THE IRE JOURNAL

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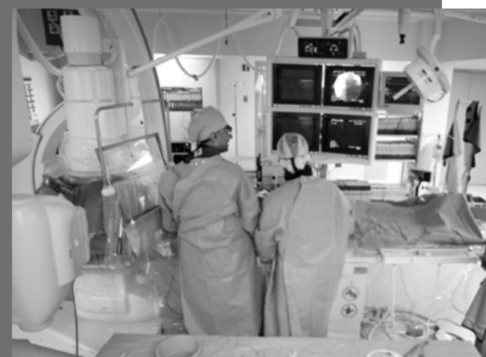

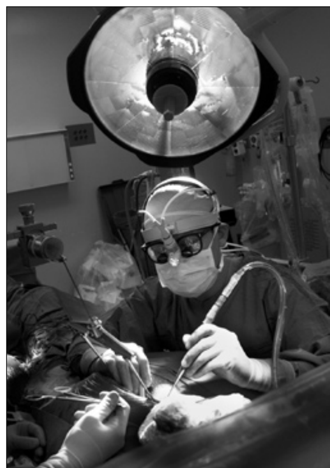

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FROM THE IRE OFFICES

Draconian security act means it's time to dig harder, deeper

BRANT HOUSTON

By now, you are probably aware of the Homeland Security Act that threatens to make secret – and keep secret – serious flaws in the critical infrastructure of the United States.

But it's well worth reading the act to get the depressing details. Under the act, any agency or employee can be prosecuted if they disclose information "related to the security of critical infrastructure or protected systems" that a private company has voluntarily submitted to the federal government. If convicted, the federal employee can be imprisoned up to a year and fined up to $5,000.

Sen. Patrick Leahy (D-Vt.) called the provision the "most severe weakening of the Freedom of Information Act in its 36-year history." Leahy said the provision hurts national security and frustrates enforcement of the laws that protect the public's health and safety.

The provision supersedes any state or local open records laws and exempts the new Department of Homeland Security from the Federal Advisory Committee Act. That law requires agencies to meet standards of openness and accountability. There is more, but you can check the entire act at the Library of Congress online site, http://thomas.loc.gov/. (For comments on the effect of the act, go to OMBWatch, a private nonprofit at www.ombwatch.org, and to The Reporter's Committee on Freedom of the Press at www.rcfp.org.)

Lessening accountability

This latest law represents a continuing effort by elected officials – both federal and local – to use concern over "security" to seal off government and business information from the public and to lessen accountability at a time it's needed most.

Long-time journalists Seymour Hersh and Bob Simon recently told a gathering of media lawyers that they have never been as worried as they are now about officials' efforts to withhold and/or control information.

But this only means that we the journalists must dig harder and deeper than ever.

A quick perusal of the archives of the IRE Resource Center reveals dozens of recent and important stories on this country's faulty infrastructure, corporate negligence, and the threats to public safety. Many stories are based on information and databases removed from the Web or closed to scrutiny in a panicked, ill-advised reaction to the Sept. 11 terrorist attacks. Among those stories are investigations into flawed airport security, unsafe dams, public health threats and exploding gas pipelines.

Nonetheless, we need to continue to pursue stories on safety and security. The latest closing down of information should encourage us to do more reporting – and better reporting – in the public interest.

Court of last resort

With the threat of prosecution always nearby, public employees probably will be less forthcoming and err on the side of denials of our requests for information. This means we will have to cultivate more sources, do more research and cross-reference more documents and databases to develop relevant and important stories. One of the reasons IRE has been co-sponsoring the Better Watchdog Workshops has been to increase local open records training.

Journalists are often called a "court of last resort" when it comes to government or business accountability. With the newest lockdowns on information, it looks like the court will have to be open longer hours.

Brant Houston is executive director of IRE and the National Institute for Computer-Assisted Reporting. He can be reached through e-mail at brant@ire.org or by calling 573-882-2042.

2003 Global Conference planned for Copenhagen

The second Global Investigative Journalism Conference organized by IRE and several European journalism organizations is set for May 1-4 in Copenhagen.

The conference will focus on outstanding stories done internationally, the latest journalistic techniques and the effect of media convergence on investigative journalism. One of its chief benefits: increasing the ability of reporters to cross borders in pursuit of the story. The event will include reporting panels, hands-on training in computer-assisted reporting and informal discussion groups.

The first conference, held in 2001, drew more than 300 journalists from 47 countries.

Complete details and registration forms can be found at www.ire.org/training/globalconference/

Watchdog Workshops adding sites for 2003

The Better Watchdog Workshop series, co-sponsored by IRE and the Society for Professional Journalists, continues to add new training sites.

The sessions teach journalists how to do investigative and enterprise reporting while on a beat and emphasize the use of freedom-of-information laws in the pursuit of these stories. The workshops specifically serve journalists from small- to medium-sized news organizations – from both print and broadcast. The SDX Foundation has helped underwrite most of the events, with additional support coming from press associations and local newsrooms.

Upcoming sites include:

Feb. 8 – Evanston, Ill.
Feb. 22 – Tempe, Ariz.
March 8 – Storrs, Conn.
March 22 – St. Petersburg, Fla.
March 28 – Minneapolis, Minn.
March 29 – Columbia, Mo.
April 5 – Cleveland, Ohio
April 5 – Atlanta, Ga.
April 12 – Spokane, Wash.
April 12 – Long Island, N.Y.
Oct. 4 – Eugene, Ore.
Oct. 25 – State College, Pa.

Visit www.ire.org/training/betterwatchdog/ for the latest additions and updates.

IRE members win big in annual SEJ awards

IRE members made an impressive showing in the Society of Environmental Journalists' 2002 awards, winning five of nine first-place prizes and several honorable mentions. The winners:

- Outstanding feature reporting, print: **Scott Streater**, *Pensacola News Journal*, for "Hidden Hazard: A look at our environment's effect on our health." Streater wrote about the investigation in the July-August 2002 issue of *The IRE Journal*.
- Outstanding deadline reporting, print: **Del Quentin Wilber** and a team of reporters at *The* (Baltimore) *Sun* for coverage of a tunnel fire in downtown Baltimore in July 2001.
- Outstanding series, print: **Ralph K.M. Haurwitz** and Jeff Nesmith, The *Austin American-Statesman*, for "Pipelines: The invisible danger," an investigation of a pipeline regulatory system that put lives at danger and spent little time enforcing the law.
- Outstanding program or series, broadcast: **Vince Patton** and Terry Renteria, KGW-Portland, Ore., for "Oregon's Changing Coast," an in-depth look at causes behind the shifting Northwest coastline.
- Outstanding small-market coverage, broadcast: **Heather King**, KOMU-Columbia, Mo., for "Herculaneum lead," a series on the high lead levels caused by an old smelter and the community that has been fighting the problem for decades.

CFIC director moves on; will continue to assist IRE

Aron Pilhofer, IRE's Campaign Finance Information Center director, has taken a job as database editor with the Center for Public Integrity in Washington, D.C.

Pilhofer will continue to work on IRE training efforts and will contribute articles on open-source software to *Uplink*, a newsletter by the National Institute for Computer-Assisted Reporting.

During his time at IRE, Pilhofer trained many community journalists, updated the campaignfinance.org Web site and helped fine-tune its two powerful search tools: the federal contracts database and the power search that allows political cash flow to be tracked across states.

MEMBER NEWS

Sonny Albarado moves to business editor of *The Commercial Appeal* in Memphis, after nearly 11 years as projects editor. ■ **Walt Bogdanich** has moved to assistant editor for *The New York Times* investigative unit. Bogdanich, who joined *The Times* as investigations editor for business stories, has worked on investigations for CBS's "60 Minutes," ABC News and *The Wall Street Journal*. ■ **Ron Chepesiuk** has been awarded a 10-month Fulbright grant as a visiting professor at Chittagong University in Bangladesh. Chepesiuk, who takes up his new post in January, will teach courses in feature writing and investigative journalism. ■ **Bob Greene**, who played an instrumental role in the founding of IRE, was awarded the Society of Professional Journalists' Lifetime Achievement Award. Greene, who just retired from Hofstra University and IRE's endowment committee, led a team of journalists in the Arizona Project, a 1977 series investigating corruption in Arizona. The series, prompted by the car-bombing death of IRE member Don Bolles, was one of IRE's defining moments. ■ **Reynolds Holding**, *San Francisco Chronicle*, received the Public Service Award from the northern California chapter of SPJ. Holding was honored for his series on how mandatory arbitration strips consumers of many legal rights. ■ **Walter Johns Jr.**, assistant managing editor of the *Houston Chronicle*, has been elected treasurer of Associated Press Managing Editors. ■ *Newsday* reporter **Thomas Maier** won the International Consortium for Investigative Journalists' 2002 award for outstanding international investigative reporting. Maier was recognized for his series on immigrant labor abuses, "Death on the job: Immigrants at risk." He explained how he reported the prize-winning story in the March-April 2002 issue of *The IRE Journal*. ■ **Patrick McDonnell** has moved from metro editor at the *El Paso Times*

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Send Member News items to Len Bruzzese at len@ire.org and include a phone number for verification.

CAR CONFERENCE
TO FEATURE BEGINNER TRACK

BY GINA BRAMUCCI
THE IRE JOURNAL

The 2003 Computer-Assisted Reporting Conference, slated for Charlotte, N.C., will introduce features for beginning and veteran CAR reporters, while highlighting some of the latest developments in the field.

The annual conference, co-hosted by *The Charlotte Observer* and NBC News, will be held at the Westin Charlotte in the heart of the financial district, and will run March 14-16, a Friday through a Sunday.

Conference organizers have more than 50 panels and workshops slated for Charlotte, and more than 50 hands-on sessions. An introductory track will span all three days for reporters who have little or no experience with CAR, while special sessions are planned for CAR experts. An added bonus this year: To ensure that no one misses a favorite panel, hands-on teaching sessions will be extended into the early evening.

Conference:
Annual Computer-Assisted Reporting Conference
March 14-16
Charlotte, N.C.
Westin Charlotte

Costs:
Registration: $150
(**students:** $100)
To attend, membership must be current. See www.ire.org/training/charlotte/ for latest details.

On Friday morning, the special beginner track will open with an overview of computer-assisted reporting stories and ways to use CAR techniques when just starting out. Most of these stories involve small datasets that are accessible on the Web, have been built by other reporters, or are slices of data that can be obtained quickly from the IRE and NICAR database library.

"These are great examples of manageable stories for someone just learning CAR," says Brant Houston, IRE's executive director.

Friday morning panels will discuss using CAR on some of the most frequently covered beats, including local government, education and crime; and in the afternoon, hands-on sessions will include training in spreadsheets for analyzing datasets on these beats and others.

"We also will focus on effective daily and beat uses of Census or other data in the opening sessions, before launching into hands-on training on Friday afternoon," Houston says. "In this first afternoon session we will concentrate on searching the Web for data and downloading it into spreadsheets."

The panel lineup for Saturday morning's beginner track will highlight stories in which journalists built their own databases and used database managers to do stories. Recent changes in campaign-finance coverage are just some of the many areas the panels will cover. On Sunday, panelists will talk about getting a story off the ground, offering story ideas journalists can tackle when they return to the newsroom.

Hands-on sessions for Saturday and Sunday afternoons will offer basic instruction in using database managers for stories, plus a walk-through of the overall CAR process – from importing a database to analysis to writing a lead.

Conference planners decided to offer advanced-level participants a special Thursday afternoon session, as well as early evening sessions. These sessions will be small roundtable discussions and workshops that will explore the latest in CAR, such as intranets, mapping and social network software. Some of the specific software to be covered includes Access, SQL Server, SAS, SPSS and mapping using ArcView. Experts will lead each of the advanced CAR sessions, which will be held in hands-on training rooms when necessary.

As always, this year's conference will have panels on specific beats and will showcase the best stories done over the past year.

"We also will have special sessions for editors working to manage CAR in their newsrooms," says Houston, "and on blending CAR with traditional investigative stories."

Gina Bramucci is a graduate student at the Missouri School of Journalism and an editorial intern for The IRE Journal.

MAPPING PROJECT EXPLORES RACIAL DISPARITY IN JURIES

By Mark Houser
(Pittsburgh) *Tribune-Review*

He usually doesn't count heads each time he enters a room, but when Reggie Flowers showed up for jury duty and glanced around at the other 87 people, he couldn't help but notice something.

He was the only black person present.

"I don't understand," he told me later. "It's supposed to be a cross-section of your community."

I, too, noticed it after a few weeks of visiting jury rooms. Though the Census shows 11 percent of Allegheny County's adult population is black, I found the typical criminal court jury room was only 4 percent black.

On the other hand, African-Armerican defendants far outnumber white ones, according to court records. Those defendants frequently have to trust a dozen white people to weigh their actions and decide their fates.

Juries clearly have an important function: They physically demonstrate the founding concept of American democracy that our government is of, by and for the people.

That's what they're supposed to do, anyway. But courtrooms in Pittsburgh, one prominent defense attorney said, look "like South Africa during apartheid."

What's going on?

In Pennsylvania, as in many other states, computers make random lists of potential jurors from voter registration and driver's license databases. Challenges to jury room imbalances in such systems, where there is no overt bias in picking possible jurors, have been struck down repeatedly in the state and federal courts. Rulings follow the U.S. Supreme Court, which has said that while the system may not discriminate, no defendant is guaranteed a racially representative jury or jury pool.

So just counting heads in the jury room wasn't good enough. I had to look at the system. Is it really random? Do blacks and whites have a reasonably equal chance of being called to jury duty?

For more detail on the computer-assisted reporting techniques used in this story, see the November-December 2002 issue of *Uplink*, a newsletter of the National Institute for Computer-Assisted Reporting. Find out how to subscribe at www.ire.org/store/periodicals.html.

The answer is no, and that conclusion was the centerpiece of a four-month (Pittsburgh) *Tribune-Review* investigative project, "A jury of peers?"

Flawed surveys

Pennsylvania's open records law is among the nation's worst, but this time I lucked out and got what I needed. The key public records I relied on were the jury arrays, the computerized daily lists of everyone summoned for jury duty, along with their addresses.

James Knox | Tribune-Review

Delvon Anderson, 38, was one of four black jurors in a group of 75 called to jury duty. "It would be better to look into things and see why it happens rather than just leave things as they are," Anderson said.

Using mapping software, I plotted the home

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Seeing things differently

The (Pittsburgh) *Tribune-Review* story "A jury of peers?" examined at a system that routinely overlooks blacks for jury service and how it threatens public trust in the courts.

The *Trib* did not examine whether all-white juries give black defendants harsher verdicts. For one thing, it would have required sifting through hundreds of trial records to get enough cases for a statistical analysis. Those records are often incomplete or contain errors.

Several trial records examined were missing the jurors' names, for instance, rendering them useless. And because those records don't record the race of jurors, it would have taken at least a dozen phone calls for every trial to find out for sure.

However, other researchers are studying how race affects verdicts. Their results probably won't surprise you.

Last year the University of Pennsylvania *Journal of Constitutional Law* published a study, "Death Sentencing in Black and White," showing how whites and blacks on juries often see things very differently. The study's authors relied on interviews with 1,155 jurors who served on 340 capital murder trials in 14 states.

The starkest differences came in cases where blacks were accused of killing whites. For instance, in such cases:

- The defendant got the death penalty 72 percent of the time when there were no black males on the jury, but only 38 percent of the time when at least one black male was on the jury.
- Only 8 percent of white jurors thought the defendant was sorry for the crime, but 44 percent of black jurors did.

The study is online at www.law.upenn.edu/journals/conlaw.

BOOKS OF 2002

BOOK-LENGTH INVESTIGATIONS RUN FROM PERSONALIZING ISSUES TO PROVIDING HISTORY LESSONS

By Steve Weinberg
The IRE Journal

Investigative books by journalists during 2002 featured lots of superb efforts by first-time authors. The veterans, however, held their own. Jimmy Breslin, keynote speaker at the 2002 IRE Annual Conference last June, wrote one of the best investigative books of the year: "The Short Sweet Dream of Eduardo Gutierrez."

Breslin is inextricably identified with New York City. Yet his books can transcend the Big Apple while still being of it. Breslin's expose of immigration law, worker safety, civil and criminal justice proceedings and corrupt politics is a tour de force.

Construction workers die every year. Some of them are immigrants who have entered the United States illegally. These workers, desperate to earn money to send to impoverished families back home, are hired easily. Their employers often care little, if at all, about obeying wage or hiring laws, assuming they will not get caught by investigators from the U.S. Labor Department or Immigration and Naturalization Service. Some employers care little, if at all, about workplace safety. They choose the cheapest construction materials and techniques, assuming they will not get caught by Occupational Safety and Health Administration inspectors.

