2018 ANNUAL REPORT

Office of the Larimer County Coroner/ Medical Examiner

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LARIMER COUNTY
COMMITTED TO EXCELLENCE

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To the Citizens of Larimer County,

The information you will find in this annual report has been gathered from records held by the Larimer County Office of the Coroner/ Medical Examiner, Donor Alliance, and the State of Colorado Health Department. Our staff strives to serve Larimer County with integrity and professionalism. It is our wish to provide the public with the most up-to-date and complete information possible in a format that is accurate and easy to read. Many of the statistics, charts, and graphs will vary year-to-year, as trends are followed and new or different information is requested.

We hope these statistics will be of value to you. If you have any questions or need any further information, please feel free to contact us.

James A. Wilkerson IV, MD
Larimer County Coroner
Chief Medical Examiner

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MISSION STATEMENT and FUNCTION OF THE MEDICAL EXAMINER'S OFFICE

MISSION STATEMENT

- To seek the truth;
- To combine forensic science and medicolegal death investigation to determine the cause and manner of death;
- To serve the community with professionalism and integrity.

The Office of the Coroner / Medical Examiner operates as a separate and independent law enforcement agency. It is a division of the Larimer County government and is funded through the Larimer County Commissioners by the citizens of Larimer County. The Medical Examiner's Office serves the residents of Larimer County by incorporating the fields of medicine and forensic science to investigate any sudden and unexpected death, or those deaths that occur under violent or suspicious circumstances. Colorado Revised Statute (CRS) 30-10-606 mandates that the Office of the Coroner investigate any death where the cause of death is unknown. When necessary to determine the cause of death, an autopsy can be ordered by the Coroner. Certain autopsies are mandated by Statute.

In early 2002, the Larimer County Medical Examiner's Office became the smallest county in the nation and the third county in Colorado to attain national accreditation as a Medical Examiner's Office through the National Association of Medical Examiners (NAME). This is a stringent accreditation of over 300 requirements which includes that a NAME Office is run by a Forensic Pathologist/ Medical Examiner, and at least one Investigator be certified through the American Board of Medicolegal Death Investigators (ABMDI). We have maintained NAME Accreditation continuously since 2002. Our most recent inspection in mid-2017 found our office to be "exemplary" compared to offices throughout the country.

The Coroner must be elected every four years. We are fortunate that for over 40 years, Larimer County has continually elected a forensic pathologist/medical examiner as its Coroner, maintaining a professional medically-run office. Our Larimer County Coroner/Chief Medical Examiner is James A. Wilkerson IV, MD. Dr. Wilkerson has over 27 years' experience as a Forensic Pathologist and is triple-board certified in Forensic, Anatomical, and Clinical Pathology. Forensic Pathology is the branch of medical science that is applied to the legal investigation of sudden, unexpected, violent, or suspicious deaths. Also included in the Forensic Pathology partnership are Michael A. Burson, PhD, MD, and Steven J. Cina, MD, each of whom is a Forensic Pathologist/ Regional Medical Examiner.

The Larimer County Coroner/Medical Examiner's staff includes a Chief Deputy Coroner/Chief Investigator and five full time Deputy Coroner/Investigators. All investigators are trained extensively in medicolegal death investigation through ongoing education. All investigators are Certified Death Investigators through the Colorado Coroners Association and are encouraged to complete the National Death Investigator certification process through the American Board of Medicolegal Death Investigators. Completing our staff is the Administrative Office Manager and part time – temporary Investigator(s).

MISSION STATEMENT and FUNCTION OF THE MEDICAL EXAMINER'S OFFICE

Duties of the Medical Examiner's Office are dictated by CRS 30-10-606 and the National Association of Medical Examiners (NAME). This includes:

- To be available to respond to a death scene, 24 hours a day, 7 days a week;
- To investigate the scene of death;
- To take all necessary steps needed to positively identify the decedent;
- To determine the date and time of death;
- To collect, preserve, and process pertinent evidence at the scene;
- To photograph, document, and/or sketch the scene;
- To remove the body from the scene in a dignified manner;
- To interview witnesses, family members, physicians, employers, friends, neighbors, etc.;
- To compile and document information in unbiased, accurate, and complete reports;
- To assist at autopsy, which will ultimately determine the cause of death;
- To notify next-of-kin;
- To process and compare fingerprints from weapons and other items;
- To provide information and assistance to families;
- To interact with other Law Enforcement, governmental, and health agencies, i.e. police/ sheriff, fire, Emergency Medical Services, attorneys, OSHA, FBI, Consumer Product Safety Commission, DEA, school districts, hospitals, funeral homes, organ donation teams, etc.;
- To release information to public through press releases and/ or media interviews;
- To provide testimony at depositions and in court;
- To provide training and education in the field of Death Investigation to other law enforcement, health, and community service agencies.

The investigative and medical staff seek to find answers to the questions which are important to the decedent's family, involved law enforcement agencies, insurance companies, the judicial system, Consumer Product Safety Commission, the Colorado Department of Health, and OSHA, to name a few. The pursuit of civil or criminal proceedings is in part determined by the ability of the Medical Examiner's Office to determine the cause and manner of death. This unique makeup of job responsibilities means the Medical Examiner's Office performs both a public service and a law enforcement role that requires the Medical Examiner to scrutinize every death within the jurisdiction to determine the events that led to that death.

The Medical Examiner's Office also functions as an advocate for families by working with them to insure they are notified of the death, relaying the medical information from autopsies, and placing families in touch with other agencies that will assist in the grieving process. Many cases brought to the Medical Examiner's office are dealt with in a routine manner because the identity of the decedent is known, and next-of-kin can be readily contacted. However, there are occasional cases that are difficult to resolve. In these deaths, one or more pertinent pieces of information are missing or difficult to establish. Identification of the deceased may require locating dental records, fingerprints, or surgical records. The decedent may not have next-of-kin, or the next-of-kin may be far removed and difficult to locate. These cases may take more time, but the Medical Examiner's staff will pursue any and all leads to resolve these issues.

MISSION STATEMENT and FUNCTION OF THE MEDICAL EXAMINER'S OFFICE

The postmortem examination (autopsy) on each decedent includes the preservation of evidence, body fluids, and tissue for microscopic examination, toxicological analyses, trace evidence analysis, and other tests deemed necessary. Photographs are taken at autopsy both externally and internally and have value both as evidence and additional documentation of cases.

The Medical Examiners and Investigators provide testimony at depositions and in court. The staff participates in meetings with police, physicians, and attorneys (Prosecution and Defense) in a variety of criminal and civil cases.

Our office works closely with organ and tissue procurement teams in a cooperative effort to ensure that the decedent's wishes and those of their family are honored.

Death investigation requires frequent contact between our office and various media personnel. The staff is skilled in responding to media inquiries that occur daily.

Deaths which fall under the jurisdiction of the Coroner are defined by statute (CRS: 30-10-606) and include, but are not limited to, the following circumstances:

- All victims of external violence, unexplained cause, or deaths with suspicious circumstances (including all actual or suspected homicides, suicides, and accidents);
- Deaths where no physician is in attendance, or where, though in attendance, the physician is unable to certify the cause of death;
- Deaths from thermal, chemical, or radiation injury, or death from any injury sustained prior to hospital admission;
- Deaths from criminal abortion, including any situation where such abortion may have been self-induced;
- Deaths from a disease which may be hazardous or contagious or which may constitute a threat to the health of the general public;
- Deaths occurring 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;
- All "crib deaths" (Sudden Unexpected Infant Death Syndrome);
- All patients that die within 24 hours of admission to a hospital or nursing home facility.

Investigators must participate in ongoing continuing education, including:

- Death Investigation Seminars and Certification
- Medical and Forensic Seminars
- Accident Investigation
- Crime Scene Investigation
- Evidence Collection and Preservation
- Medical Training
- Interviewing and Dealing with Grief

MISSION STATEMENT and FUNCTION OF THE MEDICAL EXAMINER'S OFFICE

The Medical Examiner's staff provides regular training and education to other law enforcement, health, and community service agencies concerning the roles and functions of this office. In 2018, our Medico-legal Investigators conducted a number of educational outreach training presentations to local agencies, schools, community service groups, and individuals, including but not limited to:

- AIMS Police Academy
- Front Range Community College Med Prep, Police Academy Board, & Criminal Justice Programs
- Larimer County & City of Fort Collins Victim's Advocates
- Larimer County Search and Rescue
- Colorado Zero Suicide/Office of Suicide Prevention
- Rocky Mountain High School
- Poudre Valley High School
- UNC Forensics & Criminal Justice Program
- Various individual meetings with students and citizens throughout the community.

We have also been asked to train other Coroners and Deputy Coroners throughout the State of Colorado as part of the Colorado Coroner's Association.

EXPLANATION OF DATA

The Larimer County Coroner's Office was established in 1881 and records have been kept continuously since. The vast majority of information presented here has been compiled from deaths that fell under the jurisdiction of the Larimer County Coroner/ Medical Examiner during the 2018 calendar year. Many of the charts and graphs include data from the last 5-10 years, as needed to show trends.

The geographic area served by the Larimer County Medical Examiner's Office includes 2,634 square miles, which is located in the north central part of the state. Weld and Jackson Counties are to the east and west, respectively, with Boulder County on the south and the State of Wyoming on the north. Larimer is the 6th largest county in Colorado, based on population. The population of Larimer County is approximately 345,000 and includes the cities and towns of Estes Park, Berthoud, Loveland, Ft. Collins, and Wellington. Small communities such as Timnath, LaPorte, Bellvue, Drake, Glen Haven, Livermore and Red Feather Lakes are also within the boundaries of Larimer County. The county extends to the Continental Divide and includes much of Rocky Mountain National Park. Over 50% of Larimer County is publicly owned, most of which is land within Roosevelt National Forest and Rocky Mountain National Park. The County has two school districts; Poudre School District R-1 and the Thompson Valley School district RJ-2. Larimer County has nine (9) State highways, three (3) US highways, and one Interstate highway crossing through its boundaries.

The data in this report is summarized from individual cases under the jurisdiction of the Coroner/Medical Examiner and presented here in aggregate form. Long term death statistics were gathered from Coroner's statistics over the last 10 (or more) years. Current yearly information and statistics were gathered from deaths in 2018.

The "Undetermined" Manner of Death category includes deaths in which the manner could not clearly be determined, as in some drug overdoses where there is no clear evidence as to whether the injury occurred with intent or accidentally. Undetermined is also used for Sudden Unexpected Infant Death Syndrome (SUIDS), and in other cases, such as found skeletal remains, where no other clear manner of death can be determined.

It is the intention of the Larimer County Medical Examiner's Office to provide factual statistics and information for and requested by the citizens of Larimer County. Graphs and tables, which display information such as classification of death, drugs of abuse, death rates, and motor vehicle crash statistics have been selected as those most likely to assist other agencies and individuals seeking statistical information.

