

Cumberland County
Office of the Coroner
Charles Hall
Coroner



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Staff

Charles Hall
Coroner
D-ABMDI

Mark Kann
Chief Deputy Coroner
D-ABMDI

Robin Eckert
First Deputy Coroner

Jeff Miller
Deputy Coroner
D-ABMDI

Chris Yohn
Deputy Coroner

Justin McNaughton
Deputy Coroner

Tim Strasbaugh
Deputy Coroner

Don Rynard
Deputy Coroner

Bob Ressler
Deputy Coroner
Part-Time

Jeremy Maugans
Deputy Coroner

Ed Erlsten
Deputy Coroner

Dave Ickler
Deputy Coroner
Part-Time

Alyssa Yantosik
Deputy Coroner

Mission

The mission of the Coroner is to investigate sudden, unexplained, violent, or suspicious deaths occurring in the County to determine cause of death, manner of death, and whether criminal activity was involved. The Coroner also provides information regarding their findings to the family of the deceased and investigating agencies, protects the property of the deceased, and preserves the confidentiality of all information received.

To achieve our mission, the Coroner's Office conducts investigations and works closely with families, law enforcement, hospitals, and other agencies to gather information and physical evidence, pertinent to the outcome of the investigation. The necessary steps to determine cause and manner of death and the presence of criminal activity vary on a case-by-case basis. These steps may include a review of medical records, an external body examination, an autopsy, or toxicology. These processes are time consuming, and some cases may be 'Pending Investigations' until further information is collected. Concerns of a deceased's family are to be addressed in a timely manner with compassion and courtesy.

Some tasks of the Coroner's Office Staff include:

- Document and photograph scenes
- Interview family and witnesses
- Collect and preserve evidence
- Protect the deceased's property by collecting valuables and securing the property
- Notify legal next of kin
- Draw biological samples for toxicological analysis and DNA purposes when necessary
- Schedule autopsies when necessary
- Provide next of kin with results of our investigation and the cause and manner of death
- Communicate with funeral homes and law enforcement
- Review all deaths prior to cremation

Reported Deaths

By law, deaths within the County which meet one of the following criteria are reported to the Coroner's Office:

16 P.S. Section 1237- Coroner's Investigations

1. Sudden deaths not caused by readily recognizable disease, or when in the cause of death cannot be properly certified by a physician on the bases of prior medical attendance.
2. Deaths occurring under suspicious circumstances, including those where alcohol, drugs or other toxic substances may have had a direct bearing on the outcome.
3. Death occurring as a result of Violence or trauma, whether apparently homicidal, suicidal or accidental (including, but not limited to, those due to mechanical, thermal, chemical, electrical or radiation injury, drowning, cave-ins and substances).
4. Any death in which trauma, chemical injury, drug overdose or reaction to drugs or medication or medical treatment was a primary or secondary, direct or indirect, contributory, aggravating or precipitating cause of death
5. Operative and pre-operative deaths in which the death is not readily explainable on the basis of prior disease
6. Any death wherein the body is unidentified or unclaimed
7. Deaths known or suspected as due to contagious disease and constituting a public hazard.
8. Deaths occurring in prison or a penal institution or while in the custody of the police.
9. Sudden infant death syndrome; and still births
10. Fall within 30 days of death and or any falls after 30 days that would contribute to their death.

Sudden deaths as referred to in the criteria above are described as:

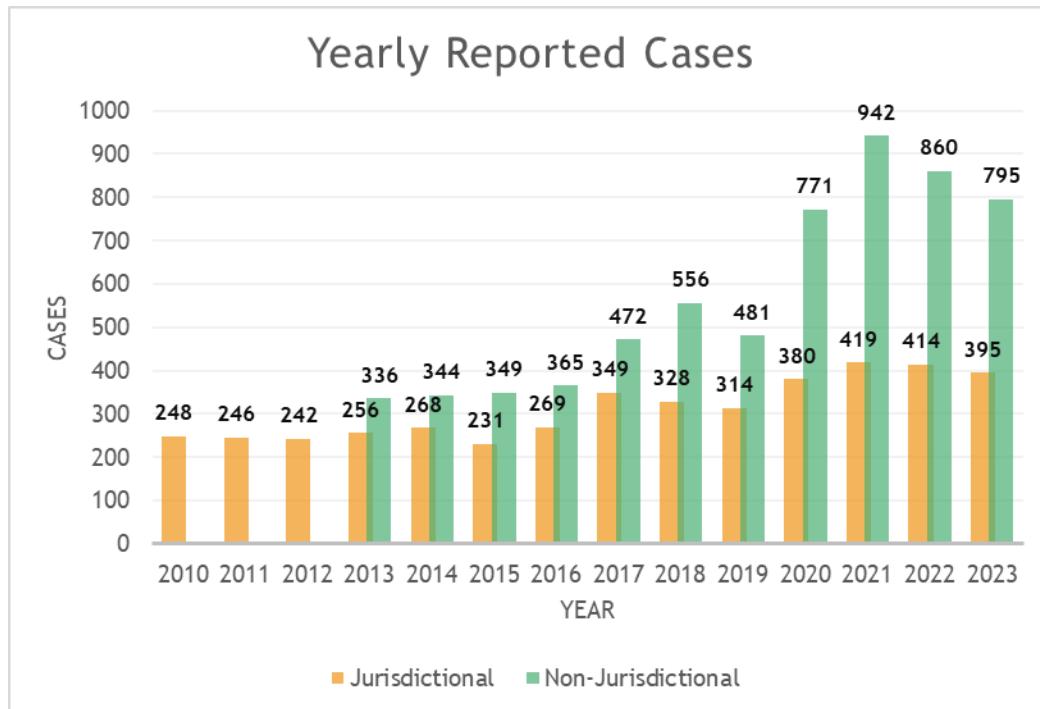
16 P.S. Section 1239- Sudden Deaths Defined

1. The Coroner Shall regard any death as sudden if it occurs without prior medical attendance by a person who may lawfully execute a certificate of death in this Commonwealth, or if within 24 hours of death, the decedent was discharged from such medical attendance or a change of such medical attendance had occurred, or if any such medical attendance began within 24 hours of death and the medical attendant refused or is unable to certify the Cause of Death. Medical attendances include hospitalization.

When there is any doubt whether a death needs to be reported, it **SHOULD** be reported. The jurisdiction of reported cases is determined by the Coroner's Office. Deaths which do not meet the criteria can be handled by the parties involved such as hospital staff, emergency personnel, law enforcement, or hospice facilities.

