NEWS RELEASE

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VENTURA, California - District Attorney Gregory D. Totten announced today the conclusion of the Ventura County Medical Examiner investigation and the issuance of a public report.

In May 2015, the Ventura County District Attorney's Office learned of serious allegations regarding the Ventura County Medical Examiner's Office including practicing medicine without a license, conflict of interest, misappropriation of public funds, and fraud. Today, the District Attorney's Office is releasing a 50-page public report detailing the scope and results of the investigation. An Executive Summary of the public report is attached to this news release. The full report may be found on the District Attorney's Web site (http://www.vcdistrictattorney.com).

As discussed in the report, while the District Attorney's investigation uncovered policies and procedures that will call into question the professionalism and integrity of the office, there is insufficient evidence to warrant the filing of criminal charges in this matter.

The District Attorney's investigation found significant deficiencies in the manner in which autopsies were conducted; in some cases by an untrained, unqualified employee of the office. Chief Deputy Administrator Armando Chavez conducted procedures that could be classified as autopsies or partial autopsies and the practice of medicine despite having no medical training or certification. These procedures were performed at the direction of Dr. Jon Smith while Dr. Smith was out of the country on vacation. This practice resulted in both medical conclusions and the preparation of autopsy reports that were not the product of a thorough examination of the body and necessary laboratory tests by a physician and medical professional.

During the investigation, it was learned that there are no definitive legal standards and no clear consensus among experts as to what constitutes an autopsy, who may perform an autopsy and whether conducting an autopsy is the practice of medicine. Because the law is unclear, and because Chavez's job classification authorizes him to assist in autopsies and "obtain tissue and fluid samples from dead bodies," criminal liability cannot be imposed for the very troubling practices described in the public report. Such legal standards need to be clarified and the report recommends that the California Legislature hold hearings to clarify this area of law.

The investigation also found that Dr. Smith was sent a cease and desist letter by the Louisiana Board of Medical Examiners and received a letter from the Oregon Medical Board alleging that a complaint had been made against him for practicing medicine without a license. In each instance, Dr. Smith performed services on behalf of Regional Pathology and Autopsy Services. Since there is insufficient evidence that the laws of the State of California were violated, no charges can be filed related to those allegations.

The District Attorney's Office further found that Dr. Smith spent significant amounts of time working for entities outside his primary responsibilities as the full-time Chief Medical Examiner and derived significant financial benefits from this work. This work included contracts with the Santa Barbara Coroner's Office, the Monterey County Coroner's Office, and Regional Pathology and Autopsy Services. However, it cannot be established that these activities directly interfered with his ability to perform his duties as Chief Medical Examiner for Ventura County. Thus, no charges can be proven related to this conduct.

Since the events discussed in this report, the Ventura County Medical Examiner's Office has adopted a number of changes to policy and procedure and has taken steps to become certified by the National Association of Medical Examiners (NAME). The District Attorney's Office believes these are positive steps that will enhance the professionalism provided by the Medical Examiner's Office to Ventura County citizens.

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A REPORT ON THE VENTURA COUNTY MEDICAL EXAMINER INVESTIGATION

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State of California

February 3, 2016

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EXECUTIVE SUMMARY

In May 2015, the Ventura County District Attorney's Office learned of serious allegations regarding the Ventura County Medical Examiner's Office (VCME), including practicing medicine without a license, conflict of interest, misappropriation of public funds, and fraud. In response, the District Attorney conducted a thorough investigation to determine the truth of the allegations and whether the law had been violated.

The investigation focused on the following allegations:

- Dr. Jon J. Smith, Chief Medical Examiner, authorized uncertified and unqualified personnel to conduct autopsies without the physical presence of a licensed medical doctor.
- Dr. Smith certified that he had conducted such autopsies despite not having been physically present when the bodies were examined.
- Armando Chavez, Chief Deputy Administrator/Supervising Medical Examiner Investigator, conspired with Dr. Smith and conducted autopsies without being qualified or licensed to do so and without the presence of a supervising physician.
- Dr. Smith contracted with numerous additional agencies/companies for significant postmortem procedures during which time he was employed as a *full-time* medical examiner with the County of Ventura and without the appropriate outside employment disclosures.
- Dr. Smith was sent a cease and desist letter by the Louisiana State Board of Medical Examiners for practicing medicine without a license when he contracted privately with Regional Pathology and Autopsy Services.

To determine the truth of these allegations, district attorney investigators interviewed dozens of witnesses, placed a pretext call to Investigator Chavez, contacted the California and Louisiana medical boards and executed several search warrants at various locations. They obtained and examined thousands of pages of documents, including records from the Medical Examiner's Office and County Recorder, e-mails, calendars, and payroll records. Potential criminal charges were reviewed by Senior Deputy District Attorney Thomas Dunlevy and Deputy District Attorney Andrew Sullivant; their written analysis forms the basis for the attached report.

The investigation found evidence establishing the following:

- At the direction of Chief Medical Examiner Jon J. Smith, Supervising Medical Examiner Investigator Armando Chavez conducted postmortem procedures which could be classified as autopsies or partial autopsies on Christopher T., Hipolito V., Nancy K., Gustavo G., and Jeffrey L. without being licensed to do so.[1]

- Dr. Smith signed documents written in a way that gave the impression that he had supervised postmortem procedures on three individuals, despite not having been physically present when those procedures were performed.

- Dr. Smith engaged in outside employment with public and private agencies including Santa Barbara County, Monterey County, and Regional Pathology and Autopsy Services while being employed as a full-time deputy medical examiner and chief medical examiner for the County of Ventura.

- Dr. Smith was sent a cease and desist letter by the Louisiana Board of Medical Examiners for practicing medicine without a license in the state of Louisiana. Further investigation revealed that Dr. Smith received a letter from the Oregon Medical Board advising him that a complaint had been made alleging that he performed an autopsy without being licensed to practice medicine in the state of Oregon. Both procedures were performed while Dr. Smith was employed as Ventura County's chief medical examiner, concurrently working for the Santa Barbara Sheriff-Coroner's Office, and working under contract for Regional Pathology and Autopsy Services.

- At the direction of Dr. Smith, postmortem procedures were delegated to an uncertified, unlicensed employee who was not qualified to determine the cause or manner of death or to assess the body for the possible presence of communicable diseases.

The Investigation

On May 11, 2015, the Ventura County District Attorney's Office received a telephone call from a person who identified himself/herself as a contract employee for the VCME. The caller asked to remain confidential and reported that he/she had witnessed Investigator Chavez perform two autopsies earlier that day without a physician present. After the procedures, the witness was told by Investigator Chavez to "keep [his/her] mouth shut." The

[1] The decedents' first names and last initials are used to respect their privacy and the privacy of their families.

caller further indicated that the name of the doctor who would be signing off on the autopsy report would be Dr. Jon Smith. Dr. Smith was out of the country at that time.

Based upon the above information, the Ventura County District Attorney's Bureau of Investigation contacted the informant who was interviewed on May 11 and 12, 2015. The informant described in detail the procedures which he/she witnessed including the extraction of vitreous humor from one of Christopher T.'s eyes, the extraction of blood from his neck and urine from his bladder, the making of a four-inch to six-inch incision down the front of his right upper leg, and the cutting of muscle tissue from his leg. At the beginning of this autopsy, Investigator Chavez commented, "Dr. Smith told me to do the autopsies."

A short time later, the witness observed Investigator Chavez make a Y-shaped incision on Hipolito V.'s body, cut tissue away from his chest using a scalpel, and use "loppers" to cut through his ribcage, ultimately removing his breast plate. The witness further observed Investigator Chavez manipulating Hipolito V.'s internal organs, unsuccessfully attempting to find his gallbladder. Investigator Chavez then removed and dissected pieces from his liver and placed them in a specimen jar.

Later that morning, Investigator Chavez summoned the witness to his office and told him/her, "You need to keep your mouth shut and do not discuss this with anyone. . . ."

On May 12, 2015, under the direction of district attorney investigators, the witness placed a recorded pretext phone call to Investigator Chavez. During the call, Investigator Chavez said ". . . we are not doing anything that's considered illegal. We're just doing what we need to do right now to save money from our budget because we're almost out of money." Investigator Chavez also admitted that he did three autopsies the day before and identified the third body as that of Jeffrey L. Investigator Chavez went on to justify his actions indicating that Dr. Smith had authorized everything he was doing. Chavez stated that Dr. Smith reviews every case and directs which cases go to a contract pathologist, Dr. Ann Bucholtz, and which cases are Investigator Chavez's responsibility.

During the course of the investigation, Dr. Bucholtz was interviewed. Dr. Bucholtz had been a forensic pathologist for 25 years and was then employed as a part-time contract pathologist with the Ventura County Medical Examiner's Office. Dr. Bucholtz has since been appointed as the Ventura County Chief Medical Examiner. Dr. Bucholtz told investigators that at the time, she and Dr. Smith were the only licensed forensic pathologists working at VCME.

Dr. Bucholtz indicated that when she arrived at work on May 11, 2015, she noticed a body on the examination table with a Y-shaped incision. Dr. Bucholtz was aware of the fact that Dr. Smith was currently out of the country. When she inquired, she was told that

Investigator Chavez did an autopsy of a Hipolito V. When Dr. Bucholtz inquired as to who authorized the autopsy, she was informed that Dr. Smith had. With knowledge that Investigator Chavez cannot author an autopsy report and Dr. Smith was out of the country, Dr. Bucholtz decided to review the preliminary draft. The draft indicated that "The case was reviewed with Dr. Jon J. Smith, Chief Medical Examiner for the County of Ventura. A postmortem examination was performed to determine the cause and manner of death."

Dr. Bucholtz also recalled an incident which had occurred in December 2013, where she observed that Investigator Chavez had made an incision, opened up the chest cavity and abdominal area, and manipulated the internal organs of Nancy K., attempting to find the primary point of cancer. When he was unable to do so, he called Dr. Smith and was advised to seek Dr. Bucholtz's assistance.

Dr. Bucholtz advised that the "Standard of Care" for forensic pathologists was set forth by the National Association of Medical Examiners (NAME) and in her opinion, the performance of an autopsy constituted the practice of medicine. Although forensic technicians, laboratory assistants and other personnel may assist with minor procedures, according to NAME standards, only a forensic pathologist or physician can determine the cause of death. Although not certified by NAME, the Ventura County Medical Examiner's Office Web site lists NAME as an "additional resource." NAME standards require that a forensic autopsy must be conducted by a licensed physician who is a forensic pathologist, or by a physician who is a forensic pathologist-in-training.

Investigators contacted Cheryl Gray, M.D., a consultant with the Medical Board of California, who opined that the act of conducting a forensic autopsy is practicing medicine. She further indicated that although some procedures may be accomplished by a trained technician, they can only be done in the physical presence of a licensed pathologist.

It is undisputed that Investigator Chavez has not attended medical school, is not licensed to practice medicine in any jurisdiction, and is not a licensed forensic pathologist or certified as a pathologists' assistant.

Investigators contacted the California Department of Consumer Affairs and learned that Dr. Smith was sent a cease and desist letter by the Louisiana State Board of Medical Examiners for the unlawful practice of medicine in the state of Louisiana when he performed an autopsy in the state on October 28, 2014, while not licensed to do so. In a letter to Dr. Smith, the Louisiana Board advised Dr. Smith, "You are engaged in the unauthorized practice of medicine in this state as defined by the Louisiana Medical Practice Act . . . more significantly, you should be aware that engaging in the practice of medicine in the absence of licensure is a crime."

It had been determined that Dr. Smith prepared the Louisiana autopsy report while working for Regional Pathology and Autopsy Services. Further investigation revealed that although Dr. Smith prepared the report which read as if he had conducted the autopsy himself, it was actually performed by a certified pathologists' assistant who was not a licensed physician. She took samples and photographs of the decedent from the funeral home and sent them to Dr. Smith, who then authored the autopsy report.

During the course of this investigation, it was also determined that Dr. Smith had recently signed a three-year, $870,000 contract with the County of Santa Barbara for forensic pathology services in addition to his *full-time* job as the Ventura County Medical Examiner, had employment with Regional Pathology and Autopsy Services, and did occasional contract work for the County of Monterey.

Criminal Filing Standards

In determining whether to file criminal charges, the Ventura County District Attorney's Office is guided by the same standards used by prosecutors throughout the state. In summary, a prosecutor may only file criminal charges if he or she believes, based on the evidence available after a thorough investigation, that the accused is in fact guilty of a crime and that guilt can be proven beyond a reasonable doubt at trial. Applying this standard, we conclude that criminal violations cannot be established in this matter.

Unauthorized Autopsy, Unauthorized Practice of Medicine, Conspiracy to Commit Unauthorized Practice of Medicine and Unlawful Mutilation of Human Remains (Health and Safety Code Sections 114 and 7052; Business and Professions Code Section 2052 and Health and Safety Code Section 7052)

Dr. Frank Sheridan, the San Bernardino County Coroner, was consulted and opined that Investigator Chavez's conduct with regard to the actions taken in three of the autopsies *could* constitute the performance of an autopsy and the practice of medicine. Specifically, Dr. Sheridan indicated that the cutting open of the abdomen and collecting samples from internal organs could constitute an autopsy/practice of medicine. He also opined that looking for a primary source of cancer could constitute the practice of medicine. This opinion is consistent with NAME standards as well as the opinions of the California, Louisiana, and Oregon medical boards. However, notwithstanding these opinions, there is no California statute which defines what constitutes an autopsy, differentiates between an

autopsy and a partial autopsy, or mandates who is authorized to conduct an autopsy.[2] There is also no statute which clearly defines the performance of an autopsy as the practice of medicine.

