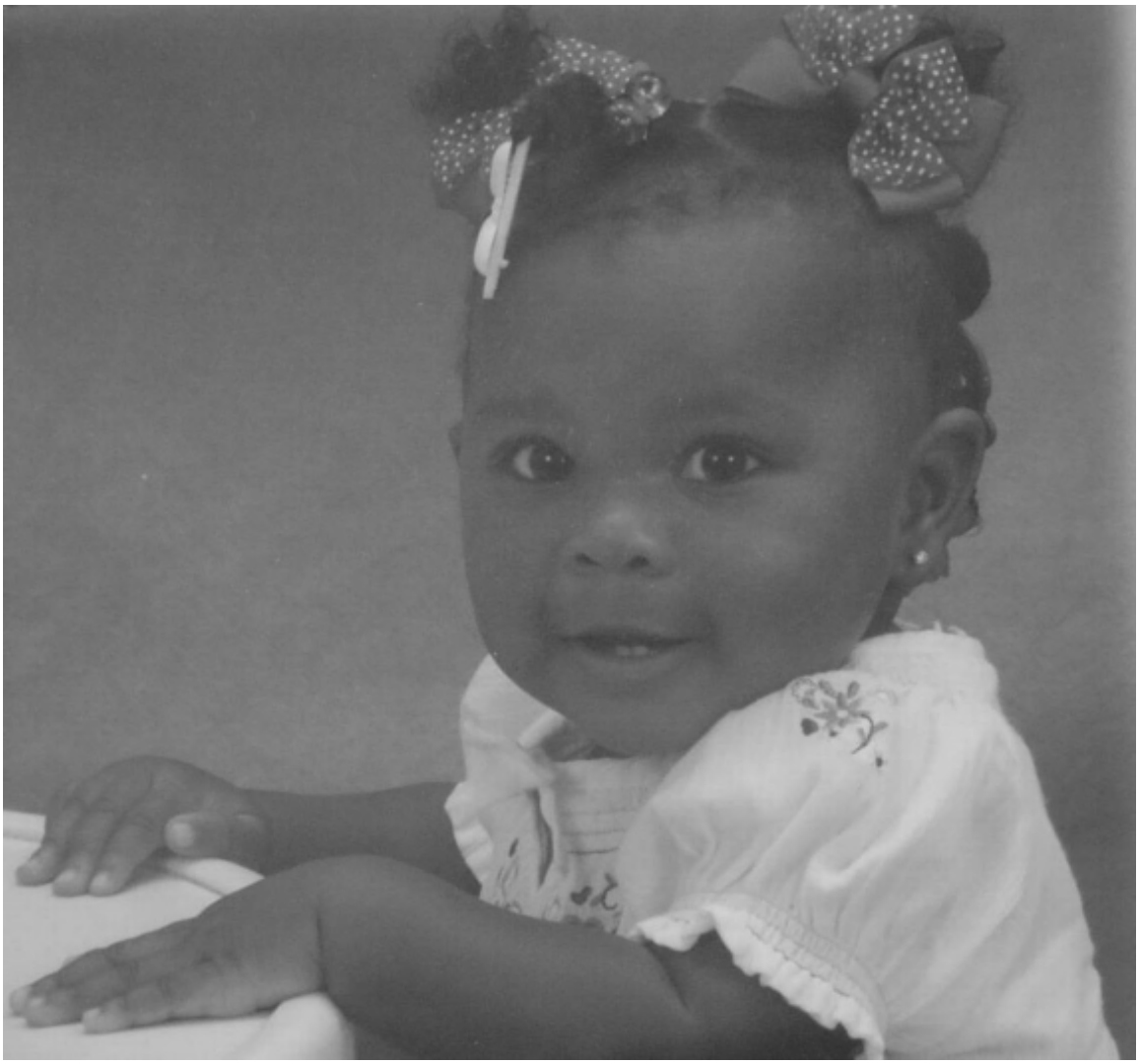

Phaneese Alexander died at 13 months of age.
Family Photo - Family photo

Police and CPS conducted multiple interviews in their investigation, but the case was closed the next month after the investigators and an assistant district attorney met with Dr. Shiping Bao — who had conducted the autopsy — and were informed that the manner of death would be listed as undetermined.

Bao, who initially flagged signs of abuse, told investigators that he now believed Phaneese's liver was damaged by her spinal cord during CPR, but could not determine what caused her fractured ribs.

He said he had confirmed the victim had pneumonia and that he did not believe her injuries alone caused her death.

As such, he ruled the cause of death as "sudden death with seizures, acute hemorrhage in adrenals, broncho-pneumonia and rib fractures" and but left the manner of death as "undetermined."

A year later, Bao would make headlines after leaving Tarrant County to work in Volusia County, Fla., where he conducted the autopsy on Trayvon Martin, a black teen whose shooting death in 2012 sparked outrage. Bao was ultimately fired from his job in Florida, not long after giving conflicting testimony during the trial of George Zimmerman, who was ultimately acquitted of murdering Martin.

'They don't care'

Henz closed the investigation after consulting with the district attorney's office after the meeting.

"In these type of cases, we have to depend on medical experts. Short of a confession, I have to go by what is told to me by medical personnel as to what would have caused this," Henz said.

Still, Henz said the uncertainty behind the girl's death bothered him enough that he kept the little girl's photograph taped to his file cabinet for the remainder of his years working in the CACU.

"She was a beautiful girl and had her whole life in front of her. She did nothing to deserve to die at such a young age," Henz said. "Looking at her picture would help give me the energy to keep working these cases."

CPS determined that someone had physically abused the girl prior to her death, but could not say if it had been the girl's mother or her boyfriend.

"The child's autopsy revealed that the child had sustained injuries consistent with abuse prior to her death, however the investigation was unable to identify who inflicted the non-lethal injuries," the CPS report states. "Both the mother and the mother's paramour served as caretaker for the child."

The mother denied in a recent Facebook exchange that Phaneese was abused.

"They can say the rib fractures were old but that had to be done when CPR was done for more than an hour," the mother insisted.

> **THEY DON'T CARE. SHE'S JUST ANOTHER NUMBER ROLLING ACROSS THE STEEL BED.**
>
> Shirley Williams, grandmother of Phaneese

Williams said she met with police and even later the medical examiner's office, pushing for justice in her granddaughter's case, but received only excuses, with each agency blaming the other.

"They don't care. She's just another number rolling across the steel bed," Williams said.

She said she was told that the different agencies, including the district attorney's office, had discussed the case and decided there was not enough evidence to arrest anybody or take the case any further.

"I never thought anything like that would happen. I know things fall through the cracks, but not on a baby."

Phaneese's mother and her boyfriend broke up after the girl's death.

Two years later, he was living with a new girlfriend in Arlington, when history seemed to repeat itself.

'Your son is dead'

Timothy Nevil had only been involved with his girlfriend for two weeks when he was sentenced to eight months in jail.

While he was away, the girlfriend learned she was pregnant with his child.

But any hopes of their relationship continuing ended when Nevil was released and chose to return to his hometown of New Orleans.

Nevil still wanted to be a part of his son's life, though, and when King Felder turned 3 months old, he returned to North Texas, ready to be a father.

He said his son had a glow about him.

“He used to walk up to me, grab my face and put his finger on my lips every time when I fussed at him,” Nevil said, laughing. “He was so friendly. He always used to smile. He had this sense of humor like no other. It used to light up my world.”

But their frequent visits stopped after Nevil married another woman, which did not set well with King’s mother.

“She tried to hold King from me,” he said.

Timothy Nevil, father of King Felder, said he has long held suspicions regarding his son's death.
Timothy Nevil - Courtesy

The father and son's last visit would be in August 2013, after Nevil's new wife reached out to King's mother through Facebook, pleading with her to let Nevil spend his birthday with his son.

"Everyone was asking me, 'What do you want for your birthday?' I told everyone, 'I want to see my son on my birthday,'" Nevil said.

King's mother agreed, letting Nevil keep the boy for two days. It was a visit that Nevil now thanks God he got to have.

"I know God works in mysterious ways," Nevil said. "It was heavy on my heart to see my son on my birthday."

Less than a month later, on Sept. 2, 2013, Nevil and his wife noticed people

sending prayers to King's mother on Facebook. King's mother called soon after.

"She didn't have no sorrow. She wasn't crying or anything. She said, 'Hey, Tim. I just want you to know your son is dead,'" Nevil said. "Those words will haunt me until the day I die."

'I need to know the truth'

Nevil said he was told his son had fallen from his highchair while at day care on Aug. 30, the Friday before. The mother told him that on Saturday, King had been running in the kitchen when he slipped and hit his head again.

The mother told Nevil that she put ice on their son's head and kept him up for a while, as he was lethargic after the fall.

She said that early the next morning, her boyfriend found the child unresponsive. He performed CPR on King, then drove the child to Medical City Arlington Hospital, where the boy was pronounced dead.

According to the CPS report, King's mother told investigators her son had two prior accidental injuries, both at the day care, that resulted in King hurting his head. Day care records confirmed the incidents but reported that the child sustained no injury, the report states.

Nevil said a detective would later confirm to him that police suspected foul play in his son's death. The father said his own suspicions grew after he learned that the cause of his son's death was ultimately ruled as blunt force injury to the abdomen.

"The whole time she's got me thinking it was a head injury," Nevil said. "I wound up calling her. I said, 'Whatever you're hiding, I need to know the truth. What actually happened to my son? I said, 'You're lying. The autopsy don't say nothing about no head injury.'"

King Felder “had this sense of humor like no other,” said his father, Timothy Nevil. “It used to light up my world.”
Courtesy of Timothy Nevil

Nevil said King’s mother got hysterical and hung up on him. They have never spoken again, he said.

Nevil, who returned to New Orleans after his son’s death, said he tried to get in touch with detectives but was told only that the case was still under investigation.

“It really hurts,” Nevil said. “I always said once I get the funds, I’m going to Texas and to try to get this case reopened. Get a lawyer. Just someone to do more investigation than I felt they did.

“I just never had any closure,” he added. “Everybody tells me, leave it in God’s hands. God is going to work it out for me.”

King's autopsy report showed the boy had bruises and abrasions on his head, torso and extremities but no significant head trauma. Abdominal injuries, however, including old and new fractures of the ribs, internal hemorrhaging and lacerated organs, were noted in the autopsy.

"There is significant and likely serious to lethal blunt force trauma of the abdomen that has occurred what appears to be several days prior to death," Deputy Chief Medical Examiner Marc Krouse noted on King's autopsy.

In ruling the manner of death as undetermined, Krouse noted that the acute liver and intra-abdominal injuries are consistent with the description of "untrained bystander CPR" given by the mother's boyfriend in his statement to Arlington police.

He also noted that the day care facility used by the mother noted multiple conflicts between King and other children, as well as occasional hyperactivity with the potential for self-injury.

Nevil said that until he was told by the Star-Telegram, he did not know his son's manner of death had been classified as undetermined or that the boyfriend of King's mother had previously had another child die in his care.

CPS: Couple abused King

CPS investigators would conclude in their own investigation that the couple physically abused the boy, leading to his death.

"While neither adult assumed responsibility for abusing the child, it is reasonable to determine that either one or both of the adults caused the injuries, and that one or both have covered for the other, and/or deceived CPS resulting in failure to protect the child from harm," the CPS report states.

CPS also stated that the mother committed medical neglect by not getting medical attention for her son until after he was found lifeless, despite acknowledging she was concerned about her son's injury.

Because there were no other children in the house, CPS closed its case.

Within days of King's death, the boyfriend was arrested for violating his probation in a 2009 possession of a controlled substance (cocaine) with intent to deliver case out of Dallas. The boyfriend pleaded true to violating conditions of his bond and was sentenced on Oct. 10, 2013, to nine years in prison.

He was released on parole in February 2016 and, that same month, married King's mother.

In a phone interview May 9, the couple denied abusing King. The boy's mother said CPS simply got it wrong.

"Just because CPS says reason to believe, that's just a reason to believe," King's mother said. "Doesn't mean it happened or it didn't."

The boyfriend said he suspects King fractured his ribs in a fall from the highchair at day care. He also denied hurting Phaneese, but declined to talk further about the children's deaths.

The couple say they now have a 3-year-old son together, who was placed under CPS' watch the first six months of his life. If they had abused or caused King's death, King's mother questioned, why would CPS allow their son to remain with them.

"He's well taken care of. They did an investigation on our son when he was born, too. They say he's fine," the boyfriend said.

Arlington police said in an email that homicide investigators were aware of the previous death involving a child in the boyfriend's care "but we had to work with the current incident and could not use previous history against him."

"The TCME Office ruled the cause of death as undetermined. No charges were pursued after consultation with the DA's Office," Arlington police officials stated. "We do not make decisions whether to charge an individual. The DA's Office determines whether to accept or reject a case and whether to present a case to the Grand Jury."

The DA's office declined to comment on the case, calling it an "ongoing investigation."

‘These cases give me grave concern’

The forensic pathologists asked by the Star-Telegram to review King’s and Phaneese’s autopsies had serious concerns about their deaths.

All of them preceded their shared opinions with the caveat that they would want to review other documents before giving a formal ruling, including pediatrician, hospital, police and CPS records.

> **“PERHAPS IF SOMEONE HAD PURSUED THIS DEATH FROM 2011, THE DEATH OF 2013 MAY NOT HAVE OCCURRED.**
>
> Dr. Joyce Carter, forensic pathologist

Carter said she believes the autopsies show that both children suffered from non-accidental blunt force traumatic injuries that are consistent with physical abuse, both acute and chronic.

“The fact that the same male is involved in both should have caused someone to take a second look,” Carter said.

That neither of the mothers — nor the common boyfriend — could offer explanations for some of the injuries only raises more red flags, she said

“Perhaps if someone had pursued this death from 2011, the death of 2013 may not have occurred,” Carter said. “...These cases give me grave concern that these children’s deaths did not receive the benefit of justice.”

Wecht and Downs said they could not disagree with the initial undetermined ruling in Phaneese’s death due to other noted medical issues, but also believed more investigation was needed into what caused Phaneese’s older rib fractures on the left and right posterior sides.

“Where the hell did they come from?” Wecht asked. “That makes it a very, very suspicious case. ...That’s not the kind of thing someone gets just from falling.”

Wecht said he has seen cases where CPR has led to rib fractures, and even a lacerated liver, but he said King’s injuries went far beyond that.

"You do not get transection of the colon and hemorrhage into the pancreas from resuscitative trauma and you don't get it from a fall, front or back," Wecht said.

Downs also echoed that the child's bowel injuries could not have come from CPR and expressed disbelief that Krouse would describe the boy's abdominal injuries in the autopsy as "significant and likely serious to lethal."

"Are you blanking kidding me?" Downs asked. "Significant and likely serious to lethal? No! These are devastating and not only potentially lethal, in this case, absolutely lethal injuries."

Downs said that while he would want to review the entire case, from what he sees from the autopsy report alone, "I would be incredibly surprised if that were not a homicide based on what I see.

"My provisional diagnosis would be homicide," Downs said.

'A very significant finding'

Peerwani called the opinions shared by the outside pathologists "disturbing because they are made without full knowledge of the case."

"It is easy to call a case a 'homicide' than to deliberate with care," Peerwani said.

He said all child deaths are peer-reviewed by the office's seven pathologists, as well as the senior forensic department staff. In addition, he said, once a month, he invites involved agencies like police and CPS to a meeting to discuss and share information on children's cases in which the deaths do not appear to be from natural causes, often before rulings are handed down.

Downs said that while reviews can be beneficial, those done by peers also run the risk of colleagues merely placating one another and "rubber stamping" findings.

"You're going to go against the deputy chief's opinion?" Downs asked. "Do you really value your job?

"And just because I have a consensus — I have a lot of people agree with me — doesn't make me right," Downs said. "I don't know why these people agreed. Guess what, there was a consensus the world was flat."

Though both Phaneese's and King's deaths have been the subject of prior peer reviews, Peerwani agreed to reopen and review the cases after being contacted by the Star-Telegram.

During that review, Peerwani said forensic pathologists discovered something previously missed by Bao in his autopsy of Phaneese in 2011 — the girl had sickle cell trait.

Dr. Nizam Peerwani said all child deaths are peer-reviewed by the Tarrant County medical examiner's office's seven pathologists, as well as the senior forensic department staff.
Ron T. Ennis - Star-Telegram archives

He says this was confirmed by a newborn screening conducted by the state, the results of which, he said, had not been included in the medical records previously provided by the girl's pediatrician after her death.

Williams said, to her knowledge, no one in the family had ever been told that Phaneese had sickle cell trait.

Peerwani said evidence of sickle cells were found in the girl's organs, including throughout her brain, leading them now to believe that the girl had sepsis, which brought on a sickle cell crisis.

"Sickle crisis is a very significant finding," said Dr. Susan Roe, a Tarrant County deputy medical examiner.

With the new discovery, Peerwani said he plans to amend her death to "natural."

"Was this child abused? The answer is yes," Peerwani said, pointing to the girls' old posterior rib fractures as evidence. But he said the rib fractures didn't cause her death.

He said he believes the acute rib fractures, as well as the liver laceration, did occur from CPR.

Peerwani said medical and forensic literature have described several injuries that can occur from resuscitation, among them perforations of the stomach and colon, liver, spleen and pancreatic lacerations, rupture of the heart and rib fractures.

'The children suffer'

Peerwani said he also believes that King was abused and calls the boy's death concerning, but said he will keep the boy's ruling as undetermined as "we have no evidence to show it as a homicide yet.

"Being concerned and then having enough information to leap to homicide are two different things," Roe said. "We are very concerned about the case."

Peerwani said King's mesa colon, the mesentery that supplies blood to the colon, was cut likely a week before his death. That injury, Peerwani said, led to necrosis of King's colon, leaving the boy susceptible to spontaneous rupture or rupture with even minor trauma.

"We have no idea how this injury occurred," Peerwani said, adding it could have occurred through abuse, fighting at day care, or falling down.

He said day care notes indicate the boy was occasionally hyperactive and prone to altercations with the potential for self-injury.

"We aren't calling it an accidental death. We're putting it back on the shoulders of the DA and police department, saying we are concerned about this case. This is an unnatural death," Peerwani said.

Downs countered that an internal visceral injury is extremely painful and, if accidental, would have likely prompted the child to mention the event that caused it and/or the pain.

"Bowel ruptures take significant force — otherwise, all those football players who get blocked and tackled all over Texas on Friday nights and in pee-wee games would be dying in droves," Downs said.

Downs said he'd need to look at photos and microscopic samples to make better sense of the case.

"Sadly, it appears that sometimes ego — and fear of looking 'wrong' — stand in the way of our shared values of truth and justice ... so the children suffer," he said. "In fact, twice — once at the hands of their killers and again at the caprices of the ME [medical examiner]."

Williams, Phaneese's grandmother, said she is suspicious of why the medical examiner's office has just now — six years after her granddaughter's death — come up with a new explanation for the cause.

"I don't believe them," she said. "I really don't."

She continues to believe her granddaughter's death was from abuse and that, if the case had been handled properly, King's death may have been prevented, too.

"I feel so sorry for Phaneese and poor King," she said. "But I know one thing. I know there's a God and I know there is angels working and I know the truth will be revealed. I may be dead and gone but the truth will be revealed."

