

# **San Mateo County Coroner 2022 Annual Report**



**Robert J. Foucrault  
Coroner**

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*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.
- 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.



**Coroner staff presented  
to death review teams.**



- 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.



**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 10<sup>th</sup> year working for San Mateo County.
- 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:



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

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



**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.



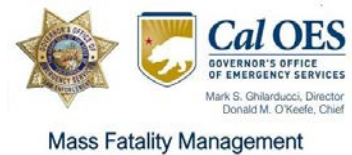


- In November 2022, Supervising Deputy Coroner Elizabeth Ortiz participated in the California Traffic Incident Management (TIM) Summit as a representative of the Coroner and Medical Examiner response to traffic incidents. The purpose of the Summit was to bring together TIM partners and participants to strengthen communication and teamwork, exchange information, generate new ideas, incorporate new technologies, and increase the efficiency of TIM.
- Throughout 2022, the Coroner's Office participated in multiple emergency preparedness and mass fatality/mass disaster training events:

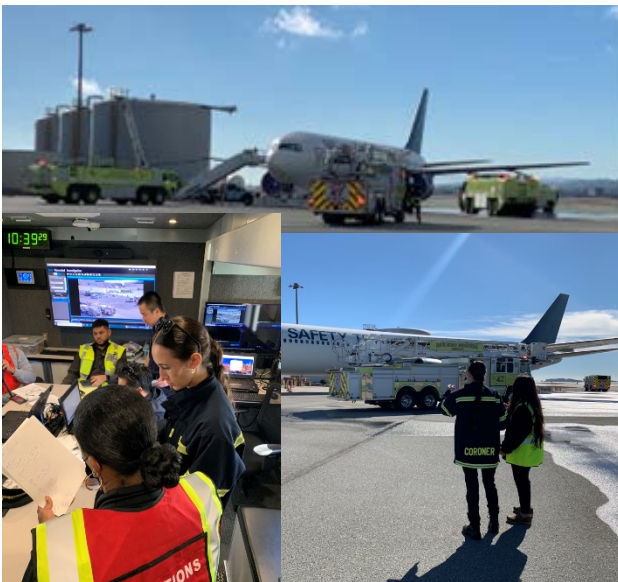


**Supervising Deputy Coroner Ortiz participated in multiple County and partner events.**

- 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.



**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  
Christi Canclini  
K'Lynn Solt  
Luz Paran-Rey  
Cara Behrens

Coroner  
Executive Assistant  
Chief Deputy Coroner  
Senior Accountant  
Office Assistant II

Elizabeth Ortiz

Supervising Deputy Coroner

Alyssa Terwilliger

Coroner Intern (Extra Help) (Jan)

## Investigations

Holly Benedict  
Hastin Stein  
Danielle Montesano  
Alana Stark  
Heather Diaz  
Laura Bailey  
Michelle Schabinger  
Eden Washburn  
Ashley Cahalan

Deputy Coroner  
Deputy Coroner  
Deputy Coroner  
Deputy Coroner  
Deputy Coroner (Jan)  
Deputy Coroner  
Deputy Coroner  
Deputy Coroner  
Deputy Coroner (Extra-Help) (Jun-Dec)

## Pathology

Alina Revilla  
German Diaz  
Kathryn Nogaki  
Nora Moreno  
Nandar Yukyi  
Daniela Landey  
Carolina Mendoza  
Isabella Ratti

Forensic Autopsy Technician (Unpaid Status)  
Forensic Autopsy Technician (Extra Help) (Jan-Jul)  
Forensic Autopsy Technician (Jan-Jun)  
Forensic Autopsy Technician (Extra Help) (Jul-Dec)  
Forensic Autopsy Technician (Extra Help) (Jul-Dec)  
Forensic Autopsy Technician (Extra Help) (Jul-Dec)  
Forensic Autopsy Technician (Sept-Nov)  
Forensic Autopsy Technician (Oct-Dec)

## Contractors

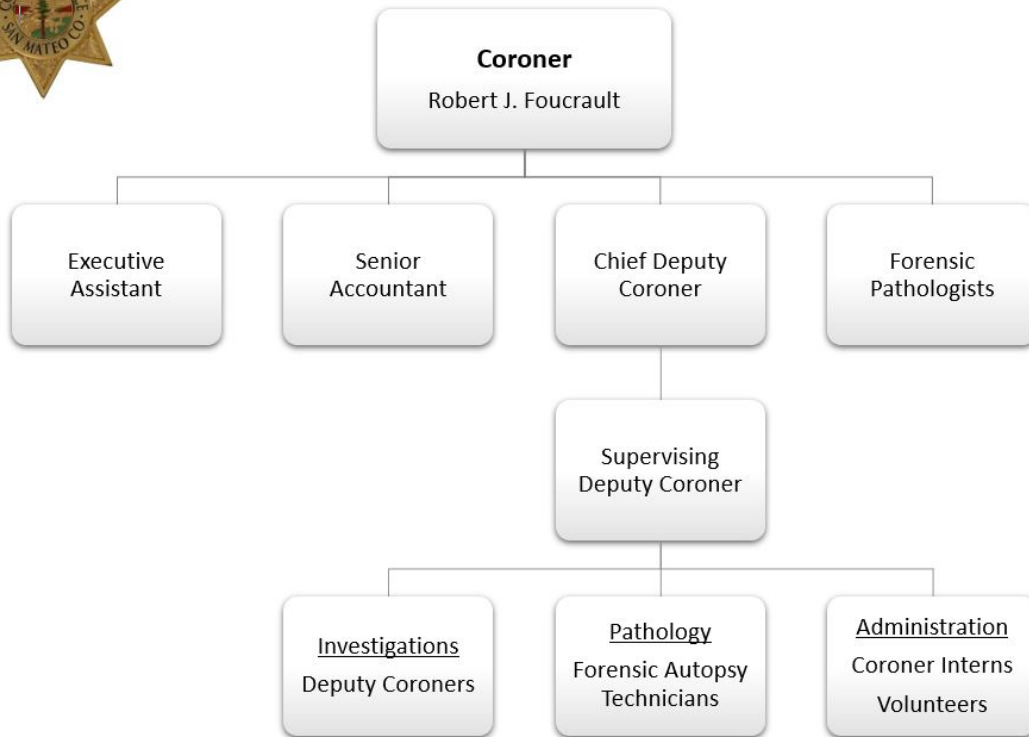
Thomas Rogers, M.D.  
Forensic Doctors Group  
Michael Hunter, M.D.  
Harinder Narula, M.D.  
Katherine Raven, M.D.  
Vivian Snyder, D.O.  
Angellee Chen, M.D., J.D.  
NAAG Pathology Group (Aug)  
Evan Matshes, M.D.  
Anna Park, M.D.  
Amelia Nakanishi, M.D.

