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Forensic Science Oversight Board Meeting

June 20th, 2025

10am – 12pm

1. Roll Call
2. May Meeting Minutes
3. OCME Complaint – Follow up
4. Prior BORIM Complaint Discussion
5. Social Law Library Fact Pattern discussion
6. Topics not reasonably anticipated within 48 hours
7. Public Comment

Undersecretary Collins brought the meeting to order at 10:03am.

1. Roll Call

Forensic Science Oversight Board - Attendance		
Name	Present	Absent
Undersecretary Kerry Collins, Chair	X	
Sabra Jones, PhD		X
Dr. Robin Cotton	X	
Richard Lempert, PhD	X	
Gina Papagiorgakis	x	
Dr. Ann Marie Mires**	X	
Clifford Goodband	x	

- At the last meeting, the board discussed the complaint but felt more information was needed before deciding whether to proceed.
- Adrienne Lynch had been working on gathering that information.
- The Chair clarified that a formal motion by a board member is required to initiate an investigation, followed by discussion and a vote.
- Ms. McGee, the complainant, was present and will be given an opportunity to speak after the board discussion regarding the complaint.
- The board must draft and send a formal letter if it requires more information to consider opening an investigation.
- Ms. McGee had contacted EOPSS through Arielle and indicated she was willing to sign a waiver to release information, however, the board advised Ms. McGee to hold off on any action as her attorney had concerns about her signing the waiver. No investigation has been officially opened, only the complaint is currently before the board. The board emphasized the importance of not requesting or sharing information until a formal investigation is voted on and initiated. This approach is intended to protect the process and prevent the premature release of potentially sensitive information. Ann Marie and Judge Gertner, with help from Adrienne, were working on drafting a letter that is currently being reviewed at this meeting. The draft letter asks Ms. McGee if she would be willing to seek unsealing of her court records.
- Adrienne clarified that due to automatic sealing within 10 days, a waiver alone is insufficient. Ms. McGee would need to petition Norfolk Superior Court to lift the impoundment.
- If granted, the board could then obtain FTRs (trial audio recordings) and other relevant court records.
- There was uncertainty among members about whether a formal vote to initiate an investigation was required before requesting more information.
- The Chair clarified: A vote is required to proceed with a request for more information, even if it's preliminary.
- Because the board is independent from EOPSS, EOPSS cannot request or receive records without a clear vote and direction from the board.
- Lisa questioned whether the board could vote just to obtain preliminary information rather than formally opening an investigation.
- This could serve as an interim step if the board lacks enough information to commit to a full investigation.
- The Chair confirmed: Yes, the board may vote to request information as a preliminary step, and today's discussion is part of determining whether any member wants to make a motion to do that.
- The board is being asked to consider whether it is appropriate or within its jurisdiction to investigate the Office of the Chief Medical Examiner (OCME). A previous complaint involving the medical examiner's office was declined because the board determined the OCME was outside its purview. However, there was discussion about a potential loophole in the law—raising concerns over who, if anyone, oversees or investigates the OCME in such cases. This larger issue is part of the ongoing debate about the role and authority of the board and whether legislative clarification is needed (reference made to input from Senator Brownsberger).

