Findings and Recommendations:

OFFICE OF THE CME
31. **OCME does not have a workplace safety and health program.**

OCME receives the remains of decedents who had tested positive for a variety of contagious diseases such as hepatitis, HIV, and tuberculosis. It also receives bodies that are badly decomposed and that expose employees to hazardous airborne pathogens. OCME disposes of biohazardous waste from these decedents periodically.

According to a recent article in *The American Journal of Forensic Medicine and Pathology* (AJFMP), an autopsy may expose employees and others to “a wide variety of infectious agents, including blood-borne and aerosolized pathogens such as human immunodeficiency virus (HIV) hepatitis B and C viruses, and *Mycobacterium tuberculosis.*” Kurt B. Nolte, M.D., David G. Taylor, PhD, and Jonathan Y. Richmond, Ph.D., *Biosafety Considerations for Autopsy*, 23(2) AM. J. OF FORENSIC MED. PATHOLOGY 107 (2002). Other hazards include exposure to toxic chemicals such as formalin, cyanide, and organophosphates. *Id.* Additionally, the article notes that surveys of British clinical laboratories between 1970 and 1989 demonstrated that the highest rate of laboratory-acquired infections were in autopsy workers and that autopsies are an “exceptionally efficient method of transmitting tuberculosis from the decedent to those present in the dissection room.” *Id* at 107 and 109.

However, the article states that these health and safety risks can be substantially mitigated through, among other things, proper risk assessment, personal protective equipment, and appropriate autopsy procedures. *Id* at 112. Finally, the article recommends that autopsy personnel utilize the following precautions:

- wear adequate personal protective devices such as respirators, masks, and goggles;
- attend training in universal precautions when handling biological specimens;23
- receive immunization against the hepatitis B virus and periodic screening for tuberculosis; and
- have access to appropriate health care when exposed to blood-borne and aerosolized pathogens or toxic chemicals.

*Id.* at 112 - 115.

To reduce the number of job-related fatalities, illnesses, and injuries, the U.S. Department of Labor Occupational Safety and Health Administration (OSHA) recommends that employers establish a workplace safety and health program that complies with OSHA standards.

NAME also recommends that all medical examiner offices have written, posted, and readily accessible health and safety policies and procedures, and adequate risk management programs. NAME also recommends that such offices have written standard operating procedures for the decontamination of autopsy instruments and surfaces.

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23 This is also recommended by the Centers for Disease Control and Prevention (CDC).
a. **OCME has no written safety policies or procedures.**

Prior to the start of the inspection, OIG requested that the CME provide all written policies and procedures on safety. None were provided at that time. The CME stated that due to inadequate staffing, he has not been able to develop written safety policies and procedures.

b. **There are no written standard operating procedures for decontamination of autopsy instruments and surfaces.**

According to *Biosafety Considerations for Autopsy*, instruments used in autopsy procedures should be decontaminated by liquid chemical soaks or by autoclaving.\(^2^4\) Kurt B. Nolte, M.D., David G. Taylor, PhD, and Jonathan Y. Richmond, Ph.D., *Biosafety Considerations for Autopsy*, 23(2) AM. J. OF FORENSIC MED. PATHOLOGY 107, 114 (2002). Autopsy surfaces should be decontaminated with an appropriate liquid chemical at appropriate concentration levels after each autopsy. *Id.* at 115. The team found that employees frequently rinse autopsy surfaces with plain water between autopsies and fail to properly decontaminate the surfaces.

Failure to properly clean and decontaminate autopsy instruments and surfaces may affect the integrity of each autopsy and toxicology report. The team observed that OCME employees often set up autopsy areas prior to starting autopsy procedures without wearing protective garments such as gloves, and risk their health and safety by touching surfaces that may not have been properly decontaminated.

c. **OCME does not provide sufficient protective equipment to autopsy workers.**

The team observed that although OCME autopsy employees are provided with gloves, surgical masks, shoe covers, and gowns, additional protective equipment is needed. OSHA requires that hypoallergenic masks, gloves, glove liners, powderless gloves, or other appropriate alternatives be available to employees who are allergic to conventional gloves and masks. The AJFMP article, cited earlier, recommends that powered air-purifying respirators be used during the examination of persons who have died of conditions such as viral hemorrhagic fevers and/or during the disposal of toxic chemicals. *Id.* at 113.

