San Mateo County Coroner
2018 Annual Report

Robert J. Foucrault, Coroner

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Introduction

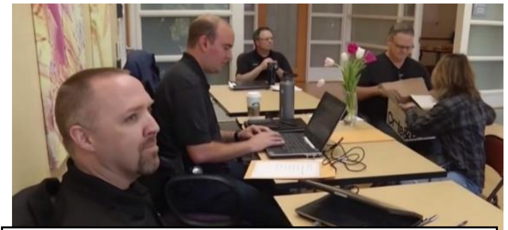
The Coroner's Office is an independent medicolegal death investigation office in the County of San Mateo. The Coroner's Office is located at 50 Tower Road in San Mateo. It is the mission of the Coroner's Office to promptly investigate and determine the cause, manner, and mode of death of decedents under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

A Coroner Office staff member instructed South County Fire personnel on the role of the Coroner.

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 2018:

- The Coroner's Office continued to offer Peace Officer Standards and Training (POST) and American Board of Medicolegal Death Investigators (ABMDI) certified training to Bay Area law enforcement officers. The course was additionally tailored to educate fire personnel and fire paramedics.
- The Coroner's Office collaborated with 15 multi-disciplinary agencies and 11 law enforcement agencies to host the inaugural "Missing Persons Day" in the Bay Area.
- The Coroner's Office reinvigorated the Domestic Violence Death Review Team and expanded the criteria for reviewing deaths related to domestic violence.
- The Coroner's Office continued to support specialized medicolegal death investigation training and required training by POST for staff members:
    - One Deputy Coroner attended the "Coroners Course" offered by the California Coroner Training Center.
    - The Assistant Coroner completed the POST "Management Course."
    - Four staff members attended the 2018 "Coroner Advanced Symposium" hosted by the California State Coroners Association.
    - One Deputy Coroner achieved ABMDI diplomate certification.



San Mateo County law enforcement detectives processed family members reporting a missing person case at "Missing Persons Day"

The Coroner's Office showcased active unidentified person cases within San Mateo County at "Missing Persons Day"

- The Coroner's Office continued to support youth and community outreach.
  - The Save-A-Life program continued to provide services to at-risk youth with 11 students attending the program in 2018.
  - One Coroner Intern completed the academic internship program in summer 2018 and two began their internship for the 2018-19 academic year.
  - Staff members participated in the annual Disaster Preparedness Day and Disaster Service Workers Day.
  - Staff members participated in three "Every 15 Minutes" and "Sober Prom" events at local high schools.
  - Staff members participated in career resource days and provided office tours

An instructor demonstrated the components of an autopsy on a dummy for students of the Save a Life program

Coroner's Office staff discussed the role of the Coroner at the annual Coroner/Crime Lab Open House. (above)

Coroner Office staff introduced a new forensics anthropology lab at Disaster Preparedness Day. (below)

Coroner Office staff members simulated the investigation and processing of a decedent at the site of a mock motor vehicle accident at Every 15 Minutes. (left)

- The Coroner’s Office introduced the “Suicide Consolidated Risk Assessment Profile” to assess the risk factors associated with deaths by suicide.
- The Coroner’s Office strengthened mass fatality planning with membership with San Mateo County Emergency Managers Association; staff attendance to a mutual aid workshop; staff training of trailer hook-ups; and participation with exercises such as Green Dawn, Yellow Command, and the 2018 San Mateo County Statewide Medical and Health Exercise.

A Coroner’s Office staff member participated in an exercise, Yellow Command, activating the San Mateo County Emergency Operations Center (EOC).

Deputy Coroners deployed to the fires in Butte County.

According to the Census Bureau, San Mateo County was estimated to have a population of 769,545 in 2018. There were approximately 4,818 deaths recorded in San Mateo County in 2018. Of these deaths, 2,247 deaths were reported to the Coroner’s Office. After initial investigation, 545 were determined to be full Coroner cases with the final cause of death signed by the Coroner, or his designated authority.

This 2018 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 2018.

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San Mateo County Coroner 2018 Staff

Robert J. Foucrault	Coroner
Emily Tauscher	Assistant Coroner
K'Lynn Solt	Supervising Deputy Coroner

Investigations

Holly Benedict	Deputy Coroner
Hastin Stein	Deputy Coroner
Elizabeth Ortiz	Deputy Coroner
Danielle Montesano	Deputy Coroner
Alana Stark	Deputy Coroner
Heather Diaz	Deputy Coroner
Laura Bailey	Deputy Coroner (Working out of class)

Pathology

Laura Bailey	Forensic Autopsy Technician
Maggi Horn	Forensic Autopsy Technician
Devan Glensor	Forensic Autopsy Technician (Limited Term)
Megan Walton	Forensic Autopsy Technician (Extra Help) (Apr-Dec)

Administration

Jackie Fleming	Public Service Specialist
Alicia Szto	Medical Transcriptionist (Jan-Mar)
Devon Botham	Management Fellow
Nisael Navarro	Coroner Intern (Extra Help)
Katherine Bates	Coroner Intern (Extra Help)
Thomas McGovern	Coroner Intern (Extra Help) (Jan-Dec)

Contractors

Peter Benson, M.D.	Forensic Pathologist
Thomas Rogers, M.D.	Forensic Pathologist

SAN MATEO County of San Mateo

CORONER'S OFFICE

ORGANIZATIONAL CHART

- **CORONER** – Robert J. Foucrault
  - Contractors
  - **ASSISTANT CORONER** – Emily Tauscher
    - **SUPERVISING DEPUTY CORONER**
      - DEPUTY CORONERS
      - ADMINISTRATIVE STAFF
      - FORENSIC AUTOPSY TECHNICIANS

Reportable Criteria
Part 1 of 3

California Government Code §27491 and Health and Safety Code §102850 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 deaths outside hospitals and nursing care facilities. This includes deaths which occur without attendance of a physician, such as when there is no history of medical attention of the deceased or when attention was so remote as to afford no knowledge in relation to the cause of death, the death is reportable. The Coroner/Deputy Coroner will determine the extent of the investigation, 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. 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/Deputy 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 sufficient knowledge to reasonable state the cause of death occurring under natural circumstances.

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 to opine the cause of death. While it has been the practice to report any and hospital deaths, which occur within 24 hours of admission, this practice is not required by state law. If a hospital has an administrative policy of reporting cases to the Coroner/Deputy Coroner when a patient dies within 24 hours after admittance, the Coroner/Deputy 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 followed by the physician. When the physician notifies the Coroner/Deputy Coroner, he/she will decide the extent of the investigation, 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/Deputy 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 the Coroner/Deputy Coroner would pursue additional investigation.

