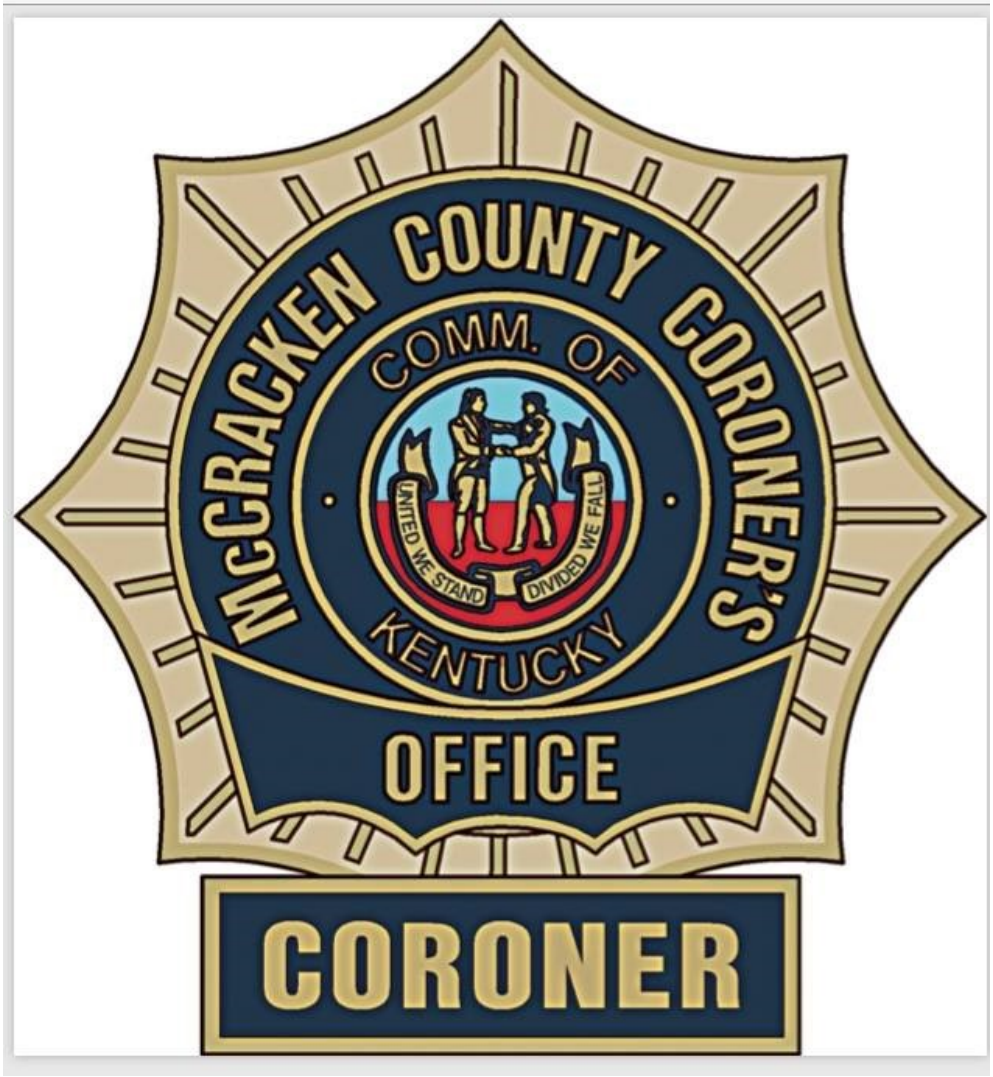
2024
ANNUAL REPORT



AMANDA MELTON, *Coroner*

Presented to the McCracken County Fiscal Court

March 17, 2025

Coroner, Amanda Melton

Jason Logsdon

James Scott

Brigitte Choate

Special Deputy
Courtney Hope McCracken

The McCracken County Coroner's Office promptly responds to those scenes which require a post-mortem investigation within the jurisdiction of McCracken County and the City of Paducah. A primary and secondary investigator are on call twenty-four hours a day, 7 days a week.

