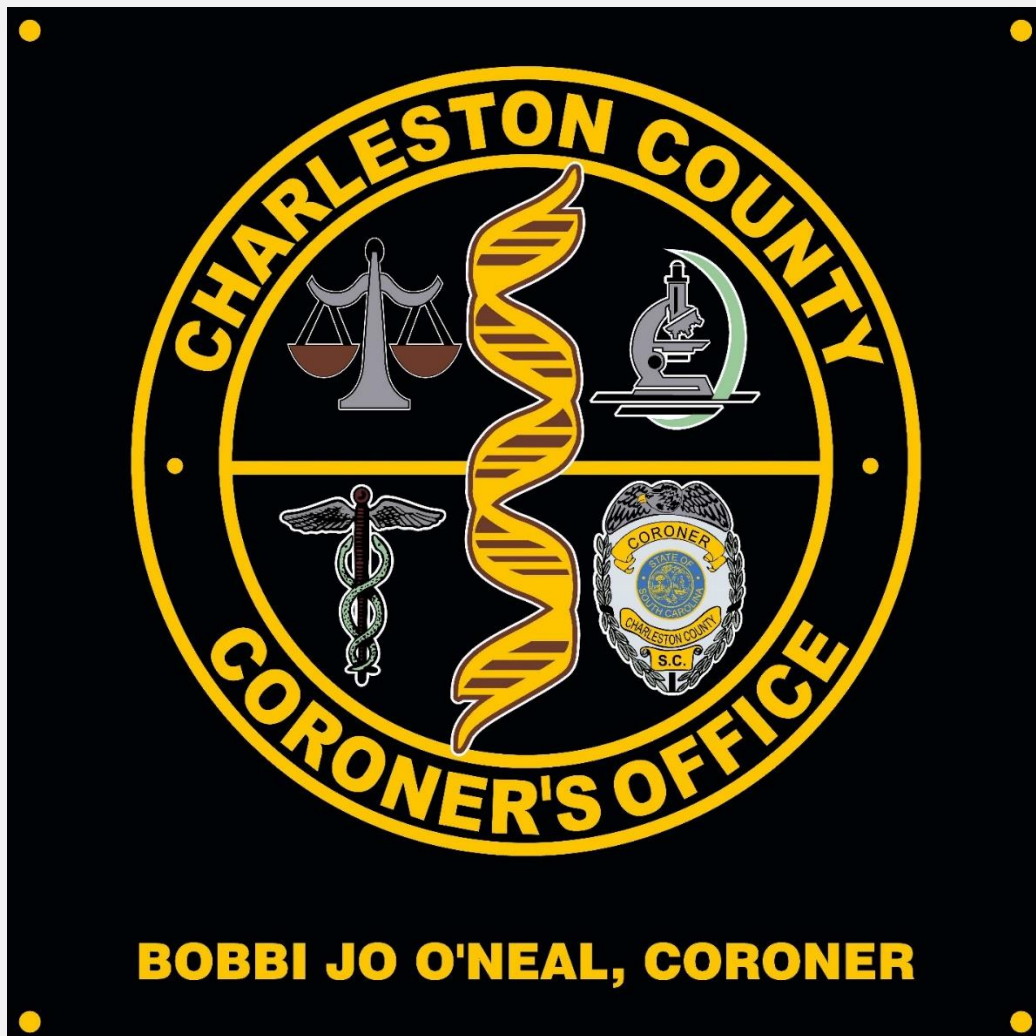


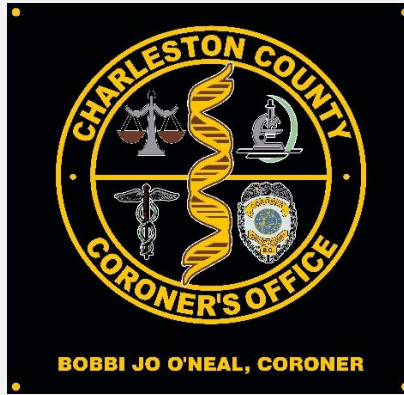
Charleston County Coroner's Office 2023 Annual Report



BOBBI JO O'NEAL, CORONER

**Bobbi Jo O’Neal
Coroner**

**Brittney W. Martin
Chief Deputy Coroner**



**Office of the Coroner
4000 Salt Pointe Pkwy.
North Charleston, SC 29405
843.746.4030**

To the Citizens of Charleston County,

I am pleased to share the 2023 Charleston County Coroner’s Office Annual Report. The goal of this report is to increase public awareness regarding the role of the Coroner’s Office by bringing attention to the causes and manners of death in our county. It is our goal to then try to reduce the number of preventable deaths to the extent possible.

The information contained in this annual report derives from sources reviewed by the Charleston County Coroner’s Office. These sources include coroner’s reports, toxicology reports, autopsy reports, police reports, death certificates, cremation permits and motor vehicle collision reports, among others.

If you have any questions or need any additional information, please feel free to contact the Charleston County Coroner’s Office.

As always, thank you for your support,

Bobbi Jo O’Neal, RN, BSN, F-ABMDI
Coroner of Charleston County, SC

DEDICATION

Dedicated to those lost in 2023.

To the citizens of Charleston County and beyond, who grieve the loss of loved ones, it has been an honor and privilege to serve you during your time of greatest need.

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MISSION STATEMENT

We will conduct medicolegal death investigations in an independent, compassionate, and professional manner to determine the full truth of the circumstances surrounding a death while serving as a representative of the decedents and an advocate to the survivors.

CORONER BOBBI JO O'NEAL



Bobbi Jo O'Neal, a Registered Nurse, and a Board-Certified Fellow with the American Board of Medicolegal Death Investigators, has served in the Coroner's Office since 1998, including serving as Chief Deputy Coroner from 2011-2020. She was elected Charleston County Coroner in 2020.

