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# **Findings and Recommendations:**

## **KEY FINDINGS**

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1  
2 The current CME was appointed in April 1998. That same year, the DC Appleseed  
3 Center (Appleseed)<sup>4</sup> issued a report entitled *Problems at the District of Columbia's Office of the*  
4 *Chief Medical Examiner: A Recommendation for Structural Reform* (Appleseed Report). The  
5 Appleseed Report cited the findings of a consultant hired by the former D.C. Financial  
6 Responsibility and Management Assistance Authority (Control Board) to assess the internal  
7 operations of OCME and other units within the Department of Health.<sup>5</sup> Appleseed Report at 5.  
8 In addition to a lack of adequate staffing at the OCME, the consultant found the following  
9 problems, which Appleseed described as “chronic”:

- 10  
11
- Lack of published standards of practice.
  - Lack of in-house policies and procedures regarding technical aspects of the pathologist’s work.
  - Lack of quality assurance standards... for all areas of operation: release of information, scene observation and investigation, police interaction, body retrieval, performance of autopsies, tissue and specimen retrieval and handling, and medical record-keeping.
  - Lack of statistical records of standard issues related to medicolegal caseloads.
  - Lack of tracking systems for histological specimens and toxicology tests.
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23 *Id.* at 5 – 6 (quoting *Final Report: Organizational and Program Assessment of the Department of*  
24 *Health of the District of Columbia*, University Research Corporation, at IIB-23 (Oct. 8, 1997)).

25  
26 The report stated that these problems were “not merely deficiencies,” but reflected a  
27 “complete absence of basic professional standards and quality control measures.” *Id.*

28 **1. Long-standing operational and personnel management problems continue under the**  
29 **current CME.**

30  
31 The OIG inspection team found that the same types of problems cited in the 1998  
32 Appleseed Report were also reported in *Washington Post* articles in 1999 and 2001 (Appendix  
33 3), and unfortunately, still exist almost 5 years later.

34  
35 In both its operational areas and personnel practices, OCME lacks sufficient internal  
36 policies and procedures, and internal controls. These deficiencies degrade the effectiveness and  
37 efficiency of all operations. Consequently, we would rate OCME as a poorly performing District  
38 agency according to current District government and nationally accepted professional standards.  
39 Based on the resources made available to OCME over the past 5 years, the team attributes the  
40 poor performance of this agency to management failures in the office of the CME.  
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<sup>4</sup> The DC Appleseed Center for Law and Justice is self-described as an advocacy organization dedicated to making the Washington Metropolitan region a better place to live and work. The DC Appleseed Center for Law and Justice, through volunteer attorneys and other experts, conducts studies of serious local issues, recommends reforms, and advocates for solutions. See DC Appleseed Center website at [www.dcappleseed.org](http://www.dcappleseed.org).

<sup>5</sup> At that time, OCME came under the Department of Health.

## KEY FINDINGS

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1           Since taking office in 1998, the CME has received significant support from both the  
2 Mayor and the City Council, as evidenced by the following:

- 3
- 4           • the OCME budget has almost doubled since 1998, from \$3.3 million to
- 5           approximately \$5.9 million for FY 2003;
- 6           • the number of positions doubled, from 32 to 65;
- 7           • OCME was moved organizationally from the Department of Health and made an
- 8           separate agency subordinate to the Executive Office of the Mayor with cabinet-
- 9           level status; and
- 10          • the OCME facility has been renovated at a cost of \$3.5 million, and a new
- 11          automated case tracking system is being installed.
- 12

13           Although OCME employees appear to be dedicated and enthusiastic about the mission of  
14 the office, they are deeply troubled about management policies and practices they believe are  
15 harmful to the well-being of both employees and office operations (*See* excerpts from the  
16 employee interviews at Appendix 4). This was the view of OCME employees 5 years ago as  
17 quoted in both the Appleseed Report and contemporaneous news articles. It should be noted that  
18 only one or two of the current employees were employed in OCME at that time.

19

20           Many employees spoke candidly during interviews, and stated that even though they love  
21 their jobs, they would leave immediately if they could find other work. The team reviewed  
22 personnel files at OCME and found the attrition rate to be high. Employees stated that much of  
23 the turnover is due to employees leaving out of frustration with OCME management or the CME  
24 terminating employees without just cause or due process (*See* Finding 36 on term employees).

25

26           Like his employees, the CME was also candid about the problems and shortcomings of  
27 his office during his interview with the team. He stated his three most important concerns to be:  
28 (1) reopening the Toxicology Laboratory;<sup>6</sup> (2) increasing the number of medicolegal  
29 investigators (MLIs) to 8-10; and (3) improving the professional level of the OCME staff. The  
30 CME noted that he has issues with the unprofessional way OCME employees write, speak, and  
31 think.

32

33           The CME also noted other concerns, problems, and issues facing OCME:

- 34
- 35           • the OCME building has been renovated, but the CME needs a larger facility
- 36           because the staff is outgrowing the current one;
- 37           • there is a lack of written policies and procedures in every department, including
- 38           those for handling hazardous materials;
- 39           • there is a backlog of autopsies, and caseloads are high; the turnaround times for
- 40           autopsies are not what he wants them to be;
- 41           • there is a backlog of public disposition cases: “We have bodies here which are
- 42           over a year old;”
- 43           • there is no staffing available so that OCME can be a training facility as is the case
- 44           in other cities;

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<sup>6</sup> The Toxicology lab is currently open, but according to the CME, it is not operating at full capacity.

