2024 Annual Report

Charleston County Coroner's Office

Bobbi Jo O'Neal

Coroner

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Bobbi Jo O'Neal
Coroner

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To the Citizens of Charleston County

I am pleased to share the 2024 Charleston County Coroner's Office Annual Report. This report is published to provide the public with information about the causes and manners of death reported to the Coroner's Office, and to use this data for public health surveillance to identify potential trends or risks. These reports also aim to increase awareness of the coroner's role and to help reduce preventable deaths.

The information contained in this annual report is derived 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.

Annual Reports are published once all autopsy reports, death certificates, and coroner reports from all the years' cases are finalized. Annual Reports going back to 2013 can be found at https://www.charlestoncounty.org/departments/coroner/index.php.

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 2024.

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.

Charleston County Coroner's Office Operations

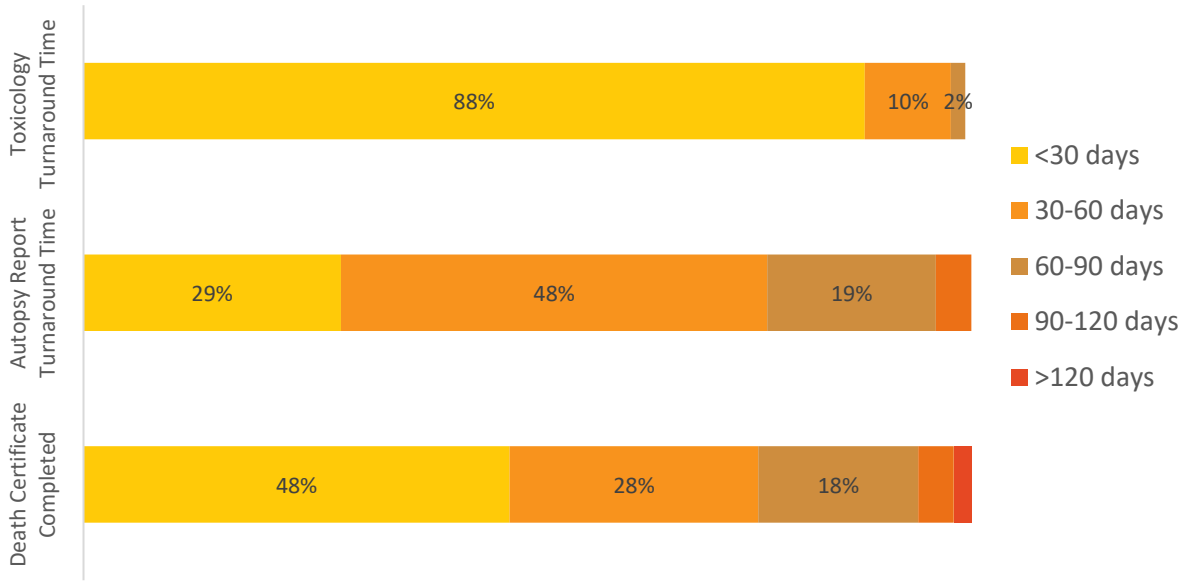
Mission Statement

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.

Accreditation

The Charleston County Coroner's Office has been fully accredited by the International Association of Coroners and Medical Examiners since 2015. In 2024, the Office began preparations for accreditation by the National Association of Medical Examiners, with inspection planned for 2025.

Figure 1. Select IACME Accreditation Criteria for 2024



Service

The Charleston County Coroner is an elected official in Charleston County government and is funded through the County Council by the citizens of Charleston County. The Charleston County Coroner's Office performs medicolegal investigations surrounding a person's death independent of law enforcement with the primary role of determining the cause and manner of death. In general, deaths investigated by this office include those that are sudden, unexpected, violent, and/or not readily explainable at the time of death. Deputy Coroners are available 24 hours a day, 7 days a week, 365 days a year to respond to calls for service and scene investigations.

Charleston County is located along the central eastern coast of South Carolina. It has a total area of 1,358 square miles, of which 918 square miles is land and 440 square miles is water. It is the largest county in the state, spanning nearly 100 miles of the Atlantic seaboard.

According to the latest data provided by the US Census Bureau, the population of Charleston County in 2024 was 431,001. The county experiences an additional 20% surge in its daytime population due to commuters who work in Charleston but reside in neighboring counties. In addition to this influx, the county has a significant year-round transient population. As a major tourist destination, Charleston welcomes nearly 8 million visitors annually through the Port of Charleston. The county is also home to numerous public and private higher education institutions, with approximately 47% of students coming from out of state.

The Port of Charleston is a significant maritime hub, handling a wide range of imports, including consumer goods, automotive products, and industrial machinery. Over 1.4 million pier containers went through the Port in 2024.

CSX Railroad Transportation has major facilities in Charleston, including a switching yard, a bulk transfer terminal, and an intermodal terminal. Norfolk Southern also operates large rail yards in Charleston.

The county hosts other key infrastructure, including Charleston International Airport and Joint Base Charleston. It is also a regional healthcare hub, featuring the Medical University of South Carolina (a Level I trauma center), Trident Medical Center (a Level II trauma center), Roper Hospital, Bon Secours-St. Francis Hospital, East Cooper Medical Center, and the Ralph H. Johnson VA Medical Center. These six facilities serve as the primary hospital care providers for the entire eastern portion of the state.

Legal Jurisdiction

The Charleston County Coroner adheres to the South Carolina Code of Laws Section 17-5 (https://www.scstatehouse.gov/code/t17c005.php).

Annotated Section 17-5-530-B: The coroner or medical examiner shall make an immediate inquiry into the cause and manner of death and shall reduce the findings to writing upon notification of deaths that are unexpected, unexplained, suspicious, violent, or in which the cause and/or manner of death is unknown.

Annotated Section 17-5-530: Deaths which fall under the jurisdiction of the Coroner are defined by SC Code of Laws (17-5-530) and include, but are not limited to, when a person dies as a result of violence, as a result of apparent suicide, when in apparent good health, in any suspicious manner, while an inmate of a penal or correctional institution or while in the custody of law enforcement officials, as a result of stillbirth when unattended by a physician, in a health care facility other than nursing homes within twenty-four hours of entering a health care facility after having undergone an invasive surgical procedure at the health care facility, or when unattended.

Annotated Section 17-5-520*:* When necessary to determine the cause of death, an autopsy can be ordered by the Coroner (17-5-520). Certain autopsies are mandated by law (17-5-520-B).

Function

The Coroner's Office investigators seek to find answers to the questions that are important to the decedent's family, involving law enforcement agencies, insurance companies, the judicial system, Consumer Product Safety Commission, the South Carolina Department of Public Health, and OSHA, to name a few. The pursuit of civil or criminal proceedings is in part determined by the ability of the Coroner's Office to identify the cause and manner of death. These unique job responsibilities mean the Coroner's Office performs both a public service and a law enforcement role that requires the Coroner's Office to scrutinize every death within the jurisdiction to determine the events that led to that death. The Coroner's Office also functions as an advocate for families by working with them to ensure they are notified of the death, relaying the medical information from autopsies, and placing families in touch with other agencies that will assist in the grieving process.

Many cases brought to the Coroner's Office are dealt with in a routine manner because the identity of the decedent is known, and next-of-kin can be readily contacted. However, there are occasional cases that are difficult to resolve. In these deaths, one or more pertinent pieces of information are missing or difficult to establish. Identification of the deceased may require locating dental records, fingerprints, or surgical records. The decedent may not have next-of-

kin, or the next-of-kin may be far removed and difficult to locate. These cases may take more time, but the Coroner's Office staff will pursue all leads to resolve these issues.

Which deaths do we investigate?

Any physician, undertaker, law enforcement officer, or other person having knowledge of the death of any person from the following reportable deaths must immediately notify the Coroner's Office or the local police or county sheriff, who in turn shall notify the Coroner's Office (SC Code of Laws Section 17-5-530).

Reportable Deaths:

- Known or suspected non-natural deaths
- Deaths due to violence or trauma of any type
- Deaths as a result of suicide
- Unexpected or unexplained deaths when in apparent good health
- Unexpected or unexplained deaths of infants and children
- Deaths of inmates or persons in custody
- Deaths on the job or related to employment
- Deaths believed to represent a threat to public health
- Deaths where neglect or abuse of extended care residents are suspected or confirmed
- Deaths where the identity of the person is unknown or unclear
- Deaths occurring under any suspicious/unusual/unnatural manner or circumstance
- Deaths of persons not under the care of a physician
- Deaths as a result of stillbirth when unattended by a physician
- Deaths in a health care facility, other than nursing homes, within twenty-four hours of entering a health care facility or within twenty-four hours after having undergone an invasive surgical procedure at the health care facility
- The Coroner's Office must likewise be notified if anatomical material suspected of being or determined to be a part of a human body is discovered.

Investigation and Disposition of Cases

Deputy Coroners will respond to all scenes that include - but are not limited to – infant and child deaths, homicides, suicides, industrial and residential accidents, motor vehicle accidents, deaths due to abuse/neglect/negligence, deaths due to terrorist acts, death due to malpractice, mass fatalities, arson, drowning, drug-related, and fire deaths.

Upon arrival at a death scene, the 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 Deputy Coroner 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 Coroner will coordinate with law enforcement officers regarding the collection of evidence.

If the Coroner or Deputy Coroner deems it necessary to conduct a postmortem examination (autopsy), the contracted transport vendor transports the decedent to the in-house morgue/autopsy suite or to the Department of Pathology and Laboratory Medicine at the Medical University. This office also notifies the associated 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 Coroner 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 Coroner's 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 secure 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.

If deemed necessary, an autopsy will be 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. Cases where autopsy is not performed are 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 provide 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 for testing [NMS Labs or the South Carolina Law Enforcement Division (SLED)]. Toxicology tests provide quantitative measures of blood and other body fluid levels for alcohol, illicit drugs, commonly abused prescription and nonprescription drugs, and other substances as needed. All toxicology results are reviewed by a board-certified Forensic Toxicologist, who consults with the Deputy Coroner and Forensic Pathologist to assess the significance of any detected drugs in relation to the cause and manner of death.

The Coroner's Office contracts the services of a forensic anthropologist and a forensic dentist for analysis and processing of evidence in the form of skeletal or badly decomposed remains. The forensic anthropologist and forensic dentist 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.

Indications for a Full Autopsy

Deputy Coroners are trained to recognize the vast majority of the deaths requiring postmortem examinations and, in those cases, immediately arrange for transport to either the Coroner's Office or MUSC for a postmortem examination.

The decision regarding whether a complete autopsy is performed is based on the International Association and Coroners and Medical Examiners (IACME) and National Association of Medical Examiners (NAME) Autopsy Performance Standards. Consequently, an autopsy is performed when the death is:

- known or suspected to have been caused by apparent criminal violence
- is unexpected and unexplained in an infant or child
- is associated with police action
- is apparently non-natural and in custody of a local, state, or federal institution
- is due to acute workplace injury
- is caused by apparent electrocution
- is by apparent intoxication by alcohol, drugs, or poison (unless a significant interval has passed, and the medical findings and absence of trauma are well documented)
- is caused by unwitnessed or suspected drowning
- is unidentified and the autopsy may aid in identification
- the body is skeletonized
- the body is charred
- the deceased is involved in a motor vehicle collision

Identification of Decedent

The Coroner or Deputy Coroner 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 the presence of prosthetics.

The Charleston County Coroner's Office requires a scientific identification in cases where visual identification of a decedent is impossible because of burns, decomposition, or other disfiguring injuries or the death is the result of an accident that involved two or more individuals who were approximately the same age, sex, height, weight, hair color, eye color, and race. In these cases, the Coroner's Office will verify the identity of the decedent through fingerprints, dental records, DNA, or another definitive identification procedure.

Death Certification

The main focus of coroner investigations is to determine the cause and manner of death. This information is provided on the death certificate.

What is the difference between Cause of Death and Manner of Death?

A cause of death is the morbid condition or disease process, abnormality, injury, or poisoning leading directly or indirectly to death. A death may result from the combined effect of two or more conditions. These conditions may be completely unrelated, arising independently of each other or they may be causally related to each other; that is, one cause may lead to another which in turn leads to a third cause, etc.

Unlike the cause of death, which can have any number of possibilities, the manner of death is limited to: Natural, Suicide, Accident, Homicide and Undetermined (Table 1). The fundamental purpose for determining the manner of death is for public health surveillance and vital statistics.

Table 1. Definitions of the Manners of Death

Natural	Death resulting from a disease or natural process, without any involvement of trauma or external causes.
Accident	Death resulting from injury or poisoning that was not deliberately inflicted and there is no evidence of intent to harm or cause death.
Suicide	Death resulting from an injury or poisoning as a result of an intentional, self-inflicted act.
Homicide	Deaths resulting from a volitional act committed by another person to cause fear, harm, or death. Intent to cause death is a common element but is not required for classification as a homicide. It must be emphasized that the classification of homicide for the purpose of death certification is a "neutral" term and neither indicates nor implies criminal intent, which remains a determination within the province of legal processes.
Undetermined	When the information pointing to one manner of death is no more compelling than one or more other competing manners of death, after thorough consideration of all available information.

