

**Findings and
Recommendations:
OFFICE OF THE CME**

1
2 **31. OCME does not have a workplace safety and health program.**
3

4 OCME receives the remains of decedents who had tested positive for a variety of
5 contagious diseases such as hepatitis, HIV, and tuberculosis. It also receives bodies that are
6 badly decomposed and that expose employees to hazardous airborne pathogens. OCME disposes
7 of biohazardous waste from these decedents periodically.
8

9 According to a recent article in *The American Journal of Forensic Medicine and*
10 *Pathology* (AJFMP), an autopsy may expose employees and others to “a wide variety of
11 infectious agents, including blood-borne and aerosolized pathogens such as human
12 immunodeficiency virus (HIV) hepatitis B and C viruses, and *Mycobacterium tuberculosis*.”
13 Kurt B. Nolte, M.D., David G. Taylor, PhD, and Jonathan Y. Richmond, Ph.D., *Biosafety*
14 *Considerations for Autopsy*, 23(2) AM. J. OF FORENSIC MED. PATHOLOGY 107 (2002). Other
15 hazards include exposure to toxic chemicals such as formalin, cyanide, and organophosphates.
16 *Id.* Additionally, the article notes that surveys of British clinical laboratories between 1970 and
17 1989 demonstrated that the highest rate of laboratory-acquired infections were in autopsy
18 workers and that autopsies are an “exceptionally efficient method of transmitting tuberculosis
19 from the decedent to those present in the dissection room.” *Id.* at 107 and 109.
20

21 However, the article states that these health and safety risks can be substantially mitigated
22 through, among other things, proper risk assessment, personal protective equipment, and
23 appropriate autopsy procedures. *Id.* at 112. Finally, the article recommends that autopsy
24 personnel utilize the following precautions:
25

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

33
34 *Id.* at 112 - 115.
35

36 To reduce the number of job-related fatalities, illnesses, and injuries, the U.S. Department
37 of Labor Occupational Safety and Health Administration (OSHA) recommends that employers
38 establish a workplace safety and health program that complies with OSHA standards.
39

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

²³ This is also recommended by the Centers for Disease Control and Prevention (CDC).

OFFICE OF THE CME

1 **a. OCME has no written safety policies or procedures.**
2

3 Prior to the start of the inspection, OIG requested that the CME provide all written
4 policies and procedures on safety. None were provided at that time. The CME stated that due to
5 inadequate staffing, he has not been able to develop written safety policies and procedures.
6

7 **b. There are no written standard operating procedures for decontamination of**
8 **autopsy instruments and surfaces.**
9

10 According to *Biosafety Considerations for Autopsy*, instruments used in autopsy
11 procedures should be decontaminated by liquid chemical soaks or by autoclaving.²⁴ Kurt B.
12 Nolte, M.D., David G. Taylor, PhD, and Jonathan Y. Richmond, Ph.D., *Biosafety Considerations*
13 *for Autopsy*, 23(2) AM. J. OF FORENSIC MED. PATHOLOGY 107, 114 (2002). Autopsy surfaces
14 should be decontaminated with an appropriate liquid chemical at appropriate concentration levels
15 after each autopsy. *Id.* at 115. The team found that employees frequently rinse autopsy surfaces
16 with plain water between autopsies and fail to properly decontaminate the surfaces.
17

18 Failure to properly clean and decontaminate autopsy instruments and surfaces may affect
19 the integrity of each autopsy and toxicology report. The team observed that OCME employees
20 often set up autopsy areas prior to starting autopsy procedures without wearing protective
21 garments such as gloves, and risk their health and safety by touching surfaces that may not have
22 been properly decontaminated.
23

24 **c. OCME does not provide sufficient protective equipment to autopsy workers.**
25

26 The team observed that although OCME autopsy employees are provided with gloves,
27 surgical masks, shoe covers, and gowns, additional protective equipment is needed. OSHA
28 requires that hypoallergenic masks, gloves, glove liners, powderless gloves, or other appropriate
29 alternatives be available to employees who are allergic to conventional gloves and masks. The
30 AJFMP article, cited earlier, recommends that powered air-purifying respirators be used during
31 the examination of persons who have died of conditions such as viral hemorrhagic fevers and/or
32 during the disposal of toxic chemicals. *Id.* at 113.
33

34 OCME employees do not have air purifying respirators and no appropriate alternatives
35 are provided to employees who are allergic to conventional latex gloves and masks.
36

37 **d. OCME does not have safety training programs.**
38

39 The CDC states that healthcare personnel should assume that biological specimens,
40 including blood and body fluids, are potentially infectious, and therefore should follow universal
41 infection control precautions at all times. OSHA requires that employers provide information
42 and training to employees in the following subjects.²⁵
43

²⁴ *Autoclaving* is sterilization by the use of pressurized steam.

