Marin County Sheriff's Office
Coroner Division
Annual Report
2019

Robert T. Doyle
Sheriff-Coroner

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INTRODUCTION

The Coroner's Division is a component of the Sheriff's Office Administration and Support Services Bureau. The Coroner's Division is located at 1600 Los Gamos Drive, Suite 205 in San Rafael, consists of one Chief Deputy Coroner, three Coroner Investigators, one Extra Hire Investigator, one Forensic Pathologist, and one Coroner Forensic Technician.

It is the mission of the Coroner's Division to provide competent and timely medicolegal investigations into deaths occurring within the County of Marin and to provide timely and accurate answers to survivors with regard to the death of their loved ones. The Coroner's Division conducts their investigations to determine the cause, manner, and circumstances of deaths meeting criteria as defined in 27491 of the California Government Code.

According to the Census Bureau in 2014, Marin County was estimated to have a population of 260,750. There were approximately **2024** deaths recorded in Marin County in 2019. Of these approximately **587** were mandated to be reported to the Sheriff's Office, Coroner Division. These deaths were reported pursuant to California Government Code Section 27491 and California Health and Safety Code Section 102850 which directs the Coroner to inquire into and determine the circumstances, manner and cause of those deaths. After initial investigation, **307** were determined to be full Coroner investigation cases with the final cause of death determined and signed by the Coroner, or his designated authority.

This Annual Report of the Coroner Division provides a summary of the cases reported and investigated by the Marin County Sheriff's Coroner Division and provides a statistical breakdown of the types of deaths that occurred within Marin County in 2019.

MARIN COUNTY SHERIFF-CORONER STAFF 2019

Sheriff Robert T. Doyle.....Sheriff-Coroner

Undersheriff Jamie Scardina.....Undersheriff

Captain Rick Navarro/Scott Harrington.....Captain

Roger Fielding.....Chief Deputy Coroner

Kaci DeMent.....Coroner Investigator

Alexandra Torres.....Coroner Investigator

Crystal Nielsen.....Coroner Investigator

Stewart Cowan.....Deputy Sheriff, Extra Hire

Doctor Joseph Cohen.....Forensic Pathologist, Contracted

Jaclyn Vaishville/Emily Mandel.....Coroner Forensic Technician

REPORTABLE CRITERIA

The Coroner Division is responsible for investigating the cause and manner of death of all sudden or unexpected deaths, natural deaths when the deceased has not been under a physician's care, as well as homicide, suicide, and accidental deaths.

The Coroner Division is also responsible for the identification of unknown decedents, for locating next-of-kin, and preserving all criminal or civil evidence, personal assets, and estates.

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

1. Unattended deaths: No physician in attendance 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 the attendance of a physician. The Coroner will proceed to conduct an investigation of the death. If, during or after the investigation, it is ascertained that the death is due to natural causes and if there is an attending physician who is qualified and willing, the Coroner will waive the case to the attending physician for his 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. In order to qualify, the attending physician must have professionally seen the decedent during the 20 days prior to death. (See #2 below)

   A patient in a hospital is always considered as being in attendance. Cases where the physician is unavailable for reasons of vacation or when attending conventions, etc., the Coroner should be called. It is not necessary that the physician attend the patient for a period of 24 hours prior to death in order to sign the death certificate. On natural deaths, a physician may be qualified to sign a death certificate provided the physician attended the patient for a sufficient time to properly diagnose the case and subsequent cause of death. If the physician only saw the patient for matter of minutes but was able to determine the cause, the physician can certify the death and sign the certificate. 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. A telephone conversation between the physician and patient IS NOT considered "in attendance". After the events and circumstances at the time of death are investigated by the Coroner, the Coroner or his deputy may order an autopsy or may consult with one qualified and licensed to practice medicine and determines the cause of death, providing such information affords clear grounds to establish the correct medical cause of death. For example, a heart condition and the patient dies at home. The doctor may give the cause of death from his or her knowledge of the patient with the Coroner signing the certificate. Another

example would be a rest home patient who is routinely seen once a month but would die at a time when the doctor had not attended to the patient during the prior twenty days. Cooperation and consultation between the physician and the Coroner may provide the cause; however, if the doctor's prior knowledge of the subject could not be applied to the death, then an autopsy would be performed.

3. Physician unable to state the cause of death (unwillingness DOES NOT APPLY). This includes all sudden, unexpected and unusual deaths and fetal deaths when the underlying cause is unknown. This would apply to a hospital, for example, where the prior knowledge of the deceased and knowledge gained while deceased was a patient at the hospital would not be sufficient to give the cause of death. This is strictly a matter of knowledge of the subject's condition.

4. Known or suspected homicide.

5. Known or suspected suicide.

6. Involving any criminal action or suspicion of a criminal act (includes child and dependent adult negligence and abuse). 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.

7. Related to or following known or suspected self-induced or criminal abortion.

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

9. Following an accident or injury (primary or contributory). Deaths known or suspected as resulting (in whole or part) from or related to accident or injury, EITHER OLD OR RECENT. This would include any accident: traffic, a fall at home, which resulted in death, at work, etc. It would include such cases where an elderly person would fall at home incurring a hip fracture, then taken to the hospital, confined to bed and would later die of bronchopneumonia or any other natural cause. On the basis that had the individual not fallen and fractured a femur with the fatal consequences there from, it must be assumed the individual would still be alive despite various infirmities. There are certain cases where, because of the time lapse between the injury and the death, a great deal of difficulty ensues when one attempts to determine whether the death be attributed to the injury or whether it be a natural one in the aged person. A standard method is to carefully investigate this type of case in response to the clinical course. For example, if the fracture occurred three months ago and the individual has not returned to baseline even in a limited sense, and he or she dies suddenly, it would be a fair statement to list the death as natural rather than an accidental one relating to the previous treatment. It is not necessary that the fracture be directly related to the immediate terminal cause of death. If it contributed to a degree, it may be shown as a significant condition contributing to, but not related, to the terminal condition. If it is felt that the fracture did contribute, the Coroner must make an investigation into the facts about how the injury occurred. The actual wording for the cause of death will either be determined by consultation with the physician or by an autopsy. SPONTANEOUS PATHOLOGICAL FRACTURES DO NOT NEED TO BE EVALUATED BY THE CORONER.

REPORTABLE CRITERIA

10. Drowning, fire, hanging, gunshot, stabbing, cutting, starvation, exposure, alcoholism, drug addiction, strangulation or aspiration. Aspiration pneumonia may be treated as a natural death and therefore proper for the private physician to sign the death certificate provided that the antecedent medical conditions do not warrant making it a Coroner's case. Aspiration of stomach contents, if from disease, should be treated as natural causes. All questionable aspiration cases should be referred to the Coroner. Exposure in this section includes heat prostration.

11. Accidental poisoning (food, chemical, drug, therapeutic agents).

12. Occupational diseases or occupational hazards. Examples would be Silicosis and other pneumoconiosis, radiation resulting from x-ray equipment, and injuries produced by changes in atmospheric pressure such as with aviation or with deep underground tunnels or in deep-sea diving (Caisson Disease).

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. 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. This mainly applies to surgical operations performed for the purpose of alleviating or correcting natural disease conditions and does not include illegal abortions or any type of illegal operations or operations performed because of complications following traumatic injury. (Traumatic injury cases are covered in Section 9). Post-operative deaths should be reported to the Coroner for evaluation and discussion. Lacking a cause of death, such as in idiosyncrasy to an anesthetic agent, the Coroner will usually "waive" the case to the attending physician for his certification and signature.

15. In prison or while under sentence (includes all in-custody and police involved deaths).

16. All deaths of unidentified persons. Where a physician can qualify and certify the cause of death, the death of an unidentified person may not require a Coroner's investigation as indicated in the previous comments. However, the case should be referred to the Coroner so an attempt can be made to identify the remains and proper internment made as provided by the Health and Safety Code.

17. All deaths of state hospital patients.

18. Suspected SIDS deaths. These are unexpected deaths of apparent healthy, thriving infants.

19. All deaths where the patient is comatose throughout the period of the physician's attendance (includes patients admitted to hospitals unresponsive and expire without regaining consciousness). These deaths are reportable for evaluation by the Coroner. In addition, the deaths of patients who are admitted to hospitals unresponsive and have not regained consciousness before death, are reportable to the Coroner for evaluation. This evaluation will consist of confirming a medical history and treatment and whether or not the attending physician can furnish a cause of death and will sign the death certificate.

