COUNTY OF COLLIN
STATE OF TEXAS
OFFICE OF THE MEDICAL EXAMINER
FY2025

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OUR MISSION

To uphold Article 49.25 of the Texas Code of Criminal Procedure.

This includes establishment of a competent cause and manner of death for all reported cases to the office. The Medical Examiner is also tasked with the issuance of cremation permits, facilitating organ and tissue procurement, as well as meeting the needs of families, law enforcement, the District Attorney, Office of Emergency Management, medical and legal communities and funeral directors.

HISTORY

The Collin County Medical examiner's Office was created in 1986 and opened on January 1, 1987. Under the requests and orders of the Commissioners Court, William B. Rohr M.D., was appointed as the Chief Medical Examiner (ME). Part-time Assistant Medical Examiner Lynn A. Salzberger M.D., retired on September 30, 2016, and Stephanie S. Burton, M.D., was added as the first full-time Assistant Medical Examiner on October 1, 2016. Dr. Rohr served as the Chief ME until his retirement in May 2023. Keng-Chih "Kenny" Su, M.D., was appointed the new Chief ME serving until August 2024. Dr. Burton served until October 2024. The current Chief Medical Examiner, Elizabeth Ventura, M.D., was appointed in November 2024. The Assistant ME, Chester Gwin, M.D., was hired December 2024. The office operated on an annual budget of $3,248,280.00 FY2025. Growing population and the establishment of trauma centers in Collin County continues to increase the caseload handled by this office in terms of pathology, toxicology, investigation, evidence, property storage and disposal, transportation of bodies and courtroom testimony. These trauma centers receive cases from north Texas, east Texas, west Texas and south Oklahoma. Once pronounced dead in these trauma centers, the case comes under the jurisdiction of the Collin County Medical Examiner.

The Office is fully accredited by the National Association of Medical Examiners (NAME), and during its last inspection, received zero deficiencies. Adult and Child Fatality Review Teams continue to be active.

Information presented in this annual report has been compiled on the deaths reported to the Collin County Medical Examiner's Office during FY2025. It is written to reflect workload and Office activity.

The statistics for FY2025 continue to reflect a trend in how workload has been handled over the last few years. A higher percentage of only record review to establish cause and manner of death, without physical examination of the deceased in the office, are being performed for all deaths certified. Morgue space has become a concern with our ever growing population. This situation was addressed by acquisition with grant funding of a portable morgue kept near the loading dock area. This has increased capacity for body storage. Further, construction of a brand new Medical Examiner facility with larger storage capacity is currently underway, with anticipated completion and occupation in Fall 2026. Concerns by human resources and administration about overtime and potential additional personnel has driven the office to perform fewer scene visits and bring in fewer cases. Doing more by record review only is becoming more prevalent across the United States, not just Collin County.

An autopsy technician was hired as a full-time county employee in August 2019, and a second technician position was added FY2020. Individuals holding these positions were trained on the job. Both examiners utilize the assistants to the fullest extent possible. County full-time assistants now provide coverage 365 days per year. Their duties and responsibilities have expanded during FY2025. In 2025, the County approved Dr. Ventura's request for a full-time Morgue Supervisor position, which was filled in December 2025.

The on-line cremation permit and funeral home fee collection for permits was instituted January 2019. This software was developed by the county. It has been a success. Funeral homes adapted this process immediately, no money passes through the office and permits are issued quicker. At this time, operating without it would be extremely difficult.

In April of FY2023 an on-line open record requests platform was also instituted to streamline the process of accessing records, ensuring greater transparency and efficiency. This digital platform allows families, journalists, and organizations to submit requests directly through a user-friendly platform. By moving the process online, the platform aims to reduce the time and resources typically required for handling requests, enabling faster responses and easier tracking of request statuses.

The case management system was introduced into the Office on January 1, 2017. Office personnel responded with great acceptance. It has streamlined many office practices and helped everyone with organization of their work. As software usually is, one continues to explore its capabilities. This certainly remains true for the case management system as the Office continues to find new uses for it. It continues to

undergo modifications. It remains a work in progress. Statistics for this report were compiled from the case management system and in-house spreadsheets.

A portable refrigerated morgue was placed in service during the fall of 2019 and is available for overflow during times of surge and storage area if a mass fatality event occurs. With its rack system providing a capacity of 24, the total capacity of the Office is boosted to 39.

