San Mateo County Coroner
2020 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 764,442 in 2020. There were approximately 5,735 deaths recorded in San Mateo County in 2020 which increased from 5,523 deaths in 2019 (3.84% increase). Of these deaths, 2,260 deaths were reported to the Coroner's Office which increased from 2,059 in 2019 (9.76% increase). After initial investigation, 653 were determined to be full Coroner cases with the final cause of death signed by the Coroner, or his designated authority; this increased from 618 in 2019 (5.66% increase).

This 2020 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 2020.

Updates & Accomplishments
In 2020, the Coroner's Office Pathology Division moved to a seven-day operating schedule resulting in improved turn around for intake and release of decedents. Additionally, the Coroner's Office contracted with two new forensic pathology service providers bringing a total of four forensic pathologists to serve the County of San Mateo since March 2020.

Impact of Coronavirus on the Coroner's Office
There was an increase in reportable cases from 1,441 in 2019 to 1,607 in 2020 and an increase in accepted cases from 618 in 2019 and 653 in 2020.

Most in-person trainings and all community outreach events including the Save-A-Life Program were suspended beginning in March 2020.

All accepted cases from December 17, 2019 to March 16, 2020 were reviewed (161 total cases), and those cases where the decedent exhibited possible flu-like symptoms prior to death, or were found deceased, were submitted for tissue testing for Covid-19. Of the twenty cases submitted, zero cases returned positive results for Covid-19.

On April 2, 2020, the Coroner's Office began submitting Covid-19 swabs from all decedents brought into jurisdiction of the office. A total of 470 cases brought into the jurisdiction of the

Coroner's Office were swabbed for Covid-19 and 33 cases were Covid-19 positive. 22 deaths were determined to be a result of Covid-19. A total of 553 reportable cases (cases not brought into the jurisdiction of the Coroner's Office) were reported to test positive for Covid-19.

Suicide Increase
Suicide deaths were up 26.2% from 2019 (82 in 2020 versus 65 suicides in 2019). There were almost three times as many male suicide deaths than female suicide deaths (61 to 21) with 31.7% (26 of 82) of the total deaths occurring between the ages of 51-60 years old. The two most common modes of death were firearm (23) and hanging (24).

Accident Increase – due to increase in Motor Vehicle Incidents and Overdoses
Accidental deaths were up 18.1% from 2019 (222 in 2020 versus 188 in 2019). Motor vehicle accidents were up 48.3% from 2019 (43 in 2020 versus 29 in 2019) and overdoses were up 20.4% from 2019 (118 in 2020 versus 98 in 2019). Of the 118 accidental overdoses, 81 cases tested positive for opioids and of those, 63 of cases tested positive for fentanyl.

Homicide Increase
San Mateo County experienced a 100% increase in homicides in 2020 (22 homicides in 2020 versus 11 homicides in 2019). Fifteen of the 22 homicides occurred in males between the ages of 20 and 40 years old.

Transient Deaths
There were 46 decedents identified as transient in San Mateo County. Of those 46 deaths, one was mannered homicide, 6 were mannered suicide, 24 were mannered accident (including 13 fentanyl related overdoses and 8 non-opioid overdoses), 13 were mannered natural, and two were mannered undetermined.

2020 Accomplishments

- In January 2020, the Coroner's Office presented the Save-A-Life program to two at-risk youths prior to the stoppage of in-person classes due to the Covid-19 pandemic.
- One Coroner Intern completed the academic internship program in 2020.
- The Coroner's Office continued to partner 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 continued to collaborate with partner agencies by meeting virtually to discuss untimely Child Deaths, Elder Deaths, and deaths related to Domestic Violence.

- Staff members participated in a youth Teazer event in February 2020 hosted by the FYI-Project, Junior Achievement of Northern California at the Belmont Library. The Coroner's Office also met with 15 students from Amador Valley High School to discuss the role of the Coroner's Office and gave them a tour of the Pathology Division. One staff member was the guest lecturer for the College of San Mateo's Introduction to Forensic Science course during one of their virtual classes. Another staff member virtually met with multiple community members who expressed interested in the field of medicolegal death investigation.
- The Coroner's Office acquisitioned a 53' refrigerated trailer as part of a donation to Coroner's and Medical Examiner's Offices in California for the response to the Covid-19 pandemic.
- One staff member completed incident Command System (ICS) 300: Intermediate Incident Command System for Expanding Incidents from September 14-16 and ICS 400: Advanced Incident Command System for Complex Incidents in September 2020, which was hosted by the City of San Mateo.
- Eight employees of the Coroner's Office participated in the virtual Charitable Contributions Campaign pumpkin carving event.

Mass Fatality Planning – 53' Donated Trailer added to Coroner assets

Coroner Staff participated in a socially distanced Charitable Contributions Campaign

- The Coroner's Office actively pursued identifications on cold case John and Jane Doe cases through multiple avenues including forensic artist renditions of unidentified persons using multiple mediums, and the disinterment of a 1974 John Doe case to collect DNA.
- The Coroner's Office successfully filled five full-time vacancies through internal promotions during the year.
- 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:
    - One Deputy Coroner completed a 16-hour "Emergency Vehicle Operations Course" as part of their basic training requirements as a deputy coroner.
    - All Deputy Coroners completed their 24-hour POST Perishable Skills two-year cycle training requirement.
    - The Chief Deputy Coroner completed the POST "Management Course."
    - One Deputy Coroners achieved ABMDI diplomate certification.

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San Mateo County Coroner 2020 Staff

Administration

Robert J. Foucrault	Coroner
Christi Canclini	Executive Assistant
Vacant	Assistant Coroner (Jan-Feb, position reclassified)
K'Lynn Solt	Chief Deputy Coroner (Feb-Dec)
Unfilled	Fiscal Office Assistant I/II
Unfilled	Office Assistant I/II
K'Lynn Solt	Supervising Deputy Coroner (Working out of class) (Jan-Feb)
Elizabeth Ortiz	Supervising Deputy Coroner (Mar-Dec)
Maria Shoats	Coroner Intern (Extra Help) (Jan-Feb)
Tritia Mallari	Coroner Intern (Extra Help) (Jan-Mar)
Joseph Begovich	Coroner Intern (Extra Help)
Annette Trujillo	Coroner Intern (Extra Help) (Aug-Dec)
Alyssa Terwilliger	Coroner Intern (Extra Help) (Aug-Dec)

Investigations

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

Pathology

Laura Bailey	Forensic Autopsy Technician (Working out of class) (Jan-May)
Devan Glensor	Forensic Autopsy Technician (Jan-May)
Alina Revilla	Forensic Autopsy Technician (Full Time) (Jun-Dec)
Michelle Schabinger	Forensic Autopsy Technician (Full Time) (Aug-Dec)
Alina Revilla	Forensic Autopsy Technician (Limited Term) (Jan-Jun)
Michelle Schabinger	Forensic Autopsy Technician (Extra Help) (Jan-Aug)
Irais Lopez	Forensic Autopsy Technician (Extra Help) (Nov-Dec)

