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All persons involved in death investigations, including law enforcement officials, emergency personnel, hospital personnel, nursing/personal care home personnel and funeral directors, should follow the following guidelines. The list provided is by no means exhaustive. My staff is available to assist with any questions you may have. In any death case, WHEN IN DOUBT, CALL THE CORONER.

Sincerely,
Kenneth A. Bacha, Coroner

GUIDELINES TO BE FOLLOWED IN DEATH CASES

A. The Coroner, Chief Deputy Coroner or Deputy Coroner 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.

(9) Deaths of persons whose bodies are to be cremated, buried at sea or otherwise disposed of so as to be thereafter unavailable for examination.

(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.

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, Chief Deputy Coroner or Deputy Coroner 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.

TO REPORT A CORONER’S CASE
24 HOURS A DAY – 7 DAYS A WEEK
CALL (724) 830-3636

If the deputy is out of the office, calls will automatically forward to the Department of Public Safety (911) after six rings. They will contact the appropriate person or provide instructions to do so.
Full-Time Staff

Kenneth A. Bacha
Coroner

Paul B. Cycak, Jr.
Chief Deputy Coroner

Jeffrey D. Monzo
Solicitor

John A. Ackerman
Deputy Coroner

Timothy P. O’Donnell
Deputy Coroner

Joshua C. Zappone
Deputy Coroner

Sean R. Hribal
Deputy Coroner

Kathleen M. Hobaugh
Secretary

Part-Time Staff

Doug Lewis
Deputy Coroner

Pierre M. DeFelice
Deputy Coroner

Jonathan Jenkins
Deputy Coroner

Matthew J. McKinnon
Deputy Coroner

Michael Kubecki
Deputy Coroner
Facilities

Westmoreland County Coroner’s Office
2503 South Grande Boulevard
Greensburg, PA 15601
**Forensic Services**

Forensic autopsies are performed by Dr. Cyril H. Wecht, M.D., J.D. and Pathology Associates.

Forensic anthropology services are provided by Dr. Dennis C. Dirkmaat, Ph.D., D.A.B.F.A., Forensic Anthropologist with Mercyhurst University, Erie, Pennsylvania.

Forensic odontology services are provided by Dr. Scott E. Learn, DMD, MAGD.

Forensic toxicology testing is performed by NMS Labs of Willow Grove, Pennsylvania.

**Websites / Social Media**

The homepage of the Westmoreland County Coroner’s Office can be found at:  
[http://www.co.westmoreland.pa.us/coroner](http://www.co.westmoreland.pa.us/coroner)

On our homepage you will find forms, brochures, answers to frequently asked questions, and helpful information to assist grieving families and friends.

Also available are statistics on investigations and information on community education, public safety training opportunities, and internship opportunities.

The Westmoreland County Coroner’s Office can be found on Facebook and Twitter:

- Twitter – @WestmdCoCoroner

Public information releases can be found on our website, Facebook, Twitter, and by signing up with the office’s Newsflash notifications, which can be found on our homepage.
Cadaver Detection Canine Unit

The Westmoreland County Coroner’s Office will assist law enforcement agencies in the search for clandestine gravesites, human remains, and blood evidence at crime and fire scenes.

Dogs have an extraordinary sense of smell and have located graves decades after burial. These dogs are important, non-destructive screeners, and helpful during the searching phase of the investigation.

“Kai” is a Belgian Malinois who was acquired through Logan Haus Kennels of Lewisburg, West Virginia in January 2013.

Deputy John A. Ackerman has over (25) years of experience in the training and handling of cadaver detection dogs.
INTERNERSHIP PROGRAM

Beginning in Coroner Ken Bacha’s first term, the Westmoreland County Coroner’s Office has continued to offer its internship program to interested high school and college students. The internship program’s guidelines are as follows:

- Must be 18 years of age or older and provide the following documents via electronic submission through the application form at the following link: www.co.westmoreland.pa.us/coroner
  - Scanned copy of valid driver's license or valid state issued photo identification.
  - Scanned copy of valid health insurance card.
  - Uploaded copy of resume.
  - Uploaded essay on the student’s understanding of the duties of the coroner's office, statistics in Westmoreland County on caseloads/investigations, coroner laws within the Commonwealth of Pennsylvania and how the internship will be relevant to the student's educational experience/major.
    - The essay is to be at minimum 500 words, double spaced, with proper spelling, grammar, and punctuation. Research information can be found on our website and the internet to assist you in your writing.
  - To be considered for participation, applicants must receive college credit and the internship must be a requirement for their major.
  - High school students receiving school credit may be considered for participation.
  - Upon receipt of application and all above documents, an interview will be scheduled with the Coroner and/or Internship Coordinator. Application and all documents must be received by the deadlines listed below.
  - Applications received without ALL required documents will be incomplete and not considered for review.
  - Applicants are advised to submit applications WELL in advance.
  - Mandatory drug testing will be completed on each applicant who is offered an internship.
  - Internship sessions and application deadlines are:
    - Fall Session: August 15th - December 31st
    - Spring Session: January 1st - May 14th
    - Summer Session: May 15th – August 14th
    - Application Deadline: June 15th
    - Application Deadline: October 1st
    - Application Deadline: March 15
  - Preference will be given to individuals pursuing careers and/or education in the following fields:
    - Criminology / Criminal Justice
    - Forensic Science
    - Mortuary Arts & Sciences
    - Law Enforcement
Successful applicants must be willing to participate in all aspects and duties of the coroner’s office including, but not limited to:

- General office duties (answering phones, logging information, data entry and filing)
- Scene investigation (general investigations under the supervision of a deputy coroner)
- Autopsy observation
- Interns will maintain a log or journal of their experience throughout their internship and submit it to the coroner at the conclusion of their internship.
- Internships are conducted each semester and the summer during the daylight shift only.

In 2016, (15) students completed the Westmoreland County Coroner’s Office Internship Program:

- (5) students from Seton Hill University
- (4) students from Franklin Regional High School
- (2) students from Duquesne University
- (2) students from California University of Pennsylvania
- (2) students from the University of Pittsburgh
- (1) student from Vassar College
- (1) student from Robert Morris University
- (1) student from Penn State University
- (1) student from Syracuse University
- (1) student from Westmoreland County Community College
Pennsylvania Coroners’ Education Board

The Pennsylvania Coroners’ Education Board, housed in the Office of Attorney General, provides the Basic Education Course which all newly elected coroners are required to attend prior to assuming office. The chief deputy and full-time deputies are required to attend the Basic Education Course within six months of appointment. The board also authorizes courses that are acceptable for fulfillment of the eight credit hours of continuing education required annually of all coroners and full-time deputies. All full-time and part-time staff of the Westmoreland County Coroner’s Office has successfully completed the Basic Education Course.

Pennsylvania State Coroners’ Association

The object of the PSCA is to hold meetings for the purpose of discussing the various questions which arise in the discharge of the duties of the office of the coroner, and for such other purposes as will conduce to greater efficiency of the operation of the office of the coroner. Additionally, the PSCA holds an annual conference and education seminar addressing various topics, questions, and current events for the coroner’s offices located throughout Pennsylvania. The coroner, chief deputy, and full-time deputies of the Westmoreland County Coroner’s Office are all members of the PSCA.

- Coroner Bacha formerly held the office of Regional Vice-President of the PSCA and is currently the Assistant Secretary Treasurer.

International Association of Coroners and Medical Examiners

The International Association of Coroners & 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. This commitment is enshrined in the association’s mission statement, “The International Association of Coroners & Medical Examiners is committed to advancing the accurate determination of the cause and the manner of death through the utilization of science, medicine, and the law.” The coroner, chief deputy, and full-time deputies of the Westmoreland County Coroner’s Office are active members of the International Association of Coroners & Medical Examiners.
Westmoreland County Law Enforcement Association

The purpose of the Westmoreland County Law Enforcement Association is to hold meetings for discussing the various questions, topics, and current events, which arise within the different agencies of law enforcement in Westmoreland County. The coroner, chief deputy, and full-time deputies of the Westmoreland County Coroner’s Office are active members of the Westmoreland County Law Enforcement Association.

- Coroner Bacha is a current board member and past president of the association.

American Board of Medicolegal Death Investigators

Coroner Ken Bacha and all full-time deputies of the Westmoreland County Coroner’s Office are registered medicolegal death investigators with the American Board of Medicolegal Death Investigators and hold the title (D-ABMDI).

- In 2013, Deputy Josh Zappone and Deputy Sean Hribal passed the board certification examination gaining fellowship status and holding the title (F-ABMDI). They are (2) of (5) holding this status in Pennsylvania and (2) of (201) holding this status in the United States.