So, when Eduardo Gutierrez, age 21, died in the November 1999 collapse of a building under construction in Brooklyn, there was no reason to think that anyone would much care,

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INVESTIGATIVE BOOKS OF 2002

Every year, Steve Weinberg does his best to compile this list for The IRE Journal. It consists of books of investigative or explanatory journalism, broadly defined, published for the first time during 2002, in the United States, in English. The authors are women and men who work primarily as journalists, and who are trying to reach general audiences through retail bookstore sales. If you know of a book unintentionally omitted from this list, please send an e-mail to Steve Weinberg at weinbergs@missouri.edu or by fax at 573-882-5431.

A

• Abramsky, Sasha
Hard Time Blues: How Politics Built a Prison Nation
(St. Martin's)

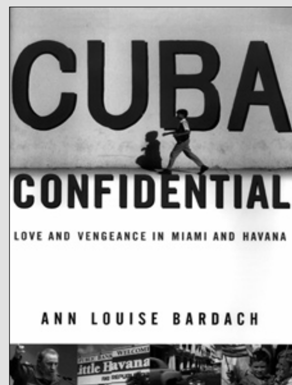
• Adair, Bill
The Mystery of Flight 427: Inside a Crash Investigation
(Smithsonian Institution Press)

• Allen, John L.
Conclave: The Politics, Personalities and Process of the Next Papal Election
(Doubleday)

• Anderson, Jon Lee
The Lion's Grave: Dispatches From Afghanistan
(Grove)

• Antilla, Susan
Tales From the Boom Boom Room: Women vs. Wall Street
(Bloomberg Press)

• Assael, Shaun
Sex, Lies and Headlocks: The Real Story of Vince McMahon and the World Wrestling Federation
(Crown)



B

• Bardach, Ann Louise
Cuba Confidential: Love and Vengeance in Miami and Havana
(Random House)

• Baskin, Yvonne
A Plague of Rats and Rubber Vines: The Growing Threat of Species Invasion
(Island/Shearwater)

• Beam, Alex
Gracefully Insane: The Rise and Fall of America's Premier Mental Hospital
(Public Affairs)

• Becker, Lisa Liberty
Net Prospect: The Courting Process of Women's College Basketball Recruiting
(Wish)

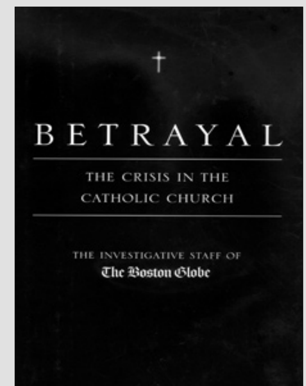
• Birkbeck, Matt
A Deadly Secret: The Strange Disappearance of Kathie Durst
(Berkley)

• Bledsoe, Jerry
Death by Journalism?: One Teacher's Encounter With Political Correctness
(Down Home Press)

• Blow, Richard
American Son: A Portrait of John F. Kennedy Jr.
(Holt)

• Blumenfeld, Laura
Revenge: A Story of Hope
(Simon & Schuster)

• Boot, Max
The Savage Wars of Peace: Small Wars and the Rise of American Power
(Basic Books)



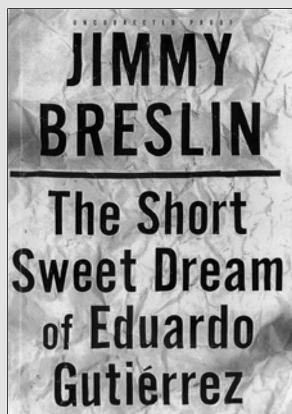
• Boston Globe team
Betrayal: The Crisis in the Catholic Church
(Little, Brown)

• Bowden, Charles
Down by the River: Drugs, Money, Murder and Family
(Simon & Schuster)

• Bowden, Mark
Finders Keepers: The Story of a Man Who Found $1 Million
(Atlantic Monthly Press)

INVESTIGATIVE BOOKS OF 2002

• Bradsher, Keith
High and Mighty: SUVs – the World's Most Dangerous Vehicles and How They Got That Way
(Public Affairs)



• Breslin, Jimmy
The Short Sweet Dream of Eduardo Gutierrez
(Crown)

• Bruni, Frank
Ambling Into History: The Unlikely Odyssey of George W. Bush
(HarperCollins)

• Bryant, Howard
Shut Out: A Story of Race and Baseball in Boston
(Routledge)

• Bryce, Robert
Pipe Dreams: Greed, Ego, Jealousy and the Death of Enron
(Public Affairs)

• Burnett, John S.
Dangerous Waters: Modern Piracy and Terror on the High Seas
(Dutton)

• Byron, Christopher
Martha Inc.
(Wiley)

C

• Campbell, Douglas A.
The Sea's Bitter Harvest
(Carroll & Graf)

• Campbell, Greg
Blood Diamonds: Tracing the Deadly Path of the World's Most Precious Stones
(Perseus)

• Caro, Robert
The Years of Lyndon Johnson: Master of the Senate
(Knopf)

• Carroll, Colleen
The New Faithful
(Loyola University Press)

• Celis, William
Battle Rock: The Struggle Over a One-Room School in America's Vanishing West
(Public Affairs)

• Clifford, Frank
The Backbone of the World: A Portrait of the Vanishing Way West Along the Continental Divide
(Broadway)

• Clifford, Hal
Downhill Slide: Why the Corporate Ski Industry Is Bad for Skiing, Ski Towns and the Environment
(Sierra Club Books)

• Cohen, Adam
The Perfect Store: Inside eBay
(Little, Brown)

• Conaway, James
The Far Side of Eden: The Ongoing Saga of Napa Valley
(Houghton Mifflin)

• Cose, Ellis
The Envy of the World: On Being a Black Man in America
(Washington Square)

• Crewdson, John
Science Fictions: A Scientific Mystery, a Massive Cover-up and the Dark Legacy of Robert Gallo
(Little, Brown)

• Crile, George
Charlie Wilson's War: The Extraordinary Story of the Largest Covert Operation in History – the Arming of the Mujahideen
(Atlantic Monthly Press)

D

• D'Orso, Michael
Plundering Paradise: The Hand of Man on the Galapagos Islands
(HarperCollins)

• Drew, Elizabeth
Citizen McCain
(Simon & Schuster)

• Drexler, Madeline
Secret Agents: The Menace of Emerging Infections
(Joseph Henry Press)

E

• Eskin, Blake
A Life in Pieces: The Making and Unmaking of Binjamin Wilkomirski
(Norton)

F

• Farrell, John A.
Tip O'Neill and the Democratic Century
(Little, Brown)

• Featherstone, Liza
Students Against Sweatshops
(Verso)

• Feinstein, John
The Punch: One Night, Two Lives and the Fight That Changed Basketball Forever
(Little, Brown)

• Fleeman, Michael
If I Die
(St. Martin's)

• Flynn, Sean
3000 Degrees: The True Story of a Deadly Fire and the Men Who Fought It
(Warner)

• Forrest, Brett
Long Bomb: How the XFL Became TV's Biggest Fiasco
(Crown)

• Francis, Eric
The Dartmouth Murders
(St. Martin's)

• Freeman, Gregory A.
Sailors to the End: The Deadly Fire on the USS Forrestal and the Heroes Who Fought It
(Morrow)

• Fried, Stephen
The New Rabbi: A Congregation Searches for Its Leader
(Bantam)

• Frump, Robert
Until the Sea Shall Free Them: Life, Death and Survival in the Merchant Marine
(Doubleday)

G

• Gantenbein, Douglas
A Season of Fire: Four Months on the Firelines of America's Forests
(Tarcher)

• Gavenas, Mary Lisa
Color Stories: Behind the Scenes of America's Billion-Dollar Beauty Industry
(Simon & Schuster)

• Gertz, Bill
Breakdown: How America's Intelligence Failures Led to Sept. 11
(Regnery)

• Gilbert, Elizabeth
The Last American Man
(Viking)

• Glatt, John
Cries in the Desert
(St. Martin's)

• Gonzalez, Juan
Fallout: The Environmental Consequences of the World Trade Center Collapse
(New Press)

• Graysmith, Robert
Zodiac Unmasked: The Identity of America's Most Elusive Serial Killer Revealed
(Berkley)

• Grossman, Elizabeth
Watershed: The Undamning of America
(Counterpoint)

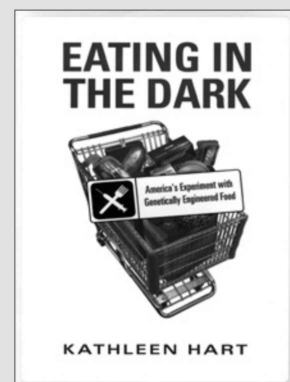
• Guinn, Jeff
Our Land Before We Die: The Proud Story of the Seminole Negro Indians
(Tarcher)

H

• Halberstam, David
Fire House
(Hyperion)

• Hallman, Tom
Sam: Boy Behind the Mask
(Putnam)

• Hancock, LynNell
Hands to Work: The Stories of Three Families Racing the Welfare Clock
(Morrow)



• Hart, Kathleen
Eating in the Dark: America's Experiment With Genetically Engineered Food
(Pantheon)

CONTINUED FROM PAGE 8

except his family and friends in San Matias Cuatchatyotla, Mexico — assuming they ever learned of his death.

Breslin cared, it turned out. He decided to use the nearly anonymous dead man as the centerpiece of a book. Breslin made it his job to learn about Gutierrez' maturation in San Matias, his decision to enter the United States illegally, his risky trek to New York City, his hiring by a disreputable builder, the building's collapse, and the criminal and civil inquiries that followed.

Along the way, Breslin introduces many other characters from San Matias, including the young woman, Silvia, whom Gutierrez loved. Her dangerous journey as a 15-year-old from central Mexico to her illegal hiring in College Station, Texas, constitutes the book's secondary plot.

When a seasoned reporter and fine stylist like Breslin decides to investigate a fresh topic, the result is often a model for younger journalists to follow. By concentrating on characters without offices, Breslin conveys how daily life is lived by the hard-working unfortunates too often invisible to journalists.

Cuba Confidential

Ann Louise Bardach has been concentrating her investigative skills on Cuba for the past decade, publishing primarily in *The New York Times* and *Vanity Fair* as a freelancer.

Her book-length investigation, "Cuba Confidential: Love and Vengeance in Miami and Havana," combines expose, gossip and straight news to explain the complexities of U.S. foreign policy close to home.

For decades, Cuba has seemed like old news to many readers. The equation looked so simple: Left-wing dictator Fidel Castro overthrew a right-wing dictatorship on the Caribbean island 43 years ago, the U.S. and Cuban governments have been at war ever since, Miami is filled with exiled Castro haters pandered to by American presidents of both parties, Castro is bound to die soon, and then everybody will see whether relations between the huge and small nations improve.

Bardach demonstrates that the equation is not so simple, and that Cuba is not really old news after all. She introduces family after family split asunder by U.S.-Cuba conflict, families such as the Medinas. Felipe Medina piloted deposed dictator Fulgencio Batista out of Cuba as Castro grabbed power. As Felipe left, his sister Abilia, a Castro revolutionary, said to a relative, "If we ever capture my brother and he is guilty, I want to be the one to send him to the firing squad." Felipe eventually settled in Miami. Abilia remained in Cuba. They never communicated.

Recently, however, Felipe's daughter Lilia decided to visit the island nation she could barely remember. With trepidation, she met her aunt Abilia for the first time. Felipe's name did not arise during the conversation — until the end. "How is my brother?" Abilia asked Lilia on the way out the door. Felipe was gravely ill. But before he died, he and Abilia exchanged letters that forged a belated

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INVESTIGATIVE BOOKS OF 2002

• Henry, Shannon
The Dinner Club: How the Masters of the Internet Universe Rode the Rise and Fall of the Greatest Boom in History
(Free Press)

• Herman, Marc
Searching for El Dorado: A Journey Into the South American Rain Forest on the Tail of the World's Largest Gold Rush
(Doubleday)

• Hertsgaard, Mark
The Eagle's Shadow: Why America Fascinates and Infuriates the World
(Farrar, Straus and Giroux)

• Hirsch, James S.
Riot and Remembrance: The Tulsa Race War and Its Legacy
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• Honigsbaum, Mark
The Fever Trail: In Search of the Cure for Malaria
(Farrar, Straus & Giroux)

J

• Jackson, Steve
No Stone Unturned: The Story of NecroSearch International
(Kensington)

• Jackson, Steve
Love Me to Death
(Pinnacle)

• Johnson, Sandra E.
Standing on Holy Ground: A Battle Against Hate Crime in the Deep South
(St. Martin's)

K

• Karam, Jana Abrams
Into the Breach: A Year of Life and Death With the EMS
(St. Martin's)

• Katz, Samuel M.
Relentless Pursuit: The Diplomatic Security Service and the Manhunt for al-Qaeda Terrorists
(Forge)

• Kessler, Ronald
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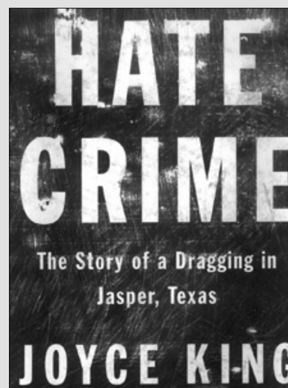
(St. Martin's)

• Kilian, Pamela
Barbara Bush: Matriarch of a Dynasty
(St. Martin's)

• King, Jeanne
Dead End: The Crime Story of the Decade – Murder, Incest and High-Tech Thievery
(M. Evans)



• King, Joyce
Hate Crime: The Story of a Dragging in Jasper, Texas
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Lone Patriot: The Short Career of an American Militiaman
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All the Men in the Sea: The Untold Story of One of the Greatest Rescues in History
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M

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Invasion: How America Still Welcomes Terrorists, Criminals and Other Foreign Menaces to Our Shores
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Nader: Crusader, Spoiler, Icon
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• Mathis, Deborah
Yet a Stranger: Why Black Americans Still Don't Feel at Home
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Bad Boy Ballmer: The Man Who Now Runs Microsoft
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Beyond the Mountains of the Damned: The War Inside Kosovo
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Blood Cold: Fame, Sex and Murder in Hollywood – the True Story of Robert Blake and Bonny Lee Bakley
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• McPhee, John
The Founding Fish
(Farrar, Straus and Giroux)

• McPhee, Michele
Mob Over Miami
(Onyx)

• Miller, G. Wayne
Men and Speed: A Wild Ride Through NASCAR's Breakout Season
(Public Affairs)

• Miller, John; Michael Stone and Chris Mitchell
The Cell: Inside the 9/11 Plot and Why the FBI and CIA Failed to Stop It
(Hyperion)

• Milton, Joyce
The Road to Malpsychia
(Encounter)

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Three Strides Before the Wire: The Dark and Beautiful World of Horse Racing
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Bamboozled at the Revolution: How Big Media Lost Billions in the Battle for the Internet
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Passion for Islam: Shaping the Modern Middle East, the Egyptian Experience
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El Nino: Unlocking the Secrets of the Master Weathermaker
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• Nevins, Joseph
Operation Gatekeeper: The Rise of the 'Illegal Alien' and the Remaking of the U.S.-Mexico Boundary
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O

• Olsen, Jack
"I": The Creation of a Serial Killer
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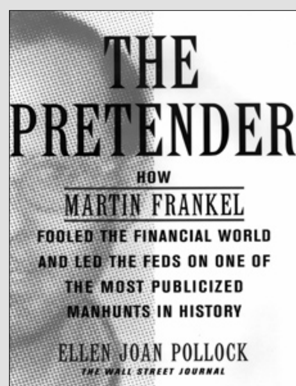
• O'Neill, Gerard, and Dick Lehr
The Underboss: The Rise and Fall of a Mafia Family
(Public Affairs)

P

• Palast, Greg
The Best Democracy Money Can Buy: An Investigative Reporter Exposes the Truth About Globalization, Corporate Cons, and High Finance Fraudsters
(Pluto)



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The Pretender: How Martin Frankel Fooled the Financial World and Led the Feds on One of the Most Publicized Manhunts in History
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Treason: How a Russian Spy Led an American Journalist to a U.S. Double Agent
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• Preston, Richard
The Demon in the Freezer
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The Other Face of America: Chronicle of the Immigrants Shaping Our Future
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Comic Wars: How Two Tycoons Battled Over the Marvel Comics Empire – and Both Lost
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Under the Knife
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• Rucker, Patrick Michael
This Troubled Land
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(Bloomsbury)

S

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Loaded: A Misadventure on the Marijuana Trail
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Fighting Back: The War on Terrorism From Inside the Bush White House
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• Schwartz-Nobel, Loretta
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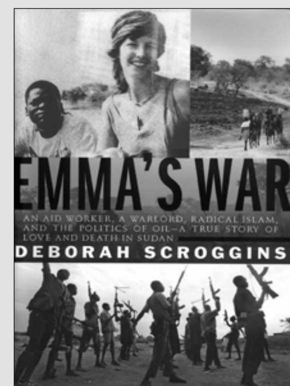
(HarperCollins)



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Emma's War: Love, Betrayal and Death in the Sudan
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The Spy Next Door: The Extraordinary Secret Life of Robert Philip Hanssen, the Most Damaging FBI Agent in U.S. History
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• Sheff, David,
China Dawn: The Story of a Technology and Business Revolution
(Harper Business)

