Marin County Sheriff's Office
Coroner Division
Annual Report
2018

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, one Coroner Forensic Technician, and one part-time volunteer intern.

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 1,973 deaths recorded in Marin County in 2018. Of these approximately 752 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, 276 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 2018.

Marin County Sheriff-Coroner Staff 2018

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

Undersheriff Michael Ridgway.....Undersheriff

Captain Rick Navarro.....Captain

Roger Fielding.....Chief Deputy Coroner

Kenneth Advincula.....Coroner Investigator

Kaci DeMent.....Coroner Investigator

Alexandra Torres.....Coroner Investigator

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

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

Jaclyn Vaishville.....Coroner Forensic Technician

Lacey Nave.....Intern

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 he attended the patient for a sufficient time to properly diagnose the case and subsequent cause of death. If he only saw the patient for matter of minutes but was able to determine the cause, he 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 knowledge of the patient with the Coroner signing the certificate. Another example

Reportable Criteria

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 him 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 (Self-Explanatory).

5. Known or suspected suicide (Self-Explanatory).

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 (Self-Explanatory).

8. Associated with a known or alleged rape or crime against nature (Self-Explanatory).

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 section covers a lot of ground and the key word is FOLLOWING an injury or accident. Of course this would include any accident: traffic, at home, at work, etc. It would include such cases as where an elderly person would fall at home incurring a fracture of his hip, 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 his femur with the fatal consequences there from, he, it must be assumed, would still be alive despite various infirmities. There are certain cases obviously where, because of the time lapse between the injury and the death, that 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 simple "rule of thumb" 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 is not returned to ambulation, even in a limited sense, and he 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 (parts of this section are self-explanatory). In respect to the question of certifying a death from aspiration, whether it be accidental or not, this is one of the most difficult problems in the field of forensic pathology. 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) – Self-explanatory.

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. Normally 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 (Self-Explanatory).

21. All deaths where the decedent was in a hospital less than 24 hours (Self-Explanatory).

2018 General Statistics

Number of Deaths Reviewed/Investigated 752

Number of cases resulting in full death investigation.....276

Number of cases by manner of death:

- **Natural 88**
- **Accident 97**
- **Suicide 58**
- **Homicide 11**
- **Undetermined 2**
- **Primary Doctor Sign Out 21**
- **Indigent 17**
- **Non-Forensic (Bones) 0**
- **Pending 0**

Number of decedents transported 208

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

Forensic Examinations

- **Autopsy 80**
- **External Examination 121**
- **Medical File Review 54**

Total Amount of Toxicological Tests Run 134

Number of cases reported as "unidentified" 11

- **Identified after investigation 1**
- **Remain unidentified 0**

Organ and tissue donations:

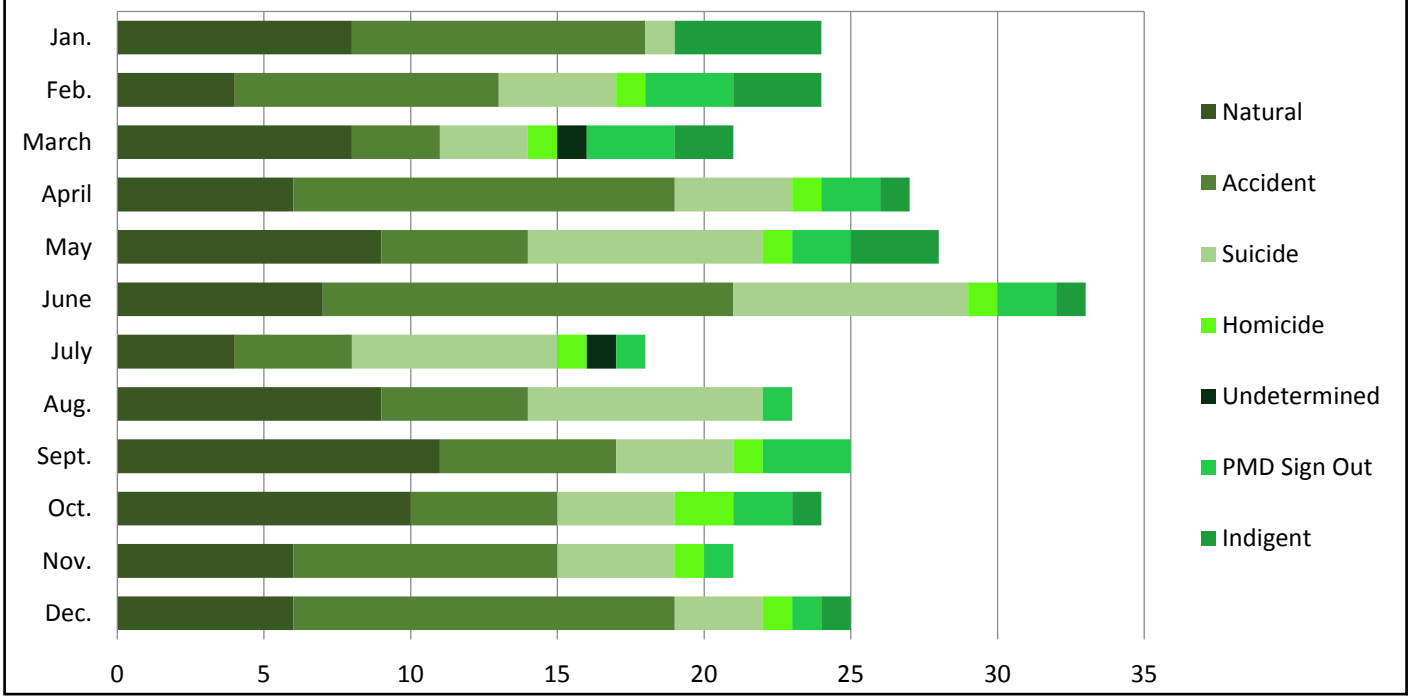
- **Total Direct Referrals 3**
- **Total Organ Donors 1**
- **Total Tissues Donors 32**
- **Total Lives Impacted 631**
- **Organ Denial.....0**

2018 Manners of Death by Month

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

2018 Manner of Death by Month



Historical Statistics 2013-2017

Coroner Case Statistics for 2013 by Month							
	Natural	Accident	Suicide	Homicide	Undetermined	Pending	Total
Jan.	10	11	5	1	1	0	28
Feb.	5	10	5	0	0	0	20
March	9	11	4	0	1	0	25
April	8	16	9	0	1	0	34
May	11	6	2	0	1	0	20
June	10	10	4	0	2	0	26
July	5	6	8	0	1	0	20
Aug.	8	8	16	1	3	0	36
Sept.	10	8	6	0	1	0	25
Oct.	10	8	6	0	0	0	24
Nov.	14	15	5	1	0	0	35
Dec.	16	9	3	0	3	0	31
Total	116	118	73	3	14	0	324

