Office of the Coroner
County of Chester
Commonwealth of Pennsylvania

Sophia Garcia-Jackson, M.S., F-ABMDI
Coroner
2022 Annual Report
# Table of Contents

Dedication.................................................................................................................. Page 3
Coroner’s Office Mission Statement........................................................................ Page 4
Letter from the Coroner.............................................................................................. Page 5
Acknowledgements................................................................................................... Page 9
Recognition ............................................................................................................... Page 10
Executive Summary.................................................................................................. Page 11
Introduction.............................................................................................................. Page 11
  Description of Chester County and Its Population................................................ Page 11
  Jurisdiction and State Statutes............................................................................... Page 12
Coroner’s Office Employees and Facilities............................................................. Page 14
Coroner and Staff Functions..................................................................................... Page 16
Strategic Plan/Managing for Results........................................................................ Page 18
Death Investigations................................................................................................ Page 18
  Overview.............................................................................................................. Page 18
  Manner of Death: Natural..................................................................................... Page 20
  Manner of Death: Homicide.................................................................................. Page 22
  Manner of Death: Accident.................................................................................. Page 23
    Accidental Drug Overdose Deaths................................................................. Page 24
  Deaths due to Falls............................................................................................... Page 27
  Motor Vehicle Collisions...................................................................................... Page 28
  Manner of Death: Suicide.................................................................................... Page 28
  Manner of Death: Could Not Be Determined.................................................... Page 31
Infant and Child Fatalities....................................................................................... Page 32
Maternal Mortality.................................................................................................... Page 34
In-Custody Deaths................................................................................................... Page 35
Natural Disasters...................................................................................................... Page 35
Unclaimed Individuals.............................................................................................. Page 36
Organ Donation........................................................................................................Page 38

Tables, Figures and Charts

Table 1 2022 Statistical Summary.................................................................Page 19
Table 2 Total # of Deaths Reported to the Coroner’s Office (2018-2022)...Page 20
Table 3 Total # Natural Deaths +/- COVID-19 (2018-2022)..................Page 21
Figure 1 Natural by Cause of Death...............................................................Page 21
Figure 2 Natural Deaths by Age.................................................................Page 22
Figure 3 Accident by Cause of Death........................................................Page 23
Figure 4 Accidental Drug Overdose Deaths by Age Distribution..........Page 24
Figure 5 Most Common Illicit Drugs............................................................Page 25
Figure 6 Most Common Prescription/OTC Medications.......................Page 26
Figure 7 Toxicological Substances in Motor Vehicle Collisions.........Page 28
Figure 8 Suicide by Age..............................................................................Page 29
Figure 9 Suicide by Gender........................................................................Page 30
Figure 10 Suicide by Cause of Death........................................................Page 30
Table 4 Child Deaths Aged 13-21...............................................................Page 34
Figure 11 Total Number of County Cremations (2018-2022).............Page 38
Chart 1 Gift of Life Organ and Tissue Donation 2022.......................Page 39

References.......................................................................................................Page 40
Dedication

To the family and friends of our valued colleague
Cameron “Cam” Campbell
Coroner’s Office Mission Statement

The Chester County Coroner’s Office is an independent agency serving the residents and honoring the deceased of the county by investigating the facts and circumstances concerning jurisdictional deaths which have occurred within Chester County in order to determine the cause and manner of death, the identity of the decedent, and to provide notification to the legal next of kin, while exhibiting the highest degree of compassion, professionalism, and integrity.
Letter from the Coroner

Hello Chester County,

As this is my first year as Chester County Coroner, let me introduce myself and thank you for allowing me to serve as Coroner for the next four years. I have had the privilege of working in this field for almost a decade after graduating with my Master’s degree in Forensic Medicine from the Philadelphia College of Osteopathic Medicine. I worked for the New Jersey Medical Examiner’s Office before joining Chester County’s Coroner’s Office in April of 2019 prior to deciding to run for Coroner and starting my term on January 3rd, 2022. I know this is a difficult role with a host of challenges and responsibilities to serve the people of Chester County. This role, and the mission of the Coroner’s Office, has a particularly sensitive responsibility of serving grieving and impacted family members at one of the most difficult times of their lives, and in complex and usually unexpected circumstances. That is a responsibility that my decade of experience and educational background have prepared me for but is not a responsibility I take lightly. I’m happy to report that upon taking office and conducting an assessment of the Coroner’s Office staff those responsibilities are at the core of the work done by the Coroner’s Office employees each day. I am proud to have an office full of people with similar values, who are compassionate, skilled, and dedicated to serving the residents of Chester County. The Coroner’s Office is staffed with various positions to keep the office running 24/7/365 to be prepared for the unpredictable nature of the job. Continuing education training is required annually for myself and all Deputy Coroners. Additional training is offered for those who wish to expand their knowledge on specific topics and was taken advantage of in 2022 by numerous team members.

Upon starting my term, one of the areas I immediately focused on was the Coroner’s Office relationship with other departments and agencies, both at the County and local levels. To improve those relationships, I met with various agencies with the goal of building connections, educating on the Coroner’s Office roles and responsibilities, and increasing inter-department dialogue. We’ve seen immediate results from this engagement and continue to expand and deepen relationships throughout all levels of local government.
Another equally important and strategic area of focus this year was our work to push forward the creation of a modern forensic facility. Our county continues to lag behind other nearby counties in our access to modern equipment, and infrastructure including Montgomery and Lancaster counties, which I’ve now had the opportunity to tour. I continued to advocate for the need for a modern forensic facility and met with the County Administrator quarterly for status updates related to the determination of the site for the new facility, the financial plan to pay for it and the general needs of the facility. In May, I submitted an application in conjunction with the Facilities Department for the use of ARPA funds (The American Rescue Plan Act of 2021) to build a modern forensic facility, which was approved by the Commissioners. During these quarterly meetings, I was able to have the needs of the office heard and met, increasing our staff for investigations, autopsy, and transportation. I’d like to thank the County Commissioners and their staff for their support in this critically important need, and the professionalism I have experienced in those planning and strategy sessions. I’m looking forward to breaking ground on the new facility before the end of my first term.

While I have inherited a dedicated, knowledgeable, and talented staff, I also recognized the need for a few targeted areas of growth in the office. In August, I hired a Chief Deputy Coroner who is responsible for overseeing the investigator team as well as day to day management of the office. They have been a tremendous asset to the Office and a great supporter and mentor to the staff and with their years of experience have further added to our ability to serve our community.

I have also hired a new contracted forensic pathologist. We now have three forensic pathologists to do more in-house examinations. This allows us to have greater flexibility in scheduling our autopsies and reduces the need for outsourcing this critical function of the office, which also reduces the significant costs to the County.