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ABOUT THIS PROJECT

In examining the broad topic of child abuse and neglect in Tarrant County, Star-Telegram reporters spent five months poring over court documents and autopsy, police and Child Protective Services reports, as well as conducting interviews with child abuse victims, family members and perpetrators, child advocacy experts, forensic scientists, law enforcement investigators, social service and mental health workers, faith leaders, doctors and educators.

The project is underwritten by Cook Children's Medical Center through the support of Bank of America, but the Star-Telegram retained complete control of editorial content.

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COMMENTS

Autopsy photos are often used to refute official conclusions

Sidebar *Page Number: 9*

From the Spring 2001 issue of *The News Media & The Law*, page 9.

The death of Dale Earnhardt has prompted legislators in many states to ask whether autopsy photos should be available to the public. The question is whether the privacy interest of the deceased or his or her family should outweigh the public's interest in having access to autopsy photographs.

In passing the Earnhardt Family Relief Act, the Florida legislature apparently dismissed the importance of public access to autopsy photos with little consideration.

However, autopsy photos often are the best evidence in cases involving everything from government cover-ups to strange crimes. While written autopsy reports are potentially tainted by the perspectives or motivations of the examiner, photos provide objective evidence for third parties.

The best, and a recurring, example of the benefit of access to these photographs is the death of someone in police custody. On occasion, an official police response will say the person died from a heart attack, with confirmation from the autopsy report. However, past cases have revealed that the cause of death may be something other than that announced by police.

Frank Valdes died while on death row in Florida in 1999. The guards originally claimed that Valdes' injuries were self-inflicted when he threw himself off a bunk bed and thrashed around a room. However, the photos clearly showed boot prints embedded in his skin from a brutal beating. Other guards eventually came forward because of the proof and admitted that Valdes had been brutally beaten.

The 1995 death of Moises DeLao in Pasadena, Texas, is another example. DeLao was arrested for public intoxication and was waiting to be bailed out of jail. Authorities found him hanging by an electrical cord. The police claimed DeLao committed suicide and the medical examiner concurred. But the medical examiner's report did not mention that DeLao's body was covered in bruises or that he had broken bones in his hands. DeLao's family did not believe DeLao would have killed himself. They hired an attorney and pursued a case against the police, discovering the autopsy photos and finding that the medical examiner completely failed to note in the written report that DeLao had been badly beaten.

Similarly, in 1992, the family of Donald Fleming of Buffalo, N.Y., questioned the official cause of his death. Fleming was arrested for robbery and died while in police custody. The medical examiner claimed that Fleming died as a result of a heart attack brought on by cocaine abuse or sickle cell traits. However, witnesses claimed that Fleming had been badly beaten and photos taken after the autopsy showed serious bruises and other signs of a beating. In fact, the funeral director called the medical examiner to the funeral home because he found a giant gash on Fleming's head, but the medical examiner had reported that there were no marks on Fleming's body.

Autopsy photographs have also helped clear an innocent British man accused of murder. In 1998, Patrick Nicholls, who had served 23 years in prison, was released from jail when a judge found that the autopsy photos proved that the alleged murder victim had died from a heart attack rather than from a beating.

Examples of the benefit of public access to autopsy photos:

• **2000:** Jonathan Burton died while on a Southwest Airlines flight. It was undisputed that Burton began acting strangely on the plane and tried to kick in the cockpit door. After his death, however, Southwest Airlines claimed that Burton died of a heart attack. The autopsy later showed that Burton was asphyxiated and some media reports stated that photos showed bruises and other signs he was badly beaten.

• **1999:** A Tucson, Ariz., publisher won the right to access and publish autopsy photographs of Mexicans shot to death when they attempted to enter the U.S. The publisher argued that the photos showed the Immigration and Naturalization Service had a policy of shooting and killing some illegal immigrants rather than detaining or subduing them.

• **1998:** National Guard Capt. Gordon Hess was found dead with more than 20 stab wounds. An Army examiner concluded that his death was a suicide. A later investigator examined the body and concluded Hess was murdered. The examinations relied largely on prior reports, including photos.

• 1997: Massachusetts nanny Louise Woodward was tried for murder. Prosecutors alleged she killed an infant by brutally shaking him. After her trial, Woodward's attorney's claimed that the child's autopsy photos would prove Woodward's innocence, but argued that they had not been given clear copies of the photos.

• 1995: Lisa McPherson died while in the care of Church of Scientology staffers in Florida. Her family had sued the church, alleging that they abused and neglected McPherson. The *St. Petersburg Times* won the right to obtain the autopsy photos. The photos showed numerous insect bites and other strange marks on her body.

• 1995: After decades of dispute, the family of President John F. Kennedy allowed independent experts to examine the autopsy photos and x-rays from the assassination of the president. The experts relied upon the photographic evidence to conclude that there were two shooters.

• 1995: Pittsburgh Steelers player Ray Seals claimed something was suspicious about the death of his cousin Jonny Gammage, who was in policy custody. A coroner promised to release the autopsy photos to clear up any concerns that foul play may have been involved.

• 1993: The death of Vince Foster, a White House deputy counsel in the Clinton administration, was ruled a suicide, but photographs of the crime scene and from the autopsy allegedly show conflicting evidence and have led some to question the official report. Although experts may dispute what happened to Vince Foster, most agree that access to the photos is important for them to evaluate what occurred.

Autopsy records, including photos, also can be used by researchers to evaluate health risks. A 1998 study on the health effect of soy was based on autopsies and showed that Japanese men are less likely than American men to die of prostate cancer probably due to soy intake.

In one instance, the *lack* of autopsy photos proved to be an important factor. In 1999, the *Washington Post* published an investigative article concerning the high number of deaths among the mentally retarded in the District of Columbia who participated in its housing program. Out of 116 deaths, only eight autopsies were performed and none of the cases were investigated, despite a law requiring unexpected deaths to be reviewed. -- *AG*

The News Media and The Law, Spring 2001

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POLITICS

Sixteen Shots

Chicago police have told their version of how 17-year-old black teen Laquan McDonald died. The autopsy tells a different story.

By JAMIE KALVEN
FEB 10, 2015 • 8:07 PM

How could an incident that began with the responding officers assessing the situation and deciding they needed a Taser end a few minutes later with 16 bullets striking Laquan McDonald?

Wikimedia Commons

An autopsy tells a story. The genre is mystery: a narrative set in motion by a corpse. The pathologist-narrator investigates the cause of death in precise, descriptive prose that ultimately allows the dead to testify about what happened to them. In the case of Laquan McDonald, a 17-year-old black youth killed by Chicago police on Oct. 20, 2014, the autopsy raises questions not only about how he died, but about how the Chicago Police Department has handled the case since. While it does not provide all the details of what transpired that night, the autopsy makes one thing clear: The account of the incident given by the police cannot be true.

Here is what police at the scene told reporters: At around 9:45 p.m., a squad car responded to a call that someone was trying to break into cars in an industrial area on the southwest side of Chicago. The officers found a boy, Laquan McDonald, standing in the street with a knife. They observed him stabbing the tires of a vehicle. When they ordered him to drop the knife, he ignored them and walked away, down the street.

Pat Camden, a longtime Chicago Police Department press spokesman who now performs that function for the police union, later described McDonald as having had "a strange gaze about him … he's got a 100-yard stare … he's staring blankly."

The responding officers didn't have a Taser. Waiting for one to arrive, they followed McDonald in their vehicle. A second squad car arrived. McDonald again refused to drop the knife. The police tried to use the two vehicles to box him in against a construction fence on Pulaski Road. He punctured a tire and damaged the front windshield of one of the police cars. Officers got out of their vehicles. McDonald lunged at them with the knife. One of the officers shot him in the chest. At 10:42 p.m., he was pronounced dead at a nearby hospital.

"The officers are responding to somebody with a knife in a crazed condition, who stabs out tires on a vehicle and tires on a squad car," Camden said at the scene. "You obviously aren't going to sit down and have a cup of coffee with them. He is a very serious threat to the officers, and he leaves them no choice at that point but to defend themselves."

The Chicago press dutifully reported the police account of the incident. The reporter for the local NBC station called it "a clear-cut case of self-defense." It was also reported that the Independent Police Review Authority (IPRA), the city agency charged with investigating police shootings, would conduct an investigation, as it does in the case of every "police-involved shooting."

In its broad outlines, this is a familiar Chicago story: A black American is shot by a Chicago police officer. A police source says the shooting was justified. IPRA announces it is investigating. Then silence. After a year or two, IPRA issues a report confirming that the shooting was indeed justified.

The statistics are stunning. According to IPRA reports, Chicago police officers shoot, on average, several residents a month. Roughly 75 percent of those shot are black. Civil rights lawyers and investigative journalists I've talked to who have covered the Chicago police for decades cannot remember the last time criminal charges were brought against a Chicago police officer for a shooting while on duty.

Sometimes before the story of a police shooting evaporates into silence, we briefly hear the voice of a family member or friend trying to find words to describe who the victim was or questioning the shooting. Not so in the case of Laquan McDonald. A ward of the state, he appears not to have left much of a trace in the world. At any rate, there was no one to speak for him during the brief moment of media attention occasioned by his death.

The press coverage did, however, contain a couple of particulars that didn't meld with the police narrative. A witness, Alma Benitez, was quoted as saying that the shooting was unnecessary, because a number of officers were present and they had control of the situation.

"It was super exaggerated," she said. "You didn't need that many cops to begin with. They didn't need to shoot him. They didn't. They basically had him face-to-face. There was no purpose why they had to shoot him."

The other detail at odds with the police narrative—mentioned in passing in a couple of news reports without comment—was that the Cook County Medical Examiner had ruled that McDonald died of "multiple gunshot wounds," not the chest wound that the CPD had described.

The question the press didn't ask—how many gunshot wounds are covered by the word "multiple"?—has now been definitively answered by the recently finalized autopsy report, which I have obtained via a Freedom of Information Act request: Laquan McDonald was shot 16 times.

Before mapping each of the 16 gunshot wounds in minute detail, the report describes Laquan McDonald. Six feet tall and 180 pounds, he had been wearing blue jeans and a black hooded sweatshirt. He had dreadlocks, the longest of which was five inches. He was, before his encounter with the police, in good health. A tattoo on his upper right arm read "Quan." Another on the back of his right hand read "Good Son." And on the back of his left hand were a pair of dice and "YOLO"—the acronym for "you only live once."

The description of each of the gunshot wounds is exhaustive, noting where the bullet entered the body, the damage it did to tissue and bone, where it exited the body, and its direction. The numbering of the wounds in the report is arbitrary; it is "without regard to sequence or severity." Here is a summary:

1. Gunshot wound of the left scalp. (Directionality cannot be determined.)

2. Gunshot wound of the neck. (The direction is left to right, slightly front to back and slightly downward.)

3. Gunshot wound of the left chest. (The direction is front to back, right to left and downward.)

4. Gunshot wound of the right chest. (The direction is front to back, left to right and slightly downward.)

5. Gunshot wound of the left elbow. (The direction is left to right, back to front and slightly upward.)

6. Gunshot wound of the right upper arm. (The direction is back to front, downward and slightly left to right.)

7. Gunshot wound of the left forearm. (The direction is back to front, slightly right to left and slightly downward.)

8. Gunshot wound of the lateral right upper leg. (The direction is right to left, downward and slightly front to back.)

9. Gunshot wound of the left upper back. (The direction is right to left and downward with no significant forward or backward deviation.)

10. Gunshot wound of the left elbow. (The direction is left to right and downward with no significant forward or backward deviation.)

11. Gunshot wound of the posterior right upper arm. (The direction is right to left, downward and slightly front to back.)

12. Gunshot wound of the right arm. (The direction is back to front and upward with no significant lateral deviation.)

13. Gunshot wound of the right forearm. (The direction is upward and slightly back to front with no significant lateral deviation.)

14. Gunshot wound of the right hand. (The direction is slightly left to right and slightly upward with no significant forward or backward deviation.)

15. Gunshot wound of the right lower back. (The direction is back to front, right to left and upward.)

16. Gunshot wound of the right upper leg. (The direction is left to right and front to back with no significant vertical deviation.)

How could an incident that began with the responding officers assessing the situation and deciding they needed a Taser end a few minutes later with 16 bullets ripping through Laquan McDonald's body from different directions? Did more than one officer fire? That might explain the bullets entering from different directions. Or did a single officer empty a full magazine? Perhaps McDonald was rolling around on the ground, in which case bullets fired from a single position might have entered his body from different directions.

Whatever happened, it's very difficult to square the police narrative with the facts established by the silent testimony of Laquan McDonald's corpse.

And there is more: I recently spoke with a witness, who asked that I not use his name for fear of police reprisals and who has also reported his story to IPRA. He said he came upon the unfolding drama at the moment when McDonald was boxed in by police cars and the construction fence. From this point forward, his version of events diverges sharply from that of the police.

From this witness's perspective, McDonald didn't pose an immediate threat to anyone, and he had nowhere to run. Several officers got out of their squad cars, he says. McDonald was shying away from the police rather than moving toward them, according to this witness, when a white male officer shot him. He fell to the ground. There was a pause. Then the officer fired again and again and again. The witness counted, he thought, six more shots, but he was uncertain whether other officers were also firing. Almost immediately, a number of police cars arrived on the scene, blocking the witness's view. The police didn't interview him or take his name.

Although the witness is adamant that McDonald was moving away from the police and not lunging toward them, let's assume the officer's assessment of risk was correct. There is a rule of thumb in law enforcement known as the "21-foot rule"—the distance an attacker with a knife can cover before his intended target, armed with a holstered sidearm, can reasonably be expected to get off an accurate shot. Perhaps that justified the first—or even the first few—shots, but what possible justification could there be for the barrage of bullets that followed?

The police department and the city have the means to answer these questions. A source close to the case confirmed to me that the dashboard camera in one of the squad cars on the scene captured the incident. (CPD policy requires officers to activate their dashboard cameras when in pursuit.) And it's clear from both the police narrative and the witness account that at least one of the squad cars on the scene had a clear perspective on the sequence of events. I have reached out to the Chicago Police Department several times for comment on the autopsy, the witness testimony, and the video, but have not heard back.

In December, Professor Craig Futterman of the University of Chicago Law School and I publicly called on the city to release all video footage of the incident. It has not done so. Nor has it addressed questions we have raised about the incident. Now the autopsy report has made those questions even more urgent.

The reality is that in a police force the size of Chicago's, no matter how well trained and supervised, bad things will sometimes happen. The critical question is how the institution responds when they do.

Last November, in an interview with the *Chicago Sun-Times*, Police Superintendent Garry McCarthy spoke of the importance of keeping the public informed after high-profile incidents such as police shootings. He said he didn't want the department to "be defensive" when such incidents occur. "Transparency," he said, "is part of our legitimacy."

Hence the importance of releasing the video footage of the Laquan McDonald shooting. Refusing to do so, in view of the questions raised by the autopsy report, can only damage the department's legitimacy.

The decision of whether or not to release the video ultimately rests with Mayor Rahm Emanuel, who is currently in the midst of a re-election campaign. His administration has taken several significant steps toward establishing a credible regime of police accountability. Among them is the transparency policy it adopted following a 2014 Illinois Appellate Court decision holding that documents relating to closed investigations of police misconduct are public information. It would be a logical extension of that policy to include open as well as closed cases, to the extent timely information can be made public without compromising ongoing investigations.

Recently, the mayor touched, in another context, on what is at stake. In connection with the announcement of a pilot program in which officers in one of the city's police districts will be outfitted with body cameras, he spoke of the damage to community-police relations done by the history of police abuses, and expressed the hope that body cameras will help rebuild "a foundation of trust" between residents and the police.

Sparked by events in Ferguson, Missouri, an extraordinary series of protests and conversations across the nation have brought us to something akin to a truth and reconciliation moment with respect to patterns of police abuse and impunity in minority communities. At the local level, this dynamic is complex and volatile , as the recent events in New York have illustrated. Statesmanship will be required on all sides, if we are to find a path forward that publicly acknowledges longstanding patterns of human rights violations, while building and maintaining the relationships that will be required, incrementally and over time, to effectively address those harms.

The McDonald footage *will* come out, but a great deal turns on *how* it comes out. Will the city be forced to release it in a way that deepens the crisis of public confidence in law enforcement, or will it be released in a way that helps restore the "foundation of trust" between residents and police on which effective law enforcement depends? If the city resists releasing the video until legally compelled to do so, outrage at what it depicts will be compounded by outrage that the city knew its contents (and the autopsy results) in the immediate aftermath of the incident yet withheld that information from the public.

The fate of Laquan McDonald—a citizen of Chicago so marginalized he was all but invisible until the moment of his death—has thus become entwined with that of Mayor Emanuel. It presents his administration with a defining moment.

THE EARNHARDT REPORT - NASCAR'S investigation into the death of Dale Earnhardt

Experts Agree On Skull Injury But Not Cause

Nascar Said The Back Of Dale Earnhardt's Head Hit Something, Killing Him. Others Weren't So Sure.

August 22, 2001 | By Robyn Suriano, Sentinel Staff Writer

Pick your favorite theory. With NASCAR's report on Dale Earnhardt's fatal crash, experts now have offered up three possible scenarios for the racing legend's death.

They all agree that Earnhardt died from a fracture to the base of his skull, which damaged the region of the brain that controls such basic functions as breathing and heart rate.

But each scenario pins the injury -- a basilar skull fracture -- on different causes.

In NASCAR's report, experts speculated that Earnhardt suffered the injury when the back of his head struck the steering wheel or something else in the car.

This contrasts with the findings of a court-appointed expert, Dr. Barry Myers of Duke University, who concluded in April that the force of Earnhardt's head whipping forward could have shattered his skull.

Earlier, a doctor working for Daytona International Speedway noted an abrasion of Earnhardt's chin and suggested the broken seat belt discovered by NASCAR could have allowed him to fly into the steering wheel.

NASCAR's analysis actually traces two crashes -- first, when Earnhardt's car collided with a car driven by Kenny Schrader, and second, when the No. 3 Chevrolet slammed into the track wall.

The initial collision jolted Earnhardt's body sideways and to the right in his seat. When the car hit the wall, NASCAR's experts said, the left rear of his head either struck the steering wheel or whipped backward on the rebound and hit something in the car -- possibly the seat, which includes a metal bar.

The blow was serious enough to crack the base of Earnhardt's skull and leave a bruise the size of a drivers license on his head, the experts said.

NASCAR's experts dismissed the idea that a chin impact caused the injury. The abrasion was more likely caused by the rubbing of the strap when his helmet was jolted on impact, they said.

They also disagree with Myers' contention that the injury was caused by the whipping motion of Earnhardt's head, perhaps coupled with a chin strike.

Dr. James Raddin from Biodynamic Research Corp. said the autopsy report did not mention the sort of neck and torso injuries that would be apparent in such a case.

"I looked to see if there was evidence of stretching in the back of the neck from a head whip, and that was not found," Raddin said. "You certainly can get a basilar skull fracture that way. [But] I think it's relatively unlikely in this case."

But another crash expert, Dr. Philip Villanueva, director of neurotrauma and head injury at the University of Miami Medical School, said NASCAR's scenario would result in more neck injuries.