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

Historical Statistics 2013-2017

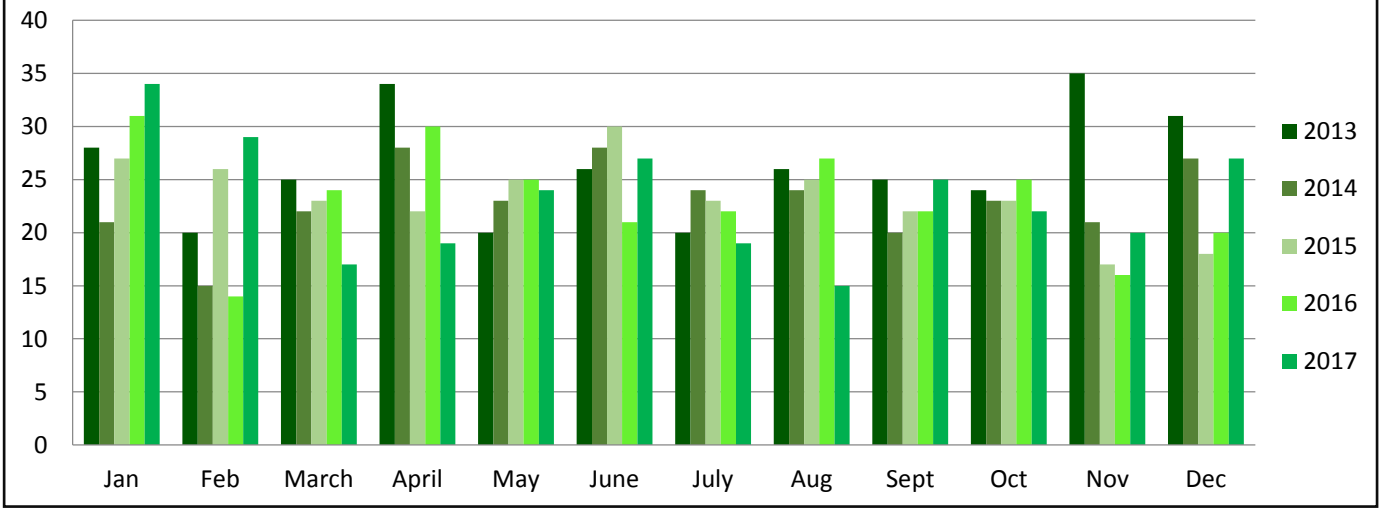
Coroner Case Statistics for 2015 by Month							
	Natural	Accident	Suicide	Homicide	Undetermined	Pending	Total
Jan.	11	12	4	0	0	0	27
Feb.	9	8	6	1	2	0	26
March	10	5	7	0	1	0	23
April	4	10	6	2	0	0	22
May	8	9	5	1	2	0	25
June	13	7	6	1	3	0	30
July	6	10	5	0	2	0	23
Aug.	13	5	5	1	1	0	25
Sept.	7	12	3	0	0	0	22
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

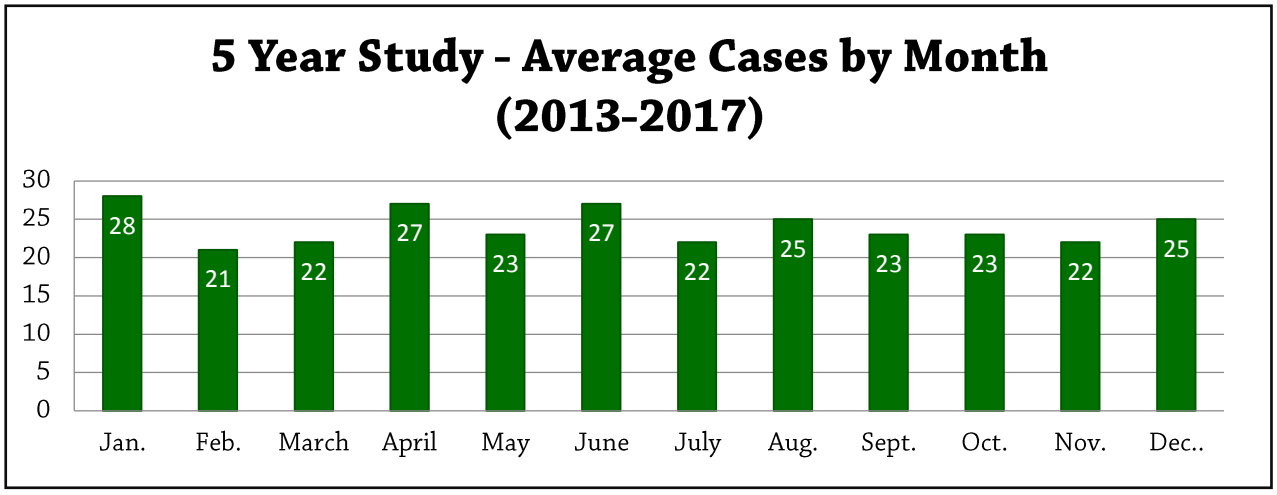
Historical Statistics 2013-2017

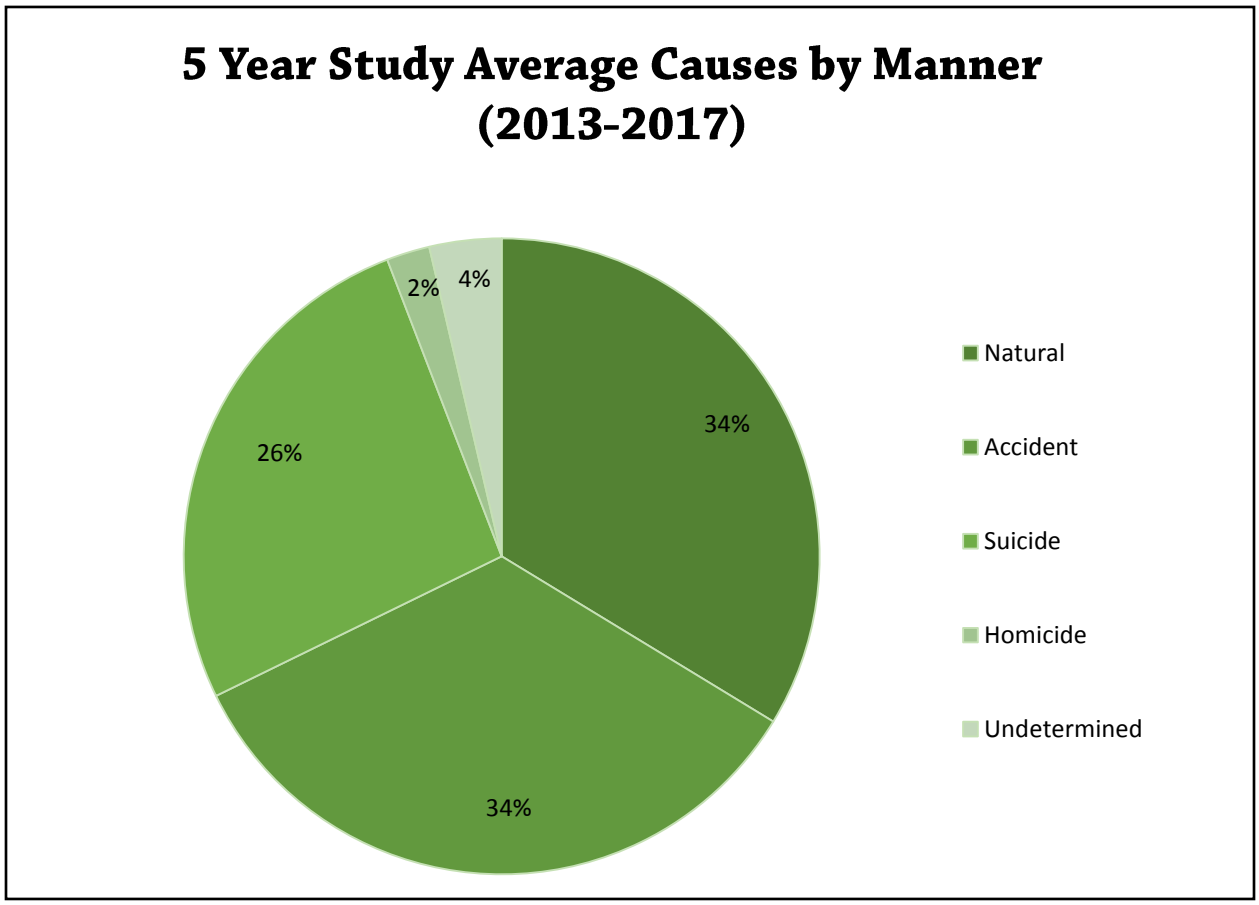
Coroner Case Statistics for 2017 by Month							
	Natural	Accident	Suicide	Homicide	Undetermined	Pending	Total
Jan.	11	9	6	0	1	0	27
Feb.	6	12	5	2	1	0	26
March	5	5	2	1	1	0	14
April	4	7	3	0	1	0	15
May	1	11	7	1	1	0	21
June	6	8	8	0	0	0	22
July	5	6	3	0	0	0	14
Aug.	6	5	4	0	1	0	16
Sept.	5	10	6	1	0	0	22
Oct.	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

5 Year Study - Number of Cases by Month (2013-2017)



Historical Statistics 2013-2017





2018 Death Statistics and Classifications

2018 Natural Deaths

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.

