



STATE OF NEW YORK  
OFFICE OF THE STATE INSPECTOR GENERAL  
**Final Report**  
**April 20, 2009**

**Technician Mishandled Autopsy Specimen**

SUMMARY OF FINDINGS/RECOMMENDATIONS

The Inspector General found that Frederik Enders, an autopsy technician in the Monroe County Medical Examiner's Office (MCME), failed to promptly refrigerate an autopsy specimen, which rendered the specimen unusable for certain tests. Enders also made false entries in laboratory paperwork concerning his handling of the specimen. MCME terminated Enders's employment. The Inspector General has referred Enders's actions to the Monroe County District Attorney's Office for review.

ALLEGATIONS

In June 2008, MCME reported to the Inspector General that Frederik Enders, an autopsy technician, failed to properly handle a liver specimen on September 13, 2007, and made a false entry on a laboratory submission report to disguise his error.

SUMMARY OF INVESTIGATION

**Introduction**

MCME receives funding as part of the Paul Coverdell Forensic Science Improvement Grants Program administered by the United States Department of Justice. The Coverdell program provides funds to state and local governments to improve the timeliness and quality of forensic science and medical examiner services and to eliminate backlogs in the analysis of forensic evidence. MCME is currently seeking accreditation from the National Association of Medical Examiners and is using the Coverdell funding to assist in this effort.

Under the federal Justice for All Act of 2004, entities applying for Coverdell funding are required to certify that "a government entity exists and an appropriate process is in place to conduct independent external investigations into allegations of serious negligence or misconduct substantially affecting the integrity of forensic results committed by employees or contractors of any forensic laboratory system . . . that will receive a portion of the grant amount." The New York State Commission on Forensic

Science, which oversees all public laboratories conducting forensic testing within the state, has designated the Inspector General the governmental entity responsible for conducting independent external investigations, as required by the act.

In accordance with this protocol, in June 2008 the Monroe County Medical Examiner's Office reported the foregoing allegation to the Inspector General.

### **The Liver Specimen**

Caroline R. Dignan, M.D., the Monroe County Chief Medical Examiner, testified to the Inspector General that on September 13, 2007, she performed an autopsy on the body of an individual who had died unattended. The body had not been discovered for days after death and decomposition had begun. The purpose of the autopsy was to determine the cause of death. Dignan was assisted by Autopsy Technician Frederik Enders. During the autopsy, Dignan removed a specimen from the liver of the body. Dignan testified that she placed the specimen in a sealed container and instructed Enders to submit it to the office's toxicology laboratory to be tested for blood alcohol and other substances.

Pursuant to MCME procedures, Enders was required to label the specimen and immediately place it in a refrigerator from which toxicology laboratory staff retrieved it for testing. Enders was also required to complete, date, and sign a "Receipt for Autopsy Samples" form that accompanies the specimen and subsequently is placed in the case file with the autopsy report. As an autopsy technician, Enders's duties do not include performing tests on autopsy samples.

According to Dignan's testimony, when she returned to the autopsy room the following morning, September 14, 2007, she found the specimen in a container still on the counter. Dignan said fluids were leaking from the top of the container, apparently from the effects of decomposition of the specimen. Dignan said she located Enders, told him that he had left the specimen out overnight, and directed him to place it in the refrigerator for toxicology testing. Dignan said she was unable to recall Enders' exact response, but did remember that he acknowledged he was responsible for mishandling the specimen. Dignan said she told Enders that his actions were unacceptable.

The Inspector General asked Dignan why she directed Enders to proceed with toxicology testing of the liver specimen rather than order that it be destroyed, given that it had not been properly stored overnight. Dignan testified that while further decomposition of the unrefrigerated specimen would have rendered it unreliable for blood alcohol testing, the sample was still viable for testing for other substances, including opiates and other drugs. Dignan testified that the specimen would also still be useful for other tests that might have been necessary as more information about the case became available. Dignan further testified that while the body remained available until later in the day on September 14, it did not occur to her to obtain another liver specimen. Dignan created no documentation reflecting the delay in refrigerating the sample.

