ld Campbell, "The Body Brokers," *The*
. www.ocregister.com/features/body/.
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Chapter 5

Investigating Those Who Guard the Public

In 2001, *Austin (Texas) American-Statesman* reporters Jeff Nesmith and Ralph K. M. Haurwitz found a far-out-of-sight danger and a government agency that was unable to control it properly.[1] The reporters learned that for decades an agency of the state Department of Transportation—the Office of Pipeline Safety—did not know the exact location of some of the pipelines or even whether pipes existed. Nesmith and Haurwitz dug deeper and found even more: unreported spills, inconsistent record keeping and loss of life. They discovered a pipeline regulatory system that did little to enforce the law and thus essentially protected the interests of the industry. Nesmith and Haurwitz called their story "Pipelines: The Invisible Danger" and led off their series with these words:

> "Out of sight and unnoticed, America's sprawling oil and natural gas pipelines are leaking oil on the scale of a ruptured supertanker. They are fouling the environment and causing fires and explosions that have killed more than 200 people and injured more than 1,000 in the past decade."

Using a strong lead to open their story, the reporters packed a punch by comparing the pipelines with a supertanker spilling oil. The report was not slowed by numbers in the takeoff; instead it created a startling image of the dangers underground and put the story in a context everyone understood. The *Austin American-Statesman* series brought many calls for reform. Thus, investigative reporters such as Nesmith and Haurwitz work to help ensure the safety of the public by checking on the performance of government agencies that were created to protect people from physical harm.

Local police and fire departments play an important role in the front lines of life and property protection. Many other government agencies also regulate industry and enforce safety rules to help citizens feel safe and secure. Some lobbying groups complain of too much regulation. Meanwhile, the agencies amass reams of documents that help an investigative reporter assess their performances. Reporters often find huge gaps in the system.

In this chapter you will learn which local, state and federal agencies protect the public and how to find and report about those that are failing to do the job. Many of the agencies are familiar because we examined some of them in Chapter 4, which was about access to information on the Internet. In Chapter 4 we were looking at the agencies to learn what official information we could glean from them to help us in investigations. Here we are looking at the agencies to see whether they are fulfilling their purposes.

Issues of Safety

Investigative stories are often of great interest to readers if they cover topics that concern average people, every day, as they go about their daily routines. Safety issues concern everyone, and investigative reporters find revelations about them are in demand.

Buildings and Structures

Local building inspectors are public safety officials who have the power to issue citations that could close down a business or condemn an unsafe property just as food inspectors can close a restaurant. The investigative reporter can conduct an inspection as well, exposing dangerous conditions such as fire escapes that are chained shut or blocked by furniture. Such reports have high visual impact and show that the inspectors do not always find the dangers, or even if they do, those unsafe conditions have not been corrected because there is no follow-up.

Cities and states have building departments. They must approve new construction to make sure it meets all the standards set by law. They also are called upon to remove hazards in existing buildings. They do not usually enter a private home to inspect, but state law provides various reasons for inspections. A business that invites the public in or has employees and an apartment building of a certain number of units would probably qualify under the law for inspection. Building inspectors are responsible for checking on elevators and carnival rides, and those inspections reports will be on file along with reports on theaters and sports complexes.

Local statutes may require that local government officials carry out inspections within a certain time period. Inspectors' work sheets are public record and in most places will be released after a written request. The local inspector may be reluctant to close down the football stadium when the local team is on a winning streak, but the reporter will be concerned about loose roofing and shaky handrails. And the reporter also can note the rigged-up electric systems around the food concession booths, where electric cords dangle or stretch across walkways. All the reporter needs do is look.

One special area for an investigation of the work of building inspectors is the access to restrooms in public places. States have laws that set rules for public restrooms. Wisconsin statutes, for example, demand that in an amusement facility where the public congregates, "the owner of a facility shall equip and maintain restrooms with a sufficient number of permanent or temporary toilets to ensure that women have a speed of access that equals men."[2] A reporter can complain if the ballpark does not comply and learn how long it takes inspectors to act.

Such investigative findings call for an answer as to the causes of the oversight. Are the public safety officials understaffed and overworked, or corrupt or lazy? We might follow them around for a day.

