



(970) 256-6462 - Office

(970) 644-3297 - Fax

E-mail: [coroner@mesacounty.us](mailto:coroner@mesacounty.us)

This report provides a summary and statistical analysis of the deaths that were investigated by the Mesa County Coroner's Office in the year 2015. Mesa County encompasses an area over 3300 square miles which consists of desert, agricultural and mountain areas. Mesa County is home to approximately 148,000 people in 12 communities. The largest of these is Grand Junction, followed by Fruita and Palisade. Other towns and unincorporated areas of the County include Clifton, Fruitvale, De Beque, Collbran, Mesa, Mack, Loma, Gateway, Glade Park and Whitewater.

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 Mesa County or in those whose traumatic event originated in Mesa County. An autopsy may be required depending upon the circumstances of the death.

The Coroner's Office investigates sudden, unexpected deaths, especially those that occur under violent or suspicious circumstances. Those deaths to be reported to the Mesa County Coroner's Office include all deaths occurring in Mesa 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 Mesa County but the initiating injuring event occurred in Mesa 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

Dean Havlik, M.D.	Coroner & Forensic Pathologist
Victor Yahn, D-ABMDI	Chief Deputy Coroner
Chuck Nelson, D-ABMDI	Deputy Coroner
Brian Clark	Deputy Coroner
Jody Hudson	Deputy Coroner
Shaye Schottel	Deputy Coroner

## General Statistics (Including deaths transferred to the county of origin)

Mesa County population in 2015 (2014 census data)	148,255
Total Mesa County deaths	1643
Percentage of Mesa County citizens who died in 2015	1.1%
Number of deaths investigated	567
Scene Investigations	298
- Victor Yahn, D-ABMDI	118
- Chuck Nelson	110
- Brian Clark	41
- Jody Hudson	29
Facility Investigations	269 (25 required autopsies)
Percentage of total deaths investigated	34.5%
Number of deaths originating in other counties	38
Jurisdiction declined	18
Number of postmortem examinations	151
Percentage of deaths having an examination	9.2%
- Complete Autopsies	147
- Partial Autopsies	3
- External Examinations	1
- Hospital deaths having complete autopsy	25
Toxicology performed	124
Community Hospital	49
AIT	73
Community Hospital and AIT	2
Gender of those deaths investigated	
Males	336
Females	231

## Race of those deaths investigated

Caucasian	517
Hispanic	43
Native American	2
Black	5
Other	0

## Body Transport

Coroner's Office	259
Coroner's Office to mortuary	7
Mortuaries – from scene	50
Mortuaries – from facilities	251

## Out of county and private cases transported to facility for postmortem examination

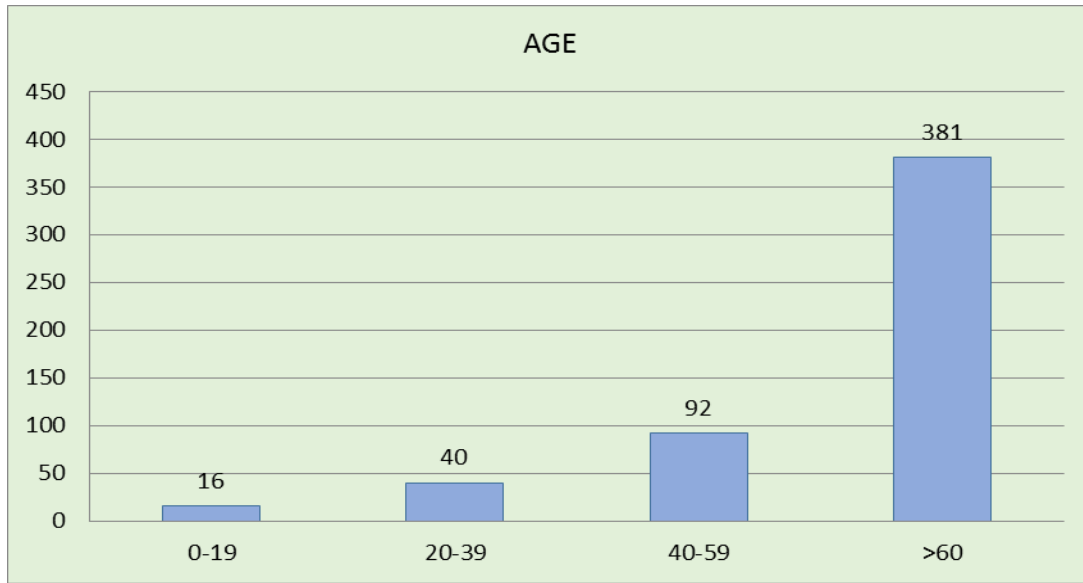
Delta County	3
Garfield County	7
Moffat County	2
Montrose County	1
Private cases	2
Rio Blanco County	1
San Juan County	1

## Additional Information

Unidentified bodies	0
Organ and Tissue referrals	43
Donated to CMU Forensic Investigation Research	3
Unclaimed bodies	0
Exhumations	0

