SENATE COMMITTEE ON PUBLIC SAFETY

Senator Jesse Arreguín, Chair
2025 - 2026 Regular

Bill No:	AB 1108	**Hearing Date:**	July 1, 2025
Author:	Hart		
Version:	May 23, 2025		
Urgency:	No	**Fiscal:**	Yes
Consultant:	AB		

Subject: ***County officers: coroners: in-custody deaths***

HISTORY

Source: Author

Prior Legislation: AB 2531 (Bryan), Ch. 968, Stats. of 2024
AB 360 (Gipson), Ch. 431, Stats. of 2023
SB 519 (Atkins), Ch. 306, Stats. of 2023
AB 2761 (McCarty), Ch. 802, Stats. of 2022
AB 1608 (Gipson), failed on Senate Floor, 2022
SB 1303 (Pan), vetoed by the Governor, 2018
SB 1189 (Pan), Ch. 787, Stats. of 2016

Support: California Medical Association; California Public Defenders Association; Oakland Privacy; Smart Justice

Opposition: California State Sheriffs' Association; Justice2Jobs Coalition; Starting Over INC; Starting Over Strong

Assembly Floor Vote: 72 - 0

PURPOSE

The purpose of this bill is to prohibit a sheriff-coroner, in any county where the offices of sheriff and coroner are combined, from determining the circumstances, manner, and cause of death for any in-custody death, and to instead require the sheriff-coroner to contract with another county or third-party medical examination provider to determine the manner, circumstances, and cause of the in-custody death, as specified.

Existing law provides that officers of a county include a sheriff and coroner, among others. (Gov. Code, § 24000 subd. (b) & (m).)

Existing law authorizes the board of supervisors to abolish by ordinance the office of coroner and provide instead for the office of medical examiner, to be appointed by the board and to exercise the powers and perform the duties of the coroner. The medical examiner shall be a licensed physician and surgeon duly qualified as a specialist in pathology. (Gov. Code, § 24010.)

Existing law authorizes county boards of supervisors to consolidate by ordinance the duties of certain county offices into one or more combinations, including the sheriff and the coroner.

(Gov. Code, § 24300.)

Existing law authorizes certain classifications of counties to additionally combine the duties of the sheriff, tax collector, and coroner. (Gov. Code, §§ 24304 & 24304.1.)

Existing law requires coroners to determine the manner, circumstances and cause of death in the following circumstances:

- Violent, sudden or unusual deaths;
- Unattended deaths;
- When the deceased was not attended by a physician, or registered nurse who is part of a hospice care interdisciplinary team, in the 20 days before death;
- When the death is related to known or suspected self-induced or criminal abortion;
- Known or suspected homicide, suicide or accidental poisoning;
- Deaths suspected as a result of an accident or injury either old or recent;
- Drowning, fire, hanging, gunshot, stabbing, cutting, exposure, starvation, acute alcoholism, drug addiction, strangulation, aspiration, or sudden infant death syndrome;
- Deaths in whole or in part occasioned by criminal means;
- Deaths associated with a known or alleged rape or crime against nature;
- Deaths in prison or while under sentence;
- Deaths known or suspected as due to contagious disease and constituting a public hazard;
- Deaths from occupational diseases or occupational hazards;
- Deaths of patients in state mental hospitals operated by the State Department of State Hospitals;
- Deaths of patients in state hospitals serving the developmentally disabled operated by the State Department of Development Services;
- Deaths where a reasonable ground exists to suspect the death was caused by the criminal act of another; and,
- Deaths reported for inquiry by physicians and other persons having knowledge of the death. (Gov. Code, § 27491.)

Existing law requires the coroner or a deputy to sign the certificate of death when they perform a mandatory inquiry. (Gov. Code, § 27491, subd. (a).)

Existing law allows the coroner or medical examiner discretion when determining the extent of the inquiry required to determine the manner, circumstances and cause of death. (Gov. Code, § 27491, subd. (b).)

