San Mateo County Coroner
2016 Annual Report

Robert J. Foucrault, Coroner

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Introduction

The Coroner's Office is an independent medicolegal death investigative office in the County of San Mateo. The Coroner's Office is located at 50 Tower Road, San Mateo. It is the mission of the Coroner's Office to promptly investigate and determine the mode, manner, and cause of death of decedents under the Coroner's jurisdiction. Services are provided in an efficient and courteous manner, respecting the needs of the families involved.

The Coroner's Office conducts medicolegal death investigations to determine the cause, manner, and circumstances of deaths meeting criteria as defined in California Government Code §27491 and California Health and Safety Code §102850.

The Coroner's Office achieved some major accomplishments in 2016.

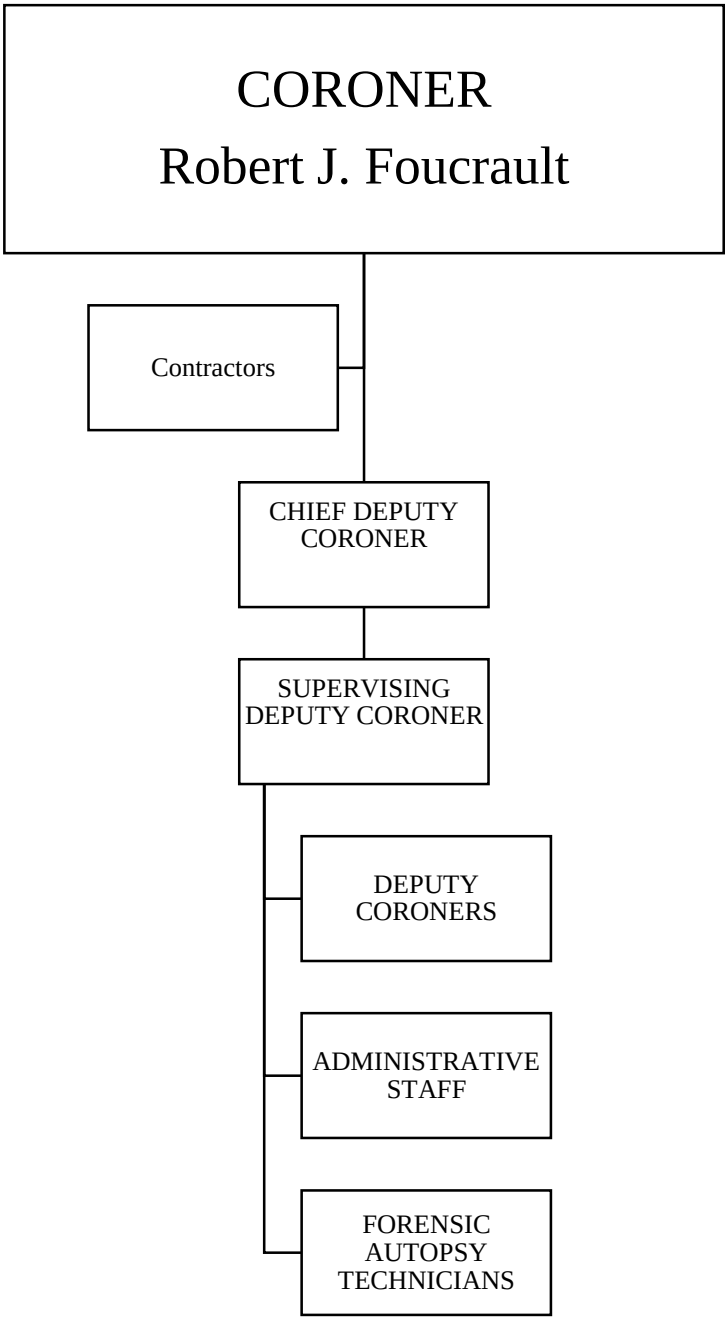
- The Supervising Deputy Coroner and two Deputy Coroners gained Diplomate certification through American Board of Medicolegal Death Investigators (ABMDI).
- The Coroner's Office continues to support specialized medicolegal death investigation training.
    - One Deputy Coroner attended the "Skeletal Recovery Workshop" offered by the Los Angeles Medical Examiner-Coroner Office.
    - Two Deputy Coroners attended the "Buried Body and Surface Skeleton Training" presented by TriTech Training Forensics.
    - One Deputy Coroner attended the 2016 Coroner Advanced Symposium sponsored by the California State Coroners Association.
    - The Coroner's Office teamed up with the District Attorney's Bureau of Investigation for presentation of "Elder Abuse and Neglect" to all Deputy Coroners.
- The Coroner's Office supported collaborative efforts with community partners.
    - Multiple personnel participated in mass casualty planning with its involvement in the 2016 San Mateo County Statewide Medical and Health Exercise.
    - The Coroner's Office implemented numerous referral processes to Donor Network West, U.S. Consumer Products Safety Commission, and San Mateo County Public Health to ensure timely notification of relevant, reportable deaths.
- The Coroner's Office continued to support youth and community outreach.
    - The Save-A-Life program continues to provide services to at risk youth with 37 students attending the program in 2016.
    - 6 Coroner interns completed the academic internship program in 2016.
    - Staff members have also participated in the annual Disaster Preparedness Day.

According to the Census Bureau, San Mateo County was estimated to have a population of 765,135 in 2015. There were approximately 4,666 deaths recorded in San Mateo County in 2016. Of these, 2108 deaths were reported to the Coroner's Office. After initial investigation, 508 were determined to be full Coroner cases with the final cause of death signed by the Coroner, or his designated authority.

This Annual Report provides a summary of the cases reported and investigated by the San Mateo County Coroner's Office and provides a statistical breakdown of the types of deaths that occurred within San Mateo County for the year of 2016.

San Mateo County Coroner 2016 Staff

Coroner Robert J. Foucrault	Coroner
Chief Deputy Coroner Jerry Cohn	Chief Deputy Coroner
Emily Tauscher	Supervising Deputy Coroner
Holly Benedict	Deputy Coroner
Hastin Stein	Deputy Coroner
K'Lynn Solt	Deputy Coroner
Elizabeth Ortiz	Deputy Coroner
Danielle Beckman	Deputy Coroner
Alana Stark	Deputy Coroner
Heather Diaz	Deputy Coroner (Extra Help)
Laura Bailey	Forensic Autopsy Technician
Maggi Horn	Forensic Autopsy Technician
Thomas McGovern	Forensic Autopsy Technician (Extra Help) (Nov-Dec)
Jackie Fleming	Public Service Specialist
Alicia Szto	Medical Transcriptionist
Bradley Buchanan	Coroner Intern (Extra Help)
Pawel Lewicki	Coroner Intern (Extra Help)
Thomas McGovern	Coroner Intern (Extra Help) (Feb-Dec)
Parrisha Fortson	STEP Intern (Extra Help) (Jun-Dec)
Peter Benson, M.D.	Forensic Pathologist (Contractor)
Thomas Rogers, M.D.	Forensic Pathologist (Contractor)


