
INTRODUCTION

INTRODUCTION

Background and Perspective

The Inspections and Evaluations (I&E) Division of the Office of the Inspector General (OIG) conducted an inspection of the District of Columbia (District) Office of the Chief Medical Examiner (OCME) from November 2002 to March 2003. OCME's mission statement calls for the investigation of all violent deaths, all deaths that occur unexpectedly, all deaths that occur in the absence of medical attention or in police custody, and all deaths that pose a threat to public health.

OCME was formerly part of the Department of Health (DOH). In 2001, it was removed from DOH and made a separate agency subordinate to the Executive Office of the Mayor. It has 50 full-time employees, and its fiscal year (FY) 2003 budget was approximately \$5.9 million. Annually, OCME employees investigate approximately 4000 deaths, conduct approximately 1400 autopsies, and perform approximately 400 external examinations of decedents.

The inspection team (team) found poor management of OCME operations and personnel; significant health and safety problems; a lack of written policies and procedures; and low employee morale. The Chief Medical Examiner (CME) frankly acknowledged problems within the agency, as well as his accountability for his agency's performance.

The team found OCME employees to be dedicated and professional, and commends them for enthusiastically performing duties that can be dangerous and emotionally draining, and for which many receive low pay. Some tasks assigned to OCME employees are rated for environmental differential pay; OCME employees, however, do not received such compensation.

Scope and Methodology

The inspection focused on the management and operations of key areas, including mortuary services, forensic investigations, record keeping, case management, laboratory services, communications, and administrative oversight of the District's Child Fatality Review Committee. The team reviewed best practices recommended by the National Association of Medical Examiners (NAME) and the operations of medical examiner offices in surrounding jurisdictions. The team conducted 54 interviews, issued an anonymous and confidential employee survey, observed all work areas and key work processes, and visited surrounding jurisdictions to determine best practices. A list of the report's 41 findings and 74 recommendations is at Appendix 1. OCME management and employees were cooperative and responsive throughout the inspection.

Compliance and Follow-Up

The OIG inspection process includes follow-up with inspected agencies on findings and recommendations. Compliance forms with findings and recommendations will be sent to OCME along with this Report of Inspection (ROI). The I&E Division Compliance Officer will coordinate with OCME on verifying compliance with the recommendations in this report over an established time period. In some instances, follow-up inspection activities and additional reports may be required.