

**GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF THE INSPECTOR GENERAL**

**OFFICE OF THE
CHIEF MEDICAL EXAMINER**

REPORT OF RE-INSPECTION

OCTOBER 2007



**CHARLES J. WILLOUGHBY
INSPECTOR GENERAL**

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Office of the Inspector General

Inspector General



October 30, 2007

Marie-Lydie Y. Pierre-Louis, M.D.
Chief Medical Examiner
Office of the Chief Medical Examiner
Government of the District of Columbia
1910 Massachusetts Avenue, S.E., Bldg. 27
Washington, D.C. 20003

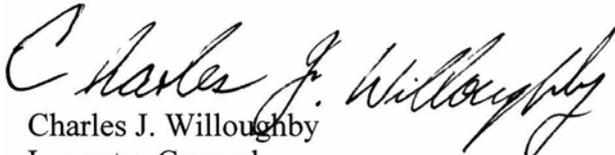
Dear Dr. Pierre-Louis:

Enclosed is our *Report of Re-inspection of the Office of the Chief Medical Examiner (OCME)*. We conducted the re-inspection of OCME as a follow-up to our initial inspection that occurred between November 2002 and March 2003. Re-inspections and follow-up reports are the key components of the OIG compliance process. This process was developed to assist District managers in improving service delivery by implementing the recommendations that were agreed upon at the conclusion of the initial inspection.

Of the 79 recommendations made in our initial inspection report, OCME has complied fully with 50; 12 are in partial compliance; 11 have not been complied with, and 6 were overtaken by events. I commend OCME for the improvements represented by those recommendations complied with, and ask that OCME managers be encouraged to work diligently and expeditiously to bring the agency into full compliance on the remaining issues and the new recommendations.

If you have questions or comments concerning this report or other matters related to the re-inspection, please contact me or Edward Farley, Deputy Assistant Inspector General for Inspections and Evaluations, at (202) 727-2540.

Sincerely,


Charles J. Willoughby
Inspector General

CJW/tc

Enclosure

cc: See **Distribution List**

DISTRIBUTION:

The Honorable Adrian M. Fenty, Mayor, District of Columbia (1 copy)
Mr. Daniel M. Tangherlini, City Administrator and Deputy Mayor, District of Columbia (1 copy)
Mr. Neil O. Albert, Deputy Mayor for Planning and Economic Development (1 copy)
The Honorable Vincent C. Gray, Chairman, Council of the District of Columbia (1 copy)
The Honorable Carol M. Schwartz, Chairperson, Committee on Workforce Development and Government Operations, Council of the District of Columbia (1 copy)
The Honorable Phil Mendelson, Chairperson, Committee on Public Safety and the Judiciary, Council of the District of Columbia (1 copy)
Ms. Tene Dolphin, Chief of Staff, Office of the Mayor (1 copy)
Ms. JoAnne Ginsberg, Director, Policy and Legislative Affairs (1 copy)
Ms. Carrie Brooks, Spokesperson, Office of Communications (1 copy)
Mr. William Singer, Chief of Budget Execution, Office of the City Administrator (1 copy)
Ms. Cynthia Brock-Smith, Secretary to the Council (13 copies)
Ms. Linda Singer, Attorney General for the District of Columbia (1 copy)
Dr. Natwar M. Gandhi, Chief Financial Officer (5 copies)
Ms. Deborah K. Nichols, D.C. Auditor (1 copy)
Ms. Kelly Valentine, Acting Director and Chief Risk Officer, Office of Risk Management (1 copy)
Mr. Jeffrey C. Steinhoff, Managing Director, FMA, GAO (1 copy)
Ms. Jeanette M. Franzel, Director, FMA, GAO (1 copy)
The Honorable Eleanor Holmes Norton, D.C. Delegate, House of Representatives,
Attention: David Grosso (1 copy)
The Honorable Henry A. Waxman, Chairman, House Committee on Oversight and Government Reform, Attention: Phil Schiliro (1 copy)
The Honorable Tom Davis, Ranking Member, House Committee on Oversight and Government Reform (1 copy)
The Honorable Danny K. Davis, Chairman, House Subcommittee on Oversight of Government Management, the Federal Workforce, and the District of Columbia,
Attention: Tania Shand (1 copy)
Mr. Caleb Gilchrist, Professional Staff Member, House Subcommittee on Oversight of Government Management, the Federal Workforce, and the District of Columbia (1 copy)
The Honorable Kenny Marchant, Ranking Member, House Subcommittee on Oversight of Government Management, the Federal Workforce, and the District of Columbia (1 copy)
The Honorable Joseph Lieberman, Chairman, Senate Committee on Homeland Security and Governmental Affairs, Attention: Holly Idelson (1 copy)
The Honorable Susan Collins, Ranking Member, Senate Committee on Homeland Security and Governmental Affairs (1 copy)
The Honorable Daniel K. Akaka, Chairman, Senate Subcommittee on Oversight of Government Management, the Federal Workforce, and the District of Columbia (1 copy)
The Honorable George Voinovich, Ranking Member, Senate Subcommittee on Oversight of Government Management, the Federal Workforce, and the District of Columbia (1 copy)
The Honorable David Obey, Chairman, House Committee on Appropriations,
Attention: Rob Nabors (1 copy)
The Honorable Jerry Lewis, Ranking Member, House Committee on Appropriations (1 copy)
The Honorable José E. Serrano, Chairman, House Subcommittee on Financial Services and General Government, Attention: Dale Oak (1 copy)

Letter to Marie-Lydie Y. Pierre-Louis, M.D.