The American Board of Medicolegal Death Investigators (ABMDI) is a voluntary national, not-for-profit, independent professional certification board that has been established to promote the highest standards of practice for medicolegal death investigators.

ABMDI certifies individuals who have the proven knowledge and skills necessary to perform medicolegal death investigations as set forth in the National Institutes of Justice 1999 publication Death Investigation: A Guide for the Scene Investigator (2011 updated version available).

ABMDI was created, designed, and developed by veteran, practicing medicolegal death investigators who were involved in the development of Death Investigation: A Guide for the Scene Investigator. It will also assist the courts and public in evaluating competence of the certified individual.

In 2005, the ABMDI was first accredited by the Forensic Specialties Accreditation Board and reaccredited in 2010.

The goal of the FSAB is to establish a mechanism whereby the forensic community can assess, recognize and monitor organizations or professional boards that certify individual forensic scientists or other forensic specialists.
Purpose of the American Board of Medicolegal Death Investigators®

- To encourage adherence to high standards of professional practice and ethical conduct when performing medicolegal death investigations.
- To recognize qualified individuals who have voluntarily applied for basic and advanced levels of professional certification.
- To grant and issue certificates to individuals who have demonstrated their mastery of investigational techniques and who have successfully completed rigorous examination of their knowledge and skills in the field of medicolegal death investigation.
- To maintain a listing of individuals granted ABMDI certification.
- To recertify individuals every five years according to established professional recertification criteria, including continuing education requirements and work verification.

Benefits of Certification

Official guidelines for medicolegal death investigators had not been established until publication of the National Guidelines for Death Investigation by the National Institute of Justice in December 1997. Twenty-nine tasks were identified that may need to be performed to properly conduct a medicolegal death investigation. The guidelines were renamed and published in 1999 as Death Investigation: A Guide for the Scene Investigator. These national guidelines were validated by the Technical Working Group for Death Investigation (TWIGDI), the National Medicolegal Review Panel (NMRP) and 146 members of the TWGDI national reviewers network. Certification provides official recognition by an independent professional certification body that an individual has acquired specialized knowledge and demonstrated proficiency in the standards and practice necessary to properly conduct medicolegal death investigations. The individual agrees to adhere to the highest standards of professional practice and ethical conduct when serving the public and when representing the profession.

- ABMDI Website – www.abmdi.org
The Westmoreland County Coroner’s Office has had a 101% increase in reported cases since 2002.
CREMATIONS

Pennsylvania state law requires any deaths of persons whose bodies are to be cremated, buried at sea or otherwise disposed of, so to be thereafter unavailable for examination, must be reported to the coroner’s office of where the place of death occurred. An investigation takes place into the death and an authorization is then granted.

- The total number of cremations include, both authorizations on cases already reported to the Westmoreland County Coroner’s Office and cases that were not required to be initially reported, but were reported for the sole purpose of gaining cremation authorization.
- Cremation authorization requests have increased 137% since 2002.
AUTOPSIES

Of the 2,763 cases that were investigated by the Westmoreland County Coroner’s Office, 250 deaths required a forensic autopsy be performed to aid in the determination of the cause and manner of death, to document disease, to identify injury patterns, and to recover evidence. Autopsies include toxicology testing to aid in determining the cause and manner of death. Toxicology testing is performed on various specimens collected at autopsy. Toxicology testing screens for alcohol, illicit drugs, prescription drugs, non-prescription drugs, and other substances requested depending on the circumstances surrounding the death.

- In (22) additional cases, toxicology only was performed. A forensic autopsy was not found to be required through investigation.
The above data reflects (1) case reported to determine a type of bone found at a location in Westmoreland County and is further explained on page 37.

PLEASE NOTE: As of May 15, 2017, there is (1) case from the year 2016 pending further investigation. This report will be updated upon the conclusion and rulings on those cases.
NATURAL DEATHS

A large majority of cases investigated by any coroner’s office are natural deaths. In 2016, there were 2,438 cases reported and investigated that were determined to be natural deaths. In many cases, after the investigation determines the death is natural, jurisdiction will be released back to the decedent’s physician, who will then issue the certificate of death. The certificate of death must be issued by the Westmoreland County Coroner’s Office on all accidental, suicide, homicide, and undetermined cases. Depending on the circumstances, the Westmoreland County Coroner’s Office may issue the certificate of death on natural cases.

