San Mateo County Coroner
2022 Annual Report

Robert J. Foucrault
Coroner

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Table of Contents

Revised 05/31/2024 to add Law Enforcement-involved and in-custody death statistics to page 19

The mission of the Coroner's Office is to serve the residents of San Mateo County by providing prompt independent investigations to determine the cause and manner of death of decedents under the Coroner's jurisdiction and to provide high quality service in a courteous manner balancing the needs of residents with the Coroner's legal requirement.

Introduction

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.

According to the United States Census Bureau, San Mateo County was estimated to have a population of 729,181 in 2022, which decreased 1.18% from 737,888 in 2021. There were 6,033 deaths recorded in San Mateo County in 2022 which increased 2.93% from 2021 (5,861 deaths in 2021). Of these deaths, 2,417 deaths were reported to the Coroner's Office which increased by 7.04% from 2,258 in 2021. After initial investigation, 593 were determined to be full Coroner cases with the final cause of death signed by the Coroner, or his designated authority; this decreased 7.92% from 644 in 2021.

This 2022 Annual Report provides an overview of the work performed by San Mateo County Coroner's Office including a statistical breakdown of the types of deaths that occurred within San Mateo County for the year of 2022.

Updates & Accomplishments

In 2021, the Coroner's Office Investigations Division returned to a 24-hour staffed office moving away from the on-call deputy coroner between midnight and 6:00 a.m. resulting in more timely response to scene investigations and around-the-clock service to our community and neighboring agencies for notification requests.

The Coroner's Office is a California P.O.S.T. agency and is accredited by the International Association of Coroners and Medical Examiners. Deputy Coroners obtain certification through the American Board of Medicolegal Death Investigators within three years of employment.

Suicide Increase

Suicide deaths were up 35.2% from 2021 (73 in 2022 versus 54 in 2021). There were just over three times as many male suicide deaths than female suicide deaths (55 males to 18 females). The three most common modes of death were hanging (26 cases), firearm (18 cases), and overdose/poisoning (8 cases).

Accident Decrease – due to decrease in alcohol and drug related deaths

Accidental deaths were down 11.2% from 2021 (207 in 2022 versus 233 in 2021). The total number of motor vehicle accidents increased 14.7% in 2022 (39 in 2022 versus 34 in 2021). Overdose deaths were down 20.1% from 2021 (107 in 2022 versus 134 in 2021). Of the 107

accidental overdoses, 77 tested positive for opioids and of those, 68 cases tested positive for fentanyl.

Homicide Decrease
San Mateo County saw a 31.6% decrease in homicides in 2022 (13 in 2022 versus 19 in 2021). Seven of the 13 homicides occurred in males between the ages of 31 and 50 years old.

Transient Deaths
There were 39 decedents identified as transient in San Mateo County. Of those 39 deaths, 2 were mannered homicide, 1 was mannered suicide, 18 were mannered accident (including 13 fentanyl related cases, 4 non-opioid related overdoses, and 1 blunt force trauma), and 18 were mannered natural.

2022 Accomplishments
In 2022, the Coroner's Office continued to pursue excellence by seeking opportunities for employee training and education in the field and supported the County's efforts focused on diversity, equity, and inclusion; hosted a variety of opportunities for members of the public to explore the role of the Coroner and medicolegal death investigations; partnered with other agencies to review untimely deaths to identify areas of need for community support and education; sought ways to generate team connectedness in wellness events; earned a variety of certifications and celebrated achievements; added new staff and contractors to the team; sought the identities of the unidentified; supported data sharing efforts locally, state-wide, and nationally; and prepared and practiced for emergencies. Below outlines some of the activities and accomplishments of the Office in 2022.

- On a quarterly basis, the Coroner's Office met with and collaborated with partner agencies to review untimely Child Deaths, Elder Deaths, and deaths related to Domestic Violence. The purpose of these death review team meetings is to identify areas of improvement, need for support, and red flags for these vulnerable populations in San Mateo County.

Coroner staff presented to death review teams.

- In 2022, staff members received training in the following topics both virtually and in person: Narcan Administration, Electronic Death Registration System, California Law Enforcement Telecommunications System, and diversity and equity.

- In 2022, the Coroner's Office continued to partner with San Mateo County Epidemiology for reporting of statistics for suspected drug and alcohol related deaths as well as California Department of Public Health for the reporting of statistics for violent deaths and opioid overdoses. The Coroner's Office shares data on a local, state, and national level.

- Throughout 2022, the Coroner's Office hired and trained five extra-help and two full-time Forensic Autopsy Technicians as well as one extra-help and one full-time Deputy Coroner.

- After a couple year hiatus due to the pandemic, the Coroner's Office Academic Internship program resumed in 2022. Three year-long Academic Interns joined the Coroner's Office to explore the fields of Medicolegal Death Investigation and Forensic Pathology.

- In early 2022, forty-eight years after John Doe 74-407 was found in the surf at Linda Mar Sate beach in Pacifica, he was given a name through DNA identification. This identification was a collaborative effort with Olivet Memorial Park Cemetery and the Department of Justice and relied on the advancement of DNA analysis and comparison. The closest living relatives of John Doe 74-407 were beyond thankful to have closure in their loved one's disappearance.

- In October 2022, Coroner case #85-655 was given a name through an identification made via genetic genealogy. This identification was a collaborative effort with the San Mateo County District Attorney's Office and the San Mateo County Sheriff's Office.

- Between May and July 2022, the Coroner's Office hosted six doctors completing their Family Medicine Residency as part of Kaiser Permanente's Community Medicine Rotation supported by the Kaiser Permanente San Jose Medical Center Graduate Medical Education Program. The future family medicine practitioners sat with a deputy coroner to understand the role of the Coroner's Office as well as understand the responsibility of death certificate attestation required by California physicians for patients who experience a natural death under their care within California. Additionally, the Coroner's Office hosted a college student on a Ride Along, interested in learning more about the field of Forensic Pathology.

KAISER PERMANENTE

Six Kaiser physicians sat in with Deputy Coroners on ride-a-longs.

- In July 2022, Deputy Coroners Hastin Stein and Laura Bailey were awarded scholarships to attend the International Association of Coroners and Medical Examiners Annual Advanced Medicolegal Symposium which covered topics such as deaths in custody, organ and tissue donation for missing persons, child and infant death investigation, leadership, wellness and mental health, and opioid and drug overdose investigations.

- In September 2022, Coroner Robert Foucrault and Chief Deputy Coroner K'Lynn Weber attended the California State Coroners Association Advanced Symposium which covered topics in officer wellness, elder death investigations, missing and unidentified persons, and rapid DNA used for identification to name a few.

- In October 2022, the Coroner's Office worked with the Board of Supervisors to approve a Master Services Agreement for Forensic Pathology Services and welcomed two new Board-Certified Forensic Pathologists as contractors for San Mateo County.

- In December 2022, Deputy Coroner Hastin Stein celebrated his 10th year working for San Meteo County.

Congratulations Hastin for completing 10 years of service for the County of San Mateo!

- The Coroner's Office continued to support specialized medicolegal death investigation training through American Board of Medicolegal Death Investigators (ABMDI) and California Peace Officer Standards & Training (POST) for staff members:

  - Five Deputy Coroners completed their 24-hours of continued education required by California Peace Officers Standards and Training (POST) including their Perishable Skills completion. Some of the courses taken by Deputies include Strategic Communications, Emergency Vehicles Operations Course (EVOC) Update, Firearms Update, Use of Force Update (AB392), Defensive Tactics, CPR Skills, Beyond Bias, Positional Asphyxiation Update, and Stress Management.

Deputy Coroner Washburn (above) and Deputy Coroner Schabinger (right) completed basic training requirements.

  - Deputy Coroner Michelle Schabinger completed a 40-hour PC832 Arrest and Control Course, a 24-hour POST PC 832 Firearms Familiarization training, and a 16-hour Emergency Vehicle Operations Course (EVOC) as part of her basic training requirements as a deputy coroner.

  - Deputy Coroner Eden Washburn completed a 40-hour PC832 Arrest and Control Course and a 16-hour Emergency Vehicle Operations Course (EVOC) as part of her basic training requirements as a deputy coroner.

Deputy Coroner Bailey earned POST Basic Coroner Certificate.

  - Deputy Coroner Laura Bailey earned her Basic POST Coroner Certification. Basic Certificates are awarded to peace officers who have met the required training and education points and the prescribed years of law enforcement experience.

  - Deputy Coroner Alana Stark earned her Advanced POST Coroner Certificate. These certificates are awarded to Deputy Coroners who are working full time, meet educational requirements, and on-going training requirements.

  - Supervising Deputy Coroner Elizabeth Ortiz earned her Supervisory POST Certification. Supervisory Certificates are awarded to peace officers who possess an Advanced Certificate, completed a minimum of sixty semester units at a college, served as a first-line supervisor for two years, and completed the POST Supervisory Course.

- Chief Deputy Coroner K'Lynn Weber earned her Management POST Certification. Management Certificates are awarded to peace officers who possess an Advanced Certificate, completed a minimum of sixty semester units at a college, served as a middle manager for two years, and completed the POST Management Course.

- Throughout the year, Coroner's staff share about the duties and responsibilities of the Coroner's Office:

  - In March 2022, Deputy Coroners Danielle Montesano and Laura Bailey shared their experience as both Forensic Autopsy Technicians and as Deputy Coroners with students in high school and college. During these interviews the Deputy Coroners shared about the field of forensic pathology, medicolegal death investigations and the role of the Coroner's Office.