Existing law provides that in all cases in which a person has died under circumstances that afford a reasonable ground to suspect that the person's death has been occasioned by the act of another by criminal means, the coroner, upon determining that those reasonable grounds exist, shall immediately notify the law enforcement agency having jurisdiction over the criminal investigation, as specified. (Gov. Code, § 27491.1)

Existing law provides that the cause of death appearing on a certificate of death signed by the coroner shall be in conformity with facts ascertained from inquiry, autopsy and other scientific findings, and prohibits the coroner from finally excluding crime, suicide or accident as a cause of death because of lack of evidence. (Gov. Code, § 27491.5.)

Existing law authorizes a coroner, in any case where a coroner is required to inquire into a death, to delegate their jurisdiction over the death to an agency of another county or the federal government when all of the following conditions have been met:

- The other agency has either requested the delegation of jurisdiction, or has agreed to take jurisdiction at the request of the coroner;
- The other agency has the authority to perform the functions being delegated; and,
- When both the coroner and the other agency have a jurisdictional interest or involvement in the death. (Gov. Code, § 27491.55.)

Existing law provides that a forensic autopsy shall only be conducted by a licensed physician and surgeon, and that the results of a forensic autopsy shall only be determined by a licensed physician and surgeon. (Gov. Code, § 27522, subds. (a), (b).)

Existing law provides that the manner of death shall be determined by the coroner or medical examiner of a county. If a forensic autopsy is conducted by a licensed physician and surgeon, the coroner shall consult with the physician in determining the cause of death. (Gov. Code, § 27522, subd. (d).)

Existing law provides that only persons directly involved in the investigation of the death of the decedent shall be allowed into the autopsy suite. (Gov. Code, § 27522, subd. (f)(1).)

Existing law provides that if an individual dies due to the involvement of law enforcement activity, law enforcement directly involved with the death of that individual shall not be involved with any portion of the post mortem examination, nor allowed into the autopsy suite during the performance of the autopsy. (Gov. Code, § 27522, subd. (f)(2).)

Existing law requires that any police reports, crime scene or other information, videos, or laboratory test that are in the possession of law enforcement and are related to a death that is incident to law enforcement activity be made available to the forensic pathologist prior to the completion of the investigation of the death. (Gov. Code, § 27522, subd. (g).)

Existing law states that the content of a death certificate must include, among other things, personal data of the decedent, date of death, place of death, disease or conditions leading directly to death and antecedent causes, accident and injury information, and information regarding pregnancy. (Health & Saf. Code, § 102875.)

Existing law requires a physician and surgeon, physician assistant, funeral director, or other person to notify the coroner when they have knowledge that a death occurred, or if they have charge of a body in which death occurred under any of the following, among others:

- Without medical attendance;
- During continued absence of attending physician and surgeon;
- Where attending physician and surgeon, or physician assistant is unable to state cause of death; and,
- Reasonable suspicion to suspect death was caused by criminal act. (Health & Saf. Code, § 102850.)

Existing law requires an attending physician's certificate be completed within 15 hours of death, or, if a coroner examined the body, within three days after examination of the body. (Health & Saf. Code, § 102800.)

Existing law provides that if a person dies while in the custody of any law enforcement agency or while in custody in a local or state correctional facility in California, the law enforcement agency or the agency in charge of the correctional facility shall report in writing to the Department of Justice (DOJ), within 10 days after the death, all facts in the possession of the law enforcement agency or agency in charge of the correctional facility concerning the death. (Gov. Code, § 12525.)

Existing law establishes the position of Director of In-Custody Death Review within the Board of State and Community Corrections (BSCC), to review investigations of death incidents occurring in local detention facilities and make recommendations to the sheriff or administrator of the local detention facility who operates the local detention facility regarding changes to policies, procedures, and practices. (Pen. Code, § 6034.)

Existing law provides that within 90 days of receipt of the director's recommendations, the sheriff or administrator who operates the local detention facility shall identify the director's recommendations that will be implemented and shall provide a timeline for implementation and the anticipated cost of implementing those recommendations. (Pen. Code, § 6034, subd. (c).)

