



CLALLAM COUNTY CHARTER REVIEW COMMISSION MINUTES of February 24, 2025

MEETING OF THE CHARTER REVIEW COMMISSION (CRC)

Chair Susan Fisch called the meeting to order at 5:30 p.m., Monday, February 24, 2025. Also present were Commissioners Bill Benedict, Jim Stoffer, Jeff Tozzer, Alex Fane, Ron Cameron, Patti Morris, Chris Noble, Paul Pickett, Ron Richards, Rod Fleck, Christy Holy, Nina Sarmiento and Cathy Walde. Mark Hodgson was excused.

Gores administered the oath for Nina Sarmiento.

REQUEST FOR MODIFICATIONS/APPROVAL OF AGENDA

Fisch noted that Dee Boughton could not present under business items, so she has asked Administrator Mielke to attend.

ACTION TAKEN: Adopted as modified

APPROVAL OF THE MINUTES

- Minutes February 10, 2025

Noble noted that on page 7 it should be read *in compliance* with his amended motion.

Pickett requested to attach a clean copy of the approved bylaws and rules to the minutes.

ACTION TAKEN: Adopted as modified

PUBLIC COMMENT ON AGENDA ITEMS

- Norma Turner, Port Angeles, commented on technology survey
- Ed Bowen, Clallam Bay, commented on petitions, trust revenue, taxing districts

CORRESPONDENCES

Gores noted receipt of correspondences from Karin Cummins, Ed Bowen, Commissioner Richards, Mark Nichols, Commissioner Pickett, John Hauck, Pepai Whipple, Commissioner Morris and Dee Boughton (see attached).

BUSINESS ITEMS

- Zoom discussion

Fisch briefed regarding zoom issues during public meetings. She has noted that participants for Board of Commissioner (BOCC) meetings will be fully locked down for meetings without allowing cameras or audio unless the Clerk requests a participant to unmute. Gores noted that the BOCC and IT Department will be discussing at their work session on Monday, March 3 options to allow participants to turn on cameras and audio to participate in meetings.

ACTION TAKEN: Holy moved to continue the current meeting in the same format as the Board of County Commissioners, Walde seconded, motion passed

(14 voted in favor of)

- County Staff Presentations:
 - Shoona Riggs – Clallam County Auditor
Riggs provided a presentation on submission deadlines. CRC Member held discussion.
 - Dee Boughton – Prosecuting Attorney's Office
Postponed to future meeting.
 - Administrator Mielke – Board of Commissioners Office (added item)
Postponed to future meeting.

CLALLAM COUNTY CHARTER REVIEW COMMISSION

MINUTES of February 24, 2025

Page 2

- Survey – Commissioner Morris

Morris briefed the CRC on the 2020 survey stating that they had 10 issues listed in the survey that the 2020 CRC thought would rise to the top for voters. To get to the survey the 2025 CRC as a group need to come up with a list of topics that they think are important. She noted that Survey Monkey was used in 2020, answers were anonymous, and it took about 2 minutes to complete. Links were published in the newspapers, online and on the website. CRC Members held discussion. She put together a handout on what the Clallam County Charter is, what the Charter can change, when the Commission meets, and requests input (see attached). CRC Members held discussion.

Morris original motion:

ACTION TAKEN: Morris moved that at the next meeting the CRC has a list of items that need to be prioritized, Cameron seconded, motion passed

(14 voted in favor of) Pickett abstains

Pickett amended motion:

ACTION TAKEN: Pickett moved to amend the motion to create a list 2 meetings away instead of the next meeting, Stoffer seconded, motion failed

(4 voted in favor of and 11 voted no)

- Proposed charter amendment regarding filling a vacancy – Commissioner Richards

Richards briefed the CRC on his proposed charter amendment. He mentioned Clallam County Code 34.10.020 and 37.01. He noted that the purpose of the charter amendment is to let the CRC know what the procedure and form needs to be followed. In looking at the code provisions he mentioned it's clear and he thinks it's important the CRC looks at both the form and procedure. He commented that it is absolutely the Prosecutor's duty to prepare the ballot title after the words of the proposed amendment are filed for registration with the Auditor. He reminded the CRC that during the first two meetings they spend a lot of time discussing filling of a vacancy. What he heard during those two meetings was it was a good idea to sort of give preference to the people that ran for the commission but it's sort of misleading to go out for applications if the CRC is just going to turn around and give it to the people who ran for the commission. What he tried to do in the findings proposed change in the charter is to set out the reasoning for the proposed amendment and then set out the form of the proposed charter amendment. He commented that in the past what has happened is the voter pamphlet did not include the proposed amendment as is specifically required by state law and that is just another way to invite a challenge to any important amendment that might be proposed. He briefed on the amendment. CRC Members held discussion.

ACTION TAKEN: Richards moved to forward the proposed amendment to the next meeting for discussion, Stoffer second, motion passed

(12 voted in favor of and 3 voted no)

SUBCOMMITTEE REPORTS

- Town Hall Outreach Committee

Cameron commented that Richards, Morris and Cameron met to discuss district II town hall outreach. He noted that they discussed having a town hall at a grange and meet and greets to educate the public prior to the town hall meeting. Morris noted that she has put a flyer together and once the CRC agrees to the information, she can make copies to distribute throughout the county. CRC Members held discussion.

- Coroner Committee

Cameron noted that they didn't get a chance to meet.

CLALLAM COUNTY CHARTER REVIEW COMMISSION

MINUTES of February 24, 2025

Page 3

REPORTS

- Chair Report – Commissioner Fisch

Fisch commented on the questionnaire that the 2020 CRC issued to other Elected Officials. CRC Members held discussion regarding the questionnaire. Benedict commented that the questionnaire can be sent to the County Administrator, and he can send out to all the elected officials and department heads.

ACTION TAKEN: Benedict moved to send out a questionnaire to the elected officials and department heads, Morris second, motion passed

(14 voted in favor of)

Fisch commented that all research or project requests for County staff need to first go through the executive committee or the entire CRC as a group to decide if the research or project is needed. She noted that she has a question to forward to the Prosecuting Attorney's Office (PAO) No objections to Fisch submitting Coroner questions to the PAO.

Stoffer requested a committee to discuss trust lands transfer. He recommended asking the Chair to the Revenue Advisory Committee to come to a CRC meeting. CRC Members held discussion. He clarified that either a committee needs to be formed, or the Chair of the RAC needs to come to a meeting to trust lands transfer. He requested to put on the agenda for the next meeting.

Tozzer commented on the priorities. He suggested having an option to allow Commissioners to rate their top priorities. Morris noted that prior years there was a rating form. Fisch requested to have lists of priorities to the executive committee by Friday, February 28. CRC Members held discussion.

PUBLIC COMMENT – Please limit comments to three minutes

- Karin Cummins, Sequim, thanked the Commission, commented on social media, depressed economic, Recompete grant, conflict of interest, County members, Jamestown Tribe, ethics, hearings board, tax dollars
- Eric Fehrmann, Sequim, thanked the Commission, commented on ethics, input, priorities
- Ed Bowen, Clallam Bay, commented on Survey Monkey, subcommittee meetings

GOOD OF THE ORDER/FUTURE AGENDA ITEMS

- Commissioner Richards requested more administrative help for the Charter Review Commission
- Memorandum of Understanding with the Auditor's Office and Commissioners Office for finances
- Mileage reimbursement forms due for January and February mileage requests

ADJOURNMENT - Meeting concluded at 7:43 p.m.

Respectfully submitted,



Loni Gores, MMC

Clerk to the Charter Review Commission

Approved: March 10, 2025



What Is The Charter Review Commission?

1. It is made up of Fifteen (15) members elected by the citizens, five (5) from each District 1, 2, & 3.
2. Charter Commission members serve without salary.
3. They shall review the Charter to determine its adequacy and suitability to the needs of the county and may propose amendments.
4. They shall conduct meetings, including town hall meetings, to fully vet in public all recommendations for changes or revisions to the Charter.
5. They can make recommendations to the Board of County Commissioners.

Clallam County Home Rule
Charter

223 E. 4th St.

Port Angeles, WA 98362

Recipient
Street Address
City, ST ZIP Code

Tel Telephone
Fax Fax

Website
Email

Clallam County Home Rule Charter

Charter Review Commission

Patte Morris
2/24/25
Hendart

What Can A Charter Change?

A great deal! It could change elected positions to appointed, or appointed positions to elected.

It can expand the number of County Commissioners.

It can provide initiative and referendum powers to voters.



Charter Commissioners have a narrow purpose to draft a Charter by the end of 2025, and propose it to the voters.

The Commission can forward recommendations to the Board of Commissioners. They shall conduct meetings, as required, including district town hall meetings, to fully vet publicly all recommendations for changes or revisions to county operations and procedures (not proposed for ballot measures) forwarded to them by the Charter



When & Where Does The Commission Meet?

The Commission generally meets every other Friday of the Month. Special Meetings will have Public Notice.

The meetings will be Hybrid, in person and online. Go to Clallam County's website (Clallam.net) and search for Clallam County Charter Review Commission for times and locations).

We Want Your Input!

Charter Amendments may be proposed by the public, County Commissioners, and the Commission members!

1. The Commission may propose amendments to the Charter by filing such proposed amendments with the Auditor, (see Charter for specific information).
2. The public may propose amendments to the Charter as provided by filing with the Auditor an initiative petition, (see Charter for specific information).
3. The Board of County Commissioners may propose amendments by the Charter by **enacting** an ordinance. (See Charter for **specific** information).
4. Contact your elected Charter Review Commissioner for your District.

The Commission was elected by citizens! You can help by providing input & attending our meetings!

Handout
Patti Morris
2/24/25

A Proposed Discussion Tool for Charter Review Commission Members **CHARTER REVIEW**

The following is a simple tool to begin to assess the level of interest by the commissioners of the 2007 CCRC. It is preliminary and will undoubtedly be amended by both commissioners interests and issues raised by the public, but it does give us somewhere to begin.

Ratings are: 0= no interest in discussing this topic

1= minimal interest

2 = moderate interest

3= high interest

The results will be compiled by a group of CCRC commissioners willing to meet and compile the survey and will be sent out with the next agenda.

RATING

TOPIC

___ Election of the DCD Director

___ Instant Run Off voting

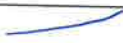
___ Number of years between Charter Review Commissions

___ Number of County Commissioners

CHARTER REVIEW COMMISSION PUBLIC COMMENT SIGN-UP SHEET

Public Comment on Agenda Items – 1st Session

I declare under penalty of perjury under the laws of the State of Washington that any testimony that I give is true and accurate. Please print name and address clearly.

Nº	PRINTED NAME	SIGNATURE	ADDRESS
1	NORMAN L. LUTHER		PA
2	Ed Bowen		Ozette
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CHARTER REVIEW COMMISSION PUBLIC COMMENT SIGN-UP SHEET

General Public Comment – 2nd Session

I declare under penalty of perjury under the laws of the State of Washington that any testimony that I give is true and accurate. Please print name and address clearly.

No	PRINTED NAME	SIGNATURE	ADDRESS
1	Karen Cummins		
2	Eric Fehrman	Eric Fehrman	Sequan
3	Ed Bowen	Ed Bowen	Ozette
4			
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CHARTER REVIEW COMMISSION

CORRESPONDENCES RECEIVED

Gores, Loni

From: Karin Cummins <karinc@olypen.com>
Sent: Monday, February 10, 2025 8:10 PM
To: Gores, Loni
Subject: Charter Review Board

Kärin Cummins

Dungeness

Good evening commisioners.

Tonight I not only want thank each you for your service to our county but to The two the prosecutor, cfo, administrator and Loni. And also thank you Todd for taking the in clarifying the wording on Robert's rule.

I noticed again the trouble people are having hearing.

Our county commissioners are just rubber stamping vouchers and resolutions in order to feel good and have no true accountability to the taxpayers of this county. Those NGO's, non profits and sovereign nations have been riding the gravy train, and the taxpayers of this county have been supplying the millions of dollars.

I am using an analogy that I heard recently.

The example:

imagine having the county courthouse icon on your computer and it's just been sitting there for decades and somebody comes along and finally double clicks on that icon and all these different files begin to appear.

Those files contain true information on NGO's, 501c3's and other sovereign nations. Information that those recipients don't want the taxpayer to see.

I as a taxpayer deserve to see where my money is going. We are an economically depressed county with over a 4 million dollar deficit. We should not be funding any foreign entity or non-governmental organization without true transparency of said organization.

I am asking you as the charter review board to incorporate much stricter guidelines regarding giving taxpayer money to organizations that are not required to be transparent.

The county needs an ethics board consisting of members of the community from all 3 districts and a hearings examiner

Sounds like this commission is committed to public outreach, The county commissioners should be required in the charter to have a public Townhall meeting once a quarter in each district. This leads to public engagement and transparency with our local government That is only 12 times a year. That is not to much to ask of public servants

The county must enact a requirement that no meeting be held on another governments sovereign land

We have a commissioner who thinks printing more money and not paying back debt is ok
We have commisioners, that cannot tell us the total dollars spent on a county road. Towne Rd
These are unacceptable. No over site.

And my mother said I didn't have much patience. Maybe the 3 minute rule should be more applied to the board and not just its citizens.

It is your responsibility to guide this community and its commissioners towards prosperity. It is not to maintain the cliques and special interest groups that have been overshadowing this

Thank you

Kärin

Gores, Loni

From: Fisch, Susan
Sent: Tuesday, February 11, 2025 11:49 AM
To: Gores, Loni
Subject: Fw: Wrong answer and abuse of power

For your correspondence file.

Susan

From: Ed B. <yellowbanks@hotmail.com>
Sent: Monday, February 10, 2025 8:30 PM
To: Fisch, Susan <susan.fisch@clallamcountywa.gov>
Subject: Wrong answer and abuse of power

You don't often get email from yellowbanks@hotmail.com. [Learn why this is important](#)

POINT OF ORDER

Commissioner Richards Claimed to provide access to the public but point in fact there was NO posting of any meeting for the Bylaws subcommittee, regardless of regular or special, 24 hours or more. Prove it because it is not on any posting platform we the people are receiving the information from (the web site or the county calendar system).

This is why Section 3 is not an acceptable procedure whereas Section 5 explained this clearly. How much more of this underhandedness of the elitist commissioners that seem to not want to uphold their oath of office in a faithful manner free of ethics issues and intent to serve the people?

I protest!

Ed Bowen



Virus-free www.avg.com

Gores, Loni

From: Richards, Ron
Sent: Tuesday, February 11, 2025 7:50 PM
To: yellowbanks@hotmail.com
Cc: Gores, Loni; Fisch, Susan
Subject: Re: Your "Wrong answer and abuse of power" email

Dear Mr. Bowen,

I know your referenced email refers specifically to the Bylaws Committee, a committee to which I do not belong. However, since your email seems to be mainly directed at me, I am answering for myself. It could well be that the Charter Review Commission, or the By-laws Committee, might also wish to respond, so please recognize that this is just my response.

I share your concerns, and I believe all the Charter Review Commissioners share your concerns, that notice of our meetings should be provided in accordance with the Open Public Meetings Act. To this end several of us worked on arranging for a meeting place for last Friday's committee meetings (Town Hall and Coroner) in plenty of time to give the notice required by the OPMA, and we made sure that such notice was given before we attended the meetings. Below I've copied the notices that were made, and at least one location on the County website where those posted. These seemed to work because four members of the public from the Clallam Bay area did learn of the meeting and did attend. Frankly, I was assuming you would also be there, and I was looking forward to meeting you in person.

Having said this, I will be first to admit that many of us are new to the CRC and learning the ropes on how to function with such a large commission with multiple committees and probably more to come. As with any endeavor, things can always be done better. To this end I would encourage you to provide me, or the CRC, with a list of other sites where we should consider posting our notices.

Regarding your preference of Article III, Section 5 over Article III, Section 3 of the By-laws, I would just say it was my clear impression that all the members of the CRC believed both sections said the same thing and chose Section 3 because of its brevity. I am sure the tapes of our last meeting will make that clear if ever necessary.

I do very much appreciate your input, and I look forward to more of a dialogue in the future.

Sincerely,

Ron Richards
360-477-5367



MEETING NOTICE

CLALLAM COUNTY CHARTER REVIEW COMMISSION

The Charter Review Commission has scheduled a Coroner Committee meeting to be held at 2 p.m., Friday, February 7, 2025 at the Sunsets West Food Co-Op, 16732 Highway 112, Clallam Bay, WA 98326.

The purpose of the meeting is to discuss the Coroner topic. No virtual option will be available.

Citizens with comments or questions regarding the Charter Review Commission may contact the Clerk of the Charter Review Commission at loni.gores@clallamcountywa.gov or 360-417-2256.

Dated this 5th day of February, 2025

A handwritten signature in black ink that reads "Loni Gores".

Loni Gores, MMC
Clerk to the Charter Review Commission



MEETING NOTICE

CLALLAM COUNTY CHARTER REVIEW COMMISSION

The Charter Review Commission has scheduled a Town Hall Committee meeting to be held at 12 p.m., Friday, February 7, 2025 at the Sunsets West Food Co-Op, 16732 Highway 112, Clallam Bay, WA 98326.

The purpose of the meeting is to discuss option for holding Town Hall Meeting for Clallam County. No virtual option will be available.

Citizens with comments or questions regarding the Charter Review Commission may contact the Clerk of the Charter Review Commission at loni.gores@clallamcountywa.gov or 360-417-2256.

Dated this 5th day of February, 2025

A handwritten signature in black ink that reads "Loni Gores".

