



ORANGE COUNTY  
**SHERIFF'S DEPARTMENT**

Sheriff-Coroner  
Homeless Death Review Committee:

**Report on 2024 Orange County  
Homeless Deaths**

# We would like to acknowledge all our committee membership

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## INTRODUCTION

This is the fourth annual report on homeless deaths in Orange County. Sheriff-Coroner Don Barnes formed the Homeless Death Review Committee (Committee) in January 2022 and tasked the group with analyzing the number of deaths and causes of death for persons experiencing homelessness (PEH) in Orange County.

The Orange County Coroner's Office, a division of the Orange County Sheriff's Department, leads the committee of technical experts from both the public and private sectors. Membership of the committee includes 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, 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 2024 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 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

This report is focused on data and trends related to 378 people who passed away in 2024 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 is data from the Orange County Health Care Agency and the Orange County Jail. Lastly, the Committee compared the 2024 data against the same dataset from previous years.

## 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 oneself.

**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.

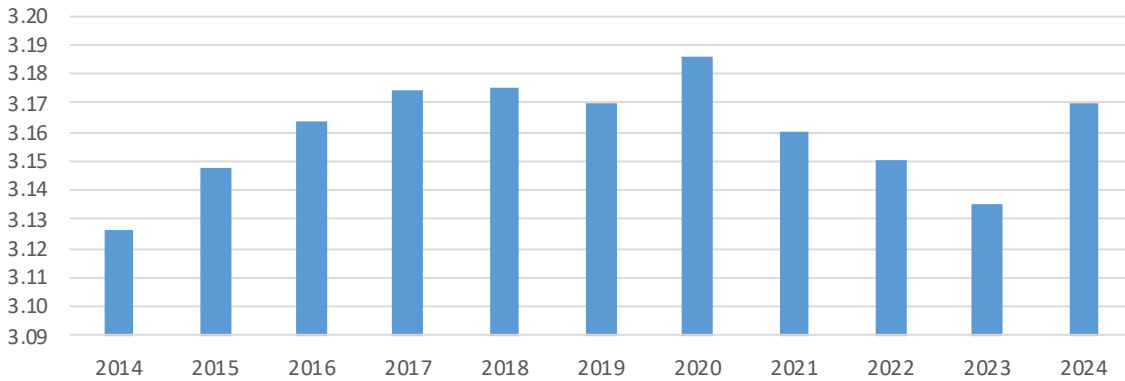
**Jurisdictional Inquiry:** A local classification used for cases that require extensive work to determine that the death does not otherwise meet the legal requirement for coroner jurisdiction. Oftentimes used as a subclassification of the "Natural" manner of death.

## ORANGE COUNTY POPULATION INFORMATION

Orange County is one of the nation's most populous counties. In reviewing the data on deaths to PEH, it is also important to understand the demographics of the current population and trends regarding the number of PEH in the community.

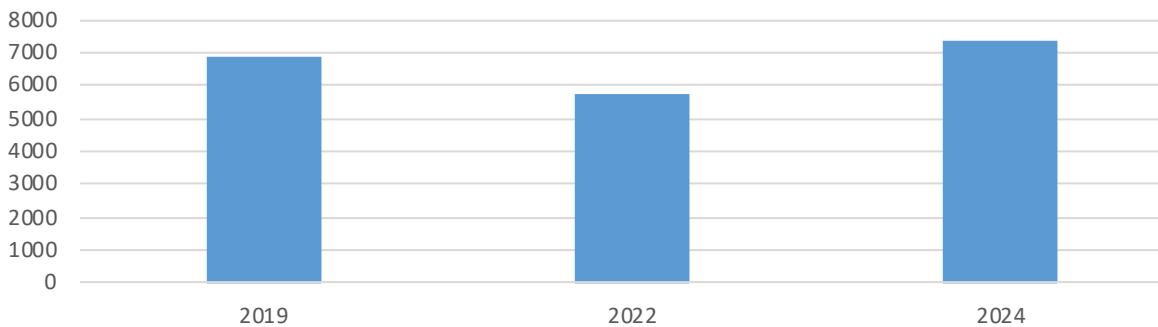
The information provided below is a representation of the estimated population of Orange County (number in millions) from 2014 through 2024 using data from the United States Census Bureau. The population numbers are estimates derived from the last census conducted in 2020. According to the data, Orange County saw a population increase of 1.4% between 2014 and 2024.

Figure 1: Orange County Population



In Orange County, a total of 7,322 PEH were counted during the 2024 Point In Time (PIT) Count. This is up 28% from the 2022 PIT Count, which counted 5,718 persons experiencing homelessness at that time. There was a change in methodology used to collect PEH data from the PIT Counts beginning in 2019 that reflects a more accurate overview of the PEH population.