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With the twisting and turning that NASCAR described, Earnhardt's neck would have been obviously damaged.

"The type of injury that Myers postulated would not lead to much soft-tissue injury in the neck -- it's more of a pulling, a stretching," said Villanueva, who has examined the Earnhardt autopsy report. "But they are postulating a lot of twisting and turning for him to strike the back of his head. That's more of a tearing and trauma."

Myers, who studied autopsy photos that were not available to NASCAR's experts, also disputed the conclusions.

"I stand by the findings of my report as correct," said Myers, adding that the forward motion of the head alone was enough to cause the fracture that he saw.

But other experts said NASCAR's in-depth analysis allowed for a more thorough investigation. Myers, for example, did not have access to Earnhardt's car, accident-reconstruction analyses and enhanced video of the crash.

NASCAR contends that the accident was much more complicated than a straightforward injury caused by the violent motion of Earnhardt's head.

"There are so many variables that come into play," said Dr. Robert Mendelsohn, a retired neurosurgeon and injury consultant in Maryland who reviewed NASCAR's report before it was released.

"Dr. Raddin had more evidence -- how fast the car was going, the angle of impact, the change in the velocity and all -- that Dr. Myers didn't have the advantage of analyzing."

Mendelsohn said NASCAR's experts were not hampered by their inability to examine autopsy photos, which Myers did with permission of a judge. The photos since have been sealed.

Villanueva said such disagreements among experts are to be expected. In a best-case scenario, the experts would have examined Earnhardt's body directly, he said.

"We are all removed, in a sense, because we are not examining the actual tissues," he said. "There will always be room for argument."

Earnhardts win fight to keep autopsy photos sealed

By **Roger Roy and Amy C. Rippel**
Sentinel Staff Writer

JUNE 14, 2001, 6:05 AM | DAYTONA BEACH, FLA.

Autopsy photos of auto-racing star Dale Earnhardt will remain sealed to spare his family an "unspeakable" violation of privacy, a circuit judge ruled Wednesday.

In the first test of a new state law inspired by the Earnhardt family, Judge Joseph Will ruled that a college newspaper and a Web site operator failed "overwhelmingly" to show any convincing reason why they should be allowed to see the photos.

"In this particular case, the release constitutes a serious invasion (of privacy) of the highest degree," Will said at the close of a three-day hearing. "There is no question it's harmful, it's unspeakable."

Earnhardt's widow Teresa, who contended that photos would end up on the Internet and cause hurt and embarrassment to her family, did not speak to reporters afterward. She thanked her attorneys, shook their hands and quickly left the courtroom.

Appeals are expected.

"I think she was pleased," said Earnhardt attorney Thom Rumberger. "But she understands this is just the start of a long process. There's no joy in Mudville tonight."

The Independent Florida Alligator, a student-run newspaper at the University of Florida, and Web-site operator Michael Uribe of DeLand sought access to photos taken of Earnhardt after the NASCAR star crashed Feb. 18 at the Daytona 500.

Alligator attorney Tom Julin argued that viewing the graphic photos, which were public records before the new law took effect, could help make sure medical examiners or police were doing their jobs. He said use of the photos could lead to safety advances that could save lives.

Even as Julin made those arguments, Teresa Earnhardt repeatedly shook her head, "No."

Will dismissed the claims as "incredibly thin excuses to violate the privacy rights of the family." He said the newspaper and Uribe failed to meet the requirements of the new law. Anyone seeking access

to autopsy photos must persuade a judge that it is needed to evaluate "governmental performance," that their release wouldn't unnecessarily intrude on the family's privacy or that the information wasn't available elsewhere.

The hearing, which included testimony from family members of NASCAR racers Neil Bonnett and Rodney Orr, whose autopsy photos were posted on Uribe's Web site, demonstrated how families suffer when the gruesome photos are misused, the judge said.

"Invasions of this type do not cut more deeply, they do not cut more painfully," Will said. "The court remains absolutely baffled as to how any person could be so heartless as to publish or distribute photos such as these."

Gov. Jeb Bush, who signed the autopsy-photos law with Teresa Earnhardt at his side, said through a spokeswoman that he was glad at how the case had ended.

Will's ruling, coming two days after he rejected arguments that the law is unconstitutional, does not end the legal battle. Julin said his client would seek a motion for a new trial. If that is denied, the case would move to the Fifth District Court of Appeal.

"The upholding of this statute makes it nearly impossible to get at autopsy photos, even when there's clearly good cause to do that," Julin said. "Most people can't afford to go through this. They can't hire lawyers, they can't battle the forces that we've seen here to get at that information."

Although he rejected their request to see the photos, Will gave the Alligator and Uribe an partial legal victory when he dropped a temporary order that had blocked access to the photos even before the law was passed in March, rather than make it permanent as Earnhardt's lawyers requested.

Will issued the temporary order for Teresa Earnhardt just days after her husband's The photos have been examined just once since then, when a court-appointed expert reviewed them to answer questions by the Orlando Sentinel and other newspapers about the cause of Earnhardt's death.

The Sentinel, which agreed to drop its request for access to the photos after the expert's inspection, was not a part of the Alligator and Uribe requests.

Will's lifting of the temporary order, Julin said, "means that the only thing standing between us and the records is the new law, which we think is unconstitutional."

Rumberger, part of a top-dollar Earnhardt legal team that included some of the best-known lawyers in the state, said he was disappointed that Will did not grant make his original order permanent. He

called the judge's ruling "a very good first step," however, and said he was confident the autopsy-photo restrictions will withstand legal challenges.

He said he saw little danger that the Earnhardt family will have to fight repeated attempts to unseal the disputed photos because of "the trouble, the expense" that is required.

The new law does not prohibit access to autopsy photos, but only sets rules for gaining access, Rumberger said.

"If you have a reason to get them, you can," he said. "It's not, "Let's go down and get the photographs and have a party.'"

But an attorney representing press organizations that had filed friend-of-the-court briefs in the case argued that the new law chips away at Florida's long history of open government records by imposing a test on those who seek them.

"It is the pebble in the water," attorney Jonathan Kaney said. "The waves will roll out."

The day after the law was adopted in March, the Sentinel and sister paper South Florida Sun-Sentinel of Fort Lauderdale filed suit in Broward County, asking a circuit judge there to declare it unconstitutional.

Wednesday's ruling has no bearing on that litigation, which Ashley Allen, spokesperson for Orlando Sentinel Communications, described as "an entirely different case."

Joseph Little, a law professor at the University of Florida, said he expects the dispute over Earnhardt's photos to be decided ultimately by the Florida Supreme Court, which may take two years.

"The fact that you have this famous personality involved in this case is unfortunate because it layers in the publicity factor that could color the thinking of a court," Little said.

But in announcing his ruling, Will said celebrity status played no role in his decision.

"I hope all of you know that this case could just as easily have involved the autopsy photos of the man who lives under the bridge, or Mr. Uribe's mother," Will said.

Uribe, who is not an attorney but who represented himself with often rambling arguments that prompted frequent admonitions by the judge, shrugged off Will's comment.

"He just doesn't like me," Uribe said. "And he's just exercising his freedom of speech."

This 'attr(data-c-typename)' is related to: Laws and Legislation, Justice System, Family, Newspapers, Newspaper and Magazine, Colleges and Universities, Auto Racing

COLUMN ONE

Harvest of Corneas at Morgue Questioned

Corneas taken without survivors' permission are resold at huge markup by eye bank, which pays coroner's office a fee. The practice is legal, but critics cite ethical lapses.

November 02, 1997 | RALPH FRAMMOLINO | TIMES STAFF WRITER

A renowned eye bank has paid more than $1 million during the last five years to the Los Angeles County coroner's office in exchange for thousands of corneas, harvested without the permission or knowledge of the families of the dead.

Although the practice is permitted under a little-known state law, officials of the coroner's office and Doheny Eye & Tissue Transplant Bank have used the statute so extensively that critics say the morgue has become a virtual cornea mill.

"Totally immoral," is how former Doheny technician Julia Brain described what is happening behind the coroner's doors--and behind the backs of families.

"Repugnant," said former coroner supervisor Peter Linder.

Under the 14-year-old state law, coroners are allowed to remove corneas in cases targeted for autopsy if there are no known objections from the next of kin.

When the law was passed, there was a shortage of corneas and long waits for people seeking transplants of the dome-like tissue that covers the eye's colored iris. Speed was of the essence because corneas usually disintegrate within 24 hours after death. For that reason, coroner officials are not specifically required under the law to seek time-consuming permission.

There is no doubt that the wide availability of corneas has helped thousands of people overcome a variety of vision-impairing maladies. But a mounting number of medical experts say the law is unnecessary today because corneas are so plentiful that none need be procured without the blessings of loved ones.

San Francisco Medical Examiner Boyd Stephens, for one, said he will not allow cornea removals without family approval. He said surveys by his office have shown that even people willing to donate internal organs draw the line at eyes.

"When you think of somebody you know, you envision their face, their eyes and nose," Stephens said. "You don't identify anybody by their liver."

In Los Angeles, that has not deterred coroner's and eye bank officials, who say they have been guided only by humanitarian concerns and the dictates of the law.

An investigation by The Times has revealed that the coroner's office and Doheny are invoking the state measure on an unprecedented scale. This has generated a cheap source of corneas that the eye bank resells for a markup of more than 1,200%. In return, the cash-strapped morgue receives payments of about $250,000 a year.

In all, at least half of Doheny's corneas--more than 1,000 annually--come from coroner cases in which consent has not been obtained, a number unmatched by any eye bank in the state.

Along the way, critics and medical experts say, ethical lapses and procedural breakdowns have occurred.

Internal documents, a computer analysis of hundreds of coroner cases and scores of interviews disclosed that:

* Employees of the coroner's office and the eye bank say they have been discouraged by superiors from asking permission of family members, even when easily accessible at death scenes, through the police or by telephone. In that way, no objections can be lodged and the corneas can be harvested under the state's so-called Coroners Law.

* The eye bank's employees are under such intense pressure to procure corneas that their productivity has been charted on monthly bar graphs. Earlier this year, when the numbers dipped, a veiled warning of possible "downsizing" was issued by the president of Doheny's management organization, Tissue Banks International, a driving force behind the 1983 Coroners Law.

* The ties between Doheny and the coroner's office are extremely close--some say incestuously so. The morgue's former director is now a key executive of Tissue Banks International. In recent years, Doheny has hired relatives of pathologists working for the coroner's office. At times, full-time morgue employees have moonlighted for Doheny. Some of the eye bank's technicians have their own keys to the coroner's office, giving them free run of the facility and its investigative files.

* Contrary to federal health-safety guidelines, Doheny technicians have removed corneas from people recently incarcerated and from drug users--high-risk candidates for infectious viruses, including hepatitis and AIDS. In addition, no family or medical histories are sought to discover other possible health dangers. Although chances of disease transmission through corneal transplants are extremely remote, most eye banks and coroners outside Los Angeles say they prefer to err on the side of safety.

Doheny and the eye bank's management firm, both of which are listed as nonprofit organizations, say they not only have complied with the law but have been motivated solely by a genuine desire to help those with vision that has been impaired by such things as cataract surgery and scarring from accidents and infections.

The Coroners Law, according to Doheny Executive Director Jeffrey A. Thomas, "enables everyone with need [for] the rapid access to sight-restoring corneas."

Officials of the Los Angeles County coroner's office also say their extensive use of the law has been justified by the long-standing demand for corneas in Southern California. Nonetheless, they say, the time has come for a change--prompted, they acknowledge, by internal dissension and recent questions from The Times.

"There were some employees feeling they should inform the families," said the coroner's top administrator, Anthony T. Hernandez. "We took a look and said maybe we should."

Hernandez said a policy requiring employees to seek family consent was drafted about eight months ago, but "fell through the cracks" until inquiries from the newspaper revived the issue. Hernandez said he expected that the new policy would be in place within days.

Former state Sen. Robert Presley (D-Riverside), who wrote the Coroners Law, said he is proud that the measure boosted the number of corneas available for transplants, but he never anticipated that family members would be disregarded in the process.

"Technically, legally, they're OK to do that," Presley said of coroner officials. "But you would think, if the family is right there, they would say, 'Do you have any objection?' "

Relatives Shocked by Disclosures

As part of its study, The Times examined 572 cases for a 12-month span beginning in July of 1996, as well as a scattering of others from years past in which corneas were taken under the Coroners Law--meaning families were unaware that the procedure had been conducted. When contacted by the newspaper, some responded with anger, others with understanding. All, however, were shocked that they had not been asked or told.

Yolanda Aguirre's son Mitchell, 18, was killed in a gang shooting Feb. 3. When his body arrived at the morgue, his corneas were promptly removed.

"It makes me want to cry," the El Monte mother said. "How come they don't send letters to tell us what they've done?"

Aguirre, unlike some others, said she finds no comfort in the knowledge that her son has possibly provided the gift of sight to another.

"A lot of people need a lot of things," she said. "I need a million dollars but I don't take it from somebody. . . . Those were my eyes. Those were my creation."

Frank Casias also was infuriated to learn that the corneas of his 20-year-old daughter, Christina, had been secretly removed.

He said he could have been asked for permission at the death scene--the family's Canoga Park apartment, where he found Christina dead from breathing complications shortly before 1 a.m. on Feb. 15. Had he been asked, Casias said, he would have answered no.

"I had just gotten finished looking into her eyes. I tried to give her CPR. It would have been hard enough to donate anything at all," recalled the father, who said he is now at peace with what was done.

Ken Brondell said permission could easily have been sought from him too. His 40-year-old daughter, Christy Lynn Hamilton, was a rookie Los Angeles police officer who was gunned down three years ago in the line of duty. She was the oldest woman to graduate from the Police Academy.

Brondell said he was in constant contact with the Police Department. As the official next of kin, he was chauffeured to the hospital and stood vigil before Hamilton's body was delivered to the morgue. He then returned home, where he said he could have been reached at any time.

"If they would have asked me, and I had a few minutes to think about it, I probably would have said yes," Brondell said. "But it kind of bothers me that it was done without any notice."

Said Hamilton's brother: "Good manners dictate that a thank you note be sent. You do that for a wedding gift."

Even families with the presence of mind to register objections on their own sometimes are too late for the quick work of Doheny's technicians, who are allowed to peruse paperwork of unfinished cases and remove bodies from the coroner's crypts.

Carlos M. Gudino, a 24-year-old Wilmington gang member, died shortly before 9 p.m. on March 26 from 12 bullet wounds to the chest and head. His sister called the morgue the next day.

"My parents told me to let them know they didn't want any organs donated or anything," Maria Gudino said during a brief interview at her family's apartment. She said she was told: " 'Don't worry, honey, we're not going to do that. Thanks for letting us know.' "

A coroner's investigator dutifully noted the objection on a supplemental note to his report: "Family is profoundly against ANY organ or tissue donation per conversation with multiple family members 03-27-97."

By then, it was too late. Gudino's corneas had been removed three hours earlier.

A similar circumstance prompted a lawsuit against Doheny and the county by the family of Carlos Lopez, a 20-year-old man shot while eating at a fast-food stand. After Lopez died at County-USC Medical Center, the family refused a nurse's request to harvest some of his skin. Lopez's body was then transported around the corner to the morgue, where Doheny employees removed his corneas--two days before the autopsy.

The case was settled for an undisclosed sum.

The failure to request permission in these and other cases was no mere oversight but, rather, common practice.

Robert Iwan once ran Doheny's Central Coast office. He now is a freelance illustrator and substitute teacher in Alhambra.

"We were, under no circumstances, to call the family or approach the family," he said. "If we were to approach the families, we risked the possibility of the family saying no. Then we would lose the corneas, at the very least, and that was something they [eye bank executives] didn't want."

Veteran coroner investigator Pam Eaker said she received the same message from her top boss.

"I was told not to ask [families]," Eaker said, because coroner administrators "didn't want us involved in that aspect."

And if the families weren't asked, there was no reason for them to wonder.

"If you take the cornea, no one knows it's gone," said Lisa Karlan Rasgon, who once operated a local tissue bank. "That's how they've gotten away with it . . . because who goes up to a dead person and opens their eyes? There's no disfigurement when the corneas are removed."

Cornea removals are disclosed on public autopsy forms, but those documents usually are not available until long after burials. What's more, the documents, by design, are worded to minimize potential problems from family members, records obtained by The Times show.

In 1991, the vice president of Tissue Banks International asked the coroner's office in a letter to stop calling corneal removals "donations" on its official paperwork.

"The question arose in our minds," he wrote, "that describing the cornea removal . . . as a donation might trigger responses from the reader which could be of concern.

"In cases where corneas are removed the NOK [next of kin] upon reading the Autopsy Report might object to the term 'donation' when in fact the 'donation' was authorized by statute." He suggested this change: "Corneas removed (CGC)"--an acronym for the California Government Code.

"We feel this statement would address the issue in a positive and completely honest manner," the executive wrote.

The coroner's office agreed, noting in its procedural manual: "Please do not use terminology such as, 'The corneas were donated,' or, 'The eyes were removed,' as this could lead to misunderstanding and concerns for the next of kin."

Information about the legislatively authorized removals also is contained in a single paragraph of a pamphlet titled "Information from the County of Los Angeles Department of Coroner." The three-page pamphlet is kept in the morgue reception area, along with a variety of others on various health issues.

Tissue Banks International contends that coroner employees provide the pamphlet to everyone identifying a body at the morgue. But coroner officials say the truth is that employees are not required to give the pamphlet, and many do not.

Coroner administrator Hernandez said distribution has been on a "catch-as-catch-can" basis. He said that, under the new policy, investigators will be required to hand the pamphlet to family members.

Eye Bank Employees Under Pressure

Doheny's county contract has paved the way for it to become one of the most productive eye banks of 111 in the nation, according to statistics compiled by the Eye Bank Assn. of America.

Last year, Doheny supplied 1,846 corneas for transplants, second only to an eye bank in Tampa, Fla., which does seek family consent, despite being in one of 21 states with laws similar to California's. Doheny also has the right to recover skin, bone and heart valves from the coroner's office on behalf of other tissue banks--taken only with family consent.

Insiders say Doheny employees have taken full advantage of their access, driven by productivity goals set by Tissue Banks International, which runs a nationwide network of eye banks.

Tissue Banks is widely credited with transforming cornea acquisitions from what used to be a small volunteer effort pioneered by the Lions Club into a highly professionalized operation with big salaries, executive perks and high overhead.

Tissue Banks International runs the administrative side of its 11 eye banks across the country, buying supplies, hiring workers and ensuring that the network has a ready supply of corneas that can be shipped on a moment's notice where the need arises. In return, Tissue Banks charges its affiliates a management fee based on the amount of money each generates on corneas and other tissues. Last year, Tissue Banks collected $600,000 from Doheny, records show.

Efforts to keep the system working--and the money flowing--are intense.

Earlier this year, when workers at Doheny and its affiliated eye banks picked up their paychecks, they also were handed a letter from Tissue Banks President Richard Fuller, urging them to work harder. The reason: "Corneal Tissue Volumes are under budget by 9%, or 376 corneas."

"This is a very serious concern since ocular programs [represent] 80% of our 'business,' " Fuller wrote.

"It is up to each of us to put forth extra effort to ensure that tissue volumes are met and costs are contained. . . . 'Re-engineering,' 'reduction in force' and 'downsizing' are all common terms these days. Let's make sure we do not have to use them to solve the problems we face."