OCME employees do not have air purifying respirators and no appropriate alternatives are provided to employees who are allergic to conventional latex gloves and masks.

d. **OCME does not have safety training programs.**

The CDC states that healthcare personnel should assume that biological specimens, including blood and body fluids, are potentially infectious, and therefore should follow universal infection control precautions at all times. OSHA requires that employers provide information and training to employees in the following subjects:\(^2^5\)

\(^{24}\) *Autoclaving* is sterilization by the use of pressurized steam.

• the nature of the hazards to which the employee is exposed and how to recognize them;
• what is being done by the employer to control these hazards;
• what protective measures the employee must follow to prevent or minimize exposure to these hazards; and
• the provisions of applicable standards.

OCME has not provided training to employees on the universal infection control precautions to take when handling biological specimens.

e. **OCME does not provide immunizations or proper health screenings.**

The U.S. Department of Labor and the U.S. Department of Health and Human Services require employers to provide the hepatitis B vaccine at no charge to at-risk health care workers. Additionally, as mentioned earlier, an AJFMP article recommends that autopsy workers have a baseline tuberculin skin test at the time of employment and periodic re-testing should also occur at regular intervals. Kurt B. Nolte, M.D., David G. Taylor, PhD, and Jonathan Y. Richmond, Ph.D., *Biosafety Considerations for Autopsy*, 23(2) AM. J. FORENSIC MED. PATHOLOGY 107, 115 (2002).

OCME employees are not required to have a hepatitis B vaccination prior to employment, and are not provided the vaccine once employed. Employees stated that OCME does not require a baseline tuberculin skin test at the time of employment and does not conduct periodic re-testing.

f. **Policies and procedures regarding employee exposure to blood-borne or airborne pathogens are inadequate.**

In the event of exposure to airborne or blood-borne pathogens, OSHA has prescribed an extensive list of evaluation and follow-up procedures that must be followed to remain compliant with the OSHA Blood-borne Pathogen Standard.

OSHA recommends that employers designate an individual within the workplace who will maintain records of exposure incidents. Exposed employees should be instructed to immediately inform that individual when an exposure incident occurs. When an incident is reported, it is the employer’s responsibility to immediately provide the employee access to a confidential medical evaluation and follow-up.

OCME has no designated employee to handle exposure incidents, and there are no written policies or procedures to ensure that employees receive immediate health care at no cost after possible exposure to blood-borne or airborne pathogens. Employees cite the CME as saying, “If you have any issues about exposure to hazards, you can go to your private physician.” Some employees stated that they have been required to finish their shift prior to seeking outside medical attention for possible exposure.
Due to a lack of written safety policies and procedures, adequate training, tuberculosis screenings, and hepatitis B vaccinations, the health and safety of autopsy employees is in jeopardy. Employees state they have:

- become ill due to the lack of respirators when disposing of hazardous chemicals and body tissue;
- been exposed to body fluids containing HIV hepatitis B and C through cuts and needle pricks and had to consult with their private physicians for treatment;
- either developed asthma or aggravated existing asthma when handling decomposed bodies; and
- developed rashes due to reactions to latex gloves and masks.

Recommendations:

a. That the CME establish written policies and procedures in accordance with OSHA guidelines.

Agree  X  Disagree

b. That the CME provide hepatitis B vaccinations to all at-risk employees.

Agree  X  Disagree

c. That the CME provide alternative protection for employees allergic to latex gloves and masks.

Agree  X  Disagree

d. That the CME provide periodic tuberculosis screenings for all at-risk employees.

Agree  X  Disagree

e. That the CME provide adequate training in universal precautions when performing autopsies and handling biological specimens.

Agree  X  Disagree

f. That the CME provide powered respirators for use in the autopsy suite.

Agree  X  Disagree

g. That standard operating procedures be written, and arrangements made, for employees to obtain immediate access to appropriate health care, at no cost, after exposure to blood-borne and airborne pathogens.

