2022 ANNUAL REPORT
FOR THE
WASHINGTON COUNTY CORONER'S OFFICE

S. Timothy Warco
Coroner

The Washington County Coroner's Office is fully Accredited by the International Association of Coroners and Medical Examiners.

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http://www.co.washington.pa.us/coroner
Phone: 724-228-6785

New In This Edition of the Report

We've made a few updates to the report based on some community feedback:

1. **The Municipal Occurrence report,** which was redesigned last year to give greater insight into the types of deaths occurring in each area of our county, was an overwhelming success.

   This year, we've moved this report from the "back end" of the report to the first few pages. It now comes after our statistical overview, and before the breakdown of individual deaths.

2. **Natural Deaths** are technically fall outside of the jurisdiction of the coroner. However, any death wherein the manner is uncertain must be reported. As a result, a number of accepted cases are autopsied and determined to be natural.

   We've received a lot of feedback requesting more insight into natural deaths. Often, the question is something like, "how does this category (cardiac disease, for example) in Washington County compare to the national average?" A fair comparison can't be made—the overwhelming majority of natural deaths do not need to be reported to the coroner, and are instead handled by the physician caring for the deceased.

   Regardless, we've made our reporting of natural deaths more detailed. Keep in mind, this is a sample of a sample: generally, deaths which couldn't be readily explained, but warranted investigation; ultimately returning "natural."

Retrospective

2022 saw several changes for the Coroner's Office.

Welcome Back

We welcome Olivia Mahla back to Washington County Coroner's Office, this time as a full-time investigator. Olivia had expressed interest in death investigation early on, spending time learning about the field while an intern at the Washington County Sheriff's Office.

She was first hired at the coroner's office when an administrative assistant position opened up; she eventually left for an opportunity as an investigator elsewhere in Pennsylvania.

She returned in October.

Disaster Preparedness

In 2021, Washington County was assigned to curate one of the Pennsylvania State Coroners Associations' disaster response trailers, formerly housed in Westmoreland County.

Washington County continues to curate the trailer, which is ready to be dispatched to the site of a mass disaster, should the need arise. Deputies from the office as well as the Coroner and Chief Deputy participate in annual drills, using 'sister' trailers.

The Association maintains 8 disaster trailers across the Commonwealth. Four are designated assistance trailers and four are refrigerated morgue trailers. The trailers are stocked with supplies and tools; ready to be deployed.

Coroner Warco serves as the vice president of PSCA's Region 5, comprised of Allegheny, Armstrong, Beaver, Butler, Greene, Fayette, Westmoreland and Washington Counties. He also serves on the PSCA's disaster preparedness committee, and this makes Washington County uniquely prepared to house one of these units.

Welcome Aboard

Wendi Wentzell, a former investigator in the West Virginia Medical Examiner system, joined the Washington County Coroner's Office in 2022 as a part-time investigator. We're pleased to have Wendi's multiyear experience complementing our team.

Wendi also serves her community as a full-time firefighter in South Strabane Township, so she's no novie emergency responder!

Best Wishes

Emma Racz: We bid farewell to investigator Emma Racz, who joined us from Cambria County. Emma has accepted a full-time investigation role at another Pennsylvania death investigation entity.

In Memoriam

The Pittsburgh Post-Gazette said in a memorial, *"(she) had a heart full of grace and compassion—her warmth and expertise was the balm that soothed grieving loved ones."*

Sadly, Susan Falvo Warco, longtime staff member and advisor to this office, died on July 29, 2021.

Susan served for 26 years, pro-bono, as Chief Deputy Coroner for Washington County. She retired from the office in 2017 but remained involved as a trusted advisor and teacher.

After her retirement, Susan became a confidante and sage mentor to the current Chief Deputy. Her presence and wisdom are terribly missed.

Susan married Tim Warco in 1970; Tim would become Coroner in 1992. Together they raised three children and managed a private business. Susan was devoted to her three cherished grandchildren.

Professionally, Susan was a nurse who then became one of the first licensed female funeral directors in Washington County. She also had a keen eye not only for fashion, but also for spelling and grammar (which came in handy at the coroner's office!)

This loss was immeasurable to the those here who were lucky enough to know her.

Guidelines

WHAT CONSTITUTES A CORONER'S CASE?

Many are surprised to learn the coroner does not respond to each and every death which occurs in the county.

Not only would this be impossible, but the Coroner's powers are both defined **and limited** by law.

In a nutshell, the coroner is charged with investigating a death falling under his jurisdiction until he or she is satisfied that the death is natural.

Deaths which fall outside the coroner's jurisdiction include the vast majority "natural" deaths. For example, a death of a person with existing natural disease does not have to be reported to the coroner unless it meets another statutory criterion.

For example, a death due to Ebola is natural, but as the result of a disease which constitutes a public health concern, must be reported.

On the other side of the coin, a death occurring at a nursing home or hospital, where a patient is under the care of a doctor, does not have to be reported unless it is in some way traumatic, or some sort of trauma hastened ("contributed to") the death.

The next section defines, through the law, the criteria of a coroner's case.

Generally, most of the following must be reported to the coroner for an investigation:

- Deaths which are the result of, or hastened by any trauma or injury, regardless of the time frame of the injury. (A debilitating injury sustained 20 years ago would still have to be reported if it contributed to a death!)
- Any death suspected to or occurring from chemical means: radiation, overdose, poisoning.
- Any death suspected to be or occurring from an outside force, condition, or hazard (an **accident**).
- Any death occurring in the workplace
- Any death appearing to be a homicide.
- Any death appearing to be a suicide.
- Any death not under the attendance of a physician (deaths at home.)

When the coroner is contacted about a death, our staff applies the principles of law to determine the nature of the investigation.

There are cases both where an autopsy is warranted, and where one is not. Balancing the law with the needs and desires of the family members while putting the interests of the deceased first is a delicate task, and one which is not taken lightly.

The guidelines followed by this office are set forth in P.S. 16, Article 12 (the Coroner's Act, part of the County Code), which follows.

A. The Coroner (or his designee), having view of the body, shall investigate the facts and circumstances concerning deaths WHICH APPEAR TO HAVE OCCURRED WITHIN THE COUNTY, REGARDLESS WHERE THE CAUSE THEREOF MAY HAVE OCCURRED, for the purpose of determining whether or not an autopsy should be conducted or an inquest thereof should be had in the following cases:

(1) Sudden death not caused by readily recognizable disease, or wherein a physician on the basis of prior medical attendance cannot properly certify the cause of death.

(a) SUDDEN DEATH DEFINED: The Coroner shall regard any death as sudden if it occurs without prior medical attendance by a person who may lawfully execute a certificate of death in this Commonwealth, or if, within twenty-four hours of death, the decedent was discharged from such medical attendance or a change of such medical attendance had occurred, or if any such medical attendance began within twenty-four hours of death and the medical attendant refuses or is unable to certify the cause of death.

Medical attendance includes hospitalization. (The provisions stated above regarding sudden death shall not be construed to affect the Coroner's discretion as to whether or not any death was suspicious, nor shall they be construed to *authorize* a Coroner to investigate a sudden death any further than necessary to determine cause and manner of death).

(2) Death occurring under suspicious circumstances including those where alcohol, drugs or other toxic substances may have a direct bearing on the death.

(3) Death occurring as a result of violence or trauma, whether apparently homicidal, suicidal or accidental (including but not limited to, those due to mechanical, thermal, chemical, electrical or radiation injury, drowning, cave-ins and subsidence).

(4) Any death in which trauma (falls or fractures), chemical injury, asphyxia, exposure, fire related, drug overdose or reaction to drugs or medical treatment was a **PRIMARY** or **SECONDARY**, **DIRECT** or **INDIRECT**, **CONTRIBUTORY**, **AGGRAVATING** or **PRECIPITATING** cause of death.

(5) Operative and peri-operative death in which the death is not readily explainable on the basis of prior disease.

(6) Any death wherein the body is unidentified or unclaimed.

(7) Deaths known or suspected as due to contagious disease and constituting a public health hazard.

(8) Deaths occurring in a prison or penal institution or while in the custody of the police.

(10) Any sudden, infant death. (11) Stillbirth.

(12) ALL emergency room**,** residence, personal care home and assisted living deaths. (including **ALL** hospice).

B. The purpose of an investigation shall be to determine the cause of any such death and to determine whether or not there is sufficient reason for the Coroner to believe that any such death may have resulted from criminal acts or criminal neglect of persons other than the deceased.

C. UNCLAIMED BODY – Hospitals, nursing homes and personal care homes are required to contact the Humanity Gifts Registry as soon as they realize they have an unclaimed body, but not longer than 36 hours after the death. The County will not accept an unclaimed body because the healthcare or personal care facility failed to notify Humanity Gifts Registry on time and failure to do so makes that facility responsible for all arrangements for the disposition of the remains.