In an interview, Fuller said the letter was intended to "nudge people a little bit. . . . We don't pressure nor do we threaten our employees."

Fuller also defended his firm's extensive use of the Coroners Law. "What we're doing is in the public good. . . . We believe it's the right thing to do."

But those on the front lines say those lofty goals, coupled with a push for productivity, can often create an almost ghoulish environment.

"We were swooping down on the dead to make money. We were feeding off the dead," said one former Doheny employee, who still remembers the glares he and others suffered from rankled county workers.

"You'd walk by and there would be a sardonic look on their face and they would flap their wings, like, 'Uh-oh, here come the vultures.' "

At one point, Doheny workers offered--and morgue attendants began demanding--food to expedite cornea cases, prompting an official memo halting the "inappropriate and unethical" practice.

"While it might seem that a doughnut here or a piece of pizza there is no big deal, it is demeaning and calls into question the integrity of the entire Department," wrote the chief of coroner investigators.

"If you don't think that a person doesn't or won't expect something in return for their 'gratuity,' you're sadly mistaken. Behind your back, you're a 'simpleton' and a 'chump' in their eyes."

Before they remove corneas, Doheny technicians routinely obtain permission from coroner officials in cases likely to require autopsies, such as homicides, thus ensuring compliance with the law.

On occasion, however, corneas have been harvested when no autopsies were conducted because of communication foul-ups or subsequent decisions not to perform them.

Former death investigation supervisor Peter Linder said he recalls about a half-dozen instances in which unnecessary autopsies were performed because corneas had been removed under questionable circumstances.

"If . . . you're afraid of a family complaint, to protect the coroner against a lawsuit, you did an autopsy," Linder said.

"The autopsy now makes the taking of the eyes legal. . . . Some of the doctors were very angry about it because their workload is heavy."

In a case last year, a Doheny technician requested a belated autopsy on a West Hills woman who had drowned in her apartment complex pool.

"Dr. Liang [a Doheny technician] requests at least a partial autopsy, as [Tissue Banks International] took corneas," according to a notation in coroner files. "Case held for tomorrow."

The autopsy was performed, despite an earlier determination that it was unwarranted. Liang said Friday that he did not recall the case.

Chief Medical Examiner Lakshmanan Sathyavagiswaran acknowledged in a recent interview that there have been "rare" instances in which such autopsies were performed. "I don't think it happens anymore," he said.

Corneas Resold at Substantial Profit

One reason Doheny and Tissue Banks International have so aggressively mined the coroner's office for corneas is because it is much easier--and more profitable--than going to the trouble and expense of seeking family approval or obtaining them from hospitals, according to eye bank experts.

Doheny, using money supplied by the Baltimore-based Tissue Banks, pays the coroner an average of about $250 for a set of corneas, which are then sold to transplant institutions for a "processing fee" of $3,400--among the highest in the nation.

Records show that the coroner's office has collected nearly $1.4 million from Tissue Banks during the last five years. Tissue Banks also has donated two vans and upgraded an autopsy room where technicians perform the 45-minute corneal removals.

County officials say the payments are merely reimbursement for the time it takes for coroner employees to consult with Doheny technicians and for the space used by the eye bank.

Tissue Banks International officials put a different spin on the payments with the state's Registry of Charitable Trusts. In public filings, they called them "grants" intended to accelerate tissue removal.

"Due to budget constraints, the Los Angeles County Coroner's Office was unable to achieve its potential for tissue donations," the filing states. "Delays to the necessary timely release of tissue arose because of staffing shortages."

Coroner administrator Hernandez said that, although the extra money each year has been helpful, it has not been crucial to his department, which he said has suffered budget cuts of 25% over the last several years.

"If we lost our 250,000 bucks, big wow," he said. "After losing $3 million [in cuts] over six years, $250,000 is not going to be a big deal."

But some say the issue transcends the amount of money being funneled to the coroner's coffers.

"The way this has been done, with them buying things for the coroners, it's implied that they are going to get something in return," said Linder, who retired from the coroner's office last year. "It makes for an incestuous relationship."

Linder and other critics say that relationship is cemented not only by money but by personnel connections.

The most conspicuous is Ilona Lewis, who was in charge of the coroner's office from 1991 until her retirement in 1993 after 26 years of county service. She promptly joined Tissue Banks as a high-ranking executive with oversight of Doheny operations.

One year earlier, while still employed by the county, Lewis authorized an extension of the eye bank's contract and later encouraged her charges to help eye bank workers meet their goals.

In a 1993 memo to coroner staffers, two months before her new job was announced, Lewis wrote: "Tissue Banks International (TBI) reported a marked increase in the number of cases for harvesting in the month of March and early April. . . . Once again, thanks for a job well done."

Lewis acknowledged in an interview that she had a "brief discussion" with Tissue Banks about a job during her last days with the county. But she stressed that, in her current position, she does not have contact with members of her former department.

The hirings did not stop with Lewis. Within a week after morgue doctor Nine Liang was laid off in a 1993 budget purge, he was hired as a Doheny cornea technician. At least three other coroner's employees have worked full time for the county while holding down part-time jobs removing corneas for Doheny.

Doheny also has employed the children of two coroner pathologists. Last year, the tissue agency hired as a laboratory assistant the nephew of Sarah Ahonima, the coroner administrator currently in charge of Tissue Banks' county contract.

Ahonima said she had nothing to do with the hiring of her relative, whom she said had heard the organization was "looking for laboratory assistants, or lab boys." She declined to say whether she provided the tip.

Asked if the employment of her nephew posed a conflict because of her oversight of the tissue bank contract, Ahonima responded bluntly: "No, it does not."

Agreeing with her are coroner administrator Hernandez and Medical Examiner Sathyavagiswaran, who said in interviews that such hirings do not violate county policy.

James Childress, a nationally recognized expert on medical ethics, sees things differently. He said the financial ties between the eye bank and the coroner's office could provide "the temptation to cut ethical corners."

"At a very minimum, [families] ought to be informed and have a right to say yes or no" to corneal removals. "That's what we do on other organs. But if you think the family might be too upset or would have other problems providing the corneas, you might just skip [seeking permission] altogether."

Childress, a University of Virginia professor of biomedical ethics who has served on national task forces on organ transplants and cloning, said the coroner's extensive use of the California law "amounts to something very close to expropriation or conscription of corneas."

Use of High-Risk Donors a Concern

Beyond the ethical questions, concerns have been raised over whether Doheny executives are in step with counterparts elsewhere in the nation on public health issues.

The chance of contracting life-threatening illnesses through corneas, which are bloodless, is extremely remote. To date, for example, there has been no documented case of HIV infection by that route. Still, federal regulators have issued a series of rules to play on the safe side.

Among them: Corneal tissue should not be removed from people who have been incarcerated, who have used drugs intravenously or who have engaged in homosexual sex--all of which put them at risk for AIDS and hepatitis.

Doheny officials say they have done their best to comply, based on the paperwork available to them at the time. Moreover, Executive Director Thomas said blood tests are conducted on every cornea donor and their bodies are examined for telltale signs of drug abuse or fresh tattoos.

Safety, Thomas said, "is paramount. I think we put tremendous efforts at having talented people, training and really following the respective guidelines."

But several former Doheny employees said their experience showed otherwise. They said they were compelled to take corneas from bodies they considered suspect because of high-risk health factors.

Ex-Doheny employee Julia Brain, now a graduate student at McGill University in Montreal, said eye bank officials transferred her out of the morgue and into a phone job when she balked at removing eye tissue from a two-time prison inmate with tattoos.

"I said, 'I'm sorry, I'm not going to take this case,' " Brain recalled. "After that, they decided I shouldn't be a [technician] for them anymore and they wanted me to take donor calls."

In a sampling of several dozen cases from earlier this year, The Times found at least 10 in which corneas were taken from people who had been jailed three days or longer within the prior year. Their criminal identification numbers were listed on autopsy reports.

One of them was Michael Wayne Marshall, whose unidentified body was brought to the morgue Feb. 27. Two months earlier, he had been released from the California Institution for Men in Chino. His autopsy report noted that he had "multiple drug violations."

Doheny executive Thomas said he doesn't remember any technician being told to take corneas from high-risk donors, but acknowledged that mistakes can happen. "I think there's a risk whenever the donor can't talk," he said.

In the hopes of minimizing that risk, federal health authorities also require that social histories on donors be obtained by interviewing family members and friends. The exception: cases in which corneas have been removed under state statutes, such as those obtained by Doheny.

Thomas said that such social histories often are unreliable. "In any situation where you're asking next of kin or asking medical personnel or professionals about a certain case," he said, "you're going to get not 100% accurate information."

Sometimes, however, you do get enough to prevent mistakes.

Jason K. Woody, director of the Central Florida Eye and Tissue Bank in Tampa, knows how important a relative can be--as do eye bank officials in California and across the country, who routinely compile social histories.

"I had a [donor] who was 65 years old and he hadn't had sex with his wife in 20 years," Woody recalled. He said the case looked like a slam-dunk until he interviewed the man's wife.

"She said, 'Honey, he probably slept with two or three prostitutes a week,' " Woody said, adding: "I had to decline that case."

Woody's state, like California, has a coroners law. But unlike here, he said, his employees remove no corneas without family consent--"whether the patient is 1 day old or 100 years old"--or from anyone considered at risk for infectious diseases. "If you're in a motor vehicle accident in Tampa, if I don't find your next of kin, I don't take your tissue."

In his view, the practices occurring in Los Angeles border on theft.

"Would you want it to happen to your son or daughter? . . . You have to live with it for the rest of your life," he said. "A part of your loved one is gone, there's nothing you can do about it, and you never knew about it. . . . There's not even the courtesy of telling the general public that it's happening."

(BEGIN TEXT OF INFOBOX / INFOGRAPHIC)

Those Who Gave

Under the California Public Records Act, The Times examined all 572 cases in which corneas were removed without family consent or knowledge during a 12-month span ending in June.

Here, based on a computer analysis of that information, are some characteristics of the donors.

* Seventy-two percent were homicide victims, who are most likely to have young, "healthier" corneas that transplant banks seek. Accident victims accounted for the next largest group at 16%.

* Nearly 60% were Latino, 21% were African American and 16% were white. The number of minority cornea donors was disproportionate compared to the number of minorities autopsied. Only 44% of all autopsies performed during the last year were of Latinos and African Americans, while 42% were of whites.

* The average age was 27.7 years, much younger than the average age of all those autopsied. Eleven of the donors were 5 years old or younger; the oldest was 69.

Eye bank officials say that they base their selection of donors purely on mode of death and that race is not a factor.

(BEGIN TEXT OF INFOBOX / INFOGRAPHIC)

Harvesting Corneas

Under a little-known state law, the Doheny Eye & Tissue Transplant Bank has harvested thousands of corneas from bodies at the county morgue without notifying the next of kin. The county receives about $250 per pair--money county officials say recovers public costs. The corneas later are resold for considerably more.

* THE CORNEA: A transparent thin-walled dome forming the front of the eyeball. To remove the tissue, a technician opens the eyelid with a speculum and cuts around the thin membrane in a circle, extending three to four millimeters into the sclera, the white part of the eye. The cornea is then lifted and preserved in a culture medium. Including preparation, the entire

process takes about 45 minutes.

Pushing for More Corneas

This memo from the president of Doheny's management firm, Tissue Banks International, was distributed with January paychecks of eye bank employees. Some former workers say this kind of productivity push has led to overzealousness inside the county morgue. Tissue Bank's president characterized the missive as a "nudge," not pressure.

The Autopsy Factor

California law states that corneas can be taken without family consent only in cases targeted for autopsy. But coroner officials acknowledge that there have been occasions when unnecessary autopsies were performed to justify cornea removal. Documents in this 1996 drowning case show that a Doheny technician, working for Tissue Banks International, requested "at least a partial autopsy" because eye tissue had been removed. Morgue doctors complied, reversing an earlier decision that an autopsy was not needed.

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CLERK OF THE COURT

ORDR

DISTRICT COURT

CLARK COUNTY, NEVADA

***

BLACK JACK BONDING

Petitioner,

v.

LAS VEGAS METROPOLITAN POLICE DEPARTMENT, and DOUGLAS GILLESPIE

CASE NO. A670077
DEPT. XXX

AMENDED ORDER GRANTING IN PART MOTION FOR ISSUANCE OF WRIT OF MANDAMUS

Petitioner Blackjack Bonding Inc.'s Motion for Issuance of Writ of Mandate was heard by this Court on November 26, 2012 and again on the 29th day of January, 2013, the Honorable Judge Jerry A. Wiese presiding, Petitioner BLACKJACK BONDING, INC. appearing by and through their attorneys, TRACY A. DIFILLIPPO, ESQ. and CONOR FLYNN, ESQ., and Respondents LAS VEGAS METROPOLITAN POLICE DEPARTMENT ("LVMPD"), and DOUGLAS C. GILLESPIE, appearing by and through their attorney, THOMAS D. DILLARD, JR., ESQ.

On April 4, 2013, petitioner's Motion for Clarification was heard. At that time, this Court certified its willingness to modify the Order Granting in Part Motion for Issuance of a Writ of Mandamus, filed on March 19. This case had already been appealed to the Supreme Court, and as such, this Court lacked jurisdiction to modify the order in the fashion the petitioners had requested. On June 7, 2013, the Supreme Court of the State of Nevada issued

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an Order of Limited Remand, certifying this Court's inclination to grant the above requested relief. (Exhibit A.) This Amended Order is in response to that Remand.

PROCEDURAL HISTORY AND FINDINGS OF FACT

1. On November 26, 2012, the Court heard oral arguments on Petitioner's motion to issue a writ of mandamus and compel Respondents to produce logs of collect phone calls made by all inmates in the Clark County Detention Center ("CCDC") in 2011 and 2012 to all bail agents through use of the phone system installed in CCDC and operated by a Century Link, a private corporation who has contracted with Respondents.

2. The contract between Century Link and Respondents allows Respondents to receive a portion of the collect charges.

3. Upon inquiry of the Court at the hearing, counsel for Petitioner represented to the Court that the information was not needed for any marketing reasons but rather to verify phone calls made through the system intended to be received by Respondents were working properly.

4. Upon further inquiry of the Court at the hearing, counsel for Respondents represented that the subject logs are not kept by Respondents in the ordinary course of business and Respondents were unaware of the ability to generate such logs until after filing of Petitioner's motion. Respondents counsel further represented that they were informed by Century Link that the logs could be generated by them but they were not certain whether Century Link would assess any charges for running and producing the 2 year phone call log.

5. The Court, upon recommendation from Respondents, declined to order the production of the documents at that time but rather order that access be given to Respondents to enter CCDC under supervision and test to see that all phones available to inmates are

working properly by placing a call to Petitioner's phone number and checking to see that it properly connects to that number.

6. The Court further ordered that the manner be continued until January 29, 2013 to report on the CCDC site inspection and the phone check.

7. On January 29, 2013, the Court heard from the parties as to the results of the site inspection and further heard oral arguments on the motion to produce two years of CCDC inmate phone records.

8. Petitioner's counsel reported that they had access to all phones in operation at the time and all phone calls to Respondents' office worked appropriately; however, counsel reiterated it still wanted to receive the phone logs for the two year period to check to see if the phones were working on that particular day.

9. Upon inquiry from the Court of exactly what information was still requested, Petitioner's counsel limited the request to phone calls just made by inmates to a list of all bail agents in Clark County for the calendar years of 2011 and 2012 (but not limited to Petitioner's bail agents alone).

10. Petitioner's counsel further represented that it would accept redaction of identification numbers and the names of the CCDC inmates and Petitioner would be responsible for any costs associated with producing this report.

11. Respondents argued the concern raised by Petitioners has been extinguished through the site inspection and the request seeks records that are not public for purposes of NRS Chapter 239.

II.

ORDER

1. The Court, finds upon balance, that the requested records request, as limited by

Petitioner, falls under the public records definition of NRS Chapter 239 – although the question is a close one and the public interest in these documents is not weighty.

2. Petitioners shall be responsible for all costs associated with the production of this report charged by Century Link to Respondents, if any.

3. The report produced shall be in the form capable to be produced by Century Link without Petitioners having to convert the information to any particular format.

4. Respondents are required to produce call attempt records from all inmates at Clark County Detention Center to all phone numbers for the bail agents set forth in Exhibit "B" of this Order for the calendar years ending 2011 and 2012, subject to the specific terms and conditions of this order.

5. The names and identification numbers of the inmates shall be redacted from this report.

6. The Court will afford Respondents two weeks from the entry of this order to produce to Petitioners the requested report.

Dated this 25th day of June, 2013

JERRY A. WIESE II
DISTRICT COURT JUDGE
DEPARTMENT XXX

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on the 27th day of June, 2013, I mailed a copy of the Foregoing: **AMENDED ORDER GRANTING IN PART MOTION FOR ISSUANCE OF WRIT OF MANDAMUS,** in a sealed envelope, to the following and that postage was fully prepaid thereon:

THOMAS D. DILLARD, JR., ESQ,
OLSON, CANNON, GORMLEY, ANGULO & STOBERSKJ
9950 West Cheyenne Avenue
Las Vegas, NV 89129

Tracy A. Difillippo, Esq.
Conor P. Flynn, Esq.
ARMSTRONG TEASDALE LLP
3770 Howard Hughes Parkway, Suite 200
Las Vegas, Nevada 89169

NEVADA SUPREME COURT
200 Lewis Ave., 17th Floor
Las Vegas, NV 89101

Vickie Freeman, JEA for Dept XXX

Exhibit A

IN THE SUPREME COURT OF THE STATE OF NEVADA

LAS VEGAS METROPOLITAN POLICE DEPARTMENT; AND DOUGLAS C. GILLESPIE,
Appellants,
vs.
BLACKJACK BONDING, INC.,
Respondent.

No. 62864

FILED

JUN 07 2013

TRACIE K. LINDEMAN
CLERK OF SUPREME COURT
BY
DEPUTY CLERK

ORDER OF LIMITED REMAND

The parties' May 8, 2013, joint motion for a limited remand to the district court for the purpose of amending the district court's order granting a writ of mandamus, which motion is supported by an April 19, 2013, order certifying the district court's inclination to grant relief, is granted. *Foster v. Dingwall*, 126 Nev. ___, 228 P.3d 453 (2010); *Huneycutt v. Huneycutt*, 94 Nev. 79, 575 P.2d 585 (1978). We therefore remand this matter to the district court for the limited purpose of allowing the district court to clarify or correct its order granting a writ of mandamus. The district court shall enter its amended order within 30 days from the date of this order, and the district court clerk shall immediately transmit a certified copy of the amended order to this court. Any aggrieved party should timely file an amended notice of appeal from the district court's amended order.

It is so ORDERED.