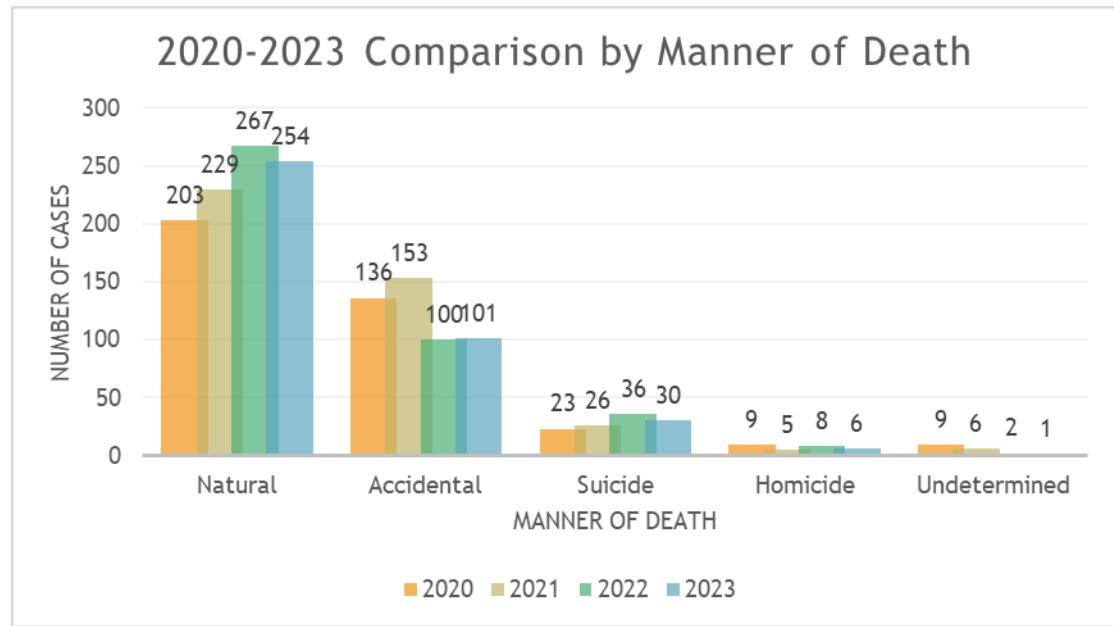
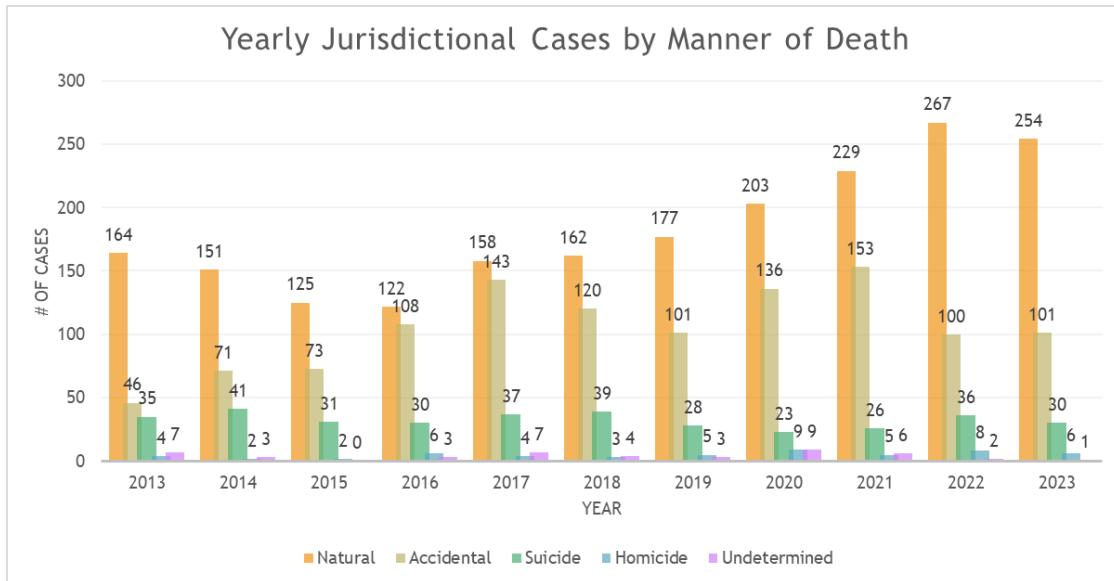
In 2023, 1,190 deaths which occurred in Cumberland County were reported to the Coroner's Office. Of these deaths, 395 required further investigation and are considered *Jurisdictional* cases while 795 were natural deaths released to a physician or qualified medical professional to certify the death and are considered *Non-Jurisdictional* cases.

Yearly Data 2010-2023

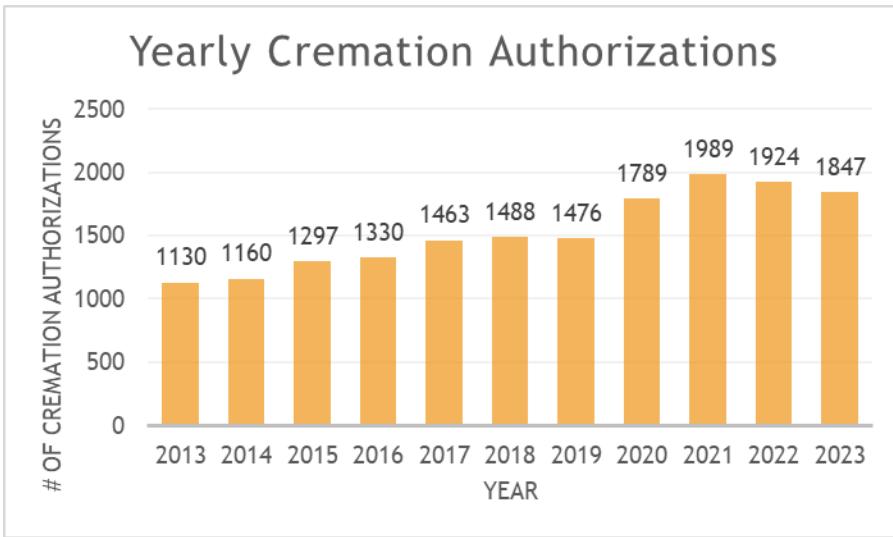


This includes all deaths reported to the coroner's office from 2010 through 2023. Total cases increased from 592 to 1,190 from 2013 to 2023. Three 2023 jurisdictional cases remain Pending Investigation and are included in total jurisdictional cases.