Existing law provides that when a person, including a juvenile, who is in custody dies, the agency with jurisdiction over the state or local correctional facility with custodial responsibility for the person at the time of their death, shall post specified information on its website for the public to view within 10 days of the date of death. (Pen. Code, § 10008, subds. (a) & (b).)

Existing law, for the purposes of the provision above, defines an "in-custody death" as the death of a person who is detained, under arrest, or is in the process of being arrested, is en route to be incarcerated, or is incarcerated at a municipal or county jail, state prison, state-run boot camp

prison, boot camp prison that is contracted out by the state, any state or local contract facility, or other local or state correctional facility, including any juvenile facility. "In-custody death" also includes deaths that occur in medical facilities while in law-enforcement custody. (Pen. Code, § 10008, subd. (c).)

This bill provides that in any county where the offices of the sheriff and the coroner are combined, the sheriff-coroner shall not determine the circumstances, manner, and cause of death for any in-custody death, but shall instead do one of the following:

- Contract with another county that has a coroner's office that operates independently from the office of the sheriff or another county that has established an office of medical examiner to determine the circumstances, manner, and cause of death.

- Contract with a third-party medical examination provider that is separate and independent from the office of the sheriff-coroner and meets specified physician qualification requirements to determine the circumstances, manner, and cause of death. The medical examination provider shall operate independently from the office of the sheriff-coroner in conducting the medical examination process, including, but not limited to, exercising professional judgment to make determinations of the circumstances, manner, and cause of death.

This bill provides that the cause and manner of death listed on the death certificate shall match the cause and manner of death determined by the coroner, medical examiner, or third-party medical examination provider.

This bill specifies that the existing requirement that the manner of death be determined by the coroner or medical examiner of a county does not apply to an examination conducted by an outside coroner, medical examiner or third-party medical examination provider pursuant to this bill.

COMMENTS

1. Need for This Bill

According to the Author:

> AB 1108 is a narrowed and targeted measure to protect the independence and impartiality of medical investigations into deaths that occur in-custody. Specifically, AB 1108 will require counties with a combined sheriff-coroner office to refer investigations of deaths that occur in custody to an independent coroner or medical examiner from a different county, or contract with a qualified private medical examiner to perform the investigation. AB 1108 aims to reduce the potential for undue influence by the sheriff's office in cases involving their own officers.

2. In-Custody Deaths in California

People held in California county jails are dying at record rates, signifying a startling trend that has progressed since the mid-2000s. According to the Department of Justice, "since the passage of Public Safety Realignment in 2011 - which mandated that individuals sentenced for specific

non-violent offenses be housed in county jails rather than state prisons - the share of deaths in custody reported from county sheriff's departments (who manage county jail systems) has grown from 17.1 percent in 2010 to 22.2 percent in 2014," and growing to 20.6 percent in 2019.[1] According to another tally, more than 2,700 have died in California jails since 2005, averaging 225 deaths per year.[2] Natural causes account for the largest share of jail deaths, followed by suicides and drug overdoses, with one expert stating that the vast majority of these deaths are preventable.[3] According to a 2021 investigation by the State Auditor's Office, in San Diego County alone, 185 people died in county jails between 2006 and 2020, marking one of the highest totals among counties in the state, though more recent data indicates a downward trend.[4] Of the report's many findings, one notable conclusion was that some deficiencies within the San Diego Sheriff's Department were the result of "statewide corrections standards that are insufficient for maintaining the safety of incarcerated individuals."[5]

Deaths in California's county jails are only a portion of deaths that fall into the category of "in-custody death." Under existing law, an "in-custody death" is of a person who is detained, under arrest, or is in the process of being arrested, is en route to be incarcerated, or is incarcerated at a municipal or county jail, state prison, state-run boot camp prison, boot camp prison that is contracted out by the state, any state or local contract facility, or other local or state correctional facility, including any juvenile facility. "In-custody death" also includes deaths that occur in medical facilities while in law-enforcement custody. While comprehensive data tallying all deaths that fall within this definition is unavailable, total deaths in facilities run by the California Department of Corrections and Rehabilitation equaled 383 in 2023 (the latest year for which there is data), against a total population of 95,267. The most common cause of death was drug overdose, primarily from fentanyl.[6]