The County reserves the right to levy a recovery fee against parties identified as responsible for a body when, in the coroner's opinion, reasonable efforts to secure arrangements for disposition have not been made.

D. In all cases where the Coroner has jurisdiction to investigate the facts and circumstances of a death, **THE BODY AND ITS SURROUNDINGS SHALL REMAIN UNTOUCHED** until the Coroner or his designee has had a view thereof or until he shall otherwise direct or authorize (Section 120, County Code, Amended 11/29/90, P.L. 602, No. 152) and the laws of the Commonwealth provide that the Coroner shall take custody of all personal effects which appear to have been **ON** or **ABOUT** the person at the time of death until lawfully claimed by proper persons. Care should be taken
in gathering of these effects in order to facilitate identification of the deceased and further any police investigation that may be in progress.

If there is any doubt as to whether the case should be referred to the coroner, contact the coroner to review the circumstances of death.

To report a death, call:

724-228-6785
Monday-Friday 9:00AM – 4:30PM

724-229-4600
Washington County 911 (for after-hours emergency calls.) Ask to speak with the on-call coroner.

Section 1211-B: Deputies

The coroner may appoint a deputy to act in the coroner's place and may appoint staff to positions established in accordance with section 1623 as the coroner determines. A deputy shall have the same powers as the coroner.

Definitions

The following are medicolegal definitions that are meant to help explain some of the terms in this report.

Terminology

Cause of Death: Any injury or disease that initiating the chain of events which culminates in death. *Ex, Atherosclerotic Cardiovascular Disease*

Mechanism of Death: The actual physiological derangement(s) or pathophysiological process causing death. *Ex, Cardiac Arrythmia.*

Manner of Death: A classification of the way in which the events preceding deaths were a factor in the death. The manner is based on an opinion on the known facts of the circumstances surrounding the death in conjunction with forensic findings.

Manners of Death:

Accidental: The unintentional, unnatural death of one person, caused either by that person, by another, or by a hazard, conditions, or chemical means.

Homicide: The death of one person, caused by another person, with intent either implicit or explicit, including actions of grossly reckless behavior.

Natural: Deaths caused solely by the progression of natural disease. If a death is hastened by injury, it is classified other than natural.

Suicide: Death of a person caused by that person's own action, with intent either explicit or implicit, to end one's life.

Undetermined: Manner assigned when there is insufficient evidence, especially with regard to intent, to assign a specific manner.

Pending: Manner assigned while the investigation is still active and cause may not yet be available or manner cannot yet be ruled.

Culpability:
Culpability is the responsibility for a fault or wrong. Essentially, *is someone else responsible for someone's death?*

Our Staff

Mission

The mission of the Washington County Coroner's Office is to serve the County of Washington by providing a thorough, respectful, and unbiased investigation into the circumstances of death to determine the cause of death and subsequently rule on a manner of death for all individuals who come under our jurisdiction. We pledge to serve with honesty and integrity.

The world is a dangerous place not because of those who do evil; but because of those who look on and do nothing. -Albert Einstein

Administrative Staff

S. Timothy Warco, D-ABMDI
Coroner

Matthew Yancosek
Chief Deputy Coroner

Alex Pochiba
Deputy Coroner/Supervisor

Olivia Mahla
Deputy Coroner/Supervisor

Steve Toprani
Solicitor

Investigators

Rodney Bush
Aubrey Onorato
BJ McKay
Wendi Wentzell

2022 Internship Program

Hannah Frantz

Coroner's Chaplains

Pastor Gary Gibson
Pastor M. John Lynam
Rabbi David C. Novitsky

Specialized Services

Forensic Pathology

Dr. Leon Rozin, MD
Chief Forensic Pathologist

Forensic Pathology, Cont'd:

Dr. Todd Luckasevic, DO
Dr. Cyril Wecht, MD
Dr. Jennifer Hammers, MD
Dr. Courtney Healy, MD

Autopsy Technical Services

Sarah Boring
Alana Engleson
Timothy Manzewitsch
Brittany Harmon

Forensic Anthropology

Dr. Dennis Dirkmaat, PhD

Forensic Odontology

Dr. David Vaughan, DMD
Dr. Scott Learn, DMD

Medical Transcription

Jackie Karwosky
Grace Manzewitsch

Histology and Microbiology

Washington Health System

Forensic Toxicology Laboratory

National Medical Services (NMS)

More Information

The Washington County Coroner's Office has a staff made up of dedicated individuals who investigate unexpected deaths, notify and meet with families, perform examinations and certifications, compile reports and provide general administrative support.

Our staff is on-call 24 hours a day, 365 days a year to respond to unexpected, traumatic, violent and unattended deaths within the Washington County.

More information can be found on our website, https://www.co.washington.pa.us/coroner.

In 2015, Washington County had about 208,261 residents. Our deputies cover a total area of 861 square miles. The County is home to three major hospitals: Canonsburg Hospital, Monongahela Valley Hospital, and Washington Hospital.

Internship Program

Each summer, the Washington County Coroner's Office will host one intern between May and August. Students must be enrolled in an accredited 2- or 4-year post-secondary program in one of the following disciplines: Criminal Justice, Forensics, Legal, Healthcare, Medical.

The intern will learn valuable practical experience in the areas of pathology, forensics, criminal justice and local government.

Interested parties should see https://www.co.washington.pa.us/coroner and select "Career Opportunities" and finally "Internships" to learn how to apply.

We regret that we cannot accept job shadow or student observers who are under the age of 18, still in high school, or those who are not enrolled in an accredited academic program.

Partners In Education

As part of our commitment to serve the community, the Washington County Coroner's Office proudly partners with Penn Commercial Business and Technical School and the Washington Hospital School of Nursing. This partnership provides unique and necessary educational opportunities to students in related fields.

We make every effort to also provide these same opportunities to students in other schools with whom we may not have a standing agreement.

Students interested in learning more about the Coroner's Office are invited to tell us a little more about themselves via coronermac@co.washington.pa.us.

Community Activities and Outreach

The Washington County Coroner's Office is committed to community outreach with the goal of bettering our neighborhoods. Coroner Warco had given countless presentations on topics such as drug use and abuse, driving under the influence, suicide prevention and more.

The Coroner's Office has participated in "Prom Promise" and mock accident programs which show students the real-life consequences of poor decisions.

If your organization is interested in a presentation, contact us at 724-228-6785.

Media Relations

In certain cases, when it is deemed "in the public interest," the coroner must make facts known about a particular death public. This is done by the responsible release of information to members of the press. This is part of the principle of "Freedom of the press," and despite the sensitive nature of death in general, it is a constitutional guarantee.

We make every effort to remain sensitive to the family's needs and to release information in a responsible, ethical manner.

Media releases are sent via email. Media outlets interested in joining our email list should send a request to coronermac@co.washington.pa.us.

About Coroner Warco

A graduate of California University and the Pittsburgh Institute of Mortuary Science, Coroner S. Timothy Warco has held office since 1992. In that time, he has conducted and supervised the investigation of over 40,000 deaths.

Tim now holds over 1,200 hours of continuing education in areas such as mass fatalities, ballistics, blood patterns and staining, forensic anthropology, forensic odontology, forensic photography, practical homicide investigation and countless other disciplines.

Coroner Warco is currently a diplomate of the ABMDI (American Board of Medicolegal Death Investigators), a certification which shows advanced knowledge of death investigation standards.

Our Facilities

Administrative Facility

In April of 2021, the Washington County Coroner's Office relocated to a thoroughly modern, more spacious workspace located at the County's Crossroads Center building; 95 West Beau Street, Suite 110, Washington Pennsylvania.

Our new space features a meeting room and separate offices for investigators where difficult discussions may be held with families in a quiet, reverent space.

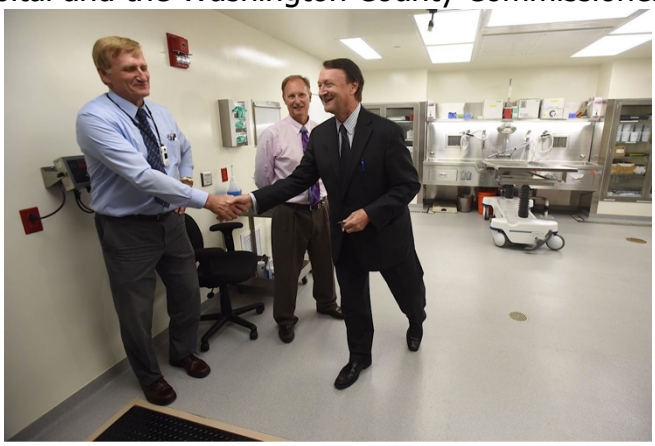
It also features a dedicated reception and waiting area, a true storage space, and meeting space for team meetings and trainings. With this new workspace, we will be better able to serve the families of Washington County.

