MEDICAL EXAMINERS COMMISSION MEETING
Embassy Suites Lake Buena Vista South
4955 Kyngs Heath Road
Kissimmee, Florida
November 3, 2015
10:00 AM

Chairman Stephen J. Nelson, M.D., called the meeting of the Medical Examiners Commission to order at **10:00 AM** at Embassy Suites Lake Buena Vista South, in Kissimmee, Florida. He advised those in the audience that the meetings of the Medical Examiners Commission are open to the public and that members of the public will be allowed five minutes to speak. He then welcomed everyone to the meeting and asked Commission members, staff, and audience members to introduce themselves.

Commission members present:

Stephen J. Nelson, M.A., M.D., District 10 Medical Examiner
Barbara C. Wolf, M.D., District 5 Medical Examiner
Wesley Heidt, J.D., Office of the Attorney General
Hon. James S. Purdy, J.D., Public Defender, 7th Judicial Circuit
Hon. Rick Beseler, Sheriff, Clay County
Robin Giddens Sheppard, L.F.D., Vice President/Funeral Director
Ken Jones, State Registrar, Department of Health
Hon. Angela B. Corey, J.D., State Attorney, 4th Judicial Circuit

Commission members absent:

Carol Whitmore, County Commissioner

Commission staff present:

Vickie Koenig
Kipp Heisterman
Doug Culbertson
Jim Martin

District Medical Examiners present:

Marie Herrmann, M.D. (District 7&24)
Michael Bell, M.D. (District 15)
Joshua Stephany, M.D. (District 9)
William Hamilton, M.D. (District 8)
Russell Vega, M.D. (District 12)
Jon Thogmartin, M.D. (District 6)
Rebecca Hamilton, M.D. (District 21)
Mary Mainland, M.D. (District 13)
Sajid Qaiser, M.D. (District 18)

Other District personnel present:

Jeff Martin (District 1)
Cathy Weldon (District 8)
Jeff Brokaw (District 4)
Craig Engelson (District 18)
Peter Gillespie, M.D. (District 4)
Kim Bynum (District 4)
Lindsey Bayer (District 5)
Vincenzo Recco (District 19)
Bill Pellan (District 6)
Koni Rogers (District 23)

Guests present:

Rebecca Sayer (LifeLink)
Heather Hoag (MEBFL)
Andrew Mullins (LEITR)
Bruce Goldberger, Ph.D. (UF)
James Rosa (LEITR)
Paula Kraft (LEITR)

Vaughn Thornton (LEITR)
Shannon Wilson (Brevard County)
Alphonso Everett (LEITR)
Nick Waite (RTI)
Ricardo Camacho (UF)
Ian Golden (Brevard County)
Nancy Williams (Wuesthoff)
Nico Pratt (RTI)
Michael Warren, Ph.D (C.A. Pound Lab)

A MOTION WAS MADE, SECONDED, AND PASSED UNANIMOUSLY FOR THE COMMISSION TO APPROVE THE AGENDA.

A MOTION WAS MADE, SECONDED, AND PASSED UNANIMOUSLY FOR THE COMMISSION TO APPROVE THE MINUTES OF THE AUGUST 14, 2015, MEDICAL EXAMINERS COMMISSION MEETING.

ISSUE NUMBER 1: INFORMATIONAL ITEMS

- District 14 Vacancy - Dr. Dr. Nelson reported that the Search Committee in District 14 (Bay, Calhoun, Gulf, Holmes, Jackson and Washington counties) had narrowed the list of applicants to two Florida licensed forensic pathologists. Dr. Nelson advised that interviews will be conducted on Thursday, November 5, 2015.

- District Medical Examiner Reappointments - The surveys and assessments for the reappointments of district medical examiners for districts 3 (Dixie county), 8, 10, 11, 12, and 13 will be sent to the constituents of these districts in January 2016.

- 2015 Interim Drugs in Deceased Persons Report – Mr. Heisterman reminded all medical examiner districts that data for the 2015 Interim Report is due January 1, 2016.

- Coverdell Grant Update – Mr. Heisterman advised those in attendance that the 2014 Coverdell grant would be closed out as soon as two receipts are provided. Only $89.93 will be returned from the 2014 grant. Mr. Heisterman stated that as soon as the MOUs for the 2015 were received from the finance office, he would be sending out award letters.

- 2016 Legislative Session – Mr. Martin informed the Commission of the following bills of interest that passed during the 2016 Legislative Session.

  House Bill 73 (Rep. Jacobs): "Relating to Controlled Substances" This bill amends section 893.03, F.S., relating to controlled substances, and adds mitragynine or 7-hydroxymitragynine, the constituents of Kratom, to the list of controlled substances. It provides for an exception for any drug product approved by the US FDA containing these substances, and penalties. Proposed effective date is October 1, 2016.