Forensic Pathologist  
  
Forensic Pathologist  
Forensic Pathologist (Apr-Nov)  
Forensic Pathologist  
Forensic Pathologist (Oct-Dec)  
Forensic Pathologist (Feb-Dec)  
  
Forensic Pathologist (Aug)  
Forensic Pathologist (Aug)  
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 reasonably 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

<b>Number of deaths reported:</b>	2,417
<b>Number of cases for full investigation:</b>	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
<b>Number of Elder (65+) cases investigated at scene and released:</b>	227
Number of mutual aid requests for death notifications:	38
<b>Number of cases by manner of death:</b>	
<b>Natural</b>	291
<b>Accident</b>	207
<b>Suicide</b>	73
<b>Homicide</b>	13
<b>Undetermined</b>	9
<b>Pending Investigation</b>	0
<b>Number of decedents transported:</b>	
<b>Coroner</b>	506
<b>Contractor</b>	48
<b>Mortuary/Funeral Home/Other</b>	43
<b>Forensic Examinations:</b>	
<b>Full Autopsy</b>	320
<b>Limited Autopsy</b>	32
<b>Clinical Review</b>	105
<b>Specialized (SUIDS / Homicide)</b>	21
<b>Hospital Autopsies</b>	0
<b>Number of cases where toxicology was conducted:</b>	371

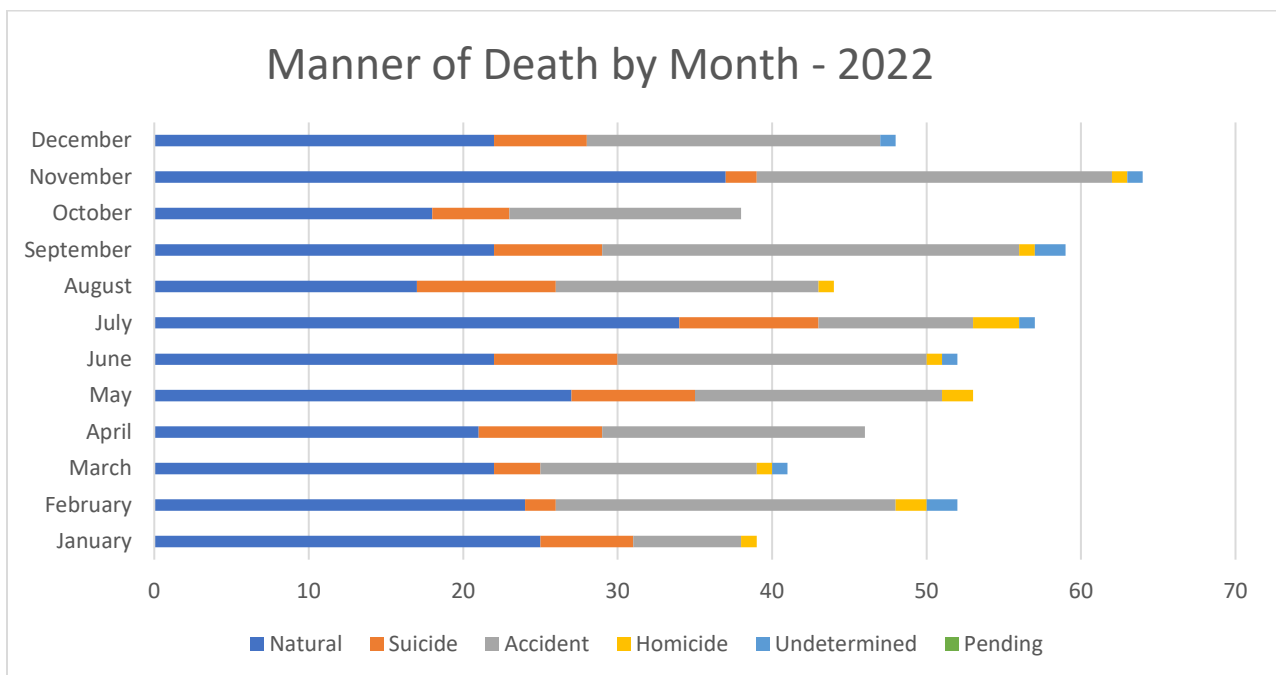


<b>Number of cases reported as “unidentified”:</b>	84
<b>Identified after investigation</b>	82
<b>Organ and tissue donations:</b>	
<b>Cases referred for donation</b>	152
<b>Total organ donors</b>	10
<b>Total organs transplanted</b>	31
<b>Total tissue donors</b>	70
<b>Exhumations:</b>	0



## General Classifications of Death by Month

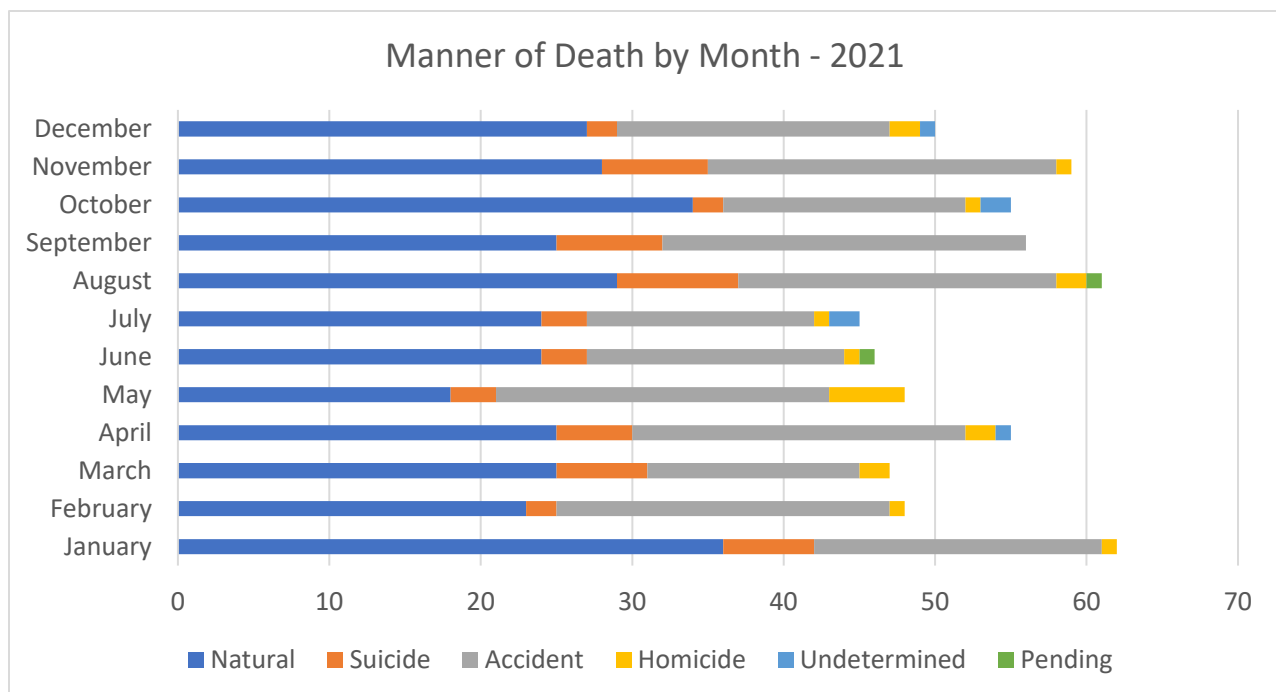
Coroner Case Statistics for 2022 by Month							
	Natural	Suicide	Accident	Homicide	Undetermined	Pending	Total
January	25	6	7	1	0	0	39
February	24	2	22	2	2	0	52
March	22	3	14	1	1	0	41
April	21	8	17	0	0	0	46
May	27	8	16	2	0	0	53
June	22	8	20	1	1	0	52
July	34	9	10	3	1	0	57
August	17	9	17	1	0	0	44
September	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
<b>Total</b>	<b>291</b>	<b>73</b>	<b>207</b>	<b>13</b>	<b>9</b>	<b>0</b>	<b>593</b>





