San Mateo County Coroner
2021 Annual Report

Robert J. Foucrault
Coroner

(This page intentionally left blank)

Table of Contents

Introduction **4**
San Mateo County Coroner Staff **9**
San Mateo County Organizational Chart **10**
Reportable Criteria **11**
Statistics for Calendar Year 2021 ..... **15**
General Classifications of Death by Month **17**
Historical Statistics **18**
Natural Deaths **23**
Suicide Deaths **26**
Accident Deaths **29**
Motor Vehicle Fatalities **32**
Homicide Deaths **34**
Undetermined Deaths **37**
Outside Jurisdiction **38**
Indigent Cremations **39**

The mission of the Coroner's Office is to serve the residents of San Mateo County by providing prompt independent investigations to determine the cause and manner of death of decedents under the Coroner's jurisdiction and to provide high quality service in a courteous manner balancing the needs of residents with the Coroner's legal requirement.

Introduction

The Coroner's Office conducts medicolegal death investigations to determine the cause, manner, and circumstances of deaths meeting criteria as defined in California Government Code §27491 and California Health and Safety Code §102850.

According to the United States Census Bureau, San Mateo County was estimated to have a population of 737,888 in 2021, which decreased 3.47% from 764,442 in 2020. There were 5,861 deaths recorded in San Mateo County in 2021 which increased 2.20% from 2020 (5,735 deaths in 2020). Of these deaths, 2,258 deaths were reported to the Coroner's Office which decreased by two cases (2,260 in 2020). After initial investigation, 644 were determined to be full Coroner cases with the final cause of death signed by the Coroner, or his designated authority; this decreased 1.38% from 653 in 2020.

This 2021 Annual Report provides an overview of the work performed by San Mateo County Coroner's Office including a statistical breakdown of the types of deaths that occurred within San Mateo County for the year of 2021.

Updates & Accomplishments
In 2021, the Coroner's Office Investigations Division returned to a 24-hour staffed office moving away from the on-call deputy coroner between midnight and 6:00 a.m. resulting in more timely response to scene investigations and around-the-clock service to our community and neighboring agencies for notification requests.

Impact of Coronavirus on the Coroner's Office
There was a slight increase in reportable cases from 1,607 in 2020 to 1,614 in 2021 and a decrease in accepted cases from 653 in 2020 to 644 in 2021.

On April 2, 2020, the Coroner's Office began submitting Covid-19 swabs from decedents brought into the jurisdiction of the office when possible. In 2021 a total of 558 cases brought into the jurisdiction of the Coroner's Office were swabbed for Covid-19 and 40 cases were Covid-19 positive. 17 deaths were determined to be a result of Covid-19.

Suicide Decrease
Suicide deaths were down 34.1% from 2020 (54 in 2021 versus 82 in 2020). There were five times as many male suicide deaths than female suicide deaths (45 to 9). The three most common modes of death were hanging (22 cases), firearm (11 cases), and jumping (7 cases).

Accident Increase – due to increase in alcohol and drug related deaths
Accidental deaths were up 5% from 2020 (233 in 2021 versus 222 in 2020). The total number of motor vehicle accidents remained almost the same in 2021 (34 in 2021 versus 36 in 2020). Overdoses were up 13.5% from 2020 (134 in 2021 versus 118 in 2020). Of the 134 accidental overdoses, 83 tested positive for opioids and of those, 71 cases tested positive for fentanyl.

Homicide Decrease
San Mateo County saw a 13.6% decrease in homicides in 2021 (19 in 2021 versus 22 in 2020). 11 of the 19 homicides occurred in males between the ages of 20 and 40 years old.

Transient Deaths
There were 36 decedents identified as transient in San Mateo County. Of those 36 deaths, one was mannered homicide, 3 were mannered suicide, 17 were mannered accident (including 10 opioid overdoses with 9 fentanyl related cases and 2 non-opioid related overdoses), 13 were mannered natural, 1 was mannered undetermined and 1 case is pending.

2021 Accomplishments

New Case Management System (CME)

- After over three years of analysis, strategic planning, and testing, the Coroner's Office went live with a new Case Management System in May 2021. The transition accomplished two significant goals for the Office; greater security for the County network and upgraded software and hardware to current technological standards. The Coroner's Office also deployed new technology bringing advancement for deputies in the field and in the office to enable more timely identifications of decedents and notifications to next of kin.

Rugged Laptops and Smart Phones for Investigators

- In June 2021, the Coroner's Office resumed normal business operations by re-opening its doors to serve the residents of San Mateo County by preparing the family room, accepting will-call report pick-ups and walk-ins, and scheduling in-person meetings to answer general questions the return of property to next of kin.

- The Coroner's Office continued to partner with the California Department of Public Health for the reporting of statistics for violent deaths and opioid overdoses on a national level.

- The Coroner's Office continued to collaborate with partner agencies by meeting virtually to discuss untimely Child Deaths, Elder Deaths, and deaths related to Domestic Violence.

- The Coroner's Office staff participated in the Jump for Joy Employee Wellness Recreation Event

- As part of the County's C.A.R.E Initiative for Employees, the Coroner's Office established the Coroner Employee Book Exchange program to benefit the employee wellness of the staff.

Employee Wellness: Book Exchange

Pursuing John and Jane Doe Identifications

- In collaboration with local law enforcement, two local cemeteries, and a forensic anthropologist, the Coroner's Office directed disinterment of two unidentified persons for the purpose of DNA extraction and anthropological examination. Both cases, from John and Jane Doe cases dating back to the 1960's and 1970's, were of interest to local law enforcement hoping for new leads in their cold cases investigations. Once the DNA was extracted the remains were reinterred. To date, the identifications are still pending.

- Coroner's Office employees assisted with more than six of San Mateo County's COVID-19 vaccination clinics at the San Mateo County Event Center and the San Francisco International Airport.

Coroner Employee Assisting at Vaccination Clinics
Photo credit: Mercury News

- The Coroner's Office continued to be an active participant in the community by participating in a virtual youth Teazer event in January 2021 hosted by the FYI-Project Rocks to talk to Ralston Middle School students about forensic science and the Coroner's Office. Another staff member presented virtually to Seattle Pacific University's Introduction to Forensic Science class regarding medicolegal death investigation in February 2021. In November 2021, a staff member was the guest lecturer for College of San Mateo's Introduction to Forensic Science class via Zoom.

Community Participation: Forensic Autopsy Technician presenting to Ralston Middle School Students

- The Coroner's Office pursued continued training in Missing and Unidentified Persons Investigations hosted by the California Department of Justice in November 2021. Two staff members attended the California State Coroners Association Advanced Symposium in September 2021. Multiple staff members received training in the following topics both virtually and in person: Wills, Trusts, and Probate Codes, Narcan Training, Electronic Death Registration Training, the County Leadership Forum, and Implicit Bias training throughout the year.

- The Coroner's Office achieved compliance with the Department of Justice for the reporting requirements of the AB953/Racial and Identity Profiling Advisory Board (RIPA).

- The Coroner's Office ended the year fully staffed – the first time in many years for the office. The Coroner's Office successfully filled one full-time vacancy for Deputy Coroner

through internal promotion, two full-time vacancies for administration staff (Office Assistant II and Senior Accountant II), and one full-time vacancy for Forensic Autopsy Technician through the civil service interview process during the year.

- The Coroner's Office continued to support specialized medicolegal death investigation training through American Board of Medicolegal Death Investigators (ABMDI) and California Peace Officer Standards & Training (POST) for staff members:
    - One Deputy Coroner completed a 24-hour POST PC 832 Firearms Familiarization training and 80-hour POST Basic Death Investigation training as part of their basic training requirements as a deputy coroner.
    - The Supervising Deputy Coroner completed the 80-hour POST "Supervisory Course."
    - The Supervising Deputy Coroner earned her Advanced POST Certification.

Coroner Employee completing basic POST Training

(This page intentionally left blank)

San Mateo County Coroner 2021 Staff

Administration

Robert J. Foucrault	Coroner
Christi Canclini	Executive Assistant
K'Lynn Solt	Chief Deputy Coroner
Luz Paran-Rey	Senior Accountant II (Dec, position reclassified)
Cara Behrens	Office Assistant I/II (April-Dec)
Elizabeth Ortiz	Supervising Deputy Coroner
Joseph Begovich	Coroner Intern (Extra Help) (Jan-March
Annette Trujillo	Coroner Intern (Extra Help) (Jan-May)
Alyssa Terwilliger	Coroner Intern (Extra Help)

Investigations

Holly Benedict	Deputy Coroner
Hastin Stein	Deputy Coroner
Danielle Montesano	Deputy Coroner
Alana Stark	Deputy Coroner
Heather Diaz	Deputy Coroner
Laura Bailey	Deputy Coroner
Michelle Schabinger	Deputy Coroner (Oct-Dec)
Eden Washburn	Deputy Coroner (Extra-Help) (Nov-Dec)

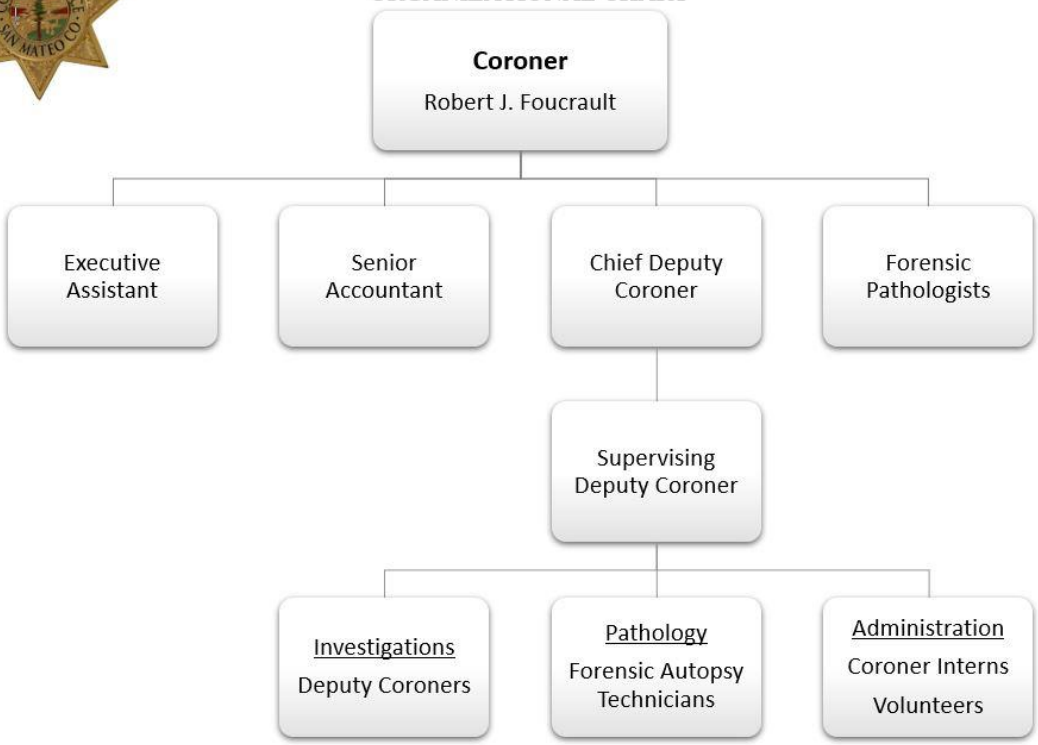
Pathology

Alina Revilla	Forensic Autopsy Technician (Full Time)
Michelle Schabinger	Forensic Autopsy Technician (Full Time) (Jan-Oct)
Irais Lopez	Forensic Autopsy Technician (Extra Help)
German Diaz Moreno	Forensic Autopsy Technician (Extra Help) (Nov-Dec)
Kathryn Nogaki	Forensic Autopsy Technician (Full Time) (Dec)