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The Hungry Gene: The Science of Fat and the Future of Thin
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• Smith, Carlton
Death of a Doctor
(St. Martin's)

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All Girls: Single-Sex Education and Why It Matters
(Riverhead Books)

• Steinberg, Jacques
The Gatekeepers: A Premier College Admits a Freshman Class
(Viking)

• Stewart, James B.
The Heart of a Soldier: A Story of Love, Heroism and September 11
(Simon & Schuster)

INVESTIGATIVE BOOKS OF 2002

• Stille, Alexander
The Future of the Past
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• Stober, Dan; and Ian Hoffman
A Convenient Spy: Wen Ho Lee and the Politics of Nuclear Espionage
(Simon & Schuster)

• Stone, Amey, and Michael Brewster
King of Capital: Sandy Weill and the Making of Citigroup
(Wiley)

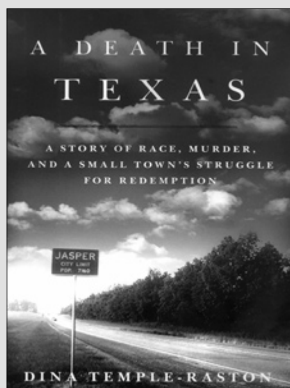
• Stratton, W.K.
Backyard Brawl: Inside the Blood Feud Between Texas and Texas A&M
(Crown)

• Sullivan, Randall
Labyrinth: A Detective Investigates the Murders of Tupac Shakur and Notorious B.I.G, the Implication of Death Row Records' Suge Knight, and the Origins of the Los Angeles Police Scandal
(Atlantic Monthly Press)

T

• Takahashi, Dean
Opening the XBox: Inside Microsoft's Plan to Unleash an Entertainment Revolution
(Prima)

• Taylor, John
The Count and the Confession: A True Mystery
(Random House)



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A Death in Texas: A Story of Race, Murder and a Small Town's Struggle for Redemption
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What Happened to Johnnie Jordan: The Story of a Child Turning Violent
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V

• Viorst, Milton
What Shall I Do With This People? Jews and the Fractious Politics of Judaism
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• Vise, David A.
The Bureau and the Mole: The Unmasking of Robert Philip Hanssen, the Most Dangerous Double Agent in FBI History
(Atlantic Monthly Press)

W

• Walker, John Frederick
A Certain Curve of Horn: The Hundred-Year Quest for the Giant Sable Antelope of Angola
(Atlantic Monthly Press)

• Ward, Diane Raines
Water Wars: Drought, Flood, Folly, and the Politics of Thirst
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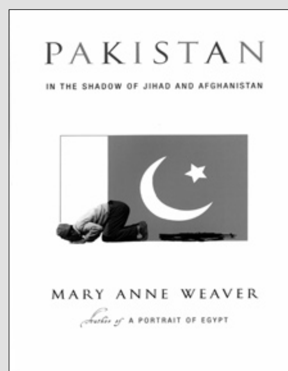

• Weaver, Mary Anne
Pakistan: In the Shadow of Jihad and Afghanistan
(Farrar, Straus and Giroux)

• Whitaker, Robert
Mad in America: Bad Science, Bad Medicine and the Enduring Mistreatment of the Mentally Ill
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• White, Emily
Fast Girls: Teenage Tribes and the Myth of the Slut
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• Wickelgren, Ingrid
The Gene Masters: How a New Breed of Scientific Entrepreneurs Raced for the Biggest Prize in Biology
(Times Books/Holt)

• Wise, David
Spy: The Inside Story of How the FBI's Robert Hanssen Betrayed America
(Random House)

• Wittes, Benjamin
Starr: A Reassessment
(Yale University Press)

• Wolff, Alexander
Big Game, Small World: A Basketball Adventure
(Warner)

• Wolman, William; and Anne Colamosca
The Great 401(K) Hoax: Why Your Family's Financial Security Is at Risk, and What You Can Do About It
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• Woodward, Bob
Bush at War
(Simon and Schuster)

• Worrall, Simon
The Poet and the Murderer
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• Wynter, Leon E.
American Skin: Pop Culture, Big Business and the End of White America
(Crown)

Y

• Yarsinske, Amy Waters
No One Left Behind: The Lt. Comdr. Michael Scott Speicher Story
(Dutton)

Z

• Zuckoff, Mitchell
Choosing Naia: A Family's Journey
(Beacon)

CONTINUED FROM PAGE 10

understanding.

"Cuba Confidential" is filled with such memorable anecdotes that derive from skillful reporting. Bardach is no slouch with documents, either, as her informative endnotes demonstrate. Those endnotes are worthy of study by journalists trying to pin down information across hostile national borders.

Presidential depth

What is probably the most important book of 2002 for investigative journalists is more of a historical reference work. That book is "The Years of Lyndon Johnson: Master of the Senate." It is volume three of what is expected to be a five-book biography of the former U.S. president, who died in 1973.

The author is Robert Caro, a former newspaper reporter for *Newsday* who has spent the past 30 years writing memorable investigative biographies. Caro's first was "The Power Broker," an expose of New York urban planner Robert Moses. The book is still in print because it holds lessons for every generation of journalists.

Caro, like Breslin, is a former IRE conference keynote speaker. The reporting that fills the 1,167 pages of volume three is, like always with Caro, mind-boggling in its thoroughness. As in the previous two volumes, however, the main reason for contemporary investigative journalists to read Caro is the writing style. Nobody tells a complicated, multi-layered story about the making of public policy better than Caro. He is a paragon of narrative.

Steve Weinberg is senior contributing editor to The IRE Journal and a former executive director of IRE.

BOOKS HELP ADD MATH TO REPORTERS' WRITING SKILLS

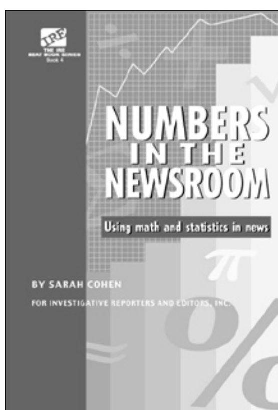
By Scott R. Maier
University of Oregon

In a focus group on newsroom use of math, a frazzled copy editor pleaded almost tearfully for a reference book she could consult on journalistic use of numbers just as she turns to the AP Stylebook for guidance on language. Fortunately, two excellent handbooks now provide a guide to the math that reporters and editors commonly encounter in their work.

Math Tools for Journalists by Kathleen Woodruff Wickham and Numbers in the Newsroom by Sarah Cohen are written on the premise that all journalists, despite their pervasive fear of numbers, need math to describe the complex world that the numbers represent. Both books seek to help take the terror out of reporting numbers by conveying math fundamentals in practical journalistic terms. Both emphasize basic math but are comprehensive in their reach. And both books draw on the authors' experience in the newsroom as well as in the classroom. In spite of their similarities, each differs in its approach to making math accessible to journalists.

In Math Tools for Journalists, Wickham notes that journalists should be able to perform basic math before they begin their basic writing courses, but many cannot because these skills were learned long ago and shunted aside. She says: "It's not that journalists can't do basic math. It's that journalists have forgotten how." To address this deficiency, Wickham starts with the most basic math – addition and subtraction – and covers increasingly complex topics ranging from percentage change to statistical analysis. For example, Wickham explains and demonstrates standard deviation in terms that journalists can understand. A former reporter who now teaches journalism at the University of Mississippi, Wickham has devised skill drills (with answers) that apply to math problems reporters confront. In addition, each chapter provides "Learning Challenges" – hands-on activities that take math lessons into the real world.

Math Tools for Journalists By Kathleen Woodruff Wickham (Oak Park, IL: Marion Street Press), 159 pages, $16.95



Numbers in the Newsroom: Using Math and Statistics in News, By Sarah Cohen (Columbia, MO: Investigative Reporters and Editors), 108 pages, $15 for IRE members

In Numbers in the Newsroom, Cohen seeks to show that skillful use of numbers requires journalistic sensibility. "Selecting the right number for just the right place in a story," Cohen says, "depends on the same news judgment you use in selecting just the right quote, anecdote or image." Rather than start with mathematical formulas, Cohen opens with the proposition that no number is perfect – at best, she says, a number offers a summary of the messy, breathing world that the figure depicts. By putting numbers "in their place," Cohen seeks to help tame the terror that numbers evoke in the newsroom. She offers non-mathematical tips for working with numbers (two of my favorites: "envision your dream number" and "gut-check" your numbers). But she also clearly and thoroughly covers the mathematics that journalists encounter, providing step-by-step instruction from calculating averages to margin of error.

While she gallantly emphasizes what journalists do right with numbers, Cohen provides "The 10 most wanted list" of common ways that journalists run afoul with numbers, including "The Mr. Spock Disease (false precision) and "Overcooking vegetables" (using an average of an average). Cohen, database editor at *The Washington Post*, worked as an economist for a decade before her journalism career began as a newspaper reporter. Among *IRE Journal* readers, Cohen perhaps is best known for the keen and good-natured instruction she provided as training director for Investigative Reporters and Editors.

Both books deserve a place in the newsroom, yet each serves a distinct purpose. Math Tools for Journalists may be most useful as a concise reference guide to basic math. However, dense with formulas and figures, reading Math Tools for Journalists could be numbing if not daunting to those who are wary of numbers. Numbers in the Newsroom excels at distilling mathematical formulas into conceptual forms that journalists can understand and readily use in their work. Numbers in the Newsroom encourages journalists to apply their interpretative skills to numbers – a notion likely to induce distress among those who simply want straight-forward rules to follow.

Personally, I keep both books in easy reach.

TEST YOURSELF

A math quiz for daily journalists by Arizona State University professor and IRE board member, Steve Doig, can be found at www.ire.org/education/math_test.html.

Scott R. Maier was a newspaper reporter for 20 years before joining the faculty at the University of Oregon, where he is an associate professor. His doctoral research at the University of North Carolina at Chapel Hill focused on numeracy in the newsroom. A version of this review was published in Newspaper Research Journal.

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Interviews with the Interviewers

Some journalists have a natural gift for interviewing. Others spend entire careers mastering the skills. During 2003, The IRE Journal presents the series "Interviews with the Interviewers." We have talked with some of the most renowned interviewers in investigative reporting. Focusing on a different style of interview each issue, we share their experiences, techniques and advice with you.

PART I

Dealing with sensitive issues

By Lori Luechtefeld
The IRE Journal

A young boy was raped and abused in a juvenile detention center. When he was released, Mary Hargrove of the *Arkansas Democrat-Gazette* took him to IHOP – the International House of Pancakes.

"He just wanted free-world food," she says.

When interviewing people on sensitive and traumatic issues, whether they are victims or family members of victims, their comfort level during the interview is crucial. In the case of this boy, he was comfortable at a pancake house.

Comfort is key in sensitive interviews because these encounters are like no other investigative interviews. Often the issues discussed in the interviews aren't the facts of the case. They're the emotions of the case. They're the real-life effects on real people. It's how a death, a rape, a scam or any other tragedy changes a person or a family.

As with any investigative piece, time is one of a journalist's greatest assets in conducting interviews on sensitive issues. Not only must subjects be comfortable in their surroundings, but with their interviewer as well. Before getting to the tough issues, Hargrove recommends talking about something easier. Talk about their families. Have them pull out photo albums.

Don't rush it

James Neff of *The Seattle Times* realized the importance of time while interviewing numerous rape victims for his book, "Unfinished Murder: The Capture of a Serial Rapist." The process was a slow one, and Neff waited until his second and third interviews with each victim before asking the hard questions.

One of the things that put the women most at ease was Neff's role as an investigative reporter. Before contacting the women, he met with a rape crisis counselor who was then able to vouch for his good intentions to the women before he interviewed them.

"A lot found it therapeutic to talk to someone who had talked to other rape survivors," Neff says.

Duff Wilson of *The Seattle Times* also found that a slow, many-step interview process was important in establishing trust. While investigating patient deaths at the Fred Hutchinson Cancer Research Center, he had to contact family members of patients who had died 15 years earlier. In this case, the sensitive aspect was not the family's fresh grief, but reopening old wounds. Giving family members time to digest what he was telling them was important.

In his initial phone calls, he introduced himself to the families, told them how he had found them and told them that he was investigating the institution at which their loved ones died. The people on the other end of the line were always surprised. They thought their family members had been provided the best care possible.

Wilson acknowledged that he was catching these families completely off-guard. Between his first and second calls, he sent the families letters that detailed his investigation as well as a few documents demonstrating the facts he was uncovering. By the second call, the families were better prepared to talk.

Define motivation

When dealing with tragedies such as these, people often are reluctant to speak with the press. Journalists often hear the angry comment "You only want to sell newspapers."

Hargrove knows this reaction well. She responds by saying "I'm sorry I'm intruding, but..." It is then up to her to explain why her investigation is important enough to merit interrupting the person's grief. Often it helps to find a friend of the person through whom to communicate with the family.

The greatest motivation families of victims

Staton Breidenthal | Arkansas Democrat-Gazette

Mary Hargrove talks about a recent story with several Democrat-Gazette reporters.

often have to speak to journalists is the prospect of preventing similar tragedies.

"Help them help it mean something," says Mike McGraw of *The Kansas City Star*.

Hargrove agrees. "Ask them, 'What can other parents do?' That gives them a purpose."

When interviewing victims for an investigative piece, it is important for journalists to remember that their subjects already have been through a terrible ordeal.

"Tell them you aren't there to victimize them further," says Valeri Williams of WFAA-Dallas. It is important that they know there is no right or wrong answer. You are dealing with how their lives have changed, not grilling them.

The most important thing, Williams says, is not to embarrass your source. The journalist is not there to cattle-prod emotions out of a subject for the sheer sake of drama.

When interviewing subjects about sensitive topics on camera, Williams tells the sources where she will take the interview, but doesn't tell them her exact questions.

"I hate practice interviews," Williams says. "They sound practiced."

"What viewing audiences want is genuineness," Williams says. Sometimes this might be tears, sometimes anger. Good questions will elicit these things naturally.

Journalists must be prepared to deal with the raw emotions of others.

"When people cry, let them cry." Hargrove says. Don't stop them just because you feel uncomfortable. Always bring Kleenex.

The interviewing process not only taxes victims and families of victims emotionally; it taxes the journalist. During the course of many intense interviews, journalists often find it hard to insulate themselves from the emotions, sometimes falling into the role of what Neff calls "the vicarious victim."

"For me it was overwhelming," Neff says. "I got pretty raw."

"It's hard," Hargrove agrees. "I've cried through a number of interviews. It doesn't make me less professional."

Hargove says it's important for journalists not to lose their humanity in interviews. The first thing she does when interviewing someone about personal tragedy is offer condolences. She is surprised by how many reporters don't.

"We're human and so are they," she says. While working on her article "Tears in the Dark," a woman hugged Hargrove after their second interview.

"Of course I hugged her back," Hargrove says. "I don't initiate touching. I'm a reporter and I need to keep that distance. But being a reporter does not mean leaving my humanity at the door."

Despite these personal connections with subjects, there are limits to what a journalist can understand about a source's personal tragedy.

"You should never say 'I understand' or 'I know how you feel,'" says Joe Hight, managing editor of *The Daily Oklahoman* and executive committee member of the Dart Center for Journalism and Trauma. "You don't know how they feel. Everyone's an individual."

Hight offers more advice for journalists handling the stresses of interviewing victims in the 30-page booklet "Tragedies and Journalists," which he co-authored with Frank Smyth, a Dart Fellow and Washington representative of the Committee to Protect Journalists.

Although many techniques on interviewing can be learned, the most important one, says Hargrove, has to come naturally: genuine caring.

Age and experience are valuable in conducting sensitive interviews.

"If I didn't have children, this would be much tougher," Hargrove says. Her own life experiences often help her see what the heart of a story really is. Stories she wrote as a young reporter would be written much differently if she did them now, she says.

Another thing experience has taught Hargrove is to use caution when dealing with recent tragedies.

"If you arrive somewhere soon after a death, make sure the family isn't so in shock that they don't know what they're saying," Hargrove says.

As a young reporter, Hargrove covered the kidnapping of a young girl from a mall. The day the girl's body was found, her father called her sobbing hysterically, telling her what had happened.

The story ran.

Two days later, the father called Hargrove again to tell her the body had been found. He didn't remember his first phone call. He blew up when he discovered a story had already run. "Why did you have to do it so fast?" he wanted to know.

Dealing with tragedy

Single copies of "Tragedies and Journalists" are available without charge from the Dart Center. Send a note to the center at **info@dartcenter.org** to request a copy or for information on bulk orders.

Lori Luechtefeld is a graduate student at the Missouri School of Journalism and a magazine studies intern with The IRE Journal.

Better Watchdog Workshops

Investigative Reporting on the Beat

Investigative Reporters and Editors Inc. and the Society of Professional Journalists, with funding from the Sigma Delta Chi Foundation, have joined forces to offer a series of workshops focused on doing investigative reporting while covering a beat.