Figure 2: PEH Population

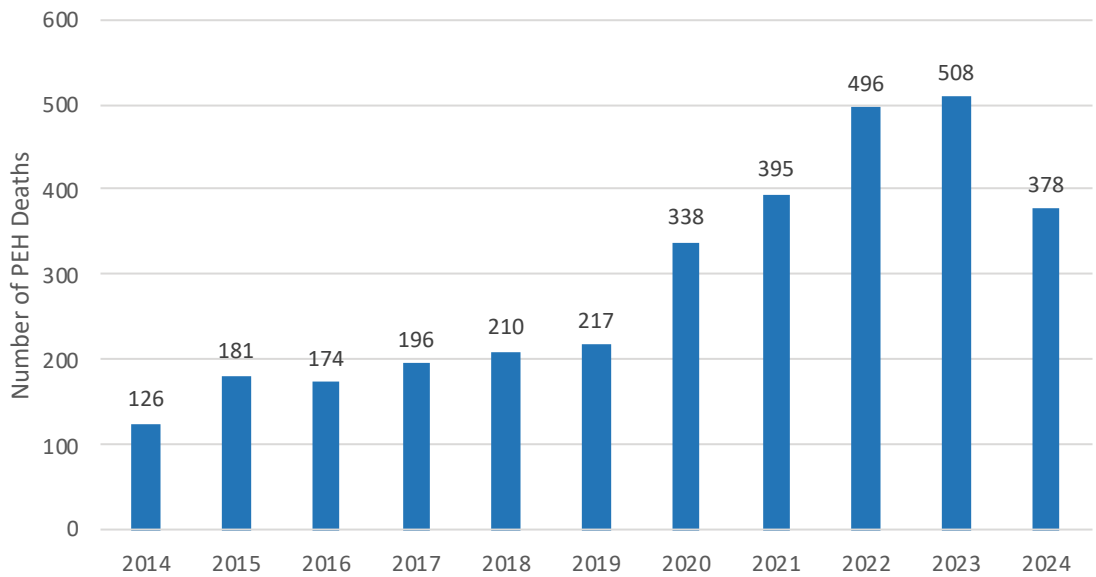


## REVIEW OF NUMBERS/DATA

### DEATHS AMONG PERSONS EXPERIENCING HOMELESSNESS

According to data from the Orange County Sheriff's Coroner Division in calendar year 2024, the total number of deaths to persons experiencing homelessness (PEH) was 378. Over the last several years, the number of PEH deaths has increased incrementally in Orange County, from 126 in 2014 to 217 in 2019. 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 3). Deaths among persons experiencing homelessness continued to increase to unprecedented heights in 2021, 2022, and 2023, reaching 395, 496, and 508 deaths, respectively, and amounting to an increase of 50% from 2020 to 2023. The first significant decline in PEH deaths in several years was in 2024 with a 25% decrease from 2023.

Figure 3: Number of Deaths to PEH in OC

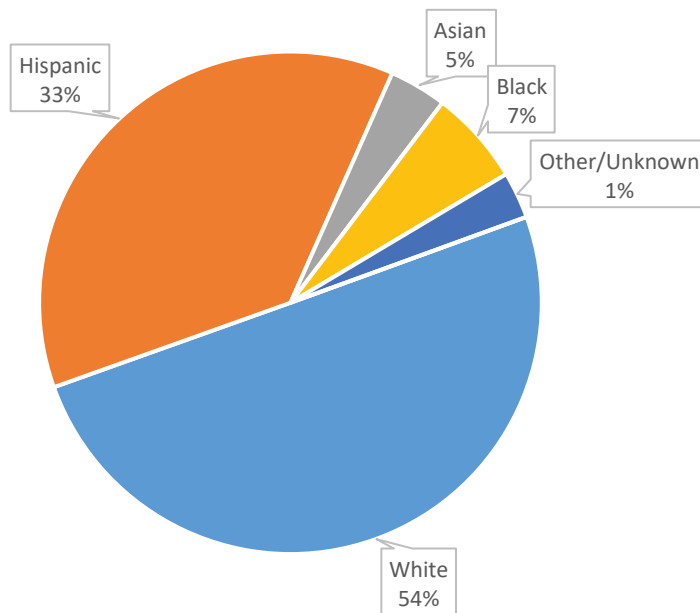


*The increase in homeless deaths is not unique to Orange County and is consistent with trends in other parts of California.*

## DEMOGRAPHICS OF PEH DEATHS 2024

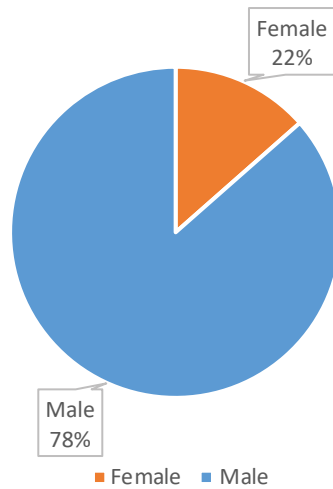
The information presented in the following section will include an in-depth analysis of deaths to persons experiencing homelessness in 2024 – the most recent and complete data available. Please note that the demographic data and data on both the manner and cause of death is from the Orange County Sheriff’s Coroner Division and the California Comprehensive Death File (CCDF) for Orange County.

Figure 4: Race/Ethnicity of PEH Decedents



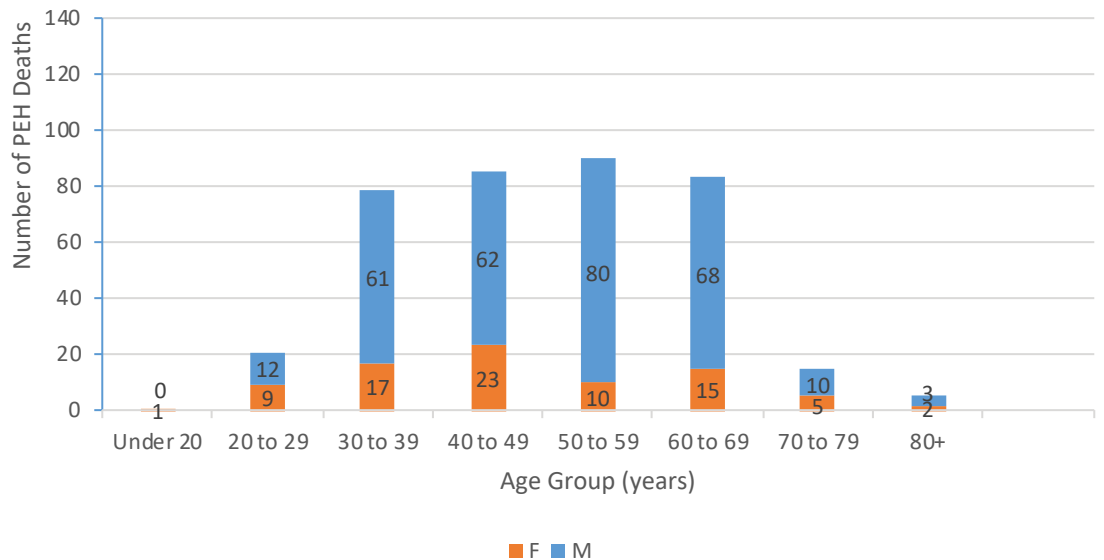
The demographic characteristics of the 378 PEH who died in 2024 is shown in Figure 4. The race/ethnicity of the decedents was 54% White, 33% Hispanic, followed by 7% Black, 5% Asian, and 1% Other/Unknown. These percentages align with the race and ethnicity breakdown reported in the 2024 Orange County Point in Time Summary for those experiencing unsheltered homelessness.

