

COUNTY OF MONTEREY
ANNUAL REPORT OF THE CORONER



2004
MIKE KANALAKIS
SHERIFF-CORONER

MONTEREY COUNTY SHERIFF'S DEPARTMENT
1414 NATIVIDAD ROAD
SALINAS, CA 93906

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2004

**SHERIFF-MARSHAL-CORONER-
PUBLIC ADMINISTRATOR**

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2004 ANNUAL REPORT OF THE CORONER

In Monterey County, the Sheriff-Marshal-Coroner and Public Administrator are one and the same. This multi-position was initiated in January, 1982. The Coroner's Division is comprised of one (1) Division Commander, one (1) Investigative Sergeant, four (4) Deputy Coroner Investigators, one (1) Forensic Autopsy Technician and one and one-half (1 ½) Coroner's Clerks. Personnel from this office are available twenty-four hours a day, seven days a week, for Coroner Investigations, family contact and assistance, as well as disaster situations.

The County of Monterey covers an area of 3,325 square miles. The State mandates that only the Coroner or his duly appointed Deputy has jurisdiction over the deceased person at any death scene, as well as the deceased's property pending lawful disposition. In the year 2004, the Division's investigating Deputy Coroner's drove a total of approximately 35,000 miles in the course of their duties.

During the 2004 calendar year, 2,297 deaths were recorded in Monterey County. Of these recorded deaths, 1,139 were reported to the Coroner's Office pursuant to California Government Code Section 27491 and California Health and Safety Code Section 102850, which directs the Coroner to inquire into and determine the circumstances, manner and cause of those reportable deaths.

After investigation, 380 of the cases reported to the Coroner were kept as full Coroner cases with the final cause of death signed by the Coroner or his designated authority. In 306 of these cases, it was necessary to perform a postmortem examination in order to determine the cause of death. The remaining 759 cases initially reported to the Coroner, with follow-up investigation, revealed the person expired of obvious "Natural" causes and were referred to their attending physician of record for certification of the death.

Occasionally the Coroner's Division employs the services of a Forensic Odontologist and/or a Forensic Anthropologist. These services are necessary to determine positive identification through dental comparison as well as ascertaining causes of death through the study of skeletal remains. All unidentified persons are listed with the Coroner's Records as either a John Doe or Jane Doe, depending on the sex. The dental records and x-rays are forwarded to the California State Department of Justice in Sacramento for possible future match with the dental records of reported missing persons. In 2004, the Coroner's Office investigated the deaths of 3 John Does with no John Doe's remaining unidentified. There were no Jane Does reported.

This Annual Report of the Coroner provides a summary of the cases reported and investigated by the Coroner's Division and a statistical breakdown of types of deaths that occur within Monterey County.

DEATHS REPORTABLE TO THE CORONER

Government Code, State of California, Section 27491 and Health and Safety Code, State of California, Section 102850, directs the Coroner to investigate into and determine the Circumstances, Manner and Cause of the following deaths which are immediately reportable.

1. No physician in attendance.
2. Medical attendance less than 24 hours (hospital or residence).
3. Wherein the deceased has not been attended by a physician in the 20 days prior to death.
4. Wherein the physician is unable to state the cause of death.
5. Known or suspected homicide.
6. Known or suspected suicide.
7. Involving any criminal action or suspicion of a criminal act.
8. Related to or following a known or suspected self-induced or criminal abortion.
9. Associated with a known or alleged rape of crime against nature.
10. Following an accident or injury, old or recent, (primary or contributory, occurring immediately or at some remote time.)
11. All deaths due to Drowning, Fire, Hanging, Gunshot, Stabbing, Cutting, Starvation, Exposure, Acute Alcoholism, Drug Addiction, Strangulation or Aspiration.
12. Accidental poisoning, (Food, Chemical Agent, Drug or Therapeutic Agent).
13. Occupational disease or occupational hazards.
14. Known or suspected contagious disease constituting a public health hazard, INCLUDING AIDS.
15. All deaths in operating rooms.
16. All deaths where the patient has not fully recovered from an anesthetic whether in surgery, recovery room or elsewhere.

REPORTABLE DEATHS TO THE CORONER (CONTINUED)

17. All deaths wherein the patient expired within 24 hours of an operation or surgical procedure.
18. All deaths in which the patient was comatose throughout the period of the physician's attendance, whether at home or hospital.
19. All solitary deaths.
20. All deaths of unidentified persons.
21. All deaths where the suspected cause of death is Sudden Infant Death Syndrome (Crib Death).
22. All deaths in prison, jails or of persons under the control of a law enforcement agency.
23. All deaths of patients in state mental hospitals.
24. Wherein there is no known next of kin.

