IN THE CIRCUIT COURT OF THE ELEVENTH JUDICIAL CIRCUIT
OF FLORIDA IN AND FOR THE COUNTY OF DADE

SPRING TERM A.D. 1987

FINAL REPORT OF THE GRAND JURY

FILED

FEBRUARY 8, 1988

I N D E X

THE AIDS (ACQUIRED IMMUNE DEFICIENCY SYNDROME) EPIDEMIC

In less than five years fear of the deadly AIDS disease has gripped this nation. AIDS has substantially changed America. AIDS has heightened America's sense of vulnerability, strained its conscience and baffled the medical, legal and public health professionals. We are gravely concerned about the impact of this crippling and deadly disease on our community.

We have reviewed countless reports and heard testimony from state and local health officials and individual victims of AIDS and AIDS related diseases. We observed the ravages of this disease firsthand, as one weakened AIDS witness died even before we completed this report. We have learned that the national Center for Disease Control (CDC) estimates that in Florida one out of nine men and one out of 75 women between the ages of 30-39 presently carries the human immunodeficiency virus (HIV), the underlying cause of AIDS and related diseases. During six months of our term, the number of reported AIDS cases in Florida increased 51%.

Part of the great mystery of AIDS unfolded as we served our term. We observed the rapid change and expansion of AIDS knowledge on an almost daily basis. What many had previously regarded as a homosexual disease evolved to a clear threat to every human being. As our knowledge increased, so did the number of questions regarding the disease and its future impact. Few answers or solutions are in sight. What is clear is that based on present statistics and projections, this disease may be the greatest public health isssue of modern times.

According to the CDC, the numbers of Americans who have developed the clinical symptoms of AIDS has escalated 14 times since 1982 to the present number of 50,265. CDC reports

that between 1986 and 1987 alone there has been a 58% increase in the number of reported AIDS cases nationwide. To date, over 28,300 Americans, including 458 children, have died from AIDS. Presently, there is no curative treatment and once clinical symptoms develop, the disease is 100% fatal.

According to the CDC, Florida has the third highest number of reported AIDS cases in America. The South Florida area, comprised of Dade, Broward and Monroe counties, ranks sixth in the nation in its number of reported AIDS cases. There are presently 3,666 reported AIDS cases in the State of Florida and 1,397 reported AIDS cases in Dade County alone. Fifty-six of Dade County's reported AIDS cases are children.

The prospects of this disease are frightening in terms of human suffering and loss of life. According to present medical knowledge, AIDS, as previously noted, is caused by the human immunodeficiency virus (HIV). A person can carry the virus, for a period of time, without developing symptoms of AIDS or AIDS Related Complex (ARC). Projections are difficult because neither the HIV infection nor the AIDS Related Complex (ARC), a preliminary form of AIDS, have yet to become reportable conditions to the CDC. Therefore, estimates by CDC health professionals are based on CDC projections and other limited isolated studies. The CDC and other health officials project that approximately 1.5 million Americans are HIV infected. Based on the CDC's formula of projections, there are potentially 183,000 HIV infected individuals statewide and approximately 70,000 in Dade County alone.

Health officials believe that for every one CDC reported case of AIDS there are ten cases of ARC which translates into an estimated 500,000 additional cases related to this disease. The CDC also estimates that for every one reported case of AIDS there are 50 unreported cases of persons infected

with the HIV virus. Health officials believe that individuals carrying the HIV virus will likely develop AIDS or ARC within ten years. No vaccine exists to prevent the geometrical spreading of the infection. Lacking sufficient hard data and longitudinal studies, the future of those infected remains perilously uncertain.

Until recently, AIDS was associated with small segments of the population, such as homosexuals, hemophiliacs and IV drug abusers. But CDC figures show that the number of heterosexual AIDS cases has increased 72 times since 1982. The same statistics show that the incidence of AIDS in children has increased 25 times. Professionals such as police, health care workers, dentists, correction officers, and fire fighters have also proven to be populations at risk for exposure. Although some populations may remain at greater risk of the infection, it is now recognized as a deadly disease that threatens each and every one of us.

