State of Alaska
Ombudsman

September 12, 2016

Ombudsman Complaint A2016-0461
Finding of Record and Closure

This investigative report has been edited and redacted to remove information made confidential by Alaska Statute and to protect privacy rights.

The widow of a man who died at a remote worksite in Southeast Alaska contacted the Alaska Ombudsman on March 8, 2016, to file a complaint against the Alaska State Medical Examiner's Office (Medical Examiner). The widow complained about several aspects of the Medical Examiner's autopsy of her late husband following his death in July 2015.

The ombudsman opened an investigation into the following allegations, stated in terms that conform to Alaska Statute 24.55.150:

> ***Allegation 1: Unreasonable: The Alaska State Medical Examiner's Office did not perform an autopsy on the complainant's husband immediately following his death.***
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> ***Allegation 2: Based on improper grounds: The State Medical Examiner made a determination on the cause of death of the complainant's husband without performing the tests required to support the finding.***
>
> ***Allegation 3: Performed inefficiently: The State Medical Examiner did not provide an autopsy report to the complainant until six weeks after the autopsy was concluded.***
>
> ***Allegation 4: Performed inefficiently: The State Medical Examiner did not return the remains of the complainant's husband to his country of origin in a timely manner.***

Ombudsman Intake Assistant Michael Jones investigated this complaint and forwarded his report to the ombudsman. Based on the ombudsman's investigation, all four allegations have been found to be ***not supported*** by reasons outlined in this report.

INVESTIGATION

Role of the Alaska Ombudsman's Office

The Alaska Ombudsman's statutory authority is outlined in Alaska Title 24.55. The Alaska Ombudsman investigates citizen complaints against State of Alaska agencies and state employees. The Office of the Ombudsman is a non-partisan, neutral, fact-finding agency and takes no sides in a dispute. The ombudsman's mandate is to determine whether state government actions are fair, reasonable, and in accordance with applicable state laws, regulations, and agency policy.

The ombudsman has no statutory authority to investigate the actions of private individuals or businesses, even if those persons or businesses were acting at the behest of a State of Alaska agency. (AS 24.55.150, AS 24.55.330)

This report reviews the administrative actions of the Alaska State Medical Examiner. Ombudsman Staff are not medical professionals and do not have the education or expertise to question the *medical* decisions of the Medical Examiner.

Investigation Process:

The investigator took the following steps in investigating this complaint:

- Interviewed the complainant;
- Interviewed Alaska State Medical Examiner Operations Manager Stephen Hoage;
- Reviewed Alaska State Trooper (AST) reports related to the death;
- Reviewed Alaska State Medical Examiner Policy and Procedure and agency records related to the death;
- Reviewed the United States Department of Labor, Occupational Safety and Health Administration (US OSHA) investigation into work conditions and safety concerns at the Prince of Wales Island worksite;
- Reviewed the Alaska Occupational Safety and Health (AKOSH) investigation into living conditions and sanitation problems at the worksite; and
- Researched current medical standards on-line;

Chronology:

The following chronology was developed from review of Medical Examiner, Alaska State Troopers, AKOSH, and US OSHA records, and documents provided by the complainant.

July 23, 2015

- 3 p.m.: A Mexican national, whose work papers listed him as 62-year-old JGR, died suddenly while working at a remote logging camp in Southeast Alaska. He was working at 2,000 to 3,000 foot altitude.
- 3:15 p.m.: Coworkers of JGR reported the death to Alaska State Troopers.
- 5:30 p.m.: AST and volunteer emergency medical technicians arrived at the scene and pronounce JGR dead.
- The physical remains were transferred to a mortuary in Southeast Alaska.
- 9:17 p.m.: Troopers contacted the Alaska Medical Examiner's Office to report a death of "apparent natural causes."

July 24, 2015

- The State Medical Examiner's Office determined an autopsy was not required.
- The Medical Examiner instructed the mortuary to draw blood samples for testing.
- The Medical Examiner notified AST that the body may be released to the mortuary for return to his family.

