U.S. OFFICE OF SPECIAL COUNSEL
1730 M Street, N.W., Suite 218
Washington, D.C. 20036-4505
202-254-3600

Analysis of Disclosures, Agency Investigation and Reports, and Whistleblower Comments
OSC File Nos. DI-10-2151; DI-10-2538; and DI-10-2734

The allegations in these matters were disclosed by three whistleblowers from 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. Specifically, their allegations concerned: 1) the improper preparation of remains of a deceased Marine; 2) the failure to resolve cases of missing portions of remains; 3) improper handling and transport of possibly contagious remains; and 4) improper transport and cremation of fetal remains of military dependents.

On May 27, 2010, the Office of Special Counsel (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 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).

Summary

The investigation substantiated some of the whistleblowers' allegations, while finding no wrongdoing with respect to others. As discussed below, 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

[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.

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." The allegations, investigative findings, Special Counsel's comments, and whistleblowers' comments are discussed below.

Preparation of Remains of Deceased Marine

Mr. Parsons, an Embalming/Autopsy Technician, disclosed information concerning an incident that occurred in February 2010, involving the preparation of the remains of a deceased Marine. He alleged that Port Mortuary Director Quinton Keel determined that the remains in this case should be made viewable for identification, despite the assessment of several Mortuary Specialists/Embalmers (Embalmers) that the remains were non-viewable and should be wrapped in a full body wrap, with the uniform placed over the body, rather than dressed in uniform.[2] Mr. Parsons noted that while a full body wrap was necessary, the Marine's head and face were in good condition and would have been preserved for viewing by the family, if desired. He stated, however, that Mr. Keel instructed him and an Embalmer to prepare and dress the remains in uniform. When they were unable to position the Marine's left arm so that it would fit into the uniform, due to massive injuries sustained in that area, they sought guidance from Mr. Keel. In response, Mr. Keel instructed them to saw off the left arm bone and place it in the right leg of the protective undergarment inside the uniform, where the lower portion of the leg was missing. Mr. Parsons refused to cut off the bone; however, the Embalmer complied with Mr. Keel's instruction and Mr. Parsons placed the bone in the right leg of the undergarment.

Mr. Parsons acknowledged that the priority is to dress the remains in uniform when possible, but stressed that the measures taken to achieve this goal must nevertheless comply with the regulatory requirements and standards. He contended that Mr. Keel's actions altered the condition of the remains in a manner that did not reflect the "highest standards of the funeral service profession," as required by Army Regulation (AR) 638-2, Appendix C, and did not afford this Marine the "reverence, care, and dignity" required under DoD Directive 1300.22. Noting that all Mortuary Specialists/Embalmers must be licensed in at least one state, he further explained that the actions Mr. Keel took and directed others to take may have violated state regulatory standards as well.

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[2]AR 638-2, App. C, defines two viewing classifications: 1) non-viewable, where there exists extreme mutilation, advanced stages of decomposition, or severe burns or charring, and restoration of viewable exposed tissue surfaces is not possible; and 2) viewable, where remains are undamaged by trauma or disease, or damaged viewable tissue surfaces are restored by restorative artwork. A third classification, viewable for identification, is referenced in Army Pamphlet 638-2, which instructs that remains may be classified as such where they are less presentable than viewable and may cause additional stress when viewed. Mr. Parsons stated that this category is used where remains do not meet the criteria for viewable but can be dressed in uniform and cosmetically prepared so that viewing by family members for identification purposes is appropriate.

According to the report, the investigation did not substantiate Mr. Parsons' allegations of improper preparation of the remains of the Marine, although the investigation largely confirmed the facts he presented. The report acknowledges that the Port Mortuary is required, under AR 638-2, to process remains in a manner reflecting "the highest standards of the funeral service profession." It further confirms that DoD Directive 1300.22 requires that "[r]emains will be handled with the reverence, care, and dignity befitting them and the circumstances," and that Joint Publication 4-06 echoes this requirement. The report also states that Port Mortuary Embalmers are required to hold a state Embalmer or Funeral Director's license; however, most states provide only general guidance or are silent on specific prohibited embalming procedures. It also notes the military's policy that every effort will be made to prepare the remains of personnel so that service members' families may view them in uniform.

The investigation confirmed that the initial assessment in this case was that the remains would be non-viewable based on the extent of trauma. The evidence demonstrates that several witnesses, including at least one of the Embalmers assigned to the case, a more senior Embalmer who initially observed the remains, the Marine Corps Liaison, Senior Marine Corps Liaison, and Mr. Parsons, believed that the remains would be wrapped in a full body wrap. 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. Like Mr. Parsons, some witnesses noted that the face and head were in good condition and would be preserved for viewing by the family, if desired. The weight of the evidence established that a full body wrap would not have required removal of the bone. The report states that Mr. Keel, as the supervisor of the temporary-duty employee assigned to embalm the remains, signed the Record of Preparation and Disposition of Remains form as the Embalmer of Record. The OIG found that Mr. Keel had the ultimate authority and responsibility in this matter, and that he made the determination that the body could be rendered viewable for identification and directed that the remains be dressed in uniform.[3]

The investigation further confirmed that due to the trauma sustained, a 12- to 15-inch portion of the left humerus protruded perpendicularly from the torso, and despite efforts by the personnel involved in preparing the remains, it could not be moved into alignment. The evidence established that those witnesses who saw this bone agreed that it would prevent dressing the Marine in his uniform. The OIG found that Mr. Keel therefore instructed Mr. Parsons and the Embalmer to cut off the bone and the Embalmer complied. The report states that the family was provided information from the Medical Examiner's "family letter," which specifically stated that the humerus was present. The evidence further showed that neither the family nor the Funeral Director of the receiving funeral home was informed of the position of the arm bone or the decision to remove the bone. The OIG found that Port Mortuary personnel failed to provide the receiving Funeral Director with the required instruction letter indicating the condition of the remains.

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[3]The report indicates that Mr. Keel introduced a new "wind tunnel" technique to dry the remains. This technique, which was unknown to the Embalmers, appeared in this case to have eliminated the concern for leakage and odor that had contributed to the initial assessment that a full body wrap was necessary.