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

21. All deaths where the decedent was in a hospital less than 24 hours.

2019 GENERAL STATISTICS

Number of Deaths Reviewed/Investigated : **894**

Number of cases resulting in full death investigation: **307**

Number of cases by manner of death:

- Natural: **121**
- Accident: **100**
- Suicide: **77**
- Homicide: **6**
- Undetermined: **3**
- Indigent: **12**
- Non-Forensic (Bones): **1**
- Pending : **0**

Number of decedents transported to the County Division morgue for full death investigation: **280**

***Some cases moved to Napa and back to Marin**

Forensic Examinations

- Autopsy: **86**
- External Examination: **153**
- Medical File Review: **43**

Total Amount of Toxicological Tests Run: **147**

Number of cases reported as "unidentified": **10**

- Identified after investigation: **9**
- Remain unidentified: **1**

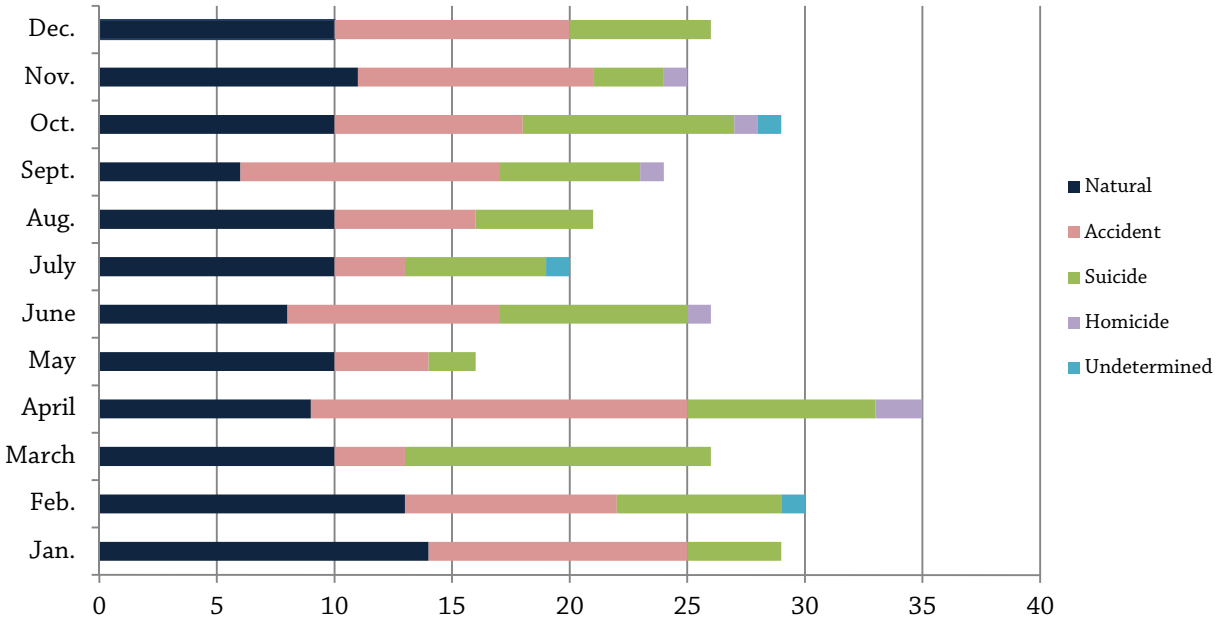
Organ and tissue donations:

- Total Direct Referrals: **3**
- Total Organ Donors: **4**
- Total Tissues Donors: **34**
- Total Lives Impacted through organ/tissue donations: **957**
- Organ Denial: **0**

2019 MANNERS OF DEATH

2019 MANNERS OF DEATH BY MONTH

	Natural	Accident	Suicide	Homicide	Undetermined	Pending	Total
Jan.	14	11	4	0	0	0	**29**
Feb.	13	9	7	0	1	0	**30**
March	10	3	13	0	0	0	**26**
April	9	16	8	2	0	0	**35**
May	10	4	2	0	0	0	**16**
June	8	9	8	1	0	0	**26**
July	10	3	6	0	1	0	**20**
Aug.	10	6	5	0	0	0	**21**
Sept.	6	11	6	1	0	0	**24**
Oct.	10	8	9	1	1	0	**29**
Nov.	11	10	3	1	0	0	**25**
Dec.	10	10	6	0	0	0	**26**
Total	**121**	**100**	**77**	**6**	**3**	**0**	**307**



HISTORICAL STATISTICS 2014-2018

CORONER CASE STATISTICS FOR 2014 BY MONTH

	Natural	Accident	Suicide	Homicide	Undetermined	Pending	Total
Jan.	7	8	6	0	0	0	**21**
Feb.	8	4	3	0	0	0	**15**
March	11	4	6	1	0	0	**22**
April	5	15	7	1	0	0	**28**
May	8	9	5	0	1	0	**23**
June	10	12	6	0	0	0	**28**
July	6	10	7	1	0	0	**24**
Aug.	11	6	5	1	1	0	**24**
Sept.	6	4	7	0	3	0	**20**
Oct.	7	10	5	1	0	0	**23**
Nov.	6	8	6	1	0	0	**21**
Dec.	12	8	5	1	1	0	**27**
Total	**96**	**98**	**68**	**7**	**6**	**0**	**275**

CORONER CASE STATISTICS FOR 2015 BY MONTH

	Natural	Accident	Suicide	Homicide	Undetermined	Pending	Total
Jan.	11	12	4	0	0	0	**27**
Feb.	9	8	6	1	2	0	**26**
March	10	5	7	0	1	0	**23**
April	4	10	6	2	0	0	**22**
May	8	9	5	1	2	0	**25**
June	13	7	6	1	3	0	**30**
July	6	10	5	0	2	0	**23**
Aug.	13	5	5	1	1	0	**25**
Sept.	7	12	3	0	0	0	**22**
Oct.	5	14	2	1	1	0	**23**
Nov.	5	9	3	0	0	0	**17**
Dec.	5	12	1	0	0	0	**18**
Total	**96**	**113**	**53**	**7**	**12**	**0**	**281**

CORONER CASE STATISTICS FOR 2016 BY MONTH

	Natural	Accident	Suicide	Homicide	Undetermined	Pending	Total
Jan.	13	11	4	0	2	0	**30**
Feb.	3	4	2	2	0	0	**11**
March	8	7	6	0	1	0	**22**
April	13	5	7	0	1	0	**26**
May	8	8	7	1	1	0	**25**
June	8	4	6	0	2	0	**20**
July	3	6	7	0	0	0	**16**
Aug.	8	7	6	1	1	0	**23**
Sept.	3	6	8	0	3	0	**20**
Oct.	6	8	7	1	1	0	**23**
Nov.	4	4	5	0	0	0	**13**
Dec.	9	8	1	0	0	0	**18**
Total	**86**	**78**	**66**	**5**	**12**	**0**	**247**

CORONER CASE STATISTICS FOR 2017 BY MONTH

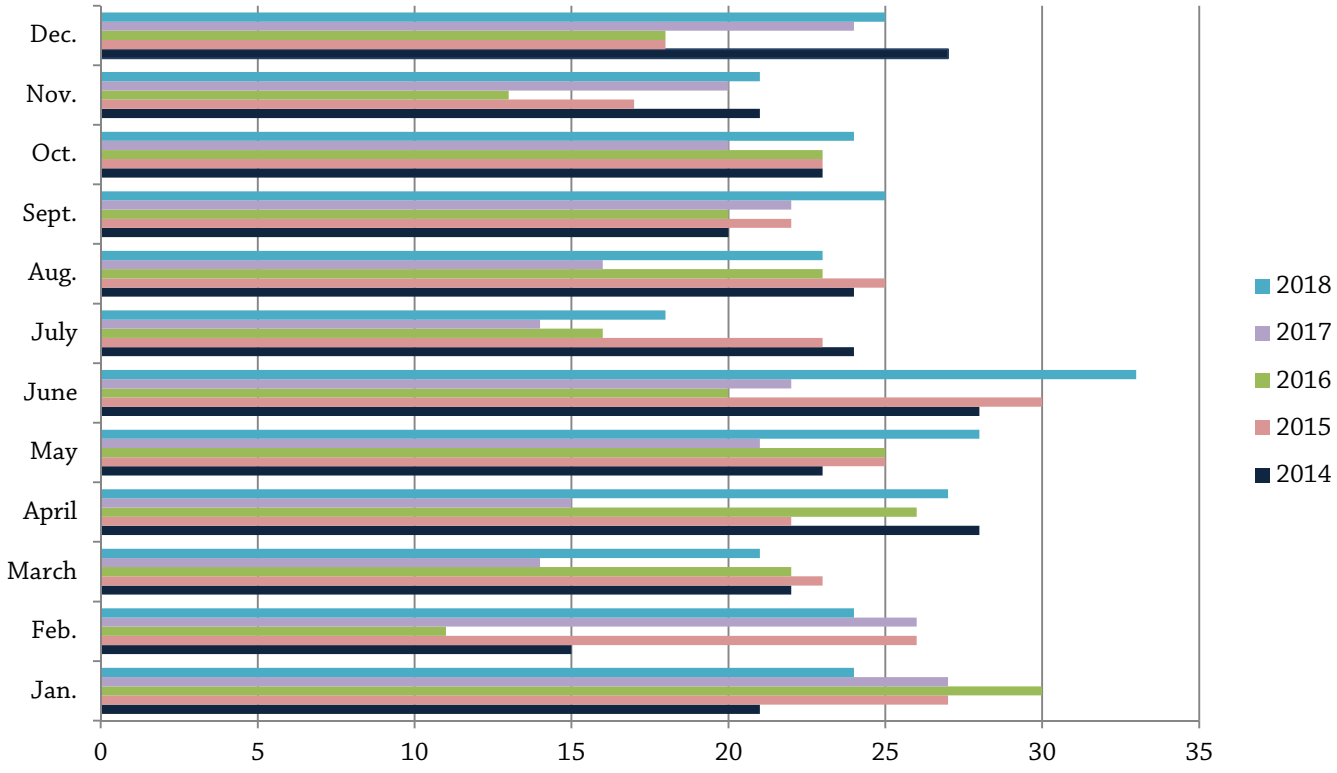
	Natural	Accident	Suicide	Homicide	Undetermined	Pending	Total
Jan.	11	9	6	0	1	0	**27**
Feb.	6	12	5	2	1	0	**26**
March	5	5	2	1	1	0	**14**
April	4	7	3	0	1	0	**15**
May	1	11	7	1	1	0	**21**
June	6	8	8	0	0	0	**22**
July	5	6	3	0	0	0	**14**
Aug.	6	5	4	0	1	0	**16**
Sept.	5	10	6	1	0	0	**22**
Oct.	9	5	6	0	0	0	**20**
Nov.	4	10	5	1	0	0	**20**
Dec.	5	10	7	1	1	0	**24**
Total	**67**	**98**	**62**	**7**	**7**	**0**	**241**

