

COUNTY OF MONTEREY

ANNUAL REPORT OF THE CORONER

2006



MIKE KANALAKIS
SHERIFF-CORONER

MONTEREY COUNTY SHERIFF'S OFFICE
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SALINAS, CA 93906

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SHERIFF-MARSHAL-CORONER

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DIVISION COMMANDER

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FORENSIC ODONTOLOGIST

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DR. ALISON GALLOWAY

2006 ANNUAL REPORT OF THE CORONER

In Monterey County, the Sheriff-Marshal-Coroner is 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 Medical Transcriptionist and one (1) part-time office assistant. 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 2006, the Division's investigating Deputy Coroner's drove a total of approximately 32,942 miles in the course of their duties.

In calendar year 2006, 2,359 deaths were recorded in Monterey County. Of these recorded deaths, 1,054 were reported to the Coroner's Office. Those cases were reported pursuant to California Government Code Section 27491 and California Health and Safety Code Section 102850, which direct the Coroner to inquire into and determine the circumstances, manner, and cause of those deaths.

After investigations, 290 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 226 of these cases, it was necessary to perform a postmortem examination (autopsy) in order to determine the cause of death. With follow-up investigation, the remaining 764 cases reported to the Coroner revealed the person died as a result of obvious "natural" causes and these cases were referred to the attending physician of record to certify the cause of 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 deceased persons are listed in Coroner's records as either a John Doe or Jane Doe depending on their sex. Dental information and x-rays are forwarded to the California State Department of Justice in Sacramento for possible matching with dental records of reported missing persons. In 2006 the Coroner's Office investigated the deaths of 5 John Does with none of the John Does remaining unidentified. This year there were no reported Jane Does.

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 occurred within Monterey County.

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 that 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.
25. Fetal deaths of older than 20 weeks gestational age.

SUMMARY OF INVESTIGATIONS

2006

	<u>INVESTIGATIONS CORONER</u>	<u>INVESTIGATIONS *PHYSICIAN CERTIFIED</u>	<u>AUTOPSIES PERFORMED</u>	<u>INVESTIGATIONS TOTAL</u>
JAN	34	72	29	106
FEB	20	59	18	79
MAR	26	80	24	106
APR	22	58	15	80
MAY	22	59	17	91
JUN	22	60	17	82
JUL	26	67	16	93
AUG	26	59	20	85
SEP	22	48	15	70
OCT	31	48	23	79
NOV	25	75	19	100
DEC	14	69	13	83
TOTAL:	290	764	226	1054

*After thorough investigation by the Coroner's Office, it was determined that these deaths were due to natural causes. The attending physician signed the death certificates without an autopsy by the Coroner's office.

STATISTICS FOR CALENDAR YEAR 2006

	<u>Natural</u>	<u>Accident</u>	<u>Suicide</u>	<u>Pending</u>	<u>Homicide</u>	<u>Undetermined</u>	<u>Accident (Vehicle)</u>	<u>Natural (Cancer)</u>	<u>Month Total</u>
January	65	15	2	0	3	2	3	16	106
February	55	5	4	0	2	0	2	11	79
March	79	8	3	0	2	0	3	11	106
April	61	4	3	0	0	1	5	6	80
May	64	8	5	0	3	1	2	8	91
June	61	8	3	0	3	0	2	5	82
July	65	4	5	0	2	1	9	7	93
August	59	6	3	0	0	0	8	9	85
September	49	11	2	0	2	0	1	5	70
October	44	9	4	1	1	0	10	10	79
November	70	7	6	0	2	1	4	10	100
December	60	1	0	3	0	10	3	6	83
Totals	732	86	40	4	20	16	52	104	1054

GENERAL CLASSIFICATIONS OF DEATHS HANDLED BY THE CORONER
2006

NATURAL.....	76
SUDDEN INFANT DEATH SYNDROME (SIDS).....	1
MOTOR VEHICLE DEATHS.....	53
ACCIDENT.....	86
SUICIDE.....	40
HOMICIDE.....	20
UNDETERMINED.....	6
PENDING.....	8
<u>TOTAL:</u>	290

CORONER INVESTIGATIONS 2000 – 2006

CLASSIFICATIONS

	<u>2006</u>	<u>2005</u>	<u>2004</u>	<u>2003</u>	<u>2002</u>	<u>2001</u>	<u>2000</u>
NATURAL	76	108	118	105	102	121	118
SIDS	1	3	7	7	5	1	5
MOTOR VEHICLE	53	58	93	62	61	61	56
ACCIDENT	86	87	72	74	77	67	49
HOMICIDE	20	18	40	27	26	32	29
SUICIDE	40	33	38	61	28	34	21
UNDETERMINED	6	10	12	10	9	4	6
PENDING	8	2	0	0	0	0	0

