San Mateo County Coroner
2023 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. The Coroner's Office is a California P.O.S.T. agency and is accredited by the International Association of Coroners and Medical Examiners. Deputy Coroners obtain certification through the American Board of Medicolegal Death Investigators within three years of employment.

According to the United States Census Bureau, San Mateo County was estimated to have a population of 764,442 in 2023, which increased 0.03% from 754,250 in 2022. There were 5,651 deaths recorded in San Mateo County in 2023 which decreased 6.33% from 2022 (6,033 deaths in 2022). Of these deaths, 2,056 deaths were reported to the Coroner's Office which decreased by 14.93% from 2,417 in 2022. After initial investigation, 508 were determined to be full Coroner cases with the final cause of death signed by the Coroner, or his designated authority; this decreased 14.33% from 593 in 2022.

This 2023 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 2023.

2023 Data Trends

Suicide Decrease
Suicide deaths were down 15.28% from 2022 (61 in 2023 versus 72 in 2022). There were just under three times as many male suicide deaths than female suicide deaths (47 males to 14 females). The three most common modes of death were hanging (20 cases), firearm (18 cases), and overdose/poisoning (9 cases). One suicide by overdose involved fentanyl.

Accident Increase – due to increase in alcohol and drug related deaths
Accidental deaths were up 5.31% from 2022 (218 in 2023 versus 207 in 2022). The total number of motor vehicle accidents decreased 5.13% in 2023 (37 in 2023 versus 39 in 2022). Drug and alcohol related deaths were up 5.61% from 2022 (113 in 2023 versus 107 in 2022). Of the 113 drug and alcohol related deaths, 68 cases tested positive for fentanyl.

Homicide Increase
San Mateo County saw a 7.14% increase in homicides in 2022 (14 in 2023 versus 13 in 2022). Seven of the 14 homicides were a result of the mass shooting in Half Moon Bay.

Unhoused Deaths

There were 40 decedents identified as transient in San Mateo County in 2023. Of those 40 deaths, none were mannered homicide, 2 were mannered undetermined, 1 was mannered suicide, 25 were mannered accident (including 14 fentanyl related cases, 3 non-opioid related overdoses, 2 non-fentanyl opioid related overdoses, and 6 blunt force trauma/crush injuries including 1 law enforcement involved case), and 12 were mannered natural.

Special Note about Half Moon Bay Mass Shooting

At the end of January 2023, the Coroner's Office received a call-out to the tragic shooting of seven individuals in Half Moon Bay. The Coroner's Office immediately responded to the scene to perform an independent investigation into the cause and manner of death for each person who lost their life. The main priority of the Office was to positively identify each deceased person and notify legal next of kin of their death with the utmost urgency and respect for the deceased and their families. Our staff worked tirelessly over the course of the scene investigation and worked diligently over the next few days, with other responding agencies, to ensure that a thorough investigation was completed.

Our continued condolences to the families of these seven individuals.

2023 Updates

In May 2023, the Coroner's Office celebrated the opening of their new Pathology Division located in the San Mateo Medical Center's new Administration Building (225 39th Avenue in San Mateo) by hosting a Ribbon Cutting and Open House. The 10,000 square foot facility is state of the art with three autopsy stations (including one in an isolated suite), a LODOX body scanner which x-rays a body in less than 12 seconds, and a secure sally port for decedent transportation.

The Coroner's Office officially moved in and began operations in the new facility in July 2023. Our exceptional Pathology Division staff, supervisor, and management took on new job duties and faced head-on the challenges of reorganizing and developing new processes within the new space.

While the Medical Center moves onto phase two of the project, the Coroner's Office continues to partner with Public Health's Mobile Clinics, the Project Development Unit,

Materials Management, and Environmental Services to help facilitate various logistical needs during construction. The Coroner's Office Administration and Investigations Divisions are looking forward to joining the Pathology Division at the Medical Center campus in the Link Building with a projected completion Summer 2025.

The Coroner's Office welcomed families of staff, San Mateo County executives, the Controller's Office, and local High School students to the new facility for guided tours of the new Pathology Division since the move.

2023 Accomplishments

In 2023, the Coroner's Office continued to pursue excellence by seeking opportunities for employee training and education in the field and supported the County's efforts focused on diversity, equity, and inclusion; hosted a variety of opportunities for members of the public to explore the role of the Coroner and medicolegal death investigations; partnered with other agencies to review untimely deaths to identify areas of need for community support and education; sought ways to generate team connectedness in wellness events; earned a variety of certifications and celebrated achievements; added new staff and contractors to the team; sought the identities of the unidentified; supported data sharing efforts locally, state-wide, and nationally; and prepared and practiced for emergencies. Below outlines some of the activities and accomplishments of the Office in 2023.

- Throughout 2023, the Coroner's Office attended the quarterly Child Death and hosted the quarterly Domestic Violence Death Review Teams to discuss relevant deaths with multiple partner agencies and community-based organizations within the County. The purpose of these death review team meetings is to review these untimely deaths and identify areas of improvement, need for support, and red flags for these vulnerable populations in San Mateo County.

Coroner staff presented to death review teams.

- One hundred percent of Coroner staff completed their 20-hour County training requirement in 2023. Staff attended a variety of trainings including Fiscal Officer's Training, Diversity and Equity trainings, field-specific trainings in forensic pathology and medicolegal death investigation, professional development trainings, and wellness trainings.

- In 2023, the Coroner's Office continued to partner with San Mateo County Epidemiology for reporting of statistics for suspected drug and alcohol related deaths as well as California Department of Public Health for the reporting of statistics for violent deaths and opioid overdoses. The Coroner's Office shares data on a local, state, and national level.

- At the start of FY2023-24, the Coroner's Office was approved to add one full-time Deputy Coroner position and one full-time Forensic Autopsy Technician position bringing the Office's total full-time employees to 17. The two positions proved to be much needed with an increasing case load and growing elder population.

- In 2023, the Coroner's Office hired and trained three full-time Forensic Autopsy Technicians and contracted with two new part-time Forensic Pathologists.

- Throughout 2023, Executive Assistant Cara Behrens helped the Coroner's Office to partner with the California Department of Public Health and the Centers for Disease Control and Prevention's (CDC) in data sharing efforts for the State Unintentional Drug Overdose Reporting System (SUDORS) and the National Violent Death Reporting System (NVDRS). These systems collect and analyze data so agencies can monitor and report out on overdose deaths and violent deaths in the state and compare the data to other jurisdictions nationwide.

- In 2023, Senior Accountant Luz Paran-Rey collaborated with the County's Procurement Unit in the acquisition of new procurement software to serve county-wide departments. Luz's expertise in fiscal matters provided much needed insight from the Coroner's Office to the project. Luz and Chief Deputy Coroner K'Lynn Weber both attended trainings related to the OpenGov software and roll-out plan.

Senior Accountant Luz collaborated with Procurement to bring OpenGov to the Coroner's Office.

- Three year-long Academic Interns joined the Coroner's Office in the summer of 2023 to explore the fields of Medicolegal Death Investigation and Forensic Pathology.

- Deputy Coroners Alana Stark and Eden Washburn and Supervising Deputy Coroner Elizabeth Ortiz were hard at work in 2023 advancing cold case John and Jane Doe cases to pursue identifications. The Coroner's Office partnered with local cemeteries to exhume one case from 1977 and two cases from 1985 which were sent off for DNA processing. Three unrelated cases from 1985 and 2004 were identified via DNA when they were reopened and sent for genetic genealogy by partnering with the Department of Justice and local law enforcement.

- In May 2023, Supervising Deputy Coroner Elizabeth Ortiz was recognized for her 10 years of service in San Mateo County. Elizabeth began her career as a Forensic Autopsy Technician in 2013 before becoming a Deputy Coroner and promoting into the Supervising Deputy Coroner position.

Congratulations Elizabeth for completing 10 years of service for the County of San Mateo!

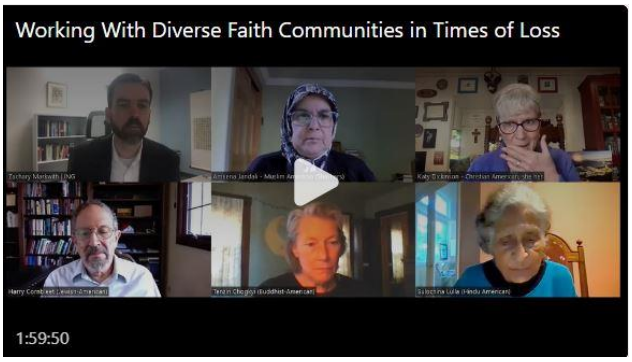
- In July 2023, Deputy Coroner Hastin Stein attended the International Association of Coroners and Medical Examiners Annual Virtual Advanced Medicolegal Symposium after being awarded a scholarship to attend. The symposium covered topics such as mass fatality incidents, postmortem interval estimation, drug toxicity-related deaths, child injury and sudden unexplained deaths of infants and toddlers, unidentified human remains investigations, challenges in forensic pathology, and organ and tissue donation.

- In September 2023, Deputy Coroner Holly Benedict was recognized for her 20 years of service in San Mateo County. Holly began her career as a Forensic Autopsy Technician in 2003 before becoming a Deputy Coroner.

Congratulations Holly for completing 20 years of service for the County of San Mateo!

- In September 2023, Coroner Robert Foucrault and Supervising Deputy Coroner Elizabeth Ortiz attended the California State Coroners Association – Coroner Advanced Symposium in San Diego which covered a variety of topics in medicolegal death investigation.

- In the fall of 2023, the Coroner's Office and the County's Chief Equity Officer partnered together to collaborate with the local non-profit organization, Islamic Network Group (ING) to develop and pilot a capacity building opportunity for staff to strengthen cultural awareness related to death, dying rituals, and sensitivities of people who adhere to major world religions including Muslim American, Christian American, Jewish American, Buddhist, Hindu American, and Sikh American. "Working with Diverse Faith Communities in Times of Loss" was offered to all Coroner staff, members of San Mateo County Health and surrounding county's medical examiner and coroner's offices in November 2023. A recording of the training was uploaded to the Equity Resource Hub. The Coroner's Office will look for more partnering opportunities to advance Diversity, Equity, and Inclusion in the future.



