# Lexington County Coroner's Office

## 2018 Annual Report


*Coroner Margaret W. Fisher*

Lexington County
South Carolina

**Margaret W. Fisher**
Coroner

Candace S. Berry, Chief Deputy
Deputy Coroners
Chandler Clardy Ronnie Corley
Grey Gain Heather Hale
Brittany Hallman Amanda Jumper
Laura Moore Mory Rosario
Patti Steen Andy Taylor
Jessica Wade

**OFFICE OF THE CORONER**

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To the Citizens of Lexington County:

As expressed in our previous annual reports, our primary goals are to educate citizens about the purpose and responsibilities of the Coroner's Office and to promote community focus on the number of preventable deaths in Lexington County. We hope that this compilation of demographic and statistical information will reach a larger audience each year, and it will be a catalyst for positive change.

As I present to you the Lexington County Coroner's Office 2018 Annual Report, I would like to express my sincere condolences to everyone who lost a loved one in 2018. The members of my staff and I have been impacted by each death, and we are fully aware that the statistics do not represent the magnitude of your loss. Our intention remains to gain and share any information that might lead to the prevention of tragedies whenever possible.

The information necessary to compile this annual report has been derived from records obtained and held by the Lexington County Coroner's Office, including but not limited to our own investigations, police reports, autopsy reports, motor vehicle collision reports, and death certificates. We have put great effort into ensuring that the information is accurate and complete.

It remains an absolute privilege to serve you all. If we may be of any assistance or you need additional information, please feel free to contact the Lexington County Coroner's Office.

Thank you for your continued support,

Margaret W. Fisher

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# *Our Mission Statement*

*The mission of the Lexington County Coroner's Office is to determine the cause and manner of death through the completion of thorough, respectful, and professional investigations. As we endeavor to be the ambassadors of all decedents for whom we are responsible, we will extend to their loved ones unparalleled compassion and commitment.*

# BACKGROUND AND OBJECTIVES OF THE LEXINGTON COUNTY CORONER'S OFFICE

Since 1900, the Lexington County Coroner's Office has functioned under the leadership of twelve different Coroners. The twelfth and current Coroner, Margaret W. Fisher, is the eighth to reach office through the process of election, and the first female to hold the position. Coroner Fisher was initially elected to office on November 13, 2014 and was honored to be re-elected in November of 2016.

Prior to being elected as Coroner, Margaret Fisher served as Senior Deputy, assigned to the Community Action Team, at Richland County Sheriff's Department (RCSD). Although she served Richland County professionally, Margaret has resided in Lexington County for more than 30 years. She began her law enforcement career with RCSD in 2007, and her service and dedication there resulted in many certifications and awards. In addition to Associates Degrees in Criminal Justice and Nursing (RN) from Midlands Technical College, Margaret received the following certifications: Bike Patrol, National Child Safety Seat, Mounted Patrol, Prevention and Deterrence of Terrorist Acts, and Search and Rescue by horseback, all-terrain vehicle, and ground searching.

Margaret Fisher gained leadership experience as a leader of the Community Action Team and Unit Commander of the Richland County Mounted Patrol Unit. She received several awards, including Region 2 Outstanding Service Award (2009), Deputy of the

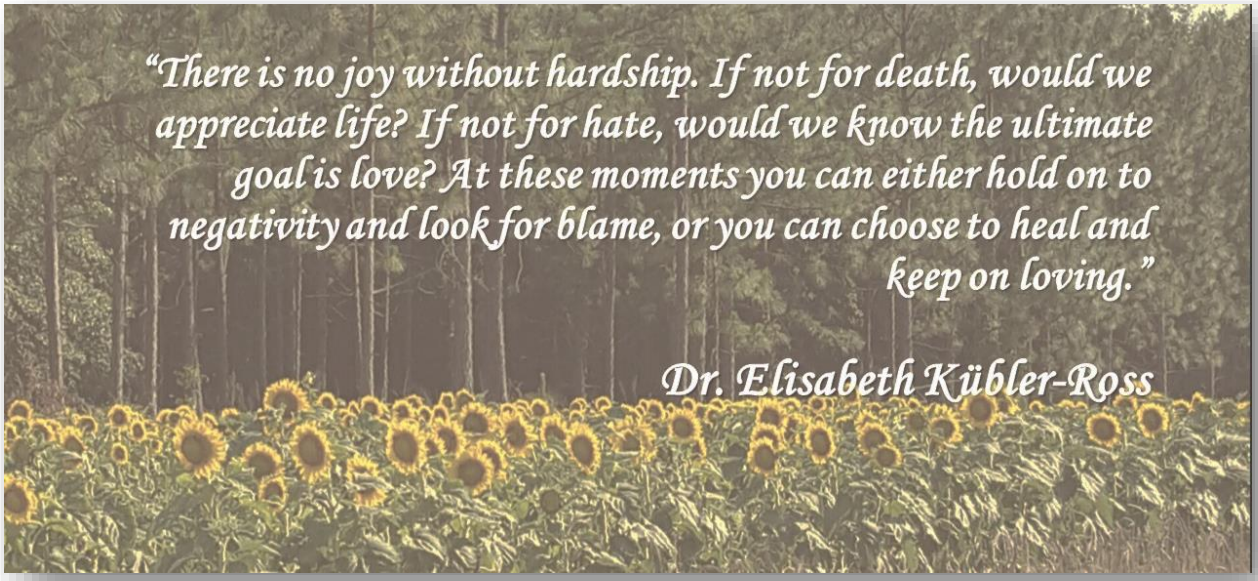
Cycle, Region 2 (2009), Community Services Division Deputy of the Year (2012), and Deputy of the Quarter (3 times since 2008). She also received Sheriff's Department Commendations in 2009 and 2010. Margaret's dedication led her to serve on the Lake Murray Marine Patrol and the multi-agency Alcohol Enforcement Team. She continues to serve on the boards of the 11th Circuit Domestic Violence Fatality Review Committee, the Lake Murray Board of Directors, and the Lexington One Task Force on Drugs and Alcohol.

Since becoming Coroner, Margaret Fisher has been certified by the American Board of Medicolegal Death Investigators (ABMDI) and has implemented various procedural improvements to increase the efficiency of the Lexington County Coroner's Office (LCCO). Her objectives clearly reflect her dedication to the citizens of Lexington County. Coroner Fisher is passionate about her role, which requires her to utilize her investigative and community relations skills. She has high expectations for all Deputy Coroners under her leadership; continual training is mandated, and certain standards of behavior must be adhered to. All current Deputy Coroners, who are eligible based on the hours of investigative experience, have obtained ABMDI certification. Additionally, the office was recently reaccredited by the International Association of Coroners & Medical Examiners (IAC&ME); only four other counties in SC are currently accredited.

In order to deserve and establish the trust of our community, it is imperative that we act with professionalism and respect, as well as compassion. Although we represent the deceased, we serve their survivors, and those individuals deserve to be handled with care and understanding as they grieve. In addition to compassion and respect, loved ones also deserve answers and, in some cases, justice. The objective of LCCO's quest for answers and truth is to represent decedents and contribute to the success of the judicial system in holding parties responsible for their deaths accountable, whether civilly or criminally. The process by which the Lexington County Coroner's Office operates and effectively upholds our investigative duties will be outlined in detail later in this report.

The primary focus of the LCCO is to determine the cause and manner of death; however, there are many additional facets that must remain a priority. For example, LCCO

personnel must conduct independent investigations, while cultivating a positive relationship with all law enforcement agencies in the county. LCCO works alongside law enforcement officers, EMS personnel, and firefighters. We are also in constant communication with physicians, funeral homes, the media, attorneys, South Carolina Department of Health and Environmental Control (DHEC), South Carolina Law Enforcement Division (SLED), Pathology Associates of Lexington, the Medical University of South Carolina Department of Pathology and Laboratory Medicine, and We Are Sharing Hope SC (organ procurement organization serving SC). The role of each of these entities is essential to the Lexington County Coroner's Office, and they will be addressed specifically throughout this report.



# ***Lexington County Coroner's Office Organizational Chart***

## Coroner

**Margaret W. Fisher**, D-ABMDI

## Chief Deputy Coroner

**Candace S. Berry**, D-ABMDI, *B.A. in Criminal Justice from Limestone College (graduated Cum Laude). Lifelong resident of Lexington County and graduate of Pelion High School; resides in Pelion.*

## Deputy Coroners

**Chandler J. Clardy**, D-ABMDI, *studied Mortuary Science at Piedmont Technical College and Criminology/Forensic Technology at ITT Tech; worked in the funeral industry for four years. Originally from Liberty, SC; resides in Lexington.*

**Grey P. Gain, II**, D-ABMDI, *10 years as a United States Marine Corps Combat Engineer, honorably discharged as Sergeant, 15 years with the Savannah River Site Law Enforcement Department, and completed University of North Dakota Death Investigations certificate program. From North Carolina; has resided in Batesburg since 2007.*

**Heather P. Hale**, *studied at Midlands Technical College, and was previously employed by the Coroner of another SC county. Grew up in Lexington County, returned in 2014, and resides in Lexington.*

**Brittany N. Hallman**, *B.A. in Psychology from the University of South Carolina. Lifelong resident of Chapin and graduate of Chapin High School.*

**Amanda S. Jumper**, *B.A. in Criminal Justice from Liberty University. Certified Emergency Medical Technician, employed as an EMT for 10 years. Lifelong resident of Lexington County; lives in Gilbert.*

**Moryanne Rosario**, D-ABMDI, *B.S. in Forensic Chemistry with Minor in Criminal Justice from Winthrop University. Graduated from Dreher High School, and is a resident of West Columbia.*

**Patricia A. Steen**, RN, *A.S. in Nursing from Midlands Technical College, B.S. in Nursing from University of Phoenix, and currently pursuing a M.A. in Leadership and Management from Western Governors University. Has been employed as a nurse for over 14 years, and resides in West Columbia.*

**Andrew S. Taylor**, *over 12 years of experience with Lexington County Fire Service, and 2 years as a Lexington County Emergency Communications Dispatcher. Resides in Gilbert; graduated from Gilbert High School.*

**Jessica C. Wade**, D-ABMDI, *A.A.S. in Mortuary Science from Piedmont Technical College (graduated with honors). Originally from Richmond, Kentucky; has resided in Chapin for over 8 years.*

## Administrative Deputy Coroner

**Laura A. Moore**, LPN, *A.S. in Nursing from Midlands Technical College; 16 years of experience with SC Vocational Rehabilitation, and 2 years at Lexington County Detention Center. Lifelong resident of Lexington, and graduate of Lexington High School.*

## Evidence/Property Custodian

**J. Ronald Corley**, *25 years in Law Enforcement and 10+ years at LCCO; lifelong resident of Lexington.*

# LEXINGTON COUNTY DEMOGRAPHIC AND GEOGRAPHIC INFORMATION

The Lexington County Coroner's Office is responsible for the entire county of Lexington, which is located in the Central Midlands region of South Carolina. The estimated population of Lexington County, per the U.S. Census Bureau, was 290,642 in 2017, making it the 6th most populated of South Carolina's 46 counties. The rate of population growth from 2010 to 2017, based on estimates, was 10.8% or more than 28,000 people, which was slightly higher than the 8.6% increase experienced by the state of South Carolina.


Geographically, Lexington County is 699 square miles, which makes it the 17th largest county in the state. The estimated persons per square mile of just over 400, however, makes Lexington among the most densely populated counties. Only the counties of Greenville, Richland, and Charleston are more densely populated.[1]

[1] Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2017; U.S. Census Bureau, Population Division. Retrieved from http://www.sccounties.org/

The population of Lexington County is 75% White, 15% Black/African American, 6% Hispanic/Latino, and the remaining 4% is a combination of individuals of multi-racial, American Indian, Asian, Native Hawaiian, and Pacific Islander descent. Slightly more than 23% of county citizens are under 18 years of age, while 15% is 65 years of age and older. Of those under age 65, approximately 11% are without health insurance, which impacts the level of healthcare, particularly of a preventive nature, that they receive.[1]

The cities and towns within Lexington County include Lexington (county seat), Batesburg-Leesville, Cayce, Chapin, Gaston, Gilbert, Irmo, Pelion, South Congaree, Swansea, West Columbia, and a portion of Columbia (state capital). Although the county has experienced significant growth and development in the past several years, a large area of the county remains quite rural, with many farms and forests. There are several rivers, as well as Lake Murray, where residents and tourists take advantage of the natural beauty and recreational opportunities that Lexington County offers.

# RESPONSIBILITIES, CASE INVESTIGATION AND DISPOSITION

Per the South Carolina Code of Laws, certain deaths must be reported to the appropriate Coroner's Office so that an inquiry into the cause and manner of death may be initiated immediately. The specific types of deaths that are required to be reported include any that occur:

- As a result of violence.
- As a result of apparent suicide.
- When in apparent good health.
- When unattended by a physician.
- In any suspicious or unusual manner.
- While an inmate of a penal or correctional institution.
- As a result of stillbirth when unattended by a physician.

Upon notification that a death of any of the above circumstances has occurred in Lexington County, the Lexington County Coroner's Office promptly responds to the location of the decedent. When the Coroner and/or Deputy Coroner arrive on scene to conduct the investigation, they follow the same general procedural guidelines, making necessary modifications as the circumstances require. They will first identify and document all first responders present (fire, EMS, law enforcement, etc.), and interview them to obtain any relevant information, including alterations made to the scene, resuscitative efforts, any possible safety concerns, etc.