Contractors

Thomas Rogers, M.D.	Forensic Pathologist
Forensic Doctors Group	
Michael Hunter, M.D.	Forensic Pathologist
Louis Pena, M.D.	Forensic Pathologist
Katherine Raven, M.D.	Forensic Pathologist

County of San Mateo
CORONER'S OFFICE
ORGANIZATIONAL CHART



Reportable Criteria
Part 1 of 3

California Government Code §27491 and Health and Safety Code §102850 direct the authority and duty of the Coroner to inquire into and determine the circumstances, manner, and cause of the following deaths which are immediately reportable:

1. When a death is not in the attendance of a physician or during the continued absence of the qualifying physician. This includes deaths outside hospitals and nursing care facilities. This includes deaths which occur without attendance of a physician, such as when there is no history of medical attention of the deceased or when attention was so remote as to afford no knowledge in relation to the cause of death, the death is reportable. The Coroner/Deputy Coroner will determine the extent of the investigation, depending on the nature and gravity of the illness preceding death, and upon the physician's opinion of the patient's actual life expectancy at the time of the physician's last visit. If, during or after the investigation, it is ascertained that the death is due to natural causes and that there is a physician who is qualified and willing, the Coroner/Deputy Coroner will release the case to the physician for his/her certification and signature, and the custody of the body will be retained by the family for removal to a private mortuary of the family's choice. For a physician to qualify certifying and signing a Certificate of Death, the physician must have sufficient knowledge to reasonable state the cause of death occurring under natural circumstances.

A patient in a hospital is always considered as being in attendance. It is not necessary that the physician attend the patient for a period of 24 hours prior to death in order to sign the Certificate of Death. On natural deaths, a physician may be qualified to sign a Certificate of Death provided he/she attended the patient for a sufficient time to properly diagnose the case and to opine the cause of death. While it has been the practice to report any and hospital deaths, which occur within 24 hours of admission, this practice is not required by state law. If a hospital has an administrative policy of reporting cases to the Coroner/Deputy Coroner when a patient dies within 24 hours after admittance, the Coroner/Deputy Coroner will discuss the case with the attending physician; however, may not accept the case for investigation.

2. Wherein the deceased has not been attended by a physician in the 20 days prior to death. The word "attended" means that the patient must have been professionally followed by the physician. When the physician notifies the Coroner/Deputy Coroner, he/she will decide the extent of the investigation, depending on the nature and gravity of the illness preceding death, and upon the physician's opinion of the patient's actual life expectancy at the time of the physician's last visit. Cooperation and consultation between the Coroner/Deputy Coroner and the physician may provide cause; however, if the doctor's prior knowledge of the subject could not be applied to the death, then the Coroner/Deputy Coroner would pursue additional investigation.

Reportable Criteria
Part 2 of 3

3. When the physician is reasonably unable to state the cause of death or when the death is sudden and unexpected. The physician reporting the case must have a reasonable basis for his/her opinion. *The physician cannot be simply unwilling to state the cause of death*.

4. Known or suspected homicides.

5. Known or suspected suicides.

6. Associated with a known or alleged rape.

7. Involving any criminal act or suspicion of a criminal act. This would include instances where there is evidence or suspicion of criminal abortion (self-induced or by the act of another), euthanasia, or the later result of an accident. This would cover deaths under such circumstances as to afford reasonable grounds to suspect that the death was caused by the criminal act of another.

8. Following an accident or injury. Whether an accident or injury caused the death immediately or even a considerable time later, the case is reportable. Whether the accident or injury was of grave nature or only slight, so long as it *is the opinion of the attending or reporting physician that it might have contributed to the death in any degree.*

If the injury is to be listed anywhere on the Certification of Death, as contributory even though not the immediate cause of death, the case must be reported to the Coroner's Office. When, in the opinion of the physician, the injury is so slight that he/she does not believe that it contributed to the death, it is best to report such deaths so the Coroner/Deputy Coroner may decide whether any criminal, civil or legal consideration enters into the case that may require further investigation. Particularly, when a second party may have liability for the occurrence, the Coroner/Deputy Coroner will weigh the circumstances to ascertain whether any authorized public purpose or any aid to the administration of justice between involved parties will be served by full coroner involvement.

9. A death relating to a known or suspected drowning, hanging, gunshot, stabbing, cutting, starvation, exposure, drug overdose, fire, and strangulation.

10. Aspirations are reportable. The law accepts that a terminal aspiration can occur during the mechanics of death from a primary natural condition. *The local registrar rejects any Certificate of Death that indicates aspiration was a contributing factor in the death unless the death has been reported to the Coroner/Deputy Coroner.*

11. Intra-operative deaths. The Coroner/Deputy Coroner will determine whether an investigation is warranted. If the operative death is due to a misadventure or procedural problem than it would typically be considered an unnatural death and is reportable.

Reportable Criteria
Part 3 of 3

Deaths in operating rooms and deaths when a patient has not fully recovered from an anesthetic, whether in surgery, the recovery room or elsewhere. The Coroner's Office will proceed with a complete death investigation, when the nature of the death or legal implications warrants it.

12. Suspected accidental or intentional deaths by poisoning (food, chemical, drugs, therapeutic agent, etc.). Deaths, wholly or in part, due to industrial agents or toxins, ordinary food poisonings, household medications, prescribed pharmaceuticals and biological agents, are reportable when these circumstances in any way directly contributed to the death.

13. Known or suspected contagious disease and constituting a public hazard. If there was not sufficient time to diagnose and confirm a case in the hospital, then the death should be referred to the Coroner/Deputy Coroner. Deaths from a contagious disease will be reported to the Coroner/Deputy Coroner.

14. When a death is clearly known to be due to, wholly or in part, an occupational disease or injury, that death is reportable.

15. In deaths of unknown or unidentified persons.

16. Suspected sudden infant death syndrome (SIDS) deaths. Any unexpected deaths of apparent healthy, thriving infants under the age of one year. Any deaths as a result of sleep related asphyxia.

17. Fetal deaths when gestation period is 20 weeks or longer.

18. Deaths while a decedent was incarcerated. This includes in-custody and police involved deaths.

19. Patients who are found comatose or remain comatose during their hospital admission and then die are reportable.

(This page intentionally left blank)

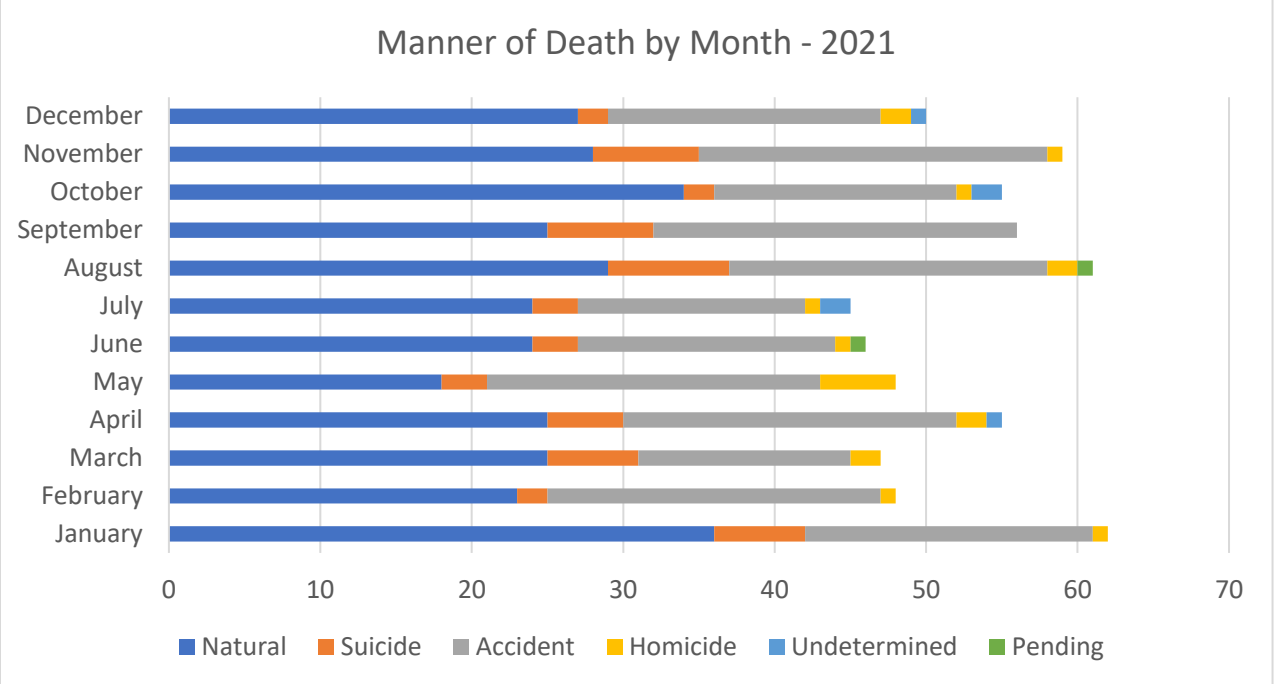
Statistics for Calendar Year 2021

Number of deaths reported:	2,258
Number of cases for full investigation:	644
Private autopsies: 3	
Indigent cremation referral only: 10	
No-post cases: 50	
Co-sign cases: 32	
Other: 8	
Non-human remains: 5	
Native American remains: 1	
Found/abandoned cremains: 2	
Number of cases investigated at scene and released:	123
Number of mutual aid requests for death notifications:	38
Number of cases by manner of death:	
Natural	318
Accident	233
Suicide	54
Homicide	19
Undetermined	6
Pending Investigation	2
Number of decedents transported:	
Coroner	548
Contractor	48
Mortuary/Funeral Home/Other	15
Forensic Examinations:	
Full Autopsy	360
Limited Autopsy	48
Clinical Review	116
Specialized (SUIDS / Homicide)	26
Hospital Autopsies	0
Number of cases where toxicology was conducted:	358
Number of cases reported as "unidentified":	102
Identified after investigation	102

Organ and tissue donations:	
Cases referred for donation	1,241
Total organ donors	16
Total organs transplanted	35
Total tissue donors	77
Exhumations:	2