CORONER CASE STATISTICS FOR 2018 BY MONTH

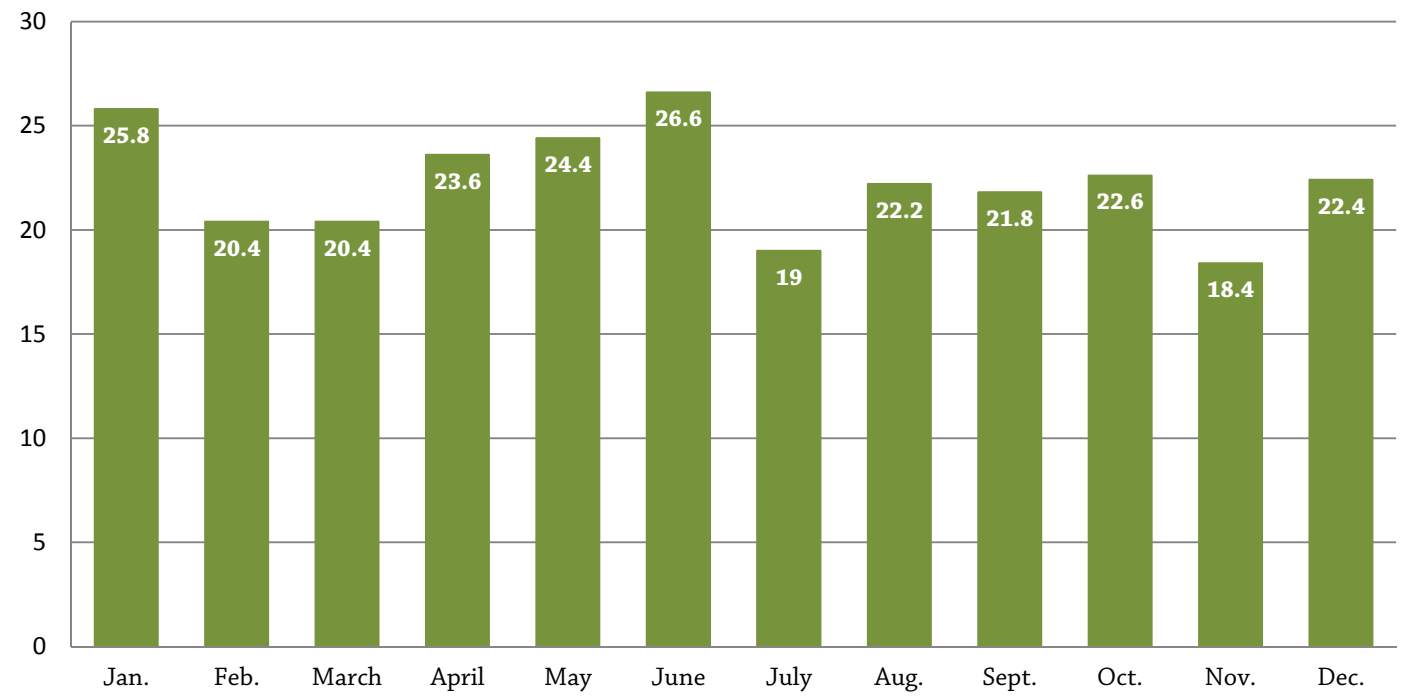
	Natural	Accident	Suicide	Homicide	Und**	PMD***	Pending	Indigent	Total
Jan.	8	10	1	0	0	0	0	5	**24**
Feb.	4	9	4	1	0	3	0	3	**24**
March	8	3	3	1	1	3	0	2	**21**
April	6	13	4	1	0	2	0	1	**27**
May	9	5	8	1	0	2	0	3	**28**
June	7	14	8	1	0	2	0	1	**33**
July	4	4	7	1	1	1	0	0	**18**
Aug.	9	5	8	0	0	1	0	0	**23**
Sept.	11	6	4	1	0	3	0	0	**25**
Oct.	10	5	4	2	0	2	0	1	**24**
Nov.	6	9	4	1	0	1	0	0	**21**
Dec.	6	13	3	1	0	1	0	1	**25**
Total	**88**	**96**	**58**	**11**	**2**	**21**	**0**	**17**	**293**

*Note: Indigent cases are also associated with a manner of death classification, creating a total death count higher than indicated on the previous page **Und=Undetermined ***PMD=Primary Medical Doctor Sign-out

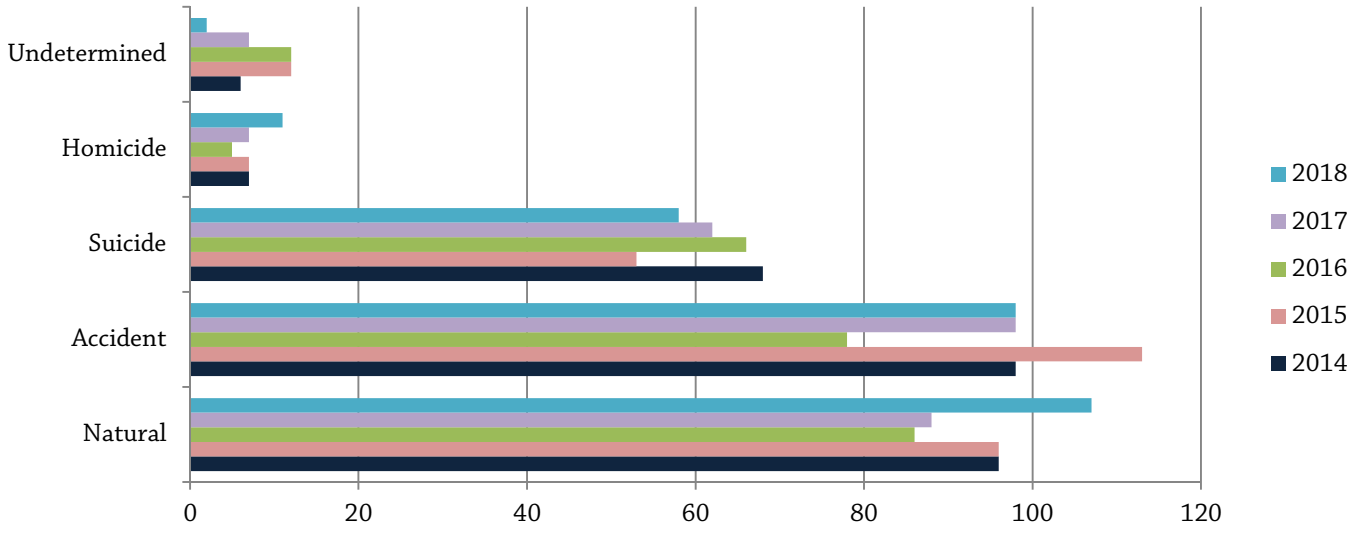
5 YEAR STUDY – NUMBER OF CASES BY MONTH (2014-2018)