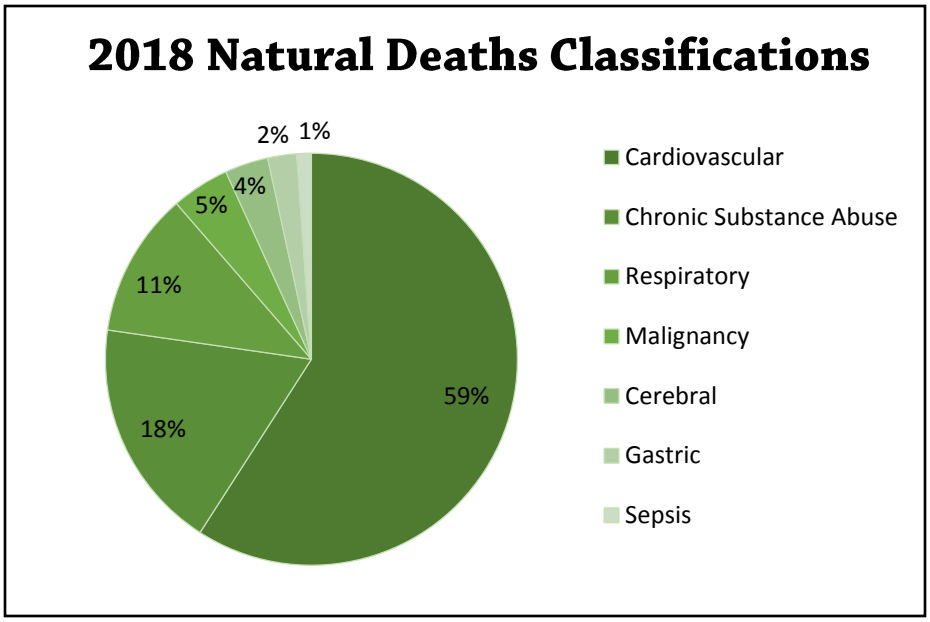
Total Natural Deaths: 88

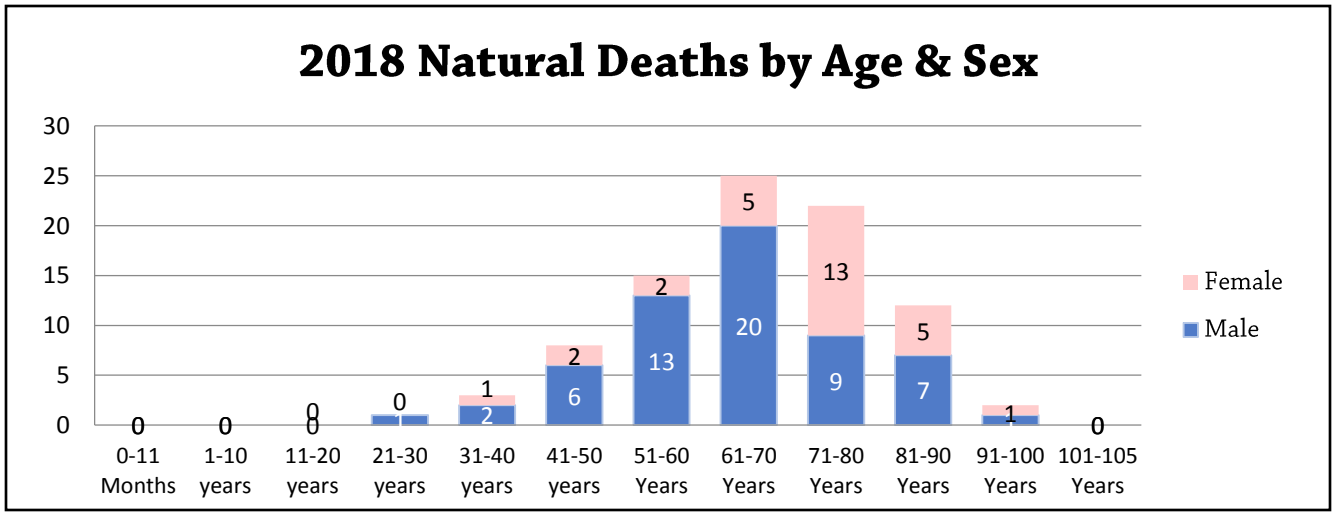
2018 Natural Deaths Classifications	
Cardiovascular	52
Chronic Substance Abuse	16
Respiratory	10
Malignancy	4
Cerebral	3
Gastric	2
Sepsis	1

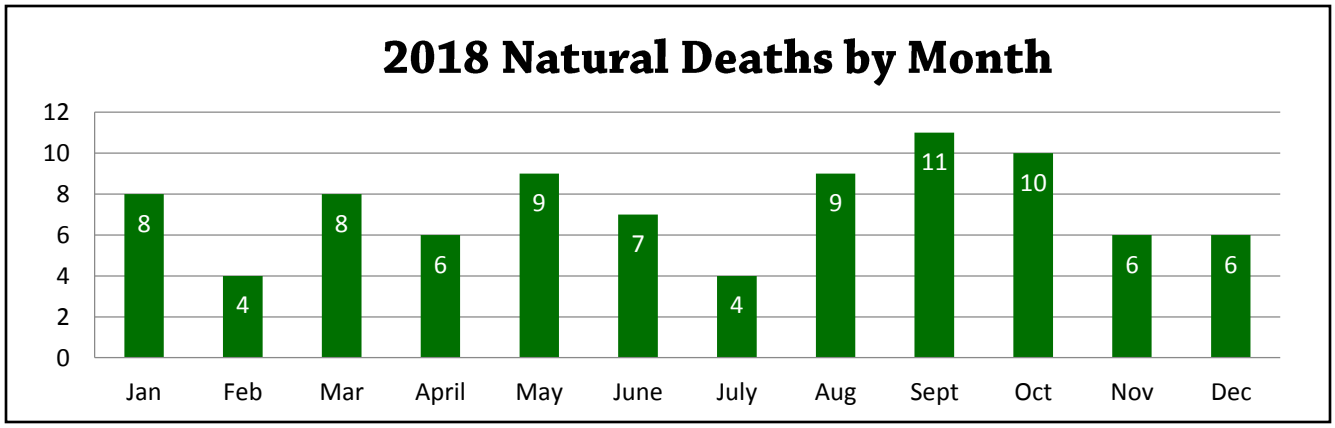
Natural Deaths by Age and Sex			
Age	**Male**	**Female**	**Total**
0-11 Months	0	0	0
1-10 years	0	0	0
11-20 years	0	0	0
21-30 years	1	0	1
31-40 years	2	1	3
41-50 years	6	2	8
51-60 Years	13	2	15
61-70 Years	20	5	25
71-80 Years	9	13	22
81-90 Years	7	5	12
91-100 Years	1	1	2

Natural Deaths by Month	
Month	**Number**
Jan	8
Feb	4
Mar	8
April	6
May	9
June	7
July	4
Aug	9
Sept	11
Oct	10
Nov	6
Dec	6

2018 Natural Deaths







2018 Accidental Deaths

An accidental death is a death, other than natural, where there is no evidence of intent.

