

# Death Investigation in Sacramento County: The Coroner's Office

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## Issue

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The 2002-2003 Sacramento County Grand Jury has become aware of significant issues regarding death investigation in Sacramento County.

Death investigation has evolved to a medical subspecialty directed by medically qualified people. Nationwide there is a movement to replace coroner systems with medical examiner systems directed by forensic pathologists independent and unrelated to law enforcement and prosecutorial agencies and responding directly to the governing body.

In Sacramento County death investigation is conducted by the Sacramento County Coroner, defined as an administrative and law enforcement position, appointed by the Board of Supervisors. The coroner and his deputy staff are not required to have formal medical training. The coroner's pathology staff does not have medical autonomy or final authority, and their medical judgments can be overruled.

Recent organizational changes within the coroner's office have potentially further compromised medical autonomy. Conflict of interest issues with respect to investigation of in-custody deaths have been raised.

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## Method of Investigation

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The Grand Jury drew information from the following:

- Seventeen physician interviews
- Eleven non-physician principal interviews
- Correspondence conducted with at least eight other principals, twenty seven other physicians and eighteen professional organizations
- Sixty-three scientific papers, documents and transcripts
- Eight other jurisdictions' coroner/medical examiner deputy staff qualifications

The jury visited the Sacramento County Coroner's Office on two occasions and the San Francisco County Medical Examiner's Office.

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## Background and Facts

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### A. General Considerations of Death Investigation

#### **Current Status of Death Investigation in the United States and California:**

There are no national death investigation laws, and systems are left to the states to establish. There has been a continuing trend to replace coroner systems with medical examiner (ME) systems since the late 1800s. ME systems tend to be found in larger jurisdictions and it has been estimated that the minimum population required to support a ME system of full time death investigation is 200,000.<sup>1</sup> Thirty-eight states have some type of ME system and MEs currently serve 48 percent of the United States' population.

Five of the largest California counties have a ME system.<sup>2</sup> They have an average population of 2.9 million and serve 40 percent of California inhabitants.<sup>3</sup>

Sacramento County, with a current population of 1.95 million (projected to be 3.65 by 2050)<sup>4</sup> is one of the largest California counties to continue with a coroner system.<sup>5</sup>

#### **Medical Considerations of Death Investigation:**

With the dramatic advance of medical science, it has become clear that all deaths, natural and otherwise, require medical direction for competent investigation and interpretation of information. Medical expertise in death investigation is also required because the quality of patient management by physician and healthcare workers often is at issue.

The California Medical Association policy states: "CMA endorses the concept that medical-legal investigation of deaths should be directly under the administration and jurisdiction of a physician, preferably a pathologist, whether these officials be titled coroners or medical examiners."<sup>6</sup>

The vast majority of decedents handled by the coroner die from natural causes, i.e., disease entities. In 2001, homicides in Sacramento County constituted only 2 percent of deaths reportable to the coroner and homicide, suicide, accidental, and undetermined combined were only 13 percent.<sup>7</sup>

Along with the Office of Public Health the medical examiner/coroner is an early responder in the management of biological, chemical and other emergencies.

Death certification is a healthcare issue. Many government agencies are interested parties in this process.<sup>8</sup> Allocation of resources for healthcare and research are in part a function of cause of death. Despite these considerations neither autopsy performance nor death certification is reimbursed through healthcare financing. Although there is a national death certificate form, it is seldom used, and state-to-state certificate variation hinders national mortality analysis. The

situation is such that death certificates are not generally used as defining endpoints for medical research clinical studies because they are notorious for error. Placing medically qualified people in charge of this process would lead to improvement.

Coroners and medical examiners operate outside of the healthcare delivery system and are not subject to the usual sources of medical scrutiny, e.g. the Joint Committee on Accreditation of Health Care Organizations or the Health Care Financing Administration. Therefore, they face no threat of loss of funding or reimbursement for poor performance. There are no national standards for quality assurance or continuing education unless the individual ME/Coroner department volunteers for accreditation and periodic review by an organization such as the National Association of Medical Examiners (NAME) or the American Board of Medical Legal Death Investigators (ABMLDI). For these reasons it is desirable to establish a strong affiliation with a local university medical center for joint development of quality assurance parameters. These affiliations may be facilitated by medically qualified people heading departments.

