San Mateo County Coroner
2019 Annual Report

Robert J. Foucrault, Coroner

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The mission of the Coroner's Office is to serve the residents of San Mateo County by providing prompt independent investigations to determine the cause and manner of death of decedents under the Coroner's jurisdiction and to provide high quality service in a courteous manner balancing the needs of residents with the Coroner's legal requirement.

Introduction

The Coroner's Office conducts medicolegal death investigations to determine the cause, manner, and circumstances of deaths meeting criteria as defined in California Government Code §27491 and California Health and Safety Code §102850.

According to the United States Census Bureau, San Mateo County was estimated to have a population of 766,573 in 2019. There were approximately 4,727 deaths recorded in San Mateo County in 2019. Of these deaths, 2,059 deaths were reported to the Coroner's Office. After initial investigation, 618 were determined to be full Coroner cases with the final cause of death signed by the Coroner, or his designated authority.

This 2019 Annual Report provides an overview of the work performed by San Mateo County Coroner's Office including a statistical breakdown of the types of deaths that occurred within San Mateo County for the year of 2019.

In 2019, the Coroner's Office achieved some major accomplishments:

- The San Mateo County Coroner's Office was awarded accreditation with the International Association of Coroners and Medical Examiners (IAC&ME). San Mateo County Coroner's Office was the first medicolegal death investigation agency to be awarded accreditation with IAC&ME in California. Accreditation of the San Mateo County Coroner's Office met well in advance the 2016 recommendation by the National Commission on Forensic Science for accreditation of all medicolegal death investigation offices by 2020 year-end. The process of accreditation was supported through the National Institute of Justice (NIJ) "Strengthening the Medical Examiner-Coroner System" grant awarded to the Coroner's Office.
- The Coroner's Office was awarded the STARS "Diversity and Inclusion Award" from San Mateo County for their SAVE-A-LIFE program.

The Coroner's Office became accredited by the International Association of Coroners & Medical Examiners (IAC&ME) on November 21, 2019

- The Coroner's Office continued to support specialized medicolegal death investigation training through American Board of Medicolegal Death Investigators (ABMDI) and California Peace Officer Standards & Training (POST) for staff members:
    - Two Deputy Coroners were awarded new certificates from POST including the "POST Basic Certificate" and "POST Advanced Certificate."
    - One Assistant Coroner was awarded the "POST Management Certificate" and one Supervising Deputy Coroner was awarded the "POST Supervisory Certificate"
    - The Assistant Coroner completed the POST "Management Course."
    - Three staff members attended the 2019 "Coroner Advanced Symposium" hosted by the California State Coroners Association.
    - Four Deputy Coroners achieved ABMDI diplomate certification.
    - One Assistant Coroner achieved ABMDI fellow board certification (fellow).
- One Deputy Coroner was awarded the "Investigator of the Year" by the California State Coroner's Association

The Coroner's Office continued to support youth and community outreach:

- The Save-A-Life program continued to provide services to at-risk youth with 11 students attending the program in 2019.
- Two Coroner Interns completed the academic internship program in fall 2019 and two new interns were selected to begin their internship for the 2019-20 academic year.
- Staff members participated in the annual Disaster Preparedness Day and Disaster Service Workers Day.
- Staff members participated in two "Every 15 Minutes" and "Sober Prom" events at local high schools.
- Staff members participated in career resource days and presented to high school students of Menlo School, university students of Notre Dame de Namur, the general public at San Mateo Public Library, a youth workshop at Redwood City Public Library, and the South San Francisco Police Department's Citizens' Academy about the Coroner's duties in San Mateo County.

An instructor demonstrated the components of an autopsy on a dummy for students of the Save a Life program

Coroner Office staff introduced a new forensics anthropology lab at a youth forensics workshop at Redwood City Public Library.

The Coroner's Office collaborated with local and national allied agencies for improving working relationships in a variety of scenarios:

- The Coroner's Office presented the "Suicide Consolidated Risk Assessment Profile" to San Mateo County's Suicide Prevention Committee to elicit feedback on the "Suicide Consolidated Risk Assessment Profile" which will assess the risk factors associated with deaths by suicide.
- The Coroner's Office strengthened mass fatality planning with membership with San Mateo County Emergency Managers Association; a staff visit to San Francisco International Airport's temporary morgue facility and collaboration with multiple agencies; staff attendance to a mutual aid workshop; and participation with exercises such as the full-scale San Francisco International Airport annual emergency exercise, the 2019 San Mateo County Statewide Medical and Health Exercise, and the Office of Emergency Services Emergency Operations Center functional activation.
- The Coroner's Office strengthened relationships with local law enforcement through presentations to evidence and property managers in San Mateo County and the San Mateo County Critical Incident Stress Management Team.
- The Coroner's Office continued to offer POST and ABMDI certified training to Bay Area law enforcement officers. The course was additionally tailored to educate fire personnel and fire paramedics.
- The Coroner's Office partnered with the California Department of Public Health for the reporting of statistics for violent deaths and opioid overdoses on a national level.
- The Coroner's Office presented the Coroner's role to hospice and home health clinicians to encourage better collaboration for at-home death investigations.

A staff member participated in the full-scale exercise at the San Francisco International Airport

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San Mateo County Coroner 2019 Staff

Robert J. Foucrault	Coroner
Christi Canclini	Executive Assistant (Mar-Dec)
Emily Tauscher	Assistant Coroner
K'Lynn Solt	Supervising Deputy Coroner
	Chief Deputy Coroner (Working out of class) (Oct-Dec)
Elizabeth Ortiz	Supervising Deputy Coroner (Working out of class) (Nov-Dec)

Investigations

Holly Benedict	Deputy Coroner
Hastin Stein	Deputy Coroner
Elizabeth Ortiz	Deputy Coroner
Danielle Montesano	Deputy Coroner
Alana Stark	Deputy Coroner
Heather Diaz	Deputy Coroner
Laura Bailey	Deputy Coroner (Working out of class) (Jan-Dec)

Pathology

Laura Bailey	Forensic Autopsy Technician
Maggi Horn	Forensic Autopsy Technician (Jan-Aug)
Devan Glensor	Forensic Autopsy Technician (Limited Term) (Jan-Aug)
	Forensic Autopsy Technician (Aug-Dec)
Megan Walton	Forensic Autopsy Technician (Extra Help) (Jan-May)
Alina Revilla	Forensic Autopsy Technician (Limited Term) (Sept-Dec)
Michelle Schabinger	Forensic Autopsy Technician (Extra Help) (Oct-Dec)

Administration

Jackie Fleming	Public Service Specialist (Jan-Mar)
Devon Botham	Management Fellow (Limited Term) (Jan-Feb)
Nisael Navarro	Coroner Intern (Extra Help) (Jan-Aug)
Katherine Bates	Coroner Intern (Extra Help) (Jan-Mar)
Teala Blackburn	Coroner Intern (Extra Help) (Apr-Aug)
Michael Aldana	Coroner Intern (Extra Help) (Apr-Sept)
Maria Shoats	Coroner Intern (Extra Help) (Sept-Dec)
Tritia Mallari	Coroner Intern (Extra Help) (Oct-Dec)
Joseph Begovich	Coroner Intern (Extra Help) (Nov-Dec)
Unfilled	Fiscal Office Assistant I/II

