

Sheriff-Coroner Homeless Death Review Committee:

Report on 2023 Orange County Homeless Deaths

# We would like to acknowledge all our committee membership

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### INTRODUCTION

his is the third annual report on homeless deaths in Orange County. Sheriff-Coroner Don Barnes formed the Homeless Death Review Committee (Committee) in January 2022 and tasked the group with analyzing the number of deaths and causes of death for persons experiencing homelessness (PEH) in Orange County.

The Orange County Coroner's Office, a division of the Orange County Sheriff's Department, leads the Committee of technical experts from both the public and private sectors. Membership of the Committee includes representatives from the Orange County Coroner's Division, the Orange County Office of Care Coordination, the Orange County Health Care Agency, the Hospital Association of Southern California, the Orange County Medical Association, multiple experts in providing direct service to individuals experiencing homelessness, and two representatives from municipal law enforcement agencies.

Throughout the past year, the Committee reviewed and analyzed data related to the deaths that occurred in calendar year 2023 of PEH. The goal of the Committee was to utilize the data to uncover potential trends related to the causes of death for PEH that would lead to either service and/or policy recommendations that may help prevent future deaths among the homeless population.

This report emerges from a collaborative task force that focuses on accountability, brings in multiple points of view, provides partnerships and data sharing, reviews results, and carries out recommendations. The report summarizes the progress to date the Committee has made in understanding deaths among PEH and is not the conclusion of the Committee's work. Through this process, the Committee noted the need to further explore the root causes of the reviewed deaths and determine what, if any, factors contributing to the deaths were preventable. Going forward, the Committee will convene to review new PEH death data on a quarterly basis. This regular review will allow the Committee to further identify and/or review trends and identify areas for additional policy action.

A Mortality Review Committee is a recommended best practice by the National Health Care for the Homeless Council. Several jurisdictions have employed the use of these committees to assist in developing policies aimed at reducing preventable deaths.

### SCOPE OF THE HOMELESS DEATH REVIEW COMMITTEE

This report is focused on data and trends related to 508 people who passed away in 2023 while experiencing homelessness as identified by the Orange County Sheriff's Coroner Division. This review analyzed data including demographics of the decedents and the manner and cause of death. Also included in the review is data from Cal Optima Health, the Orange County Health Care Agency and the Orange County Jail. Lastly, the Committee compared the 2023 data against the same dataset from previous years.

## **GLOSSARY OF TERMS**

## Manner and Cause of Death

In reviewing the data on manner and cause of death, it is important to understand the terms used. The terms are consistent with industry standards in California.

**Cause of death:** The condition or injury (or circumstances of the injury) that initiated the train of morbid events leading directly to death.

**Manner of death:** A classification of death based on the circumstances surrounding a particular cause of death and how that cause came into play. The manner of death classifications are: Natural, Accident, Suicide, Homicide and Undetermined (Could not be determined).

**Natural:** A death solely or nearly totally due to disease and/or the aging process.

**Accidental:** When an injury or poisoning causes death and there is little or no evidence that the injury or poisoning occurred with the intent to harm or cause death. In essence, the fatal outcome was unintentional.

**Suicide:** An injury or poisoning resulting from an intentional, self-inflicted act committed to do self-harm or cause the death of one's self.

**Homicide:** A death resulting from a volitional act committed by another person to cause fear, harm, or death.

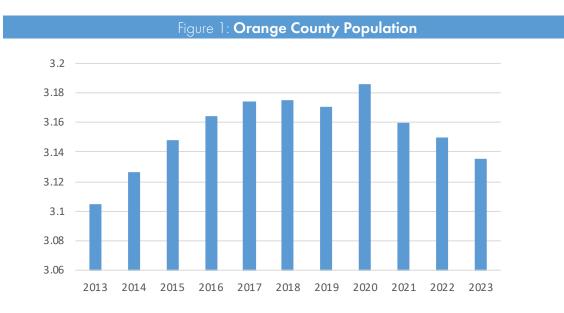
**Undetermined (Could not be determined):** The information pointing to one manner of death is no more compelling than one or more other competing manners of death in thorough consideration of all available information.