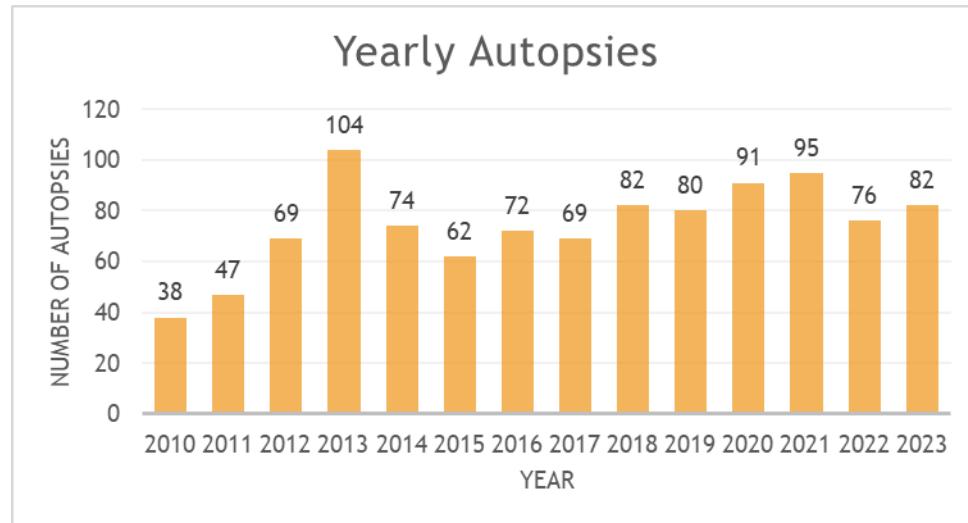
*No data was available for non-jurisdictional cases from 2010 through 2012.



Jurisdictional cases from 2013 through 2022 were broken down by manner of death, with a closer comparison of the past four years. This data excludes cases listed as Pending Investigation which account for 3 of 395 jurisdictional cases in 2023.