October 30, 2007

Page 3 of 3

The Honorable Ralph Regula, Ranking Member, House Subcommittee on Financial Services and General Government (1 copy)

The Honorable Robert C. Byrd, Chairman, Senate Committee on Appropriations,
Attention: Terrence E. Sauvain (1 copy)

The Honorable Thad Cochran, Ranking Member, Senate Committee on Appropriations (1 copy)

The Honorable Richard Durbin, Chairman, Senate Subcommittee on Financial Services and General Government (1 copy)

The Honorable Sam Brownback, Ranking Member, Senate Subcommittee on Financial Services and General Government (1 copy)

Inspections and Evaluations Division

Mission Statement

The Inspections and Evaluations (I & E) Division of the Office of the Inspector General is dedicated to providing District of Columbia (D.C.) Government decision makers with objective, thorough, and timely evaluations and recommendations that will assist them in achieving efficiency, effectiveness, and economy in operations and programs. I & E goals are to help ensure compliance with applicable laws, regulations, and policies; to identify accountability, recognize excellence and promote continuous improvement in the delivery of services to D.C. residents and others who have a vested interest in the success of the city.

TABLE OF CONTENTS

INTRODUCTION.....	1
Background.....	2
Summary of Findings.....	2
Scope and Methodology	3
Report Format	3
KEY FINDINGS	4
Management of Personnel and Operations Improved.....	5
OCME Takes Steps Toward Inspection and Accreditation	6
Autopsy Backlog Reduced but Remains High.....	7
Number of Stored Bodies Significantly Reduced.....	8
Autopsy Policies and Procedures Vetted by OCME Staff	10
Histology Lab Closed, Waste Chemicals Problem Solved.....	11
Support to Child Fatality Review Committee Improved	12
Staffing for Some Critical Areas Remains Inadequate.....	13
Annual Report Production Improved, but Statistics are Insufficient.....	17
HEALTH AND SAFETY ISSUES	18
X-ray Operations Improved.....	19
Stretcher and Cart Deficiencies Abated.....	20
Biohazardous Waste Policies, Procedures and Training Established.....	21
Biohazardous Contamination Prevention Policies Established	21
Written Hazardous Communication Program Established	22
Autopsy Suite Tissue Storage Area Ventilation Improved.....	23
Procedures in Place for Safe Handling of Personal Protective Equipment	23
Male Shower Used as a Storage Closet	24
HVAC System Violation Received Due to Poor Ventilation.....	25
MORTUARY.....	26
OCME Responsibility to Pronounce Death Unclear	27
Policies in Place for Handling and Transporting Bodies.....	28
Procedures in Place for Processing Bodies into the Morgue	29
Skeletal Remains Identified, Labeled, and Removed.....	29
Fingerprinting Policies and Procedures Established.....	30
Policies Established for Visually Identifying Decedents.....	31
Policies and Procedures Established for Releasing Bodies	32
OCME Retains Decedent Personal Property Dating From 1997.....	32
Mortuary Technicians Receive Salary Increase.....	34

TABLE OF CONTENTS

FORENSIC INVESTIGATIONS.....	35
OCME and MPD Collaborate on Investigations	36
OCME Policies & Procedures for Death Scene Investigations Implemented; MLIs Certified	37
OCME Now Obtains Findings from Other Investigative Agencies	38
OFFICE OF THE CHIEF MEDICAL EXAMINER	39
OCME Establishes Workplace Health and Safety Program	40
OCME Establishes Mass Fatality Plan	42
OCME Prepared to Respond to All After-Hours Requests	43
OCME Establishes Tracking System for Complaints and Inquiries.....	44
Quality Assurance Program in Place for Autopsies and Toxicology	45
Some Support Positions Still Filled With Term Employees.....	46
IT Consultant No Longer Supervises Staff Employees	46
Employees Now Receive Annual Evaluations but Seek Pay Review	47
ADMINISTRATION	48
Case Records Security Improved.....	49
Automated Records System Operational.....	50
Power Deficiencies in Toxicology Lab Abated.....	50
APPENDICES.....	51
Appendix 1: List of Original Findings and Recommendations	
Appendix 2: MAR 03-I-005	
Appendix 3: MAR 03-I-003	
Appendix 4: MAR 07-I-003	
Appendix 5: OCME Response to MAR 07-I-003	
Appendix 6: MAR 07-I-008	
Appendix 7: OCME Response to MAR 07-I-008	
Appendix 8: OCME Response to OIG Draft Report of Re-inspection	
Appendix 9: OAG Response to MAR 07-I-008	

ACRONYMS

ACRONYMS

ABMDI	American Board of Medicolegal Death Investigators
ASHRAE	American Society of Heating, Refrigerating and Air-Conditioning Engineers
AU	Administrative Unit
CDC	Center for Disease Control
CFRC	Child Fatality Review Committee
CIAU	Communications Intake Assistant Unit
CLF	Consolidated Laboratory Facility
CME	Chief Medical Examiner
CU	Communications Unit
DCMR	District of Columbia Municipal Regulations
DCHR	Department of Human Resources
DCOP	District of Columbia Office of Personnel
DCME	Deputy Chief Medical Examiner
DHS	Department of Human Services
DNA	Deoxyribonucleic Acid
DOH	Department of Health
DVRB	Domestic Violence Review Board
EHA	Environmental Health Administration (Department of Health)
EMT	Emergency Medical Technician
FACTS	Forensic Analytic Case Tracking System
FIU	Forensic Imagery Unit
FRU	Fatality Review Unit
FTE	Full-Time Employee