The report also documents instances in which Mr. Keel misrepresented the circumstances and his actions in this case to agency officials. According to the report, he prepared a summary for Colonel Robert Edmondson, then-AFMAO Commander, to respond to an inquiry from the Marine Commandant concerning this case. Mr. Keel's summary described the 12- to15-inch humerus as a "3 inch bone shard" and stated that "[w]e unanimously agreed that the right thing to do was to reset the bone back into its correct anatomical position." Neither Mr. Keel's summary nor the summary Col. Edmondson forwarded to his superiors stated that the bone was cut off. The report reflects that Mr. Keel made similar misleading representations, including statements to the OIG in this investigation, regarding the "unanimous decision" to "cut and reset" the three-inch bone fragment to "restore it to its natural state" and that "[t]his option met with no objections from any personnel involved."[4]

The OIG found that the determinations made in this case were consistent with DoD regulations. The family member serving as the Person Authorized to Direct Disposition (PADD) had given authorization to the Port Mortuary to "prepare, dress and casket" the remains on the Statement of Disposition of Remains form and had verbally expressed a desire to have the Marine dressed in uniform. The report notes that under Air Force Instruction (AFI) 34-242, preparation of remains includes embalming, wrapping or dressing, and cosmetizing consistent with the PADD's disposition instructions. It further states that AR 638-2 defines preparation of remains broadly to include major restorative art.[5] The OIG determined that under the applicable regulations, "removal of the bone cannot be excluded from the meaning of major restorative art." The report states that "[t]o leave the bone in such an unusual position would present the remains in an unnatural state, even if it could have fit into the uniform. Consequently, the authorization by the PADD 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 these measures." The supplemental report affirmed the determination that the broad interpretation of the regulations, coupled with the express desire of the family to have the Marine dressed in uniform, provided sufficient evidence to support a finding of implied consent.

Significantly, the report acknowledges that the majority of witnesses, all of whom are experienced in the field of mortuary science, stated that specific permission from the family (*i.e.*, the PADD) was necessary, or that they would have obtained such permission, prior to removing the bone. In addition to several Port Mortuary Embalmers who stated specific permission from the family was necessary, the report indicates that the Senior Navy Liaison stated repeatedly that, under the circumstances in this case, he would have obtained permission from the family. The report points out that the Senior Marine Liaison testified that he had no problem with the bone being cut off and did not believe it was necessary to obtain permission from the PADD to do so.

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[4]Mr. Keel testified that the word "reset" is commonly used in the embalming business to mean removal and repositioning. However, the OIG could not find this term in the glossary of any of the military rules or regulations, or the multi-page glossaries within the embalming textbooks referenced in the report.

[5]AR 638-2 defines "restoration" as the "[t]reatment of the deceased in the attempt to recreate natural form and color." It states that "[m]ajor restorative art is an integral part of the processing and/or reprocessing of remains" and provides a non-exclusive list of examples, such as rebuilding a large wound or facial features, removal of damaged tissue followed by restoration, and the application of cosmetics on restored surfaces. It further requires that such restoration be accomplished in accordance with the "highest professional standards."

However, he was not aware that the remains had been dressed in uniform, rather than a full body wrap, until just before his second interview with the OIG. Although he stated that this fact did not change his opinion, the report presents unresolved conflicting statements that he made. For instance, he testified that "[c]utting the arm off would be more in line with mutilation," which he explained is "removing something you shouldn't," and that his office automatically seeks instructions from the PADD before shaving off a beard or mustache. He explained, "It's not for us to decide what the family wants to do."

In addition to interviewing Port Mortuary personnel, the OIG contacted seven civilian funeral service professionals from Virginia, Ohio, and Indiana to inquire about a scenario involving removal of a bone. Several of these witnesses commented that they have never encountered such a scenario and/or that they considered the need to remove tissue or bone to be extremely rare. Some noted that such removal would not be considered a restorative procedure. A representative of the Ohio Board of Embalmers and Funeral Directors, which oversees ethical standards and regulations for the profession in Ohio, where Mr. Keel is licensed, stated that communication with the family under such circumstances would be essential. All seven of the civilian funeral service professionals, which included Funeral Directors, Embalmers, and state professional board and association members, gave the opinion that specific permission from the family would be necessary prior to removal of the bone.

The report further acknowledges that these opinions are consistent with the expert textbooks referenced in the report. For instance, the report includes excerpts from the textbook by nationally recognized embalming expert Robert G. Mayer, who was recently hired to conduct training at the Port Mortuary. Mr. Mayer instructs that "whenever the service is made challenging because of the circumstances of death, the embalmer should communicate realistic expectations to the family. . . Representations concerning embalming and restoration should be full and factual." He further states that "[i]f excision or similar extensive restorative procedures are to be performed, specific restorative permission should be obtained." The textbook of another expert, J. Sheridan Mayer, explains that excisions during the course of major restoration "can be legally described as mutilation," and states that permission should be secured before undertaking such major restorative procedures.

Despite this consensus of professional opinion, in evaluating the actions taken in this case, the OIG distinguished the Port Mortuary from the civilian funeral service profession. The report states 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." It further notes 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."

In support of this distinction, the report and supplemental report explain that the Air Force applied a "tort law" concept, equating generally accepted practices established in the embalming and mortuary industry with the required standard of care for professionals, considering their skill, knowledge, and the communities and circumstances in which they practice. The supplemental report states that the opinions of the civilian funeral professionals provide insight

into civilian practice, but cannot be regarded as the standard for the Port Mortuary, when such opinions were given without consideration of the unique community and circumstances in this case. The supplemental report further expands this explanation, stating that "the decision 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 report indicates that the family had already been advised of the condition of the Marine's remains in the family letter, and the report does not reflect any evidence that these issues were, in fact, ever considered in determining not to seek permission to remove the bone in this case.

In light of the "uniqueness of the military mission at the Port Mortuary and the flexibility allowed by the applicable regulations," the OIG concluded that "under the circumstances of the Port Mortuary and this particular case, the conduct of the embalmers and Mr. Keel did not violate the applicable common law standard of care" by removing the bone and not seeking permission from the family to do so. The OIG further found that their conduct did not violate standards that apply to these professionals by virtue of their state licensure. The report concludes that "[i]n light of the significant differences between AFMAO and the civilian sector, the challenges associated with AFMAO's processing of severely damaged bodies, including unique trauma associated with war . . . and rules governing AFMAO, the preponderance of the evidence supports a finding that there was no violation of a law, rule or regulation, and that AFMAO handled the remains with 'reverence, care, and dignity befitting them and the circumstances.'" The OIG did find, however, that the Port Mortuary's failure to provide the receiving Funeral Director with the required instruction letter concerning the condition of the remains constituted a violation of AFI 34-242.

