Marin County Sheriff's Office
Coroner Division
Five Year Report
2011-2015

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, located at 1600 Los Gamos Drive, Suite 205 in San Rafael, consisted of one Lieutenant, four Coroner Investigators, one Extra Hire Investigator, one Forensic Pathologist, one Forensic Technician, three Office Assistant Extra Hires and two part-time volunteer interns as of March 2016.

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.

Marin County has a population of 254,007 (Census Bureau 2013). The average number of deaths recorded in Marin County from 2011 to 2015 was 1,963. Of these, an average of 3,979 were reported to the Sheriff's Office, Coroner's Division. These deaths were reported pursuant to California Government Code Section 27491 and California Health and Safety Code Section 102850 which direct the Coroner to inquire into and determine the circumstances, manner and cause of those deaths. After initial investigation, 1,505 were determined to be full Coroner cases with the final cause of death signed by the Coroner, or his designated authority.

This 2011 to 2015 Five Year Report of the Coroner's Division provides a summary of the cases reported and investigated by the Marin County Sheriff's Coroner's Division and provides a statistical breakdown of the types of deaths that occurred within Marin County over the past five years.

Current Marin County Sheriff-Coroner Staff

Sheriff Robert T. Doyle	**Sheriff-Coroner**
Undersheriff Michael Ridgway	**Undersheriff**
Captain Doug Endy	**Captain**
Darrell Harris	**Chief Deputy Coroner**
Emily Schum	**Coroner Investigator**
Kenneth Advincula	**Coroner Investigator**
Roger Fielding	**Coroner Investigator**
Sandra Potter	**Coroner Investigator**
Stewart Cowan	**Deputy Sheriff, Extra Hire**
Doctor Joseph Cohen	**Forensic Pathologist, Contracted**
Alex Torres	**Forensic Technician, Contracted**
Marilyn Kwuan	**Office Assistant, Extra Hire**
Alex Torres	**Office Assistant, Extra Hire**
Emily Morris	**Intern**
Jaclyn Vaishville	**Intern**

Reportable Criteria
Part 1 of 3

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 would be a rest home patient who is routinely seen once a month but would die

Reportable Criteria
Part 2 of 3

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.

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

Reportable Criteria
Part 3 of 3

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)

Totals for 2011-2015

Number of deaths reported:	~3,979
Number of cases for full investigation:	1,505
Number of cases by manner of death:	
Natural	570
Accident (including Motor Vehicle Fatalities)	549
Suicide	315
Homicide	19
Undetermined	38
Pending	14
Number of decedents transported:	1,311
***Some cases moved to Napa and back to Marin**	
Forensic Examinations	
Autopsy	593
External Examination	434
Medical File Review	418
Number of toxicology cases conducted:	630

Historical Statistics from 2011-2015

Coroner Case Statistics for 2011 by Month							
	Natural	Accident	Suicide	Homicide	Undetermined	Pending	Total
Jan.	24	6	10	0	1	0	41
Feb.	12	5	3	0	1	0	21
Mar.	14	6	6	0	0	0	26
Apr.	11	6	2	0	0	0	19
May	7	6	12	1	0	0	26
June	8	8	3	0	0	0	19
July	15	8	5	0	0	0	28
Aug.	11	5	6	0	0	0	22
Sept.	8	11	5	1	0	0	25
Oct.	8	2	3	0	0	0	13
Nov.	11	14	1	0	1	1	28
Dec.	8	8	5	0	0	0	21
Total	137	85	61	2	3	1	289
%	47%	29%	21%	0.7%	1%	0.3%	100%

Coroner Case Statistics for 2012 by Month							
	Natural	Accident	Suicide	Homicide	Undetermined	Pending	Total
Jan.	13	7	6	1*	0	0	27
Feb.	11	7	5	0	0	0	23
Mar.	10	14	2	0	1	0	27
Apr.	13	10	5	0	1	0	29
May	8	13	6	0	0	0	27
June	15	8	4	0	1	0	28
July	11	14	3	0	1	0	29
Aug.	10	17	9	0	0	1	37
Sept.	5	9	4	0	1	0	19
Oct.	9	7	4	0	0	2	22
Nov.	10	12	5	0	0	1	28
Dec.	10	18	7	0	0	3	38
Total	125	136	60	1	5	7	334
%	37%	41%	18%	0.3%	1%	2%	100%

*2012 Homicide was a result of injuries sustained during a violent crime in Oakland, CA. The case was turned over to Alameda County and classified as a homicide by them.

Historical Statistics from 2011-2015

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
Mar.	9	11	4	0	1	0	25
Apr.	8	16	9	0	0	1	34
May	11	6	2	0	1	0	20
June	11	10	4	0	1	1	27
July	5	6	8	0	1	0	20
Aug.	8	8	16	1	3	1	37
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	117	118	73	3	12	3	326
%	36%	36%	22%	1%	4%	1%	100%

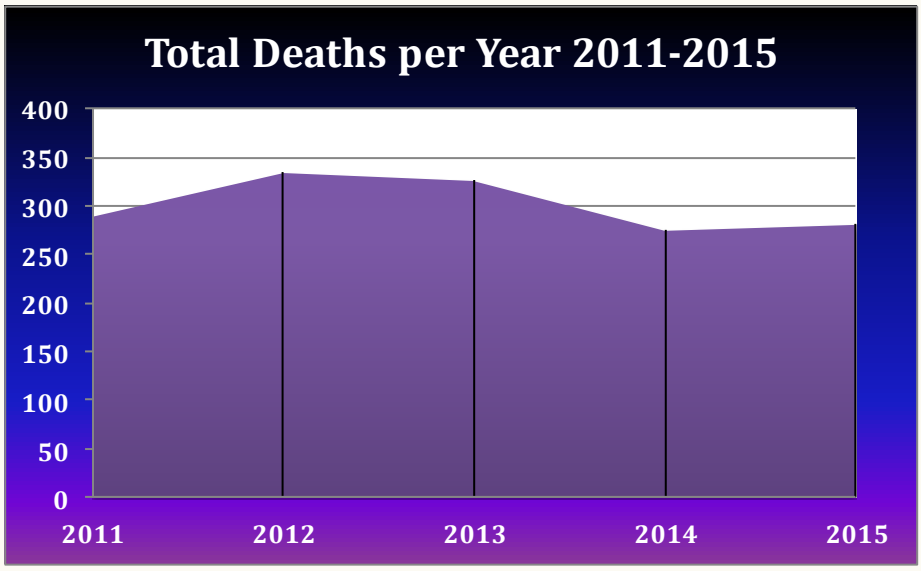
Coroner Case Statistics for 2014 by Month							
	Natural	Accident*	Suicide	Homicide	Undetermined	Pending	Total
Jan.	7	8	6	0	0	0	21
Feb.	8	4	3	0	0	0	15
Mar.	11	4	6	1	0	0	22
Apr.	5	15	7	1	0	0	28
May	8	9	5	0	1	0	23
June	10	12	6	0	0	0	28
July	6	10	7	1	0	0	24
Aug.	10	6	5	0	1	1	23
Sept.	6	4	7	0	3	0	20
Oct.	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	6	6	1	275
%	35%	36%	25%	2%	2%	0.4%	100%

Historical Statistics from 2011-2015

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	6	6	1	3	1	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.	4	12	1	0	0	1	18
Total	95	112	53	7	12	2	281
%	34%	40%	19%	2%	4%	0.7%	100%

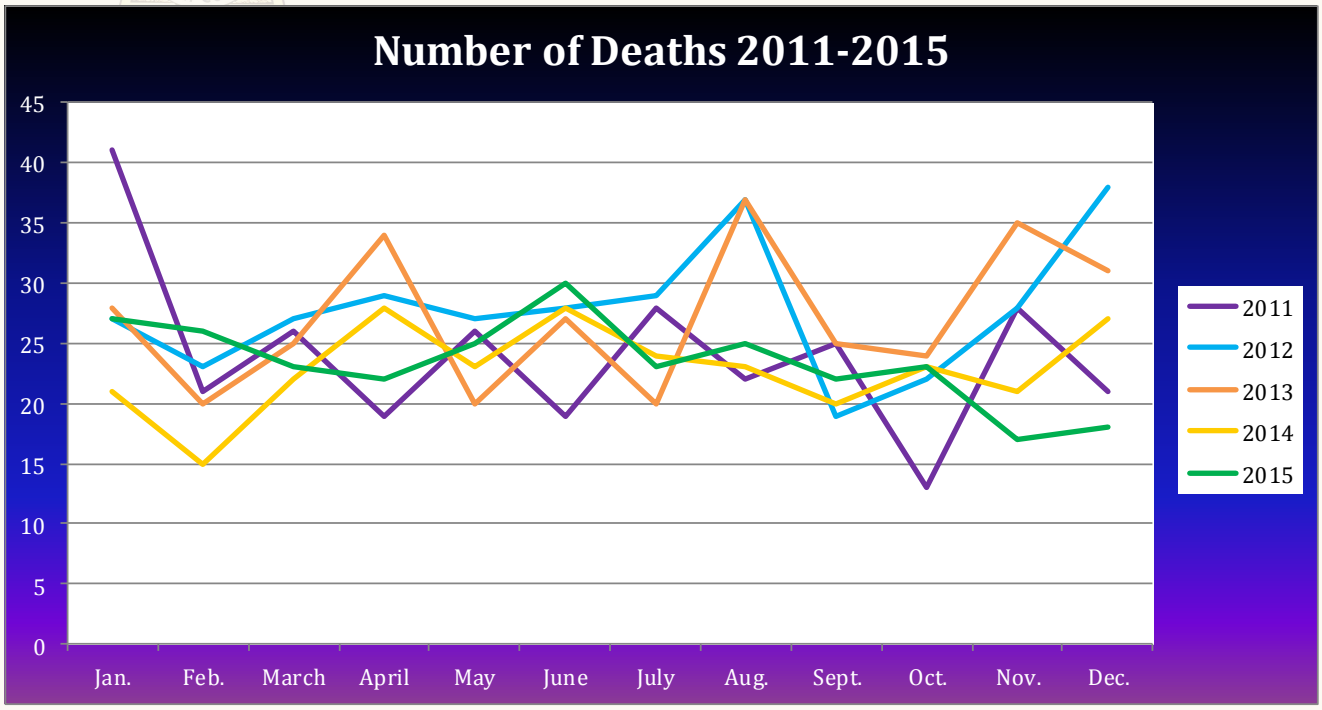
* includes motor vehicle fatalities

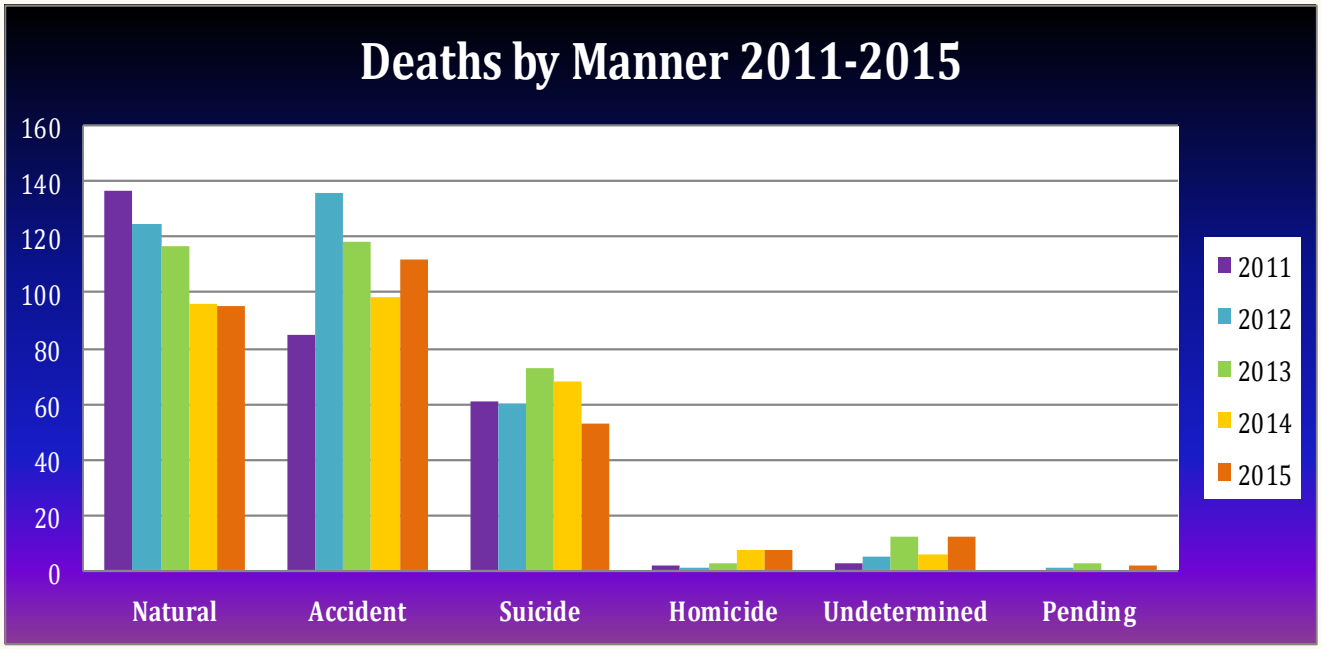
Average number of cases per year (2011-2015): 301



Average Cases by Month	
January	28.8
February	21
March	24.6
April	26.4
May	24.2
June	26.4
July	24.8
August	28.8
September	22.2
October	21
November	25.8
December	27

