



This Report is dedicated
to all those who have died
in Columbiana County, Ohio in the year 2006
to their families, their loved ones
and their friends

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Annual Report – 2006

Office of the Coroner

Columbiana County
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This publication marks the sixth annual report of the Office of the Coroner for Columbiana County. The report will take a somewhat different approach to reporting the statistics for the year 2006. Currently there are 9030 cases entered in the database partially representing known data from the years 1934 through 2006.

We will first present a short synopsis of general information about the coroner's duties and how those duties may involve you. We will next report and graph data generated in 2006. We will next compare this data to that data collected from 2004 thru 2006. We will then present and document an alarming trend in Columbiana County ... that of **Budget**.

For those readers unfamiliar with the mechanics of statistics, namely **Normal Distribution** and **Standard Deviation (SD)**, we provide a quick review in Appendix A.

General Information:

When to Report a Death

When a person dies under any of the below circumstances, the death must be reported to the local Office of the Coroner.

Accidental Deaths

If the death occurs when in apparent good health or in any suspicious or unusual manner including:

- Asphyxiation by gagging on foreign substance, including food in airway; compression of the airway or chest by hand, material, or ligature; drowning; handling cyanide; exclusion of oxygen; carbon monoxide; and/or other gasses causing suffocation.
- Blows or other forms of mechanical violence
- Burns from fire, liquid, chemical, radiation or electricity Carbon monoxide poisoning. (Resulting from natural gas, automobile exhaust or other.)
- Cutting, stabbing or gunshot wounds.
- Death from electrocution.

- Drowning (actual or suspected).
- Drug overdose from medication, chemical or poison ingestion, (actual or suspected). This includes any medical substance, narcotic or alcoholic beverage, whether sudden, short or long term survival has occurred.
- Electrical shock
- Explosion
- Falls, including hip fractures or other injury.
- Firearm injuries
- Stillborn or newborn infant death where there is a recent or past traumatic event involving the mother, such as vehicular accident, homicide, suicide attempt, or drug ingestion that may have precipitated delivery or had a detrimental effect to the newborn.
- Vehicular accidents, including auto, bus, train, motorcycle, bicycle, watercraft, snowmobile or aircraft, including driver, passenger, or related non-passenger, (e.g. such as being struck by parts flying or thrown from a vehicle).
- Weather related death (e.g. lightning, heat exhaustion, hypothermia or tornado).

Homicidal Deaths

- By any means, suspected or known.

Suicidal Deaths

- By any means, suspected or known.

Occupational Deaths

Instances in which the environment of present or past employment may have caused or contributed to death by trauma or disease. Deaths in this classification include caisson disease (bends), industrial infections, pneumoconiosis, present or past exposure to toxic waste or product (e.g. nuclear products, asbestos or coal dust), fractures, burns or any other injury received during employment or as a result of past employment, which may have contributed to death.

Sudden Deaths

If the death occurs when in apparent good health or in any suspicious or unusual manner including:

- DOA : Any person pronounced dead on arrival at any hospital, emergency room of a hospital or doctor's office shall be reported.
- Infants and young children : Any infant or young child found dead shall be reported, including Sudden Infant Death Syndrome (5.1.0.5. or Crib Death).
- All stillborn infants where there is suspected or actual injury to the mother.
- All deaths occurring within 24 hours of admission to a hospital unless the patient has been under the continuous care of a physician.
- Deaths occurring while in any jail, confinement or custody.
- All deaths occurring within 24 hours of admission to a hospital unless the patient has been under the continuous care of a physician.
- Deaths under unknown circumstances whenever there are no witnesses or where little or no information can be elicited concerning the deceased person.

- Sudden death on the street, at home, in a public place, or at place of employment.
- Alcoholism.
- Drug abuse, habitual use of drugs or drug addiction.

Special Circumstances

Any death involving allegations of suspicious medical malpractice or possibly poor medical/surgical care.

- Any maternal or infant death where there is suspicious or illegal interference by unethical or unqualified persons or self-induction.
- Any maternal or infant death where there is suspicious or illegal interference by unethical or unqualified persons or self-induction.
- "Delayed death," an unusual type of case, where the immediate cause of death may actually be from natural disease. However, injury may have occurred days, weeks, months, or even years before death and is responsible for initiating the sequence of medical conditions or events leading to death. This would be considered a Coroner's case and is therefore reportable. The most common examples of this type of case are 1) past traffic accidents with debilitating injury and long-term care in a nursing home and 2) hip fractures of the elderly where there is a downward course of condition after the injury.

Therapeutic Deaths

- Death occurring under the influence of anesthesia, during the anesthetic induction, during the post-anesthetic period without the patient regaining consciousness (including death following long-term survival if the original incident is thought to be related to the surgical procedure and/or anesthetic agent).
- Death during or following any diagnostic or therapeutic procedure, whether medical or survival time, if death is thought to be directly related to the procedure or complications from said procedure.
- Death due to the administration of a drug, serum, vaccine, or any other substance for any diagnostic, therapeutic or immunological purpose.

Any Death Where There is a Doubt, Question or Suspicion Not all reported cases fall into the above noted categories. After the investigation is completed, many will be returned to the jurisdiction or institution where the death certificate will be signed by the attending physician as a natural death.

Only the Coroner can legally sign a death certificate of a person who has died as a direct or indirect result of any cause listed in the previously noted reportable deaths.

How to Report a Death

In order to report a death, call the Office of your respective County Coroner, day or night, and state "I wish to report a death."

It is requested that the following information, if known, be provided:

- Name and address of the deceased
- Age and date of birth
- Sex and race
- Social Security number
- Marital status
- Next-of-kin, name, address, phone number
- Place and manner of occurrence
- Date and time of occurrence
- Date and time of death
- Name of person pronouncing death
- Name of person reporting death
- Any other information which may be helpful
- Location of the body
- Name of funeral home

Laws / Attorney General Opinion

Click on the link below to view the entire Ohio Revised Code Coroner Chapter.

Ohio Revised Code

The following selected sections of the Ohio Revised Code (ORC) are listed so that the responsible individual may fully understand that providing information to the Coroner is to comply with the law and that failure to do so would place that person in jeopardy of prosecution.

ORC 313.01 ELECTED; TERM

ORC 313.02 QUALIFICATIONS FOR CORONER; CONTINUING EDUCATION

ORC 313.14 NOTICE TO RELATIVES; DISPOSITION OF PROPERTY

ORC 313.01 ELECTED; TERM

A coroner shall be elected quadrennially in each county, who shall hold his office for a term of four years, beginning on the first Monday of January next after his election. As used in the Revised Code, unless the context otherwise requires, "coroner" means the coroner of the county in which death occurs or the dead human body is found.

ORC 313.02 QUALIFICATIONS FOR CORONER; CONTINUING EDUCATION

(A) No person shall be eligible to the office of coroner except a physician who has been licensed to practice as a physician in this state for a period of at least two years immediately preceding election or appointment as a coroner, and who is in good standing in the person's profession, or is a person who was serving as coroner on October 12, 1945.

B)(1) Beginning in calendar year 2000 and in each fourth year thereafter, each newly elected coroner, after the general election but prior to commencing the term of office to which elected, shall attend and successfully complete sixteen hours of continuing education at programs sponsored by the Ohio state coroners association. Within ninety days after appointment to the office of coroner under section 305.02 of the Revised Code, the newly appointed coroner shall attend and successfully complete sixteen hours of continuing education at programs

sponsored by the association. Hours of continuing education completed under the requirement described in division (B)(1) of this section shall not be counted toward fulfilling the continuing education requirement described in division (B)(2) of this section.

As used in division (B) (1) of this section, "newly elected coroner" means a person who did not hold the office of coroner on the date the person was elected coroner.

(2) Except as otherwise provided in division (B)(2) of this section, beginning in calendar year 2001, each coroner, during the coroner's four-year term, shall attend and successfully complete thirty-two hours of continuing education at programs sponsored by the Ohio state coroners association. Except as otherwise provided in division (B)(2) of this section, each coroner shall attend and successfully complete twenty-four of these thirty-two hours at statewide meetings, and eight of these thirty-two hours at regional meetings, sponsored by the association. The association may approve attendance at continuing education programs it does not sponsor but, if attendance is approved, successful completion of hours at these programs shall be counted toward fulfilling only the twenty-four-hour requirement described in division (B)(2) of this section.

(3) Upon successful completion of a continuing education program required by division (B) (1) or (2) of this section, the person who successfully completes the program shall receive from the association or the sponsoring organization a certificate indicating that the person successfully completed the program.

ORC 313.14 NOTICE TO RELATIVES; DISPOSITION OF PROPERTY

The coroner shall notify any known relatives of a deceased person who meets death in the manner described by section 313.12 of the Revised Code by letter or otherwise. The next of kin, other relatives, or friends of the deceased person, in the order named, shall have prior right as to disposition of the body of such deceased person. If relatives of the deceased are unknown, the coroner shall make a diligent effort to ascertain the next of kin, other relatives, or friends of the deceased person. The coroner shall take charge and possession of all moneys, clothing, and other valuable personal effects of such deceased person, found in connection with or pertaining to such body, and shall store such possessions in the county coroner's office or such other suitable place as is provided for such storage by the board of county commissioners. If the coroner considers it advisable, he may [,] after taking adequate precautions for the security of such possessions, store the possessions where he finds them until other storage space becomes available. After using such of the clothing as is necessary in the burial of the body, in case the cost of the burial is paid by the county, the coroner shall sell at public auction the valuable personal effects of such deceased persons, found in connection with or pertaining to the unclaimed dead body, except firearms, which shall be disposed of as provided by section 313.141 [313.14.1] of the Revised Code, and he shall make a verified inventory of such effects. Such effects shall be sold within eighteen months after burial, or after delivery of such body in accordance with section 1713.34 of the Revised Code. All moneys derived from such sale shall be deposited in the county treasury. A notice of such sale shall be given in one newspaper of general circulation in the county, for five days in succession, and the sale shall be held immediately thereafter. The cost of such advertisement and notices shall be paid by the board upon the submission of a verified statement therefore, certified to the coroner.