With her leadership, the Charleston County Coroner's Office is one of only 40 coroner offices in the country that holds accreditation by the International Association of Coroners and Medical Examiners. Additionally, as a grant writer for the Coroner's Office, O'Neal has successfully brought in over \$2 Million in funds to Charleston County.

O'Neal is the President of the South Carolina Coroner's Association, the immediate past President of the International Association of Coroners and Medical Examiners (IACME) and the current Chair of the IACME Board of Directors. She serves on the Executive Committee for the Lowcountry Healthcare Coalition and the Board of Directors of the Consortium of Forensic Science Organizations representing IACME. She is also a President's Appointee to the Justice and Public Safety Policy Steering Committee for the National Association of Counties and a member of the Public Safety, Corrections and Judicial Steering Committee for the South Carolina Association of Counties.

An experienced emergency room nurse, O'Neal received her Bachelor of Science in Nursing from Belmont University in Nashville, Tennessee. She is and has been actively involved in the specialty of forensic nursing, first in sexual assault investigation and then as a death investigator.

She is a member of the National Association of Medical Examiners, a Fellow with the American Academy of Forensic Science, a member of the South Carolina Coroner's Association, and a member of numerous national committees which seek to develop protocols and training material for medicolegal death investigators.

A former Director-at-Large for the International Association of Forensic Nurses, O'Neal is the author of the book "Investigating Infant Deaths". Coroner O'Neal has had the unfortunate distinction of investigating the mass fatalities for the 9 firefighters killed during the fire at the Charleston Sofa Super Store in 2007 and the 9 victims of the Mother Emanuel AME mass shooting in 2015.

Coroner Bobbi Jo O'Neal was awarded Coroner of the Year in 2022 by the South Carolina Coroner's Association and received the 2023 Partner Award from We Are Sharing Hope for her support of organ and tissue donation.

PROFILE OF THE CHARLESTON COUNTY CORONER'S OFFICE

The Office investigates the circumstances surrounding a person's death independently of any law enforcement agency with the primary role of determining the "Cause" and "Manner" upon notification of deaths that are unexpected, unexplained, suspicious, violent or in which the cause and/or manner of death is unknown. Additionally, the coroner is also responsible for identifying decedents and making notification to next-of-kin.

The Coroner's Office advocates for families by notifying and advising them of the circumstances surrounding the death known at the time. The Office provides updates to the families after autopsy and/or when further investigation reveals new information. Additionally, we refer families to resource agencies when necessary to assist them through the grieving process.

This Office works with organizations such as We Are Sharing Hope and Miracles in Sight to facilitate the family or decedent's wishes regarding organ and tissue donation whenever possible. The Office also collaborates with involved law enforcement agencies, the concerned parties of civil suits and criminal cases within the judicial system, insurance companies, the Consumer Product Safety Commission, the South Carolina Department of Health and Environmental Control (DHEC), the Occupational Safety and Health Administration (OSHA) and many others.

Medicolegal death investigation provided by the Charleston County Coroner's Office may involve many things, to include but not limited to, scene response, scene and decedent photography, ordering of forensic autopsies (authorized by SC Code 17-5-520), anthropologic and odontology examinations, fingerprint collection and ordering of fingerprint comparison, etc. Collection and testing of toxicology samples and/or DNA samples are also part of the investigation.

Scene investigations include, but are not limited to, child and infant death investigations and re-enactments, homicides, suicides, industrial and residential accidents, motor vehicle accidents, deaths due to abuse/neglect/negligence, terrorist acts, death due to malpractice, mass fatalities, arson, drowning, drug-related and fire deaths. The Coroner may hold a formal inquest to determine the "Manner of Death". There were no inquests held in 2023.

Charleston County is located along the southeastern coast of South Carolina. It encompasses approximately 916 square miles of land, marshes, rivers and wetlands with a coastline that stretches nearly 100 miles along the Atlantic Ocean. The Office serves approximately 424,367 residents of Charleston County.

The Charleston County Coroner's Office homepage can be found here: <https://www.charlestoncounty.org/departments/coroner> and on Facebook: <https://www.facebook.com/charlestoncoroner>; Instagram: Chscoroner.

COMMUNITY ENGAGEMENT AND EDUCATION

Throughout the course of 2023, Coroner O'Neal and various deputy coroners presented case studies and/or training lectures at numerous professional organization and association annual conferences, training sessions or events.

Some of the organizations or events included:

- International Association of Coroners and Medical Examiners
- RTI International
- SC International Association for Identification
- American Academy of Forensic Sciences
- National Association of County and City Health Officials
- CDC Foundation
- Mcleod Regional Medical Center Forensic Nursing Training Program
- Charleston Charter School of Math and Science
- Charleston Police Department
- Black Expo Charleston
- Charleston Southern University
- Patriot Villas Breaking Bread Event
- Charleston County Emergency Medical Technicians Training Academy
- Career Fair for Wando/East Cooper Center for Advanced Studies
- National Forum on Overdose Fatality Reviews
- National Violent Death Reporting System
- Lowcountry Healthcare Coalition
- Historic Cemeteries Research Symposium

LEGISLATIVE ADVOCACY AND RECOGNITION

For the past few years, Coroner O'Neal has been a strong advocate for legislative amendments to several statutes which govern coroner affairs. In conjunction with the SC Coroner's Association, she spoke to the SC House and Senate subcommittees about the following statute amendments:

- Section 17-5-150 so that coroners and deputy coroners are considered public safety officers who qualify for line of duty death benefits.
- Section 17-5-135 which allows coroners or deputy coroners to possess and administer opioid antidotes and Section 44-130-90 which provides procedures after the administration of the antidote and for the reporting of their use.
- Section 17-5-130 so that coroner candidates for office shall have completed appropriate training/education and not merely be enrolled in a qualifying program. Additionally, that qualifying candidates may include licensed paramedics with three years of experience.