Manners of Death 2011 through 2015



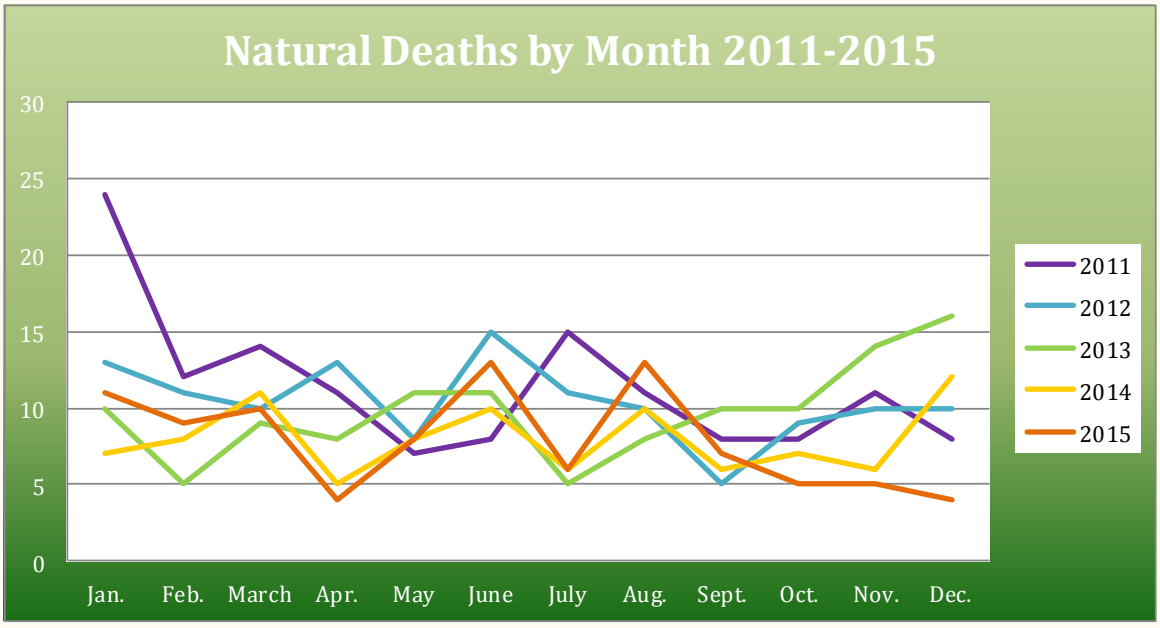


Natural Deaths in 2011-2015

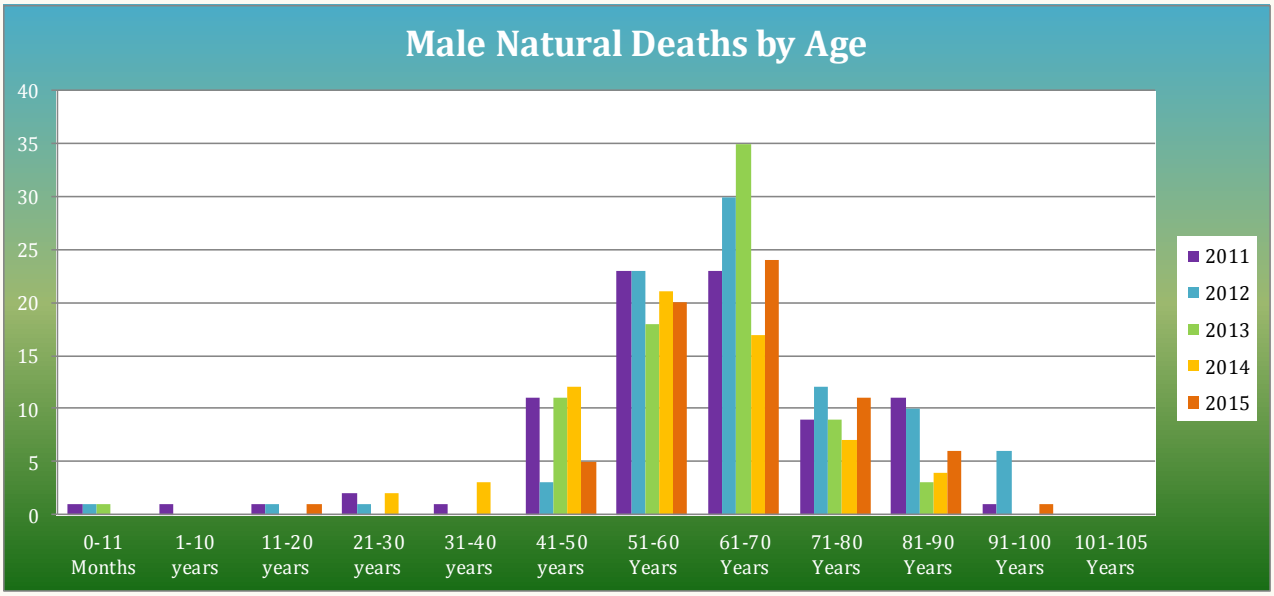
Deaths are classified as natural due to the sudden and unexpected nature of the death in an apparently healthy individual. This includes deaths by disease or by old age. If a natural death is hastened by an injury such as a fall, the manner of death is classified as an accidental instead of a natural.

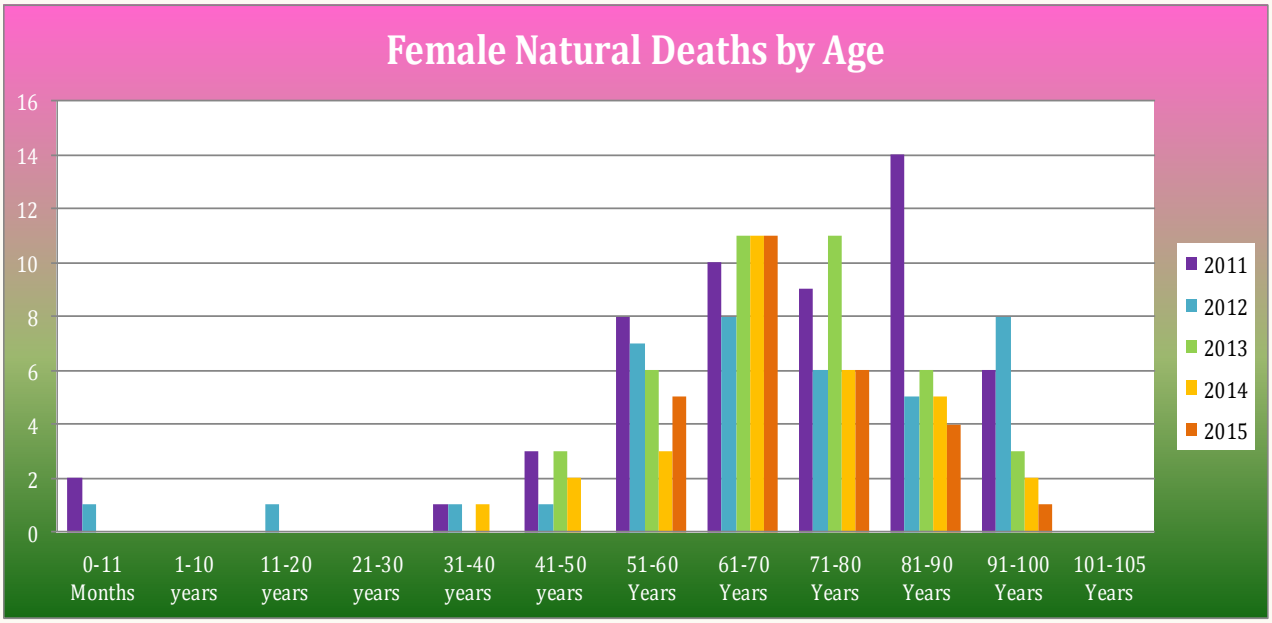
Average Number of Natural Deaths 2011-2015: 114 per year

Natural Deaths by Month 2011-2015					
	2011	2012	2013	2014	2015
Jan.	24	13	10	7	11
Feb.	12	11	5	8	9
March	14	10	9	11	10
April	11	13	8	5	4
May	7	8	11	8	8
June	8	15	11	10	13
July	15	11	5	6	6
Aug.	11	10	8	10	13
Sept.	8	5	10	6	7
Oct.	8	9	10	7	5
Nov.	11	10	14	6	5
Dec.	8	10	16	12	4
Total	137	125	117	96	95