## 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
<b>Total</b>	<b>318</b>	<b>54</b>	<b>233</b>	<b>19</b>	<b>6</b>	<b>2</b>	<b>631</b>

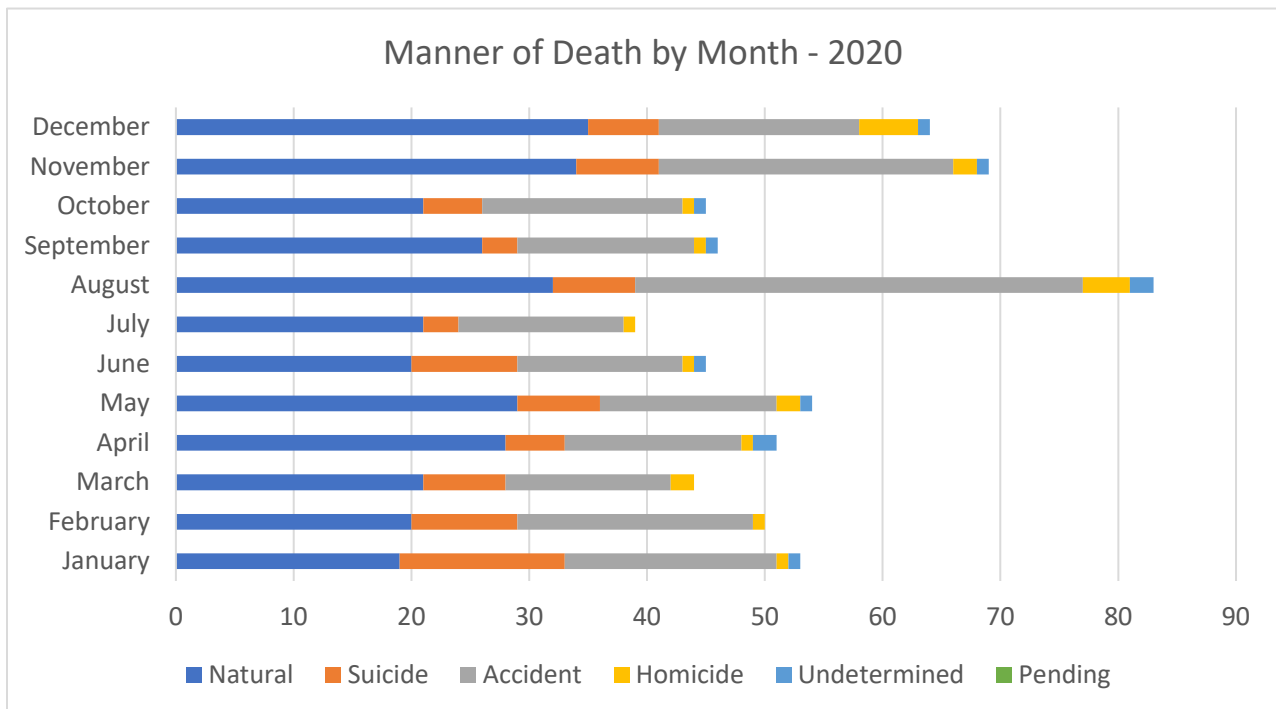


## Historical Statistics (continued)

### Coroner Case Statistics for 2020 by Month

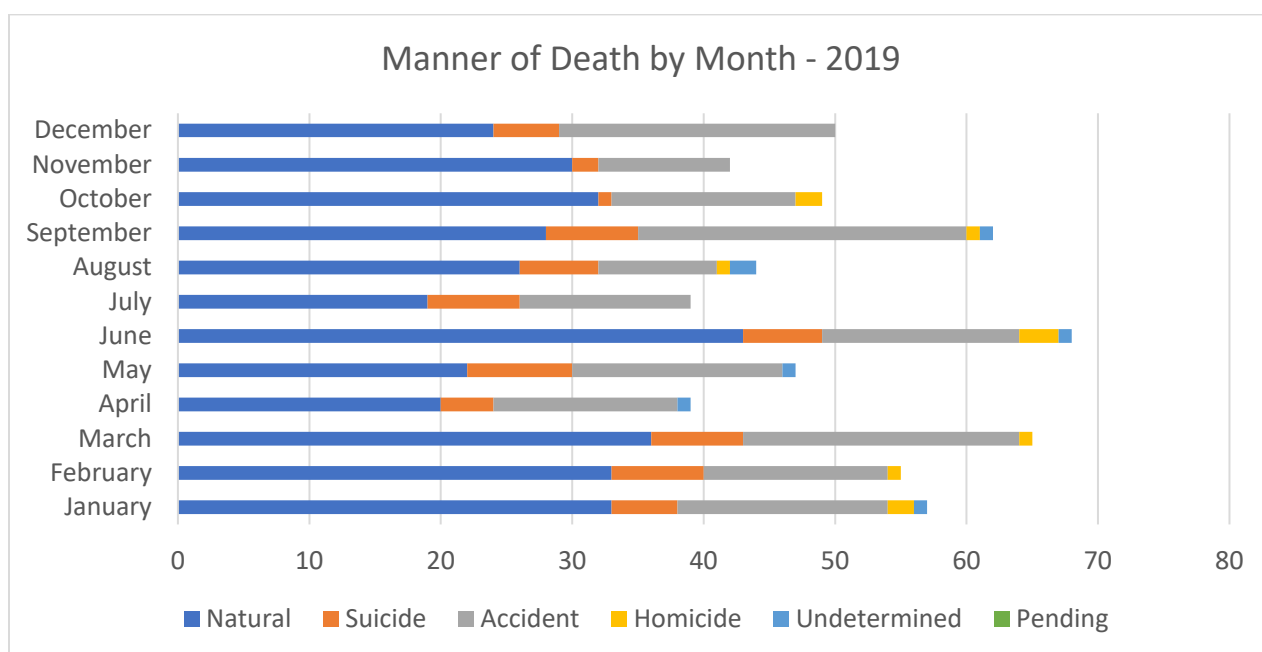
	Natural	Suicide	Accident	Homicide	Undetermined	Pending	Total
<b>January</b>	19	14	18	1	1	0	53
<b>February</b>	20	9	20	1	0	0	50
<b>March</b>	21	7	14	2	0	0	44
<b>April</b>	28	5	15	1	2	0	51
<b>May</b>	29	7	15	2	1	0	54
<b>June</b>	20	9	14	1	1	0	45
<b>July</b>	21	3	14	1	0	0	39
<b>August</b>	32	7	38	4	2	0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