²⁵ See U.S. Department of Labor, Occupational Safety and Health Administration at www.osha.gov.

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

7
8 OCME has not provided training to employees on the universal infection control
9 precautions to take when handling biological specimens.

10
11 ***e. OCME does not provide immunizations or proper health screenings.***

12
13 The U.S. Department of Labor and the U.S. Department of Health and Human Services
14 require employers to provide the hepatitis B vaccine at no charge to at-risk health care workers.
15 Additionally, as mentioned earlier, an AJFMP article recommends that autopsy workers have a
16 baseline tuberculin skin test at the time of employment and periodic re-testing should also occur
17 at regular intervals. Kurt B. Nolte, M.D., David G. Taylor, PhD, and Jonathan Y. Richmond,
18 Ph.D., *Biosafety Considerations for Autopsy*, 23(2) AM. J. FORENSIC MED. PATHOLOGY 107, 115
19 (2002).

20
21 OCME employees are not required to have a hepatitis B vaccination prior to employment,
22 and are not provided the vaccine once employed. Employees stated that OCME does not require
23 a baseline tuberculin skin test at the time of employment and does not conduct periodic re-
24 testing.

25
26 ***f. Policies and procedures regarding employee exposure to blood-borne or***
27 ***airborne pathogens are inadequate.***

28
29 In the event of exposure to airborne or blood-borne pathogens, OSHA has prescribed an
30 extensive list of evaluation and follow-up procedures that must be followed to remain compliant
31 with the OSHA Blood-borne Pathogen Standard.

32
33 OSHA recommends that employers designate an individual within the workplace who
34 will maintain records of exposure incidents. Exposed employees should be instructed to
35 immediately inform that individual when an exposure incident occurs. When an incident is
36 reported, it is the employer's responsibility to immediately provide the employee access to a
37 confidential medical evaluation and follow-up.

38
39 OCME has no designated employee to handle exposure incidents, and there are no
40 written policies or procedures to ensure that employees receive immediate health care at no cost
41 after possible exposure to blood-borne or airborne pathogens. Employees cite the CME as
42 saying, "If you have any issues about exposure to hazards, you can go to your private physician."
43 Some employees stated that they have been required to finish their shift prior to seeking outside
44 medical attention for possible exposure.

OFFICE OF THE CME

1 Due to a lack of written safety policies and procedures, adequate training, tuberculosis
2 screenings, and hepatitis B vaccinations, the health and safety of autopsy employees is in
3 jeopardy. Employees state they have:
4

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

12
13 **Recommendations:**

- 14
15 a. That the CME establish written policies and procedures in accordance with
16 OSHA guidelines.

17 Agree _____ **X** _____ Disagree _____

- 18
19 b. That the CME provide hepatitis B vaccinations to all at-risk employees.

20 Agree _____ **X** _____ Disagree _____

- 21
22 c. That the CME provide alternative protection for employees allergic to latex
23 gloves and masks.

24 Agree _____ **X** _____ Disagree _____

- 25
26 d. That the CME provide periodic tuberculosis screenings for all at-risk employees.

27 Agree _____ **X** _____ Disagree _____

- 28
29 e. That the CME provide adequate training in universal precautions when
30 performing autopsies and handling biological specimens.

31 Agree _____ **X** _____ Disagree _____

- 32
33 f. That the CME provide powered respirators for use in the autopsy suite.

34 Agree _____ **X** _____ Disagree _____

- 35
36 g. That standard operating procedures be written, and arrangements made, for
37 employees to obtain immediate access to appropriate health care, at no cost, after
38 exposure to blood-borne and airborne pathogens.

39 Agree _____ **X** _____ Disagree _____

OFFICE OF THE CME

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

2
3 If possible. Will explore availability through DOH.

4
5 **CME's comments regarding Recommendation (c.) as received:**

6
7 This is being done.

8
9 **CME's comments regarding Recommendation (d.) as received:**

10
11 Has been done recently.

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

14
15 These are available.

16
17 **CME's comments regarding Page 73, Line 35, as received:**

18
19 This is not true. Positive pressure respirators ("PAPRS") are available, and are used by
20 some employees. Alternatives for those with allergies to latex gloves and standard masks have
21 been sought and purchased.