Transportation

Traffic experts in the local street departments mark the lanes and repair and replace the traffic signs. The purpose is safety. The public often complains that markings fade at such places as crosswalks, and their absence causes accidents. Once again, the reporter has a visual story, this time from the lack of markings. If a stop sign is knocked down, does the policeman on the beat notify the street department? And does the street department take immediate action to replace it? Maybe not, because the police officers may not have regular rounds but only respond to calls.

The investigative reporter will learn of the sign being down when a bad traffic accident is the result. Then the reporter will talk to residents in the neighborhood who may know how long the sign has been down and will file an FOIA request with the police and street departments for any records of it having been reported. Does it seem like too small of an investigation? Not if it is a matter of life or death.

Likewise, the reporter will follow up accident reports to learn whether the accident was caused by an obstruction such as high weeds. It could be that the accident was caused by a pothole that local drivers had reported weeks before.

Federal regulations require that school bus drivers walk around their buses each morning and check them for any problems before taking them

out on the road. They must check the tires, the electrical system and mirrors. Do they really do it? Who is checking on them? Do they never miss a morning? Am I supposed to believe that they never miss a morning inspection in a deserted parking lot when the sun is not yet up? An investigative reporter could observe.

Are the conditions that caused a fatal bus accident in another state present in similar circumstances in the reporter's coverage area? And should they have been corrected by the street department? For example, in an accident in another state, a bus jumped the curb and smashed into a sheltered sidewalk bus stop, and several people who were waiting in the shelter are killed. A U.S. Department of Transportation report obtained off the Internet cites the fact that there had not been any protection between the shelter and street traffic. The reporter will observe whether such a hazard exists on local streets and will write about it to warn the public and local officials.

Environment

State and federal environmental protection agencies protect citizens from unclean air and water. A reporter could enlist the aid of a private laboratory to test water or air samples and learn whether the inspectors are reporting all contamination. The reporter could dip a cup into the local river, take the water sample to a lab and pay for an analysis. The sample would be taken from the river upstream as it enters the reporter's local area. Then, if a problem is found, the reporter will want to contact university public relations offices for names of experts who accept requests for interviews. They will most likely offer their thoughts about what caused the contamination. The reporter will be a big hero in town after exposing the fact that an industry far upstream is polluting the local water and is being forced to stop.

Workplace

The Occupational Safety and Health Administration within the U.S. Department of Labor works to remove safety hazards in the workplace. OSHA's findings make an interesting survey that is placed in detail online. Is OSHA finding all the hazards and following up to see whether they are corrected? One way for a reporter to find out is to go to the local files of claims under workers' compensation laws. "Workers' comp" is a federal program that provides workers with payments for any injuries at work, and it protects employers from inordinate damages in lawsuits. The records are public and are indexed according to states. A reporter must find the

agency that administers the program, run names of employers through the database and learn who had the best and worst accident records. Did OSHA inspect and find or not find hazardous conditions that caused these claims? Reporters are not satisfied with writing about what the local or federal inspectors saw; they will try to learn whether the dangerous safety conditions have been corrected, which can sometimes be seen from the public entrances and passageways.

Medicine

The Food and Drug Administration (FDA) controls the marketing of pharmaceuticals and the production and importation of food. After an official announcement of spoiled food, a reporter might ask how much of the spoiled food ordered off shelves was located. The agency provides such information on the Internet.

A story alleging FDA errors won a Pulitzer Prize in 2001 for David Willman of the *Los Angeles Times*.[3] He showed with statistics and reports from the FDA and interviews with experts that too many dangerous drugs were being approved with too little testing. Telling this highly technical and scientific story was a challenge that this reporter met. It deserves a close look for content, organization and style:

> "For most of its history, the United States Food and Drug Administration approved new prescription medicines at a grudging pace, paying daily homage to the physician's creed, 'First do no harm.' "

This investigative story opens with a traditional, familiar narrative. It tells the reader "Once upon a time . . ."

> "Then in the early 1990s, the demand for AIDS drugs changed the political climate."

Immediately one can feel an ill wind blowing. Change is in the air, and the reader is set to hear some bad news. Tell us what happened next!

> "Congress told the FDA to work closely with pharmaceutical firms in getting new medicines to market more swiftly. President Clinton urged FDA leaders to trust industry 'as partners, not adversaries.' The FDA achieved its goals, but now the human cost is becoming clear."