- Although only 446 cases were reported for the sole purpose of cremation, the remaining 979 cremations out of the 1,425 total, come from cases already reported from all manners of death.
**ACCIDENTAL DEATHS**

In 2016, a total of 254 accidental deaths were investigated by the Westmoreland County Coroner’s Office.

<table>
<thead>
<tr>
<th>Type of Death</th>
<th>Number of Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>A &amp; C Overdose and traffic related deaths</td>
<td>174</td>
</tr>
<tr>
<td>B Post complications from falls</td>
<td>41</td>
</tr>
<tr>
<td>C Traffic related</td>
<td>25</td>
</tr>
<tr>
<td>D Blunt force injuries</td>
<td>6</td>
</tr>
<tr>
<td>E Asphyxiation</td>
<td>4</td>
</tr>
<tr>
<td>F Fire related</td>
<td>2</td>
</tr>
<tr>
<td>G Hypothermia</td>
<td>1</td>
</tr>
</tbody>
</table>

**ACCIDENTAL DEATHS BY TYPE: 2016**

2016 ACCIDENTAL DEATHS: 254

A & C Overdose and traffic related deaths are explained in further detail on pages 20 – 29.

B Post complications from falls are classified as, medical complications sustained by the elderly, who suffered a fall and died as a result of that fall being a contributing factor in the decedent’s death. (41) individuals died due to post complications from a fall.

D (6) individuals died as a result of blunt force injuries. (4) individuals died due to falling down stairs. (1) individual died due to falling from a balcony. (1) individual died due to falling from a cliff.

E (4) individuals died as a result of asphyxiation. (2) individuals died due to drowning. (1) individual died due to foreign body airway obstruction. (1) individual died due to a riding lawn mower accident.

F (2) individuals died as a result of thermal injuries due to a residential structure fire.

G (1) individual died as a result of hyperthermia due to environmental exposure.
TRAFFIC RELATED DEATHS

Traffic related deaths include only those individuals whose death occurs within Westmoreland County, regardless of where the traffic incident takes place. This data does not include those individuals transported by ambulance or medical helicopter to out of county hospitals.

TRAFFIC RELATED DEATHS: 2002 - 2016
2016 TRAFFIC RELATED DEATHS: 25

TRAFFIC RELATED DEATHS BY MONTH: 2016
2016 TRAFFIC RELATED DEATHS: 25
A helmet was utilized in (2) out of the (4) motorcycle fatalities.
TRAFFIC RELATED DEATHS

- Age/Day/Time data comes from the time the incident occurs. Incidents happen where the decedent may be kept alive for days to years in the hospital or other facilities and the death is still due to the traffic incident.
(4) passengers were killed in (4) separate traffic related collisions where the driver was found to be intoxicated. The intoxicated driver was killed in (2) out of the (4) incidents.

The (4) passengers are included in the (15) total alcohol related crashes in 2016.
OVERDOSES

Overdose data includes only accidental overdoses.
Fatal accidental overdoses have increased 691% since 2002.
Suicides by overdose are not included, but that data can be found on page 32.
OVERDOSES

DRUG AND ALCOHOL OVERDOSES BY INCIDENT LOCATION: 2016
2016 OVERDOSE DEATHS: 174

- Incident location data comes from the municipality where the overdose occurred. Overdoses occur where the individual is pronounced dead at the scene or transported to the hospital where death is pronounced. Overdoses also occur where the individual may be kept alive for a length of time in a hospital, or other facility, and the death is still due to the initial overdose.

- A coroner’s office jurisdiction is determined by the place of death. This data does not reflect overdoses where the decedent is transported out of the county and the death is pronounced.

- If a municipality is not listed then it had (0) overdose deaths reported to this office in 2016.
PLEASE NOTE: In (151) of the (174) drug overdoses investigated by the Westmoreland County Coroner’s Office, the cause of death was the result of a combination of multiple drugs found in the decedent’s toxicology, referred to as “Acute Combined Drug Toxicity”. The above chart indicates that the drug listed was contributory in the death, either alone or in combination with another drug(s).

For example, marijuana was present in (39) of the (174) overdose deaths. However, no deaths were the result of marijuana alone, but were due to the combination with other substances across the chart.

Heroin overdoses increased 68% since 2015 and 683% since 2002.