In addition to meeting with other departments and agencies the Coroner’s Office also runs outreach presentations and discussions with the community directly. In 2022, we increased our community outreach presentations from two in 2021 to six and we remain committed to continuing to increase awareness to the public on what the Coroner’s Office role and responsibilities are in the years to come. Specifically, we hope to host a training seminar for the
public on drug trends in Chester County and the surrounding mid-Atlantic area and have focused on one drug in particular, Xylazine as the first topic. We are partnering with agencies like the FBI to bring that information directly to the community in one of these forums.

In 2022, I joined the Pennsylvania State Coroner’s Association (PSCA) legislation committee, so that I can advocate for new and improved legislation in the PSCA and by also contacting my local representatives to ask for support for Coroner Offices across the Commonwealth. Two bills are currently in the works. House Bill 1451 “Line of Duty Death”, if amended would extend the death benefit that is currently available to emergency responders to include Coroner, Deputy Coroner and Medical Examiners. House Bill 2088 “JNET”, if introduced would provide Coroner with access to certain records maintained by PennDOT and JNET, which will allow Coroners the ability to make positive identification of the deceased, locate the Next of Kin to make death notification and to determine if the deceased was an organ and tissue donor. Both of these bills are very important to the Chester County Coroner’s Office, and Coroner Offices across Pennsylvania to allow us to do our job well. In the case of House Bill 1451, our deputies need to know that the state understands the risks and particular difficulties that this job entails and properly provides benefits should the worst occur. In the case of House Bill 2088, it is important to have every tool at our disposal to quickly and properly identify decedents so that we can provide answers to their family members in a timely manner. Your support on both of these measures is needed so please contact your local representative and ask them to support these measures.

One of the most critical roles my office has is to be as proactive to prevent deaths wherever possible. To that end, I continued our work agreement with the Office of Drug Surveillance and Misuse Prevention and entered into a new agreement with the Pennsylvania Violent Death Reporting System (PAVDRS) which brings in grant funds for the Coroner’s Office. This allows sharing of high-quality comprehensive data for overdose deaths, violent deaths, and maternal deaths to the Pennsylvania Department of Health. That abstract analysis is used to create better strategies to reduce and prevent various types of death.
In the coming pages of this report, you will find the work and efforts of the Coroner’s Office for 2022. Two areas of particular importance are the 27.27% increase in Suicides from 2021, and a slight decrease of 5.50% of accidental deaths related to overdoses from 2021 metrics. Both areas have been top priorities of the Office and of County and Local government efforts to combat however, as these numbers clearly show more effort, attention and resources are needed. The staggeringly large increase in Suicides especially point to the need for further analysis of the root causes and the need for special attention and innovative proactive solutions by the community at large. The Coroner’s Office will continue to educate, respond, and work with all agencies that are focused on the difficult and complex problems of substance use disorder and mental health but with our role primarily being that of a “last responder”, the vast toolset necessary to combat these issues must be a broad coalition of organizations.

As I close out my first letter of my first term, I’d like to take a moment and thank you again for your trust in me as your County Coroner. As I mentioned at the beginning of this letter it is a role with a lot of responsibility that I take very seriously, and I appreciate the support the County has shown to me during my election and since taking office. Thank you.

Thank you again, Chester County.

Sophia Garcia-Jackson, M.S., F-ABMDI
Coroner of the County of Chester, sworn in January 3, 2022
Acknowledgements

In 2022, the Chester County Coroner’s Office saw a dramatic increase in the number of Suicides in the County in recent history and experienced a first of its kind, the tragedy of losing a colleague.

After this up close and personal trauma, the Office came together for a debriefing with the help of a counselor trained in providing emotional support for first responders. During this time, we offered support to each other, focusing on our strengths and encouraging self-care. We acknowledged and appreciated each other, restoring purpose and building resilience to continue to be the hard working, compassionate professionals the County depends on.

The job of a Deputy Coroner, colloquially named “last responder,” not only comes with work that is satisfying but it also has the risk of compassion fatigue. Compassion fatigue is split into two main components: burnout and secondary trauma stress. Burnout that goes unrecognized can follow a path that leads to undesirable mental and physical health conditions. Secondary trauma occurs from experiencing and observing a traumatic event that is happening or has happened to someone else.

The Coroner’s Office receives weekly peer support newsletters from the Pennsylvania Coroner’s Association Executive Director, this reminder provides an opportunity to check on each other’s mental health and well-being throughout the year.

The Coroner’s Office would like to send a huge THANK YOU to all first and “last responders” and any other death care professionals who provide support to individuals dealing with the grief of losing their loved ones, your work does not go unnoticed.
Recognition

The Suicide Prevention Task Force Care Team delivered individually wrapped geraniums to all Coroner Office employees along with thank-you notes and resource cards as a token of appreciation for all their hard work during the Pandemic on April 28, 2022.

The “Care Team” developed this outreach program to show appreciation and care to targeted community workers who may be at a higher risk of mental health concerns or suicide. The Team's philosophy states, "every kind act is suicide prevention."

*If you or someone you care about is experiencing a mental health or emotional crisis, call or text 9-8-8.*
Executive Summary

- A total of 1,494 cases were investigated, including 622 non-jurisdictional cases.
- 2,784 cremation reviews and authorizations were approved by the Office.
- Excluding 249 COVID-19 deaths, the total number of reported deaths in 2022 continues to exceed that of pre-pandemic year 2019 by approximately 11.96%.
- Jurisdictional deaths included 12 Homicides, 256 Accidents, and 70 Suicides. In 6 cases, the manner of death Could not be Determined.
- Suicides increased from 2021 by 27.27%.
- Accidental deaths included 103 drug overdoses, 83 falls, and 29 motor vehicle collisions.
- Autopsies were performed in 290 jurisdictional deaths.
- 2022 transports of decedents increased by 14.65% from 2021.
- The Coroner’s Office maxed capacity on the only county vault available for unclaimed persons and were unable to inter the unclaimed cremains of 34 adults and 16 fetuses. There was a 38.46% increase in the number of unclaimed bodies from the last non-veteran interment of 2020.
- The Coroner’s Office approved organ donation authorization in 45 cases with Gift of Life.
- The Coroner’s Office performed 6 community outreach presentations to various organizations.

Introduction

Description of Chester County and its Population

The U.S. Census Bureau, Population Estimates Program (PEP) of Chester County on July 1, 2022 was 545,823. As determined by that Census, Chester County’s population was 83.9% White, 7.7% Hispanic or Latino, 6.3% Black or African American, and 7.2% Asian peoples. Another 2.2% identified as two or more races, or as American Indian/Alaska native (0.3%) or Native Hawaiian/Pacific Islander (0.1%).

According to the US Census Bureau’s American Community Survey 2017-2021 ACS 5-year estimates, which are the most recent available, 21.8% of residents are
under the age of 18, 21.8% are between the ages of 18 and 64, and 17.9% are 65 or older. Females make up 50.3% of the population in Chester County.

