Marin County Sheriff's Office

Coroner Division

Annual Report

2023

Jamie Scardina

Sheriff– Coroner

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Statistics compiled and report written by A. Torres

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 and one Forensic Pathologist.

It is the mission of the Coroner's Division to provide legally mandated, competent, and appropriate 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 2021, Marin County was estimated to have a population of 260,206. There were **2,212** deaths recorded in Marin County in 2023. Of these **914** 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, **353** were determined to be full Coroner investigation cases (or indigent cremations) 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 2023.

MARIN COUNTY SHERIFF-CORONER STAFF 2022

Sheriff Jamie Scardina..Sheriff-Coroner

Undersheriff Sylvia Moir.......................................Undersheriff

Captain Scott Harrington......................................Captain

Roger Fielding......................................Chief Deputy Coroner

Alexandra Torres...................................Coroner Investigator

Emily Mandel...Coroner Investigator

Brycen Carter...Coroner Investigator

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

Jessica Cantwell....................................Forensic Technician

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

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/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. 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 a 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.

REPORTABLE CRITERIA

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 20-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 an accident or injury, EITHER OLD OR RECENT. This would include any accident which resulted in death including: traffic, a fall at home, 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 decline jurisdiction and defer the case to the attending physician for his/her 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.

2023 GENERAL STATISTICS

Total Number of deaths in Marin County: **2,212**

Number of Deaths Reviewed/Investigated: **914 (includes full cases)**

Number of cases resulting in full death investigation: **353**

Number of cases by manner of death:

Natural: **123***

*Coroner Cases with Natural Causes Provided by Primary Care Doctors: **29**

Accident: **148**

Suicide: **39**

Homicide: **6**

Undetermined: **8**

Forensic Examinations:

Autopsy (*includes limited autopsies): **68**

External Examination: **187**

Medical File Review: **69**

Total Amount of Toxicological Tests Run: **184**

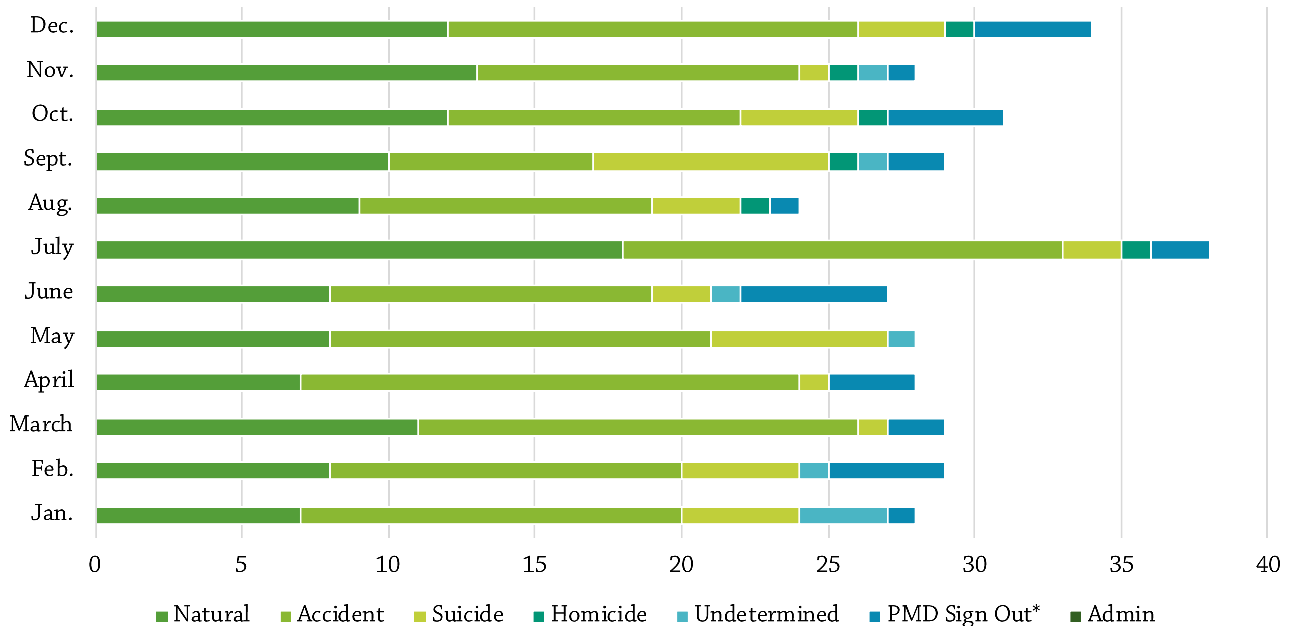
2023 Manners of Death

2023 MANNERS OF DEATH BY MONTH

	Natural	Accident	Suicide	Homicide	Undeter-mined	PMD Sign Out*	Admin	Total
Jan.	7	13	4	0	3	1	0	**28**
Feb.	8	12	4	0	1	4	0	**29**
March	11	15	1	0	0	2	0	**29**
April	7	17	1	0	0	3	0	**28**
May	8	13	6	0	1	0	0	**28**
June	8	11	2	0	1	5	0	**27**
July	18	15	2	1	0	2	0	**38**
Aug.	9	10	3	1	0	1	0	**24**
Sept.	10	7	8	1	1	2	0	**29**
Oct.	12	10	4	1	0	4	0	**31**
Nov.	13	11	1	1	1	1	0	**28**
Dec.	12	14	3	1	0	4	0	**34**
Total	**123**	**148**	**39**	**6**	**8**	**29**	**0**	**353**

*A PMD Sign Out is a case in which either a Coroner Investigator responded to the scene; however, ultimately the decedent's Primary Medical Doctor (PMD) provided a final cause of death rather than the Coroner Division or cases taken for Indigent cremations.

**Note: 1 Administrative case was taken as subject was pronounced deceased in Marin; however, the San Francisco Police Department requested the San Francisco Medical Examiner assume jurisdiction as the original incident occurred in San Francisco



HISTORICAL STATISTICS 2019-2022

CORONER CASE STATISTICS FOR 2019 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

CORONER CASE STATISTICS FOR 2020 BY MONTH

	Natural*	Accident	Suicide	Homicide	Undetermined	Pending	Total
Jan.	19	9	3	1	0	0	32
Feb.	14	12	4	0	0	0	30
March	11	7	8	0	1	0	27
April	15	11	2	0	0	0	28
May	15	8	2	0	0	0	25
June	19	11	5	0	0	0	35
July	16	9	4	1	2	0	32
Aug.	17	12	2	1	1	0	33
Sept.	7	15	5	1	1	0	29
Oct.	25	16	3	0	0	0	44
Nov.	16	14	7	0	1	0	38
Dec.	25	11	4	0	0	0	40
Total	199	135	49	4	6	0	393

*Natural cases included Death Certificates signed by the Primary Care Physician (10 total)

CORONER CASE STATISTICS FOR 2021 BY MONTH

	Natural	Accident	Suicide	Homicide	Undeter-mined	PMD Sign Out*	Total
Jan.	14	20	6	0	1	3	**44**
Feb.	11	10	6	0	2	0	**29**
March	14	12	1	1	0	3	**31**
April	10	20	6	0	2	6	**44**
May	13	15	6	3	1	8	**46**
June	13	6	1	0	1	7	**28**
July	11	5	5	3	1	8	**33**
Aug.	16	8	2	1	1	4	**32**
Sept.	9	9	5	1	0	5	**29**
Oct.	14	10	7	0	1	1	**33**
Nov.	16	5	3	0	1	5	**30**
Dec.	9	10	3	0	1	11	**34**
Total	**150**	**130**	**51**	**9**	**12**	**61**	**413****

*A PMD Sign Out is a case in which either a Coroner Investigator responded to the scene; however, ultimately the decedent's Primary Medical Doctor (PMD) provided a final cause of death rather than the Coroner Division or cases taken for Indigent cremations.