CORONER
Robert J. Foucrault
Contractors
CHIEF DEPUTY CORONER
SUPERVISING DEPUTY CORONER
DEPUTY CORONERS
ADMINISTRATIVE STAFF
FORENSIC AUTOPSY TECHNICIANS

Reportable Criteria
Part 1 of 3

Section 27491 of the California Government Code and Section 102850 of the Health and Safety Code direct the authority and duty of the Coroner to inquire into and determine the circumstances, manner, and cause of the following deaths which are immediately reportable:

1. When a death is not in the attendance of a physician or during the continued absence of the qualifying physician. This includes all deaths outside hospitals and nursing care facilities. This includes all deaths which occur without attendance of a physician, such as where there is no history of medical attention of the deceased or where attention was so very remote as to afford no knowledge in relation to the cause of death, the death is reportable. The Coroner/Deputy Coroner will decide whether to investigate the death fully or not, depending on the nature and gravity of the illness proceeding death, and upon the physician's opinion of the patient's actual life expectancy at the time of the physician's last visit. If, during or after the investigation, it is ascertained that the death is due to natural causes and that there is a physician who is qualified and willing, the Coroner will release the case to the physician for his/her certification and signature, and the custody of the body will be retained by the family for removal to a private mortuary of the family's choice. For a physician to qualify certifying and signing a Certificate of Death, the physician must have professionally seen the patient during the 20 days prior to death. (See #2 below).

A patient in a hospital is always considered as being in attendance. It is not necessary that the physician attend the patient for a period of 24 hours prior to death in order to sign the Certificate of Death. On natural deaths, a physician may be qualified to sign a Certificate of Death provided he/she attended the patient for a sufficient time to properly diagnose the case and subsequent cause of death. While it has been the practice to report any and all hospital deaths, which occur within 24 hours of admission, this practice is not required by State Law and should be the policy decision of the institution involved. If a hospital has an administrative policy of reporting cases to the Coroner when a patient dies within 24 hours after admittance, the Coroner will discuss the case with the attending physician; however may not accept the case for investigation.

2. Wherein the deceased has not been attended by a physician in the 20 days prior to death. The word "attended" means that the patient must have been professionally seen by the physician. When the physician notifies the Coroner/Deputy Coroner, he/she will decide whether to investigate the death fully or not, depending on the nature and gravity of the illness preceding death, and upon the physician's opinion of the patient's actual life expectancy at the time of the physician's last visit. Cooperation and consultation between the Coroner and the physician may provide cause; however, if the doctor's prior knowledge of the subject could not be applied to the death, then an autopsy would be performed.

Reportable Criteria
Part 2 of 3

3. When the physician is reasonably unable to state the cause of death or where the death is sudden and unexpected. The physician reporting the case must have a reasonable basis for his/her opinion. *The physician cannot be simply unwilling to state the cause of death*.

4. Known or suspected homicides. These cases are reported for obvious medicolegal reasons.

5. Known or suspected suicides. These cases are reported for obvious medicolegal reasons.

6. Associated with a known or alleged rape or crime against nature.

7. Involving any criminal act or suspicion of a criminal act. This would include instances where there is evidence or suspicion of criminal abortion (self-induced or by the act of another), euthanasia, or the later result of an accident. This would cover deaths under such circumstances as to afford reasonable grounds to suspect that the death was caused by the criminal act of another.

8. Following an accident or injury. Whether an accident or injury caused the death immediately or even a considerable time later, the case is reportable. Whether the accident or injury was of grave nature or only slight, so long as it *is the opinion of the attending or reporting physician that it might have contributed to the death in any degree.*

If the injury is to be listed anywhere on the Certification of Death, as contributory even though not the immediate cause of death, the case must be reported to the Coroner's Office. When, in the opinion of the physician, the injury is so slight that he/she does not believe that it contributed to the death, it is best to report such death so the Coroner/Deputy Coroner may decide whether any criminal, civil or legal consideration enters into the case that may require further investigation. Particularly, where a second party may have liability for the occurrence, the Coroner/Deputy Coroner will weigh the circumstances to ascertain whether any authorized public purpose or any aid to the administration of justice between involved parties will be served by full coroner involvement.

9. A death relating to a known or suspected drowning, hanging, gunshot, stabbing, cutting, starvation, exposure, drug overdose, fire, strangulation, or aspiration.

10. All aspirations are reportable. The law accepts that a terminal aspiration can occur during the mechanics of death from a primary natural condition. *The local registrar must reject any Certificate of Death that indicates aspiration was a contributing factor in the death unless the death has been reported to the Coroner.*

11. All intra-operative deaths. During upon the circumstances, the Coroner will determine whether an investigation is warranted. If the operative death is due to a misadventure or procedural problem than it would typically be considered an unnatural death and is reportable.

Reportable Criteria
Part 3 of 3

All deaths in operating rooms and all deaths where a patient has not fully recovered from an anesthetic, whether in surgery, the recovery room or elsewhere. The Coroner's Office will proceed with a complete death investigation, when the nature of the death or legal implications warrants it.

12. Suspected accidental or intentional deaths by poisoning (food, chemical, drugs, therapeutic agent, etc.). Deaths, wholly or in part, due to industrial agents or toxins, ordinary food poisonings, household medications, prescribed pharmaceuticals and biological agents, are reportable when these circumstances in any way directly contributed to the death.

13. Known or suspected contagious disease and constituting a public hazard. If there was not sufficient time to diagnose and confirm a case in the hospital, then the death should be referred to the Coroner. All other deaths from a contagious disease will be reported to the Coroner.

14. When a death is clearly known to be due to, wholly or in part, an occupation disease or injury, that death is reportable.

