WHO CARES FOR THE DEAD WHEN THE DEAD DON'T VOTE?
An Interim Report (IR) by the
2015-2016 Los Angeles County Civil Grand Jury

I. EXECUTIVE SUMMARY

The citizens of Los Angeles County expect that their dead will be treated with dignity and respect. The Department of the Medical Examiner-Coroner (DMEC) and the Office of Decedent Affairs (ODA) in the Department of Health Services (DHS) provide services to transport, examine, and cremate or bury the county's dead, depending on the circumstances surrounding a particular death.

The 2015-2016 Civil Grand Jury (CGJ) considered in detail whether these services are provided promptly, efficiently, and according to the expectations of citizens. This report examines the present workings of these two offices. It principally finds that DMEC is significantly understaffed in both coroner investigator and laboratory positions, has a sobering backlog in toxicology testing, and that if these issues are not addressed DMEC's accreditation may likely be withdrawn during 2016.[1] Loss of accreditation may subject Los Angeles County and DMEC to attacks on their credibility in criminal cases.

The Board of Supervisors (BOS) has provided inadequate resources to support the stated significant needs of DMEC prompting the current Medical Examiner-Coroner to submit his resignation on March 11, 2016.[2] For reasons explained below,[3] the CGJ is very concerned that the leadership position in DMEC may be vacant for some time to come.

The CGJ also considered whether the lack of unification of all decedent services impedes quality investigation and consistent service for the people of Los Angeles County. The CGJ believes that having separate offices in two departments unnecessarily separates county-provided services to the dead and for their survivors. A merger of the two offices to provide a single point of contact for citizens could benefit county residents, but should not be considered until after DMEC is sufficiently staffed to meet its statutorily-mandated mission.

[1] The National Association of Medical Examiners (NAME) awarded a five-year re-accreditation to DMEC effective August 2011, through August 2016. DMEC is also due in 2016 for re-accreditation by the Institute of Medical Quality/California Medical Association (IMQ/CMA) and for a yearly site visit by the American Society of Crime Laboratory Directors/Laboratory Accreditation Board (ASCLD/LAB).
[2] All references in this report to the Medical Examiner-Coroner refer to Dr. Mark Farjado who is scheduled to leave that office on April 15, 2016.
[3] See pages 10-11.

A. The Medical Examiner-Coroner

The Los Angeles County DMEC is tasked to investigate and determine the circumstances, manner and cause of all violent and unusual deaths occurring in the county, including those where the decedent has not seen a medical doctor within 20 days of death. It responds to scenes of death regardless of time or location and uses investigators, forensic pathologists, laboratory technicians and toxicologists to conduct its investigations. The net county cost of the DMEC budget for FY 2015-2016 was estimated to be $35.5 million, or 0.13% of the adopted Los Angeles County budget of $27.1 billion.

Staffing affects the timing of autopsies and other investigative work and also the resultant reliability of DMEC's findings. The National Association of Medical Examiners (NAME), the certifying medical board for forensic medicine, has set a minimum acceptable standard of 90 days for completion of a coroner's work on each case. DMEC now routinely exceeds that limit. Simply put, if its problems are not rectified, the department is likely to lose its accreditation and may not be even provisionally accredited after it is reviewed in August 2016.

What problems currently exist at DMEC can be attributed to too few budgeted positions, including direct and indirect support personnel, worker fatigue and burnout, and to salary constraints that inhibit recruitment and retention of qualified professionals. Additional pressure is added to this stressful environment by BOS requests averaging 16 times per month for immediate processing of selected cases, which negatively impacts DMEC internal prioritization of investigations.

In response to the ongoing numerous vacancies in the DMEC Forensic Toxicology unit and the backlog specifically in blood alcohol testing, the Los Angeles County Chief Executive Officer (CEO) directed the Medical Examiner to redeploy staff who hold licenses to do blood alcohol testing to the toxicology laboratory. Unfortunately, even if this directive is successful in dealing with this particular backlog it will create new backlogs in other areas from which the newly reassigned testers were taken.

More troubling, the lack of staffing in that unit has caused DMEC to suspend a number of operations, including Gunshot Residue and Scanning Electron Microscopy (GSR/SEM) and Law Enforcement/Officer Involved Shooting (LER/OIS) case review. Further, physicians have deferred toxicology testing and are using less definitive and more elementary procedures.[4]

In addition, DMEC has no cushion to absorb extra work generated by catastrophes and extended staff leaves of absence, for example maternity leave, bereavement, illness, etc.

[4] The CGJ is informed, for example, that physicians are using urine dip-sticks rather than running toxicology tests.

The CGJ believes the budgeted numbers of investigators, forensic pathologists, and toxicologists need to be increased immediately by BOS to improve the provision of services by DMEC.

DMEC operates from a central location in downtown Los Angeles and three small satellite offices in the Antelope Valley, Lomita, and San Fernando. The vast size and constant congestion of Los Angeles County require the coroner staff to travel 30 to 90 minutes, and sometimes up to three hours, to investigate a scene of death and remove bodies.[5] A body cannot be moved from an accident or crime scene until the coroner arrives or gives permission. The CGJ believes a second facility for processing bodies would be beneficial and should be located somewhere in the west San Fernando Valley.

B. The Office of Decedent Affairs

ODA is a small unit in DHS and has a total budget of under $400,000, compared to the total DHS budget of about $7 billion. The three functions of ODA employees are to operate the county morgue at the LAC+USC Medical Center, the county crematory, and the county cemetery. ODA performs a function that is remote from the core mission of DHS, operating at a distance of three managerial levels from even the administration of the hospital.

Although Los Angeles County operates the crematory for the purpose of cremating its indigent dead, DMEC must contract with private crematories to process its unclaimed bodies. The CGJ questions whether continued operation of the county crematory is an effective use of resources.

C. The Proposed Consolidation

At least as far back as 2009 there have been serious discussions involving BOS, CEO, DMEC, and DHS regarding the transfer of the functions of ODA to DMEC. In the spring of 2015 DMEC and DHS were each asked to provide budget estimates relating to such a consolidation. The estimates, based on separate assumptions, were miles apart and the talks stalled.[6] All parties involved appear to support a merger of these functions at some point in the future.

