ORANGE COUNTY
SHERIFF'S DEPARTMENT

Sheriff-Coroner
Homeless Death Review Committee:

Report on 2022 Orange County Homeless Deaths

We would like to acknowledge all our committee membership

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ILLUMINATION FOUNDATION DISRUPTING THE CYCLE OF HOMELESSNESS

Fountain Valley Regional Hospital Tenet Health Pacific Coast

COUNTY OF ORANGE CALIFORNIA OC SocialServicesAgency Our Community, Our Commitment

INTRODUCTION

The experience of homelessness has well-documented, long-term consequences on health and well-being. 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 Division, 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 Division, the Orange County Sheriff's Department Custody Operations Behavioral Health Bureau, the Orange County Office of Care Coordination, the Orange County Health Care Agency, the Orange County Social Services Agency, the Hospital Association of Southern California, the Orange County Medical Association, multiple experts 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 of PEH that occurred in calendar year 2022. 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 report emerges from a collaborative task force that focuses on accountability, brings in multiple points of view, provides partnerships and data sharing, reviews results, and carries out recommendations. The report summarizes the progress to date the Committee has made in understanding deaths among PEH and 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 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 focused on reviewing the data and trends related to 496 people who passed away in 2022 while experiencing homelessness, as identified by the Orange County Sheriff's Coroner Division. 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 2022 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 personal 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 recommended legislation last year to authorize Counties to convene a homeless death review committee and share specified data. This legislation was sponsored by Sheriff-Coroner Don Barnes and authored by California State Assemblywoman Sharon Quirk-Silva. This legislation, AB 271, was introduced during the 2023 legislative cycle, passed by both the State Assembly and Senate, and was signed by Governor Newsom in September 2023. The legislation goes into effect in January 2024 and will allow the full sharing of information among Committee members.

RECOMMENDATION OUTCOMES FROM LAST YEAR'S COMMITEE REPORT

The Committee made four recommendations based on findings in last year's report. The recommendations and results are as follows:

- **Recommend the Sheriff pursue legislation to enable a full sharing of available data among members of a County Homeless Death Review Committee.**
  - This recommendation was completed with the legislation going into effect on January 1, 2024, as mentioned above.

- **Recommend the Sheriff's Department continue to work with other county departments in effort to enhance opportunities for substance abuse treatment.**
  - This recommendation was well received and countywide efforts continue. In addition, this year, the Orange County Sheriff's Department expanded their in-custody Substance Use Disorder Treatment Counseling Program to serve both the male and female inmate population. Operated by Phoenix House California, the program is facilitated in two dedicated housing units, creating an environment where Care Coordinators and Counselors help guide participants toward a path of recovery and success. Services are evidence-based, gender-specific, trauma-informed, and culturally competent to foster long-lasting behavioral change.

- **Recommend the Sheriff's Department continue to work with other county departments to pursue opportunities to expand the availability of Narcan.**
  - Expansion of Narcan availability efforts continue; specifically the Health Care Agency Mental Health and Recovery Services (MHRS), which has been engaged in community education, leveraging the larger OCSD efforts to get information out into the community on fentanyl. This includes distribution of Narcan and Kloxxado, opioid antagonists that reverse an overdose, to unhoused individuals through MHRS Outreach and Engagement.

- **Recommend changes to sentencing laws that compel participation in programs.**
  - Efforts continue related to changing sentencing laws. The Sheriff and Board of Supervisors supported multiple pieces of legislation related to fentanyl. AB 701, which increased penalties for trafficking fentanyl, was signed into law in October 2023. While AB 701 does not address participation in programs, it does help address the flow of fentanyl into the community. Fentanyl is a leading cause of death to the PEH population.

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 death.

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.