Agree  X  Disagree
OFFICE OF THE CME

CME’s comments regarding Recommendation (b.) as received:
If possible. Will explore availability through DOH.

CME’s comments regarding Recommendation (c.) as received:
This is being done.

CME’s comments regarding Recommendation (d.) as received:
Has been done recently.

CME’s comments regarding Recommendation (f.) as received:
These are available.

CME’s comments regarding Page 73, Line 35, as received:
This is not true. Positive pressure respirators (“PAPRS”) are available, and are used by
some employees. Alternatives for those with allergies to latex gloves and standard masks have
been sought and purchased.

CME’s comments regarding Page 74, Line 24, as received:
Periodic TB testing has been provided at OCME.

32. **OCME does not have a Mass Fatality or Disaster Plan.**

NAME defines a Mass Fatality Plan as one developed to handle any situation in which
there are more human bodies to be recovered and examined than can be handled by the usual
local resources. One should be developed by OCME with the participation of law enforcement,
fire, rescue, and emergency agencies, and hospitals. In addition, the office should coordinate
with surrounding jurisdictions on mass disaster planning. OCME should also participate in local
and regional mass disaster exercises and training.

The District’s OCME does not have a Mass Fatality or Mass Disaster Plan. OCME
employees stated that they have not participated in any mass disaster exercises and have not been
asked to participate in local mass disaster plan seminars or classes.

Without a written Mass Fatality and Disaster Plan, OCME is unprepared for a
catastrophic situation that produces an unusual number of dead bodies that must be processed
and stored. As previously stated, the OCME storage area is already filled to capacity. In light of
events such as terrorist attacks and other threats to national security, as well as massive nightclub
fatalities, it is imperative that OCME have a Mass Fatality and Disaster Plan.
Recommendations:

a. That the CME develop a written Mass Fatality and Disaster Plan as soon as possible.

   Agree ______ X _______ Disagree _____________

b. That the CME send appropriate OCME employees to training on Mass Fatality and Disaster Planning.

   Agree ______ X _______ Disagree _____________

CME’s comments regarding Recommendation (a.) as received:

The CME is appointed by the Mayor to the Emergency Preparedness Council, and has participated in the preparation of the District Response Plan (DRP). The CME supplied the DRP pocket guide materials for Mass Fatalities under ESF-8. The CME, with the assistance of the Deputy Mayor for Public Safety and Justice, has identified a consultant who can create a mass fatality plan for OCME, with expected delivery date in November.

CME’s comments regarding Recommendation (b.) as received:

Some OCME employees have participated in disaster training and exercises. Several employees are participants in D-MORT, which includes mandatory training.

OCME is not prepared to handle after-hours autopsies in response to requests from other investigative agencies or District authorities.

OCME is not sufficiently staffed and has no employees on call to handle special investigative requests for after-hours autopsies or postmortem examinations. Following the sniper shooting that occurred in the District, the CME said he was unable to comply with a special request from MPD to conduct an immediate autopsy because he could not put an autopsy team together after normal duty hours (Appendix 11 OIG Special Report: How OCME Handled the Autopsy of Sniper Victim Pascal Charlot). Medical examiners stated that they are not aware of any autopsies having been performed in OCME after normal duty hours.

The team believes that current concerns generated by the threat of terrorist attacks in the nation’s capital, the regional sniper attacks, and high local murder rates call for consideration of policies and procedures that make critical OCME services available to investigators and District officials on a 24 hour-per-day basis.
Recommendation:

That the CME, in collaboration with affected agencies and officials, consider development of an after-hours plan for conducting autopsies, and providing other OCME services and assistance to investigative agencies such as MPD, or other District or federal authorities, as may be required.

Agree ___________ Disagree ________ X ________

CME’s comments regarding Recommendation as received:

Some OCME services are available on a 24-hour per day basis. There is always a medical examiner on call, either for telephone consultation, or to respond to exceptional death scenes. The CME is on call every night, and has responded to death scenes when needed. As noted in 8a above, OCME needs additional MLIs to cover investigations and scenes 24-hours per day.

