State of Florida
Medical Examiners Commission

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August 7, 2015

MEMORANDUM

To: Stephen Nelson, M.A., M.D., F.C.A.P.
Chairman, Medical Examiners Commission

From: **PROBABLE CAUSE PANEL:**
Bruce A. Hyma, M.D.
Mr. Ken Jones
Ms. Robin Giddens Sheppard, L.F.D.

Subject: Report of the Panel – Complaint against District 18 Medical Examiner's Office

In December 2014 the family of Mr. John McDonough filed a formal complaint against District 18 Medical Examiner Sajid S. Qaiser, M.D. The complaint alleged that Dr. Qaiser failed to perform an appropriate review of the medical information presented at the time of their father's death, and that he conducted an incomplete investigation into the cause and manner of death. Dr. Qaiser determined that Mr. John McDonough died due to chronic myelogenous leukemia and contributed a left humeral fracture, coronary artery disease and atrial fibrillation, and ruled the manner of death an accident.

The complaint further alleged that a potential overdose of morphine by Mr. McDonough's current wife and her children were responsible for Mr. McDonough's death while he was in hospice care. The Brevard County Sheriff's Office investigated the circumstances and found no criminal intent regarding Mr. McDonough's death.

Staff thoroughly reviewed the information in the complaint, as well as all case documents provided by the District 18 Medical Examiner's Office. It should be noted that the District 18 office had disposed of the medical records; however, they obtained copies at staff's request. Lacking in depth medical knowledge regarding the levels of morphine presented in the toxicology findings, staff requested that a probable cause panel be convened to determine if Dr. Qaiser's decisions in the case were sound and well-founded.

Probable Cause Findings

In response to your memorandum of April 14, 2015, the Probable Cause Panel convened on May 4, 2015 at the Plaza Hotel in Daytona Beach. All assigned panel members were present: Dr. Bruce Hyma, Mr. Ken Jones and Ms. Robin Giddens Sheppard. Also in attendance was Bruce Goldberger, Ph.D. as an ex-officio member of the panel, as well as Commission staff members Vickie Koenig, Doug Culbertson, Kipp Heisterman, Jim Martin, and Director Dean Register.

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Staff had already emailed the panel members the files containing their findings and the reference materials upon which they based their conclusions.

The first order of business was the election of a chairman, which Dr. Hyma accepted. Next the panel reviewed the statutory reference which established the panel as well as the procedures the panel and Medical Examiners Commission will follow in these proceedings. Staff then reviewed the reference material previously forwarded to the panel members.

The panel discussed the complaint in detail. During the course of the discussion, the panel determined that Dr. Qaiser accepted jurisdiction of a hospice case due to the allegations made by the decedent's children regarding the circumstances surrounding his death; however he did not perform an autopsy, he was careless in his review of medical records, and he was not willing to quantify the toxicology results unless the family paid for the quantification.

With Dr. Goldberger's assistance the panel determined that the morphine concentration levels were typical for a hospice patient receiving 20mg every hour, and that opiate naivety was irrelevant. These morphine levels are necessary as part of hospice's comfort care during the decedent's end-of-life care for renal failure.

The panel felt that since the jurisdiction of a hospice case was accepted, and allegations of potential foul play had been made, Dr. Qaiser should have performed a more thorough investigation, and that an autopsy should have been performed. As a result the panel unanimously found *probable cause* that:

1. Dr. Qaiser violated § 406.075(1)(i), F.S., which states in part "Negligence or the failure to perform the duties required of a medical examiner with that level of care or skill which is recognized by reasonably prudent medical examiners as being acceptable under similar conditions and circumstances"; and

2. Dr. Qaiser violated Rule 11G-2.003(5)(b), F.A.C. which states "Absent good cause, an autopsy shall be performed when a reasonable suspicion exists that the death is by accident, suicide, or poison, unless the death is by poison and the deceased has survived in a hospital for a time sufficient to metabolize the poison; or the death is by accident or suicide and the cause of death can be determined from a review of the circumstances, history, and available medical records.

The basis for the finding of probable cause is directly related to:

1. Dr. Qaiser did not perform an autopsy on the decedent.

2. Dr. Qaiser refused to quantify the toxicology results until the family had agreed to pay the expense associated with the quantification.

3. Dr. Qaiser failed to accurately determine the cause of death. He had no gross findings because an autopsy was not performed. The medical records were not thoroughly reviewed because there is documentation that Mr. McDonough did not have chronic myelogenous leukemia (CML) but rather had chronic myelomonocytic leukemia (CMML), which is a dysplastic, but benign, bone marrow condition and not the cause of death.

The panel further directed staff to conduct an additional administrative investigation at the District 18 Medical Examiner's Office in order to determine if these oversights indicated a pattern, or if it was an isolated incident. The panel requested that staff review all of the 2014 cases that consisted of visual inspections in order to determine if Dr. Qaiser's lack of performance in the McDonough case was an isolated incident or part of a performance deficiency effecting other investigations.

Staff Review of District 18 2014 Cases

Staff notified the District 18 Medical Examiner's Office of the administrative investigation May 15th and asked that they arrange to have the files available for review upon arrival. The administrative investigation was conducted on May 20-21, 2015.

There were 303 cases involving inspections, including the McDonough case. Pursuant to state retention guidelines, medical records only need to be retained until obsolete. District 18 advised that not all the medical records are kept, but they would obtain any medical records needed upon request. Staff review indicated that most of the case files contained the salient medical records to support the conclusion and findings for the cause and manner of death. A practice of doing toxicology on inspection cases was not identified. Eleven cases were identified for review (see below). Staff noted that beginning in November 2014, District 18 included a new form, Toxicology Collection Sheet, in all case files regardless of whether toxicological results were obtained.