July 27, 2015

- An employee from the Mexican Consulate in Anchorage[1] contacted the Alaska Medical Examiner:
  - She advised the Medical Examiner that, according to the decedent's family, the decedent was not JGR, but rather his younger brother, AGR, age 54.
  - She requested the Medical Examiner not issue a death certificate until the identity could be confirmed by law enforcement.

August 3, 2015

- The FBI notified the Medical Examiner that a search of the FBI fingerprint database confirmed that the body was that of AGR, the complainant's husband.

August 12, 2015

- Alaska Occupational Safety and Health (AKOSH) advised the Medical Examiner that the U.S. Occupational Safety and Health Administration (US OSHA) had received reports that AGR may have died as a result of severe dehydration.
- The Medical Examiner reevaluated the case and decided that an autopsy was required to determine if dehydration is a factor in the death.
- The Medical Examiner requested the body from the Mortuary.

August 14, 2015

- AGR's remains arrived at the Medical Examiner office in Anchorage.
- Medical Examiner performed autopsy at 7:50 a.m.
- Medical Examiner drew samples of the vitreous humor[2] from the body to send to an out-of-state lab for testing.
- The body was transferred to a mortuary in Anchorage, Alaska.

August 19, 2015

- The widow of AGR submitted a request to the Medical Examiner to be provided a copy of the autopsy report.

August 26, 2015

- Results of testing on the vitreous humor sample were delivered to the Medical Examiner.

[1] The Anchorage Office of the Mexican Consulate closed in November 2015. http://www.adn.com/article/20150924/mexican-consulate-anchorage-close

[2] "Vitreous humor is a transparent, semigelatinous substance contained in a thin hyoid membrane and filling the cavity behind the crystalline lens of the eye. Some indications of the hyaloid canal may persist in the vitreous humor, which is not penetrated by any blood vessels and is nourished at its periphery by vessels of the retina and the ciliary processes. The vitreous humor is concave anteriorly to accommodate the crystalline lens and is closely applied to the retina around the wall of the eyeball. Also called **corpus vitreum, vitreous body**." Mosby's Medical Dictionary, 9th edition. © 2009, Elsevier.

August 27, 2015

- Deputy Medical Examiner Cristin Rolf, MD, signed the Certificate of Non-Contagious Disease – which listed an incorrect date of birth for AGR.

August 28, 2015

- Dr. Rolf signed the autopsy report which listed the cause of death as "hypertensive and atherosclerotic cardiovascular disease with moderate coronary artery stenosis." In other words, AGR died of a heart attack caused by a blockage of one of his arteries.

September 3, 2015

- The Anchorage mortuary requested that the Certificate of Non-Contagious Disease be reissued with the correct date of birth.

September 9, 2015

- The Mexican Consulate employee contacted the Medical Examiner to determine the status of the autopsy report. She said she was going to be away from the consulate for two weeks and wanted to send the report to the widow before she left.

September 11, 2015

- The physical remains of AGR were returned to Guadalajara, Mexico.

October 7, 2015

- The Consulate employee called the Medical Examiner again to check the status of the document request. An administrative assistant at the Medical Examiner office checked the computerized database and stated all documents had been received and the report should be sent that day or the next.

October 9, 2015

- The Consulate employee called yet again about the autopsy report. Case notes indicate the call was forwarded to another employee.

October 12, 2015

- The widow again contacted the Medical Examiner by phone to request the autopsy report and the corrected Death Certificate.
- The Medical Examiner provided the autopsy report to the Mexican Consulate in Anchorage to transmit to the widow.

November 6, 2015

- The widow sent the Medical Examiner a fax stating her concerns about how the autopsy was performed and questioning the conclusion. An office assistant at the Medical Examiner's office conferred with Dr. Rolf and spoke to the widow and employee at the Mexican Consulate.

March 8, 2016

- The widow filed an ombudsman complaint against the Alaska Medical Examiner.

ANALYSIS AND FINDING OF RECORD

Alaska Statute 24.55.150 authorizes the ombudsman to investigate administrative acts of state agencies that "the ombudsman has reason to believe might be contrary to law; unreasonable,

unfair, oppressive, arbitrary, capricious, an abuse of discretion, or unnecessarily discriminatory, even though in accordance with law; based on a mistake of fact; based on improper or irrelevant grounds; unsupported by an adequate statement of reasons; performed in an inefficient or discourteous manner; or otherwise erroneous." The ombudsman reformulates citizen complaints against state agencies as allegations using these statutory terms. AS 24.55.150 also provides that "the ombudsman may investigate to find an appropriate remedy."