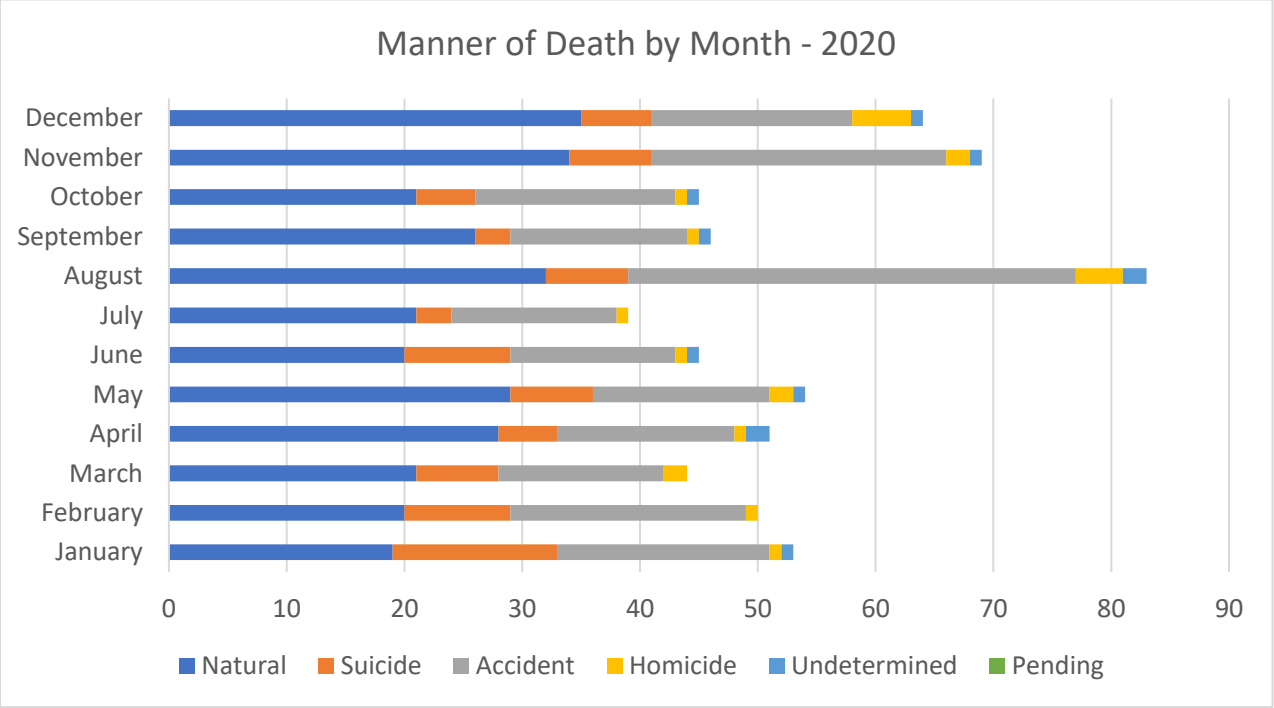
General Classifications of Death by Month

Coroner Case Statistics for 2021 by Month							
	Natural	**Suicide**	**Accident**	**Homicide**	**Undetermined**	**Pending**	**Total**
January	36	6	19	1	0	0	62
February	23	2	22	1	0	0	48
March	25	6	14	2	0	0	47
April	25	5	22	2	1	0	55
May	18	3	22	5	0	0	47
June	24	3	17	1	0	1	46
July	24	3	15	1	2	0	45
August	29	8	21	2	0	1	61
September	25	7	24	0	0	0	56
October	34	2	16	1	2	0	55
November	28	7	23	1	0	0	59
December	27	2	18	2	1	0	50
Total	318	54	233	19	6	2	631



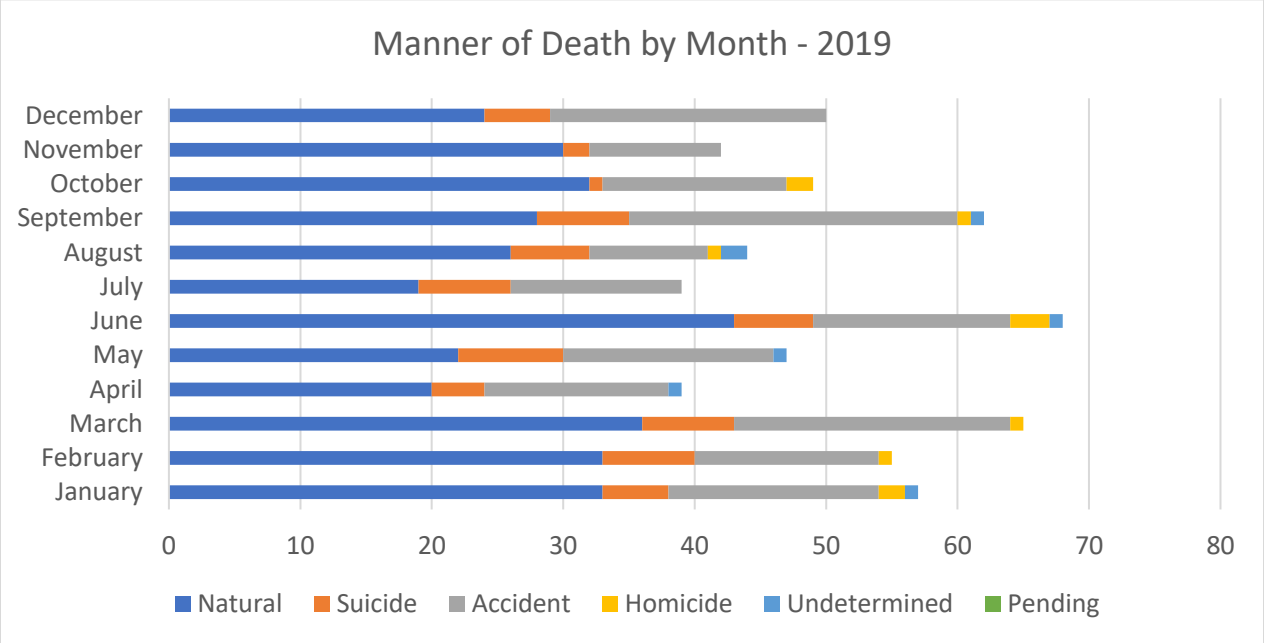
Historical Statistics

Coroner Case Statistics for 2020 by Month							
	Natural	**Suicide**	**Accident**	**Homicide**	**Undetermined**	**Pending**	**Total**
January	19	14	18	1	1	0	53
February	20	9	20	1	0	0	50
March	21	7	14	2	0	0	44
April	28	5	15	1	2	0	51
May	29	7	15	2	1	0	54
June	20	9	14	1	1	0	45
July	21	3	14	1	0	0	39
August	32	7	38	4	2	0	83
September	26	3	15	1	1	0	46
October	21	5	17	1	1	0	45
November	34	7	25	2	1	0	69
December	35	6	17	5	1	0	64
Total	306	82	222	22	11	0	643



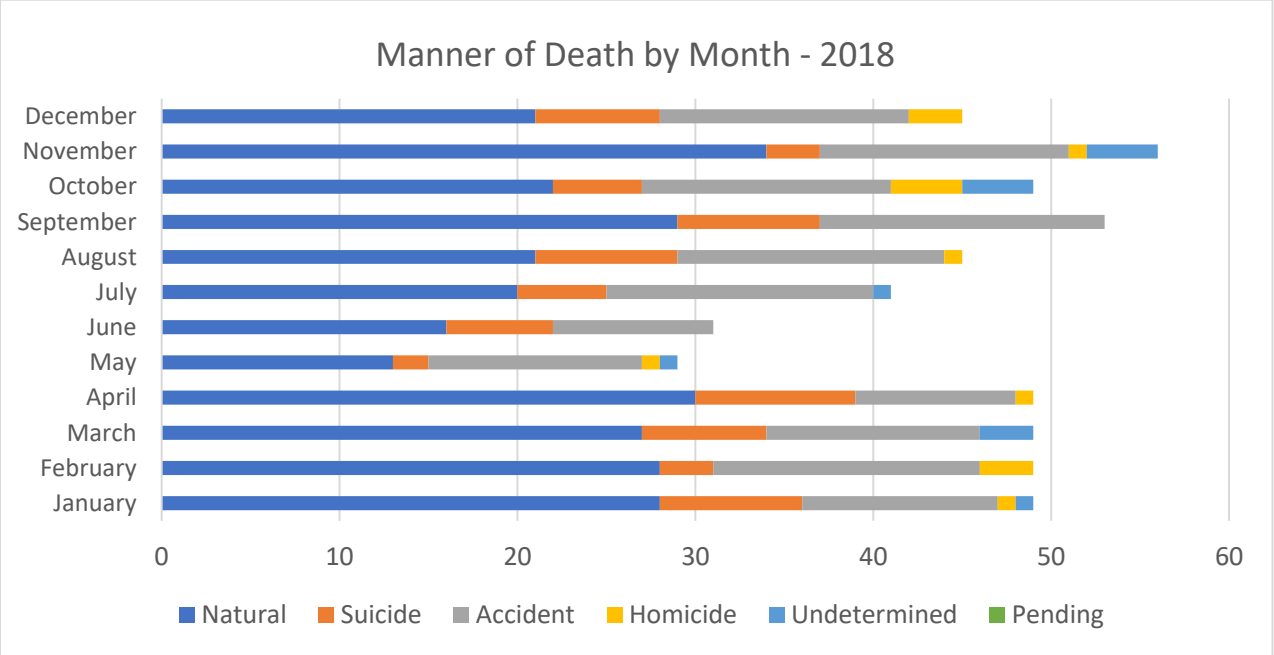
Historical Statistics (continued)

Coroner Case Statistics for 2019 by Month							
	Natural	**Suicide**	**Accident**	**Homicide**	**Undetermined**	**Pending**	**Total**
January	33	5	16	2	1	0	57
February	33	7	14	1	0	0	55
March	36	7	21	1	0	0	65
April	20	4	14	0	1	0	39
May	22	8	16	0	1	0	47
June	44	6	15	3	1	0	69
July	19	7	13	0	0	0	39
August	26	6	9	1	2	0	44
September	28	7	25	1	1	0	62
October	32	1	14	2	0	0	49
November	30	2	10	0	0	0	42
December	24	5	21	0	0	0	50
Total	347	65	188	11	7	0	618