ACRONYMS

FY	Fiscal Year
HCS	Hazard Communication Standards
I&E	Inspections and Evaluations
IG	Inspector General
IA	Intake Assistant
MAR	Management Alert Report
MCU	MPD Mobile Crime Unit
MEU	Medical Examiners Unit
MFRC	Maternal Fatality Review Committee
MLI	Medicolegal Investigators
MLIU	Medicolegal Investigators Unit
MPD	Metropolitan Police Department
MRDDFR	Mental Retardation and Developmental Disabilities Fatality Review
MRU	Medical Records Unit
MTU	Medical Transcription Unit
MU	Mortuary Unit
NAME	National Association of Medical Examiners
NS	Natural Squad
OAG	Office of the Attorney General
OCC	Office of Corporation Counsel
OCME	Office of the Chief Medical Examiner
OCTO	Office of the Chief Technology Officer
OIG	Office of the Inspector General

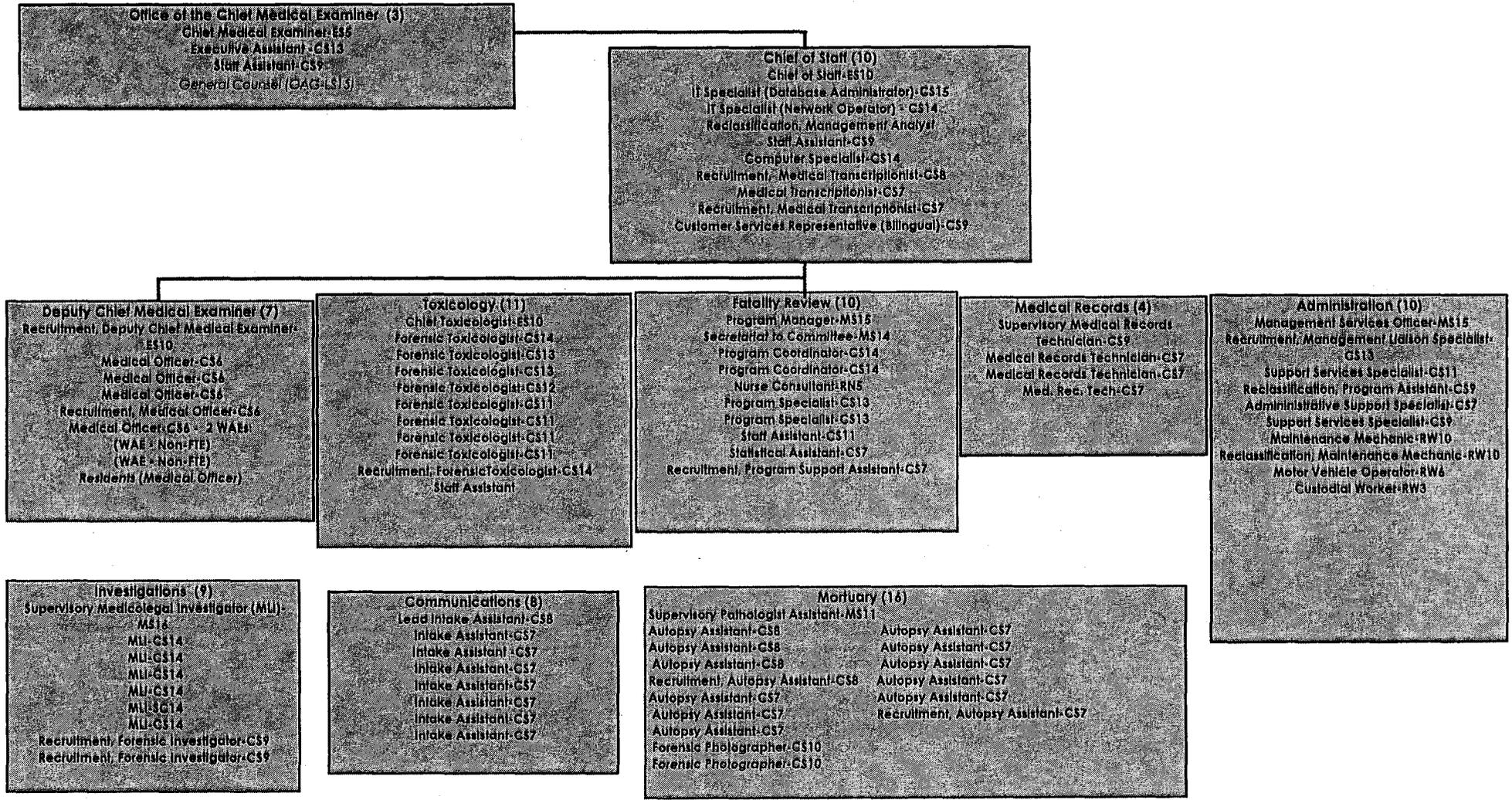
ACRONYMS

OPM	Office of Property Management
DC/OSH	District of Columbia Office of Occupational Safety and Health
OSHA	Occupational Safety and Health Administration
PCIE	President's Council on Integrity and Efficiency
PPE	Personal Protective Equipment
ROI	Report of Inspection
TL	Toxicology Laboratory

ORGANIZATION CHART

ORGANIZATION CHART

**Office of the Chief Medical Examiner
ORGANIZATIONAL CHART
February 21, 2007**



INTRODUCTION

INTRODUCTION

Background

The re-inspection of the District of Columbia Office of the Chief Medical Examiner (OCME) was a follow-up to the initial inspection conducted by the Office of the Inspector General (OIG) from November 2002 to March 2003. The OIG inspection process includes follow-up with inspected agencies to determine their compliance with agreed-upon recommendations. This follow-up inspection and report are part of the compliance process that the OIG has implemented to help District of Columbia (District) managers work toward continuous improvement in the delivery of services to residents and other stakeholders.

OCME's mission is to investigate and certify all violent deaths in the District of Columbia, and deaths that occur without explanation or medical attention, that take place when individuals are in custody, or that pose a threat to the public health.

