County of Lehigh | Office of the Coroner

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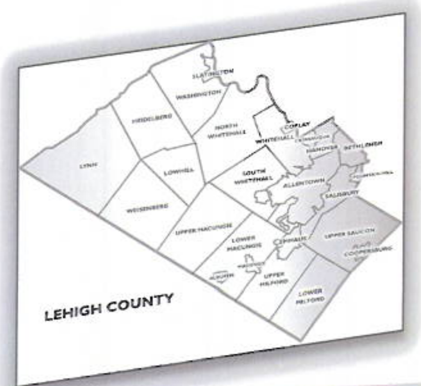
CORONER

LEHIGH COUNTY

VIRTUE LIBERTY AND INDEPENDENCE

2012

Year End Report

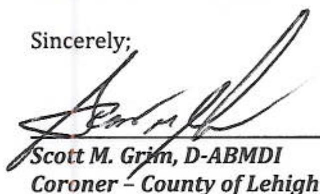


DEDICATION:

IT IS RECOGNIZED THAT EACH STATISTIC LISTED IN THIS REPORT REPRESENTS THE DEATH OF A PERSON WHOSE LOSS IS GRIEVED BY FAMILY, FRIENDS, AND LOVED ONES. OUR COMPASSIONATE TEAM TAKES PRIDE IN EVERY PERSON WE SERVE, FROM THE DECEDENTS TO THEIR FAMILIES THAT MOURN THEIR LOSS.

TO THE PERSONS OF LEHIGH COUNTY AND BEYOND THIS COMMONWEALTH AND NATION THAT HAVE SUFFERED THE LOSS OF A FAMILY MEMBER, LOVED ONE, FRIEND, OR NEIGHBOR; THIS REPORT IS DEDICATED.

Sincerely;



Scott M. Grim, D-ABMDI
Coroner – County of Lehigh

INTRODUCTION

The Coroner's Office serves families by investigating sudden and unexpected deaths to determine the Cause and Manner of Death. Moreover, deaths that occur under violent or suspicious circumstances are what seem to make the top headlines. The Coroner's Office is tasked by Statutes of the Commonwealth of Pennsylvania to investigate all reportable deaths that occur within the geographical boundaries of the County of Lehigh.

The Lehigh County Coroner's Office staff recognizes that tragedy surrounds a premature death and performs their investigations, in part, to assist the grieving family. A complete and thorough investigation can simply serve to answer the question of what happened, or it may be able to provide insight for siblings and children to be evaluated and assist in dealing with any inherent problems they could potentially face.

Often questions and tasks performed by our investigators seem very irrelevant in the immediate hours following the death of a loved one; however, these can become significantly more important in the following months. The surviving families, friends, and general citizenry can be assured that a thorough investigation is completed by the Lehigh County Coroner's Office. It should be noted that the Lehigh County Coroner's Office annual report does not include ***all*** deaths occurring in Lehigh County, rather the cases investigated by the Lehigh County Coroner's Office. For a total description of deaths occurring in Lehigh County please consult:

Vital Records, Pennsylvania Department of Health
P.O. Box 1528
101 South Mercer Street
New Castle, PA 16101
(724)-656-3100

This annual report is presented in three sections; 1) Overview of the Coroner's Office, 2) Total Case Information, and 3) Cause and Manner of Death. Sections 2 & 3 are aimed at presenting data routinely collected by the Coroner's Office. The graphs, charts, and numbers are designed to be self-explanatory and provide a picture of the investigations the Lehigh County Coroner's Office performs.

DESCRIPTION OF THE CORONER'S OFFICE

The Coroner's Office is an independent, investigative division of the Lehigh County Government. The citizens of Lehigh County fund us through the Office of the Lehigh County Executive and Board of Commissioners.

Under the direction of Coroner Scott M. Grim, our office provides Medicolegal Death Investigations, Authorization of Autopsies; as needed, and Administrative Support as well as many other family assistance services.

The six basic functions of the Lehigh County Coroner's Office are:

- Determine the Cause and Manner of Death for individuals in a timely fashion.
- Identify the deceased with the highest degree of certainty possible and provide written documentation of same.
- Proper and timely notification of the legal next of kin.
- Prepare, maintain, and safeguard thorough and timely reports regarding our investigations.
- Account for, maintain, and safeguard personal property of the decedent and evidence.
- Provide assistance to families involved in our investigations as applicable.

The Coroner is an elected position, voted by the citizens of Lehigh County; the elected Coroner, Scott M. Grim, D-ABMDI, is well respected among his peers. He has served many years as President of the Pennsylvania State Coroner's Association. Currently, he is the President of International Association of Coroners and Medical Examiners. Additionally, he serves on the Board of the American Board of Medicolegal Death Investigators, which is the accrediting agency for Medicolegal Death Investigators around the world. Coroner Grim was a founding committee member of the Scientific Working Group for Medicolegal Death Investigators (SWGMDI), an FBI/NIJ sponsored group that is charged with developing new guidelines for Medicolegal Death Investigators across the Nation. Additionally, Coroner Grim is a sitting Board of Directors member of the Society of Medicolegal Death Investigators, Inc. (SOMDI). Prior to being named Coroner and subsequent elections' Coroner Grim was a sworn Law Enforcement Officer.

OUR MISSION

The mission of the Lehigh County Coroner's Office is to investigate the Cause of Death and to determine the Manner of Death of individuals who die within the boundaries of the County, as a result of a sudden, unattended, violent or suspicious circumstances.

PURPOSE OF THE CORONER'S OFFICE

The Coroner's Office is an independent investigatory office. We are charged with determining the Cause of Death, as well as the Manner of Death. We receive this directive based upon the Commonwealth of Pennsylvania Title 16 § 1237. Whereas, the Coroner having a view of the body shall investigate the facts and circumstances concerning deaths which appear to have happened within the county, regardless where the cause thereof may have occurred, for the purposes of determining whether or not an autopsy should be conducted or an inquest thereof should be had in the following cases:

a) SUDDEN DEATHS NOT CAUSED BY READILY RECOGNIZABLE DISEASE, OR WHEREIN THE CAUSE OF DEATH CANNOT BE PROPERLY CERTIFIED BY A PHYSICIAN ON THE BASIS OF PRIOR MEDICAL ATTENDANCE.
b) DEATHS OCCURRING UNDER SUSPICIOUS CIRCUMSTANCES, INCLUDING THOSE WHERE ALCOHOL, DRUGS OR OTHER TOXIC SUBSTANCES MAY HAVE HAD A DIRECT BEARING ON THE OUTCOME.
c) DEATHS OCCURRING AS A RESULT OF VIOLENCE OR TRAUMA, WHETHER APPARENTLY HOMICIDAL, SUICIDAL, OR ACCIDENTAL.
d) ANY DEATH IN WHICH TRAUMA, CHEMICAL INJURY, DRUG OVERDOSE OR REACTION TO DRUGS OR MEDICATION OR MEDICAL TREATMENT WAS A PRIMARY OR SECONDARY, DIRECT OR INDIRECT, CONTRIBUTORY, AGGRAVATING OR PRECIPITATING CAUSE OF DEATH.
e) OPERATIVE AND/OR PERI-OPERATIVE DEATHS IN WHICH THE DEATH IS NOT READILY EXPLAINABLE ON THE BASIS OF PRIOR DISEASE.
f) ANY DEATH WHEREIN THE BODY IS UNIDENTIFIED OR UNCLAIMED.
g) DEATHS KNOWN OR SUSPECTED AS DUE TO CONTAGIOUS DISEASE AND CONSTITUTING A PUBLIC HEALTH HAZARD.
h) DEATHS OCCURRING IN PRISON OR A PENAL INSTITUTION OR WHILE IN THE CUSTODY OF POLICE.

i) Deaths of persons whose bodies are to be cremated, buried at sea or otherwise disposed of so as to be thereafter unavailable for examination.
j) Sudden infant death syndrome
k) Stillbirths

As part of this investigation, the coroner shall determine the identity of the deceased and notify the next of kin of the deceased.

CORONER ACTIVITY

The staff of the Coroner's Office is involved in a wide variety of activities commensurate with the mission of the office. This includes responding to and investigating deaths at various locations throughout the geographic boundaries of the County, attending postmortem examinations, reviewing the detailed findings in order for the certification of the Cause and Manner of Death, and providing assistance to the families that we serve.