Coroner O'Neal also advocated to the SC House of Representatives and Charleston County Council to recognize National Coroner Week in proclamations which took place in 2023 and early 2024.

BUDGETING AND FISCAL RESPONSIBILITY

The Coroner of Charleston County is an elected official and the Coroner's Office is funded by tax revenue provided by the citizens of Charleston County. Annually, Coroner O'Neal submits a budget proposal to Charleston County Council for approval. Once the budget is approved by the full Council, the Finance Department of Charleston County administers the approved funds.

The Fiscal Year 2023 approved budget for the Coroner's Office was \$3,238,909. The Fiscal Year 2024 approved budget for the Coroner's Office is \$3,571,750. The last six months of FY2023 and the first six months of FY2024 combine to financially account for the calendar year 2023.

On January 1, 2023, the National Center for Fatality Review and Prevention (NCFRP) in collaboration with the CDC Foundation, awarded the Charleston County Coroner's Office \$56,450.00 for the Barriers to Participation in CDC's Cooperative Agreement for the Sudden Unexpected Infant Death (SUID) and Sudden Death in the Young (SDY) Case Registry grant. This grant funded personnel to improve the Child Fatality Review process and upload data to the NCFRP Case Registry database.

On July 1, 2023, the Charleston County Coroner's Office was awarded \$47,835.00 from the South Carolina Department of Public Safety Office of Justice Programs Paul Coverdell Forensic Science Improvement Grants Program for the grant titled: "Improving and Expanding Forensic Autopsy Services in Charleston County, SC". This is the second year of a possible three-year grant which improves the quality and timeliness of forensic autopsy services by employing a full-time autopsy technician.

On September 30, 2023, the Center for Disease Control and Prevention (CDC) awarded the Charleston County Coroner's Office a Cooperative Agreement, giving the Coroner's Office \$1,095,300 over five years. These funds will expand and improve the death investigations of minors in Charleston County and surrounding counties. It will support the quality and timeliness of child death data entered in databases for the National Center of Fatality Review and Prevention, the Sudden Unexpected Infant Death, and the Sudden Death in the Young registries. It will also expand biological and genetic testing for complex cases.

In addition, Coroner O'Neal submitted two large project proposals to the SC Department of Public Health's Lowcountry Healthcare Coalition's Healthcare Preparedness Program (HPP) which was fully grant-funded totaling \$385,215.

The projects were:

1. The purchase of approved contract, training and supplies for the SC Coroner's Association Mass Fatality Strike Team (MAST) formation, coordination, training and exercising to meet the needs identified in the state and local Incident Action Plans regarding mass fatality situations. Once formed and trained, this unique MAST unit will be able to competently respond anywhere in the state

should a mass fatality occur. Additionally, this grant will fund the purchase of family reunification software. The appropriation for this was \$233,425.

2. Secondly, \$50,970 was awarded to purchase items listed within the approved Lowcountry Healthcare Coalition project guidelines to include “I Love U Guys” (ILUG) training and mass fatality tabletop exercises for the Lowcountry Healthcare Coalition partners (LHCC). The ILUG Foundation provides a continuity of expectations and actions for schools during security or emergency situations. The training for the LHCC and school emergency managers provided for the uniform, planned, and practiced response to any emergent incident with specific focus on the operation of a family reunification center.
3. Lastly, Coroner O’Neal’s application for an award of \$101,000 for an additional advanced point-of-care forensic toxicology unit to the Lowcountry Healthcare Coalition was approved in 2023. This desktop unit known as an Evidence Multistat made by Randox Toxicology is an automated analyzer that enables on-site simultaneous detection of up to 21 classical, prescription and synthetic drugs from a single sample. The testing platform provides a complete toxicology profile within minutes. Having an additional unit in the region improves medicolegal services, decreases the wait time for forensic autopsies, and mitigates the shortage of forensic pathologists while caring for decedents in a professional way.

UNCLAIMED VETERAN BURIAL

The unclaimed cremated remains of two US Veterans who were in the care of the Charleston County Coroner’s Office were escorted to Columbia in early December 2023 in preparation for their interment at Fort Jackson National Cemetery the following week. About 20 staff members from the Coroner’s Office stood in honor of the Veterans as they left our Office escorted by 22 motorcycle riders from the American Legion Chapter 166 from Goose Creek and the Patriot Guard Riders.

UNCLAIMED OR IDENTIFIED REMAINS

From 1980-2022, the Charleston County Coroner’s Office entered 35 cases into the National Missing and Unidentified Persons System (NamUs) (www.namus.jjj.ojp.gov). NamUS is a national centralized repository and resource center for missing, unidentified persons, and unclaimed remains cases across the United States. NamUs helps investigators match long-term missing persons with unidentified remains to resolve cases and bring resolution to families. In 2023, the Office added two more cases to NAMUS. One case involved a decedent who was subsequently identified through our investigation. The second case was a recovered mandible which is pending further testing.

POTTER'S FIELD

From the early 1960s to the mid-1990s, Charleston County maintained an indigent or unclaimed decedent cemetery comprised of unmarked grave sites within a triangular 2.65-acre track located on Johns Island. This site is referred to as a "Potter's Field". Coroner O'Neal retained Brockington and Associates, Inc. to prepare a map of the depressions within the cemetery and to conduct a ground penetrating radar (GPR) survey. That survey was started and completed in 2023. Additionally, the property was mowed, and many small trees were removed. A new perimeter fence will be installed. Plans for the site include installing an updated and complete fence on the perimeter and regular landscape maintenance.

NON-CHARLESTON COUNTY RESIDENT CASES

The Charleston County Coroner's Office investigated 144 deaths in 2023 in which the decedent resided out-of-county. These non-Charleston County resident deaths largely originate from medical complexes that draw high-level trauma patients from surrounding counties. They also come from transient populations such as tourists, out-of-state college students, and migrant workers. While non-Charleston County residents made up just 10% of Charleston County Coroner cases, these investigations consumed approximately 10% of the total amount spent on autopsies and toxicology costs.

