

**ORIGINAL****THE UNIVERSITY OF MICHIGAN
NARRATIVE / SUPPLEMENT REPORT**

<input type="checkbox"/> ORIGINAL <input checked="" type="checkbox"/> SUPPLEMENT	DATE & TIME OF THIS REPORT 4/27/2008	INCIDENT TYPE Death Investigation	ORIGINAL YEAR 2008	INCIDENT NUMBER 1400
REPORTING OFFICER: R. Soichet	NARRATIVE NAME: Investigation 3	INFORMATION RECEIVED FROM:	SUPERVISOR REVIEW: RN	

NATURE:
U-M Hospital Death Investigation

SUMMARY:

I interviewed [redacted] who told me he had informed [redacted] of the suspicious nature of the death and the family's request to file a police report. I interviewed [redacted] nurse's aide, who found the trach tube out. She told me she had checked the patient 10-15 minutes before as well, and she was fine.

JOURNAL ENTRY:

4/27/08

I interviewed [redacted] at his office in the hospital. I asked him to review with me what happened regarding the report that came in on 2/24/08 regarding the death of a patient on 12/11/07.

STATEMENT OF

[redacted] said that because the death had occurred 6 weeks earlier and it sounded as if it had already been reported (to Risk Management and patient relations) he thought that as long as he had an officer take the report information, that he would check on that and if the report needed to go to the police it would then be upgraded to a police report.

[redacted] said that on 2/27/08 he emailed and spoke with Risk Management [redacted] who told him she was aware of the report. He asked her if people pulled out their own trach tube and she said she hadn't ever heard of that happening. She then told him to talk to [redacted] about filing a police report. He then called [redacted]

and reviewed the incident with him, including sharing the information about the unlikelihood of a patient pulling out her own trach tube and that the only other person in the room at the time was her daughter. He asked if they wanted to upgrade it to a police report. He was told by [redacted] that the incident was being handled and a police report wasn't necessary.

I asked him if he was told not to file a report and he said he couldn't remember the exact words, but that the gist was that it wasn't necessary to file one because it was being handled.

He then decided to write himself a note briefly detailing his conversation with [redacted] about escalating the report to a police report. He added these notes to the email he had already sent to [redacted] He declined to give me the letter, but allowed me to read it.

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4/28/08

I tried to reach _____ at her listed phone number; it's still being checked for trouble.

5/2/08

I left another message for _____ advising I was a police officer investigating a death from 12/11 at the hospital and requesting she call.

I tried to reach _____ again; still being checked for service.

5/4/08

I interviewed _____ at her residence at _____

STATEMENT OF

_____ first checked the patient sometime after midnight and was scheduled to check her every two hours. She also checked on the patient about 10 or 15 minutes before she and RN _____ went in together, checking from the right side, to see if she would need to get anything for her. She spoke to her at that time. She noticed that the trach tube was properly in place and the Velcro straps in place.

When she and the nurse went in, she again checked her from the right side and noticed the trach was gone. She then spotted the tube on the floor near the wall.

She saw that the entire trach set up was off (all you could see was the hole in her throat) and that the patient's throat was clean as if it had been wiped off. She mentioned this to _____ later.

The trach tube was by the wall under the sharps collector.

The mask was over the patient's shoulder between the patient and the rail and still connected to the hose. She wondered why it was there. She doesn't remember where the rest of the trach was; she doesn't think she ever saw it.

The call button was still in the bed (they had to move it when trying to treat the patient)

The patient had said that she was going home tomorrow. After the fact, she was now unsure if she meant home, or to Jesus. None of the doctors said anything about her going home the next day. The daughter had agreed that that had not been said.

She has been a nurse's aide for 8 years, 6 years at U-M and has never seen anything like this. She never saw the patient move vigorously or demonstrate that she had the strength to pull out the trach tube, although someone had said she tried to pull on her blood pressure cuff.

Daughter said earlier (between the two times that she had been in to see the patient) that mom had been banging on the rail to get her attention, but only wanted her to wipe her face.

_____ said she thought that the daughter's reaction to her mom's death was _____ she was very quiet and she did _____

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not see her shed a tear. She just quietly said, "mom, mom get up mom". She climbed into her mom's bed and stayed for hours. She said that the door was almost always shut, or almost shut, but can't specifically remember this time.

was a light sleeper and she didn't think she would not have awakened if mom were choking. She doesn't know if the trach was inflated or not.

5/5/08

I called and left a message if he had determined who responded to the first incident involving the machine alarming when it was disconnected and was found trying to reconnect it.

He called back and left a message advising that he had not been able to find out who responded but he wanted to let staff know before I talked to them.

