San Mateo County Coroner
2025 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 743,568 in 2025, which increased 0.09% from 742,893 in 2024. There were 5,350 deaths recorded in San Mateo County in 2025 which decreased 3.7% from 2024 (5,555 deaths). Of these deaths, 2,261 deaths were reported to the Coroner's Office which decreased by 12.5% from 2,009 in 2024. After initial investigation, 481 were determined to be full Coroner cases with the final cause of death signed by the Coroner, or his designated authority; this decreased 7.3% from 519 in 2024.

This 2025 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.

2025 Data Trends

Suicide Decrease
Suicide deaths were down 13.75% from 2024 (69 in 2025 versus 80 in 2024). There three times as many male suicide deaths than female suicide deaths (52 males to 17 females). The three most common modes of death were firearm (24 cases), hanging (17 cases), and overdose/poisoning (11 cases).

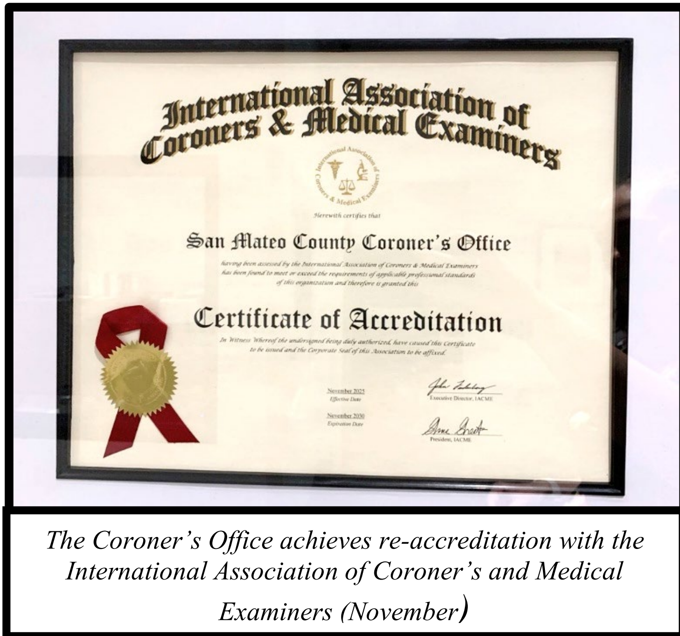
Accident Increase
Accidental deaths were up 3.2% from 2024 (196 in 2025 versus 190 in 2024). The total number of motor vehicle accidents decreased 25% in 2025 (24 in 2025 versus 32 in 2024). Drug and alcohol related deaths were down 3.4% from 2024 (86 in 2025 versus 89 in 2024). Of the 86 drug and alcohol related deaths, 30 cases tested positive for fentanyl.

Homicide Decrease
San Mateo County saw a 53.8% decrease in homicides in 2025 (6 in 2025 versus 13 in 2024).

2025 Office Highlights

The Coroner's Administration and Investigations Divisions move to new office in October joining their Pathology Division

In October 2025, the Coroner's Office officially moved into their new office on the San Mateo Medical Center campus consolidating all operations on one campus and under one connected roof. For the first time in San Mateo County Coroner's Office history, the administration, investigations, and pathology teams are working as one. Shortly after move-in, the Coroner's Office underwent a re-accreditation inspection and achieved accreditation from the International Association of Coroners and Medical Examiners (IACME) for another five years.



International Association of Coroners & Medical Examiners

Herewith certifies that

San Mateo County Coroner's Office

having been assessed by the International Association of Coroners & Medical Examiners has been found to meet or exceed the requirements of applicable professional standards of this organization and therefore is granted this

Certificate of Accreditation

In Witness Whereof the undersigned being duly authorized, have caused this Certificate to be issued and the Corporate Seal of this Association to be affixed.

November 2025
Effective Date

Executive Director, IACME

November 2030
Expiration Date

President, IACME

The Coroner's Office achieves re-accreditation with the International Association of Coroner's and Medical Examiners (November)

Throughout 2025, 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 to the team; supported data sharing efforts locally, state-wide, and nationally. Below outlines some of the activities and accomplishments of the Office in 2025.

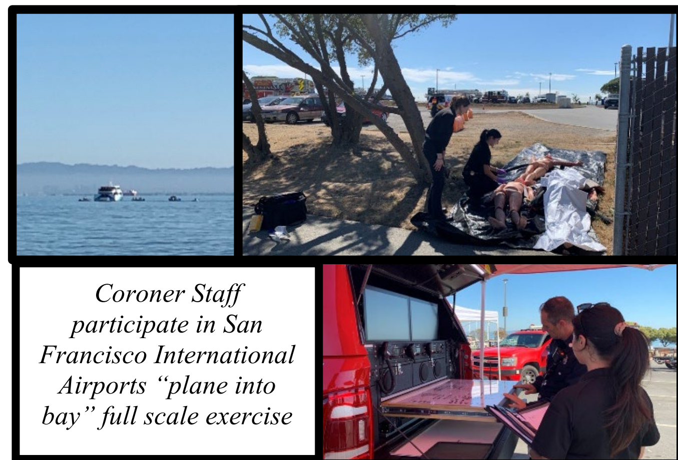
Collaboration and Partnerships

Collaborative Meetings Attended: 17
# of Agency Trainings Presented: 6
# of Full-Scale Mass Fatality Exercises Participated In: 1

- Throughout 2025, 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.

- 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.



Coroner Staff participate in San Francisco International Airports "plane into bay" full scale exercise

- In March 2025, the Supervising Deputy Coroner presented about the Coroner's Office role and responsibilities at six briefing trainings for a local law enforcement agency. This type of training allows for improved collaboration between agencies during reports of death and scene investigations.

- In September 2025, four Coroner staff participated in the San Francisco International Airport (SFO) Full Scale Exercise with numerous first responder, emergency management, and law enforcement agencies in San Francisco and San Mateo counties. This large-scale exercise evaluated the performance of duties and collaboration among agencies in the scenario of a plane landing in San Francisco Bay.

