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REQUIRED RESPONSES

Pursuant to Penal Code section 933.05, the following responses are required:
From the following Plumas County officials (within 90 days):

- Plumas County Board of Supervisors: **F-1 through F-6 and R-1 through R-3**

INVITED RESPONSES

The Grand Jury invites the following response from (within 60 days):

- Agricultural Commissioner/Sealer: **F-1 through F-6 and R-1 through R-3**

PLUMAS COUNTY SHERIFF-CORONER: Death Investigations and Autopsies

[Cautionary note to readers: This report addresses coroner functions and necessarily includes certain graphic details concerning death circumstances. Some readers may find portions of the content objectionable or disconcerting.]

SUMMARY

In Plumas County, as in many counties in California, the sheriff and sheriff's department also serve as the coroner and coroner's department. Under California law, the coroner is responsible for investigating and determining the cause, manner and circumstances of deaths in which the decedent was not under a doctor's care within 20 days prior to death, or where the death was unattended, suspicious, or unnatural. (California Government Code (GC) §27491). Included are violent, sudden, unattended or unusual deaths that can result from drownings, suicides, exposure, homicides, and accidents, as well as certain medical conditions, to list but a few.

Death investigations in such instances often include, or often should include, forensic autopsies, but California law does not dictate the circumstances in which autopsies must be obtained, leaving the matter to the exercise of informed professional judgment by the coroner or medical examiner. There are, however, two situations in which California law does require that an autopsy be conducted: (1) in the case of certain infant deaths, and (2) where requested by appropriate next of kin. Professional standards issued by the National Association of Medical Examiners (NAME) specify additional instances when forensic autopsies should occur, in order to help ensure competent investigations and to better protect the public interest. Lacking a medical examiner, Plumas County contracts with the Washoe County (NV) Medical Examiner's office to perform autopsies and related services in connection with deaths occurring in Plumas County.

Prompted by a citizen's complaint regarding a death that was investigated by the Plumas County Sheriff's Department (Sheriff's Department), and the apparent decision not to obtain a forensic autopsy, the Plumas County Civil Grand Jury (Grand Jury) began an investigation of the coroner function in the Sheriff's Department in September 2019. It focused on (i) compliance by the Sheriff's Department with GC §27520(a) (which requires the coroner to perform or facilitate an autopsy when requested to do so by certain next-of-kin) in the complainant's case, (ii) the coverage of the Sheriff's Department policies and procedures governing death investigations and coroner functions (Coroner P&Ps), including in respect of their attention to autopsies, and (iii) overall compliance by Sheriff's Department personnel with the Coroner P&Ps and certain Government Code provisions in connection with a sample of coroner death investigation reports reviewed by the Grand Jury.

The Grand Jury found that the Sheriff's Department did not adhere to GC §27520 in the instance involving the complainant in that it did not facilitate or procure an autopsy where one had been requested by the decedent's next of kin. With regard to the Coroner P&Ps, the Grand Jury found multiple omissions and deficiencies that, if not corrected, may lead to failure to adhere to legal requirements or best practice standards in the future. The Grand Jury also found instances in which the Sheriff's Department had failed to adhere to its Coroner P&Ps and certain provisions of the Government Code. It also found that the Coroner's investigation reports lacked sufficient clarity and detail as to cause, manner and circumstances of death, and that they were not updated upon receipt of autopsy or toxicological exam results. The Grand Jury therefore recommends that appropriate changes be made to the Coroner P&Ps and their maintenance, and to report generation practices.

BACKGROUND

Coroner Functions

Unlike some states, California has a county-based death investigation system, focused on the county coroner or medical examiner. In about two-thirds of California's counties, including Plumas County, the county board of supervisors has consolidated the duties of sheriff and coroner, under GC §24304.1. Thus, in Plumas County, the Sheriff also assumes the role and duties of the coroner.

The coroner's duties encompass three functional areas:

- Investigative – Conducting investigations to determine cause of death and/or to establish identity of the deceased; conducting inquests.
- Medical - Procuring autopsies to determine cause of death; transporting and removing bodies; verifying cause of death and signing death certificates; appearing at all unattended deaths unless the deceased has been seen by a physician within 20 days prior to death.
- Administrative - Maintaining all records; responding to inquiries by law enforcement agencies, doctors, and others with potential cases; providing proper custody and security of valuables; arranging sale of unclaimed property (which may also be done by the public guardian-public administrator); and locating families when necessary.

Under California law, coroners are responsible for determining three things in connection with investigations of certain unattended, sudden or violent deaths—the cause, the manner, and the circumstances of death (GC §24791). The *cause* of death is the specific injury or disease that led to the death. The *manner* of death indicates how the injury or disease led to the death. Typically, there are five manners of death—accident, suicide, homicide, natural and undetermined. Finally, the *circumstances* of death describe the way the death came about—that is, through what series of events or circumstances.