According to its New Employee Orientation Guide, OCME is divided into 9 units: Administration Unit (AU), Communications Intake Assistant Unit (CIAU), Fatality Review Unit (FRU), Forensic Imagery Unit (FIU), Medical Examiner's Unit (MEU), Medical Transcription Unit (MTU), Medicolegal Investigator's Unit (MLIU), Medical Records Unit (MRU), and Mortuary Unit (MU). There is also a Toxicology Laboratory (TL). OCME is open to the public during normal business hours from 8:30 a.m. to 4:30 p.m., Monday through Friday. However, official business is conducted 24-hours a day, 7 days a week. OCME's current Chief Medical Examiner (CME) was made Interim CME in October 2003, and confirmed as CME in December 2004.

Summary of Findings

The re-inspection team (team) found that OCME has made substantial progress in correcting many of the deficiencies found during the initial inspection. Of the 79 recommendations made in the initial inspection, OCME is in compliance with 50, in partial compliance with 12, has not complied with 11, and 6 were overtaken by events.

During this re-inspection, the team found that OCME has:

- Developed formal policies and procedures that provide guidelines for decedent identification, autopsies, biohazardous waste and chemicals, tissue disposal and retention, release of bodies, and security and maintenance of records. These guidelines are instrumental in helping OCME employees bring consistency, efficiency, and safe practices to OCME's day-to-day business.
- Significantly reduced the backlog of autopsy reports and unclaimed or unidentified bodies. Reductions in these areas allow OCME to generate death certificates with minimal delay, maintain sufficient refrigerated storage space, and maintain sanitary conditions.

INTRODUCTION

- Installed and implemented a new automated case tracking system (Forensic Analytic Case Tracking System (FACTS)). FACTS allows OCME to track data, and generate case reports as well as track the intake, release, storage, and disposition of decedents and other information associated with case management.

Scope and Methodology

The re-inspection began in May 2006 and evaluated OCME's compliance with recommendations made in the September 2003 Report of Inspection (ROI) No. 03-0011CM. The re-inspection also addressed recommendations regarding radiology problems made in a Management Alert Report (MAR) issued in July 2003 (See Appendix 2). During the re-inspection, the team conducted interviews, directly observed work processes, reviewed documentation, and inspected work areas and facilities. OIG inspections and re-inspections comply with standards established by the President's Council on Integrity and Efficiency.

Report Format

In each of the following sections of this report, the team presents the original inspection findings, the original recommendations and their current status, and any new recommendations resulting from the team's observations. See Appendix 8 for OCME's comments about specific re-inspection findings. Unless noted otherwise in the body of this report, OCME agreed with each of the OIG's original recommendations. Please note that because of errors in the original report, the numbering of some of the recommendations presented here (Findings 10, 18, 26, and 31 for example) may not match the number of the related finding. See Appendix 1 for a complete list of the original findings and recommendations.

**FINDINGS AND
RECOMMENDATIONS:**

KEY FINDINGS

KEY FINDINGS

Management of Personnel and Operations Improved

Original Finding 1: Long-standing operational and personnel management problems continue under the current CME.

During the initial inspection, the team found the former Chief Medical Examiner's (CME) management style and operational oversight in need of significant improvement.

Original Recommendation (a.)

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

Current Status: In compliance. Since the initial inspection, the current CME has implemented policies and procedures for operational areas and personnel practices, particularly those affecting employee health and safety. Although OCME management stated that all employees have access to a policies and procedures manual located in the main office during the normal 8-hour business day, Mortuary Unit employees on duty after normal business hours must contact OCME security to gain access to the manual. The CME has also published an OCME New Employee Orientation Guide.

Original Recommendation (b.)

That the CME take a "lessons learned" approach to the information in this report and make adjustments in his management style and operational oversight in order to improve both the perception and the reality of a District agency that is performing poorly.

Current Status: Overtaken by events. The former CME resigned. Since his departure, the current CME reportedly has significantly increased staff morale by giving Employee Incentive Awards, holding general staff meetings, conducting workshops and briefings, and maintaining an open-door management policy.

Original Recommendation (c.)

That the Deputy Mayor for Public Safety and Justice¹ review this and previous reports on OCME and work with the CME to develop both the near- and long-term plans and specific goals for improving all OCME operations.

Current Status: Overtaken by events. The specific collaboration between OCME and the Mayor's office cited in this recommendation was overtaken by events due to personnel changes. However, under the new CME, OCME developed and published strategic plans for fiscal year (FY) 2005-2006 and FY 2007-2008. According to OCME

¹ This position no longer exists.

KEY FINDINGS

internal documentation containing Key Result Measures that the agency tracked from October 31, 2003, through May 31, 2006, OCME achieved an annual average of 8 out of 13 of its published target goals.² According to OCME management, the agency continues to find it difficult to hire employees because in the national medical examination field, unfavorable information about OCME continues to spread. In addition, OCME claims that it has lost candidates for employment because of D.C. Department of Human Resources' (DCHR)³ slow hiring processes, or because of what applicants have considered unsatisfactory salary offers. Management stated that the perception that OCME is a District agency that is performing poorly still exists, but the reality is that the agency has improved.

New Recommendation: The OIG recommends that OCME put copies of the policies and procedures manual in areas of the facility that are easily accessible to employees of all units.

OCME Takes Steps Toward Inspection and Accreditation

Original Finding 2: OCME has not been inspected and accredited as have its counterparts in surrounding jurisdictions.

During the initial inspection, the team found that OCME operated without an external, objective peer review of its operations. Similar operations in the nearby jurisdictions of Baltimore, Fairfax, and Philadelphia had been inspected and accredited by the National Association of Medical Examiners (NAME), but the District's OCME had not. There are no District regulations requiring inspection, accreditation, or evaluation of OCME. Consequently, stakeholders could not be assured that OCME was meeting established national standards or providing recognized levels of quality service to District citizens.