**Note: Total of 413 does not include cases taken for administrative purposes

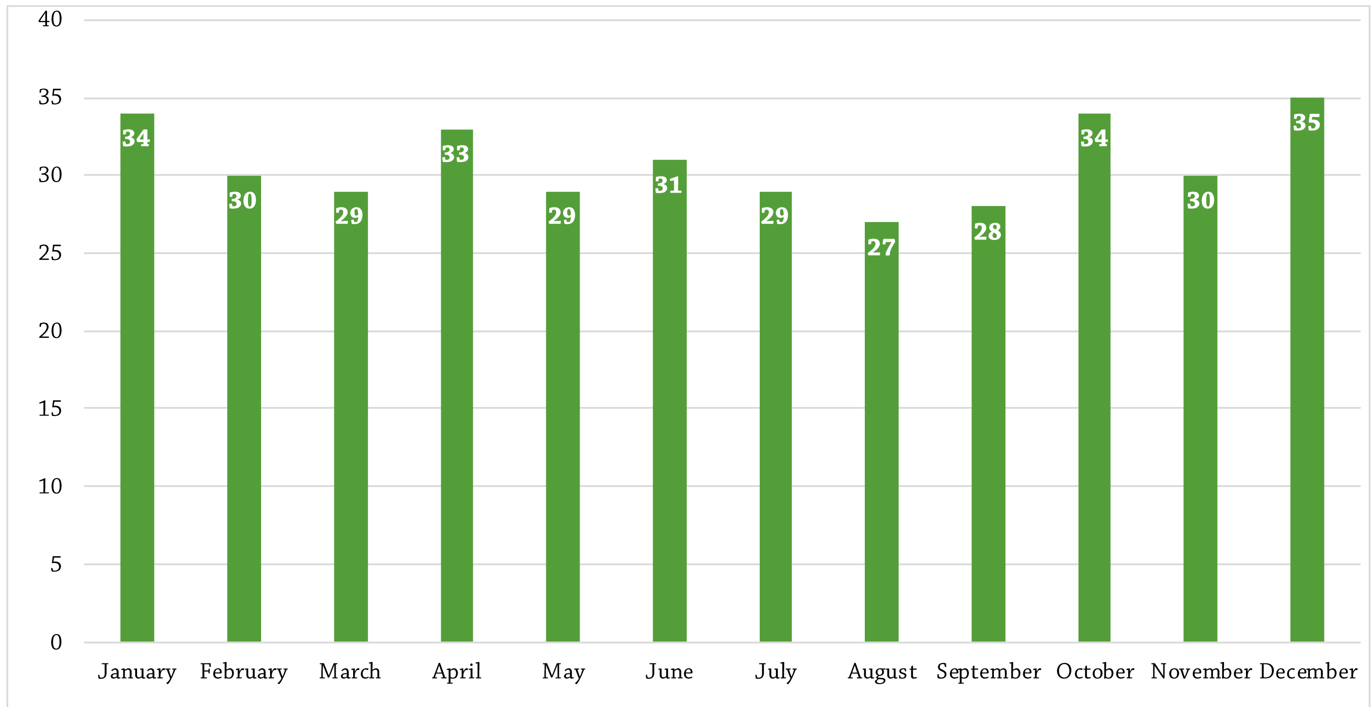
CORONER CASE STATISTICS FOR 2022 BY MONTH

	Natural	**Accident**	**Suicide**	**Homicide**	**Undeter-mined**	**PMD Sign Out***	**Admin**	**Total**
Jan.	15	10	11	0	1	2	0	**39**
Feb.	10	15	4	0	0	2	0	**31**
March	12	10	3	1	1	3	0	**30**
April	14	9	7	0	0	0	0	**30**
May	9	18	3	0	0	2	0	**32**
June	14	8	11	2	0	4	1	**40**
July	8	9	3	2	1	3	0	**26**
Aug.	11	4	4	0	2	2	0	**23**
Sept.	12	11	4	2	0	1	0	**30**
Oct.	13	12	4	0	0	2	0	**31**
Nov.	11	11	2	0	0	4	0	**28**
Dec.	17	10	4	1	1	5	0	**38**
Total	**145**	**127**	**60**	**8**	**6**	**30**	**1**	**377**

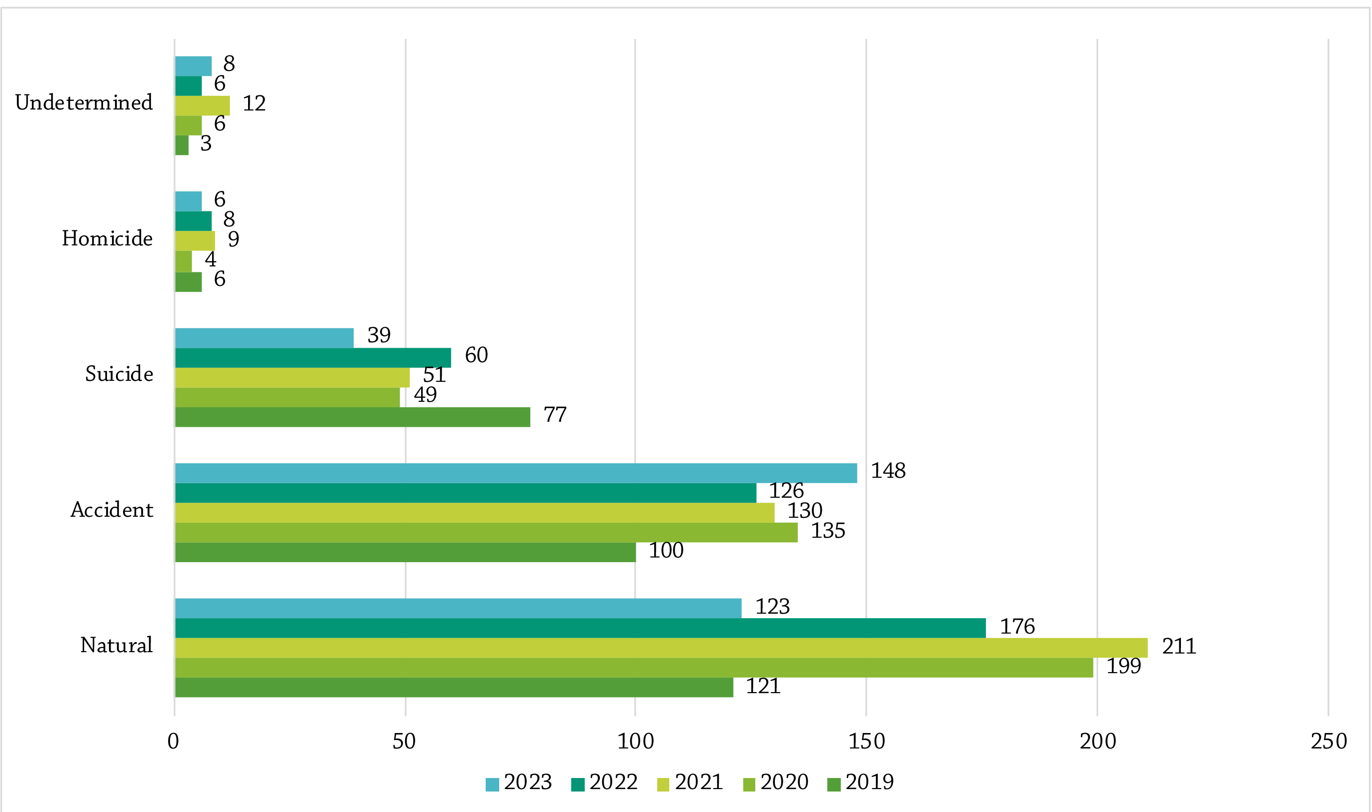
*A PMD Sign Out is a case in which either a Coroner Investigator responded to the scene; however, ultimately the decedent's Primary Medical Doctor (PMD) provided a final cause of death rather than the Coroner Division or cases taken for Indigent cremations.

**Note: 1 Administrative case was taken as subject was pronounced deceased in Marin; however, the San Francisco Police Department requested the San Francisco Medical Examiner assume jurisdiction as the original incident occurred in San Francisco

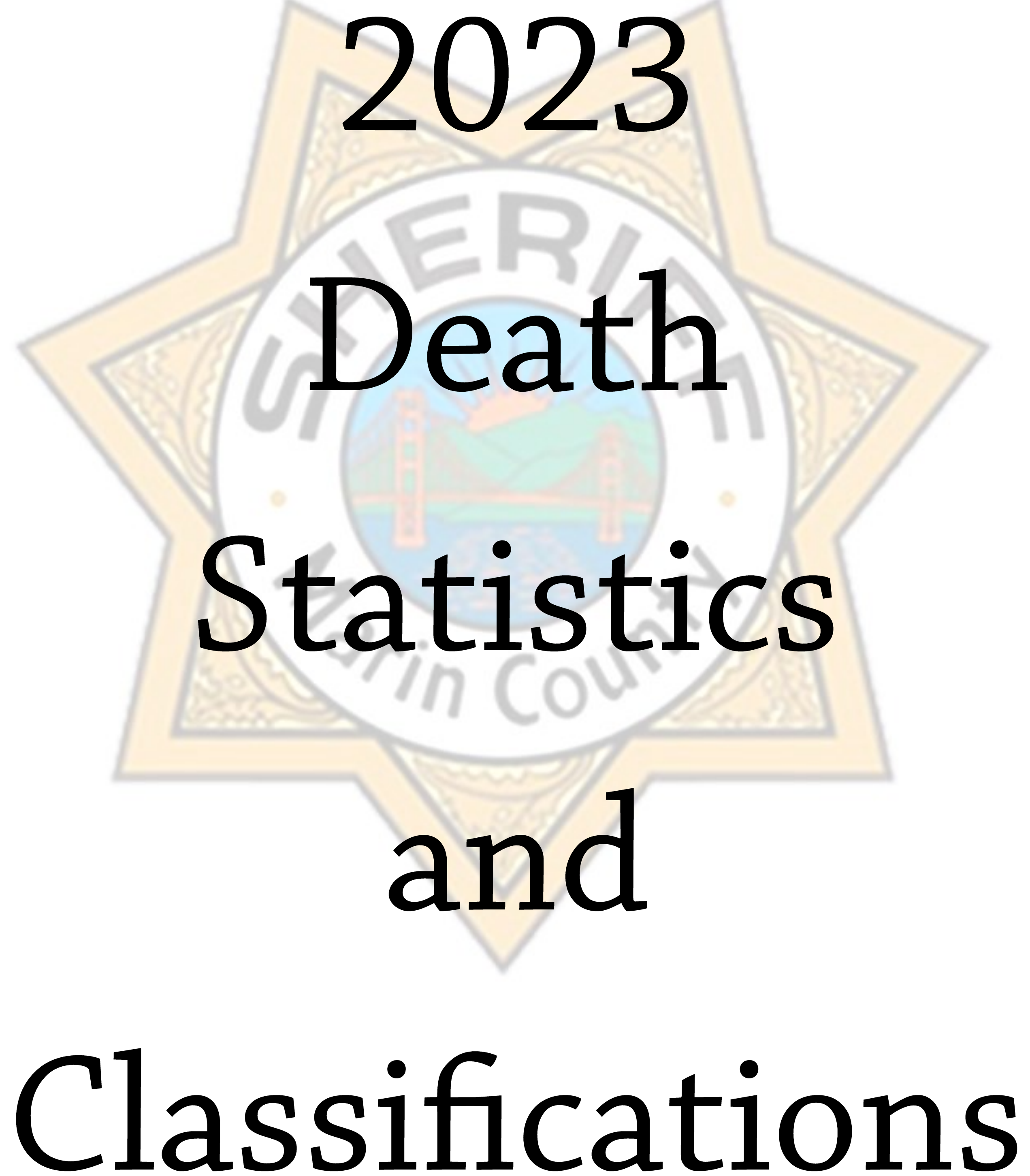
5 YEAR STUDY – AVERAGE NUMBER OF CASES BY MONTH (2019-2023)



