ORANGE COUNTY
SHERIFF'S DEPARTMENT

Sheriff-Coroner
Homeless Death Review Committee:

Report on 2021 Orange County Homeless Deaths

We would like to acknowledge all our committee members

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INTRODUCTION

In January 2022 Sheriff-Coroner Don Barnes announced his intent to commission the County's (County) first Homeless Death Review Committee (Committee) to analyze the number of deaths and causes of death for persons experiencing homelessness (PEH) in Orange County.

The Sheriff commissioned the committee through the Orange County Coroner's Office, a division of the Orange County Sheriff's Department. The Homeless Death Review Committee is comprised of technical experts from both the public and private sectors, including representatives from the Orange County Coroner's Office, the Orange County Office of Care Coordination, the Orange County Health Care Agency, the Hospital Association of Southern California, the Orange County Medical Association, CalOptima Health, multiple experts in providing direct service to individuals experiencing homelessness, and two representatives from municipal law enforcement agencies.

Throughout the past year, the Committee reviewed and analyzed data related to the deaths that occurred in calendar year 2021 of PEH. The goal of the Committee was to utilize the data to uncover potential trends related to the causes of death for PEH that would lead to either service and/or policy recommendations that may help prevent future deaths among the homeless population.

This initial report summarizes the progress to date the Committee has made in understanding deaths among PEH; it is not the conclusion of the Committee's work. Through this process, the Committee noted the need to further explore the root causes of the reviewed deaths and determine what, if any, factors contributing to the deaths were preventable. Going forward, the Committee will convene to review new PEH death data on a quarterly basis. This regular review will allow the Committee to further identify and/or review trends and identify areas for additional policy action.

A Mortality Review Committee is a recommended best practice by the National Health Care for the Homeless Council. Several jurisdictions around the nation have employed the use of these committees to assist in developing policies aimed at reducing preventable deaths.

SCOPE OF THE HOMELESS DEATH REVIEW COMMITTEE

For the past year, the Committee's focused on reviewing the data and trends related to 395 people who died in 2021 while experiencing homelessness as identified by the Orange County Coroner's Office. This review analyzed data including demographics of the decedents and the manner and cause of death. Also included in the review was data from Cal Optima Health, the Orange County Health Care Agency and the Orange County Jail. Lastly, the Committee compared the 2021 data against the same dataset from previous years.

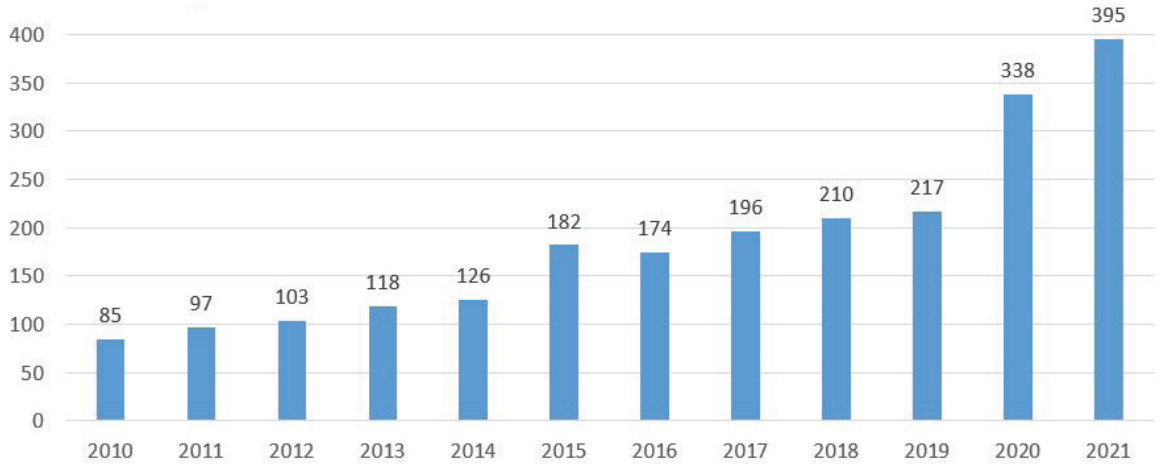
The original intent of the Committee was to conduct a case by case review of each death, but there are significant limitations of individual level information that can be shared in such a setting due to legal restrictions. Similar committees convened to review specified deaths, such as the Child Death Review Team, do not have such limitations because they are authorized by statute. To rectify this barrier, the Committee is recommending legislation to authorize Counties to convene a homeless death review committee and share specified data.