  House Bill 161 (Rep. Kerner): "Driving or Boating under the Influence" This bill specifies that a person with 5 nanograms or more of delta 9-tetrahydrocannabinol per milliliter of blood commits the offense of driving under the influence or boating under the influence. Proposed effective date is October 1, 2016.

  House Bill 315 (Rep. Roberson) / SB 620 (Sen. Grimsley): "Medical Examiners" This bill amends section 382.011, F.S., to prohibit a district medical examiner or county from charging a member of the public a fee for an examination, investigation or autopsy performed to determine the cause of death pursuant to s. 406.11(1), F.S. The bill allows a county to adopt a resolution or

ordinance to charge a medical examiner approval fee not to exceed $50 when a body is to be cremated, buried at sea or dissected, provided the fee is not charged for a death under the jurisdiction of the medical examiner pursuant to s. 406.11(1)(a), F.S. Proposed effective date is October 1, 2016.

House Bill 4021 (Rep. Vasilinda) / SB 616 (Sen. Bullard): "Cannabis" These bills remove cannabis from the schedule of controlled substances. Proposed effective date is July 1, 2016.

Senate Bill 174 (Sen. Bean): "Cold Case Task Force" This bill creates a task force within the Department of Law Enforcement; specifying membership of the task force that includes a forensic pathologist; prescribing duties of the task force; requiring the task force to submit a report to the Governor and the Legislature by a specified date; providing for expiration of the task force. Proposed effective date is July 1, 2016.

ISSUE NUMBER 2: DISTRICT 18 PROBABLE CAUSE

Dr. Hyma read the findings of the final District 18 Probable Cause Panel report from September 24, 2015 into the record.

During the Probable Cause Panel report to the Medical Examiners Commission at its August 14, 2015 meeting, District 18 Medical Examiner Sajid S. Qaiser, M.D., raised concerns that the Commission did not have all the documentation from the eleven additional cases identified by staff that were copied and provided for review. Based on the concerns raised by Dr. Qaiser, the Commission tabled the Probable Cause Panel's report and findings until the next Medical Examiners Commission meeting. This was done to allow staff to obtain all the case documentation for review and possible revision of the panel's findings.

While staff conducted a preliminary review of the case files immediately following the August 14 meeting, in an abundance of caution, staff requested full copies of all the case files to include photographs. The full case file copies were received on September 3, 2015.

Staff reviewed the case files and compared the contents of the documents originally provided during their onsite inspection to those provided subsequent to the inspection. Seven of the eleven case files originally reviewed contained identical pertinent documentation. However, there were additional documents found to be administrative in nature in these seven files.

There were four cases with additional documentation and changes to original documentation that were not originally provided to staff. A summary of the additional documentation that was not administrative in nature is provided below.

- Case #451 – Loria Lewis: West Melbourne Radiology Results (3 pages), Palm Bay Hospital Emergency Department documents (3 pages), West Melbourne Radiology Results (2 pages), and fifty-four (54) photographs (45 taken on 8/7/14, 9 taken on 8/14/14). The additional records have information that should have prompted an autopsy: IV drug use and septic pulmonary emboli versus metastatic lung cancer. The records were received on August 8, 2014. The body was examined six days later.

- Case #454 – James Barbree: Photographs and the body diagram document a major, recent abdominal surgery. No inquiries about the reason for this surgery are documented.

- Case #489 – Gene Prospero: information highlighted and notations made on the investigative report, Adult Advocacy & Representation documents (2 pages), Wuesthoff Health Systems Collaborative Care Worksheet (3 pages), Wuesthoff Medical Centers History and Physical/Consultation (5 pages), Wuesthoff Medical Center lab results (4 pages), Wuesthoff Rockledge Radiology Results (4 pages), and Wuesthoff Medical Center Physician Documentation (3 pages). Additional records provide a differential diagnosis: heat stroke, rhabdomyolysis, seizures, respiratory failure and ventricular tachycardia. Hospital toxicology urine drug screen was negative for common drugs of abuse with the caveat that results are for medical purposes only and a more specific chemical method such as GC/MS must be used in order to obtain a confirmed analytical result if results are to be used for legal or administrative purposes. The office did not send ante-mortem blood for further analysis.

- Case #555 – Michael Moloney: Seven additional paragraphs were added at the investigative report, Melbourne Police Department Report – Officer S. Smith (7 pages – duplicate copies of pages 1 and 2, dated 8/7/2015), and Melbourne Police Department Report – Officer T. Wash (7 pages, dated 8/7/2015). Photographs have facial injuries suggesting a recent fall. Prescription drugs and ethanol were on the scene.

