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The Special Counsel

November 8, 2011

The President
The White House
Washington, D.C. 20500

Re: OSC File Nos. DI-10-2151; DI-10-2538; and DI-10-2734

Dear Mr. President:

Pursuant to 5 U.S.C. § 1213(e)(3), enclosed please find agency reports responding to whistleblower disclosures made by three employees of the Department of the Air Force (Air Force), Air Force Mortuary Affairs Operations (AFMAO), Port Mortuary Division (Port Mortuary), Dover Air Force Base (AFB), Delaware.[1] The whistleblowers, James Parsons, Mary Ellen Spera, and William Zwicharowski, raised serious allegations concerning the improper handling, processing, and transport of human remains of deceased personnel and military dependents. The whistleblowers consented to the release of their names.

Specifically, the whistleblowers' allegations concerned: 1) the improper preparation of remains of a deceased Marine; 2) improper handling and transport of possibly contagious remains; 3) improper transport and cremation of fetal remains of military dependents; and 4) the failure to resolve cases of missing portions of remains. The Office of Special Counsel (OSC) determined that there was a substantial likelihood that the allegations constituted violations of law, rule, or regulation, gross mismanagement, and a substantial and specific danger to public health.

On May 27, 2010, OSC referred Mr. Parsons' allegations to then-Secretary of Defense Robert M. Gates to conduct an investigation pursuant to 5 U.S.C. § 1213(c) and (d). Ms. Spera's and Mr. Zwicharowski's allegations were jointly referred to Secretary Gates on July 8, 2010. Secretary Gates delegated responsibility for investigating and responding to these matters to Secretary of the Air Force Michael B. Donley, who tasked the Air Force Office of Inspector General (OIG) with investigating the allegations. The report states that the allegations of improper transport and processing of remains of military dependents were referred to the Department of the Army OIG and Air Force Office of Special Investigations (AFOSI) for investigation. On May 11, 2011, OSC received the Air Force's report signed by Secretary Donley, which is a compilation of all of the investigative findings. A supplemental report was

[1]Pursuant to Department of Defense (DoD) Directive 1300.22, *Mortuary Affairs Policy*, and Joint Publication 4-06, *Mortuary Affairs in Joint Operation*, the Secretary of the Army serves as the Executive Agent for Mortuary Affairs for DoD and manages the coordination of policy, procedures and training materials that are common for all military services. The Air Force is responsible for operating the Port Mortuary in support of all military services.

received on August 30, 2011. OSC requested copies of the reports of investigation prepared by the Army OIG and AFOSI; however, the Air Force declined to provide the reports. The whistleblowers provided comments on the reports pursuant to § 1213(e)(1), which are also enclosed.

Summary of Findings and Conclusions

The investigation substantiated some of the whistleblowers' allegations, while finding no wrongdoing with respect to others. As discussed below and in the enclosed analysis, while the report contains all of the information required by statute, several of the Air Force's findings are not supported by the evidence presented and thus do not appear reasonable. In these instances the report demonstrates a pattern of the Air Force's failure to acknowledge culpability for wrongdoing relating to the treatment of remains of service members and their dependents. While the report reflects a willingness to find paperwork violations and errors, with the exception of the cases of missing portions, the findings stop short of accepting accountability for failing to handle remains with the requisite "reverence, care, and dignity befitting them and the circumstances."

This is most evident in the Air Force's conclusion that Port Mortuary personnel did not engage in any wrongdoing in February 2010 by cutting off the arm bone of a deceased Marine without obtaining specific permission from the family, in order to dress the Marine in his uniform. The report indicates that then-Port Mortuary Director Quinton Keel made the determination to classify the remains as "viewable for identification" and instructed personnel to dress the Marine in uniform, despite the initial assessment of experienced Embalmers that the remains should be classified as "non-viewable." When personnel encountered difficulty placing the remains in uniform due to trauma sustained in the left arm, Mr. Keel instructed them to remove the arm bone. Specific permission from the family was neither sought nor obtained. The report reflects that, even had the remains been classified as "non-viewable," as initially recommended, the family could have viewed the Marine in a full body wrap, with the uniform placed over the body. The weight of the evidence established that a full body wrap would not have required removal of the bone.

The report confirms that the Port Mortuary is required to maintain the "highest standards of the funeral service profession." The investigation established through the overwhelming majority of witnesses, including numerous funeral service and embalming professionals from several states, that specific permission should have been obtained from the family prior to undertaking the extraordinary measure of removing the bone. However, in this case, despite the compelling evidence of the standard within the funeral service profession, the Air Force, applying a "tort law" theory, distinguished the Port Mortuary from civilian funeral service facilities, stating that "[b]ecause of its unique mission and the nature of its work, the circumstances of the Port Mortuary 'community' of embalmers are not comparable to those of a civilian funeral home."