On October 29, 2007, the toxicology laboratory reported the results of its testing of the liver specimen to Dignan. The report indicated, among other findings, a high level of alcohol in the specimen. Dignan testified that she was concerned that if the liver specimen described in the report was the same specimen Enders had left out overnight on September 13, 2007, the blood alcohol test result would not be reliable. In an effort to determine if it was the same specimen, Dignan said, she checked the paperwork Enders had prepared for submission of the specimen to the toxicology laboratory at the time of the autopsy. Dignan said she learned that the paperwork stated that the specimen was submitted on the day the autopsy was completed, which would indicate that the specimen had not been left out. However, still concerned it might be the same specimen, Dignan requested the office's Chief Investigator, Robert J. Zerby, Jr., to examine the audit trail of the toxicology laboratory submission for the specimen.

The MCME's computer system includes an auditing feature capable of showing when a document is created or modified. Only Zerby has access to the auditing system, which creates logs that cannot be altered. According to Zerby, the audit log showed that the toxicology test request for the liver specimen was created on September 14, 2007, the day following the autopsy, although the request bore the date of the actual autopsy, September 13, 2007. This information confirmed Dignan's suspicion that the specimen described in the toxicology report was the same specimen that Enders had left out overnight, and further demonstrated that Enders had backdated the test request. As a result, Dignan disregarded the results of the toxicology test in completing the autopsy report associated with that specimen.

When interviewed by the Inspector General, Enders admitted that he failed to place the liver specimen in the refrigerator until the day after the autopsy. Enders testified that he also completed the laboratory submission form the next day, but dated it September 13, 2007, the day of the autopsy. Enders denied backdating the receipt in an effort to cover up his failure to refrigerate the specimen in a timely manner, claiming that his actions were inadvertent. However, Enders offered several inconsistent and implausible explanations for his purported mistake.

### **MCME's Response**

After discovering the dating error, Dignan referred Enders' conduct to the Monroe County Human Resources Department. Dignan testified that, in addition to this incident, Enders had a history of poor work performance and emotional instability. Dignan stated that, after consulting with the human resources staff, a decision was made to evaluate Enders in accordance with Section 72 of the New York State Civil Service Law to determine if he was "capable of performing his job" or if there was a psychological, psychiatric, medical or cognitive reason that would explain his poor work performance. Enders was placed on paid leave pending the results of the evaluation.

In May 2008, the Human Resources Department reported to MCME that the evaluation identified no psychological, psychiatric, medical or cognitive issues that would preclude Enders from performing his duties. After the evaluation, MCME

commenced proceedings to terminate Enders, citing the September 14, 2007, backdating incident as well as other documented instances of poor work performance. MCME terminated Enders on June 6, 2008. Enders appealed his termination and is currently scheduled for an arbitration hearing.

## FINDINGS AND RECOMMENDATIONS

The Inspector General found that Autopsy Technician Frederik Enders negligently violated laboratory procedures when he failed to properly refrigerate a liver specimen obtained during an autopsy. Enders then exacerbated his misconduct by falsely indicating in a laboratory record that he had submitted the sample for toxicology testing at the time of the autopsy, when, in fact, he did not submit it until the following day. Enders's actions rendered the specimen unusable for certain tests and the results of the testing erroneous and misleading in regard to the blood alcohol content of the specimen. In this manner, Enders's actions substantially affected the integrity of the laboratory report. MCME terminated Enders's employment. The Inspector General has provided evidence relating to Enders's conduct to the Monroe County District Attorney's Office for its review.

While the Inspector General found that Chief Medical Examiner Caroline Dignan took appropriate action in commencing the employee disciplinary process against Enders based upon his actions described above, the Inspector General also found that Dignan should have promptly documented Enders's failure to properly refrigerate the liver specimen when she discovered the error the day after the autopsy. Lacking such documentation, Dignan was left to rely on her memory that the toxicology testing results reported to her more than six weeks later related to the case in which Enders's error had occurred. As it happened, her suspicion that the test results pertained to that case proved correct. The Inspector General recommended that MCME adopt policy and procedure requiring that anomalous events such as occurred in this instance be documented at the time they are detected.

By letter dated April 8, 2009, Monroe County Director of Public Health Andrew S. Doniger, M.D., informed that Inspector General that the Department and the Medical Examiner's Office agreed that the Inspector General's findings "accurately reflect the circumstances surrounding the event." Dr. Doniger further advised that based upon the Inspector General's recommendation the Monroe County Medical Examiner's Office has amended its policy and procedure manual to require that "special circumstances or anomalous events" are documented as soon as they are discovered, and never more than 24 hours after their discovery. The revised policy further states that unusual circumstances or events that are related to a case should be documented in the case notes, narrative, or other written portion of the investigation.