Not only do HIV infected persons fear a long and painful period of illness and ultimate death, they fear other types of adverse personal action. Individuals with AIDS, ARC and positive HIV antibody status have met with discrimination, misinformation and stigmatization. We heard cases of individuals who became social untouchables. They were fired from jobs, expelled from schools, abandoned by families and were denied affordable health care and social services. They were stripped of basic human dignity. What occurred with the three Ray hemophiliac children, carriers of the HIV virus but not showing any AIDS symptoms, is an example of society's ignorant and shameful response to this disease. They were expelled from school and shunned by neighbors and friends. Ultimately their home was burned, which forced the family to leave Arcadia, Florida.

The U.S. Surgeon General C. Everet Koop was recently

quoted as calling AIDS, "the number one health problem on this planet." Koop further stated that, "the moral and ethical issues in dealing with AIDS are as difficult as the scientific and medical ones." We cannot fight the disease with fear. Our anger and frustration should be focused on the virus not on its innocent carriers. AIDS and HIV infection are health issues and should not be the subject of political or social morality.

Presently a growing conflict exists between a community's interest in stopping the disease and in preserving important fundamental values of individual liberty and equal rights. This poses compelling ethical challenges to medicine, science, public health and to our individual integrity. Policy makers must proceed cautiously in developing policies regarding controversial issues such as mandatory screening, testing, confidentiality, contact tracing, insurance coverage, employment, housing and treatment.

Enhanced educational programs may presently be the only effective defense against unwarranted fear, the spread of the virus and its potential economic impact. Until a vaccine is discovered, its transmission can only be stopped by behavioral change. Although AIDS is presently 100% fatal, it is almost 100% preventable. The American Medical Association and the U.S. Surgeon General have recommended that education be provided from kindergarten on up. This makes sound sense when faced with rather frightening statistics regarding our youth. According to the American School Health Association (ASHA), 2.5 million teenagers annually contract a sexually transmitted disease. CDC reports a 34% increase last year in the national rate of syphilis, an affliction particularly affecting teenagers and college age youths. The ASHA also reports that by age 17, 50% of today's youth have had sexual intercourse. Greater sexual activity among teens only increases the danger of HIV infection.

Apart from the tremendous cost in human suffering and loss of life, the economic ramifications of this disease could prove staggering if not disastrous. Because no definitive study exists on the future progression of the illness for the projected millions of HIV infected victims potential costs are difficult to estimate. One San Francisco study indicates that 78% of those presently HIV infected will develop AIDS or ARC within 6.5 years of infection. CDC projects that within five years 30% will develop symptoms of the disease.

AIDS patients intermittently require hospital care as the disease progresses. Due to the long duration of the disease, those who once might have been financially solvent and insured, in most cases become dependent on publicly supported medical care. Hospital administrators report that 85% of AIDS or ARC patients receive treatment at a public hospital. Jackson Memorial Hospital is Dade County's primary provider of acute hospital care for AIDS patients. According to JMH administrators, of the AIDS patients receiving treatment, 57% are indigent and 14% receive medicaid coverage and state assisted social service care.

During the six months of our service there was a 43% increase in the number of pediatric cases statewide. Officials from JMH and the Department of Health and Rehabilitative Services (HRS) project five to six new pediatric AIDS cases per month. They reported that 80% of these babies were born to mothers with either AIDS or HIV virus. In most cases, the mothers were unable to care for the babies so they remained unwanted. Too often JMH remained their residence of last resort at a cost of $447 per day. By the age of five, 70% of these children will die.

As new cases are diagnosed and those infected become ill and destitute, accessible and affordable treatment, care and housing will be needed. Communities across the nation will need

to increase funding for counseling, housing, treatment and fundamental care. For instance, in Dade County, if only half of the projected 70,000 infected individuals develop AIDS or ARC, our health care system will be greatly strained. In addition to increased funding, the establishment of greater community based AIDS programs and care facilities will be needed.

Alternative housing and care facilities such as adult congregate living facilities (ACLF), nursing homes and foster care homes are preferable for the patient. They also represent a substantially lower cost of care than unnecessary hospitalization. Incentives for foster care for the pediatric cases will need to be developed for those babies who do not require hospitalization. We learned towards the end of our term that HRS modified its ACLF administrative rules to now allow the housing of AIDS patients. Previously, this was not permissible. We commend HRS for this action.

