

Sheriff-Coroner's Office and Morgue Inspection

Summary

The Sonoma County Civil Grand Jury (Grand Jury) received a citizen complaint requesting an investigation into the County's contractual arrangements with Forensic Medical Group (FMG) of Fairfield, California to provide pathology services at the County Morgue. The Grand Jury was also asked to investigate whether the County could be better served by an alternative to the current elected Sheriff-Coroner model and whether the County might establish a modern, scientific facility designed specifically for the investigation of human deaths.



The Grand Jury researched the contractual agreement between the County and FMG. The Grand Jury also researched the history of electing a Sheriff-Coroner. With respect to the County's Morgue facilities, after determining that the Grand Jury had not published a report on these facilities in the last 15 years, the Grand Jury conducted an inspection of the Coroner's Office and Morgue.

The Grand Jury found that FMG, the current County contractor for pathology services, has consistently been late in providing final autopsy reports. Fines specified in the contract have never been imposed.

The County has had an elected Sheriff-Coroner since 1974. The vast majority of California counties use this model. Prior to 1974, the coroner and the sheriff were elected separately, a model still used by some California counties. In lieu of an elected coroner, a few counties appoint a medical examiner, a licensed forensic physician. A nationwide shortage makes it difficult for counties to recruit and retain qualified forensic pathologists. The Grand Jury recognizes that the use of the Sheriff-Coroner model is a matter of current concern because of potential conflicts of interest between the sheriff and the coroner roles, but it takes no position on the appropriateness of this model for the County.

With respect to the Morgue's physical facilities, the Grand Jury found that the administrative office space on the upper level and autopsy examination rooms, equipment, and the body-receiving area on the lower level are separate, secure, and well maintained. However, it also found the administrative office space to be small, overcrowded, and lacking in modern technology such as an up-to-date computer case management system. The Morgue needs a hands-free recording system for dictating autopsies during the procedure.

Background

The Grand Jury may routinely investigate all departments in its jurisdiction at any time or upon receiving a citizen complaint alleging irregularities in local governmental bodies or boards. In addition to investigating the complaint, the Grand Jury also inspected the operations and facilities of the Coroner's Office and Morgue. Prior Grand Juries have not issued a report on this department since 1999.

Approach

The Grand Jury inspected the Coroner's administrative office space and morgue facilities. The Grand Jury also interviewed members of the Sheriff-Coroner's Office and the County Administrator's Office. The Grand Jury evaluated the facilities and internal functions of the Coroner's Office and

Morgue using criteria set forth by the National Association of Medical Examiners. It also reviewed documents related to the operation of the Coroner's Office and researched pertinent websites. Jurors attended meetings of the Law Enforcement Accountability Subcommittee of the Community and Local Law Enforcement Task Force concerning the suitability of the Sheriff-Coroner model.

Discussion

Contractual Arrangements with FMG

FMG was awarded a five-year contract in 2012 to provide forensic services to the Coroner's Office and Morgue, and it has provided forensic services to the County since at least 2000. Although not the lowest bidder, FMG offered a comprehensive level of services which involved accepting all requests for post mortems. The contract provides for penalties if required reports are not submitted on time.

Documents provided to the Grand Jury revealed that some final autopsy reports were more than a year overdue. As of March 5, 2014, over 300 autopsy reports remained incomplete:

- For 2010 and 2011, one autopsy report in each year was still incomplete.
- For 2012, 286 reports were completed and 110 reports were incomplete.
- For 2013, 104 reports were completed and 244 reports had not yet been submitted.

The Coroner's Office was unable to provide the number of overdue final reports from December 2013 or the first two months of 2014.

Final reports include autopsy results, investigative reports, and all laboratory reports. Investigative reports are compiled by the four detectives assigned to the Coroner's Office and include death scene information as well as data from persons interviewed and laboratory reports. Laboratory results may take from two to four weeks to complete and are provided by independent laboratories. Final reports are not complete until autopsy results are received stating the cause of death.

The Coroner's Office works with families of the deceased to expedite paperwork required for legal, insurance, or other matters to ensure they receive the information needed to settle the estate. Legal cases that involve criminal activity or suspicious deaths are expedited and are never late.