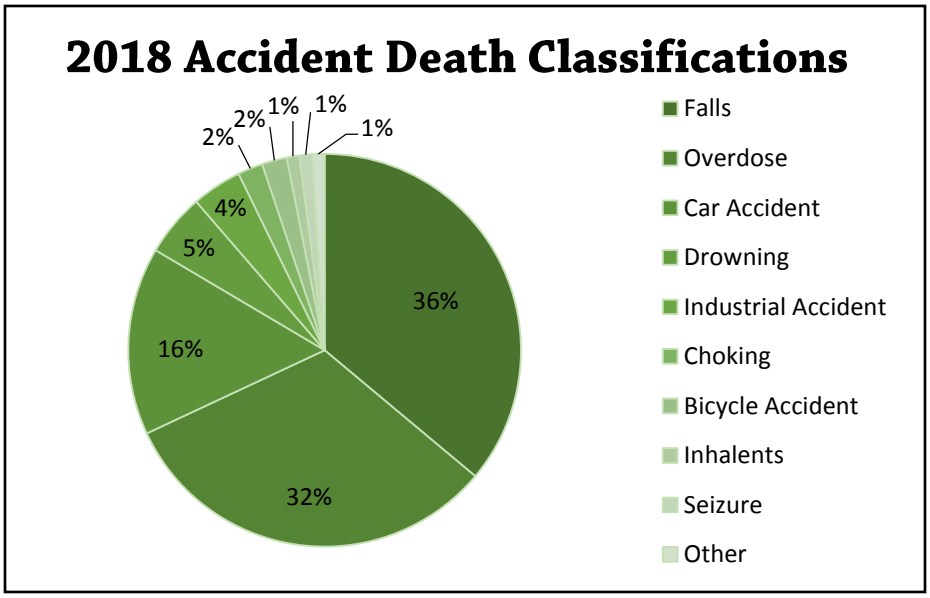
Total Accidental Deaths: 97

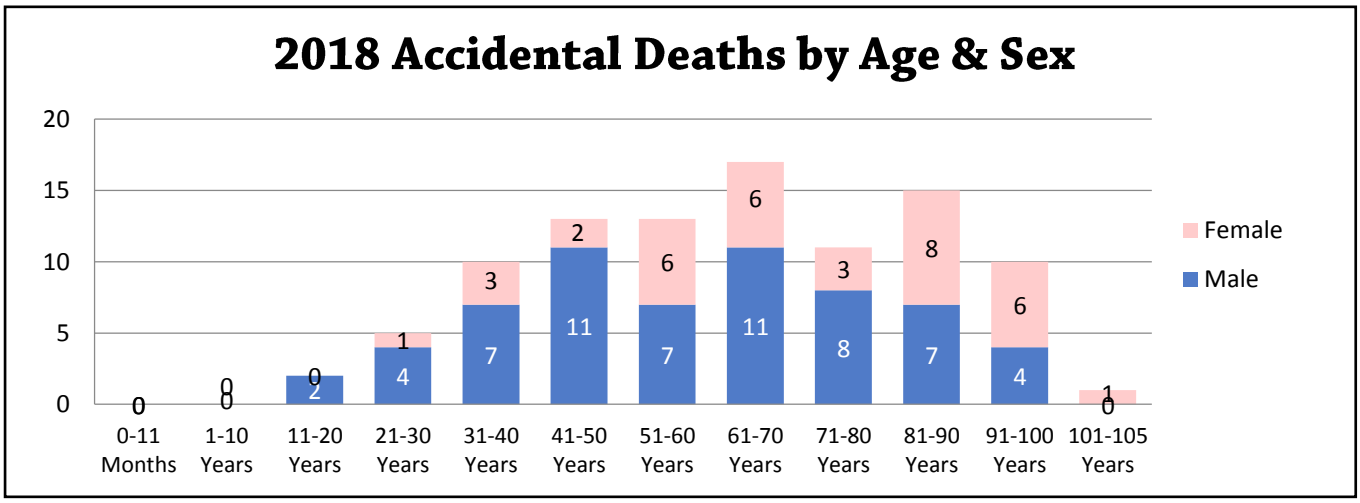
2018 Accidental Death Classification	
Falls	35
Overdose	31
Car Accident	15
Drowning	5
Industrial Accident	4
Choking	2
Bicycle Accident	2
Inhalants	1
Seizure	1
Other	1

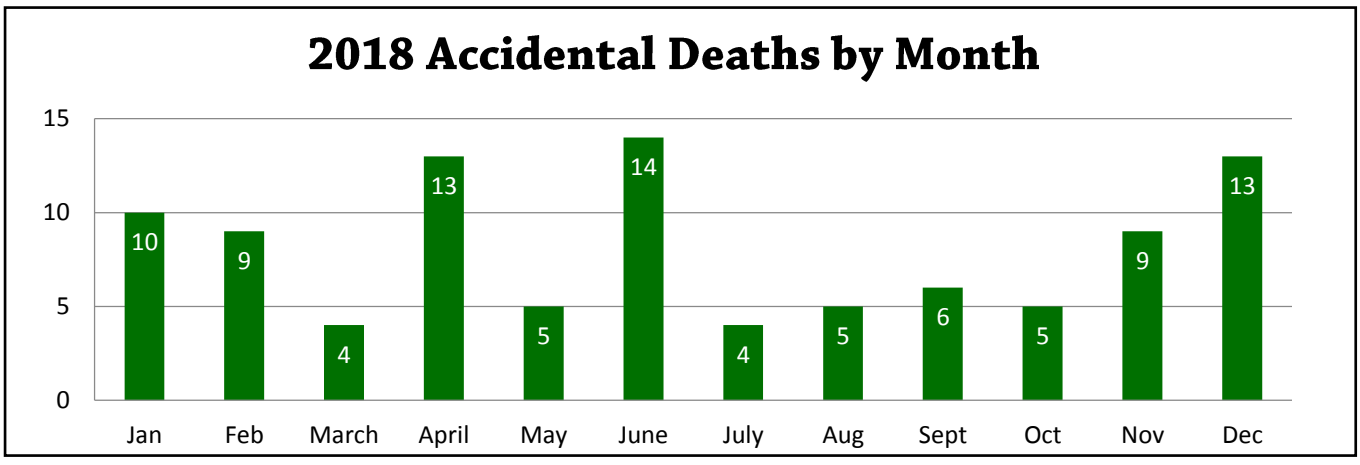
Accidental Deaths by Age & Sex			
Age	**Male**	**Female**	**Total**
0-11 Months	0	0	0
1-10 Years	0	0	0
11-20 Years	2	0	2
21-30 Years	4	1	5
31-40 Years	7	3	10
41-50 Years	11	2	13
51-60 Years	7	6	13
61-70 Years	11	6	17
71-80 Years	8	3	11
81-90 Years	7	8	15
91-100 Years	4	6	10
101-105 Years	0	1	1

Accidental Deaths by Month	
Month	**Number**
Jan	10
Feb	9
March	4
April	13
May	5
June	14
July	4
Aug	5
Sept	6
Oct	5
Nov	9
Dec	13

