EXHIBIT “A”
Requested Records re Marlon Osbourne

City of Philadelphia

Memo

To: Dr. Marlon Osbourne

From: Dr. Gary L. Collins

Date: 7/24/2012

Re: Findings of Homicide Autopsy Report Review

Reports were selected from the years 2009 – 2011 and include a variety of cases. The purposes of the review is to identify the presence of significant deficiencies and provide recommendations for future case management and report preparation in an attempt to insure that acceptable report preparation is performed on all reports in the future.

In the cases selected there were a few minor typographical and grammatical errors that will not be highlighted. However I would recommend that typographical and grammatical errors be kept to a minimum if at all present. The following cases had errors that I recommend better attention be paid to in the future to avoid making such occurrences.

1. Case 09-3835; cause of death: Delayed complication of gunshot wounds. The report reveals a discrepancy in the description between the surgery and trauma to the intestines and the liver. In addition in the internal examination the first paragraph lists 'chest wall and abdomen have no hemorrhagic injuries'. I recommend that for cases of this nature documentation of the presence or absence of bullets on radiologic evaluation be performed and documented. In addition the report should contain more details about the surgery or surgical intervention that you detected during your examination.
2. Case 09-4740; cause of death: Stab Wound to Chest. The end of the external examination contains the sentence 'The body has no external evidence of recent significant traumatic injury'. Considering the decedent died of a stab wound to chest this sentence is inaccurate. I recommend that if a template is used care must be taken to remove sentences or statements from the template that contradict the findings of the autopsy.
3. Case 10-1794; cause of death: Multiple Gunshot Wounds. The first paragraph from the internal examination states that some of the ribs have no fractures. My recommendation is similar to the recommendation for the case prior.
4. Case 10-111; cause of death: Blunt Force Head Trauma. This report did not include a description of the examination of the back to document the presence or absence of trauma. My recommendation is with blunt impact injuries an examination of the back may be beneficial and should be performed and the findings (present or absent) documented.
5. Case 10-2527; cause of death: Multiple Gunshot Wounds. The 'Findings and Opinions' sections of the report has Penetrating gunshot wound of back'. In the report it is listed as 'Penetrating gunshot wound to torso. The second error noted is the external examination describes no injuries to the scalp, lips or the tongue and back. However, there is injury to each of those locations. The trauma to torso documented bullet perforating the heart. There is no documentation of the presence of a hemothorax and the volume. The internal examination

mentions the internal pleural cavities contain no fluid. I recommend careful review of the report to ensure less discrepancy between the injuries and the internal examination.

6. Case 10-3727; cause of death: Gunshot Wounds to Head and Torso. The evidence of injury to the face and torso lack the findings associated to trauma such as hemothorax and pneumothorax. Such findings are beneficial in determining the mechanism of death. It is recommended that significant associated findings be included with the associated trauma / injuries. The autopsy photographs reveal an injury to the left side of the face below the nose and it is not documented in the report. I recommend that all significant findings be included in the report, especially if it is documented photographically.
7. Case 10-3757; cause of death: Multiple Blunt Impact Injuries. This report does not include documentation of examination of the back and cervical region, and no documentation of the presence or absence of cervical vertebral injury. In my opinion the trauma are relatively minor and does not clearly identify a definitive mechanism from an injury stand point such as large volume hemothorax and pneumothorax or surgical injury. My recommendation is that a thorough examination be performed to clearly identify an anatomic mechanism of death.
8. Case 10-4491; cause of death: Multiple Gunshot Wounds. This report was difficult to understand and interpret. There is no documentation of clothing or perforations to the clothing and no documentation of the presence of absence of gunpowder residue. Gunshot wound "D" of face has no documentation of associated findings. Gunshot wound of chest has no documentation of associated findings. Gunshot wounds of back the report does not state clearly whether it is left or right side of back or does not provide clear indication of the anatomic location. Gunshot wound 'X' and 'Y' also lack clear documentation of the location on the body. It is in my recommendation that cases of this nature where there are many wounds the description of each wound should be reviewed thoroughly and location on the body be made clear. The associated findings if significant or distinct should be described with each injury / trauma. There should be proper correlation between the injuries and internal examination.
9. Case 11-996; cause of death: Stab Wound to Chest. The first paragraph of the internal examination states that the chest wall has no injuries. The decedent received a stab wound to the chest. The therapeutic findings of the bilateral chest tubes were not mentioned in the report. In addition the findings associated with the stab wound were not clearly identified. Associated findings are important in documenting the mechanism of death.
10. Case 11-2634; cause of death: Stab Wound of Chest. The description of the anatomic location on the body can be more precise. Stab wound of right leg is actually a stab wound of right thigh. The wound to the chest lacks the depth of penetration. It is recommended that for all stab wounds a depth of penetration be included and the proper anatomic location stated for all wounds, stab wound or otherwise.
11. Case 11-2084; cause of death: Multiple stab Wounds. The examination lacks mention of the laparotomy scar. The wound depth could be clearer in the description of the stab wounds.