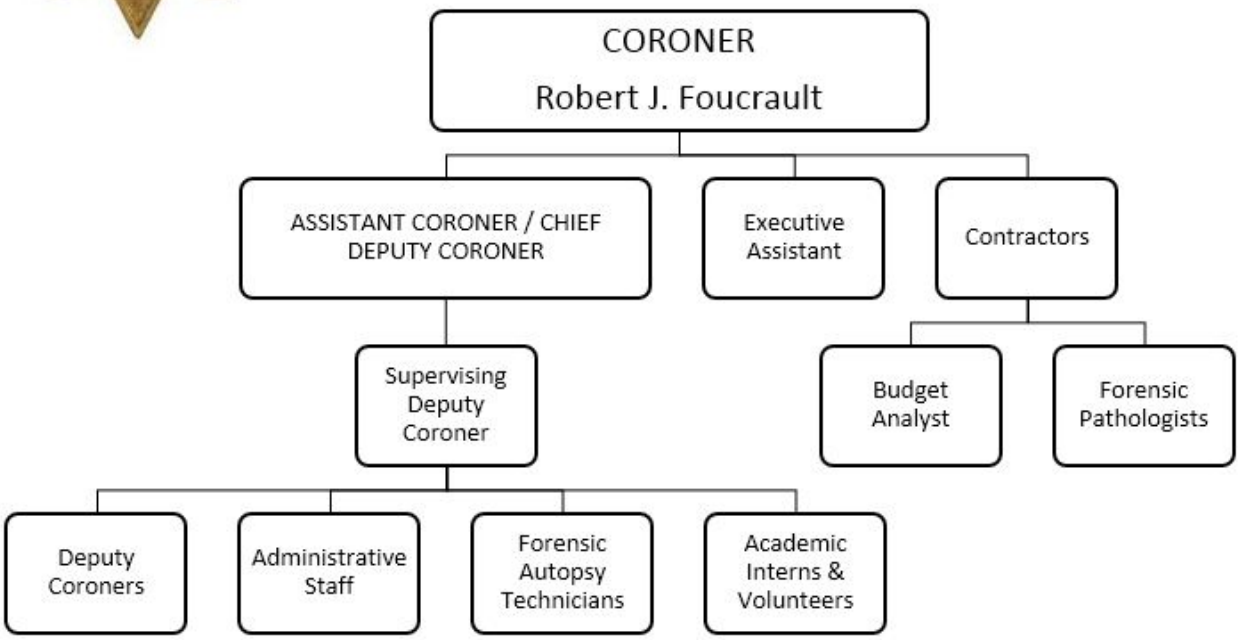
Contractors

Peter Benson, M.D.	Forensic Pathologist (Jan)
Thomas Rogers, M.D.	Forensic Pathologist
Forensic Doctors Group	
Michael Hunter, M.D.	Forensic Pathologist (Mar-Dec)
Louis Pena, M.D.	Forensic Pathologist (Mar-Dec)
Katherine Raven, M.D.	Forensic Pathologist (Mar-Dec)
Greg Pizarro, M.D.	Forensic Pathologist (Mar-Apr)

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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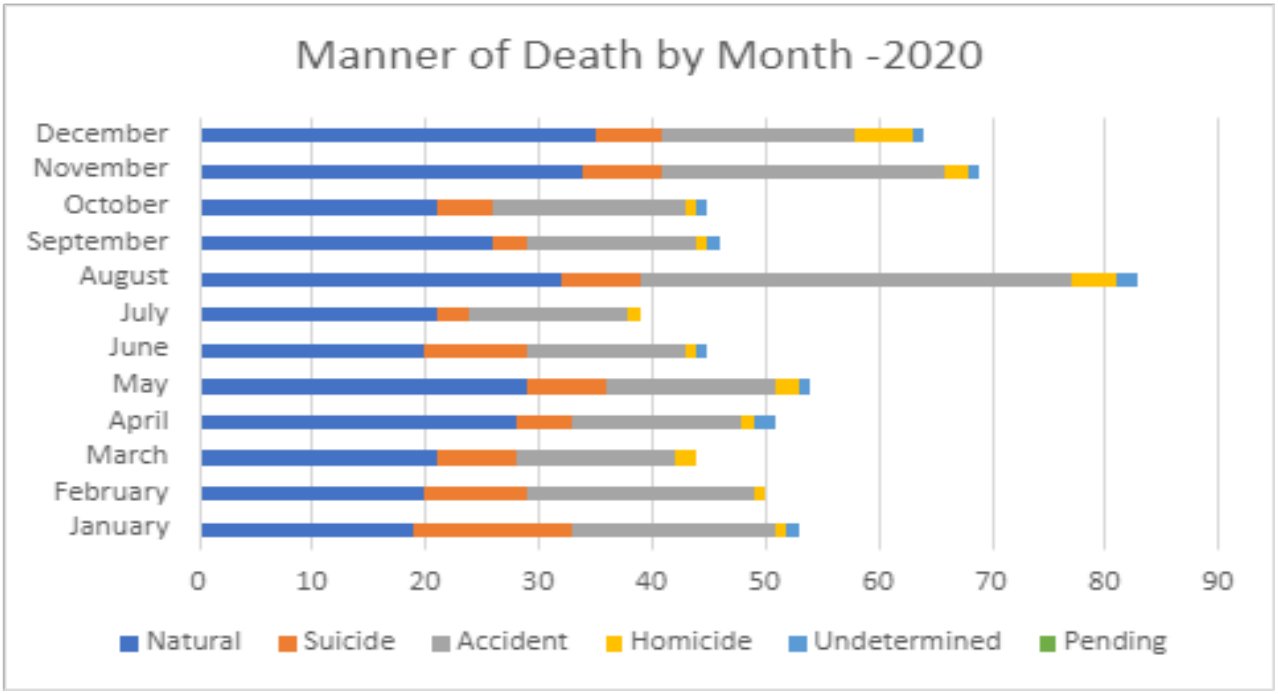
Statistics for Calendar Year 2020

Number of deaths reported:	2,260
Number of cases for full investigation:	653
Number of cases investigated at scene and released:	28
Number of cases by manner of death:	
Natural	306
Accident	222
Suicide	82
Homicide	22
Undetermined	11
Pending Investigation	0
Number of decedents transported:	
Coroner	515
Contractor	72
Mortuary/Funeral Home/Other	12
Forensic Examinations:	
Full Autopsy	329
Limited Autopsy	69
Clinical Review	127
Specialized (SUIDS / Homicide)	25
Hospital Autopsies	0
Number of toxicology cases conducted:	376
Number of cases reported as "unidentified":	82
Identified after investigation	81
Remain unidentified	1
Organ and tissue donations:	
Cases referred for donation	1,457
Total organ donors	9
Total organs transplanted	30 (21 recipients)
Total tissue donors	70
Exhumations:	1

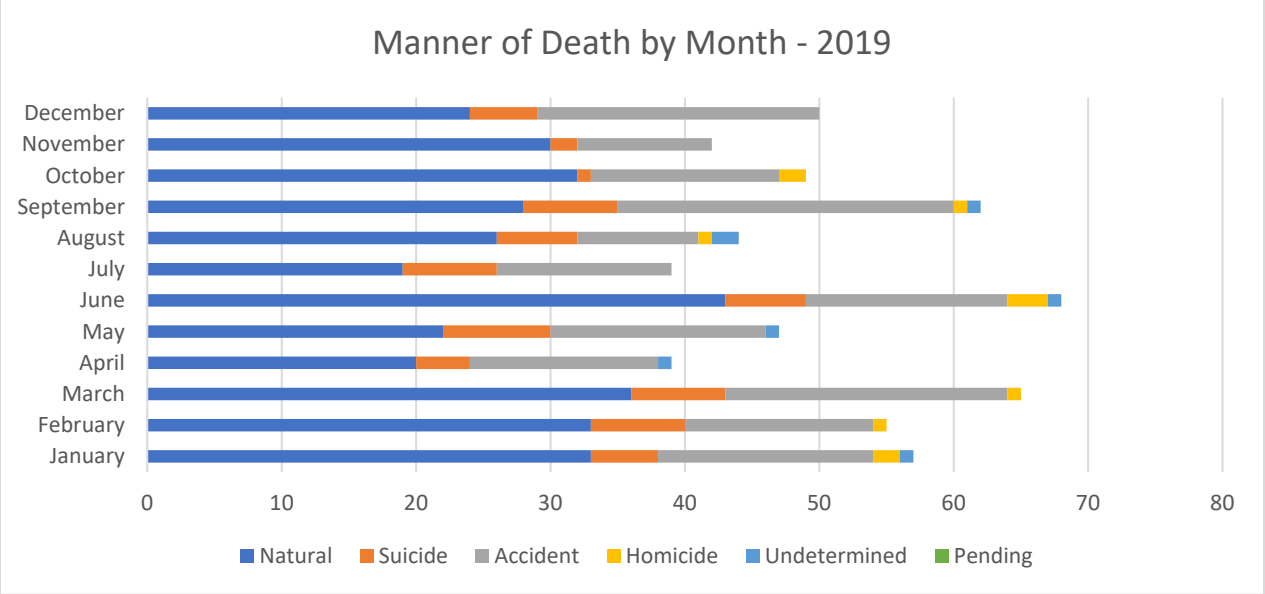
General Classifications of Death by Month