5/8/08

Sgt. Alessi and I went out to residence. I left a card in the door requesting that she call me.

5/9/08

I spoke with by phone regarding the investigation. I asked her is she had heard that her mother say that she was coming home the next day. She told me that she had not heard of this. I asked her if she thought that her mother might have meant that she was going home to Jesus. She said this put a whole new light on the case, indicating that this might have been what her mother was saying. I told her that the time frame was now very small, 10 – 15 minutes when her other was known to be ok and then found without the trach inserted, and that I had not found any staff who saw anyone else on the floor who was not supposed to be there and the only two people in the room were her mother and her sister. She told me that she knew her sister and she would not have done anything to their mom. She told me that perhaps her mom inadvertently pulled the trach tube out.

I called and left a message for her requesting that she email the photo she took of the trach tube.

I met with at his office in the U-M Hospital. provided me the names of the nurses who he thinks might have responded to the 11/12 incident (in which Porterfield became detached form the machine and her daughter was found standing over her holding the detached tube). The names he provided are

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is out on leave). He told me he would contact them and give them my number.

I went to office, but she was out for the day.

5/13/08

I called and left a message to call me back.

I called and requested she call back.

I met with and dropped off copies of questions I had for the staff who were on the floor the night of 12/11/07.

I also asked her some follow-up questions. She told me she wasn't sure when the trach tube went missing from her office, but noticed it was gone around the time the sentinel event review took place.

I asked her what happened to the collar portion of the trach tube and she told me that she never saw that part. She said she did not notice any damage to the trach tube which she collected.

CASE STATUS:

Open

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REPORTING OFFICER: R. Soichet	NARRATIVE NAME: Investigation 4		INFORMATION RECEIVED FROM:	SUPERVISOR REVIEW: RN

NATURE:
U-M Hospital Death Investigation

SUMMARY:

I continued the investigation into the above. I spoke with _____ and met with one of his investigators, _____. I obtained search warrants for _____ computer, office, email and shared drive records. I interviewed _____ who replaced the trach tube after it was found on the floor.

Journal Entry

5/15/08

I spoke with _____ to review the situation with him and ask for his assistance in understanding the medical records and implications. He referred me to one of his medical examiner investigators, _____.

I spoke with _____ and made arrangements for him to meet with me later this date.

I obtained search warrants for the computer, office and email for _____. The warrants were executed at around 2 p.m. An additional warrant was obtained by Off. Dorta for the S drive where _____ stores his computer work. Sgt. Alessi and Off. Zavala served the warrant on Dominos farm location (for email). Off. Dorta, Mathews, Lucas and I served the warrant on _____ at his office and seized his computer.

While we were with _____ I asked him if he had read the affidavit. He said he had. I asked if we were going to find anything in the documents (not on the computer). He said no, there were only the two phone calls and he didn't remember the one from _____. He said _____ had told him her feeling that the death was suspicious but they had somehow gotten away from that. He said that although he didn't remember the call from _____ that _____ must have called him, because he wouldn't make a decision like that on his own.

After service of the warrants, I spoke on a conference call with _____ administrator at the hospital, and requested his assistance in getting to speak to whoever responded to the incident on 11/12/07, to _____ to whoever put in the trach tube last and to expedite the response to the questions I left with _____. Also present at my end were Bill Bess and Robert Neumann.

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5/16/08

I spoke with _____ who told me he was unable to meet with me yesterday because of a death he had to respond to. We arranged for him to meet with me later this morning. I received a message from _____ requesting that I call her. I called her back and she told me she had obtained 4 of the questionnaires back and had been waiting to get them all before calling to come get them. She also told me the name of the nurse who inserted the trach tube the last time, _____ I arranged to go over to pick up the information from her later today.

I met with _____ at my office. He provided the case number his office assigned to this investigation 08-313. We reviewed some of the medical records I had obtained and I gave him copies of my original report, the death certificate and the autopsy report. _____ told me that he and _____ would be following up with the doctor who conducted the autopsy.

I met with _____ and obtained 4 of the questionnaires, _____ All responded to the room. None had any prior contacts with the patient or _____ None saw anyone on the floor who was not providing patient care. She also provided the phone numbers for _____ cell _____ and home

I met with _____ He agreed to have all 4 nurses call me by Tues. 5/20/08.

At around 14:45 I again called for _____ and left my name and number.

I received a call from _____ advising that _____ was in her office. I spoke with her by phone.

STATEMENT OF

She told me this was the first and only time she dealt with the patient. She had almost no conversation with mother or daughter, although mother was able to communicate somewhat.