After-hour autopsies are generally bad practice. When done, they often compromise procedures, use fatigued staff, and jeopardize documentation and evidence collection. Under rare circumstances, exceptions may become necessary, but this should not rise to the level of an after-hours plan, as if anticipating this becoming a frequent occurrence. Even in a mass fatality disaster, autopsies are not typically done 24 hours per day.

The statement in the first paragraph above in #33 mischaracterized my statement to the inspectors. I did inform them that I could not put together the usual team in the middle of the night, although I also informed them that I made the judgment not to perform the autopsy for the reasons enumerated above about why after-hour autopsies are not good policy. The details found in the OIG investigation into the OCME handling of the sniper shooting (Appendix 11) also demonstrate that the time-course of transporting the body to OCME (arriving at 0230), performing check-in procedures, taking instant photos and multiple X-rays would have not made the body available for autopsy until close to 0400 - not that long before the start of the next workday. Trying to do this overnight would not have gained much time, but would have entailed some risks.

OIG Response: OIG continues to recommend that the CME develop an after-hours autopsy plan for contingencies such as the 2002 sniper events.

34. OCME does not have a tracking system for public complaints and inquiries.

OCME is responsible for tracking cases, complaints, and inquiries from families and other parties received directly at OCME or from the Mayor’s automated call center. When there is a complaint, OCME must investigate and report back to the call center or the complainant.

Best practices in Maryland, Virginia, and Pennsylvania require that a system be in place to properly monitor correspondence regarding complaints and requests for information on the status of autopsy reports, death certificates, cremations, and insurance inquiries. However, OCME has no system for tracking and responding to complaints and inquiries. The executive
assistant who has been responsible for tracking complaints is no longer an OCME employee. Since this vacancy occurred in October 2002, management has not reassigned the responsibilities to another employee.

Recommendation:

That the CME assign complaint and inquiry tracking and response duties to a responsible staff person immediately.

Agree X Disagree

CME's comments regarding Recommendation as received:

This has already been done. The complaints and inquiries are being tracked better under this employee than they have ever been during the tenure of this CME.

35. **OCME does not have a quality assurance program.**

NAME recommends that all medical examiner offices have written and implemented a policy or standard operating procedure for quality assurance. NAME states that continuous quality improvement of such offices can be ensured by the following means:

- daily staff conferences for discussion and disposition of pending and problem cases; and
- random selection and detailed review of autopsy reports by an assigned autopsy pathologist, with a written evaluation form that is maintained in a quality assurance file.

  a. **OCME does not utilize conferences at the end of the day to discuss all autopsy cases conducted.**

The team reviewed best practices in Maryland and Virginia and found CMEs have a daily conference or meeting at the end of the day to discuss all autopsy cases conducted. This allows the CME to stay abreast of current, problem, and pending cases. Although OCME has daily morning meetings to assign cases and determine the types of autopsies and examinations to be performed, it does not have the kind of end-of-the-day meetings recommended. Medical examiners stated that such conferences aid in prioritizing backlogged cases. In addition, the CME is often unavailable during the day for consultation on problem or pending cases.

  b. **Autopsy reports are not randomly selected for evaluation of their quality and completeness.**

Surrounding jurisdictions have written policies and procedures for autopsy reports and randomly select and evaluate them regularly; OCME does not. These evaluations ensure the integrity and completeness of the reports and their conformity with uniform standards established by the office. Medical examiners stated that the CME sometimes changes their autopsy reports,
but there are no written standards or criteria for making these changes, and no uniformity in how
their autopsy reports are presented.

Medical examiners also stated that often the CME will change an autopsy report or
require that the medical examiner amend a significant finding in the autopsy report regarding
cause and manner of death even if the medical examiner is not in agreement. Medical examiners
stated that they are required to sign-off on these reports without amendments being added noting
their disagreement. They stated they have been threatened with disciplinary action or
termination if they refuse to sign the reports. Because the CME did not perform the autopsy in
question, medical examiners believe the integrity of these autopsy reports could be called into
question. NAME recommends that medical examiners be responsible for the conduct of each
postmortem examination, the diagnoses made, the opinions formed and any subsequent
testimony.