15. In all deaths of unknown or unidentified persons.

16. Suspected SIDS deaths. These are unexpected deaths of apparent healthy, thriving infants under the age of one year.

17. All fetal deaths when gestation period is 20 weeks or longer.

18. All deaths while a decedent was incarcerated. This includes all in-custody and police involved deaths.

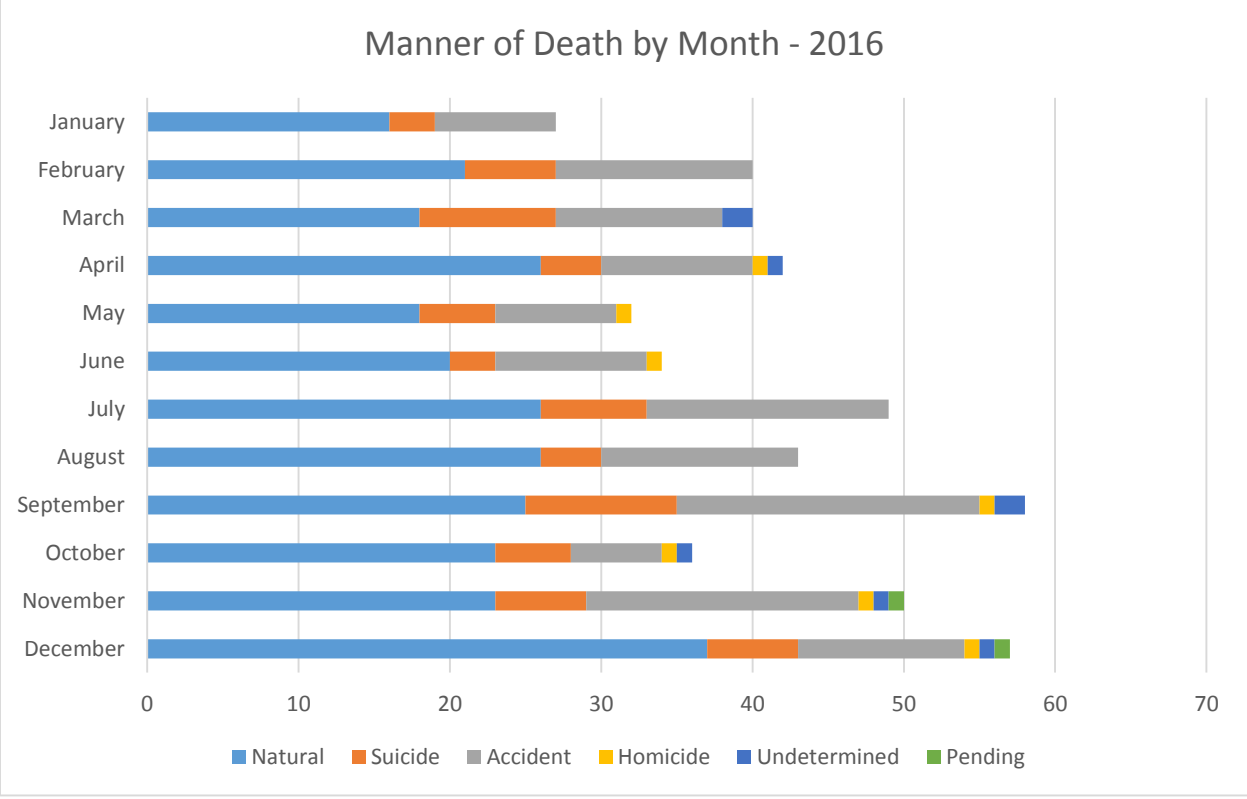
19. All patients who are found comatose or remain comatose during their hospital admission are reportable.

Statistics for Calendar Year 2016

Number of deaths reported:	2108
Number of cases for full investigation:	508
Number of cases investigated and released:	117
Number of cases by manner of death:	
Natural	279
Accident	144
Suicide	68
Homicide	7
Undetermined	8
Pending Investigation	2
Number of decedents transported:	
Coroner	276
Contractor	169
Mortuary/Funeral Home	7
Forensic Examinations:	
Full Autopsy	229
Limited Autopsy	91
Clinical Review	188
Number of toxicology cases conducted:	348
Number of cases reported as "unidentified":	21
Identified after investigation	21
Remain unidentified	0
Organ and tissue donations:	
Cases referred for donation	64
Total organ donors	7
Total tissue donors	72
Total organs transplanted	36

General Classifications of Death by Month

Coroner Case Statistics for 2016 by Month							
	Natural	**Suicide**	**Accident**	**Homicide**	**Undetermined**	**Pending**	**Total**
January	16	3	8	0	0	0	27
February	21	6	13	0	0	0	40
March	18	9	11	0	2	0	40
April	26	4	10	1	1	0	42
May	18	5	8	1	0	0	32
June	20	3	10	1	0	0	34
July	26	7	16	0	0	0	49
August	26	4	13	0	0	0	43
September	25	10	20	1	2	0	58
October	23	5	6	1	1	0	36
November	23	6	18	1	1	1	50
December	37	6	11	1	1	1	57
Total	279	68	144	7	8	2	508



Natural

Natural deaths are due solely or nearly totally to disease and/or the aging process.