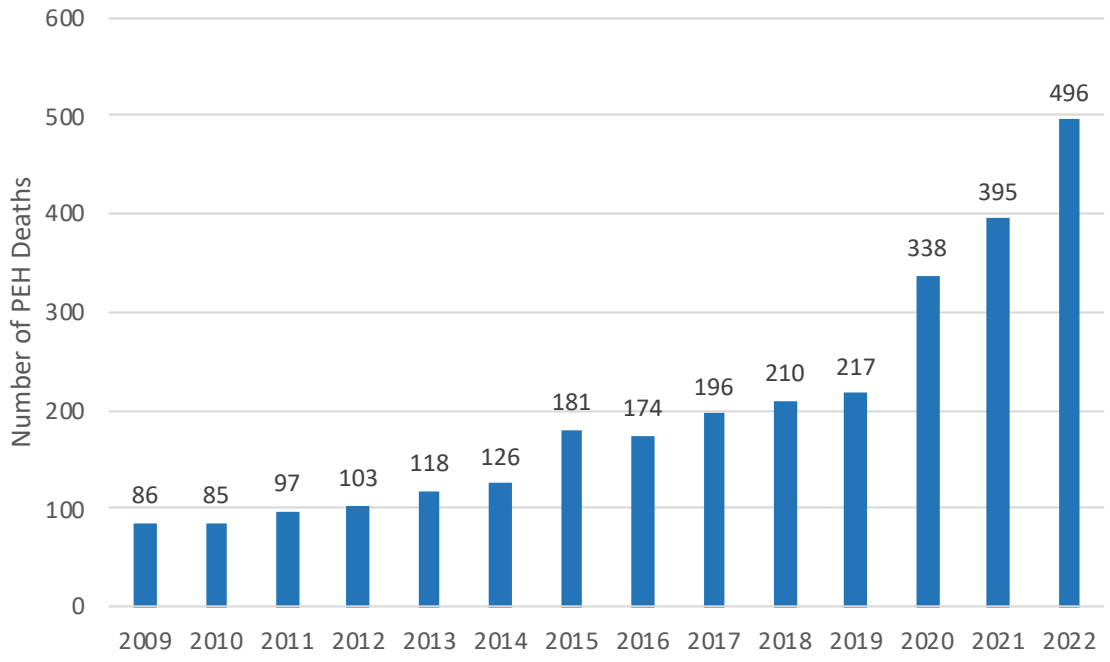
Jurisdictional Inquiry: A local classification used for cases that require extensive work to determine that the death does not otherwise meet the legal requirement for coroner jurisdiction.

REVIEW OF NUMBERS/DATA

DEATHS AMONG PERSONS EXPERIENCING HOMELESSNESS

According to data from the Orange County Sheriff's Coroner Division, in 2022, the total number of deaths to persons experiencing homelessness (PEH) was 496. Over the last several years, the number of PEH deaths has increased incrementally in Orange County. A substantial increase in deaths occurred between 2019 and 2020 when deaths increased by 56% from 217 to 338 during the first year of the pandemic **(Figure 1)**. Deaths among persons experiencing homelessness continued to increase to unprecedented heights in 2021 and 2022, reaching 395 and 496 deaths, respectively, and amounting to an increase of 47% from 2020 to 2022.

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

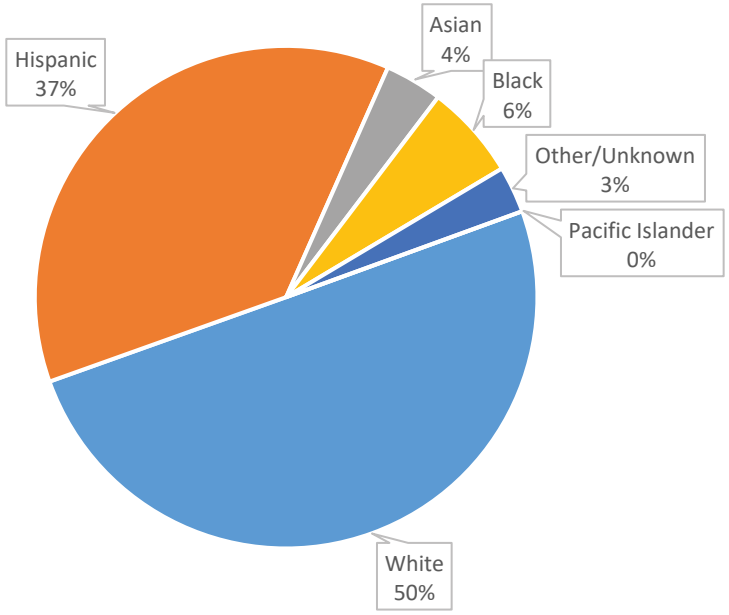


The increase in homeless deaths is not unique to Orange County and is consistent with trends being seen in other parts of California.

DEMOGRAPHICS OF PEH DEATHS 2022

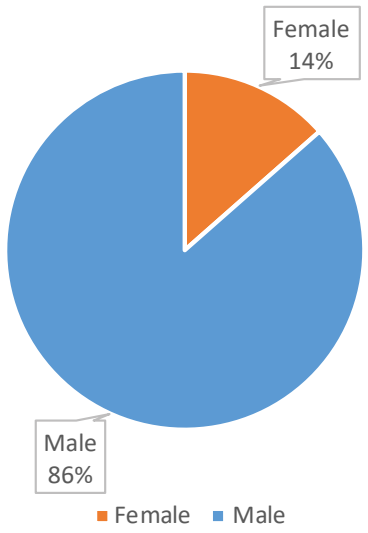
The information presented in the following section will include an in-depth analysis of deaths to persons experiencing homelessness in 2022 – the most recent and complete data available. Please note that the demographic data and data on both the manner and cause of death is from the Orange County Sheriff's Coroner Division and the California Comprehensive Death File (CCDF) for Orange County.