**Jurisdictional Inquiry:** A local classification used for cases that require extensive work to determine that the death does not otherwise meet the legal requirement for coroner jurisdiction.

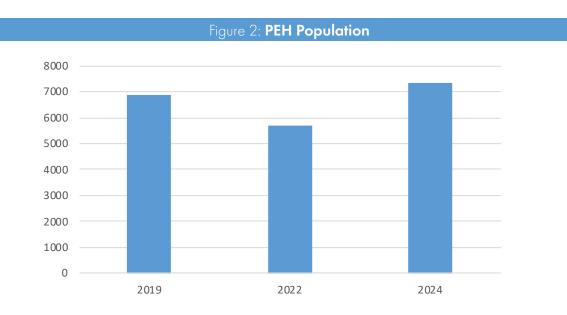
### ORANGE COUNTY POPULATION INFORMATION

Orange County is one of the nation's most populated counties. In reviewing the data on deaths to PEH it is also important to understand the demographics of the current population and trends regarding the number of PEH in the community.

The information provided below is a representation of the estimated population of Orange County (number in millions) from 2013 through 2023 using data from the United States Census Bureau. The population numbers are estimates derived from the last two censuses conducted in 2010 and 2020. According to the data, Orange County saw a population increase of 1% between 2013 and 2023.



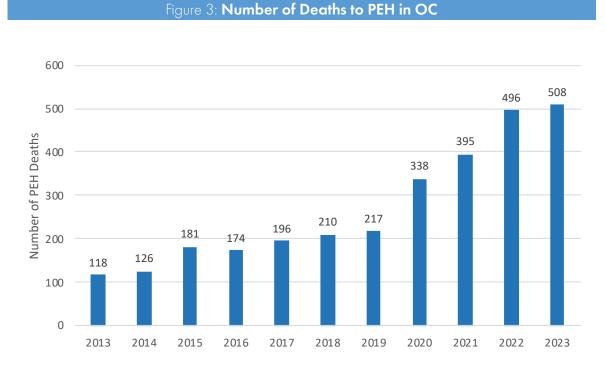
In Orange County, a total of 7,322 PEH were counted during the 2024 Point In Time (PIT) Count. This is up 28% from the 2022 PIT Count which counted 5,718 persons experiencing homelessness at that time. There was a change in methodology used to collect PEH data from the PIT Counts beginning in 2019 that reflect a more accurate overview of the PEH population.



# **REVIEW OF NUMBERS/DATA**

### DEATHS AMONG PERSONS EXPERIENCING HOMELESSNESS

According to data from the Orange County Sheriff's Coroner Division, in calendar year 2023, the total number of deaths for persons experiencing homelessness (PEH) was 508. Over the last several years, the number of PEH deaths has increased incrementally in Orange County, from 118 in 2013, to 217 in 2019. A substantial increase in deaths occurred between 2019 and 2020 when deaths increased by 56% from 217 to 338 during the first year of the pandemic (Figure 3). Deaths among persons experiencing homelessness continued to increase to unprecedented heights in 2021, 2022 and 2023, reaching 395, 496 and 508 deaths, respectively, and amounting to an increase of 50% from 2020 to 2023.



The increase in homeless deaths is not unique to Orange County and is consistent with trends being seen in other parts of California.

# **DEMOGRAPHICS OF PEH DEATHS 2023**

The information presented in the following section will include an in-depth analysis of deaths to persons experiencing homelessness 2023 – the most recent and complete data available. Please note that the demographic data and data on both the manner and cause of death is from the Orange County Sheriff's Coroner Division and the California Comprehensive Death File (CCDF) for Orange County.