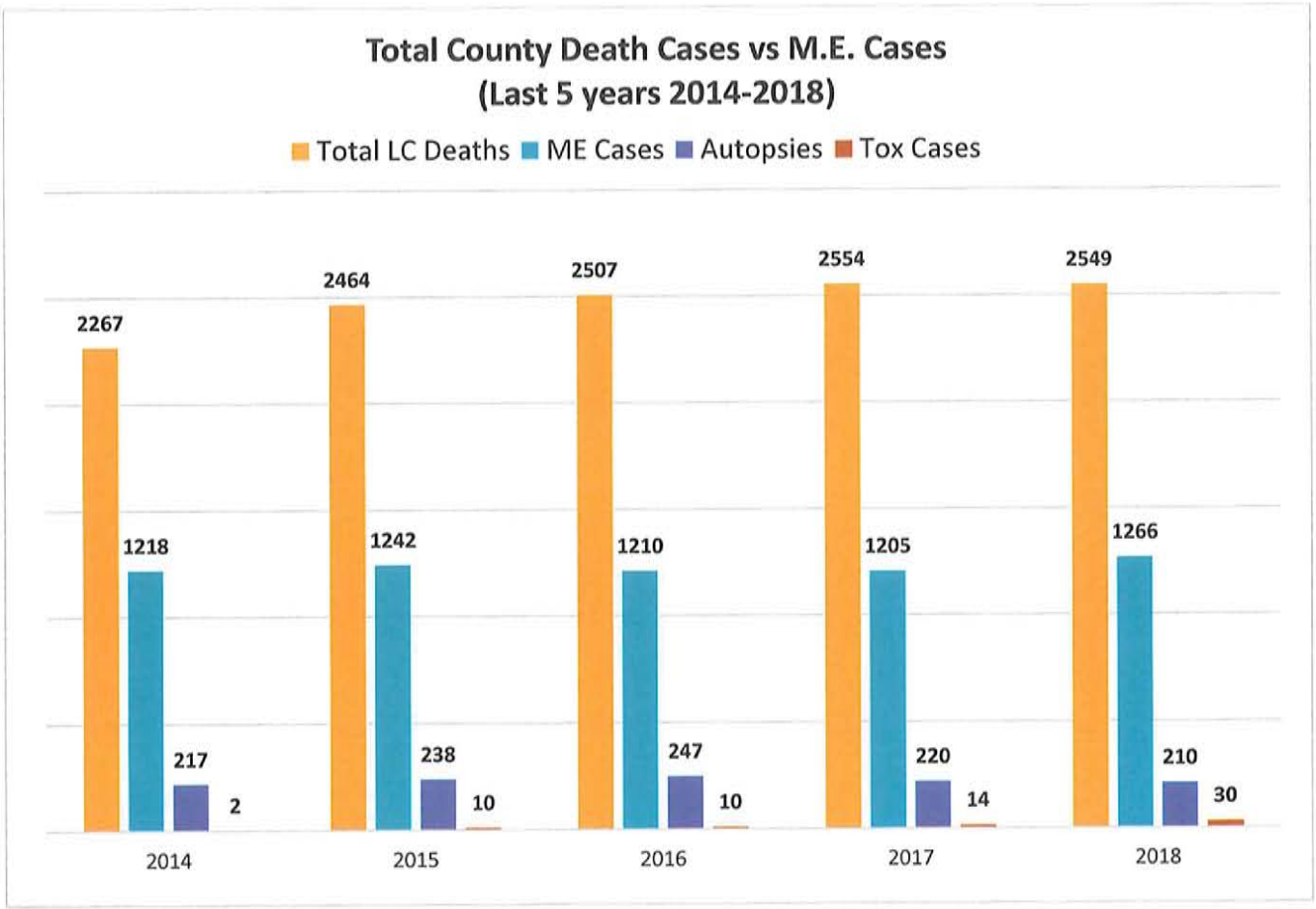
Abbreviations are used for modes of death throughout the various charts and graphs in this report. They are as follows:

- CO (carbon monoxide)
- GSW (gunshot wound)
- AH (asphyxia by hanging)
- MVC (motor vehicle crash)
- OD (overdose)

TOTAL LARIMER COUNTY DEATHS VS. MEDICAL EXAMINER CASES IN 2018

Larimer County Medical Examiner's Office requires all deaths within Larimer County to be reported to our office. The only exception is fetal deaths under 21 weeks gestation, which do not fall under Coroner Statute. In 2018, the total number of deaths reported to our office was 2,549. The Medical Examiner's Office assumed jurisdiction in 1266 (49.7%) of these cases. Larimer County Medicolegal Investigators review medical information and conduct necessary telephone interviews on all M.E. cases, and it was deemed necessary to respond to the death scene and conduct a thorough medicolegal scene investigation in 370 of the 1266 cases. Out of these investigations, complete forensic autopsies were performed in 210 cases (16.6%) of the accepted Coroner cases. Plus, in 30 additional cases, only toxicology studies were deemed necessary. Seventeen (17) cases were transferred back to the jurisdiction in which the event originated. The remaining 1,009 cases not autopsied or tested for toxicology were those in which the scene investigation, circumstances of death, medical documentation, interviews, social history, and/ or external examination of the body provided sufficient information for certifying the cause of death.

Cases in which jurisdiction was not assumed by the Medical Examiner (1283 deaths), were those individuals in nursing homes, facility hospices, or hospital settings longer than 24 hours, and with a known fatal disease process and no evidence of extenuating circumstances, thus enabling the primary physician to certify the cause of death without Medical Examiner involvement. The following tables, graphs, and figures summarize all cases where the Medical Examiner assumed jurisdiction.



MANNER OF DEATH

The **Manner of Death** is a classification of the way in which the Cause of Death came about, whether by force of natural events, accidental means, self-inflicted wounds, or other external forces. Manner of Death is determined largely by means of the investigation. There are only five (5) manners of death, listed below.

NATURAL - Death caused *solely* by disease. If natural death is hastened by injury or any other non-natural event (ex: fall), the manner of death will not be considered natural. If the terminal disease process is *caused* by a non-natural event (ex: pneumonia due to long-term bed confinement as a result of a motor vehicle accident), the manner of death will not be considered natural. Most deaths are Natural deaths and over half occur in hospital or nursing home setting and hence, do not fall under Coroner jurisdiction. Of the total 2,549 deaths in Larimer County in 2018, 2,293 were Natural deaths, meaning that only 256 deaths were not Natural events. Of the 2,293 Natural deaths, 1,010 had had extenuating circumstances causing them to fall under Coroner's jurisdiction.

SUICIDE - Death as a result of a purposeful action set in motion (explicit or implicit) to end one's life. In 2018, there were 80 deaths certified as Suicides.

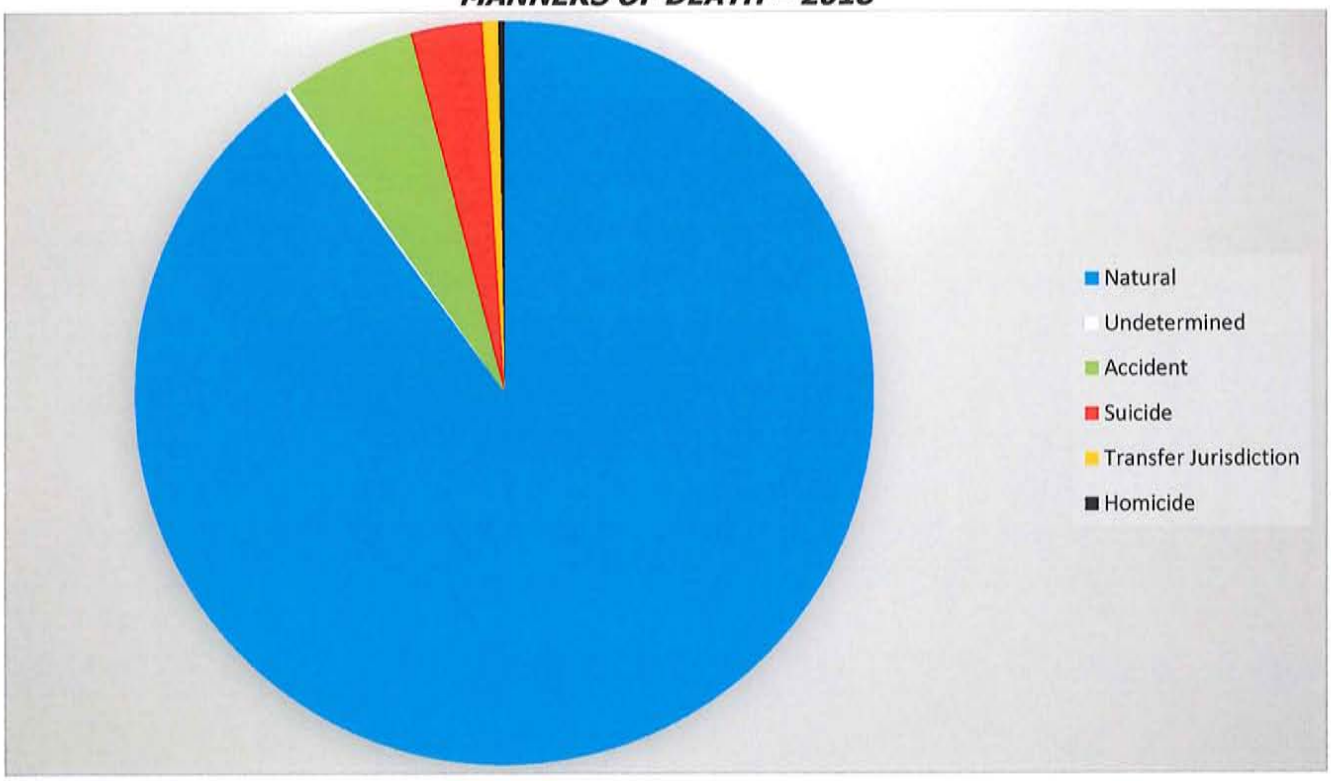
ACCIDENT - Death other than natural where there is no evidence of intent; i.e. an unintentional event or chain of events. This category includes most motor vehicle accidents, falls, drowning, accidental drug overdoses, drug reactions, etc. In 2018, we had 146 Accidents, 41 of which were motor vehicle fatalities.

HOMICIDE - Death resulting from injuries intentionally inflicted by another person (explicit or implicit) or inflicted on another by one's grossly reckless behavior (does not include vehicular homicide). In 2018, there were 7 Homicides in Larimer County.

UNDETERMINED - Manner assigned when there is insufficient evidence, or conflicting/ equivocal information (especially about intent), to assign a specific manner. In 2018, we had 6 deaths where Manner could not be accurately determined. These are listed as Undetermined.

(TRANSFERS) - Jurisdiction transferred back to the originating County where the injury occurred in 17 cases.

MANNERS OF DEATH – 2018



2018 YEAR - END STATISTICAL OVERVIEW

In 2018, the Larimer County Medical Examiner's Office had a total of 2549 deaths reported to us. Of these, 1,266 deaths fell under Coroner jurisdiction and required investigation. Of the 1,266 deaths, 1,010 were Naturals, 146 were Accidents, 80 were Suicides, 7 were Homicides, 17 were transferred back to the County of origin, and 6 were classified as Undetermined. Of the 1,266 deaths, our 6 Medicolegal Investigators responded to and conducted complete medicolegal investigations into 370 death scenes. The remaining 896 cases were home Hospice or hospital deaths falling under Coroner Statutes but determined to be death solely from Natural causes with no suspicious or unusual circumstances. These deaths were investigated via telephone and medical record review.

Not every accident or suicide is necessary to autopsy. This usually occurs when the person has been a patient in a hospital or nursing home and there is adequate medical history and a documented diagnosis which can eliminate the need for an autopsy. However, a complete medicolegal investigation is still done.

Accidents: 146 total — **79 autopsied; 10 Toxicology only**

- 50 - Falls
- 41 - Motor Vehicle Crash (MVC)
- 35 - Drug Overdose (OD)
- 5 - Drowning
- 2 - Asphyxia (mechanical, positional)
- 2 - Choked on food/ foreign object
- 2 - Hypo/ hyperthermia
- 2 - Gunshot
- 2 – Fire/ Thermal
- 2 – Carbon Monoxide
- 1 – Bicycle (alone, no other vehicles)
- 1 – Medical Mishap
- 1 – Industrial Mishap

Suicides: 80 total — **77 autopsied; 1 Toxicology only**

- 40 - Gun Shot Wound (GSW)
- 17 - Asphyxia by Hanging (AH)
- 13 - Drug Overdose (OD)
- 3 - Asphyxia (gas/hood)
- 3 – Cutting/stabbing
- 2 – Jump from height
- 1 – Asphyxia (mechanical)
- 1 – Pedestrian vs motor vehicle

Homicides: 7 total — **7 autopsied**

- 5 - Gun Shot Wound (GSW)
- 1 – Officer Involved Shooting
- 1 – Blunt trauma/strangulation

Undetermined: 6 total — **4 autopsied**

- 2 – Disease vs. Suicidal OD/Intoxication
- 1 – Disease vs. Accidental OD vs. Suicidal OD
- 1 – SUID
- 1 – Undetermined cause, trauma vs disease vs intoxication
- 1 – Historic bones/burial site discovery

Naturals: 1,010 total — **43 autopsied; 19 Toxicology only**

Transfer of Jurisdiction: 17 total

Total Forensic Autopsies Performed: 210
30 Toxicology-Only studies

SUICIDE

STATISTICS

2018 Suicide Information

Suicide is death caused by intentional, self-inflicted injuries. In Larimer County during 2018 there were 80 deaths by suicide. Death by Suicide comprised 6.3% of our investigated cases and 3.1% of all Larimer County deaths.