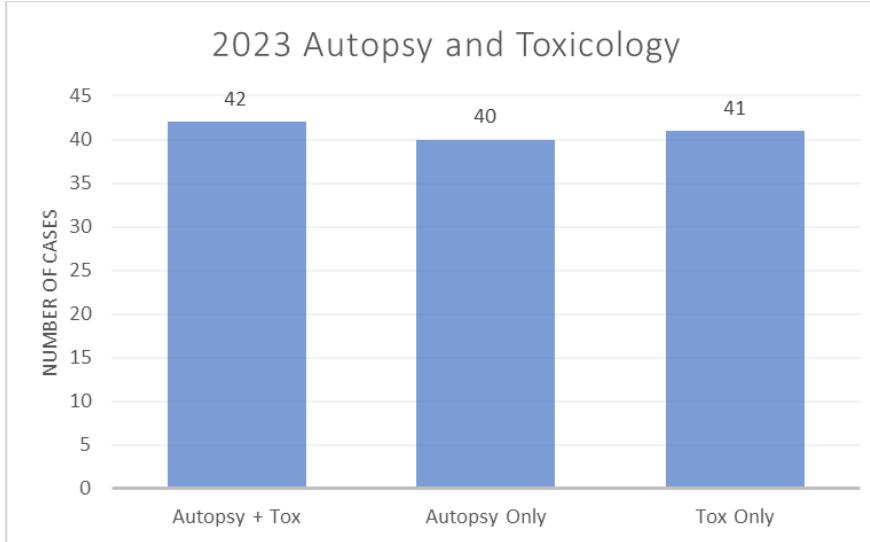
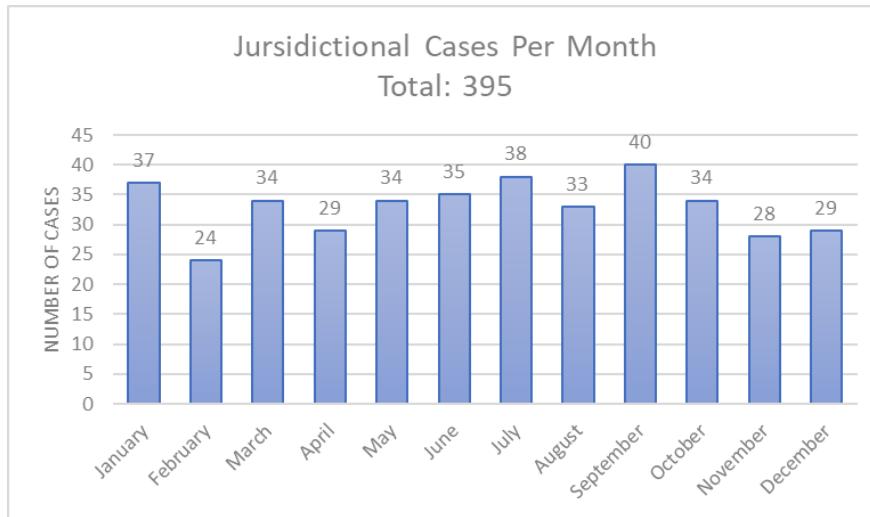
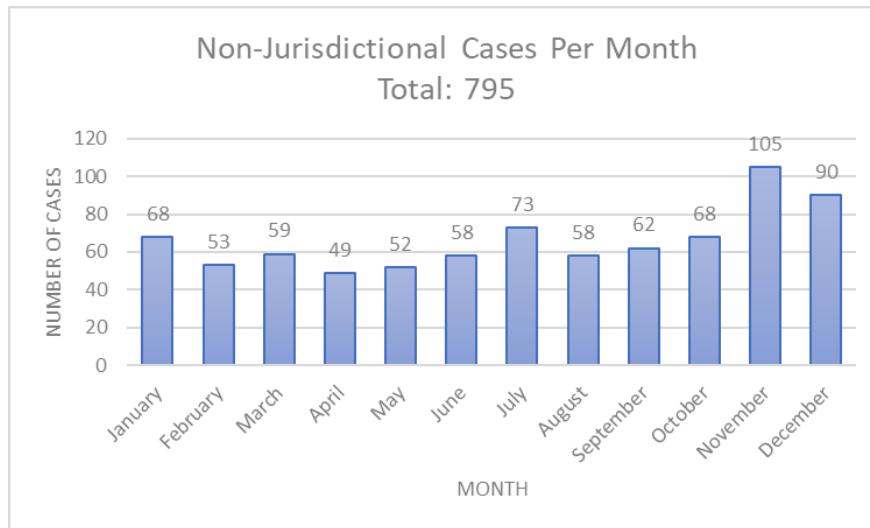
Funeral homes are required to receive authorization to cremate for every death that occurred in Cumberland County, even those not reported to the office. The death certificate is reviewed by the coroner's office prior to cremation to verify all information and review the cause and manner of death, before authorizing the funeral home to cremate.