Special Counsel's Comments

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."

The report further states that the decision not to seek permission was based on consideration for the family and to spare the family from undue distress. However, as noted, the evidence shows that the family had already been made aware of the condition of the Marine's remains. 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.

Indeed, for other findings, such as those involving the transport of fetal remains, discussed below, the Air Force relied on the civilian standards. Moreover, given the Air Force's position that military and civilian funeral service providers are not comparable, it is not clear why the Air Force chose to interview seven civilian professionals from various states throughout the country concerning the propriety of removing a bone and whether specific permission from the family would be required.

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 is, thus, not reasonable.

It is noted, however, that despite these troubling findings, the Air Force has taken corrective action and, consistent with the industry standard, now requires that specific, written consent be obtained from the family in such cases.

Corrective Actions

Although the OIG did not find a violation of law, rule, or regulation in the preparation of the remains of the Marine, the report states that the Air Force has taken steps to improve its processes relating to the preparation of remains and obtaining permission from the PADD in cases such as this one. In March 2011, the AFMAO Commander issued a Directive, now incorporated into a Joint Standard Operating Procedure (JSOP), setting forth circumstances in which notification to and written permission from the PADD are necessary. Pursuant to the new JSOP, specific, written consent must be obtained where restoration of the remains is beyond the viewable areas where consent to restore to a natural state is implied, *i.e.*, face and hands. The

JSOP also sets forth a process for conflict resolution when Embalmers disagree on issues related to viewability classifications and embalming and restorative procedures, with final authority resting with the AFMAO Deputy Commander. The Directive also addressed the finding of a violation of AFI 34-242 for failure to send the letter of instruction to the receiving Funeral Director in this case, directing that such letters must be sent in all cases. The report states that no disciplinary action was taken with respect to these allegations.

Improper Handling of Cases of Missing Portions

Mr. Zwicharowski, a Senior Mortuary Specialist at the time of his disclosure,[6] and Ms. Spera, a Mortuary Specialist, both disclosed 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 whistleblowers alleged that Port Mortuary officials failed to notify the appropriate military components or the families of the deceased service members that these portions were lost. The whistleblowers contended that the actions of Port Mortuary leadership did not comport with the requirements of agency policies and regulations and did not afford the requisite reverence, care, and dignity owed to these service members.

The investigation substantiated the allegations that Port Mortuary leadership failed to properly resolve the two cases in which portions of remains of deceased service members were lost. The OIG found that the Port Mortuary failed to account for portions of remains on two separate occasions, and because of this loss of accountability, it could not be established that the dispositions of these portions were consistent with the desires of the respective families. Thus, the report concludes that the loss of accountability of these portions resulted in "a negligent failure" to meet the requisite standard of care for handling remains, and resulted in violations of DoD Directive 1300.22, DoD Instruction 1300.18, Joint Publication 4-06, and AFI 34-242.

With respect to the first incident, the investigation confirmed that the remains of an Army soldier arrived at the Port Mortuary in August 2008. The PADD in this case elected to receive the incomplete remains that had been identified. In the event that portions of remains were subsequently identified, the PADD elected not to be notified and authorized the military to make appropriate disposition. In September 2008, two subsequent portions of remains were identified to this soldier through DNA testing and stored in a refrigerator (reefer) pending release from the Medical Examiners and military disposition. While preparing for a military disposition cremation on April 21, 2009, Ms. Spera discovered the empty bag for one of these portions, with a slit in the bag, in the reefer. The report confirms that after Ms. Spera and Mr. Zwicharowski reported the missing portion to then-Port Mortuary Director Trevor Dean, then-Commander Col. Edmondson ordered a Command Directed Investigation (CDI).

The report confirms that, despite the CDI and an extensive search, the portion was never found, and the CDI could not establish responsibility for the loss of accountability or dereliction of duty with respect to this portion. The CDI report concluded that the lack of instruction to AFMAO personnel on written policies and procedures for maintaining the chain of custody of

[6]In August 2011, Mr. Zwicharowski was promoted to Director of the Port Mortuary.

remains and a lack of security of the reefers prevented reliable safeguarding and accountability of remains. The CDI report recommended updating policies and procedures and providing formalized training to all AFMAO personnel, implementing security measures, and enhancing coordination between the Medical Examiners and Port Mortuary personnel for re-bagging remains. The evidence reflects that while some measures were taken to improve security and control access to the reefer, Col. Edmondson, Mr. Dean, and Mr. Keel did not conduct training for medical examiners and permanent AFMAO personnel or take any steps to address coordination with the Medical Examiners. The OIG concluded that had this recommendation been implemented, it may have precluded the second incident of a lost portion. The report also confirms that the CDI results were not shared with the whistleblowers or other personnel, and that communication between senior and lower level managers on this issue was not effective.

Further, the OIG found that in at least four statements in the record, including his testimony in this investigation, Mr. Dean stated that he believed that proper disposition of the portion occurred under one of two possible scenarios: 1) the portion was "re-associated" or "articulated" with the originally identified remains; or 2) the portion was included in a military disposition cremation as directed by the PADD, without being accounted for in the Mortuary Operations Management System (MOMS). Under either scenario, Mr. Dean asserted that the slit in the portion bag was made by a Medical Examiner. Mr. Keel provided similar statements and Col. Edmondson concurred with their conclusions. The OIG determined, however, that neither of these scenarios is supported by the evidence. It found no evidence that Medical Examiners slice portions bags. The report states that in advocating the first scenario, "Mr. Dean and Mr. Keel ignored information readily available to them." The OIG found no evidence of an articulation of the remains. In fact, the evidence showed that articulation was not physically possible.[7] Similarly, there is no evidence that the portion was included in a military disposition. The Port Mortuary did not conduct a military disposition cremation between August 2008, when the remains arrived, and April 21, 2009, when the portion was discovered missing. Further, the evidence does not support a conclusion that the portion was part of a group burial.