Pickering, C.J.

cc: Hon. Jerry A. Wiese, District Judge
Olson, Cannon, Gormley, Angulo & Stoberski
Armstrong Teasdale, LLP/Las Vegas
Eighth District Court Clerk

Exhibit B

Pereira Bonding Services	LV	702-228-2683
On Time BB	LV	702-250-3495
Ceballos BB	LV	702-262-0088
Coach Ebarb BB	LV	702-333-4357
Mobile BB	LV	702-364-2245
Free, Mary		702-368-2683
County Jail BB	LV	702-382-2936
All Star Bonding Inc & All Star BB & A	LV	702-382-9000
Mayfield, Shawn & Garcia, Jeffrey Paul		702-382-9009
Mayfield, Shawn & Lopez, Ramona Rachael		702-382-9030
Mayfield, Shawn & Lopez, Nathan		702-382-9050
Mayfield, Shawn		702-382-9060
Mayfield, Shawn		702-382-9070
Mayfield, Shawn		702-382-9080
Easy Bail	HD	702-384-3279
Sheikhan, Shila & 1st Priority & 1st P	LV	702-384-3733
Caruso, Eugene & Goodfellas Bail Bonds & Goodfell		702-384-5245
Caruso, Paul		702-384-9939
Bail, Chris & Scream and Shout Bail Bonds & Screar		702-385-2222
Mayfield, Shawn		702-386-0186
Guadalupe, Pablo		702-386-2994
Mayfield, Shawn		702-386-5981
Smith, Michael A		702-386-7985
Mayfield, Shawn		702-386-7985
Valverde, Michael A		702-386-8750
Smith, Gregory Randall		702-386-9960
Blackjack Bonding & Benitscheck, Je	LV	702-387-0996
Caruso, Paul & 0 Bail Bonds, LLC & I	LV	702-387-1066
Caruso, Paul		702-387-1079
Caruso, Paul		702-387-5438
All Star Bail Bonds, Inc & All Star BB	NLV	702-399-0065
Mayfield, Seaynoah & Mayfield, Shawn		702-399-0677
Mayfield, Seaynoah & Betancourt, Jaime		702-399-0910
Mayfield, Shawn		702-399-1256
Mayfield, Shawn		702-399-2918
Mayfield, Shawn		702-399-5859
Padilla, Oscar L.		702-399-8513
It Wasn't Me BB Agency	LV	702-432-2245
Welles, Brigitte & Bail Bond Store , Inc & BB Store		702-433-2245
Sheikhan, Shila & 1 Way Out & 1 Way Out, LLC		702-433-3733
Free, Mary & 1,2,3 Get 'Em Out Fast & Free, Thoma		702-433-5245
Ceballos, Jose & Aztec Bail Bonds & Aztec BB & Cel		702-438-5245
Chaykin, Robert & Clark County Bail Bonds & Clark (		702-438-9999
Waggoner, Jake & Bailman & Bailma	LV	702-444-2245
Ceballos, Jose & Casablanca Group Inc & Casablan		702-451-2245
Sheikhan, Shila & Cheapest Bail Bonds & Cheapest		702-452-2245

Ceballos, Jose & Ceballos, Lilia & Jackpot Bail Bond		702-456-2245
Aslain, Oscar & All Pro BB & All Pro Bail Bonds & Oj		702-456-2676
E Bail & E Bail, LLC & Gabriel, Marc	LV	702-462-9200
E Bail LLC	LV	702-462-9822
Queen, Ronda R		702-464-2245
Eder, Daniel		702-471-8600
Coach Eberb BB & Eberb, Richard J.	HD	702-476-3733
Bail Boss BB	LV	702-476-5050
Bail King & Bail King, Inc & Deam, Ti	LV	702-489-8400
Daley, Clayton & In-N-Out Bail Bonds & In-N-Out BB		702-547-5245
Mayfield, Shawn		702-565-0023
Mayfield, Shawn & Smith, Jerry L		702-565-0098
Mayfield, Shawn & Avalos-Pina, Maria D		702-565-1757
Trujillo Flores, Albino		702-566-0023
Mayfield, Shawn & Lyon, Rocky Louis		702-566-4173
Lyon, Rocky Louis & Betancourt, Jaime		702-566-4809
Caruso, John & Free, Mary & Free Bail Bonds & Fre		702-596-3733
Aguayo, Enrique		702-633-2245
Brent Robert Helgold & Stay Clean B	NLV	702-648-2663
Giacopelli, Anthony		702-649-2245
Garcia, Martin R		702-678-5080
Thomas & Sons	LV	702-685-5438
Montelongo, Angelita M & Salas, Alexes		702-731-2245
Ward, Parrish & Bail Bonds.Com & B	LV	702-732-3000
Bedson, Brooke & BB Bail Bonds & E	LV	702-739-0335
Reech, Linda & Statewide Bail Bonds & Statewide Bl		702-740-5555
Caruso, Eugene & Super Bail LTD		702-792-2245
Powell, Larry & Sheikhan, Shila & Ba	LV	702-836-2245
Pereira, Miguel & Tecate Bail Bonds	LV	702-858-2663
Action Annie's & Action Annie's Inc	CC	702-883-6549
Big Bang BB	LV	702-944-2500
0 & 0 Bail Bonds, LLC & 0 & 0 BB & I	LV	702-221-1005
Bad Girl Bail Bonds & Shea, Christin	LV	702-222-2245
Vegas Bail, Inc & Vegas Bail & Reasi	LV	702-228-2245
Aasbeduation Bail Bonds & Aasbedu	LV	702-228-3000
Hero Bail Bonds, LLC & Hero BB & C	LV	702-228-4376
Bail Connection, LLC & Bail Connecti	LV	702-233-3733
A Easy Way Out Bail Bonds & A Eas	LV	702-236-5731
A G Bail Bonds, LLC & A G BB & Val	LV	702-248-8800
1 Stop Bail Bonds & 1 Stop BB & Per	LV	702-253-5245
Anyway Bail Bonds & Anyway BB & S	HD	702-254-2245
Bust Out Bail Bonds, Inc & Bust Out I	LV	702-255-2245
Cyclop Bail Bonds, Inc & Cyclop BB &	LV	702-267-6434
A-Dollar Bail Bonds & A-Dollar BB &	LV	702-294-2663
All Star Bail Bonds, Inc & All Star BB	LAUG	702-298-0025
Ceballos Bonding, Inc & Maloney, Pa	LV	702-333-2245

3 Way Bail Bonds, LLC & 3 Way BB	LV	702-383-2883
Big O Bail Bonds & Big O BB & Asial	LV	702-386-0493
Welles Bail Bonds, LLC & Welles BB	LV	702-373-3366
Jail Busters Bonding & Caruso, Euge	LV	702-382-2245
0 Kiss 0 Bail Bonds, LLC & 0 Kiss 0 E	LV	702-382-4900
Acme Bail Bonds & Acme BB & Acm	LV	702-382-5245
Welles, Brigitte & 007 Bail Bonds, LL	LV	702-383-9055
Bingo Bail Bonds & Bingo BB & Bute	LV	702-384-0440
Slattery, Lynn & All American Bail Bo	Reno	702-384-0699
Anthony's Bail Bonds & Anthony's BE	LV	702-384-2130
Foster, Jon & Bail Bond Specialist & Lightning Bail B		702-384-2245
Caruso, Paul & Godfathers Bail Bonds & Godfathers		702-384-4007
Slattery, Lynn & Big Daddy's Bail Bor	LV	702-384-7802
Bad Boys Bail Bonds & Bad Boys BB	LV	702-384-9111
Smith, Gregory		702-385-2533
Chubbs Bail Bonds, LLC & Chubbs B	LV	702-385-3235
Clarke, Michael E & Dave's Bail Bonds & Dave's BB		702-385-3737
Aardvark Bail Bonds & Aardvark BB /	LV	702-385-7393
Bob's Bail Bonds & Bob's BB & Murr	LV	702-385-8989
All Star Bail Bonds, Inc & All Star BB	LV	702-386-0095
Rescue Bail Bonds & Knuttbosch, Lamar & Rescue B		702-386-9116
Caruso, Paul & 005 Speedway Bail B	NLV	702-387-1064
Caruso, Paul & Bail Bonds of Las Ve	NLV	702-387-1068
Ward, Chris & A Affordable Bail Bonc	LV	702-387-5959
Henderson, Lloyd		702-399-7521
Pereira, Miguel		702-423-7285
Gorlick, Iris & Escape Bail Bonds & E	NLV	702-437-5245
Ward, Parrish		702-451-7100
Valdez, Paul & Lady Luck Bail Bonds	LV	702-456-4444
Pereira, Miguel & 7-11 Bail Bonds &	LV	702-456-5245
Mays, Gregory		702-457-2245
Ebarb, Tamara & Dad's Bail Bonds &	LV	702-458-2245
Free, Mary & 00:00:00 Midnight BB & Free, Thomas		702-458-5245
Clarke, Dave & A Royal Flush Bail Bc	LV	702-478-1500
911 Bail Bonds & 911 BB & Collins, C	LV	702-489-3000
Gorlick, Iris & 8-Ball Bail Bonds & 8-E	LV	702-545-0888
Nordeen, Ronald & Bail Bonds Inc. o	HD	702-563-2721
Aardvark Bail Bonds & Aardvark BB /	HD	702-564-7090
All Star Bail Bonds, Inc. & All Star BE	HD	702-565-0022
Pereira, Miguel & CSI Bail Bonds & C	LV	702-567-5245
Gorlick, Iris & 7 Sins Bail Bonds & 7 S	LV	702-586-0777
Torres, Arturo Alfred		702-588-2445
Chaykin, Robert & McCabe, J. Kevin	LV	702-643-3333
Free, Mary & Pereira, Miguel & 1st C	LV	702-644-2245
Ward, Chris & Giacopelli, Anthony &	LV	702-647-2245
Ransom, Richard & A AND A Bail Bo	NLV	702-649-9695

Ward, Chris & Caruso, Paul & 0 Dow	LV	702-678-6008
Didn't Do It Bail Bonds, LLC & Didn't	LV	702-686-2245
No Citations Bail Bonds, LLC & No C	LV	702-733-1616
Ryan, Kevin & Lucky Bail Bonds & Lu	LV	702-771-1000
Hamilton, Jackson & Innocent Bail Bonds & Innocent		702-795-2222
A+ Bail Bonds & A+ BB & Caruso, Ts	LV	702-795-2245
Sheikhan, Shila & #1 Paisanos Bail E	LV	702-869-5245
Free, Thomas & Budget Bail Bonds &	LV	702-870-5245
Cohen, Craig		702-871-2245
Pereira, Miguel & 21 Bail Bonds, LLC	LV	702-891-5245
Rebel Bail Bonds & Rebel BB & Wak	LV	702-891-8777
Ajax Bail Bonds & Ajax BB	LV	702-898-2245
Harris, Ronald & Silver State Bail Bonds & Silver Sta		702-997-9053
Clarke, Dave		720-478-1500
Justin, Richard		775-337-9400
Abra Cadabra BB & Vanella, Anthony	Pahrump	775-751-3400
Roberts, Rebecca		775-883-6549
Kelly, Daniel K		877-450-2245
Satreet, Inc & Satreet	AZ	928-255-7999

IN THE SUPREME COURT OF THE STATE OF NEVADA

CLARK COUNTY OFFICE OF THE CORONER/MEDICAL EXAMINER, Appellant, vs. LAS VEGAS REVIEW-JOURNAL, Respondent.	Case No.: 74604 Appeal from the Eighth Judicial District Court, the Honorable Jim Crockett Presiding

APPELLANT'S REPLY APPENDIX
Volume 1, Bates Nos. 1–91

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INDEX TO APPELLANT'S REPLY APPENDIX

REGISTER OF ACTIONS

CASE NO. A-12-670077-W

Black Jack Bonding, Inc., Plaintiff(s) vs. Las Vegas Metropolitan Police Department, Defendant(s)

Case Type: **Civil Writ**
Date Filed: **10/12/2012**
Location: **Department 4**
Cross-Reference Case Number: **A670077**
Supreme Court No.: **62864**
63541

PARTY INFORMATION

Defendant	**Gillespie, Douglas C**	**Lead Attorneys** **Thomas D. Dillard Jr** *Retained* 7023844012(W)
Defendant	**Las Vegas Metropolitan Police Department**	**Thomas D. Dillard Jr** *Retained* 7023844012(W)
Plaintiff	**Black Jack Bonding, Inc.**	**Tracy A. Difillippo** *Retained* 702-678-5070(W)

EVENTS & ORDERS OF THE COURT

DISPOSITIONS

10/15/2015 **Order** (Judicial Officer: Wiese, Jerry A.)
Debtors: Las Vegas Metropolitan Police Department (Defendant)
Creditors: Black Jack Bonding, Inc. (Plaintiff)
Judgment: 10/15/2015, Docketed: 10/22/2015
Total Judgment: 75,650.16
Satisfaction: Satisfaction of Judgment

OTHER EVENTS AND HEARINGS

10/12/2012 **Case Opened**
10/12/2012 **Petition for Writ of Mandamus**
Petition for a Writ of Mandamus Pursuant to the Nevada Public Records Act, NRS Chapter 239
10/12/2012 **Initial Appearance Fee Disclosure**
Initial Appearance Fee Disclosure
10/16/2012 **Motion**
Motion For Issuance of Writ of Mandate
10/22/2012 **Affidavit of Service**
Affidavit of Service - Dogulas C Gillespie
10/22/2012 **Affidavit of Service**
Affidavit of Service - Las Vegas Metropolitan Police Department
11/02/2012 **Opposition to Motion**
Respondent's Opposition to Petitioner's Motion for Issuance of Writ of Mandate
11/19/2012 **Reply in Support**
Reply in Support of Motion for Issuance of Writ of Mandamus
11/26/2012 **Motion** (9:00 AM) (Judicial Officer Wiese, Jerry A.)
11/26/2012, 01/29/2013
Plaintiff's Motion For Issuance of Writ of Mandate
Parties Present
Minutes
Result: Continued
03/19/2013 **Order**
Order Granting in Part Motion for Issuance of a Writ of Mandamus
03/20/2013 **Notice of Entry of Order**
Notice of Entry of Order
03/21/2013 **Notice of Appeal**
Notice of Appeal
03/26/2013 **Case Appeal Statement**
Case Appeal Statement
03/29/2013 **Motion for Clarification**
Motion for Clarification of Order Granting in Part Motion for Issuance of a Writ of Mandamus on an Order Shortening Time
03/29/2013 **Motion to Stay**
Respondents' Motion to Stay Enforcement of Judgment Pursuant to NRCP 62(c), (d) & (e) Pending Appeal on Order Shortening Time
04/01/2013 **Receipt of Copy**

Receipt of Copy

04/02/2013 **Opposition to Motion**
Respondents' Opposition to Petitioner's Motion for Clarification of Order Granting in Part Motion for Issuance of Writ of Mandamus on an Order Shortening Time

04/03/2013 **Reply in Support**
Reply in Support of Motion for Clarification of Order Granting in Part Motion for Issuance of a Writ of Mandamus on an Order Shortening Time

04/03/2013 **Response**
Response to Respondents' Motion to Stay Enforcement of Judgment Pursuant to NRCP 62(c), (d), & (e) Pending Appeal on Order Shortening Time

04/04/2013 **Motion For Stay** (9:00 AM) (Judicial Officer Wiese, Jerry A.)
Respondent's Motion to Stay Enforcement of Judgment Pursuant to NRCP 62(c), (d) &(e) Pending Appeal on OST.
04/09/2013 Reset by Court to 04/04/2013
Result: Granted

04/04/2013 **Motion for Clarification** (9:00 AM) (Judicial Officer Wiese, Jerry A.)
Petitioner's Motion for Clarification of Order Granting in Part Motion for Issuance of a Writ of Mandamus on an OST
Result: Granted in Part

04/04/2013 **All Pending Motions** (9:00 AM) (Judicial Officer Wiese, Jerry A.)
Parties Present
Minutes
Result: Matter Heard

04/11/2013 **Motion for Attorney Fees and Costs**
Motion for Attorney's Fees and Costs Pursuant to NRS 239.011

04/12/2013 **Certificate of Service**
Certificate of Serice of Motion for Attorney's Fees and Cost Pursuant to NRS 239.011

04/19/2013 **Order**
Order Granting in Part and Denying in Part Respondents' Motion for Stay of Execution of Order; Order Denying in Part Petitioner's Motion for Clarification of Order Granting in Part Issuance of a Writ of Mandamus; Certification of Intent to Modify March 29, 2013 Order Granting in Part Issuance of a Writ of Mandamus

04/22/2013 **Notice of Entry of Order**
Notice of Entry of Order Granting in Part and Denying in Part Respondents' Motion for Stay of Execution of Order; Order Denying in Part Petitioner's Motion for Clarification of Order Granting in Part Issuance of a Writ of Mandamus; Certification of Intent to Modify March 29, 2013 Order Granting in Part Issuance of a Writ of Mandamus

05/01/2013 **Opposition to Motion**
Respondents' Opposition to Petitioner's Motion for Attorney's Fees and Costs Pursuant to NRS 239.011

05/14/2013 **Reply in Support**
Reply in Support of Motion for Attorney's Fees and Costs Pursuant to NRS 239.011

05/15/2013 **Certificate of Service**
Certificate of Service of Reply in Support of Motion for Attorney's Fees and Costs Pursuant to NRS 239.011

05/21/2013 **Motion for Attorney Fees and Costs** (9:00 AM) (Judicial Officer Wiese, Jerry A.)
Plaintiff's Motion for Attorney's Fees and Costs Pursuant to NRS 239.011
Parties Present
Minutes
Result: Motion Denied

06/26/2013 **Order Denying Motion**
Order Denying Petitioner's Motion for Attorney's Fees and Costs

06/26/2013 **Notice of Entry of Order**
Notice of Entry of Order

07/01/2013 **Amended Order**
Amended Order Granting In Part Motion For Issuance Of Writ Of Mandamus

07/02/2013 **Notice of Appeal**
Notice of Appeal

07/02/2013 **Notice of Entry of Order**
Notice of Entry of Amended Order Granting in Part Motion for Issuance of Writ of Mandamus

07/02/2013 **Case Appeal Statement**
Case Appeal Statement

07/09/2013 **Amended Notice**
Amended Notice of Appeal

07/09/2013 **Case Appeal Statement**
Amended Case Appeal Statement

07/17/2013 **Certificate**
Certificate that no Transcript is Being Requested

03/06/2015 **Notice of Hearing**
Notice of Hearing

03/18/2015 **Notice of Appearance**
Notice of Appearance

04/09/2015 *CANCELED* **Status Check** (9:00 AM) (Judicial Officer Wiese, Jerry A.)
Vacated - Moot
Status Check: Supreme Court Return (No 62864)

07/01/2015 **Notice of Hearing**
Notice of Hearing

08/04/2015 **NV Supreme Court Clerks Certificate/Judgment - Affd/Rev Part**
Nevada Supreme Court Clerk's Certificate Judgment - Affirmed in Part, Reversed in Part and Remand; Rehearing Denied; Petition Denied

08/07/2015 **Memorandum of Costs and Disbursements**
Amended Memorandum of Costs and Disbursements

