COUNTY OF LOS ANGELES

ANNUAL REPORT

OF

THE CORONER

THEO. J. CURPHEY, M.D., *Coroner*

Fiscal Year July 1, 1957—June 30, 1958

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BOARD OF SUPERVISORS

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THEO. J. CURPHEY, M.D.
CORONER

COUNTY OF LOS ANGELES

OFFICE OF CORONER

HALL OF JUSTICE
LOS ANGELES 12, CALIFORNIA

FREDERICK D. NEWBARR, M.D
CHIEF MEDICAL DIVISION

Honorable Board of Supervisors
County of Los Angeles,
Los Angeles, California.

Gentlemen:

Herewith is presented the annual report of the Coroner of Los Angeles County for the fiscal year ending June 30, 1958. It covers the first full fiscal year since the separation of the offices of Coroner and Public Administrator on March 19, 1957 and the appointment of a certified pathologist as Coroner.

The report contains a statement of the functions and the organization of the office, and documents the progress currently made in the reorganization of the various divisions, aimed at providing a more scientific and efficient service to the community, comparable to the high level of efficiency and public service supplied by other departments of County Government, and commensurate with the increasing importance of forensic medicine in the life of the most rapidly growing and progressive community in the nation. The report also contains a summary of the operations and selected statistics bearing on the cases investigated.

With the submission of this report goes my sincere gratitude to the members of the Board of Supervisors for their support of the program necessary to modernize the office, and also to the Chief Administrative Officer and his various departmental heads and staff personnel, who have fully cooperated to the extent of their time and their experience in aiding in the necessary changes and improvements of the past fiscal year.

Respectfully submitted,

Theo. J. Curphey

THEO. J. CURPHEY, M.D.
CORONER

FOREWORD

In the 1956-1957 report to the Board of Supervisors, attention was called to the planned program for improvement in investigating cases of sudden or unexpected death in Los Angeles County. The immediate plans called for better use of the existing physical facilities through the installation of refrigerated crypts, the provision of modern work areas for the performance of the autopsy and the technique of embalming, as well as for recruiting a larger number of part time qualified medical personnel.

This was to be supplemented by efforts aimed at increasing the output of the medical secretariat, by revising certain of the various official forms in the interest of greater usefulness, and discontinuing others that had long outlived their original use. Correlated to this was an effort to improve the flow of files of cases under study by various divisions by means of centralizing the data on each case at a control point; so that following any request for information from the public as to the present status of a given case, it would be possible to supply this readily from the control point. Attention was also to be given to improving our verbal and written communications with the public and also at the interdivisional level.

It is gratifying to be able to report a great measure of progress in all these plans. During the fiscal year there has been an extensive alteration building program which will be completed and will be ready for use in the next fiscal year. This consists of the acquisition and installation of 63 refrigerated crypts; the construction of separate autopsy and embalming areas, with the installation of the latest modern equipment and the installation of a photographic unit adjacent to these areas. In addition, following surveys made by the Communications Department our intra-office telephonic system has been completely modernized and automatic tape recorders have been installed to record all deaths referred to the Coroner.

A survey of our office methods was made at our request by staff personnel of the Chief Administrative Officer's office, following which numerous changes especially in the nature of new office forms have been instituted and adopted, and a study leading the establishment of a punch card system of statistical recording has been instituted. In addition to this the medical personnel have been provided with portable recording machines for dictation of their findings at autopsy or investigation of those cases outside of the metropolitan area that are handled in the various mortuaries. These cases represent approximately 50% of the total cases for the year.

During this same period considerable success has been attained in the matter of recruiting qualified medical personnel. Experience in this field has consistently shown that a better quality of professional service is given if the individual is soundly trained in basic pathology before entering into the medico-legal field. The major difficulty lies in attracting these men to full time positions, based chiefly on prevailing economic conditions. The only alternative lies in establishing part time positions, which in the case of younger men in the process of their special training, offers a current solution to the problem of competent professional service. During the fiscal year it has been possible to attract 14 physician pathologists-in-training who serve part time in the Coroner's Office.

