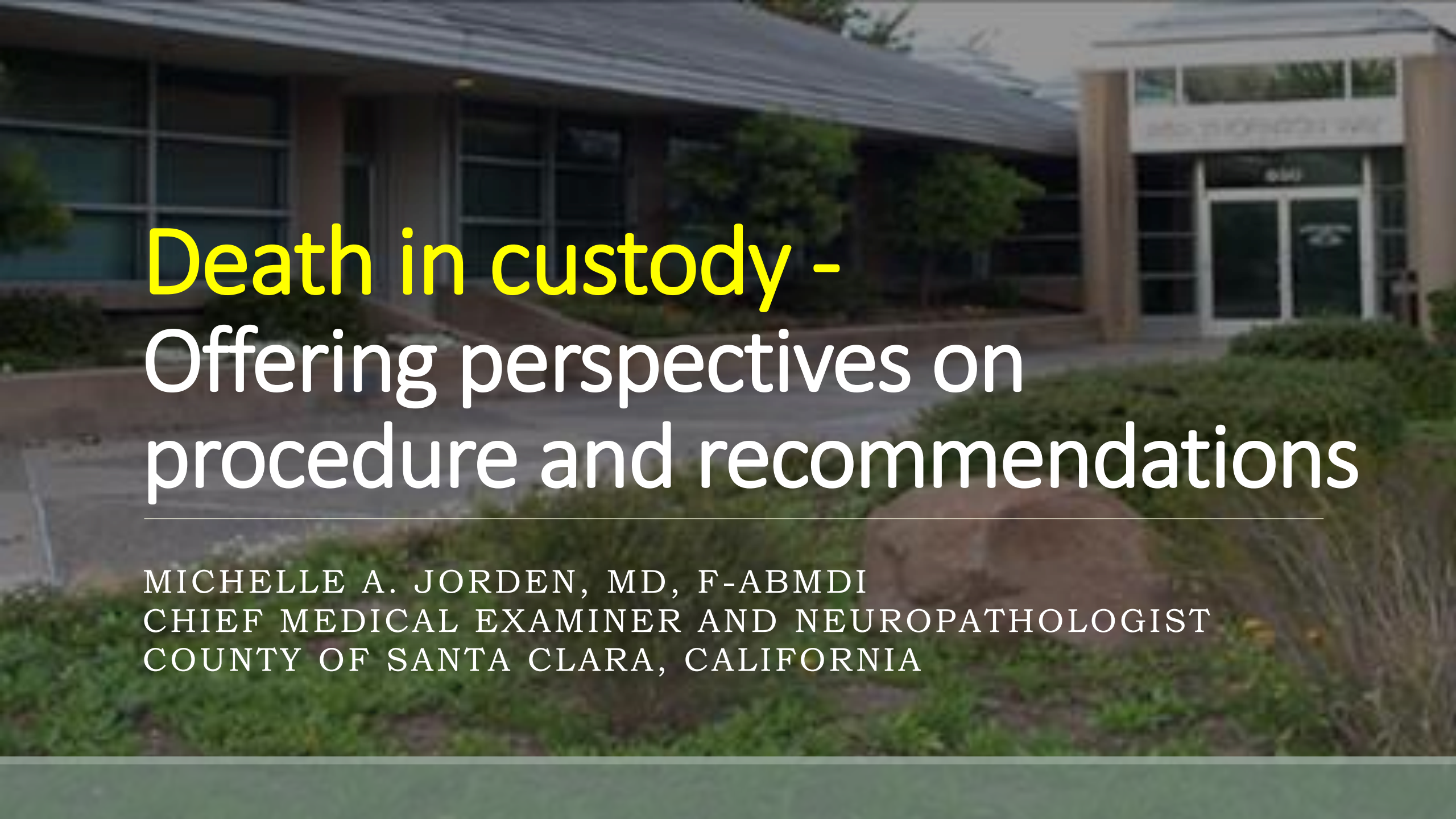

Death in custody - Offering perspectives on procedure and recommendations

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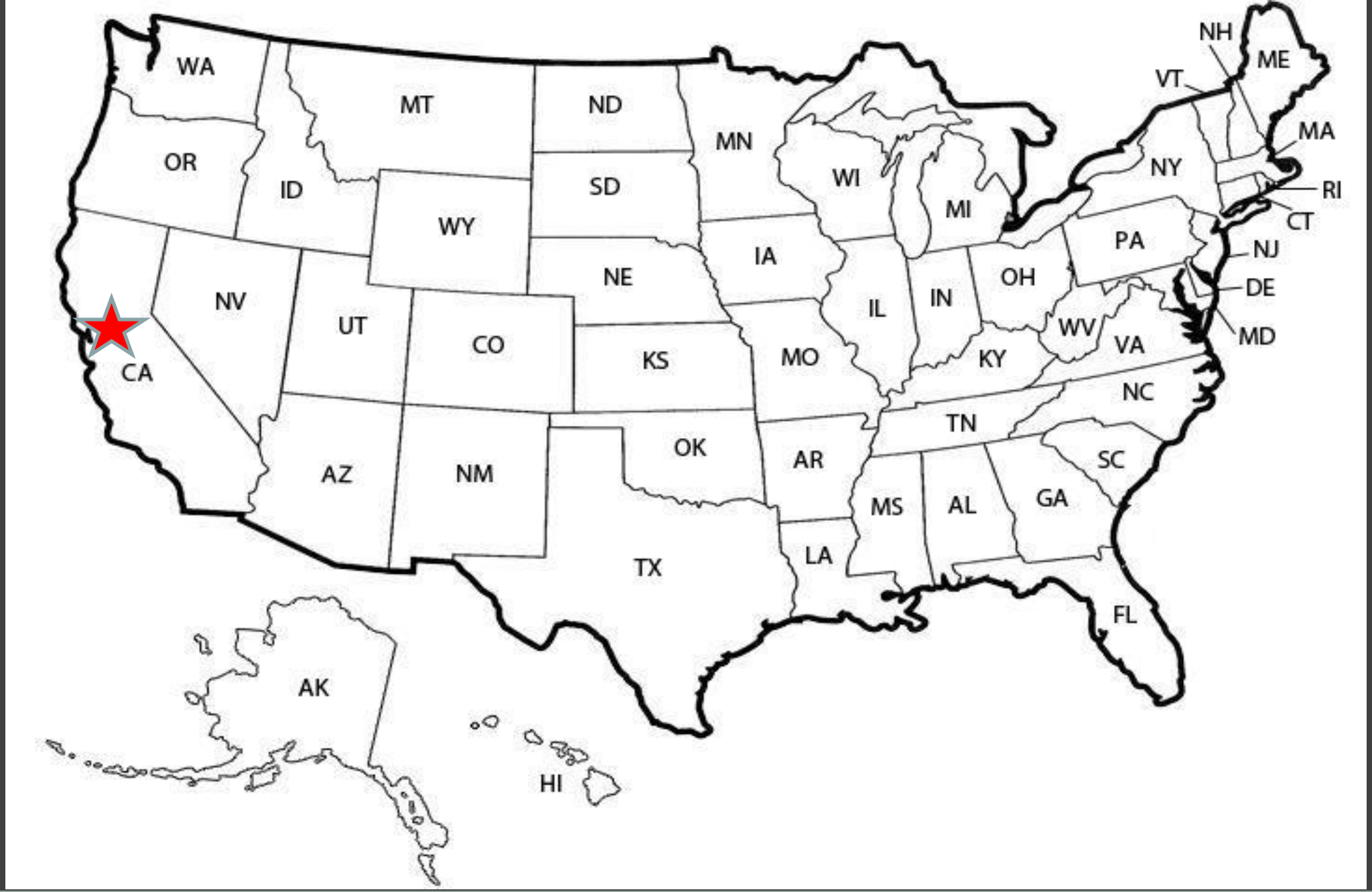
COUNTY OF SANTA CLARA, CALIFORNIA

Disclosure

- I serve as the National Association of Medical Examiners (NAME)'s vice president
- For today's presentation, I do not represent NAME but represent my own experiences and opinions as a practicing forensic pathologist and Neuropathologist in northern California

Presentation outline:

- County of Santa Clara Medical Examiner-Coroner (ME-C)
- Our perspective on a death in custody investigation
- Recommendations for **National Academy of Sciences** (NAS)
  - Monitor legislation
    - Ensure forensic pathologists maintain their independence
  - Custody Health Death Review Team
  - Transparency
    - Death certificates
    - Data dashboard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CT
NJ
DE
MD
AK
HI

Silicon Valley

Large county

2 million people

1304 sq. miles

24/7 office

History

Medical Examiner system for decades

2004 – Sheriff Administration (hybrid system)