2018 Accidental Deaths

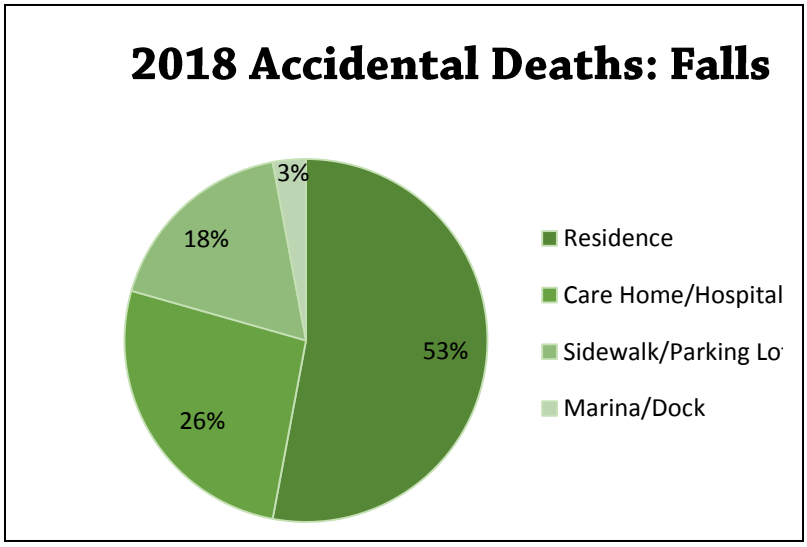




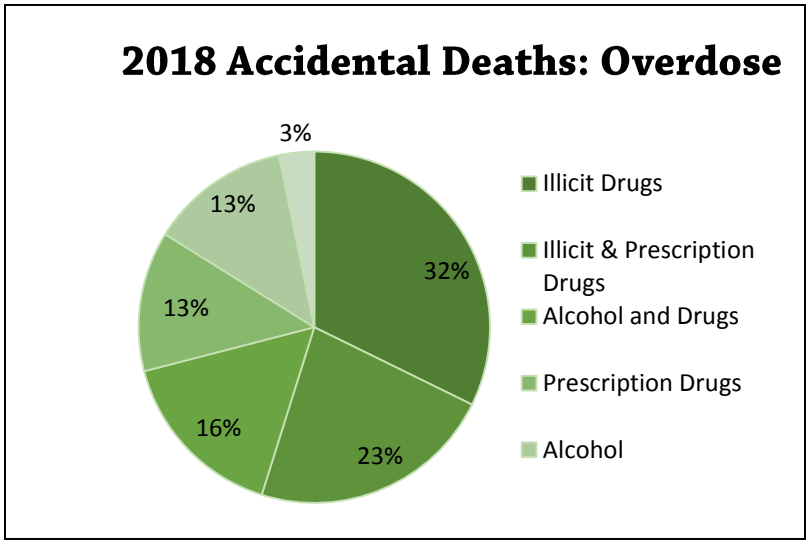


2018 Accidental Deaths

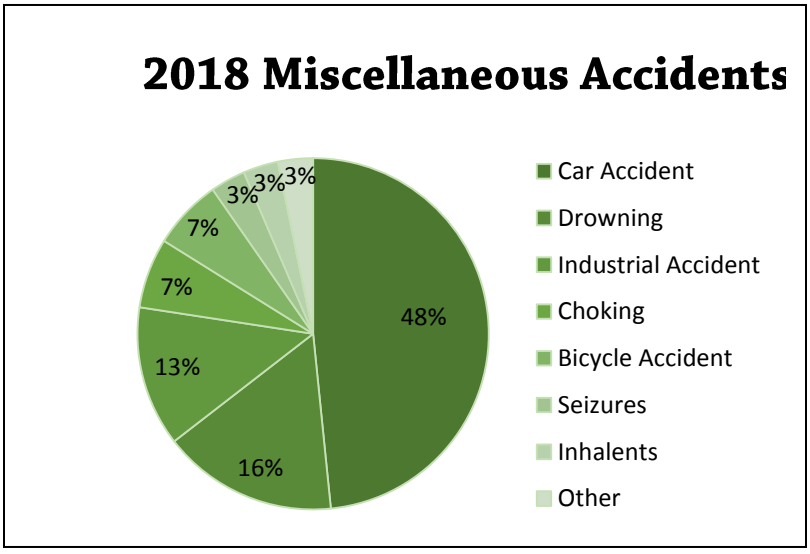
Falls	35
Residence	18
Care Home/Hospital	9
Sidewalk/Parking Lot	6
Marina/Dock	1
Private Social Club	1



Overdoses	31
Illicit Drugs	10
Illicit & Prescription Drugs	7
Alcohol and Drugs	5
Prescription Drugs	4
Alcohol	4
Opioids	1



Miscellaneous	31
Car Accident	15
Drowning	5
Industrial Accident	4
Choking	2
Bicycle Accident	2
Seizures	1
Inhalants	1
Other	1



2018 Motor Vehicle Fatalities

The Coroner Division, as well as other law enforcement agencies within the jurisdiction of the motor vehicle fatality, conducts a thorough investigation. 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 & Sex			
Age	**Male**	**Female**	**Total**
0-11 Months	0	0	0
1-10 Years	0	0	0
11-20 Years	1	0	1
21-30 Years	2	1	3
31-40 Years	1	0	1
41-50 Years	2	2	4
51-60 Years	0	1	1
61-70 Years	2	1	3
71-80 Years	2	1	3
81-90 Years	2	1	3
91-100 Years	0	0	0

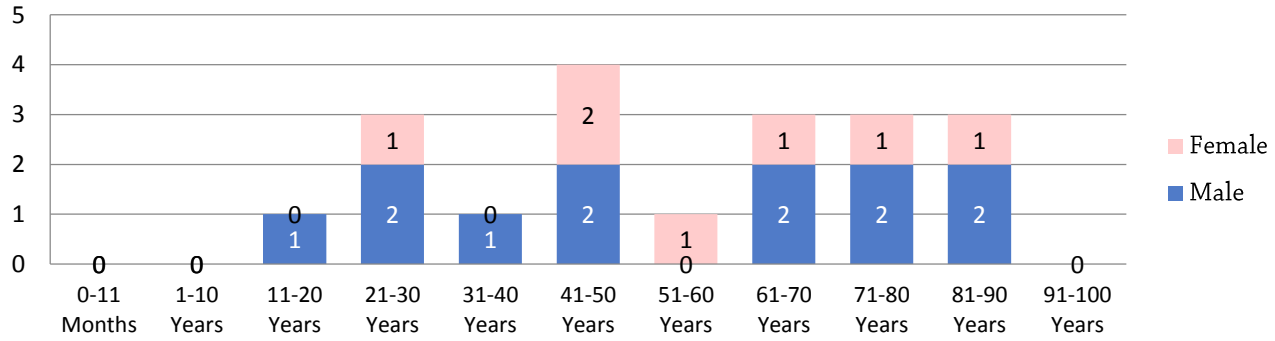
Motor Vehicle Fatalities by Month	
Month	**Number**
Jan	2
Feb	1
March	2
April	2
May	0
June	4
July	1
Aug	0
Sept	2
Oct	2
Nov	3
Dec	0

2018 Motor Vehicle Fatalities Decedent Classification	
Automobile Operator	6
Pedestrian	6
Automobile Passenger	3
Motorcycle	3
Bicyclist	1
Total	19

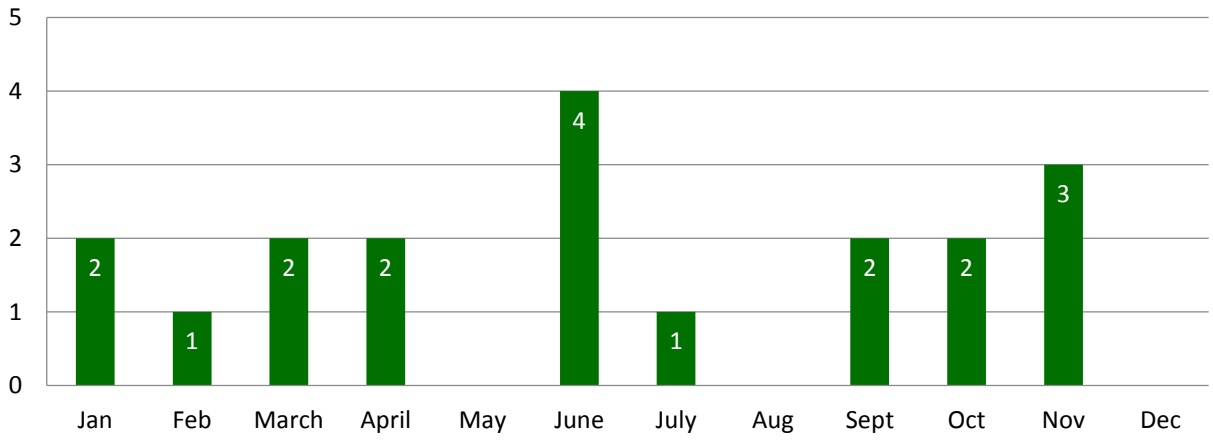
2018 Motor Vehicle Fatalities Manner of Death	
Accident	15
Homicide	3
Suicide	1
Natural	0

2018 Motor Vehicle Fatalities

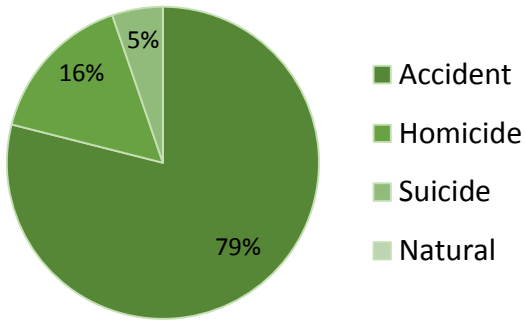
2018 Motor Vehicle Fatalities by Age & Sex



