BROWARD OFFICE OF THE INSPECTOR GENERAL

MEMORANDUM

To: Dr. Darin Trelka, Interim Chief Medical Examiner, Broward County Office of the Medical Examiner and Trauma Services

From: John W. Scott, Inspector General
Broward Office of the Inspector General

Date: February 6, 2012

Subject: **OIG Final Report Re: *Employee Misconduct and Gross Mismanagement by the Broward County Office of the Medical Examiner in the Handling of Narcotic Medications, Ref. OIG 11-022***

Attached please find the final report of the Broward Office of the Inspector General (OIG) regarding the above-captioned matter. The OIG investigation confirmed that Broward County Office of the Medical Examiner and Trauma Services (ME) Medical Legal Investigator Supervisor Linda Krivjanik engaged in misconduct in connection with the handling and disposal of several thousand narcotic medication pills, and also determined that the supervisory ME staff engaged in gross mismanagement by failing to ensure that medications entrusted to its care, including narcotic medications, were properly secured, cataloged, and destroyed.

As a result, the ME presently cannot determine the whereabouts of at least 3,600 pills, including over 2,100 oxycodone and over 150 hydrocodone, which are classified as controlled substances. In the age of burgeoning "pill mills," the failure to account for thousands of pills of controlled substances represents a public safety concern for all Broward residents. However, since County government is now conducting a thorough review to rectify the shortcomings identified at the ME, the OIG will not offer any recommendations at this juncture.

Attachment

cc: Honorable John E. Rodstrom, Jr., Mayor, Broward County
and Members, Broward Board of County Commissioners
Bertha Henry, County Administrator
Joni Coffey Armstrong, County Attorney
Al Lamberti, Broward Sheriff
Michael J. Satz, Broward State Attorney
Individuals previously provided a Preliminary Report (under separate cover)

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BROWARD OFFICE
OF THE INSPECTOR GENERAL

FINAL REPORT

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OIG 11-022
FEBRUARY 6, 2012

Employee Misconduct and Gross Mismanagement by the Broward County Office of the Medical Examiner in the Handling of Narcotic Medications

FINAL REPORT RE: EMPLOYEE MISCONDUCT AND GROSS MISMANAGEMENT BY THE BROWARD COUNTY OFFICE OF THE MEDICAL EXAMINER IN THE HANDLING OF NARCOTIC MEDICATIONS

SUMMARY

In November 2011, the Broward Office of the Inspector General (OIG) began an investigation based on allegations that the Broward County Office of the Medical Examiner and Trauma Services (ME) was unable to account for several thousand narcotic medication pills, including oxycodone and hydrocodone. Specifically, it was alleged that the Medical Legal Investigator Supervisor, Linda Krivjanik, had been seen going through evidence bags and pouring pills into her hands, after which she shredded the medication inventory intake forms (inventory form) which purported to identify the pills. It was further alleged that Ms. Krivjanik routinely left numerous large black garbage bags containing medications in a file room, rather than properly arranging for their inventory and storage in the evidence room.[1]

The OIG investigation substantiated the allegations of Ms. Krivjanik's misconduct, as well as allegations that the supervisory ME staff, including former Chief Medical Examiner Joshua Perper and Ms. Krivjanik, engaged in gross mismanagement by failing to ensure that medications entrusted to its care, including narcotic medications, were properly secured, cataloged, and destroyed. ME management's failure to adopt adequate procedures and conduct any training resulted in ME investigators' routine failure to properly inventory medications seized by the ME, and permitted the keeping of controlled substances in garbage bags scattered throughout the office, in contravention of Florida law and Broward County's District 17 Medical Examiner Procedure Manual (Manual).

The OIG investigation found that ME personnel openly derided the lack of professionalism at the ME, including describing staff meetings with Dr. Perper and their outcomes as a "joke;" being "flabbergasted" by the lack of supervision, which allowed for investigators to leave medications in the open, rather than locking them up; describing evidence handling as being "too lax, for too long;" referring to internal controls as "loosey goosey;" and observing that inventorying medications was "not viewed as a top priority." Even the newly-assigned Interim Chief Medical Examiner (Interim Chief) acknowledged that as recently as 2010, the manner in which medications were stored resembled a "free for all." As a result, the ME presently

[1] This report stems from investigations conducted by the Broward County Human Resources Division (Human Resources) and the Broward Sheriff's Office (BSO) regarding Ms. Krivjanik's activities. In December 2011, Human Resources terminated Ms. Krivjanik after finding that she engaged in misconduct. The primary focus of this report is the gross mismanagement which the OIG found to exist at the highest supervisory levels of the ME. We appreciate the assistance we received from Human Resources, the County Administrator, and the BSO during our investigation.

cannot determine the whereabouts of at least 3,600 pills, including over 2,100 oxycodone and over 150 hydrocodone, which are classified as controlled substances.[2]

In fact, the haphazard manner in which the ME inventoried and maintained medications has made it impossible to determine the number of medications that have gone missing. The stated number of missing pills, presently over 3,600, is possibly only a small sample of the pills that have gone missing from the ME's office. In the age of burgeoning "pill mills," the failure to account for thousands of pills of controlled substances represents a public safety concern for all Broward residents. As revealed by the OIG investigation, years of undocumented narcotics disposals and the failure to properly inventory medications mean that the extent of the risk to public safety will never be accurately determined.

OIG CHARTER AUTHORITY

Section 12.01 of the Charter of Broward County empowers the Broward Office of the Inspector General to investigate misconduct and gross mismanagement within the Charter Government of Broward County and all of its municipalities. This authority extends to all elected and appointed officials, employees and all providers of goods and services to the County and the municipalities. On his own initiative, or based on a signed complaint, the Inspector General shall commence an investigation upon a finding of good cause. As part of any investigation, the Inspector General shall have the power to subpoena witnesses, administer oaths, require the production of documents and records, and audit any program, contract, and the operations of any division of the County, its municipalities and any providers.

The Broward Office of the Inspector General is also empowered to issue reports, including recommendations, and to require officials to provide reports regarding the implementation of those recommendations.

ENTITIES AND INDIVIDUALS COVERED IN THIS REPORT

Broward County Office of the Medical Examiner and Trauma Services

The ME investigates all violent, suspicious, unnatural and unattended deaths. In addition, the ME performs toxicology testing for drugs and poisons for police and health departments. The ME also provides education, consultation, and research for local and national medical, legal, academic, and law enforcement communities.

[2] The Controlled Substances Act, at Title 21, United States Code, Section 812, identifies both oxycodone and hydrocodone as Schedule II narcotic controlled substances, which—like morphine and opium, which are also listed on Schedule II—have a high potential for abuse which may lead to severe psychological or physical dependence.

Dr. Joshua Perper

Dr. Perper was the Chief Medical Examiner from 1994 until his resignation on October 31, 2011. As Chief Medical Examiner, Dr. Perper was responsible for the oversight of all functions of the ME.

Linda Krivjanik

Ms. Krivjanik was the Medical Legal Investigator Supervisor for the ME from 2008 until December 2011. Ms. Krivjanik was primarily responsible for the day-to-day operations of six medical legal investigators (investigators). She had been with the office since 2001.

RELEVANT GOVERNING AND ADMINISTRATIVE AUTHORITIES

The Medical Examiners Act

The Medical Examiners Act (Act), Florida Statutes, Chapter 406, generally defines and governs the duties, responsibilities, and basis of discipline of the Medical Examiner. It also authorizes the Medical Examiner Commission to adopt rules within the Florida Administrative Code that govern the standards of conduct relating to medical examiner investigations.

