SENATE COMMITTEE ON PUBLIC SAFETY

Senator Jesse Arreguín, Chair
2025 - 2026 Regular

Bill No:	SB 1379	**Hearing Date:**	April 21, 2026
Author:	Cervantes		
Version:	March 25, 2026		
Urgency:	No	**Fiscal:**	Yes
Consultant:	ML		

Subject: ***County of Riverside: separation of county offices: in-custody reports***

HISTORY

Source: Author

Prior Legislation: AB 1109 (Hart), Ch. 389, Stats. of 2025
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), died on Senate floor, 2022
SB 1303 (Pan), vetoed, 2018
SB 1189 (Pan), Ch. 787, Stats. of 2016

Support: ACLU California Action; California Public Defenders Association; Ella Baker Center for Human Rights; Justice2Jobs Coalition; La Defensa

Opposition: California State Sheriffs' Association; Riverside County Sheriff's Office

PURPOSE

The purpose of this bill is to require the County of Riverside Board of Supervisors to separate the county offices of sheriff and coroner by July 1, 2027; to move medicolegal death investigation services to the coroner's office; to require the use of an independent medical examiner model for those services; and to require the county to publish incident reports related to in-custody deaths on its website.

Existing law organizes the 58 counties of the state into classes based upon their population, for purposes of determining the compensation of county officers. (Gov. Code, §§ 28020-28079.)

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 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 the 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 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 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 sheriff-coroners 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. Requires that the contracted entity 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. (Gov. Code, § 27491.556, subd. b.)

Existing law requires that for any in-custody death investigated by such a contracted entity, the cause and manner of death listed on the death certificate must match the cause and manner of death determined by the contracted party. (Gov. Code, § 27491.556, subd. c.)

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 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 requires the County of Riverside Board of Supervisors to separate the county offices of sheriff and coroner by July 1, 2027.

This bill moves medicolegal death investigation services to the coroner's office and requires the use of an independent medical examiner model for those services.

The bill prohibits anyone other than the coroner or a medical examiner from signing a death certificate or any portion of a postmortem examination.

This bill requires the county to publish the following on its website:

- An initial incident report of an in-custody death within 24 hours of the death.
- A preliminary report of an in-custody death within 72 hours of the death.
- In-custody death data in a centralized public database that includes, but is not limited to, all of the following:
    - The number of deaths by facility.
    - The cause of death for each death.
    - Demographic data of the deceased.
    - Medical response times to the incident resulting in the death.
- A notice of each in-custody serious incident, including, but not limited to, all of the following:
    - A suicide attempt.

- A drug overdose, including any Narcan reversal.
- A person suffering severe withdrawal symptoms.
- A person suffering medical distress during restraint.
- Any time a person's medical requests are repeatedly ignored.

COMMENTS

1. The Need for This Bill

The author writes:

> Under current law, counties may consolidate the offices of sheriff and coroner. In Riverside County, this structure has contributed to persistent challenges regarding the deaths of individuals in custody in the county's jails, including underreporting, inconsistent determinations of causes of death, and limited access to information for families and the public. In some cases, deaths involving trauma or neglect have been classified as 'natural' or 'undetermined,' raising serious concerns about investigative integrity and oversight. According to the Inland Empire Lives Lost report, between 2012 and 2022, over 226 people died while in custody in Riverside County jails. In addition, the County has had to pay out nearly $100 million in taxpayer funds for judicial settlements related to in-custody deaths. A CalMatters investigation found that 'some of the state's deadliest jails are in Riverside County and counted 45 people who have died in lockup there since Jan. 1, 2021.' Senate Bill 1379 would require the Riverside County Board of Supervisors to separate the offices of county sheriff and coroner by July 1, 2027, and employ an independent medical examiner model. By ensuring that in-custody deaths investigations are conducted by independent, qualified medical professionals and strengthening transparency requirements, SB 1379 will help renew public confidence in Riverside County's justice system

2. Consolidated Sheriff-Coroners

a. Coroners

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.[1] 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.[2] The coroner is required to perform an autopsy if the surviving spouse requests them to do so in writing. If there is no surviving spouse, that right devolves to a surviving parent or child, and subsequently, if

