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TRANSCRIPT OF THE MINUTES

of the

COMMITTEE ON WOMEN'S ISSUES
COMMITTEE ON HEALTH

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CHAIRPERSON ARROYO: Good morning everyone. My name is Maria del Carmen Arroyo. I chair the Committee on Health in the Council, and I want to thank my colleague, Council Member Julissa Ferreras, chair of the Committee on Women's Issues for joining me in examining the important issues that we are discussing here today. This hearing is a follow up to an oversight hearing held by both of these committees February 15th of this year where we examined the mishandling of DNA evidence in sexual assault cases by the Office of the Chief Medical Examiner, OCME. We held our February hearing after news reports that the OCME mishandled evidence from around 150 sexual assault cases over a decade and failed to upload DNA data to the state database in 56 of those cases. We will also hear two pieces of legislation. The first, Intro number 1058 sponsored by Council Member Ferreras, of which I am also a co-sponsor, which seeks to improve transparency of the OCME by requiring it to post information about proficiency of its lab workers and other documents relating to procedures used in the DNA lab. The second bill, Intro 1051, which I

sponsor and Council Member Ferreras is the co-sponsor is designed to improve the accountability of the OCME by requiring it to conduct a root cause analysis whenever significant event occurs and share the root cause analysis report with the Council, the Mayor, as well as other entities and parties, and we will be going to hear a lot about the term root cause analysis today. So hopefully by the end of the hearing we will all know what it means and what it seeks to accomplish. Today's hearing comes on the heels of recent developments concerning OCME including a consultant's report on the management structure and operations of the office that was revealed on May 2nd of this year. Another recent incident in which deputy director of the DNA lab resigned amid accusations that she violated protocol. The consultant's report makes recommendations for improving leadership, supervision and communications in the DNA lab, which if implemented could improve the lab's performance in the future; however, this report does not help us to understand the source of extensiveness of many of the problems in the lab and in the Office of the Medical Examiner as a

whole, including those that led to the incident that we examined in the February hearing. In addition, we have just received a report containing what the OCME deems to be a root cause analysis, a document which only confirms that the legislation we are hearing today is absolutely necessary. Finally, we will also be discussing another very recent and tragic incident in the Office of the Chief Medical Examiner in which a young Irish man came to the city to work for the summer, was killed by a hit and run driver in the Bronx and has remained - - carelessly and thoughtlessly stuffed in the back of a van next to bags of trash and recycling. Our hearts go out to his family. We assure you that this is not the way our city intends to treat the sacred remains of our loved ones. While the focus of today's hearing will be the bills before us, we expect answers from OCME on that particular incident. I had a hearing in this committee last week with the Department of Health and Mental Hygiene and one of the last statements I made to that agency before they excited the hearing room was my absolute level of frustration and concern about that

agency's lack of cooperation regarding the legislation that we were discussing at that hearing. I am a lady most of the time, and I behave most of the time, but when put in a position where I have no choice but to lash out and challenge how administrations in these agencies fail to be forward and collaborative with our committees, I get really unpleasant. I certainly hope that today I so not have to repeat the words that I expressed to OCME to DOHMH last week. Cooperation is critical to us being able to address the concerns that occur in our city and how the issues that we confront affects the residents of our city, and we are partners. At least that is my belief. We, the Council are the administration's partners in trying to resolve issues. With that said, I will turn it over to my colleague for her opening statements, and before that I want to thank Dan Hayfitz, counsel to the Committee, Crystal Goldpon, the policy analyst and Krillian Francisco, for their work in preparing us for these hearings. Council Member?

CHAIRPERSON FERRERAS: Thank you, Madam Chair. Good morning, my name is Council

Member Julissa Ferreras, and I am the chair of the Women's Issues Committee. I'd like to thank Chair Arroyo for her attention and collaboration on this issue. I would also like to thank the staff of the Committees for their work. As was pointed out, we are here to follow up on a previous hearing in February involving some very disturbing information--the allegations of improper procedures and mishandling of DNA evidence in sexual assault cases. The implications were truly disturbing, especially when you think about it from the perspective of the victim. It is the criminal justice system's job to guarantee they will do the best they can to provide justice to the victims who come forward and protection to the public from possible future attacks. The role of the Office of the Chief Medical Examiner's Department of Forensic Biology is one piece of this guarantee. It is unthinkable that those errors went on for as long as they did without being detected, that is why the Committee has very much looked forward to a frank discussion regarding the two bills on today's agenda. One of the bills which I am the sponsor of focuses on

transparency, but requires OCME to post data on the proficiency of lab workers and other documents relating to procedures used in DNA lab ensuring that these documents are public would provide the transparency and accountability of the office. In addition making such data public represents a critical step forward by improving transparency in the criminal justice process overall better achieving what every victim deserves--justice itself. We also look forward to hearing what steps OCME has already taken to rectify its issues and to work with them on the bills before us today. We continue to expect more from those involved and we hope that the situation has been addressed with the gravity it deserves. Thank you, Madam Chair, for co-chairing today.

CHAIRPERSON ARROYO: Thank you. Before I turn it over to our panel, I want to acknowledge members that have joined us and you will forgive me I don't know what committees they sit on, but we have been joined by Council Member Vallone, who I know is a member of the Committee on Health, Council Member Van Bramer, also from Health, Council Member Rose also from Health,

Council Member Chin Women's Issues. Thank you for joining us. Welcome, and thank you for being here for your testimony. As my colleague was giving her opening remarks committee counsel whispered in my ear that you have been very cooperative in the process of preparing the legislation, so I thank you for that, and thank you for not putting me in a position to not be so nice. So at the table we have the Acting Chief Medical Officer, Dr. Barbara Sampson, Barbara Butcher, Chief of Staff and Interim Director of the DNA Lab, Mimi Mayers [phonetic], attorney for the DNA matters for the Office of the Chief Medical Examiner. Welcome, ladies. You have done this before. Identify yourself for the record and we will hear all the testimony and we will come back for questions when you are done. Okay? Thank you.

DR. BARBARA SAMPSON: Chairpersons Arroyo and Ferreras, thank you so much.

CHAIRPERSON ARROYO: You have the same problem with your mic. Try the other one.

DR. BARBARA SAMPSON: Can you hear me? Thank you so much for inviting us to speak with you today. I am Dr. Barbara Sampson, the

Acting Chief Medical Examiner and to my right is Barbara Butcher, our Chief of Staff and our Interim Director of the DNA Laboratory and to my left is Mimi Mayers, our attorney for DNA matters. Before I begin my prepared testimony regarding this legislation I would like to take a moment to apologize for the shameful incident which appeared in the New York Post on June 17th, 2013 in which recycling material was seen in a medical examiner's truck. OCME has treated this incident with the utmost seriousness. Losing someone you love is beyond difficult, and it is our job to ensure that this loss is not compounded by insensitivity. It saddens me that this event has added to the family's grief, and in addition sullied the reputation of our over 600 employees who work tirelessly, 24 hours a day, 7 days a week to serve families struck by tragedy. The motor vehicle operator who has acknowledged placing the material into the vehicle was placed on suspension immediate upon his return to work pending the results of an investigation currently being performed by the employee law unit of the Department of Health and Mental Hygiene. Once the

facts become known to us, we will act in accordance with our responsibility to the public and our responsibility under the collective bargaining agreement to address this issue swiftly and appropriately. I would like to take this opportunity to apologize to the family of Kevin Bell [phonetic], for the additional burden upon them at this most agonizing time. Moving on now to the legislation at hand. I would like to start by briefly reviewing for you the scope of work performed by New York City Medical Examiner's Office before I discuss the details of the legislation itself. The agency as you know has two major functions--death investigation and DNA analysis. You are aware that as dictated by the City Charter we investigate all deaths that are sudden, violent or unexpected. We work cooperatively though independently with many entities including law enforcement and the criminal justice and medical communities to ensure that family members of decedents are served with compassion and technical excellence. Equally important, but less well known, is our role in public health monitoring disease and accidents.

The Department of Health and several federal agencies routinely use our data to improve the lives of citizens. Our work in this area is regulated by federal, state and local government as well as by professional medical groups. No area of our work though is more highly regulated or overseen than that of our forensic biology laboratory. As the largest public forensic DNA lab in the country, we are closely regulated by federal authorities as well as our accrediting bodies. Additionally, New York State highly regulates all forensics labs, making us subject to scrutiny of the highest order. Our oversight bodies include the New York State Commission on Forensic Science, the DNA Subcommittee, the Department of Criminal Justice Services, the FBI, the American Society of Crime Lab Directors Laboratory Accreditation Board, ASCLD, the International Organization for Standardization, ISO, the New York City Council and the Mayor's Office. We have studied the proposed charter amendments carefully to understand Council's suggestions and concerns. We share and indeed fully embrace the Council's goal of ensuring a

high level of transparency and accountability. We are cautious however about many of the specific provisions of the bill and we would like to bring them to your attention. First, it is already a requirement of the DNA accrediting bodies that we perform a root cause analysis in the event of any incident, which affects casework. This is described in Standard number 4.11.2 of ISO/IEC 17025 as well as the FBI DNA quality assurance standard 14.1B. The bill also contains a provision that we designate a root cause analysis officer, which we already have in the person of our technical leader and quality assurance director, Eugene - - . Root cause analysis is a part of our internal culture at OCME. We are concerned though that the proposed bill's detailed requirements for composing a root cause analysis committee could frustrate our ability to perform a quality incident review. The bill states that we must convene the committee within 48 hours of discovering an error. The Committee must contain at least seven members of varying credentials relative to the incident in question and a consultant employed by the Health and Hospitals

Corporation must be engaged as a member of said committee. Gathering seven members for a committee is unwieldy likely slowing the process of a good investigation, and achieving all this within 48 hours would be difficult if not impossible. Further HHC's participation in the committee as apparently required by the bill would likely be voluntary and at their discretion as HHC is an independent public benefit corporation. If the bill requires that this consultant be retained outside of his or her normal work for HHC then this would seem to be a highly unusual legislative contracting requirement, which might in any event require HHC's consent. As this Committee may be aware, there are many different types of root cause analysis applicable in different situations. We are unclear if under the bill we would retain the discretion to choose the type of analysis we think best suited or are we limited to using only one methodology, and if so, which one? The language in a root cause analysis report can be quite technical and not likely to be of benefit to the general public. The reports may also be explicit in characterizing errors and mistakes

made by identified individuals, and we fear that the publication of root cause analysis reports on the internet might discourage some from embracing a culture of reporting mistakes or writing openly and frankly about errors. This is precisely why hospital root cause analyses are internal, and not made public. Although the legislation states that no individual shall be named when describing errors in a case we believe based on our experience that some will seek to publicize those names in an effort to impugn testimony that is unrelated to the incident being reviewed. It has long been our practice to notify criminal justice entities of any error in a specific case. That practice is part of our protocols, and is codified by our regulatory bodies. To protect the quality and integrity of our review procedures as well as the confidentiality of the identities in those involved, we believe it to be essential that these reports are not unnecessary widely distributed beyond those that have a direct interest in the matter. Efforts to maintain the anonymity of OCME employees and the subjects of our work may not always be able to be achieved merely by striking

their names from a published root cause analysis report. The particular facts and circumstances of an incident could identify someone even if his or her name is not mentioned. In matters where an incident may have stemmed from employee misconduct, wide distribution of a root cause analysis might seriously frustrate or even prejudice the city's efforts to investigate and potentially discipline our employee while not furthering the purpose of ensuring meaningful review of our labs' practices and procedures. Perhaps our greatest concern is how publishing these reports in a public forum might affect the judiciary and other investigative bodies. It may take years to investigate and adjudicate any given case, and we fear that publishing the results of a root cause analysis may interfere with the ongoing criminal justice process. Although the bill describes investigation of the systematic framework from which mistakes arise, it is often necessary in a sound root cause analysis to identify those individual causes which lead back to the system failure. As stated earlier, we immediately notify the relevant parties of a

mistake in any particular case. The amendment requires that we provide these reports to the mayor, City Council, accrediting bodies of the state and federal government, district attorneys, Legal Aid Society, all public defenders under contract to the city and representatives of the 18B assigned counsels for New York in addition to publishing the reports on the website. It is already our required practice to provide the relevant information to members of the criminal justice bar whose cases were involved in or affected by a mistake. This is accomplished through the affected district attorneys, who are mandated by law to notify defense counsel in a relevant matter. We are not in the position to know who the defense counsel is at the time the bill requires our action, and notifying virtually the entire criminal defense bar would in almost all cases be vastly disproportionate to the particular matter at issue while discouraging in practice the kind of internal scrutiny that creates real improvement. With respect to the second bill directing publication of proficiency test results we do not object in principle, but do

have some comments on the specific requirements. First, proficiency tests are given to each and every criminalist twice a year and are graded on a pass/fail basis, so we cannot provide an average score. We can provide aggregate data that we believe would satisfy the bill's intent and that is the same format as the report which we already provide each year to ask ASCLD as part of our accreditation requirements. The bill also directs us to publish all our manual and protocols and certificates of accreditation on our website, which we already do far in advance of any other lab in the state.

[background noise]

CHAIRPERSON ARROYO: Let's take a moment. Okay? I think it was too dark or something. The spirits like the light. Please, I am sorry. You may proceed.

DR. BARBARA SAMPSON: We urge the Council to take time to reconsider specific provisions of these amendments so that we can achieve our mutual goal of transparency while avoiding unintended consequences. We would also like to bring you up to date on our search for a

new DNA laboratory director. We have completed a nationwide search for this position and are pleased to tell you that we have decided up Tim Comferschmidt [phonetic] pending the usual vetting processes of the city. We are especially fortunate to have him as he is aware of the recent problems of the laboratory and understands the structure and systems that gave rise to those problems. His credentials are exactly what we had hoped for. In addition to holding two master's degrees in forensic science and business administration, he is extremely well-regarded in the forensic community for his management acumen and leadership skills. Mr. Comferschmidt has been a lab director of both public and private forensic laboratories, the Maine state police crime lab and myriad genetics laboratories. In addition Tim was the laboratory manager for the Armed Forces Institute of Pathology. As a founder and director for Sorenson [phonetic] Forensics Tim consulted for the Department of Criminal Justice and other government agencies, teaching root cause analysis, six sigma process mapping and management techniques for forensic laboratories nationwide.

Mr. Comferschmidt is a director of the board of American Society of Crime Lab Directors and chairman of the ethics committee, the commissioner of the Forensic Science Education Commission and an active member of the American Academy of Forensic Sciences. Tim is the author of numerous articles on laboratory management as well as forensic and DNA science and speaks often at national conferences. We look forward to building further on the reforms we have already made in the laboratory under his experienced leadership. We thank you for your consideration.

CHAIRPERSON FERRERAS: Thank you very much for your testimony. I just have a few questions before I pass it over to my colleagues. We are knocking everything over today. Thank you. So thank you for your suggestions on the bills. Clearly, we have our own perspective and that is what this dialogue is about. I know that you mentioned the technical leader quality assurance director, Eugene Lean [phonetic]. How long has he been assigned to this position?

BARBARA BUTCHER: Essentially always. The person who is in charge of quality

control, quality assurance has always been the person who begins the root cause analysis process.

CHAIRPERSON FERRERAS: I am just--I know that we had a hearing in February, so this is the person that you are highlighting as someone who is the director of the root cause analysis or officer, and then highlighting him as still a component of resolving the problem as we go in the future, but he was kind of part of the issue in not identifying the problem that we had in the past. Can you give me clarity? Because that is what I am understanding from here.

BARBARA BUTCHER: Yes, Mr. Lean was always the technical leader and quality assurance director. We didn't specifically call him the officer. We just called him the person who did the root cause analyses or headed up whatever team was doing it, so saying he was part of the problem, I would have to disagree in that the quality assurance process did catch the mistakes that originally gave rise to this problem.