In conclusion, we urge that every possible step be taken in the areas of research for a vaccine, curative treatment, education and public awareness as prevention for further infection and care for those presently ill. National and local leadership is needed to form cautious yet coherent policies on AIDS. A coordinated strategy, which is morally balanced and fiscally sound must be developed to deal with this complicated medical and social dilemma. The federal government, to a large extent, controls the monies and policies for research. Nonetheless, Florida and Dade County must forge ahead in the areas of research, education and health and social services, regardless of cost.

Resources must be committed to understanding how this disease progresses in order to plan for the immediate needs of the health care system. Steps must be taken to obtain and report hard, verifiable data on the prevalence of HIV positivity while affirming the rights of the individual. Strong local leadership

will be needed to soundly and effectively plan to minimize human suffering while avoiding fiscal disaster. The victims of this disease must be treated with compassion and dignity not shunned by lack of services. None of us are immune to this disease. We are all responsible for confronting and ultimately defeating it. We must proceed with vigorous research and educational efforts to eliminate both the scourge of AIDS and the social havoc that has accompanied it.

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FILED

MAY 12, 1988

Circuit Judge Presiding

EDWARD S. KLEIN

Officers and Members of the Grand Jury

OSCAR A. LARRAURI
Foreperson

YOLANDA GASPERINI
Vice Foreperson

DEBORAH McCOMB
Clerk

MARGARET LONG
Treasurer

RONALD L. AURINGER	JAMES PAUL FLEMING
WILLIAM E. BUCHWALD	YOLANDA FOGLER
WARREN L. CHRISTIAN	PEGGY GOMEZ
HARLAN JULES COHN	JOSE HEIBLUM
HAROLD E. COX	JOANNE Q. KUDZMA
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Official Court Reporter

NATIONAL REPORTING SERVICE

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Bailiff

GEORGE BARNES

THE DEATH OF OFFICER DAVID HERRING

On September 3, 1986, City of Miami Police Officer David Herring tragically died behind the wheel of his assigned police vehicle. He died as the result of carbon monoxide poisoning. City of Miami detectives conducted a comprehensive investigation of the circumstances surrounding this horrible and needless death. We reviewed the facts revealed by this investigation. We also took testimony, reviewed reports, records and memos, and observed for ourselves the vehicle in which Officer Herring died. Based on all that we heard, we conclude that Officer Herring's tragic and unnecessary death was the result of serious deficiencies in two areas: The City of Miami motor pool and police department.

This tragedy occurred over a year ago and the City of Miami has taken some steps to correct this situation. However, since the Grand Jury began this investigation, it has come to our attention that there have been complaints of fumes in police vehicles of other departments in Dade County. This news is alarming and disturbing to us, in view of what happened to Officer Herring.

We urge all administrators in all public agencies (and private employers should take warning as well) to take immediate steps to ensure the safety of all vehicles utilized by their employees. So that administrators will understand what led to Officer Herring's death, we call attention to the indifference that led to it and we then make specific recommendations applicable to all fleet owners and administrators that can avoid such tragedies in the future.

I. FACTS

Officer Herring was driving Car 148, a 1981 Plymouth Grand Fury with 67,407 miles at the time of his death. The car was examined by Drs. Robert Adt and Joseph Metka, of Mechanical Systems Analysis Assoc., and Frank Grate, an engineer and

metallurgist, to determine what had caused a lethal amount of carbon monoxide to leak into the passenger compartment.

Three defects were identified as contributing factors:

(1) The end of the tailpipe was directed toward the rear bumper, causing the exhaust fumes to rise and accumulate in the area where the trunk is supposed to be sealed.

(2) The trunk lid did not seal properly, such that the fumes entered into the trunk and then into the driver compartment.

(3) The air pump which is part of the emission control system was removed, thereby causing increased carbon monoxide in the exhaust fumes.