- Deputy Coroner Hastin Stein and Chief Deputy Coroner K'Lynn Weber joined three other divisions within the Sheriff's Department in the Deputy Sheriff's Association Non-Sworn Law Enforcement Unit negotiations between September 2023 and December 2023. A new 4-year agreement was approved by the Board of Supervisors in November. The new Memorandum of Understanding will be in place for the next four years.

Congratulations K'Lynn for completing the Management Development Program!

- In December 2023, Chief Deputy Coroner K'Lynn Weber graduated from the 2023 Management Development Program. This internal leadership program is aimed at developing leaders and building capacity within San Mateo County's management positions.

- The Coroner's Office continued to support specialized medicolegal death investigation training through California Peace Officer Standards & Training (POST) for staff members:

  - Between March and April 2023, Deputy Coroner Michelle Schabinger attended the 80-hour Coroner Academy at Orange County Sheriff-Coroner's Department from March 27 to April 7, 2023. Deputy Coroner Schabinger successfully completed the course, finishing her basic California Peace Officer Standards and Training (POST) training requirements.

Deputy Coroner Stark (right) and Deputy Coroner Schabinger (above) were awarded certificates from California POST

  - In October 2023, Deputy Coroner Alana Stark was awarded the Advanced Coroner Certificate and Deputy Coroner Michelle Schabinger was awarded the Basic Coroner Certificate from the California Peace Officers Standards and Training (POST). Certificates are awarded to peace officers who have met the required training and education points and have the prescribed years of law enforcement experience.

- Throughout the year, Coroner's staff share with the community the duties and responsibilities of the Coroner's Office:

  - In December 2023, Deputy Coroner Danielle Montesano hosted the Coroner's Office first Save-A-Life class since 2020. Two juveniles on probation were referred to the course to learn about risky behavior and the dramatic consequences of that behavior. The Coroner's Office will offer the course quarterly in 2024.

  - In July 2023, the Coroner's Office hosted a visit from the Sheriff's Office Interns so they could have an inside perspective of the work performed by the Coroner's Office. This visit included a brief tour of the Administration and Investigation Divisions on Tower Road.

  - In April 2023, Supervising Deputy Coroner Elizabeth Ortiz joined the District Attorney's Office and the Sheriff's Office Forensic Laboratory presenting to local law enforcement detectives about Officer Involved Critical Incident (OICI) investigations. Supervising Deputy Coroner Ortiz provided the perspective of the Coroner's Office involvement and responsibilities as well as

Supervising Deputy Coroner Ortiz presented to detectives about the role of the Coroner's Office

talked about collaboration expectations with the various agencies.

- In September 2023, Deputy Coroner Eden Washburn was a guest speaker for the College of San Mateo's Introduction to Forensic Science class. Deputy Coroner Washburn shared her as a deputy coroner in San Mateo County and provided an opportunity for students to learn more about the field of medicolegal death investigations. This is the fourth year a Deputy Coroner has presented to this class.

- In November 2023, Coroner Robert Foucrault presented to the San Mateo County Suicide Prevention Committee regarding the role of the Coroner's Office and provided suicide-related death statistics to the committee members.

- For the second year in a row, between May and June 2023, the Coroner's Office hosted five doctors completing their Family Medicine Residency as part of Kaiser Permanente's Community Medicine Rotation supported by the Kaiser Permanente San Jose Medical Center Graduate Medical Education Program. The future family medicine practitioners sat with a deputy coroner to understand the role of the Coroner's Office as well as understand the responsibility of death certificate attestation required by California physicians for patients who experience a natural death under their care within California.

Five Kaiser physicians sat in with Deputy Coroners on ride-a-longs.

- Throughout the year, the Coroner's Office offers ride along opportunities to people in the community over the age of 18 who are interested in learning more about the Coroner's Office and the work performed. Community members who are interested in going on a ride along must complete an application and be cleared for participation. The ride along is four hours long and designed to give participants a first-hand experience in the office and in the field. In 2023, the Coroner's Office hosted three community members for a ride along.

- Throughout 2023, the Coroner's Office participated in multiple emergency preparedness and mass fatality/mass disaster training events:

  - In August 2023, Forensic Autopsy Technicians Nandar Yukyi and Nora Moreno hosted a table at the annual Disaster Preparedness Day at the County Event Center. The Coroner's Office table highlighted anthropological non-human bone identification and provided resources such as "What do I do Now?" pamphlets and "Vial of Life" forms to the public.

  - During the fall of 2023, Chief Deputy Coroner K'Lynn Weber joined many other Bay Area law enforcement and County agencies in preparation for the Asia-Pacific

Economic Cooperation (APEC) Economic Leader's Week Conference which was hosted by San Francisco in November 2023. The purpose of the preparatory meetings was to gain greater situational awareness of the dignitaries coming into the San Francisco Bay Area, the events taking place within San Mateo County, and prepare for increased potential for disruption and mass casualty incidents. These briefings were organized by the Department of Emergency Management (DEM). During the week of APEC, Coroner Robert Foucrault and Chief Deputy Coroner Weber met with the Director of DEM, Dr. Shruti Dhapodkar to observe the activation of the Emergency Operations Center in planning for a Department Operations Center in the new Coroner's Office Administration and Investigations Divisions in the Link Building on the San Mateo Medical Center campus.

- The Coroner's Office values staff wellness.
    - In January 2023, the Coroner's Office celebrated National Medicolegal Death Investigators Week (January 23-29) with pizza and a visit from therapy retrievers from the First Responders Therapy Dog organization. The visit brought a much-needed dose of happiness and positivity to staff. Throughout the year, the Coroner staff celebrated a variety of life milestones and holidays together including onsite and offsite gatherings.

Coroner staff and families celebrating holidays and recognizing the importance of the work staff performs on a daily basis.

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San Mateo County Coroner 2023 Staff

Administration

Robert J. Foucrault	Coroner
Christi Canclini	Executive Assistant
K'Lynn Solt	Chief Deputy Coroner
Luz Paran-Rey	Senior Accountant
Cara Behrens	Office Assistant II

Investigations

Elizabeth Ortiz	Supervising Deputy Coroner
Holly Benedict	Deputy Coroner
Hastin Stein	Deputy Coroner
Danielle Montesano	Deputy Coroner
Alana Stark	Deputy Coroner
Laura Bailey	Deputy Coroner (Jan-Feb)
Michelle Schabinger	Deputy Coroner
Eden Washburn	Deputy Coroner
Ashley Cahalan	Deputy Coroner (Extra-Help) (Jan-Feb) Full Time (Feb-Jun)

Pathology

Isabella Ratti	Forensic Autopsy Technician
Veronica Vargo	Forensic Autopsy Technician (Jan-Nov)
Katherine Jensen	Forensic Autopsy Technician (Sep)
Supna Nair	Forensic Autopsy Technician (Oct-Dec)
Katelynn Fichou	Forensic Autopsy Technician (Nov-Dec)
Nandar Yukyi	Forensic Autopsy Technician (Extra-Help) (Jan-Aug)
Nora Moreno	Forensic Autopsy Technician (Extra-Help) (Jan-Sep)
Daniela Landey	Forensic Autopsy Technician (Extra-Help) (Jan-Jul)

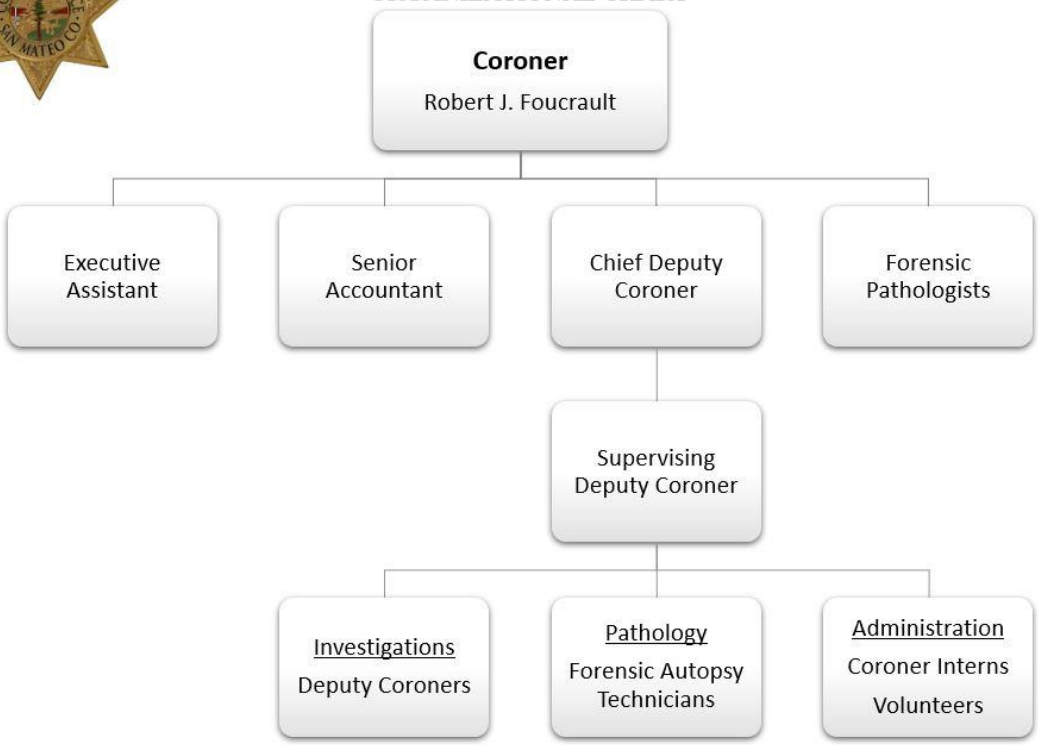
Contractors

Thomas Rogers, M.D.	Forensic Pathologist
Michael Hunter, M.D.	Forensic Pathologist
Vivian Snyder, D.O.	Forensic Pathologist
Angellee Chen, M.D., J.D.	Forensic Pathologist
Ellen Moffatt, M.D.	Forensic Pathologist
Varsha Podduturi, M.D.	Forensic Pathologist