Probable Cause Panel Review of Additional Cases

The Probable Cause Panel reconvened on September 24, 2015 at the Department of Health in Jacksonville to discuss the additional documentation found in these cases. Mr. Ken Jones and Ms. Robin Giddens Sheppard were present, and Dr. Bruce Hyma and Bruce Goldberger, Ph.D. attended via teleconference. Staff members present were Vickie Koenig, Doug Culbertson and Kipp Heisterman, with Jim Martin present via teleconference.

Staff advised the panel that they did not request copies of the administrative documents or photographs during their onsite inspection. Staff informed the Probable Cause Panel that District 18 Investigator Craig Engleson had informed them that additional documentation had been added to Case #555 after the staff visit in May. Mr. Engleson said that Dr. Qaiser was unaware of the additions, and that no misconduct was intended; however, photographs have facial injuries suggestive of a recent fall and prescription drugs and ethanol were on the scene. The original finding of probable cause stands.

In Case #451 and Case #489, the Panel determined that the omission of the additional documents that were included in the full case request was a copying error. The additional documents in these cases confirmed that an autopsy should have been performed and the original finding of probable cause stands.

In Case #454, photographs and the body diagram document major, recent abdominal surgery. No inquiries about the reason for this surgery are documented.

For the remaining seven cases, the Probable Cause Panel determined that there is nothing in the full case files that would change their previous finding of Probable Cause, except in Case #488 and Case #711, which should not have been medical examiner cases at all. The additional information contained in the other nine case files further supported the previous conclusion that autopsies should have been conducted. The Panel found that nine cases showed a pattern of substandard work, of shortcuts being taken, and that these cases, as well as the McDonough case, support the finding of negligence or the failure to perform the duties required of a medical examiner with that level of care or skill which is recognized by reasonably prudent medical examiners as being acceptable under similar conditions and circumstances.

Conclusions

The panel determined that there has been no change in their opinion stated in the Probable Cause Panel Report dated August 7, 2015, in that probable cause exists that there was a violation of § 406.075(1)(i), F.S. and Rule 11G-2.003(5)(b), F.A.C., by the District 18 Medical Examiner's Office regarding its investigation of the death of John McDonough, as well as the additional cases reviewed at the July 31, 2015 panel meeting.

The panel still believes that the District 18 Medical Examiner's Office needs clear policies and procedures to ensure that this type of violation does not occur again.

The panel recommends that Dr. Qaiser be placed on a probationary period of one year, during which time clear policies and procedures should be enacted that guarantee no family should pay for a toxicology quantification, and that any death in which jurisdiction is taken under similar circumstances will not violate Florida Statutes or Administrative Rule. The recommendation of probation shall include a provision for Commission staff to conduct unannounced random reviews of case files for all external examinations conducted during the probationary period.

The panel is prepared to discuss this matter and the reasoning behind their conclusions.

Following Dr. Hyma's report, Mr. Timothy McDonough, son of the decedent, addressed the Commission and read a statement on behalf of his siblings into the record.

Mr. Chairman and distinguished Commissioners,

Thank you for granting me the time to provide some information on the record in my father's case that is germane to the decision you must make about the conduct of the 18th District Medical Examiner.

I am professor of economics Timothy McDonough, Ph.D. of Dallas, Texas. My sister is Maureen Roddy, RN, of San Francisco, CA, and our brother is retired Oceanside, CA homicide detective Christopher McDonough. We are the biological children of long time Brevard county resident, MgySgt John J. McDonough, United States Marine Corps, retired, age 85 at the time of his death in April 2014 at his home in Melbourne.

It has been more than 19 months since our father's death. The public record reflects the ruling of Dr. Sajid Qaiser, the 18th District Medical Examiner, that the cause of his death is chronic myelogenous leukemia, a disease for which he did not, nor ever did have a diagnosis, and that the manner of his death is accident.

In December 2014, we filed a formal complaint with this Commission alleging that in response to our objection that this absurd public record of our father's death cannot stand, this medical examiner has committed numerous violations of Florida statutes in our father's case and that we, the grieving family of the victim, have been treated by the medical examiner's office as adversaries, a possible violation of federal "color of law" statutes.

Pursuant to the Practice Guidelines for Florida Medical Examiners that you wrote, Mr. Chairman, a medical examiner can handle the provision of the death certificate in one of two ways:

1. Issue a medical examiner death certificate based on inquiry, or

2. Let the physician certificate stand.

The 18th District Medical Examiner has elected option number two in our father's case in spite of the overwhelming medical record evidence that he and his investigators claim to have reviewed in formal inquiry, that shows beyond a reasonable doubt that the hospice physician's report is utterly false and had the hospice physician read our father's medical record he too would have known that our father did not have CML. Dr. Qaiser further defies logic by citing an accidental injury, sustained a month before his death, that the medical records show was healing well and being treated appropriately, as the manner of death. Why not cite that he stubbed his toe two months before as the accident cited in the manner?

