Medical Examiner's Office

Report of the 1999-2000 San Francisco Civil Grand Jury

SUMMARY

The 1999-2000 San Francisco Civil Grand Jury (CGJ) reviewed the San Francisco Medical Examiner's Office (the MEO). The initial impetus for this review was generated by third-party and anecdotal information and concerns as to alleged unfortunate and insensitive interaction with officials of the MEO investigators-response team and members of the public. After commencing the review, the CGJ became aware of an audit conducted by the Board of Supervisor's Budget Analyst and submitted to the San Francisco Board of Supervisors on April 18, 1997.

The CGJ concludes that the MEO Investigator/Response Team, individuals facing extremely difficult challenges each day, are a dedicated group of individuals who conduct their duties professionally and compassionately. Not only does an extensive background check secure quality applicants, but the investigators receive very thorough training by the MEO. The CGJ also concludes that many of the critical items set forth in the Budget Analyst's audit have been corrected. The CGJ has determined that other criticisms set forth in the audit were either not warranted or were not in need of further review or recommendation on the part of the CGJ.

The CGJ makes several recommendations, including greater availability of MEO department information, establishment of a method to notify affected parties if MEO representatives are going to be delayed, and consideration of contingency plans in the event of retirement by the current Chief Medical Examiner.

BACKGROUND

The MEO is mandated by Section 24010 of the California Government Code. This law allows a county board of supervisors to abolish the office of the coroner and provide instead for the office of a medical examiner to be appointed by the board and to exercise powers and perform the duties of a coroner. As against a "coroner," a position usually occupied by or appointed by a County Sheriff, a Medical Examiner shall be a licensed physician and surgeon duly qualified as a specialist in pathology. Prior to 1996, the MEO was under the jurisdiction of the office of the Chief Administrative Officer. Under the 1996 Charter Reform, the position of the Chief Administrator Office was replaced by the position of City Administrator. The MEO now reports to the Director of the Department of Administrative Services.

The duties of the MEO are many, varied, highly technical and of such a nature that failure to properly and professionally follow statutory guidelines and accepted procedures could lead to significant liability being assessed against San Francisco. Indeed, the MEO is governed and constrained by well over 150 sections of the California Welfare and Institutions Code, Government Code, Health and Safety Code, Code of Civil Procedure, Labor Code, Penal Code, Probate Code, Business and Professions Code and Vehicle Code as well as numerous federal statutes and regulations.

The foremost responsibility of the MEO is the investigation and certification of a variety of deaths. These include death by homicide, suicide, following injury, where there has

been medical attendance of less than 20 days, where there has been no physician in attendance, where the physician was unable to state the cause of death or by suspected food, chemical or drug poisoning. Additionally, investigation is made of occupational or industrial deaths, or deaths where a patient has not fully recovered from an anesthetic, deaths in operating rooms, solitary deaths, all deaths in which the patient is comatose throughout the period of the physician's attendance, deaths of unidentified persons, deaths in which there are grounds to suspect that a death occurred in any degree from a criminal act, deaths involving contagious disease, deaths in prison or while under a sentence, all deaths associated with a rape, all deaths related to or following an abortion and all deaths involving a violent act or resulting from starvation, exposure, alcoholism or drug addiction.

Closely associated with responsibility for investigation and certification of deaths, the MEO is charged with protecting and safekeeping property belonging to deceased individuals, conducting inquests where indicated, maintaining proper public records, making reports to other agencies, identification of deceased persons, interment of the indigent and many other death-related activities.

The MEO interacts closely with state and the municipal agencies. In this connection the MEO provides crucial information used by the District Attorney's office and the Public Defender's office in the prosecution of suspects. Working in conjunction with the State Department of Health Services and the City and County of San Francisco Department of Public Health, the MEO participates in studies tracking AIDS cases and AIDS-related deaths in the City.

The MEO has been a pioneer in Sudden Infant Death Syndrome (SIDS) research. MEO participation in the "Back To Sleep" program has been the subject of wide praise. As mandated by §462 of the California Health and Safety Code, the Chief Medical Examiner participates on the California SIDS Advisory Committee.

The MEO is very concerned with the subject of child abuse. Review is made not only of deaths involving suspected child abuse but injuries resulting from child abuse. It should be noted that this is another distinction between a medical examiner and a coroner. A medical examiner as against a coroner may be concerned with injuries to living persons. The coroner is concerned with death cases exclusively. With respect to possible child abuse, the MEO may be contacted by Child Protective Services, hospitals, pediatricians, the juvenile department, the police department or the district attorney's office. Following review, if the MEO determines that there is a case of child abuse, the MEO is mandated to file a written report with the State Attorney General's office.

As required by law the MEO analyzes specimens taken from individuals suspected of driving under the influence of alcohol or being under the influence of illegal narcotics. The MEO has prepared a kit which is distributed to appropriate authorities with directions as to how to draw the samples. The samples are then sent to the MEO for analysis. Closer related to this function is the analysis of samples collected from police and fire department applicants.

California Government Code mandates that the MEO be concerned with alleged abuses in nursing homes. The MEO reviews all deaths occurring in nursing homes and is quite often able to spot elder abuse. Referrals are from Adult Protective Services as well as hospitals and other authorities. As in the situation with child abuse, when the MEO

suspects elder abuse there is mandated a written report to the State Attorney General's Office.

The MEO is also responsible on occasion to examine alleged poisoned animals. This is not mandated by law but the MEO has taken on the duty where veterinarians have determined that an unusual poison may be involved.

