

SHERIFF-CORONER'S BUREAU

The Manner of Death—A Final Diagnosis

SUMMARY

Frequently, when citizens learn of an accidental death or one of unknown or suspicious cause, the report often ends with the statement that the cause of death is “under investigation” by the coroner or medical examiner’s department. Immediately, people conjure up the Hollywood version of a sterile surgical morgue facility with the latest technology and forensic pathologists informing the detectives as to the cause and manner of death. Operating at the nexus of medicine and criminal justice, these death detectives manage to thoroughly investigate each suspicious fatality, complete with toxicology results, and do it within the hour. The reality of these investigations is much different, with dedicated personnel working in difficult conditions to accomplish an unglamorous but critical public service.

The 2012-2013 Santa Barbara County Grand Jury (Jury) undertook an investigation into the reality of the daily work done by the Santa Barbara County Sheriff-Coroner’s Bureau (Bureau). While death under any circumstance is difficult, those citizens who must face the matter of death at the Bureau deserve to receive competent and professional service in a high-quality facility. Likewise, those county employees who perform this most difficult but necessary work must be provided the professional education needed to develop the required specialized skills while also acquiring a sensitivity for the cultural, ethnic and religious backgrounds of the people they serve. These skilled employees also deserve high-quality resources necessary to successfully perform their jobs in a safe, healthy and efficient working environment.

During this investigation, the Jury learned that there are some 2,300 coroner/medical examiners’ facilities in the United States with a wide range of standards and competence. In California’s 58 counties, the government adopts one of three general models: medical examiner, sheriff-coroner or lay coroner. All staff operate under the statutory authority of the *California Government Code: Section 27491* and the *California Health and Safety Code: Section 102850*. In some of the larger counties, including Ventura County, the medical examiner model has been adopted. Since 1947, Santa Barbara County uses the model of sheriff-coroner, who is an elected officer.

While the Jury finds the Bureau to be in compliance with the law, the Bureau’s physical facility is in immediate need of significant improvements and merits a long-range strategic plan by the Santa Barbara County Board of Supervisors for the development of an accredited medical examiner department in an industry-standard facility with the capability of being accredited by the National Association of Medical Examiners.

It's difficult for people to spend money on medical examiners systems. They see it often as wasting money on the dead, without realizing that everything that is done in a medical examiner office or a coroner office, is truly done for the living. We try to protect society. We look for deaths that are premature, or that should not have happened, so that we can go forth and correct those errors in society.¹

BACKGROUND

Santa Barbara County has had a sheriff-coroner since 1947 when the Santa Barbara County Board of Supervisors (BOS) adopted the sheriff-coroner model. With the adoption of this model, the County joined 39 other counties using the sheriff-coroner model. In the remaining counties, 13 have a lay coroner model and 5 have a medical examiner model. The sheriff-coroner model does not work independently from law enforcement supervision nor is it subject to mandatory state or national accreditation. However, a medical examiner model operates under more stringent regulations and must meet national accreditation and quality assurance standards.

Originally the Coroner's office was located in the Santa Barbara County Historic Courthouse. Later, it was moved to the new Sheriff's headquarters on Calle Real. The coroner utilized local hospitals and mortuaries for autopsies under contract with a local pathology medical group. In 1987, the Sheriff-Coroner requested that the BOS provide emergency funds to construct a stand-alone coroner's facility.² This facility was intended to handle all aspects of investigating the cause and manner of death that California law requires, as well as to provide independent office space for the coroner's staff.

Upon approval of the emergency need, the BOS directed the construction of a facility to be built on County-owned property on San Antonio Road, adjacent to the former women's honor farm. There is no record of a building permit on file, indicating the building never went through the normal review and approval process. The building was constructed by inmate labor from the County Jail, at a cost of less than \$100,000.²

A review of the few available building plans revealed that the facility was originally designed to have two autopsy rooms, a refrigeration unit and two offices for the staff. The second autopsy room was never utilized, but eventually became a toxicology lab and currently is used as a storage and break room. Later, the main staff office was divided to provide a grieving room for

¹ Thompson, A.C., "Medical Examiners In America: A Dysfunctional System", ProPublica 2011

² Santa Barbara News-Press, February 5, 1989 "High Tech Morgue" by Woody Behrens

consulting with next of kin. The only other major upgrade to the main building has been the installation of an emergency backup generator. As more staff was assigned to the Bureau, an existing portable building on-site provided additional office space. A Conex box (shipping container) was installed adjacent to the front of the main building to provide additional storage space.

