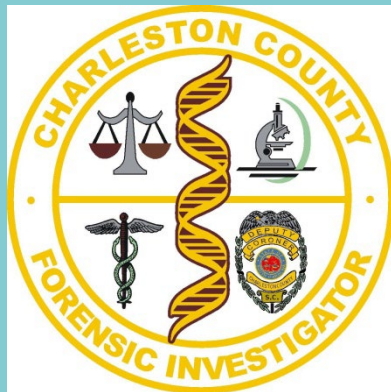


# **Charleston County Coroner's Office**

## **2021 Annual Report**

**Coroner Bobbi Jo O'Neal**



**Charleston County  
South Carolina**

**Bobbi Jo O'Neal**  
**Coroner**

**Brittney W. Martin**  
**Chief Deputy Coroner**



**OFFICE OF THE CORONER**

4000 Salt Pointe Parkway  
North Charleston, SC 29405  
Phone: (843) 746-4030  
Fax: (843) 746-4033

To the Citizens of Charleston County,

I am pleased to share the 2021 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 derives 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,

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

DEDICATION

Dedicated to the decedents, and 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 this 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.***

## 2021 PROFILE OF THE CHARLESTON COUNTY CORONER'S OFFICE

The Coroner's Office investigates the circumstances surrounding a person's death independently of any law enforcement agency that may also be investigating the death. The role of the coroner's office is to determine the "Cause" and "Manner" of a person's death.

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's Office 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.

Charleston County is located on the southeastern coast of South Carolina and measures about 916 square miles and is the third largest county in South Carolina by population. Charleston County's population was approximately 413,024 in 2021.

## Charleston County Coroner's Office – 2021 Annual Report

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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. Coroner O'Neal submitted an annual budget to Charleston County Council for approval. The Finance Department of Charleston County Government administers the approved funds.

The Fiscal Year 2021 approved budget for the Charleston County Coroner's Office was \$2,531,775. The Fiscal Year 2022 approved budget for the Coroner's Office was \$2,996,138. The last six months of FY2021 and first six months of FY2022 combine to financially account for the calendar year 2021.

In 2021, the Charleston County Coroner's Office was awarded \$54,924.00 from the South Carolina Department of Public Safety Office of Justice Programs Paul Coverdell Forensic Science Improvement Grants Program (5NF000620) for the grant titled: "Opioid related deaths: A Mass Fatality Disaster" written and managed by Coroner O'Neal.

In addition, Coroner O'Neal submitted three project proposals to the Low Country Healthcare Coalition and the Healthcare Preparedness Program (HPP), which comes under the umbrella of the South Carolina Department of Health and Environmental Control (SCDHEC) which were fully grant funded totaling \$86,657.10.

The projects were:

1. Improvement of forensic services within the region by providing the equipment and training for IDEMIA MorphoIDent fingerprint units. The Coroner's Office assisted with the purchase of the required items and accessories as well as one year of maintenance fees and coordinated training for regional Coroners. Award amount \$25,291.00.
2. Improvement of mobile morgue service for fatality management by purchase of a 14' morgue trailer that would be listed as an asset in the Regional Mass Fatality Plan in coordination with the Coroners in the region, and the Low Country Healthcare Coalition key partners and emergency management. Award amount \$50,940.90.
3. Improvement of radiographic capabilities and training in the region by providing Radiation Safety Officer training to four (4) individuals and the purchase of a new laptop computer to operate the software for the Nomad Dental X-Ray unit. Award amount \$10,425.20.

## THE CORONER



Coroner 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 34 coroner offices in the country that is accredited 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 \$1 million in funds to Charleston County.

O'Neal is the President of the International Association of Coroners and Medical Examiners and serves on the Executive Committee for the Lowcountry Healthcare Coalition, which has taken a lead in the coronavirus preparation and response locally.

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 the area of sexual assault 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.