Original Recommendation

That the CME take the necessary steps to be inspected and evaluated by the National Association of Medical Examiners.

Current Status: Partially in compliance. The current CME stated that since the OIG's initial inspection, OCME has conducted a self-inspection as recommended by NAME, in line with NAME's inspection and accreditation policies and procedures. OCME is using NAME's Accreditation Checklist to identify the deficiencies that need correcting before submitting an application to NAME for an accreditation inspection.

² The language in this finding was amended based on comments from OCME. *See* Appendix 8.

³ At the time of the initial inspection, DCHR was called the D.C. Office of Personnel (DCOP).

KEY FINDINGS

Autopsy Backlog Reduced but Remains High

Original Finding 3: OCME has a significant backlog of unwritten autopsy reports.

During the initial inspection, medical examiners stated that the autopsy report backlog was a result of too few medical examiners, and inadequate administrative staff to edit and retrieve files, perform general clerical duties, and conduct the mandatory microscopic studies on all autopsies. Best practices show that autopsy reports should be produced promptly so that a completed death certificate (certificate) can be generated and provided to the next of kin with minimal delay. A completed certificate for a decedent who must undergo an autopsy cannot be issued until an autopsy report has been produced. Although an incomplete certificate (one that does not show the cause and manner of death) can be used for burials, next of kin must have a completed certificate in order to claim insurance and government benefits, settle an estate, or initiate legal action.

Original Recommendation (a.)

That the CME consider contracting with private pathologists to reduce the backlog of autopsy reports. (The CME at the time of the initial inspection disagreed with this recommendation. He stated that he did not see how it would be possible to hire private pathologists for this task.)

Current Status: In compliance. The current CME hired a full-time pathologist on a temporary basis, two residents,⁴ and a part-time pathologist to reduce the backlog. The agency's deputy chief medical examiner position remains vacant although the agency has continued to advertise the position since mid-2005. The deputy chief medical examiner (DCME) is responsible for performing autopsies and writing reports.

Since the completion of the initial inspection in March 2003, OCME eliminated the backlog of autopsy reports from 1996 through 2005. In March 2007, according to OCME, 146 autopsy reports from calendar year 2006 were incomplete. As of September 30, 2007, 129 autopsy reports were due and incomplete.

NAME recommends that an agency complete 95% of homicide autopsy reports within 2 months of an autopsy, and non-homicide autopsy reports within 3 months. OCME does not use the NAME recommended standards for completion of autopsy reports. Instead, OCME uses the performance measures assigned by the Executive Office of the Mayor regarding completion of autopsy reports. OCME management informed the team that the agency exceeded its target performance measures for completing autopsy reports on homicide cases within 60 days for FY 2005 and FY 2006, but not FY 2004 or FY 2007. In addition, OCME did not meet its targets for completing autopsy reports from non-homicide cases within 90 days for FY 2004 through FY 2007. For FY 2007, OCME completed 70% of homicide autopsy reports within 2 months, and 71% of non-homicide

⁴ According to the American Heritage Stedman's Medical dictionary, a "resident" is "a physician during residency."

KEY FINDINGS

reports within 3 months. The following table represents the details regarding the OCME's autopsy report achievements for homicide and non-homicide cases.

OCME Performance Measures for Completion of Autopsy Reports							
FY 2004		FY 2005		FY 2006		FY 2007	
Target	Actual	Target	Actual	Target	Actual	Target	Actual
Complete 60% of Homicide Reports within 60 days	47%	Complete 70% of Homicide Reports within 60 days	72%	Complete 80% of Homicide Reports within 60 days	85%	Complete 80% of Homicide Reports within 60 days	70%
Complete 50% of Non-Homicide Reports within 90 days	34%	Complete 70% of Non-Homicide Reports within 90 days	60%	Complete 80% of Non-Homicide Reports within 90 days	70%	Complete 80% of Non-Homicide Reports within 90 days	71%

Source: E-mail sent from OCME to OIG Inspector

Original Recommendation (b.)

That the CME review the concerns and suggestions of his medical examiner team regarding reduction of the backlog.

Current Status: In compliance. The current CME has worked with medical examiners to reduce the backlog. OCME medical examiners stated that the reduction in the autopsy report backlog is a result of hard work and teamwork, which includes employees in the MRU and MTU.

New Recommendation: The OIG recommends that the CME work with DCHR to explore all recruitment avenues to fill the vacant positions in the MEU.

Number of Stored Bodies Significantly Reduced

Original Finding 4: Unidentified, unclaimed bodies date back to 2000 and are a health hazard.

During the initial inspection, the team found that 60 of the 189 bodies in the cold room at OCME had been stored longer than 30 days. District regulations require that bodies unidentified

KEY FINDINGS

or unclaimed after 30 days be released to the Anatomical Board,⁵ cremated, or otherwise disposed of according to law. Records indicated that these bodies had dates of death and reception in OCME dating back to 2000 and 2001. The team observed that bodies were decomposing and leaking fluids from body bags. Many bodies were double stacked, and others were placed on the floor. OCME employees indicated to the initial inspection team that the agency had not removed the bodies because OCME was not processing public disposition⁶ cases (unclaimed or unidentified bodies) in a timely manner.

Original Recommendation

That the CME take steps immediately to eliminate the backlog of body release and disposal, and release or otherwise transfer bodies from OCME within 30 days as required by District regulations. (The CME at the time of the initial inspection disagreed with this recommendation. He argued that there was no “legal or practical mechanism to transfer bodies from OCME.” The OIG cited 28 DCMR § 5004.2, which requires that bodies unidentified or unclaimed after 30 days be released to the Anatomical Board, cremated, or otherwise disposed of according to law.)