In the early 2000s, autopsies continued to be performed by the contracted pathology medical group until the Sheriff-Coroner hired its own full-time forensic pathologist.

METHODOLOGY

In the course of the Jury's mandated annual inspection of the Bureau, the Jury noted conditions that prompted further investigation. The Jury:

- Toured the Bureau's facility on multiple occasions
- Reviewed historical documents relating to the building of the facility
- Researched records at the County Building Department
- Interviewed former and current forensic pathologists
- Interviewed past and present staff, including senior officers at the Sheriff's Office
- Interviewed County employees and contract employees who work or service the Bureau
- Interviewed staff from The Goleta Sanitary District
- Researched current industry standards for this type of facility
- Reviewed websites of several California county coroners and medical examiners
- Reviewed the "Post Mortem" video co-produced by ProPublica and PBS Frontline³

OBSERVATIONS AND ANALYSIS

Bureau Staff

The staff includes a Sergeant, a Forensic Pathologist, an Office Assistant and four Deputy Detectives (Coroner Detectives). In 2011, there were 2,871 deaths in the county with 1,476 requiring an investigation. The Bureau detectives have the highest caseload in the Sheriff's Office, conducting all the required death investigations within the County regardless of law enforcement agency jurisdiction. If the deceased has not been under the care of a medical

³ PBS.org/frontline2011

professional within 20 days of death, by law the death becomes a coroner case.⁴ Approximately 150 autopsies are performed annually. From interviews at every level of the Sheriff Office, the Jury learned the Bureau is understaffed and in need of a full-time forensic technician to assist the pathologist during autopsies. Currently this position is being filled by retired personnel from the Bureau on a part-time basis.

Any detective can be dispatched to a death scene. However, the Jury was told that detectives not assigned to the Bureau may not be adequately trained in death-scene investigation. This lack of training could unknowingly compromise important evidence.

All new Bureau staff receive a dedicated two week coroner training course and the Jury was assured all staff were current on the POST (Police Officer Standards Training, State of California) Training. Among the Jury concerns were conflicting and inconsistent answers given by various employees regarding any specialized training, its documentation and who is responsible for monitoring that employees receive it. According to Centers for Disease Control (CDC) recommendations, the public and the staff would be better served if the staff received more specialized training in areas such as infection control and blood-borne pathogens.⁵

Bureau Facilities – Santa Barbara

The physical facility consists of three structures: the main building, a portable structure and a Conex box. The public area of the main building includes a reception area, the Sergeant's office and a grieving room. The employee area of the building includes a break room, a storage room and a small computer work space. These two areas are connected via a corridor that passes by the walk-in refrigeration unit for the deceased and goes through the autopsy room. The arrangement of these rooms exposes the entire working environment to noxious odors and possibly to airborne contaminants.

During interviews and visits, the Jury learned that the interior walk-in refrigeration unit is designed to accommodate 16 bodies and is connected to a backup generator. There is also an outside refrigeration unit where the deceased can be placed temporarily.

The Jury was informed by staff that the current ventilation system is 25 years old and since no building permit could be located, the system may not have been designed to provide adequate

⁴Santa Barbara County Sheriff's Office, 2011 Annual Report

⁵<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5308a1.htm> (CDC.gov Recommendations and Reports June 11, 2004, /53(RR08) Medical Examiners, Coroners, and Biologic Terrorism)

ventilation to this type of facility. Adequate ventilation which includes negative air pressure^{6,5} is a necessary requirement for the control of infection, removal of noxious odors, dilution and expulsion of contaminants. Conducting autopsies in an area with inadequate ventilation presents a risk of circulating airborne pathogens. The ventilation system is not equipped with a filtration component to prevent the spread of airborne bacterial, viral or other organisms. This system presents a potential health and safety risk for employees. To provide for the safety of the staff and visiting public, a code-compliant ventilation system, must be installed to ensure contaminated air is exhausted from all rooms and not redistributed into other areas of the building.