This section does not invalidate section 1713.34 of the Revised Code.

Frequently Asked Questions

How long does it take for a death ruling to be made?

This procedure is handled differently by various Counties. However, in most cases, a signed death certificate accompanies the body when it is released by the Coroner. When there is insufficient information available to complete the death certificate, a pending Findings, Fact and Verdict death certificate is issued that accompanies the body. This death certificate enables the funeral services and burial to take place while additional chemical, microscopic slide preparation and examination, and investigation continues. At the culmination of these tests and investigation, the ruling is made based on all available information. A supplemental death certificate is then issued with the cause of death and ruling which supersedes the pending death certificate.

When will the autopsy report be completed?

The autopsy report, also called the protocol, usually takes about four weeks to be completed after the autopsy. If microscopic and chemical tests are performed, this time period can lengthen to six to eight weeks.

Where may the clothing of the deceased be located?

Usually, the clothing of the deceased is released to the funeral director for disposal or use as the family requests. In cases of homicide, various suicides, or vehicular deaths, the clothing may be held by the Coroner or the investigating law enforcement agency for use as evidence.

How is a funeral director selected?

Most often, the next-of-kin discusses the selection of the funeral director with the other family members, clergy or friends. The Office of the Coroner is prohibited from recommending a funeral director. A listing of funeral directors is available in the telephone book as well as other sources.

What is an autopsy and is there a charge for it?

An autopsy is a systematic examination by a qualified physician of the body of a deceased person for the purpose of determining the cause of death. A record is made of the findings of the autopsy, including microscopic and toxicological laboratory tests. These laboratory tests are conducted before the release of the body to the next-of-kin for burial. There is no charge to the next-of-kin for an autopsy, nor for any of the tests that may be conducted by the Coroner.

Does the Coroner need permission from the next-of-kin for an autopsy?

Ohio Law (ORC 2108-52) provides that the Coroner does not need permission for an autopsy. The Office of the Coroner will attempt to comply with the wishes of the next-of-kin, provided this does not conflict with the duties of the Coroner as charged by Ohio Law including due regard for the deceased's religious persuasion.

When is an autopsy performed?

Not all persons brought to the Coroner's Office are autopsied. Certain cases are not autopsied where no foul play is suspected and evidence of a natural death is present. In other cases where the possibility of legal proceedings may arise as a result of a homicide, accident, suicide, etc., an autopsy will be performed. In these cases, both positive and negative information ordinarily is found which substantiates the ruling and cause of death as signed by the Coroner. Under a recent change in the Ohio Revised Code, any child under the age of two years that is referred to the Coroner's Office with no known potentially lethal disease shall be autopsied unless contrary to the parents' religious beliefs. (ORC 313.131)

Why is a body brought to the Coroner's Office?

The remains of deceased persons are brought to the Coroner's Office because Ohio Law requires that the Coroner investigate deaths of persons dying from criminal violence, by accident, by suicide, suddenly, when unattended by a physician for a reasonable period of time, in detention, or in any suspicious or unusual manner. Another reason that a body may be brought to the Coroner's Office is that the identity of the deceased or the next-of-kin is unknown.

How can the deceased's personal effects and other valuables be obtained?

By Ohio Law (ORC 313.14), the Office of the Coroner will take possession of monies and other personal effects of the deceased. These items are inventoried and released to the next-of-kin. (Money over \$100.00 may only be released with a release From Probate Order from the court or a letter of Appointment naming an executor of the estate of the deceased.)

How do I make arrangements for a body to be released from the Office of the County Coroner?

Routinely, the Coroner releases the body to a licensed funeral director. The next-of-kin of the deceased person should notify a funeral director who, in turn, will arrange transportation for the deceased to the funeral home and obtain the necessary documents for burial or cremation.

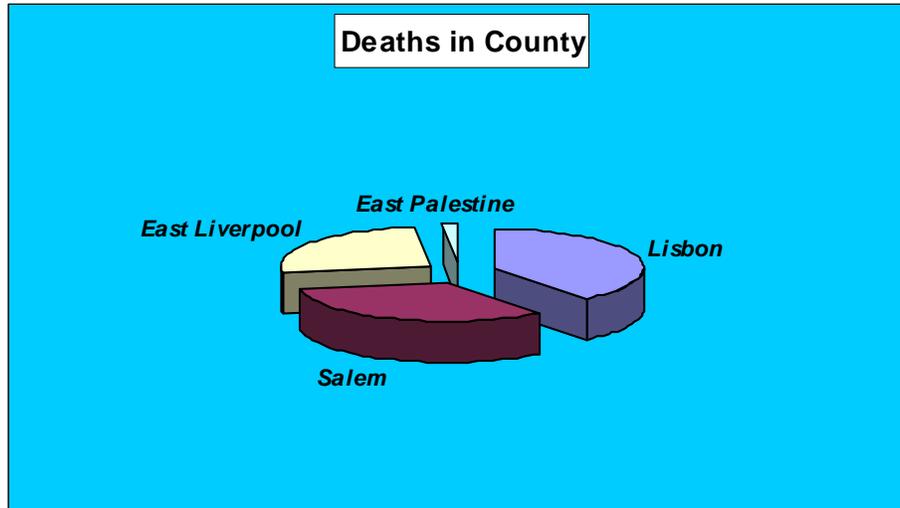
Where can copies of the death certificate be obtained?

Certified copies of death certificates can be obtained only from the Bureau of Vital Statistics of each respective county.

How can I obtain records, including a Coroner's report, autopsy report, and/or toxicology report, pertaining to a death on a case that was referred to the Coroner?

This procedure differs from County to County. To obtain this information, contact your County Coroner.

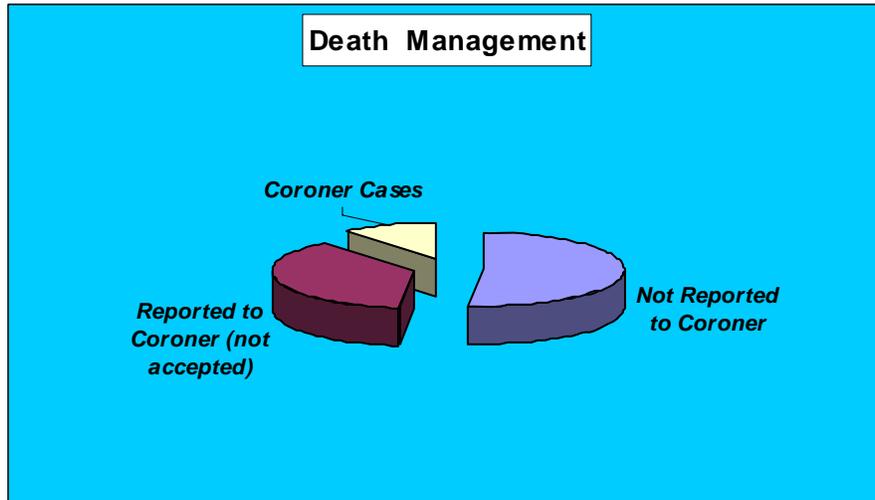
Total Deaths Reported Across the County in 2006



The amount of deaths reported from January 1, 2006 to December 31, 2006 in the county totaled 1,026. This was a slight decrease as compared with the last year total of 1089. The values displayed were acquired from Lisbon, Salem, East Liverpool, and East Palestine health departments. Each reported the following reported deaths:

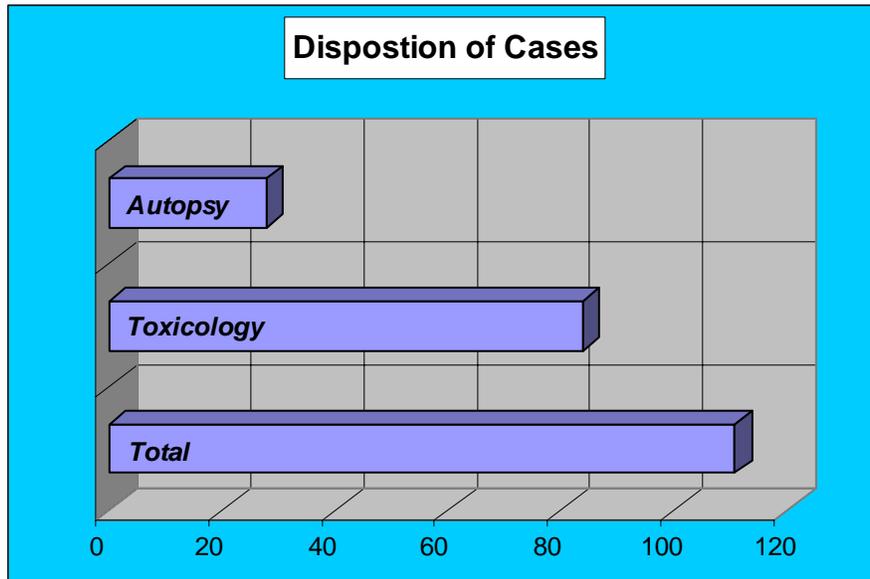
<u>Health Departments Data</u>	
Lisbon	404
Salem	337
East Liverpool	268
East Palestine	17
<i>Total</i>	1026

Death Management for Reported Deaths



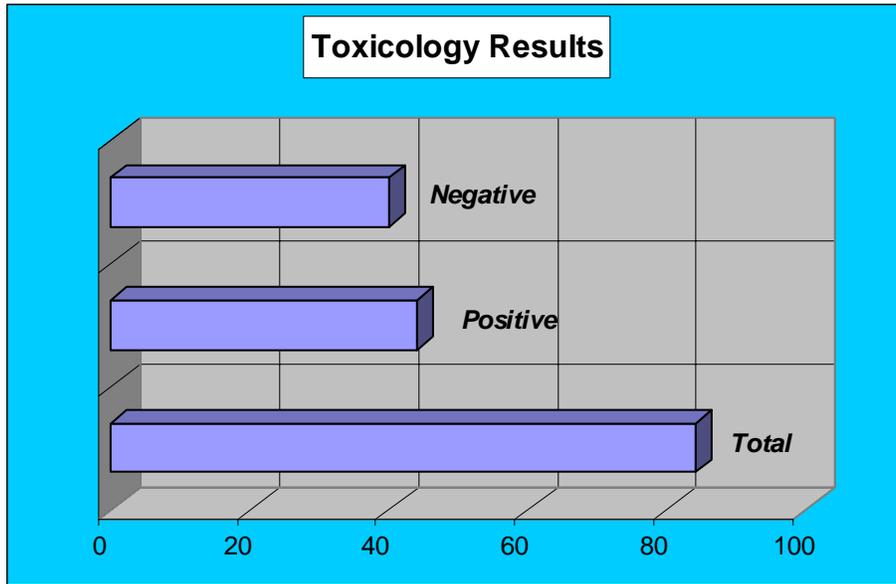
Not all of the cases reported to the coroner are taken. Some cases do not meet the criteria of a coroner's case, therefore they are recorded as reported to the coroner but do not get investigated by the coroner. However, there are many cases that become coroner cases and for those a full investigation and final determination are rendered. This year there were 111 cases taken by the coroner, 386 reported but not accepted by the coroner and the rest of the 1026 deaths were not reported, which totaled 529 deaths.

