Date of Hearing: April 30, 2025

ASSEMBLY COMMITTEE ON LOCAL GOVERNMENT
Juan Carrillo, Chair
AB 1108 (Hart) – As Amended April 10, 2025

SUBJECT: County officers: coroners: conflict of interest

SUMMARY: Requires a combined sheriff-coroner's office that has a conflict of interest in determining the circumstances, manner, and cause of death to request another county's office of medical examiner, or a third-party medical examination team, to determine the manner, circumstances, and cause of death. Specifically, **this bill**:

1) Provides that in any county where the offices of the sheriff and the coroner are combined, if the sheriff-coroner has a conflict of interest when determining the manner, circumstances, and cause of death, including any in-custody death, as defined in existing law, the sheriff-coroner shall not perform the autopsy or determine the manner, circumstances, and cause of death, but shall instead do either of the following:

    a) Request another county that has established an office of medical examiner to determine the manner, circumstances, and cause of death.

    b) Request a third-party medical examination team that is separate and independent from the office of the sheriff-coroner to determine the manner, circumstances, and cause of death, subject to the following requirements:

        i) The medical examination team shall operate independently from the sheriff-coroner's office in conducting autopsies, including, but not limited to, exercising professional judgment to make determinations of manner, circumstances, and cause of death.

        ii) The third-party medical examination team physician must be a licensed physician and surgeon duly qualified as a specialist in pathology.

2) Specifies that the following requirements in existing law do not apply to an independent medical examination conducted pursuant to this bill:

    a) The manner of death must be determined by the coroner or medical examiner of a county; and

    b) If a forensic autopsy is conducted by a licensed physician and surgeon, the coroner or medical examiner must consult with the licensed physician and surgeon in the determination in the manner of death.

3) Provides that, if the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.

4) Makes related findings and declarations.

EXISTING LAW:

1) Defines "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. (Penal Code § 10008)

2) Establishes the number, appointment, and election procedures for county officials, including the board of supervisors and the sheriff. (Government Code § 25000-25025)

3) Requires, under the California Constitution, all counties to elect a sheriff, district attorney, assessor, and board of supervisors. (California Constitution, Article XI, Section 1)

4) Allows counties to adopt charters to specify their own governance structure. (California Constitution, Article XI, Section 3)

5) States that officers of a county include a sheriff and coroner, among others. (Government Code § 24000)

6) 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 is required to be a licensed physician and surgeon duly qualified as a specialist in pathology. (Government Code § 24010)

7) 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. (Government Code § 24300.)

8) Authorizes certain classifications of counties to additionally combine the duties of the Sheriff, tax collector, and coroner. (Government Code §§ 24304 & 24304.1)

9) Requires coroners to determine the manner, circumstances and cause of death in the following circumstances: (Government Code § 27491)

    a) Violent, sudden or unusual deaths;

    b) Unattended deaths;

    c) 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;

    d) Deaths known or suspected as due to homicide or suicide, including suicide where the deceased has a history of being victimized by domestic violence;

e) Deaths suspected as a result of an accident or injury either old or recent;

f) Drowning, fire, hanging, gunshot, stabbing, cutting, exposure, starvation, acute alcoholism, drug addiction, strangulation, aspiration, or sudden infant death syndrome;

g) Deaths in whole or in part occasioned by criminal means;

h) Deaths associated with a known or alleged rape or crime against nature;

i) Deaths in prison or while under sentence;

j) Deaths known or suspected as due to contagious disease and constituting a public hazard;

k) Deaths from occupational diseases or occupational hazards;

l) Deaths of patients in state mental hospitals operated by the State Department of State Hospitals;

m) Deaths of patients in state hospitals serving the developmentally disordered operated by the State Department of Development Services;

n) Deaths where a reasonable ground exists to suspect the death was caused by the criminal act of another; and,

o) Deaths reported for inquiry by physicians and other persons having knowledge of the death.

10) Provides a coroner with discretion to determine the extent of the inquiry to be made into any death occurring under natural circumstances where applicable. (Government Code § 27491)

11) Requires a coroner, upon determining that 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, to immediately notify the law enforcement agency having jurisdiction over the criminal investigation. (Government Code § 27491.1)

12) 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: (Government Code § 27491.55)

a) The other agency has either requested the delegation of jurisdiction, or has agreed to take jurisdiction at the request of the coroner;

b) The other agency has the authority to perform the functions being delegated; and,

c) When both the coroner and the other agency have a jurisdictional interest or involvement in the death.