### Manner of Death by Month - 2020



## Historical Statistics (continued)

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

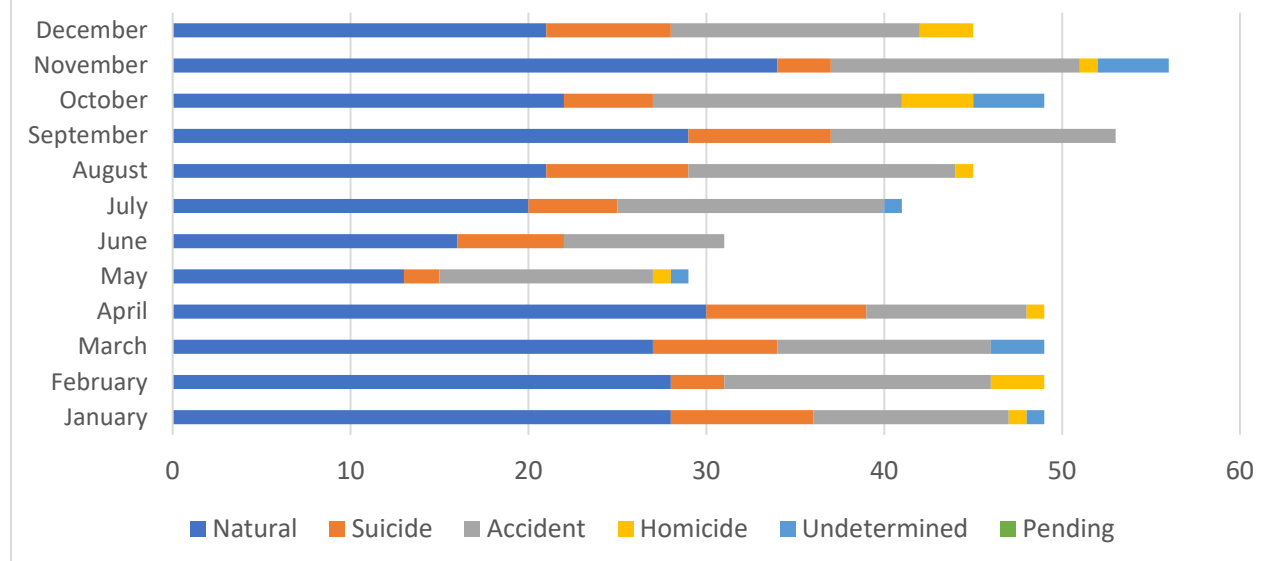


## Historical Statistics (continued)

### Coroner Case Statistics for 2018 by Month

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

### Manner of Death by Month - 2018

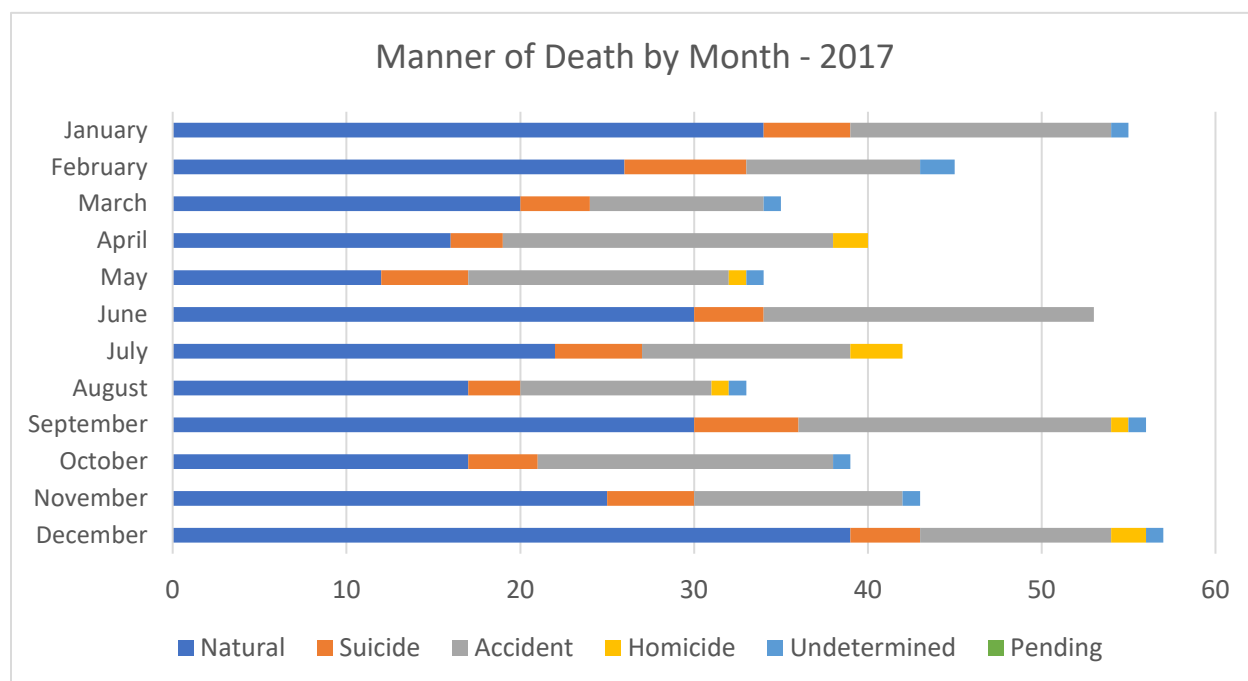


## Historical Statistics (continued)

### Coroner Case Statistics for 2017 by Month

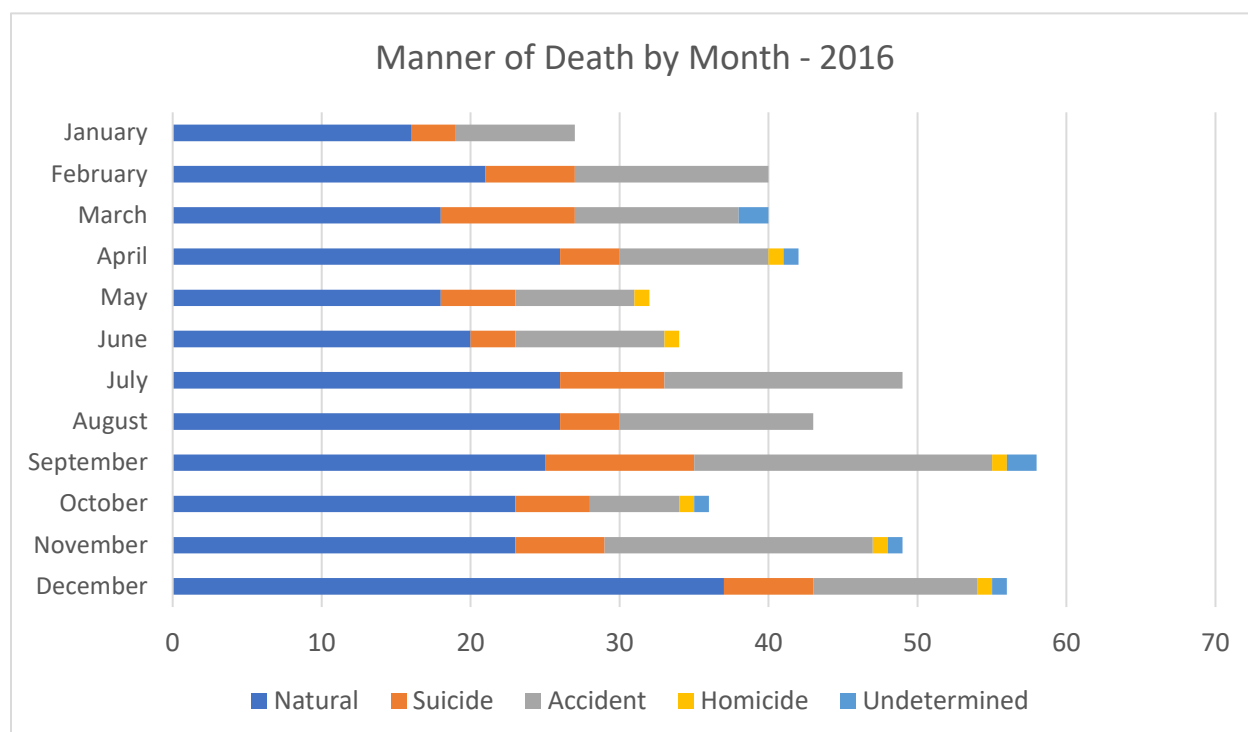
	Natural	Suicide	Accident	Homicide	Undetermined	Pending	Total
<b>January</b>	34	5	15	0	1	0	55
<b>February</b>	26	7	10	0	2	0	45
<b>March</b>	20	4	10	0	1	0	35
<b>April</b>	16	3	19	2	0	0	40
<b>May</b>	12	5	15	1	1	0	34
<b>June</b>	30	4	19	0	0	0	53
<b>July</b>	22	5	12	3	0	0	42