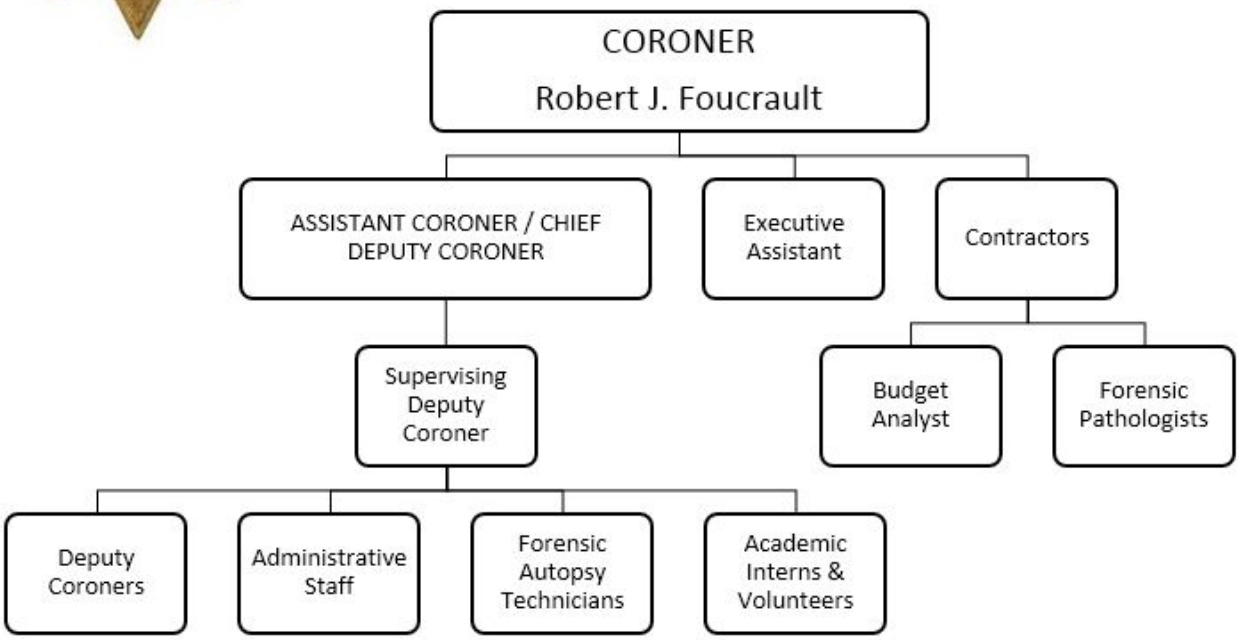
Contractors

Peter Benson, M.D.	Forensic Pathologist
Thomas Rogers, M.D.	Forensic Pathologist

SAN MATEO County of San Mateo

CORONER'S OFFICE

ORGANIZATIONAL CHART



Reportable Criteria
Part 1 of 3

California Government Code §27491 and Health and Safety Code §102850 direct the authority and duty of the Coroner to inquire into and determine the circumstances, manner, and cause of the following deaths which are immediately reportable:

1. When a death is not in the attendance of a physician or during the continued absence of the qualifying physician. This includes deaths outside hospitals and nursing care facilities. This includes deaths which occur without attendance of a physician, such as when there is no history of medical attention of the deceased or when attention was so remote as to afford no knowledge in relation to the cause of death, the death is reportable. The Coroner/Deputy Coroner will determine the extent of the investigation, depending on the nature and gravity of the illness preceding death, and upon the physician's opinion of the patient's actual life expectancy at the time of the physician's last visit. If, during or after the investigation, it is ascertained that the death is due to natural causes and that there is a physician who is qualified and willing, the Coroner/Deputy Coroner will release the case to the physician for his/her 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. For a physician to qualify certifying and signing a Certificate of Death, the physician must have sufficient knowledge to reasonable state the cause of death occurring under natural circumstances.

A patient in a hospital is always considered as being in attendance. It is not necessary that the physician attend the patient for a period of 24 hours prior to death in order to sign the Certificate of Death. On natural deaths, a physician may be qualified to sign a Certificate of Death provided he/she attended the patient for a sufficient time to properly diagnose the case and to opine the cause of death. While it has been the practice to report any and hospital deaths, which occur within 24 hours of admission, this practice is not required by state law. If a hospital has an administrative policy of reporting cases to the Coroner/Deputy Coroner when a patient dies within 24 hours after admittance, the Coroner/Deputy 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 followed by the physician. When the physician notifies the Coroner/Deputy Coroner, he/she will decide the extent of the investigation, depending on the nature and gravity of the illness preceding death, and upon the physician's opinion of the patient's actual life expectancy at the time of the physician's last visit. Cooperation and consultation between the Coroner/Deputy Coroner and the physician may provide cause; however, if the doctor's prior knowledge of the subject could not be applied to the death, then the Coroner/Deputy Coroner would pursue additional investigation.

Reportable Criteria
Part 2 of 3

3. When the physician is reasonably unable to state the cause of death or when the death is sudden and unexpected. The physician reporting the case must have a reasonable basis for his/her opinion. *The physician cannot be simply unwilling to state the cause of death.*

4. Known or suspected homicides.

5. Known or suspected suicides.

6. Associated with a known or alleged rape.

7. Involving any criminal act or suspicion of a criminal act. This would include instances where there is evidence or suspicion of criminal abortion (self-induced or by the act of another), euthanasia, or the later result of an accident. 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.

8. Following an accident or injury. Whether an accident or injury caused the death immediately or even a considerable time later, the case is reportable. Whether the accident or injury was of grave nature or only slight, so long as it *is the opinion of the attending or reporting physician that it might have contributed to the death in any degree.*

If the injury is to be listed anywhere on the Certification of Death, as contributory even though not the immediate cause of death, the case must be reported to the Coroner's Office. When, in the opinion of the physician, the injury is so slight that he/she does not believe that it contributed to the death, it is best to report such deaths so the Coroner/Deputy Coroner may decide whether any criminal, civil or legal consideration enters into the case that may require further investigation. Particularly, when a second party may have liability for the occurrence, the Coroner/Deputy Coroner will weigh the circumstances to ascertain whether any authorized public purpose or any aid to the administration of justice between involved parties will be served by full coroner involvement.

9. A death relating to a known or suspected drowning, hanging, gunshot, stabbing, cutting, starvation, exposure, drug overdose, fire, and strangulation.

10. Aspirations are reportable. The law accepts that a terminal aspiration can occur during the mechanics of death from a primary natural condition. *The local registrar rejects any Certificate of Death that indicates aspiration was a contributing factor in the death unless the death has been reported to the Coroner/Deputy Coroner.*

11. Intra-operative deaths. The Coroner/Deputy Coroner will determine whether an investigation is warranted. If the operative death is due to a misadventure or procedural problem than it would typically be considered an unnatural death and is reportable.

Reportable Criteria
Part 3 of 3

Deaths in operating rooms and deaths when a patient has not fully recovered from an anesthetic, whether in surgery, the recovery room or elsewhere. The Coroner's Office will proceed with a complete death investigation, when the nature of the death or legal implications warrants it.

12. Suspected accidental or intentional deaths by poisoning (food, chemical, drugs, therapeutic agent, etc.). Deaths, wholly or in part, due to industrial agents or toxins, ordinary food poisonings, household medications, prescribed pharmaceuticals and biological agents, are reportable when these circumstances in any way directly contributed to the death.

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/Deputy Coroner. Deaths from a contagious disease will be reported to the Coroner/Deputy Coroner.

14. When a death is clearly known to be due to, wholly or in part, an occupational disease or injury, that death is reportable.

15. In deaths of unknown or unidentified persons.

16. Suspected sudden infant death syndrome (SIDS) deaths. Any unexpected deaths of apparent healthy, thriving infants under the age of one year. Any deaths as a result of sleep related asphyxia.