The Florida Administrative Code

The Florida Administrative Code (F.A.C.), Chapter 11G, authored by the Florida Medical Examiners Commission, and adopted by the Florida Department of Law Enforcement, expands upon the Act. The F.A.C., 11G-2.003—*Investigation.*, states that:

(1) A medical examiner shall investigate under the authority of Section 406.11, F.S., in order to determine the cause of death and such circumstances surrounding it as are necessary and in the public interest.

With regard to the retention of medications seized by the Medical Examiner, the F.A.C., 11G-2.004—*Physical Evidence.*, states that:

(2) The medical examiner shall seize such physical evidence as shall be necessary to determine the cause and manner of death, presence of disease, injury, intoxication, and identification of the decedent, or to answer questions arising in criminal investigations, and shall label, prepare, analyze, examine, and *catalog* such evidence as needed (emphasis added).

Broward County's District 17 Medical Examiner Procedure Manual

The ME has also developed the Manual, which prescribes policies and procedures for the function of the office. The Manual's procedures for handling medications, at page 73, state that:

> The Medical Examiner's Office representative will collect all prescription medication belonging to the decedent….
>
> All medications brought to the Medical Examiner's Office will be cataloged. Medications are discarded only after completion of all toxicological analyses and review by the medical examiner who must sign the inventory sheet prior to disposal.
>
> All such medications are kept in separate bags or containers in a locked room for two years, until incineration at a local hospital. The incineration process is to be witnessed by the hospital staff and Medical Examiner Investigators.

INVESTIGATION

Investigation Overview

This investigation is predicated on information alleging that the ME engaged in gross mismanagement by failing to ensure that medications in its custody, including narcotic medications, were properly secured, cataloged, and destroyed. The OIG investigation substantiated the information, and also found that the ME presently cannot determine the whereabouts of over 3,600 pills, including oxycodone and hydrocodone. We also determined that Dr. Perper and Ms. Krivjanik failed to properly train investigators to handle and release medications in accordance with procedures set forth in Florida law and the ME's own Manual.

The investigation involved the review of substantial documentation by OIG Special Agents including, but not limited to, ME records, guidelines, procedures, and case materials; legal authorities governing the conduct of the ME; and Human Resources and BSO investigative materials. OIG Special Agents also conducted interviews of current and former ME officials, including Dr. Perper.

Events and Findings Regarding Ms. Krivjanik's Misconduct

Summarized below are the events and findings which led to Ms. Krivjanik's termination:

1. Witness Accounts

In October 2011, an investigator (Investigator A) started having suspicions that something was "not right" with his medication evidence bags.[3] While he was in the evidence room he noticed that some of his evidence bags were not sealed, and that some of his inventory forms were missing from his boxes. He then went through a few of his boxes and noticed that two bags of medications were missing. His first thought was that Ms. Krivjanik must have pulled them at

[3] Physical evidence, specifically medication associated with a decedent, is kept in brown paper medication evidence bags or clear evidence bags. The bags are associated with case numbers for the specific death investigation conducted by the ME.

the request of an attorney,[4] so he marked an "M" for "missing" on his case inventory log—which was placed on the outside of his boxes—as a mental note for the future.

However, a few weeks later he noticed that one of the boxes he labeled with an "M" was missing. Investigator A also began to observe Ms. Krivjanik bringing other investigator's boxes into her office, and he started to see large black garbage bags appearing in the file room. He noticed a pattern developing at the end of each Friday, wherein Ms. Krivjanik was bringing boxes of evidence into her office, then dragging garbage bags out of her office into the file room.

On Friday, October 28, 2011, Investigator A saw Ms. Krivjanik taking medication boxes into her office. He watched her tear off the inventory form from a brown bag, open it, and pour pills from a bottle into her hand. As he watched her, he also noticed an empty, unmarked Ziploc plastic bag on her desk. At that point, Investigator A believed that Ms. Krivjanik may have seen him looking at her, because she placed the brown bag on the floor under her desk, came out of her office, and shredded the inventory forms.

On the night of October 31, 2011, Investigator A opened one of five garbage bags in the file room. The garbage bag contained several brown paper medication evidence bags. Investigator A noticed that the medication bags in the garbage bag he inspected were in "total disarray," including "loose" medication bottles. At random, he examined two medication bags and discovered that both were unsealed. Thereafter, he printed out the inventory forms for both bags—each noting that oxycodone had been seized—and discovered that the first bag was missing 19 oxycodone pills, and the second bag was also missing all its oxycodone pills, although he could not recall the exact number. Investigator A promptly informed the Interim Chief of his observations.

On November 1, 2011, the Interim Chief personally examined a garbage bag located in Ms. Krivjanik's office containing medication evidence bags for several cases.[5] He inspected medication evidence bags for two cases which he then compared to the inventory forms for those cases. The inventory forms indicated there were four separate bottles containing oxycodone pills, but the Interim Chief observed that two of them were empty. The Interim Chief then contacted the Deputy County Administrator. County officials promptly notified the BSO.

[4] Investigator A recalled that in 2008, when he first started working at the ME, he had asked Ms. Krivjanik about missing bags and she had told him that she would take medication evidence bags from the investigators' boxes when an attorney requested that the ME not dispose of certain medications due to a pending criminal or civil case. Back in 2008, Ms. Krivjanik had taken out his missing medication bags from her office, presumably to show him she had them. He recalled that the sealed bags were later returned to his box.

[5] The Interim Chief took photos of the contents of Ms. Krivjanik's office, which are attached as Exhibit 1. OIG Special Agents also took photos of the ME evidence room, which are attached as Exhibit 2, and depict unsealed medication evidence bags and empty bottles. These photos have been redacted to eliminate personal identification information.

2. Findings

BSO investigators examined one garbage bag and three boxes that were located in Ms. Krivjanik's office, containing medication evidence bags for a total of 46 individual cases. Acting with ME assistance, they conducted an inventory of all the medication evidence bags and recorded the findings of that inventory onto a spreadsheet, a copy of which is attached as Exhibit 3. The BSO's analysis of the medication evidence bags was significantly hampered by the fact that of the 46 cases, only 12 had inventory forms attached which identified their contents. Of those 12, the BSO found that at least 342 Oxycodone pills were missing from the bags.

In addition, five other garbage bags containing medications were observed in the file room, which were subsequently inventoried by Human Resources personnel. The results of the inventory findings were documented. The OIG has created the following summary of that information.

Drug Name	Missing Pill Amounts[6]
Alprazolam	21
Diazepam	0
Endocet	192
Hydrocodone	170
Liquid Oxycodone	7
Oxycodone et al	1844
Percocet	28
Roxicet	49
Total Missing Select Drugs Documented by HR	**2311**
Total Missing Oxycodone Documented by the BSO	**342**

Human Resources was ultimately able to determine that over 3,600 pills were missing. Of those, over 2,300 pills with significant street value were missing from the five garbage bags. However, the analysis conducted by Human Resources was similarly hampered by the significant lack of inventory forms, thus they could not obtain an accurate count of the true number of pills missing from the bags they inspected.

As part of the disciplinary process, Human Resources reported that among Ms. Krivjanik's professional failings, she was grossly negligent, displayed extremely poor judgment, and

[6] Human Resources totaled only the missing pills for select drugs. Other missing pills, including some known controlled substances, were identified but not totaled. It appears only a count of those pills with known street resale value was totaled.

poorly performed her professional duties. She was terminated from her position effective December 1, 2011.

