CORONER DIVISION
ANNUAL REPORT 2018

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Introduction

Divisional History

When the County of Orange was founded in 1889, I.D. Mills became the County's first Coroner/Public Administrator. The partnership between these two branches of government existed until 1965 when a county ordinance separated the Coroner and Public Administrator functions. Five years later in 1970, the Orange County Board of Supervisors voted to co-join the Office of Coroner and the Office of Sheriff, making it the 31st Sheriff-Coroner Department in California on January 4, 1971. Today, the majority of the 58 counties in the state are Sheriff-Coroner systems.

Coroner Division Mission Statement

The mission of the Orange County Coroner Division is to serve the citizens and visitors of Orange County by conducting thorough medicolegal death investigations with compassion and specialized expertise.

Value Statement

Service is our number one priority.

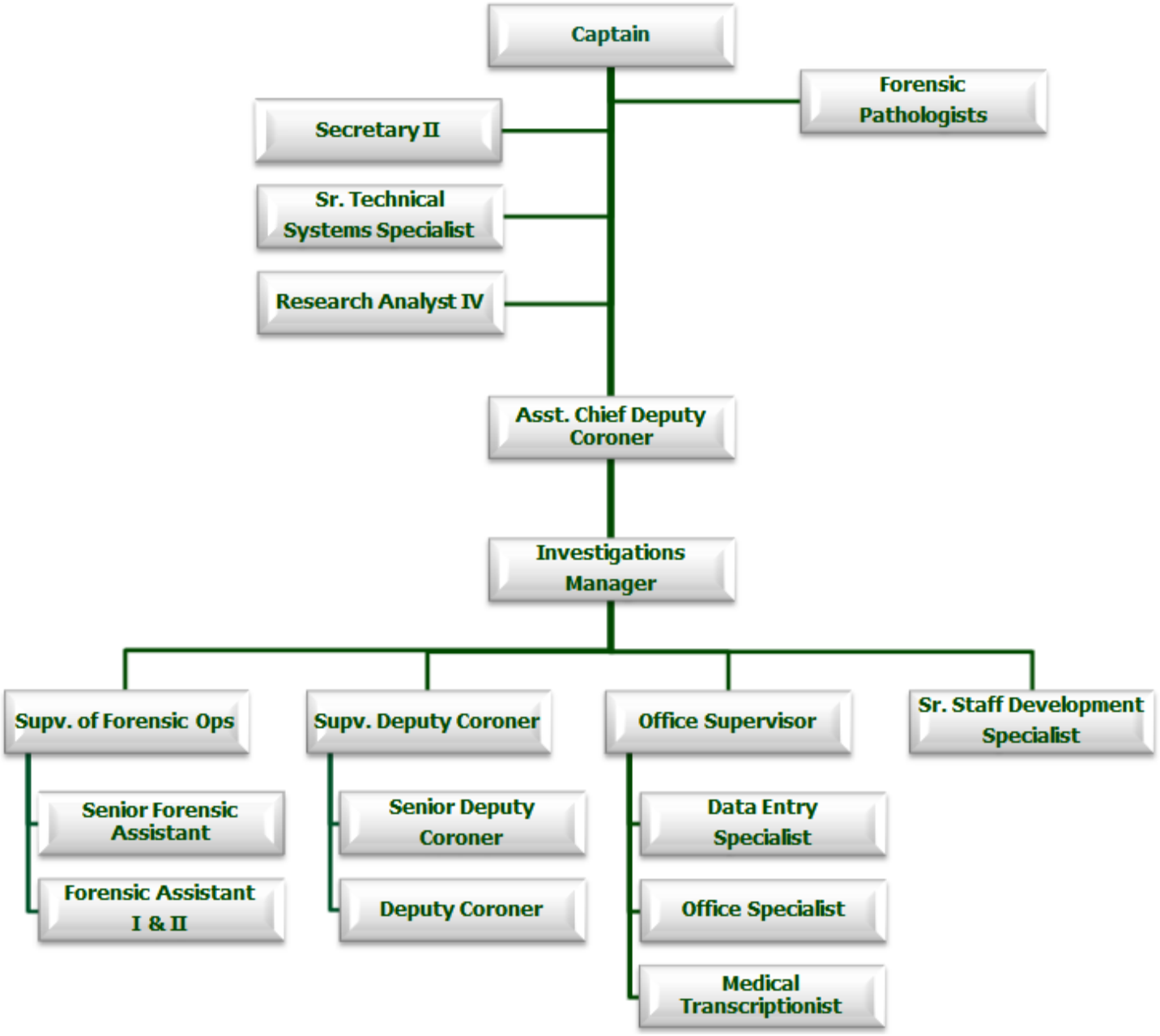
In recognition of the significant impact our actions have on those we serve, we strive collectively to provide prompt resolution to our investigations and deliver expert medicolegal services through genuinely compassionate people.

Our organizational culture and environment will promote high ethical standards, safety, collaboration, efficient and effective processes, innovative thinking, mutual respect, and caring.

Goals

1. Provide Exceptional Service
2. Ensure Safe Practices and Environment
3. Enhance and Maintain a Positive Divisional Culture
4. Embody Servant Leadership

Organizational Chart



Training and Education

1. California Coroner Training Center

In the year 2000, Governor Gray Davis and members of the State Assembly and Senate, recognizing the need for a statewide coroner training facility to provide education and training for coroners, pathologists and other professionals involved in death investigation, appropriated $10 million dollars to fund a new state of the art training center. The County of Orange contributed another $2 million dollars for a total of $12 million. As a result, the California Coroner Training Center opened its doors in March of 2004. Since then, countless Coroners, Deputy Coroners, and other law enforcement officials have attended training courses designed to meet the job specific needs of Coroners and other professionals involved in death investigations. Examples of courses offered are: Basic Death Investigation, Drowning Death Investigation, Death Notification, and Elder Death Investigation.

2. Resident and Medical Student Pathology Program

Since September of 1999, the Coroner Division has participated in the College of Medicine, University of California, Irvine approved residency training and medical student externship program in Pathology. This professional relationship allows residents and medical students to work either a two or four week rotation at the Coroner Division thereby gifting them with hands-on experience under the expert tutelage of our Board Certified Forensic Pathologists.

3. Child Death Review Team

The Orange County Child Death Review Team (OCCDRT) was established in 1987 to provide a forum for the multi-disciplinary review of child deaths reported to the Coroner. Initially, the team's focus was on fetal deaths and deaths of children through 12 years of age, with particular focus on improving multi-agency communication on child homicides and unexplained child deaths. One year after the conception of the OCCDRT, the California Legislature authorized counties to officially establish interagency child death review teams. In 1993, the review process expanded to include children through 17 years of age. With the improved coordination and communication among the many agencies responsible for child health, safety, and protection achieved by the pioneering team, the primary objectives of the OCCDRT are now broadening to include prevention efforts.

Core members of this multi-disciplinary team are drawn from public agencies responsible for the investigation of child deaths and agencies responsible for protecting the health and welfare of children. These agencies include: Coroner's Office, Sheriff's Department, Health Care Agency, District Attorney's Office, County Counsel, Department of Education, Probation Department, Local Police Agencies, Social Services, The Raise Foundation (a local child abuse prevention council), County Fire Authority, UCI Pediatric Injury Prevention Research Group, Visiting Nurses Association of Orange County, Child Abuse Services Team (Orange County's multi-disciplinary investigative team for child sexual abuse), and the County Emergency Medical Services.

Training and Education

4. Elder Death Review Team (EDRT)

The Orange County Elder Death Review Team was formed in 2003. Its purpose is to carefully examine cases involving decedents who are 65 or older in which there is suspected abuse by a caregiver or relative. Additionally, the team recognizes that a careful review of the fatalities will provide the opportunity to develop education, prevention and if necessary prosecution strategies, that will lead to improved coordination of services for families and the elder population. The goals of the EDRT are to prevent elder abuse fatalities; examine deaths of elders with suspected elder abuse and/or neglect; identify patterns that lead to fatal outcomes; determine whether reviewed deaths could have been prevented; develop prevention strategies; increase awareness of the responsibility of each Health Care Provider to consider abuse or neglect as a contributing factor to death; increase awareness of the responsibility of each Health Care Provider to refer cases arising from abuse or neglect to the appropriate agencies including, but not limited to: Coroner, Adult Protective Services, State Licensing Department, Ombudsman, and Law Enforcement; improve system responses by identifying gaps in delivery services; prosecution of offenders; and develop intervention strategies to reduce fatalities and eliminate ongoing abuse and/or neglect.

5. Domestic Violence Death Review Team (DVDRT)

In 1995, the California Legislature passed a bill (Penal Code section 11163.3) authorizing counties to establish interagency DVDRT's to assist local agencies in identifying and reviewing domestic violence deaths, and facilitating communications among the various agencies involved in domestic violence cases. Its purpose is to review cases where domestic violence is either a major factor in the cause of death or a contributing factor. These cases are studied by the team in hopes of finding solutions to fill any gaps in the system, improving data collection, and recommending ways to prevent future tragedies. The Orange County DVDRT was formed in 2000.

Coroner Jurisdiction

The Coroner Division is an investigative unit responsible for carrying out the statutory duties of the Coroner. Those duties include conducting investigations into the circumstances surrounding all deaths falling within the Coroner's jurisdiction for the purpose of determining the identity of the deceased, the medical cause of death, the manner of death, and the date and time of death. Medicolegal death investigations are conducted countywide on all homicides, suicides, accidents, suspicious and unexplained deaths. Other duties include notifying the next of kin, safeguarding personal property, collection of evidence, and completion of mandatory records and documents. The Division is also proactive in the community, participating in programs geared towards preventing drunk driving and drug use; identifying consumer products causing fatal injury; domestic violence, child abuse and elder abuse; and providing educational services for medical, legal, and law enforcement professionals. Other contributions to the community include cooperative relationships with non-profit organ and tissue procurement agencies to enhance the quality of life and save lives. The Division also collaborates with research organizations pursuing medical science advancements.

Reportable Deaths

Pursuant to Government Code 27491, it shall be the duty of the Coroner to inquire into and determine the circumstances, manner, and cause of the following deaths:

- Without medical attendance which includes all deaths outside of hospitals or skilled nursing facilities.
- Wherein the deceased had not been attended by a physician in the 20 days prior to death or had not been attended by a hospice nurse within 30 days prior to death.
- The attending physician is unable to render a reasonable opinion as to the cause of death.
- When homicide is known or suspected.
- When suicide is known or suspected.
- When a criminal action is involved or suspected to be involved in the death.
- Related to, or following known or suspected self-induced or criminal abortion.
- Associated with a known or alleged rape or crime against nature.
- Known or suspected as resulting in whole or in part from an accident or injury, either old or recent.
- When aspiration, starvation, exposure, drug addiction or acute alcoholism is the known or suspected cause.
- When poisoning is known or suspected.
- When occupational disease or hazards are the known or suspected cause.
- When a contagious disease is the known or suspected cause.
- When death occurred while in-custody of a law enforcement agency or while in prison.
- All deaths of State Hospital patients.
- All Sudden Infant Death Syndrome (SIDS) deaths.
- Deaths during or related to surgery or surgical procedures, or following a surgery or surgical procedure if the deceased did not awaken from the anesthetic.

Manner of Death Definitions

The deaths identified in this report are organized in five main categories; these are Natural, Accident, Homicide, Suicide, and Undetermined. Listed below are each of these categories and their definition.

Natural

Natural Deaths discussed in this report are those that were reported to the Coroner and determined to be caused by disease (morbid process) attributable to known or unknown cause, non-traumatic, and not a result of act or omission of another. If the cause of death is ascertained by autopsy, the death certificate is signed by the Coroner.

Accident

Unforeseen event, misfortune, loss, act or omission causing death; when death is caused by conduct of another human agency, not being intentional in nature, and free of gross negligence.

Suicide

Suicide Deaths are those where the death is the result of an intentional, self-inflicted act intended to commit self-harm or cause death to oneself. Methods may include asphyxia (via hanging or suffocation), gunshot, and overdose of medication or other drugs.

Homicide

Homicide Deaths are those where the death is caused by the hands of another, other than by accident. The intent to cause death is not required for classification as Homicide and deaths classified as Homicide do not indicate or imply criminal intent was determined.

Undetermined

Classified in the Undetermined Death category are those deaths where the designation of Natural, Accident, Suicide, or Homicide could not be determined. After thorough consideration of all available information, the classification of one manner of death may be no more compelling than the other competing manners.

Generally, these deaths have been thoroughly investigated by the Coroner, including an autopsy examination and related scientific tests. In many cases the cause of death may be known, however the external factors cannot be confidently established.

SONA, or Signed Out-No Autopsy

Those deaths which, prior to 2010, would normally require an autopsy, however, after being triaged the case was signed out without an autopsy.

In the latter part of December 2009, in order to better manage Coroner Division resources, the case triage process was implemented with the goal of effectively reducing the number of autopsies performed by the Coroner. The triage process required all cases normally receiving a post-mortem examination to undergo a thorough evaluation to determine whether an autopsy was essential for establishing the cause and manner of death. This evaluation included a detailed review of medical records, clinical tests, and interviews with informants and witnesses. The triage team determined if the extent of the investigation was adequate to establish the probable cause and manner of death without the benefit of an autopsy. In this manner, cases from the lowest end of the

risk spectrum were signed out without an autopsy. This type of case is referred to as a SONA case (Signed Out - No Autopsy).

SONA cases are grouped in the Investigated Case Category. Per policy, Undetermined cases will not be signed out without autopsies, therefore a SONA designation can only be used on Natural, Accident, Suicide, and Homicide cases. The term "Clinical" is added to the Manner to identify the case as a SONA. There were 384 SONA cases in 2018.

Sub-Classifications of Death Definitions

NNA, or Natural-No Autopsy

Those deaths in which the Deputy Coroner authorized the treating physician to certify the medical cause of death after an investigation determined that the physician had sufficient knowledge of the patient's history and all unnatural circumstances were ruled out.