We know that there are also efforts to cite end stage renal disease as a cause. Here again, the medical records are clear. Our father sustained an acute kidney injury, caused by a kidney infection, in January 2014, that was being treated with antibiotics, steroids and dialysis. By March 27th, three days before his wife admitted him to hospice with a durable power of attorney dating back to July 2012, his chemistry showed that his bun was 11 mg/l (considered normal), creatinine 1.83 (a little high but just out of normal range) and his EGFR was 37.5 (not considered ESRD range and compatible with life). His nephrologist gave a positive prognosis and evidence of that was the decision to leave in a tessio catheter that could be removed when dialysis was no longer needed and not construct a permanent av fistula for long term dialysis. His kidney function was almost back to his normal baseline when his wife unilaterally ended his dialysis without following the dialysis cessation protocols.

His wife and her daughters inquired about hospice care on January 23, 2014. He was not a party to that inquiry. She formally requested that he be discharged from the Rockledge Rehabilitation Center to long term care on March 6, 2014 but the VA, who was paying for his short term rehab care, refused. The record shows that he was finally discharged home from Rockledge and the reason for the discharge, as documented in the attending physician's discharge summary, was "improved health". Upon discharge he was immediately admitted to hospice care by the sole authority of the wife wielding the 2012 DPOA. There is no record of his consent in spite of the report that on the day of his arrival at home he was alert, in good spirits, had a good appetite and entertained guests with song (he was a classically trained tenor).

Immediately upon arrival home he was administered morphine sulfate (roxanol) by the wife's granddaughter, a licensed nurse who flew in from Colorado on March 27th specifically to care for him. Over the next 72 hours she continued to administer morphine, culminating in a bolus dose of 90mg over an hour and 40 min. On April 5th, part of a 190 mg administration in 24 hrs. The record shows that even after the hospice nurse gave clear and unambiguous instructions to the granddaughter, a nursing professional, to stop the administration of the roxanol, she administered a further 20 mg just 30 minutes after the stop order. As described in the medical record he was already exhibiting cheyne stokes respiration at this point.

Sometime on that same day between 7:30 pm and 11:05 pm our father died. We don't know the time of death as there was no autopsy.

Immediately after his body was transported to the funeral home the wife's daughter called the funeral director who had custody of his body stating emphatically that the family's wishes were that his body be immediately cremated. The funeral director inquired about next of kin and his wife's daughter at first denied that any biological children existed but when she called later she told him that there was an estranged daughter who lived in California but that she was not involved in his life and there was no way to contact her. The funeral director then shocked the

wife and daughters by informing them that his biological children had not only been in contact with him, but that he had a will, naming his son Christopher as his executor. He further informed them that the will stipulates that his body is to be transported to Arlington National Cemetery for a full military honors funeral and interment. His will was properly probated and all of its provisions were executed by court order. He is buried per his wishes. Neither the wife, nor any of her family attended the funeral.

Upon our insistence, the medical examiner agreed to order a quantitative toxicology analysis, but only on the condition that we pay for the test, which we did. The toxicology report fully corroborates the hospice care records that a lethal dose of morphine was administered.

We, his biological children were in frequent contact with our father, in spite of continuous attempts by his wife to isolate him from us. She would routinely unplug his bedside phone at the rehab that we would have to get plugged back in by the duty nurses. We were not allowed to visit their home, nor were any of his grandchildren. The isolation extended to the final days of his life. Just days before his discharge we spoke to him about attending his grandson's Ph.D. hooding ceremony in May at SMU in Dallas. I was going to pick him up with our personal airplane. He never spoke to us about end of life or hospice admission. This is not only odd because his son is the executor to his estate but it is utterly out of character. He has never excluded us from discussions about important life events. Another odd aspect of his admission to hospice is that the hospice record states he did not have advanced directives when in fact he had very clear and concise advance directives that are completely contrary to the purpose of hospice care. His advanced directives were withheld from hospice by his wife.

We were not informed of his admission. We found out by accident and by the time we did find out it was too late. He was already under the heavy influence of morphine and communication was impossible.