The Coroner and her deputies function as the on-scene death investigator for the State Medical Examiner, ensure that Kentucky state law is followed, and serve as an advocate for the deceased person.

The primary responsibilities of Coroner Investigators are to determine cause and manner of death, positively confirm the identity of the decedent, and locate and notify their next of kin. Additionally, the Coroner serves as the liaison between police agencies, family, and the funeral home.

MCCO 2024 Annual Report

General Overview

Calls for service:

1,433 (-64 2023)

Death investigations: 304 (+3 2023)

Cremation permits issued: 675 (-113 2023)

Hospital case reviews: *66

Hospice case reviews: 290

Court Orders: 6

Indigent financial assistance: 29 (+13 2023)

Information Assist: 22

Subpoenas: 7

County burials (Wilmington) : 34

l causes	2022 Q3	2022 Q4	2023 Q1	2023 Q2	2023 Q3	2023 Q4	2024 Q1	2024 Q2
All causes, 12 months ending with quarter (Crude)	1298.6	1264.4	1210.8	1202.1	1188.9	1171.9	1174.3	1169.7*
All causes, 3-month period (Crude)	1163.7	1290.8	1232.7	1121.4	1110.7	1223.3	1243.1	1103.

The crude death rate for all causes in Kentucky for the 3-month period ending with 2024 Q2 was 1103.0, which was lower than the crude death rate of 1121.4 in 2023 Q2.

Death investigations: 304 total

A death investigation is undertaken in any of the following circumstances as required by KRS 72.025:

When the death of a human being appears to be caused by homicide or violence;
When the death of a human being appears to be the result of suicide;
When the death of a human being appears to be the result of the presence of drugs or poisons in the body;
When the death of a human being appears to be the result of a motor vehicle accident and the operator of the motor vehicle left the scene of the accident or the body was found in or near a roadway or railroad;
When the death of a human being occurs while the person is in a state mental institution or mental hospital when there is no previous medical history to explain the death, or while the person is in police custody, a jail or penal institution;
When the death of a human being occurs in a motor vehicle accident and when an external examination of the body does not reveal a lethal traumatic injury;
When the death of a human being appears to be the result of a fire or explosion;
When the death of a child appears to indicate child abuse prior to the death;
When the manner of death appears to be other than natural;
When human skeletonized remains are found;
When post-mortem decomposition of a human corpse exists to the extent that external examination of the corpse cannot rule out injury or where the circumstances of death cannot rule out the commission of a crime;
When the death of a human being appears to be the result of drowning;
When the death of an infant appears to be caused by sudden infant death syndrome in that the infant has no previous medical history to explain the death;
When the death of a human being occurs as a result of an accident;
When the death of a human being occurs under the age of forty (40) and there is no past medical history to explain the death;
When the death of a human being occurs at the work site and there is no apparent cause of death such as an injury or when industrial toxics may have contributed to the cause of death;
When the body is to be cremated and there is no past medical history to explain the death;
When the death of a human being is sudden and unexplained; and
When the death of a human being occurs and the decedent is not receiving treatment by a licensed physician and there is no ascertainable medical history to indicate the cause of death.

Targeted death statistics:

Suicide: 17 (-2 2023)

Accidental overdose: 21 (+10 2023)

Homicide: 2 (unchanged)

Motor vehicle collision fatality: 6

Motor vehicle versus pedestrian: 0

Under 18: 6

Autopsy: 19

Cases requiring toxicology: 63

Undetermined: 1

Covid-related: 2

McCracken County is home to two regional health care facilities (Baptist Health Paducah and Mercy Health-Lourdes Hospital) and multiple skilled care facilities. Because our hospitals and skilled care facilities serve a large rural region, we are disproportionately impacted by deaths which occur in our Emergency Departments. Many people are urgently transported here from surrounding counties. As a result, these deaths occur in jurisdiction and are required to be investigated by our agency.