17. Fetal deaths when gestation period is 20 weeks or longer.

18. Deaths while a decedent was incarcerated. This includes in-custody and police involved deaths.

19. Patients who are found comatose or remain comatose during their hospital admission and then die are reportable.

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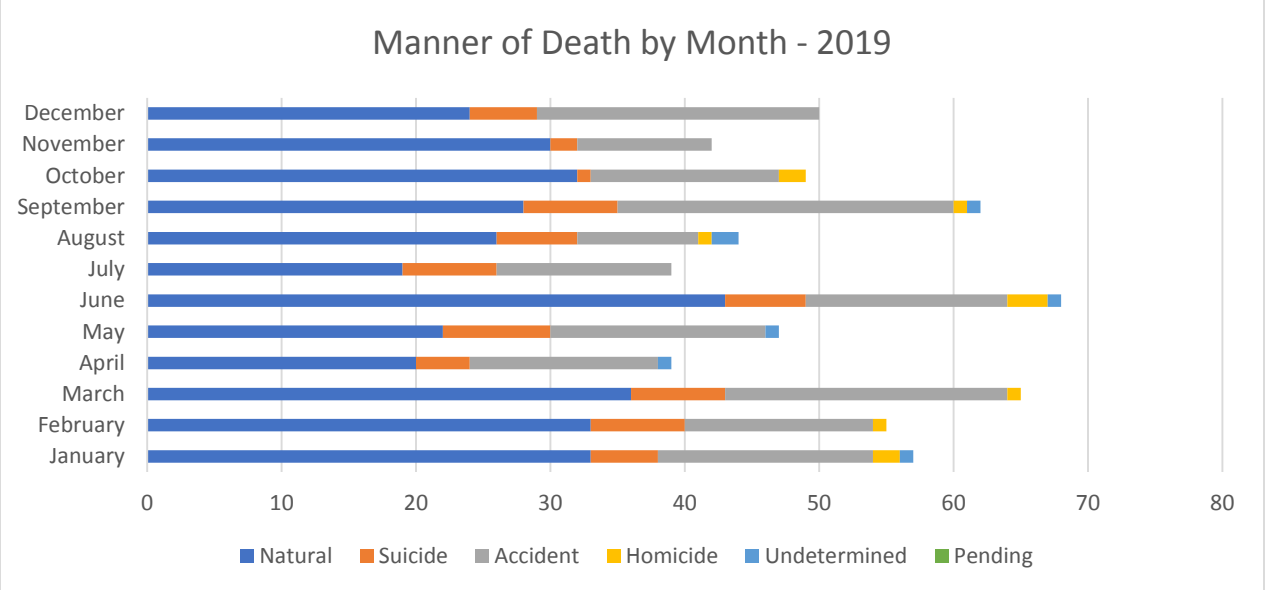
Statistics for Calendar Year 2019

Number of deaths reported:	2,059
Number of cases for full investigation:	618
Number of cases investigated at scene and released:	25
Number of cases by manner of death:	
Natural	347
Accident	188
Suicide	65
Homicide	11
Undetermined	7
Pending Investigation	0
Number of decedents transported:	
Coroner	496
Contractor	68
Mortuary/Funeral Home/Other	12
Forensic Examinations:	
Full Autopsy	269
Limited Autopsy	153
Clinical Review	92
Hospital Autopsies	0
Number of toxicology cases conducted:	443
Number of cases reported as "unidentified":	63
Identified after investigation	63
Remain unidentified	0
Organ and tissue donations:	
Cases referred for donation	1,487
Total organ donors	18
Total tissue donors	84
Total organs transplanted	57
Total tissue recipients	1,852
Exhumations:	0

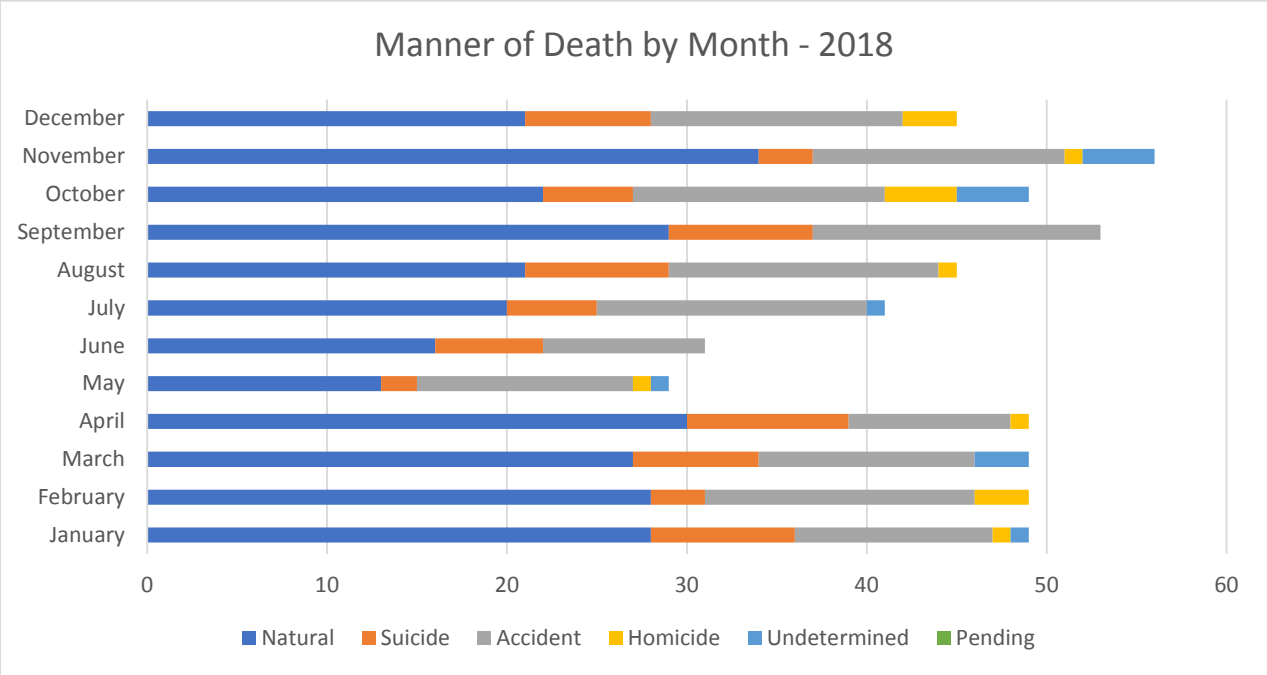
General Classifications of Death by Month

Coroner Case Statistics for 2019 by Month							
	Natural	**Suicide**	**Accident**	**Homicide**	**Undetermined**	**Pending**	**Total**
January	33	5	16	2	1	0	57
February	33	7	14	1	0	0	55
March	36	7	21	1	0	0	65
April	20	4	14	0	1	0	39
May	22	8	16	0	1	0	47
June	44	6	15	3	1	0	69
July	19	7	13	0	0	0	39
August	26	6	9	1	2	0	44
September	28	7	25	1	1	0	62
October	32	1	14	2	0	0	49
November	30	2	10	0	0	0	42
December	24	5	21	0	0	0	50
Total	347	65	188	11	7	0	618



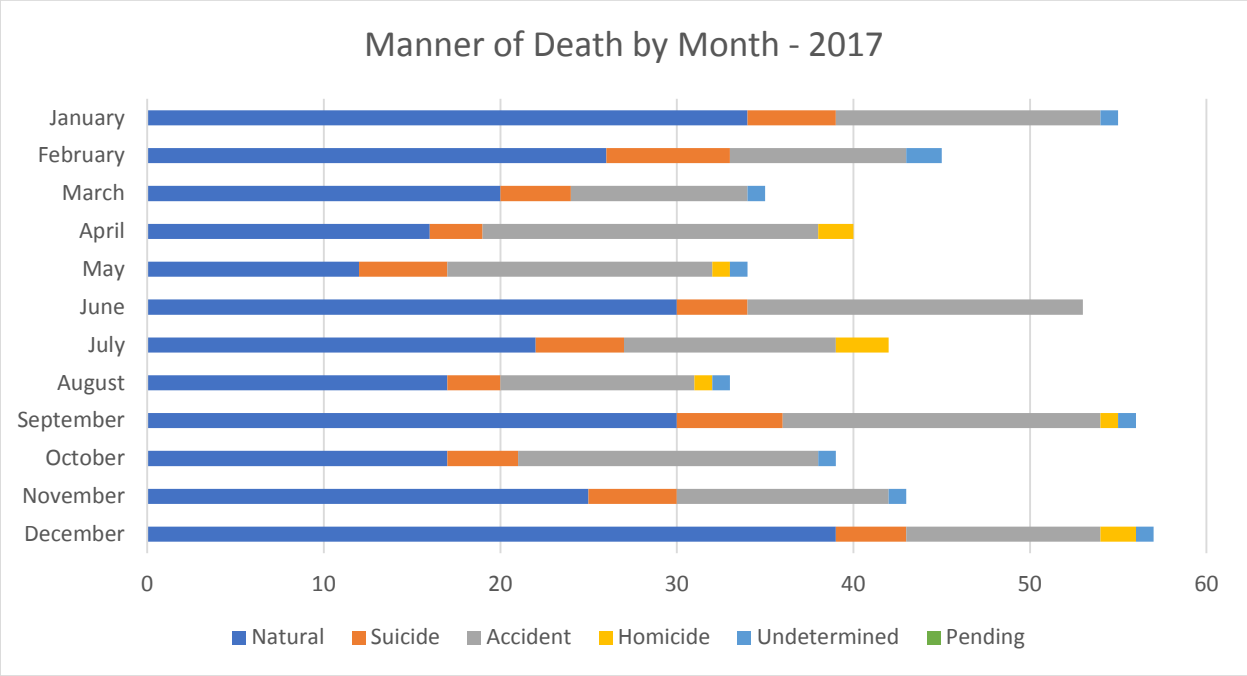
Historical Statistics

Coroner Case Statistics for 2018 by Month							
	Natural	**Suicide**	**Accident**	**Homicide**	**Undetermined**	**Pending**	**Total**
January	28	8	11	1	1	0	49
February	28	3	15	3	0	0	49
March	27	7	12	0	3	0	49
April	30	9	9	1	0	0	49
May	13	2	12	1	1	0	29
June	16	6	9	0	0	0	31
July	20	5	15	0	1	0	41
August	21	8	15	1	0	0	45
September	29	8	16	0	0	0	53
October	22	5	14	4	4	0	49
November	33	3	15	1	4	0	56
December	21	7	14	3	0	0	45
Total	288	71	157	15	14	0	545