CHAIRPERSON FERRERAS: But did it catch it in ten years?

BARBARA BUTCHER: Yes, ma'am, it

did.

CHAIRPERSON FERRERAS: So it took ten years to catch the same problem and only until the Post does a story on it are we having a hearing about it is when we are looking at how to correct it?

BARBARA BUTCHER: Well, if I understand your question correctly the problem continued for ten years which as you point out is inexcusable, but the real fault lay not in detecting the errors, but in failing to do something about them on a higher management level. The accountability was essentially missing there--

CHAIRPERSON FERRERAS: [interposing] So who does accountability? If this gentleman who did the root cause analysis is not his responsibility 'cause he just puts the formulas together, so the formula worked, and it was identified, so then who is the person who now moving forward is going to be able to be responsible that if ten years ago or five years ago or five days from now there is a problem that we are not sitting in this room a year from now and you are telling me, well, that person just

puts in the protocol, but the enforcement is really what the problem was.

BARBARA BUTCHER: It should be and will be the laboratory director. It should have been. In the past that laboratory director failed to take the appropriate action and is no longer leading the lab. Our new laboratory director will be responsible and will be held accountable for implementing whatever problems--

CHAIRPERSON FERRERAS: [interposing] So this is a brand new position of your laboratory director? This is non-existent?

BARBARA BUTCHER: This is not a brand new position. We had a lab director, who has been removed.

CHAIRPERSON FERRERAS: I know that the person who was terminated had a number of poor evaluations. What did the quality assurance director do to alert upper management?

BARBARA BUTCHER: This person actually was missing many of her evaluations, which was part of the problem, which we identified in the root cause analysis and some of the evaluations were fair. They were not good nor

bad. When the actions were discovered--I'm sorry, not the actions, but the mistakes were discovered, it was because there was a poor evaluation done by a manager who said this person--or a supervisor, who said this person is not doing the appropriate work. It was a detailed evaluation that then the quality assurance director said, well, then she needs retraining, and he in undergoing her retraining process discovered that she made consistent mistakes and then moved to have--

CHAIRPERSON FERRERAS: [interposing] But they identified that several times, correct? In the last ten years?

BARBARA BUTCHER: I am sorry?

CHAIRPERSON FERRERAS: That issue was identified on several occasions in the last ten years.

BARBARA BUTCHER: Yes, in the evaluation process.

CHAIRPERSON FERRERAS: Well, the quality assurance person--I just think that name quality assurance, if I am buying something, if I am buying a product and it says it went through quality assurance then I feel like this product is

going to work 100 percent 'cause it went through the quality assurance saying that it is assured that it is 100 percent in quality, but not in this case.

BARBARA BUTCHER: Another flaw that was discovered in doing the root cause analysis that even though evaluations of the employees were done, the deputy director of the lab who was responsible for overseeing the quality assurance person and that whole process did not review those evaluations, neither did the laboratory director. Since I have been the interim director, I have reviewed several years' worth of evaluations-- well, 97 percent compliance in having evaluations done timely, and I have reviewed and read every single one to detect any possible problems, so that came out in the root cause analysis process, so yes, you are right.

CHAIRPERSON FERRERAS: I know that you mentioned that one of the ways that we are going to ensure that this doesn't happen again is the new lab director, and this Council understands this individual used to work for ASCLD lab and OCME's accrediting body. ASCLD labs has been

criticized for insufficient oversight of the OCME. Why didn't the OCME select a candidate with a more independent background? Do you see any potential conflict of interest between this person's duties to the OCME and past working with one of its regulators?

BARBARA BUTCHER: Not at all. He was an inspector for ASCLD as are many of our own scientists. It's an oversight body, an accrediting body and we are not aware of any valid criticisms of their accreditation processes that--

CHAIRPERSON FERRERAS: [interposing] How many other people did you interview for this position?

BARBARA BUTCHER: I'm sorry? There were five applicants for the position. Only two qualified for an interview.

CHAIRPERSON FERRERAS: Wow, okay. And this was a nationwide search you mentioned.

BARBARA BUTCHER: Yes, ma'am. We put it in the Sunday New York Times in a large banner ad and we put it on the American Academy of Forensic Sciences website for a prolonged period as well as the NAME, National Associated Medical

Examiners. We put it all out in the scientific community because we really wanted to find the absolute best person.

CHAIRPERSON FERRERAS: I have another additional question, but I want to give my colleague an opportunity. I just wanted to ask. I know your testimony you made reference to posting any of these information online, specific to the bodies of legislation that we are talking about, will discourage victims from reporting, yet in the same statement you said that it is very complex, so the average person wouldn't understand, so if it's so complex, why would it discourage people from reporting? I am trying to get your - - exactly. Maybe we can circle back to it.

CHAIRPERSON ARROYO: It's page three of the testimony, the second paragraph as the Committee may be aware, there are many different types of root cause analysis applicable in differing circumstances and you are unclear if under the bill we would retain discretion to choose the type of analysis suited. The language in the root cause analysis report can be quite

technical and not likely to benefit the general public. I take exception to the statement first of all 'cause who are we? We could never understand this. That is how I am hearing it, and I think I take exception because I think the goal of the root cause analysis is to identify what went wrong. It is not intended to be a punitive process. Mistakes are not terms that should be used when examining a process and what potentially went wrong. The goal of the analysis in a sound, strong quality improvement and quality assurance program is that it is part of your ongoing work, so I disagree that it would--I think it would benefit the general public, and I think more of us thank you think would absolutely understand and appreciate the information that can be drawn from it.

DR. BARBARA SAMPSON: I agree with your statements entirely. We did not mean at all to be disparaging to the public by this. It was just that some of the root cause analyses that we have done in the past are extremely technical when it comes to very detailed issues concerning procedures within the laboratory, but to the more

general question--

CHAIRPERSON FERRERAS: Okay. So we got that clear. Yes? I wanted to specifically talk about Intro 1058, the local law to amend New York City's Charter in relation to the transparency of the Office of Chief Medical Examiner. In February's hearing the OCME testified that historic manuals and protocols would be posted on its website so that the defense and prosecution would know what manuals and guidelines were in place at a given time. Has this happened? When has it happened? How often will it happen in the future?

BARBARA BUTCHER: If you are speaking of the publishing of the manuals and protocols on the website that happened back around the time of the hearing, our accreditation, I am not certain when that was first published on the website, but I believe it has been for some time, actually longer than the manuals. There is discussion among the various laboratories in New York State about putting their manuals and protocols online or making them available to the public. We were the first to do so. As far as

the ongoing process, yes, they will remain there and as substantial changes occur in protocols or in the manuals; we will update them because they are living documents in a sense. Science changes constantly as you know.

CHAIRPERSON FERRERAS: Our counsel is asking--you have not put up your historic manuals online? So I guess manuals that you used in the past?

BARBARA BUTCHER: No, we have not published those.

CHAIRPERSON FERRERAS: So if we are looking at cases that happened ten years ago are the manuals that are presently posted, would those work for defense attorneys or prosecution because--are they the same manuals that we used ten or 15 years ago?

MIMI MAYERS: Hi. I am Mimi Mayers. Thank you. That is an excellent question. Only the current protocols are online. We do have a plan to place the historic protocols online as well because as the Council notes, it is very important for the defense community to know in a case that is ten or eight years older what

the protocols were applicable at the time, so we do have a plan to do that as well.

CHAIRPERSON FERRERAS: Do we have a date or a timeline? Was this part of the consultant's report?

MIMI MAYERS: We do not. Though, I think it would be reasonable that we would aim to do that by the end of this year.

CHAIRPERSON FERRERAS: Okay. Can someone explain the proficiency test that the criminalists are required to complete twice a year?

BARBARA BUTCHER: Yes. There are independent entities that prepare evidence kits, and these evidence kits are completely unknown to anyone except the company and they are sent to us unlabeled anonymously just with a code, and each criminalist is given a kit to which they must examine and determine if there are serologic fluids present, and if so, is there DNA present, can it be extracted, amplified and can a profile be made? These are done twice a year, and it is either a pass or a fail. If anyone fails a proficiency test, they are taken off casework

immediately.

CHAIRPERSON FERRERAS: Mm-hmm.

CHAIRPERSON ARROYO: It is pass or fail because you know the answer before they take it? You expect a particular result from the kit, not the criminalist, but whoever is reviewing the kit and the findings of the analyst or the criminalist. How do you pass/fail? Who knows what the right is?

DR. BARBARA SAMPSON: The commercial company that provided us this kit to do the testing in the first place. They do all the--

CHAIRPERSON ARROYO: [interposing] So the criminalist conducts the analysis, packages and then it goes back to the company, so somewhere along this chain they expect a particular result from that proficiency test, and it is either that, and if it is not, then they fail?

DR. BARBARA SAMPSON: That is correct.

CHAIRPERSON FERRERAS: Thank you, Council Member. I just wanted to kind of go back to our original - - evaluations. I know that you had stated that sometimes these evaluations came

back as fair. Is fair good enough? Is fair still good enough after all that we have been through?

BARBARA BUTCHER: Well, the ratings are outstanding, very good, good, conditional or I think there is an unacceptable is the final one, so good is what I would consider just the norm--what people should so. Conditional ratings are what make us take action.

CHAIRPERSON FERRERAS: So in this case, I know that she mentioned fair, so fair isn't one of the categories. So what was her rating?

BARBARA BUTCHER: She had ratings that included good with some items being conditional--and you will see in the root cause analysis report that under any given evaluation I can think of one in particular where they had I believe there were three items that she was rated conditional. The rest were rated good, so I would consider that below fair. If someone had one conditional rating, for instance, in an area of keeping up the latest articles or participating in teaching activities--if they had conditional, that is not something I would consider them to be an

egregious breach of casework, but rather where they weren't contributing to their ongoing education, and so they would be counseled about that.

CHAIRPERSON FERRERAS: It seems to me that if that is one of the options that you measure people by that we should take all aspects of it seriously, and I understand that you wouldn't deem one thing over another of personal development or whatever the case, but it is something you analyze, so on average at least technical technicians, right, what is the average status of outstanding? I would hope everybody would be outstanding, but things happen, so are we in good, outstanding, fair, conditional, what is the average of your lab workers?

BARBARA BUTCHER: The average I would say would be good to very good. I would say in the high good range, and I actually could give you statistics on that. There are I think 163 evaluations where we could give you the weight of where those evaluations fall.

CHAIRPERSON FERRERAS: So you said the higher end of good, so good has also

variables?

BARBARA BUTCHER: Well, it is rated by percentage. If you have ten categories and you are rated good in 70 percent of those categories and then very good in the other 30 percent, your overall rating would be good, and that would rate high in the good area. If in 60 percent of the categories you were rated good and 40 percent very good, we would be leaning a little bit more toward the very good range, so you see it falls all along the bell curve.

CHAIRPERSON FERRERAS: I would love for your committee to submit what your current standing is on these evaluations, so that we can better understand the rating of good and very good because if someone comes in--this person was deemed good with a couple of conditional. Obviously, this was a very big problem. Something failed, and I don't think she should have been in the good category at all, so maybe your good is not that great, and that is what I am trying to figure out here. So are we are trying to make all of this make sense I think this is another place where we have to kind of figure out clear

evaluations 'cause this makes no sense that you could be good on the high end or good on the bad end and one condition on three conditionals. I think we are leaving too much to a supervisor to interpret, and that is a problem that we have. If you go in, this is very technical as we have all been privy to and we are all learning 'cause I have learned more in these hearings about this topic--these different levels of evaluating for you to be able to know if this person is working is this very tool. This is it. This is a tool that you have and your tool I have a hard time understanding. I think we have a problem. Another problem.

DR. BARBARA SAMPSON: We agree, and we are looking at additional supervisory accountability and training our supervisors to make these evaluations truly meaningful and to reflect what is going on actually with each and every employee.

CHAIRPERSON ARROYO: I have a lot of questions to ask too. I will turn it over to Council Member Vallone and double back. On The employee evaluation, staff evaluation process that

you have identified that they have been done, but not reviewed by a supervisor or a higher level manager. What will the mechanism be moving forward to ensure that the staff evaluation process accomplishes what it seeks to accomplish, which is help an employee understand particularly where there are some weaknesses that collectively management and the employee need to strategize on improving? Because in my mind, that process ought not to be a punitive process. It should be a process that helps us management and employee work together to improve the individual's performance. That should be the ultimate goal of it. It is not about mistakes. It is not bout identifying those that are no good. No. it is a joint effort, and it is management's responsibility to make sure that it helps an employee improve his or her performance. How are you going to make sure that moving forward evaluations are done timely and that the outcome or the result of that individual evaluation will set forward a plan to help an individual improve in the areas that they have been found lacking?

BARBARA BUTCHER: I couldn't agree

more, and thank you for stating it concisely--

CHAIRPERSON ARROYO: [interposing] I worked for a living before I came to the City Council in a very technical area.

BARBARA BUTCHER: In the root cause analysis under the action section we draw two very similar conclusions to what you stated, and that is that the evaluation process was flawed in that after it was done, no one reviewed it, so--

CHAIRPERSON ARROYO: [interposing] So then it wasn't done?

BARBARA BUTCHER: Exactly.

CHAIRPERSON ARROYO: Because it doesn't accomplish what the goal of the evaluation is, so if it is done and not reviewed, and not reviewed how, not reviewed sitting with the employee to have a conversation about what is lacking or how they are very good at what they are doing and maybe we can use them to help others who may need some support and improvement?

BARBARA BUTCHER: I'll clarify the process. Once an evaluation is done by a supervisor they sit with the employee and go over it extensively, and then the employee signs it to

indicate that it has been reviewed and they understand everything in there.

CHAIRPERSON ARROYO: In every case that was done?

BARBARA BUTCHER: Yes. In every case. And within the evaluation, it lists performance--what they want the employee to focus on in the future and suggestions for how to improve. So in that sense it worked well. Now I think it didn't work well was only in that the director of the lab did review them, so two of the actions we have taken are that the lab director review every single evaluation, which is now done, and more importantly, that when any employee is transferred between supervisors or between different units in the lab, which happens frequently, the new supervisor must take the past three years evaluations, review them carefully with the employee and then establish for them a career plan that will look at areas that need improvement, look at strengths that we can capitalize on and decide together with the employee, where do you want to be in the future in this lab. How can we best make your career

something that will satisfy you and will help the laboratory? So I think that is one of the most important actions that we have taken.

CHAIRPERSON ARROYO: Don't you see some redundancy in that? How often are there transfers between units or labs?

BARBARA BUTCHER: That is difficult to say. Some people like to move between different--like between the homicide section or sexual assault or property crimes. Some people like that--

CHAIRPERSON ARROYO: [interposing] Some people like it but it sounded to me like that is a deliberate process that the office engages in, so individuals are transferred between units for the receiving supervisor to sit and review three years' worth of evaluations, and set out a plan for the individual employee. That is something that should be done as part of the ongoing annual evaluation. It just seems too redundant and how overwhelming can that be for the receiving supervisor to have to sit and go over what has already been done, and presumably reestablish a strategy for helping the employee

improve his or her performance. The spirit of it is that to set a career path for them. I am not sure if that is what evaluations are supposed to accomplish.

BARBARA BUTCHER: Right. I think this goes beyond the yearly evaluation. One of the things we noticed with the criminalist who made those errors was that when she was transferred to a new supervisor, the supervisor, the new one was not aware of what had transpired under her previous team.

CHAIRPERSON ARROYO: - - for the rest of the day. Council Member Vallone?

COUNCIL MEMBER VALLONE: Thank you, Madam Chair. Let's start with that incident because the root cause analysis regarding that incident concludes that there was no systemic failure. "The mistakes made the criminalist were due to inattentiveness and failure to double-check her work and there is no single pattern that would indicate systemic failure." If she did that once, then it is her fault. If she has done that over 11 years that is the definition of systemic failure. I am going to quote from your report.