The workshops, specifically for journalists at small- to medium-sized news organizations and those in bureaus of larger organizations, will emphasize the use of freedom-of-information laws and address juggling a beat while producing investigative and enterprise pieces.

"You'll learn enough in the first 15 minutes to keep you busy for a month."
Kevin McGrath, *The Wichita Eagle*

Workshops are scheduled for:

Feb. 8 – Evanston, Ill.
Feb. 22 – Tempe, Ariz.
March 8 – Storrs, Conn.
March 22 – St. Petersburg, Fla.
March 28 – Minneapolis, Minn.
March 29 – Columbia, Mo.
April 5 – Cleveland, Ohio
April 5 – Atlanta, Ga.
April 12 – Spokane, Wash.
April 12 – Long Island, N.Y.
Oct. 4 – Eugene, Ore.
Oct. 25 – State College, Pa.

For more information, visit **www.ire.org/training/betterwatchdog**.

To request a workshop for your area, contact Executive Director Brant Houston at **brant@ire.org**.

Jurors

CONTINUED FROM PAGE 7

addresses of the 45,000 people summoned to serve on a county criminal jury in the previous 18 months.

From the 2000 Census, I knew the adult population of each municipality or Pittsburgh neighborhood. With these numbers, I came up with a "jury service rate" for about 150 municipalities and neighborhoods.

After that, the color patterns were clear.

Countywide, 44 of every 1,000 adults were called for criminal jury duty over the last year and a half. But in neighborhoods that were at least 98 percent white, an average of 53 jurors were called. In a few white neighborhoods it was 65 or more.

But in majority black neighborhoods, the average was 26. And not one of those neighborhoods had more than 31 jurors called per 1,000 adults.

In other words, people living in overwhelmingly white neighborhoods were twice as likely to be called for jury service, on average, as people living in black neighborhoods.

Call it what you want, but that's not random.

So what's wrong with the system? For one thing, flawed survey methods.

Think of it this way: If you wanted to do a residential telephone poll about the next election, what would happen if your pollsters only made weekday calls? Your respondents would be mostly homemakers and pensioners, and you'd miss most people who are employed.

If you wanted a broader picture, the pollsters would have to call back in the evening to catch the people who work during the day. If they didn't, if they only relied on the people who answered the first time, the survey sample wouldn't represent the public at large, and all the survey conclusions would be suspect.

The Allegheny County Jury Commission is making a similar mistake.

After it gets a random list of names from the rolls of voters and drivers, but before anyone is actually called for jury duty, the commission sends questionnaires to the potential jurors to see if they should be exempted or disqualified from duty for reasons like current military service, lack of U.S. citizenship or a criminal record.

A third of those forms never get a response. Many are returned to sender because the recipient has moved. The commission never tries to track down new addresses, because it gets back enough forms for its purposes. (The commission used to send out inspectors to track down nonrespondents, but those jobs were eliminated to cut costs.)

African Americans are less likely to own homes than whites, according to the Census. Renters move more often. That factor alone may go a long way toward explaining the disparity.

Also, statistics indicate black residents often work in low-wage jobs, the kind that don't pay employees for days missed for jury duty. Considering that the paltry $9 daily stipend the court pays won't even cover downtown parking, those people might be strongly inclined to ignore their questionnaires because they can't afford to serve. (Some states try to counter this by offering higher

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juror pay or requiring employers to pay jurors, but not Pennsylvania.)

There could be other explanations, but local records — such as driver's licenses — are either unavailable or too out-of-date to check. Recent Census Bureau election surveys show very little difference between black and white registration rates nationwide, so that explanation remains murky.

In any case, the daily parade of black defendants before white juries takes a toll on frustrated attorneys, concerned judges, jurors who worry they're part of an unfair system, defendants who think they've been railroaded and spectators who see their suspicions of institutionalized racism confirmed. Even if all-white juries are scrupulously fair to black defendants, the damage is done.

Lots of blacks and whites told the *Trib* they feared the system was stripping the courts of their legitimacy. A judge had even gone so far in one recent trial as to abandon randomness altogether, ordering attorneys to interview every minority in the room for jury selection before any whites.

Fixing the problem

Disillusionment and distrust crept up even in places I didn't expect it. One black man whose son was gunned down by another black man looked at the all-white jury judging his son's accused murderer and muttered, "I don't see none of his peers."

The *Trib's* package ran on a Sunday. On Monday, the district attorney called the jury commissioners and demanded they form a plan to fix the problem. He and another county official also met with black church leaders and asked them to speak to their congregations about the importance of jury duty. The NAACP got involved. A member of the state Senate judiciary committee vowed to introduce a resolution to study jury room racial imbalances in all 67 counties in Pennsylvania.

Meanwhile, a blue ribbon panel created by the Pennsylvania Supreme Court three years ago to look at racial bias in the justice system is gearing up to deliver its recommendations.

The chairman is the dean of a Pittsburgh law school. After reviewing our numbers, he told the *Trib* that the problems the newspaper detailed threaten to undermine the legitimacy of the courts and erode social order.

Mark Houser is an investigative reporter specializing in computer-assisted techniques for the Pittsburgh Tribune-Review.

FOI REPORT

Federal commission changing access rules to avoid FOIA guidelines

CHARLES DAVIS

A regulatory battle with huge implications for federal freedom of information is playing out in Washington, D.C., and – but for the energy trade press – no one is paying much attention. This bodes poorly for the Freedom of Information Act, as many access battles swirling around homeland security will take place not on the floor of Congress, but in dimly lit administrative proceedings where the mainstream press rarely treads.

In September, the Federal Energy Regulatory Commission unveiled a notice of proposed rulemaking restricting access to "critical energy infrastructure information" (CEII). In what would be the first such permanent action by a government agency, the commission said it makes little sense to continue handling document requests on pipelines, electric transmission networks and power plants through the FOIA. But rather than turn to Congress for a legislative solution, it unilaterally changed the rules to suit itself.

The new FERC rule departs from previous access policy in two significant ways. No. 1: it drops limits imposed on access to maps and other information revealing the location and routing of energy facilities, but extends other information restrictions still applicable to existing energy facilities to proposed facilities as well. No. 2: it designates a "CEII coordinator" to make decisions on information requests pursued outside the FOIA.

Tiered access

The proposal marks the first public manifestation of the post-Sept. 11 inquiries into what should and should not be available after the terrorist attacks. In effect, FERC has moved to a tiered system of public access. While anyone can request anything under the FOIA, the commission would withhold certain previously public information that it says is exempt from mandatory disclosure and would only make such information available to requesters who are deemed to have a "legitimate need" for it.

FERC stressed that the new category of selectively available information would consist only of information already exempt from disclosure under the FOIA, but the trend toward tiered access is hard to miss.

FERC argued that the act is not well-suited for requests about sensitive documents, because under FOIA the commission is not permitted to restrict what parties do with documents after they're released. The new guidelines allow FERC staff to limit what happens to energy project information after it is made available. For example, the commission could now demand a nondisclosure agreement to be signed by landowners, environmentalists or other likely recipients that would restrict how information is handled or shared following its release.

Cut through the regulatory language, and you have rules that essentially clear the way for the commission to override FOIA for certain document requests on pipelines, power plants and electric transmission networks.

The rules indicate that FERC now imposes access restrictions "to those who have a legitimate need for the information," and it intends to place the recipients "under an obligation to protect the information from disclosure." In other words, FERC decides who gets it and what they do with it.

A brief history lesson: the federal FOIA was enacted, in large part, to repudiate the widely hated Administrative Procedures Act of 1946, a deferential piece of legislation that gave agencies broad discretion in deciding what information to disclose, including the ability to make information available on a preferential basis. The FOIA was enacted to limit agency discretion regarding disclosure and to close the loopholes used to deny legitimate information to the public.

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Charles Davis is executive director of the Freedom of Information Center, an associate professor at the Missouri School of Journalism and a member of IRE's First Amendment task force.

PARENTS SURRENDER CHILDREN TO GAIN MENTAL HEALTH AID

BY JEREMY OLSON
OMAHA WORLD-HERALD

It was month eight of a 10-month investigation of Nebraska's child mental health care system and I still hadn't met the star of the series.

Drew, a 17-year-old state ward, had been confined to the state's rehabilitation and treatment center for boys – a juvenile jail, essentially. His state caretakers had decided early on not to let me see him, much less talk to him.

The mishandling of this boy's treatment for bipolar disorder was too remarkable – portraying so many of the system's failures – to let that be a hindrance. So I continued reporting anyway. The persistence would payoff, eventually.

The struggle to meet Drew exemplified what the team of *Omaha World-Herald* reporters faced as it examined a system that is so tight-lipped and protective that it's nearly impossible to judge how well it cares for mentally ill children.

Early reporting identified so many problems with the child mental health system that it was difficult to choose which ones would become the focus of our series:

- Parents surrendering custody of their children to the state as a last-resort way of getting them mental health treatment.
- Detention centers cluttered with mentally ill children but providing little or no treatment.
- A shortage of mental health experts that left family doctors practicing psychiatry or patients waiting months for an appointment. Many couldn't wait, instead ending up in emergency rooms, in crisis.

Even more difficult was getting past the stigma of mental illness enough to coax children and their parents to talk about these injustices.

The publication of "Trust Betrayed: Failing Our Mentally Ill Children" was the result of grunt-work reporting.

When we couldn't call sources, we wrote to them. When one doctor wouldn't talk, we called another. When state officials delayed providing data or protested the requests, we kept the pressure on, calling and e-mailing until they came through. When data wasn't available, we created our own surveys and research projects to quantify systemic problems.

While waiting to meet Drew, I interviewed and re-interviewed his mom, his grandparents, his brother, his sister, his attorneys and some of his therapists. I examined hundreds of records about his treatment, schooling and state care. I reviewed his old schoolwork, childhood drawings and letters he sent home from Kearney, Neb. I armed his mother with questions to ask him during one of her visits to him.

It wasn't enough for the narrative I aspired to write about the four years he spent in state custody, starting when he was 13.

This young man had been tossed from inpatient treatment programs to detention centers and back. His medications had been changed as if they were brands of toothpaste. He was sent home with inadequate follow-up support, and his downward spiral ended predictably with a manic confrontation with his mother and then confinement in a state facility geared for tough teens, not the mentally ill.

And all while the state administered his care. His older brother, by contrast, was never a ward of the state after being diagnosed years earlier as bipolar. He was treated at a single private facility, Boys Town. He succeeded in school, eventually enrolling in college to study engineering.

At the bare minimum, I wanted to ask Drew the ultimate cliché: How did this make you feel?

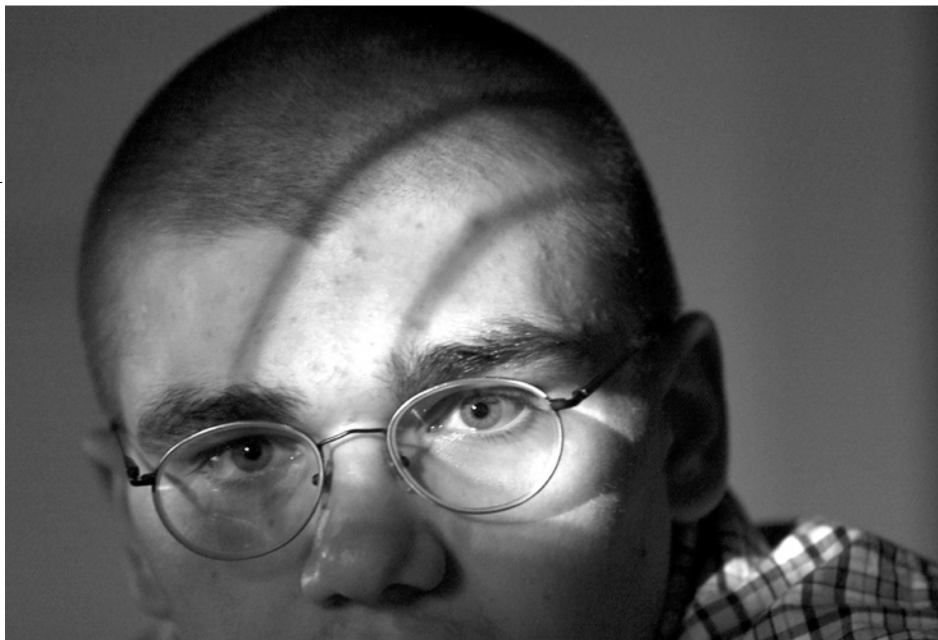
While the medical profession strenuously shields its patients' privacy, mental health agencies are even more protective. There are sound reasons for these barriers, but they also make it easier to conceal problems in the mental health system from public scrutiny.

It took months to build up trust with hospital leaders, psychiatrists and mental health advocates. We let them know exactly what we were doing, even if it was going to result in criticisms of their work. They opened up somewhat and introduced us to children and parents who decided on their own whether to tell their stories.

We had to be flexible and anticipate prob-

Kent Sievers | Omaha World-Herald

A child wrestles with his tutor, Joyce Rein, after he half-heartedly swung at her hand with a pencil.


Kent Sievers | Omaha World-Herald

Drew, 17, is shown during a home visit in Lincoln the night before going to Boys Town in Omaha. Nebraska is among the worst states in providing care for mentally ill youths.

lems from the start. Project editor Cate Folsom and the newsroom leadership decided early on that name issues wouldn't be an obstacle to good stories, which is why several stories include only first names of children and their families.

The payoff:

- Stories on the state's rehabilitation and treatment center for boys in Kearney, written by Robynn Tysver, contrasted the prevalence of mental illness among children there with the small amount of mental health care provided. They revealed Kearney's bastardized "peer culture" program, which allowed children to regulate other children, often by physical restraint. Gov. Mike Johanns at first defended the program, bolstered by information from his staff that other states still used peer culture. He changed his mind when further reporting by Tysver showed that none of those states used it anymore and that some thought it was an archaic, "Lord of the Flies" way to run a juvenile facility. He called for an end to the restraint system.
- The series inspired legislation. In particular, legislators were struck by the stories of parents forced to surrender custody of their children to the state because it was the only way to provide them with mental health care. Federal and state legislation has been proposed to address this issue, either by allowing children to enroll in Medicaid without becoming state wards or by compelling better private insurance coverage of mental health care.
- Other stories showed how children were being poorly placed in inappropriate levels of care, where they were doomed to fail, and how creative, community-based treatment in other states could be used in Nebraska. We also revealed he state's lack of data to track the progress of state wards. Computer-assisted reporter Joe Kolman helped expose these problems. A key to his work was his diligence, together with learning the terminology of the Nebraska Health and Human Services System. Leaders of the system were not going to volunteer information unless Kolman knew exactly what document or data source to request.
- My stories and others by Judith Nygren revealed the plights of mentally ill children and their families. Nygren's contrasted the success that one family had in getting help for their mentally ill child and the struggles of another family that was spiraling out of control even after years of involvement by public officials and mental health agencies. My story about Drew was told over four days and prompted dozens of calls from parents who had their own Drews at home.

"I don't feel so alone anymore," one mother wrote.

The break in our efforts to meet Drew came when his older brother, the Boys Town graduate, lobbied to get him moved from Kearney to Boys Town in Omaha.

Leaders at Boys Town were skeptical, given Drew's repeated failures in residential treatment. He was behind in school, too. But he wrote a sincere letter, asking to be accepted, which clinched his move.

On the trip to Omaha, Drew stopped to spend the night at his mother's house in Lincoln. From a reporting standpoint, it was the only chance to meet Drew, since Boys Town – like the state – has a closed-door policy, especially for state wards.

He agreed to share several hours with a reporter and photographer. Project photographer Kent Sievers was particularly relieved. He had created a series of gripping photos but had none of Drew.

Maybe Drew was as anxious to meet me as I was to meet him at that point. We played chess, his best game. We talked in the living room, with his mom, about the details of the previous four years, and then talked privately on the front porch about things he didn't want his mother to know.

Drew had grown much more self-assured than the child described in so many documents and interviews – the 13-year-old taken to a psychiatric hospital for the first time after making 30 long cuts on his arms with a razor blade.

He was no longer on psychotropic drugs and had suffered far fewer manic or depressive episodes, but the harm from being bounced around the mental health and juvenile justice systems was clear.

When we published the series, Drew disagreed with his characterization in an introductory story as being "sometimes violent" and worried the stories made him look like "damaged goods." He was the new guy at Boys Town, and his anxiety came in part from the fact that classmates now knew all about his past.

But he also hoped his participation in the series would make a difference. And some new friends reassured him they recognized his story in their own lives.

"I want other kids who think they're alone and think there's no hope for them in life to know that there are people who can help," he wrote to me after the series was published. "Even though the present may seem dark and frightening, there is always a light in the future. Don't stop looking for it, you will find it."

That last line applies to reporters covering mental-health care, too.

Jeremy Olson is the medical reporter for the Omaha World-Herald

BED-TO-BED INFECTIONS

Deadly germs spreading through nation's hospitals

By Michael J. Berens
Chicago Tribune

Even before the first death, doctors feared operating room No. 2.