This fiscal year FY2025 fentanyl continues to be high. The statistics are striking:

Fentanyl (calendar year):
2019 - 10
2020 - 36
2021 - 52
2022 - 73
2023 - 54
2024 - 60
2025 - 41

The office has responded to many requests for office data concerning this issue. Many of these deaths also had other illicit substances and/or alcohol contributing to death. All had fentanyl in blood at death. The office continues to work closely with law enforcement agencies on this issue.

To understand just what these charts and graphs represent a glossary is included:
DEATH REPORT: Any reported death. This could also be referred to as an INQUEST as defined by the Texas Code of Criminal Procedure.

NO CASE: A reported death in which the attending physician is allowed to sign the death certificate. The death must meet four criteria.
1. Death in the presence of a good witness.
2. There is a physician able and willing to sign the death certificate.
3. Death not under confinement by law enforcement or a mental health institution.
4. Death unrelated to any possible trauma.

CASE: A death not meeting all of the above four criteria and requiring an examination by the medical examiner. The medical examiner always signs the death certificate.

ABSENTIA (IN ABSENTIA): A death not meeting all four of the above criteria but not undergoing an examination by the medical examiner. The medical examiner always signs the death certificate.

EXAMINED: Another term for case. There are two types of examination by the medical examiner. INSPECTION in which the body is only examined externally. AUTOPSY in which there is an external and internal examination of the body. Body fluids are obtained externally for further testing in either type of examination.

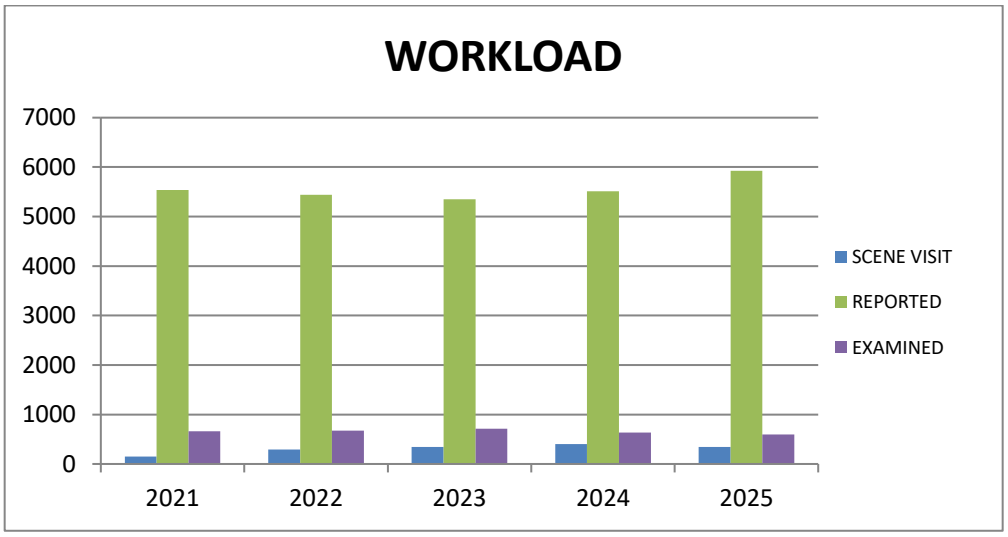
SCENE: The field agent travels to the scene of death to gather further information for the medical examiner and to assist law enforcement with their investigation. A medical examiner attends in select cases.