Lack of oversight by a weak management team, six of 11 years she did not receive an annual evaluation despite it being a requirement, a letter written in 2002 said that she wasn't able to work independently, and - - and yet she continued to work independently. That is the definition of a systemic failure. Who did this report?

BARBARA BUTCHER: I did.

COUNCIL MEMBER VALLONE: You did?

BARBARA BUTCHER: Yes. Yes, sir.

COUNCIL MEMBER VALLONE: Great, so then how could you possibly conclude that that is not the definition of a failure of an oversight system?

BARBARA BUTCHER: I am sorry, sir. I guess the miscommunication there is that what I meant specifically that process in which she engaged as a technician. In other words the process of evidence exam was not systemically flawed in and of itself 'cause there are different ways certainly to process an evidence kit. What I meant was that in that specific process; however, yes, the entire incident, the whole - - , was a

systemic failure in speaking in the wider sense of the laboratory management. Yes.

COUNCIL MEMBER VALLONE: Perhaps that could have been made clear because if the individual process is not flawed, but the people doing it are making mistakes which aren't checked, then I would consider that a flaw in the individual process, but I think in the future--so you will be doing any root cause analysis that we mandate would also be done by you?

BARBARA BUTCHER: No, sir. It would depend on the different department. I am an administrator at the agency, so as the Council bill defines there would be different people within the group from let's say if it were the toxicology lab, it would toxicologists plus administrative people, other scientists. If it were the DNA lab, it would be them. I was just one player in this particular…

COUNCIL MEMBER VALLONE: So you have assured us that there are now systems in place to ensure that this won't happen again?

BARBARA BUTCHER: I could never say that it won't happen again. I can say that we

will do our best to prevent these type of actions, but human beings being what they are…

COUNCIL MEMBER VALLONE: Obviously someone is going to be able to screw up once and there is nothing you can do about it, but can you say with certitude that if someone made the mistakes that this person made for 11 years you would be able to find out earlier and ensure that this type of massive failure doesn't happen again?

BARBARA BUTCHER: Yes.

COUNCIL MEMBER VALLONE: That is great. However, we had a hearing in February, and we were assured that there would be proper oversight, and then last week, we read that there is a body in a van with recyclables. You assured us that this type of thing couldn't happen again, and yet I doubt this is the first time an ME van was used with recyclables. What has your investigation revealed so far about how that was allowed to occur?

DR. BARBARA SAMPSON: The investigation is being run by the employee law unit, and they are just beginning, so we have no details at this point, but we will be glad to

share them with you when we get them.

COUNCIL MEMBER VALLONE: There is no DNA evidence necessary in this one. It is rather simple. You have got a driver with recyclables in the van. Are recyclables allowed in your vans?

DR. BARBARA SAMPSON: No, they are not.

COUNCIL MEMBER VALLONE: How long has this driver been working for you?

DR. BARBARA SAMPSON: He started with the city in 1998 and with us I believe since '02 or '03.

COUNCIL MEMBER VALLONE: And has he been disciplined in the past for anything similar to this?

DR. BARBARA SAMPSON: No, he has not.

COUNCIL MEMBER VALLONE: Well, it has been a week. It seems relatively simple to get answers to this situation at least, and I know that our chairs will continue to follow up on this so that we can have answers because we did have a hearing planned for today, and we would have liked

to have some answers today as to how this was allowed to occur, and what you have put in place to ensure that it doesn't occur again. Has there been any changes to your system when it comes to drivers and vans to ensure that this doesn't happen again?

DR. BARBARA SAMPSON: Yes. Absolutely. As I said, we are taking this extremely seriously. We have increased our supervisors actually laying their eyes on these vehicles that travel all throughout the city seven days a week 24 hours a day. It is difficult because we won't have as much staff as we would like to do this, but it is absolutely imperative that we do so, so we are doing that. We are doing increased spot checks at scenes to ensure that all our employees are behaving in the most professional way that we require at OCME.

COUNCIL MEMBER VALLONE: Those all sound like very good procedures to have in place. We are concerned however because the last incident took 11 years to root out and on the heels of being assured that there would be better quality control, something which is very difficult to do

without being noticed--recyclables in a van--was allowed to occur. So I have faith in our chairs that they will continue to oversee this to ensure that these systems are actually put in place and we don't read about a failure like this again in the future. That being said, I do have a lot more confidence in the people at this table than I have in the past, so please continue the good work that you have started. Thank you.

DR. BARBARA SAMPSON: Thank you very much.

CHAIRPERSON ARROYO: Thank you, Council Member Vallone. We have been joined by Council Member Oliver Koppell, who is not a member of either of the committees, but the incident with the issue of the deceased being put in a van with recyclables happened in his district, and I want to give him an opportunity to ask some questions.

COUNCIL MEMBER KOPPELL: Thank you, Madam Chair. As you mentioned, I am not a member of the committee, but I appreciate being able to participate, and I apologize for being late. I had obligations in the Bronx that I had promised to do a long time ago, and that is why I am late.

I am pleased that Council Member Vallone raised this issue. I believe there are a number of people that are here from the Woodlawn community. If you are from Woodlawn, would you mind raising your hand? I must tell you, Madam Chair, that there is tremendous--there was a big meeting Friday night, and there is tremendous anguish frankly because people respect people who have died, and they think they have to be treated with respect and not insulted by the manner in which the body is treated. I really am here to vehemently object. I gather that you did issue an apology at the beginning, and we appreciate that, but nonetheless, this has created a great deal of anguish as you might understand. I just need to know a few things because I am not that well aware of your operations. How many--is it your office's responsibility to pick up the bodies or the remains of people who have died who are not picked up by an ambulance or picked up by a funeral parlor? Is that the obligation of your office?

DR. BARBARA SAMPSON: Yes, it is.

COUNCIL MEMBER KOPPELL: And how do you find out about the fact that someone - - like

this young man was struck by a car and killed--how do you find out?

DR. BARBARA SAMPSON: The police notify us.

COUNCIL MEMBER KOPPELL: I see. So the police notify you and then you dispatch a van?

DR. BARBARA SAMPSON: That is correct.

COUNCIL MEMBER KOPPELL: What kind of van is it that you dispatch?

DR. BARBARA SAMPSON: It's a van that is particularly designed to transport decedents.

COUNCIL MEMBER KOPPELL: How many vans of this sort do you have?

DR. BARBARA SAMPSON: Approximately five.

COUNCIL MEMBER KOPPELL: Is there one in each borough or how are they deployed?

DR. BARBARA SAMPSON: Generally one in each borough, but we shift that as necessary depending on what is going on in the city in any particular time.

COUNCIL MEMBER KOPPELL: So when

you get a call to--are the vans out there standing on street corners like the ambulances or are they in a particular garage?

DR. BARBARA SAMPSON: They are generally at an OCME facility, and then go to the scene unless they are at a previous scene when they get that call in which--

COUNCIL MEMBER KOPPELL: [interposing] And where is the facility that serves the north Bronx?

DR. BARBARA SAMPSON: At Jacoby Hospital on that campus.

COUNCIL MEMBER KOPPELL: I see. So presumably this van came from the Jacoby Hospital?

DR. BARBARA SAMPSON: I am not sure in this particular case. It might have come from there or it might have come from another scene.

COUNCIL MEMBER KOPPELL: You haven't checked that yet?

DR. BARBARA SAMPSON: I don't know that particular detail.

COUNCIL MEMBER KOPPELL: Frankly speaking, Madam Chair, I am surprised that even though it is relatively only a few numbers of days

that you haven't at least ascertained where it came from because has the van driver who brought the van there and then put the decedent in that van with the garbage or the cans or whatever was in there, has he or she been disciplined?

DR. BARBARA SAMPSON: He has been suspended pending the investigation.

COUNCIL MEMBER KOPPELL: I see. And what about--are there people at the Jacoby Hospital depot for instance? Are there supervisors there or people there?

DR. BARBARA SAMPSON: Yes.

COUNCIL MEMBER KOPPELL: And have any of them been questioned about this?

DR. BARBARA SAMPSON: They are in the process of being questioned about this.

COUNCIL MEMBER KOPPELL: They haven't been suspended yet?

DR. BARBARA SAMPSON: No, not yet pending the outcome of the investigation.

COUNCIL MEMBER KOPPELL: It would seem to me that it would be logical - - that when the vans are in their depot there that they be checked to make sure they are clean and

appropriate for being dispatched. Is that part of your protocol?

DR. BARBARA SAMPSON: I know that we do that at least on occasion. I don't know the part of the daily routine that is, but that is an excellent suggestion to do.

COUNCIL MEMBER KOPPELL: I mean it seems to me that I am not that familiar. I know Council Member Vallone is probably more familiar than I am with the fire department, but I think that from just observing fire companies over the years when the fire truck comes back to the firehouse it is cleaned up, the equipment is restored to the place where the equipment is supposed to be restored, the engine is cleaned and ready to go for the next run. It seems to me that protocol should be in place for these vans just the same way. Is it?

DR. BARBARA SAMPSON: It may very well be. I don't know about that detail.

BARBARA BUTCHER: We have a fleet manager as well as various supervisors in the different boroughs who oversee the morgue attendants who are responsible to clean out the

vans, but they do go out 24-7 and additionally they might not be coming back to the depot or to the medical examiner facility for as long as nine or ten hours when they are out on a shift, and when they do come back of course they are checked then, but what happens at that in between spot is something that is being investigated.

COUNCIL MEMBER KOPPELL: Well, I would suggest that each time the van comes back to the depot, someone be responsible for making sure it is clear and appropriately outfitted, whatever equipment is there, and then a check off is put, the van was here, it was cleaned, it was so on. When do you think your investigation of this will be complete of this incident?

BARBARA BUTCHER: The employee law unit is doing the investigation--

COUNCIL MEMBER KOPPELL: [interposing] I am sorry. I misunderstood--

BARBARA BUTCHER: The investigation is being done by the employee law unit at Department of Health. They have investigators there who are looking into this deeply, and not just at this one driver, but at the procedures as

well as in house. Our deputy commissioner for operations is looking into it, so we are not looking at just this one incident, but as is done in any root cause analysis, what is the systemic flaw that allowed this to happen.

COUNCIL MEMBER KOPPELL: I would ask the medical examiner, I would ask that you do a two level analysis. I have no problem with you doing a more systemic analysis, but I think that there should be a prompt report issued as to this incident, and who is responsible, not only the driver, but also if they are responsible, the people at the depot because I think that we are entitled to know. Before you do a complete overall analysis--that may take months. I don't know. I would think that this incident could be evaluated relatively quickly, and I would like to you to send a copy of the report to the chair, but also to my office, please. This is very regrettable. As I say, it has caused a great deal of upset and anguish in the community, and the people want to know that this is not going to happen again, but they also want to know who is responsible. I mean in our justice system we ask

for justice even though we can't necessarily bring the victim back or bring the victim back to health, but we want justice to be done to those who are responsible, and it seems to me here clearly there have been serious violations of protocol which have caused a great deal of anguish, and Madam Chair, it is not only anguish in Woodlawn, but this has been communicated in Ireland, and there have been headlines in the Irish newspapers, and it puts a black eye not only our city, but our whole country actually when something like this takes place, so this is not something to be brushed under the rug. Really, it is a serious matter and must be treated seriously and promptly.

CHAIRPERSON ARROYO: Thank you, Council Member. I have a couple of follow up questions. I also want to make note that we are scheduled to be out of this committee room at one o'clock. The Council has a general stated meeting scheduled then in the chamber, and this room serves as an overflow room for all kinds of different activities, so I am going to ask a couple of follow up questions on the handling of

the fleet of the office, and then focus questions on the legislation that we are hearing. The employee law unit why isn't the Office of the Medical Examiner conducting this evaluation itself? Why the Department of Health and Mental Hygiene?

DR. BARBARA SAMPSON: The initial interviews were begin by OCME, but early in the process, we consulted with the employee law unit in order to ensure that we were following all city protocols to the T when handling this investigation, and they felt that it was better for them to handle this to be able to look from the outside in at what was going on here. Also, if we moved to terminate this employee, the employee law unit would be the one handling this process, so we wanted to make sure we were in step with them.

CHAIRPERSON ARROYO: I don't understand why the Department of Health and Mental Hygiene has to be the one to step in and conduct the investigation to--just a second. I thought you were in charge of staff--

DR. BARBARA SAMPSON: I am in

charge.

CHAIRPERSON ARROYO: --performance issues in the Office of the Medical Examiner, and I know that you are still on your honeymoon, and that you walked into a position at a time when a lot of things are in flux, and I appreciate that, but I don't understand why another agency has to take over for your office a process that your office should be absolutely capable or should be capable of handling itself. I don't understand that.

DR. BARBARA SAMPSON: Maybe I mischaracterized it. They haven't taken over. They are leading the investigation in--

[crosstalk]

CHAIRPERSON ARROYO: Call it what you want. You, the Office of the Medical Examiner, is not the entity overseeing and responsible for the beginning to the end process of identifying what went wrong and ultimately coming to a conclusion that if employee discipline is necessary that you have the mechanism to make sure that that is done in a process that one, is fair and that at the end of it you can set up a

mechanism for making sure it doesn't happen again. It comes right back to the mishandling of the DNA. All of it comes back to why, who is in charge of what is going on in the Office of the Medical Examiner and that again and again we come back to a conversation of we have got to find out what happened, and I have a great deal of respect for the work that your office does, the value that your office provides to the city, the reputation that your office has as a leader in the work that you do, and for now two hearings in a row you sit here and you don't have a handle on what happened or how to take care of it. Help me understand why you are sitting here saying the same thing about the mishandling of this body and how we are now having to apologize to a family for a driver not handling his function appropriately.

DR. BARBARA SAMPSON: I think OCME handled this as swiftly as possible by suspending the employee immediately upon his return to work, and we are conducting this investigation with the employee law unit. You have to remember OCME is--especially our HR structure--is intimately related with the Department of Health, so we are working

with them.

CHAIRPERSON ARROYO: Explain that please because I know that, but everyone in this room thinks at this moment that you are inept and you can't handle your business, so please explain why the employee law unit of the Department of Mental Health and Hygiene is involved in this process.

DR. BARBARA SAMPSON: The Office of Chief Medical Examiner is for much of what it does an independent agency; however, we are also considered within the city as a bureau within the Department of Health and Mental Hygiene. For our HR related processes--

CHAIRPERSON ARROYO: [interposing] Human resources.

DR. BARBARA SAMPSON: Human resources, I am sorry, processes we work through the Department of Health and with their advisors to bring about particularly in this case, employee discipline, so we wanted them involved from the very beginning to ensure that we did this absolutely correctly, so we could take any necessary action that was deemed necessary after

the completion of the investigation, and I will be happy to provide the outcome of that investigation as soon as it is ready.

CHAIRPERSON ARROYO: Thank you for that explanation 'cause I am frustrated. I can't imagine how the public feels at this moment about what seems to not be going so well in the Office of the Medical Examiner. I am going to go back to the issue of the report that was prepared by a consultant, a consultant who now is hired or is the prime candidate of the position of the lab director, that individual who wrote this report questioned the lab director, and the function of the lab director who is responsible for reviewing the evaluations and the director didn't review the evaluations. I don't want to believe that it is very convenient for that report to identify he lab director as the problem and then this guy now gets hired in that position. Conflict… how do you explain that away?

DR. BARBARA SAMPSON: The outcome of the Sorenson report was the same as Barbara Butcher's internal investigation that she did after the review of--interview with over 80

employees at the forensic biology lab and the conclusion was that while the science is excellent, the management and the structure and the culture in the laboratory was the problem. So our internal review came to the same conclusion as our external consultant. His report in no way was a surprise to us, and after meeting him and reviewing his CV, his credentials, he is uniquely qualified to lead our lab at this time mainly because not only is he an outstanding scientist, but he is also an outstanding manager, and that is what we sorely, sorely need at OCME at this time.