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



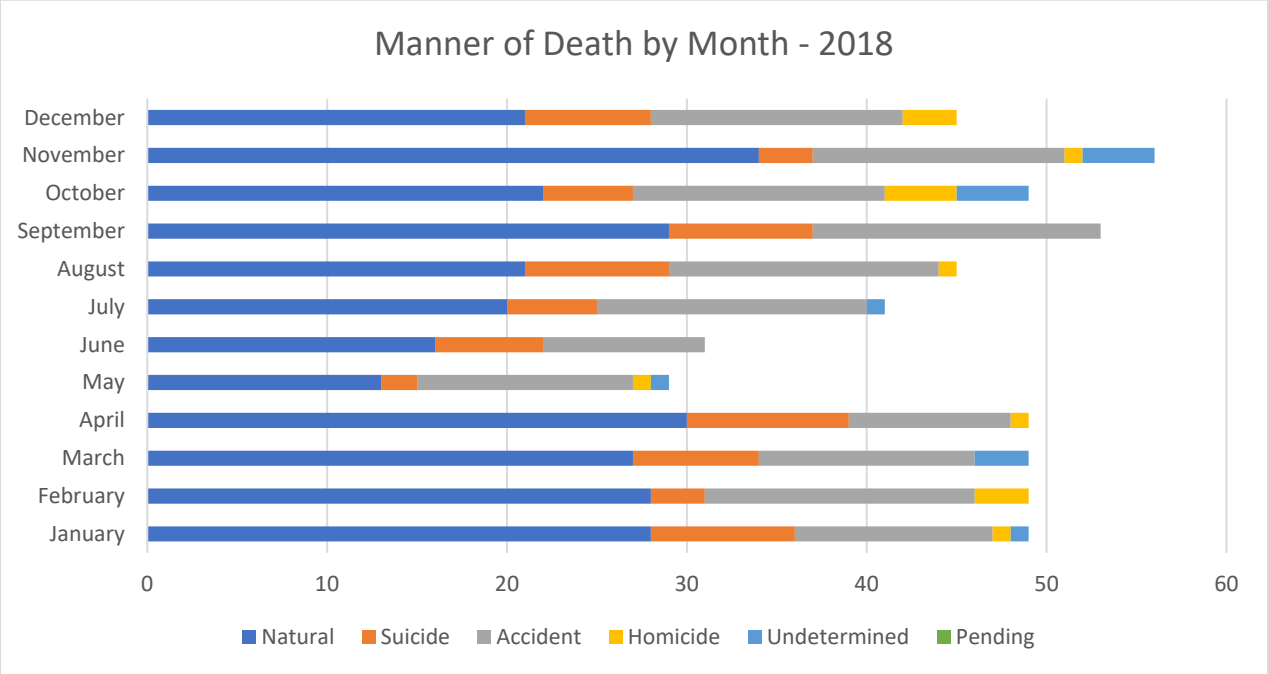
Historical Statistics

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



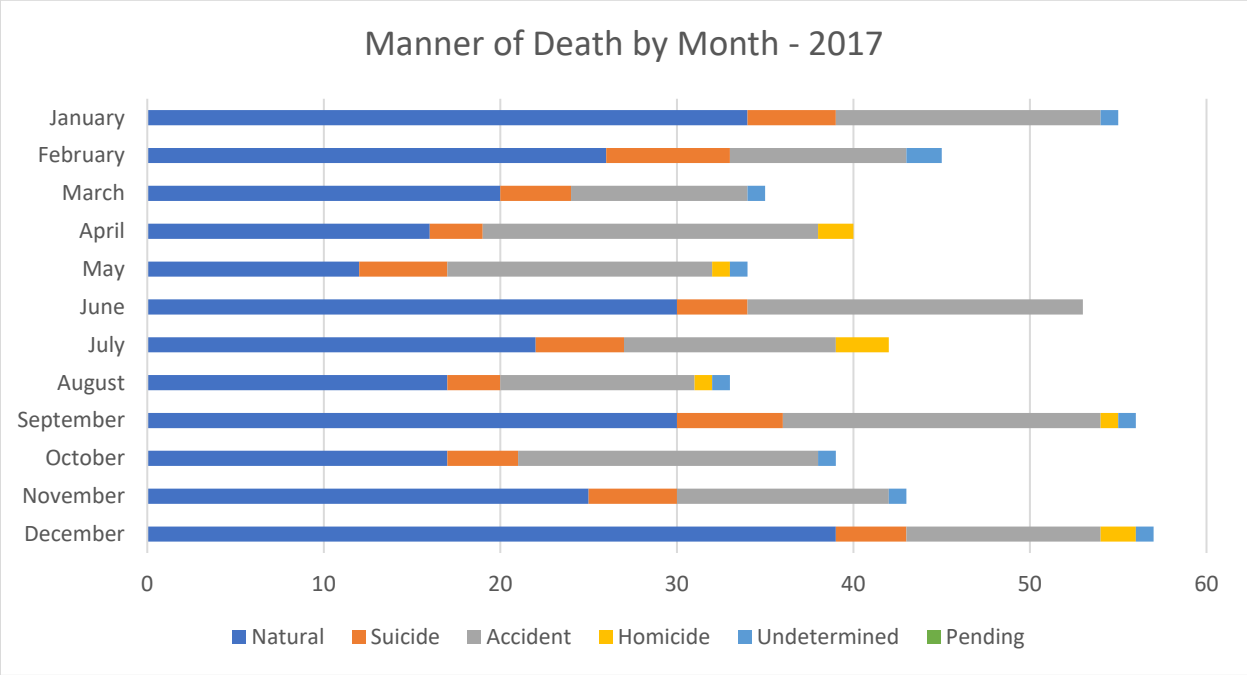
Historical Statistics (continued)

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



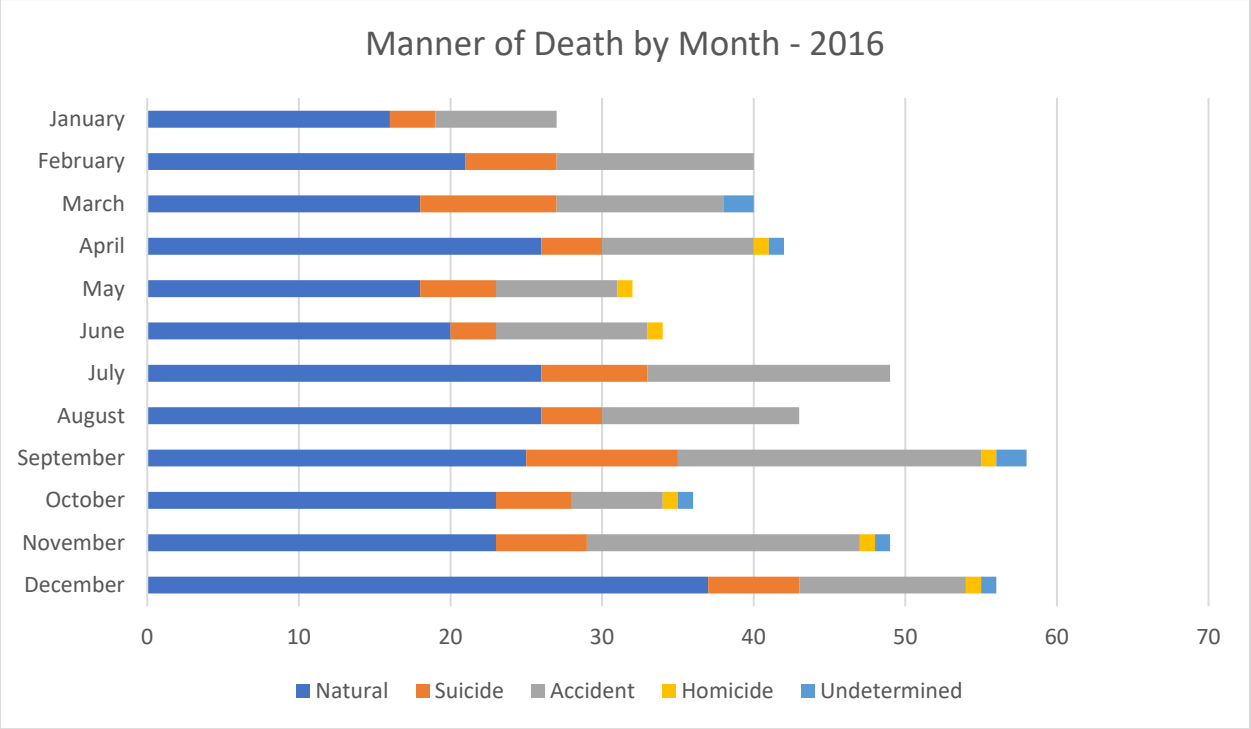
Historical Statistics (continued)

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.