3. Coroners and Sheriff-Coroners Generally

Under existing law, it is the duty of the county coroner to inquire into and determine the circumstances, manner and cause of deaths that occur within their jurisdiction, including violent, sudden or unusual deaths, unattended deaths, known or suspected homicide, suicide or accidental poisoning, deaths from or related to injury or accident, and death in whole or in part occasioned by criminal means, among others.[7] Existing law also authorizes the coroner to perform an autopsy upon any victim of sudden, unexpected, or unexplained death or any death known or suspected of resulting from an accident, suicide, or apparent criminal means.[8] The coroner is required to perform an autopsy if the surviving spouse requests them to do so in writing. If there

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[1] *Death in Custody from 2010 to 2019*. Department of Justice, July 5, 2023. https://openjustice.doj.ca.gov/data-stories/2019/death-custody-2010-2019

[2] "California jails are holding thousands fewer people, but far more are dying in them." *CalMatters*. 25 March 2024. Deaths in California jails increase despite decline in inmates - CalMatters

[3] *Ibid.*

[4] "Report 2021-109, San Diego County Sheriff's Department – It Has Failed to Adequately Prevent and Respond to the Deaths of Individuals in Its Custody." California State Auditor. 3 February 2022. Report 2021-109; "County jail deaths drop, but families say more work to be done." *The Coast News Group.* 3 January 2025. County jail deaths drop, but families say more work to be done

[5] Report 2021-109, pp.

[6] "Analysis of 2023 California Correctional Health Care Services Mortality Reviews." *California Correctional Heatlhcare Services,* pp.6-7. 18 March 2025. Analysis of 2023 CCHCS Mortality Reviews

[7] Gov. Code §27491, (a), (b), §§ 27491.2, 27491.5

[8] Gov. Code §§ 27491.4(c), 27491.43(c).

is no surviving spouse, that right devolves to a surviving parent or child, and subsequently, if there is no surviving parent or child, to the next of kin.[9]

Coroners are also authorized to conduct inquests, or more formal investigations into the cause of a death, of their own volition, and are required to conduct them if requested to do so by the Attorney General, district attorney, sheriff, city prosecutor, city attorney or chief of police in their jurisdiction.[10] Autopsies are usually, but not always, a central component of inquests, if they had not been conducted prior to the commencement of the inquest. Pursuant to their statutory duties, coroners are responsible for the production and completion of various records and documents regarding a particular death under investigation. Centrally, coroners are generally responsible for signing death certificates, which indicate the manner of death.

County sheriffs, by contrast, have three primary duties: keeping the peace (involving patrol and arrest), attending the courts (including providing courthouse security), and operating the county jails. While the sheriff is a constitutionally elected official in all counties, some counties have elected coroners and others have appointed coroners, or medical examiners who perform the duties of a coroner (discussed further below). Under existing law, counties have the authority to consolidate the offices of sheriff and coroner, and currently 48 counties have done so.[11] This consolidation usually occurs for two reasons: (1) the maintenance and function of two separate officers is more expensive, especially for smaller counties, and (2) many of the deaths that a coroner investigates have criminal or other law enforcement components.

Critics of consolidated sheriff-coroners argue that the duality of these offices constitutes an inherent conflict of interest. For instance, in consolidated counties, even if a forensic pathologist or medical examiner determines that someone was beaten to death, the sheriff-coroner has the authority to officially declare it an accident. Such an incident occurred in San Joaquin County, where a lawsuit was filed in 2018 alleging the sheriff's department changed an autopsy report at the center of a police excessive-force case. The year before in that same county, two pathologists resigned from the office and alleged that the sheriff changed the manner of death in autopsy reports without their knowledge. The pathologists called for a split of the offices so that the independence of the coroner could be guaranteed, and the county's board of supervisors ultimately voted to replace the coroner's office with a medical examiner.[12]