- Adrienne commented that, in past investigations, the board had access to full transcripts and reports, which helped frame their understanding (e.g., the Essex case).
- She emphasized: The board may not have jurisdiction over medical examiners or medical opinions. Even if it did, it currently lacks the necessary information to evaluate the complaint. Without the unsealing of records, especially transcripts of expert testimony and information about cross-examinations, the board cannot meaningfully assess or define the scope of a potential investigation. A board member emphasized that without access to the sealed trial records, it's impossible to fully understand what happened or evaluate the substance of the complaint. In previous cases, legal counsel provided transcripts and additional context, which helped the board decide whether to investigate. In this case, records are impounded by operation of law, meaning the board does not currently have access to critical materials. It is suggested that a step-by-step approach, rather than rushing to a vote on opening an investigation. There was concern about the board's ability to evaluate medical opinions, especially given that it does not include medical professionals. It was questioned whether the board has the expertise or jurisdiction to assess medical determinations that relate to legal outcomes, like manslaughter charges. The board must know what it is investigating before making any decision to proceed.
- The Chair reminded the board about the discussion at the Social Law Library symposium with Senator Brownsberger who had discussed prior legislative efforts to include the Chief Medical Examiner (or designee) on this forensic science board. He had introduced two bills—one in 2013 and another in 2018—that specifically proposed adding a medical examiner seat to the board. When the Governor introduced the Criminal Justice Reform Act that ultimately created this board, a provision to include a medical examiner was proposed. However, that proposal was sent to study and did not pass, meaning the medical examiner role was never officially included. This legislative history was cited as relevant to the current discussion of whether this board has jurisdiction or authority over the Office of the Chief Medical Examiner (OCME). Adrienne's earlier point was echoed—that since no medical professionals sit on the board, it may lack the expertise to evaluate medical findings or testimony.
- Senator Brownsberger had originally proposed creating a board with robust investigatory powers, including:
 - The ability to compel testimony
 - The authority to require production of documents
 - The power to investigate professional negligence or misconduct, not only by forensic scientists, but also by attorneys and law enforcement
- However, the version of the bill that was ultimately enacted created a more limited body: A forensic policy board, rather than a full investigative agency. Its role focuses on reviewing broader forensic practices and systemic issues. It may examine reports and make policy recommendations, but it does not have the legal authority to conduct direct investigations into individual misconduct. This legislative background explains some of the current limitations in what the board can do—especially relevant when considering whether to investigate matters involving the Medical Examiner's Office.
- The Chair acknowledged that this may not be the appropriate venue for complaints involving medical examiners but emphasized this was not a directive—just advisory context.
- Board members were encouraged to discuss and decide for themselves, with Arielle available to provide legal/statutory guidance.

- Gina - After reviewing the limited documentation, she agreed with Adrienne that the issue seems centered on a medical opinion, rather than a matter of forensic science methodology. The complaint does not clearly involve scientific processes or techniques that the board is designed to review. This raises questions about whether the complaint falls within the board's scope, as defined by its statutory mandate. Ms. McGee's complaint (or her attorneys') raised concerns about possible misconduct or negligence. She referenced her work on Subsection E, which addresses such issues, and clarified that the Board does not currently have the authority to investigate allegations of individual misconduct or negligence. The recommendations made under Subsection E were meant to suggest how such complaints could be addressed—by labs or other entities—but not by the board directly. Given the board's current statutory makeup and authority, it likely cannot move forward with this complaint in a formal investigative capacity.
- Rick - expressed confusion around the board's jurisdiction, especially regarding the Office of the Chief Medical Examiner (OCME), it would be helpful to gather more information. If no agency (including the medical board) has authority over the OCME's courtroom testimony or practices, that represents a serious oversight or gap in accountability. There should be a resolution from this meeting to seek clarification—either to confirm the board's jurisdiction, or to recommend that another body be granted it. The Board has previously reviewed testimony from forensic scientists in court, and in that context, it's unclear why medical examiner testimony would be excluded. While the Board may lack authority to audit the OCME as an institution, it might still have a standing to evaluate courtroom testimony, especially if that testimony relates to forensic evidence. Some prior complaints involved scientific disputes (e.g., toxicology methods or screening vs. quantitation) that may not strictly require medical expertise, but rather scientific understanding but the need for clear confirmation and, if necessary, legislative or procedural adjustments to ensure someone has oversight over such issues in the future.
- The Chair explained the Medical-Legal Commission, and referenced the Massachusetts General Law Chapter 6, Section 184, is the body responsible for oversight of the Office of the Chief Medical Examiner (OCME) and the responsibilities of the commissions function that it is regulatory and administrative — not investigatory of case-specific misconduct or testimony.
- Lisa - The Medical-Legal Commission, despite its title, does not have investigatory authority, creating a large area of forensic science with no true independent oversight. The OCME has a documented history of problems, including scathing audits from national accrediting bodies. In contrast, the board has worked collaboratively and transparently with entities like the State Police Crime Lab and Boston Police Crime Lab, which has demonstrated the value of accountability. The board's statute does not explicitly prohibit investigating the OCME. As the board routinely reviews forensic testimony and scientific processes, members seek external expertise—which could also be done for medical-forensic topics. That lack of internal expertise is not a valid reason to decline review, as the board has navigated complex subjects without dedicated specialists before. There is a deep concern that excluding medical-legal investigations (e.g., cause and manner of death determinations in murder cases) from oversight undermines the integrity of the forensic system. It troubling that every other forensic discipline is held to standards of review and transparency except for the OCME, especially given the stakes involved in such cases. It is proposed that, if a majority of the board votes to assert jurisdiction, the onus would be on the OCME to challenge that authority. A request was made for a review of the Medical-Legal Commission's rules and regulations, as some of its members may not even have