Additional Findings of Gross Mismanagement by the ME

The OIG investigation found evidence of the ME's gross mismanagement, which is summarized below:

1. Failure to Effectively Communicate

The source of many of the ME's management issues has been rooted in a failure of communication between Dr. Perper and Ms. Krivjanik and, in turn, the investigators she supervised. Although Dr. Perper regularly conducted staff meetings on a variety of subjects, including the handling of medications, his directives were routinely countermanded by Ms. Krivjanik. Ms. Krivjanik openly discouraged participation by her subordinates at the staff meetings, in part so that Dr. Perper would not ask her to personally follow up on any issues which may have been raised. For example, in one meeting, Dr. Perper had raised questions regarding evidence handling, and suggested that Ms. Krivjanik implement a system which would require two investigators to be present whenever anyone entered the evidence room. Ms. Krivjanik refused to follow through with Dr. Perper's request, and told one investigator that "Perper will not remember what he wanted by next week." In addition, when Dr. Perper asked why investigators were not attending—and logging their attendance—at death scenes, Ms. Krivjanik responded by purportedly referring to a logbook to provide Dr. Perper with inflated numbers misrepresenting the number of times investigators had actually gone to death scenes. Another investigator described the staff meetings with Dr. Perper and their outcomes as a "joke."

2. Failure to Educate, Enforce and Supervise Compliance with Written Policies

Another area of management deficiency at the ME was the failure to ensure adherence to written policies, whether enumerated by Florida law or the ME's own Manual. The ME leadership failed to develop adequate policies and procedures, particularly those regarding the handling of medications, and to train investigators to follow them. All of the investigators interviewed by OIG Special Agents admitted that they received no formal training and, at best, "on the job" training, or "learning by watching others." One investigator stated that although Ms. Krivjanik provided him with a policy and procedure manual, she also told him that "the information written in it is not part of the daily routine you will be doing." As described below, the fruits of such negligence were most strikingly realized by the ME's inconsistent and inadequate handling of medications.

a. Failure to Properly Inventory and Store Medications

The Manual's procedures for handling medications, at page 73, merely state that "[a]ll medications brought to the Medical Examiner's Office will be cataloged."[7] With regards to the storage of the medications, the Manual only requires that they be kept in a locked room. Nonetheless, the OIG discovered that some investigators never followed even these minimal requirements, never counting medications, much less logging them into the computer system. For example, one investigator merely kept a garbage bag in her office, where she stored medications without logging them. Garbage bags full of medications were also left in the file room, where one investigator said that he often observed that high school and community college students, who were volunteer workers, were left unattended, with unfettered access to the medications.

In addition, prior to moving into their current facility in May 2010, the investigators were housed in a trailer, where they stored medications either in a bathroom or out in the open. The Interim Chief admitted that medications were stored wherever there was space in the trailer, in a manner so unregulated that it resembled a "free for all." Not only has haphazard conduct hindered the inventories conducted by the BSO and Human Resources, it has made it impossible to determine how many medications are truly missing from the ME facility.

b. Failure to Properly Dispose of Medications

Although the Manual's procedures for handling medications, also at page 73, require that the incineration of medications be witnessed by ME investigators, the OIG learned of multiple instances during which that mandate was ignored. One investigator recalled that in 2011, investigators loaded two vehicles with approximately 20 garbage bags containing medications—which had previously been stored in the file room—for incineration at Memorial Regional Hospital. The investigator stated that after the incinerator staff told them they would have to wait because other material was being burned, Ms. Krivjanik decided that they would not stay to personally witness the incineration.

Another ME official stated that he had confronted the former medical legal investigator supervisor who admitted she had falsely claimed to have witnessed an incinerator burn of medications. After the matter was reported to Dr. Perper, he directed the investigator supervisor and her assistant to sign a document affirming that they had properly disposed of the medications.

[7] OIG Special Agents repeatedly requested copies from ME staff of any additional documents addressing the handling and inventory of medications, and none were provided in response.

The Manual also requires that medications only be discarded after "review by the medical examiner who must sign the inventory sheet prior to disposal." During his interview with OIG Special Agents, Dr. Perper indicated that when a disposal was planned, Ms. Krivjanik would only inform him of the cases slated for disposal. His primary concern was whether there were any open cases. It appears that he was not reviewing or signing inventory forms prior to disposal.[8] Thus, the ME cannot be certain that the medications were properly destroyed, rather than, for example, improperly appropriated by any number of individuals who had access to them.

Remedial Action by the Broward County Government

Since it was notified of Ms. Krivjanik's misconduct, County government has taken a number of steps designed to eliminate the misconduct and gross mismanagement at the ME. First, of course, Human Resources promptly terminated Ms. Krivjanik's employment. In addition, the ME has now created new procedures governing the handling of evidence and medications.[9] Finally, a consultant has been retained to review ME policies and procedures, and to make further recommendations for improvement.

INTERVIEW SUMMARIES

As a part of the investigation, OIG Special Agents conducted numerous witness interviews. Significant interviews are summarized below: [10]

1. Interview of Investigator "A"

Investigator A stated that since he began working for the ME in 2008, he reported directly to Ms. Krivjanik, until her recent termination. He further stated that although Ms. Krivjanik provided him with a policy and procedure manual, she also told him that "the information written in it is not part of the daily routine you will be doing." Investigator A stated that he noticed that the manuals were "out of date" and that, in practice, they were not adhered to by ME investigative staff. However, he also stated his belief that the policy for the handling and release of personal property including medications, described at page 73 of the Manual, was expected to be followed at all times.

Investigator A stated that Ms. Krivjanik openly discouraged participation by her subordinates at staff meetings held by Dr. Perper, lest he ask her to personally follow up on any issues which may have been raised. He stated that she preferred the "status quo" because "less work is better." He also recalled that in a recent meeting, Dr. Perper had raised questions regarding evidence handling,

[8] No signed inventory sheets were found in the records contained in Ms. Krivjanik's office, nor could the Interim Chief provide any additional records related to the disposal of medications.
[9] A copy of those procedures, which the Interim Chief provided to OIG Special Agents, is attached as Exhibit 4. The new procedures establish a more stringent inventory process for the handling of medications, including establishing chain-of custody procedures for investigators.
[10] Ms. Krivjanik declined to be interviewed.

and suggested that Ms. Krivjanik implement a system in which swipe cards for two investigators would be needed in order for them to enter the evidence room at the same time. Investigator A stated that Ms. Krivjanik was uneasy with that recommendation, so that she never followed through with Dr. Perper's request. He also stated that Ms. Krivjanik routinely disregarded Dr. Perper's recommendations because, in her opinion, "Perper will not remember what he wanted by next week." The investigator stated that, for example, when Dr. Perper asked why investigators were not attending—and logging their attendance—at death scenes, Ms. Krivjanik responded by purportedly referring to a logbook to provide Dr. Perper with inflated numbers misrepresenting the number of times investigators had actually gone to death scenes.

With regard to the ME's handling of medications, Investigator A stated that some investigators never followed procedures, including never counting medications, much less logging them into the computer system. He also stated that one investigator merely kept a big black garbage bag in her office, where she stored medications without logging them. Investigator A stated that prior to moving into the current facility in May 2010, the investigators were housed in a trailer, where they stored medications either in a bathroom or out in the open.

With regard to procedures for the disposal of medications, Investigator A stated that he had never received any formal training on the disposal of medications, and that if there was any required paperwork to be completed, he was unaware of it. He stated that "I was never involved with the disposal of the medications other than following Krivjanik to the incinerator." He recalled that on one occasion in early 2011, the investigators loaded approximately 20 garbage bags containing medications—which had previously been stored in the file room—for incineration at Memorial Regional Hospital. Investigator A stated that after the incinerator staff told them they would have to wait because other material was being burned, Ms. Krivjanik decided that they would not stay to personally witness the incineration.

