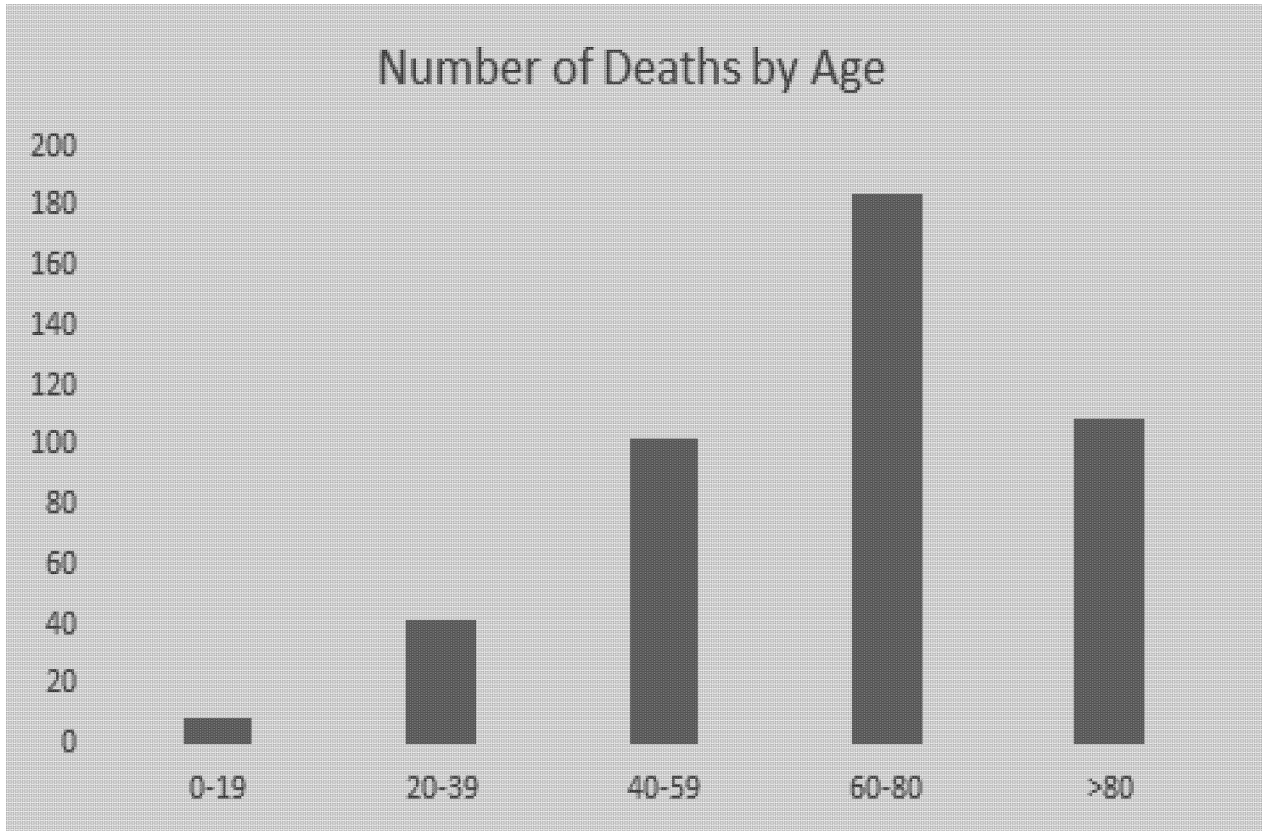
Body Transport

| | |
|-------------------------|-----|
| Coroner's Morgue | 112 |
| Mortuaries - from scene | 254 |