[1] Gov. Code §27491, (a), (b), §§ 27491.2, 27491.5
[2] Gov. Code §§ 27491.4(c), 27491.43(c).

there is no surviving parent or child, to the next of kin.[3] There is no existing requirement that county coroners, including sheriff-coroners, be licensed physicians or surgeons.[4]

Coroners are also authorized to conduct inquests or more formal investigations into the cause of a death of their own volition, and they 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.[5] 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.

b. Sheriffs

County sheriffs in California have three primary duties: keeping the peace (involving patrol and arrest), attending the courts (including providing courthouse security), and operating the county jails. 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.

c. Sheriff-Coroners

Under existing law, counties have the authority to consolidate the offices of sheriff and coroner.[6] As of 2024, 48 counties have done so.[7] This consolidation usually occurs because the maintenance and function of two separate officers is more expensive, especially for smaller counties, and because many of the deaths that a coroner investigates have criminal or other law enforcement components.

California is one of just four states that uses a sheriff-coroner system, according to the US Centers for Disease Control and Prevention.[8] Many states, like Virginia, Maryland, and Massachusetts, use state-run systems made up of forensic pathologists overseen by medical examiners, who are either physicians, forensic pathologists or both; those systems are not associated with law enforcement agencies.[9]

Critics of consolidated sheriff-coroners argue that the duality of these offices constitutes an inherent conflict of interest because the position oversees investigation of deaths that occur in custody or at the hands of law enforcement. A 2023 study by researchers at the University of Southern California found that California counties that use a sheriff-coroner system "grossly undercount" deaths involving officers.[10]

---

[3] Gov. Code § 27520.
[4] Medical examiners, however, must be licensed physicians or surgeons with a specialization in pathology under Gov. Code, § 24010.
[5] Gov. Code § 27491.6.
[6] Gov. Code, §§ 24300, 24304.
[7] Madison Aument and Mike Kessler, *In a California county where the sheriff is also the coroner, families seek change*, The Guardian (Jun. 6, 2024) <https://www.theguardian.com/us-news/article/2024/jun/06/riverside-california-sheriff-chad-bianco-coroner> [hereafter "Aument and Kessler"].
[8] *Ibid.*
[9] *Ibid*.
[10] Prados et al., *Do sheriff-coroners Underreport Officer-Involved Homicides?* (2022) 12 Acad. Forensic Pathol. 140.

3. Prior Legislation

AB 1189 (Pan), Chapter 787, Statutes 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.

SB 1303 (Pan) of the 2017-2018 would have required non-charter counties with a population greater than 500,000 to replace the office of the coroner or sheriff-coroner with an office of the medical examiner. Governor Brown vetoed that measure, writing in his veto message that "[c]ounties 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." AB 1608 (Gipson) of the 2021-2022 legislative session would have required all counties to separate the offices of sheriff and coroner. That bill died on the Senate floor.

AB 1108 (Hart), Chapter 389, Statutes of 2025, prohibited sheriff-coroners, in any county where those offices are consolidated, from determining the circumstances, manner and cause of death for any in-custody death. Instead, the bill required 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.[11] Under the bill, the selected contracted entity 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 required the cause and manner of death listed on the death certificate to match the cause and manner of death determined by the contracted party.

4. In-Custody Deaths in Riverside County Jails

In 2024, the New York Times labeled Riverside "one of America's deadliest jail systems."[12] There were 226 jail in-custody deaths from 2011 to 2022 in Riverside County, according to a report by the criminal justice nonprofit Care First California.[13] In 2022, at least 19 people died while held in Riverside County detention facilities, which is a higher rate of jail deaths than in LA County that year, which had three times as many inmates.[14] A New York Times investigation determined that "the department has omitted pertinent facts about the deaths in communications to the families of the dead and to the public."[15] Attorney General Bonta opened an ongoing civil rights investigation into the increase in deaths in custody last year, and Riverside County agreed to pay more than $12 million to settle lawsuits linked to detainee deaths going back to 2020. In 2024, at least a dozen cases were still pending.[16]