Declines

Those deaths in which the circumstances did not meet the Coroner's statutory jurisdictional requirements.

JI, or Jurisdictional Inquiry

Deaths either initially understood to meet jurisdictional criteria or the initially reported circumstances required significant investigation to determine jurisdiction.

Consults

Those deaths in which the Coroner signed the death certificate based on consultation with the decedent's primary physician.

AOA, or Assist Outside Agency

Deaths that are cases brought to Orange County by either Inyo or Mono Counties for forensic services in accordance with protocol and contractual agreements. In 2018 there were two AOA cases but these cases are not a part of our caseload and as such do not appear in our graphs.

National Association of Medical Examiners Accreditation

The National Association of Medical Examiners (NAME) is the professional organization for physician medical examiners and coroners, medical death investigators and medicolegal system administrators who investigate deaths of public interest in the United States. NAME has developed an accreditation process to improve the quality of death investigation within medical examiner offices and systems. When an office is accredited by NAME, it is an endorsement that the office has provided an environment adequate for a medical examiner to practice his or her profession and that the office can adequately serve its jurisdiction. The accreditation process includes but is not limited to: inspection of facilities, review of facility and personnel safety, qualification of medical examiners, review of medical legal procedures, and review of reports and records. One requirement within the reports and records section is an annual statistical report, which the Orange County Coroner fulfills with this report although as of yet we are not NAME accredited. The following data is needed for the NAME requirement for the annual statistical report:

A. Deaths reported:	8,479
B. Cases accepted:	5,879
C. Manners of death:	
1. Accident	975
2. Homicide	77
3. Natural	912
4. Suicide	370
5. Undetermined	44
D. Field Responses:	2,399
E. Bodies received:	2,114
F. Autopsies:	2,001 (1,993 were 2018 cases)
G. Cases with toxicology:	1,593
H. Unidentified bodies after examination:	0
I. Unidentified Decedents Identified	238
J. Brain Donations:	41
K. Unclaimed bodies:	33
L. Exhumations:	0

Summary of Data

The data in this report reflects deaths reported to the Coroner during the 2018 calendar year. This includes both residents and non-residents whose deaths occurred within the borders of the County of Orange.

In 2018, 21,307 deaths were recorded by the Orange County Health Department, Birth and Death Registration. Of those deaths, 8,479 were reported to the Coroner, which is 40% of the total deaths. The Coroner investigated 5,879.

After investigating the 5,879 reported cases, 2,375 deaths, or 40%, resulted in the final cause of death being signed by the Coroner or his delegated authority.

Of the 2,375 deaths certified by the Coroner's Office, 1,993 or about 84%, required an autopsy to determine the cause of death. Of these 1,993 cases, 853 were found to be due to natural causes.

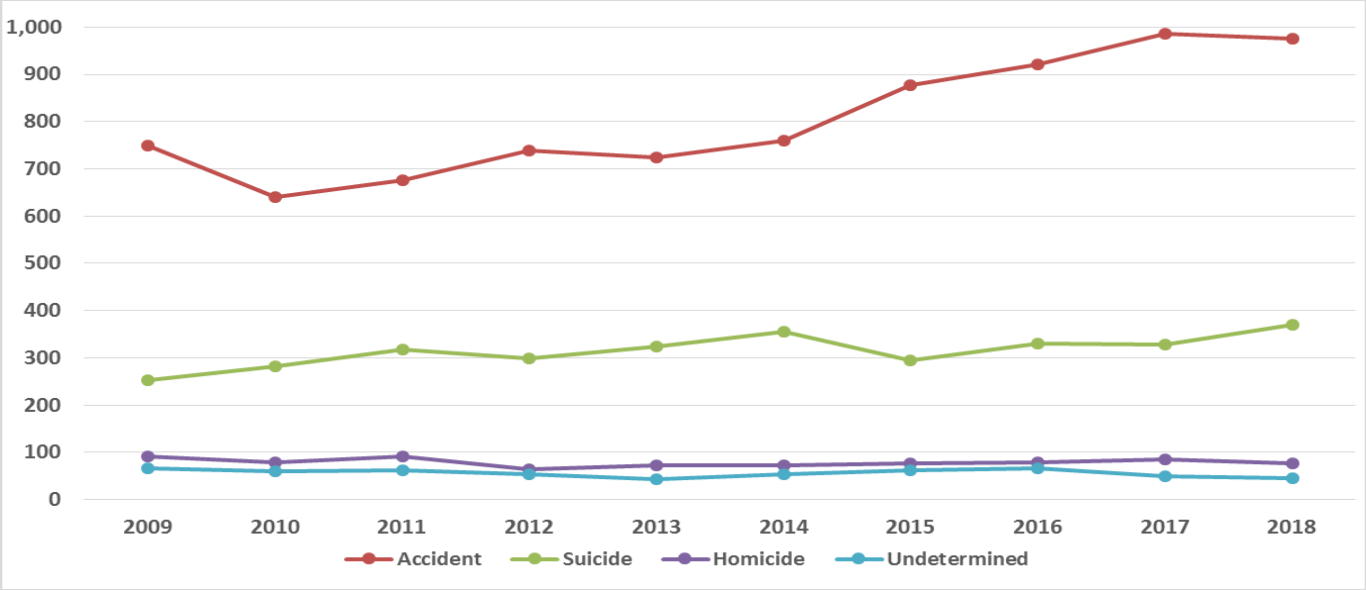
Accidental deaths totaled 975, with 26% of those involving motor vehicles. Overdoses accounted for 384 of the accidental deaths, which translates into 39% of all Accidents occurring in 2018.

There were 77 Homicide deaths during the calendar year with most incidents involving gunshots (56%) and males (74%). Thirty-five percent of the total Homicide deaths occurred in the City of Santa Ana with an additional 12% occurring in the City of Anaheim.

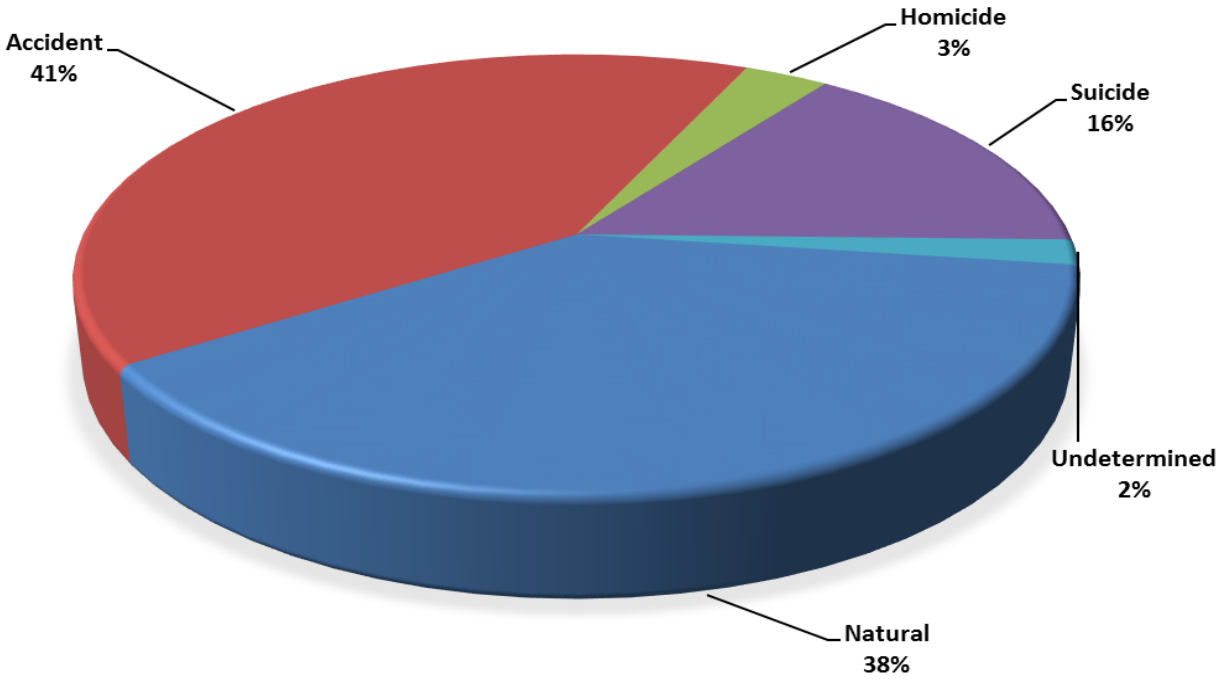
Suicides accounted for 16%, or 370 cases, in 2018, with asphyxia (43%) being the most favored type, followed by gunshots (27%). Fifty and sixty year olds made up the majority of decedents at 36% or 131 deaths, and males far exceeded females at 75% vs. 25% respectively. Interestingly, only 16% of decedents left a suicide note in 2018, as opposed to 18% in 2017.

Forty-four deaths were classified as Undetermined, with 28 (64%) of those having an unknown cause of death followed by 10 (23%) being the result of an overdose.

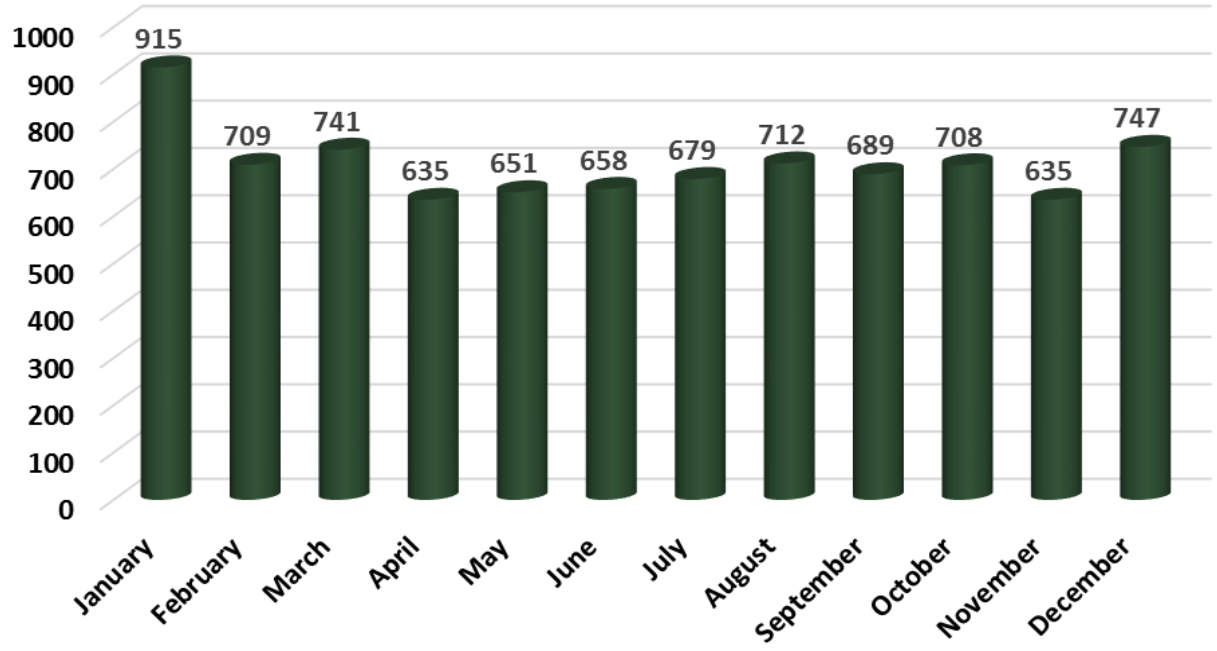
Total Non-Natural Cases by Year of Death by Manner, 2009—2018