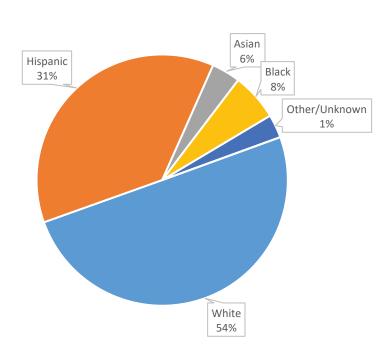
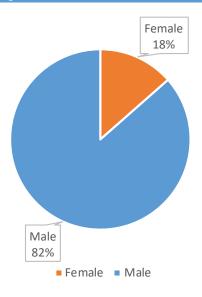


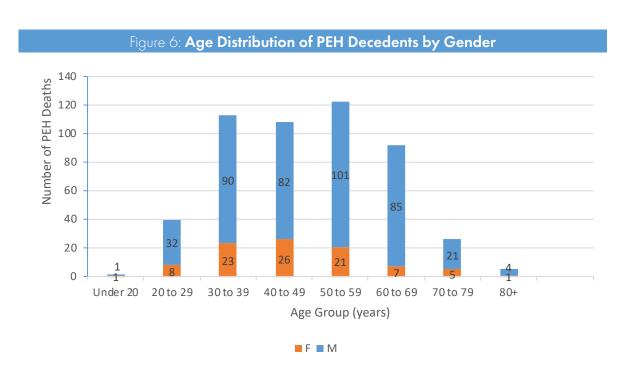
Figure 4: Race/Ethnicity of PEH Decedents

The demographic characteristics of the 508 PEH who died in 2023 is shown in Figure 4. The race/ethnicity of the decedents was 54% White, 31% Hispanic, followed by 8% Black, 6% Asian, and 1% Other/Unknown. These percentages align with the race and ethnicity breakdown reported in the 2024 Orange County Point in Time Summary for those experiencing unsheltered homelessness.

Figure 5: Gender of PEH Decedents



The PEH deaths were 82% male and 18% female, representing a 13% overrepresentation of males compared to the 2024 Orange County Point in Time Count Summary that reported 73.5% of people experiencing unsheltered homelessness identifyed as male. (Figure 5)



The average age at death for PEH who died in 2023 was 48 years old (F 45; M 49), compared to 76 years old for the housed population who died that year. (Figure 6)

# **MANNER OF DEATH**

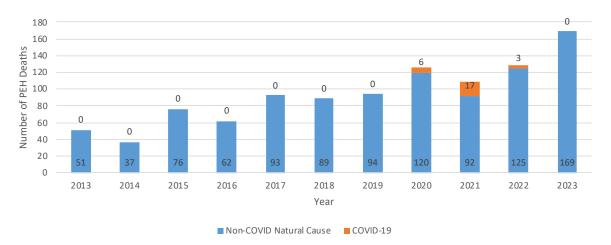
	Table	1: Mai	nner of	Death	to PEH	(2019 t	o 2023	3)		
Homeless Deaths	20	19	2020		2021		2022		2023	
Manner of Death	Num- ber	Per- cent								
Accident	99	46%	181	54%	235	59%	324	65%	307	60%
Homicide	6	3%	7	2%	11	3%	8	2%	7	2%
Natural	94	43%	126	37%	109	28%	128	26%	169	33%
COVID-19			6	2%	17	4%	5	1%	0	0%
Suicide	14	7%	15	4%	22	6%	19	4%	22	4%
Undetermined/	4	1%	3	1%	1	0%	12	2%	3	1%
Pending*										
Total	217	100%	338	100%	395	100%	496	100%	508	100%

Prior to 2019, deaths of PEH were primarily due to natural (e.g., cancer, heart disease, liver disease) and accidental (unintentional) causes (**Table 1**). However, in 2019 (99) deaths due to accidental (unintentional) injuries increased and continued to increase through 2021 (235) and 2022 (324).

Although accidental deaths are still the primary manner of death for PEH in 2023 (307), this is a 5% **decrease** from 2022.

Figure 7: **PEH Death Trends Accidental Injury Death Trends** Number of PEH Deaths Years

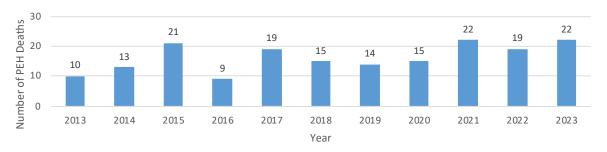
# Natural Death Trends (with COVID-19)



# **Homicide Death Trends**



# **Suicide Death Trends**



The trends for manner of death for PEH (Figure 7) show that over the past nearly two decades (since 2005) the number of deaths in each category have increased markedly. However, the growth in some of the manners of death have far outpaced others. In just the past decade, for example, the number of accidental deaths (unintentional) increased from 39 in 2013 to 307 in 2023 (a 687% increase). Natural deaths increased 231%, from 51 in 2013 to 169 in 2023. A similar pattern was observed for homicide and suicide deaths (albeit small numbers of cases). Homicides increased from 4 deaths in 2013 to 7 deaths in 2023 (a 75% increase), while suicide deaths more than doubled from 10 to 22 during this same time period (a 120% increase).