The CGJ agrees that decedent services should eventually be consolidated in one county department, DMEC, but cautions that such consolidation should not take place until DMEC first receives appropriate additional personnel positions to be functional in its core mission. The consolidation, further, must include new positions dedicated to support the new responsibilities in order to assure that the State's statutory mandates are met by DMEC.

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[5] Laura J. Nelson, "Los Angeles Area Can Claim the Worst Traffic in America. Again." Los Angeles Times, March 15, 2016. http://www.latimes.com/local/lanow/la-me-ln-la-worst-traffic-20160314-story.html

[6] DHS requested $400,000 to fulfill its function assuming no changes in personnel or other resources. DMEC requested $2.3 million for 27 additional positions, including 12 investigators, and 2 vans. The DMEC request assumed that the medical examiner would be given the proper resources to apply its statutorily-mandated "identify and notify" procedure, utilizing all resources – local, state, federal, and international – to identify each case originating from the morgue, a procedure now followed on each case opened by DMEC.

II. RECOMMENDATIONS

IR2.1 Los Angeles County and DMEC, within the next 90 days, should initiate a study to identify and correct barriers to recruitment and retention of board certified professionals with respect to budgeted but unfilled positions at DMEC, including, among others, forensic pathologists, investigators, and toxicologists.

IR2.2 Los Angeles County and DMEC should increase staffing at DMEC immediately in order to reduce the risk of error, the need for high amounts of overtime, employee redeployment in cases of rapidly growing backlogs, and employee burnout. Evidence that Los Angeles County is providing additional resources to the department might allow DMEC to keep its accreditation, currently in great jeopardy, on a provisional basis. Specifically, staffing should be increased by:

IR2.2(a) 12 full time investigators,

IR2.2(b) 2 full time forensic pathologists, and

IR2.2(c) 7 full time toxicologists.

IR2.3 Los Angeles County and DMEC should, beyond the positions required by recommendation IR2.2, further increase staffing at DMEC in order to achieve median staffing levels per millions of population strongly recommended by NAME. Specifically, staffing should be increased by:

IR2.3(a) 1 full time investigator,

IR2.3(b) 7 full time forensic pathologists, and

IR2.3(c) 15 full time toxicologists.

IR2.4 Los Angeles County and DMEC should increase compensation, by means perhaps of starting such employees at higher steps on the county's pay scale, and other incentives, in order to effectively recruit and retain these specialized individuals.

IR2.5 Los Angeles County and DMEC should, within the next fiscal year, establish in the West Valley area a facility comparable and redundant to the medical examiner's sole facility.

IR2.6 Should Los Angeles county continue operation of its crematory, Los Angeles County and DHS should replace the crematory retorts (furnaces), including necessary upgrading of plumbing, electrical, and HVAC systems. The

crematory floor needs to be replaced. Other structural issues also may need to be addressed.

IR2.7 Los Angeles County should not move the indigent-related functions of ODA from DHS to DMEC until the 21 additional personnel needed by DMEC to be basically functional in its mission, recommended previously in IR2.2, are provided. The CGJ recommends that if, or when, the consolidation goes forward it include additional staff for DMEC, along with other appropriate support, necessary for the work to be properly performed by DMEC, according to the laws of California, on behalf of the people of Los Angeles County. Specifically, staffing should be increased by:

IR2.7(a) 6 full time investigators,

IR2.7(b) 5 full time transport workers, and

IR2.7(c) 2 full time clerks.

III. BACKGROUND

The CGJ investigated all Los Angeles County functions dealing with the dead, including the medical examiner's office and decedent services provided by DHS. The CGJ is aware there have long been discussions about consolidating these two offices so that just one entity would process the dead for whom Los Angeles County is responsible.

A. The Department Of The Medical Examiner-Coroner

The office of the Los Angeles DMEC is statutorily charged with investigating "all violent, sudden, or unusual deaths within the County."[7] The Medical Examiner-Coroner informed the CGJ that in one out of three deaths in the county DMEC is called to the scene. Of the 60,000 – 80,000 deaths each year in Los Angeles County approximately 20,000 – 25,000 are reported to DMEC. The department accepts jurisdiction in about 10,000 of those and actually brings in 8,000 – 9,000 bodies for closer examination. The department operates 24 hours per day, seven days per week.

The staff of DMEC conducts its work in the largest metropolitan area in the United States and is exceptionally well trained. The large, diverse population in our county produces post mortem investigations across a broad spectrum of complexity and manner of death. Each year forensic pathologists, investigators, toxicologists, and other criminalists conduct myriad independent, objective medicolegal investigations in the public interest.[8]

DMEC determines facts to assist in court cases and also to contribute knowledge in the areas of occupational disease, epidemic disease, and industrial accidents. Such investigations additionally aid the public health purposes of revealing unsuspected contagious disease and preventable hazards to health.[9]

More than 50 years ago, forensic pathologists in the Los Angeles DMEC pioneered the practice of psychological autopsy, which has aided policy development in suicide prevention.[10] Toxicologists in DMEC also have identified testing methods for new designer drugs while conducting post mortem analyses, although current severe staff shortages have eliminated DMEC's ability to do this.

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[7] Cal.Govt.Code § 27491. See Appendix for text. Other types of deaths not listed in the statute but also reportable are all deaths in which injury or accident, regardless of how remote in time or place, is a contributing cause of death. http://mec.lacounty.gov/wps/portal/mec/ourservices/forhospitals.

[8] "The medicolegal autopsy is conducted with the possibility of litigation in mind. The autopsy is designed to determine the cause of death, properly document findings, and collect evidence. A primary objective is to try to reconstruct the circumstances and events that led to the death so that a manner (natural, accident, suicide, homicide, or undetermined) can be established. . . . It is imperative that findings be recorded clearly and objectively. Any forensic pathologist should be able to interpret the findings years later without difficultly." DME Manual, County of Los Angeles, Department of the Medical Examiner-Coroner (August 2014), p. 8.

[9] Ibid.