REVIEW OF NUMBERS/DATA

Deaths Among Persons Experiencing Homeless

According to data from the Orange County Sheriff's Coroner Division, in calendar year 2021, the total number of deaths to persons experiencing homelessness (PEH) was 395. Over the last several years, the number of PEH deaths has increased incrementally in Orange County, from 103 in 2012, to 217 in 2019. A substantial increase in deaths occurred between 2019 and 2020 when deaths increased by 55% from 217 to 338 during the first year of the pandemic **(Figure 1)**.

Figure 1: **Number of Deaths to PEH in OC**

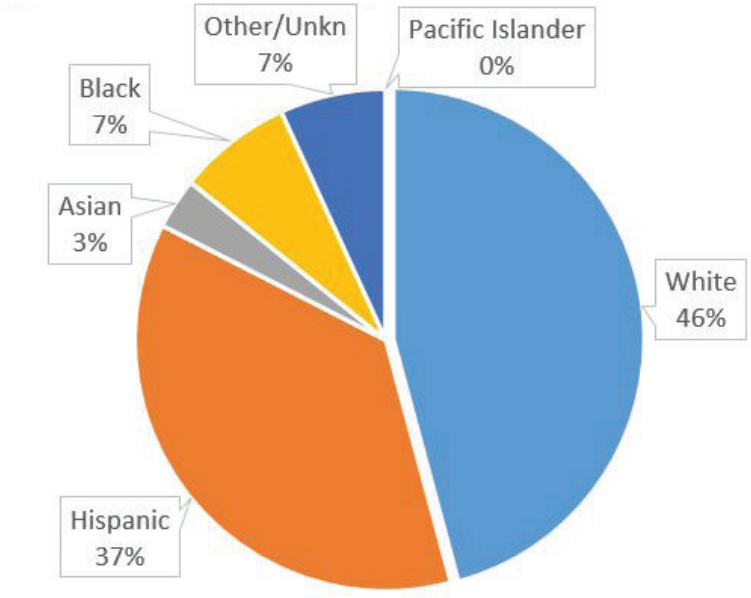


The increase in homeless deaths is not unique to Orange County and is consistent with trends being seen in other parts of California.

DEMOGRAPHICS OF PEH DEATHS 2021

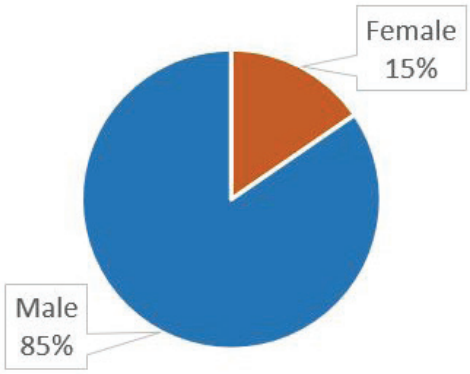
The information presented in the following section will include an in-depth analysis of deaths to persons experiencing homelessness 2021 – the most recent and complete data available. Please note that the demographic data and data on both the manner and cause of death is from the Orange County Sheriff's Coroner Division and the California Comprehensive Death File (CCDF) for Orange County.

Figure 2: **Race/Ethnicity of PEH Decedents**



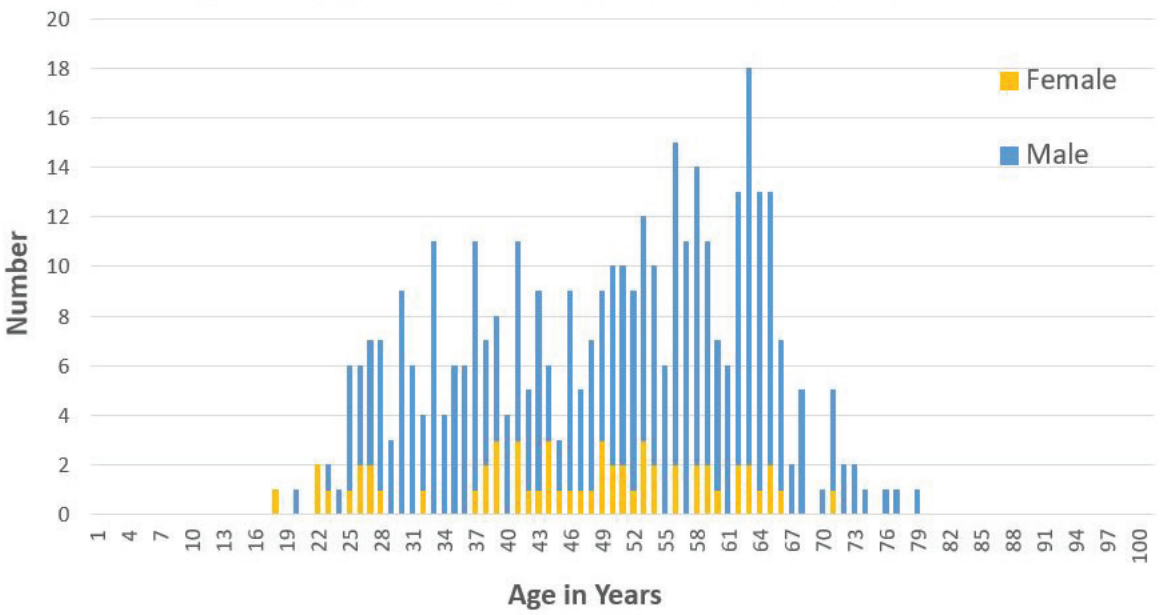
The demographic characteristics of the 395 PEH who died in 2021 is shown in **Figure 2**. The race/ethnicity of the decedents was 46% White, 37% Hispanic, followed by 7% Black, 3% Asian, and 7% Other/Unknown. These percentages align with the race and ethnicity breakdown reported in the 2022 Orange County Point in Time Summary for those experiencing unsheltered homelessness.