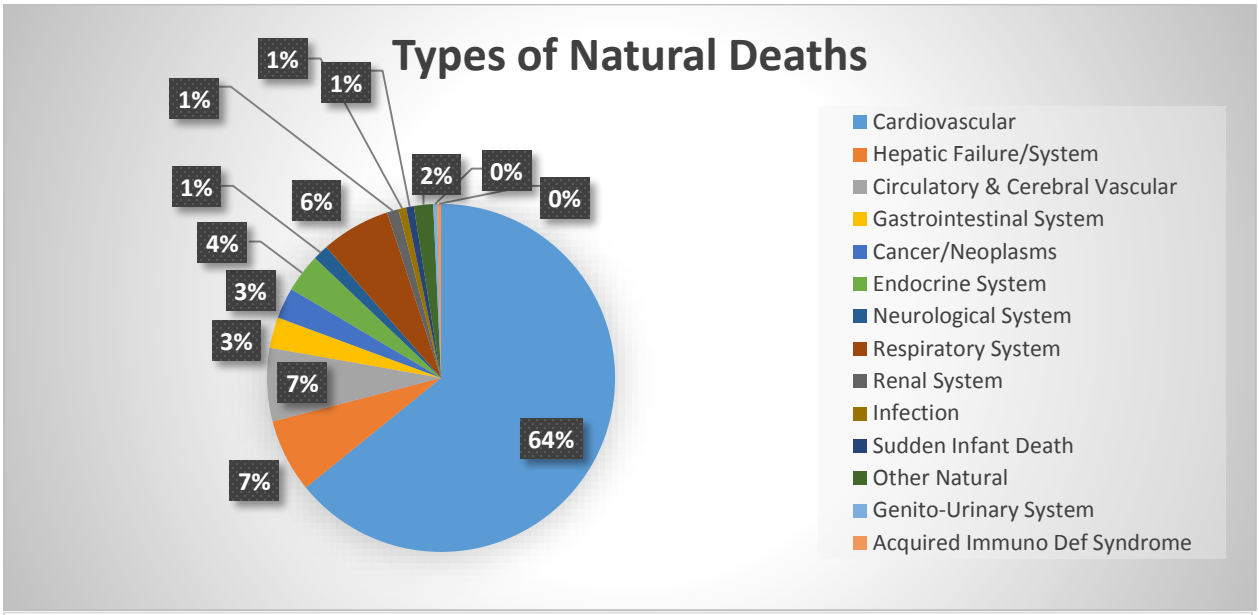
Total Natural Deaths in 2016: 279

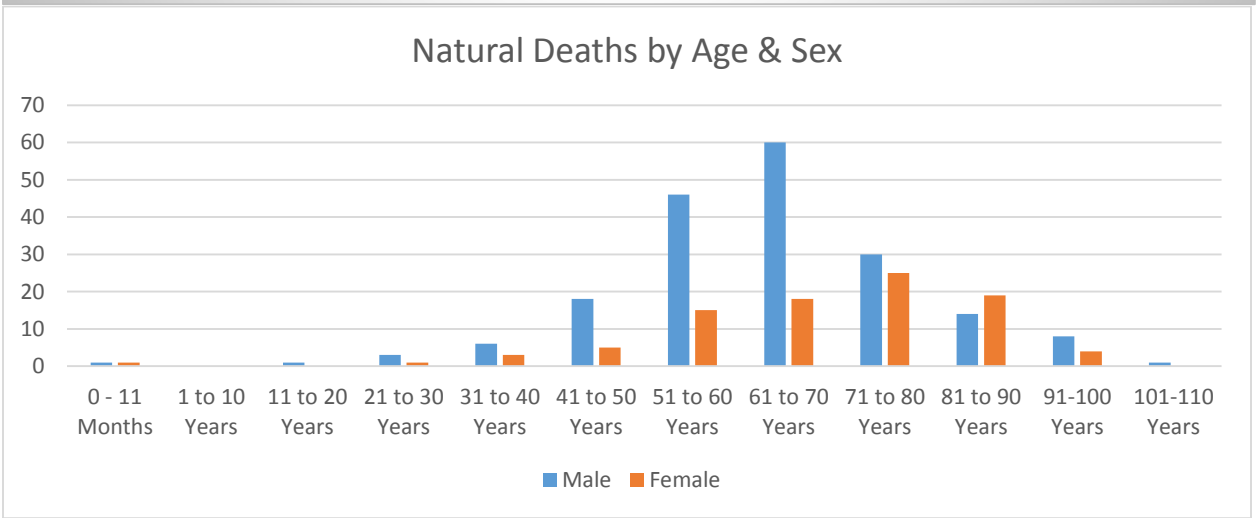
Types of Natural Deaths	
Cardiovascular	179
Hepatic Failure/System	19
Circulatory & Cerebral Vascular	19
Gastrointestinal System	8
Cancer/Neoplasms	8
Endocrine System	10
Neurological System	4
Respiratory System	18
Renal System	3
Infection	2
Sudden Infant Death	2
Other Natural	5
Genito-Urinary System	1
Acquired Immuno Def Syndrome	1

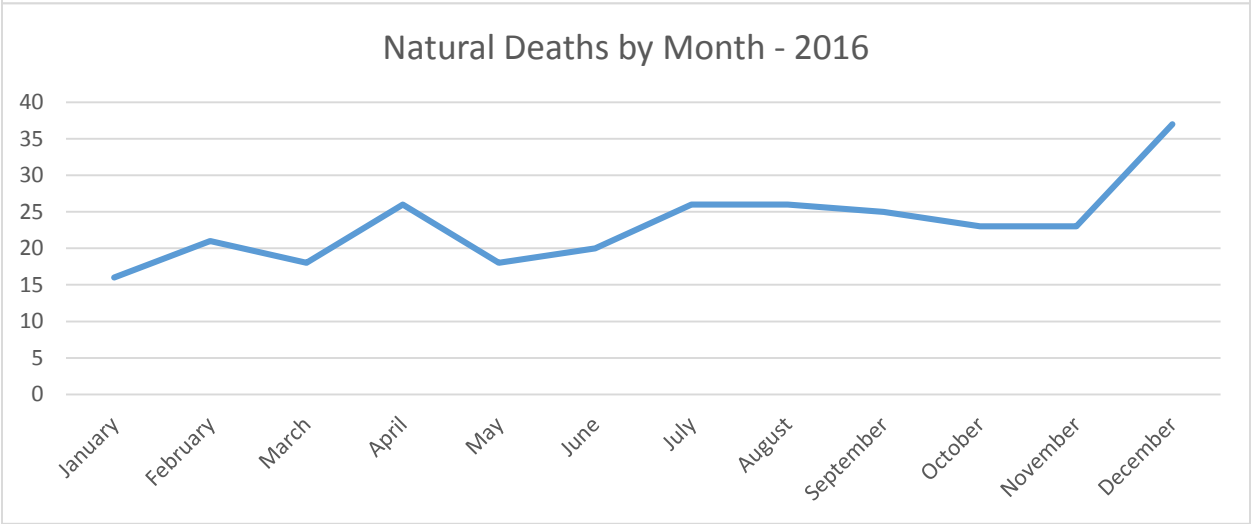
Natural Deaths by Age & Sex		
Age	Male	Female
0 - 11 Months	1	1
1 to 10 Years	0	0
11 to 20 Years	1	0
21 to 30 Years	3	1
31 to 40 Years	6	3
41 to 50 Years	18	5
51 to 60 Years	46	15
61 to 70 Years	60	18
71 to 80 Years	30	25
81 to 90 Years	14	19
91-100 Years	8	4
101-110 Years	1	0

Natural Deaths by Month	
Month	Number
January	16
February	21
March	18
April	26
May	18
June	20
July	26
August	26
September	25
October	23
November	23
December	37

Natural


Types of Natural Deaths
1%
1%
1%
1%
2%
0%
0%
6%
4%
3%
3%
7%
7%
64%
Cardiovascular
Hepatic Failure/System
Circulatory & Cerebral Vascular
Gastrointestinal System
Cancer/Neoplasms
Endocrine System
Neurological System
Respiratory System
Renal System
Infection
Sudden Infant Death
Other Natural
Genito-Urinary System
Acquired Immuno Def Syndrome


Natural Deaths by Age & Sex
70
60
50
40
30
20
10
0
0 - 11 Months
1 to 10 Years
11 to 20 Years
21 to 30 Years
31 to 40 Years
41 to 50 Years
51 to 60 Years
61 to 70 Years
71 to 80 Years
81 to 90 Years
91-100 Years
101-110 Years
Male
Female


Natural Deaths by Month - 2016
40
35
30
25
20
15
10
5
0
January
February
March
April
May
June
July
August
September
October
November
December

Suicide

Suicides result from an injury or poisoning as a result of an intentional, self-inflicted act committed to do self-harm or cause the death of one's self.