She first went in at around midnight to suction her. The daughter had turned the light on to let her know it was needed. There were bloody secretions but she was not leaking. They turned her at the time, she thinks to the left. At 1:30 the light was on again and the patient was communicating, with the trach in. She looked in on her a couple more times between then and 2:30 when she looked in again and at 3 she and _____ went in and found her with the trach tube out across the room on the floor by the med box. The moist air was off her, to the right of her on the bed.

She is not sure about where the collar piece was; she thinks it might have been partly attached to the trach tube, but she's not sure.

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There was no mucous or blood on the patient (around the stoma).
 She doesn't think the cuff was inflated on the trach tube, but she is not sure.
 She doesn't remember if there was a syringe by the bed.
 She said the daughter was asleep when she looked in at 2:30 and asleep when they went in at 3. She woke up when they started working on the patient, called rapid response etc.

I asked if she remembered being in the room at 2:30, between the patient and her daughter and she said she didn't remember that.

I called the _____ to check on the history of the address
 _____ well as any contacts with _____ and her mother. I spoke with
 _____ who advised that he found no incidents reported at that address.

I called _____ at her home.

STATEMENT OF

_____ told me that she re-inserted the new trach tube after the tube was thrown across the room. The cuff was down (deflated) on the one on the floor.

There was no bleeding around the trach area or on her clothes.

I asked her about putting in the trach tube, since she had mentioned there being no problem. I asked her if she saw any obstructions in the stoma, perhaps a mucous plug.

She told me that there was no way to tell if there was a mucous plug. She didn't have any trouble putting in the trach but the plug could have been deeper down. No particular problem giving the breaths.

_____ just kind of wandered out and said her patient's trach was out. She asked, "Did you put it back in? No." Then she rushed in and put it in.

She had to yell I need a 5cc syringe to give her rescue breaths.

No blood on her to indicate trauma at trach site.

_____ asked me to put the trach in because I know how. Months ago they (believes it was _____) were asking who heard the family say if anything happened to the family they were going to sue. (_____ heard it) She thought the U had settled by paying out money.

She has worked 16 years as a nurse, worked in ICU and knows how to put in trachs. She said of U-M hospital, "The best care of any place she has ever worked, best quality."

She told them they need to call risk management.

(Must have been Dr's decision to call it natural death)

If a new trach was put in that night, then it might not have been inflated – since patient was lucid and no indication she would try to remove it.

She's never seen anything like it in 16 years. In her experience a patient would be making noise, flailing, if choking and if someone was in the room they'd hear it.

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She doesn't believe anyone on staff would have done anything to the patient, especially an old lady with cancer.

She said her first instinct was to think of this as weird and as a suspicious death.

I asked why I hadn't seen her name in the medical record. She told me that she asked if they wanted her to chart, but she was told no.

CASE STATUS:

Open

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REPORTING OFFICER: R. Soichet	NARRATIVE NAME: Investigation 5	INFORMATION RECEIVED FROM:	SUPERVISOR REVIEW: RN	

NATURE:
U-M Hospital Death Investigation

SUMMARY:

I continued the investigation into the above. I continued to try to locate the hospital staff person who responded to the 11/12/07 incident involving [redacted] and her mother's disconnected oxygen, without success. I obtained the last 4 statements from staff who were working the night of Dorothy Porterfield's death. I confirmed with [redacted] that she noted the disappearance of the trach tube around 2 weeks after the death, after Risk Management asked her for the tube. I spoke again with [redacted] who does not remember if the trach cuff was up or down. I spoke with [redacted] who said that her mother would not have deliberately pulled out her trach tube since she would have thought that meant she was going to hell. She said that her sister [redacted] was able to save lots of money over the years. I confirmed that there was a small life insurance policy for Dorothy Porterfield with Met Life, most of which went to pay for the funeral. I continued to review the email records retrieved pursuant to search warrant on [redacted] computer and other drives.

Journal Entry

5/20/08

I received a call from [redacted] saying that he had the people who might have responded to the incident on 11/12/07 call me. He also said that one of the staff, [redacted] He said that she told him that she had not responded to the incident on 11/12 or deal with the patient. I spoke with [redacted] and [redacted] both said they hadn't responded to the incident. [redacted] also did not respond to the incident.

5/27/08


I spoke with [redacted] He told me he would review the case with [redacted] next day and get back to me after [redacted] spoke with the other ME. I reviewed the contents of evidence seized for the hospital.

5/28/08

I continued to review the contents of evidence seized from the hospital.

5/29/08

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I spoke with _____ customer service consultant of Met Life, and confirmed that there was only a small policy on Mrs. Porterfield, paid to beneficiary and that most of it went to cover the funeral expenses.