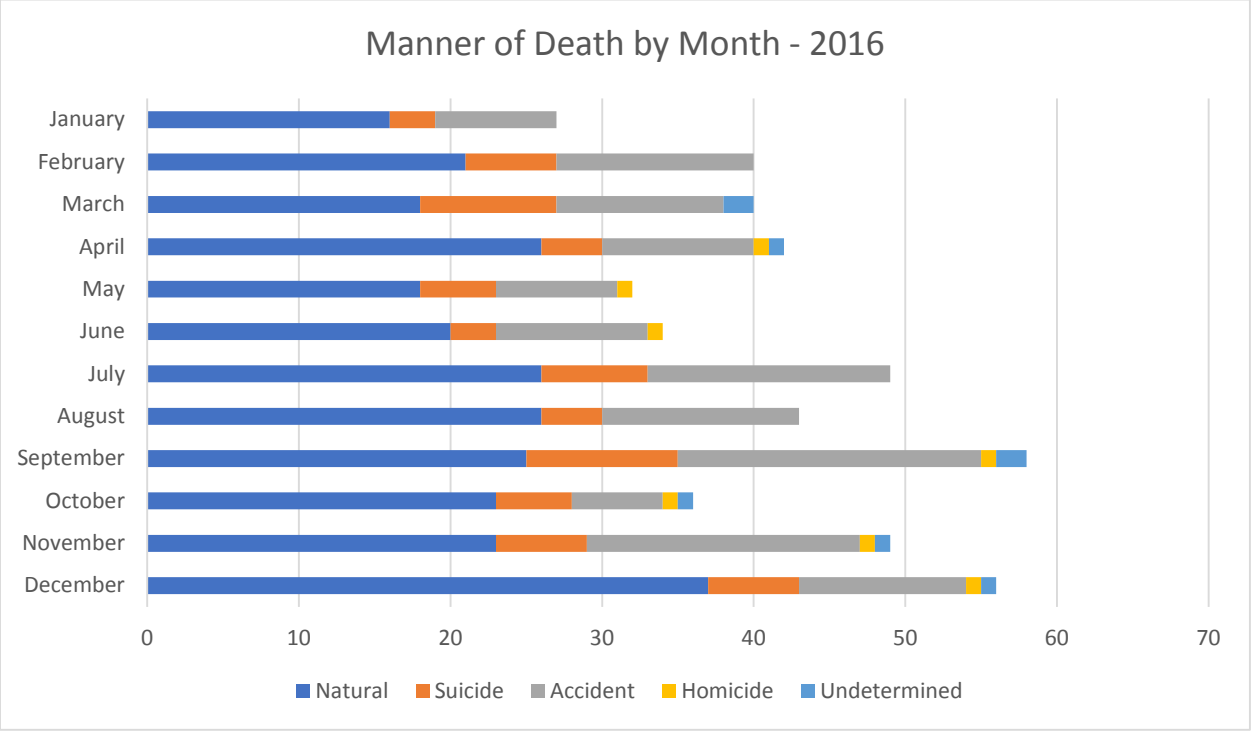
Historical Statistics (continued)

Coroner Case Statistics for 2017 by Month							
	Natural	**Suicide**	**Accident**	**Homicide**	**Undetermined**	**Pending**	**Total**
January	34	5	15	0	1	0	55
February	26	7	10	0	2	0	45
March	20	4	10	0	1	0	35
April	16	3	19	2	0	0	40
May	12	5	15	1	1	0	34
June	30	4	19	0	0	0	53
July	22	5	12	3	0	0	42
August	17	3	11	1	1	0	33
September	30	6	18	1	1	0	56
October	17	4	17	0	1	0	39
November	25	5	12	0	1	0	43
December	39	4	11	2	1	0	57
Total	288	55	169	10	10	0	532



Historical Statistics (continued)

Coroner Case Statistics for 2016 by Month							
	Natural	**Suicide**	**Accident**	**Homicide**	**Undetermined**	**Pending**	**Total**
January	16	3	8	0	0	0	27
February	21	6	13	0	0	0	40
March	18	9	11	0	2	0	40
April	26	4	10	1	1	0	42
May	18	5	8	1	0	0	32
June	20	3	10	1	0	0	34
July	26	7	16	0	0	0	49
August	26	4	13	0	0	0	43
September	25	10	20	1	2	0	58
October	23	5	6	1	1	0	36
November	23	6	18	1	2	0	50
December	37	6	12	1	1	0	57
Total	279	68	145	7	9	0	508



Natural

Natural deaths are due solely or nearly totally to disease and/or the aging process.