Additionally, as a supervising medical examiner investigator, Investigator Chavez's job classification authorized him to "obtain tissue and fluid samples from dead bodies." In an April 30, 2015, e-mail to staff, Dr. Smith wrote that Investigator Chavez would "perform some tasks related to sample collection or evidence collection" and any cases handled in this manner would have abbreviated reports authored by Dr. Smith upon his return. Since there is a dispute within the medical community as to what constitutes an autopsy and whether the performance of an autopsy or partial autopsy constitutes the practice of medicine, and since no clear standards are set forth in California law, the evidence fails to establish beyond a reasonable doubt that Dr. Smith and Investigator Chavez conspired to or did practice medicine without a license or in any way mutilated human remains within the meaning of California law.

Procuring or Offering False or Forged Instrument for Recording (Penal Code Section 115), Preparing False Documentary Evidence (Penal Code Section 134)

Although VCME is a public office within the State of California, there is a question as to whether an autopsy report is an "instrument" for purposes of this statute. Additionally, even if an autopsy report is an "instrument" under the statute, there are no statements in the autopsy reports in question which can be demonstrably proven false or untrue. Working "under the direction and supervision" of Dr. Smith is not synonymous with "direct supervision" but is sufficiently ambiguous as to confuse the reader as to whether or not Dr. Smith had been physically present. There is no evidence that any of the physical findings or conclusions in the autopsy reports were untrue or unsupported by the facts of the case. As a result, there is insufficient evidence to prove that the statements made were demonstrably false.

Potential Charges Related to Louisiana and Oregon Autopsies

Dr. Smith authored autopsy reports as a contract pathologist for Regional Pathology and Autopsy Services in Louisiana on October 28, 2014, and in Oregon on January 26, 2015. In each of these cases, Dr. Smith was not physically present for the postmortem examination. It is undisputed that Dr. Smith is not licensed to practice medicine in Louisiana or Oregon.

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[2] In an interview, Dr. Smith stated that in a full autopsy, the cranial, thoracic and abdominal cavities are all open; in a partial autopsy, only one or two of the cavities are open.

However, there is no evidence to suggest that Dr. Smith violated any California statutes as a result of the autopsy reports issued in the Louisiana or Oregon cases.

Misappropriation of Public Funds/Fraudulent Claims (Penal Code Sections 424 and 72)

In June 2012, the Ventura County Board of Supervisors appointed Dr. Smith as the chief medical examiner for Ventura County. On May 14, 2014, the Ventura County Board of Supervisors approved authorization for Ventura County Health Care Agency Director Barry R. Fisher to sign a contract with the County of Santa Barbara for high-risk autopsies defined as "postmortem examinations of a decedent who had or is likely to have had, a serious infectious disease. . . ." Under the contract, the County of Santa Barbara would reimburse the County of Ventura $3,500 for each autopsy, estimated to be two autopsies per year.

On July 1, 2014, Dr. Smith signed a one-year contract with the County of Santa Barbara to perform all forensic pathologist services as an independent contractor. On May 19, 2015, the Santa Barbara County Board of Supervisors approved a contract extension from July 1, 2015, through June 30, 2018, for pathology services not to exceed $870,000 over the three-year life of the contract. Health Care Agency Director Fisher approved the employment with Santa Barbara County. His belief at the time was that all work performed for Santa Barbara County would be over and above the 40 hours per week that Dr. Smith worked for Ventura County. Fisher further indicated that he was aware of the work that Dr. Smith performed for Regional Pathology and Autopsy Services.

Dr. Smith also signed a contract with Monterey County to perform forensic pathologic postmortem examinations on a contract basis starting on July 1, 2011. This contract was extended until June 30, 2013. Evidence suggests that Dr. Smith requested and was approved for a leave of absence from Ventura County each time he performed services for Monterey County.

It is undisputed that Dr. Smith was a salaried employee for the County of Ventura who was expected to work 80 hours per biweekly pay period. However, according to Health Care Agency Director Fisher, Dr. Smith was free to flex those hours to accommodate other commitments including his contract work for Santa Barbara County, Monterey County and Regional Pathology and Autopsy Services. Because there is insufficient evidence to prove beyond a reasonable doubt that he defrauded the County of Ventura by falsely claiming that he worked hours for the County when he was instead performing contract work for another entity, he cannot be prosecuted for misappropriation of public funds or making fraudulent claims.

Statement of Economic Interests

The Conflict of Interest Code for the Ventura County Health Care Agency requires that persons serving in specified positions, including the chief medical examiner, file a Form 700, Statement of Economic Interests. Prior to 2015, the chief medical examiner was not required to disclose all sources of income on his Form 700. The Conflict of Interest Code was amended effective 2015 to require that the chief medical examiner disclose all sources of income. Dr. Smith failed to disclose the income that he earned through Regional Pathology and Autopsy Services. However, because there is no proof that Dr. Smith was ever notified of the change in the reporting requirements, there is insufficient evidence to prove that he committed the crime of *willfully* failing to comply with the reporting requirements.

Conclusion

This report is not intended to be an indictment of the Ventura County Medical Examiner's Office. Professionals working for this department are highly skilled, dedicated individuals who take seriously their obligation to accurately determine the cause, manner, and circumstances of deaths that fall under their jurisdiction. They work tirelessly to identify decedents, and locate and notify next-of-kin in a compassionate and timely manner. They can provide critical information for the next-of-kin who are dealing with sudden or unexpected fatalities. They can also be the frontline in the dissemination of information necessary for public safety as it relates to communicable diseases.

It is also not the intention of the District Attorney to judge the quality of medical expertise employed by the Medical Examiner's Office or the manner in which forensic examinations are conducted.

It is clear, however, that Dr. Smith spent significant amounts of time working for entities outside his primary responsibilities as the full-time Chief Medical Examiner and derived significant financial benefits from these responsibilities. It is also clear that for financial reasons, Dr. Smith directed and allowed an unqualified, uncertified person to conduct complex and sensitive medical procedures. We note that upon learning of Dr. Smith's actions, the Ventura County Healthcare Agency administration implemented a number of valuable changes to ensure such practices are not allowed in the future.

This investigation has exposed the need for legislation to clarify whether the performance of an autopsy is included in the "practice of medicine." Clarification is also necessary to define the terms "autopsy" and "partial autopsy" and to clearly define the qualifications and training required for forensic examiners who conduct such procedures. The legislature must reconcile existing law that allows non-physicians to serve as coroners.

SECTION ONE - PURPOSE AND SCOPE OF THE REPORT

In May 2015, the Ventura County District Attorney's Office learned of serious allegations of potentially criminal activity by members of the Ventura County Medical Examiner's Office (VCME). Early reports contained allegations that Chief Deputy Administrator/Supervising Medical Examiner Investigator Armando Chavez was performing autopsies or partial autopsies without being a licensed physician or a certified pathologist and without the direct supervision of a licensed physician. These procedures were allegedly authorized by Chief Medical Examiner Jon J. Smith, M.D. who was a full-time employee of the Ventura County Health Care Agency. During the course of this investigation, it was learned that Dr. Smith was also contracted by the County of Santa Barbara, the County of Monterey, and Regional Pathology and Autopsy Services.

In determining whether to file criminal charges, the Ventura County District Attorney's Office uses the criteria adopted by California prosecutors. A prosecutor may file criminal charges only if he or she believes, based on the evidence available after a thorough investigation, that the accused is guilty of a crime, and that guilt can be proven beyond a reasonable doubt at trial. In evaluating whether the evidence is sufficient to prove guilt, prosecutors are obligated to consider not only the statements of the accused, but the likely defenses to be asserted at trial. As explained in this report, we have concluded that criminal violations cannot be established in this matter.

We are issuing this report to inform the public as to the facts we have found and our legal conclusions.[3] The medical examiner fulfills an essential role in determining the cause of death in violent, unusual, or suspicious circumstances. Thorough and competent postmortem examinations serve both the criminal justice system and the public health system, including determining whether death is at the hands of another, the result of accident or suicide, the result of infectious disease, or other natural causes. The survivors and society deserve accurate determinations as to the cause of death. This report seeks to inform and educate the public as to how these responsibilities have been carried out, and explain why criminal prosecution is not warranted.

In addition to evaluating potential criminal charges against VCME personnel, the District Attorney's Office also investigated whether the alleged misconduct impacted pending homicide cases that involved autopsies conducted by VCME. We found no questionable conduct in any autopsies involving criminal cases, and none of the specific cases discussed in this report are criminal cases. However, in those homicide cases pending trial in which Dr. Smith conducted the autopsy, we had Dr. Smith's conclusions reexamined by another

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[3] Issuance of a public report on a matter of public interest is in the public interest. (*Bradbury v. Superior Court* (1996) 49 Cal.App.4th 1108; *Kilgore v. Younger* (1982) 30 Cal.3d 770.)

pathologist. We also complied with our discovery obligations in pending criminal cases by providing defense counsel with comprehensive information regarding our investigation of VCME.

It is the duty of the District Attorney's Office to investigate potential criminal conduct, not to evaluate the wisdom of particular local or state governmental decisions. However, this investigation has revealed certain deficiencies in California law and practice that have resulted in a lack of clarity for the administration of coroner and medical examiner offices and inconsistent standards for the forensic examination of the cause and manner of death.

SECTION TWO - DUTIES OF CORONERS AND MEDICAL EXAMINERS

California law provides that the county coroner has the duty to perform autopsies in specified circumstances. Some counties have a sheriff-coroner in which one official holds both positions. In other counties, like Ventura, a medical examiner is appointed to perform the duties that otherwise would be performed by the coroner.[4] The significant provisions regarding these positions are discussed below.

Coroners

Government Code, title 3, division 2, part 3, chapter 10, enumerates the powers and duties of coroners. Despite the fact that a coroner is an elected official and need not be a licensed physician, the Government Code authorizes the coroner to perform autopsies.

Government Code section 27491 provides:

> It shall be the duty of the coroner to inquire into and determine the circumstances, manner, and cause of all violent, sudden, or unusual deaths . . . . In any case in which the coroner conducts an inquiry pursuant to this section, the coroner or a deputy shall personally sign the certificate of death . . . . For purposes of inquiry, the coroner shall have the right to exhume the body of a deceased person when necessary to discharge the responsibilities set forth in this section.

[4] Of California's 58 counties, 13 have coroners, 41 have sheriff-coroners, and 4 have medical examiners.

Government Code section 27491.4, subdivision (a), states, in pertinent part:

> For purposes of inquiry the coroner shall, within 24 hours or as soon as feasible thereafter, where the suspected cause of death is sudden infant death syndrome and, in all other cases, the coroner may, in his or discretion, take possession of the body, which shall include the authority to exhume the body, order it removed to a convenient place, and **make or cause to be made a postmortem examination or autopsy thereon**, and make or cause to be made an analysis of the stomach, stomach contents, blood, organs, fluids, or tissues of the body. The detailed medical findings resulting from an inspection of the body or autopsy by an examining physician shall be either reduced to writing or permanently preserved. (Emphasis added.)

While Government Code section 27491.4, subdivision (a), makes reference to preserving the detailed findings of an examining physician, nothing in the language of the section indicates an autopsy must be performed by a physician. To the contrary, the language of the statute, "shall...make or cause to be made a postmortem examination or autopsy," gives the coroner the power to conduct an autopsy or to have someone else, such as a physician, conduct the autopsy for the coroner.

Government Code section 27520, entitled "Duty of coroner," provides in subdivision (a):

> The coroner shall perform or cause to be performed an autopsy on a decedent, for which an autopsy has not already been performed, if the surviving spouse requests him to do so in writing . . . .

Government Code section 27491.25 provides:

> The coroner, or the coroner's appointed deputy, on being notified of a death occurring while the deceased was driving or riding in a motor vehicle, or as a result of the deceased being struck by a motor vehicle, shall take blood and urine samples from the body of the deceased before it has been prepared for burial.

Government Code section 27530 provides:

> If the coroner is absent or unable to attend, the duties of his office may be discharged by any of his deputies with like authority and subject to the same obligations and penalties as the coroner.

Therefore, if the coroner is absent, his or her deputy may discharge the role of coroner with the same authority granted to the coroner by law, including the power to conduct autopsies.

Medical Examiners

Ventura County has a medical examiner rather than a coroner. Government Code section 24010 provides counties with the ability to abolish the office of coroner and appoint a medical examiner. The provision reads:

> Notwithstanding any other provision of law, the board of supervisors may by ordinance abolish the office of coroner and provide instead for the office of medical examiner, to be appointed by the said board and **to exercise the powers and perform the duties of the coroner**. The medical examiner shall be a **licensed physician and surgeon** duly qualified as a specialist in pathology. (Emphasis added.)

In a medical examiner county, the medical examiner exercises the same statutory powers and duties of the coroner pursuant to Government Code section 24010. (*People v. Dungo* (2012) 55 Cal.4th 608, 625, fn. 2 (conc. opn. of Werdeger, J.).) However, California law has not expressly addressed the issue of whether a medical examiner, like a coroner, has the power to appoint a non-physician deputy to discharge his or her duties, including the power to conduct autopsies. (See Government Code sections 1194, 24100-24105.)