Forensic Autopsy Technician Nogaki demonstrating autopsy procedures to Mid-Peninsula students.

  - In April 2022, Forensic Autopsy Technicians Kathryn Nogaki and German Diaz guided Mid-Peninsula High School's Forensic Science class through an interactive tour of the Coroner's Office Pathology Division and discussed the role of the Coroner's Office in San Mateo County. This is the fourth year that the Coroner's Office has partnered with Mid-Peninsula High School to provide this enriching experience.

  - In April 2022, Supervising Deputy Coroner Elizabeth Ortiz joined several others asked to share their experience as a supervisor in San Mateo County for the Career Spotlight forum. This forum, hosted by Human Resources, was offered virtually to those who were interested in career development and future leadership roles. Supervising Deputy Coroner Ortiz had the opportunity to speak about her current role, what she found helpful in preparing for her role, and what she most rewarding aspect of supervising a team, among other things related to supervising a team.

  - In July 2022, Deputy Coroner Danielle Montesano met with San Mateo County Sheriff's Office Detectives to present the Role of the Coroner and discuss agency collaboration and scene response.

  - In September 2022, Deputy Coroner Eden Washburn was a guest speaker for the College of San Mateo's Introduction to Forensic Science class. Deputy Coroner Washburn shared her experience in San Mateo County and provided an opportunity for students to learn more about the field of medicolegal death investigations.
  - In November 2022, Supervising Deputy Coroner Elizabeth Ortiz presented to the San Mateo County Suicide Prevention Committee regarding the role of the Coroner's Office and provided relevant statistics to the committee members.

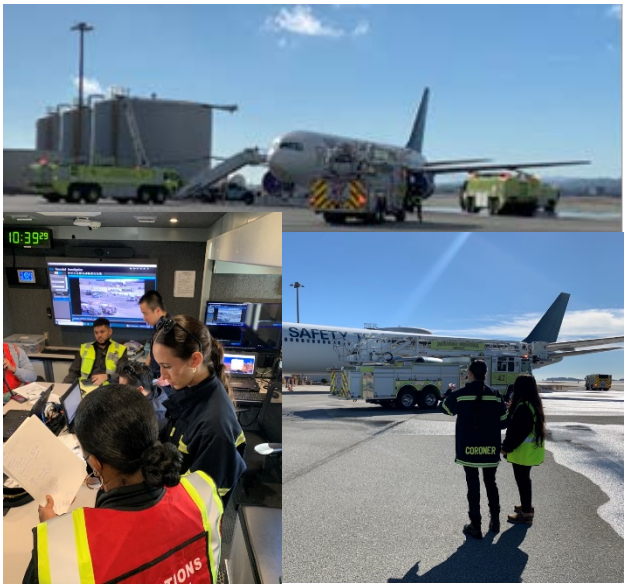
- In November 2022, Supervising Deputy Coroner Elizabeth Ortiz participated in the California Traffic Incident Management (TIM) Summit as a representative of the Coroner and Medical Examiner response to traffic incidents. The purpose of the Summit was to bring together TIM partners and participants to strengthen communication and teamwork, exchange information, generate new ideas, incorporate new technologies, and increase the efficiency of TIM.

Supervising Deputy Coroner Ortiz participated in multiple County and partner events.

- Throughout 2022, the Coroner's Office participated in multiple emergency preparedness and mass fatality/mass disaster training events:

  - In May 2022, Deputy Coroner Holly Benedict attended the CalOES Mass Fatality Training in Monterey with multiple other public health, law enforcement, and medicolegal death investigation agencies. This training, part of a million-dollar grant, focused on aligning response and expectations for mutual aid in the event of a large mass disaster / fatality event out of an effort to improve response after the Camp Fire. Also, Chief Deputy Coroner K'Lynn Weber attended the Emergency Management Concepts Course at the County's Regional Operations Center (ROC) hosted by the County Executive's Office.

Cal OES
GOVERNOR'S OFFICE OF EMERGENCY SERVICES
Mark S. Ghilarducci, Director
Donald M. O'Keefe, Chief
Mass Fatality Management



Emergency Preparedness: Coroner staff participate at SFO's Mass Disaster Exercise.

- In July 2022, Deputy Coroner Danielle Montesano hosted a table at the annual Disaster Preparedness Day at the County Event Center. At the Coroner's Office table, resources such as "What do I do Now?" pamphlets and "Vial of Life" forms were available to the public.

- In September 2022, Supervising Deputy Coroner Elizabeth Ortiz, Deputy Coroner Ashley Cahalan, and Forensic Autopsy Technician Carolina Mendoza participated in a Mass Disaster Exercise at San Francisco International Airport (SFO). During the simulated event the Coroner's Office responded to three fatalities on the plane.

- The Coroner's Office values staff wellness and in 2022, Coroner staff spent some time outside of the office socializing at Foster City's Off the Grid food truck event as well as celebrated a variety of life milestones together.

Coroner staff celebrating milestones and socializing at Foster City's Off the Grid events.

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San Mateo County Coroner 2022 Staff

Administration

Robert J. Foucrault	Coroner
Christi Canclini	Executive Assistant
K'Lynn Solt	Chief Deputy Coroner
Luz Paran-Rey	Senior Accountant
Cara Behrens	Office Assistant II
Elizabeth Ortiz	Supervising Deputy Coroner
Alyssa Terwilliger	Coroner Intern (Extra Help) (Jan)

Investigations

Holly Benedict	Deputy Coroner
Hastin Stein	Deputy Coroner
Danielle Montesano	Deputy Coroner
Alana Stark	Deputy Coroner
Heather Diaz	Deputy Coroner (Jan)
Laura Bailey	Deputy Coroner
Michelle Schabinger	Deputy Coroner
Eden Washburn	Deputy Coroner
Ashley Cahalan	Deputy Coroner (Extra-Help) (Jun-Dec)

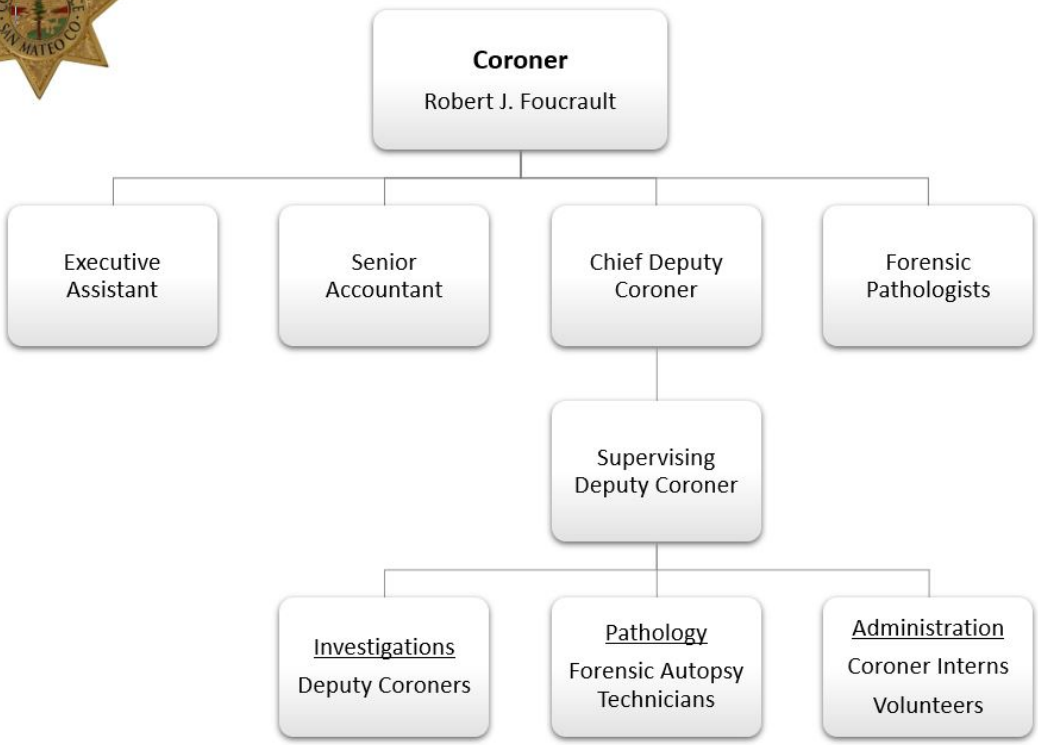
Pathology

Alina Revilla	Forensic Autopsy Technician (Unpaid Status)
German Diaz	Forensic Autopsy Technician (Extra Help) (Jan-Jul)
Kathryn Nogaki	Forensic Autopsy Technician (Jan-Jun)
Nora Moreno	Forensic Autopsy Technician (Extra Help) (Jul-Dec)
Nandar Yukyi	Forensic Autopsy Technician (Extra Help) (Jul-Dec)
Daniela Landey	Forensic Autopsy Technician (Extra Help) (Jul-Dec)
Carolina Mendoza	Forensic Autopsy Technician (Sept-Nov)
Isabella Ratti	Forensic Autopsy Technician (Oct-Dec)