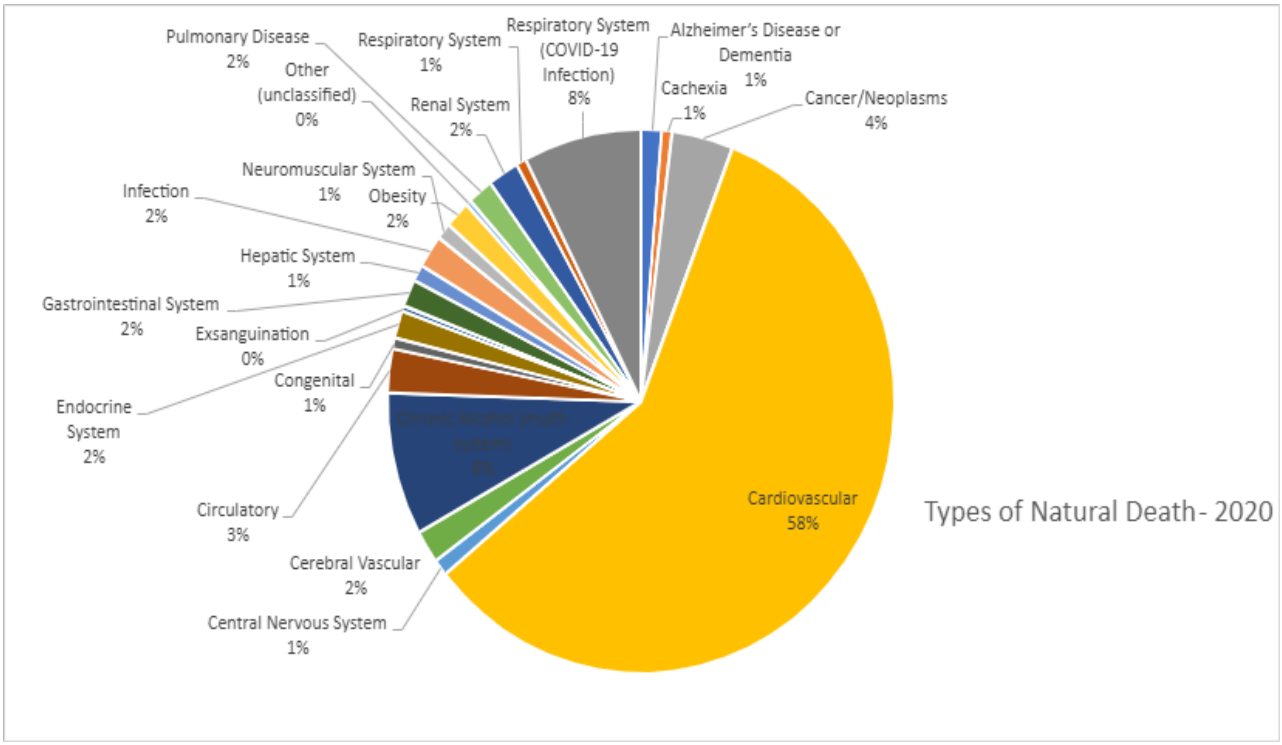
Total Natural Deaths in 2020: 306

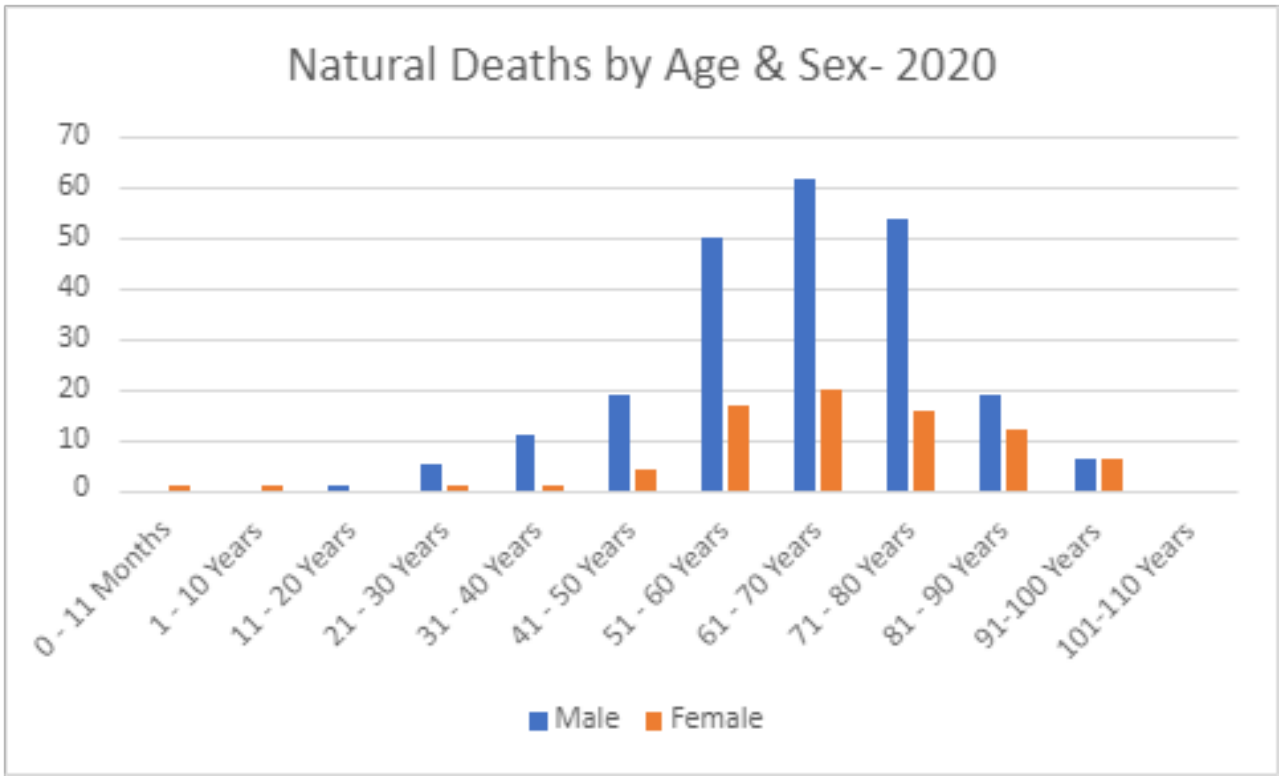
Types of Natural Deaths by Sex			
Types of Natural Deaths	**Total**	**Male**	**Female**
Alzheimer's Disease or Dementia	4	2	2
Cachexia	2	1	1
Cancer/Neoplasms	12	10	2
Cardiovascular	178	132	46
Central Nervous System	3	2	1
Cerebral Vascular	6	3	3
Chronic Alcohol (multi-system)	26	19	7
Circulatory	8	7	1
Congenital	2	1	1
Endocrine System	5	4	1
Exsanguination	1	0	1
Gastrointestinal System	5	4	1
Hepatic System	3	2	1
Infection	6	5	1
Neuromuscular System	3	1	2
Obesity	5	4	1
Other (unclassified)	1	0	1
Pulmonary Disease	5	4	1
Renal System	6	4	2
Respiratory System	2	1	1
Respiratory System (COVID-19 Infection)	23	21	2