Reportable Criteria
Part 2 of 3

3. When the physician is reasonably unable to state the cause of death or when 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.

5. Known or suspected suicides.

6. Associated with a known or alleged rape.

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 deaths so the Coroner/Deputy Coroner may decide whether any criminal, civil or legal consideration enters into the case that may require further investigation. Particularly, when 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, and strangulation.

10. 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 rejects any Certificate of Death that indicates aspiration was a contributing factor in the death unless the death has been reported to the Coroner/Deputy Coroner.*

11. Intra-operative deaths. The Coroner/Deputy 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

Deaths in operating rooms and deaths when 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/Deputy Coroner. Deaths from a contagious disease will be reported to the Coroner/Deputy Coroner.

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

15. In deaths of unknown or unidentified persons.

16. Suspected SIDS deaths. Any unexpected deaths of apparent healthy, thriving infants under the age of one year. Any deaths as a result of sleep related asphyxia.

17. Fetal deaths when gestation period is 20 weeks or longer.

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

19. Patients who are found comatose or remain comatose during their hospital admission and then die are reportable.

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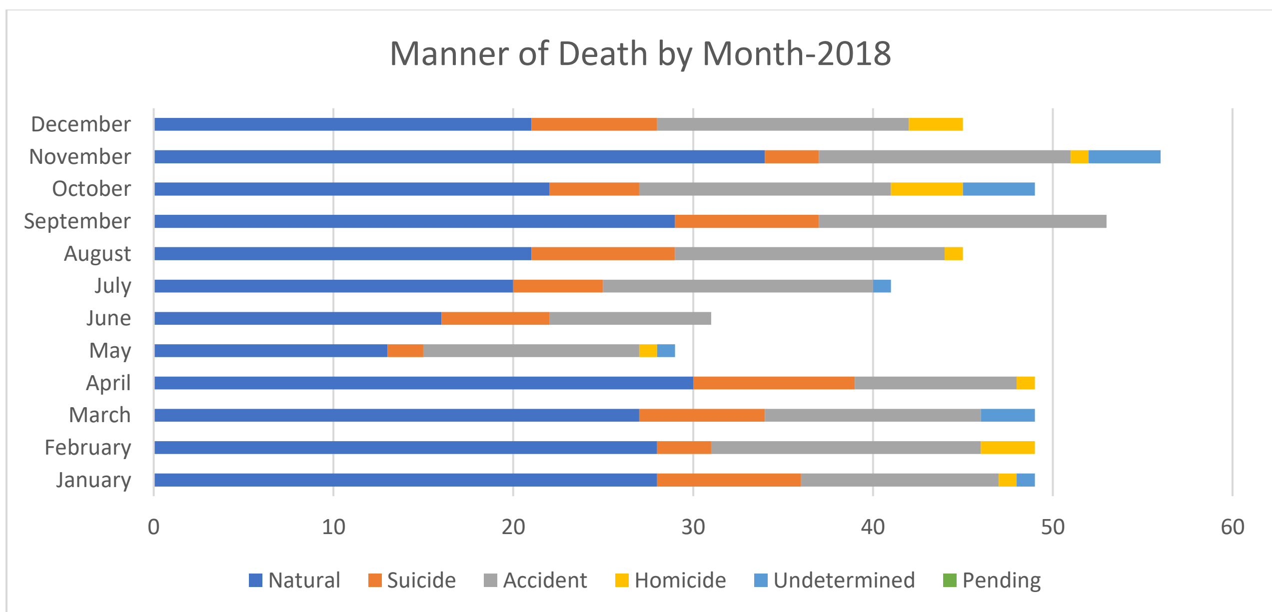
Statistics for Calendar Year 2018

Number of deaths reported:	2247
Number of cases for full investigation:	545
Number of cases investigated at scene and released:	64
Number of cases by manner of death:	
Natural	288
Accident	157
Suicide	71
Homicide	15
Undetermined	14
Pending Investigation	0
Number of decedents transported:	
Coroner	402
Contractor	86
Mortuary/Funeral Home/Other	13
Forensic Examinations:	
Full Autopsy	206
Limited Autopsy	135
Clinical Review	204
Hospital Autopsies	0
Number of toxicology cases conducted:	397
Number of cases reported as "unidentified":	54
Identified after investigation	51
Remain unidentified	3
Organ and tissue donations:	
Cases referred for donation	39
Total organ donors	10
Total tissue donors	85
Total organs transplanted	36
Exhumations:	0

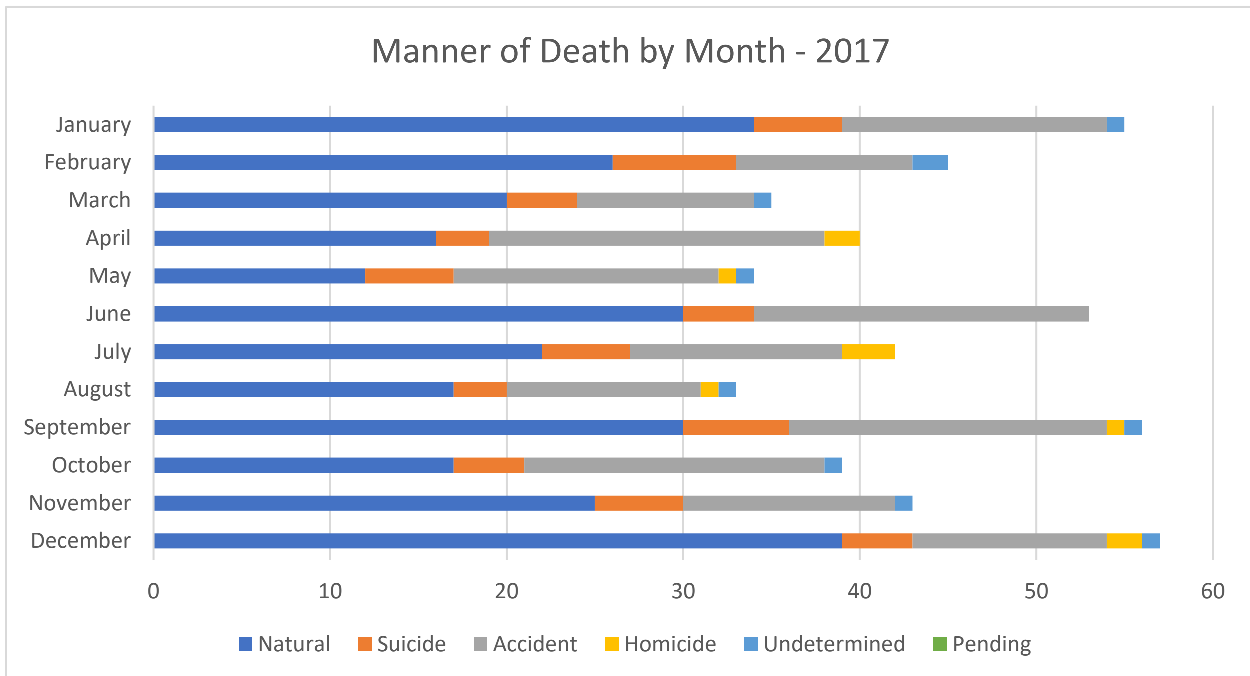
General Classifications of Death by Month