In summary, the medical records are clear:

- He did not suffer from chronic myelogenous leukemia as stated on the death certificate nor any other form of cancer.
- His acute kidney injury was healing with a positive prognosis.
- He was administered a lethal dose of morphine by a member of his wife's family, a trained medical professional who no doubt knew the full ramifications of a 90 mg bolus dose of roxanol.
- The cessation of his dialysis was contrary to the established protocol in the profession, there is no language anywhere that he was consulted about the effects of stopping his dialysis or that he participated in the clinical practice of shared decision making with his nephrologist.
- He was alert and fully capable of admitting himself to hospice if he so wished, yet the admission was accomplished solely on the authority and signature of the wife based on a 2012 DPOA.
- He had numerous advance directives that were current and all expressed the same wishes for extraordinary medical effort and categorical denial of DNR.

These facts and numerous other circumstantial facts contained in nearly 800 pages of documentation all clearly repudiate the finding of CML or ESRD as cause of death and that the manner is homicide.

We know that this commission cannot direct a medical examiner to amend a death certificate. We present our case to you so that through you the people of Florida can see that the defiance of

scientific evidence and reason by this medical examiner is prima facie evidence of a gross misconduct and abuse of public trust.

This office has failed our family and has failed the people of Florida who it is mandated to serve. As this agency can no longer be trusted to provide our family and the people of Florida with a truthful determination of cause and manner of death of our beloved father, we therefore have directly appealed to Phil Archer, State Attorney for the 18th Judicial District, serving Brevard and Seminole counties, to submit a petition to the 18th District Court to convene a Public Coroner's Inquest in accordance with Title 47 Chapter 936 of the Florida Statutes, to determine the cause and manner of our father's death.

Neither our family nor the people of Florida can trust that a fair and impartial consideration of the substantial medical and circumstantial evidence of foul play in our father's case can take place behind the closed doors at the 18th District Medical Examiner's Office. Let the public see all the evidence and let a judge, as coroner in a 936 inquest, rule on the cause and manner of our father's death according to the law.

Fortunately for the people of Florida, inquests under this statute are rarely needed to be invoked. But as the family of a man who we allege is the victim of a homicide that this medical examiner's office has attempted to conceal, either by gross incompetence or criminal complicity, it is clearly our right to demand justice under the 936 statute and it is the sovereign right of the people of Florida to benefit from its administration.

Thank you again for your service to the people of Florida and for your patient reception of our tragic narrative.

Dr. Qaiser submitted a seven page letter dated November 2, 2015 to the Commission. This letter provides detailed information regarding his office's involvement with the McDonough case.

Assistant Brevard County Attorney Shannon Wilson addressed the Commission on Dr. Qaiser's behalf. Ms. Wilson stated that there were areas of the Probable Cause Panel's conclusions with which she disagreed. She provided an overview of the timeline surrounding the McDonough case and asked for clarification from the Probable Cause Panel regarding some of its findings and recommendations. However, she stated that a term of probation along with guidance from MEC staff on policy and procedure enhancements would be acceptable.

A MOTION WAS MADE, SECONDED, AND PASSED UNANIMOUSLY FOR THE COMMISSION TO FILE AN ADMINISTRATIVE COMPLAINT AGAINST DR. QAISER WITH A PROPOSED DISCIPLINARY ACTION A PROBATIONARY PERIOD OF ONE YEAR OR LESS AS DETERMINED BY THE MEDICAL EXAMINERS COMMISSION, DURING WHICH TIME CLEAR POLICIES AND PROCEDURES WILL BE ENACTED TO GUARANTEE THAT NO FAMILY WILL HAVE TO PAY FOR ANY TOXICOLOGY QUANTIFICATION, AND THAT ANY DEATH IN WHICH JURISDICTION IS TAKEN UNDER SIMILAR CIRCUMSTANCES WILL NOT VIOLATE FLORIDA STATUTES OR FLORIDA ADMINISTRATIVE RULES.

ISSUE NUMBER 3: DISTRICT 15 PROBABLE CAUSE

Dr. Nelson read the findings of the District 15 Probable Cause Panel report into the record:

On June 15, 2015, staff received a written complaint from the Palm Beach County Inspector General's Office against District 15 Medical Examiner Michael D. Bell, M.D. The complaint alleges that Dr. Bell was practicing without a medical license, and performed an autopsy while blindfolded. The complaint also had other issues that are outside of the purview of the Medical Examiners Commission and therefore were not addressed. The complaint contained photographs of Dr. Bell performing an autopsy while wearing a blindfold.

Staff thoroughly reviewed the information in the complaint, as well as case documents provided by the District 15 Medical Examiner's Office. The documents provided by District 15 also contained photographs of Dr. Bell performing an autopsy while blindfolded. Dr. Bell stated in an e-mail to MEC staff that he was performing the autopsy while blindfolded in order to demonstrate to a visiting medical student "…*that the removal of the chest and abdominal organs is a relatively simple and repetitive process and could be done 'blindly' relying on tactile clues, a thorough knowledge of anatomy and years of experience*."