Figure 3: **Sex of PEH Decedents**



The majority (85%) of deaths to PEH were males and 15% females **(Figure 3)**. This represents a 11.5% overrepresentation of males compared to the 2022 Orange County Point in Time Count Summary that reported 73.5% of people experiencing unsheltered homelessness identifying as male.

Figure 4: **Age Distribution of PEH Decedents by Sex**



The age distribution of PEH who died in 2021 **(Figure 4)** identify the average age at death was 48.4 years old (F 45.3; M 48.5), compared to 75.3 years for the housed population who died that year.

Military Service

5.3% of the homeless decedents (n=21) were known to have served in the US Armed Forces which is comparable to the 4.7% of individuals experiencing unsheltered homelessness during the 2022 Orange County Point in Time Count that identified as veterans.

MANNER OF DEATH

Table 1: Manner of Death to PEH (2017 to 2021)

Homeless Deaths	2017		2018		2019		2020		2021	
Manner of Death	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Accident	70	36%	91	43%	99	46%	181	54%	235	59%
Homicide	9	5%	12	6%	6	3%	7	2%	11	3%
Natural	93	47%	89	42%	94	43%	126	37%	109	28%
COVID-19							*6*	*2%*	*17*	*4%*
Suicide	19	10%	15	7%	14	7%	15	4%	22	6%
Undetermined/ Pending*	5	3%	3	1%	4	2%	3	1%	1	0%
Total	**196**	**100%**	**210**	**100%**	**217**	**100%**	**338**	**100%**	**395**	**100%**

Up until 2020, deaths to PEH were primarily due to natural (e.g., cancer, heart disease, liver disease) and accidental (unintentional) causes (Table 1). However, in 2020 (n=181) and 2021 (n=229) deaths due to accidental (unintentional) injuries increased significantly and became the leading manner of death among PEH. Indeed, 59% of deaths to the PEH population were categorized as accidental in 2021.

Figure 5: **PEH Death Trends**

The trends for manner of death to PEH **(Figure 5)** show that over the past decade (since 2011) the number of deaths in each category have increased markedly. For example, the number of accidental deaths (unintentional) increased from 40 in 2011 up to 235 in 2021 (a 488% increase). Similarly, natural deaths increased 319%, from 26 in 2011 up to 109 in 2021. A similar pattern was observed for homicide and suicide deaths (albeit small numbers of cases). Homicides increase from three in 2011 up to 11 in 2021 (a 267% increase) while suicide deaths doubled from 11 to 22 during this same time period (a 100% increased).

LEADING CAUSES OF DEATH TO PEH (2021)

A detailed analysis of the leading causes of death to PEH **(Table 2)** based on the International Classification of Disease (ICD-10) codes for the 50 most common causes of death in the nation. As mentioned previously, accidents or unintentional injuries were the most common cause (58.5%) followed by diseases of the heart (12.2%), suicide (5.6%), COVID-19 (4.3%) and Homicide (2.8%) in the top five.