The report also confirms that AFMAO leadership did not notify the Army Liaison (Liaison) of the lost portion. Col. Edmondson and Mr. Dean concurred that it was not necessary to do so based on the conclusion that proper disposition of the portion was accomplished. Mr. Dean admitted that it would be up to the Liaison to determine whether to communicate with the family where a portion was lost. He explained, however, that his theory of disposition "allows [him] to rationalize not notifying them." He admitted that the Liaison was not apprised of the CDI results, because he "personally reached the conclusion that the remains must have been re-associated with him." The Non-Commissioned Officer in Charge of the Army Liaison Team for the Port Mortuary stated that he did not recall the incident, but that he would expect to be notified and believed the PADD should be advised of a missing portion, even where the PADD elected not to be notified of subsequently identified remains. The report concludes, however,

[7]The report explains that articulation would involve a perfect fit between the bone in the portion with a bone in the remains. The missing portion was an incomplete ankle and the originally identified remains included a non-intact torso missing both legs.

that there is no law, rule, or regulation requiring notification to the Liaison or PADD in these circumstances. Thus, there was no violation.

Regarding the second case of missing portions, the investigation confirmed that while the remains of two Air Force members were being processed in July 2009, it was discovered that a portion that had been placed in a portion bag during Triage and forwarded to the X-Ray station, was no longer in its bag. The portion had not yet been positively identified to either service member. Although MOMs reflected that the portion remained in the Autopsy suite, the portion was never found or accounted for. The report states that after conducting an informal inquiry, Mr. Keel determined, contrary to the evidence, that no portion had ever been placed in the bag. He concluded that the Medical Examiners estimated the number of portions to process and the Triage staff created an extra bag not associated with a portion when they mass-produced a set of labeled bags. The report states that Mr. Dean and Col. Edmondson accepted Mr. Keel's erroneous conclusions without examining the evidence or further investigating the matter.

The OIG found that Mr. Keel's conclusions are not supported by the evidence provided to him at the time of his inquiry or obtained during this investigation. The report indicates that most, if not all, witnesses who worked on the day the portion was lost recalled seeing the portion or its residue in the bag. All of the personnel who worked in the Triage station refuted his conclusions about the mass-production of portion bags and the creation of an extra empty bag. The report concludes that "[i]n light of the overwhelming testimony indicating that a portion had been placed in the portion bag and the fact that Mr. Keel, during his interview, admitted that he had not worked at the Triage station, placing portions in bags, his stated conclusion that there was no portion in the bag is simply not credible."

The report indicates that it could not be confirmed how the portion was lost or who was responsible for its disappearance; however, the evidence indicates that the portion was either included with the remains identified to one of the two service members and shipped to the respective PADD, or it was included with remains that were not identified to either service member and part of a group burial. Regardless of the disposition, the OIG concluded that Port Mortuary personnel failed to maintain accountability for the portion, which prevented achieving positive identification. As in the first case, the OIG determined that because there is no law, rule, or regulation requiring notification to the Liaison or PADD under these circumstances, there was no violation by failing to communicate the loss to the Liaison.

The OIG found, however, that AFMAO leadership failed to conduct a formal investigation in this second case, and that their actions and inaction regarding the loss of accountability did not afford the remains the required standard of care. The report explains that the CDI conducted in response to the first missing portion "essentially established the minimum standard of care when accountability is lost." However, when the second portion was lost within months of the first, signaling more significant, systemic concern, the report states that management "provided substantially less [care], significantly reducing the chances of locating the missing portion, identifying it to a particular Service member, determining its disposition with certainty, and identifying the root cause of the problem."

The OIG found that the specific actions of Mr. Keel, Mr. Dean, and Col. Edmondson were inappropriate. It determined that Mr. Keel "precluded a more diligent search and investigation by reporting conclusions that were wholly inconsistent with the facts;" that Mr. Dean "uncritically accepted the patently erroneous account of Mr. Keel without examining the available evidence;" and that Col. Edmondson "did less" by not questioning "the inconsistency in the level of response to this second loss of accountability of a portion for which he had ultimate responsibility -- when, if anything, it should have increased concern about the adequacy of AFMAO's processes to protect the remains of fallen warriors." The report indicates that Mr. Keel's account precluded not only an investigation to determine the status of the remains, but also a second report to Headquarters, which would have likely prompted a higher inquiry. Either inquiry at the time of the loss would have increased the chances of resolving the matter.

Thus, the OIG concluded that AFMAO leadership failed to afford the standard of care in handling these remains, in violation of DoD Directive 1300.22, DoD Instruction 1300.18, and Joint Publication 4-06. The OIG also found that neither of the lost portions were recorded in the MOMs as missing, and concluded that the failure to locate and account for the portions constituted a violation of the Port Mortuary SOPs. Further, the OIG concluded that the failure to identify flaws in the "problematic portion accountability process" before incidents occurred and fully address the problems after portions were lost, along with "the affirmative steps taken to minimize or hide the problem," constitute gross mismanagement by Mr. Keel, Mr. Dean, and Col. Edmondson.

Special Counsel's Comments

The findings substantiating violations of rules and regulations and gross mismanagement concerning AFMAO leadership's failure to resolve cases of missing portions appear to be reasonable. 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.

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. I 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 Mr. Dean, and the "failure of leadership" by former AFMAO Commander Col. Robert Edmondson, I question whether the Air Force has taken appropriate disciplinary action.

Corrective Actions

In response to the findings of gross mismanagement and violations of rules and regulations relating to these allegations, the Air Force has taken extensive corrective action, including the development and implementation of procedures in the event of a potential loss of accountability of portions. AFMAO and AFME have executed a memorandum of understanding outlining responsibilities and relationships between these two entities concerning the continuous accountability of remains, and they have developed a JSOP. The JSOP provides comprehensive operational guidance for all personnel handling portions, outlines routine procedures, and incorporates several corrective actions relating to the processing and storage of portions. The Air Force has also increased training in all areas and, as noted, has invited nationally-recognized professionals, such as embalming expert Robert Mayer, to provide technical expertise and training for AFMAO personnel.

The agency has also taken disciplinary action against Col. Edmondson, Mr. Keel, and Mr. Dean. The supplemental report confirms that Mr. Keel was downgraded to a non-supervisory GS-13 position for gross mismanagement, lack of candor, misrepresentation in a government IT system (MOMS) and violation of SOPs. He was transferred from his position as Port Mortuary Director to the position of Air Force Survivor Assistance Program Manager, where he reports directly to a supervisor in Air Force Headquarters and no longer has contact with Port Mortuary or AFMAO employees. Agency officials confirmed with OSC that this position was specifically created for Mr. Keel.