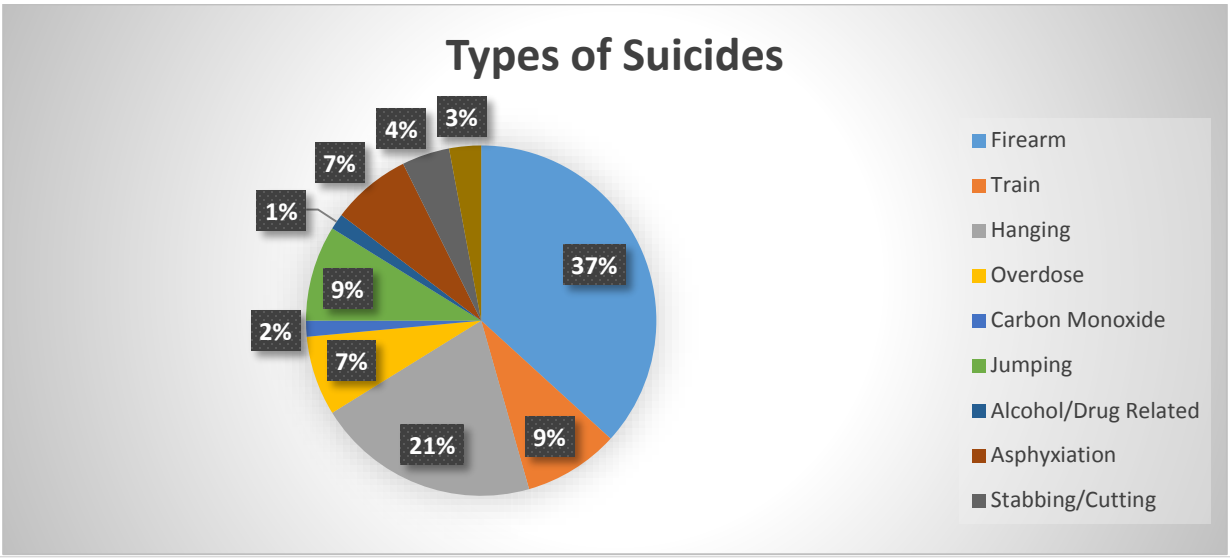
Total Number of Suicides in 2016: 68

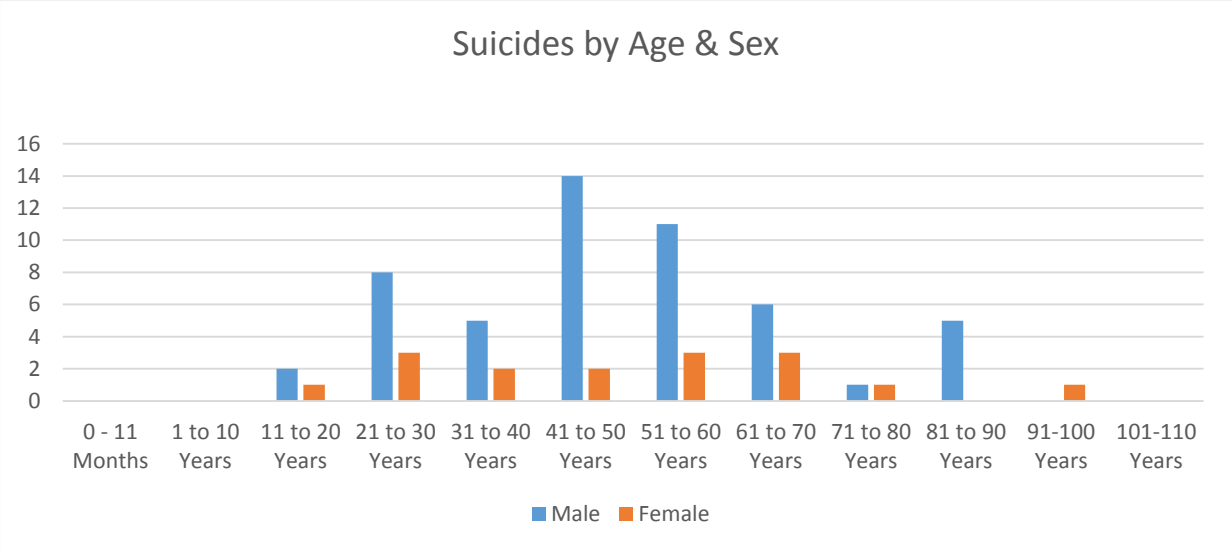
Types of Suicides	
Firearm	25
Train	6
Hanging	14
Overdose	5
Carbon Monoxide	1
Jumping	6
Alcohol/Drug Related	1
Asphyxiation	5
Stabbing/Cutting	3
Drowning	2

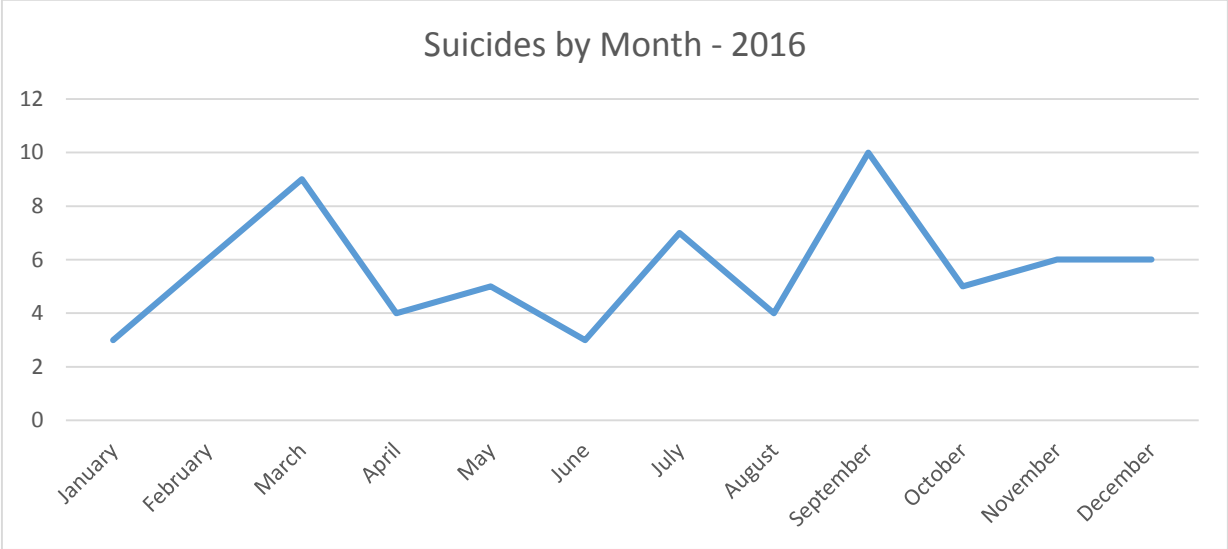
Suicide by Age & Sex		
Age	Male	Female
0 - 11 Months	0	0
1 to 10 Years	0	0
11 to 20 Years	2	1
21 to 30 Years	8	3
31 to 40 Years	5	2
41 to 50 Years	14	2
51 to 60 Years	11	3
61 to 70 Years	6	3
71 to 80 Years	1	1
81 to 90 Years	5	0
91-100 Years	0	1
101-110 Years	0	0