Another area of progress deals with the plans for the new Coroner's Office. During the year schematic plans have been prepared by the architect and have been under study both as to adaptation to the site of the building and also as to special needs of the various divisions relative to space and location. Future progress will be more rapid when a final decision as to the site of the building is made.

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I. SUMMARY OF OPERATIONS

During 1957-58 the Coroner's Department investigated 9,959 cases, an increase of 375 over the preceding fiscal year. Of these cases 4,153 were handled in the Coroner's Mortuary in the Hall of Justice, while 5,806 were handled in private mortuaries beyond the metropolitan area serviced by the Coroner's Mortuary. Of the total number of cases handled autopsies were performed in 4,632 cases (46.5%). The Coroner's laboratories made 14,830 microscopic examinations and conducted toxicological studies in 3,726 cases. Inquests were held in 425 cases.

Of the 9,959 cases investigated in 1957-58, 6,354 cases or 63.8% of all cases involved deaths from natural causes. These deaths frequently require more extensive medical investigation and laboratory study than deaths from trauma, since a history of illness or hospitalization may not be available to the medical examiner. The popular notion that a preponderance of cases investigated by medicolegal agencies involve homicide or other acts of violence is disproved by the experience of this and similar offices. In 1957-58, there were 233 homicides investigated by the Coroner, or 2.3% of the total number of cases handled.

There were 818 cases of suicide (8.2%) investigated in 1957-58, an increase of 100 cases handled in the preceding fiscal year. An increase of 46 over the preceding year was observed in the number of suicides involving barbiturates.

Motor vehicle fatalities decreased from 1,052 in 1956-57 to 961 in 1957-58. These fatal accidents accounted for 9.6% of all cases investigated by the Coroner. Collision of vehicles accounted for 525 deaths; 110 deaths resulted from non-collision accidents; and pedestrian fatalities were 326.

It is significant that in 1956-57, motor vehicle fatalities were responsible for 10.9% of all Coroner's cases, while in 1957-58 the proportion had decreased by 1.3% to 9.6% of all cases. In 338 tested cases of driver fatalities, 25.7% had blood alcohol levels in excess of .15% while in 197 tested cases of pedestrian death, 21.8% had blood alcohol levels above .15%. (See Table 3A)

II. FUNCTIONS AND SERVICES OF THE DEPARTMENT

It is the responsibility of the Coroner under the laws of the State of California to investigate all cases of sudden and unexpected death within the County. This responsibility is not limited to homicides, suicides, and death under suspicious circumstances, which are commonly thought to be the province of the Coroner, but extends to deaths in which no physician attended the deceased in life, to accidents of all sorts which result in death, and to deaths attributable to industrial or occupational causes. The Coroner's investigation of these deaths is a medical investigation and supplements the investigations made by other law enforcement agencies. Investigation by the Coroner may include a visit to the scene of death by the medical examiner assigned to the case, the study of the medical history of the deceased, examination of the body, autopsy, toxicological examination of body fluids and organs, and microscopic study of tissues to reveal pathological conditions not observable on simple visual examination. Each case is a particular problem, unique in itself, and each requires a different combination of medical techniques.

The investigation conducted by the Coroner of the circumstances and cause of death permits the Coroner's Department to issue death certificates in which these circumstances and cause of death become a matter of permanent public record. The cause of death and the manner in which it occurred, as certified by the Coroner, may become the basis of criminal or civil action in the courts. In such cases the medical examiners, toxicologists, and technicians of the Coroner's Department appear as expert witnesses. It is important to observe that the Coroner's investigation is impartial, factual, and based upon scientific knowledge and experience. Members of the staff of the Department appear in court to state the facts as these have been determined, not to support the contentions of either prosecution or defense.