Fentanyl related overdoses increased 364% since 2015

Categories marked with an (*) are broken down in more detail on pages 27-29.
OVERDOSES

**OPIOIDS**

<table>
<thead>
<tr>
<th>Medication</th>
<th>Number of Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fentanyl</td>
<td>109</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>22</td>
</tr>
<tr>
<td>Methadone</td>
<td>16</td>
</tr>
<tr>
<td>Buprenorphine</td>
<td>8</td>
</tr>
<tr>
<td>Morphine</td>
<td>6</td>
</tr>
<tr>
<td>Oxymorphone</td>
<td>6</td>
</tr>
<tr>
<td>Hydrocodone</td>
<td>4</td>
</tr>
<tr>
<td>Tramadol</td>
<td>4</td>
</tr>
</tbody>
</table>

**BENZODIAZEPINES**

<table>
<thead>
<tr>
<th>Medication</th>
<th>Number of Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alprazolam</td>
<td>30</td>
</tr>
<tr>
<td>Clonazepam</td>
<td>30</td>
</tr>
<tr>
<td>Diazepam</td>
<td>5</td>
</tr>
<tr>
<td>Lorazepam</td>
<td>2</td>
</tr>
</tbody>
</table>

**ANTIDEPRESSANTS**

<table>
<thead>
<tr>
<th>Medication</th>
<th>Number of Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Citalopram</td>
<td>13</td>
</tr>
<tr>
<td>Amitriptyline</td>
<td>5</td>
</tr>
<tr>
<td>Filoxetine</td>
<td>12</td>
</tr>
<tr>
<td>Bupropion</td>
<td>9</td>
</tr>
<tr>
<td>Duloxetine</td>
<td>5</td>
</tr>
<tr>
<td>Venlafaxine</td>
<td>4</td>
</tr>
<tr>
<td>Trazodone</td>
<td>4</td>
</tr>
<tr>
<td>Doxepin</td>
<td>4</td>
</tr>
<tr>
<td>Mirtazapine</td>
<td>5</td>
</tr>
<tr>
<td>Sertraline</td>
<td>4</td>
</tr>
<tr>
<td>Clomipramine</td>
<td>1</td>
</tr>
</tbody>
</table>
OVERDOSES

### ANTIHISTAMINES

<table>
<thead>
<tr>
<th>Medication</th>
<th>Number of Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diphenhydramine</td>
<td>12</td>
</tr>
<tr>
<td>Hydroxyzine</td>
<td>7</td>
</tr>
<tr>
<td>Doxylamine</td>
<td>1</td>
</tr>
<tr>
<td>Chlorpheniramine</td>
<td>1</td>
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</table>

### ANTIPSYCHOTICS

<table>
<thead>
<tr>
<th>Medication</th>
<th>Number of Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quetiapine</td>
<td>7</td>
</tr>
<tr>
<td>Ziprasidone</td>
<td>2</td>
</tr>
<tr>
<td>Risperidone</td>
<td>2</td>
</tr>
<tr>
<td>Aripiprazole</td>
<td>2</td>
</tr>
<tr>
<td>Olanzapine</td>
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</tbody>
</table>

### ANTICONVULSANTS / ANTIEPILEPTIC / MOOD STABILIZERS

<table>
<thead>
<tr>
<th>Medication</th>
<th>Number of Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Topiramate</td>
<td>6</td>
</tr>
<tr>
<td>Lamotrigine</td>
<td>3</td>
</tr>
<tr>
<td>Gabapentin</td>
<td>3</td>
</tr>
<tr>
<td>Levetiracetam</td>
<td>2</td>
</tr>
</tbody>
</table>
OVERDOSES

MUSCLE RELAXERS

<table>
<thead>
<tr>
<th>Medication</th>
<th>Number of Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carisoprodol</td>
<td>13</td>
</tr>
<tr>
<td>Metaxalone</td>
<td>10</td>
</tr>
<tr>
<td>Cyclobenzapine</td>
<td>2</td>
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</table>

BARBITUATES

<table>
<thead>
<tr>
<th>Medication</th>
<th>Number of Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phenobarbital</td>
<td>4</td>
</tr>
<tr>
<td>Butalbital</td>
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</table>

STIMULANTS

<table>
<thead>
<tr>
<th>Medication</th>
<th>Number of Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amphetamine</td>
<td>2</td>
</tr>
<tr>
<td>Methylphenidate</td>
<td>1</td>
</tr>
</tbody>
</table>