5 YEAR STUDY – AVERAGE NUMBER OF CASES BY MONTH (2014-2018)



5 YEAR STUDY –CAUSES BY MANNER (2014-2018)



2019 Death Statistics and Classifications

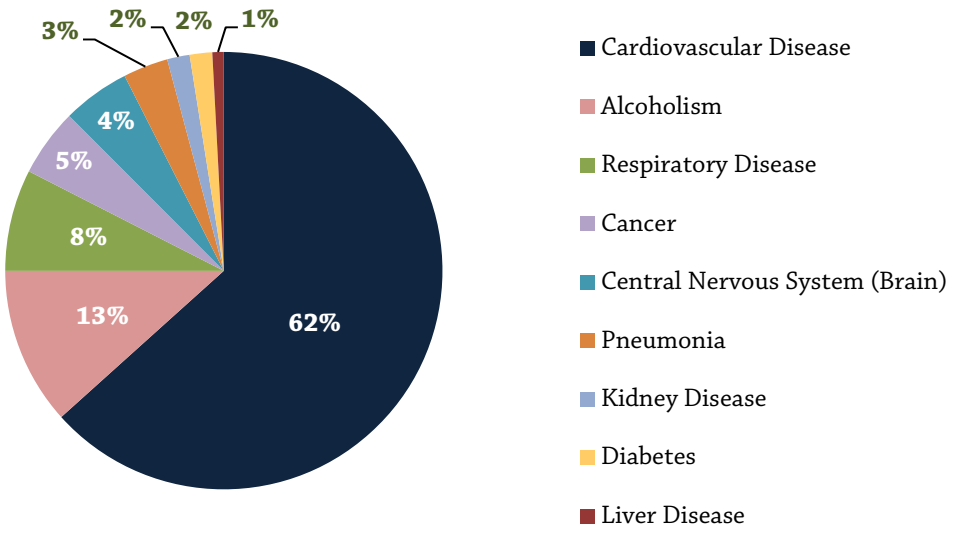
2019 NATURAL DEATHS

The MCSO Coroner Division investigated **121** natural deaths in 2019. Deaths are classified as natural due to the sudden and unexpected nature of the death in an apparently healthy individual. This includes deaths by disease or by old age. If a natural death is hastened by an injury such as a fall, the manner of death is classified as an accident instead of a natural.

NATURAL DEATHS BY CAUSE OF DEATH

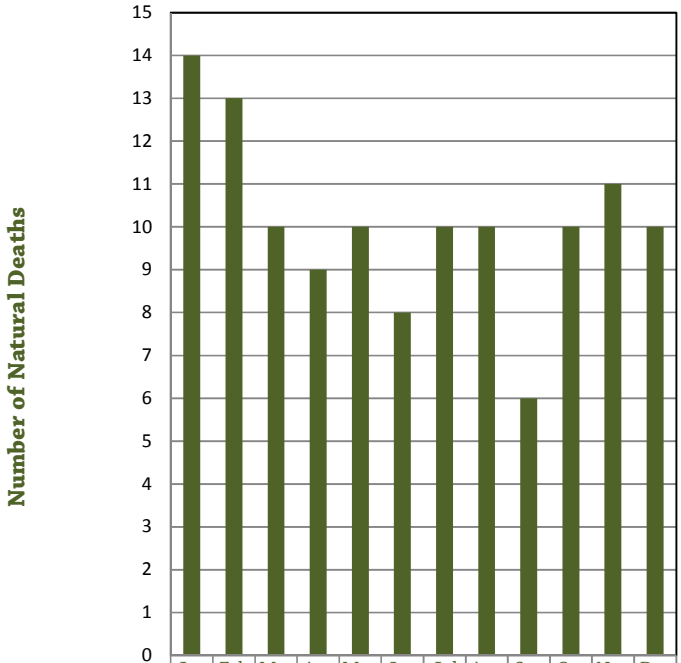
Cause	Number of Natural Deaths	% of Total Natural Deaths
Cardiovascular Disease	75	62%
Alcoholism	16	13%
Respiratory Disease	10	8%
Cancer	6	5%
Central Nervous System (Brain)	5	4%
Pneumonia	4	3%
Kidney Disease	2	2%
Diabetes	2	2%
Liver Disease	1	1%

PIE CHART – NATURAL DEATHS BY CAUSE OF DEATH



Note: The percentages in the "Pie Chart" are rounded up or down to nearest whole number.

NATURAL DEATHS BY MONTH



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Number of Natural Deaths	14	13	10	9	10	8	10	10	6	10	11	10

NATURAL DEATHS BY SEX

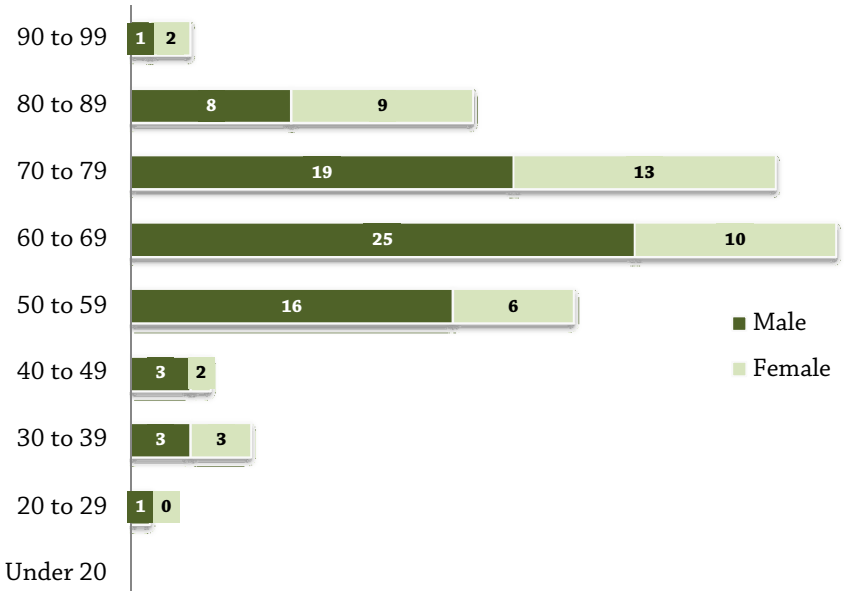
Sex	Number of Natural Deaths	% of Natural Deaths
Male	76	63%
Female	45	37%
Total	121	100%

NATURAL DEATHS BY AGE GROUP

Age	Number of Natural Deaths	% of Natural Deaths
Under 20	0	0%
20 to 29	1	1%
30 to 39	6	5%
40 to 49	5	4%
50 to 59	22	18%
60 to 69	35	29%
70 to 79	32	27%
80 to 89	17	14%
90 to 99	3	2%

Note: Indigent deaths are recorded as the date reported to the MCSO Coroner Division.

NATURAL DEATHS BY AGE GROUP & SEX



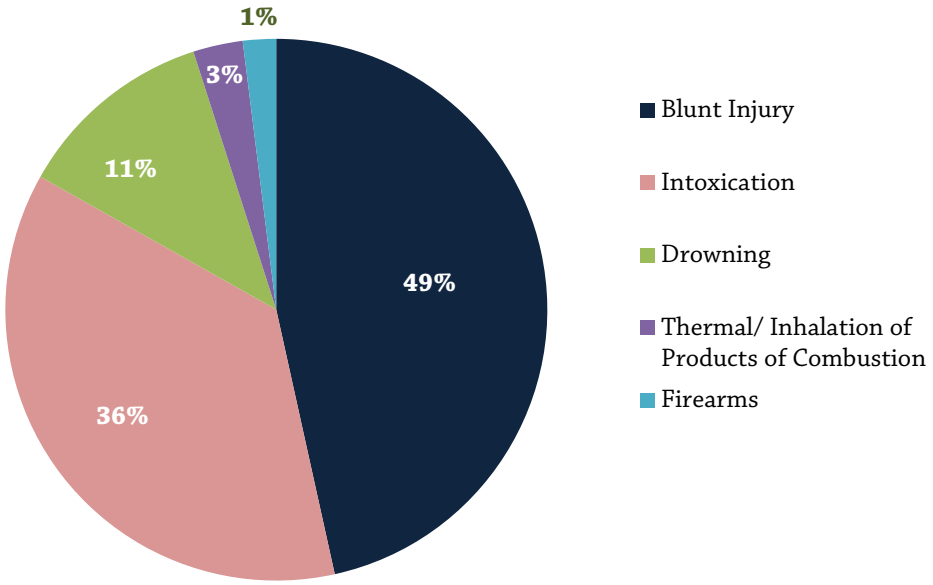
2019 ACCIDENTAL DEATHS

The MCSO Coroner Division investigated **100** accidental deaths in 2019. Deaths are classified as natural due to the sudden and unexpected nature of the death in an apparently healthy individual. This includes deaths by disease or by old age. If a natural death is hastened by an injury such as a fall, the manner of death is classified as an accident instead of a natural.