A former Director-at-Large for the International Association of Forensic Nurses, O'Neal is the author of the book "Investigating Infant Deaths" and has had the unfortunate distinction of working the mass fatalities of the Charleston Super Store fire and the Emanuel AME mass shooting.



**2021 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 Coroners***

*Anita Hasert, BS, F-ABMDI*

*Sara K. Tuuk, BS, MS, D-ABMDI*

*Elizabeth Dobbins, BFA, D-ABMDI*

*Ty'Reik Faulks, BS*

*Shane Bowers, MDiv., D-ABMDI*

*Stacey Toto, BS, D-ABMDI*

*Alison Garbarini, MPH*

*David Reynolds*

*Angela Biela, RN*

*Ella Butler, MSc, Special Opioid Investigator (grant funded)*

***Apprentice: Nickayla Riley, BA***

**Administrative Services**

***Coordinator - Nicole Brown, BHuServ, BA***

***Paralegal - Joe Crawford, M. Ed., MSCJ***

***Administrative Assistant - Kennedy Camburn***

**Forensic Services**

***Sr. Deputy/Supervisor***

*Kelly Gallagher, BA*

***Autopsy Technician II***

*Dep. Kelley Nevill*

***Autopsy Technician I***

*Alexandra Roelig*

***Forensic Evidence Tech II***

*Dep. Nancy Ritter-Peacock*

**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. Eric Eason*

## 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 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 22% percent of the deaths that were given a full investigation, which is 571 out of 2,594 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 and 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.

“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.

## 2021 STATISTICS

There were 2,594 deaths reported to the Charleston County Coroner's Office in 2021. Regarding those deaths, 2,082 were classified as "Natural" deaths, 354 were classified as "Accident"; 75 were classified as "Suicide"; 67 were classified as "Homicide"; and 15 were classified with an "Undetermined" manner. One case is "pending" investigation.

In addition to investigating these deaths and authorizing cremations for 1,465 of those cases, the Coroner's Office had involvement to various degrees with 3,378 requests for services which included: 10 cases of recovered bones (1-human and 9 non-human); 1,684 additional requests for a cremation permit which was outside of a fully assumed case investigation which requires deputy review; 49 requests to make a death notification to next-of-kin by other jurisdictions; 88 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 2 agency assists where work was completed to assist other jurisdictions in a death investigation, 1 research of a death. Additionally, there were 1,465 requests for cremation permits for disposition where jurisdiction was accepted and 79 requests for a fetal cremation letter.

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.

The grand total of all requests for services plus death investigations was 5,972.

Other/details of statistics include:

Grand total of cremation permits: 3,226

    Cremation permits issued with Coroner Cases: 1,465

    Stand-alone Cremation Permits 1,684

Full autopsy: 571 cases

    At the Coroner's Office: 468

    Contracted to MUSC: 103

Number of external exams ordered: 6

    At the Coroner's Office: 6

    Contracted to MUSC: 0

Deceased transports to morgue: 562

Deceased transported for storage only: 95 (Coroner's Office: 80, MUSC Morgue: 15)

Toxicology tests ordered: 616

Unidentified decedents: 0

Exhumations: 0

Unclaimed: 8

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

    Release for organ donation: 13; actual organ donation cases: 12

    Release for tissue donation: 127; actual tissue donation cases: 25

    Coroner cases declined for donation: Zero (0)