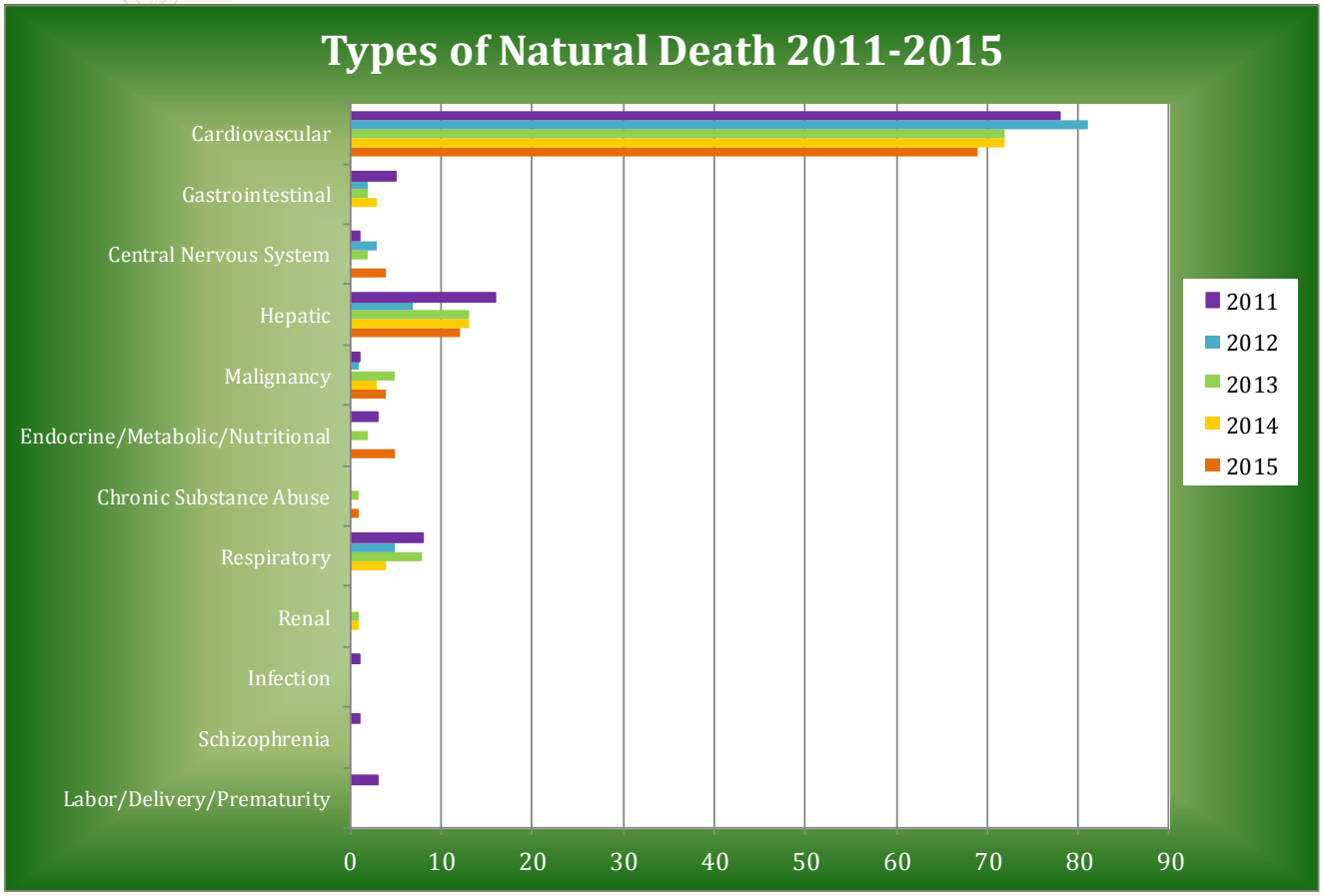


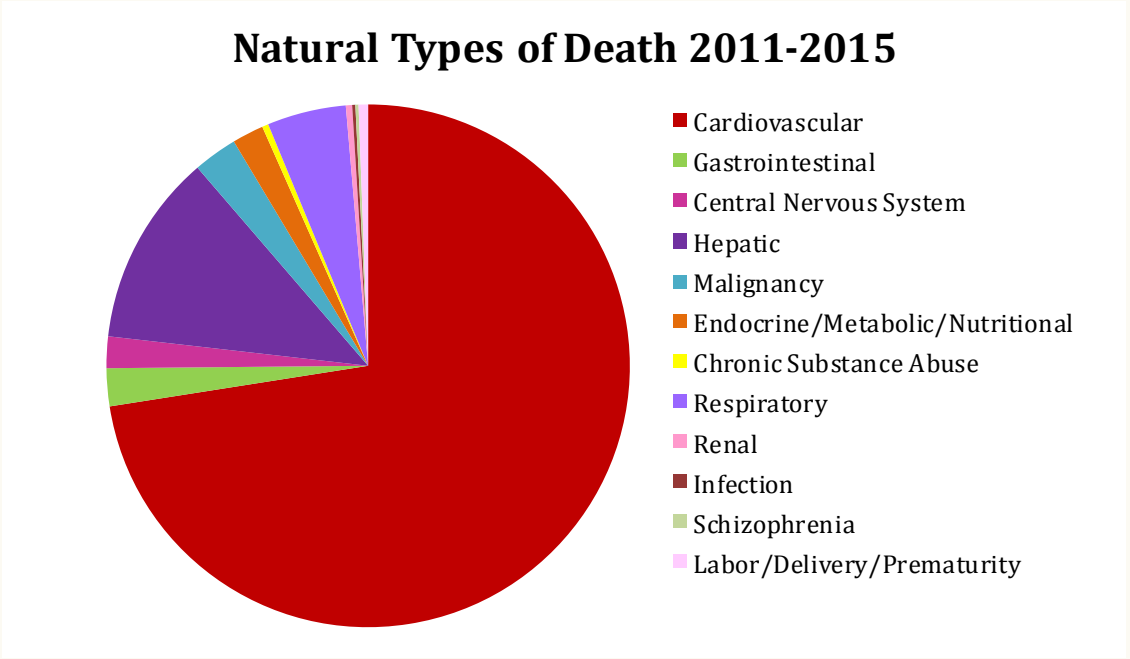
Natural Deaths by Age and Sex 2011-2015





Natural Deaths by Type 2011-2015



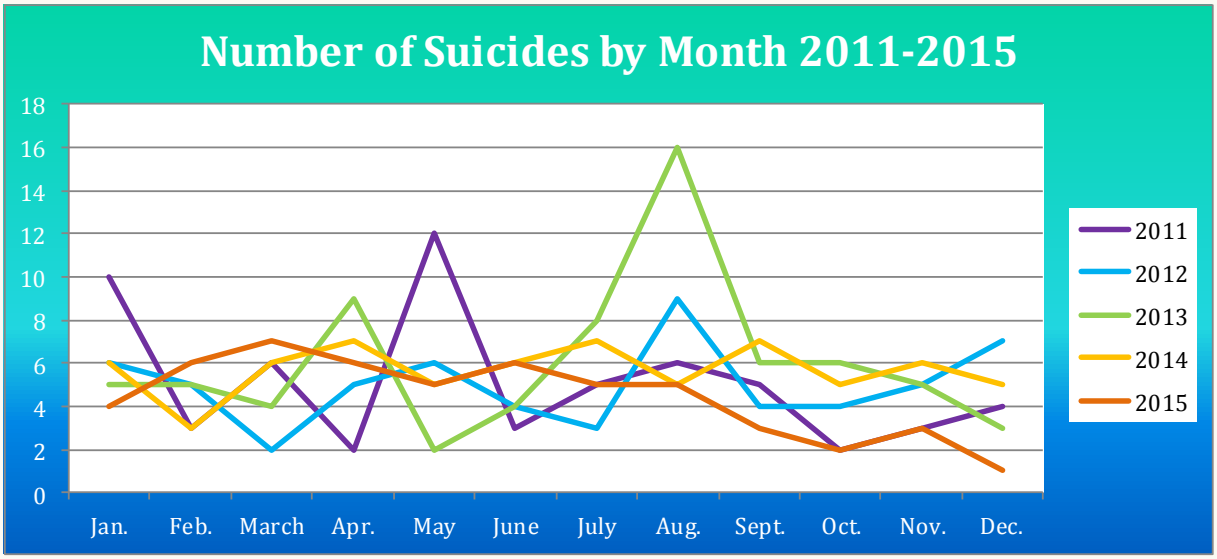


Suicide

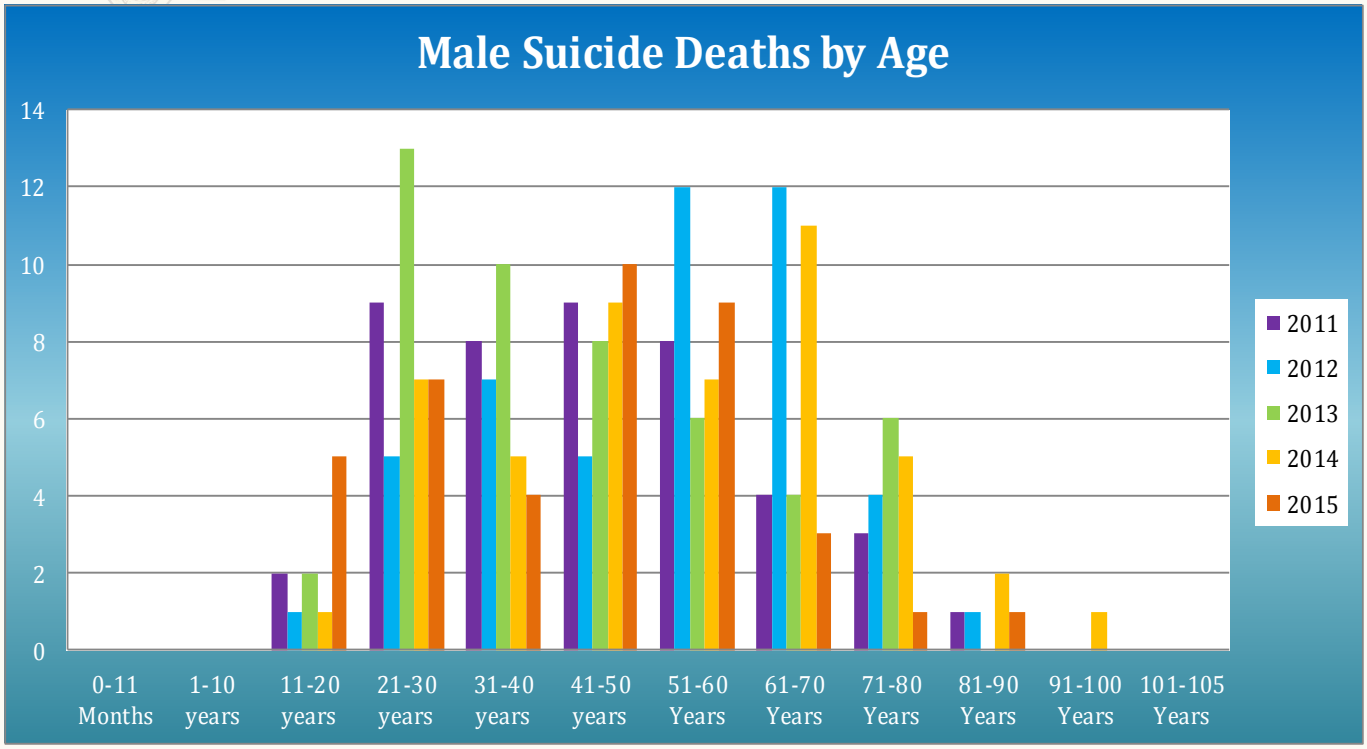
Suicides are those deaths caused by self-inflicted injuries with evidence of intent to end one's life. Evidence of intent includes an explicit expression, such as a suicide note or verbal threat, or an act constituting implicit intent such as deliberately placing a gun to one's head or rigging a vehicle exhaust.

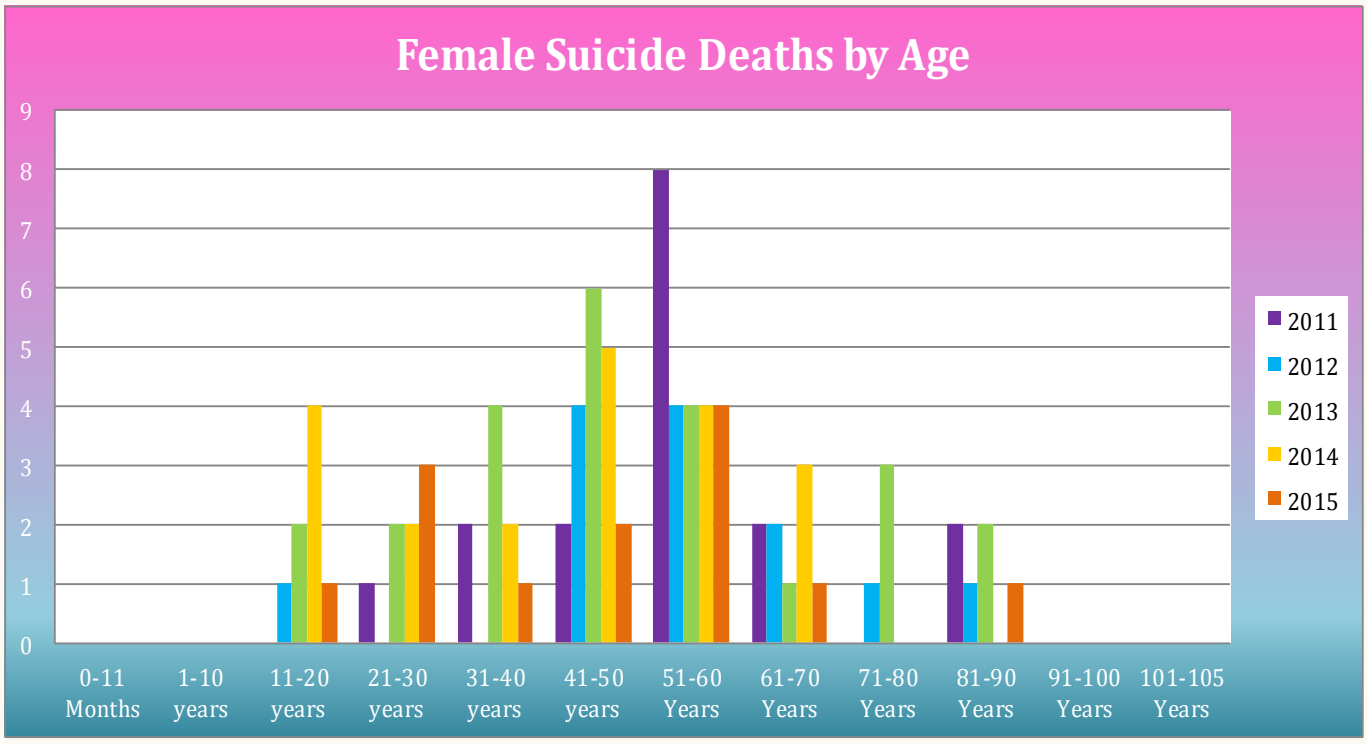
Average Number of Suicides 2011-2015: 63 per year

Suicides by Month 2011-2015					
	2011	2012	2013	2014	2015
January	10	6	5	6	4
February	3	5	5	3	6
March	6	2	4	6	7
April	2	5	9	7	6
May	12	6	2	5	5
June	3	4	4	6	6
July	5	3	8	7	5
August	6	9	16	5	5
September	5	4	6	7	3
October	2	4	6	5	2
November	3	5	5	6	3
December	4	7	3	5	1
Total	61	60	73	68	53