Contractors

Thomas Rogers, M.D.	Forensic Pathologist
Forensic Doctors Group	
Michael Hunter, M.D.	Forensic Pathologist
Harminder Narula, M.D.	Forensic Pathologist (Apr-Nov)
Katherine Raven, M.D.	Forensic Pathologist
Vivian Snyder, D.O.	Forensic Pathologist (Oct-Dec)
Angellee Chen, M.D., J.D.	Forensic Pathologist (Feb-Dec)
NAAG Pathology Group (Aug)	
Evan Matshes, M.D.	Forensic Pathologist (Aug)
Anna Park, M.D.	Forensic Pathologist (Aug)
Amelia Nakanishi, M.D.	Forensic Pathologist (Aug)

County of San Mateo
CORONER'S OFFICE
ORGANIZATIONAL CHART



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 sudden infant death syndrome (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 2022

Number of deaths reported: 2,417

Number of cases for full investigation: 593

- Private autopsies: 3
- Indigent cremation referral only: 8
- No-post cases: 78
- Co-sign cases: 37
- Other: 11
  - Non-human remains: 3
  - Native American remains: 1
  - Found/abandoned cremains: 7

Number of Elder (65+) cases investigated at scene and released: 227

Number of mutual aid requests for death notifications: 38

Number of cases by manner of death:

Natural	291
Accident	207
Suicide	73
Homicide	13
Undetermined	9
Pending Investigation	0

Number of decedents transported:

Coroner	506
Contractor	48
Mortuary/Funeral Home/Other	43

Forensic Examinations:

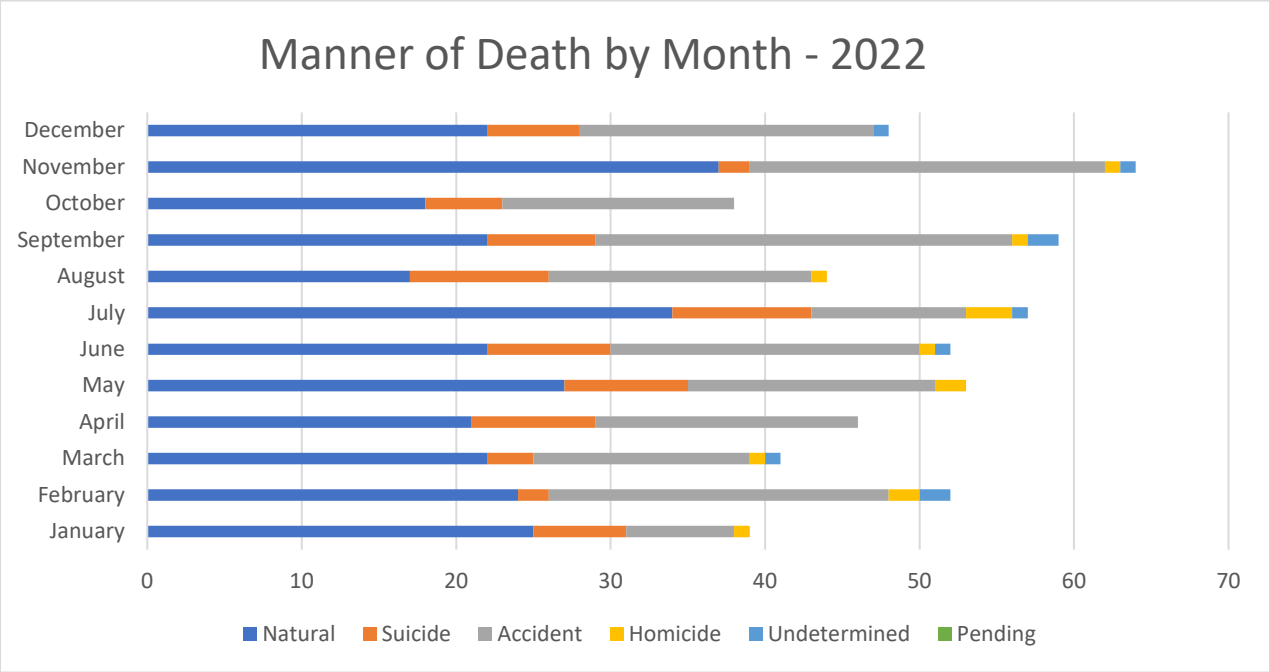
Full Autopsy	320
Limited Autopsy	32
Clinical Review	105
Specialized (SUIDS / Homicide)	21
Hospital Autopsies	0

Number of cases where toxicology was conducted: 371

Number of cases reported as "unidentified":	84
Identified after investigation	82
Organ and tissue donations:	
Cases referred for donation	152
Total organ donors	10
Total organs transplanted	31
Total tissue donors	70
Exhumations:	0
Number of Law Enforcement-involved and in-custody deaths:	**3**
Total Law Enforcement-involved	**2**
Natural	0
Accident	0
Suicide	0
Homicide	2
Undetermined	0
Total In-custody	**1**
Natural	1
Accident	0
Suicide	0
Homicide	0
Undetermined	0

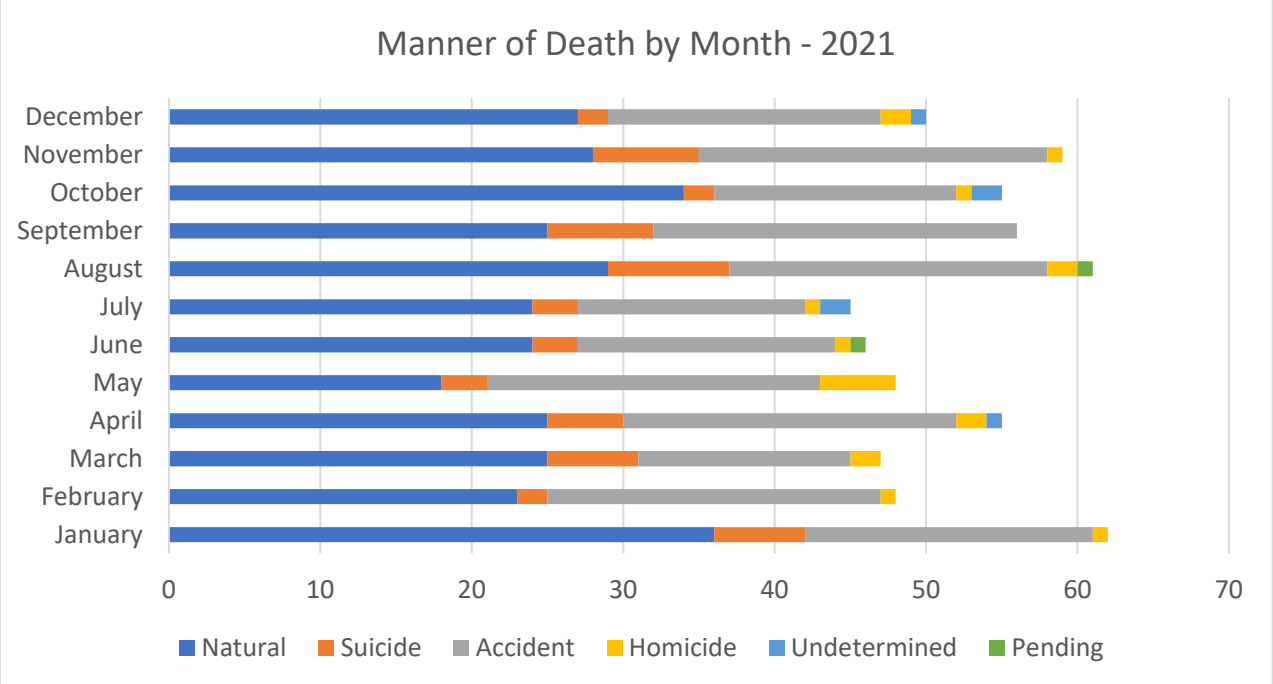
General Classifications of Death by Month

Coroner Case Statistics for 2022 by Month							
	Natural	**Suicide**	**Accident**	**Homicide**	**Undetermined**	**Pending**	**Total**
January	25	6	7	1	0	0	39
February	24	2	22	2	2	0	52
March	22	3	14	1	1	0	41
April	21	8	17	0	0	0	46
May	27	8	16	2	0	0	53
June	22	8	20	1	1	0	52
July	34	9	10	3	1	0	57
August	17	9	17	1	0	0	44
September	22	7	27	1	2	0	59
October	18	5	15	0	0	0	38
November	37	2	23	1	1	0	64
December	22	6	19	0	1	0	48
Total	291	73	207	13	9	0	593