5 YEAR STUDY –CAUSES BY MANNER (2019-2023)



*2021 & 2022 Natural death statistics include PMD Sign Outs (2021 = 57 total; 2022 =30 total)



2023 Death Statistics and Classifications

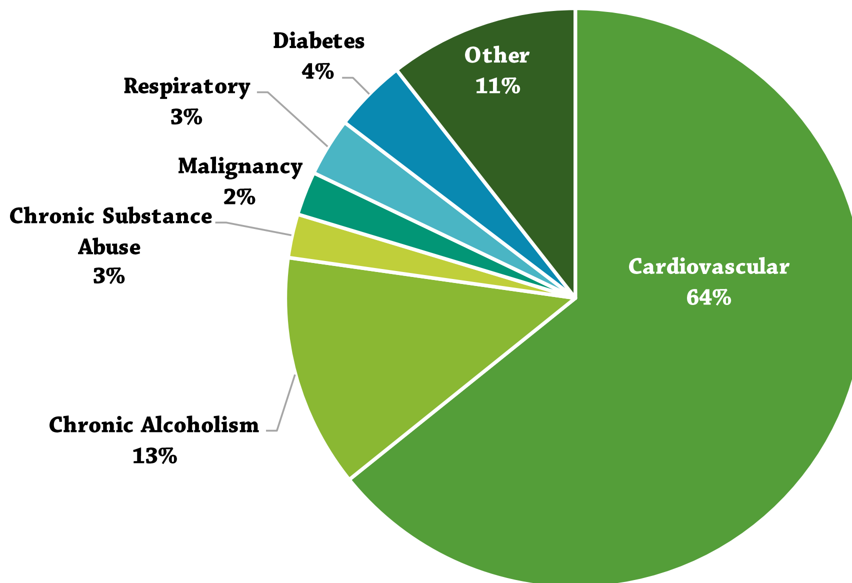
2023 NATURAL DEATHS

The MCSO Coroner Division investigated and certified **123** natural deaths in 2023. 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.

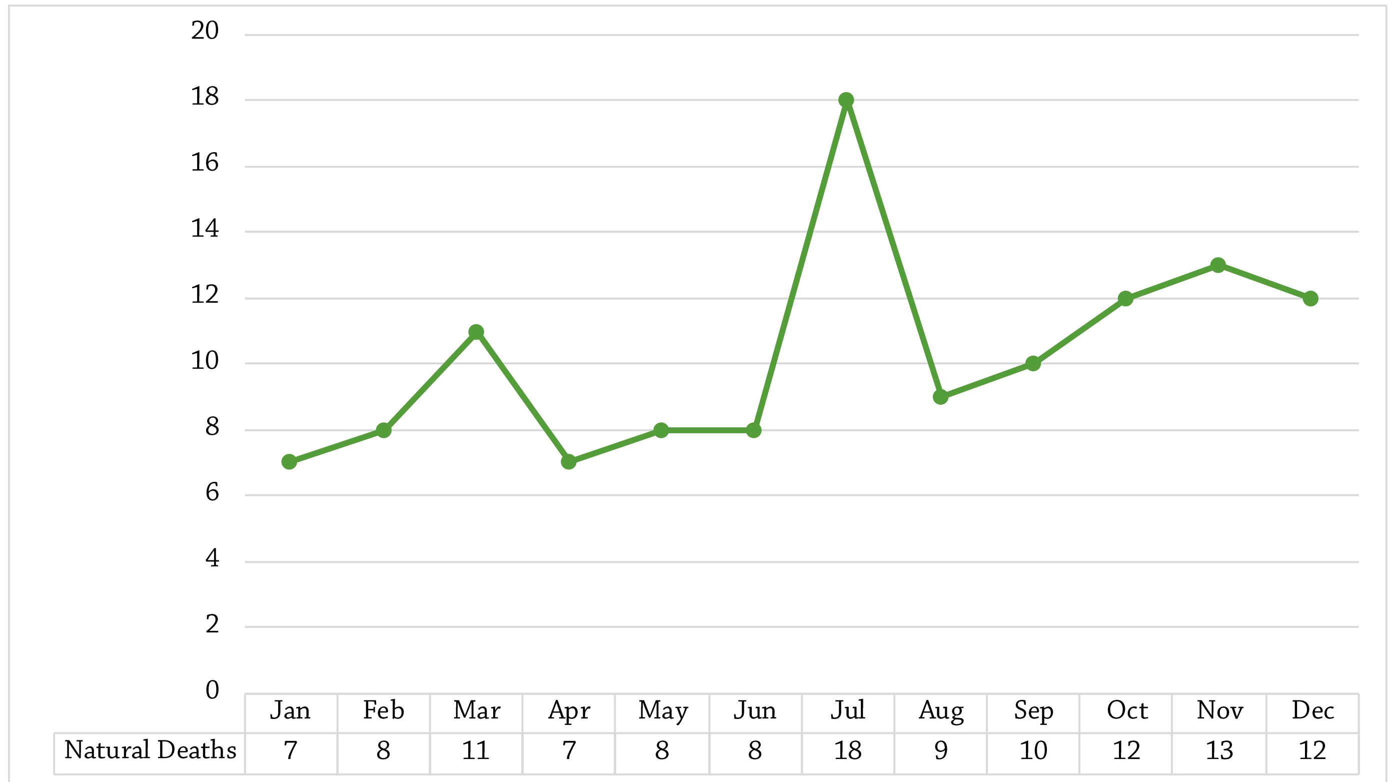
NATURAL DEATHS BY CAUSE OF DEATH

Types of Natural Deaths	
Cardiovascular	79
Chronic Alcoholism	16
Chronic Substance Abuse	3
Malignancy	3
Respiratory	4
Diabetes Related	5
Other	13