Coroner Case Statistics for 2018 by Month							
	Natural	Suicide	Accident	Homicide	Undetermined	Pending	Total
January	28	8	11	1	1	0	49
February	28	3	15	3	0	0	49
March	27	7	12	0	3	0	49
April	30	9	9	1	0	0	49
May	13	2	12	1	1	0	29
June	16	6	9	0	0	0	31
July	20	5	15	0	1	0	41
August	21	8	15	1	0	0	45
September	29	8	16	0	0	0	53
October	22	5	14	4	4	0	49
November	33	3	15	1	4	0	56
December	21	7	14	3	0	0	45
Total	288	71	157	15	14	0	545



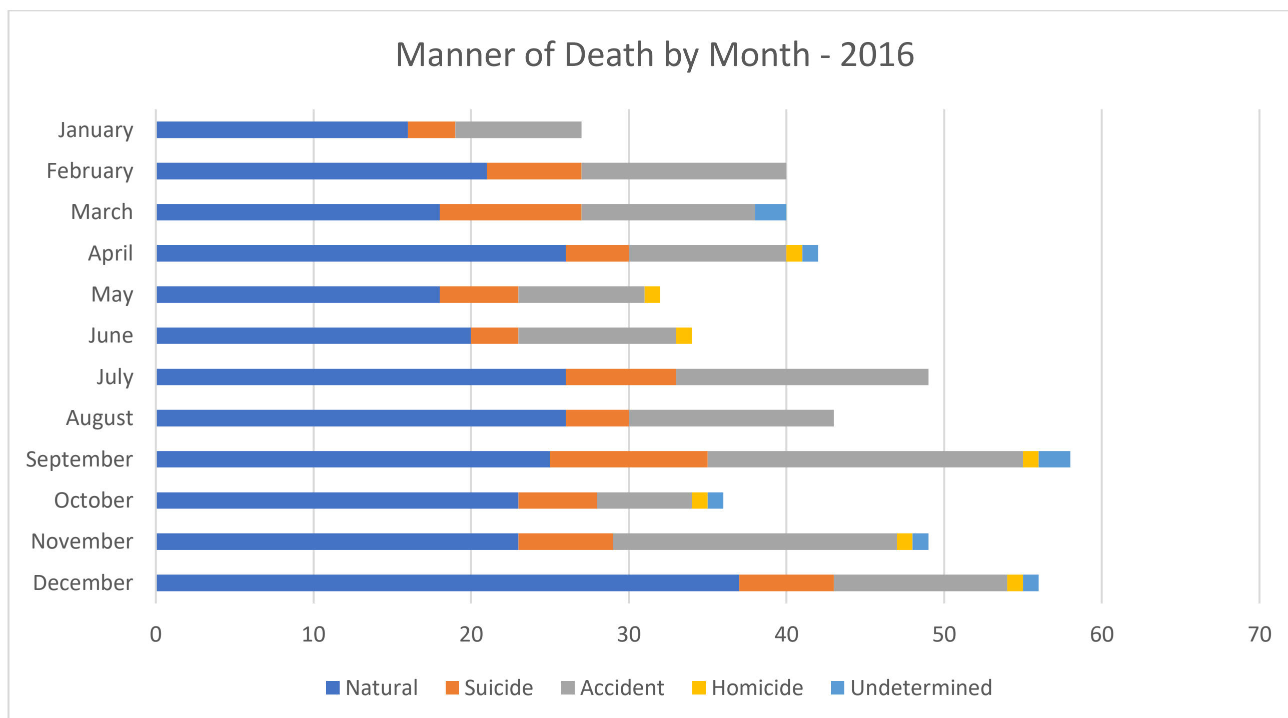
Historical Statistics

Coroner Case Statistics for 2017 by Month							
	Natural	**Suicide**	**Accident**	**Homicide**	**Undetermined**	**Pending**	**Total**
January	34	5	15	0	1	0	55
February	26	7	10	0	2	0	45
March	20	4	10	0	1	0	35
April	16	3	19	2	0	0	40
May	12	5	15	1	1	0	34
June	30	4	19	0	0	0	53
July	22	5	12	3	0	0	42
August	17	3	11	1	1	0	33
September	30	6	18	1	1	0	56
October	17	4	17	0	1	0	39
November	25	5	12	0	1	0	43
December	39	4	11	2	1	0	57
Total	288	55	169	10	10	0	532



Historical Statistics (continued)

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	2	0	50
December	37	6	12	1	1	0	57
Total	279	68	145	7	9	0	508