MASS FATALITY PREPARATION AND EXERCISES

In the Spring of 2023, the Office participated in a virtual/functional mass casualty exercise hosted by the SC DHEC Lowcountry Healthcare Coalition. This virtual/functional exercise simulated a situation which would overwhelm the area healthcare infrastructure resources.

In June of 2023, the Office participated in an objective driven and capability-based Mass Rescue Operations (MRO)/Mass Casualty Incident (MCI), operational-based full-scale exercise (FSE) hosted by the Charleston County Emergency Management Department. The FSE was conducted to test and evaluate the county's emergency operations plan, policies, and procedures during its prevention, protection, mitigation, response, and recovery from an all-hazards incident involving a cruise ship that collided with an offshore supply vessel in the Charleston Harbor.

In September, Chief Deputy Martin participated in a Family Assistance Operations course Tabletop Exercise (TTX) hosted by the National Transportation Safety Board as part of the Family Assistance Operations Course in Fairfax, VA. This exercise scenario involved an airplane accident occurring on airport property with multiple fatalities and survivors. In mid-September here in Charleston, members of the Office participated in a full-scale mass casualty exercise hosted by the Charleston County Aviation Authority Operations Department.

BUILDING ANNEX AND RENOVATION PROJECT

Throughout the year and in conjunction with the Charleston County Capital Projects Department and with approval from County Council, plans were solidified to add a 3,000 sq. ft. annex and a partial renovation of the Coroner's Office facility. The plans surround the addition of a grant-funded CT machine by relocating the existing evidence storage rooms to the annex and renovating those spaces to house the CT machine. Included in the renovation of the existing building are plans to add office space and relocation of the second-floor conference room to the first floor. A second morgue cooler will be added to the annex. Groundbreaking will begin in the Spring of 2024.

PUBLIC HEALTH GRANT FUNDED PROJECTS

The Charleston County Coroner's Office employs a full-time Child Death Review Coordinator and a Sudden Death in the Young Research Coordinator funded through a cooperative agreement with the Center for Disease Control (CDC). These employees work to reduce the amount of sudden unexplained infant deaths by advancing the investigation of child deaths, improving the quality and timeliness of data sharing among agencies, addressing communities that are disproportionately affected by sudden infant deaths, and identifying prevention strategies and proposing policy changes at the local and state level.

The Office also employed two full time opioid specialists funded through the Bureau of Justice Assistance and the CDC Foundation to advance the quality of drug death investigations by improving the timeliness of toxicological results and by working to share drug death data with nationwide stakeholder agencies. They participate in harm reduction activities alongside treatment centers and are active in local overdose fatality reviews.

2023 ORGANIZATIONAL CHART

Citizens of Charleston County

Coroner

Bobbi Jo O’Neal, RN, BSN, F-ABMDI

Chief Deputy

Brittney W. Martin, BS, F-ABMDI

Investigations

Sr. Deputy/Supervisor

Dottie Lindsay, F-ABMDI

Deputy Coroner III

Sara K. Tuuk, BS, MS, F-ABMDI

Deputy Coroner II

Anita Roman, BS, F-ABMDI

Elizabeth Dobbins, BFA, D-ABMDI

Kelley Nevill, D-ABMDI

Stacey Toto, BS, F-ABMDI

Deputy Coroner I

Ty’Reik Faulks, BS

David Reynolds

Angela Biela, RN

Ella Butler, MSc,

Joshua Ambrite, RN

Crystal Bright, BS, MS

Administrative Services

Coordinator - Nicole Brown, BHuServ, BA

Paralegal - Joe Crawford, M. Ed., MSCJ

Administrative Assistant – Nickayla Riley

Forensic Services

Supervisor

Dep. Kelly Gallagher, BA

Autopsy Technicians

Dep. Miracle Randall, LFD

Katie Copp, BS (grant funded)

Rebecca Phipps, BA

Project and Evidence Mgr.

Dep. Nancy Peacock

Epidemiology and Grants Mgr.

Suzanne Abel, PhD

Grant-Opioid Investigator

Ashleigh Jordan, BA

Grant- Child Death Review Specialist

Alison Garbarini, MPH, D-ABMDI

Contracted Consultants

Forensic Anthropologist

Suzanne Abel, PhD

Forensic Odontologist

Dr. Wolf D. Bueschgen, DMD

Forensic Pathologists

Dr. Janice Pat Ross

Dr. J.C.U. Downs

Dr. Stephen Cina

INVESTIGATION and DISPOSITION OF CASES

The following description is a general overview of the processes during a “jurisdiction assumed”, full investigation and the follow-up processes.

Upon arrival at a death scene, the Coroner, or a deputy coroner, will speak with first responders, law enforcement officers and any witnesses to become familiar with the circumstances surrounding the incident and any safety considerations prior to entering the immediate scene. The Coroner, or the deputy, will take notes and utilize photographs and/or video to further document the scene. They also collect and preserve evidence and personal property on or around the body/remains. In some crime scene situations, the Coroner or deputy will coordinate with law enforcement officers regarding the collection of evidence.

The Coroner or deputy makes every effort to identify the decedent utilizing at least two of the following methods: government-issued photo ID of the decedent that matches the decedent’s physical characteristics/features; fingerprint analysis; comparison of significant scars, marks and tattoos; birth defects and presence of prosthetics; coordination of odontology examination (dental X-rays); coordination of forensic anthropology analysis (skeleton/bones); DNA analysis and other methods.

If the Coroner or deputy deems it necessary to conduct a postmortem examination (autopsy), the contracted transport vendor transports the decedent to our in-house morgue/autopsy suite or to the Department of Pathology and Laboratory Medicine at the Medical University. This office also notifies the interested law enforcement agency of the autopsy schedule. The collection and preservation of all evidence rendered from an autopsy is of utmost importance to the investigation.