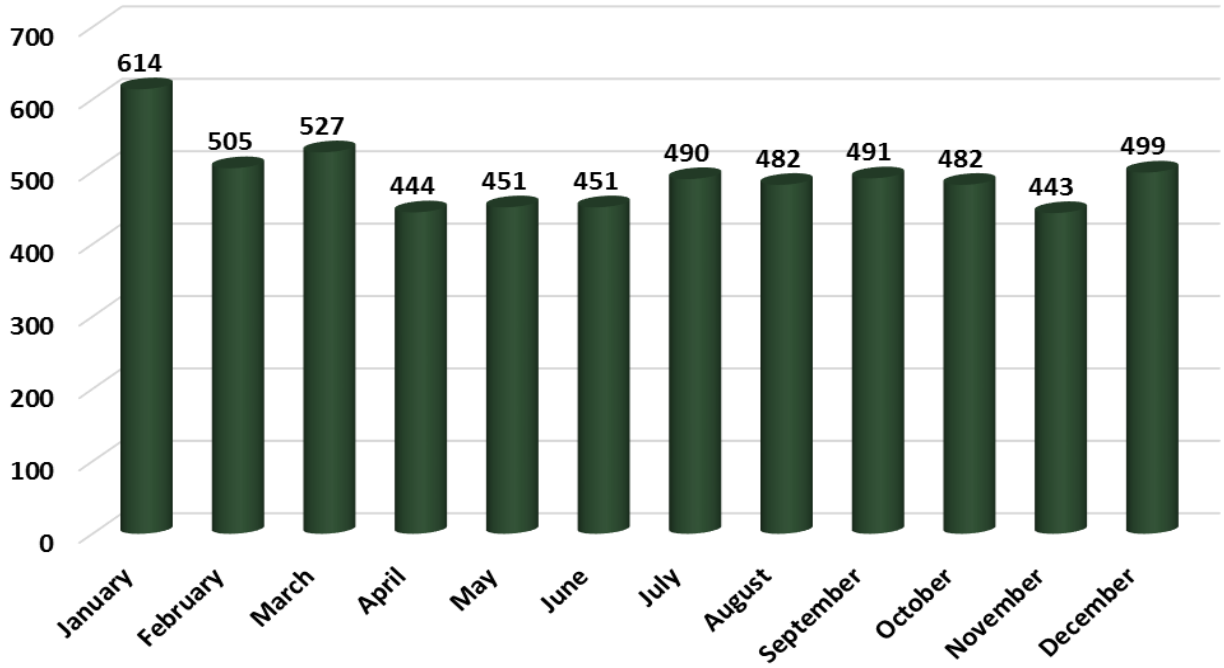
Total Cases by Manner, 2018



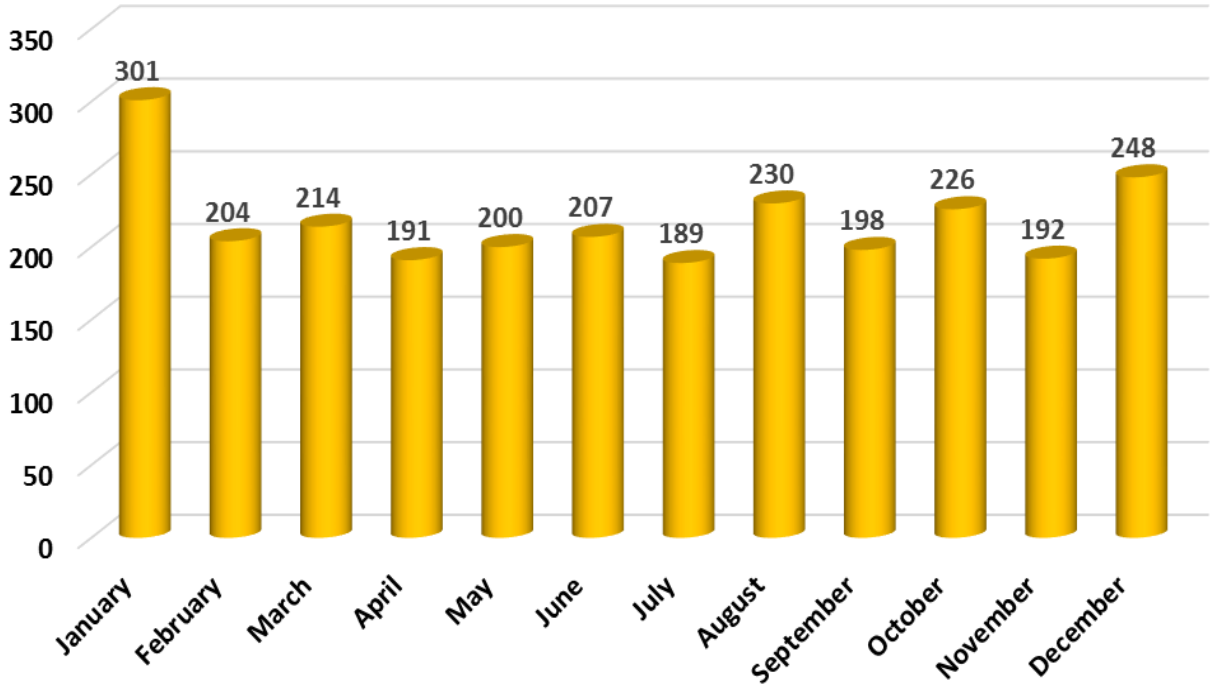
Total Caseload by Month Reported, 2018



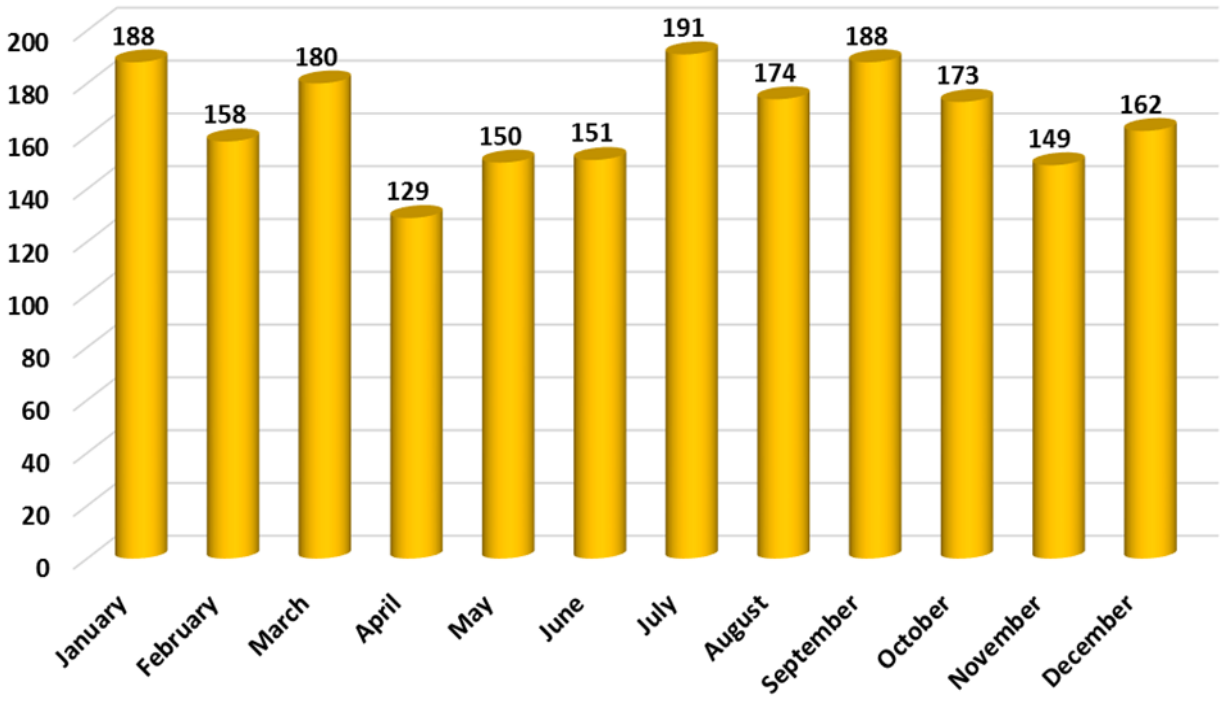
Total Investigated Cases by Month Reported, 2018



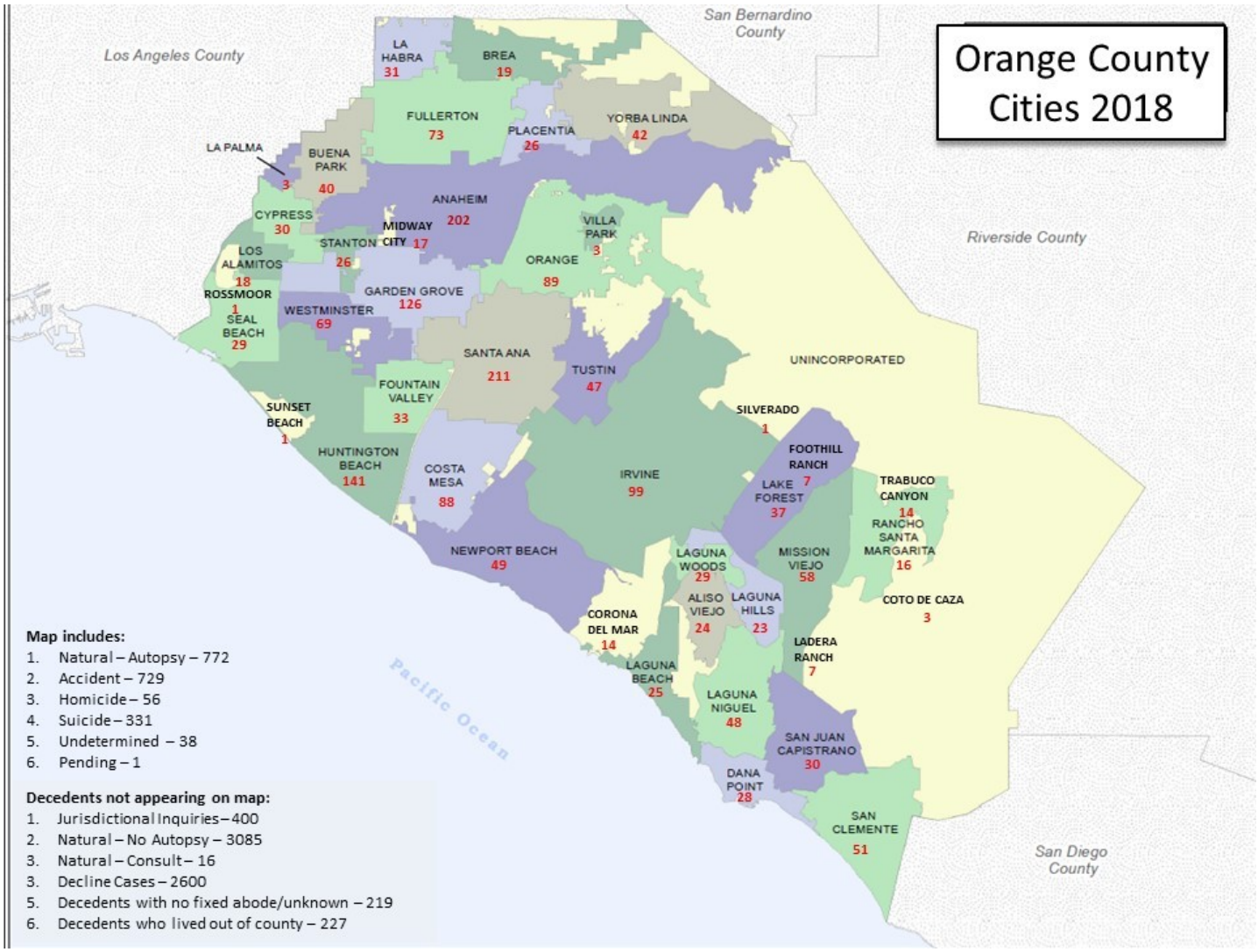
Total Non-Jurisdictional Inquiries by Month Reported, 2018



Total Autopsies By Month 2018



Cases by City of Residence, 2018



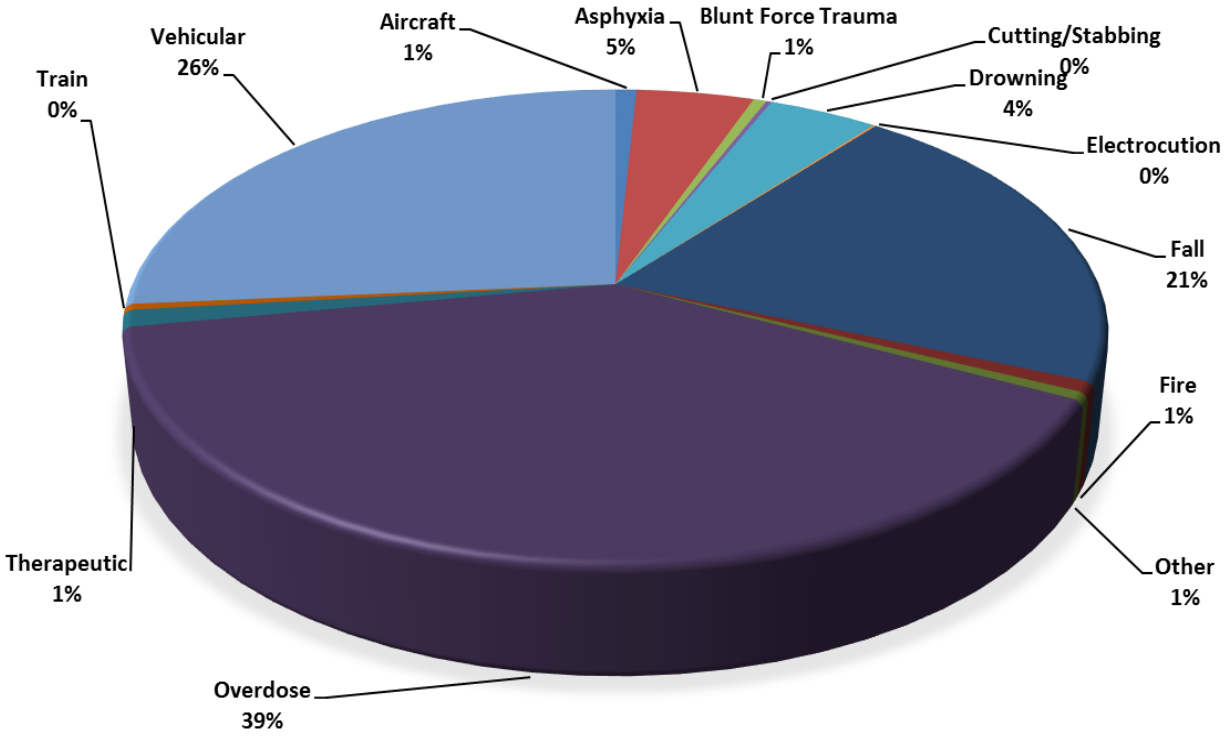
Accidental Deaths by Cause, 2018

AIRCRAFT	**8**
Operator	2
Passenger	6
ASPHYXIA	**45**
Aspiration	33
Autoerotic	3
Carbon Monoxide	4
Compression	2
Other	1
Positional	2
BLUNT FORCE TRAUMA	**5**
Blunt Object	1
Crushing	1
Other	2
Unknown	1
CUTTING/STABBING	**2**
Other	2
DROWNING	**42**
Bathtub	8
Ocean	12
Other	1
Pool	19
Spa	2
ELECTROCUTION	**1**
High voltage	1
FALL	**204**
Height	23
Other	4
Same Level	161
Unknown	16
FIRE	**7**
Residence	6
Other	1

Accidental Deaths by Cause, 2018 continued

OTHER	**5**
Other (Hot sauna heat exposure while intoxicated)	1
Other (Burned while cooking)	1
Other (Heat exposure)	1
Other (Fresh water thermal burns)	1
Other (scratched by cat)	1
OVERDOSE	**384**
Abuse (Illicit drugs only)	170
Drugs (Prescription drugs only)	76
Ethanol	24
Mixture (Combination of illicit and prescription drugs)	113
Other (Nitrous oxide inhalation)	1
THERAPEUTIC	**11**
Medical	5
Surgical	6
TRAIN	**4**
Pedestrian	4
VEHICULAR	**257**
Bicycle - Operator	14
Motorcycle - Operator	33
Occupant	5
Operator	86
Other (Two skateboarder vs. auto)	2
Passenger	30
Pedestrian	87
TOTAL	**975**