PIE CHART – NATURAL DEATHS BY CAUSE OF DEATH

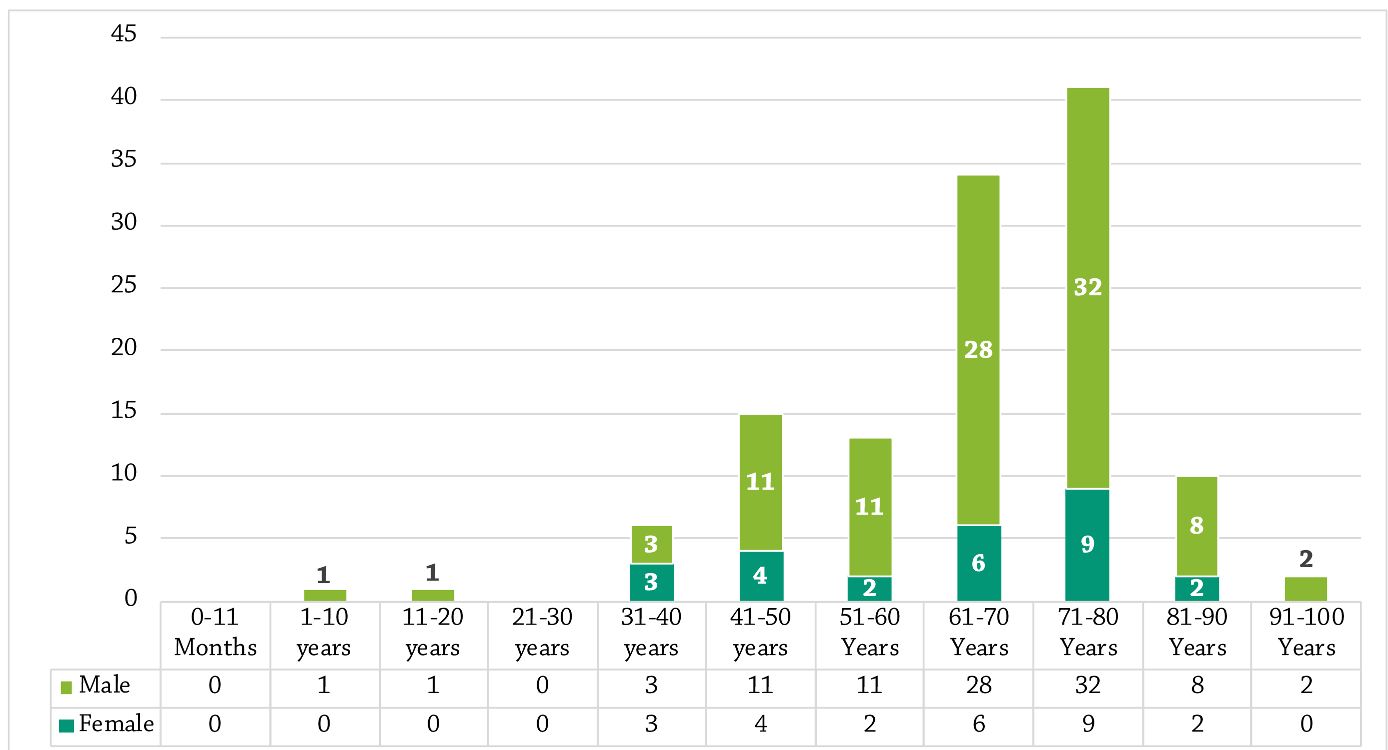


NATURAL DEATHS BY MONTH



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Natural Deaths	7	8	11	7	8	8	18	9	10	12	13	12

NATURAL DEATHS BY AGE GROUP & SEX



	0-11 Months	1-10 years	11-20 years	21-30 years	31-40 years	41-50 years	51-60 Years	61-70 Years	71-80 Years	81-90 Years	91-100 Years
Male	0	1	1	0	3	11	11	28	32	8	2
Female	0	0	0	0	3	4	2	6	9	2	0

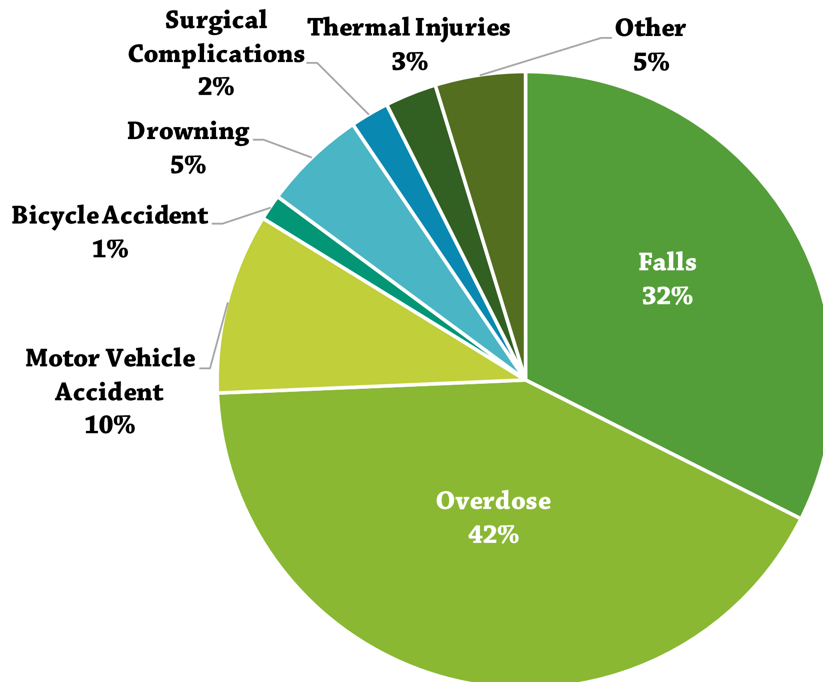
2023 ACCIDENTAL DEATHS

The MCSO Coroner Division investigated **148** accidental deaths in 2023. Deaths are classified as accidental when an unfortunate incident happens unexpectedly and unintentionally, which results in the death of an individual. 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.

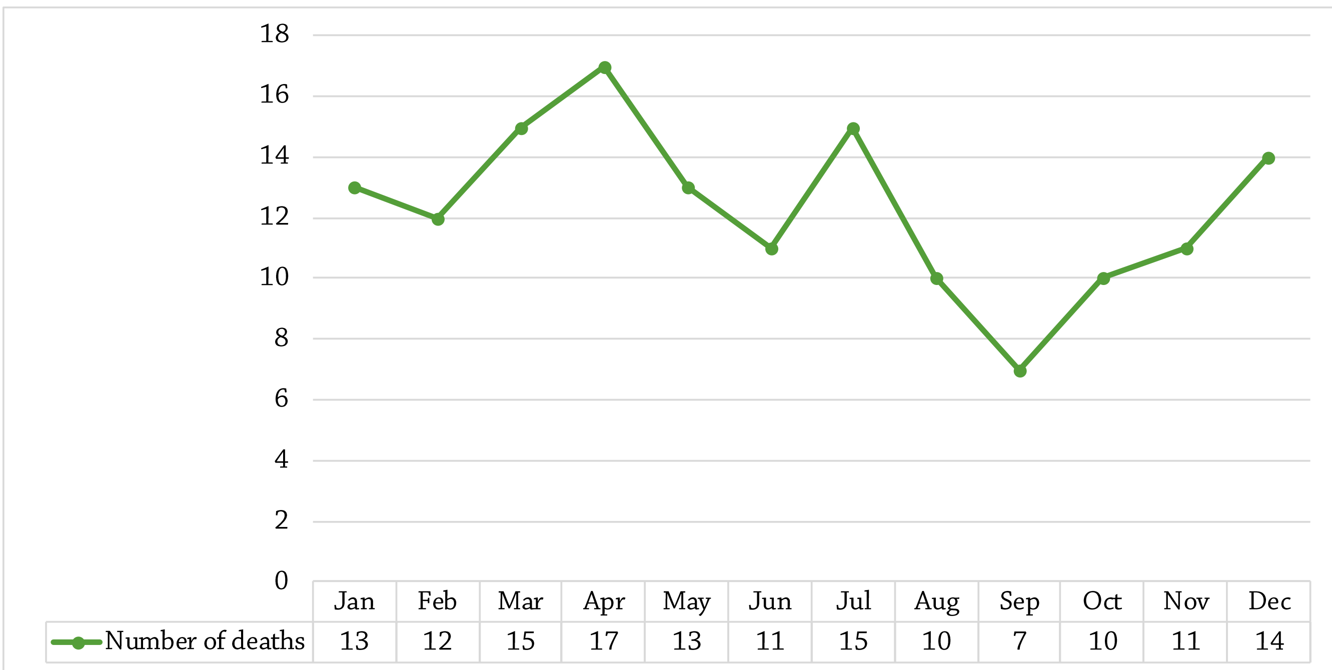
ACCIDENTAL DEATHS BY CAUSE OF DEATH

Cause	Number
Falls	48
Overdose	62
Motor Vehicle Collision	14
Bicycle Accident	2
Drowning	8
Surgical Complications	3
Thermal Injuries	4
Other	7