<b>August</b>	17	3	11	1	1	0	33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

### Manner of Death by Month - 2017



## Historical Statistics (continued)

Coroner Case Statistics for 2016 by Month							
	Natural	Suicide	Accident	Homicide	Undetermined	Pending	Total
<b>January</b>	16	3	8	0	0	0	27
<b>February</b>	21	6	13	0	0	0	40
<b>March</b>	18	9	11	0	2	0	40
<b>April</b>	26	4	10	1	1	0	42
<b>May</b>	18	5	8	1	0	0	32
<b>June</b>	20	3	10	1	0	0	34
<b>July</b>	26	7	16	0	0	0	49
<b>August</b>	26	4	13	0	0	0	43
<b>September</b>	25	10	20	1	2	0	58
<b>October</b>	23	5	6	1	1	0	36
<b>November</b>	23	6	18	1	2	0	50
<b>December</b>	37	6	12	1	1	0	57
<b>Total</b>	279	68	145	7	9	0	508



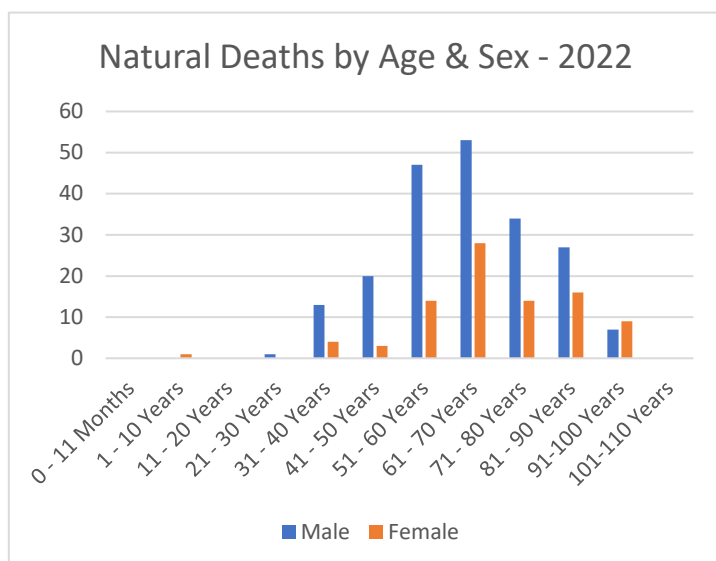
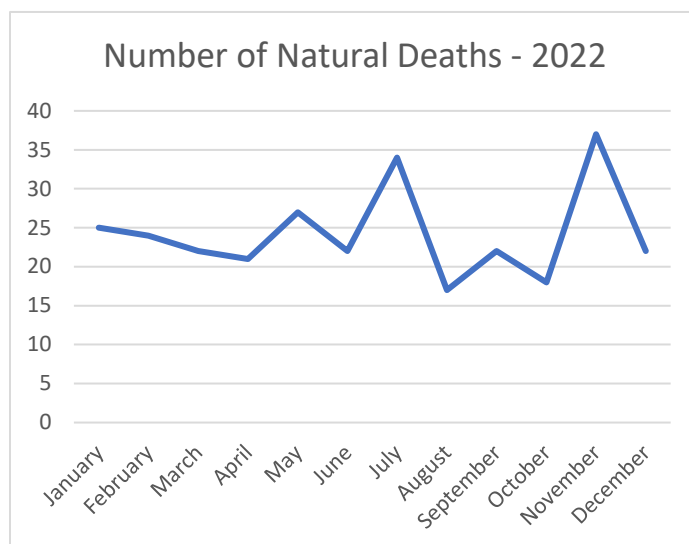