Mr. Frank Grate concluded that the tailpipe had been in that position for a number of months and had never been repaired. Yet, in the year immediately preceding Officer Herring's death, Car 148 had been turned into the Motor Pool for repairs forty-four (44) times. Work orders for each of those incidents indicated that on four (4) occasions, January 17, 1986 (twice), January 30, 1986, May 16, 1986, the complaint was gas fumes in the car. On two other occasions in that period it was noted that the trunk would not close.

At least ten other patrol cars other than 148 were reported to have a problem with exhaust fumes in the year preceding Officer Herring's death. Additionally, six drivers of one public service vehicle, #297, were hospitalized for fume inhalation after driving that vehicle. Commencing the day after his death, the Dade County Public Health Department tested carbon monoxide levels in 201 police vehicles. The levels in sixteen (16) of those vehicles exceeded that deemed to be safe by Occupational Safety and Health Administration (OSHA) (50 parts per million).

On October 21, 1985, the Dade County Department of

Environmental Resources Management (DERM) formally advised the City of Miami of the enactment of a County Ordinance, effective October 1, 1985, "making illegal the operation of motor vehicles on which pollution control systems have been tampered with...." On April 1, 1986, DERM inspected ninety (90) vehicles in the City of Miami fleet. Seven police vehicles failed that inspection, every one of which failed on account of the air injection reactor (air pump). Car 148 was one of the failing vehicles. During the end of October and the beginning of November, 1986, DERM conducted another inspection of the City of Miami fleet. Of the five hundred and three (503) vehicles examined, sixty-eight (68) failed with twenty-two (22) of those failures attributable to the air pump. In the interim between April 1, 1986, and the date of Officer Herring's death, September 3, 1986, not one of the seven failing police vehicles had its air pump repaired or replaced. One vehicle, Car 135, had the air pump replaced on September 30, 1986. The motor pool was notified of the April 1st DERM test results immediately and explicitly.

At the time of Officer Herring's death, the City of Miami Police fleet was operating under a six (6) year/seventy thousand (70,000) mile replacement schedule. This resulted in patrol vehicles being used far longer than most comparable police fleets. For example, the Metro-Dade Police Department replaces patrol vehicles every two years.

II. MOTOR POOL

The Motor Pool of the City of Miami is a division of the City's General Services Administration (GSA) and is responsible for the maintenance and repair of the City fleet including police vehicles. Its main facility for light vehicles is located at 1901 Northwest 12th Avenue with an annex at the Police Department. From November 1, 1984, to August 29, 1986, the superintendant of the Motor Pool was Tariq Riaz.

Tariq Riaz was in charge of the Motor Pool at the time Dade County passed the Anti-Tampering Ordinance. He received notice of the ordinance through certified letter and in fact sent a foreman to a workshop held on "How to Recognize Tampering". After the DERM, April 1, 1986, inspection, Tariq Riaz was notified by certified letter of the seven vehicles which failed the inspection. Mr. Riaz has indicated that he had assigned a foreman to oversee the mandated repairs and that he was subsequently informed that they had been completed. At the time of Officer Herring's death, his vehicle, Car 148, as well as the seven others on the April 1, 1986, DERM list, had still not been repaired.

Tariq Riaz was suspended with pay from his position as Motor Pool Superintendent several days before Officer Herring's death for reasons unrelated to this report. A replacement for his position was finally hired in October 1987.

In the years preceding Officer Herring's death, the Motor Pool was woefully understaffed. The mechanic to car ratio was approximately one (1) to fifty-two (52) as compared to the national fleet average of one (1) mechanic for every twenty-three (23) cars. Rigid hiring criteria were non-existent; although the job specifications called for a written exam, none had been given or required in recent memory. Training or continuing education was haphazard at best: only one person, a foreman, attended the program offered by DERM on January 8 - 10, 1986, to acquaint mechanics with the operation and maintenance of the pollution control system.

Four specific deficiencies logically contributed to the lethal condition of Car 148. Firstly, although repair work orders had been computerized for over two years prior to September, 1986, there was no protocol or program to review the repair history of any vehicle when it came in for another repair. Thus, each mechanic operated in the dark as to whether a

particular complaint or problem, such as fumes, had been a recurring one. Furthermore, no system was in place to assure the recall to the Motor Pool of any vehicle which had been returned to patrol but required additional work.