If first responders did not find any obvious indications that the death was violent or suspicious, the Coroner or Deputy Coroner will perform an initial walk-through of the scene to make general observations, while taking notes and photographs. If for any reason the death appears suspicious, the Coroner or Deputy Coroner will immediately discontinue their observation and contact the appropriate law enforcement agency. No

further entry or observations will be conducted until the required investigators and personnel are present.

Law enforcement will almost always be on scene; the responding agency will be determined by the location and jurisdictional guidelines. LCCO, although conducting a separate and independent investigation, must coordinate with all law enforcement agencies. Depending on the circumstances surrounding a death, SLED and/or specific units, such as Crime Scene Investigation (CSI), from the responding law enforcement agency may be requested. The CSI unit of the appropriate agency will conduct an investigation in cases of violent or suspicious deaths, including homicides, suicides, and some deaths that are later determined to have been accidental or natural in manner. Some circumstances that prompt a scene investigation by SLED include: if a decedent was an inmate at a penal or correctional institution, if the decedent was in custody of law enforcement, or if a law enforcement officer was involved in the death.

When the investigation resumes, with all investigators present, the Coroner or Deputy Coroner will document and photograph anything that may be helpful in determining cause and manner of death, as well as date and time of death. Environmental details, such as living conditions and climate, may be pertinent to how and when the death occurred. An assessment of the decedent's body is necessary to determine if the death may have been the result of injury, when the death occurred, and the identity of the decedent. In many cases, decedents are identified using government-issued photo ID's or physical characteristics specific to them, such as tattoos, scars, or other physical markings.

Another responsibility of the Coroner/Deputy Coroner is to collect any property on or near the decedent's body, and secure and document the property until it can be returned to the decedent's legal next of kin. Prescription medications belonging to decedents are also collected, documented, and secured by LCCO until they can be properly destroyed. Any evidence, or potential evidence, is documented by all agencies and collected by the appropriate agency for processing.

After the scene has been processed and physical information has been gathered by all agencies, the Coroner/Deputy Coroner requests the assistance of a contracted removal service to transport the decedent. All decedents are removed and transported respectfully, and according to DHEC policies. Decedents remain in one of two secure morgue locations until all necessary identification confirmation and/or an autopsy is completed. In order to obtain positive identification of a decedent, LCCO may utilize one or more of the following methods: forensic anthropology analysis (skeleton/bones); DNA analysis; forensic odontology (dental X-rays); fingerprint analysis; the presence of prosthetics and/or birth defects.

If there are family members, witnesses, and/or potential suspects on scene, they will be interviewed in order to obtain as many details as possible. The questions asked by LCCO may vary, based on the specific situation, but the information that is typically requested includes: the decedent's identity; when and by whom the decedent was discovered; next of kin and primary physician of the decedent; account of what happened, including decedent's actions; date and time decedent was last seen or spoken to; decedent's past medical, social, and family history.

In the event that no family members or persons familiar with the decedent are present at the scene, every effort is made by the Coroner or Deputy Coroner to locate and notify the legal next of kin as soon as possible. Any notifications within Lexington County, whether related to a death being investigated by LCCO or another jurisdiction, are made by the Coroner or Deputy Coroner in person. When necessary, LCCO contacts the appropriate agencies in other jurisdictions to make notifications.

When an autopsy is necessary, LCCO notifies one of two contracted vendors, Pathology Associates of Lexington or MUSC Department of Pathology. The circumstances of a death dictate which vendor will be used; for example, MUSC performs autopsies of all potential homicide victims. When MUSC performs an autopsy, related specimens are taken to the SLED crime lab or NMS Labs, a nationally accredited laboratory for toxicology, or other required, testing. Toxicology testing of specimens related to autopsies conducted by Pathology Associates of Lexington is performed by NMS Labs.

In cases of violent or suspicious deaths, the law enforcement agency responsible for investigating may choose to attend the autopsies. Upon completion of an autopsy, the decedent's legal next of kin is contacted and made aware of any available findings.

When a decedent was known to suffer from significant health conditions, and the scene investigation produced no reason to suspect the death was not natural, the decedent's physician may be willing to certify his or her death. If for any reason the decedent's physician is unavailable or unwilling to do so, medical records may be obtained by LCCO. After a thorough review of those records, the Coroner may certify the death as natural without requiring an autopsy.

The next of kin is responsible for selecting a funeral home and informing LCCO when a decision has been made. The decedent is then released by LCCO to the appropriate funeral home. In the event that no next of kin can be located or the next of kin is financially incapable of procuring the services of a funeral home, county resources are appropriated to provide cremation services.

Whenever possible, the Lexington County Coroner's Office works with We Are Sharing Hope SC, the not-for-profit, federally designated organ procurement organization, to effectuate the wishes of each decedent and his/her family. In some situations, unfortunately, organs and tissues do not meet the standards of quality and condition necessary for donation. Several organs, such as the heart, lungs and kidneys, may be transplanted. Tissues, including corneas, tendons, veins and skin, are among those that can be donated.

The Solicitor's Office, Public Defender's Office, and law enforcement agencies may, in some cases, request a copy of the investigative report compiled by the Coroner's Office. In order to ensure that these requests may be fulfilled and the reports are helpful, the Coroner and Deputy Coroners promptly complete thorough reports.

The Lexington County Coroner's Office is also responsible for keeping the public informed, which we do by communicating with the media. Various local news outlets, including newspapers and television stations, are often aware of certain types of deaths early in an investigation. The law enforcement agency involved may make an initial statement to the media regarding the situation, but LCCO must provide some additional information as it becomes available.

# MANNERS AND CAUSES OF DEATH

The specific injury or condition that led or directly contributed to an individual's death is known as the **cause of death**. The different specific causes are innumerable, and they vary enormously. For example, a cause of death may be Lung Cancer, Asphyxiation, Exsanguination, Myocardial Infarction, or any conceivable disease or injury.

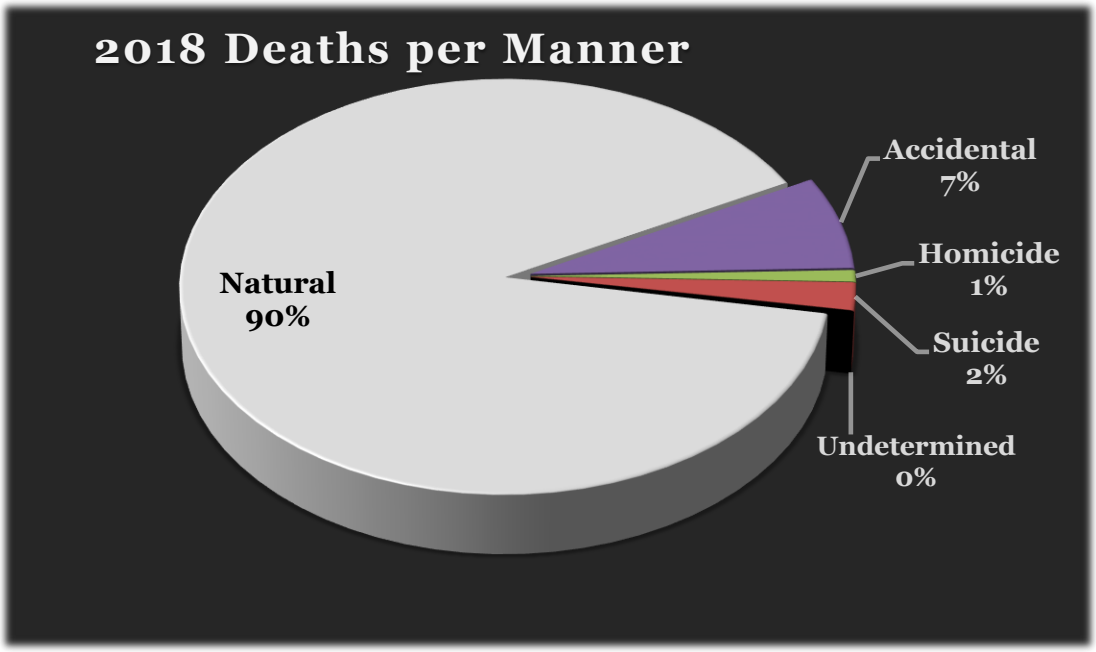
Although the cause of death is typically determined by a decedent's medical history, injuries found during an autopsy and/or toxicology testing, the **manner of death** is determined by the circumstances surrounding the cause. For instance, if a death was caused by a disease, then the manner would be natural. The manner of death is limited to one of the following five classifications:

- **Accident:** Deaths that are not natural but lack any evidence of intent on the part of the decedent or others; motor vehicle collisions, falls, unintentional drug overdoses, etc.
- **Homicide:** Deaths that result from injuries, whether intentionally or negligently, inflicted by another person or people.
- **Natural:** Deaths that occur due to diseases or health conditions that were not the result of some unnatural event.
- **Suicide:** Death resulting from the intentional and purposeful action of a decedent to end his/her life. In some cases, such as drug overdoses, if there are no letters left to establish intent and the individual had not threatened or attempted suicide previously, the death would be classified as an accident.
- **Undetermined:** Deaths are assigned this manner when the evidence and information obtained is insufficient or contradictory, particularly regarding intent, making it impossible to determine a specific manner.

# 2018 MANNERS OF DEATH

## Total Deaths: 2,347

| | |
|---|---|
| Natural: | 2,098 |
| Accidental: | 173 |
| Undetermined: | 5 |
| Homicide: | 21 |
| Suicide: | 50 |




## Additional Services Provided in 2018

| | |
|---|---|
| Cremation Permits (for non-LCCO cases): | 235 |
| Cremation Permits (for LCCO cases): | 1,040 |
| Notifications for Other Jurisdictions: | 26 |
| Indigent Cremations / Burials: | 19 |
| **Total Service Requests:** | **1,320** |

Consistent with statewide and national mortality statistics, the majority (89.4%) of deaths in Lexington County were determined to be natural in manner. Natural deaths in Lexington County accounted for 2,098 of the 2,347 total deaths. Deaths that do not require on-scene investigation, such as deaths of individuals under hospice care, do receive limited investigations. Of the 2,098 natural deaths handled by the Lexington County Coroner's Office in 2018, 1,733 required only limited investigations. The remaining 365 received full, on-scene investigations.

In addition to those 365 natural deaths, the combined 249 deaths classified as accidental, undetermined, homicide, or suicide received full on-scene investigations. Of the 614 fully investigated deaths in Lexington County, 177 required full autopsies, 87 received external examinations, 4 required a partial autopsy, and toxicology testing was performed in all of these cases, as well as 17 that required only toxicology testing, to determine the cause of death. Following the necessary postmortem examinations and/or testing, it was concluded that 173 deaths (7%) were accidental, 50 deaths (2%) were suicides, 21 deaths (1%) were homicides, and only 5 (<1%) were of an undetermined or pending manner.

| | *Natural* | *Accidental* | *Undetermined* | *Homicides* | *Suicides* |
|---|---|---|---|---|---|
| **# of Full Autopsies** | **82** | **62** | **5** | **20** | **8** |
| **# of Partial Autopsies** | **1** | **1** | **0** | **0** | **2** |
| **# of External Examinations** | **1** | **49** | **0** | **0** | **37** |
| **Toxicology Testing (Only)** | **4** | **12** | **0** | **0** | **1** |
| **Total Cases (excluding limited investigations)** | **365** | **173** | **5** | **21** | **50** |
| **% of Cases that Received Autopsy and/or Toxicology Testing** | **24.1%** | **71.7%** | **100%** | **95.2%** | **96%** |

As shown in the table, natural deaths are the only manner of which a majority did not receive autopsies and/or toxicological testing. The primary reasons for conducting autopsies in cases determined to have been natural deaths were: lack of significant recorded medical history, no physician was familiar with the decedent, the condition of the decedent when found made it difficult to determine if injuries were present, and there was a possibility that the death was the result of an unnatural event (e.g. fall, unintentional injury).

In certain accidental death cases, autopsies were not required because the decedents had survived for long enough periods in the hospital that records from diagnostic procedures, such as radiology reports, were available and provided the information necessary to establish cause of death. Additional investigative procedures were completed in order to determine the manner of death in these cases. In other accidental deaths that did not receive autopsies, the cause of death was apparent and the manner was investigated.

Nearly all suspicious deaths and obvious homicides required some type of postmortem examination; typically a full autopsy or analysis by a forensic anthropologist. In 2018, the only homicide that did not receive a full autopsy was a case in which the victim survived for days in the hospital. Homicides typically require a full autopsy or analysis for the purpose of obtaining items and information of evidentiary value because they will hopefully result in criminal proceedings.

Some families may object to the performance of an autopsy for cultural or religious reasons. While we respect all beliefs, autopsies may be unavoidable in certain cases. For instance, it is important for the grieving process, as well as insurance purposes, to distinguish an accident from a suicide. Providing all possible evidence in a homicide case is also important to ensure that justice is carried out. The law provides LCCO with the authority to perform autopsies, regardless of objections, in order to fulfill our legal responsibility to determine manner and cause of death. However, every effort will be made to help families understand, as well as to enable their adherence to time constraints set forth by cultural/religious burial customs and death rituals.