2. Interview of Investigator "B"

Investigator "B" (Investigator B), whose employment background includes service with another medical examiner in Florida, stated that he was "flabbergasted" by the way in which the ME operated compared to other places he had worked. He also stated that the manner in which investigators performed their duties was in "total conflict" with the Manual, and that the investigative unit "lacked structure." Specifically, Investigator B stated that there was no training on the statutes and regulations which govern the work of the ME, and that there was no training on the receipt, logging and storage procedures for medications and other evidence that would accompany bodies.

Investigator B described the staff meetings with Dr. Perper and their outcomes as a "joke." For example, he stated that although Dr. Perper directed investigators to attend death scenes, Ms. Krivjanik insisted that the investigators stay in the office. He recalled an incident in which a call came in related to a double fatality resulting from an automobile accident, just minutes away from

the office. Investigator B stated that when he got up to leave the building to visit the scene, he was stopped by Ms. Krivjanik, who told him to return to his cubicle.

Investigator B stated that he timely counted, logged and re-sealed medication evidence bags for lock up on every occasion, and again remarked that he was "flabbergasted" by the lack of supervision at the ME which allowed for investigators to leave medications in the open. After OIG Agents asked him to describe any instances in which it would be acceptable for medications to be removed from the lock up, Investigator B stated that once properly counted and logged into the computer database—which then made available all of the needed information—such medications should never be removed. However, he stated that he had routinely seen Ms. Krivjanik remove medications from the lock up, albeit with the understanding that she was checking for unsafe items while preparing the medications for the incineration process. Investigator B, who regularly worked Saturdays, further stated that if Ms. Krivjanik came in on Saturdays, she typically spent "85 percent of her day" going through the medication evidence bags, "supposedly looking for items that could explode during a burn." Investigator B stated that on weekends, he often observed that high school and community college students, who were volunteer workers, were left unattended in the file room, with unfettered access to garbage bags filled with medications.

3. Interview of the Senior Medical Legal Investigator

The Senior Medical Legal Investigator (Senior Investigator) stated that she had received no formal training and that she learned "on the job" by watching and talking to others. She did not recall any administrative codes or written procedures concerning the proper handling of medications and evidence. She added that inventorying medications was "not viewed as a top priority."

The Senior Investigator stated that it was her belief the ME was "mismanaged." She further stated that she had brought medication control issues to the attention of upper management in the past, but her concerns were ignored. Furthermore, she stated, everyone in the unit knew that when such issues were brought to Dr. Perper's attention, they would simply "die." She also stated that evidence handling at the ME was "too lax, for too long," and referred to internal controls as "loosey goosey." The Senior Investigator stated that she had observed Ms. Krivjanik and other ME employees remove medications from the evidence room for unknown reasons. She added that Ms. Krivjanik would drag garbage bags to her office and go through the bags, supposedly searching for any explosive devices that could damage the incinerator. She stated, however, that she had no knowledge of Ms. Krivjanik shredding or destroying any inventory forms, intake receipts, or any other documents.

4. Interview of the Assistant to the Director

The Assistant to the Director (Assistant) stated that he reported directly to the Chief Medical Examiner. The Assistant stated that he is the head of Trauma Services and supervises the administrative staff. He stated that Ms. Krivjanik was directly responsible for oversight of the day to day operations of the investigators, and that she reported directly to Dr. Perper. The Assistant

further stated that the security and operation of the ME facility is the ultimate responsibility of the Chief Medical Examiner.

The Assistant stated that when he was reviewing the evidence room security camera video and swipe card reader reports, he noticed that Ms. Krivjanik had entered the evidence room many times on Saturday, October 15, 2011. He stated that this was unusual, since she did not routinely work on the weekends. He also stated that the camera video shows her removing boxes containing medication evidence bags from the evidence room. There is no security camera in the file room.

The Assistant stated that approximately one week after the initial reporting of Ms. Krivjanik's actions, an investigator had informed the Interim Chief Medical Examiner that she had medication evidence boxes in her office, which included bags of medications. He further stated that although inventory forms were on the cases, some of the bags were unsealed.

During the interview, the Assistant opened the locked door of a conference room so that OIG Special Agents could photograph the garbage bags of evidence. OIG Special Agents also took several photos of evidence stored in the file room and the evidence room, which included unsealed envelopes and empty pill bottles.

5. Interview of the Former Deputy Medical Examiner

The former Deputy Medical Examiner (Deputy) stated that he was employed at the ME from January 2007 until May 15, 2011, where he reported directly to Dr. Perper. The Deputy stated that he was Director of Pathology, where he supervised the doctors and photographers, as well as liaised with the Broward County Commission. He also stated that he acted as Chief Medical Examiner in Dr. Perper's absence.

The Deputy stated that he had observed a number of incidents during his tenure at the ME which revealed a general lack of accountability and effective policies and procedures. One such incident occurred in 2007, he stated, when Dr. Perper was informed that the investigator supervisor had not actually witnessed the disposal of medications. Dr. Perper subsequently directed the investigator supervisor and her assistant to sign a letter stating that they had personally observed the incineration of narcotic medications at the North Broward Medical Center when, in truth, they had not. The Deputy also stated that in another incident a sum of $3,000 cash was missing from the personal effects of a decedent, only after which a safe was installed in the ME office.[11] The Deputy stated that the "loose handling" of valuables and narcotics by the investigators was similar to the overall lack of effective controls at the ME.

The Deputy stated that when he began employment in early 2007, he observed a number of toy dolls in the ME forensic tissue sample storage room. He stated that he learned from a colleague that in recent years one or more employees were apparently using the ME facility as an "e-Bay toy

[11] OIG Special Agents determined that the safe had never been in regular use.

store." Specifically, the Deputy stated a large shipment of toys was received at the ME and held in the tissue storage room.[12]

6. Interview of Dr. Joshua Perper

Dr. Perper stated that as Chief Medical Examiner, he was responsible for the entire operation of the ME, including the conduct of all of the investigators. He stated that he provided training to the investigators at staff meetings that were usually held on Wednesdays, and that they would read from manuals and books on a variety of subjects. Dr. Perper also stated that not only would he have weekly staff meetings with the investigative personnel as a group, he would also meet casually with the investigators individually to see if they needed any assistance or if they were having any problems. He further stated that he had a meeting with the investigative staff approximately two to three weeks prior to his resignation in which he discussed two "sensitive issues," namely, how they were handling money and drugs. Dr. Perper stated that the investigators assured him that everything was "O.K."

Dr. Perper identified page 73 of the Manual as the written ME policy for the handling and release of personal property including valuables, clothing, personal effects and medications. However, he could not recall if there was a written policy that stated the investigators were to count medications upon receiving them. He also stated that investigators "log in" medications into the ME's LabLynx computer system, but that the system was only developed within "the last few months."

With regard to the disposal of medications, Dr. Perper stated, "I am not sure how the drugs are destroyed." He explained that Ms. Krivjanik would bring him a list of all the cases associated with medications that were to be destroyed. He would approve destruction so long as she could assure him that no law enforcement officials or attorneys had requested that medications for a particular open case be retained. Dr. Perper stated that he relied upon Ms. Krivjanik to ensure the cases were ready to be destroyed. He further stated that he believed that medications were usually sent to the incinerator every two years, and were destroyed only in the presence of law enforcement personnel.[13] He also stated that he never gave Ms. Krivjanik permission to open medication evidence bags to search for explosives, ammunition or pacemakers.

Dr. Perper acknowledged that during his 17-year tenure as Chief Medical Examiner, neither he nor anyone on his staff ever conducted an inventory of the evidence room. He also acknowledged that "there was never a chain-of-custody form" in use at the ME, since medications were only moved "internally." Dr. Perper stated that it would be very surprising to him if there were several

[12] OIG Special Agents also interviewed the ME employee who had placed the toys in the tissue storage room. After having been asked whether he was running any type of e-Bay operation involving toys through the morgue, the employee responded, "it was mine," but subsequently denied marketing them on e-Bay. The OIG determined that County government promptly addressed the issue and the toys were subsequently removed.