### **Law Enforcement Considerations. Independence and Authority for Death Investigation:**

Death investigation and the coroner system evolved as a part of law enforcement. However, many current observers believe death investigations should be performed by an independently funded, autonomous office not tied to law enforcement or any prosecutorial agency. The goal is an objective agency with clear separation of scientific medical duties and decisions from influence and control by non-qualified individuals, and political interests.

Defenders of the coroner system state that law enforcement training is essential for death investigation. However, death scene investigation is an integral and extensive part of the forensic pathology (FP) fellowship-training program and is subject to the certification examination.<sup>9</sup> In Sacramento County the authority for death investigation would come to the medical examiner through creation of the office. In counties which create a medical examiner's office, that office performs "the powers and perform the duties of the coroner" (Government Code Section 24010).<sup>10</sup>

### **General Qualifications of Coroners and Medical Examiners:**

Coroners tend to be lay elected or appointed individuals with no medical qualifications or background. Only 7 of 28 states with coroners require medical training of any kind, and only four states require coroners to be physicians.<sup>11</sup>

Medical examiners are physicians licensed to practice by their respective states and generally are forensic pathologists who in addition to medical school have completed three to five years of residency in general pathology and one year of forensic pathology fellowship. They are certified by the American Board of Pathology in anatomic pathology (the study of body tissues), clinical pathology (the study of body fluids) and are also separately certified in forensic pathology (the

application of medical science to legal problems). Qualifications of MEs in the United States vary somewhat from jurisdiction to jurisdiction.

## **B. Death Investigation in Sacramento County**

### **Organization:**

In Sacramento County the Office of Coroner is within the Public Protection Agency along with six other agencies.<sup>12</sup> This agency reports to the County Executive and the Board of Supervisors.

The Sacramento County Coroner position is defined as an administrative position and peace officer status is required (see below). It has historically been held by career county employees, frequently in concert with other county positions, as a part-time job.

### **Specific Qualifications and Duties of the Coroner and Staff in Sacramento County:**

#### **Coroner:**

Qualifications: In Sacramento County the qualifications for the office of coroner include “any combination of training or experience equivalent to graduation from college and 3 years of progressively responsible administrative experience”. There are also “knowledge of” provisions that are undefined objectively.<sup>13</sup> An interview-examination is given, the details of which are not available to the Grand Jury.<sup>14</sup>

Penal Code Section 830.35 states that the coroner and deputy coroners are peace officers.

Duties: The coroner is charged with determining the circumstances (events temporally related), manner (natural, undetermined, homicide, suicide, accidental) and cause (the actual vital organ injury or disease process) of death. These duties fall to his assistants as noted below.

#### **Assistant Coroner:**

Qualifications: Possession of a Peace Officer Standards and Training (POST) certificate and either 3 years as deputy coroner in Sacramento County or 3 years experience in a California public law enforcement agency performing death investigation duties equivalent to those of a Sacramento County deputy coroner.

Duties (among others): “Directs Pathology Staff as to level of medical inquiry into Coroner cases. Plans, develops and implements the policies and procedures of the department. Determines final classification of manner and cause of death in Coroner Investigations. Meets regularly with the Pathology staff to determine management of cases. Represents Coroners office as liaison to other law enforcement agencies, e.g. the district attorney (DA), attorneys, physicians, hospitals, and contract service providers.”<sup>15</sup>

#### **Deputy Coroner Level I:**

Qualifications: Candidates must have a 2-year college degree or 60 semester hours with undefined “coursework in anatomy, criminal justice, science, health science, or closely related field.”<sup>16</sup> An 80-hour Coroner’s Death Investigation course originating in Orange County is required. (POST Plan III, CC #2060-31200)

Duties: Same as level II below but investigations are less complex, and there is more supervision.<sup>17</sup>

**Deputy Coroner Level II:**

Qualifications: Possession of Peace Officer Standards and Training Regular Basic or Specialized Basic certificate and either 1 year experience as deputy level I or 2-year degree or 60 college units as above and 1 year experience in California public law enforcement agency performing death investigations, crime scene investigations or related duties. Several undefined “knowledge of” and “ability to” sections are also required. The formal continuing education requirement is 24 hours every other year. These courses tend to be weighted toward law enforcement topics. From July 2000 to July 2003, twenty-three courses were scheduled and six or possibly seven were on medical topics.<sup>18</sup> Deputies must qualify with firearms three times yearly.