- Annually in November, a Coroner's Office representative presents to the San Mateo County Suicide Prevention Committee (SPC) regarding the role of the Coroner's Office, provides updated suicide-related death statistics, and responds to questions from committee members.

Community Involvement

Ride-Alongs Hosted: 13
# of Morgue Tours Given: 5
# of Teaching or Other Community Engagements: 6

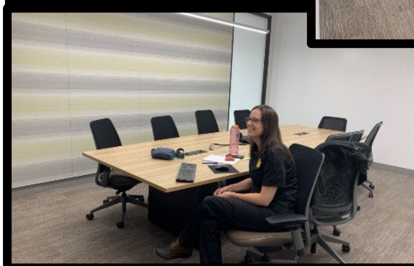
Coroner's Office Pathology Staff and Interns with Kenai at Disaster Preparedness Day (August)

- 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, four ride-alongs, and met with one high school student for an informational interview about medicolegal death investigations.

- For the fourth 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 nine 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.

- During 2025, two deputy coroners were guest speakers at their alma maters. One deputy coroner spoke to the College Park High School Honors Human Body System class, part of the Biomedical Career Technical Education (CTE) pathway, regarding her experience becoming a deputy coroner and working in the field of medicolegal death investigations. A second deputy coroner presented to Seattle University's Introductory Forensic Science course regarding her tenure and experience in the field for the second time.

A Deputy Coroner is the guest lecturer for a collegiate Introduction to Forensic Science course



- In May 2025, Coroner representatives participated in the San Mateo County Career Fair at the San Mateo County Event Center. Staff hosted a table and shared job opportunities with community members interested in working for the Coroner's Office.

- In August 2025, the Coroner's Office hosted a table at the 21st Annual Disaster Preparedness Day at the San Mateo 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 2025, a deputy coroner was a guest lecturer 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 6th year a deputy coroner has presented to this class.

Coroner staff speak at Skyline College Career Fair

- In October 2025, the Supervising Deputy Coroner and Supervising Forensic Autopsy Technician participated in the Skyline College Event & Job Fair. The Supervising Deputy Coroner was a panelist discussing their experience "Working in County Government" / "How to Start Your Career in Public Service" while the Supervising Forensic Autopsy Technician hosted a table to meet with students and answer their questions regarding the department mission, job roles, public service impact, career paths and internships.

Training & Continued Professional Development

Total Employee Hours of Training: 676 hours

- Two deputy coroners completed the 40-hour PC832 Arrest and Control 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.

Forensic Autopsy Technician Ratti at the POST Basic Autopsy Technician Course

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

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

- One employee 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.

- Two employees completed their training on the Lodox radiology equipment in the Pathology Division.

- In January 2025, one forensic autopsy technician attended the 24-hour California Peace Officer Standards and Training (POST) Basic Autopsy Technician Training Course at the Orange County Sheriff-Coroner Training Center. The training course is to equip individuals with the necessary knowledge and skills to effectively support coroners and medical examiners in investigating and determining the cause and manner of death. The course covered topics such death investigation, autopsy techniques, anatomy, physiology, wound recognition, decedent management, identification, evidence collection, and mental/ physical health related to the autopsy technician role.

Coroner's Office support staff at Christmas

- In May 2025, the second annual radiation safety training was held by the department as a refresher for the forensic autopsy technicians who operate radiology equipment. This annual check-in and retraining opportunity allows for updates to be shared and questions to be reviewed.

- One hundred percent of Coroner staff completed their 20-hour County training requirement in 2025. Staff attended a variety of trainings including field-specific trainings in forensic pathology and medicolegal death investigation, professional development trainings, and wellness trainings.

- In September 2025, the Coroner and two representatives of the Coroner's Office attended the California State Coroners Association – Coroner Advanced Symposium in San Diego which covered a variety of topics in medicolegal death investigation.

- In October 2025, one deputy coroner attended courtroom testimony training taught by the San Mateo County District Attorney's Office.

- One supervising forensic autopsy technician attended three of the four required "essential supervisory series" training classes offered in 2025

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

News and Recognition

# of New Employees Hired: 2
# of Academic Interns Completing Internships: 5

- In 2025, the Coroner's Office hired two new forensic autopsy technicians, both of which were previous academic interns, to support the needs of the Pathology Division.

New staff in 2025

- The Coroner's Office celebrated National Medicolegal Death Professionals Week from January 19-25, 2025, with team breakfasts in the new conference room. This week is designated to honor the work of the "last responder" and all the support staff who compassionately and respectfully serve the community of San Mateo County.

- In July 2025, the Coroner's Office was visited by First Responder Therapy Dogs, an organization to provide emotional support to emergency responders. This visit brought a dose of happiness and positiveness for staff.

First Responder Therapy Dog visit for staff wellness (July)

- In September 2025, the Coroner's Office welcomed one new academic intern to the office, joining two others to continue learning alongside our deputy coroners and forensic autopsy technicians. This hands-on experience provides insight and necessary training for a future in medicolegal death investigation or a related field. Interviews for a new wave of incoming academic were held in December 2025 to begin after the new year.

San Mateo County Coroner 2025 Staff

Robert J. Foucrault, Coroner (Elected)

