

Marin County Coroner's Office: What it Does and Why a Morgue is Needed

May 15, 2001

Summary

This Grand Jury Report is based on a study of the Marin County Coroner's Office. The Grand Jury reviewed the operation, functions and programs of the coroner and his staff.

Marin County does not have a central forensics facility (morgue). The coroner has informal arrangements with several private mortuaries in the county, and these private facilities are used for the autopsies that the coroner is required to conduct. On the basis of interviews with people knowledgeable in the field of forensic science, as well as jurors' visits to three mortuaries, these facilities were found to be inadequate for the requirements of the coroner and his staff. In addition, the use of these facilities creates potential serious legal and liability problems.

The county needs a central forensics facility as soon as possible. This report discusses the numerous problems, both actual and potential, created by the use of private mortuary facilities by the coroner's office.

Two other areas of concern should be addressed immediately. First, unlike other counties in California, Marin does not have a written death investigation protocol that is accepted and followed by those jurisdictions in the county that are involved in death investigations. The coroner should take the lead in involving the necessary agencies in the county in establishing such a written protocol.

Second, the coroner and his investigative staff, despite being sworn peace officers, do not receive Safety Retirement benefits. They are eligible for such benefits under state statutes, but have been denied these benefits. (Safety Retirement consists of enhanced benefits compared to normal retirement. This includes retirement at an earlier age, greater retirement amounts and, in some instances, the benefits are tax-free. Contributions from both employers and employees are increased.)

The coroner's office is performing its assigned duties and responsibilities in a more than satisfactory manner to the benefit of the citizens of the county. The county should: (1) establish a central forensics facility; (2) develop a written death investigation protocol; and (3) grant the coroner and his investigative staff Safety Retirement benefits to which they are entitled.

Background

The Marin County Coroner's Office investigates and determines the circumstances, causes and manner of all sudden, unexplained or unexpected deaths within the county, or natural deaths where the deceased was not under the close care of a physician. The coroner is also responsible for the identification of any unknown decedent and for the location and notification of next of kin. All criminal and/or civil evidence pertaining to the body of the deceased and the decedent's personal assets must be preserved by the coroner.

In Marin County, the coroner is elected. The coroner's office has not been reviewed by the Grand Jury, according to the recent history of available Grand Jury Reports. The people of Marin County are probably unaware of the office's functions and responsibilities; therefore, the Grand Jury conducted a general review of the office,

Eight of California's 58 counties have separate coroners' offices. The majority of counties combine this function with the sheriffs' departments (see [Appendix A](#)). Of the eight counties with separate coroners, only Los Angeles and San Francisco have forensic pathologists who serve as coroner/medical examiner. Marin County has a separate coroner's office. The Grand Jury believes that a separate, stand-alone coroner's office helps to ensure that an independent death investigation is conducted. This might reduce any public perception that the death investigation could be influenced by other segments of the criminal justice system.

Coroners and deputy coroners are sworn peace officers (California Penal Code, section 830.5). The Penal Code, in addition to other California codes, defines the authority, duties, functions and responsibilities of a coroner's office. The most important is to determine the circumstances, manner and cause of those death listed in Government Code section 27491 (see [Appendix B](#)). These specific deaths must be immediately

reported to the coroner's office by a health-care facility, law enforcement agency, organization or individual. Government Code section 27491 grants the coroner's office the authority and discretion to determine the extent of investigation for all reported deaths. This reporting requirement is also defined in section 10250 of the Health and Safety Code. All deaths in which a physician is unable to state a cause of death are automatically coroner cases.

There are approximately 1,500 to 1,800 deaths in Marin County each year. Of this total, about 1,100 are coroner's deaths (see [Appendix B](#)). The coroner is called to the scene in about 400 of those deaths each year; approximately 300 of them result in an autopsy.

Half of California's 58 counties have their own morgue. Twenty-one have a population greater than 250,000 (the size of Marin County); seven have populations that are less than 250,000; and one (Santa Cruz) is the same size as Marin. A small county population is not a legitimate argument for or against having a central morgue.

In addition to the required duties involving death investigations, the Marin County coroner and his staff are also involved in a number of related - and sometime unique — activities, such as:

- community outreach programs, including the Marin Family Substance Abuse Coalition, continuing education programs with physicians at hospitals in Marin and training with local police and fire departments;
- Marin Child Death Review Committee;
- Marin Seniors Ombudsman;
- Marin Domestic Violence Coordinating Council.

