# ORANGE COUNTY SHERIFF-CORONER

**CONFLICT OF INTEREST STUDY**

## SUMMARY

The Grand Jury investigated the question of whether the Coroner Division should be separated from the Orange County Sheriff-Coroner Department and made into a stand-alone county department. This issue has been raised from time to time in the past because of the perception that there is a potential conflict of interest with a Sheriff-Coroner Department investigating deaths involving activities of law enforcement personnel. The Grand Jury found that there is no conflict of interest in such matters because investigation procedures by the Office of the District Attorney rule out the possibility of a conflict of interest.

The Orange County Sheriff-Coroner Department should remain intact, as it is currently constituted, because it is the most efficient arrangement for the county in terms of costs and efficiency of investigations. Staffing levels need to be increased and hardware upgraded.

## INTRODUCTION AND PURPOSE

In Orange County the offices of Sheriff and Coroner are combined under one elected official. This duality has lead to questions as to whether or not one person can effectively manage two distinct functions that on the surface pose a perceived conflict of interest when law enforcement personnel are involved with the death of a person. The alleged conflict of interest problem stems from the notion that it would be inappropriate for sheriff personnel to investigate others within law enforcement.

This important issue was examined in detail, including the related matters such as staffing, training, funding, organizational structure and cost-effectiveness of various styles of coroner operations. The Grand Jury sought to answer the question whether the citizens of Orange County were better served by separating the Coroner operation into a stand-alone department or keeping the joint operation intact as it currently exists.

The counties in the State of California deal with this potential problem in a variety of ways. There are five types of coroner operations employed by the 58 counties in the State (see Table 1). The vast majority uses the Sheriff-Coroner combination. The remainder is evenly distributed among other styles, with the exception of Los Angeles County, which has the only Department of Coroner office in the State of California. In Los Angeles, oversight of the department is split into two separate but equal positions. An Administrative Coroner (or Director) handles all the administrative aspects of the office. A Chief Medical Examiner-Coroner is responsible for all medical aspects. This partnership is unique in California.

**TABLE 1**
**CALIFORNIA DISTRIBUTION OF CORONER SYSTEMS**

| Sheriff-Coroner | Coroner | Coroner-Public Administrator | Department of Coroner | Medical Examiner Coroner |
|---|---|---|---|---|
| 43 | 5 | 5 | 1 | 4 |

# METHOD OF STUDY

The Grand Jury toured the facilities of the Orange County Sheriff Department and its Coroner Division. The Grand Jury also visited Coroner facilities in San Diego, San Bernardino, Los Angeles, and Alameda counties. These particular counties were chosen as they represent a sampling of the various major types of Coroner systems currently existing within the State of California:

- San Diego: Medical Examiner-Coroner Office.
- San Bernardino: Coroner-Public Administrator/Public Guardian
- Los Angeles: Department of Coroner
- Alameda: Sheriff-Coroner

Extensive interviews were conducted at each of the Coroner units visited. Information was obtained from deputies, investigators, technicians and management personnel at these facilities. County budgets and staffing levels were also examined as well. Deputy District Attorneys of Orange County were also interviewed, and documentation received concerning their role in the investigation of officer-involved deaths.

# BACKGROUND

The 1984–85 Orange County Grand Jury studied the issue of conflict of interest regarding the Sheriff-Coroner Department. The Grand Jury report did not resolve the conflict of interest question, and the Board of Supervisors requested that an outside consulting firm examine the issue. The Board chose Arthur Young International to study the issue and make recommendations. This study concluded that the combined office of Sheriff-Coroner was the most cost-efficient option available. The study pointed out that there would be substantial cost increases if the Coroner function were separated from the Sheriff's Department. This separation would lead to an increase in overhead costs necessary to establish and carry out such operations as payroll, forensics, dispatch, evidence control, and internal affairs. Secondly, the Arthur Young study recommended that the Office of the District Attorney assume control of all investigations involving Sheriff Department related deaths in order to eliminate any potential for, or perception of, conflict of interest between the Sheriff and Coroner functions.