Age

Average Age	47
Juvenile (<18)	1
Adult	79
Oldest:	87
Youngest:	13

Gender

Female	21
Male	60

Race

Black	2
Hispanic	3
Native Amer	0
White	74
Mixed/ other	2

Alcohol and/ or Drugs Present

(Includes over-the-counter and Rx meds, recreational and illicit drugs)

Total	58/80 (72.5%)
ETOH	28/80 (35%)
THC	15/80 (19%)

Mode of Suicide

Gun Shot Wound (GSW)	40
Asphyxia by Hanging (AH)	17
Drug Overdose (OD)	13
Asphyxia by gas/hood	3
Cutting/ stab	3
Jumped from height	2
Asphyxia (mechanical)	1
Motor vehicle vs. pedestrian	1
	80

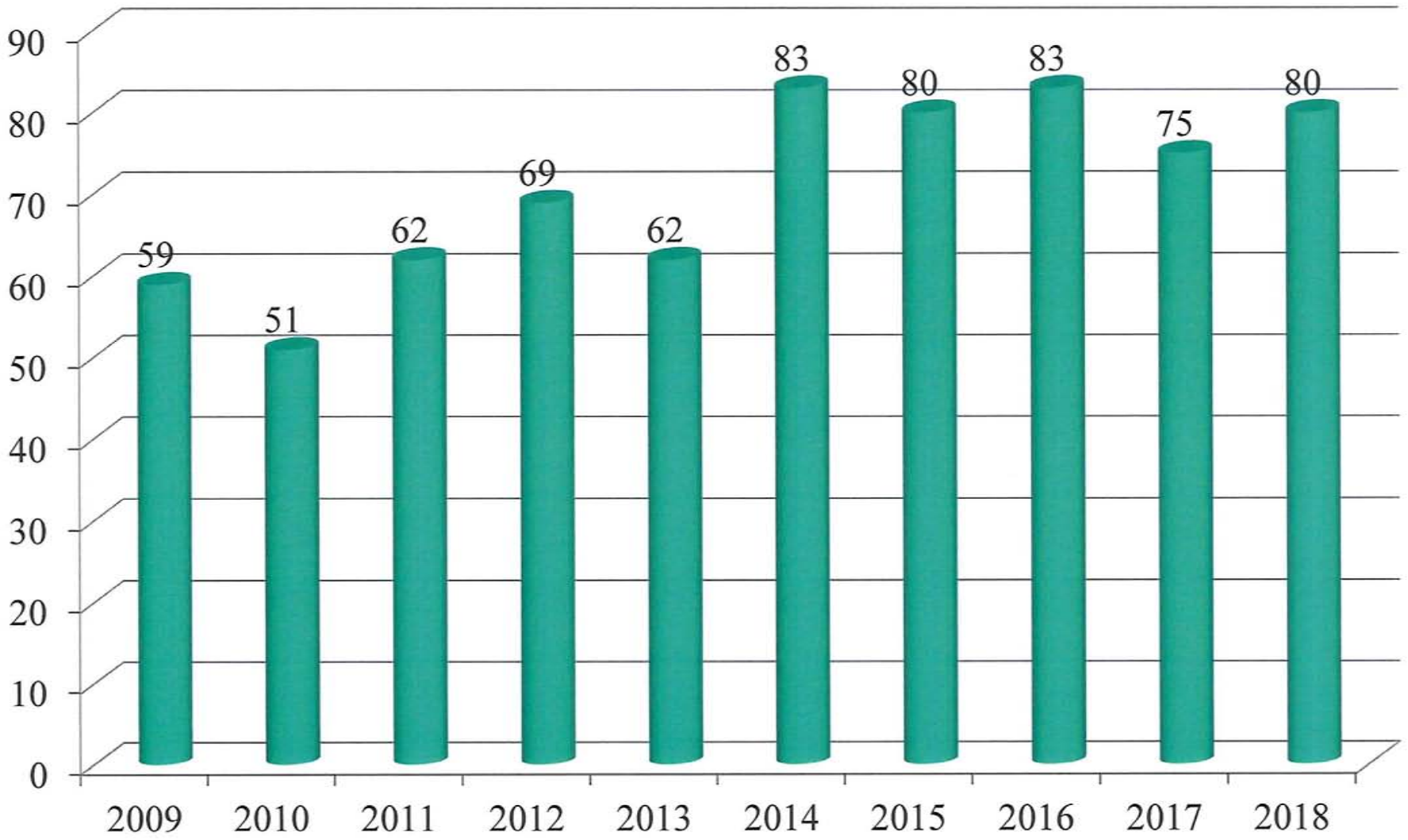
Mental Health/ Suicide Notes

Left note or other message: (46%)	37/80
Prior ideation or attempts: (61%)	49/80

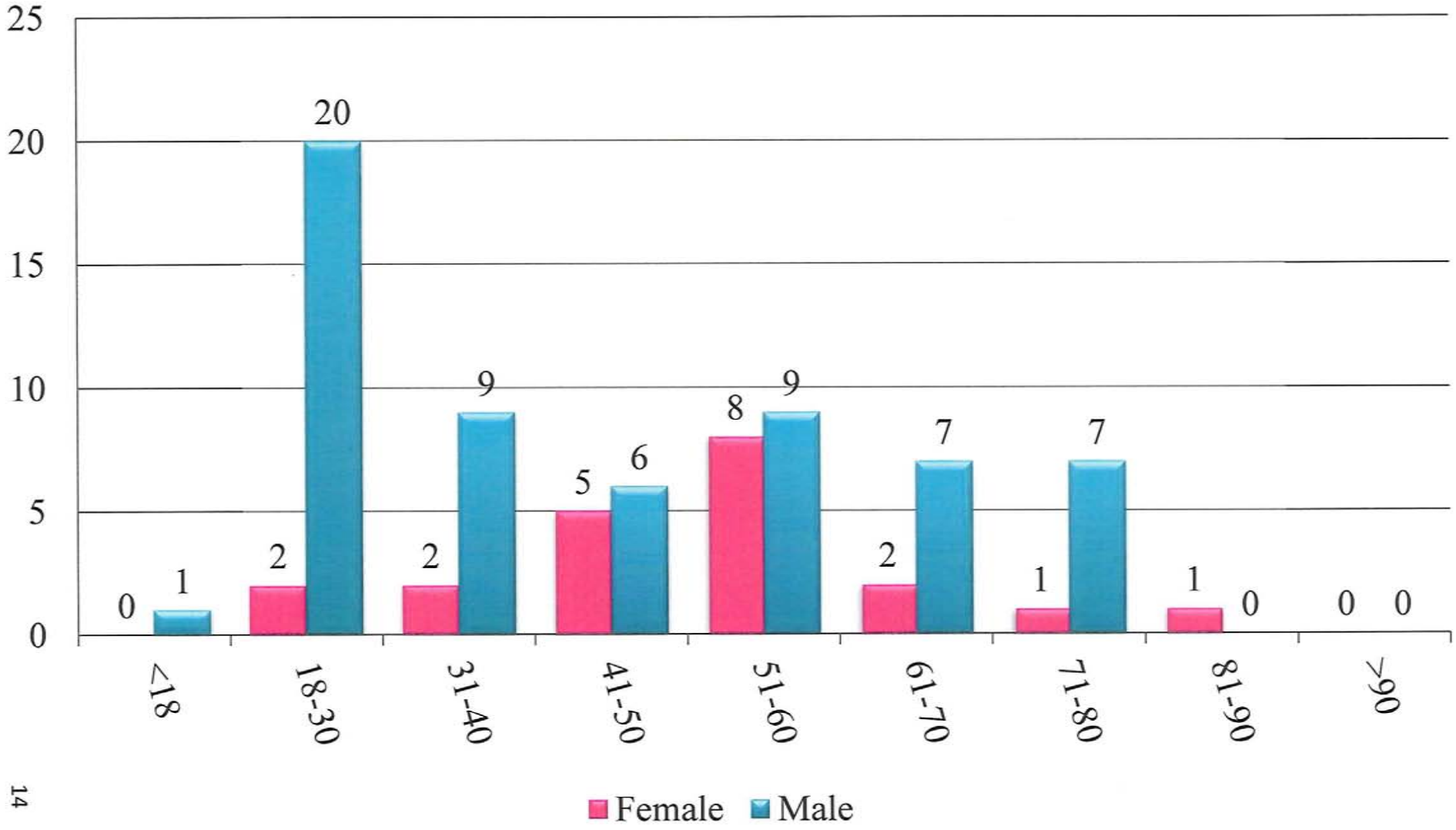
Monthly Breakdown

Jan	10
Feb	4
Mar	6
Apr	3
May	5
Jun	4
July	10
Aug	10
Sept	9
Oct	4
Nov	10
Dec	5
	80

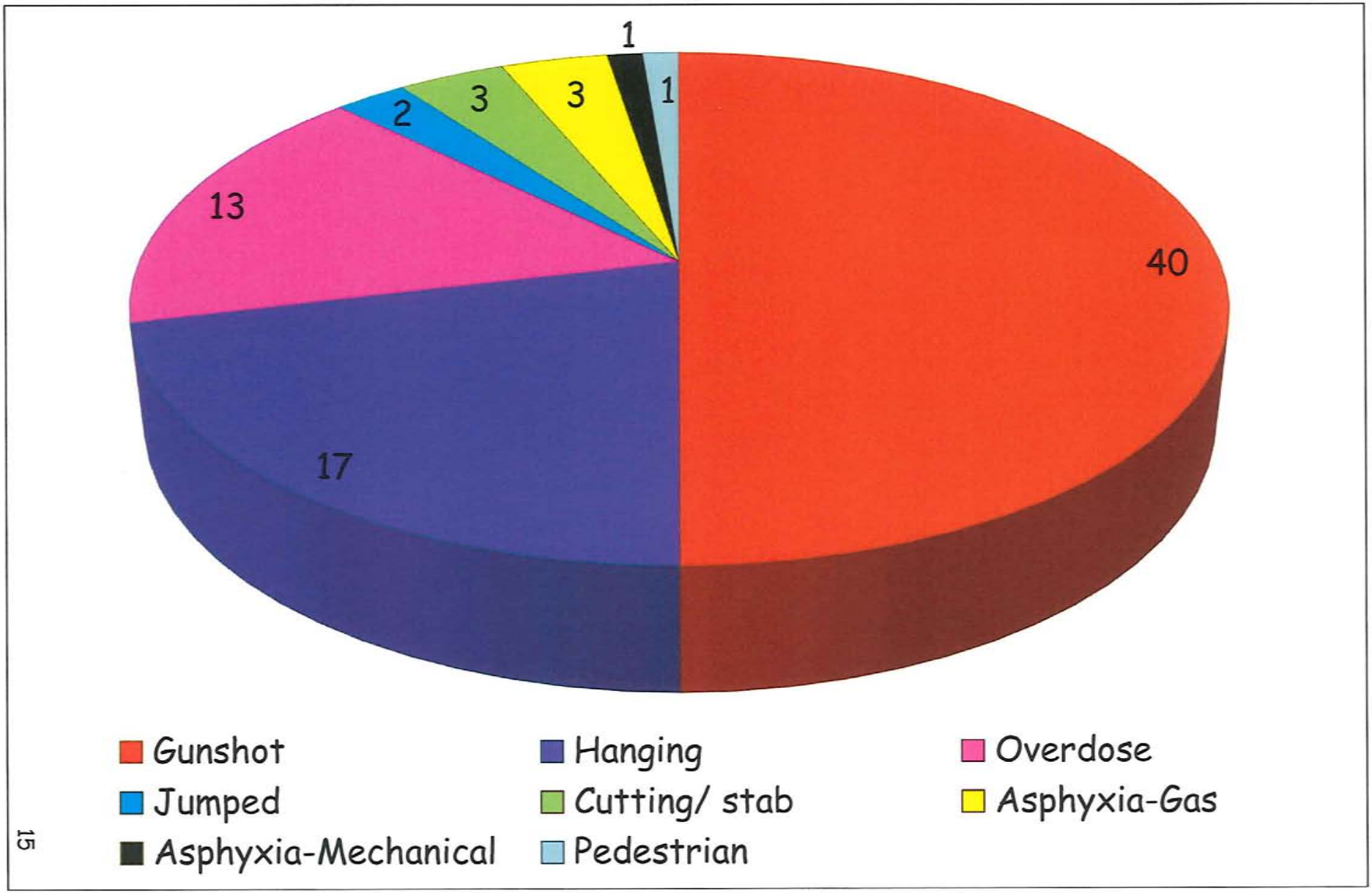
Suicide Totals - Last 10 Years
2009 - 2018