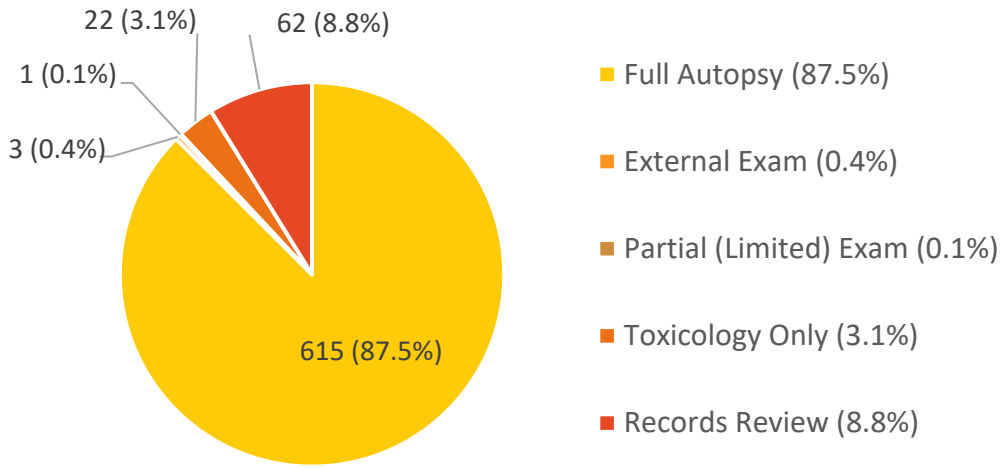
Types of Investigations and Examinations

Deaths reported to the Coroner's Office undergo different types of investigations and examinations depending upon circumstances. Table 2 describes the types and Figure 2 reports the counts and percentages for each type performed in 2024:

Table 2. Types of Investigations and Examinations

Full Examination	A complete autopsy includes external and internal examination, plus toxicology.
External Examination	An external examination includes a careful evaluation of the circumstances of the death and an examination of the external surfaces of the body, with possible laboratory/toxicology testing.
Limited Examination	A partial autopsy includes external and limited internal examination by the pathologist, plus toxicology at the discretion of the pathologist and deputy coroner.
Toxicology Only	A comprehensive laboratory-based examination that detects the presence and amounts of drugs (including over-the-counter, prescription, and illicit drugs) in blood and other body fluids.
Record Review	The Coroner's Office accepts jurisdiction, but the body is not viewed by a forensic pathologist. This type of investigation can occur when a decedent has been hospitalized for a period of time following an injury, when lethal injuries have been otherwise sufficiently documented, or when the deputy coroner is reviewing a case for cremation permit authorization.

Figure 2. Counts and Percentages for Each Type of Investigation and Examination Performed, 2024 (n=703)



Cremation Permit Authorization

South Carolina state law (SC Code of Laws Section 17-5-600) requires funeral directors and embalmers to obtain a signed permit from the coroner for the county in which the death occurred. The request for authorization to cremate involves reviewing the death certificate provided by the funeral director to assure that deaths that should have been reported to the office were, in fact, reported. Any cause and manner of death that were not properly reported on the death certificate by the certifier are investigated before cremation is authorized.

Public Health and Safety

While the major purpose of the Coroner's Office is to conduct death investigations, aggregate data obtained from death investigations is studied to address public health and safety issues.

Fatality Reviews

The Coroner's Office regularly holds in-house Child Death Reviews (SC Code of Laws Section 17-5-541) where case information is shared with law enforcement and public health stakeholders to review the cause and manner of death and to work to prevent future deaths. While not legislatively mandated, the Coroner's Office also conducts in-house Overdose Fatality Reviews to identify gaps in care and offer evidence-based strategies to prevent overdose deaths in the community. Next-of-kin have given permission for their loved ones' information to be shared. Elder Death Reviews are conducted to investigate the deaths of older adults to identify factors leading to abuse or neglect that resulted in death.

Public Health Stakeholders

The Coroner's Office participates with the South Carolina Department of Health State Unintentional Drug Overdose Reporting System (SUDORS), which collects de-identified data on unintentional and undetermined intent drug overdose deaths from death certificates, coroner reports, and postmortem toxicology results to target harm reduction strategies. The Coroner's Office also participates in the National Violent Death Reporting System (NVDRS), which collects and analyzes de-identified data on violent deaths across the United States to understand the magnitude, characteristics, and circumstances surrounding these deaths. These data are used by public health officials, researchers, and policymakers to inform violence prevention efforts and improve public safety.

Education

Training in Anatomical Pathology

In 2024, the Coroner's Office hosted two pathology residents (Medical College of Georgia at Augusta University and Allegheny General Hospital), three physician assistants (Anderson University, Charleston Southern University), one autopsy intern (Texas A&M University), and one autopsy apprentice (Charleston).

Training on Case Management Systems

In 2024, the Coroner's Office continued to hold webinars on the use of shared case management software. Monthly virtual "MDILog Office Hours" provided new and experienced users guidance and suggestions on how to best use the software.

Facility

The Coroner's Office has been at the 4000 Salt Pointe Parkway, North Charleston, location since 2017. In conjunction with the Charleston County Capital Projects Department and with support from Charleston County Council, plans were finalized to add a 3,000 square foot annex to the original 9,000 square foot stand-alone building. The construction of the annex surrounds 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 were plans to add office space and relocation of the second-floor conference room to the first floor. A second morgue cooler was added to the annex. Groundbreaking began in the fall of 2024, with completion in spring 2025.

Coroner and Staff

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

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 42 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 $4 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* (2007, CRC Press). 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 2024 Partner Award from We Are Sharing Hope for her support of organ and tissue donation.

Coroner's Office Staff

Administration & Support Personnel

Bobbi Jo O'Neal, RN, BSN, F-ABMDI, F-AAFS, *Coroner*
Brittney Martin, BS, F-ABMDI, *Chief Deputy Coroner*
Nancy Peacock, *Deputy Coroner/Project Officer III (Emergency & Evidence)*
Cooper Batley, BS, *Evidence Technician*
Suzanne Abel, PhD, *Deputy Coroner/Project Officer III (Epidemiology & Grants)*
D'artagnan Brownlee, BA, HRS, *Opioid Specialist* (Grant funded)
Cathleen Stanley, MS, *Opioid Specialist* (Grant funded)
Alison Garbarini, MPH, D-ABMDI, *CDR Coordinator* (Grant funded)
Kaaliyah Harris, BA, *SDY Coordinator* (Grant funded)
Nicole Brown, BHuServ, BA, *Coordinator of Administrative Services*
NIckayla Riley, *Administrative Assistant*
Joe Crawford, M. Ed., MSCJ, *Paralegal*
Ashleigh Jordan, BA, *Forensic Case Coordinator*

Deputy Coroners

Sara K. Tuuk, BS, MS, F-ABMDI, *Deputy Coroner III*
Anita Roman, BS, F-ABMDI, *Deputy Coroner II*
Stacey Toto, BS, F-ABMDI, *Deputy Coroner II*
Kelley Nevill, D-ABMDI, *Deputy Coroner II*
Elizabeth Dobbins, BFA, LFD, D-ABMDI, *Deputy Coroner II*
Ella Butler, MSc, *Deputy Coroner I*
Crystal Bright, BS, MS, *Deputy Coroner I*
David Reynolds, *Deputy Coroner I*
Kaitlin Kulesia, BSN, RN, *Deputy Coroner I*
Michael Frederick, RN, *Deputy Coroner I*

Forensic Services

Kelly Gallagher, BA, *Deputy Coroner/Supervisor of Forensic Services*
Miracle Randall, LFP, *Deputy Coroner/Autopsy Technician*
Katie Walker, BS, *Autopsy Technician*
Rebecca Phipps, BA, *Autopsy Technician*
Taylor Washington, BA, A*utopsy Technician* (Grant funded)
Tyrone Wigfall, *MDI Apprentice*

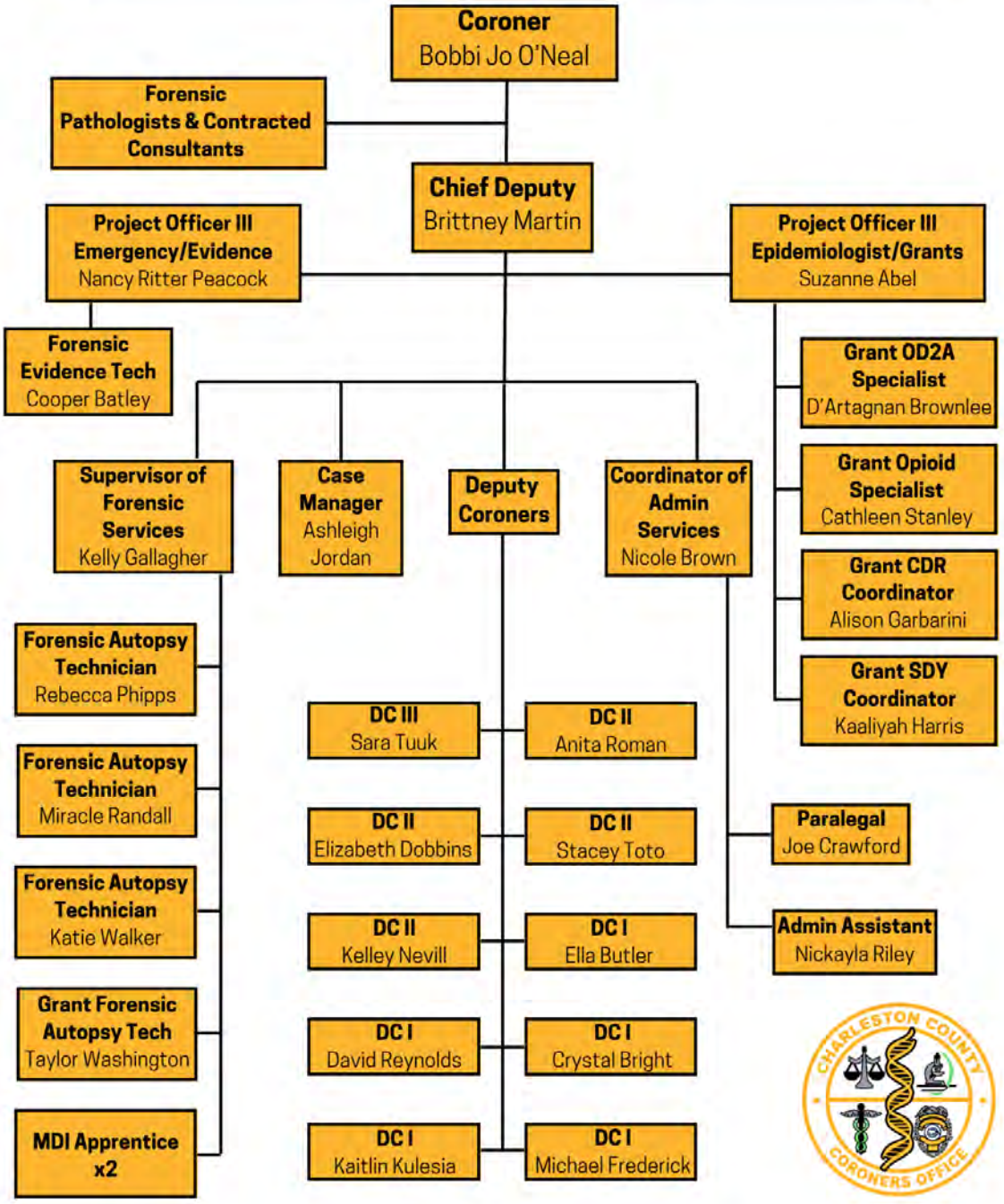
Contracted Consultants

Albert Williams, MD, *Forensic Pathologist*
Janice Pat Ross, MD, *Forensic Pathologist*
J.C.U. Downs. MD, *Forensic Pathologist*
Jan Gorniak, MD, *Forensic Pathologist*
Stephan Cina, MD *Forensic Pathologist*
Demi Garvin, PharmD, RPh, F-ABFT, *Forensic Toxicologist*
Suzanne Abel, PhD, *Forensic Anthropologist*
Wolf D. Bueschgen, DMD, *Forensic Dentist*

Staff Medicolegal Certifications

During 2024, 7 of the 12 investigators at the Charleston County Coroner's Office were professionally certified by the American Board of Medicolegal Death Investigators (5 Fellows and 2 Diplomates). All contracted pathologists are board-certified in forensic pathology and are licensed under the South Carolina Board of Medical Examiners.

