Date of Hearing: April 8, 2025
Counsel: Ilan Zur

ASSEMBLY COMMITTEE ON PUBLIC SAFETY
Nick Schultz, Chair

AB 1108 (Hart) – As Amended March 28, 2025

UPDATED

As Proposed to be Amended in Committee

SUMMARY: Requires a combined Sheriff-Coroner's Office that has a conflict of interest in a manner-of-death determination, which includes 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. 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, 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 and subject to specified physician qualification requirements, to determine the manner, circumstances, and cause of death, subject to the following requirements:

        i) Any such 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, who makes cause-of-death determination, must be a licensed physician and surgeon duly qualified as a specialist in pathology.

2) Defines "in-custody" death, for the purposes of when a Sheriff-Coroner has a conflict of interest, to mean any 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, as well as deaths that occur in medical facilities while in law-enforcement custody.

3) Specifies that the requirement that the manner of death be determined by the coroner or medical examiner of a county, does not apply to an independent medical examination conducted pursuant to this bill.

4) Includes legislative findings and declarations.

EXISTING LAW:

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

2) 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)

3) 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.)

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

5) Requires coroners to determine the manner, circumstances and cause of death in the following circumstances:

    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. (Gov. Code, § 27491, subd. (a).)

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

7) 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. (Gov. Code, § 27491.1.)

8) 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:

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. (Gov. Code, § 27491.55.)

9) States 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. (Pen. Code, § 27522, subd. (d).)

10) States that only persons directly involved in the investigation of the death of the decedent shall be allowed into the autopsy suite. (Pen. Code, § 27522, subd. (f)(1).)

11) 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. (Pen. Code, § 27522, subd. (f)(2).)

12) 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. (Pen. Code, § 27522, subd. (g).)

13) Defines "in-custody death," for the purposes of agency reporting requirements, to mean 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, as well as deaths that occur in medical facilities while in law-enforcement custody.

FISCAL EFFECT: Unknown

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) **Coroners**: The Office of the Coroner typically has three main responsibilities: medical, investigative, and administrative.[1] Medical responsibilities include conducting autopsies to determine cause of death within the jurisdiction, transporting and removing bodies, verifying cause of death and signing death certificates, and appearing at all unattended deaths unless the deceased has been seen by a physician within a specified period of time.[2] Investigative functions are composed of conducting investigations to determine causes of death, and establishing the identity of the deceased person.[3] Finally, administrative responsibilities include maintaining all records, and responding to inquiries by law enforcement agencies, doctors, and others with potential cases.[4]

3) **Sheriff-Coroner Offices:** Forty-eight of California's 58 counties have combined Sheriff-Coroner offices, meaning the two offices are consolidated and the sheriff also serves as the coroner.[5] The consolidation typically occurs for two reasons: 1) the maintenance and function of two separate offices is more expensive, especially for smaller counties; and 2) many of the deaths that a coroner investigates have criminal or other law enforcement components.

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[1] California State Association of Counties, *Sheriff-Coroner* (accessed March 28, 2025), available at: https://www.counties.org/county-office/sheriff-coroner
[2] *Ibid.*
[3] *Ibid.*
[4] *Ibid.*
[5] California State Association of Counties, *Sheriff-Coroner* (accessed March 28, 2025), available at: https://www.counties.org/county-office/sheriff-coroner

The duality of Sheriff-Coroners may present a conflict of interest. Medical experts determine a subject's cause of death, but the sheriff, as an elected official, possesses final say in determining a subject's manner of death.

In San Joaquin County, for example, a lawsuit was filed in 2018 alleging the sheriff's department changed an autopsy report at the center of a police excessive-force case.[6] 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.[7] The San Joaquin County Board of Supervisors ultimately voted to replace the coroner's office with a medical examiner.[8]

This potential conflict of interest associated with Sheriff-Coroners was reiterated in a recent Sheriff-Coroner's use of "excited delirium" as a cause of death in a law-enforcement related death. This diagnosis has become increasingly controversial as it is generally attributed to sudden, unexplained deaths of individuals while in police custody, which may be used as a justification for excessive police force.[9] This diagnosis has since been prohibited.[10] This was most notably demonstrated in December 2020 when Angelo Quinto died in police custody while suffering a mental health episode.[11] 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. The Contra Costa County's Coroner Office, which is combined with its Sheriff's office, ruled the cause of Angelo's death was a result of "excited delirium."[12]

In contrast, other counties utilize an office of the medical examiner that is independent from the Sheriff's Office. 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. (Gov. Code, § 24010.) 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. Unlike Sheriff-Coroners, a medical examiner must be a licensed physician and surgeon duly qualified as a specialist in pathology. (Gov. Code, § 24010). Medical examiners responsibilities may include investigating sudden or unnatural deaths, performing forensic medicine and pathology consultations, counseling families regarding manners and causes of