Out of county and cases transported to facility for postmortem examination

| | |
|------------------|---|
| Jefferson County | 6 |
|------------------|---|

Age



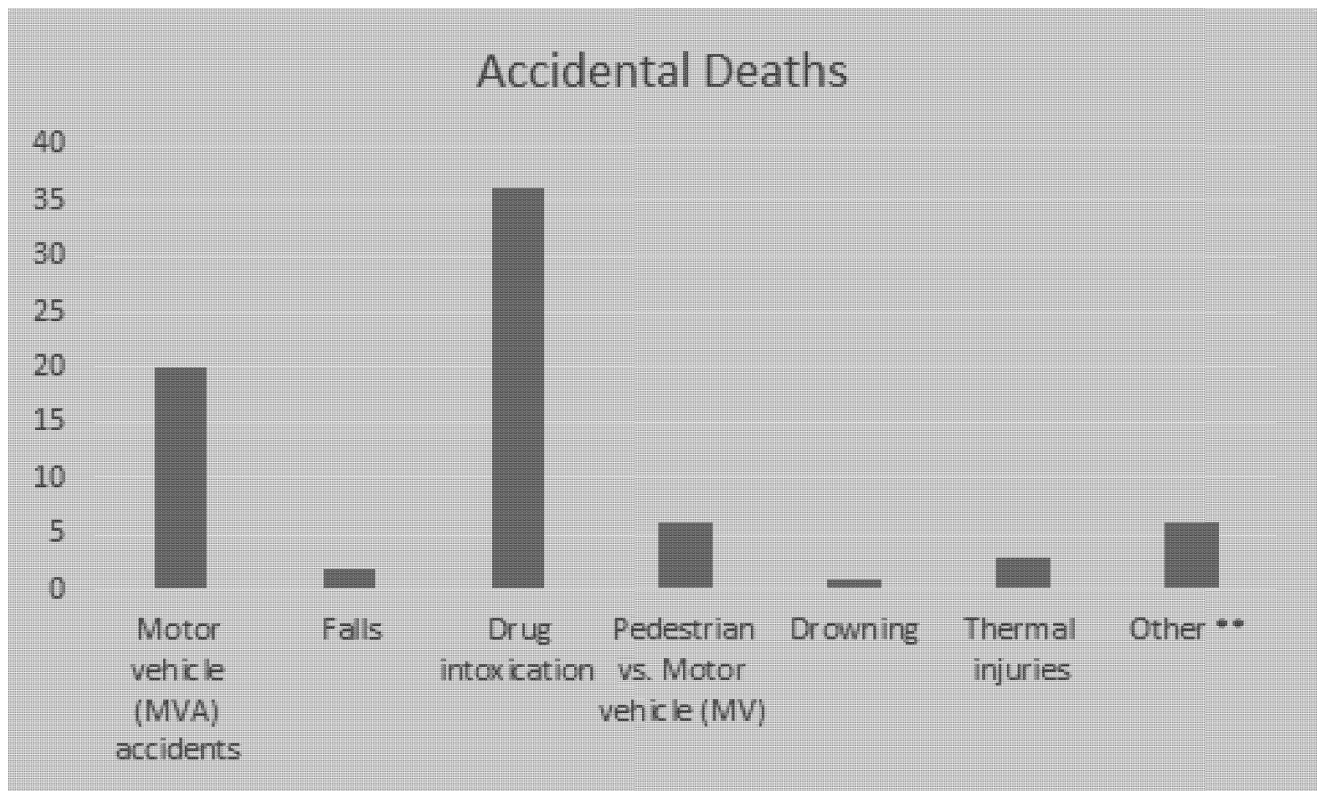
Manner of Death

| Manner | # of cases | #of full postmortems at AL DFS | # of partial exams at AL DFS | % receiving full postmortem exam** |
|--------------|------------|--------------------------------|------------------------------|------------------------------------|
| Natural | 337 | 15 | 0 | 5% |
| Accident | 74 | 26 | 0 | 35% |
| Suicide | 24 | 8 | 2 | 42% |
| Homicide | 8 | 8 | 0 | 100% |
| Undetermined | 5 | 5 | 0 | 100% |

** All field investigations receive external exam by SCCO

Accidental Deaths

| Type | Number of deaths |
|-----------------------------------|------------------|
| Motor vehicle (MVA) accidents | 20 |
| Falls | 2 |
| Drug intoxication | 36 |
| Pedestrian vs. Motor vehicle (MV) | 6 |
| Drowning | 1 |
| Thermal injuries | 3 |
| Other ** | 6 |