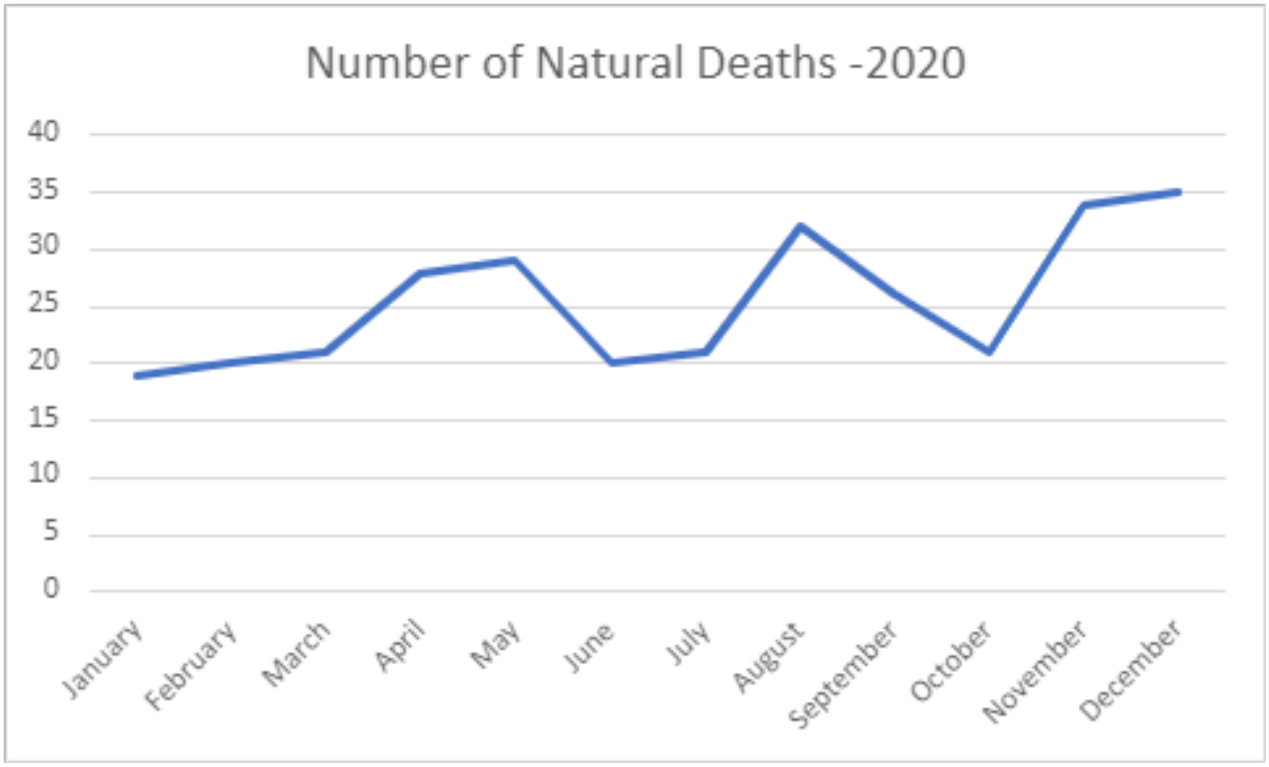
Natural Deaths by Month	
Month	**Number of Natural Deaths**
January	19
February	20
March	21
April	28
May	29
June	20
July	21
August	32
September	26
October	21
November	34
December	35

Natural Deaths by Age & Sex					
Age	**Male**	**Female**	**Age**	**Male**	**Female**
0 - 11 Months	0	1	51 - 60 Years	50	17
1 - 10 Years	0	1	61 - 70 Years	62	20
11 - 20 Years	1	0	71 - 80 Years	54	16
21 - 30 Years	5	1	81 - 90 Years	19	12
31 - 40 Years	11	1	91-100 Years	6	6
41 - 50 Years	19	4	101-110 Years	0	0

Natural


Pulmonary Disease 2%
Respiratory System 1%
Respiratory System (COVID-19 Infection) 8%
Alzheimer's Disease or Dementia 1%
Other (unclassified) 0%
Renal System 2%
Cachexia 1%
Cancer/Neoplasms 4%
Neuromuscular System 1%
Obesity 2%
Infection 2%
Hepatic System 1%
Gastrointestinal System 2%
Exsanguination 0%
Congenital 1%
Endocrine System 2%
Chronic Alcohol (multi-system) 8%
Cardiovascular 58%
Circulatory 3%
Cerebral Vascular 2%
Central Nervous System 1%
Types of Natural Death- 2020


Natural Deaths by Age & Sex- 2020
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 -2020
40
35
30
25
20
15
10
5
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 oneself.

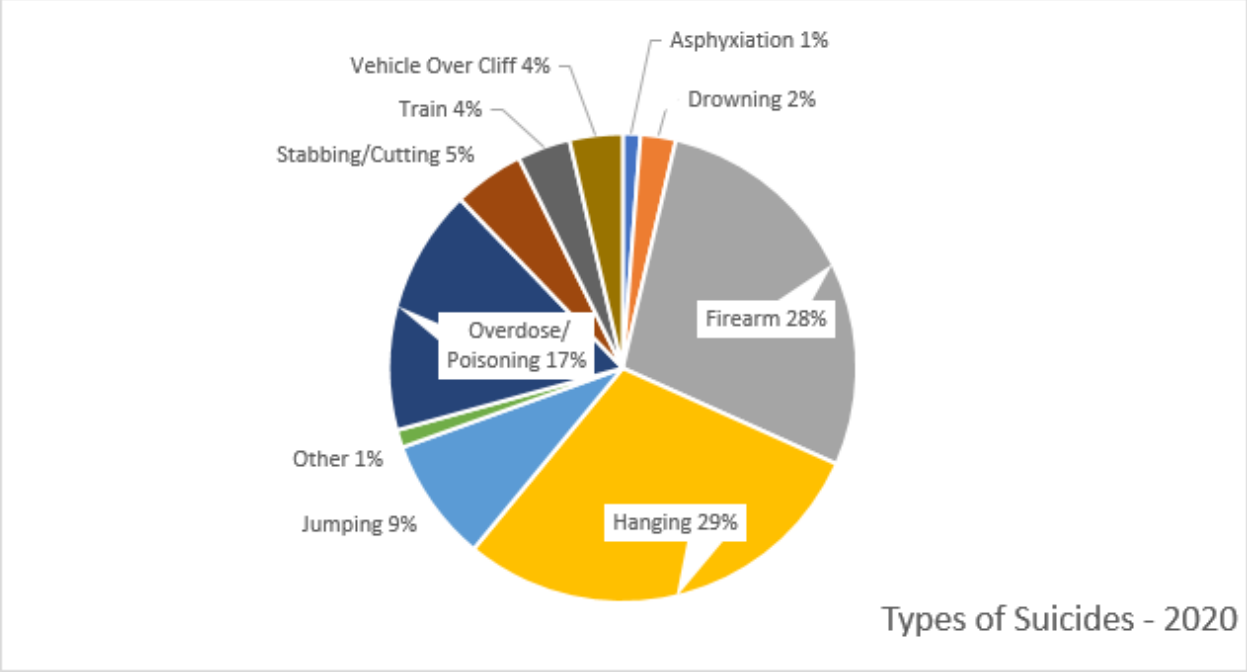
Total Number of Suicides in 2020: 82

Types of Suicides by Sex			
Types of Suicides	**Total**	**Male**	**Female**
Asphyxiation	1	1	1
Drowning	2	0	1
Firearm	23	20	3
Hanging	24	20	4
Jumping	7	6	1
Other	1	1	0
Overdose/ Poisoning	14	5	9
Stabbing/Cutting	4	4	0
Train	3	2	1

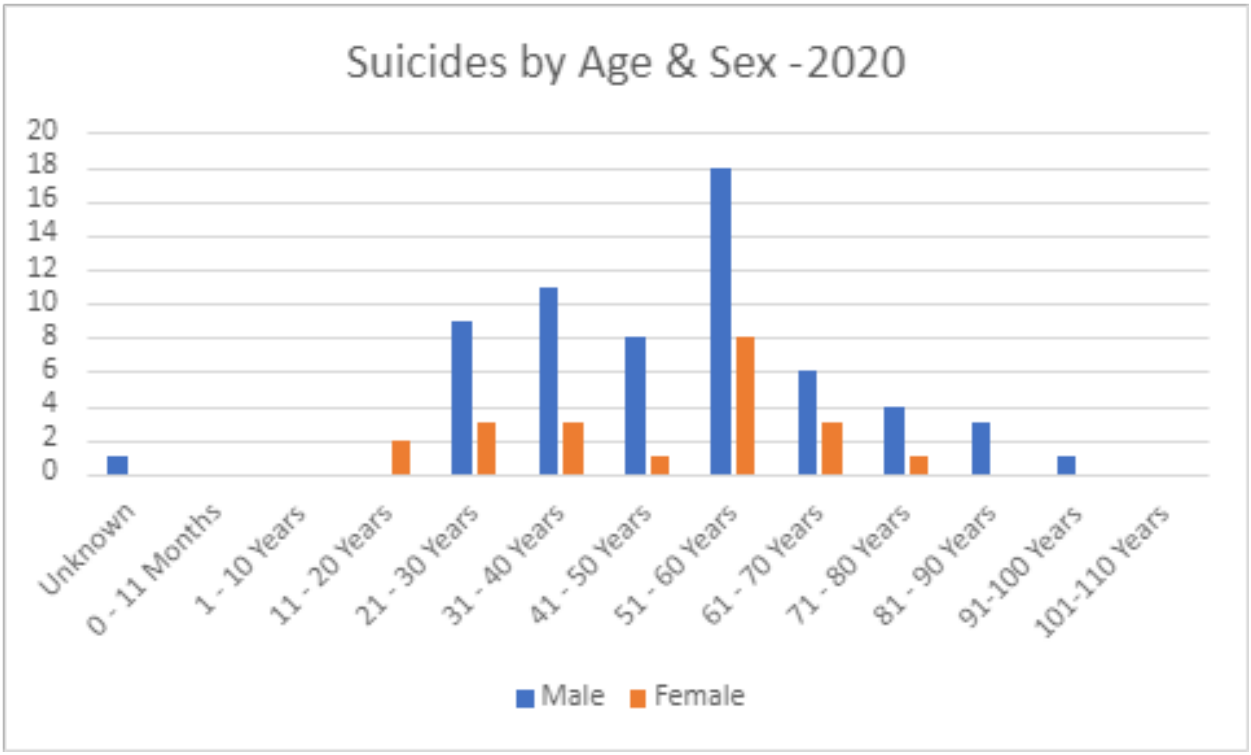
Suicide by Month	
Month	**Number of Suicides**
January	14
February	9
March	7
April	5
May	7
June	9
July	3
August	7
September	3
October	5
November	7
December	6