The Coroner’s Office serves the 759 square miles that comprise the geographic area of Chester County. It is bounded by four other Pennsylvania counties and two other states: 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.

Chester County had four acute care hospitals at the beginning of 2022: Chester County Hospital, Paoli Memorial Hospital, and Phoenixville Hospital, with one level-2 trauma center at Paoli Memorial Hospital. Brandywine Hospital closed January 31, 2022. There are two veterans’ facilities, the Coatesville Veterans Affairs Medical Center and the Southeast Veterans Center. Also located in the County are long term care facilities (nursing homes, assisted living, and congregate living), and home health care and hospice agencies.

**Jurisdiction and State Statutes**

The Coroner’s Office has jurisdiction for certain categories of deaths which occur in the County of Chester, regardless of whether the decedent was a County resident or non-resident. County residents who die in other counties do not fall under the Chester County Coroner’s Office jurisdiction, even if the precipitating event for the death occurred in Chester County. Only the Coroner can certify a death that occurred by a manner other than Natural.

According to Pennsylvania Statute (16 P.S. § 1218-B “Coroner’s Investigation”), the categories of deaths that fall under the Coroner’s jurisdiction are:

1. A sudden death not caused by a readily recognizable disease or, if the cause of death cannot be properly certified, by a physician on the basis of prior recent medical attendance.
2. A death occurring under suspicious circumstances, including if alcohol, a drug or another toxic substance may have had a direct bearing on the outcome.
3. A death occurring as a result of violence or trauma, whether apparently homicidal, suicidal or accidental, including, but not limited to, a death due to mechanical, thermal, chemical, electrical or radiational injury, drowning, cave-in or subsidence.

4. A death in which trauma, chemical injury, drug overdose or reaction to a drug or medication or medical treatment was a primary or secondary, direct or indirect, contributory, aggravating or precipitating cause of death.

5. A perioperative death in which the death is not readily explainable on the basis of prior disease.

6. A death in which the body is unidentified or unclaimed.

7. A death known or suspected to be due to contagious disease and constituting a public hazard.

8. A death occurring in prison or a penal institution or while in the custody of the police.

9. A death of an individual whose body is to be cremated, buried at sea or otherwise disposed of so as to be unavailable for examination thereafter.

10. A sudden and unexplained infant death.

11. A stillbirth. (Fetal death over 16 weeks’ gestation per Pennsylvania law)

The role of the Coroner is to investigate the facts and circumstances surrounding such deaths for the purpose of determining the cause and manner of death and whether there is sufficient reason for the Coroner to believe that the death may have resulted from a criminal act or criminal neglect of a person other than the deceased. If the investigation does not provide the necessary information, the Coroner shall order an autopsy on the body and/or may conduct an inquest.

As part of their investigation, the Coroner shall determine the identity of the deceased and notify the next of kin (NOK) of the deceased.
Coroner’s Office Employees and Facilities

At the end of 2022, the Coroner’s Office was almost fully staffed except one open part-time Coroner’s investigator position (an interview was pending for early 2023). A total of five new part-time positions were added, three permanent positions and two temporary positions they include one permanent part-time autopsy technician, one temporary part-time autopsy technician, two permanent part-time Coroner’s investigators, and one temporary part-time transporter. The office consisted of the Coroner, a Chief Deputy Coroner, a First Deputy Coroner, an Office Manager, a part-time Office Administrator, nine Deputy Coroner’s a.k.a. Coroner’s investigators (four full-time and five part-time), six part-time Transporters, one full time Autopsy Technician, one full-time hybrid Autopsy Technician/Coroner’s Investigator and two part-time autopsy technicians. The temporary part-time office administrator position created in 2019 was converted to a permanent position in 2022. All are County employees except the Coroner, who is an elected official.

At the end of 2022, five Deputy Coroners were nationally certified Diplomats by the American Board of Medicolegal Death Investigators (D-ABMDI) and the Coroner achieved national certification as a Fellow of the American Board of Medicolegal Death Investigators (F-ABDMI), becoming the 12th person to hold that board certification in Pennsylvania.

Under routine circumstances, one or two Deputy Coroners, a Transporter, and a supervisor on-duty were able to respond to dispatches 24/7/365 in 2022. Autopsies, which are ordered by the Coroner, are performed by contracted physicians who are board-certified forensic pathologists.

The Office has two administrative/investigator vehicles used by Deputy Coroners for scene responses throughout the County, and autopsy technicians to respond to Chester County Hospital to assist with examinations. Three transport vehicles, a Ford Transit, a GMC Savana Van (expected to be replaced in 2023) and a Ford F250 truck. No new vehicles were put into service in 2022.

The administrative office is located in the Government Services Center (GSC) at 601 Westtown Road, Suite 090, in West Chester (West Goshen Township). In May of 2020, a temporary morgue area (refrigerated body storage), funded by CARES dollars,
was constructed in a maintenance garage at the GSC. This temporary morgue space continues to be used daily in 2022. The cooler holds up to 15 bodies and an adjacent freezer holds up to three bodies. This body storage space continued to reach capacity on several occasions in 2022, requiring the Coroner’s Office to utilize morgue storage space within the hospitals throughout the County often.

Transportation of decedents continued to increase in 2022 because the temporary morgue and the examination suites are in different locations. On average a decedent is transported three times: from the scene to the temporary morgue, from the morgue to the examination suite and from examination back to the morgue awaiting pick up by a funeral home or cremation service once one has been designated. In 2022, 1072 transports were done, this is a 14.65% increase from 2021 which was 935 transports.

In 2022, the Coroner’s Office continued to use the antiquated autopsy suite at Chester County Hospital (CCH) for examinations and dramatically increased the use of a contracted pathology service in Lehigh County due to CCCO going from three forensic pathologists down to two, starting in November of 2021, placing the contracted pathology service on rotation every third week starting in December 2021. A third forensic pathologist was hired in December 2022. Chester County Hospital’s autopsy suite space continues to not be able accommodate the many kinds of cases the office handles including bariatric (over 250 lbs.), decomposed, fire related deaths, multiple fatalities, and hazardous substances. For these cases, in addition to contracting out the services, the office rented space and performed examinations using our contracted forensic pathologists and autopsy technicians at Montgomery County’s Forensic Facility located in Norristown PA. We are looking forward to being able to utilize Montgomery County’s new Forensic Facility projected to be in operation April of 2023.

The Coroner met with the County Administrator quarterly to keep up with updates provided as to the development of Chester County’s very own Modern Forensic Facility. During the October 2022 capital budget meeting, when asked by Chair of the Commissioners about the progress on the building, the County Administrator stated they “hope to break ground on the facility in 2023.”
Coroner and Employee Functions

Coroner Office employees are involved in a wide variety of activities corresponding with the mission of the office. These activities include responding to scenes and investigating deaths, performing postmortem examinations, certifying the cause and manner of death, and providing information and assistance to families.