# 2018 NATURAL DEATH STATISTICS

**Total Deaths: 2,098**

**On-Scene Investigations: 365** **Limited Investigations: 1,733**

| *Race* | |
|---|---|
| White: | 1,806 |
| Black: | 257 |
| Hispanic: | 17 |
| Other: | 18 |

| *Gender* | |
|---|---|
| Male: | 993 |
| Female: | 1,105 |

| *Age* | |
|---|---|
| Fetus: | 24 |
| Birth - 10 years: | 5 |
| 11 - 20 years: | 4 |
| 21 - 30 years: | 8 |
| 31 - 40 years: | 22 |
| 41 - 50 years: | 64 |
| 51 - 60 years: | 196 |
| 61 - 70 years: | 381 |
| 71 - 80 years: | 499 |
| 81 - 90 years: | 594 |
| 91 - 100 years: | 290 |
| 101+ years: | 11 |

| *Deaths per Day* | |
|---|---|
| Monday: | 278 |
| Tuesday: | 309 |
| Wednesday: | 287 |
| Thursday: | 271 |
| Friday: | 309 |
| Saturday: | 352 |
| Sunday: | 292 |

| *Month* | |
|---|---|
| January: | 218 |
| February: | 190 |
| March: | 183 |
| April: | 162 |
| May: | 188 |
| June: | 163 |
| July: | 169 |
| August: | 179 |
| September: | 157 |
| October: | 148 |
| November: | 150 |
| December: | 191 |

| *Race and Gender* | |
|---|---|
| White Males: | 856 |
| White Females: | 950 |
| Black Males: | 116 |
| Black Females: | 141 |
| Hispanic Males: | 12 |
| Hispanic Females: | 5 |
| Other Males: | 9 |
| Other Females: | 9 |

| | |
|---|---|
| **Average age:** | 74.8 |
| **Oldest:** | 111 |

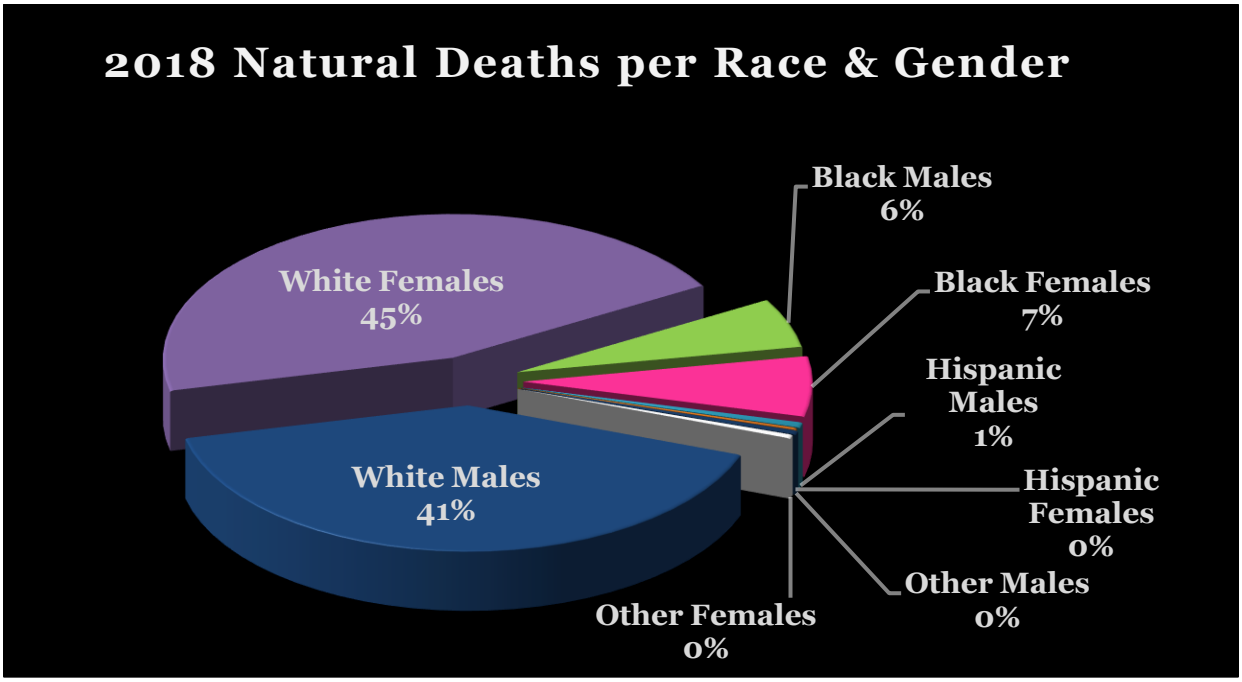
| *Number of Natural Deaths per Specific Cause* | |
|---|---|
| Heart-Related: | 520 |
| Cancer / Malignant Neoplasms: | 492 |
| Alzheimer's / Dementia / Neurodegenerative: | 352 |
| Chronic Lower Respiratory Diseases: | 229 |
| Cerebrovascular Diseases / Strokes: | 119 |
| Kidney-Related: | 105 |
| Liver-Related: | 63 |
| Influenza / Pneumonia: | 57 |
| Gastrointestinal: | 37 |
| Diabetes Mellitus: | 37 |
| Septicemia: | 34 |
| Short Gestation / Congenital Anomalies: | 28 |
| Adult Failure to Thrive: | 16 |
| HIV: | 5 |
| Other: | 4 |

In regard to the deaths reported to and investigated by the Lexington County Coroner's Office in 2018, 92% (2,160) were attributed to ten leading causes of death. Those ten causes, which include accidents and suicides along with eight natural causes, were very similar to the most recently reported leading causes nationally and statewide. Nine of the leading causes of death in 2018 in Lexington County were also present among the top ten causes based on 2016 data for the nation. The tenth leading cause of 2018 deaths in the county, intentional self-harm (suicide), was ranked tenth nationally in 2016 and statewide in 2017. Chronic liver disease and cirrhosis was ranked eighth among deaths in the county, despite not being among the top ten nationally or in the state.

| Cause of Death | Rank | | | Deaths per Cause | | |
|---|---|---|---|---|---|---|
| ***Leading Causes, All Ages*** | U.S. (2016) | S.C. (2017) | Lex. County (2018) | U.S. (2016) | S.C. (2017) | Lex. County (2018) |
| Diseases of heart | 1 | 1 | 1 | 635,260 | 10,412 | 520 |
| Malignant neoplasms (cancer) | 2 | 2 | 2 | 598,038 | 10,346 | 492 |
| Accidents (unintentional injuries) | 3 | 3 | 5 | 161,374 | 3,143 | 173 |
| Chronic lower respiratory diseases | 4 | 4 | 4 | 154,596 | 2,980 | 229 |
| Cerebrovascular diseases | 5 | 5 | 6 | 142,142 | 2,690 | 119 |
| Alzheimer's disease | 6 | 6 | 3 | 116,103 | 2,549 | 352 |
| Diabetes mellitus | 7 | 7 | - | 80,058 | 1,535 | 37 |
| Influenza and pneumonia | 8 | - | 9 | 51,537 | 723 | 57 |
| Nephritis and nephrosis (kidney disease) | 9 | 8 | 7 | 50,046 | 948 | 105 |
| Intentional self-harm (suicide) | 10 | 10 | 10 | 44,965 | 838 | 50 |
| Septicemia | - | 9 | - | 40,613 | 884 | 34 |
| Chronic liver disease and cirrhosis | - | - | 8 | 40,545 | 718 | 63 |

Of the 2,744,248 deaths recorded in the U.S. in 2016, 74.1% were attributed to the ten leading causes. In 2017 in South Carolina, there were 49,408 deaths and 73.5% of those were due to the top ten causes of death.[2] [3]

As would be anticipated, considering the demographic information of the county detailed earlier in this report, a large majority of the natural deaths in 2018 were of White citizens. Also consistent with the county population, slightly less than 53% of the decedents were female. White individuals, not of Hispanic or Latino descent, represented 75% of the county population and 86% of the natural deaths, and were



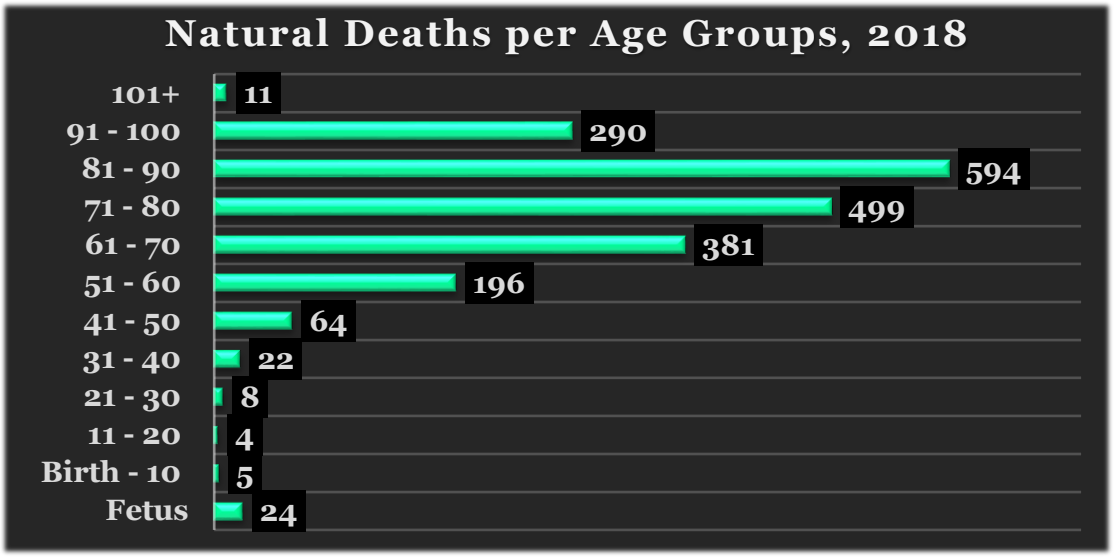

followed by Black or African American citizens who accounted for 12.25% of natural deaths (15% of population). While Hispanic or Latino individuals form 6% of the county population, they represented less than 1% of the natural deaths, and males and females of other origins, primarily Asian, accounted for slightly less than 1% of deaths.

Just under 85% (1,775) of natural deaths in 2018 were of individuals 61 years of age and over, with the oldest being 111 years. The most recent U.S. Census Bureau estimate (July, 2017) found that 15.4% of the population of Lexington County was of age 65 years

[2] Mortality in the United States. NCHS, National Vital Statistics System, Mortality. (2016).
[3] Mortality from Ten Leading Causes of Death. South Carolina Department of Health and Environmental Control, Division of Biostatistics. (2017).

and over. Slightly more than 17% of the state population was estimated at that time to be 65 years of age and older, and 34,760 (70.4%) of the 49,408 deaths in S.C. in 2017 were of residents of that age group. Statewide, the leading cause of death among residents between 65 and 84 years of age in 2017 was malignant neoplasms (cancer), and diseases of heart were the primary cause for those 85 years and over.

According to the National Center for Health Statistics (NCHS), the life expectancy for the U.S. population in 2016 was 78.6 years.[4] In cases of natural deaths only, which constituted 2,098 of deaths handled by LCCO in 2018, a total of 1,005 decedents were of age 79 years and older. There were 346 natural deaths of individuals 90 years of age and over. The leading causes of death among decedents of age 79 years and above were diseases of the heart, and Alzheimer's and other neurodegenerative diseases; 281 and 274 deaths were attributed to each of these causes, respectively. Cancer was the third leading cause among this age group with 150 deaths.

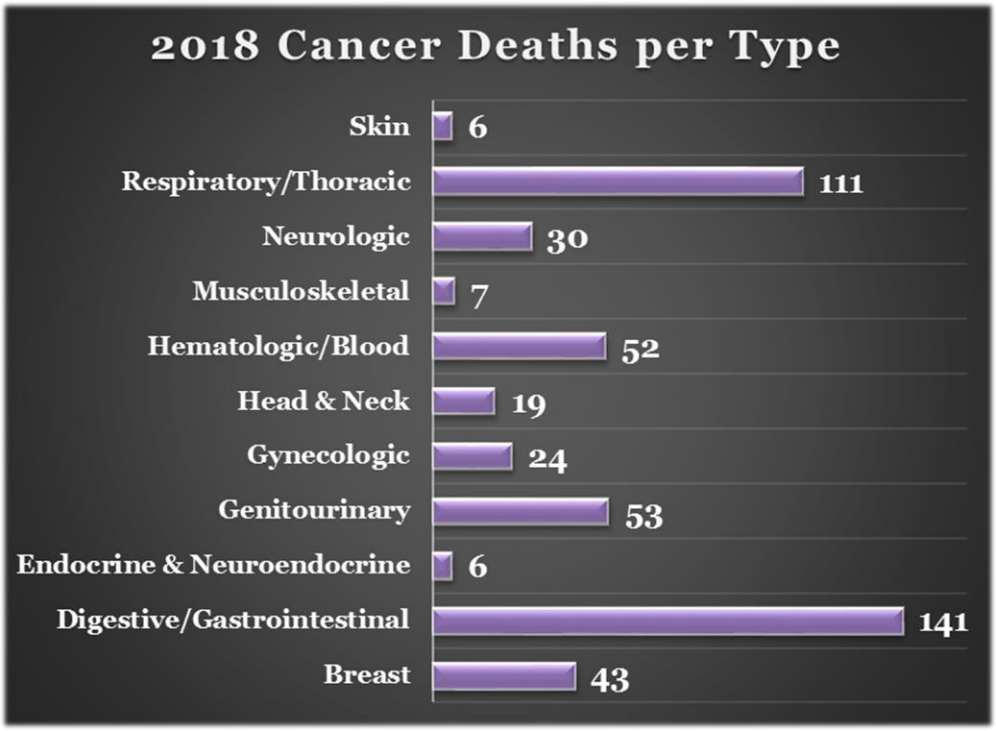



Of the 365 natural deaths in Lexington County that required full investigations in 2018, 217 of them involved decedents of the age 65 years and over. The largest percentage of those deaths were of White males (115) and White females (79), and the leading cause of death among that age group were diseases of the heart, which accounted for 131 of the

[4] Xu, J.Q., S.L. Murphy, K.D. Kochanek, and E. Arias. (2016). *Mortality in the United States, 2016*. NCHS data brief, no. 267. Hyattsville, MD: National Center for Health Statistics. https://www.cdc.gov/nchs/products/databriefs/db267.htm

fully investigated deaths. Cancer was determined to have been the cause of death in only 11 of the fully investigated deaths of individuals age 65 years and older; however, in the same age group, 336 of the deaths that required only limited investigations were due to cancer. The difference, primarily, was due to the utilization of hospice care.