13) Defines a forensic autopsy as an examination of a body of a decedent to generate medical evidence for which the cause of death is determined. At the direction and supervision of a coroner, a medical examiner, or a licensed physician and surgeon, trained county personnel who are necessary to the performance of an autopsy may take body measurements or retrieve blood, urine, or vitreous samples from the body of a decedent. (Government Code § 27522)

14) 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. (Government Code § 27522)

15) Provides that only persons directly involved in the investigation of the death of the decedent shall be allowed into the autopsy suite. (Government Code § 27522)

16) 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. (Government Code § 27522)

17) 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. (Government Code § 27522)

FISCAL EFFECT: This bill is keyed fiscal and contains a state-mandated local program.

COMMENTS:

1) **Author's Statement**. According to the author, "AB 1108 is a common-sense measure designed to protect the independence and impartiality of medical investigations into deaths involving sheriff's deputies. By providing counties with options already in use by counties with separate coroner-sheriff offices, the bill improves oversight and transparency. Specifically, AB 1108 will require counties with a combined sheriff-coroner office to refer investigations of deaths in custody, or involving the use of force, 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) **Background**. Each county elects or appoints a variety of officials to carry out local governance. The California Constitution requires all counties to elect, among other offices, a sheriff and a board of supervisors. For general law counties – those governed by state statutes rather than a local charter – state law specifies additional required officers, including a coroner. In contrast, the state's 15 charter counties – Alameda, Butte, El Dorado, Fresno, Los Angeles, Orange, Placer, Sacramento, San Bernardino, San Diego, San Francisco, San Mateo, Santa Clara, Shasta, and Tehama – have greater leeway to determine their own governance structure. Most charter counties specify the coroner as a county office in their charter.

3) **Offices of the Sheriff and Coroner.** The California Constitution specifies that the sheriff is an elected office, while the coroner may be elected or appointed, depending on the county's governance structure. For example, the charter for Los Angeles County specifies that the coroner is appointed by the Board of Supervisors, while in Sacramento County, the coroner is appointed by the County Executive and subject to confirmation by the Board of Supervisors.

   State law permits counties – whether general law or charter – to combine the sheriff and coroner into a single elected office, commonly referred to as the sheriff-coroner. This combined office is specified in the charters of some counties, including Butte, El Dorado, Placer, and Shasta. For general law counties or charter counties whose charters do not specify a sheriff-coroner model, the board of supervisors may enact an ordinance to consolidate the offices. Alternatively, the board of supervisors may, by ordinance, abolish the office of coroner and instead appoint a medical examiner to carry out the coroner's duties. A medical examiner must be a licensed physician and surgeon specializing in pathology.

   Of California's 58 counties, 48 have consolidated the sheriff and coroner into a single office. Three counties – Inyo, Sacramento, and San Mateo – maintain separate offices for the sheriff and the coroner. The remaining seven counties – Alameda, Los Angeles, San Diego, San Francisco, San Joaquin, Santa Clara, and Ventura – have adopted an independent medical examiner model.

4) **Responsibilities of the Sheriff and Coroner.** Under existing law, the sheriff is responsible for preserving the peace and, to accomplish this objective, is authorized to sponsor, supervise or participate in any object of crime prevention, rehabilitation of persons previously convicted of crime, or the suppression of delinquency.

   The coroner's office is generally responsible for medical, investigative, and administrative duties related to death investigations, as follows:

   a) Medical responsibilities include performing autopsies and determining causes of death for cases under the coroner's jurisdiction.

   b) Investigative responsibilities include conducting investigations into the cause of death and identifying deceased individuals, including holding inquests when necessary.

   c) Administrative responsibilities include managing records, responding to inquiries, and securing valuables from the deceased.

   The coroner is legally responsible for determining the cause, manner, and circumstances of deaths that are, among other things, violent, sudden, or unusual; unattended; or potentially criminal in nature. Further, the coroner has discretion to conduct autopsies upon any victim of a death that is sudden, unexpected, unexplained, or known or suspected of resulting from an accident, suicide, or apparent criminal means. A death that occurred during or soon after the deceased individual interacted with law enforcement may, therefore, fall under the jurisdiction of the coroner.

