RIVERSIDE COUNTY
STANLEY SNIFF, SHERIFF

Sheriff

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August 13, 2015

Honorable Harold Hopp
Presiding Judge
Riverside County Superior Court
4050 Main Street
P.O. Box 431
Riverside, CA 92501

Reference: **Response to 2014-2015 Grand Jury Report: Riverside County Sheriff's Department Coroner's Bureau – Coroner's Review**

Dear Judge Hopp:

Pursuant to California Penal Code Section 933 et. seq. please find enclosed the response of the Riverside County Sheriff's Department to the above entitled Grand Jury Report. As always please feel free to contact me should you have any questions regarding this or any other matter. I may be reached at (951) 955-2446.

Sincerely,

STAN SNIFF, SHERIFF

cc. Clerk of the Board of Supervisors
County of Riverside

Mr. Jay Orr
County Executive Officer

SLS:pk

2014-2015 GRAND JURY REPORT

Riverside County Sheriff's Department Coroner's Bureau – Coroner's Review

Finding 1 ***Misleading Statement***

Upon reviewing the supplemental page of Coroner's Packets #2013-10639 (Attachment #1) and #2013-11723 (Attachment #2), it was observed that each contained a similar misleading statement.

They both read, on the applicable date, Riverside County Sheriff-Coroner Stanley Sniff conducted a Coroner's Review in the matter of the death of the decedent. After the facts were presented, Sheriff-Coroner Stanley Sniff certified the death. These written statements are misleading as Sheriff-Coroner Stanley Sniff was not present at either review.

Response to Finding 1:

Riverside Sheriff's Department agrees with the finding in part.

Respondent acknowledges Sheriff-Coroner Stan Sniff was not present at the Coroner Review for case #2013-10639 (09/04/14) or #2013-11723 (10/30/14); however, disagrees that there are any misleading statements contained in the respective coroner reports. The Sheriff is the Chief Executive Officer of the Department and is the final authority in all matters dealing with the Department. The Sheriff may delegate authority to his executive staff. Members of the Sheriff's Department Executive Team act on behalf of the Sheriff on a daily basis. The Executive Team consists of the Undersheriff, Assistant Sheriffs, and Chief Deputies.

Coroner Reviews are presented to invited Grand Jury members, designated law enforcement agencies, and the District Attorney's Office. At the commencement of each presentation, the Coroner's Bureau commander introduces members of the expert panel, and indicates that the Undersheriff (or Assistant Sheriff) is present and acting on behalf of the Sheriff. Therefore, the fact that a member of the Executive Team is acting on behalf of the Sheriff is evident and expressed during the proceeding and not misleading.

Recommendation 1:

1. *The supplemental page of all Coroner's packets recommending the cause, mode, and manner shall be reworded to reflect that a Coroner's Review was conducted on behalf of the Sheriff-Coroner Stanley Sniff.*

Response to Recommendation 1:

The recommendation will be implemented to avoid confusion.

Finding 2 Delay of Files/Documents

On October 30, 2014, members of the Grand Jury attended Coroner's Review of Coroner Case File #2013-11723. The Sheriff-Coroner certified death as:

- *Cause of death: Acute methamphetamine and heroin intoxication*
- *Mode of death: Administered illicit drugs to self*
- *Manner of death: Accident*

At the conclusion of the review, the Grand Jury requested a Coroner's Packet for this case file. On November 5, 2014, a follow-up telephone call was made to the Coroner's Office inquiring into the status of the requested Coroner's Packet. Later that day, the Grand Jury Foreperson received a voice mail message advising the packet was not complete and the cause of death was still undetermined, even though the cause of death was certified on October 30, 2014. A second follow- up telephone call was placed on November 24, 2014. The Grand jury was advised that the requested Coroner's packet was waiting final approval. A third follow-up phone call was placed on December 4, 2014, this time the Grand Jury was advised the packet was awaiting a signature. The requested packet was finally received on December 15, 2014.

Response to Finding 2:

Riverside Sheriff's Department disagrees with the finding.

Although the respondent cannot confirm the details described in the finding, there is nothing to indicate that the details or timeline are inaccurate; however, there was no delay in providing the packet.

The Riverside Sheriff's Department recognizes the importance of responding to requests for official records by the Grand Jury and has provided such records in a timely manner. Such requests by the Grand Jury are handled in a priority manner and reports are expedited.

Although the majority of coroner reports are available within 90 days of death, Coroner Review cases can take much longer due to the complexity and multi-agency involvement. A Coroner Packet is not complete until all of the investigative reports are obtained, which can take several months.