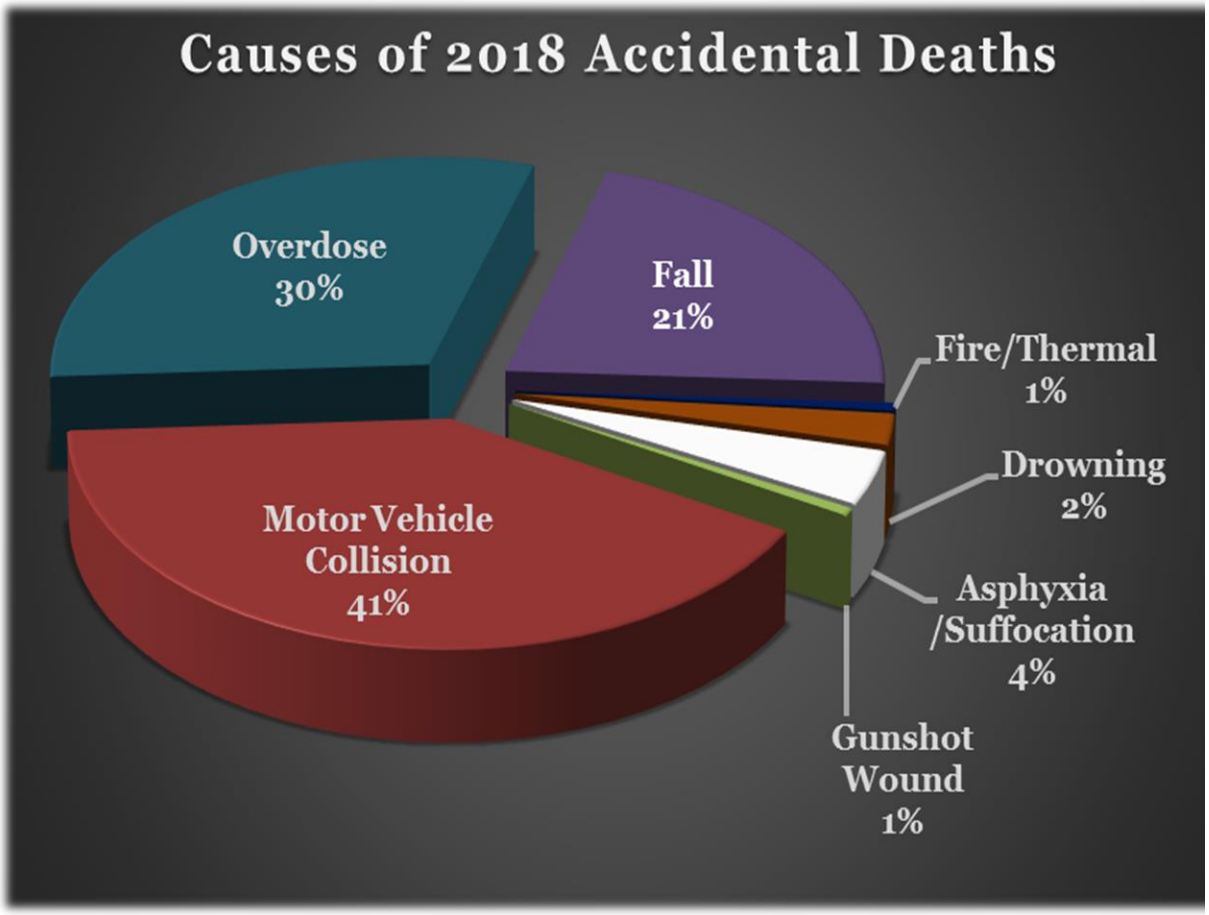
In 2018, malignant neoplasms, or cancer, caused 492 of the deaths in Lexington County, and 28.9% of those deaths were due to digestive/gastrointestinal cancers. Pancreatic, liver, colon, esophageal, gallbladder, stomach and rectal cancers are among those classified as digestive/gastrointestinal cancers. Respiratory/thoracic cancers include lung cancer, mesothelioma and carcinoma, and 22.6% of cancer deaths were attributed to those. Genitourinary cancers, which were the cause of 10.8% of cancer deaths, include cancers of the bladder, kidneys, prostate, penis, ureters, testicles, and urethra. Leukemia and lymphoma are classified as hematologic/blood cancers, and melanoma and sarcoma are skin cancers. Neurologic cancers develop in the brain or spinal cord, while head and neck cancers include laryngeal, neck, mouth, nasopharyngeal, sinus, salivary gland, and throat cancers. Cervical, endometrial, ovarian, peritoneal, vaginal, and vulvar cancers are among those classified as gynecologic cancers. Endocrine and neuroendocrine cancers originate in the endocrine system, which includes the thyroid, parathyroid, adrenal and pituitary glands.



# 2018 ACCIDENTAL DEATH STATISTICS

## Total Deaths: 173

| *Causes of Death* | *Deaths per Cause* | *Average Age per Cause* |
|---|---|---|
| Motor Vehicle Collision | 70 | 40 years |
| Overdose | 53 | 42 years |
| Fall | 37 | 75 years |
| Fire/Thermal | 1 | 52 years |
| Drowning | 4 | 49 years |
| Suffocation/Asphyxia | 7 | 21 years |
| Gunshot Wound | 1 | 34 years |



# 2018 MOTOR VEHICLE FATALITY STATISTICS

## Total Deaths: 70

### *Race*

| | |
|---|---|
| Black: | 21 |
| White: | 48 |
| Other: | 1 |

### *Gender*

| | |
|---|---|
| Male: | 51 |
| Female: | 19 |

### *Age*

| | |
|---|---|
| </=15 years: | 6 |
| 16 - 20 years: | 8 |
| 21 - 30 years: | 13 |
| 31 - 40 years: | 13 |
| 41 - 50 years: | 9 |
| 51 - 60 years: | 10 |
| 61 - 70 years: | 4 |
| 71 - 80 years: | 6 |
| 81+ years: | 1 |

### *Roadways with the Most Fatalities*

| | |
|---|---|
| Interstate 26: | 11 |
| Augusta Hwy: | 7 |
| Interstate 20: | 6 |
| Hwy 321: | 4 |
| Hwy 6: | 4 |

### *Collisions per Time of Day***

| | |
|---|---|
| Early Morning: | 20 |
| Late Morning: | 17 |
| Afternoon: | 13 |
| Night: | 20 |

### *Month*

| | |
|---|---|
| January: | 1 |
| February: | 7 |
| March: | 9 |
| April: | 10 |
| May: | 12 |
| June: | 5 |
| July: | 3 |
| August: | 1 |
| September: | 3 |
| October: | 8 |
| November: | 5 |
| December: | 6 |

| | |
|---|---|
| **Average age:** | 40 years |
| **Youngest:** | 3 years |
| **Oldest:** | 81 years |

### *Alcohol/Drugs*

| | |
|---|---|
| Contributed: | 20 |
| Average BAC: | 0.200 |
| Highest BAC: | 0.422 |
| Impaired Pedestrians: | 7 |

### *Fatalities per Weekday*

| | |
|---|---|
| Monday: | 10 |
| Tuesday: | 10 |
| Wednesday: | 11 |
| Thursday: | 10 |
| Friday: | 8 |
| Saturday: | 9 |
| Sunday: | 12 |

### *Race and Gender*

| | |
|---|---|
| Black Males: | 15 |
| Black Females: | 6 |
| White Males: | 35 |
| White Females: | 13 |
| Other Males: | 1 |
| Other Females: | 0 |

### *Type of Roadway*

| | |
|---|---|
| Two Lane: | 30 |
| Four Lane: | 20 |
| Interstate: | 18 |
| Railroad: | 2 |

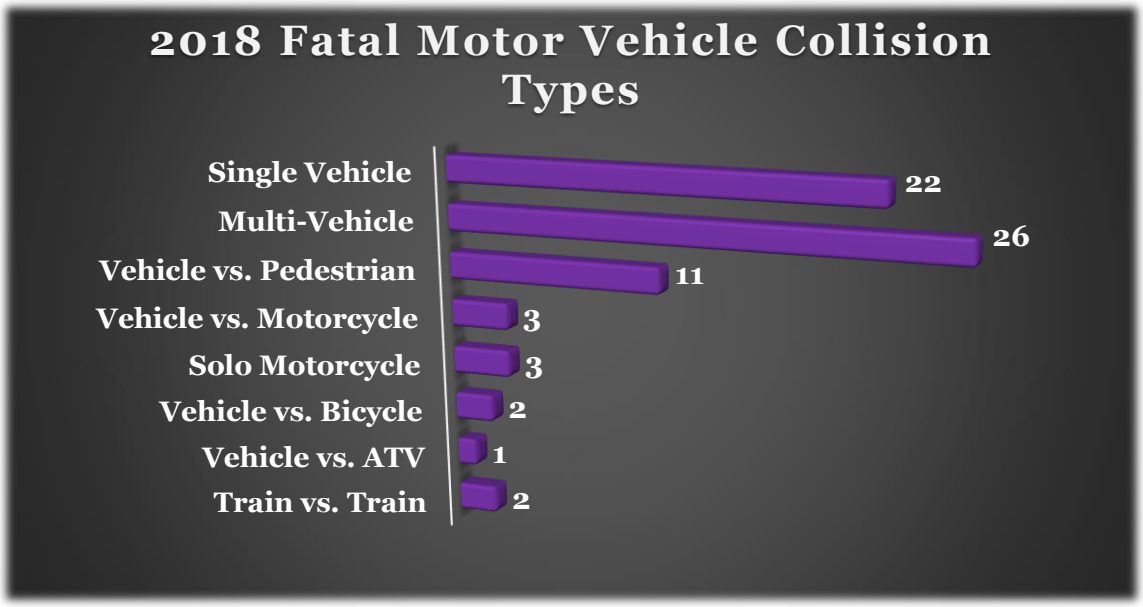
### *Position of Decedent*

| | |
|---|---|
| Vehicle Driver: | 37 |
| Vehicle Passenger: | 11 |
| Motorcycle/Moped Operator: | 6 |
| Pedestrian: | 11 |
| Bicyclist: | 2 |
| Train Personnel: | 2 |
| ATV Operator: | 1 |

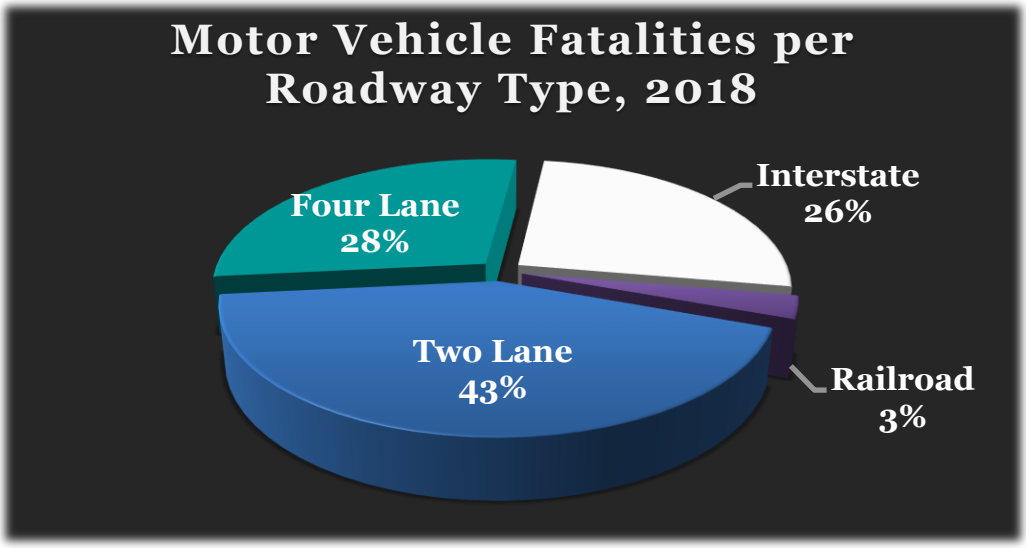
### *Type of Collision*

| | |
|---|---|
| Vehicle vs. Vehicle: | 21 |
| Single Vehicle: | 22 |
| Motorcycle vs. Vehicle: | 3 |
| Solo Motorcycle: | 3 |
| Vehicle vs. Pedestrian: | 11 |
| Train vs. Train: | 2 |
| Vehicle vs. Bicycle: | 2 |
| Vehicle vs. ATV: | 1 |
| Multiple Vehicles: | 5 |

**For the purpose of this report, the times of day are defined as: early morning is 12:00AM to 6:00AM; late morning is 6:00AM to 12:00PM; afternoon is 12:00PM to 6:00PM; and night is 6:00PM to 12:00AM.