METHODOLOGY

In carrying out the examination, the CGJ on several occasions met and conferred with MEO administration and staff. The 1997 audit was reviewed in detail, as were the MEO Annual Reports for the fiscal years 1997-1998 and 1998-1999, as well as assorted "in-house" MEO material regarding employee training and safety issues. Review was made of hundreds of letters from members of the public that were delivered in response to solicitations for information from the MEO. Three lawsuits filed against San Francisco which involved the MEO were reviewed. Interviews and correspondence were had with representatives of the City Attorneys office, the Police Department, the Department of Administrative Services and the Judiciary. A solicitation for information from the District Attorney's office was not responded to.

RESULTS OF INVESTIGATION

The MEO budget for the fiscal year 1998-1999 was $3,557,167. The budget for the fiscal year 1999-2000 is $4,109,513.00.

An organization chart covering the MEO is attached to this report as Attachment 1. As noted above, the Chief Medical Examiner has extensive experience and is highly regarded by his peers. His present salary is $157,383 per year. He receives no compensation for being called back to the office evenings or weekends. The Assistant Medical Examiner's salary is $149,370 per year. In addition, he receives compensation for stand-by, call back, and weekend and holiday time. The specific salaries of the toxicologist, pathologist and investigators will be discussed later in this report.

As required by law, the MEO submits to the Mayor, Board of Supervisors and Director of Administrative Services an Annual Report. The CGJ has reviewed the last three Annual Reports. They are detailed and informative. During the fiscal year 1998-1999, there were 7,188 deaths in the City and County of San Francisco. Of these, 4,449 were reported to the Medical Examiner. 2,828 were investigated and cleared for a physician's signature. The remaining 1,621 cases were accepted and reviewed by the MEO. The manner of death, whether accidental, homicide, suicide, etc. is set forth in the Annual Report. The manner of death by race, by age, and sex is also delineated with appropriate graphs and statistics. A ten-year comparison of the Medical Examiner's cases includes the number of cases and the manner of death by race, age, and sex. Sadly, a significant portion of the annual report is devoted to deaths resulting from drug abuse. The number of deaths involving drug abuse and the incidents by sex, race, age and alcohol involvement is detailed. Finally, and perhaps of particular interest to other City agencies, a detailed review is given as to vehicular deaths. It is of particular note that 32% of the vehicular deaths during fiscal year 1998-1999 were suffered by pedestrians.

Review of the MEO in Conjunction with the 1997 Budget Analyst's Audit

The 1997 audit initially determined that the Chief Medical Examiner was very well respected in the forensic pathology community and was certified by the majority of the western states in Western Canada as a forensic expert. This recognition was of great value to San Francisco and has been a key factor in generating the City's reputation in providing the highest quality forensic services. Furthermore, the MEO staff was extremely dedicated. The employees faced difficult challenges interacting with the public during stressful and emotional times. Finally, while there were reported incidents of citizens who were not pleased with the outcome of investigations or other interaction with the MEO and the investigators in particular, after reviewing incidents that were brought to the analysts' attention, the report indicted that the investigator's responded appropriately and acted in accordance with the established laws of the State of California and existing policies and procedures of the MEO.

However, the audit found serious concerns with a number of aspects of the MEO. The audit report faulted the MEO with respect to several Occupational Safety Health Administration (OSHA) violations. With respect to the testing by the MEO of office employees for communicable diseases, the audit determined that while California law requires written consent prior to testing any person for the HIV virus, two employees contended in 1994 that the MEO tested them for HIV without their implied or written consent. These tests resulted in two lawsuits against the City. The audit report also faulted the MEO with respect to sanitary conditions and the use of universal precautions to reduce the risk of infection to MEO staff, understaffing and inappropriate procedures in the toxicology lab, inadequate staffing and procedures in the pathology department, failure to notify the police department and district attorney of all inquests, and inadequate staffing and procedures in the investigation's department.

A. OSHA

The CGJ reviewed several OSHA citations. The first, issued in November of 1992 included allegations of inadequate documentation of safety and health training for each employee. In January of 1993, this citation was withdrawn after OSHA reviewed additional data. Another citation was issued in August of 1994. This citation related to improper use of formaldehyde and failure to have certain regulated waste containment procedures. The matters were abated and the citation was withdrawn. A 1997 citation regarding ventilation and an exhaust system in the autopsy room was abated in September of that year.

The 1997 audit expressed concern with the apparent reuse of disposable needles and syringes. The 1997 audit did acknowledge that there are no OSHA regulations regarding the reuse of needles. However, the audit cautioned that OSHA regulations regarding the proper treatment and handling of contaminated needles were not being followed.

The MEO maintains a Written Exposure Control Plan for Compliance with the Cal-OSHA Blood Borne Pathogen Standard in Compliance with Title 8 of the California Code of Regulations, Section 5193. The Plan is kept current to comply with changing regulations. The most recent revision was that on June 30, 1999. The Plan is applicable to all MEO employees who may be exposed to blood or other potentially infectious materials. The Plan is made available to all employees who are required to be familiar with it and failure to follow procedures outlined therein may result in disciplinary action.

All employees of the MEO who have occupational exposure to blood-borne pathogens shall participate in a training program covering:

- applicable regulations;
- an explanation of the epidemiology, symptoms, and modes of transmission of blood-borne pathogens;
- an explanation of the MEO Exposure Control Plan;
- an explanation of methods for recognizing tasks and other activities that may involve exposure to blood and other potentially infectious materials;
- an explanation of the use and limitations of methods that will prevent or reduce exposure and proper use, location of, removal of, handling, decontamination and disposal of personal protective equipment.