I continued to review the contents of evidence seized from the hospital.

5/30/08

I met with _____ and picked up the final 4 statements from staff who were working the night of Mrs. Porterfield's death. _____ confirmed to me that she noticed the trach tube she collected was gone about two weeks after she collected it, when Risk Management told her they needed it. I also spoke to nurse _____ who told me that she didn't remember if the cuff was up or not (if the trach had been inflated or not) when she was treating Ms. Porterfield.

I spoke with _____ and made arrangements to go out to _____ next week. I emphasized that I needed to get a copy of the photo that her niece had taken of the trach tube and that I would pay for the print or bring some device to send the photo to. I also emphasized that I needed to speak with _____ as she was the person in the room when whatever happened to their mother happened.

_____ who said that her mother would not have deliberately pulled out her trach tube since she would have thought that meant she was going to hell. She said that her sister _____ was able to save lots of money over the years.

I continued to review evidence seized from the hospital.

6/3/08

I spoke with _____ by phone. She told me that she saw the letter that was _____

_____ She told me that she did not write the letter and was prepared to report the letter to the police. She said that her sister thought it was their other sister _____ writing, but it wasn't.

She told me that her sister _____ doesn't always get the details of what she's told right. After she heard about the trach tube being out she told this to _____ and _____ reinterpreted this to mean that she and _____ thought that _____

I asked her if _____ had ever told her that their mother had died peacefully. She said no, the only thing that _____ told her was that when she called at 3:34 was that the nurse's aide came in (around 3 a.m.) and turned on the light and said "where's Mrs Porterfield's trach?" and _____ also said where's my momma's trach? _____ also told her that the nurse's aide had talked to their mother for about 10 minutes and mom had said she was going to bake pies. She also said that the medical staff gave their mother something to make her sleep.

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She also wanted to make sure that I knew that there had been blood in her mother's trach tube the night before and suggested that maybe the staff had done something and punctured something in her mother. (We discussed this and reviewed that the medical examiner didn't find anything to support this) She said that her mother didn't want to be a drug addict and had said no more morphine after had injected her with some , at the direction of the visiting nurse. She said her mother had said the same thing in the hospital.

CASE STATUS:
Open

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<input type="checkbox"/> ORIGINAL <input checked="" type="checkbox"/> SUPPLEMENT	DATE & TIME OF THIS REPORT 6/6/2008	INCIDENT TYPE Death Investigation	ORIGINAL YEAR 2008	INCIDENT NUMBER 1400
REPORTING OFFICER: R. Soichet 	NARRATIVE NAME: Investigation 5	INFORMATION RECEIVED FROM:	SUPERVISOR REVIEW: RN 	

NATURE:

U-M Hospital Death Investigation

SUMMARY:

I continued the investigation into the above. On 6/5/08 Sgt. Alessi and I went to _____ and spoke with _____ daughter of the deceased, who was present in the room at the time of her death. _____ did not consent to allow us into her house; however she did speak with us as we remained on her porch.

STATEMENT OF

_____ at first said that she did not feel well and did not want to talk to us. She said that an aunt of hers had just died and she was still upset about her mother's death. After Sgt. Alessi and I asked her to please help us with the investigation she agreed to talk with us, although we remained outside and the screen door between us.

_____ said she was with her mom almost the whole time she was in the hospital. She had a conversation earlier the night her mom died, with _____ the nurse's aide, talking about her mom going home soon and her mom was kind of dancing in the bed (She demonstrated this to us.) She said she didn't remember her mom saying she was going home the next day and said that her mom would never have deliberately pulled out the trach tube; she was looking forward to going home to her own house. She also told us that she loved her mom; that she had lived her whole life with her mom and that she would never pull out her mom's trach and that she did not pull out her mom's trach tube.

At around 2:30 – she thinks about 20 minutes before the nurse and nurse aide found her mom with the trach tube out – the nurse (a blond woman) came in and was between her in the chair and her mom in the bed, doing something with her mom's tubes, she didn't know what.

She didn't wake up until the nurse's aide and the nurse came back in the room and the nurse's aide turned on the light and said "what happened to Mrs. Porterfield's trach?". Then she got up and said what happened to my momma's trach? She saw the trach away from the bed, but she wasn't sure where. She also noticed that the patient alarm button was not in the bed. She noticed that the whole trach set up (including the collar) was not on her mother any more.

She told us that the doctor (attending physician who came in and pronounced her mother dead) asked her if she wanted an autopsy done on her mother and she told him no, that she would have one done on her own.