Each investigation generates a great deal of paperwork. Within this office we complete the great majority of that paperwork, including final reports and death certificates. We also investigate requests for cremations, work with funeral directors and meet with families.

Office hours are Monday through Friday, 9:00AM to 4:30PM. Due to the nature of our work, visitors should make an appointment before arriving to the office. Call 724-228-6785.

Forensic Facility

In 2015, Coroner Warco, the staff of Washington Hospital and the Washington County Commissioners dedicated a brand-new, forensic facility including a walk-in cooler and a state-of-the-art autopsy suite.



This facility replaced a cramped, aging morgue with outdated equipment and an old-fashioned drawer style cooler.

The opening of this facility was several years in the making, and it wouldn't have come together without the cooperation between Washington Health System, the County Commissioners and the Coroner, the County purchasing department and several vendors.

Professional Memberships and Standards Organizations

Pennsylvania State Coroner's Association

Coroner S. Timothy Warco is currently an executive board member of the PSCA, serving as vice president representing Region 5 (Allegheny, Armstrong, Beaver, Butler, Fayette, Greene, Washington and Westmoreland counties.) The PSCA represents all 67 counties of the Commonwealth who, in the spirit of cooperation, work together to address the issues facing Pennsylvania's medicolegal death investigators. The PSCA support training opportunities as well as awareness and preparedness initiatives from which every county in Pennsylvania may benefit.

International Association of Coroners and Medical Examiners

The Washington County Coroner's Office has been accredited since 2017.

The International Association of Coroners and Medical Examiners has over 70 years of experience in the presentation of educational seminars for the purpose of assisting coroners and medical examiners in the performance of their duties.

In addition, the IACME is a professional standards organization which sets forth a series of industry standards relating to operational efficiency, standard procedure and operating with honesty, integrity and compassion. Accreditation involved a thorough review of policies, procedures, documentation practices as well as a facility inspection.

Coroner Tim Warco is a member of the IACME. The operation of the Washington County Coroner's Office has been accredited by the IACME since 2016.

American Board of Medicolegal Death Investigators

Coroner Warco has been a diplomate of the ABMDI since 2015.

Coroner Tim Warco is a registered medicolegal death investigator with the American Board of Medicolegal Death Investigators, carrying the title D-ABMDI.

The ABMDI is a voluntary, national, not-for-profit professional standards board created to promote the highest standards of practice. AMDI only certifies individuals who have the proven knowledge and skills necessary to perform medicolegal death investigations as set forth in the National Institutes of Justice's 1999 working guide.

Society of Medicolegal Death Investigators

Coroner Warco has been a member since 2016.

The SOMDI works to promote training, educational and networking opportunities for medicolegal death investigators. Their mission is to advocate for excellence in the field, the highest standards of ethical conduct and professional development and to work toward establishing best practices for death investigation.

General Statistics

Population Served, 2015 Estimate:	**208,261**
Area Served, Mi^2	**861**

Total cases reported to the Coroner's Office	**2918**
Investigated and Released	1245
Cremation Authorizations	1399
Total Autopsies	274
Inquests	0
Abandoned or Unclaimed	21
County Dispositions	16
Unidentified Persons	0
Organ Donations	6
Autopsies by Type	
Natural Deaths	96
Investigated/PND	16
Accidental Deaths	116
Suicides	38
Homicides	10
Stillborns	0
Sudden Unexplained Infant Deaths	4
Cannot Be Determined	14
Pending	0

Investigations by Month

January	21	July	24
February	32	August	23
March	25	September	34
April	15	October	31
May	27	November	18
June	18	December	16

City, Township, Boro(ugh)	Total	Natural	Suicide	Homicide	Accident	Undetermined
Allenport	1	0	0	0	1	0
Amwell Township	2	2	0	0	0	0
Bentleyville	5	3	0	0	2	0
Blaine Township	1	0	1	0	0	0
Burgettstown	1	0	1	0	0	0
California	4	0	1	0	3	0
Canonsburg	11	6	2	0	3	0
Canonsburg Hospital	8	1	0	1	6	0
Canton Township	9	3	4	0	2	0
Carroll Township	3	1	1	0	1	0
Cecil Township	9	1	2	0	6	0
Charleroi	8	2	2	0	3	1
Chartiers Township	6	3	1	0	2	0
Children's Hospital*	1	0	0	1	0	0
Coal Center	3	0	0	0	3	0
Cokeburg	1	1	0	0	0	0
Cross Creek Township	1	0	0	0	1	0
Deemston Boro	1	0	1	0	0	0
Donegal Township	1	1	0	0	0	0
Donnell House	1	1	0	0	0	0
Donora	5	2	0	0	3	0
East Bethlehem Township	1	1	0	0	0	0
East Finley Township	1	0	1	0	0	0
East Washington Borough	3	2	0	0	1	0
Eighty Four	1	0	0	0	1	0
Elco Borough	1	0	0	0	0	1
Ellsworth	4	2	0	0	2	0
Fallowfield Township	6	1	1	0	4	0
Finleyville	3	1	0	1	1	0
Fredericktown	1	0	0	0	1	0
Jefferson Township	1	0	1	0	0	0
Marianna	1	0	1	0	0	0
McDonald	3	0	1	1	1	0
McMurray	1	1	0	0	0	0
Monongahela	8	4	2	0	1	1
Monongahela (MVH)	31	12	0	2	13	4
Mt. Pleasant Township	2	0	0	1	0	1
New Eagle	3	1	0	0	2	0
North Franklin Township	1	1	0	0	0	0
North Strabane Township	9	2	2	0	5	0
Peters Township	8	3	0	0	5	0
Robinson Township	4	1	1	0	1	1
Smith Township	7	3	0	0	3	1
South Franklin Township	2	0	0	0	2	0
South Strabane Township	10	2	4	0	3	1
Union Township	4	0	1	0	3	0
Washington	35	11	4	0	18	2
Washington (WHS)	37	21	1	3	11	1
Weirton WV*	1	0	0	0	1	0
West Bethelehem Township	1	0	1	0	0	0
West Finley Township	2	0	1	0	1	0

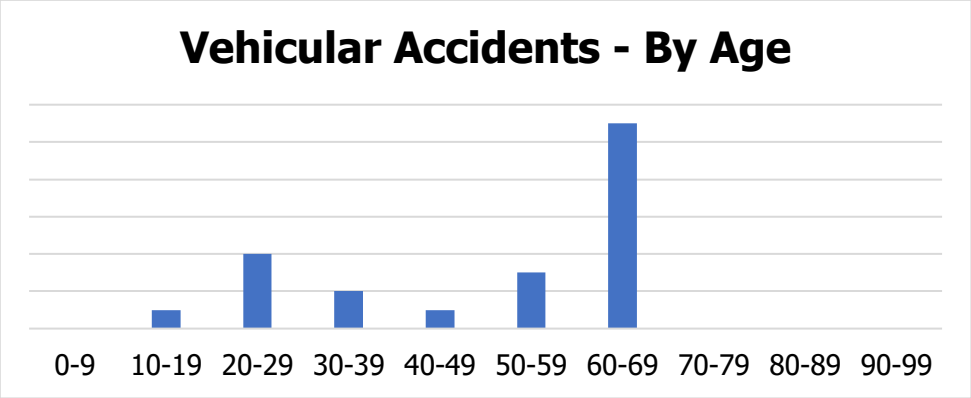
Violent, Traumatic and Accidental Deaths