Charleston County Coroner's Office Organizational Chart



Recognitions

On October 17, 2024, the Charleston County Coroner's Office was awarded the prestigious Barrett Lawrimore Memorial Regional Cooperation award on behalf of the South Carolina Association of Counties. This award recognizes the importance of regional partnerships by honoring two or more local governments that collaborated on an innovative project to better serve their communities. The winning project, a partnership between the Charleston and Beaufort County Coroners' Offices, established a framework for sharing resources and investigative tools to improve data standardization and communication between the counties. Additionally, it addressed challenges that can delay death investigations and the issuance of death certificates, particularly in cases involving natural disasters, the opioid crisis, or mass fatalities. Supported by grant funding, the initiative also enhanced the county offices' abilities to manage mass fatalities and provide services to their combined 630,000 residents.

In April 2024, Coroner O'Neal was nominated as a Justice and Public Steering Committee Member of the National Association of Counties. The Justice and Public Safety Steering Committee members review and make recommendations on public policy issues and legislation pertaining to criminal justice and public safety systems, including criminal justice, law enforcement, courts, corrections, homeland security, crime prevention, juvenile justice, emergency management, fire prevention, and civil disturbances. The policy development process initiated by the steering committee is the foundation for the American County Platform, which drives advocacy work of the National Association of Counties.

On May 17, 2024, Mothers Against Drunk Driving (MADD) formally recognized Deputy Coroner David Reynolds for earning the MADD Compassionate Hero Award. This award is given to a first responder who goes above and beyond in demonstrating support and compassion for victims of an impaired driving crash.

On June 24, 2024, Deputy Coroner Anita Roman was named the 2024 Lowcountry Region Deputy Coroner of the Year by the South Carolina Coroner's Association.

Budget

Fiscal Responsibility

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 2024 budget for the Coroner's Office was $3,571,750.00. The Fiscal Year 2025 budget for the Coroner's Office was $4,249,984.00. The last six months of FY2024 and the first six months of FY2025 combine to financially account for the calendar year 2024.

Grants Awarded

The Coroner's Office supplemented the 2024 annual budget with several extramural, competitive awards from state/federal grantors, public health agencies, the SC Opioid Settlement Fund, and independent/nonprofit agencies (Figure 3).

Figure 3. Grants, Cooperative Agreements, and Positions Awarded to the Coroner's Office, 2024

Agency	Grant Title	Award Date	Amount	Purpose
SC Department of Public Safety, Office of Justice Programs, Paul Coverdell Forensic Sciences Improvement Grant	Forensic Science Improvement Grant	July 1, 2024	$49,835.00	Improve the quality and timeliness of forensic services by funding a full-time autopsy technician
Bureau of Justice Assistance, Paul Coverdell Forensic Sciences Improvement Grant	Forensic Science Improvement Grant	October 1, 2024	$92,718.00	Improve the quality and timeliness of forensic services by funding a full-time data analyst
SC Department of Public Health	Overdose Data to Action in States (OD2A-S)	May 8, 2024	Organization-Funded Position	Provides technical and professional services to the Coroner's Office to support overdose surveillance activities

Centers for Disease Control and Prevention	Cooperative Agreement to Support State-Based Safe Motherhood and Infant Health Initiative Program	August 1, 2024	$235,099.00	Expand and improve the death investigations of minors in Charleston County and surrounding counties
SC Department of Public Health	Healthcare Preparedness Program	October 23, 2024	$120,000.00	Purchase of a rapid DNA unit as well as supplies and training
SC Department of Public Health	SC DPH Funds for Coroners	January 1, 2024	$65,000.00	Toxicology reimbursement
SC Opioid Recovery Fund	Guaranteed Political Subdivision Subfund	January 1, 2024	$16,947.00	Supplies for rapid blood screening performed at the Coroner's Office, travel for opioid specialists, and enhanced technological features in the Coroner's Office case management system
CDC Foundation	Overdose Data to Action Local (OD2A-L)	January 4, 2024	Organization-Funded Position	Harm reduction activities, coordinates in-house Overdose Fatality Reviews (OFRs), and participates in regional OFRs

Activities

Community Engagement

On November 7, 2024, the Coroner's Office held its inaugural in-house Overdose Fatality Review (OFR). OFRs are confidential meetings in which a diverse group of invested stakeholders collaborate to share data and study the death of a specific individual or group of individuals to identify gaps in the system to help save lives. OFRs conducted at the Coroner's Office follow the guidelines set forth by the Bureau of Justice Assistance Comprehensive Opioid, Stimulant, and Substance Abuse Program. The Coroner's Office also continues to be actively engaged in public harm reduction efforts. The Coroner's Office partners with local treatment centers, MUSC addiction physicians, housing providers, peer support specialists, and others in the community during outreach events. In 2024, a total of 1,441 naloxone (Narcan®) kits were distributed throughout the community by the Coroner's Office.

Throughout the course of 2024, Coroner O'Neal, deputy coroners, and staff presented case studies and/or training lectures at numerous professional organizations and annual conferences, training sessions, and events. Some of the organizations or events included:

- International Association of Coroners and Medical Examiners
- American Academy of Forensic Sciences
- National Association of Counties
- National Association of County and City Health Officials
- CDC Foundation
- Consortium of Forensic Science Organizations
- Lowcountry Healthcare Coalition
- Emergency Services Behavioral Health Summit
- SC Governor's Opioid Summit
- SCCA annual conference
- SC Coroner's Association Coroner's Academy
- Council of State and Territorial Epidemiologists
- SC Adverse Childhood Experiences
- Annual Infant and Maternal Mortality Awareness Symposium
- Forensic Technology Center of Excellence
- Waring Senior Center
- Charleston County Emergency Medical Technicians Training Academy
- Veterans Suicide Prevention Coalition
- Charleston Police Department
- Charleston Southern University
- Charleston County Emergency Medical Services

These same professionals participated in the following local and national activities:

- Walk like MADD
- Career Fair for Wando/East Cooper Center for Advanced Studies
- National Forum on Overdose Fatality Reviews
- National Violent Death Reporting System
- Lowcountry Healthcare Coalition
- Goodnight Lights
- National Injury Prevention Day
- National First Responders Day
- MUSC and Safe Kids Charleston
- Overdose Awareness Day
- International Overdose Awareness Day
- Emergency Services Behavioral Health Summit
- National EMS Memorial Celebration
- Survivors of Homicide

Legislative Advocacy

United States Congressional Policy Legislation

As President of the South Carolina Coroner's Association, Board Member of the Consortium of Forensic Science Organizations (CFSO), and Board Member of the National Association of Counties (NACo), Coroner O'Neal worked on the following bills and resolutions in 2024:

- S.Res.532 - National Medicolegal Death Investigation Professionals Week
  In January 2024, the United States Senate passed Resolution 532: A resolution recognizing and supporting the goals and ideals of the National Medicolegal Death Investigation Professionals Week. This resolution honors the coroners, deputy coroners, and medicolegal death investigation professionals who serve our citizens every day.

- S.4159/H.R. 8069 - Strengthening the Medical Examiner and Coroner System Act of 2024
  This legislation was filed to strengthen the medical examiner, coroner and toxicologist systems through fellowships and training grants. It will support and encourage qualified medical graduates to enter the practice of forensic pathology and educate, train, and certify qualified individuals to enter the field of medicolegal death investigation. Increasing the number of Board-certified Forensic Pathologists and Medicolegal Death Investigators must be a top priority to ensure that the United States can address current and emerging death issues and be prepared for crisis situations such as natural disasters and global pandemics.

South Carolina General Assembly Legislation

- H.3865 - Coroner Qualifications
  In April 2024, the full Senate Judiciary Committee unanimously voted to approve bill H. 3865 with amendments suggested by the South Carolina Coroner's Association. This bill would extend the qualifications for a coroner to include a licensed paramedic who has at least three years of experience. A Senate Judiciary subcommittee also adopted an amendment to remove the option where a candidate enrolled in a certification program to be completed within one year of being elected to the office of coroner could meet the qualification requirements, a South Carolina Association of Counties policy position. Candidates would need to have completed a recognized forensic science degree or certification program to qualify. Time limitations precluded the passing of this bill in the 2023-2024 Senate session and the bill was re-filed in the 2025-2026 session as H.3048.

Mass Fatality Preparation and Exercises

In May of 2024, the Coroner's 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 2024, 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 of 2024, 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.

Five individuals from the Coroner's Office (Coroner Bobbi Jo O'Neal, Chief Deputy Coroner Brittney Martin, Deputy Coroner II Anita Roman, Deputy Coroner Nancy Ritter-Peacock, and Deputy Coroner Kelly Gallagher) are members of the South Carolina Mortuary Assistance Strike Team (SC MAST). SC MAST personnel can be deployed should a mass fatality occur in any area of the state. The team integrates with healthcare coalitions

and state/local response partners to ensure a unified approach to the critical work necessary in mass fatalities.

The Coroner's Office has an ANDE® Rapid DNA unit that can be used to quickly develop DNA profiles to help identify victims of mass fatalities. Additionally, one non-refrigerated and two refrigerated morgue trailers are maintained for deployment during mass fatalities if needed.

Unclaimed Veterans Burial

In 2024, the unclaimed cremated remains of two US Veterans in the care of the Charleston County Coroner's Office were escorted to Columbia in May in preparation for their interment at Fort Jackson National Cemetery. Twenty-two motorcycle riders from the American Legion Chapter 166 from Goose Creek and the Patriot Guard Riders provided the escort.

Unidentified Remains

From 1980-2024, the Charleston County Coroner's Office entered 32 cases into the National Missing and Unidentified Persons System (NamUs) (www.namus.jij.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 2024, the office added 2 more cases to NamUs.

Report a sighting

Share this poster

UNIDENTIFIED

NCMEC: 1265773 - NCIC: Not Entered - NamUS: 8421

John Doe2006

Extra Photo

Date Found: Aug 20, 2006
Location Found: Mount Pleasant, SC
Estimated Age: 14-19
Sex: Male
Race: Black
Hair Color: Unknown
Eye Color: Unknown

On August 20, 2006 a skull was recovered by fisherman in the Wando River in Charleston County, South Carolina. The skull was found under the Wando Bridge. It?s estimated that the male had been deceased for several years before being found. He is estimated to be 14-19 years old. An anthropological assessment determined the child is of mixed ancestry, showing both black and white traits. Only the cranium was recovered, no other bones including the mandible have been found. The image shown is a facial reconstruction completed by a NCMEC Forensic Artist and depicts what the male may have looked like in life. While the mandible was not recovered, the artist was able to utilize a suitable match to complete the reconstruction. The lower half of his mouth down to his chin is an approximation by the artist.

ANYONE HAVING INFORMATION SHOULD CONTACT
1-800-843-5678 (1-800-THE-LOST®)
Charleston County Coroner?s Office (South Carolina) 1-843-746-4030

Report a sighting

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UNIDENTIFIED

NCMEC: 1426228 - NCIC: - NamUS: 77018

John Doe 2020

Extra Photo

Date Found: Dec 29, 2020
Location Found: Daniel Island, SC
Estimated Age: 17 - 21
Sex: Male
Race: Black
Hair Color: Unknown
Eye Color: Unknown

On December 29, 2020 skeletal remains of an unidentified male were found in a marsh off the Wando River in Charleston, South Carolina. The marsh was next to Daniel Island. Only the skull was recovered. Forensic professionals have assessed that the male was African American and approximately 17 to 21 years old. He had been deceased for an extended period of time, likely over a year. The image displayed is a facial reconstruction created by a NCMEC Forensic Artist and depicts what the male may have looked like in life.

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1-800-843-5678 (1-800-THE-LOST®)
Mount Pleasant Police Department (843)743-7200, Charleston County Coroner's Office (843) 746-4030

Report a sighting | Español

Share this poster

UNIDENTIFIED

NCMEC: 1265774 - NCIC: - NamUS: 8581

John Doe2006

Date Found: Jan 14, 2006
Location Found: North Charleston, SC
Sex: Male
Hair Color: Brown
Eye Color: Brown
Estimated Height: 5'1"
Estimated Weight: 117 lbs

On January 14, 2006 an unidentified male was found deceased in North Charleston, South Carolina. The male was found inside a minivan that was parked at a rest area along the eastbound lanes of Interstate 26. He had only been deceased a few hours before he was found. The male is estimated to be 18-30 years old. He had dark brown hair and brown eyes. He stood approximately 5?1? tall and weighed around 117 pounds. An abdominal scar was present that was consistent with the male having a prior appendectomy. The male was found clothed wearing black jeans, a short-sleeved multicolored striped polo shirt with a long-sleeve maroon plaid button up shirt on top. A Mexican voter registration card with the name ?Gustavo Rosas Hernandez? was found with the male but it is unknown if it belonged to him or not. The image above is a facial reconstruction created by a NCMEC Forensic Artist and depicts what the male may have looked like in life.