In all cases investigated by the Coroner’s Office, it is essential that the decedent’s identity is established, and the next-of-kin is located and notified regarding the death. In certain cases, identification requires additional effort in locating antemortem dental, medical, or police records. Scientific methods for positive identification include fingerprint comparison, forensic odontology, and DNA comparison. Occasionally circumstantial data such as tattoos or serial numbers on implanted medical devices are used to determine identity.

Another function of the Coroner’s Office is identifying the legal next-of-kin and informing them of a death. Some individuals may have died leaving no next-of-kin or next-of-kin cannot be located. The Coroner’s Office is frequently assisted by law enforcement in identifying bodies and locating/notifying next of kin. Ensuring that all leads have been exhausted in pursuit of next-of-kin can be a time-consuming but ultimately rewarding effort. When there is no next-of-kin, the CCCO authorizes cremation to be performed at the expense of the County, unless the office has been able to arrange a whole-body donation. Commonwealth law requires Humanity Gifts Registry to be notified within 36 hours of any unclaimed body.

Autopsies are performed at the direction of the Coroner and no other agency or individual can demand or refuse an examination. All autopsies are performed by a physician who is a board-certified forensic pathologist. If a postmortem examination is required, various specimens for microscopic and toxicological analysis may be examined in addition to the internal and/or external examination. Photographs are taken during all examinations. Photographic documentation is essential evidence in those cases where the forensic pathologist or CCCO employees must provide court testimony. The forensic pathologists, Coroner, and Deputy Coroners may provide testimony in court and at depositions.
Autopsy reports and related data from individual investigations are provided to law enforcement, attorneys, and other agencies including Occupational Safety and Health Administration (OSHA), Federal Aviation Administration, National Transportation Safety Board, the Consumer Product Safety Commission, and the Drug Enforcement Agency as required by law and if they have any jurisdictional or legal duties with regard to the death.

Funeral homes that 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 to the Coroner’s Office. A Deputy Coroner reviews these documents and if there are no medicolegal questions relating to the death of the individual, the Office will issue a cremation authorization. If there are questions relating to the death, a case is opened, and the Deputy Coroner will investigate the death before issuing a cremation authorization. If the CCCO determines a death was not due to natural causes, a new death certificate is issued after completion of an investigation.

The Coroner, Deputy Coroners and Forensic Pathologists participate in continuing education trainings in accordance with licensing, statutory, and certification requirements.

The Coroner’s Office supports an internship program and typically has one or two college or graduate student interns per semester. Many interns come from our own backyard, West Chester University or as far away as West Virginia University. They are provided with hands on experience and observe post-mortem examinations. It is not uncommon for the Coroner’s Office to hire their own interns after they graduate with a degree. https://www.chesco.org/4235/Internships

The Coroner’s Office provides statistics to the public monthly on the Coroner’s Office website. https://www.chesco.org/209/Coroner

The Coroner’s Office continues to increase their community outreach post-pandemic to various agencies to increase public awareness on the function and role of the Coroner’s Office. Presentations were made to the following organizations in 2022:

1. Park Rangers with Chester County Parks and Preservation
2. Forensic Students at Devon Preparatory School
3. Forensic and Toxicological Chemistry students at West Chester University
4. Employees of the Crime Victims’ Center of Chester County
5. Participants of the Uwchlan Township Citizens Police Academy
6. Law Enforcement Officers/Detectives for the Basic Crime Scene Investigation Course hosted by the Chester County District Attorney’s Office

**Strategic Plan / Managing for Results**

Chester County government developed a new strategic 5-year plan in 2018 to cover the period from 2019 through 2023. In 2022, the County met and began discussions for the next phase of the County’s Strategic Plan. During these discussions, Departments spoke about their priorities, objectives, goals, and measures of the past and the future and how they can better utilize collected data, monitor their progress, and communicate out what county government is doing. The Coroner’s Office plans to identify and submit new strategic goals and related objectives in 2023 to be in line with the Commissioners' Priority Based Budgeting.

**Death Investigations**

**Overview**

Death investigations are classified, counted, and reported in three different categories: non-jurisdictional, jurisdictional, and cremation authorization. Non-jurisdictional cases are natural deaths which are reported to the Coroner’s Office, and it is determined that further investigation by the Office is not needed. The decedent’s health care provider must be willing and able to certify the death, otherwise it becomes jurisdictional. Jurisdictional cases are deaths that meet the statutory requirements for reporting to the Coroner’s Office, a decision is made that further investigation by this Office is needed to determine the cause and manner of death.

Pennsylvania's death certificates allow for five manners of death: Natural, Accident, Suicide, Homicide, and Could not be Determined a.k.a. Undetermined. The manner of death for jurisdictional cases can be natural or non-natural (Homicide, Suicide, Accident, and Could not be Determined). Only a Coroner or Medical Examiner can certify a death with a manner other than Natural.
In 2022, a total of 1,494 deaths were reported to the Chester County Coroner’s Office. The Office authorized 2,784 cremations (Table 1). Because not all deaths in Chester County are reported to the Coroner’s Office, the data in this report cannot be used to calculate overall mortality rates or natural death mortality rates.

Excluding 249 COVID-19 deaths, the number of reported deaths in 2022 exceeded that of pre-pandemic year 2019 by approximately 11.96%.

Autopsies, including partial autopsies (the opening of the head or chest only) were performed in 290 cases. External-only examinations occurred in 51 cases. Toxicology-only investigations occurred in 65 cases.

Accidental deaths decreased from 260 cases in 2021 to 256 cases in 2022. Suicide deaths increased from 55 in 2021 to 70 in 2022. Homicides increased for a third year in a row, accounting for 12 deaths. The manner of death remained Undetermined in six cases after a full investigation was conducted.

Table 1. 2022 Statistical Summary

<table>
<thead>
<tr>
<th>Reported Cases</th>
<th>1494</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-jurisdictional Cases</td>
<td>622</td>
</tr>
<tr>
<td>Jurisdictional Cases</td>
<td>872</td>
</tr>
<tr>
<td>Natural Causes</td>
<td>1,150</td>
</tr>
<tr>
<td>COVID-19</td>
<td>249</td>
</tr>
<tr>
<td>Accident</td>
<td>256</td>
</tr>
<tr>
<td>Suicide</td>
<td>70</td>
</tr>
<tr>
<td>Homicide</td>
<td>12</td>
</tr>
<tr>
<td>Could not be Determined</td>
<td>6</td>
</tr>
<tr>
<td>Non-Human Remains</td>
<td>0</td>
</tr>
<tr>
<td>Autopsies (Full and/or Partial)</td>
<td>290</td>
</tr>
<tr>
<td>External-Examination Only</td>
<td>51</td>
</tr>
<tr>
<td>Toxicology-Only</td>
<td>65</td>
</tr>
<tr>
<td>Inquests</td>
<td>0</td>
</tr>
<tr>
<td>Transports (total)</td>
<td>1072</td>
</tr>
<tr>
<td>Unidentified Bodies</td>
<td>0</td>
</tr>
<tr>
<td>Exhumations</td>
<td>0</td>
</tr>
<tr>
<td>Cremation permits issued</td>
<td>2784</td>
</tr>
</tbody>
</table>
A comparative review of total cases reported to the Office over a five-year period including and excluding COVID related deaths can be seen in Table 2.