voting rights, and the scope of its oversight remains unclear that the broader issue must be addressed in future board discussions.

- The Chair asked in reference to “scathing audits” of the Office of the Chief Medical Examiner (OCME), that they should identify specifically what audits are cited, as the current OCME, under Dr. Mindy Hull, has not been subject to that level of criticism.
- Lisa emphasized that since Dr. Hull took over, the office has been consistently and robustly accredited, and that the prior negative audits predated the formation of the current Forensic Science Oversight Board. The question remains not about whether the OCME is currently functioning well, but whether it, like other forensic institutions, should be subject to the same independent oversight structure.
- The Chair reiterated that this board is not the appropriate forum for handling oversight of the Medical Examiner’s Office, not intending discourage open dialogue on the issue. The goal was to ensure that all members and the public clearly understand their position—that this board may not be the correct venue for such matters, regardless of their importance.
- Ann Marie - The Board of Registration in Medicine (BORIM) has already weighed in on the medical issues in question. This board (the Forensic Science Oversight Board) should not adjudicate medical matters and should defer to BORIM and medical experts on those topics. However, this complaint also raises questions about the delivery of forensic services, including: The integrity of expert testimony. Training, protocols, and ethics. Whether the information presented in court by the Medical Examiner’s Office reflects appropriate scientific practice. I agree with prior comments (from Lisa and Rick) that this is a separate issue from traditional medical judgment and therefore could still fall under this board’s scope—depending on the details. This was part of the motivation for a proposed legislative referral letter, to clarify jurisdiction across agencies.
- Lucy - Was the complaint formally reviewed by the Board of Registration in Medicine? (It has been submitted there and is currently pending.) There is concern about dual review by two boards simultaneously, suggesting it could be poor policy and confusing.
- Adrienne brought up the limitation of the Board of Registration in Medicine, that board typically oversees care involving living patients. This complaint involves a postmortem examination, so it’s unclear whether that board will ultimately act on it.

There was broad agreement that More information is needed before deciding how to proceed. It is currently unclear whether the complaint pertains to: A medical opinion (outside the board’s scope), or the delivery of forensic services (potentially within scope). The challenge is that the complainant (Ms. McGee) does not control the relevant medical records, complicating how the board might obtain the necessary documentation to assess the claim.

- The Chair explained Medical Examiners (MEs) are licensed doctors who practice medicine by offering professional medical opinions, particularly in determining the cause and manner of death. The Board of Registration in Medicine (BORIM) has previously exercised oversight into the Office of the Chief Medical Examiner (OCME) in other complaints. In at least one past case, BORIM did not reject the case due to lack of jurisdiction; instead, they evaluated it and closed it based on the substance of the complaint, not a jurisdictional issue. BORIM does jurisdiction over all OCME has historically accepted and reviewed complaints against Medical Examiners. There is a previous BORIM decision involving the ME's office, where a complaint was reviewed and then closed after determining it did not warrant disciplinary action. It was suggested the board consider drafting a letter to legislators that would recommend that legislators clarify or address this gap in oversight through legislative action.
- Tim - This matter is outside the board's jurisdiction, and I strongly oppose the board venturing into medical territory. From extensive courtroom experience, I have consistently declined to give an opinion medical matters, especially in death-related cases, because of the high risk and complexity. On one hand, forensic pathology is indisputably a forensic science discipline — medicine applied within the criminal justice context — so oversight seems like it logically fits within your board's mission

It was proposed that without clear agreement on jurisdiction or statutory authority, the board risks overstepping the scope of the Board. It is suggested that consensus or legislative clarity before moving forward with individual complaints is the direction that should be considered. Clarify the scope of authority to ensure the board can confidently act on complaints.