Duties: Investigates death scenes for evidence relating to the cause and manner of death, including taking possession of the body and appropriate evidence and interviewing witnesses. Confers with law enforcement to coordinate investigations of deaths resulting from criminal acts. Confers with decedents, physicians, hospitals, and other medical personnel and reviews medical records to determine medical background information for investigation. Photographs and fingerprints the decedent, notifies next of kin, assists in autopsies by accepting labeling and safeguarding evidence. And others.<sup>19</sup>

Currently a large majority of deputy coroners have law enforcement background.<sup>20</sup>

**Pathology Staff:**

Currently the Chief Forensic Pathologist is a contractual employee. His contract calls for performance of autopsies, external exams and medical record reviews, supervising other forensic pathologists, developing policies and procedures for clinical functions, attending county and community meetings.<sup>21</sup> The other two pathologists are county employees.

**Deaths in Sacramento County. Chain of Events. Authority for Direction of Death Investigation. Issues of Medical Autonomy.**

**Systemic Compromise of Medical Autonomy:**

In Sacramento County a deputy coroner with qualifications outlined above and no formal medical training authorizes the signature of death certificates in 4500 reportable deaths without consultation with or knowledge of the department forensic pathologists. The assistant coroner determines the level of death investigation and the final manner of death and cause of death of the 1400 decedents transported to the office for evaluation. This can include overruling the pathologist.

Under Health and Safety Code Section 102850, the coroner must be notified when a death occurs (a) without medical attendance (b) during the continued absence of the attending physician and surgeon (c) where the attending physician and surgeon or the physician assistant is unable to state the cause of death (d) where suicide is suspected (e) following an injury or an

accident (f) under circumstances as to afford a reasonable ground to suspect that the death was caused by the criminal act of another. These circumstances are stated in more detail in Government Code Section 27491.

In approximate numbers there are 10,000 deaths annually in Sacramento County. Of those, 4000 occur under medical supervision with death certification by the attending physician. The coroner is not involved. The remaining 6000 are reportable to the coroner by statute as noted above.<sup>22</sup> Of the reported deaths, 4500 are resolved by the deputy coroner discussing the case with those involved in the care of the decedent and by the deputy authorizing the last physician in attendance to sign the death certificate. These cases are sometimes clear-cut and sometimes not. The coroner's pathologist is not involved in these discussions and decisions and has no knowledge of their disposition. Consultation is not required.

At the deputy coroner's order, approximately 1400 decedents are delivered to the morgue for further study per year. The assistant coroner determines the extent of evaluation to be performed. This may include record review, external examination, and autopsy. Annually, approximately 900 autopsies and 300 external exams with medical record review are performed. The pathologist performs the autopsy and states his /her opinion as to cause of death but the assistant or deputy coroner makes the final determination of and manner of death and signs the death certificate as the coroner designee.

#### **Case-Specific Compromise of Medical Autonomy:**

Not only is it possible for the pathologist to be excluded from case management decisions and the final determination of manner and cause of death, his/her specific medical recommendations may also be overruled by the coroner and theoretically by the executive levels between him and the Board of Supervisors, namely the Public Protection Agency, and the County Executive.

An illustrative situation arose in 2001 with the disposition of an apparent Sudden Infant Death Syndrome (SIDS) victim who died after brief hospitalization at University of California Davis Medical Center (UCD). The diagnosis of SIDS is exclusionary and requires a full autopsy and other investigation that fail to reveal another cause of death.

A primary aim is to exclude child abuse.<sup>23</sup> This position was confirmed and expanded by the American Academy of Pediatrics Policy statement in 2001.<sup>24</sup> Therefore, by definition, death scene investigation, interview of family, review of family social case records, review of medical records, and performance of full autopsy is required to support the diagnosis of SIDS.