# Natural

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

## Total Natural Deaths in 2022: 291

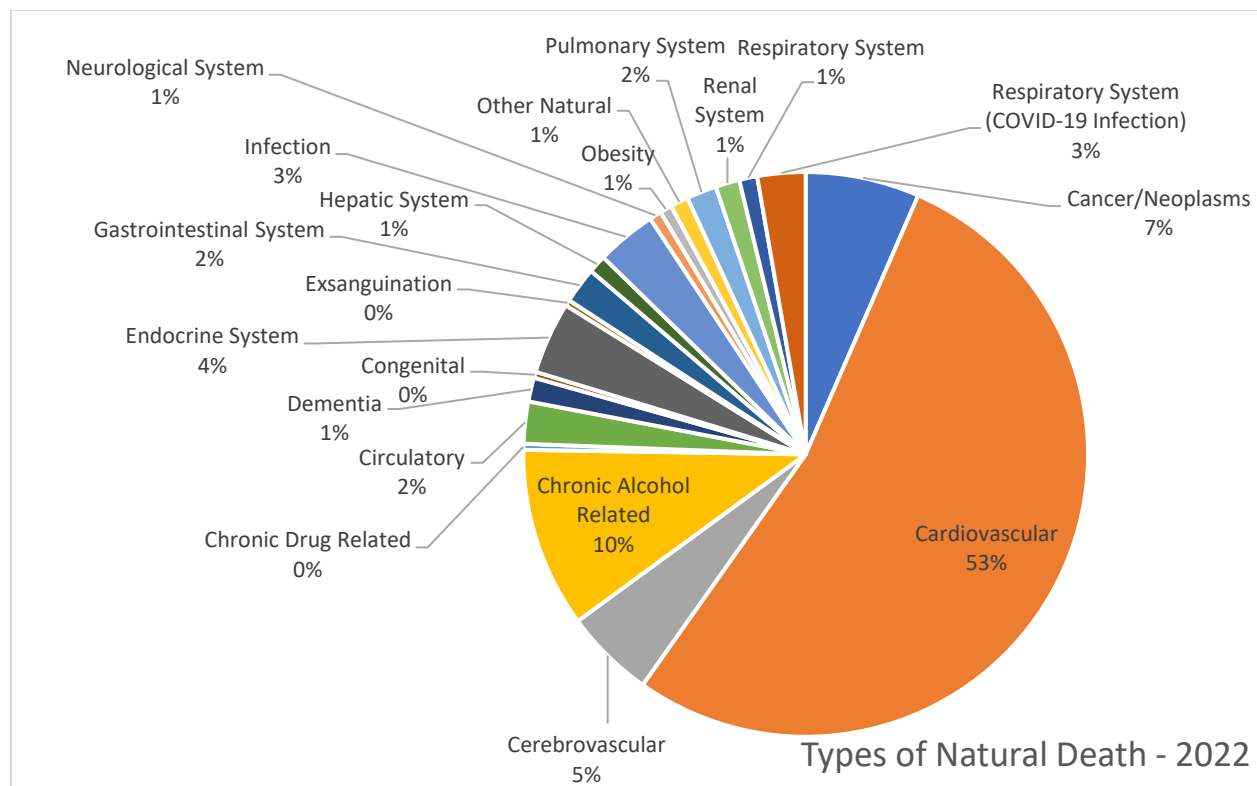
Natural Deaths by Month	
Month	Number of Natural Deaths
January	25
February	24
March	22
April	21
May	27
June	22
July	34
August	17
September	22
October	18
November	37
December	22



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

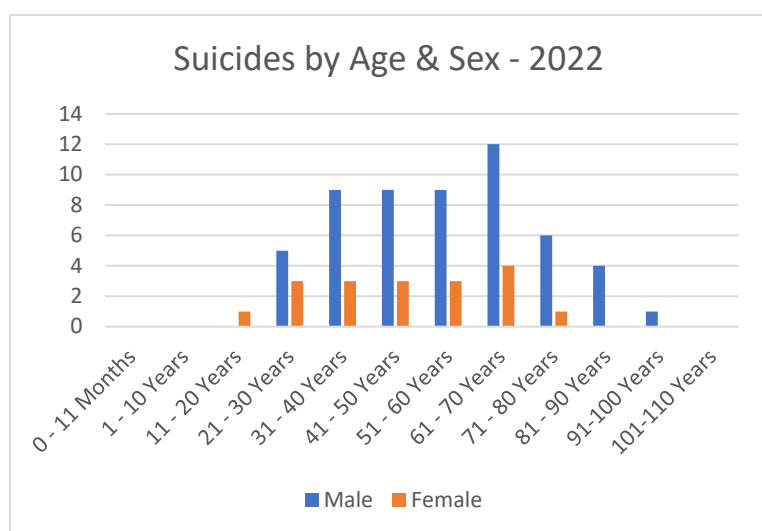
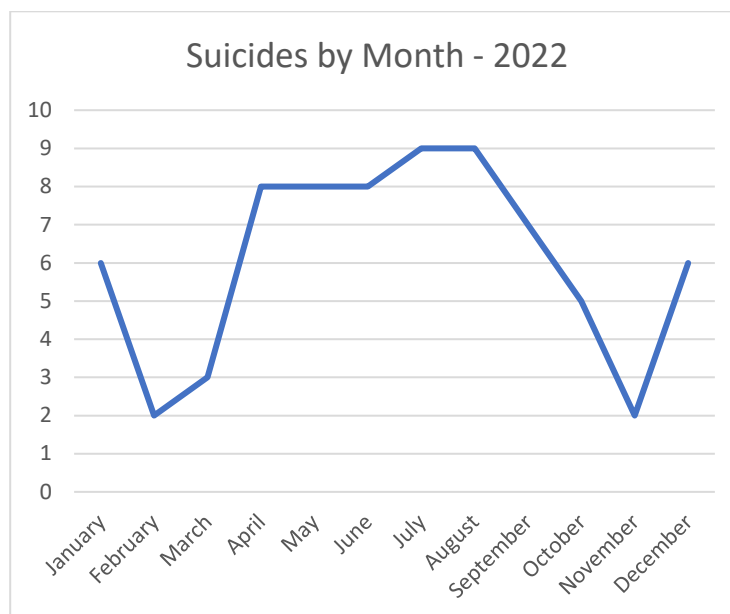


# Suicide

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

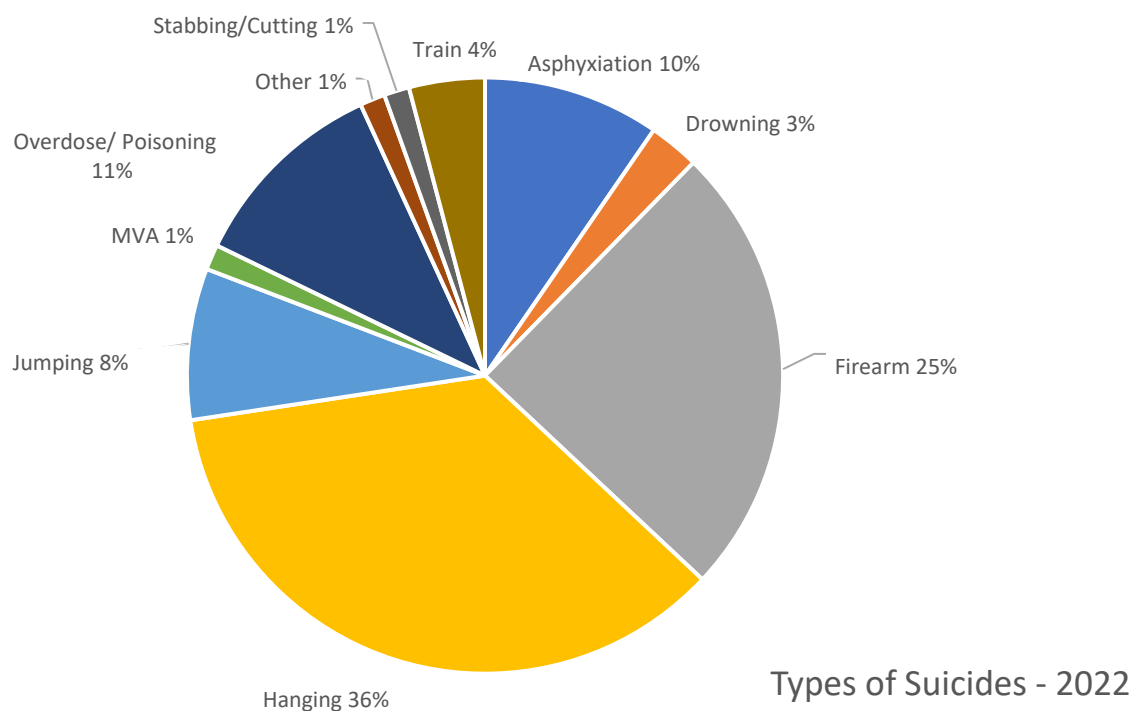
Suicide by Month	
Month	Number of Suicides
January	6
February	2
March	3
April	8
May	8
June	8
July	9
August	9
September	7
October	5
November	2
December	6