SECTION THREE - STATEMENT OF FACTS

Armando Chavez

Armando Chavez has worked for VCME since 1997. He began as a part-time forensic technician and subsequently became a full-time forensic technician. As a forensic technician, Investigator Chavez estimated he assisted in hundreds of autopsies. The county's definition of this job classification includes assisting in the collection and legal preservation of evidence, clothing, toxicology samples, and biologic samples. The definition also includes assisting board certified forensic pathologists or board certified pathologists in the performance of medico-legal autopsies. Duties listed for the job classification include assisting in the collection of blood, body fluids, and tissue specimens for forensic toxicology.

Chavez promoted from forensic technician to medical examiner investigator in 2007. In June 2013, Chavez was appointed Chief Deputy Administrator of the Ventura County

Medical Examiner's Office by Chief Medical Examiner Jon J. Smith. At the time of his appointment, both Dr. Smith and Investigator Chavez acknowledged that this title did not correspond to Investigator Chavez's county job classification, which was Supervising Medical Examiner Investigator. The county's job description for this position includes "obtain tissue and fluid samples from dead bodies."

Chavez received no formal training either for his position as a forensic technician or for his position as a medical examiner investigator. Prior to working for VCME, he received training for surgically removing corneas for transplant, and worked for a brain and research center and an eye and tissue bank. His training as forensic technician consisted of on-the-job training by Dr. Ronald O'Halloran (the former Ventura County Chief Medical Examiner) and others. He is not a certified pathologists' assistant.

Postmortem Procedures Conducted by Investigator Chavez

The investigation revealed that Investigator Chavez performed postmortem procedures on the following individuals at Dr. Smith's direction: Nancy K., Gustavo G., Jeffrey L., Christopher T., and Hipolito V. The investigation further showed that Investigator Chavez performed these procedures without a supervising physician present onsite.

Nancy K.

Nancy K. died on December 8, 2013. She had a large growth near her groin indicative of cancer. Some time prior to December 11, 2013, Investigator Chavez opened her abdominal cavity. There is a factual dispute between witnesses regarding what other actions Investigator Chavez took on this case.

Dr. Ann Bucholtz, who was a contract pathologist with VCME at the time, reported that Investigator Chavez performed a Y-incision on Nancy K.'s body without supervision by an onsite physician. The forensic technician who assisted Chavez with the procedure recalls Chavez asking that Nancy K.'s body be brought into the autopsy suite so that he could "take a look at her." The forensic technician brought the body into the autopsy suite and indicated that Investigator Chavez made a straight-line incision down the length of the abdomen. According to the forensic technician, Investigator Chavez examined the body for about 30 minutes. The forensic technician did not have a specific recollection of Investigator Chavez manipulating organs, but believes Investigator Chavez probably did. Investigator Chavez did not take any biopsies or collect any samples. Investigator Chavez did not say he was acting under Dr. Smith's direction. The forensic technician does not recall Investigator Chavez looking at any notes, e-mails, or other documents while examining the body.

Dr. Bucholtz said that Investigator Chavez later approached her and said he had been unable to locate the primary source of Nancy K.'s cancer. Investigator Chavez told Dr. Bucholtz that

Dr. Smith directed him to seek her assistance. Dr. Bucholtz never discussed Investigator Chavez's actions directly with Dr. Smith. Dr. Bucholtz said that to date, she does not know whether Dr. Smith authorized or directed Investigator Chavez to perform an autopsy on Nancy K.

Rather than simply assisting Investigator Chavez as requested, Dr. Bucholtz felt it prudent to conduct a full autopsy herself on Nancy K. and authored the autopsy report. The report did not reference Investigator Chavez having previously opened the body.

No e-mails between Investigator Chavez and Dr. Smith regarding the Nancy K. autopsy were ever located. Investigator Chavez did not specifically recall the Nancy K. autopsy, but said that if he opened the body, he did so to take a biopsy sample only, not to ascertain the cause of death.

Dr. Smith had a vague recollection of the Nancy K. case. He said he recalled Nancy K. having a big mass near her groin. Dr. Smith recalled telling Investigator Chavez to collect a sample from the growth so Dr. Smith could examine it under a microscope when he returned from vacation.

Dr. Smith said Investigator Chavez could easily have obtained the sample from the external growth. Dr. Smith denied telling Investigator Chavez to open the body. Dr. Smith denied telling Investigator Chavez to search for the primary source of cancer, observing that such a task was outside Investigator Chavez's training. If Dr. Smith did not authorize Investigator Chavez to make a straight line or a Y-incision, it is unclear why Investigator Chavez would do so.

Vacation Arrangements

There is no evidence to indicate Investigator Chavez performed postmortem procedures on any other bodies until May 2015. However, in May 2015, Dr. Smith went on a cruise outside the country. While he was on vacation in May 2015, Investigator Chavez performed postmortem procedures on Gustavo G., Jeffrey L., Christopher T., and Hipolito V.

On April 30, 2015, Dr. Smith sent an e-mail to all medical examiner investigators describing the procedures he would employ while on vacation. This e-mail was not sent to forensic technicians or other staff members. Dr. Smith began the e-mail by referencing staffing challenges due to circumstances beyond his control. He wrote that because of these challenges, he would continue to triage cases while out of the office between May 2 and May 17, 2015. Dr. Smith wrote that Investigator Chavez would perform some tasks with regards to sample collection or evidence collection in Dr. Smith's absence. Dr. Smith advised any cases handled in this matter would have abbreviated reports authored by Dr. Smith upon his return. Dr. Smith instructed the investigators to e-mail him with specific

information regarding each case that might require an examination. The information requested included case number, decedent's name, age, investigative summary, and any photographs that might be helpful.

Gustavo G.

On May 3, 2015, a medical examiner investigator sent an e-mail to Dr. Smith containing information related to the death of Gustavo G. Attached to the e-mail were photographs of the body. Dr. Smith sent an e-mail to Investigator Chavez on May 4, 2015, with specific instructions pertaining to Gustavo G. Dr. Smith directed Investigator Chavez to collect blood and vitreous samples. Dr. Smith instructed Investigator Chavez to send one eye vitreous for electrolytes testing and the other eye vitreous and blood for toxicology testing. As to collecting a blood sample, Dr. Smith advised, "For blood, try for subclavian (easier than femoral), if you can't get either, then cut down the legs to milk the vessels for blood. Also try for urine and get a sample of right quadriceps muscle." Dr. Smith gave Investigator Chavez further direction regarding the pictures Investigator Chavez should take of the body.

The specific date on which Investigator Chavez performed postmortem procedures on Gustavo G.'s body is unclear. A forensic technician was listed in the autopsy report as assisting. He/she did not specifically recall this incident. The samples were submitted to the lab for testing on May 8, 2015, so the postmortem must have occurred between May 4, 2015, and May 8, 2015.

Dr. Smith authored an autopsy report for Gustavo G. dated June 5, 2015. According to the autopsy report, blood, vitreous humor, urine, and right quadriceps muscle samples were collected. These samples would not have required Investigator Chavez to open the body, aside from cutting into the leg for the quadriceps muscle sample. The autopsy report reads, in pertinent part, "An abbreviated postmortem examination was performed for the acquisition of toxicological biological specimens under the direction and supervision of Jon J. Smith, M.D." Investigator Chavez's name was not mentioned in the report. Dr. Smith determined the cause of death to be atherosclerotic hypertensive cardiovascular disease and the manner of death to be natural.

Jeffrey L.

Investigator Chavez performed postmortem procedures on Jeffrey L.'s body on May 11, 2015. Dr. Smith received information regarding the circumstances of Jeffrey L.'s death in an e-mail from a medical examiner investigator. On the morning of May 11, 2015, Dr. Smith e-mailed Investigator Chavez, instructing him to bring the body into the office and collect specimens for toxicology analysis. Dr. Smith specifically instructed Investigator Chavez to obtain the following: blood, vitreous, urine, and quadriceps muscle. Dr. Smith added, "If you can't get urine then open abdomen to collect gastric, liver, bile, and urine."

Based on the samples collected, which included bile and gastric contents, Investigator Chavez had to have opened the abdominal cavity during the Jeffrey L. autopsy. However, there is no witness to this particular incident. The autopsy report, authored by Dr. Smith, listed a forensic technician as the photographer and assisting during the autopsy. The forensic technician had no recollection of being present for the Jeffrey L. autopsy. Investigator Chavez did not recall details regarding this particular autopsy when interviewed. However, during a pretext call, Investigator Chavez mentioned the Jeffrey L. autopsy in a way that indicated he recalled being present.

The autopsy photographs were external only. There were no photographs taken documenting Investigator Chavez cutting into the abdominal cavity.

Dr. Smith authored an autopsy report, dated June 18, 2015. The report stated, "An abbreviated postmortem examination was performed for the acquisition of toxicological biological specimens under the direction and supervision of Jon J. Smith, M.D." Investigator Chavez was not mentioned in the report. Dr. Smith determined the cause of death to be acute polysubstance intoxication and the manner of death to be accident.

The death investigation worksheet for the Jeffrey L. file had the "no" box checked for autopsy. However, it should be noted the initial worksheet was completed by a medical examiner investigator. A subsequent draft of the death investigation worksheet had the "yes" box checked for autopsy.

Christopher T.

Dr. Smith received information regarding the circumstances of Christopher T.'s death in an e-mail from a medical examiner investigator. On the afternoon of May 10, 2015, Dr. Smith instructed Investigator Chavez via e-mail as follows: "This will be an Etox for me. Same as last week – pull specimens. Send a red top vitreous from one eye for electrolytes and glucose. Other vitreous in gray tube to be sent for tox with blood."

Investigator Chavez performed postmortem procedures on May 11, 2015. He was assisted by a forensic technician. The forensic technician recalls the details of the autopsy. The technician recalled Investigator Chavez cutting tissue from the right quadriceps muscle and extracting fluids with syringes. Investigator Chavez obtained peripheral blood, vitreous humor, and urine samples. He did not open the body.

Dr. Smith authored an autopsy report on June 8, 2015, for the postmortem. As with the Gustavo G. and Jeffrey L. reports, it stated, "An abbreviated postmortem examination was performed for the acquisition of toxicological biological specimens under the direction and supervision of Jon J. Smith, M.D." Dr. Smith determined the cause of death to be atherosclerotic cardiovascular disease and the manner of death to be natural.

Hipolito V.

Dr. Smith received information regarding the circumstances of Hipolito V.'s death in an e-mail from a medical examiner investigator on May 10, 2015. The same day, Dr. Smith e-mailed Investigator Chavez with the following instructions:

> Partial autopsy for me. Basically an Etox but open belly to obtain gastric, bile, liver, and urine. Document total amount of gastric scooped out and total milliliters of bile aspirated from gallbladder. Send vitreous from one eye in red top tube for electrolytes with glucose. Send blood and vitreous from other eye in gray tube for toxicology.

On May 11, 2015, Investigator Chavez performed postmortem procedures with the assistance of a forensic technician. The forensic technician observed Investigator Chavez make a Y-incision on the body. Investigator Chavez pulled and cut tissue away from the body. Investigator Chavez removed the breastplate with loppers and the forensic technician observed Investigator Chavez "picking" around the body and asked what he was doing. Investigator Chavez said he was looking for the gallbladder because he needed to get bile. Investigator Chavez said he could not find the gallbladder. Investigator Chavez then cut off a piece of the liver. Investigator Chavez put the piece of liver on a tray and cut it into smaller pieces, which he then placed in specimen jars. The forensic technician noted that Chavez was consulting print-outs of e-mails during the procedures he performed that day. The forensic technician said he/she would not refer to Investigator Chavez's action of cutting the piece of liver into smaller pieces as dissection, because based on his/her medical knowledge, dissection includes cutting the tissue in a very particular pattern to look for disease.

Dr. Bucholtz entered the room and saw the body. Dr. Bucholtz questioned the forensic technician about what had occurred. The forensic technician told Dr. Bucholtz that Investigator Chavez performed the autopsy. Dr. Bucholtz confronted Investigator Chavez, who said he was collecting samples for Dr. Smith.

Later that day, Investigator Chavez called the forensic technician into his office. According to the forensic technician, Investigator Chavez told him/her to keep his/her mouth shut and not to discuss the cases on which Investigator Chavez worked with anyone, especially "Dr. B," referring to Dr. Bucholtz.

The forensic technician was alarmed by Investigator Chavez's conduct and contacted the Ventura County District Attorney's Office on May 11, 2015, to report his/her concerns. Under the direction of district attorney investigators, the forensic technician placed a pretext telephone call to Investigator Chavez on May 12, 2015. During the call, Investigator Chavez acknowledged performing postmortem procedures on Jeffrey L., Christopher T., and

Hipolito V. Investigator Chavez said, "For me it's more of just collection, collection of samples and that's just blood, urine, gastric..." Investigator Chavez told the forensic technician what he did was not against the law. Investigator Chavez said Dr. Smith was aware of everything Investigator Chavez was doing and had given Investigator Chavez directions regarding what samples to collect. Investigator Chavez told the forensic technician, "We're just doing what we need to do right now to save money from our budget because we're almost out of money." Investigator Chavez made this statement in the context of discussing Dr. Bucholtz performing more postmortem procedures than he and Dr. Smith believed were necessary. Investigator Chavez stated that, as a result, the office was "almost out of money" on Dr. Bucholtz's contract. Investigator Chavez said the reason he told the forensic technician not to discuss the procedures he was doing was because Dr. Bucholtz would just be upset she was not getting the work. Investigator Chavez said Dr. Bucholtz is upset because she "needs the money."[5]

Investigator Chavez did not recall specifics about the Hipolito V. postmortem. However, he believed he opened up the body to collect gastric and bile samples. Investigator Chavez was later given an opportunity to review the case file, at which time he was able to recall that he did not collect bile because Hipolito V. did not have a gallbladder. When Dr. Smith was questioned about whether it would concern him if Investigator Chavez was unable to locate a gallbladder, Dr. Smith said it would concern him. However, Dr. Smith also said that if the person's gallbladder had been removed prior to death, then obviously the examiner could not locate a gallbladder to collect a bile sample.

