San Mateo County Coroner 2024 Annual Report

Robert J. Foucrault
Coroner

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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. The Coroner's Office is a California P.O.S.T. agency and is accredited by the International Association of Coroners and Medical Examiners. Deputy Coroners obtain certification through the American Board of Medicolegal Death Investigators within three years of employment.

According to the United States Census Bureau, San Mateo County was estimated to have a population of 742,893 in 2024, which decreased 2.82% from 764,442 in 2023. There were 5,555 deaths recorded in San Mateo County in 2024 which decreased 1.7% from 2023 (5,651 deaths). Of these deaths, 2,009 deaths were reported to the Coroner's Office which decreased by 2.29% from 2,056 in 2023. After initial investigation, 519 were determined to be full Coroner cases with the final cause of death signed by the Coroner, or his designated authority; this increased 2.17% from 508 in 2023.

This 2024 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.

2024 Data Trends

Suicide Increase

Suicide deaths were down 31.1% from 2023 (80 in 2024 versus 61 in 2023). There were just under four times as many male suicide deaths than female suicide deaths (63 males to 17 females). The three most common modes of death were hanging (32 cases), firearm (19 cases), and overdose/poisoning (9 cases).

Accident Decrease – due to decrease in alcohol and drug related deaths

Accidental deaths were down 12.8% from 2023 (190 in 2024 versus 218 in 2023). The total number of motor vehicle accidents decreased 13.5% in 2024 (32 in 2024 versus 37 in 2023). Drug and alcohol related deaths were down 21.2% from 2023 (89 in 2024 versus 113 in 2023). Of the 89 drug and alcohol related deaths, 28 cases tested positive for fentanyl. There was a significant decrease in fentanyl-related deaths from 68 in 2023, down 58.8% in 2024.

Homicide Decrease

San Mateo County saw a 7.14% decrease in homicides in 2024 (13 in 2024 versus 14 in 2023).

2024 Office Highlights

In 2024, the Coroner's Office continued to pursue excellence by seeking opportunities for employee training and education in the field; hosted a variety of opportunities for members of the public to explore the role of the Coroner and medicolegal death investigations; partnered with other agencies to review untimely deaths to identify areas of need for community support and education; sought ways to generate team connectedness in wellness events; earned a variety of certifications and celebrated achievements; added new staff and contractors to the team; supported data sharing efforts locally, state-wide, and nationally. Below outlines some of the activities and accomplishments of the Office in 2024.

Colleagues and Family come together to celebrate the Holidays (December)

Collaboration and Partnerships

# of Collaborative Meetings Attended: 18

- Throughout 2024, the Coroner's Office attended the quarterly Child Death Review Team and hosted the quarterly Domestic Violence Death Review Team to discuss relevant deaths with multiple partner agencies and community-based organizations within the County. The purpose of these death review team meetings is to review these untimely deaths and identify areas of improvement, need for support, and red flags.

- Each year the Coroner's Office partners with the California Department of Public Health and the Centers for Disease Control and Prevention's (CDC) in data sharing efforts for the State Unintentional Drug Overdose Reporting System (SUDORS) and the National Violent Death Reporting System (NVDRS). These systems collect and analyze data so agencies

can monitor and report out on overdose deaths and violent deaths in the state and compare the data to other jurisdictions nationwide.

Coroner's Office Administrative and Investigative staff

- In March 2024, a Coroner's Office representative met virtually with multiple representatives from the California State Attorney General's Office to discuss San Mateo County's Domestic Violence Death Review Team's current practices. The Attorney General's Office was on a fact-finding mission to better understand how Senate Bill 863 will potentially impact teams across the state as counties prepare for implementation of near-death cases in domestic violence incidents in new or existing teams or councils.

- In March 2024, a Coroner's Office representative participated in an interview with a public health analyst with RTI International, an independent non-profit research institute, to test the Bureau of Justice Statistics' draft instrument for the Census of Medical Examiner and Coroner Offices (CMEC). The CMEC instrument is designed to produce meaningful, relevant, and timely statistics to serve the community.

- Representatives from the Coroner's Office and Public Administrator's Office met for quarterly check-ins to ensure all case referrals are appropriately managed, updates are provided, and invaluable communication occurs for the successful collaboration between partner agencies.

Wellness activities incorporated in all-staff meeting (April)

- In May 2024, representatives from the Coroner's Office and Epidemiology met to discuss ongoing data collection efforts including unhoused death data and reporting of suspected alcohol and drug related death data in San Mateo County.

- In June 2024, representatives of the Coroner's Office met with the California Department of Public Health's Overdose Response Strategy team to discuss onboarding to ODMAP. ODMAP is now being used state-wide to collect fatal and near-fatal overdose events.

- In June 2024, representatives from the Coroner's Office, Caltrans, San Mateo County Public Works, Bay Area Metro – Metropolitan Transportation Commission, California State Parks, CALFIRE, and California Highway Patrol met to discuss the traffic safety concerns at the intersection of Highway 1 and Pescadero Creek following multiple incidents resulting in fatalities within the last couple years.

- In July 2024, a representative of the Coroner's Office participated in the first in person Bay Area Incident Management Task Force meeting since 2019. The purpose of the task force is to bring together a multidisciplinary team of key stakeholders to debrief large traffic incidents including fatalities, perform tabletop exercises, and brainstorm new legislation or improvements to unsafe roadways.

- In November 2024, a Coroner's Office representative presented to the San Mateo County Suicide Prevention Committee regarding the role of the Coroner's Office and provided suicide-related death statistics to the committee members.

Community Involvement

# of Ride-Alongs Hosted: 7
# of Morgue Tours Given: 8
# of Teaching or Other Community Engagements: 4

- Throughout the year, the Coroner's Office offers morgue tours and ride-along opportunities to community members who are over the age of 18 who are interested in learning more about the Coroner's Office and the work performed. Tours of the Coroner's Office Pathology Division morgue provide an insider's look into the world of medicolegal death investigation. In 2024, the Coroner's Office hosted five morgue tours, two ride-alongs, and met with one high school student for an informational interview about medicolegal death investigations.

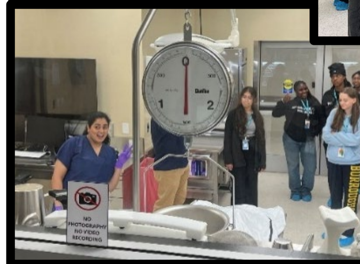
Coroner's Office Pathology Staff

- In January 2024, one forensic autopsy technician participated in the County's Annual Homeless Count.

