Medicolegal Death Investigation Structures in California

There are Three Models in California...

1. **The medical examiner system:** An independent medical examiner is appointed by the county in 6 counties: Los Angeles, San Diego, San Francisco, San Joaquin, Santa Clara, and Ventura.
2. **The sheriff-coroner system:** the elected sheriff is also automatically the coroner in 48 counties.
3. **The coroner system:** an independent coroner is elected in 4 counties: Calaveras, Inyo, Sacramento, and San Mateo.

California is 1 of only 3 states that use the Sheriff-Coroner model.

Shortcomings of California's Death Investigation Structure

Conflict of Interest: The person responsible for investigating all violent, sudden, unusual deaths, or unattended deaths including those in custody deaths that involve law enforcement misconduct, is often the county's highest-ranking law enforcement officer.

Law Enforcement Interfere in Investigations: Independent death investigation staff have reported law enforcement attempting to exert pressure to change findings.

Lack of Education and Training: There are no formal national educational or training requirements for death investigators in California, allowing them to operate with minimal training in forensic science, legal procedures, or cause-of-death analysis. This increases the risk of errors in death determination.

Deaths go Unreported: A nationwide study found that in US counties in which law enforcement can certify the cause of death, including counties that appoint the sheriff as the lead death investigator, showed police killings were 40% more likely to go underreported than comparable counties. This underreporting may result from the intentional omission of details that might incriminate law enforcement, and the lack of an appropriate response from the state.

Deaths are Misclassified: A groundbreaking 2022 report analyzed jail autopsies from Los Angeles County jails between more than half of the deaths classified as "natural" also involved blunt force trauma, reinforcing concerns that visible violence is often concealed in official classifications. Misclassification issues persist even in seemingly clear-cut cases like gunshots wounds and intentional use of force cases.

Medical vs. Legal Determinations of Death: From a medical pathology perspective, any time a person in custody dies due to reasons that would not have otherwise caused their death out of custody that death could not be classified as natural, even if it was ultimately due to a medical reason. Similarly, a homicide is classified as any "death at the hands of another", regardless of any preliminary or final determination of criminal liability. From the perspective of many law enforcement, any death they do not believe the death was intended should be ruled accidental.

Abuse of HIPAA to Evade Accountability: While HIPAA is intended to protect patient privacy, it has become a way for officers to withhold critical evidence, even from governmental departments or oversight bodies.

A Critical Barrier to Change

The national shortage of qualified forensic pathologists worsens these issues. **There are currently only 400-500 physicians who practice forensic pathology full time**, only half of which are working in the public sector. This is less than half of the total estimated need in the United States.

Unfortunately, this gap does not seem to be closing. **Only 27 states have accredited forensic pathology training** programs and fewer than 1% of medical students choose to pursue pathology, let alone forensic pathology. In sum, less than 40 board-certified forensic pathologists are trained each year in the United States.

Low pay also contributes to the shortage, with most non-chief forensic pathologists earning far below the average physician salary. Coroners earn even less.

Key Recommendations

Prevention is critical… and can be accomplished by keeping people out of jail through alternative crisis response models, diversion to community-based alternatives, cite and release, zero bail policies, and less restrictive conditions of release. Furthermore, carceral settings lack adequate physical and mental health services for a population that's disproportionately impacted by chronic health problems as well as substance use and mental health problems.

Recommendation #1: Separate Death Investigations and Law Enforcement - Counties with a Sheriff-Coroner model should separate these roles/offices and move medicolegal death investigation services into non-law enforcement departments such as public health or transition to an independent, lay Coroner or Medical Examiner model. For smaller counties, a regional option would be fiscally prudent.

Recommendation #2: Restrict Access to Medical Investigations - Prohibit the Sheriff from signing death certificates and identify appropriate alternatives such as the County Health Officer and prohibit all law enforcement from any portion of the postmortem examination.

Recommendation #3: Improve Rigor and Quality of Death Investigations - Require that death investigation offices attain accreditation, increase medical training requirements for death investigators, and establish job (re)training opportunities such as a forensic nursing pathway.

Recommendation #4: Improve Rights of Families -Require family notification within 24 hours of a death under and receive regular status updates; enable the decedent's legal representative or family member to request an alternative medical examination; and require that law enforcement agencies and other public entities make available any information related to a death to the decedent's legal representative or family members, upon the legal representative's or family member's request.

Recommendation #5: Strengthen Oversight and Accountability Mechanisms - Empower the ICDR Division to conduct audits, review investigations, and issue corrective actions; implement a system of performance-based funding; mandate the Board of Supervisors in each county or the BSCC to levy penalties or recommend funding reductions in cases of sustained non-compliance or litigation; and include whistleblower protections for staff within medico-legal death investigation offices.

About Us

The No More Deaths in Custody Workgroup, a project of the Justice2Jobs Coalition, is a statewide convening of impacted families, advocates, and academic researchers.

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