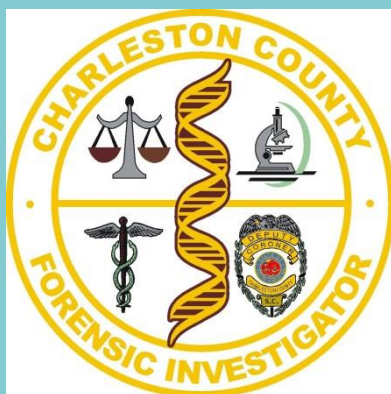


Charleston County Coroner's Office

2019 Annual Report

Coroner Rae H. Wooten



**Charleston County
South Carolina**

Charleston County Coroner's Office – 2019 Annual Report

Rae H. Wooten, Coroner

Chief Deputy Coroner
Bobbi Jo O'Neal

Deputy Coroner Supervisors
Brittney Martin
Kimberly Rhoton



OFFICE OF THE CORONER

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To the Citizens of Charleston County,

I am pleased to share the 2019 Annual Report for the Charleston County Coroner's Office. The goal of providing this information to the public is to increase public awareness of the role of the Coroner's Office and to focus attention on the causes and manners of death in our county in an effort to reduce the number of preventable deaths to the extent possible.

The information contained in this annual report is gathered from sources reviewed by the Charleston County Coroner's Office to include autopsy reports, police reports, death certificates, cremation permits and motor vehicle reports, among others.

I hope that you will find this up-to-date and complete information to be in a format that is easy to read and is of value to you.

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,

Rae H. Wooten, RN, BSN, F-ABMDI
Coroner of Charleston County, SC

DEDICATION

This report is dedicated to the decedents, and the citizens of Charleston County and beyond, who grieve the loss of loved ones whose deaths are statistically reflected here. It has been an honor and privilege to serve you during this time of greatest need.

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MISSION STATEMENT

To conduct medicolegal death investigations in an independent, compassionate and professional manner, serving as a representative of the decedents and survivors, to determine the "Cause of Death" and the "Manner of Death."

PURPOSE AND FUNCTION OF THE CHARLESTON COUNTY CORONER'S OFFICE

The South Carolina Code of Laws (17-5-530(B)) mandates "The coroner or medical examiner shall make an immediate inquiry into the cause and manner of death and shall reduce the findings to writing on forms provided for this purpose.", upon notification of deaths that are unexpected, unexplained, suspicious, violent or in which the cause and/or manner of death is unknown. The Coroner is also responsible for identifying decedents and making notification to next-of-kin.

The Coroner is an elected official and the Coroner's Office is funded by tax revenue provided by the citizens of Charleston County. The Coroner submits an annual budget to the Charleston County Council for approval. The Finance Department of Charleston County Government administers the approved funds.

The Fiscal Year 2019 approved budget for the Charleston County Coroner's Office was \$2,074,655. This partially covers the period of January 1, 2019 – June 30, 2019.

The Fiscal Year 2020 approved budget for the Coroner's Office was \$2,540,037. This partially covers the period of July 1, 2019 – December 31, 2019.

THE OFFICE

The Coroner's Office investigates the circumstances surrounding a person's death and provides information to the decedent's family, involved law enforcement, the judicial system, insurance companies, the Consumer Product Safety Commission, the South Carolina Department of Health and Environmental Control (DHEC), Occupational Safety and Health Administration (OSHA) and many others.

The Coroner's Office advocates for families by notifying and advising them of the circumstances surrounding the death known at that time. The Office provides updates to the families after autopsy and/or 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 Sharing Hope to facilitate the family or decedent's wishes regarding organ and tissue donation whenever possible.

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 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 investigation 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 this year.

Measuring about 916 square miles, Charleston County is located on the southeastern coast of South Carolina and has approximately 100 miles of Atlantic Ocean coastline. The third largest county in South Carolina by population, Charleston County's population was approximately 411,406 in 2019.

In late 2018 to early 2019, the office opened and operated an in-house autopsy suite and morgue.

In September, the Charleston County Coroner's Office received a Paul Coverdell Forensic Science Improvement Grant for Improving the Quality of Autopsy and Forensic Services for \$84,576 by the Department of Justice.

Deputy Coroner Elizabeth Dobbins was selected the 2019 Employee of the Year for Charleston County.