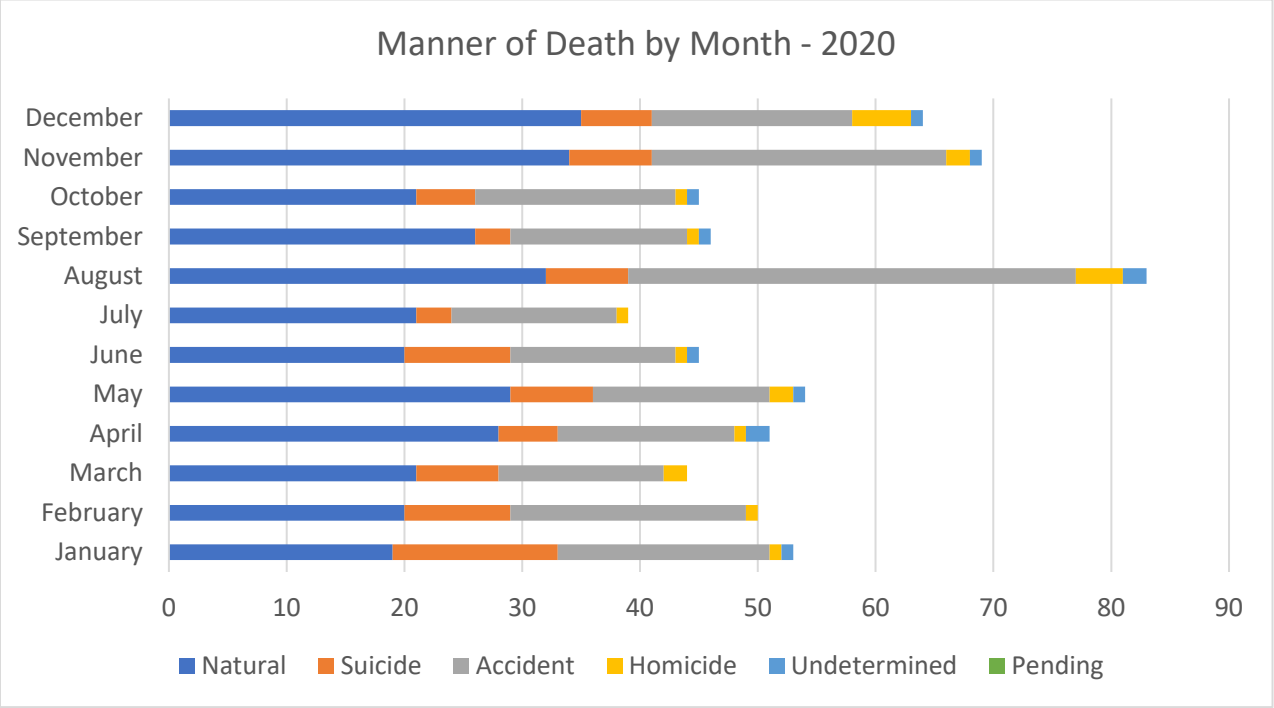
Historical Statistics

Coroner Case Statistics for 2021 by Month							
	Natural	**Suicide**	**Accident**	**Homicide**	**Undetermined**	**Pending**	**Total**
January	36	6	19	1	0	0	62
February	23	2	22	1	0	0	48
March	25	6	14	2	0	0	47
April	25	5	22	2	1	0	55
May	18	3	22	5	0	0	47
June	24	3	17	1	0	1	46
July	24	3	15	1	2	0	45
August	29	8	21	2	0	1	61
September	25	7	24	0	0	0	56
October	34	2	16	1	2	0	55
November	28	7	23	1	0	0	59
December	27	2	18	2	1	0	50
Total	318	54	233	19	6	2	631



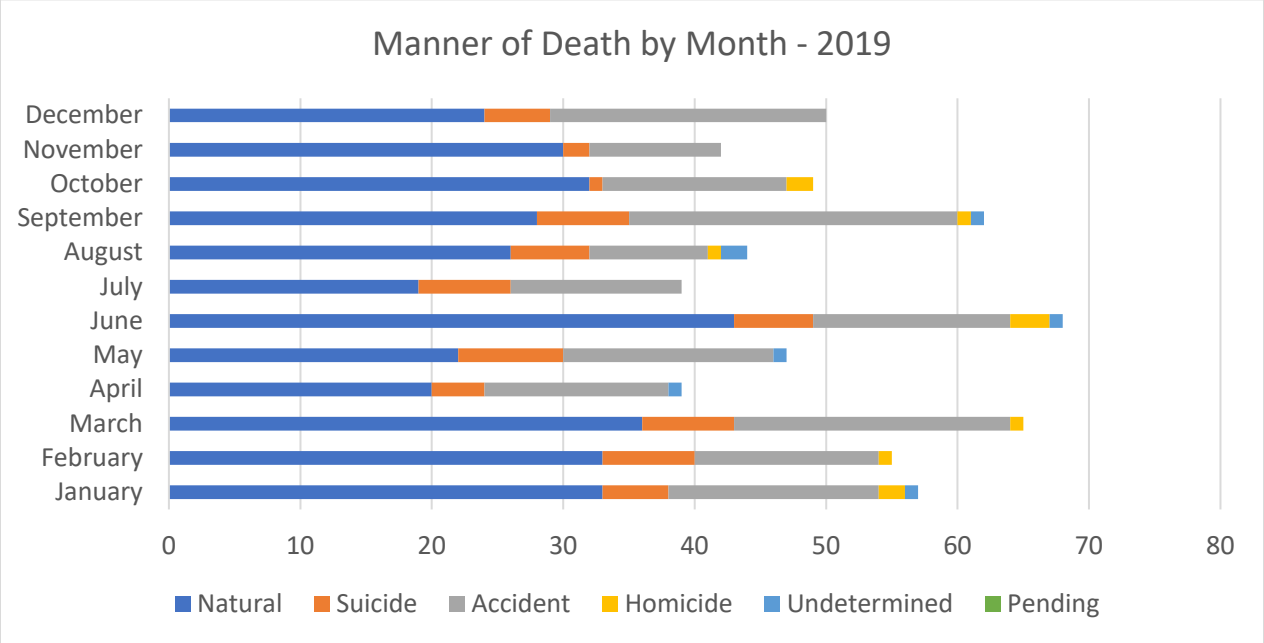
Historical Statistics (continued)

Coroner Case Statistics for 2020 by Month							
	Natural	**Suicide**	**Accident**	**Homicide**	**Undetermined**	**Pending**	**Total**
January	19	14	18	1	1	0	53
February	20	9	20	1	0	0	50
March	21	7	14	2	0	0	44
April	28	5	15	1	2	0	51
May	29	7	15	2	1	0	54
June	20	9	14	1	1	0	45
July	21	3	14	1	0	0	39
August	32	7	38	4	2	0	83
September	26	3	15	1	1	0	46
October	21	5	17	1	1	0	45
November	34	7	25	2	1	0	69
December	35	6	17	5	1	0	64
Total	306	82	222	22	11	0	643



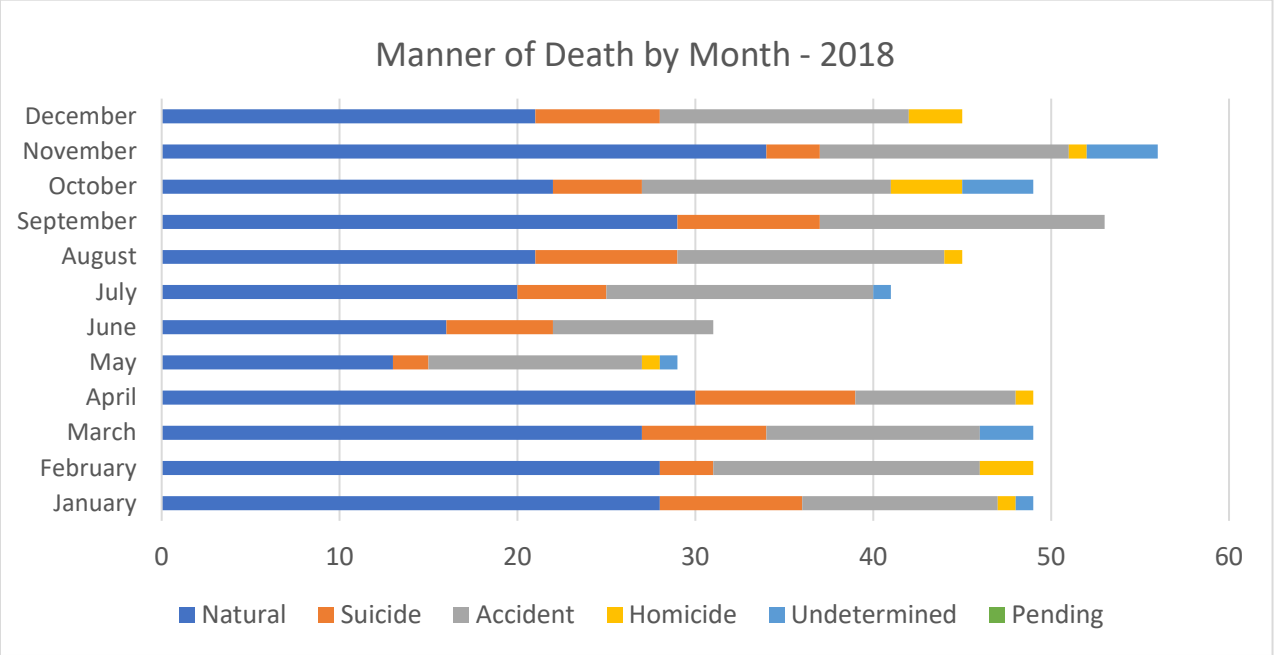
Historical Statistics (continued)

Coroner Case Statistics for 2019 by Month							
	Natural	**Suicide**	**Accident**	**Homicide**	**Undetermined**	**Pending**	**Total**
January	33	5	16	2	1	0	57
February	33	7	14	1	0	0	55
March	36	7	21	1	0	0	65
April	20	4	14	0	1	0	39
May	22	8	16	0	1	0	47
June	44	6	15	3	1	0	69
July	19	7	13	0	0	0	39
August	26	6	9	1	2	0	44
September	28	7	25	1	1	0	62
October	32	1	14	2	0	0	49
November	30	2	10	0	0	0	42
December	24	5	21	0	0	0	50
Total	347	65	188	11	7	0	618