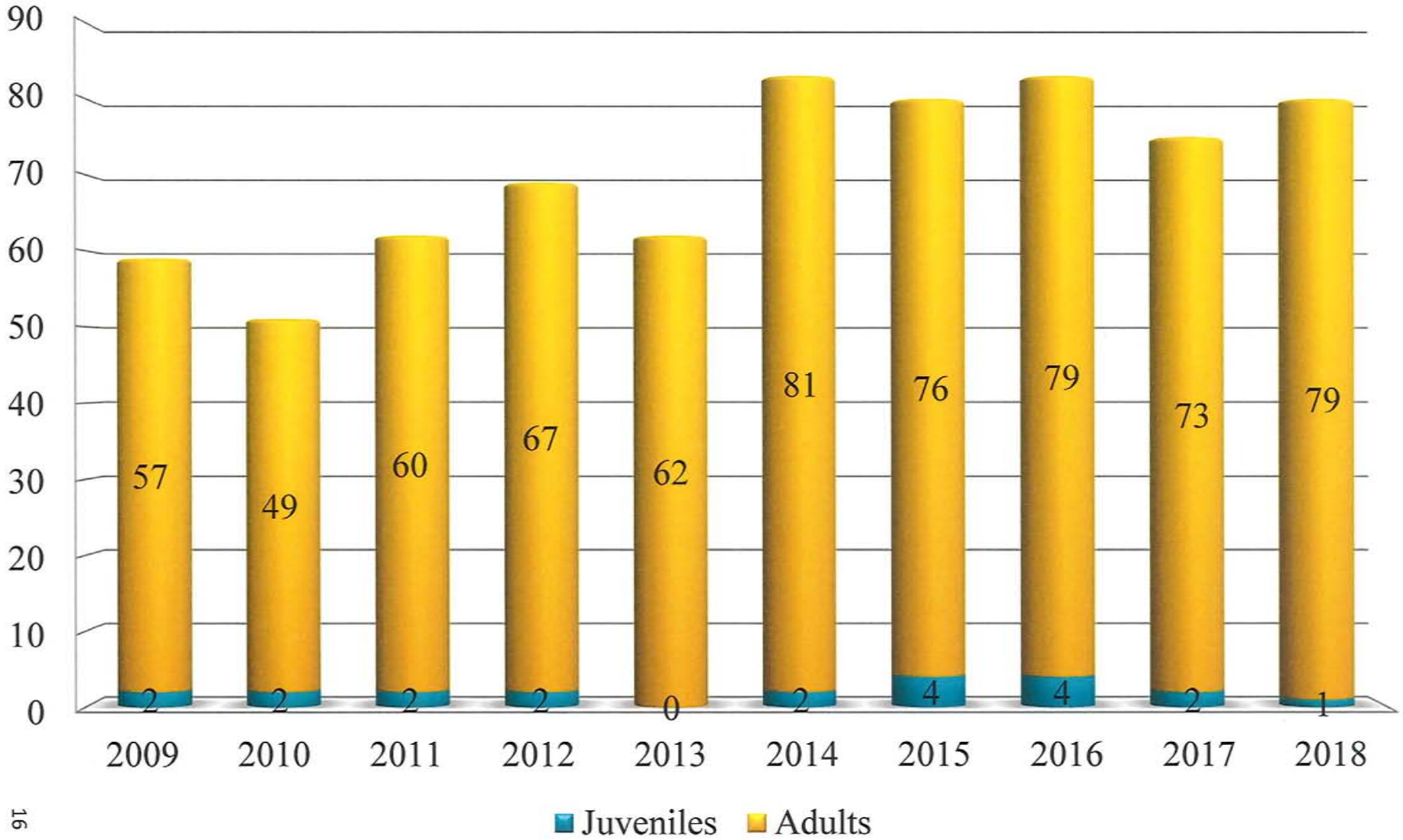
2018 Suicides by Age and Gender Distribution



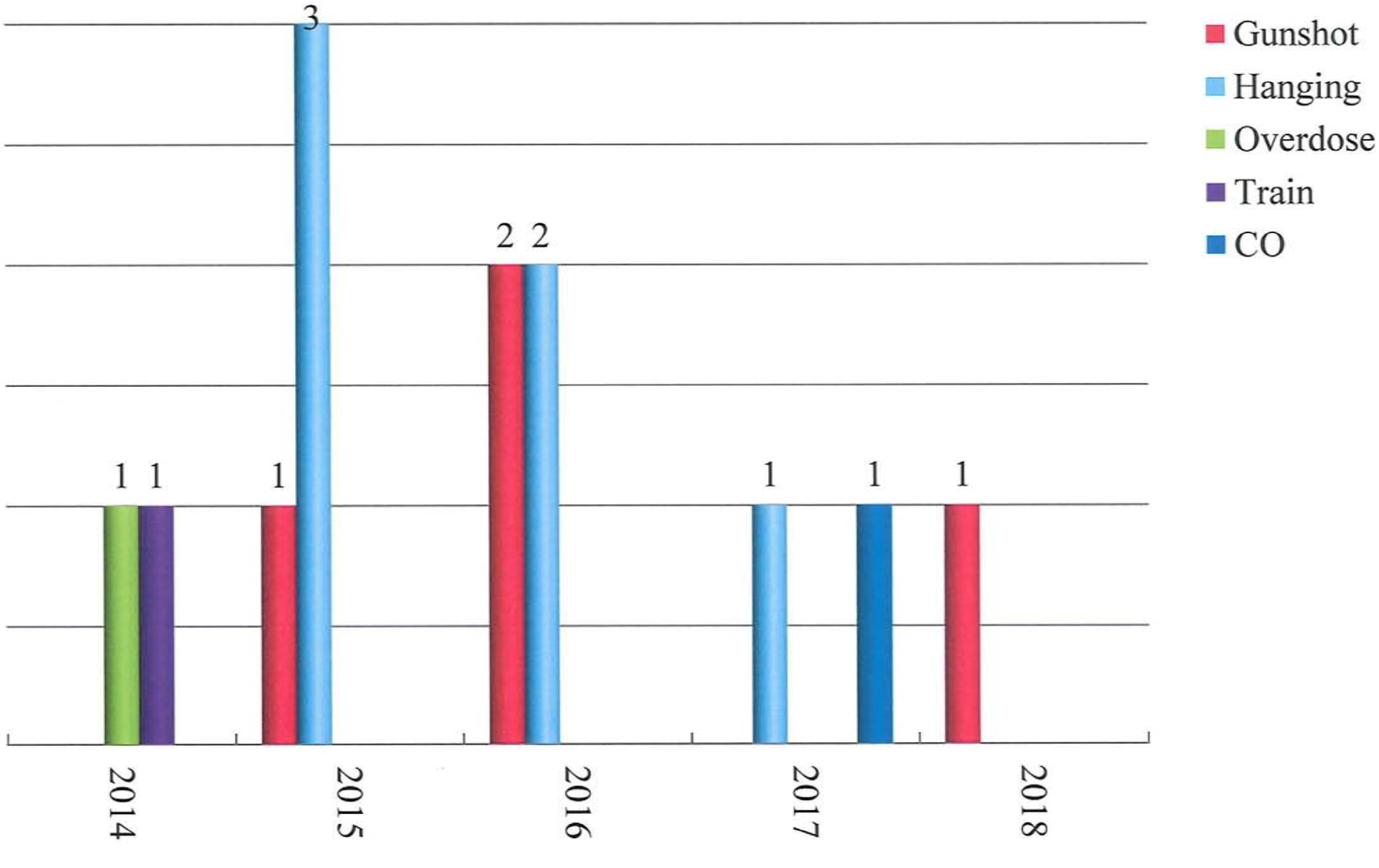
2018 Suicides
Distribution by Mechanism



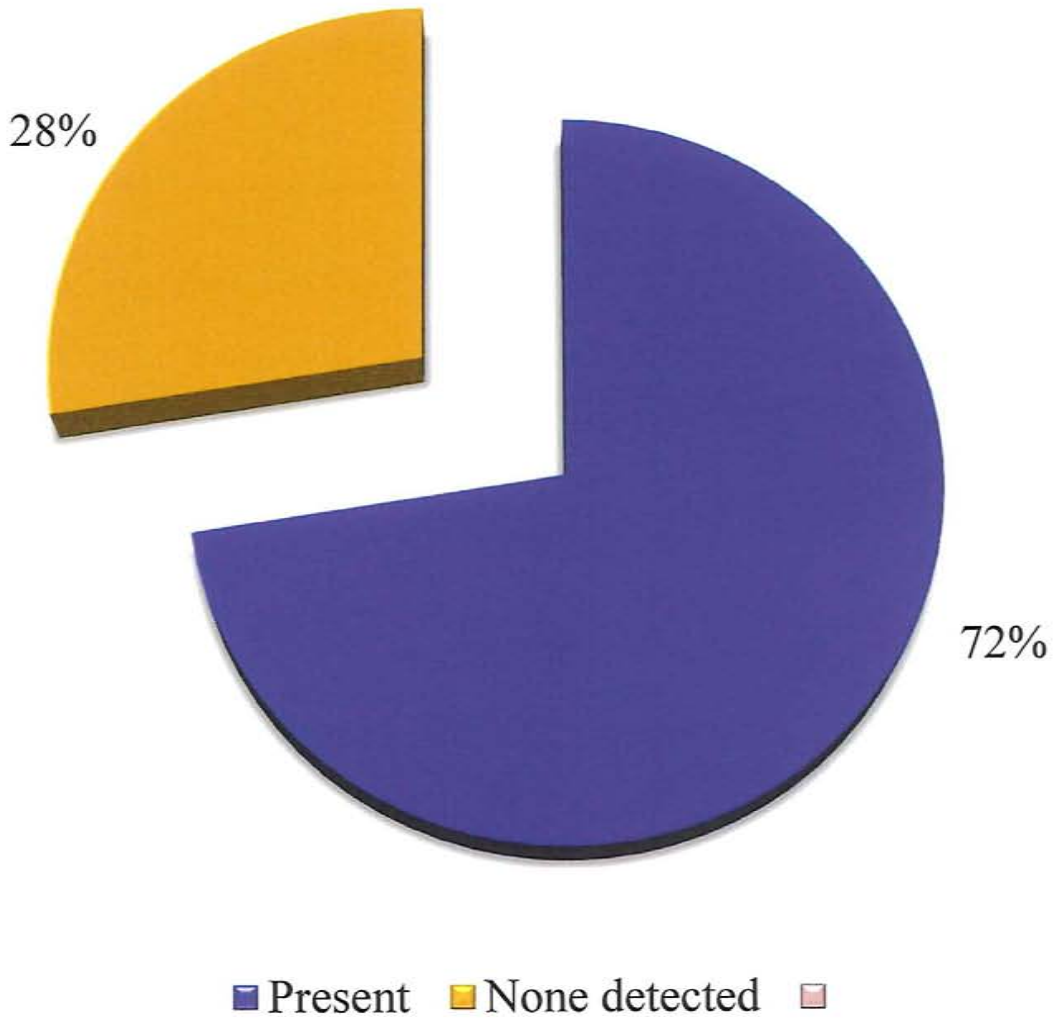
Juvenile (<18) vs. Adult Suicides
10 Years: 2009 - 2018



Mechanism of Juvenile Suicides
5 Years: 2014 thru 2018



Alcohol and/or Drug-Related Suicides 2018



DRUGS AND ALCOHOL IN SUICIDE DEATHS – 2018

TOTAL: 58 out of 80 (72.5%)