[13] OIG Special Agents asked Dr. Perper three times if the ME policy was that law enforcement had to be present when the medical investigators were destroying the medications, and on all three occasions he responded "Yes."

thousand missing pills from the evidence room. He further stated that it would also be surprising if medications had been incinerated on several occasions within a two-year period, without the presence of law enforcement officials. Dr. Perper stated that "it was very upsetting to hear" that medications were missing from the ME facility, and added that "if the employees were not following the policies then the employees were wrong." He further stated "they knew what the policies were" and that the employees were responsible to follow them. Dr. Perper also stated that "if people do not follow what they were supposed to do, then it was a violation of trust."

7. Interview of the Interim Chief Medical Examiner

The Interim Chief Medical Examiner was named to that position on October 30, 2011, the day before Dr. Perper's retirement. He has been an employee of the ME since August 2009. The Interim Chief stated that after learning of the allegations regarding Ms. Krivjanik, he conducted his own internal investigation, including a review of the handling of medications by investigators. The Interim Chief stated that he discovered that the investigators had not been following previously-established procedures in every instance.

The Interim Chief stated that he discovered that each of the investigators counted the medications received by the ME differently. He stated some of the investigators counted some medications immediately, but that none of the investigators could confirm that they counted all of the medications, and some of the investigators admitted that they never counted them. He also stated that some investigators would count medications, but would leave them on their desks, under their desks, locked in their desks, not locked in their desks, and would only retrieve them at a later date. The Interim Chief further stated that before the investigators were moved into their current office space in 2010, they were located in a trailer which had no evidence room. He stated that the medications were stored wherever there was space in the trailer, in a manner so unprofessional that it resembled a "free for all."

RESPONSES TO THE PRELIMINARY REPORT AND OIG COMMENT

In accordance with Section 12.01(D)(2)(a) of the Charter of Broward County, a preliminary version of this report was provided to Ms. Krivjanik, Dr. Perper, the Interim Chief Medical Examiner, and the Broward County Administrator for their discretionary written responses. The OIG received responses from the County Administrator and Dr. Perper, which are attached and incorporated herein as Appendix A and Appendix B, respectively. We appreciate receiving the responses.

1. Response of the County Administrator

In her response, the County Administrator stated that a "thorough review" of the policies, procedures, and practices of the ME has been initiated, and is expected to be completed in February 2012. She further stated that the review will result in a report intended to rectify any shortcomings identified, and also identify opportunities for efficiencies and cost savings.

2. Response of Dr. Perper

In his response, Dr. Perper stated that he properly instructed ME investigators regarding the handling and release of evidence medications. He also stated that each of the investigators received training on the handling and storage of medications from the American Board of Medicolegal Death Investigators, located at St. Louis University. He further stated that a thorough audit of the ME was performed by the Florida Medical Examiner Office, albeit six years ago. Dr. Perper also stated that it was "unclear" to him why the preliminary version of this report only cited information obtained from three investigators, and questioned whether the others had been interviewed by OIG Special Agents.[14] He stressed that he always directed that all reports be accurately completed, and never directed an investigator to incorrectly state that she had witnessed the incineration of drugs. Dr. Perper stated that with regard to the missing $3,000, handling procedures for currency were upgraded, including the purchase of a safe.

Dr. Perper stated that he was "very upset by the betrayal of Ms. Krivjanik," who "repeatedly sabotaged, derided, and derailed" his instructions for the betterment of the ME. He also stated that he was saddened by the fact that investigators "chose to remain silent" rather than notifying ME senior management of "grave violations." Finally, Dr. Perper stated that he was "dismayed and disappointed" to learn of the large number of pills that were unaccounted for and that, in retrospect, the issue should have been addressed proactively, although no "red flags" had been raised at the time.

Although Dr. Perper stated in his response that the investigators were properly trained, it is readily apparent that in practice, any such training was disregarded. Otherwise, the ME would never have resembled the "free for all" so aptly described by the Interim Chief. Indeed, that condition alone should have raised a series of bright red flags that Dr. Perper claims were otherwise not discernible. His discretionary response does not alter the findings reached by the OIG in the preliminary version of this report.

CONCLUSIONS

The OIG investigation revealed that the ME has failed to properly safeguard medications entrusted to its custody and care, and has also failed to properly train its staff in the handling of those medications. As a result, it cannot locate at least 3,600 pills—many of which by now may have entered into an illicit stream of commerce. By any measure, such cause and effect represent unacceptable performance by public officials. However, the OIG is encouraged by the swift manner in which County government has acted to rectify the shortcomings identified at the ME. Thus, the OIG will not make any recommendations at this juncture, but we request that we be provided with a copy of the report referenced by the County Administrator when it is completed, as well as any other materials that reflect corrective action.

[14] In fact, all six of the investigators were interviewed by OIG Special Agents, and both the preliminary and final reports contain information obtained from all of them.

OIG 11-022

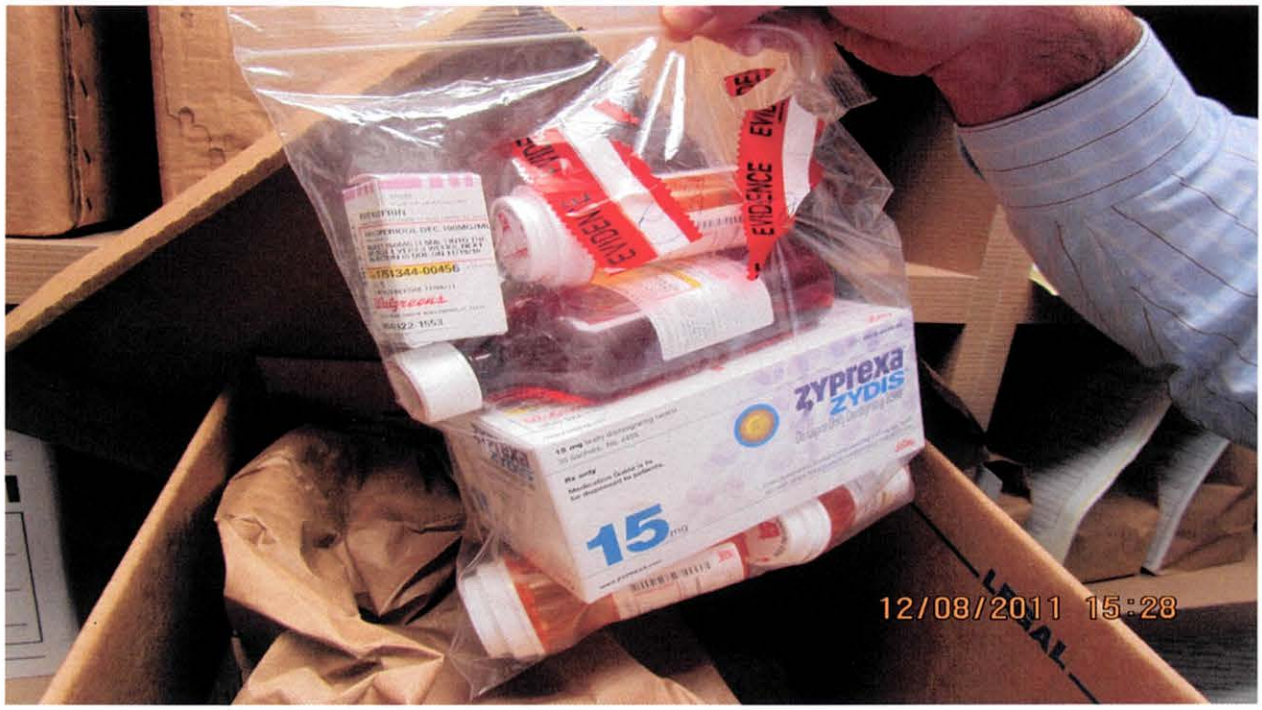
EXHIBIT 1


INVESTIGATI


2/14/86
B6-257
REDS

OIG 11-022

EXHIBIT 2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Walgreens
Zyprexa
ZYDIS
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Rx only
12/08/2011 15:28

