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Foreword

The Coroner’s Office of the County of Chester serves the community by investigating sudden, unexpected, violent, suspicious, or unnatural deaths. The Coroner’s staff recognizes the tragedy surrounding an untimely death and performs investigations, in part, to assist the grieving family. A complete investigation provides for the quick settling of estates and insurance claims, as well as implementing civil and criminal actions. Questions which seem irrelevant in the initial hours after death can become significant in the following months. The surviving family, friends, and general public can have the assurance that the Coroner conducted a comprehensive investigation.

When a death occurs on the job or is work-related, the Coroner’s Office immediately forwards the results of its investigation to OSHA in order for the family to gain the full benefit of the findings. Private insurance companies also routinely use the findings to settle claims.

The public health role of the Coroner’s Office is designed to isolate and identify causes of sudden, unexpected deaths that might affect more than one person. When an infectious agent or toxin is implicated in a death, the Coroner’s Office notifies the family and contacts of the deceased so they may receive any needed medical treatment. Trends in injury and violence are monitored. In this era of concern about emergency response and bioterrorism, the Coroner’s Office provides an important level of preparedness and surveillance.

Civil or criminal judicial proceedings frequently require the medical investigation of violent deaths. Thus, the Coroner’s Office of the County of Chester conducts a prompt medical investigation to provide the criminal justice system with medical information and evidence required for adjudication. Although criminal death investigations constitute a small portion of deaths investigated by the Coroner’s Office, these deaths are studied in great detail because of the issues and legal consequences involved. In this way, the Coroner’s Office provides the criminal justice system the best support that medical science can provide.

In summary, the Coroner’s Office of the County of Chester provides expert medical evaluation and extensive services related to the investigation of deaths that are of concern to the health, safety, and welfare of the community.
Coroner’s Office of the County of Chester

Executive Summary

The 2015 Annual Report of the Coroner’s Office reflects the activities in investigating non-jurisdictional and jurisdictional deaths in the County of Chester. The mission of the Coroner’s Office is to investigate sudden, unexpected and unnatural deaths in the County of Chester with the highest level of professionalism, compassion and efficiency, and to provide a resource for improving the health and safety of the community.

The purpose of the Coroner’s Office is to bring trained medical evaluation to the investigation of deaths that are of concern to the public health, safety, and welfare of the community.

We continue to work on issues of emergency and disaster preparedness along with planning for the future, as funding allows. This office played a major role in the development of regional mass fatality for the County of Chester.

Death Investigations are classified, counted and reported in three different categories: non-jurisdictional, jurisdictional and cremation authorization cases. Non-jurisdictional cases are deaths which are reported to the Coroner’s Office where a physician with knowledge and awareness of the decedent’s state of health certifies the death certificate. These are natural deaths, with a predominance of individuals in nursing homes and hospitals. Jurisdictional cases are deaths where the coroner or deputy coroner certifies the cause and manner of an individual’s death.

Funeral homes which plan on cremating an individual who died in Chester County are required to complete a cremation authorization request and submit a copy of the death certificate. The office reviews the cremation request and the death certificate and if there are no medical questions relating to the death of the individual the office will issue a cremation authorization. If there are medical questions relating to the death, a case is opened and the Coroner’s staff will investigate the death before issuing a cremation authorization.

In addition to determining the cause and manner of death, the office works to provide accurate identification of decedents under their jurisdiction and to notify the next of kin. Each decedent is treated with dignity and respect, and families are supported with compassion, courtesy, and honest information to help them with their grief and to make appropriate arrangements.
A few selected findings are as follows:

In 2015 there were 1,156 deaths reported to the Coroner’s Office. This number included 889 natural deaths, 193 accidental deaths (of which 36 were motor vehicle accidents), 62 suicides, 7 homicides, 4 of an undetermined manner along with 1 case of non-human remains.

The Coroner’s Office took jurisdiction in 524 of the reported deaths. Of these cases, a scene response was required in 517 cases. The Coroner’s Office performed autopsies in 242 cases (46%) of those jurisdictional deaths, of which 68 were externals and the remainder were full autopsies. Toxicology was performed in 269 of the jurisdictional cases, with some individuals having multiple testing done.

The Coroner’s Office transported 320 deceased individuals.

The Coroner’s Office authorized 2, 283 cremations during the calendar year.

The Coroner’s Office professional staff for 2015 includes the Coroner, Chief Deputy Coroner, Office Manager, Deputy Coroners, Transporters, Forensic Pathologists, Forensic Technicians, and Histologists.