#	GENDER	AGE	MODE	Alcohol	PRIMARY DRUG(S) PRESENT
1	Male	29	GSW		
2	Male	37	GSW	0.147	
3	Female	54	OD	0.103	Bupropion, Fluoxetine
4	Male	58	GSW		
5	Male	36	Asphyxia		THC
6	Male	46	OD		Salicylate, Clonazepam, Diphenhydramine, Chlorpheniramine, Zopiclone
7	Female	26	Hanging		Amphetamine, Butalbital
8	Male	84	GSW		
9	Male	30	GSW	0.297	
10	Female	50	OD		Oxycodone, Duloxetine, Lamotrigine, Amitriptyline, Diphenhydramine, THC
11	Male	73	GSW		
12	Male	29	GSW	0.220	
13	Male	23	GSW	0.162	
14	Female	36	OD		Potassium Chloride
15	Male	18	GSW		THC, Alprazolam
16	Male	23	GSW	0.203	
17	Male	41	OD	0.024	Olanzapine, Clonazepam, Lamotrigine
18	Male	60	GSW	0.050	
19	Female	59	OD		Insulin
20	Male	65	GSW		Secobarbital
21	Male	78	GSW		
22	Male	44	Asphyxia	0.016	THC, Nitrogen gas
23	Female	55	GSW	0.099	Lorazepam, Bupropion, Lamotrigine, 10-Hydroxycarbazepine
24	Female	57	OD		Hemlock, Lamotrigine, Quetiapine, Venlafaxine, Verapamil, Dextro/Levomethorphan
25	Male	74	GSW		
26	Male	66	OD		Diphenhydramine, Oxycodone, Oxymorphone, Diphenhydramine, Amitriptyline
27	Male	24	MV vs. Ped		Lorazepam, Lurasidone, Haloperidol, Lamotrigine, Aripiprazole
28	Male	40	GSW		
29	Male	24	Hanging	0.119	Methamphetamine, THC
30	Male	69	GSW		
31	Female	57	Hanging	0.079	Alprazolam

DRUGS AND ALCOHOL IN SUICIDE DEATHS – 2018

TOTAL: 58 out of 80 (72.5%)

#	GENDER	AGE	MODE	ALCOHOL	PRIMARY DRUG(S) PRESENT
32	Male	36	GSW	0.192	
33	Female	56	GSW		
34	Male	78	GSW		Hydromorphone, THC
35	Male	33	GSW	0.287	Nordiazepam, Chlordiazepoxide
36	Male	29	GSW		Warfarin, Lamotrigine, Paroxetine
37	Female	58	OD	0.027	Citalopram, Quetiapine
38	Male	24	Asphyxia	0.177	Cocaine
39	Male	20	Fall - greater than 10ft		THC
40	Male	49	GSW		
41	Male	21	Hanging		THC
42	Female	47	Asphyxia		Nitrogen
43	Male	57	GSW	0.216	
44	Male	67	GSW		THC
45	Female	47	OD	0.249	Bupropion, Sertraline, Naltrexone
46	Male	28	Hanging	0.138	
47	Female	27	Hanging		7-Amino Clonazepam, Diphenhydramine
48	Male	55	GSW	0.259	
49	Female	45	Hanging		
50	Male	68	Cut/Stab		THC
51	Male	23	GSW		
52	Male	19	Hanging		Methylphenidate, Fluoxetine
53	Male	52	Hanging		
54	Female	69	Cut/Stab		
55	Male	40	GSW	0.318	
56	Female	73	Hanging		
57	Female	31	OD		Acetaminophen, Oxy/Hydrocodone, Venlafaxine, Zolpidem, Hydroxyzine, Buspirone, Cyclobenzaprine
58	Male	60	GSW		Temazepam, Hydrocodone
59	Male	32	Hanging		
60	Male	77	GSW		Diazepam/Nordiazepam
61	Male	30	GSW		Methamphetamine
62	Male	21	GSW	0.140	
63	Female	44	Jump		Gabapentin, Methamphetamine
64	Male	86	OD		Tramadol, Diphenhydramine, Oxy/Hydrocodone, Lorazepam, Temazepam, Sertraline
65	Male	74	GSW	0.022	Fluoxetine

DRUGS AND ALCOHOL IN SUICIDE DEATHS – 2018

TOTAL: 58 out of 80 (72.5%)

#	GENDER	AGE	MODE	ALCOHOL	PRIMARY DRUG(S) PRESENT
66	Male	31	Cut/Stab		Cocaine, THC
67	Male	63	GSW		
68	Female	58	Hanging		THC
69	Male	74	GSW		
70	Male	57	Hanging	0.242	Nordiazepam
71	Male	13	GSW		
72	Female	87	GSW		
73	Male	38	Hanging	0.019	
74	Male	30	OD		Baclofen, Gabapentin, Topiramate
75	Male	23	GSW	0.102	Cocaine
76	Male	56	Hanging		
77	Male	57	GSW	0.227	THC
78	Male	67	GSW	0.187	THC
79	Male	20	Hanging		Acetaminophen, Olanzapine, THC
80	Female	70	Hanging		

Abbreviations used:

CO = Carbon Monoxide
GSW = Gunshot Wound
OD = Overdose
MV = Motor vehicle
Ped = Pedestrian

Asphyxia (other than hanging = huffing, mechanical, bag over head, etc.)

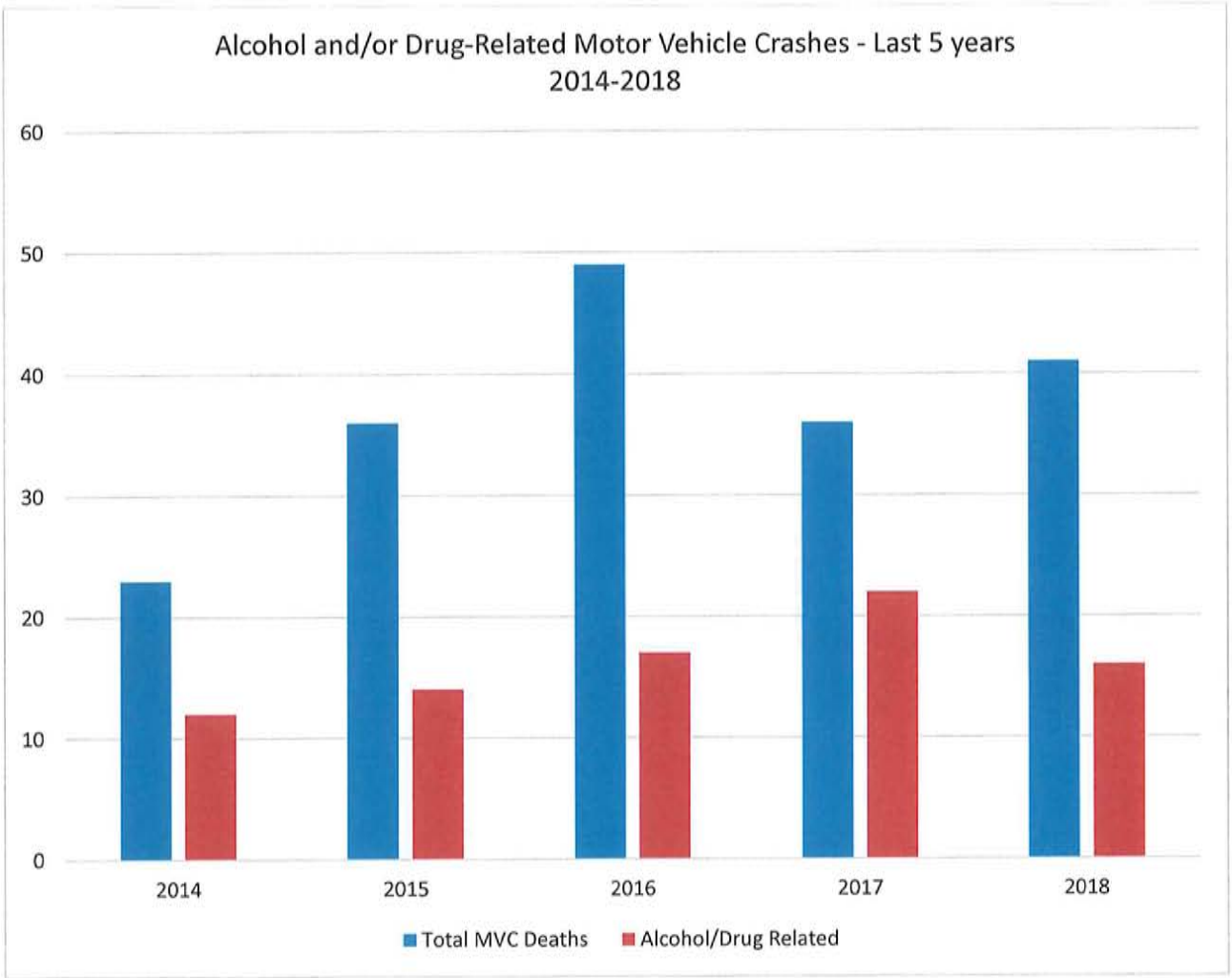
ACCIDENT

STATISTICS

2018 Accident Statistics

Accidental deaths are deaths other than natural where there is no evidence of intent; i.e. an unintentional event or chain of events. This category includes most motor vehicle crashes (MVC), falls, drowning, accidental drug overdoses (OD), choking, etc. During 2018, 146 deaths were certified in Larimer County as accidents.

Forty-one (41) of these deaths were from motor vehicle (or traffic) crashes (MVCs). Our statistical information will deal first with the MVCs. The other 105 accidental deaths will be discussed on page 27.



In 2018, there were 41 motor vehicle ***fatalities*** in 39 ***crashes.***
Out of the 39 crashes, 23 drivers of involved vehicles (59%) were considered to be under the influence of alcohol and/or drugs.

Motor Vehicle Crash Fatalities (41)

Age

Average Age:	41
Juveniles (<18):	2
Adults:	40
Youngest:	7
Oldest:	78

Decedent's Position in Vehicle

Driver:	29
Passenger:	7
Pedestrians hit by vehicle:	2
Bicyclists:	3

Safety Measures by Decedents

Seatbelt used:	9
Seatbelt ***NOT*** used:	15
N/A: ATV, scooter, or motorcycle:	13
N/A: Pedestrians/ bicyclists hit:	4
Unknown:	3

Weather Related/ Adverse Road Conditions

Snow, Ice, and/or Strong Wind:	2

Time of Day (39 crashes):

Unknown AM:	3
00:01 - 06:00:	1
06:01 - 12:00:	9
12:01 - 18:00:	4
18:01 - 00:00:	22

Number of vehicles involved (39 crashes):

One vehicle only:	16
Two or more vehicles:	23

DRUG & ALCOHOL-RELATED MOTOR VEHICLE CRASHES (MVC'S) 2018

Of the 39 TOTAL Motor Vehicle Crashes (with 41 fatalities), 21 involved drivers, living or deceased (51%), tested positive for alcohol and/or drugs

Incident #	Gender	Age	# of vehicles involved	Driver(s) suspected of drugs/alcohol
1	Female	26	1	Yes
2	Female	54	4	No
3	Male	48	1	Yes
4	Male	72	1	No
5	Male	55	1	Yes
6	Female	24	2	No
7	Female	32	2	Yes
8	Female	7	Same crash as above	Same crash as above
9	Male	51	1	No
10	Male	28	2	Yes
11	Female	20	2	No
12	Male	31	2	Yes
13	Male	20	2	Yes
14	Female	85	1	Yes
15	Male	78	2	No
16	Male	13	1	Yes
17	Male	28	1	Yes
18	Male	26	2	No
19	Male	24	1	Yes
20	Male	60	3	No
21	Male	27	2	Yes
22	Male	54	3	Yes
23	Male	60	2	No
24	Male	21	2	No
25	Female	75	2	No
26	Male	39	2	Yes
27	Male	55	1	No
28	Male	62	1	No
29	Male	20	2	No
30	Female	54	2	Yes
31	Female	59	1	No
32	Male	22	2	Yes
33	Male	60	1	No
34	Male	23	1	No

DRUG & ALCOHOL-RELATED MOTOR VEHICLE CRASHES (MVC'S) 2018

Of the 39 TOTAL Motor Vehicle Crashes (with 41 fatalities), 21 involved drivers, living or deceased (51%), tested positive for alcohol and/or drugs

Incident #	Gender	Age	# of vehicles involved	Driver(s) suspected of drugs/alcohol
35	Female	37	2	Yes
36	Male	50	1	Yes
37	Male	49	2	Yes
38	Female	38	4	Yes
39	Male	55	Same crash as above	Same crash as above
40	Female	43	1	No
41	Male	36	1	Yes

2018 Accidents
(Excluding Motor Vehicle Crashes)

In 2018, Larimer County had 105 accidental deaths that were not traffic-related. They are classified as follows:

- Falls - 50
- Drug Overdose (OD) - 35
- Drowning - 5
- Hyper/ hypothermia - 2
- Choking on food/foreign object - 2
- Asphyxia (mechanical, positional) - 2
- Gunshot - 2
- Carbon Monoxide - 2
- Fire/ Thermal injury - 2
- Bicycle crash (alone) - 1
- Medical Mishap - 1
- Industrial workplace mishap - 1

Age:

Average Age: 61.7
Adults: 102
Juveniles (<18): 3

Alcohol and/or drugs found in system: 46/ 105 (43%)

HOMICIDE

and

GUN-RELATED

STATISTICS

2018 Homicide Information

Homicide is a death that results from injuries intentionally inflicted by another person (explicit or implicit) or inflicted on another by one's grossly reckless behavior. Vehicular homicides are *NOT* included in this category, as these deaths do not show intent to kill and are hence counted in the Motor Vehicle Crash statistics.