The Jury was informed that on warm days the autopsy room, which has a window mounted air conditioner unit, is not adequately cooled to create a comfortable working environment.

The Bureau's facility is not equipped with an isolation room suitable for working on high-risk cases. An isolation room is needed and must be provided with its own autopsy table and sink, to protect staff from contagious diseases. The ventilation system for this room must be separate from the rest of the facility and, according to industry standards, provide for negative air pressure.⁶ Air from this isolation room must be filtered and exhausted directly to the outside, separated from supply-air intakes and populated areas.

The Goleta Sanitary District (GSD) failed to re-issue an Industrial Wastewater Permit under its Ordinance No. 77, which also covers hospitals and mortuaries, although the Bureau submitted the correct paperwork. The Jury was informed that medical and infectious waste from the facility is being discharged into the sanitary system during autopsies without the proper permit from GSD.

Temperature logs are not being kept for the refrigerator which holds blood samples in the autopsy room. The Jury is concerned that temperature fluctuations could compromise evidence.

The American National Standards Institute and Occupational Safety & Health Administration (OSHA) recommend an eye wash station for employees who are exposed to hazardous materials.⁷ There was no eye wash station at the facility.

During an autopsy, the Forensic Pathologist dictates his findings into a microphone that is strung through a ceiling tile that hangs over the autopsy table. This dictation is fed into a cassette

⁶ http://www.nrctraining.com/air_force.htm (National Resource Center, Department of the Air Force, Medical Facility Ventilation)

⁷ <http://webstore.ansi.org/RecordDetail.aspx?sku=ANSI%2FISEA+Z358.1-2009>

system that then has to be transcribed into electronic form for retention and distribution. For efficiency and preservation of information gathered during an autopsy, digital equipment is needed to replace the obsolete equipment currently in use. The Centers for Disease Control and Prevention current standards state that, “mechanisms should be in place to ensure that electronic death investigation data can be shared with public health authorities, law enforcement agencies, and other death-investigation agencies while providing for appropriate confidentiality and control of the release of information to authorized personnel or organizations only”.⁸

The Conex storage unit is located in the parking lot. It holds the records of closed cases and other evidence. The paper files are being scanned electronically when time permits, usually when the Sheriff’s Office has personnel on light duty due to injury.

The portable building was once used as a classroom for the inmates of the women’s honor farm. Now it serves as the office for the four detectives and the forensic pathologist. This separation of the staff is not an efficient arrangement due to continual travel between buildings. During the hot months of the year, the air conditioning unit in the portable building is not sufficient which makes working conditions difficult.

The entire area that immediately surrounds the three structures is poorly maintained, as evidenced by abundant weeds, untended shrubs, bushes and ground rodents. The space between the main building and the portable building is full of holes and weeds. Staff has attempted to address this issue, including trying to maintain the outside area on their own time. The condition of the grounds still presents fire and safety hazards.

A More Centralized Location

A refrigeration unit near the Santa Maria Sheriff’s facility holds the deceased from this area, until they can be transported to Santa Barbara. This transport time subtracts from the coroner detective’s investigation time. A more centralized Bureau within the county would improve this issue. In the early 1960’s, the population of Santa Barbara County was less than 200,000. The 2010 census revealed that Santa Barbara County has grown to a population of 423,900. The greater population growth has occurred in the north. Former and current staff of the Bureau suggested that the County might be better served with a more centralized location, since 55% of their caseload growth is now in the north.

⁸ Department of Health and Human Services Centers for Disease Control and Prevention.

CONCLUSION

The Jury finds that the Bureau requires an immediate upgrade to the existing facilities to correct serious inadequacies which may jeopardize the health and safety of the staff and the public. Despite the inadequacies in the physical facilities, every staff member interviewed reported that even with an increasing caseload, they work in a cooperative and collegial manner as they carry out their complex responsibilities.

Although the California Constitution requires each county to have a coroner, each county board of supervisors may establish and provide for a specialized department. The Jury recommends that in all future strategic planning the Santa Barbara County Board of Supervisors adopt the goal of establishing a facility and staff that are eligible for full accreditation by the National Association of Medical Examiners. A new, fully accredited facility would provide greater capability to address the challenges of twenty-first century America due to deaths related to natural disasters, man-made mass emergencies, issues related to Homeland Security and even perform a positive role in the burgeoning field of organ and tissue donation.