I would like to acknowledge and thank the Commissioners of the County of Chester: Terence Farrell, Kathi Cozzone and Michelle Kichline for their support of the Coroner’s Office.

It is my privilege to present this executive summary of the Coroner’s Office for the calendar year of 2015. It is my sincere hope that this summary is both informative and useful to you.

[Signature]

Dr. Gordon R. Eck, Coroner of the County of Chester
Coroner’s Office Mission Statement

The mission of the Office of the Coroner is to provide investigation of all deaths occurring in the County of Chester requiring a public inquiry and to determine and record the cause and manner of death for law enforcement, the medical community, and the family of the decedent so that they can affix responsibility, protect the public health and safety, effect a resolution, and have closure.

To achieve this mission, the Coroner’s Office will:

Treat decedents and their effects with dignity and respect, and without discrimination.

Coordinate investigative efforts with law enforcement, hospitals, and other agencies in a professional and courteous manner.

Conduct investigations and autopsies professionally, scientifically, and conscientiously; and complete reports expeditiously with regard for the concerns of family members, criminal justice, and public health and safety.

Provide compassion, courtesy, and honest information to family members and, with sensitivity for cultural differences, make appropriate efforts in assisting with their grief, medical and legal questions, disposition of decedents and effects.

Collect, compile, and disseminate information regarding deaths in a manner consistent with the laws of the Commonwealth of Pennsylvania and consistent with the mission of Public Health.

Provide medical and scientific testimony in court and in deposition as well as medico legal consultation for prosecuting attorneys, defense attorneys, and attorneys representing surviving family members.

Promote and advance through education the sciences and practices of death investigation.

Promote and maintain an emotionally and physically healthy and safe working environment for the Coroner’s employees, following Public Health policies for standards of conduct, management, and support for employee diversity, training, and development.

Expand communication throughout Public Health and the community at large regarding the roles, responsibilities, and objectives of the Coroner’s Office of the County of Chester.
Coroner’s Office Goals

Strategic Goal 1 Public Education

Chester County citizens and those in the legal and medical communities will have improved access to information about County death investigations and fatality trends as evidenced by:

● By 2017, 100% of basic death investigation statistics will be available via the Coroner's website.
Introduction

The duties and responsibilities of the County Coroner are many and varied, but in essence can be described as the investigative arm of the government of the County of Chester concerning deaths of an unexpected, violent or criminal nature.

The Coroner’s Office assumes jurisdiction on deaths occurring in the County of Chester that include both County residents and non-residents. County residents who die in other counties do not fall under the Coroner’s Office jurisdiction.

Pennsylvania State Statute charges the Coroner’s Office with determining the *Cause* and *Manner* of the death of those individuals who die within the geographical boundaries of Chester County. “Purdon’s Pennsylvania Statutes: Title 16, Section 1237” defines the deaths that fall under the Coroner’s jurisdiction. The Coroner is directed by this law to “investigate a death that happens in the county, regardless where the cause may have occurred”. Examples of the type of deaths that fall under the Coroner’s purview are:

1. Sudden death not related to a known medical condition.
2. Deaths occurring under suspicious circumstances where alcohol, drugs or other toxic compounds may have a bearing on the outcome.
3. Deaths occurring as a result of violence or trauma, whether apparently homicidal, suicidal or accidental.
4. Medical misadventures. Any case where trauma, drug therapy, surgery, or post surgery is in anyway contributory to the death, directly or indirectly.
5. Deaths where the body is unidentified or unclaimed.
6. Deaths known or suspected as due to a contagious disease and constituting a public hazard.
7. Deaths occurring in prison, or while in custody of police.
8. Deaths of persons whose bodies are to be cremated or otherwise disposed of (buried at sea), so as to be thereafter unavailable for examinations.
9. Sudden unexplained infant deaths.
10. All fetal deaths over 16 weeks maternal gestation.

The purpose of the investigation shall be to determine the cause and manner of death which may assist law enforcement in determining if the death is due to criminal acts or criminal neglect of persons other than the deceased.

As part of this investigation, the coroner shall determine the identity of the deceased and notify the next of kin of the death.
In the absence of a county morgue, the Coroner’s Office uses the morgue facilities of four of the hospitals located within Chester County. The main usage of each morgue is for the individuals who die while in the care of each hospital. The numbers below indicate the absolute maximum spaces available in each of the morgues in the hospitals within our county. The Coroner’s Office has use of the available spaces in the following hospitals:

- Brandywine Hospital - 4
- Chester County Hospital – 6
- Paoli Memorial Hospital - 4
- Phoenixville Hospital - 3

The main functions of the Coroner’s Office include:

- Respond to and investigate deaths that occur outside of hospital or clinical settings with such investigations including scene analysis, photography, witness interviews, body examination, and utilization of other forensic tests as indicated.