The case file for Hipolito V. contained two drafts of a death certificate. The first draft appeared to have been prepared by the assigned investigator. On this draft, under the "Autopsy performed?" section, the "no" box was checked. The second draft appears to have been prepared by Investigator Chavez, and checked the "yes" box under "Autopsy performed?"

Dr. Smith and Investigator Chavez exchanged e-mails on May 11, 2015, regarding whether the autopsy "yes" or "no" box should be checked for Hipolito V.'s death certificate. In Investigator Chavez's e-mail to Dr. Smith, Chavez wrote, "Question? On the DC for [V.],

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[5] Dr. Bucholtz was paid one amount for partial autopsies, and a larger amount for complete autopsies. When interviewed, unrelated to the Hipolito V. autopsy, Dr. Bucholtz explained the solemn duty to conduct a thorough examination to accurately determine the cause and manner of death, to identify communicable diseases, if any, and the need to give family members some answers and peace of mind. She used the example of a parent who had lost a child and blamed themselves without proper knowledge of the true cause of death.

autopsy-yes or autopsy-no? I opened belly for gastric and liver." Dr. Smith replied, "Autopsy yes."

No autopsy report was completed by Dr. Smith for the Hipolito V. case.

Additional E-mails of Note During Dr. Smith's Absence

Although Investigator Chavez did not ultimately perform any postmortem procedures on the body of David J., there was an exchange of e-mails between Dr. Smith and Investigator Chavez pertaining to this case worthy of note.

On May 12, 2015, Dr. Smith e-mailed Investigator Chavez concerning the David J. case. Dr. Smith instructed Investigator Chavez to obtain blood, vitreous, urine, and quadriceps muscle. Dr. Smith said there was "no need to open belly unless can't get blood." Dr. Smith added, "Autopsy no on DC if belly not opened."

Investigator Chavez responded to Dr. Smith's e-mail the same day. Investigator Chavez advised Dr. Smith that representatives of the Simi Valley Police Department wanted to attend. Investigator Chavez wrote, "They were expecting us to perform a postmortem examination. What should I tell them?" Dr. Smith sent a reply e-mail which read in part, "Then just have Dr. B do a post."

Also on May 12, 2015, Investigator Chavez sent an e-mail to Dr. Smith regarding Maria C.'s death. Chavez stated that the decedent had been in a head-on motor vehicle accident and described her injuries as reported in the emergency room and the medical treatment she received. She died almost three weeks after the accident. Chavez stated that the Oxnard Police Department was investigating the death and asked Dr. Smith, "How would you sign this case out?" Without having seen the body, Dr. Smith responded with an e-mail: "Complications of blunt force injuries (weeks) Manner: accident List major surgeries. Sent using OWA for iPhone." Chavez signed the Certificate of Death, showing that no autopsy was performed, and the cause of death as "complications of blunt force injuries."

Armando Chavez Interview

Investigator Chavez was interviewed at VCME on June 22, 2015. Investigator Chavez readily admitted to performing procedures on bodies at Dr. Smith's direction while Dr. Smith was out of the office. Investigator Chavez expressed an inability to recall details of specific autopsies without reviewing his notes. However, he acknowledged collecting fluid samples from multiple bodies without supervision. He also admitted to opening the abdominal cavity of two individuals to collect bile and gastric samples.

Investigator Chavez believed he had the authority to perform the procedures because he was acting at Dr. Smith's direction. Investigator Chavez was not aware of any law that prevented him from doing so. He also stated that he was a deputy medical examiner although his job title listed on the public Web site identifies him as the Chief Deputy Administrator. Investigators James Baroni, Michael Tellez, Zeb Dunn, and Bryce Elder are identified as deputy medical examiners on the same public Web site. According to Investigator Chavez, this position entitled each of them to certify death certificates, which he did on multiple occasions.[6]

Investigator Chavez was asked about whether the procedures he performed constituted autopsies. Investigator Chavez said that for purposes of reporting the death certificate to the Electronic Death Registration System (EDRS), if you open up the body to collect a sample, then you would technically have to check the box indicating an autopsy was performed.[7]

Investigator Chavez gave an example of opening the body to collect a gastric sample as a situation where he would need to check the autopsy box for EDRS reporting purposes. Investigator Chavez stated, however, that under this broad definition, there are actions investigators regularly conduct in other counties without a physician present that would constitute an autopsy. He provided an example of "Los Angeles County *Coroner* investigators" taking liver temperatures in the field regularly.[8] This requires the investigator to cut into the body and insert a thermometer directly into the liver.

Upon further questioning, Investigator Chavez said he did not believe his actions constituted an autopsy. He distinguished between opening the body merely to collect samples and examining the body to determine the cause and manner of death. Investigator Chavez defined an autopsy in his words as, "somebody who's going to remove all vital organs, and examine them and offer an opinion as to all right, I think this person has liver cancer..." He further stated he did not believe his actions constituted the practice of medicine because he was not making a diagnosis.

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[6] VCME has since changed its policy to allow only a board certified forensic pathologist MD to sign a death certificate.

[7] District attorney investigators contacted Mel Salazar, an employee of the California Department of Public Health, who is responsible for overseeing the EDRS. Mr. Salazar said the procedure for completing a death certificate is contained in the Physician's Handbook on Medical Certification of Death. The handbook contains no guidance on what constitutes an autopsy. Mr. Salazar said the physician completing the form has sole discretion to determine whether an autopsy was performed for reporting purposes.

[8] Los Angeles County actually has a medical examiner rather than a coroner.

At one point in the interview, Investigator Chavez referenced the National Association of Medical Examiners (NAME). He stated that VCME is not NAME-accredited. He explained that Dr. O'Halloran never sought NAME accreditation, nor did Dr. Smith.[9]

Dr. Jon J. Smith Interview

Dr. Smith was interviewed on June 22, 2015, at VCME. Dr. Smith readily admitted to having Investigator Chavez perform certain postmortem procedures for him in May 2015 when Dr. Smith was on vacation.

Dr. Smith said that Investigator Chavez performed a couple of partial autopsies for Dr. Smith in order to acquire appropriate toxicology specimens. Dr. Smith later estimated that during the two-week period he was on vacation, he had Investigator Chavez collect samples on a total of four cases. Dr. Smith said he then authored a report on those cases when he returned from vacation. He admitted this was "not the best" procedure, but cited budgetary limitations as the cause. He said he directed Investigator Chavez to collect samples on certain cases rather than giving the cases to Dr. Bucholtz because Dr. Bucholtz was routinely disregarding his instructions and doing more thorough exams than he believed were absolutely necessary.[10]

When questioned further about Investigator Chavez performing autopsies, Dr. Smith stated that he did not believe Investigator Chavez performed autopsies, nor did he believe Investigator Chavez was practicing medicine. Dr. Smith said there are jurisdictions in which acquisition of specimens for toxicology is regularly done by non-medical personnel. Dr. Smith said he is not aware of any law that says a doctor or forensic pathologist must be present when a technician is collecting samples, even internal samples. Dr. Smith said that, in his mind, the practice of medicine and the performance of an autopsy go beyond making an incision and collecting samples. There must be an examination of organs and an interpretation of findings to determine the cause and manner of death to constitute an autopsy.

Dr. Smith discussed NAME standards during the interview. He said that NAME has proposed standards that may or may not be accepted nationally, depending on whether your agency is NAME accredited. He said VCME is not NAME accredited. He said there is no written or published standard of care for the State of California pertaining to postmortem examinations and who is authorized to perform them.

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[9] It should be noted that the Ventura County Medical Examiner's Web site lists NAME as a resource.
[10] Dr. Bucholtz disagreed with Dr. Smith regarding when full autopsies were appropriate. See footnote 5, above.

Dr. Smith was questioned about the cease and desist letter he received from the Louisiana Medical Board. He said that matter was resolved without him admitting to practicing medicine in Louisiana because he did not practice medicine in Louisiana. He said he had never physically been to the state of Louisiana. He did acknowledge that the way he authored the autopsy report in question could give the impression he had been physically present and conducted the autopsy.

Louisiana Autopsy

Dr. Smith stated that he had a contract with Regional Pathology and Autopsy Services based in Oakland, California. Dr. Smith was not an employee of the company. Under Dr. Smith's contract, he authored reports for private autopsies. He told district attorney investigators he reviewed data collected by pathology assistants. He said he has never personally conducted an autopsy for the company. He estimated he conducted approximately 100 such case reviews per year, earning approximately $65,000 per year.

On December 29, 2014, Dr. Smith authored an autopsy report regarding the death of an individual who resided in the state of Louisiana. The report listed the date of autopsy as October 28, 2014. The report listed Dr. Smith as the pathologist and certified pathologists' assistant Frances Zitano as the assistant.

Zitano states she has never personally met with Dr. Smith or spoken to him. She also said the only e-mail communications she had with Dr. Smith were after she had performed her tasks on the bodies. He did not provide her with directions or instructions ahead of time.

The executive director of the Louisiana Board of Medical Examiners sent Dr. Smith a cease and desist letter dated January 28, 2015. The executive director indicated that based on the report of December 29, 2014, it appears that Dr. Smith performed an autopsy in the state of Louisiana. The executive director went on to state, "The performance of an autopsy is the practice of medicine in this state and can only be performed by a Louisiana licensed physician." The executive director informed Dr. Smith that the Louisiana Board of Medical Examiners had determined he was engaged in the unauthorized practice of medicine, as defined in Louisiana Medical Practice Act, Louisiana Revised Statute 37:1262.

The autopsy report authored by Dr. Smith did not directly state that he was present when the autopsy was performed. However, the language included observations that could only be made by being physically present to examine the body, as opposed to looking at photographs after the fact. For example, the report referenced the trachea being "palpable in the midline" and the abdomen being "dull to percussion." The medical definition of "palpable" is detectable by touch. Dr. Smith could not personally have made these observations without physical manipulation of the body. The report never provided a disclaimer that these

observations were made by Zitano rather than Dr. Smith. As such, the report clearly gave the impression that Dr. Smith personally conducted the autopsy.

Oregon Autopsy

Dr. Smith also authored an autopsy report for Regional Pathology and Autopsy Services for an autopsy conducted in Oregon on January 26, 2015, on the body of Christopher Winkler. Dr. Smith's autopsy report is dated March 9, 2015.

An investigator from the Oregon Medical Board sent a letter to Dr. Smith care of Regional Pathology and Autopsy Services dated October 6, 2015. The letter informed Dr. Smith that a complaint had been made against him alleging that he performed an autopsy on Mr. Winkler at First Call Mortuary Services in Portland, Oregon, on January 26, 2015, without being licensed to practice medicine in the state of Oregon.

Nick Daniels, founder of Regional Pathology and Autopsy Services, sent a reply letter to the Oregon Medical Board. In the letter, Daniels stated that Dr. Smith had never been an employee of their company and acted only as an independent contractor consultant. Daniels asserted that Dr. Smith stopped taking new cases from Regional Pathology in March 2015. As to the work performed on Winkler's body, Daniels stated that Zitano conducted the "actual 'hands on' initial gross resection tissue harvesting." Daniels further added, "The remaining work, analysis, testing, histological slide examination, diagnoses, etc. were all done solely in the state of California by Jon Smith, M.D." Daniels explained that Zitano is a nationally certified pathologists' assistant and that certified pathologists' assistants perform procedures including gross specimen removal, documentation and dissection, and they do not make any diagnosis nor do they reach any medical conclusions. Daniels wrote, "Their actions are solely under the direction of an M.D. Pathologist who then examines the organ or tissues, histological slides, tests, analyzes the tissue or organ(s) to make his/her conclusions, diagnoses. It is also the M.D. pathologist who would then write his/her Autopsy Report as is the responsibility and purview of the pathologist alone (Dr. Smith in this case)."

The Oregon autopsy report included phrases such as "trachea is palpable at the midline" and "unremarkable without palpable lesion." Since Dr. Smith was not present when the autopsy occurred, he could not have made these observations. Yet, as with the Louisiana report, this report contained no disclaimer that these observations were made by Zitano rather than Dr. Smith, or that Dr. Smith was not physically present when the autopsy occurred.

Santa Barbara Sheriff-Coroner Staff Interviews

The County of Santa Barbara has a sheriff-coroner. Santa Barbara Coroner staff members were interviewed regarding their interactions with Dr. Smith during his work on Santa Barbara autopsies. They stated that Dr. Smith never directed them to perform any postmortem procedures on bodies out of his presence.