The Forensic Laboratory Manager reports directly to the Chief Medical Examiner and is responsible for all employee training and the updating of all applicable governmental regulations regarding the MEO.

The CGJ is satisfied that the MEO is following OSHA regulations regarding the proper treatment and handling of contaminated needles. Specifically, the MEO Exposure Control Plan dealing with "reusable sharps," which include needles, provides that all needles and other disposable sharps shall be disposed of in a puncture resistant container immediately or as soon as possible after use; disposable sharps shall not be reused; contaminated needles and sharps shall not be sheared or broken. Containers for contaminated sharps shall be easily accessible and located as close as feasible to the immediate area where the sharps are used and immediately or as soon as possible after use, contaminated sharps shall be placed in a puncture resistant leak proof container. Reusable sharps or needles that are contaminated with blood or other potentially infectious materials shall not be stored or processed in a manner that requires employees to reach by hand into the containers where the sharps have been placed. A picking tool shall always be used to remove reusable sharps from the container. In other words, placing sharps in sponges is prohibited. Sharps containers when filled are to be taped and disposed of as medical waste. The CGJ concludes that the concerns raised in the OSHA citations and the audit are satisfactorily resolved.

B. Testing of Employees for Communicable Diseases

The 1997 audit recited that in 1994 two employees of the MEO contended that they were tested for HIV without their implied or written consent contrary to law. These alleged acts resulted in charges being filed with the Equal Employee Opportunity Commission (EEOC) and lawsuits against San Francisco.

The CGJ review has determined that the lawsuits [1] were dismissed with no damages being assessed against San Francisco and that the MEO is in full compliance with respect to all legal requirements regarding testing for HIV, Hepatitis B, Tuberculosis and other communicable diseases.

The CGJ has determined that, at best, the complaint to the EEOC and the lawsuits resulted from communication errors. The required consent form was, in fact, in place at the time of the testing. The courts dismissed both matters.

The MEO Exposure Control Plan also provides for recordkeeping by the MEO regarding every employee with occupational exposure. These records shall include the name and

social security number of the employee, a copy of the employee's Hepatitis B vaccination status, a copy of all results of examinations, medical testing and follow-up procedures, and a copy of any health care professional's written opinion. The confidentiality of this material is specifically spelled out in the Exposure Control Plan. Included within the Appendices to the Exposure Control Plan are copies of a Hepatitis B vaccination declaration and a release for HIV testing. With respect to the Hepatitis B vaccine declaration which calls for the signature of the employee, it is clearly set forth that due to occupational exposure to blood or other potentially infectious materials, the employee may be at risk of acquiring Hepatitis B. The employee is given the opportunity to be vaccinated at no charge. The employee may, if he or she wishes, decline to be so vaccinated. However, by declining the vaccine the employee understands that the risk of acquiring Hepatitis B continues. The employee can at a later date choose to be vaccinated.

The release for HIV testing clearly specifies that on the date executed, the employee is requesting to have his blood drawn for HIV testing. He or she understands that the test is totally voluntary. The employee can elect to have the test done by another lab or physician other than at the MEO. The test results will be given to the Chief Medical Examiner who will give the employee the results in private. The test is shielded so that only the employee and the Chief Medical Examiner will be aware of the results. The release for HIV testing will be kept as a record in the employee's medical file. Only if requested in writing will the results of the HIV test be placed there.

The CGJ concludes that the concerns raised in the 1997 audit regarding testing of employees for communicable diseases are covered.

C. Sanitary Conditions

The 1997 audit expressed concern with the state of the autopsy area. On investigating this matter the CGJ is satisfied that the observations made in the 1997 audit reflected an isolated incident. At the time of the auditor's review, the autopsy area was active with ten autopsies having been done that day. The one autopsy technician available was cleaning as rapidly as possible. The CGJ observed the autopsy area on three different occasions. On all occasions it appeared clean and sanitary. Finally, it should be noted that the MEO Exposure Control Plan provides in detailed format for the maintenance of a clean and sanitary work site. With special reference to the autopsy room, cabinets, drawers and work surfaces shall be thoroughly cleaned daily with disinfectant. All blood, dirt and grime on work surfaces shall be removed immediately. Plastic sheets on work surface tops shall be changed daily. Doors and equipment such as paper towel holders and telephones shall be cleaned with disinfectant daily. The autopsy tables, tops, sides and area underneath, sinks and other fixtures shall be cleaned with disinfectant after the final autopsy of the day.

The CGJ is satisfied and concludes that the concerns raised in the 1997 Audit are no longer on point.

D. Toxicology

Toxicology is the study of the interaction of foreign compounds, such as drugs, with living organisms utilizing sophisticated machinery and more common procedures, biological samples such as blood, urine, gastric contents, liver, etc. These tests are

directed towards determining a cause of death as well as in evaluating significance of chemicals found in the living.

The 1997 audit found that, at that time, the MEO was not staffed with a Forensic Toxicologist. The position was eliminated during the fiscal year 1993-1994 budget process and later replaced with an Assistant Forensic Toxicologist II position. The Chief Medical Examiner assumed management and supervisory duties. The audit concluded that the Chief Medical Examiner spent less than five hours per week in the toxicology laboratory, which was an inadequate amount of time to provide overall management of the laboratory, supervise the laboratory staff, validate new drug assays and maintain a quality assurance program. While the audit determined that the MEO needed a Forensic Toxicologist to provide these duties, the audit recommended that the MEO utilize the existing Forensic Laboratory Manager to perform these duties. The Forensic Laboratory Manger could serve as the Chief Forensic Toxicologist to conduct appropriate staff training resulting in a more equitable redistribution of the workload.