Cremation Authorizations 675

Ky. Rev. Stat. § 213.081
(1) No person shall cremate or cause to be transported for the purpose of cremation the body of any person whose death occurs in the Commonwealth, without first obtaining from the coroner of the county in which the death occurred, a permit stating the cause of death and authorizing the cremation or transportation for cremation of the body. The permit shall be filed immediately following cremation with the local registrar of vital statistics.

Hospital Case Reviews 66

Both hospitals have established protocol which requires their nurse managers/clinical house supervisors to conduct a case review for hospital deaths which have met certain parameters as a means of assuring quality control/risk management. A few examples of cases which are reviewed between the coroner's office and the hospital are those facility deaths which have been admitted for less than twenty-four hours and those whose initial reason for admission may have met one of the conditions listed in KRS 72.025. The hospital review cases may be intercepted at this time and subsequently an investigation may be launched.

Hospice Case Reviews 290

A registered nurse employed by a health facility as defined in KRS 216B.015, may pronounce death in accordance with the requirements of KRS 446.400. "The nurse shall notify the patient's attending physician or other appropriate practitioner of the death in accordance with the facility's policy. The registered nurse is authorized to sign the provisional report of death as furnished by the state registrar of vital statistics.
" KRS 314.181 Determination of death by registered nurses – Notification.

Coroner Melton and Deputy Coroners Logsdon,Scott, and Choate have successfully completed the required 40-hour Basic Coroner Training class; presented by the Department of Criminal Justice Training Division.

2024 Continuing education training (18 hours minimum) :

Coroner Melton- DOCJT Coroner Conference

Deputy Logsdon- DOCJT Coroner Conference

Deputy Scott- DOCJT Mass Fatality & Incident Response

Deputy Choate- DOCJT Forensic Pathology

Purchase Area Coroner's Association

The bi-annual meeting of the Purchase Area Coroner's Association will be held during the Kentucky Coroner Convention in April. All regional coroners and their deputies participate in this cooperative effort to build a strong alliance throughout the region. *The collaborative efforts of PACA allow us to contribute statistics to area agencies that focus on tracking trends and preventative measures for our citizens.*

Participating counties are: ***McCracken, Livingston, Marshall, Calloway, Graves, Fulton, Hickman, Carlisle, and Ballard.***

PREVENTION/ADVOCACY

Child Fatality Review-

A diverse group of community professionals has been amassed by Coroner Melton to serve on the Child Fatality Review team as required by KRS 211.686. An extensive review of the death of any minor child whose death occurred in McCracken County or is a resident of McCracken County but whose death occurred out of jurisdiction is assessed by this team of professionals. In most circumstances, the Child Fatality Review State Coordinator and the regional Medical Examiner attend these meetings as well. Issues identified at these meetings may prompt a need for more extensive prevention/advocacy efforts.

The team members are: **Amanda Melton**-Coroner; **Sarah Canella**-CFR District Coordinator/Purchase District Health Department; **Jeremy Jeffrey**-EMS Director; **Leah Fondaw**-VP, Clinical Services Four Rivers Behavioral Health; **Cynthia Turner**-Prevention Specialist, Four Rivers Behavioral Health; **Julie Holmes**- Department for Community Based Services; **Chelsee Breakfield**- Detective, Paducah Police Department; **Kyle Seratt**- Detective, McCracken County Sheriff's Department; **Heather Anderson**-Transitional Student Coordinator, Paducah Public Schools; **Nicole Wadley**, Children's Advocacy Center, Lotus; **Grace Stewart**, McCracken County Commonwealth Attorney's Office; **Amberly Haverstock**-Director of Specialized Services, Lotus.

The team reviewed 7 cases at our in-person meeting on July 17, 2024.

The State CFR team was in attendance.

Safe Sleep Campaign

The American Academy of Pediatrics is opposed to bed-sharing: It "should be avoided at all times" with a "[full-]term normal-weight infant younger than 4 months," the AAP writes in its 2016 recommendations for pediatricians. The organization says the practice puts babies at risk for sleep-related deaths, including sudden infant death syndrome, accidental suffocation and accidental strangulation.
About 3,700 babies die each year in the U.S. from sleep-related causes.