In the instance in question the examining pathologist made the written recommendation for autopsy, but the coroner overruled the pathologist, and the office signed off without autopsy. Reasons given for this decision included religious beliefs of family, backlog of bodies in the coroner's office awaiting autopsy, and the fact that the infant received medical diagnostic evaluation before death. However, it should be noted that the family's religious objections had been addressed by UCD staff, making autopsy acceptable to them. Also, it has been well documented that ante mortem diagnostic studies can miss trauma later found at autopsy. Prioritization of this autopsy was offered by the pathologists to resolve the backlog problem, but was refused by the coroner's staff.<sup>25</sup>

A controversial “loophole” in the law does allow for omission of autopsy in suspected SIDS cases if the attending physician signs the death certificate. It is true that a second year pediatrics resident certified the death; however, documents and interviews indicate that the resident had the understanding an autopsy was to be performed.<sup>26</sup>

The Sacramento Sierra Valley Medical Society (SSVMS) registered a complaint with the Board of Supervisors stating this case was “mishandled in that there was no autopsy performed. The forensic pathologists advised that such an autopsy was the community standard and required in all instances of SIDS.”<sup>27</sup> The Child Death Review Team<sup>28</sup> expressed their objection by classifying the cause of death and manner of death in this case as “undetermined.”<sup>29</sup> The coroner has acknowledged that another SIDS disposition without autopsy has occurred in recent years.<sup>30</sup>

This case demonstrates that the current system allows non-medical authorities to overrule not only their own pathologists, but the recommendations of national experts and academic associations as well.

### **C. 2002 Conversion of Coroner Pathology Staff to County Employees. Potential Further Compromise of Medical Autonomy:**

On September 11, 2001 the Board of Supervisors heard a proposal by the coroner and the administrator of the Public Protection Agency to terminate the contractor pathologists and contractor morgue staff that had been serving the county for 12 and 27 years respectively and recruit similar personnel as county employees. As justification for the changeover the coroner wished “control over the process as opposed to buying the product.” Enhanced customer service was also a stated goal.

The coroner said dysfunction existed between pathologists and morgue attendants; others said the disharmony was primarily between coroner and pathologists because of medical autonomy issues. Usually this disagreement was about the extent of death investigation performed by the deputy and the availability of medical records, information thought to be extremely important to determination of cause of death and need for autopsy. There were safety issues cited as well. On occasion the absence of medical records failed to alert staff to the presence of potentially fatal infectious disease.

Cost considerations were not an issue because negligible savings were projected. With respect to “customer service,” no change was proposed of the liaison to all customers or the assistant coroners, who were already county employees.

Many in the medical community saw the proposed conversion to county employees as a step backward for medical autonomy.<sup>31 32 33 34</sup> This contravention of physician medical autonomy was repeatedly denied by the Public Protection Agency administrator and the coroner. But this denial was at odds with a published quote of the coroner: “It’s the difference between being

able to say “Doctor, you shall do it” versus “Doctor, will you please do it?”<sup>35</sup> and testimony by the administrator regarding gaining total control within the coroner’s office.

The Chief Deputy District Attorney stated in the hearing that there was a history of excellent quality of pathology work in the coroner’s office since 1989. Others concurred with this opinion.<sup>36</sup> Several expert observers emphasized the difficulty of finding qualified pathologists in the proposed Sacramento situation when they would be reporting directly to a non-physician.<sup>37</sup>

The time-lines relative to the proposed conversion raised questions as well. Notice of termination effective December 31, 2001 was given the pathologists on June 22, 2001. However, the issue was not presented to the Board of Supervisors until September 11, 2001. This brief execution interval rendered recruitment of replacement pathologists problematic and refusal by the board essentially impossible. Notice of the hearing was given very late.

The supervisors voted unanimously to accept the coroner’s conversion proposal, with an alteration, if possible, to extend the existing pathology contract to June 2002. This proviso was highly unlikely, as the pathologists in question had been seeking other positions since their June 2001 notification.

It is interesting to note that the result thus far has been to replace one contractual forensic pathologist with another. The new Medical Director-Chief Forensic Pathologist is a contractual employee with a county commitment of three years.