Loni Gores, MMC

Clerk to the Charter Review Commission



CLALLAM COUNTY

Washington

Departments

Animal Solutions Advisory
Committee

Behavioral Health Advisory
Board (BHAB)

Board of Equalization

+

Board of Health

Boundary Review Board (BRB)

Building Code Board of Appeals

Carlsborg Community Advisory
Council

+

Charter Review Commission
(CRC)

Clallam Bay / Sekiu Community
Advisory Committee

Clallam Bay / Sekiu Sewer
Advisory Committee

Conservation Futures Program
Advisory Board (CFPAB)

Crescent Community Advisory

Chart

Agenda

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Overview

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[Upcoming](#)
[Meeting d](#)
at <https://>

January 27
August 11

[Meeting](#)
[CRC Comi](#)

Gores, Loni

From: Nichols, Mark
Sent: Wednesday, February 12, 2025 7:26 AM
To: Gores, Loni
Subject: Law Review article for the CRC
Attachments: ARTICLE_ A Deadly Pair_ Conflicts of Interest Between D (003).pdf

Loni,

I would appreciate if you would please forward this email, including the attached law review article, to Chair Fisch for further dissemination as she sees fit. This article contains quite a bit of useful information regarding the coroner function, including an in- depth discussion of conflicts of interest (starting at page 12).

Thank you.

Mark

ARTICLE: A Deadly Pair: Conflicts of Interest Between Death Investigators and Prosecutors

2018

Reporter

79 Ohio St. L.J. 901 *

Length: 10444 words

Author: IRA P. ROBBINS *

* Barnard T. Welsh Scholar and Professor of Law and Justice, American University, Washington College of Law. A.B. University of Pennsylvania; J.D. Harvard University. I am more than ordinarily grateful to my superb and indispensable research assistants--Joseph Briscar, Carly Brown, Lauren Goldschmidt, Hannah Nallo, Belgin Palaz, Catherine Potter, and Deirdre Smith--whom I consider to be my colleagues and my friends, and to Dean Camille Nelson, for providing summer financial support. Copyright (c) 2018 by Ira P. Robbins. All rights reserved.

Highlight

As an inevitable fact of life, death is a mysterious specter looming over us as we move through the world. It consumes our literature, religions, and social dialogues--the death of a prominent figure can change policies and perceptions about our approaches to many problems. Given death's significance, it is reasonable to try to understand causes of death generally, as well as on a case-by-case basis. While scholars and mourners attempt to answer the philosophical questions about death, the practical and technical questions are typically answered by death investigators. Death investigators attempt to decipher the circumstances surrounding suspicious and unexplained deaths to provide solace to family members and information to law enforcement services to help them determine whether further investigative steps are necessary. But while the answers provided by death investigators may provide some direction, in many ways the death investigation system actually inhibits the pursuit of justice.

The current death investigation system creates conflicts of interest between death investigators and prosecutors. Death investigators and prosecutors are often organized under the same governmental structure or even within the same offices. This close association between the two systems results in patterns of relationships that disadvantage defense teams and prevent equal access to death investigation resources. This Article explores the ways in which the death investigation system is constrained by prosecutorial discretion and the institutional proximity of the two offices. This Article also examines how this relationship constitutes a failure of the justice system in the form of both overt and discreet conflicts of interest between death investigators and prosecutors. The effects of these conflicts can be remedied, however. The Article thus provides recommendations to enhance the accuracy and integrity of the death investigation process.

Text

[*902] I. INTRODUCTION

In the middle of the 2016 presidential campaign, an unexpected occurrence changed the landscape of American jurisprudence: Supreme Court Justice Antonin Scalia was found dead in his sleep.¹ Justice Scalia died at a West Texas ranch while on a hunting trip with friends.² His death sparked a political battle for control over the Supreme Court, with the United States Senate refusing to conduct hearings on a replacement justice with eleven [*903] months left in President Obama's last term.³ While many people knew the political ramifications of Justice Scaia's death, few people focused on the procedural problems related to how his death was handled.⁴

Justice Scalia was discovered in bed with a pillow over his head. His breathing apparatus had been switched off, and his head was elevated on three pillows.⁵ Despite the curious scene, the justice of the peace declared Scalia dead from natural causes; he issued this finding by telephone without having any official examine the body, let alone perform an autopsy.⁶ While this process led to numerous conspiracy theories and paranoia, the investigation surrounding Justice Scaia's death sheds light on the sorry state of death investigations in the United States. There is no federal framework governing death investigations or the qualifications of death investigators. Thus, local officials in small counties are left with the power to make sometimes momentous decisions that have far-reaching impact. Because Justice Scalia died in Texas, state law governed, giving a small town judge and a justice of the peace sole power to determine the cause of Justice Scaia's death without an autopsy.⁷

As in Justice Scaia's case, death investigators are generally charged with classifying suspicious, unexplained, or mysterious deaths. The death [*904] investigator examines the deceased, investigates the scene, and makes a determination concerning the extent to which further investigation is needed.⁸ Despite these lofty responsibilities, each state sets its own standards on what type of death investigation system to utilize and what qualifications are necessary for becoming a death investigator.⁹ Regardless of the system selected, death investigators are intended to serve as an independent body that answers important personal and social questions about the cause

¹ See Amy Brittain & Sari Horwitz, *Texas Sheriff's Report Reveals More Details on Supreme Court Justice Scalia's Death*, WASH. POST (Feb. 23, 2016), https://www.wash.ingtonpost.com/world/national-security/texas-sheriff-releases-report-on-supreme-court-justice-scalias-death/2016/02/23/8c0bdb0c-da82-11e5-891a4ed04f4213e8_story.html [<https://perma.cc/VN3K-N34P>] (reporting that Justice Scalia died on February 13, 2016).

² See *id.*

³ See Nina Totenberg, *170-Plus Days and Counting: GOP Unlikely to End Supreme Court Blockade Soon*, NPR (Sept. 6, 2016), <http://www.npr.org/2016/09/06/492857860/173-days-and-counting-gop-unlikely-to-end-blockade-on-garland-nomination-soon> [<https://perma.cc/GQP6-XP77>] (explaining that Senate Republicans refused to hold hearings, take votes, or take any action at all to confirm President Obama's Supreme Court nominee, Merrick Garland, to fill Justice Scaia's vacant Supreme Court seat). After the election of Donald Trump to the presidency, he rescinded the Garland nomination, and then nominated Neil Gorsuch to fill Justice Scaia's seat; the Senate later confirmed Gorsuch. See Ariane de Vogue & Dan Berman, *Neil Gorsuch Confirmed to the Supreme Court*, CNN (Apr. 7, 2017), <http://www.cnn.com/2017/04/07/politics/neil-gorsuch-senate-vote/index.html> [<https://perma.cc/MLG6-LR9N>].

⁴ See generally Nora Kelly, *Why Wasn't Antonin Scalia Given an Autopsy?*, THE ATLANTIC (Feb. 17, 2016), <https://www.theatlantic.com/politics/archive/2016/02/antonin-scalia-autopsy/463251/> [<https://perma.cc/PG8U-AQKV>] (stating that, while one might assume that a federal investigation would take place, in actuality the local government in a small Texas town handled Justice Scaia's death).

⁵ See *Antonin Scalia Suffered from Many Health Problems, Doctor Says*, CBS NEWS (Feb. 23, 2016), <https://www.cbsnews.com/news/antonin-scalia-suffered-from-many-health-problems-doctor-says> [<https://perma.cc/N6GG-9GCU>].

and nature of deaths.¹⁰ To meet these goals, they provide evidence to prosecution and defense teams in criminal and civil cases.¹¹

The actuality, however, has fallen far short of the ideal. While death investigators may generally be successful at classifying deaths, limited resources, bureaucratic realities, and the types of work they do have placed them in close proximity with prosecutors, ultimately jeopardizing their objectivity and their independence.¹² The system is structured in a way that places defense teams at a disadvantage and creates a situation that is ripe for conflicts of interest between death investigators and prosecutors.¹³ Some of these conflicts might result from outright collusion, while others may present themselves in subtle ways.¹⁴ Even the most well-intentioned death investigators might find themselves in situations in which they are influenced by the pressures of the system.¹⁵

This Article explores the relationship between death investigators and prosecutors, and how the structure of the system leads to conflicts of interest between them. Part I explores the essential actors who operate in the death investigation system and how the system is constrained by prosecutorial discretion and official immunity. Part II examines how conflicts of interest manifest between death investigators and prosecutors, specifically due to both [*905] inappropriate influence and the proximity of the death investigator and prosecutor offices. Part III highlights the most crucial recommendations for strengthening and reforming the death investigation system: establishing a federal agency to implement uniform death investigation standards; abolishing the coroner system in favor of a medical examiner system; and requiring advanced medical training and education for future death investigators. The Article concludes that implementing these recommendations will help correct the focus of the death investigation system towards a more balanced and independent organization.

II. BACKGROUND

When a person dies of unexplained or suspicious causes, the American death investigation system begins to examine the circumstances surrounding the death.¹⁶ Generally, the system is composed of medical and forensic

⁶ See Kelly, *supra* note 4 (noting that local justices of the peace were initially called to examine Justice Scalia's death, but they were not available; a county judge pronounced Scalia dead of natural causes over the phone); see also Mark Berman, *Texas Judge Defends Decision Not to Order Autopsy for Justice Scalia*, WASH. POST (Feb. 16, 2016), <https://www.washingtonpost.com/news/post-nation/wp/2016/02/16/texas-judge-defends-decision-not-to-order-autopsy-for-justice-scalia> [<https://perma.cc/78E8-4LGP>] (reporting that the county judge who pronounced Justice Scalia dead of natural causes without an autopsy did so out of respect for Justice Scalia's family's wishes).

⁷ See Kelly, *supra* note 4 (noting that, under Texas law, an over-the-phone death investigation is legal).

⁸ FAQ, AM. BD. MEDICOLEGAL DEATH INVESTIGATORS, <http://www.abmdi.org/faq> [<https://perma.cc/VWR7-WBD7>].

⁹ See *Things to Know-No National Standards, Little Oversight*, PBS (Feb. 1, 2011), [hereinafter *Things to Know*] <http://www.pbs.org/wqbh/pages/frontline/post-mortem/things-to-know/no-standards.html> [<https://perma.cc/WLW2-MX22>] (explaining that there is no federal oversight of death investigations and very few offices are accredited, resulting in variations among states).

¹⁰ See INST. OF MED., BD. OF HEALTH PROMOTION & DISEASE PREVENTION, MEDICOLEGAL DEATH INVESTIGATION SYSTEM: WORKSHOP SUMMARY 7, 32-33 (2003) [hereinafter MEDICOLEGAL DEATH INVESTIGATION SYSTEM] ("To ensure the quality and integrity of death investigations, medical ... professionals should form institutions that are truly independent.").

¹¹ See *id.* at 7.

¹² See *id.* at 10-11, 33 (discussing the challenges facing the death investigation field and the proximity of prosecutors to death investigators).

experts who investigate the scene of death and examine the corpse via an autopsy.¹⁷ Death investigators provide critical forensic evidence and testimony, which helps parties--such as the prosecution--develop a theory explaining the cause of death.¹⁸ In circumstances in which foul play is suspected, investigators provide evidence and reports to the prosecutor.¹⁹ The prosecutor is endowed with great discretionary powers that shape how investigations proceed.²⁰ While potentially constrained by some standards that protect defendants, the prosecutor influences the death investigation system by dictating the ways in which results may be used, potentially influencing the actions of the investigators.²¹ This Part explores the history and structure of the death investigation system and explains how prosecutorial discretion, evidentiary standards, and immunity constrain death investigators.

A. Death Investigators

Death investigations classify the circumstances surrounding a suspicious or unexplained death.²² Death investigators inspect crime scenes, perform [*906] autopsies, and classify deaths resulting from crimes, health, safety or environmental hazards, and inadequate medical care.²³ There is no centralized federal investigation system.²⁴ States thus have flexibility to choose among a coroner system, a medical examiner system, or a hybrid system. While states choose which system will work best based on their needs and available resources, the lack of a uniform system has led to many inconsistencies across the country.²⁵ This Section considers how the death investigation system changed over time and how these systems continue to operate today.

1. History and Advances

The earliest death investigations were conducted by coroners who, during twelfth century England, determined whether property of the deceased would go to the king.²⁶ Coroners, or "crownors," as they were originally known, protected the king's proprietary interest against various individuals and groups who attempted to take possession of real and personal property that became available after suspicious deaths.²⁷ It was not until 1887 that coroners shifted their focus from protecting the king's interests to making medical determinations regarding the cause of

¹³ See *id.* at 31 (stating that the defense has the right to participate in the medical investigation, but it is nearly impossible because the defendant can rarely find a death investigator in the twenty-four-hour limit).

¹⁴ See *id.* at 31-32.

¹⁵ See *id.* (highlighting instructions from prosecutors to medical examiners to testify in a way that does not allow cross-examination from a defense attorney).

¹⁶ MEDICOLEGAL DEATH INVESTIGATION SYSTEM, *supra* note 10, at 7.

¹⁷ See *id.* at 7-8.

¹⁸ See *id.* at 31-32.

¹⁹ See *id.* at 31. The death investigator goes to the scene of the death, examines the body and the surrounding area, takes photographs of the scene, transports the body to their office, and generally usually performs an autopsy. *Id.* The evidence collected through this process is passed on to the prosecutor. *Id.*

²⁰ See *id.*

²¹ See *infra* Parts II.B.2-3.

²² Suspicious or unexplained deaths that require a death investigation typically include "homicides, suicides, unintentional injuries, drug-related deaths, and other deaths that are sudden or unexpected. Approximately 20% of the 2.4 million deaths in the US each year are investigated by medical examiners and coroners" MEDICOLEGAL DEATH INVESTIGATION SYSTEM, *supra* note 10, at 7.

death.²⁸ Additionally, coroners were appointed based on political favoritism, thus leading to a potentially corrupt system.²⁹

The coroner system came to America with the earliest settlers, as signified by the first inquest in 1635.³⁰ At first, the American system mirrored the English system in that coroners were appointed; over time, however, America began to elect coroners.³¹ The move from appointments to elections was aimed at reducing corruption within the coroner system and preventing coroners from [*907] using their power for self-serving interests.³² These changes did little to improve the quality of the death investigation system, however; political issues and scandals³³ continued to be a problem.³⁴ Catalyzed by consistent coroner inadequacies and scientific advances, many states began to move away from the traditional coroner system by adopting or supplementing their systems with a medical examiner.³⁵ This shift to a medical examiner paradigm was aimed at improving the quality of death investigations by requiring medical examiners to meet certain qualifications, such as holding an advanced medical degree.³⁶ In addition, through model rules and ethical standards, states have attempted to unify their death investigation systems across jurisdictions.³⁷ Despite these various reform attempts, however, the death investigation system in America remains disjointed at the state and county levels.³⁸

[*908] 2. Modern Day Death Investigation Systems

Today, death investigation systems exist primarily as coroner systems or medical examiner systems, with some variations. Coroners and medical examiners direct teams of experts that include professionals such as forensic pathologists, forensic scientists, toxicologists, and scene investigators.³⁹ While qualifications for coroners and medical examiners vary from state to state, the death investigator's role remains constant: to examine suspicious and unexplained deaths. There are four basic death investigation systems in the United States: (1) a county-, district-, or parish-based coroner system;⁴⁰ (2) a centralized medical examiner system; (3) a county- or district-based medical examiner system; and (4) a hybrid/mixed system.⁴¹ When deciding which type of system to

²³ See *id.* Modern-day death investigations are divided into three categories: medicolegal, institution-based, and private investigation. RANDY HANZLICK, DEATH INVESTIGATION: SYSTEMS AND PROCEDURES 11-12 (2007). This Article focuses on medicolegal investigations.

²⁴ See *Things to Know*, *supra* note 9.

²⁵ See MEDICOLEGAL DEATH INVESTIGATION SYSTEM, *supra* note 10, at 9.

²⁶ See *id.* at 8; Cyril H. Wecht, *Legal Medicine and Forensic Science: Parameters of Utilization in Criminal Cases*, 34 DUQ. L. REV. 797, 799-800 (1996).

²⁷ Wecht, *supra* note 26, at 799-800. "If a carriage with six horses had been involved in the negligent death of someone, if a ship had gone aground on the shoals and killed some people and there was a cargo, these instruments of death might be confiscated and taken by the king." *Id.* at 799.

²⁸ *Id.* at 801; History, CORONERS' SOC'Y ENG. & WALES, <https://www.coronersociety.org.uk/the-coroners-society/history/> [<https://perma.cc/C44S-W5JE>].

²⁹ See Wecht, *supra* note 26, at 799.

³⁰ JENNIFER MOORE, CORONERS' RECOMMENDATIONS AND THE PROMISE OF SAVED LIVES 39 (2016) (describing the English coroner system and how it was transposed to the colonies several centuries later); see also Wecht, *supra* note 26, at 799-800 (same).

³¹ MOORE, *supra* note 30, at 40.

³² See *id.* at 39 (noting that the credibility of coroners was reduced over time because the office was over-politicized and filled with unqualified individuals).

implement, jurisdictions weigh several factors, such as the availability of existing and future funding, a state's population density, qualified personnel, and a locality's organizational structure.⁴²

a. Coroner System

While there have been advances in medical technology, the framework and purpose of the coroner system have remained relatively constant since it came to America. Coroners today are still empowered to, among other things, certify the cause and manner of unexplained or unnatural deaths.⁴³ In all [*909] coroner jurisdictions, the position of coroner is elected and must meet only the most basic qualifications; generally, there are no age, education, or even medical training requirements.⁴⁴ Indiana, for example, requires only that the county coroner reside in the state, attend a forty-hour training course within six months of taking office, and take an eight-hour training course each year.⁴⁵ Some states allow government officials--such as the sheriff, justice of the peace, or prosecutor--to assume coroner duties in lieu of having a separate office of the coroner.⁴⁶

b. Medical Examiner System

Unlike the coroner system, which requires few qualifications, the medical examiner system adheres to strict education and medical training requirements. A medical examiner is a forensic doctor who uses his or her medical expertise when conducting death investigations, including performing autopsies.⁴⁷ Moreover, medical examiners are civil servants as opposed to elected officials. Because medical examiners have greater medical expertise than most coroners, many states have abandoned their coroner system entirely or supplemented that system with medical examiners.⁴⁸

[*910] Unlike the general standards for coroners, most jurisdictions require, at a minimum, that medical examiners "be physicians licensed to practice medicine" ⁴⁹ Other jurisdictions, like New Hampshire, impose more significant educational standards, requiring that medical examiners be certified pathologists.⁵⁰ In Massachusetts,

³³ See, e.g., Wecht, *supra* note 26, at 801-02.