Natural

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

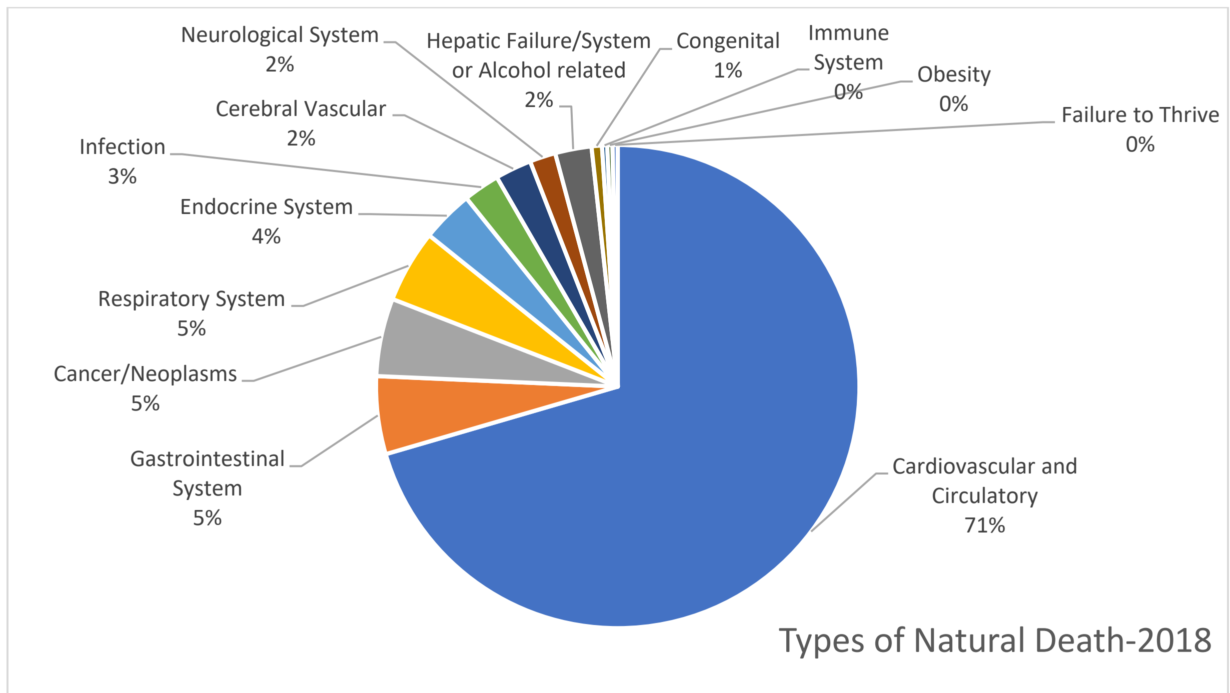
Total Natural Deaths in 2018: 288

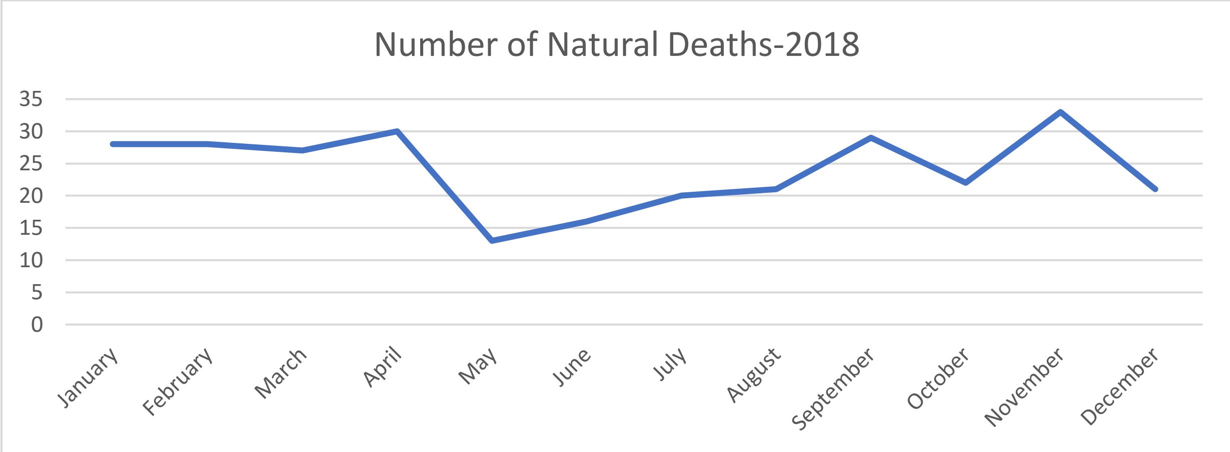
Types of Natural Deaths by Sex			
Types of Natural Deaths	Total	Male	Female
Cardiovascular and Circulatory	203	157	46
Gastrointestinal System	15	7	8
Cancer/Neoplasms	15	9	6
Respiratory System	14	9	5
Endocrine System	10	7	3
Infection	7	5	2
Cerebral Vascular	7	3	4
Hepatic Failure/System or Alcohol related	7	2	5
Neurological System	5	1	4
Congenital	2	1	1
Immune System	1	1	0
Obesity	1	1	0
Failure to Thrive	1	0	1

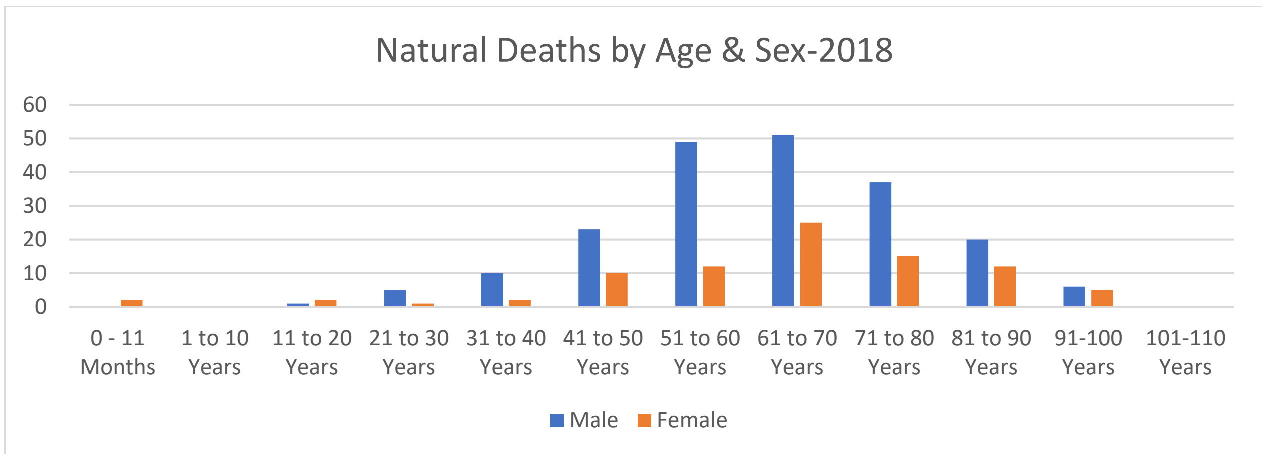
Natural Deaths by Month	
Month	Number of Natural Deaths
January	28
February	28
March	27
April	30
May	13
June	16
July	20
August	21
September	29
October	22
November	33
December	21

Natural Deaths by Age & Sex		
Age	Male	Female
0 - 11 Months	0	2
1 to 10 Years	0	0
11 to 20 Years	1	2
21 to 30 Years	5	1
31 to 40 Years	10	2
41 to 50 Years	23	10
51 to 60 Years	49	12
61 to 70 Years	51	25
71 to 80 Years	37	15
81 to 90 Years	20	12
91-100 Years	6	5
101-110 Years	0	0

Natural







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.