Figure 5: Gender of PEH Decedents



The majority, 78%, of deaths to PEH were male and 22% were female (Figure 5). This represents a 6% overrepresentation of males compared to the 2024 Orange County Point in Time Count Summary that reported 72% of people experiencing unsheltered homelessness identify as male.

Figure 6: Age Distribution of PEH Decedents by Gender



The age distribution of PEH who died in 2024 (Figure 6) identify the average age at death was 49 years old (F 48; M 50), compared to 76 years old for the housed population who died that year.

## MANNER OF DEATH

Table 1: Manner of Death to PEH (2020 to 2024)

Homeless Deaths Manner of Death	2020		2021		2022		2023		2024	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Accident	181	54%	235	59%	324	65%	307	60%	226	60%
Homicide	7	2%	11	3%	8	2%	7	2%	8	2%
Natural	126	37%	109	28%	128	26%	169	33%	113	30%
COVID-19	6	2%	17	4%	5	1%	0	0%	0	0%
Suicide	15	4%	22	6%	19	4%	22	4%	23	6%
Undetermined/ Pending*	3	1%	1	0%	12	2%	3	1%	8	2%
<b>Total</b>	<b>338</b>	<b>100%</b>	<b>395</b>	<b>100%</b>	<b>496</b>	<b>100%</b>	<b>508</b>	<b>100%</b>	<b>378</b>	<b>100%</b>

Prior to 2019, 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 and continued to increase through 2021 (235) and 2022 (324).

Although accidental deaths are still the primary manner of death to PEH, there was a slight decline in 2023 (307), showing a 5% **decrease** from 2022. This downward trend continued in 2024 (226) which is a 26% **decrease** from 2023.

Figure 7: PEH Manner of Death Trends

### Accidental Injury Death Trends

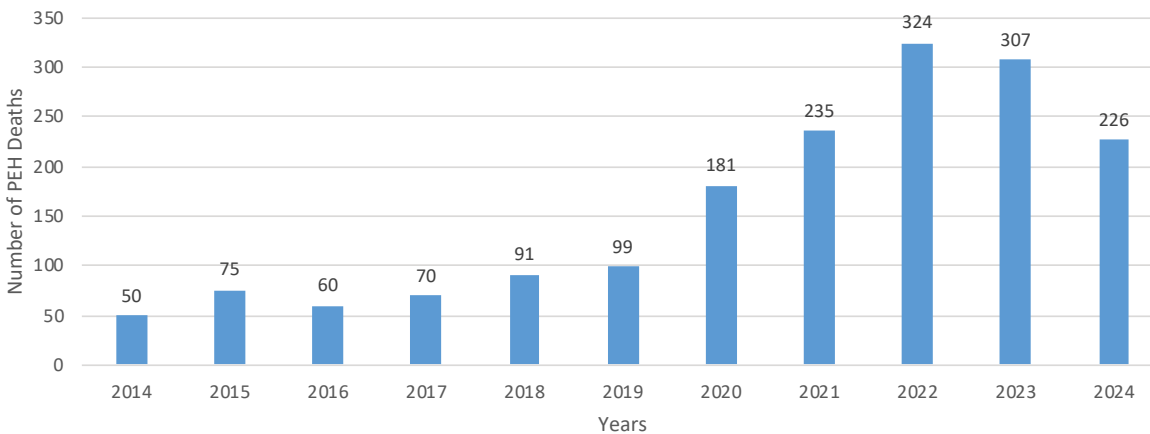
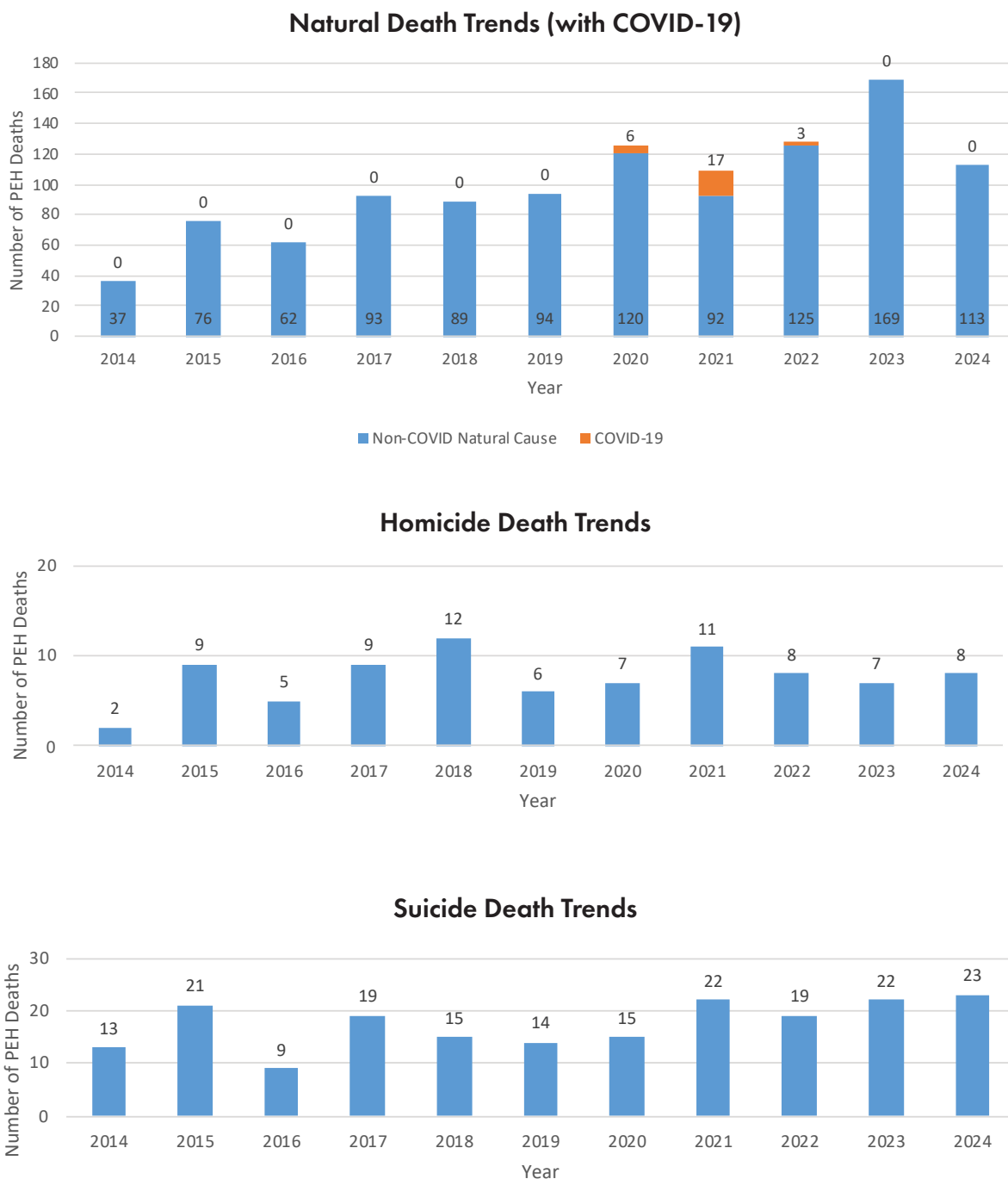