Staff determined the complaint was legally sufficient and recommended a Probable Cause Panel be established in order to review the materials and make the final determination of any violations of Statute or Administrative Code, in accordance with F.S. §406.075(3)(a).

The Probable Cause Panel convened on October 9, 2015 at 10:00 AM at the District 10 Medical Examiner's Office in Winter Haven. Panel members Dr. Stephen J. Nelson and Mr. Wesley H. Heidt were present. Mr. James S. Purdy participated via teleconference. Also in attendance were members of the Commission staff: Vickie Koenig, Doug Culbertson, Kipp Heisterman, and Jim Martin. Staff had previously mailed the panel members a notebook and thumb drive with their findings and the reference material upon which they based their opinions.

The first order of business was the election of a chairman, which Dr. Nelson accepted. Next the panel reviewed the statutory reference which established the panel as well as the procedures the panel and the Medical Examiners Commission will follow in these proceedings. Staff then presented the reference material previously forwarded to the panel members.

The panel discussed the complaint in detail. The panel determined that the allegation regarding practicing without a medical license was not factually supported since Dr. Bell's medical license is current with an expiration date of January 31, 2016.

The panel reviewed the photographs in this case, and Dr. Bell's statement regarding his conduct during the performance of the autopsy. Dr. Bell's statement indicated that "*Furthermore, I would never have used a blindfold during the actual autopsy because it would have adversely affected my ability to determine the cause and manner of death.*" Dr. Bell stated that he was not blindfolded during the external examination of the deceased, while examining internal organs or when drawing blood or other body fluids for toxicology analysis. The photographs clearly depict Dr. Bell performing the Y-incision, cutting and removing the breast plate, and placing his hands inside the opened body cavity while blindfolded. As a result, the panel unanimously found *probable cause* that Dr. Bell violated § 406.075(1)(i), F.S., which states in part, "*Negligence or the failure to perform the duties required of a medical examiner with that level of care or skill which is recognized by reasonably prudent medical examiners as being acceptable under similar*

conditions and circumstances." The basis for the finding of probable cause is directly related to Dr. Bell conducting an autopsy while blindfolded.

Conclusions

The panel found probable cause exists that there was a violation of F.S. §406.075(1)(i), by District 15 Medical Examiner Michael D. Bell, M.D., regarding his investigation into this death. The panel found that Dr. Bell was negligent and failed to perform the duties required of a medical examiner with that level of care or skill which is recognized by reasonably prudent medical examiners when he conducted an autopsy blindfolded.

The panel recommends a reprimand at a future Medical Examiners Commission meeting as the proposed discipline for this case.

The panel is prepared to discuss this matter and the reasoning behind their conclusions at the Medical Examiners Commission meeting scheduled for November 3, 2015 in Kissimmee.

Following Dr. Nelson's report, District 15 Medical Examiner Michael D. Bell, M.D. was given time to address the Commission regarding the Probable Cause Panel's findings. Afterward, several MEC members asked questions regarding prior Commission discipline and the proposed discipline in this case.

A MOTION WAS MADE, SECONDED, AND PASSED WITH 7 YEAS AND ONE NAY FOR THE COMMISSION TO FILE AN ADMINISTRATIVE COMPLAINT AGAINST DR. BELL WITH A PROPOSED DISCIPLINARY ACTION A REPRIMAND AND NO COMPLAINTS RECEIVED FOR 1 YEAR.

ISSUE NUMBER 4: DISTRICT 21 PROBABLE CAUSE

Dr. Nelson read the findings of the District 21 Probable Cause Panel report into the record:

In April 2015, staff received a written complaint from the family of decedent Alexis Jesus Sosa against District 21 Medical Examiner Rebecca A. Hamilton, M.D. The complaint alleges that Dr. Hamilton kept body parts belonging to Alexis Sosa in violation of s. 406.11(2)(b), Florida Statute and Rule 11G-2.004(6), Florida Administrative Code.

Staff thoroughly reviewed the information in the complaint, as well as case documents and photographs provided by the District 21 Medical Examiner's Office. Lacking in-depth medical knowledge of human remains, staff requested that a Probable Cause Panel be convened to determine if any violation of Administrative Code or Statute occurred.

The Probable Cause Panel convened on October 9, 2015 at 10:00 AM at the District 10 Medical Examiner's Office in Winter Haven. Panel members Dr. Stephen J. Nelson and Mr. Wesley H. Heidt were present. Mr. James S. Purdy participated via teleconference. Also in attendance were members of the Commission staff: Vickie Koenig, Doug Culbertson, Kipp Heisterman, and Jim Martin. Staff had already mailed the panel members a notebook and thumb drive with their findings and the reference material upon which they based their conclusions.