- In March 2024, forensic autopsy technicians guided Mid-Peninsula High School's Forensic Science class through an interactive tour of the Coroner's Office Pathology Division and discussed the role of the Coroner's Office in San Mateo County. This is the 6th year that the Coroner's Office has partnered with Mid-Peninsula High School to provide this enriching experience to high school students.

- For the third year in a row, the Coroner's Office has partnered with Kaiser Permanente's Community Medicine Rotation supported by the Kaiser Permanente San Jose Medical Center Graduate Medical Education Program to host five physicians completing their Family Medicine Residency on a ride along between April and June. Deputy coroners give the visiting physicians a better understanding of the role of the Coroner's Office and the responsibility of death certificate attestation required by California physicians for patients who experience a natural death under their care. This partnership continues to foster valuable relationships between the Coroner's Office and physicians in the Bay Area.

Coroner Investigations and Pathology Staff give morgue tours and talks to young community members



- In 2024, the Coroner's Office presented one Save-A-Life class to three juveniles referred to the course as part of their probation. This class is designed for juveniles to learn about the extreme consequences of risky behavior.

- The Coroner's Office hosted two classes from EXPLO's Pre-College Summer Program as part of their Criminal Investigations track for a morgue tour and deputy coroner discussion. Forensic autopsy technicians guided the groups of students through an interactive tour of the Coroner's Office Pathology Division and discussed the role of the Pathology Division in medicolegal death investigation. Following the tour of the morgue, the supervising deputy coroner met with the students to discuss the role of the Investigations Division and the role of the Coroner's Office in San Mateo County.

- In August 2024, the Coroner's Office hosted a table at the annual Disaster Preparedness Day at the County Event Center. The Coroner's Office table highlighted anthropological non-human bone identification and provided resources such as "What do I do Now?" pamphlets and "Vial of Life" forms to the public.

- In September 2024, a deputy coroner was the guest speaker for the College of San Mateo's Introduction to Forensic Science class sharing their experience as a deputy coroner in San Mateo County in the field of medicolegal death investigations. This is the 5th year a deputy coroner has presented to this class.

Training & Continued Professional Development

Total Employee Hours of Training: 768 hours

Deputy Coroners complete CA POST continued education and perishable skills requirements

- One deputy coroner completed the 24-hour PC832 Firearms Familiarization class which satisfies one of four California Peace Officer Standards and Training (POST) basic course requirements for Deputy Coroners.

- One deputy coroner completed the 80-hour Coroner Academy hosted by Orange County Sheriff-Coroner's Bureau. This course is a basic requirement for deputy coroners employed by a California Peace Officer Standards and Training (POST) agency.

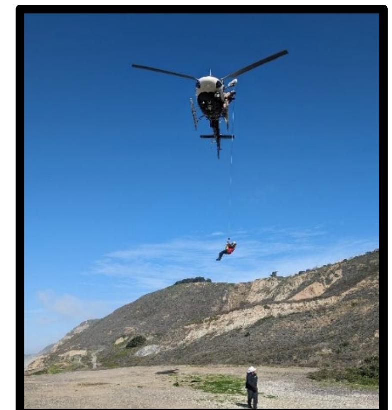
- Five deputy coroners completed the 4-hour Emergency Vehicle Operators Course (EVOC) to satisfy California's Commission on Peace Officer Standards and Training (POST) continued education and perishable skills requirements.

- Six deputy coroners completed the 4-hour firearms update course which satisfies California's Commission on Peace Officer Standards and Training (POST) perishable skills requirement.

- Seven deputy coroners completed their 8-hour First Aid/CPR/AED biannual recertification training which satisfies California Commission on Peace Officer Standards and Training requirements.

- Three employees attended a four-hour California Law Enforcement Telecommunications System (CLETS), required by the California Department of Justice.

- Two employees attended the California Department of Public Health (CDPH)'s Electronic Death Registration System and Fetal Death Registration System training classes. These classes are each four hours long and are a requirement of the state to access these systems.



A deputy coroner goes above and beyond for an investigation (January)

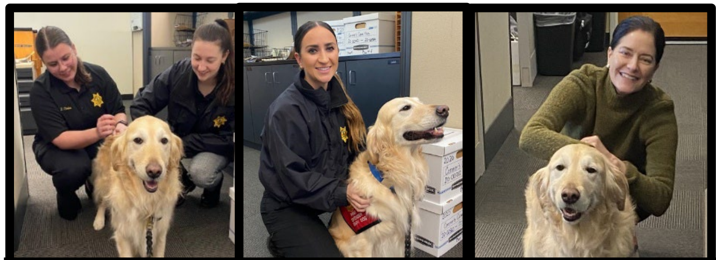
Employees recognized for a variety of accomplishments throughout the year

- In April 2024, investigative staff attended a virtual training taught by the San Mateo County District Attorney's Elder Abuse Inspector. This partnership between the Coroner's Office and District Attorney's Office to understand, thoroughly investigate, and collaborate has led to several successfully tried cases in San Mateo County.

- In May 2024, multiple deputy coroners and forensic autopsy technicians attended Narcan Administration training given by a representative of the Narcotics Task Force. The training ensures that all Coroner staff are prepared to administer Narcan to any one unintentionally or intentionally exposed to fentanyl during day-to-day operations. Narcan administration packs are allocated to each deputy coroner to have with them out in the field as well as available throughout the Coroner's Investigations and Pathology Divisions.

- In May 2024, the first annual radiation safety training with the forensic autopsy technicians who operate radiology equipment to take x-rays for each case brought into Coroner jurisdiction. This annual check-in and retraining opportunity allow for updates to be shared and questions to be reviewed.

- One hundred percent of Coroner staff completed their 20-hour County training requirement in 2024. Staff attended a variety of trainings including field-specific trainings in forensic pathology and medicolegal death investigation, professional development trainings, and wellness trainings.



National Medicolegal Death Professionals Week (January)

- In July 2024, one representative of the Coroner's Office attended the International Association of Coroners and Medical Examiners Annual Virtual Advanced Medicolegal Symposium. The symposium covered topics such as classification of child and youth suicide, cognitive bias, cold case deceased identifications, novel psychoactive substances, forensic investigative genetic genealogy, building resilient medicolegal professionals, supporting families following the loss of a loved one, unidentified persons investigations, infant death investigations, and fire deaths.