PIE CHART – ACCIDENTAL DEATHS BY CAUSE OF DEATH

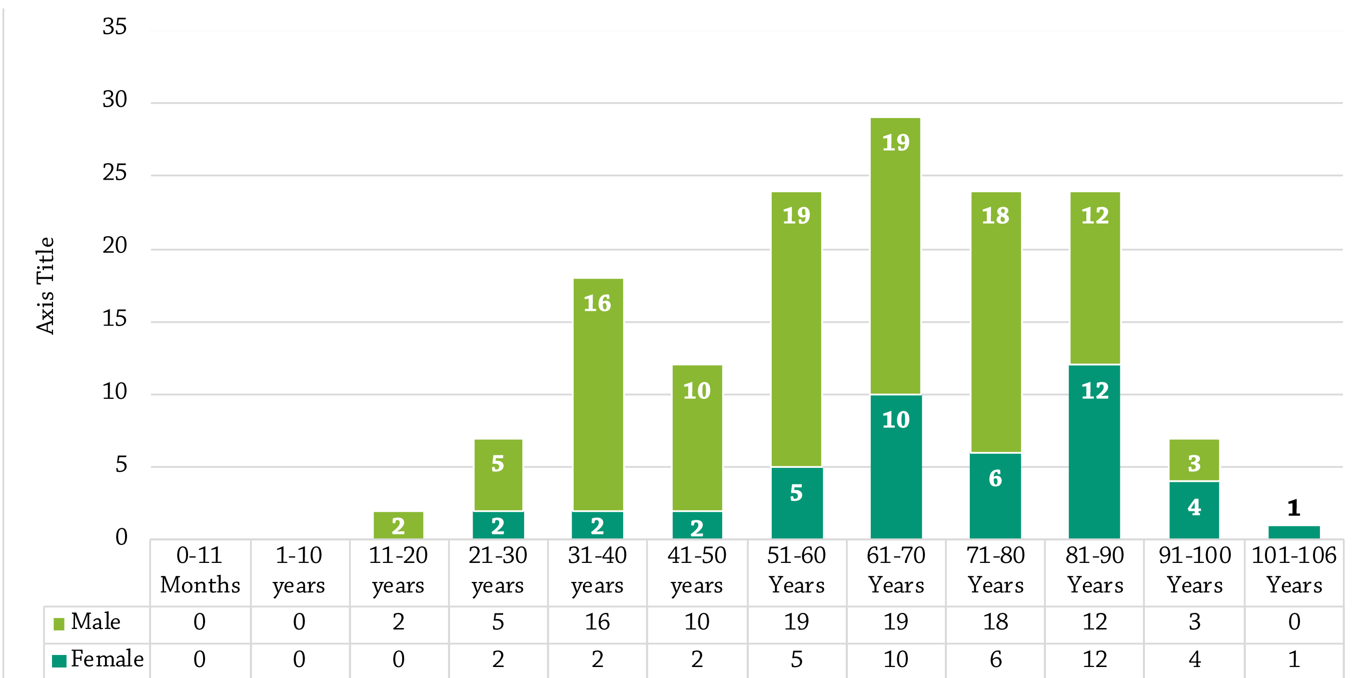


ACCIDENTAL DEATHS BY MONTH



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Number of deaths	13	12	15	17	13	11	15	10	7	10	11	14

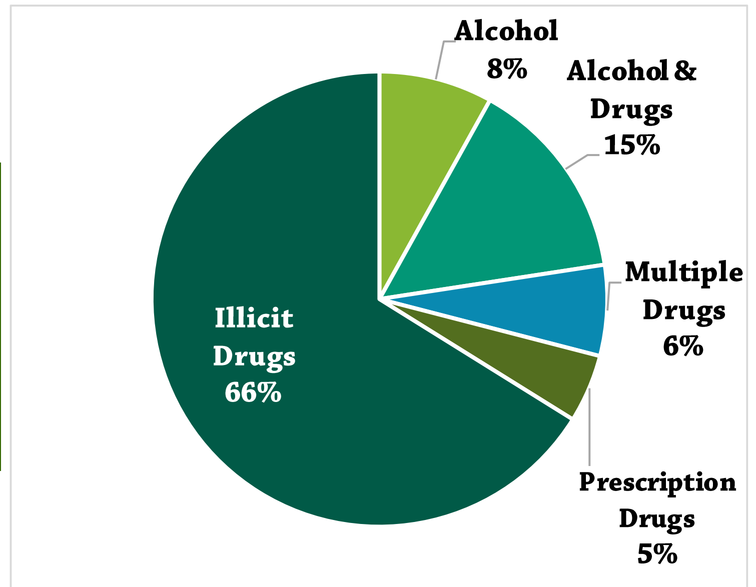
ACCIDENTAL DEATHS BY AGE GROUP & SEX



	0-11 Months	1-10 years	11-20 years	21-30 years	31-40 years	41-50 years	51-60 Years	61-70 Years	71-80 Years	81-90 Years	91-100 Years	101-106 Years
Male	0	0	2	5	16	10	19	19	18	12	3	0
Female	0	0	0	2	2	2	5	10	6	12	4	1

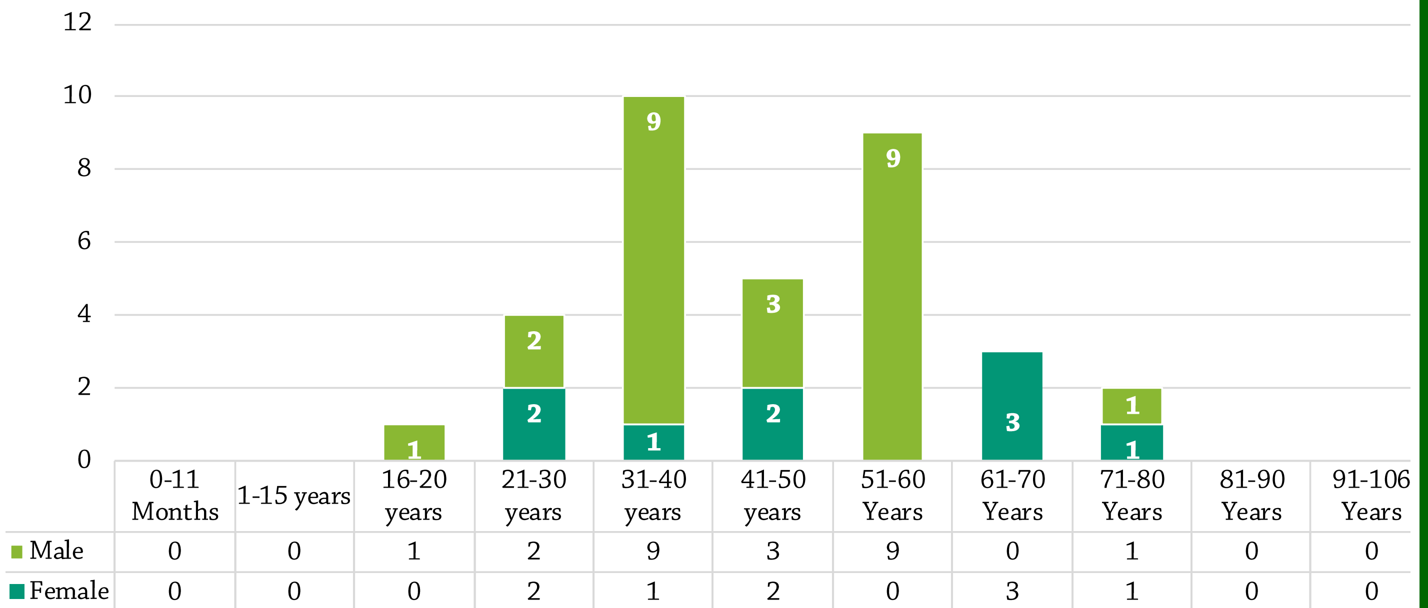
ACCIDENTAL DEATHS BY CAUSE OF DEATH – INTOXICATION

Type of intoxication	Number
Alcohol	5
Alcohol & Drugs combined	9
Multiple Drugs (Illicit and Prescription)	4
Prescription Drugs	3
Illicit	41



FENTANYL RELATED DEATHS

In 2023, a total of **34** deaths were recorded where fentanyl was noted in the subject's toxicology results. All 34 deaths were deemed to be accidental.

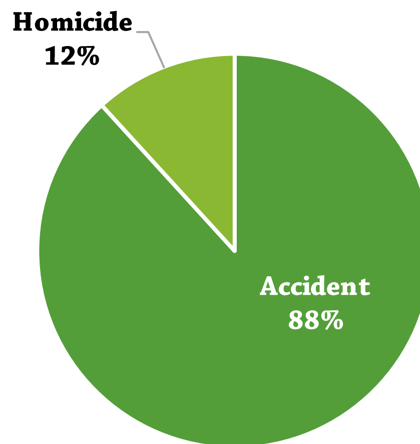


	0-11 Months	1-15 years	16-20 years	21-30 years	31-40 years	41-50 years	51-60 Years	61-70 Years	71-80 Years	81-90 Years	91-106 Years
Male	0	0	1	2	9	3	9	0	1	0	0
Female	0	0	0	2	1	2	0	3	1	0	0

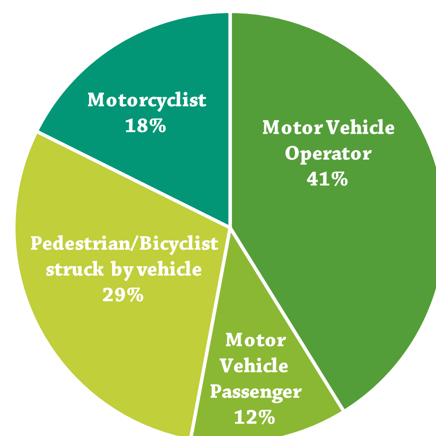
2023 MOTOR VEHICLE FATALITIES

The MCSO Coroner Division investigated **17** Motor Vehicle Fatalities in 2023. These death investigations were conducted along with the local law enforcement agency 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 collision. A traffic fatality may also be ruled as a suicide, an accident or even a homicide. Included in this data are cases in which the motor vehicle collision happened several years prior, and the decedent's passing occurred due to life-long injuries sustained at the time of the collision.