[10] Drs. T. Botello, T. Noguchi, L. Sathyavagiswaran, L. Weinberger, and B. Gross, "Evolution of the Psychological Autopsy: Fifty Years of Experience at the Los Angeles County Chief Medical Examiner-Coroner's Office," Journal of Forensics, Volume 58, Issue 4 (March 2013), pp. 924-926. http://onlinelibrary.wiley.com/wol1/doi/10.1111/1556-4029.12138/full

1. The DMEC Workload

With more than 10 million residents, Los Angeles County is the most populous county in the nation. It covers 4,752 square miles and, significantly, is congested with nearly 8 million registered vehicles.[11]

DMEC's sole facility is located in downtown Los Angeles, although there are three satellite facilities out of which a handful of investigators operate.[12] No one is allowed to touch or move a body at an accident or crime scene unless the Coroner gives them permission to do so or until a Coroner's Investigator arrives.[13] The CGJ has been informed that the average time for an investigator to travel through traffic from the downtown headquarters to a death scene in most areas of the county is usually 30 to 90 minutes and sometimes nearly three hours. Thus, distance and population density both affect the effective conduct of DMEC's work.

DMEC processes about 9,000 – 10,000 bodies and performs about 4,000 autopsies per year. While its workload is comparable to that of the medical examiner offices in New York City (all boroughs are organized under one medical examiner) and Cook County (Chicago), which report performing more than 5,000 and about 3,700 autopsies per year, respectively, those other jurisdictions are physically smaller, serve smaller populations, and employ more critical staff per capita than DMEC.

[11] California Department of Motor Vehicles Forecasting Unit: total for 2014 was 7,719,360. https://www.dmv.ca.gov/portal/wcm/connect/add5eb07-c676-40b4-98b5-8011b059260a/est_fees_pd_by_county.pdf?MOD=AJPERES

[12] Two investigators are assigned to a small office in Lancaster, CA, four investigators are assigned to office space in Lomita, CA, and two investigators are assigned to an office in the San Fernando Police Department. In Lancaster there is a small office and non-working refrigerated space that could accommodate six bodies. In some cases, because of lack personnel, DMEC must depend on a local funeral company to transport bodies from Antelope Valley to the Los Angeles office, the only location in the county where autopsies are performed. Neither the Lomita nor the San Fernando offices contain anything other than desks for the investigators who work there. These regional offices allow DMEC to more rapidly respond to a scene of death which mitigates traffic obstructions.

[13] Cal.Govt.Code § 27491.2 (b) "For purposes of inquiry, the body of one who is known to be dead from any of the causes or under any of the circumstances described in Section 27491 shall not be disturbed or moved from the position or place of death without permission of the coroner or the coroner's appointed deputy. Any violation of this subdivision is a misdemeanor."

Table 1: Population Served Per Critical Staff Member

	Population served per Forensic Pathologist	Population served per Coroner Investigator*	Population served per Toxicologist	Total Population Served	Area Served in Square Miles
Los Angeles	434,700	222,200	769,200	10,000,000	4,752
New York (5 Boroughs)	242,800	293,100	386,400	8,500,000	303
Cook County (Chicago)	385,700	337,500	385,700	5,400,000	945

*Put another way, each of the 46 investigators in Los Angeles County can be said to "cover" 103 square miles, while 29 investigators in New York each cover 10.5 square miles and 16 investigators in Cook County each cover 59 square miles.

The Medical Examiner-Coroner informed the CGJ that DMEC, despite severe understaffing, is committed to provide a 48-hour turnaround time with regard to preliminary results in cases in which it accepts jurisdiction.

2. The Investigation and Examination Process

According to the standard of care applied by medical examiners across the country autopsies are completed within 48 hours of death. ***The forensic pathologist cannot begin an autopsy or even an external examination, however, until the investigator completes a report detailing the scene at which a body is found, including personal effects gathered there.***

In each case determined to be within the jurisdiction of DMEC, the deceased is taken to DMEC's facility and examined by a deputy medical examiner to determine the cause and manner of death. That physician assesses whether an autopsy and/or laboratory tests are required as part of the investigation. At its present rate DMEC takes on average much longer than 90 days to complete final autopsy reports, the minimum standard for completion required by NAME for full accreditation of a forensic death investigation facility. This substantial period of time can be attributed to a lack of sufficient staff, including professional and direct and indirect support personnel.

During an autopsy the decedent's body is examined for external wounds. A detailed internal examination is conducted during which organs are examined and weighed. Bodily fluids are collected. Tissue samples are taken and retained to determine if there

is a presence of drugs, poison, and/or disease(s) and to preserve DNA. Forensic pathologists work closely with law enforcement but conduct their investigations independently to reach scientific conclusions as to cause of death.

Moreover, toxicology samples are very time and temperature sensitive. A body lying on ninety (90) degree asphalt will begin to decompose within an hour. Samples retrieved more than two weeks after death likewise will have degraded and therefore may not be optimally reliable.[14] The DMEC toxicology lab currently requires ***six or seven months*** to analyze samples taken in routine autopsies,[15] jeopardizing accreditation of the entire facility. The Forensic Laboratory standards, which are international standards of analysis, are higher now than were expected even five years ago. They are much more time consuming and labor intensive than previous standards.

DMEC continues to have on average more than 400 bodies stored in its crypt and is incapable of meeting, in the vast majority of its cases, the minimum acceptable standard autopsy report completion time of 90 days. Some 160 bodies await external examination and/or autopsy, and more than 250 additional bodies are stored for further testing (about 10 percent of the number), to be identified (delayed because there are not enough coroner investigators to do the statutorily-required work), or have been abandoned by survivors and therefore are left for final disposition by Los Angeles County.

3. Accreditation

DMEC has maintained its accreditation -- a measure of acceptable standards in management, personnel, operations, procedures, instruments, physical site, and safety -- although it currently is so far behind the minimum standards that losing accreditation is a likelihood in 2016.[16] Such accreditation has been attained by only 82 medical examiner or coroner offices, including DMEC, out of the more than 2,000 counties across the nation. Los Angeles County DMEC worked hard to attain this elite status among peer facilities.