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



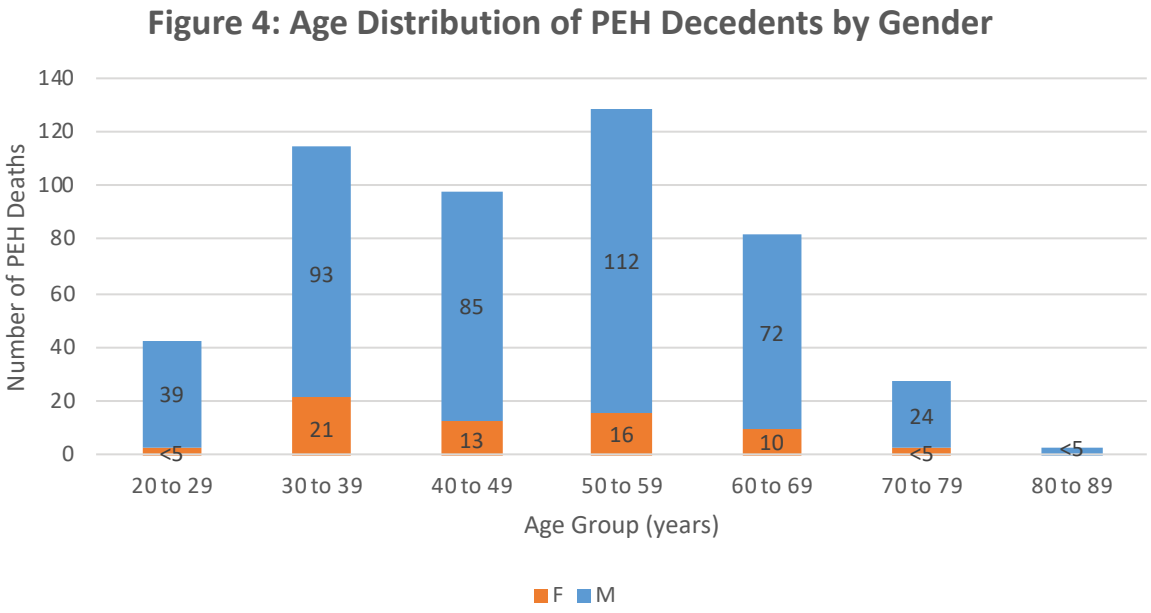
The demographic characteristics of the 496 PEH who died in 2022 is shown in **Figure 2**. The race/ethnicity of the decedents was 50% White, 37% Hispanic, followed by 6% Black, 4% Asian, and 3% Other/Unknown. These percentages align with the race and ethnicity breakdown reported in the 2022 Orange County Point in Time Summary for those experiencing unsheltered homelessness.

Figure 3: **Gender of PEH Decedents**



The majority (86%) of deaths to PEH were male and 14% were female **(Figure 3)**. This represents a 13% overrepresentation of males compared to the 2022 Orange County Point in Time Count Summary that reported 73.5% of people experiencing unsheltered homelessness identified as male.

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



The age distribution of PEH who died in 2022 **(Figure 4)** identify the average age at death was 48 years old (F 46; M 48), compared to 76 years old for the housed population who died that year.

MILITARY SERVICE

Of the homeless decedents (27), 5.4% 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 who identified as veterans.