The first order of business was the election of a chairman, which Dr. Nelson accepted. Next the panel reviewed the statutory reference which established the panel as well as the procedures the

panel and the Medical Examiners Commission will follow in these proceedings. Staff then presented the reference material previously forwarded to the panel members.

The panel discussed the complaint in detail. The panel noted a report authored by Michael W. Warren, Ph.D, of the University of Florida's C.A. Pound Human Identification Laboratory on April 10, 2015. This report concluded that the remains in question were from a single individual.

The report also indicated that the burned and fragmented remains were a biological profile and dental restorative pattern match to Alex Sosa.

The panel reviewed the photographs of the fragmented remains in this case. The panel was able to clearly identify a hip joint, multiple portions of skull, and portions of the radius, patella, and metatarsal bones. As a result, the panel unanimously found *probable cause* that Dr. Hamilton violated:

- Rule 11G-2.004(6)(a), F.A.C., which states in part "*Human remains released by a medical examiner to the legally authorized person shall include all body parts unless the legally authorized person explicitly agrees to claim an incomplete body.*"; and
- Rule 11G-2.004(6)(d), F.A.C., which states in part "*Body parts retained by the medical examiner shall be subsequently released to the legally authorized person or disposed of pursuant to paragraph (6)(e) of this rule section.*"

The basis for the finding of probable cause is directly related to the determination by the panel that the photographs of charred and fragmented remains contain body parts, which were retained by the medical examiner. The family's complaint indicated that the family wishes for the remains to be returned for burial with the other remains of the deceased.

Conclusions

The panel found probable cause exists that there was a violation of 11G-2.004(6)(a) and (6)(d), F.A.C., by the District 21 Medical Examiner Rebecca A. Hamilton, M.D., regarding her investigation into this death. The panel found that Dr. Hamilton retained body parts. However, the panel also recognizes that Rule 11G-2.004(6)(d) provides that "*body parts retained by the medical examiner shall be subsequently released to the legally authorized person or disposed of pursuant to paragraph (6)(e) of this rule section.*"

The panel recommends Dr. Hamilton release the body parts retained by the medical examiner to the legally authorized person pursuant to Rule 11G-2.004(6)(d), F.A.C., and if Dr. Hamilton complies, the panel recommends that no administrative complaint be issued. If Dr. Hamilton refuses to return the body parts, that have been identified by a forensic anthropologist as belonging to Alexis Jesus Sosa, to the family, the panel directs the Medical Examiners Commission to file an administrative complaint for the violation of Rule 11G-2.004(6)(a) and (6)(d), F.A.C.
The panel is prepared to discuss this matter and the reasoning behind their conclusions at the Medical Examiners Commission meeting scheduled for November 3, 2015 in Kissimmee.

Following Dr. Nelson's report, District 21 Medical Examiner Rebecca A. Hamilton, M.D. was given time to address the Commission regarding the Probable Cause Panel's findings. Dr. Hamilton stated that she agreed with the Probable Cause Panel's recommendation to return the remains to the family of the decedent, and that she has already contacted the funeral home that had originally interred the decedent. Dr. Hamilton said that she would also try to contact the family regarding their wishes for the return of the remains.

A MOTION WAS MADE, SECONDED, AND PASSED UNANIMOUSLY TO ALLOW DR. HAMILTON TO RETURN THE REMAINS TO THE FAMILY OF THE DECEASED AND THAT NO ADMINISTRATIVE COMPLAINT WILL BE FILED.

At 12:03 PM Chairman Nelson adjourned the meeting for a brief break.
At 12:20 PM Chairman Nelson reconvened the meeting.

ISSUE NUMBER 3: DISTRICT 15 PROBABLE CAUSE

Following the break, the Commission readdressed the recommended disciplinary penalty for the Administrative Complaint against District 15 Medical Examiner Michael D. Bell, M.D. for clarification. The additional condition attached to the reprimand would be to have no sustained *violations* rather than no *complaints* against Dr. Bell received by the Commission for a period of one year.

A MOTION WAS MADE, SECONDED, AND PASSED WITH 7 YEAS AND ONE NAY FOR THE COMMISSION TO FILE AN ADMINISTRATIVE COMPLAINT AGAINST DR. BELL WITH A PROPOSED DISCIPLINARY ACTION A REPRIMAND AND NO SUSTAINED VIOLATIONS OF CHAPTER 406 FLORIDA STATUTES OR RULE 11G FLORIDA ADMINISTRATIVE CODE FOR 1 YEAR.