CHAIRPERSON ARROYO: The report, Sorenson, was the prime candidate to become the director of the laboratory, right?

DR. BARBARA SAMPSON: Yes.

CHAIRPERSON ARROYO: His report is based on interviews with 39 employees, e-mails from 18 employees, focus groups and a review of the lab management manual. Were there any systematic reviews of personnel, files, lab files, and if not, why not?

DR. BARBARA SAMPSON: No, that was because Barbara Butcher did that in her review.

CHAIRPERSON ARROYO: Okay. I was under the impression based on the discussion we had earlier this year that the management report that was being conducted by this consultant was going to conduct--include a systematic review. The goal of the analysis I believed was to help you identify where in the system in the process of conducting the work that is required there might be areas that need to be addressed and develop a strategy for improving it.

BARBARA BUTCHER: Yes, this was in conjunction. It was part of the root cause analysis done by me and a team at OCME that did the review of--

CHAIRPERSON ARROYO: [interposing] You conduct the root cause analysis. Your issue with our legislation is what? That we should not publicize them because you feel that individuals might not participate in disclosing and/or identifying areas where there might be a problem?

BARBARA BUTCHER: No, not at all. It is just that we had concerns about some of the requirements for publication. We believe that they should of course go to the oversight bodies,

including the Council. They should go to any persons or criminal justice bodies or entities involved in a particular case, which may have been or is possibly affected by what is identified in the root cause analysis; however, we didn't feel that the entire report should be broadcast on a website or posted on a website to the general public that it should be directed--

CHAIRPERSON ARROYO: [interposing] Because we wouldn't understand it.

BARBARA BUTCHER: No, ma'am. I'm sorry. That was not our intent. It depends on--

CHAIRPERSON ARROYO: [interposing] It's one of the reasons as cite din the testimony that the publication of the report really wouldn't serve the general public because they are so technical in nature.

BARBARA BUTCHER: We did not intend that to be an insult.

CHAIRPERSON ARROYO: So we are going to strike that from your testimony then?

BARBARA BUTCHER: Yes, ma'am.

CHAIRPERSON ARROYO: Because… okay. the DNA accrediting bodies that perform--you are

required to perform the root cause analysis in the event of an incident. And you cite the manual, the standard number of the ISO and the IEC and the FBI quality assurance standard. One is not public. One is not available. Which one is it and how does the public get then access to the report?

BARBARA BUTCHER: The summaries of an ongoing action are published for a two month period on the--

CHAIRPERSON ARROYO: [interposing] Of which one?

BARBARA BUTCHER: The Forensic Science Commission, DNA Subcommittee. They are published on the website there, including the live meetings, and--

CHAIRPERSON ARROYO: [interposing] You cite two specific standards, number 4.11.2 of ISO 717025 as well as the FBI DNA quality assurance standard 14.1B. Of the two, which is the one that is public?

BARBARA BUTCHER: Those are requirements just that we perform a root cause analysis, each of those. The publication standard

is in an entirely oversight body, that being the forensic science commission.

CHAIRPERSON ARROYO: So on your website, do you identify for anyone who is looking for information about a study that has been done regarding an issue that occurred and where they can find information about that particular problem or that particular study?

BARBARA BUTCHER: No, we have not up until now. No.

CHAIRPERSON ARROYO: It is one of the reasons that you state it is already required, and as far as I understand one of those documents is already publically available. How does that gentleman in the front row know that that is public information and where he can get it?

BARBARA BUTCHER: I guess they wouldn't know.

CHAIRPERSON ARROYO: They would not know.

BARBARA BUTCHER: Right.

CHAIRPERSON ARROYO: Okay. So give me a reason not to have to pursue the root cause analysis legislation. I don't like to introduce

legislation just for the sake of doing so. It is my belief that what we do here should serve a purpose and it should serve a purpose only in the event that our government agencies are not providing for whatever it is that we are seeking to resolve here. We the Council, our advocates in the community and the legal advocates in our city are crying for transparency from this office, and when we hear the public testimony that is what I am going to be told time and time again. Give me a reason not to pursue this legislation and help me inform the public better about the work that you do and that when you identify a problem that you are on top of it, that you are taking care of it because what we heard in February and what I am hearing today doesn't convince me that that is the case. So what other recommendations do you have? We are going to hear some from the public how to make this legislation better or how you are going to change your practices so that transparency is given, not because legislation is enacted, but because the practices of the office are such that we public has information.

BARBARA BUTCHER: We don't object

to the legislation at all. We agree with it. There is just specific provisions that we would like to discuss with you. Certainly don't want to take up all your time today, but things like requiring that there be seven members--is there room for flexibility there?

CHAIRPERSON ARROYO: The issue in your testimony about the committee and the committee must contain seven members of varying credentials relative to the incident in question and the HHC consultant whether HHC would be engaging in that or not, my experience from HHC is that they are a very forthcoming public entity and that they absolutely want to participate in ensuring in any way possible that what we do as a city we do well. I don't foresee HHC pushing back on making someone available to provide you some guidance in that direction. It helps that this committee has oversight of that entity as well, but my experience is that they would be very forthcoming in that, and I think would probably enjoy and look forward to participating in that process. That gathering seven members of a committee is unwieldy likely slowing the process

of a good investigation and achieving all of this in 48 hours would be difficult if not impossible--yeah, because you don't have a quality assurance process in place. Don't get me started 'cause we have had this conversation, and I have not heard from you what your ongoing quality assurance monitoring processes are, and how committee members identified--and they know that as part of their role they participate in that process and that it includes people throughout the spectrum of what you do up and down the food chain from the low level employee to the top management position, that if you have that mechanism in place as an ongoing process gathering a committee within 48 hours is not difficult at all, and we are going to hear from some experts in the field and maybe you should talk to them about--and this is where I recommended talk to HHC. They have this down to a science--quality assurance, quality monitoring, so pulling together seven people slow a process, I don't accept. Don't accept and won't tolerate either as a reason why this legislation would be problematic. Would you care to comment?

BARBARA BUTCHER: Well, if we have

a standing committee of seven people but perhaps we misinterpreted the legislation in that it deemed what the qualifications of each member should be depending on an incident is how we read it, so if you want a standing committee absolutely.

CHAIRPERSON ARROYO: If it is pulling together seven different people whether it is a standing committee or not these are individuals that are in your system that can be tapped at any given time and asked or given an assignment to participate in the review of the process, so whether it is a standing committee or whether it is one that you have to pull together within 48 hours, I believe that a standing committee might be more efficient, but even if you have to pull it together within 48 hours, I don't see that as a major issue of being able to carry out the language in the legislation, and we will look at the language around the committee and work with you to make sure that the legislation or the goal of it and your ability to execute what the language requires is not a burdensome process for your at all because we don't want you to work

harder. We just want you to work better. Smarter. I cannot stress enough that in looking at how we do what we do is not a punitive process. When we examine what we do and how we do it the goal of that is to identify areas where we need to improve, and it shouldn't be identifying any individual by name, and it shouldn't be identifying anyone to blame in the process, so posting a report and being worried that someone is going to be identified and/or that it is going to hinder or help a defense attorney manage his or her case is also something that I don't agree with. This is intended to help the Office of the Medical Examiner be able to quickly and efficiently examine what goes wrong, timely results so that we can bring corrective action as soon as possible and further minimize the opportunity for something to go wrong. I have faith that we will be able to get to a place where language in the legislation both Council Member Ferreras' and mine is legislation that makes sense, and accomplishes what we seek, and I say again, I don't want--and it doesn't have to be through a legislative process, it should be

embedded as part of the ongoing process that you engage in in providing the services and doing the work that you do so that if the gentleman in the front row in the glasses wants access to information about the Office of the Medical Examiner and how you have been forthcoming in posting a report about an incident that happened I don't know that we need legislation to accomplish that, but that it is embedded in your ongoing every day mechanism and that the public is able to get information and therefore the transparency is provided. If we have to legislate, fine. We will do that too, but it shouldn't have to be necessary. We shouldn't have to force the issue. We should be able to be confident that how you do what you do provides the transparency to the public. We are not trying to hide anything, and I don't want the public to feel that you are hiding something because I don't believe that that is the case. I see our role as the mediators between you and the public at this point and that how we move this conversation forward will further strengthen our confidence in the work that you are doing, and that you are

doing the best work possible. Not perfect because I don't know what employee that you find that is always perfect, but my experience has been that as human beings we do make mistakes often unintentional, and correction is necessary to help us figure out how not to make that mistake again in the future, and that is the goal of these two pieces of legislation and more importantly to keep the public informed about when there is a problem you have identified it and that you acted quickly to resolve it. We were joined by Council Member Rivera. We have been joined by Council Member Mendez. Any questions? I thank you for your cooperation with the staff. I look forward for that to continue, and I know that there are individuals in the public and advocates that are very interested in making sure that this legislation moves forward. I offer you an opportunity to meet with them and have conversations with them. We can identify who they are for you, and I hope that you do take opportunity from that because it will make whatever we do better. Thank you.

BARBARA BUTCHER: Thank you.

CHAIRPERSON ARROYO: I am going to call up a panel four individuals--Dr. Weiss [phonetic], Montefiore Medical Center, Sarah Chu [phonetic], Innocence Project, Lawrence Koblinsky [phonetic] and Marvin Schechter [phonetic], Truth Justice…and something else, and you didn't write it. Marvin? Okay. So those who come to the public hearings of this committee know that I hate to put people on a clock to limit the amount of time that they testify. Please summarize your statements as much as you can. Don't read your testimony verbatim. We have three other panels to get through, and we need to be out of this room by one o'clock, which gives us about an hour, so cooperate. We will all get along and we will all learn something in the process. You may begin when you are ready. As you can see, we are having a little trouble with the sound, so if you can speak directly into the mic. When the light is on, the mic is on. Identify yourselves for the record.

MARVIN E. SCHECHTER: Marvin E. Schechter, criminal defense attorney.

CHAIRPERSON ARROYO: Do you

testimony, and identify when you begin your testimony, so go ahead since you spoke first.

MARVIN E. SCHECHTER: Councilwoman Arroyo, Chairperson Ferreras, members of the Committee, first of all thank you for the invitation and the opportunity to come before the City Council of my city. I have been a resident here all my life, and it is only the second time that I have had this opportunity. I also want to take a moment to express to the committee my thanks to Dan Hayfitz and Crystal Goldpon, who have done just an excellent job at pinpointing these complicated issues and making them understandable to the public.

CHAIRPERSON ARROYO: They are the reason I sound so smart most of the time.

MARVIN E. SCHECHTER: My comments that I have submitted to you in writing are extensive and somewhat controversial. Let me first say I support both of the bills that are proposed with some minor modifications and one major modification. The very fact that this municipality for the first time, a funding municipality, is saying to one of its labs report

to us is a historic moment in the United States. It has not been done before, and therefore, if you success this will become the template by which many other cities who have problems with their labs, some much worse than ours and some as extensive as the ones you are uncovering, will be able to follow. Secondly, the root cause analysis bill is to my way of thinking at the heart of the issue. What has been troubling is I have listened to the testimony of the OCME and I caution you about this. You need to find out what they think what cause analysis is. It is a term of art. I have seen great root cause analysis as a member of the Commission on Forensic Science of this state particularly done by the chief of detectives of the New York City Police Department. When he has a problem, and it is revealed to the Commission he goes through a root cause analysis that is deep down into the weeds. Root cause analysis means different things to different people. In fact, for labs in the state of New York and OCME is included in that, the term that they are more comfortable with is one that the get from ASCLD lab called corrective action. Corrective actions

are not the same as root cause analysis, and what that leads to because of the obtuseness of the ASCLD lab rules and regulations is often we hear from these labs that a problem occurred, here is the problem, this is what happened, and it is usually not a very lengthy explanation of how the problem was discovered, and here is what we have done about it. That is it, and that is acceptable to ASCLD's lab, and that is the accrediting agency for this state. It is the accrediting agency for OCME and interestingly enough, ASCLD lab's rules and regulations are not public. They are secret. They are kept confidential. They are only available to the lab directors and the labs who are accredited by them and they are available to the Commission on Forensic Science or other state commissions. They are available occasionally to investigative bodies such as the one that investigated the SBI lab scandal in North Carolina several years ago, but otherwise those are not published. They are confidential documents and they are not available to the public. One of the things that I have indicated to you that you should require is to have OCME publish all of

their accreditation documents publically, and do you know why? Because if it goes on the website, the public will understand it, and the public will ask questions and do you know who else will ask questions? That great entity, the fourth estate [phonetic], the press. They want to ask questions and they can't right now. They are hamstrung because many people in the press go to prosecutors and defense attorneys to try to find out what is going on, but only if we had this stuff online publically disseminated would everybody be able to participate and by the way, so we are really clear about it, there is not one thing, not one discipline that the OCME engages in that cannot be discerned with a little bit of study by members of the public. I am living proof of that, so let's be really clear about that. Oh sure, DNA can be very complicated. I read last night very complicated DNA testimony of Dr. Mitchell testifying at a hearing in Brooklyn - - challenge to a new tool that has been developed by the OCME. I didn't understand all the technical terms. Ms. Chu, I am sure, can explain them to you and to me quite well, but I will tell you this. I

understood every part of the testimony where the legal aid attorneys cross examining Dr. Mitchell were able to show that she didn't keep her records, she didn't keep her validation studies, she didn't have the records available, and she violated some of the most basic principles of science. What we found here today and why I think your transparency bill is an excellent bill is it will cause the OCME to focus and to become much more open whether they like it or not, and they don't like it. Most of these labs have enjoyed a 30 year history where they are quite comfortable reporting to ASCLD lab. That is their one place where they know nothing will happen to them, and indeed we know from a series of IG reports of the New York State IG office dating back to 2008 that we have had massive lab failures. You think this is the first time we have had a ten year systemic failure? We had one in 2008 in the New York State Forensic Investigations Center in Albany where a technician in the trace evidence unit for ten years faked his reports. Here we are in 2013. We are right back where we started. In my written comments to you I also pointed out and I think

this morning we got just a real good taste of how resistant the labs are to these kinds of changes. You get a sense from the labs that this is their domain and that it is not your domain and so while they will say in one hand we agree with your legislation on the other hand they will tell you we don't want any part of it. I don't have by the way the same degree of confidence and certitude that Councilman Vallone expressed a few moments ago. My certitude is the other way. I almost believe at this point that the OCME is just not going to change, and that is why these two bills are so important because it mandates that change whether they like it or not, and so I urge you to read some of my other comments in my written testimony. I hope they are helpful to you, but that is basically where I came out today.