Autopsies are often a part of a death investigation. An autopsy is an external and internal (surgical) examination of a deceased person performed to document injuries, diseases and even normal conditions of a body. It often provides valuable information as to the cause and manner of death and may be followed by laboratory tests such as toxicology.

Autopsies are surgical procedures that must be performed by trained medical personnel, such as a medical examiner. Plumas County does not have a medical examiner and as a result it contracts with the Washoe County (NV) Medical Examiner's Office (WCME Office) to perform autopsies and related services requiring such expertise in connection with deaths occurring in Plumas County. Thus, a decision to have an autopsy performed involves a payment to be made by Plumas County to the WCME Office, as opposed to the regular payment of salary as would be the case if Plumas County had medical examiners on staff. However, the determination as to whether and when to have an autopsy conducted is exercised by the Plumas County Sheriff-Coroner (Coroner) or his designee.

When a death is reported to the Sheriff's Department, a deputy is dispatched to the scene and makes an initial assessment. Then, depending on the circumstances, the case is either investigated fully by the Sheriff's Department (referred to as a "Coroner's Case") or handled as a "Coroner's Referral," where the decedent's physician signs the death certificate. A Coroner's Case involves much more investigation and information gathering by the Sheriff's Department. Following the completion of the Coroner's Case investigation, the death record containing the cause and manner of death is entered by a member of the Sheriff's Department into the state-run Electronic Death Reporting System (EDRS), reviewed by the Plumas County Health Department and then forwarded to the County Registrar and the State of California Public Health Department. There may be occasions when the cause and manner of death is not initially apparent, in which case the initial death certificate is created, but the cause of death is listed as 'pending'. Once the investigation, blood test results, or autopsy results are completed, and the cause and manner of death are determined, the death certificate record is amended by the Coroner.

Legal and Professional Standards Governing Death Investigations

The California Government Code regulates some aspects of the coroner's duty to investigate certain deaths. Most importantly for purposes of this report (full text of these code provisions are reprinted in the Appendix to this report):

- **GC Section 24791** states that it is the duty of the coroner to "inquire into and determine the circumstances, manner and cause of all violent, sudden or unusual deaths", as well as certain unattended deaths. Section 24791 specifically lists a number of types of deaths falling within these categories, including "deaths due to drowning, fire, hanging, gunshot, stabbing, cutting, exposure, starvation, drug addiction, strangulation" and many others.
- **GC Section 27463** specifies appropriate coroner documentation regarding death investigations. It provides that the "cause of death, when known, with reference or

direction to the detailed medical reports upon which the decision as to the cause of death has been based” shall be entered into the report or register of the investigation.

- **GC Section 27520** provides that the coroner “shall cause to be performed an autopsy” where one is not otherwise being performed, if requested by a surviving spouse, or if none, by a surviving child or parent. The cost of such a requested autopsy shall be borne by the person so requesting.

The California legislature, unlike many other states, has not seen fit to regulate when autopsies must be conducted as a matter of law, leaving it to the informed professional judgment of the coroner or medical examiner. However, there are two exceptions to this general rule. GC §27491.41 requires that the coroner cause an autopsy to be performed in any case where “an infant has died suddenly and unexpectedly.” The other exception is GC §27520, described above.

However, beyond legal requirements there are professional standards, including those applicable to persons conducting autopsies, such as medical examiners. The WCME Office website references the standards promulgated by the National Association of Medical Examiners (NAME). NAME is a national, professional organization that, among other things, promotes best practice standards for medical examiners and other stakeholders in death investigations. NAME’s publicly available *Forensic Autopsy Performance Standards* (NAME Standards) set forth circumstances in which an autopsy must be conducted in order to ensure “the best opportunity for competent investigation”. Those circumstances include (among others, such as death by criminal violence and deaths associated with police action) cases when:

- the death is caused by apparent electrocution
- the death is by apparent intoxication by alcohol, drugs or poison
- the death is caused by unwitnessed or suspected drowning
- the body is unidentified, or skeletonized, or charred
- the forensic pathologist deems an autopsy necessary to determine cause or manner of death or to collect evidence

In each of these cases, NAME views the public interest as so compelling that “one must always assume that questions will arise that require information obtainable only by forensic autopsy.”

Although the Coroner is not a medical examiner, medical examiners cannot perform their function in accordance with the NAME Standards unless the referring coroners adopt similar procedures in deciding whether to submit a body to them for autopsy.