- In September 2024, the Coroner and two representatives of the Coroner's Office attended the California State Coroners Association – Coroner Advanced Symposium in Monterey which covered a variety of topics in medicolegal death investigation.

News and Recognition

# of New Employees Hired: 3
# of New Forensic Pathologists: 1
# of Academic Interns Completing Internships: 5

New staff / contractors in 2024

- Throughout 2024, the Coroner's Office brought on three new deputy coroners and one contracted locum tenens forensic pathologist to support the needs of the office.
- The Coroner's Office celebrated National Medicolegal Death Professionals Week from January 21-27, 2024, with team breakfasts and visits from Kenai from the First Responder Therapy Dog organization. The visit brought a dose of happiness and positiveness to staff while they were honored for the difficult work they do day in and day out.

- The Coroner's Office focused on wellness during First Responders Wellness Week from March 27-31, 2024. Daily reminder emails and conversations about wellness were shared among management and staff to promote awareness of wellness resources and activities including those provided through the County.

- In September 2024, the Coroner's Office welcomed new academic interns to the office. Interns spend up to two 8-hour shifts a week alongside deputy coroners and forensic autopsy technicians to learn about the field of medicolegal death investigation and forensic pathology.

- In August 2024, several council members from the City of Half Moon Bay recognized twelve members of the Coroner's Office for their dedication to their work and tireless efforts to investigate the tragic deaths of eight people during the mass shooting in Half Moon Bay on January 23, 2023.

City of Half Moon Bay Recognizes the Coroner's Office (August)

San Mateo County Coroner 2024 Staff

Robert J. Foucrault, Coroner (Elected)

Administration

K'Lynn Weber	Chief Deputy Coroner
Christi Canclini	Executive Assistant
Luz Paran-Rey	Senior Accountant
Cara Behrens	Office Assistant II

Investigations

Elizabeth Ortiz	Supervising Deputy Coroner
Holly Benedict	Deputy Coroner
Hastin Stein	Deputy Coroner
Danielle Montesano	Deputy Coroner
Alana Stark	Deputy Coroner
Michelle Schabinger	Deputy Coroner
Eden Washburn	Deputy Coroner (Jan-Aug)
Chelise Ornelas	Deputy Coroner (Feb)
Brisa Victorio	Deputy Coroner (Aug)
Grace Leimpeter	Deputy Coroner (Dec)

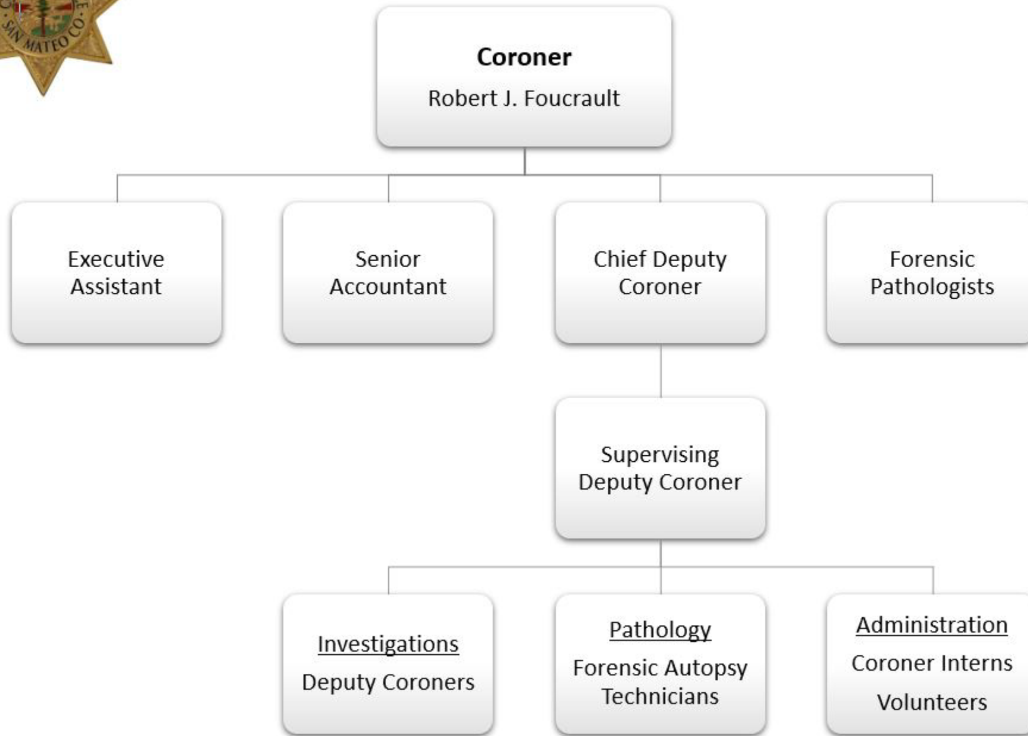
Pathology

Isabella Ratti	Forensic Autopsy Technician
Supna Nair	Forensic Autopsy Technician
Katelynn Fichou	Forensic Autopsy Technician

Contractors

Thomas Rogers, M.D.	Forensic Pathologist
Michael Hunter, M.D.	Forensic Pathologist
Vivian Snyder, D.O.	Forensic Pathologist
Angellee Chen, M.D., J.D.	Forensic Pathologist
Ellen Moffatt, M.D.	Forensic Pathologist
Varsha Podduturi, M.D.	Forensic Pathologist
Jared Brooks, 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 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.

Statistics for Calendar Year 2024

Number of deaths reported:	2,009
Number of cases for full investigation:	641
Private autopsies: 6	
Indigent cremation referral only: 17	
No-post cases: 91	
Co-sign cases: 37	
Other: 8	
Non-human remains: 7	
Native American remains: 0	
Found/abandoned cremains: 1	
Number of Elder (65+) cases investigated at scene and released:	269
Number of mutual aid requests for death notifications:	27
Number of cases by manner of death:	
Natural	312
Accident	190
Suicide	80
Homicide	13
Undetermined	13
Pending Investigation	0
Number of decedents transported:	
Coroner	548
Contractor	27
Mortuary/Funeral Home/Other	10
Forensic Examinations:	
Full Autopsy	300
Limited Autopsy	17
Clinical Review	148
Specialized (SUIDS / Homicide)	21
Hospital Autopsies	0
Number of cases where toxicology was conducted:	383