22
23 **CME's comments regarding Page 74, Line 24, as received:**

24
25 Periodic TB testing has been provided at OCME.

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

27
28 NAME defines a Mass Fatality Plan as one developed to handle any situation in which
29 there are more human bodies to be recovered and examined than can be handled by the usual
30 local resources. One should be developed by OCME with the participation of law enforcement,
31 fire, rescue, and emergency agencies, and hospitals. In addition, the office should coordinate
32 with surrounding jurisdictions on mass disaster planning. OCME should also participate in local
33 and regional mass disaster exercises and training.

34
35 The District's OCME does not have a Mass Fatality or Mass Disaster Plan. OCME
36 employees stated that they have not participated in any mass disaster exercises and have not been
37 asked to participate in local mass disaster plan seminars or classes.

38
39 Without a written Mass Fatality and Disaster Plan, OCME is unprepared for a
40 catastrophic situation that produces an unusual number of dead bodies that must be processed
41 and stored. As previously stated, the OCME storage area is already filled to capacity. In light of
42 events such as terrorist attacks and other threats to national security, as well as massive nightclub
43 fatalities, it is imperative that OCME have a Mass Fatality and Disaster Plan.

OFFICE OF THE CME

1 **Recommendation:**

2
3 That the CME, in collaboration with affected agencies and officials, consider
4 development of an after-hours plan for conducting autopsies, and providing other OCME
5 services and assistance to investigative agencies such as MPD, or other District or federal
6 authorities, as may be required.
7

8 Agree Disagree **X**

9 **CME's comments regarding Recommendation as received:**

10
11 Some OCME services are available on a 24-hour per day basis. There is always a
12 medical examiner on call, either for telephone consultation, or to respond to exceptional death
13 scenes. The CME is on call every night, and has responded to death scenes when needed. As
14 noted in 8a above, OCME needs additional MLIs to cover investigations and scenes 24-hours
15 per day.
16

17 After-hour autopsies are generally bad practice. When done, they often compromise
18 procedures, use fatigued staff, and jeopardize documentation and evidence collection. Under
19 rare circumstances, exceptions may become necessary, but this should not rise to the level of
20 an after-hours plan, as if anticipating this becoming a frequent occurrence. Even in a mass
21 fatality disaster, autopsies are not typically done 24 hours per day.
22

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

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

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

37
38 OCME is responsible for tracking cases, complaints, and inquiries from families and
39 other parties received directly at OCME or from the Mayor's automated call center. When there
40 is a complaint, OCME must investigate and report back to the call center or the complainant.
41

42 Best practices in Maryland, Virginia, and Pennsylvania require that a system be in place
43 to properly monitor correspondence regarding complaints and requests for information on the
44 status of autopsy reports, death certificates, cremations, and insurance inquiries. However,
45 OCME has no system for tracking and responding to complaints and inquiries. The executive
46

1 **CME's comments regarding Page 79, Line 36, as received:**
2

3 The afternoon conferences were interrupted for a time, but have been re-established
4 prior to receiving this report. They are now being held regularly (albeit with some missed days
5 due to scheduling conflicts). The CME frequently consults with those MEs who ask; some do
6 not avail themselves of the opportunity.
7

8 **CME's comments regarding Page 80, Line 2, as received:**
9

10 The format for the autopsy report is standardized, and the MEs had knowledge and input
11 to it when it was revised under the former Deputy Chief ME. There is not yet a random review
12 process, which is certainly a valuable procedure.
13

14 The CME is the policy-making official for the agency, and has the most experience as a
15 medical examiner (also having worked in five jurisdictions) of the professional staff. He is
16 ultimately responsible for the functioning and output of the entire agency. If he reviews cases or
17 reports and finds errors or items that should be presented differently to prevent serious
18 repercussions, then he has the right and the duty to bring this to the attention of his staff. When
19 such an incident is a matter of factual correctness or significant procedural concern, he also has
20 the right to direct his subordinates to change their reports or practices. In matters strictly of
21 professional judgment, he does not have the right to dictate how they think or opine. This
22 function does not need any written standards or criteria; it is implicit in the duties of the agency
23 director supervising or reviewing the work of his professional staff.
24

25 **CME's comments regarding Page 80, Line 13, as received:**
26

27 Disagreements that are strictly issues of professional judgment or style are not dictated
28 to the MEs, though the CME may raise them for discussion. (Presenting and defending one's
29 analysis and conclusions of an issue are typical in a medical setting. This includes not only
30 teaching, but also peer interactions.)
31