## KEY FINDINGS

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- 1 • an automated case management system is in the works, but OCME is paper
- 2 intensive: “We cannot compile relevant data and statistics”;
- 3 • there is no correspondence tracking system;
- 4 • telephone customer service training is poor, and public relations functions need
- 5 improvement;
- 6 • the administrative staff needs to work more efficiently; and
- 7 • there are no written organizational or performance standards.

8  
9 The CME cited FY 2002 as “not a strong performance year” and stated that he takes  
10 responsibility. He noted that he received a significant increase in his budget for staffing, but  
11 failed to fill positions in a timely manner.

12  
13 The CME noted that internal communication is “inconsistent,” and that under the surface  
14 there are “rumblings and morale issues;” many employees (he included himself) are underpaid;  
15 more training is needed but employees do not have time to attend; and most external complaints  
16 OCME receives concern timeliness problems with autopsy reports and death certificates. He  
17 stated that there is no tracking system to log complaints and keep track of them in order to make  
18 improvements. He also stated that he requested software from the Mayor’s office, but he never  
19 completed the required “assessment of needs” in order to acquire the software.

20  
21 When asked what he thought was being done well in OCME, the CME said the work of  
22 his MLIs is the foundation of OCME operations, and he praised the quality of the medical work  
23 and courtroom testimony.

### 24 **Recommendations:**

- 25  
26  
27 a. That the CME immediately begin writing and implementing policies and standard  
28 procedures for the most critical operational areas (particularly those affecting  
29 employee health and safety) in order to bring consistency, efficiency, and safe  
30 practices to the way employees conduct OCME business from day-to-day.

31 Agree \_\_\_\_\_ **X** \_\_\_\_\_ Disagree \_\_\_\_\_

- 32  
33 b. That the CME take a “lessons learned” approach to the information in this report  
34 and make adjustments in his management style and operational oversight in order  
35 to improve both the perception and the reality of a District agency that is  
36 performing poorly.

37 Agree \_\_\_\_\_ **X** \_\_\_\_\_ Disagree \_\_\_\_\_

- 38  
39 c. That the Deputy Mayor for Public Safety and Justice review this and previous  
40 reports on OCME and work with the CME to develop both near- and long-term  
41 plans and specific goals for improving all OCME operations.

42 Agree \_\_\_\_\_ **X** \_\_\_\_\_ Disagree \_\_\_\_\_

## KEY FINDINGS

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1 **CME's comments regarding Recommendation (a.) as received:**  
2

3 I agree that OCME needs written policies and procedures for many aspects of the  
4 operation, and that we should give priority to writing and implementing them. It must be  
5 recognized that not all procedures are now inconsistent, inefficient or unsafe. Efforts have been  
6 made over several years to write policies, some successful, but frequently derailed by the  
7 pressing daily needs of managing the agency. As an example, I previously worked in the  
8 OCME for New York City, which went through a similar transformation effort to the District's  
9 OCME, and is now a premier office; the first comprehensive agency policy and procedure  
10 manual was issued about six years into the new CME's administration.  
11

12 **CME's comments regarding Recommendation (b.) as received:**  
13

14 I agree that I will take some valuable lessons from this report. I will make adjustments  
15 as needed to improve the functioning of the office.  
16

17 **CME's comments regarding Page 25, Line 24, as received:**  
18

19 This comment should not be allowed to stand as is. I have not terminated any  
20 employees without just cause or due process, even if other employees perceive it as such.  
21 Neither the employees nor this public document are legally privy to protected personnel  
22 information.  
23

24 **CME's comments regarding Page 26, Line 19, as received:**  
25

26 I do not think I said that. Please check your source and context.  
27

28 **OIG Response: Our inspectors stand by this statement as written.**

29 **2. OCME has not been inspected and accredited as have its counterparts in**  
30 **surrounding jurisdictions.**  
31

32 Best practices recommend that medical examiner offices be inspected and accredited by  
33 an external entity. The goal is to improve OCME operations through objective evaluation and  
34 constructive criticism. Accreditation provides reasonable assurance that an office or system  
35 meets established standards and procedures and is capable of providing the required services.  
36 The accreditation should be conducted by the medical examiners' peers and provide a realistic  
37 assessment of the quality of the facility and recommendations for improvement.  
38

39 Although the surrounding jurisdictions of Baltimore, Fairfax, and Philadelphia are  
40 inspected and accredited by NAME, the District's OCME is not, and there are no District  
41 regulations requiring inspection, accreditation, or evaluation of the agency. Because OCME is  
42 not classified as a medical facility, it also is not required to undergo inspection by the District's  
43 Department of Health (DOH).  
44

45 OCME operates without an external, objective peer review of its operations.  
46 Consequently, District stakeholders cannot be assured that it meets established national standards  
47 and provides recognized levels of quality service to District citizens.

## KEY FINDINGS

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1       **Recommendation:**  
2

3       That the CME take the necessary steps to be inspected and evaluated by the National  
4       Association of Medical Examiners.<sup>7</sup>  
5

6                   Agree        \_\_\_\_\_ **X** \_\_\_\_\_ Disagree        \_\_\_\_\_

7       **CME's comments regarding Recommendation as received:**  
8

9           This has been a stated agency performance goal for some time. However, to achieve  
10       this goal requires reaching a certain level of resources, infrastructure and operations, which  
11       takes considerable time while reforming an agency. It must also be seen in the context that  
12       NAME accreditation is voluntary, not mandatory, and that many major ME offices are not  
13       accredited, including New York City, Miami-Dade County, St. Louis and Wayne County, MI  
14       (Detroit).  
15