Staff members are well versed in dealing with families and assisting them in their time of need. Some details that the Deputy Coroner / Investigator assist families with are; office procedures, release of remains following an investigation, and release of property of the deceased that may have come into the possession of the Office of the Coroner. Additional duties include, reviewing investigative findings with the legal next of kin, and coordinating release of the deceased and/or any materials to the funeral home of the families choosing.

The Coroner's Office staff provides testimony both in court and in depositions. This can be for both civil and/or criminal matters. Investigators routinely interact with police officers/investigators, attorneys for the defense, attorneys for the prosecution, laboratory personnel, etc. Staff provides a wide range of services through the entire process of dealing with death and/or crimes related to a death.

Reporting is provided by the Office of the Coroner to Pennsylvania Department of Labor and Industry, Occupational Safety and Health Administration, U.S. Consumer Products Safety Commission, Pennsylvania Department of Transportation, and many other government and regulatory agencies. As part of efforts to keep the public safe and informed of the dangers of many items in public use this practice is continued, in hopes that it will make a difference by involving agencies that can correct issues with certain products. We cooperate routinely and are actively involved in the Child Death Reporting System, where various members of the present health care systems as well as local health bureau review all children's deaths under the age of 21 to assist in various programs and needs ranging from suicide prevention to pandemic preparedness. Additionally, the staff is routinely active in other entities of death investigation, whether it is for education, guidelines, or resources to assist with current trends in investigation procedures. Some of these agencies are American Board of Medicolegal Death Investigators (ABMDI), Society of Medicolegal Death Investigators (SOMDI), International Association for Identification (IAI), National Association of Medical Examiners (NAME), and many others.

The Lehigh County Coroner's Office is the first Coroner's Office in the Commonwealth of Pennsylvania and the second worldwide to have received accreditation from the International Association of Coroners and Medical Examiners (IACME). We are currently certified. We have complied with recertification, continue to uphold the highest standards to maintain this accreditation and we are slated to be certified again in 2016.

Death investigations today are on the forefront of some government programs that are calling for major changes. This shall include certification of the medicolegal death investigators, updated standards, increased education requirements, and increased continuing education requirements annually. Currently, 68% (13/19) of our investigators have attained the certifications that will become standard. All of our investigators attend annual training to attain and maintain the continuing education requirements, as well as attaining certification by the Commonwealth of Pennsylvania – Office of the Attorney General/Coroner's Education Board.

As you can tell by our advances, our office is prepared, trained, highly motivated, and educated to meet the needs of this demanding field and serve the deceased and their loved ones when the time comes.

ORGANIZATIONAL CHART

SCOTT M. GRIM, D-ABMDI

LEHIGH COUNTY CORONER

PAUL F. HOFFMAN, SR., D-ABMDI

CHIEF DEPUTY CORONER

ERIC D. MINNICH, D-ABMDI

FIRST DEPUTY CORONER
OPERATIONS MANAGER

MARIANNE GRANITZ

ADMINISTRATIVE ASSISTANT

RAYMOND W. ANTHONY, III, D-ABMDI

SENIOR INVESTIGATOR
DEPUTY CORONER

DANIEL A. BUGLIO, D-ABMDI

SENIOR INVESTIGATOR
DEPUTY CORONER

WENDY BRANTLEY

SENIOR INVESTIGATOR
DEPUTY CORONER

CRAIG HANZL, D-ABMDI

SENIOR INVESTIGATOR
DEPUTY CORONER

DAVID M. KRAUSE

SENIOR INVESTIGATOR
DEPUTY CORONER

RICHARD KROON

SENIOR INVESTIGATOR
DEPUTY CORONER

RICHARD B. PENDER, D-ABMDI

DEPUTY CORONER

JASON A. NICHOLAS, D-ABMDI

SENIOR INVESTIGATOR
DEPUTY CORONER

EDWARD ZUCAL, D-ABMDI

DEPUTY CORONER

MICHAEL BARTHOLOMEW

DEPUTY CORONER

ELISABETH CASCINO, D-ABMDI

DEPUTY CORONER

JACK A. FLITER, JR., D-ABMDI

DEPUTY CORONER

KELLY E. GILLIS,M.A.,F-ABMDI

DEPUTY CORONER

DANIEL HALL

DEPUTY CORONER

ANDREW KEHM, D-ABMDI

DEPUTY CORONER

STEPHANIE L. MOLNAR

DEPUTY CORONER

EXPLANATION OF DATA

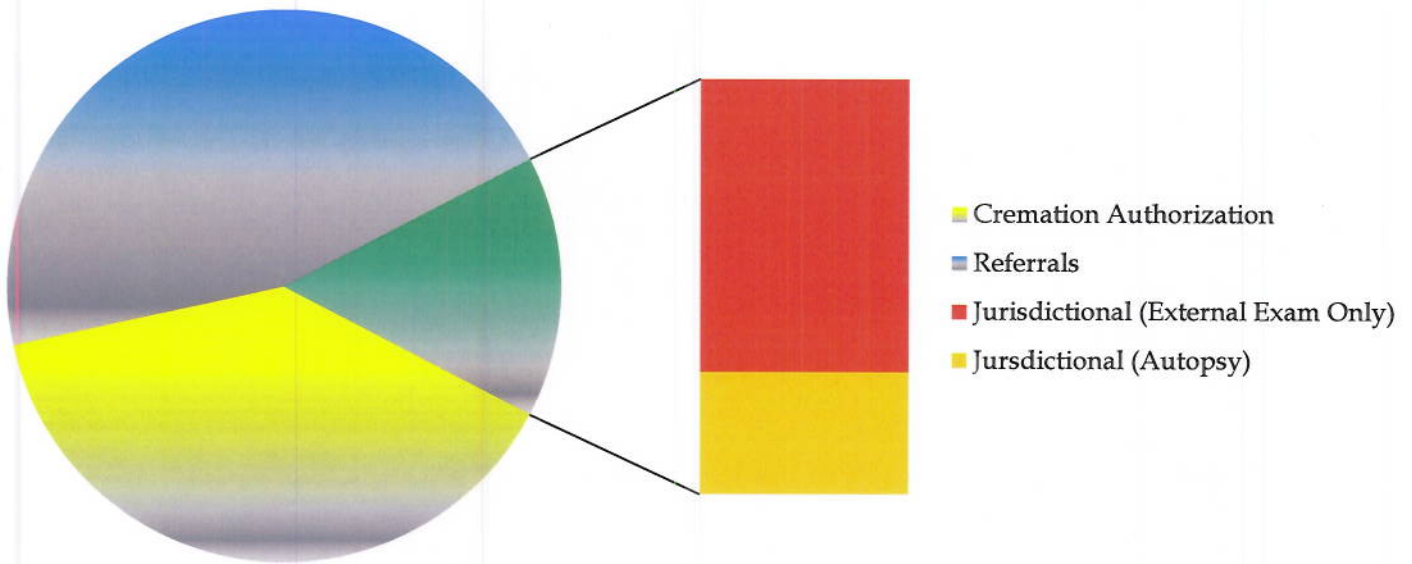
The information provided in this report was compiled on deaths that were reported to the Lehigh County Coroner's Office and occurred during the calendar year 2012. The report will review routinely collected data in a way to answer questions regarding mortality and public health; the implication of alcohol, medications, drugs of abuse, and firearms in violent deaths is emphasized. If there is to be a change in the quality of life amongst Lehigh County, perhaps this report can be the precipitating factor.

The County of Lehigh encompasses some 347 square miles, with U.S. Census figures showing the current estimated population of Lehigh County at just over 355 thousand people. Please keep in mind that with the two regional trauma centers (St. Luke's Hospital – Fountain Hill and Lehigh Valley Hospital – Cedar Crest) our office technically, does not only serve Lehigh County citizenry. We are also responsible to investigate the deaths of individuals at either of these two facilities that may have been brought here because of their specialty services; such as trauma care, burn care, and pediatric care. In all, there are ten (10) hospital located in Lehigh County.