ANYONE HAVING INFORMATION SHOULD CONTACT
1-800-843-5678 (1-800-THE-LOST®)
Charleston County Coroner?s Office (843)746-4030

UNIDENTIFIED

Jane Charleston County Doe 1973

NCIC# Unknown , NamUs# 9998

Date Found: July 12, 1973

Location Found:Charleston County , SC, US

Estimated Age: 14-17 Years Old

Female

EXTRA PHOTOS

Skeletal remains of an unidentified female were found at the Charleston County Coroner's Office from an unknown origin. The only identifying information with the remains suggest that she was initially found on or before July 12, 1973. Specifics of where and when the remains were originally discovered is undetermined. Forensic assessments of the skull reveal that the decedent is a Caucasian female, approximately 14 to 20 years old at the time of death. She stood approximately 4'8" to 5'0" tall. Hair and eye color cannot be determined. Dental restorations were observed in her teeth indicating that she had received dental treatment in life. Foul play is suspected. The images shown are a facial reconstruction completed by a NCMEC Forensic Artist and depicts what the female may have looked like in life.

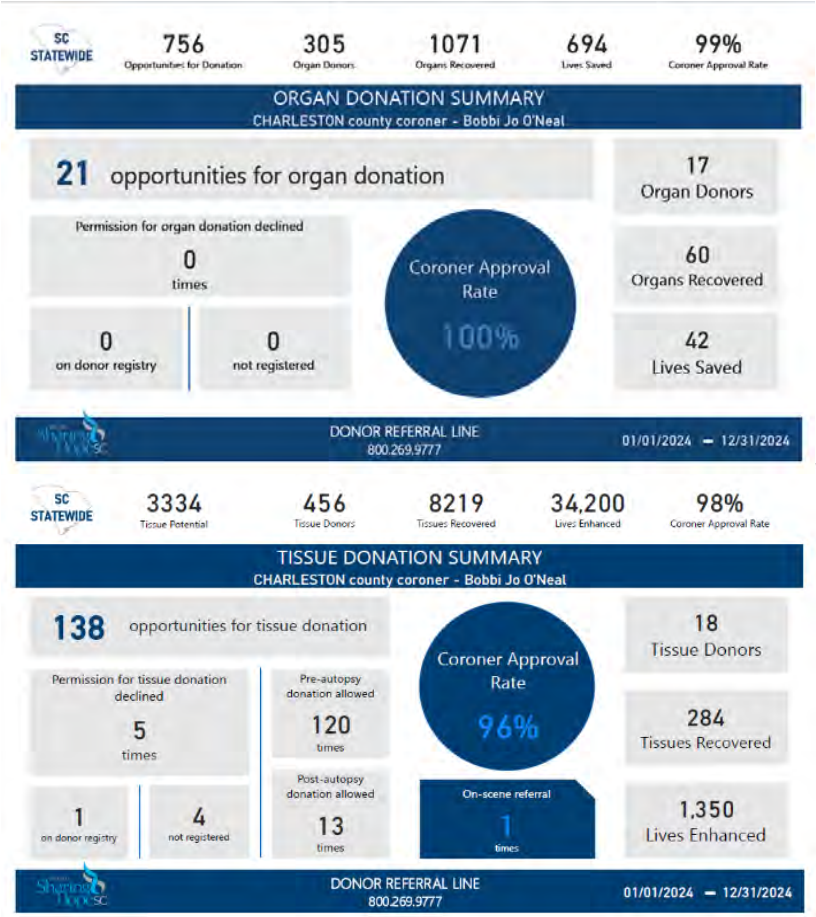
Potter's Field

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. Plans for the site include installing an updated and complete fence on the perimeter and regular landscape maintenance. In 2024, vault space was purchased at a local funeral home for the future placement of cremated remains of unclaimed decedents.

Organ and Tissue Procurement

The Coroner's Office works closely with Sharing Hope South Carolina and Miracles in Sight to honor the wishes of decedents and their families to donate organs and tissues after death. In 2024, 21 cases were released for organ donation, and all were accepted. A total of 133 cases were released for tissue donation and 18 were accepted (Figure 4).

Figure 4. Organ and Tissue Donation Summaries, 2024



Statistics

Explanation of Data

Origin of Data

The data included in this section has been compiled from cases investigated during the 2024 calendar year and are presented here in aggregate form. Many of the tables, charts, and graphs also include data from previous years as needed to show trends. It is the intention of the Charleston County Coroner's Office to provide factual statistics and information for and requested by the citizens of Charleston County. Graphs and tables, which display information such as classification of death, unintentional drug deaths, and motor vehicle crash statistics have been selected as those most likely to assist other agencies and individuals seeking statistical information.

Death Date vs. Injury Date

Deaths in this report are grouped by the year in which the death occurred, regardless of the date of injury. For example, if someone was injured in 2023, but did not die from those injuries until 2024, they are included in this report. Total death counts are also based on the date the death was reported to the Coroner's Office, which may or may not be the actual date of death. For example, if a decedent died in late 2023, but was not found or reported to the Coroner's Office until early 2024, they would be included in this 2024 report.

Race and Ethnicity

The Charleston County Coroner's Office classifies a decedent's race and ethnicity using broadly used public health definitions. The CDC defines race as a person's self-identification with one or more social groups, not based on biological or genetic factors. It allows individuals to report as White, Black or African American, Asian, American Indian and Alaska Native, Native Hawaiian and Other Pacific Islander, or some other race. The CDC defines ethnicity as a characterization of people based on shared cultural and historical elements, including language, traditions, and beliefs. The CDC also uses ethnicity to categorize populations based on Hispanic or Latino origin, separate from race. The Coroner's Office extracts race and ethnicity data from the death certificate; these classifications are provided by family members as they work with funeral homes to complete the demographic section of the death certificate.

At-a-Glance Numbers: 2024 Year-End Overview

As of May 12, 2025, provisional statistical death data provided by the South Carolina Vital Statistics Division at the SC Department of Public Health reported 5,138 deaths in the county in 2024.

A total of 4,359 deaths were reported to the Coroner's Office; 92 of which were erroneously reported to the Coroner's Office when jurisdiction was for a different county, leaving 4,267 deaths reported (jurisdiction acceptance rate 98%). Of these deaths, 52 (2%) were classified as "Homicides", 76 (3%) were classified as "Suicides", 341 (12%) were classified as "Accidents", 2,238 (82%) were classified as "Natural" deaths, and 25 (1%) were classified with an "Undetermined" manner.

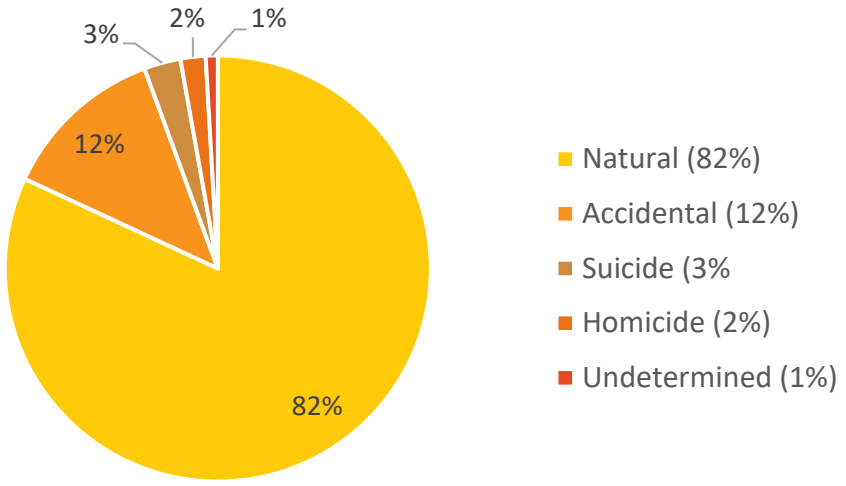
In addition to investigating these deaths, the Coroner's Office was involved to various degrees with requests for numerous services. The grand total of all requests for services plus death investigations in 2024 was 4,359. Table 3 provides the counts for each service and Figure 5 provides the percentages for each manner of death for 2024.

Table 3. All Services Provided by the Coroner's Office, 2024

Deaths in jurisdiction	5,138
Deaths reported to Office	4,359
Wrong county	92
Cases accepted/Investigated by Office	4,267
Complete autopsies	616
Autopsies completed at CCCO	492
Autopsies completed at MUSC	124
External examinations	3
Limited/Partial autopsies	0
Toxicology only cases	22
Total cremation permits authorized	3,113
Cremation permits issued with reported deaths	1,644
Stand-alone cremation permits	1,469
Found cremains	1
Total toxicology tests ordered	641
Total cases involving scene investigations	904
Bodies transported by Office or order of Office to morgue	669
Bodies transported for storage only	95
Total death notifications for other jurisdictions	46
Agency assists	8
Total number of inquests	0
Decedents in law enforcement custody	15
Reported deaths under 18 years old	54

Total anthropology exams	9
Total non-human anthropology bone cases	5
Total odontology exams	3
Unidentified decedents	3
Exhumations	0
Unclaimed decedents	8
Released for organ donation	21
Actual organ donors	21
Released for tissue donation	133
Actual tissue donors	18
Coroner cases declined for donation-organ	0
Coroner cases declined for donation-tissue	5
Research cases	2
Out of county residents	159
All requests for services plus death investigations	4,359

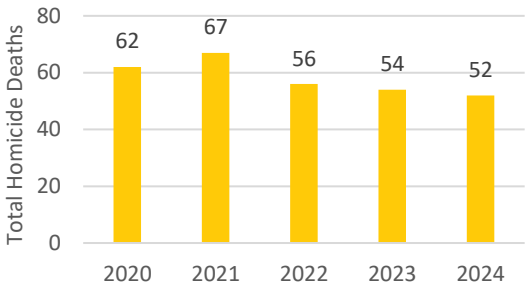
Figure 5. Percentages for Each Manner of Death, 2024 (n=2,732)



Homicides

In 2024, there were 52 homicides reported to the Coroner's Office. 100% of these cases received a full autopsy examination. The county continues the slight downward trend in homicide deaths for 2024 (Figure 6).

Figure 6. Total Reported Homicides, 2020-2024



The Coroner's Office is not responsible for determining if a homicide was or was not justified. 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.

In the following, demographic information and mechanism of homicide death specifically for 2024 is presented.

Figure 7 shows the age distribution by sex for all homicide deaths. There were 44 male victims (85%) and 8 female (15%) victims. Due to the social differences between adolescents and young adults, age is stratified into children/adolescents (0 to 17 years) and young adults (18 to 24 years). Most males were in the 35 and 44 years old, while most females were 75+ years old. A more detailed breakdown of homicides in individuals < 18 years of age is reported in Appendix A: Annual report on Child Deaths.

Figure 7. All Reported Homicide Deaths by Sex and Age Group, 2024 (n=52)

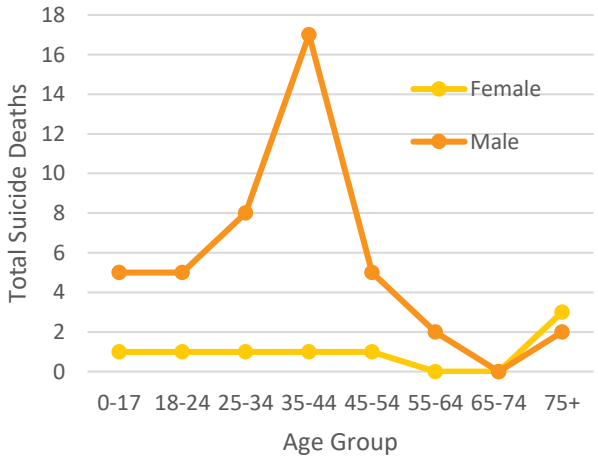


Figure 8 shows the race and ethnicity by sex for all homicide deaths. The majority of victims (69%) were Black or African-American/non-Hispanic males.

Figure 8. Percentages of Race/Ethnicity for All Reported Homicides, 2024 (n=52)

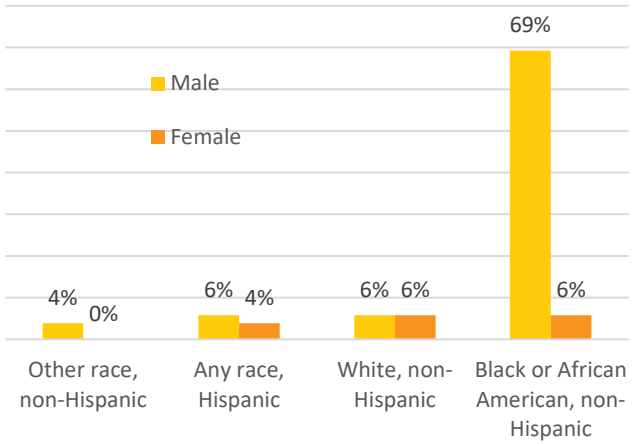


Table 4 provides counts and percentages of mechanisms of death by sex. The majority of homicides involved firearm injuries toward males (67%).