32 I have stated openly that if an ME presents a report or conclusion with which I have
33 substantive disagreement, and the ME cannot support that conclusion based on medical
34 evidence, then it is within my purview to direct that it be done differently. I have further stated to
35 the MEs that if I direct them to sign something that they are uncomfortable with, as the agency
36 director, I will take the responsibility and sign it personally. I have never threatened a medical
37 examiner with discipline or termination related to this issue.
38

39 If there is a disagreement concerning the contents of a medicolegal autopsy report, it
40 absolutely cannot be issued with an amendment noting the disagreement. These documents
41 are often admitted as evidence in court, and are the subject of cross-examination. They are not
42 committee or consensus reports; significant uncertainty is dealt with by a ruling of
43 "undetermined," not by reporting majority and minority opinions. There must be a final, official
44 opinion reached on behalf of the agency, for which the CME is ultimately responsible (see
45 comments for the immediately preceding paragraph). Even the NAME recommendation that
46 MEs be responsible for their own cases does not obviate the authority of the CME.

1 **36. The CME has filled support positions that require permanent staffing with term**
2 **employees. This practice may be contrary to the intent of D.C. Personnel**
3 **Regulations.**
4

5 OCME operations require permanently-staffed support positions such as autopsy
6 technicians, body transporters, communicators, and administrative employees. Although the
7 CME has been allocated permanent positions to meet this requirement, he has hired term
8 employees who work from 1 to 4 years and who are then terminated and must be replaced.
9 Staffing turnovers under these circumstances appear to be unnecessary and disruptive, and
10 inhibit the development of an experienced and loyal workforce for these critical areas.
11

12 DPM § 823.1 states “[a] personnel authority may make a term appointment for a period
13 of more than (1) year when the needs of the service so require and the employment is for a
14 limited period of four (4) years or less.” The OCME support functions cited above are
15 permanent requirements in support of the basic mission of this office.
16

17 In addition, current and former term employees complained that the CME has told them
18 they can be terminated at will and without cause, and allege that he uses this threat to demand
19 additional work hours (as many as three work shifts in succession), as well as the performance of
20 duties outside the scope of their jobs. Employees stated that they feel compelled to comply
21 because of the perceived tenuousness of their employment status.
22

23 Many employees stated that terms were not renewed because employees were taking
24 classes in the evening or had another job, even though this did not conflict with their duties. It
25 should be noted that many of the term employees are grades DS/7 or below who stated they must
26 supplement their incomes to support their families. However, supervisors often call them at the
27 last minute for unscheduled work, which keeps them from their part-time jobs. Employees
28 expressed fear that not being available 24 hours per day to cover various shifts may result in
29 termination.
30

31 Term employees stated they were also told they had no grievance procedure or appeals
32 process if they have a complaint. Consequently, some stated that they would not report unsafe
33 work practices to management because they feared retaliatory action or termination with no
34 means of redress. Both term and permanent employees stated that the treatment of term
35 employees has contributed to morale problems in OCME.
36

37 The DCOP provided the following information concerning term appointments and
38 employees:
39

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

OFFICE OF THE CME

1 According to Title 27 DCMR § 1901.3(d), “the contracting officer shall ensure that a
2 contract for expert or consulting services does not establish or allow... [s]upervision of District
3 employees by the contractor.” In addition, a contracting officer may not contract for a consultant
4 “[t]o perform work of a policy-making, decision-making, or managerial nature that is the direct
5 responsibility of agency officials.” *Id.*
6 § 1901.2(a).²⁶
7

8 Section 1902 of the DCMR carves out an exception to these general prohibitions by
9 permitting IT consultants to supervise District employees where authorized by a personal
10 services contract. 27 DCMR § 1902.2. Specifically, Sections 1902.3(d) and (e) state that a
11 personal services contract may allow “[s]upervision of District employees by the contractor” and
12 “[p]erformance of work of a policy-making, decision-making, or managerial nature.”
13

14 However, the contract for the OCME computer specialist does not authorize her to
15 supervise or manage District government employees. The contract, executed on September 4,
16 2002, generally provides for the contractor to assist OCME and OCTO in the installation of
17 software to upgrade the CMS. More specifically, the contractor is required to meet weekly with
18 the software vendor to ascertain the status of the project, conduct a review of third-party vendor
19 software, report on the software installation, and make final recommendations. While the
20 contract does contemplate that the contractor will “coordinate with District employees,” there is
21 no reference to supervisory or managerial duties or to the exception of 27 DCMR § 1902.
22