The Coroner or deputy makes every effort to identify, locate and notify the legal next of kin of the death in a timely manner and in person, if possible. The Office also facilitates the release of the remains to the funeral home selected by the next of kin or facilitates the cremation and burial for unclaimed decedents.

The Coroner’s Office is responsible for obtaining and reviewing medical records related to both the present event, and past medical records, as they might have relevance to the death. This office summarizes the information gathered through the investigation in a written report and stores related documents in a records management system. Upon request, the Coroner’s Office provides copies of their investigative case records to the Solicitor’s Office, the Public Defender’s Office and invested law enforcement agencies.

The Coroner’s Office contracts the services of Drs. Suzanne Abel (forensic anthropologist) and Wolf Bueschgen (forensic odontologist) for analysis and processing of evidence in the form of skeletal or badly decomposed remains. The anthropologist and odontologist work together to provide the Charleston County Coroner’s Office with biological profiles that assist the Coroner’s Office with identifying individuals, as well as documenting findings that may assist with determining cause

and manner of death. They also provide timely, precise, and detailed reports that assist in furthering the investigation.

In approximately 27% percent of the cases, which is 718 out of 2,654 deaths reported, a full forensic autopsy was performed to aid in the determination of the cause and manner of death and to evaluate any disease or injuries that may be present and to recover any items of evidentiary or investigative value. The cases not autopsied were those in which a combination of scene investigation, known circumstances of death, medical documentation, interviews, social history, and/ or external examination of the body and toxicology information provided sufficient information for certifying the cause of death.

Specimens for toxicology testing, which may be helpful in determining the cause and manner of death, are submitted to a nationally accredited laboratory or the State Law Enforcement Division (SLED) crime lab for testing. Toxicology tests provide quantitative measures of blood levels for: alcohol, illicit drugs, commonly abused prescription and nonprescription drugs, and other substances as needed. In 2023, the Office ordered 743 tox tests.



Our office at 4000 Salt Pointe Parkway in North Charleston since 2017.

“CAUSE” and “MANNER” OF DEATH

The **Cause of Death** is the official determination of the specific disease or injury and the sequence of events that leads to an individual's death.

The **Manner of Death** is determined largely by means of the investigation and relates to circumstances surrounding the death. In South Carolina, as is common in the United States, there are five manners of death as listed below.

NATURAL: Death caused by disease.

SUICIDE: Death because of a purposeful action to end one's own life.

ACCIDENT: Death, other than natural, where there is no evidence of intent.

HOMICIDE: Death resulting from injuries inflicted by another person.

UNDETERMINED: Manner assigned when after a thorough investigation there is insufficient evidence, or conflicting/ equivocal information (especially about intent), to assign a specific manner.

2023 STATISTICS

There were 2,654 deaths reported to the Charleston County Coroner's Office in 2023. Regarding those deaths, 2,082 (78%) were classified as "Natural" deaths, 412 (16%) were classified as "Accident"; 74 (3%) were classified as "Suicide"; 54 (2.0%) were classified as "Homicide"; and 32 (1%) were classified with an "Undetermined" manner. The grand total of all requests for services plus death investigations was 4,444.

In addition to investigating these deaths which was 50% of all deaths in our county (5,311 total) and authorizing cremations for 2,405 of the investigated cases, the Coroner's Office was involved to various degrees with requests for services which included:

- 58 requests to make a death notification to next-of-kin by other jurisdictions,
- 99 cases were preliminarily investigated via telephone inquiries which subsequently were turned over to other jurisdictions due to their having jurisdiction in the case.
- 1 agency assist where work was completed to assist other coroner jurisdictions in a death investigation.
- 17 cases of recovered bones (3 human and 14 non-human).
- Grand total of cremation permits: 3,078
 - Cremation permits issued with reported deaths: 1,544
 - Stand-alone Cremation Permits: 1,440
 - Fetal Cremation Letter: 92
 - Agency Assist for ID and cremation: 1
 - Notification with Cremation Permit: 1
- Full autopsy: 718 cases; At the Coroner's Office: 538; At MUSC: 180
- Number of external exams ordered: 2; At the Coroner's Office: 2
- Decedents in law enforcement custody: 3. Two at the AI Cannon Detention Center: 1-Natural manner; 1- Accident manner/drug toxicity. One involved a police vehicle chase/motor vehicle collision- Accident manner.
- Number of cases utilizing contracted forensic anthropology: 17
- Number of cases utilizing contracted forensic odontology: 3
- Deceased transports to morgue: 707; transported for storage only: 88
- Toxicology tests ordered: 743
- Unidentified decedents: 0
- Exhumations: 0; Unclaimed: 15
- Release for organ donation: 12; actual organ donation cases:10
- Release for tissue donation: 122; actual tissue donation cases: 10
- Coroner cases declined for donation: 0 organ and 7 for tissue.
- Scene Investigations: 948
- Reported deaths in children under 18 years old: 71, see statistics on pg. 23

2023 “HOMICIDE” STATISTICS

The manner of death is classified as a “Homicide” when it results from injuries inflicted by another person or inflicted on another by one’s grossly reckless behavior. The Coroner’s Office is not responsible for determining if a homicide was justified or not and classifies those deaths as “Homicides” in these statistics.