Vehicular or Highway Fatalities

Motor Vehicle Fatalities	**12**
Male	9
Female	3

Age Breakdown

0-9	0
10-19	1
20-29	4
30-39	2
40-49	1
50-59	3
60-69	1
70-79	0
80-89	0
90-99	0

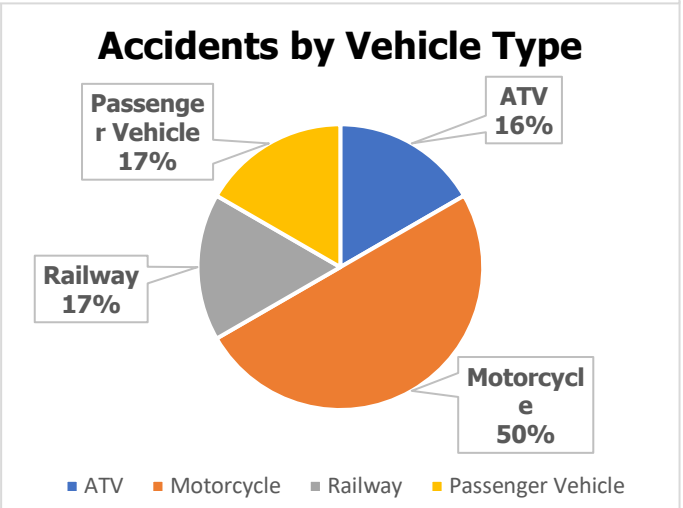


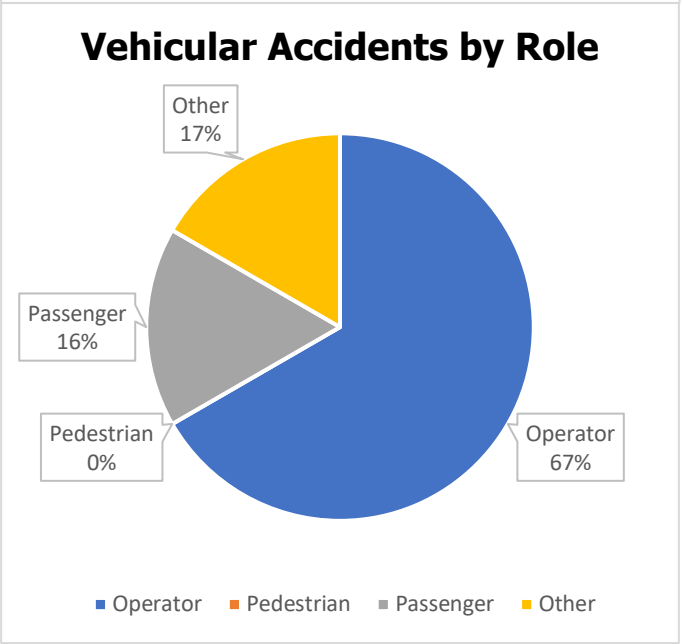
Car/Vehicle Accidents	**6**
Operator	4
Passenger	2
Pedestrian	0

ATV/Quad Accidents	**1**
Operator	1
Passenger	0
Pedestrian	0

Motorcycle Accidents	**3**
Operator	3
Passenger	0
Pedestrian	0

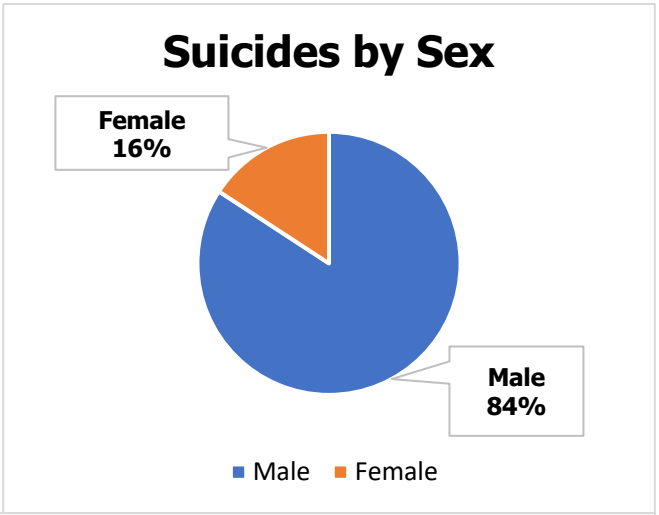
Other Motor Vehicle Fatalities	**2**
Vehicle Striking Owner – Private Property	1
Railway – Train vs. Vehicle	1

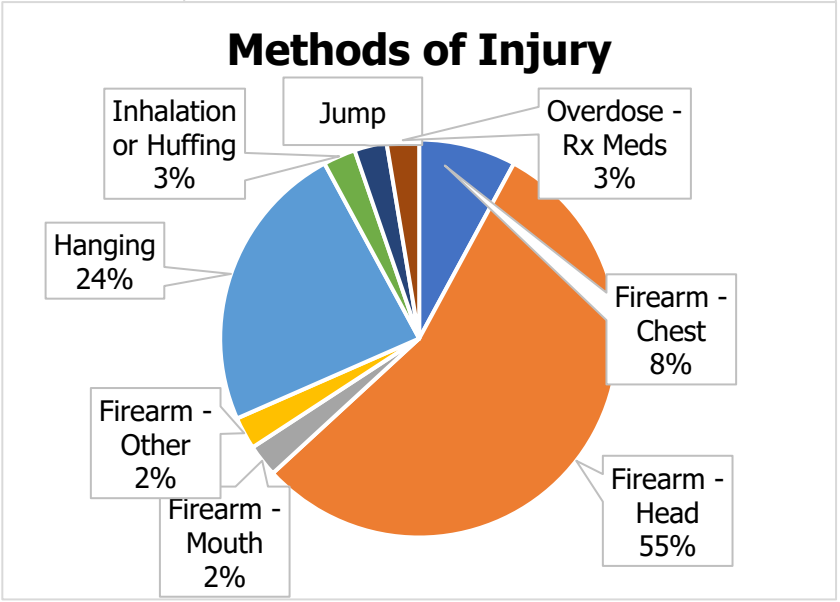


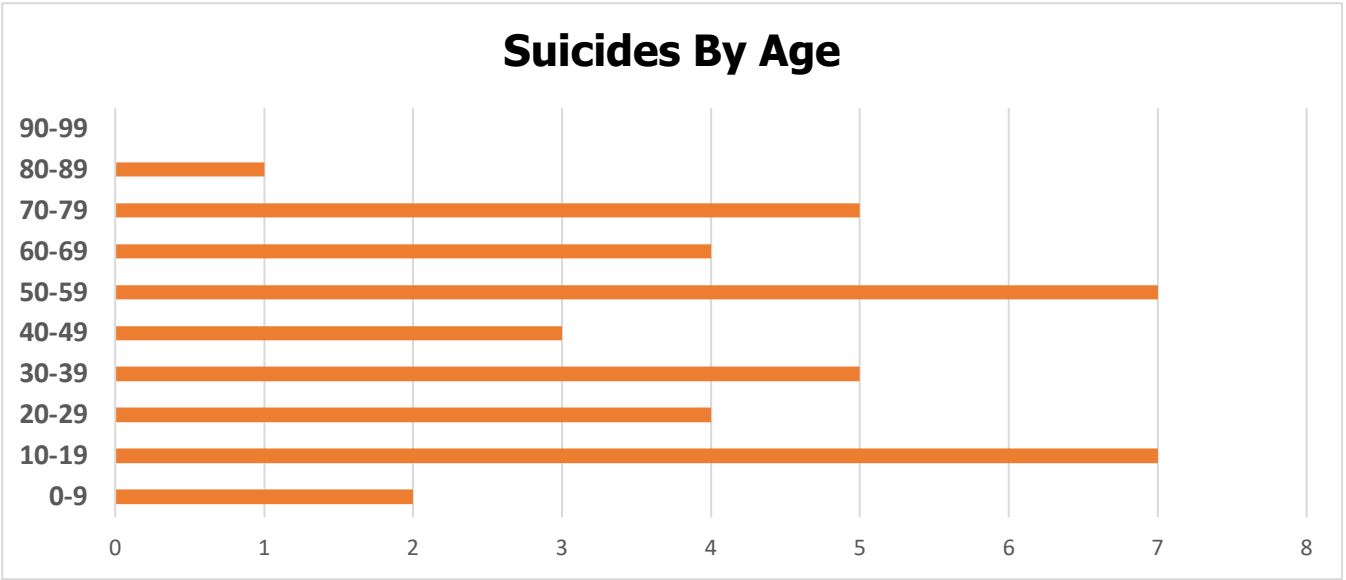


Deaths by Suicide

Suicides	**38**
Male	32
Female	6
Firearm Wound – Chest	3
Firearm Wound – Head	21
Firearm Wound – Mouth	1
Firearm Wound – Other	1
Hanging	9
Inhalation/Huffing	1
Jump – From Structure	1
Overdose – Prescription Meds	1
Age Breakdown	
0-9	
10-19	2
20-29	7
30-39	4
40-49	5
50-59	3
60-69	7
70-79	4
80-89	5
90-99	1
100+	0