**The following information pertains only to deaths that were not transferred back to the county of origin.**

**Age**



\*\* In the 0 to 19 years old group there were 16 deaths which included 10 males and 6 females. Of these, 2 were from complications during birth at home, 7 were accidents, 2 were suicides, 3 were homicides, and 2 were undetermined. The 7 accidental deaths included: 4 infant positional asphyxia deaths, a 3-year-old that was struck by a bus, and a 13-year-old and a 19-year-old that involved motor vehicles. The suicides were a 15-year-old death from a self-inflicted gunshot wound and a 16-year-old death as a result of mixed drug intoxication. The homicides were a 2-year-old death as the result of blunt force injuries, a 14-year-old death that was shot while hunting, and a 17-year-old death that was the result of an officer involved shooting. The undetermined deaths were an 18-year-old from a mixed drug intoxication and another 18-year-old that had multiple blunt force injuries that either fell or jumped from an overpass (accident vs. suicide).

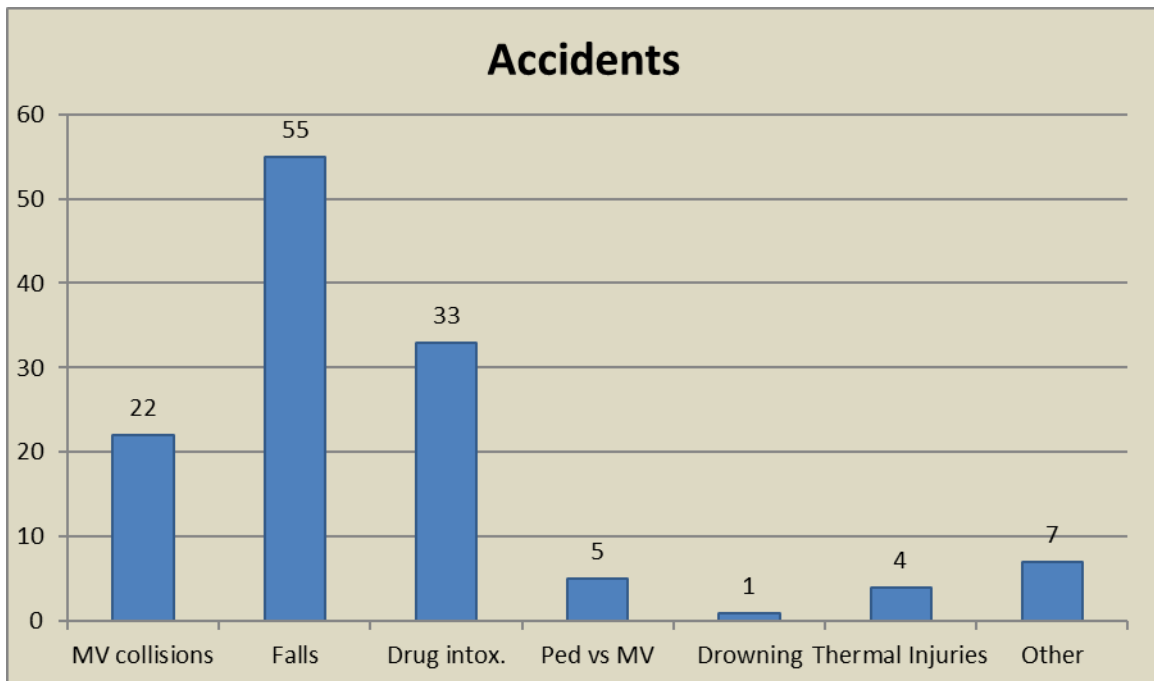
## Manner of Death

Manner	# of cases	# of postmortem exams	% receiving a postmortem exam **
Natural	355	40	9%
Accident	127	65	51%
Suicide	37	37	100%
Homicide	6	6	100%
Undetermined	4	4	100%

\*\* In the 62 accidental deaths in which no postmortem examination was performed, the majority were of decedents who were hospitalized for an extended period of time and the injuries were well documented in the hospital or care facility. Of these 62 deaths: 7 were motor vehicle accidents (4 were a result of the decedent's quality of life diminishing great and dying years later) that died at a care facility, 49 were falls predominantly from a standing height in older individuals that died at a care facility, 1 was an elderly person who fell down a flight of stairs and died at a care facility, 1 was an elderly person who fell from his roof and died at a care facility, 1 was from the result of a fuel tank explosion and died in a care facility, 1 was the result of the decedent witnessed choking on food, and 1 was an elderly person who fell while riding a bicycle and died in a care facility.

## Accidental Deaths

Type	Number of deaths
Motor vehicle (MV) collisions	22
Falls	55
Drug intoxication	33
Pedestrian vs. Motor vehicle (MV)	5
Drowning	1
Thermal injuries	4
Other **	7



\*\*The “other” cases include: 1 bicycling accident, 1 foreign body airway obstruction, 4 infant positional asphyxia from unsafe sleep environment, and 1 adult positional asphyxia from being pinned under a vehicle.

The majority of the falls were of elderly individuals who fell from a standing height, many of which resulting in a fractured hip or traumatic brain hemorrhage.

