ORANGE COUNTY
SHERIFF'S DEPARTMENT

CORONER DIVISION Annual Report

2022

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INTRODUCTION

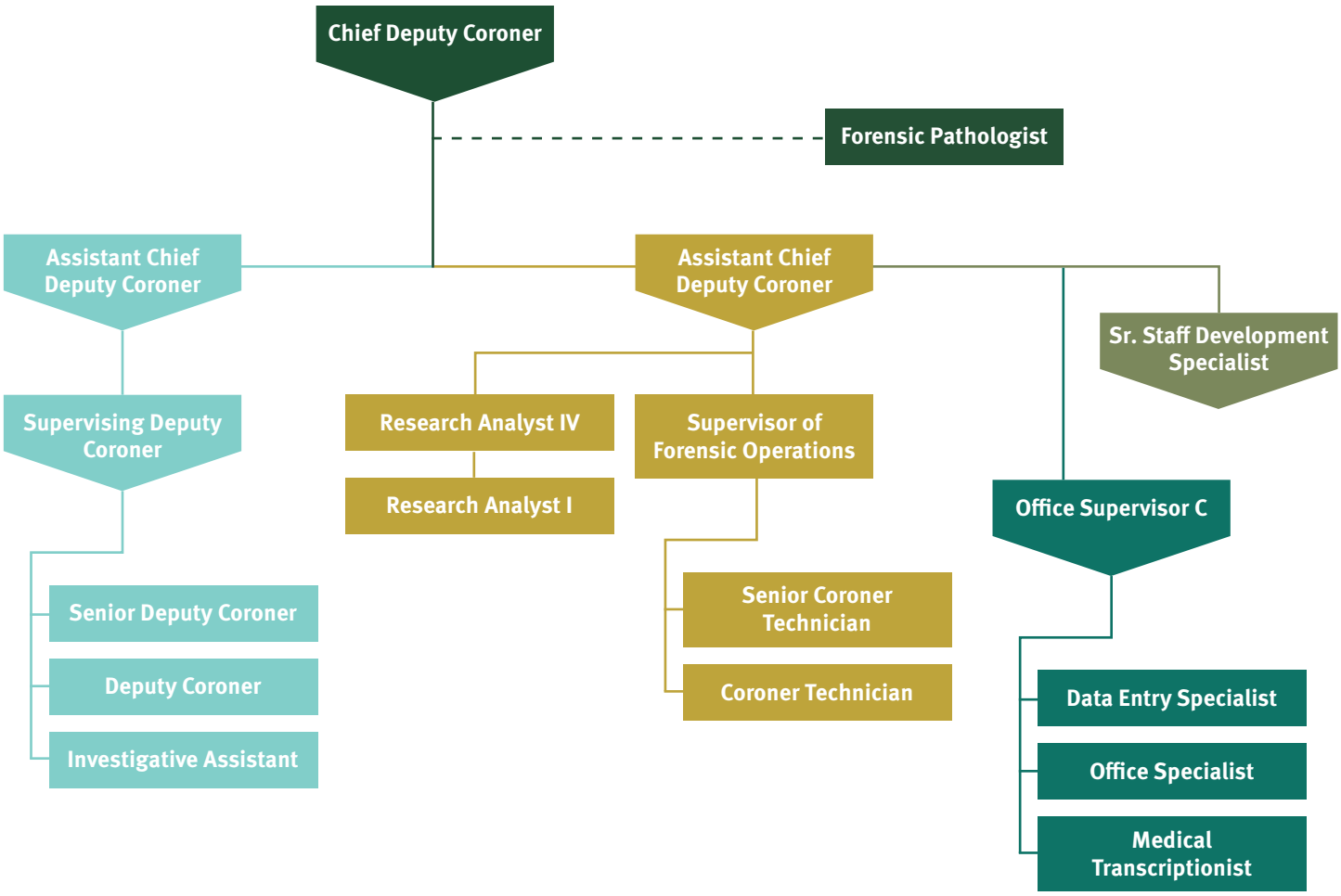
Divisional History

When the County of Orange was founded in 1889, I.D. Mills became the County's first Coroner/Public Administrator. The partnership between these two branches of government existed until 1965 when a county ordinance separated the Coroner and Public Administrator functions. Five years later in 1970, the Orange County Board of Supervisors voted to cojoin the Office of Coroner and the Office of Sheriff, making it the 31st Sheriff Coroner Department in California on January 4, 1971. Today, the majority of the 58 counties in the state are Sheriff Coroner systems.

Coroner Division Mission Statement

The mission of the Orange County Coroner Division is to serve the citizens and visitors of Orange County by conducting thorough medicolegal death investigations with compassion and specialized expertise.

ORGANIZATIONAL CHART



TRAINING AND EDUCATION

1. California Coroner Training Center

In the year 2000, Governor Gray Davis and members of the State Assembly and Senate, recognizing the need for a statewide coroner training facility to provide education and training for coroners, pathologists and other professionals involved in death investigation, appropriated $10 million dollars to fund a new state of the art training center. The County of Orange contributed another $2 million dollars for a total of $12 million. As a result, the California Coroner Training Center opened its doors in March of 2004. Since then, countless Medical Examiner Investigators, Deputy Coroners, and other law enforcement officials have attended training courses designed to meet the job specific needs of Coroners and other professionals involved in death investigations.

2. Resident and Medical Student Pathology Program

Since September of 1999, the Coroner Division has participated in the College of Medicine, University of California, Irvine approved residency training and medical student externship program in Pathology. This professional relationship allows residents and medical students to work either a two or four week rotation at the Coroner Division thereby gifting them with hands-on experience under the expert tutelage of the County's contracted Board Certified Forensic Pathologists.

3. Child Death Review Team

The Orange County Child Death Review Team (OCCDRT) was established in 1987 to provide a forum for the multidisciplinary review of child deaths reported to the Coroner. Initially, the team's focus was on fetal deaths and deaths of children through 12 years of age, with particular focus on improving multi-agency communication on child homicides and unexplained child deaths. One year after the conception of the OCCDRT, the California Legislature authorized counties to officially establish interagency child death review teams. In 1993, the review process expanded to include children through 17 years of age. With the improved coordination and communication among the many agencies responsible for child health, safety, and protection achieved by the pioneering team, the primary objectives of the OCCDRT are now broadening to include prevention efforts.

Core members of this multi-disciplinary team are drawn from public agencies responsible for the investigation of child deaths and agencies responsible for protecting the health and welfare of children. These agencies include: the Coroner's Division, Health Care Agency, District Attorney's Office, County Counsel, Department of Education, Probation Department, Local Law Enforcement Agencies, Social Services, The Raise Foundation (a local child abuse prevention council), County Fire Authority, UCI Pediatric Injury Prevention Research Group, Visiting Nurses Association of Orange County, Child Abuse Services Team (Orange County's multidisciplinary investigative team for child sexual abuse), and the County Emergency Medical Services.

4. Homeless Death Review Committee

The Coroner Division of the Orange County Sheriff's Department leads the Homeless Death Review Committee, commissioned by Orange County Sheriff Don Barnes in January 2022. The Committee includes broad representation of technical experts from county agencies, municipal police departments, hospitals, and non-profits. The Committee has met multiple times since March 2022 to explore the root causes of homeless deaths to determine what, if any, factors contributing to the deaths were preventable.

5. Elder Death Review Team (EDRT)

The Orange County Elder Death Review Team was formed in 2003. Its purpose is to carefully examine cases involving decedents who are 65 or older in which there is suspected abuse by a caregiver or relative. Additionally, the team recognizes that a careful review of fatalities will provide the opportunity to develop education, prevention and if necessary prosecution strategies, that will lead to improved coordination of services for families and the elder population. The goals of the EDRT are to prevent elder abuse fatalities; examine deaths of elders with suspected elder abuse and/or neglect; identify patterns that lead to fatal outcomes; determine whether reviewed deaths could have been prevented; develop prevention strategies; increase awareness of the responsibility of each Health Care Provider to consider abuse or neglect as a contributing factor to death; increase awareness of the responsibility of each Health Care Provider to refer cases arising from abuse or neglect to the appropriate agencies including, but not limited to: Coroner, Adult Protective Services, State Licensing Department, Ombudsman, and Law Enforcement; improve system responses by identifying gaps in delivery services; prosecution of offenders; and develop intervention strategies to reduce fatalities and eliminate ongoing abuse and/or neglect.

6. Domestic Violence Death Review Team (DVDRT)

In 1995, the California Legislature passed a bill authorizing counties to establish interagency DVDRT's to assist local agencies in identifying and reviewing domestic violence deaths, and facilitating communications among the various agencies involved in domestic violence cases. Its purpose is to review cases where domestic violence is either a major factor in the cause of death or a contributing factor. These cases are studied by the team in hopes of finding solutions to fill any gaps in the system, improving data collection, and recommending ways to prevent future tragedies. The Orange County DVDRT was formed in 2000.

CORONER JURISDICTION

The Coroner Division is responsible for carrying out the statutory duties of the Coroner. Those duties include conducting investigations into the circumstances surrounding all deaths falling within the Coroner's jurisdiction for the purpose of determining the identity of the deceased, the medical cause of death, the manner of death, and the date and time of death. Medicolegal death investigations are conducted countywide on all homicides, suicides, accidents, suspicious and unexplained deaths. Other duties include notifying the next of kin, safeguarding personal property, collection of evidence, and completion of mandatory records and documents. The Division is also proactive in the community, identifying consumer products causing fatal injury; participating in multiple death review teams (domestic violence, child abuse and elder abuse); and providing educational services for medical, legal, and law enforcement professionals. Other contributions to the community include cooperative relationships with non-profit organ and tissue procurement agencies to enhance the quality of life and save lives in accordance with Health & Safety Code 7150.20 (Anatomical Gift Act).