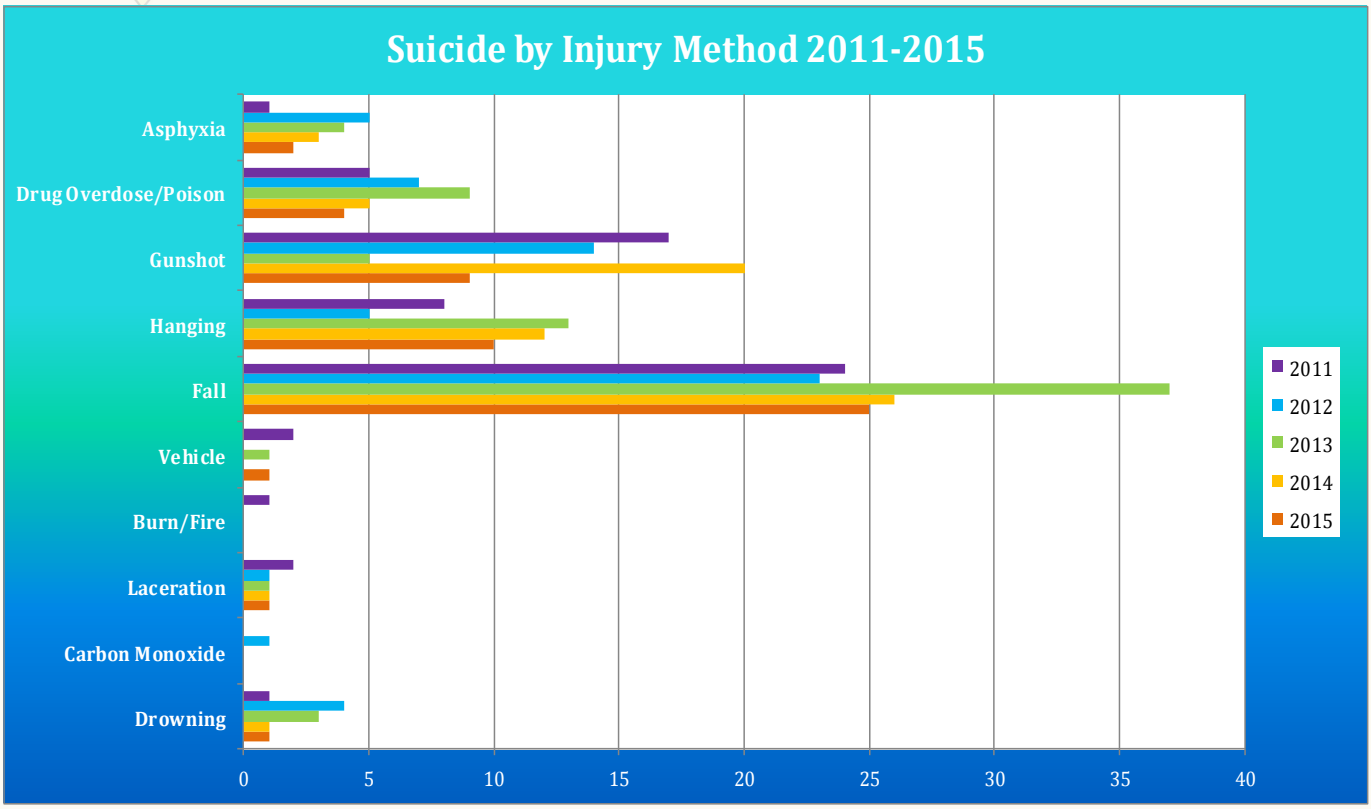


Suicide by Sex and Age

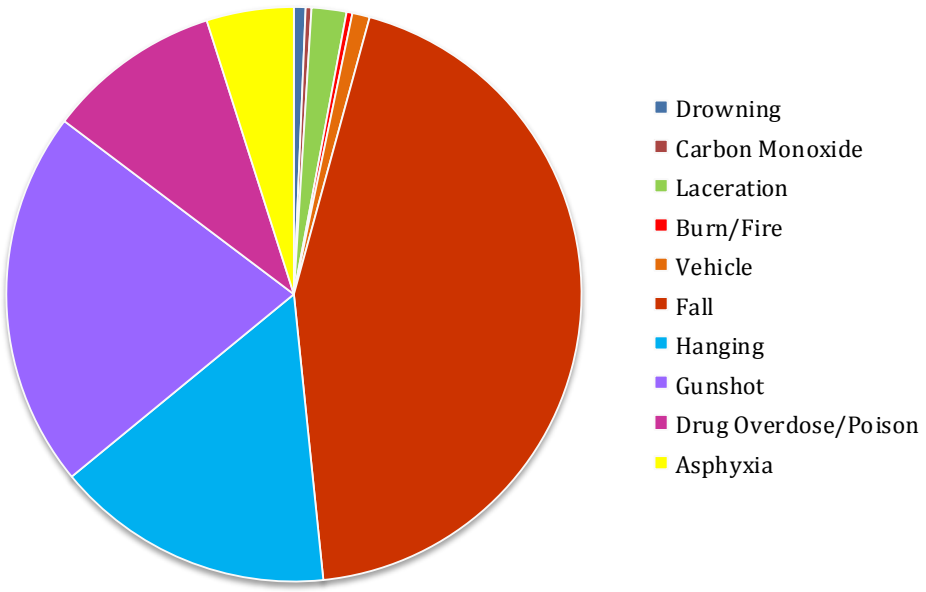


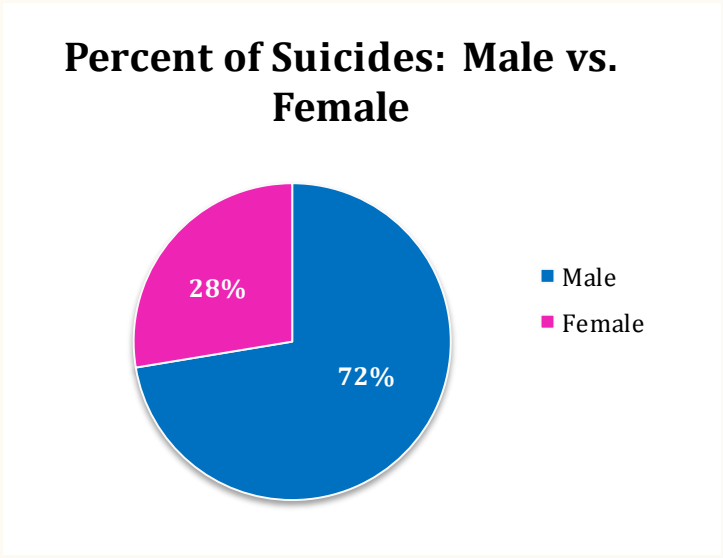


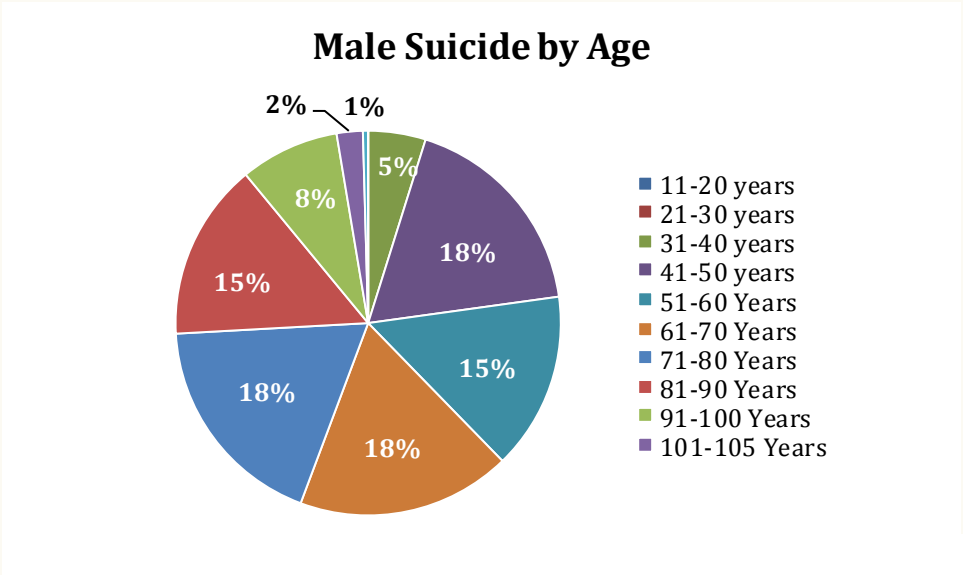
Suicide by Injury Method 2011-2015

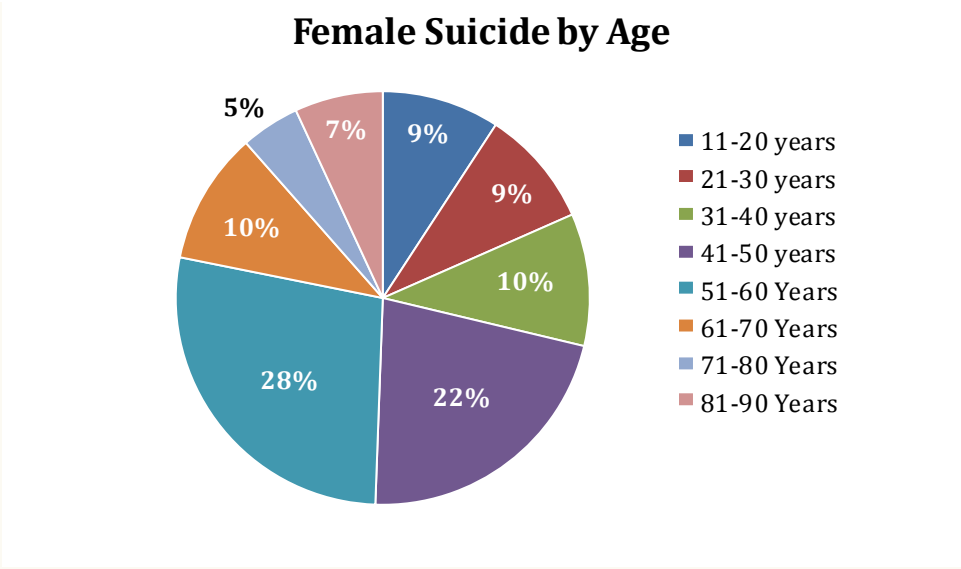


Suicides by Type 2011-2015




Percent of Suicides: Male vs. Female
28%
72%
Male
Female


Male Suicide by Age
2%
1%
5%
8%
18%
15%
18%
15%
18%
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
101-105 Years


Female Suicide by Age
5%
7%
9%
9%
10%
10%
28%
22%
11-20 years
21-30 years
31-40 years
41-50 years
51-60 Years
61-70 Years
71-80 Years
81-90 Years

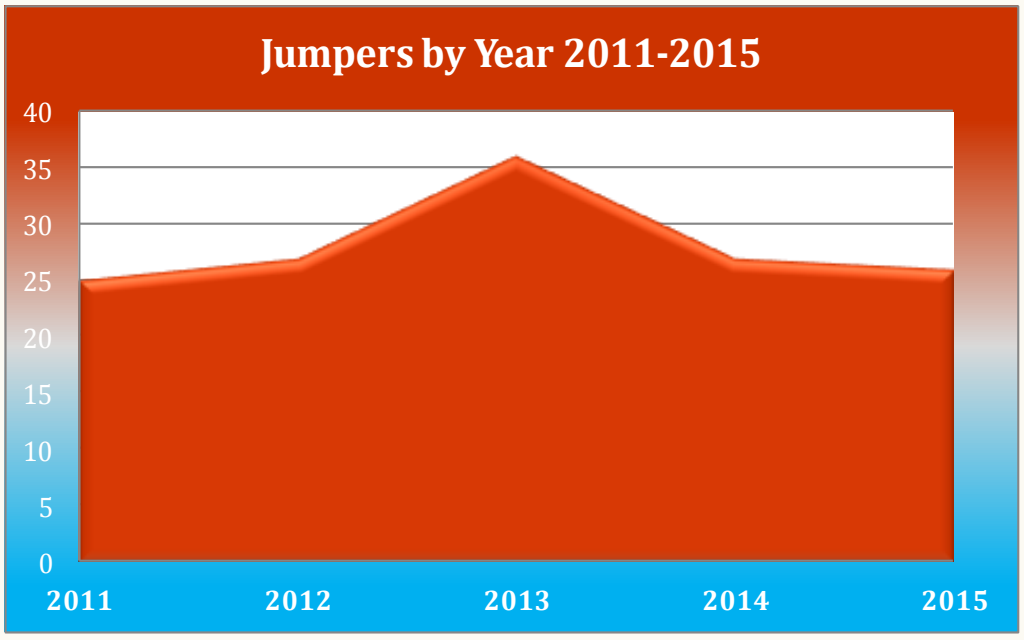
Golden Gate Bridge Jumpers 2011-2015

Average Number of Bridge Jumpers 2011-2015: 28 per year*

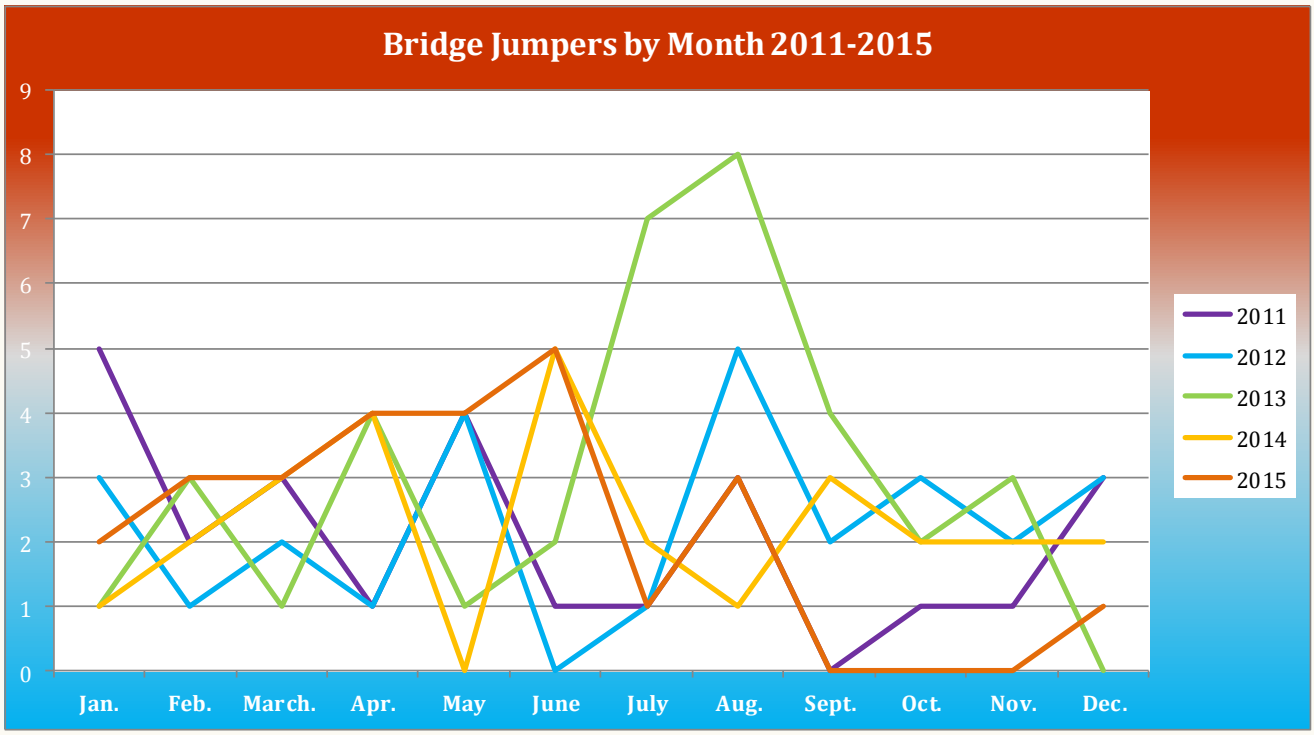
***includes 3 from the Richmond/San Rafael Bridge**

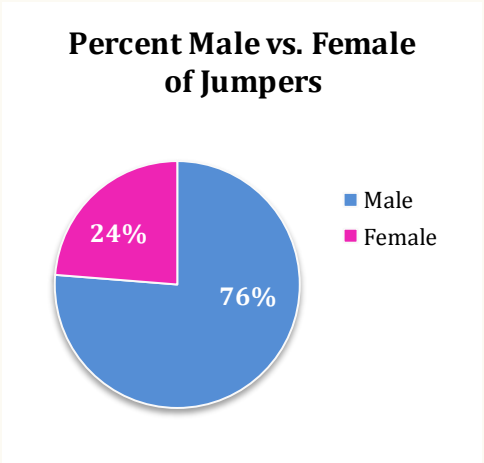
Bridge Jumpers by Month					
	2011	2012	2013	2014	2015
January	5	3	1	1	2
February	2	1	3	2	3
March	3	2	1	3	3
April	1	1	4	4	4
May	4	4	1	0	4
June	1	0	2	5	5
July	1	1	7	2	1
August	3	5	8	1	3
September	0	2	4	3	0
October	1	3	2	2	0
November	1	2	3	2	0
December	3	3	0	2	1
Total	25	27	36*	27	26**

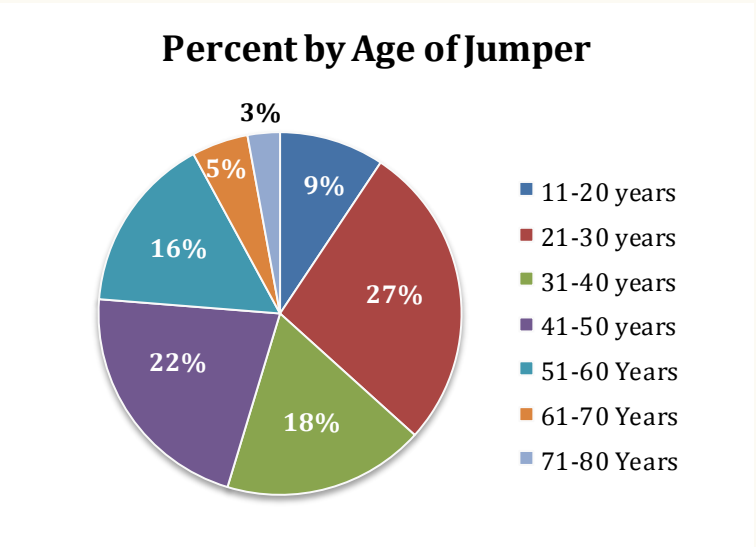
*Includes 1 jumper from the Richmond/San Rafael Bridge
**Includes 2 jumpers from the Richmond/San Rafael Bridge