Administration

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

Investigations

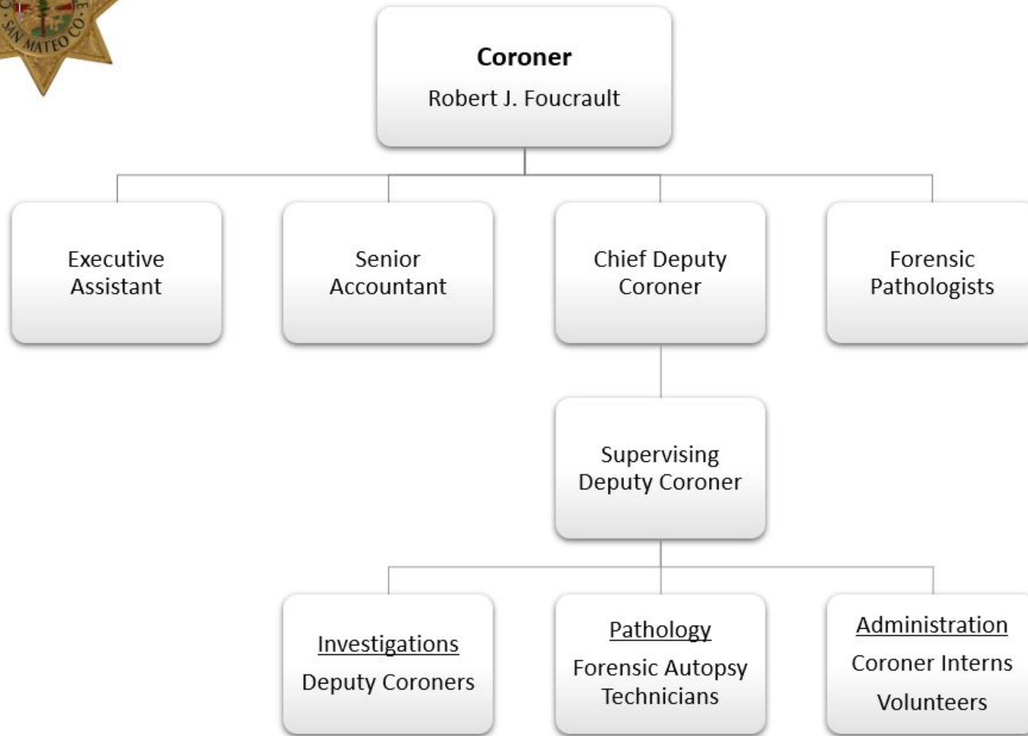
Elizabeth Ortiz	Supervising Deputy Coroner
Holly Benedict	Deputy Coroner
Hastin Stein	Deputy Coroner
Danielle Montesano	Deputy Coroner
Alana Stark	Deputy Coroner
Michelle Schabinger	Deputy Coroner
Chelise Ornelas	Deputy Coroner
Brisa Victorio	Deputy Coroner
Grace Leimpeter	Deputy Coroner

Pathology

Isabella Ratti	Forensic Autopsy Technician
Tara Eckert	Forensic Autopsy Technician (Mar-Dec)
Gloria Hernandez	Forensic Autopsy Technician (Oct-Dec)

Contractors

Thomas Rogers, M.D.	Forensic Pathologist (Jan-June)
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 (Jan-June)
Varsha Podduturi, M.D.	Forensic Pathologist (Jan-June)
Jared Brooks, M.D.	Forensic Pathologist


County of San Mateo
CORONER'S OFFICE
ORGANIZATIONAL CHART
Coroner
Robert J. Foucrault
Executive Assistant
Senior Accountant
Chief Deputy Coroner
Forensic Pathologists
Supervising Deputy Coroner
Investigations
Deputy Coroners
Pathology
Forensic Autopsy Technicians
Administration
Coroner Interns
Volunteers

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.

Statistics for Calendar Year 2025

Number of deaths reported:	2,261
Number of cases for full investigation:	618
Private autopsies: 6	
Indigent cremation referral only: 42	
No-post cases: 75	
Co-sign cases: 47	
Other: 14	
Non-human remains: 4	
Native American remains: 1	
Found/abandoned cremains: 9	
Number of Elder (65+) cases investigated at scene and released:	206
Number of mutual aid requests for death notifications:	34
Number of cases by manner of death:	
Natural	271
Accident	196
Suicide	69
Homicide	6
Undetermined	13
Pending Investigation	1
Forensic Examinations:	
Full Autopsy	281
Limited Autopsy	17
Clinical Review	112
Specialized (SUIDS / Homicide)	22
Hospital Autopsies	0
Number of cases where toxicology was conducted:	365
Number of cases reported as “unidentified”:	58
Still Unidentified after investigation :	1

Organ and tissue donations:

Cases referred for donation	64
Total organ donors in SMC	13
Total organs transplanted	36
Total tissue donors in SMC\	94

Exhumations: 0

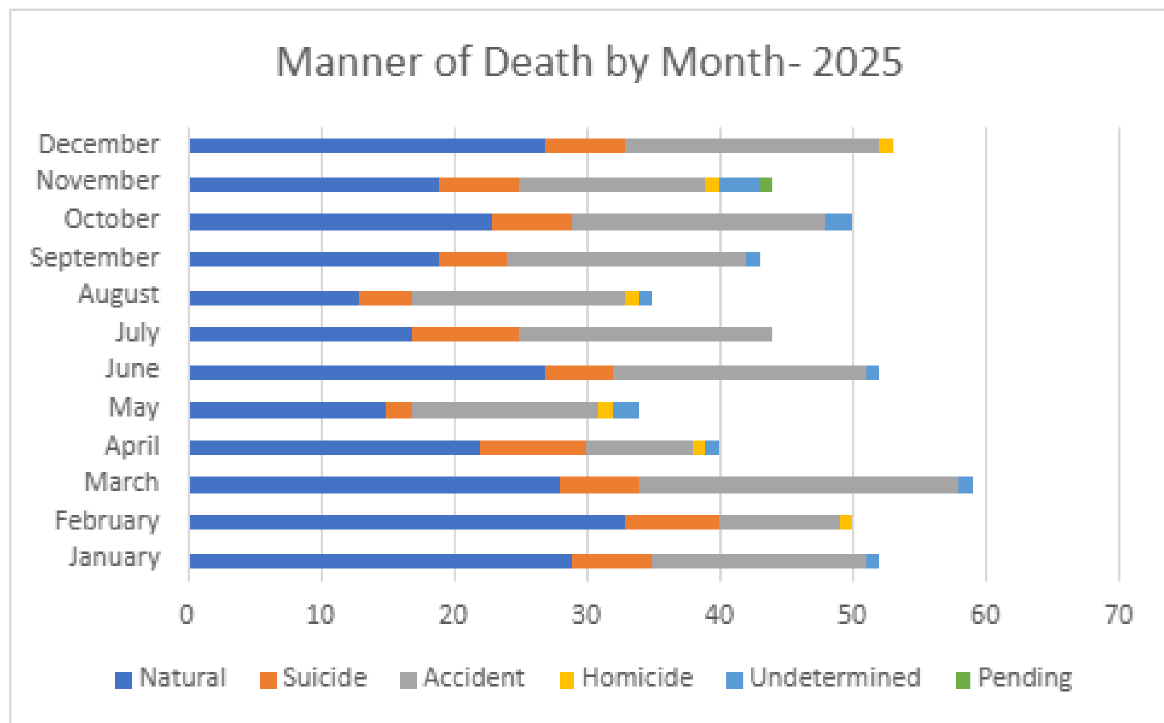
Number of Law Enforcement-involved and in-custody deaths: **6**