In reference to the BORIM complaint Ann Marie had summarized for the Board the core question that she had. It sounds like the family's concerns shift from purely medical determinations — cause and manner of death — to how the medical examiner's office is handling case files, confidential information, communication with families, and internal behavior. That distinction might be crucial because:

Delivery of forensic services (handling evidence, confidentiality, case management, professional conduct) could squarely fall within the board's limit, as it relates to forensic integrity and service quality. Whereas medical opinions about cause and manner of death are probably more strictly within the domain of medical boards or specialized commissions. Do we have jurisdiction and should consider these service delivery issues. Is it a gray area needing legislative or regulatory clarification or do we dismiss for lack of jurisdiction. If it is a gray area, perhaps drafting a letter to the legislature or relevant oversight bodies would be a constructive next step — it shows due diligence and a proactive approach without overstepping our authority.

The Chair proposed the Board could frame what board's role should be regarding the medical examiner's office, especially considering that Miss McGee's complaint is already before BORM (Board of Registration in Medicine) and may be resolved by the next meeting in September.

The Chair acknowledged Ms. McGee would like to address the board.

Madam Chair, members of the oversight board, Your Honor if Judge Gertner is present, thank you for the opportunity to speak today. My goal is simple: to ensure that forensic misconduct does not continue unchecked. Five years ago, Dr. Rebecca Dietrich decided that it was not grounded in science, not supported by evidence, and driven by bias. Her misclassification of my ex-husband's manner of

death as homicide led to my wrongful indictment for involuntary manslaughter. I was forced into a five-year legal battle that ended with my acquittal on February 5th, 2025. Justice delayed is justice denied, and no verdict can restore what was taken from me. Massachusetts has seen firsthand the impact of forensic failures. Cases like the Annie Dookan and Sonja Farak crime lab scandals—where manipulated forensic results led to hundreds of overturned convictions—proved how unchecked forensic misconduct can ruin lives and undermine justice. Dr. Dietrich's failures fit the same tragic pattern. Forensic misconduct is not just about flawed conclusions; it is about the irreversible harm caused to innocent people. Because of Dr. Dietrich's reckless determination, I lost five years of my life fighting for justice. But the most devastating consequence was the loss of my son. When I was indicted, my former brothers-in-law took my 12-year-old son out of state, cutting me off from him for five years. I missed birthdays, milestones, and his entire high school experience. Last week, my son graduated from high school—I was not there to celebrate with him. I was forced to watch on YouTube TV, with no financial resources to hire an attorney. I represented myself in two state family courts—in Connecticut and Massachusetts—fighting alone to regain my parental rights. After five long years, I finally prevailed and saw my son again when he was 17. If I had been convicted, I could have lost 20 years—20 years for a crime I did not commit. Twenty years stolen from my son, my family, and my life. Dr. Dietrich's actions were not just improper—they were a fundamental betrayal of forensic integrity. The lack of standardized homicide classification protocols and oversight measures within the Office of the Chief Medical Examiner allowed forensic bias to lead directly to wrongful prosecution.

I respectfully urge this board to conduct a formal investigation into Dr. Dietrich's forensic practices. Audit homicide classifications within the Office of the Chief Medical Examiner to identify patterns of misclassification. Implement stricter oversight measures to ensure forensic accountability. If no action is taken, if negligence is allowed to stand, then Massachusetts will remain a state where forensic misconduct is not just a mistake, but a sentence. That must not be allowed to happen.

The Chair acknowledged Mark Adams: Thank you for allowing me the opportunity to speak. I want to start by acknowledging the time and effort many of you have put into reading our complaint, and I appreciate the thoughtful debate that has taken place today. First and foremost, I want to be clear that I hold no personal animosity toward anyone in the Office of the Chief Medical Examiner (OCME). I respect the institution and understand that individuals are doing their jobs in their professional capacities. I also want to say that Secretary Collins has been respectful and professional in all our interactions, for which I'm grateful.