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 2023

Number of deaths reported: 2,056

Number of cases for full investigation: 583
- Private autopsies: 2
- Indigent cremation referral only: 19
- No-post cases: 75
- Co-sign cases: 40
- Other: 8
  - Non-human remains: 7
  - Native American remains: 0
  - Found/abandoned cremains: 1

Number of Elder (65+) cases investigated at scene and released: 137

Number of mutual aid requests for death notifications: 27

Number of cases by manner of death:

Natural	276
Accident	218
Suicide	61
Homicide	14
Undetermined	9
Pending Investigation	0

Number of decedents transported:

Coroner	481
Contractor	57
Mortuary/Funeral Home/Other	9

Forensic Examinations:

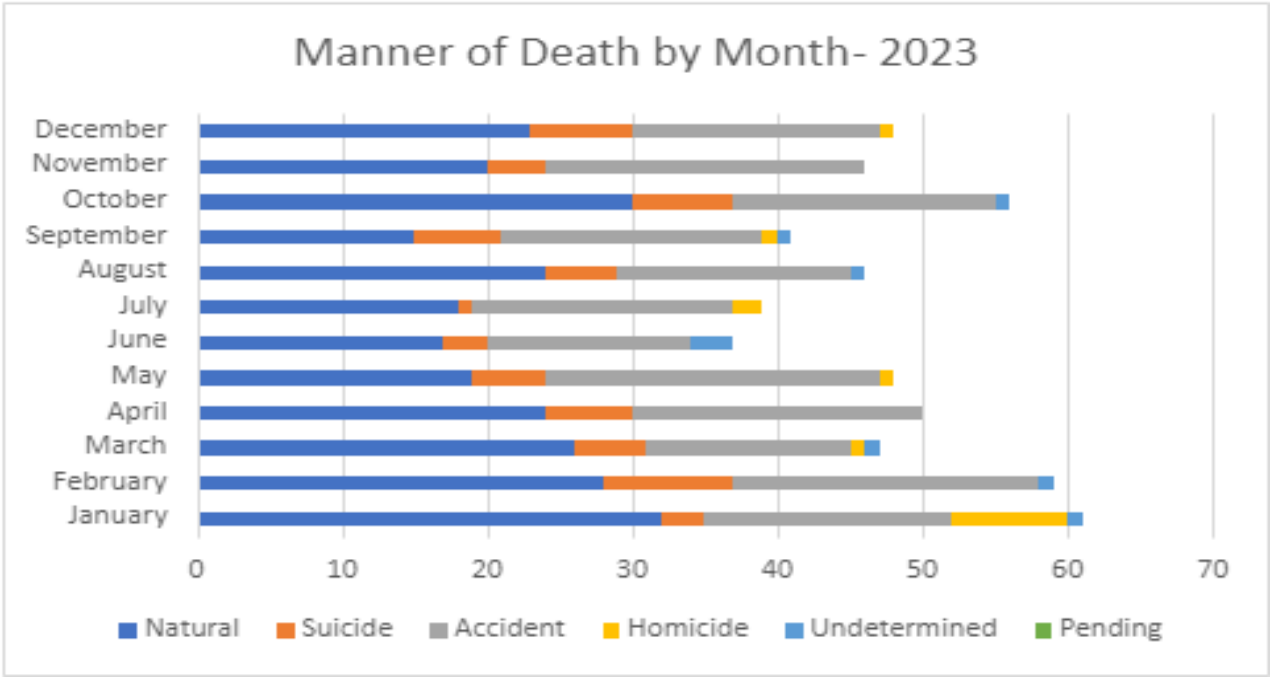
Full Autopsy	293
Limited Autopsy	25
Clinical Review	130
Specialized (SUIDS / Homicide)	17
Hospital Autopsies	0

Number of cases where toxicology was conducted: 375

Number of cases reported as "unidentified":	67
Identified after investigation	1
Organ and tissue donations:	
Cases referred for donation	118
Total organ donors	11
Total organs transplanted	40
Total tissue donors	62
Exhumations:	3
Number of Law Enforcement-involved and in-custody deaths:	**6**
Total Law Enforcement-involved	**1**
Natural	0
Accident	1
Suicide	0
Homicide	0
Undetermined	0
Total In-custody	**5**
Natural	1
Accident	1
Suicide	2
Homicide	1
Undetermined	0

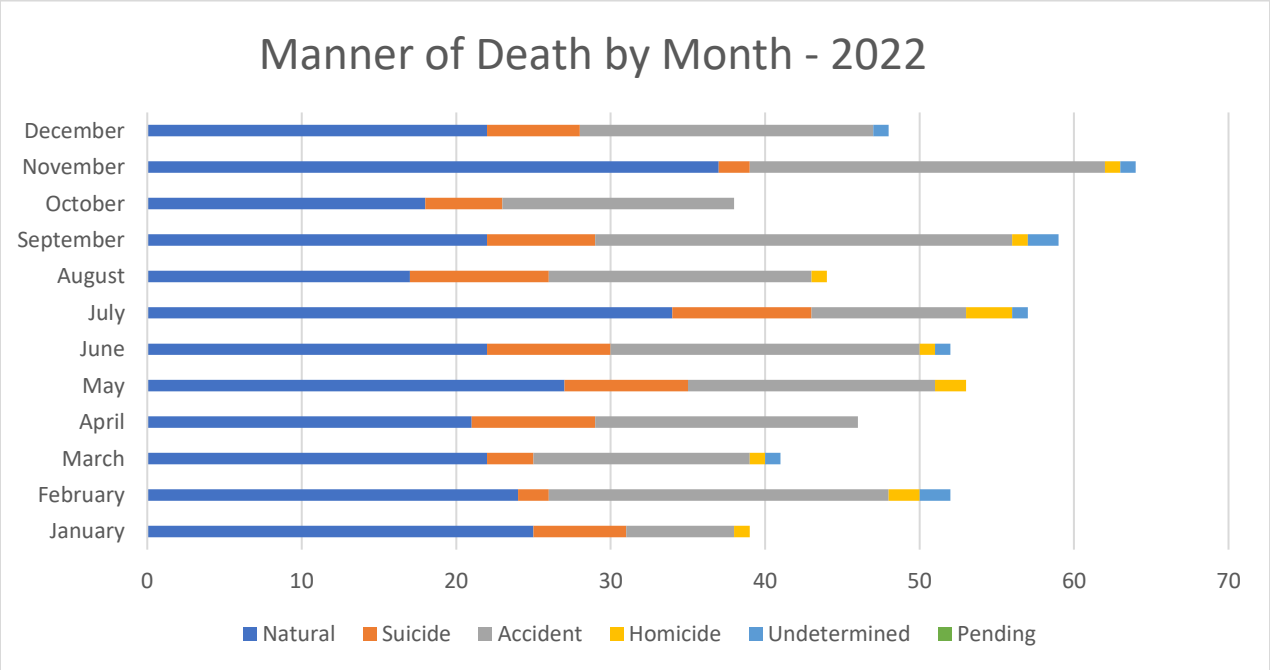
General Classifications of Death by Month

Coroner Case Statistics for 2023 by Month							
	Natural	**Suicide**	**Accident**	**Homicide**	**Undetermined**	**Pending**	**Total**
January	32	3	17	8	1	0	61
February	28	9	21	0	1	0	59
March	26	5	14	1	1	0	47
April	24	6	20	0	0	0	50
May	19	5	23	1	0	0	48
June	17	3	14	0	3	0	37
July	18	1	18	2	0	0	39
August	24	5	16	0	1	0	46
September	15	6	18	1	1	0	41
October	30	7	18	0	1	0	56
November	20	4	22	0	0	0	46
December	23	7	17	1	0	0	48
Total	**276**	**61**	**218**	**14**	**9**	**0**	**578**