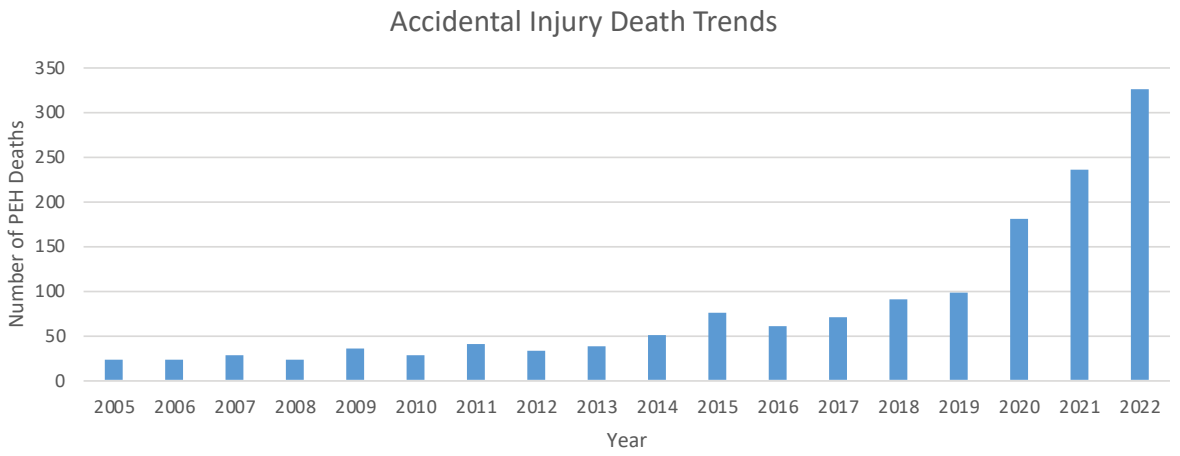
MANNER OF DEATH

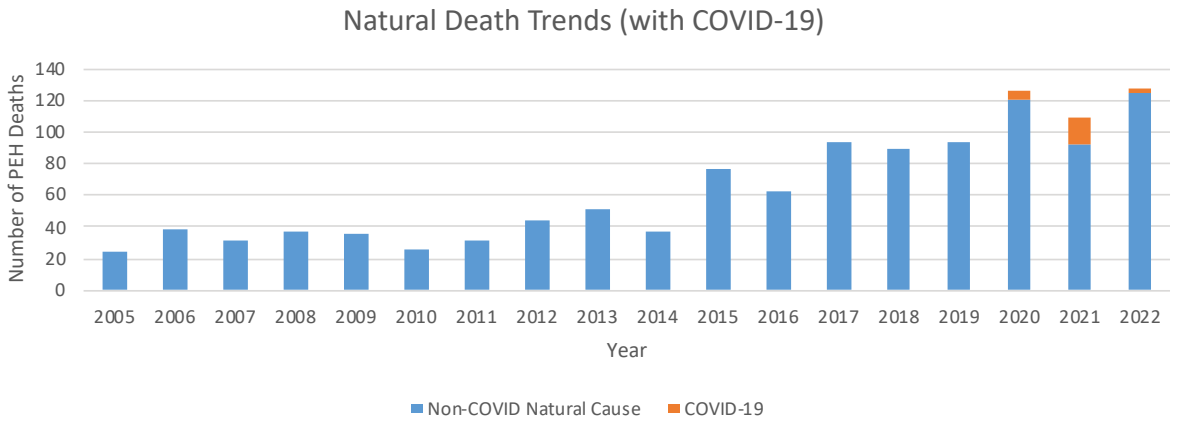
Table 1: Manner of Death to PEH (2018 to 2022)

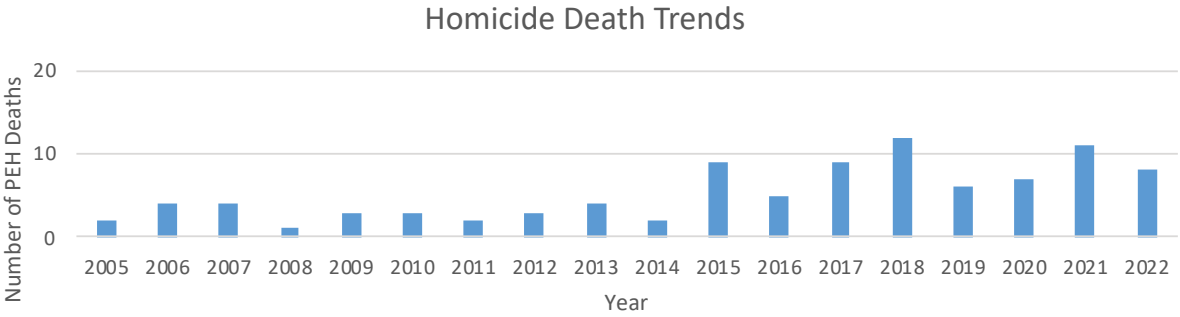
Homeless Deaths	2018		2019		2020		2021		2022	
Manner of Death	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Accident	91	43%	99	46%	181	54%	235	59%	324	65%
Homicide	12	6%	6	3%	7	2%	11	3%	8	2%
Natural	89	42%	94	43%	126	37%	109	28%	128	26%
COVID-19					*6*	*2%*	*17*	*4%*	*5*	*1%*
Suicide	15	7%	14	7%	15	4%	22	6%	19	4%
Undetermined/ Pending*	3	1%	4	2%	3	1%	1	0%	14	3%
Total	**210**	**100%**	**217**	**100%**	**338**	**100%**	**395**	**100%**	**496**	**100%**

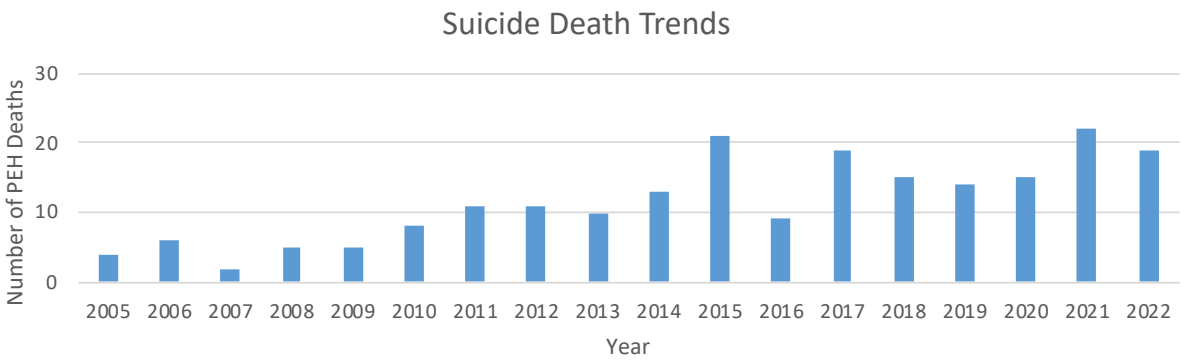
Up until 2020, deaths to PEH were primarily due to natural (e.g., cancer, heart disease, liver disease) and accidental (unintentional) causes **(Table 1)**. However, in 2020 (181), deaths due to accidental (unintentional) injuries increased significantly and continued to increase through 2021 (235) and 2022 (324) becoming the majority manner of death among PEH. Indeed, 65% of deaths to the PEH population were categorized as accidental in 2022.