Current Status: Partially in compliance. The team observed during the re-inspection that the previous poor conditions in the cold room no longer exist. OCME now has written procedures for releasing unclaimed or unidentified bodies. However, at this writing, OCME had 13 bodies that had been stored over 30 days. OCME was storing one body over 30 days in response to a mandate from the United States Attorney’s Office.

According to OCME management, the agency does not interpret the phrase “after a period of thirty (30) days” to mean that OCME is violating the 30-day period if unidentified or unclaimed bodies are stored more than 30 days. It is viewed as a flexible tool designed to balance the agency’s need to transfer bodies as quickly as possible to the appropriate next of kin, while preventing a buildup of bodies stored in the morgue. OCME management also stated that the 30-day guideline allows most families sufficient time to receive notice of the death of a loved one and to contact the facility to make plans for quick disposition of the remains. According to OCME, most families can do this in less than 30 days.

New Recommendation: That OCME release and/or dispose of bodies that have been stored at OCME for more than 30 days.

OIG Comment: In light of OCME’s response to the draft report of re-inspection, the OIG suggests that OCME work with the City Council to amend Title 28 of the DCMR in order to more clearly define the actions OCME should take, and timeframes for their completion, in those instances when a body has been held at OCME for more than 30 days.

⁵ The Anatomical Board receives the bodies of persons who have donated their remains for medical research and education.

⁶ According to 28 DCMR § 5007.1 (j), public disposition is defined as “the burial or cremation of an unclaimed human body that is paid for by the District of Columbia.”

KEY FINDINGS

Autopsy Policies and Procedures Vetted by the OCME Staff

Original Finding 5: Policies and procedures for conducting autopsies are inadequate.⁷

Original Finding 5a. Medical examiners say autopsy procedures lack important criteria, and some contradict the CME's verbal instructions.

In November 2002, the initial inspection team requested a copy of autopsy procedures but was told that none had been written. The team also found that OCME did not have policies or procedures regarding the retention and handling of organ and tissue specimens. In February 2003, the former CME provided written autopsy procedures to the team; however, OCME medical examiners considered those procedures deficient because they contradicted the CME's verbal instructions, did not cover autopsy technicians, and were written by the CME without the technicians' input even though they perform all autopsies.

Original Recommendation (a.)

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

Current Status: In compliance. The medical examiners informed the team that the current CME collaborated with them on the sufficiency of policies and procedures pertaining to autopsies and other operations, and that she gives consideration to their input through roundtable meetings. Medical examiners stated that autopsy policies include procedures on tissue retention and disposal, and are otherwise sufficient overall. However, OCME could strengthen the written procedures by including more detail regarding the role of the autopsy technician.

Original Finding 5b. There is no consistent policy for handling requests for special autopsy procedures based on a family's religious preferences.

Original Recommendation (b.)

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

Current Status: In compliance. Since the initial inspection, OCME has established written criteria for handling religious objections to autopsy raised by a decedent's family. Family requests are now handled in a more consistent manner.

Original Finding 5c. OCME does not have a written policy and procedure covering the retention of organ tissue and tissue specimens stored in the autopsy suite.

⁷ This overall finding has three sub-findings - a., b., and c. - that are addressed separately.

KEY FINDINGS

Original Recommendation (c.)

That the CME develop a policy and procedure for retaining and disposing of organ and tissue specimens.

Current Status: In compliance. OCME has included tissue retention and disposal in the autopsy policy and procedure.

New Recommendation: The OIG recommends that the CME, medical examiners, and autopsy technicians jointly review the autopsy policy and procedure to ensure clarity of the role of autopsy technicians.

Histology Lab Closed, Waste Chemicals Problem Solved

Original Finding 6: The histology laboratory is not properly vented, and waste chemicals are improperly stored and disposed of, causing the lab to be shut down in June 2003.

During the initial inspection, the team found that the OCME histology laboratory was not properly vented. Fumigation hoods had not been ordered for the laboratory, and the team found strong chemical odors that made breathing hazardous for employees. Despite these problems, the histology laboratory was not included in the OCME's general renovations.

Original Recommendation (a.)

That the CME order and install fumigation hoods in the histology laboratory.

Current Status: Overtaken by events. Since the initial inspection, the histology lab has been closed. Presently, the OCME contracts histology services to a vendor.

Original Recommendation (b.)

That the CME establish policies and procedures for the storage and disposal of waste chemicals.

Current Status: In compliance. OCME's toxicology and mortuary units have designated facilities to store waste chemicals, and the CME has established policies and procedures for their storage and disposal. The toxicology unit temporarily stores waste chemicals in its chemical flame cabinet, located in the toxicology lab. The mortuary unit uses the chemical formalin, which is stored in 30-gallon steel drums in the specimen room of the autopsy suite. Both units inform the Support Services Specialist (Specialist) when the units are ready to dispose of waste chemicals. Once notified, the Specialist generates disposal lists and contacts the vendor to arrange for a pick-up of the chemicals. OCME provided the team with a copy of a uniform hazardous waste manifest dated July 2006 for review.

KEY FINDINGS

Support to Child Fatality Review Committee Improved

Original Finding 7: The CME's relationship with the Child Fatality Review Committee (CFRC) has been marred by problems.⁸

The initial inspection team found that funding was made available by DOH and DHS for two CFRC support positions, but the former CME did not fill them and would not transfer the positions to the OCME budget. In addition, there was a lack of timeliness in purchasing office supplies, training employees, and obtaining a contract to print the annual CFRC report.

Original Finding 7a: The CME has not provided adequate administrative support to the CFRC.

Original Recommendation (a.)

That the CME make the appropriate personnel transfers and fill critically needed administrative staff positions for the CFRC.