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She told us about an incident about 3 days after her mom was moved to the 6th floor (which she referred to as "intensity" care). Her mom was hooked up to a ventilator for oxygen and to a monitor and the ventilator tube that was attached to the trach just came apart. She called for staff, but the alarm doesn't show what room it happened in, it just shows that an alarm went off and the staff had to go into each room to check. She didn't know how to reattach the tube so she just had to wait.

She said she talked about this with _____ at the hospital, who told her how she too had decided to stay with her father in the hospital. She said that some of the nurses on the 6th floor _____ were rude and smelled, and sometimes wouldn't come and take care of her mother right away, although they were available to. She said the care her mother received on the 4th floor was excellent and she didn't know the nurse's on the 5th floor because they weren't there that long.

I asked if she would be willing to take a polygraph so that we could continue the investigation by eliminating her and showing that what she had told us was true. She hesitated and then told us that she would have to ask a lawyer first.

At many times during the interview _____ was in tears and in pain. Towards the end of our talking, she went into the house and brought us a picture of her mother and one of her father as well.

I left a message for Respiratory Therapist _____ to call me back. (_____ was the last RT listed on the charts as having dealt with the patient on 12/10/07.)

6/6/08

I spoke to _____ and informed her that I had been able to interview her sister _____ and that the investigation was continuing.

I received a call from _____ At first she did not remember dealing with patient Porterfield except on the 6th floor. After I read to her from the chart she had made she remembered that the patient was breathing more rapidly then normal and she gave her treatment, (like for asthma she explained) which appeared to help her. She told me that her daughter did not allow her to suction her. (She remembered the daughter as the woman with the glasses. She also remembered that she was very supportive of her mom, encouraging her to get better.)

I asked her if she remembered the trach cuff being inflated or not and she said that it was up when she on the 6th floor, but she couldn't remember if it was still inflated on the 5th floor. She told me that she would think about it and if she remembered she would

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call me back. She also explained to me that the time that she electronically entered the record did not necessarily correlate to the time she saw the patient. She explained that often, a patient would be seen at a fixed schedule – every 4 or 6 hours; however, she couldn't remember which was the case with Mrs. Porterfield.

CASE STATUS:
Open

9

Documents from computer

Date created -	Title
5/10/06	Security Services Policy Search and Seizure on UMHHC Property Note V.M.

10/20/00

2/21/2003

12/27/05 by - DPS-Hospital Security relationship

9/25/03 by -DPS- Hospital Security Relationship

2/29/2000

1/18/2000

3/1/00

3/20/03 (last saved 12/27/05)

7/31/03

5/1/08

5/1/08

A

EMAIL TIMELINE

Date of email	Nature	Title of writer	Senders
5/14/2008	patient suspect fraudulent script Turned over to Clinton PD	Hospital Security Sgt.	Latrece Taylor
5/12/2008			
5/9/2008			
4/18/2008			
4/17/2008			
3/11/2008			
3/10/2008	Drug diversion suspect	forwards below to Latrece and Corbie	Erik Mattila
3/8/2008	Drug diversion suspect	Nursing Supervisor ER	Jon Fairchild
3/7/2008			
3/7/2008			

1/31/2008			
4/27/2007			
4/2/2007			
3/1/2007	UNC Hospital policy – must report to police	Chief of UNC Hospital Police to Hospital Sec. Head	Thomas Smith to Hollier
9/25/2006			
9/14/2006			
3/10/2005			
5/21/2004			
4/19/2004			
4/8/2004			

4/8/2004			
1/21/2004			
2/20/2003			
2/20/2003			

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EMAIL TIMELINE (EMAILS INCLUDED)

Date of emails and emails	topic	Dept.	writers
5/14/2008 051408\Re 96180.txt Followup for File	patient suspect fraudulent script	Turned over to Clinton PD	Latreece Taylor
5/12/2008			
5/9/2008			
4/18/2008			
4/17/2008			

	minimum		
3/11/2008			
3/10/2008 <u>031008\Re Fwd Drug diversion.txt</u>	Drug diversion suspect	Nurse Supervisor ER Security Lt.	Jon Fairchild, Erik Mattila forward to Hospital Investigators
3/8/2008 <u>030808\Re Fwd Drug diversion.txt</u>	Reports Drug diversion suspect	Nurse Supervisor	Jon Fairchild
3/7/2008			
3/7/2008			

1/31/2008			
4/27/2007			
4/2/2007			
3/1/2007 <u>030107\03010701\Fwd FW Policy.txt</u> <u>030107\03010702\FW Policy.txt</u> <u>030107\03010703\Criminal Investigations C-17.doc</u>	UNC Hospital policy – must report to police	Chief of UNC Hospital Police	Thomas Smith
9/25/2006			