The CGJ disagrees with the 1997 audit. The Chief Forensic Toxicologist referred to in the audit had been on staff for 13 years. During that period of time he had done none of the activities recommended in the audit. The particular Chief Forensic Toxicologist was laid off as a result of a 1993-1994 budget process. He filed an unlawful termination lawsuit, which was eventually dismissed. However, as it had gone up on appeal the MEO was forced to leave open the position for several years. The CGJ notes that, in addition to the 1997 audit general description of the duties of the Forensic Toxicologist, the Chief Medical Examiner, in "filling in" as Forensic Toxicologist, spends time going to court on relatively mundane matters such as driving under the influence cases, routine testing and dealing with attorneys both prosecution and defense who often call for expert advice on certain aspects of toxicology. All of this results in inhibiting the Chief Medical Examiner's ability to deal with situations more appropriate for his attention as Chief Medical Examiner. In relation to this point the CGJ has determined the Chief Medical Examiner spends 20-30 hours per week as "acting" Forensic Toxicologist rather than the five hours per week mentioned in the 1997 audit. Finally, the recommendation in the 1997 audit that the Forensic Laboratory Manager perform duties presently assigned to the Forensic Toxicologist is not realistic. The Forensic Laboratory Manager has specific and important duties and functions such as record keeping, assuring that the MEO practices are in compliance with State and Federal Regulations as well as assorted other administrative tasks. The Forensic Laboratory Manager's present duties allow no time to assume the duties of Forensic Toxicologist. Finally, it must be noted that the present Forensic Laboratory Manager is trained in pharmacology not toxicology.

The problems presently facing the Forensic Toxicology Section are not of the type that will be cured by moving people around or changing job titles. The problem is money. More specifically, the lack of money to attract qualified applicants.

As noted above, the position of Chief Forensic Toxicologist is presently vacant with the Chief Medical Examiner handling supervision of management of the section. The position of Chief Forensic Toxicologist is budgeted at $110,610 per year. However, as a result of the passage of time, occasioned by the former Forensic Toxicologist having been laid off with a resulting lawsuit and appeal, the competitive salaries for a Forensic Toxicologist now have risen to $120,000 to $140,000 per annum. Furthermore, as a

result of salary increases over the years, the salaries of the Assistant Forensic Toxicologists now approach the $110,610 per annum that is allocated for a Forensic Toxicologist. The MEO advertised diligently to fill the position of Forensic Toxicologist. No one with appropriate qualifications replied to the advertisement.

E. Pathology

The Clinical and Forensic Pathology Section of the MEO is budgeted for five Forensic Pathologists, three Forensic Autopsy Technicians, and two Clinical Laboratory Technologists or Scientists.

In general, pathologists conduct autopsies. However, Forensic Pathologists within the MEO have additional duties. Where death has resulted from a crime they go to the crime scene and participate in the scene investigation. In so doing they gather evidence and interpret evidence on the scene. They advise appropriate representatives of the police department as to what should be collected. Having gathered this evidence, together with the conducting of the autopsy, the pathologists are able to determine the circumstances and manner of death.

The 1997 audit expressed concern as regarding the Pathology Department. More specifically it concluded that Forensic Autopsy Technicians were not being utilized to their potential and there was a lack of proper training for pathology staff and the workload in the pathology department did not appear to justify the current authorized staffing level of Forensic Pathologists.

The CGJ disagrees with the 1997 audit on these points.

With respect to utilization of Forensic Autopsy Technicians to handle duties of Forensic Pathologists, the National Association of Medical Examiners clearly mandates that Technicians do not and should not do autopsies. Indeed, the duties of the Technicians at the MEO involve merely setting out the remains prior to the autopsy, setting up the various instruments and supplies that are needed for the autopsy, assisting in the autopsy by handing instruments to the Pathologist, cleaning up the body, releasing the body to a funeral home, and taking personal property to the police department property room.

With respect to the workload of the Pathology Department the statistics relied upon in the 1997 audit were faulty. The audit reviewed the overall case load of the MEO, divided that by the five budgeted Forensic Pathologist positions and determined that regardless of the number of full autopsies being performed, the overall case load in San Francisco did not justify the need for five Forensic Pathologists. This determination was made in comparison with other jurisdictions. However, the audit overlooked the fact that at the time in question there were only two Forensic Pathologists on staff with the Chief Medical Examiner acting as one. In actuality, rather than the 263 full autopsies alleged to have been performed by each Forensic Pathologist, the two Forensic Pathologists performed over 800 full autopsies during the period in question.

Another factor not considered in the 1997 audit is that the San Francisco MEO, unlike other jurisdictions, performs autopsies seven days a week. The Chief Medical Examiner has directed this being sensitive to the average person's desire to bury a loved one as soon as possible and being cognizant of religious beliefs mandating early interment.

As with the Forensic Toxicology Section, the primary problems in the Pathology Section involve lack of appropriate funding. Ideally, the Pathology Department should be staffed with five Forensic Pathologists. While budgeted for five Forensic Pathologists, the section presently only has two filled positions. This requires the Chief Medical Examiner to also participate in conducting autopsies. An additional Forensic Pathologist is scheduled to begin work on June 12, 2000. However, it takes up to two months of intensive training and interface with other members of the MEO team before a new Forensic Pathologist is qualified to conduct "calls" or crime scene visits. The MEO is attempting to retain a fourth Forensic Pathologist. To date, the budgeted salary for a Forensic Pathologist, $152,346.00 appears not to be sufficient remuneration to attract qualified candidates.