The investigation of the Coroner produces permanent medicolegal records of autopsies performed and laboratory investigations completed. These are available to the District Attorney, the Public Defender, law enforcement agencies of municipalities, the insurers of the deceased, and other interested public and private agencies. The primary medical records are also made available to hospitals in which the deceased were patients, or to physicians who treated them in life. For both mandatory legal reasons and equally cogent reasons of medical knowledge it is important that these records be complete, accurate, and available to those whose interest requires the study of these documents.

In addition to the primary responsibility of the Coroner for the medical investigation of cause of death, it is also the responsibility of the Department to assume custody of the bodies and property of deceased persons, the circumstances of whose deaths require the Coroner's investigation. In the central metropolitan area of the County the bodies of deceased persons are brought to the Coroner's morgue in the Hall of Justice by the personnel and equipment of the Coroner's Department. In areas lying outside of this area, this service is performed for the Coroner by cooperating mortuaries, which act for the Coroner in their districts. In districts having more than one mortuary this service is handled by rotation on a monthly basis. Under present conditions approximately one-half of all Coroner's cases are handled in the central morgue, with the remaining half being handled in districts outside the central area. All homicide and abortion cases are handled in the central morgue.

The service rendered by the Coroner in the investigation of those deaths which require his legal intervention is an essential service of local government. It is essential not only in the obvious cases of possible homicide or suicide, but in the less obvious cases of death occurring from occupational disease, industrial accident, epidemic disease, and in differentiating natural deaths from those which result from accident. The facts revealed by the Coroner's investigation can contribute to the public health as well as the public safety, may direct attention to hazardous conditions of employment, may detect the presence of unsuspected disease of epidemic nature, or reveal the existence of hazards to health which preventive measures can eliminate.

In addition to the primary function of medical investigation to determine the cause and circumstances of death, the Coroner may, in his discretion, hold a formal inquest. Transcripts of the inquest proceedings are made available to the District Attorney for review and possible action by his office. The function of the inquest is primarily that of determining criminal responsibility for death.

In the performance of its legal duties the Coroner's Department provides such services as the fingerprinting and identification of deceased persons, the notification of next of kin, notification of law enforcement agencies, the Veterans Administration, and other branches of government of the deaths of persons in whom these agencies have an interest.

III. ORGANIZATION OF THE DEPARTMENT

The Department is headed by the Coroner, Dr. Theodore J. Curphey, and its functions are performed by five major divisions: (1) Medical Division, which is directed by the Assistant Chief Deputy Medical Examiner; (2) Toxicology Division, directed by the Head Toxicologist; (3) Embalming Division, directed by the Chief Embalmer; (4) the Administrative Division, directed by the Executive Assistant, and (5) the Inquest Division, headed by an Inquest Deputy.

The Medical Division is responsible for the medical investigation of each Coroner's case, and for the determination of the cause and mode of death. This work is performed by deputy medical examiners under the direction of the Assistant Chief Deputy Medical Examiner. The medical examiners are assisted by an autopsy technician, autopsy-assistant photographers, and histopathology technicians. The medical examiners conduct investigations, perform postmortem examinations, request laboratory studies, and obtain medical histories and other information from hospitals, the police, and other sources. As of June 30, 1958, there were 20 deputy medical examiners assigned to the Medical Division in addition to the Assistant Chief Deputy Medical Examiner. Of these, 6 were full time and 14 part time members of the division.

The Toxicology Division is responsible for the chemical analysis of specimens submitted by the Deputy Medical Examiners for laboratory study. These specimens include blood, tissue, and other organic substances. Laboratory studies are made to determine the presence or absence of toxic agents such as the alcohols, narcotics, barbiturates, carbon monoxide, heavy metals, and other poisons. In many cases, such studies are fundamental for the positive determination of the cause of death. The Division is staffed by a Head Toxicologist, two toxicologists, an assistant toxicologist, and two laboratory assistants. There were submitted 3,726 cases for toxicological examination during the fiscal year. This represents 37.4% of the total cases. The results are presented in Table 13.