Under 21 AAC 20.210 the ombudsman evaluates evidence relating to a complaint against a state agency to determine whether criticism of the agency's actions is valid, and then makes a finding that the complaint is *justified*, *partially justified*, *not supported*, or *indeterminate*. A complaint is *justified* "if, on the basis of the evidence obtained during investigation, the ombudsman determines that the complainant's criticism of the administrative act is valid." Conversely, an allegation is *not supported* if the evidence shows that the administrative act was appropriate. If the ombudsman finds both that an allegation is *justified* and that the complainant's action or inaction materially affected the agency's action, the allegation may be found *partially justified*. An allegation is *indeterminate* if the evidence is insufficient "to determine conclusively" whether criticism of the administrative act is valid.

The standard used to evaluate all Ombudsman complaints is **the preponderance of the evidence**. If the preponderance of the evidence indicates that the administrative act took place and the complainant's criticism of it is valid, the allegation should be found justified.

Allegation 1: Unreasonable: The Alaska State Medical Examiner's Office did not perform an autopsy on the complainant's husband immediately upon his death.

According to the Office of the Ombudsman's Policies and Procedures Manual at 4040(2) an administrative act is **unreasonable** if:

> (A) the agency adopted and followed a procedure in managing a program that was inconsistent with, or failed to achieve, the purposes of the program,
>
> (B) the agency adopted and followed a procedure that defeated the complainant's valid application for a right or program benefit, or
>
> (C) the agency's act was inconsistent with agency policy and thereby placed the complainant at a disadvantage relative to all others.

During the summer of 2015, AGR was working as a migrant laborer in Southeast Alaska on a reforestation project. The work involved thinning out undergrowth in timber forests using chainsaws. The worksite was remote and accessible only by boat or float plane.

AGR was working under the identity papers of his older brother, JGR. According to information provided to the Medical Examiner by the Mexican Consulate, AGR had been deported from the Unites States decades prior and was ineligible to work in this country.

On July 23, 2015, at about 3 p.m., laborers at the worksite witnessed AGR collapse while fueling a chainsaw. The death occurred suddenly and there was no reported evidence of trauma or injury. The laborers contacted the Alaska State Troopers (AST) at 3:15 p.m. Troopers arrived at the camp with volunteer medical technicians two hours later. The medical technicians declared AGR dead at the scene.

AGR's body was taken to a nearby town and placed at the mortuary. Troopers contacted the Medical Examiner that evening. The next day, the Medical Examiner notified the mortuary that an autopsy was not required and requested the mortuary draw a blood sample before embalming the remains. The Medical Examiner also released the remains to the mortuary to make arrangements for transport back to his family in Mexico.

Medical Examiner Operations Manager Stephen Hoage told the ombudsman investigator the Medical Examiner initially determined an autopsy was not required because, when a male over 50 years of age dies suddenly with no evidence that another person caused him harm, the death is almost always due to some form of heart disease. He said the statistical likelihood that heart disease is the cause of death under those conditions is so high that the time and expense of performing an autopsy is not considered to be justifiable. He said this practice is in accordance with current medical research and is similar to practices in other parts of the United States.

The Policy and Procedures Manual for the State Medical Examiner's Office states in the policy **Deaths Reportable to the Medical Examiner's Office/ Assuming Jurisdiction and When to Transport:**

> **111. SUDDEN OR UNATTENDED APPARENT NATURAL DEATHS**
>
> **A. Deaths that occur suddenly, when in apparent good health, and no significant medical history and the deceased is under 50 years of age shall be transported to the SMEO [State Medical Examiner's Office].**
>
> **B. If over 50, but the death appears natural, the body can be released to a funeral home from [the] scene, but placed on hold until photographs and review of circumstances with on-call pathologist can be done.**
>
> C. All deaths that fall under the [Medical Examiner's] jurisdiction in the Anchorage area will be attended by an investigator.
>
> D. All infants and children shall be transported unless previously diagnosed disease sufficient to account for death is recorded. [Emphasis Added]