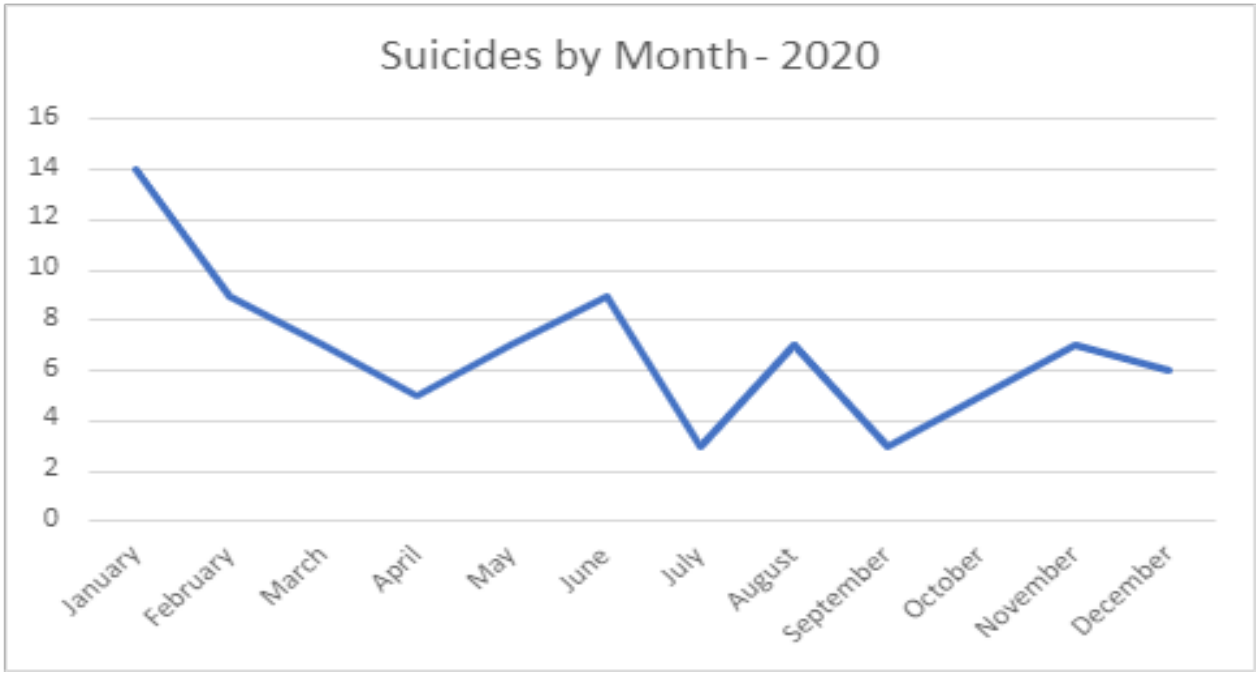
Suicide by Age & Sex		
Age	**Male**	**Female**
0 - 11 Months	1	0
1 - 10 Years	0	0
11 - 20 Years	0	0
21 - 30 Years	0	2
31 - 40 Years	9	3
41 - 50 Years	11	3
51 - 60 Years	8	1
61 - 70 Years	18	8
71 - 80 Years	6	3
81 - 90 Years	4	1
91-100 Years	3	0
101-110 Years	1	0

Suicide



Types of Suicides - 2020




Suicides by Month - 2020
16
14
12
10
8
6
4
2
0
January
February
March
April
May
June
July
August
September
October
November
December

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.

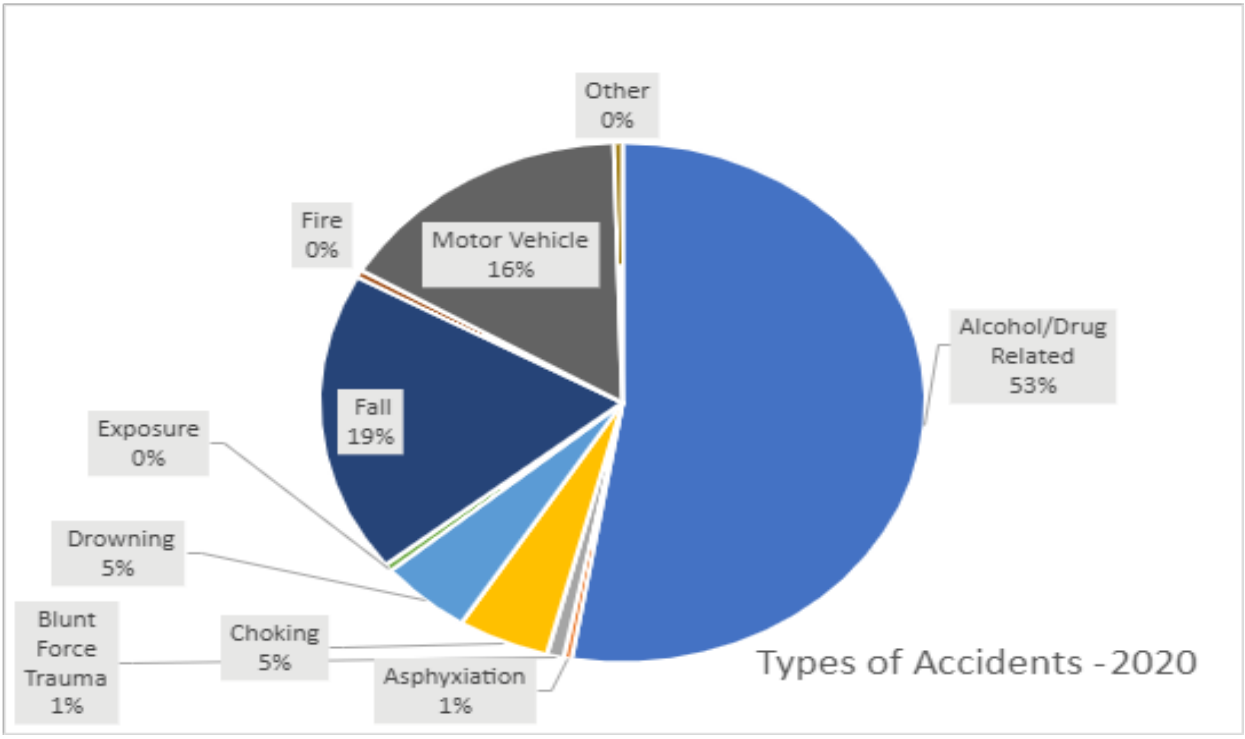
Total Number of Accidental Deaths in 2020: 222