16       **CME's comments regarding Page 27, Line 45, as received:**  
17

18           As is true of almost all government agencies.

19       **3.       OCME has a significant backlog of unwritten autopsy reports.**  
20

21           Autopsies are performed to determine cause of death, or to verify diagnosis of an illness.  
22       In addition to the categories of human deaths enumerated in D.C. Code § 5-1405(b) (LEXIS  
23       through March 14, 2003), the District's regulations require the CME to investigate all known or  
24       suspected unnatural deaths, all deaths occurring when the decedent has been without medical  
25       attention within 10 days prior to death, and all deaths occurring within 24 hours of hospital  
26       admission. 22 DCMR § 2401.1(a).  
27

28           A completed death certificate (certificate) for a decedent who must undergo an autopsy  
29       cannot be issued until an autopsy report has been produced. Although an incomplete certificate  
30       (one that does not show the cause and manner of death) can be used for burials, next of kin must  
31       have a completed certificate in order to claim insurance benefits, receive government benefits,  
32       settle an estate, or initiate legal action. Best practices show that autopsy reports should be  
33       produced promptly so that completed death certificates can be generated and provided to next of  
34       kin with minimal delay. The team found that surrounding jurisdictions contract with private  
35       pathologists to ensure timely production of autopsy reports within 30 days of a death.  
36

37           The CME submitted the following autopsy goal and performance measurement as part of  
38       the Mayor's FY 2002 Scorecard Program for autopsies:  
39

40           "Improve the death investigation/certification process to provide timely autopsy  
41       results to decedents' families and ensure the integrity of evidence for court  
42       proceedings. The measurement goal is to complete 50% of all autopsy reports  
43       within 10 weeks in FY 2002."

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<sup>7</sup> The National Association of Medical Examiners Accreditation Checklist can be found at [www.thename.org](http://www.thename.org).

## KEY FINDINGS

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1 NAME also recommends that 95% of autopsy reports be completed within 2 months  
2 from the time of autopsy in homicide cases, and 95% of reports within 3 months from the time of  
3 autopsy in all other cases.

4  
5 The team requested a report from the CME detailing the:

- 6
- 7 • total number of autopsies performed and the case numbers;
- 8 • total number of pending autopsy reports and case numbers;
- 9 • dates autopsy cases were opened; and
- 10 • reasons autopsy cases are still pending.

11  
12 The CME was unable to provide this information.

13  
14 Individual caseloads provided by three current OCME medical examiners<sup>8</sup> show that 33%  
15 of their 2001 cases are still pending, and 43% of 2002 cases are still pending.

16  
17 Each OCME medical examiner performs over 300 autopsies per year. They stated that  
18 there are too few medical examiners, and there is inadequate administrative staff for editing, file  
19 retrieval, and general clerical duties. These deficiencies contribute to the case backlog. They  
20 also stated that they are required to conduct microscopic studies<sup>9</sup> on all autopsies. This was not  
21 always the standard operating procedure in OCME, and also increases the backlog. Medical  
22 examiners stated they have advised the CME that these studies are not justified on each autopsy,  
23 and this is not standard operating procedure in surrounding jurisdictions which have accredited  
24 medical examiner offices.

### 25 26 **Recommendations:**

- 27
- 28 a. That the CME consider contracting with private pathologists to reduce the  
29 backlog of autopsy reports.

30 Agree \_\_\_\_\_ Disagree  X

- 31
- 32 b. That the CME review the concerns and suggestions of his medical examiner team  
33 regarding reduction of the backlog.

34 Agree  X  Disagree \_\_\_\_\_

### 35 36 **CME's comments regarding Recommendation (a.) as received:**

37  
38 I do not see how this is possible, given the expertise needed and the legal constraints.

39  
40 **OIG Response: We accept the CME's response as stated, and recommend that he**  
41 **consider hiring additional medical examiners.**  
42

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<sup>8</sup> The team was unable to obtain caseload files for two of the five medical examiners.

<sup>9</sup> Microscopic studies relate to the observation of organ tissue samples with a microscope and slide samples.

## KEY FINDINGS

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1 **CME's comments regarding Page 29, Line 20, as received:**  
2

3 This is not accurate. Microscopic studies have never been required on ALL autopsies.  
4 There is a difference of opinion between some of the medical examiners and the CME on the  
5 level of use of microscopic exams needed; the CME has exercised his discretion to set the  
6 policy according to his 20 years experience in the field.

7 **4. Unidentified, unclaimed bodies date back to 2000 and are a health hazard.**  
8

9 NAME recommends that medical examiner offices have sufficient refrigerated storage  
10 space to accommodate the highest number of bodies that can be handled during peak periods. In  
11 order to do this, it is imperative that bodies be removed from OCME on a regular basis. The  
12 team toured surrounding jurisdictions in Maryland and Virginia and found that they do not allow  
13 bodies to remain in their facilities longer than 30 days.  
14

15 Title 22 DCMR § 2407.1 states that “[b]odies which are unidentified or unclaimed after a  
16 period of thirty (30) days following reception at the Office of the Chief Medical Examiner shall  
17 be released to the Anatomical Board pursuant to the provisions of the Act or shall be cremated,  
18 or otherwise disposed of according to law.” The team found that of the 189 bodies stored at  
19 OCME as of December 29, 2002, 60 had been stored for longer than 30 days following  
20 reception. Records indicated that these bodies had dates of death and reception at OCME dating  
21 back to 2000 and 2001. Employees indicated that these bodies are not being removed because  
22 OCME is not processing public disposition (e.g., unclaimed or unidentified bodies) cases in a  
23 timely manner. Also, the procurement process for solicitation of contracts for the transfer of  
24 these bodies delays the process. OCME must solicit bids for contractors through the competitive  
25 bid process.  
26