Bridge Jumpers 2011-2015*

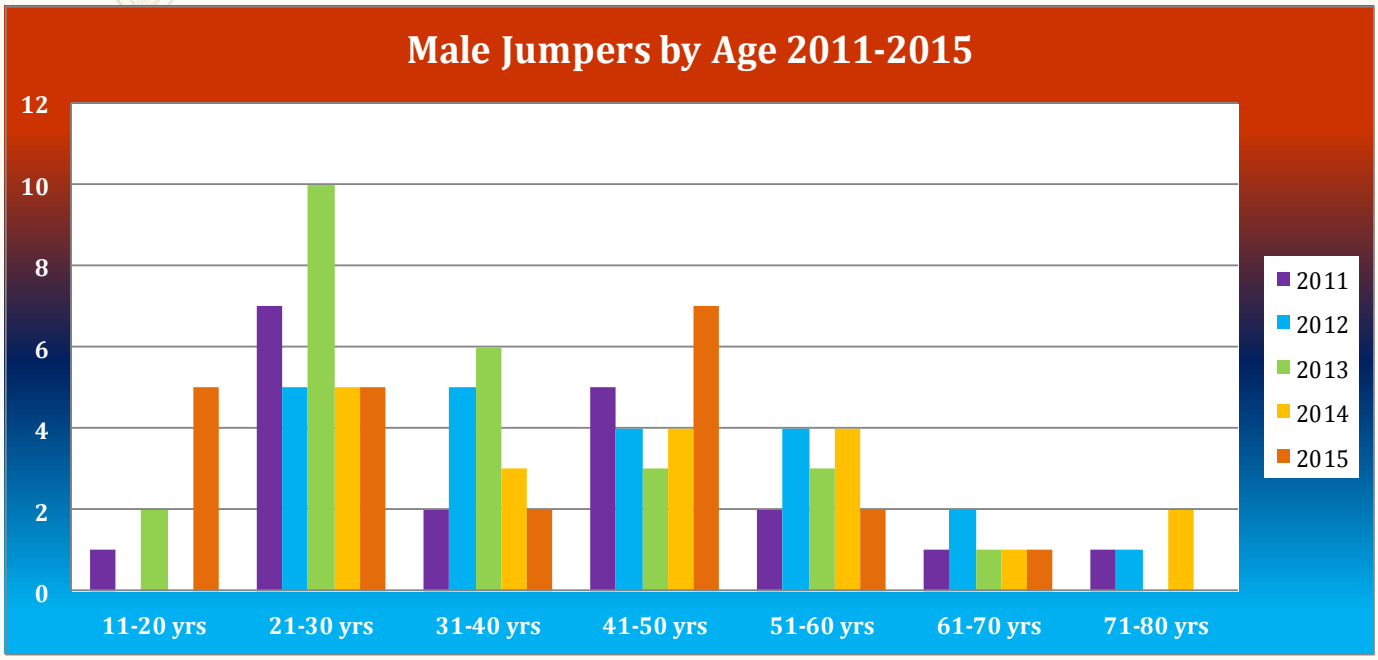


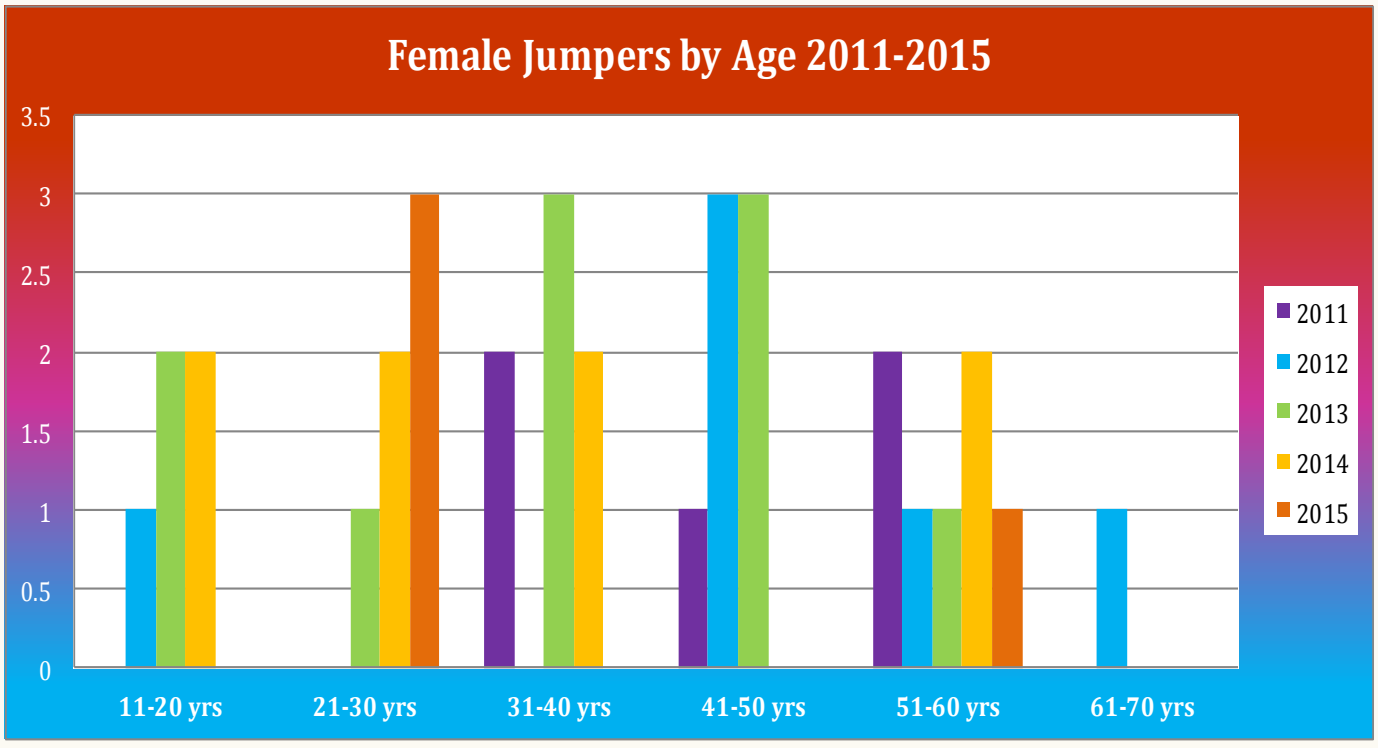




*All data includes 3 jumpers from the Richmond/San Rafael Bridge

Golden Gate Bridge Jumpers 2011-2015





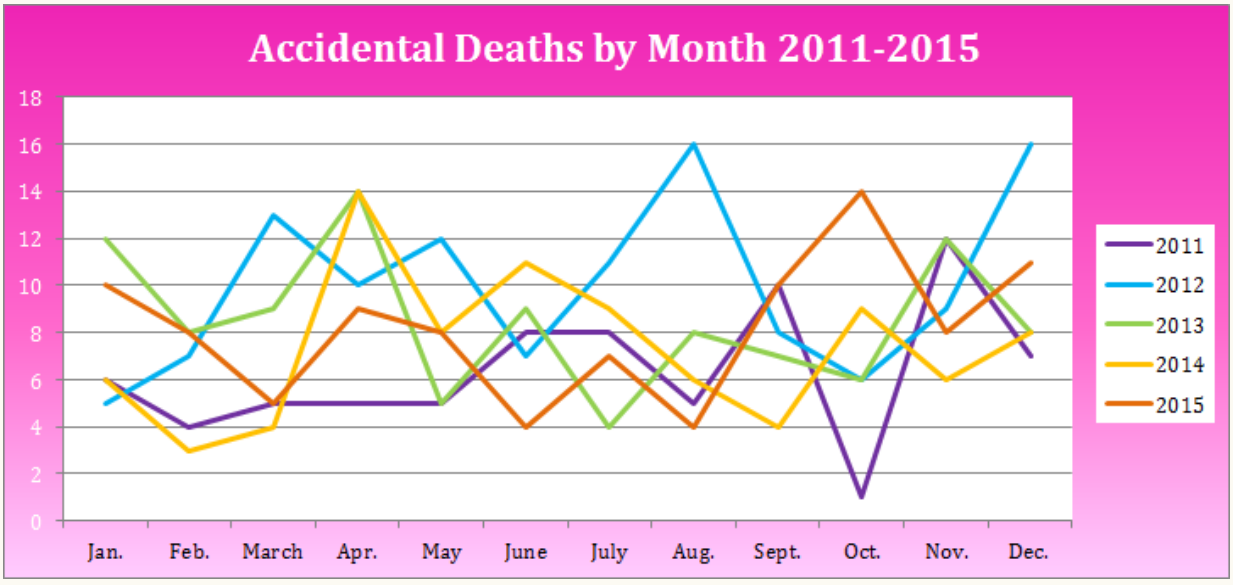
*All data includes 3 jumpers from the Richmond/San Rafael Bridge

Accidental Deaths in 2015

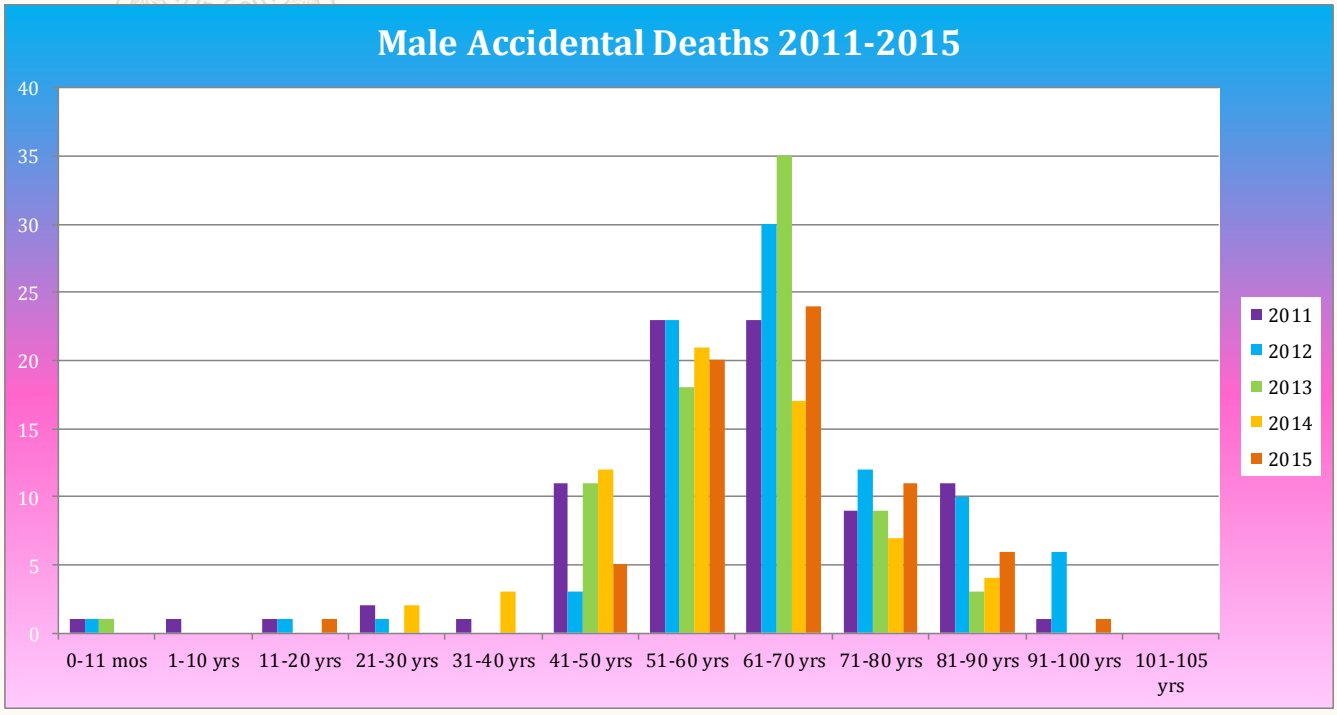
An accidental death is a death, other than natural, where there is no evidence of intent.
Motor Vehicle Accidents are not included in the statistics below.

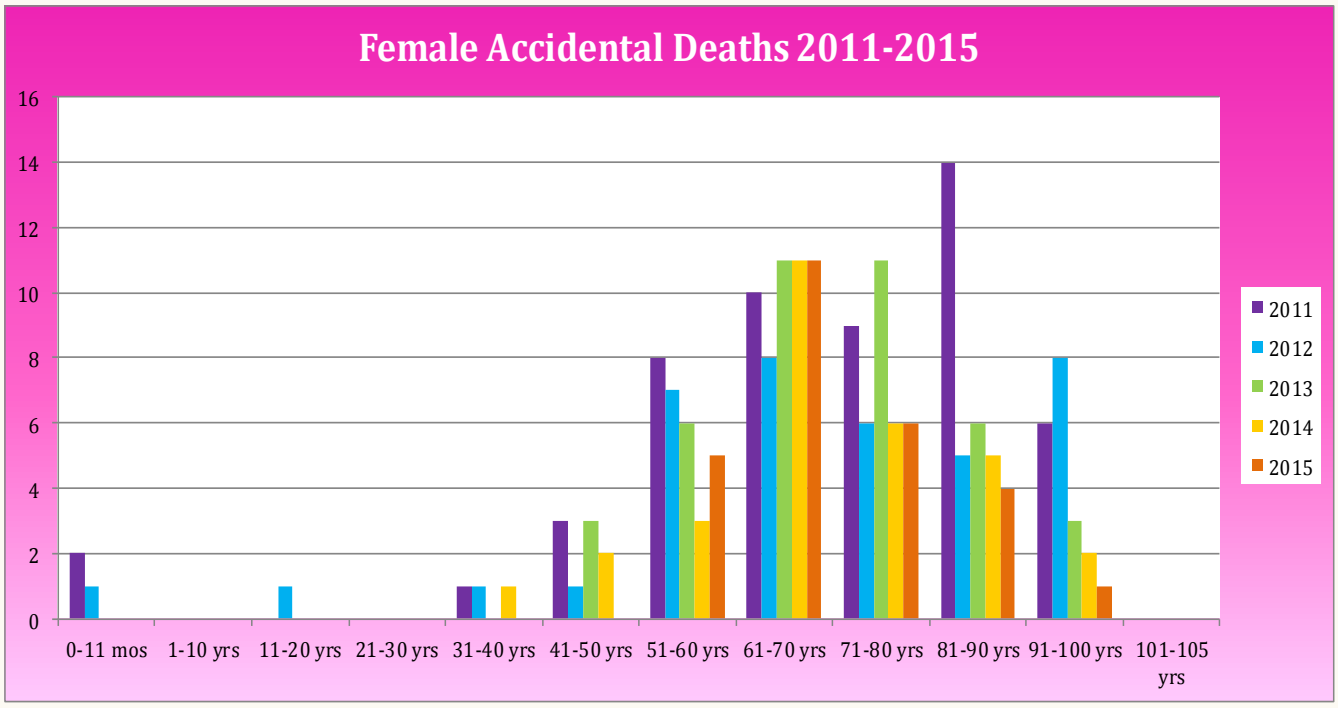
Average number of Accidental deaths per year 2011-2015*= 97
*not including automobile accidents

	2011	2012	2013	2014	2015
January	6	5	12	6	10
February	4	7	8	3	8
March	5	13	9	4	5
April	5	10	14	14	9
May	5	12	5	8	8
June	8	7	9	11	4
July	8	11	4	9	7
August	5	16	8	6	4
September	10	8	7	4	10
October	1	6	6	9	14
November	12	9	12	6	8
December	7	16	8	8	11
Total	76	120	102	88	98