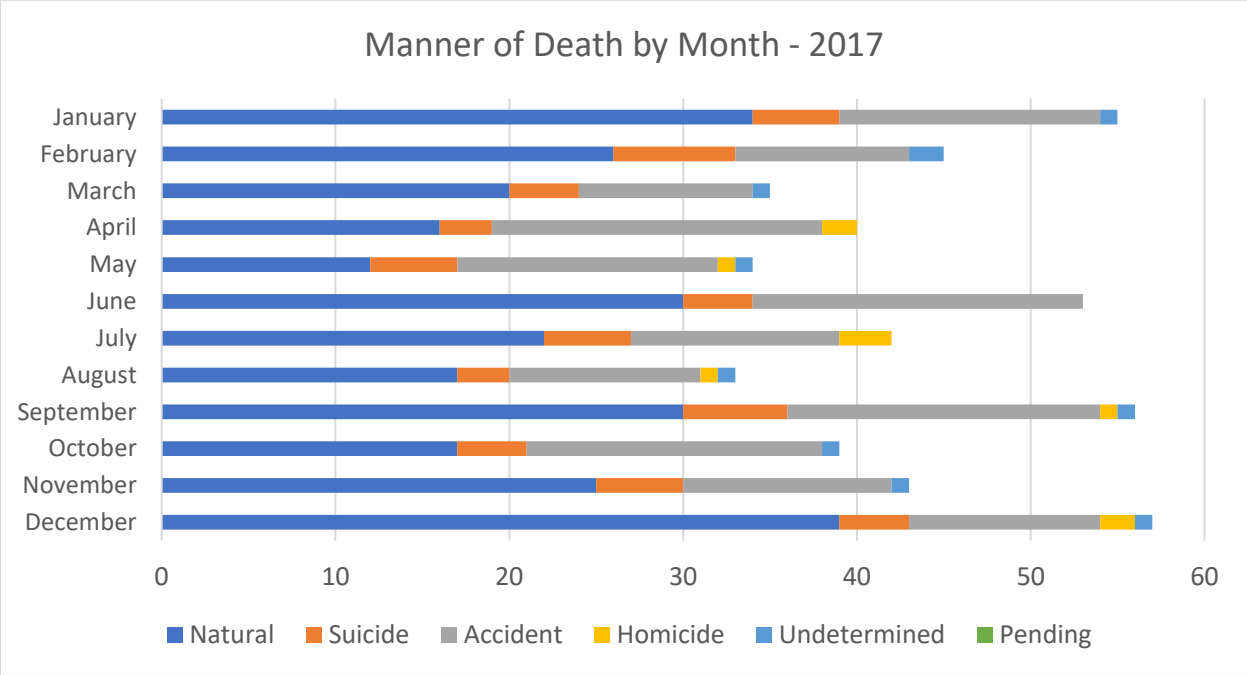
Historical Statistics (continued)

Coroner Case Statistics for 2018 by Month							
	Natural	**Suicide**	**Accident**	**Homicide**	**Undetermined**	**Pending**	**Total**
January	28	8	11	1	1	0	49
February	28	3	15	3	0	0	49
March	27	7	12	0	3	0	49
April	30	9	9	1	0	0	49
May	13	2	12	1	1	0	29
June	16	6	9	0	0	0	31
July	20	5	15	0	1	0	41
August	21	8	15	1	0	0	45
September	29	8	16	0	0	0	53
October	22	5	14	4	4	0	49
November	33	3	15	1	4	0	56
December	21	7	14	3	0	0	45
Total	288	71	157	15	14	0	545



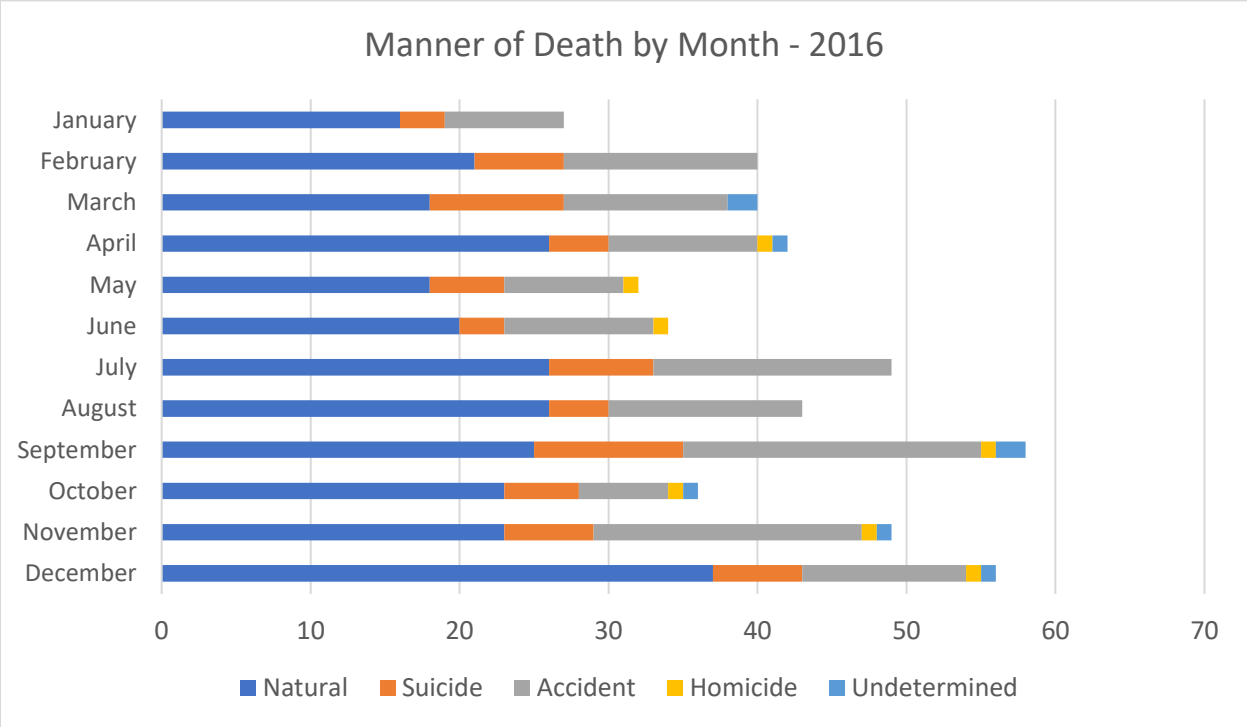
Historical Statistics (continued)

Coroner Case Statistics for 2017 by Month							
	Natural	**Suicide**	**Accident**	**Homicide**	**Undetermined**	**Pending**	**Total**
January	34	5	15	0	1	0	55
February	26	7	10	0	2	0	45
March	20	4	10	0	1	0	35
April	16	3	19	2	0	0	40
May	12	5	15	1	1	0	34
June	30	4	19	0	0	0	53
July	22	5	12	3	0	0	42
August	17	3	11	1	1	0	33
September	30	6	18	1	1	0	56
October	17	4	17	0	1	0	39
November	25	5	12	0	1	0	43
December	39	4	11	2	1	0	57
Total	288	55	169	10	10	0	532



Historical Statistics (continued)

Coroner Case Statistics for 2016 by Month							
	Natural	**Suicide**	**Accident**	**Homicide**	**Undetermined**	**Pending**	**Total**
January	16	3	8	0	0	0	27
February	21	6	13	0	0	0	40
March	18	9	11	0	2	0	40
April	26	4	10	1	1	0	42
May	18	5	8	1	0	0	32
June	20	3	10	1	0	0	34
July	26	7	16	0	0	0	49
August	26	4	13	0	0	0	43
September	25	10	20	1	2	0	58
October	23	5	6	1	1	0	36
November	23	6	18	1	2	0	50
December	37	6	12	1	1	0	57
Total	279	68	145	7	9	0	508



Natural

Natural deaths are due solely or nearly totally to disease and/or the aging process.