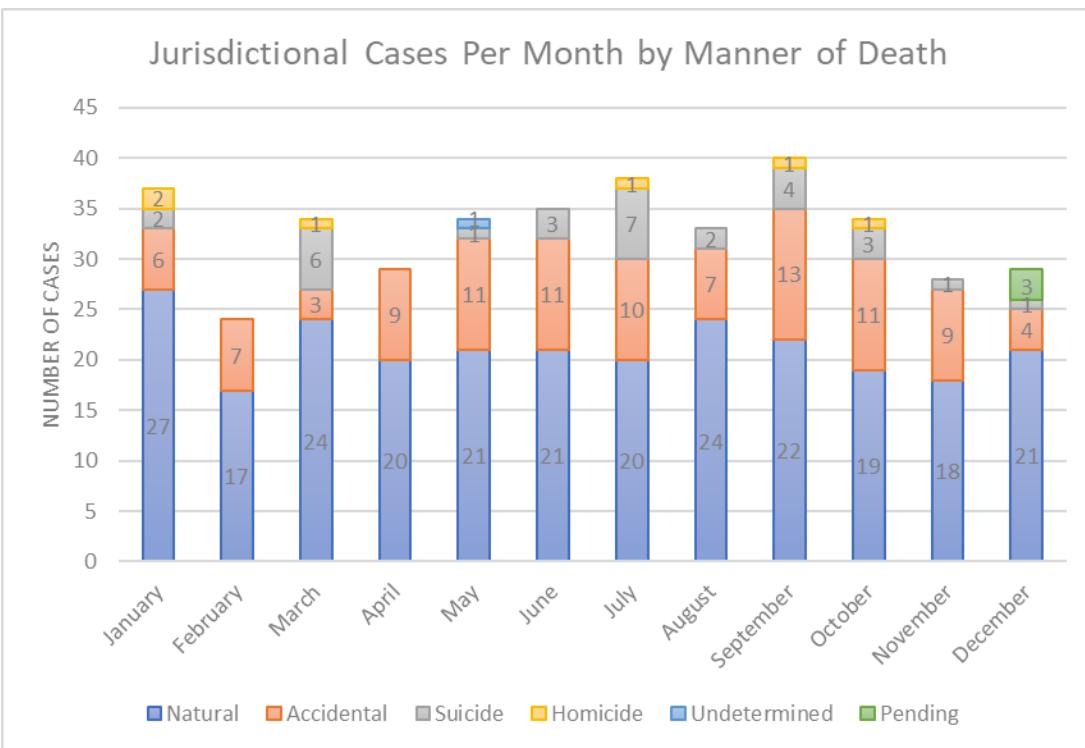


In 2023, autopsies were performed on 82 of 395 Jurisdictional cases.

*No data was available for natural deaths from 2010 through 2012.