An advantage of these services being in-house, apart from any costs savings, is the important fact that the chain of evidence and evidence security can be easily controlled. In a variety of other counties evidence is routinely sent out for testing to private, off-site contract companies and such methods hold the potential for loss or destruction of evidence, or the premature release of results in high profile cases. It is clear that in-house testing, such as is the case in Orange County, is a quick, secure and effective method of operation.

As a result of this study several changes occurred. A Memorandum of Understanding was adopted between the Sheriff-Coroner and the District Attorney in 1985. This Memorandum of Understanding provides for the Office of the District Attorney to take the lead and investigate all Sheriff-Coroner Department related deaths upon notification by the Sheriff's Department. The Office of the District Attorney then mobilizes a "roll-out" team of investigators, which responds to the scene. Upon arrival they assume primary investigative responsibility for the incident, and initiate all written reports of interviews. The District Attorney Investigators collect reports from all investigative sources, and are responsible for maintaining the master case file on the incident. Under this Memorandum of Understanding the Orange County Sheriff-Coroner Forensic Team will function as the scientific investigative personnel, collecting and processing all physical evidence as directed by District Attorney Investigators. If needed, the District Attorney Investigators will utilize Deputy District Attorneys for legal opinions, legal process, search warrants, or anything required to facilitate the investigation. Initiating agency personnel may also be requested to participate in all or select phases of the investigation, as needed. Moreover, this Memorandum of Understanding specifies that the Office of the District Attorney will,

in these instances, oversee the Coroner's investigation. The District Attorney will also arrange for an independent forensic pathologist from outside Orange County to perform the autopsies, at District Attorney's expense. To strengthen the objectivity of the investigation of the facts underlying law enforcement-involved deaths, the Grand Jury is routinely invited to participate in a Coroner's Review of such cases along with District Attorney personnel. Upon completion of the investigation the District Attorney's Office will notify the initiating agency of the results.

The Office of the District Attorney has further broadened its role of an independent investigating body regarding law enforcement-related to include all police departments in Orange County, with the exception of Huntington Beach. The city of Huntington Beach signed a Memorandum of Understanding in December 1990, which states that the Orange County Sheriff-Coroner Department will conduct the investigation of any Huntington Beach Department officer-involved incident. Currently, it is standard procedure for the remaining cities in Orange County to accept this offer of the Office of the District Attorney assistance, with the provision that the Office of the District Attorney is the agency in charge of the investigation. In 1986, the Board of Supervisors directed the County Administrative Office to conduct a post-implementation review of the Memorandum of Understanding to determine if it had served the desired purpose of eliminating conflict of interest concerns. The County Administrative Office reported that the Memorandum of Understanding achieved the desired result and further recommended that the Chief Deputy Coroner report directly to the Sheriff. This organizational change was implemented soon after, and is in effect today.

The lack of affiliation with a Sheriff Department in stand-alone coroner or medical examiner office, results in loss of visibility. This has historically impaired these offices from obtaining the necessary funding required to run state-of-the-art operations and jeopardized close working relationships with other law enforcement entities. This complaint was echoed on more than one occasion in various counties. As a result, the citizens of such counties may not be receiving the level of service needed. In counties other than Orange County it was not uncommon to encounter Coroner personnel working in buildings in excess of thirty years of age, with outdated equipment. In one extreme case it was noted that a county's budget for coroner services had actually decreased substantially, by almost 30% in the past seven years, even though costs and workloads increased noticeably in the same time frame.

In Orange County, close working relationships exist between Deputy Coroners and other law enforcement personnel, such as homicide investigators. This open access allows early and constant lines of communication to be formed, facilitating the sharing of information. Such open sharing of information is not done as a matter of course in other counties, with the result that it can be difficult or impossible for stand-alone Coroner's investigators to obtain law enforcement reports on matters that they are investigating. In

no other county that the Grand Jury visited did it encounter this level of cooperation and planning among the various agencies involved in law enforcement related deaths. In fact, in all other counties visited there is generally no involvement of the District Attorney in these types of deaths. Orange County clearly stands out in this matter.