---

[11] Ch. 389, Stats. of 2025; Gov. Code, § 27491.56.
[12] Christopher Damien, *The Deadliest Year Inside One of America's Deadliest Jail Systems*, The New York Times, (Nov. 1, 2024) <https://www.nytimes.com/2024/11/01/us/california-jail-deaths-riverside-county.html> [hereafter "Damien"].
[13] Deborah Brennan, *Amid jail deaths spike, groups call for splitting coroner from Riverside sheriff's Office*, CalMatters (Apr. 2, 2025) <https://calmatters.org/justice/2025/04/riverside-sheriffs-office/> [access April 13, 2026].
[14] Aument and Kessler, *supra*.
[15] Damien, *supra*.
[16] *Ibid.*

In one case, Lisa Matus's son Richard died of a fentanyl overdose at one of Riverside County's jails in 2022. The autopsy performed by the sheriff-coroner Chad Bianco ruled that Richard Matus had died of a fentanyl overdose. But it also found that his left anterior descending artery, which provides half the heart's blood, was 80-90% closed. Richard's family alleges he was not given adequate medical attention while in jail, despite requesting care on multiple occasions. Lisa Matus said she called the sheriff's department multiple times to locate Richard's body but could not get answers until she got an attorney involved. Lisa Matus has filed a civil suit against the department, which is ongoing.[17]

In another case, Christopher Zumwalt died in 2020 after sheriff's deputies raided his jail cell with pepper spray and shocked and restrained him, according to reporting by the New York Times. The sheriff's department determined Zumwalt's cause of death to be cardiac arrest, yet the coroner ruled it a justified homicide.[18]

In December 2023, Riverside County supervisors Kevin Jeffries and V. Manuel Perez authored a proposal to study the separation of the coroner from the sheriff. "While there is no evidence of any improprieties in Riverside County regarding the operations of the coroner's office under the sheriff," they wrote, "the optics of a potential conflict of interest can lead to a loss of confidence in our institutions." The group that conducted the study ultimately advised against separating the sheriff from the coroner, citing costs. However, in March of 2024, the board voted in favor of a new arrangement: autopsies for people who die in the county's detention facilities will be outsourced to neighboring counties.[19]

5. The Effect of This Bill

This bill would require the County of Riverside Board of Supervisors to separate the county offices of sheriff and coroner by July 1, 2027. It would move medicolegal death investigation services to the coroner's office and require the use of an independent medical examiner model for those services. The bill would further prohibit anyone other than the coroner or a medical examiner from signing a death certificate or any portion of a postmortem examination.

Finally, the bill would require the county to publish the following on its website:

- An initial incident report of an in-custody death within 24 hours of the death.
- A preliminary report of an in-custody death within 72 hours of the death.
- In-custody death data in a centralized public database that includes, but is not limited to, all of the following:
    - The number of deaths by facility.
    - The cause of death for each death.
    - Demographic data of the deceased.
    - Medical response times to the incident resulting in the death.
- A notice of each in-custody serious incident, including, but not limited to, all of the following:
    - A suicide attempt.
    - A drug overdose, including any Narcan reversal.

[17] *Ibid*.
[18] Damien, *supra.*
[19] Damien, *supra.*

- A person suffering severe withdrawal symptoms.
- A person suffering medical distress during restraint.
- Any time a person's medical requests are repeatedly ignored.

6. Policy Considerations

a. AB 1108

The Riverside County Sheriff-Coroner's Office argues that the issue of conflict of interest in in-custody death investigations was addressed under AB 1108 (Hart, 2025), discussed above, which requires independent medical determinations in in-custody death cases.[20] Therefore, they argue, this bill is unnecessary.

As discussed above, under AB 1108, a sheriff-coroner must contract with a coroner or medical examiner from another county (provided it is not a sheriff-coroner), or a third-party medical examination service, to determine the circumstances, manner, and cause of an in-custody death.[21] The bill's provisions stress that the contracted coroner's office or third-party service must operate independently from the sheriff-coroner who engaged their services, including but not limited to exercising professional judgment to make determinations of the circumstances, manner, and cause of death.[22] Further, the cause and manner of death listed on the death certificate must match the cause and manner of death determined by the coroner or third-party medical examination provider.[23]

It appears possible, on its face, that AB 1108 addressed the conflict of interests inherent in a sheriff-coroner conducting investigations into in-custody deaths, because the bill requires those deaths to be investigated by independent, contracted entities. However, it is not yet clear exactly how these independent entities will function in practice, and it remains possible that their independence will not function as well as intended. Because AB 1108 was enacted last year, counties such as Riverside are still in the process of implementing the bill. The bill under consideration by the Committee would intervene to restructure the sheriff-coroner before the effects of AB 1108 are known.