08/10/2015 **Amended Certificate of Service**
Amended Certificate of Service

08/17/2015 **Motion to Retax**
Motion to Retax Costs

08/18/2015 **Notice of Motion**
Notice of Motion

08/20/2015	**Motion for Attorney Fees and Costs** *Petitioner Black Jack Bonding, Inc.'s Renewed Motion for Attorneys' Fees and Costs Pursuant to NRS 239.011 and Motion for Order Requiring Respondents to Immediately Produce Telephone Records*
08/20/2015	**Appendix** *Petitioner Jack Black Bonding, Inc.'s Appendix*
08/25/2015	**Receipt of Copy** *Receipt of Copy of Petitioner Black Jack Bonding, Inc.'s Renewed Motion for Attorneys' Fees and Costs Pursuant To NRS 239.011 and Motion for Order Requiring Respondents to Immediately Produce Telephone Records and Petitioner Black Jack Bonding, Inc.'s Appendix*
08/25/2015	**Receipt of Copy** *Receipt of Copy of Petitioner Black Jack Bonding, Inc.'s Renewed Motion for Attorneys' Fees and Costs Pursuant To NRS 239.011 and Motion for Order Requiring Respondents to Immediately Produce Telephone Records and Petitioner Black Jack Bonding, Inc.'s Appendix*
08/31/2015	**Stipulation and Order** *Stipulation and Order to Continue Status Check Hearing on Motion to Retax Costs*
08/31/2015	**Notice of Entry of Stipulation and Order** *Notice of Entry of Stipulation and Order to Continue Status Check Hearing and Hearing on Motion to Retax Costs*
09/08/2015	**Opposition to Motion** *Petitioner Black Jack Bonding, Inc.'s Opposition to Motion to Retax*
09/09/2015	**Notice of Rescheduling** *Notice of Rescheduling*
09/09/2015	**Opposition to Motion** *Opposition to Black Jack Bonding, Inc.'s Renewed Motion for Attorneys' Fees and Costs and Opposition to Motion for Order Requiring Respondents to Immediately Produce Telephone Records*
09/15/2015	**Reply in Support** *Petitioner Black Jack Bonding, Inc.'s Reply in Support of Renewed Motion for Attorneys' Fees and Costs Pursuant to NRS 239.011 and Motion for Order Requiring Respondents to Immediately Produce Telephone Records*
09/15/2015	**Reply** *Reply in Support of Motion to Retax Costs*
09/22/2015	**Status Check** (9:00 AM) (Judicial Officer Wiese, Jerry A.) *Status Check: Supreme Court Return* *08/27/2015 Reset by Court to 09/22/2015*
09/22/2015	**Motion to Retax** (9:00 AM) (Judicial Officer Wiese, Jerry A.) *Defendant's LVMPD and Douglas C. Gillespie's Motion to Retax Costs* *09/17/2015 Reset by Court to 09/22/2015* Result: Denied
09/22/2015	**Motion for Attorney Fees and Costs** (9:00 AM) (Judicial Officer Wiese, Jerry A.) *Petitioner Black Jack Bonding, Inc.'s Renewed Motion for Attorneys' Fees and Costs Pursuant to NRS 239.011 and Motion for Order Requiring Respondents to Immediately Produce Telephone Records* Result: Granted
09/22/2015	**All Pending Motions** (9:00 AM) (Judicial Officer Wiese, Jerry A.) Parties Present Minutes Result: Matter Heard
09/23/2015	**Receipt of Copy** *Receipt of Copy*
10/15/2015	**Order** *Order and Judgment regarding (1) Petitioner's Renewed Motion for Attorneys' Fees and Costs and Motion for Order Requiring Respondents to Immediately Produce Telephone Records and (2) Respondents' Motion to Retax Costs*
10/19/2015	**Notice of Entry of Order** *Notice of Entry of Order and Judgment Regarding: (1) Petitioner's Renewed Motion for Attorneys' Fees and Costs Pursuant to NRS 239.011 and Motion for Order Requiring Respondents to Immediately Produce Telephone Records, and (2) Respondents' Motion to Retax Costs*
12/17/2015	**Receipt** *Receipt of Check*
03/28/2016	**Satisfaction of Judgment** *Satisfaction of Judgment*
03/30/2016	**Amended Certificate of Service** *Amended Certificate of Service*
07/02/2018	**Case Reassigned to Department 4** *Reassigned From Judge Wiese - Dept 30*

Financial Information

Defendant Las Vegas Metropolitan Police Department

	Total Financial Assessment			3.50
	Total Payments and Credits			3.50
	Balance Due as of 11/12/2018			**0.00**
03/29/2016	Transaction Assessment			3.50
03/29/2016	Efile Payment	Receipt # 2016-30819-CCCLK	Las Vegas Metropolitan Police Department	(3.50)

Plaintiff Black Jack Bonding, Inc.

	Total Financial Assessment			294.00
	Total Payments and Credits			294.00
	Balance Due as of 11/12/2018			**0.00**
10/15/2012	Transaction Assessment			270.00
10/15/2012	Efile Payment	Receipt # 2012-128012-CCCLK	Black Jack Bonding, Inc.	(270.00)

07/02/2013	Transaction Assessment			24.00
07/02/2013	Efile Payment	Receipt # 2013-80138-CCCLK	Black Jack Bonding, Inc.	(24.00)

NEWS › INVESTIGATIONS

Failed to death: Abused children's cries for help were ignored

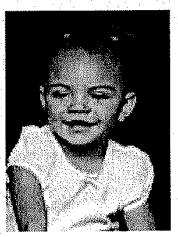
By **JENNIFER BROWN** | jbrown@denverpost.com, **CHRISTOPHER N. OSHER** | cosher@denverpost.com and **JORDAN STEFFEN** | jsteffen@denverpost.com | The Denver Post

PUBLISHED: November 10, 2012 at 8:27 am | UPDATED: May 9, 2018 at 12:09 am

Since 2007, 175 children in Colorado have died of abuse and neglect – beaten, starved, suffocated and burned. Deepening the tragedy is that the families or caregivers of 72 of them were known to caseworkers whose job was to protect them.

Mary Ann Hartman worried the little girl across the street was going to die.

A GRAVE FOR A LITTLE GIRL.



Alize Vick, left, whose body rests at Roselawn Cemetery in Pueblo, was killed at the age of 2 in October 2007 after her foster mother, Jules Cuneo, hurled her five feet, head-first into a coffee table. Based on the reports filed by her foster mother, Alize was extremely accident prone during the five months she lived with Cuneo. But a neighbor, Mary Ann Hartman, could hear what was going on inside the house through a baby monitor and began recording what prosecutors later described as the ongoing torture and abuse of Alize by Cuneo. The recording wouldn't be enough. (Craig F. Walker, The Denver Post)

Hartman's baby monitor captured the 23-month-old's screams and stifled sobs as her 300-pound foster mother sat on her. She recorded the horror coming from the house where the foster mother yelled and ridiculed and the children cried.

Hartman mailed the recording to El Paso County child welfare authorities with a note: "She really needs you. I am doing my part by writing to you, but you must do the rest."

Then Hartman waited. She called the county when she heard more screaming, when she heard foster mother Jules Cuneo refuse to give the toddler food.

She wondered if anyone would rescue the girl with the toothy grin and big brown eyes.

No one did.

More than 40 percent of the children who died of abuse and neglect in the last six years in Colorado had families or caregivers known to child protection workers who could have saved them.

Those 72 children – many beaten, starved, suffocated or burned – died despite warnings from relatives, neighbors, teachers and strangers, or even the baby monitor recording of blatant abuse sent to caseworkers. Many of their deaths were not only preventable, they were foretold.

It happens, on average, every 30 days. Somewhere in Colorado, a police officer investigates a child's death from abuse and neglect only to learn the victim is a familiar face to county social workers.

Nine such kids have died so far this year.

A Denver Post and 9News investigation of the Colorado child welfare system revealed a pattern of disturbing failures in which warnings were ignored, cases closed without even a visit and children given to foster parents who killed them.

Caseworkers and their supervisors failed to complete investigations in the time required by law 18 times before children ended up dead. They routinely — at least 31 times — did not contact neighbors and acquaintances who might have told them a child was at risk of harm or even death. More than half of the time, caseworkers violated at least one state rule when conducting abuse investigations, according to an analysis of fatality case reviews by the state Department of Human Services.

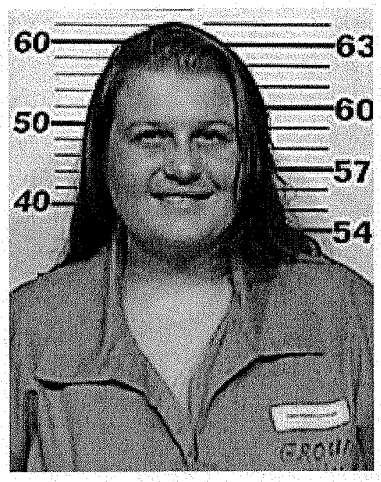
The system is plagued by a lack of accountability and transparency — every county in Colorado decides how to run its own child protection department, with minimal input from the state. It is so disjointed, state officials cannot pinpoint the average workload of caseworkers, and cannot fire or discipline a county employee.

Despite years of warnings from expert panels and earnest expressions of concern from three governors and legions of legislators, Colorado's $375 million system to protect kids from dying remains stubbornly broken.

More kids have died of abuse and neglect in this state in the last five years than in the five years before that, and an increasing number of those children were known to child welfare workers before they were killed. This is despite the highly publicized starving death of 7-year-old Chandler Grafner in 2007 that galvanized attention on the child welfare system.

"It's 2012, and all the advancements we have in our society, whether it's technological or medical, we can't figure out how to keep kids safe?" said Stephanie Villafuerte, director of the Rocky Mountain Children's Law Center, a nonprofit law firm that often represents foster children. "You are talking about dead children."

No one at El Paso County took Mary Ann Hartman's letter and baby monitor recording seriously enough.



Alize Vick, the girl across the street, died five months later, in October 2007, after her foster mother hurled her five feet, head-first into a coffee table. Cuneo was enraged because the toddler wouldn't talk to her.

A caseworker said she listened to the recording and visited the home. But the worker determined it wasn't enough to take Alize away from Cuneo.

In many other cases that resulted in dead children, a caseworker never came at all.

CAREGIVER.
Jules Cuneo, who was the foster mother for 2-year-old Alize Vick, is serving a 32-year prison sentence for the child's death. (Handout)

Almost half of the children known to social services who died of abuse and neglect since 2007 had at least one call "screened out," or not investigated, because child welfare workers deemed the allegations did not meet the threshold for child abuse or they didn't have enough information.

Caseworkers had seven chances to help Ciarea Witherspoon's family before she was left alone in a bathtub.

Seven times — the majority of them before Ciarea was born — someone called authorities to say things were not right at the family's house. The allegations piled up.

What would it take for authorities to intervene?

Not the reports of guns and fighting. Not the claims that her father threatened to throw her mother in the trash and that he threatened to kill her. Ciarea's 7-year-old brother had bruises and went to school with a black eye. Her brother was covered in feces, acted much younger than his age, and he sometimes pretended to slam his head into a wall and said his stepfather hurt him. He told people at school he might get cocaine under the Christmas tree.

In every instance, authorities chose not to intervene. Three of the seven calls were screened out. The four other times, caseworkers assessed whether there were safety threats and ultimately recommended against opening an investigation.

Then in June 2009, 6-month-old Ciarea and her 2-year-old brother were left alone at bath time. By the time her father returned from answering the door and cooking some chicken, she was face down in the water and unresponsive. She lived for nine more months — on a ventilator, with a feeding tube and a leg amputated due to an infection.

As she lay unconscious in the hospital, the state put her in foster care. Ciarea died March 18, 2010.

Problems were "training issues"

Caseworkers assigned to Ciarea's family violated several state regulations, including failing to interview key people after allegations of abuse prior to the little girl's death. Arapahoe County officials told The Post there was "absolutely no connection" between the policy violations and the girl's death, and that the problems were caseworker "training issues."

That happens regularly.

In more than half of child abuse deaths in the last six years, caseworkers did not follow state policy regarding how to investigate neglect and abuse allegations, according to The Post's review of state fatality reports. Of 59 reports released to the newspaper, 31 listed violations of state rules.

Caseworkers erred by screening out calls that deserved follow-up, failing to check on children within the time allowed by law and neglecting to communicate with law officers or another county's child welfare division when a child moved, according to state reviews of the deaths.

Each case is a judgment call, and caseworkers can't always prevent evil, said Ruby Richards, child protection manager for the Colorado Department of Human Services.

"Caseworkers don't kill these kids," she said.

Since 2007, the state has reviewed the deaths of 30 children who had an assigned caseworker — a worker who at minimum was tasked with visiting a home to find out whether ongoing oversight was needed. These are cases where allegations were not screened out but were elevated to require at least one follow-up.

BEHIND CLOSED DOORS.
Maria Gardner stands in her room at the Denver Women's Correctional Facility in Denver. Gardner poured gasoline over her five children then lit them on fire, killing 16-month-old Ashya Joseph and severely burning the other four on Jan. 28, 2008. In a plea

That included Maria Darlene Gardner and her family.

El Paso County caseworkers were warned on Jan. 23, 2008, by an employee at a family services center that Gardner, distraught over her husband's suicide, was making funeral arrangements for herself and her five young children.

agreement, she pleaded guilty to child abuse causing death and four counts of child abuse causing serious bodily injury. Gardner is now serving 85 years in prison. Gardner says the Department of Human Services should have done more. "They should have taken my children from my home, and they should have put me somewhere " (Craig F. Walker, The Denver Post)

A caseworker tried to "problem solve" with Gardner and helped her make a plan for babysitting so Gardner could go to therapy. The caseworker called Gardner the next day, and the mother told her she was "fine" and not suicidal. But five days later, on Jan. 28, Gardner gathered her five children in her Colorado Springs home, doused them with gasoline and set them on fire.

Four children survived, but not 16-month-old Ashya Joseph.

One child was on fire as he called 911.

"Why did you? ... You killed them. Why did you kill them? I loved them," the 8-year-old boy says during the phone call. The children's burns covered 20 to 90 percent of their bodies.

Before Gardner set the fire, she looked into a video camera and explained she couldn't live now that her husband was dead, and she wanted to bring her kids with her. She is serving an 85-year prison sentence.

A state review of Ashya's death found El Paso County caseworkers had been alerted to problems involving physical abuse in the home six other times, beginning in 2004, but did not remove the children.

The job of a caseworker is partly about following the law and partly about following instinct.

Caseworkers teeter along a thin line of respecting people's rights to privacy in raising their children and the legal definition of abuse and neglect.

Parents can spank their kids, but they aren't allowed to leave serious bruises, bleeding, burns or bone fractures, according to state law. The law doesn't say what age a child can stay home alone; it's a judgment call.

State law says child abuse includes the failure to provide "adequate food," but that's not exactly black and white. Just because a child's home has only a half loaf of bread and Pop-Tarts to last two weeks, that isn't necessarily cause to assign a caseworker.

The law also says abuse investigators must consider "accepted child-rearing practices" of the child's culture.

Caseworkers are criticized when they tear children away from their parents and crucified when a child on their watch ends up dead.

"Social services is damned if we do and damned if we don't," Richards said.

State officials concede there are failures, times when inaction ends in a child's death, but that there are examples, too, when a caseworker does everything right and a child still dies.

Gov. John Hickenlooper said caseworkers are "doing some of the hardest jobs on earth" and that state officials are reviewing child deaths, looking for ways caseworkers can improve.

"Was it they were busy? Were they overworked? Did they make several calls and they couldn't connect on this allegation of neglect? They made three calls and they just got distracted?" he said. "What we've tried to do is create solutions for those parts of the problem we control."

In the case of little Torrey Brown Jr., a caseworker chose not to intervene after the baby's grandmother warned his life was in danger.

Torrey's mother had said he was a crybaby, that she was going to strangle him, that he would end up in a casket, the infant's father and grandmother recalled.

Torrey's grandmother, Corinthiah Brown, got to keep Torrey for only one night after she told an Adams County caseworker she feared for his life. Then, after the caseworker told her she was overreacting, Brown said, she was ordered to give him back.

The baby was gone within a few months.

SAYING GOODBYE TO A BABY.

Torrey Brown Sr., 26, talks with his mother Corinthiah Brown and funeral director Jehn-ai Jackson at Caldwell-Kirk Mortuary in Denver on June 3, 2012. Brown was making service arrangements for his son, Torrey Brown Jr., above. The Commerce City Police Department found the remains of the 6-month-old infant May 31, 2012, at the Denver Arapahoe Disposal Site. Sharrieckia Page, 23, the baby's mother, is charged with first-degree murder and child abuse resulting in death. Torrey Sr. says the Department of Human Services should have done more, "She talked about doing something before. Everybody took her serious but the Department of Human Services. She would call and make threats, 'I'm going to choke him.'" (Craig F. Walker, The Denver Post)

After a painstaking, 52-day search through trash 20 feet deep at a Commerce City landfill, authorities found Torrey's remains in May. Police say his mother suffocated the 6-month-old baby and threw him away.

Brown wishes caseworkers had taken her more seriously. And she wishes that even when they didn't that she hadn't backed down.

"I tried to stay out of the way," she said, tears streaking her cheeks as she sat in her Aurora living room. "I never thought it would turn out like this. This is what I get."

The state does not track whether its child welfare workers are overburdened with work, whether they are overwhelmed with so many kids they don't try as hard as they should to talk to relatives, neighbors and babysitters to find out whether kids were safe.

Sharrieckia Page, 23, Torrey Brown's mother, is charged with first-degree murder and child abuse resulting in death.

Colorado is one of 11 states that do not report caseload data to the federal government.

In this state, each county decides what to pay caseworkers and how much work to give them. Expert panels have suggested the state study staff workloads, but state officials said that is not a priority.

The number of calls reporting alleged child abuse and neglect has jumped 20 percent from 2007 to fiscal 2011, yet the number of investigations opened based on those referrals went up by only 5 percent. In fiscal year 2011, only about half of the 107,854 referrals were investigated.

And state officials do not know whether Colorado has more caseworkers now than it did five or 10 years ago; counties, which are in charge of their workers, aren't required to tell the state.

Adams County, for one, has three fewer caseworkers now than five years ago. In the same span, annual referrals regarding child abuse and neglect increased by 1,245.

Child advocates question whether there are an adequate number of caseworkers and whether Colorado and its counties spend enough to retain the best workers.

"You actually do get what you pay for," said Des Runyan, executive director of The Kempe Center for the Prevention and Treatment of Child Abuse and Neglect, who is frustrated by what he sees as Colorado's minimalist spending on child abuse prevention. "The good people find other things to do."

Colorado's two previous governors — a Democrat and a Republican — zeroed in on one key flaw that hinders child safety in Colorado: a county-run child welfare system with limited state oversight.

After 7-year-old Grafner's death in 2007, then-Gov. Bill Ritter, a Democrat, created an expert panel to study child welfare. Grafner, who starved to death, had been trapped in a linen closet with no food or water and only a litter box to go to the bathroom, even as school officials called child welfare authorities.

The committee worked for two years, putting forth 34 recommendations for changes in law and policy. Some eventually became reality, including a caseworker-training academy now open in Parker. But two of the biggest reforms died in a political battle that pitted county commissioners against state officials and child advocates.

The panel of child welfare experts wanted a statewide hot line to report child abuse, a central place to screen calls. And they wanted a regionalized system, where rural counties would combine resources and expertise.

"We looked at the urgency of this because of the well-being of children, who one way or another seemed to be falling through the cracks in the most fatal ways," said Ritter, who called the "turf issue" with counties one of the most contentious of his tenure. It was "terribly frustrating," he said, that his child welfare task force could not get statewide data because each county has its own authority.