Medical Examiner policy: **CRITERIA FOR AUTOPSY, LIMITED AUTOPSY, AND EXTERNAL EXAMINATION Procedures and Practices**:

> When examination is required, complete autopsies are performed by the SMEO, with the exceptions described below. Even if any given case meets the criteria described under the categories below, a complete autopsy can be performed at the discretion of the medical examiner under any circumstance.
>
> **I. Criteria for External Examination in natural deaths:**
>
> > **A. Age of decedents greater than 50 years. Age can be less than 50 years only if the decedent has significant medical history (attending physician unavailable).**
> >
> > **B. No evidence of significant injury either at the investigative scene, or by examination of the medical examiner. The presence of a locked, secured residence (at the investigative scene) is helpful, but not a strict requirement.**
> >
> > C. If investigation does not indicate misuse or excessive use of medications.

> D. If the body is decomposed, the above criterion applies, but in addition, there must be a means to satisfactorily identify the decedent. In the case of decomposed remains, the decedent must have been found in a locked or otherwise secured environment.
>
> E. In circumstances where a decedent is transported to a local funeral home before it is realized the [Medical Examiner] will be responsible for the death certificate, an external examination may be performed by a SMEO investigator at the mortuary, and documented as a brief narrative entry in the database. [Emphasis Added]

The Medical Examiner decided not to perform an autopsy based on the false identification used by AGR, which led them to believe he was 62 years old. However, had the Medical Examiner known AGR's true age was 54 years old, the case would still have met the criteria for an external examination only, and an autopsy would not have been performed.

Three weeks later, new information changed the circumstances of the case. On August 12, 2015, the Alaska Occupational Safety and Health Section (AKOSH) received reports from the U.S. Occupational Safety and Health Administration (USOSHA) that there may have been insufficient suitable drinking water at the work site. If so, severe dehydration could have been a factor in AGR's death. The complainant told the ombudsman investigator she had been in contact with US OSHA and "insisted again and again that the autopsy be performed" because she believed that dehydration caused her husband's death. The ombudsman investigator was unable to determine whether any other parties made similar reports to US OSHA because that information was redacted from the federal records the ombudsman investigator reviewed. The ombudsman does not have jurisdiction over federal agencies.

Mr. Hoage explained to the ombudsman investigator that death caused by dehydration could be a legal liability issue, and the autopsy was necessary to confirm or rule out dehydration as a factor. The Medical Examiner took jurisdiction of the case on August 12, 2015, the same day the office received notice that dehydration could have been a potential factor in the death. The next day, AGR's remains were transported by air to Anchorage, a distance of over 1,000 miles. The autopsy was performed August 14, 2015, at 7:50 a.m., less than 48 hours after the Medical Examiner took jurisdiction of the case.

The Medical Examiner's original decision against performing an autopsy because of the age of the decedent is in accordance with agency policy and current medical practice. The Medical Examiner also followed policy later by reversing that decision after AKOSH reported that dehydration was suspected to be a contributing factor in the death. These actions appear to be timely, according to policy, and reasonable based on the information the Medical Examiner had at the time.

For these reasons the ombudsman finds ***not supported*** the allegation that the Alaska State Medical Examiner's Office unreasonably did not perform an autopsy on the complainant's husband immediately upon his death.

Allegation 2: Based on improper grounds: The Alaska Medical Examiner made a determination on the death of the complainant's husband without performing the tests required to support the finding.

The Office of the Ombudsman's Policies and Procedures Manual at 4040(11) defines the standard *Based on Improper Grounds* as:

> The agency failed to consider all relevant information or factors in making a decision.

Deputy Medical Examiner Cristin Rolf, MD, performed the autopsy on AGR on August 14, 2015. Dr. Rolf is a licensed physician in the State of Alaska and is nationally certified in forensic pathology. She was looking for signs of severe dehydration in AGR's body.