The volume of cases for which DMEC is responsible overwhelms a staff that is significantly smaller than recommended in standards set by NAME. The budget provided to DMEC also has been flat in the past two fiscal years and the CEO's recent proposed budget reduces the level of funding for FY 2016-2017.

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[14] "Factors such as delay in autopsy, sampling technique, and specimen preservation contribute more to inaccuracies associated with toxicological testing than do the testing procedures themselves, but procuring and storing toxicology specimens under optimal conditions mitigate these factors." Dr. G. G. Davis and the National Association of Medical Examiners and American College of Medical toxicology Expert Panel on Evaluating and Reporting Opioid Deaths, "National Association of Medical Examiners Position Paper: Recommendations for the Investigation, Diagnosis, and Certification of Deaths Related to Opioid Drugs," (March 2013), p. 77. https://netforum.avectra.com/public/temp/ClientImages/NAME/a8f3230e-d063-4681-8678-e3d15ce9effb.pdf

[15] Interview with DMEC staff.

[16] The minimum standard is that 90 percent of toxicology tests will be completed in 90 days. NAME, "Inspection and Accreditation Checklist for Autopsy Services, Adopted February 2013," p. 16. https://netforum.avectra.com/public/temp/ClientImages/NAME/c43b8bca-ad7b-4a40-990b-7f45283a66ab.pdf

Table 2: DMEC Budget

	FY 2012-2013	FY 2013-2014	FY 2014-2015	FY 2015-2016	CEO Proposed FY 2016-2017
Net County Cost	$31,704,000	$31,789,000	$35,656,000(a)	$35,515,000	$33,583,000
Budgeted Positions	216	217	244(b)	227	227

(a) The majority of the $3.8 million increase over the 2013-2014 budgeted amount reflects the county-wide salary and benefit increases as a result of a Memoranda of Understanding (MOU) and one-time miscellaneous equipment funding.

(b) The 27 additional positions over the 2013-2014 budgeted numbers reflect 20 volunteer (non-paid) positions (added in error to the 2014-2015 Adopted Budget ordinance), six positions added at the time of Chief Medical Examiner-Coroner's appointment, and one position added in exchange of reduced expense funds.

Critical staff and the challenges in recruiting and retaining them include:

- *Forensic Pathologists:* At present there are only about 500 - 600 board-certified forensic pathologists in the United States,[17] although NAME estimates, significantly, a need for double that number.[18]

  In 2015 just 43 doctors passed the examination to become board certified forensic pathologists.[19] Each year there are 15,000 new medical students, but only 37 of the 131 medical schools provide accredited training programs in forensic pathology. On average, just 47 medical students from all schools go on to become forensic pathology residents.[20] Los Angeles County each year offers two residency positions in DMEC but cannot always fill both. The starting salary for forensic pathologists in Los Angeles County was recently set by the CEO. "All new employees would start at an annual salary of $187,728 unless they had outside experience and then they would start at a higher step commensurate with their experience."[21]

[17] "Between 2007 and 2013, a total of 290 people were trained in forensic pathology, an annual average of 41 per year. . . . Considering an annual creation rate of 21 FPs per year [who attain board certification], and given the current work force of 500 FPs, it would take approximately 25 years to create enough FPs to serve the current U.S. population, assuming no population growth during that time. Compounding this issue, the FP workforce is annually decreasing due to attrition from retirement, death, and other factors, including job dissatisfaction because of the stressful nature of political, legal, and media encounters; poor working conditions; the nature of the work, and/or low salaries." National Institute of Standards and Technology, National Commission on Forensic Science, "Increasing the Number, Retention, and Quality of Board-Certified Forensic Pathologists," p. 3. http://www.justice.gov/ncfs/file/641646/download

[18] Ibid.

[19] Denise McNally, Executive Director of NAME, telephone interview February 2, 2016.

[20] Scientific Working Group on Medicolegal Death Investigation (SWGMDI), "Increasing Forensic Supply of Forensic Pathologists in the United States," (December 5, 2012), p. 2. http://www.swgmdi.org/images/si4.fpsupplyreportpublisheddecember2012.pdf
National Institute of Justice, Forensic Death Investigation Symposium, June 7-9, 2010, National Academy of Sciences Report, p. 5. https://www.ncjrs.gov/pdffiles1/nij/249252.pdf

[21] Email from Senior Manager, Benefits and Compensation Policy, Los Angeles County Chief Executive Office, March 17, 2016.

As a result of this dearth of practicing forensic pathologists it is difficult to fill pathologist positions as senior physicians resign or retire. Los Angeles County employs 23 forensic pathologists. The Medical Examiner-Coroner just resigned and there is a critical need for two additional doctors.

NAME statistics suggest a median staffing level of 3.2 forensic pathologists per million of population,[22] translating into a staffing level of 32 forensic pathologists at DMEC.

- *Coroner investigators* are sworn law enforcement officers who lead the crime scene investigation and coordinate all evidence collection at the scene of a death. The investigator takes charge of physical evidence, including the personal belongings and evidentiary samples taken from the deceased, making sure that it is properly cataloged and handled. He or she helps to move the body and may be in attendance at the autopsy as well. Coroner investigators are also involved in disposition or release of the body once DMEC's investigation has been concluded.

  DMEC has 46 budgeted investigator positions for a total caseload of about 10,000 incidents per year, which does not include the 10,000 - 15,000 additional cases in which a coroner investigator is called to a scene of death but determines there to be no jurisdiction for DMEC. There are four vacancies, including Chief of Coroner Investigations, at this time. Investigations inevitably lag behind the steady flow of cases for which DMEC is statutorily responsible and autopsies are delayed, producing stress and heartache in survivors.

  NAME statistics suggest a median staffing level of 5.9 investigators per million of population,[23] translating into a staffing level of 59 investigators at DMEC.

- *Criminalists/forensic toxicologists* are extremely critical to DMEC's operation. They examine tissues, bodily fluids, and blood to determine the cause and manner of death, and frequently provide expert testimony in court proceedings, which requires these staff to be specifically board certified, for example, in opioids, alcohol or some other area. These positions are highly specialized and require several years of experience and training.