That said, I must take issue with the characterization of the OCME under Dr. Hull's leadership as being consistently strong or without controversy. The record does not support that. Multiple credible sources, including Representative Decker, media outlets like the Boston Herald, The Globe, and Channel 25—have documented a few serious scandals involving the OCME. These are not isolated complaints. In fact, two individuals were terminated during the relevant time, and the behavior that led to their firing caused severe harm to my wife, to me, and most tragically, to our children. I understand this board may not be the body to decide the cause and manner of my son's death—that's not what I'm asking. But what we are bringing forward relates to how those determinations were made and whether proper forensic procedures were followed. Mr. Adams went on to site expert testimonies including Dr. Barry Logan, Dr. Jones, Dr. Andrew, and Dr. Barbara Wolf, which were dismissed by the OCME. Mr. Adams would like is accountability from the OCME regarding their

actions. If this is not possible then perhaps, he may bring his concerns before those who can. Mr. Adams was muted as he went off topic.

The Chair encouraged Mr. Adams to submit a letter to the board outlining exactly what you would like the board to consider and close the discussion.

The Chair addressed the board:

- Should this board take up the issue of the methodology used by the Office of the Chief Medical Examiner (OCME)?
- Should we review the delivery of services provided by OCME?
- Is this something that more properly falls under the jurisdiction of the Medical-Legal Commission, which is charged with reviewing and approving those services?

5) Social Law Library

Fact pattern for The Social Law Library Presentation that is scheduled for December 3rd, involving DNA under fingernails and potentially latent fingerprints. The key focus is on transfer vs. direct deposition of DNA and how analysts are limited in what they can testify to—mainly inclusion/exclusion, not how or when DNA got there.

- Activity level propositions (e.g., transfer theories)
- Limits of forensic testimony
- Emerging national guidance, especially from NIST and the Texas Forensic Science Commission
- Potential inclusion of latent print testimony issues, based on new training insights

Perhaps replacing a bloodstain example in the fact pattern with a latent fingerprint issue, which may better reflect current forensic standards. Adrian and Lisa are asked to add a blurb about this.

For the symposium, Robin is confirmed as a presenter. You still need a DNA expert, but final expert selection depends on whether the focus will be DNA or fingerprints. Natalie suggested fingerprints might be the better direction. Experts will be lined up when the focus is finalized.

Next Steps:

- Finalize the title of the session
- Refine and finalize the fact pattern
- Develop and post pre-event materials (recordings, articles, etc.)
- Confirm and schedule additional expert speakers
- Prepare a focused, efficient agenda within the 90-minute format (presentation + discussion)

Topics Not Reasonably Anticipated:

Lisa and Adrienne met with Lynn Garcia from the Texas Forensic Science Commission, to discuss recent developments related to DNA activity level propositions, particularly in connection with the Tiffany Roy complaint and two new studies (including the Richardson case) published this week by Tim Kalafut and others. Lynn shared recent efforts in Texas to address the limits of DNA testimony, especially regarding activity level (how and when DNA was deposited).

Texas is:

1. Creating template language for lab reports that clearly state these limits.
2. Developing scripts/guidance to help analysts handle courtroom questions appropriately.

They propose inviting Lynn to speak at the September board meeting, along with possible experts from NIST and the Kansas City crime lab, to help guide the board's understanding and next steps—possibly adopting limiting language or developing training for lawyers and judges.

Lisa and Adrienne will follow up with Lynn for names and send them to Kathy.

Lisa received from Lynn Garcia a PDF and two additional recent studies related to activity level DNA assessments. These include articles from the *Journal of Forensic Sciences (JFS)*, 2025.

- o Titles include:
 - “Murder in Boston”
- “Murder in Austin”
- One report is part of an FYI or FSC document.
- Kathy will forward the articles to the board after the meeting
- Kathy will send out a poll regarding a September meeting date.

Meeting adjourned 12:03pm