The District 18 Medical Examiner's Office consistently reports the manner of death as "accident" if the decedent experienced some type of trauma prior to death. This includes elderly decedents who may have fallen, broken a bone, and never fully recovered due to other medical conditions, and those who may have lingered in hospital or hospice care for some time prior to death.

Staff copied the following eleven inspection cases for the Probable Cause Panel's review.

Case Number	Decedent's Name	Date of Death	Manner of Death
E-14-216	Regina White	4/18/2014	Suicide
E-14-224	Shelia Carnley	4/21/2014	Suicide
E-14-451	Loria Lewis	7/21/2014	Accident
E-14-454	James Barbree	8/7/2014	Accident
E-14-488	Keia Knight	8/22/2014	Natural
E-14-489	Gene Prospero	8/23/2014	Accident
E-14-555	Michael Moloney	9/20/22014	Natural
E-14-585	Kelly Maldonado	10/2/2014	Accident
E-14-595	Joseph Dunham	10/6/2014 (found)	Natural
E-14-701	Robert Knight	11/24/2014	Natural
E-14-711	Danielle Remaley	12/1/2014	Natural

Probable Cause Panel Review of Additional Cases

On July 31, 2015, the Probable Cause Panel reconvened at the Department of Health in Jacksonville, Florida to discuss the additional cases presented by staff. Mr. Ken Jones and Ms. Robin Giddens Sheppard were present, and Dr. Bruce Hyma and Bruce Goldberger, Ph.D. attended via teleconference. Staff members present were Vickie Koenig, Doug Culbertson, and Kipp Heisterman.

- Case #216 – Regina White: Her death was delayed 7 weeks after alleged drug ingestion. No medical records were in the case file and no data to indicate toxicology testing that would support the opinion of cause and/or manner of death.
- Case #224 – Shelia Carnley: No medical records and no hospital toxicology report were in the case file. This was a 15-day delayed death due to [redacted]
- Case #451 – Loria Lewis: The decedent died hours after admission. The case file contained no medical records and no toxicology report from the hospital. Cause of death was most likely [redacted] however, no autopsy was performed. Admission blood was not requested.
- Case #454 – James Barbree: The case file contained no medical records or hospital toxicology report to support the conclusions. This was a 10-day delayed death due to a [redacted] as contributing causes.
- Case #488 – Keia Knight: The case file contained no medical records. The panel determined that this would not normally be a medical examiner case if there are medical records to support the cause and manner of death.
- Case #489 – Gene Prospero: Mr. Prospero died less than 72 hours after collapsing at a bus stop. His core body temperature was 109' Fahrenheit. The case file contained no medical records, no toxicology report, no police report, and no autopsy was performed. The panel felt that this case fell below the standard of care.
- Case #555 – Michael Moloney: The decedent had a history of prescription drug abuse and had recently talked of suicide. He was found unresponsive in his bedroom by his roommates. The case file contained no toxicology report, and an autopsy was not performed. The cause of death was [redacted] as contributing causes.
- Case #585 – Kelly Maldonado: A 3-day delayed death. The decedent was found submerged in the bathtub after huffing "Dust Off." The case file contained no medical records and no hospital toxicology report to support the diagnosis.
- Case #595 – Joseph Dunham: The decedent was found dead at home and had a history of ethanol abuse. Drugs were found at the scene of the death; however, the case file did not have a toxicology report, police report or medical records. An autopsy was not done and the cause of death was [redacted]

- Case #701 – Robert Knight: The decedent was found dead at home with [redacted] The case file did not have medical records to support the diagnosis and no autopsy was performed. Cause of death was [redacted] as a contributing cause.

- Case #711 – Danielle Remaley: The cause of death is [redacted] Medical records are in the file supporting this diagnosis. This should not have been a medical examiner case.

The panel determined that the District 18 Medical Examiner's Office should not have taken jurisdiction in two of the cases (488 and 711). The case files were severely lacking in supporting documentation, investigative reports lacked pertinent information and that autopsies should have been performed in several cases. Medical records and police reports must be obtained and retained, especially if they support the cause and manner of death opinion, Additionally, eight of the eleven cases reviewed had "Date and time of *autopsy*" on the cover sheet of the external examination report. The panel found that these cases showed a pattern of substandard work. The panel found probable cause on these cases in addition to the original complaint involving Mr. McDonough.

Upon secondary review of the McDonough case file, it was also noted that the cover sheet of the external examination report reflected "Date and time of *autopsy*" and stated "*Autopsy* Findings" when describing general observations to support conclusions for the cause and manner of death.

Conclusions

The panel found probable cause exists that there was a violation of § 406.075(1)(i), F.S. and Rule 11G-2.003(5)(b), F.A.C., by the District 18 Medical Examiner's Office regarding its investigation of the death of John McDonough, as well as the eleven additional cases reviewed at the July 31, 2015 meeting. The panel felt that the District 18 Medical Examiner's Office needs clear policies and procedures to ensure that this type of violation does not occur again. The Panel further finds that there is no excuse for making a grieving family pay for quantification of toxicology results, and that any new policies created should address that concern.

The panel recommends that Dr. Qaiser be placed on a probationary period of one year, during which time clear policies and procedures should be enacted that guarantee no family should pay for a toxicology quantification, and that any death in which jurisdiction is taken under similar circumstances will have a complete autopsy performed. The recommendation of probation shall include a provision for Commission staff to conduct a review of all case files for all external examination death investigations conducted during the probationary period.

The panel is prepared to discuss this matter and the reasoning behind their conclusions. In the meantime, please contact Dr. Bruce Hyma or staff if you have any questions or if the panel can be of further assistance.

BAH/dc