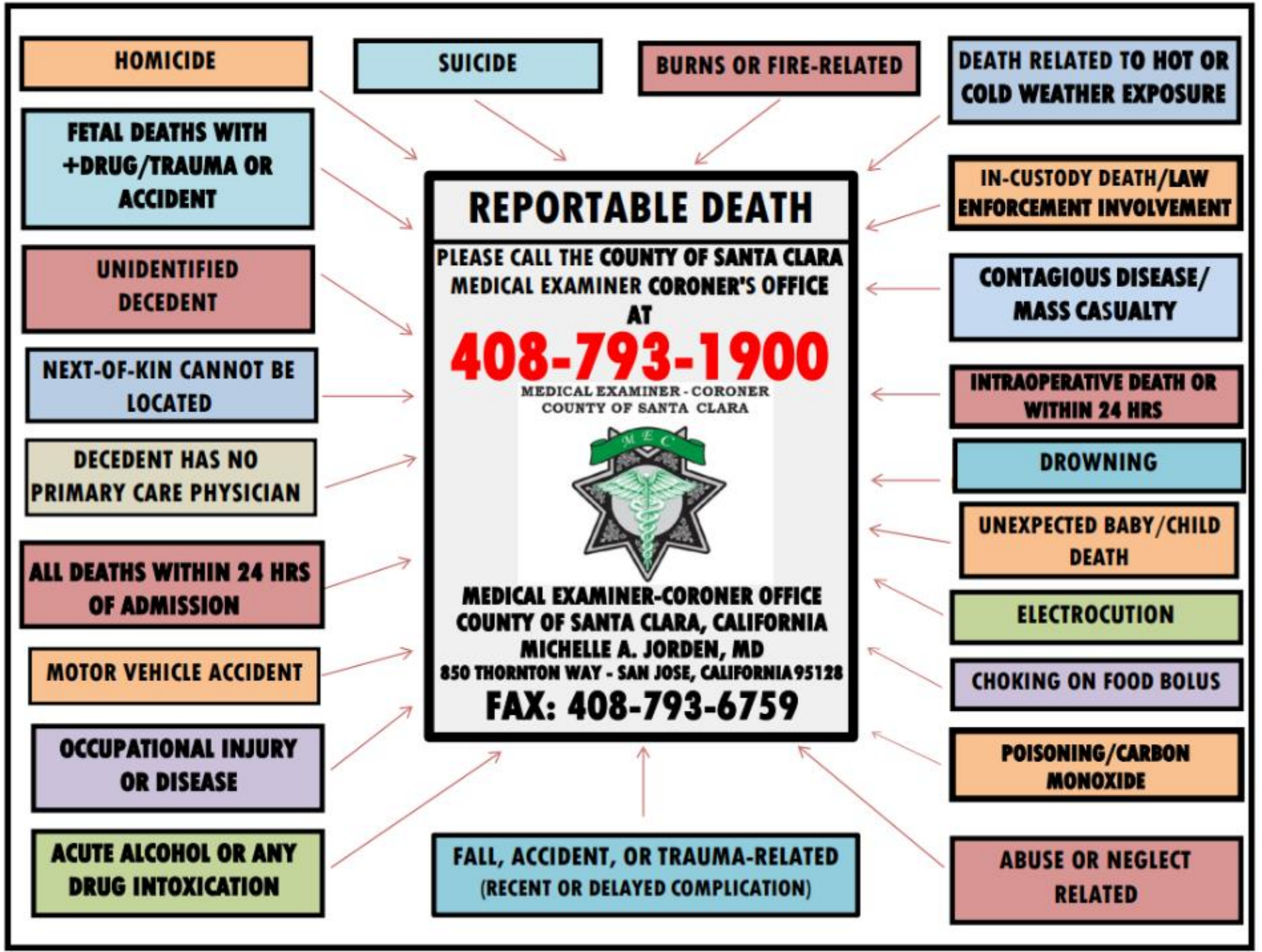
2016 – Transitioned back to Medical Examiner – direct report to County Executive