# **LEADING CAUSES OF DEATH FOR PEH (2023)**

Because accidental injuries accounted for so many of the deaths of PEH (60.4%), a more detailed summary of this category is required (**Table 2**). The majority (51%) of unintentional deaths were due to overdose (poisoning) and 43% (220) of all unintentional deaths to PEH are specifically due to the very potent synthetic opioid, fentanyl.

Table 2: Accidental (Unintentional Injury) Cause Group Detail	Homeless	%Homeless Deaths
Poisoning/Overdose with Fentanyl	220	43.3%
Poisoning/Overdose (Non-Fentanyl)	41	8.1%
Pedestrian Traffic	32	6.3%
Motor Vehicle Traffic	2	.4%
Falls	7	1.4%
Pedal Cyclist Traffic	2	.4%
Drowning	3	.5%
Other/Unknown/Ill-Defined	0	0%
Total	307	65.3%

Compared to 2018, just five years prior to the data explored in this report, fentanyl accounted for 12 PEH deaths. This increase in fentanyl-related deaths as a portion of the drug-related deaths is consistent with deaths in the general population both in Orange County and nationwide.

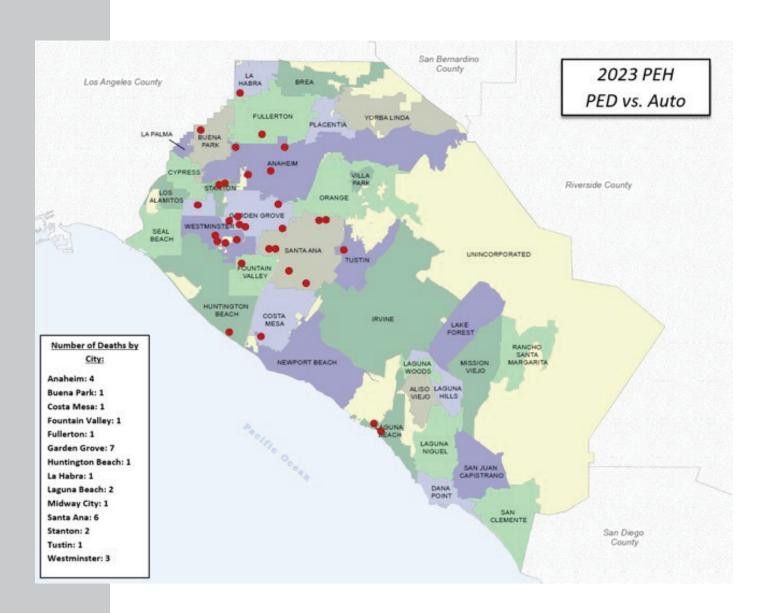
Beginning in 2022, the Health Care Agency, Mental Health & Recovery Services (MHRS) has engaged in community education, leveraging the larger OCSD efforts, to get information out into community on fentanyl. This includes the community distribution of Narcan and Kloxxado to reverse an overdose, including the distribution, through MHRS Outreach & Engagement to individuals who are unhoused. Additional prevention efforts are underway, as well as the enhancement and expansion of treatment options that are also made available to the unhoused community via Outreach & Engagement, as well as prior to release from custody. This includes discharge planning of individuals who are on Medicated Assisted Treatment (MAT), ready to be released from custody, and who are unhoused. Overdose prevention kits are also provided in the community and upon release form custody. Collaboration through our local shelters and housing partners also has been increased to address prevention, treatment, and recovery supports for those individuals who are unhoused, have a substance use disorder, and are at risk for a drug overdose.