The County Administrative Office's report was submitted to the Board of Supervisors in March 1987. The report concluded that the County should retain the consolidated Sheriff-Coroner system. It further noted "The wide use of combined Sheriff-Coroner systems tends to confirm that this organizational option, while not free from some controversy, is both reasonable and appropriate. Confidence and credibility of death-related findings are one of the best effectiveness measures of a Coroner Office. In this respect, the Orange County Coroner system has served as a model for other counties, and is perceived to be one of the better systems statewide." This point from 1987 regarding the wide use of combined Sheriff-Coroner systems has been further strengthened in the passing years. The number of counties in California with combined systems has increased from 36 to 43; with three of them (Riverside, Kern, and Alameda) being large metropolitan areas.

In addition to the aspect of conflict of interest, lie the issues of cost and operation. In 1998 sixteen Deputy Coroners investigated 8,720 cases, which is a marked increase in the workload for the Coroner Division. In 1982 the total number of cases investigated by Deputy Coroners was 4,941. In the sixteen-year period since 1982 the caseload increased 76%, yet the number of Deputy Coroners responsible for investigating these cases increased by only 19%. Currently the Deputy Coroners are assigned two to a desk, in an attempt to utilize the available space as efficiently as possible.

Four Supervising Deputy Coroners augment these sixteen Deputy Coroners, and it should be noted that this Supervising role is a twenty-four hour, 365-day-a-year, manned position. The number of Supervising Deputy Coroners has remained the same since 1983, even as the workload increased. The responsibilities of the Supervising position have also expanded to include the overseeing of such special projects as the Coroner's Basic Death Academy and the Youthful Drunk Driver Program. The staffing in the Coroner Division consists primarily of personnel assigned to work directly at the Coroner's main function, that of determining causes of death. They are supplemented by seven clerical personnel, one of which is devoted to medical transcribing. This relatively lean staffing is made possible by the fact that many of the functions necessary to run such an operation are conducted by existing divisions within the Sheriff-Coroner Department, such as Personnel, Fiscal, Property, etc.

## FINDINGS

Under *California Penal Code* §933 and §933.05 the Grand Jury requires responses from the appropriate agencies and officials to each of the following findings.

1. A stand-alone Coroner Department would cost county taxpayers more money. Administrative overhead costs would be increased in order to duplicate an infrastructure that currently exists within the combined department. Examples include, but are not limited to forensics, photography, fiscal, toxicology, and criminalists.

   A response to Finding 1 is required from the **Orange County Sheriff-Coroner Department.**

2. Effective and comprehensive policies already exist in place to nullify any charges of conflict of interest in matters surrounding law enforcement-related deaths. The District Attorney has accepted the responsibility of directing these investigations. The Sheriff-Coroner does not direct, nor influence such investigations. The Orange County Coroner Division, the Sheriff-Coroner, and the Office of the District Attorney have established policies.

   A response to Finding 2 is required from the **Orange County Sheriff-Coroner Department** and the **Office of the District Attorney**.

3. In Orange County, Deputy Coroners have access to *all* relevant information produced by Sheriff's Investigators as well as that produced by city police detectives in matters they are investigating. Beyond the issue of visibility and funding lies hidden benefits of combined Sheriff-Coroner operation. The combined office also allows easy and unfettered access to such things as toxicological and other forensic facilities.

   A response to Finding 3 is required from the **Orange County Sheriff-Coroner Department**.

4. Staffing is inadequate for the current and future workloads in the Coroner Division. The staffing level of Supervising Deputy Coroners has remained static for 16 years, with steadily increasing work and responsibilities.

   A response to Finding 4 is required from the **Orange County Sheriff-Coroner Department.**

5. The autopsy rooms and equipment date from 1981 and are beginning to show signs of age. The computer system also requires upgrading, both the existing in-house equipment, as well as the planned laptops and wireless modems for the staff field vehicles. Currently the computer software used is unwieldy and inefficient. Currently, the clerical personnel are required to manually input information repeatedly in various fields within the program, increasing the workload and decreasing the efficiency.