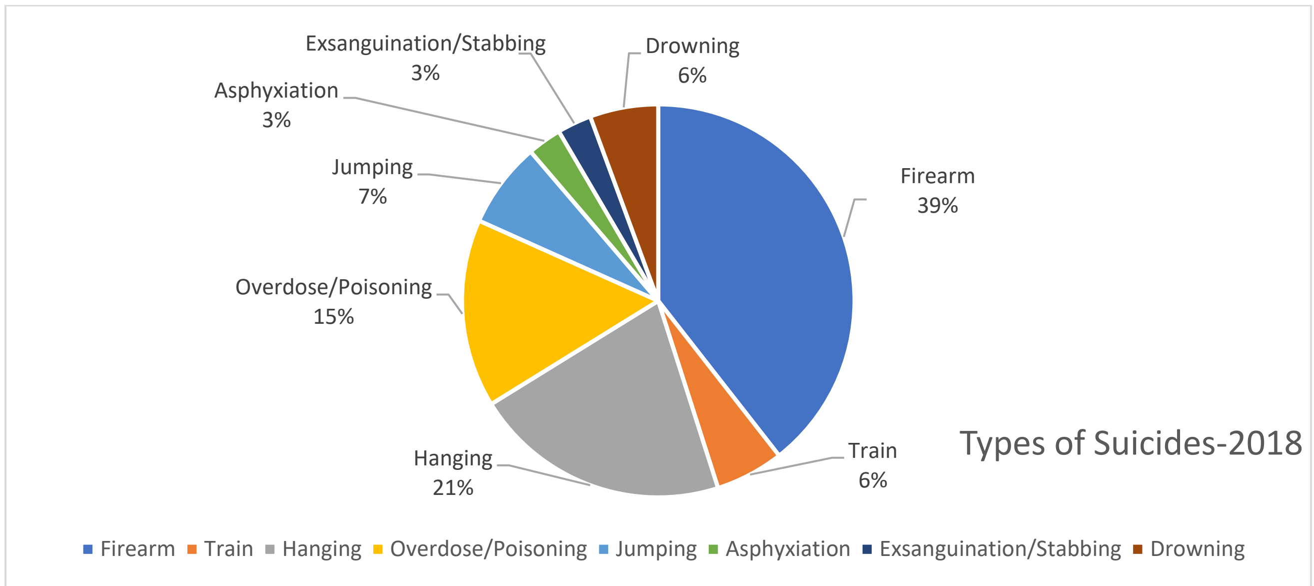
Total Number of Suicides in 2018: 71

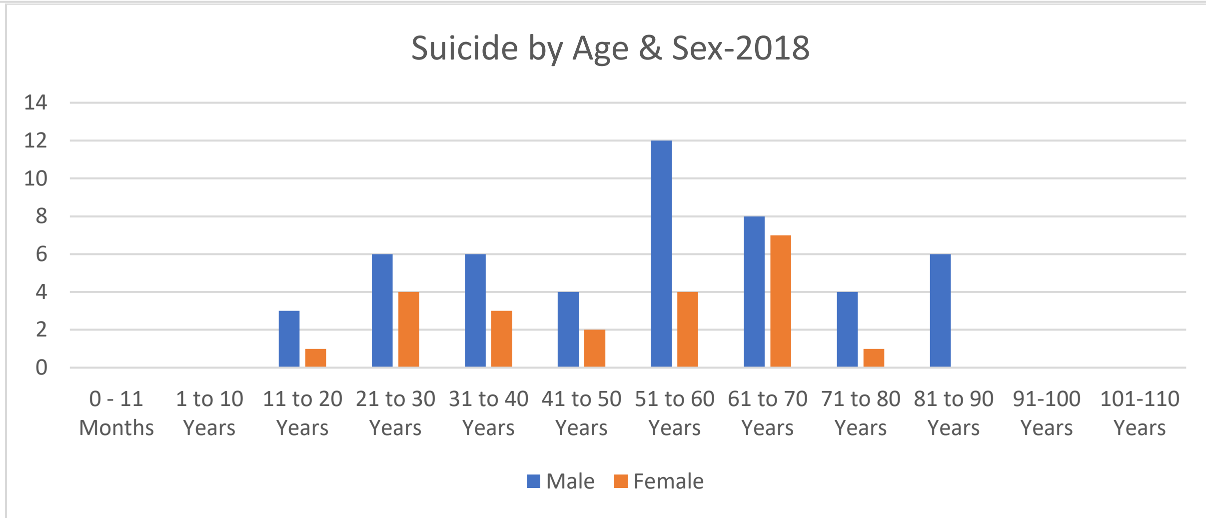
Types of Suicides by Sex			
Types of Suicides	Total	Male	Female
Firearm	28	25	3
Hanging	15	6	9
Overdose/Poisoning	11	4	7
Jumping	5	5	0
Train	4	3	1
Drowning	4	2	2
Asphyxiation	2	2	0
Exsanguination/Stabbing	2	2	0