### Table 2.

**Total # of Deaths Reported to the Coroner’s Office (2018-2022)**

<table>
<thead>
<tr>
<th>Year</th>
<th>Population Of Chester County</th>
<th>Total # of Deaths reported to the Coroner’s Office</th>
<th>% Difference from the previous Year</th>
<th>COVID Deaths</th>
<th>Total # of Deaths minus COVID Deaths</th>
<th>% Difference from the previous Year minus COVID Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018</td>
<td>522,256</td>
<td>1,137</td>
<td>-</td>
<td>0</td>
<td>1,137</td>
<td>-</td>
</tr>
<tr>
<td>2019</td>
<td>524,989</td>
<td>1,112</td>
<td>2.20% decrease</td>
<td>0</td>
<td>1,112</td>
<td>2.20% decrease</td>
</tr>
<tr>
<td>2020</td>
<td>534,413</td>
<td>1,824</td>
<td>64.03% increase</td>
<td>638</td>
<td>1,186</td>
<td>6.65% increase</td>
</tr>
<tr>
<td>2021</td>
<td>538,649</td>
<td>1,624</td>
<td>10.97% decrease</td>
<td>408</td>
<td>1,216</td>
<td>2.53% increase</td>
</tr>
<tr>
<td>2022</td>
<td>545,823</td>
<td>1,494</td>
<td>8.00% decrease</td>
<td>249</td>
<td>1,245</td>
<td>2.39% increase</td>
</tr>
</tbody>
</table>

### Manner of Death: Natural

Not all natural deaths are reported to the Coroner’s Office, so data in this section reflects only a portion of natural deaths in Chester County. Natural deaths that are reported to the Office usually involve one or more factors: sudden and unexpected death, lack of a physician able or willing to certify the death, death within 24 hours of hospital admission, unattended at home death, no next of kin, unclaimed remains or suspicious circumstances.

In 2022, 1,150 reported deaths were attributed to a Natural manner of death. This was a 10.51% decrease from 2021 [1285 (2021)], but higher by pre-pandemic standards. COVID-19 was no longer the most common cause of death in the natural death category, as it was in 2020 [638 deaths] and 2021 [408 deaths], attributing to 249 deaths, a decrease by 38.97% from 2021 and 60.97% from 2020 (Table 3). Due to this decrease, there will not be detailed breakdown charts based on age, sex and race of the COVID-19 cases, as were done in previous year annual reports (2020-2021). A breakdown of natural causes of death categories can be seen in Figure 1.
Cardiac related causes of death accounted for 424 (36.87%) of the reported natural deaths in 2022. Males comprised 268 (63.21%) of reported cardiac deaths. Many natural cardiac deaths are not required to be reported to the Coroner's Office. Of these natural deaths, 37 were fetal demises and 11 were neonatal demises.

Cardiac related causes of death accounted for 424 (36.87%) of the reported natural deaths in 2022. Males comprised 268 (63.21%) of reported cardiac deaths. Many natural cardiac deaths are not required to be reported to the Coroner's Office. Of these natural deaths, 37 were fetal demises and 11 were neonatal demises.

Cardiac related causes of death accounted for 424 (36.87%) of the reported natural deaths in 2022. Males comprised 268 (63.21%) of reported cardiac deaths. Many natural cardiac deaths are not required to be reported to the Coroner's Office. Of these natural deaths, 37 were fetal demises and 11 were neonatal demises.
Figure 2. Natural Deaths by Age

Manner of Death: Homicide

The manner Homicide is used when the death results from a volitional act committed by another person. The intent to cause the death can be present but is not required. For manner of death, the word Homicide is a neutral term and does not indicate or imply criminal intent. The prosecuting attorney determines whether and what kind of charges will be filed against the person inflicting the death. (Hanzlick, 2002)

Coroners are responsible for death investigation when a Homicide victim dies in their county, regardless of where the injury originally occurred.

In 2022, the Coroner’s Office classified 12 deaths as Homicides, similar to 11 Homicide deaths in 2021, an increase seen for the third year in a row. Note that two deaths were classified with the manner as Undetermined in 2022 because Homicide could not be excluded; they are not included here.

Three of the victims sustained their fatal injury or injuries in Montgomery County and were pronounced deceased at Paoli Hospital, Chester County’s only Level II Trauma Center, located in Willistown Township, their death investigation fell within the
jurisdiction of the Chester County Coroner’s Office. The remaining nine victims’ injury or injuries occurred in Chester County.

One victim was an unborn child. In Pennsylvania, fetal demise certificates are required to be registered for all fetal deaths 16 weeks gestation and older. Manner of death is not a category on a fetal death certificate, but this category is designated and documented in the Coroner Office statistics.

The 12 Homicide victims ranged in age from zero to 65, with five being aged 21 and under (see section titled Infant and Child Fatalities). Six were male, five were female, and one was transgender. Four out of five females were victims of domestic violence. Five were Black or African American, four were White, two were Hispanic (Puerto Rican), and one was Korean. All but one of the Homicides were firearm fatalities, the other was from sharp force injuries.

**Manner of Death: Accident**

The Coroner’s Office certified 256 deaths with the manner as Accident for 2022. As in previous years, the most common cause of death was drug overdose and the second was fall related. Motor vehicle collision was the third most common cause of accidental death and choking was the fourth. The remaining causes of accidental deaths can be seen in Figure 3.

![Accident by Cause of Death - 2022](image)

**Figure 3. Accident by Cause of Death**
Accidental Drug Overdose Deaths

The total number of accidental drug overdose deaths in 2022 was 103, two of which were fetal demises where the main cause of death was listed as intrauterine fetal demise with positive findings of illicit substances listed under the other significant cause section, manner of death is not a category on fetal death certificates, but a category is designated and documented in the Coroner Office statistics.

CCCO saw a 5.50% decrease in accidental drug overdoses compared with 109 in 2021. It is unknown the reason for this trend.

This category tracks illicit, prescription and alcohol related fatalities. As in past years, males (64.07% of cases) were disproportionately represented in drug overdose death statistics and the majority (77.67%) of deaths were in Whites.

The age distribution was the highest in the age group 35-44 in 2022 (Figure 4). There were more deaths in those ages 18-44 and less deaths in the 45-75+ age groups, which was the opposite seen in 2021. Excluding the fetuses, the average age for a fatal drug overdose was 44 years old and the ages ranged from 19-76 years old.