The reader has the background in three short paragraphs and is now ready for the full impact. The "nut graph" goes here, and the writer must summarize the story as briefly as possible.

> "Seven drugs approved since 1993 have been withdrawn after reports of deaths and severe side effects. A two-year *Los Angeles Times* investigation has found that the FDA approved each of those drugs while disregarding danger signs of

> blunt warnings from its own specialists. Then, after receiving reports of significant harm to patients, the agency was slow to seek withdrawals."

At this point, the reader knows what the story is about and will read on if the promised story is meaningful. A series of informative paragraphs follows:

> "According to 'adverse events' reports filed with the FDA, the seven drugs were cited as suspects in 1,002 deaths. Because the deaths are reported by doctors, hospitals and others on a voluntary basis, the true number of fatalities could be far higher, according to epidemiologists."

Another defender of the public from accident and disease is the local health department. Local and state health departments regularly inspect nursing homes and hospitals to check whether they are maintaining high standards. A reporter can get these reports, many from the Internet, and then see whether the complaints of hazardous facilities have been corrected.

Officials of the Chicago Board of Health and the Illinois Public Health Department were embarrassed to be found lacking in 1975 when the *Chicago Tribune* sent a reporter undercover as a janitor at a hospital. The reporter learned that the owner, a surgeon, was performing unnecessary surgery, overbilling Medicaid, and running an unsanitary surgery room. The stories that resulted were an example of how to find a problem in a nationwide program by investigating it on a local level, but the stories were perhaps not a good example of how to gather information.

The reporter, William Gaines, author of this text, worked on a series of stories that won a Pulitzer Prize in 1976,[4] and he testified about his experiences to the U.S. Senate Special Committee on Aging.[5]

The hospital that was the focus of the stories was dangerously understaffed and poorly maintained. Doctors used its surgery facilities to rack up payments for surgery that experts said was unnecessary—for example, the one-day removal of all the tonsils from all the members of a family of five. The reporter told the senators of his discoveries.

> Mr. Gaines: When the *Chicago Tribune* Task Force began an investigation of hospital care, one hospital soon emerged as needing special scrutiny.
>
> It was Von Solbrig hospital, an 83-bed facility in a white, middle-class neighborhood in Chicago. The hospital is unique in Chicago because it is the only general hospital in the city that has profit making as its expressed purpose.
>
> Its founder and sole owner is Dr. Charles von Solbrig, who is also the administrator, medical director, and chief surgeon. He controls every facet of the hospital operation. He conducts surgery without fear of criticism of any hospital board that he does not control.
>
> The Board of Health of the City of Chicago, which is empowered to enforce state regulations on the licensing of hospitals, would make routine

inspections, carrying a checklist of possible sanitary violations. The fire department inspectors would check fire extinguishers and doors and the like.

A hospital surveillance program set up many years ago in Illinois to monitor decisions in the use of public welfare money did not check on Von Solbrig Hospital. The hospital was judged too small for that.

Professional medical organizations would not be critical of doctors. We found that no doctor would go on the record as critical of another doctor. And when a lay person complained, doctors would say, "Who are you to criticize? You're not a doctor."

So I got a job as a janitor in Von Solbrig Hospital and I found that I didn't need to know anything about medicine to know that something was wrong. All I needed to do was count the staff in the surgery area, patient wards, and emergency room. I found that nurses were doing the job of doctors. Nurses' aides were doing the job of registered nurses, and I, as a janitor would do the job of orderly, aide, and nurse.

There was no doctor specifically assigned to the emergency room. On some days, the only physician available was the radiologist. There was no specialist in pediatrics or geriatrics available although patients ranged in age from infants to octogenarians. The short staffing of the surgery room was shocking.

Many times, the only doctor in the hospital would be in surgery, performing one operation after another. Assembly line operations were performed on children on public aid.

The recovery room would either be bypassed entirely or an untrained aide would be placed there to awaken a patient after surgery and remove him to his room.

One aide inside the surgery room was a 16-year-old high school student who volunteered to work in the hospital and was assigned to the surgery room within four days and without any training. His duties included counting sponges to see that none were left inside the patient.