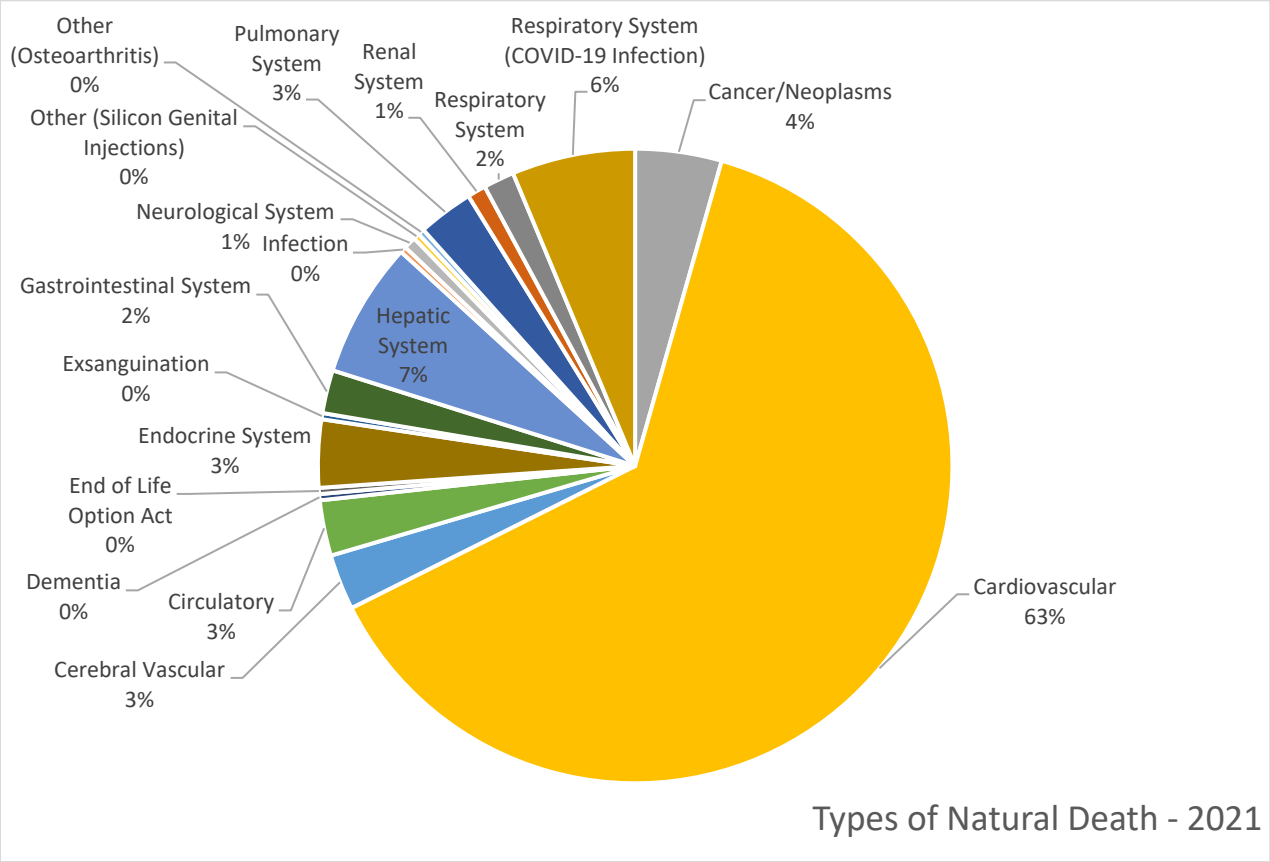
Total Natural Deaths in 2021: 318

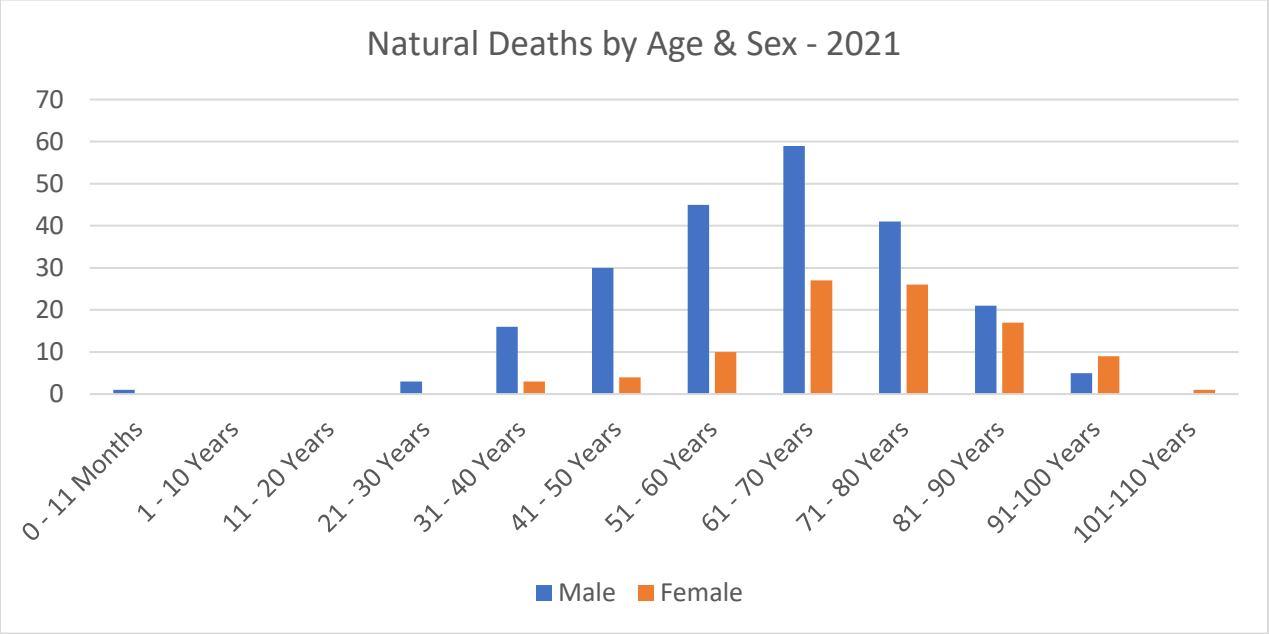
Types of Natural Deaths by Sex			
Types of Natural Deaths	**Total**	**Male**	**Female**
Cancer/Neoplasms	14	7	7
Cardiovascular	201	142	59
Cerebral Vascular	9	6	3
Circulatory	9	3	6
Dementia	1	0	1
Congenital			
End of Life Option Act	1	1	0
Endocrine System	11	8	3
Exsanguination	1	0	1
Gastrointestinal System	7	7	0
Hepatic System	22	17	5
Infection	1	0	1
Neurological System	2	2	1
Other (Silicon Genital Injections)	1	1	0
Other (Osteoarthritis)	1	0	1
Pulmonary System	9	6	3
Renal System	3	2	1
Respiratory System	5	5	0
Respiratory System (COVID-19 Infection)	20	14	6

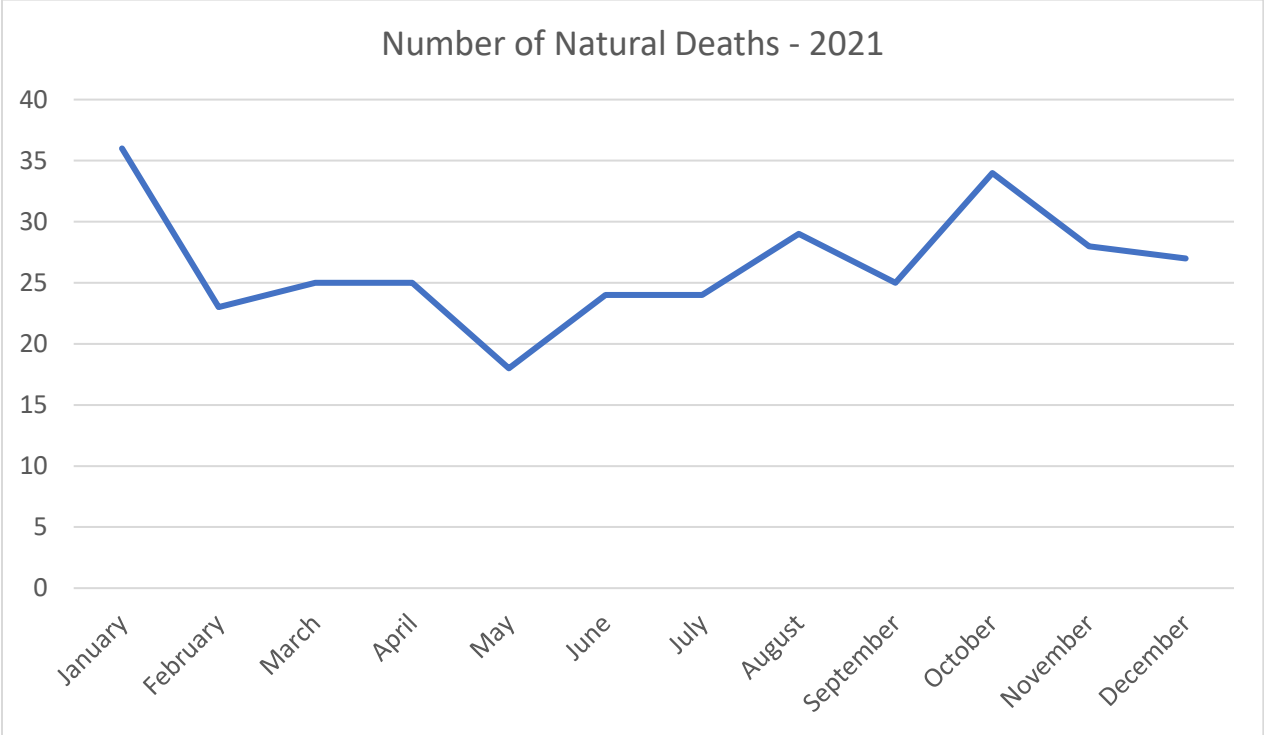
Natural Deaths by Month	
Month	**Number of Natural Deaths**
January	36
February	23
March	25
April	25
May	18
June	24
July	24
August	29
September	25
October	34
November	28
December	27

Natural Deaths by Age & Sex					
Age	**Male**	**Female**	**Age**	**Male**	**Female**
0 - 11 Months	1	0	51 - 60 Years	45	10
1 - 10 Years	0	0	61 - 70 Years	59	27
11 - 20 Years	0	0	71 - 80 Years	41	26
21 - 30 Years	3	0	81 - 90 Years	21	17
31 - 40 Years	16	3	91-100 Years	5	9
41 - 50 Years	30	4	101-110 Years	0	1

Natural


Other (Osteoarthritis) 0%
Pulmonary System 3%
Renal System 1%
Respiratory System (COVID-19 Infection) 6%
Respiratory System 2%
Cancer/Neoplasms 4%
Other (Silicon Genital Injections) 0%
Neurological System 1%
Infection 0%
Gastrointestinal System 2%
Hepatic System 7%
Exsanguination 0%
Endocrine System 3%
End of Life Option Act 0%
Dementia 0%
Circulatory 3%
Cerebral Vascular 3%
Cardiovascular 63%
Types of Natural Death - 2021


Natural Deaths by Age & Sex - 2021
70
60
50
40
30
20
10
0
0 - 11 Months
1 - 10 Years
11 - 20 Years
21 - 30 Years
31 - 40 Years
41 - 50 Years
51 - 60 Years
61 - 70 Years
71 - 80 Years
81 - 90 Years
91-100 Years
101-110 Years
Male
Female


Number of Natural Deaths - 2021
40
35
30
25
20
15
10
5
0
January
February
March
April
May
June
July
August
September
October
November
December

Suicide

Suicides result from an injury or poisoning as a result of an intentional, self-inflicted act committed to do self-harm or cause the death of oneself.