Another group that provides best practice standards for coroners and medical examiners is the Centers for Disease Control, which publishes handbooks, reference material and statistics with regard to death investigations and the medical examiner and coroner’s roles and duties. The *Medical Examiners’ and Coroners’ Handbook on Death Registration and Fetal Death Reporting*

(CDC Handbook) addresses the Coroner's duties in collecting and accurately reporting information on death certificates. Among other things, it stresses the importance, in describing the cause of death, of presenting a cause and effect explanation of the "order, type and association of events resulting in death" and that the description be sufficiently specific that there is "no doubt as to why it developed." (CDC Handbook, p. 12) It also requires updating 'pending' causes and manner of death in a report immediately once the results of autopsies or other tests are completed. (CDC Handbook, pp. 6, 14) It also notes that one of the most difficult tasks of the medical examiner or coroner is to determine whether a death is an accident or the result of an intent to end life. It counsels that the coroner "must use all information available to make a determination about the death", including autopsy, toxicological, investigatory, and psychological evidence. (CDC Handbook, p. 21).

METHODOLOGY

The Grand Jury conducted a six-month investigation into this matter, prompted by a citizen's complaint submitted to the Grand Jury, presented below. The investigation included several elements:

- Review of complaint and interview with Complainant
- Review of the death investigation referenced in the complaint, as well as 25 other death investigation cases randomly selected from those that had been investigated by the Sheriff's Department over the past five years
- Interviews with employees of the Sheriff's Department
- Interviews with employees of the Plumas County Public Health Department
- Review of Sheriff's Department Policy Manual, specifically the Coroner P&Ps
- Online research of NAME, Centers for Disease Control and Prevention, California government codes, police officer training, coroner duties with regard to death investigations, and related matters
- Online research of the EDRS and review of the EDRS operating manual

DISCUSSION

Coroner Policies and Procedures

The Sheriff's Department performs its coroner functions under the death investigation and departmental coroner's manual policies and procedures (together, Coroner P&Ps), which are embedded in its Operations Policy Manual (Policy Manual), available online. The Policy Manual indicates that it was adopted June 30, 2013, although the Coroner P&Ps state that they were revised as of January 2007. The stated purpose of the Coroner P&Ps is to provide information to responding Deputy Coroners as to death investigations within the County, including providing "Deputy Coroners with applicable laws regarding Death Investigations" and "information regarding their duties at a Death Investigation" (Policy Manual, Section 360.3.1-

2). Section 360.1 of the Coroner P&Ps states, “[t]he thoroughness of death investigations cannot be emphasized enough.”

The Coroner P&Ps restate most or all of GC §27491, which requires coroner investigations in connection with certain deaths, as described above, but they do not mention GC §27520, which requires that the coroner facilitate an autopsy when so requested by next-of-kin to the decedent. The Coroner P&Ps also do not provide detailed guidance as to when an autopsy should be arranged in connection with death investigations under GC §27491, nor does it reference professional standards documents, such as the NAME Standards or the CDC Manual. Apart from references to autopsies performed in connection with unidentified bodies (and subject to GC §27521), the sum and substance of the guidance provided by the Coroner P&Ps as to when an autopsy should be obtained is contained in subsection 360.3.6, listing the duties associated with Coroner’s Cases:

“18. Contact Washoe County Coroner’s Office to schedule autopsy if appropriate and the forensic evidence gained would assist in the determination of cause of death. Fax report to Washoe County Coroner’s Office.” (Policy Manual, Section 360.3.6(18))

The Coroner P&P’s do not indicate when it would be deemed “appropriate” to obtain an autopsy, and only specify obtaining one when it “would assist in the determination of the *cause* of death”, without providing further guidance or elaboration. (emphasis added) However, as recognized in the NAME Standards, an autopsy might also be informative as to the *manner* of death. In some cases, it may also help clarify the *circumstances* of death. Under GC §27491, the coroner is responsible for determining all three factors in connection with certain deaths—cause, manner, and circumstances.

Several years ago, the Sheriff’s Department acquired its Policy Manual (including the Coroner P&Ps) by subscribing to the services of a vendor company that develops and updates similar policy manuals for various counties and other jurisdictions. However, the Sheriff’s Department continued subscribing to this service for only a short time after the initial set up of the manual. Maintaining and updating the Policy Manual is therefore now left to Sheriff’s Department personnel having subject matter expertise. However, at least as to the Coroner P&Ps, this does not appear to have occurred on a regular basis; there is no set yearly review or other ongoing supervisory monitoring to ensure that the Coroner P&Ps continue to reflect changing legal requirements, professional standards, or best practices.

Citizen’s Complaint; Non-Compliance with GC §27520

As noted, this investigation was prompted by a citizen’s complaint to the Grand Jury relating to a death of a relative, which was of a type listed in GC §24791. The Grand Jury determined that the Sheriff’s Department commenced an investigation into the cause, manner and circumstances of death, as required by GC §27491, but although the death was unwitnessed and occurred under uncertain circumstances, no autopsy was ordered. The complainant requested in writing that the

Sheriff's Department arrange for an autopsy, but that request was refused. The complainant was compelled to procure a private autopsy in another county, some hours' drive away. The autopsy results were shared with the Sheriff's Department, but did not factor into the investigation report, which had already been completed.