Figure 7: PEH Manner of Death Trends, Continued



The trends for manner of death to PEH (Figure 7) show that over the past decade (since 2014) the number of deaths in each category has 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 50 in 2014 to 226 in 2024. Natural deaths increased from 37 in 2014 to 113 in 2024. A similar pattern was observed for homicide and suicide deaths (albeit small numbers of cases). Homicides increased from 2 deaths in 2014 to 8 deaths in 2024, while suicide deaths almost doubled from 13 to 23 during this same time period. Although the deaths have increased over the past 10 years, they have remained within the average range over the last five years.

## LEADING CAUSES OF DEATH FOR PEH (2024)

Because accidental injuries accounted for so many of the deaths to PEH (59.7%), a more detailed summary of this category is required (Table 2). The majority (44%) of unintentional deaths were due to overdose (poisoning), and 31% (117) of all unintentional deaths to PEH are specifically due to the very potent synthetic opioid, fentanyl.

<b>Table 2: Accidental (Unintentional Injury) Cause Group Detail</b>	<b>Homeless</b>	<b>%Homeless Deaths</b>
Poisoning/Overdose with Fentanyl	117	31%
Poisoning/Overdose (Non-Fentanyl)	49	13%
Pedestrian Traffic	34	9%
Motor Vehicle Traffic	6	1.6%
Pedal Cyclist/Skateboard Traffic	8	2.1%
Falls	4	1%
Drowning	4	1%
Other/Unknown/Ill-Defined	4	1%
<b>Total</b>	<b>226</b>	<b>59.7%</b>

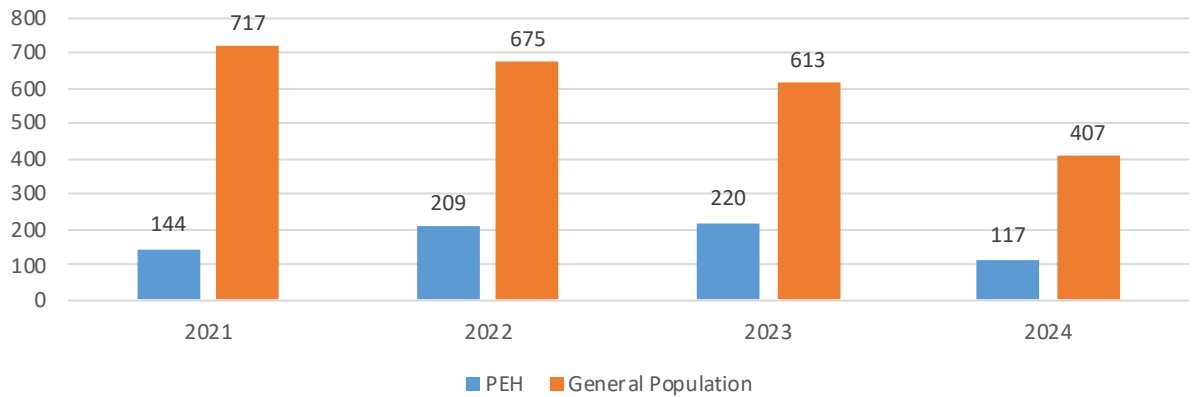
Although fentanyl continued to account for a substantial share of accidental deaths among people experiencing homelessness (PEH), the number of fentanyl-related deaths in this population declined in 2024 for the first time in several years. Previous Homeless Death Review Reports documented steady increases—from 144 deaths in 2021, to 209 in 2022, and 220 in 2023. In 2024, however, fentanyl deaths among PEH fell by 46%, dropping to 117.