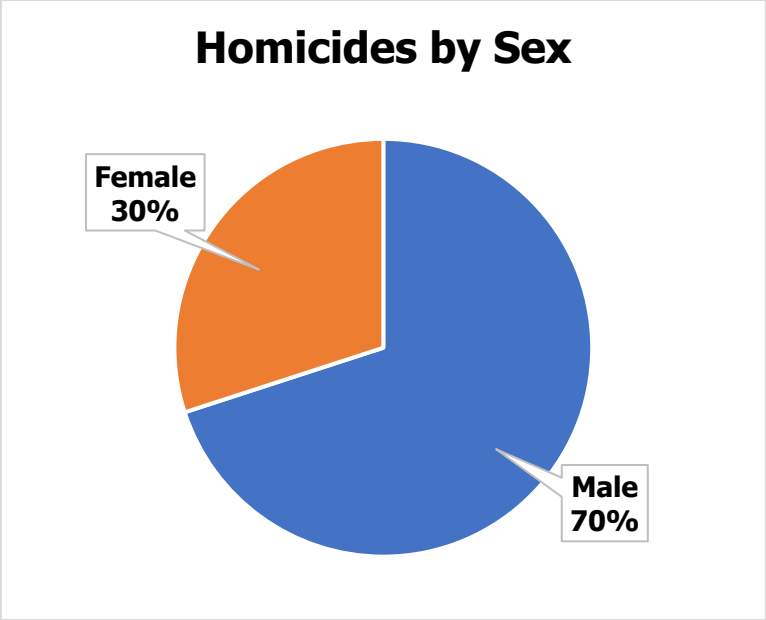


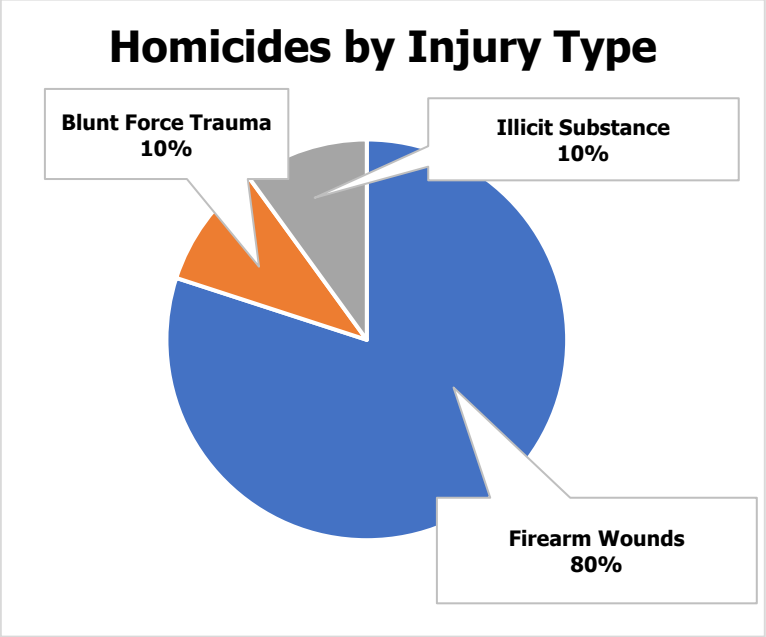
Deaths by Homicide

Homicides	**10**
Males	7
Females	3

Homicides	**10**
Firearm Wound – Abdomen/Trunk	1
Firearm Wound – Chest	3
Firearm Wound – Head	1
Firearm Wounds – Multiple	2
Gun Shot Wound (Other)	1
Blunt Force Trauma	1
Illicit Substance (Negligence)	1

Age Breakdown	
0-9	2
10-19	1
20-29	3
30-39	1
40-49	2
50-59	1
60-69	0
70-79	0
80-89	0
90-99	0
100+	0





Other Traumatic Deaths

"Other Traumatic Deaths" list deaths that don't fit in the previously reported on categories of suicide, homicide, or motor-vehicle related incidents.

Other Accidental Deaths	**12**
Total Males	7
Total Females	4
Fall (Accidental Fall)	4
Asphyxiation – Choking/Obstruction	1
Asphyxiation – Auto-erotic	1
Hypothermia (Cold Exposure)	4
Undetermined	2

Note: *Peri-surgical or therapeutic misadventures is a classification for deaths which resulted from, or were hastened by, a medical procedure. They may have occurred before or during a procedure, as a complication of the procedure itself, or in a recovery period (including once discharged).*

Natural Deaths

Natural Death Classification	**96**
Natural - Brain Aneurysm/Hemorrhage	2
Natural - Cancer	2
Natural - Cardiac	38
Natural - Cardiopulmonary or Embolism	1
Natural - COVID19 Sequelae	2
Natural - Degenerative Neurological	1
Natural - Metabolic/Diabetic	2
Natural - Obesity Sequelae	1
Natural - Presumed (No Autopsy)	26
Natural - Referred to PCP for Certification	6
Natural - Renal/Hepatic	7
Natural - Respiratory	5
Natural - Sepsis/Infection	3

Natural Deaths By Age			
Under 1 Year	1	50-59	14
0-9	0	60-69	27
10-19	0	70-79	18
20-29	6	80-89	9
30-39	4	90-99	2
40-49	15	100+	0

Overdoses

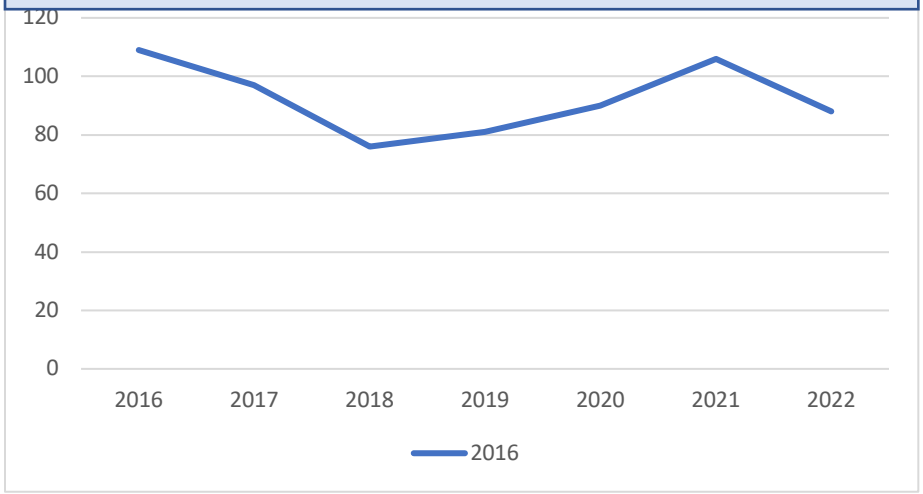
General Statistics

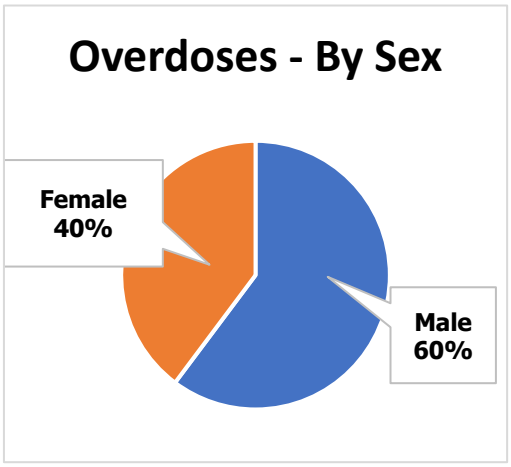
Deaths by Drug Overdose **88**

Data In Perspective

Our "record year" for overdose-related deaths was 2016 (109 deaths.)

2016	2017	2018	2019	2020	2021	2022
109	97	76	81	90	106	88



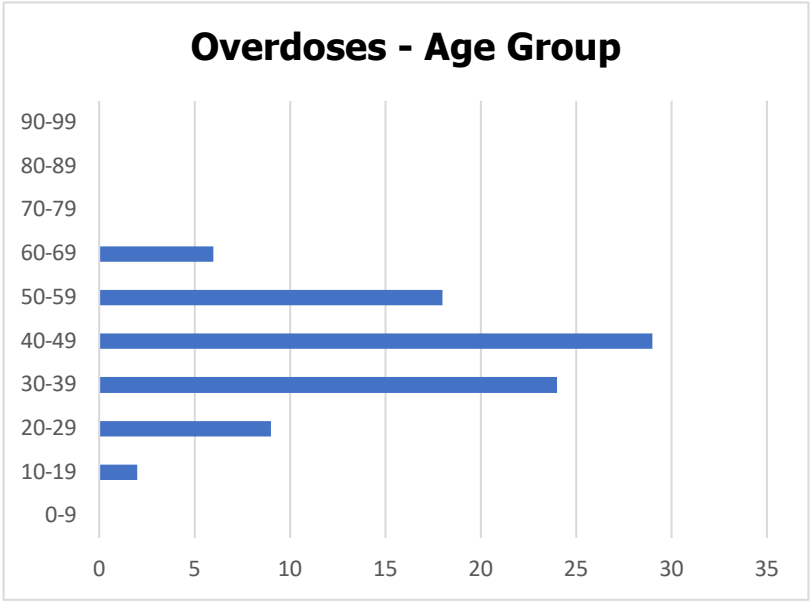


Overdoses by Sex

Male	53
Female	35

Age Breakdown

1-9	0
10-19	2
20-29	9
30-39	24
40-49	29
50-59	18
60-69	6
70-79	0
80-89	0
90-99	0



Statistical Analysis of Compounds

While it is still somewhat common to see an overdose by a single drug, increasingly, overdoses are the result of **polysubstance use**, or the use of two or more drugs in a given time period.