In this case, the Sheriff's Department did not comply with GC §27520. Although a written request for an autopsy was provided by an appropriate next-of-kin, the Sheriff's Department failed to cause an autopsy to be performed as is required by that section, even though the complainant was obligated to pay for the autopsy under GC §27520.

The Grand Jury believes that one reason for this failure was the lack of any mention of GC §27520 in the Coroner P&Ps. While the Coroner P&Ps are intended to present the legal requirements associated with death investigations, they omitted any reference to this important section of the Government Code. This likely occurred because Section 27520 was originally enacted into law in 2008, while it appears that the Coroner P&Ps were last revised in 2007. In any event, this key policy omission was not caught and corrected by Sheriff's Department personnel, who assumed responsibility for the document by discontinuing the subscription with the manual's vendor.

Review of Selected Coroner Cases

The Grand Jury decided to undertake a review of a random sampling of Coroner Cases that appeared to fall within the scope of GC §27491, to gain a better understanding as to when autopsies have been obtained by the Coroner and to assess compliance by the Sheriff's Department with its own Coroner P&Ps. To do this, the Grand Jury first requested all death records from Plumas County Health Department (Public Health) for the time period of January 1, 2015 through December 31, 2019, looking specifically for cases handled by the Sheriff's Department. Public Health provided a list of all deaths in the County during that time, redacting personal information, but retaining the gender and ages of the decedents. This list also included cause of death and any complications, diseases or injuries leading to the cause of death as identified by the Coroner.

From January 1, 2015 through December 31, 2019, 359 death cases were handled by the Sheriff's Department. To arrive at a list focused on GC §27491, the Grand Jury set aside all obvious natural deaths. Of the 127 possible cases for review, after consultation with the Sheriff's Department as to feasibility of producing investigation reports for a given size of sample, the Grand Jury decided to use 26 cases as its sample group, all of which appeared to fall within GC §27491. It selected 25 cases, in addition to the complainant's case. Six cases were at that time shown as "pending" in the EDRS and there was no indication as to cause or manner of death; 19 were cases where the cause of death initially appeared unnatural (including suicides, exposures, drownings, and drug or alcohol related). The Grand Jury intended that a sample of this size would provide a sufficient indicator of Coroner performance in similar instances over the past five years.

The Sheriff's Department provided copies of the Coroner's investigation reports for the 26 cases with personal information redacted. The report copies included all the narrative and supplement information, but did not include medical records, death certificates, evidence, or photos. None of the cases reviewed were vehicle accidents or homicides, and no cases involving juveniles were reviewed. By agreement with the Sheriff's Department, none of the cases provided were ongoing investigations.

Of the 26 cases reviewed, one was determined to have been handled as a Coroner's Referral, as the decedent had been under a doctor's care, had a recently documented medical history, and the doctor signed the death certificate. This case was dropped from the sample, leaving 25 cases for the Grand Jury to review.

After reviewing each of the investigation reports for the selected cases and following up with the Sheriff's Department, the final causes of death were categorized against manner of death as follows:

Cause of Death	Accident	Natural	Suicide
Alcohol Abuse		5	
Carbon Monoxide Poisoning	1		
Cut Self			1
Drowning	3		
Exposure	3		
Gunshot wound			2
Hanging			1
Heart Disease		5	
Overdose	2		1
Thermal Injuries	1		

Based on the investigation reports, in all of the 25 cases deputies were dispatched to the scene and investigations were undertaken as Coroner's Cases.

The Grand Jury reviewed the 25 investigation reports for compliance with the Coroner P&Ps and GC §27463, including verifying whether the responding deputy completed a narrative summary and indicated how the cause of death was determined using medical records and other source materials. It was also noted whether an autopsy was procured. Among other things, it was confirmed whether the report indicated that the responding deputy obtained relevant medical records or reviewed the case with last known physician (as required by item 17 of subsection 360.3.6 of the Coroner P&Ps) and, if no autopsy was deemed necessary, whether a blood sample was obtained and forwarded to the Evidence Clerk (as required by item 20).

The table (Summary of Sampled Cases and Case Reports), which is in the Appendix to this report (Summary Table), provides a breakdown of the reviewed cases. It shows (i) the stated cause and manner of death, as shown in the final death certificate, (ii) whether the investigation

report provided a clear narrative as to the circumstances of the death, as determined by the Sheriff's Department, (iii) whether the Sheriff's Department requested medical records, (iv) whether an autopsy was conducted, (v) if no autopsy was conducted, whether a blood sample was taken, and (vi) the number of days that elapsed from the date of commencement of the Coroner's investigation until the final recording of the death certificate.