Detective Carlson, who is employed as a deputy coroner at the Santa Barbara Coroner's Office, said that as part of his duties, he is allowed to obtain samples from bodies. These include vitreous, blood, and muscle tissue. He also has opened bodies to obtain a blood sample from the chest cavity. Santa Barbara Coroner's Office deputies believe they are entitled to conduct autopsies as deputy coroners. They would generally call a pathologist only in cases involving multiple traffic fatalities, SIDS deaths, and homicides. The sheriff's deputies indicated they attended an 80-hour course at the Coroner's Academy and obtained on-the-job training and experience to qualify them to conduct postmortem examinations.

Dr. Ronald O'Halloran Interview

Ronald O'Halloran, M.D., is the former Chief Medical Examiner for the County of Ventura. Dr. O'Halloran was interviewed in connection with this investigation by district attorney investigators. Dr. O'Halloran stated that he is not aware of any law that says an autopsy must be performed by a licensed physician, or that would prevent Dr. Smith from allowing an assistant to perform autopsies when he is not present. He stated, however, that he would not have allowed, and did not allow, investigators or forensic technicians to perform postmortem procedures when he is not physically present onsite. He said this was a matter of good practice but not a legal requirement.[11]

Dr. O'Halloran stated that NAME is trying to push its position that autopsies should be performed only by a forensic pathologist who is a licensed physician. He said he never felt the need to obtain NAME certification because he was running the office well. He said it is very difficult and costly to obtain NAME certification, especially for a small county like Ventura. He did not see a reason, for example, to send his staff to expensive NAME training courses when he could teach them just as well what they needed to know through on-the-job training. He emphasized that NAME standards are guidelines, not requirements.

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[11] Dr. O'Halloran also expressed concern that Dr. Smith had taken home a microscope. Ventura County Health Care Agency Director Barry Fisher addressed this concern with Dr. Smith. Dr. Smith said he used a County microscope at home for County work only. Mr. Fisher instructed Dr. Smith to return the microscope to VCME, which Dr. Smith did.

Dr. O'Halloran said he would not consider making a Y-incision, removing the breast plate, and taking a sample of liver to be an autopsy. He said, in his opinion, an autopsy involves examining internal organs, removing organs, and dissecting organs to determine the cause and manner of death.

Dr. Frank Sheridan Consultation

Frank Sheridan, M.D., is the Chief Medical Examiner for the County of San Bernardino. Dr. Sheridan was consulted and asked to provide an expert opinion as to the practice of pathology, the definition of "autopsy" and the "practice of medicine." Dr. Sheridan opined that the following actions do *not* constitute the practice of medicine and need not be performed by a licensed physician: extracting vitreous fluid from the decedent's eye, extracting blood from vessels, extracting urine from the bladder with a needle, and making an incision in the quadriceps muscle to collect a sample of tissue. Dr. Sheridan also stated there was no consensus within the field of pathology that the aforementioned procedures, which could be accomplished without opening any internal cavities, would constitute performance of an autopsy. He indicated these types of procedures could be performed by a pathologists' assistant without a physician present.

Dr. Sheridan opined that an autopsy occurs when an internal cavity is opened and organs are examined and/or samples taken for the purpose of determining the cause or manner of death. He considers such actions to be the practice of medicine. He feels there is consensus within the field of pathology on these points. However, he is not aware of any law that specifically requires such actions be performed by a licensed physician, nor is he aware of any law that specifically prohibits a pathologists' assistant from cutting into the body and obtaining samples without a physician present.

Dr. Sheridan based his opinions in large part on the NAME standards. However, he acknowledged that there is debate within the field of forensic pathology as to whether these standards should be considered best practices guidelines or requirements that must be followed. He stated that pathologists in smaller counties, with smaller budgets, do not believe they can comply with NAME standards because of the costs involved in doing so.

National Association of Medical Examiners (NAME) Standards

NAME is a national organization for medical examiners. NAME published a list of standards for pathologists entitled "Forensic Autopsy Performance Standards." In the preface to this document, the authors state that the objective of the standards is to provide a constructive framework that defines the fundamental services rendered by a professional forensic pathologist. The preface contains the following disclaimer: "NAME recognizes that certain

standards may not be applicable where they conflict with federal, state, and local laws. Deviation from these performance standards is expected only in unusual cases when justified by considered professional judgment." (National Association of Medical Examiners, Forensic Autopsy Performance Standards (2005) ("NAME Standards"), Preface, p. iii.)

Standard B4 of NAME's publication states that performance of an autopsy is the practice of medicine. It further states that the pathologist must directly supervise support staff and warns that allowing "non-forensic pathologists to conduct forensic autopsy procedures without direct supervision and guidance is fraught with the potential for serious errors and omissions." (NAME Standards at p. 4.) NAME defines direct supervision as "supervision of personnel performing actions in the immediate presence of the supervisor." (*Id.* at p. 25.) Standard B4.1 provide that a forensic pathologist or resident in pathology shall perform all autopsies. (*Id.* at p. 4.) Standard B4.2 provides that a forensic pathologist shall directly supervise all assistance rendering during postmortem examinations. (*Ibid.*)

There is a procedure by which coroner and medical examiner offices can apply for NAME accreditation. However, most coroner systems cannot qualify for accreditation because of problems related to size, budgetary restraints, insufficient staff and equipment, and insufficiently trained personnel. (*Strengthening Forensic Science in the United States: A Path Forward: Review of Medical Examiner and Coroner Systems* (2009), authored by the National Research Council, published by the United States Department of Justice, p. 258.) The National Research Council, which is affiliated with the National Academy of Sciences, made the above observations following an extensive nationwide survey and analysis of death investigation in the United States. The Council noted that there is no one recognized set of performance standards or best practice standards for medical examiner/coroner systems, nor is there a universally accepted or promulgated method of quality control or quality assurance. (*Ibid.*) The Council also observed that, to some degree, all medical examiner/coroner agencies suffer from an imperfect legal structure or code controlling death investigations. (*Id.* at p. 247.)

Effective June 23, 2015, VCME has adopted a policy that its forensic pathologists follow the NAME Forensic Autopsy Performance Standards. VCME is currently taking steps to become NAME accredited.

SECTION FOUR - ANALYSIS OF POTENTIAL CHARGES RELATED TO POSTMORTEM PROCEDURES INVESTIGATOR CHAVEZ PERFORMED AT DR. SMITH'S DIRECTION

We have reviewed the following potential criminal charges against Investigator Chavez for the postmortem procedures performed on Nancy K., Jeffrey L., and Hipolito V.: 1) Unauthorized Autopsy (Health and Safety Code section 7114, misdemeanor); 2) Unauthorized Practice of Medicine (Business and Professions Code section 2052, subdivision (a), felony); 3) Conspiracy to Commit Unauthorized Practice of Medicine (Business and Professions Code section 2052, subdivision (b), felony); and 4) Unlawful Mutilation of Human Remains (Health and Safety Code section 7052, felony).

As to Dr. Smith, we have reviewed the following potential criminal charges related to his conduct in directing Investigator Chavez to perform postmortem procedures on Nancy K., Jeffrey L., and Hipolito V.: 1) Permitting Unauthorized Autopsy (Health and Safety Code section 7114, misdemeanor); and 2) Conspiracy to Commit Unauthorized Practice of Medicine (Business and Professions Code section 2052, subdivision (b), felony).

At the outset, we note that we are confining our review to the postmortem procedures performed on Nancy K., Jeffrey L., and Hipolito V. because it is the opinion of Dr. Sheridan that these procedures constituted the performance of an autopsy and the practice of medicine. In his opinion, the procedures performed on Gustavo G. and Christopher T. would not constitute either the performance of an autopsy or the practice of medicine, as their bodies were never opened.

Unauthorized Autopsy, Health and Safety Code Section 7114

Statutory Requirements

Health and Safety Code section 7114 provides:

> Any person who performs, permits or assists at, an autopsy on a dead body . . . is guilty of a misdemeanor, except that this section shall not be applicable to the performance of an autopsy by the coroner or other officer authorized by law to perform autopsies.

This is a "strict liability" offense that does not require that the individual have a wrongful intent. (See *People v. Casey* (1995) 41 Cal.App.4th Supp. 1, 6.) Thus, Investigator Chavez would be potentially culpable under this statute if it could be shown he performed an autopsy.

Autopsy Definition

Unfortunately, no California statute defines the term "autopsy." In the absence of a specific legal definition for a term, jurors would be instructed to apply the term using its ordinary, everyday meaning. (Judicial Council of California, Criminal Jury Instructions (Fall 2014), CALCRIM 200.)

The dictionary defines "autopsy" as "an examination of a body after death to determine the cause of death or the character and extent of changes produced by disease – called also *necropsy*." It comes from the Greek word *autopsia*, "act of seeing with one's own eyes." (*Merriam-Webster.com*, accessed January 17, 2016.)

"Autopsy" was defined in a published opinion of the Attorney General of California, 53 Ops. Cal. Atty. Gen. 220 (1970), as follows:

> An autopsy is a form of postmortem examination in which a dead body is examined and at least partially dissected for the purpose of ascertaining the cause of death, the nature and extent of lesions of disease, or any other abnormalities present. *In re Disinterment of Body of Jarvis*, 244 Iowa 1025, 58 N.W.2d 24 (1953); *E.O. Painter Fertilizer Co. v. Boyd*, 93 Fla. 354, 114 So. 444 (1927); *cf.* 11 Ops. Cal. Atty. Gen. 150, 151 (1948).

"Dissect" is defined as "to separate into pieces: expose the several parts of (as an animal) for scientific examination." It comes from the Latin word meaning "to cut apart." (*Merriam-Webster.com*, accessed January 17, 2016.)

The term "postmortem examination" is broader than the term "autopsy." A "postmortem examination" has been described as "the dissection of the body, made within a few hours, or at the furthest a few days, after the death." (11 Ops. Cal. Atty. Gen. 150, 151 (1948).) "A postmortem examination is an examination of a body after death, and does not necessarily imply an autopsy, which is an examination of a dead body, by dissection to ascertain the cause of death." (*Ibid.*)

NAME Standards define the term "autopsy" more specifically as a procedure performed by a physician:

> An examination and dissection of a dead body *by a physician* for the purpose of determining the cause, mechanism, or manner of death, or the seat of disease, confirming the clinical diagnosis, obtaining specimens for specialized testing, retrieving physical evidence, identifying the deceased or educating

> medical professionals and students. (NAME Standards, Terms and Definitions, p. 19, emphasis added.)

The National Research Council defines an autopsy as, "The systematic external and internal examination of a body to establish the presence or absence of disease by gross and microscopic examination of body tissues..." (*Strengthening Forensic Science in the United States, supra*, p. 247.) It further explains that "medicolegal autopsies are conducted to determine the cause of death; assist with the determination of the manner of death as natural, suicide, homicide, or accident." (*Ibid.*)

Thus, there appears to be general agreement within the field of pathology that an autopsy involves an examination, including partial dissection of the body, for purposes of determining the cause of death. However, there is dispute regarding what specific actions constitute an autopsy. There is also dispute within the field regarding the dividing line between collecting samples and performing an autopsy.

Legal Analysis

Dr. Smith and Investigator Chavez assert that because Investigator Chavez was not attempting to ascertain the cause of death, but was only collecting samples, his actions do not constitute the performance of an autopsy. Dr. Smith was the one who provided the medical opinion regarding the manner and cause of death, not Investigator Chavez.

Dr. Sheridan disagrees and opines that collecting samples in anticipation that those samples will later be used to determine the cause of death constitutes an autopsy, even if another person ultimately determines the cause of death. Dr. Sheridan contrasts this with organ harvesting, which involves removing organs from the body for transplant rather than to determine the manner of death. Dr. Sheridan stated that, in his opinion, a technician could perform organ harvesting without physician supervision.

Unfortunately, the law provides no clarity regarding the dividing line between sample collection and performance of an autopsy. While Dr. Sheridan's opinion is helpful, it is not uncontroverted. Dr. O'Halloran expressed an opinion that opening the body with a Y-incision and removing the breast plate to obtain a liver sample would not constitute an autopsy.

This lack of clarity in the law and in the professional community is further compounded by Investigator Chavez's job description as a Chief Deputy Administrator/Supervising Medical Examiner Investigator. By its terms, the job qualifications include obtaining tissue and fluid samples from dead bodies.

The e-mail exchanges between Dr. Smith and Investigator Chavez reveal that Chavez was uncertain about whether his actions on Hipolito V. constituted an autopsy for purposes of EDRS reporting. Dr. Smith's responses in the Hipolito V. and David J. postmortem procedures appear to indicate that Dr. Smith believed an autopsy had occurred when the body was opened to collect a sample. However, Dr. Smith's e-mail responses focused on the reporting requirements for filling out the death certificate to be input to the EDRS.

The most invasive procedure performed by Investigator Chavez involved his opening the abdominal cavity of Nancy K. in an effort to identify the primary source of her cancer. This action went well beyond mere sample collection and, in the opinion of Dr. Sheridan, constituted an autopsy and the practice of medicine. However, because the Nancy K. autopsy occurred in December 2013, and because unauthorized performance of an autopsy under Health and Safety Code section 7114 is a misdemeanor, the statute of limitations is one year (Penal Code section 802), which expired well before the District Attorney's Office learned of the Nancy K. matter.