F. Inquests

Section 27491.6 of the California Government Code allows the MEO to hold inquests to determine the circumstances and manner of death in cases that are within the MEO's jurisdiction. An inquest is a formal court proceeding that is conducted to provide information that will assist in determining the manner in which an individual died. In many cases the inquest serves to determine whether the manner of death should be noted as suicide or accident. Other reasons for holding inquests would include monitoring the quality of services provided by after hospital care facilities, monitoring the quality of service provided by hospital emergency treatment, establishing a record of incidents occurring at licensed care facilities if there is a question or concern about treatment or decision making processes, and providing families with a means of addressing concerns regarding the death of a family member and the circumstances surrounding that death. With respect to the latter, the Chief Medical Examiner specifically noted to the CGJ that an inquest can serve to give a family their "day in court" and hopefully some degree of assistance in healing and closure. The parties may have an attorney present at the inquest but the attorney may not ask questions. Questions and statements can be presented to the Medical Examiner relative to the inquest.

The 1997 audit concluded that while inquests may be requested by the Attorney General, District Attorney, Sheriff, City Attorney, or Chief of Police, they are generally held at the discretion of the Chief Medical Examiner. Such being the case, the 1997 audit concluded that they are generally held without representatives of the Police Department or the District Attorney's office being present. Thus the Police Department and District Attorney's office may not be alerted to situations that would warrant further investigation due to questionable responses or behavior of witnesses in the inquest process.

As noted above, the California Government Code places absolute discretion in the MEO as to whether or not an inquest should be had. The CGJ, having discussed this issue in detail with the Chief Medical Examiner as well as with representatives of the Police Department, is satisfied that the Medical Examiner always notifies appropriate agencies of an inquest which may be of interest to them. The appropriate contact in the Police Department advised that he had worked with the Medical Examiner for the past four years. He has always received appropriate notification of inquests. This is a particular concern in the area of child death, domestic violence death, or inconclusive or

suspicious death. As noted earlier in this report, the CGJ made inquiry of the District Attorney's office relative to the issue of inquest. No response was received from the District Attorney's office. The Chief Medical Examiner has advised the CGJ that he conducts 30-50 inquests per year. He would like to do more but is prohibited by constraints on his time.

G. Investigations

The Investigations Division is responsible for investigating the circumstances of death of all cases which come within the jurisdiction of the MEO. As presently constituted the section includes one Chief Investigator and 11 Medical Examiner Investigators. In actuality, there are presently eight Investigators on staff. One position is unfilled and two investigators are out on long-term disability. The Investigation Section includes the individuals who are dispatched to a scene where a death has occurred. It is their duty to determine if the death is one that falls within the jurisdiction of the MEO. In addition to confirming the death of the individual and dealing with families or friends on the scene and later removing the remains, the investigation section is responsible for scene investigation which includes reconstruction and analysis, evidence collection and testing, blood spatter analysis, and interpretation and trace evidence collection.

The 1997 audit voiced concern regarding the Investigation Section. The audit concluded that the Section was overstaffed in permanent investigator positions. Part-time drivers were being paid the same salary as entry-level investigators although drivers did not possess the same licensing and other qualifications as full-time investigators. The audit recommended that the MEO prepare a comprehensive training program for all investigators. Furthermore, the number of investigator positions should be reduced by one position to a total of ten positions. Finally, it was recommended that in cooperation with the Human Resources Department the MEO formerly create a part-time Driver Classification resultant of a decrease in salary requirements.

The CGJ disagrees with these points raised in the 1997 audit.

The MEO does not include within the investigation section "drivers" part-time or otherwise and no such category is budgeted. As noted above, the investigator's duties are highly sensitive and the proper engagement of those duties requires intensive, specialized training. Indeed, investigators once fully trained are sworn peace officers. The tasks attended to by investigators could not be conducted by untrained drivers and any attempt to do so could subject the City to potential liability. The MEO has used part-time drivers on certain occasions when the investigation section was seriously understaffed. However, the drivers were limited to just that, driving the ambulance. The part-time drivers were recruited from other City departments. Their salaries were already fixed. If those salaries approached the salaries of entry level investigators, as alleged in the 1997 audit, there was nothing the MEO could do about it.

There are presently in place and coming on line various state and federal programs allowing for further training or "post certification" of investigators. These programs which include formal two-week courses on various subjects including fingerprinting, detection of trace evidence and other subjects are geared toward establishing a minimum national standard for death investigation. The programs are not open to persons other than previously trained and licensed investigators. Specifically, they are not open to drivers. To engage drivers at a lower salary than investigators to conduct or participate in the

duties of investigators might, in the short run, save money. However, in the long run it will result in poorer investigations and as investigators would include persons not deemed to posses minimum training for death investigations, could lead to lawsuits and serious liability being assessed against the City.

Sensitivity and Interaction with the Public

As noted in the introduction to this report, the initial impetus for the CGJ review of the MEO was third-party anecdotal information and concerns as to alleged unfortunate and insensitive interaction with officials of the MEO Investigators-Response Team and members of the public. Indeed, during the period of the CGJ review an article appeared in the San Francisco Chronicle regarding an alleged insensitive and unfortunate incident where allegedly investigators from the MEO did not properly attend to a death with resulting emotional anguish to the family. [2]

After thoroughly reviewing this area, the CGJ is pleased to concur in the conclusions of the 1997 audit that the investigators and indeed the entire MEO staff have responded appropriately and acted in accordance with established laws of the State of California and existing policies and procedures of the MEO.