Observations from Case Reviews

The Grand Jury's review of the investigation reports for the sample cases yielded a number of interesting observations. In every case, the reports did evidence that a death investigation was commenced and conducted by the deputies, as required by both law and policy. However, additional findings were made difficult by a lack of detail and conclusiveness in many of the reports. For example, none of the reports expressly identified the cause and manner of death, and (as shown in the Summary Table) in about half of the cases they failed to provide a clear statement of the circumstances of the death. Instead, the reports often simply described the scene at which the decedent's body was discovered. While this is no doubt part of the assessment that GC §27491 contemplates in requiring that the coroner "inquire into and determine the circumstances... [of death]", clearly it is not all that is contemplated by the Government Code. It is unclear whether these omissions were a result of lack of certainty on the part of the Coroner as to the actual circumstances of death, or merely poor preparation of the reports by the reporting officer. If the former, then a question may arise as to whether an autopsy should have been ordered. See CDC Handbook, p. 13.

The Sheriff's Department did not adhere to GC §27463(e) in preparing its reports insofar as it failed to indicate in the reports both the cause of death and a reference to the medical reports upon which the cause of death is based. Pursuant to GC §27463(e), a member of the Sheriff's Department enters the cause of death with reference or direction to the detailed medical reports upon which the decision as to cause of death has been based. Where autopsies, toxicological reports or the like are being obtained, the CDC recommends in its coroner's handbook that a supplemental report be filed as soon as the investigation is complete (CDC Handbook, pp. 10, 22). The Grand Jury reviewed all 25 cases for compliance with GC §27463(e) and found there was no supplemental narrative statement supporting how the cause and manner of death was determined.

In addition, the sample reports failed to observe the CDC Handbook best practice standard noted above, in not clearly presenting the cause of death.

The Grand Jury was therefore unable to assess fully the process by which the Sheriff's Department arrived at its determinations as to cause, manner and circumstances of death, and the extent to which they made use of autopsy, toxicological and other technical data in reaching their conclusions.

Based on the reports reviewed, autopsies were obtained in 20% of the sample cases (5 of 25, not including the partial autopsy in Case 8). Autopsies were not obtained in connection with certain deaths where NAME Standards best practices suggest they ordinarily should be obtained—including death by fire, involving thermal injuries (Case 5), death by drowning (Case 24) and death resulting from alcohol or drug abuse (Cases 7, 14, 18, 21, 23, 26). Moreover, in only one of the suicides was an autopsy performed. Similarly, no autopsy was obtained in certain cases deemed “accidents” that were not observed—Cases 5, 17, 24. The reports do not indicate why it was felt there was no need for an autopsy in any of these instances.

It is the view of the Sheriff’s Department that the decision to obtain an autopsy is simply discretionary, and that this discretion is exercised by appropriate members of the Sheriff’s Department. The Grand Jury does not dispute that the decision to undertake an autopsy in California is (with the two exceptions noted above) one for professional judgment under the circumstances, but such discretion does not mean there is a complete absence of standards to be applied, or that the decision can be made arbitrarily or for inappropriate reasons, such as saving costs. Accordingly, it is appropriate for third parties such as the Grand Jury to try to assess the Sheriff’s Department performance in this area.

Under the terms of the Coroner P&Ps, if an autopsy is not ordered, investigating deputies must obtain a blood sample. Based on the review of the reports, there were seven instances where, although an autopsy was not ordered, no blood sample was taken. These cases included all three exposure cases as well as one suicide and the death during a structure fire. In the majority of these cases, the decedent hadn’t been seen for a while prior to death and the narratives usually only set forth how the victim was found. In about a third of the sample cases, the reports did not indicate whether medical records had been requested. The Coroner P&Ps provide that medical records should be obtained in all Coroner Cases.

Particularly in cases lacking an autopsy, blood sample results, and review of medical records (as in Cases 5, 13, 16), it is difficult to tell from the investigation report how the Sheriff’s Department determined with confidence the manner and cause of death.

Case Closures and Updating Pending Death Certificates

As noted above, near the beginning of the investigation, there were six cases in the sample listed as “Pending” in the EDRS. Follow up with the Sheriff’s Department revealed that these cases were considered “closed”. The EDRS system was not updated and it was determined that the Sheriff’s Department relied on the copies of medical records, toxicology or autopsy results as attachments to the report instead of referencing the findings in the report.

Based on the data provided by Public Health, on the dates the cases were recorded with the final determined cause and manner of death, there were multiple cases that took an extended amount of time to update. While cases that included an autopsy could expect to be delayed depending on how quickly the autopsy is completed, it would be reasonable to expect to wait no longer than

three months for results. Six of the 25 cases took longer than three months to update; one took nearly five years before it was updated, two took nearly two years to update and the other three were updated within a year from the date of death. Only one of these cases had an autopsy performed and one other case had a blood sample taken. There were no other circumstances documented in the reports to indicate why there were such lengthy delays. The CDC Handbook states that the cause of death should be updated “immediately” when known.