## 2021 "HOMICIDE" STATISTICS

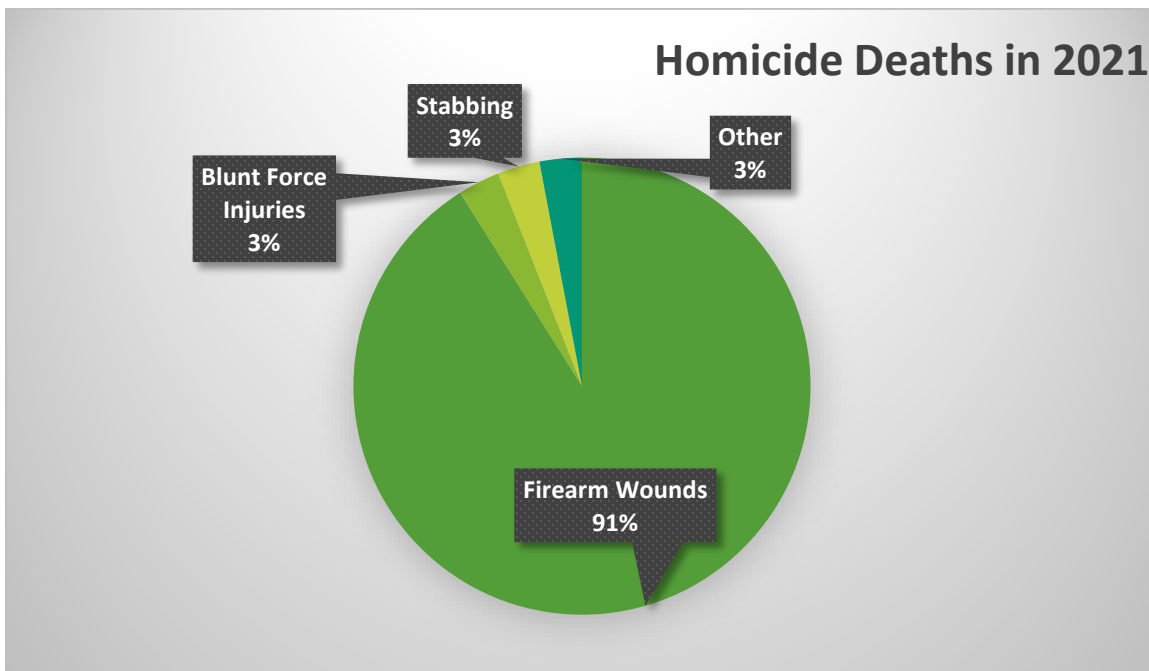
The manner of death classified as a "Homicide" when it results from injuries inflicted by another person or inflicted on another by one's grossly reckless behavior. The Coroner's Office is not responsible for determining if a homicide was justified or not and classifies those deaths as "Homicides" in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

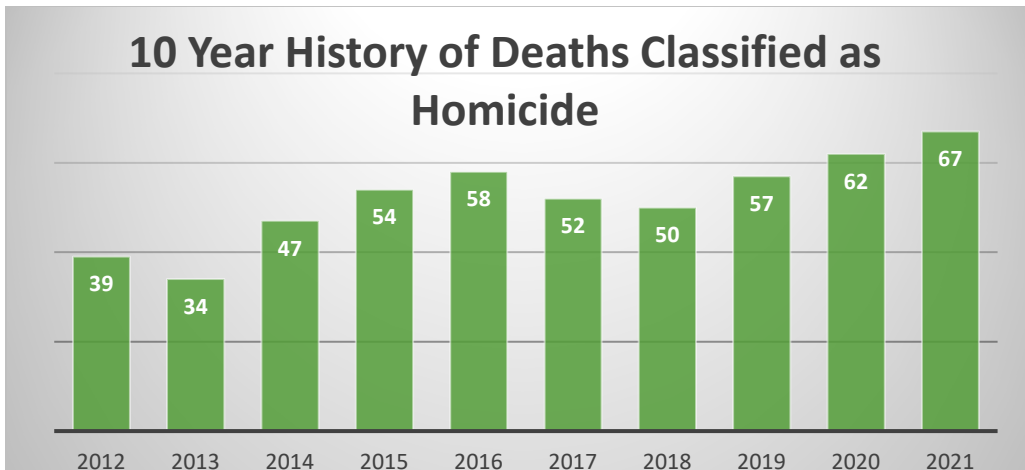
South Carolina Code of Laws section 16-3-5 states "A person who causes bodily injury which results in the death of the victim is not criminally responsible for the victim's death and must not be prosecuted for a homicide offense if at least three years intervene between the injury and the death of the 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 2021, there were 67 deaths classified as "Homicide" in Charleston County. Sixty-one (61) due to firearm injuries. Of the six remaining deaths, 2 were due to sharp force injuries, 2 were due to blunt force injuries and two due to other causes.