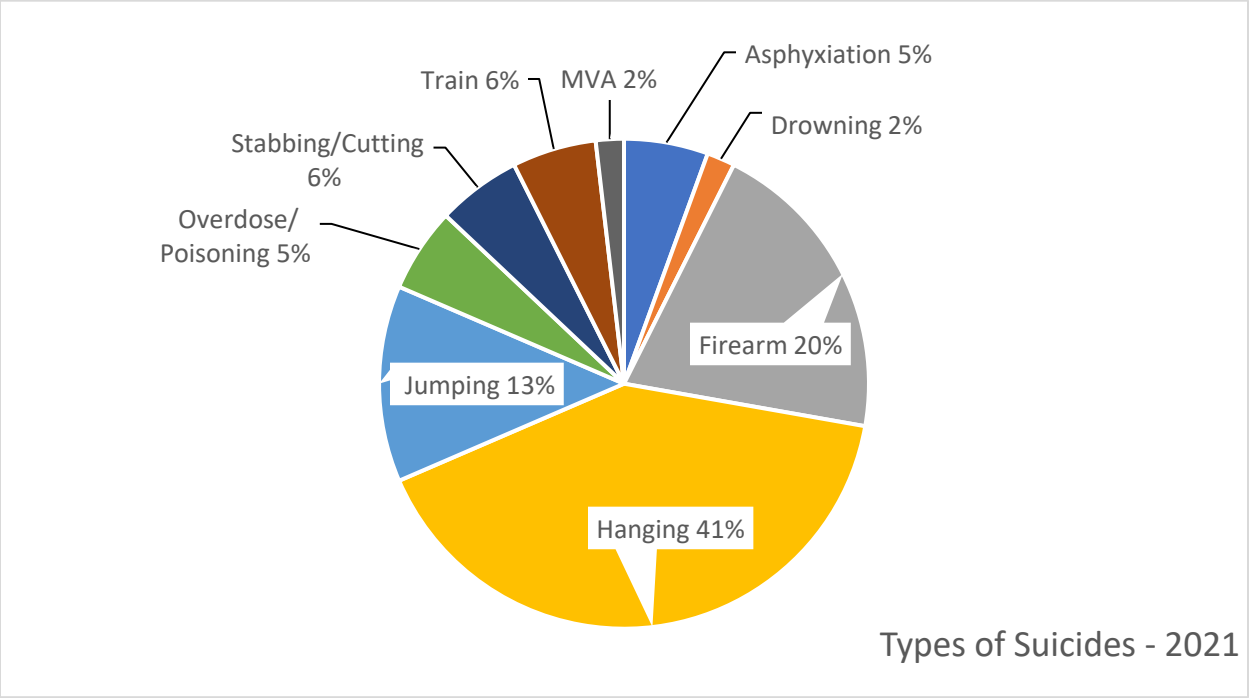
Total Number of Suicides in 2021: 54

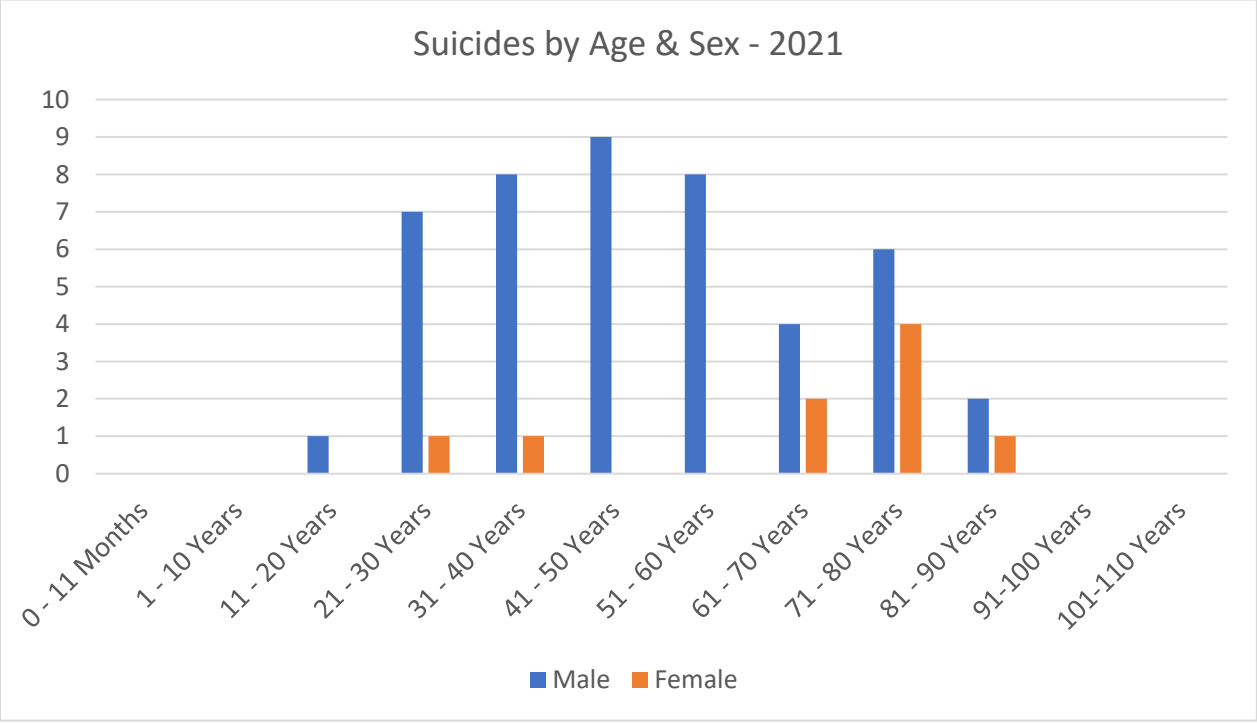
Types of Suicides by Sex			
Types of Suicides	**Total**	**Male**	**Female**
Asphyxiation	3	2	1
Drowning	1	1	0
Firearm	11	9	2
Hanging	22	19	3
Jumping	7	6	1
Overdose/ Poisoning	3	1	2
Stabbing/Cutting	3	3	0
Train	3	3	0
MVA	1	1	0

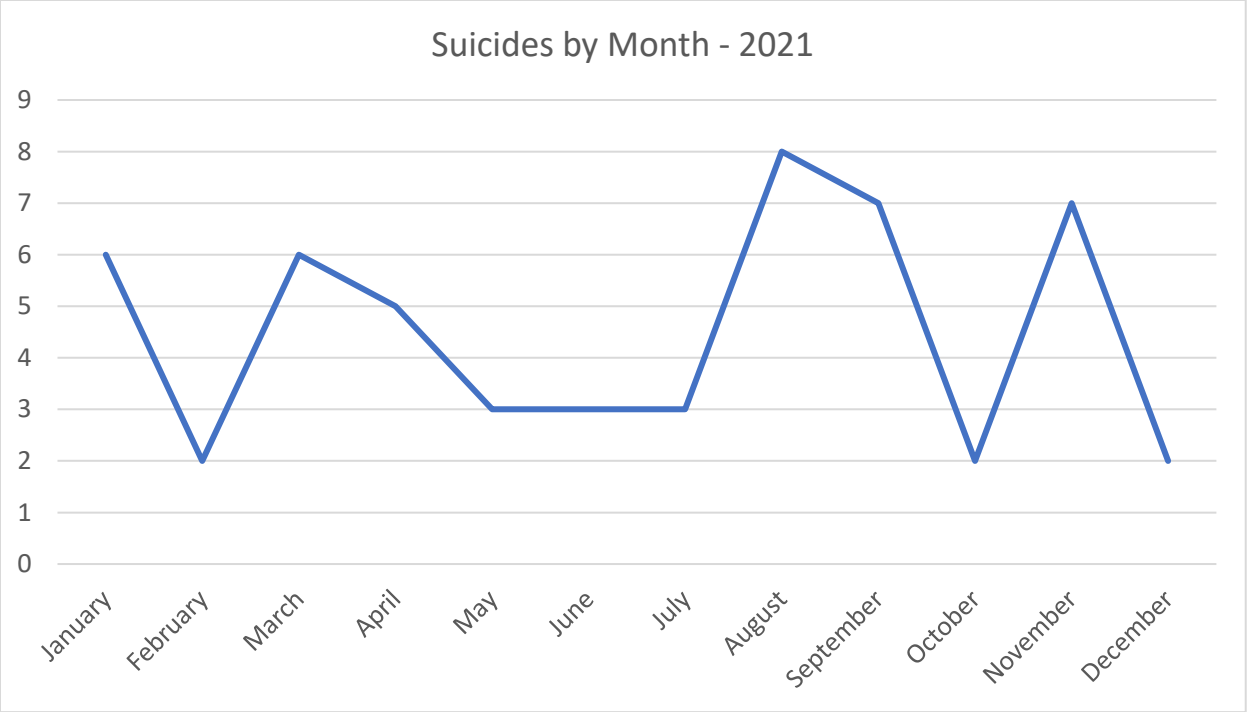
Suicide by Month	
Month	**Number of Suicides**
January	6
February	2
March	6
April	5
May	3
June	3
July	3
August	8
September	7
October	2
November	7
December	2

Suicide by Age & Sex					
Age	**Male**	**Female**	**Age**	**Male**	**Female**
0 - 11 Months	0	0	51 - 60 Years	8	0
1 - 10 Years	0	0	61 - 70 Years	4	2
11 - 20 Years	0	0	71 - 80 Years	6	4
21 - 30 Years	1	0	81 - 90 Years	2	1
31 - 40 Years	7	1	91-100 Years	0	0
41 - 50 Years	8	1	101-110 Years	0	0

Suicide


Train 6%
MVA 2%
Asphyxiation 5%
Drowning 2%
Stabbing/Cutting 6%
Overdose/ Poisoning 5%
Firearm 20%
Jumping 13%
Hanging 41%
Types of Suicides - 2021


Suicides by Age & Sex - 2021
10
9
8
7
6
5
4
3
2
1
0
0 - 11 Months
1 - 10 Years
11 - 20 Years
21 - 30 Years
31 - 40 Years
41 - 50 Years
51 - 60 Years
61 - 70 Years
71 - 80 Years
81 - 90 Years
91-100 Years
101-110 Years
Male
Female


Suicides by Month - 2021
9
8
7
6
5
4
3
2
1
0
January
February
March
April
May
June
July
August
September
October
November
December

Accident

An accident applies when an injury or poisoning causes death and there is little or no evidence that the injury or poisoning occurred with intent to harm or cause death. In essence, the fatal outcome was unintentional.

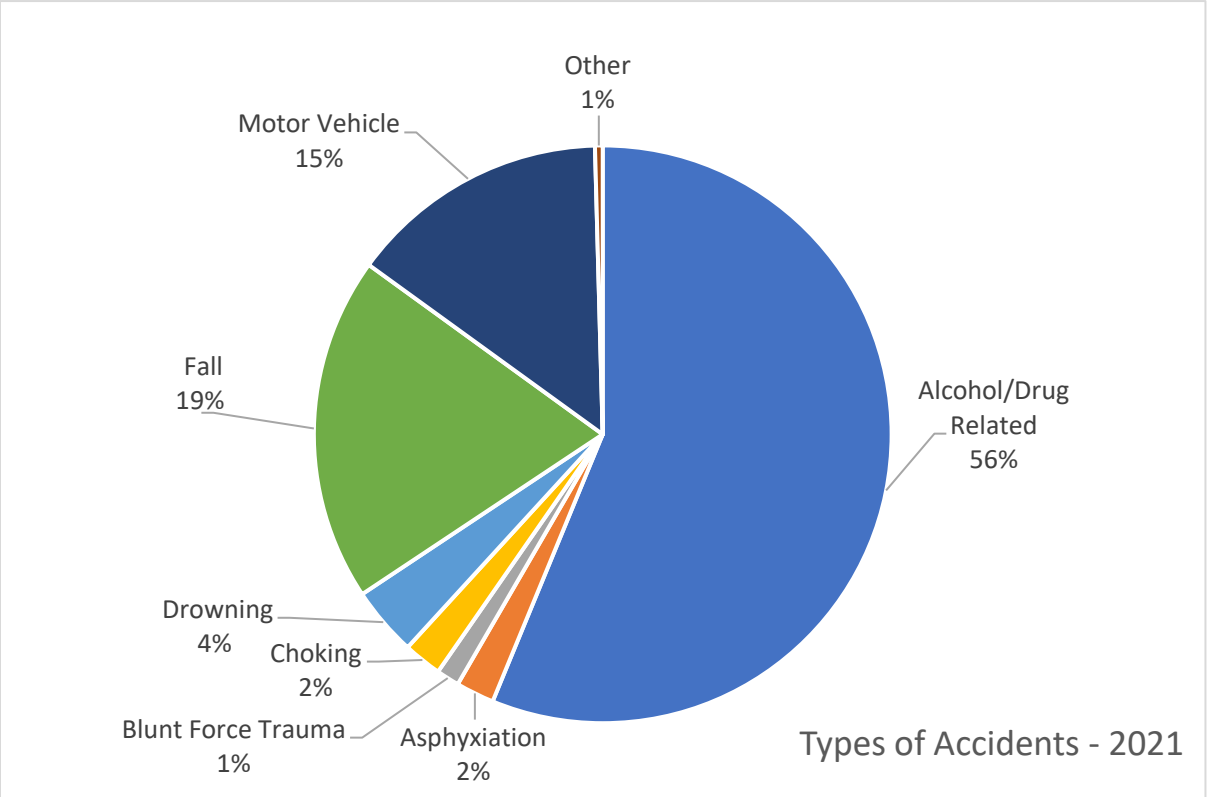
Total Number of Accidental Deaths in 2021: 233