Recommendations:

a. That the CME consider holding conferences at day’s end to address cases and
backlogs, and to solicit employee views and ideas on improving OCME
operations.

Agree  X  Disagree  

b. That the CME establish and implement an autopsy report evaluation program that
holds medical examiners responsible for the conduct and results of all autopsies
without unwarranted interference by the CME.

Agree  X  Disagree

CME’s comments regarding Recommendation (a.) as received:

Being done.

CME’s comments regarding Recommendation (b.) as received:

I have stated my desire to implement a QA program, but have not yet had the chance to
implement one. I cannot concur with the judgmental language of the recommendation, as the
involvement of the CME does not constitute “unwarranted interference.”

OIG Response: The OIG recommendation was not intended as a judgment, but as a
recommendation for a systematic review process.
CME's comments regarding Page 79, Line 36, as received:

The afternoon conferences were interrupted for a time, but have been re-established prior to receiving this report. They are now being held regularly (albeit with some missed days due to scheduling conflicts). The CME frequently consults with those MEs who ask; some do not avail themselves of the opportunity.

CME's comments regarding Page 80, Line 2, as received:

The format for the autopsy report is standardized, and the MEs had knowledge and input to it when it was revised under the former Deputy Chief ME. There is not yet a random review process, which is certainly a valuable procedure.

The CME is the policy-making official for the agency, and has the most experience as a medical examiner (also having worked in five jurisdictions) of the professional staff. He is ultimately responsible for the functioning and output of the entire agency. If he reviews cases or reports and finds errors or items that should be presented differently to prevent serious repercussions, then he has the right and the duty to bring this to the attention of his staff. When such an incident is a matter of factual correctness or significant procedural concern, he also has the right to direct his subordinates to change their reports or practices. In matters strictly of professional judgment, he does not have the right to dictate how they think or opine. This function does not need any written standards or criteria; it is implicit in the duties of the agency director supervising or reviewing the work of his professional staff.

CME's comments regarding Page 80, Line 13, as received:

Disagreements that are strictly issues of professional judgment or style are not dictated to the MEs, though the CME may raise them for discussion. (Presenting and defending one's analysis and conclusions of an issue are typical in a medical setting. This includes not only teaching, but also peer interactions.)

I have stated openly that if an ME presents a report or conclusion with which I have substantive disagreement, and the ME cannot support that conclusion based on medical evidence, then it is within my purview to direct that it be done differently. I have further stated to the MEs that if I direct them to sign something that they are uncomfortable with, as the agency director, I will take the responsibility and sign it personally. I have never threatened a medical examiner with discipline or termination related to this issue.

If there is a disagreement concerning the contents of a medicolegal autopsy report, it absolutely cannot be issued with an amendment noting the disagreement. These documents are often admitted as evidence in court, and are the subject of cross-examination. They are not committee or consensus reports; significant uncertainty is dealt with by a ruling of “undetermined,” not by reporting majority and minority opinions. There must be a final, official opinion reached on behalf of the agency, for which the CME is ultimately responsible (see comments for the immediately preceding paragraph). Even the NAME recommendation that MEs be responsible for their own cases does not obviate the authority of the CME.
36. **The CME has filled support positions that require permanent staffing with term employees. This practice may be contrary to the intent of D.C. Personnel Regulations.**

OCME operations require permanently-staffed support positions such as autopsy technicians, body transporters, communicators, and administrative employees. Although the CME has been allocated permanent positions to meet this requirement, he has hired term employees who work from 1 to 4 years and who are then terminated and must be replaced. Staffing turnovers under these circumstances appear to be unnecessary and disruptive, and inhibit the development of an experienced and loyal workforce for these critical areas.

DPM § 823.1 states “[a] personnel authority may make a term appointment for a period of more than (1) year when the needs of the service so require and the employment is for a limited period of four (4) years or less.” The OCME support functions cited above are permanent requirements in support of the basic mission of this office.

In addition, current and former term employees complained that the CME has told them they can be terminated at will and without cause, and allege that he uses this threat to demand additional work hours (as many as three work shifts in succession), as well as the performance of duties outside the scope of their jobs. Employees stated that they feel compelled to comply because of the perceived tenuousness of their employment status.