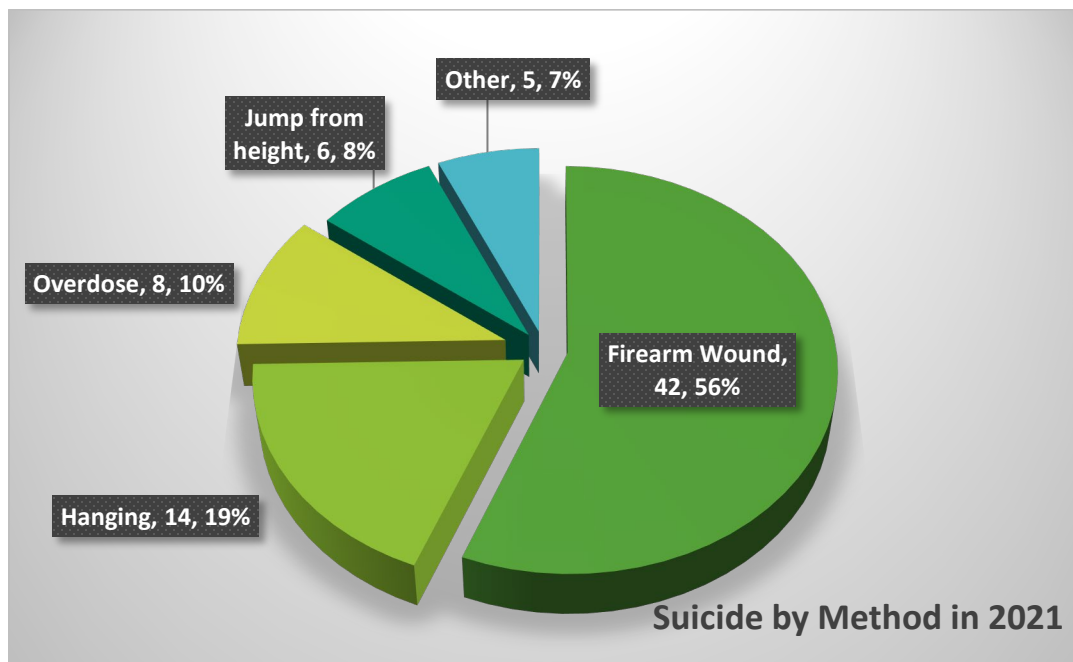


A review of the number of deaths classified as “Homicide” in Charleston County over the past 10 years shows the average number per year is 52.