Mr. Dean was issued a letter of proposed disciplinary action proposing a 14-day suspension for gross mismanagement and lack of candor. OSC recently learned that Mr. Dean has been reassigned as the Entitlements Branch Chief in the Mortuary Affairs Division. Col. Edmondson was served a Letter of Reprimand for gross mismanagement and failure of leadership concerning the missing portions. The report also confirms that the Air Force appointed a new Commander at AFMAO, who has made significant improvements in several areas.

Improper Handling and Transport of Remains with Possible Contagious Disease

Ms. Spera alleged that, in May 2010, Port Mortuary management failed to take precautionary measures or provide adequate warnings in response to a determination that remains of a deceased "third country national" received by the Port Mortuary were possibly infected with contagious tuberculosis.[8] In addition, Ms. Spera alleged that Mr. Keel and Major Cami Johnson, Chief of the Departures Branch, improperly ordered the transport of the possibly contagious remains back to Kuwait with an instruction to open the transfer case for re-

[8]A "third country national" is a non-U.S. citizen employed by a contractor providing services to the U.S. military overseas. As such, these individuals are not entitled to mortuary benefits; however, if their death occurs on a U.S. military base, their remains are transported to the Port Mortuary for an autopsy and a U.S. death certificate. The unembalmed remains are then transported back to the location of the contractor for final disposition. In this case, the third country national was a citizen of India who was working for a contractor in Kuwait at the time of his death.

icing at Ramstein AFB, Germany. Ms. Spera contended that the remains should not have been shipped with the instruction to open the transfer case for re-icing, because the case was not adequately marked to alert personnel to take precautionary measures. The investigation substantiated Ms. Spera's allegations in part.

The report confirms that on Saturday, May 29, 2010, a Medical Examiner determined through an autopsy that the remains were possibly infected with contagious tuberculosis and verbally informed personnel working in the Port Mortuary that day. The OIG found that Mr. Keel was made aware of the situation and discussed precautionary measures with an Autopsy/Embalming Technician on duty, who isolated the remains in the embalming suite, wore protective gear during embalming, placed the remains in an extra human remains pouch marked with a warning, and placed the remains in a reefer with controlled access. The evidence reflects that he also verbally advised other employees of the possibly contagious remains on Saturday and Sunday.

The report further confirms that it was Ms. Spera who placed a warning sign on the reefer door after she learned about the remains. Although Ms. Spera stated that she was not notified of the remains until the following Tuesday and posted the sign thereafter, the OIG found that the preponderance of evidence indicated she was notified on Sunday. Consistent with Ms. Spera's allegations, however, the evidence suggests that the sign was not posted on the reefer door until Tuesday, after Ms. Spera and a Medical Examiner spoke with Mr. Keel. During that discussion, Mr. Keel denied knowledge of the case. The report states that he acknowledged he had this conversation and indicated that he previously knew they had a "potential TB case," but that the Medical Examiner told him it was an "active TB case." The supplemental report states that "[e]ven if it were clear that Ms. Spera did not receive notification until the following Tuesday, that fact would not change the finding that adequate warnings were given and precautionary measures were taken," and "the fact that a sign was not placed on the reefer door until Tuesday, does not undermine the finding."

The report and supplemental report stress that the personnel who handled the remains were aware of the possible contagious condition and took proper precautions, and that based on the testimony of the Medical Examiners, once the remains were sutured and bagged, they posed little or no risk to personnel in the facility. Testimony from the Chief Medical Examiner indicated that shutting down the HVAC system within the embalming and autopsy suites would have been counter-productive, as the system is designed to cleanse the air, and that there was no need to shut down the system in the remaining parts of the facility. The report further states that while there are general provisions regarding safety and sanitation, the investigation did not reveal a law, rule, or regulation detailing procedures for Port Mortuary personnel. Thus, the OIG found no violation of a law, rule, or regulation, or a substantial and specific danger to public health.

The report does conclude, however, that while adequate precautionary measures were taken, "what was missing was any action to issue a general warning to the AFMAO/Port Mortuary staff. The record reflects that no one from the Port Mortuary, including Mr. Keel, sent an e-mail out to Port Mortuary staff, advising them of the presence of possibly contagious remains in the Port Mortuary." Nor does the record reflect that an e-mail was sent to staff

notifying them that the results of the tuberculosis analysis were negative. The report concludes that "Mr. Keel was remiss in attending to the needs of his employees." The report notes 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 report concludes that his failure to do so did not violate a law, rule, or regulation.

In addition, the OIG found no violation of law, rule, or regulation with respect to Mr. Keel's instruction to Major Johnson to transport the possibly contagious remains back to Kuwait with instructions to re-ice the remains in Germany. The report states that under the Armed Services Public Health Guidelines, where the cause of death was a contagious or communicable disease, the transfer case shall be marked "CONTAGIOUS." It distinguishes this case, however, stating that the remains had not been positively determined to be contagious and the cause of death was not a contagious disease. The OIG found that the transfer case was not marked as "CONTAGIOUS," but the documentation in the envelope attached to the case indicated that the remains were possibly contagious and the remains pouch was marked "TB Positive." It further found that Major Johnson e-mailed all personnel who would be handling the transfer case to notify them that the remains were positive for tuberculosis, and that re-icing was accomplished without opening the remains pouches. According to the Medical Examiners, there was minimal risk to personnel as long as the pouches were not disturbed. The report further indicates that the Port Mortuary could not have embalmed or cremated the remains, as suggested by Ms. Spera, because the Port Mortuary did not have authorization to do so.[9]

The OIG did find, however, that Mr. Keel was responsible for violating AFI 34-242, the Armed Services Public Health Guidelines, and Port Mortuary SOPs by failing to contact Kuwait to determine the current shipping requirements for remains and submit required documentation to the embassy and consulate for shipping approval.