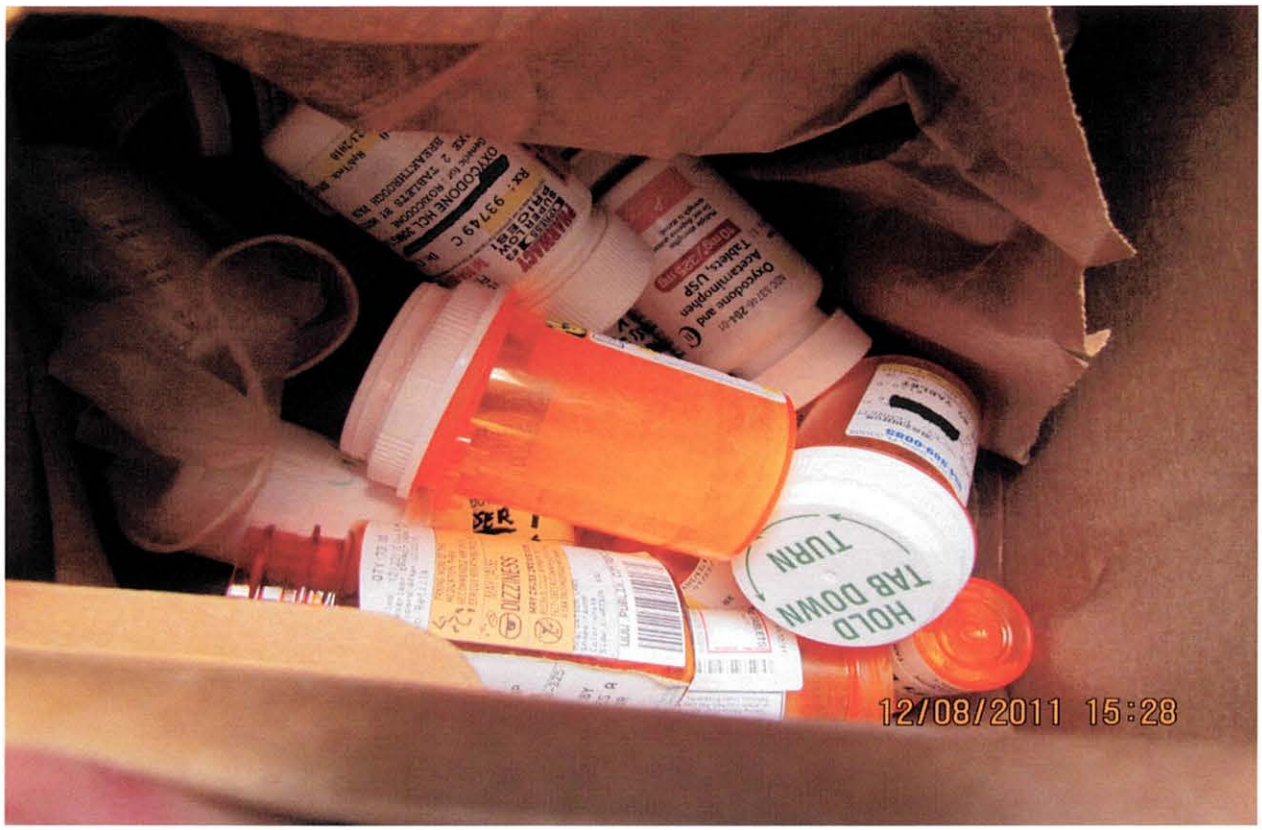
OXYCODONE HCL
Oxycodone and
Acetaminophen
Tablets, USP
DIZZINESS
HOLD TAB DOWN
TURN
12/08/2011 15:28

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EXHIBIT 3

MEDICATION FOUND IN LINDA KRIVJANIK OFFICE BSO

		RX AMT	COUNT	# missing	Medication Type	Manifest	DATE	Investigator	
Box 1	11-0204					N	2/2/2011	Dellagloria	
Box 1	11-0639					Y	5/1/2011	Dellagloria	
Box 2	10-0604					N	4/20/2010	Steinkamp	
Box 2	11-0226					N	2/7/2011	Crane	
Box 2	11-0317					N	2/23/2011	Dellagloria	
Box 2	11-1156					N	8/25/2011	Hoffman	
Box 2	11-1279					N	9/20/2011	Hoffman	
Box 3	11-0825					N	6/14/2011	Dellagloria	
Box 3	11-0882					N	6/26/2011	Dellagloria	
Box 3	11-0888					N	6/27/2011	Dellagloria	
Box 3	11-0891					N	6/27/2011	Dellagloria	
BAG	09-0369					N	3/8/2009	Palermo	
BAG	??-1394					N			
BAG	10-0838	120	87	87	Oxycodone 30 mg.	Y	6/7/2010	Steinkamp	
BAG	10-0903					Y	6/20/2010	Dellagloria	
BAG	10-0905					Y	6/21/2010	Dellagloria	
BAG	10-0906					Y	6/21/2010	Dellagloria	
BAG	10-0913					N	6/22/2010	Dellagloria	
BAG	10-0936					Y	6/27/2010	Dellagloria	
BAG	10-1284					Y	9/4/2010	Johnson	
BAG	11-0113					N	1/18/2011	Dellagloria	BOX
BAG	11-0161					N	1/25/2011	Steinkamp	
BAG	11-0162					N	1/26/2011	Crane	
BAG	11-0171					N	1/27/2011	Steinkamp	
BAG	11-0190					N	1/31/2011	Steinkamp	
BAG	11-0231					Y	2/8/2011	Steinkamp	
BAG	11-0236					Y	2/9/2011	Steinkamp	
BAG	11-0272					N	2/15/2011	Steinkamp	
BAG	11-0291					Y	2/18/2011	Steinkamp	
BAG	11-0313					N	2/22/2011	Steinkamp	
BAG	11-0322					N	2/23/2011	Crane	

BAG	11-0369					N	3/6/2011	Crane
BAG	11-0394					Y	3/10/2011	Steinkamp
BAG	11-0653					N	5/4/2011	Steinkamp
BAG	11-0682	90	80	80	Oxycodone 10 mg.	Y	5/9/2011	Steinkamp
		90	67	67	Oxycodone 10 mg.	Y	5/9/2011	Steinkamp
		90	74	74	Oxycodone 10 mg.	Y	5/9/2011	Steinkamp
		90	34	34	Oxycodone 5 mg.	Y	5/9/2011	Steinkamp
BAG	11-0683					N	5/9/2011	Steinkamp
BAG	11-0697					N	5/12/2011	Crane
BAG	11-0701					N	5/13/2011	Steinkamp
BAG	11-0715					N	5/16/2011	Steinkamp
BAG	11-0717					N	5/16/2011	Crane
BAG	11-0740	120	131			N	5/23/2011	Crane LINDA'S CABINET
BAG	11-0928					N	7/5/2011	Crane
		RX AMT	COUNT	# missing	Medication Type	Manifest		
BAG	11-0930					N	7/6/2011	Crane
BAG	11-0931					N	7/6/2011	Crane
BAG	11-0938					N	7/7/2011	Saccone
BAG	11-0958					N	7/11/2011	Crane
TOTAL				342				

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EXHIBIT 4

Medications

A. Intake Directives:

1. When medications are present at a scene where medical examiner jurisdiction has been assumed, if the medications are thought to be related to the death, the Broward County Medical Examiner Office (BCMEO) medicolegal death investigator will ask the reporting officer the name of the medication, to whom it was prescribed, the physician's name who prescribed the medications and, if possible in a timely manner, the content as to how many pills/tablets/capsules/volume is/are remaining.