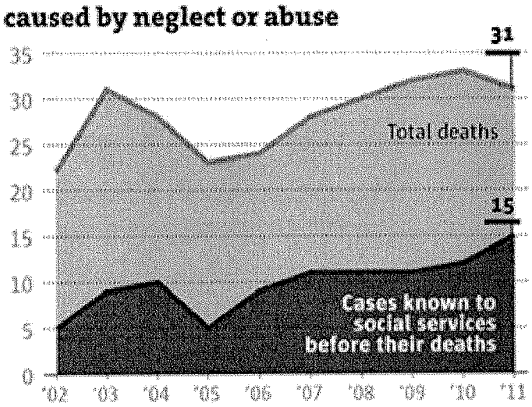
Former Gov. Bill Owens, a Republican who held the office before Ritter, recalled the same problem.

"We have a real challenge because authority is so diffused," he said. "Where you would think that a governor and a state have the responsibility and authority, in many cases they don't. While many of our counties have very strong departments of social services, regrettably, some do not, and it's very hard to establish statewide accountability and structure when there are such huge variations."

Tragic figures

Each year since 2002, between 22 and 33 children have died of abuse and neglect in Colorado. Many of those children's families or caregivers were known to the child welfare system before they were killed.

Child fatalities in Colorado caused by neglect or abuse



Nationwide child maltreatment fatality rates in 2010

Rank	Number of fatalities per 100,000 children
1. Florida	4.44
2. New Mexico	3.72
3. Texas	3.22
4. Vermont	3.17
5. Ohio	3.06
6. Michigan	3.02
7. Georgia	2.98
8. Kentucky	2.96
9. Oklahoma	2.94
10. Arkansas	2.68
19. Colorado	**2.20**
Nationwide	2.07

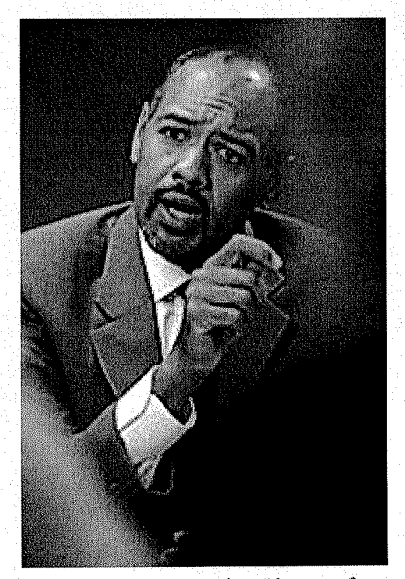
Sources: Colorado Department of Human Services; U.S. Department of Health and Human Services

The Denver Post

Hickenlooper stopped short of calling for less county control, but said he might consider it in a few years if his administration's reforms don't work.

Hickenlooper's key effort is a state scoring system, created by the new director of the Colorado Department of Human Services, that rates counties' handling of child abuse investigations. He hopes public pressure will encourage county departments to improve their work, even though county-by-county ratings do not appear on a state website that shows how the state stacks up against federal guidelines and past performance.

"We are always going to be one step removed because the counties are going to have that ultimate control," Hickenlooper said. "Now the only way that I can see that the state can begin to exert serious authority ... is through transparency."



Reggie Bicha, Executive Director for the Colorado Department of Human Services (Craig F. Walker, The Denver Post)

It's one reform in a list of overhauls announced by Human Services director Reggie Bicha, who took over the department in January. He also has called for clearer and more consistent procedures across all counties.

"We are trying to shift a huge ocean liner in our child welfare culture in Colorado," Bicha said. "I want us to turn the boat in a better direction for kids and families."

About 30 kids, on average, die of abuse and neglect in Colorado each year, putting the state among the top half nationally in per-capita death rates. Since 2007, 175 children have died of abuse and neglect in Colorado.

"It's all of our fault," said Skip Barber, executive director of the Colorado Association of Family and Children's Agencies, a group of not-for-profit advocacy agencies.

More often than not, child abusers are the children's own parents, a relative or their mother's boyfriend. Those are the people to blame.

But the blame stretches further, experts said.

"Children don't vote. They don't have a strong enough advocacy," said Tracey Feild, director of the child welfare strategy group at the Annie E. Casey Foundation. "There is an assumption that abused and neglected children are only 'those' people."

Clearly, though, even when people plead for help, that is not always enough.

The El Paso County caseworker who listened to the baby monitor audio recordings of 2-year-old Alize Vick said there wasn't enough evidence to remove Alize from the foster home. The worker was reassigned to another county job, and the county revamped its practices so it could, among other things, react faster to help children in danger. The foster mother, Cuneo, is serving a 32-year prison sentence.

The girl's neighbor who had recorded the abuse, Mary Ann Hartman, would tell a state Senate committee that El Paso County ignored her.

"I believe that preconceived ideas and attitudes can run through an institution like a virus," she said. "I was met with skepticism and disrespect."

She had written a letter, called and met authorities — but could not get their attention, Hartman said.

"I was in total disbelief ... I was trying to save a little girl, and they would not believe me," she said. "I kept telling them, she is going to kill the little girl. She will kill her, and they still did not believe me."

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Child abuse referrals

The graphic below shows the child abuse referral rates in Colorad's 64 counties. The two bottom graphics show that referrals have increased dramatically since 2007, while the number of investigations has increased modestly and the number of children under ongoing protection services also is on the decline.

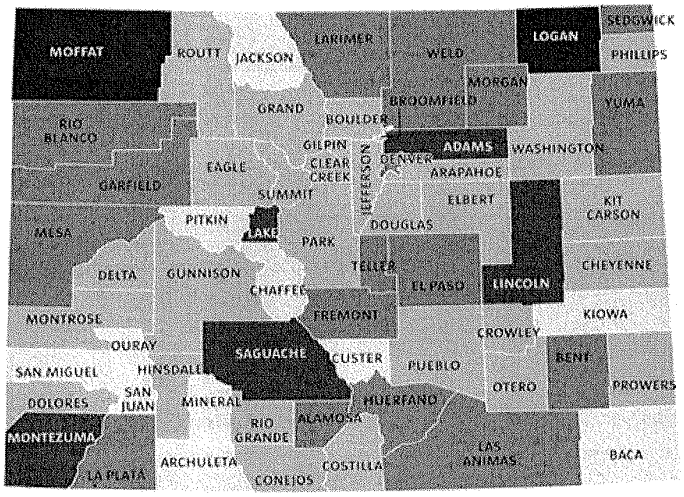
Referrals by county

Number of referrals per 1,000 people

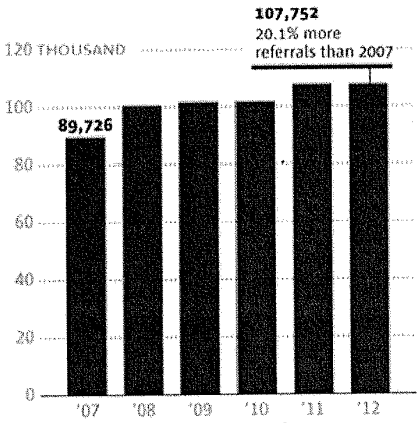
- 0 - 9.9
- 10.0 - 19.9
- 20.0 - 29.9
- 30.0 - 39.9
- 40.0 +

Top 5	Rate
1. Moffat	44.83
2. Logan	43.19
3. Lake	34.74
4. Saguache	32.11
5. Lincoln	32.09

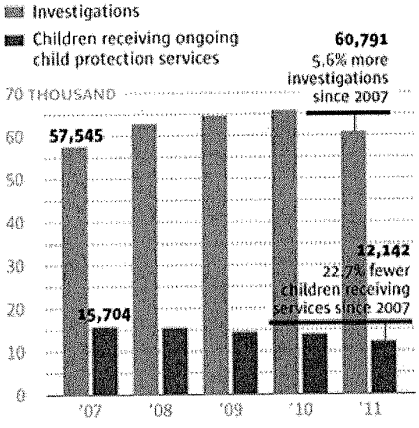
Bottom 5	Rate
60. Chaffee	5.24
61. San Miguel	5.07
62. Jackson	2.19
63. San Juan	1.45
64. Custer	0.95



Total referrals in Colorado



Investigations vs. involvements



Note: Rates calculated with population data from 2011 estimates. Data for fiscal years.

Sources: Colorado Department of Human Services; Division of Child Welfare Services; U.S. Census Bureau *The Denver Post*

View an interactive version of this graphic, and search Colorado's child abuse referrals by county, type and year.

Child fatality reviews

When a child who was part of the child welfare system dies of abuse or neglect in Colorado, county and state officials complete a child fatality review. Many of the findings in this series come from those reports.

Caseworkers, county child protection supervisors and state officials review each fatal case — including any referrals involving the family before the child was born — to create a detailed history of involvement in the system. The review team identifies any risk factors that were present for the child or the family before the death.

The review determines whether there were any concerns or policy violations in the way caseworkers investigated claims of child abuse or neglect, said Ruby Richards, child protection manager for the state.

But the parameters for when and how a report is completed have fluctuated.

In 2011, state officials excluded an unknown number of children's deaths from ever being reviewed by decreasing the amount of time within the child welfare system — from within the last five years to within the last two years — necessary to trigger a review.

Also, beginning in 2012, reports provided fewer details about the child and the child's family history with the department, Richards said. Instead of a narrative style, information was provided in a list format. The reports also listed fewer violations of state regulations, noting the violations only if officials determined they were "systemic" concerns.

"Pointing out an isolated issue doesn't seem fair," Richards said earlier this year.

In the course of a Denver Post investigation, state officials stopped the release of any other reports so that they could redo them in a format they say is more transparent.

TAGS: **FAILED TO DEATH, FAILED TO DEATH SERIES**

Jennifer Brown

Jennifer Brown is an investigative reporter for The Denver Post, where she has worked since 2005. She has written about the child welfare system, mental health, education and politics. She previously worked for The Associated Press, The Tyler Morning Telegraph in Texas, and the Hungry Horse News in Montana.

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Jordan Steffen

Jordan Steffen was the legal affairs reporter for The Denver Post. She left the organization in June 2016 after joining in January 2011. Her past coverage areas included breaking news, child welfare, the western suburbs and crime. She was raised in the Colorado mountains and graduated from the University of Colorado Boulder.

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STATE OF COLORADO

cdhs

Colorado Department of Human Services
people who help people

OFFICE OF CHILDREN, YOUTH AND FAMILY SERVICES
George Kennedy, Deputy Executive Director

DIVISION OF CHILD WELFARE
1575 Sherman Street
Denver, Colorado 80203-1714
Phone 303-866-4365
FAX 303-866-5563
www.cdhs.state.co.us

Bill Ritter, Jr.
Governor

Karen L. Beye
Executive Director

March 19, 2010

Richard Bengtsson, Director
El Paso County Department of Human Services
105 North Spruce
Colorado Springs, CO 80905

Dear Mr. Bengtsson:

Please find enclosed the final child fatality reports on the death of Ashya Joseph for your records. We apologize for the delay in providing you a copy of the report, which is the result of a records review by the Child Protection Intake Administrator and review by the Colorado Department of Human Services State Child Fatality Review Team. Please provide to the Colorado Department of Human Services a letter indicating any policy or practice changes that have been implemented since the county internal review and state child fatality review of the death of Ashya Joseph. This documentation shall be provided to CDHS within 45 days of the receipt of this report.

We are committed to releasing these reports more timely in the future and appreciate your patience.

This state fatality review report is available through my office to anyone requesting a copy.

Sincerely,

Ruby Richards

Ruby Richards
Child Protection Intake Administrator

Enclosure: Final Child Fatality Report

cc: Karen L. Beye, CDHS Executive Director
George Kennedy, CYF Deputy Executive Director
Lloyd Malone, Child Welfare Services Director

CONFIDENTIAL
Colorado Department of Human Services
Child Fatality Review Team
May 31, 2008
Child Fatality Summary

A. Identifying Information:

Child: Ashya M. Joseph	**D.O.B** 09/25/2006	**D.O.D.** 01/28/2008
Biological Parents:		
Mother: Maria Gardner	**D.O.B.** 10/30/1982	
Father: Simeon Joseph	**D.O.B.** 08/04/1980	**D.O.D.** 10/09/2007
Surviving Siblings:		
Brother:	**D.O.B.** 7/21/1998	
Brother:	**D.O.B.** 9/1/1999	
Sister:	**D.O.B.** 12/7/2002	
Brother:	**D.O.B.** 7/2/2004	

Subject of Investigation: Maria Gardner

B. Involved County: El Paso County Department of Human Services (EPCDHS)

C. Introductory Statement:

The Colorado Department of Human Services (CDHS) Child Fatality Review Team conducted the review of the circumstances surrounding the death of Ashya Joseph. The purpose of the review is to examine existing practices and policies and how they currently affect the county child welfare programs. These findings should not be construed to link the county's actions to the actions allegedly perpetrated on this child by her guardians/caregivers.

Statutory authority for this review is in Title 26-1-111, Colorado Revised Statutes. The Colorado Department of Human Services supervisory authority is outlined in the areas of child welfare and other programs as specified. It is in the capacity of supervision of the county's administration of child welfare programs that the state has the legal responsibility to require the corrective actions and to conduct follow-up reviews.

D. Case Summary:

Ashya Joseph died on 01/28/2008 as a result of smoke inhalation and thermal injuries because of a fire that her mother, Ms. Gardner, intentionally set at the family's residence. The manner of death was listed as homicide. Her remaining siblings were seriously injured in the fire and were hospitalized. The extent of the children's burns

on their bodies ranged from 20% to 90%. All but one of the surviving siblings reside with the paternal grandmother. The most severely burned child is still hospitalized out of state.

The victim's father, Mr. Joseph, committed suicide on 10/09/2007. This was a precipitant for Ms. Gardner's actions on 01/28/2008, as she had reported that she felt responsible for Mr. Joseph's death and wanted to die, along with her children. She had made elaborate plans for her own death and burial that she had recorded on a DVD, in letters to her family, and in a journal.

E. Chronology:

The family was originally referred to EPCDHS on 05/04/2004 for physical abuse to one of the victim's siblings by Mr. Joseph. There have been seven referrals on the family, primarily for allegations of physical abuse.

- **05/04/2004:** A five-year-old sibling of the victim had five cuts on his right forearm (one and a half to two inches long), three cuts on his right thigh (three to three and a half inches long), and two cuts on his back (three to four inches long). He reported that his younger sibling accidentally hit him. Ms. Gardner reported that he had received a "whoopin" from Mr. Joseph, for trying to jump out of a window. Ms. Gardner said that she was outside when the five-year-old was "disciplined" by his stepfather and she advised that this was the first time Mr. Joseph had ever used physical punishment. Ms. Gardner denied any domestic violence or substance abuse problems. She also said that she had little confidence in child protective services, as they were involved with her family when she was a child. Ms. Gardner and one of her sisters had been sexually abused by a brother, and two of Ms. Gardner's sisters are currently involved with EPCDHS because of child protection issues. When questioned again, the five-year old reported that he had gotten in trouble because he did not want to take a nap and was going to jump out of the window. He said that "Dad" hit him hard with two belts and one spoon. He said that he gets "whooped" and has to do exercises when he gets in trouble, but he reported that this was the first time that he sustained any injuries. The other children were interviewed and denied any abuse. Mr. Joseph was interviewed ten days later on 05/14/2004 and he reported the five-year old had been getting into trouble at school because of a classmate who is a bad influence. Mr. Joseph reported he "lost it" and wanted some help with learning better methods of discipline. He agreed to receive home-based services from Team Success. The allegation of medium physical abuse by Mr. Joseph was founded for this child. This referral was closed on 05/21/2004.

- **08/04/2004:** A referral was made because a four-year-old sibling of the victim had a bruise on the inside of his elbow; the report also alleged that the five-year-old sibling smelled of urine. The referral was assigned for assessment. The investigator saw all the children in the household. The two named children told different stories. Ms. Gardner denied any physical abuse or domestic violence.

Mr. Joseph was interviewed by phone on 9/13/04 and denied spanking the children. The hygiene issue was never addressed and the assessment was closed on 12/21/2004 as inconclusive.

- **09/10/2004:** A referral was made for possible minor physical abuse to the five-year-old sibling of the victim, as was the subject of the 05/04/2004 report. He was observed to have a mark below his eyebrow. He had come to school with a black left eyelid. He and his older sibling told completely different versions of what happened. The five-year-old reported that his mother threw a popsicle at him and it hit him in the eye. This referral was screened out, as there was no available information that would allow the referral to meet the legal definition of child abuse and/or neglect and determined to be an accident. The referral information was sent the Team Success caseworker.

- **09/25/2007:** A referral regarding domestic abuse was received because the Mr. Joseph allegedly shot at his wife in their yard with all the children present. He then left the home before the police arrived. Mr. Joseph committed suicide four days later after returning to the home; he died on 10/09/2007. The Safety Assessment did not find any safety concerns. The mother denied that the father had tried to shoot her. The referral was closed on 10/10/2007 as inconclusive for medium physical abuse and medium environment injurious by Mr. Joseph.

- **01/23/2008:** A referral was received from a community services provider stating the mother was making funeral arrangements for herself and the children. Her plan was very complete, including admitting if child welfare intervened, she would deny everything and then kill herself and the children. The mother reported feeling responsible for Mr. Joseph's death.

  A caseworker responded to the home and Ms. Gardner denied any suicidal ideation. She reported she had just insisted her sister and her sister's children leave her home, where they had been residing with Ms. Gardner and her children, as she (Ms. Gardner) felt she could no longer deal with her sister's problems. Ms. Gardner's sister has been receiving services from EPCDHS because of substance abuse. The caseworker tried to problem-solve with Ms. Gardner, including making a plan to take the children to a babysitter so that Ms. Gardner could go to the Crisis Center that night for an evaluation. The mother agreed to sign a one-week Protective Plan, which involved going to the Crisis Center and having the therapist call the caseworker. Ms. Gardner went to the Crisis Center and the therapist called the caseworker at 7:00 P.M., advising that Ms. Gardner did not need to be hospitalized and had gone home after the session. The caseworker called Ms. Gardner the next day and Ms. Gardner told her she was fine. No safety concerns were identified and the mother continued to deny any suicidal ideation. The plan was to close the referral with an inconclusive finding.

- **01/29/2008:** A referral from law enforcement was received reporting that on 01/28/2008, the mother attempted to kill herself and her children by dousing the

children with gasoline and setting fire to her house. Ashya Joseph died in the fire and Ms. Gardner and her four surviving children were hospitalized with serious injuries. EPCDHS obtained protective custody orders so the children could receive prompt medical attention while the investigation was completed. Ms. Gardner was initially picked up by a fire department paramedic several blocks from the house and transported to the hospital where she was interviewed by the police and then incarcerated at the El Paso County Justice Center.

F. Policy Findings:

Policy findings result from county child welfare actions that are found to be in violation of State statute or rule. Corrective actions are required by EPCDHS in response to each finding listed below.