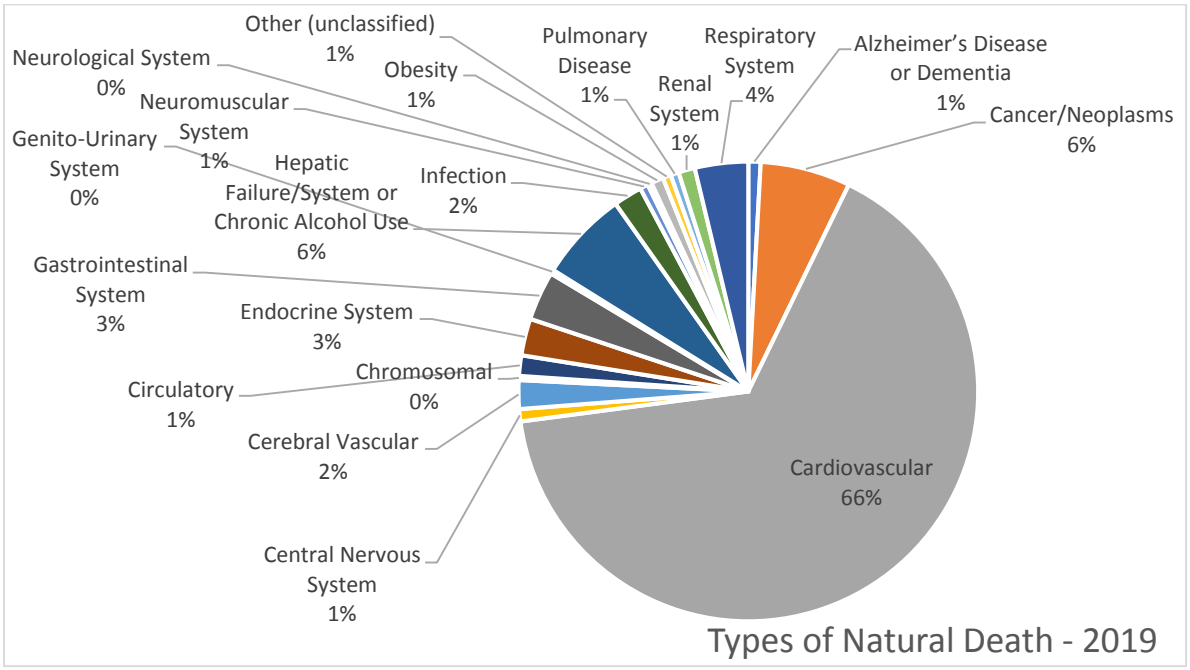
Total Natural Deaths in 2019: 347

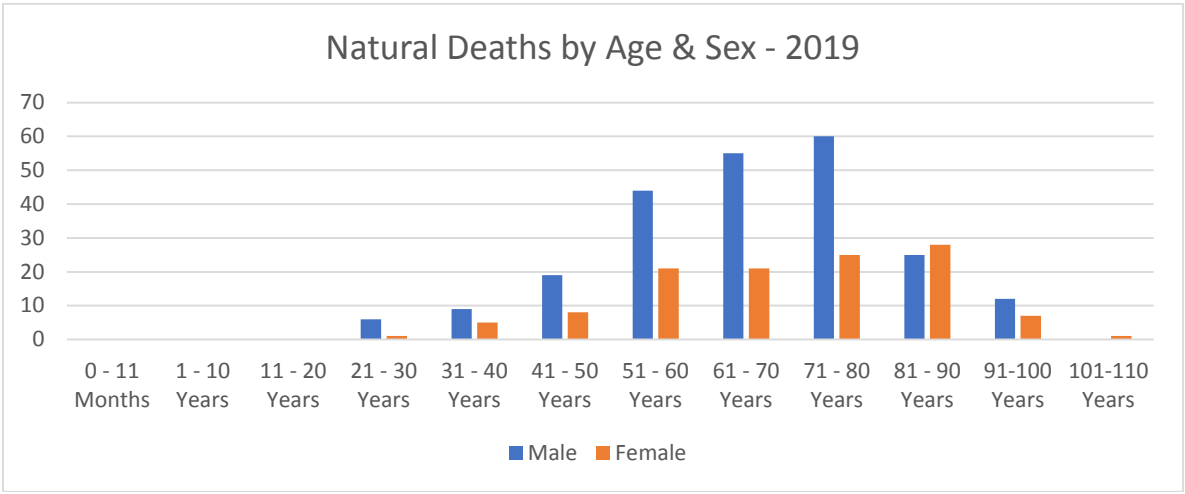
Types of Natural Deaths by Sex			
Types of Natural Deaths	**Total**	**Male**	**Female**
Alzheimer's Disease or Dementia	3	3	0
Cancer/Neoplasms	22	13	9
Cardiovascular	228	158	70
Central Nervous System	3	0	3
Cerebral Vascular	7	5	2
Chromosomal	1	0	1
Circulatory	5	1	4
Endocrine System	9	5	4
Gastrointestinal System	12	9	3
Genito-Urinary System	1	0	1
Hepatic Failure/System or Chronic Alcohol Use	22	17	5
Infection	7	4	3
Neuromuscular System	2	2	0
Neurological System	1	1	0
Obesity	3	2	1
Other (unclassified)	2	2	0
Pulmonary Disease	2	2	0
Renal System	4	3	1
Respiratory System	13	3	10

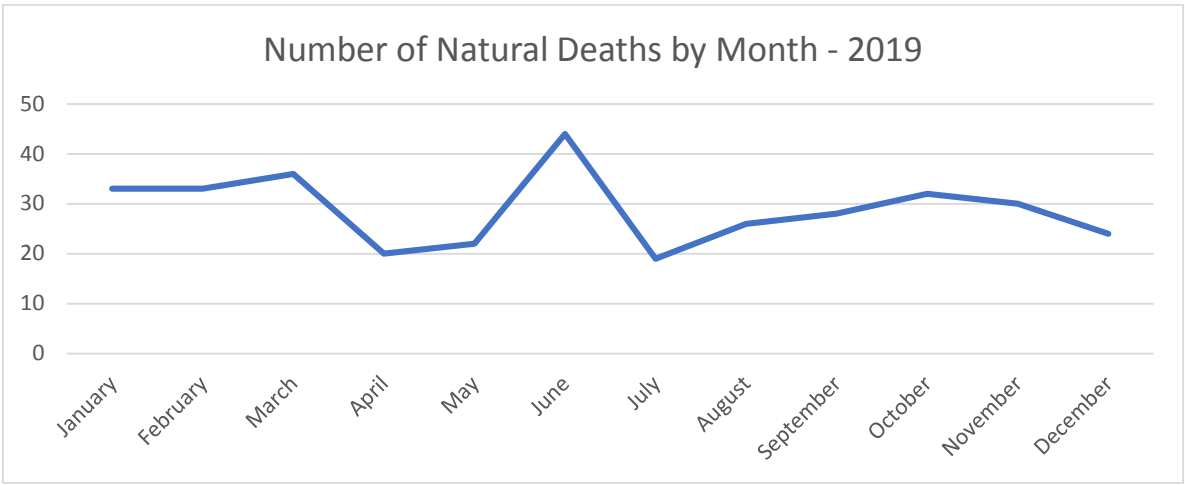
Natural Deaths by Month	
Month	**Number of Natural Deaths**
January	33
February	33
March	36
April	20
May	22
June	44
July	19
August	26
September	28
October	32
November	30
December	24

Natural Deaths by Age & Sex					
Age	**Male**	**Female**	**Age**	**Male**	**Female**
0 - 11 Months	0	0	51 - 60 Years	44	21
1 - 10 Years	0	0	61 - 70 Years	55	21
11 - 20 Years	0	0	71 - 80 Years	60	25
21 - 30 Years	6	1	81 - 90 Years	25	28
31 - 40 Years	9	5	91-100 Years	12	7
41 - 50 Years	19	8	101-110 Years	0	1

Natural


Other (unclassified) 1%
Neurological System 0%
Obesity 1%
Pulmonary Disease 1%
Respiratory System 4%
Alzheimer's Disease or Dementia 1%
Renal System 1%
Neuromuscular System 1%
Cancer/Neoplasms 6%
Genito-Urinary System 0%
Hepatic Failure/System or Chronic Alcohol Use 6%
Infection 2%
Gastrointestinal System 3%
Endocrine System 3%
Chromosomal 0%
Circulatory 1%
Cerebral Vascular 2%
Cardiovascular 66%
Central Nervous System 1%
Types of Natural Death - 2019


Natural Deaths by Age & Sex - 2019
70
60
50
40
30
20
10
0
0 - 11 Months
1 - 10 Years
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
101-110 Years
Male
Female


Number of Natural Deaths by Month - 2019
50
40
30
20
10
0
January
February
March
April
May
June
July
August
September
October
November
December

Suicide

Suicides result from an injury or poisoning as a result of an intentional, self-inflicted act committed to do self-harm or cause the death of one's self.

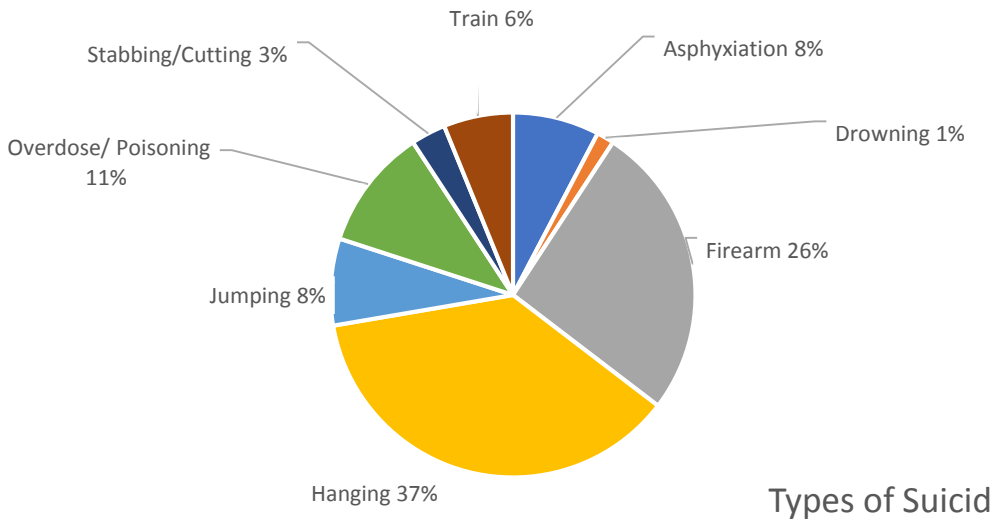
Total Number of Suicides in 2019: 65

Types of Suicides by Sex			
Types of Suicides	**Total**	**Male**	**Female**
Asphyxiation	5	2	3
Drowning	1	0	1
Firearm	17	15	2
Hanging	24	20	4
Jumping	5	4	1
Overdose/Poisoning	7	4	3
Stabbing/Cutting	2	2	0
Train	4	3	1