Table 2: Leading Causes of Death in Orange County (2021)	PEH Deaths	%PEH Deaths
Accidents (unintentional injuries)	231	58.5%
Diseases of heart	48	12.2%
All Other Causes	36	9.1%
Intentional self-harm (suicide)	22	5.6%
COVID-19 (U07.1)	17	4.3%
Assault (homicide)	11	2.8%
Chronic liver disease and cirrhosis	7	1.8%
Malignant neoplasms	4	1.0%
Diabetes mellitus	4	1.0%
Cerebrovascular diseases	4	1.0%
Human immunodeficiency virus (HIV) disease	2	0.5%
Nutritional deficiencies	2	0.5%
Influenza and pneumonia	2	0.5%
Chronic lower respiratory diseases	2	0.5%
Pneumonitis due to solids and liquids	1	0.3%
Peptic ulcer	1	0.3%
Complications of medical and surgical care	1	0.3%
TOTAL	395	**100.0%**

Table 3: Accidental (Unintentional Injury) Cause Group Detail	PEH Deaths	%PEH Deaths
Drug Related with Fentanyl	144	36.5%
Drug Related (Non-Fentanyl)	33	8.4%
Pedestrian Traffic	34	8.6%
Motor Vehicle Traffic	4	1.0%
Falls	3	0.8%
Pedal Cyclist Traffic	2	0.5%
Drowning	0	0.0%
Other/Unknown/Ill-Defined (W20-W49, R99)	11	2.8%
Total	231	58.5%

Because accidental injuries accounted for so many of the deaths to PEH, a more detailed summary of this category is required. The majority (44.9%) of unintentional deaths were drug related, specifically involving the very potent synthetic opioid, fentanyl **(Table 3)**.

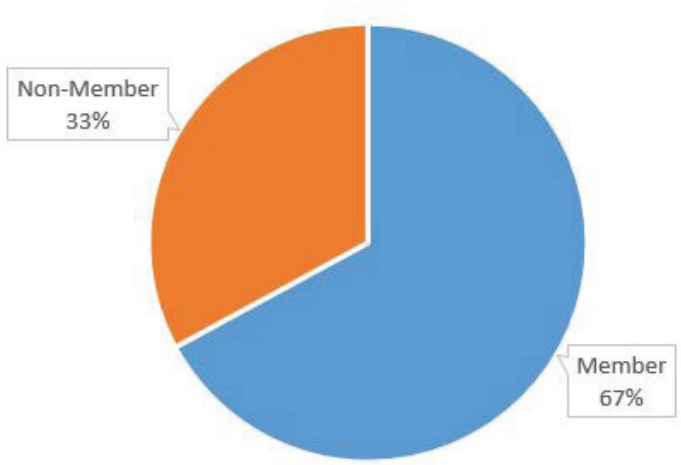
Fentanyl was a factor in 144 deaths or 81% of all drug related deaths. Compare this to 2018, just three years prior to the data explored in this report, fentanyl accounted for 12 PEH deaths. This increase in fentanyl-related deaths as a portion of the drug-related deaths is consistent with deaths in the general population both in Orange County and nationwide.

The second most common category of unintentional injury deaths was due to PEH being hit by motor vehicles (8.6%, n=34) while walking.

HEALTH-HOSPITALIZATIONS TO PEH POPULATION IN ORANGE COUNTY

The Committee reviewed data on the number of hospitalizations to for the entire PEH population in Orange County. Due to existing legal constraints a review of the hospitalization of each PEH decedent was not possible. Hospitalizations of the entire PEH population in Orange County increased 677% over the past decade, from 727 in 2011 up to 5,649 admissions in 2021. The main reason for hospitalization for PEH in 2021 of both sexes was due to mental illness (1,543), followed by infections (603), diseases of the circulatory system (485), and then alcohol/drug related substance use disorders (481). Notably, many hospitalizations were due to chronic medical conditions, presumably many not properly managed leading to admission.