TOTAL CASE INFORMATION

In 2012, there were 5,331 investigations reported to our office. Of these investigations, 2,441 were cases where scene investigation and external examinations were not required. Additionally, 2,075 of them were for authorizations to cremate. 815 of the death investigations required the Office of the Coroner to provide scene investigations as well as external examinations. Autopsies, in non-criminal cases, were not performed where scene investigation, circumstances, medical history, and external examination provided enough detail for death certification. In the 815 deaths, that the office provided detailed investigations of, we autopsied approximately 30% of those cases, or 241 autopsies.

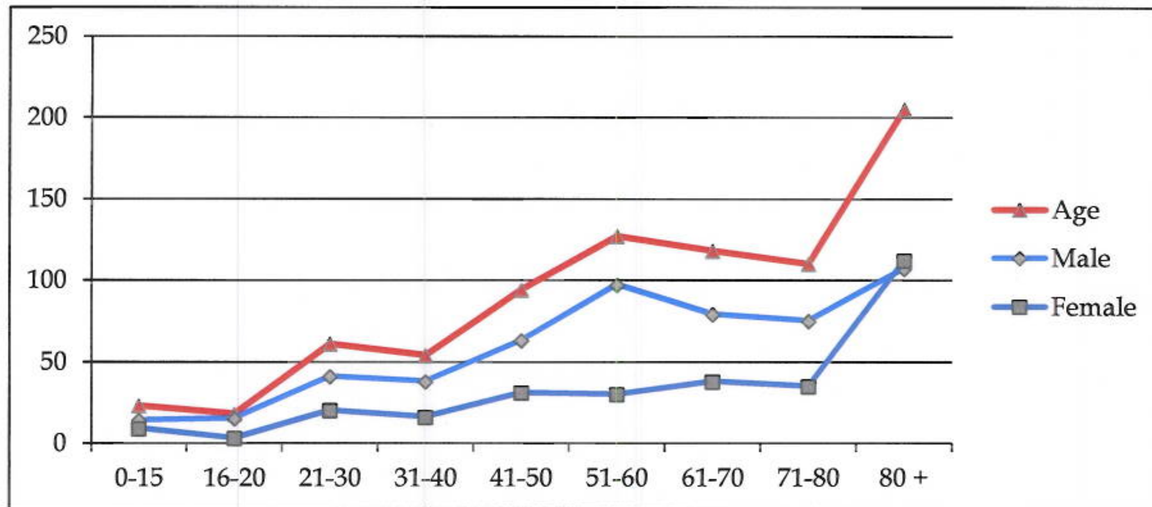
The tables and figures summarize the manner of death in all cases reported to the Coroner's Office. Of the cases that fell under the jurisdiction of the Coroner, a majority of 46% were natural, 54% were non-natural. While homicides seem to make up the spotlight of the news reporting for our investigations, these death investigations only comprised 3%.



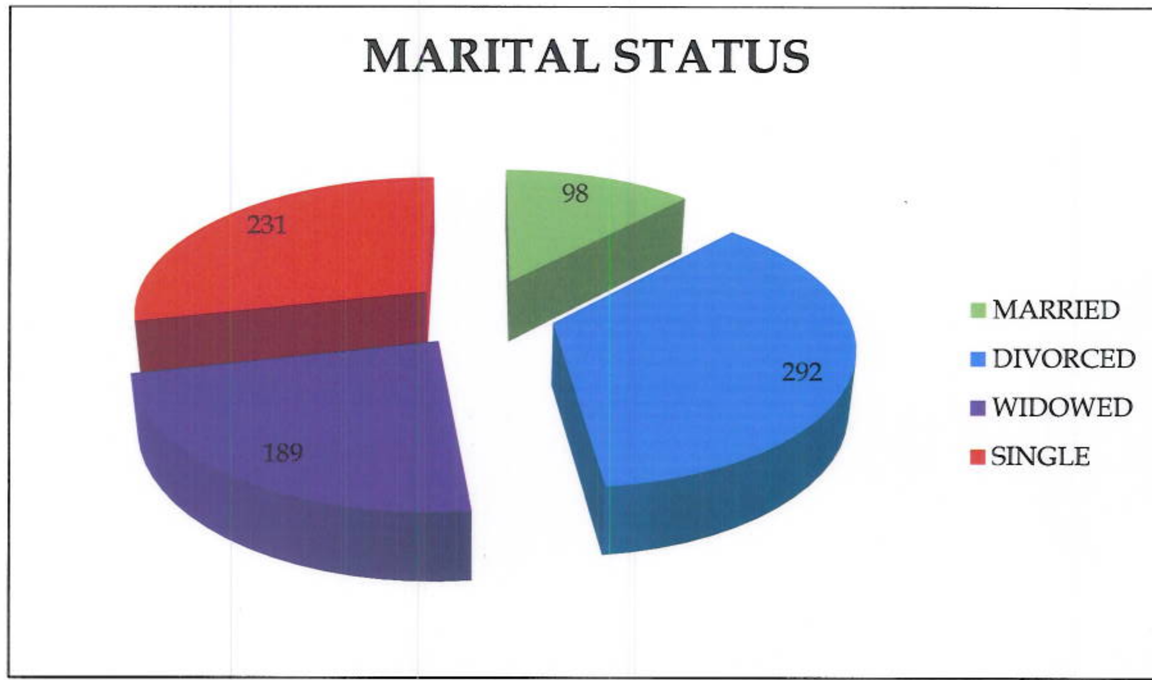
DEMOGRAPHIC BREAKDOWN

During 2012, there was a vast breakdown of demographic characteristics. Please refer to charts below for information on age groups, male vs. female, marital status, race, and more. Obviously, we are well-diversified society and these numbers only reaffirm this information.

AGE GROUPS / MALE VS. FEMALE



MARITAL STATUS



RACE

Race

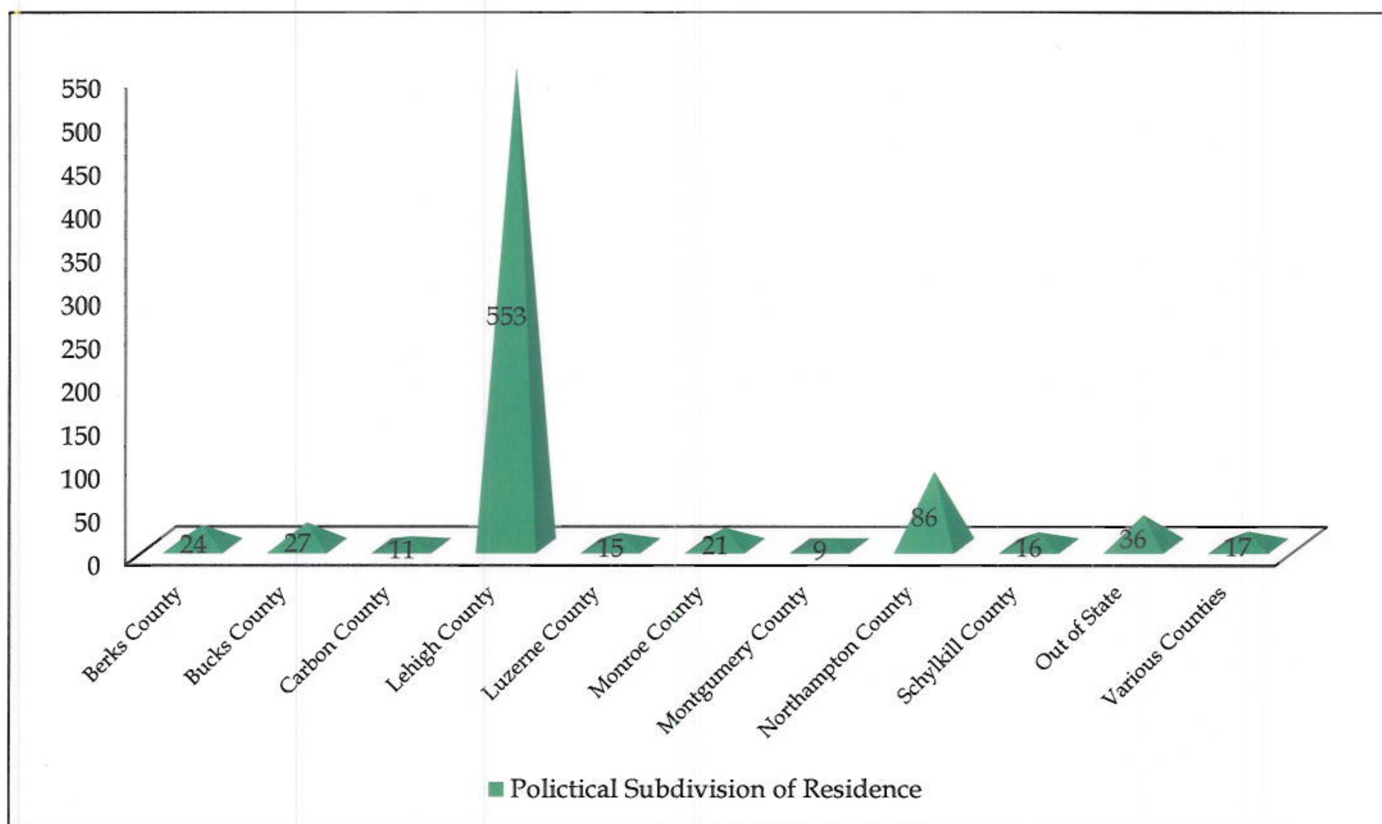
Race	
Other	26
White	696
Vietnamese	2
Samoan	0
Other Pacific	0
Other Asian	1
Hawaiian	0
Korean	1
Japanese	0
Guamanian	1
Filipino	0
Chinese	1
Black / African American	36
Asian Indian	1
American Indian / Alaska Native	1