9/14/2006			
3/10/2005			
5/21/2004			
4/19/2004			
4/8/2004			
4/8/2004			
1/21/2004			

2/20/2003			
2/20/2003			

THE UNIVERSITY OF MICHIGAN
NARRATIVE / SUPPLEMENT REPORT

<input type="checkbox"/> ORIGINAL	DATE & TIME OF THIS REPORT	INCIDENT TYPE	ORIGINAL YEAR	INCIDENT NUMBER
<input checked="" type="checkbox"/> SUPPLEMENT	05-20-2008	Death Investigation	2008	1400
REPORTING OFFICER: Mathews, Michael	NARRATIVE NAME: Supplement	INFORMATION RECEIVED FROM:	SUPERVISOR REVIEW: R Neumann	

NATURE:

Death Investigation

INFORMATION:

On 05-15-2008, Sgt. Soichet obtained a search warrant for University of Michigan Hospital office and contents.

Inv. Dorta, Inv. Lucas and I assisted in serving the search warrant and reviewing the contents of desk.

PHOTOGRAPHS;

Prior to beginning the search, photographs of office and of his computer were taken. All photographs were taken with a Nikon digital camera. The photographs were transferred from the camera to a compact disk. The disk was labeled with the case number and remains with the case jacket.

1. Exterior of office with name placard to the left of the door
2. Close view of the name placard
3. Overview of office/desk area
4. Overview of officer/desk area (area below desk)
5. View of computer monitor
6. View of the work area around computer
7. View of computer, connection cords, under desk
8. Further view of the connection cords
9. View of the UPC style label on the back of computer
10. Top view of the computer with compact disk bay open
11. Overview of the identifying tags on the top of computer

The photo log ends with photograph #11.

SEARCH:

In assisting with the search, I did not locate any items similar to those listed in the warrant.

STATUS:

Open

ORIGINAL

THE UNIVERSITY OF MICHIGAN NARRATIVE / SUPPLEMENT REPORT

<input type="checkbox"/> ORIGINAL <input checked="" type="checkbox"/> SUPPLEMENT	DATE & TIME OF THIS REPORT 6/17/08 10:00 hours	INCIDENT TYPE Suspicious Incident	ORIGINAL YEAR 2008	INCIDENT NUMBER 1400
REPORTING OFFICER: Dorta, Jose	NARRATIVE NAME: COMPUTER EXAMINATION		INFORMATION RECEIVED FROM:	SUPERVISOR REVIEW: R.N.

NATURE OF ORIGINAL INCIDENT:
Suspicious Incident.

LOCATION:
University of Michigan Hospital, 1500 East Medical Center Drive, Ann Arbor



SUMMARY:
I assisted Sgt. Soichet with the investigation of this incident. I prepared and swore to a search warrant for electronic records, and conducted computer data investigations along with Officer Lucas and Sgt. Soichet of records recovered from the Medical Campus Information Technology (MCIT) Office, and a forensic examination of a computer recovered from

SEARCH WARRANTS:
On 5/15/08 I met with Sgt. Soichet, who asked for my assistance in recovering electronic data from Hospital regarding a suspicious date. I assisted Sgt. Soichet in the original execution of the search warrant on office and directed Officer Mathews on the proper way to remove the computer from his office. I also contacted of MCIT and asked him to re-set the password for University account known as previous to executing the search warrant in his office. I then prepared a search warrant for roaming computer profile and the Hospital Share drive, to which would have access during his daily work. the gateway keeper of records for Hospital Security.

Upon drafting my search warrant, APA Siller reviewed it, and I swore to it in front of Magistrate Gatti on 5/15/08. I then served the warrant on at MCIT. Due to the nature of the information requested on this warrant and another warrant for Groupwise e-mail account, informed me that it would be a hardship for their daily business operations to give access to their servers, but that his office would make copies of the data requested from their servers, without having to knock out service to all staff at the hospital. was able to provide part of the requested information on 5/21/2008. I met with on this date and received from him a copy of the contents of e-mail account and copies of roaming computer profile and Novell shared drive data which was not right protected. informed me that he was not sure if I would need files to which had no writing privileges, so he had not provided them. I told that I would need that data as well, and he was able to provide it on 5/22/08 in the form of a third disk.

SEARCH WARRANT TABULATION:
I received from three disks as well as supporting documentation for two warrants served on his office.