The manpower concern also proved significant. The coroner hired the only three pathologists who applied, including one physician who because of personal legal problems is restricted from performing autopsies which might become the subject of court testimony. According to the District Attorney’s office this restriction is permanent.<sup>38</sup>

#### **D. Correctional Health and the Coroner. Conflict of Interest.**

On December 11, 2001 the Board of Supervisors established the Department of Coroner and Correctional Health Services, adding medical and dental care for detainees at county correctional facilities (Main Jail, Juvenile Hall, Rio Cosumnes Correctional Center, Boys Ranch, Warren E. Thornton Youth Center) to the Office of Coroner. This action relegated both positions to part-time status. It also created an obvious conflict of interest which has been noted on more than one occasion by the local medical society and others, i.e. the person in charge of inmate medical care is also in charge of investigation of in-custody deaths.<sup>39 40</sup> The Sacramento Sierra Valley Medical Society described the Supervisors’ decision as “curious” and noted, “there were several other logical choices that would have avoided potential conflicts.”<sup>41</sup> The conflict was said to be mitigated by a contract for autopsy of in-custody decedents with the San Joaquin County Coroner’s Office and by transfer of numbered, sealed body bags. However, death scene investigation, of equal or greater importance, continued under the Sacramento County Coroner’s office in concert with Sheriff’s homicide detectives, adding two conflicts of interest to one another. An additional problem is that the body and associated

evidence are in the custody of the coroner's office until the "next business day" which can be as long as 60 hours.

This discussion highlights the compromised position of the county inherent in such an arrangement. There is pending litigation which originated during the tenure of this conflict. It would appear that the conflict is partially resolved by transfer of correctional health to the Sheriff's Department on January 10, 2003 and would be completely resolved by conversion to an independent ME system answering only to the governing board of the county. That office would perform in-custody death investigation, perhaps in concert with a district attorney investigator.

## **E. Conversion to Medical Examiner System in Sacramento County.**

### **Operational Considerations:**

Most principals knowledgeable of the local situation were of the opinion that conversion to a ME system in Sacramento County would be fairly straightforward from the perspective of department operation. The coroner's staff would not have to be replaced en masse, but rather the change to medical emphasis would permeate rapidly via policies, procedures and continuing education of medical nature.

Dr. Randy Hanzlick<sup>42</sup> has made the following operational recommendations for Sacramento County. Encourage diversity of background of investigators and change emphasis of recruitment to medical from law enforcement. A department forensic pathologist should make all case-related decisions on reportable deaths and subsequently confirm that the required investigation has been completed and that necessary autopsy or external exam has been performed. Such scrutiny is advisable, as studies have shown discrepancy between death investigator and pathologist with respect to the manner of death in a significant number of cases.<sup>43</sup> The supervising forensic pathologist should sign the death certificate and all death certificates should be reviewed by the chief ME-department head.

All department pathologists should be board certified in forensic pathology. All investigator-deputies should be required to take the Registry Certification examination of the American Board of Medical Legal Death Investigators and board certification should be encouraged. Continuing education should have medical emphasis and department meetings should be of educational value for the deputies.

A strong affiliation with the UCD Department of Pathology is desirable and is attainable. Dr. W. E. Finkbeiner, chief of Anatomic Pathology at UCD, stated, "There are many opportunities and areas of mutual interest between the University and Sacramento County in the area of forensic science, forensic pathology and death investigation. I believe that with the proper planning and cooperation we can build a model program in these fields that will meet both the service and educational needs of our county and state."<sup>44</sup>

Sacramento County currently has the assets for development of a model, state of the art, death investigation program. These include an excellent physical plant and nearby university medical center. All that is required is an administrative organization assuring medical autonomy.

The Grand Jury has reviewed a comparative financial analysis of the current coroner system versus a medical examiner system for the county and has concluded there would be no additional funding necessary.

### **Process of Conversion to ME System in Sacramento County**

Sacramento is a charter county. Section 27 of the Charter provides for certain appointive officers, including the Coroner. According to County Counsel, in order for this county to abolish the coroner and replace that office with another, a charter amendment would be required. The same procedure would be necessary to provide different qualifications or a different job description for the same office. A charter amendment must be proposed by initiative, a charter commission, or the board of supervisors and then approved by a majority vote of the electors within the county.<sup>45</sup> The Voter Registration and Elections office estimates the cost of adding a charter measure to the ballot to be approximately \$5000.

### **F. Death Certification, Local Problem.**

The Grand Jury is aware of physician complaints regarding undue pressure from deputy coroners to assign a cause of death even when the physician had not seen the patient for many months and had no knowledge of the cause of death. In at least one instance, a misdemeanor charge was threatened if the doctor did not comply. The California Medical Association has also noted similar complaints.<sup>46</sup> Pertinent is Government Code Section 27491 and Health and Safety Code Sections 102850, 102855, and 12860. Review of this issue by County Counsel concluded that the coroner is required to sign death certificates for deaths reported for investigation pursuant to the above codes including instances where the attending physician is unable to state the cause of death. The latter statutes (102850, et seq.) were amended and reorganized in 1995.