  The American Board of Toxicology requires the following criteria for certification: a doctorate and at least three years full time experience in toxicology; a master's degree and at least seven years full time experience in toxicology; or a bachelor's degree and at least ten years full time experience in toxicology. All the degrees must be in a life or chemical science.

[22] Drs. M. Weinberg, V. Weedn, S. Weinberg, and D. Fowler, "Characteristics of Medical Examiner/Coroner Offices Accredited by the National Association of Medical Examiners," Journal of Forensic Sciences, Vol. 58, No. 5 (September 2013), p. 1196.
[23] Ibid.

BOS has budgeted 13 forensic toxicology positions for DMEC. NAME-suggested levels, however, suggest a staff significantly larger. There are six vacancies in the unit, including Chief of Forensic Laboratories, two supervising criminalists, and three senior criminalists. Four additional positions are held by employees on leave so that currently only three toxicologists are handling an overwhelming workload. The inability to fill even the budgeted positions is based largely on the failure of Los Angeles County to offer competitive salaries for the severe workload involved in these positions.

NAME statistics suggest a median staffing level of 3.5 toxicologists per million of population,[24] translating into a staffing level of 35 toxicologists at DMEC.

DMEC is understaffed in forensic pathology, investigator, and criminalist (laboratory) positions, due in part to difficulties recruiting and retaining staff in all of these professional areas in a hyper-competitive market. It is that much more difficult to recruit and retain these specialized personnel in Los Angeles County where the cost of living is very high[25] and DMEC has not been able to offer salaries high enough to compete with other locations.

[24] Ibid.
[25] Experian Data Quality, "The Cost of Living in America," https://www.edq.com/data-quality-infographics/cost-of-living-in-america/

Table 3: Starting Salaries Offered
For Forensic Pathologists in Selected Jurisdictions[26]

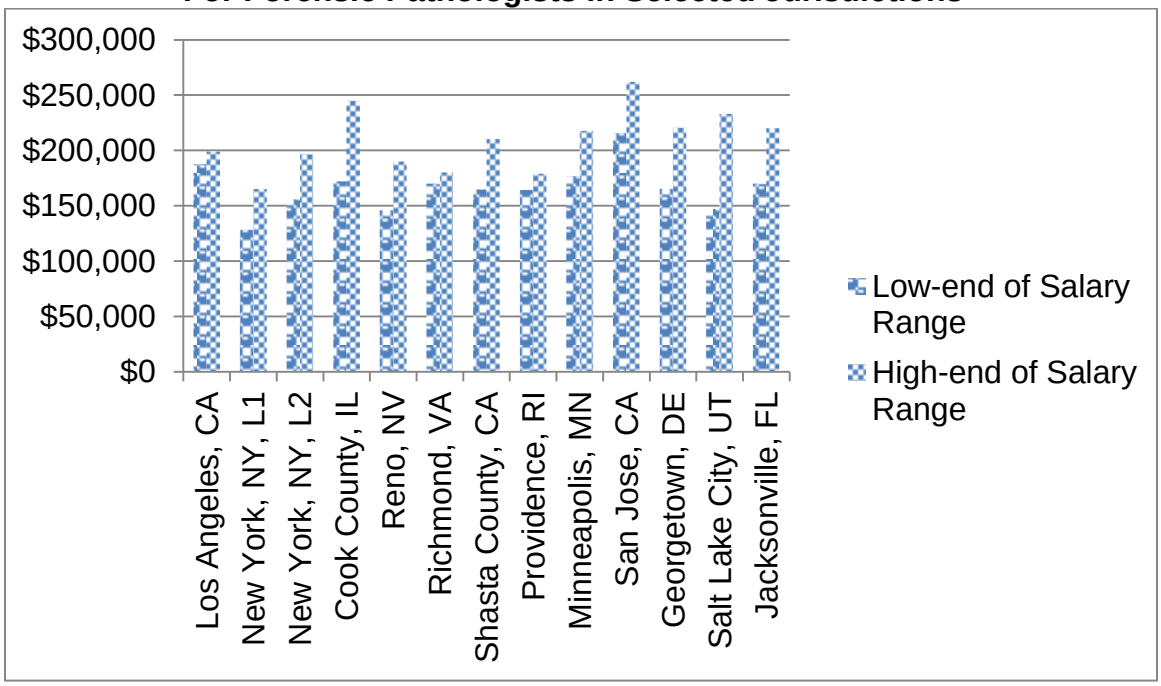
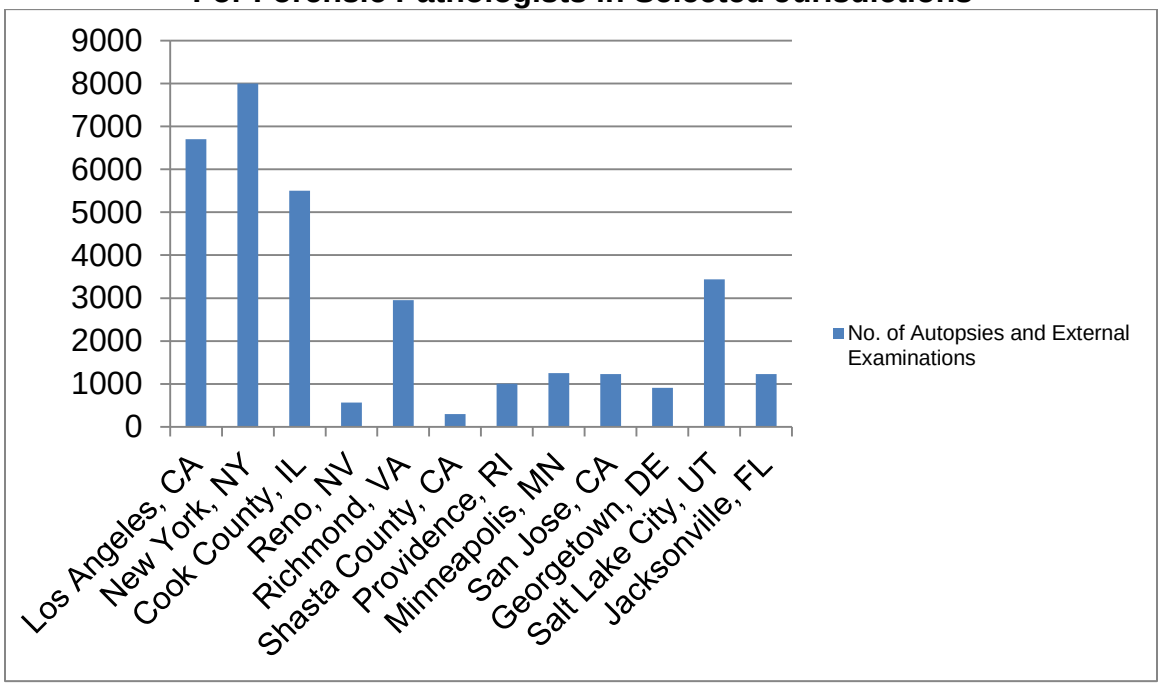