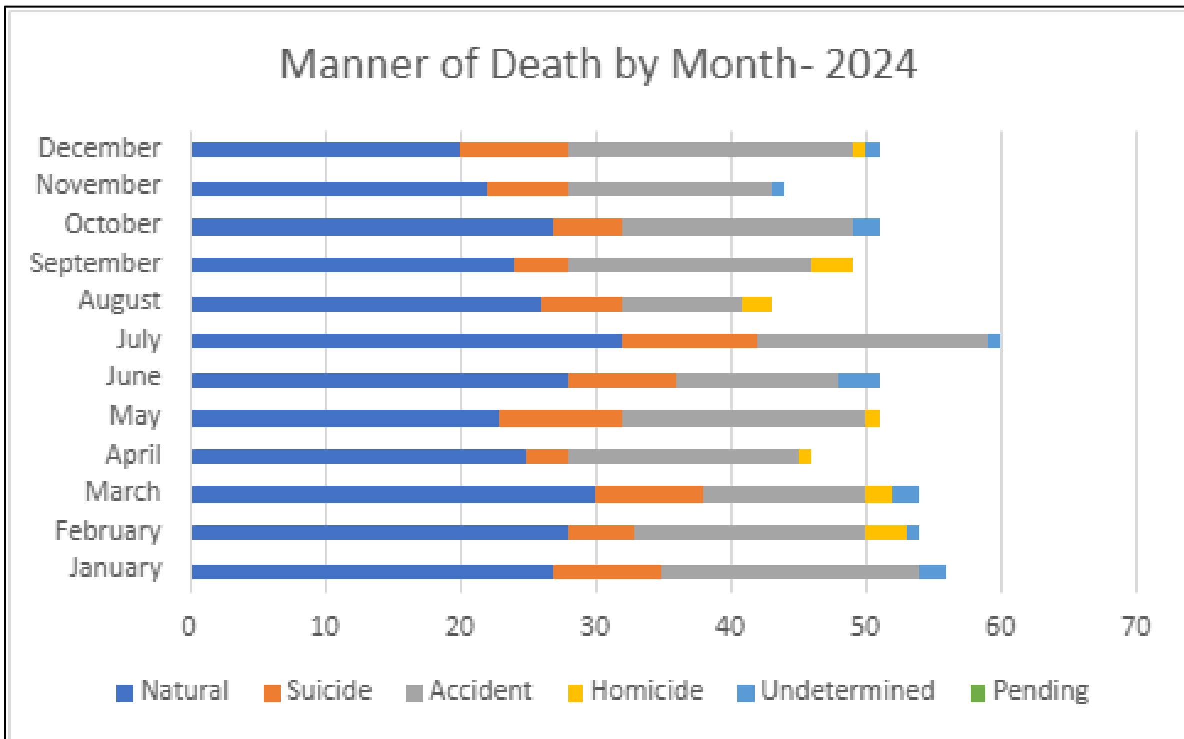
Number of cases reported as “unidentified”:	95
Still Unidentified after investigation:	3
Organ and tissue donations:	
Cases referred for donation	175
Total organ donors	9
Total organs transplanted	19
Total tissue donors	70
Exhumations:	0

Number of Law Enforcement-involved and in-custody deaths: 3

Total Law Enforcement-involved	**1**
Natural	0
Accident	0
Suicide	0
Homicide	1
Undetermined	0
Total In-custody	**2**
Natural	1
Accident	0
Suicide	1
Homicide	0
Undetermined	0

General Classifications of Death by Month

Coroner Case Statistics for 2024 by Month							
	Natural	**Suicide**	**Accident**	**Homicide**	**Undetermined**	**Pending**	**Total**
January	27	8	17	0	2	0	54
February	28	5	17	3	1	0	54
March	30	8	12	2	2	0	54
April	25	3	17	1	0	0	46
May	23	9	18	1	0	0	51
June	28	8	12	0	3	0	51
July	32	10	17	0	1	0	60
August	26	6	9	0	0	0	43
September	24	4	18	3	0	0	48
October	27	5	17	0	2	0	52
November	22	6	15	0	1	0	44
December	20	8	21	1	1	0	51
Total	**312**	**80**	**190**	**13**	**13**	**0**	608



Historical Statistics

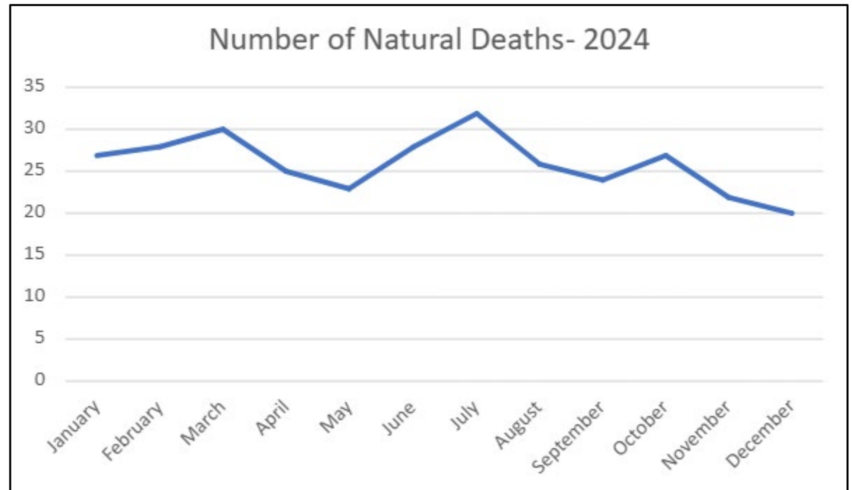
Historical Statistics (2016-2023)							
Year	**Natural**	**Suicide**	**Accident**	**Homicide**	**Undetermined**	**Pending**	**Total**
2023	276	61	218	14	9	0	578
2022	291	73	207	13	9	0	593
2021	319	54	223	20	6	0	631
2020	306	82	222	22	11	0	643
2019	347	65	188	11	7	0	618
2018	288	71	157	15	14	0	545
2017	288	55	169	10	10	0	532
2016	279	68	145	7	9	0	508