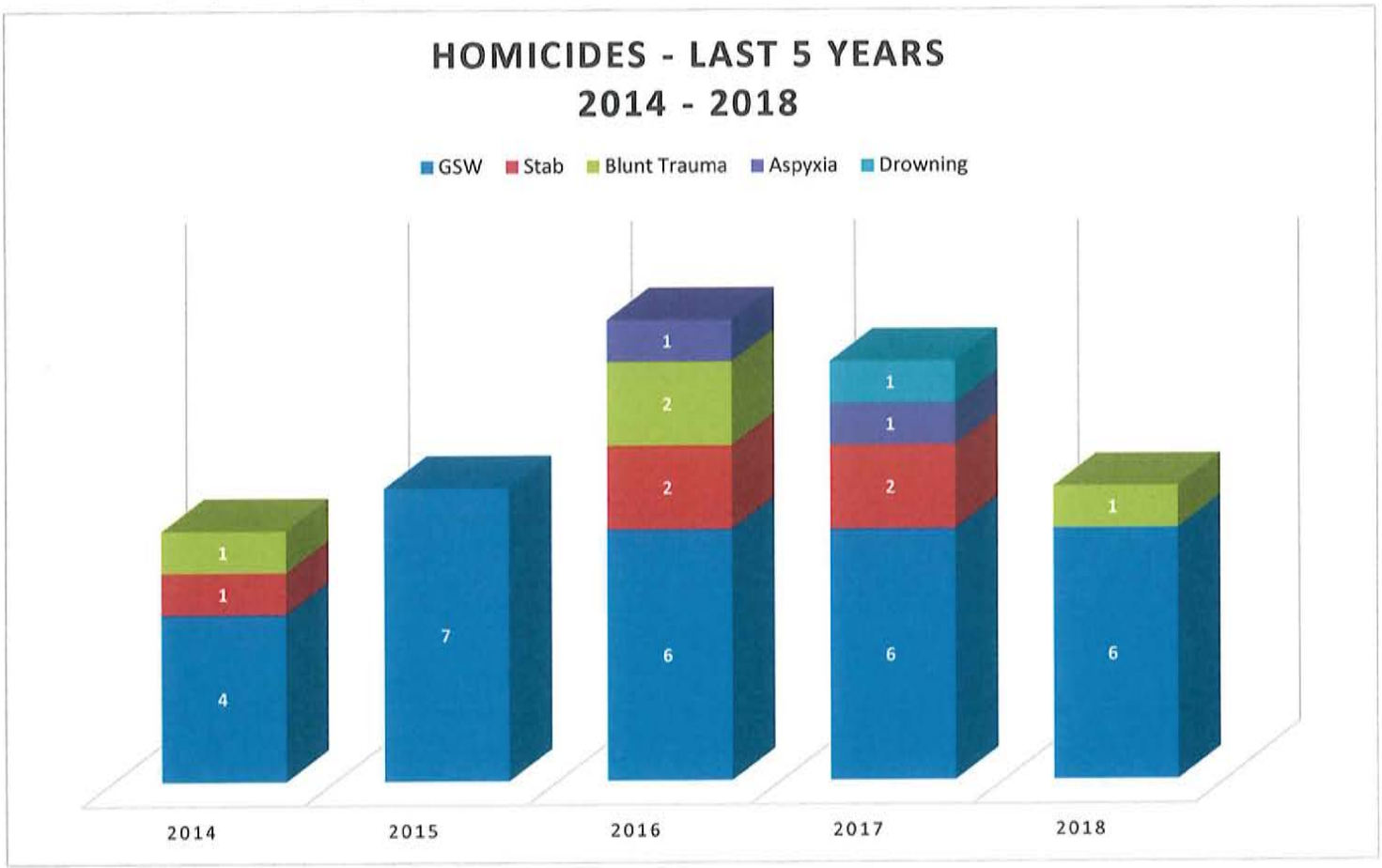
In 2018, there were 7 homicide victims in Larimer County.

Age
Average Age: 30.9
Adult: 5
Juvenile: 2

Race
White: 6
Hispanic: 1
Mixed/Other: 0

Gender:
Male: 6
Female: 1

Alcohol/ Drug-Related ** We do not report on alcohol or drugs in our homicide statistics, as we do not want any positive results to imply fault on the part of the victim. The perpetrator is presumed innocent until proven guilty and is HIPAA-protected.



GUN-RELATED DEATHS IN LARIMER COUNTY

Last 5 years
(Juvenile: < 18)

2018

Total County Deaths:	2549	
Total Gun Deaths:	48	(1.9% of all deaths)
Suicides:	40	(39 adults, 1 juvenile)
Accidents:	2	
Homicides:	6	(4 adult, 2 juveniles)
Undetermined:	0	

2017

Total County Deaths:	2554	
Total Gun Deaths:	40	(1.6% of all deaths)
Suicides:	33	(33 adults)
Accidents:	0	
Homicides:	6	(6 adults)
Undetermined:	1	(1 adult)

2016

Total County Deaths:	2507	
Total Gun Deaths:	60	(2.4% of all deaths)
Suicides:	54	(52 adults, 2 juvenile)
Accidents:	0	
Homicides:	6	(5 adults, 1 juvenile)
Undetermined:	0	

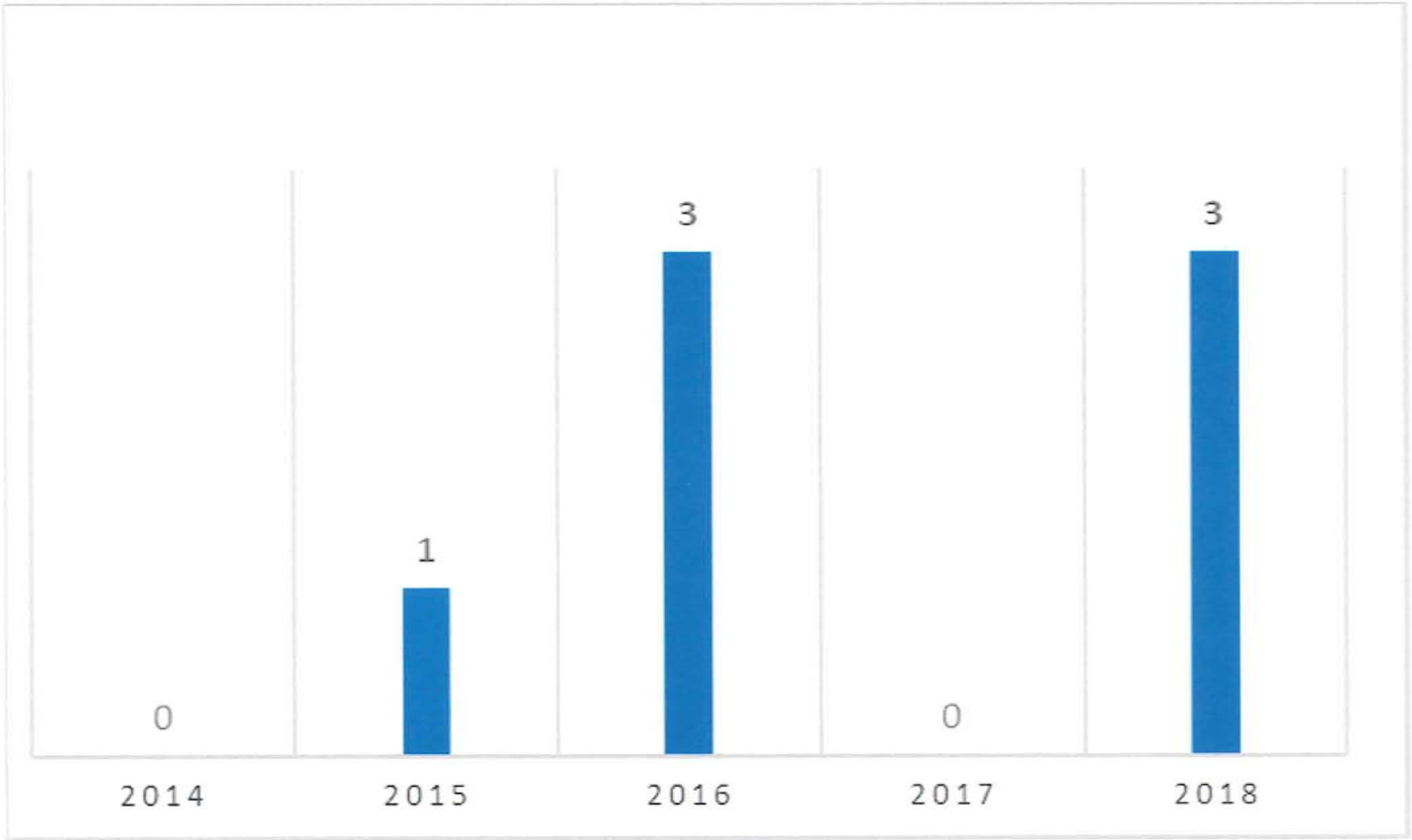
2015

Total County Deaths:	2464	
Total Gun Deaths:	53	(2.15% of all deaths)
Suicides:	45	(44 adults, 1 juvenile)
Accidents:	0	
Homicides :	7	(7 adults)
Undetermined:	1	(1 adult)

2014

Total County Deaths:	2267	
Total Gun Deaths:	43	(1.9% of all deaths)
Suicides:	39	(39 adults)
Accidents :	0	
Homicides:	4	(4 adults)
Undetermined:	0	

JUVENILE (<18) DEATHS FROM GUNSHOT WOUNDS 2014 – 2018



GUNS IN THE HANDS OF JUVENILES

(Juvenile: < 18)

Statistics below are to show deaths occurring at the hands of a juvenile with a gun during the last 10 years. They include suicides, accidental shootings resulting in death, and homicides ***perpetrated*** by a juvenile. They DO NOT include juveniles who are ***victims*** of homicide.