SARAH CHU: Hello. Thank you, Chairperson Arroyo, Chairperson Ferreras for holding this hearing today on the root cause analysis bill and the transparency bill that your committees are introducing. If enacted, the Innocence Project believes that these bills would restore the OCME's place of leadership among

forensic science providers because currently to my knowledge no forensic laboratories in the country would have processes in place such as the ones that you have introduced today in your legislation. As you can see, I am not Peter Newfeld [phonetic]. Unfortunately Peter wasn't able to make it. He is traveling right now, and he sends his regards. He is disappointed that he couldn't be here in person to support the bills himself, but you have me. My name is Sarah Chu and I am the Forensic Policy Advocate for the Innocence Project. The Innocence Project as you know is an organization that exonerates people who are wrongfully convicted of crimes they did not commit and we are able to prove their innocence using forensic DNA technology. Now using root cause analysis terminology you can think of a wrongful conviction as a significant event in the criminal justice system because if you are innocent there should be no reason why you are convicted of a crime that you didn't commit, and at the Innocence Project we have taken all 309 of the DNA exonerations to date, we deconstruct them and we take a look at all the contributing factors

that had to happen in order for this wrongful conviction to occur and what we have learned is that it is a very rare case where you have just one person or one single event that causes a wrongful conviction. Rather is an accumulation of errors along the way in the criminal justice system that leads to these wrongful convictions and so we base our policy approaches on research that is designed to address the major contributing factors, and you have heard of some of these contributing factors--misidentification, incentivized testimony, false confessions and invalidated or improper forensic evidence contributes to about half of DNA exonerations. As Marvin mentioned before, I am not a lawyer. My background is in science, and right now it is an exciting time in forensic science because things are changing and the National Academy of Sciences released a report in 2009 and we happen to have an esteemed member of that commissioner here, that took a look at the state of forensic science in the United States, and that report said we respect the forensic science community, the hardworking forensic scientists for doing their best, but we

have a long way to go. What the City Council did today, which is extraordinary and pioneering is taking the advances and the lessons learned from clinical science and putting them into practice at the forensic science laboratory in New York City. This is important because the forensic science community often feels incredibly burdened by the fact that they have so many issues to address and the extent of what they need to accomplish and the challenges that they face, but today with these bills what you are saying is we are taking a load off. We have a model for you. The clinical science world has already dealt with a lot of these analogous problems, and here is some solutions and we are providing the solutions to you to make your work better and to improve the quality of forensic science in New York City. The root cause analysis bill is one of these approaches that is really important. Again, a lesson learned from clinical science that can improve forensic science labs. As was mentioned before, the OCME is accredited by ASCLD Lab. That is the ASCLD Lab organization. it is an accreditation organization that accredits

laboratories based on an international voluntary consensus standard called ISO 17025. ISO 17025 has that 14.11.2 standard that requires a cause analysis. Now although we have been told that a root cause analysis has been conducted this morning; it appears that Barbara Butcher has conducted one at the OCME, we have not yet seen it, and so because ASCLD Lab and ISO 17025 don't specify what goes into a root cause analysis, what the procedures are, we don't know how rigorous the methodology is that was applied in the Butcher report. We don't know what the results of that report was, and we can't confirm its rigor and that is why your legislation is so important, and forensic laboratories unlike clinical laboratories have not had that much experience with root cause analysis and they haven't had the level of facility with root cause analysis that clinical labs have had and so it is important for us to not only to have these reports made public, but also to be able to make sure that the root cause analysis that was applied is the right process and the right approach that is going to get us to a better place because we are not here

to just point fingers. This Council has made it very clear that you are here to get to a better place, and rigorous root cause analysis will do that. With regard to the transparency bill you will hear from other panelists today that the OCME could benefit from other improvements in transparency that are beyond the scope of today's hearing; however, the Council is correct in its instinct that there is a distinction that you have to draw between medical and health privacy in terms of publishing reports and being public about your materials, and a government entity that is responsible for proffering evidence at a trial. The privacy requirements are very different there, and your legislation would not only bring the OCME in line with other major laboratories across the country who are posting their technical manuals, their policies and procedures and their accreditation certificates, you are going a step further by requiring the proficiency test report which no one is doing right now. One suggestion that I would like, and Marvin has already mentioned this, is the posting of the accreditation materials. An accreditation

certificate simply says that a laboratory is accredited from this period to this period. It doesn't provide the inspection reports, the surveillance studies or any of the underlying material that allows you to really get a sense of a laboratory's health and that is what the citizens of New York City, the stakeholders in the criminal justice system need to know. And so if these accreditation materials if they cannot be posted online, then at minimum they should be made available upon demand because right now defense attorneys have a difficult time getting them and they are not available--

CHAIRPERSON ARROYO: [interposing] Sarah, I am going to ask you to wrap up. thank you.

SARAH CHU: Yes.

CHAIRPERSON ARROYO: Please don't take that to mean anything; it is just that we are pressed for time.

SARAH CHU: Of course. So these bills while they are important separately synergistically together they will work to accomplish so much more, and so I thank the

Chairpersons for introducing these two bills. We support them and we look forward to a day when there is more accountability, there is a reflection whenever errors occur and when the OCME will be able to implement tangible change.

DR. JEFF WEISS: My name is Jeff Weiss. I am a physician and I am the vice president for medical affairs at Montefiore Medical Center, and I am responsible for patient safety--among other things, the patient safety function and felt it might be helpful to explain our journey as far as patient safety, peer review and use of RCAs and some of the parallels that we see to the criminal justice system and some of the lessons we have learned in the--sometimes painfully, in the last ten to 15 years that seem along a similar journey that is going on here from what I am hearing in the room today. We have 40 QI committees across our 24 academic department and that rolls up to a peer review board that is a multidisciplinary group and then that rolls up to a quality council that is a system wide look and then that report goes up to a board of trustees, and that is a huge apparatus and each meeting of

these quality committees when you talk about the number of people we are pulling out of really important stuff taking care of patients because of the value we put on this, each of those meetings has somewhere between three and ten people, and there is 40 of them and most of them meet monthly, and our peer review meets for about three hours monthly and that is 20 people, multi-disciplinary. We have 50 root cause analysis each year and those 50 root cause analysis each year are from the most serious cases that happen and each of those root cause analyses let's say it is almost one a week we have somewhere between 10, 20 people that are often the most senior leaders in the organization which show the seriousness of which we take this and the rigor that we think is important, but if I go back only five to ten years ago, and we were behind. And the IOM report from the late '90s said that healthcare is way behind and we were having a lot of errors related to safety, and I think there is a lot of parallels there. Most of our peer review systems were built to find fault with the practitioner. It just sounds like there are some parallels there. And in the end when I

took over this function about five years ago and I looked at the minutes from our peer review board, which is looking at 40 committees' worth of work each month, the end product of that was elaborate amounts of work, but it was about finding fault and what did the clinician do wrong, and in the end we didn't learn enough. We weren't fixing enough. There wasn't enough linkage between learning and fixing, and so we have really soul searched and said our end goal here is how can we create a culture where people are comfortable telling us what is wrong, things that have already happened, but more important even near misses before they even happen. How can w3 get people comfortable to tell us about these and then have rigorous processes, RCA processes and others where peoples' goal is to learn and fix, not to retrospectively look back and smack someone 'cause it just doesn't make it any safer? So in doing that we have set up a pretty elaborate system, which I think is somewhat portable to any industry and again, we are behind the airline industry in aeronautics who did this years and years ago, and so one thing is separating out kind of the

punitive or the discipline - - from the root cause analysis process, which is really a different lens. The lens here is even if there is a human error or someone did something wrong, what can we do to fix the systems in which they work to make it less likely to happen again? So really building redundancies in systems so even the average employee or even a little bit below average employee will not make the errors before the systems are in place to prevent them, to help them from making the errors. Even the best of us in healthcare, really good doctors they make mistakes. To provide an example, which I think really summarizes where we are in the parallels to what is going on in the lab system here, we had a very bad case a few years ago of someone who wrote a serious medication for a patient in one of our ICUs and the wrong patient got the medication. Fortunately, it was caught and the patient did not have a bad outcome. It was a very serious event. We had a root cause analysis. We realized that what happened was that our computer order entry systems in hospitals, which we have in a lab room decreased errors by 80,90 percent, but they have

set up some new types of errors and one of them is people are very busy and they get distracted and they wind up on the wrong patient, and so they are taking care of one patient, they get a phone call, they look back, they forget where they are, and they put in an order on the wrong patient. That is what this person did. This was a very good doctor who was well-intentioned, and in the peer review system at the time, this person got what we call an H1 which is a serious deviation from care. They got an angry letter in their file, but we didn't do anything to change the system. - - . Somebody was pretty smart and said how often is this actually happening, so we were able to create a very creative approach to say anytime someone puts in an order in our system and within five minutes gets rid of that order, DCs that order and puts in the exact same order in another patient is that likely an indicator that that is what happened? So we got a bunch of interns to call people when they did that--put in an order say for Tylenol on one patient, stop that order, and then within five minutes order the exact same dose of Tylenol in another patient and we called them in

real time and found out that 80 percent of the time that is what the error was. it was just that they meant to order for one; they ordered for another. We looked back at our records. That happened thousands of times each year and 30 percent of the doctors in our institution had done it at least once in the previous year. And we looked across the country; it is something that is inherent to electronic medical records. The best of the doctors in the world can make this error, but in our previous system - - happen, we would just smack people and we never fixed it. It perpetuated. It was happening 1,000 times a year. We had a root cause analysis. Nobody was looking to get blamed. We realized that it was a system and we have now come up with a very effective decision support tool in our electronic medical record that makes it difficult for this to happen any time you put in an order you get a prompt and you have to put in the name, the age and the medical record number of the person. It's a little bit inconvenient just like people push back. It is an extra seven seconds every single encounter. Some people have hundreds of

encounters, but we have reduced those errors by about half by looking at that, and it was just a different lens and one of the things that it--and it takes time is a cultural change, so it is not just improving the root cause analysis process, which I think is critical and needs external oversight and sounds like what you are doing is in the right direction, but it is getting people also comfortable that these root cause analysis are not going to be a punitive environment, and that the real goal of the whole institution is leaning, and once you start doing that it is amazing how much more things will come forward and come forward earlier because people will realize they are not trying to get anyone in trouble. They are sincerely interested in making the environment better, and so we have had several indications. We have gotten a lot more reports now in our environment 'cause people now realize that we are all in this together to make it safer, and so the last thing I would say is something else that came up is the root cause analysis is not an entity into itself. There needs to be a linkage to operational improvement from it, and people who

are doing this work need to be freed up to do it, and need to have the training and - - improvement methodology and other things so that after this thing is done, there is very clear corrective actions, very clear data to show improvement over time and then a clear oversight of those processes over time, so I am optimistic of what I am hearing today, but I think it is a long journey and ours has been several years, but I think we are significantly safer than we were before, and people in our environment are significantly more comfortable telling us about stuff when it happens, and we are learning we are getting more and more people telling us about stuff before it happens 'cause they think we are actually going to do something about it.

LAWRENCE KOBLINSKY: Good morning, Madam Co-chairs and members of the Council. My name is Larry Koblinsky. I am chairman of the Department of Sciences at John Jay College of Criminal Justice in New York City. My field of interest is DNA, so whenever something happens at OCME I like to know about it. Like many others, I became aware of the issues through the articles

that have come in the media, the New York Times and other media, and I did testify at the first hearing. Since that time, the Sorenson Group has issued a report that came out in May. They were hired to do an analysis of the organizational structure and management at OCME, so I was happy to see that, and I looked at that report. When I saw the two bills that are being moved forward, I wanted to come speak for. I am not an expert on root cause analysis. We don't use it at John Jay College, but obviously we have to have a way of handling problems when they come up, but with an office the OCME where their customers are not only law enforcement, defendants, victims and their families, prosecutors, defense attorneys, and the triers of fact. They have got a lot of customers, so it is important that the results be reliable and that transparency--the other bill about transparency is very meaningful to me. These are things I have always believed in and I certainly think the root cause analysis is something that is very important once a significant problem comes up, and I would rather see it handled systematically than done in an ad hoc way, which

is the way most people handle problems, but I think for me the issue is not root cause analysis. What do you do once there is a problem? It is how do you prevent those problems from happening and it's clear. I think everybody understands you can't prevent problems. They are going to happen, but how do you minimize them? What do you do to prevent having something happen over and over and over? I have come up with a few recommendations. This is going to be very brief. I just wanted to describe a few ways in which you can minimize these kinds of things from happening. Firstly, I think getting the right employees, hiring personnel that already come to the office, they are not trained in doing the kind of procedures the office does, but they are trained in the scientific method, and they respect it and believe in it, and they are trained in the basic sciences, biology, chemistry, physics and statistics. They come to the office already with the right mindset and with training and ethics, so it is very crucial that the right employees be hired. I am very happy 'cause many of my former students actually in the OCME not only as analysts at all

levels, but also as deputy directors, so I think getting the right employees is critical. Secondly, obviously the training of newly hired employees is critical and I understand there is a six month training period when they are given training by experts. I also think that there ought to be an ethics component in their training, so that they understand the significance of what they are doing, they have people's lives in their hands, and I think most of them know it, but I think it has to be incorporated into the training process. Obviously quality control we have all spoken about that and what that means to a laboratory and how it functions. The issue of transparency, I just want to get into that very quickly. I very often review their lab notes. Defense attorneys will often come to me and ask for assistance in interpreting these notes, and I think you can increase transparency y having them incorporate all of the data. Right now they leave out, they omit the quantitative determination of how much DNA is in a sample. They could incorporate the calibration curves and their mathematical calculations to show that the right

quantities are being determined. The other thing is and this is something that is very easy to do-- defense attorneys come to me and I often suggest to them go to OCME, speak to the analysts and see what they have to say about the work that they do and they don't want to go. They don't trust them. They think that there is some bias. Now obviously forensic science is an area where you have to-- forensic scientists are trained to be neutral and unbiased. They don't work for law enforcement, but there is a feeling out there that they can't trust the analysts. I think there needs to be an open door policy so that defense attorneys feel just as comfortable to go to the analyst as the prosecutors do. I think that is very important. Continuing education, laboratories should make available these very short intensive courses on an ongoing basis to ensure that personnel know all of the latest developments in their respective fields and that they learn about the practices in their discipline. I think these training sessions should be mandatory and they should be conducted in house and at seminars and symposia held regularly and also I think it is important to have

analysts go to regional and national meetings, maybe at least once every two years, so that they see what the outside world is doing. We talked about proficiency testing. That is a given. They are doing that now. Again I recommend seminars on ethics should be routinely offered by the laboratory using external consultants, and these sessions should be mandatory for everybody working in the office regardless of what level they are employed at and the last item is something that I spoke about the first time. I just want to reiterate that that redundancy of testing is a great way to eliminate most of the problems that we worry about. When an analyst knows that somebody else is going to be testing the same and coming to their own conclusions, they are going to be much more careful with what they do, not to take shortcuts, do it according to protocol. The concept has been tested in a number of ways. - - I heard at the last hearing that that has actually been started, and I don't even think it needs to be done with every single sample. It needs to be done perhaps one in five or one in ten samples. It is the idea that the analyst knows someone else

is going to be doing the same work - - coming to a conclusion, you are going to be much more careful in what you do. Thank you.

CHAIRPERSON ARROYO: Thank you all for your testimony, and I know that we have your contact information if you don't mind that we make your contact information available to OCME. You may already have a working relationship with them, you might not. The goal of this is to hear and have conversations and you heard their testimony. They are open to having conversations about how they can do what they do better. Thank you. I am going to turn it over to my colleague, and we were joined by Council Member Eugene. He is in the back. Okay.

CHAIRPERSON FERRERAS: Thank you very much. not only are they open, but they are still here which is commendable 'cause usually the administration, they always stay--that is not necessarily common in other agencies. So I thank you very much for your testimony. It definitely helps us a great deal from your perspectives and I enjoyed the diversity of suggestions and our legal teams are already jotting down and making sure we

will circle back with you also, so thank you very much for coming to testify today, I am going to call up the next panel Michael Corming [phonetic] New York County Defender Service, William Gebny [phonetic], the Legal Aid Society, Jessica Gulthwait [phonetic], Legal Aid Society, Marika Miys[phonetic], the Bronx Defenders, Anastasia Hagar, Office of the Appellate Defender and Alexandra Keeling, Office of the Appellate Defender also. Again, you won't be on a clock, but brief would be great. We have two other panels, and we have to give up this room in a short time, but your testimonies will be read as you submitted them and we take them all very seriously. You may begin.

MALE VOICE: --for 24 years. Before that, I will be very brief. First of all we perceive the end results - - prosecution, and unfortunately here in Manhattan where we get no information and no discovery we can't depend on the DA's office to tell us anything, so this bill is really important to us to be informed directly rather than have it coming through another source. Next, I also was a village justice out of Nassau

County. We were assured that we had the finest lab in the state and it had the same oversight that - - office has. All the same organizations were in place and then when we picked it up and looked under the rock we found out that tests were being falsified and mistakes were being made for about ten years, and right now 9,000 cases are in dispute. There are lawsuits flying all over the place. They are convictions being overturned. It has been a disaster--total loss of confidence in the system out there. Again because nobody knew what was going on outside. So this bill is--if they had this bill in Nassau County it wouldn't have happened, and it would have saved them millions and millions of dollars. Again, quickly, trust is the issue. We know that transparency is the issue. That is all that is important here. We are not saying we are not doing a good job, but without the trust and transparency, we have nothing.