Accidental Deaths by Cause, 2018

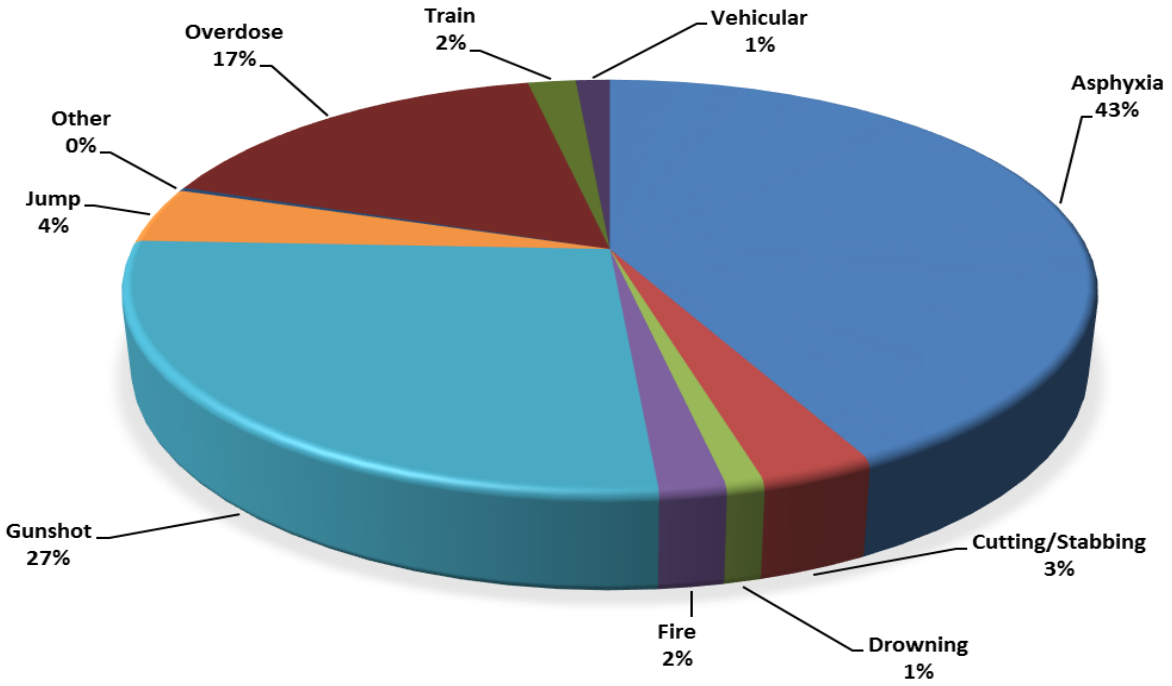


Type of Accident	Number of Cases
Aircraft	8
Asphyxia	45
Blunt Force Trauma	5
Cutting/Stabbing	2
Drowning	42
Electrocution	1
Fall	204
Fire	7
Other	5
Overdose	384
Therapeutic	11
Train	4
Vehicular	257

Suicide Deaths by Cause, 2018

ASPHYXIA	**157**
Carbon Monoxide	6
Compression	1
Hanging	137
Strangulation	2
Suffocation	10
Unknown	1
CUTTING/STABBING	**12**
Sharp Object	12
DROWNING	**4**
Bathtub	2
Ocean	2
FIRE	**7**
Immolation	3
Residence	1
Vehicle	3
GUNSHOT	**100**
Handgun	92
Rifle	5
Shotgun	3
JUMP	**16**
Height	16
OTHER	**1**
Other (Ingestion of anti-freeze)	1
OVERDOSE	**61**
Drugs (Prescription drugs only)	52
Mixture (Combination of illicit and prescription drugs)	9
TRAIN	**7**
Pedestrian	7
VEHICULAR	**5**
Operator	1
Pedestrian	4
TOTAL	**369**

Suicide Deaths by Cause, 2018

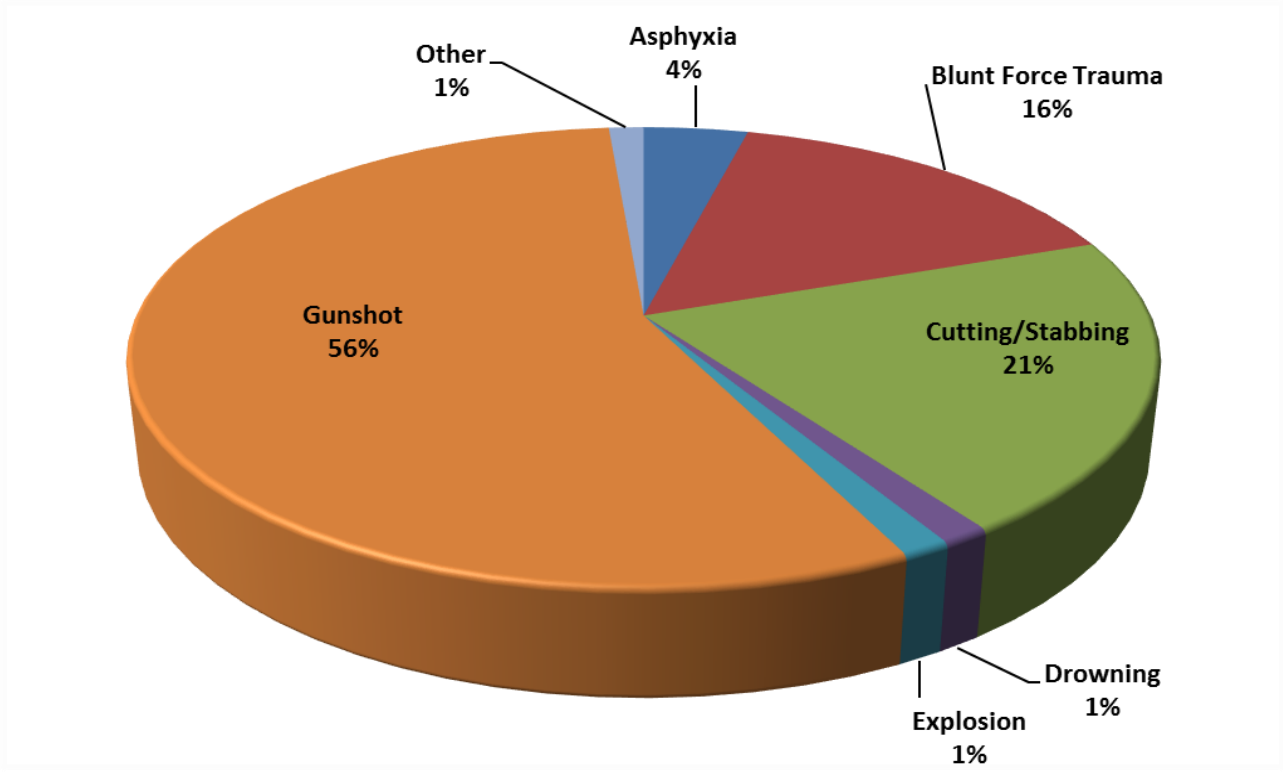


Type of Suicide	Number of Cases
Asphyxia	157
Cutting/Stabbing	12
Drowning	4
Fire	7
Gunshot	100
Jump	16
Other	1
Overdose	61
Train	7
Vehicular	5

Homicide Deaths by Cause, 2018

ASPHYXIA	**3**
Strangulation	2
Suffocation	1
BLUNT FORCE TRAUMA	**12**
Blunt Object	6
Unknown	6
CUTTING/STABBING	**16**
Sharp Object	16
DROWNING	**1**
Pool	1
EXPLOSION	**1**
Explosive	1
GUNSHOT	**43**
Handgun	29
Rifle	2
Unknown	12
OTHER	**1**
Other (Physical altercation while under the influence of methamphetamine)	1
TOTAL	77

Homicide Deaths by Cause, 2018

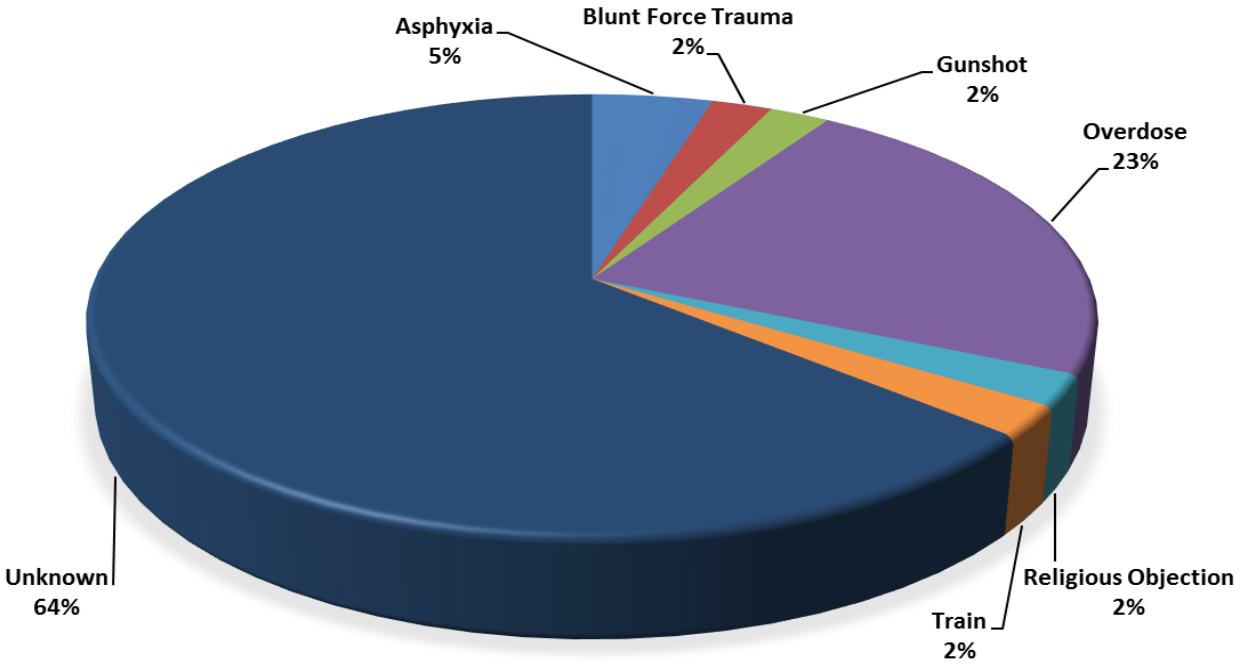


Type of Homicide	Number of Cases
Asphyxia	3
Blunt Force Trauma	12
Cutting/Stabbing	16
Drowning	1
Explosion	1
Gunshot	43
Other	1

Undetermined Deaths by Cause, 2018

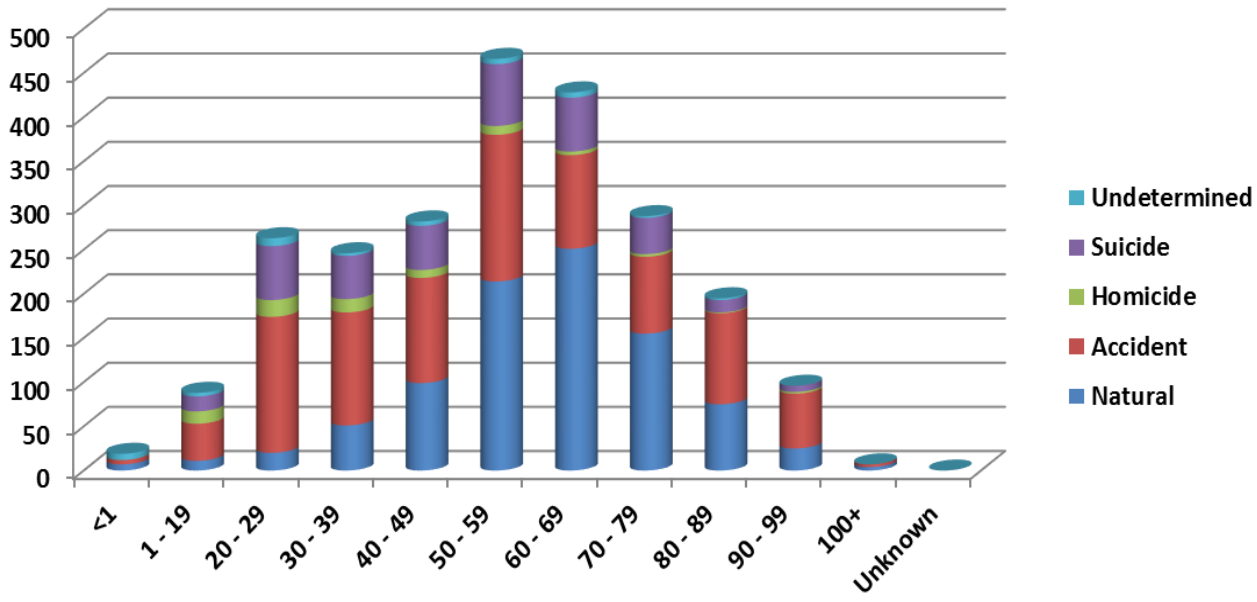
ASPHYXIA	**2**
Carbon Monoxide	1
Suffocation	1
BLUNT FORCE TRAUMA	**1**
Unknown	1
GUNSHOT	**1**
Handgun	1
OVERDOSE	**10**
Abuse (Illicit drugs only)	2
Drugs (Prescription drugs only)	3
Mixture (Combination of illicit and prescription drugs)	5
RELIGIOUS OBJECTIONS	**1**
To Autopsy	1
TRAIN	**1**
Pedestrian	1
UNKNOWN	**28**
Undetermined Cause of Death	28
TOTAL	**51**