Secondly, and most astonishingly, the Motor Pool had no testing device to ascertain levels of carbon monoxide in vehicles although such devices were available in the County or could have been purchased at no great expense. This shortcoming persisted despite the universal awareness of the deadly nature of carbon monoxide. Without such devices, the attempts to remedy reported fume problems were amazingly unscientific, varied from mechanic to mechanic, shift to shift and were doomed to failure.

Thirdly, mechanics performed maintenance or undertook repairs only as to the items specified in the work order. Due to the workload and other constraints, no preventative maintenance was done nor would mechanics examine a vehicle to see if safety related parts, not complained of, were in good working order. Such defects as a bent tailpipe or bad trunk seal could persist for months unattended to.

Fourthly, mechanics, and to a certain degree the Motor Pool as a whole were under extreme pressure to make the maximum number of vehicles available for patrol. This pressure was both internal, within GSA and the Motor Pool and external, from the Police Department. As a result, if a vehicle could run it would be returned to service even if the problem was not fixed unless the problem was viewed as safety related; i.e. brakes, steering. Pollution control equipment, specifically the air pump, was not so viewed. Even in the face of the aforementioned Dade County Ordinance absent or non-working air pumps were prevalent as evinced by the condition of Car 148 on September 3, 1986, and the DERM October - November 1986 inspection. While records exist as to which mechanic worked on a particular car on a particular day, it is impossible to prove that a specific deficiency was that

mechanic's fault since each insisted that a problem was not present when they worked on the car.

III. POLICE DEPARTMENT

The City of Miami Police Department leases its fleet from GSA and relies upon the Motor Pool to maintain the fleet. Within the Department, there has existed a Division of Fleet Management which until June of 1986 was staffed by non-professionals who did little more than account for the number of vehicles available at any given time. A competent and professional Fleet Manager took over in June 1986, however, in October 1987 that person was removed. The Police Department did not take upon itself the responsibility for coordinating with the Motor Pool the repair and maintenance of the fleet. And, except on an ad hoc basis, no individual in the Department took upon themselves the responsibility for coordinating with GSA on the status or expansion of the fleet. The result was patrol officers performing their duties in too old and inadequately maintained cars.

Again, it is predictable that a certain amount of complaining will exist with a fleet the size of the City of Miami's. To the extent these complaints involve other than serious problems there is no cause for alarm. However, in the two-year period prior to Officer Herring's death, a number of officers on patrol and public service aides complained of having been overcome by fumes in their car. These were not unsubstantiated, subjective complaints, but rather were documented by emergency room admissions and examinations at Cedars of Lebanon Hospital.

By memorandum dated March 18, 1986, Colonel Mary Stair, then commander of special operations, now commander of patrol, was informed by Officer Juan Diaz, supervisor of the school crossing guards, that there was a problem with the vehicles assigned to his unit. Specifically, it was noted that Car 297 was responsible for

sending six people to the hospital due to the inhalation of fumes. Colonel Stair sent a copy of the memo to Fleet Management. No remedial action eventuated since Car 297 was the worst offender of those tested by the Health Department in September 1986.

In the face of the other life-threatening incidents, no evidence was uncovered that anyone in the Police Department other than the particular officer's sergeant was aware of the incapacitation of these officers or any fume problems. Moreover, there is no evidence that anyone in the Police Department ever communicated to the Motor Pool the seriousness of the problem except for Car 297. In other words, the other cars were turned in to the Motor Pool with the complaint of fumes, but no one bothered to alert the Motor Pool that the problem was serious enough to send an officer to the hospital.

In stark contrast to the aforementioned inaction and inattention by the Miami Police Department, is the experience of the City of Baltimore. There, in 1975, one officer was overcome by fumes in his patrol vehicle, also a Plymouth. He was treated at the hospital and suffered no ill effects. Nevertheless, within hours of the incident, a task force was created to investigate the cause and assure that it would not reoccur. Then within seveny-two (72) hours, the problems were identified: tailpipe deflection into the bumper and incomplete sealing of the trunk, similar to Car 148. Thereupon, the entire fleet of Plymouths was outfitted with tailpipe extensions by Chrysler which eliminated the hazard. Additionally, the integrity of the body shell, particularly the trunk area, was inspected in every vehicle in the fleet to insure that fumes could not enter the passenger compartment.