AB 1108, notably, however, only applies to in-custody deaths. It does not apply to deaths involving law enforcement that are not in-custody deaths. For example, if a law enforcement officer shot a suspect in the street, that death would still be investigated by the sheriff-coroner, presenting a potential conflict of interest. However, Riverside County is singled out in this legislation because of in-custody deaths, not because of law enforcement deaths generally.

b. Cost and Efficiency Concerns

The Riverside County Board of Supervisors recently conducted an evaluation of whether to separate the Coroner and Public Administrator from the Sheriff's Office. According to the analysis, the Coroner's Bureau operates with a budget of approximately $20.6 million, with an additional $6 million in shared overhead spread across the Sheriff's Department. Separation would eliminate those efficiencies and "result in a greater cost" due to duplication of core

[20] Ch. 389, Stats. of 2025.
[21] Gov. Code, § 27491.56., subd. (b).
[22] *Ibid.*
[23] Gov. Code, § 27491.56., subd. (c).

functions. The County further found that separation would lead to "increased budgets, bureaucracy, communication challenges, and duplication of efforts, all while decreasing overall effectiveness."

c. Application to Riverside County Only

As noted, this bill targets only Riverside County, yet Riverside County is not the only county in California with significant numbers of in-custody deaths and concerns regarding the conflict of interest within the sheriff-coroner office. San Bernardino, for example, had 216 deaths in custody from 2011-2022.[24] This record of deaths has drawn criticism from civil rights advocates and prompted calls for greater transparency and stronger medical oversight.[25]

Riverside County's Sheriff-Coroner Office has had high-profile instances where the office's determinations have conflicted with other factual accounts, raising concerns specifically about conflicts of interest. On the other hand, the San Bernardino County sheriff-coroner has not produced the same track record of controversy. Still, given the constitutional issues outlined below, the author and Committee may consider addressing this distinction in the legislative findings of the bill.

7. Constitutional Issues

a. Special Legislation

Article IV, Section 16(b) of the California Constitution states: "A local or special statute is invalid in any case if a general statute can be made applicable."[26] "A law is a general one when it applies equally to all persons embraced in a class founded upon some natural, intrinsic, or constitutional distinction; on the other hand, it is special legislation if it confers particular privileges, or imposes peculiar disabilities or burdensome conditions, in the exercise of a common right, upon a class of persons arbitrarily selected from the general body of those who stand in precisely the same relation to the subject of the law."[27]

Here, the state already has a general statutory scheme that grants the Boards of Supervisors in *all* general law counties the discretion to consolidate or separate the offices of sheriff and coroner. (Gov. Code, §§ 24300, 24304.). Requiring Riverside County to separate its offices and incur the administrative costs of two departments—while allowing San Bernardino or Kern counties to consolidate theirs—imposes a "peculiar disability" on a specially selected county.

The most analogous precedent is *White v. Church* (1986) 185 Cal.App.3d 627. In *White*, the state legislature passed a law specifically canceling a San Mateo County sheriff's election following the death of a candidate, overriding the general statutory framework that governed such scenarios. The Court of Appeal struck down the statute as unconstitutional special legislation, reasoning that the legislature cannot arbitrarily displace a functioning general law with a localized mandate.

---

[24] Deborah Brennan, *Inland Empire has high number of jail deaths*, CalMatters (Oct. 16, 2024) <https://calmatters.org/justice/2024/10/inland-empire-jail-deaths/> [accessed April 14, 2026].
[25] Sofia Youngs, *West Valley Jail Death Highlights Ongoing Concerns Over In-Custody Care*, Los Angeles Magazine (Feb. 18, 2026) < https://lamag.com/news/west-valley-jail-death-highlights-ongoing-concerns-over-in-custody-care/> [accessed April 14, 2026].
[26] Cal. Const., art. IV, § 16
[27] *People v. Western Fruit Growers, Inc.,* 22 Cal.2d 494, 506.

