OAKLAND COUNTY MICHIGAN
MEDICAL EXAMINER

OAKLAND COUNTY EXECUTIVE L. BROOKS PATTERSON

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August 22, 2018

Craig A. Daly, Esq.
Attorney at Law
Ford Building
615 Griswold, Suite 820
Detroit MI 48226

Re: People vs. Mario Willis
WCCC No.: 09-028750-01-FC

Dear Mr. Daly:

You have asked me to review the materials listed below and provide consultation in the field of forensic pathology, which I have practiced full-time for more than thirty years.

I am employed in the capacity of the Chief Forensic Pathologist/Chief Medical Examiner for Oakland County, Michigan, and have been in that position since 1991. I am certified by the American Board of Pathology in Anatomic Pathology (1982), Neuropathology (1985) and Forensic Pathology (1987). My Curriculum Vitae and the list of my court testimonies are attached.

MATERIALS REVIEWED:

1) **The records from Detroit Receiving Hospital regarding Walter Harris, dec'd**
2) **The Wayne County Medical Examiner's Office Case Registration Summary/ME Case No. 08-11592, Walter Harris, dec'd**
3) **The autopsy report WCME #08-11592, Walter Harris, dec'd, issued by Dr. John Bechinski**
4) **The autopsy photographs for WCME #08-11592**
5) **The transcript of Dr. Bechinski's trial testimony regarding the above captioned case**
6) **The NIOSH firefighter fatality report**
7) **State of Michigan Court of Appeals Decision to vacate the above defendant's sentences and remand for resentencing**

CASE SYNOPSIS AND ISSUES TO BE ADDRESSED:

The above criminal court case is based on the death of a 38-year-old career Fire Fighter who was participating in attempts to extinguish the blaze located on Sheridan Street and East Kirby Street, in Detroit, on November 15, 2008.

On arrival the firefighters initiated a defensive fire attack to extinguish the fire through the second floor windows. After the knockdown, fire crews entered the second floor to perform overhaul operations. During the activity the roof of the house engulfed in the fire collapsed with several firefighters still inside, on the second floor. The victim, Mr. Walter Harris, and two other firefighters were reportedly trapped under a section of the collapsed roof. The two firefighters self-rescued, but Mr. Harris could not be found. After cutting through roofing materials, the victim was found unconscious and unresponsive, by the fellow firefighters. Mr. Harris was reportedly "apparently crushed" by the debris of the collapsing roof structure, however, firefighter Terril Hardaway stated that he found firefighter Harris *slumped over* wearing his full gear and debris from the roof was on his back.

Even though the incident analysis continued long after its actual occurrence, the scene investigation identified the critical contributing factors surrounding this death: 1) dilapidated building conditions, 2) incendiary fire originating in the unprotected structural roof members, 3) inadequate risk-versus-gain analysis prior to committing the interior operations involving a vacant/abandoned structure, 4) inadequate accountability system, 5) lack of safety office, 6) an inadequate maintenance program for self-contained breathing apparatus (SCBA) and 7) poorly maintained and likely inoperable personal alert safety systems (PASS), 8) ineffective strategies for prevention and remediation of vacant/abandoned structures and arson prevention. Apparently, none of the information ever reached Dr. Bechinski, who performed the autopsy on the body of firefighter Walter Harris one day later and issued the autopsy report on the same date.

Based on the information that had been communicated to him, without personal investigation of the scene, or photographic documentation of the scene, Dr. Bechinski concluded that Mr. Harris died of *mechanical asphyxia*, with the explanation that the same "results when heavy weight on the chest or upper abdomen prevents respiration."