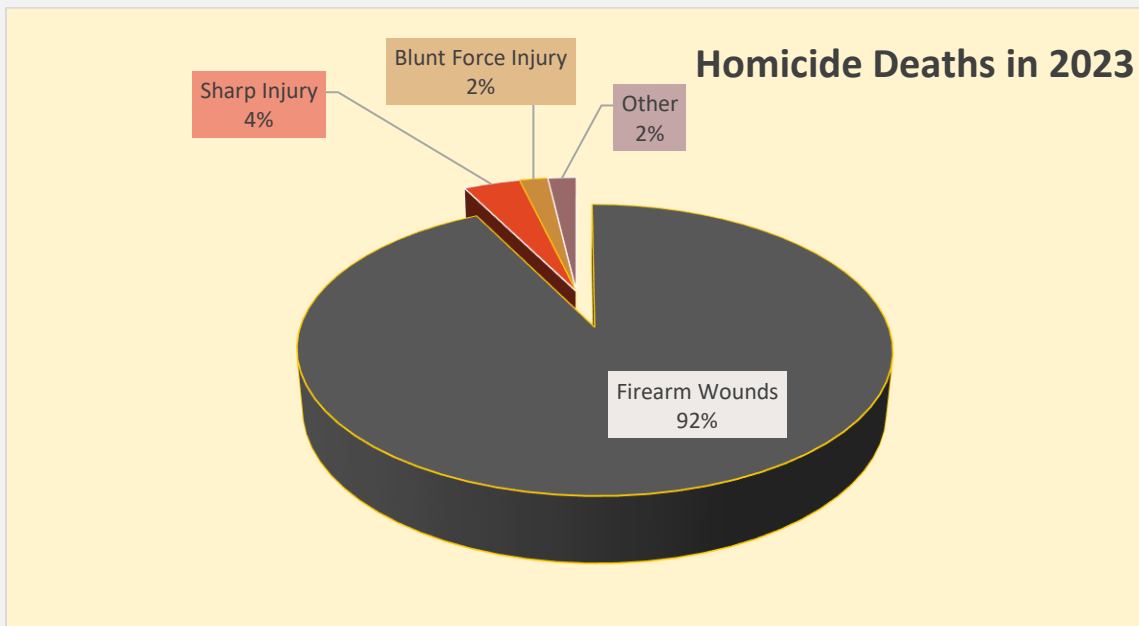
In addition, a death is classified as a “Homicide” regardless of the length of time between an incident causing injuries that results in death which can be attributed to those injuries.

South Carolina Code of Laws section 16-3-5 states “A person who causes bodily injury which results in the death of the victim is not criminally responsible for the victim's death and must not be prosecuted for a homicide offense if at least three years intervene between the injury and the death of the victim.” This three-year window does not apply to the classification of manner of death when the death is attributed to the injuries inflicted by another person or inflicted on another by one’s grossly reckless behavior.

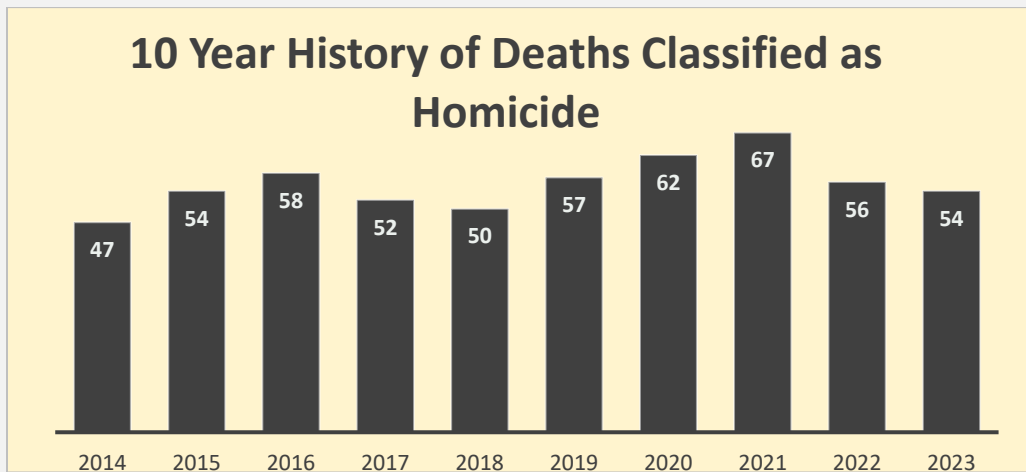
Vehicular collisions, occurring in circumstances of reckless driving or driving under the influence, are NOT included in this category but are counted in the traffic collision statistics under the manner - Accident.

In 2023, there were 54 deaths classified as “Homicide” in Charleston County. The causes include:

- 50 firearm injuries
- 2 sharp force injuries
- 1 blunt force injuries
- 1 toxic effects of lidocaine administration



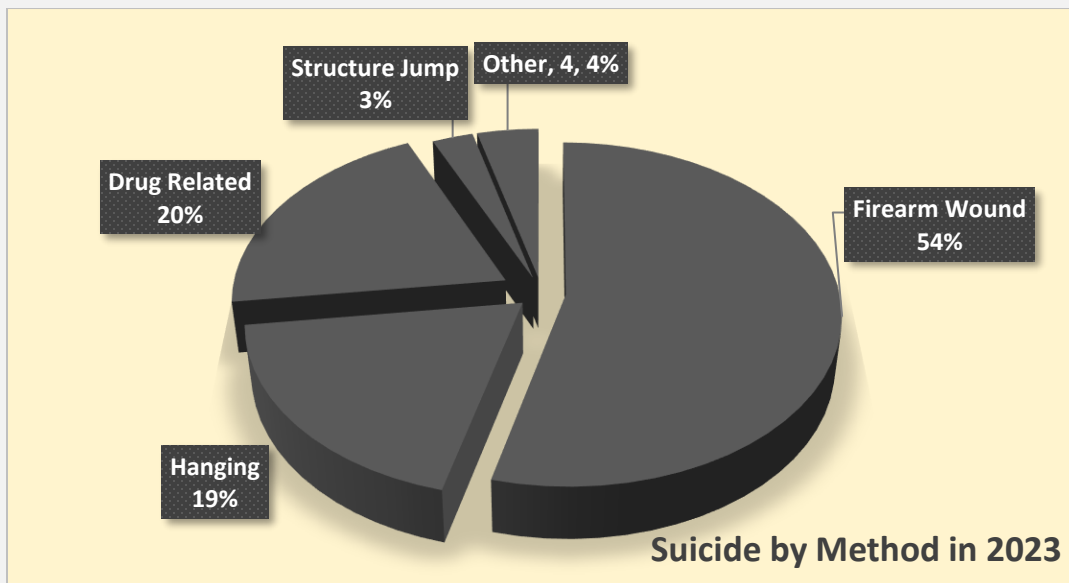
A review of the number of deaths classified as “Homicide” in Charleston County over the past 10 years shows the average number per year is 56.