³⁴ MOORE, *supra* note 30, at 39 (illustrating how corruption in the coroner system galvanized the reform movement).

³⁵ See HANZLICK, *supra* note 23, at 42. For example, in 1877, Massachusetts abolished the coroner system in favor of a medical examiner system, which required death investigators to have medical experience. Paul MacMahon, *The Inquest and the Virtues of Soft Adjudication*, 33 YALE L. & POL'Y REV. 275, 282 (2015); see also Robert D. Felder, Comment, *A Coroner System in Crisis: The Scandals and Struggles Plaguing Louisiana Death Investigation*, 69 LA. L. REV. 627, 633 (2009) (stating that the first major reforms to the coroner system in the U.S. occurred due to several scandals).

³⁶ See MEDICOLEGAL DEATH INVESTIGATION SYSTEM, *supra* note 10, at 23-24 (describing the benefits of instituting a medical examiner system over a coroner system, including improved quality of death investigations, uniformity, and central administration).

³⁷ In 1928, the National Academy of Sciences first addressed the state of death investigation, making specific recommendations: "(1) that the office of coroner be abolished ... (2) that the medical duties of the coroner's office be vested in the office of medical examiner; (3) that the office of medical examiner be headed by a scientifically trained and competent pathologist." NAT'L RESEARCH COUNCIL OF THE NAT'L ACADEMIES, STRENGTHENING FORENSIC SCIENCE IN THE UNITED STATES: A PATH FORWARD 242 (2009) [hereinafter A PATH FORWARD]; see also Andrea R. Tischler, *Speaking for the Dead: A Call for Nationwide Coroner Reform*, 33 SW. U. L. REV. 553, 556 (2004).

³⁸ Tischler, *supra* note 37, at 557.

The first thing one must realize is that the word "system" is a misnomer, when used in the context of death investigation in the United States. There is no "system" of death investigation that covers the more than 3,000 jurisdictions in this country. No nationally accepted guidelines or standards of practice exist for individuals responsible for performing death-scene

the chief medical examiner must be a physician licensed to practice in the Commonwealth and a graduate of an approved fellowship program in forensic medicine with a certification in anatomic pathology and subspecialty certification in forensic pathology.⁵¹ New Jersey, while similar to New Hampshire and Massachusetts, imposes additional training, requiring thirty hours of basic education in death investigation, sponsored by an institution of higher education or other agency approved by the State Medical Examiner; a basic course conducted by the Office of the State Medical Examiner; and seven full days of internship training at the New Jersey State Medical Examiner Office.⁵²

While a medical examiner system is more reliable than the coroner system, the diverse requirements from one jurisdiction to another prevent uniform training across the country, leading to barriers to entry in a field that is greatly in need of qualified professionals. Although many jurisdictions may prefer to rely on medical examiners rather than coroners, there are not enough qualified medical examiners in the United States to staff all of the open positions.⁵³ The strict requirements of the medical examiner system led to more comprehensive death investigations, but those requirements also prevent many offices from staffing all available positions.⁵⁴

[*911] c. Hybrid Systems

Dispersed populations, a dearth of qualified medical examiners, and inconsistent political will have led some states to employ a hybrid death investigation system—one in which counties across a state vary in terms of whether they use a coroner or medical examiner.⁵⁵ Alabama provides an interesting example of this approach. It is statutorily classified as a coroner system,⁵⁶ but in practice it qualifies as a hybrid system because at least three counties abolished the office of the coroner and replaced it with the office of a medical examiner.⁵⁷ The hybrid systems encapsulate the overall deficiencies and lack of uniformity of the death investigation system.⁵⁸ The patchwork of laws and approaches employed across states causes confusion for those trying to understand death investigations in America.⁵⁹

investigations. No professional degree, license, certification, or minimum educational requirements exist, nor is there a commonly accepted training curriculum. Not even a common job title exists for the thousands of people who routinely perform death investigations in this country.

DEPT OF JUSTICE, DEATH INVESTIGATION: A GUIDE FOR THE SCENE INVESTIGATOR I (1999).

³⁹ See HANZLICK, *supra* note 23, at 49 (listing the major disciplines of forensic sciences); *What Is a Coroner?*, CrimeSceneInvestigatorEDU, <https://www.crimesceneinvestigatoredu.org/coroner> [<https://perma.cc/M5BW-9NBZ>].

⁴⁰ For this category, the CDC includes any state in which all counties, districts, and parishes are served by a coroner, even if there is an overall state medical examiner's office. *Death Investigation Systems*, CTRS. FOR DISEASE CONTROL & PREVENTION (last updated Oct. 26, 2016), <http://www.cdc.gov/php/publications/coroner/death.html> [<https://perma.cc/Z9AD-UMR2>]. Some scholars categorize these types of states as hybrid/mixed. See HANZLICK, *supra* note 23, at 89-97.

⁴¹ *Death Investigation Systems*, *supra* note 40. A hybrid/mixed system generally means that the state has some coroners, but also has at least one county with a medical examiner system. See HANZLICK, *supra* note 23, at 89.

⁴² See A PATH FORWARD, *supra* note 37, at 257 (noting that many death investigator positions remain vacant "because of manpower shortages and/or insufficient funding of pathologist positions"). In Georgia, the mayor may perform coroner duties in municipalities with 5,000 people or fewer. *Ga. Code Ann. § 45-16-1* (2016). In Washington, in counties with fewer than 40,000 people, the local prosecutor is the ex-officio coroner. *WASH. REV. CODE ANN. § 36.16.030* (West 2003 & Supp. 2018). In Wisconsin, cities with fewer than 500,000 residents are not allowed to have a coroner and those with more than 500,000 have the option to have a coroner; two or more counties may also institute a joint medical examiner system in Wisconsin. *WIS. SCAT. ANN. § 59.20* (West 2013 & Supp. 2015).

B. Prosecutors

The structure of the death investigation system gives prosecutors enormous control over scientific evidence and testimony, which in turn helps to further their case theories. This arrangement, coupled with a prosecutor's largely unfettered discretion, creates great potential for abuse. Prosecutorial discretion dictates the direction, outcome, and underlying mechanisms of criminal cases.⁶⁰ Indeed, one federal district judge recently wrote that, "for the immediate future at least, prosecutors, rather than judges, will be the real rulers of the American criminal justice system. And I ask you: is that fair?"⁶¹

Current constraints meant to lessen abuse of prosecutorial discretion fall short of eliminating conflicts of interest and reducing prosecutorial control. **[*912]** This Section explores the prosecutor's role in death investigations, how their discretion increases their authority, and how existing constraints are ineffective.

1. The Modern Prosecutor's Role in the Death Investigation

The modern prosecutor fulfills a dual role of an adversary and an agent of the sovereign. As an adversary, the prosecutor's goal is to win the case; as an agent of the sovereign, the prosecutor must seek both the conviction of the guilty and the acquittal of the innocent.⁶² In these dual roles, prosecutors have significant discretion concerning whether to bring a case, what charges to file, and what sentence to pursue.⁶³ During a death investigation, prosecutors work closely with death investigators and law enforcement to determine the cause of death and whether the state should seek charges.⁶⁴ As part of this work, prosecutors have control over scientific evidence, the ability to shape the facts, and the power to persuade a factfinder of a defendant's guilt. A prosecutor's dominion over criminal proceedings constrains the objectivity and independence of the death investigation system, essentially situating death investigators under the direct command of prosecutors.

⁴³ There are currently fourteen states that have a county- district- or parish-based coroner system. [ARK. CODE ANN. § 14-15-301](#) (2013); [COLO. REV. STAT. § 30-10-601](#) (2017); [IDAHO CODE § 34-622](#) (Michie 2015); [IND. CODE ANN. § 36-2-14-2](#) (West 2006); [KAN. STAT. ANN. § 22a-226](#) (West 2008); [KY. REV. STAT. ANN. § 72.410](#) (LexisNexis 2014); [LA. STAT. ANN. § 13:5701](#) (2012); [MONT. CODE ANN. § 7-4-2901](#) (2015); [NEB. REV. STAT. ANN. § 23-1820](#) (LexisNexis 2011); [NEV. REV. STAT. ANN. § 259.010](#) (LexisNexis 2011); [N.D. CENT. CODE § 11-10-02](#) (2012); [S.C. CODE ANN. § 17-5-5](#) (2014); [S.D. CODIFIED LAWS § 7-7-1.1](#) (2004); [WYO. STAT. ANN. § 7-4-101](#) (2017).

⁴⁴ But see [KAN. STAT. ANN. § 22a-226](#) (2017) (requiring all coroners to be licensed physicians).

⁴⁵ [IND. CODE ANN. §§ 36-2-14-2, -22.3, -23](#) (West 2006 & Supp. 2015).

⁴⁶ See, e.g., [NEB. REV. STAT. ANN. § 23-1210](#) (LexisNexis 2011) ("The county attorney shall perform all of the duties enjoined by law upon the county coroner and the county attorney shall be the ex officio county coroner."); *Death Investigation Systems*, *supra* note 40 (finding that Hawaii's chief of police is authorized to play a significant role in a death investigation, and that justices of the peace in Texas can perform coroner duties). This feature can also apply to coroners in a hybrid or mixed system. See, e.g., [HAW. REV. STAT. ANN. § 841-1](#) (West 2008) ("The chief of police or his authorized subordinate ... shall, ex officio, be the coroner for his respective county.").

⁴⁷ See *What Is a Coroner?*, *supra* note 39 (explaining that coroners may be medical professionals and may perform autopsies). But see [W. VA. CODE § 61-12-7](#) (2016) (explaining that, in West Virginia, the office of medical examiner may be held by non-physicians, such as nurses, paramedics, or physicians' assistants).

⁴⁸ Sixteen states and the District of Columbia have centralized medical examiner systems. [ALASKA STAT. § 12.65.015](#) (2016); [CONN. GEN. STAT. ANN. § 19a-406](#) (West 2011); [DEL. CODE ANN. TIT. 29, § 4704](#) (Michie 2017); [D.C. CODE § 5-1402](#) (2001 & Supp. 2018); [ME. REV. STAT. ANN. TIT. 22, § 3023](#) (2004 & Supp. 2017); [MD. CODE ANN., HEALTH-GEN. § 5-306](#) (LexisNexis 2015); [MASS. ANN. LAWS ch. 38, § 2](#) (LexisNexis 2006 & Supp. 2016); [N.H. REV. STAT. ANN. § 611-B:2](#) (2001 & Supp. 2017); [N.M. STAT. ANN. § 24-11-3](#) (LexisNexis 2015); [N.C. GEN. STAT. § 130A-382](#) (2015); [OKLA. STAT. ANN. tit. 63, §](#)

One may think that, in a death investigation, the prosecutor steps in after all of the evidence has been collected and the facts are set. In reality, however, the prosecutor's influence commences at the beginning of the investigation.⁶⁵ The structure of the criminal justice system is such that death investigators and prosecutors are intended to be independent entities. But they are housed under the same governmental framework, thus placing them ostensibly on the same team.⁶⁶ In some cases, they even work in the same building, further blurring the lines of independence.⁶⁷ This architecture enables prosecutors to influence [*913] scientific evidence and testimony, sometimes creating substantial conflicts of interest.

2. Prosecutorial Discretion

Prosecutorial discretion is a key component of the criminal justice system. Without this discretion, prosecutors' limited time and resources might be spent on frivolous or unwarranted cases.⁶⁸ Discretion allows prosecutors to prioritize cases according to the social and political priorities of the jurisdiction.⁶⁹ In a practical sense, discretion may lead to more just outcomes because it allows prosecutors to balance real life circumstances with black letter law.⁷⁰

Despite the need for prosecutorial discretion, the seemingly unlimited ability of the prosecutor to control a case often results in the abuse of power.⁷¹ Furthermore, there is no substantive check on a prosecutor's discretion; they are accountable only to a supervisor who usually has the same goals and interests, and public mechanisms generally are ineffective at holding prosecutors accountable.⁷² With a culture of winning at all costs and pursuing convictions with zeal, prosecutors--knowingly or unknowingly--may cross the line into questionable or illegal behavior, creating conflicts of interest.⁷³ Without meaningful standards or reform, prosecutorial misconduct and questionable practices are rarely challenged.⁷⁴

⁹³⁷ (West 2016); OR. REV. STAT. § 146.065 (2017); 23 R.I. GEN. LAWS § 23-4-2 (2008); UTAH CODE ANN. § 26-4-4 (LexisNexis 2013 & Supp. 2016); VT. STAT. ANN. tit. 18, § 507 (2017); VA. CODE ANN. § 32.1-277 (2015); W. VA. CODE ANN. § 61-12-7 (LexisNexis 2014). Six states have county- or district-based medical examiner systems. ARIZ. REV. STAT. ANN. § 11-592 (2012); FLA. STAT. ANN. § 406.05 (West 2016); IOWA ADMIN. CODE r. 641-127.1 (2018); MICH. COMP. LAWS SERV. § 52.201 (LexisNexis 2006); N.J. STAT. ANN. § 52:17B-83 (West 2010); TENN. CODE ANN. § 8-9-101 (2016); see also *Death Investigation Systems*, *supra* note 40 (noting that Tennessee allows for counties to maintain a coroner system, but there are currently no active coroners).

⁴⁹ See D.C. Code § 5-1402; see also ME. REV. STAT. ANN. tit. 22, § 3022 ("The Chief Medical Examiner must possess a degree of doctor of medicine or doctor of osteopathy, be licensed to practice in the State and be expert in the specialty of forensic pathology.").

⁵⁰ N.H. REV. STAT. ANN. § 611-B:2.

⁵¹ MASS. ANN. LAWS ch. 38, § 2.

⁵² N.J. Admin. Code 13:49-7.1 (2018).

⁵³ A PATH FORWARD, *supra* note 37, at 257-58 (explaining that, at this time, the estimated need is for about 1,000 forensic pathologists; about 10% of available positions are vacant because of manpower shortages). While seventy forensic pathology positions become available each year, only 70% of those available positions are ultimately filled. *Id.* at 257. Many of these positions remain vacant due to lack of funding and manpower shortages. *Id.*

⁵⁴ See HANZLICK, *supra* note 23, at 42 (noting that the lack of qualified professionals and unfilled positions leads to varying quality in death investigations).

⁵⁵ Fifteen states currently have a hybrid/mixed system. ALA. CODE § 11-5-1 (LexisNexis 2008); ALA. CODE § 45-27-60 (2011); CAL. GOV'T CODE § 24010 (West 2003); CONN. GEN. STAT. ANN. § 19a-406 (West 2011); GA. CODE ANN. § 45-16-80 (2016); HAW. REV. STAT. ANN. § 841-1 (West 2008); 55 ILL. COMP. STAT. ANN. 5/3-3003, -3044 (West 2004); MINN. STAT. ANN. § 390.005 (West 2005 & Supp. 2016); Miss. CODE ANN. § 41-61-57 (West 2007 & Supp. 2017); MO. REV. STAT. §§ 58.010, 58.700 (West 2017); N.Y. COUNTY LAW § 671 (McKinney 2017); OHIO REV. CODE ANN. § 313.01 (LexisNexis 2016);

[*914] 3. Constraints on Prosecutors

Despite the prosecutor's apparently unlimited authority, there are numerous constraints on prosecutorial discretion, from a defendant's right against self-incrimination to due process protections. Most prevalent to the death investigation system are standards that constrain prosecutors in their use of scientific evidence and testimony. The standard set out in *Brady v. Maryland*⁷⁵ is a prime example of how evidentiary standards that require strict disclosure may curb abuses of prosecutorial discretion.⁷⁶ *Brady* imposes an affirmative obligation on prosecutors to disclose exculpatory evidence to the defendant and applies, for example, when prosecutors solicit false testimony or allow false testimony to go uncorrected.⁷⁷ If a prosecutor fails in this obligation, provided the issue at hand is material, the defendant is typically entitled to a new trial.⁷⁸

In theory, standards such as *Brady* place a check on prosecutorial discretion; in reality, however, these standards fall short of protecting the innocent and fail to sufficiently condemn prosecutorial abuse.⁷⁹ When examining an alleged *Brady* violation, courts require a finding of egregious misconduct and require defendants to meet a nearly unattainable bar of materiality.⁸⁰ Such insubstantial constraints mean that prosecutors are rarely [*915] investigated or disciplined, even when a defendant's rights have clearly been violated.⁸¹ Since the standard is so high, most allegations fail to trigger a *Brady* violation. Even well-meaning prosecutors, through their relationship and access to death investigators, can bend the results of an investigation and encourage the production of false or misleading evidence that may send an innocent defendant to prison.

In addition to the difficulties associated with asserting a *Brady* violation, statutory immunity serves to insulate prosecutors from misconduct charges. Even when government officials act illegally or unethically, they generally enjoy immunity as long as they are "acting within the scope of their employment," regardless of the nature of the violation.⁸² The provision of immunity is an attempt to balance both the need to hold officials accountable and the need to protect officials acting reasonably from "harassment, distraction, and liability."⁸³ But just as disclosure obligations are ineffective at holding prosecutors accountable, immunity shields prosecutors from misconduct claims and lowers the bar of accountability.⁸⁴

53 PA. STAT. AND CONS. STAT. ANN. § 3092 (West 2016); TEX. CODE CRIM. PROC. ANN. art. 49.02, .04, .25 (West 2006); WASH. REV. CODE ANN. § 36.16.030 (West 2003 & Supp. 2018); Wis. STAT. ANN. § 59.20 (West 2013 & Supp. 2015).

⁵⁶ ALA. CODE § 11-5-1.

⁵⁷ See *Death Investigation Systems*, *supra* note 40.

⁵⁸ See Beth Pearsall, *Improving Forensic Death Investigation*, NAT'L INST. JUST. (Mar. 3, 2011), <https://www.nij.gov/journals/267/pages/investigation.aspx> [<https://perma.cc/5KLW-LZ2E>] (discussing the deficient death investigation system and possible solutions).