INVESTIGATIONS

	CORONER CERTIFIED	PHYS. CERT.	TOTAL INVEST.	TOTAL AUTOPSIES	TOTAL EXTERNALS	TOTAL PC AUT.
2006	288	766	1054	226	47	1
2005	319	724	1043	251	48	2
2004	380	759	1139	306	69	4
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

NATURAL DEATHS – 2006

NATURAL DEATHS BY AGE AND SEX

AGE	MALE	FEMALE	TOTAL
00-11 (MOS)	1		1
01-10 (YRS)		1	1
11-20	1		1
21-30	5		5
31-40	5		5
41-50	12	5	16
51-60	14	6	20
61-70	15	5	20
71-80	1		1
81-90	4	1	5
91-100		1	1
101-105			0

TOTAL: 76

NATURAL DEATHS BY MONTH

JAN	9	JUL	3
FEB	6	AUG	9
MAR	10	SEP	5
APR	9	OCT	6
MAY	3	NOV	4
JUN	5	DEC	7

SUDDEN INFANT DEATH SYNDROME – 2006

MONTH	MALE	FEMALE	AGE
DECEMBER	X		9 MONTHS
<u>2006 TOTAL: 1</u>			

SIDS DEATHS IN RECENT YEARS

2005	3
2004	7
2003	7
2002	5
2001	1
2000	5

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 occurs in 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.

2006 – MOTOR VEHICLE FATALITIES

OPERATORS OF MOTOR VEHICLES.....	27
PASSENGERS OF MOTOR VEHICLES.....	12
PEDESTRIANS.....	9
MOTORCYCLIST.....	4
TRACTOR DRIVER.....	1

TOTAL: 53

The Coroner’s Office as well as the law enforcement agency having jurisdiction where a motor vehicle fatality occurs, conduct a thorough investigation. A suspected traffic fatality can sometimes be the end result of natural causes that can be determined in many cases at time of autopsy. The death may be determined to be a “natural” death due to a heart attack for example, as opposed to an “accidental” death from traumatic injuries as a result of a crash. A traffic fatality might also be ruled a suicide, accident or even a homicide.

MOTOR VEHICLE FATALITIES – 2006

AGE	MALE	FEMALE	TOTAL
0-11 (MOS)	1		1
01-10 (YRS)		2	2
11-20	4		4
21-30	8	1	9
31-40	8	2	10
41-50	9	3	12
51-60	2	1	3
61-70	2		2
71-80	2	2	4
81-90	5		5
91-100		1	1

TOTAL: 53

BY MONTH

JAN	3	JUL	9
FEB	2	AUG	9
MAR	3	SEP	1
APR	5	OCT	10
MAY	2	NOV	4
JUN	2	DEC	3

2006 – TRAFFIC FATALITY – ALCOHOL/DRUG TOXICOLOGY

The Coroner investigates suspected traffic fatalities. 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. These samples are used to determine the alcohol and/or drug related derivative contents if any, in the body. In some cases the traffic victims are hospitalized for a lengthy period of time prior to expiring and therefore relevant blood and urine samples are not available for testing.

ALCOHOL RESULTS

Not tested: 1

Negative: 39

Alcohol present: 13

<u>ALCOHOL PRESENT</u>	<u>TOTAL</u>
.00 TO .05	1
.06 TO .09	3
.10 TO .15	3
.16 TO .20	2
.21 TO .30	3
.31 TO .40	1
.41 TO .50	0

DRUG SCREEN RESULTS

Not tested: 1

Examples of drugs found:

Negative: 38

Citalopram, cocaine, Delta 9-THC, Metoprolol, Alenolol, Atropine, Methamphetamine, Venlafaxine

Drug Positive 14

2006 – TYPES OF FATAL ACCIDENTS

TOTAL ACCIDENTAL DEATHS: 86

BY ACCIDENT TYPE

ASPHYXIATION:	1
GUNSHOT:	2
DROWNINGS:	15
BATHTUB.....	2
BOAT.....	1
HOT TUB.....	1
OCEAN.....	3
RIVER.....	1
SCUBA.....	7
FALLS:	13
DANCING.....	1
FISHING/ROCKS.....	1
HILLSIDE.....	1
HOSPITAL.....	1
RESIDENCE.....	6
ROOF.....	1
SIDEWALK.....	1
VEHICLE.....	1
OVERDOSE:	48
ALCOHOL.....	3
ALCOHOL/DRUG.....	1
DRUG.....	1
DRUGS MULTIPLE.....	11
PRESCRIPTION DRUGS.....	8
ILLICIT DRUGS.....	24
MISCELLANEOUS:	
CHOKED ON MEAT.....	3
RAILROAD BOXCAR WHEELS.....	1
LAWN MOWER.....	1
PINNED BY TRACTOR.....	1
PLANE CRASH.....	1