The Grand Jury found that in all cases, overdue final reports were incomplete because they were missing autopsy results. The current contract with FMG calls for a 2 percent daily penalty for final reports not completed within 30 days, unless delayed laboratory results necessitate a 30-day extension. This fine has never been imposed.

Sheriff-Coroner Model

The Sheriff-Coroner is a County-wide elected position. The Sheriff provides law enforcement, court security, and detention services. The Coroner's Office and Morgue operate under the Sheriff's Office Investigations Bureau. Administrative offices and morgue facilities are supervised by a detective sergeant who serves as Deputy Coroner. The Deputy Coroner is a three-year position with the possibility of reappointment.

Four detective investigators also rotate through the Coroner's department approximately every three years. According to the Coroner's Office, skills acquired in forensic services can prove useful when these detectives rotate to other units within the Sheriff's Office.

The County began electing a Sheriff-Coroner in 1974. Prior to that, coroner and sheriff were separate elected positions. As an alternative, some counties appoint a medical examiner. A medical examiner is a licensed forensic physician hired by a county to obtain medical findings through autopsies to determine the cause of death. In California's 58 counties, 48 use the Sheriff-Coroner

model, six have independent coroners, and four have medical examiners. Potential conflicts of interest exist between the sheriff and coroner roles. However, a national shortage of forensic pathologists makes it difficult for counties to recruit and retain qualified pathologists or medical examiners.

The responsibility of the Coroner's Office is to provide competent and timely law enforcement and scientific investigations of all deaths that meet the criteria as defined by the California Government Code Section 27490-27512 and California Health and Safety Code Section 102850-102870. The Health and Safety Code requires that a death certificate be issued within three days of examination of the deceased and be signed by a physician. However, the Coroner's Office reported that issuing certificates may take up to eight days. Certificates for deaths resulting from criminal activity are a priority and are delivered on time.

Coroner's Office and Morgue Facilities Inspection

The Grand Jury investigated Morgue operations and toured the facilities. Information provided here is given as of the inspection date. Remodeled in 1990, the building has been in use as a morgue since 1970, and before that as a boiler room for the old Community Hospital.

Physical Facilities

Facilities: Office space is limited with room for the two assistants and office equipment near the entrance. Four workstations for the detective investigators and a semi-private office for the Deputy Coroner are in an open work area that also serves as a passageway through the office. Space for filing and storage of reports is insufficient. Stacks of boxes line the floor and walls in an adjacent room. Active files are stored in boxes kept close by for easy access and review.

Security: Access to the facility is well controlled and secured by locked entrance doors. The waiting room is small and separate from the rest of the building. Doors accessing the building's office areas are kept locked. Morgue facilities located on the lower level are locked and separate from office work areas.

Administrative Space: Four detective investigators assigned to this department share an open work area with office staff, the Deputy Coroner, and a lunch/break area. The administrative area at ground level is separate from the Morgue, autopsy area, and body-receiving area on the lower level. Visitors and business contacts can work with the Coroner's staff without exposure to visual, auditory, or olfactory effects from the Morgue or any autopsy procedures that may be underway.

Safety: Employees are safe from physical, chemical, and biological hazards. Blood-borne pathogen controls are in place. Hazardous material is kept in proper containers, and safety cabinets are used for volatile solvents. Evacuation routes are posted.

Maintenance: The public and administration areas, even though small and crowded, seemed well maintained. All scientific equipment appeared to be clean and functional.

Identification: If the decedent has not yet been identified upon arrival at the Morgue, the facility has access to tests that may confirm identity using fingerprints, photographs, dental exams, x-rays, serology, and DNA analysis.

Morgue Operations

The Morgue is well maintained and meets the cleanliness and safety standards for this type of facility.

Body Handling: All bodies are handled using standard safety precautions in areas sequestered from public view. The refrigerated space appears adequate for the Morgue's storage needs. Access to this area is monitored and limited.

Autopsy: Two autopsy stations appear to serve the Morgue's needs. They are clean, well-lit, and free from odors. Protective gear is readily available. No dictation equipment is available in the autopsy room. The pathologist makes written notations as the autopsy is being performed. Post-mortem findings are dictated by the pathologist after the autopsy is completed.