On a positive note I have noticed improvement in the overall style of the more recent autopsy reports for the cases that occurred later in 2011. It is my hope that this memo serves as a guide to help you produce accurate and precise documentation. Included with this memo is a copy of the Forensic Autopsy Performance Standard as prepared by the National Association of Medical Examiner's. Please do not hesitate to seek advice from myself or any of the pathologists, with any concerns you may have with your cases.

Please be advised that this will be the last informal coaching session regarding the quality of your reports and documentation. Any further serious inadequacies and or reprimands will be made in writing and followed with progressive disciplinary action.

cc. Dr. Sam Gulino
cc. File
Inclusions

CITY OF PHILADELPHIA

DEPARTMENT OF PUBLIC HEALTH
Donald F. Schwarz, MD, MPH
Deputy Mayor, Health & Opportunity
Health Commissioner

Nan Feyler, JD, MPH
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Memo

To: Dr. Marlon Osbourne

From: Dr. Gary L. Collins

Date: 8/31/2012

Re: Written Reprimand for Inaccurate/ Incomplete Autopsy Reports

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Dear Dr. Osbourne,

Due to a non-work-related injury you were granted an extended medical leave from June 28, 2012 until August 27, 2012. Prior to your being out on leave you, Dr. Gulino and myself had discussions about making sure all of your outstanding cases had the autopsy reports completed (whether the report was finalized or not). You assured us that all of your outstanding dictations would be completed prior to your absence. To ensure that the paper work was completed you were removed from the autopsy rotation to give you the necessary desk time to perform these duties. By the end of our discussion, you made it clear to us that your dictations would be complete.

It has been brought to my attention that seventeen cases were discovered to have either incomplete autopsy reports or inaccurate information contained therein. You did not complete the reports for the outstanding cases as you said that you would. Nor did you inform either of us of the incomplete reports so that we could make some arrangements to have the cases completed. It is important that you understand the Report of Autopsy is our primary product. Incomplete, inaccurate and or unnecessarily delayed reports can have significant impact on the families and agencies we serve.

In an attempt to complete the pending and unsigned cases that were left after you went out on medical leave, we discovered further errors and discrepancies, some of which were very severe and could have grave consequences for the family. There were four cases from 2012, one from March (12-0912), one from April (12-1528) and two from May (12-1829 and 12-1830) in which the causes of death were unpended in CME but the reports were not finalized and signed and turned over for review. As a result these cases could have been completed and death certificates sent out but they were delayed because you did not complete the case in its entirety.

During the review of your cases the following trends were observed:

1. You are not routinely describing postmortem changes (rigor, livor etc). Description of postmortem changes should be a routine component of all autopsy reports.

2. When completing the death certificate, item 28 ("Did tobacco contribute to death?') is not routinely filled in. All relevant items on the death certificate should be appropriately completed in all cases.

3. Lesions observed grossly for which a microscopic section is taken for diagnosis, should be described in the report. Case 12-2030 has a microscopic section of a liver lesion that was not mentioned in the description of the liver.

In the early part of 2012 you will recall we had coaching sessions on your homicides. During these sessions I highlighted the importance of proper and adequate documentation of examination findings. Following review of one of your multiple gunshot wounds homicide cases, it was noticed that you listed the clothing but made no mention of the presence of bullet holes or the presence or absence of soot or gunpowder. The main reason we examine the clothing is to look for the presence of bullet holes and gunfire residue, which should be documented in our reports. This case in question was 10-2773. As a result, you will review all of your gunshot wound homicides and the clothing (assuming the clothing is still available) to insure that proper documentation of the presence or absence of gunfire residue is made and the appropriate addendum be made to these reports. Additionally in our coaching sessions I highlighted the importance of complete and proper documentation and the need to proofread your reports to make sure that the documentation accurately reflects findings on the autopsy. This same case (10-2773) had errors in your description and interpretation of the gunshot wounds. For instance, you failed to mention specific features of some of the gunshot entrance wounds.

Even more serious and dangerous flaws in your work were evidenced in case 12-0316, which has been pending since January 2012. Review of the photographs and circumstances clearly shows that there is evidence of strangulation and that the manner of death is a Homicide. The autopsy photographs clearly show a ligature mark around the neck and petechiae of the eyes. Your report reads: "The conjunctiva has no petechiae". Your report describes blunt hemorrhage in the sternocleidomastoid muscle but does not describe another hemorrhage in what appears to be the sternothyroid muscle that is visible in photograph number six. Your report describes a retroperitoneal hematoma and states, "There is no trauma to the left kidney". However photograph eight clearly shows what appears to be a renal hilar laceration. Another poorly handled case is case number 12-1702. The autopsy was performed on April 25, 2012.

The cause of death is pending. The autopsy photographs show a large liver laceration and subcapsular hematoma. The rough notes that you made at the time of the autopsy shows that there was a lesion on the liver that you observed (and made a note of). However your report describes a normal liver and makes no mention of the liver laceration. Dr. Osbourne, these major discrepancies show an obvious lack of care for your work. Had these reports been reviewed and or handled appropriately, you would have been able to formulate opinions as to cause and manner of death much sooner. These long, overdue cases also show that you are not reviewing your cases and doing appropriate follow-up and evaluations of the cases in a timely manner. Coincidentally, for case 12-1702, I have received telephone inquiries from this family regarding the final cause and manner of death of their relative.