Later, I would be called into the surgery room to help move patients off the table during a week when the high school boy was home with the measles. It didn't matter that moments before I was called into the surgery room, I was mopping floors or unloading a truck in the parking lot and wearing my dirty janitor outfit.

Every day, between janitor jobs, I would help lift elderly patients. One elderly Medicaid patient was in a cast, and an aide, the teenage volunteer and I struggled to lift her in and out of the bed as she cried out in pain. None of us had any training in handling patients, and the hospital had no mechanical lifts. . . .

Senator Moss: On these family surgeries of five children, did you talk with members of the family, the mothers and the father of any of those?

Mr. Gaines. Yes, we did; we talked with as many as we could find.

Senator Moss: And was this on the recommendation of the doctor, that all of this occurred, or how did they get five of them in a row?

Mr. Gaines: Well, the symptoms for tonsillitis are sore throat, loss of hearing and high fever, and we found that when a child was brought in by his

mother into the clinic he might just have had a sore throat, he might not have had the other symptoms, and that the other member of the family did not have those same symptoms, but the mother was asked to bring in the other members of the family, and have them examined, and then the diagnosis would be tonsillitis for the entire family.

The mothers who brought their children in felt that the doctor was concerned, because he asked them to bring in their other children.

It seemed to them he was doing his job, and they would trust him when they brought them in, and although the governing authorities did not find out about these mass tonsillectomies, when I first started at the hospital, I found out that even janitors there were aware that something was wrong. . . .

Senator Percy: How many others were on the maintenance staff?

Mr. Gaines: There were no more than five fulltime employees, including myself. There was one shift of maintenance workers on the day shift. There were no maintenance workers at night or overnight.

Senator Percy: Did the other people on the maintenance staff have the same kind of experiences that you did, or were you an exception rather than the rule?

Mr. Gaines: I saw other janitors called to assist with the patients. Sometimes they took two janitors to lift a patient, that we were called together to help with the patients.

Senator Percy: Did anyone check your references before you were hired?

Mr. Gaines: No, they did not. . . .

Senator Percy: In the period you worked at Von Solbrig, did you see any evidence of monitoring of conditions at the facility by state officials?

Mr. Gaines: I was not there at any time when an inspection was conducted, but I learned that since I left, that there was an inspection.

Senator Percy: But while you were there, you saw no evidence of inspection procedures?

Mr. Gaines: No, I did not.

Senator Percy: Would it be apparent to an inspector walking in [that] there were flagrant violations of minimum standards that should be corrected?

Mr. Gaines: I think by a head count of the nurses and the aides, checking what positions they were assigned to, and the inspector could walk in at any time, and interview these people, and check their qualifications, as they worked and find this out, but it would not be a matter of just coming and seeing them, I would not think, because it did take me quite a while myself to find out who was doing what, because in this particular hospital, no one wore name tags, and there was no uniform to designate who had what job.

Senator Percy: Finally, do you have any reason to, or did you come to any conclusion as to why these conditions could exist, when we had investigations 4 years ago revealing the laxity in inspections by city and State officials? Why is it that a facility like this had to be discovered by you when there are inspectors paid for by departments funded for that very purpose?

Mr. Gaines: I think they did not have enough experience to find out what happens. They have certain lists, and those are the things they would check. . . .

Senator Percy: There is a picture, and I am sorry that we cannot put pictures in the record but there is a picture of the staff directory in the lobby of the Von Solbrig Hospital. Very imposing, staff doctors, and names of them, how many names roughly are on that list?

Mr. Gaines: There are 50 names on that list.

Senator Percy: And how many of them actually could be located by you, that actually worked at the hospital?

Mr. Gaines: Eighteen persons. They were not staff doctors, but at one time, they had a patient there, and considered themselves associated in some way at the hospital.

Senator Percy: Were all of the doctors listed on that list alive?

Mr. Gaines: No. Several were dead. Some had never brought a patient to the hospital.

Senator Percy: Do you suppose they were still voting in Cook County? I will not ask for an answer to that.

So that there was an apparent deception here, or at least the listing had fallen out of date certainly. . . . Mr. Chairman, I would request that when our hearings are available and printed, in printed form, that copies be sent to appropriate law enforcement officials, the attorney general of the State of Illinois, the state's attorney in Cook County, and wherever in whatever county we might have testimony. . . .