0 50 100 150 200 250 300 350 400 450 500 550 600 650 700

Race

GEOGRAPHIC REGION

As depicted in the Explanation of Data section outlined on page 5, our office is faced with an influx of death investigations based on the location of the Level 1 Trauma Centers in our region. Below are two charts that outline the location of the populous of residency for our investigations. As you can clearly see, we serve more than just the residents of the County of Lehigh on quite a routine basis. The larger population that our office serves is from obviously Lehigh County, however Northampton County, Berks County, and many others require our services.



CAUSE AND MANNER OF DEATH INFORMATION

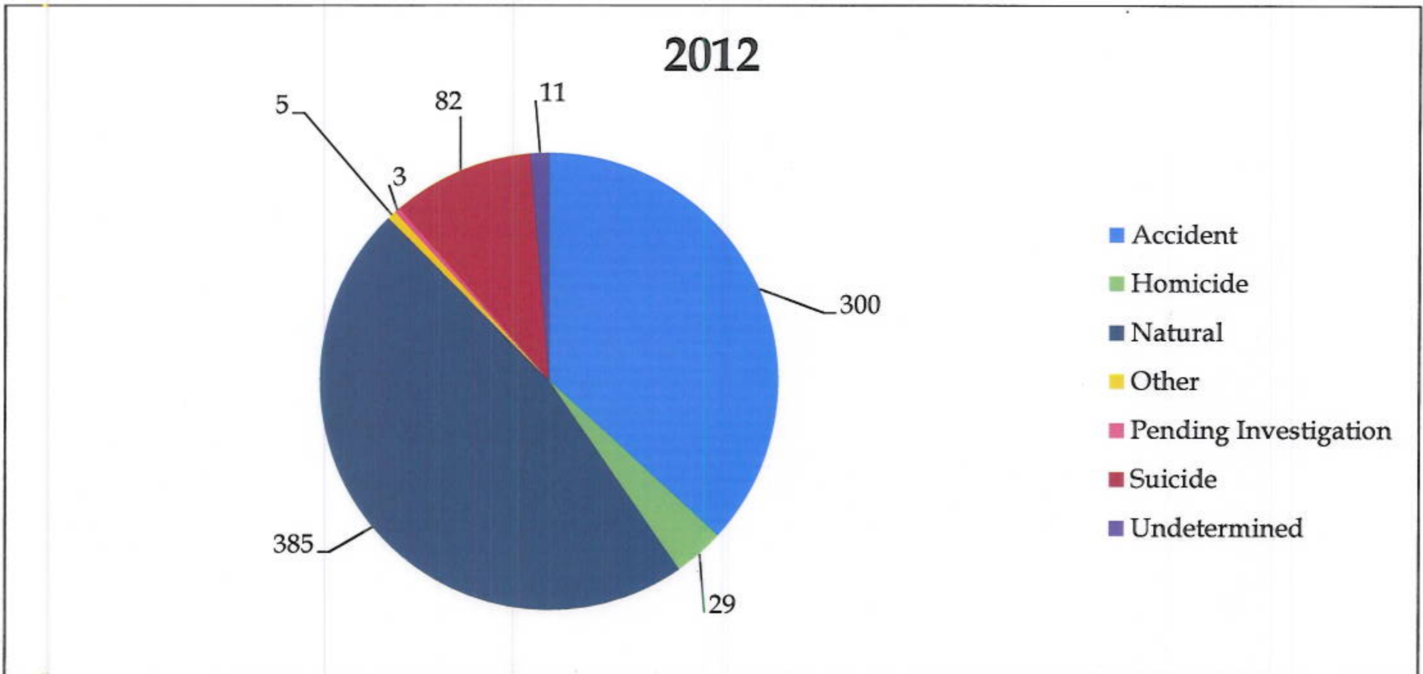
MANNER OF DEATH

Manner of Death was originally not required on the certification of death, however in 1910 the classification of the manner of death was added to the United States Certificate of Death. Currently, Manner of Death is not directly addressed by the World Health Organization. This was added to the death certificate by public health agents in an attempt to classify the circumstances of death.

Currently there are five (5) Manner of Death classifications on final death certificates. They are; Natural, Accident, Suicide, Homicide, and Could Not be Determined. If the investigation is in process, we can and will annotate the Manner of Death as Pending Investigation. This means simply stated, that the investiation is ongoing, however a death certificate is issued to allow for the families of the deceased to proceed with services.

Additonally we do conduct investigations where there is no death certifcate issued and we will classify these deaths as Other. These investigations are technically not death investigations, however do fall under our perview. They are investigations such as bones found; typcially animal remains, when a crypt of burial site is defaced and bones are unearthed, or simply when remains are found that it is unclear whether they are indeed human.

Out of the 815 scene investigations conducted by our office, there were: 375 Natural deaths, 284 Accident deaths, 78 Suicide deaths, 28 Homicide deaths, 5 Undetermined deaths, 5 Other (Bones/Crypt/etc.). Below is a chart to show the breakdown.



Lehigh County Coroner'sOffice — Year - to - Date Monthly Statistics — 4/8/2013

Jurisdictional Cases		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Total (Cases Only)		67	69	64	64	54	66	70	61	67	77	77	79	815
	Natural	34	39	35	29	24	35	26	28	31	34	36	34	385
	Accident	20	22	21	21	23	27	34	23	26	27	25	31	300
	Suicide	8	6	4	9	5	1	6	6	6	11	10	10	82
	Homicide	4	0	3	3	1	0	2	4	3	5	1	3	29
	Undetermined	0	1	0	1	0	2	1	0	1	0	4	1	11
	Other	1	1	1	0	0	1	1	0	0	0	0	0	5
	Pending	0	0	0	1	1	0	0	0	0	0	1	0	3
Non-Jurisdictionals		214	191	217	198	210	186	152	222	183	210	207	251	2441
Cremation		187	166	182	180	178	165	157	175	162	178	161	184	2075
Autopsy		20	13	16	24	18	25	19	18	23	16	26	21	241
	Tox. Only	0	0	0	0	0	0	0	0	0	0	0	0	0
	Consult Only	0	0	0	0	0	0	0	0	0	1	0	0	1
D.A. Ordered Autopsy	In County	2	0	2	2	1	0	1	2	5	5	1	2	23
	Out of County	2	0	0	0	0	0	1	1	0	0	0	1	5
Monthly Totals		468	426	463	442	442	417	379	458	412	465	445	514	5331

Breakdown other than Natural Deaths

Accident			
MVA	80	Industrial	3
Falls	116	Choking	6
Fire / Burns	13	Water Related	4
Exposure	6	Drug	66
Other	5	Carbon Mon.	1
Total		300	

Suicide			
Gun	38	Burns	1
Asphxia		Jump	5
Hanging	21	Knife	1
C.O.	4	Drug	11
Train		Other	1
Total		82	