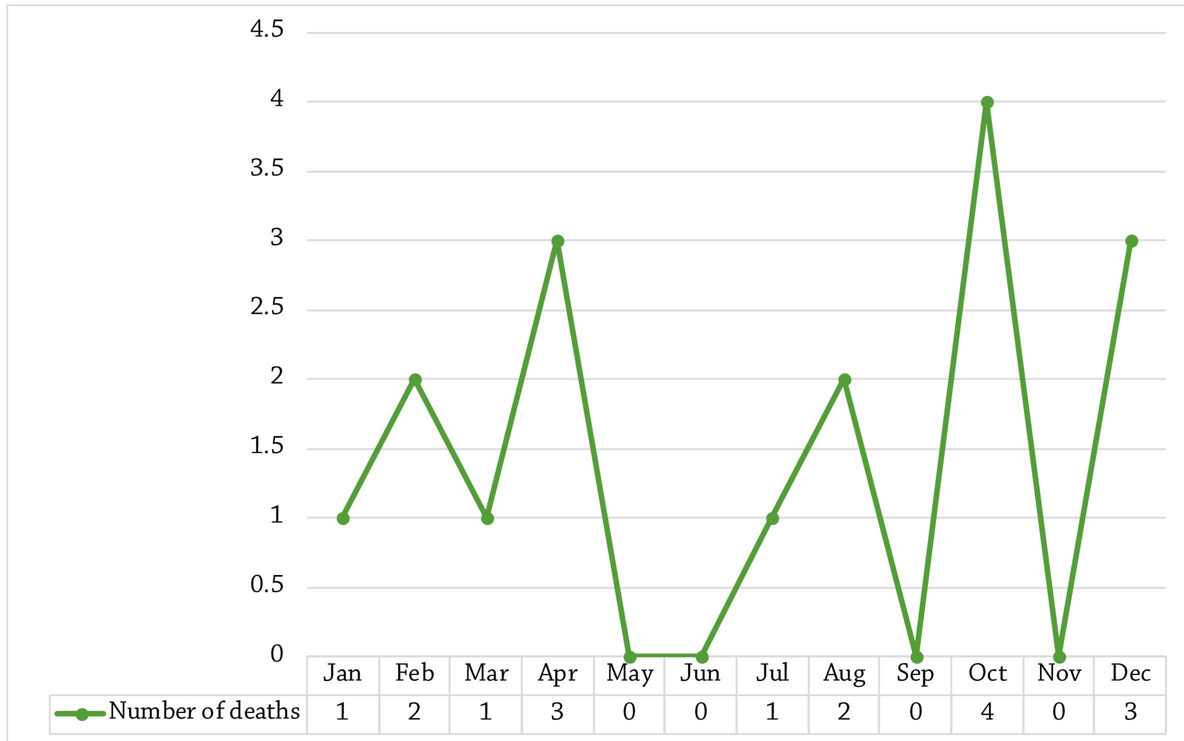
MOTOR VEHICLE FATALITIES BY MANNER OF DEATH	
Accident	15
Homicide	2



MOTOR VEHICLE FATALITIES BY DECEDENT CLASSIFICATION	
Motor Vehicle Operator	7
Motor Vehicle Passenger	2
Pedestrian/Bicyclist struck	5
Motorcyclist	3

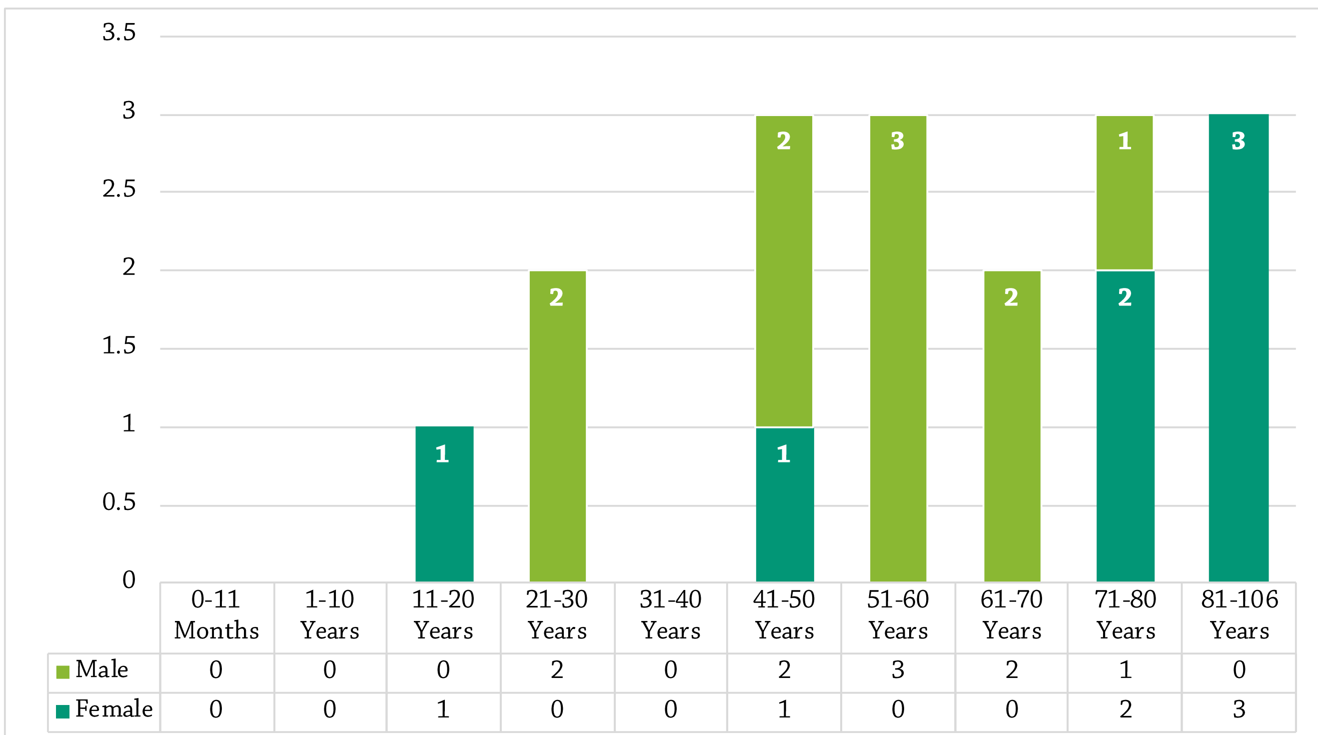


MOTOR VEHICLE FATALITIES BY MONTH



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Number of deaths	1	2	1	3	0	0	1	2	0	4	0	3

MOTOR VEHICLE FATALITIES BY AGE GROUP & SEX



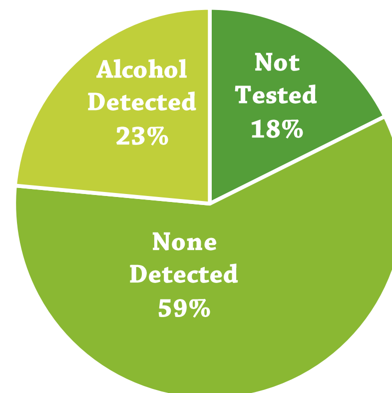
	0-11 Months	1-10 Years	11-20 Years	21-30 Years	31-40 Years	41-50 Years	51-60 Years	61-70 Years	71-80 Years	81-106 Years
Male	0	0	0	2	0	2	3	2	1	0
Female	0	0	1	0	0	1	0	0	2	3

2023 MOTOR VEHICLE FATALITIES INVOLVING ALCOHOL AND/OR DRUGS

The MCSO Coroner Division investigated **17** motor vehicle fatalities in 2023. 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.

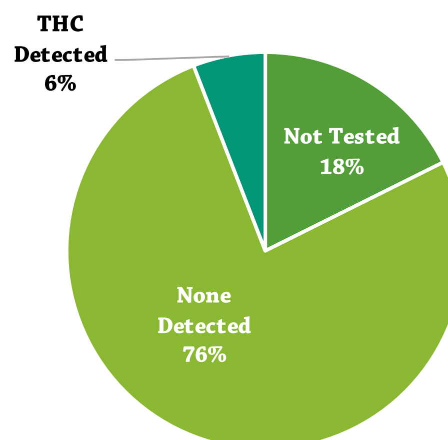
TOXICOLOGY RESULTS RELATING TO ALCOHOL

Toxicology Results Relating to Alcohol	
Not Tested	3
None Detected	10
Alcohol Detected	4



TOXICOLOGY RESULTS RELATING TO ILLICIT DRUGS

Toxicology Results Relating to Illicit Drugs	
Not Tested	3
None Detected	13
Illicit Drugs Only Detected	0
THC Detected	1