SUMMARY OF INVESTIGATIONS

2004

	<u>INVESTIGATIONS CORONER</u>	<u>INVESTIGATIONS *PHYSICIAN CERTIFIED</u>	<u>AUTOPSIES PERFORMED</u>	<u>INVESTIGATIONS TOTAL</u>
JAN	29	87	24	116
FEB	31	54	24	85
MAR	38	70	31	108
APR	38	64	30	102
MAY	41	61	34	102
JUN	25	59	20	84
JUL	26	65	25	91
AUG	30	57	27	87
SEP	32	49	23	81
OCT	23	64	20	87
NOV	30	56	23	86
DEC	37	73	25	110
<u>TOTAL:</u>	380	759	306	1139

* After thorough investigation by the Coroner's Office, it was determined that these deaths were due to natural causes and could be signed out by the Attending Physician without being carried as Coroner's cases and no autopsies were required by our office.

2004

CASES REPORTED TO CORONER

NUMBER OF CASES REPORTED DURING OFFICE HOURS.....	179*
NUMBER OF CASES REPORTED OUTSIDE OFFICE HOURS.....	201
NUMBER OF CASES REPORTED OVER THE WEEKEND.....	116

	<u>DURING OFFICE HRS.</u>	<u>OUTSIDE OFFICE HRS.</u>	<u>WEEKENDS</u>	<u>TOTAL</u>
JAN	13	16	16	29
FEB	17	14	7	31
MAR	18	20	10	38
APR	17	21	14	38
MAY	14	27	12	41
JUN	11	14	9	25
JUL	10	16	9	26
AUG	15	15	7	30
SEP	18	14	4	32
OCT	10	13	8	23
NOV	19	11	9	30
DEC	17	20	11	37
TOTAL:	179	201	116	380

* Coroner cases reported during office hours consist of any death which is reported between the hours of 8:00 AM and 5:00 pm, Monday through Friday.

2004

REPORTED CASES RELEASED TO PRIVATE PHYSICIANS

NUMBER OF CASES REPORTED DURING OFFICE HOURS.....520*
NUMBER OF CASES REPORTED OUTSIDE OFFICE HOURS.....239
NUMBER OF CASES REPORTED OVER THE WEEKEND.....119

	<u>DURING OFFICE HRS.</u>	<u>OUTSIDE OFFICE HRS.</u>	<u>WEEKENDS</u>	<u>TOTAL</u>
JAN	59	28	14	87
FEB	30	24	9	54
MAR	53	17	3	70
APR	47	17	12	64
MAY	43	18	9	61
JUN	42	17	12	59
JUL	41	24	11	65
AUG	41	16	9	57
SEP	34	15	9	49
OCT	47	17	15	64
NOV	37	19	5	56
DEC	46	27	11	73
TOTAL:	520	239	119	759

*Coroner cases reported during office hours consist of any death which is reported between the hours of 8:00 AM and 5:00 PM, Monday through Friday. The above reported cases were investigated and found to be of Natural cause and origin and were released to private physicians for the issuance of the death certificate.

GENERAL CLASSIFICATION OF DEATHS HANDLED BY CORONER

2004

NATURAL.....	118
SUDDEN INFANT DEATH SYNDROME (SIDS).....	7
MOTOR VEHICLE DEATHS.....	93
ACCIDENT.....	72
SUICIDE.....	38
HOMICIDE.....	40
UNDETERMINED.....	12
<u>TOTAL:</u>	380

CORONER INVESTIGATIONS 1998 – 2004

CLASSIFICATIONS

	<u>2004</u>	<u>2003</u>	<u>2002</u>	<u>2001</u>	<u>2000</u>	<u>1999</u>	<u>1998</u>
NATURAL	118	105	102	121	118	115	118
SIDS	7	7	5	1	5	2	1
MOTOR VEHICLE	93	62	61	61	56	46	45
ACCIDENT	72	74	77	67	49	80	64
HOMICIDE	40	27	26	32	29	32	29
SUICIDE	38	61	28	34	21	27	42
UNDETERMINED	12	10	9	4	6	4	4

INVESTIGATIONS

	CORONER CERTIFIED	PHYS. CERT.	TOTAL INVEST.	TOTAL AUTOPSIES	TOTAL EXTERNALS	TOTAL PC AUT.
2004	380	759	1139	306	69	2
2003	346	789	1135	286	58	3
2002	308	864	1172	245	48	1
2001	328	827	1155	246	49	2
2000	284	798	1082	232	29	1
1999	309	820	1129	273	12	8
1998	303	788	1091	276	21	0