Orange County’s general population also experienced a significant decline in fentanyl deaths in 2024, though decreases had already been occurring in 2022 and 2023. Countywide deaths fell from a peak of 717 in 2021 to 675 in 2022, 613 in 2023, and 407 in 2024. Overall, fentanyl deaths in the general population have declined 43% over the past three years compared with the 2021 peak.

The decline in fentanyl-related deaths coincides with a concerted effort to reduce the supply and demand for fentanyl in Orange County.

Strategies employed by the Sheriff’s Department include investing in narcotics teams, holding traffickers accountable, offering treatment in custody, and educating youth. New provisions in law created by Proposition 36 and efforts to stop fentanyl at the southern border present additional opportunities to reduce the impact of fentanyl in future years.

Figure 8: Fentanyl Related Deaths



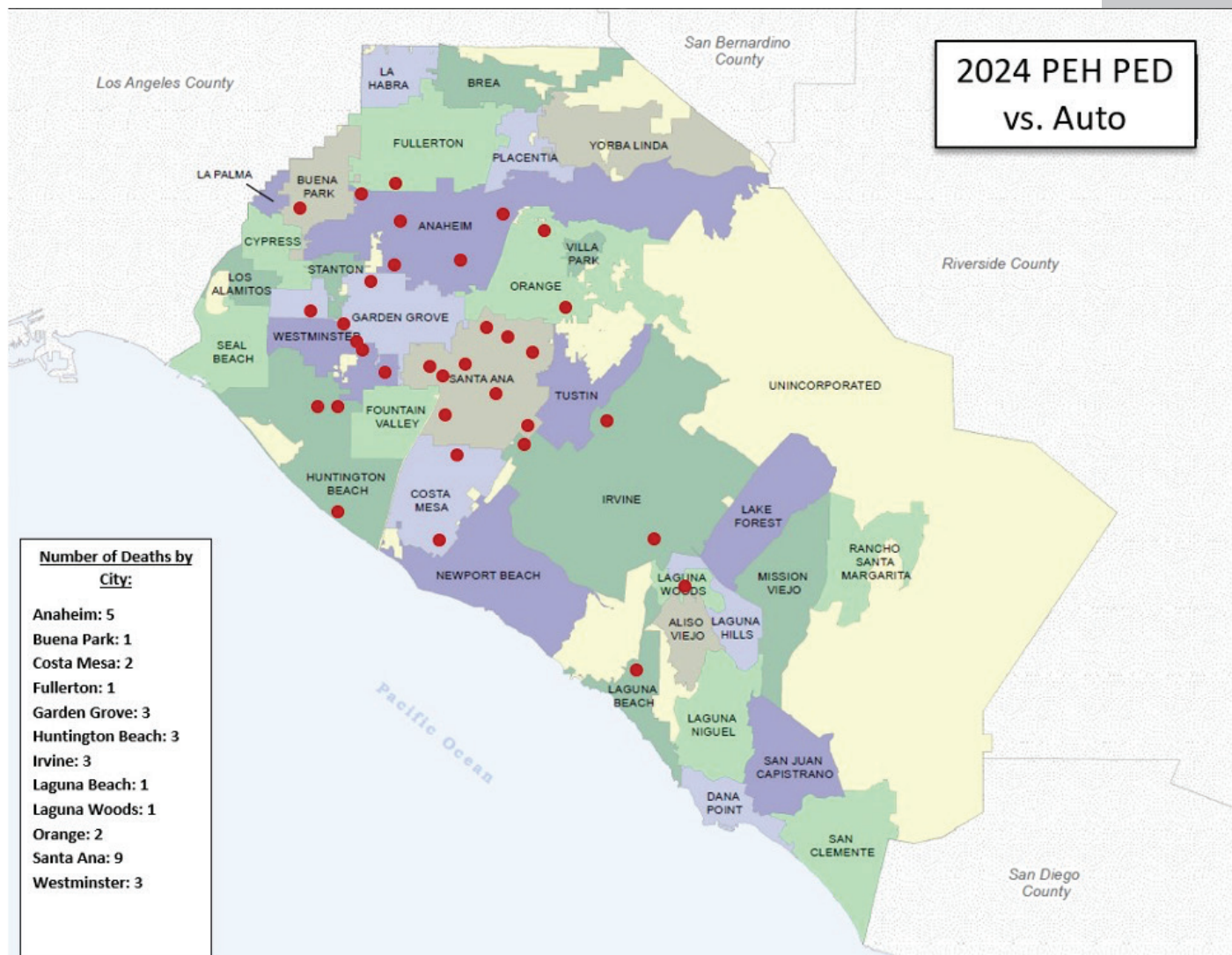
Beginning in 2022, the Health Care Agency, Mental Health & Recovery Services (MHRS) has been engaged in community education, leveraging the larger Sheriff's Department efforts, to get information out into community on fentanyl. This includes the distribution of Narcan and Kloxxado to reverse an overdose to the community, including the distribution, through MHRS Outreach & Engagement to those individuals who are unhoused. Additional prevention efforts are underway, as well as the enhancement and expansion of treatment options that are also made available to the unhoused community via Outreach & Engagement, as well as prior to release from custody. This includes discharge planning of those individuals who are on Medicated 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 our local shelters and housing partners also has been increased to address prevention, treatment, and recovery supports for those individuals who are unhoused, have a substance use disorder, and at risk for a drug overdose. For instance, in 2024 there were 21,322 units of Naloxone distributed to the community.

In addition to concerns about drug-related deaths among accidental PEH deaths, it is also important to note the role drugs can play in natural death trends. For example, methamphetamine use is linked to long-term health impacts. A 2022 study published in the Journal of the American Heart Association found that individuals who used methamphetamine had a 32% overall increased risk for cardiovascular disease.

## PEH PEDESTRIAN VS. MOTOR VEHICLES

The second most common category of unintentional injury deaths was due to PEH being hit by motor vehicles while walking, 9% (34).