27 By not releasing and disposing of bodies in a timely manner, OCME has created  
28 overcrowded and unsanitary conditions. Many bodies are double stacked and others are placed  
29 on the floor.<sup>10</sup> The team found many bodies were decomposing and leaking fluids from body  
30 bags and reported this situation in a Management Alert Report (MAR 03-I-003, Appendix 7)  
31 dated January 31, 2003. The CME’s response to this MAR is located at Appendix 8.  
32

33 **Recommendation:**  
34

35 That the CME take steps immediately to eliminate the backlog of body release and  
36 disposal, and release or otherwise transfer bodies from OCME within 30 days as required  
37 by District regulations.  
38

39 Agree \_\_\_\_\_ Disagree  X

40 **CME’s comments regarding Recommendation as received:**  
41

42 I agree that eliminating the backlog and disposing of bodies timely is important.

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<sup>10</sup> OCME has storage capacity for 145 bodies.

## KEY FINDINGS

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1 Efforts begun before the inspection have resulted in significant progress in making public  
2 disposition of unclaimed bodies, and has reduced the backlog considerably. As of 10  
3 September, there were 88 bodies (81 adults and 7 infants/fetuses) stored at OCME, down from  
4 the 189 cited during the inspection. In calendar year 2003, 130 bodies were sent for public  
5 disposition (85 adults and 45 infants/fetuses), and the week after this writing, 16 more adults will  
6 be sent out, leaving 43 public disposition bodies (37 adults, 6 infants/fetuses) in-house. At that  
7 time, approximately 40% of all bodies at OCME will have been in-house less than 30 days.  
8 There is no legal or practical mechanism to “otherwise transfer” bodies from OCME. Further,  
9 the recommendation to dispose of bodies *within 30 days* incorrectly states the regulations. In  
10 fact, OCME cannot make disposition until AFTER 30 days have passed, according to the  
11 regulations.

12  
13 **OIG Response: *OIG concurs with the CME that the recommendation should state***  
14 ***after 30 days instead of within 30 days. *OIG continues to recommend the timely release of****  
15 ***bodies after 30 days to prevent the overcrowded and unsanitary conditions documented in***  
16 ***November 2002 when the cold storage room was 69 bodies over capacity.***

17  
18 **CME's comments regarding Page 30, Line 29, as received:**

19  
20 This is no longer the case.

21  
22 **CME's comments regarding Page 30, Footnote, as received:**

23  
24 Actually, the capacity of rack storage system in the cold rooms is 115 adult bodies;  
25 about five more bodies can be stored on carts outside the racks without crowding the rooms.

26 **5. Policies and procedures for conducting autopsies are inadequate.**

27  
28 The team requested a copy of autopsy procedures in November 2002, but was told there  
29 were none in writing at that time. In February 2003, the CME provided written procedures to the  
30 team; however, OCME medical examiners consider them to be deficient because they were  
31 written by the CME without their input, even though they perform all autopsies.

32  
33 ***a. Medical examiners say autopsy procedures lack important criteria, and some***  
34 ***contradict the CME's verbal instructions.***

35  
36 Medical examiners stated that there is a lack of written criteria for determining whether  
37 medical examiners should perform complete or partial autopsies, or only external examinations  
38 as recommended by NAME. Medical examiners also stated that many of OCME's written  
39 procedures differ from the standard operating procedures used in surrounding jurisdictions and  
40 from NAME standards. They stated that some procedures contradict verbal instructions they  
41 have received from the CME. They also stated that the decision on what procedures should be  
42 followed is made at the discretion of the CME, who is inconsistent in the criteria he uses and  
43 does not conform to established best practices. In addition, the procedures do not cover the  
44 duties and responsibilities of autopsy technicians, who the medical examiners say play a vital  
45 role in assisting them during autopsies. The medical examiners believe that because they were  
46 not included in developing these procedures, autopsies are not as timely and cost-effective as  
47 they should be, and their integrity cannot be assured.

## KEY FINDINGS

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1           ***b.     There is no consistent policy for handling requests for special autopsy***  
2           ***procedures based on a family's religious preferences.***  
3

4           Some families request that a full autopsy not be performed on a decedent for religious  
5 reasons. Medical examiners stated that the CME does not honor these requests in a consistent  
6 manner and without regard to the religious faith involved, but appears to favor families of certain  
7 faiths. Medical examiners stated that the CME's inconsistency places them in an uncomfortable  
8 position when they must perform autopsies despite the religious objections of some families, but  
9 are instructed not to perform them in other cases. They view this practice as discriminatory.

10  
11           ***c.     OCME does not have a written policy and procedure covering the retention of***  
12           ***organ and tissue specimens stored in the autopsy suite.***  
13

14           NAME recommends that medical examiner offices have a written policy and procedure  
15 covering the retention and disposition of organ, fluid, and tissue specimens taken during  
16 autopsies. The policy should cover the circumstances under which next of kin are or are not to  
17 be notified of retention and disposition of such items. Best practices also suggest that some  
18 organs and tissue samples be retained for an established period in the event that further  
19 examination and evidence is needed to certify the cause and manner of death.

20  
21           The team found that medical examiner offices in Maryland, Virginia, and Pennsylvania  
22 have specific written policies covering the retention, cataloging, and disposition of organ and  
23 tissue specimens. The District's OCME, however, has no such policies or procedures; therefore,  
24 the retention and handling of these specimens may not be adequate and, consequently, the  
25 specimens may not be available when needed.