ISSUE NUMBER 5: C.A. POUND HUMAN IDENTIFICATION LABORATORY UPDATE

Michael W. Warren, Ph.D. announced that he will retire in 2017 as Director of the Laboratory. He assured those in attendance that he would try to ensure that his replacement would be a board-certified forensic anthropologist. Dr. Warren also advised that there will be a fee increase for the C.A. Pound Laboratory's anthropology services, as this is necessary to keep the Lab running at an optimal level of staffing and service.

ISSUE NUMBER 6: NAME ACCREDITATION PROCESS

Dr. Wolf gave a brief synopsis of the proposed changes to National Association of Medical Examiners (NAME) accreditation process. She asked that any District Medical Examiner with questions concerning the NAME accreditation process to please contact her directly.

ISSUE NUMBER 7: INFANT DEATH DATA COLLECTION FOR ANNUAL WORKLOAD REPORT

District 6 Medical Examiner Jon R. Thogmartin, M.D. gave a brief presentation showing inconsistencies in the reporting of infant deaths. Dr. Thogmartin showed a spreadsheet that he had developed that would eliminate these reporting inconsistencies, and said that he would be glad to share it with anyone who is interested.

Dr. Wolf indicated that she would work with Dr. Thogmartin to refine the spreadsheet, and in distributing it to the districts. Data collection changes will be effective January 1, 2016.

ISSUE NUMBER 8: QUESTIONS ABOUT OFFICIAL DATE OF DEATH

Dr. Nelson reminded everyone in attendance that when an individual has been declared "brain dead" the date/time of that confirmatory pronouncement should be listed on their Death Certificate, not the date/time when resuscitative instruments are withdrawn or the respirator is disconnected.

ISSUE NUMBER 9: UNIDENTIFIED DECEASED INITIATIVE

Mr. Culbertson informed the Commission that there was one success story to report this quarter.

District 5 Operations Manager Lindsey Bayer reported that in 2002 the skeletal remains of extremities were found, and were identified through MtDNA at UNT this year. Since the skeletal remains are only extremities, District 5 is working out the next course of action with law enforcement.

ISSUE NUMBER 10: 2016 FAME EDUCATIONAL CONFERENCE

Bruce A. Goldberger, Ph.D. informed everyone in attendance that at this time no one had volunteered to host the next Florida Association of Medical Examiners (FAME) Educational Conference. As a result, currently there is no time, place, or venue for the 2016 conference.

ISSUE NUMBER 11: OTHER BUSINESS

- Dr. Nelson read the following resolution for recently retired longtime MEC staff member Debbie Turvaville into the record:

WHEREAS the Medical Examiners Commission was created in 1970 by the passage of Chapter 406, Part I, Florida Statutes, also known as the Medical Examiners Act; and,

WHEREAS this Commission plays a vital role in support of the State of Florida's criminal justice system, to the families of the deceased in determining the cause and manner of death of their loved ones whose deaths come under the jurisdiction of the medical examiner, and by contributing to the protection of the public health of the citizens of the State of Florida; and,

***WHEREAS*,** the staff which serves the Medical Examiners Commission is housed within and supported by the Florida Department of Law Enforcement; and,

***WHEREAS*,** Ms. Debbie Turvaville has served the citizens of the state of Florida for 47 years, and joined the staff of the Medical Examiners Commission in 1986; and,

***WHEREAS*,** Ms. Turvaville has earned the reputation as being respectful, dedicated, and diligent; and,

***WHEREAS*,** Ms. Turvaville has enriched the Medical Examiners Commission and staff with her enthusiasm during her tenure.

NOW THEREFORE let it be resolved that this Commission on behalf of Florida's Medical Examiners, the medical-legal community, and all of the citizens of Florida whom she has served so

well, does hereby recognize and commend Ms. Debbie Turvaville for the dedication and valuable service she has offered to the Florida medical examiners system and hopes that she maintains her enthusiasm, professionalism, and success in future endeavors.

PASSED AND RECORDED, in the official minutes of the Medical Examiners Commission meeting on this Tuesday, the 3rd day of November, 2015, in Kissimmee, Osceola County, Florida.

- Dr. Nelson congratulated District 12 Medical Examiner Russell S. Vega, M.D. for his October 6th appointment by Gov. Scott to the Violent Crime and Drug Control Council as the statutorily-mandated medical examiner (F.S. §943.931(2)(i)). Dr. Vega replaces Dr. Nelson for a 2-year term.

- Dr. Nelson congratulated the District 4 Medical Examiner's Office for receiving accreditation from the National Association of Medical Examiners (NAME), and for having four investigators who became Fellows of the American Board of Medicolegal Death Investigators (ABMDI).

With no further business to come before the Commission, the meeting was adjourned at 1:10 P.M.