From an adjoining room, a viewing window allows observation of autopsy proceedings, and observers are able to communicate via microphone with the pathologist during the autopsy procedure. Autopsies are only performed where the manner of death is undetermined or in situations required by law. The pathologist's office is small with poor lighting. Storage space for pathology files appears inadequate.

Isolation equipment: An adequate supply of plastic gowns, gloves and masks is available.

X-ray: The x-ray room contains lead aprons and radiation monitoring badges to measure radiation exposure. This equipment was most recently inspected on January 31, 2013 and passed with no corrective actions needed.

Laboratory: Local laboratories are usually utilized for testing, and turnaround time can be a few days to a couple of weeks.

Toxicology: Multiple blood, body fluid, and tissue specimens are collected and sent to a laboratory in Pennsylvania. The return of final lab results may take two to four weeks.

Histology: Tests on tissue samples are done by FMG per County contract.

DNA: These specimens are kept indefinitely.

Medical Waste: During an annual inspection in 2009, County inspectors recommended the development of a waste management plan with a decontamination procedure. In 2010, the plan was implemented and included a decontamination plan for blood spills. Recent inspections revealed no violations.

Transcription Services: This service is provided by FMG per County contract.

Reports and Record Keeping: Because file storage space is insufficient, case files and related materials are filed in cardboard boxes stored on the floor and in an additional room. The Coroner's Office has recently recommended that an updated computer case management system will effectively organize information unique to staff needs and allow enhanced data management. File security is guaranteed by locked entry doors.

Coroner Investigators: Coroner detectives respond to the scene of a suspicious death and assist in securing the area and gathering evidence along with the involved law enforcement agencies. These agencies may include the Sheriff's Office, city police, or fire departments. Detectives at the scene send photographs of the suspected crime scene to the Coroner's Office for use by the pathologist and investigators, who also have access to emergency room records and hospital charts.

Organ donors: The contracted pathologist is mandated to cooperate and support the authorized removal and disposal of human tissue from bodies of deceased persons as authorized by the California Uniform Anatomical Gift Act. The Sheriff's Office is consulted to confirm that the donor procedure does not adversely interfere with an investigation or the determination of the cause of death.

Findings

- F1. The close to 400 delinquent final autopsy reports due from FMG show a lack of effective oversight by the Sheriff-Coroner's Office.
- F2. The Sheriff-Coroner's Office has not exercised means within its control to bring about the timely issuance of final autopsy reports by imposing the 2-percent daily fine for overdue reports.

- F3. The Coroner's Office lacks adequate storage for the extensive records currently in cardboard boxes stacked throughout the facility.
- F4. Coroner operations can be negatively affected by delays resulting from failure to use up-to-date file management software tailored to its needs or hands-free recording equipment during autopsies.

Recommendations

The Grand Jury recommends that:

- R1. The Sheriff-Coroner's Office impose contractually stipulated penalties for late autopsy reports while evaluating the suitability of its continued relationship with FMG for forensic services.
- R2. The Sonoma County Board of Supervisors give priority to exploring possibilities for remodeling or relocating the existing Coroner's Office and Morgue.
- R3. The Coroner's Office and Morgue adopt technological improvements, including a modern file management system and hands-free recording devices in the autopsy room.

Required Responses

Pursuant to Penal Code Section 933.05, the Sonoma County Grand Jury requires responses as follows:

- R1, R2, R3 – Sonoma County Sheriff-Coroner
- R1, R2, R3 – Sonoma County Board of Supervisors

The governing body indicated above should be aware that the comment or response of the governing body must be conducted subject to the notice, agenda, and open meeting requirements of the Brown Act.

Bibliography

California. Government Code Sections 227490-27512.

_____. Health and Safety Code Sections 102850-102870.

National Association of Medical Examiners. *Inspection Checklist*.

Sonoma County. Sheriff's Office. *Agreement for Forensic Pathology Services*.

Reports issued by the Civil Grand Jury do not identify individuals interviewed. Penal Code Section 929 requires that reports of the Grand Jury not contain the name of any person or facts leading to the identity of any person who provides information to the Civil Grand Jury.