Another incident occurred in December 2020, when 30-year-old Navy veteran and Antioch resident Angelo Quinto died in police custody while suffering a mental health episode. Quinto's family alleged that on the night he was taken into custody, officers knelt on Quinto's neck for nearly 5 minutes until he became unresponsive, a claim disputed by police. Quinto died in the hospital 3 days later, and the Contra Costa County Sheriff-Coroner's Office ruled that the death was a result of "excited delirium."[13] This is a particularly controversial diagnosis, as the term is generally attributed to sudden unexplained deaths of individuals while in police custody, and

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[9] Gov. Code § 27520.
[10] Gov. Code § 27491.6.
[11] Gov. Code, §§ 24304 & 24304.1.
[12] "Pathologists Who Resigned Call For San Joaquin County Sheriff-Coroner Split." *CBS News.* 8 December 2017. Pathologists Who Resigned Call For San Joaquin County Sheriff-Coroner Split - CBS Sacramento; "San Joaquin County Sheriff Stripped of Role in Death Investigations." *KQED.* 25 April 2019. https://www.kqed.org/news/11664465/san-joaquin-county-sheriff-stripped-of-role-in-death-investigations
[13] https://www.mercurynews.com/2021/08/20/death-of-angelo-quinto-after-struggle-with-cops-blamed-on-excited-delirium-a-controversial-diagnosis-the-ama-says-is-used-to-shield-police-violence/

critics argue it can be used as a justification for excessive use of force by police.[14] The diagnosis has since been prohibited in California.[15]

As referenced above, and in contrast to sheriff-coroners, many counties utilize an office of the medical examiner that is independent from the Sheriff's Department. Existing law authorizes board of supervisors to abolish the office of coroner and provide instead for the office of medical examiner, to be appointed by the board and to exercise the powers and perform the duties of the coroner. County medical examiners must, under state law, be licensed physicians with a specialization in pathology.[16] Given the lower costs associated with maintaining a single Sheriff-Coroner Office, this option is typically utilized by larger, better-resourced counties. A medical examiner functions as the medical doctor responsible for examining bodies post mortem to determine cause of death. Medical examiners responsibilities may include investigating sudden or unnatural deaths, performing forensic medicine and pathology consultations, counseling families regarding manners and causes of death, testifying in courts, conducting physical examinations and laboratory tests, conducting inquests, and serving subpoenas for witnesses.

4. Recent Legislation and Effect of This Bill

There have been several legislative efforts in recent years attempting to address the conflict of interest issues presented by the dual role of sheriff-coroners. AB 1189 (Pan, Ch. 787, Stats. of 2016) required that a forensic autopsy must be conducted by a licensed physician, and, for cases where an individual dies due to law enforcement activity, prohibited law enforcement personnel directly involved with the care and custody of that individual from being involved with the postmortem examination. Two years later, SB 1303 (Pan, 2018) would have required non-charter counties with a population greater than 500,000 to replace the office or the coroner or sheriff-coroner with an office of the medical examiner. Governor Brown vetoed that measure, writing in his veto message that "counties have several options when delivering coroner services to the public. This decision is best left to the discretion of local elected officials who are in the best position to determine how their county offices are organized." Most recently, in 2022, AB 1608 (Gipson) would have removed counties' authority to consolidate the offices of sheriff and coroner, and mandated the separation of exiting sheriff-coroner offices, but that measure failed on the Senate Floor.

This bill prohibits sheriff-coroners, in any county where those offices are consolidated, from determining the circumstances, manner and cause of death for any in-custody death, and instead requires them to either contract with another county that has an independent coroner's office or office of the medical examiner, or to contract with a third-party medical examination provider that is "separate and independent" from the office of the sheriff-coroner to make that evaluation. Under the bill, if a sheriff-coroner elects the latter option, the provider must meet specified physician qualification requirements and must operate independently from the sheriff-coroner's office in conducting the medical examination process, including, but not limited to, exercising professional judgement to make determinations of the circumstances, manner and cause of death. Finally, for any death investigation conducted under its provisions, the bill requires the cause and

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[14] For more information on the "excited delirium" diagnosis, see Strommer, Ellen, et. al. "The role of restraint in fatal excited delirium: a research synthesis and pooled analysis." *Forensic Science, Medicine and Pathology*. Published 22 August 2020. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7669776/

[15] AB 360 (Gipson), Chapter 431, Stats. of 2023, enacting Health and Safety Code §§ 24400-24403.