This problem appears to be resolved, and advice to that effect is available through the CMA website. The Sacramento County Department of Health and Human Services has distributed through various channels<sup>47</sup> a letter of instruction to physicians to assist in accurate death certificate completion. The public health officer is available for consultation at any time, day or night.<sup>48</sup>

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## **Findings and Recommendations**

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**Finding #1.** Death investigation historically has been folded into law enforcement duties. This combination is inappropriate in the face of advanced medical knowledge in the diagnosis of

unnatural and violent deaths. Death investigation is a medical science and should be performed by medically qualified people. Death certification is a healthcare issue.

**Finding #2.** In the United States there has been a trend in large population centers to convert to a medical examiner system of death investigation. Such a system now serves 48 percent of the population of the United States and 40 percent in California.

**Finding #3.** Coroners with few exceptions are administrators and/or peace officers with no medical qualifications or training. Very few are physicians. Medical Examiners are licensed physicians who have completed medical school, four to six years of postgraduate training in pathology, including forensic pathology fellowship. They are board certified in anatomic, clinical, and forensic pathology.

**Finding #4.** Death investigation should be performed by an independently funded, autonomous office unrelated to law enforcement or prosecutorial agencies, answering only to the governing board of the jurisdiction. There should be clear separation of scientific medical decisions from non-qualified individuals, agencies and political interests.

**Finding #5.** The performance of death investigation does not require law enforcement background. Forensic pathology fellowship includes this training, and forensic board certification requires this knowledge.

**Finding #6.** There is no legal impediment to a medical examiner discharging all functions of death investigation. In Sacramento County the authority for death investigation would be conveyed by creation of the Office of Medical Examiner.

**Finding #7.** In Sacramento County the Office of the Coroner is within the Public Protection Agency and operates under the administrator of that agency and the county executive. It is defined as an administrative position with no formal medical qualifications required. It is frequently combined with other county positions.

**Finding #8.** In Sacramento County, on an annual basis, a deputy coroner with no formal medical qualifications authorizes the signature of death certificates in approximately 4500 reportable deaths without consultation or knowledge of the department forensic pathologists. The assistant coroner, also with no formal medical training, is empowered to determine the extent of death investigation and the final manner of death and cause of death of the approximately 1400 decedents transported to the office for evaluation. This provision can include overruling the judgment of the pathologist. The compromise of medical autonomy is not just theoretical; cases confirming have been documented.

**Finding #9.** On September 11, 2001 the Board of Supervisors authorized change in the coroner's office from contractual pathology and morgue services to county employees, further compromising medical autonomy and discharging a pathology group that by all accounts was professionally excellent. The transition may have created problems with respect to recruitment

of pathologists and homicide testimony. The decision was made despite significant opposing written advice and testimony from the local medical community. The chief forensic pathologist continues to be a contractual employee.

**Finding #10.** On December 11, 2001 the Board of Supervisors created a conflict of interest in the investigation of in-custody deaths by placing the coroner in charge of correctional health. This conflict was in place at a time of intense scrutiny regarding inmate deaths/suicides. There is pending litigation. The conflict was only partially resolved by an autopsy contract with San Joaquin County and the very recent transfer of correctional health to the Sheriff 's Department. This action was also the subject of major objection in the medical community. Investigation of in-custody deaths by an independent medical examiner's office in concert with a district attorney's investigator will resolve this conflict.

**Finding #11.** Coroner and Medical Examiner systems operate outside the usual medical oversight and control. There are no national standards or guidelines. Therefore voluntary review and certification by organizations such as NAME and ABMDI are desirable. Affiliation with the UCD Department of Pathology would facilitate subspecialty consultation, development of policy and quality assurance.

**Finding #12.** With the above review and affiliation, the excellent physical plant already in place and conversion to a medical examiner system assuring medical autonomy, Sacramento County will attract excellent forensic pathologists and be in position to develop a state of the art death investigation program.

**Finding #13.** Conversion to a medical examiner system would not be difficult from an operational standpoint. The coroner's staff would not have to be replaced and would adapt quickly to medical emphasis and supervision.