The Embalming Division is responsible for the transportation of bodies of deceased persons whose deaths occur in the metropolitan area as well as for the transportation of all suspected homicide cases that occur in any part of the County. This Division operates the Coroner's morgue in the Hall of Justice, has custody of remains of deceased persons, and embalms these remains. Personnel of the Division have an important duty in

gathering information and evidence at the scene of death, as well as assuming custody of property found on the person of the deceased. The Division is staffed by a Chief Coroner's Embalmer, thirteen Coroner's Embalmers, and four mortuary aids. The Division operates on a twenty-four hour per day basis.

The Administrative Division has responsibility for the receiving of reports of death, of maintaining the case records pertaining to all Coroner's cases; of notifying the next of kin of the deceased; of releasing remains on authorization of persons entitled to claim remains; of holding and releasing property; of issuing death certificates; and maintaining the Coroner's Register as required by law. This Division also handles internal departmental administration such as the procurement and issue of supplies; the maintenance of departmental accounts, and the collection of statistical information. The Division operates on a twenty-four hour per day basis.

The Inquest Division is responsible for the holding of formal inquests into the deaths of persons from unnatural causes. Purpose of the inquest is to determine if death is the result of criminal act on the part of another. Inquests are held in the Hall of Justice, or in the area where the death occurred. Proceedings are conducted by one of two inquest deputies, and the verdicts are rendered by Coroner's juries convened for the purpose. The proceedings are recorded and transcripts are made available to the District Attorney, City Attorneys, and others.

SELECTED STATISTICS

TABLE No. 1

Cases investigated by the Coroner:	1957-1958	1956-1957
In the Coroner's Metropolitan Area	4153	3452
In other areas of Los Angeles County	5806	6132
	9959	9584
Increase in 1957-1958 over 1956-1957	375	

TABLE No. 2 - MANNER OF DEATH

Natural Causes	6354	5983
Motor Vehicle Fatalities	961	1052
Home Accidents	841	881
Occupational Accidents	118	155
Aircraft Accidents	77	39
Railway Accidents	22	17
Other Accidents	449	432
Suicides	818	718
Homicides	233	235
Stillbirths	50	48
Abortions	8	18
Undetermined	28	6
	9959	9584

SELECTED STATISTICS

TABLE No. 2A

DEATHS FROM NATURAL CAUSES - IN MAJOR GROUPS
(International List)

Infective and parasitic diseases	47
Neoplasms	203
Allergic, endocrine, metabolic and nutritional diseases	22
Diseases of the blood and blood forming organs	5
Mental, psychoneurotic and personality disorders	33
Diseases of the nervous system and sense organs	268
Diseases of the circulatory system	4731
Diseases of the respiratory system	634
Diseases of the digestive system	281
Diseases of the genito-urinary system	10
Diseases of pregnancy, childbirth and the puerperium	14
Diseases of the skin and cellular tissue	2
Diseases of the bones and other organs of movement	1
Congenital malformations	31
Diseases of early infancy	80
Symptoms, senility and ill-defined conditions	28
	6390

SELECTED STATISTICS

TABLE No. 3 - MOTOR VEHICLE FATALITIES

	1957-1958	1956-1957
Pedestrians	326	390
Vehicular Collisions	525	549
Non-collision Accidents	110	113
	961	1052

TABLE No. 3A - MOTOR VEHICLE FATALITIES
Incidence of Alcohol (see next page)

TABLE No. 4 - HOME ACCIDENTS

	1957-1958	1956-1957
Burns and Explosions	71	101
Electrocutions	9	5
Falls	538	507
Firearms	11	11
Mechanical Asphyxia	77*	65
Miscellaneous	24	16
Poisoning	106**	174
Violence of Undetermined Origin	5	2
	841	881

* 11 Drownings in home swimming pools by children included in this figure.
** 10 Carbon monoxide deaths from gas heaters burning in closed room in this figure.