FINDINGS AND RECOMMENDATIONS

Finding 1

The continuing use of part-time retired staff is not adequate to assist during autopsies.

Recommendation 1

That the Sheriff-Coroner employ a full-time forensic technician within the next two years.

Finding 2

Specialized training of the staff in the areas of infection control and blood-borne pathogens is inconsistent.

Recommendation 2a

That the Sheriff-Coroner implement policies and procedures that require training of each Coroner's Bureau employee in areas of infection control and blood borne pathogens on an annual basis.

Recommendation 2b

That the Sheriff-Coroner provide for employee training records to be maintained on site at the Coroner's Bureau and to be updated annually.

Finding 3a

The presence of lingering noxious odors in the Coroner's Bureau indicates that the existing ventilation system is not adequate.

Finding 3b

A code compliant ventilation system is necessary to control and prevent the potential of infectious agents affecting the health of Bureau staff and the public.

Recommendation 3a

That the Santa Barbara County Board of Supervisors allocate the funds to retain a mechanical engineering firm to study and make design recommendations for the Coroner facility ventilation system.

Recommendation 3b

That the Santa Barbara County Board of Supervisors allocate the funds to implement the design recommendations for the ventilation system in the Coroner's facility.

Finding 4

Currently there is no isolation area in the Coroner's Bureau suitable for performing autopsies on high-risk cases.

Recommendation 4

That the Sheriff-Coroner provide an isolated area in the Coroner's Bureau suitable for performing autopsies on high-risk cases.

Finding 5

The current autopsy room air conditioner is not adequate to provide an efficient, comfortable working environment.

Recommendation 5

That the Sheriff-Coroner upgrade the air conditioning system in the current autopsy room to provide an efficient, comfortable working environment until the engineering study is completed and recommendations are implemented.

Finding 6

The Goleta Sanitary District failed to issue the correct Industrial Wastewater Permit under its Ordinance No. 77, to the Coroner Bureau.

Recommendation 6

That The Goleta Sanitary District issue the appropriate permit consistent with the Bureau's application for discharge of medical waste from autopsies.

Finding 7

There is no log to record the internal temperature of the autopsy room evidence refrigerator.

Recommendation 7

That the Sheriff-Coroner require that a daily refrigeration internal temperature log be maintained on the autopsy room evidence refrigerator.

Finding 8

The Coroner's Bureau does not have an eye wash station.

Recommendation 8

That the Sheriff-Coroner install an eye wash station in each autopsy room.

Finding 9

Inefficient and obsolete dictation equipment is currently used during autopsies.

Recommendation 9

That the Sheriff-Coroner purchase and install digital dictation equipment for efficiency in preservation of and access to the pathologist's findings.

Finding 10

The air conditioning unit in the portable building is not sufficient to provide a comfortable working environment on warm days.

Recommendation 10

That the Sheriff-Coroner provide an air conditioning system sufficient to cool the portable building.

Finding 11

The landscape area surrounding the Coroner's Bureau is a weed patch overrun by rodents.

Recommendation 11

That within the next six months the Sheriff-Coroner install landscaping, provide rodent removal and implement a regular maintenance schedule.

Finding 12

A Coroner's Bureau is not required to be accredited.

Recommendation 12

That the Board of Supervisors include in all long-range strategic planning the goal of establishing and staffing a more centrally located facility that is eligible for full accreditation by the National Association of Medical Examiners.

REQUEST FOR RESPONSE

In accordance with *California Penal Code Section 933.05*, each agency and government body affected by or named in this report is requested to respond in writing to the findings and recommendations in a timely manner. The following are the affected agencies for this report, with the mandated response period for each.

Santa Barbara County Board of Supervisors – 90 days

Finding 3a, 3b, 12

Recommendation 3a, 3b, 12

Santa Barbara County Sheriff-Coroner – 60 days

Finding 1, 2a, 2b, 3a, 3b, 4, 5, 6, 7, 8, 9, 10, 11

Recommendation 1, 2a, 2b, 3a, 3b, 4, 5, 6, 7, 8, 9, 10, 11

The Goleta Sanitary District – 90 days

Finding 6