Special Counsel's Comments

The evidence presented in the report does not support the finding that adequate notice was given regarding the existence of potentially contagious remains, and thus this finding does not appear reasonable. The report includes conflicting testimony regarding when personnel were informed of the presence of the remains and statements by Mr. Keel denying knowledge of the case days after he supposedly provided instructions for the precautions to be taken. It is unclear how the OIG determined that Ms. Spera's testimony, that she was not notified until Tuesday, was not accurate, when the evidence confirms that she posted the sign on Tuesday. Further, the

[9]OSC raised its concern with the Air Force regarding the report's inclusion of unsubstantiated allegations and inaccurate statements made by Major Johnson about Ms. Spera (on pages 76, 77, 84 (fn 68) and 105 (fn 89)). OSC requested removal of the remarks about the whistleblower, as their relevance to this investigation and inclusion in the report appeared highly questionable. The Air Force acknowledged that Ms. Spera was not questioned about these allegations during the investigation and agreed to redact the statements from the redacted version of the report for OSC's Public File. However, the Air Force declined to remove the statements from the original un-redacted report. OSC therefore notes its strong objection to the inclusion of the disparaging statements referenced above.

conclusion in the supplemental report that it would not make a difference whether this employee with access to the reefer was notified on Sunday or Tuesday is concerning.

Moreover, 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. I note, however, that despite these troubling findings, the Air Force has taken important corrective actions to improve safety procedures at the Port Mortuary.

Corrective Action

The agency has taken corrective action to improve its procedures, despite no finding of a violation of law, rule, or regulation concerning the precautionary measures taken in the case of possibly contagious remains. Port Mortuary management issued a revised Exposure Control Plan outlining precautionary measures and recommended communications with staff. The AFMAO Commander also issued a Commander's Safety Policy, appointed safety representatives, and established a safety working group. In response to the findings of violations concerning the shipping of these remains, guidance in SOP 34-242-02 has been modified to direct personnel to follow all country requirements where death was caused or suspected to be caused by a contagious disease.

Improper Transport and Processing of Remains of Military Dependents

Ms. Spera also alleged that Port Mortuary officials failed to address recurring incidents in which the fetal remains of dependants of military personnel were shipped to the Port Mortuary for cremation in an unsafe and disrespectful manner, and often lacking the requisite paperwork for disposition. She further contended that Port Mortuary management failed to adhere to applicable regulations, directives, and standard operating procedures in conducting cremations for these remains. According to the report, the investigation did not substantiate the allegations concerning improper packaging and transport of fetal remains. However, Ms. Spera's allegations that cremations were conducted without the required paperwork were substantiated.

The investigation confirmed that the fetal remains in five cases between February and May 2010 were shipped from the U.S. Army Mortuary Affairs Activity-Europe (USAMAA-E), Landstuhl, Germany, to the Port Mortuary inside plastic pails, most likely hospital specimen

pails, within non-reinforced cardboard shipping boxes packed with casket pillows and cotton. The evidence showed that all five of the remains were those of substantially underdeveloped fetuses, weighing less than 500 grams each, which necessitated the use of some type of sealed container. The report concludes that the use of such containers for shipping these remains was not unreasonable or inappropriate. The report stresses that no fetal remains were actually damaged in transit.

The report states that no specific guidance was found on the proper packaging and shipment of fetal remains. It indicates that under AFI 34-242, remains transported by government aircraft from a mortuary facility in Europe "should be uncasketed and placed in an aluminum transfer case." It further notes that there is no exception for fetal, infant or child remains, and there is no instruction for remains shipped to the Port Mortuary for cremation. The report states, however, that this provision pre-dates the establishment of the crematory at the Port Mortuary in 2009, and that this is important because the industry standard for shipping remains for cremation is a cardboard box or a "combination box" reinforced with wood, which differs from the standard for shipping remains for processing and restoration. The report concludes that "the better interpretation of AFI 34-242 in this circumstance is that it does not require the use of a transfer case when fetal remains are shipped to the Port Mortuary for cremation. The report further states that AR 638-2 provides that "a transfer case may be used to ship remains of an . . . infant or child to the Port Mortuary in the United States; this is provided if a suitable casket is not available." The OIG concluded that, under this provision, using a transfer case is not required. Therefore, the report concludes, neither AFI 34-242 nor AR 638-2 was violated in these cases.

The report also confirms that the families of these five fetal remains requested that the remains be treated as the remains of human beings. Accordingly, the report states that the remains came under the purview of Joint Publication 4-06, DoD Directive 1300.22, and DoD Instruction 1300.18, which require that the remains be treated with the reverence, care, and dignity befitting them and the circumstances. Although Ms. Spera, Mr. Keel, and the AFMAO Entitlements Branch Chief all observed the packaged remains and stated that the boxes did not accord the requisite reverence, care, and dignity, the report concludes that these regulations were not violated.

According to the report, Mr. Keel testified that the manner in which these fetal remains were shipped "wasn't very dignified." He stated that the cardboard boxes used were "improper," that sturdier containers should have been used, and that the packaging should have been improved. Mr. Keel stated that he tried to work closely with the Landstuhl Mortuary regarding the shipping process, that he suggested they use a sturdier, hardwood container to transport the remains, and that Landstuhl personnel were receptive to his suggestions. The evidence does not demonstrate, however, that Mr. Keel discussed his concerns or suggestions with Landstuhl personnel in his e-mail communications with them. The Entitlements Branch Chief observed some of the containers holding the fetal remains and stated that he was concerned and did not believe they were packaged appropriately. He stated that the remains should have been shipped in an infant casket. The report does not reflect any statements from Port Mortuary witnesses who believed the packaging of these remains was appropriate.

The Army OIG also investigated these allegations to the extent that they implicated actions by USAMAA-E personnel at the Landstuhl Mortuary. The findings of the Army OIG investigation are incorporated into the Air Force report. According to the report, witnesses at Landstuhl stated that they believed their practice of shipping fetal remains in cardboard boxes they had on-hand was adequate. Witnesses explained that sturdier shipping boxes had been ordered in January 2010; however, the shipment never arrived and the order was cancelled. The report reflects conflicting testimony regarding whether the Port Mortuary, and specifically Mr. Keel, communicated with Landstuhl personnel regarding the concerns about the manner in which fetal remains were being shipped prior to a May 17, 2010 e-mail forwarded from Ms. Spera. In an effort to seek clarification on this issue, OSC requested a copy of the Army OIG's investigation report from the Air Force. As reflected in the supplemental report, however, the Air Force declined to provide the report. OSC was therefore unable to gain a clear understanding of the evidence obtained in the investigation.[10]

The report reflects that Landstuhl witnesses described the special shipping procedures used with the boxes, including wrapping the boxes in brown paper, adding special handling labels, and stowing the boxes in the nose of the airplane with nothing placed on top of them, to ensure that they were handled with reverence, care, and dignity. Explaining that there was no evidence that the shipping of these remains posed a substantial and specific danger to public health, the report states that "[w]hile the shipping boxes for these fetal remains may have been sub-standard, they were still clearly labeled and treated with care." The report confirms that in July 2010, USAMAA-E began using rigid, wooden shipping containers.