In addition to concerns about drug-related deaths among accidental PEH deaths, it is also important to note the role drugs can play among natural death trends. For example, methamphetamine use is linked to long term health impacts. A 2022 study published in the Journal of the American Heart Association found that individuals who used methamphetamine had a 32% overall increased risk for cardiovascular disease.

# PEH PEDESTRIAN VS. MOTOR VEHICLES

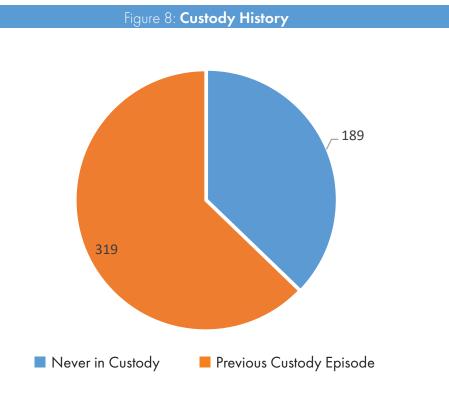
The second most common category of unintentional injury deaths was due to PEH being hit by motor vehicles while walking 6.3% (32).

Of the 32 PEH hit by motor vehicles while walking, 87.5% (28) were under the influence of drugs and/or alcohol at the time of incident, with 68.8% (22) of incidents occurring between 8 p.m. and 6 a.m. In addition, 90.6% (29) of incidents occurred outside of a marked crosswalk.



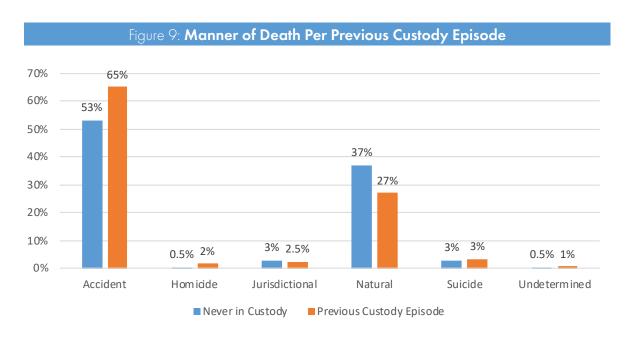
# **CUSTODY INFORMATION**

Based on booking records from the Orange County Sheriff's Department, the majority of 2023 PEH decedents (63%, 319) had at least one episode of custody in the Orange County Jail, while 37% (189) had never been in custody. The percentage of PEH who had a previous episode in the Orange County Jail declined from 2022 and 2021. Among 2022 PEH decedents 68% (342) had a booking in the Orange County Jail. Among 2021 PEH decedents, 78% (309) had an experience in the Orange County Jail.



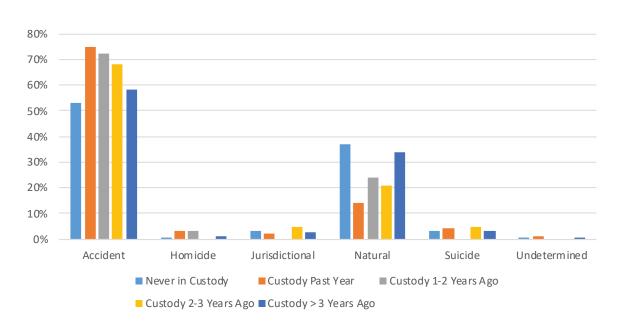
Of the 319 PEH decedents who have been in the Orange County Jail, 176 had been in custody within the last five years.

Regardless of prior custody experience, PEH decedents were likely to have died accidently. The gap between accidental and natural causes was less pronounced for the 189 PEH decedents who had never been in custody.



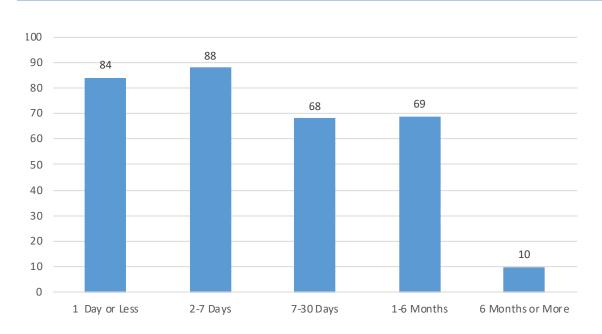
An examination of PEH decedents by time since their last custody episode shows that accidental remained the most likely mode of death for all categories, followed by natural death. The most significant gap between accidental and natural death were for individuals who died within a year of their release from custody.