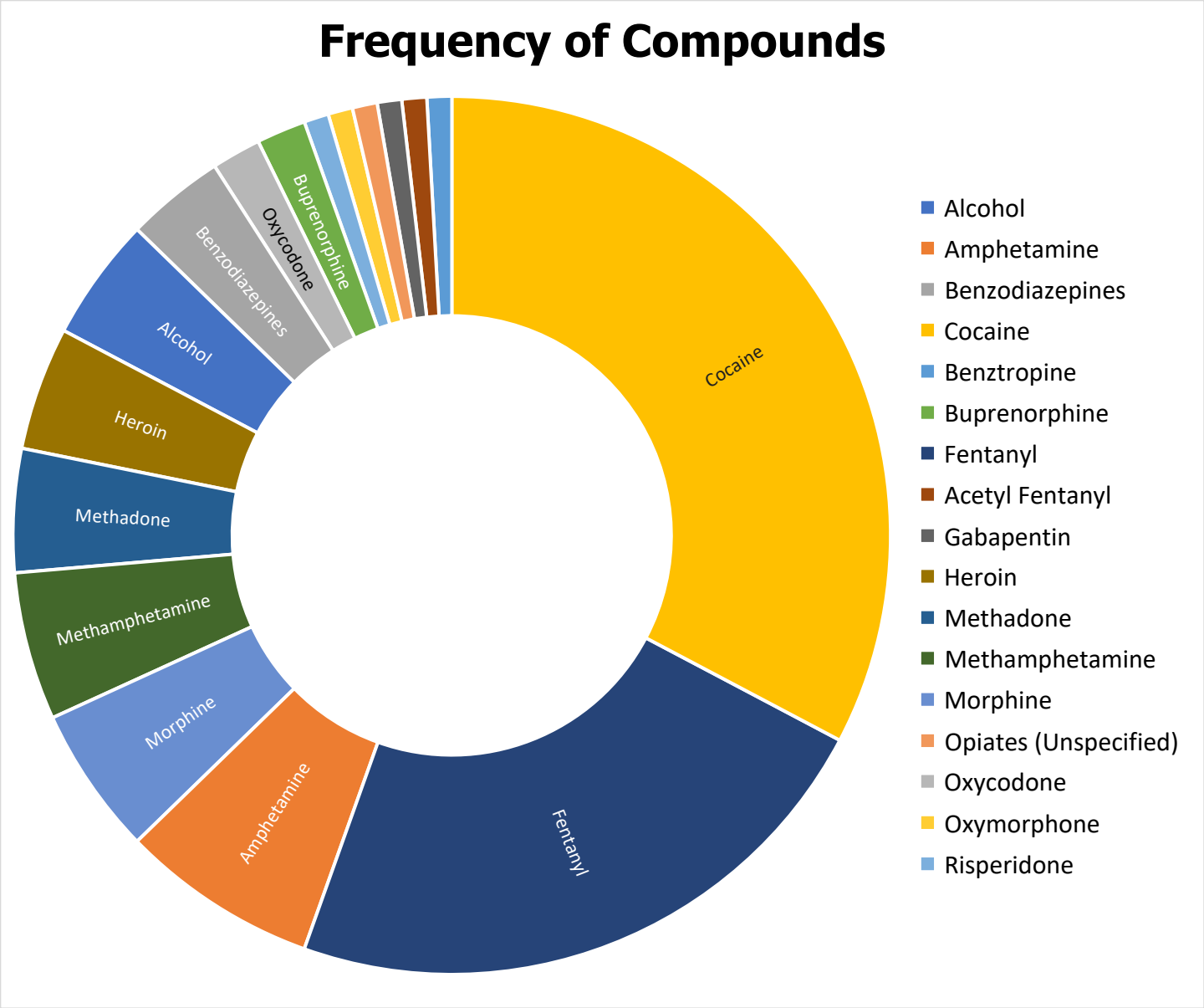
Why? Some drugs are intentionally "cut" or adulterated with other substances. For example, we often see cocaine and fentanyl or fentanyl and heroin sold together. This can increase the perceived potency of what's been purchased. It also increases the lethality.

On the unintentional front, some users don't know or consider the dangers of using multiple substances. For example, alcohol, prescription pain killers, and prescription anti-anxiety medications all depress the central nervous system. When taken together, and in sufficient quantity, they can rapidly cause respiratory depression.

Our goal with this section is to give some insight into:

- The various drugs seen in overdoses
- The compounds found in single-compound overdoses
- The compounds found together in polysubstance-related overdoses

Compounds Found In Overdose



This compound appeared in...	% of Deaths
Alcohol	6%
Amphetamine	9%
Benzodiazepines	5%
Cocaine	41%
Benztropine	1%
Buprenorphine	2%
Fentanyl	28%
Acetyl Fentanyl	1%

This Compound appeared in	% of Deaths
Gabapentin	1%
Heroin	6%
Methadone	6%
Methamphetamine	7%
Morphine	7%
Opiates (Unspecified)	1%
Oxycodone	2%
Oxymorphone	1%
Risperidone	1%

One Drug	**32**
Fentanyl	27
Alcohol	2
Methadone	3

Two Drugs	**34**
Acetyl Fentanyl, Fentanyl	1
Amphetamine, Fentanyl	1
Buprenorphine, Cocaine	1
Cocaine, Fentanyl	21
Ethanol, Fentanyl	2
Fentanyl, Heroin	2
Fentanyl, Methadone	1
Fentanyl, Methamphetamine	2
Fentanyl, Morphine	2
Fentanyl, Oxycodone	1

Three Drugs	**14**
Amphetamine, Fentanyl, Methamphetamine	2
Amphetamine, Cocaine, Fentanyl	1
Benzoylecgonine, Ethanol, Oxymorphone	1
Buprenorphine, Cocaine, Fentanyl	1
Buprenorphine, Cocaine, Norbuprenorphine	2
Cocaine, Fentanyl, Heroin	3
Cocaine, Fentanyl, Morphine	3
Fentanyl, Methadone, Methamphetamine	1

Four Drugs	**5**
Amphetamine, Benzoylecgonine, Fentanyl, Methamphetamine	1
Amphetamine, Cocaine, Fentanyl, Methamphetamine	1
Buprenorphine, Diazepam, Oxazepam, Temazepam	1
Cocaine, Fentanyl, Midazolam, Norfentanyl	1
Fentanyl, Hydromorphone, Methadone, Morphine	1

Five Or More Drugs	**2**
Benztropine, Buprenorphine, Carbamazepine, Gabapentin, Risperidone	1
Buspirone, Cylcobenzaprine, Fluoxetine, Hydroxyzine, Lamotrigine,Oxycodone, Quetiapine	1

Unspecified Drugs of Opiate Class	1

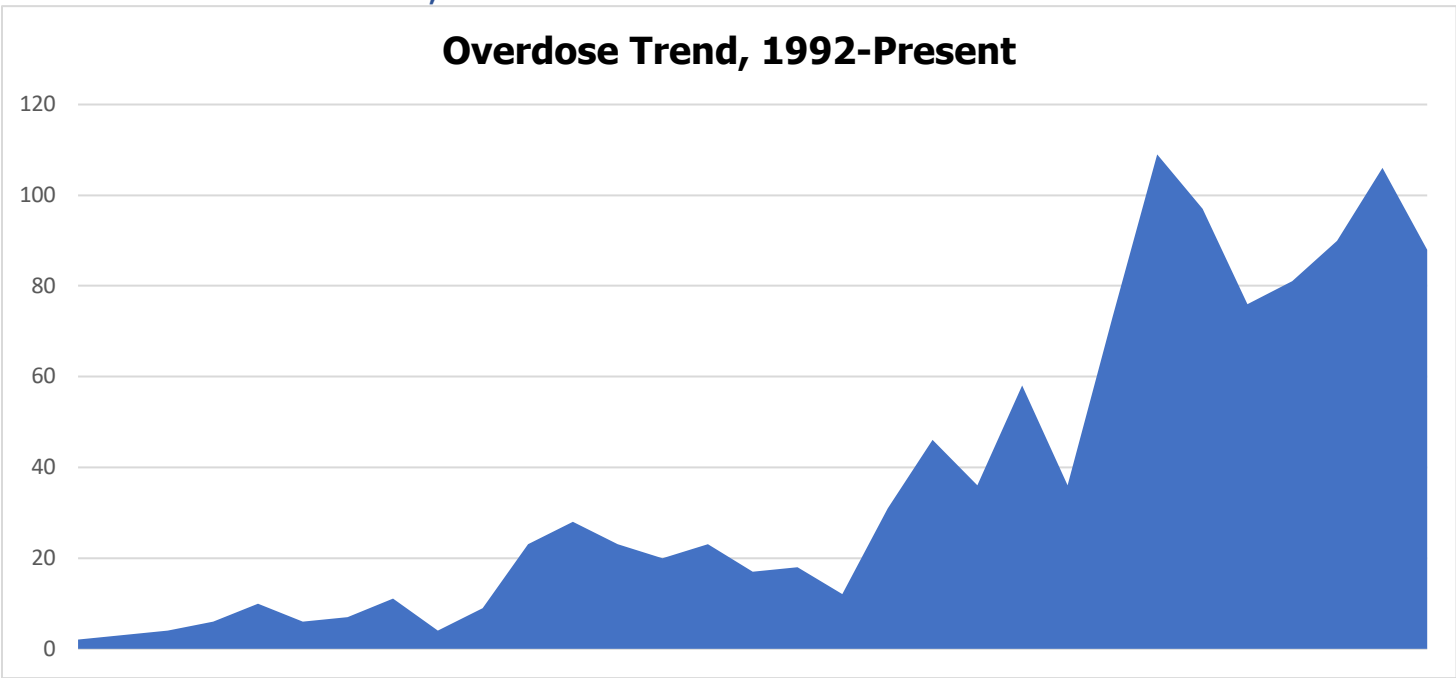
Investigating Authorities

The following are the law-enforcement and (county-authority) organizations with whom the Coroner's Office worked to investigate these cases. Clinical indicates a death which occurred under a clinical setting and may not necessarily have police involvement.