Figure 5: **PEH Death Trends**









The trends for manner of death to PEH **(Figure 5)** show that over the past nearly two decades, (since 2005) the number of deaths in each category have increased markedly. However, the growth in some of the manners of death have far outpaced others. In just the past decade, for example, the number of accidental deaths (unintentional) increased from 39 in 2013 to 324 in 2022 (a 731% increase). Natural deaths increased 151%, from 51 in 2013 to 128 in 2022. A similar pattern was observed for homicide and suicide deaths (albeit small numbers of cases). Homicides increased from 4 deaths in 2013 to 8 deaths in 2022 (a 100% increase), while suicide deaths nearly doubled, from 10 to 19, during this same time period (a 90% increase).

LEADING CAUSES OF DEATH TO PEH (2022)

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 (65%), followed by diseases of the heart (14%), suicide (4%), liver disease and cirrhosis (3%), and homicide (<2%).

Table 2: Top 5 Leading Causes of Death in Orange County (2022)	%PEH Deaths
Accidents (unintentional injuries)	65%
Diseases of the heart	14%
Intentional self-harm (suicide)	4%
Chronic liver disease and cirrhosis	3%
Assault (homicide)	<2%

Because accidental injuries accounted for so many of the deaths to PEH (65.3%), a more detailed summary of this category is required **(Table 3)**. The majority (55%) of unintentional deaths were due to overdose (poisoning), and 42% (209) of all unintentional deaths, to PEH are specifically due to the very potent synthetic opioid, fentanyl.

Table 3: Accidental (Unintentional Injury) Cause Group Detail	Homeless	%Homeless Deaths
Poisoning/Overdose with Fentanyl	209	42.1%
Poisoning/Overdose (Non-Fentanyl)	64	12.9%
Pedestrian Traffic	32	6.5%
Motor Vehicle Traffic	5	1.0%
Falls	<5	<1.0%
Pedal Cyclist Traffic	<5	<1.0%
Drowning	5	1.0%
Other/Unknown/Ill-Defined	<5	<1.0%
Total	324	65.3%

Compare this to 2018, just four 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.

Beginning in 2022, the Health Care Agency's Mental Health and Recovery Services (MHRS) has been engaged in community education, leveraging the larger OCSD efforts to get information out into community on fentanyl. This includes distribution of Narcan and Kloxxado to unhoused individuals through MHRS Outreach and Engagement. Additional prevention efforts are underway, including enhancing and expanding treatment options available to the

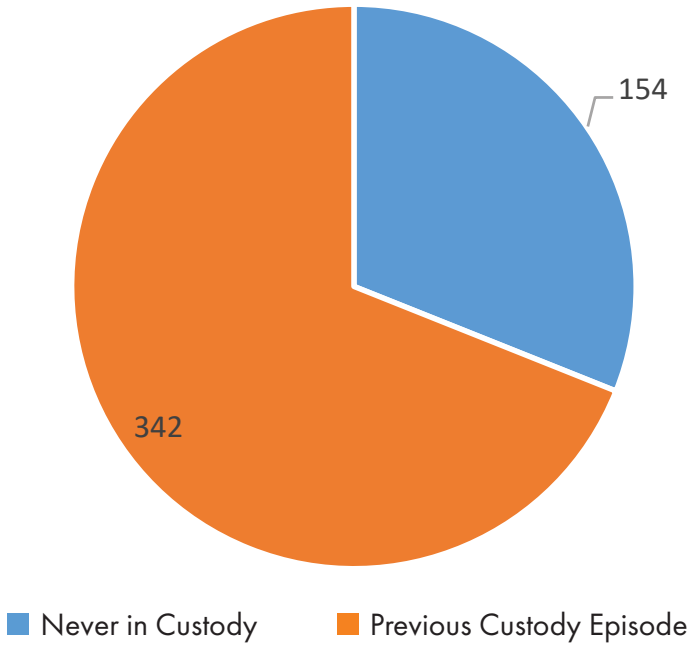
unhoused community through outreach and engagement and prior to release from custody. This includes discharge planning of individuals who are on Medication Assisted Treatment (MAT), ready to be released from custody, and who are unhoused. Overdose prevention kits are also provided in the community and upon release from custody. Collaboration through local shelters and housing partners also has been increased to address prevention, treatment, and recovery support for individuals who are unhoused, have a substance use disorder, and are at risk for a drug overdose.