Marin County does not have a central forensics facility (morgue). Autopsies are performed in one of several local mortuaries, depending on the location where the death occurred. This lack of a morgue creates a number of problems for the coroner and his staff, for the forensic pathologists who perform the autopsies and for members of law enforcement who are involved with homicides. In addition, the use of private mortuaries creates potential serious legal and liability problems for the county.

The jury noted two other items of concern during its study. First, unlike some other counties in California, Marin does not have a written death investigation protocol that is accepted and followed by all of the agencies, departments and jurisdictions involved in the investigation of a death, regardless of the cause or circumstances. Second, the coroner and his investigative staff are sworn peace officers, but do not receive Safety Retirement benefits, as do other sworn peace officers (e.g., sheriff's deputies and police officers) in the county.

Methodology

The Grand Jury reviewed the duties and functions of the coroner's office by:

- interviewing the coroner;
- interviewing the assistant county coroner and one of the coroner's investigators;
- interviewing the former county coroner;
- interviewing the county administrator;
- obtaining information from county counsel pertinent to legal liability issues in respect to the operations of the coroner's office;
- interviewing the coroner of Sacramento County and the sheriffs' deputies in charge of the morgues in Sonoma and Solano counties;
- interviewing law enforcement investigators from the San Rafael Police Department, the Marin County Sheriff's Department and the Marin County District Attorney's Office regarding homicide investigations;
- interviewing two forensic pathologists who conduct autopsies for the coroner's office in Marin County;
- accompanying a coroner's investigator on a death investigation (non-homicide);
- visiting three mortuaries in Marin County where autopsies are performed for the coroner's office;

- speaking with funeral directors;
- visiting the county morgues (central forensics facilities) in Sacramento, Sonoma and Solano counties;
- visiting the Tissue Banks International (TBI) facility in San Rafael;
- interviewing the senior vice president of TBI;
- attending a meeting of the Child Death Review Team of Marin County;
- talking with the Senior Citizens' Ombudsman regarding elder abuse;
- reviewing pertinent documents and civil statutes regarding the duties and functions of the coroners' offices in California; and
- conducting library research.

Marin County Needs a Central Forensics Facility (Morgue)

The job of the coroner in this county is made more difficult because there is no central morgue. Private mortuaries are used to perform autopsies and to store bodies until they are released for burial. There are a number of problems in using these facilities for autopsies. While these facilities are adequate for private funeral uses, they are inadequate for the legal requirements of the coroner.

Space in these private mortuaries is limited. A body still under the jurisdiction of the coroner is stored side by side with one or more non-coroner cases. When a homicide case is being autopsied, there is usually a group of people involved with the case that need to view the autopsy. Sometimes viewing is not possible; other times, space is very limited.

Security is a major issue. It is not possible for the coroner to restrict access to a body while it is in a private facility. Although the jury did not find any evidence of unauthorized personnel entering the facility and tampering with the body or related evidence, the coroner cannot ensure that such incidents will not occur. The coroner has little control over the situation while the body is in a private facility.

(The jury was informed of one recent case where the body of the victim in a fatal shooting case was embalmed for a private funeral by the mortuary staff *before* the coroner *released* the body. An active police investigation was still in progress and, while this event had no direct negative impact on the outcome of the case, there was the potential for disaster.)

The preservation of the chain of evidence in a homicide is critical to the outcome of the investigation and the apprehension of the perpetrator. This includes having the necessary space and equipment to process and store evidence. Such space is not available in the private mortuaries used by the county. While the jury found no case where the integrity of this chain of evidence was broken or tampered with, there is no way to ensure that it does not happen as long as the county does not have a central morgue. Should this county ever have an "O. J. Simpson"-type case, in which the defense claims that the forensic evidence has been tampered with, the full impact of this liability would become painfully clear.

The coroner has no control over the qualifications of the privately employed personnel who come in contact with a death-investigation body while it is at the mortuary. These facilities often do not have appropriate equipment for the disposal of hazardous materials or adequate protection against potential communicable disease hazards. A county morgue would correct these problems.

Private mortuaries lack the space and security to store the instruments, supplies and equipment necessary for an autopsy. While some materials are stored there, the forensic pathologists who perform autopsies must bring their own specialized instruments.

Additionally, these private mortuaries do not have x-ray facilities and the coroner must rely on the use of private mobile x-ray companies. There is no control over their schedules, availability or responsiveness. Once the x-rays have been taken, the mobile unit leaves, and there is no way to get another x-ray on short notice if one is required at the time of autopsy. This can lead to problems in locating bullets or bullet fragments. Also, x-rays are often critical in cases of infant or child death in order to confirm or rule out instances of child abuse.

Communications and schedules between the pathologists, the coroner's staff and police investigators regarding an autopsy are difficult at times due to a lack of a central county facility for autopsies and the storage of bodies.