Table 4. Mechanisms of Death by Sex, 2024 (n=52)

	Male		Female	
	Count	%	Count	%
Firearm	35	67.0	2	4.0
Asphyxia-hanging	1	2.0	0	0.0
Blunt force trauma	4	8.0	1	2.0
Carbon monoxide-structure fire	0	0.0	1	2.0
Drug toxicity	0	0.0	2	4.0
Neglect	0	0.0	1	2.0
Sharp force trauma	3	6.0	1	2.0
Motor vehicle collision-pedestrian	1	2.0	0	0.0
Total	44		8	

Figures 9-11 provide additional information on homicides involving firearms. The majority of homicides were seen among males in the 35-44 year age group. The youngest male was 15 years of age and the youngest female was 20 years of age. The majority of deaths were seen in Black or African-American/non-Hispanics (83%). The most frequent regions of firearm injury were the chest (49%), lower extremity (43%), and upper extremity (43%).

Figure 9. Percentage of Homicides Involving Firearms by Sex and Age Group, 2024 (n=37)

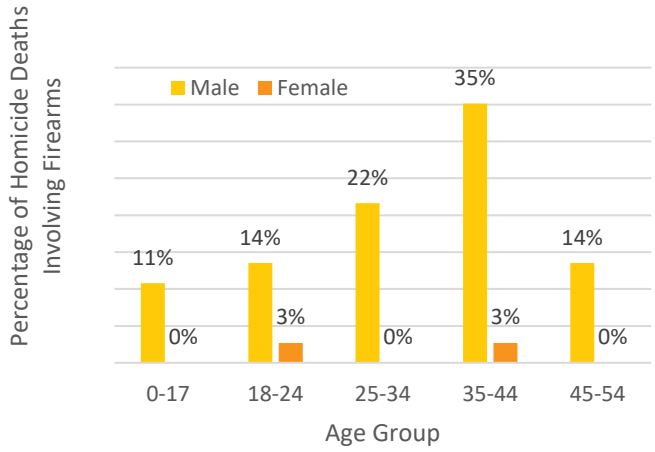


Figure 10. Percentage of Homicides Involving Firearms by Sex, Race, and Ethnicity, 2024 (n=37)

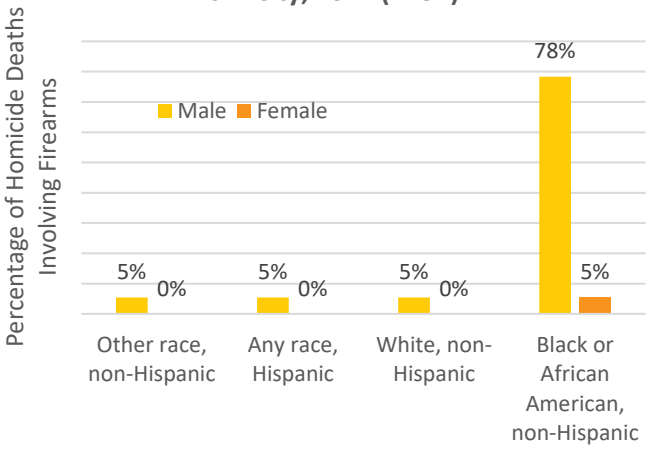
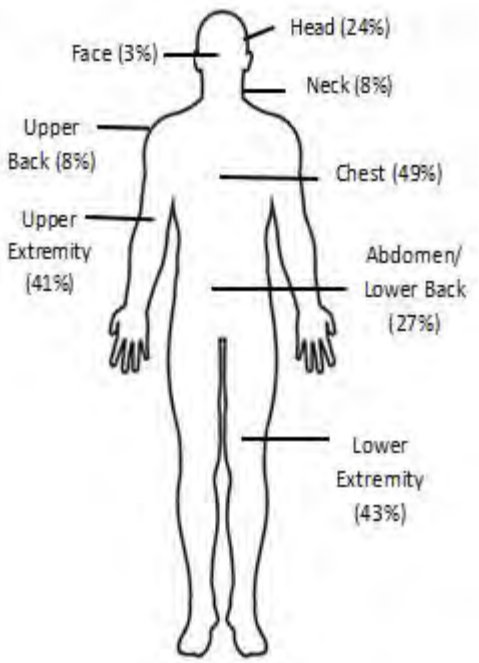


Figure 11. Wound Distribution for Homicides Involving Firearms, 2024 (n=37)



Suicides

In 2024, there were 76 suicides reported to the Coroner's Office (Figure 12) . This is a slight increase from 2023. Of the 76 suicides in 2024, 93% received a full autopsy examination.

In this section, we present demographic information and mechanisms of suicide deaths specific for 2024. Sixty-one (80%) were male and 15 (20%) were female. Figure 13 shows the age distribution of suicide deaths by sex and age group. The average age at death for males was 44 while the average age for females wasof 51. Among males, the youngest age was 12 and the oldest was 83. Among females, the youngest age was 21 and the oldest was 83.

Figure 14 shows that the majority of suicide deaths (62%) were seen in White/non-Hispanic males, followed by White/non-Hispanic females (20%).

Table 5 shows the counts and percentages by mechanism of death by sex. Figure 15 shows the percentages by sex. Among males, the highest percentage of suicide deaths were due to self-inflicted firearm injuries (43.4%). Among females, the highest percentage of suicide deaths were due to intentional drug toxicity (7.9%).

Figure 12. Total Reported Suicides, 2020-2024

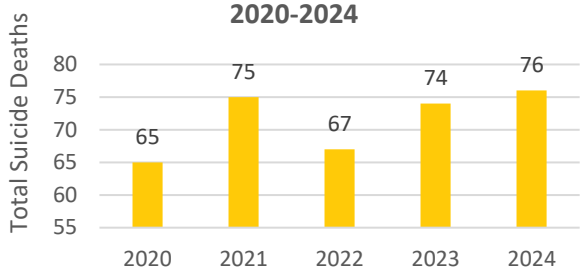


Figure 13. Total Reported Suicide Deaths by Sex and Age Group, 2024 (n=76)

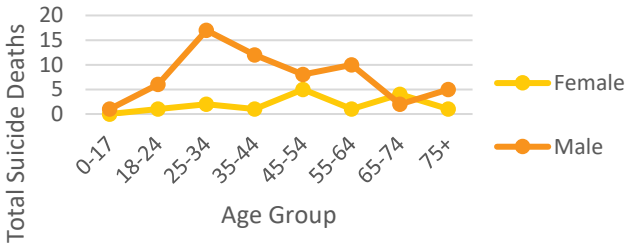


Figure 14. Percentages of Reported Suicide Deaths by Race/Ethnicity, 2024 (n=76)

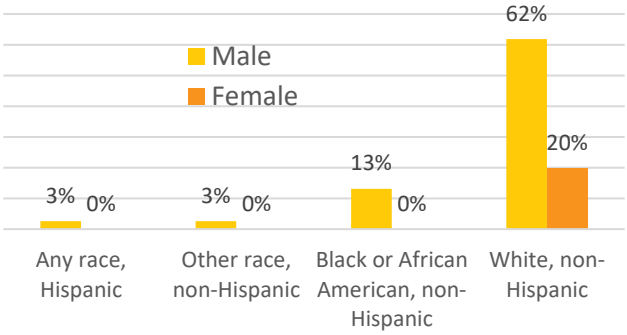
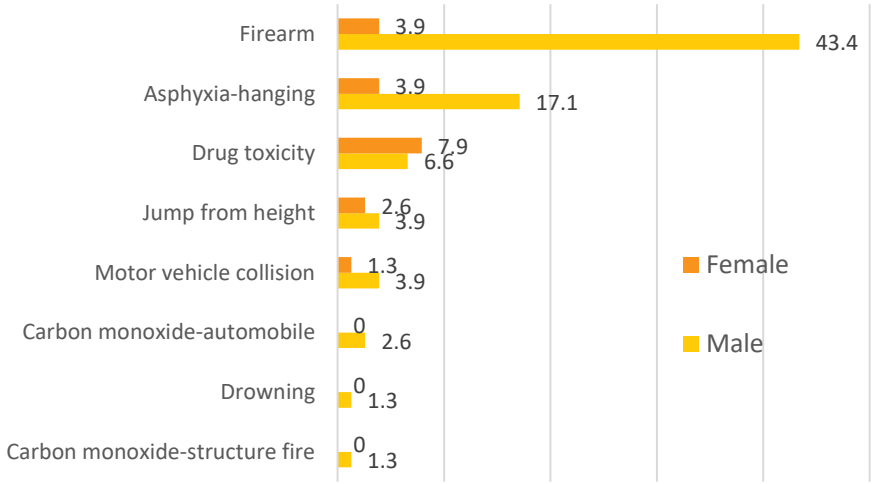


Table 5. Mechanisms of Death for All Reported Suicides by Sex, 2024 (n=76)

	Male		Female	
	Count	%	Count	%
Firearm	33	43.4	3	3.9
Asphyxia-hanging	13	17.1	3	3.9
Drug toxicity	5	6.6	6	7.9
Jump from height	3	3.9	2	2.6
Drowning	1	1.3	0	0
Motor vehicle collision	3	3.9	1	1.3
Carbon monoxide-automobile	2	2.6	0	0
Carbon monoxide-structure fire	1	1.3	0	0
Total	61		15	

Figure 15. Mechanism of Death by Percent for All Reported Suicides by Sex, 2024 (n=76)



Veteran Suicides

In 2024, there were 13 suicides of individuals who were either active-duty military or veterans. Twelve were males and one was female. Two individuals were Black or African American/non-Hispanic and 11 were White/non-Hispanic. The most common mechanism of death among these individuals was self-inflicted firearm injury (69%).

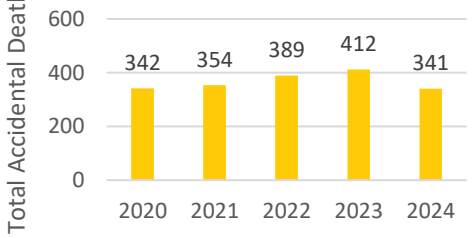
The Charleston County Coroner's Office is an active participant in the local Veteran Suicide Prevention Coalition. The coalition is formed by organizations, agencies, and neighbors working together for the prevention of veteran suicide in Berkeley, Charleston and Dorchester counties. Resources are shared and suicide responses are discussed to create actionable strategies that may lead to reducing veteran suicide deaths.

Accidental Deaths

In 2024, there were 341 accidental deaths reported to the Coroner's Office. This is a 17% decrease from 2023 (Figure 16). Of all accidental deaths in 2024, 72% received a full autopsy.

As in the previous sections, we now present demographic information and mechanisms of death for 2024. We will also focus on deaths attributed to drowning, drug toxicity, and motor vehicle collisions (MVCs), as those are often of particular concern.

Figure 16. Total Reported Accidental Deaths, 2020-2024



Of the 341 accidental deaths, 69% of these decedents were male, and 31% were female. Figure 17 shows the age distribution of decedents by sex. The highest number of accidental deaths in males occurred in the 55-64 year age group. The highest number of accidental deaths in females occurred in the 75+ age group.

Figure 17. Reported Accidental Deaths by Sex and Age Group, 2024 (n=341)

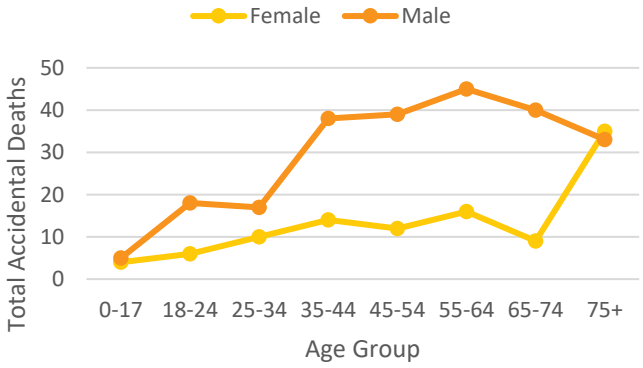


Figure 18 shows the race and ethnicity distribution of these decedents. Of the 341 accidental deaths, 63% of decedents were White/non-Hispanic and 32% were Black or African American/non-Hispanic.

Table 6 and Figure 19 show mechanism of accidental death by sex. For male decedents, the most common mechanisms are drug toxicity (38.1%), motor vehicle collisions (13.2%), and falls (10.3%). For female decedents, the majority of accidental deaths were drug deaths (12.6%), falls (10.6%), and motor vehicle collisions (5%).