Figure 6 : **CalOptima Membership Among PEH Decedents**



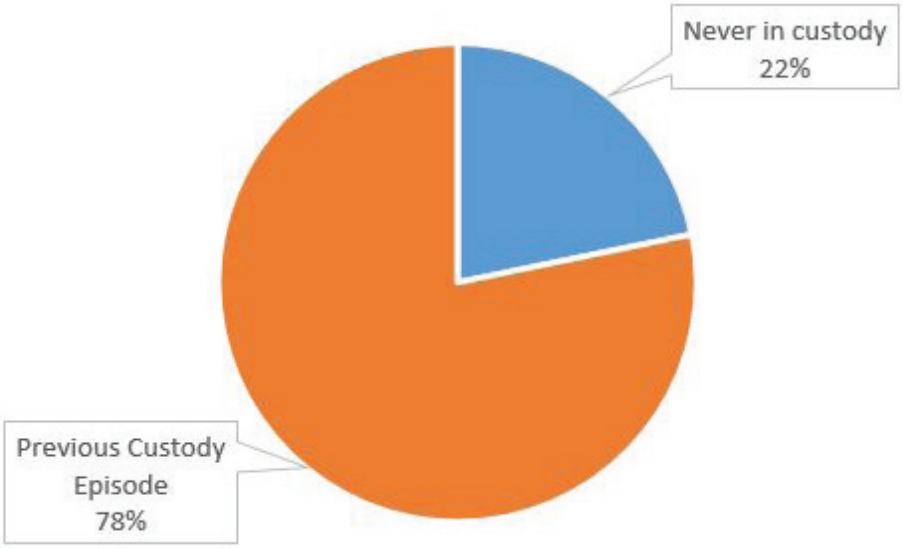
CalOptima Health was created by the Orange County Board of Supervisors in 1993 as a County-Organized Health System (COHS). CalOptima is the single largest health insurer in Orange County, providing coverage for one in four residents through four programs, Medi-Cal, OneCare Connect, OneCare and PACE.

CalOptima Health had eligibility information on 67% (n=265 of the 395) PEH decedents in 2021. Of those with coverage, there were 588 emergency department visits and 168 hospital admissions **(Figure 6)**.

CUSTODY INFORMATION

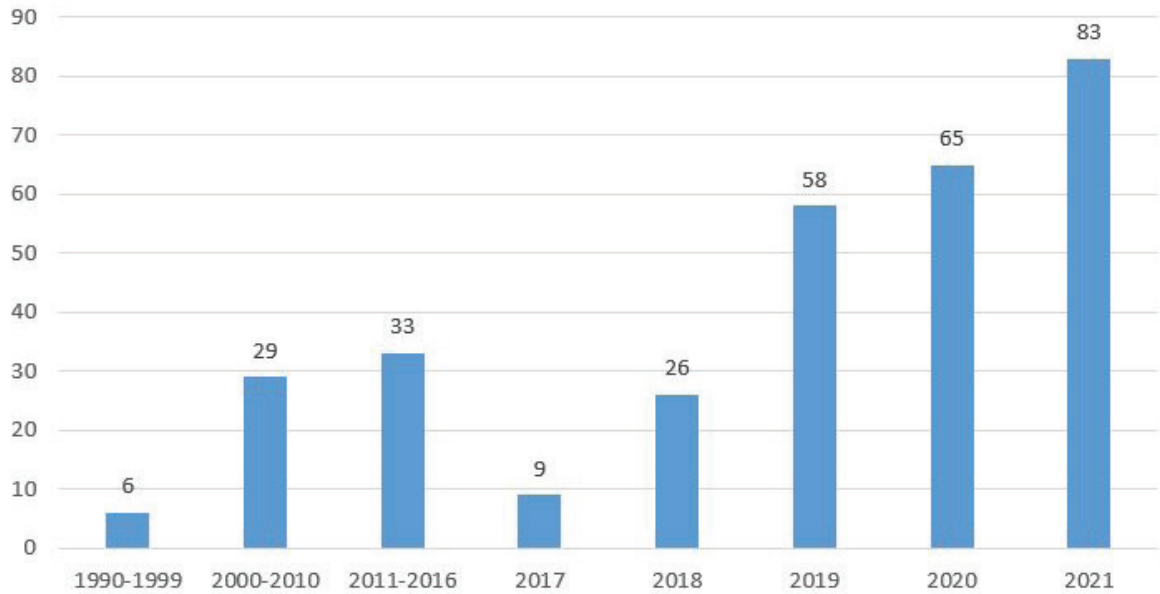
Based on booking records from the Orange County Sheriff's Department, the majority of 2021 PEH decedents (78%, n=309) had at least one episode of custody in the Orange County Jail, while 22% (n=86) had never been in custody **(Figure 7)**. It is important to note that this data does not include custody stays outside of Orange County.

