



**COUNTY OF COLLIN
STATE OF TEXAS
OFFICE OF THE MEDICAL EXAMINER
FY2018**

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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 County Medical Examiner who retains this position to this day. The Office has full accreditation by the National Association of Medical Examiners. Assistant Medical Examiner Lynn A. Salzberger M.D. retired on September 30, 2016. Stephanie S. Burton, M.D. was added as the new assistant Medical Examiner on October 1, 2016. This enables Dr. Rohr to maintain a personal workload acceptable for accreditation in a cost-effective manner yet still conduct autopsy services for Grayson and Fannin counties. The office operated on an annual budget of \$1,974,612 FY 2018. Growing population and the re-opening of services outside of Collin County has increased the caseload handled by this office in terms of pathology, toxicology, investigation, evidence, property storage and disposal, transportation of bodies and courtroom testimony. Adult and Child Fatality Review Teams continue to be active. Both are chaired by Dr. Rohr.

Five-year on-site inspection of the Office by the National Association of Medical Examiners (NAME) took place in mid-August 2016. The Office was inspected by Barbara Wolf, MD, head of the NAME Inspections and Accreditation Committee from Leesburg, Florida and Ponni Arunkumar, M.D., Chief Medical Examiner of Cook County, Illinois. As a result of this office inspection, Full Accreditation was maintained. Only one deficiency in a lengthy checklist was noted: Dr. Rohr well exceeded the recommended case load of less than 250/year. It had approached 325/year. This situation was corrected for FY 2017 by the conversion of the part-time medical examiner

position to full-time. The position was filled by Dr. Burton. Each medical examiner is expected to have a case load under the recommended 250/year through FY 2017. In April 2017 and April 2018 the Office had Full Accreditation maintained. This is fully expected to again be maintained in April 2019.

Information presented in this annual report has been compiled on the deaths reported to the Collin County Medical Examiner's Office during FY 2017. It is meant to reflect workload and Office activity rather than public health concerns.

The statistics for FY2018 continue to reflect significant differences in how workload is handled compared to FY 2016. Fewer deceased individuals are now brought into our office in favor of record review only to establish cause and manner of death. The decision to bring cases into the office has become more of a negotiation between law enforcement and the family. This modified decision making is based on two issues. First and most importantly, morgue space has become a concern with our ever growing population. Second, 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 for physical examination. Determining cause and manner of death more by record review only is becoming more prevalent across the United States.

A 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 is certainly true for the case management system as the Office continues to find new uses for it. For this fiscal year (FY 2018) all statistics were gathered through use of the case management system.

To understand just what the charts and graphs represent a glossary is included:

DEATH REPORT: Any reported death.

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.