Disposition of Cases Taken by the Coroner



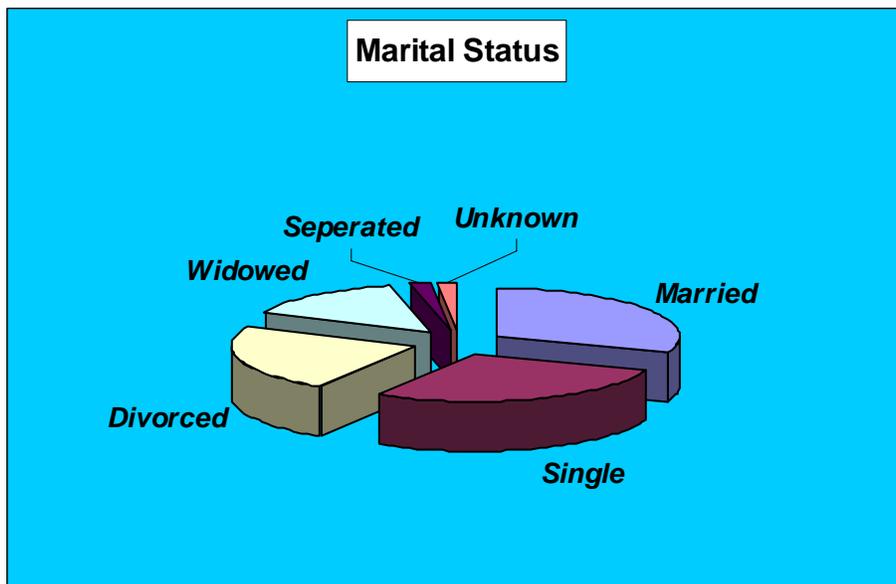
The coroner determines whether or not to run toxicology or an autopsy on a decedent. For this year, of the 111 death cases, 28 were autopsies and 84 had toxicology run on the specimens obtained from the decedents.

Toxicological Results of Decedents of 2006



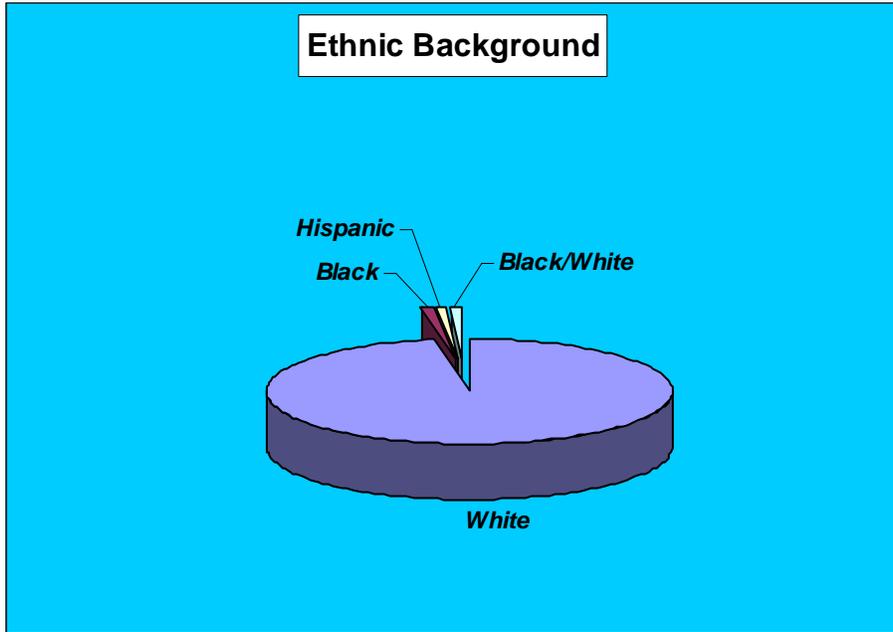
The toxicology testing that is performed many times comes back the way the coroner believes it will; however, sometimes it can be surprising. As shown it is a close comparison between the positive and negative results. The negative results were seen in 40 cases and 44 cases resulted positive. Thus, drugs were found in 44 decedents.

Distribution of Decedents by Marital Status



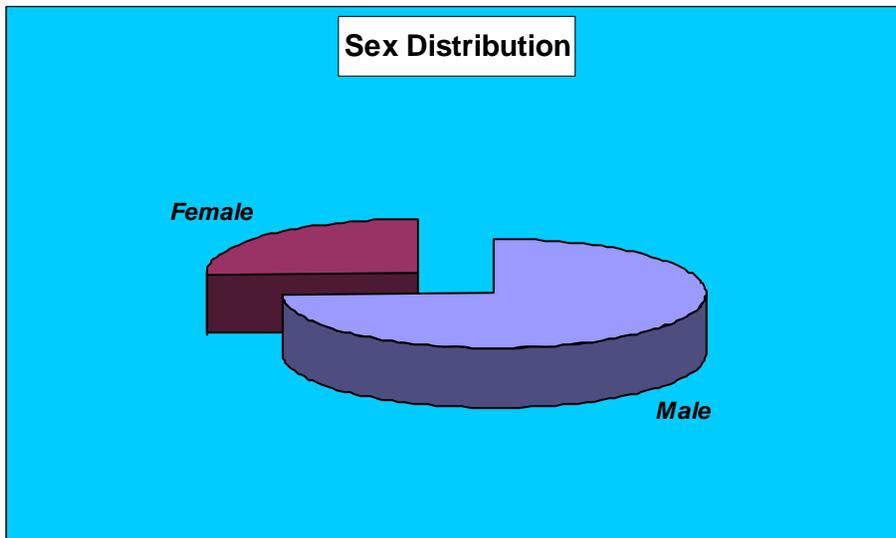
For the coroner cases the decedent's information is obtained and documented. The results were as diverse as the decedents themselves and included at least a few people from each type of marital status. There were 34 people that were married, 31 single, 26 divorced, 16 widowed, 2 separated and 2 unknown.

Distribution of Decedents Based on Ethnic Background



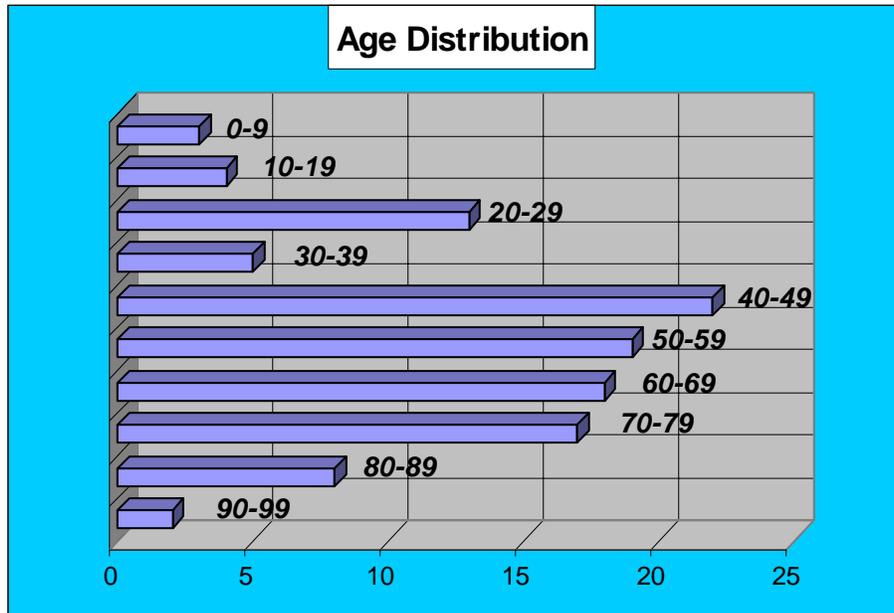
Although the marital status was diverse the ethnic distribution was not. There were mostly white decedents this year with a total of 108. There was one of each of the other three categories of black, hispanic and black/white.

Distribution of Decedents by Sex



In the year 2006, there were almost three times as many males as females that were accepted as coroner cases. The totals more accurately were 83 males and 28 females.