A germ lived inside what was supposed to be the hospital's safest and most sterile place. For more than a year, the devastatingly swift predator infiltrated dozens of patients with infections, destroying bone and tissue.

Gloria Bonaffini, 71, was unaware that hospital germs had burrowed into the bodies of up to one in five Connecticut patients who passed through the room. She didn't know that room No. 2 was a place where dust sometimes littered the air because of faulty ventilation, where flies buzzed overhead during open heart surgery as some doctors wore germ-laden clothes from home into surgery, or failed to wash their hands.

She didn't learn any of these things before her death.

Nor do tens of thousands of patients who enter U.S. hospitals where the promise of clean and safe care has been undermined by widening cost-cutting measures and negligence.

But if so many people are unnecessarily dying or injured by germs inside hospitals — as detailed in a *Tribune* investigation, "Unhealthy Hospitals" — journalists might wonder why there appears to be scant evidence of this national crisis.

Last summer, the *Tribune* reported that in 2000, nearly three-quarters of deadly hospital-acquired infections — or about 75,000 — were preventable.

Specifically, deaths linked to hospital germs represent the fourth-leading cause of mortality among Americans, behind heart disease, cancer and strokes.

The pursuit of this story begins in the traditional trenches of journalism — court records, investigative reports

Continued on page 22

SURGERY, DEATH RATES

Analysis of statistics provides local picture

By Charlotte Huff
Fort Worth Star-Telegram

In 1995, the Texas Legislature passed a law requiring the collection of hospital death rates and other statistics for consumer report cards. Five years later, the hospitals were accused of stonewalling and there was no sign that the statistics would be published by the state or by anyone else.

The cost of the data needed to crunch the numbers was hefty: $4,000 for a year's worth. The *Star-Telegram* decided it was worth the investment, and bought the two years available, 1999 and 2000. The newspaper devoted three reporters, two editors, a photographer and several researchers and copy editors to the task of analyzing and reporting on the data.

In the end, the *Star-Telegram* was able to tell its readers which local hospitals had high death rates and which ones performed unnecessary surgeries. Our readers learned, for example, that:

- Nineteen hospitals in the Fort Worth/Dallas area had bypass programs, but only one met criteria set by researchers. They recommend that a hospital perform at least 500 bypasses annually to get the best results. Eleven of the hospitals didn't perform even 200 surgeries a year.
- The rate of Caesarean sections in the region ranged from 20 percent to 31 percent. Along the Texas/Mexico border it was even higher, more than 40 percent.
- A patient's chance of dying could vary widely depending on where they were hospitalized. A stroke patient's risk ranged from 2 percent to 16 percent. For pneumonia patients, the death rate ranged from 5 percent to 14 percent.

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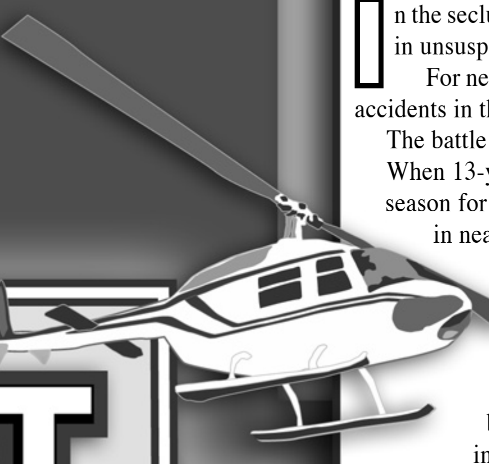

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CHOPPER WARS

Competition for patients becomes dangerous game

By Kirk Swauger
The (Johnstown) *Tribune-Democrat*

In the secluded serenity of the central Pennsylvania mountains, a medical helicopter war has placed accident victims in unsuspecting danger.

For nearly a decade, four helicopter providers often have ruthlessly fought to be the first at car crashes and other accidents in the Johnstown region. It is competition critics contend is driven solely by greed.

The battle climaxed in late 2001 outside a small country high school 15 miles east of Johnstown.

When 13-year-old Jeremy Weyant died after falling through a plate glass window while celebrating an undefeated season for the Chestnut Ridge Junior High football team, it was a tragedy that shattered the close-knit community in nearby Bedford County.

Little did anyone suspect his death may have been preventable.

A week or so later, during an interview on a completely unrelated story, I received a tip from a source that emergency room doctors at Conemaugh Hospital in Johnstown were outraged the boy was flown by helicopter to Pittsburgh, instead of being transported to Johnstown.

Conemaugh, the primary trauma center between Pittsburgh and Harrisburg, is just 10 minutes away by air from Chestnut Ridge. By contrast, it took a helicopter 38 minutes to reach Children's Hospital in Pittsburgh, a flight that wasted valuable time in what emergency personnel call the "golden hour" for

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VETERANS CARE

Records detail nation's treatment, oversight gaps

By Joan Mazzolini
The (Cleveland) *Plain Dealer*

When plastic surgeons at Cleveland Veterans Affairs Medical Center found infection spreading inside the belly of an elderly vet and called for assistance, they expected the hospital's top surgeon to enter the operating room.

Instead of Dr. John Raaf, they got a resident, a doctor in training. While the chief of surgery was scheduled to be at the VA for emergencies like Halver Durbin's, he was actually on the other side of University Circle about a mile away, at University Hospitals, operating on patients from his private medical practice.

It wasn't an aberration for Raaf. In fact, he had set up a routine that on Mondays and Fridays, when he was scheduled and paid by the VA, he actually was seeing private patients at University Hospitals. It was an open secret.

And it's happening at VA hospitals across the country.

The Plain Dealer produced a five-day series to detail how well – or poorly – VA hospitals care for the men and women who risked their lives in service to their country.

But the problems investigated continue: doctors not doing their jobs; unsupervised residents rotating in and out of the VA, leaving veterans' medical care postponed again; and death rates for open-heart surgery centers that would be unacceptable at any other hospital.

The VA, with more than 170 hospitals across the country, is the largest health care system in the nation. More than $19 billion of taxpayer dollars flow through them each year. But in some ways, I feel the hospitals are often ignored until a major foul-up becomes public.

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BED-TO-BED INFECTIONS

CONTINUED FROM PAGE 20

and interviews — and culminates in stacks of computer databases that were merged in creative ways.

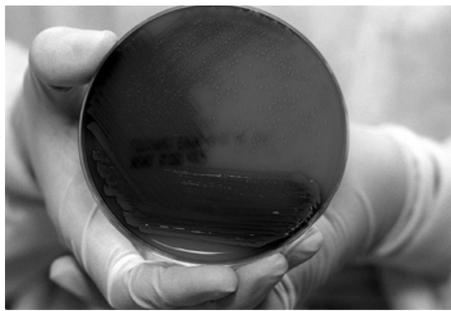
Bed to bed

In 1998, at least 31 Chicago children contracted flu-like infections and eight died as a microscopic invader snaked through a 93-bed long-term care medical center. The tragedy marked one of the city's most devastating infection outbreaks. Yet the Chicago Department of Public Health kept the deadly outbreak a secret from the public.

City employees, however, couldn't resist the temptation to write about the case for an obscure health care journal read typically by medical professionals. The article contained stunning details, such as how dozens of nurses routinely failed to wash their hands and how a dozen ill and feverish workers continued to provide care to healthy children as the germ spread bed to bed.

In hundreds of cases nationally, hospital infection rates can be gleaned from research reports even when the hospital refuses to provide current or historical data. You might be pleasantly surprised by the confessional tone of many reports. One doctor wrote about how a multinational pharmaceutical company, touting a new infection control drug, flew dozens of doctors to a Western U.S. resort lodge and lavished gifts and food on them.

Photos: Nancy Stone | Chicago Tribune



Above: A petri dish displaying an infection that will be tested for its DNA fingerprints. Northwestern Hospital is one of the few hospitals in the country that perform genetic typing so they can tell right away if they have an infection that is spreading in the hospital. They compare DNA fingerprints by hand to look for matches.

Right: In 1997, an infection killed four babies at Grace-Sinai Hospital in Detroit. Tracey Jones (left) gave birth to twins, a boy and a girl named Timothy and Tamia. Timothy, shown here on his father's lap, never contracted the infection but Tamia died from hers.

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INVESTIGATING YOUR LOCAL HOSPITAL

By Michael J. Berens

The two most useful documents for uncovering events inside hospitals are "survey" and "complaint" reports found in state and federal agencies.

Most states periodically survey hospitals for potential health and safety violations. State inspectors also investigate specific complaints filed by patients or others. The final investigative records are public in most states. A few, such as Colorado, even publish synopses on the Web.

Federal survey and complaint files also are public and can be obtained from the U.S. Department of Health and Human Services, the Centers for Medicare and Medicaid Services (CMS). The press office can be reached at 202-690-6145. Regional offices are listed at **www.hhs.gov/news/press2.html**.

Inspection reports are laced with rich anecdotal stories. Each incident is linked to a numerical violation code. Infection-related violations contain the prefix 250. For example, 250.1300 (b) designates a doctor who failed to wear a mask during surgery. However, always ask for the full report. Completed reports also include hospitals' "plan of correction," which typically disputes or confirms the allegations and outlines remedies.

Here are few inside tips:

- State employees under federal contract conduct most federal surveys. The quickest access to federal reports is through the state agency, which always keeps a copy. Federal officials are notorious for lethargic FOIA responses.

- HHS regional offices can provide a computerized list of all surveyed hospitals in your area. The list is useful in crafting FOI requests, as well as gauging how often hospitals in your area have been surveyed. There is a large disparity nationally, ranging from once a year to once every six years or more.

- Survey and investigative reports rely on a confidential document called the witness list, which includes identities and occupations of every person interviewed. The non-public document frequently can be obtained through court records, attorneys or patient advocates.

- Other records include workplace safety files from the Occupational Safety & Health Administration (OSHA), which can be searched by hospital name at **www.osha.gov/oshstats/**

- Additionally, the Food and Drug Administration (FDA) contains records on unsafe medical equipment, particularly reused and unclean medical devices linked to infections. The FDA also tracks the number of hospitals cited for Medicaid or Medicare fraud; those files can provide dozens of angles, including how hospitals performed unnecessary surgeries or fraudulently billed patients.

If you plan a similar investigation, pay special attention to papers or presentations delivered at medical conferences. At a conference early last year, an Alabama nurse set up a poster board display to show the path of a deadly germ in a nursery unit.

Research reports typically mask the name of hospitals. Simply find where the authors are employed; more times than not, the primary author is employed where the outbreak occurred.

One suggestion is to log research reports by date, location, hospital name, etc., into a spreadsheet. Do the same for state and federal hospital survey and complaint reports. And log every lawsuit involving an infection case. It's a lot of work, but the payoff is obvious. Cross-match the data to bring it all together.

For example, the *Tribune* found that three-quarters of the nation's 5,000-plus hospitals have been cited for significant cleanliness and sanitation violations since 1995.

Billing databases

For billing purposes, hospitals are required to create massive computer databases encompassing patient admissions. Details include personal information (age, sex, race), medical background (diagnosis and procedures), as well as financial data (how did the patient pay; how much was the bill). There are dozens of categories. Best of all, it's generally a public record.

The federal government keeps a national patient admission database called MEDPAR — the Medicare Provider Analysis and Review.

The Web downloads are partial files and subsets. You'll have to negotiate for the full database. MEDPAR encompasses all government-subsidized hospitalizations — about 60 percent of all hospital admissions.

Also, about 17 states maintain computer databases of every patient who is admitted to a hospital. These are the most valuable. For instance, the California database (costing $200) indicates if an ailment was hospital-acquired or already present when the patient was admitted.

Instead of purchasing it, an inexpensive alternative is to seek out private or university researchers who will share access to the database. Most will do it for free. This is a good strategy for getting a peek into MEDPAR, which is costly and time-consuming to obtain.

In essence, these are billing databases. Each record contains dozens of pieces of information, including a patient's age, sex, zip code, length of stay, hospital identification, diagnosis of

Nancy Stone | Chicago Tribune

Mindy, 8, helps her mother Debra Shore with her intravenous antibiotics used to fight an infection. Deaths linked to hospital infections represent the fourth leading cause of mortality among Americans.

major ailments, and procedures performed. The data allows you to track how many people were admitted through the emergency room, from a nursing home, even from prison. The data also designates whether the patient died.

The challenge is that medical information is listed as numerical codes known as ICD-9 and DRG codes. The Centers for Disease Control and Prevention offer a free CD listing these codes. Many Web sites provide free search engines, such as: http://within.dhfs.state.wi.us/cgi-bin/plookup

It's possible to concoct very specific analysis. For example, you can track patients who have undergone cardiac bypass surgery who later had their sternums removed because of post-surgery infection. Or, how many newborns developed pneumonia? How many joint-replacement surgeries later resulted in amputations from infections?

Coupling patient admission databases with hospital survey reports and investigations can yield many stories, such as how many patients died from infections during a time when a hospital was cited for shutting down its infection control department because of cost.

Investigating hospitals often requires a patchwork of paper records, computerized data and human sources. Individually, these sources can yield wonderful stories. Combined, they form a powerful spotlight to uncover the healthcare industry's darkest and most protected nooks.

Michael J. Berens is a project reporter for the Chicago Tribune.

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Centers for Disease Control and Prevention - National Center for Infectious Disease
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www.cdc.gov/ncidod

Medicare Provider Analysis and Review
The federal government's national patient admission database.
http://cms.hhs.gov/statistics/medpor

Medical dictionaries
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www.nlm.nih.gov/medlineplus/dictionaries.html

The Society for Healthcare Epidemiology of America
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www.shea-online.org/

Peter English portal site
Links to hundreds of communicable disease and health care sites worldwide.
www.fam-english.demon.co.uk/comdis.htm

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Go to main page, look for special reports in left margin. Free registration is required.
www.chicagotribune.com

SURGERY, DEATH RATES

CONTINUED FROM PAGE 20

Hospitals fight release

The project also explored data collection efforts in other states and showed how Texas has lagged in releasing information to consumers, in part because of efforts by hospitals.

We obtained confidential memos and documents showing repeated hospital efforts to slow the process behind the scenes. We used the state's public information laws to obtain figures on how many hospitals had been fined for refusing to release their information to the state.

We also reported on how the hospitals had successfully lobbied in 1999 for a change in the law to bar Texans from obtaining the types, or even the number, of complaints filed against their local hospitals.

The project took four months. Before we even got to the reporting, we made several key decisions involving which illnesses and treatments to study, as well as the best way to "risk adjust" the numbers to fairly account for differences in patient conditions.

The state was looking at 25 illnesses and treatments, but we decided to focus on nearly a dozen of the most common, including C-sections and heart bypasses.

We combined the 1999 and 2000 data because statisticians said the results would be more reliable, avoiding wide swings from year to year. And we broadened our analysis to include hospitals in nearby Dallas, knowing that some of our readers cross city lines for care.

Risk adjustment, a statistical method that lowers a hospital's death rates if its patients are older and sicker than normal, is always controversial. Statisticians frequently disagree on the best approach. Hospitals often will dispute any figure, saying that no analysis can fairly account for the complexities of medical care.

We decided to go with the method that also would be used by the state, developed by the federal Agency for Healthcare Research and Quality and Stanford University. We hired a professor to run the risk-adjustment program, written in SAS programming language, and analyzed the results ourselves.

Then we hit a snag. The Texas hospitals were the first to be analyzed with the federal computer program and they complained about some of its methods. The critics finally convinced federal officials and Stanford researchers to revise their approach. To eliminate any debate over the numbers, we waited for the new software, and then recalculated the statistics.

Even with all of our careful planning, some hospitals resisted commenting on the results, which we usually e-mailed to them. The 40-plus hospitals we studied rarely questioned the accuracy of our analysis. But they bristled at our plan to publish any statistics from the state's data before the state issued its first official report.

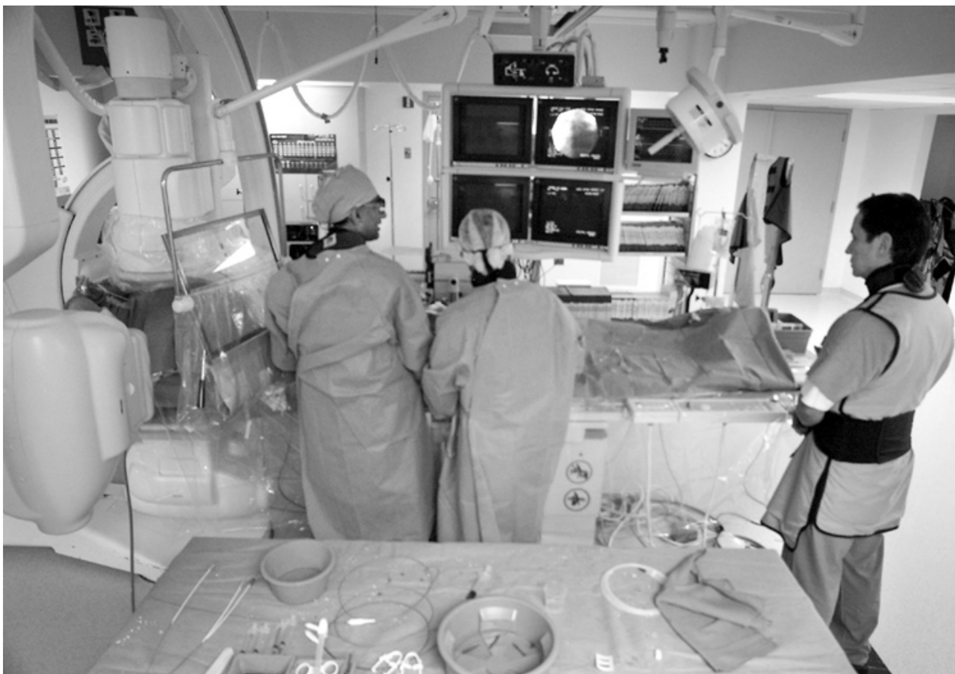
Varied reactions

Surprisingly, hospitals with poor results were often the most open. The facility with the highest heart bypass death rate in the area talked candidly about how it was modernizing techniques, cracking down on infection control and referring more high-risk patients to hospitals with larger programs.