Reportable Deaths

Pursuant to Government Code 27491, it shall be the duty of the Coroner to inquire into and determine the circumstances, manner, and cause of the following deaths:

- Without medical attendance which includes all deaths outside of hospitals or skilled nursing facilities.
- Wherein the deceased had not been attended by a physician in the 20 days prior to death or had not been attended by a hospice nurse within 30 days prior to death.
- The attending physician is unable to render a reasonable opinion as to the cause of death.
- When homicide is known or suspected.
- When suicide is known or suspected.
- When a criminal action is involved or suspected to be involved in the death.
- Known or suspected as resulting in whole or in part from an accident or injury, either old or recent.
- When aspiration, starvation, exposure, drug addiction or acute alcoholism is the known or suspected cause.
- When poisoning is known or suspected.
- When occupational disease or hazards are the known or suspected cause.
- When a contagious disease is the known or suspected cause.
- When death occurred while in-custody of a law enforcement agency or while in prison.
- All deaths of State Hospital patients.
- All Sudden Unexpected Infant Death Syndrome (SUIDS) deaths.
- Deaths during or related to surgery or surgical procedures, or following a surgery or surgical procedure if the deceased did not wake from the anesthetic.

Manner of Death Definitions

The deaths identified in this report are organized into five manners; these are Natural, Accident, Homicide, Suicide, and Undetermined. Listed below are each of these manners of death and their definition.

Natural

Natural Deaths are those that are caused by a medical event or disease process where the decedent requires a death certificate signed by the Coroner due to the absence of a physician willing or able to state the cause of death.

Accident

Accidental deaths are those that result from an injury or poisoning, where there is little to no evidence that the injury or poisoning occurred with intent to harm or cause death.

Suicide

Suicide Deaths are those that result from an injury or poisoning, as an intentional, self-inflicted act committed to do self-harm or cause the death of one's self.

Homicide

Homicide Deaths are those that result from the volitional act committed by another person.

Undetermined

The classification of Undetermined is used when, with through consideration of all available information, no singe manner of death is more compelling or likely that one or more other competing manners of death.

Sub-Classifications of Death Definitions

SONA or Signed Out No Autopsy

Prior to 2010, those which would require an autopsy, however, after being triaged the case was signed out without an autopsy.

In the latter part of December 2009, in order to better manage Coroner Division resources, the case triage process was implemented with the goal of effectively reducing the number of autopsies performed by the Coroner. The triage process required cases which the death occurred in a hospital facility normally receiving a post-mortem examination to undergo a thorough evaluation to determine whether an autopsy was essential for establishing the cause and manner of death. This evaluation included a detailed review of medical records, clinical tests, collaboration with law enforcement, and interviews with informants and witnesses. The triage team determined if the extent of the investigation was adequate to establish the probable cause and manner of death without the benefit of an autopsy. In this manner, cases from the lowest end of the risk spectrum were signed out without an autopsy. This type of case is referred to as a SONA case (Signed Out - No Autopsy).

NNA or Natural No Autopsy

Those deaths in which the Deputy Coroner authorized the treating physician to certify the medical cause of death after an investigation determined that the physician had sufficient knowledge of the patient's history and all unnatural circumstances were ruled out.

Declines

Those deaths in which the circumstances did not meet the Coroner's statutory jurisdictional requirements.

SUMMARY OF DATA

A. Deaths reported: 11,846

B. Cases accepted: 7,823

C. Manners of death:

1. Accident 1,557
2. Homicide 78
3. Natural 1,133
4. Suicide 340
5. Undetermined 63

D. Field Responses: 2,456

E. Bodies received: 2,875

F. Autopsies: 2,796

G. Cases with toxicology: 2,264

H. Unidentified bodies after examination: 1

I. Unidentified Decedents Identified 256

J. Unclaimed bodies: 255

The data in this report reflects deaths reported to the Coroner Division during the 2022 calendar year. This in-cludes both residents and non-residents whose deaths occurred within the borders of the County of Orange.

In 2022, 24,644 deaths were recorded by the Orange County Health Department, Birth and Death Registration. Of those deaths, 11,846 were reported to the Coroner, which is 48% of the total deaths. The Coroner Division as-sumed jurisdiction and investigated 7,823 cases.

After investigating the 7,823 reported cases, 3,194 deaths, or 41%, resulted in the final cause of death being signed by the Coroner Division.

Of the 3,194 deaths certified by the Coroner Division, 2,796 or about 88%, required an autopsy to determine the cause of death. Of these 2,796 cases, 1,133 or 41% were found to be due to natural causes.

Accidental deaths totaled 1,557, with 19% of those involving traffic accidents. Overdoses accounted for 899 of the accidental deaths, which translates into 58% of all accidents occurring in 2022.

There were 78 Homicide deaths during the calendar year with most incidents involving gunshots (65%) and males (88%). 35% of the total Homicide deaths occurred in the city of Santa Ana with an additional 15% occurring in the city of Anaheim.

Suicides accounted for 11%, or 340 cases, in 2022, with asphyxia (33%) being the most favored type, followed by gunshots (31%). 40-50 year olds made up the majority of decedents at 35% or 118 deaths, and males far exceeded females at 71% vs. 29% respectively. Only 17% of decedents left a suicide note in 2022 which is slightly lower than in 2021 (18%).

63 deaths were classified as Undetermined, with 48 (76%) of those having an unknown cause of death followed by 5 (8%) being the result of blunt force trauma.

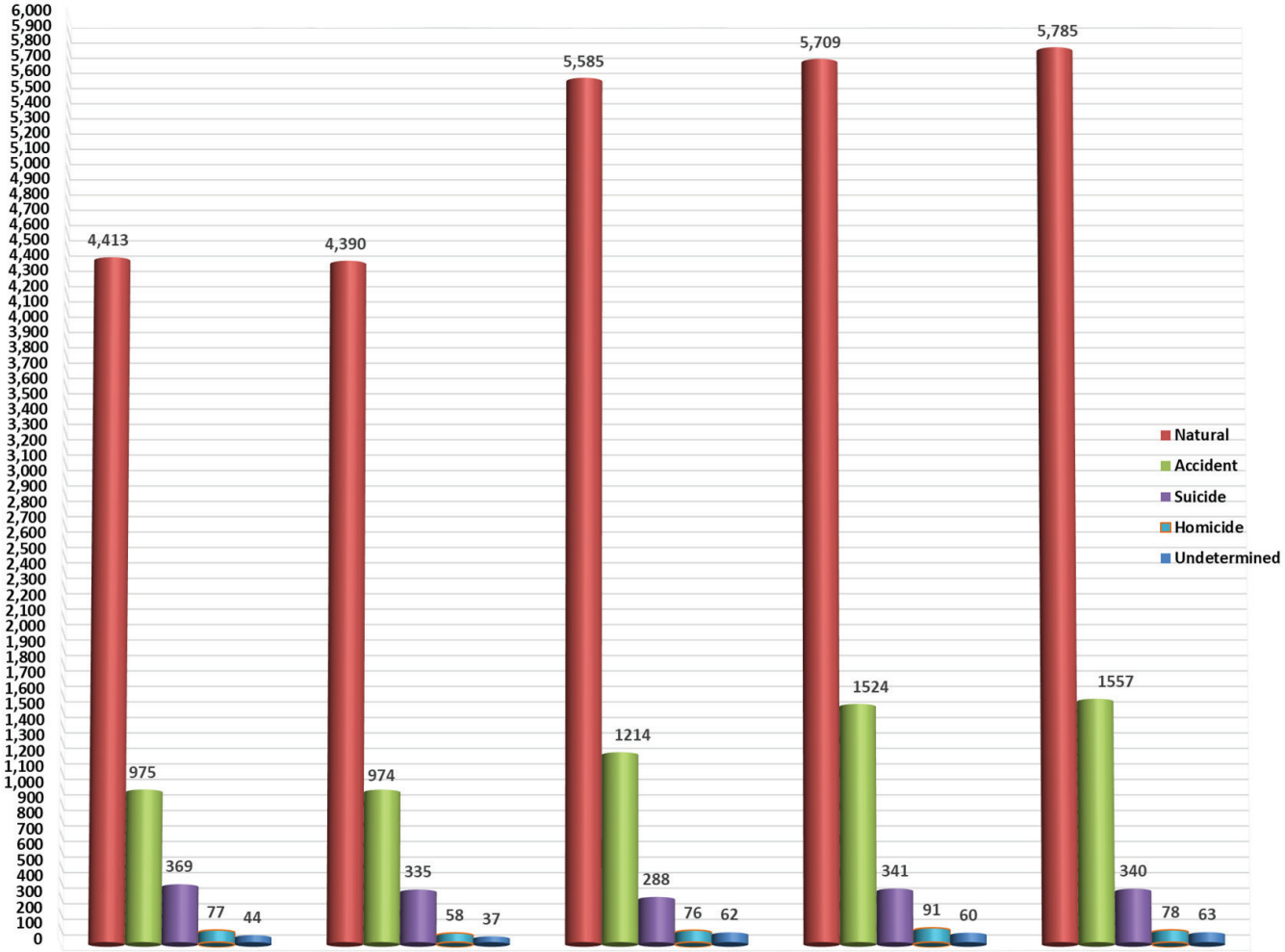
2,264 requests for toxicology were submitted to the Orange County Crime Lab in 2022 which was a 4% increase over 2021 (2,179).