Figure 7: **Custody History**



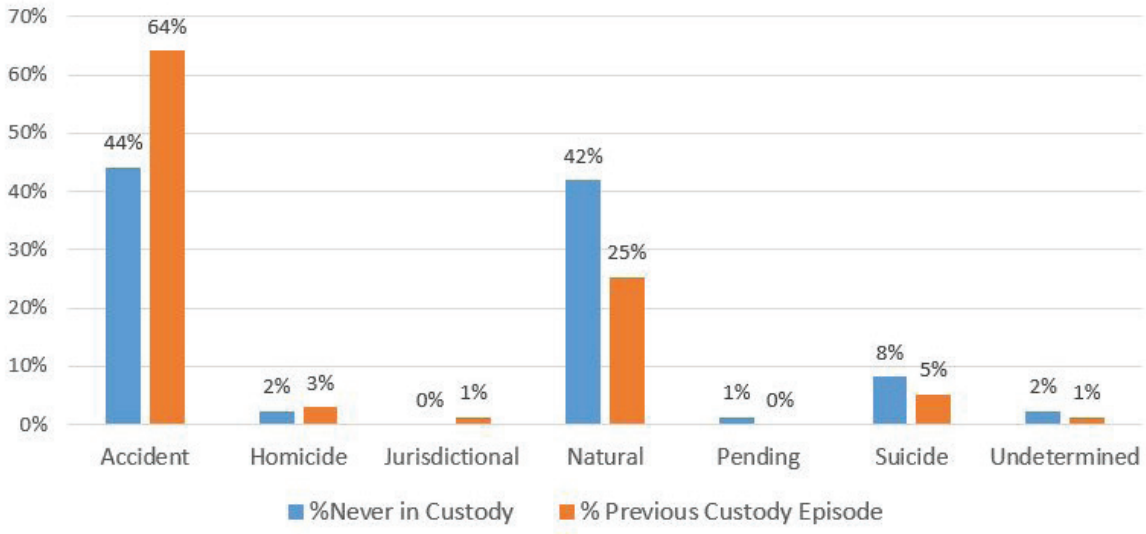
Of the 309 PEH decedents who have been in the Orange County Jail, 241 had been in custody within the last five years **(Figure 8)**.

Figure 8: **Most Recent Custody Experience**



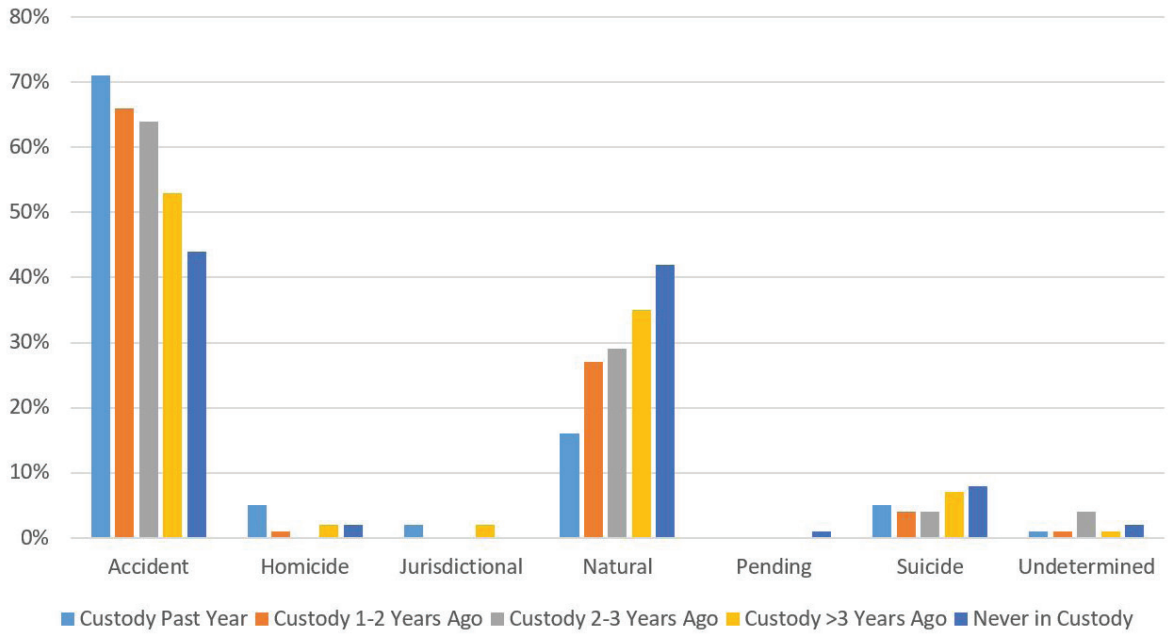
PEH decedents who had never been in custody (n=86) were equally likely to have died accidentally (44% - primarily drug related) or naturally (42%) **(Figure 9)**. However, those with a prior episode in custody were more likely to die accidentally (64% - again primarily drug related) compared to only 25% due to natural causes.

