

IN THE SUPREME COURT OF THE STATE OF OKLAHOMA
IN THE DISTRICT COURT OF OKLAHOMA

FILED IN THE DISTRICT COURT
OKLAHOMA COUNTY, OKLA.

JUL 20 2009

PATRICIA PRESLEY, COURT CLERK

by _____ Deputy

IN THE MATTER OF THE TWELFTH)
MULTICOUNTY)
GRAND JURY, STATE OF OKLAHOMA)

Case No. SCAD- 2009-18
District Court No. CJ-2009-1925

Multicounty Grand Jury Interim Report

We, the undersigned members of the State of Oklahoma's Twelfth Multicounty Grand Jury, being duly empaneled and sworn inform the Court that we have heard testimony and received exhibits concerning the Office of Chief Medical Examiner for the State of Oklahoma (Medical Examiner Office). This report contains the Grand Jury's findings, recommendations and observations regarding the current state of operations within the Medical Examiner Office. In determining its findings, this grand jury heard lengthy testimony from numerous witnesses and examined various exhibits. Based on the evidence received, the Grand Jury submits to this Honorable Court an interim report as follows:

I.

**Statutory Authority
and
Responsibilities of the Medical Examiner's Office**

Pursuant to *Title 63 O.S. § 933*, the office of Chief Medical Examiner for the State of Oklahoma was established to be operated under the control and supervision of the Board of Medicolegal Investigations (Board). The office is directed by the Chief Medical Examiner and the Chief Medical Examiner may employ such other staff members as specified by the Board. The

Chief Medical Examiner is directly responsible to the Board for the performance of the duties prescribed by law including the administration of the overall office.

In accordance with *title 63 O.S. § 938 et seq.*, the Medical Examiner Office has the sole responsibility of investigating sudden, violent, unexpected and suspicious deaths. Information gained from these medicolegal investigations is frequently required in the form of evidence and expert testimony in both criminal and civil legal proceedings. In some instances, the medical examiner also helps identify potentially unsafe consumer products. The public health function of the Medical Examiners Office is further apparent in the investigation of cases in which poisons, hazardous work environments or infectious agents are implicated. The operations of the Medical Examiner Office have an immeasurable impact on bringing closure to those experiencing unexpected and inexplicable loss, the adjudication of court proceedings and the overall protection of public health and safety.

II.

Overview of Evidence Presented

On its official website, the Medical Examiner Office claims to recognize the sensitive and important nature of its responsibilities. Further, the Medical Examiner Office claims to represent a resource of impartial professionals and support staff providing services to families of victims and the citizens of the State of Oklahoma at-large. Over the past few months, this jury has heard testimony leading it to conclude that there has been either willful blindness or gross incompetence on the part of those responsible for administration of the office. Others who should have been limited in their scope of authority have been allowed to exercise apparent authority over the entire

office overriding the agency's organizational chart. Ultimately, some staff members have suffered at the hands of another. The manner in which the Medical Examiner Office was run has resulted in the office falling short of its true calling. Mal administration has ultimately led to various existing and potential problems identified by the grand jury.

In the State of Oklahoma, the top administrator for the Medical Examiner Office has always been a pathologist. The Medical Examiner Office occupies a position of utmost public trust. The office is given enormous responsibilities. Although the Chief Medical Examiner is the top administrator, for a number of years, many of the administrative duties have fallen to the person who served as chief investigator. One former Chief Medical Examiner testified that he was paid \$235,000.00 a year to be the Chief Medical Examiner and that he only spent approximately 25% of his time performing in an administrative capacity. Based on the evidence collected by the grand jury, administrative duties such as overseeing the day to day operations of the physical offices for the Chief Medical Examiner, hiring and firing staff and setting office procedure and policy were delegated to the former chief investigator. The former chief investigator was used as the funnel through which all decisions were made by Chief Medical Examiners. The grand jury found that what resulted is an abuse of power by the person who served as chief investigator. The extent to which one employee was given unbridled authority is astounding to the grand jury. The grand jury understands Chief Medical Examiners dating back several years were made aware of brewing problems concerning the former chief investigator, however, he was allowed to continue the exercise of what can only be described as absolute power, control and authority over the entire office.

The grand jury concludes that delegation of such a large degree of authority to one person

who was obviously abusive was no less than derelict on behalf of Chief Medical Examiners. For some time, Chief Medical Examiners were made aware that the former chief investigator's behavior, in particular, was abrasive, sexually harassing and sometimes rose to violations of criminal law. The grand jury believes the former chief investigator's conduct could have been stopped by proper oversight.

After listening to testimony, it became evident that comments were made to several women and men that were inappropriate and sexual in nature. Testimony showed that not only did the former chief investigator make the referenced comments, but he set the tone in the office for other males to feel comfortable making similar types of comments to female staff. Testimony indicated that sexual harassment and sexual battery were carried out within the office.