Undetermined Deaths by Cause, 2018



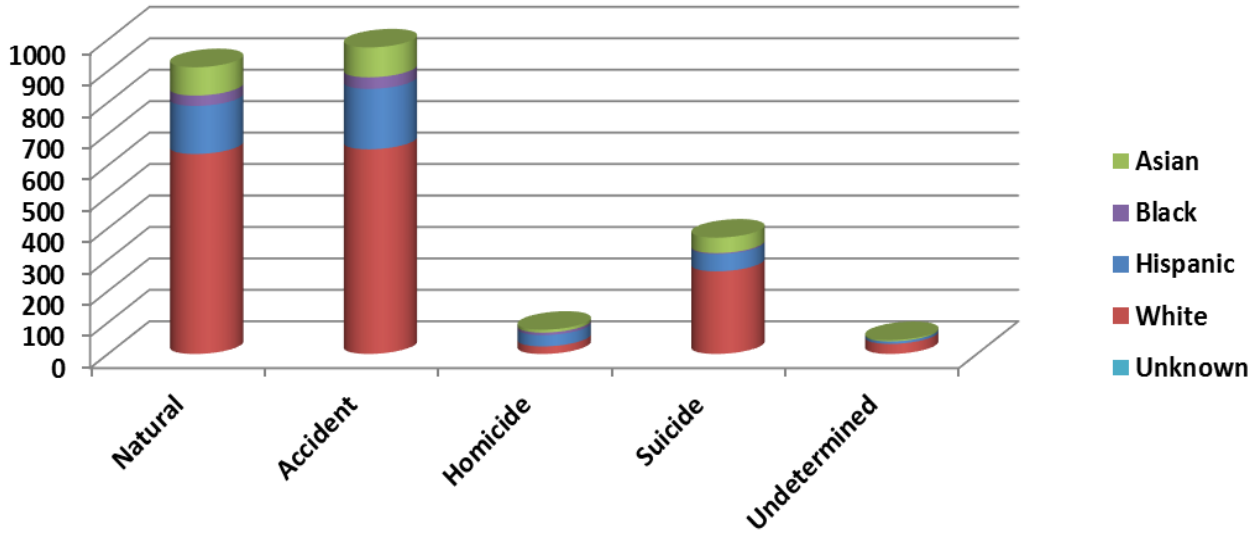
Type of Undetermined	Number of Cases
Asphyxia	2
Blunt Force Trauma	1
Gunshot	1
Overdose	10
Religious Objection	1
Train	1
Unknown	28

Manner Distribution for Each Age Group, 2018



Age Group	Natural	Accident	Homicide	Suicide	Undetermined
<1	7	5	0	0	7
1 - 19	11	42	14	17	4
20 - 29	20	154	19	61	9
30 - 39	51	128	15	49	3
40 - 49	99	119	9	50	5
50 - 59	214	166	10	70	6
60 - 69	251	106	4	61	6
70 - 79	155	87	3	41	2
80 - 89	75	103	1	14	2
90 - 99	25	62	2	7	0
100+	4	3	0	0	0
Unknown	0	0	0	0	0

Racial Distribution for Each Manner, 2018

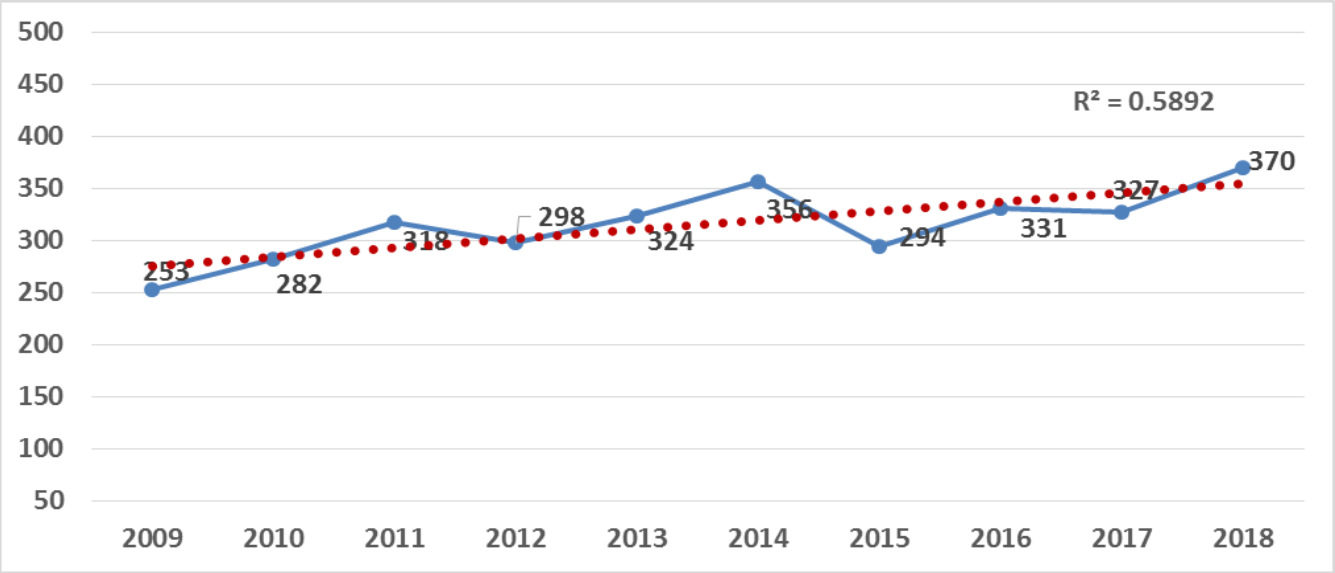


Ethnicity	Natural	Accident	Homicide	Suicide	Undetermined
Asian	90	95	9	49	4
Black	33	37	8	3	0
Hispanic	153	192	36	55	8
White	636	651	24	263	32
Unknown	0	0	0	0	0

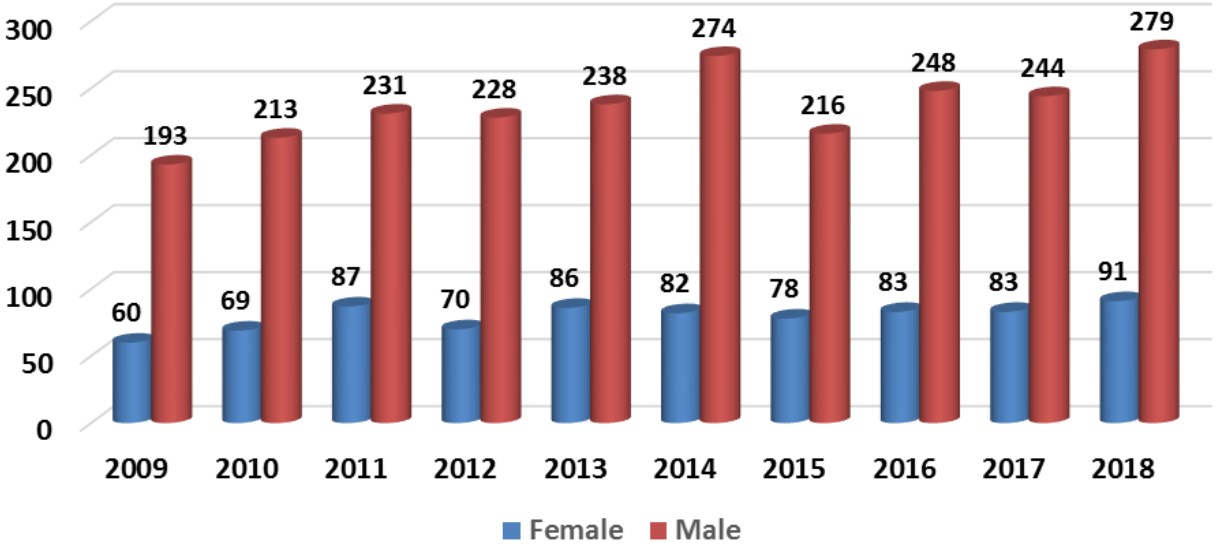
Special Report - Suicide Deaths in Orange County

In the year 2009, 253 suicidal deaths occurred within the borders of Orange County. Suicidal deaths rose to 369 in 2018 which is a 46% increase in the ten year span. The following charts compare different aspects of ten years' worth of suicide death data. The increases are seen across gender lines as well as most races.

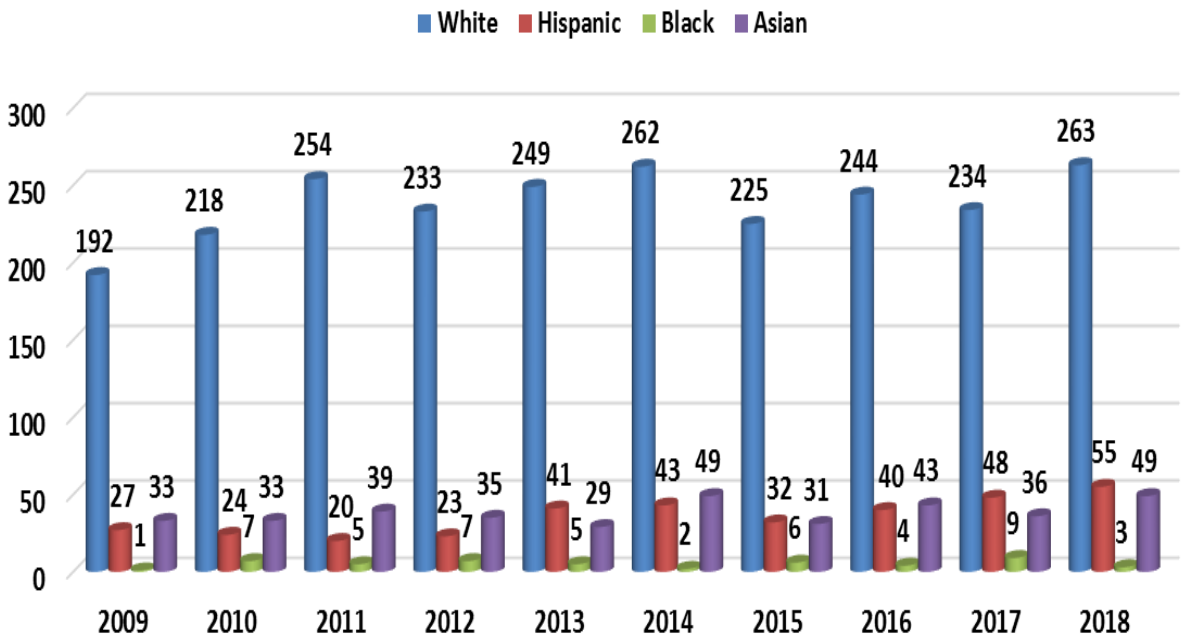
Suicide Deaths - A Ten Year Comparison



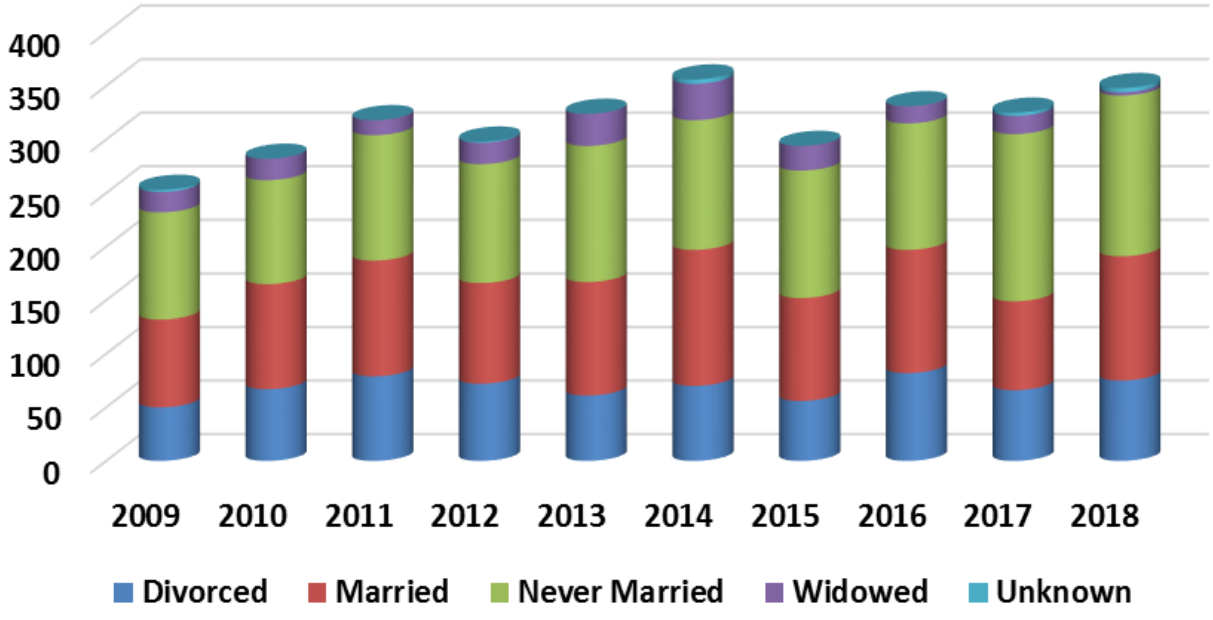
Suicide Deaths By Gender - A Ten Year Comparison