In 2022 Deputy Coroners responded to 2,456 scenes which was a 15% decrease from 2021 (2,887).

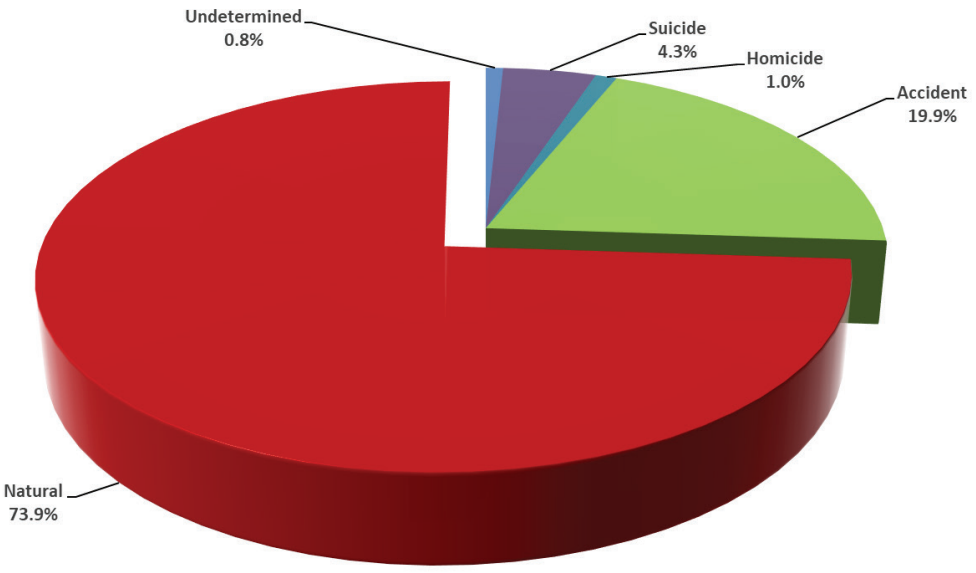
The Coroner Division received 2,875 deceased persons into the facility in 2022, a decrease of 9% from 2021 (3,174).

256 unidentified decedents were positively identified in 2022. This was a 0.4% increase over 2021 (255).

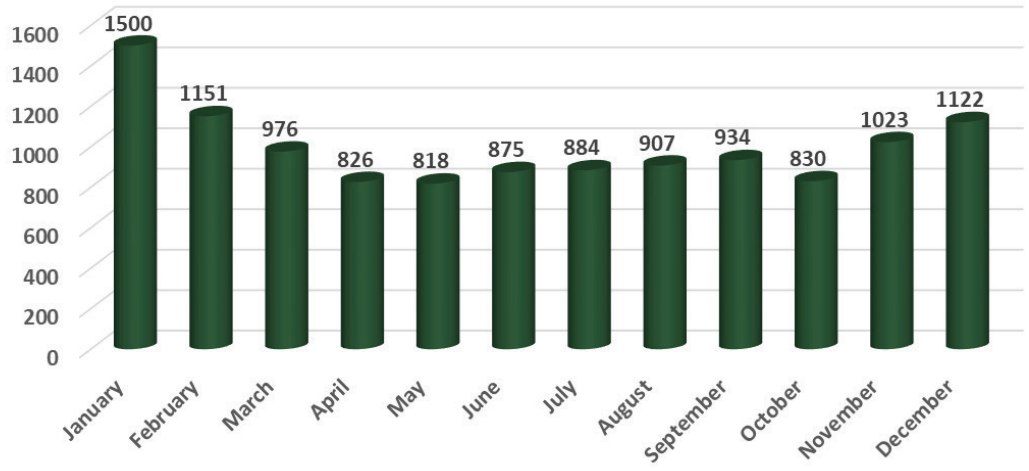
Total Cases by Year of Death by Manner, 2018 - 2022



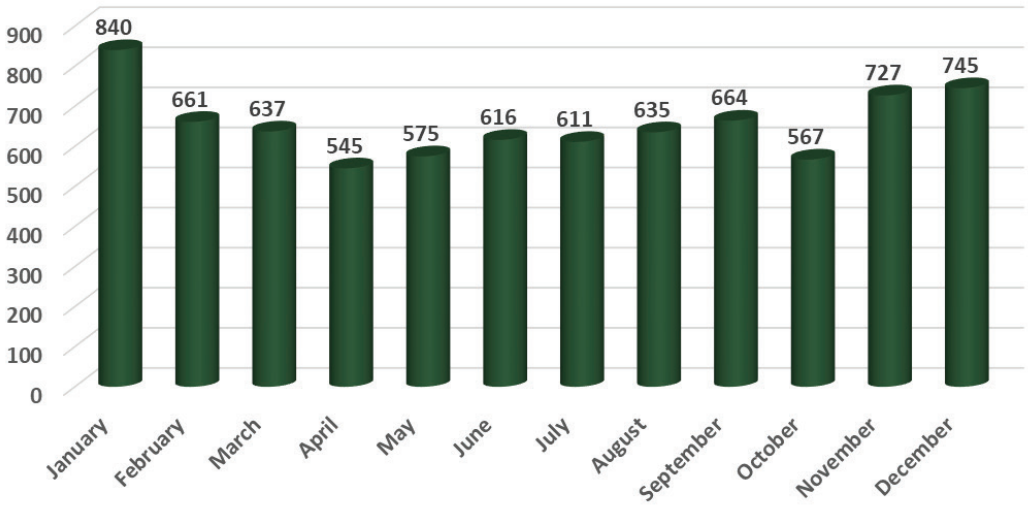
Total Cases by Manner, 2022



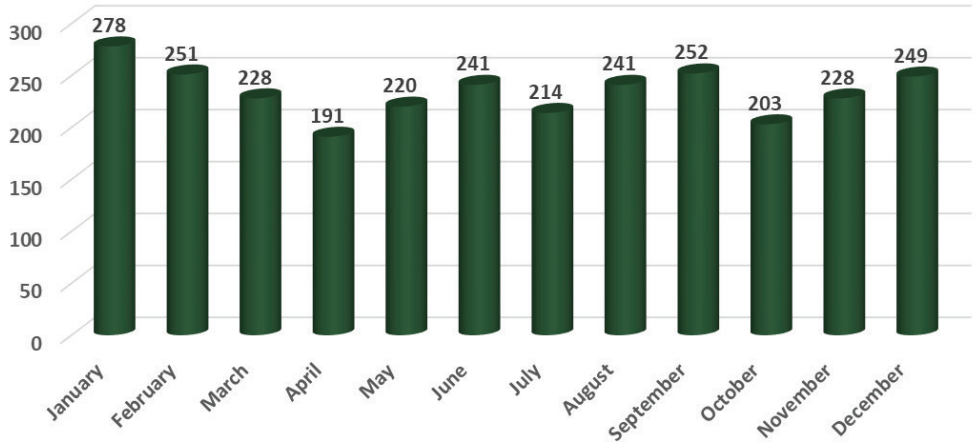
Total Caseload Including Declines by Month Reported, 2022



Total Investigated Cases by Month Reported - 2022



Total Autopsies by Month 2022



Total Cases by City of Death, 2022

City of Death	Total Cases 2022
Aliso Viejo	30
Anaheim	1006
Brea	62
Buena Park	141
Capistrano Beach	11
Corona del Mar	13
Costa Mesa	208
Coto de Caza	1
Cypress	72
Dana Point	60
Foothill Ranch	5
Fountain Valley	366
Fullerton	471
Garden Grove	330
Huntington Beach	410
Irvine	443
La Habra	84
La Palma	54
Ladera Ranch	13
Laguna Beach	69
Laguna Hills	180
Laguna Niguel	74
Laguna Woods	76
Lake Forest	73
Lakewood*	1
Los Alamitos	163
Midway City	13
Mission Viejo	489
Newport Beach	475
Newport Coast	13
Orange	834
Placentia	127
Rancho Mission Viejo	2
Rancho Santa Margarita	36
Rossmoor	1
San Clemente	83
San Juan Capistrano	48
Santa Ana	753
Seal Beach	70
Silverado	8
Stanton	62
Sunset Beach	1
Trabuco Canyon	22
Tustin	90
Villa Park	11
Westminster	202
Yorba Linda	67

*Pursuant to Health and Safety Code 7104, the decedent died outside of Orange County; however, he was a resident of Orange County. Therefore, the Coroner Division accepted the case and assumed jurisdiction.