Undetermined			
Fire		Other	6
Gun		C.O.	
Knife			
Drug	2		
Child	3		
Total		11	

Other	
Burial/Crypt	1
Bones	4
Other	
Total	5

Homicide			
Gun	14	Assault	4
Fire		Beating	
Knife	8	Other	3
Totals		29	

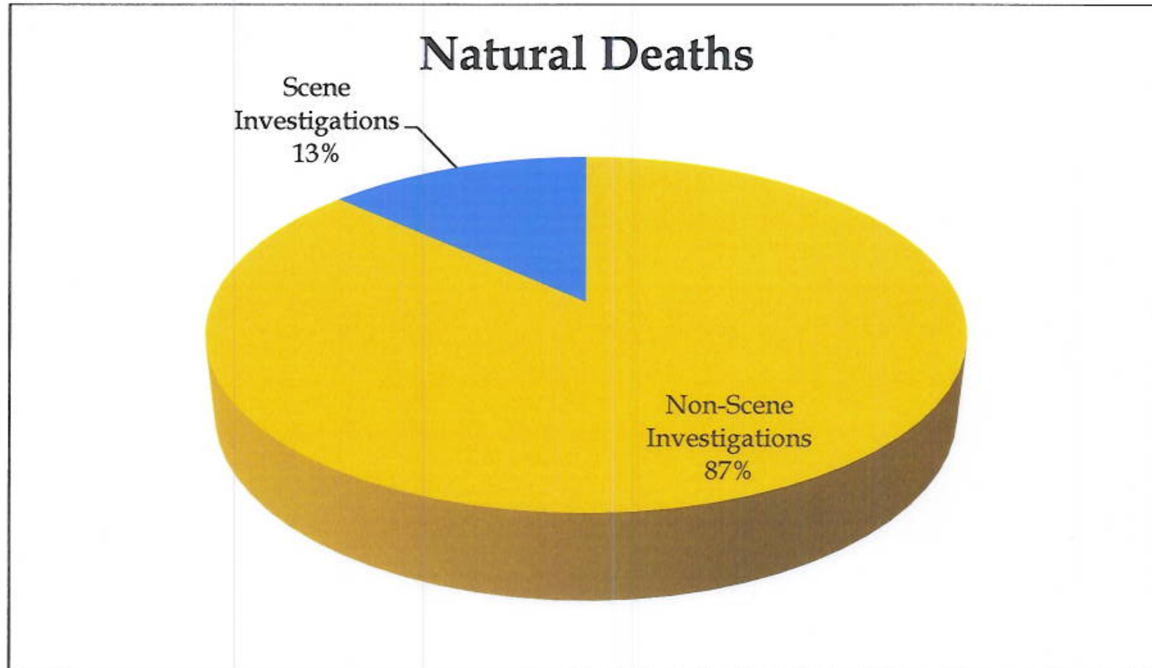
Homicide Breakdowns	
In County	22
Out of County	7
In A'town	*16*
Total	29

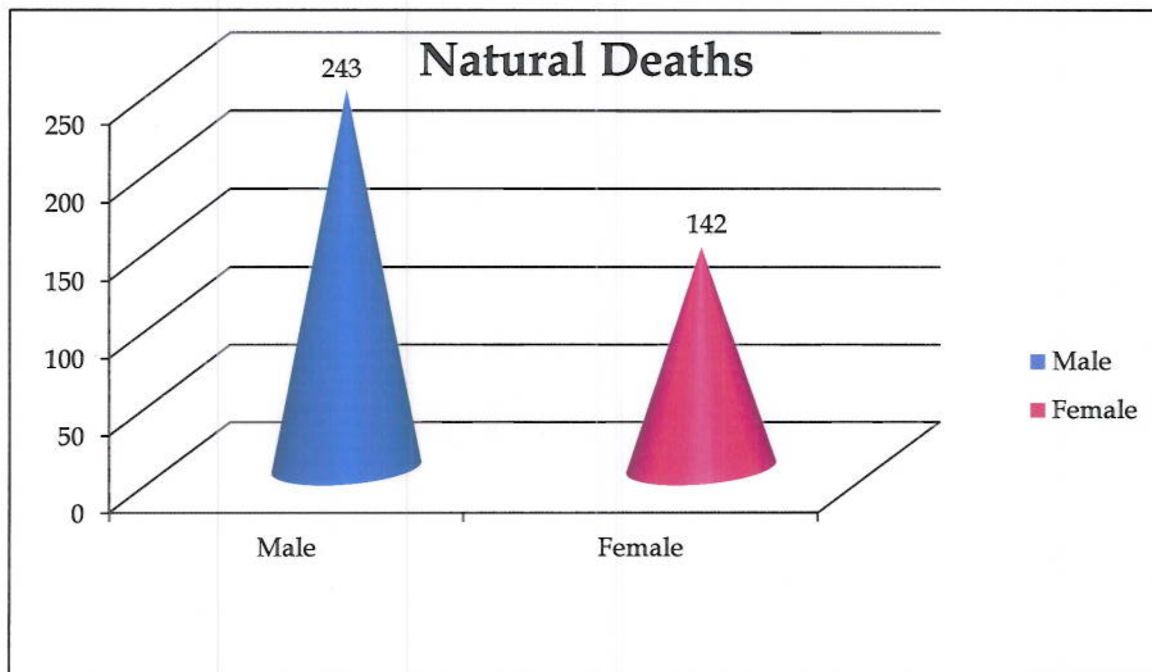
2012 MONTHLY STATISTICS.xlsx

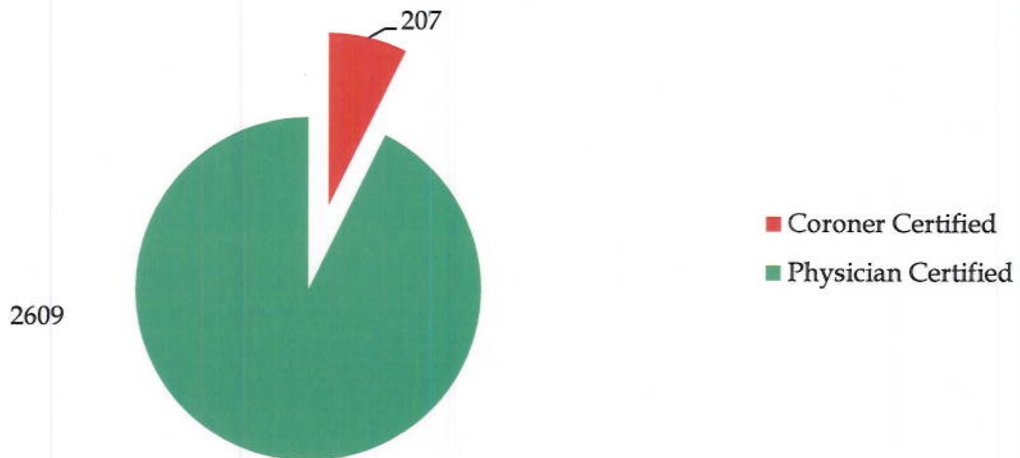
NATURAL DEATH INVESTIGATIONS

Our office conducted 2,816 Natural death investigations in calendar year 2012. Of these over 2,800 investigations, only 375 required scene investigation and external examinations of the deceased. Of these investigations, the Office of the Coroner certified 207 of the deaths. The deceased's attending physician certified the remaining 2,609 deaths. In the Commonwealth of Pennsylvania, physicians are only able to certify Natural deaths and our office affords the opportunity of the attending physician to certify the death following our investigation if he/she so chooses. If the attending physician opts not to certify the death, our office will certify and issue the death certificate.

We investigated the deaths of 243 male and 142 females.