Figure 18. Percentages of Reported Accidental Deaths by Race/Ethnicity, 2024 (n=341)

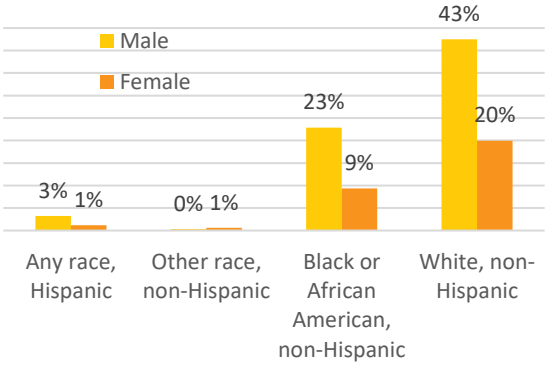
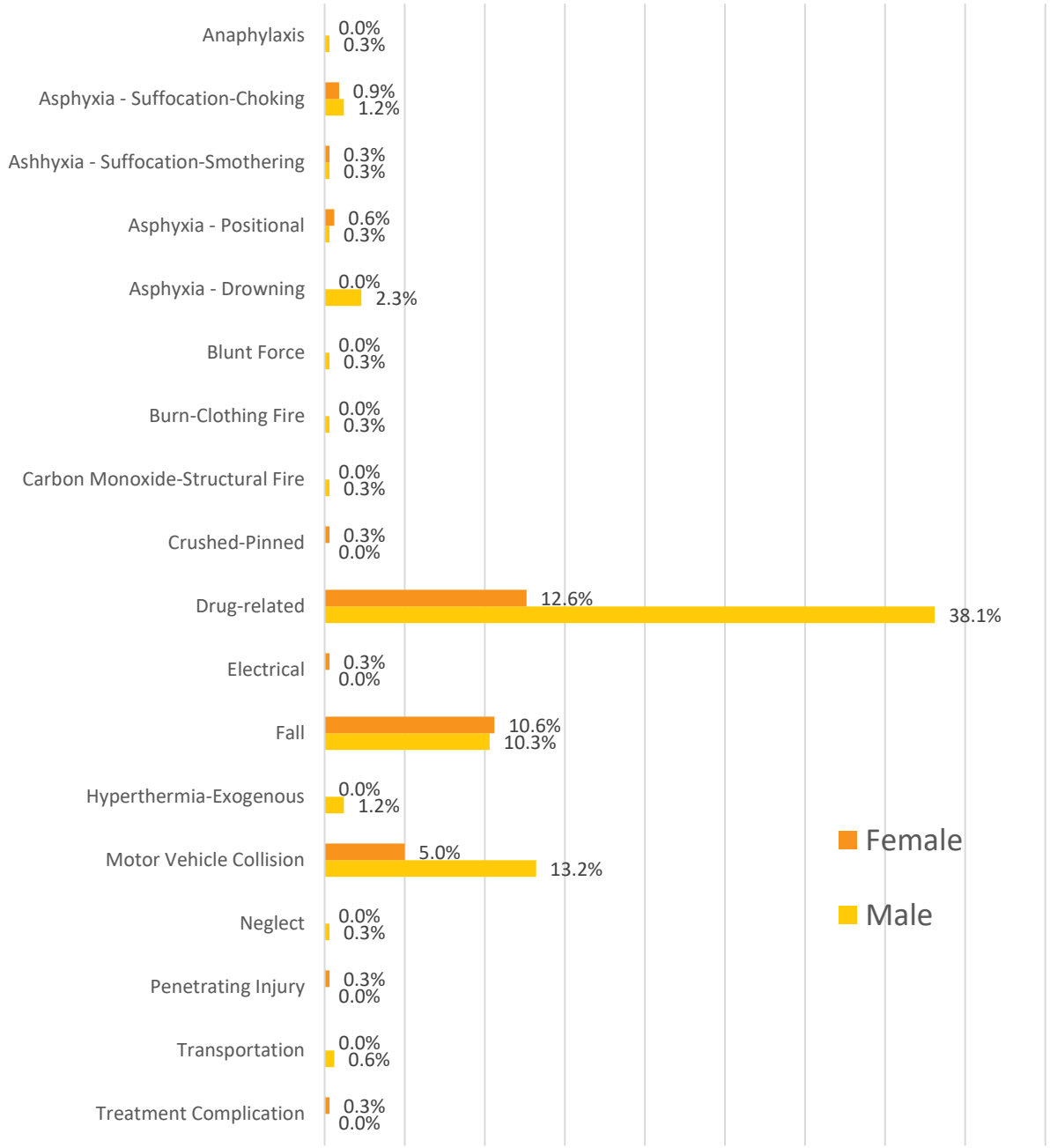


Table 6. Mechanisms of Death for All Reported Accidental Deaths by Sex, 2024 (n=341)

	Male		Female	
Mechanism	Count	%	Count	%
Anaphylaxis	1	0.3%	0	0.0%
Asphyxia - Suffocation-Choking	4	1.2%	3	0.9%
Asphyxia - Suffocation-Smothering	1	0.3%	1	0.3%
Asphyxia - Positional	1	0.3%	2	0.6%
Asphyxia - Drowning	8	2.3%	0	0.0%
Blunt Force	1	0.3%	0	0.0%
Burn-Clothing Fire	1	0.3%	0	0.0%
Carbon Monoxide-Structural Fire	1	0.3%	0	0.0%
Crushed-Pinned	0	0.0%	1	0.3%
Drug toxicity	130	38.1%	43	12.6%
Electrical	0	0.0%	1	0.3%
Fall	35	10.3%	36	10.6%
Hyperthermia-Exogenous	4	1.2%	0	0.0%
Motor Vehicle Collision	45	13.2%	17	5.0%
Neglect	1	0.3%	0	0.0%
Penetrating Injury	0	0.0%	1	0.3%
Transportation	2	0.6%	0	0.0%
Treatment Complication	0	0.0%	1	0.3%
Total	235		106	

Figure 19. Mechanism of Death by Percent for All Reported Accidental Death by Sex, 2024 (n=341)

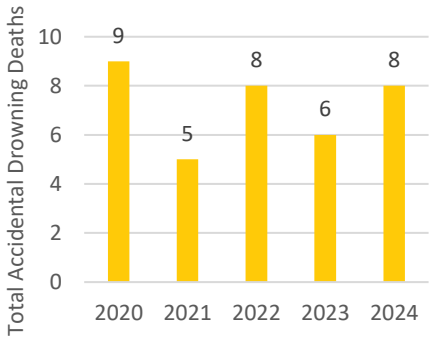


Accidental Drowning Deaths

In 2024, there were 8 deaths attributed to asphyxia/drowning. This is a slight increase from 2023 (Figure 20).

For the 2024 accidental drowning deaths, all 8 individuals were male. One was Hispanic and 7 were White/non-Hispanic. Two individuals were just 1 year of age and the oldest was 69 years of age. Three individuals knew how to swim, 3 did not, and in 2 cases it was unknown if they knew how to swim. Postmortem toxicology revealed that alcohol was involved in 4 of the adult deaths. More information on child drowning deaths can be found in Appendix A: Annual Report on Child Deaths.

Figure 20. Total Reported Accidental Drowning Deaths, 2020-2024



Accidental (Unintentional) Drug-Related Deaths

In 2024, there were 173 accidental drug-related deaths (unintentional overdoses). This is a 27% decrease from 2023 (Figure 21). In cases where there is no evidence of intent to self-harm, the Coroner's Office considers these drug deaths accidental in manner, which follows national standards and the guidelines of the National Association of Medical Examiners.

Figure 22 shows the age distribution of accidental drug-related deaths by age category. The peak age group for males was in the 45–54-year age group. The peak age group for females was 35-44.

Of the 173 unintentional drug-related deaths, 67% were due to a finding of mixed drug toxicity. Mixed drug toxicity means that more than one drug was found to have contributed to the death. More information on drug-related deaths can be found in Appendix B: Annual Drug Report.

Figure 21. Total Reported Accidental (Unintentional) Drug-Related Deaths, 2020-2024

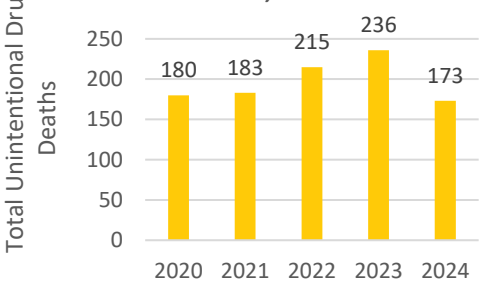
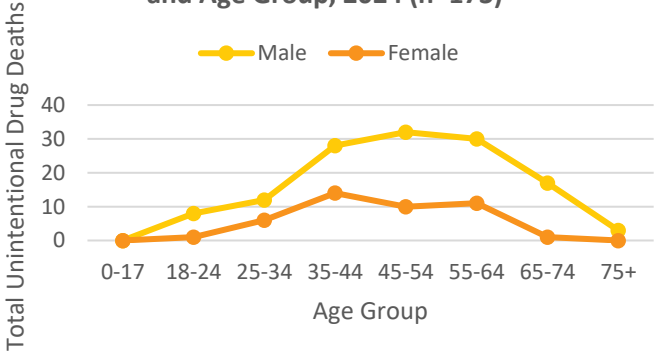


Figure 22. Reported Accidental (Unintentional) Drug-Related Deaths by Sex and Age Group, 2024 (n=173)



Accidental Motor Vehicle Collision (MVC) Deaths

In 2024, there were 57 motor vehicle collisions resulting in 62 accidental deaths. This is a 25% decrease from 2023 (Figure 23).

Figure 24 shows the distribution of these decedents by sex and age group. This distribution is varied; several peaks and troughs for both males and females indicate a lack of significant patterning to the data.

Figure 25 shows the race and ethnicity of decedents involved in accidental motor vehicle collisions. A lower proportion of MVC decedents were Hispanic (13%) compared to Black or African American/non-Hispanics (47%) and White/non-Hispanics (40%), who are both relatively even in distribution.

Figure 26 illustrates the decedent position in MVCs. The majority (40%) were the driver of the vehicle, followed by either the vehicle occupant (19%) or pedestrian (19%). Motorcycle and moped operators made up 15% of accidental MVC deaths.

Figure 23. Total Reported Accidental MVC Deaths, 2020-2024

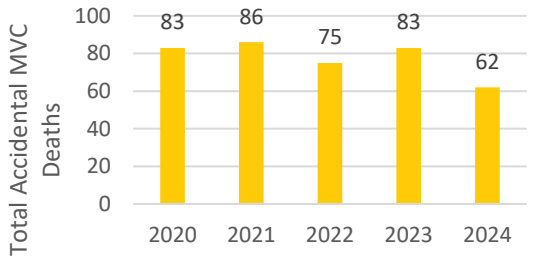


Figure 24. Total Reported Accidental MVC Deaths by Sex and Age Group, 2024 (n=62)

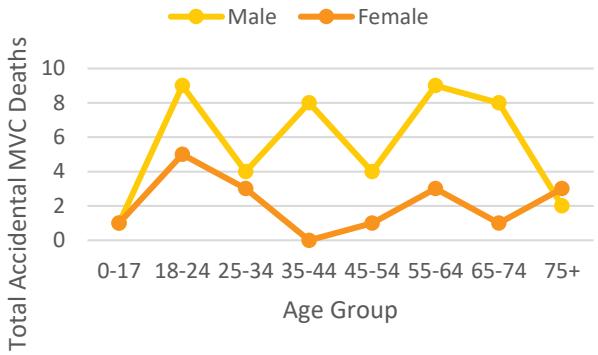


Figure 25. Percentages of MVC by Race/Ethnicity, 2024 (n=62)

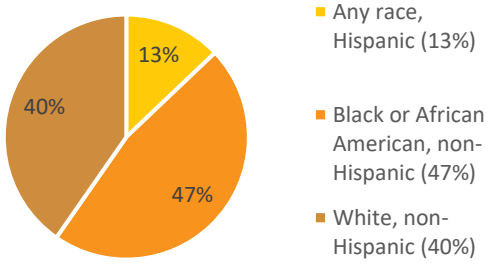
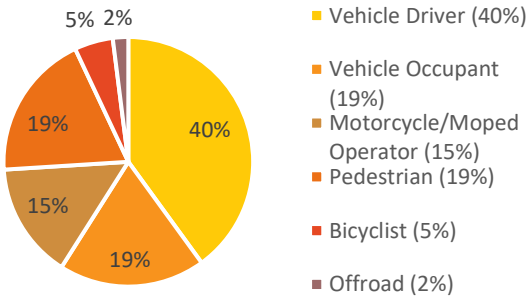


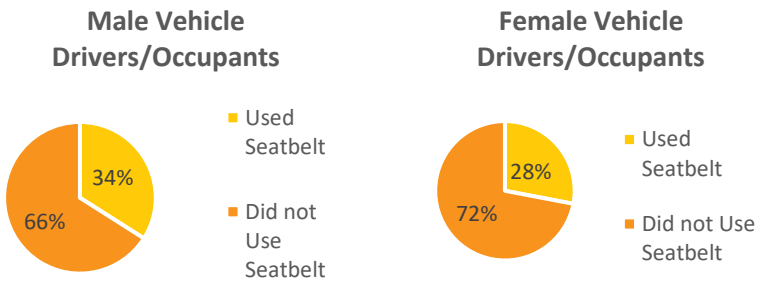
Figure 26. Decedent Position in MVC Deaths, 2024 (=62)



Use of Safety Restraints/Devices

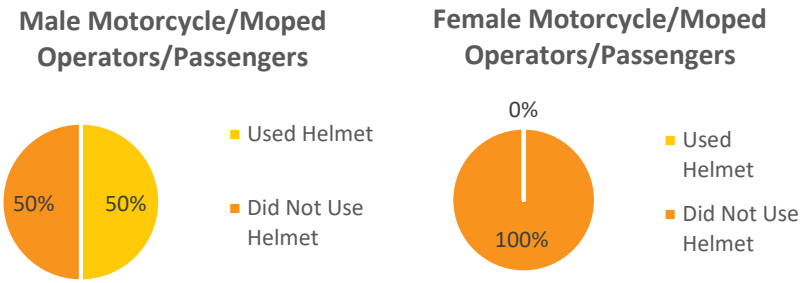
Of the accidental MVC deaths involving motorized vehicles, 31 decedents were male and 5 were female. Of the males, 66% did not use a seatbelt when seatbelt use could be determined. Of the females, 72% did not use a seatbelt (Figure 27).