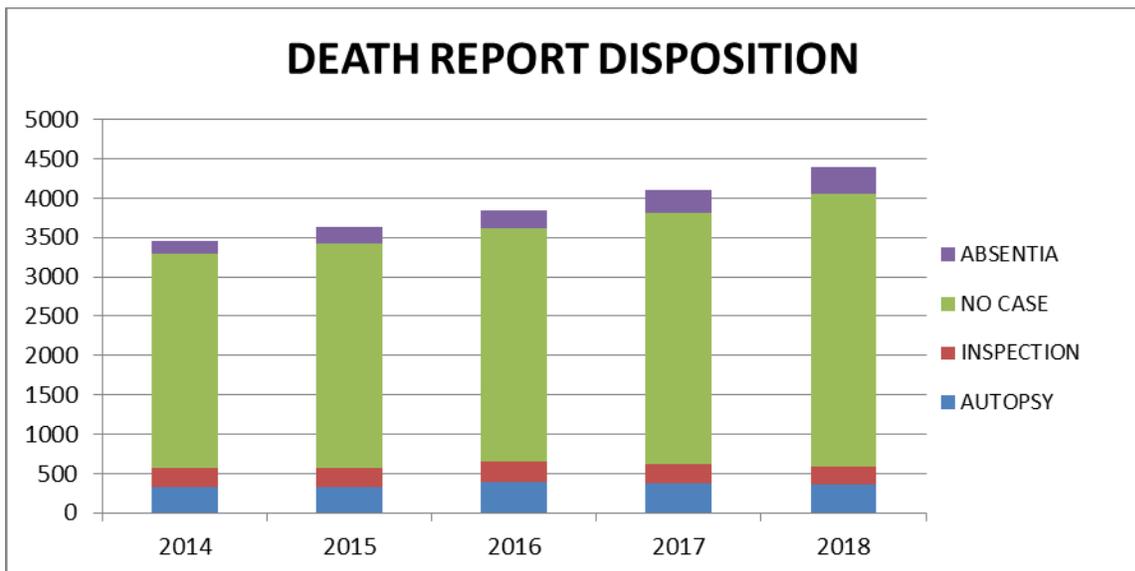
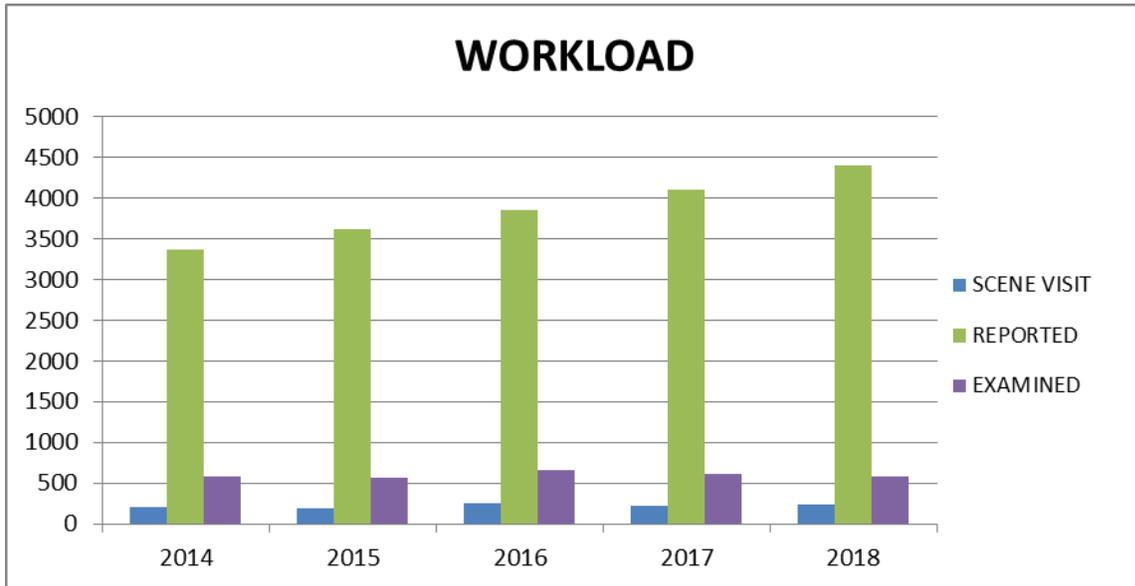
SCENE: The field agent travels to the scene of death to gather further information for the medical examiner and to assist law enforcement with their investigation. A medical examiner attends in select cases.