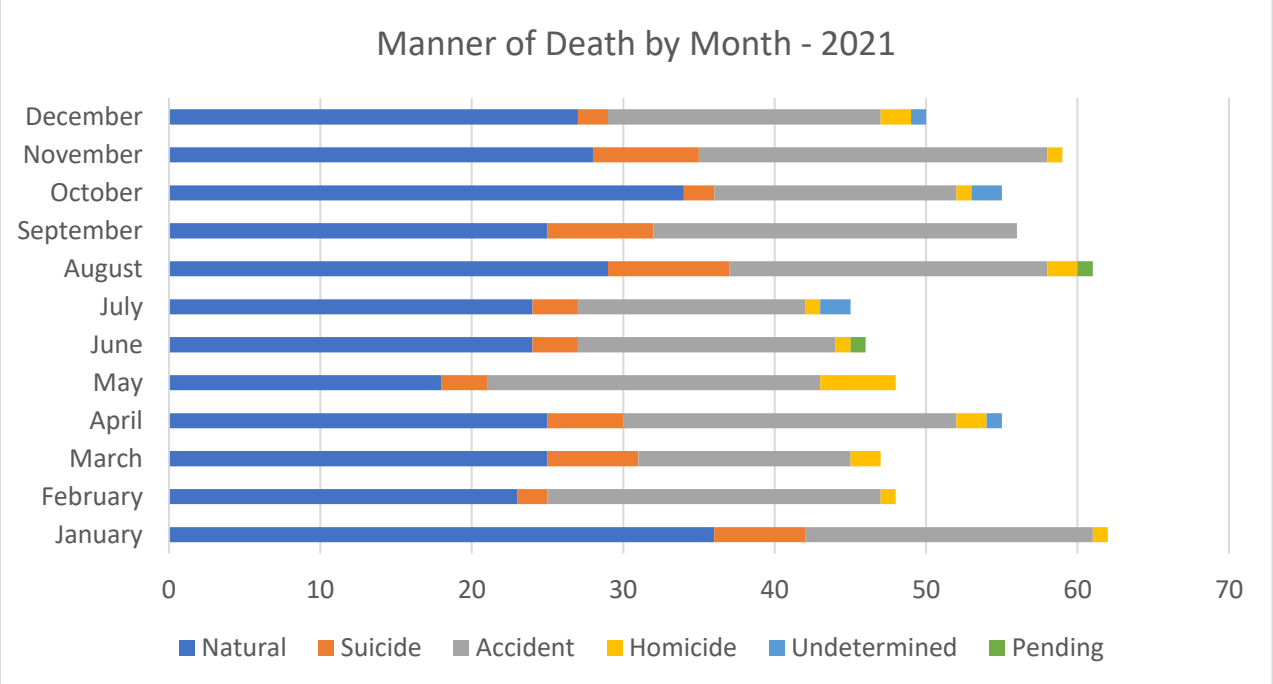
Historical Statistics

Coroner Case Statistics for 2022 by Month							
	Natural	**Suicide**	**Accident**	**Homicide**	**Undetermined**	**Pending**	**Total**
January	25	6	7	1	0	0	39
February	24	2	22	2	2	0	52
March	22	3	14	1	1	0	41
April	21	8	17	0	0	0	46
May	27	8	16	2	0	0	53
June	22	8	20	1	1	0	52
July	34	9	10	3	1	0	57
August	17	9	17	1	0	0	44
September	22	7	27	1	2	0	59
October	18	5	15	0	0	0	38
November	37	2	23	1	1	0	64
December	22	6	19	0	1	0	48
Total	291	73	207	13	9	0	593



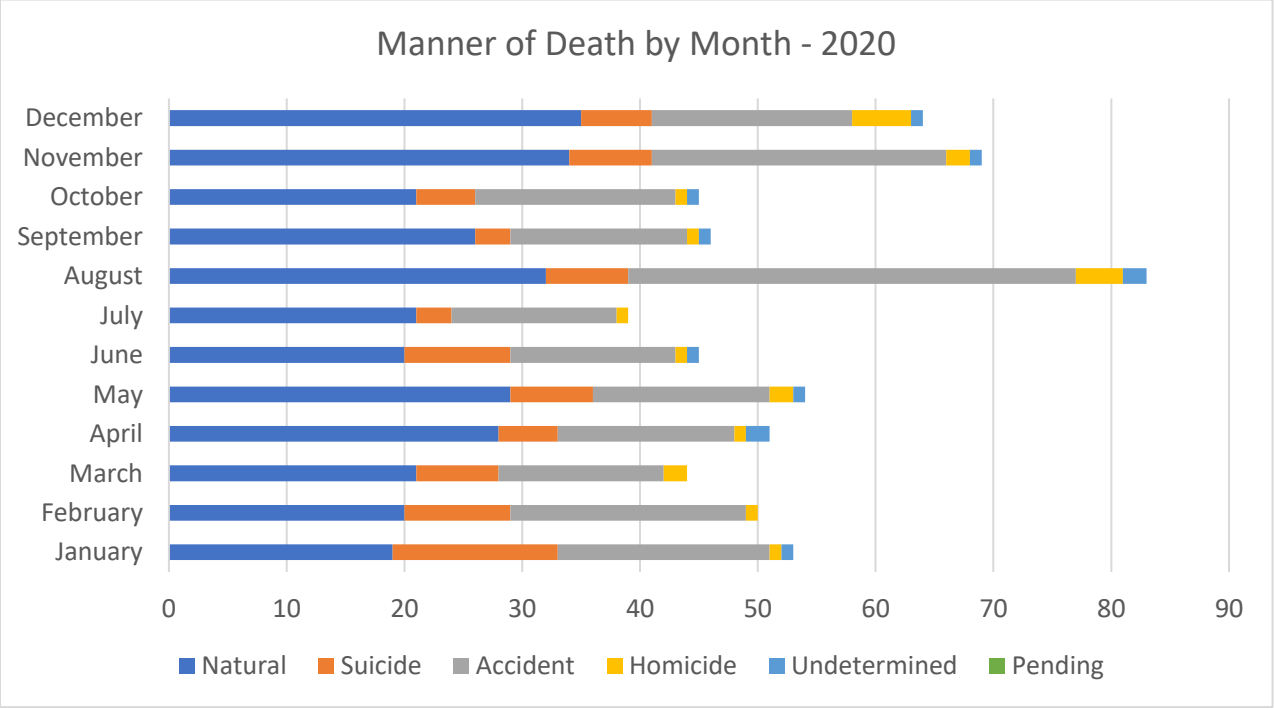
Historical Statistics (continued)

Coroner Case Statistics for 2021 by Month							
	Natural	**Suicide**	**Accident**	**Homicide**	**Undetermined**	**Pending**	**Total**
January	36	6	19	1	0	0	62
February	23	2	22	1	0	0	48
March	25	6	14	2	0	0	47
April	25	5	22	2	1	0	55
May	18	3	22	5	0	0	47
June	24	3	17	1	0	1	46
July	24	3	15	1	2	0	45
August	29	8	21	2	0	1	61
September	25	7	24	0	0	0	56
October	34	2	16	1	2	0	55
November	28	7	23	1	0	0	59
December	27	2	18	2	1	0	50
Total							



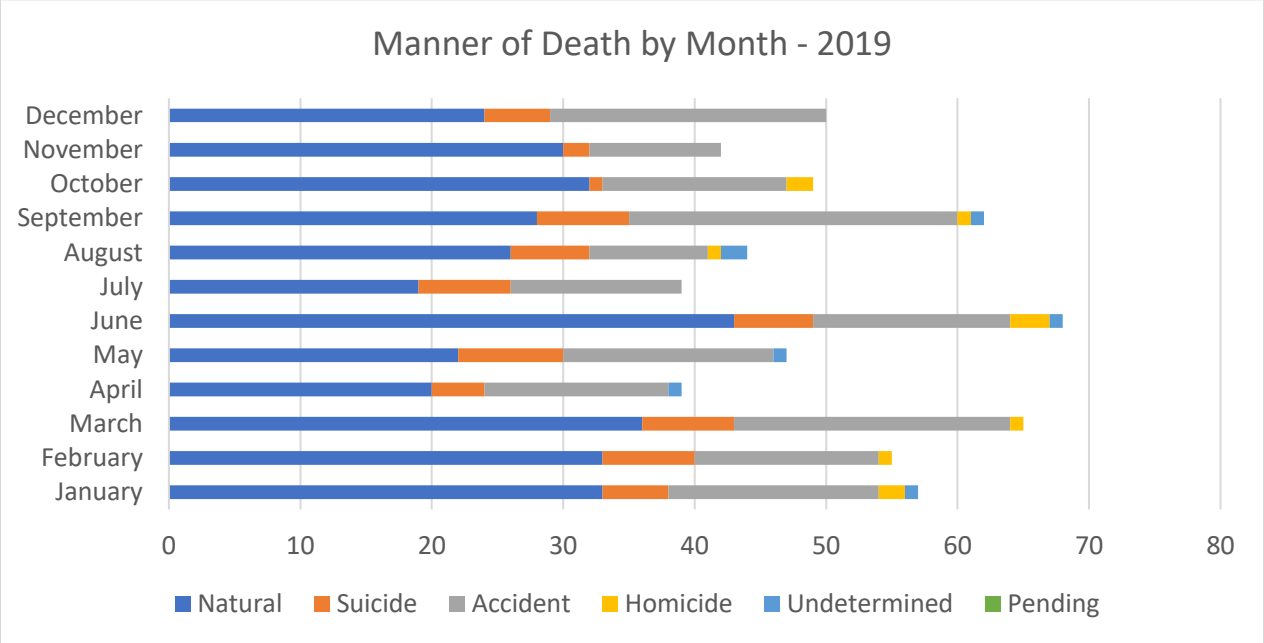
Historical Statistics (continued)

Coroner Case Statistics for 2020 by Month							
	Natural	**Suicide**	**Accident**	**Homicide**	**Undetermined**	**Pending**	**Total**
January	19	14	18	1	1	0	53
February	20	9	20	1	0	0	50
March	21	7	14	2	0	0	44
April	28	5	15	1	2	0	51
May	29	7	15	2	1	0	54
June	20	9	14	1	1	0	45
July	21	3	14	1	0	0	39
August	32	7	38	4	2	0	83
September	26	3	15	1	1	0	46
October	21	5	17	1	1	0	45
November	34	7	25	2	1	0	69
December	35	6	17	5	1	0	64
Total	306	82	222	22	11	0	643