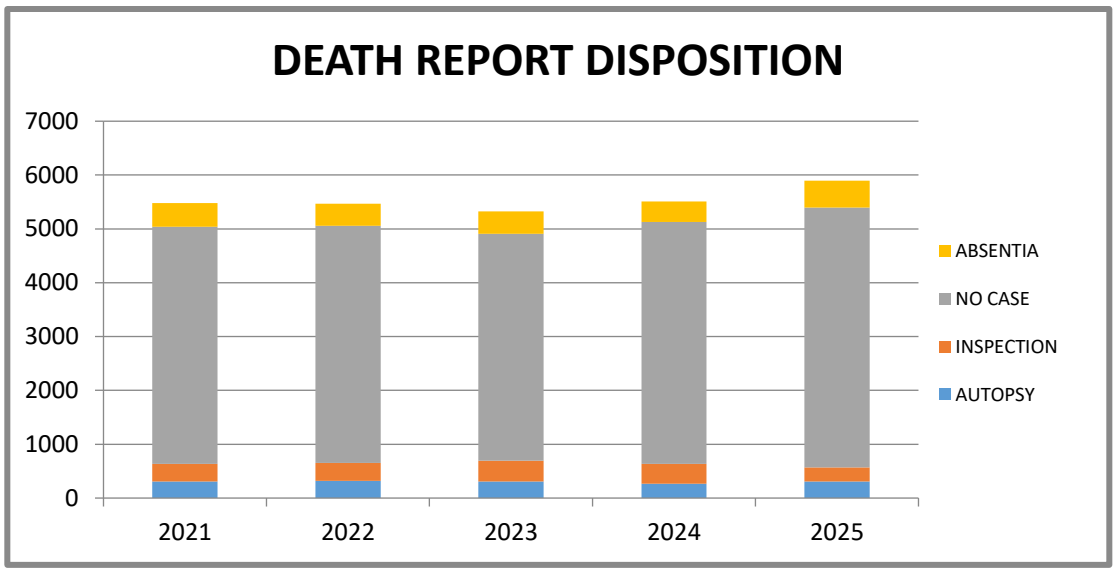
CREMATION PERMIT: A certificate issued by the medical examiner allowing a cremation to go forward. The certificate is required by the Texas Code of Criminal Procedure. Authorization for the cremation always comes from the family. A short informal investigation is always undertaken by the Office before the certificate (permit) is signed. A few requests require a more significant investigation including full autopsy. There is a fee of $25 charged for every permit issued. For FY 2019 a system was instituted to collect these fees electronically.

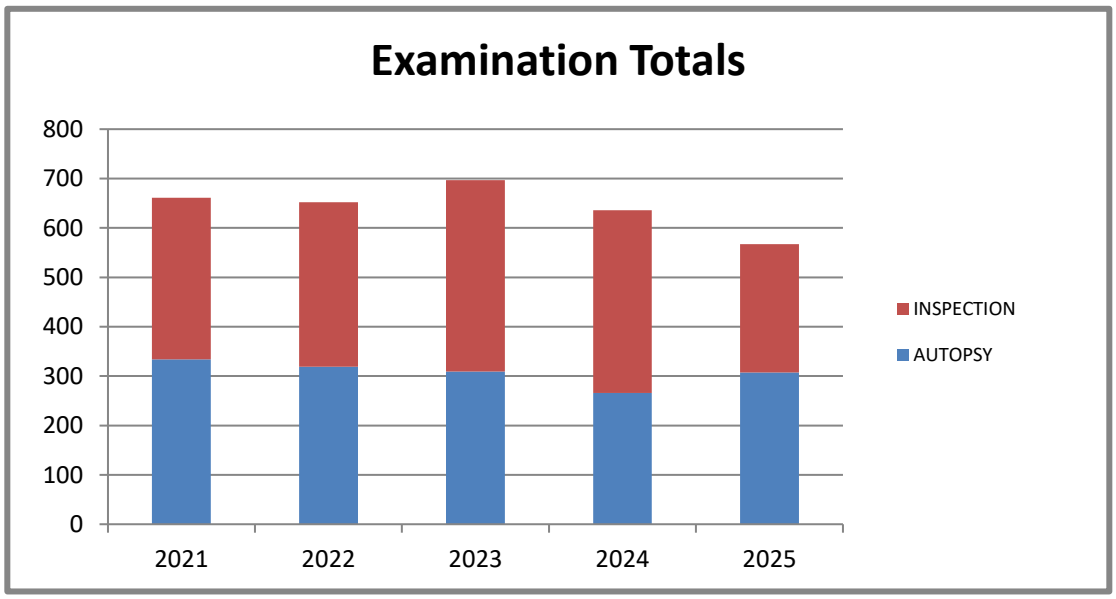
MANNER OF DEATH: This is the fashion about which death occurred. The medical examiner is required to make this determination for each death reported to the Office. There are several choices for manner of death. NATURAL is a death completely unrelated to trauma. ACCIDENT is when a death is in any way related