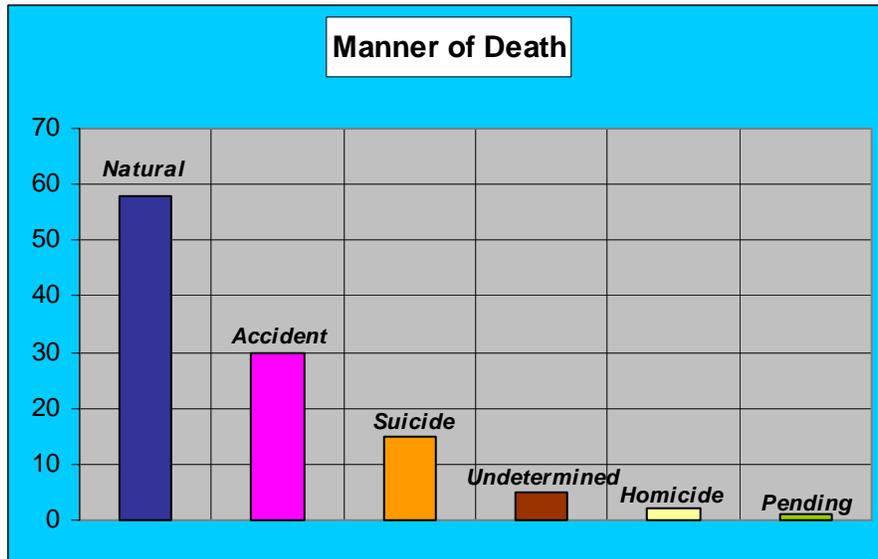
Distribution of the Decedents by Age



The decedent's age ranged from as young as 2 months old up to 95 years of age. There were especially high values in the 40-79 range and a peak from 20-29. The exact values of each range are as follows.

<u>Age (range)</u>	<u>#</u>	<u>Age (range)</u>	<u>#</u>
0-9	3	50-59	25
10-19	5	60-69	10
20-29	17	70-79	14
30-39	17	80-89	12
40-49	15	90-99	3
		100-109	1

Distribution for Manner of Death Determined by Coroner



For each of the 111 cases, the coroner had to make a determination as to manner of the decedent's death. In all but one he came to a conclusion and a final decision was rendered. For the year there were 58 natural deaths, 30 accidents, 15 suicides, 5 undetermined, 2 homicides and one case is pending further investigation.

The distribution of the manner of death when compared with age is as follows:

Age	Natural	Accident	Suicide	Homicide	Undetermined	Totals
0-9	0	0	0	0	2	3*
10-19	0	1	3	0	0	4
20-29	1	10	1	1	0	13
30-39	0	3	1	1	0	5
40-49	15	0	6	0	1	22
50-59	13	2	2	0	2	19
60-69	14	4	0	0	0	18
70-79	13	4	0	0	0	17
80-89	2	4	2	0	0	8
90-99	0	2	0	0	0	2
Totals	58	30	15	2	5	110*

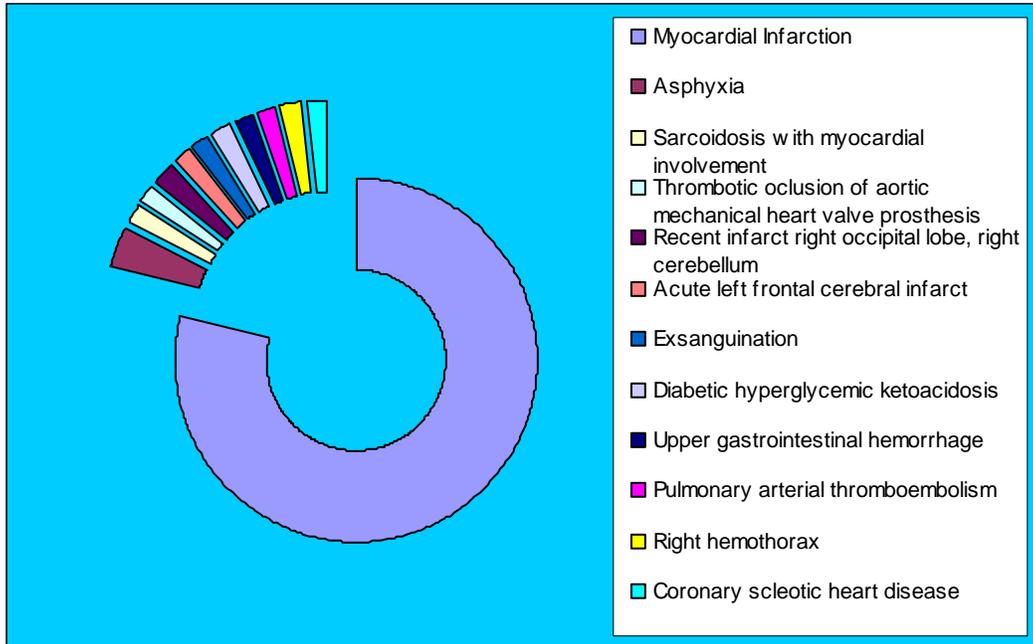
**One case in this range is pending.*

The distribution of the manner of death when compared to sex is as follows:

Sex	Natural	Accident	Suicide	Homicide	Undetermined	Totals
Male	44	21	12	1	4	82*
Female	14	9	3	1	1	28
Totals	58	30	15	2	5	110*

**One case in this range is pending.*

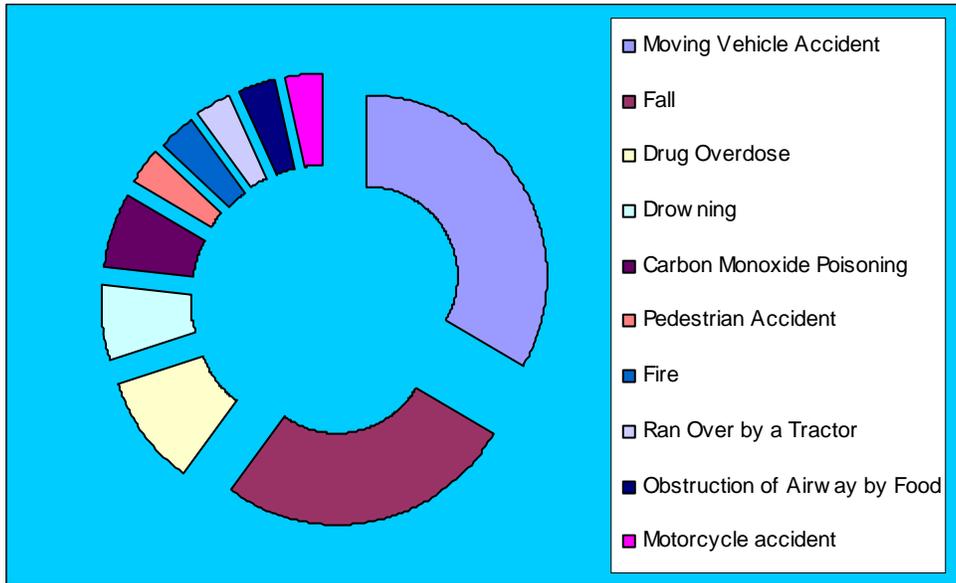
Natural Death Distribution



Each death that is determined to be natural in manner the coroner gives a cause. Above are the distributions of the various causes of natural deaths for this year and the exact amounts are as follows:

Myocardial Infarction	45
Asphyxia	2
Sarcoidosis with myocardial involvement	1
Thrombotic occlusion of aortic mechanical heart valve prosthesis	1
Recent infarct right occipital, right cerebellum	1
Acute left frontal cerebral infarct	1
Exsanguination	1
Diabetic hyperglycemic ketoacidosis	1
Upper gastrointestinal hemorrhage	1
Pulmonary arterial thromboembolism	1
Right hemothorax	1
Coronary sclerotic heart disease	1
Total	57

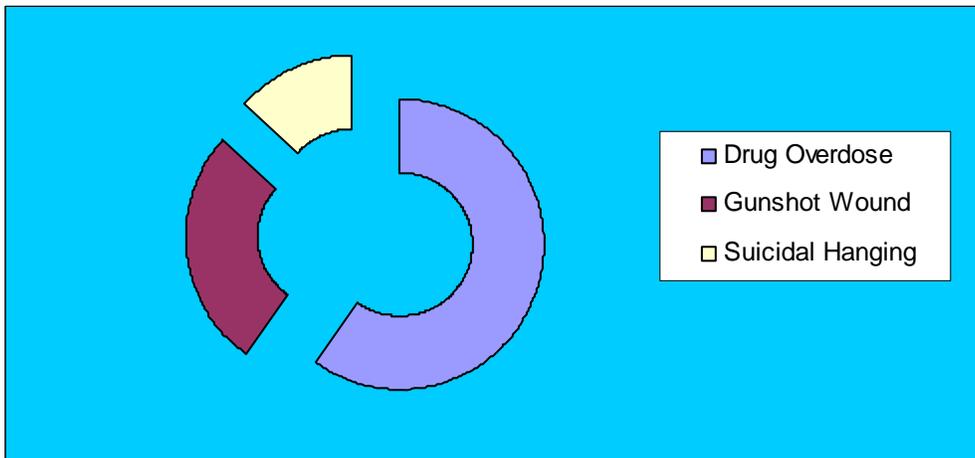
Distribution of Accidental Deaths



As with the natural deaths, the accident deaths the coroner gives a cause. The exact amounts of the causes of the 30 accidents are as follows:

Moving Vehicle Accident	10	Pedestrian Accident	1
Fall	8	Fire	1
Drug Overdose	3	Ran Over by a Tractor	1
Drowning	2	Obstruction of Airway by Food	1
Carbon Monoxide Poisoning	2	Motorcycle Accident	1

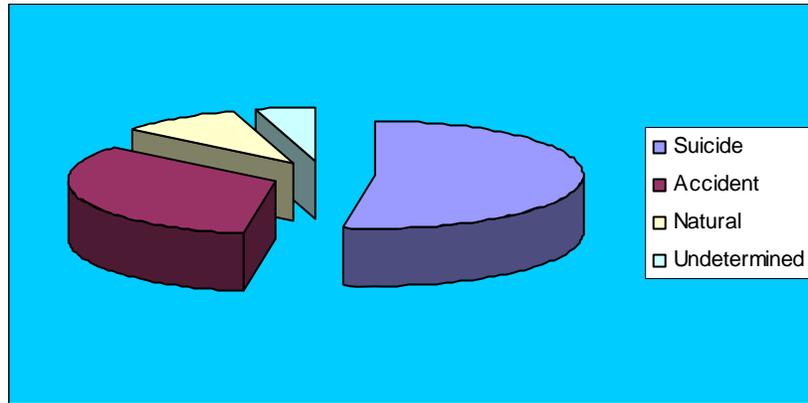
Distribution of Suicidal Deaths



The causes of the 15 suicides were also determined by the coroner and they are as follows:

Drug Overdose	9
Gunshot Wound	4
Suicidal Hanging	2

Distribution of Asphyxia Deaths



Of the 21 Asphyxia deaths for the year there were the following manners of deaths that were determined:

Suicide	11
Accident	7
Natural	2
Undetermined	1

Distribution of Deaths by Town

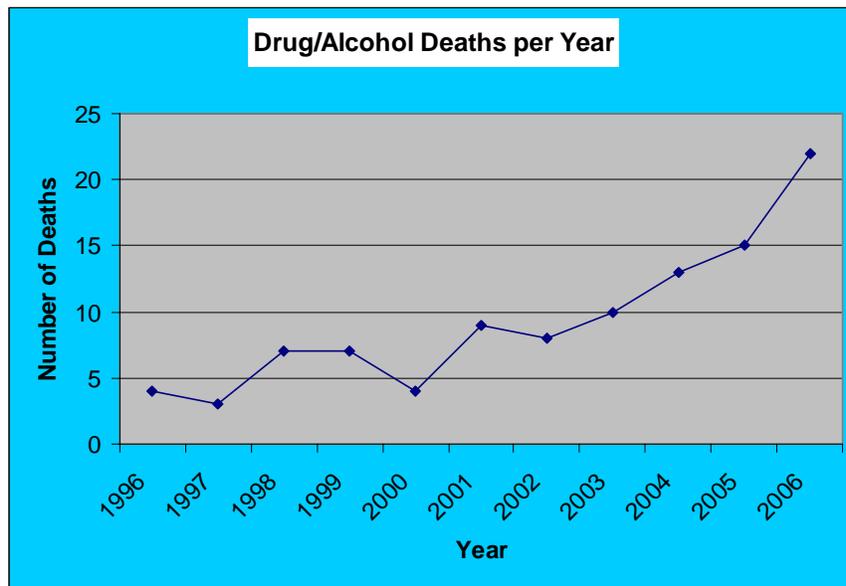
Town	Natural	Accident	Suicide	Homicide	Undetermined	Pending	Total
Salem	23	11	3	0	1	0	38
East Liverpool	19	6	6	1	3	1	36
Lisbon	7	2	1	0	1	0	11
Columbiana	0	3	1	0	0	0	4
East Palestine	3	0	0	1	0	0	4
Salineville	1	0	2	0	0	0	3
Alliance	1	0	1	0	0	0	2
East Rochester	1	1	0	0	0	0	2
Leetonia	1	1	0	0	0	0	2
Minerva	1	0	1	0	0	0	2
Fairfield Township	0	1	0	0	0	0	1
Hanover Township	0	1	0	0	0	0	1
Hanoverton	0	1	0	0	0	0	1
Kensington	0	1	0	0	0	0	1
Knox Township	0	1	0	0	0	0	1
Negley	0	1	0	0	0	0	1
New Waterford	1	0	0	0	0	0	1
Total	58	30	15	2	5	1	111

Distribution of Deaths by Zip Code

Zip Code	Natural	Accident	Suicide	Homicide	Undetermined	Pending	Total
44460	23	12	3	0	1	0	39
43920	19	6	6	1	3	1	36
44432	7	2	1	0	1	0	11
44408	0	4	1	0	0	0	5
44413	3	0	0	1	0	0	4
43945	1	0	2	0	0	0	3
44423	0	2	0	0	0	0	2
44431	1	1	0	0	0	0	2
44601	1	0	1	0	0	0	2
44625	1	1	0	0	0	0	2
44657	1	0	1	0	0	0	2
44427	0	1	0	0	0	0	1
44441	0	1	0	0	0	0	1
44445	1	0	0	0	0	0	1
Total	58	30	15	2	5	1	111

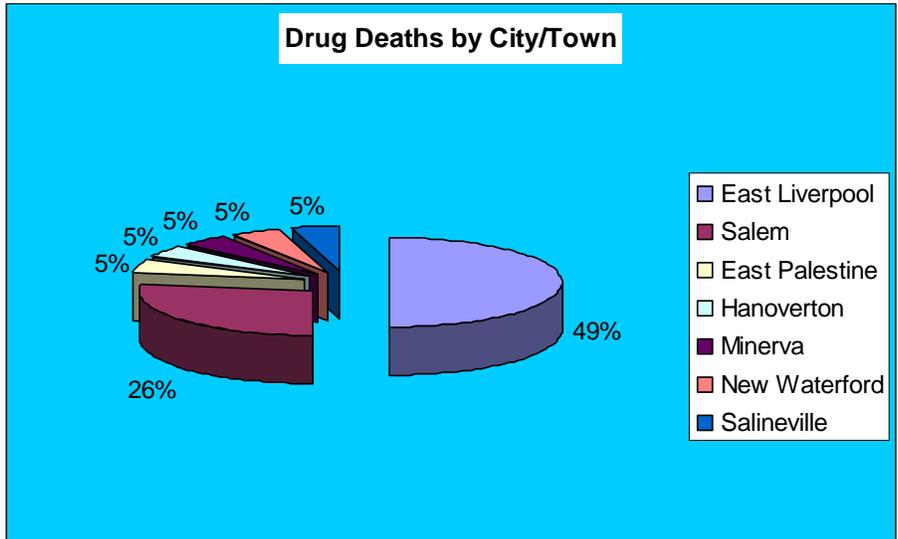
The previous tables display the distribution of manner of death in the cities and zip codes from where the decedents died in 2006.

Distribution of Drug and Alcohol Deaths by Year



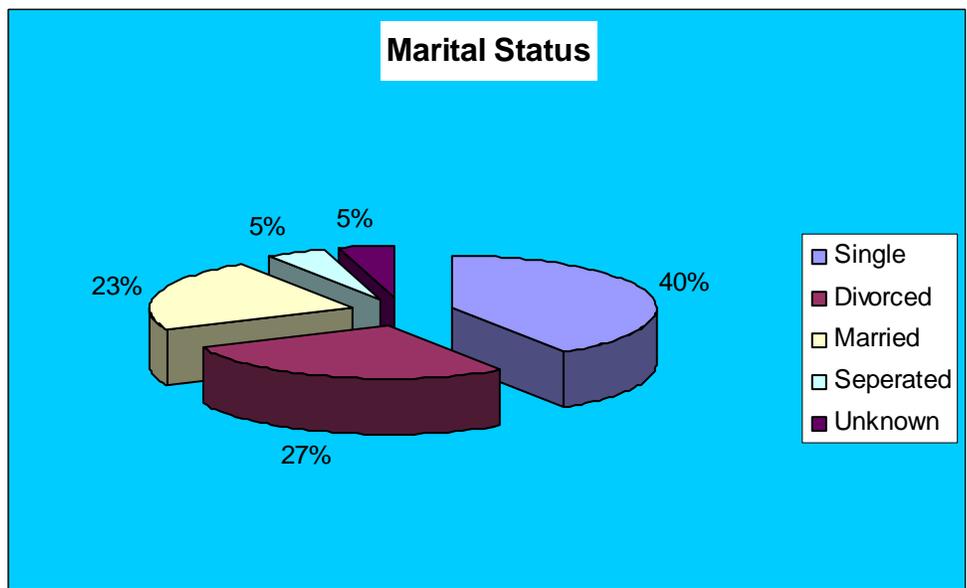
This graph displays the deaths where drugs alcohol directly caused the decedents' deaths for the past 11 years and shows a tremendous jump from previous years to 22 for this year when compared to the 15 from last year. This office predicted the major importance of drugs to the coroner's office and it was dramatically understated as 22 deaths were caused by drugs or alcohol and the other 22 of the 44 positive toxicology results that did not cause the decedents' deaths but drugs or alcohol were found in these individuals.

2006-City or Town of Drug Deaths



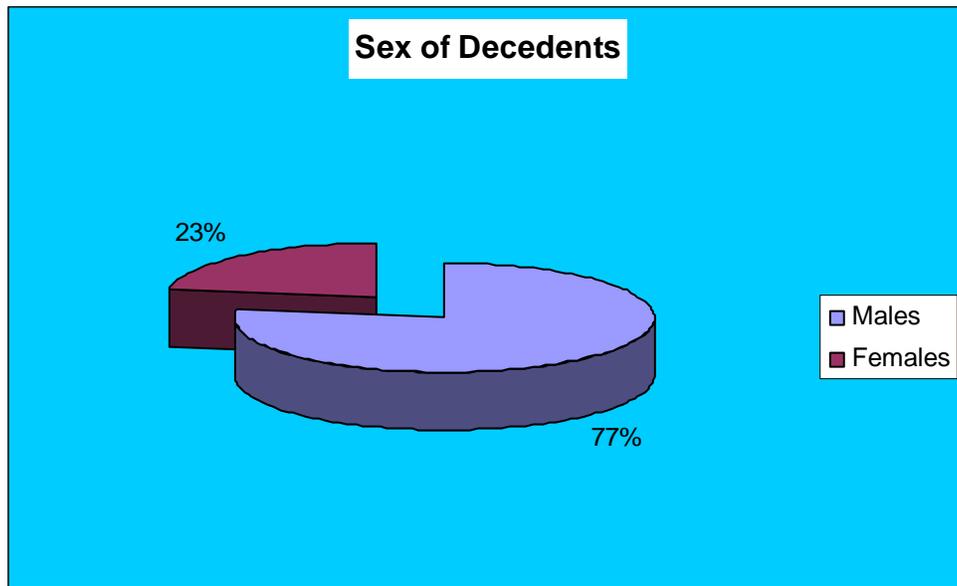
For the drug deaths in 2006 the city where the decedent's died was evaluated and recorded. Of the 22 deaths, East Liverpool had 11, Salem had 6 and the rest of the cities (East Palestine, Hanoverton, Minerva, New Waterford, Salineville) had one. These results displayed East Liverpool and Salem were the top two at 49 and 26 percent of the deaths.