A. Initial Visual Impressions

For members of the family, or the general public, the first person or persons from the MEO that the family or member of the public will have contact with is a representative of the Investigator's Section. It is essential that the Investigator be able to immediately, effectively and sensitively deal with the situation. With respect to initial visual impression the MEO mandates appropriate dress regulations including a coat, trousers, shirt, tie, shoes, etc. The investigators are in fact "uniformed." They wear a badge on their left breast and name tags are to be worn on their right breast opposite a star. There is an initial visual impression of professionalism.

B. Order of Response

Members of the Investigation Section are thoroughly trained with respect to operational procedures. The MEO provides for an order of response giving priority to certain situations. First response is to a homicide. In descending order, the required response to a situation where a decedent is in public view then is:

- a death with family members at the scene;
- a death with police officers at the scene;
- solitary deaths;
- death in a hospital emergency room;
- death in a hospital, convalescent hospital room, rest home or board and care home;
- indigent cases.

C. Delayed Response

The CGJ closely reviewed with the MEO the issue of delayed response to a call regarding a death. This was an area where the CGJ received anecdotal information. The Chief of the Police Department advised the CGJ that representatives of the MEO are more often than not on the scene before the police arrive. However, the Chief Medical Examiner did acknowledge that there were often delays with respect to

representatives of the Investigation Section arriving at a home where family members were on the scene. As noted above, this chiefly involved a situation where the Investigation Team was required to attend to a homicide case or a situation where there was a decedent in public view. As noted above, these situations have a higher order of response than the situation involving a death with family members on the scene. The MEO Administrative Guidelines Manual does provide that if the investigation representatives are going to be delayed, the investigators should telephone the MEO to advise of the delay. The CGJ recommended to the MEO that if the investigator cannot arrive at the scene of the death within one hour of advising the parties on the scene, (particularly the situation involving deaths with family members present), they should telephone the individuals at the scene, explain the delay and give an approximate time of arrival. It is recommended that the investigator's ambulance contain a cell phone.

D. Public Information

There is available at the MEO in the Hall of Justice several brochures in different languages delineating in a very sensitive and informative manner the duties and functions of the MEO and providing other information to survivors. It is recommended that this literature also be available in the investigator's ambulances so that it may be distributed to the survivors or friends of the deceased at the time the investigators visit the scene.

The CGJ raised with the Chief Medical Examiner the issue of how members of the public may secure help in cleaning a premises that has been the scene of a violent crime. The Chief Medical Examiner advised that it is against the policy of the MEO to steer people to certain crime-scene cleaners. The MEO suggests that people look in the phone book for such services. The CGJ feels that this reticence to inform victims of violent crime as to cleaning services is not warranted. The CGJ does understand that the MEO does not want to be accused of steering members of the public to a particular vendor. Indeed there is a clear policy prohibiting referrals to a particular funeral home. However, it does seem a bit abrupt to advise people who are quite naturally in a state of shock to "look in the phone book." It is the CGJ's recommendation that a master list of crime-scene cleaning services be prepared and made available on request.

E. Cultural and Language Concerns

In that the population of San Francisco is so diverse in incorporating the number of recent immigrants from cultures that do not or may not understand the duties and functions of the MEO, it is particularly appropriate that the MEO be sensitive to difficulties in dealing with family members in such situations including the refusal of family members to allow access to the decedent or refusal to allow removal of the remains. The MEO Administrative Guidelines Manual provides that where access to the decedent is denied or the family or others refuse to allow removal of the decedent various procedures are to be followed. If the death is by natural causes, the investigators should explain to the family the ramifications of removal and the difficulty of certification of death. The investigators are cautioned to try to talk to one family member. If there is continued refusal it is suggested that the Investigator call the MEO. Contact with a clergyman or physician is suggested. Attempts should be made to get an outside friend, relative or professional involved. Finally, the investigators are instructed to be courteous and polite at all times.

The CGJ has determined that the inability of certain members of the public to speak English has not presented a significant problem to the effective operations of the MEO. In those situations where there is not present a family member or friend who can translate, the MEO calls upon translators from the Police Department or the Department of Public Health.

F. Sudden Infant Death

The very traumatic situation involving sudden infant death syndrome cases is treated in detail in the Administrative Guidelines Manual. The investigators are specifically instructed to never leave a mother by herself. There should be an attempt to ascertain when the husband or partner will be home. Either a neighbor or friend should be present. The investigators must leave SIDS literature with the family and explain that a San Francisco County Public Health Nurse will be calling. Section 462 of the California Health and Safety Code requires in SIDS cases that the County Health Officer or designated agent immediately contact the person or persons who had custody of the infant and explain to such persons the nature and causes of SIDS to the extent that current knowledge permits. It is the policy of the MEO to send a letter to the parents of a SIDS victim. This letter is extremely sensitive, tactful and informative. After initially conveying the utmost sympathy on the loss of the child the letter discusses the state of the knowledge regarding SIDS, appropriate support groups and services and the MEO's particular attention to examining the circumstances of the death in question. A copy of this excellent letter is attached to this CGJ report (Attachment 2).