ACCIDENTAL DEATHS BY CAUSE OF DEATH

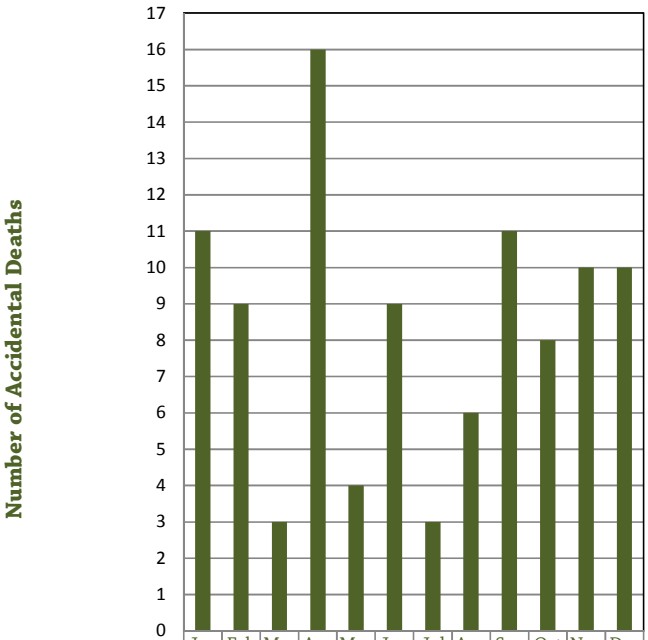
Cause	Number of Accidental Deaths	% of Total Accidental Deaths
Blunt Injury -Due to Fall (29) -Due to Traffic (18) -Due to Fallen Gate (1) -Due to Fallen Tree (1)	49	49%
Intoxication	36	36%
Drowning	11	11%
Thermal/Inhalation of Products of Combustion	3	3%
Firearms	1	1%

PIE CHART – ACCIDENTAL DEATHS BY CAUSE OF DEATH



Note: The percentages in the "Pie Chart" are rounded up or down to nearest whole number.

ACCIDENTAL DEATHS BY MONTH



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Number of Accidental Deaths	11	9	3	16	4	9	3	6	11	8	10	10

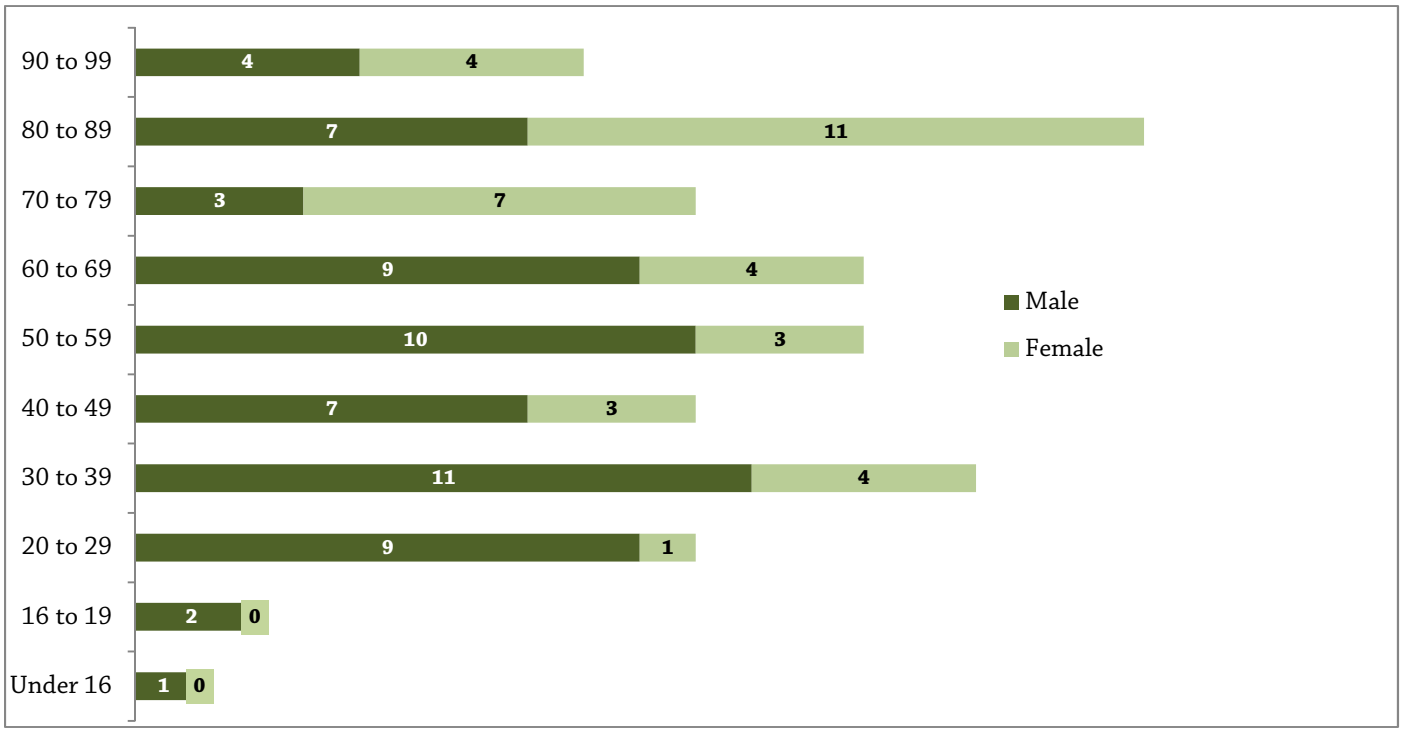
ACCIDENTAL DEATHS BY SEX

Sex	Number of Accidental Deaths	% of Accidental Deaths
Male	63	63%
Female	37	37%
Total	100	100%

ACCIDENTAL DEATHS BY AGE GROUP

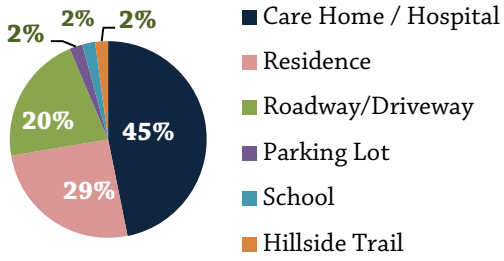
Age	Number of Accidental Deaths	% of Accidental Deaths
Under 16	1	1%
16 to 19	2	2%
20 to 29	10	10%
30 to 39	15	15%
40 to 49	10	10%
50 to 59	13	13%
60 to 69	13	13%
70 to 79	10	10%
80 to 89	18	18%
90 to 99	8	8%

ACCIDENTAL DEATHS BY AGE GROUP & SEX



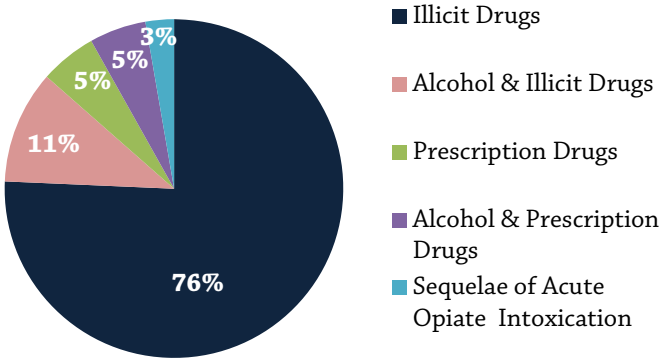
ACCIDENTAL DEATHS BY CAUSE OF DEATH – BLUNT IMPACT INJURY

Place of Death	Number of Deaths
Care Home/Hospital	22
Residence	14
Roadway/Driveway	10
Parking Lot	1
School	1
Hillside Trail	1



ACCIDENTAL DEATHS BY CAUSE OF DEATH – INTOXICATION

Type of Intoxication	Number of Deaths
Illicit Drugs	27
Alcohol & Illicit Drugs	4
Prescription Drugs	2
Alcohol & Prescription Drugs	2
Sequelae of Acute Opiate Intoxication	1



2019 MOTOR VEHICLE FATALITIES

The MCSO Coroner Division investigated **25** Motor Vehicle Fatalities in 2019. These death investigations were conducted along with the local law enforcement where the traffic collision took place. A suspected traffic fatality can sometimes be the end result of natural causes that can be determined, in many cases, at the time of autopsy. The death may then be determined to be a "natural" death due to a natural cause (for example a heart attack), as opposed to a crash. A traffic fatality may also be ruled as a suicide, an accident or even a homicide.