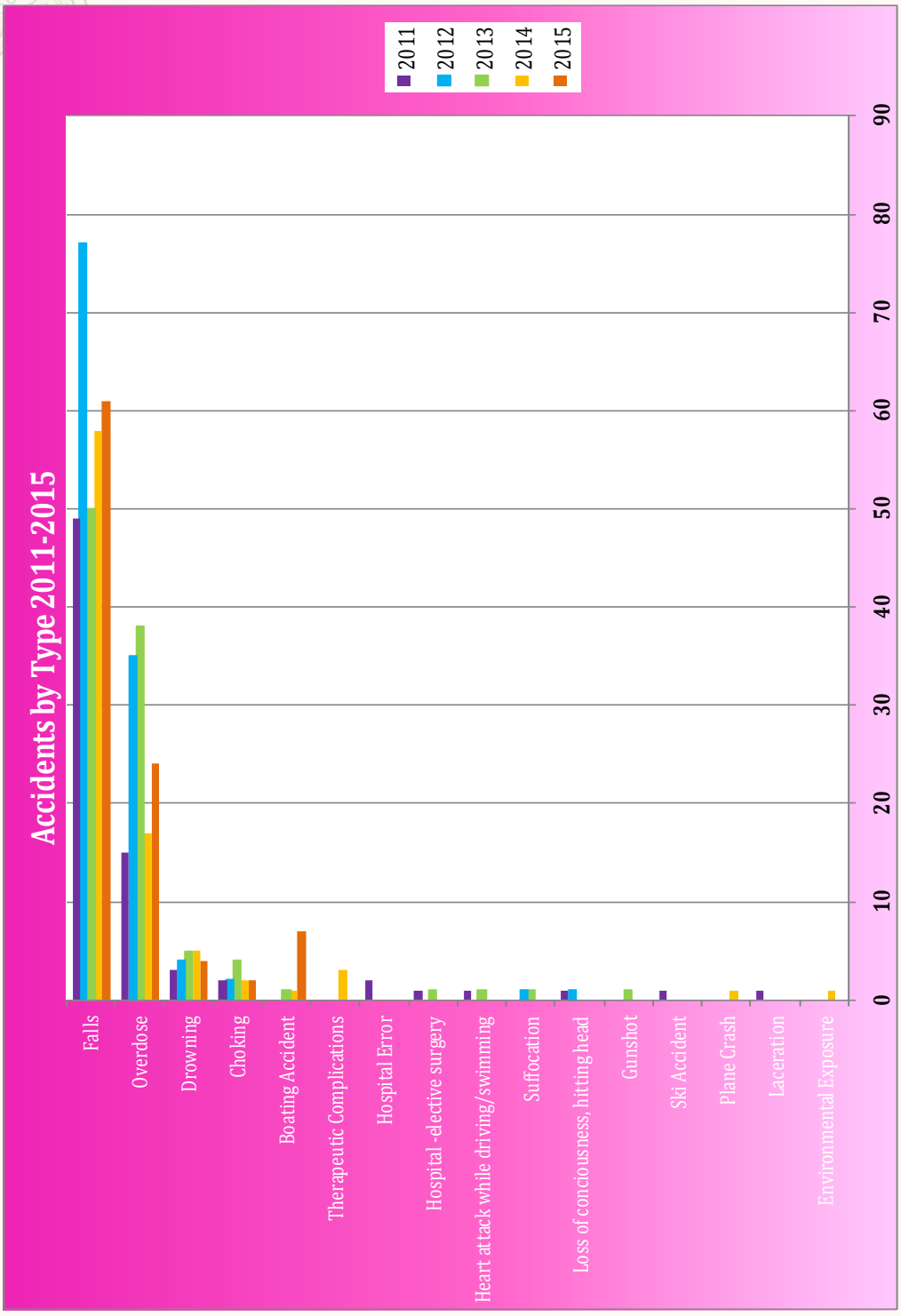


Accidental Deaths in 2011-2015





Breakdown of Accidental Deaths by Type of Accident in 2011-2015

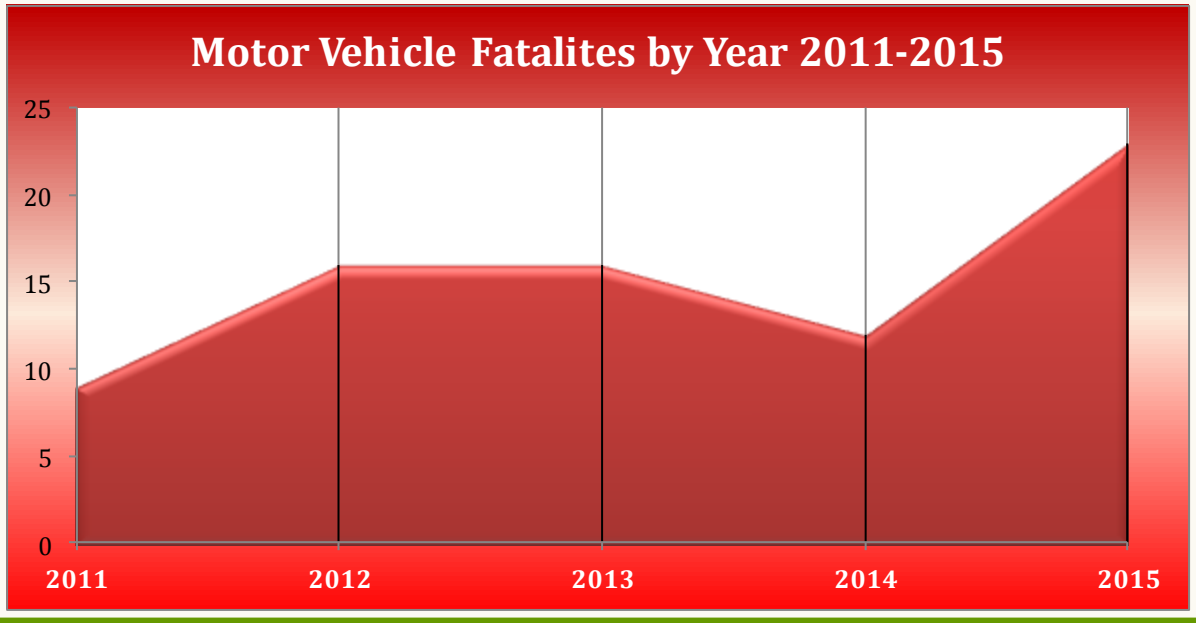


Motor Vehicle Fatalities in 2011-2015

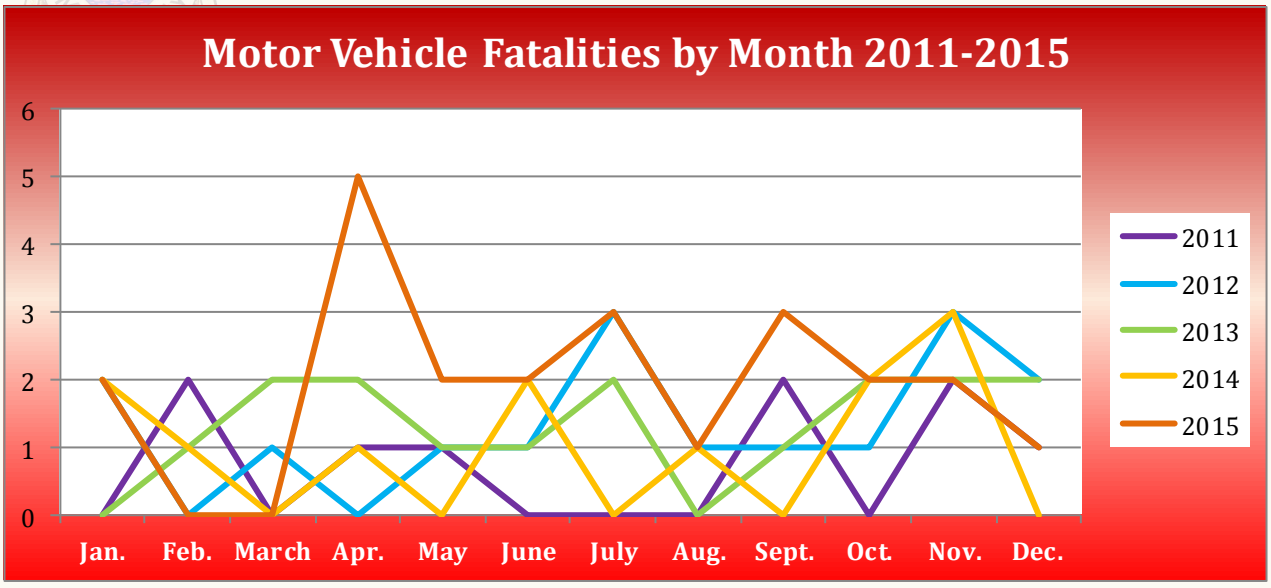
The Coroner Division, as well as other law enforcement agencies within the jurisdiction of the motor vehicle fatality, conducts a thorough investigation of any accident involving a motor vehicle. A suspected traffic fatality can sometimes be the end result of natural causes which, in many cases, can be determined 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.

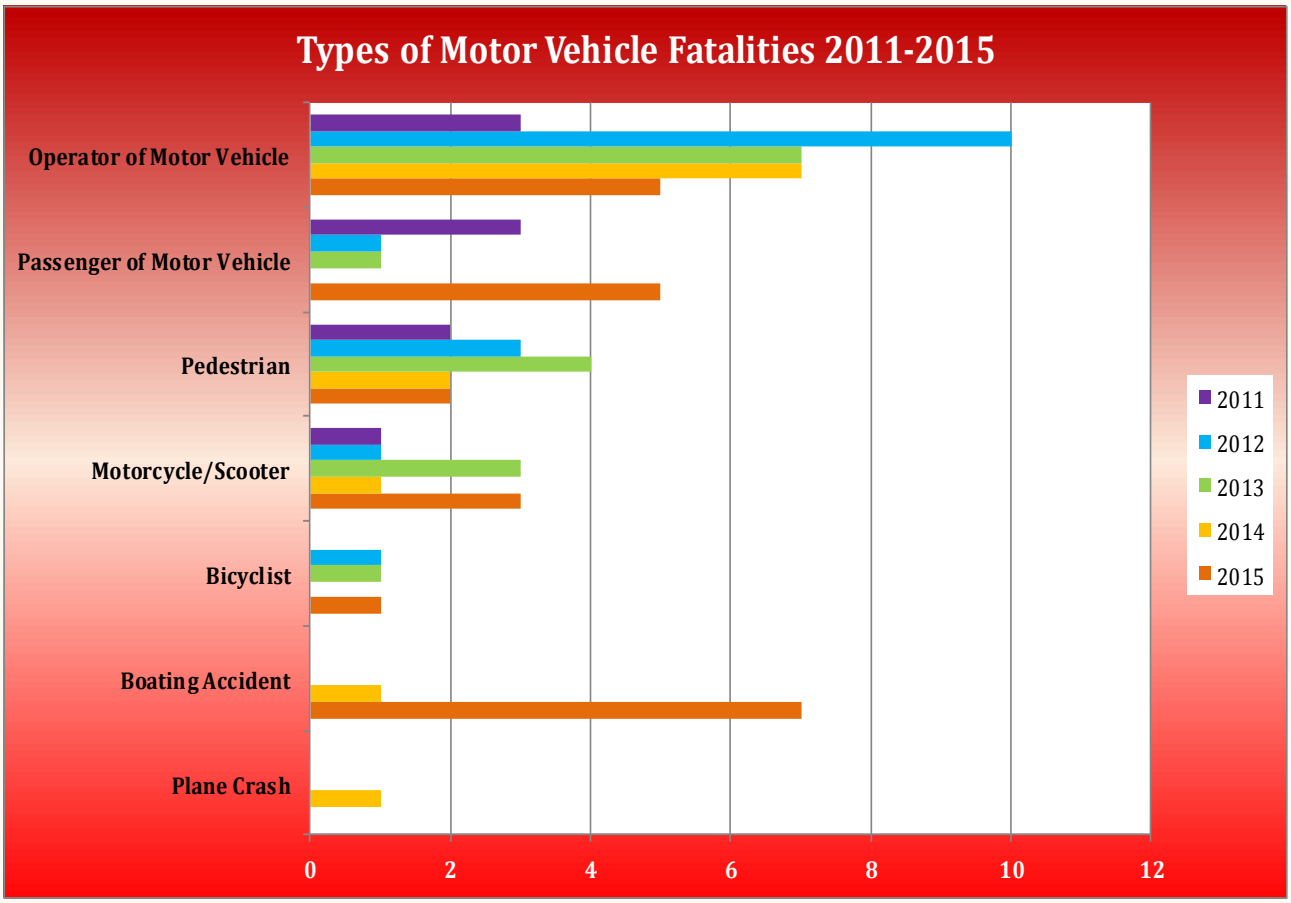
Average Number of Motor Vehicle Fatalities 2011-2015: 15

Motor Vehicle Fatalities by Month					
	2011	2012	2013	2014	2015
January	0	2	0	2	2
February	2	0	1	1	0
March	0	1	2	0	0
April	1	0	2	1	5
May	1	1	1	0	2
June	0	1	1	2	2
July	0	3	2	0	3
August	0	1	0	1	1
September	2	1	1	0	3
October	0	1	2	2	2
November	2	3	2	3	2
December	1	2	2	0	1
Total	9	16	16	12	23