G. Care of Personal Property

Section 27491.3 of the California Government Code provides that the Coroner or Medical Examiner may take charge of any and all personal effects, valuables and property of a deceased at the scene of death and hold or safeguard the property until lawful disposition thereof can be made. The MEO Administrative Guidelines Manual details treatment of personal effects and property and treats the subject with sensitivity. If a legal next of kin is present at the scene any personal property or effects of the deceased will be removed and a receipt will be given to the next of kin. In a case of solitary deaths, all searches must be conducted by the investigating deputy only. It is emphasized that the investigator must always have a civilian witness at the scene such as the hotel manager, friends, the person who found the deceased, etc. It is specified that clothing should not be destroyed indiscriminately. Any clothing that is clean and appears serviceable should be removed, appropriately wrapped and stored and placed with the deceased. The guidelines note that the staff is to be especially careful with belt buckles or other such accouterments. The one thrown away will be the one "Uncle Harry had for 100 years and is irreplaceable."

H. Complaint Procedures - Responses

The subject of complaints received from the public or other agencies is treated exhaustively in the Administrative Guidelines Manual. Any complaint received must be immediately reported to the Administrator. The caller must be informed that the Administrator will return their call as soon as possible. The person receiving the call shall provide the Administrator with a written statement of the facts concerning the complaint or any alleged deviation from MEO policy. The Department Head or the Chief

Medical Examiner may hold a fact-finding session with the employees concerned in order to establish the facts.

Every month, ten cases are selected at random from cases investigated by the MEO. Form response letters are sent to the survivors. This is a one page document wherein the following questions are asked: (1) Were the investigators who came into the death scene courteous, dressed appropriate, helpful; (2) Did the investigators recommend a specific funeral director; (3) Did the investigators recover the deceased jewelry in front of you; (4) Did the investigators explain why they were taking the family member to the MEO; (5) Comments. The cover letter with this form states that the office:

...recently investigated the death of your loved one. In order to monitor and improve our service to the community, we ask that you take a few moments to complete the enclosed questionnaire and return it in the self-addressed, stamped envelope provided. If you have any questions or concerns that you would like to address to me directly, please feel free to contact me at the number listed below. Signed, [Chief Medical Examiner]

As noted earlier, the CGJ reviewed literally hundreds of response letters received following solicitation by the MEO. There were only a very few complaints. One complaint had to do with the number of police cars in front of the house and officers laughing, etc. Another complaint concerned what was on the death certificate. The respondent felt that the death certificate appeared to make out the deceased as a drug addict which he was not. The respondent wanted the death certificate changed to "natural causes." One response did indicate that the staff was not sympathetic or helpful. However, the respondent indicated that she was in a state of shock and did not understand what was going on. She complained that no one later followed up with a telephone call and that she had to call the MEO. However, the great majority of the responses indicated that the investigators were "dignified," "courteous," "professional," "sensitive," and "went out of their way to locate relatives." Several individuals wrote lengthy comments and indeed some were specifically typed out on a separate page. It is of note that there were no responses that would indicate language or communication difficulties.

I. Public Information

The Administrative Guidelines Manual details regulations pertaining to public information. To foster cooperation and mutual respect between the public, the news media and the MEO, the Chief Medical Examiner or his authorized representatives are designated as the only personnel authorized to release any information regarding decedents. No information regarding a decedent or the circumstances of the death shall be released to the media unless the immediate next of kin has been notified. To assure that authorized personnel are communicating with a relative, the appointed representative of the family, or a member of a law enforcement agency, proper identification will be required before the MEO will release any information. Finally, the Administrative Guidelines Manual provides that, notwithstanding the MEO's cooperative attitude with the public and the media, certain information must be withheld from the public and the media in order to protect the rights of the next of kin.

J. Identification of the Deceased

The visual identification of a deceased friend or loved one is perhaps one of the most traumatic experiences a human being may be called upon to endure. The MEO is extremely sensitive to this issue. It is the policy of the MEO, as addressed definitively in the Administrative Guidelines Manual that, if a decedent is traumatized or in post-mortem decomposition, visual identification should not be utilized. If a family insists on viewing the traumatized and/or post-mortem decomposed decedent, and in the opinion of the investigator/pathologist that decedent is unviewable, every option should be taken to dissuade the viewing. If the family still insists, a waiver should be signed before viewing. It is of note that the Administrative Guidelines Manual specifically states that "common sense should prevail! The viewing room is for identification only, but the office is here to serve the public, and as such each case should be served on its individual merit."

The CGJ investigated the possibility that unauthorized third persons might enter areas of the MEO, specifically the autopsy room or storage area and view the remains of decedents. Indeed there was concern that unauthorized personnel might even photograph the remains. The CGJ is confident that appropriate security now exists to prevent such a happening. Some time ago the Chief Medical Examiner was working late and heard noises in the autopsy room. He investigated and found that the janitor had brought certain friends in to see the autopsy room. The MEO now cleans or otherwise attends to all janitorial services with respect to the autopsy room and other sensitive areas. There is a potential problem with the door utilized by the investigators' ambulances and funeral director's vehicles. This is the original door that was constructed at the time the Hall of Justice was built. While locked and made of steel, the Chief Medical Examiner is concerned that it could be crowbarred open. Were someone to do this and gain access to the MEO and photograph or otherwise take inappropriate action with respect to human remains, the uproar and potential liability to the City would be horrendous. It is strongly recommended that an appropriate requisition be made for the replacement of the existing door with a door matching all appropriate standards for security.