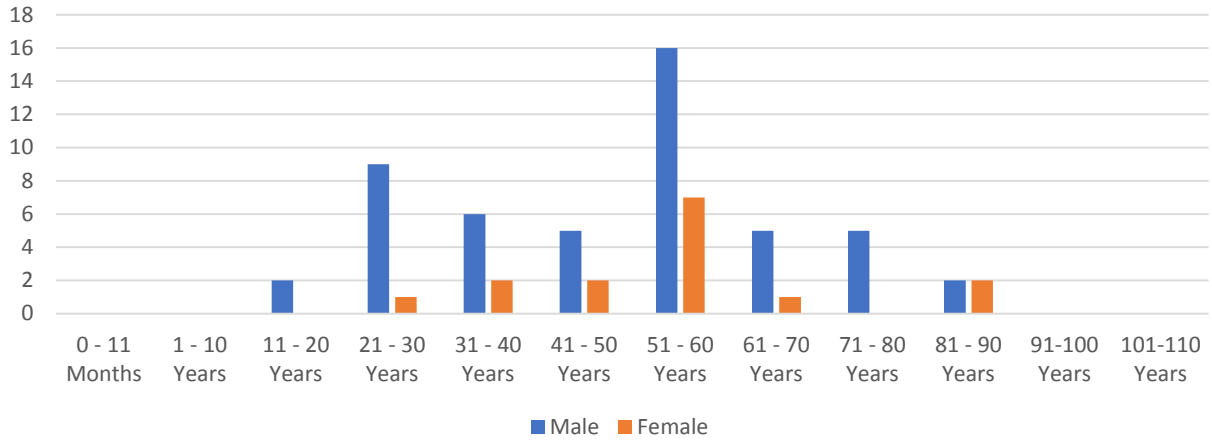
Suicide by Month	
Month	**Number of Suicides**
January	5
February	7
March	7
April	4
May	8
June	6
July	7
August	6
September	7
October	1
November	2
December	5

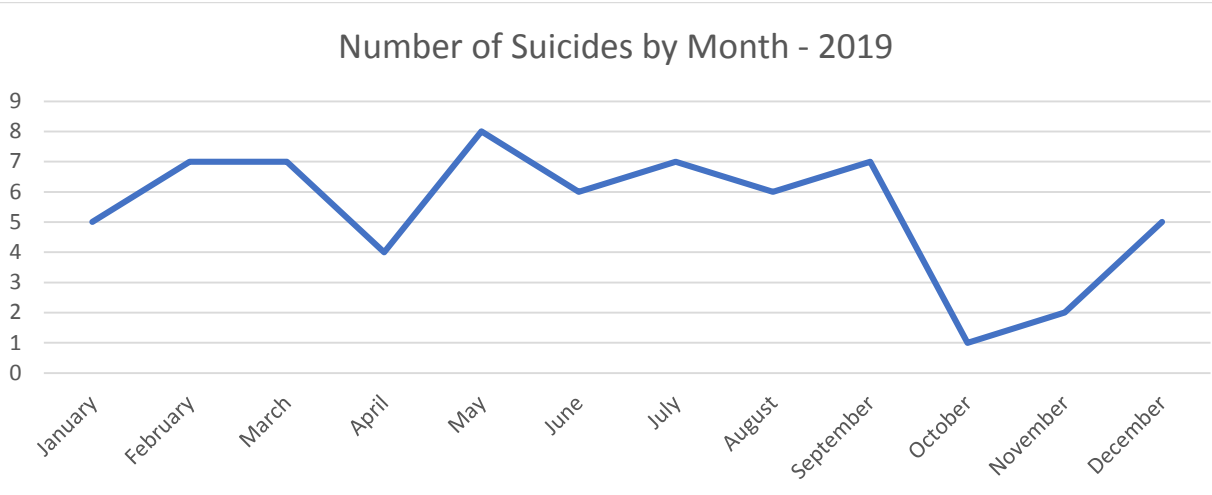
Suicide by Age & Sex		
Age	**Male**	**Female**
0 - 11 Months	0	0
1 - 10 Years	0	0
11 - 20 Years	2	0
21 - 30 Years	9	1
31 - 40 Years	6	2
41 - 50 Years	5	2
51 - 60 Years	16	7
61 - 70 Years	5	1
71 - 80 Years	5	0
81 - 90 Years	2	2
91-100 Years	0	0
101-110 Years	0	0

Suicide



Types of Suicides - 2019





Accident

An accident applies when an injury or poisoning causes death and there is little or no evidence that the injury or poisoning occurred with intent to harm or cause death. In essence, the fatal outcome was unintentional. Motor Vehicle Accidents are not included in the statistics below.

Total Number of Accidental Deaths in 2019: 161

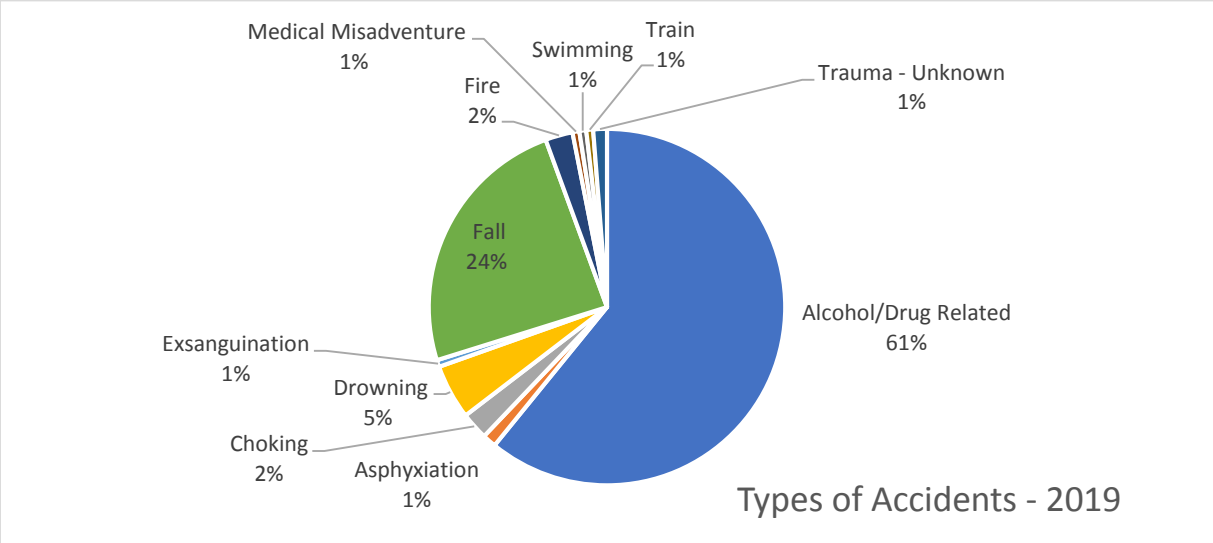
**not including motor vehicle accidents*

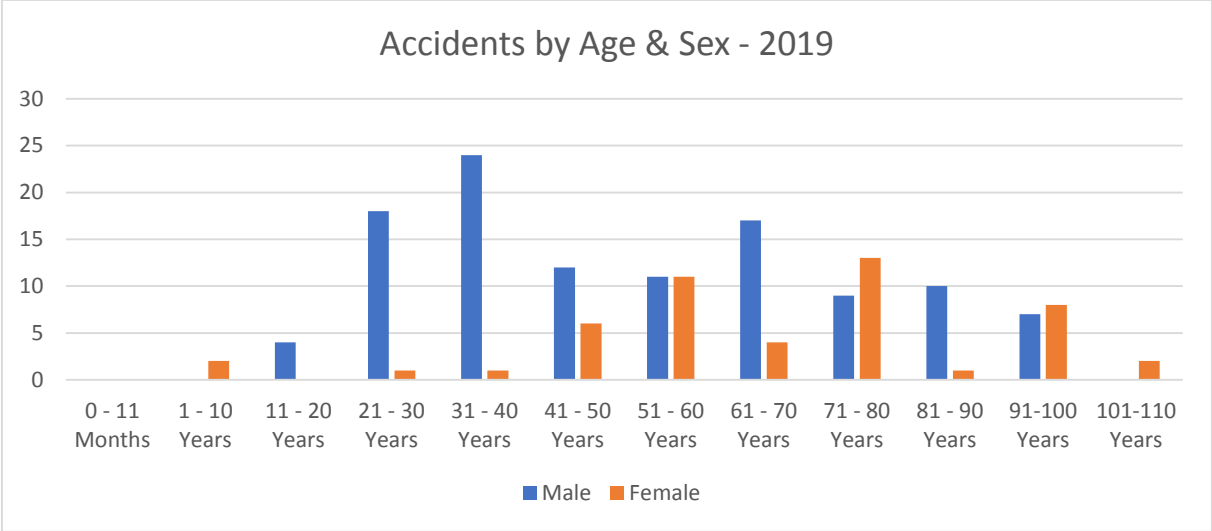
Types of Accidents by Sex			
Type of Accident	**Total**	**Male**	**Female**
Alcohol/Drug Related	98	76	22
Asphyxiation	2	1	1
Choking	4	3	1
Drowning	8	6	2
Exsanguination	1	1	0
Fall	39	20	19
Fire	4	1	3
Medical Misadventure	1	1	0
Swimming	1	1	0
Train	1	1	0
Trauma - Unknown	2	1	1