Similarly, here, this bill displaces Government Code section 24300 solely for Riverside County. Because a general statute is already successfully applied to govern the consolidation of county offices statewide, displacing it for a single county likely constitutes special legislation.

The state's primary defense will rely on the "rational classification" exception. The courts will occasionally uphold legislation applicable to a single county or entity, provided there is a rational basis for it.[28] For the legislation to survive, the state must prove that there is a "conceivable state of facts which can reasonably support difference in legislative treatment."[29] For example, in *City of Los Angeles v. City of Artesia* (1977), the court upheld a statute regarding police service contracts that effectively only applied to Los Angeles County, reasoning that the county's unprecedented size and complex web of 78 incorporated cities created a genuinely unique law enforcement environment justifying special state intervention.[30]

To apply this defense to this bill, the legislative record must demonstrate that Riverside County presents unique, insurmountable challenges under a consolidated model that do not exist in similarly situated counties (such as San Bernardino or Kern). Here, the amended legislative findings note that Riverside has incurred an exceptionally high rate of in-custody deaths, which may justify this special statute. However, as noted above, San Bernardino has also experienced a high rate of in-custody deaths—the findings may need to be modified to make clear why the bill is singling out Riverside and not San Bernardino or other counties with high rates of in-custody deaths.

b. Vagueness

There are a number of provisions in this bill that may be unconstitutionally vague. A statute is unconstitutionally vague if it does not provide adequate notice of the conduct proscribed.[31] "A statute which either forbids or requires the doing of an act in terms so vague that men of common intelligence must necessarily guess at its meaning and differ as to its application, violates the first essential of due process of law."[32]

This bill requires Riverside County to post a notice of each in-custody serious incident, including, but not limited to:

- A suicide attempt.
- A drug overdose, including any Narcan reversal.
- A person suffering severe withdrawal symptoms.
- A person suffering medical distress during restraint.
- Any time a person's medical requests are repeatedly ignored.

There may be some ambiguity as to what qualifies as a "serious incident." For example, "a person suffering from severe withdrawal symptoms," could be interpreted multiple ways. What symptoms qualify as "severe"?

---

[28] *Board of Education v. Watson* (1966) 63 Cal.2d 829, 833.
[29] *City of Los Angeles v. City of Artesia* (1977) 73 Cal.App.3d 450, 456.
[30] *Ibid.*
[31] *People v. Superior Court (Caswell)* (1988) 46 Cal. 3d 381, 389.
[32] *Connally v. General Const. Co.* (1926) 269 U.S. 385, 391.

Similarly, the phrase "a person suffering medical distress during restraint" is open to interpretation. What is "medical distress"? If someone has a panic attack, is that medical distress?

Finally, the phrase "any time a person's medical requests are repeatedly ignored" may be too vague as well. How many instances constitute "repeatedly"? What is a "medical request"? Is a medical request a request for medical care, only? If a request is acknowledged, but not acted upon, is it "ignored?"

The author and Committee may consider providing more specific guidelines on these points to assist Riverside County in following the reporting provisions of this bill.

8. Argument in Support

ACLU California Action writes:

> As long as sheriff-coroner offices remain combined, the inherent conflict of interests will obscure the truth about how loved ones died under the sheriff's custody. While this issue persists throughout California, SB 1379's approach of separating the offices of the sheriff and coroner in a county with a disproportionate number of in-custody deaths is an important step in the right direction.
>
> In California, 48 of the state's 58 counties place the functions of the coroner or medical examiner's office under the sheriff, although sheriffs are not required to have any medical background or certification to assume the duties of a coroner. California is one of only three states that allow the offices of the coroner to be combined with sheriffs despite the inherent conflicts of interest with respect to investigating causes of death at the hands of law enforcement. Counties like Los Angeles, San Diego, and San Francisco have already separated the duties of the coroner from the sheriff. Their coroners are independent medical examiners, who are required to be licensed physicians and surgeons duly qualified as a specialist in pathology. Californians in all counties - regardless of their population size or budget - deserve access to a fair, unbiased, and transparent process.
>
> Riverside County has reported disproportionately high in-custody deaths for over a decade, including high in-custody death rates during sheriff Chad Bianco's tenure. From 2011-2022, there were 226 in-custody deaths reported in Riverside County and 216 in San Bernadino County. In other words, these counties accounted for 19% of the state's in-custody deaths during that period, despite only making up around 12% of the state population. These deaths have only continued since then, with 45 in-custody deaths recorded in Riverside County from 2021 – 2024.
>
> One unfortunate example of the failures in Riverside's jails is the story of Richard Matus. Matus had been in Riverside's custody for four years when he reported being sick and dizzy. Despite his symptoms not improving with blood pressure medication, Matus was never taken to the hospital. Hours after a phone call with his mother, Matus was found unresponsive in his cell. Despite no history of addiction and the County's autopsy listing that one of his coronary arteries was