Figure 9: **Mode of Death Per Previous Custody Episode**



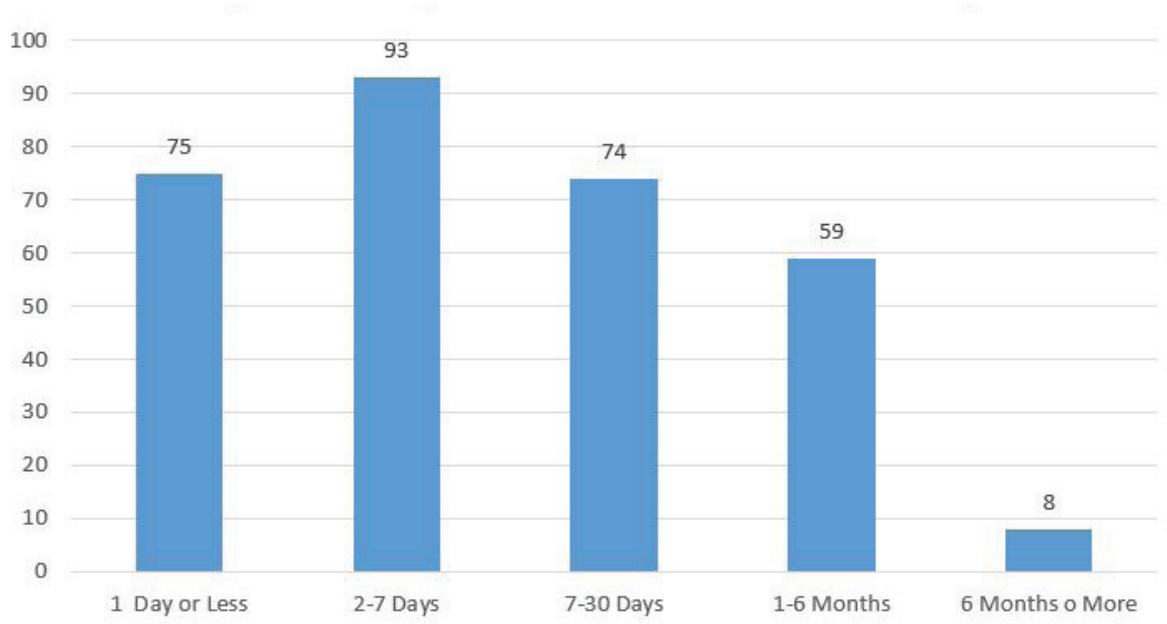
Those PEH decedents who were never in custody were equally likely to have died from Accidental (44%) or Natural (42%) causes **(Figure 10)**. Those who had a prior episode in custody primarily died accidentally, but the percentage decreased the more time had passed since the decedent had been in custody (i.e., 71% within one year down to 53% after three years). Conversely, the percentage of natural deaths increased with time since last custody episode (i.e., from 16% within one year up to 35% after three years). These results suggest that the medical care received while in custody may have helped prevent deaths upon release into the community.

Figure 10: **Mode of Death by Time Since Custody Release**



Only 30 of the 309 PEH decedents who were in the Orange County Jail participated in a reentry program during a previous custody experience. The minimal participation is likely due to the short time in custody for the PEH decedents; 54% served a week or less and nearly 80% served 30 days or less **(Figure 11)**.

Figure 11: **Length of Most Recent Time in Custody**



FINDINGS AND RECOMMENDATIONS

FINDINGS

- Deaths among people experiencing homelessness (PEH) have increased in Orange County over the last decade, from 103 in 2012 to 395 in 2021.
- The PEH decedents are predominately male (85%), white (46%) and the average age of the decedents is 48 year old.
- The leading manner of death among PEH in 2021 was accidental (59%). Accidental death became the majority of PEH deaths in 2020 and continued into 2021.
- The leading cause of death among accidental PEH deaths was drug related. Drug-related deaths account for 177 accidental deaths (76%), with fentanyl being a factor in 144 of those deaths.
- A total of 265 of the 395 PEH decedents had some interaction with Cal Optima. Access to health care does not seem to be an issue, but effective utilization of those services appears to be a challenge.
- The majority of PEH decedents (309) had at least one experience in custody at the Orange County Jail. In looking at the most recent custody experience of each decedent, 54% served a week or less and nearly 80% served 30 days or less. Less than 10% participated in a program during a custody experience.