THE CORONER



Coroner Rae H. Wooten

The Coroner, Rae H. Wooten, RN, BSN, F-ABMDI, is an elected official who oversees a separate and independent law enforcement agency serving the residents of Charleston County by conducting parallel investigations of any sudden and unexpected death, or those deaths that occur under violent or suspicious circumstances.

Coroner Wooten, was born, raised and educated in Columbia, South Carolina before moving to the Charleston area in 1973. She graduated from the University of South Carolina with a Bachelor of Science in Nursing and subsequently worked as a registered nurse in various settings before joining the Charleston County Coroner's Office in April 1995. She became Chief Deputy Coroner in July 1996 and continued in that position until September 1, 2006 when Governor Mark Sanford appointed her Coroner of Charleston County. She won the election for Coroner of Charleston County in November 2008 and was re-elected in 2012 and 2016.

The South Carolina Coroner's Association recognized her as "Coroner of the Year" for 2012.

2019 ORGANIZATIONAL CHART

Citizens of Charleston County

Coroner

Rae H. Wooten, RN, BSN, F-ABMDI

Chief Deputy

Bobbi Jo O'Neal, RN, BSN, F-ABMDI

Deputy Coroner Supervisors

Kimberly Rhoton, RN, ANP-BC, F-ABMDI

Brittney W. Martin, BS, F-ABMDI

Deputy Coroners

Dottie Lindsay, F-ABMDI; Anita Hasert, BS, D-ABMDI; Christina Harrison, RN, BSN, D-ABMDI; Elizabeth Dobbins, BFA; Shane Bowers; Kelley Nevill

Administrative Services Coordinator - Nicole Brown

Case Manager- Deputy Coroner Sara K. Tuuk, BS, MS, D-ABMDI

Paralegal-Joe Crawford, M. Ed., MSCJ

Evidence Technician- Nancy Ritter-Peacock

Receptionist- Jeanelle Harris

Special Opioid Investigator (1 year grant position) - Codi Cammer

Morgue and Autopsy Suite Coordinator - Ty'Reik Faulks, BS

Security Officer Assigned via Walden Security- Herman Whitney

Contracted Consultants:

Forensic Anthropologist
Suzanne Abel, PhD

Forensic Odontologist
Dr. Wolf D. Bueschgen, DMD

Forensic Pathologist
Dr. Janice Pat Ross

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 deem it necessary to conduct a post mortem examination (autopsy), the contracted transport vendor transports the decedent to our in-house morgue/autopsy suite (214 cases) or to the Department of Pathology and Laboratory Medicine at the Medical University (271 cases). The contracted forensic pathologist Dr. Janice Pat Ross conducts all in-house autopsies. 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 collects documents related to the investigation in a case file. Upon request, the Coroner's Office provides copies of their investigative case file 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 21% percent of the deaths that were investigated, which is 485 out of 2,296 deaths reported, a full forensic autopsy was performed to aid in the determination of the cause and manner of death, to document disease, to identify injury patterns, and to recover items of evidentiary/investigative value. The cases not autopsied were those in which the scene investigation, circumstances of death, medical documentation, interviews, social history, and/ or external examination of the body 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 collected during the investigation or autopsy, or upon admission to a hospital, are submitted to a nationally accredited laboratory or the State Law Enforcement Division (SLED) crime lab for testing. In 2019, the coroner's office ordered 469 toxicology tests. Screening tests include alcohol, illicit drugs, commonly abused prescription and nonprescription drugs, and other substances as needed.

“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 at the time of, or 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.

2019 STATISTICS

There were 2,296 deaths reported to the Charleston County Coroner's Office in 2019. Regarding those deaths, 1,874 were classified as "Natural" deaths, 282 were classified as "Accident"; 68 were classified as "Suicide"; 57 were classified as "Homicide"; and 15 were classified with an "Undetermined" manner.

In addition to these deaths, the Coroner's Office had involvement to various degrees with 2,989 requests for services which included: 13 cases of recovered bones (3-human and 9 non-human, 1-unidentified bone); 1,596 additional requests for a cremation permit which requires deputy review; 39 requests to make a death notification to next-of-kin by other jurisdictions; 70 cases were preliminarily investigated via telephone inquiries which subsequently were turned over to other jurisdictions due to their having jurisdiction in the case. There were three agency or citizen assists which did not involve a death investigation but unique assets of the Coroner's Office were utilized to resolve unusual circumstances. Additionally, there were 1,268 requests for cremation permits for disposition where jurisdiction was accepted.

