Coroner Case Reviews: An Examination of the Process

1. Summary

The Orange County Sheriff-Coroner periodically conducts formal hearings into facts surrounding the deaths of all persons who die while in custody or at the hands of law enforcement personnel. The hearings are called "Coroner Case Reviews." They are referred to in this report as the "review" or "reviews."

The 2004-2005 Orange County Grand Jury examined the current review process, concluding that it is well developed, thorough, and impartial. However, the grand jury found the process leading up to the formal case reviews to be too long (five to seven months). Because a case review by the sheriff-coroner is necessary before a death certificate can be issued, the length of time involved creates both emotional and practical burdens for the families of the deceased. The length of time between the incident and the formal review also delays notification to the public as represented by the grand jury.

2. Introduction and Purpose of Study

This study examines the coroner's review process. The deaths involved occurred as a result of actions by law enforcement officers in the field—such as officer-involved shootings—as well as deaths that occurred while the decedent was in jail or otherwise in custody. The process applies to all police agencies in Orange County. The grand jury serves as the public's representative at the reviews.

The study explores the extent to which the reviews are objective and unbiased. It discusses the resources used in preparing for the formal reviews and the efficiency of the process. It also compares the process used in Orange County with those used in two neighboring counties.

The study does not address:

- The separate investigative process conducted by the Orange County District Attorney's office. This investigation determines if there is any criminal culpability on the part of law enforcement officers involved in such incidents.
- Any administrative investigations conducted separately by either the sheriff-coroner or the local law enforcement agency involved in these types of deaths. The purpose of these investigations would be to determine what, if any, violations of departmental policies or procedures might have occurred and what corrective action might be necessary.

3. Method of Study

During the 2004-2005 year, the jury attended six coroner's reviews covering 23 deaths. Tours, interviews, and reviews of regulations and procedures were conducted with pertinent agencies and personnel. Comparisons were made with methods used in two other counties.

State laws, county regulations, memoranda of understanding (MOUs), and agreements between law enforcement agencies were reviewed. Each staff member who participates in the reviews was interviewed as to his or her role, the adequacy of resources, and his or her thoughts about the process. In addition, grand jurors attended a coroner's review in Riverside County, which uses a process similar to the one used in Orange County. To get another perspective, grand jurors visited San Diego County, which uses a different process.

4. Background

4.1 The Review Defined

The coroner case reviews are conducted solely to:

- Confirm the identity of the decedent and the place, date, and time of death
- Determine the medical cause of death
- Determine the manner of death as one of the following:
  - Homicide (defined as death at the hands of another)
  - Suicide
  - Accident
  - Natural
  - Unknown

4.2 History

The elected Orange County Sheriff-Coroner is the combined office of what once were separate county agencies. They were combined in January 1971. Statewide, 45 of the 58 counties have combined these offices under a law that allows each county to choose the method of carrying out the coroner function.

In 1985, an MOU was adopted by the Orange County Sheriff-Coroner and the county's District Attorney. Essentially, it said the district attorney's office would conduct all investigations regarding deputy-involved or in-custody deaths under the sheriff's jurisdiction.

Since 1990, based on a protocol adopted by the sheriff and local police chiefs, all cities "shall request an immediate investigation by an uninvolved agency to determine criminal culpability, if any, of those involved." It has become customary for the district attorney's office to be invited to lead these types of investigations for all city police departments except the Huntington Beach Police Department. It has a similar agreement with the Sheriff's Department. The purpose of these agreements is to avoid any appearance of a conflict of interest.

4.3 Current Review Process

Upon notification of a death in which law enforcement personnel are involved, special investigative teams are notified and dispatched to the scene. These teams involve investigators from the district attorney's staff, deputy coroners, and specialists from the county's forensics laboratory. Members of these teams are on call 24 hours a day, seven days a week.

An investigation of the scene is conducted. Physical evidence is collected and preserved. Photos are taken. Diagrams are drawn. The remains of the victim or victims are transported to the coroner's facility in Santa Ana, where an autopsy is normally performed within 24 hours. Toxicology tests are conducted, and x-rays taken. Interviews of all witnesses and other appropriate parties are conducted.

The following chart shows the participants in this process, their responsibilities, and whether they investigate at the scene or report at a later time during the overall review process.

Participant Responsibilities for Coroner Case Reviews

Participant	Reports to:	Investigates at Scene	Formal Review Process	Duties:
District Attorney Investigator and Team	District Attorney	Yes	Yes	• Leads Investigation • Coordinates activities of all participants at the scene on sheriff's calls • Collects information from all participants and prepares final report for DA
Sheriff-Coroner Forensic Specialist and Team	Director Forensic Sciences	Yes	Yes	• Collects physical evidence at scene of death • Investigates and analyzes all physical evidence • Reports all information and conclusions to DA investigator and Chief Deputy Coroner
Deputy Coroner and Team	Chief Deputy Coroner	Yes	Yes	• Investigates physical characteristics of decedent's body at the scene to include location and time of death • Reports all information and conclusions to DA investigator and Chief Deputy Coroner
Sheriff Coroner Toxicologist and Team	Director Forensic Sciences	No	Yes	• Performs toxicology studies on decedent to determine presence of drugs • Reports findings to DA investigator and Chief Deputy Coroner
Forensic Pathologist*	Contract Position	No	Yes	• Performs autopsy on decedent within 24 hours of death to determine medical cause of death • Reports results to Chief Deputy Coroner