MARIKA MIYS: My name is Marika Miys. I am the legal director of the Bronx Defenders. We are a community based holistic defender that provides defense to 28,000 Bronx

residents annually. I thank you for the opportunity. As defenders on the front lines, my office sees firsthand how the OCME's lack of transparency and accountability impacts individual litigants as well as the criminal justice system as a whole, and the public more generally. I would like to provide just a few examples of how the current inadequacy of the OCME's current procedures for dealing with internal problems sheds light on the needs for these bills and further reforms. First, in terms of transparency this was already touched on previously, but the OCME Department of Forensic Biology only recently posted their current protocols online, although many other states were previously doing so, and I believe they did so only at the prompting of this Council in the prior hearing that was held in February and while that was a great advancement it is long overdue and it is not enough. It was also mentioned about the need for historical protocols, which we as defenders and I believe as the public are also greatly interested in as many of the cases that are heading towards trial now involve testing that occurred long ago when the current

protocols weren't in place, so we applaud the transparency bill, and we think it will provide much needed openness in this area and also in terms of providing not just the protocols, but the other guidelines, proficiency tests and accreditation reports that will allow both defenders and the public access to this information. If the OCME were truly transparent then it would provide access to all of these protocols and reports past and present. As another example, the OCME changes its policies and procedures without notifying the defense bar or the public. For one example, the OCME has a policy in place where when they tested firearms, they would swab three different areas and then analyze individually each of those swabs. At some point they changed the policy to combine these three swabs to do a single analysis, but apparently when they discovered that that policy was actually creating mixtures that might make the DNA analysis different and more complicated, they switched back to the original policy, but nobody was informed of this, not in the criminal defense bar and not in the public, and this lack of

transparency threatens the important independence of the OCME. In terms of an example of lack of accountability, in January of 2013, our office was in the middle of a trial for a man against whom one of the key pieces of evidence was DNA. After the criminalist had actually testified in that case and spoken on the record about having the utmost confidence in the lab and everyone who was an employee there, the New York Times published the article about Sarita Mitchell [phonetic], and it was at that point that we learned that Sarita Mitchell had been involved in that very case, yet neither defense counsel was not informed by either the DA's office or the OCME. Had the lawyer trying the case not read that article and made an inquiry that prompted the judge to also make further inquiry the lawyer would have never known, the judge would never have known and the jurors who were members of the public sitting on that case never would have known and when they were questioned by the court as to why they hadn't disclosed this information, the DA's office said well, we didn't disclose it because our understanding is that OCME has a policy of telling

defense counsel when they meet with the criminalist in pre-trial preparation. Well, we had that meeting, and the criminalist didn't tell us either, and in fact the criminalist told us we don't have any such policy, and we heard echoes of this sort of passing the blame and responsibility in OCME's testimony earlier today where they said their obligation in terms of disclosing when incorrect testing or when an error has occurred extends only to informing the DA's office and it falls on the DA's office to them inform the defense community, but we believe that this example illustrates how the OCME doesn't have a clear procedure at their lab because they have so little accountability to the city, the public and the criminal justice system stakeholders and while we like that the root cause analysis bill addresses these concerns by focusing on the larger problem, the reason for a problem occurring and preventing it from happening in the future, we support that reform, but I would just note that as criminal defenders, we also have an obligation to know of individual parties in an error of this nature so that we can fulfill our constitutional

obligation to our clients and to their rights to confront various individuals against them. There are many other examples in my written testimony. I will just close by saying we believe these bills do provide much needed transparency and oversight to the OCME. We believe that increased transparency and accountability will improve the integrity of the criminal justice system, our ability to - - represent our clients, fairness to those accused of crimes and also just the public confidence in the OCME. So we applaud the Committee and these bills and we do support them. Thank you.

WILLIAM GEBNY: Hello. Good morning. Good afternoon. I am William Gebny from the Legal Aid Society, and with me is Jessica - - . I have a few comments generally on the bills, and Jessica is going to talk more about oversight issues of OCME. We thank the Committees for holding this hearing. We heard this morning that it has long been our practice to report to criminal justice agencies. I can only echo the refrains that among the criminal justice agencies that are getting reports from OCA, the defense

community is not included. We have not been getting direct reports from OCME, and we also heard this morning that the prosecution is mandated by law to notify defense counsel as is true in case after case that we have experienced. We wish someone who tell the prosecutors of that obligation because not only is OCME not supplying the reports in a timely way, but neither are the prosecutors. We are here to support the legislative proposals from the Council. We think they provide a significant step toward the recurrence of the problems that have occurred at OCME. We see the root cause analysis as a way to require OCME to analyze, recognize and confront the existence of a serious problem in a timely way, which obviously has failed to occur in the past. There is a condition in the root cause analysis that requires OCME to report to the defense community findings or conclusions in a report in such report may be reasonably found to have an impact on a criminal investigation or whether ongoing or completed. We are hesitant about this condition because we have seen some real defensiveness in the past from OCME in a

situation where they should have been admitting errors. So for example in the January of this year New York Times article Dr. Prince was quoted as saying we can assure the public that we know nobody was wrongfully convicted, but it turned out that that was at a point where they hadn't even completed their case by case review of the problematic cases, so we are drawing conclusions that that there is no real problem here before we have even completed our analysis. It's that kind of defensiveness that gives us pause to allow any judgment call on behalf of OCME. We would prefer if a case is connected, if the problem, a significant error is connected with a pending case or a past case that there just be an automatic report required. We so suggest that in addition to the root cause analysis that there be an impact statement that someone should take a look at what is the potential impact for pending cases or past cases as a result of the error that we have located, so that there would be a greater analyses on the remedial steps that have to be taken in order to not just correct the error in the future, but to take a look at what damage that type of

error might have caused in the past, and we really appreciate the questioning of OCME about the historical reports because we agree with the Bronx Defenders. There are many pending cases now that have had--that were done under prior protocols, and those are not now posted anywhere. We don't have access to those. I think that would be a really useful benefit. Jessica?

JESSICA GULTHWAIT: Good afternoon, and thank you. My name is Jessica Gulthwait, and I am a staff attorney with the Legal Aid Society DNA Unit. I just want to reiterate my colleague's comments that the City Council legislation which we support offers important steps to increasing accountability and transparency, which are not only the cornerstone of good government, but good science. Lack of transparency affects the quality of the scientific work being done at OCME. Science which is exposed to open and full review is better quality science than secret science, and as such, OCME's forensic science must be equally available to all members of the criminal justice community including the defense to echo my colleague's comments. This we testified back in

February is the recommendation of the National Academy of Sciences 2009 report. I would like to give the council members an update. We had reported on three disclosures that we had received back in February and prior to February. We did receive another disclosure about the analyst who had mishandled the sexual assault evidence. This disclosure came from the district attorney's office after the jury was sworn in the case--that is obviously belated disclosure. While the district attorney in that case elected not to present the DNA evidence and the rape kit evidence obviously the disclosure to the defense is extremely belated and prejudicial and does not allow us to zealously defend our clients, and this is why it is so important that we get disclosure along with the other members of the criminal justice community, so we certainly appreciate that portion of the legislation that mandates disclosure of the root cause analysis reports also to members of the defense community. We would like to suggest for additional recommendations for the Council to consider first in line with what we were saying about equal disclosure OCME should be

required to provide to the defense disclosure of all materials related to DNA evidence, including but certainly not limited to electronic raw data produced during testing. This is very important for the defense to zealously defend their clients. Additionally OCME should provide access to the various databases that they maintain and rely upon to do their work, and we have in our testimony a list of the specific technical aspects that we believe should go up on their website alone with the protocols that are there. We would like to emphasize again the need for the past protocols. This is important any time OCME generates a lab report that has a result. There is a statistic offered. We need to know how they come up with that statistic, and this information should be made open source on the internet and I would note that the National Institute of Standards and technology does make this information publically available. So should OCME. We would also like to recommend that liaisons from the defense community and district attorney offices in all of the counties in New York City be created that will work with OCME on issues related to lab analysis,

accreditation and matters before the City Council, and the New York State Forensic Commission. As the Council may be aware, there are liaisons in each of the five district attorney's offices, so should OCME work with liaisons from the defense community. And finally, we would like to recommend that to improve quality OCME should implement a policy of blind proficiency testing program. We did offer a suggestion about how it could begin to be implemented, but we believe this would be an important step toward improving quality, which again we would like to emphasize how much we believe that proposed legislation does increase transparency and accountability, which will increase quality. Thank you.

CHAIRPERSON ARROYO: Thank you, and I think we have two more members of the panel? Alexandra and Anastasia? Right, yes?

ANASTASIA HAGAR: We are both conviction counsel, so it is appropriate that we go last. Good afternoon, and thank you for this opportunity to address the Committees. My name Anastasia Hagar, and I am the director of the reinvestigation project at the Office of the

Appellate Defender, one of the oldest providers of appellate representation to indigent defendants convicted of felonies in New York City, and with me today is Alexandra Keeling. She is the deputy attorney in charge at OAD. The reinvestigation project focuses on wrongful conviction cases before post-conviction remedies are exhausted, and for obvious reasons we are extremely concerned not only about the integrity and reliability of OCME testing, but ensuring reliability and accountability at OCME. As virtually everyone who has spoken before me has reiterated the stakes are extremely high. DNA is viewed as the gold standard of evidence. It is extremely persuasive to juries. It is a critical consideration in plea negotiations. With that as background, we would like to highlight three points. First, professionalism and high standards are critical, but it is equally important for any organization such as OCME to have external quality assurance that is outside eyes looking in. And the defense bar is uniquely situated to provide such a check. The role of the defense attorney at both the trial and appellate levels includes facility

transparency and helping to ensure the legitimacy of criminal proceedings. Second, there is an expectation of finality in our criminal justice system and we can tell you as past conviction counsel the critical importance of doing things right the first time. It is not easy to fix things after a conviction. The law severely limits what can be reviewed after a conviction, thus it is vitally important for evidence to be handled properly, disclosed in a thorough and timely manner and meaningfully tested in a court of law. When there are questions or uncertainty about the veracity of DNA evidence the more time that goes by, the more problems for every part involved--the victims, the prosecution and criminal defendants. This can also impose a significant financial burden on the city. Post-conviction litigation that entails reexamination of evidence is costly and time consuming and in the worst case scenario a wrongful conviction an innocent person has lost years of their lives. Finally, and most importantly, it cannot be left to the prosecution alone to be the gatekeepers of information about problems at OCME. A prosecutor

may not believe that a criminal conviction needs to be reexamined because of a belief that there is sufficient other evidence to sustain the conviction, but we know and the public is beginning to be educated about this. Much of the evidence that we once believed was strong evidence such as eyewitness identification, confessions, informant testimony is in fact very unreliable and related to this point I just wanted to echo something that was raised by Bill Gebny at the Legal Aid Society is the provision of subsection 3 in the root cause analysis bill, which mandates disclosure when the findings may be reasonably found to have an impact on a criminal investigation. As these root cause analyses are triggered by significant events, which are described in the legislation, I would argue that any of these events could be reasonably found to have an effect on a criminal investigation, and we are extremely concerned that any such determination would be made outside of the judicial processor by the prosecutor alone. That is what our adversarial system is for. In closing, we believe it is imperative for all such

reporting to be disclosed to both the prosecutors and the defense bar, but we support both pieces of these legislations as important steps in the right director for ensuring transparency and accountability at OCME. Thank you.

CHAIRPERSON ARROYO: No one else is testifying? I thought I had two more. Okay. Well, thank you for joining us. Thank you all for your testimony. Like my previous panel my question to all the ones who sat here--are you open to having discussions with OCME regarding how to best handle improvement?

FEMALE VOICE: Certainly.

CHAIRPERSON ARROYO: And your colleagues are not at the table, but I know they are in the audience. Can you raise your hands? We will not share your information unless you don't want us to. I mean unless you… Yes? I see one. Everybody is nodding. Thank you for your testimony, and thank you for your feedback is really essential to making sure that what legislation moves forward is one that we can all coalesce around in the best way possible. Our next panel, Dr. Mark Taff [phonetic], Elizabeth

Daniel Vasquez [phonetic] and Michael McCasland [phonetic], the guy in the front row in the glasses. Hi Michael. That is who I was pointing at. I think we have one more panel after this, and if I can put you on notice so that we go through--Lisa McGovern, Hugh McMorrow [phonetic], Mary Dugan Sheehan [phonetic] and Father Richard Gorman [phonetic]. You are on queue. There he goes. Hi. Welcome. You may begin when you are ready. If the light is on the mic is working.

DR. MARK TAFF: Hi. My name is Dr. Mark Taff. I am the forensic pathologist and - - in forensic pathology for over 40 years, former chief medical examiner for Rockland County and I am a pathologist who has been engaged in the private practice for forensic medicine and pathology, one of the first people to start a private practice going back to 1988. Part of my responsibilities have been acting as a forensic consultant to different criminal bar associations, criminal attorneys, insurance companies who get involved in the litigation process involving cases handled by OCME. So since Dr. Hirsch became chief in 1989 was around the same time I started my

practice, so I would say over the thousands of cases that OCME handles each year, I get involved with dozens of cases that ascend what I call the ladder or the hierarchy of death litigation, which means basically the cases that really affect the medical examiner are the accidents and the homicides. Those are the major cases that make it into the legal system. we are a service industry that provides testimony for lawyers and for the justice system. that gets lost in a lot of this discussion here today, but that is what we are really doing. Natural deaths and suicides are not contested as frequently as accidents and homicides, so the thing I wanted to mention to you briefly, we call the medical examiner's as such, but it is also it is a government medical laboratory, but years ago when I was coming up the ranks, it used to be called the hospital for the dead. Okay? And as the hospital for the dead, the pathologists--also people forget they are physicians and we are supposed to care for the dead just like they are living individuals so if a test is done on a person if a pathologist who is a physician orders a test at the Medical Examiner's