Of the 319 PEH decedents who were in the Orange County Jail, a total of 60 (18%) participated in a reentry program during a previous custody experience. The minimal participation is likely due to the short time in custody for the PEH decedents; 53% served a week or less and 75% served 30 days or less.

Figure 11: Length of Most Recent Time in Custody



# **CAL OPTIMA HEALTH**

CalOptima Health was created by the Orange County Board of Supervisors in 1993 as a County-Organized Health System (COHS). CalOptima is the single largest health insurer in Orange County, providing coverage for one in four residents through four programs, Medi-Cal, OneCare Connect, OneCare, and PACE.

CalOptima Health had eligibility information on 342 (67%) of the 508 PEH decedents in 2022. Of those with coverage, there were 603 emergency department visits and 175 hospital admissions. In 2021, CalOptima had information on 294 or 59% of the 496 PEH decedents.

Non Member 33%

Member 67%

Figure 12: CalOptima Membership Among PEH Decedents

### **FINDINGS**

- Deaths among persons experiencing homelessness (PEH) have increased in Orange County over the last decade, from 118 in 2013 to 508 in 2023. The largest increase occurred from 2019 to 2020, with deaths increasing by 55%, from 217 to 338.
- Similar to the 2022 Homeless Death Review Committee Report, the PEH decedents are predominately male (82%), white (54%), and the average age of the decedents is 48 years old.
- For the third straight year, accidental death continues to be the leading manner of death among PEH. In 2023, 60% of PEH died as the result of an accident, down from 65% in 2022. Accidental death first became the majority of PEH deaths in 2019.
- The leading cause of death among accidental PEH deaths was drug-related. Drug-related deaths account for 261 accidental deaths (51%), with fentanyl being a factor in 220 of those deaths.
- The second most common category of unintentional injury deaths was due to PEH being hit by motor vehicles while walking. In 2023, 32 PEH were hit and killed by motor vehicles while walking; 28(87.5%) were under the influence of drugs and/or alcohol at the time of incident.
- Sixty-three percent of PEH decedents (319) had at least one experience in custody at the Orange County Jail. The percentage of PEH who had a previous episode in the Orange County Jail declined from 2021 and 2022.

### HOMELESS DEATH REVIEW COMMITTEE AFTER ACTION ITEMS

Looking ahead, the priority for the Committee in 2025 will be to continue to conduct a more comprehensive review of PEH deaths. With recently passed legislation that went into effect in January of 2024 the Committee will be able to share more personalized information amongst each other, allowing for a more detailed analysis of the data available.

# **APPENDIX A**

Table 3 summarizes the location of death for the 508 PEH decedents in 2023.

CITY	Number	Percent
Anaheim	80	15.7%
Brea	2	<1%
Buena Park	9	1.8%
	1	<1%
Capistrano Beach	ļ ·	
Costa Mesa	17	3.3%
Cypress	7	1.4%
Dana Point	3	<1%
Foothill Ranch	1	<1%
Fountain Valley	22	4.3%
Fullerton	33	6.5%
Garden Grove	45	8.9%
Huntington Beach	29	5.7%
Irvine	6	1.2%
La Habra	7	1.4%
La Palma	2	<1%
Ladera Ranch	1	<1%
Laguna Beach	4	<1%
Laguna Hills	3	<1%
Laguna Niguel	2	<1%
Lake Forest	6	1.2%
Los Alamitos	2	<1%
Midway City	1	<1%
Mission Viejo	12	2.4%
Newport Beach	13	2.6%
Orange	30	5.9%
Placentia	10	2%
Rancho Santa Margarita	1	<1%
San Clemente	8	1.6%
San Juan Capistrano	3	<1%
Santa Ana	101	19.9%
Seal Beach	2	<1%
Stanton	11	2.2%
Sunset Beach	1	<1%
Tustin	11	2.2%
Westminster	22	4.3%
TOTAL	508	100%