MOTOR VEHICLE FATALITIES BY AGE GROUP & SEX

Age	Male	Female	Total
0-11 Months	0	0	0
1-10 Years	0	0	0
11-20 Years	3	0	3
21-30 Years	1	0	1
31-40 Years	4	2	6
41-50 Years	2	0	2
51-60 Years	3	0	3
61-70 Years	2	2	4
71-80 Years	1	4	5
81-90 Years	0	1	1
Total	**16**	**9**	**25**

MOTOR VEHICLE FATALITIES BY MONTH

Month	Number
Jan	3
Feb	2
March	2
April	5
May	1
June	2
July	1
Aug	0
Sept	4
Oct	1
Nov	1
Dec	3

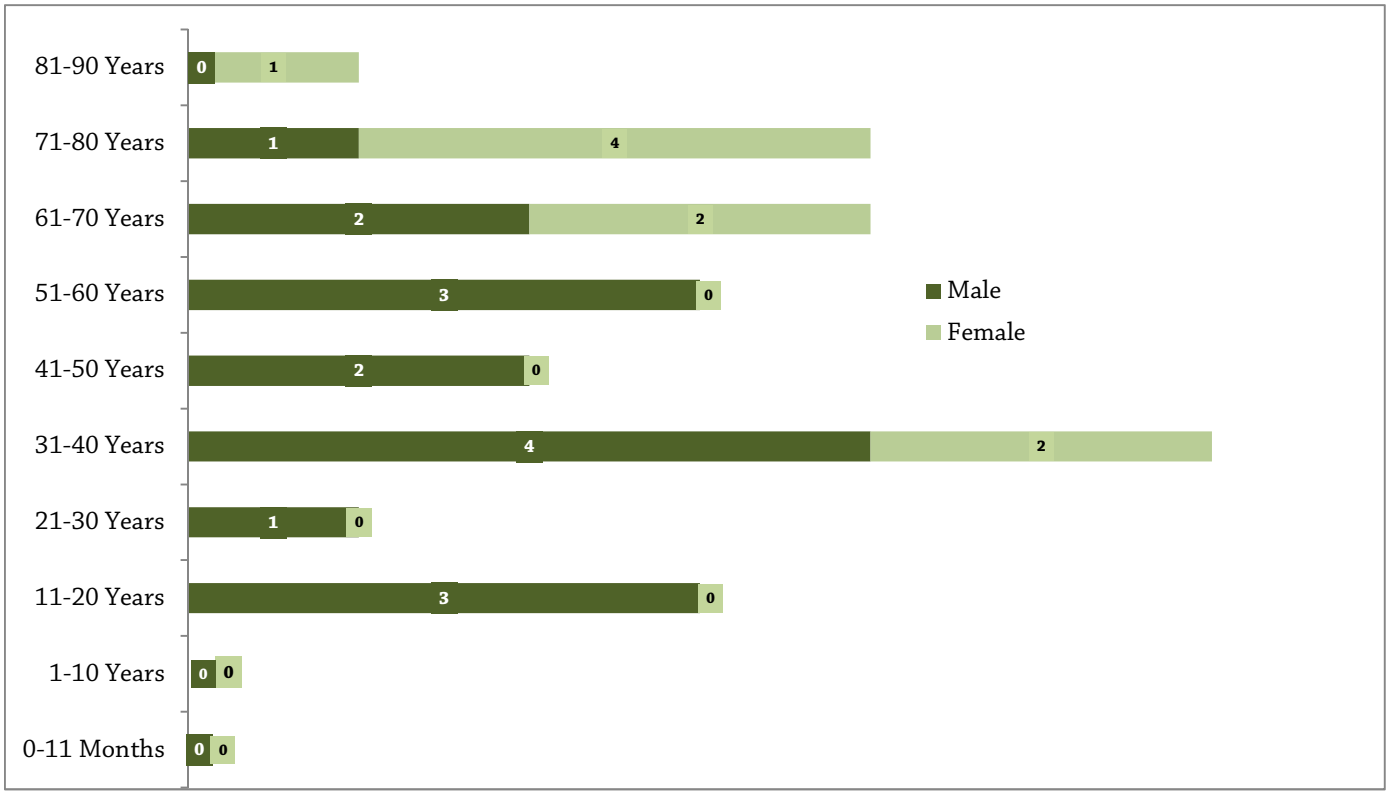
MOTOR VEHICLE FATALITIES BY DECEDENT CLASSIFICATION

Automobile Operator	14
Pedestrian	7
Automobile Passenger	2
Bicyclist	1
Unknown	1

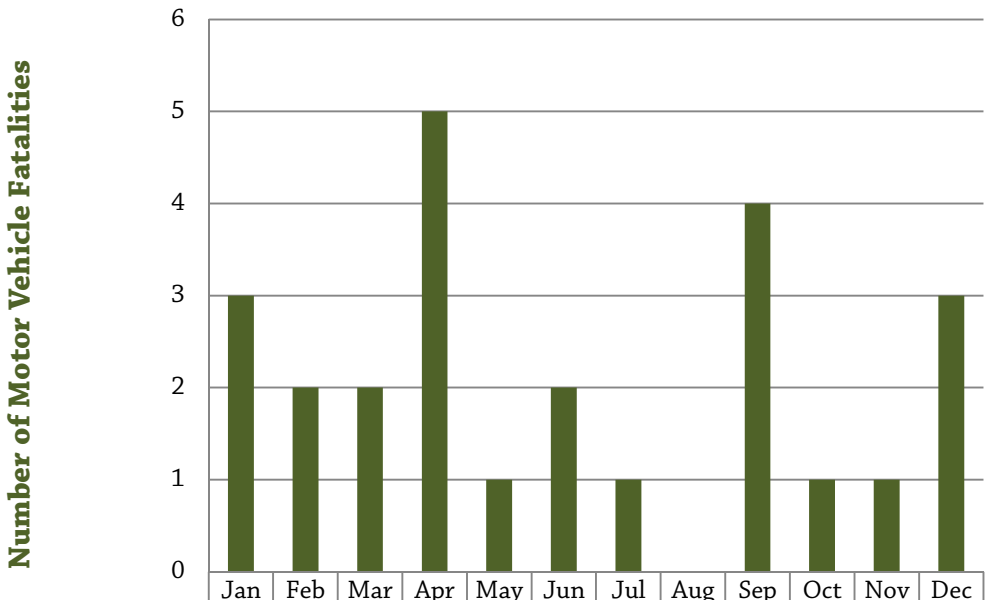
MOTOR VEHICLE FATALITIES BY MANNER OF DEATH

Accident	20
Homicide	4
Suicide	1
Natural	0

MOTOR VEHICLE FATALITIES BY AGE GROUP & SEX



MOTOR VEHICLE FATALITIES BY MONTH



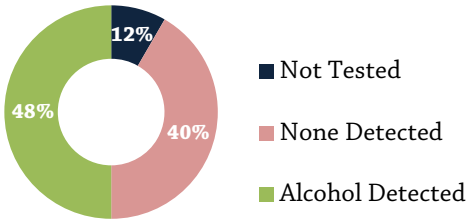
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Number of Motor Vehicle Fatalities Number	3	2	2	5	1	2	1	0	4	1	1	3

2019 MOTOR VEHICLE FATALITIES INVOLVING ALCOHOL AND/OR DRUGS

The MCSO Coroner Division investigated **25** motor vehicle fatalities in 2019. Pursuant to California Government Code Section 27491.25 the Coroner's pathologist takes available blood and urine samples from the deceased to make appropriate related chemical tests. These samples are used to determine the alcohol and/or drug related derivative contents, if any, in the body. In some cases the traffic victims are hospitalized for a lengthy period of time prior to expiring and therefore, relevant blood and urine samples are unavailable for testing.

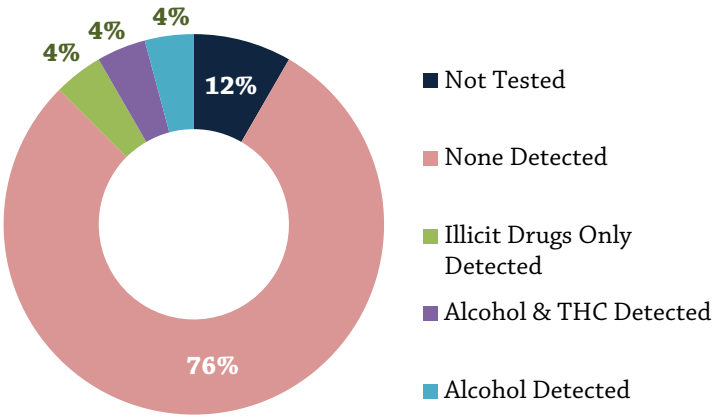
TOXICOLOGY RESULTS RELATING TO ALCOHOL

Not Tested	3
None Detected	10
Alcohol Detected	12
Total	**25**



TOXICOLOGY RESULTS RELATING TO ILICIT DRUGS

Not Tested	3
None Detected	19
Illicit Drugs Only Detected	1
Illicit Drugs & Alcohol Detected	1
Alcohol & THC Detected	1
Total	**25**



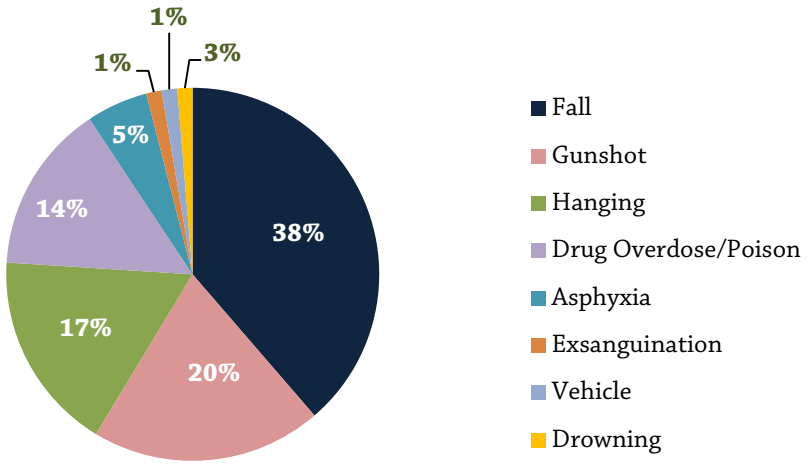
2019 SUICIDE DEATHS

The MCSO Coroner Division investigated **77** suicides in 2019. Suicide deaths are those caused by self-inflicted injuries with evidence of intent to end one's life. Evidence of intent includes an explicit expression, such as a suicide note or verbal threat, or an act constituting purposeful intention.