⁵⁹ See *id.*

⁶⁰ See RUSSELL L. WEAVER ET AL., *PRINCIPLES OF CRIMINAL PROCEDURE* 291 (3d ed. 2008).

⁶¹ Jed S. Rakoff, *Why Prosecutors Rule the Criminal Justice System--And What Can Be Done About It*, [111 NW. U. L. REV. 1429, 1436 \(2017\)](#).

⁶² See Charlie DeVore, Comment, *A Lie Is a Lie: An Argument for Strict Protection Against a Prosecutor's Knowing Use of Perjured Testimony*, [101 J. CRIM. L. & CRIMINOLOGY 667, 667 \(2011\)](#) (noting that prosecutors must balance the desire to achieve legislative victories with justice and fairness); see also [United States v. Agurs, 427 U.S. 97, 110-11 \(1976\)](#) ("[T]hough the attorney for the sovereign must prosecute the accused with earnestness and vigor, he must always be faithful to his client's overriding interest that justice shall be done. He is the servant of the law, the twofold aim of which is that guilt shall not escape or innocence suffer." (citation and internal quotation marks omitted)).

⁶³ See WEAVER ET AL., *supra* note 60, at 291 (stating that prosecutorial discretion is rooted in the separation of powers doctrine and that such discretion is "ill-suited to judicial review" (quoting [Wayte v. United States, 470 U.S. 598, 607 \(1985\)](#))).

The opportunity for the misuse of scientific evidence and testimony, coupled with an unattainable immunity standard, complicates how prosecutors interact with death investigators. The system is already structured in a way that lends itself to conflicting interests for prosecutors and death investigators. Without proper checks on that system, however, conflicts may go unchecked or unresolved. On one level, the evidentiary standards established by courts seem to indicate a willingness to address these problems. On another level, though, the inability of the public to hold officials accountable cuts the other way. The following Part highlights the improper association between prosecutors and death investigators resulting from the failure of the constraints on both offices.

[*916] III. CONFLICTS OF INTEREST

The term "conflict of interest" elicits visions of outright corruption and backroom deals. While conflicts of interest may be apparent in some circumstances, they can also result from discreet pressures over time.⁸⁵ It is difficult to define or understand what constitutes a conflict of interest,⁸⁶ in part because many professionals do not believe they could possibly fall victim to inappropriate influences; as a result, they often overlook the subtle tensions in their professional lives.⁸⁷ A conflict of interest occurs between a death investigator and a prosecutor when one party submits to competing interests or loyalties,⁸⁸ whether knowingly or unknowingly, and it adversely affects an individual's independent and professional judgment.⁸⁹

Prosecutors and death investigators confront personal and institutional pressures resulting in pervasive conflicts of interest that undermine their independence and integrity. While the two offices have distinct goals,⁹⁰ the prosecutor's commanding authority over medical evidence, combined with a close relationship with the death investigator's office or the individual death investigator on the case, gives the prosecutor overwhelming influence in the relationship.⁹¹ That influence may push the investigator to knowingly or [*917] unknowingly compromise his or her professional independence in many stages of the investigation. These pressures result in overt conflicts of interest, such as collusion between the two offices,⁹² or unconscious and inappropriate influence that threatens the integrity of the entire justice system.⁹³

⁶⁴ See MEDICOLEGAL DEATH INVESTIGATION SYSTEM, *supra* note 10, at 31 (explaining that after a suspected homicide, prosecutors consult with death investigators to determine the manner, cause, and time of death).

⁶⁵ See *id.*

⁶⁶ See *id.* at 33 (lamenting the control that prosecutors have over the death investigators resulting from the institutional framework).

⁶⁷ See *id.* at 36-37 (arguing that death investigator offices should be removed from departments of public safety like prosecutor and police offices in order to reduce conflicts of interest).

⁶⁸ ANGELA J. DAVIS, ARBITRARY JUSTICE: THE POWER OF THE AMERICAN PROSECUTOR 13 (2007). Nationwide, local criminal justice systems do not have enough resources to pursue charges in every alleged criminal case. *Id.* at 13-14; see also RONALD J. ALLEN ET AL., CRIMINAL PROCEDURE: INVESTIGATION AND RIGHT TO COUNSEL 4 (3d ed. 2016) (explaining that the availability of resources may force prosecutors to be selective in choosing cases to prosecute).

⁶⁹ See DAVID K. SHIPLER, RIGHTS AT RISK: THE LIMITS OF LIBERTY IN MODERN AMERICA 108 (2012).

⁷⁰ See Ronald Wright & Marc Miller, *The Screening/Bargaining Tradeoff*, 55 STAN. L. REV. 29, 30-35 (2002) (arguing that appropriate use of prosecutorial discretion, or "screening," may result in only "appropriate charges" being filed, which can lead to a more balanced and fair system).

⁷¹ See Angela J. Davis, *The American Prosecutor: Independence, Power, and the Threat of Tyranny*, 86 IOWA L. REV. 393, 397, 399 (2001).

⁷² *Id.* at 397 ("Most citizens know very little about the practices and policies of their local prosecutor."); DAVIS, *supra* note 68, at 16.

Although conflicts of interest between prosecutors and death investigators pervade the justice system, there has been very little focus on the conflicts between the offices. Instead, scholars have focused on death investigator and prosecutor misconduct separately.⁹⁴ This Section analyzes the interaction between the two offices and what occurs when they are allowed to influence each other without adequate oversight or consequences.

A. Overt and Apparent Conflicts of Interest

From fraudulent medical exams to state cover-ups, there are many examples of overt conflicts of interest in the death investigation field. Overt conflicts of interest are clear and apparent instances of inappropriate influence created by institutional structures and personal biases.⁹⁵ These conflicts may be separated into two categories: when a prosecutor serves as a coroner⁹⁶--an inherent institutional conflict--and when at least one party knowingly acts due to inappropriate influence⁹⁷--a combination of institutional and personal biases. Institutional structures and personal biases allow each office to influence the other and in turn blur the lines of duty, responsibility, and independence.⁹⁸ Overt conflicts of interest are contrary to all principles of justice and fair process.

[*918] 1. Allowing the Prosecutor to Serve as the Coroner Creates an Overt Conflict of Interest

A feature unique to the coroner system is that some jurisdictions allow officials who already occupy a governmental position also to hold the position of coroner, thus creating an inherent conflict of interest. Pursuant to state statutes, officials such as sheriffs,⁹⁹ mayors,¹⁰⁰ prosecutors,¹⁰¹ and justices of the peace¹⁰² are permitted to hold the office of the coroner simultaneously.¹⁰³ While states have enacted these statutes to promote efficiency, combat a lack of medical expertise, and manage limited resources, conflicts of interest are unavoidable.¹⁰⁴ When the office that conducts the post-mortem death investigation is the same office that pursues criminal charges against a suspect, the traditionally independent offices often end up with contradictory goals.¹⁰⁵

⁷³ DAMS, *supra* note 68, at 16-18. "[E]ven well-meaning prosecutors often fail because they exercise discretion arbitrarily and without guidance and standards, under the daily pressures of overwhelming caseloads in a system with inadequate representation for most defendants, and judges who are more interested in efficiency than justice." *Id.* at 16.

⁷⁴ Daniel Woislav, Comment, *Absolute Immunity: Applying New Standards for Prosecutorial Accountability*, 26 GEO. MASON U. C.R.L.J. 349, 365-66 (providing data reflecting the lack of professional and criminal liability and professional disciplinary action for prosecutors who have engaged in prosecutorial misconduct leading to wrongful convictions). *But see* Tony Saavedra, *Prosecutors Who Falsify, or Withhold Evidence Could Become Felons Under Proposed State Legislation*, ORANGE COUNTY REG. (Aug. 11, 2016), <http://www.ocregister.com/articles/county-725339-prosecutors-orange.html> [<https://perma.cc/9D2D-JUBA>] (describing proposed penalties of between sixteen months and three years for prosecutors who intentionally falsify or withhold evidence).

⁷⁵ 373 U.S. 83 (1963).

⁷⁶ In addition to the *Brady* standard, the *Napue* standard guides prosecutors in their use of evidence and testimony. The *Napue* standard declares that a prosecutor's knowing misuse of false evidence or testimony at trial is a violation of due process. *See Napue v. Illinois*, 360 U.S. 264, 269 (1959) (holding that the Fourteenth Amendment Due Process Clause bars prosecutors from knowingly presenting false testimony and obligates them to correct such testimony when it occurs).

⁷⁷ *See Brady*, 373 U.S. at 87 ("We now hold that the suppression by the prosecution of evidence favorable to an accused upon request violates due process where the evidence is material either to guilt or to punishment, irrespective of the good faith or bad faith of the prosecution."); *see also* BENNETT L. GERSHMAN, *PROSECUTORIAL MISCONDUCT* 243 (2d ed. 2015) ("Nondisclosure of exculpatory evidence by prosecutors is one of the most pervasive forms of prosecutorial misconduct, and may account for more miscarriages of justice than any other type of prosecutorial infraction.").

⁷⁸ *See Giglio v. United States*, 405 U.S. 150, 153 (1972) (explaining that *Brady* holds that suppression of material evidence by a prosecutor, regardless of good or bad faith, "justifies a new trial").

[*919] Allowing the prosecutor to serve as coroner creates an overt conflict because one cannot completely compartmentalize the goals and obligations of each position. On the one hand, prosecutors face pressure to maintain a high conviction rate, while at the same time attempting to seek justice.¹⁰⁶ On the other hand, coroners aim to conduct thorough, objective death investigations and provide accurate medical results.¹⁰⁷ A prosecutor who serves as coroner may have difficulty balancing these goals and may be inclined to pursue a theory of death that serves the purposes of the prosecution. As previously discussed, prosecutors have a great deal of discretion in the criminal justice system.¹⁰⁸ Permitting the prosecutor to act as coroner eliminates a check on prosecutorial discretion and provides the prosecutor with even more control over the process. Affording one person this unbridled, virtually unregulated power compromises the independence of each role and the ability to have an objective, correct determination of death and a potentially unbiased trial.¹⁰⁹

Nevertheless, state courts in Nebraska and Washington have upheld the validity of this relationship. In 1941, in *Sturgeon v. Crosby Mortuary, Inc.*,¹¹⁰ for example, the Nebraska Supreme Court sustained the constitutionality of combining the coroner's office and the prosecutor's office.¹¹¹ The court explained that the prosecutor serving as a coroner "constituted a reasonable exercise of the powers of his office."¹¹² More recently, the Nebraska court reiterated the position expressed in *Sturgeon* by explicitly stating that there is no danger of a conflict of interest when a prosecutor serves as coroner because the prosecutor's judicial duties are separate and distinct from its coroner duties.¹¹³ While the Nebraska statute *permits* the prosecutor to serve as coroner, the Washington State statute *requires* that the prosecutor serve as coroner in cities with populations less than 40,000 people.¹¹⁴ Permitting or [*920] requiring the prosecutor to serve as coroner eliminates the independence that safeguards the fair outcome of death investigations.

While it may make superficial sense for cities with fewer resources and smaller budgets to combine the role of prosecutor and coroner,¹¹⁵ the greater concern for justice outweighs the relatively modest savings provided by combining the roles.¹¹⁶ Efficiency and cost savings should not be pursued at the expense of a thorough and accurate death investigation.

⁷⁹ See Cynthia E. Jones, *A Reason to Doubt: The Suppression of Evidence and the Inference of Innocence*, 100 J. CRIM. L. & CRIMINOLOGY 415, 434 (2010) ("[T]he *Brady* disclosure duty has become one of the most unenforced constitutional mandates in the criminal justice system.").

⁸⁰ See, e.g., *Giglio*, 405 U.S. at 154 (indicating that a *Brady* violation results in a new trial when the violation materially affects the outcome of a case); *United States v. Reese*, 745 F.3d 1075, 1083 (10th Cir. 2015) ("Evidence is *material* if there is a reasonable probability that the result of the proceeding would have been different had the evidence been disclosed. A *reasonable probability* means the likelihood of a different result is great enough to undermine confidence in the outcome." (citation and internal quotation marks omitted)).

⁸¹ Cadene A. Russell, Comment, *When Justice Is Done: Expanding a Defendant's Right to the Disclosure of Exculpatory Evidence on the 51st Anniversary of Brady v. Maryland*, 58 HOW. L.J. 237, 246-50 (2014) (discussing the shortcomings of *Brady* in addressing prosecutorial misconduct and noting that the tendency to favor the government "is evident where bar associations are not inclined to 'discipline prosecutors for even the most egregious *Brady* violations'" (quoting Elizabeth Napier Dewar, *A Fair Trial Remedy for Brady Violations*, 115 YALE L.J. 1450, 1456 (2006))).

⁸² See *Chesher v. Neyer*, 477 F.3d 784, 796 (6th Cir. 2007) (citing OHIO REV. CODE ANN. § 2744.03(A)(6)).

⁸³ *Pearson v. Callahan*, 555 U.S. 223, 231 (2009).

⁸⁴ See Russell, *supra* note 81, at 267 ("Unfortunately, prosecutorial immunity is more of a hindrance to effective *Brady* policies than it is a benefit."); Woislav, *supra* note 74, at 349 (arguing that absolute immunity prevents the public from holding prosecutors accountable for misconduct because it exempts prosecutors from civil liability for violations of individual rights).

⁸⁵ Don A. Moore et al., *Introduction*, in CONFLICTS OF INTEREST: CHALLENGES AND SOLUTIONS IN BUSINESS, LAW, MEDICINE, AND PUBLIC POLICY 3 (Don A. Moore et al. eds., 2005) [hereinafter CONFLICTS OF INTEREST].

2. One Party or Both Parties Knowingly Act Due to an Obvious Conflict of Interest

In addition to the conflicts of interest that are apparent when a prosecutor serves as coroner, there are opportunities for overt conflicts of interest between prosecutors and death investigators even while serving in their individual capacities. An overt conflict of interest exists when, at the time of the interactions between the death investigator and the prosecutor, one or both parties knowingly act due to inappropriate influence.¹¹⁷ These conflicts manifest in situations in which a prosecutor actively pressures an investigator to change or conceal the results of an investigation.¹¹⁸ In turn, the death investigator knowingly compromises his or her duty and objectivity in support of the prosecution. Further, prosecutors and death investigators may actively work together to achieve a more favorable outcome for the prosecution.¹¹⁹ These cases reflect situations in which both offices allow competing interests and loyalties to cloud their independent and professional judgment.

In *State v. Beecroft*,¹²⁰ there was no dispute over whether the defendant had stabbed her newborn infant and put the baby in the trash; the question prosecuting attorney shall be ex officio coroner."). Once the population of a county attains forty thousand, the coroner must be elected. *Id.* [*921] instead was whether the infant had been born alive or dead.¹²¹ The prosecution maintained the former, making the horrific scene a murder.¹²² With blind ambition, the prosecution intimidated the defense team's death investigators, preventing them from testifying in opposition to the prosecution's theory.¹²³ The prosecution materially affected the outcome of the case by limiting the defense team's access to resources and qualified death investigators, and by threatening to dismantle the investigator's career and blackmail her supervisors.¹²⁴ Since the prosecutor was willing to compromise his integrity and the independence of his office, he made the defense team's experts so fearful for their "professional and financial well-being," Beecroft was denied a fair and just trial.¹²⁵

⁸⁶ Samuel Issacharoff, *Legal Responses to Conflicts of Interest*, in CONFLICTS OF INTEREST, *supra* note 85, at 191.

⁸⁷ CONFLICTS OF INTEREST, *supra* note 85, at 3.

⁸⁸ See *Conflict of Interest*, BLACK'S LAW DICTIONARY (10th ed. 2014) (defining "conflict of interest" as "[a] real or seeming incompatibility between one's private interests and one's public or fiduciary duties").

⁸⁹ See *People v. Clark*, 261 P.3d 243, 343-44 (Cal. 2011) (acknowledging that there can be actual and potential conflicts of interest); *State v. White*, 114 S.W.3d 469, 476 (Tenn. 2003) (defining conflicts of interest as when a professional cannot exercise judgment free of competing interests and loyalties); BENNETT L. GERSHMAN, PROSECUTION STORIES ch. 7 (2017) (discussing "the problem of divided loyalties" and conflicts of interest in specific situations); BRENT E. TURVEY & STAN CROWDER, ETHICAL JUSTICE: APPLIED ISSUES FOR CRIMINAL JUSTICE STUDENTS AND PROFESSIONALS 265 (2013) (explaining that conflicts of interest can include a need to satisfy multiple roles, duties, or obligations).

⁹⁰ During a death investigation, death investigators analyze scientific evidence to determine the causes and surrounding circumstances of a death; in appropriate cases, prosecutors then actively pursue a conviction. See HANZLICK, *supra* note 23, at 11 (discussing the role of death investigators within medicolegal death investigations); Carolyn B. Ramsey, *The Discretionary Power of "Public" Prosecutors in Historical Perspective*, 39 AM. CRIM. L. REV. 1309, 1311-12 (2002) (discussing the historical patterns of prosecutors actively seeking convictions).

⁹¹ See Davis, *supra* note 71, at 408 (explaining the far-reaching discretion and power of prosecutors in criminal case outcomes); Bennett L. Gershman, *Misuse of Scientific Evidence by Prosecutors*, 28 OKLA. CITY U. L. REV. 17, 18 (2003).

Intimidating death investigators because their testimony conflicts with the prosecution's theory is an obvious conflict of interest. These issues are exacerbated by the very structure of the death investigation system that allows for the power of the prosecutor to go unchecked. The nature of the adversary system is inherently contentious and matches competing experts against one another. Both the prosecution and the defense should have equal access to qualified and competent death investigators; in reality, however, the death investigation system gives the prosecution a clear advantage. Allowing a prosecutor to intimidate death investigators and experts, without repercussion, not only chills what is intended to be an independent and adversarial system, but also promotes faulty forensic science.