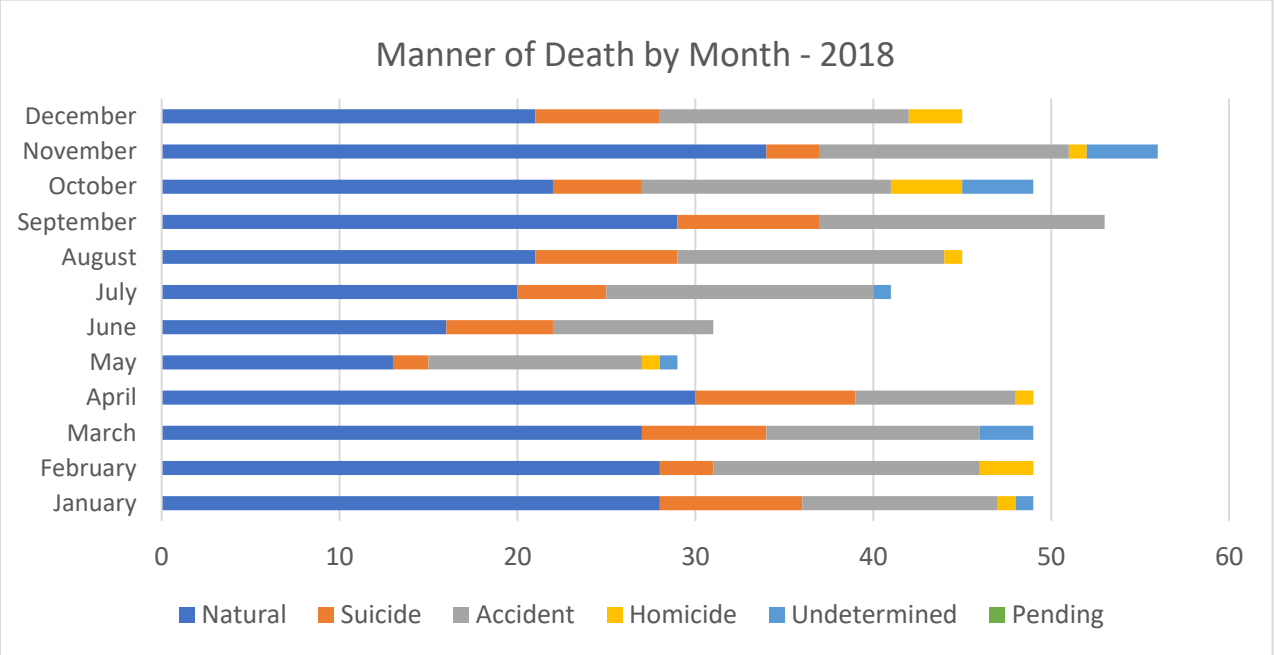
Historical Statistics (continued)

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



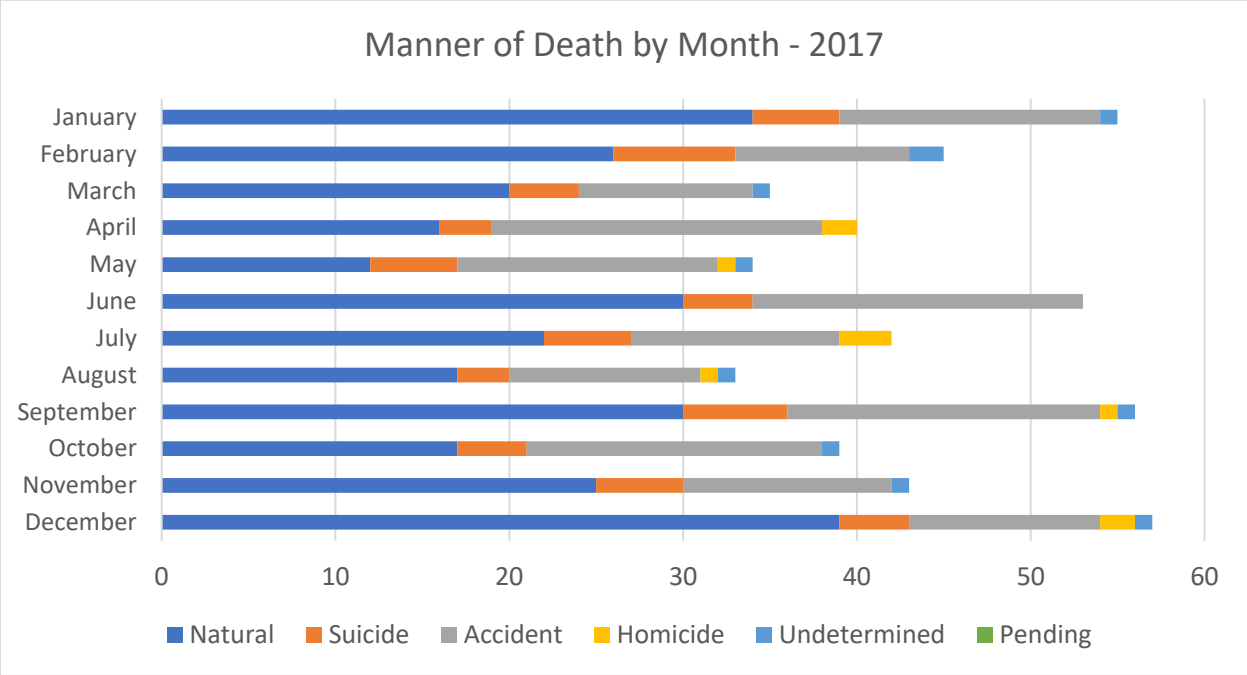
Historical Statistics (continued)

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



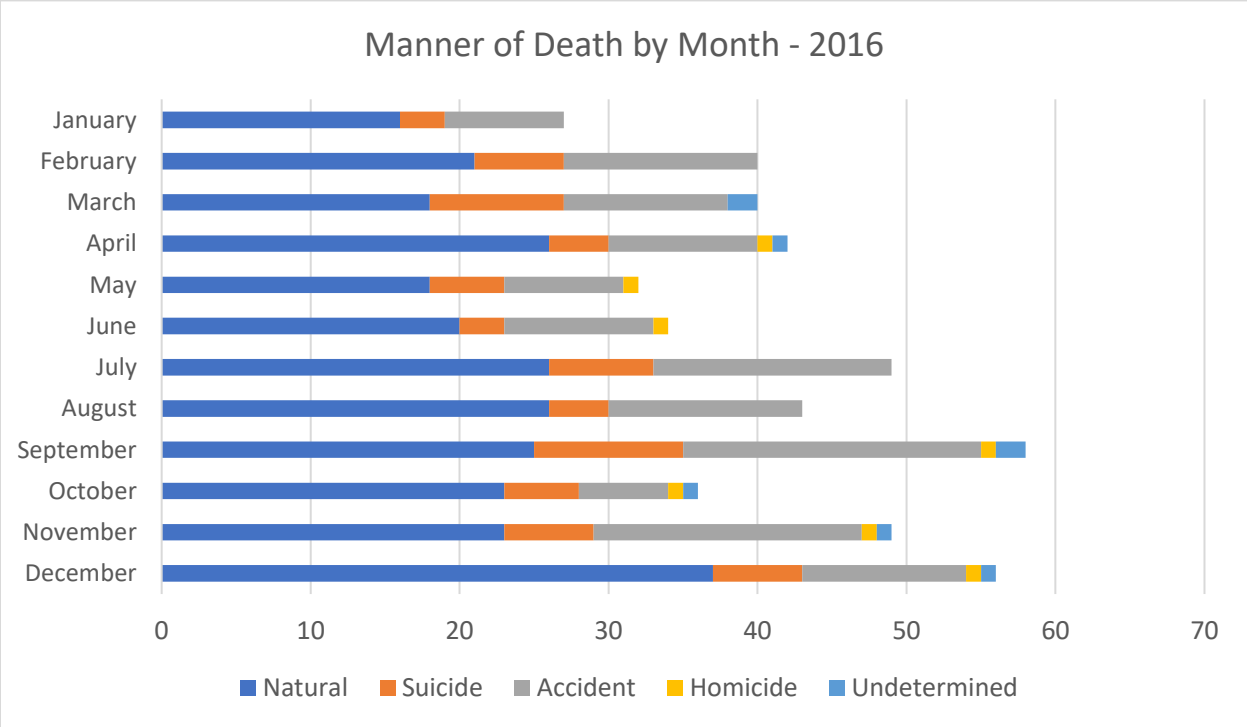
Historical Statistics (continued)