**THE UNIVERSITY OF MICHIGAN
NARRATIVE / SUPPLEMENT REPORT**

<input type="checkbox"/> ORIGINAL <input checked="" type="checkbox"/> SUPPLEMENT	DATE & TIME OF THIS REPORT 6/17/08 10:00 hours	INCIDENT TYPE Suspicious Incident	ORIGINAL YEAR 2008	INCIDENT NUMBER 1400
REPORTING OFFICER: Dorta, Jose 	NARRATIVE NAME: COMPUTER EXAMINATION	INFORMATION RECEIVED FROM:	SUPERVISOR REVIEW:  R.N.	

Groupwise account- received 1 Memorex DVD-R labeled- SI 100 9832-01 5-16-08, with a two page document labeled Incident 100 9832, in which details the steps taken to retrieve the e-mail account and how to activated for viewing.

Roaming account and shared drive- I received from 1 Memorex DVD-R labeled SI 1009 832-03 5-20-08, along with a two page document detailing the steps taken in retrieving the data.

On 5/22/08 I received a second DVD-R disk from on this warrant labeled SI 1009832-05 5-21-2008, along with a 1 page document detailing the process of retrieving the data. This disk contained the write protected files to which had access. Tabulation for both warrants were turned over to the court officer for delivery on 5/28/08.

Although not covered in the warrant, I also received from copies of chain of custody forms for the three disks I received from him, which his office prepares as part of any data they obtain for law enforcement. These forms are included with this report.

FORENSIC EXAMINATION:

On 5/22/08 I removed from the Dell Computer recovered from Office by Officer Mathews (see supplemental report), the single hard disk drive located inside, a Samsung hard drive with serial number

image was made and placed in an evidence hard drive sterilized by Officer Lucas on 5/21/08. I ran a verification of the forensic image after imaging and the was found to match. A copy of the imaging log is included with this supplement.

I mounted the image made into and conducted and examination of the hard drive. No relevant evidence was found in the hard drive.

EVIDENCE RETURN:

On 5/22/2008 Officer Mathews and I met with at his office and his computer was returned to him. I prepared a property form/ release form, which signed. It is included with this supplement.

EXAMINATION OF SEARCH WARRANT DATA:

During the course of the weeks following the receipt of the data from MCIT, Officer Lucas and I, as well as Sgt. Soichet went through e-mail account. Because of the way in which Groupwise works, we were unable to do direct exporting of files, and had to instead save copies of e-mails of interest into the evidence folder. I saved several e-mails into different folders in the evidence folder. I also printed hard copies of e-mails of interest, which I turned over to Sgt. Soichet.

**THE UNIVERSITY OF MICHIGAN
NARRATIVE / SUPPLEMENT REPORT**

<input type="checkbox"/> ORIGINAL <input checked="" type="checkbox"/> SUPPLEMENT	DATE & TIME OF THIS REPORT	INCIDENT TYPE	ORIGINAL YEAR	INCIDENT NUMBER
	6/17/08 10:00 hours	Suspicious Incident	2008	1400
REPORTING OFFICER: Dorta, Jose <i>AD</i>	NARRATIVE NAME: COMPUTER EXAMINATION	INFORMATION RECEIVED FROM:	SUPERVISOR REVIEW: <i>AD</i> R.N.	

I also examined the contents of the shared drive, which I was able to do through *AD* which allowed for bookmarking files of interest. I bookmarked several documents, and printed hard copies of them, which I turned over to Sgt. Soichet.

I also found several encrypted files within the *AD* shared drive. After Decryption (some files were unable to be decrypted), it was found that this files were of no evidentiary value.



I also created a draft time-line file for Sgt. Soichet, in which documents and e-mails believed to be pertinent to the investigation are hyperlinked to the timeline. I placed this file along with the supporting files into a thumb drive and turned it over to Sgt. Soichet to finish.

CASE STATUS:

Open- ongoing investigation- pending *AD* report on Bookmarked data.

 ORIGINAL

THE UNIVERSITY OF MICHIGAN
NARRATIVE / SUPPLEMENT REPORT

<input type="checkbox"/> ORIGINAL <input checked="" type="checkbox"/> SUPPLEMENT	DATE & TIME OF THIS REPORT 6/18/2008	INCIDENT TYPE Death Investigation/Obstruction	ORIGINAL YEAR 2008	INCIDENT NUMBER 1400
REPORTING OFFICER: R. Soichet 	NARRATIVE NAME: TOT Pros	INFORMATION RECEIVED FROM:	SUPERVISOR REVIEW: RN 	

NATURE:
U-M Hospital Suspicious Death Investigation
Obstruction

SUMMARY:

I spoke with _____ after he had a chance to review the autopsy report and selected Dorothy Porterfield medical records, which I provided. _____ told me that he did not find enough in the records to support Dr. Virani's conclusion that the cause of death was asphyxiation due to removal of the trach tube.