The Coroner’s Office does not have adequate data to analyze the reason for these shifts from the previous year.

Figure 4. Accidental Drug Overdose Deaths by Age Distribution
Extensive forensic toxicological testing is performed on all suspected drug overdose deaths. This allows confirmation of the cause of death as well as identification of trends in illicit and prescription drug abuse. Figure 5 shows the top five illicit drugs found on toxicological testing in 2022. In most fatal drug deaths, multiple drugs were present and represented 72 (69.90%) of all total cases. **Fentanyl remained the most common drug and was present in 70 (67.96%) accidental drug overdose deaths compared to 66 (60.6%) in 2021.** Methamphetamine was found in 33 (32.04%) of the overdose deaths, followed closely with Xylazine 32 (31.07%). Cocaine dropped down to 19 (18.45%) and heroin was seen in 8 (7.77%) cases.

![Figure 5. Most Common Illicit Drugs](image)

Xylazine – Per national institute of drug abuse:
“Xylazine, a non-opioid veterinary tranquilizer not approved for human use, has been linked to an increasing number of overdose deaths nationwide…Studies show people exposed to xylazine often knowingly or unknowingly used it in combination with other drugs, particularly illicit fentanyl.”
Of the 103 accidental drug related deaths in 2022, 16 (15.53%) had alcohol as one of the main causes of death. Of those sixteen, **five were deaths where alcohol was the only fatal substance.**

Figure 6 shows the top five prescription/over the counter (OTC) drugs found on toxicological testing in 2022. Prescription medication gabapentin, used to treat pain was the highest abused drug seen in 9 (8.74%) and citalopram/escitalopram used to treat depression and anxiety was seen in 6 (5.83%) of accidental drug overdoses. Followed by Oxycodone 5 (4.85%), Sertraline 4 (3.88%) and Diphenhydramine 4 (3.88%).

![Figure 6. Most Common Prescription/OTC Medications](image)

The Chester County Coroner’s Office shares its data regarding overdose deaths with several agencies, including the District Attorney’s Office, the Chester County Overdose Prevention Task Force, The Chester County Department of Drug and Alcohol, the Pennsylvania Department of Health, and [https://www.overdosefreepa.org/](https://www.overdosefreepa.org/).
Death due to Falls

There were 83 fall-related deaths in 2022 accounting for 32.42% of accidental deaths. **This was a decrease of 9.78% from the 92 fall-related deaths that occurred in 2021.** Most (97.59%) of these deaths were in those age 65 years or older, with the average age being 80 years old. The majority of the falls were males 47 (56.63%). Falls can be a direct cause of death, such as when they resulted in traumatic head injuries. Falls can often be an indirect cause of death. For example, a fall may have resulted in a hip fracture that required surgery with the subsequent hospital course or rehabilitation, accompanied by various complications, rapid functional decline, and no return to baseline. Extensive medical record reviews are conducted on these complex deaths to determine whether the injury caused the death and a non-natural manner of death is considered.

Fall-related deaths are believed to be underreported. The reason being the role of a fracture in the death of an elderly person is not reported to the Coroner's Office by medical personnel who may attribute the death entirely to natural causes. Review of death certificates during cremation authorizations identifies some of these cases, seven cases were identified this way in 2022, but only if a fall, fracture or brain bleed was listed in the cause of death section. Occasionally the Pennsylvania Division of Vital Records of the PA Department of Health refers a death certificate to the Coroner's Office for review and re-certification for a cause of death that appears non-natural in nature that were not cremations but burials, eight cases were identified this way in 2022. Six cases were reported to the Office directly from Funeral Home Directors concerned with the cause of death listing a traumatic injury on a death certificate they received.

At this time under current Pennsylvania Coroner Statutes, nursing homes and long-term care facility deaths are not reportable to the Coroner’s Office unless the cause of death is non-natural. Some county Coroners in Pennsylvania require nursing homes and long-term care facilities to **report all deaths.** If the Coroner’s Statute was to be amended legislatively to include nursing homes, it may provide independent oversight of institutional deaths and minimize underreporting of non-natural deaths.
Motor Vehicle Collisions

Twenty-four of the 29 decedents had toxicological testing performed. Testing was not performed in the five of the decedents due to the time that had elapsed since the day of the injury and the day the death was reported to the Coroner’s Office. Eight drivers and one pedestrian were positive for blood alcohol. Including the pedestrian, all but one was above the legal limit of 0.08 BAC. Fourteen out of 20 drivers tested were positive for drugs and/or alcohol (Figure 7).

The Coroner’s Office submits what’s known as an AA-34 form titled Coroner’s Motor Vehicle Death Report to the Pennsylvania Department of Transportation for all motor vehicle collision fatalities.

Figure 7. Toxicological Substances in Motor Vehicle Collisions

Manner of Death: Suicide

The manner Suicide occurs from an injury or poisoning that was an intentional or self-inflicted act committed to do self-harm or cause the death of one’s self. (Hanzlick, 2002). Evidence of intent can include explicit expression such as a suicide note or verbal threat, or an act constituting implicit intent. To classify a manner as Suicide, the evidence presented should be more likely than not and be more than 51%. If the
classification of Suicide is a little more than an educated guess, better options for manner would be Accident or Undetermined. (Hanzlick, 2002).

In 2022, there were 70 suicide deaths compared with 55 in 2021 and 53 in 2020. Individuals who died by suicide ranged in age from 15 to 89 years old. (Figure 8). Eight were known to be veterans.

Suicide deaths are among the most difficult and traumatic cases investigated by the Coroner’s Office. The occurrence of suicides of persons in the transgender community was a particular cause for concern in 2022. (Figure 9). The Coroner’s Office provided this data to both the Chester County Suicide Prevention Task Force and the Chester County LGBT Equality Alliance to seek additional resources and advocate for this specific population.
The cause of death categories for the manner Suicide is shown in Figure 10. As in previous years, firearms were the most common and hanging the second most common category of Suicide. Suicide is extremely complex and while there may be various circumstances leading up to the act, the Coroner’s Office does not speculate or determine the why.
Manner of Death: Could Not Be Determined
Also known as Undetermined

When extensive investigation, autopsy, and additional testing do not provide enough evidence for the Coroner’s Office to consider one manner of death more likely than any of the others, less than 50% certainty, the manner is certified as Could not be Determined also known as Undetermined. In 2022, the manner of death was certified as Could not be Determined in 6 cases (compared with 11 in 2021). The cause of death was determined in all but one case where only skeletal remains could be examined, and current toxicological testing capabilities on the suspected toxic substance was limited and could not be conducted on bone specimens.

The possibility of Homicide could not be eliminated in two of the six cases. At the end of 2022, the Coroner's Office was unaware of any charges being filed or planned in any of these deaths and the manner remained Undetermined.