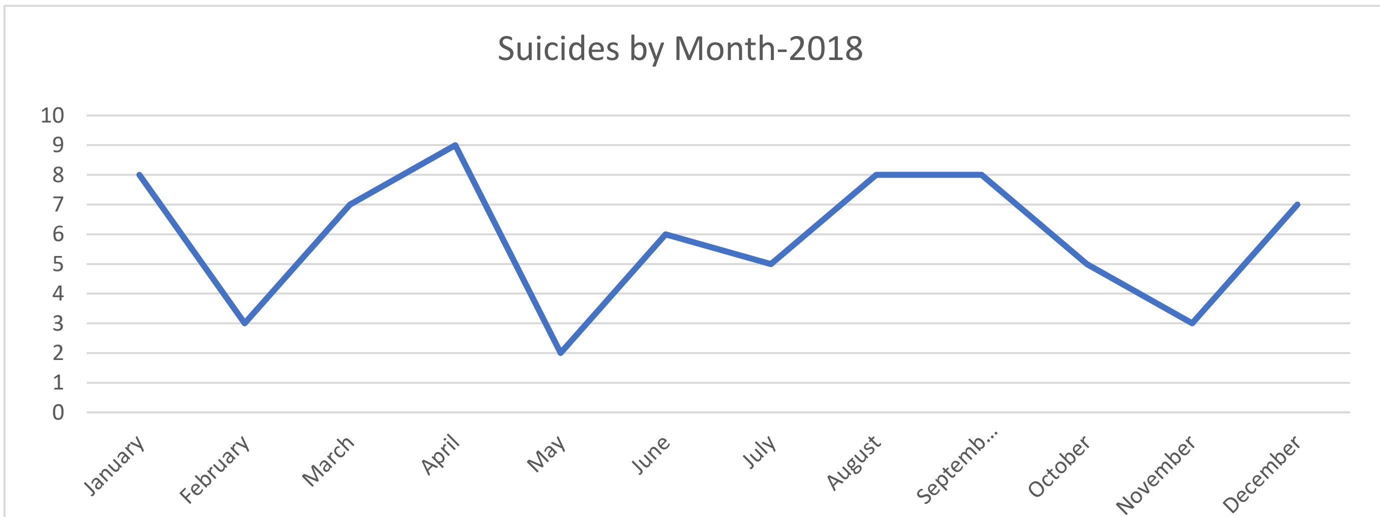
Suicide by Month	
Month	Number of Suicides
January	8
February	3
March	7
April	9
May	2
June	6
July	5
August	8
September	8
October	5
November	3
December	7

Suicide by Age & Sex		
Age	Male	Female
0 - 11 Months	0	0
1 to 10 Years	0	0
11 to 20 Years	3	1
21 to 30 Years	6	4
31 to 40 Years	6	3
41 to 50 Years	4	2
51 to 60 Years	12	4
61 to 70 Years	8	7
71 to 80 Years	4	1
81 to 90 Years	6	0
91-100 Years	0	0
101-110 Years	0	0

Suicide







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 2018: 126

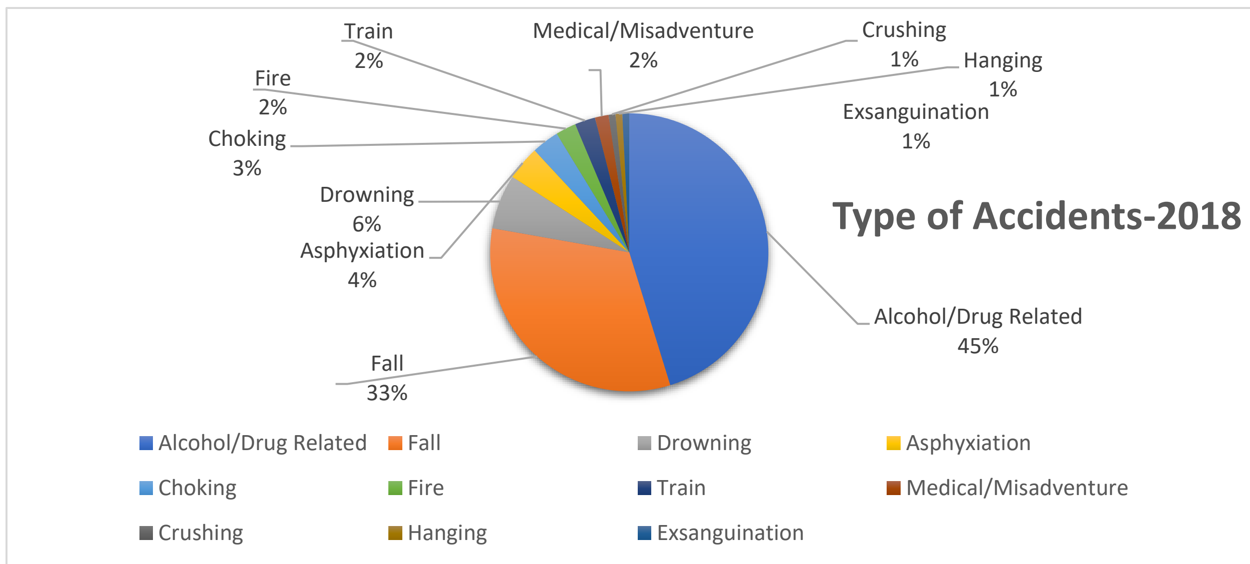
**not including motor vehicle accidents*

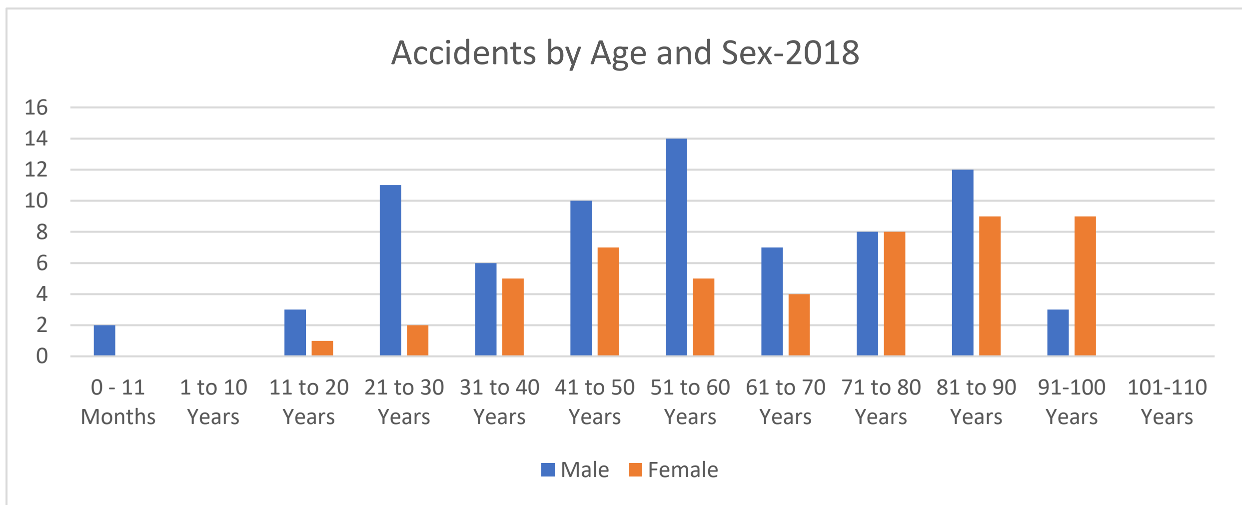
Types of Accidents by Sex			
Type of Accident	Total	Male	Female
Alcohol/Drug Related	57	38	19
Fall	41	19	22
Drowning	8	5	3
Asphyxiation	5	5	0
Choking	4	2	2
Fire	3	2	1
Train	3	2	1
Medical/Misadventure	2	1	1
Crushing	1	1	0
Hanging	1	1	0
Exsanguination	1	0	1