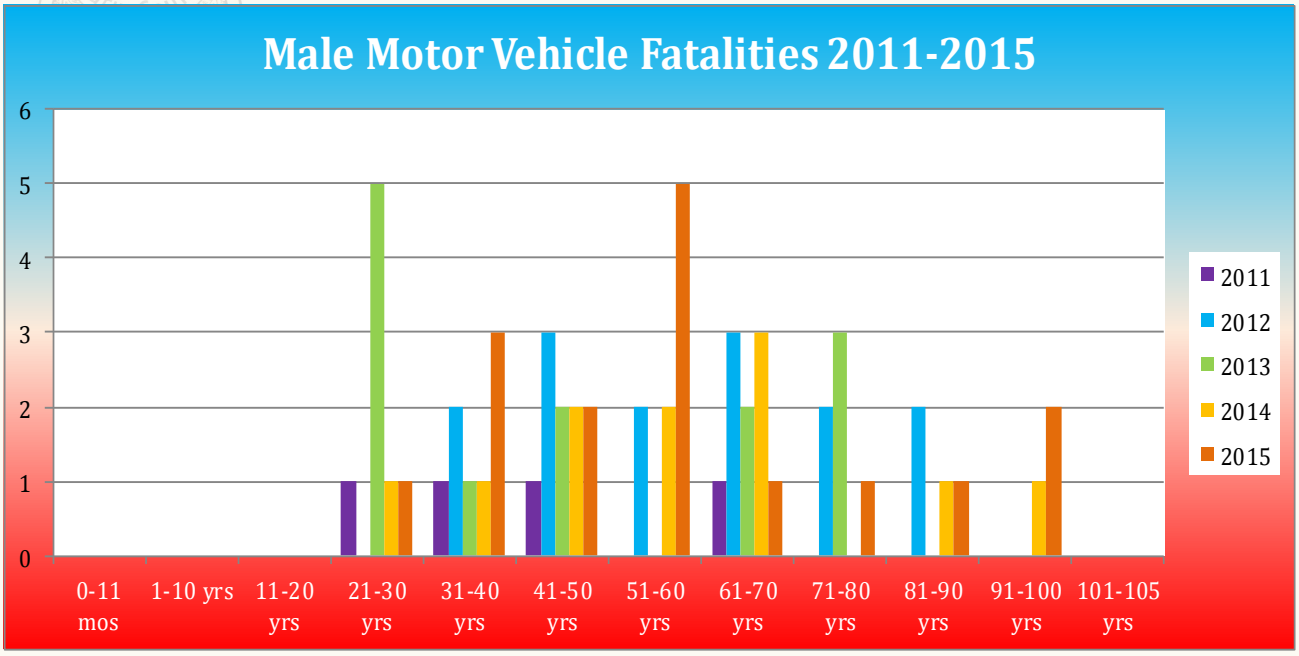


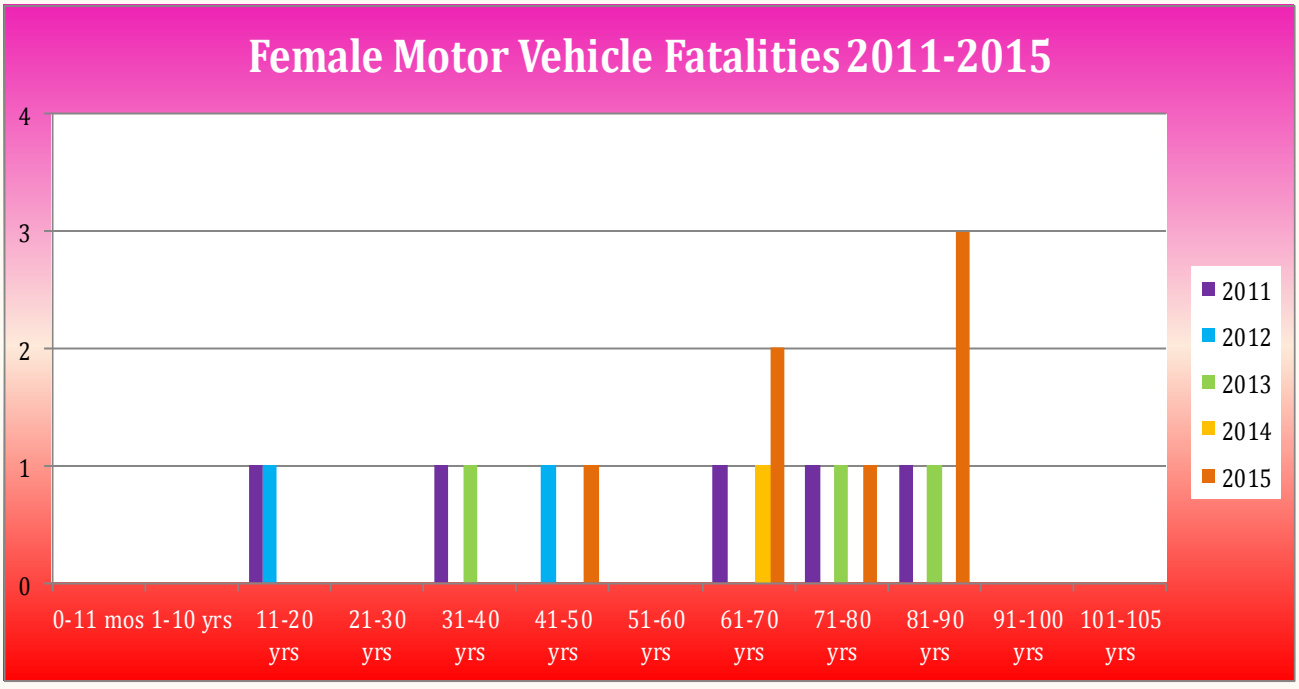
Motor Vehicle Fatalities in 2011-2015





Motor Vehicle Fatalities by Age 2011-2015



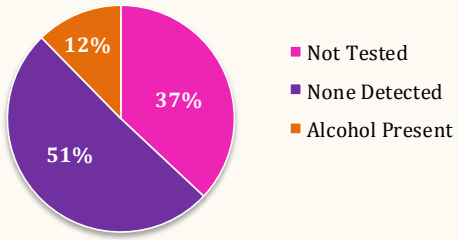


Motor Vehicle Fatalities
Involving Alcohol and/or Drugs in 2011-2015

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 death and therefore, relevant blood and urine samples are unavailable for testing.

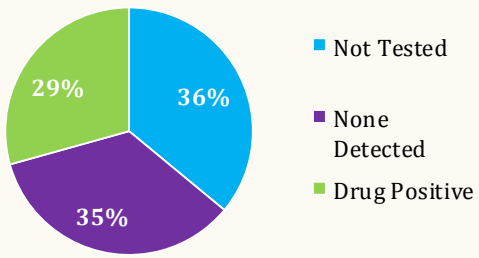
Toxicology Results Relating to Alcohol by Year					
	2011	2012	2013	2014	2015
Not Tested	3	6	6	1	11
None Detected	2	9	8	10	8
Alcohol Present	1	1	2	1	4

Toxicology Results relating to the presence of Alcohol



Toxicology Results Relating to Drugs by Year					
	2011	2012	2013	2014	2015
Not Tested	3	6	6	1	11
None Detected	2	4	8	5	7
Drug Positive	3	6	2	6	5

Toxicology Results relating to the presence of Drugs



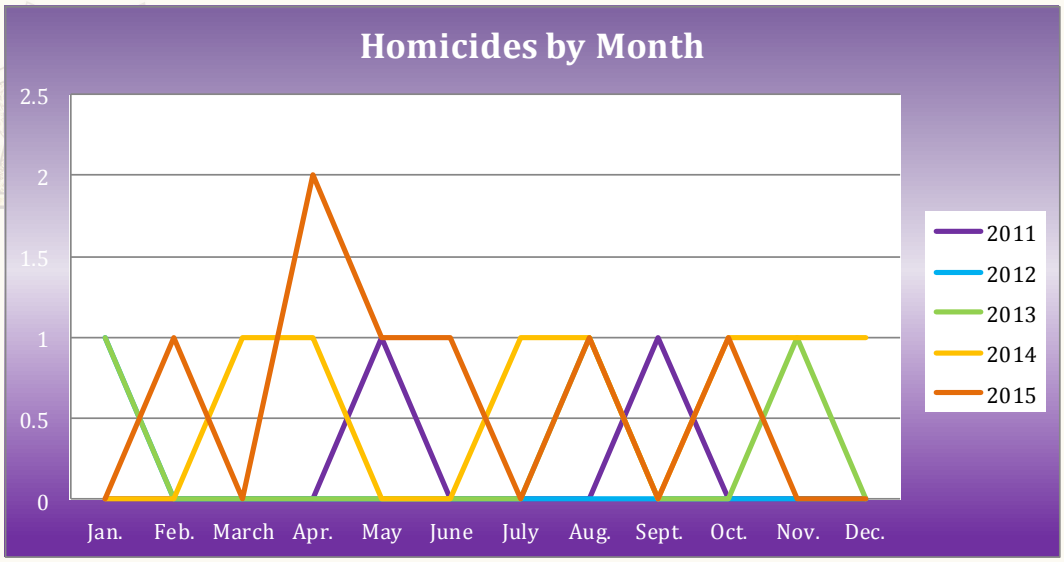
Homicide

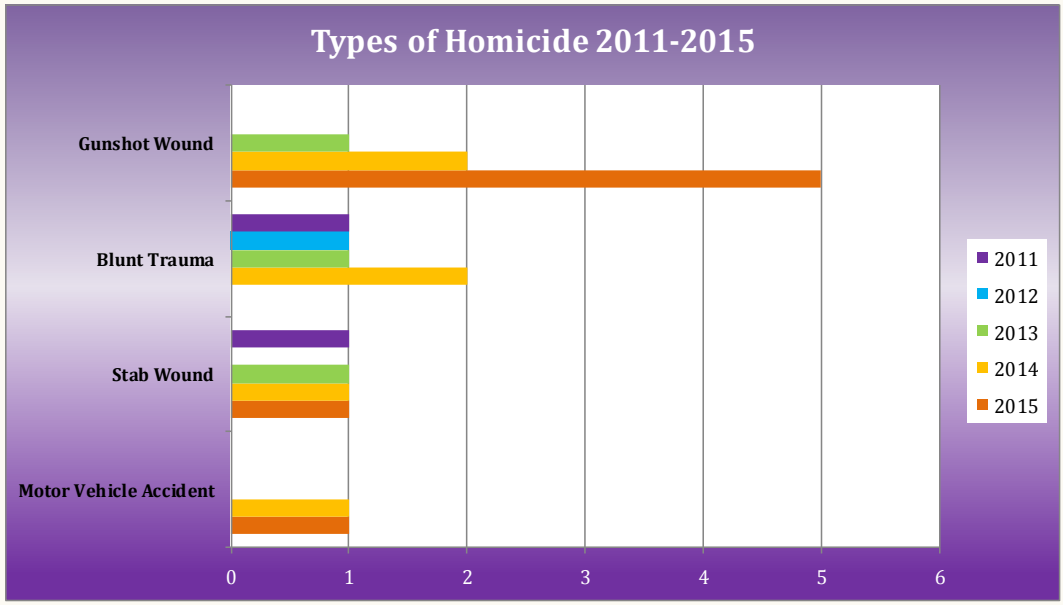
A homicide is a death caused by the intentional harm (explicit or implicit) of one person by another. These include acts of grossly reckless behavior. In this context, the word "homicide" does not necessarily imply the existence of criminal intent behind the action of the other person.

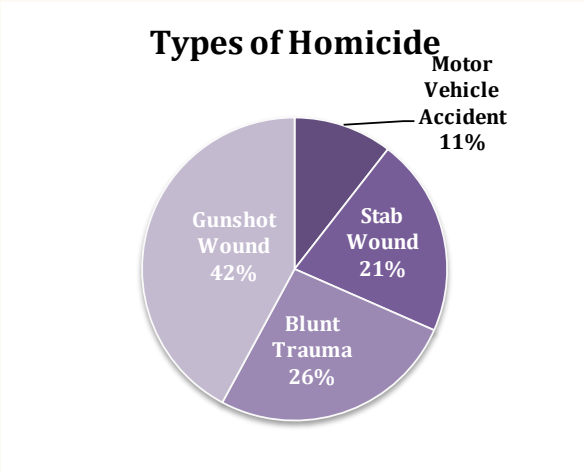
Average Number of Homicides per year 2011-2015: 4

Homicides by Month					
	2011	2012	2013	2014	2015
January	0	1	1	0	0
February	0	0	0	0	1
March	0	0	0	1	0
April	0	0	0	1	2
May	1	0	0	0	1
June	0	0	0	0	1
July	0	0	0	1	0
August	0	0	1	1	1
September	1	0	0	0	0
October	0	0	0	1	1
November	0	0	1	1	0
December	0	0	0	1	0
Total	2	1*	3	7	7

*2012 Homicide was a result of injuries sustained during a violent crime in Oakland, CA. The case was turned over to Alameda County and classified as a homicide by them.


Homicides by Month
2.5
2
1.5
1
0.5
0
Jan.
Feb.
March
Apr.
May
June
July
Aug.
Sept.
Oct.
Nov.
Dec.
2011
2012
2013
2014
2015


Types of Homicide 2011-2015
Gunshot Wound
Blunt Trauma
Stab Wound
Motor Vehicle Accident
0
1
2
3
4
5
6
2011
2012
2013
2014
2015


Types of Homicide
Motor Vehicle Accident 11%
Stab Wound 21%
Blunt Trauma 26%
Gunshot Wound 42%

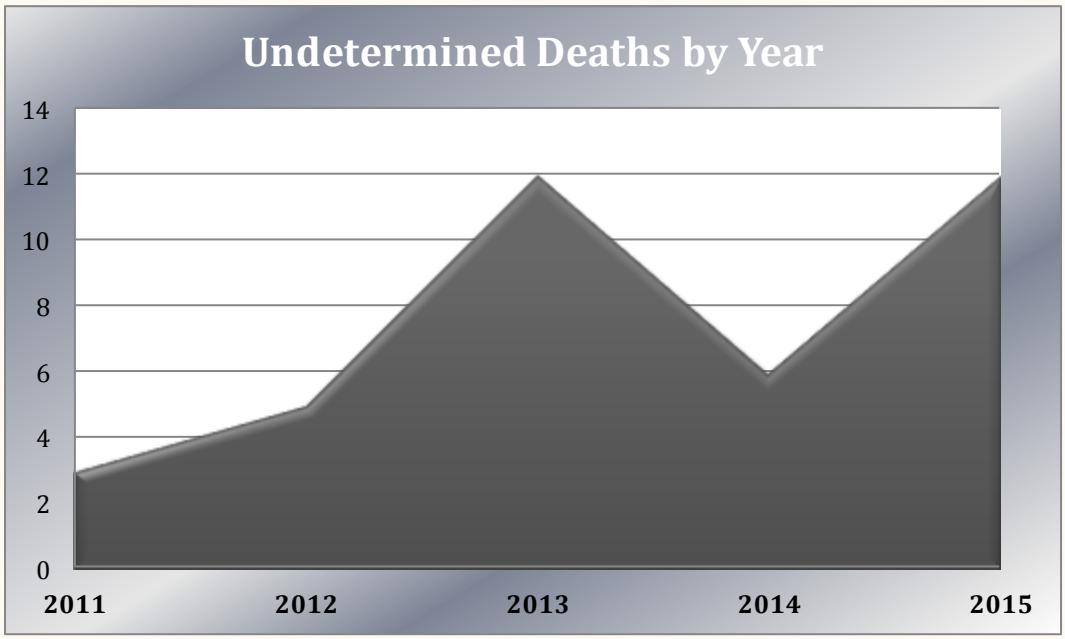
Undetermined

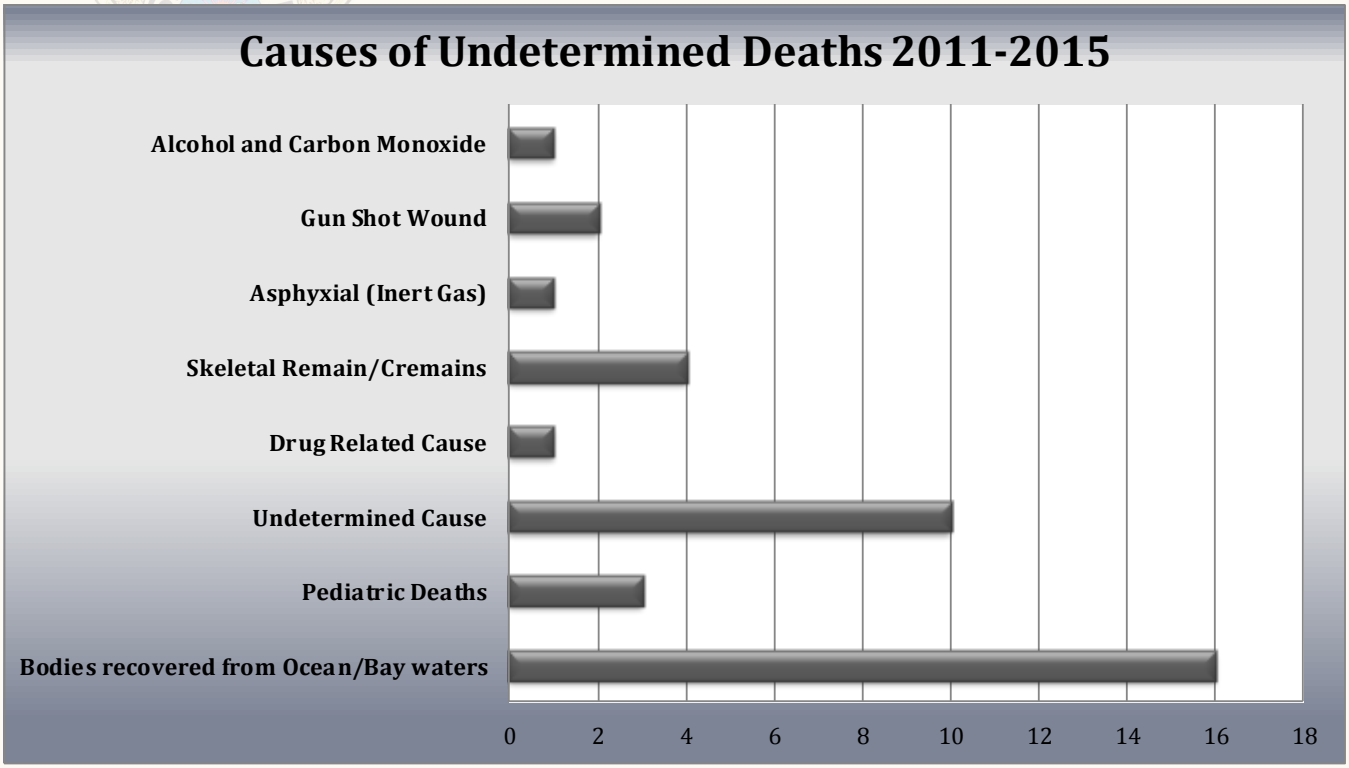
Although a cause of death may be ascertained, there are times when the manner of death remains undetermined. A death is certified as undetermined when available information regarding the circumstances of death is insufficient to manner the death as a natural, an accident, a suicide, or a homicide. Sometimes information concerning the circumstances of death may be inadequate due to lack of witnesses, a lack of background information, or because of a lengthy delay between the occurrence of 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 a manner of death is not possible. If an extensive investigation and autopsy cannot clarify the circumstances which led to a death, the death is then classified as undetermined.