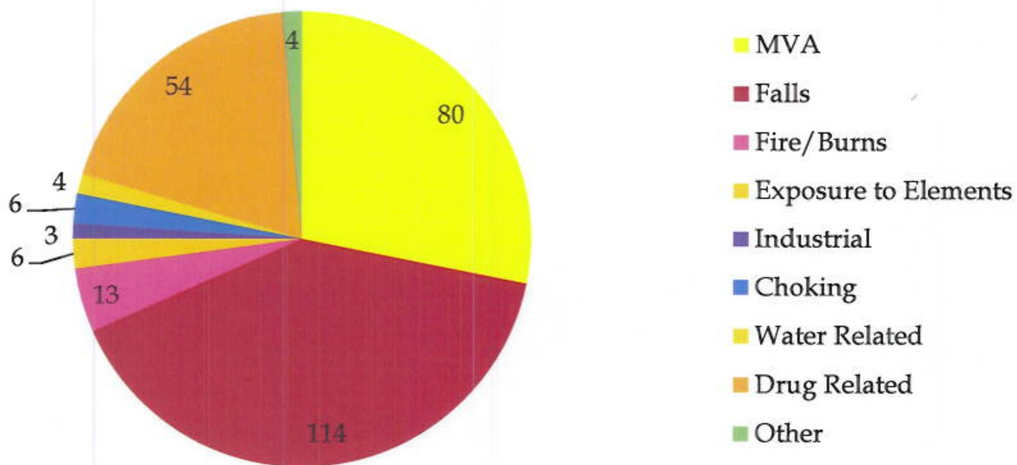


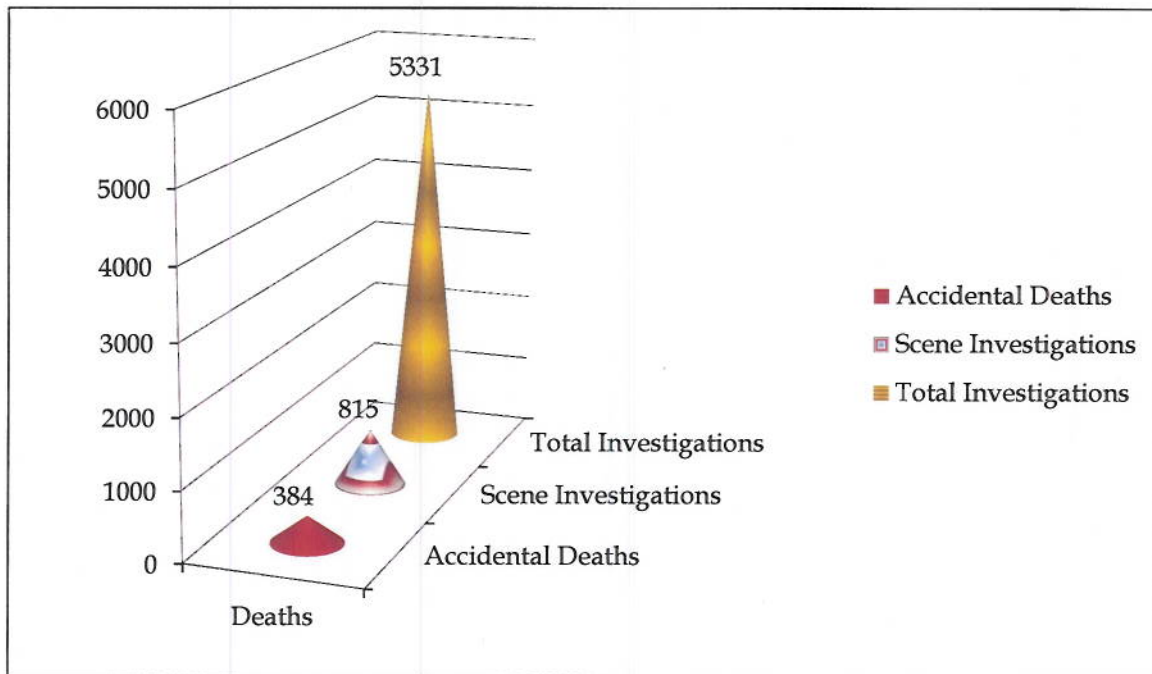
ACCIDENT DEATH INVESTIGATIONS

Our office investigated 375 deaths that were resultant of some type of injury and based on our investigation, the Manner of Death is Accident.

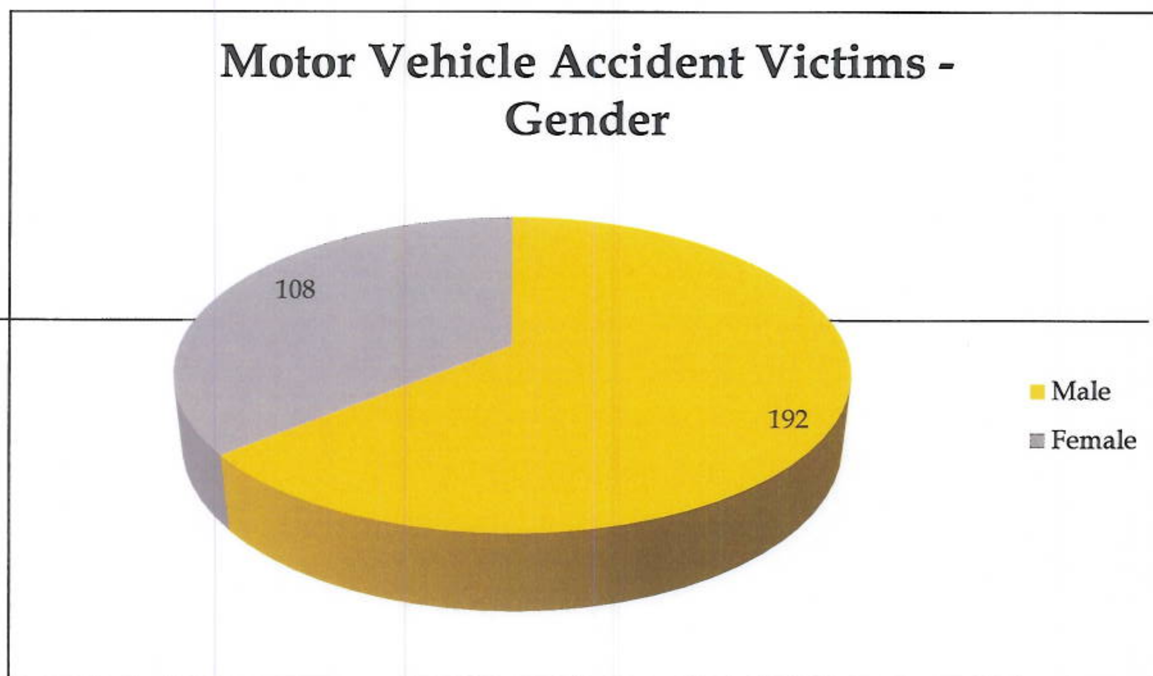
These deaths ranged from Motor Vehicle Accidents to Falls to Choking. On average, accidental deaths make up 46% of our scene investigations. This is caused by not only the vast highway system in Lehigh County, but also the influx of critically injured parties, via the two level one trauma centers within geographical boundaries of Lehigh County.

Please see the charts below that will depict some information regarding the demographics, breakdown of relevant circumstances, and sheer numbers of the accidental deaths our office investigates.