The last three cases have causes that are sudden unexpected or unexplained child deaths. The certifier determines the manner and the decision to choose between Undetermined or another manner is at their discretion (Corey, 2019). The most objective approach would be to use the manner Undetermined, since the cause of death is also undetermined (Hunzlick, 2002).

Undetermined cases are periodically reviewed and reclassified when new information becomes available or the reanalysis of existing evidence is conducted.

Inquests, as provided for in state law, should be employed when the manner of death remains undetermined and law enforcement investigations remain open with no charges filed at the Coroner’s discretion in conjunction with the District Attorney’s Office under Pennsylvania law (16 P.S. §1224-B) Cooperation with the District Attorney, the District Attorney may act as counsel to the Coroner in matters relating to inquests. No inquests were conducted in 2022.
Infant and Child Fatalities

Pennsylvania law (16 P.S. §1220-B) – Child Deaths

(a) General Rule. A coroner shall perform or order an autopsy to be conducted in the case of the sudden and unexplained death of a child who is not more than three years of age. If an autopsy is required, the autopsy shall be conducted in the manner the coroner determines is the least invasive manner appropriate.

(b) Investigation

(1) For a death of a child who is not more than three years of age where the coroner has determined that an investigation is appropriate, the investigation shall include the following information:

(i) Demographic information on the child and the child’s primary caregivers.

(ii) Witness interview.

(iii) Infant medical history.

(iv) Biological mother’s prenatal history.

(vi) Scene and body diagrams.

(2) In conducting the investigation under paragraph (1), the coroner shall consider nationally recognized standards for pediatric death review.

(c) Deoxyribonucleic acid.—A deoxyribonucleic acid (DNA) sample shall be collected for the purpose of aiding in the research of the causes of sudden and unexplained infant deaths and to provide genetic information as to the manner of death.

The Coroner’s Office reports on child deaths that occur within the County, regardless of residence of the decedent. Information on these deaths goes to the Center for Disease Control and Prevention (CDC) and contributes to national mortality statistics. The Coroner’s Office participates on the Child Death Review Committee meetings for Chester County. The Coroner’s Office follows the CDC guidelines and other nationally recognized standards to conduct a comprehensive infant death scene investigation which includes photographic documentation, witness interviews, a doll reenactment, and completes the Sudden Unexpected Infant Death Investigation
Reporting Form (SUIDIRF) to develop a narrative report for the forensic pathologist prior to the post-mortem examination.

The Commonwealth of Pennsylvania categorizes anyone aged 21 and under as a “child” for purposes of inclusion in Child Fatality Reviews. Deaths of live-born children under one year of age are classified as infant deaths.

Fetal demises (also known as stillbirths) in Pennsylvania are reportable to the Coroner’s Office for fetuses 16 weeks’ gestation or older. A fetal death certificate (legal document for reportable stillbirths) is completed for each case, it can be signed by the OBGYN or the Coroner’s Office.

In 2022, 60 deaths were reported to the Office under the age of one. Of these, 37 deaths were categorized as natural fetal demises and 11 were categorized as natural neonatal demises (newborns). Five fetal death certificates listed COVID-19 as a contributing cause of death. Two fetal demises occurred in the context of maternal drug use and had illicit drugs present in the toxicology testing, positive drug findings were listed under the contributing cause of death, these were categorized as accidental drug related deaths. One fetal demise was the result of a firearm fatality inflicted on the mother and was categorized as a Homicide. Six of these fetal demises had a post-mortem examination performed.

The remaining child deaths under the age of one, were not categorized as fetal demises. Three deaths have causes that are sudden unexpected or unexplained child deaths and the manner was listed as Undetermined. One death was categorized with the manner as Accident, the extrinsic factors of co-sleeping on an unsafe sleep surface was determined to be contributory to the death.

Two deaths occurred under the age of five. One death was determined to be COVID-19 related and ruled Natural and the other was a firearm fatality and ruled an Accident. Research was done in the Coroner’s Office electronic case management system for similar circumstances of a child self-inflicted accidental firearm fatality and no other cases were able to be found searching back to 2000. The District Attorney’s Office was contacted, and they believe the last case similar to this case happened in the 1980’s.
The remaining 18 child deaths were between the ages of 13 and 21 (Table 4). Of these 18 deaths one was Natural, seven were Accidental, five were Suicides, four were Homicides, and one was Undetermined.

**Table 4. Child Deaths Aged 13-21**

<table>
<thead>
<tr>
<th>Age</th>
<th>Race</th>
<th>Gender</th>
<th>Cause of Death Category</th>
<th>Manner of Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>13</td>
<td>White</td>
<td>Male</td>
<td>Firearm Fatality</td>
<td>Homicide</td>
</tr>
<tr>
<td>15</td>
<td>White</td>
<td>Male</td>
<td>Blunt Force Injuries</td>
<td>Suicide</td>
</tr>
<tr>
<td>15</td>
<td>White</td>
<td>Female</td>
<td>Brain</td>
<td>Natural</td>
</tr>
<tr>
<td>16</td>
<td>White</td>
<td>Male</td>
<td>Motor Vehicle Collision</td>
<td>Accident</td>
</tr>
<tr>
<td>16</td>
<td>White</td>
<td>Male</td>
<td>Motor Vehicle Collision</td>
<td>Suicide</td>
</tr>
<tr>
<td>18</td>
<td>Hispanic</td>
<td>Male</td>
<td>Motor Vehicle Collision</td>
<td>Accident</td>
</tr>
<tr>
<td>18</td>
<td>White</td>
<td>Male</td>
<td>Drowning</td>
<td>Accident</td>
</tr>
<tr>
<td>18</td>
<td>Black</td>
<td>Male</td>
<td>Motor Vehicle Collision</td>
<td>Accident</td>
</tr>
<tr>
<td>19</td>
<td>White</td>
<td>Male</td>
<td>Hanging</td>
<td>Suicide</td>
</tr>
<tr>
<td>19</td>
<td>White</td>
<td>Male</td>
<td>Drug Related Death</td>
<td>Accident</td>
</tr>
<tr>
<td>20</td>
<td>White/Hispanic</td>
<td>Female</td>
<td>Drowning</td>
<td>Suicide</td>
</tr>
<tr>
<td>20</td>
<td>White</td>
<td>Transgender</td>
<td>Hanging</td>
<td>Suicide</td>
</tr>
<tr>
<td>20</td>
<td>White</td>
<td>Male</td>
<td>Undetermined</td>
<td>Undetermined</td>
</tr>
<tr>
<td>20</td>
<td>White/Hispanic</td>
<td>Female</td>
<td>Firearm Fatality</td>
<td>Homicide</td>
</tr>
<tr>
<td>20</td>
<td>White</td>
<td>Male</td>
<td>Drug Related Death</td>
<td>Accident</td>
</tr>
<tr>
<td>21</td>
<td>Black</td>
<td>Male</td>
<td>Sharp Force Injury</td>
<td>Homicide</td>
</tr>
<tr>
<td>21</td>
<td>White/Hispanic</td>
<td>Female</td>
<td>Firearm Fatality</td>
<td>Homicide</td>
</tr>
<tr>
<td>21</td>
<td>White</td>
<td>Male</td>
<td>Drug Related Death</td>
<td>Accident</td>
</tr>
</tbody>
</table>
Maternal Mortality