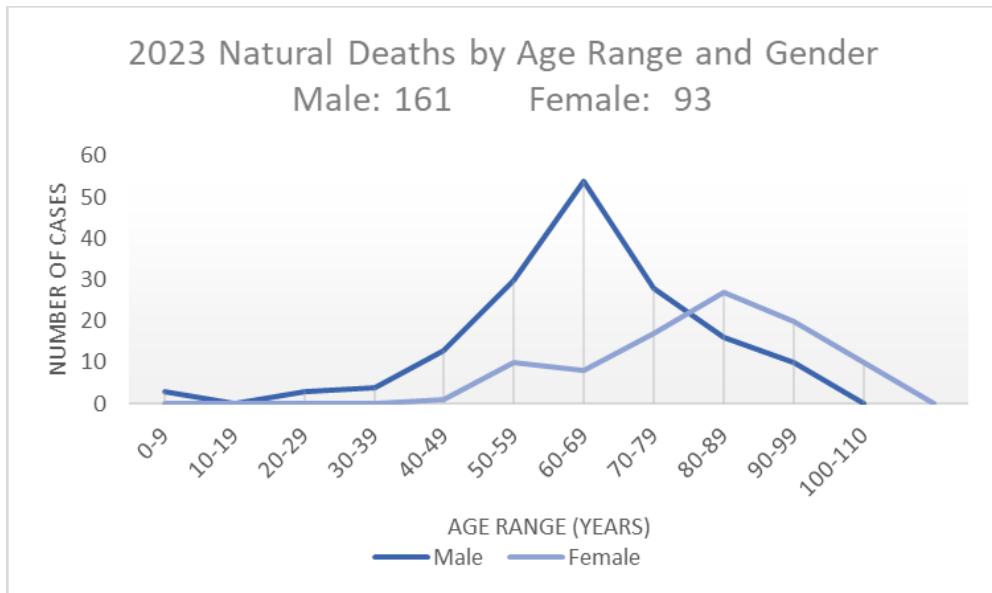
2023 Summary

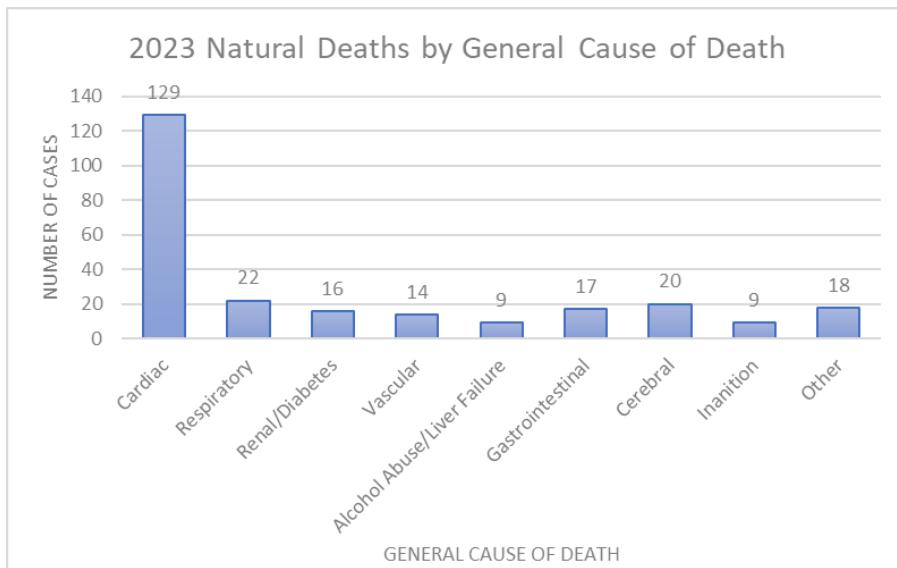




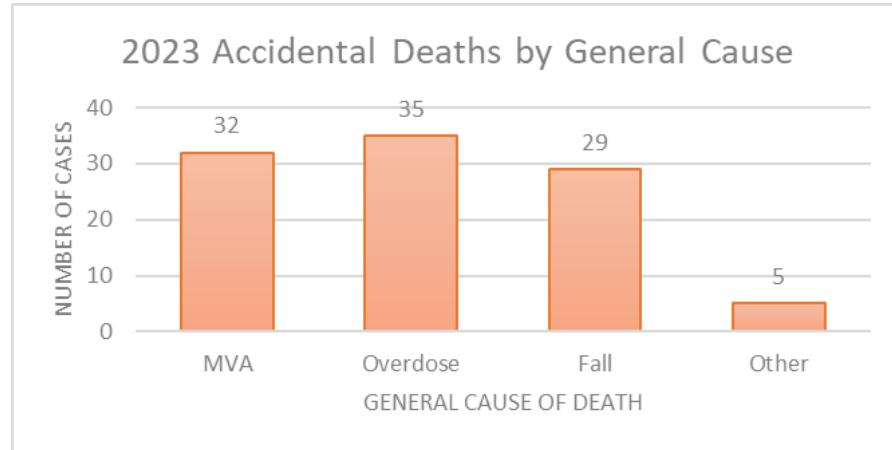
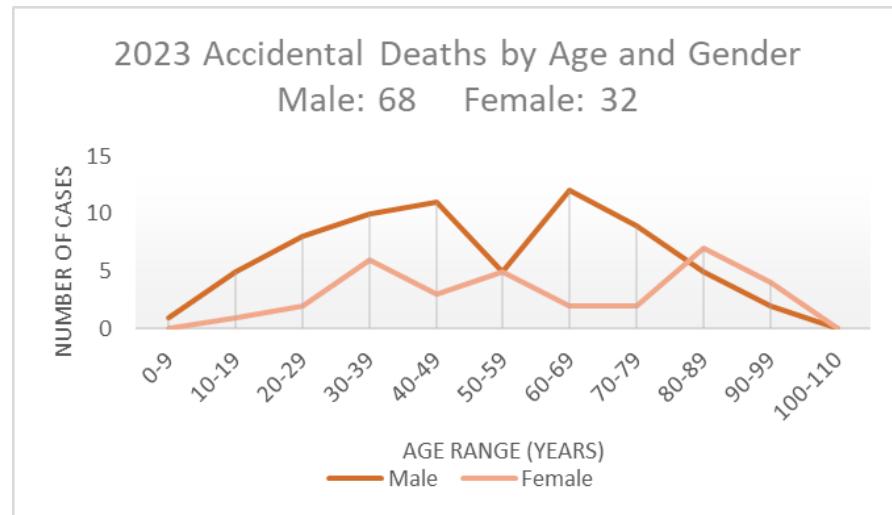
2023 Jurisdictional Cases by Manner of Death