Many employees stated that terms were not renewed because employees were taking classes in the evening or had another job, even though this did not conflict with their duties. It should be noted that many of the term employees are grades DS/7 or below who stated they must supplement their incomes to support their families. However, supervisors often call them at the last minute for unscheduled work, which keeps them from their part-time jobs. Employees expressed fear that not being available 24 hours per day to cover various shifts may result in termination.

Term employees stated they were also told they had no grievance procedure or appeals process if they have a complaint. Consequently, some stated that they would not report unsafe work practices to management because they feared retaliatory action or termination with no means of redress. Both term and permanent employees stated that the treatment of term employees has contributed to morale problems in OCME.

The DCOP provided the following information concerning term appointments and employees:

- Term appointments cover grades DS-12 and below, and can be made non-competitively.
- Term appointments (from 1-4 years) are not to exceed 4 years, and a personnel action must be done for each extension after the first year’s appointment. Each personnel action contains a “Not-to-Exceed” date.
- Term employees serve a one-year probationary period, and then have the same rights and benefits as Career Service employees.
OFFICE OF THE CME

• Disciplinary actions and terminations are governed by DCOP regulations. For example, contrary to the apparent belief of some OCME term employees, their employment cannot be terminated arbitrarily, but must be for “cause” (such as poor performance).

• Contrary to the belief of some OCME term employees, they cannot be automatically “converted” to Career Service status. The positions they occupy must be filled competitively according to DCOP procedures at the end of their term.

Recommendation:

That the CME consult with DCOP on the regulatory requirements and proper use of term appointments, and ensure that he and all current and future term employees are fully versed on their separate responsibilities and entitlements.

Agree X Disagree

CME’s comments regarding Recommendation as received:

The CME has met with the DCOP Director recently to discuss this, among other issues. OCME was already in the process of converting most term positions to permanent, and has begun hiring all new positions as permanent.

CME’s comments regarding Page 82, Line 20, as received:

This is untrue. I am quite familiar with civil service protections afforded to employees, having managed in the New York City system for over 8 years before coming to the District. I would never tell employees that I could terminate them without cause. I am aware that some OCME employees have spread such unfounded rumors about the tenuousness of employment, but they have the obligation to know the personnel system, too.

CME’s comments regarding Page 82, Line 24, as received:

Employees may speculate about anything, but personnel information is confidential and protected. They are not privy to the facts. Legitimizing uninformed assertions as facts, which cannot be legally discussed in public, is not appropriate.

CME’s comments regarding Page 82, Line 32, as received:

This is also flatly untrue.

37. **An IT consultant hired by the Office of the Chief Technology Officer (OCTO) to automate some OCME operations has been given supervisory and managerial responsibilities in violation of District regulations.**

OCME and OCTO initiated a project to implement an automated system for death reporting and investigations as well as a case management system (CMS). OCTO provided OCME with a contractor for this project.
According to Title 27 DCMR § 1901.3(d), “the contracting officer shall ensure that a contract for expert or consulting services does not establish or allow... [s]upervision of District employees by the contractor.” In addition, a contracting officer may not contract for a consultant “[t]o perform work of a policy-making, decision-making, or managerial nature that is the direct responsibility of agency officials.” Id. § 1901.2(a).26

Section 1902 of the DCMR carves out an exception to these general prohibitions by permitting IT consultants to supervise District employees where authorized by a personal services contract. 27 DCMR § 1902.2. Specifically, Sections 1902.3(d) and (e) state that a personal services contract may allow “[s]upervision of District employees by the contractor” and “[p]erformance of work of a policy-making, decision-making, or managerial nature.”

However, the contract for the OCME computer specialist does not authorize her to supervise or manage District government employees. The contract, executed on September 4, 2002, generally provides for the contractor to assist OCME and OCTO in the installation of software to upgrade the CMS. More specifically, the contractor is required to meet weekly with the software vendor to ascertain the status of the project, conduct a review of third-party vendor software, report on the software installation, and make final recommendations. While the contract does contemplate that the contractor will “coordinate with District employees,” there is no reference to supervisory or managerial duties or to the exception of 27 DCMR § 1902.