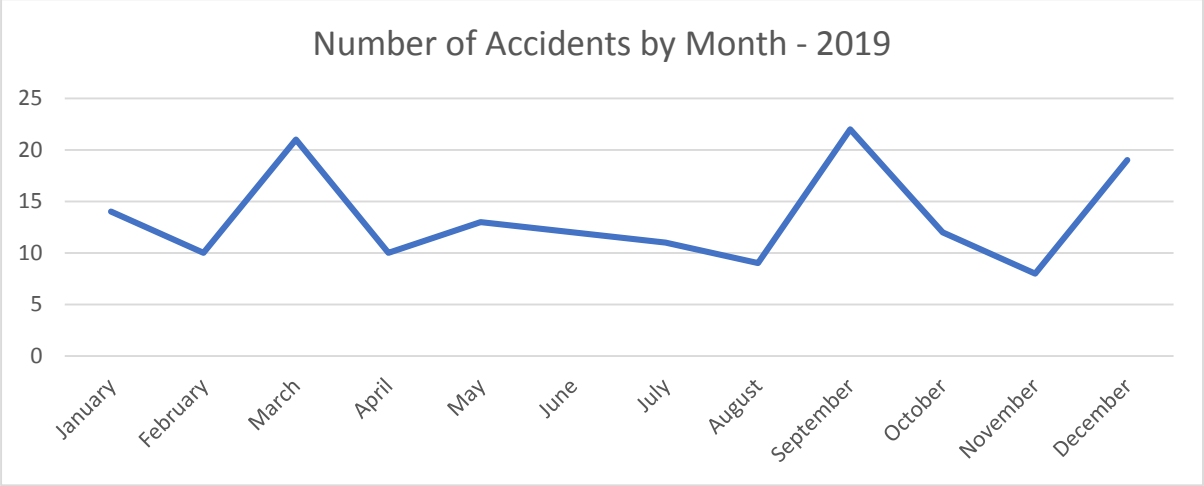
Accidents by Month	
Month	**Number of Accidents**
January	14
February	10
March	21
April	10
May	13
June	12
July	11
August	9
September	22
October	12
November	8
December	19

Accidents by Age & Sex		
Age	**Male**	**Female**
0 - 11 Months	0	0
1 - 10 Years	0	2
11 - 20 Years	4	0
21 - 30 Years	18	1
31 - 40 Years	24	1
41 - 50 Years	12	6
51 - 60 Years	11	11
61 - 70 Years	17	4
71 - 80 Years	9	13
81 - 90 Years	10	1
91-100 Years	7	8
101-110 Years	0	2

Accident


Medical Misadventure 1%
Swimming 1%
Train 1%
Fire 2%
Trauma - Unknown 1%
Fall 24%
Alcohol/Drug Related 61%
Exsanguination 1%
Drowning 5%
Choking 2%
Asphyxiation 1%
Types of Accidents - 2019


Accidents by Age & Sex - 2019
30
25
20
15
10
5
0
0 - 11 Months
1 - 10 Years
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
101-110 Years
Male
Female


Number of Accidents by Month - 2019
25
20
15
10
5
0
January
February
March
April
May
June
July
August
September
October
November
December

Motor Vehicle Fatalities

The Coroner's Office, as well as other law enforcement agencies within the jurisdiction where the motor vehicle fatality occurs, conducts a thorough investigation of any accident involving a motor vehicle or traffic collision. Following a thorough investigation and an autopsy examination, the manner of death may be determined to be natural, accident, suicide, homicide, or undetermined.

Total Number of Motor Vehicle Fatalities in 2019: 29

Types of Motor Vehicle Fatalities	
Type	**Number of Fatalities**
Automobile - Driver	8
Automobile - Passenger	3
Automobile - Unspecified	1
Bicyclist	2
Motorcyclist	7
Pedestrian	6
Pinned by Vehicle	2

Fatalities by Manner	
Manner of Death	**Number of Fatalities**
Natural	2
Accident	27
Suicide	0
Homicide	0
Undetermined	0

Fatalities by Month	
Month	**Number of Fatalities**
January	2
February	4
March	0
April	4
May	3
June	3
July	2
August	1
September	3
October	2
November	2
December	3

Fatalities by Age & Sex		
Age	**Male**	**Female**
0 - 11 Months	0	0
1 - 10 Years	0	0
11 - 20 Years	0	0
21 - 30 Years	6	1
31 - 40 Years	5	0
41 - 50 Years	1	0
51 - 60 Years	6	0
61 - 70 Years	1	3
71 - 80 Years	3	0
81 - 90 Years	2	1
91-100 Years	0	0
101-110 Years	0	0

Motor Vehicle Fatalities
Involving Alcohol and/or Drugs

Pursuant to California Government Code §27491.25, the Coroner's forensic pathologist takes blood and urine samples from the deceased to conduct appropriate, related chemical tests to determine the alcoholic contents, if any, of the body. If necessary, the Coroner may perform other chemical tests to determine the drug contents, if any, of the body. Testing of deceased persons under the age of 15 years is not required, unless the circumstances indicate the possibility of alcoholic and/or drug consumption. In some cases, the victims are hospitalized for a lengthy period of time prior to death and therefore, relevant blood and urine samples are unavailable for testing.

Total Number of Motor Vehicle Fatalities in 2019: 29

Type of Test Conducted and Substances Detected			
Results	**Alcohol Only**	**Routine Drug (Including Alcohol)**	**Complete Drug (Including Alcohol)**
Alcohol Only Present	2	3	2
Prescription Drugs Only Present	N/A	0	3
Illicit Drugs Only Present	N/A	0	0
Alcohol and Prescription Drugs Present	N/A	0	0
Alcohol and Illicit Drugs Present	N/A	0	1
Prescription and Illicit Drugs Present	N/A	0	1
Nothing Detected	8	5	2
Total	10	8	9
No Test Completed	2		

Homicide

A homicide occurs when death results from a volitional act committed by another person to cause fear, harm, or death. Intent to cause death is a common element, but it is not required for classification as homicide. It is to be emphasized that the classification of Homicide for the purpose of death certification is a term that neither indicates nor implies criminal intent, which remains a determination within the province of legal processes.