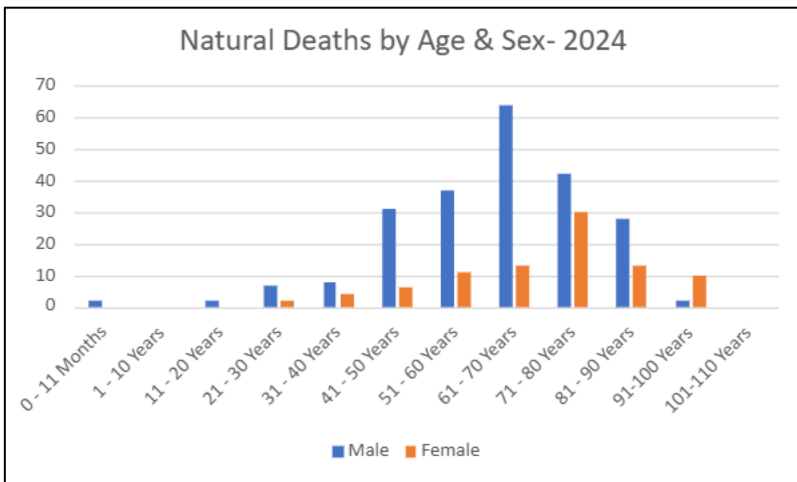
Natural

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

Total Natural Deaths in 2024: 312

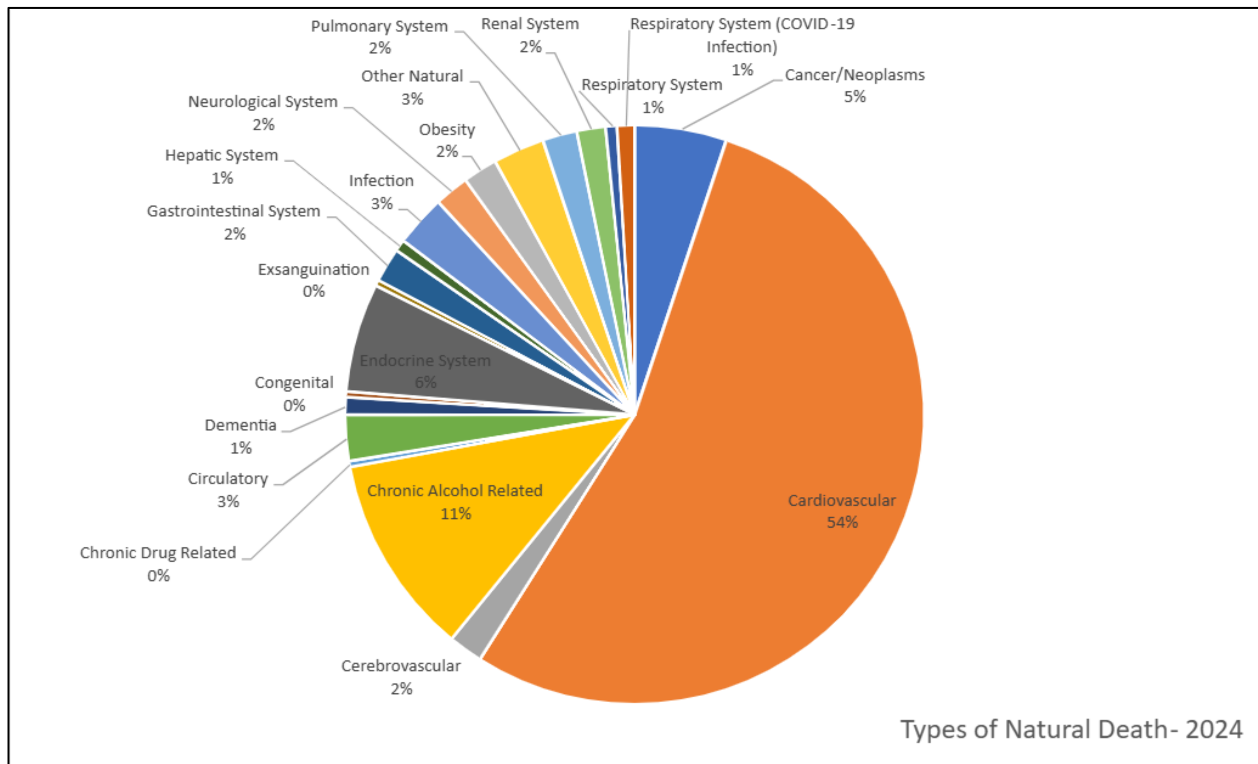
Natural Deaths by Month	
Month	**Number of Natural Deaths**
January	27
February	28
March	30
April	25
May	23
June	28
July	32
August	26
September	24
October	27
November	22
December	20





Natural Deaths by Age & Sex		
Age	**Male**	**Female**
0 - 11 Months	2	0
1 to 10 Years	0	0
11 to 20 Years	2	0
21 to 30 Years	7	2
31 to 40 Years	8	4
41 to 50 Years	31	6
51 to 60 Years	37	11
61 to 70 Years	64	13
71 to 80 Years	42	30
81 to 90 Years	28	13
91-100 Years	2	10
101-110 Years	0	0

Types of Natural Deaths by Sex			
Types of Natural Deaths	**Total**	**Male**	**Female**
Cancer/Neoplasms	16	7	9
Cardiovascular	168	119	49
Cerebrovascular	6	6	0
Chronic Alcohol Related	35	30	5
Chronic Drug Related	1	1	0
Circulatory	8	6	2
Dementia	3	0	3
Congenital	1	1	0
Endocrine System	19	10	9
Exsanguination	1	0	1
Gastrointestinal System	6	4	2
Hepatic System	2	1	1
Infection	9	9	0
Neurological System	6	5	1
Obesity	6	5	1
Other Natural	9	7	2
Pulmonary System	6	6	0
Renal System	5	4	1
Respiratory System	2	2	0
Respiratory System (COVID-19 Infection)	3	0	3