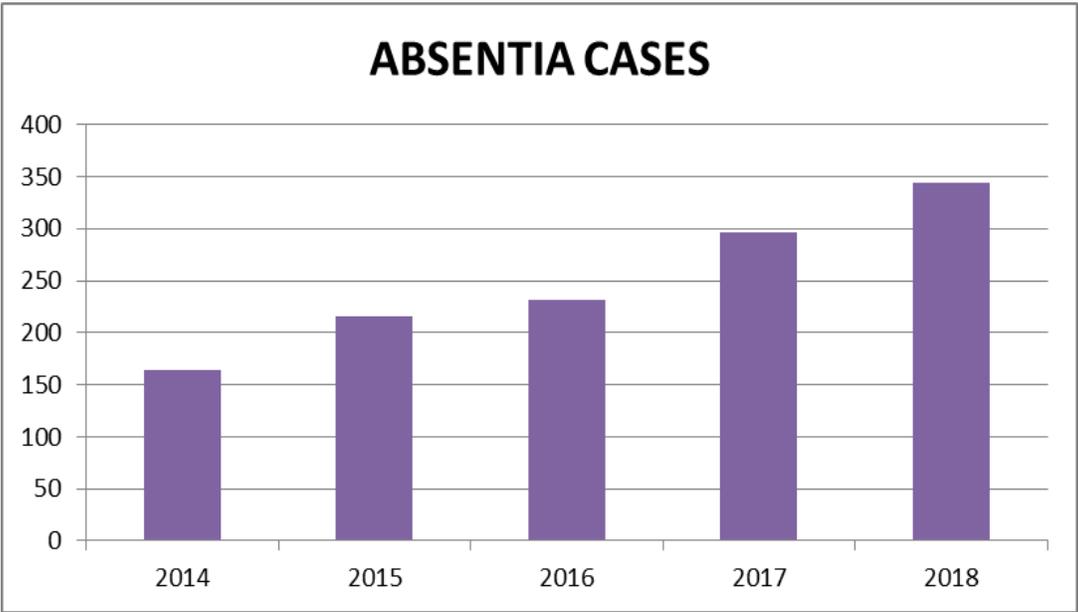
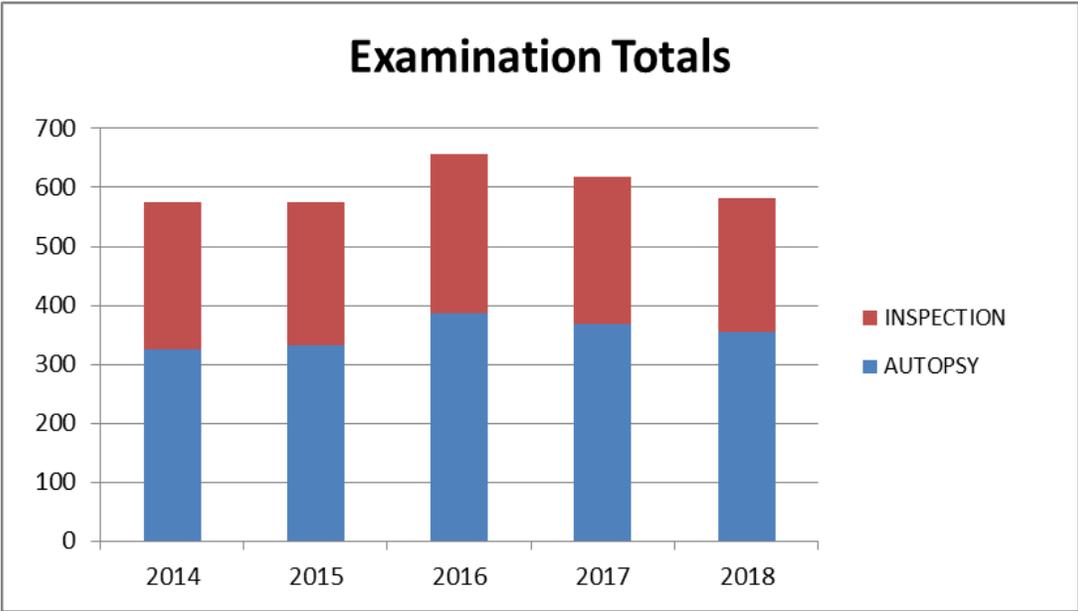
CREMATION PERMIT: A certificate issued by the medical examiner allowing a cremation to go forward. The certificate is required by the Texas Code of Criminal Procedure. Authorization for the cremation always comes from the family. A short informal investigation is always undertaken by the Office before 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.

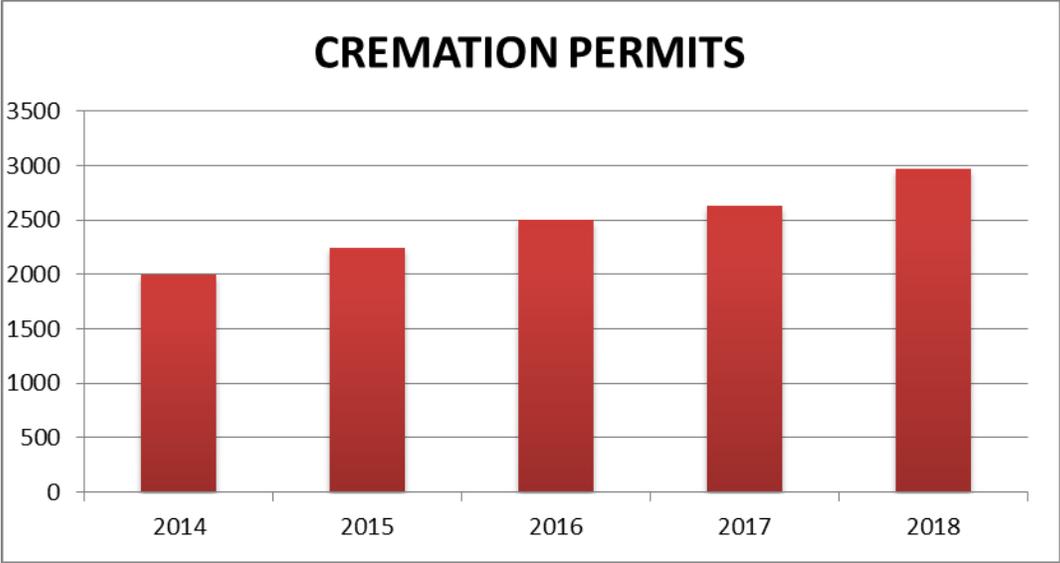
MANNER OF DEATH: This is the fashion about which death occurred. The medical examiner is required to make this determination for each death reported to the Office. There are several choices for manner of death. **NATURAL** is a death completely unrelated to trauma. **ACCIDENT** is when a death is in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