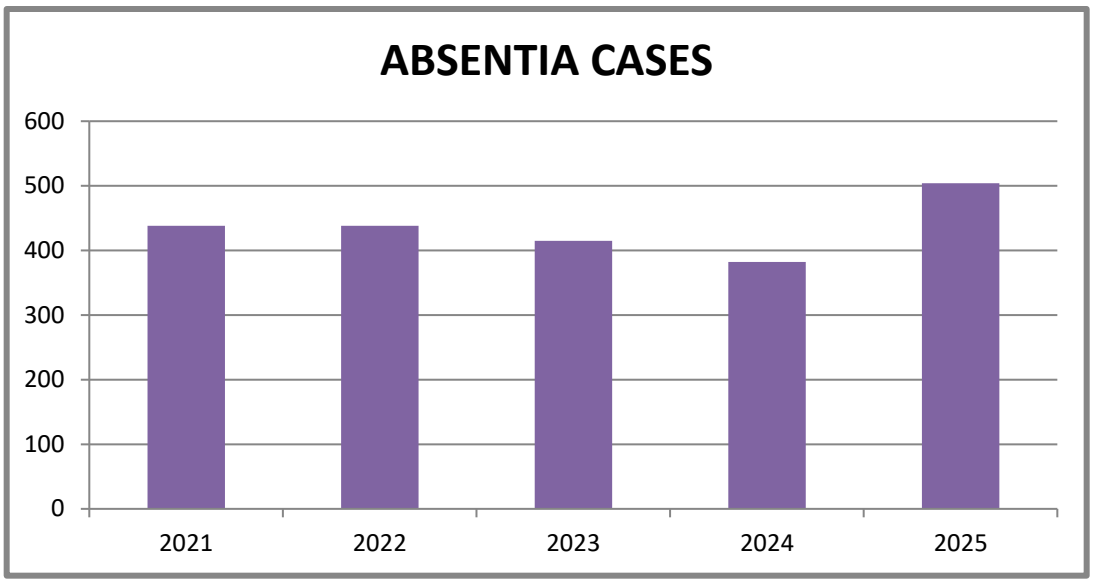
to trauma. SUICIDE is a special type of traumatic death in which one dies at their own hand. HOMICIDE is a special type of traumatic death in which one dies at the hand of another. UNDETERMINED is when the medical examiner lacks sufficient information to make one of the above four determinations.

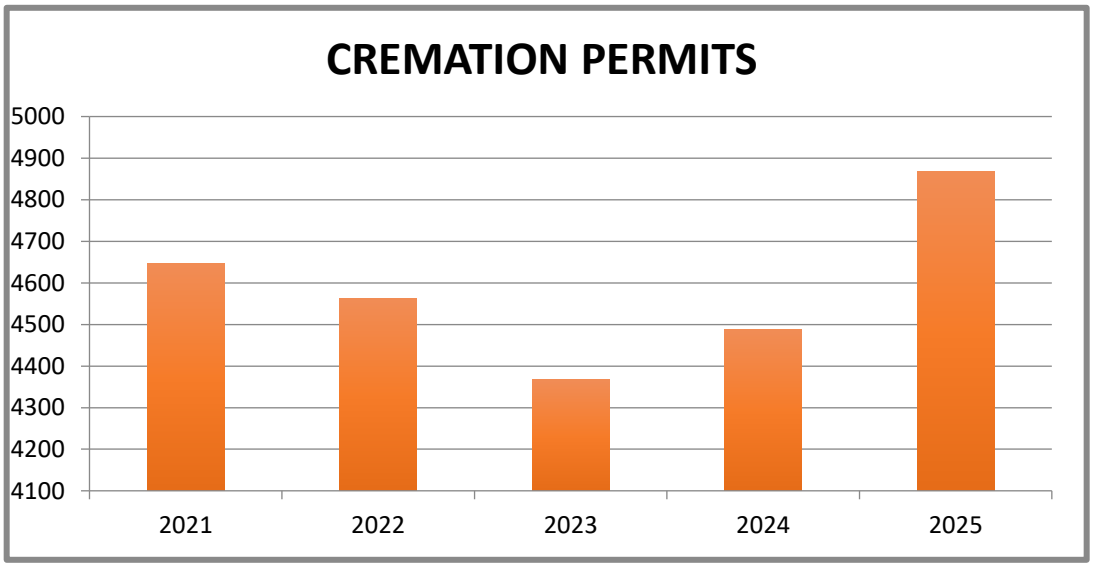
For the following charts and graphs years are fiscal years, not calendar years.