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[6] CBS News, *Lawsuit: Sheriff's Department Changed Autopsy Report in Police Excessive Force Case* (April 21, 2018), available at: https://www.cbsnews.com/sacramento/news/lawsuit-sheriff-changed-autopsy-report/
[7] CBS News, *Pathologists Who Resigned Call for San Joaquin County Sheriff-Coroner Split* (Dec. 8, 2017), available at: https://www.cbsnews.com/sacramento/news/pathologists-who-resigned-call-for-san-joaquin-county-sheriff-coroner-split/
[8] KQED, *San Joaquin County Sheriff Stripped of Role in Death Investigations* (April 25, 2018), available at: https://www.kqed.org/news/11664465/san-joaquin-county-sheriff-stripped-of-role-in-death-investigations
[9] American Medical Association, *New AMA policy opposes 'excited delirium' diagnosis* (Jun. 14, 2021), available at: https://www.ama-assn.org/press-center/press-releases/new-ama-policy-opposes-excited-delirium-diagnosis
[10] *See* AB 360 (Gipson), Chapter 431, Statutes of 2023.
[11] Gartrell, *Death of Angelo Quinto, Navy vet who died after struggle with Antioch cops, blamed on 'excited delirium'* (Aug. 23, 2021), available at: 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/
[12] *Ibid.*

death, testifying in courts, conducting physical examinations and laboratory tests, conducting inquests, and serving subpoenas for witnesses.

4) **Effect of this Bill:** Existing law bestows counties with discretion to either maintain a combined Sheriff-Coroner office or to abolish the office of the coroner and provide instead for the office of the medical examiner. (Gov. Code, §§ 24010, 24304, 24304.1.) Certain, albeit minimal, conflict of interest protections exist for counties with a combined sheriff-coroner office. If an individual dies due to the involvement of law enforcement activity, law enforcement directly involved with the death of that individual are not allowed to be involved with any portion of the post mortem examination, or allowed into the autopsy suite during the performance of the autopsy. (Pen. Code, § 27522, subd. (f)(2).) However, irrespective of whether law enforcement is allowed into the autopsy suite, the sheriff nonetheless has the final say in determining a subject's manner of death.

   This bill attempts to remedy the potential conflict of interest by requiring combined Sheriff-Coroner offices that have conflict of interest in a manner-of-death determination, which includes any in-custody deaths, as specified, to request another entity to make that cause of death determination. Specifically, if a death poses a conflict of interest, the Sheriff-Coroner must either: 1) request another county that has established an office of medical examiner to determine the manner, circumstances, and cause of death; or 2) request a third-party medical examination team that is separate and independent from the office of the Sheriff-Coroner and subject to specified physician qualification requirements, to determine the manner, circumstances, and cause of death. Any third party medical examination team must operate separately and independently from the Sheriff-Coroner's office, and must meet the same qualifications as a medical examiner.

   In terms of the scope of this bill, as proposed to be amended it would require a Sheriff-Coroner to request other entities to make a manner of death determination for in-custody deaths, such as those that occur during an arrest or detention by a peace officer. For purposes of this bill, in-custody death is defined to mean "any 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, as well as deaths that occur in medical facilities while in law-enforcement custody."

   In effect, this prohibits a Sheriff-Coroner from making a manner of death determination for any death that occurs as a result of a person being detained or arrested by law enforcement in the Sheriff-Coroner's county. While this will likely encompass most deaths associated with a peace officer's use of force, there may be some deaths that result from a law enforcement officer's use of force that may not necessarily occur "in-custody." For example – those that occurs days or weeks after a use-of-force incident, or deaths that occur when the victim was never actually arrested or detained. Because a Sheriff-Coroner's conflict of interest is arguably present in all instances of law enforcement-related deaths, not just those that occur "in-custody," to promote uniformity and equal application of this bill, the author may wish to expand the types of deaths that trigger a conflict to include other deaths that occur in connection with a peace officer's use of force.

Notably, permitting a Sheriff-Coroner to comply with this bill by requesting a third-party medical team to determine the cause of death may not, without more statutory guidance, effectively resolve a Sherriff-Coroner's conflict of interest in death that occurs in law enforcement custody. For example, take a Sheriff-Coroner's office that opts to comply with this bill by contracting with a local physician to provide such services, thereby creating a provider-client relationship. While the proposed amendments state that such a third-party medical team must be separate and independent from the Sheriff-Coroner's office, without more detail and specificity pertaining to how such independence will be ensured, a physician arguably may still still have an incentive to make cause-of-death determinations favorable to their client, the Sheriff-Coroner. The author may wish to consider further amendments that provide greater specificity as to what factors or criteria are sufficient or necessary for a third party medical team to be considered "separate and independent" from the Sheriff-Coroner.