Government agencies had overlooked rather than overseen this hospital and other medical facilities about which the *Chicago Tribune* wrote. The conditions at the hospital were widely discussed in the medical profession, and the fire department stopped taking emergency cases there, but the local inspectors took no action. These conditions are what had caused the *Tribune* to employ the once acceptable practice of a reporter secretly gathering information through misrepresentation although very little such undercover reporting is done by journalists. It is considered unethical, dangerous and a nightmare for media attorneys.

Could this report on Von Solbrig Hospital have been done without the infiltration of the target of the investigation? To a degree it could have. If a reporter was doing a complete study of the workings of the hospital, bills to the state for public aid recipients would have been found and examined, and it could have become apparent that inordinate numbers of tonsillectomies were being performed and that patients had much longer stays than their diagnoses required. The names of the doctors who were missing from the roster were displayed in the hospital lobby and could have been checked by anyone dropping in. Of course, the impact of the story would have suffered without the excitement of a first-person account, but critics would say that the story should stand on its own merits and not be hyped by an undercover adventure.

Fire Protection

The Detroit fire department was found by *The Detroit News* to be poorly equipped and thinly staffed and unable to do a proper job. Investigative reporter Melvin Claxton joined with Charles Hurt in 2000 to show that rampant negligence and mismanagement in the fire department had led to 20 deaths in four years.[6] Claxton, winner of a Pulitzer Prize at a Virgin Islands newspaper in 1994, said he finds it best to focus on three areas of investigation when he deals with a large organization such as the fire department:

Personnel training. How are personnel trained? Are there enough firefighters (in this case)?
Equipment. How is equipment maintained?
Management decisions. Where does the department spend its money?

"One interesting thing about fires is that people never blame the fire department," Claxton said. The reporters could find no lawsuit against the fire department blaming it for a death. Working with sources in the Detroit firefighters' union, Claxton and Hurt learned of internal dispatcher records that had not been included among routine records kept by the department and dispatcher broadcast tapes. The broadcast tapes revealed this plea: "I'm at the scene, my ladder doesn't work. I can't rescue people."

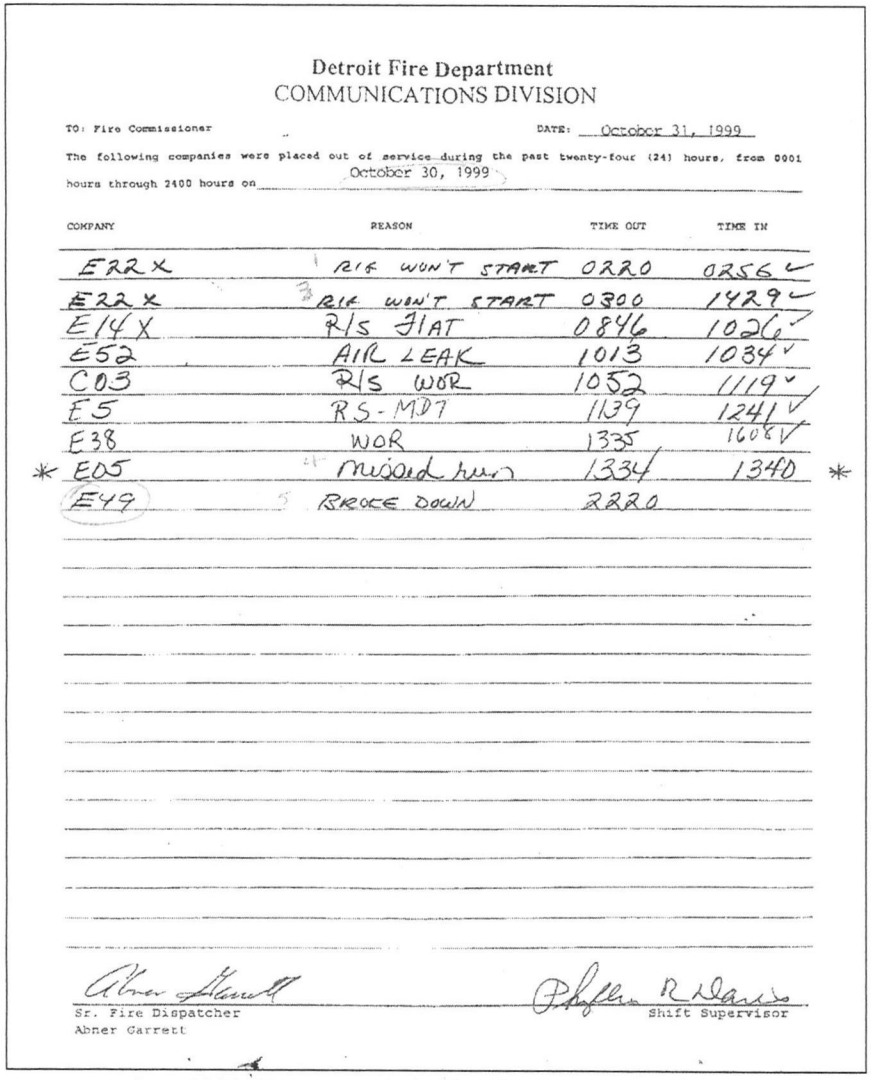
This dispatcher log, accessed through an FOIA request, reveals a litany of daily problems (see Figures 5.1 and 5.2).