2006 – ACCIDENTS

ACCIDENTS BY AGE AND SEX

<u>AGE</u>	<u>MALE</u>	<u>FEMALE</u>	<u>TOTAL</u>
1-10(YRS)			0
11-20	2	2	4
21-30	8	2	10
31-40	11	3	14
41-50	20	4	24
51-60	11	7	18
61-70	4	1	5
71-80		1	1
81-90	3	5	8
91-100		2	2

TOTAL: 86

ACCIDENTS BY MONTH

JAN	15	JUL	4
FEB	5	AUG	5
MAR	8	SEP	11
APR	4	OCT	9
MAY	8	NOV	8
JUN	8	DEC	1

TYPES OF HOMICIDES - 2006

ASPHYXIA.....	2
BEATEN.....	1
GUNSHOT.....	11
STABBED.....	4
TRAUMA/BLUNT FORCE.....	1
RUN-OVER BY CAR.....	1
<u>TOTAL:</u>	20

OF THE 20 HOMICIDE CASES, 10 WERE DETERMINED TO BE GANG RELATED

<u>TYPES OF HOMICIDES:</u>	<u>2000</u>	<u>2001</u>	<u>2002</u>	<u>2003</u>	<u>2004</u>	<u>2005</u>
DRUG INTOXICATION	0	0	0	0	1	0
ASPHYXIATION	0	0	0	0	2	2
ASSAULT	0	1	0	0	1	0
STABBING	4	4	2	2	2	4
GUNSHOT (GSW)	24	23	24	19	27	9
GSW/STABBED	0	1	0	0	4	0
UNDETERMINED	0	0	0	0	0	0
STRANGULATON	1	1	0	4	0	0
TRAUMA/BLUNT FORCE	3	3	0	0	3	3
<u>TOTAL HOMICIDES:</u>	32	33	26	27	40	18

2006 – HOMICIDE VICTIMS BY AGE AND SEX

<u>AGE</u>	<u>MALE</u>	<u>FEMALE</u>	<u>TOTAL</u>
0-11 (MOS)			0
1-10 (YRS)			0
11-20	2		2
21-30	8	1	9
31-40	5		5
41-50	2	1	3
51-60	1		1
61-70			0
71-80			0
<u>TOTAL: 20</u>			

HOMICIDES BY MONTH

JAN	3	JULY	2
FEB	2	AUG	0
MAR	2	SEP	2
APR	0	OCT	1
MAY	3	NOV	2
JUN	3	DEC	0

SUICIDES - 2006

SUICIDES BY TYPE

ASPHYXIA.....	3
DROWNING.....	1
DRUG OVERDOSE.....	1
GUNSHOT.....	14
HANGING.....	16
CUTTING/INCISING.....	1
LACERATIONS.....	1
VEHICLE.....	2
SMOKE INHALATION.....	1

TOTAL: 40

2006 SUICIDE VICTIMS BY AGE AND SEX

AGE	MALE	FEMALE	TOTAL
1-10 (YRS)	1		1
11-20	3	1	4
21-30	5		5
31-40	5	1	6
41-50	12	1	13
51-60	3		3
61-70	2	2	4
71-80	2		2
81-90	1	1	2

TOTAL: 40

SUICIDES BY MONTH

JAN	2	JUL	5
FEB	4	AUG	3
MAR	3	SEP	2
APR	3	OCT	4
MAY	5	NOV	6
JUN	3	DEC	0

2006 - UNDETERMINED DEATH MODES

<u>MONTH REPORTED</u>	<u>SEX</u>	<u>AGE</u>
JANUARY	F	38
	M	53
APRIL	M	48
MAY	M	25
JULY	M	48
DECEMBER	F	NEWBORN

TOTAL: 6

2006 - INDIGENT CREMATION

JAN 0	MAY 2	SEP 1
FEB 2	JUN 0	OCT 0
MAR 1	JUL 1	NOV 1
APR 0	AUG 1	DEC 0

TOTAL: 9

*By Monterey County resolution, cremation is the method of final disposition for indigent remains.

INDIGENT CREMATIONS IN PREVIOUS YEARS

<u>YEAR</u>	<u>TOTAL</u>
2000	20
2001	17
2002	13
2003	4
2004	13
2005	9