Authorized Officers under Health and Safety Code Section 7114

Beyond the significant issues noted above, Health and Safety Code section 7114 permits an autopsy to be performed "by the coroner or other officer authorized by law to perform autopsies." Neither the Health and Safety Code nor any other provision of law provides guidance as to the term "other officer authorized by law to perform autopsies" as used in this section. As the Attorney General observed, "Unfortunately, the Legislature has not expressly enlightened us, either in section 7114 or elsewhere in the codified laws of California, as to the identity of such other officers. Probably the purpose was to avoid unforeseen consequences of the section at the time of original enactment." (53 Ops. Cal. Atty. Gen. 220, 222.)

While NAME standards would require a pathologist to personally perform autopsies and to directly supervise any assistance rendered by non-pathologists, its standards are not a substitute for law.

The role of "forensic technician" in our county is a role often referred to as a pathologists' assistant in other counties. Business and Professions Code section 1269.3 addresses both certified and non-certified pathologists' assistants in terms of their respective abilities to complete certain tasks under the law. A certified pathologists' assistant may, under the supervision and control of a pathologist, prepare human surgical specimens for gross description and dissection, prepare and perform human postmortem examinations, including, but not limited to, selection of tissues and fluids for further examination, and gather any other information necessary for an autopsy report. (Business and Professions Code, section 1269.3, subdivision (a).) However, Chavez does not have the required training or certification to be a certified pathologists' assistant.

An uncertified pathologists' assistant may prepare human surgical specimens for gross description and dissection under the direct supervision of a qualified pathologist. (Business and Professions Code section 1269.3, subdivision (b).) "Direct supervision" is defined in subdivision (c) as a physician being physically present onsite in the vicinity of the clinical laboratory where the specialty of pathology is being performed and who shall be available for consultation and direction. (Business and Professions Code section 1269.3, subdivision (c).) As discussed above, Dr. Smith was not present when Investigator Chavez performed some of the procedures, and Dr. Bucholtz was not aware of what procedures Chavez was performing.

It is not clear that the pathologists' assistant provisions would apply to Chavez. Given the lack of clarity in the law, and the duties in Chavez's job description to "obtain tissue and fluid samples from dead bodies," it cannot be proven beyond a reasonable doubt that Chavez was not an officer authorized by law to perform autopsies.

Unauthorized Practice of Medicine, Business and Professions Code Section 2052, Subdivision (a)

Business and Professions Code section 2052 provides the following regarding the practice of medicine by persons not holding a certificate (license) as physician and surgeon:

> (a) Notwithstanding Section 146, any person who practices or attempts to practice, or who advertises or holds himself or herself out as practicing, any system or mode of treating the sick or afflicted in this state, or who diagnoses, treats, operates for, or prescribes for any ailment, blemish, deformity, disease, disfigurement, disorder, injury, or other physical or mental condition of any person, without having at the time of so doing a valid, unrevoked, or unsuspended certificate as provided in this chapter or without being authorized to perform the act pursuant to a certificate obtained in accordance with some other provision of law is guilty of a public offense.
>
> (b) Any person who conspires with or aids or abets another to commit any act described in subdivision (a) is guilty of a public offense, subject to the punishment described in that subdivision . . . .

Business and Professions Code section 2038 defines "diagnose" as follows:

> Whenever the words "diagnose" or "diagnosis" are used in this chapter, they include any undertaking by any method, device, or procedure whatsoever, and whether gratuitous or not, to ascertain or establish whether a person is suffering from any physical or mental disorder . . .

Autopsy Procedure and the Practice of Medicine

Business and Professions Code section 2052 does not specifically address whether conducting an autopsy on a dead body constitutes the practice of medicine. NAME standards provide that performance of a forensic autopsy is the practice of medicine. (NAME Standards, Standard B4.) However, beyond the NAME standard being quoted in a concurring California Supreme Court opinion (*People v. Dungo* (2012) 55 Cal.4th 608, 624 (conc. opn. of Werdeger, J.)), there are no California cases that have directly addressed this issue.

The Court of Appeals of New York, that state's highest court, has concluded that the practice of medicine includes the performance of autopsies. (*Gross v. Ambach* (1988) 71 N.Y.2d 859, 861 [522 N.E.2d 1043, 527 N.Y.S.2d 745].) The court interpreted New York Education Law section 6521, which defines the practice of medicine as "diagnosing, treating, operating or prescribing for any human disease, pain, injury, deformity or physical condition." The court stated:

> Contrary to petitioner's claim that medicine may be practiced only on living patients, the statute contains no such limitation. . . . Clearly, an autopsy is the ultimate diagnostic procedure through which are determined the cause and means of death. Accordingly, since the practice of medicine includes the performance of autopsies, subject matter jurisdiction obtains.

However, the New York decision is not binding in California.

In the present case, the law is not clear as to whether performing an autopsy is the practice of medicine, or whether the procedures Chavez performed constituted an autopsy or the performance of medicine. It is also factually arguable whether he was merely obtaining samples at the direction of a licensed physician, Dr. Smith. Accordingly, it cannot be proven beyond a reasonable doubt that Armando Chavez practiced medicine without a license.

Aiding and Abetting Unauthorized Practice of Medicine, Business and Professions Code Section 2052, Subdivision (b)

Business and Professions Code section 2052, subdivision (b), provides:

> Any person who conspires with or aids or abets another to commit any act described in subdivision (a) is guilty of a public offense, subject to the punishment described in that subdivision.

As discussed above, it cannot be proven beyond a reasonable doubt that the procedures Investigator Chavez performed constituted the practice of medicine. Nor can the necessary intent be proven to establish that Dr. Smith aided and abetted the authorized practice of medicine.

Business and Professions Code section 2052, subdivision (b), requires proof of specific intent on the defendant's part to violate the law, because commission of the crime requires either a conspiracy or aiding and abetting. (*People v. Bernhart* (1963) 222 Cal.App.2d 567, 586-587.) A necessary element is the existence in the mind of the perpetrator of the specific intent to violate the section or that the defendants entered into the common purpose with knowledge that a violation of law would result from the commission of the contemplated act or acts. (*Ibid.*) A mistake of law is a defense to this charge if it negates the requisite intent. (*Ibid.*)

The evidence fails to conclusively establish that Dr. Smith believed Investigator Chavez was conducting an autopsy or was engaged in practicing medicine. Accordingly, it cannot be proven beyond a reasonable doubt that Dr. Smith aided and abetted the unauthorized practice of medicine under Business and Professions Code section 2052, subdivision (b).

Unlawful Mutilation of Human Remains, Health and Safety Code Section 7052, Subdivision (a)

Health and Safety Code section 7052, subdivision (a) provides:

> Every person who willfully mutilates, disinters, [or] removes from the place of interment . . . any remains known to be human, without authority of law, is guilty of a felony.

"Human remains" is defined in Health and Safety Code section 7001 as "the body of a deceased person, regardless of its state of decomposition, and cremated remains." The term "mutilate," while not defined in the code, has been interpreted to mean "to cut off a limb or an essential part of the body." (*People v. Bullington* (1938) 27 Cal.App.2d 396.)

While there are no appellate court opinions dealing with a criminal prosecution of a pathologist or pathologists' assistant under Health and Safety Code section 7052, subdivision (a), a civil action was upheld for a violation of this section against a physician who, though authorized by law to examine the body in question, was not authorized to remove a portion of the body and retain possession thereof despite a demand by the surviving spouse that it be returned. (*Palmquist v. Standard Acc. Ins. Co.* (S.D. Cal. 1933) 3 F.Supp. 358.)

In order to prove a violation of Health and Safety Code section 7052, subdivision (a), we must prove the defendant acted "without authority of law." Thus, any provision of law that arguably grants defendant the authority to act as he did constitutes a defense to this charge. Due to the lack of clarity in California law and based upon the same reasoning and analysis above, the prosecution could not overcome a claim that Investigator Chavez acted under authority of law.

SECTION FIVE - ANALYSIS OF POTENTIAL CHARGES RELATED TO AUTOPSY REPORTS AUTHORED BY DR. SMITH

Dr. Smith authored autopsy reports for Gustavo G., Jeffrey L., and Christopher T., despite not having directly examined the bodies himself nor being present when Investigator Chavez performed postmortem procedures on the bodies. If these reports contained material misrepresentations, Dr. Smith could potentially be criminally liable pursuant to Penal Code section 115, Felony Procuring or Offering False or Forged Instrument for Recording, and Penal Code section 134, Felony Preparing False Documentary Evidence.

Procuring or Offering False Instrument for Recording, Penal Code Section 115

Penal Code section 115, subdivision (a) provides:

> Every person who knowingly procures or offers any false or forged instrument to be filed, registered, or recorded in any public office within this state, which instrument, if genuine, might be filed, registered, or recorded under any law of this state or of the United States, is guilty of a felony.

VCME is a public office within the State of California. However, an autopsy report may not qualify as an "instrument" for purposes of this statute. Courts have held a death certificate is not an "instrument" within the meaning of the statute. (*People v. Soriano* (1992) 4 Cal.App.4th 781, 783-784.) An "instrument" within the meaning of Penal Code section 115 is "a writing which transfers title to or creates a lien on real property, or gives a right to a debt or duty." (*Id.* at p. 753, citing *Generes v. Justice Court* (1980) 106 Cal.App.3d 678, 682-684.) Based upon this decisional law, we believe it is unlikely a court would find that an autopsy report qualifies as an "instrument."

Further, there are no statements Dr. Smith made in the autopsy reports in question that can be proven false or untrue. All three autopsy reports in question contain the following description of the procedures employed: "An abbreviated postmortem examination was performed for the acquisition of toxicological biological specimens under the direction and supervision of Jon J. Smith, M.D." While the language may be misleading, it is not demonstrably false. Investigator Chavez performed abbreviated postmortem examinations for the acquisition of toxicological and biological specimens. Investigator Chavez acted under Dr. Smith's "direction and supervision," in that Dr. Smith directed Investigator Chavez via e-mail what samples to collect and procedures to perform on the bodies in question. The term "direction and supervision" is not defined in California law. It is not synonymous with "direct supervision," which requires onsite supervision. (Business and Professions Code section 1269.3, subdivision (c).) While Dr. Smith was not forthcoming in disclosing that a medical examiner investigator performed the postmortem procedures while he "supervised" via e-mail from a remote location, we cannot prove beyond a reasonable doubt that the statements made were false. For the reasons set forth above, we cannot prove a violation of Penal Code section 115 against Dr. Smith.

Preparing False Documentary Evidence, Penal Code Section 134

Penal Code section 134 provides:

> Every person guilty of preparing any false or ante-dated book, paper, record, instrument in writing, or other matter or thing, with intent to produce it, or allow it to be produced for any fraudulent or deceitful purpose, as genuine or true, upon any trial, proceeding, or inquiry whatever, authorized by law, is guilty of a felony.

Penal Code section 134 is broader than Penal Code section 115 in the scope of documents covered. An autopsy report would certainly qualify as a "paper, record... or other material or thing." However, there is no evidence that Dr. Smith intended to produce, or allow to be produced, any of these autopsy reports for a fraudulent or deceitful purpose, upon a trial, proceeding, or other inquiry authorized by law. The autopsies did not pertain to potential criminal cases, nor did Dr. Smith have reason to anticipate civil litigation for which these reports would be produced. More importantly, it cannot be proven that he made any false statements in the reports, as explained above. Therefore, we cannot prove a violation of Penal Code section 134 against Dr. Smith.

SECTION SIX - ANALYSIS OF POTENTIAL CHARGES RELATED TO LOUISIANA AND OREGON AUTOPSIES

Dr. Smith authored autopsy reports as a contract pathologist for Regional Pathology and Autopsy Services, including autopsies in Louisiana and Oregon. Whether or not the laws of those states were violated, "[i]t has long been established that a state will entertain a criminal proceeding only to enforce its own criminal laws, and will not assume authority to enforce the penal laws of other states or the federal government through criminal prosecutions in its state courts." (*People v. Betts* (2005) 34 Cal.4th 1039, 1046, citing *Huntington v. Attrill* (1892) 146 U.S. 657.) No charges can be filed in California regarding those autopsies because we have no evidence that Dr. Smith committed acts in California in violation of California law.

Nor can we prosecute a conspiracy to commit a violation of Oregon or Louisiana law. A conspiracy to commit "any crime," as the term is used in Penal Code section 182, is limited to conspiracies to violate only crimes created by California law. (*People v. Zacarias* (2007) 157 Cal.App.4th 652.)

SECTION SEVEN - ANALYSIS OF POTENTIAL FRAUD-RELATED CHARGES

This section outlines the legal principles, evidence, and analysis of potential fraud-related and theft-related charges as it pertains to Dr. Smith's employment obligations to the County of Ventura.

Applicable Laws

Time Reporting

As a doctor receiving an annual salary, Dr. Smith was not subject to some requirements applicable to hourly employees. Federal law classifies salaried physicians as "learned professionals" who are exempt from the maximum hour and overtime provisions of the Fair Labor Standards Act. (29 USC § 213(a)(1); 29 CFR § 541.304.) However, such exempt employees can be required to deduct time they are not working from their leave banks. (*Conley v. Pacific Gas and Elec. Co.* (2005) 131 Cal.App.4th 260; *People v. Groat* (1993) 19 Cal.App.4th 1228, 1235.)

Dr. Smith's employment with the County of Ventura was governed by the Management, Confidential Clerical and Other Unrepresented Employees Resolution ("Management Resolution"), and the Ventura County Personnel Rules and Regulations (PRR). The normal biweekly pay period is 80 hours. (Management Resolution, section 801.) An agency/ department head may, following approval of the County Executive Officer, assign an employee to a different schedule. (Management Resolution, section 802.)