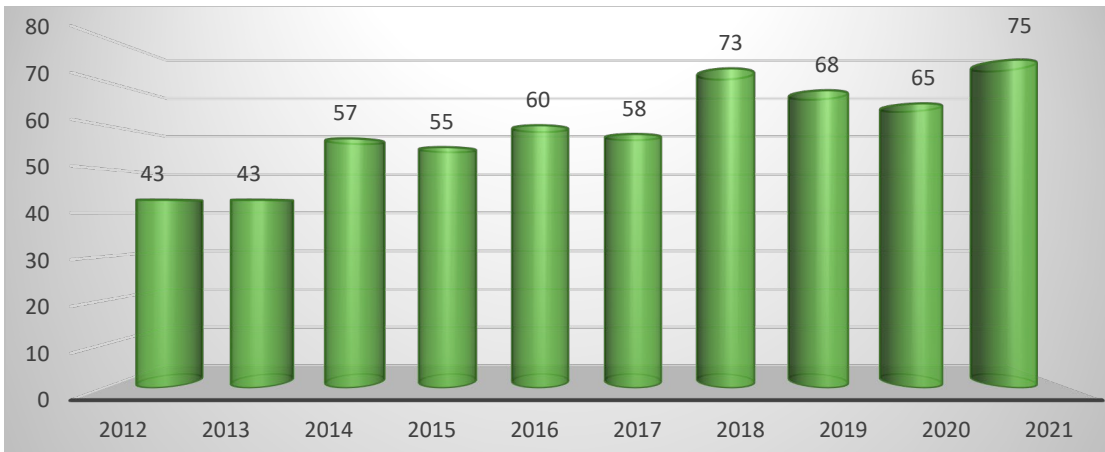


### 2021 “SUICIDE” STATISTICS

Suicide is death caused by intentional, self-inflicted injuries. In Charleston County during 2021, there were 75 deaths by suicide. The most prevalent method of suicide in 2021 was via firearm wound totaling 42. There were fourteen (14) hangings; eight (8) overdoses; six deaths by jumping from a height (two from the Ravenel Bridge, 4 from a building); five (5) other causes.



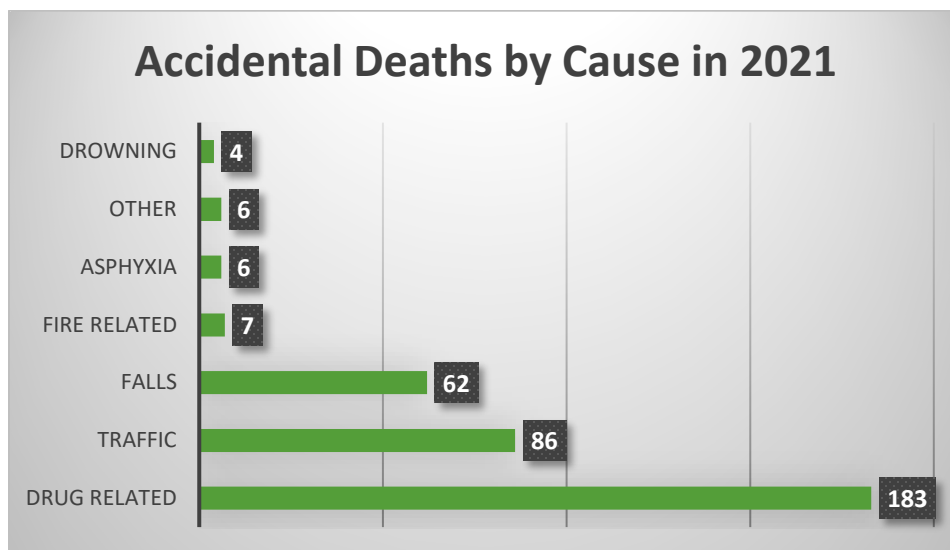
A ten-year review of the number of suicides in Charleston County shows an average of 59 per year.



### 2021 “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.

Three hundred fifty-four (354) deaths certified as “Accident”. The causes include: 183 drug related deaths; 86 traffic collisions; 62 falls; 4 drowning; 2 foreign body asphyxia (food/emesis); 2 infant overlay, 2 other types of asphyxia, 1 fire- burns, 6 fire-Carbon Monoxide, 1 CO2 inhalation not fire related, 1 hyperthermia, 1 hypothermia, and three treatment complication related deaths.