Office, he is supposed to be responsible to oversee the entire case--the physician; it is a physician oriented business. This is all lost. Basically, - - wanted to educate this committee, and I commend you for trying to get to the root of all of these problems, and I am going to try to make it as simple as possible. The medical examiner goes through basically six stages of a death investigation. The first stage is a history provided to us by law enforcement and a healthcare personnel, but our involvement really starts at the second phase which is called the scene investigation and when there is a scene investigation the medical examiner goes to the scene in a van and there are people that are supposed to be trained as to how to handle the body and collect that evidence and photograph and document. That person--if it is an outdoor scene, you have got to get to the scene quickly. You have got to have vans that operate that have gasoline and air in the tires. You go there. You cannot operate in New York City with just five vans. Rockland County had 300,000 people. We had two vans and they had to be equipped and there

had to be a quick response time, especially for a public death which is going to hold up traffic and cause curiosity seekers to come out, so at the scene they get there, they scoop up the body, they document the case. You bring the body back to the Medical Examiner's Office, which is a laboratory where you have trained physicians, autopsy surgeons who are supposed to oversee the entire death investigation. They are skilled at doing dissections, but they also order tests and those tests are done during stage four of a death investigation. It is called ancillary laboratory tests - - pathology, anthropology, dentistry, all these different types of--DNA, toxicology. If you order a test, it is the same thing for a live patient. If a patient comes to you and you say look, I need a urine specimen, you are supposed to get a result, interpret that and incorporate that into your report, so it is the medical examiner he or she is the person who is solely responsible for the total investigation of a case. The fifth phase would be the bureaucratic phase, the creation of an autopsy report. After a person is dead, after the person has been reduced from a

three dimensional person, into a two dimensional paper person you have a report which goes to the public domain, which goes to the next of kin, which goes to lawyers. That is all that is left and that autopsy report becomes the script for the medical examiner when he or she testifies in court. If the case escalates into the justice system, that is the evidence that you are going to be testifying from. The sixth and final phase is the signing of the death certificate which includes the other sequential interdependent stages I talked about. You sign the death certificate, the legal document that has a cause and a manner of death, possibly a time of death, and that also is needed for burial purposes. It is kind of your passport to move bodies around to go to heaven or hell after you are gone. So that is what the death certificate is all about. What is also important is when we talk about DNA, it is a test that is done primarily, I think which has been lost in these discussions here. The main consumers of DNA in New York City these days is law enforcement for burglaries and rape cases. Years ago before medical examiners had this

highfalutin technology how do we identify people? We didn't have DNA, but we had experts in anthropology, dentistry and radiology. Most of the cases that we get as medical examiners do not require the DNA. Most of the identifications are from visual or circumstantial or fingerprinting. If it is DNA, we sent off specimens. The lab will then generate a report. Why there has been a delay in the interpretation of these reports over the years is beyond me, and I will say this, when I have testified as an expert in courts of law on sexual homicides or non-fatal rape cases first of all I as a medical examiner would never be qualified in a court of law to testify about DNA. That usually is reserved people who have special lab expertise, but even still the DNA test results comes back and is incorporated into the autopsy file so the medical examiner if he ordered those tests should be somewhat aware of the results but would defer to somebody with more expertise than him or herself to testify in a court of law. In preparation for this presentation this morning I spoke with several chairmen of departments of pathology - - in all the medical schools of New

York City and I said to them what do you think we should do about the DNA problem here? Why did I speak to them? Because they are a source of manpower for the Medical Examiner's Office. From the medical schools we get medical residents, pathology residents who if they were to pursue careers in forensics we need bodies to help us do these investigations years down the road. We have to train them, so in speaking to the chairmen, the general consensus was that the next person who is going to become the director of that lab should be a physician, a MD, with special certification in clinical pathology and molecular pathology, someone who is experienced in running a laboratory. That was the general consensus from the different chairmen and other people I have spoken to. The other thing was that I think should also be reminded to the committee, the Medical Examiner's Office is an agency in the Department of Health. It is separate from law enforcement. If it is part of the Department of Health my boss and Dr. Hirsch's boss was the commissioner of health. We answer to that individual, so in speaking to everybody the

recommendation I heard--and I agree with it and I will pass this on to this committee. I believe that the medical examiner they resorted to using DNA technology after 9/11 when they woke up that day with 3,000 bodies, fragmented bodies that needed to be identified expeditiously, but now that things have calmed down and who knows if there is a mass disaster waiting out there sometime down the road, the recommendation I am making of - - is that the Medical Examiner's Office should divest itself from the DNA lab, that that lab should be an independent lab, part of the Department of Health and that the medical examiner who will not be involved with the interpretation of the DNA results should not be involved with that. They should basically be using the DNA lab like the police do on a consultation basis on a vase by case basis, and that was the recommendations that I heard. The other thing I just wanted to mention to you is before you start making layers of legislation I try not to interfere--I know you are doing your job, just from my point of view, the office is now in a leadership transition period. The chief medical

examiner is a mayoral appointment. The mayoral elections are in a few months. It is probably going to take about six to eight months for a new person to be chosen in that office, and I think before we start making policies, I think the new chief whoever that person might be should be involved with some of the decision making policies of that office. So that would my comments to this committee.

CHAIRPERSON ARROYO: Thank you. Very timely. I was going to ask you to wrap up.

ELIZABETH DANIEL VASQUEZ: Good afternoon. My name is Elizabeth Daniel Vasquez, and I am here on behalf of Professor Erin Murphy [phonetic] of NYU School of Law. Professor Murphy apologizes that she cannot be here in person to give this testimony, but she asked me to read this prepared statement on her behalf because she feels these important bills deserve comment. As you may recall from Professor Murphy's testimony this spring at the oversight hearing on these matters she is an internationally recognized scholar of forensic science, who focusses particularly on DNA evidence and her work has been cited numerous

times by the United States Supreme Court. Prior to my graduation form NYU this spring I worked closely with Professor Murphy on issues related to forensic DNA testimony. It is my pleasure to share with you the following statement. It is with great pride in my local City Council and with special acclaim for Members Arroyo and Ferreras that I testify in support of these two critical and visionary bills for oversight of the Office of the Chief Medical Examiner. The last time we gathered in this room, we undertook the somber task of attempting to discern how a flagship laboratory such as OCME had allowed a forensic technician to make significant and uncorrected mistakes in roughly one in ten of her cases over a period of ten years. At that time I pointed out in my testimony that this lapse was particularly troubling given that the New York State has been one of the most robust forensic oversight systems in the country, and lamented that OCME's problems were representative of greater structural infirmities in the administration and management of forensic laboratories nationwide. Observing that existing processes and institutions had

proven systematically incapable of conducting truly meaningful supervision I close my testimony by comparing the city's strict procedures for regulating its food establishments with its relatively lax approach to its forensic labs. Today's hearing happily is an occasion for celebration. The two proposed bills constitute innovative and bold steps toward establishing a DNA laboratory system that will be the pride of the city and a model for governments everywhere. I'd like to comment briefly on each bill. First the transparency bill represents a long overdue effort to shift the culture of forensic science practice from that of a partisan in the adversarial battle to neutral scientific participant in the criminal justice process. As the 2009 National Academy of Sciences' report on strengthening forensic science in the United States observed all forensic laboratories should have established protocols, regular proficiency testing and meaningful accreditation in order to safeguard the integrity of their results. This bill simply makes those important documents readily accessible. Such a move is consistent

with the American Bar Association's standards on DNA evidence, which require a prosecutor to disclose reports of all proficiency examiners of each testifying expert and each person involved in the testing, reports of laboratory contamination and other laboratory problems affecting testing procedures or results relevant to the evaluation and comprehensive documentation of accreditation, protocols and quality assurance procedures. Unfortunately, New York's criminal procedure law lags behind the ABA's detailed rule, and contains only a vague reference to disclosure of scientific tests, but that seems more a product of the time of its enactment rather than a deliberate choice. After all, the CPL is more comprehensive in its disclosure rules in Section K, which deals with testing equipment used for traffic violation enforcement, and it is hard to imagine that legislators made a conscious decision to privilege breathalyzer or speed gun calibration over DNA instrumentation. Regardless there is no justification for keeping secret or making difficult to review the material covered by the proposed bill. As OCME itself in part recognized

just before the February hearing when on its own initiative it posted some of this material on its website. In fact, the ready availability of these critical items is essential for two reasons. First, mandating that the OCME make this material public in turns gives the institution a strong incentive to keep its protocols current, and its proficiency test scores high. Importantly the National Academy of Sciences report found that labs often lacked accountability when it came to adhering to their own guidance documents finding that protocols and quality assurance manuals were all off often vague and not enforced in any meaningful way. That very finding is apparent in the case that brought this Council's attention to this issue. Given among other things that the technician had apparently repeatedly failed the test that qualified her to do her work and there were questions about fidelity to internal rules--a rule requiring that the OCME make such information public might have led management to act more aggressively and in a more timely fashion to address such patently inadequate work. Second, even if public transparency does not promote OCME

toward more rigorous self-policing it will at least enable other actors in the criminal justice system to better fulfill their institutional roles. The supreme court has repeatedly affirmed that the adversarial process is a time honored way to guarantee the integrity of evidence, but sophisticated scientific evidence can post challenges even for enthusiastic litigants. Consider how bulky and cumbersome this documentation cited in the American Bar Association's rule can be. It is hardly the kind of material that can be readily handed over in a tidy discover package, particularly given the rushed and congested atmosphere in the criminal courts, but as the New York Court of Appeals had acknowledged in affirming the right of - - to exclude expert testimony where late disclosure of expert material creates logistic problems. Without such material an opposing party is unable to engage the proffered testimony. Accordingly open access to protocols, proficiency tests and accreditation documents helps to ensure that all stakeholders are able to raise challenges when appropriate. This is true not just of the

defense, but also the prosecution. For example, the Nassau County lab scandal provides a stark illustration of how poor communication between a lab and its customers can be. In that case the district attorney learned by accident through informal channels that the laboratory had been placed on probationary status by its accreditor. This brings me to the second bill, which establishes practices of personnel for a root cause analysis. The requirements of transparency in the first bill go far to prevent against an incident like the one that brought us here today, but no laboratory is perfect. Inevitably there will be shortcomings or mistakes and in such cases the provisions of the second bill exist to ensure that the laboratory takes a hard look at the structural features that led to the problem rather than treat each incident as an isolated case of one bad apple. As my earlier testimony noted, the accreditation and oversight mechanism in place in time of the incident here obviously failed in part because those mechanisms lack some of the requirements found in this bill. As members of your honorable committees well know, root cause

analysis practices are considered standard among clinical laboratories because they constitute an essential safeguard of the integrity of laboratory processes. Enactment of this bill simply places the testing we perform to make decisions about human liberty on par with that done to make decisions about prescribing antibiotics. In addition. The bill contains additional critical components that will enhance the reliability of forensic DNA testing, first by linking the trigger for such an analysis to the standards already used for accreditation. This bill ensures that any serious incident will be addressed in a meaningful way. Second the mandatory deadlines impose a duty of prompt and timely investigation, which forecloses the delay that occurred in this case, which took several years to investigate and come to light from happening again. Finally, the disclosure provisions, especially the requirement that local district attorneys and representatives of the defense bar received notice guarantee that any such investigation will not occur without full awareness on the part of those that regularly rely on OCME's services. In closing, these bills

represent swift and significant responses to the crisis that occasioned these hearings and the Council should move without hesitation to adopt them. With these bills, the New York City Council will restore the OCME to its proper place as a leader and model provider in the field of forensic science while at the same time reassuring the people of New York City that no offender will evade justice and no person be wrongfully confused as a result of faulty forensic testing.

MICHAEL MCCASLAND: Hello? Can you hear me okay? MY name is Michael McCasland. I am a criminalist level three at the Office of the Chief Medical Examiner and also the chapter union president under Local 375. I'd like to thank you for giving me the opportunity to speak before you today, and I also want to thank the OCME for granting me release time to allow me to come and speak today. I thought that was worth mentioning. So as the chapter president of the OCME, I represent the criminalists, the DNA criminalists that do DNA testing as well as city research scientists. These members are the people who do the DNA testing. They are a part of the quality

control system, and they are also the people that end up testifying in court, and we are actually the shepherds or the responsible party for our case files. I just wanted to mention that because I want you to understand exactly what these DNA criminalists do and the level of scrutiny that they are under, that we are under in our job. I want to say that the union and myself conditionally supports this legislation. I called a meeting last week with the membership, with my co-workers and we went over this legislation and we discussed it. I would like to give you the thoughts that I heard from those members as well as my own so that you can contemplate them as well as some suggestions. Again it is a conditional endorsement for this legislation. The OCME's DNA lab is the largest in the country and we do great work, and I have a lot of pride for the work that I do and my coworkers so, and I can say the work that is done in our laboratory from somebody who actually does the work is of the highest quality. That said, our employees are under some of the highest scrutiny. If you think about individuals who in their 20s, 30s and 40s who have to testify

in court on these type of cases and these kind of results our credibility is of utmost importance, and so if you can imagine the pressure and the scrutiny that these individuals are under. Alongside that scrutiny and pressure is the fact that the criminalists are the front line on quality. We are the ones that do the work. We know that is going on. The information that we provide as people on the floor in the lab is valuable for root cause analysis and for making our processes better. So under those two assumptions I wanted to say that given our scrutiny that we are under as DNA criminalists alongside the fact that we are the front lines for quality, we have four suggestions that I want you to keep in mind. The first one is that we want something written explicitly in the legislation on the root cause analysis officer holding them accountable. This is understandable because as we know with the DNA oversight hearing issues have happened in the OCME over a ten year span, and there was some accountability issues and there were some lack of accountability, and I would like to make sure that this root cause analysis

officer, who is the gatekeeper to this committee, that they have some sort of accountability in the legislation meaning that if issues come to this officer it says in that legislation that they have to document their rationale for forming the committee or for not forming the committee. That way there is a paper trail and you can ensure consistency between root cause analysis officers. We don't want to have another issue where something was not addressed in a timely manner or somebody was not held accountable in the way they should have and this type of documentation will ensure that the root cause analysis officer forms a committee appropriately and in a consistent manner. Secondly, the union finds it very important that we have some representation on this committee, and that is not because we just want to be on the committee and have influence. We feel that if you mandate that a union representative needs to be on that committee they are actually going to add value to the root cause analysis. They are going to ensure that a root cause analysis is done and the systems are looked at and not the individual. It is true we have not been

made privy to the root cause analysis on the mishandling of DNA evidence or nor have we been given access to the Sorenson Report, but Councilman Vallone mentioned earlier that there was a couple of sentences in that root cause analysis report that spoke to the individual and that may have been dealing with a particular process, but I want you to recognize that in a root cause analysis you have to speak about individuals, and there is going to be a natural tendency to drift towards talking about the individual. It is great that you are going to have an outside hospital person come in to give it objectively, but I believe that you need to have a union representative on that committee because we are the people who are in touch with the members. We know what is going on on the floor. People speak honestly to us on what the issues are and we can bring that, those concerns to the committee. Numerous employees and co-workers had that exact same recommendation. They want to see some sort of union representation at that committee. The legislation does ask that you have a lab member sit on the committee, a minimum of one, but think

about it if you have a committee that is decided by a root cause analysis officer and they choose one member in the lab, that person might not be as forthcoming. They might feel the pressure. This is a lab worker, and yes, you have some strong lab workers who speak up and you might have some people who are going to be more silent. You have some lab workers who know some things about what is going on. You have other lab workers who know other things. So that is why I think if you put in a union representative, they are going to have the experience and the strength to speak for the members on root cause analysis, ensure that it sticks to root cause analysis and not the individual and also they are going to have a breadth of information because those delegates who funnel all of the grievances and issues to the members to the officers of the chapters, so I think this request is not about the union trying to make a power grab. I actually believe that they would add some value, and I think that if the people who actually do the work have a stronger voice that is written in legislation or that is in the system because the management at the OCME is

very good about meeting with members on the floor and talking to them and hearing issues, which is great, but if you actually put a system where you actually let the union rep and a member sit at the table, I think you are going to get a much better root cause analysis and reap the benefits to that. I have two more recommendations. I do share the management of the OCME's concern with the privacy, and that shouldn't be a surprise coming from the union chapter president, and I kind of hinted at it before. I sympathize with my co-workers. It is a high pressure job. Mistakes are made. Mistakes happen, and I would like to sit down in front of another profession in this city where you are at such maybe a low pay grade or in the hierarchy of the city, but you are under so much scrutiny. We are not managers. We don't represent huge pieces of legislation but we testify in court and we are under a lot of pressure because of the downstream clients of our reports. And so I just want you to be sympathetic. I know that you want transparency, but when you start talking about the internet and what gets out on the internet and what you can

Google, and what you can search for, I just want you guys--I ask that you respectfully ask that you take special care in how this legislation is worded in terms of the workers' privacy. One request specifically is I know that in terms of the report that the root cause analysis committee has to give to the City Council it explicitly says in the first bill that names could not be included. In the transparency bill, the second one, you talk about a summary of proficiency testing results, and yes, you say you want it to be a summary and an average and very broad brush stroke statistics. I'd like to make a respectable suggestion to actually as explicitly just like you said in the other bill say that names cannot be included. Even though I understand that the spirit of that was broad statistics, I was requested that we add that explicitly for that protection and then lastly, I want to say one of the reasons why I think this is great is that members make mistakes and sometimes employees make mistakes that reach to a level of a disciplinary action, and I understand that. Having this root cause analysis committee could be so beneficial to

people doing the work because if somebody is going to be disciplined it would be nice to know that a root cause analysis was done prior to them being disciplined because people have been disciplined and how do you know that if you did a root cause analysis you might find yes, this person did make some mistakes and they should be maybe given a 30 day suspension or a ten day suspension, but in fact because a root cause analysis was not done--I am not saying this has happened, but conceptually--because a root cause analysis was not done, you might move to termination because you only see what is front of you. You haven't done the fact finding, so I just want to share with you that I think this is good in the fact that requiring it is done, setting the parameters, making it transparent is going to - - this level of accountability, and ultimately, I think it is going to help the systems and also help the members in terms of their disciplinarians. That said, I don't want this root cause analysis committee to serve as like an ad hoc or in some sense as a disciplinary hearing. It needs to be clear that they are separate. Clearly, root cause

analysis deals with systems and it is not supposed to deal with the individual, but I don't want any overlap. I really ask that the information that is found in a root cause analysis committee not be used in disciplinarians because the members have that right for their own separate disciplinary hearing. So I respectfully ask that you add that to the legislation as well. Thank you.