In Lexington County there were 23 more motor vehicle fatalities in 2018 than 2017. The number of fatalities involving motorcycle/moped operators and passengers decreased, while the number of single-vehicle fatalities more than doubled. The number of fatal collisions that occurred on four-lane roadways also more than doubled. Of the 20 cases in which the decedent's toxicology report contained alcohol and/or drugs that may have contributed to the collision, seven were pedestrians, six were single-vehicle incidents, four involved two or more vehicles, and three were operating motorcycles. Two of the deaths in 2018 resulted from the collision of a passenger train with a freight train.



# 2018 ACCIDENTAL OVERDOSE STATISTICS

## Total Deaths: 53

| *Race* | |
|---|---|
| Black: | 1 |
| White: | 52 |
| Other: | 0 |

| *Gender* | |
|---|---|
| Male: | 33 |
| Female: | 20 |

| *Age* | |
|---|---|
| </=15 years: | 0 |
| 16 - 20 years: | 5 |
| 21 - 30 years: | 5 |
| 31 - 40 years: | 17 |
| 41 - 50 years: | 11 |
| 51 - 60 years: | 10 |
| 61 - 70 years: | 5 |
| 71+ years: | 0 |

| *Month* | |
|---|---|
| January: | 2 |
| February: | 5 |
| March: | 3 |
| April: | 7 |
| May: | 5 |
| June: | 4 |
| July: | 7 |
| August: | 4 |
| September: | 3 |
| October: | 4 |
| November: | 5 |
| December: | 4 |

| | |
|---|---|
| **Average age:** | 41.9 |
| **Youngest:** | 19 |
| **Oldest:** | 67 |

| *Cases per Substance*** *(Based on Tox Reports; Some Overlaps )* | |
|---|---|
| Alcohol | 2 |
| Amphetamine / Methamphetamine | 18 |
| Benzodiazipines | 19 |
| Cocaine | 8 |
| **Codeine & Metabolites** | **8** |
| Acetaminophen | 3 |
| **Fentanyl & Metabolites** | **22** |
| **Heroin** | **6** |
| Duloxetine/Fluoxetine | 6 |
| Methadone | 6 |
| **Morphine & Metabolites** | **13** |
| Tramadol & O-Desmethyltramadol | 3 |

**Substances in **bold** are opiates/opioids.

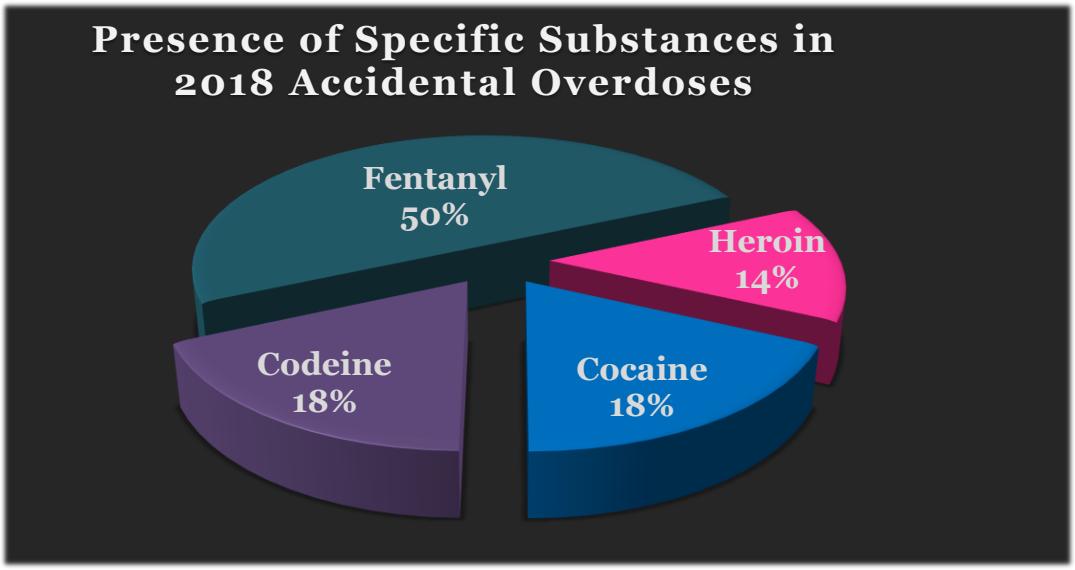
| *Marital Status* | |
|---|---|
| Single: | 22 |
| Married: | 12 |
| Divorced: | 14 |
| Widowed: | 4 |
| Separated: | 1 |

| *Race and Gender* | |
|---|---|
| Black Males: | 1 |
| Black Females: | 0 |
| White Males: | 32 |
| White Females: | 20 |

| *Location of Overdose* | |
|---|---|
| Batesburg: | 0 |
| Cayce: | 2 |
| Chapin: | 1 |
| Columbia: | 7 |
| Gaston: | 5 |
| Gilbert: | 3 |
| Leesville: | 3 |
| Lexington (29072): | 5 |
| Lexington (29073): | 9 |
| Pelion: | 4 |
| Swansea: | 2 |
| West Columbia: | 12 |

| *Highest Education Level* | |
|---|---|
| </= 8th grade: | 2 |
| 9th - 12th grade: | 6 |
| HS Diploma / GED: | 22 |
| Some College: | 9 |
| Associate degree: | 1 |
| Bachelor's degree: | 5 |
| Master's degree: | 4 |
| Higher degree: | 1 |
| Unknown: | 3 |

In consideration of the ongoing media coverage surrounding the heroin/opioid epidemic, the number of cases in which heroin appeared on the toxicology report seems low. There are many factors to consider, however, prior to making this judgment. First and foremost, those six deaths, along with the other 47, were enormous losses, particularly to the loved ones of those individuals, and those deaths were entirely preventable. Additionally, heroin is only one of many opioids and opiates, including prescription medications such as morphine, fentanyl, and codeine. Another important factor is that heroin metabolizes very rapidly in the body, which prevents its detection in many cases. There are certain metabolites, such as 6-MAM, that can only result from heroin use. The presence of fentanyl, morphine, and other substances may also be indicative of heroin use.[5]




Morphine, specifically, may be an indication of heroin use because heroin is a derivative of a potent form of morphine. At the turn of the 20th century, heroin was heralded as the alternative to the addictive morphine. However, in 1924 heroin was prohibited in the U.S. due to the discovery that it essentially was a more potent, highly addictive form of morphine.[6] The illicit form of heroin that we know today exists in a variety of forms

[5] Bedford, K. *Opiate Chemistry and Metabolism*. XII-Biotech-C-Opiate Chemistry. http://www.nzic.org.nz/ChemProcesses/biotech/12C.pdf

[6] *Substances – Heroin*. New York University Center for Health, Identity, Behavior and Prevention Studies. (2017). http://steinhardt.nyu.edu/appsych/chibps/heroin

and purity levels. Pure heroin is typically cut with additive substances prior to distribution; these additives vary from powdered milk to poisonous substances, such as strychnine or quinine.[7]

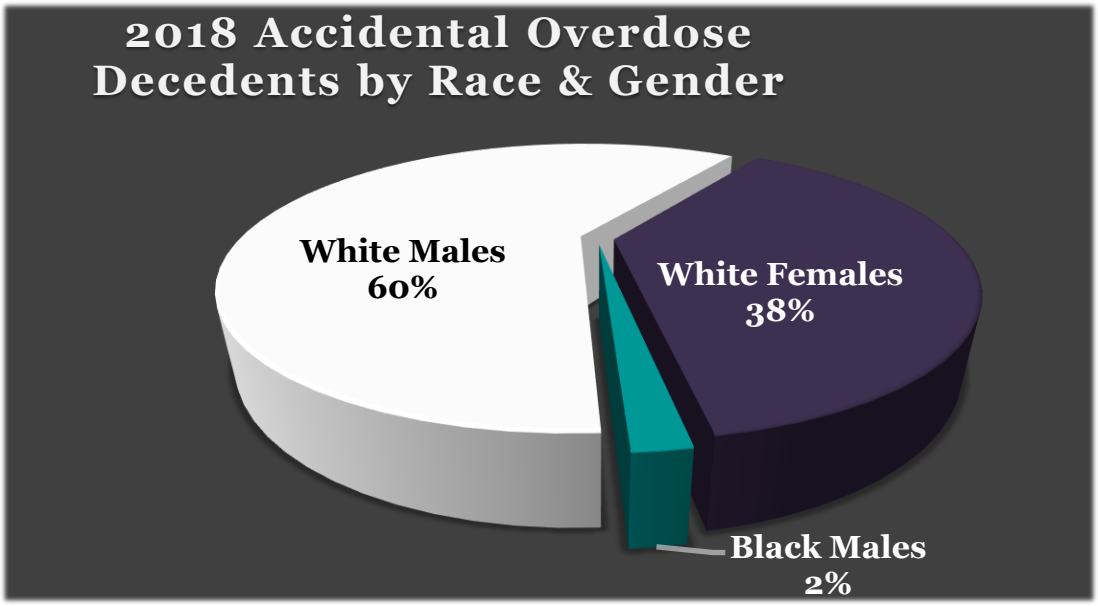
Fentanyl, an analgesic more potent than morphine, may indicate heroin use because it is sometimes used as an additive or cutting agent, creating a highly lethal combination. Fentanyl-laced heroin is so dangerous that it created an epidemic of its own across the U.S. in 2006. Users are typically unaware of the precise composition of the heroin that they purchase and risk encountering an especially lethal combination, such as heroin and fentanyl, which can elicit immediate respiratory failure.[8]

Opioids have historically been prescribed and used for pain management; however, the potential for misuse of legally available opioids is great. Repeated improper use of prescription painkillers may create an increased tolerance that leads to heroin use when the legal opioids are no longer available or strong enough. Abuse of prescription opioids also presents serious health risks that could be fatal.[8] According to the CDC, opioids were involved in 47,600 deaths in the U.S. in 2017.[9] Of the 53 overdose fatalities in Lexington County in 2018, 34 were opioid-related, and several of those decedents were known to have undergone surgical procedures, and/or had suffered from chronic pain or serious illness for which opioid painkillers were prescribed. Thirty-four of the fifty-three individuals whose deaths were due to overdose were known to have been prescribed at least one opioid painkiller. Most of those decedents did not have the prescription opioid in their systems; rather they had ingested or injected lethal amounts of fentanyl and/or heroin.

[7] "The Purity of Heroin". Retrieved from http://heroin.net/types-of-heroin/heroin-purity/

[8] http://www.samhsa.gov/atod/opioids

[9] Centers for Disease Control and Prevention. "Drug Overdose Deaths – United States, 2016 to 2017." Retrieved from https://www.cdc.gov/drugoverdose/data/statedeaths.html

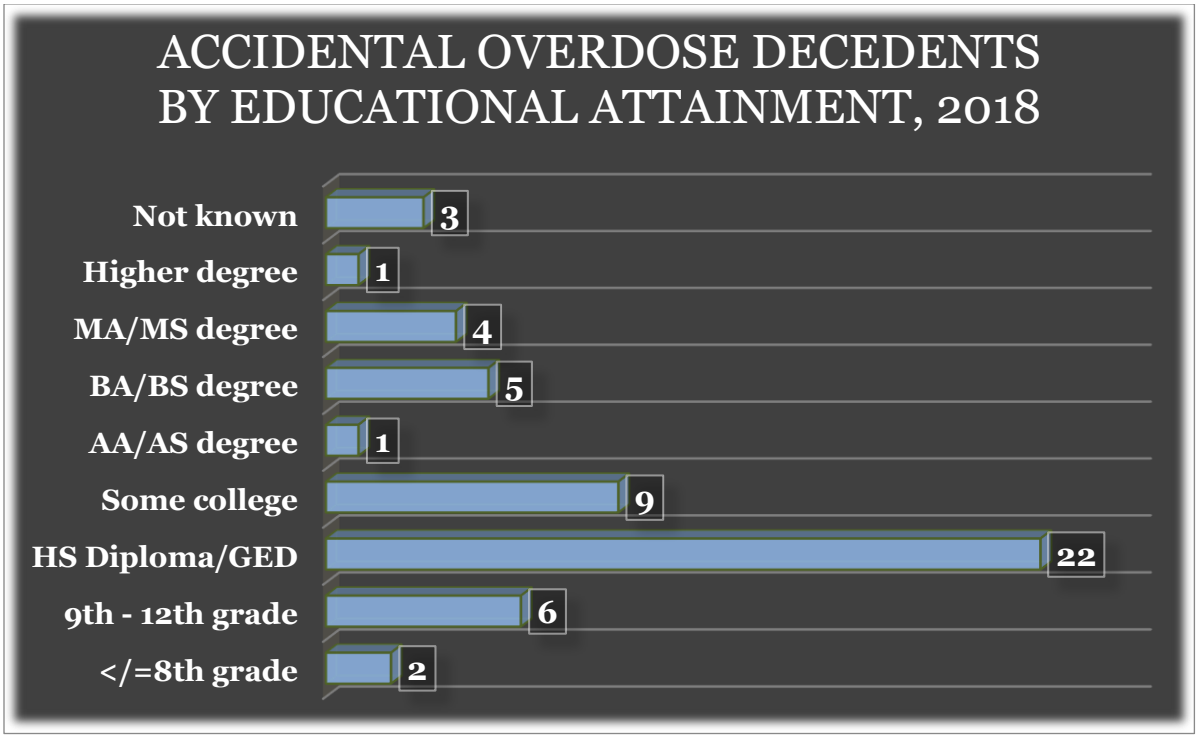



The National Survey on Drug Use and Health (NSDUH) revealed that 11.1 million Americans, aged 12 years or older, admitted to misuse of prescription pain relievers in 2017, and 5.3 million people surveyed had used heroin at some point in their lives.[9] According to the National Advisory Committee on Rural Health and Human Services, rural areas have an increased risk of opioid addiction and opioid overdose fatalities. Residents of rural areas, like Lexington County, are more likely to have physically demanding occupations that make them prone to injuries for which opioids may be prescribed for pain management. Socioeconomic factors that increase vulnerability to opioid addiction and overdose include educational attainment, lack of health insurance, low income, and poor health.[10]

According to the National Advisory Committee on Rural Health and Human Services, another of the factors that has contributed to the increase in opioid-related deaths in rural areas is the limited access to adequate treatment. There are fewer evidence based treatment programs, such as medication-assisted treatment, counseling, and social

[10] National Advisory Committee on Rural Health and Human Services. "Families in Crisis: The Human Service Implications of Rural Opioid Misuse." (2016).

support programs, available in rural areas. In order to be most effective medications, like methadone, that are used to help people addicted to heroin and other opiates must be part of a comprehensive program. Without the necessary counseling and support, patients can become addicted to methadone and take too much due to lack of supervision. Methadone, although effective in lessening the painful symptoms of withdrawal from opioids, is dangerous and may lead to negative health effects and death due to overdose.[11] Six of the accidental overdose deaths in Lexington County were the result of methadone.