Once a Coroner Review is complete, the investigating deputy coroner completes a supplemental report, which includes death certification and manner and mode of death as determined by the Coroner Review. The report must be reviewed and approved by a supervisor and manager; therefore, a report may not be available for an additional 30 to 60 days after the Coroner Review.

This Coroner Review in case #2013-11723 was presented on October 30, 2014, the reports were completed, processed, and delivered within 30 business days. This does not constitute an unreasonable delay.

Recommendation 2:

2. *The Sheriff-Coroner shall not hold Coroner's Reviews until cause, mode, and manner of death have been verified.*

Response to Recommendation 2:

The recommendation will not be implemented.

This recommendation contradicts the purpose of a Coroner Review. As described on page 1 in the Background section of the Grand Jury report, "The coroner's reviews are conducted solely to: . . . determine the cause of death, determine the mode of death, [and] determine the manner of death . . . ." Therefore, since Coroner Reviews are conducted to determine the cause, mode, and manner of death, this recommendation cannot be implemented.

Finding 3 Inaccurate Information

On two occasions, members of the Grand Jury met with a city chief of police. During these meetings, the chief expressed concerns, as he was advised by the Sheriff that the Grand Jury only attends three Coroner's Reviews a year. The chief felt that this left his officers in a state of anxiety. He further stated he understood that if the Grand Jury was not present, a Coroner's Review could not be conducted. The Grand Jury is invited to attend Coroner's Reviews as the watchdog, representing the citizens of Riverside County.

Response to Finding 3:

Respondent has no information regarding conversations between the Grand Jury and any chief of police. Although the Grand Jury is invited to attend all Coroner Review presentations, the review takes place as scheduled. On rare occasion, although invited, the Grand Jury has not attended.

Recommendations 3:

3. *Sheriff-Coroner Personnel shall not advise anyone that the Grand jury must be present for a Coroner's Review to take place, and shall be written into the Sheriff's Coroner Policy and Procedure Manual.*

Response to Recommendation 3:

The Respondent has no information that the Sheriff or Sheriff-Coroner personnel indicated the information contained in Finding 3 above. The Sheriff-Coroner policy and procedure manual indicates that the Grand Jury is invited to all Coroner Reviews and their presence is optional.

Finding 4 Accuracy/Amending Files

The Grand Jury requested Coroner's Packet for Coroner File #2013-11723. Contained in the Coroner's Packet was a copy of the Coroner Investigative Report, prepared on December 25, 2013, by a Coroner Corporal assigned to the Indio office. In this Coroner Investigation Report, the Coroner Corporal wrote concerning the female decedent: "There were no known recent suicidal attempts or past suicide attempts . . ."

At the Coroner's Review on October 30, 2014, the Administrative Deputy Coroner presented the timeline for this case. The Grand Jury noted the following discrepancies between the report prepared by the Coroner Corporal and the timeline as presented by the Administrative Deputy Coroner:

- *The Administrative Deputy Coroner's timeline stated that there was an attempted suicide by drug overdose in 2008*

- *The Administrative Deputy Coroner's timeline also stated that on September 26, 2013, she made a suicidal statement while incarcerated, and was taken to be medically assessed prior to being placed in a medical safety cell. A review of the safety cell log confirmed she was placed in a safety cell on this date at 0904 hours. At 1315 hours, the same day, she was cleared by Mental Health staff and moved to a holding cell*

The Grand Jury did not find any corrections within the Coroner Investigation Report, as written by the Coroner Corporal Investigator.

Response to Finding 4:

The Riverside Sheriff's Department disagrees with the finding.

In case #2013-1723, the Coroner Corporal indicated that the stepfather of the decedent was interviewed and indicated that there were no known recent suicidal ideations and no known suicide attempts in the past. The fact that the administrative deputy coroner subsequently determined that there had in fact been previous suicidal statements and attempts would not negate what the stepfather had told the Coroner Corporal at the time of death. The statements in the report are true and accurate representations of the statements made by the stepfather during the interview conducted by the Coroner Corporal.

Recommendation 4:

1. *Coroner Investigation Reports shall be amended as new information becomes available.*

Response to Recommendation 4:

This recommendation will not be implemented.

Investigative reports are not amended when new information comes to light. New information is added to existing reports in the form of supplemental reports, so as to provide an accurate timeline of when information was discovered.

Finding 5 *The Grand Jury Report does not include information on Finding 5*

Response to Recommendation 5:

The Riverside Sheriff's Department is unable to respond based on no finding included in the Grand Jury report.

Recommendation 5 *The Sheriff-Coroner shall comply with the delivery date and time as mandated within a Grand Jury Subpoena.*

Response to Recommendation 5:

The Riverside Sheriff's Department is unable to specifically respond to recommendation 5 due to the lack of information on the finding; however, the Department fully supports compliance with all subpoenas as provided by law.