The second most common category of unintentional injury deaths was due to PEH being hit by motor vehicles (6.5%, 32) while walking.

CUSTODY INFORMATION

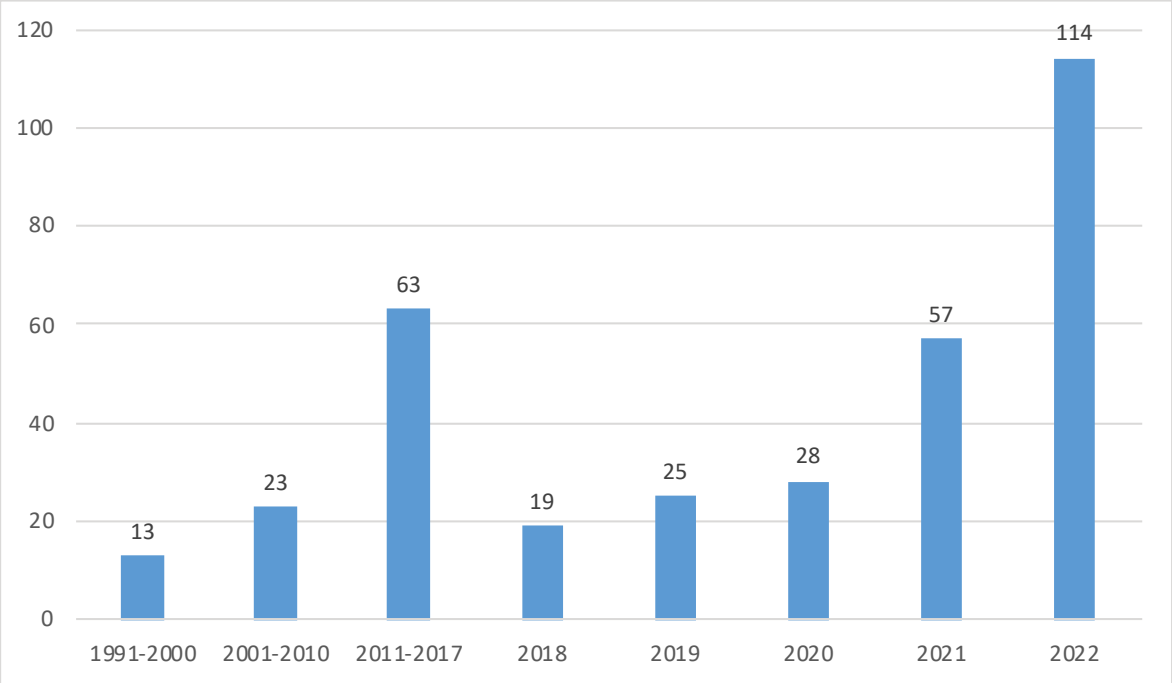
Based on booking records from the Orange County Sheriff's Department, the majority of 2022 PEH decedents 68% (342) had at least one episode of custody in the Orange County Jail, while 32% (154) had never been in custody. The percentage of PEH previously in custody the Orange County Jail declined from 2021. Among 2021 PEH decedents, 78% (309) had an experience in the Orange County Jail.

Figure 6: **Custody History**



Of the 342 PEH decedents who have been in the Orange County Jail, 241 had been in custody within the last five years.

Figure 7: **Most Recent Custody Experience**



Regardless of prior custody experience, PEH decedents were likely to have died accidently. The gap between accident and natural causes was less pronounced for the 154 PEH decedents who had never been in custody.