Mr. Hoage explained to the ombudsman investigator that when a person has suffered severe dehydration, internal organs will show visible signs of damage. Dr. Rolf found no such evidence of severe dehydration in AGR's body.

The Medical Examiner also sent a sample of the body's vitreous humor to an outside laboratory for testing. Vitreous humor is a clear gel located behind the lens of the eye that can be tested for certain elements after a person dies. According to Dr. Rolf, the lab results did not indicate that dehydration was a factor in the death. The complainant disagreed, arguing that the levels of sodium and chloride in the tests were low, leading to her belief that dehydration was likely a factor.

A brief Internet search led the ombudsman investigator to an article[3] intended for medical students describing the pattern of electrolytes in the vitreous humor that indicates a person was suffering from severe dehydration at the time of death. According to that article, the vitreous humor of a person who has suffered severe dehydration should have *raised*, not lowered, levels of sodium and chloride and moderately raised levels of urea. Results of laboratory testing show that AGR's levels of these three electrolytes was much lower than the accepted range to indicate dehydration. As stated earlier, ombudsman staff are not qualified to second guess Dr. Rolf's medical expertise, but investigators were easily able to find published research supporting her conclusion.

The complainant contended that the Medical Examiner should have tested the blood for cholesterol and triglycerides. Mr. Hoage explained to the ombudsman investigator that, once a person dies, the blood begins to break down immediately. Many elements that can be tested in blood drawn from a living person cannot be tested in blood drawn after a person dies. Cholesterol and triglyceride levels are among those that cannot accurately be measured after a person dies, he said.

Agency records, the investigator's interview with Mr. Hoage, and publicly available information, lead the ombudsman to conclude that the Medical Examiner considered all the relevant information available to her to determine the cause of AGR's death.

For these reasons the ombudsman finds the allegation that the Alaska Medical Examiner made a determination on the death of the complainant's husband without performing adequate tests to be ***not supported*** by the evidence.

[3] http://www.forensicmed.co.uk/science/toxicology/post-mortem-biochemistry/

Allegation 3*: *Performed inefficiently: The Medical Examiner's office did not provide an autopsy report to the complainant until six weeks after the autopsy was concluded.

The Office of the Ombudsman's Policies and Procedures Manual at 4040(14) discusses and defines the standard *Performed Inefficiently:*

> "Performed inefficiently" generally covers instances of unreasonable agency delay and ineffectual performance.
>
> (A) The timeliness of an administrative act is sometimes an issue. An agency performed inefficiently when an administrative act exceeded:
>
> > (a) a limit established by law (statute, regulation, or similar enacted source), or
> >
> > (b) a limit or a balance established by custom, good judgment, sound administrative practice, or decent regard for the rights or interests of the person complaining or of the general public.
>
> (B) An agency performed ineffectually when it mishandled the decision-making process or the process of implementing an act or service. The agency might have:
>
> > (a) proceeded with too much caution or spent too much time in internal consultation and thus delayed action; …

This complaint focuses on the timeliness of the issuance and delivery of the autopsy report to the complainant. To recap the chronology:

- **July 23, 2015:** AGR died in front of a group of workers on a remote island in Southeast Alaska. The body was transported to a nearby mortuary for arrangements the same day.
- **July 24, 2015:** The Alaska Medical Examiner determined that an autopsy was unnecessary because of AGR's documented age and the lack of any trauma or other evidence that would suggest homicide.
- **July 27, 2015:** The Mexican Consulate contacted the Medical Examiner and informed them that the decedent was using his older brother's identification and in the United States illegally. The Consulate asked that identity of the body be confirmed through fingerprints.
- **August 3, 2015:** The FBI reported confirmation that the body was that of AGR.
- **August 12, 2015:** Alaska OSHA notified the medical examiner that the US OSHA had received reports that AGR died as a result of severe dehydration. The Alaska Medical Examiner had the body transported to Anchorage for examination.
- **August 14, 2015**: The body arrived in Anchorage, the autopsy was conducted, fluid samples were taken and sent to an outside laboratory, and the body was transferred to a mortuary in Anchorage.
- **August 19, 2015**: AGR's widow requested a copy of the autopsy report.
- **August 26, 2015**: Medical Examiner received laboratory testing results of the vitreous humor.
- **August 27, 2015:** Dr. Rolf signed the Certificate of Non-Contagious Diseases which contained an incorrect birthdate.
- **August 28, 2015:** Dr. Rolf signed the Autopsy Report.