23 The inspection revealed that the contractor was performing supervisory duties for areas
24 outside the scope of her contract. The team reviewed a memorandum and electronic
25 correspondence (Appendix 12) stating that the CME granted full approval and authority to the
26 OCTO contractor to make management decisions and perform management duties unrelated to
27 her CMS role. The contractor assumed the title of Chief Technology Officer, and her
28 responsibilities were expanded to include the following:
29

- 30 • coordinate all IT aspects of OCME projects;
- 31 • coordinate all aspects of OCME IT purchases and procurements;
- 32 • supervise the OCME computer specialist; and
- 33 • record the minutes of administrative staff meetings.
- 34

35 The OCME computer specialist no longer has the authority and flexibility to
36 perform his duties independently. Additionally, assigning such supervisory and managerial
37 responsibilities to a contractor (without contractual authority) distracts the contractor from giving
38 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

1 **Recommendation:**

2
3 That the CME revoke supervisory and management duties assigned to the OCTO
4 independent contractor that are outside the scope of her consultant contract and ensure
5 that these responsibilities (duties) are reassigned to the appropriate employee(s).

6
7 Agree _____ Disagree _____ **X**

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

9
10 (See also comments on Recommendation #40, below.)

11
12 When the consultant started at OCME, the state of the IT environment was miserable,
13 due to neglect by the computer specialist, and the lack of supervision of him by anyone within
14 OCME who had IT subject-matter expertise. Therefore, the agency attempted to follow the
15 model implemented District-wide by the Chief Technology Officer (CTO) of having an Agency
16 Chief Information Officer (CIO), which will be required of all agencies as of FY04. (Note: in the
17 memo cited in Appendix 12, this title was mistakenly listed by the CME as "Agency CTO," when
18 it should have been "Agency CIO.") The consultant brought to the CME's attention that the
19 hardware purchases made by the computer specialist (and approved by the then Deputy for
20 Administration) were not within the District standards. Because of this improper purchasing,
21 OCME was not getting the best prices, and thousands of dollars of unused computer equipment
22 was in storage. In the Agency CIO model, the CIO reviews purchases and makes
23 recommendations to keep within District guidelines and standards. This brings consistency
24 within systems and the broader District IT environment, provides economy of scale for
25 purchases, and minimizes waste.

26
27 The CME did not grant the contractor full authority to make management decisions. Her
28 role to coordinate IT functions and purchases was to make the professional assessment of the
29 IT environment and needs, and to make recommendations to OCME administration, which then
30 made the management decisions. All of these conclusions were reached jointly between the
31 consultant and the computer specialist before being forwarded to the OCME Management
32 Services Officer. The reference in that memo (Appendix 12) to supervising the computer
33 specialist specifies for technical issues (i.e., IT matters) only. The computer specialist was
34 administratively supervised (time and attendance, performance evaluation, etc.) by OCME
35 administration. The computer specialist was not denied the authority and flexibility to perform
36 his duties independently; his position was never entitled to such independence.

37
38 The Agency CIO duties did not distract the contractor from completing the CMS. They
39 created the environment that allowed the project to continue. Without the CIO
40 accomplishments, the CMS project would have failed (see #40, below).

41
42 (Note: Since February 2003, the contractor has been a District employee. OCME
43 continues to follow the OCTO Agency CIO model.)

44
45 OIG Response: **The OIG stands by its findings, but accepts the CME's comments**
46 **that the original conditions described have been rectified.**

OFFICE OF THE CME

1 **CME's comments regarding Page 84, Line 33, as received:**
2

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

5 **38. Employees do not receive annual performance evaluations in accordance with the**
6 **District Personnel Manual.**
7

8 Chapter 14, Subpart 1.5 (A) of the DPM states “[e]mployees are to be rated for the
9 period, which begins on April 1 of each year and ends on March 31 of the following year.”
10

11 Some employees stated they have not received annual performance evaluations. Others
12 who have received performance evaluations, said that management prepares evaluations without
13 any discussions with the employee.
14

15 **Recommendation:**
16

17 That the CME ensure that employees receive annual performance evaluations in a timely
18 manner, and that they are discussed with each employee in accordance with District
19 personnel regulations.
20

21 Agree _____ **X** _____ Disagree _____

22 **CME's comments regarding Recommendation as received:**
23

24 OCME has had prior deficiencies completing performance evaluations. This year, all
25 were completed timely. All were discussed with the employees when completed.
26
27