2. If the medications are felt to be material to the death, they will be conveyed to the BCMEO by the contracted transport service. If they are not felt to be material to the death, they will remain in the possession of the law enforcement agency having jurisdiction of the scene for final disposition.

3. If the medications are material to the death and are to be conveyed to the medical examiner's office, they must be packaged by law enforcement and the package must be sealed with evidence tape and must be initialed by a law enforcement officer. Transport services contracted by the BCMEO will not accept any medications without having first been initialed and sealed by law enforcement and an evidence receipt attached to the medications. Thereafter, medications can be conveyed with the body by the contracted transport service.

4. Upon arrival to the BCMEO, all medication will be taken to the morgue cooler and dropped into the evidence box behind the locked cage located within the morgue cooler.

5. Every morning after the 0900 morning meeting the previously on call investigator and another investigator will check the medication drop box behind the locked cage.

6. Prior to acceptance, the medication bag(s) must be compared to the Interstate Removal Service transport receipt in order to confirm the presence, number, and content (if known) of medication bags assigned to each case. Because the morgue has not technically taken in these medications, the morgue intake sheets do not have to be updated.

7. If medication bags are present, upon arrival of morgue staff, a LabLYNX ETRC evidence barcode label with the appropriate case number will be generated by the morgue staff person and this label will be placed on the medication bag.

8. The Broward County staff member who logs into LabLYNX and who scans the barcode on the medication bag is the virtual "owner" of the medication bag. This should be the medicolegal death investigator assigned to the case.

9. If the accepting medicolegal death investigator is not the medicolegal investigator assigned to the case, the medication bag can then be transferred to the investigator assigned to the case (if they are present) by clicking the "transfer" tab, filtering for the staff investigator recipient's name, then the investigator recipient must key in their LabLYNX password and save it to receive the bag of medications.

10. Once the investigator recipient has virtually "received" the bag of medications, they can now virtually "place" it in the "medication lock up" or transfer it to another investigator if need be by selecting the destination or another investigator recipient.

11. The medicolegal death investigator will convey the medication to their section and, with accompaniment with another investigator, the medication will be secured in the evidence/medication storage room after which , the two investigators must sign the log sheet that is just inside the evidence/medication storage room door on the left hand side. In addition, the paper property receipt must reflect the next custodian be "storage in the evidence/medication room".

Anyone who enters into the evidence/medication storage room must sign the log sheet that is just inside the evidence/medication storage room door on the left hand side.

No one is permitted to access the evidence/medication storage room alone (this includes Doctors, Investigators, Toxicologists, and all Administrative Support staff). All movement into and out of evidence/medication storage is to be done in the presence of another BCMEO employee

Anytime a medication bag is brought into or taken out of the evidence/medication storage room, the investigator involved must sign the evidence/medication storage room log sheet as well as virtually transferring the medication bag to themselves from the "medication lock up" within LabLYNX.

The investigator will be responsible for signing the property receipt and documenting the purpose of why the bag of medication is entering or leaving the evidence/medication storage room (i.e. Need to count meds or need to obtain doctor's info-see next section).

B. <u>Medication Inventory Directives:</u>

1. The medication will be counted ONLY at the discretion of the medical examiner assigned to the case. These requests will be documented in the LabLYNX system.

2. If the medical examiner assigned to the case directs the investigator to count the medications, the investigator will "transfer" the medication bag from the "medication lock up" to him/her self in LabLYNX.

3. The investigator will, while accompanied by another investigator, go to the evidence/medication storage area and both investigators will complete the log sheet within the evidence/medication storage area as appropriate. The reason section of the log sheet will detail the medical examiner's name and that an inventory was requested.

4. The investigator assigned to the case will complete the paper property receipt as they are the recipient of the medication bag and the reason for the transfer.

5. The assigned investigator will then begin counting the medication while in the presence of and witnessed by another medicolegal death investigator without interruption.

6. Following the witnessed and verified inventory of the medication, a medication inventory will be completed in the LabLYNX system in the "evidence" tab.

7. After the medication bottle is counted, the investigator assigned to the case will then be responsible for sealing the top of the medication bottle closed with evidence tape, writing the medication count on the front of the bottle, and ***both*** investigators will initial and date the evidence tape.

8. Following medication inventory, the investigator assigned to the case is responsible for resealing the medication bag with evidence tape.

9. Both investigators will initial and date the seal.

10. The LabLYNX inventory form will be completed and will be printed out and affixed to the sealed and initialed medication bag.

11. Both investigators will initial and date the LabLYNX medication inventory.

12. The investigator assigned to the case will virtually transfer the medication bag back to the "medication lock up" within LabLYNX , and will then resign the property receipt to document the replacement of the medication bag back into the evidence/medication storage room.

13. The sealed and initialed medication bag with property receipt and LabLYNX inventory will be secured in the evidence/medication storage room with accompaniment by another investigator.

14. Both investigators will complete the log sheet within the evidence/medication storage area as appropriate.

C. <u>Directives for deriving a physician's name from the medication bottles:</u>

1. If an investigator was unable to obtain a doctor's name from law enforcement on scene, the investigator must attempt to obtain the doctor's name from the decedent's family. If the investigator is unable to obtain the doctors information from law enforcement and the decedent's family, then the investigator will have to get permission from the medical examiner assigned to the case to access the medication bag to retrieve the doctor's information. This permission will be documented in the LabLYNX system.

2. Once the seal of the medication bag is compromised, an inventory of the medications must be completed by the medicolegal death investigator assigned to the case.

3. If the medical examiner assigned to the case permits the investigator to collect physician information from the medication bottles, the investigator will "transfer" the medication bag from the "medication lock up" to him/her self in LabLYNX.

4. The investigator will, while accompanied by another investigator, go to the evidence/medication storage area and both investigators will complete the log sheet within the evidence/medication storage area as appropriate. The reason section of the log sheet will detail the medical examiner's name and that a physician inquiry was requested and that the medication will be inventoried.

5. The investigator assigned to the case will complete the paper property receipt as they are the recipient of the medication bag and the reason for the transfer.

6. ***<u>The investigators will follow the Medication Inventory Directives (Section B).</u>***

7. Once the medications have been inventoried and all of the physician's information has been obtained, the assigned investigator is responsible for resealing the medication bag with evidence tape.

8. Both investigators will initial and date the seal.

9. The LabLYNX inventory form will be completed and will be printed out and affixed to the sealed and initialed medication bag.

10. Both investigators will initial and date the LabLYNX medication inventory.

11. The investigator assigned to the case will virtually transfer the medication bag back to the "medication lock up" within LabLYNX , and will then resign the property receipt to document the replacement of the medication bag back into the evidence/medication storage room.

12. The sealed and initialed medication bag with property receipt and LabLYNX inventory will be secured in the evidence/medication storage room with accompaniment by another investigator.

13. Both investigators will complete the log sheet within the evidence/medication storage area as appropriate.

All this can be tracked by accessing the chain of custody form in the Reports section of LabLYNX.

D. <u>Destruction:</u>

Medications are to be held for 1 year, and will be discarded only after completion of all toxicological analyses. Final disposition is pending investigation of Broward County Sheriff procedures. The incineration process is to be witnessed by medical examiner staff. (Until this is finalized no medications are to leave this facility for destruction without the written consent of the Chief Medical Examiner.)