A couple of witnesses testified that they filed grievances in reference to allegations of sexual harassment. The grand jury found that the handling of grievances by those working in human resources did not provide for creating and maintaining files in reference to formal grievances wherein such files would be kept in a secure location separate and apart from other personnel files. In fact, the grand jury learned that documentation concerning the referenced grievances were either lost or stolen and could not be found in personnel files for either the accuser(s) or the accused. The grand jury also found that nothing ultimately happened in reference to the formal grievances. The grand jury is left to wonder whether the former chief investigator's behavior would have escalated to criminal conduct had the grievances for sexual harassment been properly handled. Multiple other witnesses testified that they would have lodged complaints against the former chief investigator and/or others but decided their efforts would be futile because:

- There are no internal procedures for lodging formal complaints;
- Investigations of complaints are not carried out; *and*
- Some complaining parties feared retaliation from the former chief investigator;

In reference to virtually every aspect of the office's operations, there are scarce written policies and procedures for employee reference. Written policies are lacking as to personnel matters as well as protocol for how investigations or cases should be handled. Witnesses including investigators appearing before the grand jury advised that they have questioned why written policies and procedures do not exist in various areas. Some witnesses advised that the former chief investigator, in particular, served as close advisor to chief medical examiners and that the former chief investigator has been quoted as saying "if a policy is in writing then we would have to follow it." Witnesses testified that written policies and procedures don't exist in some areas because the former chief investigator did not want them to be in writing.

As a result of the absence of written policies and procedures, there is inconsistency in how routine practices are carried out by staff. Some individuals have developed best practice rules for self governance. However, even if the staff consists of a majority of individuals who tend to be methodical, leaving each individual to develop his or her own procedure runs the risk of inconsistency within the agency. Furthermore, the absence of written policy and procedure in reference to personnel matters can only result in inequity when resolving the same or similar matters.

It is the grand jury's belief that misconduct and abuse of power incidents don't just happen

out of the blue. It is fairly rare that one finds an inexperienced employee involved in misconduct of the magnitude and degree revealed to the grand jury in this investigation. The grand jury is of the opinion that the absence of structure and weak Chief Medical Examiners for an extended period of time lead to misplaced authority within the Medical Examiner Office.

Contrary to the official web-site, the Medical Examiner Office has failed its mission to carry out its duties professionally. Improvements in the overall management of the office are greatly needed. One of the saddest realities is that some dedicated state employees have been victimized psychologically, emotionally and sexually. We acknowledge that the findings of this investigation probably would not have ensued if the structure within the Medical Examiner Office was more sound. Over the years, many alarms have sounded, however, business has been carried out as usual with Chief Medical Examiners turning a blind eye to the environment cultivated within an agency with few policies and procedures and random enforcement of the few procedures actually in place.

Another area of concern identified through the grand jury's investigation is the Medical Examiner Office's handling of personal property and items thought to have evidentiary value. The grand jury heard testimony that items such as jewelry are not always secured properly. Although there is a safe in the Oklahoma City office where such valuables should be stored, witnesses testified that a standard procedure for securing valuables is not routinely followed. Furthermore, other items which may have evidentiary value such as crack pipes and other drug paraphernalia are not treated as evidence. In fact, employees within the Medical Examiner Office have been allowed to maintain possession of drug paraphernalia taken from decedents. Some employees prominently display their collection of drug paraphernalia on their desks.

Another example of improper handling of evidence is the manner in which a decedent's clothing is handled when drying and/or packaged. Grand Jury evidence documented instances when blood stained clothing was hanging to dry, however, no safeguards were taken to make sure there was no cross contamination with other items located in the same drying area. The grand jury evidence revealed that boxes and bags containing items with potential evidentiary value are located throughout the Oklahoma City Office and are not routinely secured. Open boxes and bags containing evidence are sometimes placed right next to trash receptacles where food and drinks are disposed.

All staff within the Medical Examiner Office must approach each case as if a court-rendered judgment or jury verdict will be affected by the manner in which a case is executed. With that approach in mind, safeguards must not only be in place but strictly applied to ensure evidence is preserved, untainted and reliable.

III. **Recommendations**

After hearing many hours of testimony, this jury makes the following recommendations:

1. Change the structure within the Medical Examiner Office so that the office is managed by an executive or office administrator who is neither a practicing pathologist nor law enforcement officer;
2. Make the Medical Examiner Office a part of the Oklahoma State Bureau of Investigation;
3. If administration of the Medical Examiner Office continues to rest upon a pathologist appointed to serve as Chief Medical Examiner, the Board evaluation of the Chief Medical Examiner must take into consideration the overall operations of the agency in determining the success of a Chief Medical Examiner.
4. Update existing personnel policies and create new ones where needed. Policies must be strictly enforced and there must be a zero tolerance policy in reference to sexual misconduct.

5. Increase security within both the Tulsa and Oklahoma City offices by installing locks and cameras that actually work.
6. Create a protocol for proper handling of evidence which should include, documenting proper chain of evidence, use of proper packaging to safeguard against contamination and setting aside secure space for storage of evidence.
7. Train investigators, lab technicians and others on the proper handling of evidence including, but not limited to:
 - The use of forms which must accompany items of evidence describing the item(s) being secured;
 - The proper packaging and storage of evidence;
 - How to seal each item of evidence (or groups of like evidence items) in separate evidence packages including use of standard materials to staple or tape the containers closed;
 - How to properly dry and package clothing;
 - How to carefully secure all fragile evidence items;

Submitted in open Court this ___ day of July, 2009.

Rachel J. Bishop

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Leshi Smith

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Doug C... [Handwritten signature]

Judy P. Wood

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Chad B... [Handwritten signature]

[Handwritten signature]

[Handwritten signature]

Shawn Beck

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Foreman