In the supplemental report, responding to concerns raised by OSC regarding the industry standard for transporting remains for cremation, the Air Force explained that while wooden supports may be recommended or even required for commercial transport of human remains shipped for cremation, there is no such requirement for cremation containers for fetal remains using military transport. The Air Force conceded that it does not believe transporting fetal remains in re-used cardboard boxes was "the best option," but it reiterated that it did not violate a law, rule, or regulation. The supplemental report concludes that "[c]onsidering the totality of the circumstances, including most importantly the way in which the boxes were packaged, shipped, and handled, the preponderance of the evidence shows that the remains were treated with reverence, care, and dignity."[11]

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[10]OSC refutes the assertion in the supplemental report that OSC acknowledged there is no legal requirement for the Air Force to provide the underlying OIG reports in these cases. To the contrary, OSC advised agency officials that, for the purpose of determining the sufficiency of the report and reasonableness of the findings, the OIG reports were necessary to the extent that they provided additional information and/or clarification of the evidence obtained.

[11] Ms. Spera also alleged that two of the five fetal remains had not been embalmed prior to shipping. The report finds, however, from the documentary evidence and witness testimony at Landstuhl that all five of the remains were embalmed. The OIG further determined that, contrary to Ms. Spera's contention, written approval from the Commander, Casualty and Mortuary Affairs Operations Center, was not necessary for cremation of the Army dependent.

Special Counsel's Comments

The Air Force's conclusions concerning these allegations are troubling. 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 that 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. Because the Air Force declined to provide OSC with the Army OIG and AFOSI reports, OSC was unable to gain a clear understanding of the evidence obtained. While the Air Force's conclusions are concerning and do not appear to be supported by the evidence, I note that the substandard practice ceased and the Air Force and Army have taken corrective actions to improve procedures and ensure that these remains are afforded the requisite dignity, care, and respect.

Corrective Action

The report states that improvements have also been made regarding the packaging and shipping of fetal remains. As noted, USAMAA-E ceased using cardboard boxes and now uses wooden boxes to ship the remains, and the remains are now placed in sealed biohazard bags rather than medical specimen pails. In addition, USAMAA-E implemented new SOPs for shipping remains, including fetal remains, for cremation. AFMAO and USAMAA-E have also agreed upon AFMAO cremation procedures, including the documents required for cremation of fetal remains, as well as embalming and shipping requirements. These procedures will be incorporated into the Crematory Section SOP.

Improper Cremations Without Required Documentation

The investigation substantiated Ms. Spera's allegations that the cremations in these five fetal remains cases were conducted without the required paperwork for disposition, and that the cremations in the absence of these documents resulted in multiple violations of the Port Mortuary's Crematory SOP 34-242-04, which was written by Mr. Keel. The SOP requires the Cremation Officer to have five documents before remains can be cremated: 1) a release of remains from medical authority certifying cause of death; 2) authorization to cremate from medical authority certifying cause of death; 3) disposition instructions from service Casualty or Mortuary officer assisting the family; 4) a completed AFMAO cremation authorization form; and 5) a burial permit. The investigation, which the report states was primarily conducted by AFOSI, confirmed that in all five fetal remains cases, only one document, the AFMAO cremation authorization form, was present in each of the Port Mortuary case files.

While three files contained memoranda from the Landstuhl Regional Medical Center releasing the remains to mortuary affairs and death certificates, none of the memoranda certified the cause of death and thus did not meet the requirements of the SOP. In the two additional cases, it was determined that the release of remains from medical authority was never done. The

evidence further showed that in four of the five cases, the authorization to cremate did not exist, and in the fifth case, the authorization did not certify the cause of death, as required. In two of the cases, Mr. Keel created an exception to policy memorandum, waiving the requirement for the authorization based on his belief that the cases did not fall within the jurisdiction of the Armed Forces Medical Examiner (AFME). The investigation revealed, however, that his belief was incorrect and the waivers were invalid. The report further notes that no such exception is indicated in the SOP; rather, the requirement of a release is emphasized. It indicates that Mr. Keel's explanation that a death certificate would satisfy the requirement of a release from a medical examiner was insufficient, and that his preparation of the two exception of policy memoranda proved he knew of the importance of the documentation. None of the five case files contained disposition instructions from a casualty or mortuary officer or burial permits.

Similarly, the report states that Mr. Keel's statement that a death certificate would satisfy the requirement for a cremation authorization was "disingenuous," because the SOP, which he certified just months prior to these incidents, specifically requires the cremation authorization. According to the report, the evidence showed that Mr. Keel knew what was required to comply with the SOP that he wrote, but that he took no steps to comply with his own SOP, properly waive the requirements, or modify the SOP when he discovered it was deficient for dealing with fetal remains. The report thus concludes that the failure to obtain the requisite documentation prior to carrying out the cremations was a violation of the SOP, which constitutes rules that must be followed by AFMAO personnel unless properly waived. The investigation established that Mr. Keel was the Cremation Officer of record in all five cases and, as such, was responsible for the violations.

The investigation also revealed that information recorded in MOMS concerning these five cases misrepresented the facts and inaccurately reflected receipt of required documentation that did not exist or had not been received. In all five cases, MOMS reflected that a medical examiner's authorization for cremation was received, and that Mr. Keel had scanned and uploaded these authorizations and verified they were successfully uploaded. The report states that "[a]s there were no medical examiner authorizations for four of the five cases, these entries cannot be true." MOMS reflected that all of the inaccurate entries were made by Mr. Keel. The report notes that it is possible that someone working for Mr. Keel could have made the entries; nevertheless, as the Cremation Officer, Mr. Keel was ultimately responsible for reviewing the entries and ensuring that all documents were in order. The report finds that this evidence established further violations of the SOP, and that as the management official charged with direct oversight of all Port Mortuary cremations and the Cremation Officer of record in the five fetal remains cases, Mr. Keel was responsible for the violations. The report states, however, that despite the SOP violations, all of the remains were properly identified, and the cremations were carried out with PADD authorization and in accordance with the wishes of the respective families.

Special Counsel's Comments

The Air Force's findings and conclusions substantiating these allegations appear reasonable. The findings of multiple instances in which Mr. Keel falsified information regarding

authorization for cremations in the electronic records system (MOMS) are concerning, and appear to be a part of a pattern of dishonest conduct on Mr. Keel's part.