Accidental Deaths by Cause, 2022

ASPHYXIA 49

Aspiration 35

Carbon Monoxide 4

Compression 3

Other 4

Positional 2

Suffocation 1

BLUNT FORCE TRAUMA 14

Blunt Object 9

Crushing 1

Other (Diving into river;
Spinal injury from diving into
pool; spinal cord injury while swimming) 3

Unknown (Blunt trauma, etiology unknown) 1

DROWNING 41

Bathtub 9

Ocean 11

Other (Flood control tunnel;
Retarding basin; Creek) 3

Pool 13

River 1

Spa 4

ELECTROCUTION 1

High voltage 1

FALL 248

Height 33

Other (Fall from mountain bike;
fall from bicycle; fall in moving shuttle) 3

Same Level 164

Unknown 48

FIRE 3

Residence 2

Vehicle 1

OTHER 5

Other (Thermal burns, hot water 2

Other (Prolonged exposure from make-shift
sauna) 1

Other (Ingestion of alcohol with environmental
heat exposure) 1

Other (Unintentional port-a-cath alteration) 1

Accidental Deaths by Cause, 2022 (continued)

OVERDOSE 899

Abuse (Illicit drugs only) 567

Drugs (Prescription drugs only) 47

Ethanol 24

Mixture (Combination of illicit and either prescription or over-the-counter drugs) 257

Other (inhalation of 1,1-difluoroethane) 3

Other (Ingestion of herbal supplement) 1

THERAPEUTIC 2

Surgical 2

TRAIN 3

Pedestrian 3

VEHICULAR 292

Bicycle - Operator 26

Motorcycle—Occupant 1

Motorcycle—Operator 33

Motorcycle—Passenger 1

Occupant 1

Operator 95

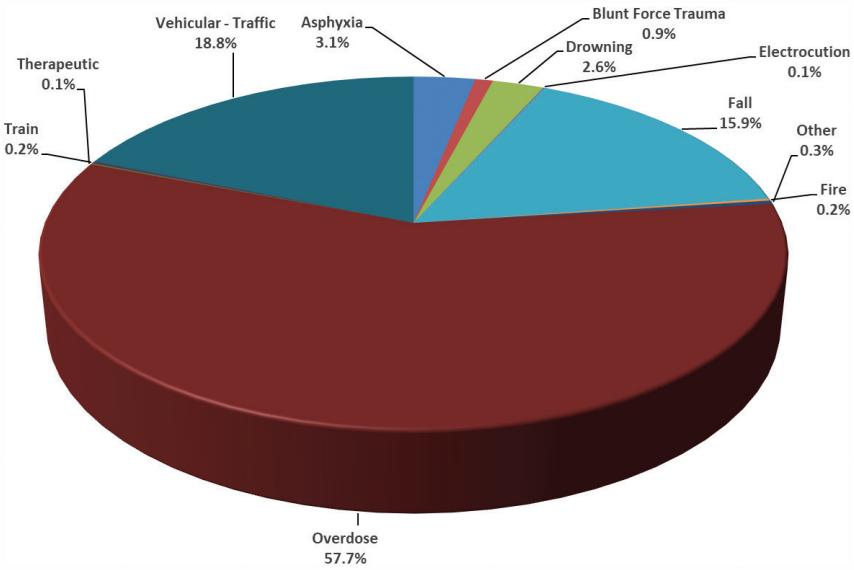
Other (Operators of motorized scooters) 3

Passenger 38

Pedestrian 94

TOTAL 1557

Accidental Deaths by Cause, 2022

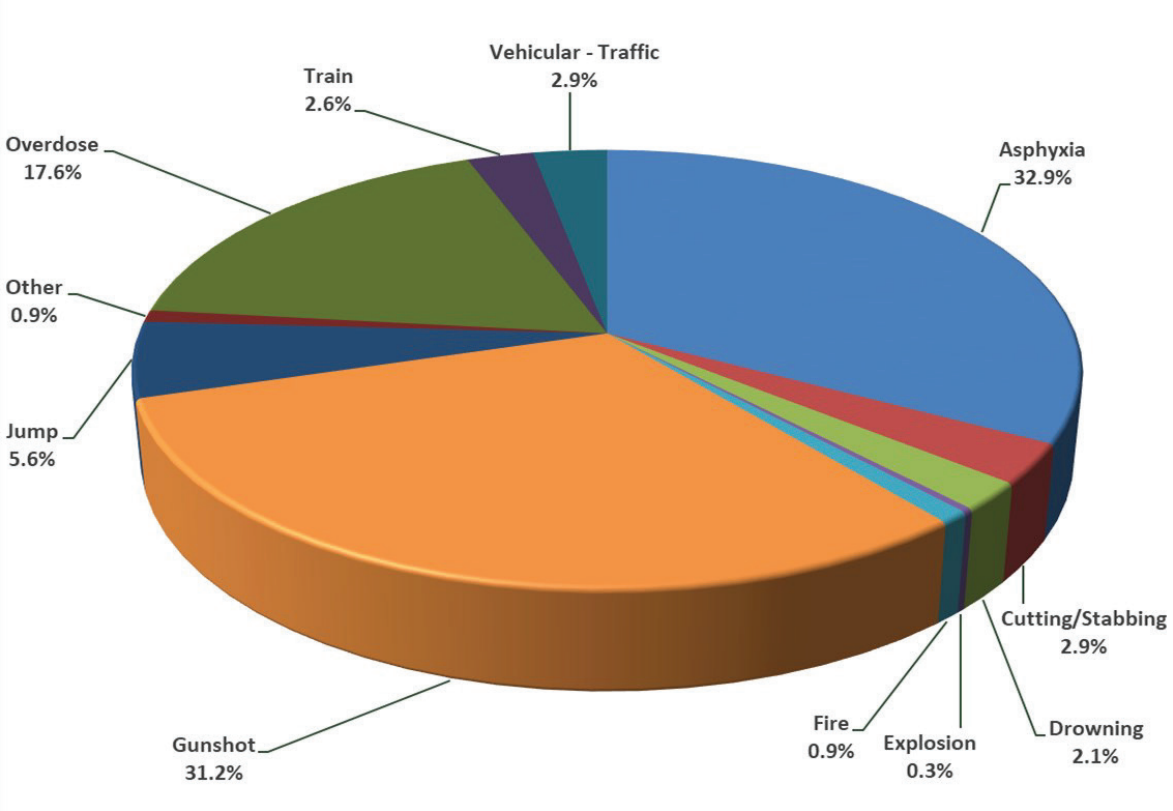


Type of Accident	Number of Cases
Asphyxia	49
Blunt Force Trauma	14
Drowning	41
Electrocution	1
Fall	248
Fire	3
Other	5
Overdose	899
Therapeutic	2
Train	3
Vehicular - Traffic	292

Suicide Deaths by Cause, 2022

ASPHYXIA	112
Asphyxia	2
Carbon Monoxide	4
Hanging	95
Other	3
Strangulation	1
Suffocation	7
CUTTING/STABBING	10
Sharp Object	10
DROWNING	7
Bathtub	2
Ocean	4
Pool	1
EXPLOSION	1
Explosive	1
FIRE	3
Immolation	2
Residence	1
GUNSHOT	106
Handgun	95
Rifle	2
Shotgun	9
JUMP	19
Height	19
OTHER	3
Other (Gunshot wound & ligature hanging; Purposeful port-a-cath alteration)	3
OVERDOSE	60
Abuse	6
Drugs (Prescription drugs only)	39
Mixture (Combination of illicit and prescription and or over-the-counter drugs)	10
Other (Ingestion of sodium nitrite)	5
TRAIN	9
Pedestrian	9
VEHICULAR	10
Operator	1
Pedestrian	9
TOTAL	**340**

Suicide Deaths by Cause, 2022



Type of Suicide	Number of Cases
Asphyxia	112
Cutting/Stabbing	10
Drowning	7
Explosion	1
Fire	3
Gunshot	106
Jump	19
Other	3
Overdose	60
Train	9
Vehicular - Traffic	10

Homicide Deaths by Cause, 2022

ASPHYXIA 1

Strangulation 1

BLUNT FORCE TRAUMA 7

Blunt Object 3

Other 2

Unknown 2

CUTTING/STABBING 14

Sharp Object 12

Unknown 2

EXPLOSION 1

Explosion 1

GUNSHOT 51

Handgun 40

Rifle 1

Unknown 10

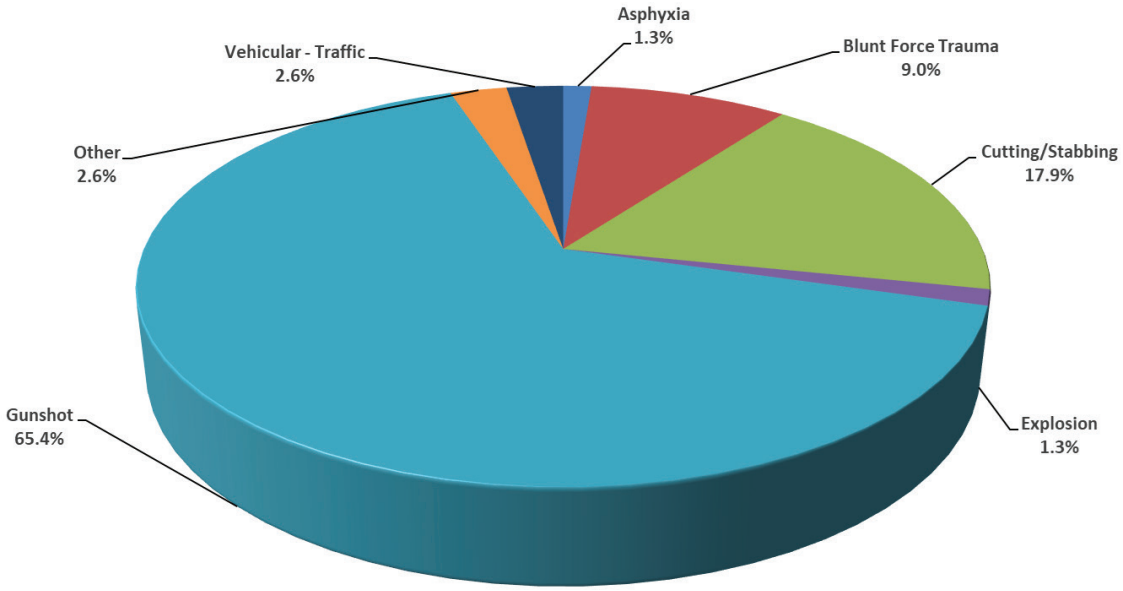
OTHER 2

Other (Battered and stabbed by another; Complications of police canine bites) 2

VEHICULAR 2

Pedestrian 2

TOTAL **78**



Type of Homicide	Number of Cases
Asphyxia	1
Blunt Force Trauma	7
Cutting/Stabbing	14
Explosion	1
Gunshot	51
Other	2
Vehicular - Traffic	2