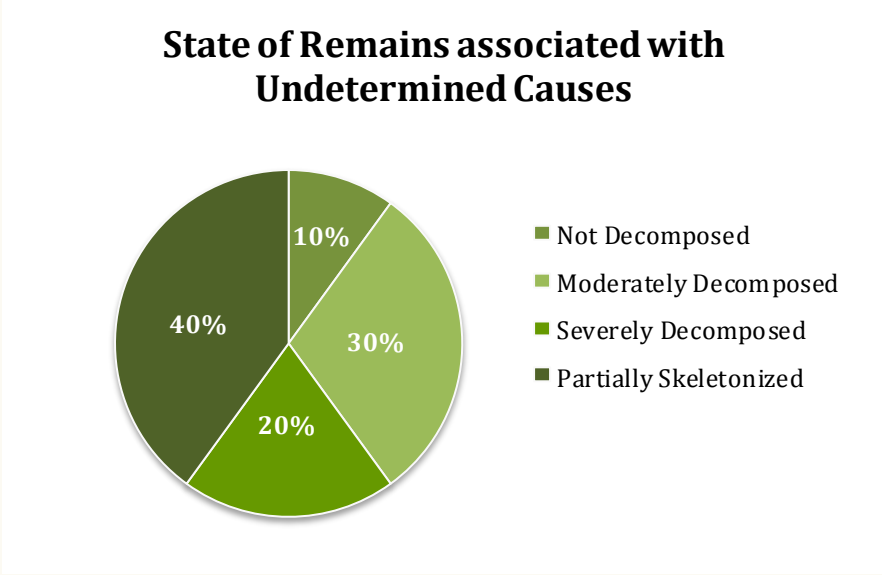
Note: Many of the undetermined manners in Marin County over the last five years are associated with remains that wash ashore from ocean or Bay waters. A portion of these cases displayed hallmarks found in other known Golden Gate Bridge jumper scenarios. However, subsequent investigations were unable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

Average number of undetermined deaths from 2011-2015: 8

Undetermined Deaths per year	
2011	3
2012	5
2013	12
2014	6
2015	12




Causes of Undetermined Deaths 2011-2015
Alcohol and Carbon Monoxide
Gun Shot Wound
Asphyxial (Inert Gas)
Skeletal Remain/Cremains
Drug Related Cause
Undetermined Cause
Pediatric Deaths
Bodies recovered from Ocean/Bay waters
0
2
4
6
8
10
12
14
16
18

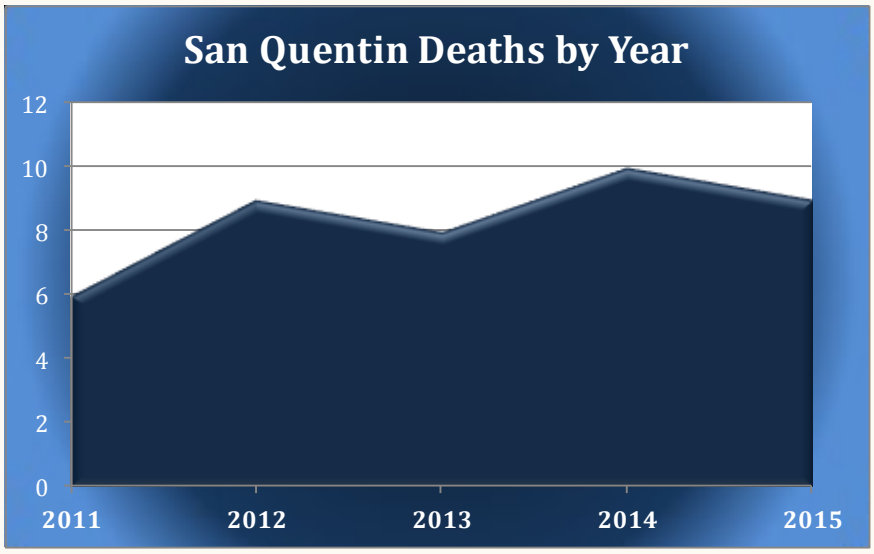

State of Remains associated with Undetermined Causes
10%
30%
20%
40%
Not Decomposed
Moderately Decomposed
Severely Decomposed
Partially Skeletonized

In Custody Death

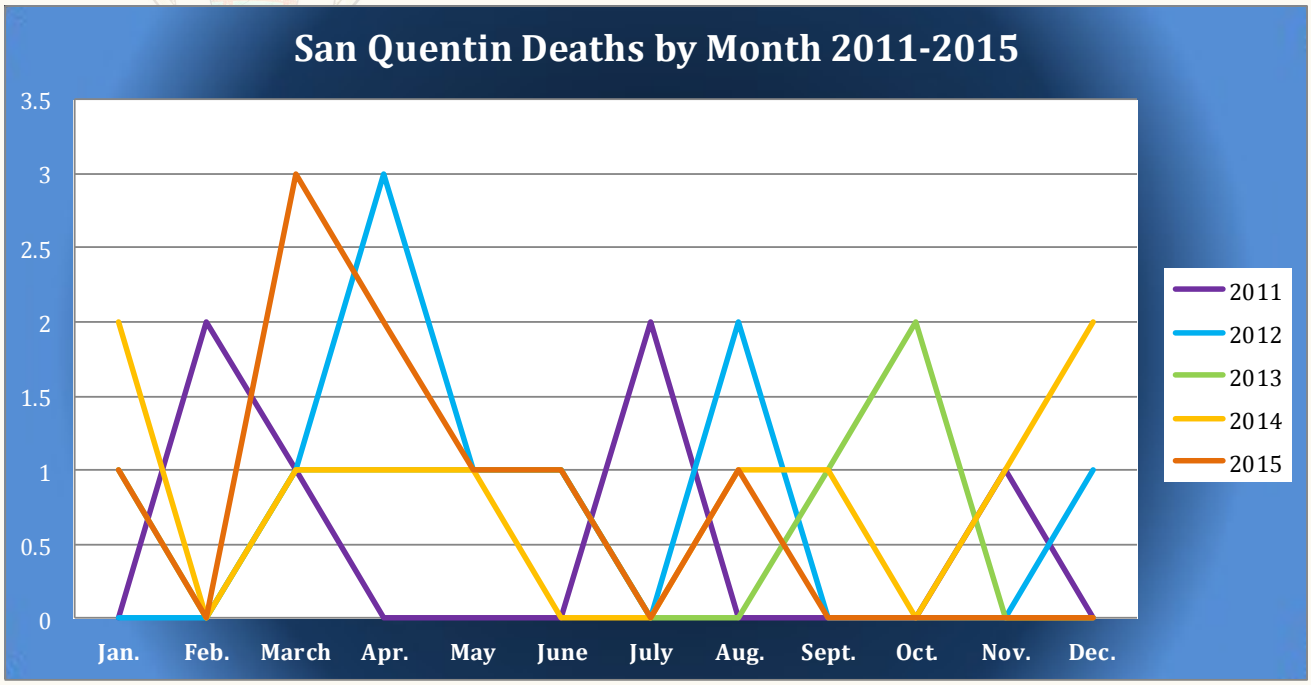
The Coroner Division investigates all in custody deaths with the exception of those that occur at the Marin County Jail. All deaths occurring at the Marin County Jail are investigated by the Sonoma County Sheriff-Coroner's office to avoid the potential for bias. When requested, the Marin County Sheriff Coroner Division will investigate in custody deaths for the Sonoma County Sheriff's Office.

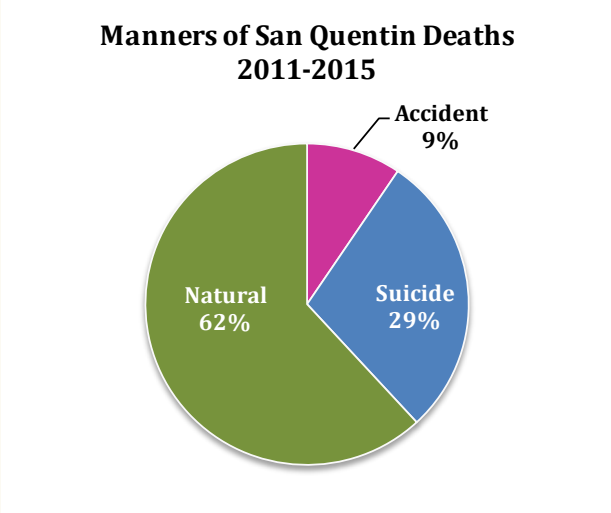
Average In Custody Deaths per Year: 8

San Quentin Deaths by Month 2011-2015					
	2011	2012	2013	2014	2015
January	0	0	1	2	1
February	2	0	0	0	0
March	1	1	1	1	3
April	0	3	1	1	2
May	0	1	1	1	1
June	0	1	1	0	1
July	2	0	0	0	0
August	0	2	0	1	1
September	0	0	1	1	0
October	0	0	2	0	0
November	1	0	0	1	0
December	0	1	0	2	0
Total	6	9	8	10	9



In Custody Deaths 2011-2015





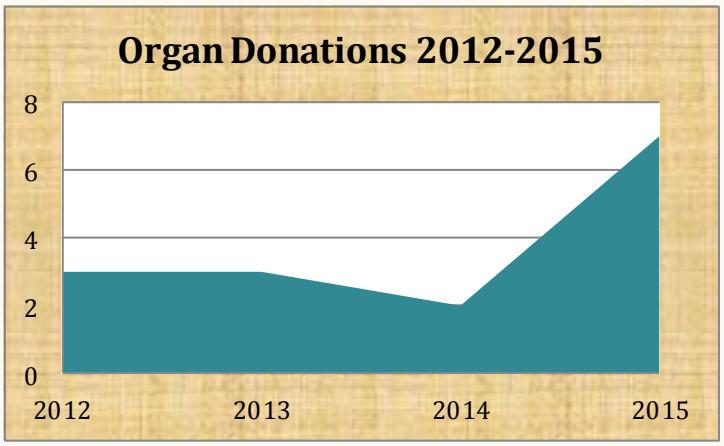
Manners of San Quentin Deaths 2011-2015					
	2011	2012	2013	2014	2015
Accident	0	1	0	2	1
Suicide	1	3	3	2	3
Natural	5	5	5	6	5
Total	6	9	8	10	9

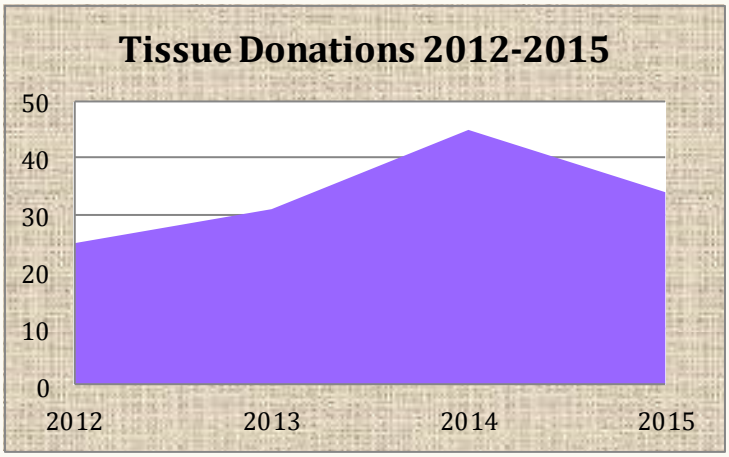
Organ Donations via Donor Network West

The Coroner Division works within the legal framework of the Uniform Anatomical Gift Act (CA Health & Safety Code 7150-7151.40) by working with our regional tissue and organ coordinator, Donor Network West (DNW), to aid families in the authorized release of tissue and/or organ donation of loved ones whose death is investigated by the Coroner Division. Statistics based on the Coroner Division's work with DNW are available for calendar years 2012-2015, as follows:

Total number of lives impacted from 2011-2015: 2,953

Organ Donations				
	2012	2013	2014	2015
Organ Donations	3	3	2	7
Tissue Donations	25	31	45	34
Total Lives Impacted	382	843	979	749





The Indigent Program 2013-2015

Indigent Program Statistics 2013-2015				
	2013	2014	2015	Total
Decedents approved for disposition through the Marin County's Indigent Disposition Program	13	8	10	**31**
Marin County's Public Administrator's Office accepted the case	0	0	3	**3**
Decedent's handled by another county due to their residence	0	1	3	**4**
Family handled disposition after Coroner Division assisted them	4	5	18	**27**
Family abandoned the remains and Coroner Division performed cremation	2	4	2	**8**
Pending	0	0	0	**0**
TOTAL:	**19**	**18**	**36**	**73**

Total Veterans Aided through the Indigent Program				
	2013	2014	2015	Total
TOTAL Veteran cremation/burial:	**2**	**0**	**1**	3