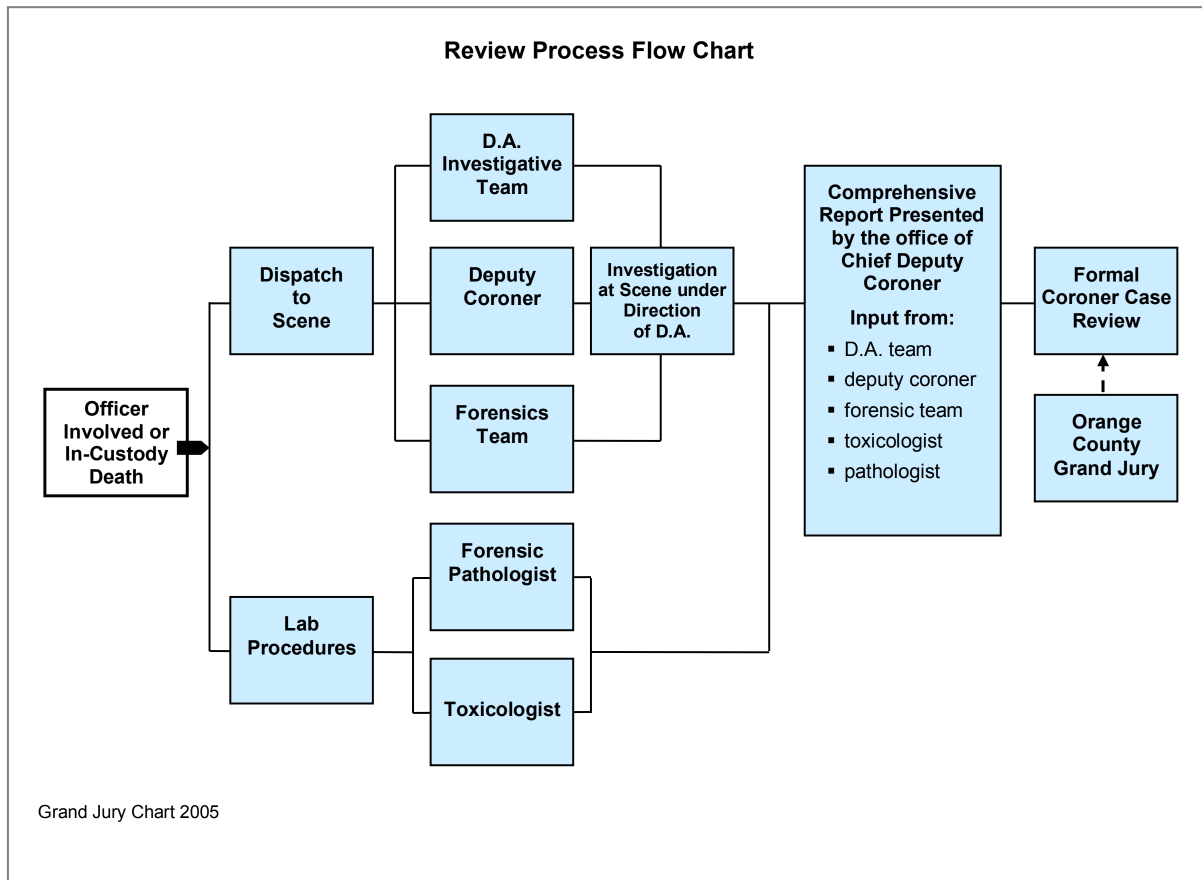
Grand Jury chart 2005

* This contract is with an Orange County Forensic Pathology medical group. When Orange County Sheriff personnel are involved, a forensic pathologist from outside Orange County performs this function.

The results of all the factors mentioned above (i.e., evidence collected at the scene, autopsy and laboratory findings) are presented at informal preliminary meetings among those participating in the investigation. This allows for questions and assessments as to whether further investigation is necessary. The entire process is lengthy and requires

many man-hours to complete. Detailed reports must be written, and time to conduct laboratory tests is required. The circumstances of each case influence this length of time, as well as the number of cases being investigated at any given time.

When the information is complete, the final results are presented at a formal Coroner Case Review, which typically covers three to four cases and takes place from five to seven months after each incident.



4.4 Formal Review Sequence

- A senior investigator from the district attorney's staff summarizes a detailed time line surrounding the death.
- A senior forensics specialist presents further details, often accompanied with schematic drawings, other illustrations, or photos.
- The forensic pathologist presents a summary of the autopsy, with an accompanying diagram, emphasizing the medical cause of death.
- The senior toxicologist provides the results of testing that was done to determine types and amounts of drugs that may have been found.
- The chief deputy coroner then announces the recommended medical cause and manner of death based on the evidence presented.

- Questions are taken from the panel, including members of the grand jury.
- The sheriff-coroner, or his designee, is then asked to accept the findings and so indicate on the death certificate.