Undetermined Deaths by Cause, 2022

BLUNT FORCE TRAUMA 5

Unknown 5

FALL 1

Height 1

FIRE 1

Unknown 1

GUNSHOT 1

Handgun 1

OTHER 1

Other (Probable lack of water intake) 1

OVERDOSE 2

Abuse (Illicit drugs only) 1

Mixture (Combination of illicit and prescription and/or over-the-counter drugs) 1

RELIGIOUS OBJECTIONS 1

Religious objection to Autopsy 1

UNKNOWN 48

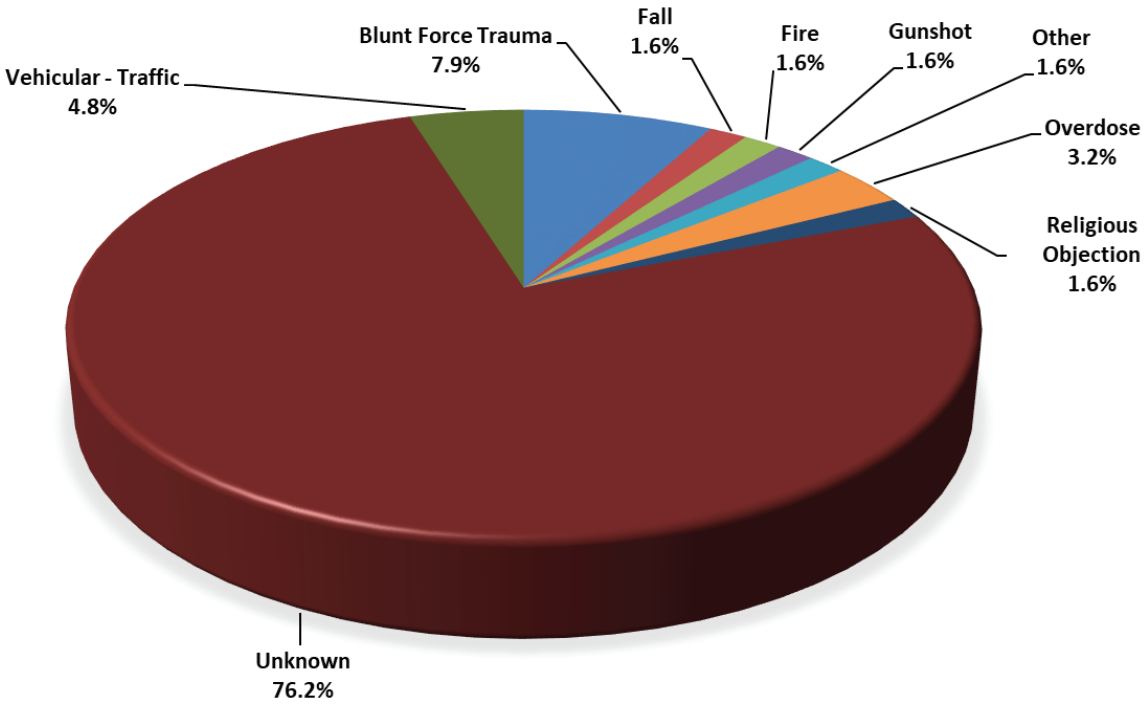
Undetermined Cause of Death 48

VEHICULAR 3

Operator 1

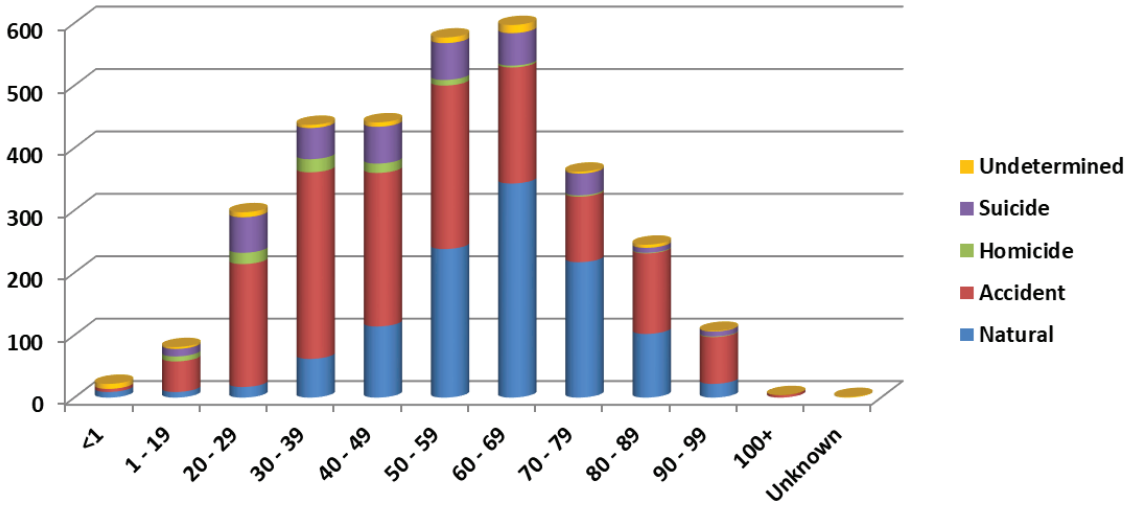
Pedestrian 2

TOTAL 63



Type of Undetermined	Number of Cases
Blunt Force Trauma	5
Fall	1
Fire	1
Gunshot	1
Other	1
Overdose	2
Religious Objection	1
Unknown	48
Vehicular - Traffic	3

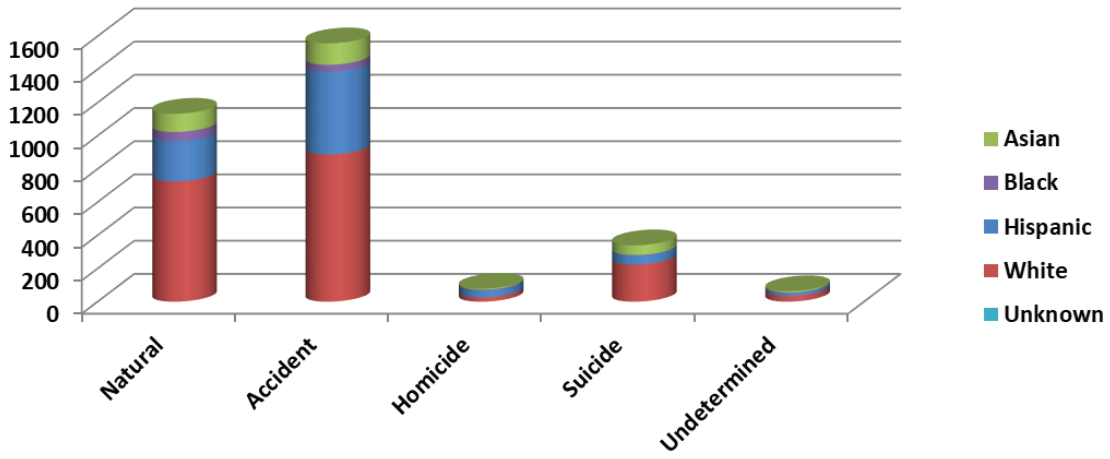
Manner Distribution for Each Age Group, 2022



Manner	<1	1-19 years	20-29 years	30-39 years	40-49 years	50-59 years	60-69 years	70-79 years	80-89 years	90-99 years	100+ years	Unknown
Natural	9	9	17	62	114	238	343	217	102	22	0	0
Accident	5	49	197	299	246	262	186	105	129	75	4	0
Homicide	0	8	18	21	15	9	3	2	1	1	0	0
Suicide	0	12	57	50	59	59	52	35	8	8	0	0
Undetermined	8	3	8	5	7	9	13	3	5	1	0	1
TOTAL	22	81	297	437	441	577	597	362	245	107	4	1

*It is important to note that the statistics provided above do not include Natural-Consult cases that have been signed by the Coroner

Racial Distribution for Each Manner, 2022



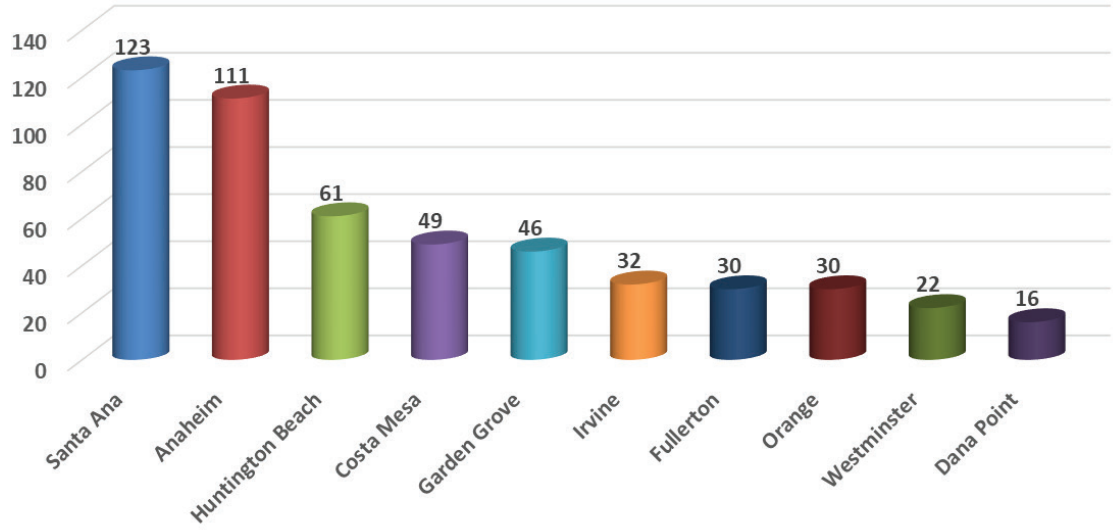
Ethnicity	Natural	Accident	Homicide	Suicide	Undetermined
Asian	110	129	6	59	8
Black	55	42	4	2	4
Hispanic	243	499	43	55	17
White	725	887	25	224	33
Unknown	0	0	0	0	1
TOTAL	1133	1557	78	340	63