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

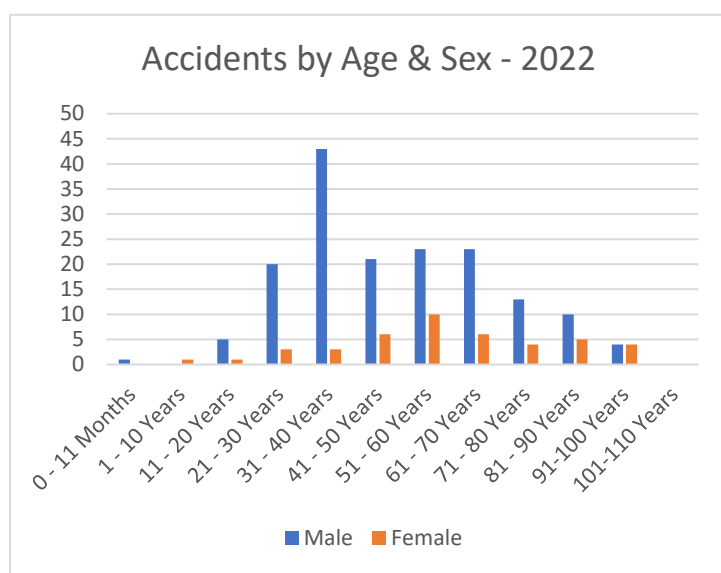
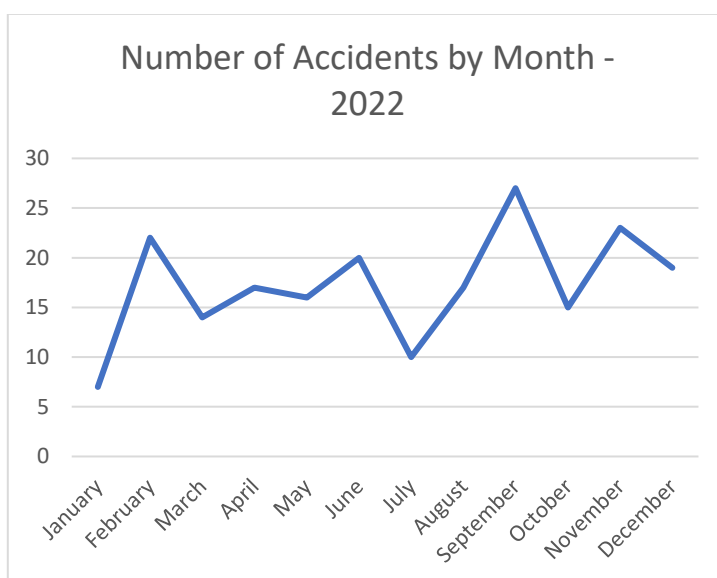


## Accident

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

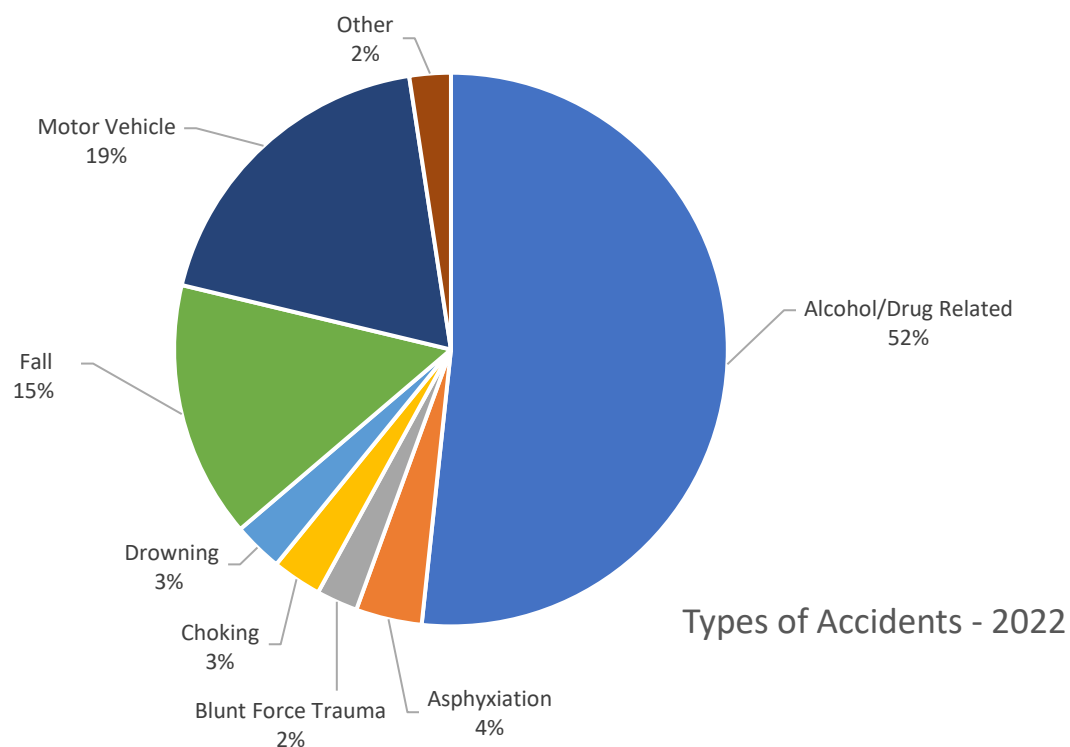
Accidents by Month	
Month	Number of Accidents
January	7
February	22
March	14
April	17
May	16
June	20
July	10
August	17
September	27
October	15
November	23
December	19