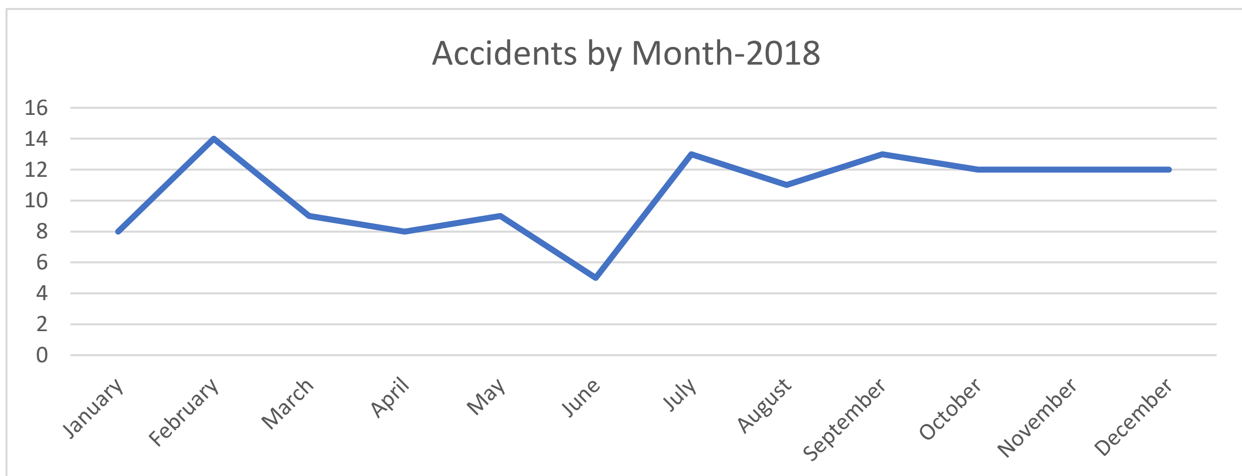
Accidents by Month	
Month	Number of Accidents
January	8
February	14
March	9
April	8
May	9
June	5
July	13
August	11
September	13
October	12
November	12
December	12

Accidents by Age & Sex		
Age	Male	Female
0 - 11 Months	2	0
1 to 10 Years	0	0
11 to 20 Years	3	1
21 to 30 Years	11	2
31 to 40 Years	6	5
41 to 50 Years	10	7
51 to 60 Years	14	5
61 to 70 Years	7	4
71 to 80 Years	8	8
81 to 90 Years	12	9
91-100 Years	3	9
101-110 Years	0	0

Accident







Motor Vehicle Fatalities

The Coroner's Office, as well as other law enforcement agencies within the jurisdiction where the motor vehicle fatality occurs, 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 2018: 32

Types of Motor Vehicle Fatalities	
Type	Number of Fatalities
Automobile-Driver	13
Motorcyclist	5
Pedestrian	5
Bicyclist	3
Other Motorized Vehicle (scooter, ATV, etc)-Driver	2
Person lying on the ground	2
Automobile-Passenger	1
Other Motorized Vehicle (scooter, ATV, etc)-Passenger	1

Fatalities by Manner	
Manner of Death	Number of Fatalities
Natural	1
Accident	31
Suicide	0
Homicide	0
Undetermined	0

Fatalities by Age & Sex		
Age	Male	Female
0 - 11 Months	0	0
1 to 10 Years	1	0
11 to 20 Years	2	2
21 to 30 Years	1	0
31 to 40 Years	4	0
41 to 50 Years	5	1
51 to 60 Years	6	0
61 to 70 Years	4	2
71 to 80 Years	2	1
81 to 90 Years	1	0
91-100 Years	0	0
101-110 Years	0	0

Fatalities by Month	
Month	Number of Fatalities
January	3
February	1
March	3
April	2
May	3
June	4
July	2
August	4
September	3
October	2
November	3
December	2

Motor Vehicle Fatalities
Involving Alcohol and/or Drugs

Pursuant to California Government Code §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.

Total Number of Motor Vehicle Fatalities in 2018: 32

Type of Test Conducted and Substances Detected			
	Alcohol Only Test	Routine Drug (Including Alcohol)	No Test Completed
Alcohol Only Present	6	3	N/A
Prescription Drugs Only Present	N/A	0	N/A
Illicit Drugs Only Present	N/A	2	N/A
Alcohol and Prescription Drugs Present	N/A	1	N/A
Alcohol and Illicit Drugs Present	N/A	2	N/A
Prescription and Illicit Drugs Present	N/A	1	
Nothing Detected	11	6	N/A
Total	17	15	0

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 it 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.