26  
27           **Recommendations:**  
28

- 29           a.     That the CME collaborate with his team of medical examiners to review the  
30           sufficiency of policies and procedures pertaining to autopsies and other OCME  
31           operations as pertinent, and give full consideration to their input.  
32

33           Agree     \_\_\_\_\_ **X** \_\_\_\_\_ Disagree     \_\_\_\_\_

- 34           b.     That the CME establish written, standard criteria for agreeing to requests for  
35           special autopsy procedures based on a family's religion.  
36

37           Agree     \_\_\_\_\_ **X** \_\_\_\_\_ Disagree     \_\_\_\_\_

- 38           c.     That the CME develop a policy and procedure for retaining and disposing of  
39           organ and tissue specimens.  
40

          Agree     \_\_\_\_\_ **X** \_\_\_\_\_ Disagree     \_\_\_\_\_

## KEY FINDINGS

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1 **CME's comments regarding Recommendation (a.) as received:**  
2

3 My agreement is conditional on the term "full consideration." I will obtain their input, but  
4 reserve the right to exercise proper discretion to set agency policies.  
5

6 **CME's comments regarding Recommendation (b.) as received:**  
7

8 I agree to establish a written policy with appropriate guidelines for considering family  
9 requests or objections to autopsies. However, each of these requests is a special case, actually  
10 an exception to the more general autopsy policy, and so will commonly involve a judgment call  
11 that will ultimately be the responsibility of the CME.  
12

13 **CME's comments regarding Page 31, Line 37, as received:**  
14

15 Partial autopsies are essentially never a consideration, by policy.  
16

17 **CME's comments regarding Page 31, Line 42, as received:**  
18

19 As is appropriate, as the CME has the final discretion on the practices of the agency.  
20

21 **CME's comments regarding Page 31, Line 43, as received:**  
22

23 This is inaccurate, and requires details and documentation if allowed to stand in a public  
24 document. The criteria used and the procedures promulgated by the CME are the result of his  
25 20 years of experience, having worked in five different ME jurisdictions, including New York  
26 City.  
27

28 **CME's comments regarding Page 32, Line 9, as received:**  
29

30 This is another example where airing unsubstantiated opinions in a public document as  
31 fact is inappropriate. In fact, their claims of inconsistency are untrue. I raise the issue of  
32 potential autopsy objections for decedents of many faiths, and use the same criteria to honor or  
33 over-rule those objections. There are no legal rights for families to object to autopsies  
34 performed under the jurisdiction of OCME in the District, but I instituted the practice of  
35 entertaining both objections and requests from families, to provide better service to the citizens.  
36 The decisions to honor or overrule objections are usually made in the context of a professional  
37 staff meeting, with justifications and reasons expressed openly. Because each case must be  
38 judged on its own merits, medical examiners will be in the position of sometimes doing  
39 autopsies over objections, and sometimes honoring those objections. This is not inconsistency,  
40 it is executive decision –making.  
41

42 **CME's comments regarding Page 32, Line 25, as received:**  
43

44 Tissue samples are saved for 3 years, following published standards found by the former  
45 General Counsel (which I believe were Federal, as no District regulations were found). (The  
46 mortuary staff certainly knows this, as they come to me each year for permission to discard the  
47 samples that have reached the end of their retention time.) Histology slides and



## KEY FINDINGS

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1    **7.    The CME's relationship with the Child Fatality Review Committee has been**  
2    **marred by problems.**  
3

4           The Child Fatality Review Committee (CFRC) was established by the Mayor and is  
5 responsible for examining past events and circumstances surrounding child deaths in the District  
6 in an effort to reduce the number of preventable child deaths, especially those attributable to  
7 child abuse, and neglect, and other forms of mistreatment. The CFRC also assists the District in  
8 gaining insight into child fatalities occurring within our community, provides a mechanism for  
9 the community to become engaged in the child fatality review process, and promotes improved  
10 integrated public and private systems serving families and children.  
11

12           CFRC is a collaboration of representatives from the following District agencies that  
13 provide services to or that affect children:  
14

- 15           •     Department of Human Services;
- 16           •     Department of Health;
- 17           •     Office of the Chief Medical Examiner;
- 18           •     Child and Family Services Agency;
- 19           •     Metropolitan Police Department;
- 20           •     Fire and Emergency Medical Services Department;
- 21           •     D.C. Public Schools;
- 22           •     Department of Housing and Community Development; and
- 23           •     Office of the Corporation Counsel.
- 24

25           The Mayor, with the advice and consent of the City Council (Council), also appoints  
26 eight community representatives to the CFRC, none of whom are employees of the District.  
27 Mayor's Order 2001-119, dated August 9, 2001, directed the CME within the OCME to be  
28 responsible for providing facilities and other administrative support for the CFRC.  
29

30           ***a.     The CME has not provided adequate administrative support to the CFRC.***  
31

32           The District's FY 2002 budget and Financial Plan provided \$296,000 in local funds to  
33 OCME to support the CFRC administratively. Prior to August 2001 and the provision of the  
34 local funds to OCME, the DOH and the Department of Human Services (DHS) provided joint  
35 administrative support for CFRC. This included staffing, supplies, and facilities. The CFRC  
36 administrative staff is located in the OCME building.  
37

38           The co-chair for CFRC stated that administrative support is critical because the  
39 administrative staff serves as a link among committee members, the District government, and  
40 various agencies involved in the CFRC. Staff duties include obtaining and distributing  
41 information related to CFRC case reviews, case preparation, and committee issues; arranging  
42 meetings; attending internal reviews of various agencies participating in CFRC operations; and  
43 maintaining a working knowledge of government policies and laws related to child welfare and  
44 the CFRC.  
45

