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CALIFORNIA

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August 9, 2005

The Honorable Frederick Horn
Presiding Judge
Orange County Superior Court
700 Civic Center Drive West
Santa Ana, CA 92702

Subject: Response to Grand Jury report – "Coroner Case Reviews: An Examination of the Process"

Dear Judge Horn:

Pursuant to California Penal Code §933 and §933.05, I am submitting to you my responses to the Grand Jury Findings and Recommendations contained in their subject report.

The Sheriff's Department appreciates the effort and the detail of review performed by the Grand Jury. Attached are specific responses to the findings and recommendations. If you have any questions regarding this report, please contact Assistant Sheriff Jo Ann Galisky at 647-1804.

Respectfully submitted,

Michael S. Carona
Sheriff-Coroner

Attachment: Responses to Grand Jury Findings and Recommendations

Cc: Bette Flick, Grand Jury Foreperson

Response to the Grand Jury
"Coroner Case Reviews: A Review of the Process"
Final Report 2004-2005

Sheriff-Coroner Michael S. Carona

Orange County Sheriff's Department

Jo Ann Galisky, Assistant Sheriff
Chief of Investigations
Santa Ana, California
July 2005

Coroner Case Reviews:
An Examination of the Process

FINDINGS

In accordance with California Penal Code §933 and §933.05, responses are required to all findings. The 2004-2005 Orange County Grand Jury arrived at the following two findings. Beneath each is the Sheriff's Department response to that finding.

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.*

The Sheriff agrees with the finding.

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.*

The Sheriff-Coroner disagrees with the first sentence of the Grand Jury's finding that the five to seven month time period between the incident and the formal hearing is too long. The length of the case review process is determined by the complexity of the individual case circumstances, the necessity for a thorough investigation and sound scientific analysis of physical evidence, and the number of agencies and/or experts involved in the case. In addition to the Coroner's Investigators and Forensic Pathologists, a minimum of three other agencies, divisions or bureaus are involved in the case review process. In Orange County Sheriff Department cases, the District Attorney also is involved as an independent third party overseeing the Coroner's performance of his duty. Each entity involved in the case review preparation is responsible for thoroughly investigating and analyzing the data pertinent to its area of responsibility. Depending on the circumstances of the case and the staffing level of the agency or the availability of specific experts, it may take from days to months to compile and evaluate all necessary information and arrive at a conclusion or recommendation. Each entity is then responsible for presenting its findings with supporting documentation in a structured format called the "Coroner Case Review". This formalized presentation of meticulously gathered and exhaustively analyzed information is a critical aid to the Sheriff-Coroner in making his thorough, objective and accurate determinations of the cause and manner of death.

Notwithstanding the need for time-consuming, careful data collection and analysis, the Coroner agrees with the second sentence of Finding 6.2 that the process may delay the issuance of an amended death certificate. In the Recommendation section under 7.2, the Sheriff-Coroner will address methods to reduce the delay, other than cutting back on the necessarily meticulous data collection and analysis.

Regarding the third sentence of Finding 6.2 about delayed notification of the public by the Grand Jury, the Sheriff-Coroner would like to take this opportunity to clarify the role of the Grand Jury in the Coroner Case Review. The Grand Jury is invited by the Sheriff-Coroner to act as witnesses on behalf of the public to the fact that Coroner Case Review proceedings occur and meet the provisions of the 1985 Memorandum of Understanding (MOU) between the Sheriff and the District Attorney. The MOU provides that the District Attorney will conduct the death investigation when an individual dies while incarcerated in a Sheriff's facility or when the death involves a Sheriff's Department employee. The District Attorney, as an independent third party investigating the death, is also responsible for bringing in an outside Forensic Pathologist to perform the autopsy. As witnesses to the proceedings, the Grand Jury is exposed to privileged and confidential information as defined in California statutes. Notification of the public regarding anything other than the fact that the case review is proceeding as defined in the MOU would be inappropriate, and could violate confidentiality laws and Grand Jury regulations.

RECOMMENDATIONS

In accordance with California Penal Code §933 and §933.05, each recommendation requires a response from the government entity to which it is addressed. Based on the findings, the 2004-2005 Orange County Grand Jury developed the following two recommendations. Beneath each is the Sheriff's Department response to that recommendation.

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

The Sheriff agrees with this recommendation.

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

The Sheriff-Coroner strives for continuous improvement in all departmental operations and will continue to examine the efficiency of the Coroner Case Review procedures and to look for ways to reduce the time period between the incident and the formal hearing without compromising either the thoroughness or accuracy of the investigation or quality of the review presentation. The Coroner Case Review process requires collaboration between several different specialized units within the Sheriff-Coroner Department, the District Attorney's Office, local Law Enforcement Agencies, and Forensic Pathologists employed in other counties. The Sheriff-Coroner will share the Grand Jury's concerns about timely resolution of the cases in the Coroner Case Review process with the other entities involved, and will encourage a review of all procedures and protocols that govern those entities' completion of their final products.

Historically, cases have been reviewed in chronological order. However, the majority of the custodial cases are medically related natural deaths, which often do not present the same complexities as other types of cases. Conducting the presentations in non-chronological order can result in a more expeditious handling of the less difficult cases. The Sheriff-Coroner has agreed to modify the current practice and allow the less complex cases to be reviewed out of order.

Additionally, the Sheriff-Coroner has contacted the State Office of Vital Records to request an extension of the 60-day deadline governing the certification of amended death certificates. Currently, the State permits the Orange County Registrar to maintain "pending" death certificates in the local office for 60 days while awaiting an amendment that identifies the cause and manner of death. If an amendment is received by the local

Registrar's office before the 60-day deadline, certified copies of the new death certificate are made immediately available at the local office. However, if the amendment does not reach the local Registrar's office within 60 days, the death certification process is transferred to the State Office of Vital Records in Sacramento, resulting in a further 10-week delay in the availability of the amended death certificate. The Director of the State Office of Vital Records has agreed to extend the deadline from 60 days to 90 days. In a small percentage of cases, this will make amended death certificates available more quickly. For the remaining cases that cannot be completed within the new 90-day period, the Director of the Office of Vital Records has agreed to work with the Coroner's Office and the local Registrar's office to expedite the issuing of the certified copies of amended death certificates.

Additionally, collaboration between the Sheriff-Coroner and the local Registrar's office is on-going regarding the implementation of the new Electronic Death Registration System. This State-developed program will allow the Coroner to input data directly into the State's System, which will provide immediate availability of the certified death certificates from the local Registrar's Office. Participation in this program will further reduce the delays experienced by family members seeking certified copies of death certificates.