**Finding #14.** A financial analysis of the transition has been reviewed by the jury and thought to be neutral, with no additional funding necessary for the operation of a medical examiner system.

**Finding #15.** Change to a medical examiner system requires a charter amendment and electorate participation.

**Finding #16.** There have been complaints of inappropriate pressure by deputy coroners placed upon attending physicians to certify deaths when the physicians had inadequate knowledge as to the cause of death. This problem appears resolved.

**Recommendation #1.** The citizens of Sacramento County should be served by a medical examiner system headed by a board certified forensic pathologist appointed by the governing board. The Office of the Medical Examiner is autonomous, independently funded, and responds only to the Board of Supervisors.

**Recommendation #2.** To establish this office the Board of Supervisors should propose and place on the ballot a charter amendment to abolish the Office of Coroner and replace it with the

Office of Medical Examiner. Failing that, the board should propose and place on the ballot a charter amendment to require the coroner to be a forensic pathologist. Failing that, the board should appoint a forensic pathologist to be coroner at the earliest opportunity.

**Recommendation #3.** The Chief Medical Examiner should be selected by a search committee of medical experts utilizing non-political and strictly professional criteria, including prior administrative experience. All staff pathologists should be board certified in forensic pathology. They can be contractual or county employees.

**Recommendation #4.** The Medical Examiner System of Sacramento County should establish a strong relationship with the UCD Medical Center for development of lines of consultation, quality assurance and continuing education programs. The system should utilize professional organizations for review, certification and guidelines of operation. There should be medical emphasis in the recruitment and continuing education of staff. A forensic pathologist should supervise each reported decedent investigation and sign the death certificate of all those studied in the medical examiners office. A pathologist should supervise all morgue functions.

**Recommendation #5.** The investigation of in-custody deaths should be separate from correctional health and the Sheriff's Department. It should be performed by an independent medical examiner and district attorney investigator.

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## Response Required

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**Penal Code Section 933.05 requires that specific responses to both the findings and recommendations contained in this report be submitted to the Presiding Judge of the Sacramento Superior Court by September 30, 2003 from:**

- **Sacramento County Public Protection Agency**
- **Sacramento County Coroner's Office**

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<sup>1</sup> Randy Hanzlick, Grand Jury communication, October 23, 2002

<sup>2</sup> Los Angeles, San Diego, San Francisco, Santa Clara, Ventura

<sup>3</sup> Randy L. Hanzlick, "Medical Examiner and Coroner Systems," Journal of the American Medical Association, Vol. 279, 1998, pp. 870-874

<sup>4</sup> L. Kalb, "Region's On Track to Grow," The Sacramento Bee, October 19, 2002, D-1, quotes S. Levy, director of the Palo Alto-based Center for Continuing Study of the California Economy

<sup>5</sup> Four California counties have a greater population than Sacramento and still have a coroner system: Alameda, Orange, Riverside and San Bernardino

<sup>6</sup> California Medical Association Policy, "Coroner Functions," HOD 29-66

<sup>7</sup> Sacramento County Coroner's Office: An overview of functions and services, November 2002

<sup>8</sup> The Consumer Product Safety Commission, Food and Drug Administration, Occupational Safety and Health, Bureau of Labor Statistics, Federal Bureau of Investigation, Center for Disease Control and Prevention, National Highway Traffic Safety Administration, National Institute of Health, Department of Justice, and state and local departments of organ and tissue procurement.

<sup>9</sup> The Accreditation Council for Graduate Medical Education

<sup>10</sup> County Counsel, Grand Jury communication, December 31, 2002

<sup>11</sup> Randy L. Hanzlick, "On the Need for More Expertise in Death Investigation," Arch Pathol Lab Med, Vol. 120, 1996, pp. 329-332

<sup>12</sup> Child Support Services, Conflict Criminal Defenders, Correctional Health, Health and Human Services, Human Assistance, Probation and Public Defender

<sup>13</sup> Sacramento County Coroner, Grand Jury communication, September 5, 2002

<sup>14</sup> Director of Personnel Services, Grand Jury communication, May 21, 2003

<sup>15</sup> Sacramento County Series Specification, April 12, 1996

<sup>16</sup> Ibid.

<sup>17</sup> Ibid.