Total Law Enforcement-involved	**4**
Natural	0
Accident	1
Suicide	0
Homicide	3
Undetermined	0

Total In-custody	**2**
Natural	0
Accident	2
Suicide	0
Homicide	0
Undetermined	0

General Classifications of Death by Month

Coroner Case Statistics for 2025 by Month							
	Natural	**Suicide**	**Accident**	**Homicide**	**Undetermined**	**Pending**	**Total**
January	29	6	16	0	1	0	52
February	33	7	9	1	0	0	50
March	28	6	24	0	1	0	59
April	22	8	8	1	1	0	40
May	15	2	14	1	2	0	34
June	27	5	19	0	1	0	52
July	17	8	19	0	0	0	44
August	13	4	16	1	1	0	35
September	19	5	18	0	1	0	43
October	23	6	19	0	2	0	50
November	19	6	14	1	3	1	44
December	26	6	20	1	0	0	53
Total	271	69	196	6	13	1	556



Historical Statistics

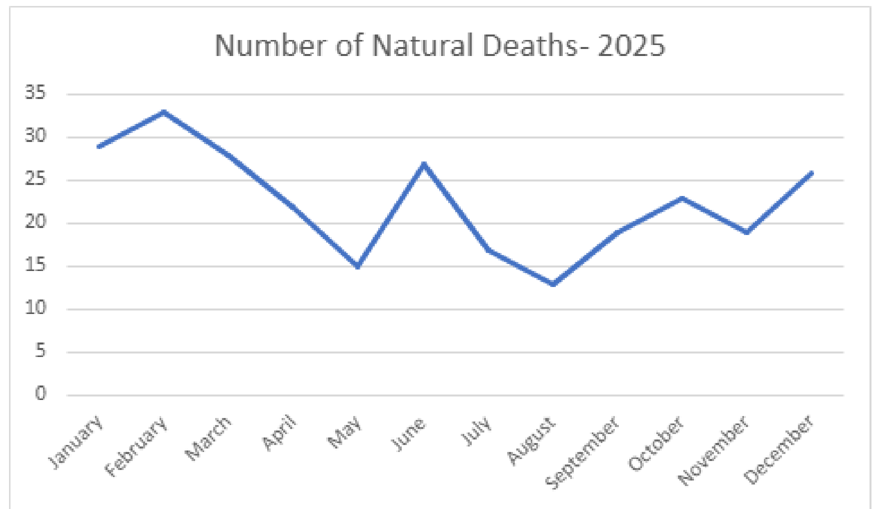
Historical Statistics (2016-2024)							
Year	**Natural**	**Suicide**	**Accident**	**Homicide**	**Undetermined**	**Pending**	**Total**
2024	312	80	190	13	13	0	608
2023	276	61	218	14	9	0	578
2022	291	73	207	13	9	0	593
2021	319	54	223	20	6	0	631
2020	306	82	222	22	11	0	643
2019	347	65	188	11	7	0	618
2018	288	71	157	15	14	0	545
2017	288	55	169	10	10	0	532
2016	279	68	145	7	9	0	508

Natural

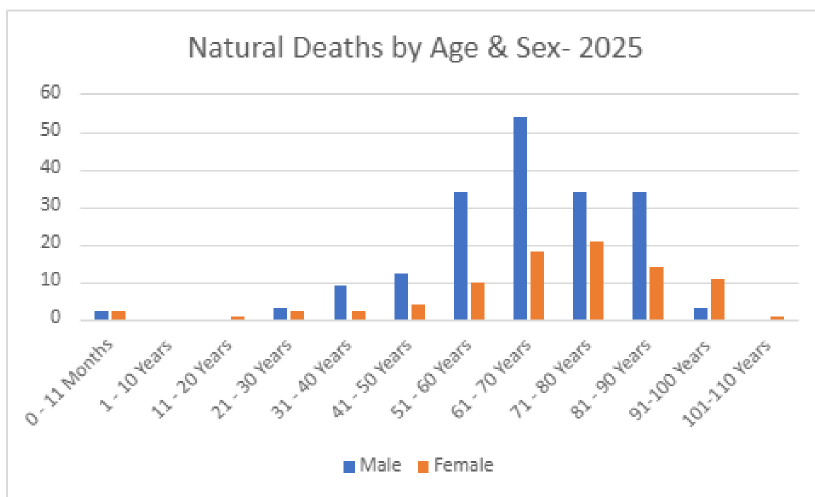
Natural deaths are due solely or nearly totally to disease and/or the aging process.