- Convene coroner's inquest to determine cause and manner of deaths involving homicides, suicides, accidents, natural and or unexplained and suspicious deaths.

- Under mandate of law, investigate the death of any ward of the Commonwealth of Pennsylvania.

- Conduct and participate in public and community education programs regarding topics such as: Drinking and Driving, Traffic Safety, Substance Abuse, Suicide Prevention and Crime/Death Scene Response.

- To report to the Commonwealth of Pennsylvania all child deaths, boating fatalities, traffic fatalities, and work-related fatalities.

- Service of legal process when the Sheriff is party to a suit or when such process by the sheriff would be a conflict of interest.

- Issue Death Certificates and Cremation Permits
2015 Coroner's Statistical Report

County of Chester, Pennsylvania

Death Investigations:

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<tr>
<th>Coroner's Reported Cases</th>
<th>Total of 1,156</th>
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<tr>
<td>Natural Causes</td>
<td>889</td>
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<tr>
<td>Accidental</td>
<td>193</td>
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<tr>
<td>Suicide</td>
<td>62</td>
</tr>
<tr>
<td>Homicide</td>
<td>7</td>
</tr>
<tr>
<td>Undetermined</td>
<td>4</td>
</tr>
<tr>
<td>Pending</td>
<td>0</td>
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<tr>
<td>Non-human remains</td>
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<tr>
<td>Cases Investigated</td>
<td>524</td>
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<tr>
<td>Autopsy's performed</td>
<td>242</td>
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<tr>
<td>Toxicology's performed</td>
<td>269</td>
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<td>Transports</td>
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<tr>
<td>Exhumations</td>
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<tr>
<td>Cremation permits issued</td>
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Demographics of Chester County, Pennsylvania

The United States Census Bureau estimate for the population of Chester County as of July 1, 2014 was 512,784 people, which represents an increase of 2.7% from April 1, 2010. Chester County is made up of 79.6% Caucasian, 7.1% Hispanic or Latino, 6.4% African American, 4.8% Asian, 1.7% identifying with two or more races, .3% American Indian or Alaska Native and .1% Native Hawaiian or other Pacific Islander.

Currently in Chester County 23.5% of the residents are under the age of 18, 62% are between the ages of 18 and 64 and 14.5% are 65 or older. Females make up 50.8% of the population in Chester County.

The Coroner’s Office serves the geographic area that includes 760 square miles of Chester County; bounded by Lancaster County to the west, Berks County to the north, Montgomery County to the northeast, Delaware County to the east, New Castle County in the state of Delaware to the southeast and Cecil County in the state of Maryland to the south.

Included within the County of Chester are 57 townships, 15 boroughs, one city, three airports and several colleges and universities served by the Coroner’s Office.

Chester County contains one level-2 trauma center which is Paoli Memorial Hospital along with five other hospitals: Brandywine Hospital, Chester County Hospital, Jennersville Hospital, Life Care Hospital, and Phoenixville Hospital. There are two veterans center, Coatesville Veterans Center and Southeast Veterans Center. Located in the County of Chester are multiple hospice agencies, 29 nursing homes, 21 assisted living facilities and over 52 home health care agencies.

Unclaimed individuals

There are a few instances when the County of Chester becomes responsible for the disposition of an individual, and they are:

1) No other family members exists.
2) After an exhaustive search, the next of kin cannot be located.
3) The family refuses to provide for the final arrangements because of financial issues or for other reasons.

During the last four years, we have seen an increase in the number of next of kin who relinquish the rights to the deceased individual to the Coroner’s office because they cannot or do not want to incur the expense associated with the final arrangements of their relative. The Coroner’s office will cremate the individuals who have been turned over to the county as long as they have been identified. The number of country cremations in 2012 were 18, in 2013 there were 20, in 2014 there were 17 and in 2015 there were 18 county cremations.