1) EPCDHS caseworkers did not contact reporting parties to obtain additional information and clarification before deciding what actions to take on 09/10/2004 and 09/20/2004 referrals. These referrals were identical, except for the date. Notation indicates that it was sent to a Team Success caseworker and identified as an "accident." These actions are in violation of Volume 7, Section 7.202.4 C, D (1-3) which states:

   7.202.4 Initial Assessment

   C. The county department shall provide appropriate referral information to the reporting party in those situations in which there are inadequate grounds to constitute assignment for assessment and investigation. Either casework or supervisory staff shall inform, whenever possible and appropriate, the reporting party of the decision not to investigate and the reasons for that decision.

   D. The county department shall review all reports and conduct an initial assessment. The initial assessment shall decide the appropriateness of further investigation. It shall include, but not be limited to, the following activities:

   1. Checking the State Department's automated system
   2. Reviewing county department files.
   3. Obtaining information from collateral sources, such as schools, medical personnel, law enforcement agencies, or other care providers.

2) EPCDHS did not document the circumstances for going beyond 30 days to achieve completion of the 08/04/2004 and 09/25/2007 investigation assessments. There was no documentation as to why the assessments remained open. The 08/04/2004 investigation was closed on 12/21/2004. During this time period, referrals were received and screened out on 09/10/2004 and 09/20/2004. The 09/25/2007 referral was not closed until 01/31/2008 and during this period of time, referrals were received on 01/23/2008 and 01/28/2008. There was no documentation that the caseworkers had entered for the subsequent referrals.

   These actions regarding contact and completion are in violation of Volume 7, Sections 7.001.6 (A) and 7.202.56 (A) (C) that state:

7.202.56 Conclusion of Investigation
A. An investigation shall be completed within 30 calendar days of the date the investigation/assessment was assigned, unless there are circumstances that have prevented this from occurring. Such circumstances shall be documented in the case record.

3) EPCDHS completed the Colorado Safety Assessment in the 08/04/2004 and 09/25/2007 investigations prior to interviewing the father, who was the "person responsible for the abuse/neglect." The completion of the Safety Concerns list, without his information concluded there were not safety concerns, despite the risk assessment results that consistently showed a final risk level of medium. The lack of interviewing the alleged perpetrator may have helped to lead to an erroneous conclusion that there were no current concerns for the children's safety.

Areas on the Safety Concerns list that could have been identified were: 1) Caregiver has caused harm to child; 2) Domestic violence exists in the home; 3) Caregiver previously abused or neglected a child; 4) Caregiver's alleged or observed emotional instability seriously affects ability to protect child. This is both a practice and policy violation of Volume 7, Section 7.202.534 (D) that states:

7.202.534 Safety Assessment Conclusion

1. If none of the fifteen (15) safety concerns are identified at the conclusion of the safety assessment process, then there is no impending danger to a child and no further safety intervention is required. Although risk issues may be identified, the assessment may be closed and further intervention is a county option.

2. If one or more of the fifteen (15) safety concerns are identified, then it is necessary to consider the child's vulnerability to determine if there is impending danger.

3. If an assessment does not determine there is a vulnerable child in the home, then there is not a threat to child safety and no further safety intervention is necessary. Although risk issues may be identified, the assessment may be closed and further intervention is a county option.

4. If an assessment indicates that there are one or more safety concerns and there is a vulnerable child in the home, then it is concluded that impending danger is present and an evaluation must be made regarding caregiver protective capacities to manage and address safety concerns.

4) EPCDHS made a referral on 05/20/2004 for this family to a program in the department under TANF for supportive services. There appears that there was only one contact with the Team Success caseworker on 9/20/04 when she was

notified that a referral was referred to her. There was no recorded documentation of the involvement; however the caseworker said there were numerous delays after the family was referred to another agency for services. She said the delay was about two-three months as a result of administrative problems with the organization. There is no record of any referrals from the Team Success caseworker despite a number of referrals from other organizations in the community.

This represents a violation of 7.200.5 Mandatory Reporting of Child Abuse and Neglect by all county staff employees. It also is a violation of 7.202.52, which requires that all collateral parties be interviewed when there is an investigation of abuse and neglect; this involved investigations from August 2004 until January 2008.

5) At the time of the fatality, the county was involved with three of Ms. Gardner's sisters and her mother. Her sister's three children and her mother had lived with Ms. Gardner at different times. A review of all the referrals received during the county involvement, which goes back to Ms. Gardner, as a child and Ms. Gardner and her first husband would have revealed this history. Trails reports list referrals on all the families, as they are connected to Ms. Gardner. This is in violation of 7.202.4 C, D (1-3), as stated in finding #1 listed above.

6) EPCDHS did not develop a safety plan that was focused on controlling safety concerns for the children when the caregiver has stated she wanted to kill herself and her children on 1/23/08. The plan did not include anyone to provide safety management.

This is in violation of 7.202.535 Safety Planning and Documentation (B), (C), (D), and (E) which states,

B. A safety plan shall be developed for all other situations in which the safety intervention analysis has indicated that an in-home safety plan can sufficiently control safety concerns. It shall be documented in the state's automated system. All children in the household assessed to be unsafe shall be included in one plan.

C. All safety plans must include the following:
   1. Safety responses that are the least restrictive response for assuring safety;
   2. Safety responses that have an immediate impact on controlling safety concerns;
   3. Activities that correspond to each specific safety concern and describe the frequency of each action;
   4. Safety response(s) that are readily accessible at the level required to assure safety;
   5. Identification of each family member and safety management provider participating in the plan;

6. Parental acknowledgement of safety concerns and a willingness to participate in the safety plan; and;
7. Caseworker activities to oversee the safety plan.

D. Parents, caregivers, and others who are a part of a safety plan shall sign the safety plan and receive a copy, and the signatures and paper form shall be retained in the file.

7) During the 1/29/08 fatality investigation it appears that the caseworker experienced some frustration in obtaining a protective court order and working with police officers that rarely work with El Paso DHS. These situations do not impact staff on a daily basis but represent an area that can be addressed administratively. There is not a written memorandum of understanding with the police department and El Paso DHS that has been administratively approved at all levels in accordance with 7.202.51.

This is in violation of 7.202.51 (A) which states: the county department shall develop written cooperative agreements with law enforcement agencies that include:

1. Protocol for cooperation and notification between parties on child abuse and neglect reports and child maltreatment deaths.
2. Proocol for distributing the Notice of Rights and Remedies when required by Section 19-3-212, C.R.S., and Section 7.200.3, G, of this staff manual.
3. Joint investigation procedures.
4. Procedures for independent investigation by either party.

8) There is no documentation in the case record of any investigations being reviewed by a county Child Protection Team (CPT).

This is in violation of 7.202.61 which states: a county department of social services receiving 50 or more reports of child abuse and neglect per year shall have a multi-disciplinary child protection team in accordance with Sections 19-1-103(22) and 19-3-308(6), C.R.S.

G. County Actions Taken:

El Paso County Department of Human Services will provide to the Colorado Department of Human Services a letter indicating any policy or practice changes that have been implemented since the county internal review and state child fatality review of the death of Preston Cheever. This documentation shall be provided to CDHS within 45 days of the receipt of this report.

NEWS

Colorado announces sweeping reforms to child welfare system

By **CHRISTOPHER N. OSHER** | cosher@denverpost.com, **JORDAN STEFFEN** | jsteffen@denverpost.com and **JENNIFER BROWN** | jbrown@denverpost.com | The Denver Post

PUBLISHED: February 6, 2013 at 7:12 am | UPDATED: April 30, 2016 at 1:12 am

Gov. John Hickenlooper on Wednesday revealed sweeping reforms to the state's child welfare system, including a multipart plan that will create a statewide hotline for reporting child abuse and neglect, new training on how to assess those reports, and a study of workloads and caseloads of child protection workers.

The plan also will steer resources to troubled families before actual abuse and neglect occur by delivering services through nurses, parenting classes and additional resources.

"We want to make sure that we keep kids healthy and safe and that we stabilize families because we know that stable families are the best launching pads there are for kids to have successful lives," Hickenlooper said at a news conference inside the state Capitol.

Hickenlooper will ask the legislature to dedicate $20 million to the reforms for the next fiscal year, nearly a third of which will come from recent reductions in the number of children incarcerated by the juvenile system. Much of the rest will come from increased tax revenues due to an improved economic climate, officials said.

The state projects that an additional $8 million annually will be available over the next five years because of a waiver from the federal government that allows the state more flexibility in how it spends child protection money.

"We want to ensure that every child in the state has well-trained, well-prepared caseworkers and supervisors with the right tools to ensure their safety," said Reggie Bicha, the executive director of the Colorado Department of Human Services.

Call for answers

The reforms follow an eight-day series published by The Denver Post in cooperation with 9News in November. The series found that 72 of the 175 children who have died of abuse and neglect in Colorado in the past six years had families or caregivers known to child protection workers. Since the launch of the series, an additional 17 children died of abuse or neglect in Colorado. Two of them were known to child protection workers.

The Post found that child protection workers did not follow state policy and regulations more than half the time when they tried to protect children who eventually died. Following the series, both the public and lawmakers demanded explanations for those children's deaths and improvements in how a child's case is handled.

State Sen. Jeanne Nicholson, D-Black Hawk, who is one of several lawmakers working with the Department of Human Services and counties to draft legislation, read the stories of more than 50 of the children included in the series, she said.

"We're all sad and appalled by this information," she said. "We may not be able to prevent every child death by abuse, but that doesn't mean we shouldn't try."

Hickenlooper announced a five-point improvement plan almost a year ago. On Wednesday, Hickenlooper, joined by Bicha and state lawmakers, announced a new wave of reforms for child welfare.

"I think we have been making progress with our most vulnerable children," Hickenlooper said. "We recognize this isn't just government's job. It is a goal of healthy families and healthy communities."

Bicha explained that the additional improvements will be focused on the "front end" of the child welfare system and will target prevention efforts, how child abuse and neglect are reported, and how those reports are assessed.

"Children should not have to experience abuse and neglect before we provide them and their families the services they need," Bicha said. "That's why we are investing in services that will assist families before they become a part of the child welfare system."

A public awareness campaign will launch in addition to the hotline, which will provide one number for people to call if they have a concern or report of child abuse.

Help for caseworkers

The state will offer new training programs for hotline and child protection workers to ensure that reports contain all necessary information and are shared and assessed properly, Bicha said.

New training programs will help hotline workers and child protection workers properly assess reports of child abuse in making decisions about their care and create more consistent practices across county departments.

In the past, protocols for when to launch an investigation were made on a county-by-county basis, allowing for wide variations. The reforms call for consistent criteria to be given to the people making those decisions.

The plan also includes measures to finance purchasing new smartphones and computer tablets so child protection workers can finish reports while they are outside the office — when, for example, they are waiting to make a court appearance.

The Post investigation also revealed that the state lacked the ability to track caseworkers' workloads.

A group of lawmakers expects to deliver a letter to the state auditor as early as next week, requesting a study of the workloads and caseloads carried by child protection workers, Nicholson said. The reform initiative will make available money for the state auditor to contract with an outside consultant to conduct the caseload and workload study, Bicha said. Such studies have been recommended numerous times in the past by child advocates. In the past, state officials have opted not to pay for one.

Summit County Commissioner Thomas Davidson, president of Colorado Counties Inc., a lobbying group for county officials, and Donna Rohde, director of Otero County's Department of Human Services and the president of the Colorado Human Services Directors Association, gave a joint interview with Bicha after Wednesday's news conference.

"You bet it makes a difference in terms of productivity," Davidson said of the plans for providing smartphones and computer tablets to caseworkers. He also praised plans for additional resources for county officials to offer services to families before abuse occurs.

The plan also includes training for "mandatory reporters," such as doctors or school teachers, who are required by law to report suspected abuse and neglect. The new training will better explain what happens when a report is made and what factors are considered when deciding whether to remove a child from the home.

The state will also work to improve on transparency by building a website where the public can see how county child welfare departments are faring at protecting children.

In addition, the state also will make available more money for core service programming, which delivers services aimed at allowing families to remain intact and preventing a child from getting placed into foster care.

AUDIT

The Denver Post investigation revealed the state lacked the ability to track workloads, how many caseworkers were on staff and whether they were disciplined for policy violations. The state plans to hire a consultant to study the workloads and caseloads within the department.

HOTLINE

A statewide, toll-free hotline will be set up to take reports of suspected child abuse and neglect. The state will launch new training programs for hotline and child protection workers to ensure that reports contain all necessary information and are shared and assessed properly.

MONEY

$20 million in state funds this year and $8 million in federal money each of the next five years will go to improve child abuse prevention programs and training. The federal funding comes through a waiver in how Colorado uses money that had been tied to spending on foster care.

TECH

Smartphone and tablet technology will be utilized so caseworkers can do paperwork remotely, between visiting homes of children. Caseworkers say they work 60-hour weeks and spend additional hours at home at night filling out paperwork in the state computer system.

PROGRAMS

The state will make available more money for services aimed at allowing families to remain intact. Other prevention money will deliver services through nurses, parenting classes and other resources — with the goal of reducing child abuse by 50 percent in seven years.

TAGS: **FAILED TO DEATH**

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Star-Telegram

SPECIAL REPORTS

Could the death of one abused child have saved the life of another?

BY DEANNA BOYD
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May 31, 2017 12:36 PM

They died more than two years apart and were not related, but the 1-year-old girl and the 3-year-old boy shared disturbing similarities in death.

Both had old and new rib fractures. Both had lacerated livers.

And both, the girl named Phaneese and the boy named King, had been under the care of their mothers and their mothers' boyfriend — the same man — when they drew their last breaths.

Police investigations in Fort Worth and Arlington and autopsies would reveal troubling injuries, but the Tarrant County medical examiner's office would rule both children's manners of death as "undetermined."

In both cases, the medical examiner's office opined that some of the injuries were caused by CPR.

No arrests were made. The boyfriend and the mothers of the two children are not being identified because they have not been charged with crimes.

But three forensic pathologists who reviewed the children's autopsy reports, at the Star-Telegram's request, expressed concerns with Tarrant County's findings.

"These injuries are not consistent with CPR," said Dr. Joye Carter, a Houston-based forensic pathology consultant, lecturer and author. "These rib fractures are consistent with forceful squeezing of the rib cage. I have seen these type injuries associated with numerous fatal child abuse injuries."

Two of the forensic pathologists consulted went as far as to say that the injuries suffered by King, the 3-year-old boy, point to his death being a homicide.

"I strongly disagree with this," Dr. Cyril Wecht, a renowned forensic pathologist from Pittsburgh who has consulted in many high-profile cases, said of the undetermined ruling handed down in the boy's case. "The injuries speak for themselves."

Though experts acknowledge there are times when an undetermined ruling is unavoidable, they say failing to make a call when the evidence is there thwarts justice and can put additional children in danger.

"If you have the ability to make a call and you don't — you call it undetermined — the next death is on you," said Dr. J.C. Upshaw Downs, a Georgia-based forensic pathologist, consultant and author.

When contacted about the Star-Telegram's findings, Tarrant County Medical Examiner Dr. Nizam Peerwani agreed to reopen both cases, and in May, brought most of the involved agencies — Fort Worth police, Child Protective Services, and the district attorney's office — together to review and discuss their findings.

Peerwani said Arlington police were invited but did not attend the meeting.

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At the review's conclusion, Peerwani did agree to change the rulings in one of the children's deaths — but not to homicide. More than six years after she died, Phaneese's death will now be deemed "natural" after Peerwani said his office discovered she had "sickle cell trait" during their recent review.

He said King's death will remain undetermined.

"This is an unnatural death, but we're not sure if it's a homicide or not," Peerwani said.

"We don't have any vested interest in this case," Peerwani said. "We're going to call it based on the best possible evidence we have at hand. If there is a doubt, how are we going to convince a jury?"

Tarrant County is No. 2 in Texas in the total number of confirmed cases, behind Harris County, but that only tells part of the story.

By McClatchy

'No, Lord! No! No! No!'

Instinct told Shirley Williams something was wrong with her granddaughter.

A paternal grandmother to Phaneese, she'd noticed that the girl seemed reluctant to return home with her mother at the end of visits. She had spotted knots on the front and back of Phaneese's head in December 2010. And, that same month at the girl's first birthday party, she'd seen how Phaneese appeared fearful of her mother's new boyfriend.

“When he came to her at the birthday party, she cringed and clinged to my chest,” Williams recalled.

Williams had helped her son raise Phaneese — her only grandchild — for the first six months of her life so that the girl’s mother could finish college. But after Phaneese’s mother and her son broke up, her relationship with the mother began to deteriorate.

On Christmas Eve 2010, when the mother came to pick up Phaneese with her boyfriend in tow, Williams became even more distressed with the situation.

“I had asked her not to bring him by my house, as him and my son were arguing each time they came by,” Williams said. “That particular evening, when I went to the car and I saw him, I said, ‘I told you not to bring that boy back over here.’ He started cussing, acting like he wanted to fight, jumping up and down. The baby just froze.”

Seeing her granddaughter’s reaction, Williams said she quit arguing with the mother’s boyfriend and walked away.

“That was the last time I saw her,” she said.

Nikki Robinson and her aunt Shirley Williams talk March 8 about the death of 13-month-old Phaneese Alexander in 2011. Phaneese was Williams' granddaughter. .

Rodger Mallison - rmallison@star-telegram.com

Shortly after 7 p.m. on Jan. 2, 2011, Williams' son received a text from his daughter's mother.

"Pray for my baby gets better ... she had a seizure due to instant high fever," it read.

The mother would later tell authorities that she and her boyfriend had left a relative's house and were driving home with Phaneese when they noticed she appeared to be having a seizure. They drove the girl to Baylor All Saints Cityview Hospital in Fort Worth.

There, Phaneese was loaded into an ambulance to be transferred to Cook Children's Medical Center, but she stopped breathing before leaving the parking lot.

When Williams and her son arrived at the hospital, medical staff were still

performing CPR on Phaneese. When the chaplain arrived, Williams knew.

“There Phaneese was — dark, lifeless, with a diaper on and they were doing compressions,” said Williams, crying. “...So I start praying. I’m like, No, Lord! No! No! No! And I got the baby and I tried to rub the baby and I knew she was gone. I just knew she was gone. And they was letting me hold her for the last time.”

When she left the hospital that night, a heartbroken Williams drove around, ending up at an east Fort Worth police station off East Lancaster Avenue.

“I was just like, I need to tell somebody this. It’s not right,” Williams said.

“They had me sit in a room by myself and write down why I thought it was suspicious,” she said. “It just crippled me. I knew it was something I needed to do.”

Tarrant County is No. 2 in Texas in the total number of confirmed cases, behind Harris County, but that only tells part of the story.

By McClatchy

‘There are signs of abuse’

The case would be investigated by Fort Worth Detective P.G. Henz, then with the Crimes Against Children Unit.

Henz said he remembers being called to the medical examiner's office as they were midway through Phaneese's autopsy.

"There are signs of abuse. You need to come down here," he recalled being told.

A CPS report states that the medical examiner initially indicated he believed the death was caused by a blow to the back, which lacerated the liver.

Phaneese's mother told authorities that the girl had been sick earlier in the month, running a fever and throwing up twice, but had seemed fine the day she died.

She denied ever abusing her daughter, or seeing her boyfriend hurt the girl, and seemed very troubled when told by police about her daughter's older rib fractures.

When questioned by police, the boyfriend also denied abusing the girl.