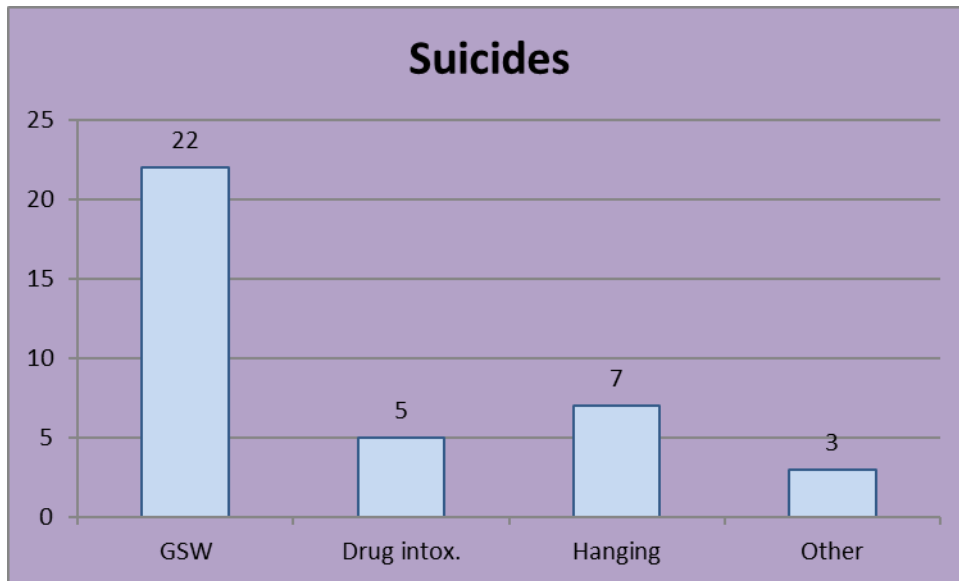
The 22 motor vehicle collision-related deaths displayed the following characteristics:

- Drivers – 18
- Passengers – 4
- Motorcycle/ATV wearing a helmet – 2
- Motorcycle/ATV without a helmet – 5
- Motorcycle/ATV unknown if wearing a helmet – 2
- Automobile victims wearing a seatbelt – 2
- Automobile victims not wearing a seatbelt – 7
- Automobile victims unknown if wearing a seatbelt – 4 (All were from incidents occurring years prior to death)
- Alcohol and/or drugs involved in at least 4 of the deaths (18% of cases)
  - Alcohol only in 0 deaths
  - Drugs only in 3 deaths
  - Alcohol and drugs in 1 deaths
  - Unknown alcohol and drugs 6 (All were care facility deaths where admission blood was no longer accessible)



## Suicides

Type	Number of deaths
Gunshot wounds (GSW)	22
Drug intoxications	5
Hanging	7
Other	3



The following are some features of the suicide deaths:

- 27 males and 10 females
- Males ranged from 16 to 88 years of age (average age 49) and included the following:
  - Gunshot wound - 18 deaths
  - Drug intoxication - 3 death
  - Hanging - 5 deaths
  - Carbon Monoxide Poisoning – 1 death
- Females ranged from 15 to 78 years of age (average age 48) and included the following:
  - Gunshot wound - 4 deaths
  - Drug Intoxication – 2 deaths
  - Hanging - 2 deaths
  - Sharp force injuries - 1 death
  - Carbon Monoxide Poisoning – 1 death

## Homicides

The 6 homicides had the following characteristics:

- 1 death due to multiple stab wounds
- 1 death due to blunt force injuries of head and neck
- 4 deaths due to gunshot wounds

## Natural deaths

Of the 355 natural deaths investigated, the majority were cardiovascular related (219 deaths, 68%). Deaths due to cardiovascular causes include myocardial infarcts (heart attacks), heart arrhythmias, strokes and aneurysms. There were 17 deaths related to infectious causes (predominantly pneumonia in elderly individuals), 30 cancer related deaths, 9 deaths related to chronic obstructive pulmonary disease (emphysema), 6 as the result of bowel obstructions, and 26 deaths due to effects of chronic alcoholism. The remaining 26 deaths were from complication of long-term disease such as: dementia, epilepsy, and gastrointestinal hemorrhage.

## Undetermined

The 4 undetermined death had the following characteristics:

- 2 deaths due to drug intoxication
- 1 death due to blunt force injuries
- 1 death with marked decomposition

## Notes of interest

This year had the highest numbers of cases investigated by the Mesa County Coroner's Office. The previous highest number was 478 (in 2014) with this year's case load being 567. The numbers of homicides and suicides were relatively similar to 2014 but the numbers of accidents increased by almost 50% and the numbers of natural deaths increased by 13%. There was one child abuse related homicide in 2015. As a comparison, there was one child abuse related homicide in 2014 and none in 2012 or 2013. There were four infants who died because of an unsafe sleep environment in 2015. This compares to 4 infants who died similarly in 2014, one each in the years 2010 through 2013, two deaths in both 2008 and 2009 and one death in 2007.