*It is important to note that the statistics provided above do not include Natural-Consult cases that have been signed by the Coroner

Deaths Caused by Drug Overdose by Event City

There have been many inquiries over the past years as to the cities in which drug overdoses are occurring. In order to answer this question we include in this report a chart showing the top ten event cities for drug overdoses and the top ten event cities for opioid drug overdoses.

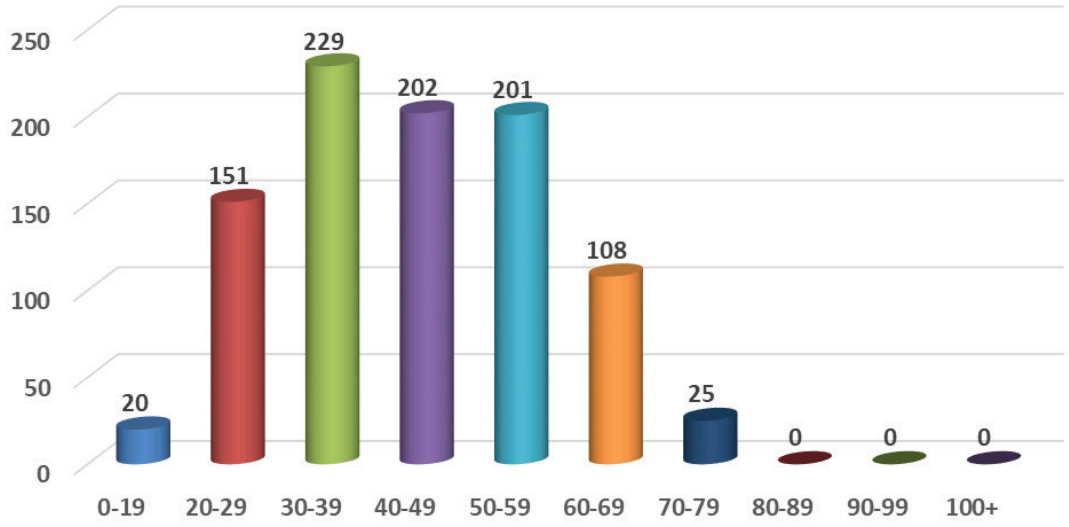
Top 10 Event Cities — Drug Overdoses



Deaths Caused by Drug Overdose by Age

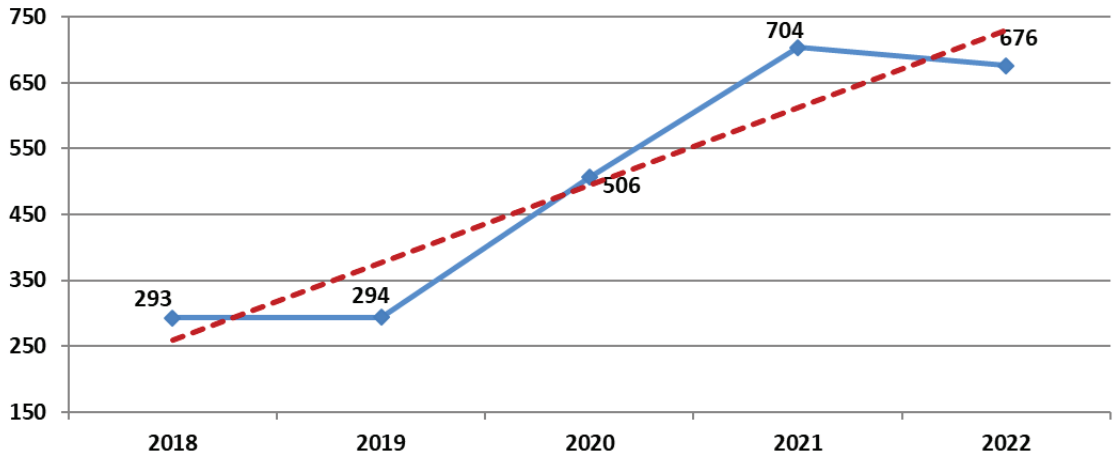
Along with the interest in where the drug overdose deaths are occurring is an interest in the ages of the decedents. To assist with that the charts below show the number of drug overdose deaths by age and the number of opioid overdose deaths by age.

Drug Overdose Deaths by Age



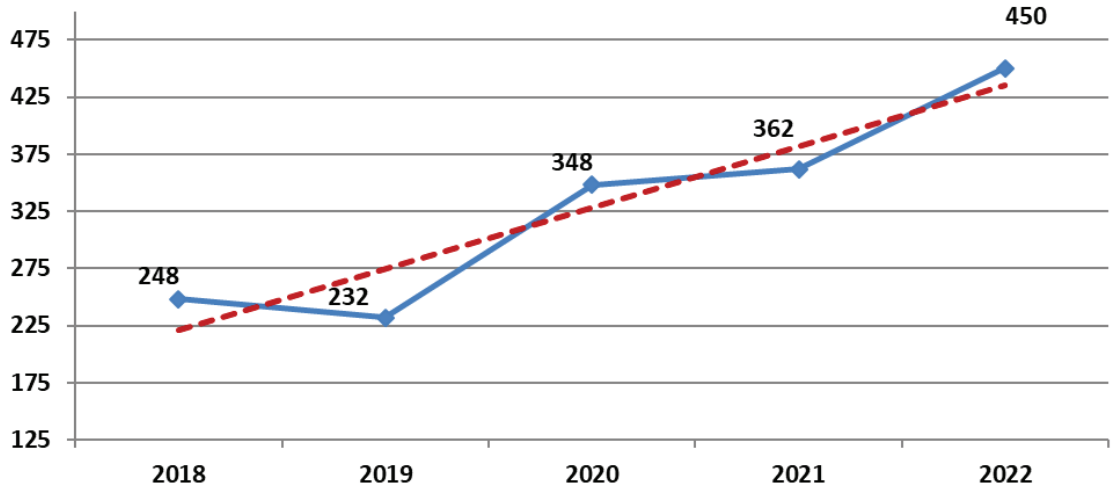
In 2013, we first referenced some noticeable trends in specific drugs. As a result, in the charts below we have illustrated the number of deaths where methamphetamine appears in the toxicology results and noted the number has decreased by 4% since 2021 .

Deaths with Methamphetamine in Toxicology Results



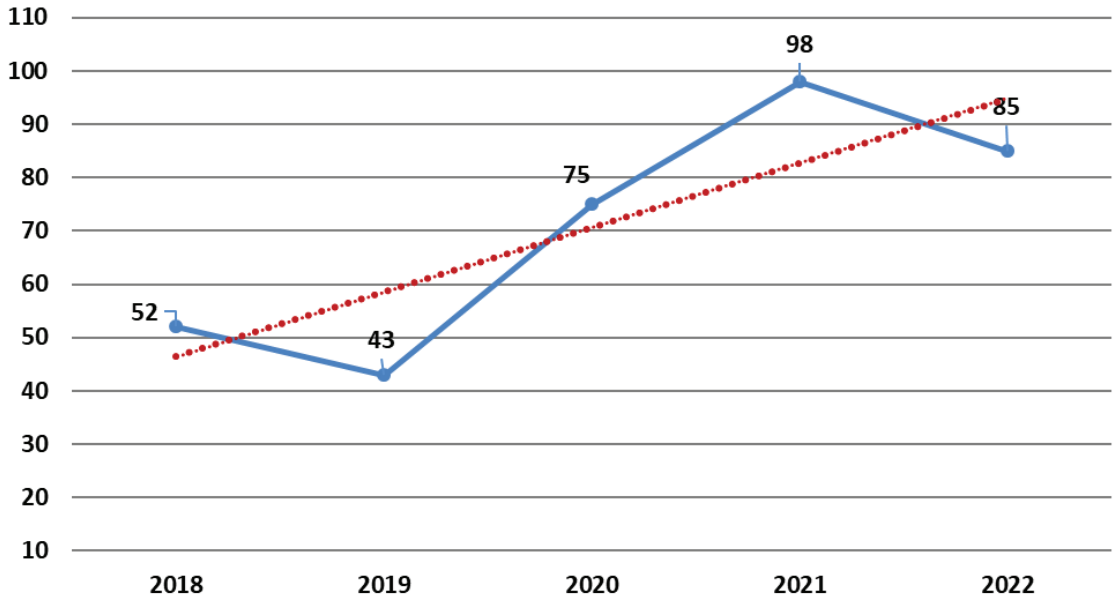
Deaths with THC, the active ingredient in marijuana, has increased by 24% increase since 2021, as seen in the chart below.