The inspection revealed that the contractor was performing supervisory duties for areas outside the scope of her contract. The team reviewed a memorandum and electronic correspondence (Appendix 12) stating that the CME granted full approval and authority to the OCTO contractor to make management decisions and perform management duties unrelated to her CMS role. The contractor assumed the title of Chief Technology Officer, and her responsibilities were expanded to include the following:

- coordinate all IT aspects of OCME projects;
- coordinate all aspects of OCME IT purchases and procurements;
- supervise the OCME computer specialist; and
- record the minutes of administrative staff meetings.

The OCME computer specialist no longer has the authority and flexibility to perform his duties independently. Additionally, assigning such supervisory and managerial responsibilities to a contractor (without contractual authority) distracts the contractor from giving full time and attention to completion of the CMS and violates 27 DCMR § 1901.3(d).

26 The two provisions provide for exceptions under limited circumstances, which are not applicable here.
OFFICE OF THE CME

Recommendation:

That the CME revoke supervisory and management duties assigned to the OCTO independent contractor that are outside the scope of her consultant contract and ensure that these responsibilities (duties) are reassigned to the appropriate employee(s).

Agree _____________ Disagree _______ X _______

CME’s comments regarding Recommendation as received:

(See also comments on Recommendation #40, below.)

When the consultant started at OCME, the state of the IT environment was miserable, due to neglect by the computer specialist, and the lack of supervision of him by anyone within OCME who had IT subject-matter expertise. Therefore, the agency attempted to follow the model implemented District-wide by the Chief Technology Officer (CTO) of having an Agency Chief Information Officer (CIO), which will be required of all agencies as of FY04. (Note: in the memo cited in Appendix 12, this title was mistakenly listed by the CME as “Agency CTO,” when it should have been “Agency CIO.”) The consultant brought to the CME’s attention that the hardware purchases made by the computer specialist (and approved by the then Deputy for Administration) were not within the District standards. Because of this improper purchasing, OCME was not getting the best prices, and thousands of dollars of unused computer equipment was in storage. In the Agency CIO model, the CIO reviews purchases and makes recommendations to keep within District guidelines and standards. This brings consistency within systems and the broader District IT environment, provides economy of scale for purchases, and minimizes waste.

The CME did not grant the contractor full authority to make management decisions. Her role to coordinate IT functions and purchases was to make the professional assessment of the IT environment and needs, and to make recommendations to OCME administration, which then made the management decisions. All of these conclusions were reached jointly between the consultant and the computer specialist before being forwarded to the OCME Management Services Officer. The reference in that memo (Appendix 12) to supervising the computer specialist specifies for technical issues (i.e., IT matters) only. The computer specialist was administratively supervised (time and attendance, performance evaluation, etc.) by OCME administration. The computer specialist was not denied the authority and flexibility to perform his duties independently; his position was never entitled to such independence.

The Agency CIO duties did not distract the contractor from completing the CMS. They created the environment that allowed the project to continue. Without the CIO accomplishments, the CMS project would have failed (see #40, below).

(Note: Since February 2003, the contractor has been a District employee. OCME continues to follow the OCTO Agency CIO model.)

OIG Response: The OIG stands by its findings, but accepts the CME’s comments that the original conditions described have been rectified.
CME's comments regarding Page 84, Line 33, as received:

This was not assigned. She volunteered to do this on occasions in the absence of other employees.

38. **Employees do not receive annual performance evaluations in accordance with the District Personnel Manual.**

Chapter 14, Subpart 1.5 (A) of the DPM states “[e]mployees are to be rated for the period, which begins on April 1 of each year and ends on March 31 of the following year.”

Some employees stated they have not received annual performance evaluations. Others who have received performance evaluations, said that management prepares evaluations without any discussions with the employee.

**Recommendation:**

That the CME ensure that employees receive annual performance evaluations in a timely manner, and that they are discussed with each employee in accordance with District personnel regulations.

Agree X Disagree

CME's comments regarding Recommendation as received:

OCME has had prior deficiencies completing performance evaluations. This year, all were completed timely. All were discussed with the employees when completed.