HYPNOTICS

<table>
<thead>
<tr>
<th>Medication</th>
<th>Number of Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zolpidem</td>
<td>2</td>
</tr>
</tbody>
</table>
SUICIDES

SUICIDES: 2002 - 2016
2016 SUICIDES: 61

NUMBER OF DEATHS

YEAR

SUICIDES BY MONTH: 2016
2016 SUICIDES: 61

NUMBER OF DEATHS

MONTH
SUICIDES

SUICIDES BY MARITAL STATUS AND GENDER: 2016
2016 SUICIDES: 61

MARITAL STATUS

SUICIDES BY AGE AND GENDER: 2016
2016 SUICIDES: 61

AGE
SUICIDES

SUICIDES BY METHOD: 2016
2016 SUICIDES: 61

NUMBER OF DEATHS

METHOD

SUICIDES BY GENDER AND METHOD: 2016
2016 SUICIDES: 61

NUMBER OF DEATHS

METHOD
HOMICIDES

HOMICIDES: 2002 TO 2016
2016 HOMICIDES: 7

HOMICIDES BY MONTH: 2016
2016 HOMICIDES: 7
HOMICIDES

HOMICIDES BY AGE AND GENDER: 2016

2016 HOMICIDES: 7

HOMICIDES BY METHOD AND GENDER: 2016

2016 HOMICIDES: 7

METHOD

NUMBER OF DEATHS
The cause of death may be defined as the disease or injury that resulted in the death, such as myocardial infarction or gunshot wound. The manner of death is a medicolegal term that describes the circumstances of an individual’s death and may be designated as natural, accidental, suicide, homicide, or undetermined. Occasionally, coroner’s offices encounter cases where the cause of death is apparent, but the evidence supporting the manner of death is equivocal or insufficient to make a determination. The determination of manner of death is an opinion based on the “preponderance of evidence”. An example might be a case in which the cause of death is a drug overdose, but from the information available, it is not certain whether the manner of death is accidental or suicide. Therefore, the manner of death may be certified as undetermined. The Westmoreland County Coroner’s Office investigated (1) case where the manner of death was classified as undetermined.

**UNDETERMINED: 2002 TO 2016**

<table>
<thead>
<tr>
<th>YEAR</th>
<th>NUMBER OF DEATHS</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>5</td>
</tr>
<tr>
<td>2003</td>
<td>3</td>
</tr>
<tr>
<td>2004</td>
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<td>6</td>
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<tr>
<td>2015</td>
<td>7</td>
</tr>
<tr>
<td>2016</td>
<td>1</td>
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</table>

**UNDETERMINED BY MONTH: 2016**

<table>
<thead>
<tr>
<th>MONTH</th>
<th>NUMBER OF DEATHS</th>
</tr>
</thead>
<tbody>
<tr>
<td>January</td>
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</tr>
<tr>
<td>February</td>
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</tr>
<tr>
<td>March</td>
<td>0</td>
</tr>
<tr>
<td>April</td>
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<td>September</td>
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<td>October</td>
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<tr>
<td>November</td>
<td>0</td>
</tr>
<tr>
<td>December</td>
<td>0</td>
</tr>
</tbody>
</table>
UNDETERMINED

UNDETERMINED BY AGE AND GENDER: 2016
2016 UNDETERMINED: 1

AGE

UNDETERMINED BY GENDER AND METHOD: 2016
2016 UNDETERMINED: 1

METHOD
BONES

The Westmoreland County Coroner’s Office receives reports from various law enforcement agencies of undetermined types of bones. The bones are then photographed with a scale and forwarded to Dr. Dennis C. Dirkmaat, Ph.D., D.A.B.F.A., Forensic Anthropologist with Mercyhurst College in Erie, PA. In 2016, the Westmoreland County Coroner’s Office received (1) case involving undetermined bones. Through investigation the case was determined to be animal bones.

<table>
<thead>
<tr>
<th>MUNICIPALITY</th>
<th>NUMBER OF DEATHS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unity Township</td>
<td>1</td>
</tr>
</tbody>
</table>

BONES BY MUNICIPALITY: 2016

2016 BONES: 1

Kenneth A. Bacha, B.S., D-ABMDI

PRIVATE DATA and reported generated by Deputy Joshua C. Zappone – April 4, 2017