Natural

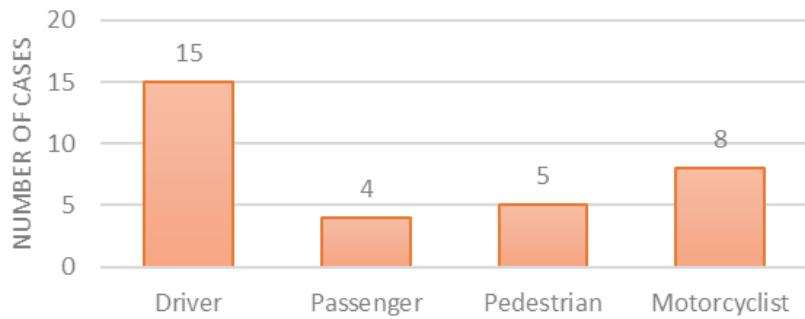




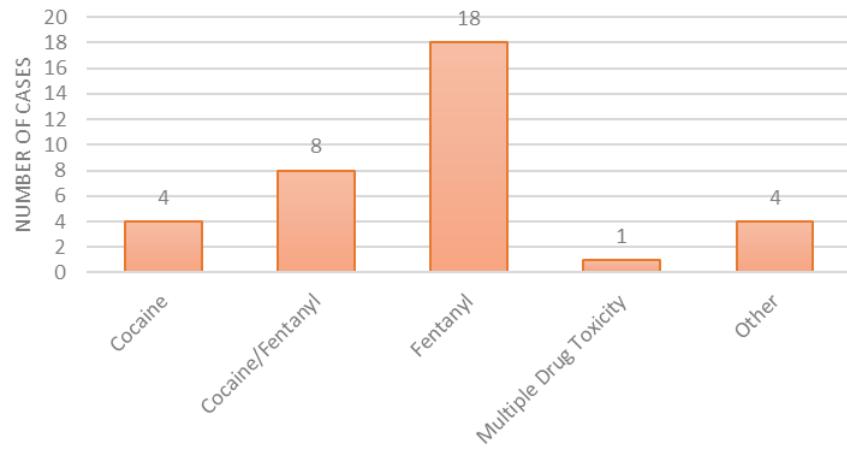
Accidental



2023 Deaths Involving Motor Vehicle Accidents



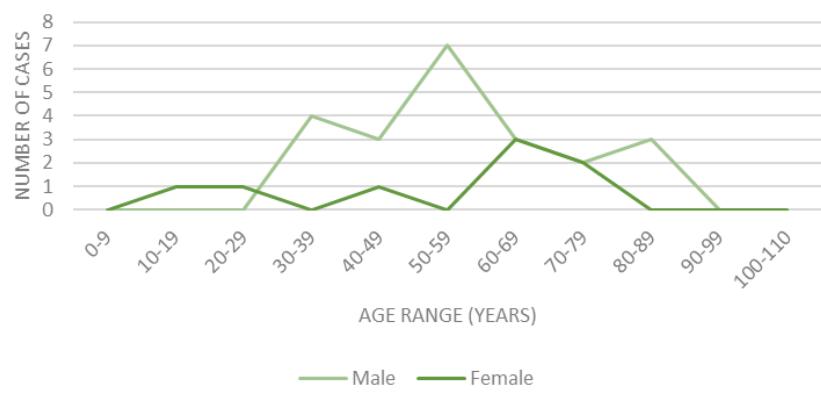
2023 Accidental Overdose Deaths by Substance

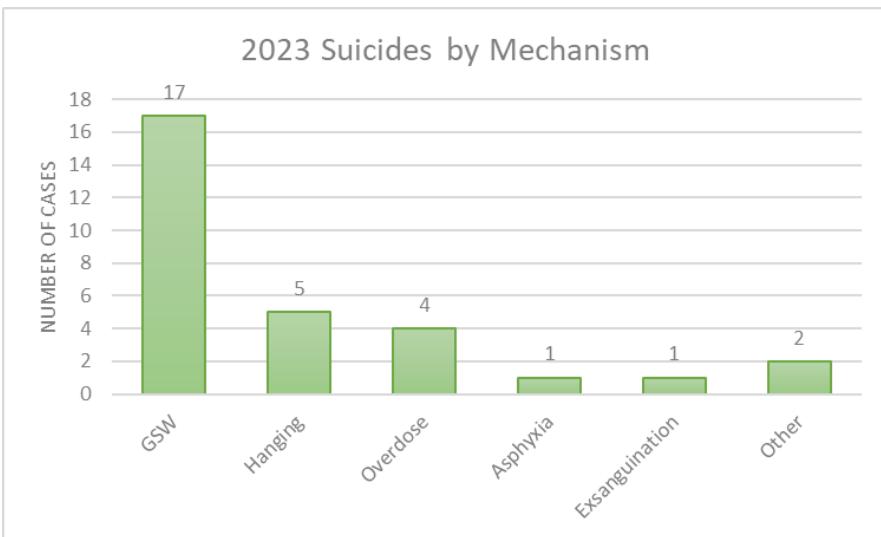


Suicide

2023 Suicides by Age and Gender

Male: 22 Female: 8





Homicide