Suicide by Month	
Month	Number
January	3
February	6
March	9
April	4
May	5
June	3
July	7
August	4
September	10
October	5
November	6
December	6

Suicide


Types of Suicides
37%
9%
21%
7%
2%
9%
1%
7%
4%
3%
Firearm
Train
Hanging
Overdose
Carbon Monoxide
Jumping
Alcohol/Drug Related
Asphyxiation
Stabbing/Cutting


Suicides by Age & Sex
16
14
12
10
8
6
4
2
0
0 - 11 Months
1 to 10 Years
11 to 20 Years
21 to 30 Years
31 to 40 Years
41 to 50 Years
51 to 60 Years
61 to 70 Years
71 to 80 Years
81 to 90 Years
91-100 Years
101-110 Years
Male
Female


Suicides by Month - 2016
12
10
8
6
4
2
0
January
February
March
April
May
June
July
August
September
October
November
December

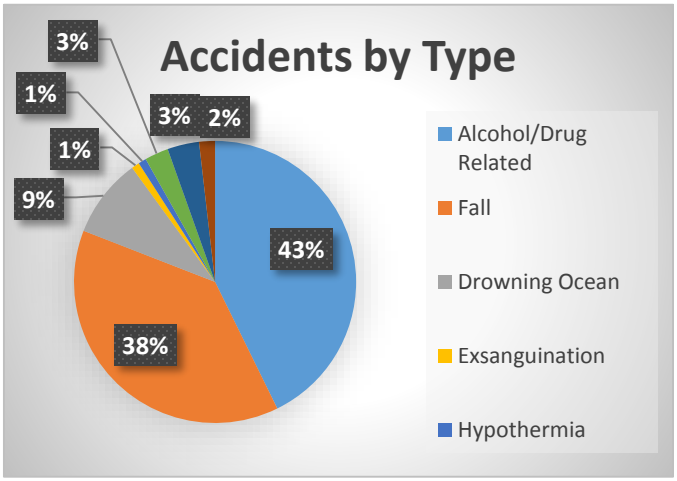
Accident

An accident applies when an injury or poisoning causes death and there is little or no evidence that the injury or poisoning occurred with intent to harm or cause death. In essence, the fatal outcome was unintentional. Motor Vehicle Accidents are not included in the statistics below.

Total Number of Accidental Deaths in 2016: 110

**not including motor vehicle accidents*

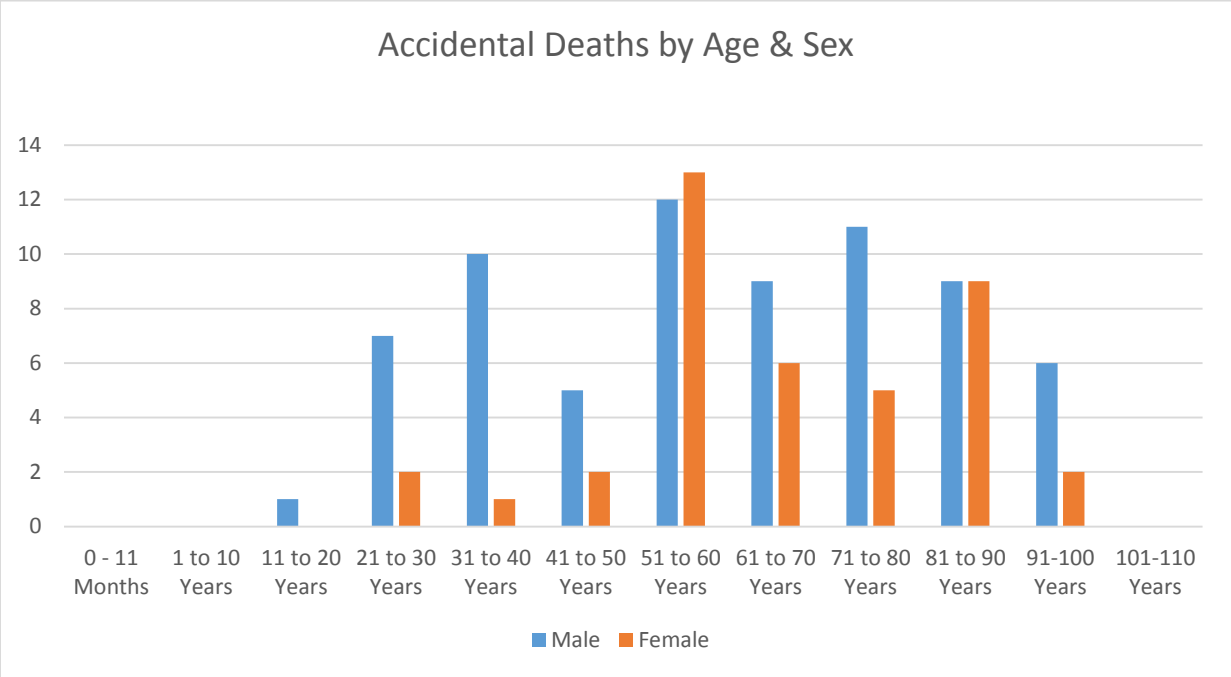
Types of Accidents	
Alcohol/Drug Related	47
Fall	42
Drowning Ocean	10
Exsanguination	1
Hypothermia	1
Choking	3
Medical/Misadventure	4
Trauma	2