Table 4: Workload (Number of Autopsies and External Examinations)
For Forensic Pathologists in Selected Jurisdictions



[26] Salaries listed were available as job offerings on-line as of March 7, 2016. New York provided information for two subcategories of "city medical examiners," level I and level II.

B. Office Of Decedent Affairs

The Office of Decedent Affairs (ODA) is a division of the Department of Health Services (DHS) with headquarters located at the LAC+USC Medical Center. It comprises the morgue, the crematory, and the county cemetery.

ODA performs a function that is remote from the core mission of the hospital, operating at a distance of three managerial levels from the administration of the hospital (which, in turn, reports to the Director of DHS). Its problems are frequently overlooked. For example the county crematory is barely able to process the remains of the county's indigent. The CGJ investigation found a disturbing backlog of about 250 bodies stored in "temporary" refrigerated trailers at the county morgue on the LAC+USC Medical Center campus. When our concerns were noted on February 17, 2016, the problem was rectified in fewer than two weeks and no backlog currently exists. A new policy was immediately put in place to keep such a backlog from ever occurring again. The ODA's remote existence as part of DHS, however, does not add to its oversight and effective provision of services.

1. The County Morgue

The morgue processes all deaths that occur in LAC+USC Medical Center. Indigent veterans, about three percent of Los Angeles County's unclaimed indigent decedents, are processed by DMEC; individuals who die in the Medical Center after being injured during the commission of a crime and treated at LAC+USC Medical Center are also processed there.[27] The morgue also receives unclaimed, indigent decedents from other county medical facilities as well as private convalescent care facilities. The bodies are retrieved by morgue transport staff.

The morgue employs one administrative staff member who attempts to contact family members to claim bodies for transfer to private mortuaries. Individual remains unclaimed after thirty days are cremated at the county crematory at county expense.

Discussions with morgue staff made clear that their objective is to get a decedent's body either to the decedent's survivors, DMEC, or to the crematory. Delays are common as the office is expected to pick up bodies at other facilities but has only five employees to do so and the one administrative aide as noted above.

The manager of the morgue reports to LAC+USC's "Support Services Administrator," and also manages the county crematory and the county cemetery.

DHS employs seven persons in the morgue. There are four vacant budgeted positions.

[27] The bodies of indigent individuals who are verified to be veterans are transported to DMEC for pick up by the Veterans' Administration and burial at the National Cemetery in Riverside, California. All persons injured in the commission of a crime in Los Angeles County are treated in secured areas at LAC+USC Medical Center.

2. The County Crematory

The bodies of indigent decedents from the morgue and other facilities around the county are cremated at the Los Angeles County Crematory[28] where only two of five existing high temperature retorts (furnaces) are currently in operation. One of the nonoperational retorts is offline and awaiting repair. Two others have been decertified, last being used in the early 1990s. There is no question that the county-operated retorts have been neglected and have long needed upgrading.

The three to four-hour cremation process starts with the burning of a body in a retort, followed by a two-hour cooling period before the ashes can be removed. Remains are further cooled following their removal from the retort, inspected for metal apparatuses, completely individually processed, carefully placed in a plastic lined box and marked with the appropriate identification tag. Each case, whether the identity of the decedent is known or not, is entered chronologically into a hand-written log book. Remains are then ready to be claimed by survivors of the decedent,[29] or if unclaimed, buried in the county cemetery during the "Funeral for the Unclaimed."[30]

The CGJ was informed that "energy saving" alterations were made in recent years on the existing retorts that reduced the operating temperatures of the furnaces. The result, evidently, is that a single cremation now takes substantially more time, requiring about six hours in the retort rather than four hours. Currently the crematory is able to process only two bodies each day, for a total of ten bodies per week. As it is currently operated by Los Angeles County, the CGJ questions whether its continued operation makes sense.

The DMEC also cremates remains but contracts with private crematories to have an average of more than 600 decedent bodies per year processed at an estimated total cost of $350 per cremation.

DHS employs two staff at the crematory. There are no vacant positions.

3. The County Cemetery

Upon its creation on August 23, 1877, Evergreen Cemetery gave a nine acre plot of land on the eastern side of its sixty-nine acre facility to the City of Los Angeles, to be used as a graveyard for the indigent. The cemetery is noteworthy for never having banned African American burials and includes graves of all manner of early Los Angeles area residents -- Armenian, Chinese, Japanese, Mexican, and early white settlers.

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[28] The CGJ understands that Los Angeles County is the only county in the state to operate its own crematory.

[29] Relatives who claim the boxed ashes at this point are charged $352 for an inpatient death or $466 if the decedent was transported to LAC+USC Medical Center from any other facility.

[30] This funeral occurs every year. Each ceremony lays to rest the unclaimed remains of those who were initially cremated 3 years prior to the current calendar year. Remains can be claimed at any time up to that date.

In 1917, the ownership of the indigent cemetery was passed from the city to the County of Los Angeles. In 1924, lacking space to bury the indigent dead, the county built a crematory at the site and began to cremate the bodies of unclaimed indigents.

The county deeded about 5 acres of land back to Evergreen Cemetery in 1964, but retained the crematory and a smaller section now being used for mass burial of unclaimed indigent remains. About 1,300 unclaimed cremated remains annually are buried in the cemetery.