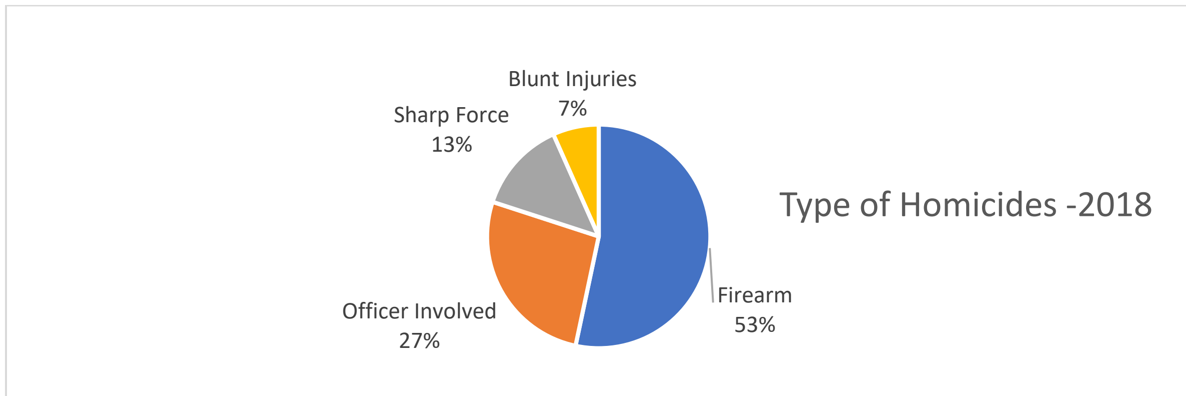
Total Number of Homicides in 2018: 15

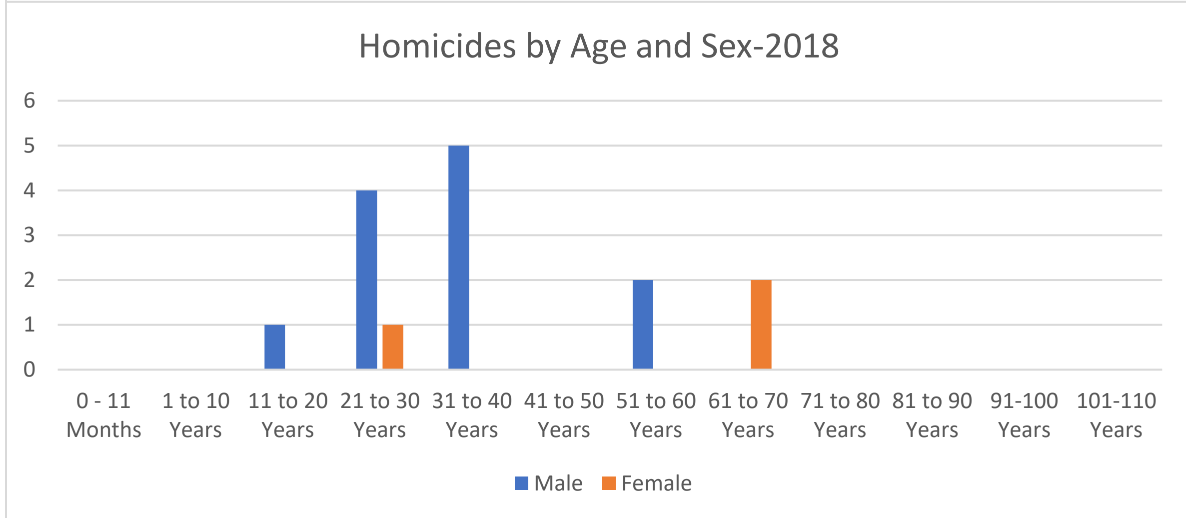
Type of Homicide by Sex			
Type of Homicide	Total	Male	Female
Firearm	8	7	1
Officer Involved	4	4	0
Sharp Force	2	0	2
Blunt Injuries	1	1	0

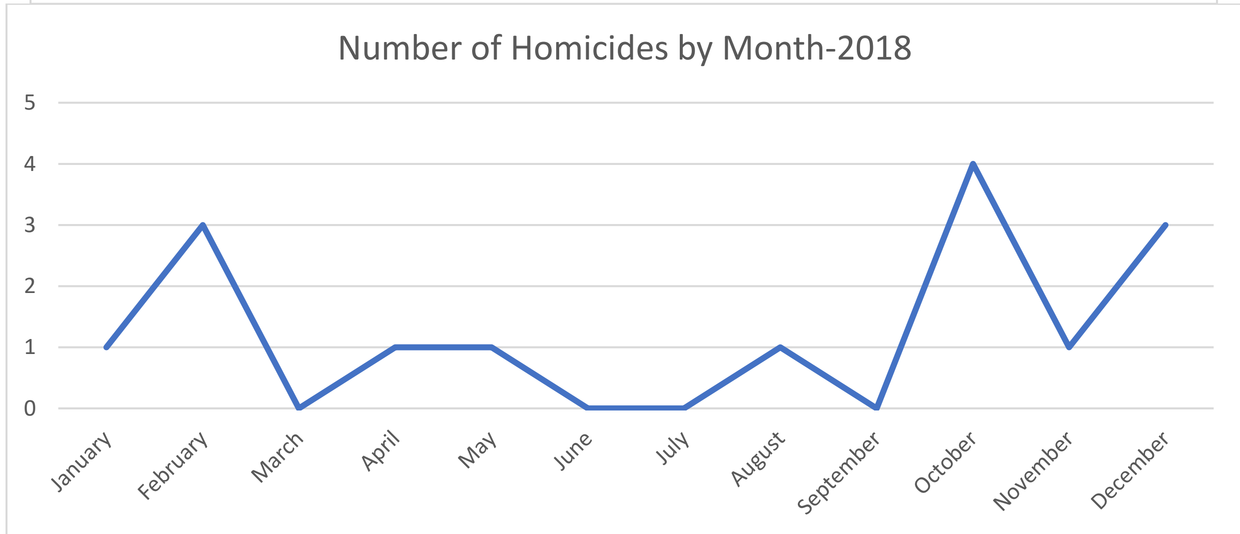
Homicides by Age & Sex		
Age	Male	Female
0 - 11 Months	0	0
1 to 10 Years	0	0
11 to 20 Years	1	0
21 to 30 Years	4	1
31 to 40 Years	5	0
41 to 50 Years	0	0
51 to 60 Years	2	0
61 to 70 Years	0	2
71 to 80 Years	0	0
81 to 90 Years	0	0
91-100 Years	0	0
101-110 Years	0	0

Homicides by Month	
Month	Number of Homicides
January	1
February	3
March	0
April	1
May	1
June	0
July	0
August	1
September	0
October	4
November	1
December	3

Homicide







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 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 2018: 14

Mode	Total
Not otherwise stated or awaiting further investigation	5
Trauma of undetermined manner	4
Decomposed Body or Skeletal Remains	3
Unexplained death in infancy	1
Unexplained death in childhood	1

Outside Jurisdiction

In any case where a Coroner is required to inquire into a death pursuant to California Government Code §27491, the Coroner may delegate his or her jurisdiction over the death to an agency of another county or the federal government under California Government Code §27491.55. This often occurs when the outside Coroner has jurisdictional interest in the death, for instance, if the suspected injury resulting in death occurred within the outside County's jurisdiction.

Total Number of Jurisdictional Releases by Another County in 2018: 19

Manner	Total
Natural	1
Accident	12
Suicide	1
Homicide	2
Undetermined	3

County of Death	Total
Santa Clara	14
San Francisco	5

Indigent Cremation

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 outside agencies: 17

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: 16