SUICIDES BY CAUSE OF DEATH

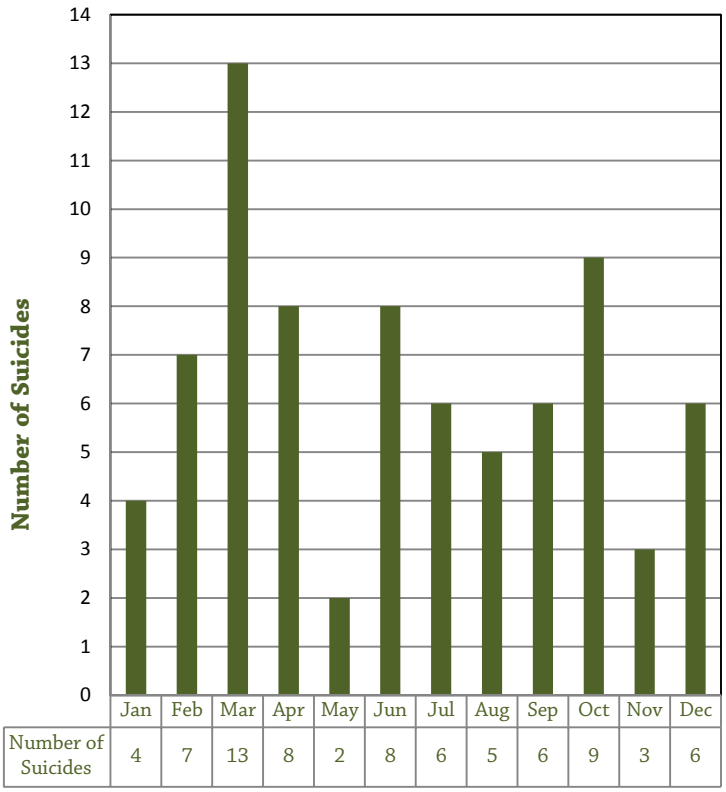
Cause	Number of Suicides	% of Total Suicides
Fall	30	38%
Gunshot	15	20%
Hanging	13	17%
Drug Overdose/Poison	11	14%
Asphyxia	4	5%
Exsanguination	1	1%
Vehicle	1	1%
Drowning	2	3%

PIE CHART - SUICIDES BY CAUSE OF DEATH



Note: The percentages in the "Pie Chart" are rounded up or down to nearest whole number.

SUICIDES BY MONTH



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Number of Suicides	4	7	13	8	2	8	6	5	6	9	3	6

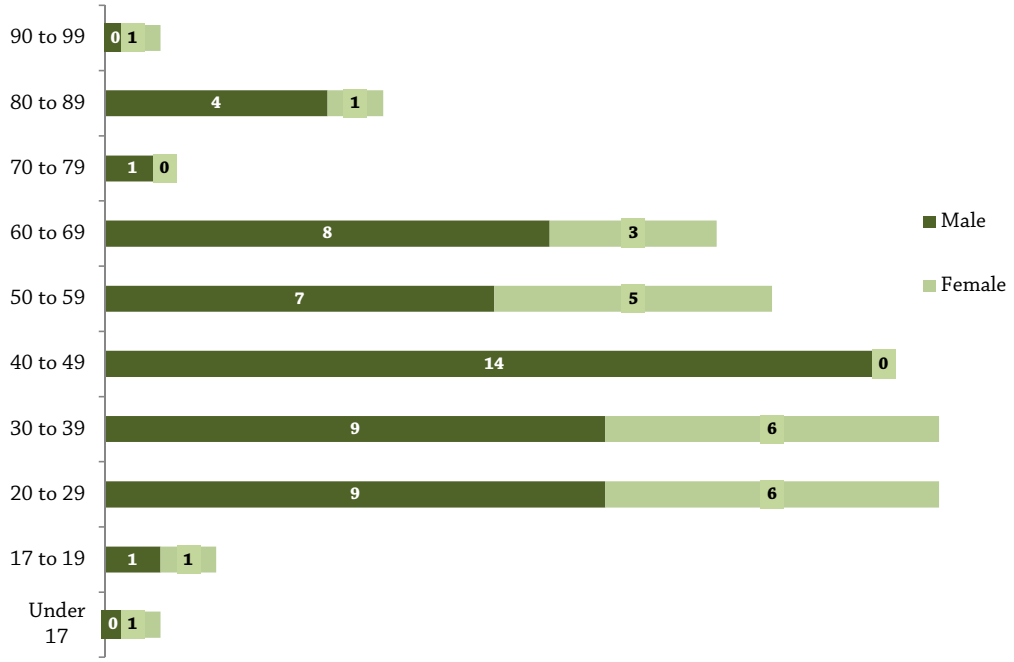
SUICIDES BY SEX

Sex	Number of Suicides	% of Suicides
Male	53	69%
Female	24	31%
Total	77	100%

SUICIDES BY AGE GROUP

Age	Number of Suicides	% of Suicides
Under 17	1	1%
17 to 19	2	3%
20 to 29	15	19.5%
30 to 39	15	19.5%
40 to 49	14	18%
50 to 59	12	16%
60 to 69	11	14%
70 to 79	1	1%
80 to 89	5	7%
90 to 99	1	1%

SUICIDES BY AGE GROUP & SEX



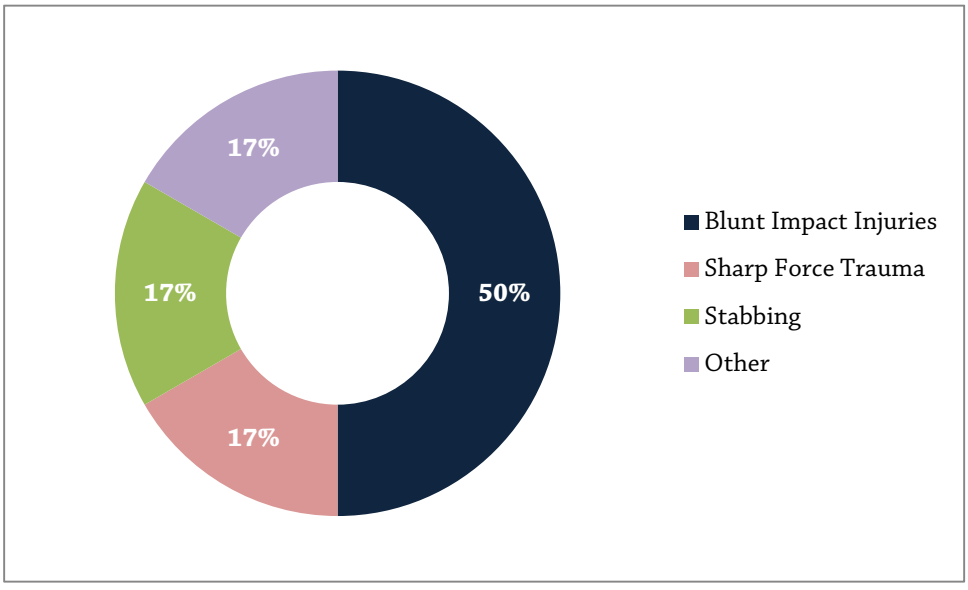
2019 HOMICIDE DEATHS

The MCSO Coroner Division investigated **6** homicides in 2019. A death is considered a homicide when it is caused by the intentional harm (explicit or implicit) of one person by another. These include acts of grossly reckless behavior. In this context the word "homicide" does not necessarily imply the existence of criminal intent behind the action of the other person.