I attempted to re-interview the last nurse who treated Porterfield prior to her death, I went to her home and left a card, but she has made no effort to respond. _____ has also not agreed to take a polygraph.

In reviewing the email and other files seized from

_____ was informed by _____ of Hospital Risk Management of the suspicious death of a patient, Dorothy Porterfield, on 12/11/2007. At this time he advised that it was not necessary to notify the police. On 2/27/08 _____ was again notified about the suspicious death by hospital Security _____ informed _____ not to file the report as a police report, despite the fact that the report had already been taken, under the guise of being a police report.

I prepared a packet for the prosecutor to review.

JOURNAL ENTRY:

6/10/2008

I spoke with _____ investigator for the medical examiner's office. He told me that _____ had not spoken to Dr. Virani. I left a message for _____ I continued the review of the seized computer files (see conclusion at end of this report).

6/11/08

**THE UNIVERSITY OF MICHIGAN
NARRATIVE / SUPPLEMENT REPORT**

<input type="checkbox"/> ORIGINAL <input checked="" type="checkbox"/> SUPPLEMENT	DATE & TIME OF THIS REPORT	INCIDENT TYPE	ORIGINAL YEAR	INCIDENT NUMBER
	6/18/2008	Death Investigation/Obstruction	2008	1400
REPORTING OFFICER: R. Soichet	NARRATIVE NAME: TOT Pros	INFORMATION RECEIVED FROM:	SUPERVISOR REVIEW: RN	

I spoke with [redacted] He told me that he had reviewed the information I provided – selected medical records regarding patient Porterfield as well as the autopsy report completed by Dr. Virani. He said that he did not support the view that asphyxiation as a result of removal of the trach was the cause of death. He mentioned the patient's history as well as the length of time since the patient had received the tracheotomy and the relatively low level of oxygen that she was receiving (35%). I asked him if there appeared to be any indication, in the autopsy report, that toxicology testing had been done. He said it did not appear that it had. I spoke to him about my concerns regarding the discrepancy between the statements of [redacted] that the last nurse to deal with her mother had been doing blood work on her mom at around 2:30 a.m., and the statement of the nurse, [redacted] that she had not been in the room at the time.

I continued the review of the seized computer files (see conclusion at end of this report).
6/12/2008

I continued the review of the seized computer files (see conclusion at end of this report).

6/13/2008



I continued the review of the seized computer files (see conclusion at end of this report). Investigator Cook and I went to [redacted] residence at around 1610 hours. I rang the bell repeatedly and left a card requesting that she call me.

6/18/2008

REVIEW OF COMPUTER FILES – SUMMARY

Found among [redacted] computer files are the following:

**THE UNIVERSITY OF MICHIGAN
NARRATIVE / SUPPLEMENT REPORT**

<input type="checkbox"/> ORIGINAL <input checked="" type="checkbox"/> SUPPLEMENT	DATE & TIME OF THIS REPORT	INCIDENT TYPE	ORIGINAL YEAR	INCIDENT NUMBER
	6/18/2008	Death Investigation/Obstruction	2008	1400
REPORTING OFFICER: R. Soichet		NARRATIVE NAME: TOT Pros	INFORMATION RECEIVED FROM:	SUPERVISOR REVIEW: RN 

(See included computer files)

CASE STATUS:
Open

ORIGINAL

THE UNIVERSITY OF MICHIGAN
NARRATIVE / SUPPLEMENT REPORT

<input type="checkbox"/> ORIGINAL <input checked="" type="checkbox"/> SUPPLEMENT	DATE & TIME OF THIS REPORT 7/29/2008	INCIDENT TYPE Hospital Death	ORIGINAL YEAR 2008	INCIDENT NUMBER 1400
REPORTING OFFICER: R. Soichet	NARRATIVE NAME: Closed/Denial	INFORMATION RECEIVED FROM:	SUPERVISOR REVIEW: RN <i>RTV</i>	

NATURE:

U-M Hospital Death Investigation
Obstruction

SUMMARY:

An elderly woman, died under what were reported to be suspicious circumstances at the U-M hospital; however neither the suspicious death nor the subsequent attempt by a family member to file a police report about the death were reported to the police, apparently at the direction of [redacted]. The warrant request for [redacted] for MCL 750.478a(2) and 750.122(7)(b) as well as 750.505 (included by the prosecutor) was denied by APA Siller citing inability to prove intent beyond a reasonable doubt. (See attached denial)

CASE STATUS:

Closed/Denial - inability to prove intent beyond reasonable doubt