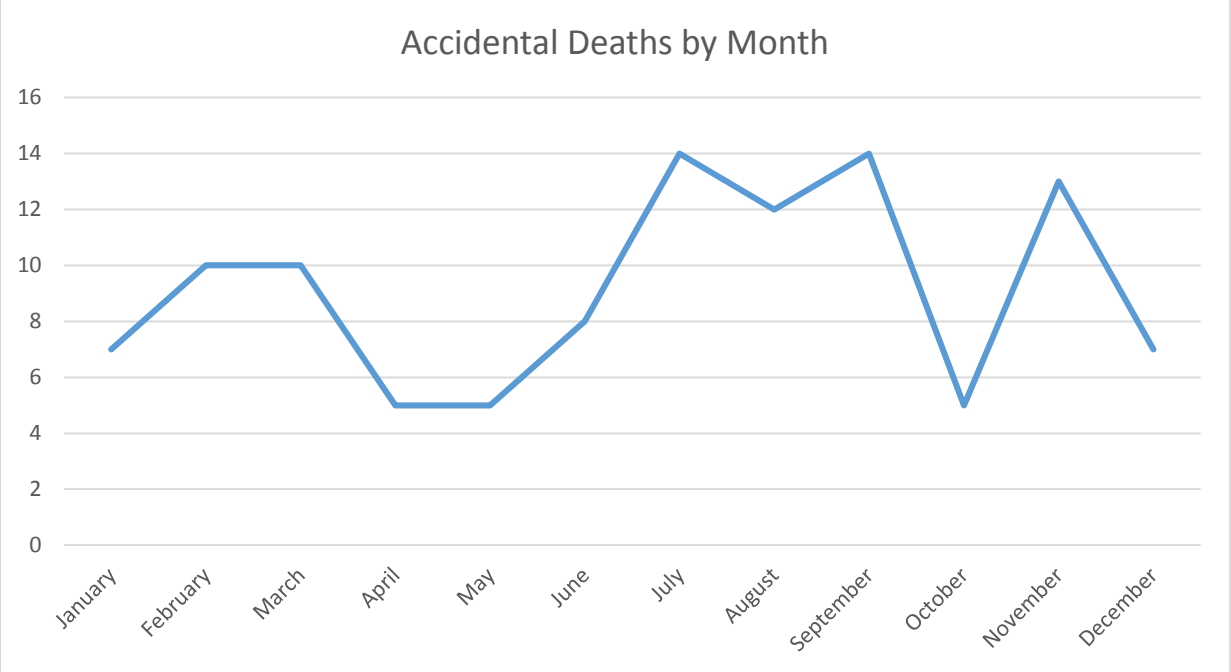


Accidents by Age & Sex		
Age	Male	Female
0 - 11 Months	0	0
1 to 10 Years	0	0
11 to 20 Years	1	0
21 to 30 Years	7	2
31 to 40 Years	10	1
41 to 50 Years	5	2
51 to 60 Years	12	13
61 to 70 Years	9	6
71 to 80 Years	11	5
81 to 90 Years	9	9
91-100 Years	6	2
101-110 Years	0	0

Accidents by Month	
Month	Number
January	7
February	10
March	10
April	5
May	5
June	8
July	14
August	12
September	14
October	5
November	13
December	7

Accident


Accidental Deaths by Age & Sex
14
12
10
8
6
4
2
0
0 - 11 Months
1 to 10 Years
11 to 20 Years
21 to 30 Years
31 to 40 Years
41 to 50 Years
51 to 60 Years
61 to 70 Years
71 to 80 Years
81 to 90 Years
91-100 Years
101-110 Years
Male
Female


Accidental Deaths by Month
16
14
12
10
8
6
4
2
0
January
February
March
April
May
June
July
August
September
October
November
December

Motor Vehicle Fatalities

The Coroner's Office, as well as other law enforcement agencies within the jurisdiction of the motor vehicle fatality, conducts a thorough investigation of any accident involving a motor vehicle or traffic collision. Following a thorough investigation and an autopsy examination, the manner of death may be determined to be natural, accident, suicide, homicide, or undetermined.

Total Number of Motor Vehicle Fatalities in 2016: 35

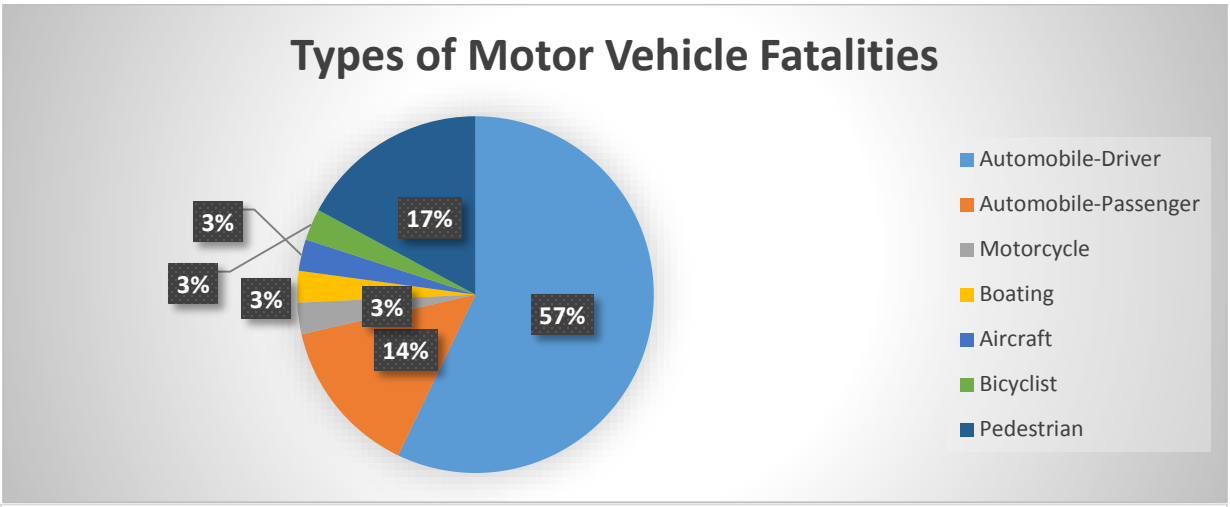
Types of Motor Vehicle Fatalities	
Automobile-Driver	20
Automobile-Passenger	5
Motorcycle	1
Boating	1
Aircraft	1
Bicyclist	1
Pedestrian	6

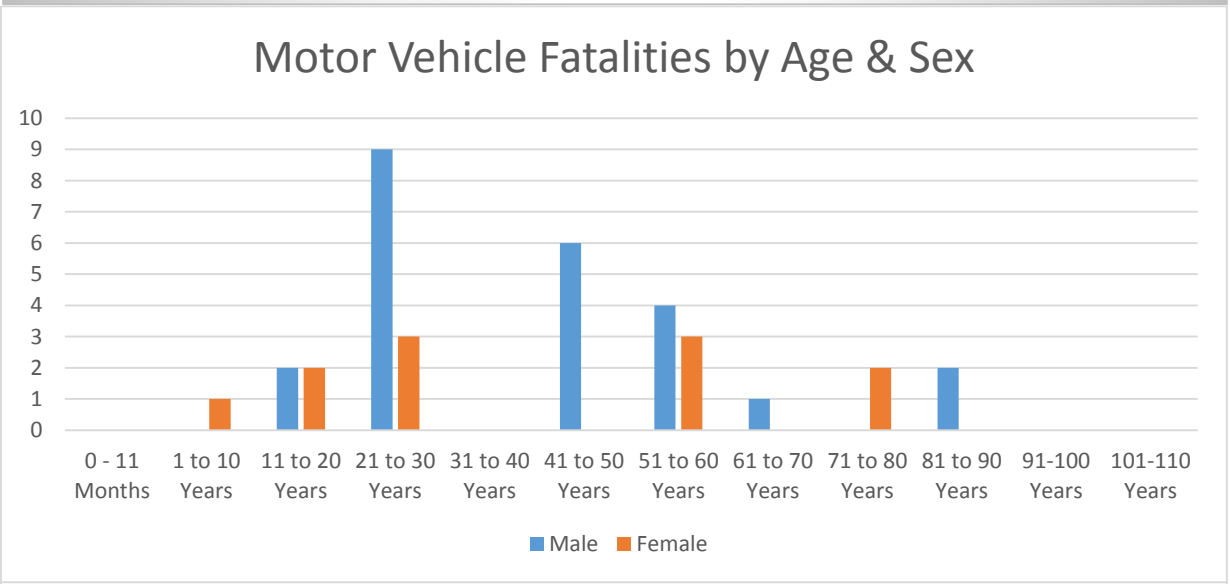
Manner of Death	
Natural	1
Accident	34
Suicide	0
Homicide	0
Undetermined	0