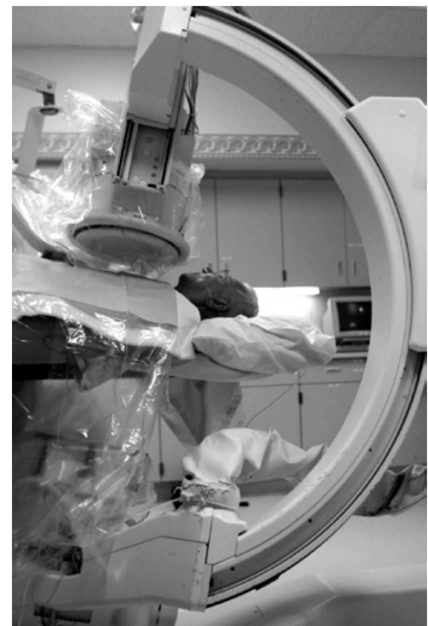
The two hospital systems that dominate the market had very different responses. One readily discussed its results and improvements that had been made. The other would only say that statistics are misleading and wouldn't discuss improvement efforts.

The death rates and other hospital results were published over two days. The feedback was overwhelmingly positive. The project was used in a local graduate studies class, consulted by researchers in other parts of the country and discussed by

Photos: Rodger Mallison | Fort Worth Star-Telegram



Medical personnel perform a heart catheterization at Baylor All Saints Medical Center. Nineteen hospitals in the Fort Worth/Dallas area had bypass programs, but only one met criteria set by researchers.



A patient is prepared for an arterial stint at Medical City Hospital in Dallas. An analysis found Texas lagged in releasing information to consumers, in part because of efforts by hospitals.

Rodger Mallison | Fort Worth Star-Telegram

Glenton Heidemann, 65, exercises in the cardiac rehabilitation unit of Osteopathic Medical Center of Texas.

floor nurses and doctors.

Some lessons we learned:

- Research your statistical method thoroughly before you start. Any method is subject to debate, so understand the strengths and weaknesses.
- Start early on collecting studies that look at the treatments you will be reviewing. Those studies not only will provide benchmarks so you know if your region is low or high compared with the national average but will help you find knowledgeable experts.
- Even before the numbers are ready, start building a list of medical experts. Many doctors will be reluctant to speak candidly about differences in care, so this will take time.
- Expect shades of gray. Not everyone agrees on the best medical treatment or how to define a worrisome death rate. For example, researchers worried for years that too many Caesarean sections were being performed. Today, the rate remains high, yet some doctors say even more surgeries should be done.

The Star-Telegram series "Vital Signs" was written by medical reporter Charlotte Huff, business reporter Trebor Banstetter and computer-assisted reporting specialist Jeff Claassen. Editors were Lois Norder and Kathy Vetter. Photographs were taken by Rodger Mallison. Stories were copy edited by Tim Sager, Scott Mitchell, Chris Borniger and John Forsyth. Steve Wilson designed the graphics. Sarah Huffstetler and Anne Burdette designed the pages. Brenda Edwards and Mary Jane O'Halloran helped with the research.

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The School of Journalism and Communication seeks to fill its Kiplinger Professorship in Public Affairs Journalism. The Kiplinger Professor mentors early- to mid-career journalists seeking a master's degree in Journalism and Communication at The Ohio State University. The Professor recruits Kiplinger fellows, teaches the Kiplinger Seminar in Public Affairs Journalism and additional courses consistent with the expertise of the Professor. As with other Professorial appointments, the Kiplinger Professor is expected to maintain an active program of scholarship or other creative work and to perform service to the School, College, University and professions in the field. The Kiplinger Professorship is a non-tenure track position, renewable up to three years.

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Review of applications will begin January 31, 2003. The Ohio State University is an equal opportunity-affirmative action employer and especially encourages applications from women, minorities, Vietnam-era veterans, and other individuals with disabilities.

CHOPPER WARS

CONTINUED FROM PAGE 21

saving lives.

Weyant died on the way.

Running with the tip, I contacted Dr. Lee Miller, director of trauma services at Conemaugh. The newspaper and Conemaugh doctors and administrators have had a contentious relationship for years, dating to the time the health system ousted its former CEO amid hundreds of job cuts.

Miller was surprisingly candid. He confirmed Conemaugh had filed a formal complaint surrounding the accident with Southern Alleghenies EMS, a subcontractor for the Pennsylvania Department of Health.

Had Weyant been transported to Johnstown, Miller contended, "the child would not have died in the back of a helicopter — that I can guarantee you.

"He may have gone on to die, but he would have died in the operating room with trauma surgeons and vascular surgeons trying to save his life."

By flying to Children's, the helicopter ignored state requirements that stipulate patients are to be transported to the nearest trauma center.

Probing questions

Because of Pennsylvania's skimpy right-to-know law, state health investigations typically are confidential.

Without a substantial paper trail to follow, the only way to piece together the story was through interviews with doctors, emergency dispatchers, paramedics and other sources developed over the years.

Their anecdotes about the problem were verifiable through police accounts and other public records, such as 911 reports and information at Southern Alleghenies EMS.

We soon found other examples of traffic accidents involving competition among choppers or late-arriving helicopters. When a van carrying Amish people crashed, Conemaugh sent helicopters even though they weren't dispatched.

Armed with that evidence, we were able to return to medical helicopter services with more probing questions.

It ignited a whirlwind of accusations and denials, reopening an issue I had probed seven years earlier in a five-part series, "Chopper Wars."

The helicopter service that transported Weyant to Pittsburgh, STAT MedEvac, soon launched an internal investigation into the case.

Emergency dispatchers from throughout the region confided the war between STAT MedEvac and Conemaugh had escalated to a dangerous level. At stake: millions of dollars.

Using figures obtained from the state health department, I found out that while medical helicopters themselves typically aren't money-makers, the nonprofit hospitals owning them benefit tremendously from the patients the choppers bring in.

> "Of the 26 calls in a year for a Conemaugh helicopter in Somerset County, the choppers were late 23 times, county 911 records indicated."

Specifically, hospitals in the Johnstown region charged an average of $38,983 to treat severe trauma cases in the region. For less serious injuries, they collected an average of $9,732.

"It's terribly scary," said Jill Miller, manager of Somerset Area Ambulance Association. "The more flights they get, the more money they make. But the fact still remains that it shouldn't be about dollars and cents, it should be about patient care."

The average cost of a helicopter transport is about $4,000, but could be more, depending on the distance. It costs about $650 an hour for fuel, crew, and maintenance costs.

"No institution makes money on helicopters, but they bring patients back to your facility and that's how you can pay for the helicopter," Conemaugh's Lee Miller said.

Promotional tool

As I probed deeper into the story, contacting doctors, emergency dispatchers and state officials, Conemaugh's altruism began to unravel. Its helicopters consistently were late in arriving at emergencies, rescue authorities declared.

And with money on the line, officials from two neighboring counties accused Conemaugh of intentionally providing misleading arrival times for its helicopters.

Of the 26 calls in a year for a Conemaugh helicopter in Somerset County, the choppers were late 23 times, county 911 records indicated.

Even more confusing, the two counties that complained most about Conemaugh subscribed to a free STAT MedEvac dispatching system, *The Tribune-Democrat* learned.

The Pittsburgh helicopter service dispatches all medical helicopters in Somerset and Bedford counties, including Conemaugh's and helicopters from the Maryland state police and West Virginia University.

Conemaugh officials claimed that the dispatching system is no more than a promotional tool for STAT MedEvac, while a STAT MedEvac official countered "it's the right thing to do. The last thing county 911 dispatchers want to be doing is helicopter shopping."

Based on *The Tribune-Democrat* investigation, emergency dispatch authorities from eight counties agreed to begin closely monitoring flight times.

The state, meanwhile, later exonerated STAT MedEvac in the death of the Bedford teen, saying the helicopter crew followed orders from a command physician in Pittsburgh.

Because the investigation exposed problems with Conemaugh's helicopters as well, Dr. Lee Miller, whose complaint triggered the probe, once again has quit speaking to me.

Interestingly, silence may be the most lasting impact of the series. Nearly a year after we published our stories, emergency dispatchers have reported no major life-or-death controversies surrounding the services.

Kirk Swauger is an investigative reporter who also covers City Hall for The Tribune-Democrat, where he has worked since 1988. Swauger won second place in the National Headliner Awards three years ago for spot news, and has earned numerous state and regional journalism awards.

VETERANS CARE

CONTINUED FROM PAGE 21

That's a shame. Because they are federal facilities, much information — data that would never be available at the public hospitals — is available through the Freedom of Information Act.

I requested from each of the VA hospitals a list of their doctors, their specialties, what departments they worked in, their salaries and whether they were full or part time. Included in that was their FTEE, or full-time equivalent status.

Because of that information, I knew, for example, that Raaf was a "seven-eighths" employee and paid more $114,000 a year to be at the VA 35 hours a week. With some good sources, I found that he had physically been in the operating room just 12 times during a year.

Other doctors stood out as well, including the director of orthopedic surgery who didn't do a single surgery in a year, and was in the operating room overseeing residents just 16 times.

While my best sources were in Cleveland, investigations by the VA's Office of Inspector General showed me this was a problem across the country.

I also did FOIA requests for every settlement and judgment against each VA for medical malpractice annually for five years. It didn't give me names, but did supply me with the month the settlement (which by law can't be sealed) or the verdict was rendered. That helped nail down the time period to search at the courthouse.

The FOIA request for the numbers of bypass surgeries performed by about 40 VA hospitals, death rates and all site-visit reports, yielded a ton of terrific information. I put the numbers into an Excel spreadsheet so I could sort them in different ways, such as the highest death rate to lowest or the least surgeries to most. I also computed the difference between the actual death rates versus the risk-adjusted rates, which I got with the FOIA.

First, it became clear that most VAs had death rates significantly higher than private hospitals, even when risk-adjusted for differences in patients. More than one-third of the veterans hospitals performing heart surgery didn't do at least 150 heart surgeries annually for five years, which is required by VA policy and what experts agree is the bare minimum necessary to ensure expert care. I also found that 10 cardiac centers were being "monitored" because of high patient death rates.

Second, the hospital inspection reports showed that even when the VA thought a program was doing a poor job and too many veterans were dying, it let the program stay open because the affiliated university hospital wanted it open for training programs.

The reports also detailed that the chiefs of cardiothoracic surgery at the university hospital knew the surgeons at the VA were substandard but let them operate on veterans anyway.

No one told the veterans, many of whom

Scott Shaw | The Plain Dealer

Terry Soles, shown here weeding his garden, died a few days after he was diagnosed with terminal cancer by emergency room doctors at a private hospital. He had lost more than 100 pounds over two years while VA residents looked for a cause.

TIMELY DATABASES FROM IRE

By Jeff Porter
The IRE Journal

The IRE and NICAR Database Library offers a growing collection of health-related databases that can spur or strengthen a local or national story:

- The **National Practitioner Databank** contains information about doctors and other health care practitioners who have had medical malpractice suits filed or adverse action taken against them. Although names are not included, some news organizations have been able to use this database with other public records to identify practitioners. This database includes information on malpractice payments and adverse licensure, clinical privileges and professional society membership.

- The **Manufacturer and User Facility Device Experience Database**, maintained by the Food and Drug Administration, includes medical devices that have failed, how they failed, and the manufacturer information. It includes information about injuries and deaths.

- The **AIDS Public Information Dataset** by the Centers for Disease Control and Prevention contains details about AIDS cases reported to state and local health departments since 1981. The CDC compiles this database every year and includes individual records for each AIDS patient and summary information by state, metropolitan area, mode of exposure to HIV, sex, race/ethnicity, age, and other details. Reporters can use this easy-to-analyze database to show local trends in AIDS cases.

- The FDA uses the **Adverse Event Reporting System** to flag safety issues and identify pharmaceuticals or therapeutic biological products (such as blood) for further epidemiological study. It may ultimately prompt regulatory responses such as drug labeling changes, letters to health care professionals, or market withdrawals. Adverse drug experiences include serious and unexpected consequences of human drug use, such as failure of "expected pharmacological action," as well as accidental or intentional overdoses or abuse. Journalists who have used this data recommend it to guide reporting on consumer medical issues, the FDA or the pharmaceutical industry.

- The Federal Election Commission's **Campaign Contributions Database** can help a journalist track how health-related companies seek political influence. The database consists of campaign contributions to candidates seeking federal offices, and those related to federal political action committees.

For more details about these and other databases, go to www.ire.org/datalibrary/databases/ or call the Database Library at 573-884-7711.

Jeff Porter is director of the IRE and NICAR Database Library.

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TAPPING RESOURCES, FINDING SOURCES

By Joan Mazzolini

In my investigation of veterans hospitals, I was able to detail other hospitals where the surgeons were rarely, if ever, in the operating rooms overseeing residents or simply operating on veterans in need. Some of the sources I used included:

- **www.va.gov/oig** is the VA Office of the Inspector General. Some of its reports are on the Web site, but others must be ordered, usually arriving after a few weeks or longer. I recently received a report more than a year after my request. Investigations often detail how long veterans waited for neurosurgery, cardiac care, orthopedic surgery, and other medical care.
- **www.va.gov** is the VA's Web site, and a great source of information. You can do searches on different topics.
- **www.gao.gov,** the Web site of the General Accounting Office, also offers helpful reports.
- A great place to go for information is your local federal courthouse. If a patient sues the VA, he first must file an administrative complaint. If that fails, he must file a federal lawsuit. While it's a little time-consuming to search for malpractice claims against the United States of America (because you also pick up the people who were injured by mail trucks, for example) it does get you the people you need to illustrate the story.

  For example, I was able to find Elizabeth Ann DeRousse's sad story through a federal lawsuit. A WWII veteran, she used the local VA, though her family wanted her to use Medicare.

  A neurosurgery resident quickly discovered an aneurysm in her brain, but he rotated back to the University of Kentucky before scheduling her surgery. (Residents usually rotate out after three months.) That happened one more time, but the third resident finally scheduled a surgery. Unfortunately, five days before her operation the aneurysm burst and she died.

  It had taken more than six months for her to get a surgery date.

Halver Durbin, shown here in a family photo, died three days after refusing more surgery at a VA hospital. When the chief of surgery was called to deal with an infection in his belly, a resident showed up instead. The chief was scheduled to work, but was operating on private patients.

could have gone to private hospitals under the Medicare program.

Other findings in the series included:

- Veterans hospitals have hired thousands of foreign doctors to care for the nation's elderly war vets, passing over qualified Americans in the process. And many of these foreign doctors were hired in part-time VA positions, with the remainder of their time spent at the better-paying university hospitals affiliated with the veterans hospitals. I looked into this issue after hearing complaints from older veterans that they couldn't understand their doctors or had other culture clashes. I used my list of all doctors at each VA, and also put in a FOIA request for a list of "logs" found at the VA headquarters showing individual hospital requests to hire foreign doctors. I also used the American Medical Association's site (www.ama-assn.org), which allows you to search for a doctor and see where the person went to medical school and did residency training. Once foreign doctors finish their residency training at hospitals across the country, U.S. immigration laws require they go home for two years before returning. But getting a full-time position at a veterans hospital gets you a waiver, as does getting a job in an area federally designated as medically underserved.
- The federal watchdogs overseeing veterans' health care in the Office of Inspector General are too understaffed to handle the 15,000 complaints that come in each year and have no real authority to order changes. The reports and inspections available at the OIG Web site, while providing a pretty good idea of the problems, also reveal the extent of OIG power. And it's pretty inadequate: Hospitals investigated last year often are found to have the same problems or deficiencies the OIG found five years ago.

Joan Mazzolini has been at The Plain Dealer for nearly 11 years. She has won a George Polk Award for medical reporting and is a past IRE winner. Her series, "In Harm's Way: Inside VA Hospitals," was a finalist for the IRE's FOI Award last year.