Pennsylvania's Maternal Mortality Review Committee (MMRC) is a multidisciplinary committee that convenes at the local level to comprehensively review deaths that occur during or within a year of pregnancy (pregnancy-associated deaths). The review committee issues a report annually and it can be found on the Department of Health’s website: https://www.health.pa.gov/topics/healthy/Pages/Maternal-Mortality.aspx

Reliable information on previous pregnancy is usually not available at the time of death, so it is possible other maternal deaths occurred.

In 2022, the office had four documented cases. One death was in the category: not pregnant, but pregnant within 42 days of death and three deaths were in the category: pregnant at the time of their death.

Coroner Sophia Garcia-Jackson applied to be a member of the Maternal Mortality Review Committee in November 2022.

In-Custody Deaths

Pennsylvania law (16 P.S. §1218-B) Coroner's Investigation.

(8) A death occurring in prison or a penal institution or while in the custody of the police.

The Chester County Coroner’s Office did not investigate any incarcerated person or in-custody deaths in 2022.

The Coroner’s Office investigated one police involved shooting, ruled a Homicide in June and one fatal crash involving a police pursuit, ruled an Accident in October.

Natural Disasters

The Centers for Disease Control and Prevention (CDC) has increased its emphasis on accurate death certificate reporting for deaths associated with natural disasters. Natural disaster events are required to be identified on the death certificate.
Deaths associated with adverse conditions such as heat or cold exposure are included in this category.

Hypothermia due to environmental exposure was a cause or contributory factor in the deaths of two people in 2022, they both died in the first month of the year. One person died of Hyperthermia in June. All deaths were ruled with the manner Accident.

Unclaimed Decedents

Pennsylvania Law (16 P.S. §1213-B) Removal of Bodies to the Morgue.

(a) Unidentified or unclaimed body. –When the body of a deceased person is unidentified or unclaimed by a proper person found within the county, the body shall be removed to the county morgue or, in a county of the third through eighth class, to a facility serving in lieu of the county morgue. If necessary, the Coroner shall have the body properly embalmed or prepared for preservation for the length of time the Coroner determines is required to determine the deceased’s identity, the identity of a party responsible for the deceased and the cause and manner of death. The body may only be examined or inspected by an individual authorized by the Coroner or who is admitted in the Coroner’s presence.

Under certain circumstances, the County of Chester becomes responsible for the disposition of an individual’s body after death:

1) No family members are known to exist
2) Legal next of kin cannot be located after an exhaustive search
3) Legal NOK, family, or guardian refuses to make final arrangements for financial or other reasons

Unclaimed bodies are reported to the Humanity Gifts Registry (HGR) after 36 hours, as required by state law, Pennsylvania General Assembly 1883 Act 106. If the body is not eligible or acceptable for HGR donation, another body donation organization may be contacted. If whole-body donation is not an option, the body is cremated at the expense of the County. The cremains of unclaimed individuals are kept by the Coroner’s Office for a minimum of one year, to allow for family or other interested parties to come
forward to claim them during that time. Unclaimed (also called unattended) veterans are interred at a National Cemetery after confirmation of eligibility by the Veterans’ Administration.

In 2022, the Coroner’s Office planned to inter 38 non-veteran adults and 16 fetal demises, in an October ceremony at Philadelphia Memorial Park. Unfortunately, after further inspection by the cemetery, the Office was notified that the donated vault was at max capacity after the 2018 and 2020 interments and the cemetery was unable to hold any more cremains in the donated vault.

At this time, all unclaimed cremains will be held at the Coroner’s Office, secured in the evidence room until further accommodations can be made. The current list of unclaimed cremains in our possession is located on our website: https://www.chesco.org/4796/Unclaimed-Cremains

Please contact the Coroner’s Office at 610-344-6165 to inquire about claiming unclaimed cremains found on our website. Note our website is constantly being updated as cremains are claimed, and others are added to the list.

In 2022, there was a significant increase in unclaimed bodies, resulting in a larger number of county cremations overseen by the Coroner’s Office (Figure 11). A total of thirty-eight bodies were unclaimed in 2022. Three have the potential to be claimed and one was claimed before the end of the year. Of the remaining 34 unclaimed decedents, next of kin were unable to be located for 18 (53%) decedents despite extensive investigation and the purchase of a new research tool in 2022 called Clear. At this time, under current legislation, Coroner Offices do not have access to JNET, a vital tool in locating next of kin and making positive identification. The next of kin or a guardian relinquished rights to the remaining 16 deceased individuals because they could not or did not want to claim the body and make final arrangements.

Coroner Sophia Garcia-Jackson envisions a mausoleum with a memorial garden and dedication plaque on the property of the soon to be built Forensic Facility, pending approval of the Commissioners and local Township Authorities, so that the deceased may be honored properly, visited by the public, and no longer held long term in an evidence room. This would also allow next of kin or other interested parties to claim the
cremains without having to pay a disinterment fee to the private Cemetery associated with the donated vault.

Figure 11. Total Number of County Cremations (2018-2022)

Organ Donation

*Pennsylvania Law (16 P.S. §1234-B) Anatomical Gifts.*

*The Coroner may order the removal of parts of a decedent’s body for donation purposes in accordance with 20 Pa.C.S. Ch. 86 (relating to anatomical gifts).*

The Chester County Coroner’s Office works with Gift of Life (GOL), the regional Organ Procurement Organization (OPO). CCCO is contacted for approval by GOL on all hospital deaths of potential donors, after first person consent or next of kin permission has been legally authorized and has been received by the Office. The Chester County Coroner’s Office does not approve the donation of organs and tissue without consent. If a death is under Coroner jurisdiction, the Coroner's Office determines what organs or tissue may be donated after discussion with the forensic pathologist and/or Coroner.
deaths that occur outside of the hospital, CCCO will refer the family to GOL, only if it is requested by the next of kin that they are interested in organ donation.

This chart summarizes organ and tissue donations from cases reported to the Chester County Coroner’s Office by Gift of Life in 2022. Thirty-nine organs from 13 donors were transplanted and 53 tissue donors.

Chart 1. Courtesy of Gift of Life
References:

https://name.memberclicks.net/assets/docs/MANNEROFDEATH.pdf


END of 2022 Chester County Coroner's Office Annual Report