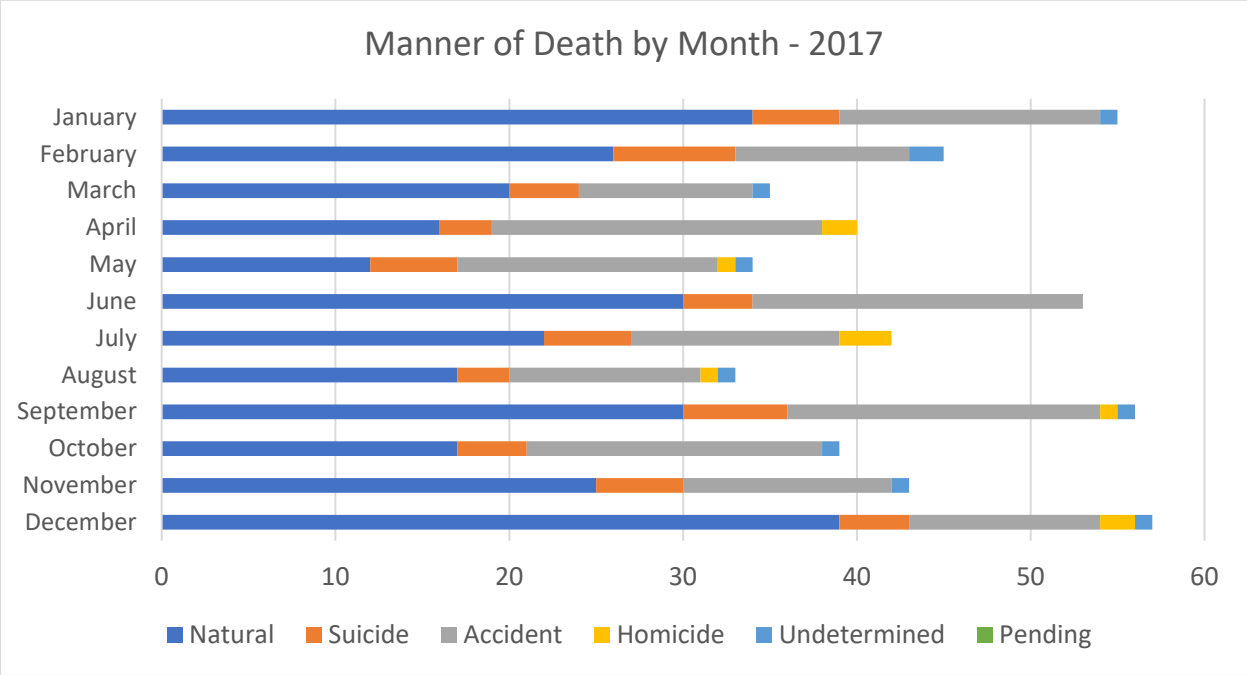
Historical Statistics (continued)

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



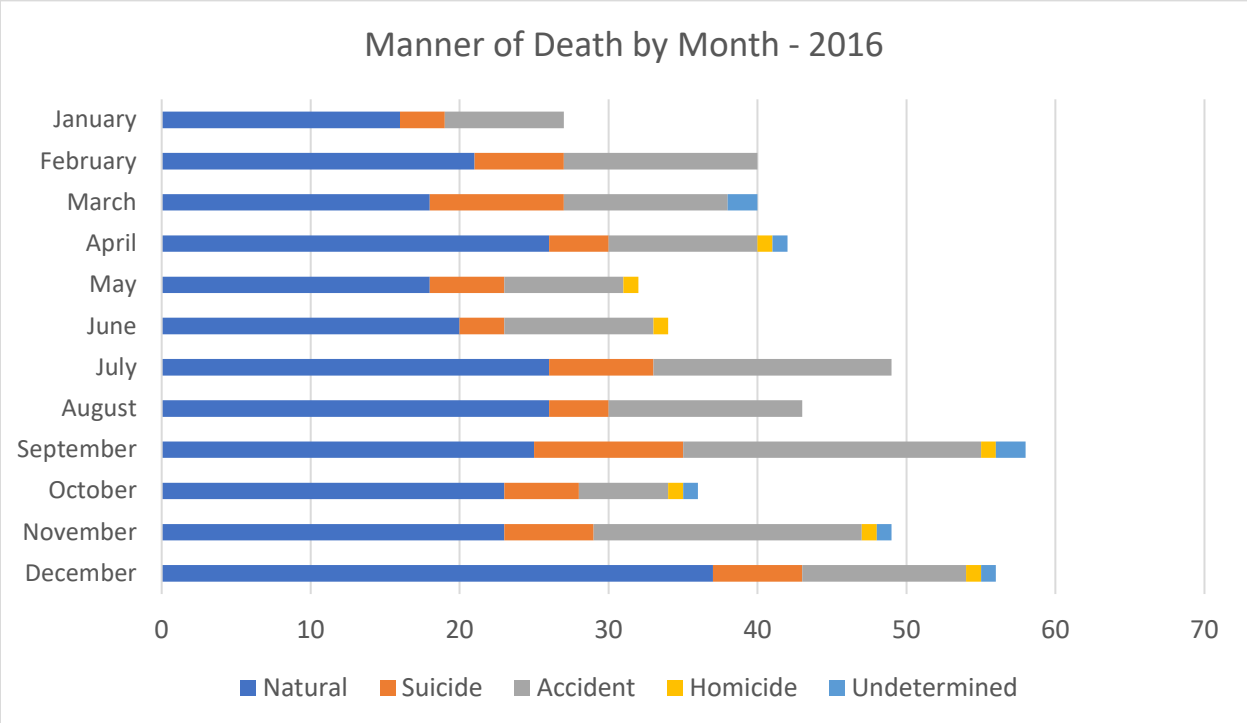
Historical Statistics (continued)