Of the 34 PEH hit by motor vehicles while walking, 85.2% (29) were under the influence of drugs and/or alcohol at the time of the incident, with 58.8% (20) of incidents occurring between the hours of 8 p.m. and 6 a.m. In addition, 88.2% (30) of incidents occurred outside of a marked crosswalk.

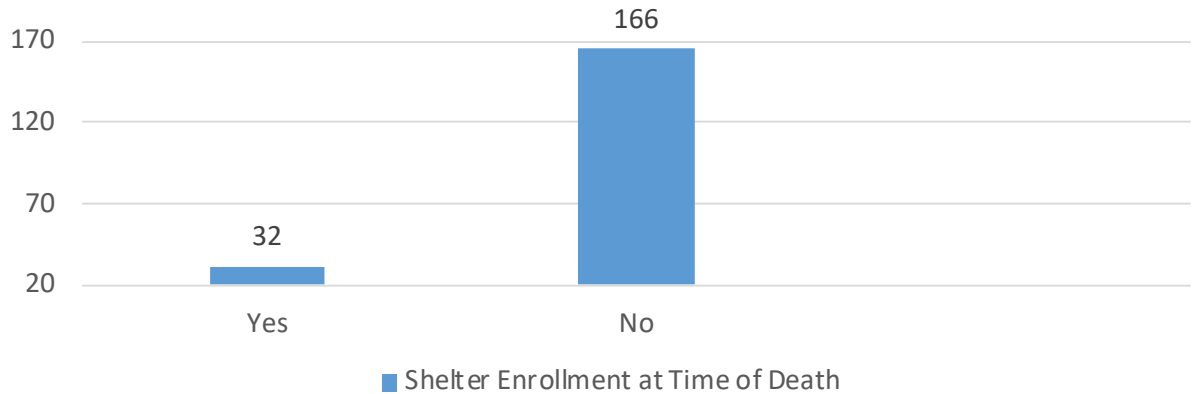


## SHELTER ENROLLMENT AND HISTORY

When reviewing the shelter enrollment and service histories of individuals who died while experiencing homelessness in 2024, the Orange County Office of Care Coordination analyzed data from the County’s Homeless Management Information System (HMIS). This analysis examined both shelter enrollment at the time of death and any prior shelter enrollment during an individual’s lifetime. HMIS is used by more than 75 percent of homeless shelters in Orange County to track shelter utilization; however, it is acknowledged that this dataset does not capture activity from the minority of shelters that do not participate in HMIS.

According to HMIS data, only 8.5 percent (32 of 378) of individuals who died in 2024 while experiencing homelessness were enrolled in a shelter at the time of their death (Figure 9).

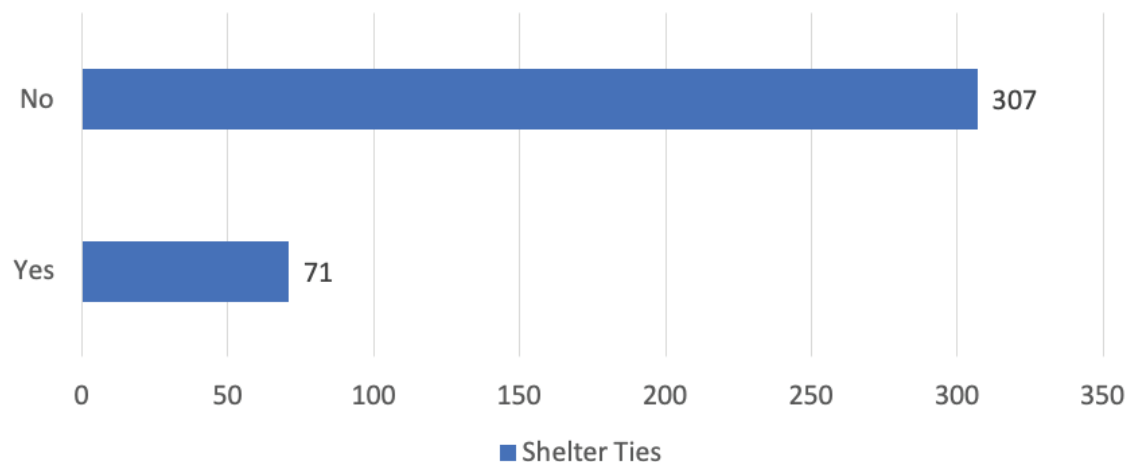
Figure 9: Shelter Enrollment at Time of Death



When examining shelter utilization over an individual’s lifetime, only 18.8 percent (71 of 378) had ever been enrolled in an Orange County shelter (Figure 10).

These low rates of shelter enrollment—both at the time of death and across an individual’s lifetime—are noteworthy and warrant further analysis to better understand the relationship between shelter access, service engagement, and mortality among people experiencing homelessness.

Figure 10: Shelter Ties

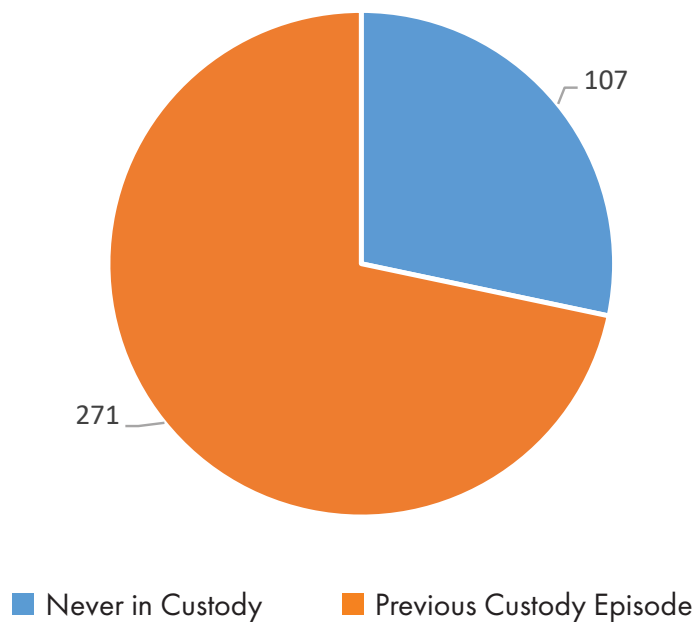


## CUSTODY INFORMATION

Based on booking records from the Orange County Sheriff's Department, the majority of 2024 PEH decedents (72%, 271) had at least one episode of being in custody in the Orange County Jail, while 28% (107) had never been in custody (Figure 11).