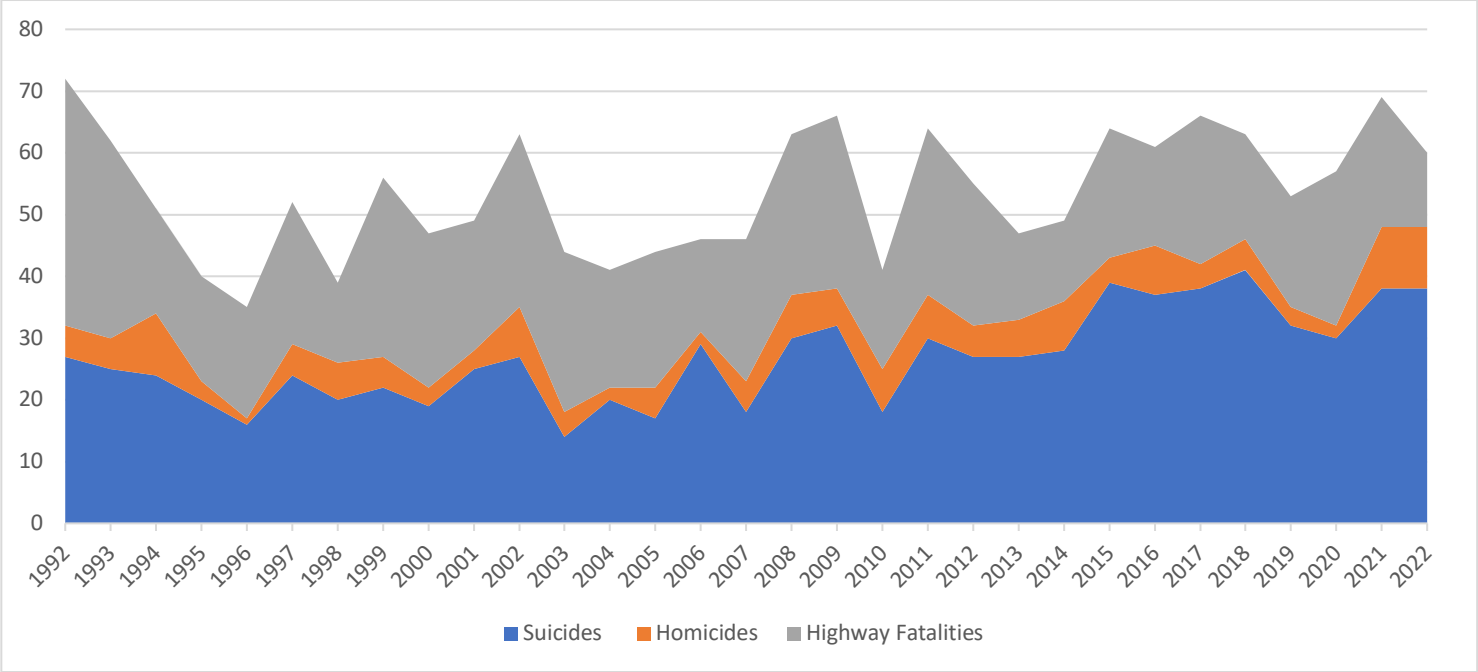
Investigating Authorities	
Adult Protective Services	0
Allegheny County Detectives	0
Bentleyville Boro Police	5
California Borough Police	4
Canonsburg Police	13
Carroll Township Police	3
Cecil Township Police	8
Centerville Boro Police	2
Charleroi Regional Police	10
Chartiers Township Police	7
Donegal Township Police	1
Donora Police	7
East Bethlehem Township Police	0
East Washington Boro Police	3
McDonald Police	5
Monessen Police	3
Monongahela City Police	19
Mt. Pleasant Township Police	2
North Franklin Township Police	0
North Strabane Township Police	15
Pennsylvania State Police	59
Peters Township Police	9
RESA Regional Police	1
Rostraver Police	3
Smith Township Police	8
South Strabane Township Police	12
Washington City Police	38
West Brownsville Police	0
Clinical	36

Trends Over Tenure:

Overdose Death Trend, 1992-Present



Other Traumatic Death Trend, 1992-Present



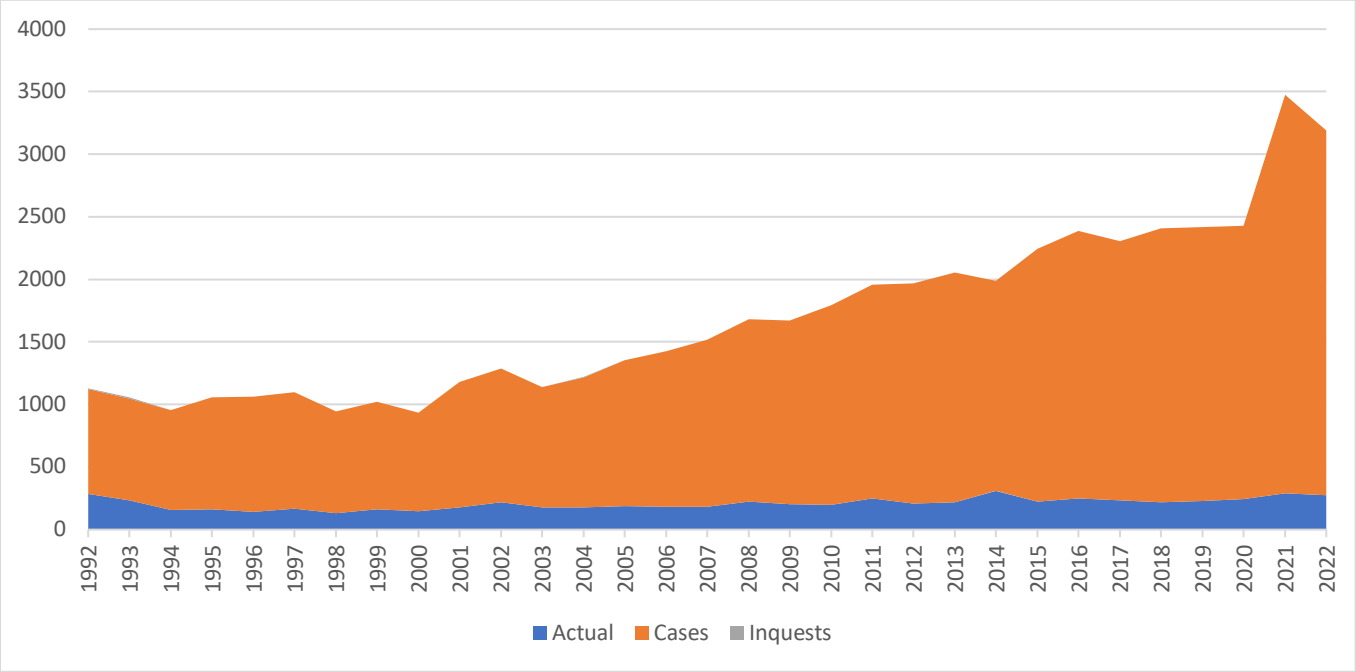
YEAR	SUICIDES	HOMICIDES	HIGHWAY FATALITIES	DRUGS
1992	27	5	40	2
1993	25	5	32	3
1994	24	10	17	4
1995	20	3	17	6
1996	16	1	18	10
1997	24	5	23	6
1998	20	6	13	7
1999	22	5	29	11
2000	19	3	25	4
2001	25	3	21	9
2002	27	8	28	23
2003	14	4	26	28
2004	20	2	19	23
2005	17	5	22	20
2006	29	2	15	23
2007	18	5	23	17
2008	30	7	26	18
2009	32	6	28	12
2010	18	7	16	31
2011	30	7	27	46
2012	27	5	23	36
2013	27	6	14	58
2014	28	8	13	36
2015	39	4	21	73
2016	37	8	16	109
2017	38	4	24	97
2018	41	5	17	76
2019	32	3	16	81
2020	34	4	25	102
2021	38	10	21	106
2022	38	10	12	88
TOTAL	**832**	**164**	**669**	**1,153**