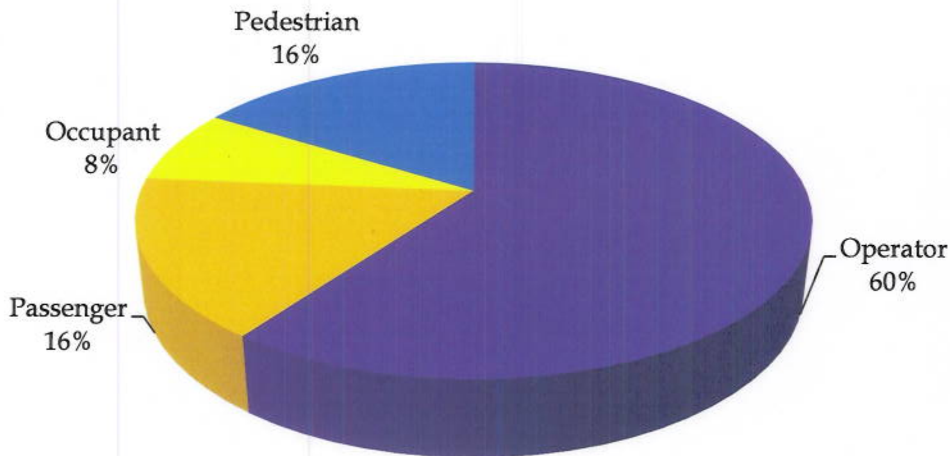


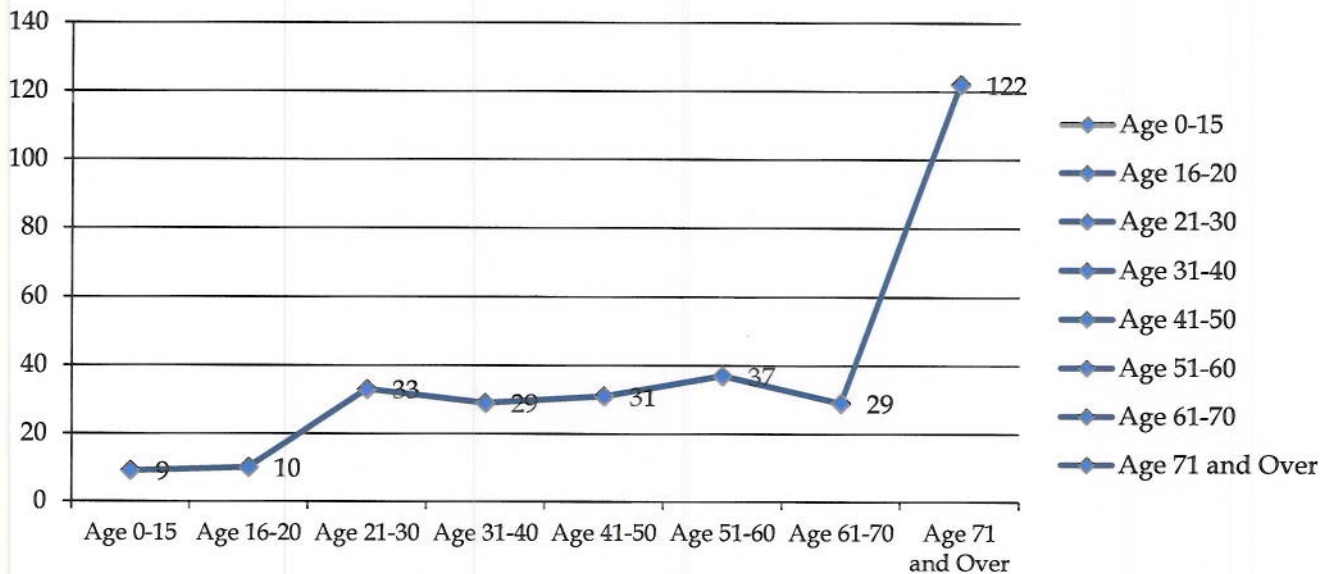


5331
6000
5000
4000
3000
2000
1000
0
815
384
Total Investigations
Scene Investigations
Accidental Deaths
Deaths
Accidental Deaths
Scene Investigations
Total Investigations



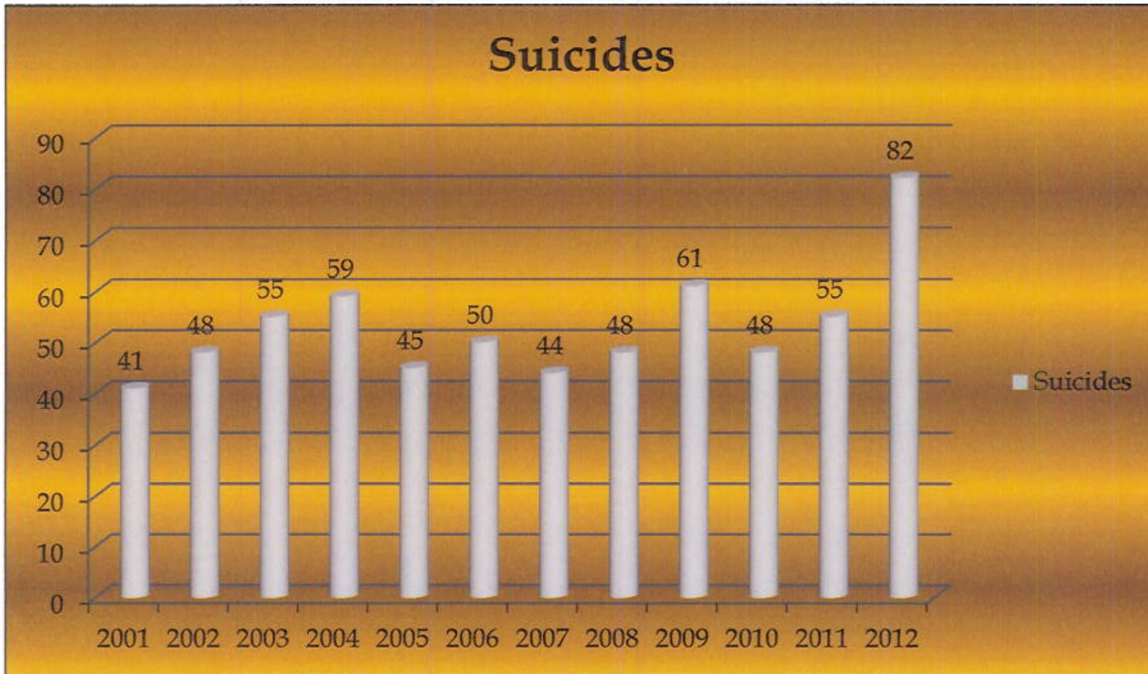
Motor Vehicle Accident Victims - Gender
108
192
Male
Female

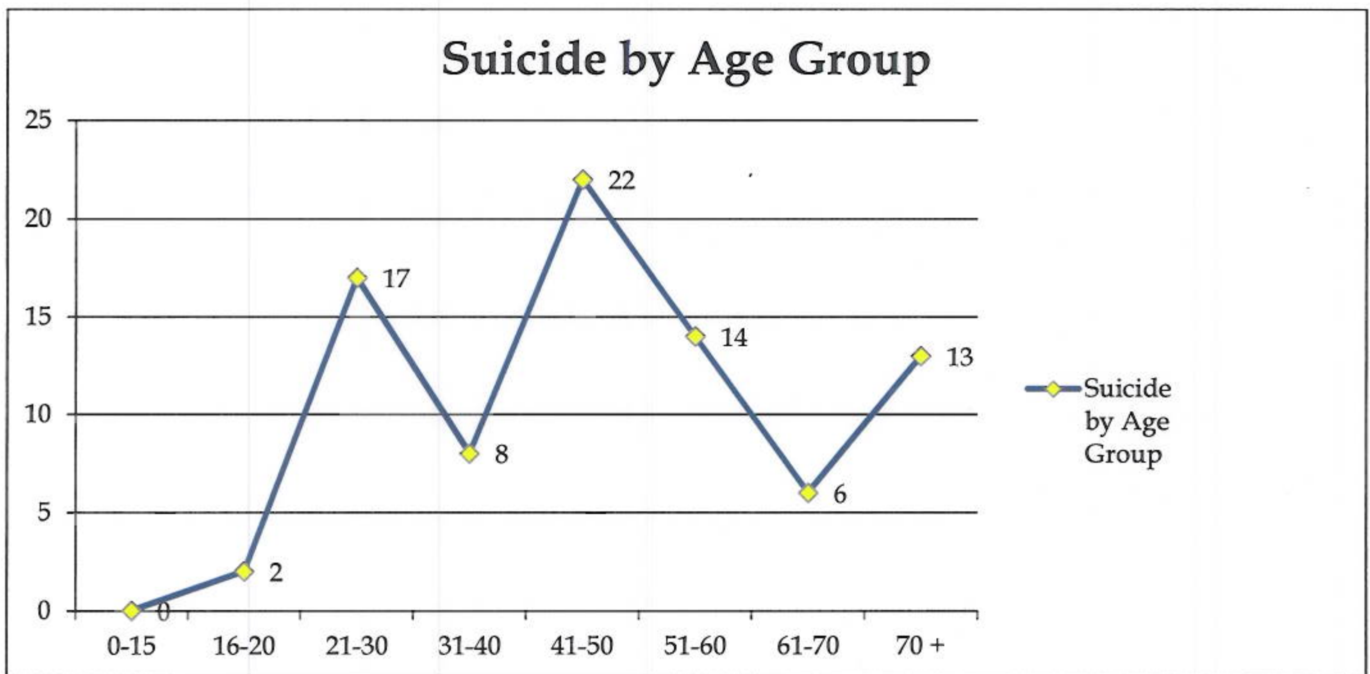




SUICIDE DEATH INVESTIGATIONS

In 2012, we have noticed a surge of suicide cases. As you can see by the chart below, there was a steady increase of suicide cases in the early 2000's, however, since that time we have maintained an average of 50 suicide deaths per year with an extraordinary total of 82 in 2012. Suicide deaths range in modalities from gun related to drug ingestions. There is a real concern coming in the later part of 2012, and continuing into 2013 as it appears that suicide cases are continuing to climb. In 2012, the average age of a suicide death was age 48; however, we had suicide cases as young as age 16 and as old as age 92. The Lehigh County Coroner's Office has been involved with suicide prevention activities, shall remain an advocate for suicide prevention, and is currently in cooperation with the Allentown Health Bureau working towards programs to support and provide awareness of the resources available to people who are contemplating turning to suicide.