Deaths with THC in Toxicology Results



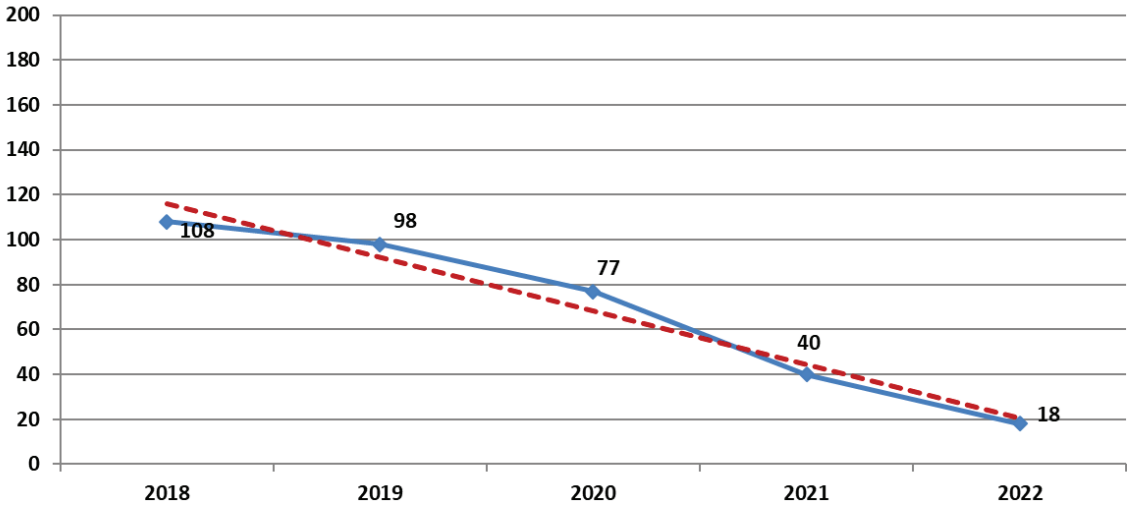
Deaths with Cocaine in Toxicology Results

2022 saw a 13% (85) decrease in cocaine related deaths compared to 2021(98).



Deaths Caused by Heroin Usage

The chart below shows the number of deaths over a five year period caused by heroin usage. There has been a 55% decrease between 2021 (40) and 2022 (18).

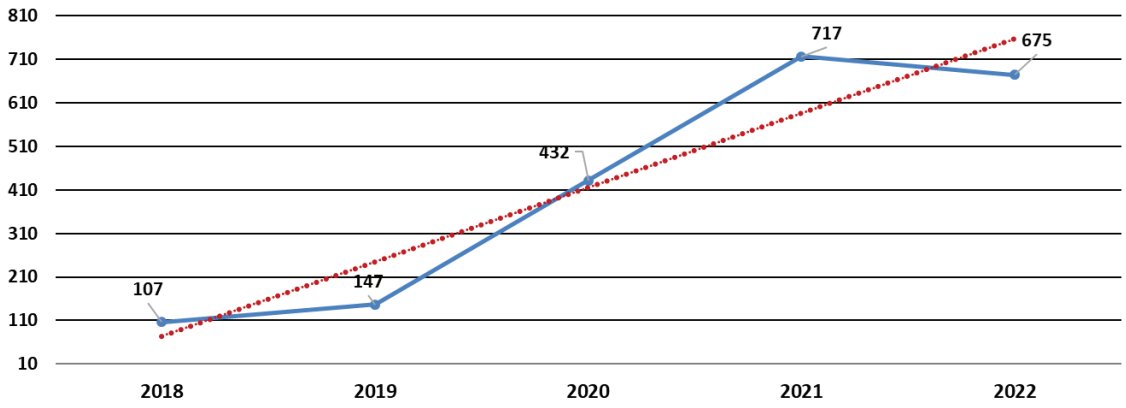


Deaths caused by Fentanyl

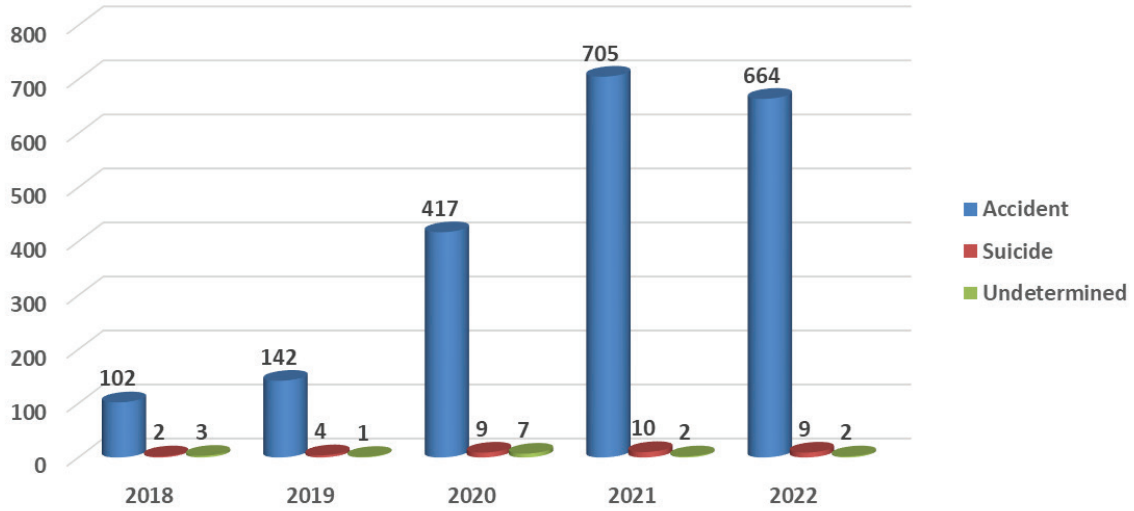
Fentanyl is a potent Schedule II synthetic opiate painkiller that can be lethal at very low doses. The majority of Fentanyl is produced clandestinely but is also prescribed by physicians. Fentanyl is up to 50 to 100 times more potent than hero-in. The dosage of Fentanyl is a microgram, one-millionth of a gram – similar to just a few granules of table salt. A mini-mal amount ingested or absorbed through the skin can kill a person. In addition to Fentanyl, the US Drug Enforcement Agency has identified at least 15 other deadly, fentanyl-related compounds, known as analogs. Analogues are slight chemical variations of the parent drug and can be even more potent than Fentanyl. Because of the extreme inherent dan-ger of these chemicals, the Coroner Division and the Forensic Chemistry section of the Orange County Crime Lab have been aggressively targeting the analysis of these compounds.

The chart below shows the number of fentanyl deaths over 5 years and combines the analog (illicit) and prescription-related deaths. From 2020 (432) to 2021 (717), fentanyl deaths increased by 66%. In 2022 (675) deaths decreased by 6% compared to 2021 (717).

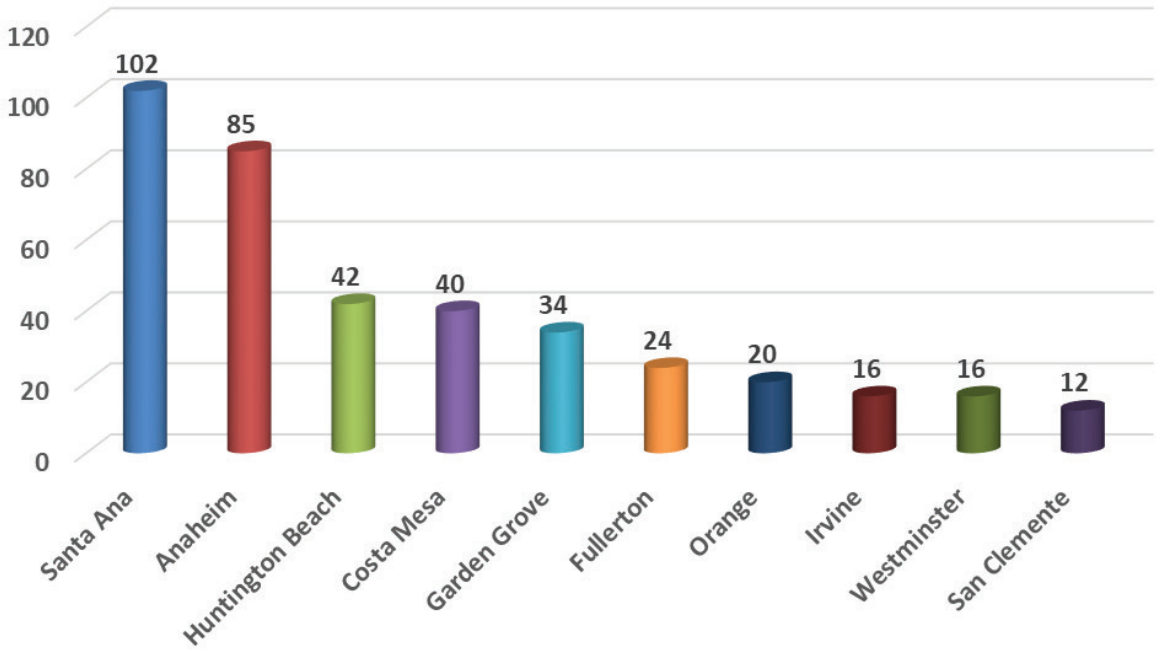
The following two pages contain a breakdown of more information concerning fentanyl deaths.