## KEY FINDINGS

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1           The CME's administrative support to CFRC has been inadequate, and he has not met  
2 staffing and budget obligations that affect DOH and DHS. The team found that:

- 3
- 4           • the CME has not filled two support positions for which funding has been  
5 provided;
- 6           • DOH and DHS continue to fund positions of CFRC employees despite repeated  
7 requests that the CME transfer these positions and their employees to OCME's  
8 budget and reimburse DOH and DHS for their salaries (DOH and DHS have  
9 threatened to recall these employees if the CME does not make permanent  
10 transfers);
- 11          • there is a lack of timeliness in purchasing office supplies, training employees, and  
12 obtaining a contract to print the annual CFRC report; and
- 13          • OCME policies and procedures have not been provided to the CFRC  
14 administrative staff to improve their understanding of OCME operations and its  
15 relationship to the CFRC.
- 16

17           The co-chair of CFRC stated that OCME's failure to permanently transfer employees and  
18 fill critically needed positions places CFRC in "administrative limbo." Insufficient staffing  
19 creates undue pressure on the CFRC administrator to perform many tasks which could be  
20 delegated to other staff persons, and causes undue delays in the review process and production of  
21 the annual report.

22

23           She further stated that although CFRC administrative support has been transferred to  
24 OCME, there is no memorandum of agreement detailing the responsibilities of DOH, DHS, and  
25 OCME to provide staff positions and transfer funds. It is not clear who should draft such a  
26 memorandum. She has asked the CME to allow the CFRC to participate in the development of  
27 the CFRC administrative budget, but the CME has refused. All funding requests for CFRC  
28 administrative support must be approved by the CME, rather than by the CFRC co-chairs or a  
29 CFRC leadership committee that could include the CME.

30

31           The team requested that OCME provide a copy of the budget line items for CFRC  
32 administrative support and was informed that this could not be done because those funds are  
33 combined with OCME's general funding.

- 34
- 35           ***b. CFRC leaders and some members believe the administrative support function***  
36 ***should be moved to a neutral location and not be overseen by a CFRC member.***

37

38           CFRC is required to file an Annual Report of Findings and Recommendations to be made  
39 available to the Mayor, the Council, and the public, and presented at a public hearing. This  
40 report is to be a comprehensive overview of the cases reviewed and the findings and  
41 recommendations of CFRC members, and should be a collaborative effort with equal input from  
42 all participating members.

43

44           Prior to the transfer of CFRC administrative functions to the CME, all CFRC committee  
45 members received the first and second drafts of the report at the same time, and met as a group  
46 for comment and discussion prior to finalization. Currently, however, the CME receives a copy



## KEY FINDINGS

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- 1 e. That the Mayor review the appropriateness of the CME's oversight of the CFRC's  
2 administrative support staff and consider a more independent oversight location.  
3

4 Agree \_\_\_\_\_ Disagree  X

- 5 f. That the CME attend all CFRC meetings or send a designee as required by the  
6 D.C. Code.  
7

8 Agree  X  Disagree \_\_\_\_\_

9 **CME's comments regarding Recommendation (a.) as received:**

10 Already done or in progress.  
11

12 **CME's comments regarding Recommendation (b.) as received:**

13 (As possible, given that the CFRC funds are embedded in the OCME NPS budget.)  
14

15 **CME's comments regarding Recommendation (c.) as received:**

16 See comments above. CFRC members may serve in an advisory capacity to set  
17 priorities for CFRC budgeting.  
18

19 **CME's comments regarding Recommendation (e.) as received:**

20 The OCME is by definition and statute a neutral party, which is also involved in the  
21 investigation of nearly all deaths coming to the attention of the CFRC. It is a logical place for a  
22 fatality review process, and the decision to locate CFRC there came from the EOM.  
23

24 **OIG Response: The OIG stands by its recommendation for a Mayoral review.**  
25

26 **CME's comments regarding Page 35, Line 33, as received:**

27 This statement is not accurate. The \$296,000 was strictly Personal Services funds for  
28 fatality reviews, mostly for CFRC but also for the MRDDA Fatality Review Committee staff.  
29 There were never any "administrative" (NPS) funds appropriated for fatality reviews; OCME was  
30 expected to provide for this out of its existing budget. Hence there was never any separate  
31 budget line for this purpose (see below).  
32

33 **CME's comments regarding Page 35, Line 38, as received:**

34 I believe that all these references to the co-chair actually should be to the committee  
35 coordinator.  
36

37 **CME's comments regarding Page 36, Line 26, as received:**

38 It is not clear that such an MOU is needed any longer. After delays both from within  
39 OCME and from the DCOP process, these transfers, postings and hirings are all either  
40 completed or moving forward now.  
41  
42

## KEY FINDINGS

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1 **CME's comments regarding Page 36, Line 27, as received:**  
2

3 The CME did not *refuse*; see above *re* there being no separate CFRC administrative  
4 budget. OCME fulfills the CFRC's needs within its existing PS budget, including supplies, office  
5 space (including providing new furniture and configuring the space according to their requests),  
6 computers and fax machines, use of vehicles and travel and training funds.  
7