IV. CONCLUSIONS

In attempting to assess or attribute criminal liability for the death of Officer David Herring, only the crime of manslaughter was considered. Under Florida Statute, $ 782.07, one could be guilty of manslaughter by causing the death of another through culpable negligence. The questions to be resolved by the Grand Jury were whether the acts or omissions on the part of any individual or government agency were the proximate cause of Officer Herring's death and whether those acts or omissions were so egregious so as to constitute culpable negligence as construed in Florida. We have concluded that based on the decisions of the Florida Supreme Court the negligence of any one person does not rise to the level of Manslaughter.

That probable cause does not exist to charge any person or entity with manslaughter in the death of Officer Herring, does not diminish the outrage felt by the Grand Jury. At the time of his death, the Motor Pool was woefully understaffed, inadequately supervised and trained. It lacked the appropriate procedures and equipment. The wholly unrealistic, expected-life of the police fleet exacerbated the Motor Pool's shortcomings. Expansion of the fleet in the years prior to Officer Herring's death without a commensurate increase in the resources of the Motor Pool strains the belief of the Grand Jury.

At the same time, the City of Miami Police Department bore the primary responsibility for the safety of its officers and it let them down. It seems almost inconceivable that officer after officer would be placed in an imminently dangerous working environment, their patrol vehicle. Officers went to the hospital with carbon monoxide intoxication, their sergeants wrote reports, Risk Management paid the emergency room bill and that was the end of it. We are very concerned with the failure to follow up to see that Car 297 was properly repaired. It was totally insufficient

and inexcusable to rely on the Motor Pool to resolve the problem, especially when there was no communication with the Motor Pool. That it took the death of David Herring to prompt any remedial action attests to the seriousness of the problem.

V. RECOMMENDATIONS

As a result of the instant investigation and in light of the foregoing observations, the Grand Jury makes the following recommendations that should be adhered to by every fleet owner whether public or private.

A. Regarding the Fleet Management Division of GSA (formerly, the Motor Pool):

1. Assure staffing with competent supervisory personnel.
2. Increase the number of qualified mechanics to acceptable national standards.
3. Adjust workshifts of mechanics to assure greatest productivity within constraints of resources available.
4. Establish and adhere to regular preventative maintenance schedules for all vehicles.
5. Establish uniform procedures and acquire the appropriate equipment for the analysis and repair of anything safety-related (brakes, tires, steering, exhaust, etc.) and provide checks and balances to insure safety-related defects are immediately corrected.
6. Provide repair histories to mechanics of all vechicles in for servicing.

7. Provide for continuing education for mechanics and supervisors.

B. Regarding the Miami Police Department:

1. Establish policies and procedures to ensure and encourage communication and access to command personnel.

2. Consolidate responsibility for all problems and issues involving the fleet in a competent Fleet Manager and provide adequate staffing.

3. Inform police personnel of the role of their Fleet Manager and his responsibility for resolving complaints about vehicles.

4. Assure that all injuries incurred by police personnel on duty be reported to the Chief of Police.

5. Establish appropriate procedures to insure that corrective action is taken in response to all safety-related complaints.

C. Regarding GSA and the Police Department jointly:

1. Establish an inter-departmental committee to maintain a current evaluation of the fleet, project retirement and replacement schedules for vehicles and coordinate budget submissions.

2. Assure equal access to all records concerning the fleet.

D. Regarding the Risk Management Department of the City of Miami:

Develop a system of reviewing claims involving recurring incidents of injury to City personnel.

The Grand Jury would be remiss if it failed to acknowledge the ameliorative measures taken by the City since Officer Herring's death. The purchase of new vehicles, the institution of a two-year replacement schedule and a take home program, the utilization of carbon monoxide detection equipment in the Motor Pool are all encouraging. However, it should not have required the loss of a human life to precipitate such measures. The Grand Jury can only wonder whether the past year's accomplishments have merely been an example of crisis management or reflect a real inprovement in the governing ability of the City of Miami. Hopefully the latter is the case and another tragedy is not waiting to happen.