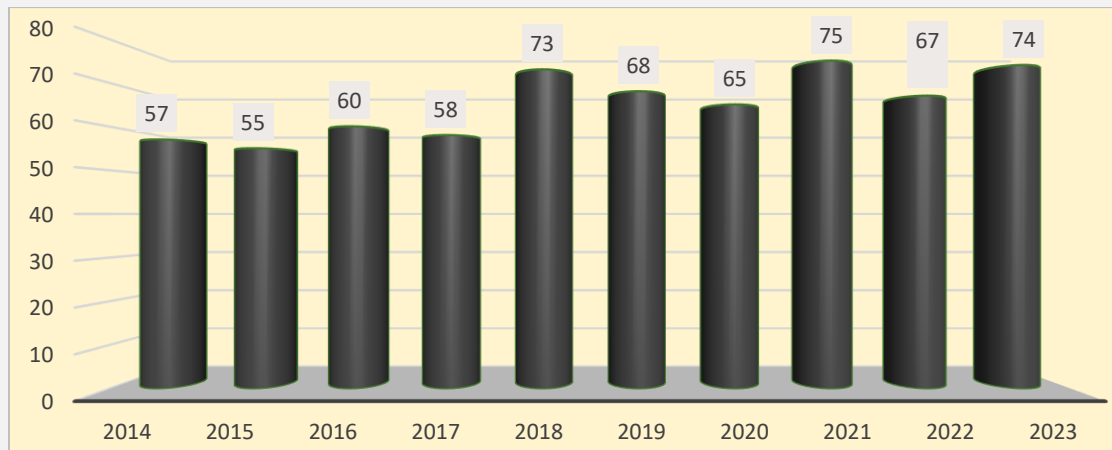
2023 “SUICIDE” STATISTICS

Suicide is death caused by intentional, self-inflicted injuries. In Charleston County during 2023, there were 74 deaths by suicide. The methods were:

- 40 firearm
- 14 asphyxia
- 15 overdoses
- 2 jumped from a height (1 from the Don Holt Bridge, 1 from a building)
- 1 by sharp injury
- 2 by drowning



A ten-year review of the number of suicides in Charleston County shows an average of 65 per year.



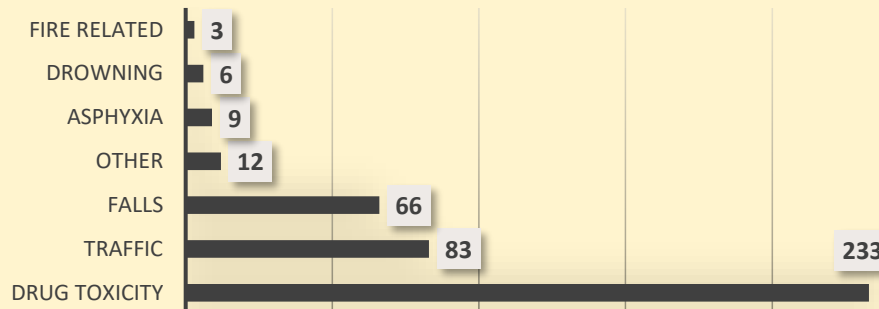
2023 “ACCIDENT” STATISTICS

Accidental deaths are those deaths that are other than natural where there is no evidence of intent, i.e. an unintentional event or chain of events. This category includes most motor vehicle collisions, falls, drowning, accidental drug toxicity, fire related deaths, etc.

Four hundred twelve (412) deaths were certified as “Accident”. The causes include:

- 233 drug toxicity related deaths
- 83 traffic collisions
- 66 falls
- 6 drowning (Beach x 3, Pool x 2, Pond x1)
- 3 foreign body asphyxia (food)
- 3 mechanical asphyxia (domestic/household accidents)
- 1 overlay/co-sleeping- asphyxia
- 2 asphyxia unsafe sleeping conditions
- 1 electric shock
- 2 gunshot injury
- 1 airplane accident
- 1 train accident
- 2 fire-carbon monoxide
- 1 fire-thermal injuries
- 1 carbon monoxide exhaust
- 3 hyperthermia
- 1 industrial accident (blunt force) and
- 2 medical treatment complication related deaths

Accidental Deaths by Cause in 2023



Ninety-seven percent (97%) of the drug related deaths were either due to a finding of acute toxicity (21%) or mixed drug toxicity (76%). Mixed drug toxicity means that more than one drug was found to have contributed to the death. Seven (7) deaths were attributed to chronic drug abuse circumstances.

Toxicology testing revealed that the following drugs or drug types were present and significant enough to either cause the death acutely or in combination with another significant drug or drug type.