NATURAL DEATHS – 2004

AGE	MALE	FEMALE	TOTAL
00-11 (MOS)			
01-10 (YRS)			
11-20		1	1
21-30	3		3
31-40	4		4
41-50	19	9	28
51-60	24	7	31
61-70	13	5	18
71-80	13	5	18
81-90	7	7	14
91-100		1	1
TOTAL: 118			
JAN	9		
FEB	12		
MAR	10		
APR	6		
MAY	13		
JUN	6		
JUL	4		
AUG	14		
SEP	10		
OCT	6		
NOV	12		
DEC	16		

SUDDEN INFANT DEATH SYNDROME – 2004

MONTH	MALE	FEMALE	AGE
FEBRUARY	1		3 MONTHS
MARCH		1	2 MONTHS
APRIL		1	2 MONTHS
JULY		1	5 MONTHS
NOVEMBER	1		7 WEEKS
	1		2 MONTHS
DECEMBER	1		7 MONTHS

TOTAL: 7

2003 7

2002 5

2001 1

2000 5

1999 2

1998 1

SIDS (BASIC FACTS)

SIDS (Sudden Infant Death Syndrome), commonly known as “crib death,” is the number one cause of death in infants after the first week of life. SIDS is not a rare disease. SIDS causes approximately 6,000 to 7,000 babies to die each year in the United States. SIDS happens about two out of every 1,000 live births.

SIDS most commonly occurs in infants between the ages of four weeks and seven months, but occasionally an older or younger baby may die of SIDS, some even as old as 14 months.

A minor illness such as a common cold may precede the death, but many victims display no observable symptoms. A typical case is when an infant is put to bed without any suspicion that things are out of the ordinary. Upon checking the infant later, he or she is discovered unresponsive.

An autopsy may reveal, at most, a minor degree of inflammation of the upper respiratory tract, but no lesion sufficient to account for the death. Often the autopsy reveals absolutely no evidence of illness.

SIDS occurs among families of all social and economic strata. For the typical SIDS victim, there are currently no sure preventive measures to be taken.

2004 – MOTOR VEHICLE FATALITIES

ACCIDENTS.....	93
HOMICIDES.....	0
UNDETERMINED.....	0
UNCLASSIFIED/PENDING.....	0
SUICIDES.....	1 (This case was classified under Suicides)
<u>TOTAL:</u>	93

OPERATORS OF MOTOR VEHICLES.....	42
PASSENGERS OF MOTOR VEHICLES.....	37
PEDESTRIANS.....	10
BICYCLIST.....	1
MOTORCYCLIST.....	4
SKATEBOARDER.....	0

A thorough investigation is conducted in the case of a motor vehicle related fatality by the Coroner’s Office, as well as that of the law enforcement agency having jurisdiction where the fatality occurred. A suspected traffic fatality can sometimes be the result of natural causes which can be disclosed, in most cases, at time of autopsy as opposed to death by traumatic injuries. Also, a traffic fatality may be ruled a suicide, accident or homicide.

MOTOR VEHICLE FATALITIES - 2004

AGE	MALE	FEMALE	TOTAL
0-11 (MOS)	2		2
01-10 (YRS)	2	2	4
11-20	13	14	27
21-30	11	5	16
31-40	5	4	9
41-50	7	4	11
51-60	5	3	8
61-70	6	2	8
71-80	4	2	6
81-90	1		1
91-100	1		1

TOTAL: 93

JAN 6

FEB 3

MAR 10

APR 17

MAY 10

JUN 9

JUL 5

AUG 5

SEP 10

OCT 7

NOV 3

DEC 8

2004 – TRAFFIC FATALITY – ALCOHOL/DRUG TOXICOLOGY

All traffic fatalities and suspected traffic fatalities are investigated by the Coroner. Pursuant to California Government Code Section 27491.25, the Coroner's Pathologist takes available blood and urine samples from the deceased to make appropriate related chemical tests to determine the alcoholic and barbituric acid derivative contents, if any, of the body. In some cases, the traffic victims are hospitalized for a lengthy period of time prior to expiration and therefore blood and urine samples are not available for testing.

ALCOHOL

Not tested: 7
Negative: 65
Alcohol present: 21

<u>ALCOHOL PRESENT</u>	<u>TOTAL</u>
.00 TO .05	2
.06 TO .09	1
.10 TO .15	3
.16 TO .20	5
.21 TO .30	5
.31 TO .40	5
.41 TO .50	

DRUG SCREEN

Not tested: 7
Negative: 59
Drug Positive 27

Drugs Found:

Cocaine, Tryamidol, Delta-9 THC, Atropine, Metoprololo, Ilatropin

2004 – TYPE OF FATAL ACCIDENTS

TOTAL: 72

ASPHYXIATION.....	2
FIRE.....	2
GUNSHOT.....	1
DROWNINGS.....	8
HOT TUB.....	1
HANG GLIDER.....	1
OCEAN.....	1
RIVER.....	3
LAKE.....	1
CLIFF.....	1
FALLS:.....	9
RESIDENCE.....	6
HORSE.....	1
CLIFF.....	1
SKILLED NURSING FACILITY.....	1
OVERDOSE:.....	45
ALCOHOL.....	1
ALCOHOL/DRUG.....	5
DRUG.....	20
DRUGS MULTIPLE.....	16
NEEDLE INJECTION.....	1
PRESCRIPTION DRUGS.....	2
CHOKED (MEAT).....	1
ENTRAPMENT (GARAGE).....	1
NECK COMPRESSION (BED).....	1
PINNED (VAN).....	1
TREE BLOWN OVER.....	1

2004 - ACCIDENTS

<u>AGE</u>	<u>MALE</u>	<u>FEMALE</u>	<u>TOTAL</u>
01-11 (MOS)	2		2
1-10 (YRS)		1	1
11-20	2	1	3
21-30	9		9
31-40	8	3	11
41-50	12	12	24
51-60	6		6
61-70	3	2	5
71-80	1	3	4
81-90		2	2
91-100	3	3	5
TOTAL:	72		
JAN	7		
FEB	8		
MAR	5		
APR	5		
MAY	9		
JUN	6		
JUL	4		
AUG	6		
SEP	7		
OCT	5		
NOV	5		
DEC	5		

TYPES OF HOMICIDES - 2004

ASPHYXIA.....	2
ASSAULT.....	1
DRUG INTOXICATION.....	1
STABBED.....	2
GUNSHOT.....	27
GUNSHOT/STABBED.....	2
SHOT/STABBED/BEAT.....	2
TRAUMA-BLUNT FORCE.....	3
TOTAL.....	40

OF THE 40 HOMICIDE CASES, 24 WERE GANG RELATED

TYPES OF HOMICIDES:	1998	1999	2000	2001	2002	2003
CHILD ABUSE	1					
ASPHYXIATION	1	1				
ASSAULT	2			1		
STABBED	6	3	4	4	2	2
GUNSHOT	22	23	24	23	24	19
GSW/STABBED	2			1		
MALNUTRITION						1
UNDETERMINED		1				
STRANGULATON	4	1	1	1		4
TRAUMA/BLUNT FORCE	1	1	3	3		
THERMAL BURN						1
<u>TOTAL HOMICIDES:</u>	39	29	32	32	26	27

<u>AGE</u>	<u>MALE</u>	<u>2004 - HOMICIDES</u> <u>FEMALE</u>	<u>TOTAL</u>
0-11 (MOS)			
1-10 (YRS)			
11-20	11		11
21-30	15	2	17
31-40	6		6
41-50	3		3
51-60	1		1
61-70	2		2
71-80			
81-90			
TOTAL: 40			
JAN	5		
FEB	2		
MAR	4		
APR	2		
MAY	4		
JUN	1		
JUL	5		
AUG	4		
SEP	3		
OCT	3		
NOV	2		
DEC	5		

TYPES OF SUICIDES

2004

ASPHYXIA	3
CARBON MONOXIDE.....	1
DROWNING.....	1
DRUG OVERDOSE.....	3
PRESCRIPTION MEDICATIONS (INSULIN OVERDOSE).....	4
GUNSHOT.....	15
HANGING.....	6
STAB WOUND.....	3
JUMPED.....	1
TRAFFIC.....	1
<u>TOTAL:</u>	38

AGE		<u>SUICIDES – 2004</u>		
0-11 (MOS)	MALE		FEMALE	TOTAL
1-10 (YRS)				
11-20	1			1
21-30	4		3	7
31-40	5			5
41-50	5		1	6
51-60	8		2	10
61-70	1		1	2
71-80	1		3	4
81-90	2		1	3
TOTAL:	38			
JAN	1			
FEB	3			
MAR	5			
APR	5			
MAY	5			
JUN	2			
JUL	6			
AUG	1			
SEP	2			
OCT	2			
NOV	5			
DEC	1			

UNDETERMINED DEATH MODES – 2004

<u>DATE REPORTED</u>	<u>SEX</u>	<u>AGE</u>
JANUARY	M	70
FEBRUARY	F	45
	M	39
MARCH	M	28
		56
	F	49
APRIL	M	56
		48
JUNE	M	59
JULY	M	55
NOVEMBER	M	19
DECEMBER	F	19

TOTAL: 12

2004

INDIGENT CREMATION

JAN 1	MAY 1	SEP
FEB 1	JUN	OCT 2
MAR 1	JUL 2	NOV 2
APR 1	AUG 1	DEC 1

TOTAL: 13

<u>YEARS</u>	<u>TOTAL</u>
1997	13
1998	26
1999	11
2000	20
2001	17
2002	13
2003	4