The cemetery is staffed by the two DHS crematory workers.

IV. METHODS AND PROCEDURES

The CGJ conducted numerous interviews with department heads, senior staff, managers, line staff, budget analysts, long-time and former high-ranking employees of DMEC.

It collected data from medical examiner departments in the larger counties of California and in the ten most populous counties across the country, and also read professional and scholarly papers presenting issues of relevance.

Manuals describing procedures at DMEC were reviewed.

The jury toured the entire headquarters facility on Mission Road in downtown Los Angeles as well as the morgue, located at LAC+USC Medical Center, the crematory, and the county cemetery.

Four jury members attended an autopsy to witness the work of staff firsthand.

V. FINDINGS

1. Of the 60,000 – 80,000 deaths each year in Los Angeles County, DMEC is called to the scene of death in approximately 20,000 – 25,000 cases. The department accepts jurisdiction in about 10,000 of those and actually brings in 8,000 – 9,000 bodies for closer examination.

2. Investigators in DMEC respond to scenes of deaths 24 hours per day, seven days per week.

3. DMEC identified critical staffing needs in the current and each of the past two budget cycles. For example, the Medical Examiner-Coroner, in his first official budget request in January 2014, said his request “reflects a number of high

priority unmet needs, first and foremost, the restoration of unfunded salary savings, without which the department will be unable to hire or sustain critical lab operations." In 2015-2016, the Medical Examiner-Coroner requested 19 additional positions to "address needs in various areas of the lab including toxicology, DNA, research and drug testing, all of which support the ME-C's commitment to best practices and maintenance of . . . accreditations . . . [and] to ensure quality and timeliness of work, and reduce risk for error and increased legal exposure."

4. DMEC needs additional staff across the board: investigators, doctors, laboratory professionals, and direct and indirect support personnel. There is insufficient staffing to cover the workload, much less routine illness or accidents and no staffing cushion to absorb additional workload during catastrophic events and extended leaves of absence.

5. DMEC prioritizes cases in a particular order.
    - First, cases involving infants and young children, because their bodies rapidly decompose.
    - Second, homicides.
    - Third, unidentified individuals.
    - Fourth, all others.

6. The budget reflects investment in DMEC of about $3.55 per resident of the county.

7. DMEC strives to provide quality services to all of its customers, including decedent's families, funeral directors, law enforcement, courts, the District Attorney, the Public Defender, and other justice agencies, foreign consulates, and the news media, in a timely, accurate, efficient, and usable manner.

8. The workload/caseload of DMEC in Los Angeles County compares with that in other very large urban counties, including New York City (all five boroughs) and Cook County (Chicago). Although their service areas are physically smaller and they serve smaller populations, those jurisdictions employ more critical staff per capita than DMEC.

9. The professional field of forensic pathology is quite small and very few medical students pursue residencies, and later careers, in the field.

10. There are numerous job listings for forensic pathologists across the nation that offer starting salaries comparable to those offered in Los Angeles County, but the workload is much less (as is the cost of living).

11. There is a vacancy in the most senior budgeted investigator position, Chief of Coroner's Investigations.

12. There are three vacancies in the most senior positions in the forensic laboratory.

13. Los Angeles County does not engage in recruitment battles for scarce professionals by offering bonuses or other incentives.

14. DMEC will lose its professional accreditation, and expose the County and DMEC to attacks on their credibility in criminal cases, if the workload cannot be handled by staff in a timely manner.

15. Los Angeles County might preserve at least a "provisional" accreditation for DMEC if NAME examiners, expected to inspect DMEC in August 2016, are aware that concrete steps have been taken by Los Angeles County and by DMEC to permanently rectify severe staffing deficiencies.

16. Due to traffic congestion and distance from the medical examiner's facility in downtown Los Angeles, travel times for investigators to the scene of a death can vary widely, but are generally 30 to 90 minutes and sometimes more than three hours. Law enforcement and paramedics must wait for DMEC staff to arrive on scene.

17. Two DMEC investigators are located in the Antelope Valley and work out of a small building (about 4,000 square feet) adjacent to the now closed High Desert Hospital. Bodies are no longer able to be refrigerated prior to transfer to DMEC's Forensic Science Center in downtown Los Angeles because that equipment is not operating. In the rear of the hospital there is an autopsy suite, out of use for at least 10 years.

18. Ambulances are prohibited by law from transporting deceased individuals.

19. In New York City mortuary services, including autopsy facilities, are located in Manhattan, Brooklyn, and Queens. The medical examiner there is in the process of reopening similar facilities in the Bronx and Staten Island.

20. DMEC sends hundreds of bodies per year to private facilities for cremation at a net cost of about $350 per body.

21. The ODA morgue staff is overworked in both transport and administrative positions. There are unfilled, budgeted positions available for additional staff.

22. The Los Angeles County morgue would continue to be located in LAC+USC Medical Center regardless of which department is responsible for its operation.

23. Only two of five existing retorts in the county crematory are operational. One of these lacks a functioning thermostat. DHS workers at the crematory are able to process only two bodies per day.

24. DHS has a policy of contracting with private crematories if the diminished capacity at the county crematory results in a backlog of ten or more bodies.

25. The crematory floor is overdue for replacement.

VI. REQUEST FOR RESPONSE

California Penal Code Sections 933(c) and 933.05 require a written response to all recommendations contained in this report. Such responses shall be made no later than ninety (90) days after the Civil Grand Jury publishes its report (files it with the Clerk of the Court). Responses shall be made in accord with Penal Code Sections 933.05 (a) and (b).

All responses to the recommendations of the 2015-2016 Civil Grand Jury must be submitted on or before July 15, 2016, to:

Presiding Judge
Los Angeles County Superior Court
Clara Shortridge Foltz Criminal Justice Center
210 West Temple Street
Eleventh Floor-Room 11-506
Los Angeles, CA 90012

Responses are required from:

Board of Supervisors: IR2.1, IR2.2(a), IR2.2(b), IR2.2(c), IR2.3(a), IR2.3(b), IR2.3(c), IR2.4, IR2.5, IR2.6, IR2.7(a), IR2.7(b), and IR2.7(c).