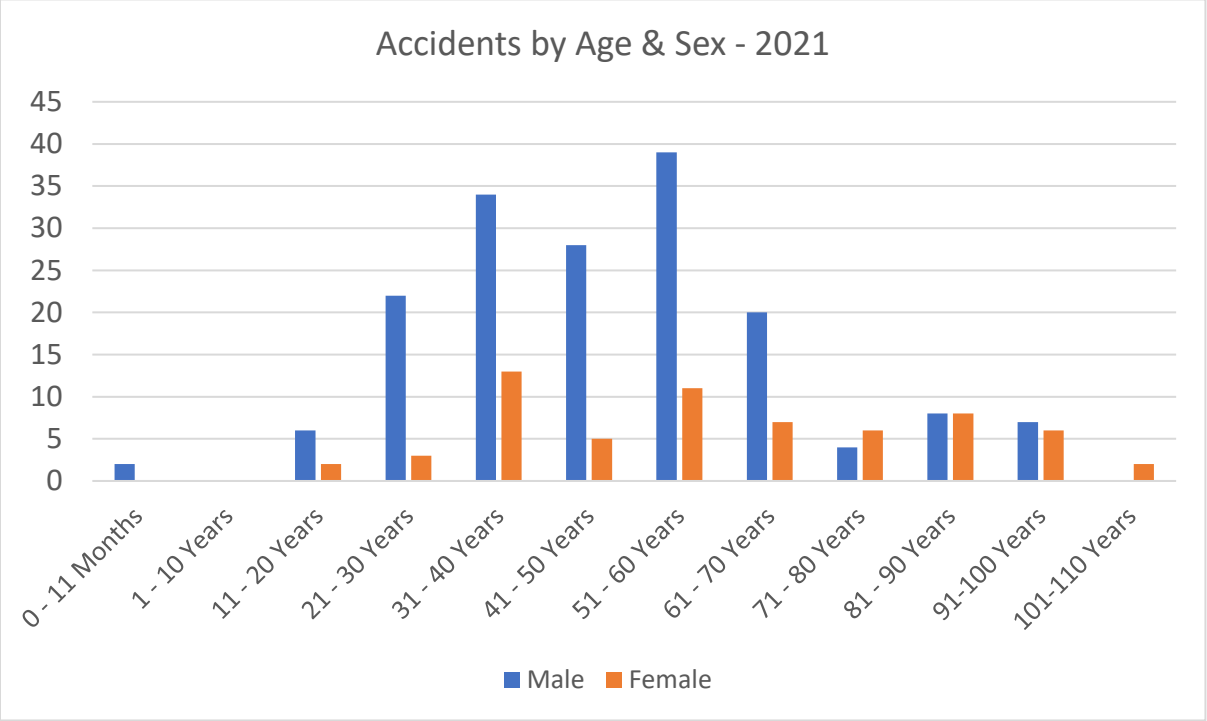
Types of Accidents by Sex			
Type of Accident	**Total**	**Male**	**Female**
Alcohol/Drug Related	131	105	26
Asphyxiation	5	4	1
Blunt Force Trauma	3	2	1
Choking	5	4	1
Drowning	9	5	4
Fall	45	24	21
Motor Vehicle	34	25	9
Other	1	1	0
Alcohol/Drug Related	131	105	26
Asphyxiation	5	4	1

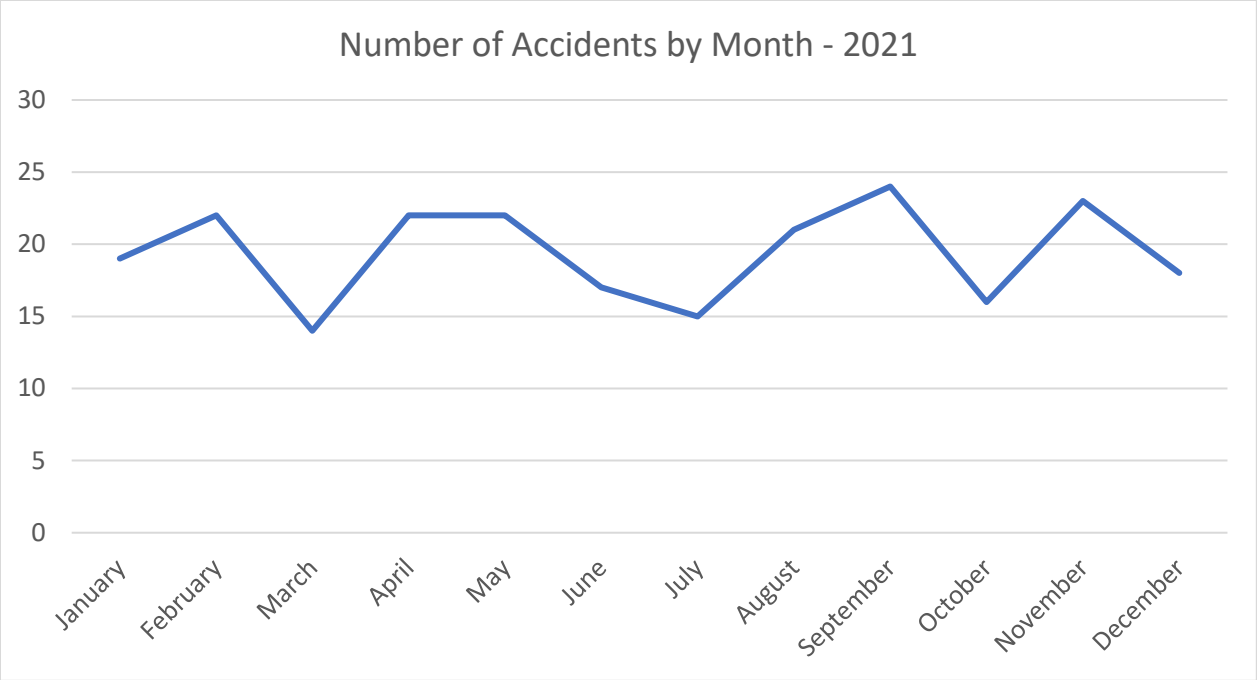
Accidents by Month	
Month	**Number of Accidents**
January	19
February	22
March	14
April	22
May	22
June	17
July	15
August	21
September	24
October	16
November	23
December	18

Accident by Age & Sex					
Age	**Male**	**Female**	**Age**	**Male**	**Female**
0 - 11 Months	2	0	51 - 60 Years	39	11
1 - 10 Years	0	0	61 - 70 Years	20	7
11 - 20 Years	6	2	71 - 80 Years	4	6
21 - 30 Years	22	3	81 - 90 Years	8	8
31 - 40 Years	34	13	91-100 Years	7	6
41 - 50 Years	28	5	101-110 Years	0	2

Accident


Other
1%
Motor Vehicle
15%
Fall
19%
Alcohol/Drug
Related
56%
Drowning
4%
Choking
2%
Blunt Force Trauma
1%
Asphyxiation
2%
Types of Accidents - 2021


Accidents by Age & Sex - 2021
45
40
35
30
25
20
15
10
5
0
0 - 11 Months
1 - 10 Years
11 - 20 Years
21 - 30 Years
31 - 40 Years
41 - 50 Years
51 - 60 Years
61 - 70 Years
71 - 80 Years
81 - 90 Years
91-100 Years
101-110 Years
Male
Female


Number of Accidents by Month - 2021
30
25
20
15
10
5
0
January
February
March
April
May
June
July
August
September
October
November
December

Motor Vehicle Fatalities

The Coroner's Office, as well as other law enforcement agencies within the jurisdiction where the motor vehicle fatality occurs, conducts a thorough investigation of any accident involving a motor vehicle or traffic collision. Following a thorough investigation and an autopsy examination, the manner of death may be determined to be natural, accident, suicide, homicide, or undetermined.

Total Number of Motor Vehicle Fatalities in 2021: 37

Types of Motor Vehicle Fatalities	
Type	**Number of Fatalities**
Automobile-Driver	**16**
Automobile-Passenger	**4**
Motorcyclist	**5**
Pedestrian	**9**
Bicyclist	**1**
Train vs Automobile	**1**
Natural Death While Driving	**1**

Fatalities by Manner	
Manner of Death	**Number of Fatalities**
Natural	1
Accident	34
Suicide	1
Homicide	1
Undetermined	0

Fatalities by Month	
Month	**Number of Fatalities**
January	4
February	3
March	3
April	5
May	3
June	0
July	2
August	5
September	3
October	3
November	4
December	2

Fatalities by Age & Sex		
Age	**Male**	**Female**
0 - 11 Months	0	0
1 to 10 Years	0	0
11 to 20 Years	2	1
21 to 30 Years	6	0
31 to 40 Years	8	5
41 to 50 Years	0	1
51 to 60 Years	4	2
61 to 70 Years	4	0
71 to 80 Years	2	1
81 to 90 Years	1	0
91-100 Years	0	0
101-110 Years	0	0

Motor Vehicle Fatalities
Involving Alcohol and/or Drugs

Pursuant to California Government Code §27491.25, the Coroner's forensic pathologist takes blood and urine samples from the deceased to conduct appropriate, related chemical tests to determine the alcoholic contents, if any, of the body. If necessary, the Coroner may perform other chemical tests to determine the drug contents, if any, of the body. Testing of deceased persons under the age of 15 years is not required, unless the circumstances indicate the possibility of alcoholic and/or drug consumption. In some cases, the victims are hospitalized for a lengthy period of time prior to death and therefore, relevant blood and urine samples are unavailable for testing.

Total Number of Motor Vehicle Fatalities Involving Alcohol and/or Drugs in 2021: 32

Number of Motor Vehicle Fatalities	37
Number of Cases Involving Drugs and/or Alcohol	28
Number of Cases Where Toxicology Test Was Completed	34
Number of Cases Where No Toxicology Test Was Completed	3
Number of Cases Where Nothing was Detected in Toxicology Test	6

Results	**Complete Drug (Including Alcohol)**
Alcohol Only Present	2
Prescription and/or Over-the-Counter Drugs Only Present	7 (THC or its derivatives present in 1 case)
Illicit Drugs Only Present	4
Alcohol and Prescription and/or Over-the-Counter Drugs Present	1
Alcohol and Illicit Drugs Present	2 (THC or its derivatives present in 1 cases)
Prescription and/or Over-the Counter and Illicit Drugs Present	3 (THC or its derivatives present in 2 cases)
Prescription and/or Over-the Counter, Illicit Drugs, and Alcohol Present	0
THC (or its derivatives) Only Present	8
THC (or its derivatives) and Alcohol Present	1

Homicide

A homicide occurs when death results from a volitional act committed by another person to cause fear, harm, or death. Intent to cause death is a common element, but it is not required for classification as homicide. It is to be emphasized that the classification of Homicide for the purpose of death certification is a term that neither indicates nor implies criminal intent, which remains a determination within the province of legal processes.