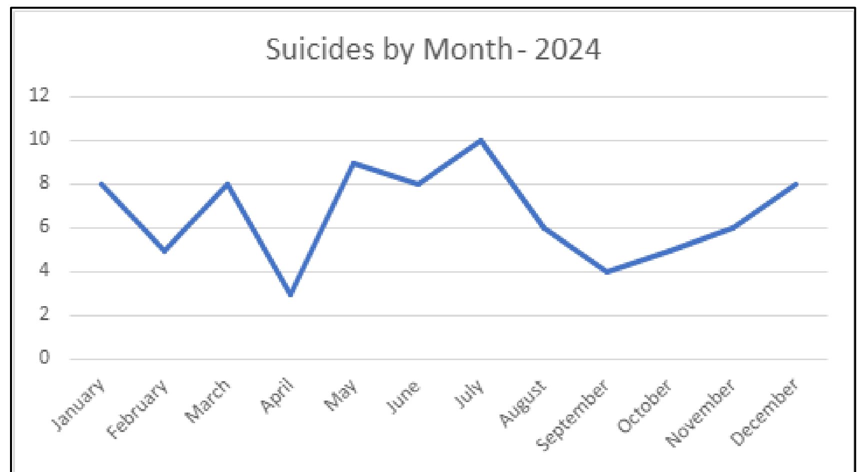


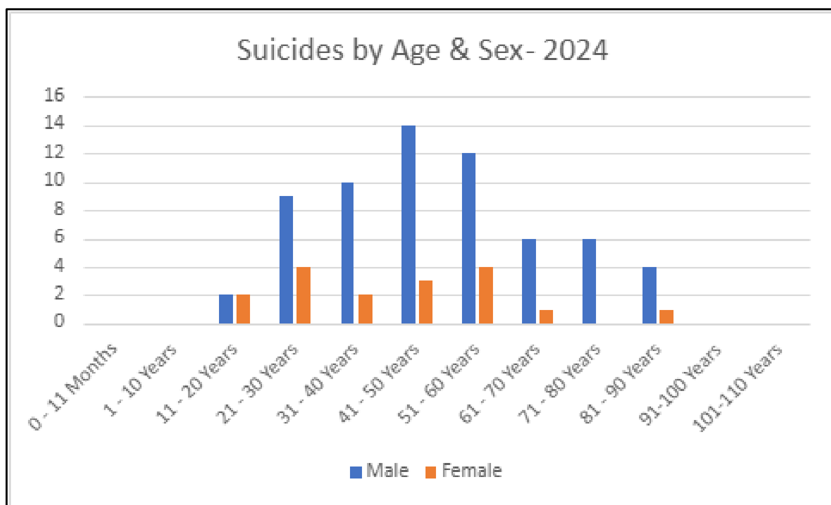
Suicide

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 2024: 80

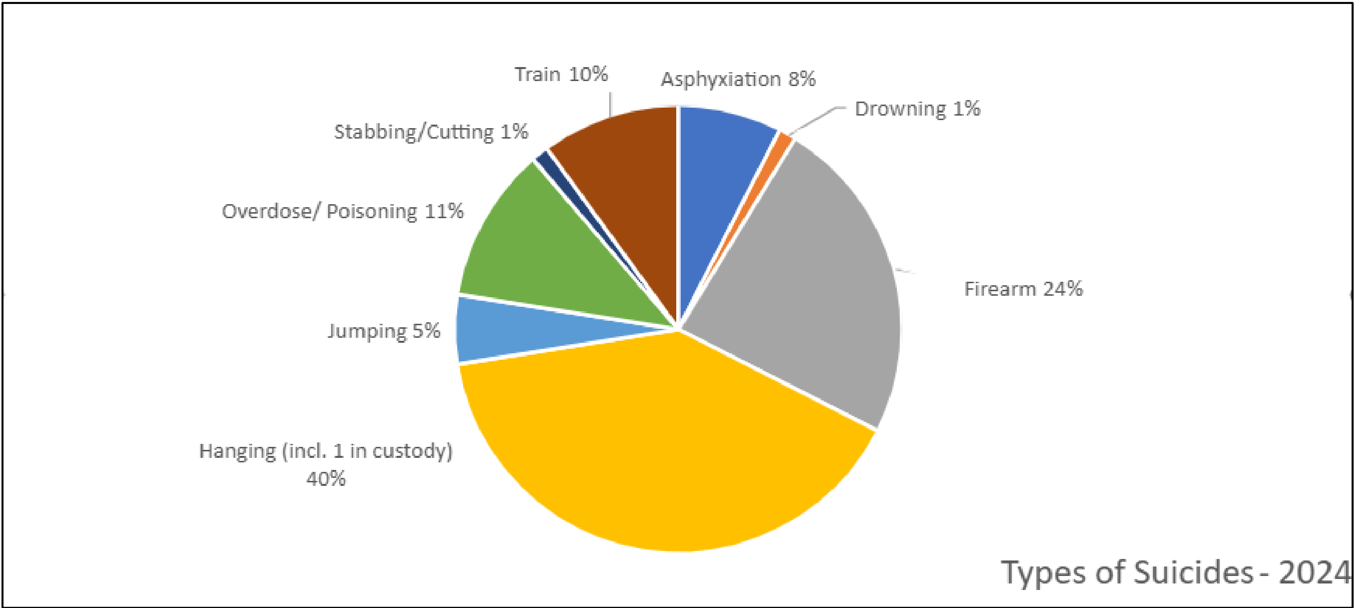
Suicide by Month	
Month	Number of Suicides
January	8
February	5
March	8
April	3
May	9
June	8
July	10
August	6
September	4
October	5
November	6
December	8





Suicide by Age & Sex		
Age	Male	Female
0 - 11 Months	0	0
1 - 10 Years	0	0
11 - 20 Years	2	2
21 - 30 Years	9	4
31 - 40 Years	10	2
41 - 50 Years	14	3
51 - 60 Years	12	4
61 - 70 Years	6	1
71 - 80 Years	6	0
81 - 90 Years	4	1
91-100 Years	0	0
101-110 Years	0	0

Types of Suicides by Sex			
Types of Suicides	Total	Male	Female
Asphyxiation	6	3	3
Drowning	1	1	0
Firearm	19	18	1
Hanging	32	25	7
Jumping	4	4	0
Overdose/ Poisoning	9	6	3
Stabbing/Cutting	1	1	0
Train	8	5	3