**The other cases include: 2 mechanical asphyxiations, 1 heat related , 1 electrocution, 2 accidental gun shot wound

Thermal injuries: 2 house fires

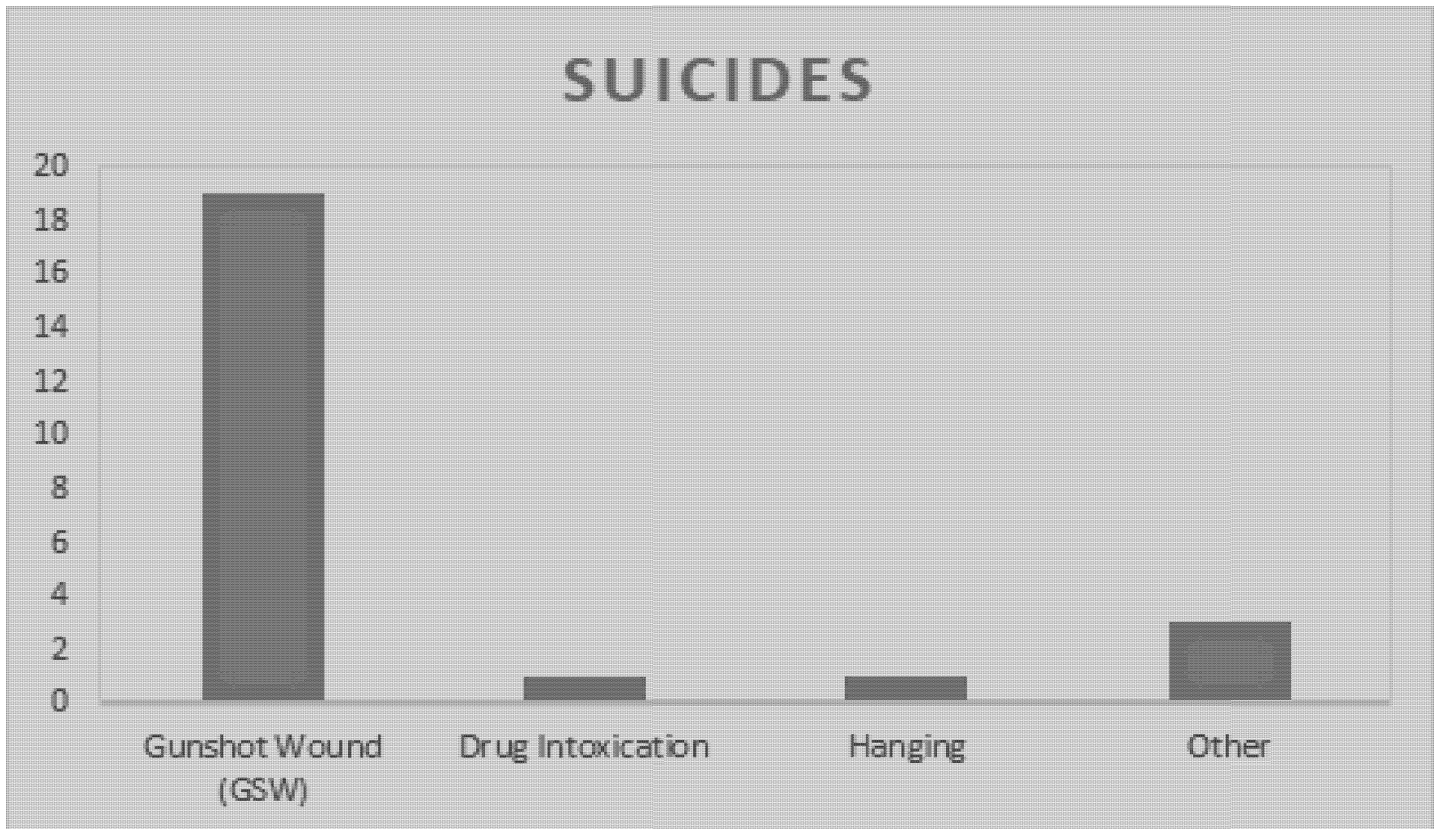
Falls were of elderly individuals who fell from heights, which resulted traumatic brain hemorrhage.

The 19 motor vehicle collision-related deaths displayed the following characteristics:

- Drivers – 16
- Passengers – 3
- Automobile victims wearing a seatbelt – 11
- Automobile victims not wearing a seatbelt – 8
- Alcohol and/or drugs involved in at least # of the deaths
 - Alcohol only in 7 deaths
 - Drugs only in 0 deaths
 - Alcohol and drugs in 3 deaths

Suicides

| Type | Number of deaths |
|----------------------|------------------|
| Gunshot wounds (GSW) | 19 |
| Drug intoxications | 1 |
| Hanging | 1 |
| Other | 3 |



The following are some features of the suicide deaths:

- 21 males and 3 females
- Males ages :
 - 0-19 0
 - 20-39 2
 - 40-59 9
 - 60-80 9
 - >80 1
- Females ages:
 - 0-19 0
 - 20-39 1
 - 40-59 2
 - 60-80 0
 - >80 0

*Other deaths include 2 Sharps Force and 1 CO Poisoning

Homicides

The 8 homicides had the following characteristics:

- 21 males and 3 females
- Males ages :
 - 0-19 3
 - 20-39 1
 - 40-59 1
 - 60-80 1
- Females ages:
 - 40-59 1
- 1 blunt force /sharp wounds
- 7 deaths due to gunshot wounds

Natural deaths

Of the 331 natural deaths investigated:

Cardiovascular related - 78

Deaths due to cardiovascular causes include MI's (heart attacks), heart arrhythmias, Congestive Heart Failure, HCVD.

Cerebrovascular related - 52

Deaths due to cerebrovascular causes include strokes, and other aneurysm related deaths.

Renal Failure/ESRD - 6

Other Disease Related - 7

Infection/Sepsis - 4

Seizure Disorders - 2

Birth Defect Related - 4

Birth Defect Related - 4

Diabetes Related - 4

Chronic Alcohol Use Related - 18

Neoplasms/Cancer Related - 48

Pancreatitis/Pancreatic Cancer - 9

COPD/PE/Lung Related - 39

Parkinsons - 6

Alzheimers/Dementia Related - 26

Undetermined

The 4 undetermined deaths had the following characteristics:

- 4 were pediatric deaths all under 9 months old
- All deaths contributed to unsafe sleep environments

Other notes of interest:

Shelby County Coroner's Office became the 1st County Coroner's Office in the State of Alabama to achieve National Accreditation with the International Coroners and Medical Examiners Association (IAC&ME). The other accrediting body, the National Association of Medical Examiners (NAME), accredits medical examiners offices. Both accrediting agencies have the same standards set forth for certification. We are extremely proud of this accomplishment. This office follows national standards and protocols for all death investigations.