Current Status: In compliance. CFRC has become a part of the new Fatality Review Unit (FRU).⁹ CFRC has selected individuals for its two vacant support positions. The CFRC has access to the FRU budget, and can staff all of its positions with permanent employees without using employees detailed from DOH and or DHS. FRU contains three fatality review committees: CFRC, Mental Retardation and Developmental Disabilities Fatality Review (MRDDFR), and the Domestic Violence Review Board (DVRB). FRU also plans to create a fourth review process, the Maternal Fatality Review Committee (MFRC).

Original Finding 7b. CFRC leaders and some members believe the administrative support function should be moved to a neutral location and not be overseen by a CFRC member.

Original Recommendation (b.)

That the CME provide the Inspector General (IG) a detailed accounting of all funds spent providing administrative support to the CFRC.

Current Status: In compliance. During the re-inspection, OCME provided the team with documentation regarding the FRU's budget and expenditures for FYs 2002 - 2003 that OCME did not provide during the initial inspection.

Original Recommendation (c.)

That the CME allow CFRC members to participate in the oversight and development of the CFRC administrative support budget to ensure the efficient use and proper accountability of funds.

⁸ This overall finding has three sub-findings, 7a through c, that correspond to recommendations a through f.

⁹ The language in this finding was amended based on comments from OCME. See Appendix 8.

KEY FINDINGS

Current Status: Overtaken by events. See Original Recommendation (a.) on the previous page.

Original Recommendation (d.)

That the CME provide the CFRC administrative staff with OCME policies and procedures.

Current Status: In compliance. FRU management stated that since the initial inspection, the CME has provided the unit with a copy of the OCME's policies and procedures manual.

Original Recommendation (e.)

That the Mayor review the appropriateness of the CME's oversight of the CFRC's administrative support staff and consider a more independent oversight location. (The CME at the time of the initial inspection disagreed with the recommendation that the CFRC should be moved.)

Current Status: Overtaken by events. See Original Recommendation (a.) on the previous page.

Original Finding 7c. Neither the CME nor his designee regularly attends CFRC meetings to review child deaths.

Original Recommendation (f.)

That the CME attend all CFRC meetings or send a designee as required by the D.C. Code.

Current Status: In compliance. In accordance with D.C. Code § 4-1371.04 (a) (3), the current CME regularly attends CFRC meetings or designates an OCME representative to attend when she cannot.

Staffing for Some Critical Areas Remains Inadequate

Original Finding 8: Staffing for some of the most critical areas is not adequate.

During the initial inspection, the team found that OCME was understaffed in a number of areas. It was budgeted for 67 full-time positions in FY 2002, but the CME did not fill 17 (25%) of the budgeted allotment in a timely manner. Many positions were vacant for a year or more.

OCME had only five medicolegal investigators (MLIs) to conduct death scene investigations. According to the former CME and the MLI supervisor, a minimum of 10 MLIs were needed to staff the investigations unit. In addition, the team found that there were no MLIs

KEY FINDINGS

on duty from 8 p.m. to 8 a.m. weekdays, and only one MLI working from 8 a.m. to 8 p.m. on Saturdays and Sundays. As a result, deaths that occurred during these periods were not investigated on-site.

Since the initial inspection, OCME staffing has reached 88 authorized positions. Seventy-four positions have been filled as of this writing, 3 FTEs are currently being reclassified, and 11 are currently in recruitment. OCME management informed the team that the agency needs a mass fatality coordinator, a risk manager, and an employee to manage quality assurance. In addition, OCME employs two forensic photographers in the Forensic Imagery Unit.

Original Finding 8a. There is no MLI available on a 24-hour basis to cover death scene investigations.

Original Recommendation (a.)

That the CME adequately staff OCME to provide on-site death scene investigations whenever required.

Current Status: Not in compliance. As was true during the initial inspection, the investigations unit remains understaffed. OCME management informed the inspection team that MLIs are regularly scheduled to be on duty 6:00 a.m. through 11:00 p.m. most Mondays through Fridays depending on weekend scheduling. In addition, on weekends and holidays, one MLI is on duty from 8 a.m. to 8 p.m. The Investigations Unit has seven MLIs, which includes the director of the unit. Consequently, OCME is still not reporting to all death scenes to conduct on-site death scene investigations. Therefore, the MLIs do not always have first-hand knowledge of the information gathered at on-site death scenes investigations, and the official pronouncement of death for some decedents occurs the next day when MLIs are not on-site at the death scenes. Since the fall 2003, three District of Columbia Metropolitan Police Department (MPD) Natural Squad (NS) detectives have been housed in the OCME Investigations Unit. The NS detectives are not OCME employees. An OCME manager informed the inspection team that NS detectives fill in for MLIs during the night shift because of the limited number of MLIs in the unit. However, pursuant to D.C. Code § 5-1405 (b), OCME is responsible for investigating incidents of human death in the District of Columbia. The statute does not state that OCME may delegate this responsibility, nor has there been a Mayor's Order delegating this responsibility to MPD.

New Recommendation: See "New Recommendations" to Original Finding 28 on page 37.

Original Finding 8b: The number of employees available for body handling and transportation is insufficient.

Original Recommendation (b.)

That the CME provide adequate staffing to ensure the timely transport of decedents.

KEY FINDINGS

Current Status: In compliance. During the initial inspection, the team found that best practices in surrounding jurisdictions require at least two employees on all shifts who can respond to death scenes and transport decedents to the medical examiner's office in a timely manner. Currently, OCME has 13 FTE positions for the mortuary unit. OCME employs 11 autopsy assistants. Five autopsy assistants work from 8 a.m. to 4:30 p.m., two assistants work from 4:00 p.m. to 12:30 a.m., and two assistants work from 12 midnight to 8 a.m.