Figure 8: **Manner of Death Per Previous Custody Episode**

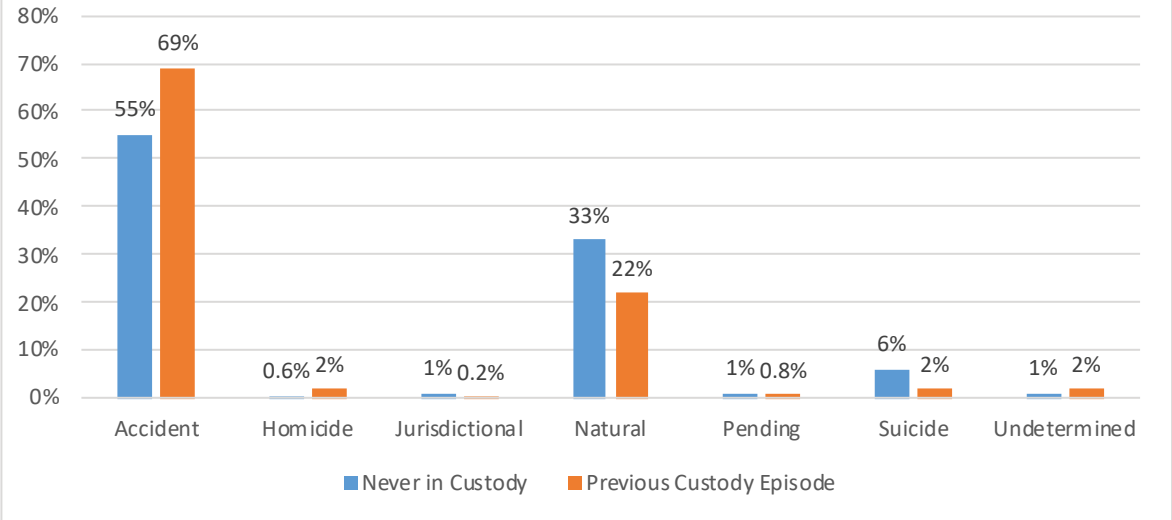
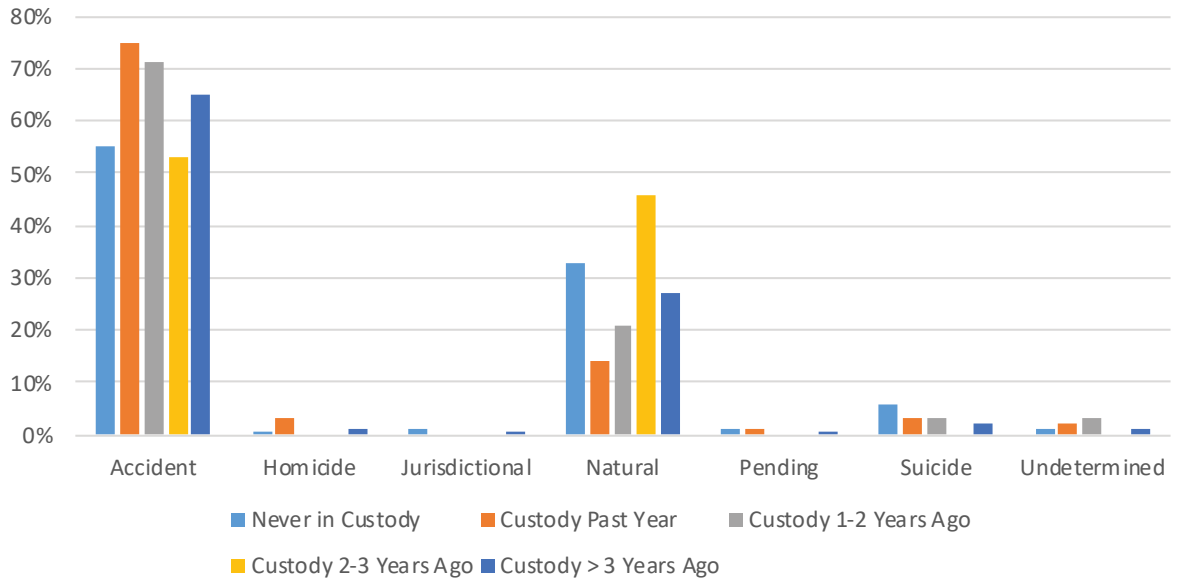


Figure 9: **Manner of Death by Time Since Custody Release**



Only 37 of the 342 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; 56% served a week or less and 75% served 30 days or less.

An examination of PEH decedents by time since their last custody episode shows that accident remained the most likely manner of death for all categories, followed by natural death. The most significant gap between accidental and natural death were for individuals who died within a year of their release from custody.