By the end of the Grand Jury’s investigation, it made a repeat inquiry and learned that five of the six cases originally classified as ‘pending’ in EDRS had been updated since January 2020. It may or may not be a coincidence that the Grand Jury had at that point been conducting interviews on this topic for some months.

A Final Note

The Grand Jury wishes to make abundantly clear that it is not averring that the Sheriff’s Department reached the determinations it apparently did in the 25 sample cases without reason, or that its death investigations were conducted negligently or inappropriately. Such a determination would require the input of experts in the relevant disciplines, which the Grand Jury did not seek or obtain as part of this particular investigation. Instead, the conclusion reached by the Grand Jury is that the coroner investigation reports that it reviewed did not contain sufficient detail or explanation to allow an outside observer to verify what conclusions the Sheriff’s Department arrived at as to cause, manner and circumstance of death, how it arrived at those conclusions, and where it seemingly did not comply with best practices or its own policies and procedures, what reasons it may have had for so doing. These information gaps are, in the view of the Grand Jury, significant and substantive, given the function and importance of coroner investigation reports. These reports, which are public documents, are the principal means members of the public have to assess the adequacy and care taken by the Sheriff’s Department in investigating the deaths of loved ones, and gauging whether there was uncertainty as to any of the determinations made. If these reports do not contain clearly articulated conclusions as to the cause, manner and circumstances of death, backed up by clear and persuasive reasoning and sources, the eventual result could well be loss of confidence by the public in the Coroner’s functions and processes. This would be in no one’s interest.

FINDINGS

F-1. The Sheriff’s Department failed to comply with GC §27520 when it did not facilitate an autopsy when one was requested in writing by an appropriate next-of-kin to the decedent. A major contributing factor to this failure was the lack of any mention of GC §27520 in the Sheriff’s Department Coroner P&Ps.

F-2. The Sheriff's Department Coroner P&Ps are lacking in that they do not provide concrete guidance as to when the Coroner's discretion should be exercised to obtain autopsies in connection with death investigations under GC §27491, nor do they reference best practices.

F-3. The sampled Coroner investigation reports lack necessary detail as to the determination of cause, manner and circumstances of death, and the basis for such determination, and did not shed light on the decision to forego autopsies in several instances in which best practices standards anticipate that autopsies would be obtained (including certain deaths involving fire, drowning, suicide, or alcohol or drug abuse).

F-4. The Sheriff's Department did not fully comply with GC §27463(e) in the sample case reports insofar as they did not show cause of death or document how the cause of death was determined.

F-5. The Sheriff's Department Coroner P&Ps risk becoming materially out of date in that they are not routinely reviewed and updated to ensure compliance with changing legal requirements.

F-6. The Sheriff's Department failed to update the cause of death in the EDRS in six reviewed cases within a reasonable amount of time after receiving necessary information.

RECOMMENDATIONS

Based on the foregoing, the Grand Jury recommends:

R-1. The Sheriff's Department amend its Coroner P&Ps to provide better and more concrete guidance, consistent with best practices, as to the circumstances that govern when the discretion of the Coroner should be exercised to obtain an autopsy, particularly in connection with deaths subject to GC §27491.

R-2. The Sheriff's Department amend its Coroner P&Ps to point out the Department's legal obligation under GC §27520, and to advise inclusion in a written communication to surviving next of kin of an advisory that an autopsy, if not otherwise obtained, will be conducted at their request and their expense.

R-3. The Sheriff's Department amend its Coroner P&Ps to add a directive to include in death investigation reports the determination as to cause, manner and circumstances of death for all deaths falling within GC §27491, and the reasons supporting such conclusions, as arrived at by the Coroner.

R-4. The Sheriff's Department amend its Coroner P&Ps to include a provision requiring annual reviews and updates of the Coroner P&Ps as needed to reflect changes in law and best practices.

R-5. The Sheriff's Department amend its Coroner P&Ps to include a policy ensuring that death records in a pending status are updated as soon as additional data is available to do so, and that investigation reports are supplemented promptly after receiving results of autopsies, toxicology reports and other procedures.

R-6. The Sheriff's Department institute yearly review of its Coroner P&Ps, to ensure compliance with updated legal requirements and best practices.