The structural and independence issues raised in *Beecroft* are further exemplified through acts of collusion between prosecutors and death investigators. In *Rivets v. Fischer*,¹²⁶ a prosecutor and death investigator colluded to produce a time of death that favored the prosecution's theory of a murder.¹²⁷ The prosecution could not prove its case unless the death investigator reexamined the autopsy report "with an eye toward expanding the time of death."¹²⁸ The investigator was motivated to please the prosecutor, perhaps because the investigator hoped that his compliance would lead to the [*922] dismissal of a pending criminal misconduct charge against him.¹²⁹ Situations like this, in which a prosecutor actively and inappropriately engages a death investigator to skew the autopsy findings in order to secure a conviction, create clear conflicts of interest. Contrary to the purposes of the death investigation system—including independence, objective outcomes, and justice—death investigators are motivated to please prosecutors in order to sustain business. Stretching science beyond a factual and accurate point only produces a skewed and subjective system.

Inappropriate relationships between the death investigator and the prosecutor often go unnoticed and, therefore, unsanctioned. When discovered, however, the relationship provides a disturbing insight into how pervasive collusion may be.¹³⁰ In *Mitchell v. Gibson*,¹³¹ for example, the death investigator, Joyce Gilchrist,¹³² worked with the prosecutor to hide exculpatory evidence from the defense counsel, leading to a wrongful conviction and a sentence of death.¹³³ Gilchrist knowingly gave false and misleading testimony that DNA found on the victim

("[T]he prosecutor dominates the system, has exclusive control of the evidence, and decides by himself how that evidence will be used.").

⁹² See [State v. Beecroft, 813 N.W.2d 814, 847-48 \(Minn. 2012\)](#) (exemplifying how prosecutors may substantially interfere with and pressure death investigators).

⁹³ See [McCarty v. State, 765 P.2d 1215, 1217-18 \(Okla. Crim. App. 1988\)](#) (describing a case in which a death investigator succumbed to implicit pressures).

⁹⁴ See generally Davis, *supra* note 71, at 408 (examining the effects of prosecutorial discretion); Felder, *supra* note 35, at 628-30 (providing an example of death investigators who abuse their power); Brandon L. Garrett & Peter J. Neufeld, *Invalid Forensic Science Testimony and Wrongful Convictions*, [95 VA. L. REV. 1, 4-12 \(2009\)](#) (highlighting prosecutor's misuse of erroneous death investigator testimony); Gershman, *supra* note 91, at 17 (discussing the prosecutor's misuse of scientific evidence while pursuing criminal convictions).

⁹⁵ See, e.g., [Rivas v. Fischer, 687 F.3d 514, 528 \(2d Cir. 2012\)](#) (illustrating the structure that allows for overt conflicts to occur).

⁹⁶ See *infra* Part II.A.1.

⁹⁷ See *infra* Part 11.B.2.

⁹⁸ See Felder, *supra* note 35, at 628 ("Whether a mistake leads to the wrongful conviction of the innocent, allows the guilty to go free, or allows an unjust award of damages, the ramifications of an ineptly governed death investigation system are felt throughout the entire justice system.").

⁹⁹ See [HAW. REV. STAT. ANN. § 841-1](#) (West 2008) (permitting the chief of police to serve as coroner in certain counties).

matched that of the defendant, permitting the prosecutor to obscure the truth and blind the jury from contradictory reports to secure a conviction.¹³⁴ Gilchrist's unbridled control over the medical evidence, combined with the prosecutor's ability to capitalize on his close relationship with her, created a space for inappropriate influence and misconduct.¹³⁵ The post-conviction trial court described this conduct as "absolutely indefensible";¹³⁶ the appellate court stated that it "strikes a heavy blow to the public's 'trust in the prosecutor.'"¹³⁷ The court granted a conditional writ of habeas corpus and invalidated Mitchell's death sentence on due process grounds.¹³⁸

While the factors contributing to overt conflicts of interest described above illuminate serious issues in the criminal justice system at large, they are only part of the problem. In addition to outright collusion and intimidation tactics, it [*923] is an overt conflict of interest when a prosecutor knowingly elicits false testimony from a death investigator. In *Drake v. Portuondo*,¹³⁹ a jury convicted the defendant on two counts of second-degree murder based largely on the prosecution's false testimony from an expert witness.¹⁴⁰ The prosecution team knew that it lacked evidence of motive, so they called a psychologist at the last minute¹⁴¹ to testify about a so-called medical theory known as "picquerism."¹⁴² The prosecution delayed notifying the defense team about the additional witness the weekend before trial, thus giving the defense minimal time to evaluate the witness and produce its own expert.¹⁴³ Furthermore, the prosecutor "did not independently investigate [the expert's] credentials or contact any other mental health professional to inquire about picquerism" before putting him on the stand.¹⁴⁴

While a prosecutor should zealously seek a conviction, he or she should not ignore evidence or testimony that is not grounded in facts or supported by accurate and credible scientific evidence. The prosecutor in *Drake* knew that picquerism was not a legitimate medical theory; nevertheless, he solicited the investigator's testimony to win the case.¹⁴⁵ The prosecutor elicited false testimony to establish motive, and the investigator lied about his credentials and provided false testimony.¹⁴⁶ When a prosecutor and the death investigator act for personal or professional gain, it creates a serious conflict of interest.

¹⁰⁰ See [GA. CODE ANN. § 45-16-1](#) (2016) (allowing mayors in municipalities with populations less than 5,000 people to serve as coroners).

¹⁰¹ See [NEB. REV. STAT. ANN. § 23-1210](#) (2011) (mandating that the county attorney perform the duties of the coroner); [N.D. CENT. CODE § 11-09-27](#) (2012) (establishing that the sheriff or county manager can perform the duty of the coroner in rare circumstances); [WASH. REV. CODE ANN. § 36.16.030](#) (West 2003 & Supp. 2018) (requiring the prosecutor to serve as coroner in counties with populations under 40,000 people).

¹⁰² See TEX. CODE CI UN. PROC. ANN. art. 49.04 (West 2006) (stating that the justice of the peace will perform the duty of the coroner). See generally Judy Melinek, *Justice Scalia's Unexamined Death Points to a Problem*, CNN (Feb. 20, 2016), <http://www.cnn.com/2016/02/18/opinions/justice-scalia-no-autopsy-melinek/> [<https://perma.cc/6W9E-V23U>] (discussing conflicts of interest arising from allowing the justice of the peace to issue Justice Scalia's death certificate without visiting the scene or performing an autopsy).

¹⁰³ Funeral directors can also serve simultaneously as coroners, thereby creating a conflict of interest when funeral directors arrive at the scene of a crime to garner business. See HANZLICK, *supra* note 23, at 19, 37.

¹⁰⁴ See *Skamania County Coroner*, SKAMANIA COUNTY, <http://www.skamaniacounty.org/prosecutor/homepage/coroner/> [<https://perma.cc/J24H-9ZN8>] (stating that counties with limited resources should combine the office of coroner and county prosecutor).

¹⁰⁵ See [State v. Beecroft](#), 813 N.W.2d 814, 834 (Minn. 2012) ("[F]orensic science is not and should not become the sole province of the police and prosecutors. In the search for truth and justice, forensic science must be 'equally available to law enforcement officers, prosecutors, and defendants.'" (quoting A PATH FORWARD, *supra* note 37, at 17)). For a recent example of an alleged conflict of interest on the part of a sheriff who also served as county coroner, see Julie Small, *Autopsy Doctor Resigns, Says Sheriff Overrode Death Findings to Protect Officers*, KQED NEWS (Dec. 4, 2017), <https://www.kqed.org/news/2017/12/04/autopsy-doctors-sheriff-overrode-death-findings-to-protect-law-enforcement/>

Similarly, in *Miller v. Pate*,¹⁴⁷ the prosecutor knowingly elicited, and the death investigator willingly provided, false testimony to support the prosecution's argument.¹⁴⁸ The prosecutor pursued a case theory that focused on a pair of blood-stained shorts that were found near the crime.¹⁴⁹ He claimed the shorts tied the defendant to the murder of an eight-year-old girl.¹⁵⁰ The death investigator intentionally lied on the stand by asserting that the shorts [*924] were stained with Type A blood, the victim's blood type, rather than Type O blood, the defendant's blood type.¹⁵¹ The prosecution did not allow the defense team to test the shorts, which gave the prosecutor and the death investigator exclusive control over key medical evidence.¹⁵² As a result of the prosecutor's and investigator's repeated lies and misstatements, the jury found the defendant guilty and sentenced him to death.¹⁵³ The case was ultimately appealed to the Supreme Court, where it became evident that the shorts were stained with paint, rather than blood, and that the prosecutor, the investigator, and nearly everyone on the government's side knew at trial that the shorts did not have blood stains.¹⁵⁴ The prosecutor and the death investigator had colluded by repeatedly misconstruing and lying about the key medical evidence.¹⁵⁵

Whether prosecutors actively approach a death investigator, or the two offices conspire, the foregoing cases demonstrate how pervasive overt conflicts of interest are throughout the criminal justice system. Until steps are taken to reform and implement oversight in the existing system, this type of conflict of interest between death investigators and prosecutors will continue. More broadly, a system that gives prosecutors exclusive control over death investigators and their scientific findings creates serious doubt that prosecutors will appropriately manage non-scientific evidence such as confessions and eyewitness testimony.¹⁵⁶

B. Discreet and Non-Obvious Conflicts of Interest

While overt conflicts of interest are detrimental to the justice system, most conflicts result from more discreet and subtle circumstances. These conflicts tend to occur when one party is not fully aware that his or her decisions are motivated by competing pressures and improper influence.¹⁵⁶ The death investigation structure allows

[<https://perma.cc/A84T-TJSA>]. According to Dr. Bennet Omalu, San Joaquin County, California's chief forensic pathologist, "The sheriff was using his political office as the coroner to protect police officers whenever someone died while in custody or during arrest. . . . I had thought that this was initially an anomaly, but now, especially beginning in 2016, it has become routine practice." *Id.* Dr. Omalu added: "The Sheriff does whatever he feels like doing as the coroner, in total disregard of bioethics, standards of practice of medicine and the generally accepted principles of medicine." *Id.*; see also Radley Balko, *It's Time to Abolish the Coroner*, WASH. POST (Dec. 12, 2017), <https://www.washingtonpost.com/news/the-watch/wp/2017/12/12/its-time-to-abolish-the-coroner/> [<https://perma.cc/EHK6-6Y4Z>] (stating, inter alia, "[i]n 41 of [California's] 58 counties, the coroner's duties are automatically assumed by the elected sheriff").

¹⁰⁶ DAVIS, *supra* note 68, at 141 (considering how prosecutors' offices "foster a culture of winning at any cost").

¹⁰⁷ HANZLICK, *supra* note 23, at 57.

¹⁰⁸ See *supra* Part I.B.1.

¹⁰⁹ The American Bar Association has formulated standards for the use of expert medical testimony; when a prosecutor acts as the coroner this standard cannot possibly be met. See STANDARDS FOR CRIM. JUST. PROSECUTION FUNCTION & DEF. FUNCTION r. 3-3.3 (AM. BAR ASS'N 1992).

¹¹⁰ [299 N. W. 378 \(Neb. 1941\).](#)

¹¹¹ [Id. at 383.](#)

¹¹² *Id.* The court noted the legislative intent to provide efficiency and cost savings. [Id. at 382.](#)

¹¹³ [McKinney v. Okoye, 806 N.W.2d 571, 578 \(Neb. 2011\).](#)

¹¹⁴ [WASH. REV. CODE ANN. § 36.16.030](#) (West 2003 & Supp. 2018) ("[I]n each county with a population of less than forty thousand no coroner shall be elected and the

investigators and prosecutors to develop a close working relationship, allows them to work in the same building, and permits [*925] both offices to promote a similar agenda.¹⁵⁷ Over time, prosecutors exert subtle influence over death investigators and gain privileged access that defense teams are routinely denied.¹⁵⁸

After years of working together and developing a rapport, death investigators begin to view themselves as part of the prosecution team and may develop a pro-prosecution bias, which is contrary to the goals of an independent death investigation system.¹⁵⁹ This in-group bias causes death investigators to shape results to help prosecutors and leads prosecutors to capitalize on that bias.¹⁶⁰ To understand how underlying pressures lead death investigators to compromise their independence and objectivity, it is necessary to examine the careers of some infamous offenders. By examining a death investigator's career, it is easy to see how the constant underlying pressure and close relationship with prosecutors can cause a gradual shift in objectivity and how, in the long run, these characters become oblivious to such implicit biases.

1. Joyce Gilchrist

Perhaps one of the most notable characters in the death investigation system who exemplifies the issue of pro-prosecution bias resulting in conflicts of interest is Joyce Gilchrist.¹⁶¹ Throughout her career, Gilchrist worked solely with prosecution teams as a death investigator, conducting investigations and serving as an expert witness.¹⁶² Over time Gilchrist developed what seemed to be a pattern of delaying evidence, severely disadvantaging defense teams, and testifying beyond the scope of her knowledge; all of her tactics appeared to [*926] favor the prosecution.¹⁶³ Gilchrist repeatedly disobeyed court orders to conduct tests that could have cleared defendants and failed to turn over evidence to defense teams.¹⁶⁴ Moreover, prosecutors knew or should have known that Gilchrist's testimony and work were inaccurate. Despite her extensive history of misconduct and bias, however, they still chose to employ her as an expert because her pattern of behavior was an asset to prosecution teams.¹⁶⁵

These conflicts of interest resulted from improper influence and the inappropriate relationship between Gilchrist's office and the prosecution team. Her legacy includes false testimony regarding medical evidence, false

¹¹⁵ *Skamania County Coroner*, *supra* note 104.

¹¹⁶ See MEDICOLEGAL DEATH INVESTIGATION SYSTEM, *supra* note 10, at 26 (noting the potential of coroners lacking knowledge or having conflicts of interest, "especially when funeral directors, prosecutors or sheriffs act as coroners").

¹¹⁷ See Jennifer E. Laurin, *Remapping the Path Forward: Toward a Systemic View of Forensic Science Reform and Oversight*, 91 TEX. L. REV. 1051, 1068 (2013) (highlighting the need for medical examiner independence from law enforcement agencies in order to reduce conflicts of interest).

¹¹⁸ See *id.* at 1055 (discussing the ways in which a prosecutor can influence a death investigation, such as influencing death investigator priorities and investigation techniques).

¹¹⁹ For a modern example of a death investigator changing his results based on the opinion of the prosecutor, see Patricia Wen, *Medical Examiners Here Can Be a Jury of One*, Bos. GLOBE (Aug. 20, 2016), <https://www.bostonglobe.com/metro/2016/08/20/life-and-death-decision-without-supervision/gRzxpXjWQ0gHY2y49Nb8LK/story.html> [<https://perma.cc/CUT6-KAZ9>] (highlighting the potential for conflicts of interest when the death investigator and prosecutor work closely and the lack of oversight for death investigations).

¹²⁰ [813 N.W.2d 814 \(Minn. 2012\)](#).

¹²¹ [Id. at 824.](#)

¹²² *Id.*

¹²³ [Id. at 826-30](#); see also Julie Jonas, *True Independence for Medical Examiners Equals Due Process for Criminal Defendants and More Efficiencies in the Criminal Justice System*, 37 WM. MITCHELL L. REV. 698, 712-13 (2011).

imprisonment of innocent defendants, and possibly even the execution of innocent people.¹⁶⁶ By exploiting Gilchrist's pro-prosecution bias, prosecution teams undermined their responsibility to the justice system. Gilchrist's actions shed light on how discreet conflicts of interest manifest over time and are the result of gradual influence creating an inherent bias, rather than manifesting as an overt attempt to advantage prosecutors.¹⁶⁷ When death investigators, such as Gilchrist, experience pressure from prosecutors or are made to feel part of the prosecution team, each office's independence is compromised.

[*927] 2. *Fred Zain*

A "super star" who could find evidence when no one else could and always gave prosecutors a win, death investigator Fred Zain's experience highlights how pro-prosecution bias corrupts the system and how untrustworthy scientific evidence is endemic. While Zain appeared to be a scientific genius to some people, he turned out to be a massive fraud who falsified results in as many as 134 cases.¹⁶⁸ Zain may have been driven by a distorted sense of justice to help prosecutors, criticizing other death investigators for being too conservative when examining evidence. His "talent," however, only hurt defendants and victims. Inadvertent errors and exaggeration may seem like negligible nudges that help the prosecution, but they are actually measured actions that can add up to massive fraud. Compounding the effects of Zain's errors, prosecutors capitalized on his results and never questioned those results that favored their side.¹⁶⁹

Even more concerning than Zain's conduct is that the system allowed these conflicts to occur and remain unchecked. When Zain should have presented accurate and reliable scientific evidence, his relationship with prosecutors and his underlying bias pushed him to find what other death investigators could not. Because prosecutors and investigators are able to form a close working relationship, the line of independence is blurred, leading investigators such as Zain to present fraudulent pseudo-science as credible. The system accepts forensic evidence as proffered by experts; and without placing checks on how evidence is examined or presented, conduct like Zain's **[*928]** can result in a "systematic practice rather than an occasional inadvertent error."¹⁷⁰

¹²⁴ The prosecutor emailed the investigator's superior to say that it was unacceptable for the investigator staff to testify for the defense team and that he would not support the supervisor's campaign for coroner if the staff continued to testify. [Beecroft, 813 N.W.2d at 827-28](#). The prosecutor threatened to file a complaint against the death investigator with the state agency and to keep her from ever teaching again at the state crime laboratory. *Id.*

¹²⁵ [Id. at 840](#).

¹²⁶ [687 F.3d 517\(2d Cir. 2012\)](#).

¹²⁷ [Id. at 528](#).

¹²⁸ [Id. at 521](#). "No matter how much circumstantial evidence the prosecution could amass tending to link Rivas to the crime, however, it had no case unless it could prove that [the victim] died [within the new timeframe]." [Id. at 524](#).

¹²⁹ See *id.* at 528 (stating that the defendant alleged that the medical examiner altered the time of death to avoid prosecution for a pending misconduct charge).