No prescription medications of the deceased are to be returned to family members.

OIG 11-022

APPENDIX A

BERTHA W. HENRY, County Administrator
115 S. Andrews Avenue, Room 409 • Fort Lauderdale, Florida 33301 • 954-357-7362 • FAX 954-357-7360

MEMORANDUM

Date: January 25, 2012

To: John Scott, Inspector General

From: Bertha Henry, County Administrator

Subject: **OIG Preliminary Report, Ref. No. OIG 11-022**

The above referenced Preliminary Report has been received and reviewed. As it indicates, County Administration has initiated a review of the policies, procedures and practices of the Medical Examiner's Office. This thorough review is expected to be completed in February 2012. It will result in a report which offers a series of recommendations to rectify any shortcomings identified during the review and identify opportunities for efficiencies and cost savings.

Should you have any questions, please do not hesitate to contact me.

BWH/ds

cc: Pam Madison, Interim Deputy County Administrator
Gretchen Harkins, Director, Office of Intergovernmental Affairs and Professional Standards

OIG 11-022

APPENDIX B

JOSHUA A. PERPER M.D., LL.B., M.SC.
FORENSIC PATHOLOGIST
14559 DRAFT HORSE LANE WELLINGTON, FL 33414
PERPER@MEDICOLEGALCONSULTING.COM
(561) 252-3961 (561) 727-8176

January 13, 2012

John W. Scott
Inspector General
Broward Office of the Inspector General
One North University Drive, Suite 111
Plantation, Florida 33324

Re: OIG Preliminary Report, Ref. No. OIG 11-022

Dear Mr. Scott:

The following are my comments in response to the above OIG report:

- The Medical Examiner Forensic Investigators were properly instructed by me how to handle and release evidence medications through the following:
    - Clearly written guidelines were provided in a manual which is consistent with the directives and regulations of the Florida Medical Examiner Commission.
    - Weekly conferences in which the Investigators were queried whether there were any difficulties or problems of any nature in their investigational work, handling of evidence, including drug evidence, and relations with police agencies, detectives, funeral directors, and bereaved families.
    - At the weekly meeting, selected sections from a forensic investigators manual were read, analyzed, and discussed.
- In fact, the report itself acknowledges on page 7: "Although Dr. Perper regularly conducted staff meetings [with the Forensic Investigators team] on a variety of subjects, his directives were routinely countermanded by Ms. Krivjanic." At no time was I informed by any forensic investigator of the subversive actions of Ms. Krivjanic or the acquiescence and compliance of other investigators with the clearly illegal countermanding of my instructions and directives as Chief Medical Examiner.

- I do not believe in a "micromanagement" style of administration which is known to often result in poor administrative outcomes as well as having a deleterious effect on staff morale. However, on a continuous basis both at formal and informal meetings, I queried the chief investigators and the individual investigators regarding ongoing investigative procedures as well as encouraging any questions which they may have. Furthermore, none of the associate medical examiners or any other members of the Medical Examiner staff, including the investigators, as well as outside law enforcement agencies or other client agencies, ever mentioned any impropriety or deficits in either recording, storage, or safety of drug evidence.

- A thorough audit performed about 6 years ago by the Florida Medical Examiner Commission, which spent 3 to 4 days in analyzing all the activities of the Broward County Medical Examiner Office, found no flaws in its investigative activities or handling of evidence of the Investigation section, or other sections, except for delayed reporting of toxicology tests.

- In is unclear to me why the Preliminary OIG Report cited information obtained from only 3 investigators whereas the report correctly stated that the Broward County Medical Examiner office has a total of 6 investigators, not including the Chief Investigator. Similarly, only 3 Medical Examiners interviews were reported whereas there were 6 working Medical Examiners, including myself.

- I always directed that all medical reports be accurately completed. At no time did I direct any investigator to state incorrectly that he or she witnessed the incineration of drugs when in fact when they did not do so, as claimed by the Former Chief Deputy Medical Examiner in the report.

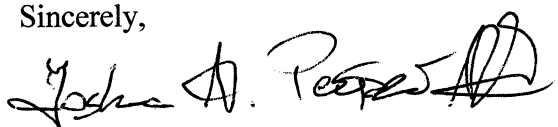
- Regarding the comment made by the Former Chief Deputy regarding a missing sum of $3,000 belonging to the deceased, this event was brought immediately to the attention of the County authorities and the County returned the entire amount to the family. An investigation was conducted by the County and no suspect was identified. As a result, the handling procedures of currency and monetary values were changed to requiring two investigators (rather than one) to jointly handle, sort, and remove monetary evidence or valuables. In addition, a safe was purchased to store currency, replacing the previous requirement of utilizing a locked room.

- I am certainly very upset by the betrayal of Ms. Krivjanic, whom I (mistakenly) considered to be a trusted, ethical, and responsible employee, but who in fact, according to the Preliminary Report, repeatedly sabotaged, derided, and derailed my instructions for the betterment of the Office. This patterned betrayal of professional and legal duty by trusted aides has been experienced in the past by directors of both governmental and private organizations, in spite of efforts to prevent it. Even sadder is the fact that

some knowledgeable Forensic Investigators chose to remain silent and not bring these grave violations to the attention of the Chief Medical Examiner or the acting Director of Operations, and thereby severely failed to consider their loyalty obligations toward Broward County.

In summary, I was dismayed and disappointed to learn that a large number of evidence medication pills were unaccounted for at the Medical Examiner Office, and possibly stolen or criminally diverted, as a result of intentional violations of both my explicit instructions and the Broward Medical Examiner Office policies. In retrospect, closer attention should have been paid to this issue in a more pro-active manner, however, looking back there were no "red flags" regarding this issue.

Sincerely,



Joshua A. Perper, MD, LLB, MSc

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14559 DRAFT HORSE LANE WELLINGTON, FL 33414
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(561) 252-3961 (561) 727-8176

January 20, 2012

John W. Scott
Inspector General
Broward Office of the Inspector General
One North University Drive, Suite 111
Plantation, Florida 33324

Re: OIG Preliminary Report, Ref. No. OIG 11-022

Dear Mr. Scott:

In my letter of January 13, I responded to the above OIG Preliminary Report. The purpose of this letter is to add an important item to that response, specifically to address the issue of formal training of investigators at the Broward County Medical Examiner's Office during my tenure.

The Preliminary Report stated incorrectly that investigators did not receive formal training regarding the preservation of evidence, specifically the storage and handling of medications collected at death scenes. In fact, between 2006 and 2010, six (6) Broward County Medical Examiner investigators have received certification by the American Board of Medicolegal Death Investigators, located at St. Louis Missouri University, after each had completed the 5-day certification course. This course included formal education on preservation of death scene evidence, including handling of medications.

A list of all Florida Registry Diplomates can be viewed online at:

http://medschool.slu.edu/abmdi/index.php?page=registry-database

NOTE: Select "Florida" from the "Search by State" menu and click the Search button.

The above list includes the names of the following Broward County Medical Examiner investigators and the dates of their certification:

Brown, Georgia P. (01/30/2007)

Crane, Wendy (01/30/2007)

DellaGloria, John P. (08/23/06)

Hoeflinger, Francis (Frank) (05/11/2010)

Jamison, Latoya (04/21/08)

Steinkamp, Thomas P. (03/23/2009)

A screenshot showing a portion of this list is shown on the next page.

Information regarding this course can be obtained at the American Board of Medicolegal Death Investigators office at 314-977-5970.

Sincerely,

Joshua Perper

Joshua A. Perper, MD, LLB, MSc