HOMICIDES BY CAUSE OF DEATH

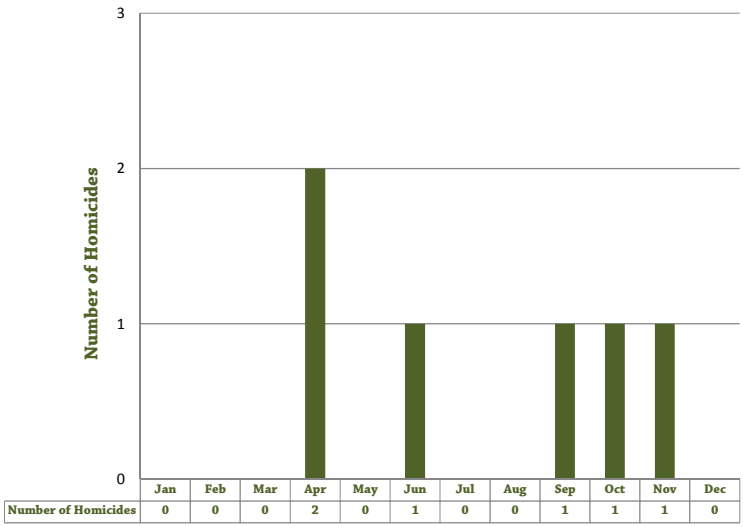
Cause	Number of Homicides	% of Total Homicides
Blunt Impact Injuries	3	50%
Sharp Force Trauma	1	17%
Stabbing	1	17%
Other	1	17%

PIE CHART - HOMICIDES BY CAUSE OF DEATH



Note: The percentages in the "Pie Chart" are rounded up or down to nearest whole number.

HOMICIDES BY MONTH



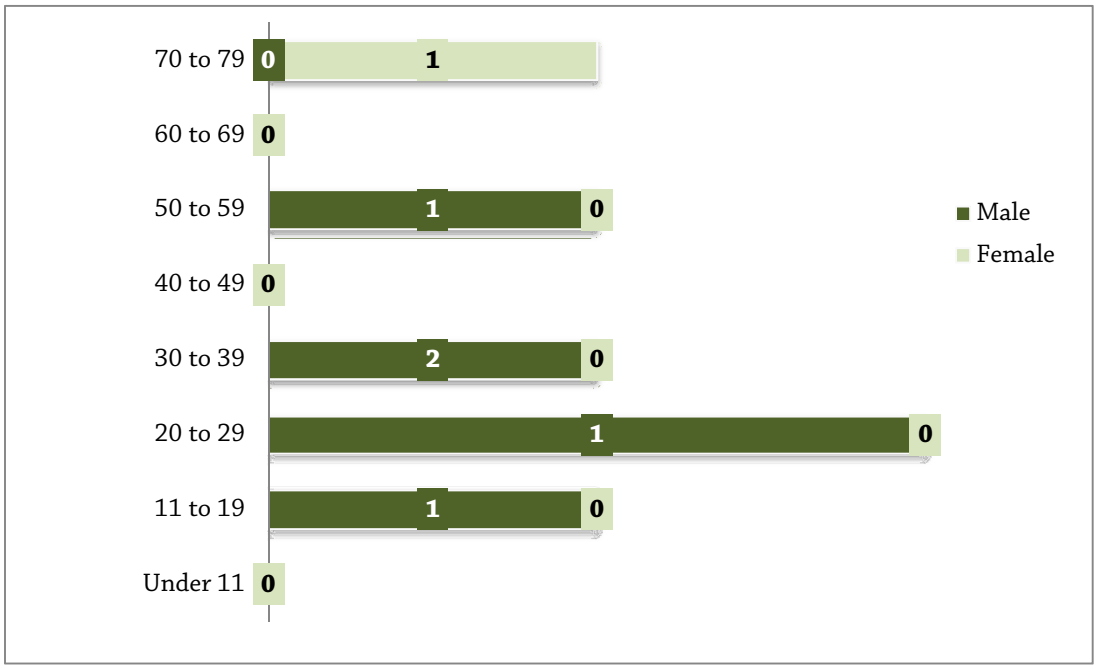
HOMICIDES BY SEX

Sex	Number of Homicides	% of Homicides
Male	5	83%
Female	1	17%
Total	6	100%

HOMICIDES BY AGE GROUP

Age	Number of Homicides	% of Homicides
Under 11	0	0%
11 to 19	1	17%
20 to 29	1	17%
30 to 39	2	33%
40 to 49	0	0%
50 to 59	1	17%
60 to 69	0	0%
70 to 79	1	17%

HOMICIDES BY AGE GROUP & SEX



2019 UNDETERMINED DEATHS

The MCSO Coroner Division investigated **3** undetermined deaths in 2019. Although a cause of death may be ascertained, there are times when the manner of death remains undetermined. A death is certified as undetermined when available information regarding the circumstances of death is insufficient to classify the death into one of the specific manners of natural, accident, suicide or homicide death. Sometimes information concerning the circumstances of death may be inadequate due to a lack of witnesses, a lack of background information, or because of a lengthy delay between the death and the discovery of the body. In other instances, the state of decomposition may hinder a determination of cause of death, and subsequently, a determination of manner is not possible. If an extensive investigation and autopsy cannot clarify the circumstances, the death is classified as undetermined.

In deaths related to prescription and/or illicit drug toxicity, intentional overdose versus accidental overutilization cannot be definitively determined, therefore the manner of death is certified as undetermined. In cases of severe post mortem decomposition, a cause of death may not be identified, which also leads to an undetermined manner. In other instances, a cause of death may be identified, such as, a traumatic injury, but the mechanism of trauma may require the manner to remain undetermined. An example of this would be a person found in an open environment with traumatic injuries of which the mechanism of injury was unwitnessed.

UNDETERMINED DEATHS BY CAUSE OF DEATH

Cause	Number of Undetermined Deaths	% of Undetermined Deaths
Skeletal Remains	2	67%
Intracerebral Hematoma	1	33%

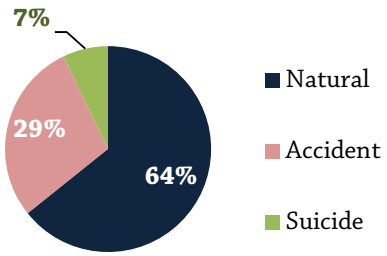
2019 IN-CUSTODY DEATHS

The Coroner Division investigates all in custody deaths which occur at San Quentin State Penitentiary. They investigated **14** San Quentin State Prison Deaths in 2019. All deaths occurring at the Marin County Jail are investigated by the Sonoma County Sheriff-Coroner's Office to avoid the potential for bias. When requested, the Marin County Sheriff Coroner Division will investigate in custody deaths for the Sonoma County Sheriff's Office.

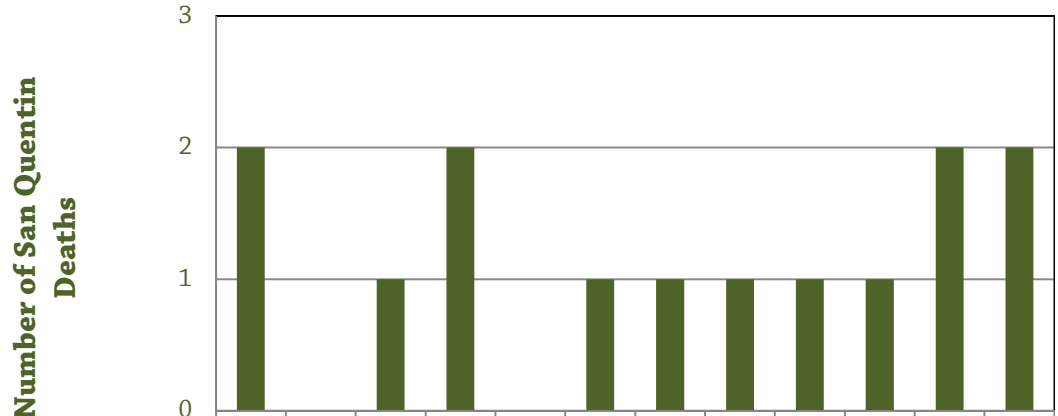
SAN QUENTIN IN-CUSTODY DEATHS BY MANNER

Manner	Number of San Quentin Deaths	% San Quentin Deaths
Natural	9	64%
Accident	4	29%
Suicide	1	7%

PIE CHART - SAN QUENTIN IN-CUSTODY DEATHS BY MANNER



SAN QUENTIN IN-CUSTODY DEATHS BY MONTH



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Number of San Quentin Deaths	2	0	1	2	0	1	1	1	1	1	2	2

* The MCSO Coroner Division Investigated **4** Sonoma County Sheriff's Department In-Custody Deaths in 2019.

2019 INDIGENT DISPOSITION PROGRAM STATISTICS

The MCSO Coroner Division managed **15** indigent cases in 2019. The Coroner Division manages Marin County's Indigent Disposition Program, which is available and offered to all Marin residents who have died and are deemed qualified for the program. The qualification process is based on financial needs, the presence of living relatives, or the abandonment by relatives. For health and safety purposes, the Coroner Division intervenes in the disposition process.

For more information, contact the Coroner Division of the Marin County Sheriff's Office.

INDIGENT CASES BY OUTCOME

Outcome of Inquiries	
Family Proceeded with Arrangements	0
Public Administrator Accepted Case	0
Sonoma County Coroner Division Accepted Case	1
Marin County Coroner Division Accepted Case	15