The cremains of these individuals are kept by the Coroner’s office for a minimum of one year, after which time the cremains are interred in a burial plot donated to the county.
Coroner and Staff Activity

The staff members of the Coroner’s Office are involved in a wide variety of activities commensurate with the mission of the office including responding to and investigating the scene of death, performing postmortem examinations, certifying the cause and manner of death, and providing information and assistance to families. Investigators, who are familiar with the emotional trauma of an unexpected death, communicate directly with the family as do the Coroner and Chief Deputy Coroner, who review their findings with the families in order to clarify the many questions that accompany a sudden loss of life. The office also provides referrals to grief support services.

In all cases investigated by the Coroner, it is essential that the decedent’s identity is established and the next-of-kin is located and notified regarding the death. In addition, property belonging to the decedent must be controlled and released according to legal requirements. In most cases these issues are resolved expeditiously. In certain cases, identification requires additional effort in locating dental, medical or police records. Some individuals may have died leaving no next-of-kin or next-of-kin far removed. Ensuring that all leads have been exhausted in pursuit of next-of-kin can be a very time consuming but ultimately rewarding effort.

The postmortem examination on each decedent includes the preservation of various body fluids and tissues for microscopic and toxicological analysis. Photographs are taken during the autopsy and are available for review at a later date if needed. Photographic documentation is also an essential item in those cases where the pathologist must provide court testimony. The forensic pathologists and investigators provide testimony in court and at depositions. Staff participates in meetings with police, medical professionals, and attorneys.

Autopsy reports and related data from individual investigations are provided to law enforcement agencies, prosecuting attorneys and many other agencies including Occupational Safety and Health Administration, Federal Aviation Administration, National Transportation Safety Board, the Consumer Product Safety Commission and the Drug Enforcement Agency.

The Coroner’s investigations require frequent contact between the Coroner’s Office and various media personnel. The Coroner, Chief Deputy Coroner, and Forensic Pathologists participate in a variety of medical conferences, and provide information on a regular basis to law enforcement and to medical personnel on various aspects regarding the role and function of the Coroner’s Office.

The data collected and presented in this and other Coroner’s annual reports also provide baseline information for further analysis. The Coroner’s Office staff analyzes data to study relevant death investigation topics that have applications in such fields as law enforcement, medicine, law, social sciences, and injury prevention. Examples include infant mortality, teenage suicide, child abuse, investigation of vehicular traffic accidents, and investigation of therapeutic complication deaths.
Death Investigations

Cases investigated by the Coroner’s office include non-jurisdictional and jurisdictional along with cremation investigations.

Manner of Death: Homicide

The Coroner classifies a death as a homicide when the death results from injuries inflicted by another person. In this context, the word homicide does not necessarily imply the existence of criminal intent behind the action of the other person. This is reflected in the fact the prosecuting attorney may either charge the person responsible for the injuries with murder or manslaughter, or decline to file charges. In 2015, the Coroner classified seven deaths as homicides.

The seven homicide victims ranged in ages from 17 to 77 years, with six males and one female. Six deaths were from gunshot wounds and one death was the result of a stabbing.
Manner of Death: Accidental

The Coroner certified 193 accidental deaths for the calendar year 2015. The percentage of accidental deaths resulting from drug overdoses were 35% (68/193). In this group there were 48 males and 20 females. This represents a 2% increase compared to the 62 drug overdoses out of 186 accidental deaths in 2014. At the time of death, 25 individuals (37%) in the category of accidental drug overdoses had heroin in their system and 21 had fentanyl in their system. Six of the 21 who had fentanyl also had heroin. The age ranges of the accidental drug deaths are:

- 19 and younger = 4
- 20 – 29 years = 21
- 30 – 39 years = 9
- 40 – 49 years = 14
- 50 - 59 years = 15
- 60 and older = 5

Accidental deaths resulting from a fall were 29% (56/193). The major percentage of these falls were ground-level falls in elderly individuals. These falls resulted in fractures leading to complications such as pneumonia or the fall caused subdural hemorrhaging.

- 49 and younger = 5
- 50 – 69 years = 7
- 70 and older = 44

The third largest group of accidental deaths were individuals who died as a result of a motor vehicle accident, representing 19% (36/193).

The remaining causes of 2015 accidental deaths were: seven died as result of a fire, six from drowning, five from alcohol poisoning, five were work/farm fatalities, two died from choking, two died from surgical complications, two were hit by a train, two were aircraft fatalities, one from hypothermia, and one from co-sleeping.
Manner of Death: Suicide

Suicides are those deaths caused by self-inflicted injuries with evidence of intent to end one’s life. Evidence of intent includes an explicit expression, such as a suicide note or verbal threat, or an act constituting implicit intent, such as deliberately placing a gun to one’s head or rigging a vehicle’s exhaust. In 2015, there were 62 suicides, accounting for 5% (62/1,156) of the deaths reported to the Coroner’s office, which is the same percentage as in 2014.