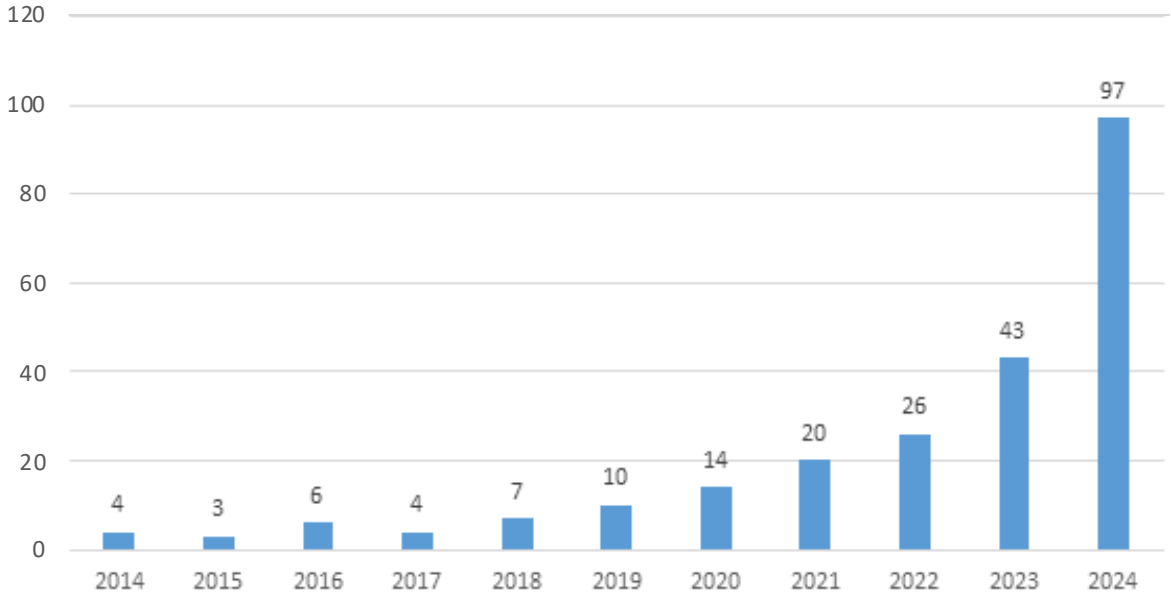
The percentage of PEH who had a previous episode in the Orange County Jail has fluctuated over the last four years. Among 2023 PEH decedents, 63% (319) had a booking in the Orange County Jail. In 2022, 68% (342) PEH decedents had an experience in the Orange County Jail, which was a decline from the 78% (309) in 2021.

Figure 11: PEH Custody History



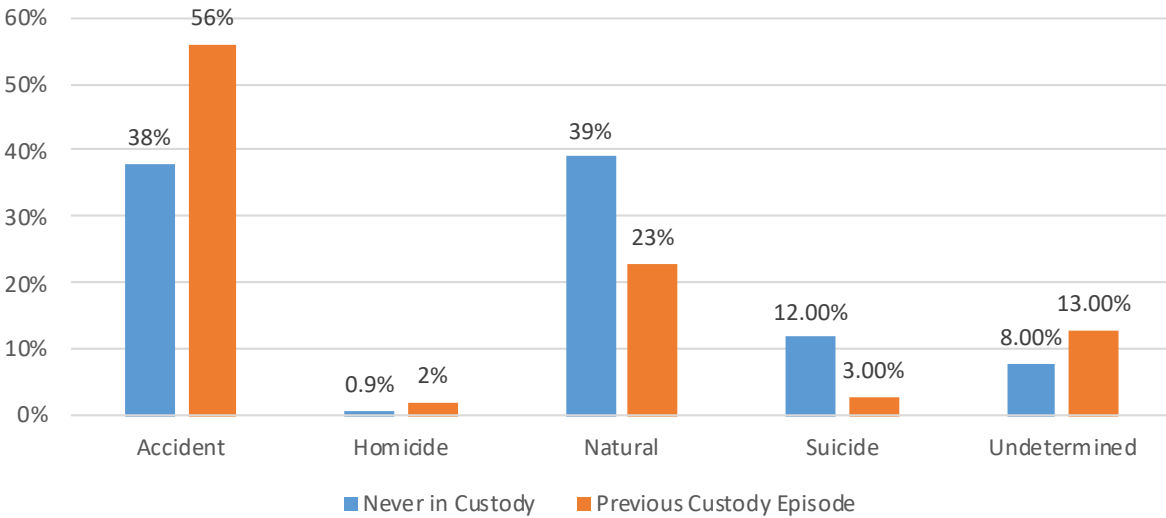
Of the 271 PEH decedents who have been in the Orange County Jail, 200 had been in custody within the last five years (Figure 12).