¹³⁰ See [Chesher v. Neyer, 477 F.3d 784, 792 \(6th Cir. 2007\)](#) (describing how the closeness of the prosecutor and death investigator's offices led to an attempt to cover up a death investigator's illegal activity); [Williams v. Hartje, 827 F.2d 1203, 1205 \(8th Cir. 1987\)](#) (alleging that the coroner and prosecutor worked together to conceal an autopsy report from the defense team); *Ellingson v. Piercy*, No. 2:14-CV-04316-NKL, 2015 U.S. Dist. LEXIS 76703, at *9-11 (W.D. Mo. June 15, 2015) (discussing the potential cover-up among the death investigator, the prosecutor, and the police department when the death investigator failed to disclose all toxicology reports).

¹³¹ [262 F.3d 1036 \(10th Cir. 2001\)](#).

3. Dr. Steven Hayne

Another example of how pro-prosecution bias corrupts the system is Dr. Steven Hayne, who fabricated medical evidence and case theories in favor of the prosecution.¹⁷¹ Dr. Hayne consistently came up with outlandish methods and theories that aided the prosecution. For example, he replicated gunpowder marks by test-firing on canine skin in order to determine the distance between the shooter and the victim; he also compared teeth marks in a partially-digested bologna sandwich to a suspect's mouth.¹⁷² Not only did Dr. Hayne fabricate theories, but he also performed 257% more autopsies than allowed by the National Association of Medical Examiners (NAME), which severely affected the quality of his work.¹⁷³

While Dr. Hayne is not innocent in his involvement in the foregoing incidents, his actions represent a larger problem in the death investigation system. Abuse of death investigator findings "are not unique to Mississippi, and are able to persist because scientific testimony is too often viewed with uncritical reverence and because the people affected by its misuse usually have [*929] little support or sympathy."¹⁷⁴ A system that allows for both overt and non-obvious conflicts of interest cries out for change.

IV. RECOMMENDATIONS

¹³² For further discussion concerning Gilchrist, see *infra* Part II.B.1.

¹³³ [*Mitchell*, 262 F.3d at 1060.](#)

¹³⁴ *Id.*

¹³⁵ Gershman, *supra* note 91, at 33.

¹³⁶ [*Mitchell*, 262 F.3d at 1060.](#)

¹³⁷ [*Id.* at 1064.](#)

¹³⁸ See *id.* at 1066.

¹³⁹ [*553 F.3d 230 \(2d Cir. 2009\).*](#)

¹⁴⁰ [*Id.* at 233.](#)

¹⁴¹ *Id.*

¹⁴² [*Id.* at 235](#) (defining picquerism as "a purported syndrome or criminal profile in which the perpetrator realizes sexual satisfaction from penetrating a victim by sniper activity or by stab or bite wounds"). The prosecutor knew that picquerism was not a legitimate medical theory and intentionally elicited the death investigator's testimony about his unsubstantiated theory and his false testimony about his involvement in the case. [*Id.* at 243.](#)

¹⁴³ See *id.* (noting that the prosecution gave the defense only one day's notice of its intent to call the death investigator).

¹⁴⁴ [*Id.* at 235.](#)

¹⁴⁵ [*Drake*, 553 F.3d at 243-14.](#)

¹⁴⁶ See *id.* at 238-39; see also Charles Patrick Ewing, *False Credentials Cause Extensive Fallout*, 34 MONITOR ON PSYCHOL. 84 (2003) (describing how the death investigator's false credentials contributed to the unfortunate outcome of the case and encouraging prosecutors to carefully vet their experts' resumes).

¹⁴⁷ [*386 U.S. 1 \(1967\)*](#) (unanimous opinion).

The current structure of the death investigation system and the ways in which it is intertwined with the criminal justice system is susceptible to conflicts of interest that inhibit the fair and effective administration of justice. These conflicts, both overt and discreet, are caused by the inadequate oversight of officials and the unregulated working relationships between death investigators and prosecutors. While the potential for conflicts may never be entirely eliminated due to of the repeat nature of the actor's interactions, steps can be taken to reduce conflicts substantially. True independence is necessary in order to restore the separate and distinct goals of each office. To prevent circumstances in which death investigators present exaggerated or tainted science and testimony, the system must implement strict education and accreditation requirements. Achieving these important goals depends on the establishment of a pure medical examiner system and a federal agency to oversee and balance the relationship between death investigators and prosecutors.

Curbing conflicts and potential abuses means divorcing the death investigators' offices from the prosecutors' offices. The structure of the death investigation system provides prosecutors with privileged access to forensic evidence and allows them to influence death investigators, ultimately substantially disadvantaging criminal defense teams. Permitting prosecutors and death investigators to be housed under the same governmental framework--inducing death investigators to feel part of the prosecution team and even allowing both entities to occupy the same space--compromises their independence.¹⁷⁵ Without real independence, death investigators will remain under the authority of prosecutorial agencies, subject to administrative and political pressure.¹⁷⁶ Independence thus requires providing death investigators with their own space, allowing defense teams equal access to medical experts and evidence, and introducing oversight to hold prosecutors accountable. By removing death investigators from the umbrella of the prosecutor, death investigators can focus on providing objective and accurate medical evidence. Ensuring independence may require more collaboration between prosecutors [*930] and death investigators, but the need for objectivity outweighs the "thoughtful calibration" required to guarantee independence.¹⁷⁷

¹⁴⁸ [*Id.* at 6-7.](#)

¹⁴⁹ [*Id.* at 3-4.](#)

¹⁵⁰ *Id.*

¹⁵¹ [*Id.* at 4, 6](#) (explaining that the prosecutor knew the entire time that he had presented false evidence and "deliberately misrepresented the truth").

¹⁵² [*Miller*, 386 U.S. at 5.](#)

¹⁵³ [*Id.* at 2.](#)

¹⁵⁴ See *id.* at 6-7.

¹⁵⁵ Gershman, *supra* note 91, at 18.

Clearly, if a prosecutor bent on winning at all costs is able to manipulate technical and seemingly objective "scientific" evidence, how much more likely is it that the prosecutor will be able to misuse more subjective and easily manipulated non-scientific evidence such as confessions to police, eyewitness identifications, and the testimony of informants, accomplices, and jailhouse "snitches?"

Id.

¹⁵⁶ See A PATH FORWARD, *supra* note 37, at 185 (recognizing that improper influence can manifest in a pro-prosecution bias); CONFLICTS OF INTEREST, *supra* note 85, at 3.

¹⁵⁷ See generally Bruce A. Green & Fred C. Zacharias, *Prosecutorial Neutrality*, [2004 WIS. L. REV. 837, 849-56 \(2004\)](#) (arguing that inherent conflicts of interest exist when offices with varying incentives work closely together).

Improving the accuracy of the death investigation system also requires strengthening educational requirements and training for death investigators. At present, there is no uniform curriculum or consensus of what educational requirements should guide death investigators, even within an individual state system. The result is a fragmented death investigation system.¹⁷⁸ With current death investigation offices overwhelmed with a backlog of autopsies,¹⁷⁹ a system without a standardized educational baseline could mean that the innocent get convicted or the guilty go free. The foundation for a competent and accurate death investigation system starts with knowledgeable and trained professionals to staff each office. The lack of real training and education, however, means that the burden of developing competent death investigators falls to on-the-job training, which is often insufficient due to the cycle of undereducated and undertrained professionals currently working in these offices.¹⁸⁰

Establishing mandatory accreditation and certification processes for death investigators can further improve the reliability and accuracy of medical evidence. Currently, accreditation and certification are voluntary efforts by death investigation offices to follow recommended standards that establish quality control measures and death investigator proficiency.¹⁸¹ Mandatory [*931] accreditation and certification would ensure that death investigation offices are effectively managed and that only qualified individuals have dominion over medical evidence.¹⁸² Accreditation would require an impartial third party to determine whether an office meets the established quality control measures.¹⁸³ Certification would require an individual to prove that he or she is qualified and obtained the necessary education and training.¹⁸⁴ A regime that requires knowledgeable professionals and competent offices buttresses the entire justice system.

In addition to strengthening qualifications for individual death investigators, instituting a nationwide medical examiner system would ensure that deaths are evaluated by qualified medical professionals, would create more uniform requirements, and would reduce conflicts of interest that pervade the system. This shift requires abolishing the coroner system. Many coroners are unprepared and incapable of meeting the basic goal of a death investigation: assessing the cause, timing, and manner of a suspicious or unexplained death.¹⁸⁵ Coroners are often elected without any medical education or expertise and are therefore unqualified to perform the duties of the position.¹⁸⁶ Not only are some coroners underqualified, but some also have misconceptions about the value and

¹⁵⁸ See, e.g., Paul C. Giannelli, *The Abuse of Scientific Evidence in Criminal Cases: The Need for Independent Crime Laboratories*, 4 VA. J. SOC. POL'Y & L. 439, 473-74 (1997) (explaining that for most defendants it is difficult to obtain defense experts).

¹⁵⁹ See Conor Friedersdorf, *CSI Is a Lie*, THE ATLANTIC (Apr. 20, 2015), <http://www.theatlantic.com/politics/archive/2015/04/csi-is-a-lie/390897/> [<https://perma.cc/NJ5A-JH3L>] (stating that "medical examiners ... typically work for the government and are generally seen as part of the prosecution's 'team,' much like the police and investigators").

¹⁶⁰ See Gershman, *supra* note 91, at 31. In fact, a culture of "winning at all costs" may push prosecutors to misuse and manipulate evidence and testimony. *Id.* at 18.

¹⁶¹ See Paul C. Giannelli & Kevin C. McMunigal, *Ethical Considerations in the Use of Expert Testimony: Prosecutors, Ethics, and Expert Witnesses*, 76 FORDHAM L. REV. 1493, 1498 (2007) (describing Gilchrist as an example of a "corrupt expert"); Belinda Luscombe, *When the Evidence Lies*, TIME (May 13, 2001), <http://content.time.com/time/magazine/article/0917110962500.html> [on file with Ohio State Law Journal] (reporting on Gilchrist's infamous cases as a forensic scientist with the Oklahoma City police department).

¹⁶² See Luscombe, *supra* note 161 (describing several instances in which Gilchrist's findings were called into question for their accuracy).

¹⁶³ See generally *Miller v. State*, 809 P.2d 1317 (Okla. Crim. App. 1991) (involving Gilchrist in a non-death investigation case); *Pierce v. State*, 786 P.2d 1255 (Okla. Crim. App. 1990) (same); *McCarty v. State*, 765 P.2d 1215, 1217-19 (Okla. Crim. App. 1988) (highlighting Gilchrist's behavior of delaying evidence and testifying beyond her qualifications in a death investigation case).

purpose of their role and may be motivated by reelection and a desire to please stakeholders or superior [*932] government officials.¹⁸⁷ An electoral system rife with conflicts of interest and misconduct makes medical examiners the preferred choice of death investigators.¹⁸⁸ Furthermore, evaluating the cause of death is a medical determination that requires a medical professional.¹⁸⁹ Medical examiners, unlike coroners, are qualified to conduct autopsies and, because of their extensive medical education, they know what is medically plausible; they are more likely, therefore, to question what may appear to be a natural death.¹⁹⁰ Finally, medical examiners are the preferred death investigator because they are hired, rather than elected officials.¹⁹¹ For these reasons, according to one knowledgeable commentator, "[t]he coroner system isn't just an anachronism; it's an anachronism that never made much sense in the first place. It's well past time to get rid of it."¹⁹²

An independent, science-based, uniform death investigation system is dependent on the creation of a federal agency or an office within an existing agency to oversee the death investigation system.¹⁹³ This federal agency would implement national standards for death investigators, require science-based death investigations, develop regulations for managing misconduct, and implement incentives to encourage medical students to enter the pathology field, ultimately improving the accuracy and reliability of death [*933] investigations.¹⁹⁴ Federal regulation and oversight would eliminate the existing patchwork of laws that govern death investigations at the state and local level. Holding all death investigators accountable under the federal standard would deter misconduct and reduce the misuse of scientific data.¹⁹⁵

While a federal death investigation system would improve the integrity and accuracy of death investigations, it could also promote information sharing between other agencies.¹⁹⁶ For example, the National Highway Traffic Safety Administration uses death investigation data to monitor trends in traffic related accidents, and the CDC and the Food and Drug Administration use data to monitor trends in drugs and diseases. A federal system would create an information sharing database among the federal government, states, and localities, thus providing comprehensive death statistics and, in turn, helping underfunded and understaffed offices direct resources appropriately.¹⁹⁷

¹⁶⁴ A prime example of Gilchrist's transgressions is exemplified in [*McCarty v. State*, 765 P.2d 1215 \(Okla. Crim. App. 1988\)](#). Gilchrist delayed testing evidence for a first-degree murder conviction for four years and did not finish her examination until the Friday before a Monday trial, precluding the defense team from obtaining an independent review of her findings. [*Id.* at 1217](#). This delay appeared to be a strategy to aid the prosecution's theory and disadvantage the defense team. Further, she went on to discredit any independent examinations that the defense team could find, stating that they could not possibly have had time to properly examine the evidence. [*Id.* at 1217-18](#). In addition, she stated at trial that, although she was unqualified to give an opinion about whether the appellant was at the scene of the crime, the DNA evidence showed that he was, in fact, there. [*Id.* at 1218-19](#). The court found that the County's District Attorney's Office placed undue pressure on Gilchrist to give an expert opinion beyond the scope of her knowledge; that led to prosecutorial comments "so prejudicial as to adversely affect the fundamental fairness and impartiality of the proceedings." [*Id.* at 1219 n.1, 1221](#). After this trial, a formal complaint of misconduct was filed against Gilchrist, but no disciplinary action was taken. [*Id.* at 1219](#).

¹⁶⁵ Giannelli & McMunigal, *supra* note 161, at 1501 ("Given the many signals that her testimony was corrupt, prosecutors should have stopped using her as a witness. . . . '[T]he district attorney's office loved having her as a witness.'").

¹⁶⁶ To add gravity to this issue, twenty-three of the cases Gilchrist worked on were death penalty cases, eleven of which have led to execution. Now there is no way to re-test Gilchrist's results, possibly exonerating any innocent defendants. See Luscombe, *supra* note 161.

¹⁶⁷ See *id.* (reporting on Gilchrist's bewilderment that people have negative perceptions of her work as a death investigator).

¹⁶⁸ See Paul C. Giannelli, *Wrongful Convictions and Forensic Science: The Need to Regulate Crime Labs*, [*86 N.C. L. REV.* 163, 172 \(2007\)](#).

The acts of misconduct on the part of Zain included (1) overstating the strength of results; (2) overstating the frequency of genetic matches on individual pieces of evidence; (3) misreporting the frequency of genetic matches on multiple pieces of

V. CONCLUSION

The death investigation system in the United States has evolved over time, growing out of centuries-old traditions in England. But this outdated framework has not kept pace with changing societal values and scientific advances. The current system is fragmented and inconsistent across county and state lines, leading to situations like Justice Scalia's death in which local laws can reduce an investigation having national and political implications to a telephone call. ¹⁹⁸ This Article does not mean to imply foul play in Justice Scalia's death; rather, the death-

evidence; (4) reporting that multiple items had been tested, when only a single item had been tested; (5) reporting inconclusive results as conclusive; (6) repeatedly altering laboratory records; (7) grouping results to create the erroneous impression that genetic markers had been obtained from all samples tested; (8) failing to report conflicting results; (9) failing to conduct or to report conducting additional testing to resolve conflicting results; (10) implying a match with a suspect when testing supported only a match with the victim; and (11) reporting scientifically impossible or improbable results.

Id. at 172-73.

¹⁶⁹ Giannelli & McMunigal, *supra* note 161, at 1497 ("[O]ne serologist testified that at least twice after Zain left the lab, evidence on which [the serologist] had been unable to obtain genetic markers was subsequently sent to Texas for testing by Zain, who again was able to identify genetic markers.").

¹⁷⁰ Kathleen Keough Griebel, *Fred Zain, the CSI Effect, and a Philosophical Idea of Justice: Using West Virginia as a Model for Change*, 114 W. Va. L. Rev. 1155, 1185 (2012).

¹⁷¹ One of the most glaring examples involved Dr. Hayne creating a two-shooter theory to the exclusion of a single-shooter theory. Edmonds v. State, 955 So. 2d 787, 791 (Miss. 2007). This fabricated explanation directly aligned with the prosecution's theory of the case. Id. at 792. The Mississippi Supreme Court found that Dr. Hayne's testimony was not based on scientific methods and, pursuant to the court's standards, that the two-shooter theory should not have been admitted at trial. *Id.* See generally K.C. Meckfessel Taylor et al., CSV *Mississippi: The Cautionary Tale of Mississippi's Medico-Legal History*, 82 MISS. L.J. 1271 (2013) (discussing the problems in Mississippi's death investigation system, with a specific focus on Dr. Hayne's misdeeds); Radley Balko, Steven Hayne, Michael West 'Expert' Witness Scandal Could Affect Mississippi Attorney General Race, HUFFPOST (Aug. 28, 2011), http://www.huffingtonpost.com/radley-balko/steven-hayne-michael-west-forensic-scandal_b_940767.html [<https://perma.cc/AC47-2TAW>] (describing Dr. Hayne as a "gun[] for hire, willing to say on the witness stand whatever prosecutors need in order to win a conviction").

¹⁷² See Meckfessel Taylor et al., *supra* note 171, at 1290-93 (describing the various outlandish techniques that Dr. Hayne employed in his work).

¹⁷³ *Id.* at 1281. Dr. Hayne's workload was so egregious that in one case he completed a report on a spleen that had been removed from the body years earlier. *Id.* at 1282-83. In a recently published book that is highly critical of the Mississippi death investigation system and Dr. Hayne in particular, one of the authors wrote: "Until and unless the state engages in a thorough, top-down investigation of [his] work, we may never know the extent of the damage [he] may have done. So far, the people with the power to initiate such an investigation haven't shown much interest." RADLEY BALKO & TUCKER CARRINGTON, *THE CADAVER KING AND THE COUNTRY DENTIST: A TRUE STORY OF INJUSTICE IN THE AMERICAN SOUTH* xvi (2018).

¹⁷⁴ Campbell Robertson, *Questions Left for Mississippi Over Doctor's Autopsies*, N.Y. TIMES (Jan. 7, 2013), <http://www.nytimes.com/2013/01/08/us/questions-for-mississippi-doctor-after-thousands-of-autopsies.html> [on file with *Ohio State Law Journal*] (describing the negative perceptions toward criminal defendants by both prosecutors and society at large).