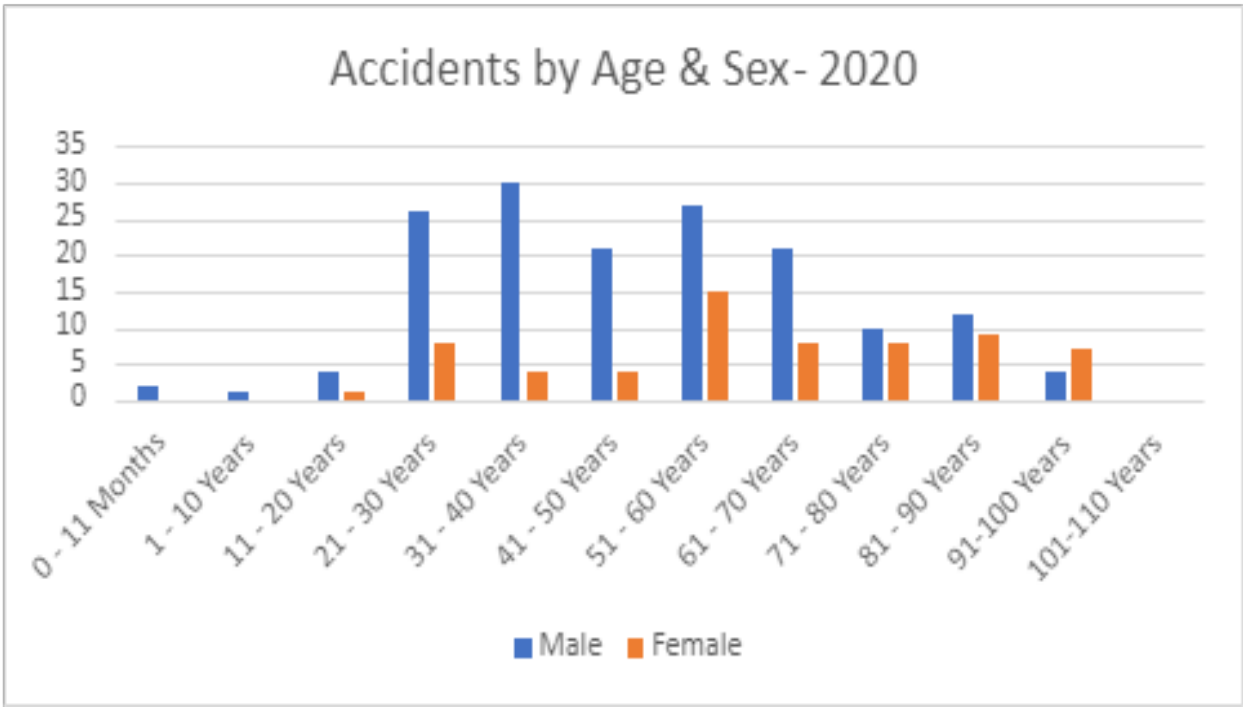
Types of Accidents by Sex			
Type of Accident	**Total**	**Male**	**Female**
Alcohol/Drug Related	118	87	31
Asphyxiation	1	1	0
Blunt Force Trauma	2	1	1
Choking	11	5	6
Drowning	11	8	3
Exposure	1	0	1
Fall	42	26	16
Fire	1	1	0
Motor Vehicle	36	30	6
Other	1	1	0

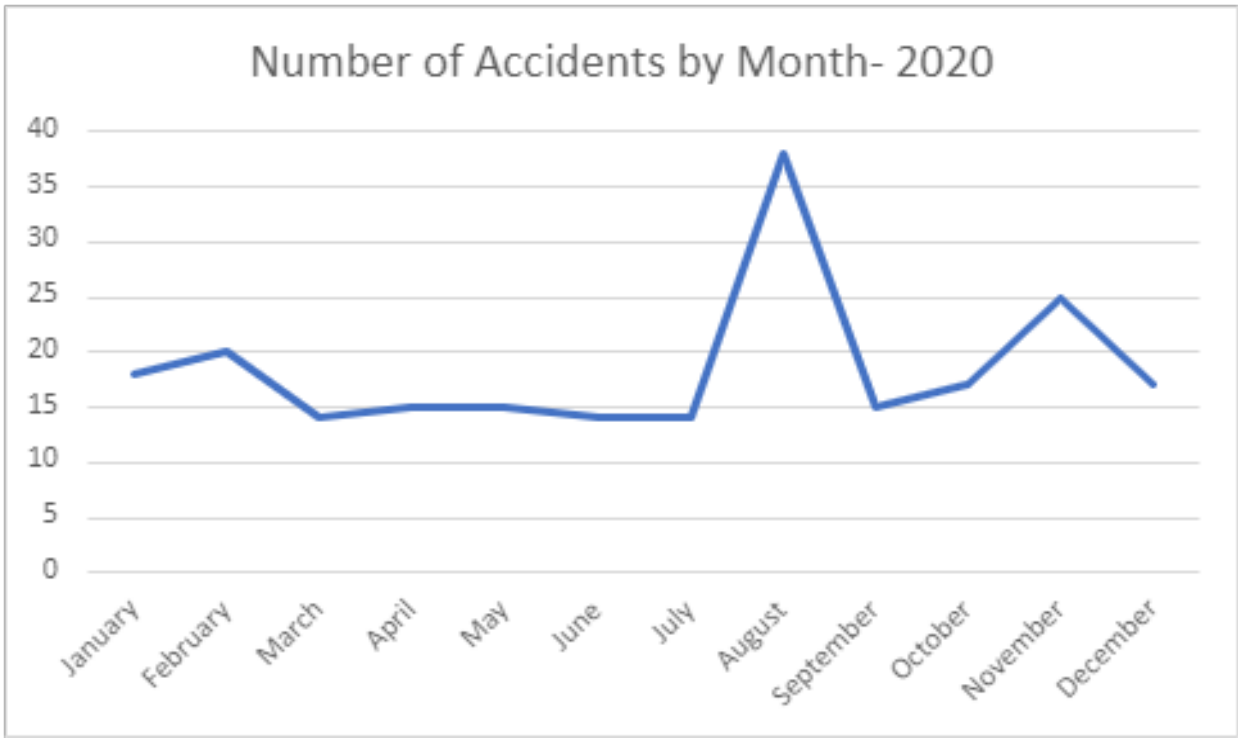
Accidents by Month	
Month	**Number of Accidents**
January	18
February	20
March	14
April	15
May	15
June	14
July	14
August	38
September	15
October	17
November	25
December	17

Accidents by Age & Sex		
Age	**Male**	**Female**
0 - 11 Months	2	0
1 - 10 Years	1	0
11 - 20 Years	4	1
21 - 30 Years	26	8
31 - 40 Years	30	4
41 - 50 Years	21	4
51 - 60 Years	27	15
61 - 70 Years	21	8
71 - 80 Years	10	8
81 - 90 Years	12	9
91-100 Years	4	7
101-110 Years	0	0

Accident


Other
0%
Fire
0%
Motor Vehicle
16%
Alcohol/Drug
Related
53%
Fall
19%
Exposure
0%
Drowning
5%
Blunt
Force
Trauma
1%
Choking
5%
Asphyxiation
1%
Types of Accidents - 2020


Accidents by Age & Sex- 2020
35
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- 2020
40
35
30
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 2020: 43

Types of Motor Vehicle Fatalities	
Type	**Number of Fatalities**
Automobile-Driver	18
Automobile-Passenger	3
Motorcyclist	4
Pedestrian	10
Bicyclist	3
Crushed by Vehicle	1
Natural Death While Driving	2
Crashed Vehicle Following Gunshot Wounds	2

Fatalities by Manner	
Manner of Death	**Number of Fatalities**
Natural	2
Accident	35
Suicide	4
Homicide	2
Undetermined	0

Fatalities by Month	
Month	**Number of Fatalities**
January	5
February	7
March	1
April	3
May	2
June	3
July	2
August	10
September	5
October	2
November	2
December	1

Fatalities by Age & Sex		
Age	**Male**	**Female**
0 - 11 Months	0	0
1 - 10 Years	0	0
11 - 20 Years	1	1
21 - 30 Years	11	2
31 - 40 Years	8	0
41 - 50 Years	3	2
51 - 60 Years	5	2
61 - 70 Years	5	1
71 - 80 Years	1	1
81 - 90 Years	0	0
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 Involving Alcohol and/or Drugs in 2020: 28

Number of Motor Vehicle Fatalities	43
Number of Cases Involving Drugs and/or Alcohol	28
Number of Cases Where Toxicology Test Was Completed	38
Number of Cases Where No Toxicology Test Was Completed	5
Number of Cases Where Nothing was Detected in Toxicology Test	11

Results	Alcohol Only (10 cases)	Complete Drug (Including Alcohol) (28 cases)
Alcohol Only Present	7	3
Prescription and/or Over-the-Counter Drugs Only Present	N/A	5 (THC or its derivatives present in 1 case)
Illicit Drugs Only Present		1
Alcohol and Prescription and/or Over-the-Counter Drugs Present		0
Alcohol and Illicit Drugs Present		3 (THC or its derivatives present in 3 cases)
Prescription and/or Over-the Counter and Illicit Drugs Present		5 (THC or its derivatives present in 3 cases)
Prescription and/or Over-the Counter, Illicit Drugs, and Alcohol Present		0
THC (or its derivatives) Only Present		4
THC (or its derivatives) and Alcohol Present		3

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.