Outside employment is prohibited "where there exists a conflict of interest or where such employment would impair an employee's ability to perform his County duties." (PRR, section 1901.) PRR, section 1904, provides:

> A written notification must be given to the department/agency head for all regular outside employment and for all occasional outside employment in excess of eight hours in any one week. Failure to provide such information may be a cause for disciplinary action. An outside work statement must contain the name of the employer, the hours to be worked and the nature and duration of the employment.

To implement Article 19 of the Ventura County Rules and Regulations, the County utilizes an Outside Employment Approval Request form.

False Claims, Penal Code Section 72

Penal Code section 72 provides:

> Every person who, with intent to defraud, presents for . . . payment to any . . . county . . . authorized to allow or pay the same if genuine, any false or fraudulent claim, bill, account, voucher, or writing, is punishable either by imprisonment in the county jail for a period of not more than one year, by a fine of not exceeding one thousand dollars ($1,000), or by both that imprisonment and fine, or by imprisonment pursuant to subdivision (h) of Section 1170, by a fine of not exceeding ten thousand dollars ($10,000), or by both such imprisonment and fine.

This section is violated when an employee submits a false claim for payment for services. Dr. Smith frequently requested time off from VCME when performing services in other counties, and Mr. Fisher clearly authorized him to flex his hours, stating that "if he worked 70 hours in a given week I would expect that employee to adjust his or her schedule to reduce his or her work hours the following week." Based on these principles and analysis of

payroll and other records, there is simply no way to prove that Dr. Smith was paid by the County of Ventura for hours which he spent working for other counties or agencies.

Misappropriation of Public Moneys, Penal Code Section 424

Penal Code section 424 provides in relevant part:

> (a) Each officer of . . . any county, . . . and every other person charged with the receipt, safekeeping, transfer, or disbursement of public moneys, who either:
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> 1. Without authority of law, appropriates the same, or any portion thereof, to his or her own use, or to the use of another; or,
>
> . . . .
>
> 3. Knowingly keeps any false account, or makes any false entry or erasure in any account of or relating to the same; or,
>
> 4. Fraudulently alters, falsifies, conceals, destroys, or obliterates any account;
>
> . . . .
>
> Is punishable by imprisonment in the state prison for two, three, or four years, and is disqualified from holding any office in this state.

These provisions would be applicable to the medical examiner as a county "officer." County officers include the coroner. (Government Code section 24000, subdivision (m).) Because a medical examiner exercises the same powers and performs the same duties as a coroner, the medical examiner would be a county officer as well. (See Government Code section 24010; 93 Ops. Cal. Atty. Gen. 78, fn. 1 (2010).)

The medical examiner also meets the general definition of an officer. "The most general characteristic of a public officer, which distinguishes him from a mere employee, is that a public duty is delegated and entrusted to him, as agent, the performance of which is an exercise of a part of the governmental functions of the particular political unit for which he, as agent, is acting," and has "a tenure of office 'which is not transient, occasional or incidental,' but is of such a nature that the office itself is an entity in which incumbents

succeed one another . . ." (*People v. Rosales* (2005) 129 Cal.App.4th 81, 86.) A medical examiner exercises statutory duties and meets the definition of public officer.[12]

For violation of unauthorized appropriation of public funds in violation of section 424, subdivision (a)(1), the prosecution must prove that the defendant knew the conduct was unlawful, or was criminally negligent in failing to know the legal requirements. (*Stark v. Superior Court* (2011) 52 Cal.4th 368, 399.) For violation of knowingly keeping a false account in violation of subdivision (a)(3), it is not necessary to show that the defendant knew or should have known the conduct was unlawful; it sufficient that the defendant knew that the entries were false. (*Stark, supra,* at pp. 403–404; *People v. Aldana* (2012) 206 Cal.App.4th 1247, 1255.) Fraudulent falsification of an account under subdivision (a)(3) would require an intent to deceive. (See Civil Code section 1572.)

However, the false statement must be *material*, meaning that the public entity paid, or was at risk of paying, the person more than they earned. (*People v. Aldana, supra,* at pp. 1256-1257.) "This conclusion is consistent with the purpose of section 424 – to protect the public purse. . . . A conviction for authorizing a timesheet that is technically false, although the falsity is not material and does not negatively affect the public purse, would not further the statute's purpose and intention." (*Id.* at p. 1257.) So if, as in *Aldana*, the total work hours reported do not exceed the number of hours actually worked for that pay period, there is no material misrepresentation, even if entries for specific days are not correct. As discussed below, the evidence does not establish any material misrepresentations of the time worked by Dr. Smith.

Dr. Smith's County of Ventura Employment

Dr. Smith became the Assistant Chief Medical Examiner for the County of Ventura on June 12, 2011. On February 14, 2012, the Board of Supervisors appointed Dr. Smith as the Chief Medical Examiner effective upon the retirement of Dr. Ron O'Halloran in June 2012.

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[12] Because the medical examiner is a county officer, it is not significant that Dr. Smith would not fall within the other group of employees who are subject to section 424, "other person[s] charged with the receipt, safekeeping, transfer, or disbursement of public moneys." Certification of a time sheet constitutes disbursement of funds, and a public employee who has authority to certify his own time sheet can be liable under section 424. (People v. Groat (1993) 19 Cal.App.4th 1228, 1233-1234.) However, an employee is not charged with disbursement of public money under section 424 if he merely submits his own timesheet for approval by another person. (People v. Aldana (2012) 206 Cal.App.4th 1247, 1254.) Dr. Smith did not approve his own time card, but submitted it to Mr. Fisher for approval.

Dr. Smith's position as the head of the VCME was a full-time position earning a biweekly salary of $8,594.54. On June 18, 2013, the Ventura County Board of Supervisors approved a 10 percent increase in salary for the positions of chief medical examiner and assistant chief medical examiner. The recommendation to the Board of Supervisors cited difficulty in recruiting qualified candidates as the reason for the need to increase the salaries—specifically an inability to fill the position of assistant chief medical examiner. Thereafter, due to the inability to fill the position of assistant chief medical examiner, Dr. Ann Bucholtz was hired to provide forensic pathology services on a contract basis where she was paid a specific amount for each postmortem examination she performed. Dr. Smith and the VCME falls under the supervision and chain of command of the Ventura County Health Care Agency.

Supervision of Medical Examiner

Barry Fisher, the Ventura County Health Care Agency Director, oversees and supervises all health care department heads in the County of Ventura including the heads of the Ventura County Medical Center, Santa Paula Hospital, Ventura County Health Care Plan, Department of Public Health, Department of Behavioral Health, and VCME. In this capacity, Mr. Fisher provides support, and approves time-off requests and outside employment requests for each of the directors of the individual health care departments.

In an interview with district attorney investigators on June 23, 2015, Mr. Fisher explained that all department directors are employed as salaried employees. Mr. Fisher expects that as salaried employees they will manage their schedules appropriately. As an example, Mr. Fisher explained that if a director works 70 hours in a given week, Mr. Fisher would expect that employee to adjust his or her schedule to reduce his or her work hours the following week. Mr. Fisher would, however, be concerned if the employee was putting in fewer than 40 hours a week on a regular basis. When asked specifically about Dr. Smith, Mr. Fisher explained that if Dr. Smith were out of the area but available by telephone, Mr. Fisher would consider that working time – especially if Dr. Smith obtained prior approval.

Santa Barbara County High-Risk Autopsies

On May 20, 2014, the Board of Supervisors approved authorization for Ventura County Health Care Agency Director Barry R. Fisher, or his designee, to sign a contract with the County of Santa Barbara for high-risk autopsies to be performed by the County of Ventura Medical Examiner's Office. In that contract – effective from June 1, 2014, through June 1, 2015 – the VCME would perform high-risk autopsies for the County of Santa Barbara, which were defined as a "postmortem examination of a decedent who had, or is likely to have had,

a serious infectious disease that can be transmitted to those present at the autopsy thereby causing them serious illness and/or premature death." In exchange for completing these autopsies, the County of Santa Barbara would reimburse the County of Ventura $3,500 for each autopsy. The contract projected two high-risk autopsies per year. VCME had been handling Santa Barbara County's high-risk autopsies informally since the early 1990s.

Dr. Smith's Contract with Santa Barbara County

In addition to the contract for high-risk autopsies, Dr. Smith also signed a contract with the County of Santa Barbara – effective July 1, 2014, through June 30, 2015 – to perform all forensic pathologist services requested by the County of Santa Barbara. Dr. Smith signed the agreement as an independent contractor who was paid per service. The fee scale included (among ancillary fees/costs) fees of $2,500 per full autopsy, $1,250 per partial autopsy, and $625 per external examination. The contract included a clause that payments to Dr. Smith under this contract period were not to exceed $308,000. There is no record that this contract was submitted to or separately approved by the Ventura County Board of Supervisors.

Mr. Fisher confirmed that outside employment in Santa Barbara County performed by Ventura County's chief medical examiner would not require approval from the County Board of Supervisors. Instead, Mr. Fisher's approval would suffice.

On October 22, 2014, over three months after the contract began, Dr. Smith submitted an Outside Employment Approval Request form to perform "postmortem examinations (autopsies)" for the Santa Barbara Sheriff-Coroner "on a temporary per diem basis until a new forensic pathologist is hired in Santa Barbara County." He listed the hours of employment as approximately 4 hours per week, with an expected duration of 6 to 12 months. Mr. Fisher acknowledged that he approved the request on October 22, 2014. Mr. Fisher was aware that Dr. Smith would be performing *all* medical examiner services for Santa Barbara County, rather than only those services limited to high-risk autopsies. Although not specifically addressed in the request form, Mr. Fisher said that his understanding of the request was that the time Dr. Smith spent working in Santa Barbara would be over and above the 40 hours per week that Dr. Smith worked for Ventura County.

Mr. Fisher explained that if Dr. Smith was working anywhere between four to eight hours per week in Santa Barbara, he would not be concerned. If Dr. Smith was working eight or more hours per week on the weekends, Mr. Fisher indicated, "That would be fine." Ventura County Counsel Leroy Smith has confirmed that a county employee may have regular recurring outside employment greater than eight hours per week with approval from the department head – in this case, Mr. Fisher.

On May 19, 2015, the Santa Barbara County Board of Supervisors approved a contract extension for pathology services by Dr. Smith for the period from July 1, 2015, through June 30, 2018. The agreement included the same terms and fee scale as the previous contract; however, the limit was not to exceed $870,000 over the three-year life of the contract. There is no indication that Dr. Smith submitted an Outside Employment Approval Request form for this contract extension, or that it was ever submitted to the Ventura County Board of Supervisors for approval.

Unlike his predecessor, Dr. Smith generally performed autopsies in Ventura County only on Monday, Wednesday, or Friday. He performed autopsies in Santa Barbara County on Tuesday or Thursday. Ventura County autopsies that were likely to require court testimony were generally assigned to Dr. Bucholtz.

Table 1 illustrates the number of postmortem examinations Dr. Smith is believed to have performed in Santa Barbara County from 2011-2014. Full autopsies are denoted with an *F*, partial autopsies are denoted with a *P*, and external examinations are denoted with an *E*. The total number of examinations performed in a given year are noted in the 'Total' column.

Table 1 – Number of Santa Barbara County Postmortem Examinations

		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
2011	F											2		2
	P													
	E													
2012	F					2	2	4		2	3		1	14
	P													
	E													
2013	F							6			7		4	17
	P													
	E													
2014	F		3		3	4		8	12	5	8	3	12	58
	P							2	3		3		1	9
	E							3		1	1			5
2015	F	11	9	9	11	2	10							52
	P	3	4	2			1							10
	E	2	1											3

Dr. Smith took vacation days off in Ventura County when completing some of the above examinations. He took vacation days for 6 of the autopsies in 2012, 4 of the autopsies in 2013, and 5 of the autopsies in 2014. We have not identified any vacation days taken by Dr. Smith in Ventura County for any of the Santa Barbara autopsies in 2011 or 2015.

Dr. Smith's Contract with Monterey County

Dr. Smith signed an agreement with the County of Monterey to perform forensic pathologic postmortem examinations on a contract basis starting on July 1, 2011. Initially, Dr. Smith's agreement with the County of Monterey was for a one-year period, set to expire on June 30, 2012. However, on June 28, 2012, Dr. Smith signed an amended agreement that extended the contract through June 30, 2013. There is no evidence that Dr. Smith submitted an Outside Employment Request for his employment in Monterey County.

Dr. Smith performed postmortem examination services for the County of Monterey in accordance with his agreement three times in 2011, and twelve times in 2012. Dr. Smith requested and was approved for a leave of absence each time he performed services in Monterey County.

Dr. Smith's Employment with Regional Pathology and Autopsy Services

Dr. Smith has worked in a consulting capacity with a private autopsy company, Regional Pathology and Autopsy Services, since 2010. Dr. Smith stated that his work with Regional Pathology and Autopsy Services consisted of reviewing data and photos collected by pathology assistants during death investigations. Dr. Smith denied ever performing an autopsy for Regional Pathology and Autopsy Services.

