

2014-2015 GRAND JURY REPORT

Riverside County Sheriff-Coroner's Review

Background

The Riverside County Coroner's Office was established on May 2, 1893. On January 4, 1999, the Coroner's Office consolidated with the Riverside County Sheriff's Department, and became the 42nd county in the State of California to consolidate the Coroner's Office with the Sheriff's Department.

The Riverside County Sheriff-Coroner's Office (Coroner's Office) works with officers and investigators from every law enforcement agency in the county: sheriff, police, railroad police, campus police, state prisons and hospitals, and other state and federal agencies.

When a death occurs involving an inmate at a prison or county detention facility, or when a person dies with law enforcement involvement, a Coroner's investigation is immediately initiated. This investigation parallels the criminal investigation and is conducted to ensure all facets of the death are reviewed by professionals in the field of medical/legal death investigations. These reviews are initiated regardless of the city or law enforcement agency involved.

The Coroner's Review results are presented to a Sheriff-Coroner's representative by the Administrative Deputy Coroner, the Forensic Pathologist, and the Forensic Toxicologist with a summation at the end.

The coroner's reviews are conducted solely to:

- Confirm the identity of the decedent, the place, date, and time of death
- Determine the cause of death
- Determine the mode of death
- Determine the manner of death as one of the following:
 - Homicide (defined as death at the hands of another)
 - Suicide
 - Accident
 - Natural
 - Unknown

Reviews are presented in the following sequence:

- The Coroner Administrative Captain opens the proceeding
- The Administrative Deputy Coroner presents the timeline of events leading to the death
- A representative from Bio-Tox Laboratories presents the toxicology findings
- A pathologist presents a power point overview of the autopsy. At the conclusion, the pathologist recommends a cause of death
- The Coroner Administrative Captain asks the Sheriff's representative, members of the Coroner's panel, Grand Jury members, and guests from Criminal Justice and designated agencies if there are any questions. The Coroner Administrative Captain then recommends the cause, mode, and manner of death. Based on the three presentations, the Sheriff-Coroner representative certifies the cause, mode, and manner of death

Methodology

- Obtained sworn testimony
- Reviewed Coroner's Packet
- Reviewed a Coroner Investigation Report
- Attended Coroner's Reviews
- Reviewed Sheriff-Coroner's Policies

Findings

Misleading Statement

1. 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.

Delay of Files/Documents

2. On October 30, 2014, members of the Grand Jury attended Coroner's Review of Coroner's Case File #2013-11723. The Sheriff-Coroner Representative certified this 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. This time the Grand Jury was advised that the requested Coroner's packet was awaiting final approval. A third follow-up 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.

Inaccurate Information

3. 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.

Accuracy/Amending Files

4. The Grand Jury requested a Coroner's Packet for Coroner File #2013-11723. Contained in the Coroner's Packet was a copy of the Coroner Investigation 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 ideations or past suicide attempts..."

At the Coroner's Review on October 30, 2014, the Administrative Deputy Coroner presented a 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 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 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.

Recommendations

Riverside County Sheriff-Coroner

Misleading Statement

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

Delay of Files/Documents

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

Inaccurate Information

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-Coroner's Policy and Procedure Manual.

Accuracy/Amending Files

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

Subpoenas

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

Report Issued: 06/30/15
Report Public: 07/02/15
Response Due: 09/28/15

Riverside County Sheriff - Coroner Division
Coroner Investigation



MODE Homicide CASE # 201310639
STATUS Coroner Review DEPT#

Coroner Supplemental

09/08/2014

Supplemental Information

On 09/04/2014, Riverside County Coroner Stanley Sniff conducted a Coroner Review in the matter of the death of Adolfo Ramirez. After the facts were presented, Coroner Sniff certified the death.

The cause of death was determined to be: Gunshot Wound of Chest

The mode of death has been determined to be: Shot during confrontation with Law Enforcement.

The manner of death has been classified as homicide.

Report prepared by: _____
Administrative Deputy Coroner,
09/08/2014

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Riverside County Sheriff - Coroner Division
Coroner Investigation



MODE **Accident**

CASE# **201311723**

STATUS **Coroner Review**

DEPUTY:

Coroner Supplemental

11/06/2014

Supplemental Information

On 10/30/2014, Riverside County Coroner Stanley Sniff conducted a Coroner Review in the matter of the death of Delicia DeAngelo. After the facts were presented, Coroner Sniff certified the death.

The cause of death was determined to be: Acute Methamphetamine and Heroin Intoxication.

The mode of death has been determined to be: Administered illicit drugs to self.

The manner of death has been classified as an accident.

Report prepared by:

Administrative Deputy Coroner,
11/06/2014

ATTN 2