¹⁷⁵ See generally Laurin, *supra* note 117, at 1052-54.

¹⁷⁶ See MEDICOLEGAL DEATH INVESTIGATION SYSTEM, *supra* note 10, at 33; Laurin, *supra* note 117, at 1065 (stating that death investigators and crime laboratories should be independent from administrative and prosecutorial control).

¹⁷⁷ See Laurin, *supra* note 117, at 1112.

¹⁷⁸ See Felder, *supra* note 35, at 643-44 (explaining that the gaps and issues in Louisiana's death investigation system resulted from inadequate education and training requirements); see also *supra* Part 1.A.2.

¹⁷⁹ Katharine Q. Seelye, *As Overdose Deaths Pile Up, a Medical Examiner Quits the Morgue*, N.Y. TIMES (Oct. 7, 2017), <https://www.nytimes.com/2017/10/07/us/drug-overdose-medical-examiner.html> [<https://perma.cc/T3ZT-ETVV>] (highlighting the opioid epidemic and the "tsunami" of bodies needing autopsies and creating a backlog for death investigation offices across the country).

¹⁸⁰ Randolph N. Jonakait, *Forensic Science: The Need for Regulation*, 4 HARV. J.L. & TECH. 109, 124-27 (1991) (discussing how poor education and training are pervasive issues in the forensic science field). Compounding this issue is the lack of interest in forensic science and death investigation. To help meet these requirements, states should improve undergraduate and graduate forensic science programs and create incentives for students to pursue these fields through scholarships and fellowships. See A PATH FORWARD, *supra* note 37, at 27-28 (noting that improved education programs will help "correct some of the existing deficiencies" of the death investigation system). "Federal crime labs (97%) were more likely than state (83%), municipal (75%), and county (51%) labs to have written standards for performance in 2014." Andrea M. Burch et al., BUREAU

assessment practices established in the small [*934] Texas county in which he died are not in step with the

OF JUSTICE STAT., U.S. DEPT OF JUSTICE, NCJ 250152, PUBLICLY FUNDED FORENSIC LABORATORIES: QUALITY ASSURANCE PRACTICES, 2014, 5 (2016), available at <https://www.bjs.gov/content/pub/pdf/pffclqap14.pdf>.

¹⁸¹ The National Association of Medical Examiners (NAME) prepares and sets accreditation standards to help improve the quality of death investigations. See *Inspection and Accreditation*, NAT'L ASS'N MED. EXAMINERS, <https://netforum.avectra.com/eweb/DynamicPage.aspx?Site=name&WebCode=Accred> [<https://perma.cc/W4LY-7BYY>]. These standards apply to offices and systems, rather than to individuals, and provide minimum standards to which the systems should comply.*Id.* The NAME standards are voluntary, however, and merely represent an endorsement by the association that the accredited system or office meets NAME's standards. *Id.*

¹⁸² See EXEC. OFFICE OF THE PRESIDENT & NAT'L, SCI. & TECH. COUNCIL, STRENGTHENING THE MEDICOLEGAL-DEATH-INVESTIGATION SYSTEM: ACCREDITATION AND CERTIFICATION--A PATH FORWARD 2 (2016) [hereinafter ACCREDITATION AND CERTIFICATION], available at https://obamawhitehouse.archives.gov/sites/default/files/microsites/ostp/NSTC/strengthening_the_medicolegal_death_investigation_system_final.pdf [<https://perma.cc/D7VN-2CYR>].

¹⁸³ *Id.* at 2-3. The two premier crime lab accreditation organizations are the American Society of Crime Lab Directors/Laboratory Accreditation Board, International (ASCLD/LAB, International) and Forensic Quality Services-International (FCS-International). As of 2014, 66% of municipal and 78% of county crime labs, as compared with 97% state and 67% federal crime labs, were accredited by the ASCLD or FCS-International. Burch, *supra* note 180, at 2-3 & tb1.1.

¹⁸⁴ ACCREDITATION AND CERTIFICATION, *supra* note 182, at 3. In 2014, 5% of municipal and 8% of county crime labs, as compared with 7% of state and 39% of federal crime labs, tested the proficiency of forensic personnel through blind examinations. Additionally, federal crime labs were more likely to conduct random case reanalysis than publicly funded labs in other jurisdictions. Furthermore, during 2014, 72% of crime labs employed at least one externally certified analyst. Burch, *supra* note 180, at 4-5.

¹⁸⁵ See MEDICOLEGAL DEATH INVESTIGATION SYSTEM, *supra* note 10, at 29-30 (discussing the hesitation and inability of coroners to conduct autopsies compared to medical examiners in cases such as heart attacks, burned bodies, and possible homicides).

¹⁸⁶ A PATH FORWARD, *supra* note 37, at 49.

¹⁸⁷ In a New York county coroner race, for example, candidates were interviewed about why they were running for the position. All of the candidates indicated that they wanted to help grieving families, rather than solve and explain mysterious and suspicious deaths. See Sarah Harris, *Run for Coroner, No Medical Training Necessary*, NPR (Nov. 3, 2013), <http://www.npr.org/2013/11/03/242416701/run-for-coroner-no-medical-training-necessary> [<https://perma.cc/H8SX-8F6M>].

¹⁸⁸ See Associated Press, *Ex-Coroner: Elected System Can Mean Conflicts of Interest*, WASH. TIMES (June 7, 2015), [hereinafter Ex-Coroner] <http://www.washingtontimes.com/news/2015/jun/7/ex-coroner-elected-system-can-mean-conflicts-of-interest/> [<https://perma.cc/49SF-VUVM>] (asserting that coroners should be appointed rather than elected, due to conflicts of interests between coroners and funeral directors).

¹⁸⁹ *Pearsall*, *supra* note 58.

¹⁹⁰ See MEDICOLEGAL DEATH INVESTIGATION SYSTEM, *supra* note 10, at 30. For example, a medical examiner is more likely than a lay coroner to conduct an autopsy in a case in which a 30-year-old died from an alleged heart attack. *Id.* The medical examiner would be more inclined to do an autopsy because the medical examiner would know that this cause of death was medically implausible. *Id.*

¹⁹¹ *Id.* at 25; see also *Ex-Coroner*, *supra* note 188 (asserting that coroners should be appointed rather than elected because of conflicts of interests between coroners and funeral directors). Opponents of this position may argue that elections are beneficial because they give coroners autonomy to take positions that are in line with their constituents, rather than be pressured by other elected officials. See MEDICOLEGAL DEATH INVESTIGATION SYSTEM, *supra* note 10, at 26.

¹⁹² Balko, *supra* note 105.

national ideals to which we should hold our death investigators, whether in the death of such an important public figure or a private individual.

The typical structure of governmental branches responsible for death investigations and prosecution are such that they tend to be physically aligned, by being housed in the same offices, and/or outcome-aligned, because they operate under the prosecutorial umbrella. The proximity of death investigator and prosecutor offices can create both overt and discreet conflicts of interest that result in fundamental miscarriages of justice. These examples of conflicts obviously go against traditional notions of justice because they can involve outright collusion between death investigators and prosecutors, or even involve prosecutors serving directly as coroner. These types of situations prevent accurate and fair outcomes, because the conflicts resulting from that result directly harm the families of the victim and reduce the suspect's opportunities for a fair trial. Perhaps even more sinister than these overt conflicts are discreet conflicts that manifest over time through subtle influence and pro-prosecution bias. The physical and organizational proximity of the death investigator and prosecutor offices, combined with the repeated use of death investigative services by prosecutors, may create bias in favor of reaching the government's theory in individual cases. This Article provides examples of particular death investigators who compromised their independence in order to give the prosecution an advantage in multiple cases; without question there are many similar stories that go unreported and undetected. These discreet non-obvious conflicts of interest put defense teams, and thereby defendants, at a substantial disadvantage: death investigators may be more willing to give favorable treatment to prosecutors, or even obscure exculpatory results.

The existing mechanisms designed to alleviate some of these issues, such as evidentiary standards, are constrained by official immunity and prevent the public from holding death investigators and prosecutors accountable. To alleviate conflicts of interest and overcome the shortcomings of the existing constraints, this Article advocates for the creation of a federal agency to create uniformity and to oversee the death investigation system. As part of the agency's role, death investigators would be subject to uniform education and training requirements, and death investigators and their laboratories would be required to meet certain accreditation and certification

¹⁹³ *A Path Forward* recommended that a new federal agency should be created because existing agencies do not have the bandwidth or the "appropriate mission" to take on issues related to the forensic science community. See *A PATH FORWARD*, *supra* note 37, at 18. The report noted that agencies that are already working on forensic science issues should continue those projects. *Id.*

¹⁹⁴ See EXEC. OFFICE OF THE PRESIDENT & NAT'L SCI. & TECH. COUNCIL, STRENGTHENING THE MEDICOLEGAL-DEATH-INVESTIGATION SYSTEM: IMPROVING DATA SYSTEMS 1 (2016), https://obamawhitehouse.archives.gov/sites/default/files/microsites/ostp/NSTC/strengthening_the_medicolegal_death_investigation_system_final.pdf.

¹⁹⁵ *Id.* Ethical codes instruct analysts on best practices and ensure that analysts work within the confines of their expertise, provide objective findings, avoid conflicts of interest, and prevent susceptibility to outside influences. Burch, *supra* note 180, at 5. During 2014, state crime labs (98%) were more likely to have a written code of ethics than county (94%), municipal (87%), and federal (85%) crime labs. *Id.*

¹⁹⁶ The Obama Administration's Committee on Medicolegal-Death-Investigation-System released a report in 2016 concluding that many federal agencies rely on death investigation data to implement federal policy. See EXEC. OFFICE OF THE PRESIDENT & NAT'L SCI. & TECH. COUNCIL, *supra* note 194, at 2. The National Commission on Forensic Science similarly recommended that the Department of Justice create a permanent office of Medicolegal Death Investigation to improve the death investigation system by coordinating support for death investigation systems and improving the quality of those systems across the country. *Id.* at 1. In addition, the Attorney General should seek funding to modernize existing technologies and recruit and retain forensic pathologists. *Id.* at 2.

¹⁹⁷ In 2011, 55% of death investigation facilities needed additional equipment or renovations. SCI. WORKING GRP. FOR MEDICOLEGAL-DEATH-INVESTIGATION, INFRASTRUCTURE COMM., MEDICOLEGAL AUTOPSY FACILITIES IN THE UNITED STATES 3 (2011), available at <http://www.swgmdi.org/images/iscomrpt3-facilities2011.pdf>.

¹⁹⁸ See Kelly, *supra* note 4.

standards to ensure that the actors are qualified. In addition, through accreditation or other means, death investigator offices need to be truly independent from prosecutor offices. Whether this means physically separating the two or providing defense teams with equal access to resources, the current system favors prosecutors too heavily. Finally, as much as possible, the agency should oversee the elimination of the coroner system. Outdated and out-of-touch, the coroner system simply does not have the same capabilities as the medical examiner system. It is possible that elected coroners may be qualified, but too often they are not, and it is the victims and defendants who suffer.

[*935] Perhaps the problem is lack of political will, or funding, or inertia, but the patchwork of systems across the country prevents true justice from being done. A federal system would provide greater resources to struggling systems and ensure uniform death investigations across the country. Without meaningful change, the current system that creates conflicts of interest will continue to thwart the accuracy and integrity of the death investigation process and fairness in individual cases.

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Gores, Loni

From: Pickett, Paul
Sent: Wednesday, February 12, 2025 6:40 PM
To: yellowbanks@hotmail.com
Cc: Gores, Loni; Richards, Ron; Fisch, Susan
Subject: Re: Your "Wrong answer and abuse of power" email

Mr. Bowen,

As Chair of the Bylaws/Rules Committee, here's a little more background. At the first Committee meeting we discussed public outreach. At that time, the new Commission hadn't thought through how to notify the public of committee meetings. It was the first committee meeting, and as a result of discussions in the Committee and in the Commission, we now have a more robust plan.

So please accept our apologies for a rough start. I think we are doing better now. As Ron notes, we are volunteers and new to this. I guarantee we are all dedicated to transparency and a robust public outreach.

And of course, any suggestions for improved notification of our meetings are welcome!

Paul Pickett

From: Richards, Ron <ron.richards@clallamcountywa.gov>
Sent: Tuesday, February 11, 2025 7:50 PM
To: yellowbanks@hotmail.com
Cc: Gores, Loni <loni.gores@clallamcountywa.gov>; Fisch, Susan <susan.fisch@clallamcountywa.gov>
Subject: Re: Your "Wrong answer and abuse of power" email

Dear Mr. Bowen,

I know your referenced email refers specifically to the Bylaws Committee, a committee to which I do not belong. However, since your email seems to be mainly directed at me, I am answering for myself. It could well be that the Charter Review Commission, or the By-laws Committee, might also wish to respond, so please recognize that this is just my response.

I share your concerns, and I believe all the Charter Review Commissioners share your concerns, that notice of our meetings should be provided in accordance with the Open Public Meetings Act. To this end several of us worked on arranging for a meeting place for last Friday's committee meetings (Town Hall and Coroner) in plenty of time to give the notice required by the OPMA, and we made sure that such notice was given before we attended the meetings. Below I've copied the notices that were made, and at least one location on the County website where those posted. These seemed to work because four members of the public from the Clallam Bay area did learn of the meeting and did attend. Frankly, I was assuming you would also be there, and I was looking forward to meeting you in person.

Having said this, I will be first to admit that many of us are new to the CRC and learning the ropes on how to function with such a large commission with multiple committees and probably more to come. As with any endeavor, things can always be done better. To this end I would encourage you to provide me, or the CRC, with a list of other sites where we should consider posting our notices.

Regarding your preference of Article III, Section 5 over Article III, Section 3 of the By-laws, I would just say it was my clear impression that all the members of the CRC believed both sections said the same thing and chose Section 3 because of its brevity. I am sure the tapes of our last meeting will make that clear if ever necessary.

I do very much appreciate your input, and I look forward to more of a dialogue in the future.

Sincerely,

Ron Richards
360-477-5367



MEETING NOTICE

CLALLAM COUNTY CHARTER REVIEW COMMISSION

The Charter Review Commission has scheduled a Coroner Committee meeting to be held at 2 p.m., Friday, February 7, 2025 at the Sunsets West Food Co-Op, 16732 Highway 112, Clallam Bay, WA 98326.

The purpose of the meeting is to discuss the Coroner topic. No virtual option will be available.

Citizens with comments or questions regarding the Charter Review Commission may contact the Clerk of the Charter Review Commission at loni.gores@clallamcountywa.gov or 360-417-2256.

Dated this 5th day of February, 2025

A handwritten signature in black ink that reads "Loni Gores".

Loni Gores, MMC
Clerk to the Charter Review Commission



MEETING NOTICE

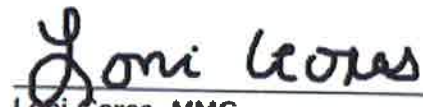
CLALLAM COUNTY CHARTER REVIEW COMMISSION

The Charter Review Commission has scheduled a Town Hall Committee meeting to be held at 12 p.m., Friday, February 7, 2025 at the Sunsets West Food Co-Op, 16732 Highway 112, Clallam Bay, WA 98326.

The purpose of the meeting is to discuss option for holding Town Hall Meeting for Clallam County. No virtual option will be available.

Citizens with comments or questions regarding the Charter Review Commission may contact the Clerk of the Charter Review Commission at loni.gores@clallamcountywa.gov or 360-417-2256.

Dated this 5th day of February, 2025



Loni Gores, MMC
Clerk to the Charter Review Commission



CLALLAM COUNTY
Washington

Departments

Animal Solutions Advisory
Committee

Behavioral Health Advisory
Board (BHAB)

Board of Equalization

+

Board of Health

Boundary Review Board (BRB)

Building Code Board of Appeals

Carlsborg Community Advisory
Council

+

Charter Review Commission
(CRC)

Clallam Bay / Sekiu Community
Advisory Committee

Clallam Bay / Sekiu Sewer
Advisory Committee

Conservation Futures Program
Advisory Board (CFPAB)

Crescent Community Advisory

Chart

Agenda

Agendas a
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[Access to I](#)

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Overview

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Meeting

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[Upcoming](#)
Meeting d
at <https://c>

January 27
August 11

Meetin
[CRC Comr](#)

Gores, Loni

From: Gores, Loni
Sent: Thursday, February 13, 2025 3:05 PM
To: PDN News
Cc: Gores, Loni; Fisch, Susan
Subject: RE: Charter Review Commission - John Hauck

Hi John,

Thank you for your email. I apologize for my delay in contacting you. It's been a tad bit crazy here this week.

The Special Charter Review Commission Meeting on February 18 was cancelled. The next meeting is on February 24, 2025 at 5:30 p.m. That agenda will come out next week.

The CRC did vote to select the next person who had the highest number of votes. She will be filling the vacant seat.

Again, I apologize for my delay.

If you need anything, please let me know.

Loni

"My email address has changed! The new format is Loni.Gores@clallamcountywa.gov Please update my contact card as your earliest convenience, Thank you!"

*Loni Gores
Clerk of the Board
Commissioners Office
223 East 4th Street, Suite 4
Port Angeles, WA 98362
Phone: 360-417-2256*

From: PDN News <pdn.news@peninsuladailynews.com>
Sent: Thursday, February 13, 2025 1:34 PM
To: Gores, Loni <loni.gores@clallamcountywa.gov>
Subject: Charter Review Commission

You don't often get email from pdn.news@peninsuladailynews.com. [Learn why this is important](#)

I see the Charter review commission is scheduled to meet on Tuesday.

I thought they canceled that meeting after they voted not to accept me for the vacant commissioner seat :)

Gores, Loni

From: Gores, Loni
Sent: Monday, February 17, 2025 9:47 AM
To: Benedict, Bill; Boughton, Dee; Cameron, Ron; Fane, Alex; Fisch, Susan; Fleck, Rod; Gores, Loni; Hodgson, Mark; Holy, Christy; Morris, Patti; Noble, Chris; Pickett, Paul; Richards, Ron; Sarmiento, Nina; Stoffer, Jim; Tozzer, Jeff; Walde, Cathy
Subject: FW: Links to Charters in other counties

Correspondences from Pickett.