Total Natural Deaths in 2025: 271

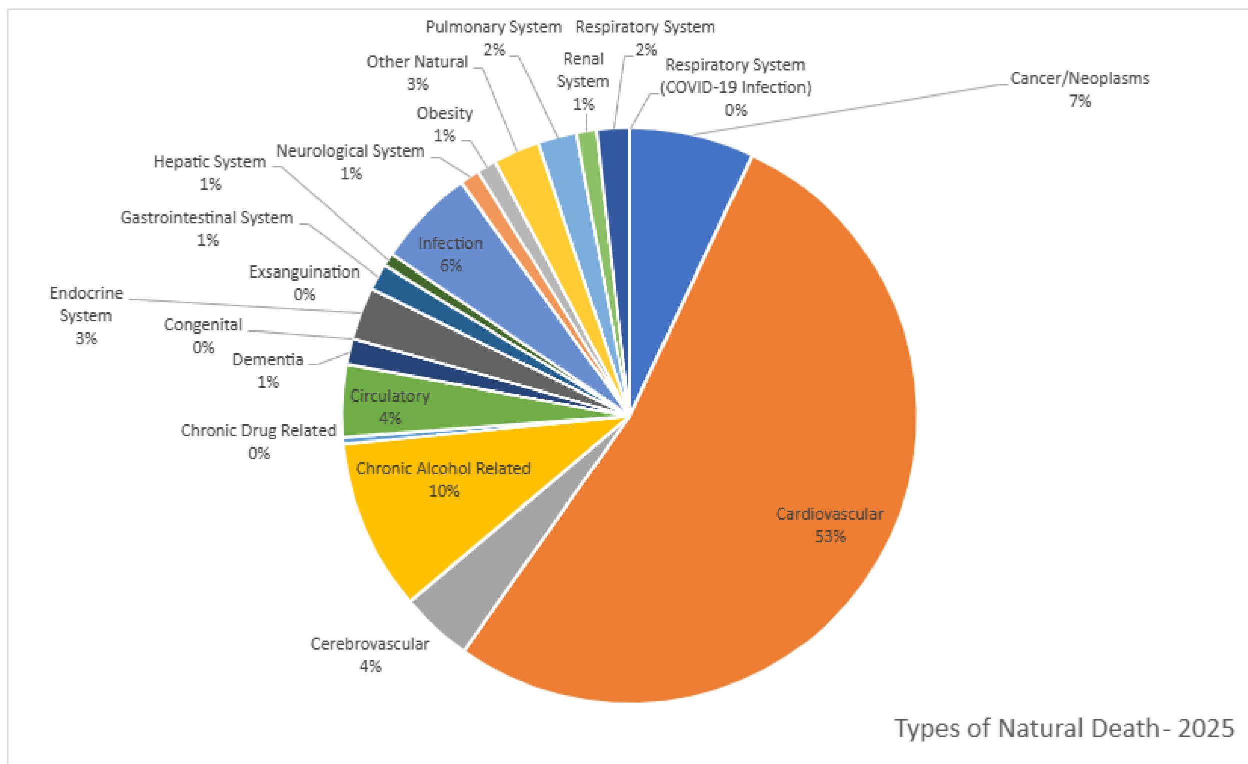
Natural Deaths by Month	
Month	**Number of Natural Deaths**
January	29
February	33
March	28
April	22
May	15
June	27
July	17
August	13
September	19
October	23
November	19
December	26



Natural Deaths by Age & Sex		
Age	**Male**	**Female**
0 - 11 Months	2	2
1 to 10 Years	0	0
11 to 20 Years	0	1
21 to 30 Years	3	2
31 to 40 Years	9	2
41 to 50 Years	12	4
51 to 60 Years	34	10
61 to 70 Years	54	18
71 to 80 Years	34	21
81 to 90 Years	34	14
91-100 Years	3	11
101-110 Years	0	1



Types of Natural Deaths by Sex			
Types of Natural Deaths	**Total**	**Male**	**Female**
Cancer/Neoplasms	19	13	6
Cardiovascular	143	100	43
Cerebrovascular	11	6	5
Chronic Alcohol Related	26	17	9
Chronic Drug Related	1	1	0
Circulatory	11	10	1
Dementia	4	1	3
Congenital	0	0	0
Endocrine System	8	5	3
Exsanguination	0	0	0
Gastrointestinal System	4	2	2
Hepatic System	2	2	0
Infection	15	8	7
Neurological System	3	2	1
Obesity	3	1	2
Other Natural	7	6	1
Pulmonary System	6	4	2
Renal System	3	3	0
Respiratory System	5	4	1
Respiratory System (COVID-19 Infection)	0	0	0