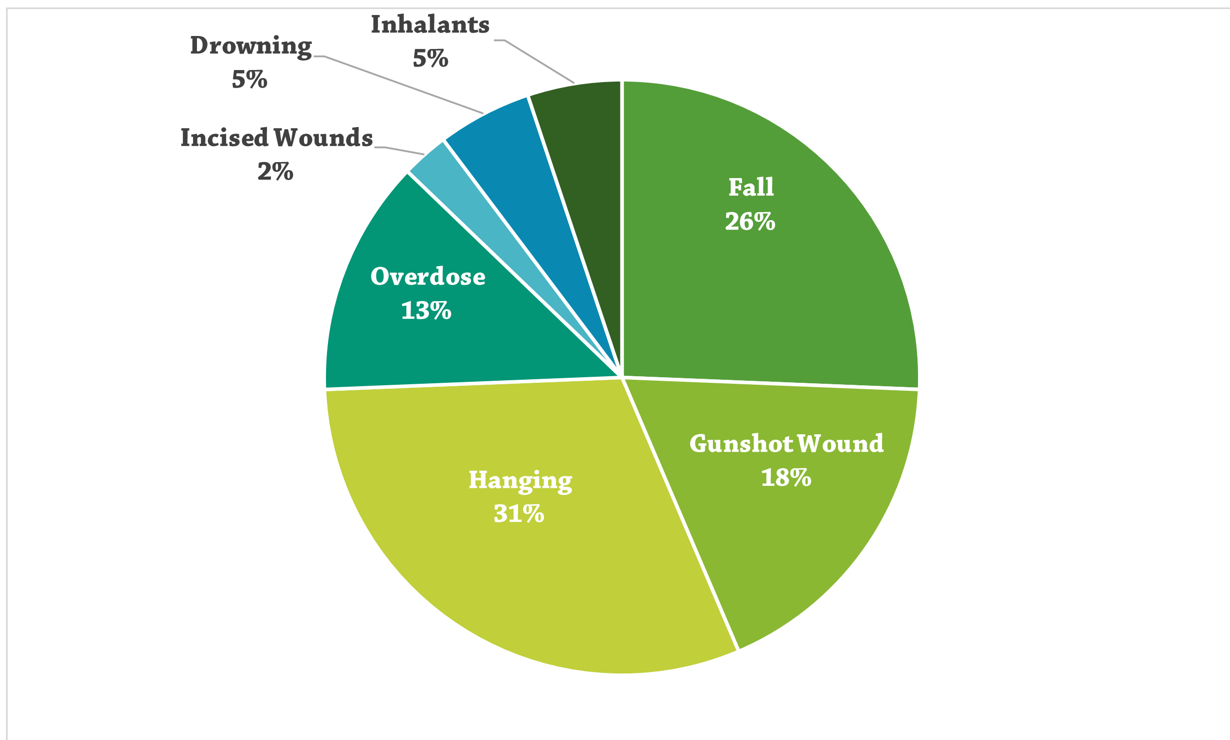
2023 SUICIDE DEATHS

The MCSO Coroner Division investigated **39** suicides in 2023. Suicide deaths are those caused by self-inflicted injuries with evidence of intent to end one's own life. Evidence of intent includes an explicit expression, such as a suicide note or verbal threat, or an act constituting purposeful intention.

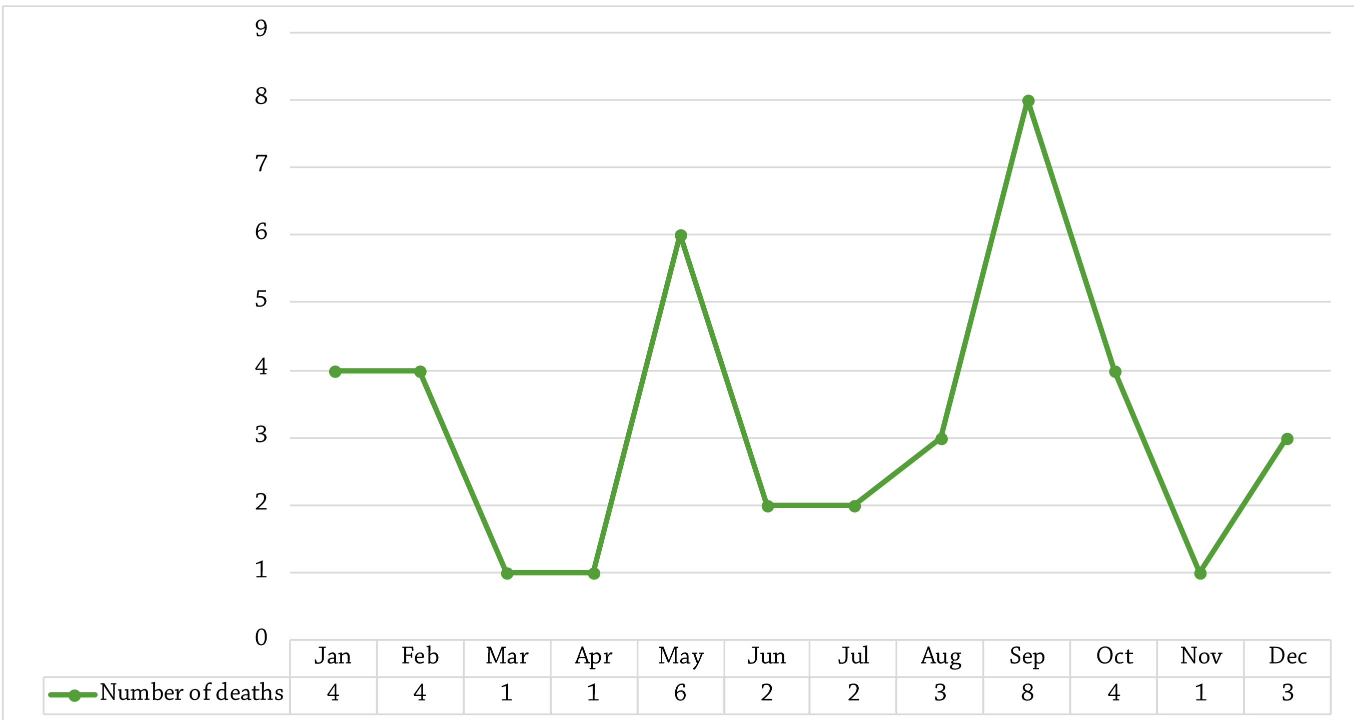
SUICIDES BY MECHANISM OF DEATH

Cause	Number
Fall	10
Gunshot Wound	7
Hanging	12
Overdose	5
Incised Wounds	1
Drowning	2
Inhalants	2

SUICIDES BY MECHANISM OF DEATH

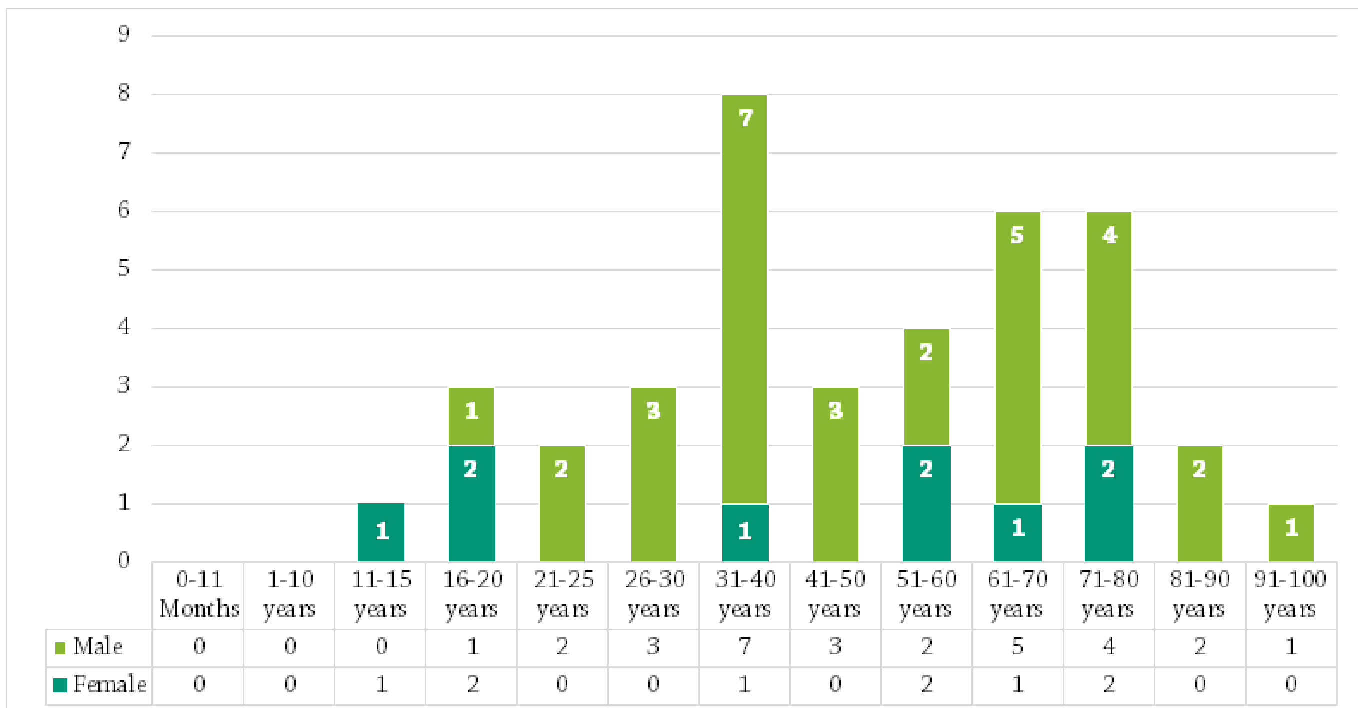


SUICIDES BY MONTH



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Number of deaths	4	4	1	1	6	2	2	3	8	4	1	3