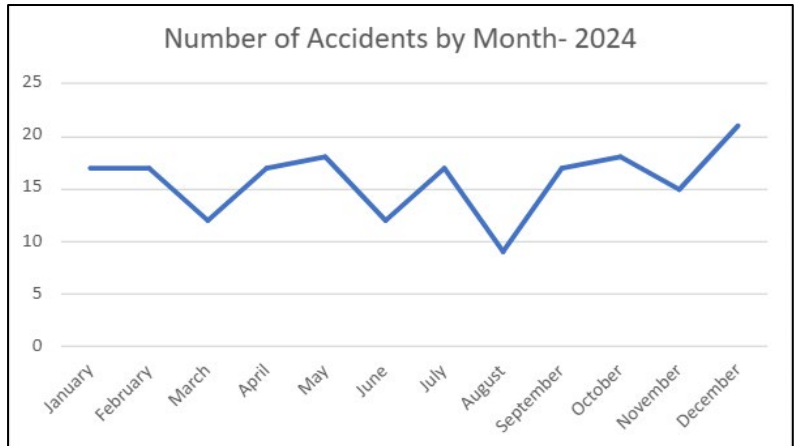


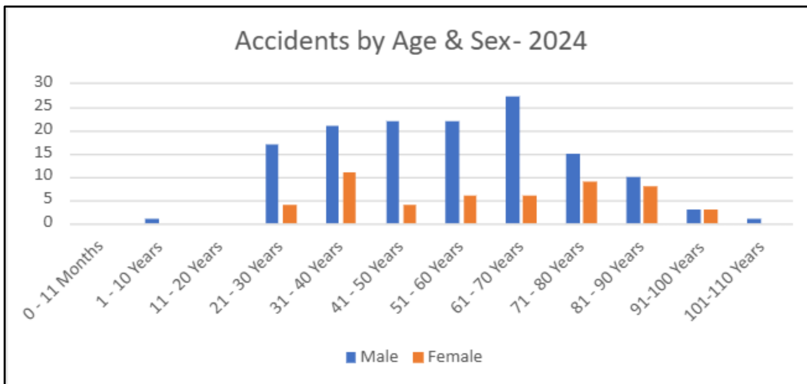
Accident

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 2024: 190

Accidents by Month	
Month	**Number of Accidents**
January	17
February	17
March	12
April	17
May	18
June	12
July	17
August	9
September	17
October	18
November	15
December	21

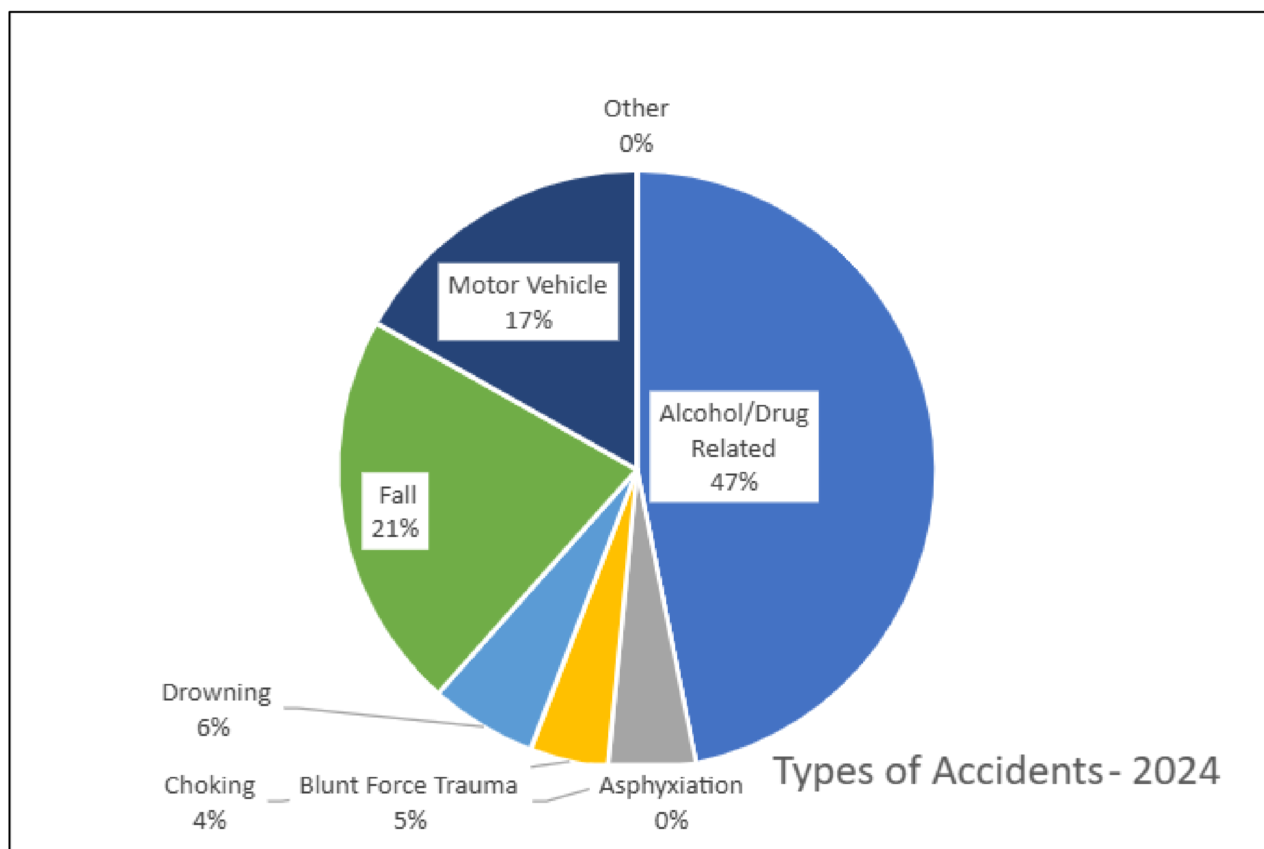




Accidental Deaths by Age & Sex		
Age	**Male**	**Female**
0 - 11 Months	0	0
1 to 10 Years	1	0
11 to 20 Years	0	0
21 to 30 Years	17	4
31 to 40 Years	21	11
41 to 50 Years	22	4
51 to 60 Years	22	6
61 to 70 Years	27	6
71 to 80 Years	15	9
81 to 90 Years	10	8
91-100 Years	3	3
101-110 Years	1	0

Types of Accidents by Sex			
Type of Accident	**Total**	**Male**	**Female**
Alcohol/Drug Related	89	73	16
Asphyxiation	0	0	0
Blunt Force Trauma	9	7	2
Choking	8	5	3
Drowning	11	7	4
Fall	41	26	15
Motor Vehicle	32	21	11
Other	0	0	0

Alcohol/Drug Related	
Type	**Total**
Fentanyl-related	28
Alcohol only	4
Other	57



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 2024: 28

Fatalities by Month	
Month	**Number of Fatalities**
January	3
February	3
March	3
April	4
May	3
June	0
July	6
August	0
September	2
October	0
November	3
December	1

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

Fatalities by Manner	
Manner of Death	**Number of Fatalities**
Natural	0
Accident	28
Suicide	0
Homicide	0
Undetermined	0

Types of Motor Vehicle Fatalities	
Type	**Number of Fatalities**
Automobile-Driver	10
Automobile-Passenger	3
Motorcyclist	4
Pedestrian	9
Bicyclist	1
Train vs Motor Vehicle	0
Natural Death While Driving	0
Other	1