   A response to Finding 5 is required from the **Orange County Sheriff-Coroner Department.**

# RECOMMENDATIONS

Under *California Penal Code* § 933 and § 933.05 the Grand Jury requires responses from the appropriate agencies and officials to each of the following recommendations. Based on the findings, the 1998–99 Orange County Grand Jury recommends that:

1. The Orange County Sheriff-Coroner Department remain consolidated as it currently exists. The current open working relationship between Sheriff-Coroner Department personnel should be maintained, that the budget of the Coroner Division should remain a priority item, and services such as forensics and toxicology should continue to be conducted in-house. (See Finding 1.)

   A response to Recommendation 1 is required from **Orange County Sheriff-Coroner Department.**

2. The current Memorandum of Understanding between the Sheriff-Coroner and the District Attorney be maintained. (See Findings 2 and 3.)

   A response to Recommendation 2 is required from **Orange County Sheriff-Coroner Department.**

3. The Orange County Sheriff-Coroner Department consider hiring one additional Supervising Deputy Coroner, additional Deputy Coroners, additional Forensic Assistants, and additional clerical staff. (See Finding 4.)

   A response to Recommendation 3 is required from **Orange County Sheriff-Coroner Department** and **Board of Supervisors**.

4. The Coroner Division develop a business plan in order to purchase newer equipment and expand its floor space. The equipment used in the autopsy room, although currently adequate, should be replaced in the near future. The equipment needs to be upgraded to maintain a state-of-the-art facility. In order to accommodate the additional personnel suggested in Recommendation # 3 above, the existing floor space needs to be expanded, if possible. It is recommended that Orange County's Coroner Division investigate the Alameda County Coroner's computer system and determine if it would be beneficial to adopt. (See Finding 5.)

   A response to Recommendation 4 is required from **Orange County Sheriff-Coroner Department**.

# COMMENDATIONS

The special programs the Coroner Division offers, in particular the Youthful Drunk Driver Program, are invaluable to the County of Orange and its residents. The Grand Jury wishes to commend this program for its efforts at working towards reducing the tragic loss of life and injuries resulting from youthful drunk drivers.

The Grand Jury also wishes to commend the Orange County Coroner Division and its personnel. The Division is held in high esteem by counties throughout California operating under a wide variety of systems, not just Sheriff-Coroner operations. Upon the Grand

Jury's review of the Orange County Coroner Division, it is clear that this praise is well founded.

# APPENDIX

*Custodial Death Investigations by the District Attorney,* March 7, 1995. Office of the Orange County District Attorney.

*Los Angeles County Department of Coroner Fact Sheet* (no date). Los Angeles County Department of Coroner.

*Memorandum of Understanding Between The Health Care Agency and the Sheriff-Coroner Department,* September 5, 1985. Medical Services Program Office of the Orange County Health Care Agency.

*National Guidelines For Death Investigation,* (no date). United States Department of Justice, Grant #96-MU-CS-0005.

*Operational & Procedural Protocol,* April 13, 1995. Orange County Sheriff-Coroner Department.

*Memorandum of Understanding and Protocol Procedure*, December 6, 1990. Orange County Sheriff-Coroner Department and Huntington Beach Police Department.

*Operational & Procedural Protocol*, January 3, 1990. Orange County Chiefs of Police and Sheriff's Association.

*Orange County District Attorney Investigation Procedures for Officer Involved Incidents,* July 5, 1985. Orange County District Attorney's Office.

*Policy Memo-In-Custody and Law Enforcement Officer-Involved Death Investigations,* July 13, 1988. Orange County Coroner Division.

*Report on Costs Associated with Separating Coroner Functions the Sheriff's Department,* April 1985. Arthur Young International.

*Sheriff-Coroner Conflict of Interest Study*, April 4, 1985. Orange County Grand Jury.

*Sheriff-Coroner Department Post Implementation Review*, March 24, 1987. County Administrative Officer.

*Youthful Drunk Driver Program* (no date). Orange County Sheriff-Coroner Department.

# INTERVIEWS

Personnel, Orange County Sheriff-Coroner Department.

Personnel, Office of the Orange County District Attorney.

Personnel, Office of the San Diego County Medical Examiner.

Personnel, Office of the Los Angeles County Department of Coroner.

Personnel, Office of the San Bernardino County Department of Coroner/Public Administrator.

Personnel, Office of the Alameda County Sheriff-Coroner Bureau.