8 **CME's comments regarding Page 36, Line 29, as received:**  
9

10 Such an arrangement would be inappropriate and likely illegal. The CFRC co-chair  
11 (there being only one) is not a District employee. This proposed leadership committee would  
12 likely include others who are not District employees, and/or employees of other District  
13 agencies. None of these people would be authorized to allocate or approve use of OCME  
14 funds, and some of them could not participate in the process of managing District business at  
15 all. It is entirely appropriate that the budget requests for the CFRC be approved through the  
16 OCME administration. The CFRC was purposely placed under OCME for administrative  
17 purposes. Previously, it functioned without ANY budget, designated FTEs, or official "home,"  
18 being "co-sponsored" by DHS and DOH, neither of which really assumed responsibility for it.  
19 The coordinator position did not exist as such; the occupant was on indefinite loan from DHS.  
20 The process of transferring, establishing and filling positions, and integrating that function into  
21 the existing structure of OCME, took longer than planned, due to the limited administrative staff  
22 at OCME, who were also responsible for many other pressing priorities both to run the agency  
23 and to try to continue the efforts to transform the agency.  
24

25 **CME's comments regarding Page 37, Line 8, as received:**  
26

27 The CME does not engage in "unilateral editing" of the CFRC reports. The reports and  
28 recommendations are still reviewed and edited collaboratively by CFRC members. The CME  
29 has added the perspective of government operations and legality into analysis of many  
30 recommendations, which had not received serious consideration in this process before.  
31

32 **CME's comments regarding Page 37, Line 21, as received:**  
33

34 This is a scheduling and staffing issue. In light of the CME's busy schedule, the  
35 absence of a Deputy Chief Medical Examiner has made it even more difficult to attend all  
36 meetings, despite the importance and statutory requirement. Other staff medical examiners will  
37 be offered the opportunity to participate in the future, hoping to spread the burden and assure  
38 attendance.

39 **8. Staffing for some of the most critical areas is not adequate.**  
40

41 Medical examiner offices are 24-hour a day operations; therefore, it is imperative that  
42 they be adequately staffed to carry out all key functions. NAME recommends that all such  
43 offices have adequate technical staff to handle the routine daily caseload for the following areas:  
44

- 45 • autopsy assistance;
- 46 • histology;
- 47 • forensic photography;
- 48 • radiology;

## KEY FINDINGS

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- 1 • toxicology; and
- 2 • investigations.

3  
4 NAME also recommends that adequate non-technical staff coverage be available to  
5 handle the routine daily caseload for the following areas:

- 6
- 7 • administration;
- 8 • visitor reception;
- 9 • communications;
- 10 • medical transcriptions;
- 11 • record keeping;
- 12 • body handling and transportation; and
- 13 • custodial and cleaning duties.

14  
15 The team found that OCME is understaffed in a number of these areas. OCME was  
16 budgeted for 67 full time positions for FY 2002. However, the CME did not fill 17 (25%) of his  
17 budgeted allotment in a timely manner. Many of these positions have been vacant for a year or  
18 more. The staff shortage results in employees having to cover multiple shifts and work overtime,  
19 and many employees say they are on the verge of burnout.

20  
21 ***a. There is no MLI available on a 24-hour basis to respond to death scene***  
22 ***investigations.***

23  
24 NAME recommends that an investigator be available on a 24-hour basis to respond to  
25 death scene investigations. Additionally, the U.S. Department of Justice's *National Guidelines*  
26 *for Death Investigations* recommend that an on-site investigation be conducted for all deaths  
27 known or suspected to be unnatural. OCME investigates approximately 4000 deaths annually,  
28 but only 228 were investigated on-site in 2000, and 508 in 2001. The CME stated that it is his  
29 goal to conduct an on-site investigation for every case in which OCME takes jurisdiction.  
30 However, OCME has only five MLIs to conduct on-site death scene investigations, and this is  
31 not enough to conduct the number of on-site investigations the CME says are necessary. The  
32 CME and the MLI supervisor stated that a minimum of five additional investigators are needed  
33 to adequately staff this department.

34  
35 According to OCME employees, the lack of adequate staff for on-site death scene  
36 investigations results in the cause of death being investigated under conditions that do not  
37 produce accurate and reliable evidence. This deficiency delays a pronouncement of death  
38 because only the CME, physicians, medical examiner, MLIs, physician assistants, or advanced  
39 practice registered nurses are authorized to make pronouncements of death. The team found that  
40 when MLIs cannot pronounce death at the scene, the official pronouncement for some decedents  
41 occurs 12 hours or longer after the body arrives at OCME.

42  
43 The team found there are no MLIs on duty from 8 p.m. to 8 a.m. weekdays, and only one  
44 MLI working from 8 a.m. to 8 p.m. on Saturdays and Sundays. As a result, deaths occurring  
45 during these periods are not investigated on-site. Additionally, OCME is so short-staffed that

## KEY FINDINGS

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1 when multiple violent and suspicious deaths or homicides are called in, MLIs cannot investigate  
2 all of these cases on-site. The team found that OCME had funding for two additional MLIs for  
3 FY 2002. However, the positions were not advertised and filled in a timely manner by the CME,  
4 and were removed from the OCME budget during the recent citywide budget shortfall.

5  
6 ***b. The number of employees available for body handling and transportation is***  
7 ***insufficient.***  
8

9 The team found that best practices in surrounding jurisdictions require at least two  
10 persons for all shifts to respond to death scenes and to transport decedents to the medical  
11 examiner's office in a timely manner. OCME has three to five<sup>12</sup> mortuary technicians working  
12 the 8 a.m. to 4 p.m. shifts, but only one working the 4:30 p.m. to 12 midnight shift, and only one  
13 working the 12 midnight to 8 a.m. shift.

14  
15 Due to insufficient staffing during the evening shifts, many body retrievals are delayed by  
16 4 to 8 hours. Employees stated families frequently complain that they must remain with a body  
17 for an excessive amount of time before it is removed. Employees also indicated that there is a  
18 safety risk in understaffing because one person cannot safely lift a body of excessive weight.