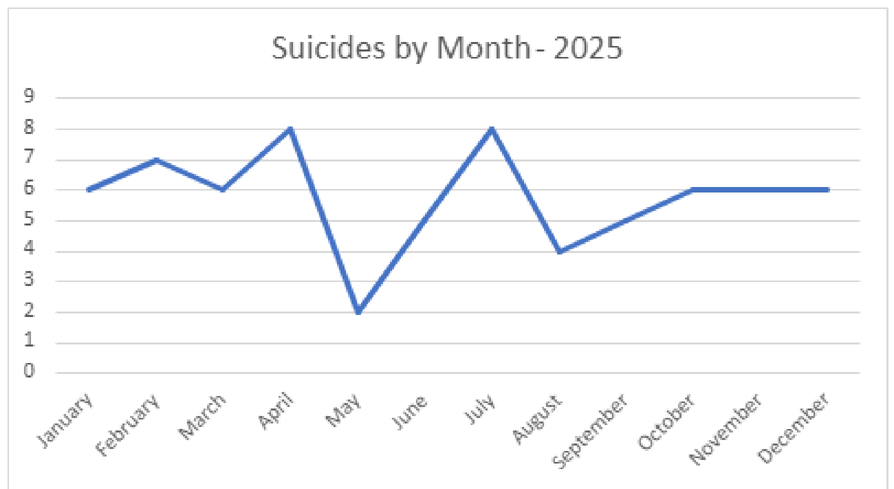


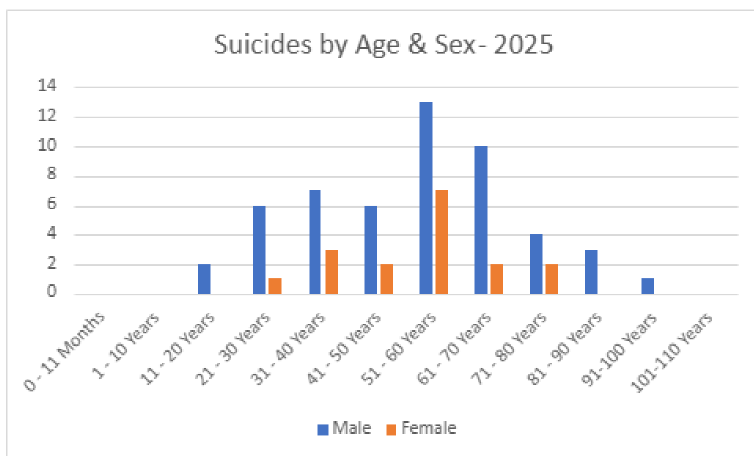
Suicide

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 2025: 69

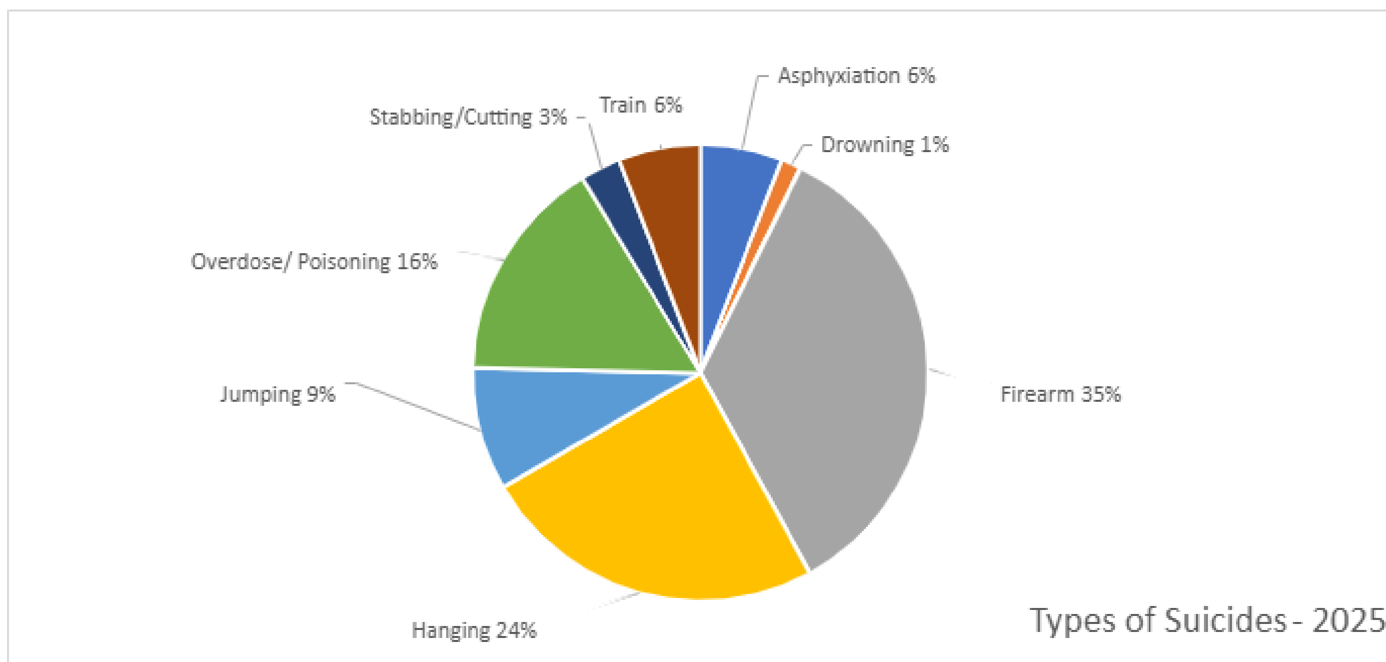
Suicide by Month	
Month	Number of Suicides
January	6
February	7
March	6
April	8
May	2
June	5
July	8
August	4
September	5
October	6
November	6
December	6





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

Types of Suicides by Sex			
Types of Suicides	Total	Male	Female
Asphyxiation	4	2	2
Drowning	1	1	0
Firearm	24	23	1
Hanging	17	11	6
Jumping	6	5	1
Overdose/ Poisoning	11	6	5
Stabbing/Cutting	2	1	1
Train	4	3	1

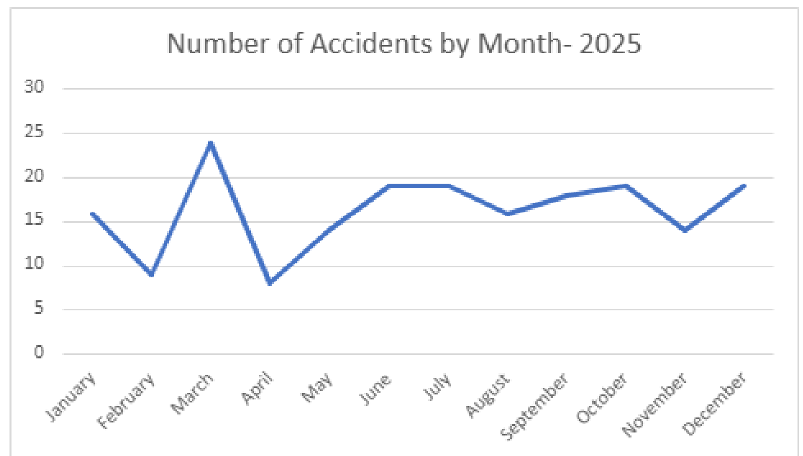


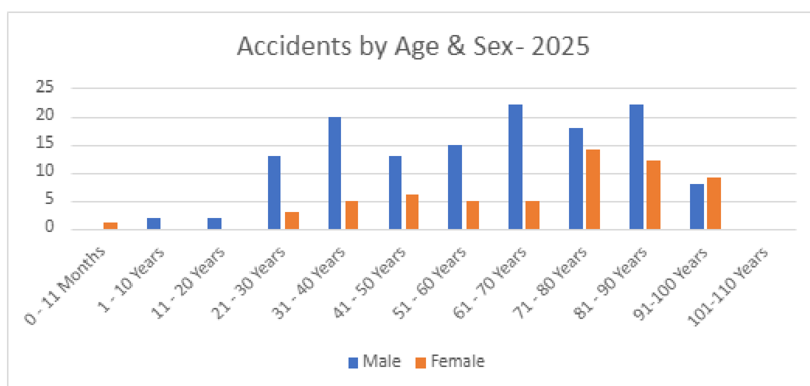
Accident

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 2025: 196

Accidents by Month	
Month	**Number of Accidents**
January	16
February	9
March	24
April	8
May	14
June	19
July	19
August	16
September	18
October	19
November	14
December	20