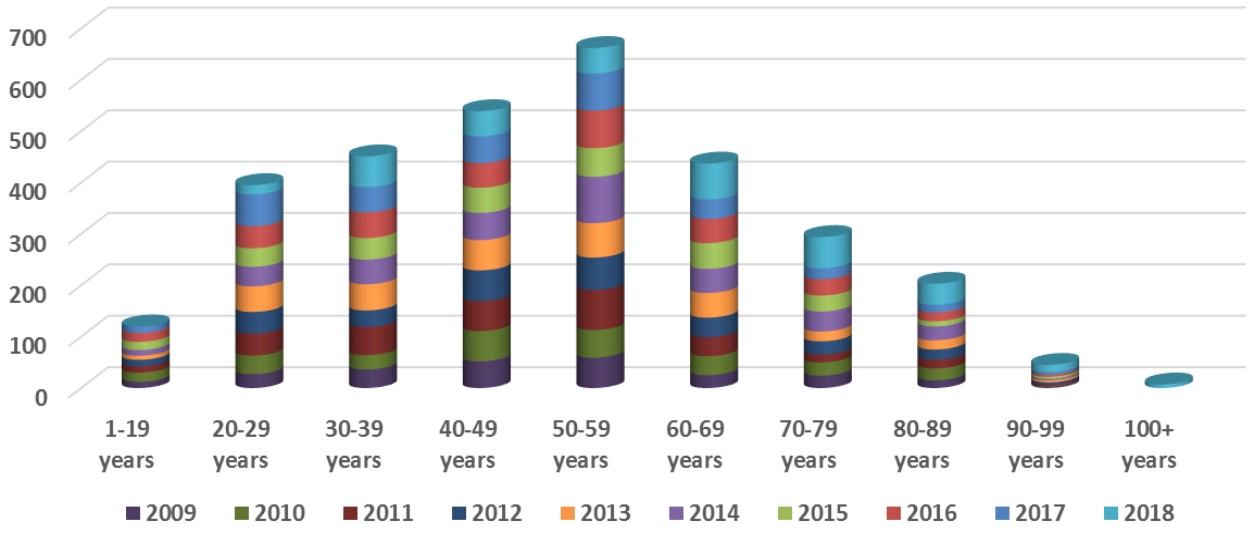
Suicide Deaths by Race - A Ten Year Comparison



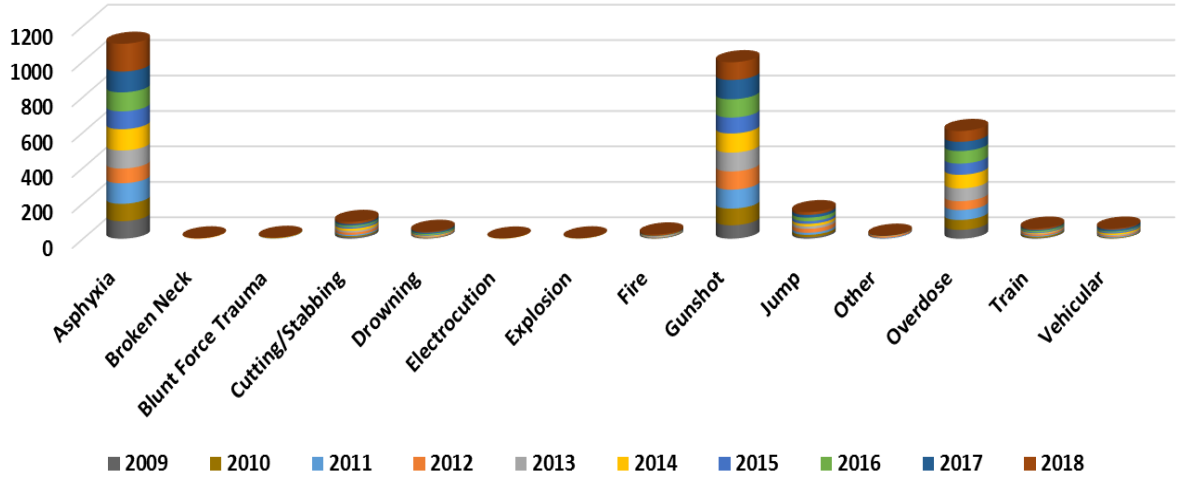
Suicide Deaths by Marital Status - A Ten Year Comparison



Suicide Deaths by Age - A Ten Year Comparison

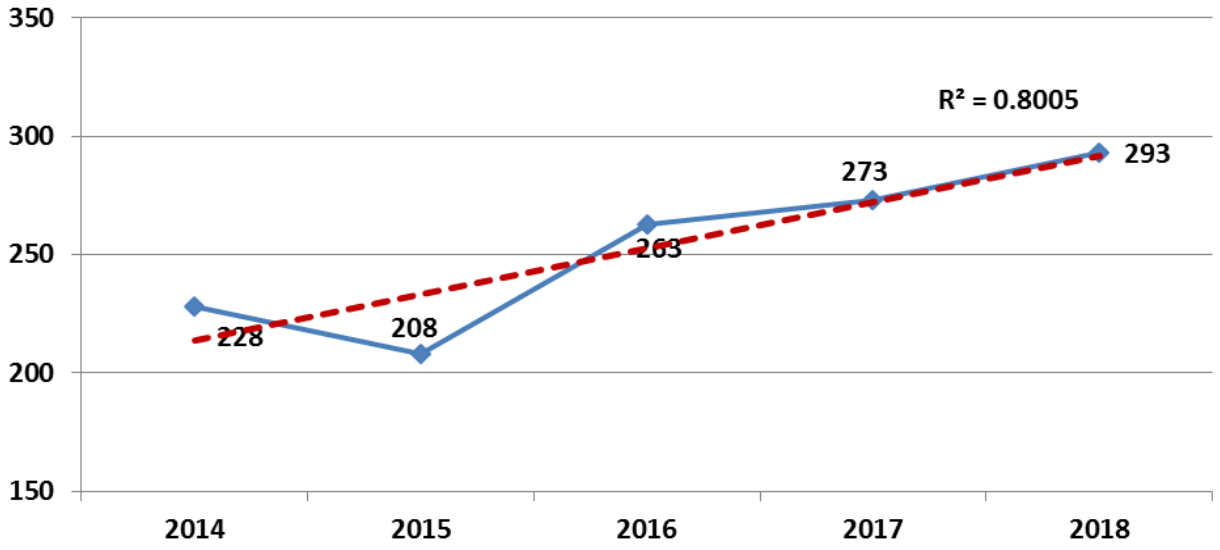


Suicide Deaths by Injury Type - A Ten Year Comparison



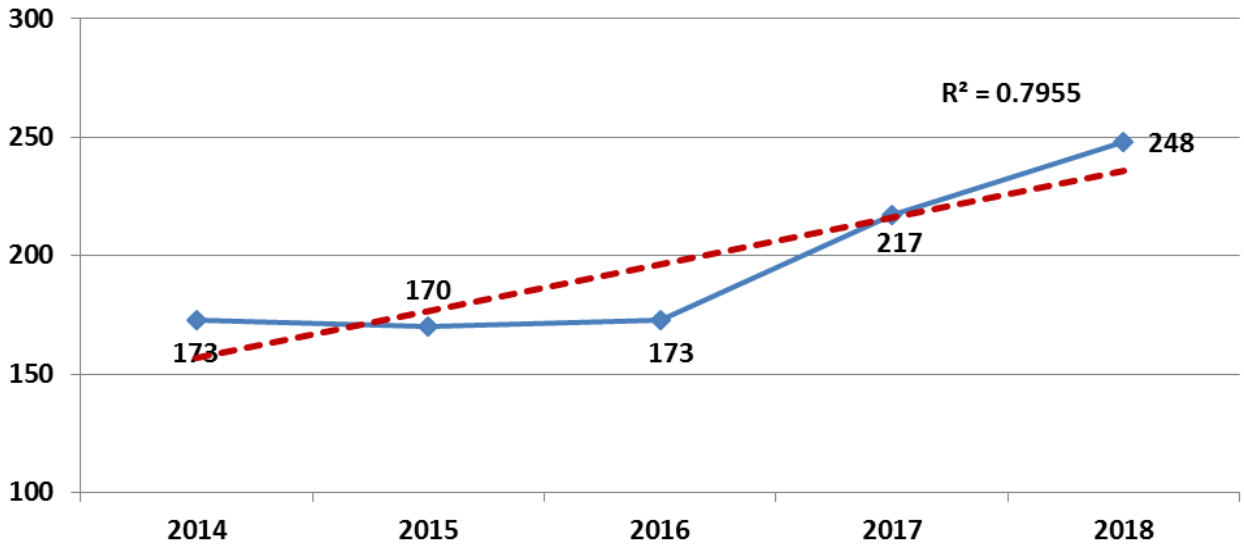
In 2013, we referenced some noticeable trends in specific drugs. Although these are merely trends they were worth monitoring with each passing year. As a result, in the charts below we have again illustrated the number of deaths where methamphetamine appears in the toxicology results and noted the number has increased by 92% since 2013 (153) but remains 7% higher than in 2017. We will continue to monitor these drugs in future reports.

Deaths with Methamphetamine in Toxicology Results



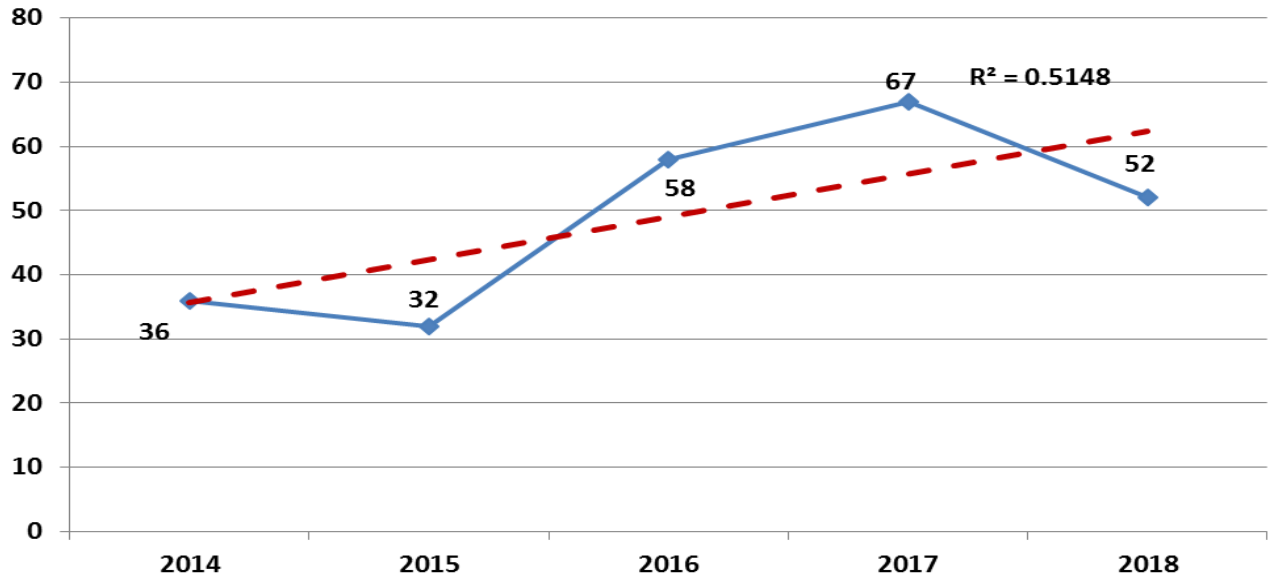
Along with that startling statistic is the fact that deaths with THC, the active ingredient in marijuana, has seen a 43% increase since 2014, as seen in the chart below.

Deaths with THC in Toxicology Results



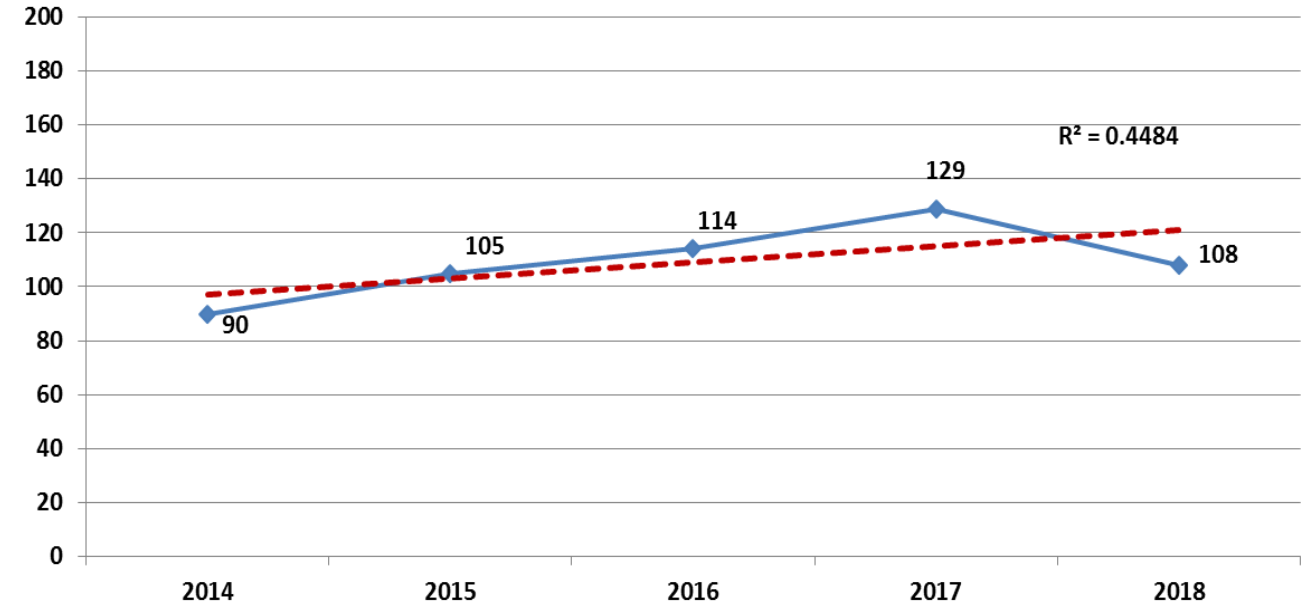
In 2012, deaths with cocaine in the toxicology results had declined by 34% since 2011. Unexpectedly, 2014 saw a 57% increase over 2012 and a 16% increase over 2013. In 2018 there was an decrease of 22% over 2017.