[16] Gov. Code, § 20410.

manner of death listed on the death certificate to match the cause and manner of death determined by the contracted party.

The contracting requirements in this bill raise policy questions that the Author and Committee may wish to consider. Under existing law, while the manner and cause of death must be determined by the coroner or medical examiner of a county, a forensic autopsy can only be conducted by a licensed physician and surgeon. This requirement is important because there is no existing requirement that county coroners, including sheriff-coroners, be licensed physicians or surgeons.[17] Additionally, when a forensic autopsy is conducted by a licensed physician and surgeon, existing law only requires the coroner or medical examiner *to consult* with the licensed physician or surgeon in the determination of the manner of death.

Under this bill, a sheriff-coroner may contract with a coroner from another county (provided it is not a sheriff-coroner) to determine the circumstances, manner and cause of an in-custody death, meaning that if no forensic autopsy is conducted, no licensed physician or surgeon will actually have any input into the cause and manner of an in-custody death. Additionally, although the goal of the bill appears to be to avoid conflicts of interest and potential dishonesty or unscrupulousness by a sheriff-coroner in determining the cause of an in-custody death, it includes no other provisions ensuring that a contracted coroner or medical examiner operate independently and with limited communication from the sheriff-coroner requesting the investigation. And similarly, although the provisions related to third-party medical examination providers stress that they operate separately and independently from the sheriff-coroner who engaged their services, there is little statutory guidance as to how such independence would be guaranteed. Would a more effective approach be to require forensic autopsies to be conducted for all in-custody deaths (thus requiring the opinion of a licensed physician or surgeon), and for in-custody deaths in counties with a combined sheriff-coroner, for the autopsy to be conducted in a different county with separate sheriff coroner offices? Such an approach could also require that the licensed physician's conclusions be included in the cause of death report along with the cause and manner and death conclusions of that county's coroner.

5. Argument in Support

According to the California Public Defenders Association:

> CPDA has historically advocated that every county in the state have a medical examiner and that the office of the medical examiner be entirely independent of law enforcement. Determinations of cause of death should not be made by law enforcement. They should be made by medical doctors who are independent and have no allegiance to a law enforcement entity. Unfortunately, California has no such requirement. AB 1108 takes a small step to ensure that cause of death determinations in cases where someone dies in custody are not made by the very entity that may well be responsible for the death. This bill will prevent an agency that has an apparent conflict of interest from determining the cause and manner of death in cases where someone dies in custody.

[17] Recall, however, that medical examiners must be licensed physicians or surgeons with a specialization in pathology under Gov. Code, § 24010.

6. Argument in Opposition

According to the Justice2Jobs Coalition:

> Under AB 1108, county's with a Sheriff-Coroner would be required to utilize third-party independent medical examination services or request another county with an established medical examiner office to conduct an independent medical examination. These solutions fall short. It is unrealistic to expect the limited county's with established medical examiner offices to have capacity to conduct additional autopsies without causing further delays in their own county's death investigations for all deaths as mandated under Government Code Section 27491 and Health and Safety Code 102850. Additionally, contracting with a third party medical examination service is the current norm in counties without independent Medical Examiner Offices given Sheriff-Coroner's and Coroner's lack of appropriate medical training. Many of these third party physicians' entire business model is centered around serving the Sheriff-Coroner, their sole client. It is safe to assume that these counties will continue to contract with the same, Sheriff-aligned physician they already work with. Ultimately, we encourage that the author's office work directly with impacted families across the state to introduce a solution that will truly address the conflict of interest inherent in the state's Sheriff-Coroner system when investigating in-custody deaths.

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