2006-Marital Status of Decedents in Drug Deaths



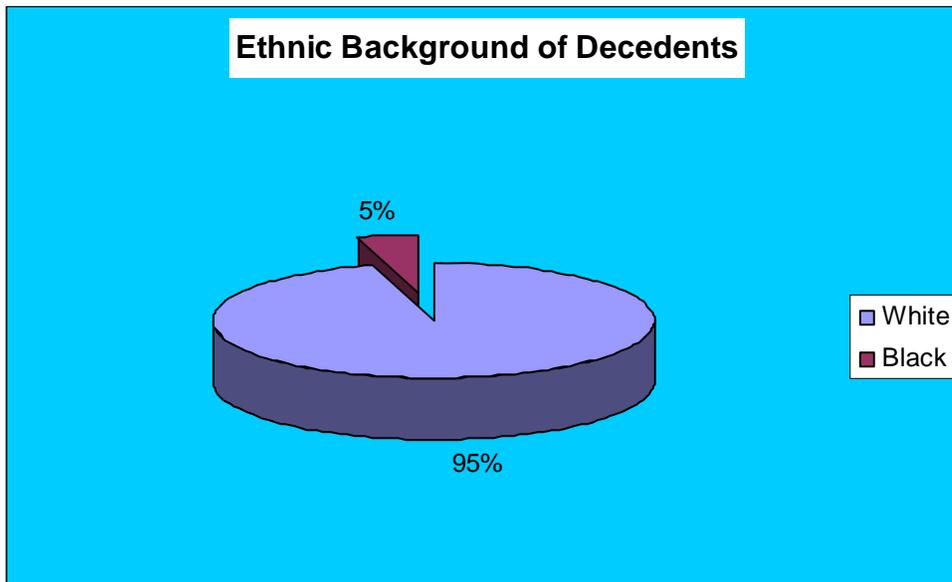
This shows the marital status of the decedents that died in a drug related death. Of the 22 decedents, 9 were single, 6 divorced, 5 married, 1 seperated and 1 unknown.

2006-Sex of Decedents in Drug Deaths



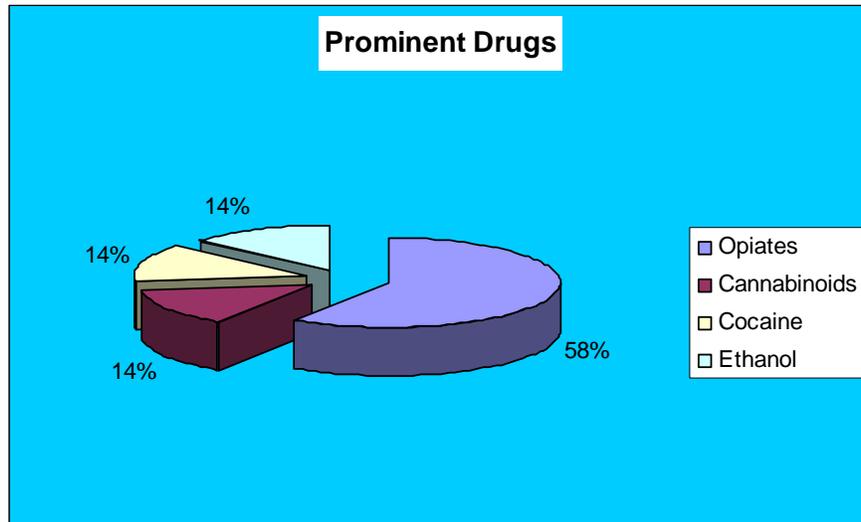
This graph shows the ratio of male to females in drug related deaths. There were 17 males and 5 females of the 22 drug related deaths. Thus, there were over three times more males than females.

2006-Race of Decedents in Drug Deaths



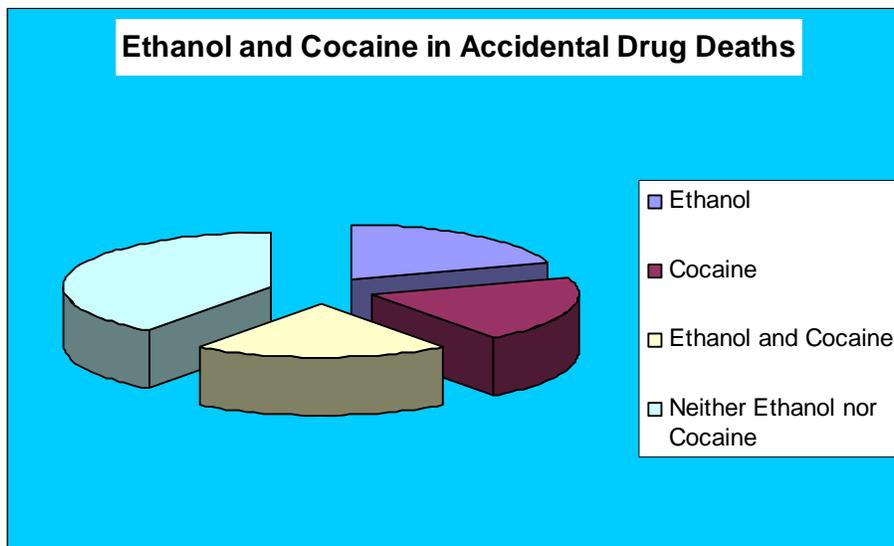
The ethnic background of the decedents was overwhelmingly white. There were 21 white individuals and 1 black decedent involved with drug related deaths.

Distribution of the 4 Most Prominent Drugs for Drug Deaths in 2006



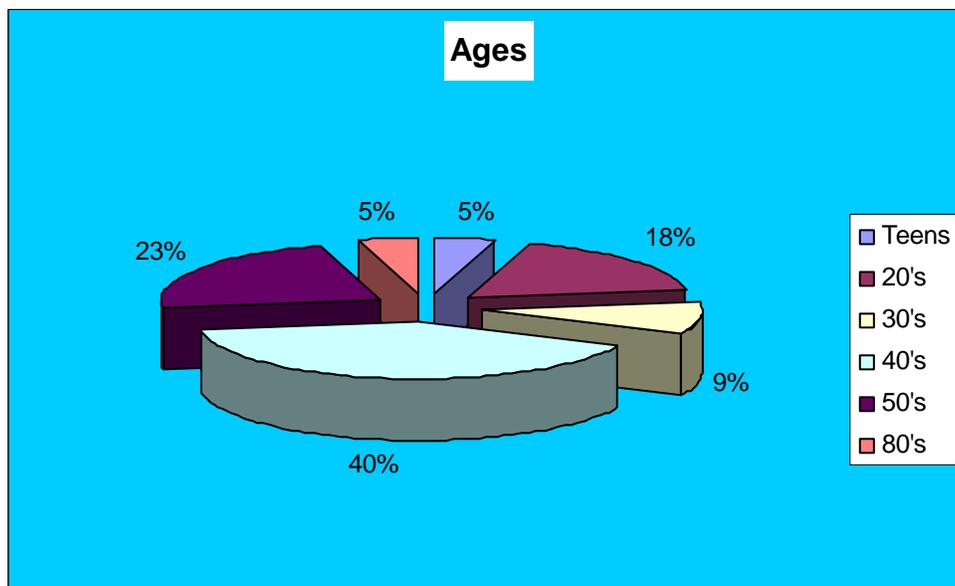
The prominent drugs for 2006 were Ethanol, Cannabinoids, Opiates and Cocaine. When compared to last year there were almost 3 times less ethanol deaths as they went down from 11 last year to 3 this year. There were 3 deaths involving Cannabinoids and 3 cocaine related deaths. The prominent drug this year was Opiates with an outstanding 13 of the 22 deaths.

Distribution of Ethanol and Cocaine among the Accidental Drug Deaths in 2006



Of the 22 drug related deaths 5 were accidental. For the 5 accidental deaths there were 2 that contained neither Ethanol nor Cocaine, one that contained both, one for only ethanol, and one for only cocaine.

Distribution of Ages of Decedents in Drug Deaths in 2006



The decedents' ages in drug deaths were quite interesting to evaluate. There were mostly decedents in their 40s. There was one person in their teens, 4 in their twenties, 2 in their thirties, 9 in their forties, 5 in their 50s, none in the 60-79 range and one person in their 80s. This shows that mostly those in their 20s-50s were involved in drug related deaths with at peak in the 40s-50s range.

Having seen the data and the graphs of the year 2006 ... we ask the question, "Was this a 'normal' year?" We will answer this question by comparing it to the previous 17 years of data. We will use the statistical tools of **Normal Distribution** and **Standard Deviation (SD)**. Refer to appendix A for a quick refresher course if needed.