4.5 Procedure in Other Counties

Grand jurors visited Riverside and San Diego counties to determine how their cases are handled.

Riverside: Riverside County also has a sheriff-coroner system and conducts coroner case reviews in much the same manner as Orange County. The most noticeable difference is the absence of district attorney involvement in Riverside's coroner reviews. The Riverside District Attorney does conduct a parallel investigation to determine responsibility and culpability, if any, but the sheriff-coroner believes there is no requirement for district attorney investigators to participate in the coroner reviews. Riverside generally has a lag time of approximately three months between the incident and the review. As in Orange County, members of the Riverside Grand Jury attend the reviews.

San Diego: The process is different in San Diego County, where the sheriff does not carry the combined title of sheriff-coroner. Identification of the deceased, and the cause and manner of death are determined solely by the county medical examiner. The sheriff has no input and the decision of the medical examiner is not subject to review by the sheriff. Any investigation as to culpability is conducted by the district attorney. This system clearly encourages independence and reduces the potential for conflicts of interest. However, San Diego's system appears to require a larger organization than the system used in Orange County. The San Diego system also inhibits the sharing of information and the potential for economizing on resources.

4.6 Numbers of Review Cases Conducted Historically

During the past five years (2000 through 2004), the number of deaths requiring Orange County coroner case reviews has increased considerably. The chart on the right illustrates the increase.

Sheriff-Coroner Review History

Year	Deaths: Shooting	Deaths: In-Custody	Total
2000	3	5	8
2001	8	6	14
2002	7	5	12
2003	11	15	26
2004	14	11	25
Total	**43**	**42**	**85**

Grand Jury chart 2005

During this same period, other deaths (non-law enforcement involved) that require the coroner to make similar investigations, such as homicides, suicides, traffic accident deaths, etc., have increased from 8,144 in 2000 to 9,481 in 2004. The number of deputy coroners has remained static at 17 and the forensic staff has remained at ten. This results in a 16.4% increase in the overall workload and contributes to the lag in time conducting coroner

case reviews. The cases in which law enforcement is not involved take an average of two months to complete.

5. Observations

Interviews conducted by the grand jury revealed that the entire process is time consuming, taking five to seven months to reach the formal review stage. This creates a burden for the loved ones of the deceased who must wait for a death certificate. This is important because death certificates are needed by survivors to settle a decedent's legal affairs. For example, death certificates are required by banks, insurance companies, the Internal Revenue Service (IRS), Social Security, and any transactions involving changes of ownership.

The grand jury also learned that if death certificates are signed within 60 days of a death, official copies may be obtained from the county in a timely manner. After that, it may take up to ten weeks to obtain a copy from the state.

The grand jury sees the formal reviews as thorough and objective in preparation and presentation. The participants involved in the process are professionals. The illustrations and schematic drawings of the scene are informative. Perhaps by using computer technology, they could be even more illustrative of the circumstances surrounding the incidents.

The participants commented to the grand jury that there is excellent communication and cooperation among the involved agencies–welcome factors in any investigation.

Further, the appearance of any conflict of interest is dispelled by the objective participation of the district attorney's office in the role of lead investigator. The taxpayer is well served by the competence of the investigators at all levels of this process and the state-of-the-art forensics equipment available for these investigations.

The grand jury represents the public at the formal review sessions and has the power to conduct an independent investigation of events presented at these reviews. However, the long period of time between an incident and the formal review dilutes the potential grand jury oversight role.

6. Findings

Under California Penal Code Sections 933 and 933.05, responses are required to all findings. The 2004-2005 Orange County Grand Jury has arrived at the following findings:

6.1 The coroner case review is thorough, objective, and accurately determines the information required of the sheriff-coroner as to the cause and manner of death.

6.2 The five- to seven-month time difference between the incident and the formal hearing is too long. This delays issuance of death certificates. It also delays notification of the public as represented by the grand jury.

Responses to *Findings 6.1* and *6.2* are required from the Orange County Sheriff-Coroner.

7. Recommendations

In accordance with California Penal Code Sections 933 and 933.05, each recommendation will be responded to by the government entity to which it is addressed. The responses are to be submitted to the Presiding Officer of the Superior Court. Based on the findings, the 2004-2005 Orange County Grand Jury makes the following recommendations:

7.1 The coroner case review is sound and should be continued. (See Finding 6.1.)

7.2 The sheriff-coroner should develop ways to reduce the time between the incidents and the formal hearings (see Finding 6.2).

Responses to *Recommendations 7.1* and *7.2* are required from the Orange County Sheriff-Coroner.

8. Bibliography

1. Constitution of the State of California
2. California Government Code; 27491, 24300-24308, 27460-27472
3. California Health and Safety Code; 102850-102870
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5. 1990 Operational and Procedural Protocol–Orange County Chiefs of Police and Sheriff Assn.
6. Web Site: www.ocsd.org/coroner
7. Web Site: www.riversidesheriff.org/coroner
8. Web Site: www.sdcounty.ca.gov/public/safety
9. Web Site: www.sdsheriff.net/sheriff1.html