DEATH REPORT DISPOSITION
7000
6000
5000
4000
3000
2000
1000
0
2021
2022
2023
2024
2025
ABSENTIA
NO CASE
INSPECTION
AUTOPSY


Examination Totals
800
700
600
500
400
300
200
100
0
2021
2022
2023
2024
2025
INSPECTION
AUTOPSY


ABSENTIA CASES
600
500
400
300
200
100
0
2021
2022
2023
2024
2025


CREMATION PERMITS
5000
4900
4800
4700
4600
4500
4400
4300
4200
4100
2021
2022
2023
2024
2025

Homicide examinations generally create the most work. Natural deaths generally create the least amount of work. Homicides are almost always autopsied. The manner of death least likely to result in an autopsy is natural. Many of the deaths certified below include the absentia cases, for which only medical records and death circumstances were reviewed, no physical examination by a medical examiner took place.

The major cause of death for each manner of death is:
NATURAL – Cardiovascular disease (hypertensive and atherosclerotic heart disease)
ACCIDENT – Blunt force injuries; motor vehicle crash, drug or fall
SUICIDE – Gunshot wound (single gunshot wound of head most likely)
HOMICIDE – Gunshot wound(s)
UNDETERMINED – Mostly accident v suicide.

2020 through 2025

	2020	2021	2022	2023	2024	2025
SUICIDE	125	132	137	155	162	161
HOMICIDE	21	51	44	41	30	41
UNDETERMINED	36	17	26	22	15	16
CREMATIONS	3763	4647	4563	4367	4487	4869
ABSENTIA	417	502	408	415	382	507
SCENE VISIT	163	148	292	346	402	345
REPORTED	5114	5520	5439	5348	5511	5924
EXAMINED	604	661	676	715	636	592
ACCIDENT EXAMINED	108	210	241	227	204	216
NON-TRAUMA EXAMINED	316	463	233	268	253	269
AUTOPSY	296	313	343	309	266	307
INSPECTION	308	326	333	388	370	260
NO CASE	4116	4403	4406	4210	4494	4827

ADDITIONAL IMPORTANT DATA:

Deceased individuals transported to the office, all by contract service – 544
Postmortem tissue procurement performed by UT Southwestern Transplant Services – 44
Unidentified individuals after examination – 0
Partial autopsies included within the total autopsies reported above – 25
There were no hospital or exhumation autopsies performed.
Unclaimed bodies subject to county disposition – 33

ADULT FATALITY REVIEW TEAM FOR FY2025

The Adult Fatality Review Team meets on the last Friday of every month via an online networking platform. The team members are:

Dr. Elizabeth Ventura – Chief Medical Examiner (Collin County)
Dr. Chester Gwin - Deputy Medical Examiner (Collin County)

Representatives from the following organizations also in attendance:

Texas Health Resources of Plano
Plano Police Department
U.S. Drug Enforcement Agency
Collin County Substance Abuse
Allen Fire Department

The purpose of the Collin County Adult Fatality Review Team is to review all deaths of adults in Collin County from a public health perspective and to enhance the skills of those investigating death in Collin County, especially the Medical Examiner, Epidemiology, Substance Abuse, and Mental Health.

The interaction that takes place among these agencies during the Review Team meetings gives insight to everyone involved and helps them to understand why these deaths take place with a focus on prevention.

CHILD FATALITY REVIEW TEAM FOR FY2025

The Child Fatality Review Team meets the first Friday of every month via an online networking platform. The team members are:

Dr. Elizabeth Ventura – Chief Medical Examiner (Collin County)

Dr. Chester Gwin - Deputy Medical Examiner (Collin County)

Representatives from the following organizations also in attendance:

Collin County Health Department
Collin County District Attorney's Office
Collin County Child Protective Services
Collin County Advocacy Center

Plano Fire Department
Plano Police Department
Allen Police Department
Allen Fire Department
McKinney Police Department
McKinney Fire Department
Frisco Police Department
Medical Center of Plano
Presbyterian Health Hospital of Plano
Texas Health Resources of Plano

The purpose of the Collin County Child Fatality Review Team is to review all deaths of children in Collin County from a public health perspective and to enhance the skills of those investigating death in Collin County. The interaction that takes place among these agencies during the Review Team meetings gives insight to everyone involved and helps them to understand why these deaths take place with a focus on prevention.

For FY2025 we autopsied and signed the death certificate for 15 infant deaths (stillborn to one year of age).

Of these, Manner of Death listed:

4 Accident, 0 Homicide, 7 Natural, 4 Undetermined