2018	
Suicides	1
Accidents	0
Homicides by Juveniles	1

2017	
Suicides	0
Accidents	0
Homicides by Juveniles	0

2016	
Suicides	2
Accidents	0
Homicides by Juveniles	0

2015	
Suicides	1
Accidents	0
Homicides by Juveniles	0

2014	
Suicides	0
Accidents	0
Homicides by Juveniles	0

2013	
Suicides	0
Accidents	0
Homicides by Juveniles	0

2012	
Suicides	0
Accidents	0
Homicides by Juveniles	0

2011	
Suicides	1
Accidents	0
Homicides by Juveniles	0

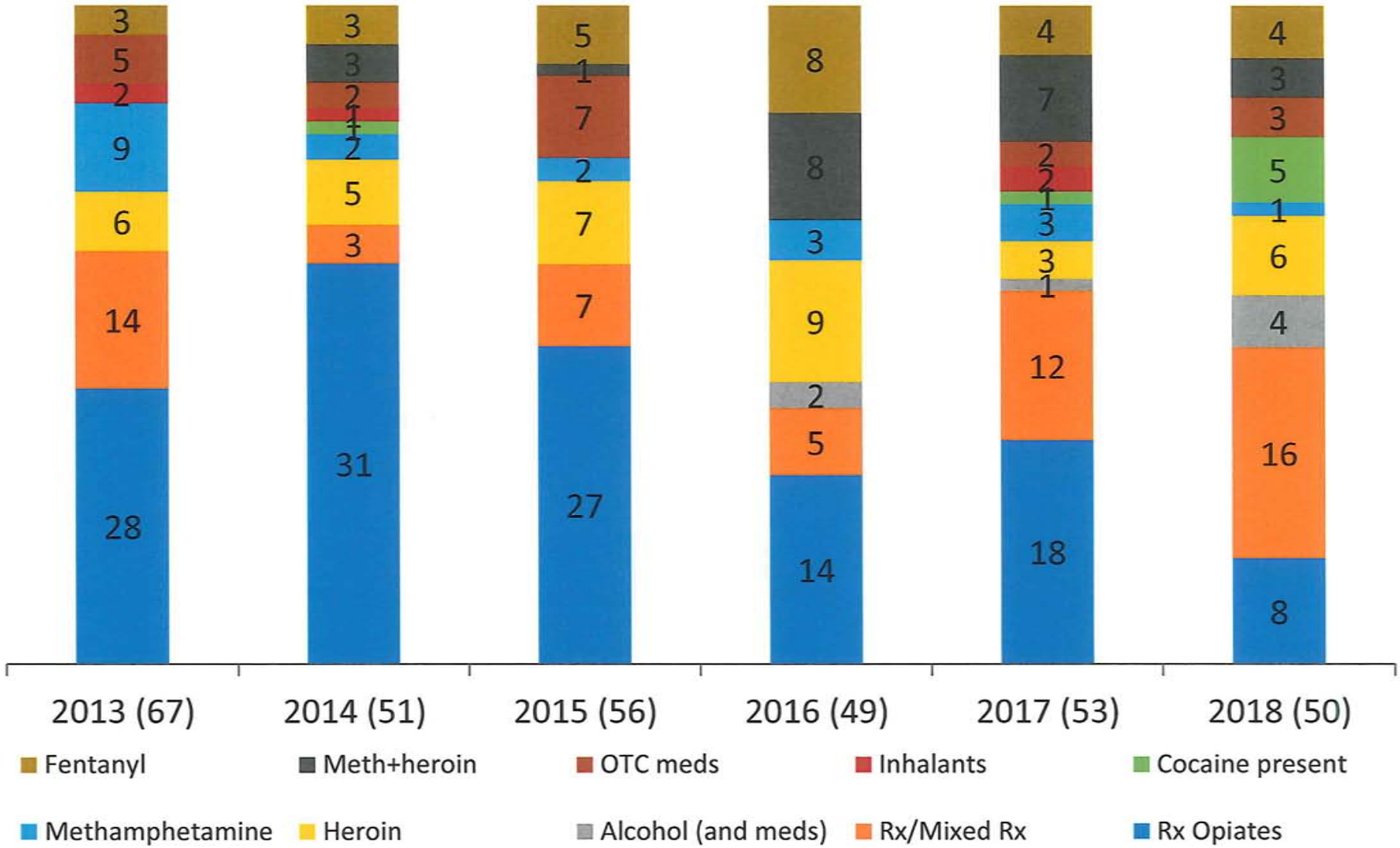
2010	
Suicides	1
Accidents	0
Homicides by Juveniles	0

2009	
Suicides	1
Accidents	0
Homicides by Juveniles	0

Drugs of Abuse and Overdose Statistics

Drugs of Abuse in Overdose Deaths
2013 – 2018

Most overdose deaths are the result of a combination of prescriptions, over-the-counter meds, alcohol, and/ or illicit drugs. We have chosen the PRIMARY drug(s) of abuse in each death.



DRUGS OF ABUSE USED IN OVERDOSE DEATHS
2018

(Total 50)

Accidents (35)	Age	Gender	Alcohol	Drug #1	Drug #2 or more
1	18	Male	0.582		
2	63	Male		Cocaine	
3	23	Female		Oxycodone	
4	50	Male		Oxycodone	Cyclobenzaprine
5	39	Female		Oxycodone	Methamphetamine
6	20	Female		Cocaine	
7	22	Female		Heroin	Methamphetamine
8	24	Male	0.189	Heroin	
9	40	Male	0.162	Oxycodone	
10	28	Male		Heroin	Methamphetamine
11	57	Male		Cocaine	Methamphetamine
12	39	Female		Methadone	Methamphetamine
13	53	Female		Oxycodone	
14	75	Male	0.212	Zolpidem	
15	22	Male		Carfentanil	
16	20	Male		Heroin	
17	38	Male	0.027	Heroin	
18	46	Male		Methamphetamine	
19	42	Male	0.012	Cocaine	
20	37	Male		Hydromorphone	
21	46	Female		Tramadol	
22	54	Male		Amitriptyline	
23	24	Male		Fentanyl	
24	59	Male		Heroin	
25	41	Female		Heroin	Methamphetamine
26	29	Male	0.218	Dextromethorphan	Guaifenesin
27	24	Male		Fentanyl	
28	34	Male		Cocaine	Methamphetamine
29	50	Male		Amitriptyline/Nortiptyline	
30	64	Male		Heroin	
31	34	Male		Hydromorphone	
32	57	Female		Methadone	
33	37	Male		Fentanyl	
34	47	Female		Oxycodone	
35	69	Male		Heroin	

DRUGS OF ABUSE USED IN OVERDOSE DEATHS
2018

(Total 50)

Suicides (13)	Age	Gender	Alcohol	Drug #1	Drug #2 or more
1	54	Female	0.103	Bupropion	Fluoxetine
2	45	Male		Salicylate (aspirin)	
3	50	Female		Oxycodone	Diphenhydramine, Duloxetine
4	36	Female		Potassium Chloride	
5	40	Male	0.024	Olanzapine	
6	59	Female		Insulin	
7	57	Female		Hemlock	Verapamil, Quetiapine, Dextromethorphan
8	65	Male		Diphenhydramine	Oxymorphone
9	57	Female	0.027	Citalopram	
10	47	Female	0.249	Bupropion	
11	31	Female		Acetaminophen	
12	86	Male		Tramadol	Oxycodone, Hydrocodone, Sertraline
13	30	Male		Baclofen	Gabapentin, Topiramate
Undetermined (2)	**Age**	**Gender**	**Alcohol**	**Drug #1**	**Drug #2**
1	35	Male		Insulin	
2	41	Male		Doxepin	Tramadol, Venlafaxine, Cyclobenzaprine

CHILD DEATHS and SUIDS

(Sudden Unexpected Infant Death Syndrome)

CHILD DEATHS BY AGE, MANNER, AND MODE

Last 5 years - < 18 years of age

2018 (16 total)	Natural	Accident	Suicide	Homicide	SUIDS & Other Undetermined
Fetal demise up to < 1 mo	5				
1 mo < 1 yr		1 - Co-Sleep/ Overlay			1 – SUID
1 yr < 4 yrs					
4 yrs < 9 yrs		1-MVA			
9 yrs < 14 yrs	1	1-Bike vs. Object 1-MV vs. Ped	1-GSW		
14 yrs < 18 yrs	1	1-Drowning		2-GSW	
TOTALS	**7**	**7**	**1**	**2**	**1**
2017 (19 total)	**Natural**	**Accident**	**Suicide**	**Homicide**	**SUIDS & Other Undetermined**
Fetal demise up to < 1 mo	2				
1 mo < 1 yr		2-Co-Sleep/ Overlay		1- Smothering	1-SUID
1 yr < 4 yrs	2	1-Drowning			1-SUID vs. Vaccine Reaction
4 yrs < 9 yrs	1	1-Drowning			
9 yrs < 14 yrs	1				
14 yrs < 18 yrs	1	1 – OD 2 - MVC	1-Hanging 1-CO		
TOTALS	**7**	**7**	**2**	**1**	**2**
2016 (18 total)	**Natural**	**Accident**	**Suicide**	**Homicide**	**SUIDS & Other Undetermined**
Fetal demise up to < 1 mo	4				
1 mo < 1 yr				1-Blunt trauma	
1 yr < 4 yrs	2				
4 yrs < 9 yrs		1-Drowning			1-Undetermined (Natural vs. Homicide)
9 yrs < 14 yrs	1	1-Drowning 1-Bike vs. MV			
14 yrs < 18 yrs		1 - OD	2-GSW 2-Hanging	1-GSW	
TOTALS	**7**	**4**	**4**	**2**	**1**

CHILD DEATHS BY AGE, MANNER, AND MODE

Last 5 years - < 18 years of age

2015 (20 total)	Natural	Accident	Suicide	Homicide	SUIDS & Other Undetermined
Fetal demise up to < 1 mo	1				
1 mo < 1 yr	1	2-Positional Asphyxia			1 –Blunt trauma (Accident vs. Homicide)
1 yr < 4 yrs		1 - Fall			
4 yrs < 9 yrs		1 - Drowning			
9 yrs < 14 yrs			3 – Hanging		1 – Hanging (Accident vs. Suicide)
14 yrs < 18 yrs	4	1 – OD 2 – MVC 1 – Train v. Ped	1-GSW		
TOTALS	6	8	4		2
2014 (28 total)	Natural	Accident	Suicide	Homicide	SUIDS & Other Undetermined
Fetal demise up to < 1 mo	12	1-Positional Asphyxia			
1 mo < 1 yr	2	1-Co-Sleep/ Overlay			
1 yr < 4 yrs	2				1-Co-Sleep/ Overlay(Accident vs. Homicide) 1 –Blunt trauma (Accident vs. Homicide)
4 yrs < 9 yrs	1	1 - MVC			
9 yrs < 14 yrs	1		1-Train v. Ped.		
14 yrs < 18 yrs	1	1-MVC 1-Drowning	1-OD		
TOTALS	19	5	2		2

- Unidentified Remains
- Public Administrator Cases & Exhumations
- Organ and Tissue Donations
- Budget – 10-County Comparison
- Organizational Chart

UNIDENTIFIED REMAINS

The Larimer County Medical Examiner's Office currently has five (5) deceased individuals or remains who are unidentified. These cases are described below, oldest to most recent.

1) Unidentified Hispanic Male: Date of Death: 09/16/94

Height: 5'10"
Approximate Age: 25-35 Weight: 140 lbs.
Hair: Black, wavy, medium length Eye Color: Brown
Scars/ Tattoos: Well-healed, old traumatic scars on right lower back and right back hip.
Clothing: Blue nylon windbreaker with logo "ATA Services, Mile High Stadium"; gray/ white plaid shirt; red long-sleeved sweatshirt; khaki trousers; black/ white canvas and vinyl athletic shoes. A religious pamphlet was found in a pocket from the Jeremiah Baptist Church, Denver.
Dental: Two silver caps on upper front incisors

This Hispanic male was apparently living a transient lifestyle. He was found deceased in the boxcar of a train in a railroad yard in north Ft. Collins. He had sustained massive blunt force injuries to the head, consistent with being caught in the slamming door of the boxcar of an abruptly stopping train. The manner of death appears to be accidental. The train in which he was found arrived in Denver from New Mexico on 09/15/94 and was forwarded on to Ft. Collins at 02:00, 09/16/94.

2) Unidentified Caucasian Female Infant: Date of Death: 08/22/96

Approximate Age: Full-term live birth, neo-natal infant
Hair: Dark brown, wavy

This live birth, full-term infant female was found in shallow water of Horsetooth Reservoir, wrapped in a garbage bag with several rocks to weigh it down. There is no natural disease process found that could have contributed to the death and autopsy findings are consistent with suffocation. The manner of death appears to be homicide.

3) Unidentified Caucasian Male: Date of Death: Approximately 07/06/97

Height: 5'11"
Approximate Age: 20-30
Weight: 150 – 170 lbs.
Hair: Sandy Brown, long, wavy; receding hairline; chin beard or goatee
Eye Color: Unknown
Teeth: Beautiful, straight, white, no fillings; All 4 wisdom teeth present; slight gap between top front incisors.
Scars/ Tattoos: Small, circular tattoo on left thumb with the letters: P.I.L; both ears pierced one time; well-manicured fingernails.
Clothing: Black tee shirt with bright pink motorcross logo "Sprucewood Express"; long-sleeved striped shirt; Rustler brand blue jeans; black leather work boots.