[11] Substance Abuse and Mental Health Services Administration. "Methadone." https://www.samhsa.gov/medication-assisted -treatment/treatment/methadone

# 2018 FATAL ACCIDENTAL FALL STATISTICS

## Total Deaths: 37

### *Race*

| | |
|---|---|
| Black: | 2 |
| White: | 34 |
| Other: | 1 |

### *Gender*

| | |
|---|---|
| Male: | 20 |
| Female: | 17 |

### *Age*

| | |
|---|---|
| >/=30 years: | 0 |
| 31 – 40 years: | 1 |
| 41 – 50 years: | 2 |
| 51 – 60 years: | 3 |
| 61 – 70 years: | 7 |
| 71 – 80 years: | 8 |
| 81 – 90 years: | 10 |
| 91 – 100 years: | 6 |
| 101+ years: | 0 |

### *Month*

| | |
|---|---|
| January: | 5 |
| February: | 1 |
| March: | 4 |
| April: | 3 |
| May: | 3 |
| June: | 2 |
| July: | 0 |
| August: | 2 |
| September: | 1 |
| October: | 7 |
| November: | 6 |
| December: | 3 |

| | |
|---|---|
| **Average age:** | 75 years |
| **Youngest:** | 33 years |
| **Oldest:** | 95 years |

### *Race and Gender*

| | |
|---|---|
| Black Males: | 2 |
| Black Females: | 0 |
| White Males: | 18 |
| White Females: | 16 |
| Other Males: | 0 |
| Other Females: | 1 |

### *Location of Fall*

| | |
|---|---|
| Residence: | 26 |
| Nursing home/Facility: | 7 |
| Public Parking Lots: | 3 |
| Workplace: | 1 |

### *Cause of Death (due to or in conjunction with fall)*

| | |
|---|---|
| Hematoma/Hemorrhage: | 26 |
| Fracture(s)/Sepsis: | 5 |
| Brain/Spine Injury: | 5 |
| Organ Damage: | 1 |

- 54% of decedents were male.
- 65% of decedents were 70 years or older.
- 70% of decedents fell at their homes.
- 19% of decedents fell while in nursing facilities.
- Alzheimer's / Dementia may have contributed to 32% of falls.
- Cause of death was a hemorrhage or hematoma in 70% of fall-related deaths.

### *Cases per Factors that Contributed to Fatal Falls*

| | |
|---|---|
| Alzheimer's / Dementia: | 12 |
| Alcohol / Drugs: | 5 |
| Limited Mobility / Other Medical Condition: | 4 |

# 2018 OTHER ACCIDENTAL DEATH STATISTICS

## Total Deaths: 13

## *Accidental Drowning Deaths: 4*

### *Age*

| | |
|---|---|
| </= 20 years: | 0 |
| 21 - 30 years: | 0 |
| 31 - 40 years: | 1 |
| 41 - 50 years: | 2 |
| 51 - 60 years: | 0 |
| 61 - 70 years: | 1 |
| 71 - 80 years: | 0 |
| 81 - 90 years: | 0 |

| | |
|---|---|
| **Average Age:** | 49 years |
| **Youngest:** | 34 years |
| **Oldest:** | 70 years |

### *Month*

| | |
|---|---|
| January: | 0 |
| February: | 1 |
| March: | 0 |
| April: | 1 |
| May: | 0 |
| June: | 1 |
| July: | 0 |
| August: | 1 |
| September: | 0 |
| October: | 0 |
| November: | 0 |
| December: | 0 |

### *Race and Gender*

| | |
|---|---|
| Black Males: | 2 |
| Black Females: | 0 |
| White Males: | 1 |
| White Females: | 0 |
| Other Males: | 1 |
| Other Females: | 0 |

### *Incident Location Type*

| | |
|---|---|
| Lake: | 1 |
| Pond: | 2 |
| River: | 1 |

## *Fire-Related, Firearm, and Adult Asphyxia Deaths: 5*

| | |
|---|---|
| **Average Age:** | 46 years |
| **Youngest:** | 30 year |
| **Oldest:** | 84 years |

### *Deaths per Specific Cause*

| | |
|---|---|
| Positional Asphyxia (Seizure; Broken chair): | 2 |
| Asphyxiation (Food): | 1 |
| Accidental Discharge of Firearm: | 1 |
| Thermal Injuries/Smoke Inhalation (House fire): | 1 |

### *Race and Gender*

| | |
|---|---|
| Black Males: | 1 |
| Black Females: | 0 |
| White Males: | 2 |
| White Females: | 2 |
| Other Males: | 0 |
| Other Females: | 0 |

### *Adult Asphyxia Deaths*

- Ages: 30 years, 30 years, 84 years
- Two White Females and One White Male
- One death in May, and two in October
- One death on a Monday, and two on Friday
- One decedent suffered from epilepsy and developmental delays
- One decedent suffered from Cerebral Palsy and a seizure disorder

### *Fire-Related Death*

- 52-year-old
- White Male
- December
- Sunday

### *Firearm Death*

- 34-year-old
- November
- Black Male
- Friday
- Handgun was in decedent's possession

## *Infant Deaths due to Co-Sleeping: 4*

| *Ages* | *Race and Gender* | | *Months and Days* | | | |
|---|---|---|---|---|---|---|
| 4 weeks | Black Males: | 3 | March: | 1 | Sunday: | 2 |
| 10 weeks | Black Females: | 0 | November: | 1 | Tuesday: | 1 |
| 4 months | White Males: | 1 | December: | 2 | Thursday: | 1 |
| 5 months | White Females: | 0 | | | | |

****Each of these tragedies occurred because of unsafe sleeping conditions. These infants were sleeping in the same bed, or on a couch, with one or both parents. These deaths are alarmingly frequent and entirely preventable. There is absolutely no justification for placing a helpless infant in a possibly lethal situation, regardless of the urge to pacify or comfort the infant.****

# 2018 HOMICIDE STATISTICS

## Total Deaths: 21

| *Race* | |
|---|---|
| Black: | 7 |
| White: | 12 |
| Other: | 2 |

| *Gender* | |
|---|---|
| Male: | 20 |
| Female: | 1 |

| *Age* | |
|---|---|
| </=15 years: | 3 |
| 16 - 20 years: | 0 |
| 21 - 30 years: | 9 |
| 31 - 40 years: | 5 |
| 41 - 50 years: | 3 |
| 51 - 60 years: | 1 |
| 61 - 70 years: | 0 |
| 71 - 80 years: | 0 |
| 81+ years: | 0 |

| *Incident Locations* | |
|---|---|
| Columbia: | 1 |
| Gaston: | 4 |
| Irmo: | 2 |
| Lexington: | 2 |
| Pelion: | 1 |
| West Columbia: | 11 |

| *Month* | |
|---|---|
| January: | 4 |
| February: | 0 |
| March: | 2 |
| April: | 1 |
| May: | 0 |
| June: | 1 |
| July: | 6 |
| August: | 2 |
| September: | 2 |
| October: | 1 |
| November: | 1 |
| December: | 1 |

| *Race and Gender* | |
|---|---|
| Black Males: | 7 |
| Black Females: | 0 |
| White Males: | 11 |
| White Females: | 1 |
| Other Males: | 2 |
| Other Females: | 0 |

| *Methods* | |
|---|---|
| Firearm: | 17 |
| Asphyxiation: | 2 |
| Blunt Force: | 1 |
| Toxic Substance: | 1 |

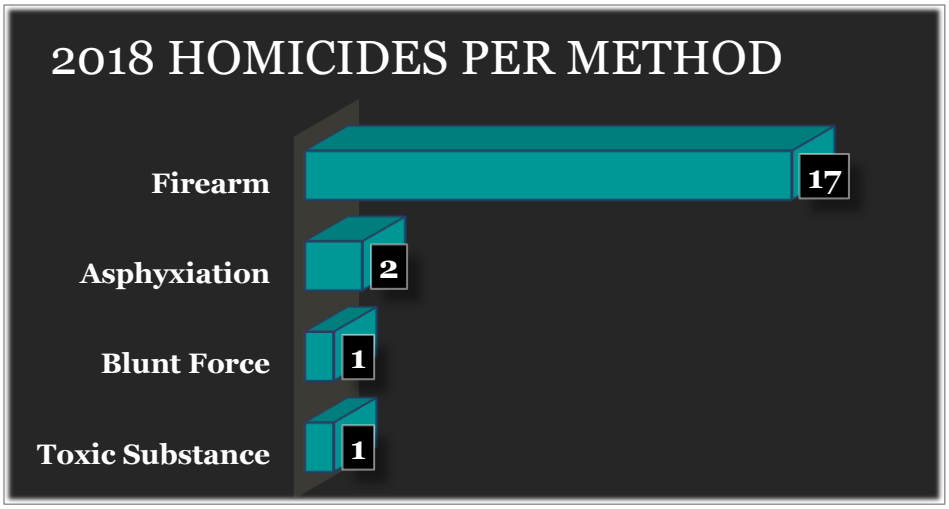
| | |
|---|---|
| **Average age:** | 29 years |
| **Youngest:** | <1 day |
| **Oldest:** | 55 years |

| *Day* | |
|---|---|
| Monday: | 1 |
| Tuesday: | 3 |
| Wednesday: | 2 |
| Thursday: | 6 |
| Friday: | 5 |
| Saturday: | 2 |
| Sunday: | 2 |

| *Shooting Victims* | |
|---|---|
| Black Males: | 6 |
| Black Females: | 0 |
| White Males: | 10 |
| White Females: | 0 |
| Other Males: | 1 |
| Other Females: | 0 |
| Average Age: | 34 years |

- 95% of victims were male.
- Firearms were used in 81% of cases.
- 67% of victims were between the ages of 20 and 40 years.
- 52% of incidents occurred in West Columbia.

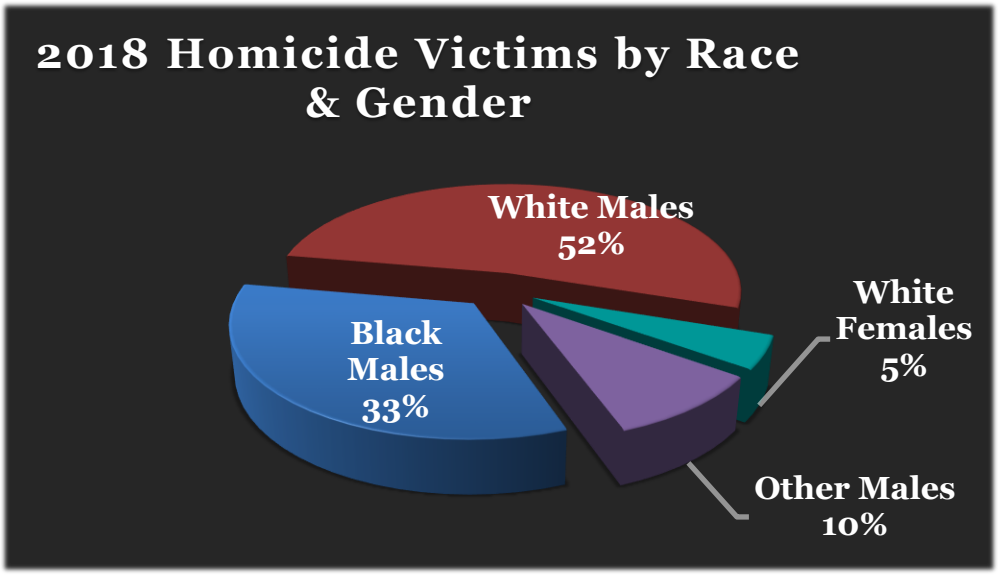
As was the case nationally in 2017, a large majority (81%) of homicides in Lexington County in 2018 were committed by use of a firearm. According to the FBI's Uniform Crime Reporting (UCR) Program, there were 15,129 homicides in the United States in 2017, and 72.6% (10,982) of those involved firearms. Less than 1% of homicide victims nationally were asphyxiated, 3.1% were killed using blunt force of a nature similar to that used in Lexington County, and 10.5% (1,591) were fatally injured by use of knives or cutting instruments.