There is no evidence that Dr. Smith submitted an Outside Employment Request for his employment with Regional Pathology and Autopsy Services. During his interview with investigators, Mr. Fisher acknowledged that he was aware Dr. Smith "was doing some sort of work" for Regional Pathology and Autopsy Services. Mr. Fisher understood Dr. Smith's work to be in an advisory capacity, and Mr. Fisher recalled believing that Dr. Smith's position with Regional Pathology and Autopsy Services was an unpaid position.

Since he began working with Regional Pathology and Autopsy Services in 2010, Dr. Smith has reviewed approximately 100 cases per year for the company. Regional Pathology and Autopsy Services pays Dr. Smith $650 per case that he reviews.

Breakdown of Hours Dr. Smith Spent Working Outside Employment

County of Santa Barbara

The fee schedules for both Dr. Smith in Santa Barbara, and Dr. Bucholtz in Ventura, are scaled to indicate the length of time a particular postmortem examination takes. For

example, full autopsies are paid the highest for both contracts, followed by partial autopsies, and finally external examinations. In his interview with investigators, Dr. Smith estimated that a full autopsy takes between 1 and 1.5 hours to complete, not including the time it takes to prepare the report.[13] We can assume that a partial autopsy would be slightly shorter – perhaps 30 to 60 minutes, and an external examination would be the shortest – perhaps 15 to 30 minutes.

The Santa Barbara County Sheriff-Coroner's Office maintained records that indicate every postmortem examination that Dr. Smith performed for Santa Barbara County, and additionally at what time he began the given examination. By reviewing the times that Dr. Smith started successive examinations, we were able to estimate how long particular examinations took. The records are consistent with Dr. Smith's 1 to 1.5 hour estimate for a full autopsy, and also corroborate the logical, fee-schedule based estimates of partial autopsies and external examinations. Using these figures, we estimated the time Dr. Smith spent (in hours) each month performing autopsies in Santa Barbara County. (See Table 2).

Table 2 – Estimated Hours Spent Working in Santa Barbara County

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total*
2011											2 - 3		2 - 3
2012					2 - 3	2 - 3	4 - 6		2 - 3	3 - 4.5		1-1.5	8 - 12
2013							6 - 9			7 - 10.5		4-6	13 - 19.5
2014		3 - 4.5		3 - 4.5	4 - 6		9.75- 15.5	13.5- 21	5.25- 8	9.75- 15.5	3- 4.5	12.5- 19	58.75 - 91
2015	13 - 20.5	11.25 - 18	10 - 15.5	11 - 16.5	2 - 3	10.5- 16							47.75 -74.5

* Total does not include autopsies performed on scheduled day off.

These data suggest that Dr. Smith spent between 2 to 3 hours on forensic exams in Santa Barbara County for the entire year of 2011; between 8 and 12 hours in 2012; between 13 and 19.5 hours in 2013; between 58.75 and 91 hours in 2014; and between 47.75 and 74.5 hours in the first six months of 2015. By dividing the total number of yearly hours by 52 weeks, we can break down the weekly averages, not including report-writing. The evidence is that

[13] It should be noted that the estimated time contained in Table 2 denotes the actual time spent conducting the forensic examination of the body. It does not include the time it takes to draft, review, and sign the actual "Autopsy Report." An autopsy report prepared in homicide, suicide, manslaughter, and other criminal cases are typically extensive, presumably requiring several additional hours of work. Since actual time spent preparing the reports is not tracked, it is not included in this report.

Dr. Smith spent less than 1 hour per week completing postmortem examinations in Santa Barbara from 2011 to 2013, between 1.1 and 1.75 hours per week in 2014, and between 1.8 and 2.9 hours per week for the first six months of 2015. All these figures are substantially less than the 4 hours that Mr. Fisher approved.

The largest figure appears to be August 2014,[14] when Dr. Smith spent between 13.5 and 21 hours performing services for Santa Barbara County.[15] Assuming that Dr. Smith spent the longer estimate of 1.5 hours on every examination he performed that month, he could have spent 4.88 hours per week. While that number exceeds four hours per week, it remains within an approximation of 4 hours. Additionally, Mr. Fisher indicated that he would only be concerned if Dr. Smith was spending more than 8 hours per week in Santa Barbara.

These figures do not include the time needed to write autopsy reports. This investigation was unable to determine when Dr. Smith prepared the reports of medical procedures conducted in Santa Barbara County, where the reports were prepared, or whether the reports were prepared on his own time or during the time he was working for Ventura County.

County of Monterey

Dr. Smith performed 15 postmortem examinations over five days for the County of Monterey between 2011 and 2012. However, the evidence establishes that Dr. Smith took a leave of absence from the County of Ventura for those procedures.

Although Mr. Fisher did not approve an outside employment request for Monterey County, Dr. Smith was never paid by Ventura County for any of the hours that he spent working in Monterey County. Therefore, no criminal theft or fraudulent misrepresentation liability can be proven from Dr. Smith's conduct as it relates to work for Monterey County.

Regional Pathology and Autopsy Services

There is no evidence to establish that Dr. Smith was neglecting his duties in Ventura County to perform services for Regional Pathology and Autopsy Services. Dr. Smith denied ever performing an autopsy for Regional Pathology and Autopsy Services, indicating that his role with the company was simply to review documents and photographs in order to determine a cause of death. It is safe to assume that because Dr. Smith was not physically examining

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[14] August 2014 was an unusual month in that Nicholas Holzer committed a multiple homicide brutally murdering both of his parents and his two children in his parents' home.

[15] It should be noted that Smith began one full autopsy (14-12201) at 6:00 p.m. – after regular business hours – on August 21, 2014. He also began performing one full homicide autopsy (14-11778) at 4:30 p.m. on August 14, and he also began performing one partial autopsy (14-11731) at 4:30 p.m. on August 12.

bodies, the time for a review would be substantially shorter than for a full autopsy. Whether or not Dr. Smith was falsifying autopsy reports by inferring that he had personally conducted the autopsy is outside the jurisdiction of this office.

If we estimate that Dr. Smith spent one hour on each case that he reviewed for Regional Pathology and Autopsy Services, the total time spent annually would amount to approximately 100 hours or an average of 1.92 hours per week. Even if we add that to the estimated number of hours Dr. Smith spent working in Santa Barbara County, it still could not be proven that it exceeded the time authorized by Mr. Fisher.

Evaluation and Conclusion

Proof of any theft-based charges resulting from employment hours for which Dr. Smith was paid but did not actually work will be a two-step process. First, we must establish that Dr. Smith was engaging in some other activity at a time when Ventura County was paying him to provide services to the people of Ventura County. Second, we will have to disprove that Dr. Smith compensated for this time by working for Ventura County during off-peak hours.

We can prove that Dr. Smith was engaging in work outside of Ventura County for some number of hours on some weeks. However, for some weeks district attorney investigators were unable to find any witnesses who could provide reliable information as to the hours Dr. Smith was actually present in the office. Nor could they find any security cards, time clocks, or any other instrument that could give us detailed information to definitively prove Dr. Smith's comings and goings. Ultimately, there is no way to pinpoint exactly how many hours Dr. Smith spent in the office or working on Ventura County cases in a given week.

In summary, the evidence does not establish that Dr. Smith misrepresented his hours or was paid for time he did not work. Accordingly, the evidence does not support charges of false claims or misappropriation of public funds.

SECTION EIGHT - ANALYSIS OF POTENTIAL CHARGES RELATED TO STATEMENT OF ECONOMIC INTERESTS

This section addresses whether Dr. Smith violated the law by failing to report outside income as required by the County of Ventura Health Care Agency's Conflict of Interest Code.

The California Political Reform Act provides two categories of public employees who are required to file an annual Statement of Economic Interests (Fair Political Practices Commission, Form 700). Government Code section 87200 lists specific officials including elected state officers, judges, county supervisors, district attorneys, city council members, etc. A coroner or medical examiner is not included in this list.

The second category of mandated reporters, referred to as "code reporters," consists of those positions listed in local agencies' conflict of interest codes "which involve the making or participation in the making of decisions which may foreseeably have a material effect on any financial interest and for each such enumerated position, the specific types of investments, business positions, interests in real property, and sources of income which are reportable." (Government Code section 87302.) The County of Ventura Health Care Agency's Conflict of Interest Code designates the chief medical examiner as a mandated reporter.

Employees in different positions are required to report different categories of income and/or investments. In the 2012 Ventura County Health Care Agency Conflict of Interest Code, based upon title 2, section 18730 of the California Code of Regulations, the position of Chief Medical Examiner was charged with disclosing potential conflicts of interest from categories 2-7.

On December 2, 2014 the Board of Supervisors approved modification of the Conflict of Interest Code for the Health Care Agency. Among other amendments, it placed the chief medical examiner in the broadest disclosure category, disclosure category 1, which includes disclosure "all sources of income."

It is not necessary to report salary, reimbursement for expenses or per diem, or other similar benefit payments received from a federal, state, or local government agency. (Fair Political Practices Commission, Form 700 Statement of Economic Interests Reference Pamphlet, available at http://www.fppc.ca.gov/Form700.html) Accordingly, even after the Conflict of Interest Code was amended, Dr. Smith was not required to report on his Form 700 income received from the County of Santa Barbara.

According to Chief Deputy Clerk of the Board Brian Palmer, the Board itself does not notify individuals what categories they have to report. Instead, the Board leaves that notification up to the individual agencies. According to Mr. Fisher's assistant, the Health Care Agency

ceased notifying department heads of their disclosure requirements beginning in 2014. In sum, there is no evidence that Dr. Smith was notified, or aware, that his disclosure requirements had changed.

In each of the statements from 2012, 2013, and 2014, Dr. Smith checked the box indicating that he had "No reportable interests on any schedule." Given his disclosure category at that time, his Form 700 statements were accurate regardless of income from other sources. After the Board of Supervisors approved the 2014 revision, Dr. Smith's reportable disclosures changed. His 2015 Form 700 should have included income that he earned through Regional Pathology and Autopsy Services. Instead, he filed his statement by checking the same box that he had checked the previous three years: "No reportable interests on any schedule." This was no longer accurate.

The Political Reform Act provides a criminal penalty that applies to noncompliance with filing a Statement of Economic Interests. Government Code section 91000, subdivision (a), states, "Any person who **knowingly or willfully** violates any provision of this title is guilty of a misdemeanor." (Emphasis added.)[16] Without evidence to establish that Dr. Smith knew his disclosure requirements had changed, it cannot be proven that Dr. Smith knowingly or willfully violated the reporting requirements.

Nor may he be prosecuted for perjury. The Form 700 is signed under penalty of perjury with the statement that "to the best of my knowledge the information contained herein and in any attached schedules is true and complete." Penal Code section 126 provides, "Every person who, being required by law to make any return, statement, or report, under oath, **willfully** makes and delivers any such return, statement, or report, purporting to be under oath, **knowing the same to be false** in any particular, is guilty of perjury, whether such oath was in fact taken or not." (Emphasis added.) Without any evidence to establish that Dr. Smith knew his disclosure requirements had changed and he was required to report his additional employment in his current Form 700, it cannot be established that he *willfully* swore to a statement he *knew to be false*.

[16] In addition, the Fair Political Practices Commission may assess an administrative penalty. (Government Code section 83116.5.)

CONCLUSION

Families of the deceased and the general public have a right to expect that postmortem procedures be conducted by trained, qualified individuals. Medical conclusions should be made by medical professionals based on a thorough examination of the body and necessary laboratory tests, and autopsy reports should clearly and accurately describe the examination.

During the investigation of this matter, we have learned that there are no legal standards, and no clear consensus among experts, as to what constitutes an autopsy, who may perform an autopsy, and whether conducting an autopsy is the practice of medicine. Because the law is unclear as to what is or is not permitted, it is impossible to assess criminal liability for the practices described in this report.

We recommend that the California Legislature hold hearings to clarify the legal standards in this area. We do not make a unilateral recommendation as to the specific statutory language that should be enacted. Due to the complexity of law in this area and the different professionals and entities that may be affected, the Legislature should seek input from stakeholders including coroners, sheriff-coroners, medical examiners, prosecutors, and professional organizations such as NAME and medical associations. The Legislature should consider amending Business and Professions Code section 2052 to clarify whether conducting an autopsy is the practice of medicine, and amending Health and Safety Code section 7114 to define the term "autopsy," and to specifically address whether it includes collection of samples from internal organs.

It is clear that Dr. Smith spent significant amounts of time working for entities outside his primary responsibilities as the full-time Chief Medical Examiner and derived significant financial benefits from this work. It cannot be established whether these activities interfered with his ability to perform his duties as Chief Medical Examiner for Ventura County. In approving outside employment by county employees, managers must carefully consider whether it will impact their county service. It is also important that those employees required to submit a Statement of Economic Interests be knowledgeable as to their reporting categories and responsibilities.

Since the events discussed in this report, beginning on June 23, 2015, the Ventura County Medical Examiner's Office has adopted a number of changes to policy and practices, including but not limited to the following:

- Only a board certified forensic pathologist MD will determine if an examination is warranted and what type of examination is warranted.
- Only a board certified forensic pathologist MD will determine the cause and manner of death, and sign the death certificate.

- Forensic pathologists will follow NAME Performance Autopsy Performance Standards.
- Quarterly audits including MD peer review are being implemented.
- Investigators will be required to be certified by the American Board of Medicolegal Death Investigators.

Beyond these changes, the Medical Examiner's Office has taken steps to become NAME accredited.

The District Attorney's Office believes these are positive steps that will enhance the professionalism provided by the Medical Examiner's Office to Ventura County citizens.