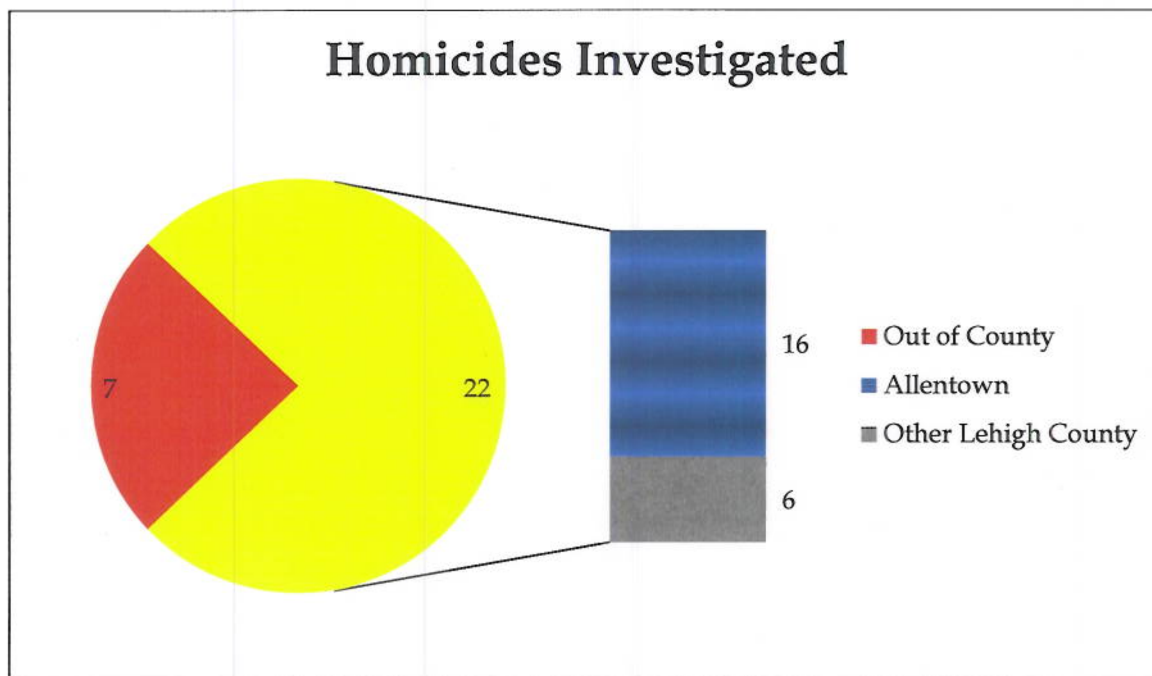


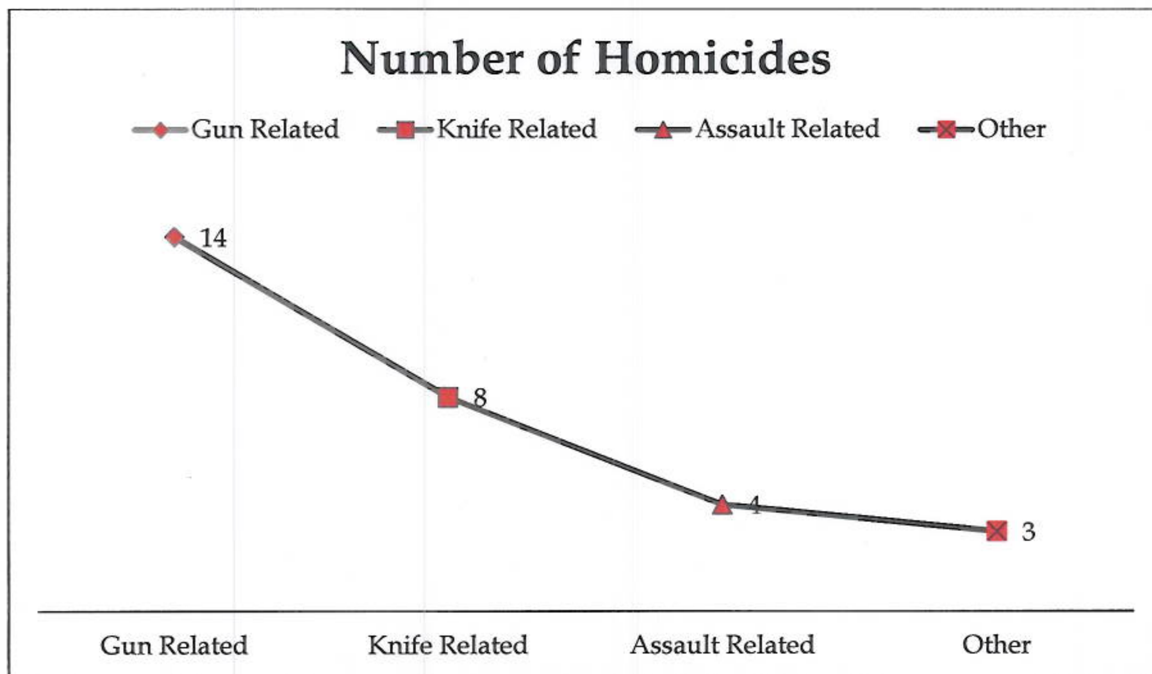


HOMICIDE INVESTIGATIONS

Homicide investigations are quite possibly the most sensationalized investigations for any Coroner or Medical Examiner's Office. These investigations garner the most media attention and probably rightfully so. In Lehigh County in the year 2012, our office investigated and ruled 29 deaths Homicide. As you will see in the breakdowns depicted below; they include deaths resultant from firearms, assaults, and knife injuries. While, we again investigate Homicides from other counties based on the local availability of the health care systems, Homicides in Lehigh County outweighed the number of Homicides brought to the local medical facilities from other Counties. In 2012, the Office of the Coroner investigated 22 Homicides

from within Lehigh County. Sixteen (16) of them were from the City of Allentown. The remaining seven (7) homicides were from other municipalities outside of Lehigh County.





UNDETERMINED

All possible efforts are made to determine both a Manner and Cause of Death for all deaths investigated by the Coroner's Office. In a very small percentage of the total cases (1.3%, 11/815cases), the Manner of Death was unable to be classified, even with a complete autopsy, scene investigation, and toxicology testing. In some of these cases, a Cause of Death was

able to be determined; however there exists continued doubt as to how the death came about. Part of this category are medication / drug related deaths (18%, 2/11) where there is insufficient evidence to rule the death anything other.

CLOSING REMARKS

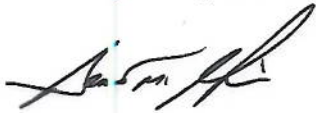
Thank you for taking time to read our annual report. This is provided to:

- County of Lehigh – Administration
- County of Lehigh Board of Commissioners
- County of Lehigh – Judiciary
- County of Lehigh – Office of the Controller
- And various boards and committees.

This is also available for public inspection on the website of the Office of the Coroner by navigating to the link provided.
http://www.lehighcounty.org/Departments/Coroner/tabid/346/Default.aspx

If you have any questions regarding this report or any operational issues of the Lehigh County Coroner's Office please feel free to contact the office or me by calling 610/782-3426.

Respectfully Submitted,



Scott M. Grim, D-ABMDI
Coroner
County of Lehigh