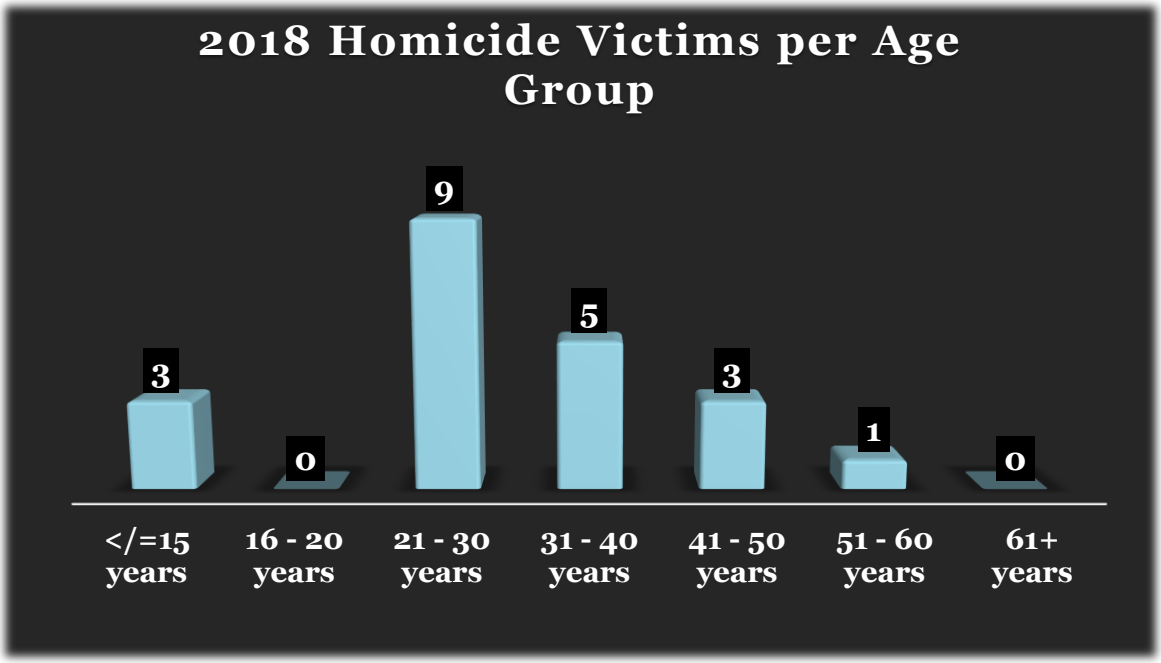

According to the FBI's UCR, the relationship between homicide victims and offenders was known by authorities in 50% of the 2017 cases. Among those cases, the largest percentage (28%) of homicide victims were killed by someone they knew other than family members (neighbor, boyfriend, employee, friend, acquaintance, etc.), 12.3 percent were killed by family members, and 9.7 percent of offenders were strangers to their victims. Although not all of the offenders of the homicides in this county in 2018 are known, and some are only suspected, most were likely known by their victims. It is known or suspected that at least seven of the twenty-one victims were killed by spouses or family members, and more than half were at least acquaintances with the offenders.

Over half, 54.1%, of homicide victims in the U.S. in 2017 were between the ages of 20 and 40 years, 51.9% were Black or African American, and over 78 percent were male.[12]

[12] Federal Bureau of Investigation. *Uniform Crime Reporting*; Homicide Data Tables. (2017). Retrieved from https://ucr.fbi.gov/crime-in-the-u.s/2017/crime-in-the-u.s.-2017/topic-pages/offenses-known-to-law-enforcement




Over half of the 2018 victims in this county were between the ages of 20 and 40, and 95% were male. Unlike in 2017, when 40% of the Lexington County homicide victims were White, more than half (57%) of the 2018 victims were White.



# 2018 SUICIDE STATISTICS

## Total Deaths: 50

### *Race*

| | |
|---|---|
| Black: | 2 |
| White: | 46 |
| Other: | 2 |

### *Gender*

| | |
|---|---|
| Male: | 39 |
| Female: | 11 |

### *Age*

| | |
|---|---|
| </=15 years: | 0 |
| 16 - 20 years: | 3 |
| 21 - 30 years: | 10 |
| 31 - 40 years: | 7 |
| 41 - 50 years: | 7 |
| 51 - 60 years: | 12 |
| 61 - 70 years: | 3 |
| 71 - 80 years: | 7 |
| 81+ years: | 1 |

### *Month*

| | |
|---|---|
| January: | 6 |
| February: | 4 |
| March: | 4 |
| April: | 5 |
| May: | 2 |
| June: | 5 |
| July: | 1 |
| August: | 7 |
| September: | 4 |
| October: | 2 |
| November: | 4 |
| December: | 6 |

### *Letters at Scene*

| | |
|---|---|
| Total: | 13 |
| Male: | 11 |
| Female: | 2 |

### *Race and Gender*

| | |
|---|---|
| Black Males: | 2 |
| Black Females: | 0 |
| White Males: | 35 |
| White Females: | 11 |
| Other Males: | 2 |
| Other Females: | 0 |

### *Methods*

| | |
|---|---|
| Firearm: | 30 |
| Hanging: | 16 |
| Overdose: | 3 |
| Carbon Monoxide: | 1 |

| | |
|---|---|
| **Average age:** | 48 years |
| **Youngest:** | 16 years |
| **Oldest:** | 85 years |

## Additional Information of Decedents 18 years of age and older:

### ***Education***

| | |
|---|---|
| </=8th grade: | 0 |
| 9th - 12th grade: | 9 |
| HS Diploma/GED: | 18 |
| Some college: | 9 |
| Associate degree: | 5 |
| Bachelor's degree: | 3 |
| Master's degree: | 4 |
| Higher degree: | 0 |
| Unknown: | 2 |

### ***Marital Status***

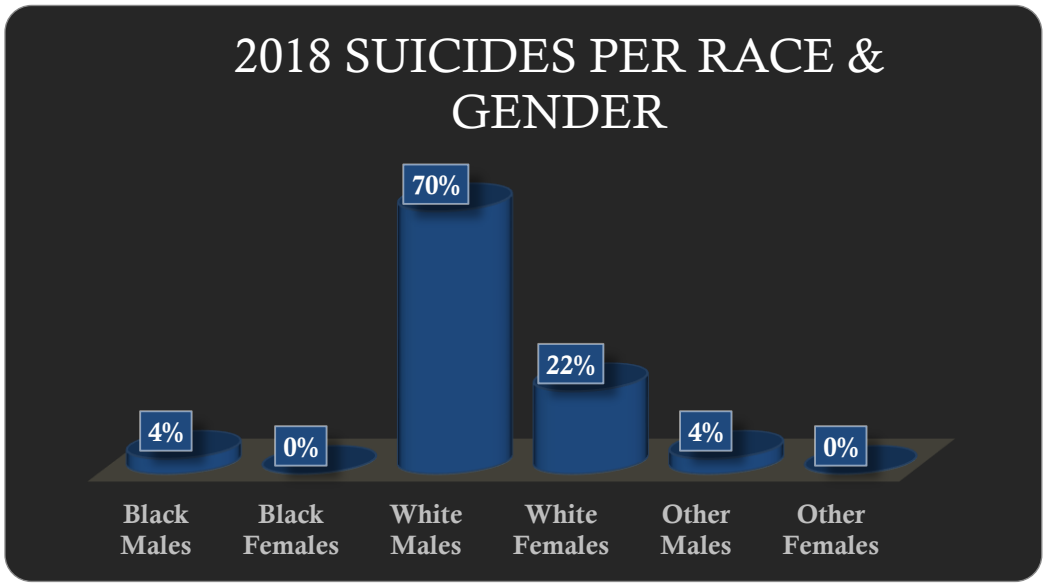
| | |
|---|---|
| Married: | 18 |
| Divorced: | 9 |
| Widowed: | 3 |
| Separated: | 1 |
| Single*: | 18 |
| Unknown: | 1 |

*Never Married.

**Decedents who ever served in United States Armed Forces: 13**

Nationally, based on 2016 data from the CDC, there were 44,965 deaths due to suicide; that is the equivalent of one death every 11.9 minutes. There was one death every 10.5 hours, or 838 total, in South Carolina due to suicide in 2017. In Lexington County in 2018 there were 50 suicide deaths, which equates to one death every 7.3 days. Statistically, in the U.S., males are approximately four times more likely to die by suicide than females; however, females attempt suicide three times more often.[13] The primary reason for this disparity is that males are statistically more likely to use methods, such as firearms, that are more lethal. Females attempt suicide through less deadly methods, such as overdose, more frequently.[14]

Suicide is a major and continuing public health concern in the U.S. and globally. Approximately 645,000 Americans died due to suicide between 1999 and 2016, with the highest annual rate occurring in 2016.[15] Although suicide is present in all demographic groups and regions, White males accounted for 61.2% of the 45,965 suicides in the United States in 2016 and 70% (35 deaths) of the suicides in this county in 2018. Among White males in Lexington County, the age group of 31 to 60 years accounted for 17 of 35 suicides. There could be many possible explanations for the high rate, such as the self-reported declines in



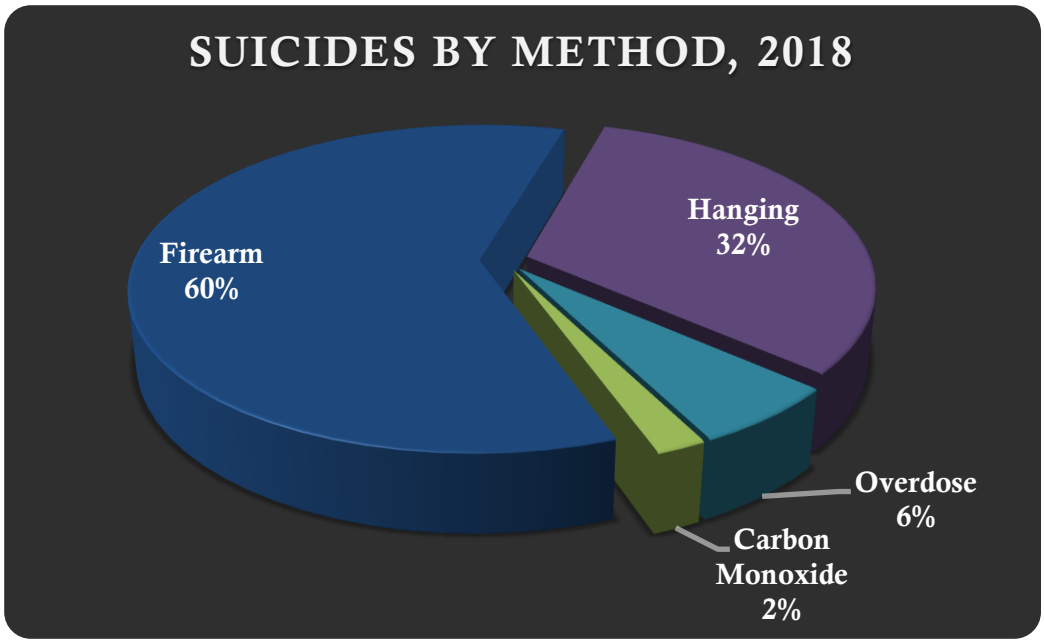

[13] American Foundation for Suicide Prevention. "Suicide Statistics". (2017). Retrieved from https://afsp.org/about-suicide/suicide-statistics/

[14] National Institute of Mental Health. *Suicide in America: Frequently Asked Questions*. Bethesda, Maryland: U.S. Department of Health and Human Services, National Institutes of Health; 2015. https://www.nimh.nih.gov/health/publications/suicide-faq/index.shtml

[15] Centers for Disease Control and Prevention (CDC). (2018, July 26). *National Vital Statistics Reports, Vol. 67.* Retrieved from http://www.cdc.gov/nchs/data/nvsr/nvsr67/nvsr67_06.pdf

mental health, physical health, inability to work and perform daily tasks, and increases in chronic pain among White adults.[16]

All people, regardless of age, gender, or ethnicity, can be at risk for suicide; however, many of those at risk have certain similarities or share characteristics. For example, the suicide rate in more rural areas is higher than in urbanized areas.[16] Firearm ownership or accessibility also increases the risk of suicide, and household firearm ownership is more prevalent in states where a larger sector of the population resides in rural areas.[17]




In 2016, firearms were the chosen method in slightly more than half, 51% or 22,938, of the suicides in the U.S. Of the 50 Lexington County suicides in 2018, 30 were completed by use of a firearm, which was the most common method among males and females.

Unlike natural deaths, homicides, or many accidental deaths, every death due to suicide is preventable. According to the National Institute of Mental Health, professionals in the field rely on sound research in order to most effectively prevent suicide. For those of us who are incapable of employing cognitive behavioral therapy, it is still crucial that we

[16] Case, A., & Deaton, A. (2015). Rising morbidity and mortality in midlife among white non-hispanic Americans in the 21st century. *Proceedings of the National Academy of Sciences of the United States of America, 112(49),* 15078. Retrieved from http://go.libproxy.wakehealth.edu/login?

[17] Miller, M., Warren, M., Hemenway, D., & Azrael, D. (2015). Firearms and suicide in US cities. *Injury Prevention, 21,* e116-e119.doi:http://dx.doi.org/10.1136/injuryprev-2013-040969

understand the risk factors and warning signs of suicide so that we may contribute to the solution. Suicidal behavior is complex, with various risk factors, ranging from a specific life event to experiences beginning in childhood, making it difficult to determine the likelihood that someone will act on their suicidal thoughts. Many of the most common risk factors may be evident in some people who never attempt suicide. Regardless, warning signs should be taken seriously because suicidal ideation is not a harmless attempt to gain attention.