These co-sleeping deaths, typically ruled as “traumatic positional asphyxiation”, are reviewed by our Child Fatality Team too often. In 2018, we began discussion about increasing education in targeted areas where adults are most likely to seek help, support, or advice. I am pleased to announce that funds were secured through the Maternal-Child Health division of our local health department. Consequently, we entered into a contract with A&SG Film Makers (Josh & Samantha Marberry) who are diligently developing content with parents, physicians, product developers, and other experts. We have purchased a package that will have a variety of material and content which will be used for short spots on TV, extended spots for possible education in the medical settings where caregivers can be reached, and sharing on social media. This project will be completed by year-end and our hope is that it is distributed by the Kentucky Child Fatality Review team to all 120 Kentucky counties. Public service announcement spots will be sought from local media outlets by which this important education will be shared.

This educational video is in the hands of a steering committee that is finalizing it for distribution.

Senate Bill 66
Nathan's Law

This bill, named for Nathan Burnett, mandates training on providing death notices and requires that a second person be with the coroner and that the notification is given verbally, in person, and respectfully.

Unclaimed urns

In Spring, 2024, our office oversaw the burial of 34 unclaimed urns in Wilmington Cemetery which have been kept by our office and area funeral homes spanning several years. The county road department, led by Randy Williams, was instrumental in completing this project.

*6 families were reunited with the urn of their loved one through this effort.

KENTUCKY CORONERS ASSOCIATION

Coroner Melton is proud to be the sole West Kentucky representative who serves as one of eighteen board members to the Kentucky Coroner's Association. This board meets in-person quarterly with occasional virtual meetings as needed.

Much like other governmental associations representing constitutional officers, the KCA strives to introduce legislation to further advance the role of the professional coroner. Most recently a bill has been introduced to help standardize the salary of rural coroners.

The KCA has also invested in a new website which provides valuable information to the public as well as centralizes a comprehensive portal for all 120 statewide coroners and their deputies.

Additionally, we strive to support and recognize the needs of coroners who represent our diverse commonwealth.

Emerging Trends

*Fentanyl, Xylazine, and Ketamine

*In the context of the Covid-19 pandemic, sedentary habits in certain age groups are presumed to have increased. Various oversight agencies are reviewing if this has had a significant effect on lifestyle, musculoskeletal health, and mortality.

*Unhoused citizens— in an effort to assist our community partners, data will be collected and categorized to assign a number to coroner investigations involving the unhoused. Specifically, if being unhoused was an immediate factor or contributor to their death.

OUTREACH/EDUCATION

Along with regular duties relating to deaths and death investigations the office--when possible-- participates in community outreach and education. In 2024 these included:

*Paducah Public Library-Evenings Upstairs Series
"From CSI to Real Life-A Day in the life of a Coroner"

*Sheriff Citizens Academy Presentation

*Kiwanis Club-Guest Speaker

*Rotary Club International-Guest Speaker

*International Overdose Awareness Day-Guest Speaker

*STEM for Girls-Guest Speaker

*Leadership Paducah Class & Youth-LEAD (Chamber of Commerce)

*Lions Club International

Secure Morgue Space-

The coroner's office continues to need dedicated private and secure space in which to examine, photograph and safely house decedents under our care. Currently, no such space exists, requiring us to rely on the generosity of Lourdes Hospital and various area funeral homes. Unfortunately, we cannot re-enter those spaces without the assistance of a representative from the hospital or funeral home, thus creating several obstacles including sufficient chain-of-custody oversight. Potentially, surplus county property could be utilized for these needs or perhaps space in an existing annex. I have secured a two-person morgue for indefinite use by our county.

Records Archive Storage-

The preservation of archived death investigation records are of great importance to our community and are requested by various entities quite often. Coroner records date back to the 70's and are currently stored in hard copy formats. A goal for 2025 is to appropriately box, label and chronologically shelf these valuable records.