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 2024: 9

Number of Motor Vehicle Fatalities	28
Number of Cases Involving Drugs and/or Alcohol	9
Number of Cases Where Toxicology Test Was Completed	24
Number of Cases Where No Toxicology Test Was Completed	3
Number of Cases Where Nothing was Detected in Toxicology Test	16

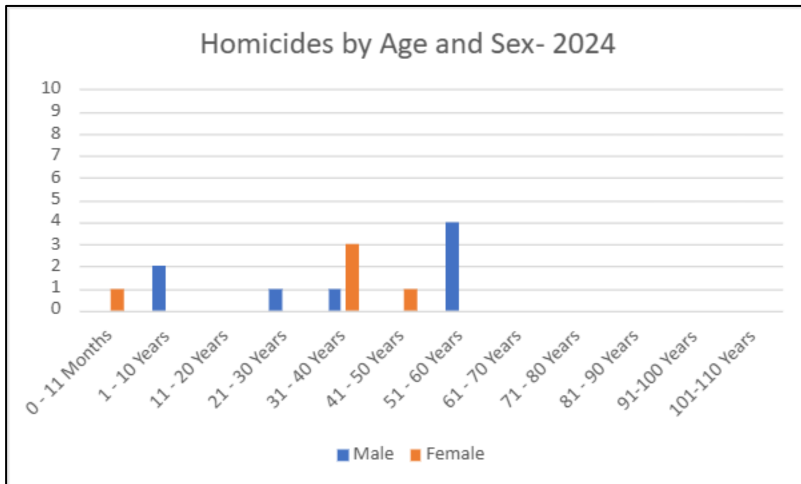
Results	Complete Drug (Including Alcohol)
Alcohol Only Present	3
Prescription and/or Over-the-Counter Drugs Only Present	1 (THC or its derivatives also present)
Illicit Drugs Only Present	2 (THC or its derivatives also present in 1 case)
Alcohol and Prescription and/or Over-the-Counter Drugs Present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

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.

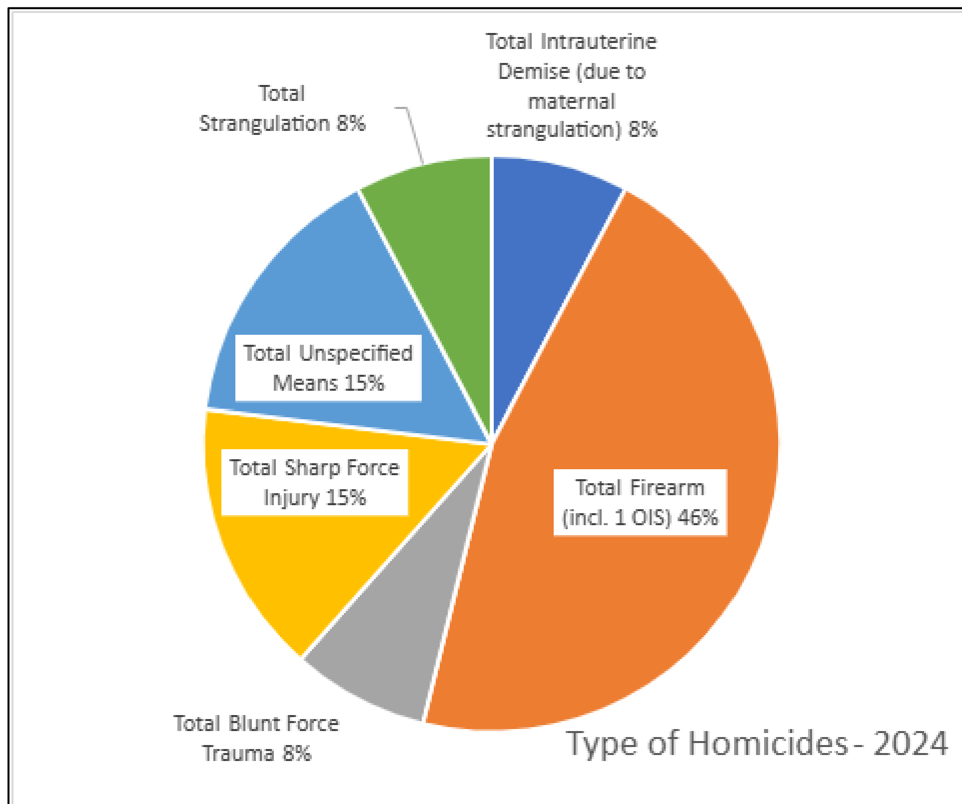
Total Number of Homicides in 2024: 13

Homicides by Month	
Month	**Number of Homicides**
January	0
February	3
March	2
April	1
May	1
June	0
July	0
August	2
September	3
October	0
November	0
December	1



Homicides by Age & Sex		
Age	**Male**	**Female**
0 - 11 Months	0	1
1 - 10 Years	2	0
11 - 20 Years	0	0
21 - 30 Years	1	0
31 - 40 Years	1	3
41 - 50 Years	0	1
51 - 60 Years	4	0
61 - 70 Years	0	0
71 - 80 Years	0	0
81 - 90 Years	0	0
91-100 Years	0	0
101-110 Years	0	0

Type of Homicide by Sex			
Type of Homicide	**Total**	**Male**	**Female**
Intrauterine Demise (due to maternal strangulation)	1	0	1
Firearm (incl. 1 OIS)	6	4	2
Blunt Force Trauma	1	1	0
Sharp Force Injury	2	1	1
Unspecified Means	2	2	0
Strangulation	1	0	1



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 2024: 13

Mode	Total
Cause known, Manner not able to be determined	1
Cause & Manner Undetermined	8
Decomposed Body or Skeletal Remains	5
Unexplained death in infancy (e.g. SUIDS)	1

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 2024: 8

Manner	Total
Natural	0
Accident	5
Suicide	0
Homicide	2
Undetermined	1

County of Death	Total
Santa Clara	5
San Francisco	3

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 2024: 37

County Cremations referred by outside agencies:	12
County Cremations referred to outside agencies:	1
Cremations performed by the San Mateo County Coroner after remains were abandoned by family:	24
Cremations performed by the San Mateo County Coroner after diligent search, but no family located:	13
Cremations performed by the San Mateo County Coroner for unidentified persons:	0
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:	22

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

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San Mateo, CA 94403

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