REQUIRED RESPONSES

Pursuant to Penal Code §933.05, the following responses are required:

From the following Plumas County official (within 60 days):

- Plumas County Sheriff-Coroner (**F-1 through F-6; R-1 through R-6**)

INVITED RESPONSES

The Grand Jury invites the following responses:

From the following Plumas County governing bodies and agency heads (requested within 90 days and 60 days, respectively):

- Plumas County Board of Supervisors (**F-1 through F-6; R-1 through R-6**)
- Director, Plumas County Department of Public Health (**F-1 through F-6**)

BIBLIOGRAPHY

Websites

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Centers for Disease Control: <https://www.cdc.gov/> and https://www.cdc.gov/nchs/data/misc/hb_me.pdf

National Association of Medical Examiners: <https://name.memberclick.net/>

Commission on Peace Officer Standards and Training: <https://post.ca.gov/basic-training-academies>

California State Association of Counties: <https://www.counties.org/county-office/sheriff-coroner>

U.C. Davis, School of Medicine: https://health.ucdavis.edu/informatics/seminar_series/pdfs/EDRS-UCD_01_08_20064.2%20hogarth%20final.pdf

APPENDIX

Summary of Sampled Cases and Case Reports

Case ID	Stated Cause of Death (Death Certificate)	Stated Manner of Death (Death Certificate)	Circumstances of Death Identified in Report?	Medical Records Requested?	Autopsy Done?	If no Autopsy done, blood sample taken?	Days to final Recording of Death Certificate
1	Arteriosclerotic and Hypertensive Cardiovascular disease	Natural	No	Yes	No	Yes	25
2	Drowning	Accident	No	Yes	Yes	[Autopsy]	98
3	Decedent cut self with a sharp instrument	Suicide	Yes	Yes	No	No	38
4	Chronic Obstructive Pulmonary Disease	Natural [Coroner's Referral]	n/a	n/a	n/a	n/a	n/a
5	Smoke inhalation and thermal injuries	Accident	No	Yes	No	No	238
6	Hypertensive, atherosclerosis, vascular disease	Natural	No	Yes	No	Yes	45
7	Overdose of prescription medication	Accident	Yes	Yes	No	Yes	34
8	Carbon Monoxide poisoning	Accident	No	Yes	Partial-lung sample only	No	1784
9	Asphyxiation by Hanging	Suicide	Yes	No	No	Yes	21
10	Cardiopulmonary arrest/dementia	Natural	No	Yes	No	No	71
11	Complications of chronic alcohol use	Natural	No	Yes	Yes	[Autopsy]	62
12	Drowning	Accident	No	Yes	Yes	[Autopsy]	127
13	Exposure	Accident	No	Yes	No	No	26
14	Long Term Ethanol Abuse	Natural	No	No	No	Yes	23
15	Cardiomegaly (enlarged heart)	Natural	No	Yes	Yes	[Autopsy]	119
16	Exposure	Accident	Yes	No	No	No	72
17	Exposure	Accident	No	Yes	No	No	9
18	Overdose of prescription medication	Accident	Yes	Yes	No	Yes	277
19	Hypertensive, atherosclerosis, vascular disease	Natural	Yes	Yes	No	Yes	82

Case ID	Stated Cause of Death (Death Certificate)	Stated Manner of Death (Death Certificate)	Circumstances of Death Determined in Report?	Medical Records Requested?	Autopsy Done?	If no Autopsy done, blood sample taken?	Days to final Recording of Death Certificate
20	Overdose	Suicide	Yes	No	Yes	Yes	80
21	Esophageal tear due to long term Ethanol abuse	Natural	Yes	Yes	No	Yes	13
22	Self-inflicted gunshot wound	Suicide	Yes	Yes	No	Yes	6
23	Long term ethanol abuse	Natural	No	Yes	No	Yes	6
24	Drowning	Accident	Yes	No	No	Yes	5
25	Self-inflicted gunshot wound	Suicide	Yes	No	No	Yes	5
26	History of chronic ethanol abuse	Natural	Yes	Yes	No	Yes	34

Selected Government Code Sections

24304.1. Notwithstanding the provisions of Section 24300, in counties of the 11th class, the board of supervisors by ordinance may consolidate the duties of certain of the county offices, in one or both of these combinations:

- (a) County clerk, assessor, and recorder.
- (b) Sheriff, coroner, and public administrator.

27463. The coroner shall keep an official register, labeled "Coroner's Register," with pages numbered, indexed and bound, in which he shall enter:

- (a) The name and any aliases of the deceased, when known, including such description as may be sufficient for identification and which may, in his discretion, include fingerprint records.
- (b) A narrative summary of the circumstances leading to and surrounding the death, together with names and addresses of any witnesses to such events.
- (c) The property taken from the person or premises of the deceased by the coroner or by any other law enforcement agency or officer.
- (d) The disposition of any property or moneys so taken.
- (e) The cause of death, when known, with reference or direction to the detailed medical reports upon which decision as to cause of death has been based.
- (f) Information as to disposition of the remains.

(g) Persons notified of the death, together with a notation of any unsuccessful attempts at notification.