However, Dr. Bechinski's autopsy report did not describe any evidence of trauma anywhere on, or in Walter Harris' body, which would be an expected standard approach in substantiating the conclusion about the listed cause of death. A standard for medico-

legal investigation of a suspected death by asphyxia calls for careful integration of critical findings at the scene of injury/death with positive findings at autopsy in the process of excluding any, and all, other potential natural or un-natural causes. Hence, *asphyxia is a diagnosis of exclusion.*

Assuming the diagnosis of asphyxia without carrying out the standard microscopic evaluation, or, at least, documenting photographically and in writing, any and all grossly abnormal organs/tissues, represents a grave error of omission in this death investigation. A total of eight photographs were taken of the external appearance of the firefighter's body demonstrating complete absence of any trauma.

The autopsy report, though, refers to the deceased as *normally nourished*, with the body weight of 305 pounds, on the body frame of 5'11". This decedent's body mass index was 42.7, which was clearly abnormal (indicative of obesity) and a likely significant contributing factor in the over-all mechanism of his demise.

There was a clearly abnormal heart, weighing 625 grams (twice the normal expected size) and the description continues with "*both ventricles were of normal size and their walls of normal(?) thickness, the left ventricle measured 1.5 cm*", to contradict itself. The firefighter's lungs were extremely heavy (right 925 grams; left 825 grams) over four times the expected normal weight for the age group and were without any reported evidence of trauma. The decedent's spleen was reported weighing 625 grams, which is clearly abnormal (at least three times the normal weight) and the enlarged liver (2,875 grams) constitute together *hepatosplenomegaly*, one of the important clinical and pathologic findings indicative of congestive heart failure.

Yet, inexplicably, not a single photograph was obtained of the clearly pre-existing grave abnormalities of the vital internal organs.

ANALYSIS AND OPINIONS:

There is no question that firefighter Walter Harris came to his death while on duty, carrying out his work with dedication, however, it was the duty of the medical examiner to properly investigate this death and to present and interpret all the details in the court testimony.

Assuming that the manner of Mr. Harris' death was homicide without a thorough and complete gathering of information and evaluation of the (at the time available) evidence

from the scene and the examination of the firefighter remains, represents a breach of professional and public duties.

Unfortunately, Dr. Bechinski testified incorrectly at the trial of this case (Transcript pages 27,28 & 29) that *"the manner of death is used for statistical purposes only by the health department to characterize what types of deaths are occurring within the state."(?)*

There are five categories of manner of death that are used worldwide to define physical circumstances that surround any particular death:

NATURAL - where death results from any disease process
HOMICIDE - where death results from a (demonstrable) purposeful act of another
SUICIDE - where death results from a (demonstrable) purposeful act by self (only)
ACCIDENT - where death results from untoward effects of someone's acts or actions (self & nature included)
INDETERMINATE (UNDETERMINED) - where there is not enough information about the circumstances surrounding an injury, or death

It is a medical examiner's statutory obligation to properly determine the cause and manner of death utilizing the standard diagnostic procedures and to reduce to paper those findings that substantiate the claim of manner of death accordingly. If the manner of death is deemed homicide, it is the duty of the medical examiner to provide demonstrable physical evidence of a deadly injury allegedly inflicted by another individual. In fact, all the findings documented in this autopsy report do the opposite and support Mr. Harris' pre-existing advanced heart disease, complicated by acute congestive heart failure, likely aggravated by the firefighter's strenuous physical efforts in attempt to help control the housefire, as *accidental* death.

Based on the autopsy report, Mr. Harris had suffered from a serious natural disease process with likely imminent deadly outcome and his physical effort placed an extra burden, acutely straining the already diminished functional reserve of his compromised heart. In consideration of the circumstances surrounding Mr. Harris' death, the documented findings at autopsy and the results of the toxicologic analyses, the manner of death should have been appropriately classified as *accident.*

In conclusion, it is my opinion that the statutory and professional obligation had not been met in the original investigation of this firefighter's death.

I trust this answers your query.

All opinions are expressed with reasonable medical certainty. I reserve the right to amend any statements or opinions if presented with additional significant information, as well as the right to rebut opinions within my area of expertise.

Sincerely,

L.J. Dragovic, M.D., FCAP, FAAFS
Forensic Pathologist and Neuropathologist