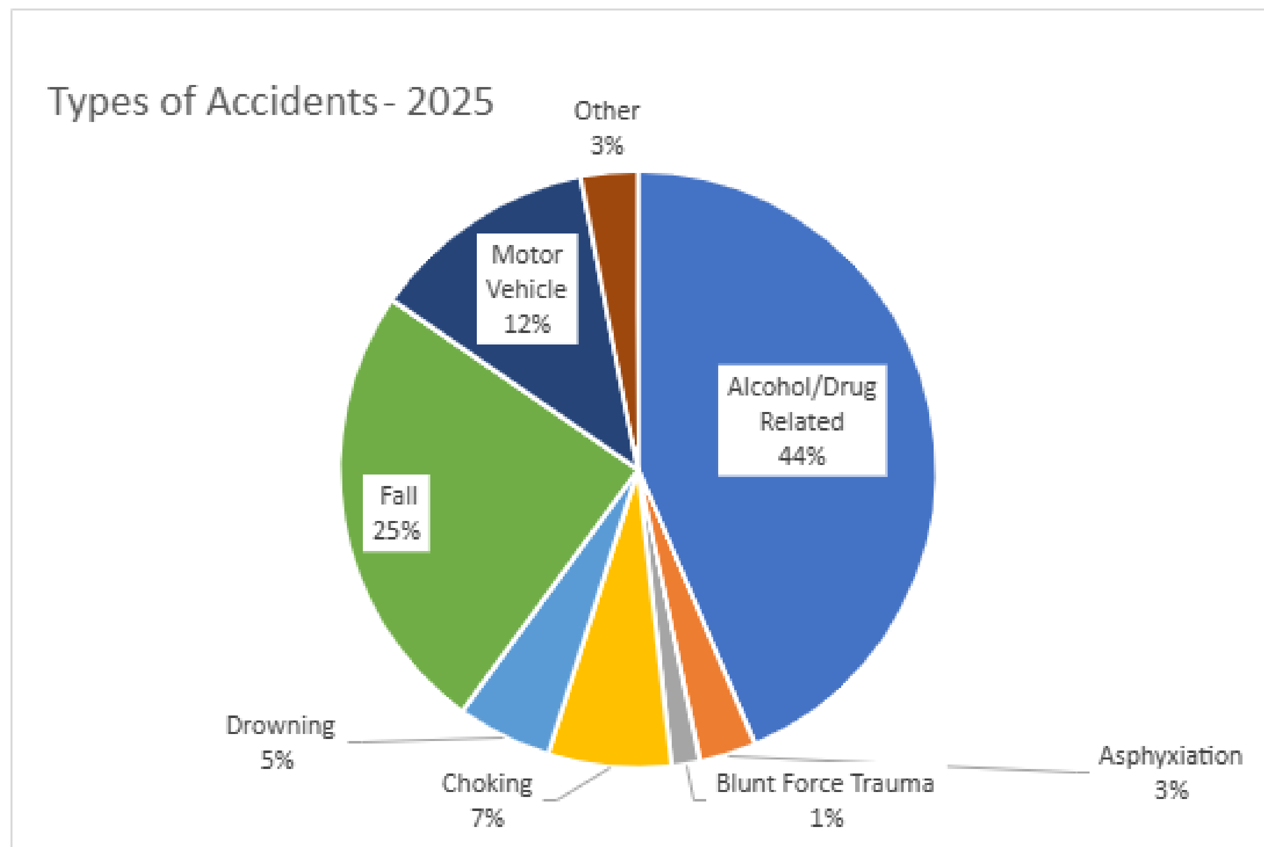




Accidental Deaths by Age & Sex		
Age	**Male**	**Female**
0 - 11 Months	0	1
1 to 10 Years	2	0
11 to 20 Years	2	0
21 to 30 Years	13	3
31 to 40 Years	20	5
41 to 50 Years	13	6
51 to 60 Years	15	5
61 to 70 Years	23	5
71 to 80 Years	18	14
81 to 90 Years	22	12
91-100 Years	8	9
101-110 Years	0	0

Types of Accidents by Sex			
Type of Accident	**Total**	**Male**	**Female**
Alcohol/Drug Related	86	66	20
Asphyxiation	6	4	2
Blunt Force Trauma	3	2	1
Choking	13	8	5
Drowning	10	6	4
Fall	48	30	18
Motor Vehicle	24	16	8
Other	6	4	2

Alcohol/Drug Related	
Type	**Total**
Fentanyl-related	30
Alcohol only	2
Other	54



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 2025: 24

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

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

Fatalities by Manner	
Manner of Death	**Number of Fatalities**
Natural	0
Accident	24
Suicide	0
Homicide	0
Undetermined	0

Types of Motor Vehicle Fatalities	
Type	**Number of Fatalities**
Automobile-Driver	11
Automobile-Passenger	2
Motorcyclist	2
Pedestrian	8
Bicyclist	1
Train vs Motor Vehicle	0
Natural Death While Driving	0
Other	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 2025: 10

Number of Motor Vehicle Fatalities	24
Number of Cases Involving Drugs and/or Alcohol	10
Number of Cases Where Toxicology Test Was Completed	19
Number of Cases Where No Toxicology Test Was Completed	5
Number of Cases Where Nothing was Detected in Toxicology Test	9