Figure 10: **Length of Most Recent Time in Custody**

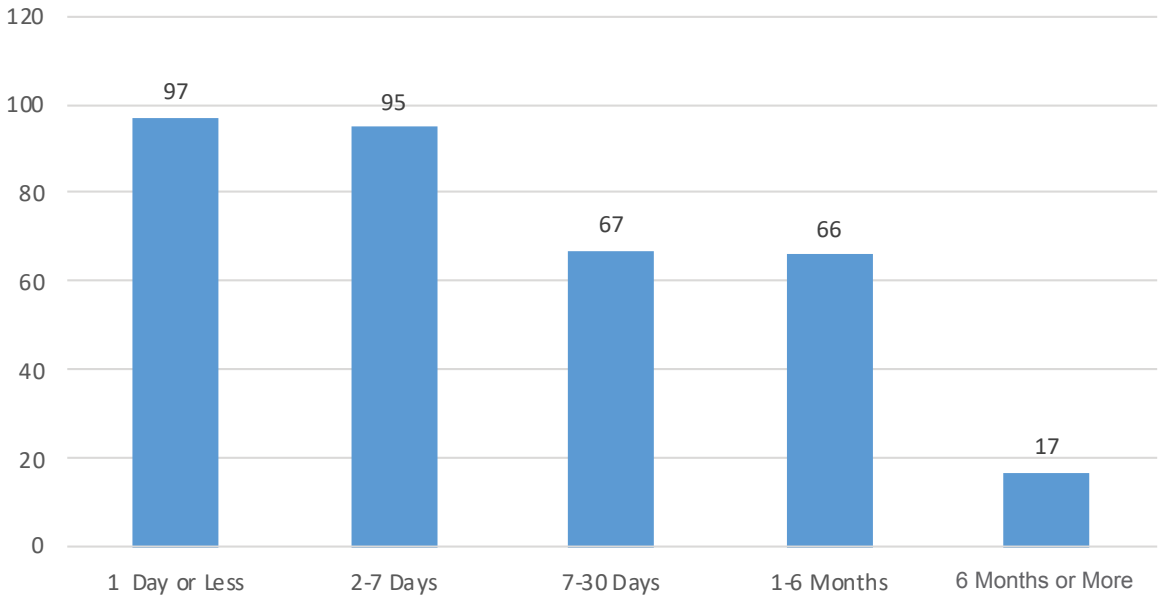
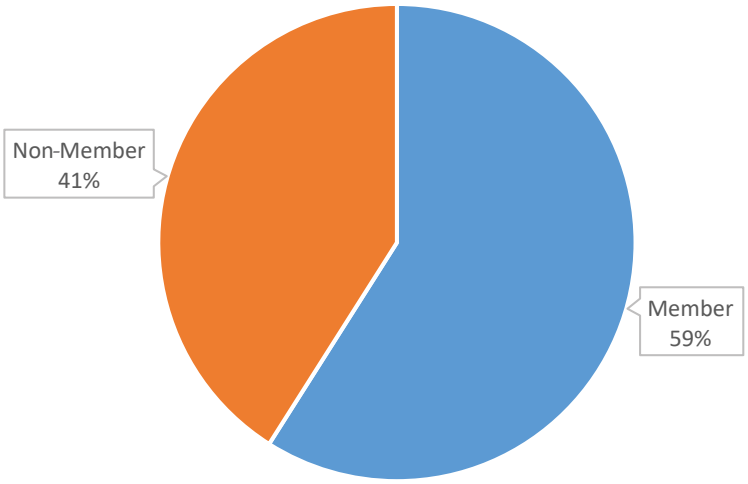


Figure 11: **CalOptima Membership Among PEH Decedents**



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 294 (59%) of the 496 PEH decedents in 2022. Of those with coverage, there were 524 emergency department visits and 123 hospital admissions. In 2021, CalOptima had information on 265 or 67% of the 395 PEH decedents. **(Figure 11)**

FINDINGS AND RECOMMENDATIONS

FINDINGS

- Deaths among people experiencing homelessness (PEH) have increased in Orange County over the last decade. The largest increase occurred from 2019 to 2020, with deaths increasing by 55%, from 217 to 338.
- Similar to the 2021 Homeless Death Review Committee Report, the PEH decedents are predominately male (86%), white (50%), and the average age is 48 years old.
- For the third consecutive year, accidental death continues to be the leading manner of death among PEH. In 2022, 65% of PEH died as the result of an accident, up from 59% in 2021. Accidental death first became the majority of PEH deaths in 2020.
- The leading cause of death among accidental PEH deaths was drug-related. Drug-related deaths account for 273 accidental deaths (55%), with fentanyl being a factor in 209 of those deaths.
- The majority of PEH decedents (342) had at least one experience in custody at the Orange County Jail. The percentage of PEH who had a previous episode in the Orange County Jail declined from 2021. Among 2021 PEH decedents, 78% (309) had an experience in the Orange County Jail.

HOMELESS DEATH REVIEW COMMITTEE AFTER ACTION ITEMS

Looking ahead, the priority for the Committee in 2024, will be to develop guidelines and a process to conduct a more comprehensive review of PEH deaths. With the recently passed legislation going into effect in January 2024, the Committee will be able to share more personalized information with each other, allowing for a more detailed analysis of the data available.

For instance, 2022 data shows accidental deaths, specifically drug overdoses/poisonings, are the leading cause of death to the PEH population. A wide-ranging analysis of these deaths will be a focus for the Committee moving forward.

APPENDIXES

Table 4 summarizes the location of death for the 496 PEH decedents in 2022.

Table 4: City where death occurred among PEH

CITY	Number	Percent
Anaheim	97	19.6%
Brea	<5	<1%
Buena Park	12	2.4%
Capistrano Beach	<5	<1%
Costa Mesa	22	4.4%
Cypress	7	1.4%
Dana Point	<5	<1%
Fountain Valley	18	3.6%
Fullerton	18	3.6%
Garden Grove	32	6.5%
Huntington Beach	34	6.9%
Irvine	5	1.0%
La Habra	<5	<1%
Laguna Beach	<5	<1%
Laguna Hills	6	1.2%
Laguna Niguel	<5	<1%
Lake Forest	<5	<1%
Los Alamitos	<5	<1%
Mission Viejo	6	1.2%
Newport Beach	17	3.4%
Orange	52	10.5%
Placentia	6	1.2%
Rancho Santa Margarita	<5	<1%
San Clemente	<5	<1%
San Juan Capistrano	8	1.6%
Santa Ana	95	19.2%
Seal Beach	<5	<1%
Stanton	12	2.4%
Tustin	5	1.0%
Westminster	18	3.6%
Total	496	100.0%