The Coroner's Office was not involved in any exhumations in 2019.

The grand total of all requests for services plus death investigations was 5,285.

Other statistics include:

Grand total of cremation permits: 2,864

 Cremation permits issued with Coroner Cases: 1,268

 Stand-alone Cremation Permits 1,596

Full autopsy: 485 cases

 Contracted to MUSC: 271

 Autopsies conducted at the Coroner's Office: 214

Number of external exams ordered: 8

Number of partial/limited autopsies ordered: 0

Number of hospital autopsies under coroner jurisdiction: 0

Deceased transports to morgue: 562

Deceased transported for storage only: 77

Toxicology tests ordered: 469

Unidentified decedents: 1

Exhumations: 0

Unclaimed: 11

Donor referrals, organ donation and tissue donation statistics from Sharing Hope SC:

 Release for organ donation: 103

 Release for tissue: 103

 Organ donors: 15

 Tissue donors: 22

2019 "HOMICIDE" STATISTICS

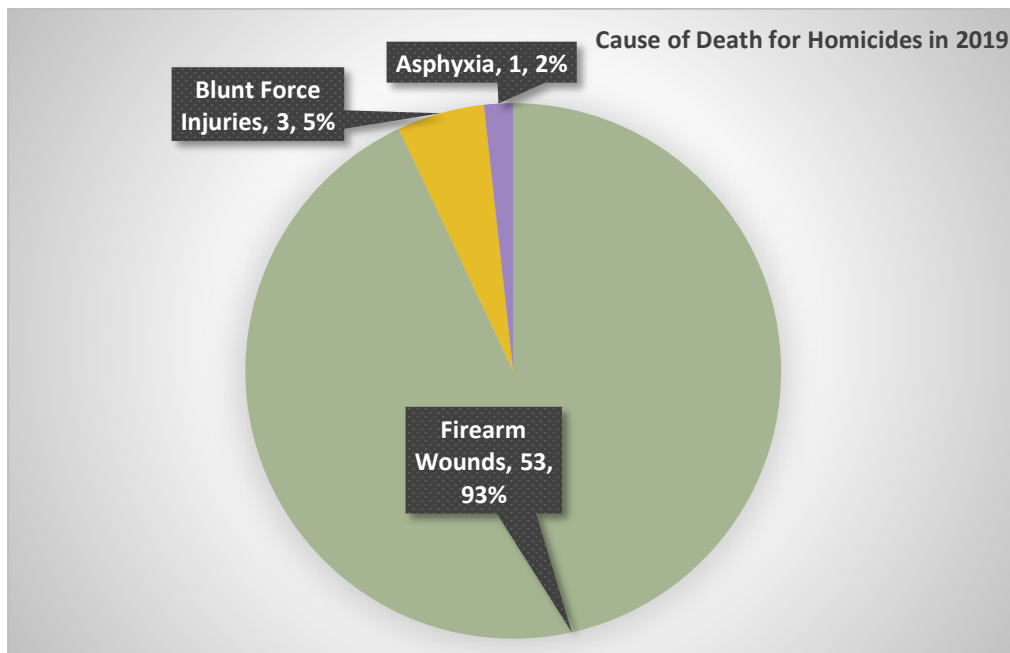
The manner of death classified as a "Homicide" when it results from injuries inflicted by another person or inflicted on another by one's grossly reckless behavior. The Coroner's Office is not responsible for determining if a homicide was justified or not and classifies those deaths as "Homicides" in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