Let's look first at the number of cases for the year 2006:

Year	Total Cases	Male	Female	Ratio
1989	94	69	25	0.734043
1990	99	76	23	0.767677
1991	78	51	27	0.653846
1992	90	60	30	0.666667
1993	78	64	14	0.820513
1994	73	50	23	0.684932
1995	89	68	21	0.764045
1996	120	95	25	0.791667
1997	88	66	22	0.750000
1998	88	57	31	0.647727
1999	98	71	27	0.724490
2000	86	56	30	0.651163
2001	96	64	32	0.666667
2002	117	73	44	0.623932
2003	94	66	28	0.702128
2004	108	78	30	0.722222
2005	82	58	24	0.707317
2006	111	83	28	0.747747
Sum				
Mean				
SD				
- 3 SD				
- 2 SD				
2006	111	83	28	0.747747
+ 2 SD				
+ 3 SD				

Now let's look at the number of homicides in the year 2006:

Year	Homicide	Male	Female	Ratio
1989	2	0	2	0.000000
1990	2	0	2	0.000000
1991	0	0	0	0.000000
1992	3	1	2	0.333333
1993	2	1	1	0.500000
1994	1	1	0	1.000000
1995	5	3	2	0.600000
1996	3	2	1	0.666667
1997	2	0	2	0.000000
1998	2	1	1	0.500000
1999	1	1	0	1.000000
2000	1	0	1	0.000000
2001	2	1	1	0.500000
2002	4	2	2	0.500000
2003	1	1	0	1.000000
2004	2	1	1	0.500000
2005	2	1	1	0.500000
2006	2	1	1	0.500000
Sum				
Mean				
SD				
- 3 SD				
- 2 SD				
2006	2	1	1	0.500000
+ 2 SD				
+ 3 SD				

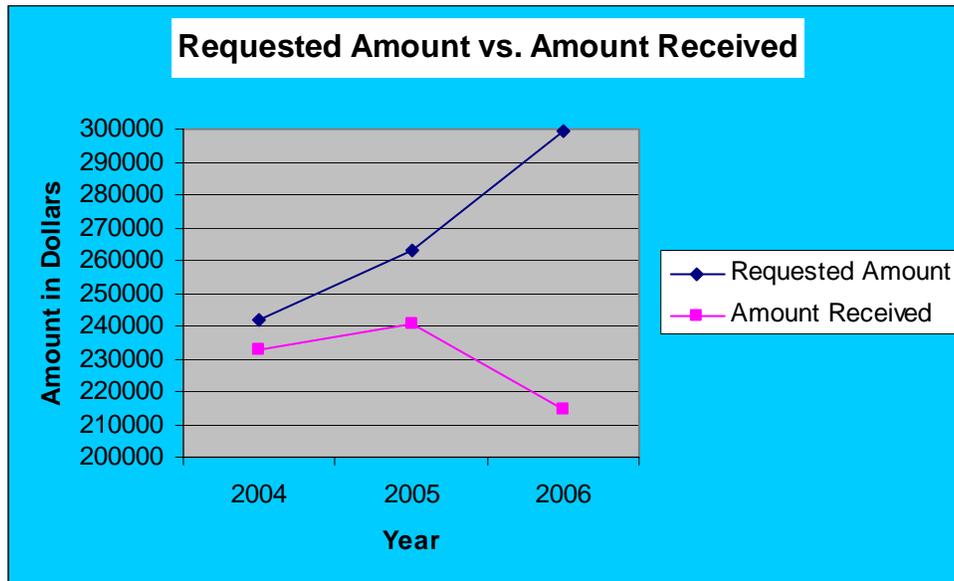
The next data set involves Suicides in the year 2006:

Year	Suicide	Male	Female	Ratio
1989	13	12	1	0.923077
1990	11	9	2	0.818182
1991	18	15	3	0.833333
1992	12	10	2	0.833333
1993	12	10	2	0.833333
1994	12	11	1	0.916667
1995	11	9	2	0.818182
1996	17	15	2	0.882353
1997	15	12	3	0.800000
1998	17	9	8	0.529412
1999	8	6	2	0.750000
2000	9	9	0	1.000000
2001	13	11	2	0.846154
2002	12	7	5	0.583333
2003	16	14	2	0.875000
2004	12	9	3	0.750000
2005	20	17	3	0.850000
2006	15	12	3	0.800000
Sum				
Mean				
SD				
- 3 SD				
- 2 SD				
2006	15	12	3	0.800000
+ 2 SD				
+ 3 SD				

Budget for Columbiana County Coroner's Office

Believe it or not there is a lot of money that is required to run a county coroner's office. They receive many calls per day, quite often leading to a heavy caseload such as the substantial amount of 111 cases in 2006. Therefore handling the finances of the coroner's office is almost as grim as the job at hand.

Each year the County Commissioners require the Coroner's Office to submit a budget request as they do each agency in the county. Each year they ask for enough that they believe will get them through the year and then the County Commissioners determine how much they are going to actually receive based on that estimate. The results of this exchange are displayed on the following graph for 2004, 2005 and 2006.

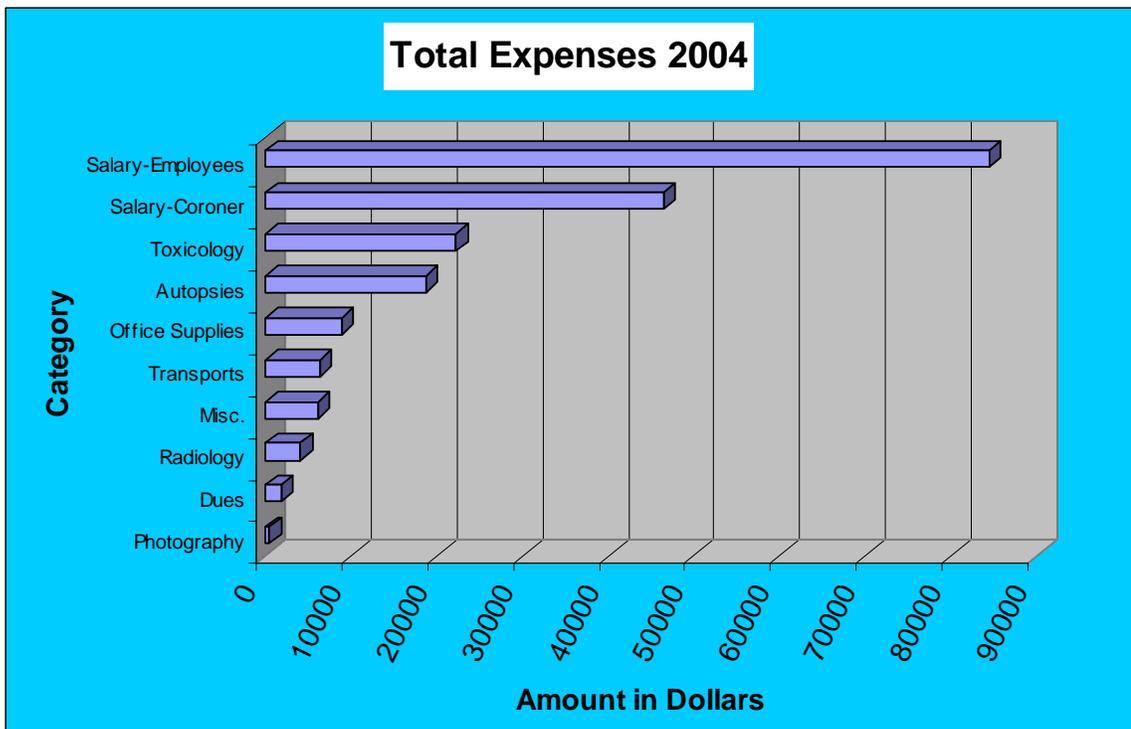


As shown the amount for the past 3 years the amount requested has been increasingly higher than the amount received. And this year the county had to give this office \$25,038.62 more just to get by until the end of the year, which is included in the amount received. Therefore the difference this year was more substantial. The following table gives the total amounts given to this office for last 3 years and compares those amounts to the amounts requested.

Years	Requested Amount	Amount Received	Difference
2004	\$241,991.37	\$232,548.00	\$9,443.37
2005	\$262,901.21	\$240,498.34	\$22,402.87
2006	\$299,581.67	\$214,786.74	\$84,794.93

One might ask, how can a coroner's office spend so much money? To better see the expenses each category has to be explored because the department's expenses range from as little as \$3.99 for office supplies to up to \$3,051.60 for laboratory analysis in 2006. Over the past few years the expenses have been evaluated and the results are incredible. Afterwards one can truly understand how much money it takes to run the coroner's office in Columbiana County.

In 2004, the expenses were totaled to be an outstanding \$199,679.64 before medical insurance, retirement benefits and workmen's compensation. The rest of the expenses are separated into categories of Toxicology, Radiology, Photographs, Transports, Autopsies, Salary for Coroner, Salary for Employees (3), Dues, Office Supply, Miscellaneous. The following graph displays the totals of each.



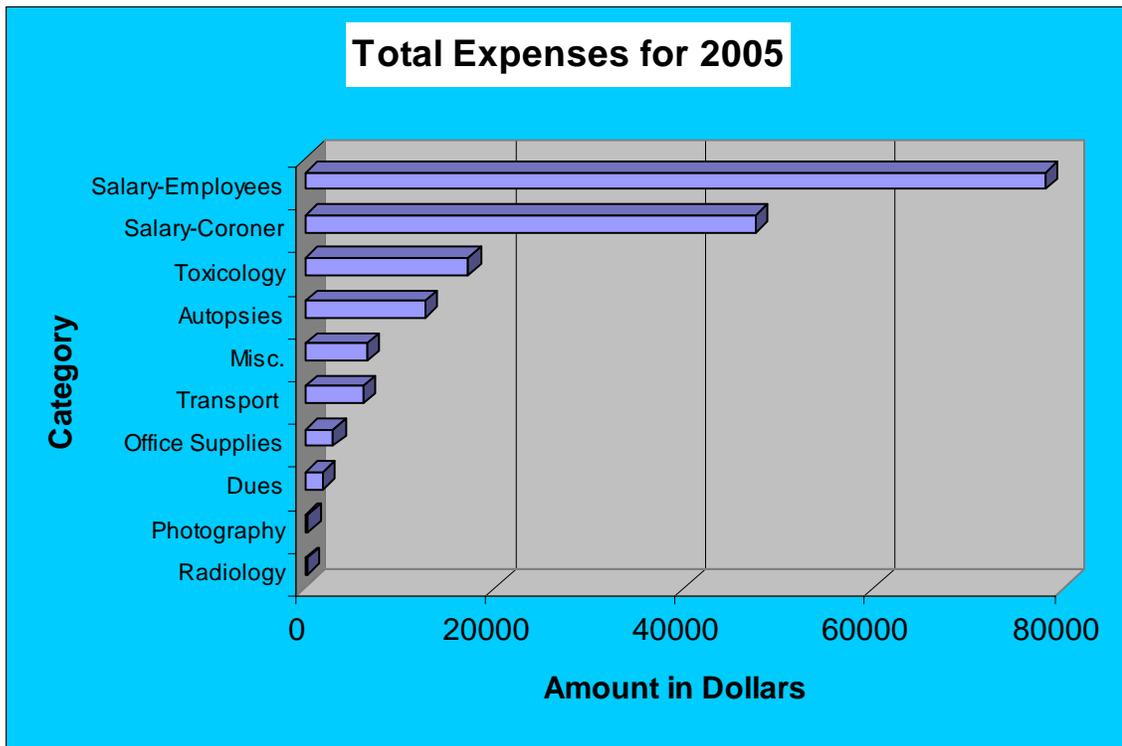
This graph gives total expenses in each category for the year 2004. The salaries have the top spot on the chart because this money employed the 2 part time investigators, a part time secretary and the elected coroner. Close behind the salaries are the toxicology and autopsy categories that come to almost half of the coroner's salary each. The next most money goes to transports of decedents, office supplies and miscellaneous. The rest of the money was spent in the radiology, dues and photography categories. The exact total amounts, ranges and averages are displayed in the table on the following page.