Deaths with Cocaine in Toxicology Results



The chart below shows the number of deaths over a five year period caused by heroin usage. Heroin overdose data has been problematic because not until late 2011 did the Coroner Division test for an important metabolite, 6-MAM. The presence of 6-MAM forensically proves heroin was used. Therefore, the data is a combination of cases where the cause of death stated "heroin" and those cases where the cause of death was morphine/codeine or morphine overdose, and there was strong evidence they came from heroin. Unexpectedly, there has been an 16% decrease in heroin deaths since 2017.

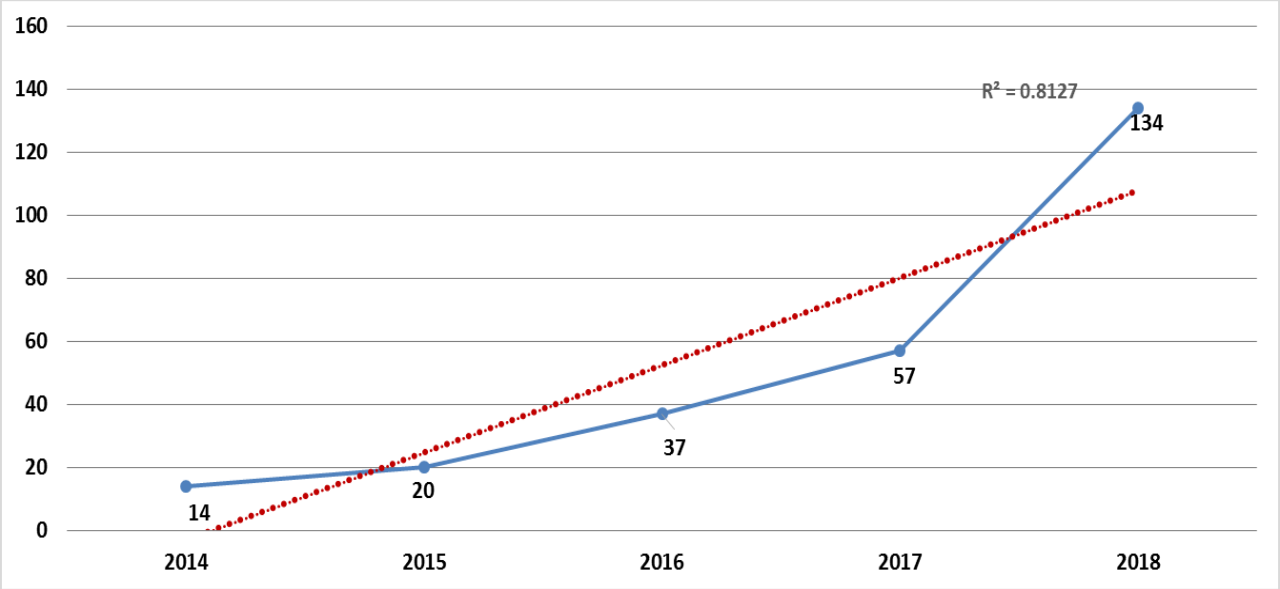
Deaths Caused by Heroin Usage



Deaths caused by Fentanyl

Fentanyl is a powerful Schedule II synthetic opiate painkiller that can be lethal and is deadly at very low doses. It is produced clandestinely in Mexico, and also comes directly from China. Fentanyl is up to 50 times more potent than heroin. The dosage of fentanyl is a microgram, one millionth of a gram – similar to just a few granules of table salt. A very small amount ingested, or absorbed through the skin, can kill a person. In addition to fentanyl, the US Drug Enforcement Agency has identified at least 15 other deadly, fentanyl-related compounds, known as analogues. Analogues are slight chemical variations of the parent drug and can be even more potent than fentanyl. Because of the extreme inherent danger of these chemicals, the Coroner Division and the Forensic Chemistry section of the Orange County Crime Lab have been aggressively targeting the analysis of these compounds.

As with heroin we have been showing the progression of fentanyl deaths by building a base in previous years and continuing to track the numbers. The chart below shows the number of fentanyl deaths over a five year period and combines the analog (illicit) and prescription related deaths. The number of fentanyl related deaths saw an increase of 164% between 2014 and 2016 and an increase of another 54% between 2016 and 2017. In the year 2018 the number has spiked to 134 deaths which is a 135% increase over 2017.

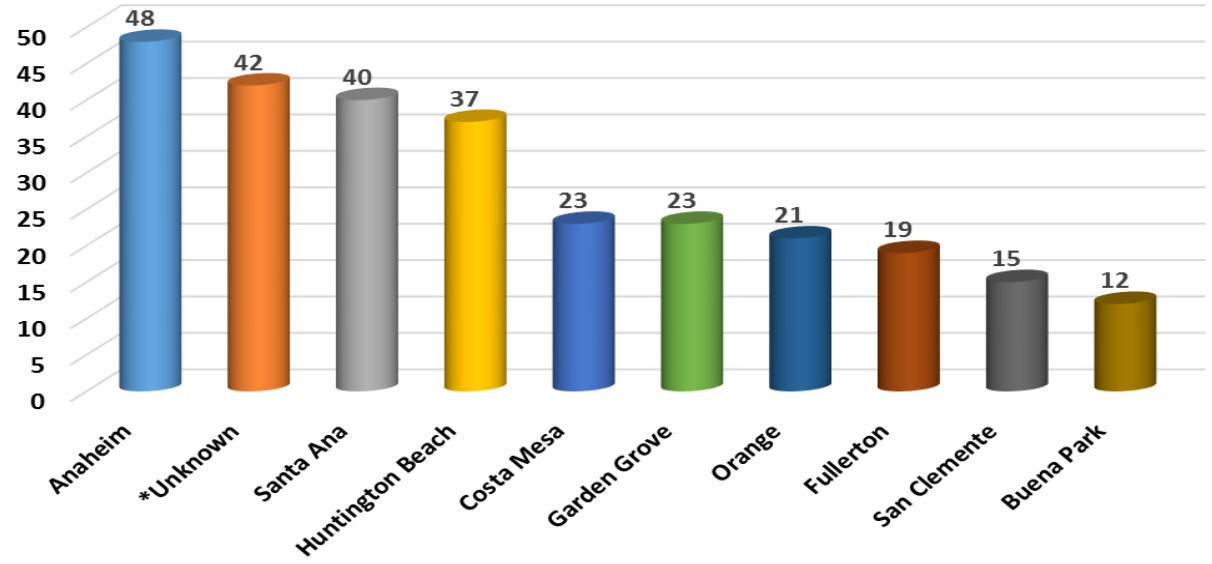


Deaths Caused by Drug Overdose By Event City

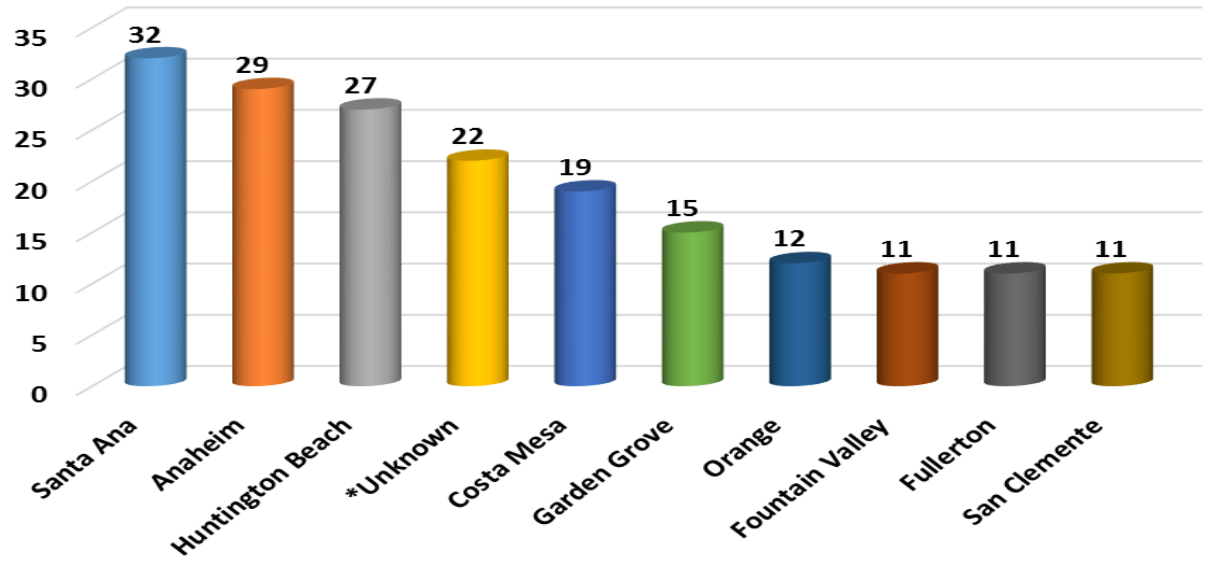
There have been many inquiries over the past years as to the cities in which drug overdoses are occurring. In order to answer this question we will now include in this report a chart showing the top ten event cities for drug overdoses and the top ten event cities for opioid drug overdoses.

*Due to the unpredictable nature of most drug overdose events, the exact location is not always known.

Top 10 Event Cities—Drug Overdoses



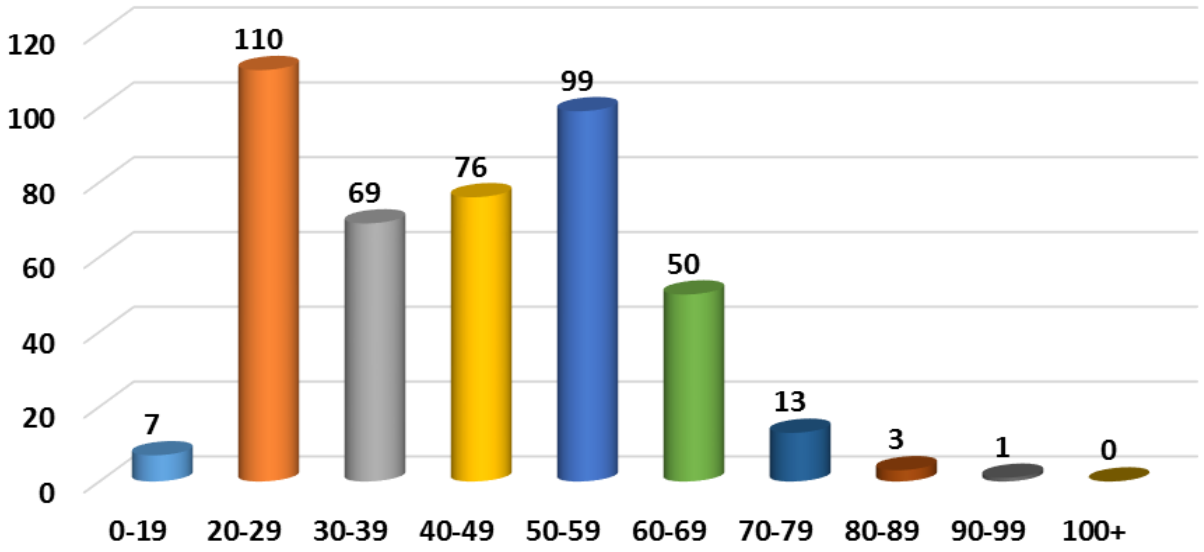
Top 10 Event Cities—Opioid Overdoses



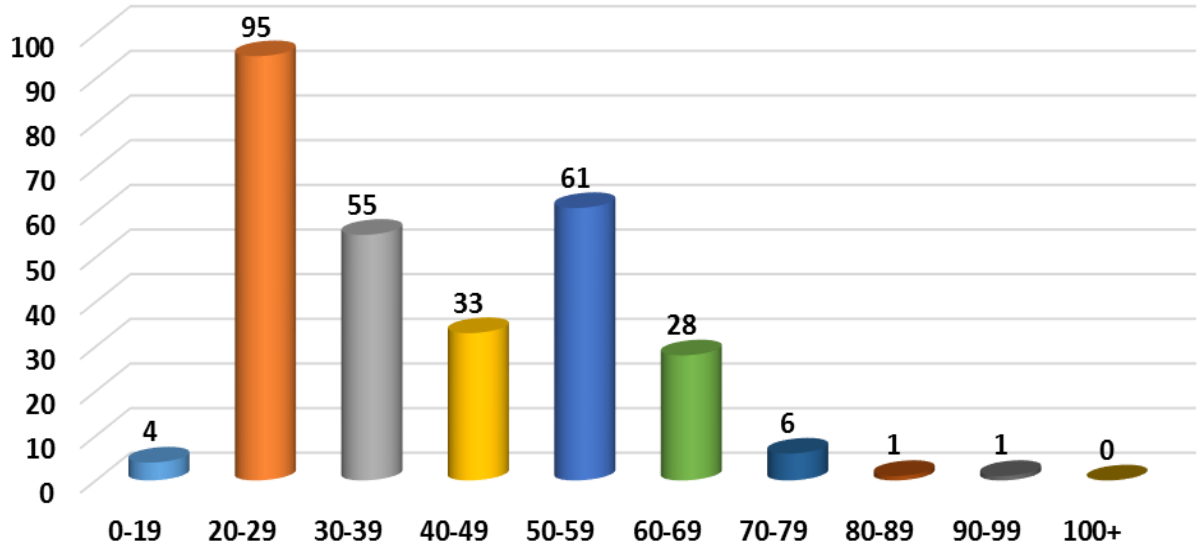
Deaths Caused by Drug Overdose By Age

Along with the interest in where the drug overdose deaths are occurring is an interest in the ages of the decedents. To assist with that the charts below show the number of drug overdose deaths by age and the number of opioid overdose deaths by age.