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

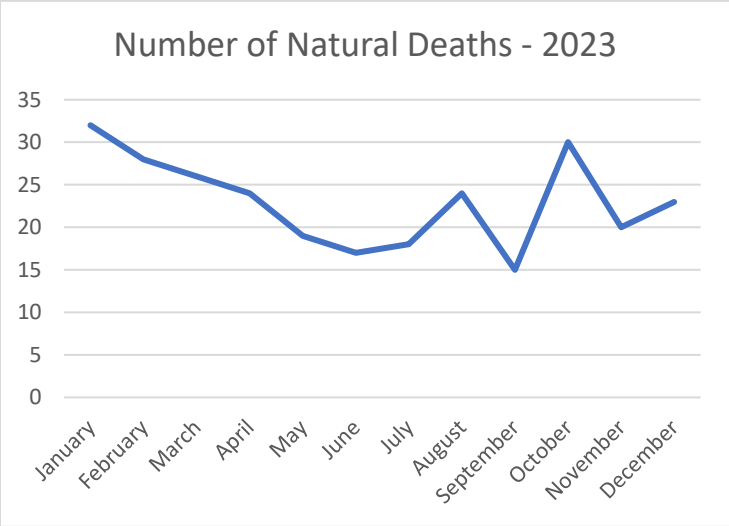


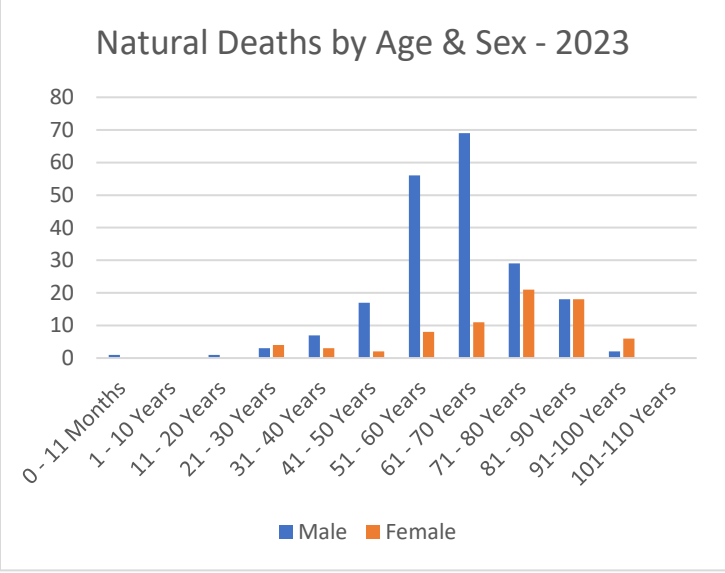
Natural

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

Total Natural Deaths in 2023: 276

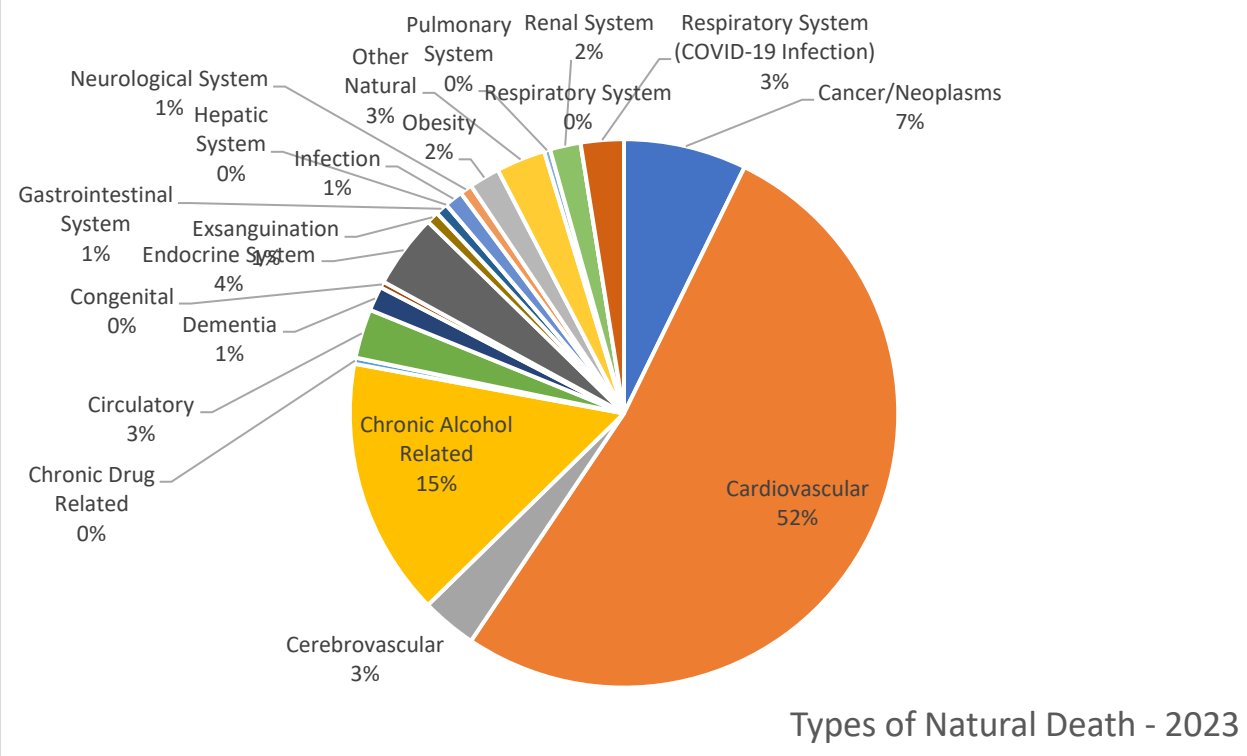
Natural Deaths by Month	
Month	**Number of Natural Deaths**
January	32
February	28
March	26
April	24
May	19
June	17
July	18
August	24
September	15
October	30
November	20
December	23





Natural Deaths by Age & Sex		
Age	**Male**	**Female**
0 - 11 Months	1	0
1 to 10 Years	0	0
11 to 20 Years	1	0
21 to 30 Years	3	4
31 to 40 Years	7	3
41 to 50 Years	17	2
51 to 60 Years	56	8
61 to 70 Years	69	11
71 to 80 Years	29	21
81 to 90 Years	18	18
91-100 Years	2	6
101-110 Years	0	0

Types of Natural Deaths by Sex			
Types of Natural Deaths	**Total**	**Male**	**Female**
Cancer/Neoplasms	20	15	5
Cardiovascular	144	101	43
Cerebrovascular	9	6	3
Chronic Alcohol Related	42	38	4
Chronic Drug Related	1	1	0
Circulatory	8	6	2
Dementia	4	0	4
Congenital	1	1	0
Endocrine System	12	8	4
Exsanguination	2	1	1
Gastrointestinal System	2	1	1
Hepatic System	0	0	0
Infection	3	2	1
Neurological System	2	1	1
Obesity	5	5	0
Other Natural	8	5	3
Pulmonary System	1	1	0
Renal System	5	5	0
Respiratory System	0	0	0
Respiratory System (COVID-19 Infection)	7	6	1

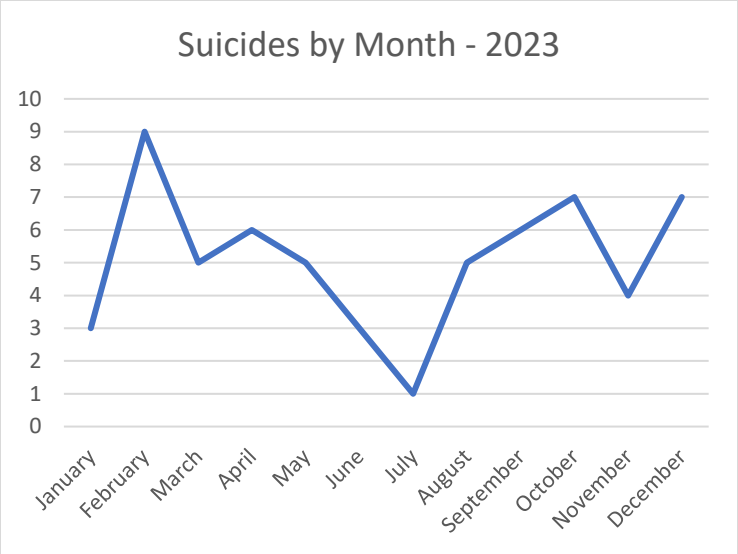


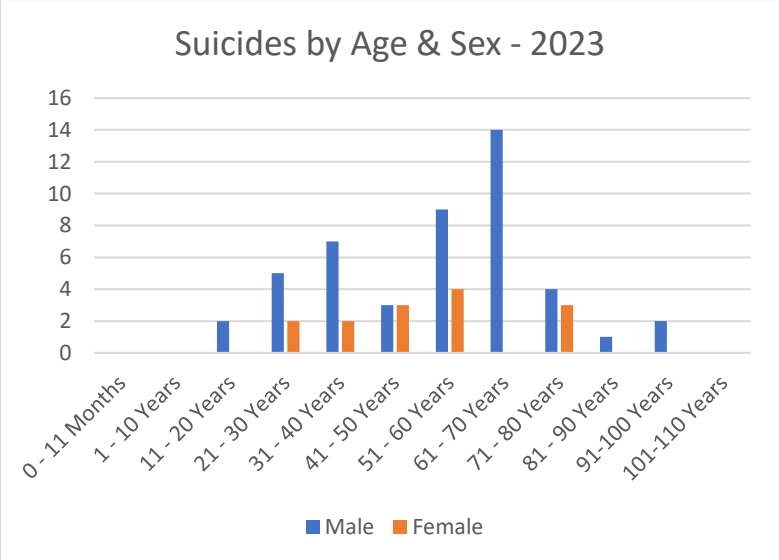
Suicide

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 oneself.

Total Number of Suicides in 2023: 61

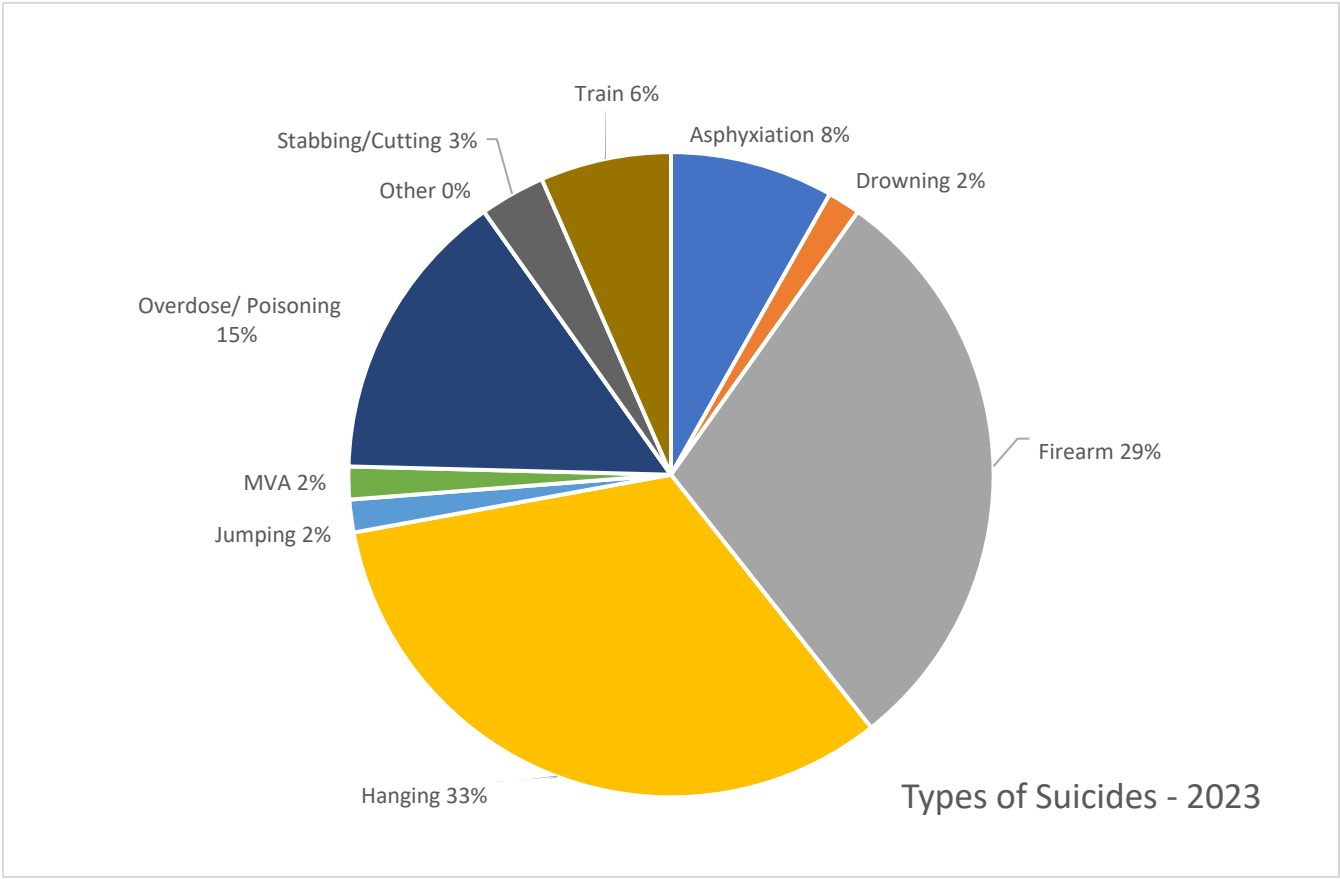
Suicide by Month	
Month	**Number of Suicides**
January	3
February	9
March	5
April	6
May	5
June	3
July	1
August	5
September	6
October	7
November	4
December	7