5) **SB 1189 of 2016.** The Legislature enacted SB 1189 (Pan), Chapter 787, Statutes of 2016, to address concerns about interference in autopsies where the death involves law enforcement. SB 1189 required forensic autopsies to be performed by a licensed physician and surgeon,

regardless of the county officer structure. SB 1189 prohibited, when an individual dies as a result of law enforcement activity, law enforcement personnel involved in the death from entering the autopsy suite or having any involvement in the examination. However, the coroner – who may not be a medical professional – still determines the manner of death. While the circumstances and causes of death can vary widely, there are only five manners of death: natural, accidental, homicide, suicide, or undetermined.

6) **Conflict of Interest Controversies.** There have been controversies related to a conflict of interest when sheriff-coroner offices have determined the cause of death in law enforcement-related cases.

   a) **San Joaquin County Controversy**. In December 2017, two pathologists in San Joaquin County – Dr. Bennet Omalu and Dr. Susan Parson – resigned after documenting numerous incidents of alleged interference by the sheriff in their death investigations, including changing the manner of death from "homicide" to "accident" in three cases of law enforcement-involved deaths. Since then, the county Board of Supervisors voted to create an independent medical examiner's office and voters in the county elected a new sheriff.

   b) **"Excited Delirium."** The use of "excited delirium" as a cause of death in law enforcement-related deaths illustrates potential conflicts of interest in combined sheriff-coroner offices. Existing law [AB 360 (Gipson), Chapter 431, Statutes of 2023] defines excited delirium as "a term used to describe a person's state of agitation, excitability, paranoia, extreme aggression, physical violence, and apparent immunity to pain that is not listed in the most current version of the Diagnostic and Statistical Manual of Mental Disorders, or for which the court finds there is insufficient scientific evidence or diagnostic criteria to be recognized as a medical condition."

      Excited delirium has been attributed to sudden, unexplained deaths of individuals while in police custody. For example, this diagnosis was listed as the cause of death by Contra Costa County, which has a combined sheriff-coroner's office, in the case of Angelo Quinto in 2020. Quinto's family alleged that a responding officer knelt on Angelo's neck for nearly five minutes while another officer restrained his legs, causing Angelo to lose consciousness. He later died in the hospital.

      In 2021, the American Medical Association adopted a policy opposing "excited delirium" as a medical diagnosis, stating in a press release, "The new policy addresses reports that show a pattern of using the term 'excited delirium' and pharmacological interventions such as ketamine as justification for excessive police force, disproportionately cited in cases where Black men die in law enforcement custody."

      AB 360 (Gipson), Chapter 431, Statutes of 2023, prohibited excited delirium from being recognized as a valid medical diagnosis or cause of death.

7) **Bill Summary.** This bill requires a combined sheriff-coroner's office that has a conflict of interest in determining the circumstances, manner, and case of death, including any death that occurs in-custody, as defined, to request another county's office of medical examiner, or a third-party medical examination team, to determine the manner, circumstances, and cause of death. This bill requires that the third-party medical examination team operates

independently from the office of the sheriff-coroner in conducting autopsies, including, but not limited to, exercising professional judgment to make determinations of the circumstances, manner, and cause of death.

This bill is author-sponsored.

8) **Policy Considerations.** The Committee may wish to consider whether adding a definition of "conflict of interest" may help clarify the scope of the bill.

9) **Previous Legislation.** AB 360 (Gipson), Chapter 431, Statutes of 2023, prohibited excited delirium from being recognized as a valid medical diagnosis or cause of death.

AB 1608 (Gipson) of 2022 would have removed counties' ability to consolidate the offices of the sheriff and coroner. AB 1608 died on the Senate Floor.

SB 1303 (Pan) of 2018 would have replaced the county office of the coroner or the sheriff-coroner's office with an office of medical examiner in counties that have not adopted a charter and have 500,000 or more residents, or required these counties to adopt a policy requiring referral of death investigations to a county with a medical examiner's office for any case representing a potential conflict of interest. This bill was vetoed by the Governor.

SB 1189 (Pan), Chapter 787, Statutes of 2016, required that a forensic autopsy, as defined, be conducted by a licensed physician and surgeon.