TABLE No. 3A - INCIDENCE OF - ALCOHOL - AUTO ACCIDENTS

	TOTAL	NEGATIVE	.01% - .04%	.05% - .09%	.10% - .15%	Above 15%	Total Cases .15% or Above
DRIVERS	338	200	17	13	21	87	25.7%
PEDESTRIANS	197	128	9	10	7	43	21.8%
PASSENGERS	139	100	7	11	12	9	6.4%

SELECTED STATISTICS

TABLE No. 5 - OCCUPATIONAL ACCIDENTS

	1957-1958	1956-1957
Burns	14	14
Crushing	19	13
Drowning	0	4
Electrocution	6	6
Explosions	3	2
Falls	28	42
Infection	21	48
Miscellaneous	27	23
Poisoning	0	3
	118	155

TABLE No. 6 - AIRCRAFT ACCIDENTS

	1957-1958	1956-1957
Commercial Aircraft	19	10
Military Aircraft	52	5
Private Aircraft	6	24
	77	39

SELECTED STATISTICS

TABLE No. 7 - OTHER ACCIDENTS

	1957-1958	1956-1957
Burns and Explosions	9	22
Falls	284	263
Firearms	10	2
Mechanical Asphyxia	67*	55
Miscellaneous	45	31
Poisoning	27**	45
Violence of Undetermined Origin	7	14
	449	432

* 3 Drownings of children in public pools included in this figure.
** Above total includes 3 carbon monoxide deaths resulting from gas heaters in closed rooms.

TABLE No. 8 - SUICIDES

	1957-1958	1956-1957
Shooting	276	239
Poisoning (Barbiturates	196	150
(Others	54	48
Jumping	29	36
Hanging	112	113
Carbon Monoxide - Auto Exhaust	89	72
All Others	62	60
	818	718

SELECTED STATISTICS

TABLE No. 9 - HOMICIDES

	1957-1958	1956-1957
Assault	11	30
Poisoning	1	12
Shooting	135	122
Stabbing	41	46
Strangulation	14	14
Suffocation	2	4
All Others	29	7
	233	235

TABLE No. 10 - MISCELLANEOUS DATA

Number of autopsies performed	4632	4940
Bodies embalmed for which fees were collected	3124	2667
Bodies embalmed for which no fees were collected	461	399
Bodies processed at Coroner's Mortuary Hall of Justice	4153	3452
Miles traveled by Medical Examiners to conduct investigations and appear as witnesses	77338	92980
Non-Coroner's cases (cases reported to Coroner but found not to be Coroner's cases)	510	472
Number of inquests held	425	441
Number of miles traveled by Coroner's vehicles to transport bodies	33777	28058

SELECTED STATISTICS

TABLE No. 11 - LABORATORY TESTS

	1957-1958	1956-1957
Microscopic examinations	14830	15199
Bacteriological examinations	34	29
Cytology examinations	230	167
Gross specimens prepared	12	19
Neuropathology brain studies	235	120
Special tissue stains	69	45

TABLE No. 12 - PHOTOGRAPHY

Number of negatives made and processed	1112	872
Number of prints made and processed	2212	1781
Number of color slides prepared	158	264
Number of black and white slides prepared	120	0

V. EXPENDITURES

	1957-1958	1956-1957
SALARIES AND WAGES	$486,525.30	$425,881.27
MAINTENANCE AND OPERATION	50,677.09	37,766.49
CAPITAL OUTLAY	23,746.60	18,397.66
	$560,948.99	$482,045.42

VI. REVENUES COLLECTED

SALARY FUND:		
EMBALMING FEES	$ 80,237.53	$ 68,524.00
SALE OF TRANSCRIPTS	6,441.52	5,858.95
	$ 86,679.05	$ 74,382.95
GENERAL FUND:		
WITNESS FEES	488.50	354.65
REFUND OF TRANSPORTATION	916.20	707.82
	$ 1,404.70	$ 1,062.47