If the county had its own central forensics facility these problems could disappear. The coroner and his staff could implement proper security and chain- of-evidence procedures, would have adequate facilities for autopsies and would have proper facilities for the storage and handling of forensic evidence. The entire staff could be housed in this single facility and proper space would be available for the use of other jurisdictions involved in a death case. All appropriate equipment and supplies, including proper x-ray facilities, would be immediately available when and as needed.

The county currently has no written contracts or agreements with any of the mortuaries that it uses. These mortuaries could increase the prices they charge the county per autopsy, or even drop out of the system at any time. The coroner has no control over those possibilities.

Organ and Tissue Banks

Coroners statewide must cooperate with tissue and organ banks in their locality, as required by the Uniform Anatomical Gift Act (Chapter 3.5 of the Health and Safety Code).

There is a technical difference between organ and tissue donations. Organ donations pertain primarily to heart, lung and kidney transplants. These organs must be obtained from a donor who is technically brain dead but whose body is still alive. In these instances time is critical since the organ must continue to be perfused with oxygenated blood. Organs are typically obtained in a hospital setting. Tissue donations, on the other hand, consist of such things as bone, tendons, ligaments, arteries, veins, heart valves and corneas. In most instances, these tissues can be obtained from a body up to 24 hours after death.

Tissue Banks International (TBI) is a non-profit, non-governmental tissue-banking network located in San Rafael. TBI has offered to provide the county with a financial subsidy to be applied to the operating costs of a central morgue in Marin County in return for a working arrangement with the county to obtain tissue from appropriate donors. Other counties in California, including Monterey and Sacramento, have similar arrangements. TBI would require the morgue to be located within a reasonable distance of its facility in order for such an arrangement to be practical.

The Cost of a Central Forensics Facility to the County

It is logical to ask what a new central forensics facility housing the coroner functions would cost. The costs are the annual operating expense and the capital outlay to establish the facility.

The coroner estimates that there would be no noticeable increase in annual operating costs if the full subsidy offered by TBI can be utilized. Even without a subsidy, the coroner estimates that the annual operating cost would not increase more than about 20% over present budget levels (the approximate net operating budget of the coroner's department is currently \$560,000). While some new costs would be incurred, some present costs would be eliminated. Overall efficiency would increase, but it is difficult to measure this in dollars.

Relocating the coroner's office to a separate facility would free up the space that it currently occupies in the Civic Center.

The Grand Jury was not able to establish the capital costs because there are still too many unknowns, such as whether or not a facility would have to be built or an existing facility obtained and remodeled. Also, it is not known whether the county would purchase or lease a facility. The jury does not believe, however, that the cost would be prohibitive and the advantages far outweigh the disadvantages.

The Need for a Written Death Investigation Protocol

The coroner and each of the other agencies involved in a death investigation have their own internal procedures. There is no single set of written procedures that is followed by all parties. This situation creates

potential and actual problems of both communications and procedure. This is especially true at a homicide investigation where competing interests and needs could cause problems for other jurisdictions. The coroner does conduct periodic training for police, fire and paramedic personnel on the coroner's needs at a death investigation. But a written protocol is also needed for all death investigations.

Written procedures that take into account the needs of all involved agencies would go a long way to resolve potential conflicts between jurisdictions and would also clarify their responsibilities. Other counties have such a written protocol; there is no reason to believe that Marin County should not also have such a written protocol.

The Marin County Coroner's Office Deserves Safety Retirement

All police officers, firefighters and sheriff's deputies in the county receive Safety Retirement benefits. Additionally Juvenile Hall group counselors, probation officers and district attorney's investigators receive these benefits. When Safety Retirement was first addressed in the California Statutes, the coroners and their staffs as well as police officers and sheriffs' deputies were among the first listed as eligible. *Coroners in over 90% of the counties in California have Safety Retirement.* Marin County apparently is not willing to acknowledge the hazardous nature of the conditions under which the coroner and his staff are called upon to perform on a day-to-day basis. Sections 31470.9 and 31470.13 of the Government Code allow Safety Retirement benefits for coroners subject to the approval of the Board of Supervisors.

The coroner and investigative staff clearly encounter physical dangers. They also encounter significant health hazards equivalent to, and in some cases surpassing, the hazards faced by the groups currently covered. The coroner and his investigative staff are trained and qualified peace officers that are expected to perform at the same level of discipline and credibility as others who receive Safety Retirement benefits. While funding issues are always critical, there are only five eligible employees, and this number is not likely to increase in the near future, even with a new central forensics facility. Thus, the incremental cost to provide the benefit to this small group is clearly not a major issue. Granting this benefit will enhance the ability of the county to continue to attract highly qualified personnel.