Scott Shaw | The Plain Dealer

Peter Melone, 73, is hospitalized for persistent problems with his amputated leg. A VA resident staffing the emergency department didn't catch his abdominal aneurysm in time.

ACCESSING HOSPITAL AND MEDICAL DATA

***The Plain Dealer's* Joan Mazzolini gave these tips on accessing hospital and medical data, as well as birth and death information, at the 2002 IRE Annual Conference in San Francisco:**

- **Hospital and medical data sources.** Check out state health departments: Nearly every state licenses hospitals, which means that facilities must collect data in certain areas. This is usually a gold mine, but may take a lot of asking.

  With diagnostic-related group data, patients are hospitalized under a particular diagnostic-related group, DRG, or type of illness. Insurance companies and Medicare pay the hospital according to the DRG code. States usually analyze this data and will give it to you. Stories drawn from this data might include looking at how long patients are hospitalized for a particular illness; most frequent causes of hospitalization; how much different hospitals charge for similar types of care; emergency room admissions; and outliers.

  While Ohio isn't one of the states that licenses hospitals, there is still some data available. For example, the state keeps information on how many open-heart surgeries are performed, as well as complication and death rates for each hospital. It does the same for heart catheterization, etc.

- **Death certificates.** These certificates are available in about 20 states. Contact your state health department or department of vital statistics. The records usually include the deceased's name, social security number, cause of death, time of death, place of death, occupation, age, race, sex, and whether there was a coroner's investigation and autopsy.

  To translate cause of death codes, you will need the International Classification of Diseases (ICD-9), ninth revision. This is available in a two-volume set of books from the World Health Organization, or on CD-ROM from the U.S. Department of Health and Human Services. For more information call the National Center for Health Statistics at 310-436-8500, or see http://wonder.cdc.gov/.

  The "wonder" site at the Centers for Disease Control also allows you to run searches for different causes of death in some states and the nation. For example, you can find how many of the children born to 12- to 14-year-old mothers in the past decade have died as infants.

  To double check on whether someone has died you can check the Social Security Web site:
  http://www.ancestry.com/search/rectype/vital/ssdi/main.htm

- **Birth certificates**. Like death certificates, birth certificates are available in about 20 states. Contact your state health department or department of vital statistics to find out if certificates are available in your state.

  The records usually include the date of birth, birthplace, child's sex, race, gestational age and weight. Records also show the ages of the mother and father, their race and education level, whether the mother had any medical problems during pregnancy or complications during labor (including a transfer to another hospital), the amount of prenatal care given, and method of delivery. Names of the babies and parents are often deleted for privacy reasons.

- **Administration records**. The Centers for Medicare and Medicaid Services, which has replaced the Health Care Financing Administration, maintains dozens of data files with information about patients who receive Medicare and Medicaid, and which hospitals, clinics, doctors and nursing homes provide services to them. For more information, visit http://cms.hhs.gov.

- **Listservs**. This is a helpful tool if you have the time and are looking for particular people. I used it when working on a transplant project and the VA project.

- **Getting the data**. Ask for:
  1. The data: On diskette or a CD, either as a DBF file or in fixed-width (ASCII). States have gotten more sophisticated and might ask if you want it in Excel or Access. You can convert them either way. Paper records are still good, but you have to do the importing.
  2. Record layout. This is the key or guide to the data, which might be given to you with no column heads.
  3. Cost: Some places still try to overcharge, but this is happening less frequently. The DRG data, for example, costs about $25 — a price that includes data on two diskettes plus shipping. The state tries to cover its costs, not to make money.

  Finally if someone is going to e-mail data to you, make sure your organization doesn't have a firewall that will stop it. The *Plain Dealer* does, so I have data e-mailed to my AOL account. Also, make a copy of the original data and leave the original alone. Manipulate the data on the copy.

Other tipsheets available through IRE

Also at the San Francisco conference, Valeri Williams of WFAA-Dallas/Fort Worth, and Natalya Shulyakovskaya, *The Orange County Register*, outlined documents and databases in the following tipsheets, available through the IRE Resource Center:

No. 1628: Natalya Shulyakovskaya, *The Orange County Register*, provides a tipsheet on databases that help compare doctors and hospitals, find hospital trends, and track down patients and victims of abuse or mistreatment

No. 1650: Valeri Williams, WFAA-Dallas/Fort Worth, gives a collection of document recommendations for any journalist looking into hospitals, malpractice or medical negligence.

Copies of these tipsheets and others related to medicine or hospitals are available from the IRE Resource Center by visiting www.ire.org/resourcecenter/ or by calling 573-882-3364.

DOMESTIC VIOLENCE

Probe prompts change in way cases prosecuted

BY RICK BRUNDRETT
THE STATE (COLUMBIA, S.C.)

When Teresa Reese was shot dead in April 2001, outside her parents' rural home near South Carolina's capital city of Columbia, *The State* carried a brief about the slaying and the arrest of her estranged husband, Willie Earl Reese Jr.

At first glance, the 29-year-old woman's death was just another sad domestic violence statistic, reinforcing a national study that ranked South Carolina first in the rate of women killed by men.

But *The State* decided to dig deeper after receiving a tip from a source. What we eventually found resulted in dozens of stories and a statewide change in the way domestic violence cases are prosecuted.

No-drop order

Two years before Teresa's death, prosecutors charged Willie Earl Reese Jr. with severely beating her. But they later dropped the case.

That was a typical pattern statewide, our investigation would find. Using state court administration computer records, database editor Chris Roberts and I analyzed dismissal rates from 1996 to 2000 for the two most serious domestic violence charges: criminal domestic violence of a high and aggravated nature, and third- and subsequent-offense criminal domestic violence.

In a front-page story, Roberts, veteran reporter Clif LeBlanc and I informed readers that their prosecutors and judges were dropping more than half of the most serious cases.

Of the 4,351 circuit court charges examined, 2,350 charges, or 54 percent, were dismissed over the five-year period. Prosecutors – called solicitors in South Carolina – dropped most of the cases.

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Reaction to our story came swiftly. Four days later, state Attorney General Charlie Condon – the state's top prosecutor – ordered solicitors statewide to quit dismissing most cases.

Prosecutors told us they often had no choice to drop charges because victims – usually women – refused to cooperate. Victim advocates said many women don't want to prosecute for a number of reasons, including fear of retaliation and financial dependence on the batterer.

But advocates and Condon told us they believed that to break the cycle of violence, tough prosecution was needed, even if victims didn't want to press charges. Condon's "no-drop" order banned prosecutors from dismissing cases solely because victims refused to cooperate.

That policy was a first in South Carolina, though it has been used for years elsewhere in the nation. We told our readers how it worked in San Diego and Duluth, Minn.

But attitudes in a historically conservative Southern state don't change easily. State government reporter Valerie Bauerlein, for example, showed how veteran state lawmaker Jake Knotts persuaded a judge to drop a domestic violence charge against a man whose wife told police her husband had assaulted her.

Our initial stories, however, might have raised some awareness at the state's General Assembly. Less than two months after our first story, lawmakers voted to increase marriage license fees statewide to provide an estimated $1 million more a year to domestic violence shelters. The bill, which was pushed by the women's caucus, had stalled before our investigation.

Soft on abusers

Not everyone cheered our work. We followed the case of a two-time domestic violence victim who contended that Condon's no-drop policy would hurt families by keeping offenders – often the primary wage earners – behind bars. The woman, who had a 10th-grade education and two small children at the time, was fighting to get a sentence reduction for her carpenter husband, who had been convicted of assaulting her mother.

Some prosecutors also were grumbling about Condon's order, sources told us. There were those who felt his directive was too strict; others didn't like being told what to do by someone in Columbia. And some accused Condon, who was running for governor, of political grandstanding. (Condon lost his gubernatorial bid in the Republican primary in June.)

Condon later issued a memo to prosecutors

Tim Dominick | The State

Adam Self was sentenced to three years in prison for criminal domestic violence. His mother-in-law, Brenda Bryant (right), says that Self has changed and it would be better for him to be working and taking care of his family than be in prison. In the center is DeAndrea Gist of the Attorney General's office.

clarifying his no-drop position. He told them his order wasn't meant to impose a blanket ban on dismissals; cases could be dropped if there was no evidence or not enough evidence to sustain a conviction.

But his instruction didn't satisfy Lexington County Solicitor Donnie Myers – the state's most well-known death penalty prosecutor. Myers transferred 60 of his domestic violence cases to Condon's office, saying he couldn't prosecute them mainly because victims either didn't want to prosecute or couldn't be located.

Condon accepted the challenge, assigning the cases to a special domestic violence team in his office. Most of the cases are still pending, though Condon's team has gotten mostly guilty pleas in the others.

The State also wanted to analyze sentencing patterns for the two most serious domestic violence charges. We figured that if most cases were being dropped, abusers who were prosecuted probably were getting little or no prison time.

We were right.

In a follow-up story, Chris Roberts and I reported that South Carolina judges gave no prison time to at least half of all offenders convicted of the most serious charges. Using state corrections and probation databases, we found that 1,728 defendants got probation only from 1996 to 2000.

And judges rarely gave long sentences to the abusers who ended up in state prison. On the aggravated assault charge, which carries a maximum 10-year sentence, offenders received an average sentence of just under three years. For the lesser charge of third and subsequent offense, which carries a maximum three-year sentence, the average sentence was slightly more than a year.

Though they didn't dispute our analysis, judges denied they were being soft on abusers. They said the worst offenders often are prosecuted under other types of assault charges that carry longer sentences than the most serious domestic violence charges.

Our investigation also found that domestic violence laws in South Carolina are weak. No charge – no matter how serious the injuries – carries more than a 10-year sentence, and none is listed as a felony. Also, no charge is classified as a violent offense, which allows serious abusers to participate in prosecution-run rehabilitation programs that can result in the dismissal of their charges.

State bills that would have toughened penalties for batterers and made Condon's no-drop policy a law died in the General Assembly.

Results encouraging

We wanted to find out how effective Condon's order was a year later. So again, we analyzed dismissal rates for the two most serious charges using the state court administration database.

Our findings, reported in a Sunday front-page story, were encouraging: Dismissal rates by prosecutors and judges statewide dropped from 54 percent during1996-2000 to 35 percent in the year after Condon's order. Convictions also rose after the order, to 48 percent from 34 percent in the previous five years.

As for Willie Earl Reese Jr. – the man whose case launched our investigation – he was convicted last December of murdering his estranged wife, Teresa. The jury deliberated less than a half hour. He was sentenced to 35 years in prison.

Rick Brundrett covers South Carolina's judicial system and legal issues. He has been with The State since 1998. Previously, he worked for 12 years at The Herald-Palladium in St. Joseph, Mich., where he was primarily a police reporter.

FROM THE IRE RESOURCE CENTER

For more information on domestic violence and the prosecution of such cases, consider these stories available from the IRE Resource Center (www.ire.org/resourcecenter):

- **Story No. 17437 –** Protection from abuse orders are awarded by the court to men or women who say they are being abused or threatened. The defendant is required to stay away from the plaintiff, but this investigation shows the system fails many of those looking for help and the court authorities are bound by regulations and unsure of how to make them better. Pam Lehman and Melissa Tyrrell, *The York* (Pa.) *Daily Record*.
- **Story No. 17234** – Domestic violence tears families apart, leaving children without mothers. A team of reporters looked behind the numbers to tell readers why men kill the women they claim to love and why the batterers are rarely punished until they finally kill the victim. Special focus was given to challenges women in rural Minnesota and Wisconsin have in escaping the abuse. Kay Harvey, Phil Pina, Rick Linsk, Charles Laszewksi, Lisa Donavan, *St. Paul Pioneer Press*.
- **Story No. 18154** – *Columbus Monthly* tells the story of Mary Lapos-Altmiller, "a well-liked Westerville librarian, a wife, a mother, benefactor to stray cats," who walked out on her life to marry her childhood sweetheart, Clee Ridenour. The story details how the "attempts to revive a first love ... turned into full-blown domestic violence," and ended up with Ridenour being charged with the murder of his wife.

STATE SLUSH FUND

Public money used to fund legislators' private interests

By Michele McNeil Solida
The Indianapolis Star

The Baptist Women's Shelter in East Chicago, Ind., illustrates what went wrong with the Build Indiana Fund, a pool of public money that became a slush fund for legislators.

A state senator funneled $445,000 from this taxpayer-financed fund to a private women's shelter, even though Indiana law required Build Indiana money be given only to local governments for public construction projects.

Further, Indiana turned over $145,000 of that grant without asking for a single receipt. To get the rest of the money, the East Chicago church pastor in charge of the project turned in forged construction invoices. State officials never followed up on the project.

The shelter was never built.

Sen. Sam Smith, D-East Chicago, and pastor Lee Gilliam are under criminal investigation for stealing and misusing the money – the result of a six-week investigation by *The Indianapolis Star.*

That was just part of the fallout from my Build Indiana Fund investigation, which began as a routine story assignment from my editors.

Questionable projects

Every two years when Indiana lawmakers pass a new state budget, they include a lengthy list of local projects to be funded with Build Indiana Fund money. My assignment was to do a story about what kinds of projects received money in the 2001 budget.

The Build Indiana Fund, created by the legislature in 1989, was robust thanks to tax revenue from Indiana's riverboats and its lottery. The law that created the fund also spelled out its use: to keep local property taxes down by paying for public construction projects in local communities, such as road improvements and courthouse renovations.

But lawmakers who wrote the law didn't follow it, my reporting found.

Since 1989, lawmakers have divvied up $260 million among themselves – with each lawmaker getting between $300,000 and $900,000 to sprinkle within their districts every two years. How large the allowance legislators receive is based upon whether they are members of the controlling political party. Lawmakers allocate the money to pet projects of their own choosing, simply by placing a line item in the state's budget. The public has virtually no say in where this money goes.

The *Star's* investigation found that lawmakers sent millions of taxpayer dollars to questionable projects, such as to private organizations for nonpublic projects. Checks were sent to projects that were never built. One lawmaker funneled money to a nonprofit organization he founded and runs, with the check sent to his own mailbox. Another lawmaker performed construction work on a project for which he secured the money. And about $40 million went to nonprofit groups – organizations never audited by the state.

My simple story about Build Indiana projects turned into an investigation after I pulled an old project file from the State Budget Agency's office just to see how the process worked. It was a renovation of a community center. But something immediately caught my eye: The lawmaker's construction company did the work. The money from the state-funded grant this lawmaker secured essentially ended up in his own pocket.

I looked through more files – some were thick with detailed project proposals and receipts, others just contained photocopies of checks. Many of the projects clearly violated the original 1989 law that required money to go only to government units. In other project files, checks were made out to groups that seemed to have nothing to do with the project description. It became apparent that millions of dollars were being spent with little or no scrutiny.

That's when I approached Janet Williams, projects editor at *The Star*, and told her a few weeks devoted to this story would prove worthwhile. After getting the OK to stray from daily Statehouse stories, I began to follow the money.

I spent a week sifting through thousands of documents on projects, flagging those that seemed troubling and others that provide good examples of where Indiana tax revenue was going.

I checked records with the Indiana Secretary of State's office on numerous organizations that were receiving money. Those business records were helpful because some entities claimed to be incorporated, but actually weren't. In other cases, I was able to use these records – listing officers and directors – to show that legislators were directly involved in the organizations to which they were sending money.

As a reporter new to the Statehouse beat, seeking help from my colleagues became important as the story grew. Janet Williams, as the editor on this project, helped guide my reporting and writing. The Statehouse intern at the time, Jennifer Wagner – now *The Star's* city hall reporter – undertook the tedious task of typing a list of hundreds of Build Indiana projects into a database so we could run it online and in the paper. And fellow Statehouse reporter Kevin Corcoran, a veteran to this beat, provided invaluable suggestions, prompting me to ask for a list of all Build Indiana checks that had been sent out by the Indiana Auditor's Office.

That list from the auditor, obtained in Excel spreadsheet format, became crucial to my story. Since the State Budget Agency's paper and electronic files weren't complete, this was the best record to show where the money went. The spreadsheet allowed me to see who was receiving the money and where the checks were being mailed. I was able to determine which projects were legal – per the original 1989 law that money go only to public entities – and which were not. This list showed me that one lawmaker was having money sent to his personal mailbox for an organization he founded and still runs.

This Excel spreadsheet also alerted me to another problem: Projects never in the state

budget were getting money.

Outrage at lawmakers

Then came scores of personal interviews. From those discussions, I learned that the State Budget Agency became so overwhelmed with the number of projects that it started issuing checks without asking for receipts. I learned that lawmakers changed their minds often, choosing to send money to projects other than those approved in the state budget.

The most remarkable part of the story came when I learned the Baptist Women's Shelter in East Chicago, Ind., didn't exist. I knew there were problems with the project because the construction invoices in the budget files didn't look authentic. Budget agency officials had attached sticky notes listing concerns about who was signing the documents. I decided to call the companies that provided the construction and furniture – and the invoices – but there were either no phone numbers, or the numbers didn't work. There also was no record in the Secretary of State's office of these companies.