SUICIDES BY AGE AND SEX



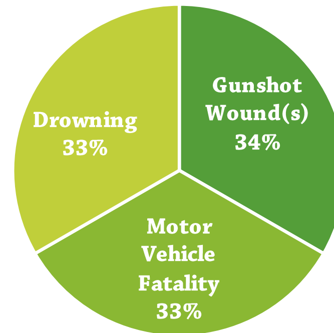
	0-11 Months	1-10 years	11-15 years	16-20 years	21-25 years	26-30 years	31-40 years	41-50 years	51-60 years	61-70 years	71-80 years	81-90 years	91-100 years
Male	0	0	0	1	2	3	7	3	2	5	4	2	1
Female	0	0	1	2	0	0	1	0	2	1	2	0	0

2023 HOMICIDE DEATHS

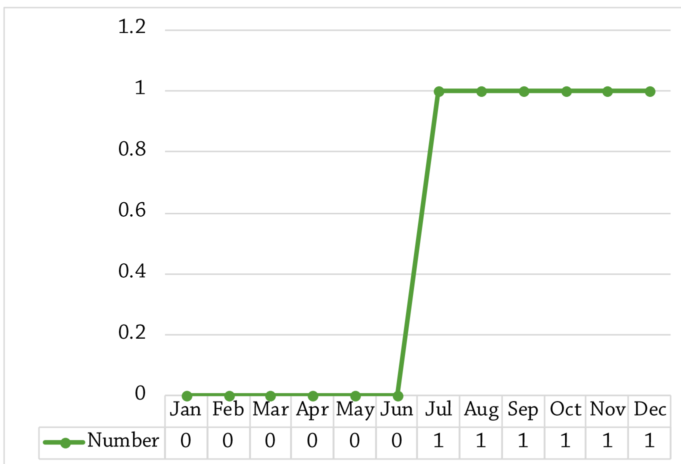
The MCSO Coroner Division investigated **6** homicides in 2023. A death is considered a homicide when it is caused by the intentional harm (explicit or implicit) of one person by another. These include acts of grossly reckless behavior. In this context the word "homicide" does not necessarily imply the existence of criminal intent behind the act.

HOMICIDES BY CAUSE OF DEATH

Cause	Number
Gunshot Wound (s)	2
Motor Vehicle Fatality	2
Drowning	2



HOMICIDES BY MONTH



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Number	0	0	0	0	0	0	1	1	1	1	1	1

HOMICIDES BY AGE AND SEX

Age	Male	Female	Total
0-11 mons	0	0	0
1-10 years	0	1	1
11-20 years	0	1	1
21-30 years	1	0	1
31-40 years	1	0	1
41-50 years	2	0	2
51-60 Years	0	0	0
61-70 Years	0	0	0
71-80 Years	0	0	0
81-90 Years	0	0	0
91-100 Years	0	0	0

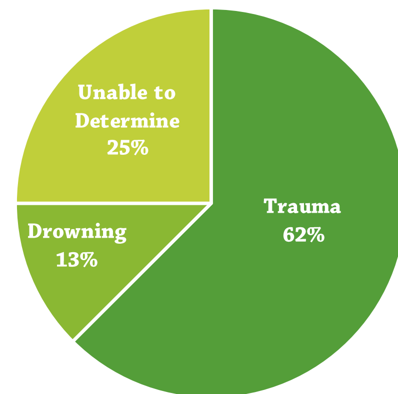
2023 UNDETERMINED DEATHS

The MCSO Coroner Division investigated **8** undetermined deaths in 2023. 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
Trauma	5
Drowning	1
Unable to Determine	2

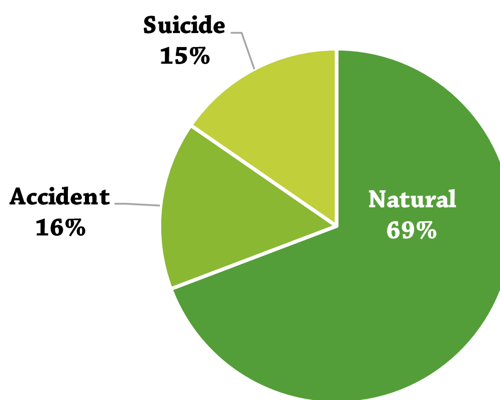


2023 IN-CUSTODY DEATHS

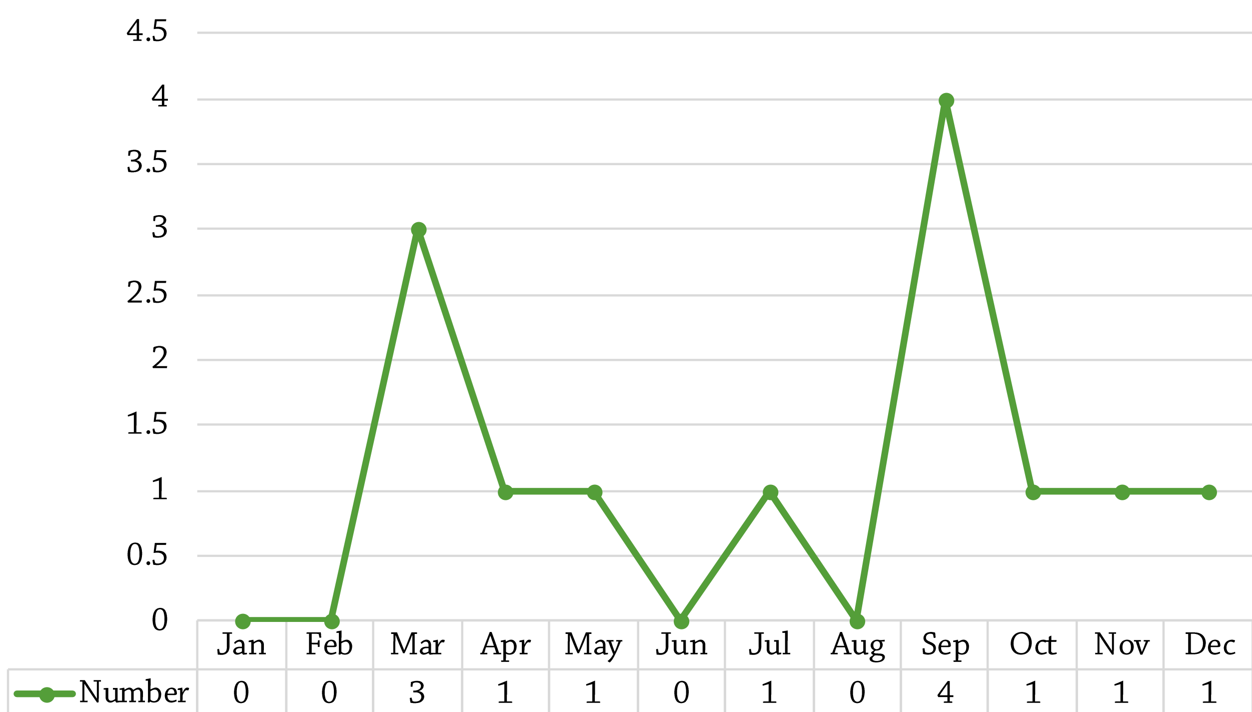
The Coroner Division investigates all in custody deaths which occur at San Quentin State Prison. They investigated **13** San Quentin State Prison Deaths in 2023. All deaths occurring at the Marin County Jail are investigated by the Sonoma County Sheriff-Coroner's Office to avoid the potential for bias and for transparency purposes. When requested, the Marin County Sheriff Coroner Division will investigate in custody deaths for the Sonoma County Sheriff's Office for similar transparency concerns. In 2023, The Coroner Division investigated **1** Sonoma County in-custody case, which was mannered as a suicide. This case is not included in the statistics below.

SAN QUENTIN IN-CUSTODY DEATHS BY MANNER

Manner	Number of San Quentin Deaths
Natural	9
Accident	2
Suicide	2



SAN QUENTIN IN-CUSTODY DEATHS BY MONTH



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Number	0	0	3	1	1	0	1	0	4	1	1	1

2023 COVID-19 DEATHS

Under Government Code 27491, all COVID-19 deaths must be reported to the Coroner Division; however not all of COVID-19 deaths are Coroner Cases. The Coroner Division has been collecting data in regards to COVID-19 deaths reported directly to the Coroner Division with the proviso that the decedent passed away within Marin County jurisdictional lines. Marin County residents who contracted the virus and passed away in another county are not included in these statistics.

The total number of COVID-19 deaths reported to the Coroner Division by Primary Care Physicians or certified by the Coroner Division in 2023 was: **37**.

2023 INDIGENT DISPOSITION PROGRAM

The MCSO Coroner Division managed **27** indigent cases in 2023. 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, please contact the Coroner Division of the Marin County Sheriff's Office.