The training program had no burn tower on which to practice, so firefighters had to practice with make-believe fires. Stations did not have the required four men on a truck, and firehouse cooks had to go out on calls. In one incident, six children died in a fire when unqualified engineers could not operate a pump.

Claxton and Hurt used a vignette lead for their series of stories, stories that were about as dramatic and tragic as the written word can tell.

> "For 25-year-old Norfessa Shannon, it was an act of sheer desperation. With a fire raging down the hall and black smoke billowing into her living room, she smashed the heavy glass of her eighth-floor window with her bare hands and tore away the screen. Shannon heaved her 7-year-old daughter onto the ledge and pleaded with her to jump if she wanted to live.
>
> "Then, screaming for someone to catch her baby, she let her child go. On the ground 80 feet below, anxious neighbors waited with blankets pulled taut to catch the little girl.
>
> "Nearby, a fire truck with a 100-foot ladder designed to rescue people from multi-story buildings sat in the driveway of the 188-unit Pallister

Figure 5.1 Detroit Fire Department dispatcher log, page 1



Detroit Fire Department
COMMUNICATIONS DIVISION

TO: Fire Commissioner DATE: October 31, 1999

The following companies were placed out of service during the past twenty-four (24) hours, from 0001 hours through 2400 hours on October 30, 1999

	COMPANY	REASON	TIME OUT	TIME IN	
	E22X	R/F WON'T START	0220	0256	
	E22X	R/F WON'T START	0300	1429	
	E14X	R/S FIAT	0846	1026	
	E52	AIR LEAK	1013	1034	
	C03	R/S WOR	1052	1119	
	E5	RS-MDT	1139	1241	
	E38	WOR	1335	1606	
*	E05	missed hum	1334	1340	*
	E49	BROKE DOWN	2220		

Abner Garrett
Sr. Fire Dispatcher
Abner Garrett

Shift Supervisor

Source: Melvin Claxton and Charles Hurt, Freedom of Information Act request, 2000

Plaisance Apartments on Detroit's west side. It had been there for more than five minutes, firefighters and witnesses agree.

But the truck, the first sent to the April 1 fire, couldn't help in the rescue effort. Its ladder didn't work.

Figure 5.2 Detroit Fire Department dispatcher log, page 2

Detroit Fire Department
COMMUNICATIONS DIVISION

TO: Fire Commissioner DATE: November 17, 1999

The following companies were placed out of service during the past twenty-four (24) hours, from 0001 hours through 2400 hours on November 16, 1999

COMPANY	REASON	TIME OUT	TIME IN
L08	AIR LEAK	0728	0926
L25	MANPOWER	0751	0755
TAC 7	MANPOWER	0751	
E54	WOR	0752	1820
E17	WOR	0757	1551
E10	P.M	0804	1702
C04	R/S	0822	1643
E58	Replace Line	0828	0953
505	WOR	1012	1208
E40	ENGRAVE LINE	1101	1209
301	O.S-Repairs	1324	1643
L30	W.O.B. @ R/S	1500	1602
L19	R/S WOR	1655	1908

Sr. Fire Dispatcher
Abner Garrett

Shift Supervisor

Source: Melvin Claxton and Charles Hurt, Freedom of Information Act request, 2000