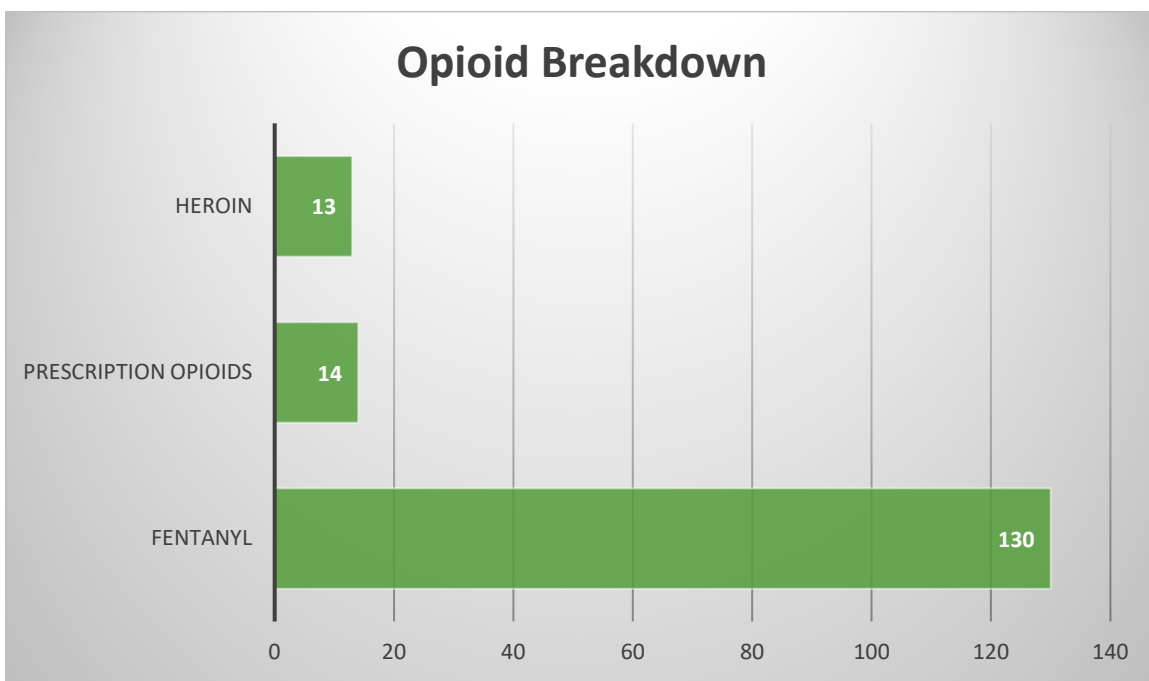
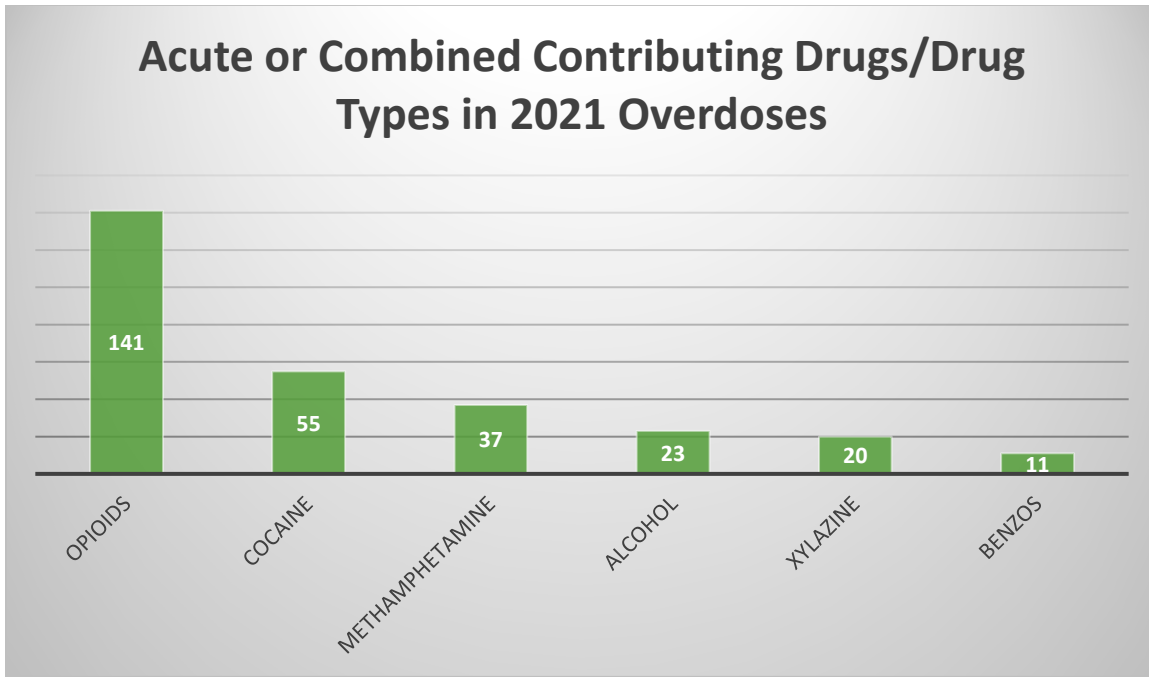