Hangings accounted for 38 % (23/62) of the 2015 suicide deaths, firearms accounted for 31% (20/62), drug overdoses accounted for 16.5% (10/62) and multiple injuries accounted for 10% (6/62). Three of the suicides caused by multiple injuries were caused by jumping from heights, two from stepping in front of a train and one from a motor vehicle accident. One suicide was from carbon monoxide inhalation, one from drowning and one from exsanguination.

The age ranges for the individuals who committed suicide were between 17 and 84 years. There were seven suicides under the age of 21. The age range between 50 and 59 years accounted for 34.5% (21/62) of the deaths. There were 46 males and 16 females who committed suicide in Chester County in 2015.
Manner of death: Natural

The Coroner assumes jurisdiction over deaths that are classified as natural due to the sudden and unexpected nature of the death in an apparently healthy individual, when there is no physician who has knowledge or awareness of the decedent’s condition, when there is no next of kin to make disposition, or when there are suspicious circumstances surrounding the death. In these situations, the Coroner becomes responsible for certification of death.

The Coroner does not assume jurisdiction over deaths that are classified as natural which occur in a hospital or a skilled care facility.

In 2015 there were 889 natural deaths which were reported to the Coroner in the County of Chester.
Manner of death: Undetermined

The Coroner’s Office certifies a manner of death as undetermined when available information regarding the circumstances of death is insufficient to classify the death into one of the four specific manners of death: natural, accident, homicide or suicide.

In some cases, serious doubt exists as to whether an injury occurred with intent or as a result of an accident. Information concerning the circumstances may be lacking due to the absence of background information or witnesses, or because of a lengthy delay between death and discovery of the body. Moreover, it may be difficult to assess street drug or medication overdose deaths as showing enough features to reasonably determine the manner of death. If an extensive investigation and autopsy cannot clarify the circumstances, the death is classified undetermined.

There were four cases in 2015 where the Coroner’s Office certified the manner of death as undetermined after autopsy and toxicology studies. The causes were dementia, subdural hematoma, traumatic brain injury and one undetermined cause.

Non-human remains

Every year, the public notifies their local police departments when they find tissue, bones or remains which they believe are human. The police departments contact the Coroner’s office and with the assistance of a forensic pathologist or an anthropologist, we determine whether or nor the remains are human. In 2015, one such case was given to this department and it was determined the remains were from a cow.
Glossary of Terms

Blood alcohol concentration (BAC): The concentration of ethanol (alcohol) found in blood following ingestion, usually expressed as a percentage. In the Commonwealth of Pennsylvania, 0.08% is considered the legally intoxicated level while driving.

Cause of Death: Any injury or disease that produces a physiological derangement in the body that results in the death of an individual.

Drug: Therapeutic drug: A substance, other than food, used in the prevention, diagnosis, alleviation, treatment, or cure of disease.

Drug-caused death: Death directly caused by a drug or drugs in combination with each other or with alcohol.

Fetal Death: Category of deaths that occur within the uterus.

Jurisdiction: The jurisdiction of the Coroner’s Office extends to all reportable deaths occurring within the boundaries of County of Chester, whether or not the incident leading to the death (such as an accident) occurred within the county. Not all natural deaths reported fall within the jurisdiction of the Coroner’s Office.

Manner of Death: A classification of the way in which the events preceding death were factors in the death. The manner of death as determined by the forensic pathologist is an opinion based on the known facts concerning the circumstances leading up to and surrounding the death, in conjunction with autopsy findings and laboratory tests.

Manner: Accidental Death, where there is no evidence of intent, i.e. unintentional.

Manner: Homicide Death resulting from intentional harm (explicit or implicit) of one person by another, including actions of grossly reckless behavior.

Manner: Motor Vehicle deaths of drivers, passengers, and pedestrians involving motor vehicles on public roadways.

Manner: Natural Death caused solely by disease. If natural death is hastened by injury (such as a fall or drowning in a bathtub), the manner of death is classified other than natural.

Manner: Suicide Death as a result of a purposeful action with intent (explicit or implicit) to end one’s own life.

Manner: Undetermined Manner assigned when there is insufficient evidence or information, especially about intent, to assign a specific manner.

Recreational drug: A drug used non-medically for personal stimulation/depression/euphoria.