"My email address has changed! The new format is Loni.Gores@clallamcountywa.gov Please update my contact card as your earliest convenience, Thank you!"

*Loni Gores
Clerk of the Board
Commissioners Office
223 East 4th Street, Suite 4
Port Angeles, WA 98362
Phone: 360-417-2256*

From: Pickett, Paul <paul.pickett@clallamcountywa.gov>
Sent: Saturday, February 15, 2025 8:33 PM
To: Gores, Loni <loni.gores@clallamcountywa.gov>
Cc: Fane, Alex <alex.fane@clallamcountywa.gov>
Subject: Links to Charters in other counties

Loni,

I was doing some research and wrote down charter county populations and links to their charters.

Could you forward to the Commissioners?

County	population	Link to charter
King	2,271,380	https://aqua.kingcounty.gov/council/clerk/code/03_Charter.htm
Pierce	928,696	http://pierce.county.codes/Charter
Snohomish	844,761	https://snohomish.county.codes/Charter
Clark	521,150	https://clark.wa.gov/councilors/charter-overview
Whatcom	231,919	https://www.codepublishing.com/WA/WhatcomCountyCH/
Clallam	77,616	
San Juan	18,566	https://www.codepublishing.com/WA/SanJuanCounty/html/SanJuanCountyCH.htm

Paul Pickett

Gores, Loni

From: noreply@civicplus.com
Sent: Friday, February 21, 2025 1:14 PM
To: Gores, Loni
Subject: Online Form Submission #6686 for Contact the Clerk of the Board

Contact the Clerk of the Board

First Name	Pepai
Last Name	Whipple
Email	pepalapu@sbcglobal.net
Phone	5303063267
Subject	Charter Review Commission
Comments	I'm writing to request that the Charter Committee pass the following to be included in the charter for County Commissioners: no Commissioner may vote or comment on requests for funds while sitting on the board of the requesting entity. The Commissioner be required to recluse him/her self during discussion and voting process.

Please Note

This form is not for emergencies. If you have an emergency, please phone 911.

Email not displaying correctly? [View it in your browser.](#)

Gores, Loni

From: Morris, Patti
Sent: Sunday, February 23, 2025 3:03 PM
To: Gores, Loni
Subject: Charter Survey Responses 2020
Attachments: Charter Survey Responses 2020 - 2-23-25.pdf

Good afternoon, Loni can you please share the 2020 Survey Responses? It will be part of my Survey presentation Monday night. Thanks, Patti

Charter Survey Introduction

Due to the current pandemic, the Clallam County Charter Review Commission has temporarily suspended its meetings and cannot hold public hearings. With this survey, the Commission invites you to give us input on ten (10) issues related to our County Charter.

Clallam County is one (1) of seven (7) counties (out of 39 counties in the state) to have a Home Rule Charter. Our Home Rule Charter allows local citizens to vote on how our county government should be structured. The Charter Review Commission (CRC) considers possible amendments to our Home Rule Charter. You then vote on each amendment in a general election.

Please fill out this survey to help us in our discussions when we reconvene.

Charter Review Commission Survey

This is the Survey Results

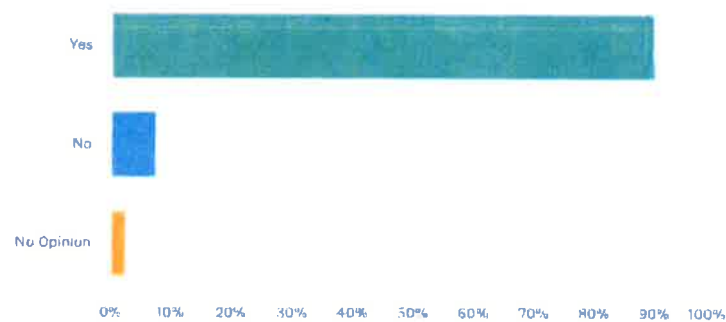
QUESTION SUMMARIES

DATA TRENDS

Q1

The County Prosecutor is currently an elected partisan (a declared party affiliation) position. Should the County Prosecutor be a non-partisan position?

Answered: 40 Skipped: 0



ANSWER CHOICES

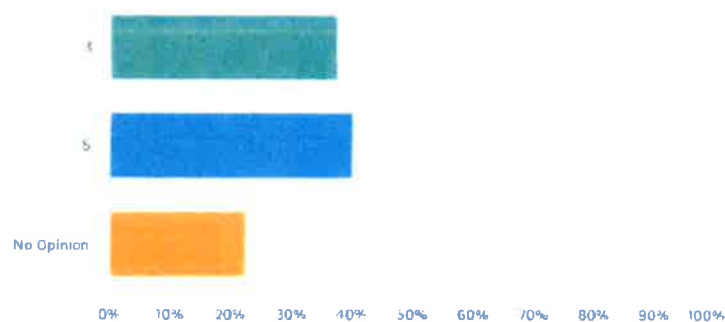
RESPONSES

Yes	90.00%	36
No	7.50%	3
No Opinion	2.50%	1
TOTAL		40

Q2

Clallam County currently elects three (3) county commissioners. How many commissioners would you like to have elected?

Answered: 40 Skipped: 0



Share Link

SHARE SETTINGS

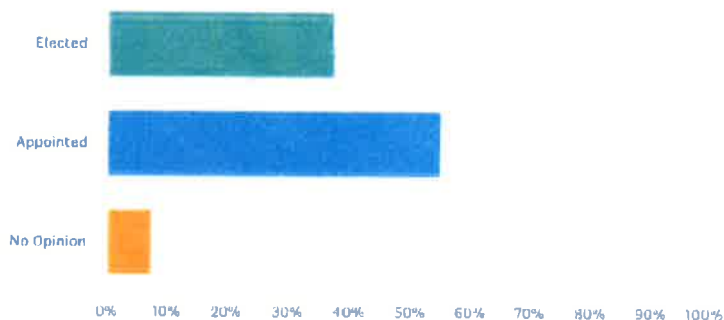
40 responses

ANSWER CHOICES	RESPONSES	
3	37.50%	15
5	40.00%	16
No Opinion	22.50%	9
TOTAL		40

Q3

Clallam County Director of the Department of Community Development (DCD) is elected and is the only elected DCD in the nation. Should the Director of DCD be elected by the voters or appointed by the County Commissioners?

Answered: 40 Skipped: 0

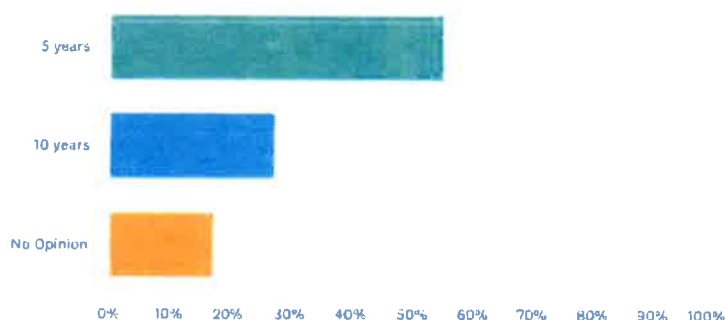


ANSWER CHOICES	RESPONSES	
Elected	37.50%	15
Appointed	55.00%	22
No Opinion	7.50%	3
TOTAL		40

Q4

Other charter counties in our state meet every ten years. Our CRC has met 7 times in 39 years. How frequently should the Charter Review Commission be elected?

Answered: 40 Skipped: 0



Share Link



SHARE SETTINGS

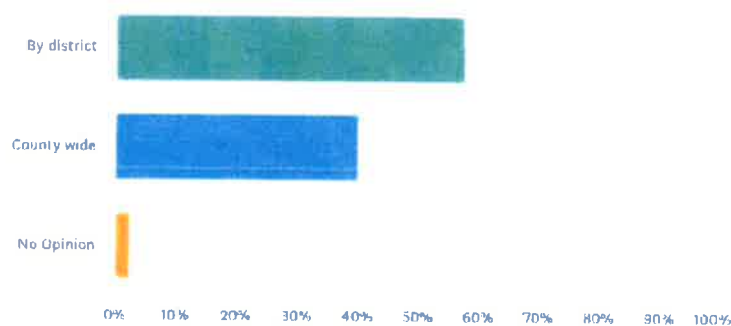
40 responses

ANSWER CHOICES	RESPONSES	
5 years	55.00%	22
10 years	27.50%	11
No Opinion	17.50%	7
TOTAL		40

Q5

Currently County Commissioners are selected and elected by district. Prior to 2015 they were selected by district and elected county wide. How should County Commissioners be elected?

Answered: 40 Skipped: 0



ANSWER CHOICES	RESPONSES	
By district	57.50%	23
County wide	40.00%	16
No Opinion	2.50%	1
TOTAL		40

Q6

Current Charter language relieves elected officials from being responsible to county policies, personnel rules and regulations. Should the elected officials comply with such rules and policies?

Answered: 39 Skipped: 1



Share Link

SHARE SETTINGS

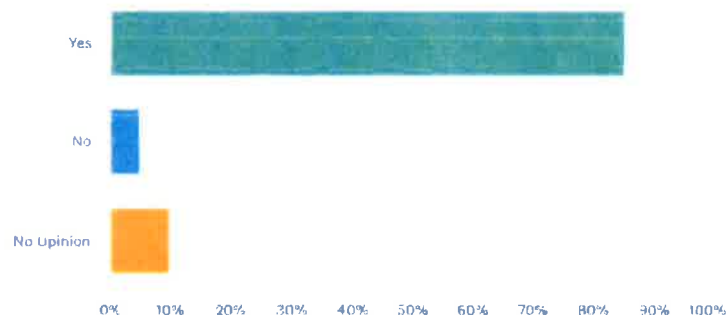
40 responses

ANSWER CHOICES	RESPONSES	
Yes	76.92%	30
No	7.69%	3
No Opinion	15.38%	6
TOTAL		39

Q7

The charter is unclear as to the authority of the Director of DCD and County Commissioners as it relates to land use planning. Should the Charter Commission propose language to resolve these differences?

Answered: 40 Skipped: 0

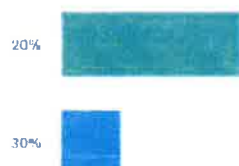


ANSWER CHOICES	RESPONSES	
Yes	85.00%	34
No	5.00%	2
No Opinion	10.00%	4
TOTAL		40

Q8

Repeal of our Charter requires signatures of 35% of ballots cast in the most recent gubernatorial election (for example in 2016 - 35% = 13,811 and 20% = 7892). Other charters require between 3% and 20%. How many signatures should be required to place, on the ballot, repeal of our charter?

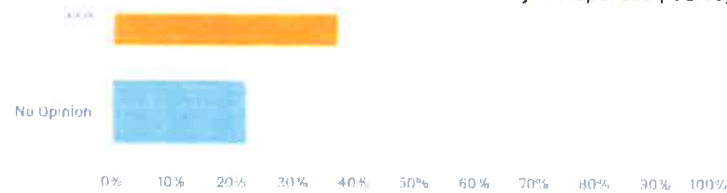
Answered: 40 Skipped: 0



Share Link

SHARE SETTINGS

40 responses



ANSWER CHOICES

20%

30%

35%

No Opinion

TOTAL

RESPONSES

30.00%

10.00%

37.50%

22.50%

12

4

15

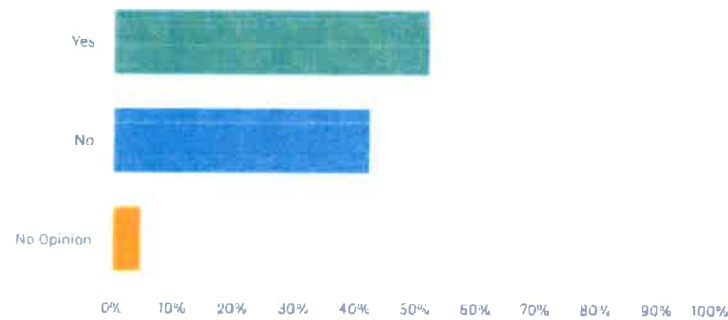
9

40

Q9

The Clallam County Charter addresses the structure of county government. Should it address issues, such as, public health and climate change?

Answered: 40 Skipped: 0



ANSWER CHOICES

Yes

No

No Opinion

TOTAL

RESPONSES

52.50%

42.50%

5.00%

21

17

2

40

Q10

Department of Natural Resources (DNR) manages Clallam County Trust lands with a mandate to return revenue to the county and junior taxing districts. Should Clallam County increase their monitoring of DNR management by hiring a forester?

Answered: 40 Skipped: 0

Share Link



SHARE SETTINGS

40 responses

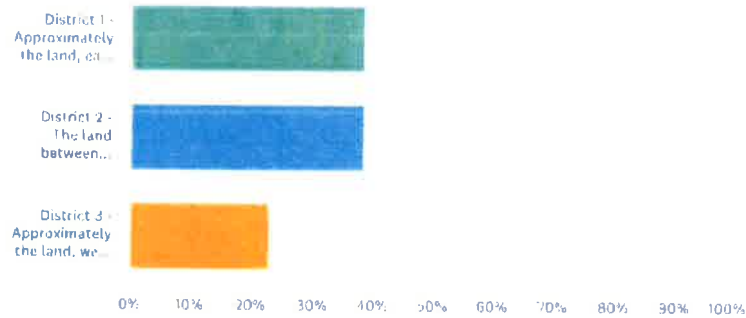
Charter Review Commission Survey - Responses | SurveyMonkey



Q11

In what County Commissioner district do you reside?
District #1 - East of Port Angeles to Jefferson County Line
District #2 - Area around and including Port Angeles
District #3 - Western part of Port Angeles to western county line (including Forks, Neah Bay, Clallam Bay)
Which County Commissioner District do you live in?

Answered: 39 Skipped: 1



ANSWER CHOICES	RESPONSES
District 1 - Approximately the land, east of MacDonald Creek to the eastern boundary of the county.	38.46% 15
District 2 - The land between MacDonald Creek and Valley Creek - includes most of Port Angeles.	38.46% 15
District 3 - Approximately the land, west of Valley Creek to the western county line.	23.08% 9
TOTAL	39

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Check out our sample surveys and create your own now

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SHARE SETTINGS

40 responses

Gores, Loni

From: Boughton, Dee
Sent: Monday, February 24, 2025 3:03 PM
To: Gores, Loni; Fisch, Susan
Subject: RE: Legal Questions

The answer to the first question is relatively straight forward and I can speak to it at the meeting tonight.

The BoCC has the authority under our existing charter to create a county office of Public Defense. No Charter amendment would be required. Here is the relevant Charter section.

Section 2.30: Powers 2.30.10: Legislative Power

The legislative power of the county, not reserved to the people, shall be vested in the Board of Commissioners. The Commissioners shall exercise their legislative power by adoption and enactment of ordinances; shall levy taxes, appropriate revenue and adopt budgets for the county; shall establish the compensation to be paid to all county officers and employees and shall provide for the reimbursement of expenses. Except as otherwise provided in this chapter or by ordinance, they may have the power to establish, abolish, combine or divide offices, departments and agencies; establish their powers, duties and responsibilities as provided by law or ordinance. They shall have the power to adopt by ordinance, comprehensive plans for the present and future development of the county. They shall have the power to conduct public hearings to assist them in the performance of their legislative responsibilities; to subpoena witnesses, documents and other evidence and to administer oaths. Any witness appearing before them shall have the right to be represented by counsel. The enumeration of particular legislative powers shall not be construed as limiting the legislative powers to the Commissioners as provided by law. (Amendment proposed by the Charter Review Commission and approved by the voters November 8, 1983.)

The second question will have to be addressed by Duncan Fobes, as the Clallam Co. Prosecutor has a previously identified conflict on the Coroner issue.

Best,

Bert Dee Boughton | Chief Civil Deputy Prosecuting Attorney | Clallam County
223 E. 4th Street, Ste. 11 | Port Angeles, WA 98362 | desk: 360.565.2720 | cell: 360.477.3125 | fax: 360.417.2543 |
dee.boughton@clallamcountywa.gov

From: Gores, Loni <loni.gores@clallamcountywa.gov>
Sent: Wednesday, February 12, 2025 4:24 PM
To: Fisch, Susan <susan.fisch@clallamcountywa.gov>
Cc: Boughton, Dee <dee.boughton@clallamcountywa.gov>
Subject: RE: Legal Questions

Susan,
Just to let you know Dee is out until Tuesday. He plans to respond when he returns.
Loni

"My email address has changed! The new format is Loni.Gores@clallamcountywa.gov Please update my contact card as your earliest convenience, Thank you!"

*Loni Gores
Clerk of the Board
Commissioners Office
223 East 4th Street, Suite 4
Port Angeles, WA 98362
Phone: 360-417-2256*

From: Fisch, Susan <susan.fisch@clallamcountywa.gov>
Sent: Tuesday, February 11, 2025 3:28 PM
To: Gores, Loni <loni.gores@clallamcountywa.gov>
Subject: Legal Questions

Loni: Can you please forward this to Dee Boughton. I have sent sent a couple of emails to non-Commissioners and have not received a response. I don't know if they are getting through.

Susan

Mr. Boughton:

Mr. Nichols spoke to the Charter Review Commission last night. After he spoke, the Commissioners requested me to forward two legal questions to you.

The first question relates to the Public Defenders. The Commission would like to know if creating an Office of the Public Defender would require a Charter Amendment. Mr. Nichols indicated that King County's Public Defenders Office was part of their Charter but he didn't know about other Charter counties.

The second question relates to the Coroner. The question is can a Charter Amendment that creates an elected position have a pre-filing requirement prior to a candidate being placed on the ballot (i.e can we require an elected coroner to have the statutory required certification before being placed on the ballot)?

Our next meeting is Monday, February 24.

Sincerely,

Susan Fisch