Finally, this bill requires a Sheriff-Coroner to "request" another entity to make a cause of death determination, not that the other agency actually determine the cause of death. If that request is subsequently ignored or denied, would the Sheriff-Coroner simply be able to proceed with making a manner of death determination? The author may wish to clarify that the death determination must actually be made by the entity receiving the request.

5) **Argument in Support**: According to the *Sister Warriors Freedom Coalition*, "The Sister Warriors Freedom Coalition (SWFC) is a statewide coalition to end the criminalization and incarceration of women and trans people of all genders, led by systems-impacted people. Our work uplifts the leadership of those who have experienced and continue to experience the devastating and intergenerational effects of incarceration, family separation, poverty, and gender-based violence. We believe those most impacted by these systems are best positioned to inform, guide, develop, and help implement impactful policy changes that secure justice, opportunity, and self-determination for all.

   "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 require the 48 counties with combined sheriff-coroner offices to contract with other coroner or medical examiner offices, or a third-party medical examination service, to perform investigations for these limited cases in which the sheriff has a conflict of interest. California is one of only three states that allows elected sheriffs to also serve as coroners. This bill will protect the integrity of the medical examination process and improve public trust in the outcomes of these investigations."

6) **Argument in Opposition**: According to *Justice for Angelo Quinto*, "This bill would require county's with a Sheriff-Coroner to utilize third-party independent medical examination services or request another county or state agency to conduct an independent medical examination to determine the cause of death when a person dies while in the custody of a county sheriff's officer or following use of force by sheriff's personnel. The solutions AB 1108 proposes to address conflicts of interest inherent in the Sheriff-Coroner model reinforces the broken status quo.

   "Angelo Quinto was asphyxiated to death by Antioch Police Officers in December of 2020 in front of his mother while experiencing a mental health crisis. He had no weapons, he was not violent, and he was not under the influence of any common substances of abuse. He died under the weight of officers fully restraining him in a prone position for a prolonged period

of time, unable to breathe. Justice for Angelo Quinto was formed to seek positive change, accountability and objectivity from a system that has led to far too many unjust deaths and cover-ups after the fact.

“The cover-up of Angelo’s death was largely perpetrated by the Sheriff-Coroner who contracted the medical examination out to an “independent” pathologist but failed to provide all information relevant to the case. This pathologist determined that Angelo died of “excited delirium” — a widely debunked, unscientific medical diagnosis used almost exclusively in cases of law enforcement-related deaths involving tasers or excessive force, and which was banned with the passage of CA AB 360 in 2023. The family’s experience informed their view that the 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.

“The National Association of Medical Examiners, one of the national professional bodies overseeing death investigators, has stressed for decades the importance of independent and transparent death investigation teams. They have stressed that teams must be led with medical expertise and independent of other law enforcement investigations, especially in the case of in custody deaths.

”Under AB 1108, county’s 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."

7) **Prior Legislation**:

a) AB 360 (Gipson), Chapter 431, Statutes of 2023, provides that "excited delirium" is not a validly recognized medical diagnosis or cause of death.

b) AB 2531 (Bryan), Chapter 968, Statutes of 2024, clarifies that death-in-custody reporting requirements apply to juveniles who die in custody and defines "in-custody death."

c) AB 1608 (Gipson), of the 2021-2022 Legislative Session, would have eliminated the authority of a county board of supervisors to consolidate the duties of the sheriff with the duties of the coroner, or the duties of the sheriff with the tax collector. AB 1608 failed passage on the Senate Floor.

d) AB 2761 (McCarty), Chapter 802, Statutes of 2022, requires a state or local correctional facility to post specified information on its website within 10 days after the death of a person who died while in custody, and to update that information within 30 days of any change.

e) SB 1303 (Pan), of the 2017-2018 Legislative session, would have replaced the coroner with an independent office of the medical examiner in counties with 500,000 or more residents or allowed counties to retain the sheriff-coroner position and adopt a policy to refer cases where the sheriff-coroner may have a conflict to a county that has an independent medical examiner. SB 1303 was vetoed.

f) SB 1189 (Pan), Chapter 787, Statutes of 2017, prohibits, if an individual dies due to the involvement of law enforcement activity, law enforcement personnel directly involved with the care and custody of that individual from being involved with any portion of the postmortem examination nor allowed inside the autopsy suite during the performance of the autopsy.

REGISTERED SUPPORT / OPPOSITION:

Support

California for Safety and Justice
California Medical Association (CMA)
California Public Defenders Association (CPDA)
Ella Baker Center for Human Rights
Oakland Privacy
Sister Warriors Freedom Coalition
Smart Justice California, a Project of Tides Advocacy

Oppose

Carceral Ecologies
Justice for Angelo Quinto
Justice2jobs Coalition

Analysis Prepared by: Ilan Zur / PUB. S. / (916) 319-3744