CONCLUSIONS AND RECOMMENDATIONS

Issues raised in the 1997 Budget Analyst audit

The CGJ has concluded that many of the critical items set forth in the 1997 audit have been corrected. Other criticisms were either not warranted or were not in need of further review or recommendation on the part of the CGJ. More specifically, past OSHA violations have been corrected. The MEO Written Exposure Control Plan and the training of employees ensures employees regarding the particular hazards inherent in their duties at the MEO. The lawsuits resulting from alleged testing of employees without their written consent were unmeritorious. All appropriate laws and regulations regarding consent for testing are in place. The MEO is meeting all regulations and requirements regarding sanitation and cleanliness. The 1997 audit's criticisms of the Toxicology and Pathology Departments were not warranted. What problems presently exist in those departments result from salary constraints inhibiting the retention of qualified professionals. The MEO is acting appropriately with respect to cooperating with other departments on the subject of inquests. The investigation division is not overstaffed but is in fact understaffed. Utilizing part-time drivers to handle certain duties

of the investigation could result in serious legal exposure to the City and County of San Francisco.

Sensitivity and interaction with the public

With respect to interaction with the public, the CGJ concludes that the MEO acts with sensitivity and in accordance with established laws and existing policies and procedures of the office. The investigators, the first person or persons from the MEO that the family or a member of the public will have contact with present an initial visual impression of professionalism and act with sensitivity and kindness. While there have been occasions of delayed response those have been relatively few in number and were generally the result of the investigators being diverted to a higher priority call. The CGJ does recommend that appropriate contact be made with family members where a scheduled visit must be delayed. The CGJ also recommends that written information be left with survivors and survivors be advised as to appropriate assistance in cleaning a premises that has been the scene of a violent crime. The inability of certain members of the public to speak English does not appear to present a significant problem to the effective operations of the MEO. The MEO acts with great sensitivity in the area of Sudden Infant Death Syndrome cases. Regulations governing the handling of personal property are detailed and appear to be adhered to. The primary focus of MEO operations is dedicated to dealing sensitively and with kindness towards the survivors of the deceased.

The Chief Medical Examiner

San Francisco is fortunate indeed to have the benefit of the services of the present Chief Medical Examiner. He is a dedicated public servant. As noted earlier in this Report, the CGJ concurs with the impressions expressed in the 1997 audit concluding that the Chief Medical Examiner was very well respected in the Forensic Pathology community which recognition was of great value to San Francisco and is the key factor in generating San Francisco's reputation for providing the highest quality forensic services. The CGJ has noted the extensive time that the Chief Medical Examiner spends at the MEO, including weekends and evenings and the fact that he is subject to being called in at any time. Budgetary constraints require his participation in the Toxicology and Pathology Departments at the expense of his being able to give more attention to general managerial and supervisory duties.

Recommendation (1)

If representatives of the Investigation Team are going to be delayed and cannot arrive at the scene of a death within one hour of advising the parties of the scheduled arrival, the investigators should telephone the individuals at the scene, explain the delay and give an approximate time of arrival. The investigator's ambulance should contain a cell phone.

Required Response

Chief Medical Examiner
Director of Administrative Services

Recommendation (2)

A master list of crime-scene cleaning services should be prepared by the MEO and made available on request to individuals requiring help in cleaning up a premises that has been the scene of a violent crime.

Required Response

Chief Medical Examiner

Recommendation (3)

Brochures currently available at the MEO in the Hall of Justice explaining the duties and functions of the MEO in several languages should also be available in the investigator's ambulances so that it may be distributed to the survivors or friends of the deceased at the time the investigators visit the scene.

Required Response

Chief Medical Examiner

Recommendation (4)

The door to the autopsy room used by ambulances and investigator vehicles is the original door constructed at the time the Hall of Justice was built and is marginally secure. Considering the potential liability of the City should a break-in occur, a requisition should be made for the replacement to a door with appropriate standards for security.

Required Response

Chief Medical Examiner
Department of Public Works
Director of Administrative Services

Recommendation (5)

The present Chief Medical Examiner is a dedicated public servant highly respected in the Forensic Pathology community, as well as with City departments, agencies, and the judiciary. Budgetary constraints currently require his active participation in virtually all aspects of MEO activity. The Chief Medical Examiner will not be with us forever. Appropriate planning and discussion must be commenced to deal with the unanticipated departure of the Chief Medical Examiner through illness or retirement.

Required Response

Director of Administrative Services
Department of Human Resources

ATTACHMENT 1

Medical Examiner's Office Organization Chart

ATTACHMENT 2

Medical Examiner Office Letter to the Parents of a SIDS Victim

Footnotes

[1] As noted above, the CGJ reviewed three lawsuits. Two involved alleged unauthorized testing. The third was a recent action brought by a survivor requesting that the MEO be ordered to change the death certificate from reflecting death resulting from natural causes to death resulting from accident. It is believed that this lawsuit was generated by a desire to recover a double indemnity provision in an insurance policy.

[2] The CGJ investigated this incident. The facts are that when the investigators arrived on the scene there were already present paramedics, police officers and a neighbor. The investigator was advised that the decedent's son in Santa Rosa had been contacted and was coming to San Francisco. The investigator then called the deceased's physician and determined that the death was natural and not under the jurisdiction of the MEO. The investigator then received a call regarding an accident that required his attendance. He so advised the police officer present as well as the other parties on the scene. Very shortly after the investigator left, the funeral director arrived and picked up the remains. It should be noted that the Chief Medical Examiner advised the newspaper of the facts but nonetheless the publication was made which misstated the facts.