Findings

1. Because the county lacks a central forensics facility, the coroner is forced to utilize private mortuaries in the county to conduct autopsies as required by law. The coroner has informal arrangements with a group of mortuaries, and autopsies are normally assigned based on the area of the county in which the death occurred.
2. These private mortuary facilities, while adequate for performing private funeral activities, are inadequate for conducting autopsies required by the coroner's office for the following reasons:
 - private mortuaries do not have adequate security to prevent unauthorized access;
 - a lack of total control over the body and the ability to completely protect the chain of evidence in homicide cases;
 - private mortuaries do not have x-ray equipment that is often needed at the time of autopsy for special examinations;
 - a lack of control over the personal effects of the deceased that might have been on the body at the time of death (e.g., jewelry, etc.);
 - the physical facilities often lack adequate light, ventilation and acceptable cleanliness;
 - private mortuaries do not have the capability to utilize available technology, such as recording, video, lasers, etc.;
 - physical space is limited, which often makes it difficult for others involved in the case, e.g. homicides, to attend and observe the autopsies;
 - lack of control over the disposal of hazardous materials;
 - lack of control over the qualifications of personnel who come in contact with the body;
 - lack of standardized, required equipment;
 - poor security of coroner's equipment that is stored at the mortuaries for use in autopsies;
 - lack of control over health and safety issues (OSHA regulations, etc.); and
 - autopsy schedules are often dictated by the private commitments of the mortuaries.

3. Marin County is at risk, in terms of potential legal liability, because it does not have a central forensics facility. The Grand Jury is not aware of any instance where the results of an autopsy or the chain of evidence has been compromised in homicide cases. Nor is the Grand Jury aware of any non-homicide cases in which the county has been held liable because of events that occurred in the use of private mortuaries to conduct autopsies. As we have been told by many knowledgeable people involved in the process, this is just a matter of luck. In the words of one, "The disaster is out there just waiting to happen." The use of private mortuaries to conduct autopsies in Marin in this day and age, and with the resources that this county has at its disposal, is "unprofessional" at best, and "scandalous" at worst.
4. The coroner has obtained an indication of financial support from Tissue Banks International (TBI) of San Rafael. TBI is interested in providing funding subsidies for the operation of a central forensics facility in the county in return for closer cooperation with TBI's program of obtaining various cadaver tissues. TBI makes various sterile tissues (e.g., bone, skin, eye lenses, tendons, heart valves, etc.) available to doctors and hospitals for use as "replacement parts."
5. There is no written protocol covering death investigations that has been accepted and is used by all the agencies in the county involved in death investigations (i.e., coroner's office, district attorney's office, sheriff's department, police and fire departments and paramedics). Other counties in California have and use written protocols.
6. The Marin County coroner and his investigative staff are sworn peace officers. They experience many of the same physical dangers, as do police officers and sheriff's deputies; they wear badges and carry guns while on duty in the field. In addition, they are subject to unique health hazards (e.g., exposure to biological and infectious agents) due to the nature of their job, which requires them to deal directly with dead bodies under many different circumstances. Unlike members of the sheriff's department and the police jurisdictions in Marin County, the coroner and his staff are eligible, but do not receive, Safety Retirement benefits because the Marin County Board of Supervisors has not approved those benefits. The current and the former coroner have requested these benefits on prior occasions but, thus far, have been unsuccessful in obtaining them.

Recommendations

1. That Marin County establishes a central forensics facility to serve as a base of operations for the county coroner's office; that this facility contains a morgue suitable for conducting all autopsies in the county as required by law; and that this facility be planned in such a way as to be adequate to handle projected growth needs of the county.
2. That the Board of Supervisors and the county coroner move to establish this facility and have it operational as soon as possible.
3. That the county avail itself of the offered financial support of TBI, which might enable the county to have this facility in operation sooner and to operate it at a lower cost to the citizens of Marin County.
4. That the coroner's office take the lead in working with other involved jurisdictions and departments in the county to develop a written death investigation protocol for use by all involved agencies. That the Board of Supervisors support and endorse this effort and provide financial assistance if needed.
5. That the Board of Supervisors approves Safety Retirement benefits for the coroner and his investigative staff.

Request for Responses

Pursuant to Penal Code section 933.05, the Grand Jury requests a response as follows:

- from the County Coroner to Findings 1 through 6 and to Recommendations 1 through 4; and
- from the Board of Supervisors to Findings 3 through 6 and to Recommendations 1 through 5.