<sup>18</sup> Sacramento County Assistant Coroner, Grand Jury communication, December 3, 2002

<sup>19</sup> Sacramento County Series Specification, April 12, 1996

<sup>20</sup> Sacramento County Assistant Coroner, Grand Jury communication, November 15, 2002

<sup>21</sup> Contract for Chief Forensic Pathologist in the Coroner's Office, December 11, 2001

<sup>22</sup> Sacramento County Coroner's Office: An overview of functions and services, November 2002

<sup>23</sup> Centers for Disease Control and Prevention. Guidelines for Death Scene Investigation of Sudden Unexplained Infant Deaths: Recommendations of the Interagency Panel on Sudden Infant Death Syndrome. MMWR Morb Mortal Weekly Rep., No. 45, 1996, pp. 1-22

<sup>24</sup> Policy Statement. Distinguishing Sudden Infant Death Syndrome From Child Abuse Fatalities (RE0036) Pediatrics, No. 107, 2001, pp. 437-441

<sup>25</sup> G. Reiber, letter to Sacramento County Coroner, December 21, 2001

<sup>26</sup> R.C. Midgley, President, Sacramento Sierra Valley Medical Society, letter to Supervisor Roger Niello, November 27, 2001

<sup>27</sup> Ibid.

<sup>28</sup> The Sacramento County Board of Supervisors in 1988 directed the Child Abuse Prevention Council by resolution to establish Child Death Review Team authorized by Penal Code Section 11166.7 and the Welfare and Institutions Code Sections 830 and 10850.1

<sup>29</sup> A. Nakamura letter to Public Health Officer, December 19, 2001

<sup>30</sup> Sacramento County Coroner, letter to Public Health Officer, December 13, 2001

<sup>31</sup> R.C. Midgley letter to Supervisor Niello and the Board of Supervisors, November 27, 2001

<sup>32</sup> R.C. Midgley letter to Penelope Clarke, September 5, 2001

<sup>33</sup> R. Ikeda letter to Supervisor Roger Niello, September 10, 2001

<sup>34</sup> W.E. Finkbeiner, Director of the division of Anatomic Pathology at UCD letter to Penelope Clarke, Coroner Smith, cc to the Board of Supervisors, September 4, 2001

<sup>35</sup> C. Garvin, "Dead Wrong," Sacramento News and Review, March 14, 2002, p. 16

<sup>36</sup> Penelope Clarke, Board of Supervisors' hearing, September 11, 2001; John O'Mara, Grand Jury communication, November 15, 2002, January 8, 2003, R. Ikeda, letter to Supervisor Roger Niello, September 10, 2001,

<sup>37</sup> P.W. Herrmann, letter to Supervisor Roger Niello, September 5, 2001; P. Rooney, letter to Supervisor Roger Niello, September 5, 2001; B.G. Stephens letter to Supervisor Roger Niello, September 5, 2001

<sup>38</sup> C. Bessemer, J. O'Mara, Grand Jury communication/interview November 15, 2002 and January 8, 2003

<sup>39</sup> R.C. Midgley letter to Supervisor Roger Niello, November 27, 2001

<sup>40</sup> C. Garvin, "Dead Wrong," Sacramento News and Review, March 14, 2002, p.19

<sup>41</sup> R.C. Midgley letter to Penelope Clarke, September 5, 2001

<sup>42</sup> Chief Medical Examiner, Fulton County, Georgia; Associate Professor, Forensic Pathology, Emory University, Forensic Pathologist with the Centers for Disease Control and Prevention, Past President, National Association of Medical Examiners (NAME)

<sup>43</sup> J.L.deJong, "Level of agreement between opinions of medical examiner investigators and forensic pathologist medical examiners regarding the manner of death," American Journal Forensic Medical Pathology 2000, Vol. 21, No. 1, March, pp.11-20

<sup>44</sup> W.E. Finkbeiner letter to Penelope Clarke and Coroner , cc to the Board of Supervisors, September 4, 2001

<sup>45</sup> County Counsel, Grand Jury communication, October 15, 2002 and October 17, 2002

<sup>46</sup> CMA on Call: [www.cmanet.org](http://www.cmanet.org), Document No. 1305

<sup>47</sup> Sacramento County Vital Records, Coroner's Office, and funeral directors

<sup>48</sup> Public Health Officer, letter to physicians, March 27, 2002