10) **Arguments in Support.** The California Medical Association, Californians for Safety and Justice, the Ella Baker Center for Human Rights, Rubicon Programs, and the Sister Warriors Freedom Coalition, in support of a previous version of this bill, state, "AB 1108 will ensure that independent medical examinations are conducted for people who die in custody at county jails or in circumstances involving use of force by sheriff's personnel…This bill will protect the integrity of the medical examination process and improve public trust in the outcomes of these investigations…"

The California Public Defenders Association, in support of a previous version of this bill, states, "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..."

Oakland Privacy states, "It is important for us to recognize when the current state of the law institutionalizes a standing conflict of interest. Over 100 Californians die after law enforcement encounters each year. It is fair to say that as political entities that run for election, and as active advocates for law enforcement-related legislation, California sheriffs have and continue to have an interest present.

"That interest can include specific coroner reports on occasions when their own departments or local law enforcement agencies are involved in or caused the death, and can also extend to cause of death stats in the aggregate, which can impact budgetary decisions and law enforcement policies across the State…

"Assembly Bill 1108 takes a more targeted approach than previous legislation on the subject. Rather than revamping the sheriff-coroner position so that the positions cannot be filled by the same individual, AB 1108 goes straight to the heart of the potential conflict of interest by mandating independent medical reviews when departmental personnel are involved with the death. This approach cuts down on the costs of the fix, and provides less disruption to existing county practices.

"That said, we want to take a moment to request that the author and committee give deep consideration to the objections to this bill from the families of some victims who died in police custody. Their lived experience at the crux of the conflict of interest this bill seeks to eradicate is really important. While we want to be practical about the failures of other bills on this subject and also be respectful of administrative burdens of counties, we request that the bill be strengthened to prevent gamification from allied sheriffs in other counties or corrupt contractors. Some options include using only independent medical examiners or having the contracting handled by an entity other than the sheriff. If we are trying to genuinely solve this problem in a targeted fashion, which we support, we should make sure we are actually solving it and not leaving loopholes…"

11) **Arguments in Opposition.** Justice for Angelo Quinto, in opposition to an earlier version of this bill, states, "The solutions AB 1108 proposes to address conflicts of interest inherent in the Sheriff-Coroner model reinforces the broken status quo…

"[T]he Sheriff Coroner lacks objectivity and accountability, and has unchecked authority and discretion when coming to determinations that reverberate throughout the criminal legal process. AB 1108 as written provides a veneer of accountability while actually making things worse. As long as law enforcement investigates itself, there can be no accountability.

"California is one of only three states that specifically uses the Sheriff-Coroner model, where the elected county Sheriff is also automatically the coroner for a county. Forensic professionals, advocates, and families alike have raised concerns about this system for a number of reasons including the lack of educational qualifications and training required of Sheriff-Coroners and the conflict of interest that exists when responsible for investigating cause of death while in the custody of personnel or facilities (i.e., county jails) overseen by the Sheriff-Coroner…

"Under AB 1108, counties with a Sheriff-Coroner would be required to utilize third-party independent medical examination services or request another county or state agency to conduct an independent medical examination. These solutions fall short. It is unrealistic to expect a neighboring county's Sheriff-Coroner's office to implicate the original county's Sheriff – especially when the original county will eventually be the one examining a death from the neighboring county. As long as Sheriff-Coroner Offices are allowed to conduct medical examinations for officer-involved incidents, conflicts of interest and bias will get in the way of providing the truth to victims' families.

"Additionally, contracting with a third party medical examination service is often the 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 their 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.

"Finally AB 1108 is too narrow as it only applies to incidents involving sheriff's officers, excluding deaths that occur while in the custody of all other local law enforcement.

"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..."

12) **Double-Referral**. This bill is double-referred to the Assembly Committee on Public Safety, where it passed on a vote of 8-0 on April 9, 2025.

REGISTERED SUPPORT / OPPOSITION:

Support

Californians for Safety and Justice (prior version)
California Medical Association (CMA) (prior version)
California Public Defenders Association (CPDA) (prior version)
California State Association of Counties (CSAC) (prior version)
Ella Baker Center for Human Rights (prior version)
Oakland Privacy
Rubicon Programs (prior version)
Rural County Representatives of California (RCRC) (prior version)
Sister Warriors Freedom Coalition (prior version)
Smart Justice California (prior version)
Urban Counties of California (UCC) (prior version)

Opposition

Carceral Ecologies
Justice for Angelo Quinto (prior version)
Justice2jobs Coalition (prior version)

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