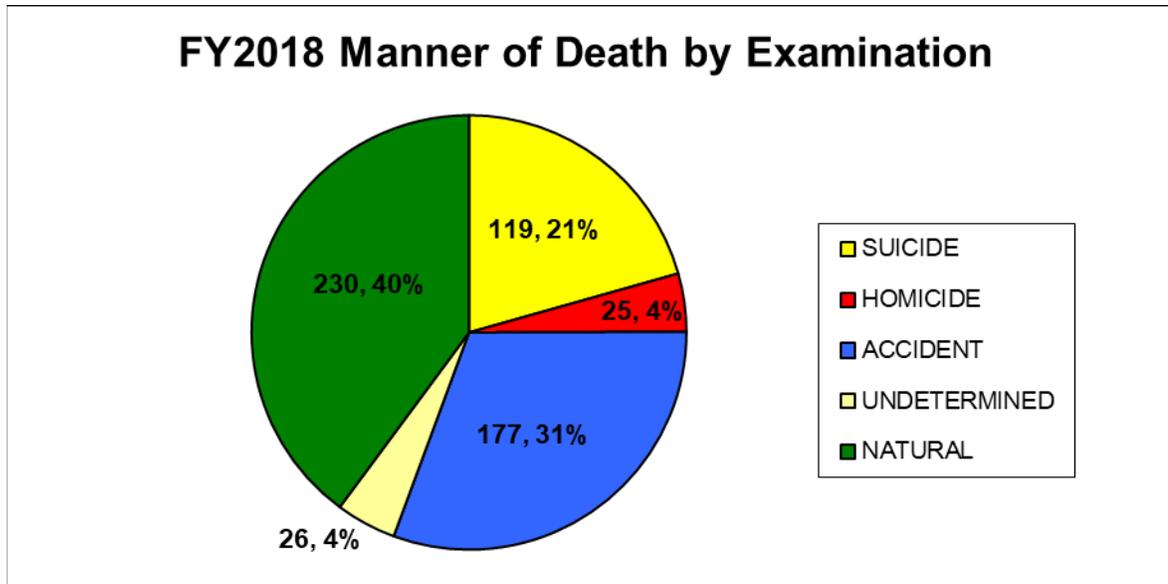
For the following charts and graphs, years are fiscal years, not calendar years.







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.



FY2014 through FY2018

	2014	2015	2016	2017	2018
SUICIDE	110	97	122	135	119
HOMICIDE	20	14	24	38	25
UNDETERMINED	36	37	36	26	26
CREMATIONS	1994	2248	2501	2632	2969
ABSENTIA	164	215	232	297	344
SCENE VISIT	203	192	248	222	232
REPORTED	3362	3618	3848	4110	4402
EXAMINED	575	574	656	617	582
ACCIDENT EXAMINED	147	154	180	185	177
NON-TRAUMA EXAMINED	262	268	284	219	230
AUTOPSY	325	331	373	369	355
INSPECTION	250	243	270	248	227
NO CASE	2727	2841	2960	3196	3477

ADULT FATALITY REVIEW TEAM FOR FY 2018

The Adult Fatality Review Team meets on the last Friday of every month at the Collin County Medical Examiner's Office. The team members are:

Dr. William Rohr – Chief Medical Examiner (Collin County)

Dr. Stephanie Burton - Deputy Medical Examiner (Collin County)

Sue Schultz, LPC, LMFT – Collin County CFRT Coordinator

Sabina Stern – CFRT Member

Jawaid Asghar MBBS, MHA– Epidemiologist - Collin County Healthcare

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

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 FY 2018

The Child Fatality Review Team meets the first Friday of every month at the Collin County Medical Examiner's Office. The team members are:

Dr. William Rohr – Chief Medical Examiner (Collin County)

Dr. Stephanie Burton - Deputy Medical Examiner (Collin County)

Sue Schultz, LPC, LMFT – Collin County CFRT Coordinator

Sabina Stern – CFRT Member

Susan Etheridge - CASA of Collin County

Jawaid Asghar MBBS, MHA– Epidemiologist - Collin County Healthcare

Dr. Brad Tate - Pediatric Hospital

Dr. Jessica Williams - ED Physician

Dr. Kristen N. Reeder, Reach Program

Representatives from the following organizations also in attendance:

Collin County District Attorney's Office

Collin County Child Protective Services

Collin County Advocacy Center

Plano Fire Department

Plano Police Department

Allen Police 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, especially the Medical Examiner, law enforcement and Child Protective Services. 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.

Organizational Chart (FY 2018)