Considering that we have had discussions and numerous coaching sessions about the need to have accurate and timely preparation of reports this document serves as written reprimand for the deficiencies that you have displayed with your cases. Please be aware this recent poor performance will be reflected in your performance evaluation.

While you were off on leave, Dr. Gulino unpended and amended 13 cases and signed an additional 27 cases, for a total of 40 of your cases that were finalized in your absence. Of the 40 cases that were finalized, only 3 of those cases did not have the toxicology results completed for you to finalize the case before you went on leave.

You must make significant improvements to the accuracy and timeliness of your autopsy preparation and your turnaround time with regard to your all of your cases. Upon your return to work in August 2012, random detailed scrutiny of your reports will be made and closer attention will be paid to your turnaround time.

I believe you have the ability to be a great forensic pathologist. I have seen you do outstanding work on your cases in the past so I know that you can do it. If there is any reasonable way that I or the other members of staff can help you function at your best, we are willing to do so. However you have to be willing to do you part, to step up to the requirements of this profession. Failure to do so will result in further disciplinary action up to an including termination.

Gary L. Collins, M.D.

cc: Sam Gulino, MD
File

Sam Gulino

From: Sam Gulino
Sent: Monday, December 16, 2013 10:16 AM
To: Marlon Osbourne
Cc: Gary Collins
Subject: Lack of documentation

Importance: High

Marlon:

I was contacted by the Chief of Trauma Surgery at AEMC to let me know about a serious issue that occurred at their hospital with regard to a homicide victim. While I was gathering information about this, I learned that Chris had been notified of this matter several days ago and that he had notified you about it as the case doctor. However, I am discouraged to see that neither you nor Chris documented anything about this in CME. It is completely unacceptable that this important information was not recorded.

Furthermore, since the information provided was about a physician continuing to dissect and examine the body even after the person was dead, which may amount to evidence tampering, you should have recognized the need to notify me about this so that the issue could be referred to the DA's Office.

I expect you to take this case as an opportunity to rethink and improve your practices with regard to documentation.

Thank you.

spg

EXHIBIT “B”

Declaration of Lyndsey Emery MD PhD

DECLARATION OF LYNDSEY EMERY, M.D., Ph.D., PURSUANT TO 42 Pa.C.S. § 6206

I, Lyndsey Emery, declare of my own personal knowledge:

1. My name is Lyndsey Emery. I am an Assistant Medical Examiner at the Office of the Medical Examiner in Philadelphia, where I have worked since October, 2017.

2. On May 11, 2021, I gave testimony in a deposition in the matter of Greenberg v. Osbourne and City of Philadelphia Office of the Medical Examiner regarding my examination of a portion of the vertebral column, spinal cord, and brain of Ellen Greenberg on August 29, 2019.

3. When questioned about a sharp object wound to the back of the neck, I testified that ordinarily one would expect to see some hemorrhage around an area of injury.

4. There are several explanations for a lack of hemorrhage in an area of injury, including: that nothing was injured along the wound path to result in hemorrhage; that there was not enough survival interval for there to be reaction hemorrhage; that bleeding in other areas of the body prevented bleeding in this area; that the injury took place after death; and that there is artifactual absence of hemorrhage and/or artifactual presence of injury as a result of probing at the time of the autopsy.

5. The plaintiff's counsel did not ask me to elaborate on other possible explanations except for the possibility of injury occurring after her death. When questioned by the City's counsel about other explanations, I did not fully understand the scope of her question and did not offer additional explanations as I have outlined herein.

6. Hemorrhaging requires, at a minimum, an injury to a blood vessel, blood volume within that blood vessel, and some degree of blood pressure (or "pulse"). The absence of any of these factors (no vascular injury, decreased blood volume, and/or decreased blood pressure) could result in a lack of hemorrhage in an injured area.

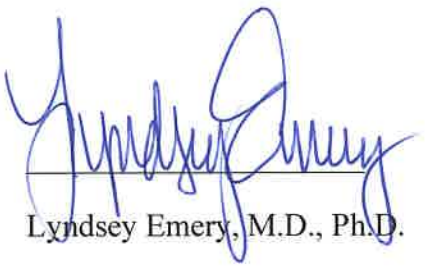
7. Furthermore, hemorrhaging can be affected by multiple additional factors, including: the sequence of injury or injuries; the presence of additional injuries; the characteristics of the wound (type, location, so forth); the position of the body; and the state of the person with injuries ("fight or flight", clotting problems, etc.).

8. It is not possible for me to determine which of these explanations given in paragraph 4 is most probable.

9. My examination was limited to a few portions of brain, a portion of the spinal cord, and a portion of the cervical vertebral column, and as I testified in my deposition, I formed no opinion as to the manner of death.

I hereby certify that the facts set forth above are true and correct to the best of my personal knowledge, subject to the penalties of 42 Pa. C.S. § 6206 for unsworn declarations.

Executed on this 10 day of June, 2021.



Lyndsey Emery, M.D., Ph.D.