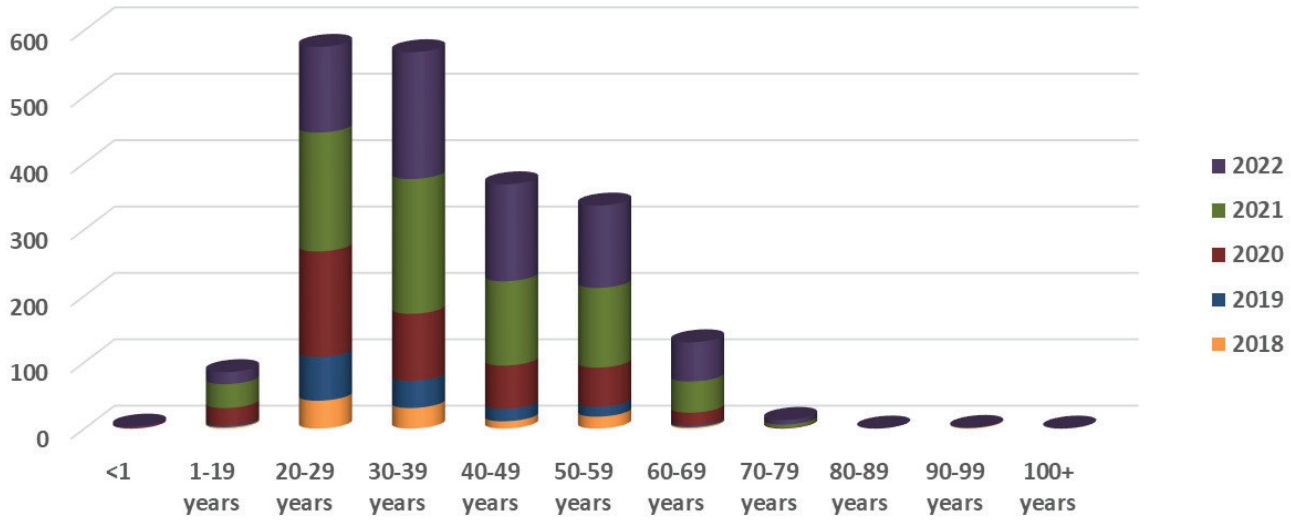
Deaths Related to Fentanyl by Manner - 5 Years



Top 10 Event Cities - Fentanyl Overdoses



Deaths related to Fentanyl by Age – 5 Years

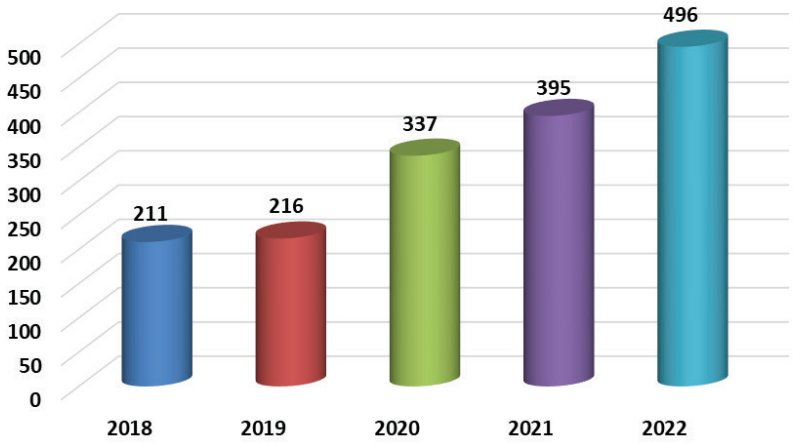


Year	<1	1-19 years	20-29 years	30-39 years	40-49 years	50-59 years	60-69 years	70-79 years	80-89 years	90-99 years	100+ years
2018	0	2	42	31	11	18	2	0	0	1	0
2019	0	3	66	41	19	15	3	0	0	0	0
2020	2	26	159	101	65	59	19	1	0	0	0
2021	0	36	179	203	127	120	47	5	0	0	0
2022	1	18	129	191	146	124	59	7	0	0	0
TOTAL	3	85	575	567	368	336	130	13	0	1	0

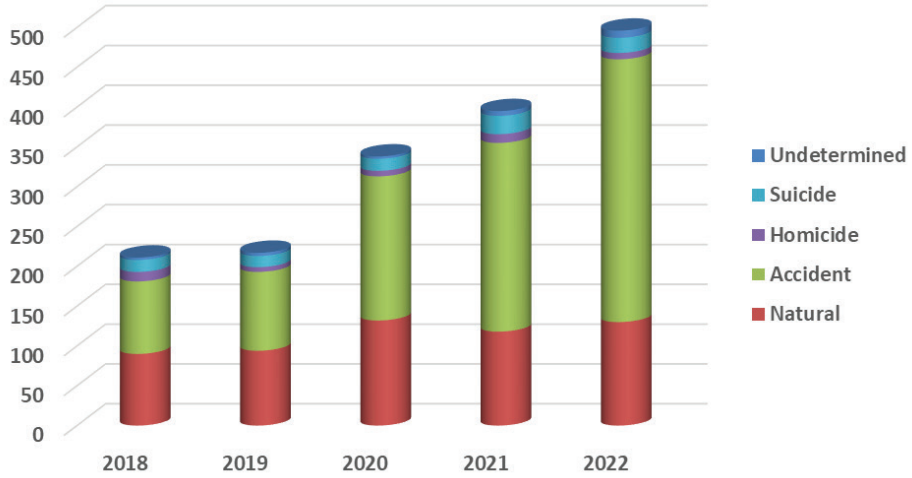
Homeless Deaths

Since 2016, the Coroner Division has noticed an increase in inquiries regarding the deaths of homeless individuals. It's important to note that not all deaths are reported to the Coroner, so the information provided may not present the complete picture but rather a piece of it. Homelessness is defined in the California Welfare and Institutions Code section 16523 as an individual or family who lacks a fixed, regular, and adequate nighttime residence. This determination can be made based on evidence, witness accounts, statements from next of kin, or as reported by the deceased before their passing.

Homeless Deaths by Year - 5 Years



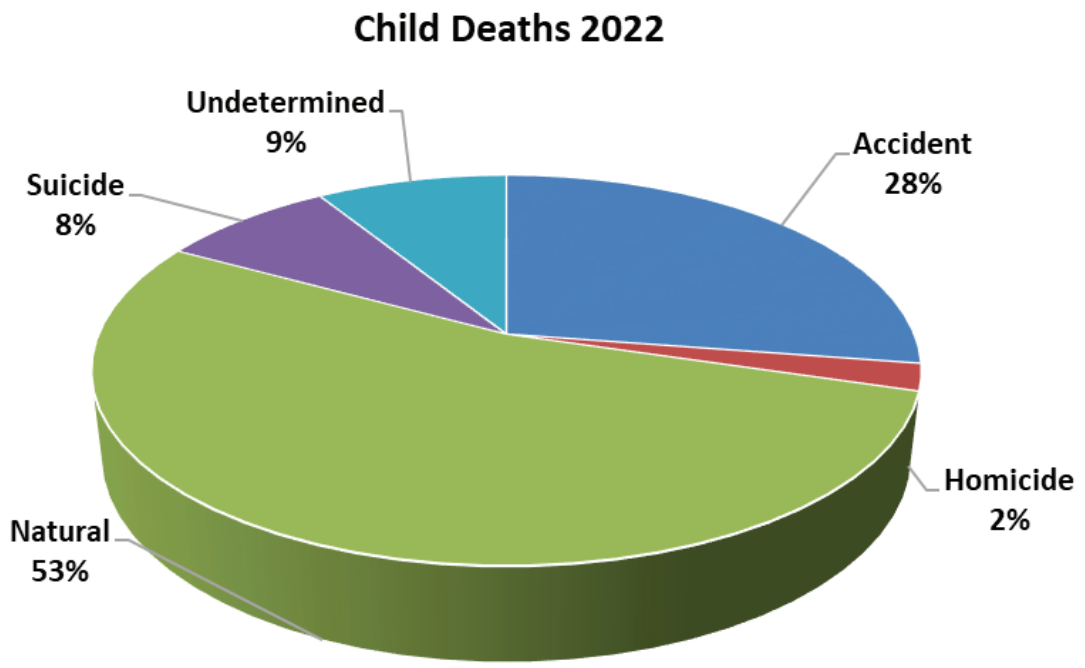
Homeless Deaths by Manner by Year - 5 Years



	2018	2019	2020	2021	2022
Natural	90	94	132	118	130
Accident	91	99	181	237	330
Homicide	12	6	7	11	8
Suicide	15	14	15	23	19
Undetermined	3	4	3	6	9
Total	211	217	338	395	496

Child Deaths

In the five years from 2018 through 2022, the Orange County Child Death Review Team (OCCDRT) reviewed 506 child deaths. OCCDRT only reviews cases that were reportable to the Coroner. In 2022, the number of cases reviewed increased by 45%, from 93 in 2021 to 135 in 2022. Traffic-related deaths stood out, as they in-creased by 160%, going from 5 deaths in 2021 compared to 13 deaths in 2022. However, we did see a decrease in overdose-related cases by 45%, as there were 11 overdose deaths in 2022 compared to 20 in 2021.



Year	Accident	Homicide	Natural	Suicide	Undetermined
2018	31	7	52	9	13
2019	19	6	34	5	9
2020	25	6	38	9	15
2021	34	5	35	8	11
2022	37	3	72	11	12
TOTAL	146	27	231	42	60

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