Expenses for 2004

Category	Range	Average per Month	Totals
<i>Salary-Employees</i>	\$2,413.80-\$3,627.00	\$3,131.29	\$84,544.80
<i>Salary-Coroner</i>	\$3869.91-\$3,869.99	\$3,869.92	\$46,439.00
<i>Toxicology</i>	\$49.25-\$3,000.70	\$925.22	\$22,205.28
<i>Autopsies</i>	\$850.00-\$2,550.00	\$1,168.75	\$18,700.00
<i>Office Supplies</i>	\$39.89-\$6,732.78	\$1,274.22	\$8,919.56
<i>Transports</i>	\$53.00-\$870.00	\$205.55	\$6,372.00
<i>Miscellaneous</i>	\$5.00-\$1,876.75	\$1,274.22	\$6,099.48
<i>Radiology</i>	\$15.50-\$1,173.00	\$273.69	\$4,105.30
<i>Dues</i>	\$1,858.00	\$1,858.00	\$1,858.00
<i>Photography</i>	\$19.24-\$113.39	\$54.33	\$436.22
Total Expenses			\$199,679.64

This table shows the exact amounts in the various categories with the grand total on the bottom. These numbers do not include all expenses. There are some various others added such as unemployment, medical insurance, workmen's compensation and retirement.

In 2005, the same categories were utilized and evaluated. The total for the year used was less and totaled to be 174,088.72 for the year before medical insurance, retirement, workmen's compensation and unemployment. The following graph shows the amounts in comparison to each other.



The previous graph illustrates the amount spent in each of the ten categories for 2005. Once again the salaries for the three part-time employees and the coroner had the highest values. Then, closely following the salaries, were the autopsy and toxicology costs which were once again almost half of the coroner's salary. Afterwards, the Miscellaneous, Transport, Office Supplies, Dues, Photography and Radiology follow respectively. The exact values of each are displayed in the table below.

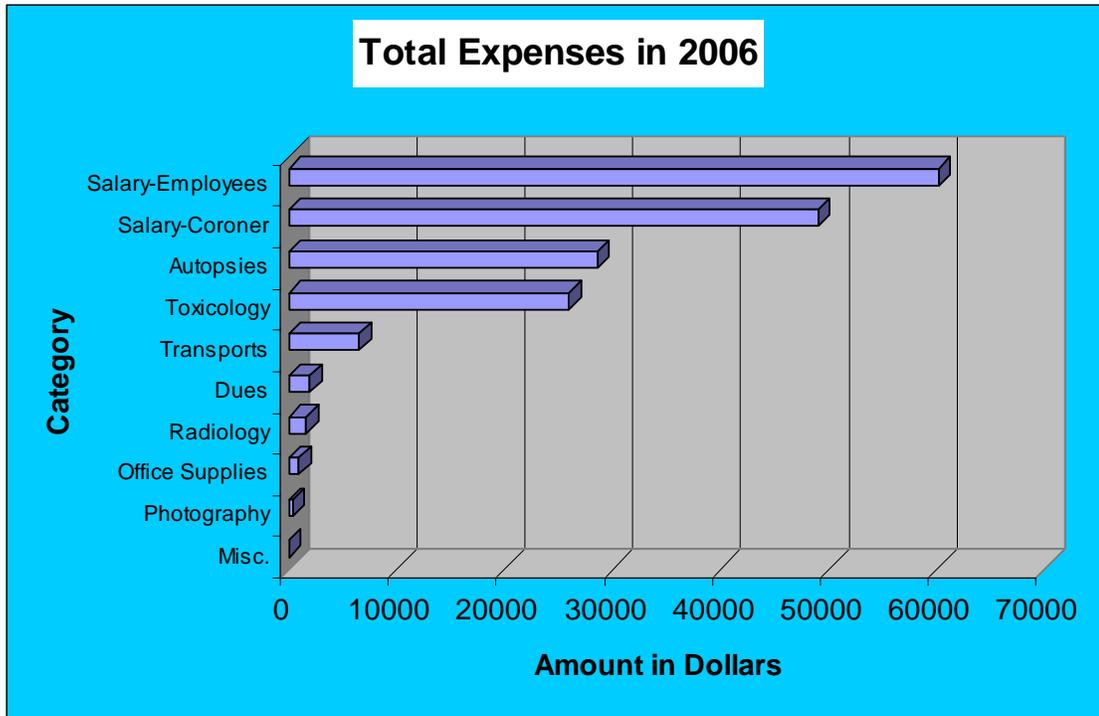
Expenses for 2005

Category	Range	Average per Month	Totals
<i>Salary-Employees</i>	\$2,479.00-\$11,891.83*	\$2,929.33	\$78,091.83
<i>Salary-Coroner</i>	\$3,962.83-\$3,962.87	\$3,962.83	\$47,554.00
<i>Toxicology</i>	\$49.25-\$2,454.38	\$690.65	\$17,266.16
<i>Autopsies</i>	\$850.00-\$2,550.00	\$1,062.50	\$12,750.00
<i>Miscellaneous</i>	\$10.00-\$3,035.00	\$174.40	\$6,627.26
<i>Transports</i>	\$50.00-\$1,634.00	\$212.94	\$6,175.15
<i>Office Supplies</i>	\$13.00-\$713.99	\$232.68	\$3,024.90
<i>Dues</i>	\$1,902.00	\$1,902.00	\$1,902.00
<i>Photography</i>	\$8.23-\$153.94	\$51.76	\$362.32
<i>Radiology</i>	\$7.75-\$239.10	\$83.78	\$335.10
Total Expenses			\$174,088.72

*The amount is so substantial because one of the investigators retired this year so that was paid from the coroner's budget.

The above values for the year were significantly less than 2005 because of the budget restraints on the county. This restricted the coroner's office resources due to fewer deaths they were able to make it through the year unlike in 2006.

In 2006, there were 111 deaths; however, the amount spent on the aforementioned categories was \$175,274.72 before retirement, workmen's compensation, medical insurance and unemployment. This was the hardest year of all. The price of autopsies increased, the salaries for the employees decreased and with increase in deaths and decrease in budget the amount of money was extremely tight. So tight that the county had to give money to the coroner's office at the end of the year to just make it through until the end of the year, paying only what had to be and doing only what absolutely had to be done. The following graph displays the breakdown of the various categories and the amounts spent in each.



The previous graph shows the amounts of money spent in each category for 2006. This shows a dramatic increase in money devoted to autopsies and toxicology which amount to well over half of the coroner's salary. The salary of the employees and the coroner categories did remain the highest. The following categories fell into the respective order of greatest to least: Transports, Dues, Radiology, Office Supplies, Photography, and Miscellaneous. The exact totals are displayed in the table below.

Expenses for 2006

Category	Range	Average per Month	Totals
<i>Salary-Employees</i>	\$626.75-\$2,770.90	\$2,316.34	\$60,224.85
<i>Salary-Coroner</i>	\$4,081.75	\$4,081.75	\$48,981.00
<i>Autopsies</i>	\$850.00-\$2,400.00	\$1,243.48	\$28,600.00
<i>Toxicology</i>	\$41.00-\$3,051.60	\$927.76	\$25,977.24
<i>Transports</i>	\$63.75-\$1,739.00	\$198.11	\$6,537.75
<i>Dues</i>	\$10.00-\$1,959.00	\$979.50	\$1,959.00
<i>Radiology</i>	\$28.00-\$453.43	\$182.92	\$1,646.28
<i>Office Supplies</i>	\$3.99-\$254.00	\$95.20	\$952.00
<i>Photography</i>	\$18.48-\$147.89	\$69.95	\$349.75
<i>Miscellaneous</i>	\$11.95-\$17.45	\$15.62	\$46.85
Total Expenses			\$175,274.72

The above values show total amounts in each category that were paid in the year 2006. These values are the highest in respects to autopsies, transports, and toxicology for all of the three years compared. The total expenses were higher than 2005, but lower than 2004 because that was all the funding that was received by the county.

As was shown by the comparison of the previous three years budgets it does take a lot of money to run a coroner's office. The resources of the coroner have been restricted and if 2007 is anything like 2006 we are going to run out of money again. This office investigates a variety of cases and one someday maybe a loved one or someone else you know wouldn't you want them to be represented. Remember the only person in your corner when you die is the coroner.

***Mission Statement:** This office is committed to represent those who can no longer represent themselves.*

***Goals:** Continue to bring the best skills of medical science to coroner investigations. Continue to serve the needs of law and justice as well as the citizens of Columbian County.*