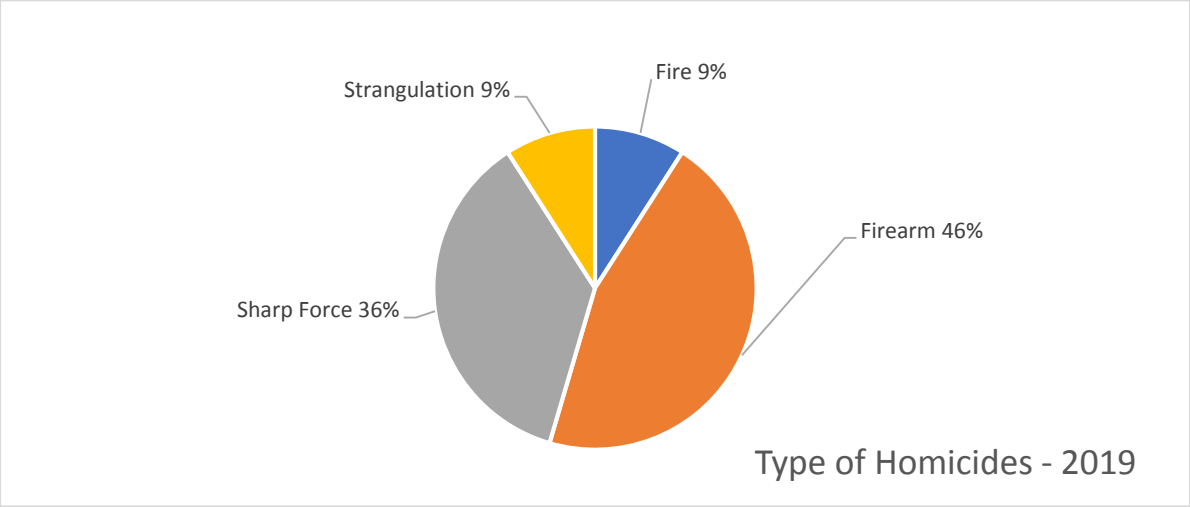
Total Number of Homicides in 2019: 11

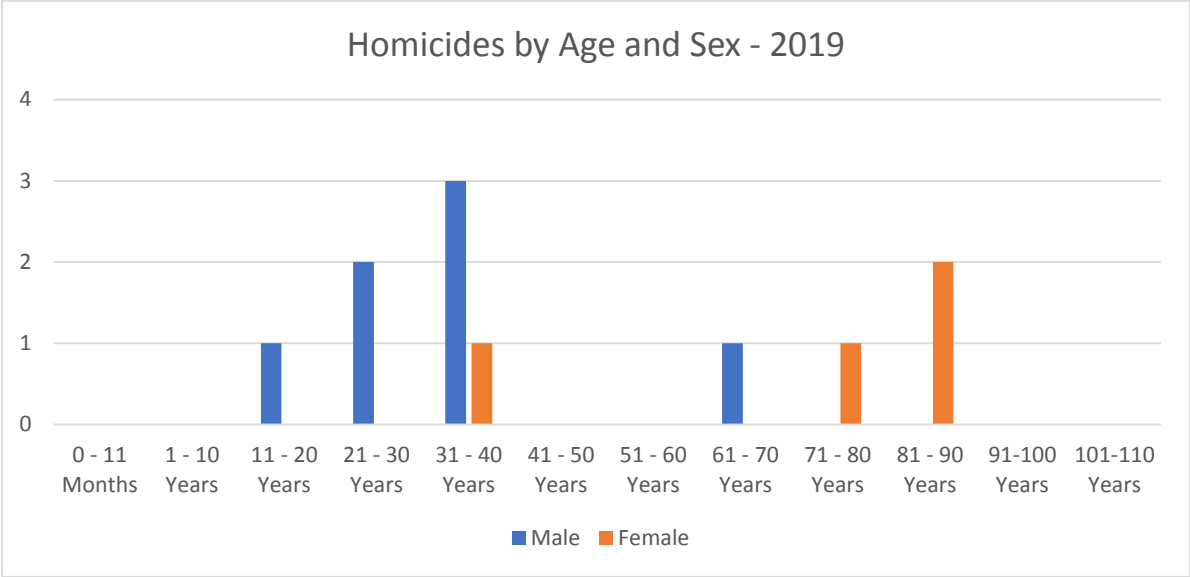
Type of Homicide by Sex			
Type of Homicide	**Total**	**Male**	**Female**
Fire	1	0	1
Firearm	5	3	2
Sharp Force	4	3	1
Strangulation	1	1	0

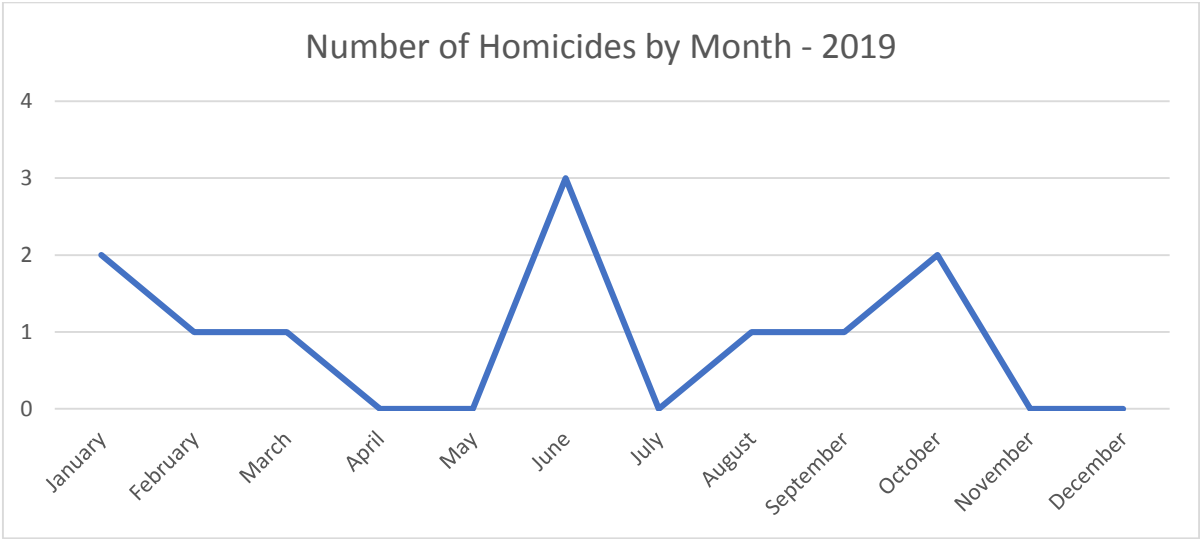
Homicides by Age & Sex		
Age	**Male**	**Female**
0 - 11 Months	0	0
1 - 10 Years	0	0
11 - 20 Years	1	0
21 - 30 Years	2	0
31 - 40 Years	3	1
41 - 50 Years	0	0
51 - 60 Years	0	0
61 - 70 Years	1	0
71 - 80 Years	0	1
81 - 90 Years	0	2
91-100 Years	0	0
101-110 Years	0	0

Homicides by Month	
Month	**Number of Homicides**
January	2
February	1
March	1
April	0
May	0
June	3
July	0
August	1
September	1
October	2
November	0
December	0

Homicide


Strangulation 9%
Fire 9%
Firearm 46%
Sharp Force 36%
Type of Homicides - 2019


Homicides by Age and Sex - 2019
4
3
2
1
0
0 - 11 Months
1 - 10 Years
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
101-110 Years
Male
Female


Number of Homicides by Month - 2019
4
3
2
1
0
January
February
March
April
May
June
July
August
September
October
November
December

Undetermined

Undetermined or "could not be determined" is a classification used when the information pointing to one manner of death is no more compelling than one or more other competing manners of death in thorough consideration of available information. Sometimes information concerning the circumstances of death may be inadequate due to a lengthy delay between the occurrence of the death and the discovery of the body. If an extensive investigation and autopsy cannot clarify the circumstances which led to a death, the death is then classified as undetermined.

Total Number of Undetermined Deaths in 2019: 7

Mode	Total
Not otherwise stated or awaiting further investigation	1
Trauma of undetermined manner	0
Decomposed Body or Skeletal Remains	4
Unexplained death in infancy	2
Unexplained death in childhood	0

Outside Jurisdiction

In any case where a Coroner is required to inquire into a death pursuant to California Government Code §27491, the Coroner may delegate his or her jurisdiction over the death to an agency of another county or the federal government under California Government Code §27491.55. This often occurs when the outside Coroner has jurisdictional interest in the death, for instance, if the suspected injury resulting in death occurred within the outside County's jurisdiction.

Total Number of Jurisdictional Releases by another County in 2019: 20

Manner	Total
Natural	1
Accident	14
Suicide	3
Homicide	2
Undetermined	0

County of Death	Total
Santa Clara	14
San Francisco	6

Indigent Cremation

Through the County Cremation process, the Coroner inters the remains of the decedent when no provisions for final disposition were made by the decedent and he or she is indigent. Additionally, if the Coroner notifies or attempts to notify the person responsible for the internment of the decedent's remains, as defined by Health and Safety Code §7100, and he or she fails, refuses, or neglects to handle the final disposition, the Coroner proceeds with internment via County Cremation.

County Cremations referred by outside agencies:	17
Cremations performed by the San Mateo County Coroner after remains were abandoned by family:	19
Dispositions handled by family after receiving a fee reduction by application for financial need:	10