- **September 3, 2015:** The Anchorage mortuary asked for a corrected date of birth on the Certificate of Non-Contagious Diseases.
- **September 11, 2015:** AGR's remains were returned to his home in Mexico.
- **October 12, 2015:** AGR's widow contacted the Medical Examiner by phone to again request an autopsy report and corrected certificate be sent to her. The report was provided to the Mexican Consulate to forward to the widow.

The timeline for the entire autopsy process demonstrates that, for the most part, the Medical Examiner handled each step promptly and efficiently. The one exception is the subject of this complaint: that more than six weeks passed from the time the autopsy report was signed by Dr. Rolf until the report was provided to the complainant.

The Medical Examiner does not have a policy specifying how long the agency has to complete and issue an autopsy report. Mr. Hoage told the ombudsman investigator that the Medical Examiner makes an effort to send requested reports within five days after a case is closed. Dr. Rolf signed AGR's autopsy report August 28, 2015, two days after the Medical Examiner received the results of the vitreous humor laboratory tests. Forty-five days then passed before the autopsy report was finalized and provided to his widow on October 12, 2015.

According to Mr. Hoage, Medical Examiner staff thoroughly evaluate each case for errors before an autopsy report is finalized. He also said that the Medical Examiner's office was experiencing staffing shortages during the summer and fall of 2015. When the Medical Examiner is short-staffed it must prioritize urgent cases, such as autopsies required for criminal investigations.

The ombudsman recognizes that by the time the complainant received the autopsy report it had been nearly three months since AGR died. This is a very long time for a grieving widow to wait for detailed information about the cause of her husband's death. Six weeks to review and correct errors in the report is admittedly not ideal, but considering the staffing issues the Medical Examiner was facing at the time, the ombudsman cannot find the delay to be unreasonable or inefficient.

For these reasons the ombudsman finds the allegation of unnecessary delay to be ***not supported*** by the evidence.

> ***Allegation 4*: *Performed inefficiently: The Medical Examiner did not return the remains of the complainant's husband to his country of origin in a timely manner.***

The process for returning the remains of a foreign citizen is governed by the decedent's home country. Per Alaska Administrative Code at 7.05.470, it is the responsibility of the funeral home to make arrangements with the country of origin to return the remains. Neither Medical Examiner nor any other State of Alaska agency participates directly in making the arrangements.

The Medical Examiner had a role in providing documentation for AGR, however. Foreign countries receiving the human remains of a citizen generally require a document called a Letter of Non-Contagious Disease, which certifies that the remains are free of any communicable diseases.

In Alaska the Medical Examiner is the agency that provides this document, and it was provided to the funeral home on August 27, 2015. However, the document listed the birthdate of AGR's

brother instead of AGR. The funeral home requested a corrected copy on September 3, 2015. Agency records do not show exactly when the corrected document was issued, but Mr. Hoage told investigators that the needed changes were simple, so the corrected document would likely have been provided that day or the next. AGR's remains arrived in Mexico eight days later on September 11, 2015.

According to the records available to the ombudsman, there were other numerous small delays throughout the process of returning the remains of AGR to his family in Mexico. Most of these delays stem from confusion caused by AGR's use of false identification to enter this country. One of those complications can be attributed to Medical Examiner error. The incorrect birthdate on the Certificate of Non-Contagious Disease may have contributed to the overall delay, but it was a clerical error based on AGR's own deception and its effect on the process was a week at most.

For these reasons the ombudsman finds the allegation of unreasonable delay in repatriating the decedent's body to be ***not supported*** by the evidence**.**

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When the ombudsman finds all allegations in a complaint to be unsupported, the complaint can be closed without seeking comment from the agency involved. In cases where investigation finds no fault on the part of the agency, the ombudsman makes no recommendations. Therefore, this case will be closed with a finding of ***not supported.*** The ombudsman will make no recommendations.

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