This man was found deceased in north Fort Collins in the sleeper cab of an abandoned semi tractor-trailer. He was probably living a recently transient lifestyle. There is no evidence of trauma or foul play. There is no natural disease process apparent at autopsy. The manner of death is undetermined.

4) Unidentified African American Female Date of Death: 07/11/11

This middle-aged African American female checked in to a local motel on 06/27/11 and arrived there by taxi. She paid for a room in cash through 07/11/11. It was later found that she had stayed at other local motels in the area, always taking a taxi, paying in cash, and giving false and different names. She told the Motel 9 that her name was Sandra Nelson, of 5203 Bosa Ave., Park City, UT. This was later found to be a non-existent address and false name. She also stated that she was originally from Los Angeles and was looking for a house in this area. On 07/11/11, she did not show up for breakfast as had been her custom. Since it was her last paid day, staff assumed she had checked out. They entered her room with a master key and found her deceased on the bed with pills at her feet and a bright blue, granular purging coming from her nose and mouth. There was no suicide note but autopsy results showed a massive overdose of multiple medications. All attempts to identify the decedent have failed.

Height: 5'06"

Age: Approximately 60 (55 – 70)

Weight: 211 lbs.

Hair: Gray/ black with more white around forehead/ face; curly

Eyes: Brown

Teeth: Natural w/ partial upper denture

Scars: round scar beneath chin; scar on lower abdomen (possible past C-section)

Clothing: Black paisley patterned blouse; black pants

Jewelry: White metal chain necklace; white metal earrings; white metal wristwatch

5) Unidentified Native American Remains Date of Report: 10/10/18

The Department of Natural Resources at Colorado State University (CSU) reached out to the Coroner's Office a possible gravesite with visible bones that were found in the Red Mountain Open Space, in an area recently purchased by Larimer County. The bones were known and reported to the county by the previous landowner who believed them to be Native American. CSU Archaeologists then worked in tandem with the state, as well as the Larimer County Coroner's Office to document and determine the forensic or historic nature of the site. There were no visible historic artifacts, clothing or tissues around the bones. All offices involved agreed the site was not of recent of forensic value and believed the site to be Native American. Arrangements were made with local tribal officials and it was decided to leave the bones in place as they are not near any public recreational areas. The site was documented with our Office, Larimer County Parks, CSU and the CO State Archaeologist records for future reference.

If you have any information concerning any of the above individuals, please contact the Larimer County Medical Examiner's Office at 970-498-6161. You can remain anonymous.

You can also e-mail us at: larimercoroner@larimer.org

PUBLIC ADMINISTRATOR CASES

No Next-of-Kin found at time of release

We are publishing this list in an effort to help families find their loved ones, if possible. If anyone has any information regarding next-of-kin on any of the decedents listed, please contact our Office at 970-498-6161 or the appropriate Funeral Home. You may also email: larimercoroner@larimer.org You may remain anonymous.

NAME	Date of Death	AGE	MANNER	LCCO#	Funeral Home
1997					
Un-ID'd White male	07/06/1997	??	Undetermined	97C-337	Allnutt-FTC (Reager's)
2004					
SMITH, James	07/01/2004	41	Accident (MVC)	04C-368	Bohlender
2006					
MCCLENNY, "Jack"	01/07/2006	80	Natural	06C-021	Allnutt- FTC
2008					
TOWNES, Sterling	10/03/2008	45	Natural	08C-676	Kibbey's
ELLSWORTH, Shawk	11/20/2008	58	Accident (Fall)	08C-814	Goes (sister?)
2009					
YODER, Karl	09/27/2009	58	Accident (Burn)	09C-678	Viegut
DORSEY, Robert	12/14/2009	65	Natural	09C-879	Vessey
2011					
Un-ID'd Black female	07/11/2011	approx 60's	Suicide (OD)	11C-558	Bohlender
DAVIS, Herbert	09/12/2011	65	Natural	11C-748	Viegut
2012					
ROBISON (aka MILLER), Randy K.	01/29/2012	50	Suicide (Cutting)	12C-097	Allnutt- FTC
MULLANEY, John F.	03/08/2012	56	Accident (Fall)	12C-214	Bohlender
FROST, Jack	09/26/2012	48	Suicide (Train)	12C-769	Allnutt- FTC
JACKSON, Duane	09/20/2012	67	Natural	12C-786	Allnutt- FTC
EASTBURN, Carl B.	09/27/2012	74	Suicide (GSW)	12C- 792	Kibbey's
2013					
TROUT, Gary	11/22/2013	66	Natural	13C-1053	Allnutt-Lvld
2014					
PALMER, Terry (aka: Terry VLICK)	05/23/2014	64	Natural	14C-452	Bohlender
2015					
GIDEON, Michael	08/23/2015	64	Natural	15C-849	Goes

PUBLIC ADMINISTRATOR CASES

No Next-of-Kin found at time of release

NAME	Date of Death	AGE	MANNER	LCCO#	Funeral Home
2016					
LONGHIBLER, Spencer	06/28/2016	63	Accident	16C-564	Allnutt-FTC
CONDON, Brian	08/20/2016	55	Suicide	16C-780	Allnutt-Lvld
KAPLAN, Joel	09/13/2016	59	Natural	16C-846	Viegut
2017					
MUTTER, Kathy A.	02/13/2017	51	Natural	17C-166	Vessey
GARNER, Joel	10/02/2017	54	Accident	17C-914	Bohlender
2018					
GAWRLYCZIK, Richard	02/24/2018	68	Natural	18CC0216	Bohlender
MARTINEZ, Ronald C.	03/01/2018	66	Natural	18CC0270	Bohlender
BLACKWELL, Phillip R.	08/25/2018	68	Suicide	18CC0820	Allnutt-FTC

EXHUMATIONS

NAME	Date of Death	AGE	MANNER	LCCO#	Date Exhumed
HETTRICK, Peggy L.	02/11/1987	37	Homicide	87C-049	05/14/1998
DECKER, Donald J.	07/06/2008	22	Undetermined	08C-459	03/15/2011

Organ and Tissue Donation

There are six (6) hospitals within the borders of Larimer County: UCHealth Poudre Valley Hospital in Ft. Collins, UCHealth at Medical Center of the Rockies in Loveland, Banner Health Center - Ft. Collins Campus, Banner Health at McKee Medical Center in Loveland, Estes Park Medical Center in Estes Park, and Northern Colorado Rehabilitation Hospital in northern Johnstown. Nearly all organ and tissue donation referrals take place in the hospital setting. It is the policy of the Larimer County Medical Examiner's Office to facilitate organ and tissue donation in as many cases as possible without compromising the integrity of the investigation.

When referrals are made to harvesting banks, this does not mean that donation automatically takes place. Donations may not occur due to a variety of reasons: Families may not wish to donate; Organ and Tissue Banks may rule out the donation due to the age of the donor, extended postmortem intervals, disease process, or substance use; and on rare occasions our Office, the District Attorney, or law enforcement may not wish to allow donation to occur, or may place certain restrictions on a donation, for investigative or legal reasons. This is usually in cases of homicide or suspected homicide, and infant deaths where organ and/ or tissue retrieval could interfere with autopsy findings and compromise a criminal investigation.

Since the majority of hospital deaths do not fall under the Medical Examiner's jurisdiction, our Office is not involved with all donation requests. Therefore, the most accurate and up-to-date donation statistics are available on the Donor Alliance and Rocky Mountain Lions Eye Bank websites: www.donoralliance.org. ; https://corneas.org/

THE BUDGET – 10-County Comparison

The Larimer County Coroner/ Medical Examiner's Office duties are mandated by Colorado Statute and the office is funded through the Larimer County Commissioners by the citizens of Larimer County. Since 1979, Larimer County has never had to pay a salary for the elected Coroner, but has to pay only for Pathology services. The previous elected Coroner's and the current Coroner/ Medical Examiner, James A. Wilkerson IV, MD is saving the citizens over $100,000 per year by operating this way.

Staff salaries are set by the County and salaries follow the standard merit and yearly cost-of-living raises that are the same across all County departments. Since the Medicolegal Investigators are considered law enforcement, the salaries coincide with other law enforcement salaries.

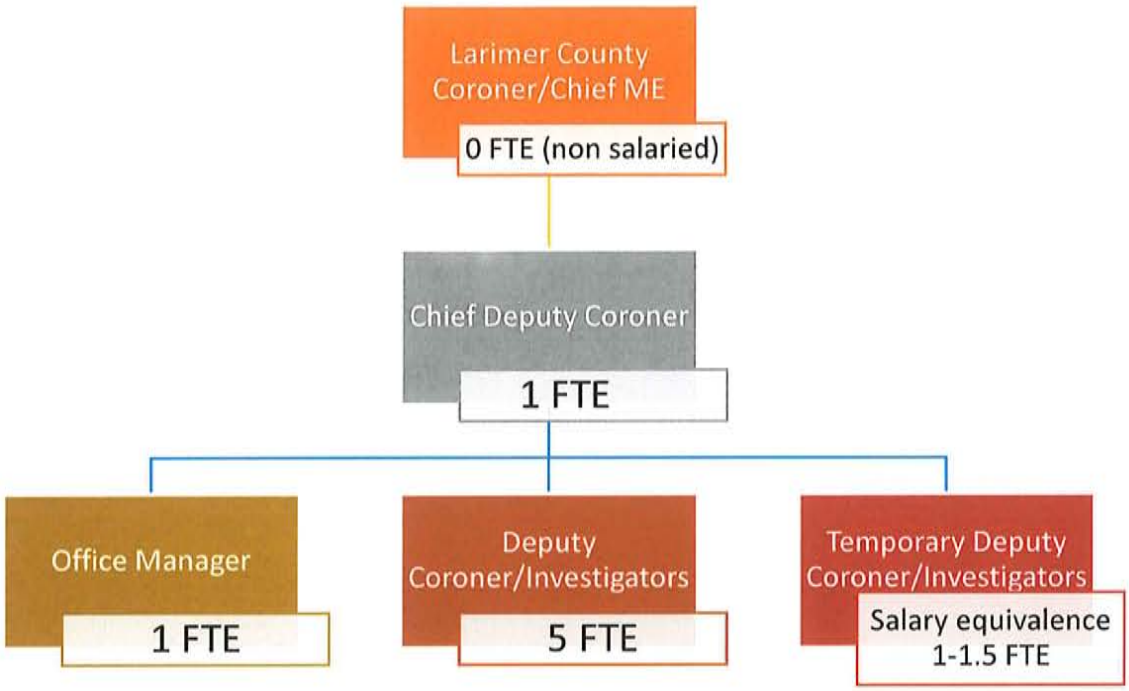
As the population of Larimer County increases, so must our budget. At least two Investigators must be "on call" at all times and we occasionally need to call out a third. Due to television and other media, the public has come to expect a thorough, professional, timely investigation and autopsy when a death occurs and we strive to provide the best investigations and public service possible.

All County budgets are Public Record and Larimer County's be accessed through the County website, www.larimer.org/budget

Below are the results of a 10-County Budget Survey of Coroner and Medical Examiner Offices in Colorado.

2018 (Rank by Population) (Denver not included)	**County**	**Coroner Or Medical Examiner System**	**Owns and/or operates autopsy facility**	**Budget**	**Employees (FTEs)**	**Total Number of Deaths Reported/ Autopsies (Approx)**	**Percent of Deaths Reported Requiring Autopsy (Approx)**
1	El Paso	ME	Y	$2,549,000	25	4779 / 844	17.6%
2	Arapahoe	ME	Y	$1,666,000	13	4182 / 480	11.5%
3	Jefferson	C	Y	$2,583,000	14	4598 / 394	8.5%
4	Adams	C	Y	$2,187,000	15	3937 / 629	16%
5	Larimer	ME	Y	$1,397,151	7	2549 / 210	8%
6	Boulder	C	Y	$1,160,000	12	2680 / 250	9.3%
7	Douglas	C	Y	$1,149,000	9	1588 / 168	10.6%
8	Weld	C	N	$1,243,000	9	1859 / 253	13.6%
9	Pueblo	C	N	$660,000	2	1863 / 273	14.6%
10	Mesa	ME	Y	$449,000	3	1783 / 136	7.6%

2018 LCMEO Organizational Chart



Total FTE's = 7 plus 2 Temporary Investigators