## Charleston County Coroner's Office – 2021 Annual Report

Ninety-seven percent (97%) of the drug related deaths were overdoses with either a finding of acute intoxication (29%) or mixed drug toxicity (68%). Mixed drug toxicity means that more than one drug was found to have contributed to the death. Five (5) 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.

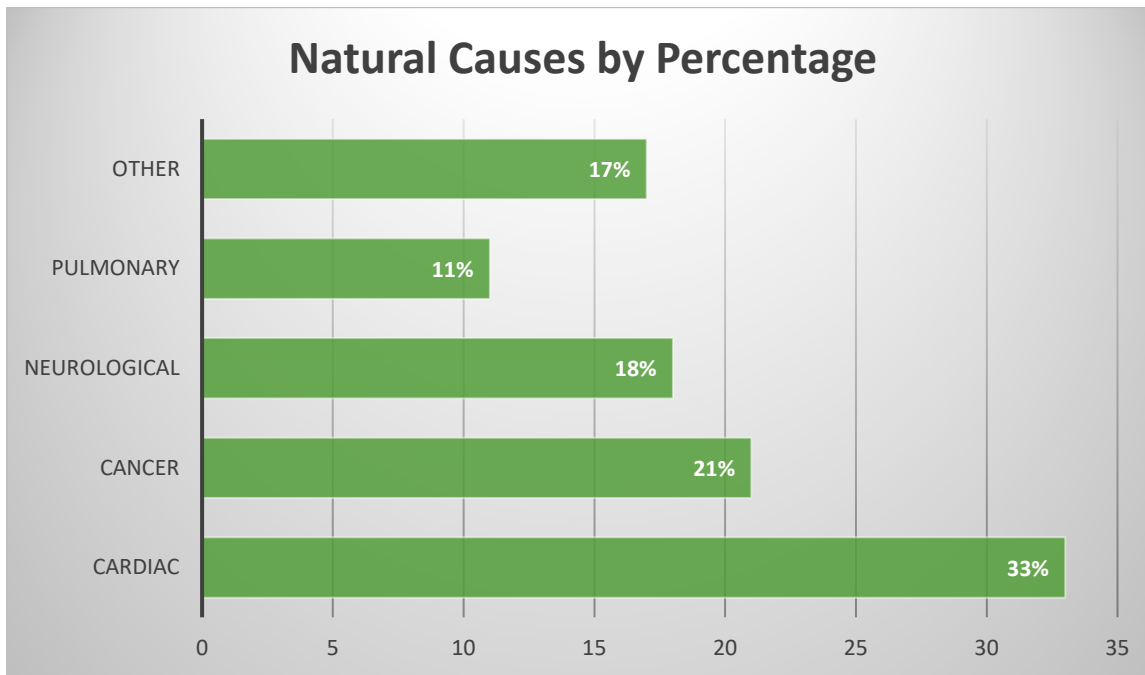


## 2021 “Natural Death” Statistics

In 2021, 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, 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 on the Death Certificate.

Natural deaths reported by law to the office who were Hospice Care decedents totaled 1,076. There were 13 cases of natural fetal demise reported to the office. Generally, the deputies conduct a preliminary investigation to determine if further action is required.

In 2021, ninety-one (91) of the 2,082 Natural deaths investigated by the Office were due to COVID-19.



## 2021 “Undetermined Death” Statistics

In 2021, the Charleston County Coroner’s Office deemed fifteen deaths were of an “Undetermined” manner.