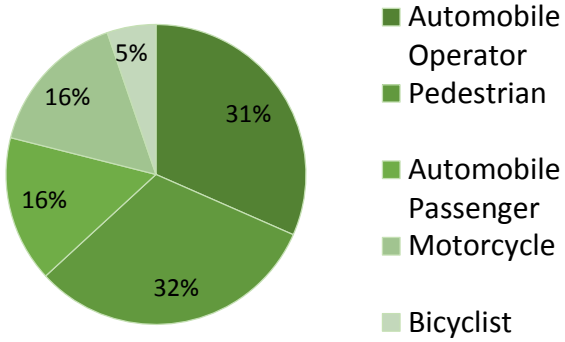
2018 Motor Vehicle Fatalities by Month



2018 Motor Vehicle Fatalities Manners



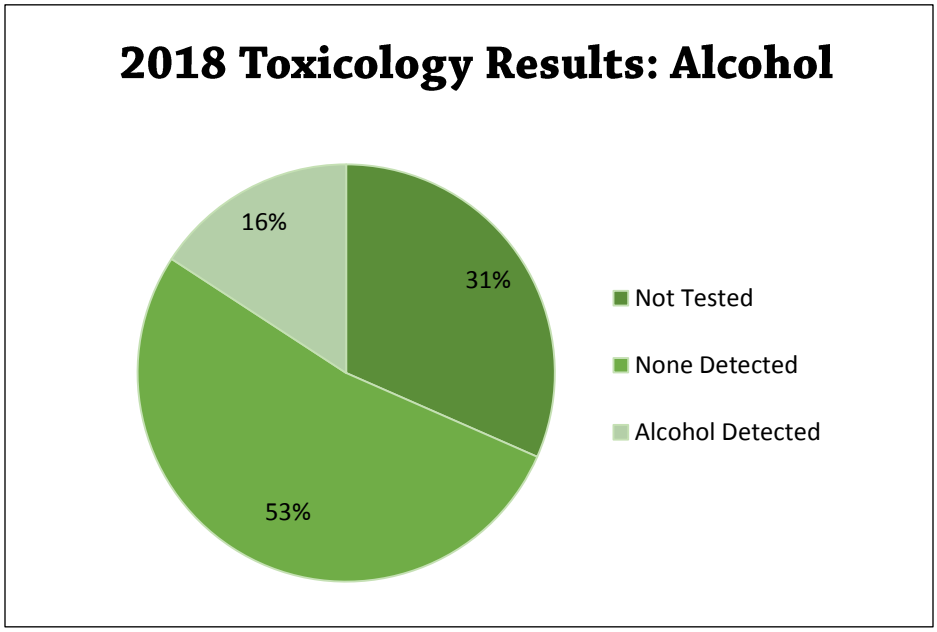
2018 Types of Motor Vehicle Fatalities



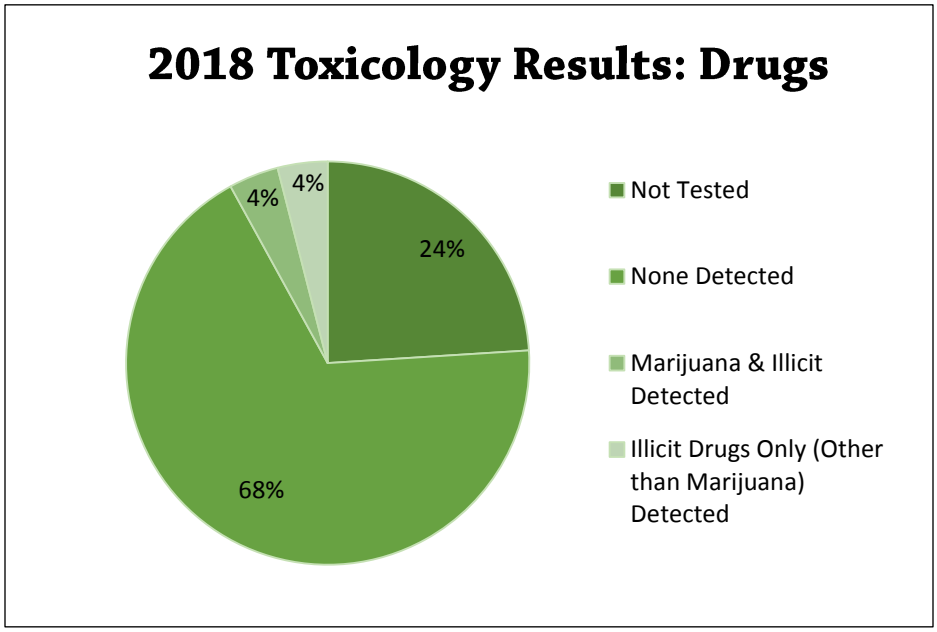
2018 Motor Vehicle Fatalities Involving Alcohol and/or Drugs

The coroner investigates suspected motor vehicle fatalities. 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	6
None Detected	10
Alcohol Detected	3



Toxicology Results Related to Drugs	
Not Tested	6
None Detected	17
Marijuana & Illicit Detected	1
Illicit Drugs Only (Other than Marijuana) Detected	1



2018 Suicide Deaths

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 implicit intent such as deliberately placing a gun to one's head or rigging a vehicle exhaust.

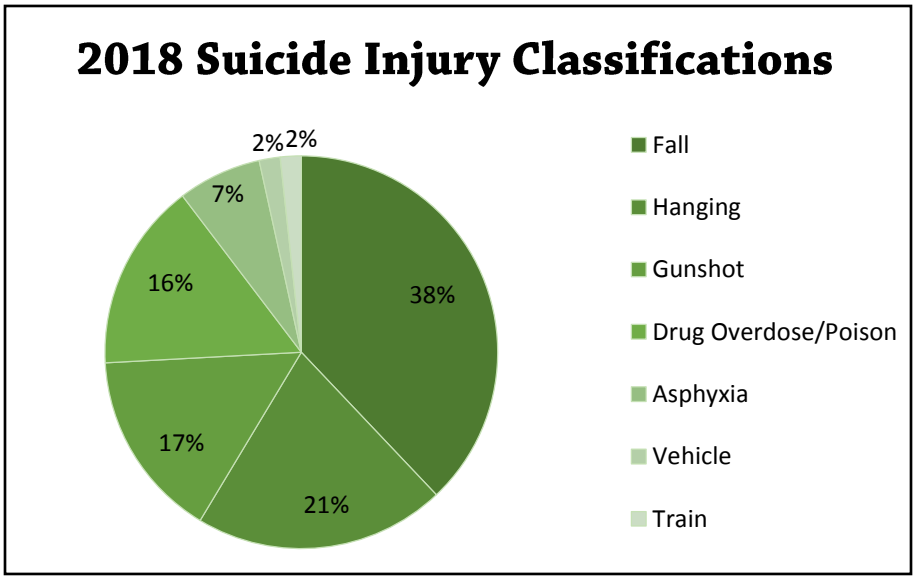
Total Suicide Deaths: 58

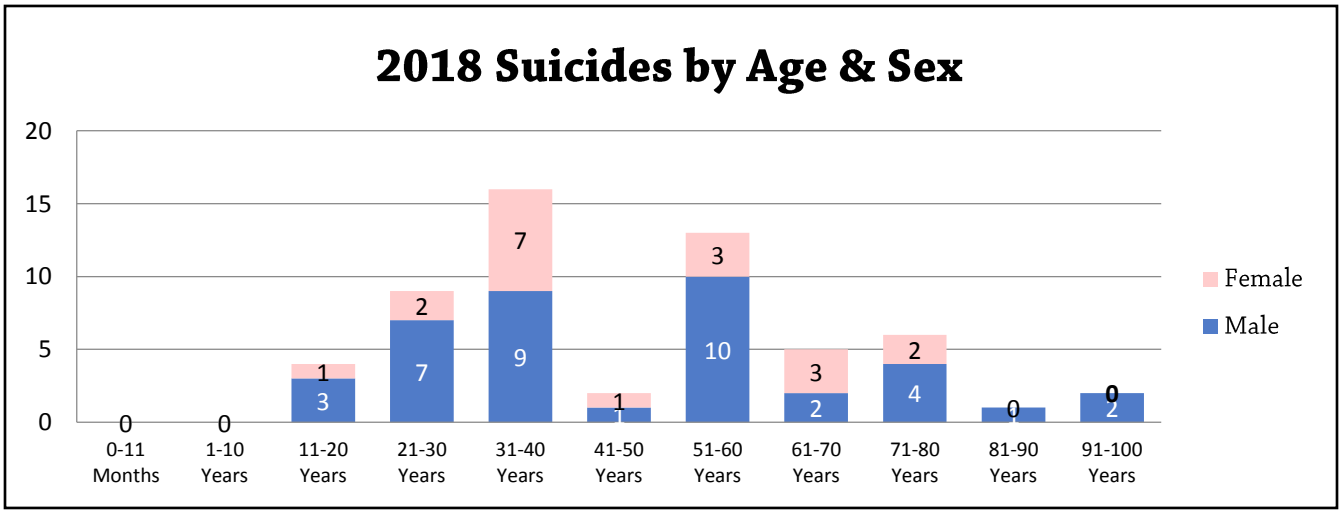
Suicide Injury Classifications	
Fall:	22
Hanging	12
Gunshot:	9
Drug Overdose/Poison:	9
Asphyxia:	4
Vehicle:	1
Train:	1