Corrective Action

As noted above, AFMAO and USAMAA-E have agreed upon AFMAO cremation procedures, including the documents required for cremation of fetal remains, as well as embalming and shipping requirements. These procedures will be incorporated into the Crematory Section SOP.

Whistleblowers' Comments

Pursuant to 5 U.S.C. § 1213(e)(1), the whistleblowers provided comments on the initial and supplemental reports, copies of which are enclosed. Mr. Parsons was critical of the agency's investigation and findings. He believes that the report was written in a manner to ensure that the Air Force was not liable for any of the actions, or lack thereof, taken by Mr. Keel and Mr. Dean. He noted that the report is clear that every Embalmer the investigators spoke with stated that they would have asked the family about cutting off the bone and would not have removed it without their consent. He asserted that if the Port Mortuary is held to the highest standard of the funeral service profession, as stated, and one state board of Embalmers indicates that it is illegal, immoral or unethical to remove a body part without the express permission of the family, then the Port Mortuary should be held to that requirement. He noted that the Oklahoma State Board of Embalmers indicated that any Embalmer holding a license in Oklahoma would have his/her license revoked for removing a body part in the manner that this Marine's bone was removed.

Mr. Parsons further contended that the remains in this case were in a mutilated condition and by regulation should have been in a full body wrap. He explained that while restorative art can be used to make remains viewable, it was not used here. He further noted that it would be obvious to anyone reading the report that there was no resetting of the bone. He asserted that the absence of a regulation prohibiting removal of a bone does not necessarily make this action right.

Commenting on the term "lack of candor" used to describe Mr. Keel's and Mr. Dean's actions, Mr. Parsons asserted that they lied under oath and it is clear from their actions that they are not qualified for their positions. He also commented that while Mr. Keel and Mr. Dean referenced textbooks by Robert Mayer, it does not appear that the investigators ever spoke with Mr. Mayer about whether cutting off a bone is considered restorative art. He noted that it seems that any questioning that would have resulted in a negative finding by the investigators was overlooked.

In her comments, Ms. Spera expressed her appreciation for the Office of the Secretary's efforts to "delve into extremely complex issues," but raised her concern that the OIG investigators did not avail themselves of legal resources within the profession and were unable to fully understand and appreciate all of the issues. She believes this is demonstrated by the contradictions that appear within the report, which states numerous times that the Port Mortuary

strives to maintain the highest industry standards in a unique environment. Where these standards are not met, however, as in the case of the Marine, she noted that the OIG cites the lowest standards and claims no violation of law, rule, or regulation. She stated that "they disregarded all opinions that did not fit within their preconceived concepts and made no opinion whether the action was ethical."

Ms. Spera further commented that AFMAO leadership "accepted luck in place of proper procedures and industry protocols," as evidenced in the case of possibly contagious remains. In allowing the remains to be transported prior to verifying they were non-contagious, she asserted that leadership showed a lack of care and respect for the personnel who would have direct contact with the un-embalmed remains. She noted that the Port Mortuary Director replaced a licensed, experienced professional with someone who had never dealt with remains or attended the Air Force Mortuary Officer's course. She also noted that OIG allowed unsubstantiated and pejorative statements that were immaterial to the case to be included in the report. She found it disheartening that the OIG "chose to quibble over the phrase 'Honor, Dignity and Respect' in order to find no fault with AFMAO and Port Mortuary leadership." Noting that she and her colleagues had raised their concerns to AFMAO leadership without success, Ms. Spera stated that she welcomes the changes that have occurred because of the Secretary's intervention in these matters.

Mr. Zwicharowski also provided comments, expressing his appreciation for the dedication and focus in the investigation and for "halting . . . a spiraling decline in the sacred care of our fallen over the past few years." He attributed this decline to senior leadership assigning unqualified personnel to key positions in AFMAO and the Port Mortuary, stating that the supervisory personnel selected had "very little or no experience in this extremely demanding, challenging, 'zero-defect' mission." He commented that the problems were compounded by management's failure to heed the advice of knowledgeable and experienced personnel. Instead, they showed disfavor for and retaliated against these individuals.

Regarding the case of the Marine, Mr. Zwicharowski gave his opinion, as a licensed Funeral Director/Embalmer with 25 years of experience, 12 in the Port Mortuary, that permission should have been obtained from the family to remove a major bone from the body for any reason. Noting that throughout the report the OIG references the highest standards of the funeral industry, he contends that the level of care at the Port Mortuary should be the highest standard of any of the 50 states. Regarding the missing portions cases, Mr. Zwicharowski acknowledged that everyone makes mistakes, but stressed that it is their solemn responsibility to the families they serve to be honest when they fall short. He asserted that whether a family requests the Port Mortuary to return subsequent portions to them or dispose of portions in a respectful manner, they do neither if they lose the remains. To Mr. Zwicharowski's knowledge, the Port Mortuary had never lost remains in its 55-year history until these two incidents occurred within six months under AFMAO leadership.

He also questioned the propriety of the Commander appointing his executive officer to conduct the CDI in the first incident, noting that such investigations are typically performed by an impartial officer equal to or higher than the Commander from outside the organization. In the

second case, he asserted that "leadership clearly avoided responsibility by not addressing the issue, and it was as if they were hoping it would go away." He also refuted the Operations Officer's statement concerning his areas of responsibility, contending that this individual should have taken some responsibility for the second portion. Finally, Mr. Zwicharowski expressed his appreciation for the efforts of the new Commander, but stated he remains concerned that senior civilian leadership has not admitted wrongdoing, which affects morale within the organization.

The whistleblowers submitted joint comments in response to the supplemental report, expressing their continued disagreement with the findings and the disregard for the ethical objections they raised. They noted the many changes and improvements at AFMAO and expressed their support for their chain of command.

Special Counsel's Conclusion

As discussed above, several of the Air Force's findings are not supported by the evidence presented and thus do not appear reasonable. These findings demonstrate 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. Despite the failure to accept accountability with respect to certain allegations, the Air Force has taken substantial corrective actions to address the findings and issues brought to light through this investigation. As noted, however, I am concerned that the retention of the individuals responsible for serious violations of rules and regulations, gross mismanagement, dishonesty, and misconduct sends an inappropriate message to the workforce.