Suicide Deaths by Age & Sex		
Age	**Male**	**Female**
0 - 11 Months	0	0
1 to 10 Years	0	0
11 to 20 Years	2	0
21 to 30 Years	5	2
31 to 40 Years	7	2
41 to 50 Years	3	3
51 to 60 Years	9	4
61 to 70 Years	14	0
71 to 80 Years	4	3
81 to 90 Years	1	0
91-100 Years	2	0
101-110 Years	0	0

Types of Suicides by Sex			
Types of Suicides	**Total**	**Male**	**Female**
Asphyxiation	5	2	3
Drowning	1	1	0
Firearm	18	17	1
Hanging	20	14	6
Jumping	1	1	0
MVA	1	1	0
Overdose/ Poisoning	9	7	2
Other	0	0	0
Stabbing/Cutting	2	0	2
Train	4	4	0

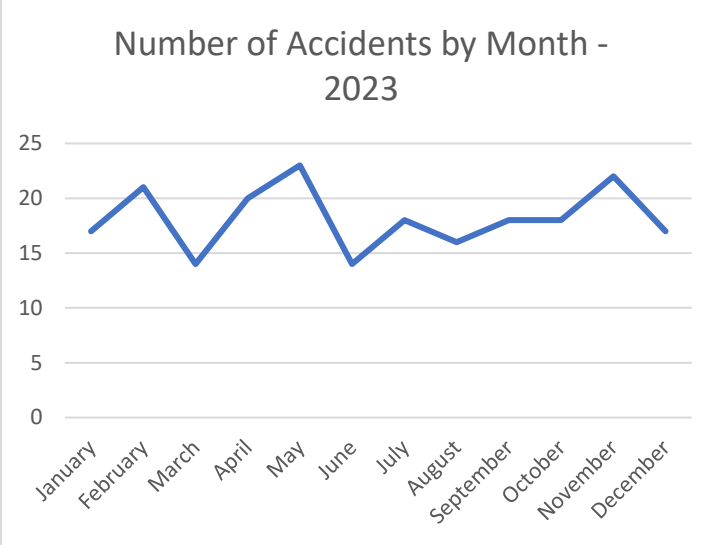


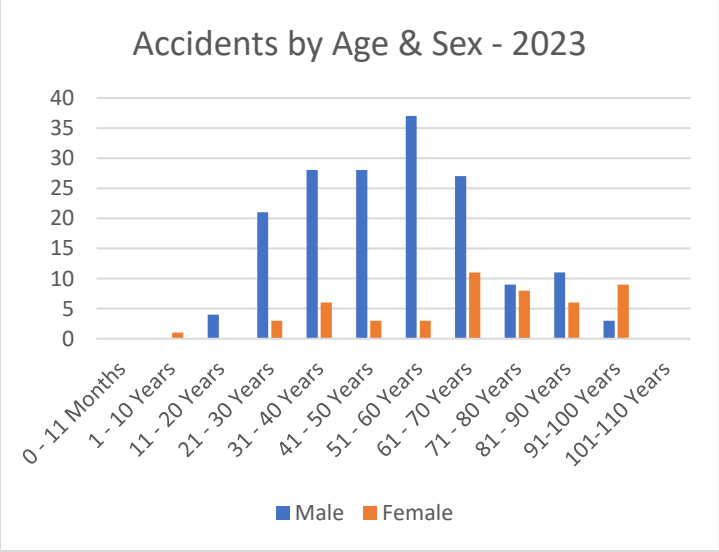
Accident

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.

Total Number of Accidental Deaths in 2023: 218

Accidents by Month	
Month	**Number of Accidents**
January	17
February	21
March	14
April	20
May	23
June	14
July	18
August	16
September	18
October	18
November	22
December	17

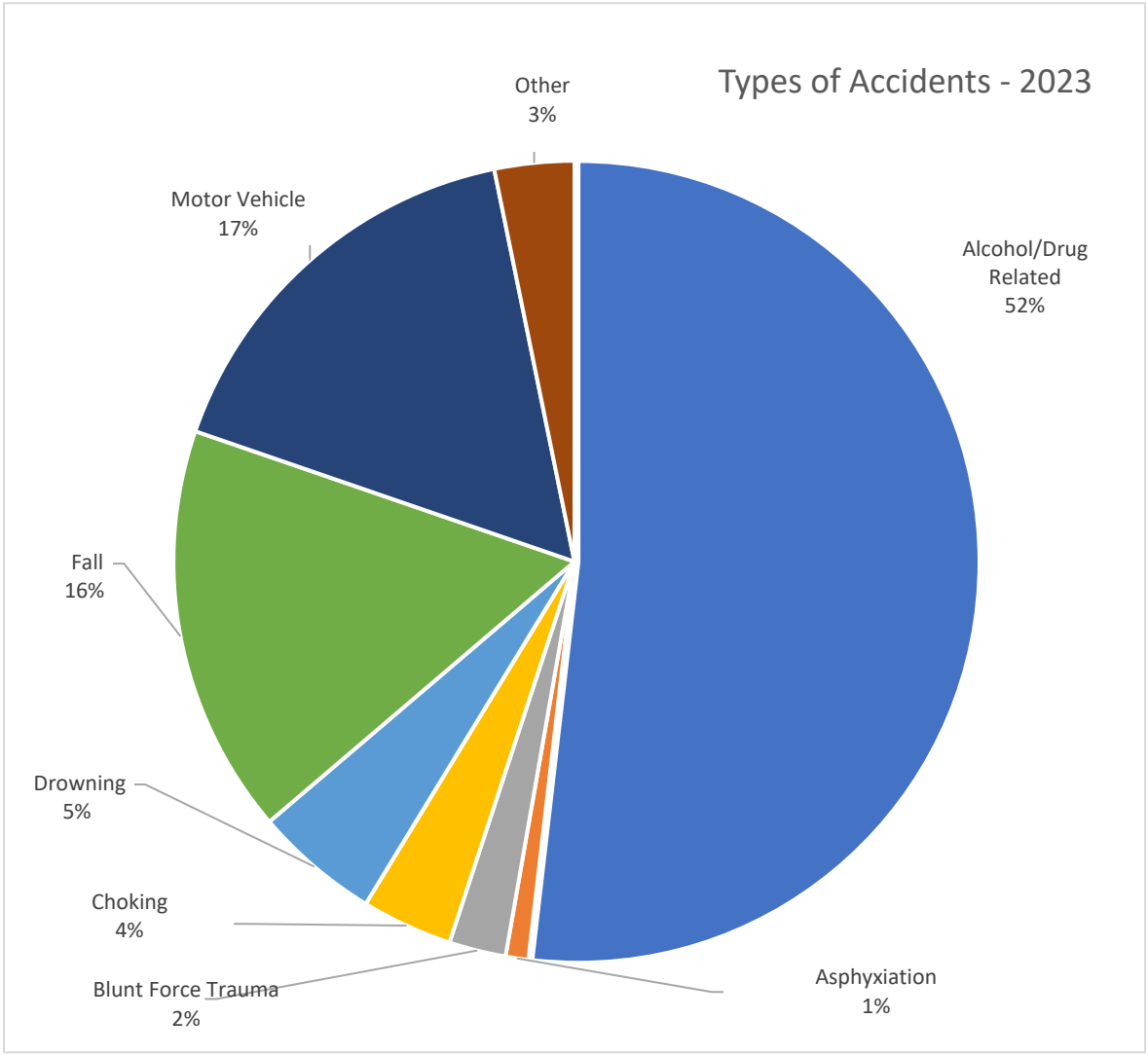




Accidental Deaths by Age & Sex		
Age	**Male**	**Female**
0 - 11 Months	0	0
1 to 10 Years	0	1
11 to 20 Years	4	0
21 to 30 Years	21	3
31 to 40 Years	28	6
41 to 50 Years	28	3
51 to 60 Years	37	3
61 to 70 Years	27	11
71 to 80 Years	9	8
81 to 90 Years	11	6
91-100 Years	3	9
101-110 Years	0	0

Types of Accidents by Sex			
Type of Accident	**Total**	**Male**	**Female**
Alcohol/Drug Related	113	98	15
Asphyxiation	2	1	1
Blunt Force Trauma	5	5	0
Choking	8	4	4
Drowning	10	7	3
Fall	36	19	17
Motor Vehicle	37	30	7
Other	7	4	3

Alcohol/Drug Related	
Type	**Total**
Fentanyl-related	69
Alcohol only	7
Other	37



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 2023: 39

Fatalities by Month	
Month	**Number of Fatalities**
January	0
February	2
March	2
April	8
May	4
June	4
July	4
August	3
September	3
October	2
November	5
December	2