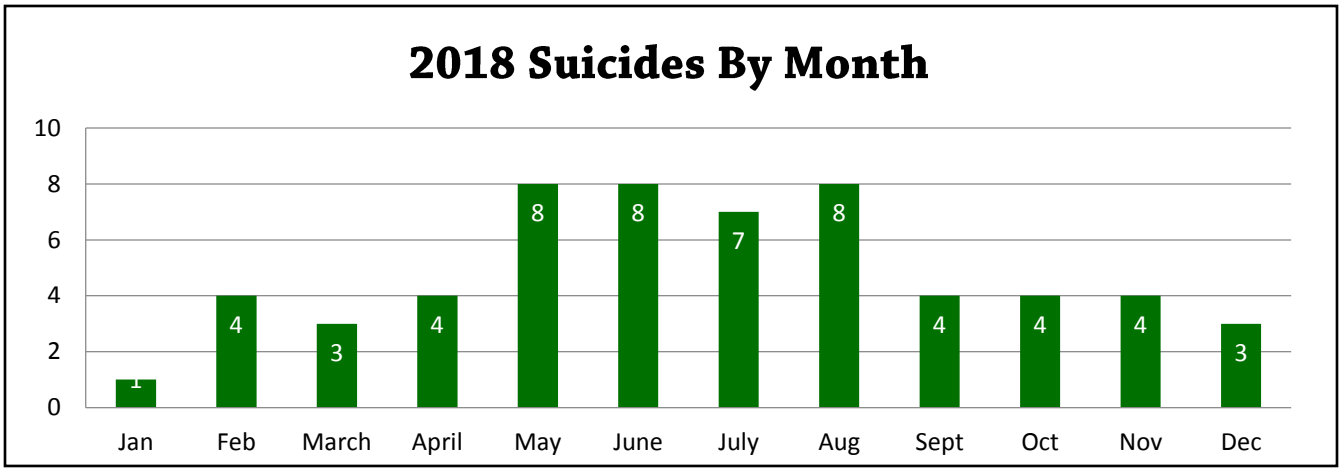
2017 Suicide by Age & Sex			
Age	**Male**	**Female**	**Total**
0-11 Months	0	0	0
1-10 Years	0	0	0
11-20 Years	3	1	4
21-30 Years	7	2	9
31-40 Years	9	7	16
41-50 Years	1	1	2
51-60 Years	10	3	13
61-70 Years	2	3	5
71-80 Years	4	2	6
81-90 Years	1	0	1
91-100 Years	2	0	2

Suicide by Month	
Month	**Number**
Jan	1
Feb	4
March	3
April	4
May	8
June	8
July	7
Aug	8
Sept	4
Oct	4
Nov	4
Dec	3

2018 Suicide Deaths







2018 Homicide Deaths

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.

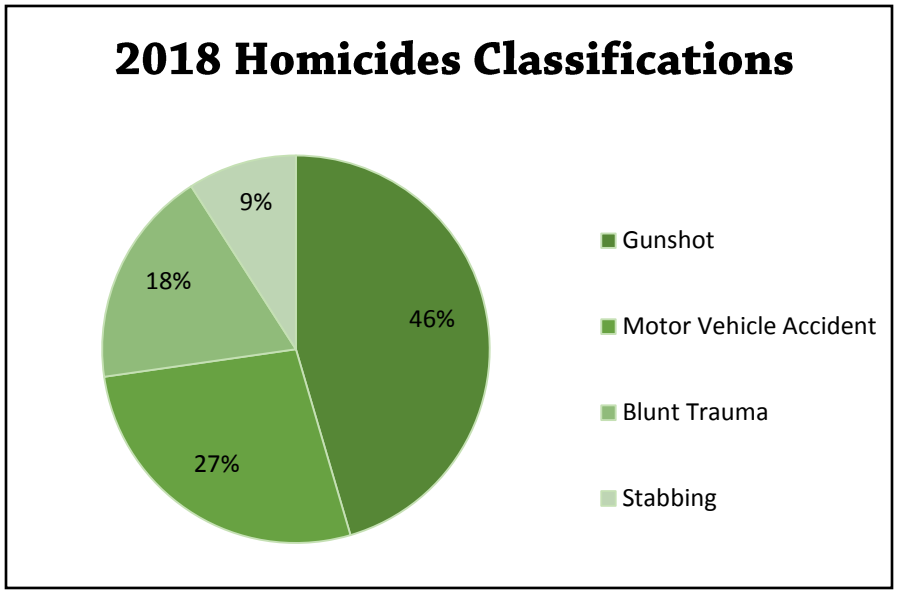
Total Homicide Deaths: 11

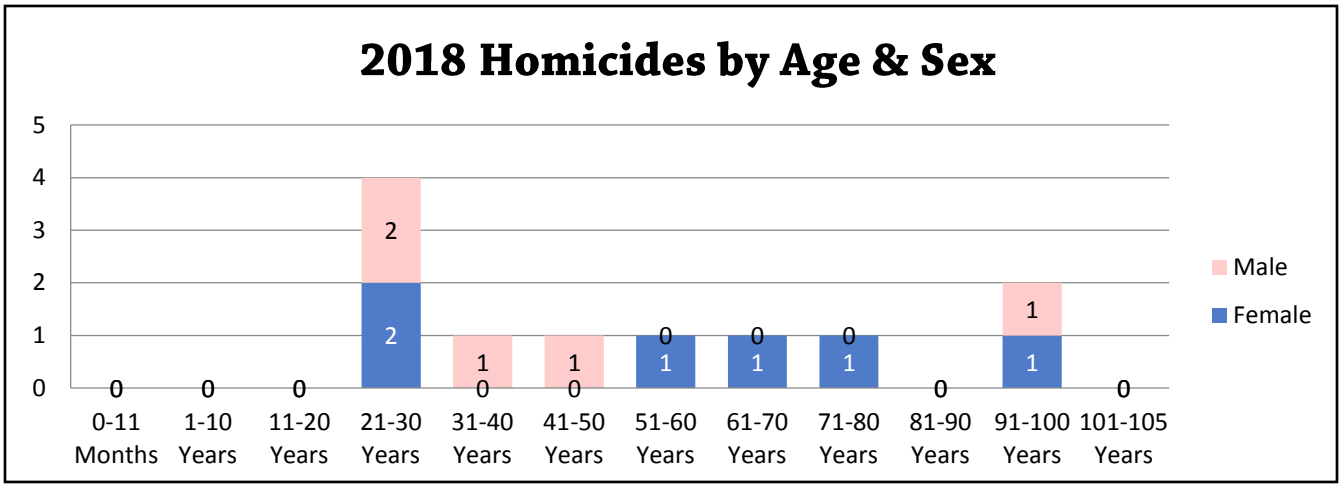
Types of Homicides	
Gunshot	5
Motor Vehicle Accident	3
Blunt Trauma	2
Stabbing	1