RECOMMENDATIONS

- **Recommend the Sheriff pursue legislation to enable a full sharing of available data among members of a County Homeless Death Review Committee.**
  A case by case review of each death was limited due to legal restrictions on how data can be shared among Committee members. Similar committees convened to review specified deaths, such as the Child Death Review Team, do not have such limitations because they are authorized by statute. To rectify this barrier, the Committee is recommending legislation to authorize Counties to convene a homeless death review committee and share specified data.
- **Recommend the Sheriff's Department and other county departments continue efforts to enhance opportunities for substance abuse treatment.**
  Fentanyl appears to be the most significant factor contributing to the increase in homeless deaths. Expanding options for treatment of those with substance use disorder is critical to helping intervene before a lethal dose.

- **Recommend the Sheriff's Department and other county departments continue to pursue opportunities to expand the availability of Narcan.**
  The use of Narcan can reverse an overdose and has been utilized successfully to save lives. To be clear, Narcan is not the solution to the long term issue of drug abuse, but it can provide the lifesaving measure needed and create an opportunity to intervene.

- **Recommend changes to sentencing laws that compel participation in programs.**
  As noted above the leading manner of death in PEH is accidental and of those accidental deaths 76% were drug related. Compelling participation for the PEH population in lieu of incarceration in a substance abuse treatment program creates an opportunity to proactively intervene.

GLOSSARY OF TERMS

Manner and Cause of Death

In reviewing the data on manner and cause of death it is important to understand the terms used. The terms are consistent with industry standards in California.

Cause of death: The condition or injury (or circumstances of the injury) that initiated the train of morbid events leading directly to death.

Manner of death: A classification of death based on the circumstances surrounding a particular cause of death and how that cause came into play. The manner of death classifications are: Natural, Accident, Suicide, Homicide and Undetermined (Could not be determined).

Natural: A death solely or nearly totally due to disease and/or the aging process.

Accidental: When an injury or poisoning causes death and there is little or no evidence that the injury or poisoning occurred with the intent to harm or cause death. In essence, the fatal outcome was unintentional.

Suicide: An injury or poisoning resulting from an intentional, self-inflicted act committed to do self-harm or cause the death of one's self.

Homicide: A death resulting from a volitional act committed by another person to cause fear, harm, or death.

Undetermined (Could not be determined): The information pointing to one manner of death is no more compelling than one or more other competing manners of death in thorough consideration of all available information.

Jurisdictional Inquiry: A local classification used for cases that require extensive work to determine that the death does not otherwise meet the legal requirement for coroner jurisdiction.

APPENDIXES

Appendix Table 1 and the map in Appendix Figure 1 summarizes the location and manner of death for the 395 PEH decedents in 2021

Appendix Table 1 - Deaths to PEH in 2021 (Manner)

CITY	Accident	Homicide	Jurisdictional Inq.	Natural	Pending	Suicide	Undetermined	Total
Anaheim	37	1	1	21	3	1	0	64
Brea	1	0	0	1	0	0	0	2
Buena Park	3	0	0	3	0	2	0	8
Costa Mesa	13	0	0	4	0	1	0	18
Cypress	0	0	0	1	0	0	0	1
Dana Point	0	0	0	1	0	0	0	1
Fountain Valley	9	0	0	6	0	1	1	17
Fullerton	11	3	0	7	2	4	1	28
Garden Grove	11	1	0	9	1	0	0	22
Huntington Beach	7	0	0	7	0	2	1	17
La Habra	2	0	0	2	0	0	0	4
La Palma	2	0	0	0	0	0	0	2
Laguna Beach	1	0	0	1	0	0	0	2
Laguna Hills	3	0	0	1	0	0	0	4
Laguna Niguel	0	0	0	3	0	0	0	3
Lake Forest	3	0	0	2	0	0	0	5
Los Alamitos	1	0	0	1	0	0	0	2
Midway City	3	0	0	1	0	0	0	4
Mission Viejo	2	0	0	2	0	0	0	4
Newport Beach	8	1	1	5	1	0	0	16
Orange	14	2	0	11	1	1	0	29
Placentia	4	0	0	0	0	0	0	4
San Clemente	2	0	0	2	0	2	0	6
San Juan Capistrano	1	0	0	1	0	0	0	2
Santa Ana	64	2	0	20	0	5	1	92
Stanton	7	0	0	0	1	0	0	8
Sunset Beach	2	0	0	0	0	0	0	2
Tustin	4	0	0	0	1	3	2	10
Westminster	14	1	1	1	1	0	0	18
Total	229	11	3	113	11	22	6	395

DEATHS TO PERSONS EXPERIENCES HOMELESSNESS (2021)

Appendix Figure 1 **Map of Deaths to Persons Experiencing Homelessness**