In furthering this distinction, the Air Force determined that "in considering the conduct of Port Mortuary personnel in this unique environment, the effect on the family of seeking such permission must weigh heavily in the determination of whether it was essential under the

particular circumstances." According to the report, the decision not to seek permission "was based on consideration for the family -- that is specifically to allow the family to see the deceased in uniform pursuant to their expressed desire while at the same time sparing the family from undue distress that would result in sharing the specific and horrifying details of . . . war trauma inflicted on their loved one." However, the evidence shows that the family had already been made aware of the condition of the Marine's remains and the trauma sustained. Moreover, the report does not reflect any evidence that these issues were, in fact, ever considered in determining not to seek permission, but rather, were reasons used to justify their actions after the fact. These distinctions between the military and civilian funeral service professions and the level of grief that a family suffers as a result of the loss of a loved one create a double standard that is not supported by the evidence or law.

Further, the Air Force's conclusion that the family had given "implied consent" is equally unfounded. The report states that "the authorization by the family to prepare, dress and casket the remains can be understood, within the context of the applicable military regulations and the circumstances, to have constituted consent" to remove the bone. However, the evidence does not support the conclusion that the removal of the bone fell within the meaning of "major restorative art" or the definition of "preparation of remains" under AR 638-2, from which implied consent could be construed. The report provides the opinion of a well-known embalming expert, who has conducted training at the Port Mortuary, that "[i]f excision or similar extensive restorative procedures are to be performed, specific restorative permission should be obtained." Indeed, the Senior Marine Corps Liaison stated that they seek permission from the family to shave a beard or mustache, because it is not for them to decide what the family wants.

The Air Force's position is that "this is an unusual case where reasonable minds could differ and did at the time the decisions were made." The report notes that the Senior Navy Liaison perhaps "best captured the essence of the dilemma when he stated 'there is probably a gray area' here 'because this is such a sensitive area.'" Critically, however, this Senior Navy Liaison repeatedly stated that under the circumstances in this case, he would have obtained permission from the family. The conclusion that Port Mortuary personnel were relieved of the obligation to obtain specific permission is inconsistent with the requirement to maintain the "highest standards in the funeral service profession" and, thus, is not reasonable.

The Air Force's unwillingness to acknowledge culpability is again reflected in the findings concerning the handling of possibly contagious remains and the transport of fetal remains of military dependents. With respect to the case of possibly contagious remains, the report includes confusing and conflicting testimony regarding when personnel were informed of the presence of such remains and statements by Mr. Keel denying knowledge of the case days after he supposedly provided instructions for the precautions to be taken. The OIG found that "Mr. Keel was remiss in attending to the needs of his employees," and that it would have been "a prudent management practice" to notify his staff of the presence of possibly contagious remains, precautionary measures to be taken, and the fact that the remains were ultimately found to be non-contagious. However, the Air Force concluded that such notification was not necessary and "adequate warnings were given and appropriate precautionary measures were taken to ensure that the risk to Port Mortuary personnel was appropriately minimized." The report further

concludes that although the shipping warnings did not conform to the requirements of the Armed Services Public Health Guidelines for contagious remains, those requirements did not apply in this case because it had not been positively determined that the remains were contagious. While the remains were ultimately determined to be non-contagious, this was not known at the time of shipping. Nevertheless, the Air Force determined that, aside from failing to submit the required paperwork for shipment, there was no violation of law, rule, or regulation concerning the shipping of these remains.

In addition, the Air Force did not substantiate the allegation that transporting fetal remains in re-used cardboard boxes failed to afford requisite reverence, care, and dignity. The Air Force conceded that the manner in which five sets of fetal remains were transported to the Port Mortuary was "substandard" and "not the best option," but determined the remains were treated with reverence, care, and dignity. This conclusion was reached despite the testimony of three Port Mortuary witnesses, including Mr. Keel, that the method of transport was not dignified. Further, the report reflects conflicting testimony regarding whether the Port Mortuary, and specifically Mr. Keel, communicated these concerns with the mortuary in Landstuhl, Germany, which was responsible for shipping the remains. Seeking clarification, OSC requested a copy of the Army OIG's investigation report from the Air Force; however, the Air Force declined to provide the report. OSC was therefore unable to gain a clear understanding of the evidence obtained.

The investigation substantiated the whistleblowers' allegations concerning two incidents in which the Port Mortuary lost portions of remains of deceased service members and failed to properly resolve those cases. The findings substantiating violations of rules and regulations and gross mismanagement by AFMAO leadership appear to be reasonable. The report presents disturbing findings and conclusions that AFMAO leadership failed to adequately address the loss of accountability, even after a second incident occurred within months of the first. More concerning, however, are the findings that these managers ignored evidence given to them, presented baseless explanations that were "simply not credible," and took affirmative steps to conceal the problem. The Air Force concluded that the loss of accountability of these portions resulted in "a negligent failure" to meet the requisite standard of care for handling remains and several violations of agency rules and regulations.