## Main Risk Factors for Suicide Include:[15]

- A prior suicide attempt
- Depression, other mental disorders, or substance abuse
- Family violence, including physical or sexual abuse
- Exposure to suicidal behavior of others (peers, family members, media figures, etc.)
- Access to drugs, firearms, or other lethal means
- Stressful life events (a death, divorce, or job loss)
- Serious or chronic pain or health condition
- Family history of suicide attempts

## Warning Signs:[18]

- Expresses feelings about:
    - Being a burden to others
    - Experiencing unbearable pain
    - Having no reason to live
- Increased use of drugs and/or alcohol
- Acting recklessly
- Withdrawing from normal activities
- Change of sleeping habits

[18] American Foundation for Suicide Prevention. "Risk Factors and Warning Signs". (2017). Retrieved from https://afsp.org/about-suicide/risk-factors-and-warning-signs/

- Isolation from friends and family
- Giving away possessions of actual or sentimental value
- Aggression
- Looks for information or materials to kill themselves

Contrary to the myth that suicide is an act of revenge, anger, or aggression, most people kill themselves because of their belief that they are a burden to others or do not belong. They view their death as a means to release their loved ones of this perceived burden.[19] In addition to feelings of burdensomeness on others, suicidal thoughts or attempts may also be the result of a belief that life is not worth living, psychosocial stressors, psychiatric illnesses, or life circumstances, such as financial instability, posttraumatic stress disorder, isolation, substance abuse, or homelessness.[20]

If you, or anyone you know, may be considering suicide, please seek help. Below are some of the available resources:

National Suicide Prevention Lifeline, available 24/7, at 1-800-273-TALK (8255)

www.suicidepreventionlifeline.org

www.ruralhealthinfo.org/topics/mental-health/websites-tools

[19] American Association of Suicidology. "Suicide Myths". http://www.suicidology.org/resources/myth-fact

[20] Tucker, R. P., Crowley, K. J., Davidson, C. L., & Gutierrez, P. M. (2015). Risk factors, warning signs, and drivers of suicide: What are they, how do they differ, and why does it matter? *Suicide and Life-Threatening Behavior, 45*(6), 679-689. doi:10.1111/sltb.12161

# 2018 UNDETERMINED DEATH STATISTICS

**Total Deaths: 5**

| *Cause of Death* | *Deaths per Cause* | *Average Age* |
|---|---|---|
| Undetermined | 2 | 54 years |
| Gunshot Wound | 1 | 33 years |
| Motor Vehicle Collision | 1 | 36 years |
| Sudden Infant Death Syndrome (SIDS) | 1 | 2 months |

| *Gender* | | *Race* | | *Race and Gender* | |
|---|---|---|---|---|---|
| Male: | 1 | Black: | 1 | Black Males: | 1 |
| Female: | 4 | White: | 4 | Black Females: | 0 |
| | | Other: | 0 | White Males: | 0 |
| | | | | White Females: | 4 |

Despite LCCO's commitment to the completion of thorough investigations in all cases, determining, without question, the manner and/or cause of death is not always possible. The results of our best efforts, combined with the independent investigations by other agencies such as the Lexington County Sheriff's Department and the SC Department of Social Services (DSS), provided inconclusive results as to the manner of each of these deaths.

In some cases, there is a lack of definitive evidence as to whether a death was the result of an intentional act by the decedent or another, or completely accidental or natural. For instance, a fatal fall down stairs could have been the result of an accident, intentional self-harm, or having been pushed by another individual. These are unfortunate situations that we work hard to avoid, but our goal and obligation is to uphold the truth. Therefore, if we are unable to make a determination, with absolute certainty, we must classify the manner as undetermined. The forensic pathologist in most cases can determine what the cause, specific fatal injury or condition, was, but an autopsy does not always provide information regarding the circumstances of that injury or condition.

# UNIDENTIFIED / UNCLAIMED DECEDENTS

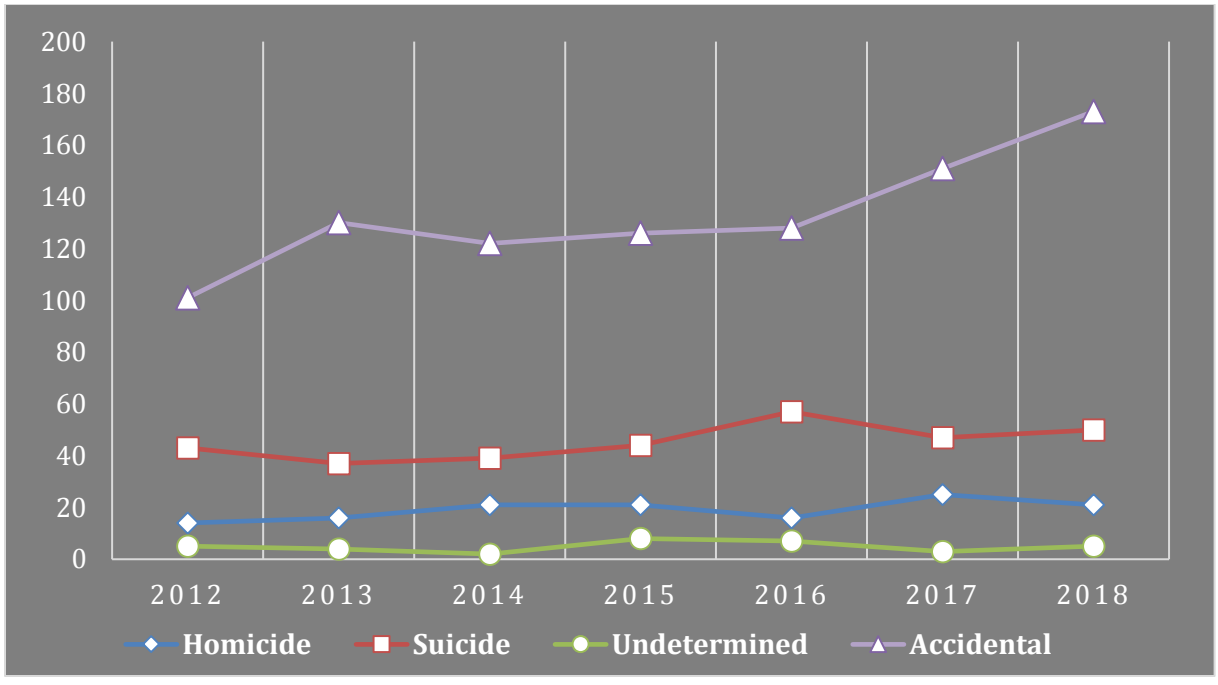
- Indigent decedents are typically cremated, per policy, and their cremated remains are buried. However, in cases of unidentified decedents, cremation is prohibited because it would prevent any later effort to make positive identification. One Hispanic male remains unclaimed and is believed to have been approximately 30 years of age. His death occurred near Gilbert in February of 2016. If you may have any information regarding his identity, please contact the Lexington County Coroner's Office.

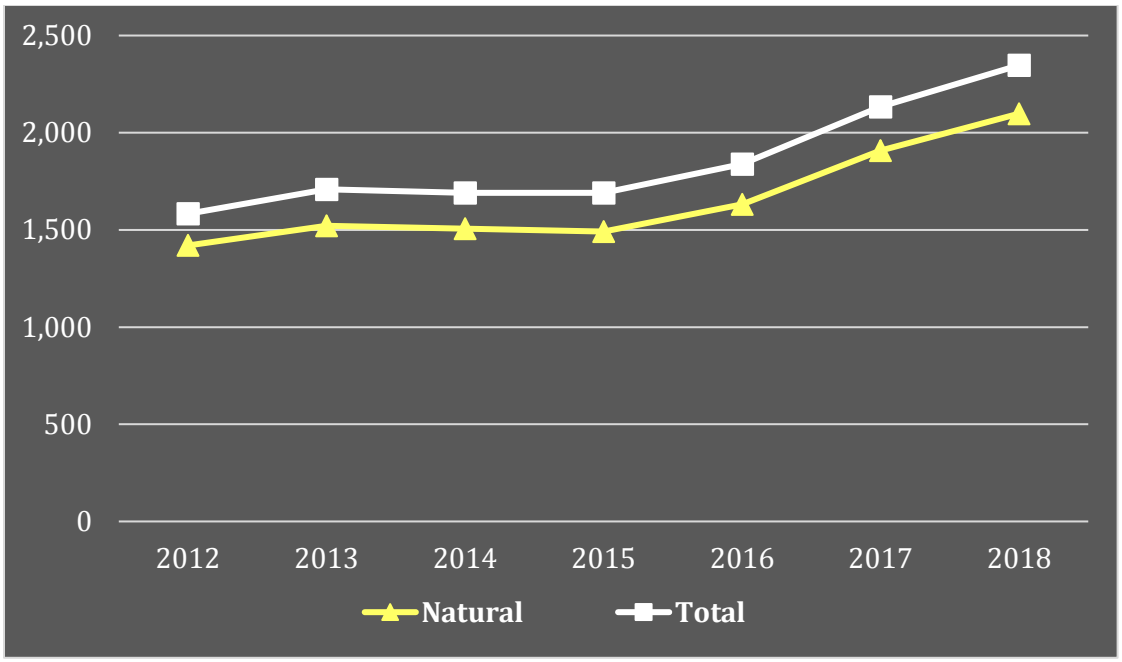
# COMMUNITY OUTREACH

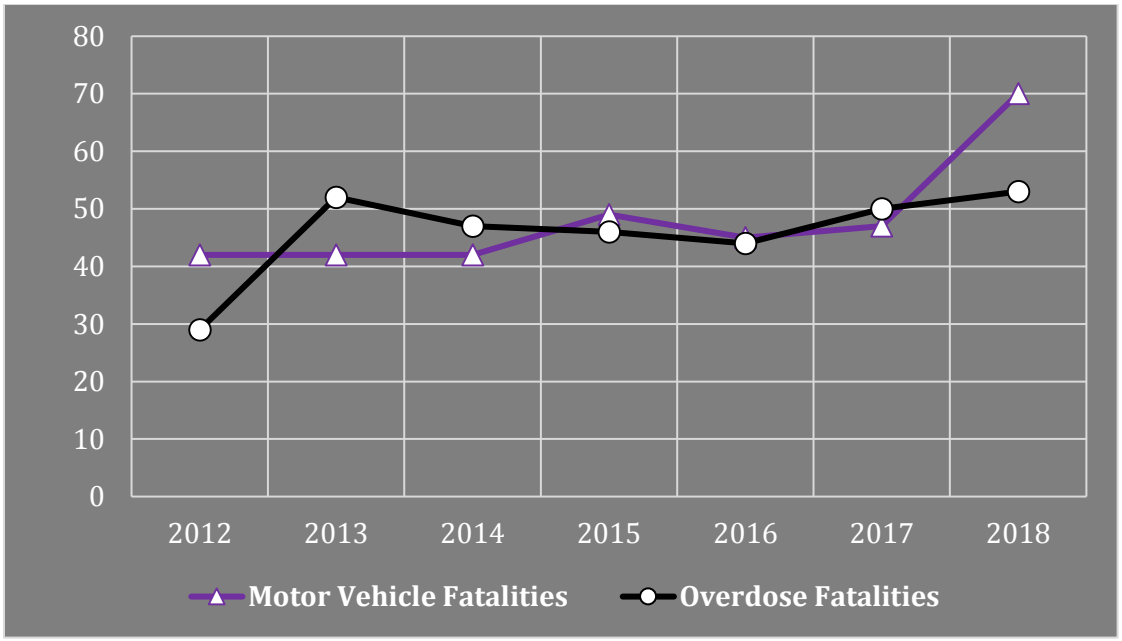
- In consideration of the importance of maintaining a positive relationship with our community, the Lexington County Coroner's Office welcomes opportunities to educate and assist whenever possible. We have already visited some local schools, upon request, to speak to students involved in classes pertaining to criminal justice and/or forensics. We have also had some school groups visit our office, which we welcome and encourage. These opportunities allow us to educate students about what the general functions of the Coroner's Office are and about our specific responsibilities, which we are hopeful may lead them to consider career paths that they were unaware of. We are happy to coordinate with teachers and/or administrators to schedule visits and presentations.

# ***Deaths Handled by LCCO***

| | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 |
|---|---|---|---|---|---|---|---|
| Natural (Total) | 1,420 | 1,521 | 1,507 | 1,492 | 1,631 | 1,908 | 2,098 |
| Natural (Response) | 281 | 268 | 290 | 381 | 459 | 472 | 365 |
| Natural (Limited Investigation) | 1,139 | 1,253 | 1,217 | 1,111 | 1,172 | 1,436 | 1,733 |
| Homicide | 14 | 16 | 21 | 21 | 16 | 25 | 21 |
| Suicide | 43 | 37 | 39 | 44 | 57 | 47 | 50 |
| Undetermined | 5 | 4 | 2 | 8 | 7 | 3 | 5 |
| Accidental (Total) | 101 | 130 | 122 | 126 | 128 | 151 | 173 |
| Accidental (Motor Vehicle) | 42 | 42 | 42 | 49 | 45 | 47 | 70 |
| Accidental (Overdose) | 29 | 52 | 47 | 46 | 44 | 50 | 53 |
| **Total** | **1,583** | **1,708** | **1,691** | **1,691** | **1,839** | **2,134** | **2,347** |




2,500
2,000
1,500
1,000
500
0
2012
2013
2014
2015
2016
2017
2018
Natural
Total


80
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60
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2012
2013
2014
2015
2016
2017
2018
Motor Vehicle Fatalities
Overdose Fatalities