Figure 12: **Most Recent Custody Experience**



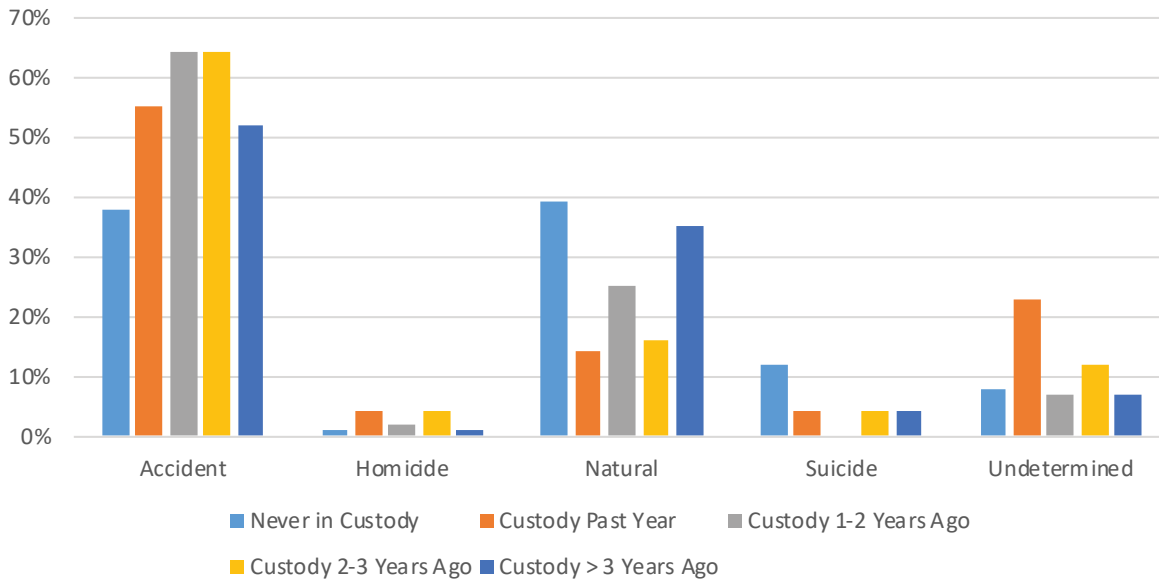
Accidental death was the leading manner of death for PEH decedents who had custody experience. Accidental and natural cause deaths were nearly even for the 107 PEH decedents who had never been in custody (Figure 13).

Figure 13: **Manner of Death by Previous Custody Episode**



An examination of PEH decedents by time since their last custody episode shows that accidental remained the most likely mode of death for all categories, followed by natural death (Figure 14). The most significant gap between accidental and natural death were for those individuals within three years of their release from custody.

Figure 14: Manner of Death by Time Since Custody Release



## FINDINGS

- Deaths among persons experiencing homelessness (PEH) have increased in Orange County over the last decade, from 126 in 2014 to 378 in 2024. The largest increase occurred from 2019 to 2020, with deaths increasing by 55% from 217 to 338. The first significant decline in PEH deaths in several years was in 2024 with a 25% decrease from 2023.
- Similar to the 2023 Homeless Death Review Committee Report, the PEH decedents are predominantly male (78%), white (54%), and the average age of the decedents is 49 years old.
- For the fourth straight year, accidental death continues to be the leading manner of death among the PEH. In 2024, 60% of PEH died as the result of an accident, the same percentage as 2023. Accidental death first became the majority of PEH deaths in 2019.
- The leading cause of death among accidental PEH deaths was drug-related. Drug-related deaths account for 166 accidental deaths (44%), with fentanyl being a factor in 117 of those deaths.
- The second most common category of unintentional injury deaths was due to PEH being hit by motor vehicles while walking. In 2024, 34 PEH were hit and killed by motor vehicles while walking; 29 (85.2%) were under the influence of drugs and/or alcohol at the time of the incident.
- Seventy-two percent of PEH decedents (271) 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 15% from 2023 (319).
- According to HMIS data, only 8.5% (32 of 378) of individuals who died in 2024 while experiencing homelessness were enrolled in a shelter at the time of their death.
- When examining shelter utilization over an individual's lifetime, only 18.8% (71 of 378) had ever been enrolled in an Orange County shelter.

## HOMELESS DEATH REVIEW COMMITTEE AFTER ACTION ITEMS

Looking ahead, the priority for the Committee in 2026 will be to continue to conduct a more comprehensive review of PEH deaths that occurred in 2025. With the recently passed legislation (AB 271) going into effect in January of 2024, the Committee will be able to share more personalized information amongst each other, allowing for a more detailed analysis of the data available.

## APPENDIX A

Table 3: City

Table 3: City where death occurred among PEH		
CITY	Number	Percent
Aliso Viejo	2	0.53%
Anaheim	58	15.34%
Brea	1	0.26%
Buena Park	10	2.65%
Capistrano Beach	1	0.26%
Costa Mesa	19	5.03%
Cypress	1	0.26%
Fountain Valley	11	2.91%
Fullerton	16	4.23%
Garden Grove	29	7.67%
Huntington Beach	23	6.08%
Irvine	11	2.91%
La Palma	2	0.53%
Laguna Beach	5	1.32%
Laguna Hills	4	1.06%
Laguna Woods	1	0.26%
Lake Forest	6	1.59%
Los Alamitos	1	0.26%
Midway City	1	0.26%
Mission Viejo	5	1.32%
Newport Beach	3	0.79%
Newport Coast	1	0.26%
Orange	33	8.73%
Placentia	2	0.53%
Rancho Santa Margarita	2	0.53%
San Clemente	1	0.26%
San Juan Capistrano	4	1.06%
Santa Ana	87	23.02%
Silverado	1	0.26%
Stanton	9	2.38%
Tustin	9	2.38%
Westminster	17	4.50%
Whittier*	2	0.53%
<b>TOTAL</b>	<b>378</b>	<b>100%</b>

**Table 3** summarizes the location of incident leading to death for the 378 PEH decedents in 2024.

\*Although Whittier is in Los Angeles County there were 2 separate individuals who were transported to an Orange County hospital and died. The Orange County Coroner Division took jurisdiction of both decedents; however, their initial incident location was in the city of Whittier.