CHAIRPERSON ARROYO: The goal of RCA is not one that is punitive or seeks to take the place of formal management supervision processes that guide how personnel action is taken within a unit or an agency, so rest assured that that is not the intent. It is not looking to supplement and/or replace strong management supervision of employees. Thank you for your testimony, and like the panels before you, you are available--I guess, Michael, you talk to the folks at OCME all the time, but to be given your contact information so that if necessary OCME can reach out to you. Okay. Thank you. We have been joined by Council Member Inez Dickens and Council Member Annabel Palma. I also want to take a moment to introduce the newest member of my staff.

He is sitting in the corner, Trayvon Frasier [phonetic]. Today is his first day. Welcome. Lisa, Hugh, Mary, and Father Gorman. Father Gorman, nice to see you. Welcome. If the light is on--

LISA MCGOVERN: Okay. Thank you for the opportunity to speak here today. My name is Lisa McGovern, and I am here representing the Emerald Isle Immigration Center with offices located in both Woodside, Queens and the Woodlawn section of the Bronx. On Thursday June 20th, the Emerald Isle Immigration Center along with the 47th precinct and the Woodlawn Taxpayer's Association held a community meeting to discuss the recent tragic death of Kevin Bell, a young immigrant from Ireland who was killed in a hit and run accident. We are here to discuss the disgraceful manner in which the Office of the Medical Examiner treated the body of Kevin Bell. Kevin's body was put into a medical examiner's van full of garbage, recyclable cans to be exact that was caught by a newspaper photographer. We are outraged that there was no respect shown to Kevin's deceased body. Everyone in New York City should be

outraged at what appeared to be New York City Medical Examiner employees recycling cans to make a few dollars on our taxpayer time, not to mention the fact that any evidence would have been severely tampered by having garbage in the van. It is a disgrace for New York City that Kevin Bell's family in Ireland had to see photos in the newspaper of their son being shoved into a van with garbage when they are trying to deal with their great loss. I heard an apology here this morning, but did anyone from the Medical Examiner's Office call to apologize to Kevin Bell's family in Ireland? We are here to seek a formal apology to the Bell family in Ireland as well as a thorough investigation into this incident. Thank you for your time.

CHAIRPERSON ARROYO: Turn on the mic. Make sure that the light is on.

MARY DUGAN SHEEHAN: With regard to the apology to the family, it is not enough just to say it here within these walls. It's not enough to call his family--

CHAIRPERSON ARROYO: [interposing] State your name for the record please.

MARY DUGAN SHEEHAN: My name is Mary Dugan Sheehan. I am representing both Woodlawn Taxpayers and the Wakefield Taxpayers, and when this has gone out on both the front page of both the news and the Post, I require personally that they apologize in the same exact manner in those forums about what happened because it is outrageous what happened there. As far as the transparency, I think that this situation where you have an acting medical examiner is going to happen more than once. This is the way things happen. That is the result of this happening that a penalty should be put on the office so that they would have to pay for this in the newspapers from their own salaries because if they are able to collect cans in medical examiner vans, they can surely pay for it out of their own pockets. It is not right. Transparency has to go both ways. We have to know what is going on with the medical examiner, and they have to know what is going on with us. The medical examiner's representative never showed up at our emergency meeting, which was held between 6 and 8 p.m. Now I am sure that they could have made it or sent some

representative. The police were there. There were at least 200 people from the community there. The medical examiner, no one showed up. It's disgraceful. As regards to the DNA samples, now they are claiming this young man was intoxicated. We don't know. The circumstances around this as far - - are very suspicious, and when they handled the body in that particular way no matter what the medical examiner says, it is wrong because it was handled all wrong from the minute they arrived there. I understand he was not picked up immediately. There were hours before he was picked up. Hours. The medical examiner doesn't pick up that many bodies in the city that it would take hours to get there. Something is very wrong there. Very wrong. I will concede to the next person now.

HUGH MCMORROW: Thank you very much for allowing us to come down here from Woodlawn. My name Hugh McMorrow. I have lived in Woodlawn for 50 years. I am a retired Verizon employee for 35 years in the Bronx. So I am very familiar with the fire department, sanitation department. I have got some of my family higher ups in the New

York City Police Department, and I am sad. I am sad we lost the young fella, and I am embarrassed, am absolutely embarrassed. We had 500 people at a mass last Friday at Saint Barnabus, and you people can tell me that, and there were 300 people that came out to a service that we had on the corner of - - and 233rd. The 47th Precinct sent four police cars and six cops to patrol the traffic. We had a service there called the rosary. It is the rosary that is said in the Catholic faith, and the priest blessed the ground that was there. We also had a community meeting as Mary said in the - - Heights Restaurant - - the other night. Over 200 people-- the people of Woodlawn are outraged. They are absolutely outraged. I am a volunteer. I do a lot of volunteer work in the community - - Queens. I am involved with the taxpayers. I am involved in - - I run the Irish - - and street fairs - - . It is not that I am bragging, but I have been in Woodlawn a lot times and I am involved with the people. Every year I walk in the street, people are saying how did this ever happen that a van, a filthy, dirty, van for the medical director officer came and picked up an individual off the

street? I don't care who it is? It could be - - Van Cortland Park - - . anybody. Everybody has to be picked up with dignity and respect. I have seen those vans. I have seen those vans - - my time. You all sit - - very familiar with those vans. I have seen cops stand over a body there for six, seven, eight hours. I went off and did two or three jobs, come back years ago in the telephone company, and I come back and the cop is still there standing watching somebody who has been shot in the deli on 175th Street or off the concourse on Walton Avenue. I have seen plenty of things and - - what do you see in the street? It is not - - disgrace. One thing I would like to know, are those vans got refrigeration when they pick the bodies up? Are those vans have got different sections - - for the other? I am embarrassed and I will tell you why technology is so today that 20 minutes as it happened here it was right in Dublin and it was right on the television. I got calls for Ireland. My daughter teaches up in Berrycliff [phonetic] and she had calls from England. I even had two people from Australia called. People have visited Woodlawn.

Woodlawn Cemetery is a very - - cemetery and a lot of people come there to visit and they are very familiar to Woodlawn Cemetery. - - Colorado called me up and says what is going on in the Bronx. I see a body that was picked up with a garbage truck full of recycling bottles. In this day and age this thing shouldn't happen, and each one of those individuals that pick up those bodies should have - - a uniform on them, a white uniform that looks respectable looking, not a guy looking to come pick up garbage. This should never, never happen again. Thank you very much for having me here. Thank you.

FATHER RICHARD GORMAN: Good afternoon. It is good afternoon 'cause we have been here a long time, and I am in the unenviable position of separating you from your next appointment or possibly your lunch, so I am going to make it very quick and to the point. My name is Father Richard Gorman. I am the chairman of Community Board 12. I am here this afternoon to add the outrage of Community Board 12 and the other neighborhoods that constitute Community District Number 12 in the Bronx, one of which is

Woodlawn Heights to express the outrage of all of our residents at what happened. This is something that should never happen in a civilized society and nevertheless in the greatest city in the world, and so all of share the outrage that has been expressed here, and the community board wants to go on record as supporting that. I know that this isn't germane particularly to this hearing, but I know we are being televised. Eventually these tapes will be played, so since the person or persons who ran over Kevin Bell that fateful morning like to get up late at night and drive around maybe some night late they will be watching the tapes of these hearings, and I would hope that that person or persons would turn him or her or themselves in and finally put to rest many of the questions that the people of Woodlawn Heights and Community Board 12 have. Those persons or that individual owes it not only to Kevin Bell and his family, but to the people of our community and really owes it to him or herself to come clean and all I can say is that if that person does hear this message, there will come a time when your head will not rest easily on the pillow at night

until you have turned around and faced the fact that you have been involved in a very tragic situation. I want to support some of the things that were said earlier today by Council Member Koppell the first of which is that this case should be looked at quickly and expeditiously and we should get a report as soon as possible. I don't think that it is going to take a massive - - Commission type investigation to come to the bottom of this. So we should get a report and on the way out I asked the Acting Medical Examiner to please send a report to the community board, and I would ask the Council, particularly this committee and you Maria to make sure that the medical examiner who said she would do that will comply with that request. It is simple enough. But beyond that, something is tragically wrong with the Medical Examiner's Office if someone could show up in a van that was supposed to pick up the body of a deceased person filled with garbage. The fact that that driver would have even gone to the scene like that shows a comfort with this kind of behavior, which certainly speaks of systemic failure, and the fact that the person then had the

audacity and the boldness the open the van, let everyone see the garbage I mean it certainly shows either a total lack of sensitivity or common sense or as I said, a comfort level with this sort of behavior, and an indication that perhaps this behavior has been going on for quite a while, and I think that this is something that hopefully this committee will make sure the medical examiner gives a full report on. I would also going back to something or referencing something that Mr. McMorrow just said, I think it would be very wise, and I think it would be very appropriate if someone from the Medical Examiner's Office when the investigation is completed to come up to Woodlawn Heights and to speak to the community. If nothing else this terrible wrong can't be undone, but at least it can be properly apologized for, and I think one of the ways that it should be properly apologized for is that the Woodlawn community should have the benefit of hearing the report from the lips of the medical examiner herself. So I hope that you will support us in that regard. I want to point out something that I think you should be aware of because I think in

the emotion of the moment, it may be overlooked. Where is the sensitivity on the part of our city employees to people's religious and cultural practices? The way this body was treated speaks of a barbarianism that we detest as Americans and that we criticize other groups for. Now I don't expect all of our city workers to be an expert on everyone's religion and everyone's cultural practices, but I know of no decent society and I know of no great religion that doesn't call for respect for the body of a deceased person. So how is it that this kind of behavior would be contemplated in any way, shape or form and how can it be countenanced? I really think it shows a lack of sensitivity that certainly should be addressed at some point. Maybe those who deal with people in emergency situations or in situations where death has occurred need to be trained to the cultural sensitivities overall that people have at the moment of death. We are basically a society that has many religious values and where people proudly practice their religion, and certainly one time that we see that in everyone's life is when there is a death in the

family, and there was a death in the Woodlawn Heights family, and I certainly think that we owed it to the people of Woodlawn Heights as we owed it to Mr. Bell personally to his family to treat his body with respect. That should not be allowed to happen again. Maybe every once in a while our workers have to be given a little sensitivity reminder. I am sure the overwhelming majority of the members of the medical service and of the Office of the Chief Medical Examiner are fine women and men who do tremendous work day in and day, very difficult work, but there was a failure here, and I think that has to be addressed. I don't know whether or not you have contemplated this, but certainly as you can see there is such outage and there is concern that perhaps that our reputation has suffered not only at home, but abroad because of what has happened, and I think that it would be appropriate maybe if this Council passed a resolution and sent it to Mr. and Mrs. Bell apologizing on behalf of the city of New York and also asking his honor, Mayor Bloomberg, to do the same. Certainly this should never ever happen again. You know, my friends, I will end up with

this thought. A little while ago a man who killed almost 3,000 of our citizens not too far from here was killed by our military and his body was disposed of, but it was disposed of in a respectful way and in a way that respected his Muslim faith even though he committed such a heinous criminal act against our people. Why is it that an Irish Catholic kid didn't get that same respect? And I think until we find out what happened and why and find out all the people responsible for it, just not that person on the scene and make sure that it doesn't happen again, then I think that we certainly have something to be very ashamed of. May poor Kevin Bell rest in peace and may God grant peace and consolation to his family. Amen. Thank you.

CHAIRPERSON ARROYO: Thank you all for your testimony, and I can assure you--first, I have to say the Acting Medical Examiner is an individual who is highly respected. Dr. Sampson actually some of my colleagues if there is a confirmation hearing that has to happen in order for her to get formally appointed that they want to be character references and speak about her

professionalism and the quality of professional that she is. I think you heard me say that she is still in her honeymoon. She stepped into this position in a time when the Office of the Chief Medical Examiner is under a great deal of scrutiny for good reason. I think she is the first to admit that and we, certainly I have a great deal of confidence that number one, she will follow up with making sure that not only this Council and Council Member Koppell, but that Community Board 12 and the community of Woodlawn Heights receives a full counting of what happened in this case and that I think she would be open to coming to provide the community an opportunity to hear the report and the findings. More importantly that whatever the findings demonstrate, the strategies to make sure that this kind of things never ever happens again, and part of what I think should be included in the report and she is still here in the room, and we always are grateful that she does that--the only technically commissioner that does that in any hearing in the City Council--to provide for us a better understanding of the process, what is the turnaround time, what is the

standard for making sure that when there is a call for a body to be picked up how long should it take given everything else that is happening, what type of vehicle are they using, are they air conditioned? And I think you are absolutely right, Father. The fact that this thing happened speaks to a very consistent practice of this particular individual or others that do this work in our city to consistently carry recyclable material in a vehicle that is designated for very specific and sacred services. My hope is that we will get a report quickly and more importantly recommendations and corrective action to make sure that there is ongoing monitoring of these vehicles and who is responsible in the process to make sure that they are inspected, checked for cleanliness and all other kinds of things that should be part of what they have on a routine basis, and I think Council Member Koppell spoke about the ambulances and how the EMTs after delivering someone to the emergency room go through a process of checking everything in the van to make sure that it is fully outfitted to perform the duties and the functions. We will look into the resolution

offering the apology formally from the City Council and that is something that we will speak to Council Member Koppell and ask him to do the due diligence to introduce the legislative request to execute that process. That should be something that we could do fairly quickly without much delay and with that, I thank you and on behalf of the City Council, the chair of this Committee, and I will turn it over to my Co-chair, we give you our deepest condolences for the loss of this young man and more importantly our deepest apology for the manner in which the handling of his body was conducted.

CHAIRPERSON FERRERAS: Thank you and we are going to be wrapping up this hearing. I also just wanted to add that in the report I know that sometimes these vans pick up multiple bodies in some cases. I think that there should be some information how long bodies remain in the vans, how many at one time, can they be in there for hours, can they not? I really think this is an opportunity for ourselves as Council Members, but also the public at large to be educated on the process of how our loved ones are handled or how

even a John Doe or a simple stranger, everyone should have the same rights and the same protections for dignity. So I thank you all for coming to testify today, and all of those of the panel that came to testify before these two pieces of legislation that both Council Member Arroyo, myself have worked very hard and diligently to make sure that we bring transparency and resolution to a lot of the issues that we have. So thank you all for coming today. Have a great day. We are calling this hearing to a close.

[gavel]

C E R T I F I C A T E

I, Kimberley Campbell certify that the foregoing transcript is a true and accurate record of the proceedings. I further certify that I am not related to any of the parties to this action by blood or marriage, and that I am in no way interested in the outcome of this matter.

Signature Kimberley Campbell

Date 7/23/13