Cases Investigated During the Tenure of S. Timothy Warco

YEAR	CORONER'S CASES	DEATHS INVESTIGATED	INQUESTS	AUTOPSIES
1992	285	841	3	61
1993	232	816	7	64
1994	159	794	1	84
1995	163	892	1	100
1996	140	922	0	90
1997	166	933	1	97
1998	131	814	1	71
1999	162	860	0	96
2000	145	788	0	90
2001	177	1004	0	106
2002	216	1071	0	91
2003	180	958	0	92
2004	180	1038	1	117
2005	189	1164	0	114
2006	182	1245	0	108
2007	183	1333	0	109
2008	224	1455	0	136
2009	204	1466	0	120
2010	197	1597	1	111
2011	249	1708	2	150
2012	207	1762	1	135
2013	218	1835	0	157
2014	309	1678	0	160
2015	225	2018	0	216
2016	250	2137	0	246
2017	236	2068	0	221
2018	220	2188	1	181
2019	227	2191	0	207
2020	245	2184	0	226
2021	291	3184	0	262
2022	274	2918	0	242
Total	**6,192**	**42,944**	**20**	**3,957**

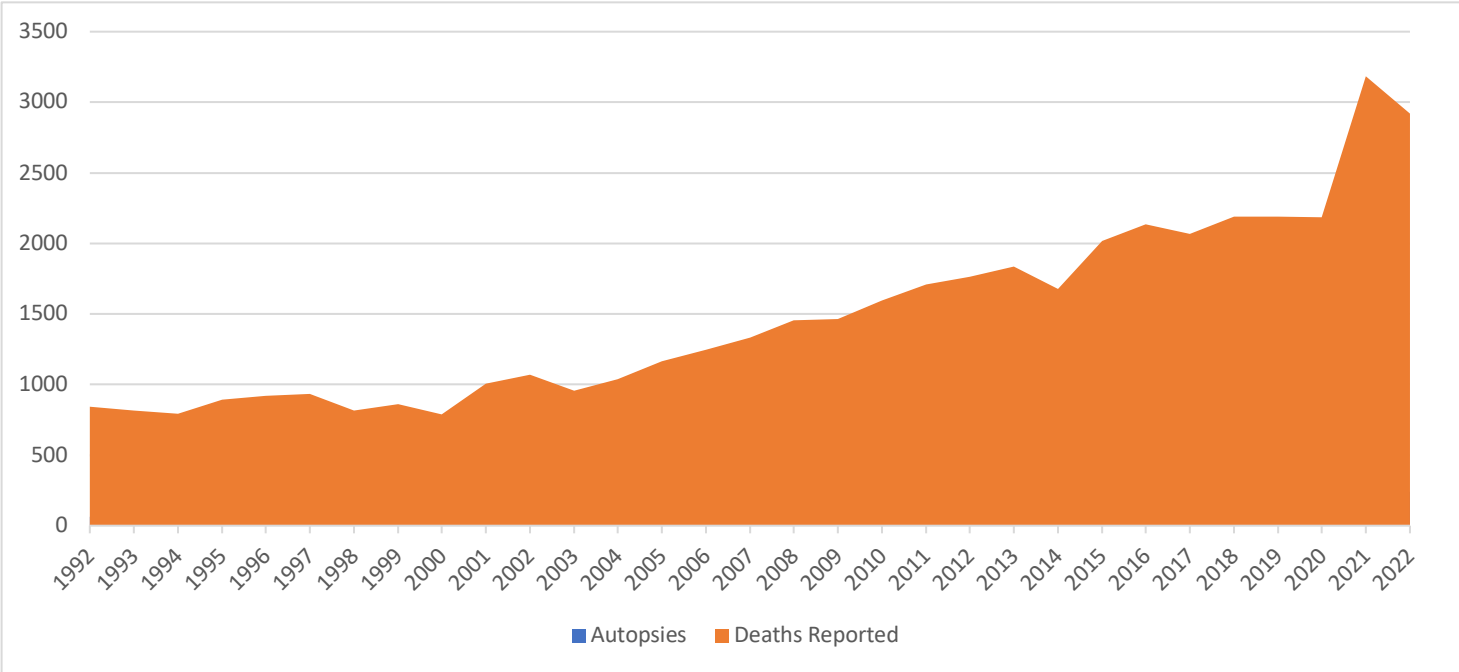
Cases Investigated; 1992-Present

Trend of the types of cases reported to the Coroner's Office over Coroner Warco's 29-year tenure. The majority of deaths reported to us are investigated and determined to be natural. The remainder become coroner's cases due to circumstance; an autopsy is not necessarily ordered, depending on that circumstance.



Cases Autopsied; 1992-Present

Extracted from the above graph to give an exploded view of the overall increase in cases in which an autopsy was indicated over Coroner Warco's 29-year tenure.



Abandoned/Unclaimed Bodies

Washington County has seen a sharp increase in the number of abandoned/unclaimed bodies reported to the office. An abandoned or unclaimed body is defined by one or more of these circumstances:

- No family members are known to survive,
- The legal next of kin cannot be located after a thorough search,
- A family member refuses to provide for the final disposition of the deceased, whether for financial or any other reasons (abandonment.)

First, we attempt to locate family through a limited number of resources. Contrary to popular belief, there is no database which exists that we can search for a given person's next of kin. We try to find leads where we can: "little black books," birthday and holiday cards. We speak to neighbors and friends, we research obituaries, we try genealogy websites and Google. We place notices in the newspaper and on Facebook.

Often, we successfully locate at least one family member. Often, especially when the decedent is estranged from their family, those family members are unwilling to accept the responsibility of final arrangements. And sometimes, it's financially out of the question.

If we cannot reunite a decedent with their family, we next attempt to arrange for a whole-body donation. The suitability of a person for donation depends on many things: how long they've been deceased and the conditions they were found in; their medical history, existence of communicable disease. Often, a living medical historian (usually a family member) is necessary to speak with the donor agency, so without this cooperation, donation is difficult.

We can hold an individual for a maximum of 15 days while attempting to locate family, or while family tries to get arrangements in place.

If family cannot be located, or relinquishes their rights to the decedent, the decedent is then cremated under the statutory authority of the Coroner. When the deceased is a veteran with honorable-discharge status, we work with local funeral directors to have them respectfully laid to rest at the National Cemetery of the Alleghenies.

In 2017, the County Commissioners approved the Coroner's purchase of a crypt at Washington Cemetery, where we lay the Forgotten Souls of Washington County to rest. As of the end of 2021, 124 individuals had been laid to rest here.

To better track the increases, we began keeping detailed statistics in 2016. This was primarily due to the new and unusual burden they place on the resources of the Coroner's office and of the County.

The typical cost of responding to an abandoned or unclaimed body (which would not otherwise fit the statutory requisites of a coroner's case) is $875.00. If the county ultimately becomes responsible for disposition, that cost becomes $1,175. To defray the costs of the investigation, transport, storage and cremation of an abandoned body, the Coroner may seek recovery of those costs from those deemed responsible. Refer to the policy on our website.

Abandoned/Unclaimed Statistics

Year	Total Cases	Claimed by Family	County Cremations	Donations
2016	17	0	8	9
2017	21	8	10	3
2018	21	6	13	1
2019	19	4	15	0
2020	34	17	14	0
2021	**27**	**7**	**19**	**1**
2022	**37**	**21**	**16**	**0**
Totals	**112**	**42**	**79**	**14**

Unclaimed Individuals Cremated and/or Entombed by the County:

138

The mission of the Washington County Coroner's Office is to serve the County of Washington by providing a thorough, respectful and unbiased investigation into the circumstances of death to determine the cause of death and subsequently rule on a manner of death for all individuals who come under our jurisdiction. We pledge to serve with honesty and integrity.

The Washington County Coroner's Office is accredited since 2017 by the International Association of Coroners and Medical Examiners (IACME.)

Coroner Tim Warco is a diplomate of the American Board of Medicolegal Death Investigators and is a member of the International Association of Coroners and Medical Examiners, the Society of Medicolegal Death Investigators, and the Pennsylvania State Coroner's Association.

Natural deaths or presumed natural deaths describe a case where advanced age or natural disease processes are documented or determined to be the cause of death at autopsy.

Most drug deaths within Washington County are ruled generally ruled "Accidental." As such, there may be some overlap between the drug deaths category and the accidental deaths category. When referencing these statistics, note that on page one, the total accidental deaths listed by manner will include drug deaths. In the subsequent pages, drug deaths and accidental deaths are tallied separately.

Similarly, highway fatalities are calculated with accidental deaths on page one, but are listed separate from "Violent or Accidental Deaths" in the following pages.

For the purposes of this report, "Accidental" refers only to the manner of death, and does not address causality or culpability regarding a death.