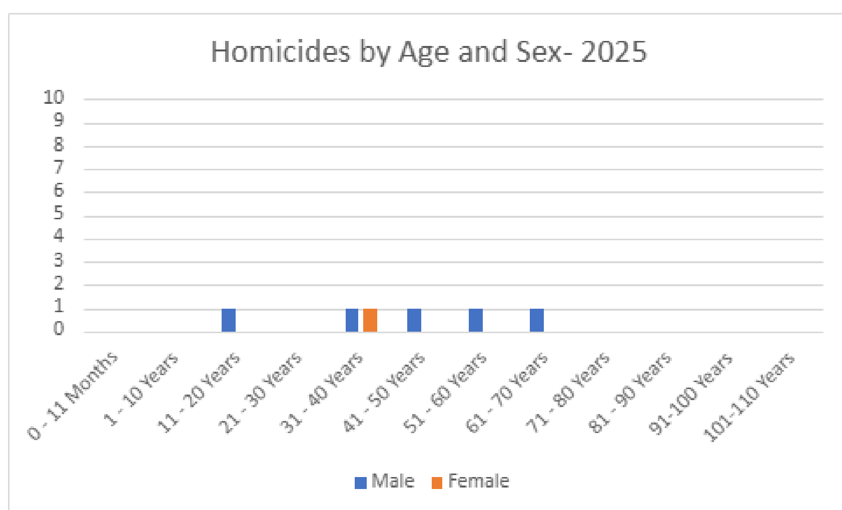
Results	Complete Drug (Including Alcohol)
Alcohol Only Present	4
Prescription and/or Over-the-Counter Drugs Only Present	0
Illicit Drugs Only Present	1 (including THC or its derivatives)
Alcohol and Prescription and/or Over-the-Counter Drugs Present	0
Alcohol and Illicit Drugs Present	2 (including THC or its derivatives)
Prescription and/or Over-the Counter and Illicit Drugs Present	0
Prescription and/or Over-the Counter, Illicit Drugs, and Alcohol Present	1 (including THC or its derivatives)
THC (or its derivatives) Only Present	1
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.

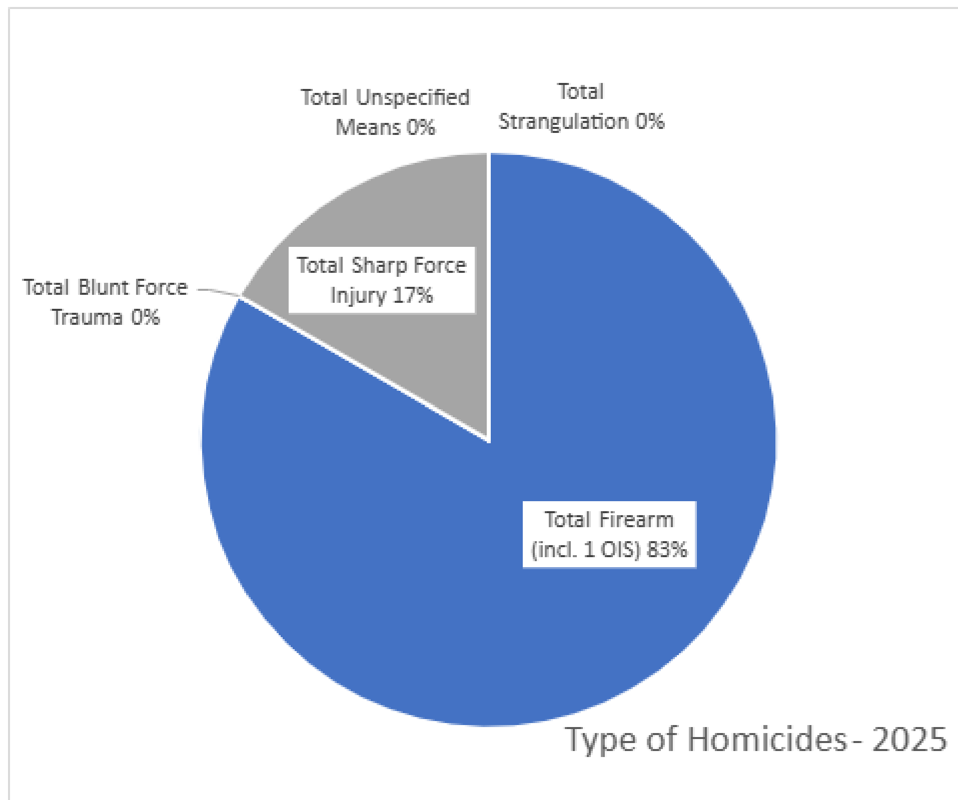
Total Number of Homicides in 2025: 6

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



Homicides by Age & Sex		
Age	**Male**	**Female**
0 - 11 Months	0	0
1 - 10 Years	0	0
11 - 20 Years	1	0
21 - 30 Years	0	0
31 - 40 Years	1	1
41 - 50 Years	1	0
51 - 60 Years	1	0
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

Type of Homicide by Sex			
Type of Homicide	**Total**	**Male**	**Female**
Firearm (incl. 1 OIS)	5	4	1
Blunt Force Trauma	0	0	0
Sharp Force Injury	1	1	0
Unspecified Means	0	0	0
Strangulation	0	0	0



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 2025: 13

Mode	Total
Cause known, Manner not able to be determined	6
Cause & Manner Undetermined	4
Decomposed Body or Skeletal Remains	0
Unexplained death in infancy (e.g. SUIDS)	3

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 2025: 18

Manner	Total
Natural	2
Accident	8
Suicide	3
Homicide	2
Undetermined	2
Pending Investigation	1

County of Death	Total
Santa Clara	13
San Francisco	5

Indigent Cremation

Through the County's indigent 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 as defined by Health & Safety Codes §7103 and §7104.

Total Number of Indigent Cremations in 2025: 40

Indigent cremations referred by outside agencies:	32
Indigent cremations referred to outside agencies:	2
Indigent cremations performed by the Coroner after remains were abandoned by family:	23
Indigent cremations performed by the Coroner after a diligent search, but no family located:	10
Indigent cremation referrals resulting in family handling final dispositions after family was located:	7
Indigent cremations performed by the Coroner for unidentified persons:	0
Cremains collected by family upon locating next of kin after indigent cremation performed:	0
Final dispositions handled by family after receiving a fee reduction by application for financial need:	26
Collected cremains received by Coroner and placed in County niche:	7
Indigent cremation referrals declined by San Mateo County:	5

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

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