The pastor receiving the money gave me different stories about where the shelter was located and its purpose. When I located the East Chicago shelter address, I found it was a private residence.

I wanted to be thorough, so I tracked down copies of the canceled checks to see who from the women's shelter project was endorsing them. That led me to an Indianapolis warehouse that houses old state records, including canceled checks from the State Treasurer's Office.

The Baptist Women's Shelter project became the lead for my story, which prompted swift reaction. Gov. Frank O'Bannon halted all spending from the fund until his office could improve accountability. He lifted the moratorium a few weeks later and announced a series of new accountability steps – including requiring receipts before money is released.

The Marion County Prosecutor's Office is investigating the Build Indiana Fund – including the Baptist Women's Shelter. Criminal charges are likely.

The story also provided many follow-ups. I wrote about how one lawmaker sent his taxpayer money to for-profit businesses – including a pizza joint and a day care center. And I wrote about how a potentially incriminating e-mail, which seemed to show an exchange of Build Indiana money for campaign help, disappeared from the files.

Readers were outraged at lawmakers, who contended their actions were legal since these projects were in the state budget. Still, they changed the Build Indiana Fund law to legalize much of what they had been doing. But they also included some new accountability measures, and equalized spending between Democrats and Republicans.

Still, the law hasn't been tested yet. The state's budget crisis prompted Gov. O'Bannon to drain the fund to help Indiana's bottom line.

Michele McNeil Solida is a statehouse reporter at The Indianapolis Star, where she has worked since 1997.

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DATABASE REPORTING REVEALS FOOD-HANDLING GONE WRONG

Work also shows inspections sometimes not taking place

BY FRED VALLANCE-JONES
THE HAMILTON (ONTARIO) *SPECTATOR*

The cook in the small family restaurant wanted to make sure the eggs weren't greasy.

So before the heaping plate of breakfast went to the customer, she used a cloth lying on the counter to dab the eggs. She then put the grease-laden rag down, ready for the next meal. It would be used for six hours before being washed.

Such was the scene witnessed by a public health inspector in Hamilton, Ontario, an industrial city with nearly half a million residents, about an hour's drive southwest of Toronto.

The inspector wrote about the incident in his notes, one of more than 2,000 pages of inspection reports released to *The Hamilton Spectator* as part of its investigation into restaurant safety.

The resulting five-part series, called "Reservations," revealed shocking food-handling practices in the back kitchens of well-known eateries.

But the series was more than just a recitation of horror stories about mouse infestations, rotting food, and cooks who never washed their hands. Using computer-assisted reporting, it also revealed that the city health department was frequently failing to do the inspections required to protect the public, and even when serious problems were found, little or nothing was being done.

Data block

Senior managers at the newspaper had wanted to do a story on restaurant safety for some time. There would be high reader interest, and similar CAR treatments by other newspapers had led to reforms in several North American cities, including Toronto.

The responsibility eventually fell to me because of my special interests in CAR and public documents research. Little did I know that getting out of the starting gate was going to take the better part of a year.

My goal was to obtain a copy of the city's database of food premise inspections, so I could see which establishments had the worst records and whether the city was doing the minimum inspections required to protect the public.

But the municipal health bureaucrats were in no hurry to hand over a disk.

What followed would make a fine curriculum for Obstruction 101. Ontario has an open records law that specifically applies to municipalities. Under it, the city was supposed to make a decision on my request within 30 days of my filing it in March 2000. In reality, it took five months and a meeting with the city clerk (who oversees local administration of the act) before I got my first response.

The answer was no. I could not have the database. But if I was willing to hand over a check for more than $1,000 Canadian (about $630 U.S.), they'd be happy to make paper printouts.

The health bureaucrats said they couldn't provide an electronic copy. Such excuses are routine for bureaucrats. But in this case they were telling the truth, albeit in a narrow, self-serving way as they made no effort to solve the problem.

The provincial health ministry had designed the database system and provided it to municipalities to make it easier for them to report inspection data to the ministry. As well as being able to spit out what the province needed, the system allowed for some standard printed reports, including a list of inspections for any one premise. The city's staff had no idea how to make a copy of the underlying data they had themselves entered.

When questioned, however, they did provide a key piece of information. The application was written in Microsoft FoxPro. As I had used FoxPro extensively in the past, I now knew it should be straightforward to write a query to produce the data I wanted.

I called the ministry people who had designed the application, and after some initial reluctance,

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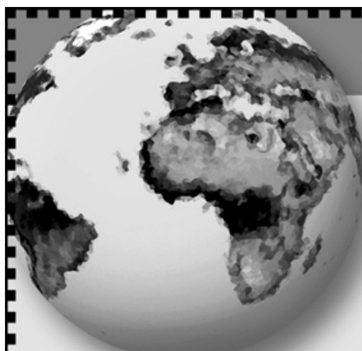

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Ted Brellisford | The Hamilton Spectator

Large bowls of newly cooked rice sit on the floor beside an open door with no bug screen. The operator of another restaurant said this was a common way to cool rice in Chinese restaurants, but health officals say it's a dangerous practice.

they agreed to write the query and provide it to the city to run.

Lessons learned

By November 2000, I finally had a disk in hand – for $30.

Lesson 1: Perseverance pays in the hunt for data. There are some wonderful tipsheets on this subject downloadable from the IRE Web site (www.ire.org).

Once my disk arrived, I was not surprised to find the data was dirty. There were two tables. One contained information about establishments, each identified with a unique ID. It linked to detailed inspection information stored in the second table.

Both tables had problems which would have caused me grief had I not identified them.

In the establishment table, a handful of the ID numbers were duplicated, with more than one establishment having the same number. Usually it happened because a premise had changed hands (and names) and someone had neglected to create a new ID. In two instances the mistake was inexplicable. I chose to eliminate those two premises from any further analysis. This seemed reasonable. Because there were only two, the impact of removing them would be minimal. Leaving them in would introduce errors.

The inspection table was twice as dirty. Some inspection entries were duplicated and a later review of paper records revealed that a small number of inspections were not entered at all.

I had to design queries to eliminate the duplicates, which could be identified from one of the fields. As for the missing inspections, they seemed few in number and health bureaucrats maintained the data was at least 98 percent complete. Still, I knew that absolute precision would never be possible with this data. The deficiencies were later revealed to readers.

Lesson 2: Make sure you figure out the limitations of a data set before you start drawing any conclusions. Check for flaws, such as unique IDs that aren't unique.

To decide which paper files I wanted to see, I used a field that recorded the number of critical violations found on an inspection visit. A critical violation is a mistake in food preparation or handling that has the potential to cause food poisoning, such as storing foods at temperatures where bacteria thrive and grow.

I compiled a list of premises that either had large total numbers of critical violations, or a large number of failing inspections. I then submitted an informal request for the detailed paper files. In contrast to my experience with the data, the health department was cooperative about providing these reports.

Lesson 3: Without the data, we never could have zeroed in so well on premises that consistently had problems. The database allowed us to see both the big picture, and the detail that mattered.

Sick customers

I received the paper records in early 2001.

From there, the project sat on the backburner until May, when our city editor, Jim Poling, assigned me to work on it full time.

By that point, I had received an updated run of the inspection data from the city. Using Microsoft Access, I queried the database extensively, and determined how many times each premise had been inspected, as well as how many inspections the department was doing. Using Excel, I calculated how much time passed between individual inspections of each establishment. All of this

CONTINUED ON PAGE 38 ➤

FROM THE IRE RESOURCE CENTER

For more information on requesting and using government data, consider these helpful tipsheets from the IRE Resource Center (www.ire.org/resourcecenter):

- **Tipsheet No. 1466** offers strategies for negotiating for data and how to proceed when the information you seek is not part of the public record, where else to get data and stories that didn't rely on data records. (Reporters built their own data.) Jennifer LaFleur, Global Investigative Reporting Conference, Copenhagen, 2001.
- **Tipsheet No. 102** describes the Association of Public Data Users, including membership information. The APDU is an organization of users, producers, and distributors of federal, state, and local statistical data concerned about the availability, use and interpretation of public data. Services offered to members include a newsletter, annual conference, membership directory, joint purchase of public data files, and telephone contacts list for statistical agencies.
- **Tipsheet No. 1634** includes useful ideas on government data: online sources, overcoming obstacles, organizing data. Some related articles included. Kevin Corcoran, 2002 IRE Annual Conference, San Francisco.
- **Tipsheet No. 1578** outlines the basic techniques for making changes to your data table using the update query and string functions. Mary Jo Sylwester, 2002 Annual CAR Conference, Philadelphia.
- **Tipsheet No. 876** offers quick suggestions on how to obtain public computer data through practical and non-confrontational means. Alan Levin, 1999 Annual CAR Conference, Boston.
- **Tipsheet No. 877** gives ideas for making your negotiations move more smoothly, since even when public record laws are on your side, which isn't often, it can take months to get electronic data from government agencies. Bob Warner, 1999 Annual CAR Conference, Boston.

Restaurant safety

CONTINUED FROM PAGE 37

revealed that the city was falling far short of the inspection schedule required by provincial law. In some cases, years passed between visits, a fact that I confirmed with the owners of the establishments themselves.

But there was still a key piece missing.

Roger Gillespie is the night managing editor at the *Spectator*, a tireless journalist who always pushes his reporters to go that extra mile, or three.

Gillespie pointed out, and I agreed, that it was important the reader understand the potential consequences of a system that failed. That meant documenting cases of food poisoning – the ultimate result of food handling gone wrong.

I filed a freedom of information request to another branch of the public health department, asking for records detailing outbreaks from the previous year and a half.

While I waited for that request to bear fruit, I got to work interviewing restaurant owners, food safety experts, the inspectors and top health bureaucrats. I wanted to ensure that any restaurant I named had every opportunity to respond. Sometimes, that meant several telephone calls or visits. Editor-in-Chief Dana Robbins knew the story would be controversial, so he wanted as complete a picture as possible.

By early September, I had received records documenting several dozen outbreaks or suspected outbreaks of food poisoning and was tracking down one of the victims, who had suffered the humiliation of seeing the guests at her own wedding meal fall ill.

It was all coming together, and Denis Leblanc, a precise editor known for his calm and steady style, had been assigned to work with me to bring the story to its conclusion.

But then came Sept. 11.

The editors saw no point in publishing while the attention of the entire world was otherwise occupied. "Reservations" finally launched Nov. 24.

We led with the wedding story and documented the failure of the city to live up to its obligations to protect the public.

On Monday (the *Spectator*, like many Canadian papers, does not publish on Sunday), we wrote about the restaurants with the worst inspection records. Three more days of stories followed, including a look at systems used by other cities to disclose the results of inspections to the public. We also ran sidebars giving necessary background on food safety issues and posted summary information derived from the city database on our Web site.

The response from the public, and from the politicians, was overwhelming in the true sense of that overused word. My voicemail was overloaded, letters and e-mails poured in, and our Web site was swamped, as outraged readers found out for the first time about filthy conditions in restaurant kitchens, and the city's failure to make them clean up.

The phones were lighting up at City Hall, too. By the second day of our series, the politicians were already promising a cleanup. By the time the last of the stories ran, councillors had voted to hire additional inspectors, and to develop an action plan to fix the problems identified by the newspaper.

The latter process continues.

In February 2002, the city introduced a temporary disclosure system that posts green signs when a restaurant passes muster, and no sign otherwise. But as we reported in April, the system is flawed because even when critical violations are found, the signs are issued anyway, so long as the problems are corrected by the time the inspector leaves. Not one single premise has been denied a sign and the public is still given no information about the problems that are found. In fact, Hamilton still requires members of the public to put in a special request to the health department to see inspection reports.

Staff are expected to bring a report to city councillors with options for a permanent disclosure system, on mandatory food-handler training, and ways to make the inspection system work more effectively.

That report is already six months past its original due date.

In the meantime, shortly after our series ran, the owner of that family restaurant ordered his staff to stop using the "egg cloths." He still insisted the cloths posed no risk to the public, but his diners apparently thought otherwise.

"Reservations" wasn't perfect, nor was it inherently original, but it was successful in raising public and political awareness of a problem that had literally festered under people's noses. The same data exist in dozens of cities, so it is a story ripe for the picking.

Fred Vallance-Jones is a reporter and CAR specialist at The Hamilton Spectator. He has taught CAR at Ryerson University in Toronto and at annual conferences of the Canadian Association of Journalists.

FOI report

CONTINUED FROM PAGE 17

Potential spread

This sneaky maneuver by FERC will be repeated by other agencies, largely because it works by camouflaging the fact that FOIA states clearly all federal agencies have but a single tool for determining which information should be protected: FOIA's nine exemptions.

Only one exemption pertains to critical energy infrastructure information – Exemption 4, which allows federal agencies to withhold "trade secrets and commercial or financial information obtained from a person and privileged or confidential."

It is worth noting, though, that nothing in the exemption would permit the agency to withhold information that the submitter already discloses to the public or makes available to competitors.

The other great sleight of hand here is FERC's straight-faced contention that it will evenhandedly determine who merits access by divining those with a "legitimate" need for information. In other words, government officials purport to make value-neutral distinctions between requesters while accommodating the public's very strong interest in knowing what its government knows.

It's not clear how FERC's regulations will affect the FOIA process on Capitol Hill, where Senate and House lawmakers will have to reconcile competing critical infrastructure exemptions in a conference committee on homeland security. In July, the Senate Governmental Affairs Committee reached a bipartisan compromise that creates a new exemption allowing for the transfer of sensitive materials to a new homeland security agency, while the House bill, H.R. 5005, includes a radical approach allowing for critical infrastructure materials "voluntarily submitted" to the government by individuals or businesses to be exempt from FOIA.

The bureaucrats who prefer secrecy like to make policy in a vacuum, where few are paying attention.

They're getting their wish so far in the post-Sept. 11 rush to protect critical infrastructure, as newsrooms seem fixated on Congress while FERC simply makes its own rules.

Member News

CONTINUED FROM PAGE 5

to assistant metro editor at the *Las Vegas Sun*. ■ **Bryan Monroe**, currently deputy managing editor of the *San Jose Mercury News*, has been named assistant vice president for news at Knight Ridder. He'll take the new position in the spring after completing a Nieman Fellowship at Harvard University. ■ **Sarah Okeson**, the *Journal Star* in Peoria, Ill., won a first-place award for business writing from the Illinois Press Association for her investigation into fraud in the operations of online auctioneer eBay. ■ **Geneva Overholser**, a former *Washington Post* ombudsman and a current member of the IRE Endowment Advisory Board, has been awarded the 10th annual Anvil of Freedom honoring individuals whose careers have shown a commitment to democratic freedoms, ethics and integrity. Overholser also holds the Curtis B. Hurley Chair in Public Affairs Reporting at the Missouri School of Journalism. ■ **Ken Picard** has moved from the *Missoula Independent* to *Seven Days*, an alternative weekly in Burlington, Vt. ■ **Laure Quinlivan** and WCPO-Cincinnati, were honored in the 2002 Excellence in Urban Journalism competition for the documentary, "Visions of Vine Street." Quinlivan spent three months investigating urban decay in Cincinnati and offering solutions for neighborhood revitalization. ■ **Roshini Rajkumar** has moved to WFTC-Minneapolis from WTVF-Nashville, where she was a consumer investigative reporter. ■ The northern California chapter of the Society of Professional Journalists has named **Seth Rosenfeld** its Journalist of the Year for his series in the *San Francisco Chronicle*, "The Campus Files: Reagan, Hoover and the UC red scare." The investigation was based on FBI files obtained through 17 years of litigation. ■ **David Zeeck**, executive editor of *The News Tribune* in Tacoma, Wash., has been elected treasurer-designate of the American Society of Newspaper Editors.

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For outstanding investigative reporting by a television outlet. Categories are: Network or syndicated program; Top 20 market; and Below Top 20 market.

Other Media:

For outstanding investigative reporting in other media such as Magazine, Newsletter, Specialty Publication, Book and Radio.

Online:

For outstanding investigative reporting that 1) appears exclusively on the Web or 2) appears first and exclusively on the Web, even though it may later be published in a newspaper or magazine or broadcast on television.

NOTE: If work is published first on the Web and later published or broadcast in traditional media, there cannot be two entries. An entrant must choose which category to enter.

Special Categories:

Tom Renner Award: Outstanding reporting in any medium covering and exposing organized crime. (Limited to 10 stories) You must submit TWO sets of copies if submitting an entry in the Tom Renner category and in another category. If only one set is received, the judges will decide in which category the entry will be placed.

IRE FOI Award: Honors individual or organization in any medium whose significant actions further open records or open government. You must submit TWO sets of copies if submitting an entry in the FOI category and in another category. If only one set is received, the judges will decide in which category the entry will be placed.

Student Award: Outstanding investigative reporting by a student in a college-affiliated newspaper, magazine or specialty publication, or broadcast work that has been publicly reviewed, screened or aired.

NOTE: Judges reserve the right to give more than one award in a category or to declare no winner in a category.

For entry forms and additional information, visit our Web site at **www.ire.org/contest**