27491. It shall be the duty of the coroner to inquire into and determine the circumstances, manner, and cause of all violent, sudden, or unusual deaths; unattended deaths; deaths where the deceased has not been attended by either a physician or a registered nurse, who is a member of a hospice care interdisciplinary team, as defined by subdivision (g) of Section 1746 of the Health and Safety Code in the 20 days before death; deaths related to or following known or suspected self-induced or criminal abortion; known or suspected homicide, suicide, or accidental poisoning; deaths known or suspected as resulting in whole or in part from or related to accident or injury either old or recent; deaths due to drowning, fire, hanging, gunshot, stabbing, cutting, exposure, starvation, acute alcoholism, drug addiction, strangulation, aspiration, or where the suspected cause of death is sudden infant death syndrome; death in whole or in part occasioned by criminal means; deaths associated with a known or alleged rape or crime against nature; deaths in prison or while under sentence; deaths known or suspected as due to contagious disease and constituting a public hazard; deaths from occupational diseases or occupational hazards; deaths of patients in state mental hospitals serving the mentally disabled and operated by the State Department of State Hospitals; deaths of patients in state hospitals serving the developmentally disabled and operated by the State Department of Developmental Services; deaths under such circumstances as to afford a reasonable ground to suspect that the death was caused by the criminal act of another; and any deaths reported by physicians or other persons having knowledge of death for inquiry by coroner. Inquiry pursuant to this section does not include those investigative functions usually performed by other law enforcement agencies.

(a) In any case in which the coroner conducts an inquiry pursuant to this section, the coroner or a deputy shall personally sign the certificate of death. If the death occurred in a state hospital, the coroner shall forward a copy of his or her report to the state agency responsible for the state hospital.

(b) The coroner shall have discretion to determine the extent of inquiry to be made into any death occurring under natural circumstances and falling within the provisions of this section, and if inquiry determines that the physician of record has sufficient knowledge to reasonably state the cause of a death occurring under natural circumstances, the coroner may authorize that physician to sign the certificate of death.

(c) For the purpose of inquiry, the coroner shall have the right to exhume the body of a deceased person when necessary to discharge the responsibilities set forth in this section.

(d) Any funeral director, physician, or other person who has charge of a deceased person's body, when death occurred as a result of any of the causes or circumstances described in this section, shall immediately notify the coroner. Any person who does not notify the coroner as required by this section is guilty of a misdemeanor.

27491.41. (a) For purposes of this section, "sudden infant death syndrome" means the sudden death of any infant that is unexpected by the history of the infant and where a thorough postmortem examination fails to demonstrate an adequate cause of death.

(b) The Legislature finds and declares that sudden infant death syndrome, also referred to as SIDS, is the leading cause of death for children under age one, striking one out of every 500 children. The Legislature finds and declares that sudden infant death syndrome is a serious problem within the State of California, and that the public interest is served by research and study of sudden infant death syndrome and its potential causes and indications.

(c) (1) To facilitate these purposes, the coroner shall, within 24 hours or as soon thereafter as feasible, cause an autopsy to be performed in any case where an infant has died suddenly and unexpectedly.

(2) However, if the attending licensed physician and surgeon desires to certify that the cause of death is sudden infant death syndrome, an autopsy may be performed at the discretion of the coroner. If the coroner causes an autopsy to be performed pursuant to this section, he or she shall also certify the cause of death.

(d) The autopsy shall be conducted pursuant to a standardized protocol developed by the State Department of Public Health. The protocol is exempt from the procedural requirements pertaining to the adoption of administrative rules and regulations pursuant to Article 5 (commencing with Section 11346) of Chapter 3.5 of Part 1 of Division 3 of Title 2 of the Government Code.

(e) The protocol shall be followed by all coroners throughout the state when conducting an evaluation as part of an autopsy required by this section. The coroner shall state on the certificate of death that sudden infant death syndrome was the cause of death when the coroner's findings are consistent with the definition of sudden infant death syndrome specified in the standardized autopsy protocol. The protocol may include requirements and standards for scene investigations, requirements for specific data, criteria for ascertaining cause of death based on the autopsy, and criteria for any specific tissue sampling, and any other requirements. The protocol may also require that specific tissue samples shall be provided to a central tissue repository designated by the State Department of Public Health.

(f) The State Department of Public Health shall establish procedures and protocols for access by researchers to any tissues, or other materials or data authorized by this section. Research may be conducted by any individual with a valid scientific interest and prior approval from the State Committee for the Protection of Human Subjects. The tissue samples, the materials, and all data shall be subject to the confidentiality requirements of Section 103850 of the Health and Safety Code.

(g) The coroner may take tissue samples for research purposes from infants who have died suddenly and unexpectedly without consent of the responsible adult if the tissue removal is not likely to result in any visible disfigurement.

(h) A coroner or licensed physician and surgeon shall not be liable for damages in a civil action for any act or omission done in compliance with this section.

(i) Consent of any person is not required before undertaking the autopsy required by this section.

27520. (a) The coroner shall cause to be performed an autopsy on a decedent, for which an autopsy has not already been performed, if the surviving spouse requests him or her to do so in writing. If there is no surviving spouse, the coroner shall cause an autopsy to be performed if