Drug Overdose Deaths by Age



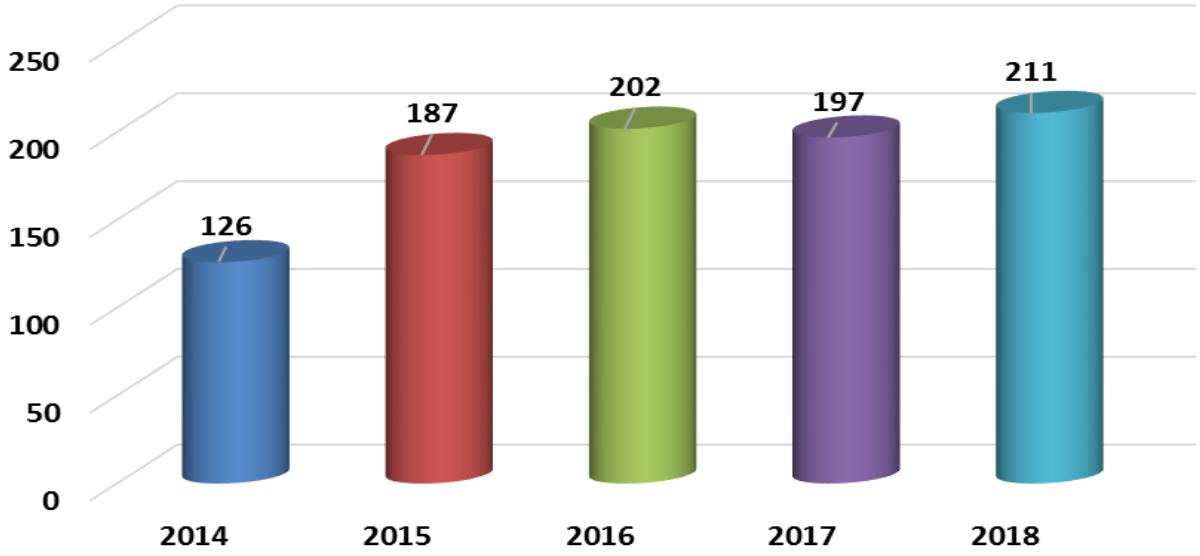
Opioid Overdose Deaths by Age



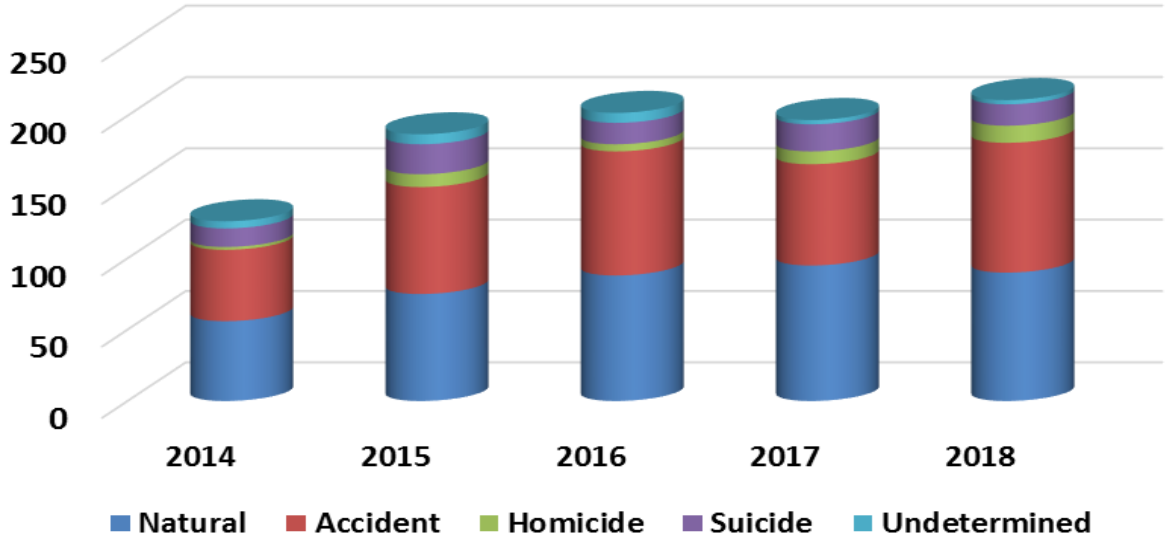
Homeless Deaths

Since 2016 the Coroner Division has seen an increase in requests for information regarding deaths of homeless people. Because not all deaths are reported to the Coroner, the following information is a partial, but very helpful, look at this growing concern. Homeless is defined as no fixed abode as reported by the decedent prior to death, evidence or next of kin.

Homeless Deaths By Year—5 Years

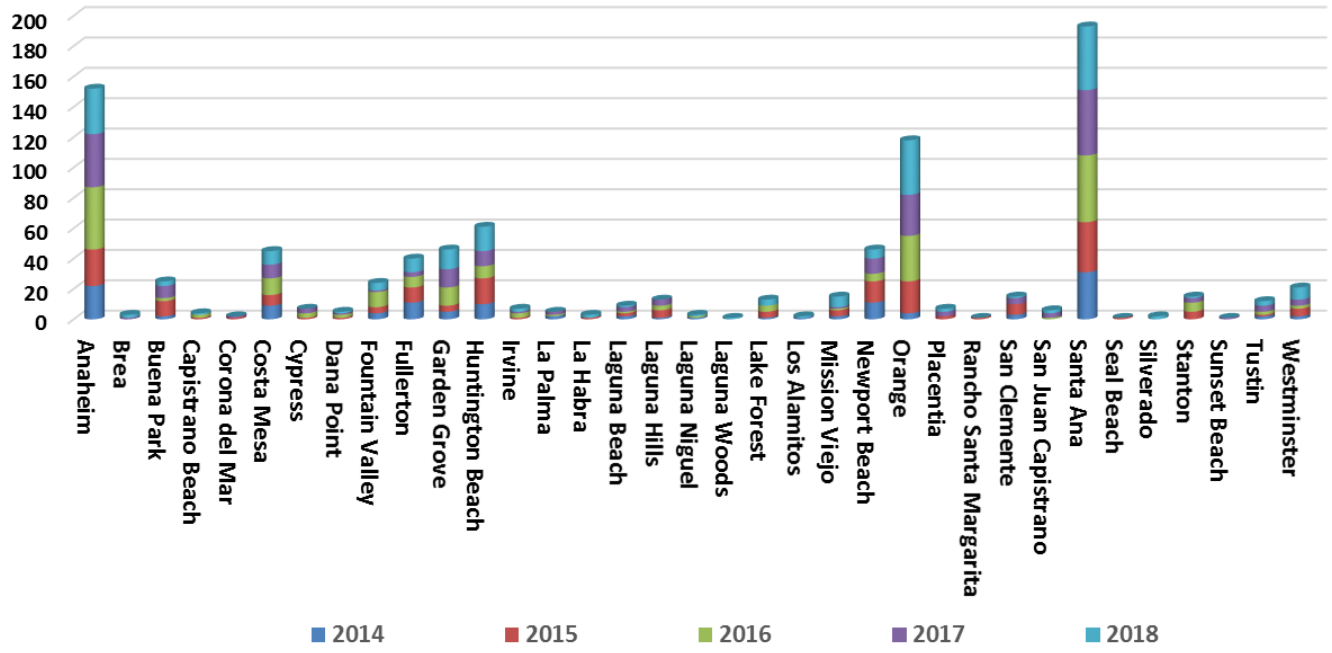


Homeless Deaths By Manner By Year—5 Years

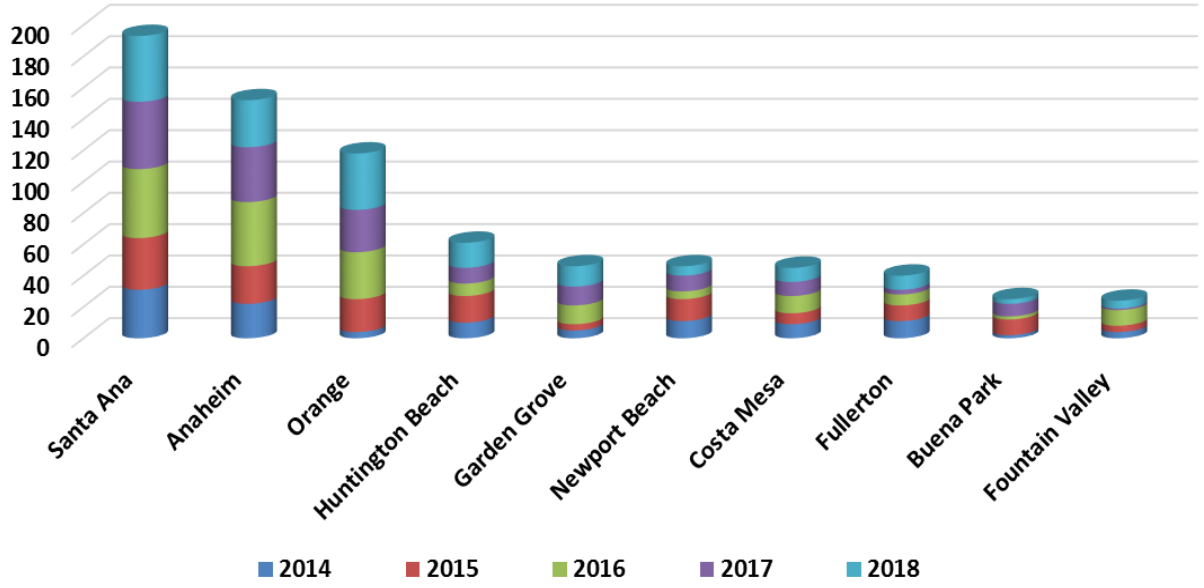


Homeless Deaths

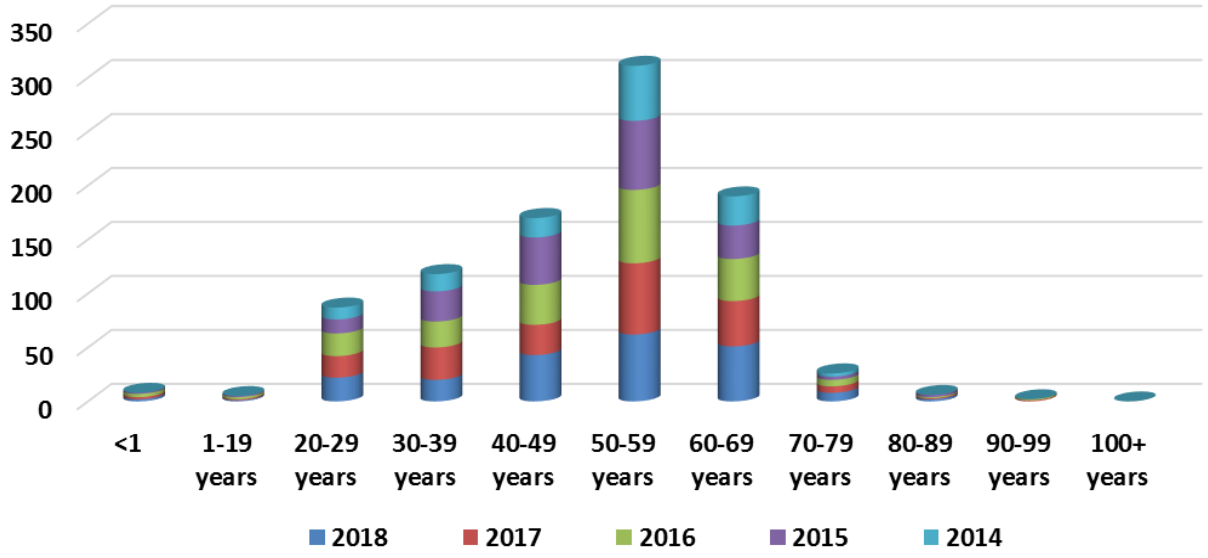
Homeless Deaths By City—5 Years



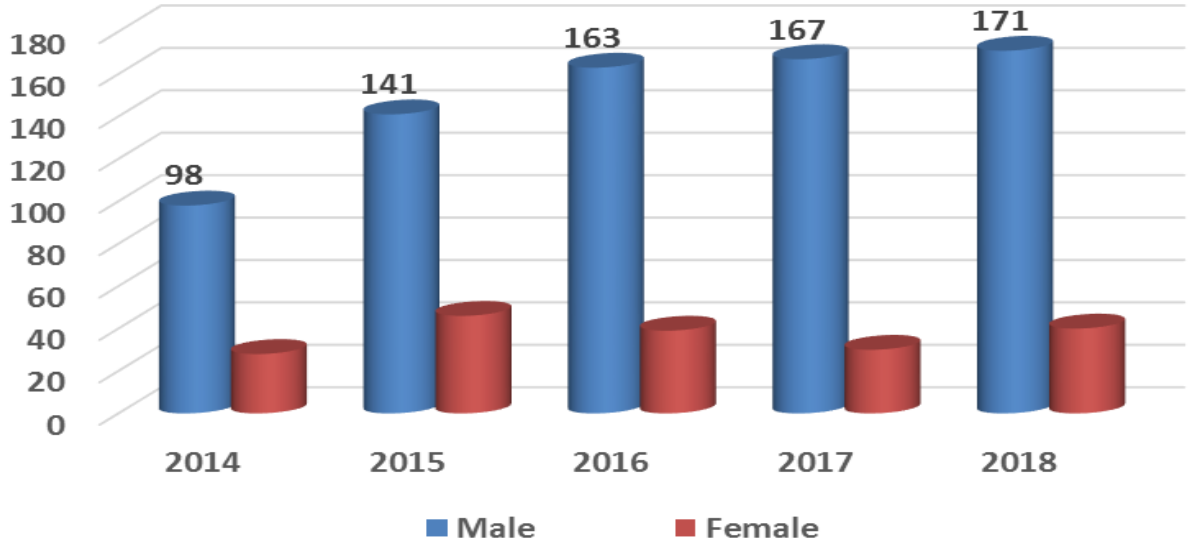
Homeless Deaths—Top 10 Cities—5 Years



Homeless Deaths By Age—5 Years



Homeless Deaths By Gender—5 Years



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