80-90% blocked, the County reported his cause of death as a fentanyl overdose. When the Matus family pressed Riverside County for more details, sheriff Bianco dismissed their complaints as "fabrications or misleading at best".

SB 1379 will ensure that medical examinations and investigations of sudden, violent, or unexplained/suspicious deaths in Riverside County jails are conducted with integrity, providing families with the closure and dignity they deserve. Moreover, these objective medical reports will help Riverside County implement the necessary reforms to drive down their epidemic of in-custody deaths. As long as sheriff-coroner Offices are allowed to conduct medical examinations for law enforcement-involved incidents, conflicts of interest and bias will get in the way of the truth.

9. Argument in Opposition

The Office of the Riverside Sheriff-Coroner writes:

On behalf of the Riverside County Sheriff's Office, we oppose SB 1379 on procedural, substantive, and local governance grounds.

Riverside County recently conducted a comprehensive, multi-month evaluation of whether to separate the Coroner and Public Administrator from the Sheriff's Office. That analysis… reached a clear conclusion: "the negative impacts of separating the Coroner's Bureau and/or Public Administrator from the Sheriff's Department *significantly outweigh the perceived benefit* (emphasis added) and would not be in the best interests of the community." SB 1379 ignores that formal finding and mandates a structural change the County has already determined would be costly, inefficient, and ineffective.

The stated basis for SB 1379 is the perceived conflict of interest in custodial death investigations. The Legislature already addressed that issue through AB 1108 (2025), which requires independent medical determinations in in-custody death cases.
…

SB 1379 does not address a new issue. It imposes a second, far more disruptive solution while counties are still implementing the first.

Riverside County has already identified specific, measurable impacts that SB 1379 proposes. The Coroner's Bureau operates with a budget of approximately $20.6 million, with an additional $6 million in shared overhead spread across the Sheriff's Department. Separation would eliminate those efficiencies and "result in a greater cost" due to duplication of core functions. The County further found that separation would lead to "increased budgets, bureaucracy, communication challenges, and duplication of efforts, all while decreasing overall effectiveness."
…

SB 1379 does not account for the impact on the Public Administrator (PA) either, which is operationally tied to the Coroner. The County found that approximately 40% of PA investigations are Coroner-referred, and both functions rely on shared

systems, coordination, and immediate access to case data. Separation would disrupt next-of-kin identification, eliminate shared case system access, and slow investigations and estate administration.
…

Riverside County already operates with multiple independent layers of review: District Attorney criminal investigations, Independent Force Investigation Detail (FID), Central Corrections Investigation (CCI), Attorney General oversight, and Civil Grand Jury review. The County concluded, "there are currently implemented measures and safeguards designed to provide increased transparency and public trust in the outcome of investigations."
…

The County also reviewed public claims regarding custodial deaths and found material inaccuracies. For example, publicly cited figures significantly overstated both totals and averages. Verified County data reflects approximately 8 custodial deaths per year, not the higher numbers often claimed. The County further found that broader systemic factors – particularly AB 109 (2011) realignment and the rise in fentanyl-related overdoses are the primary drivers of these trends, not the structure of the Coroner's Office.
…

SB 1379 is not a statewide reform – it is targeted to a single county. The Legislature has historically addressed custodial death issues through uniform statewide policy, as seen with AB 1108. Moving away from that approach to impose a county-specific structural mandate raises concerns about consistency and precedent. If governance structures can be overridden county-by-county, it creates uncertainty for local governments and undermines local accountability.

-- END --