Fatalities by Age & Sex		
Age	**Male**	**Female**
0 - 11 Months	0	0
1 to 10 Years	0	0
11 to 20 Years	0	0
21 to 30 Years	8	1
31 to 40 Years	4	1
41 to 50 Years	4	0
51 to 60 Years	11	1
61 to 70 Years	3	1
71 to 80 Years	2	2
81 to 90 Years	0	1
91-100 Years	0	0
101-110 Years	0	0

Fatalities by Manner	
Manner of Death	**Number of Fatalities**
Natural	1
Accident	37
Suicide	1
Homicide	0
Undetermined	0

Types of Motor Vehicle Fatalities	
Type	**Number of Fatalities**
Automobile-Driver	13
Automobile-Passenger	7
Motorcyclist	4
Pedestrian	10
Bicyclist	4
Train vs Motor Vehicle	0
Natural Death While Driving	1
Other	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 Involving Alcohol and/or Drugs in 2023: 21

Number of Motor Vehicle Fatalities	38
Number of Cases Involving Drugs and/or Alcohol	21
Number of Cases Where Toxicology Test Was Completed	33
Number of Cases Where No Toxicology Test Was Completed	5
Number of Cases Where Nothing was Detected in Toxicology Test	12

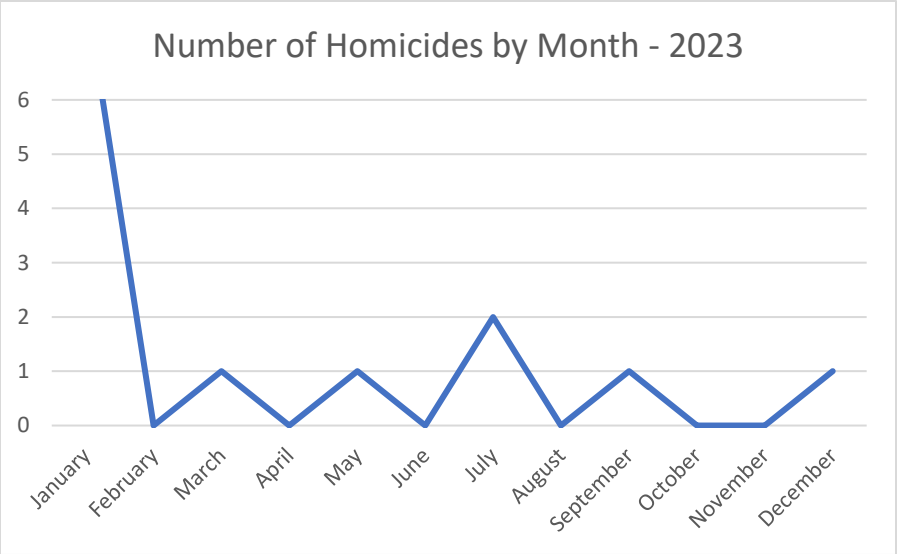
Results	Complete Drug (Including Alcohol)
Alcohol Only Present	2
Prescription and/or Over-the-Counter Drugs Only Present	2 (THC or its derivatives present in 1 case)
Illicit Drugs Only Present	1
Alcohol and Prescription and/or Over-the-Counter Drugs Present	2
Alcohol and Illicit Drugs Present	5
Prescription and/or Over-the Counter and Illicit Drugs Present	2
Prescription and/or Over-the Counter, Illicit Drugs, and Alcohol Present	0
THC (or its derivatives) Only Present	3
THC (or its derivatives) and Alcohol Present	4

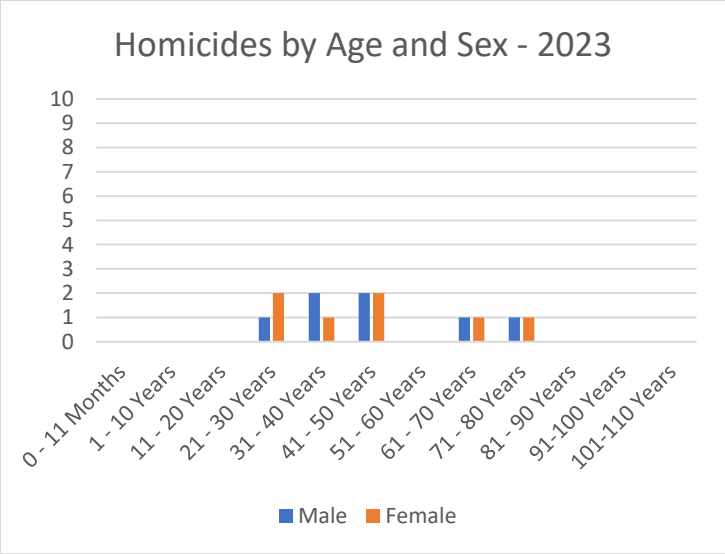
Homicide

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 2023: 14

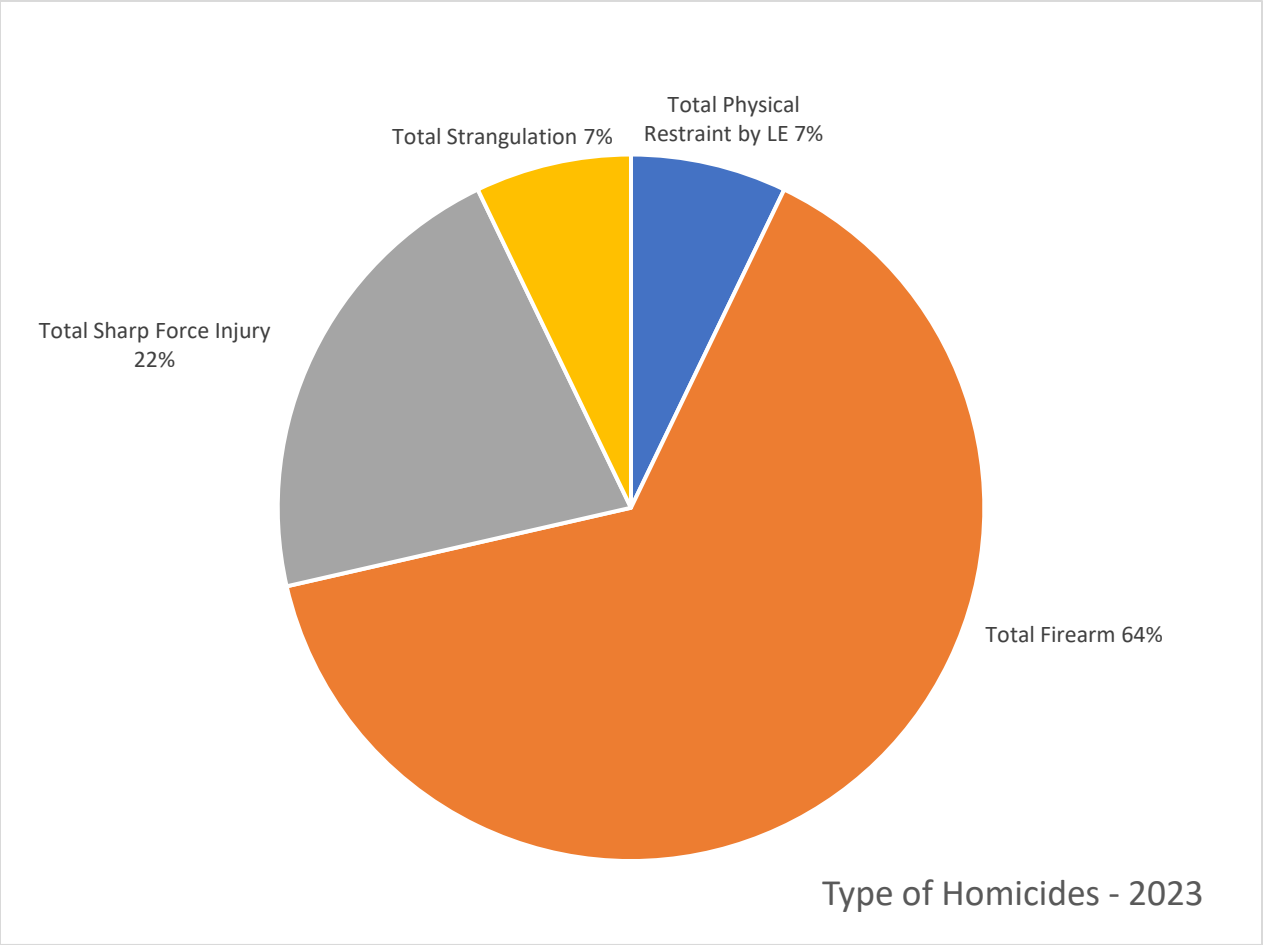
Homicides by Month	
Month	**Number of Homicides**
January	8
February	0
March	1
April	0
May	1
June	0
July	2
August	0
September	1
October	0
November	0
December	1





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

Type of Homicide by Sex			
Type of Homicide	**Total**	**Male**	**Female**
Physical Restraint by LE	1	0	1
Firearm	9	5	4
Sharp Force Injury	3	1	2
Strangulation	1	1	0



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 2023: 9

Mode	Total
Cause known, Manner not able to be determined	2
Cause & Manner Undetermined	1
Decomposed Body or Skeletal Remains	6
Unexplained death in infancy (e.g. SUIDS)	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 2023: 7

Manner	Total
Natural	0
Accident	6
Suicide	0
Homicide	1
Undetermined	0

County of Death	Total
Santa Clara	6
San Francisco	1 - accident

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.

Total Number of Indigent Cremations in 2023: 54

County Cremations referred by outside agencies:	20
County Cremations referred to outside agencies:	1
Cremations performed by the San Mateo County Coroner after remains were abandoned by family:	36
Cremations performed by the San Mateo County Coroner after diligent search, but no family located:	18
Cremations performed by the San Mateo County Coroner for unidentified persons:	0
Cremains collected by family upon locating next of kin after cremation performed:	0
Dispositions handled by family after receiving a fee reduction by application for financial need:	25

For questions or comments, please contact the Coroner's Office:

San Mateo County Coroner
50 Tower Road
San Mateo, CA 94402

(650) 312-5562
smcgov.org/coroner