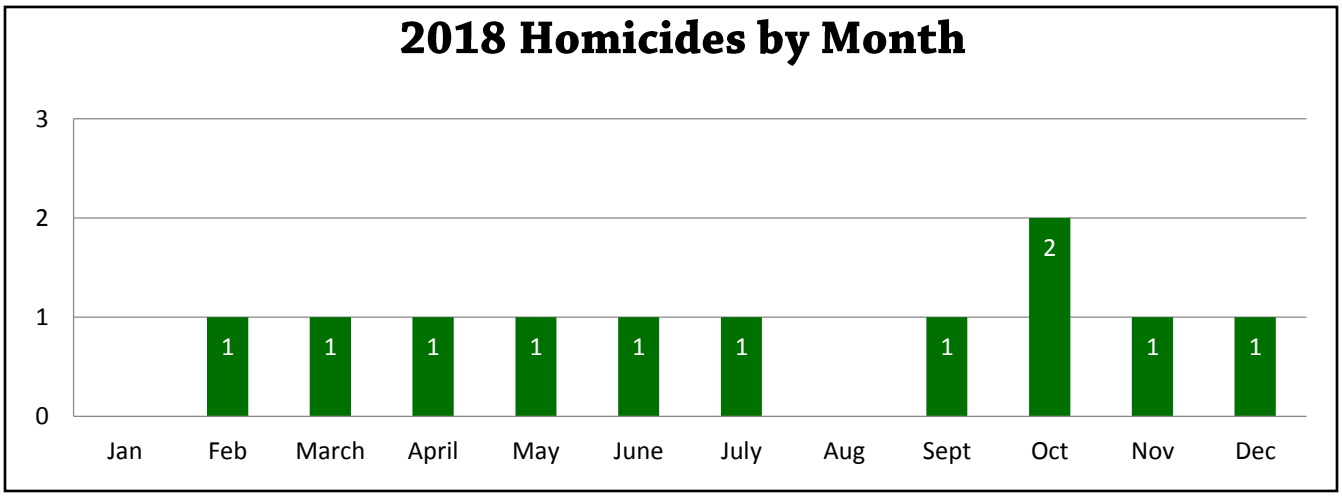
Homicides by Age and Sex			
Age	**Male**	**Female**	**Total**
0-11 Months	0	0	0
1-10 Years	0	0	0
11-20 Years	0	0	0
21-30 Years	2	2	4
31-40 Years	0	1	1
41-50 Years	0	1	1
51-60 Years	1	0	1
61-70 Years	1	0	1
71-80 Years	1	0	1
81-90 Years	0	0	0
91-100 Years	1	1	2

Homicides by Month	
Month	**Number**
Jan	0
Feb	1
March	1
April	1
May	1
June	1
July	1
Aug	0
Sept	1
Oct	2
Nov	1
Dec	1

2018 Homicide Deaths







2018 Undetermined Deaths

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.

Many of the undetermined manners in Marin County over the last five years are associated with remains that wash ashore from ocean or bay waters. A portion of these cases displayed hallmarks found in other known Golden Gate Bridge jumper scenarios. However, subsequent investigations were unable to confirm these suspicions and therefore the manner was 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.

Total Undetermined Deaths: 2

Scenario Types Related to Undetermined Manners of Death	
Human Bones found	1
Mechanism of Injury Unknown	1

2018 Primary Medical Doctor Sign-Outs

These cases are initially investigated by the Coroner's Division and ultimately deemed natural deaths. Decedents under this category have documented medical history and a civilian physician is authorized to provide cause of death.

Although initially investigated by the Coroner, their causes and manners of death are not included in our final statistics, as an outside physician provided the cause of death.

Total PMD Sign-Out Cases: 21

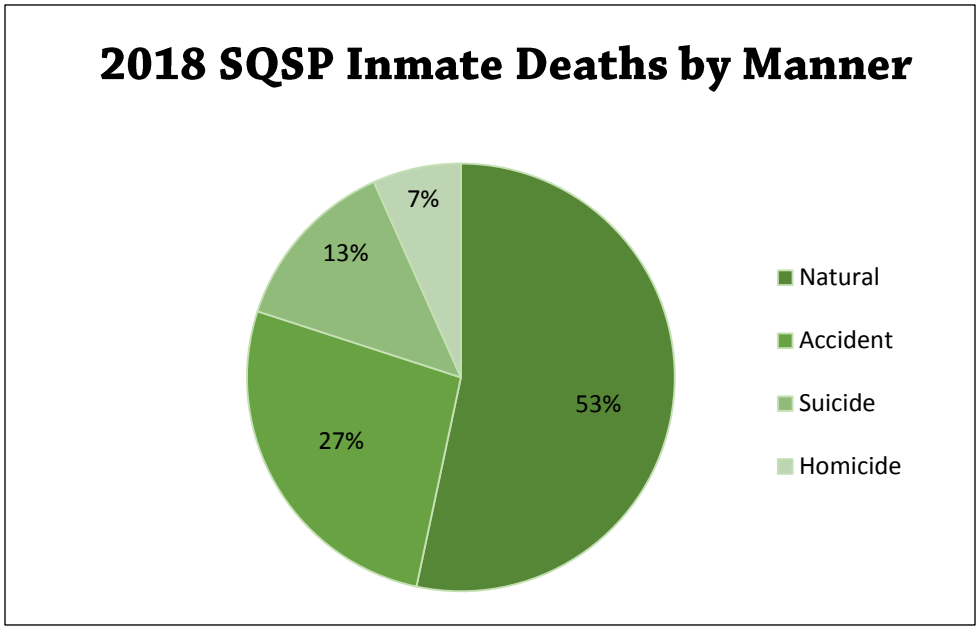
Deaths by Month	
Month	**Number**
Jan	0
Feb	3
March	3
April	2
May	2
June	2
July	1
Aug	1
Sept	3
Oct	2
Nov	1
Dec	1

2018 In-Custody Deaths

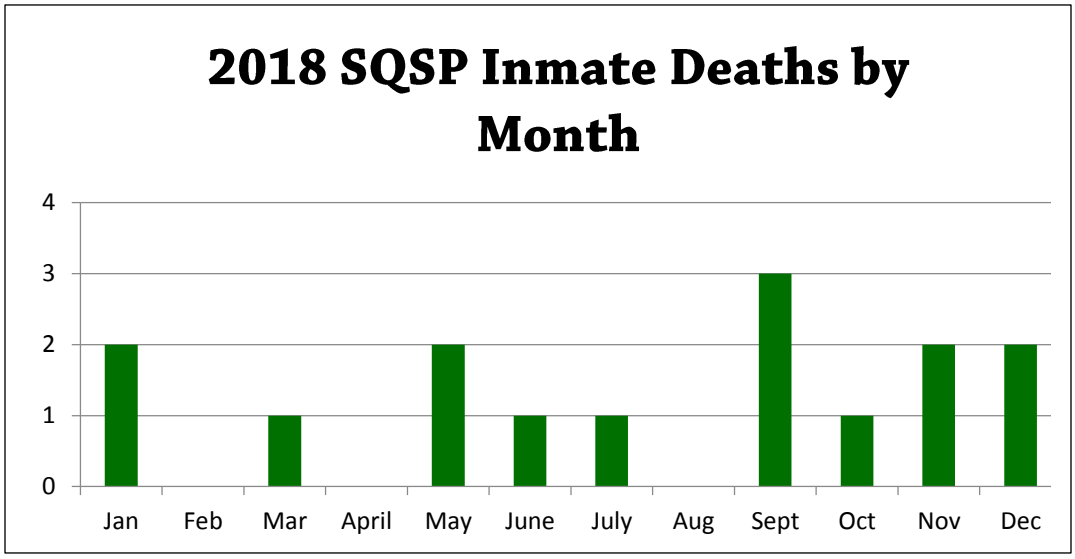
The Coroner Division investigates all in custody deaths which occur at San Quentin State Penitentiary. All deaths occurring at the Marin County Jail are investigated by the Sonoma County Sheriff-Coroner's Office to avoid the potential for bias. When requested, the Marin County Sheriff Coroner Division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

Total San Quentin Deaths: 15

San Quentin In-Custody Deaths	
Manner	**Amount**
Natural	8
Accident	4
Suicide	2
Homicide	1



San Quentin Deaths by Month	
Month	**Number**
Jan	2
Feb	0
Mar	1
April	0
May	2
June	1
July	1
Aug	0
Sept	3
Oct	1
Nov	2
Dec	2



2018 Indigent Disposition Program Statistics

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 and/or the presence of living relatives.

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

Due to the Coroner Division Due Diligence in locating family and/or a Public Administrator's Office handling the case, Marin County saved approximately 4,800.

Total Number of Inquires Made: 17

Outcome of Inquiries	
Family Proceeded with Arrangements	4
Public Administrator Accepted Case	1
Sonoma County Coroner Division Accepted Case	1
Marin County Coroner Division Accepted Case	11

Outcome of Cases Handled by the Coroner Division	
Decedent Abandoned by Family	4
Decedent has No NOK and Were Truly Insolvent	7