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

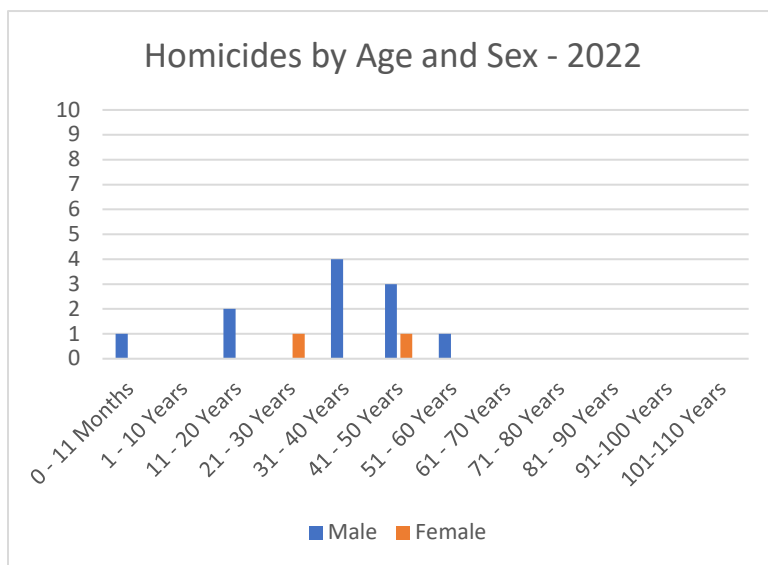
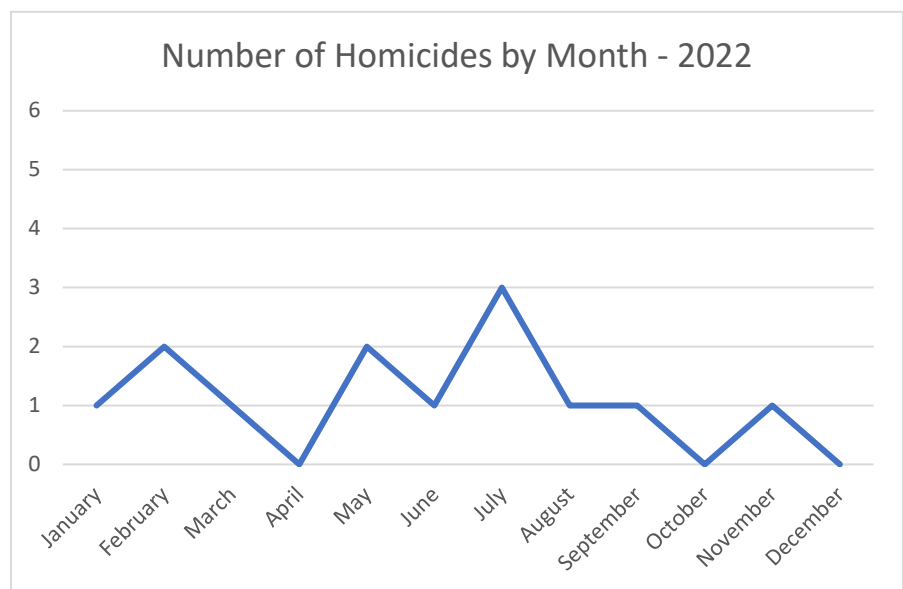


# Homicide

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

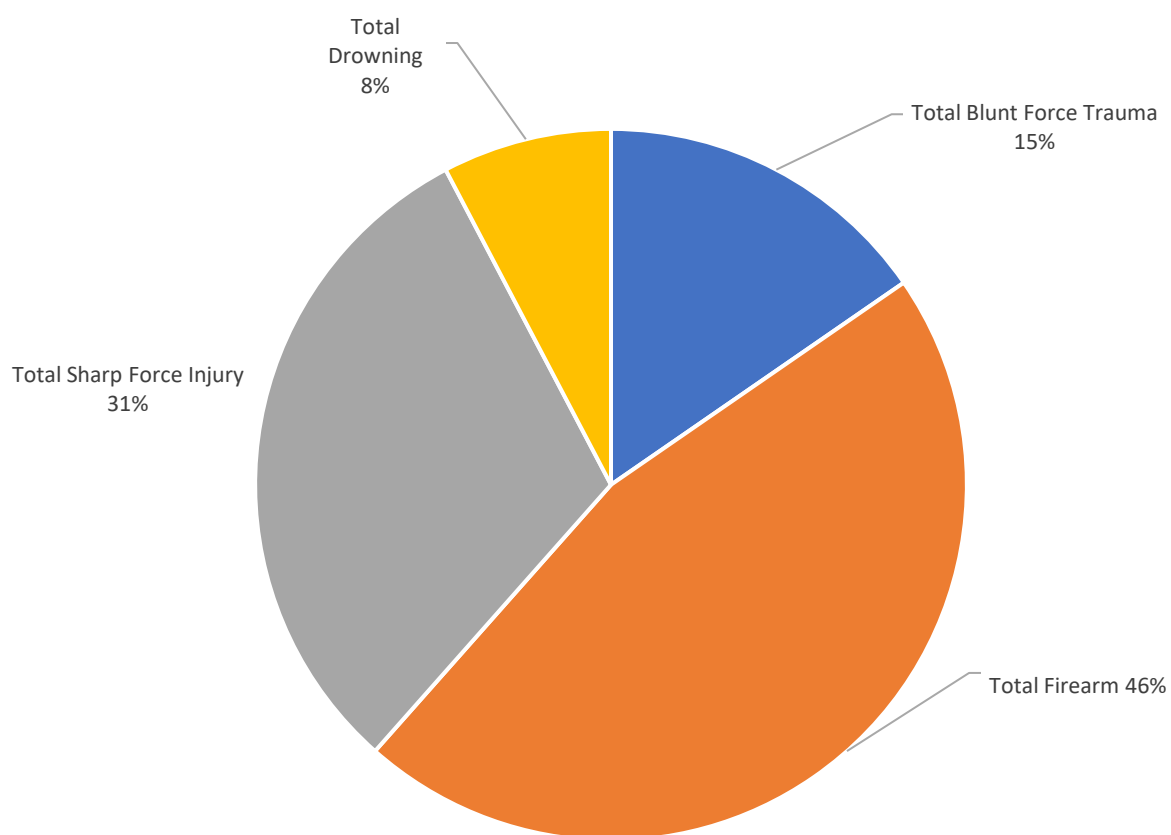
Homicides by Month	
Month	Number of Homicides
January	1
February	2
March	1
April	0
May	2
June	1
July	3
August	1
September	1
October	0
November	1
December	0



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



Type of Homicides - 2022



## 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**

<b>Manner</b>	<b>Total</b>
Natural	0
Accident	5
Suicide	0
Homicide	5
Undetermined	1

<b>County of Death</b>	<b>Total</b>
Santa Clara	7
San Francisco	4



## **Indigent Cremation**

Through the County Cremation process, the Coroner interments 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 interment 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 interment via County Cremation.

### **Total Number of Indigent Cremations in 2022: 35**

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



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

***San Mateo County Coroner***

*50 Tower Road*

*San Mateo, CA 94402*

*(650) 312-5562*

*[smcgov.org/coroner](http://smcgov.org/coroner)*