Department of Health Services: IR2.6.

Department of the Medical Examiner-Coroner: IR2.1, IR2.2(a), IR2.2(b), IR2.2(c), IR2.3(a), IR2.3(b), IR2.3(c), IR2.4, and IR2.5.

VII. ACRONYMS

BOS	Board of Supervisors
CEO	Chief Executive Officer
CGJ	Civil Grand Jury
DHS	Department of Health Services
DMEC	Department of the Medical Examiner-Coroner
ODA	Office of Decedent Affairs
MOU	Memorandum/Memoranda of Understanding
NAME	National Association of Medical Examiners

VIII. COMMITTEE MEMBERS

Victor Lesley Co-Chair
Molly Milligan Co-Chair
Rene Childress
Judy Goossen Davis
Sandy Orton
Heather Preimesberger
Stephen Press
Arun Sharan
Bob Villacarlos

APPENDIX

California Government Code Sections:

27491. It shall be the duty of the coroner to inquire into and determine the circumstances, manner, and cause of all violent, sudden, or unusual deaths; unattended deaths; deaths where the deceased has not been attended by either a physician or a registered nurse, who is a member of a hospice care interdisciplinary team, as defined by subdivision (g) of Section 1746 of the Health and Safety Code in the 20 days before death; deaths related to or following known or suspected self-induced or criminal abortion; known or suspected homicide, suicide, or accidental poisoning; deaths known or suspected as resulting in whole or in part from or related to accident or injury either old or recent; deaths due to drowning, fire, hanging, gunshot, stabbing, cutting, exposure, starvation, acute alcoholism, drug addiction, strangulation, aspiration, or where the suspected cause of death is sudden infant death syndrome; death in whole or in part occasioned by criminal means; deaths associated with a known or alleged rape or crime against nature; deaths in prison or while under sentence; deaths known or suspected as due to contagious disease and constituting a public hazard; deaths from occupational diseases or occupational hazards; deaths of patients in state mental hospitals serving the mentally disabled and operated by the State Department of State Hospitals; deaths of patients in state hospitals serving the developmentally disabled and operated by the State Department of Developmental Services; deaths under such circumstances as to afford a reasonable ground to suspect that the death was caused by the criminal act of another; and any deaths reported by physicians or other persons having knowledge of death for inquiry by coroner. Inquiry pursuant to this section does not include those investigative functions usually performed by other law enforcement agencies.

(a) In any case in which the coroner conducts an inquiry pursuant to this section, the coroner or a deputy shall personally sign the certificate of death. If the death occurred in a state hospital, the coroner shall forward a copy of his or her report to the state agency responsible for the state hospital.

(b) The coroner shall have discretion to determine the extent of inquiry to be made into any death occurring under natural circumstances and falling within the provisions of this section, and if inquiry determines that the physician of record has sufficient knowledge to reasonably state the cause of a death occurring under natural circumstances, the coroner may authorize that physician to sign the certificate of death.

(c) For the purpose of inquiry, the coroner shall have the right to exhume the body of a deceased person when necessary to discharge the responsibilities set forth in this section.

(d) Any funeral director, physician, or other person who has charge of a deceased person's body, when death occurred as a result of any of the causes or circumstances described in this section, shall immediately notify the coroner. Any person who does not notify the coroner as required by this section is guilty of a misdemeanor.

27491.1. In all cases in which a person has died under circumstances that afford a reasonable ground to suspect that the person's death has been occasioned by the act

of another by criminal means, the coroner, upon determining that those reasonable grounds exist, shall immediately notify the law enforcement agency having jurisdiction over the criminal investigation. Notification shall be made by the most direct communication available. The report shall state the name of the deceased person, if known, the location of the remains, and other information received by the coroner relating to the death, including any medical information of the decedent that is directly related to the death. The report shall not include any information contained in the decedent's medical records regarding any other person unless that information is relevant and directly related to the decedent's death.

27491.2. (a) The coroner or the coroner's appointed deputy, on being informed of a death and finding it to fall into the classification of deaths requiring his or her inquiry, may immediately proceed to where the body lies, examine the body, make identification, make inquiry into the circumstances, manner, and means of death, and, as circumstances warrant, either order its removal for further investigation or disposition or release the body to the next of kin.

(b) For purposes of inquiry, the body of one who is known to be dead from any of the causes or under any of the circumstances described in Section 27491 shall not be disturbed or moved from the position or place of death without permission of the coroner or the coroner's appointed deputy. Any violation of this subdivision is a misdemeanor.

27491.25. The coroner, or the coroner's appointed deputy, on being notified of a death occurring while the deceased was driving or riding in a motor vehicle, or as a result of the deceased being struck by a motor vehicle, shall take blood and urine samples from the body of the deceased before it has been prepared for burial and make appropriate related chemical tests to determine the alcoholic contents, if any, of the body. The coroner may perform other chemical tests including, but not limited to, barbituric acid and amphetamine derivative as deemed appropriate. The detailed medical findings, resulting from those examinations that are conducted, shall either be reduced to writing or permanently preserved on recording discs or other similar recording media and shall include all positive and negative findings pertinent to the presence or absence of any alcoholic or other substance content. This section shall not apply to the testing of deceased persons under the age of 15 years, unless the surrounding circumstances indicate the possibility of alcoholic, barbituric acid, and amphetamine derivative consumption, nor shall it apply when the death has occurred more than 24 hours after the accident.

27491.5. The cause of death appearing on a certificate of death signed by the coroner shall be in conformity with facts ascertained from inquiry, autopsy and other scientific findings. In case of death without medical attendance and without violence, casualty, criminal or undue means, the coroner may, without holding an inquest or autopsy, make the certificate of death from statements of relatives, persons last in attendance, or persons present at the time of death, after due medical consultation and opinion has been given by one qualified and licensed to practice medicine and so recorded in the records of the death, providing such information affords clear grounds to establish the correct medical cause of death within accepted medical practice and within the

requirements for accuracy prescribed by the Division of Vital Statistics of the State Department of Health Services. The coroner shall not finally exclude crime, suicide, or accident as a cause of death because of lack of evidence.

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