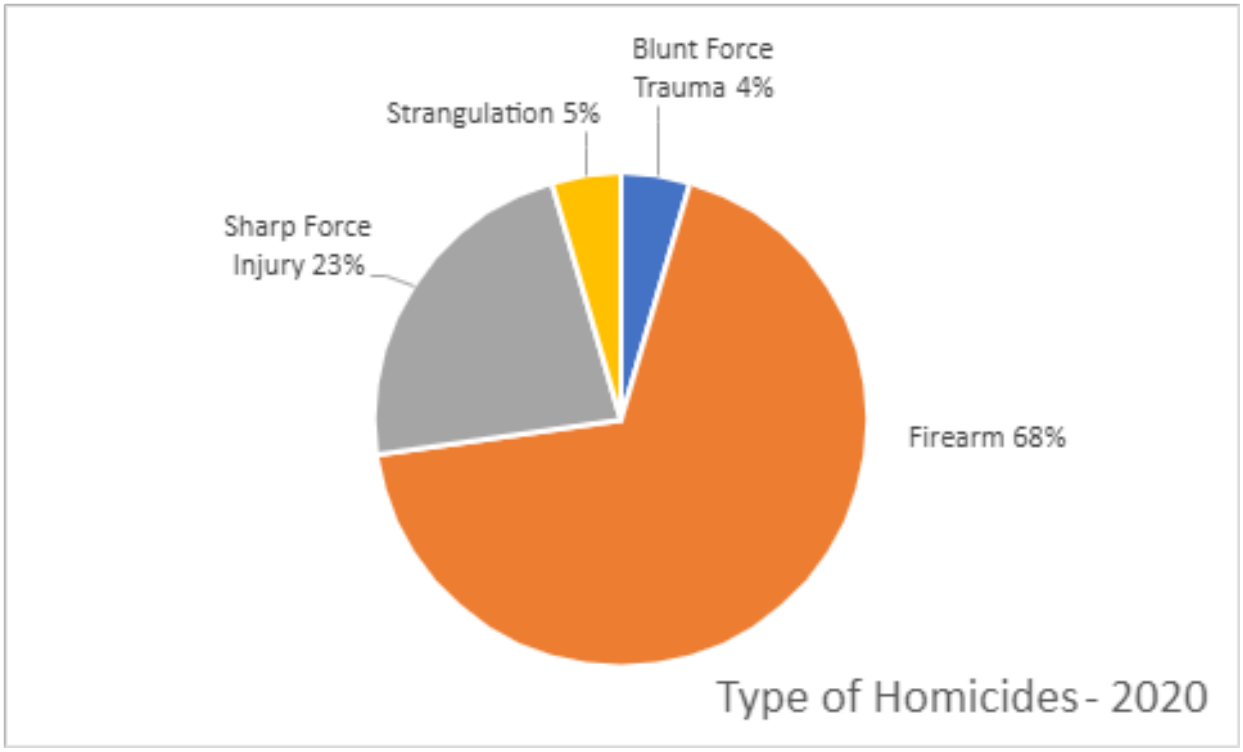
Total Number of Homicides in 2020: 22

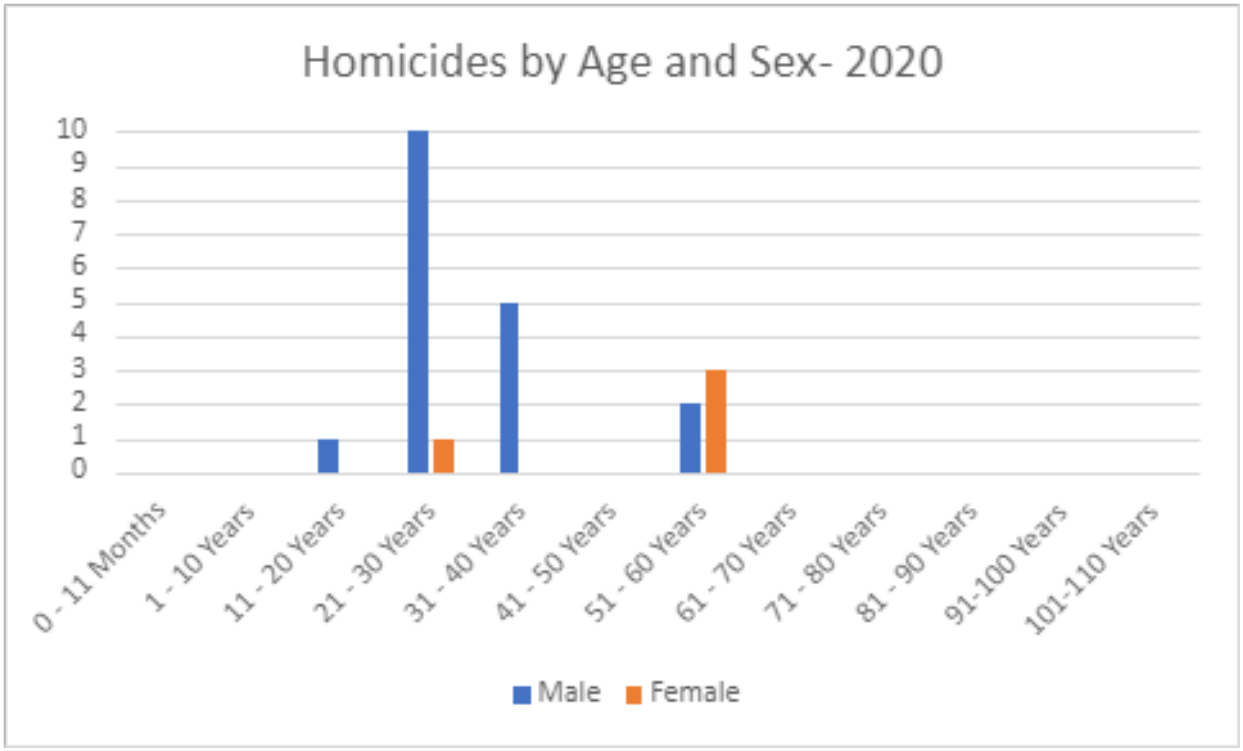
Type of Homicide by Sex			
Type of Homicide	**Total**	**Male**	**Female**
Blunt Force Trauma	1	1	0
Firearm	15	13	2
Sharp Force Injury	5	3	2
Strangulation	1	1	0

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	10	1
31 - 40 Years	5	0
41 - 50 Years	0	0
51 - 60 Years	2	3
61 - 70 Years	0	0
71 - 80 Years	0	0
81 - 90 Years	0	0
91-100 Years	0	0
101-110 Years	0	0

Homicides by Month	
Month	**Number of Homicides**
January	1
February	1
March	2
April	1
May	2
June	1
July	1
August	4
September	1
October	1
November	2
December	5

Homicide


Blunt Force Trauma 4%
Strangulation 5%
Sharp Force Injury 23%
Firearm 68%
Type of Homicides- 2020


Homicides by Age and Sex- 2020
10
9
8
7
6
5
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- 2020
6
5
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 2020: 11

Mode	Total
Not otherwise stated or awaiting further investigation	2
Trauma of undetermined manner	4
Decomposed Body or Skeletal Remains	4
Unexplained death in infancy	1
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 2020: 18

Manner	Total
Natural	1
Accident	8
Suicide	5
Homicide	4
Undetermined	0

County of Death	Total
Santa Clara	11
San Francisco	7

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 2020: 17

County Cremations referred by outside agencies:	5
County Cremations referred to outside agencies:	1
Cremations performed by the San Mateo County Coroner after remains were abandoned by family:	8
Cremations performed by the San Mateo County Coroner after diligent search, but no family located:	8
Cremains collected by family upon locating next of kin after cremation performed:	1
Dispositions handled by family after receiving a fee reduction by application for financial need:	30

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

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

(650) 312-5562
Coroner.smcgov.org