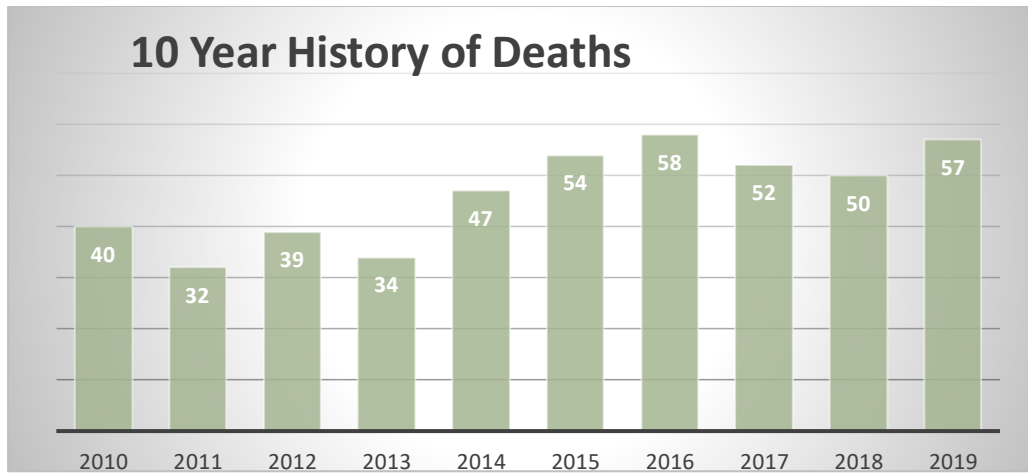
South Carolina Code of Laws section 16-3-5 states "A person who causes bodily injury which results in the death of the victim is not criminally responsible for the victim's death and must not be prosecuted for a homicide offense if at least three years intervene between the injury and the death of the victim." This three-year window does not apply to the classification of manner of death as long as 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 2019, there were 57 deaths classified as "Homicide" in Charleston County. Fifty-three (53) due to firearm injuries. Of the four remaining deaths, three due to blunt force trauma, and one death was due to asphyxia.

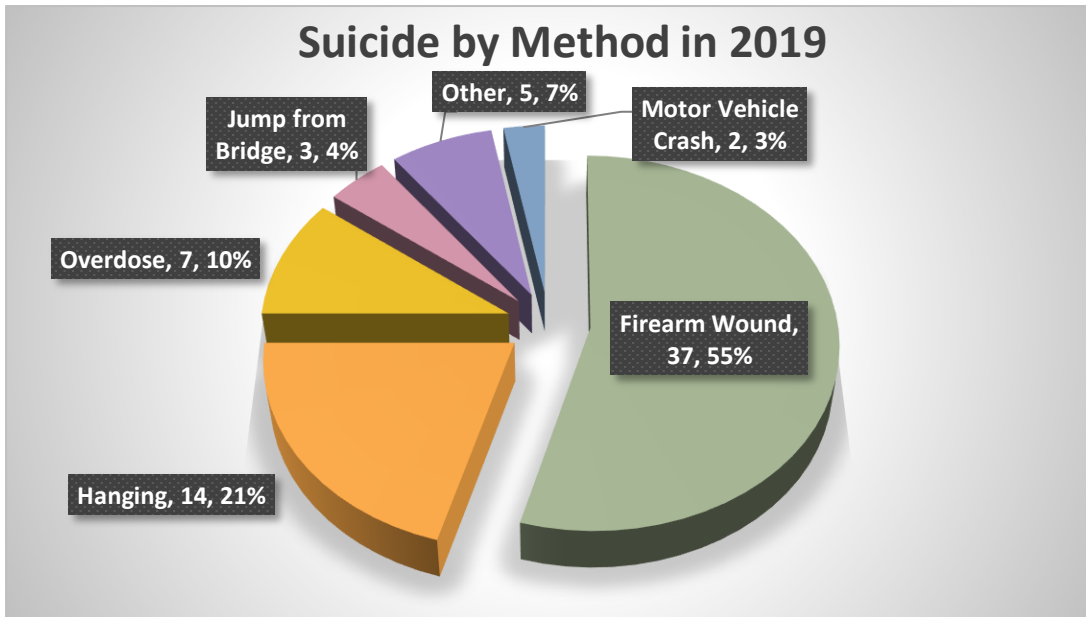


A review of the number of deaths classified as “Homicide” in Charleston County over the past 10 years shows the average number per year is 46.