2017 and 2018 – Mass Fatality planning, in custody death procedure

2019 – Gilroy Garlic Festival mass shooting

2020 – COVID-19

2021 – COVID-19, VTA mass shooting, increase in deaths and drug overdoses


HOMICIDE
SUICIDE
BURNS OR FIRE-RELATED
DEATH RELATED TO HOT OR COLD WEATHER EXPOSURE
FETAL DEATHS WITH +DRUG/TRAUMA OR ACCIDENT
IN-CUSTODY DEATH/LAW ENFORCEMENT INVOLVEMENT
UNIDENTIFIED DECEDENT
CONTAGIOUS DISEASE/ MASS CASUALTY
NEXT-OF-KIN CANNOT BE LOCATED
INTRAOPERATIVE DEATH OR WITHIN 24 HRS
DECEDENT HAS NO PRIMARY CARE PHYSICIAN
DROWNING
ALL DEATHS WITHIN 24 HRS OF ADMISSION
UNEXPECTED BABY/CHILD DEATH
MOTOR VEHICLE ACCIDENT
ELECTROCUTION
OCCUPATIONAL INJURY OR DISEASE
CHOKING ON FOOD BOLUS
ACUTE ALCOHOL OR ANY DRUG INTOXICATION
POISONING/CARBON MONOXIDE
FALL, ACCIDENT, OR TRAUMA-RELATED
(RECENT OR DELAYED COMPLICATION)
ABUSE OR NEGLECT RELATED
REPORTABLE DEATH
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MEDICAL EXAMINER-CORONER OFFICE
COUNTY OF SANTA CLARA, CALIFORNIA
MICHELLE A. JORDEN, MD
850 THORNTON WAY - SAN JOSE, CALIFORNIA 95128
FAX: 408-793-6759

Death in custody

Procedure: Notification (pre-scene)

- By law, a death in custody falls under the jurisdiction of the Medical Examiner
- On call Assistant Medical Examiner, Chief Medical Examiner and Chief Investigator notified
  - Exchange of information
- Scene response
- Natural, accident, homicide, suicide and undetermined

Procedure: Scene response

- Scene investigation conducted in jail and hospital (if transported)
- On scene: important for others to understand the role of the ME-C (determine why the person died and under what circumstances?)
  - Investigating law enforcement agency
  - District Attorney
  - Medical Examiner-Coroner

Procedure: Scene response

ME-C conducts medicolegal death investigation

- Access to law enforcement, correctional officers
- If needed, scene re-enactment may be performed (restraint deaths)

- Body examined
- If suicide, mandatory for ME-C to retrieve the ligature/note
- Body placed in black body bag and sealed
- Booking sheet and medical intake records
- Medical records
- Body cam videos/any videos provided to our office
  - Senate bill no. 1189 - California

Procedure: Autopsy

- Investigating agency or agency involved in the death are not present for the autopsy – what about evidence?
  - Preserve medical independence
  - Reduces actual or perceived biases
  - Avoids misinterpretation of medical findings
- Full body X-rays
- Majority undergo full autopsy
  - Delayed fatal or natural disease (metastatic cancer)
- Urine toxicology
- Specialized dissection if needed
- Expanded panel for toxicology performed on postmortem blood

Organ retention

Duties of the Medical Examiner/Coroner *California*

Organs can be retained in the state of California if needed for cause and manner of death determination

Brain, spinal cord and heart are most common organs retained

Organ donation

Organ donation

- We strive to fulfill the decedent's desire for organ donation (if first person consent) or at the family's wishes

- Organ donation can occur for a death in custody and has not interfered with cause and manner of death determination
  - Requirements:
    - The ME-C has a strong working relationship with our regional organ procurement team and written protocols are in place
    - Strong communication

Procedure: post-autopsy

- Debrief (verbal or written) is provided and can include the investigating agency, the County Executive, Custody Health, District Attorney's Office

- For restraint cases, case is reviewed and discussed with all doctors in the office

Next steps/recommendations

Legislation and support

Commitment to transparency

Legislation

- Forensic pathologists must preserve their independence
  - Legislative efforts
    - State level
    - Federal level
  - Others
    - Medical organizations

Transparency

- Cause and manner death determination
- Death certificate
  - Call for a more uniform approach to death certification for in custody deaths
    - Custody health death review team
    - Check box on the death certificate for in custody deaths
      - Improves state and national statistics
- Mobilize partners
  - State level, federal level
- Data Dashboard

Our AMA advocates for a change to the U.S. Standard **Certificate** of **Death** to include a "check box" that would capture deaths in custody and further categorize the custodial **death** using cause and manner of **death** and information from the "How Injury occurred" section of the **death certificate**.

Transparency – data dashboard