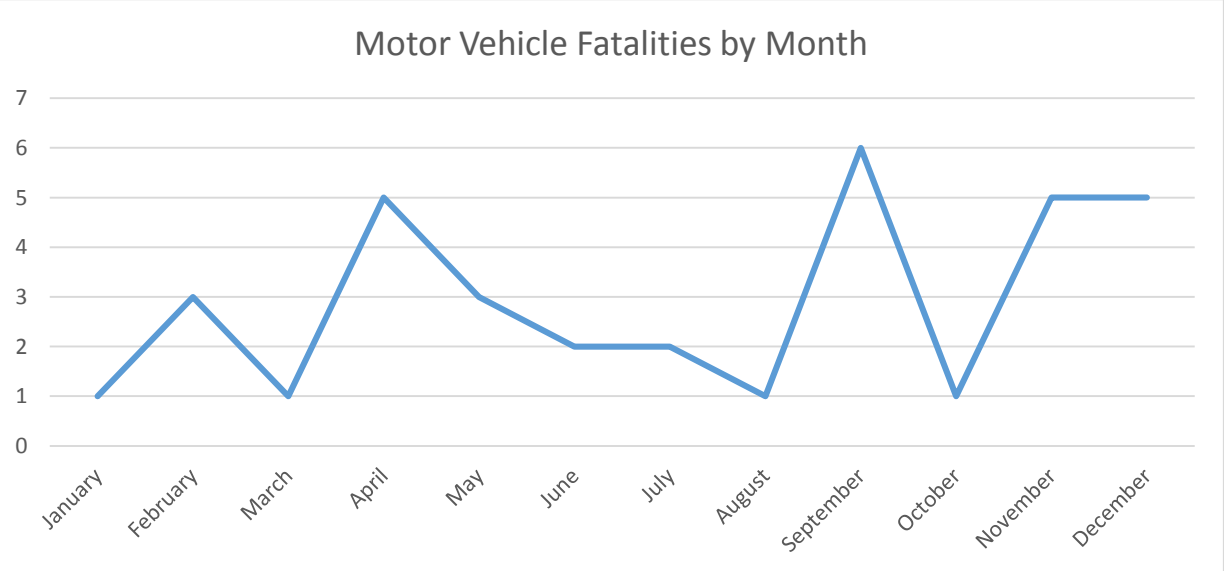
Motor Vehicle Fatalities by Age & Sex		
Age	Male	Female
0 - 11 Months	0	0
1 to 10 Years	0	1
11 to 20 Years	2	2
21 to 30 Years	9	3
31 to 40 Years	0	0
41 to 50 Years	6	0
51 to 60 Years	4	3
61 to 70 Years	1	0
71 to 80 Years	0	2
81 to 90 Years	2	0
91-100 Years	0	0
101-110 Years	0	0

Motor Vehicle Fatalities by Month	
Month	Number
January	1
February	3
March	1
April	5
May	3
June	2
July	2
August	1
September	6
October	1
November	5
December	5

Motor Vehicle Fatalities







Motor Vehicle Fatalities
Involving Alcohol and/or Drugs

Pursuant to California Government Code Section 27491.25, the Coroner's pathologist takes blood and urine samples from the deceased to conduct appropriate, related chemical tests to determine the alcoholic contents, if any, of the body. If necessary, the coroner may perform other chemical tests to determine the drug contents, if any, of the body. Testing of deceased persons under the age of 15 years is not required, unless the circumstances indicate the possibility of alcoholic and/or drug consumption. In some cases, the victims are hospitalized for a lengthy period of time prior to death and therefore, relevant blood and urine samples are unavailable for testing.

	Alcohol only test	**Routine drug screen**	**No Test completed**
Alcohol present	9	2	-
Prescription drugs present	-	4	-
Illicit drugs present	-	2	-
Not detected	8	10	2
Total	17	16	2

Homicide

A homicide occurs when death results from a volitional act committed by another person to cause fear, harm, or death. Intent to cause death is a common element but is not required for classification as homicide. It is to be emphasized that the classification of Homicide for the purpose of death certification is a term that neither indicates nor implies criminal intent, which remains a determination within the province of legal processes.

Total Number of Homicides in 2016: 7

Types of Homicides	
Gunshot	5
Blunt Force	2

Homicides by Age & Sex		
Age	Male	Female
0 - 11 Months	0	0
1 to 10 Years	0	1
11 to 20 Years	1	0
21 to 30 Years	3	1
31 to 40 Years	1	0
41 to 50 Years	0	0
51 to 60 Years	0	0
61 to 70 Years	0	0
71 to 80 Years	0	0
81 to 90 Years	0	0
91-100 Years	0	0
101-110 Years	0	0

Homicides by Month	
Month	Number of Homicides
January	0
February	0
March	0
April	1
May	1
June	1
July	0
August	0
September	1
October	1
November	1
December	1

Undetermined

Undetermined or "could not be determined" is a classification used when the information pointing to one manner of death is no more compelling than one or more other competing manners of death in thorough consideration of all available information. Sometimes information concerning the circumstances of death may be inadequate due to a lengthy delay between the occurrence of the death and the discovery of the body. If an extensive investigation and autopsy cannot clarify the circumstances which led to a death, the death is then classified as undetermined.

Total Number of Undetermined Deaths in 2016: 8

Indigent Cremation in 2016

Through the County Cremation process, the Coroner inters the remains of the decedent when no provisions for final disposition were made by the decedent and he or she is indigent. Additionally, if the Coroner notifies or attempts to notify the person responsible for the internment of the decedent's remains, as defined by Health and Safety Code §7100, and he or she fails, refuses, or neglects to handle the final disposition, the Coroner proceeds with internment via County Cremation.

County Cremations referred by San Mateo County Public Administrators' Office:	14
Cremations performed by the San Mateo County Coroner after remains were abandoned by family:	11
Dispositions handled by family after receiving a fee reduction by application for financial need:	30