19  
20 ***c. The Communication Unit 24-hour phone is not adequately staffed.***  
21

22 NAME recommends that medical examiner offices have a phone staffed 24 hours a day  
23 by someone able to arrange a body disposition. The OCME Communication Unit 24-hour phone  
24 (202-698-9000) is not adequately staffed to receive calls at all times. Only one intake assistant  
25 covers the 12 a.m. to 8 a.m. shift. If this person is unable to report to work or must leave the  
26 office due to illness or emergency, there is no coverage by the Communication Unit. Callers  
27 must leave a voicemail message that will not receive a response until another intake assistant  
28 reports for duty at 8 a.m. the following day. Consequently, several hours may pass during which  
29 the response to calls is delayed and the reporting process is unnecessarily prolonged.

30  
31 ***d. OCME does not have adequate staff for building maintenance.***  
32

33 Medical examiner offices should be clean, comfortable, and well-maintained. NAME  
34 recommends that all medical examiner facilities have written and implemented policies and  
35 procedures covering facility and equipment repairs and maintenance.

36  
37 The team often found large amounts of trash in some areas of the facility and floors not  
38 swept or mopped. Several times during the winter, the heat was not working. The mortuary  
39 supervisor provided the team with a list of structural and equipment problems in need of urgent  
40 repair. The list included the following conditions:

- 41  
42
  - poor lighting on the back dock area;
  - foot pedals on sinks at autopsy tables leak;  
43

---

<sup>12</sup> These three to five employees are autopsy assistants who assist medical examiners with autopsies, in addition to transporting decedents.





## KEY FINDINGS

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1 **CME's comments regarding Page 40, Line 29, as received:**  
2

3 This is incorrect. I stated that it is my goal to conduct on-site investigations in every  
4 case where OCME takes jurisdiction *and the body remains on the scene*. If the statement  
5 attributed to me were correct, I would be committing to performing scene investigations in  
6 accepted hospital deaths, which was clearly not my intent.  
7

8 **CME's comments regarding Page 40, Line 37, as received:**  
9

10 This is a gross overstatement. The lack of adequate numbers of investigators is a  
11 significant deficiency, but it is not fair to say that our investigations are providing unreliable  
12 results. This also needs to be seen in the context that before I became CME, there were NO  
13 investigators of this type at OCME; the agency NEVER responded routinely to scenes, but  
14 relied on police to obtain the medical evidence needed. If we only cover 12 hours per day now,  
15 it is 12 more than before; a vast improvement, even if not complete  
16

17 **CME's comments regarding Page 41, Line 4, as received:**  
18

19 This statement is untrue. The funding for these positions was cut BEFORE the fiscal  
20 year began; it was not withdrawn because of failure to fill the positions. In fact, the same  
21 scenario occurred in FY03, but we have recently re-allocated PS funds to create two new  
22 investigator positions. On the day this is being written, three new investigators have been  
23 selected to fill these and one recently vacated position. The longer vacated position of Director  
24 of Investigations has also been recently filled, by promoting from within.  
25

26 **CME's comments regarding Page 42, Line 16, as received:**  
27

28 OCME now has a cleaning contract in place.

29 **9. The CME is not producing statistical data and annual reports on deaths and**  
30 **autopsies as required by District law.**  
31

32 D.C. Code § 5-1412(d) (LEXIS through March 14, 2003) states:  
33

34 **[t]he CME shall prepare an annual report to the Mayor which**  
35 **includes information on the number of autopsies performed,**  
36 **statistics as to the causes of death, and any other relevant**  
37 **information the Mayor may require. The annual report shall**  
38 **be open to inspection by the public. The annual report shall**  
39 **not identify by name deceased persons examined.**  
40

41 NAME recommends that annual reports should contain statistical data on:  
42

- 43 • deaths reported;
- 44 • cases accepted;
- 45 • manner of death;
- 46 • scene visits by medical examiners or medical examiner investigators;
- 47 • bodies transported by the office or by order of the office;

## KEY FINDINGS

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- 1 • external examinations;
- 2 • complete autopsies;
- 3 • partial autopsies;
- 4 • hospital autopsies retained under medical examiner's jurisdiction;
- 5 • cases where toxicology is performed;
- 6 • bodies unidentified after examination;
- 7 • organ and tissue donations;
- 8 • unclaimed bodies; and
- 9 • exhumations.

10  
11 The team found that the CME has not produced an annual report as required by the D.C.  
12 Code since he assumed his office almost 5 years ago, and does not appear to be capable of  
13 producing such a report. OCME records are made up primarily of hard copy files and documents  
14 that are not well organized. As will be pointed out in another section of this report, OCME does  
15 not have an automated records management system and must work exclusively with hard copy  
16 files and documents, some of which are handwritten. This made it difficult for the team to gather  
17 any concrete statistical information on OCME cases and backlogs, and almost certainly inhibits  
18 the CME's retrieval of such information for inclusion in an annual report to the Mayor.

19  
20 **Recommendation:**

21  
22 That the CME provide the Mayor with annual reports as required by the D.C. Code and  
23 as recommended by NAME.

24  
25 Agree \_\_\_\_\_ **X** \_\_\_\_\_ Disagree \_\_\_\_\_

26 **CME's comments regarding Page 45, Line 12, as received:**

27  
28 And neither have my predecessors for many years.

29  
30 **CME's comments regarding Page 45, Line 18, as received:**

31  
32 Please note that the administration of this CME is well along in the process of  
33 implementing just such a system, which had not been attempted by any previous CME.  
34  
35