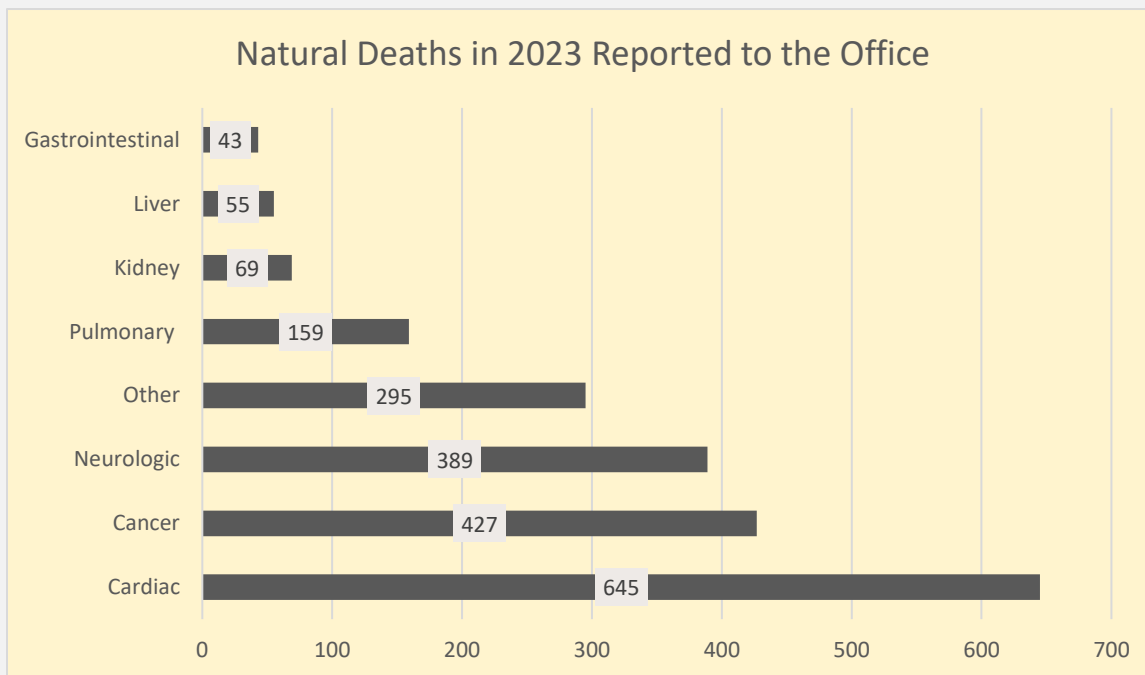
2023 Accidental Drug-Related Deaths		233
Contributing Substances for 2023 Drug Related Deaths		
Substance	# Of Cases	% of All Deaths
Opioid/ Synthetic Opioids	195	83%
Fentanyl/ Fentanyl Analogs	180	77%
Heroin	4	2%
Xylazine	29	12%
Cocaine	91	39%
Methamphetamine	55	24%
Benzos	35	15%
Alcohol	54	23%
Suspected Fentanyl Carrier Combinations		
Cocaine+Fentanyl	69	30%
Methamphetamine+ Fentanyl	41	18%

2023 “Natural Death” Statistics

In 2023, there were 2,082 deaths reported to our office that were determined to be “Natural” deaths. The deputies receiving these notifications either investigate in person and assume jurisdiction for determining cause and manner of death or determine that no further action is warranted. If no detailed, investigation was required, the deputy contacted the physician of record and after discussing the circumstances of the death, the physician agreed to certify the decedent’s cause and manner of death on the Death Certificate.

Natural deaths reported to the office in which the decedent was under hospice care totaled 1,200. There were 14 cases of natural fetal demise reported to the office. Generally, the deputies conduct a preliminary investigation to determine if further action is required.

In 2023, twenty-one (21) of the 2,082 Natural deaths reported to the Office involved COVID-19.



2023 “Undetermined Death” Statistics

In 2023, the Charleston County Coroner’s Office deemed thirty-two deaths were of an “Undetermined” manner. After a full investigation, there is not a preponderance of information to classify the manner. Deaths in this category are the most thoroughly investigated. Often determination between suicide vs an accidental drug toxicity cannot be made resulting in an “Undetermined” classification.

2023 Children’s Statistics

Although children’s deaths are counted in the overall statistics previously outlined in this report, it’s important to highlight the information surrounding children’s deaths. For the purposes of these statistics, a child is anyone who has not reached the age of 18. In 2023, there were 71 child deaths reported to the Charleston County Coroner’s Office.

HOMICIDE:

Total: 0

SUICIDE

Total: 0

ACCIDENT

Total: 12

Miscellaneous Accidents

Total: 10

Causes: 1- fell from height, 2-asphyxia while in unsafe sleeping environment, 1-asphyxia while co-sleeping with an adult; 3-drownings (2-pool, 1 at beach); 1-medical treatment complication; 1- automobile exhaust (asphyxia-CO2), 1-positional/mechanical asphyxia in activity chair.

Age range: 3 months to 17 years old

Gender: 6 males; 4 females

Race: 2 African American; 7 Caucasian; 1 Latin American/Hispanic

Motor Vehicle Collisions

Total: 2

Ages: 1 day, 14 years

Position: 1 vehicle occupant, 1 pedestrian,

Gender: 2 males

Race: 2 White/Hispanic

NATURAL

Total: 32

Age range: minutes old to 7 years

Causes include: Complications of prematurity/congenital disease/birth defects or pregnancy complications.

UNDETERMINED

Total: 9

Age range: 5 days to 2 years

Causes: 4 undetermined causes while unsafe sleeping related; 1 asphyxia, 2 undetermined causes; 2 other causes

Gender: 6 females; 3 males

Race: 5 African American; 4 Caucasian

FETUS CASES

Reports of fetal deaths: 18

Full Investigation: 5; Undetermined manner-2; Natural determination – 3

Preliminary investigation revealed they were under a doctor's care: 13

INFANTS

Included in the above children's statistics are the following reported deaths regarding infants aged from a few minutes old to 1 year, their manner and cause with autopsy statistics.

Homicide: 0

Accident: 5; Cause: 3 – Asphyxia (unsafe sleeping environment x 2, co-sleeping with adult x 1); 1 vehicle collision, 1- blunt trauma/fall. All 5 were autopsied.

Natural: 26 reports of natural deaths with various causes- mostly, prematurity or pre-viability/pulmonary issues. One case autopsied.

Undetermined: 8 cases with various or undetermined causes, autopsies for all 8 cases.