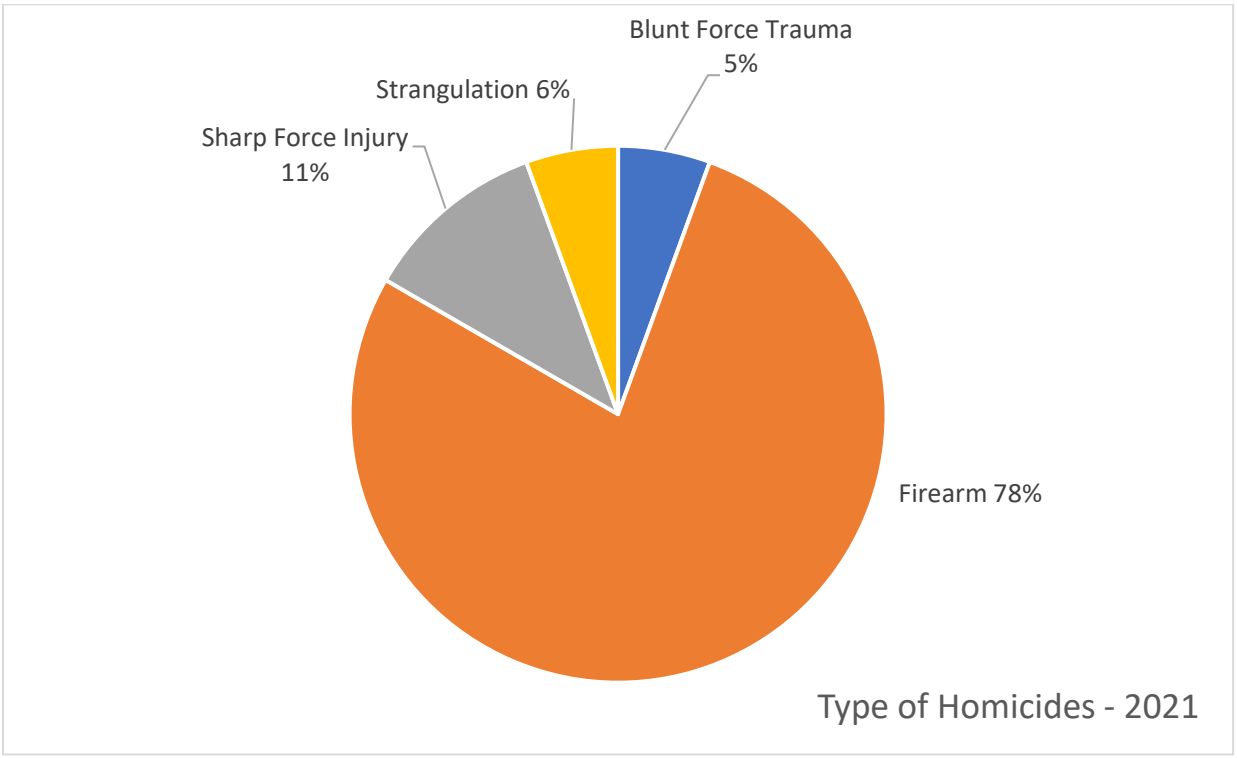
Total Number of Homicides in 2021: 19

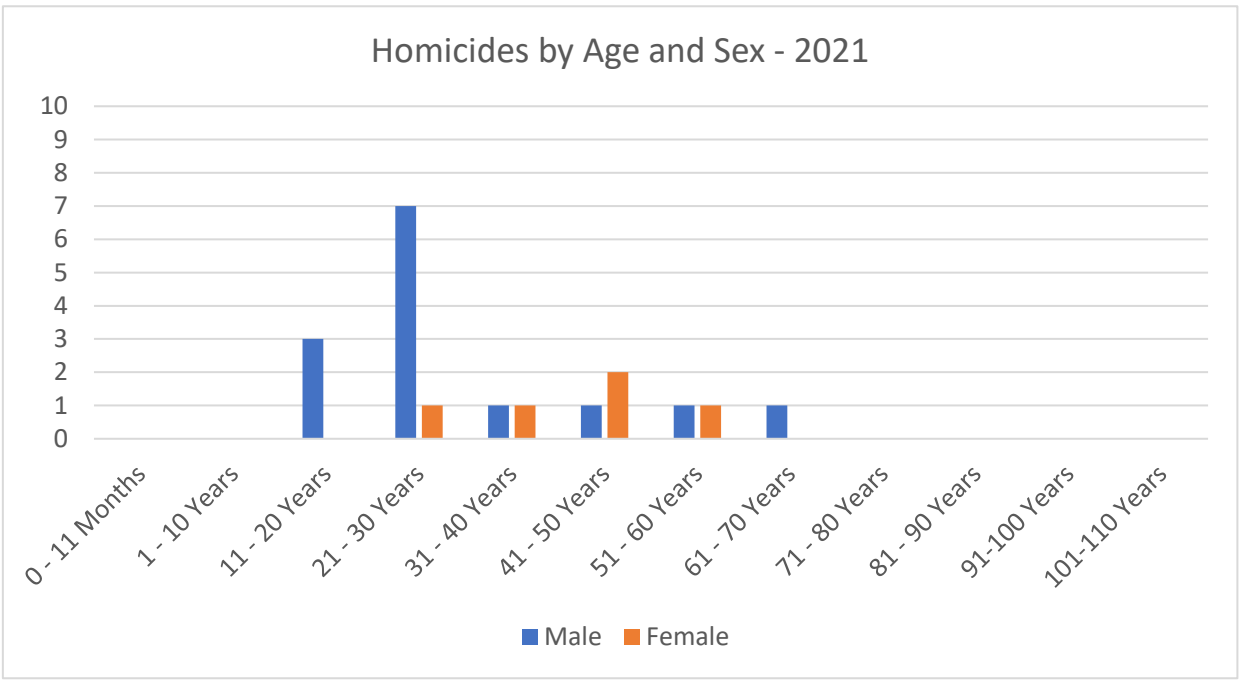
Type of Homicide by Sex			
Type of Homicide	**Total**	**Male**	**Female**
Blunt Force Trauma	1	0	1
Firearm	14	13	1
Sharp Force Injury	2	1	1
Strangulation	1	0	1
Multiple Injuries	1	0	1

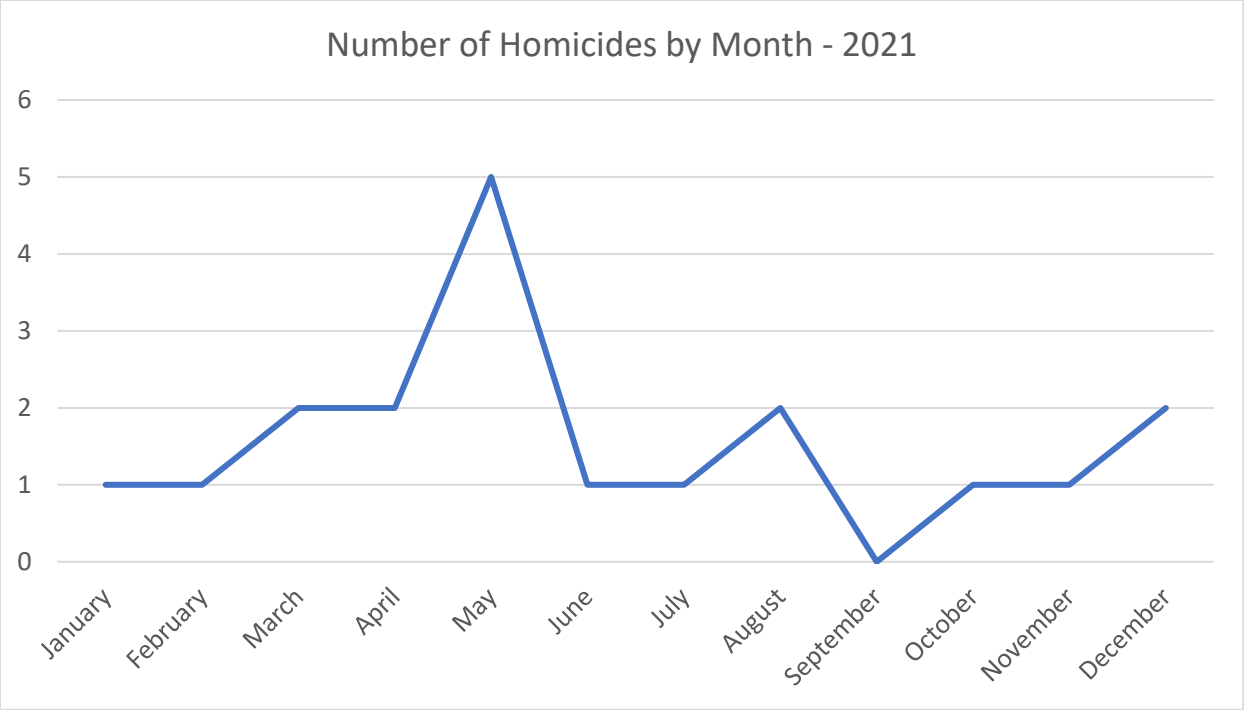
Homicides by Month	
Month	**Number of Homicides**
January	1
February	1
March	2
April	2
May	5
June	1
July	1
August	2
September	0
October	1
November	1
December	2

Homicides by Age & Sex		
Age	**Male**	**Female**
0 - 11 Months	0	0
1 - 10 Years	0	0
11 - 20 Years	3	0
21 - 30 Years	7	1
31 - 40 Years	1	1
41 - 50 Years	1	2
51 - 60 Years	1	1
61 - 70 Years	1	0
71 - 80 Years	0	0
81 - 90 Years	0	0
91-100 Years	0	0
101-110 Years	0	0

Homicide


Blunt Force Trauma
5%
Strangulation 6%
Sharp Force Injury
11%
Firearm 78%
Type of Homicides - 2021


Homicides by Age and Sex - 2021
10
9
8
7
6
5
4
3
2
1
0
0 - 11 Months
1 - 10 Years
11 - 20 Years
21 - 30 Years
31 - 40 Years
41 - 50 Years
51 - 60 Years
61 - 70 Years
71 - 80 Years
81 - 90 Years
91-100 Years
101-110 Years
Male
Female


Number of Homicides by Month - 2021
6
5
4
3
2
1
0
January
February
March
April
May
June
July
August
September
October
November
December

Undetermined

Undetermined or “could not be determined” is a classification used when the information pointing to one manner of death is no more compelling than one or more other competing manners of death in thorough consideration of available information. Sometimes information concerning the circumstances of death may be inadequate due to a lengthy delay between the occurrence of the death and the discovery of the body. If an extensive investigation and autopsy cannot clarify the circumstances which led to a death, the death is then classified as undetermined.

Total Number of Undetermined Deaths in 2021: 6

Mode	Total
Partial remains	1
Decomposed Body or Skeletal Remains	5
Unexplained death in infancy	0
Unexplained death in childhood	0

Outside Jurisdiction

In any case where a Coroner is required to inquire into a death pursuant to California Government Code §27491, the Coroner may delegate his or her jurisdiction over the death to an agency of another county or the federal government under California Government Code §27491.55. This often occurs when the outside Coroner has jurisdictional interest in the death, for instance, if the suspected injury resulting in death occurred within the outside County's jurisdiction.

Total Number of Jurisdictional Releases by another County in 2021: 25

Manner	Total
Natural	2
Accident	12
Suicide	0
Homicide	10
Pending	1

County of Death	Total
Santa Clara	15
San Francisco	10

Indigent Cremation

Through the County Cremation process, the Coroner inters the remains of the decedent when no provisions for final disposition were made by the decedent and he or she is indigent. Additionally, if the Coroner notifies or attempts to notify the person responsible for the internment of the decedent's remains, as defined by Health and Safety Code §7100, and he or she fails, refuses, or neglects to handle the final disposition, the Coroner proceeds with internment via County Cremation.

Total Number of Indigent Cremations in 2021: 36

County Cremations referred by outside agencies:	10
County Cremations referred to outside agencies:	2
Cremations performed by the San Mateo County Coroner after remains were abandoned by family:	8
Cremations performed by the San Mateo County Coroner after diligent search, but no family located:	22
Cremains collected by family upon locating next of kin after cremation performed:	0
Dispositions handled by family after receiving a fee reduction by application for financial need:	26

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

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

(650) 312-5562
Coroner.smcgov.org