Figure 27. Seatbelt Use Among Vehicle Drivers and Occupants, 2024 (n=36)



Half of all male motorcycle/moped operators and passengers were not wearing a helmet. For females, the helmet was not worn in 100% of deaths (Figure 28).

Figure 28. Helmet Use Among Motorcycle/Moped Operators/Passengers, 2024 (n=10)



For bicyclists struck by motor vehicles, all decedents were male; 67% were not wearing a helmet (Figure 29).

Figure 29. Helmet Use Among Bicyclists, 2024 (n=3)

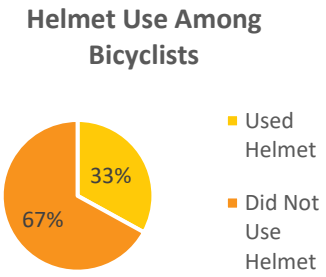


Figure 30 shows the percentages of MVC deaths with positive toxicology results. If a decedent had positive toxicology for substances such as alcohol, recreational drugs, or prescription medications that could cause impairment, they were included here. Figure 30 only shows the percentages of those with substances detected; it does not necessarily indicate or exclude impairment as toxicology levels are not considered. The percentages of positive toxicology

results for male and female pedestrian/bicyclist decedents are similar – 86% of females and 88% of males had positive toxicology results. More male (65%) than female (40%) vehicle drivers or operators had positive toxicology results.

Figure 31 shows the percentages of MVC decedents with a blood alcohol concentration (BAC) greater than or equal to .08 g/mL. Proportionately more female (57%) than male (38%) pedestrians and bicyclists had a BAC greater than .08 g/mL. Additionally, proportionately more female (40%) than male (29%) drivers/operators of motorized vehicles had a BAC greater than .08 g/mL.

Figure 30. Percentages of MVC Deaths with Positive Toxicology Results by Sex, 2024

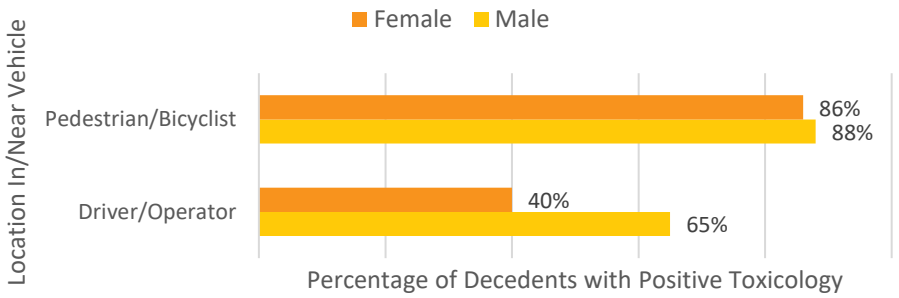
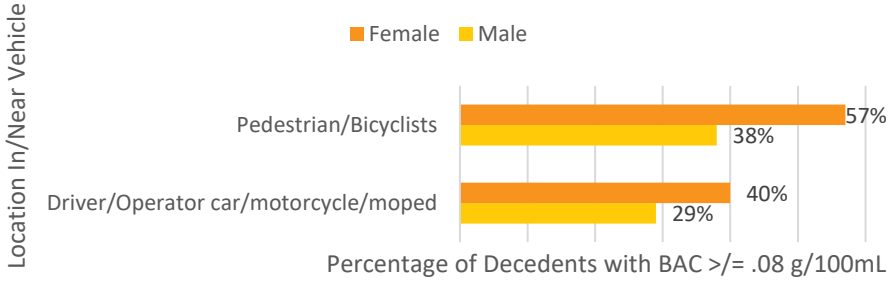


Figure 31. Percentages of MVC Decedents with BAC >/= .08g/mL by Sex



Natural Deaths

In 2024, there were 2,238 deaths reported to the Coroner's Office that were determined to be natural deaths. Of these, 18 were natural fetal demises. Deputy Coroners receiving notifications of natural deaths may investigate in person and assume jurisdiction for determining cause and manner of death or determine that no further action is warranted. If a detailed investigation was not required, the Deputy Coroner 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 1,295 in 2024. In these cases, deputies review the death certificate for proper documentation of cause and manner of death, which is completed by the attending physician or other certifier. If correctly documented and there is nothing concerning about the circumstances of death, no investigation is needed. If the cause and manner of death are improperly documented or there is anything concerning about the circumstances of death, deputies will investigate the death further.

In the following, we focus on the 925 natural deaths that were actively investigated by the Coroner's Office in 2024. In these cases, Deputy Coroners have done one or more of the following: attended the scene, reviewed medical records, and/or requested autopsies.

Of the 925 natural deaths, 542 (59%) of decedents were male and 383 (41%) were female. Figure 32 shows the age distribution of decedents by sex and age group. The age distribution of males and females is approximately similar. As might be anticipated, the average age for decedents with a natural manner of death is higher than homicide, suicide, or accident.

Figure 32. Natural Death Counts (Non-Hospice) by Sex and Age Group, 2024 (n=925)

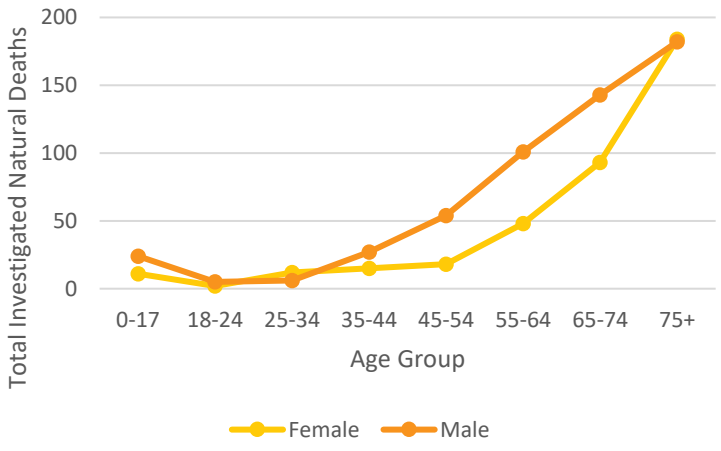


Figure 33 shows the percentages of decedents by race, ethnicity, and sex for all natural deaths that were not under hospice care at the time of death.

Figure 33. Percentages of Race/Ethnicity for All Reported Natural (Non-Hospice) Deaths, 2024 (n=925)

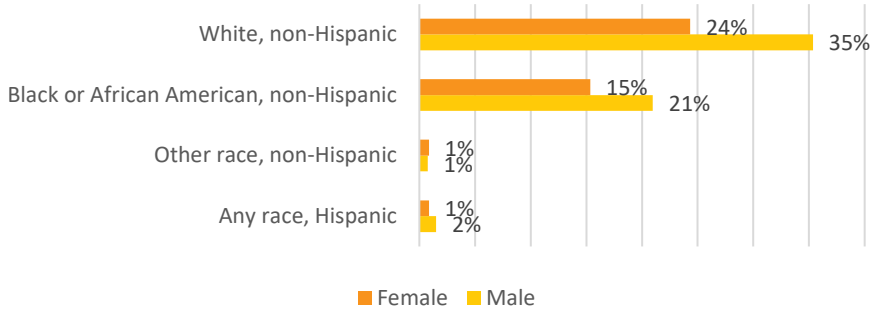
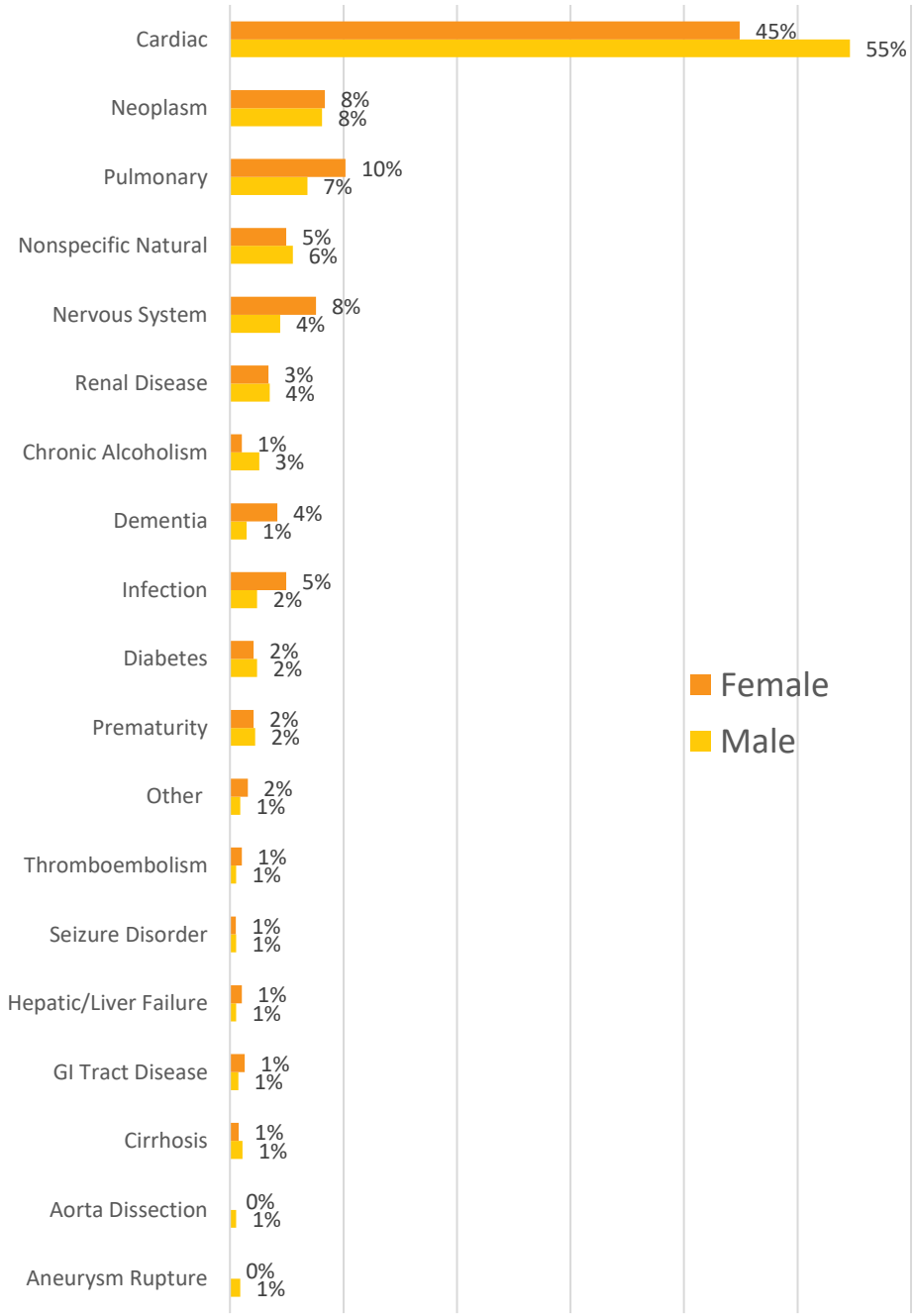


Table 7 shows the counts of natural causes of death by sex. The majority of natural deaths for both male and female decedents were due to a cardiac-related cause. Neoplasms and pulmonary disease are the next most-common cause of death for both male and female decedents. Figure 34 shows the differences in proportion between the sexes for causes of death by order of frequency.

Table 7. Causes of Natural Death by Sex, 2024 (n=925)

	Male	Female
Aneurysm Rupture	5	0
Aorta Dissection	3	0
Cardiac	296	172
Chronic Alcoholism	14	4
Cirrhosis	6	3
Dementia	8	16
Diabetes	13	8
GI Tract Disease	4	5
Hepatic/Liver Failure	3	4
Infection	13	19
Neoplasm	44	32
Nervous System	24	29
Prematurity	12	8
Pulmonary	37	39
Renal Disease	19	13
Seizure Disorder	3	2
Thromboembolism	3	4
Nonspecific Natural	30	19
Other	5	6
Total	542	383

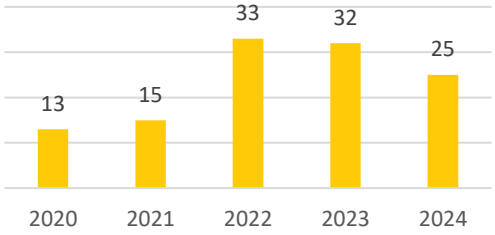
Figure 34. Percentages of Causes of Natural Death (Non-Hospice) by Sex, 2024 (n=925)



Undetermined Deaths

In 2024, the Charleston County Coroner's Office deemed that 25 deaths were of an undetermined manner. This was a 22% decrease from 2023 (Figure 35). Of these cases, 92% received full autopsy (1 case was skeletonized and instead received a full anthropological examination and 1 case received an external exam with toxicology).