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

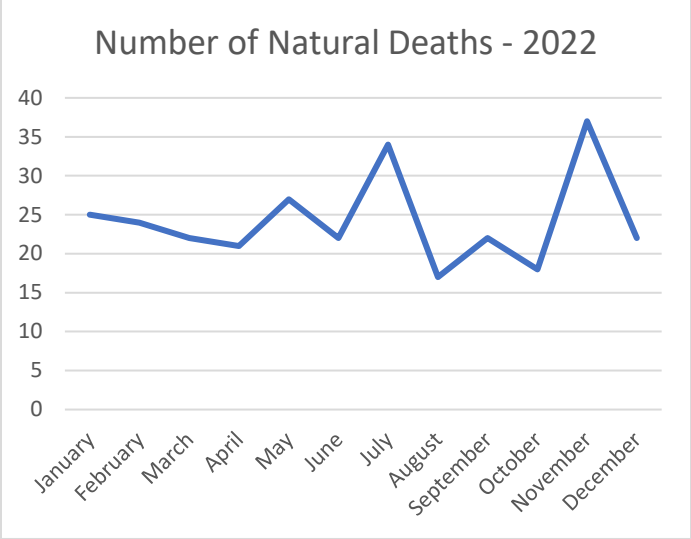


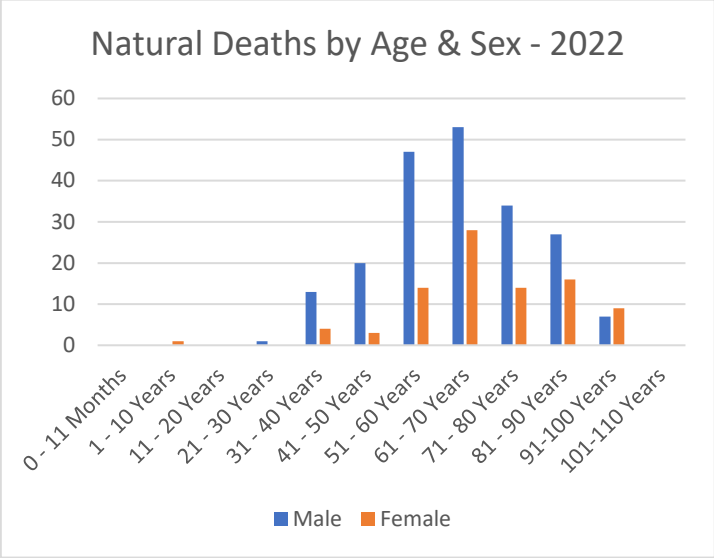
Natural

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

Total Natural Deaths in 2022: 291

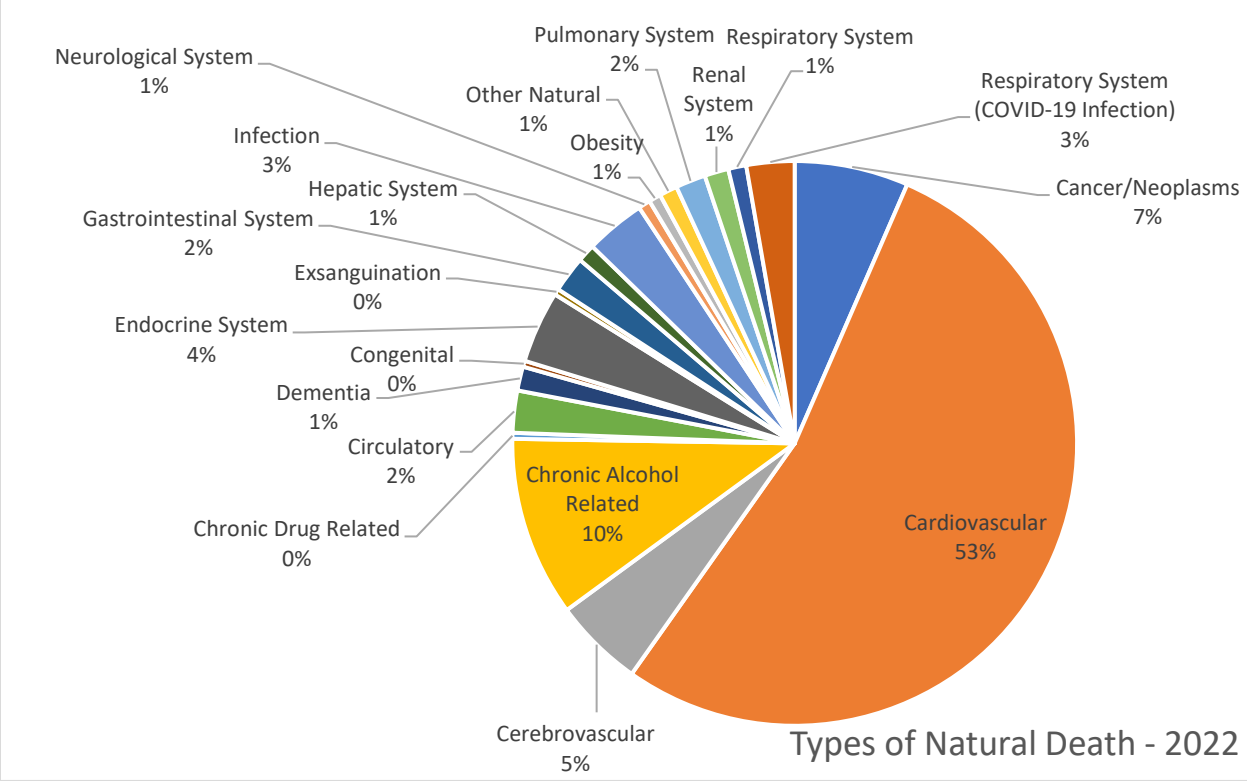
Natural Deaths by Month	
Month	**Number of Natural Deaths**
January	25
February	24
March	22
April	21
May	27
June	22
July	34
August	17
September	22
October	18
November	37
December	22





Natural Deaths by Age & Sex		
Age	**Male**	**Female**
0 - 11 Months	0	0
1 to 10 Years	0	1
11 to 20 Years	0	0
21 to 30 Years	1	0
31 to 40 Years	13	4
41 to 50 Years	20	3
51 to 60 Years	47	14
61 to 70 Years	53	28
71 to 80 Years	34	14
81 to 90 Years	27	16
91-100 Years	7	9
101-110 Years	0	0

Types of Natural Deaths by Sex			
Types of Natural Deaths	**Total**	**Male**	**Female**
Cancer/Neoplasms	19	13	6
Cardiovascular	155	110	45
Cerebrovascular	15	6	9
Chronic Alcohol Related	30	23	7
Chronic Drug Related	1	1	0
Circulatory	7	5	2
Dementia	4	2	2
Congenital	1	1	0
Endocrine System	12	8	4
Exsanguination	1	1	0
Gastrointestinal System	6	5	1
Hepatic System	3	1	2
Infection	10	6	4
Neurological System	2	1	1
Obesity	2	1	1
Other Natural	3	2	1
Pulmonary System	5	3	2
Renal System	4	1	3
Respiratory System	3	2	1
Respiratory System (COVID-19 Infection)	8	7	1

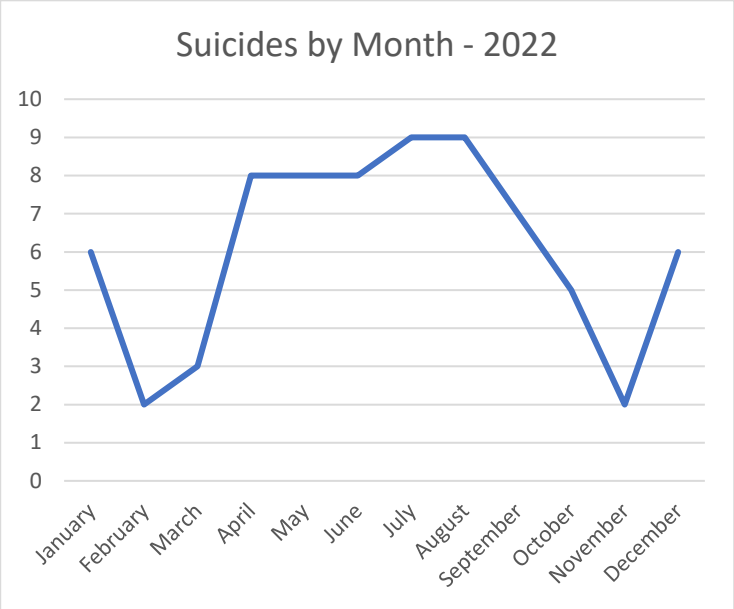


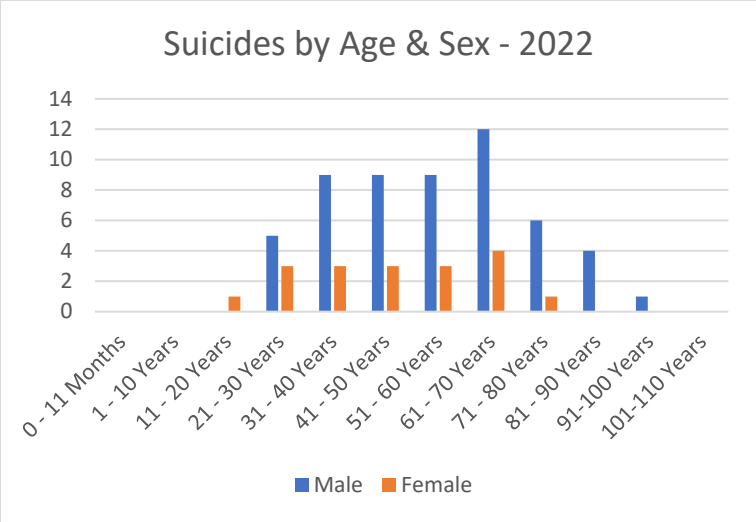
Suicide

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 oneself.

Total Number of Suicides in 2022: 73

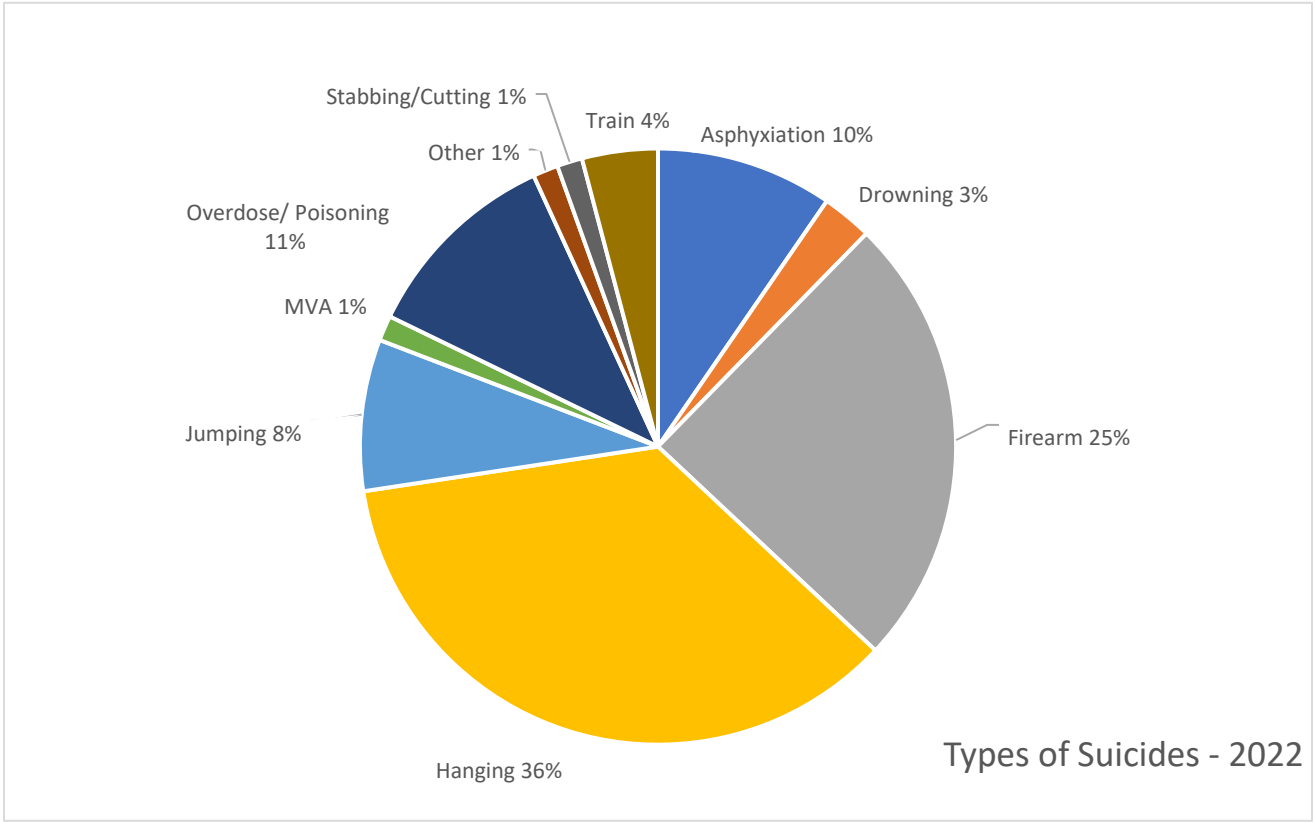
Suicide by Month	
Month	**Number of Suicides**
January	6
February	2
March	3
April	8
May	8
June	8
July	9
August	9
September	7
October	5
November	2
December	6