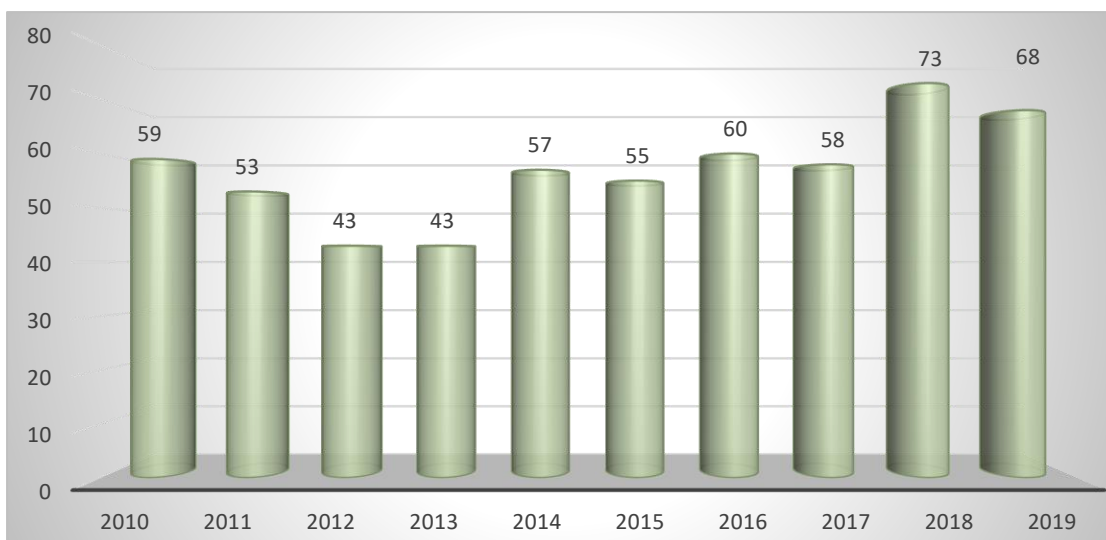


2019 "SUICIDE" STATISTICS

Suicide is death caused by intentional, self-inflicted injuries. In Charleston County during 2019, there were 68 deaths by suicide. The most prevalent method of suicide in 2019 was via firearm wound totaling 37. There were fourteen (14) hangings; seven (7) overdoses; three deaths from jumping from the Ravenel Bridge; two motor vehicle crashes and five (5) other various causes.



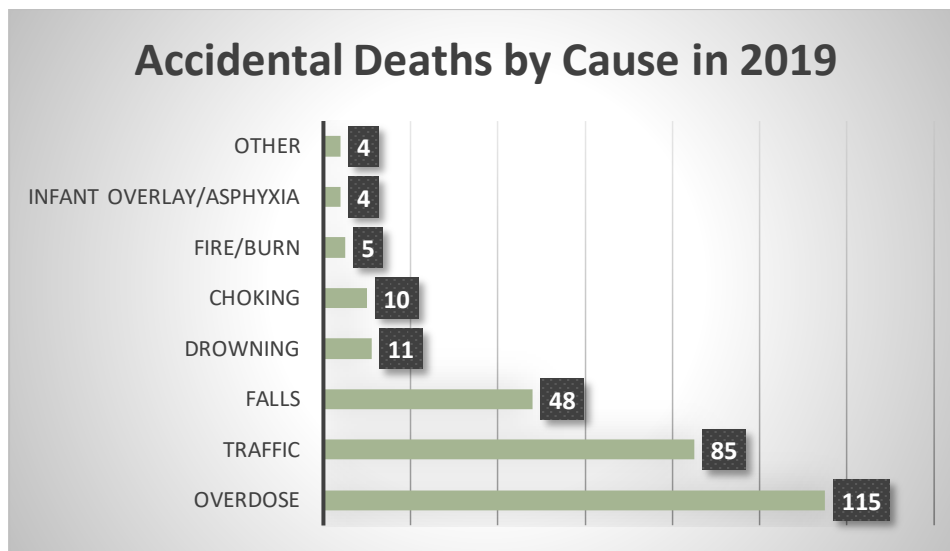
A ten-year review of the number of suicides in Charleston County shows an average of 57 per year.



2019 “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 overdoses, fire related deaths, etc.

During 2019 there were 282 deaths certified as “Accident”. The causes include: 115 overdoses; 85 traffic collisions; 48 falls; 11 drowning; 10 foreign body asphyxia (food/emesis); 4 infant overlay/positional asphyxia, 5 fire or burns and 4 other accidents.



2019 "Natural Death" Statistics

In 2019, there were 1,874 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 (285 of those cases) or determine that no further action is warranted. If no detailed, in-person 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 (567 cases) on the Death Certificate.

Natural deaths reported by law to the office who were Hospice Care decedents totaled 1,004.

There were 18 cases of natural fetal demise reported to the office. Generally, the deputies conduct a preliminary investigation to determine if further action is required.

2019 "Undetermined Death" Statistics

In 2019, the Charleston County Coroner's Office deemed fifteen deaths were of an "Undetermined" manner.

While a great deal of effort has gone into compiling accurate statistics for this report, they are subject to change as "Causes" and "Manners" of death, dates, etc., may change should new or additional information become available