Figure 35. Total Undetermined Deaths, 2020-2024



Of the total, 15 (60%) were male and 10 (40%) were female. Of the total, 68% were White/non-Hispanic, 28% were African American or Black/non-Hispanic, and 4% were Hispanic.

When there is not a preponderance of information to classify the manner of death as a homicide, suicide, accidental, or natural death, it is classified as undetermined. For example, if determination between suicide versus an accidental drug toxicity or natural versus accidental infant death cannot be made, it is classified as "undetermined". For the majority of these cases, multiple manners of death were potentially compelling to a degree that is difficult to summarize concisely.

Rapid Blood Screening

The Charleston County Coroner's Office performs qualitative rapid blood screening on all in-house autopsies and toxicology-only cases using a Randox® Evidence MultiSTAT unit that detects 20 different drugs of abuse (Figure 36). The Coroner's Office largely adheres to the National Association of Medical Examiners recommendation that all suspected drug-related deaths undergo full autopsy, regardless of screening results. Screening guides investigations, especially when illicit drugs are detected in decedents who were not originally suspected to have died due to drug toxicity.

Figure 36. Randox® Evidence MultiSTAT

Rapid screening provides preliminary toxicology results that allow for timelier data for law enforcement, harm reduction efforts, and public health stakeholders. Death certificates are signed as pending until laboratory-based confirmatory toxicology testing with interpretation by forensic toxicologist is completed. All opioid case data is closely monitored by in-house opioid specialists.

In 2024, a total of 378 rapid blood screens were performed. Eleven screens were not performed due to specimen quality/condition and/or insufficient sample size. In 9 cases, autopsies were not performed based on screen results and thorough review of the medical history (Figure 37). Figure 38 illustrates the percentages of each drug/drug class detected for all 378 screens performed in 2024.

Figure 37. Rapid Blood Screening Totals, 2024

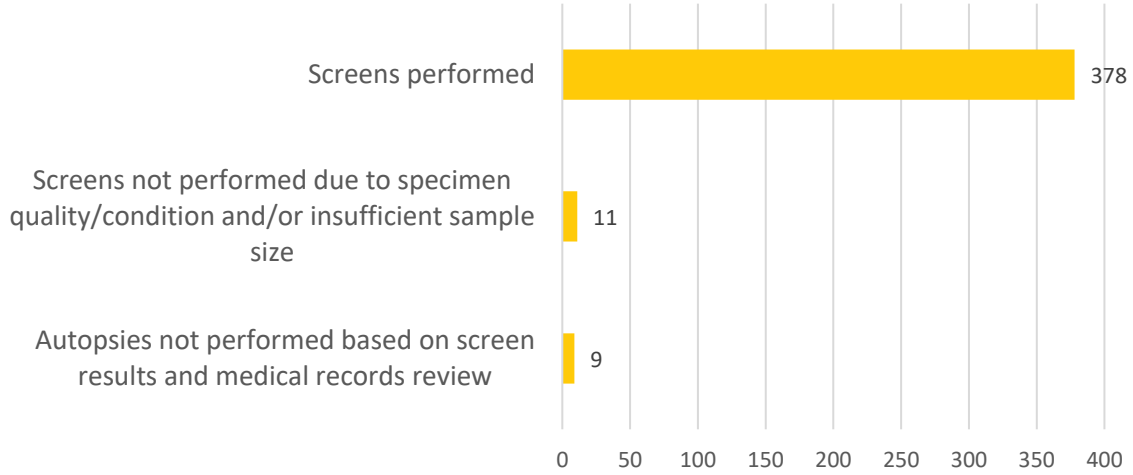
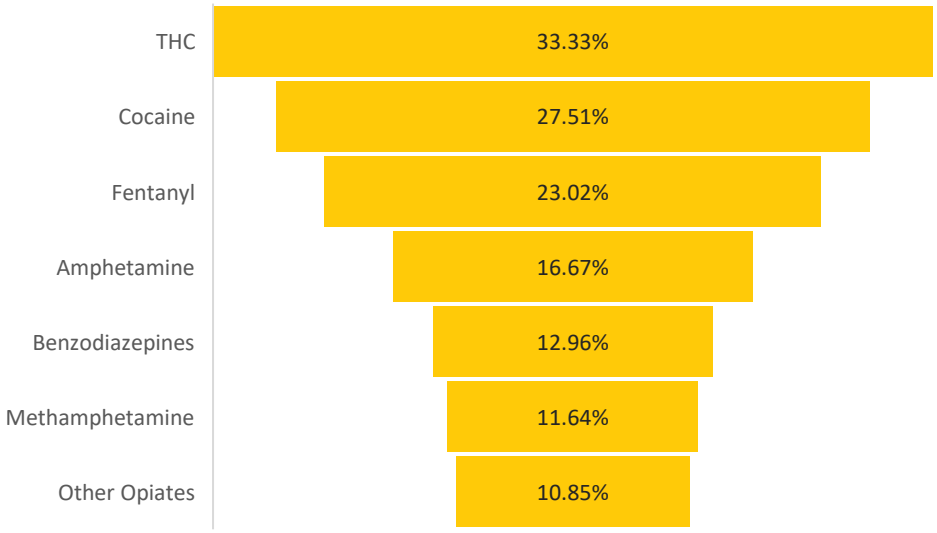


Figure 38. Drug/Drug Classes Detected During Rapid Blood Screening, 2024 (n=378)



Child Deaths

Please refer to Appendix A: Annual Report on Child Deaths for a thorough exploration of all deaths of individuals less than 18 years of age.

Maternal Mortality

In 2024, there were 5 cases of maternal mortality, which is defined as pregnant at the time of death or up to one year of death. Four of the five received full autopsy (one death was a delayed hospital death and did not require an autopsy). One individual was African American or Black/non-Hispanic, one was White/non-Hispanic, one was White/Hispanic, and two were other races/non-Hispanic. Four individuals were in the 25–34-year age group and another was in the 35–44-year age group. Four deaths were natural deaths and one was accidental.

Intimate Partner Violence Deaths

In 2024, there were 8 deaths related to intimate partner violence. Intimate partner violence is defined as abuse or aggression that occurs in a romantic relationship, between current or former spouses and dating partners. Individuals may or may not be cohabitating with former or current intimate partners at the time of death. All 8 individuals received full autopsy.

Three individuals were female and five were male. Three were in the 25–34-year age group and five were in the 35–44-year age group. Five individuals were African American or Black/non-Hispanic, two were White/non-Hispanic, and one was Hispanic.

One death was accidental, four were homicides, and three were suicides. Firearms were involved in 6 deaths (75%).

First Responder Deaths

In 2024, there was 1 death of a first responder.

In-Custody Deaths

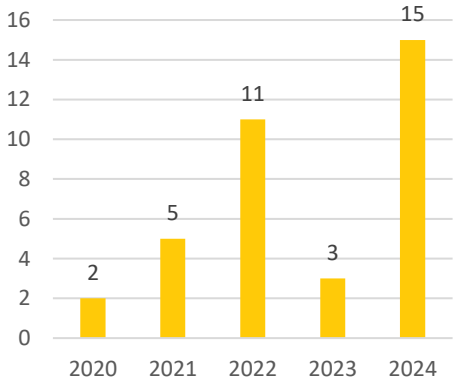
The Charleston County Coroner's Office considers "In-custody deaths" to be those where the circumstances of the death place the decedent in either direct or indirect contact with law enforcement during incarceration, apprehension and/or pursuit. This includes pre-custody situations where the person was under perceived restraint of their freedom of movement (e.g., casual encounters with law enforcement, police chases, the person self-barricaded, or when a person is detained for questioning).

The Death in Custody Reporting Act of 2013 (H.R. 1447) further clarifies an "in-custody" death as the death of any person who is detained, under arrest, or is in the process of being arrested, is in route to be incarcerated, or is incarcerated at a municipal or county jail, State prison, State run boot camp prison, boot camp prison that is contracted out by the State, any State or local contract facility, or other local or State correctional facility, including any juvenile facility.

"In-custody" is a classification related to the time and place of death; it does not always implicate cause of death.

In 2024, there were 15 "in-custody" deaths (Figure 39). Eleven deaths occurred pre-detention, before the decedent was a resident of the detention center. Five of these deaths were accidents, three were homicides, and three were suicides. Four deaths occurred after the decedent became a resident of the detention center. One manner of death was natural, two were suicides, and one was undetermined.

Figure 39. Total In-Custody Deaths, 2020-2024



Ages of decedents who died while in-custody ranged from 19 years of age to 62 years of age, with the majority of individuals (38%) in the 25–34-year age group (Figure 40).

Black or African-American/non-Hispanic (44%) and White/non-Hispanic (44%) individuals were the largest groups represented, with Hispanic individuals making up 6% (Figure 41).

Figure 40. Total In-Custody Deaths by Age Group, 2024 (n=15)

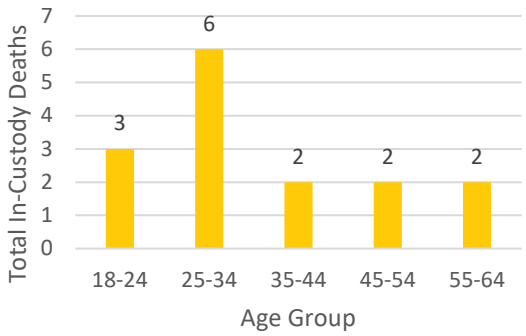
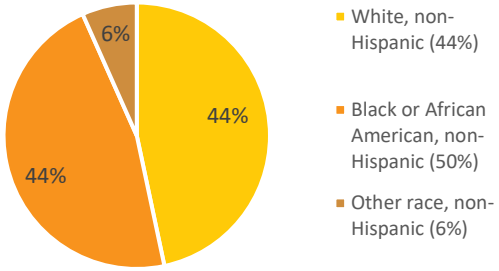
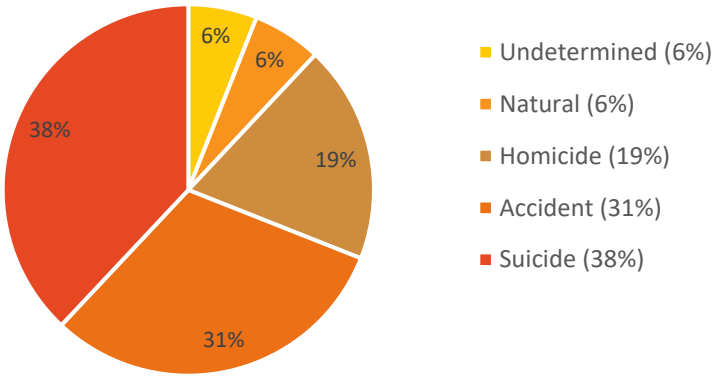


Figure 41. Percentages of In-Custody Deaths by Race/Ethnicity, 2024 (n=15)



For the manner of death for all in-custody deaths, the majority (38%) were suicide, followed by accidental (31%) and homicide (19%). Natural and undetermined each comprised 6% (Figure 42).

Figure 42. Percentages of Manner of Death for In-Custody Deaths, 2024 (n=15)



Non-Charleston County Resident Deaths

The Charleston County Coroner's Office investigated 159 deaths in 2024 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 daily commuters from surrounding counties and other transient populations such as tourists.

Office-Specific Data

Table 8. Select IACME and NAME Criteria for 2024

% of autopsies and external examinations performed within 48 hours of autopsy request	432/619 (70%)
% of autopsies and external examinations performed within 72 hours of autopsy request	552/619 (89%)

Pathologist Report Turnaround Time					
Coroner's Office Contracted Personnel					
Pathologist	*Total examinations performed*	*<30Days*	*30-60 days*	*60-90 days*	*>90 days*
Ross	249	127	108	13	1
Downs	179	9	88	72	10
Williams	44	5	32	7	0
Gorniak	8	0	7	0	1
Cina	1	0	1	0	0
MUSC Personnel					
Pathologist	*Total examinations performed*	*<30Days*	*30-60 days*	*60-90 days*	*>90 days*
Presnell	15	7	7	1	0
Beaver	25	2	10	10	3
Reimer	17	3	8	5	1
Phillips	17	4	11	2	0
Batalis	10	4	5	1	0
Richards	20	8	9	2	1
Butler	28	10	11	3	4
Sullivan	2	0	1	1	0

Social Media

https://www.facebook.com/charlestoncoroner

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Appendices

Appendix A: Annual Report on Child Deaths
Appendix B: Annual Drug Report