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

Types of Suicides by Sex			
Types of Suicides	**Total**	**Male**	**Female**
Asphyxiation	7	4	3
Drowning	2	1	1
Firearm	18	17	1
Hanging	26	21	5
Jumping	6	4	2
MVA	1	0	1
Overdose/ Poisoning	8	4	4
Other	1	1	0
Stabbing/Cutting	1	1	0
Train	3	2	1

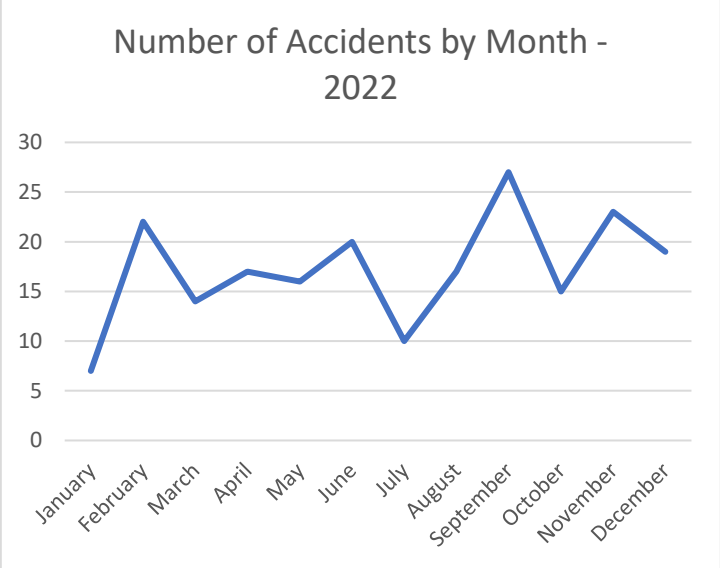


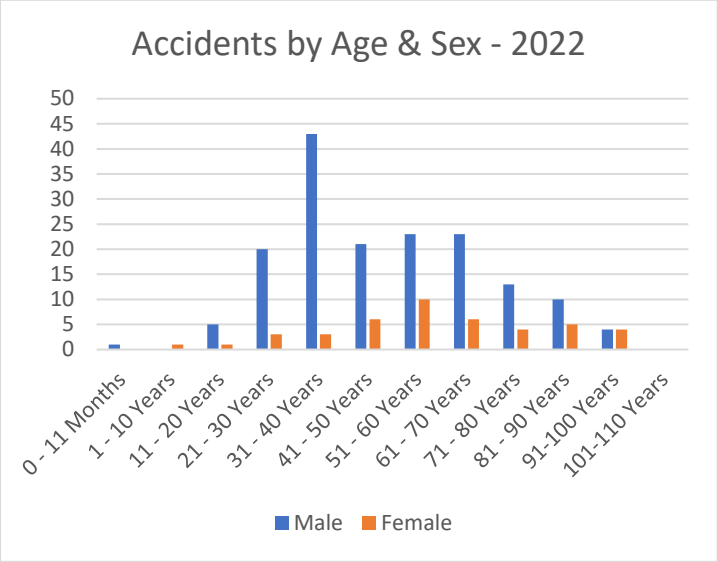
Accident

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.

Total Number of Accidental Deaths in 2022: 207

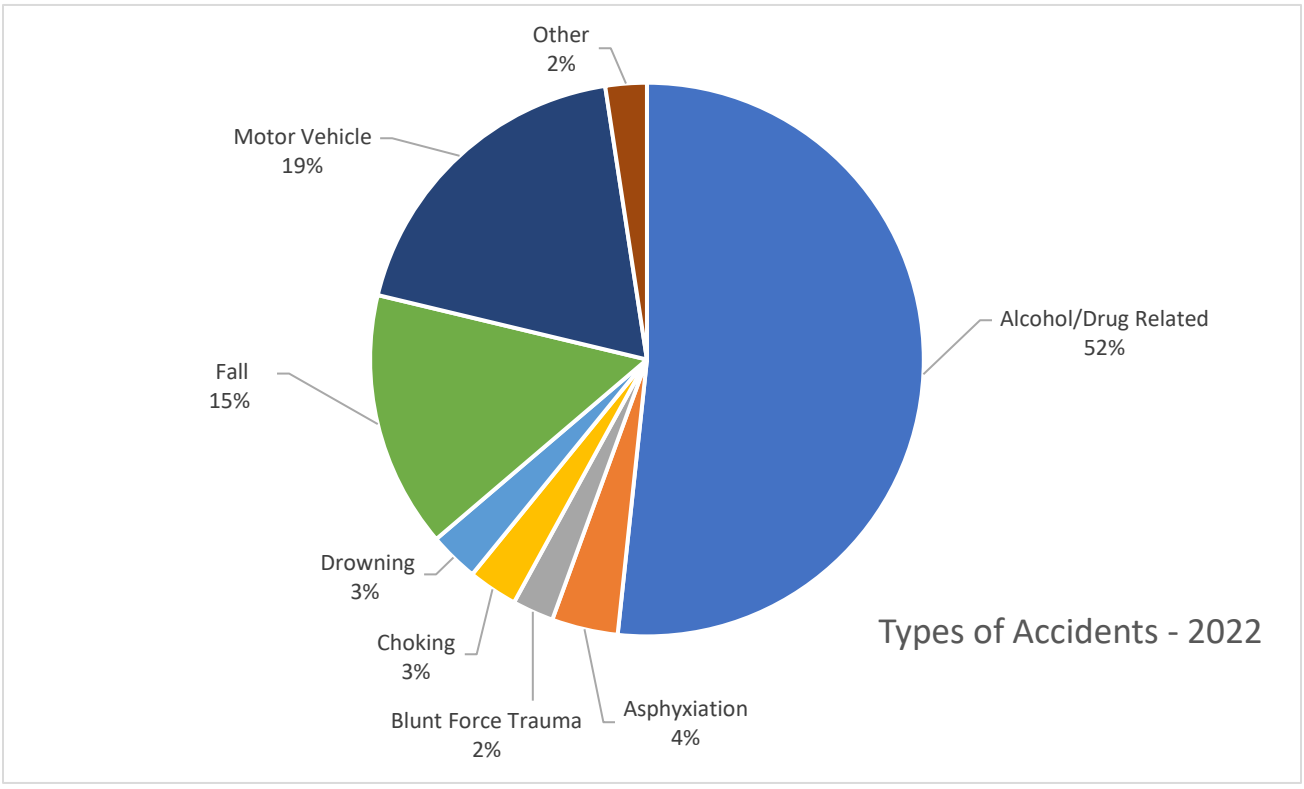
Accidents by Month	
Month	**Number of Accidents**
January	7
February	22
March	14
April	17
May	16
June	20
July	10
August	17
September	27
October	15
November	23
December	19





Accidental Deaths by Age & Sex		
Age	**Male**	**Female**
0 - 11 Months	1	0
1 to 10 Years	0	1
11 to 20 Years	5	1
21 to 30 Years	20	3
31 to 40 Years	43	3
41 to 50 Years	21	6
51 to 60 Years	23	10
61 to 70 Years	23	6
71 to 80 Years	13	4
81 to 90 Years	10	5
91-100 Years	4	4
101-110 Years	0	0

Types of Accidents by Sex			
Type of Accident	**Total**	**Male**	**Female**
Alcohol/Drug Related	107	92	15
Asphyxiation	8	6	2
Blunt Force Trauma	5	5	0
Choking	6	4	2
Drowning	6	5	1
Fall	31	19	12
Motor Vehicle	39	30	9
Other	5	3	2



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 2022: 42

Fatalities by Month	
Month	**Number of Fatalities**
January	0
February	4
March	2
April	4
May	5
June	4
July	4
August	2
September	5
October	4
November	5
December	3

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

Fatalities by Manner	
Manner of Death	**Number of Fatalities**
Natural	1
Accident	38
Suicide	3
Homicide	0
Undetermined	0

Types of Motor Vehicle Fatalities	
Type	**Number of Fatalities**
Automobile-Driver	13
Automobile-Passenger	7
Motorcyclist	7
Pedestrian	9
Bicyclist	3
Train vs Motor Vehicle	2
Natural Death While Driving	1
Other	2

Motor Vehicle Fatalities
Involving Alcohol and/or Drugs

Pursuant to California Government Code §27491.25, the Coroner's forensic 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 Involving Alcohol and/or Drugs in 2022:

Number of Motor Vehicle Fatalities	42
Number of Cases Involving Drugs and/or Alcohol	19
Number of Cases Where Toxicology Test Was Completed	39
Number of Cases Where No Toxicology Test Was Completed	3
Number of Cases Where Nothing was Detected in Toxicology Test	20

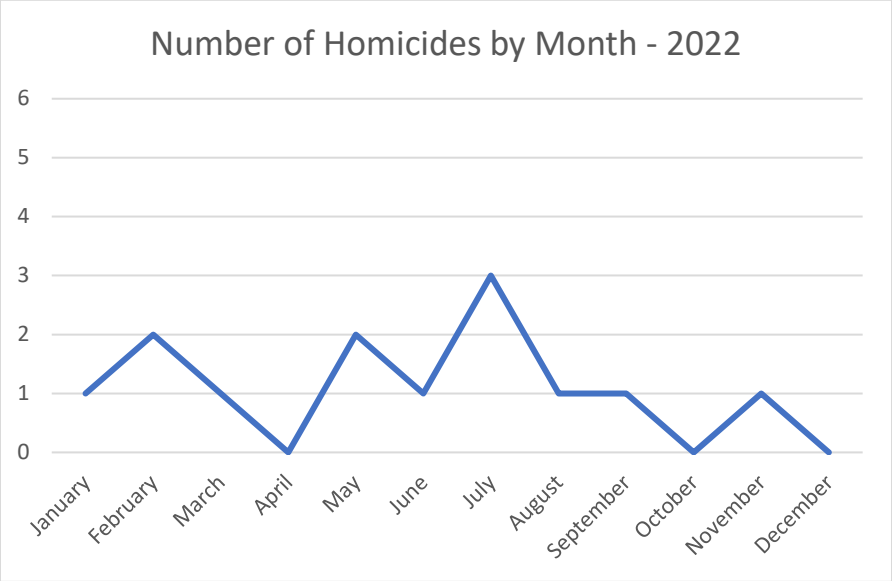
Results	Complete Drug (Including Alcohol)
Alcohol Only Present	6
Prescription and/or Over-the-Counter Drugs Only Present	4 (THC or its derivatives present in 2 cases)
Illicit Drugs Only Present	3 (THC or its derivatives present in 1 case)
Alcohol and Prescription and/or Over-the-Counter Drugs Present	1 (THC or its derivatives present in 1 case)
Alcohol and Illicit Drugs Present	2 (THC or its derivatives present in 1 cases)
Prescription and/or Over-the Counter and Illicit Drugs Present	0
Prescription and/or Over-the Counter, Illicit Drugs, and Alcohol Present	0
THC (or its derivatives) Only Present	2
THC (or its derivatives) and Alcohol Present	1

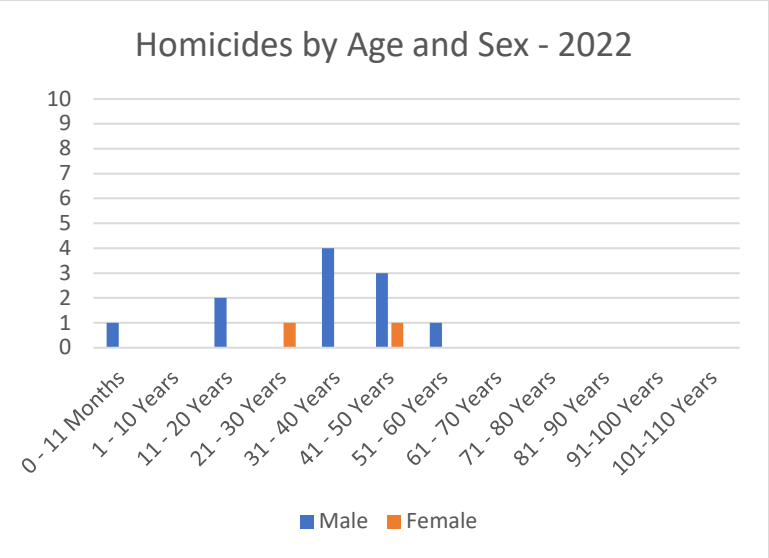
Homicide

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 2022: 13

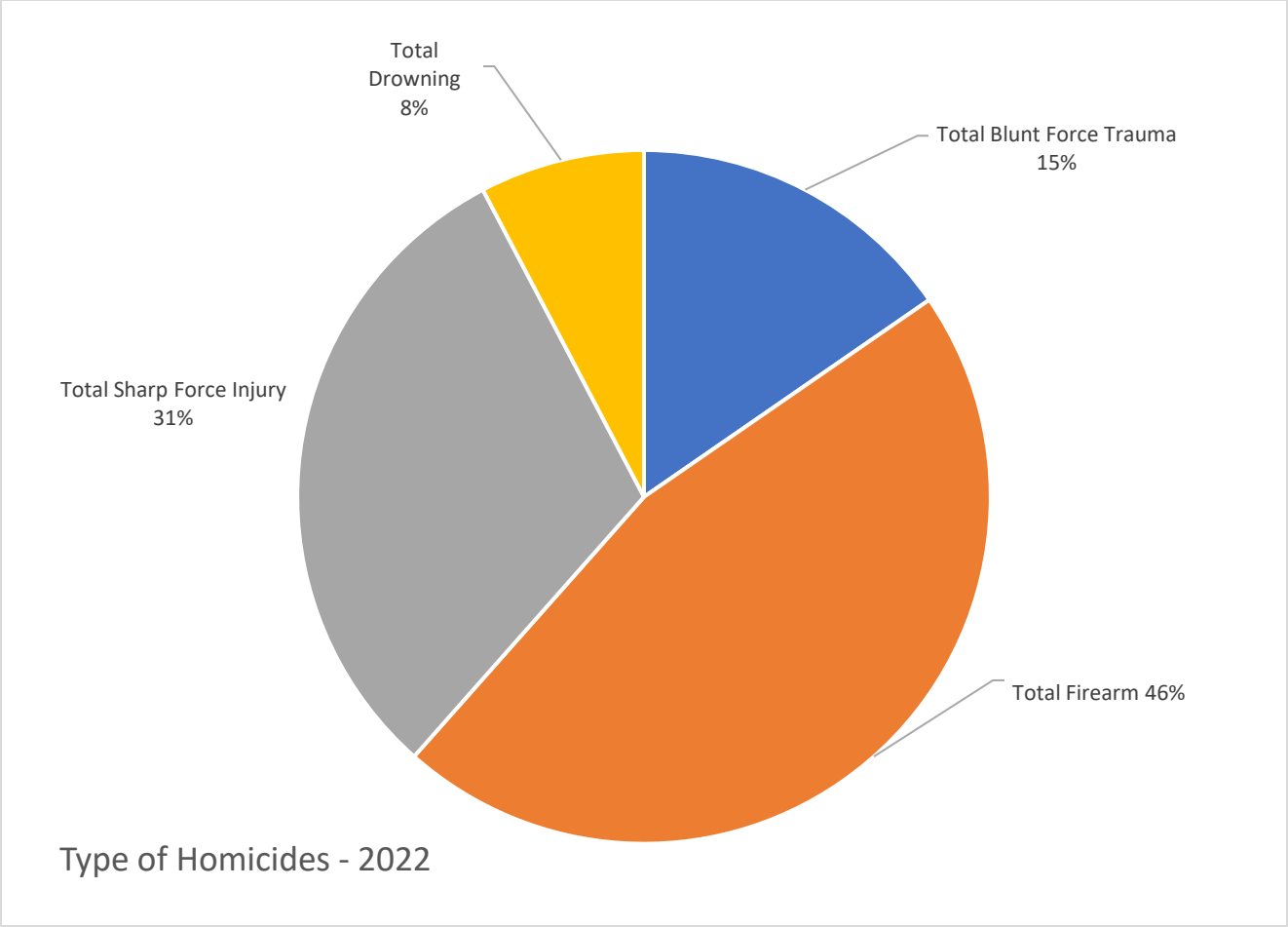
Homicides by Month	
Month	**Number of Homicides**
January	1
February	2
March	1
April	0
May	2
June	1
July	3
August	1
September	1
October	0
November	1
December	0





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

Type of Homicide by Sex			
Type of Homicide	**Total**	**Male**	**Female**
Blunt Force Trauma	2	2	0
Firearm	6	5	1
Sharp Force Injury	4	3	1
Drowning	1	1	0



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 2022: 9

Mode	Total
Cause known, Manner not able to be determined	1
Cause & Manner Undetermined	2
Decomposed Body or Skeletal Remains	4
Unexplained death in infancy (e.g. SUIDS)	2

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 2022: 11

Manner	Total
Natural	0
Accident	5
Suicide	0
Homicide	5
Undetermined	1

County of Death	Total
Santa Clara	7
San Francisco	4

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.

Total Number of Indigent Cremations in 2022: 35

County Cremations referred by outside agencies:	10
County Cremations referred to outside agencies:	2
Cremations performed by the San Mateo County Coroner after remains were abandoned by family:	17
Cremations performed by the San Mateo County Coroner after diligent search, but no family located:	14
Cremations performed by the San Mateo County Coroner for unidentified persons:	2
Cremains collected by family upon locating next of kin after cremation performed:	0
Dispositions handled by family after receiving a fee reduction by application for financial need:	19

For questions or comments, please contact the Coroner's Office:

San Mateo County Coroner
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San Mateo, CA 94402

(650) 312-5562
smcgov.org/coroner