I do note with concern, however, the conclusion that, because there is no law, rule, or regulation specifically requiring notification to the family when a portion is lost, there was no finding of any wrongdoing by failing to provide such notification. The fact that there is no specific provision for a scenario that, until these cases, was largely unanticipated does not remove the question of whether a duty was owed to inform the families when Port Mortuary personnel determined they could not guarantee that disposition of the remains had been carried out in accordance with their instructions. I further note that the Air Force has taken significant corrective action to address these issues and improve the accountability of remains. However, given the pattern of negligence, misconduct, and dishonesty by Mr. Keel and former AFMAO Deputy Director Trevor Dean, and the "failure of leadership" by former AFMAO Commander Col. Robert Edmondson, I question whether the Air Force has taken appropriate disciplinary action.

I have significant concerns regarding evidence of untruthful and inconsistent statements and improper actions by Mr. Keel, which are summarized throughout the report. The report reflects that Mr. Keel knowingly misrepresented to agency officials and investigators the instruction he gave and the action taken with respect to the preparation of the deceased Marine. The report further finds that, in multiple instances, Mr. Keel falsified information concerning authorization for cremations in the electronic records system, and it reflects inconsistent statements he made concerning the case of possibly contagious remains. The report also details evidence of Mr. Keel's improper conduct concerning the missing portions cases, including his failure to respond in a manner consistent with the required duty of care, reporting conclusions that were "wholly inconsistent with the facts," and presenting statements and explanations found to be "not credible."

Further, I note that on September 9, 2010, during the course of the OIG investigation in this case, Mr. Keel abruptly terminated one of the whistleblowers, Mr. Parsons, as well as David Vance, a Mortuary Inspector who participated in the OIG investigation. OSC promptly contacted the Air Force Assistant General Counsel, believing that Mr. Keel terminated Mr. Parsons and Mr. Vance in retaliation for their participation in the OIG investigation and for Mr. Parsons' disclosures. After speaking with OSC, on September 11, 2010, the Air Force instructed Mr. Parsons and Mr. Vance to immediately return to their positions and officially rescinded the terminations upon completion of an internal review. Ms. Spera and Mr. Zwicharowski also allege that Mr. Keel and Mr. Dean took multiple adverse personnel actions against them in reprisal for disclosing similar wrongdoing. All three whistleblowers, as well as Mr. Vance, have prohibited personnel practice complaints pending with OSC.

Despite the substantial evidence of gross mismanagement, violations of rules and regulations, and a disturbing pattern of dishonesty and misconduct, Mr. Keel currently holds the position of Air Force Survivor Assistance Program Manager, a position the Air Force has confirmed was created specifically for him when he was removed as Port Mortuary Director. Mr. Dean now holds the position of Entitlements Branch Chief in the Mortuary Affairs Division. I am concerned that the retention of these individuals sends an inappropriate message to the workforce.

I note that OSC is limited in its response to agency reports in disclosure cases such as this one because the statute does not allow us to conduct an investigation into the allegations disclosed by the whistleblowers. Instead, OSC must rely on reports provided by agencies as a result of the agency's investigation. Thus, OSC has no ability to require that agencies take a particular action to address any wrongdoing identified through the investigation. It should be noted that the Air Force has taken substantial corrective actions to address the findings and issues brought to light through this investigation. I note with concern, however, that even after these matters were referred by OSC and fully investigated by the Air Force, the Air Force chose to delay notifying the families of the involved service members until publication of the reports was imminent.

As required by law, 5 U.S.C. § 1213(e)(3), I have sent copies of the agency's reports and the whistleblowers' comments to the Chairmen and Ranking Members of the Senate and House Armed Services Committees. I have also filed copies of the agency's redacted reports, substituting employee and witness position titles for names, and the whistleblowers' comments in our public file, which is available on-line at www.osc.gov. OSC has now closed these matters.[2]

Respectfully,

Carolyn N. Lerner

Enclosures

[2]The Air Force provided OSC with redacted reports that, with the exception of the subjects, substituted position titles for the names of employees and witnesses referenced therein. The Air Force cited the Privacy Act of 1974 (Privacy Act) (5 U.S.C. § 552a) as the basis for these redactions to the reports produced in response to 5 U.S.C. § 1213. OSC objects to the Air Force's use of the Privacy Act to remove the names of the employees and witnesses on the basis that the application of the Privacy Act in this manner is overly broad. OSC concurred with the Air Force's redaction of identifying information concerning the deceased service members discussed in the reports.