Original Finding 8c: The Communications Unit's 24-hour phone is not adequately staffed.

Original Recommendation (c.)

That the CME increase Communications Unit staffing of the midnight tour for the 24-hour phone number to ensure proper and adequate coverage.

Current Status: Not in compliance. During the initial inspection, the team found that OCME's Communications Unit (CU) 24-hour telephone service was not adequately staffed to receive calls at all times. Only one intake assistant covered the 12 a.m. to 8 a.m. shift. If this person was unable to report to work or had to leave the office due to an illness or emergency, there was no telephone coverage by the Communications Unit. The re-inspection team found that the Communications Unit has its full complement of eight FTEs. CU employees rotate through three shifts, which are 12 a.m. – 8:30 a.m., 8 a.m. – 4:30 p.m., and 4 p.m. – 12:30 a.m. According to OCME management, the CU only has one Intake Assistant (IA) on duty from 12 a.m. to 8:30 a.m. and 4 p.m. – 12:30 a.m. However, if the IA assigned to rotation duty during the shifts in question is unable to report to work or must leave the office due to illness or emergency, another IA is contacted to fill in and if another IA is not available, the Lead Intake Assistant covers for the absent IA. However, no one answers the 24-hour telephone number when the IA is at lunch during the shifts in question. The IA checks the voicemail for messages after returning from lunch.

New Recommendation: The OIG recommends that OCME increase Communications Unit staffing of the 12 a.m. – 8:30 a.m. and 4 p.m. – 12:30 a.m. shifts for the 24-hour telephone number to ensure proper and adequate coverage.

Original Finding 8d: OCME does not have adequate staff for building maintenance.

During the initial inspection, the team found large amounts of trash in some areas of the facility and floors not swept or mopped. The former CME allocated only one employee for cleaning and maintenance, although OCME received funding to hire an additional maintenance employee. OCME employees stated that their requests for cleaning or repairs often went unanswered because the maintenance employee was overwhelmed by the scope of his responsibilities.

KEY FINDINGS

Original Recommendation (d.)

That the CME increase staffing for maintenance and upkeep of the OCME facility. (The CME at the time of the initial inspection disagreed with the recommendation to increase staffing and advocated contracting out this task.)

Current Status: In compliance. OCME employs one custodian who performs janitorial duties. The agency has a machine for the custodian to use to clean the floors in the mortuary area, which makes cleaning the mortuary unit easier and more efficient. Further, OCME management told the re-inspection team that the agency only needs the one custodian because OCME also uses a contractor for janitorial and maintenance services. The custodian performs minor repairs, but OCME informs the Office of Property Management (OPM) or the contractor when major repairs are required.

Original Finding 8e: Structural and equipment repairs are not completed.

During the initial inspection, the mortuary supervisor at the time provided the team with a list of structural and equipment problems in need of urgent repair. The team found that some of the needed structural and equipment repairs appeared to be the result of poor work by the contractor who renovated the OCME facility in 2002. The mortuary supervisor stated that he had attempted to contact the contractor on several occasions, as well as OPM, to have repairs done, but received no response. The list included the following conditions:

- poor lighting on the back dock area;
- foot pedals on sinks at autopsy tables leak;
- leaking faucets and sinks in the x-ray rooms;
- eyewash station drain empties onto the floor and not into a drainage pipe;
- improper drainage in cold body storage area causing a pooling of body fluids;
- plumbing problems with the waste disposals of autopsy tables causing periodic spilling of biohazardous materials on the floor;
- cold room storage doors need replacement;
- hoses and sprayers for autopsy tables need replacement; and
- thermostats installed improperly.

Original Recommendation (e.)

That the CME work with the OPM to ensure that structural and equipment repairs are completed as required by the renovation contract.

Current Status: Partially in compliance. The re-inspection team observed five of the nine structural and equipment items listed above that were in need of urgent repair during the initial inspection and that are still in disrepair: (1) the eyewash station drain empties onto the floor and not into a drainage pipe; (2) improper drainage in the cold body storage area (the floor is flat rather than concave to direct water flow); (3) plumbing problems with the waste disposals from autopsy tables cause periodic spilling of biohazardous

KEY FINDINGS

materials on the floor; (4) the cold room storage door needs repair or replacement; and (5) hoses and sprayers for autopsy tables need replacement. According to information from OCME management, these problems exist because employees did not bring them to management's attention. In addition, OCME management stated that it might not be feasible to make the remaining structural and equipment repairs because the District is moving forward to establish a Consolidated Laboratory Facility (CLF). The CLF would house OCME, a bio-safety lab, public health lab, and an MPD forensics lab.¹⁰ According to information provided by the OCME, the District has started the site selection process for the CLF.

New Recommendation: The OIG recommends that the CME work with OPM to repair the noted outstanding structural and equipment items and ensure that the noted disrepairs do not pose a health and safety risk to employees pending completion of the CLF.

Annual Report Production Improved, but Statistics are Insufficient

Original Finding 9: The CME is not producing statistical data and annual reports on deaths and autopsies as required by District law.

During the initial inspection, the team found that the CME had not produced an annual report for approximately 5 years. In addition, OCME records were comprised primarily of hard copy files and documents that were not well organized. The OCME did not have an automated records management system, which made it difficult for the team to gather accurate statistical information.

Original Recommendation

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

Current Status: Partially in compliance. Since the initial inspection, the CME has published annual reports for 2003, 2004, and 2005.¹¹ The information included in the published reports pertain to the number of autopsies performed, statistics as to the causes of death, and other relevant information as required by D.C. Code § 5-1412(d). Although the statistical information in the reports was sufficient according to District law, the reports do not contain all the statistical data recommended by NAME, such as: data regarding death scene visits by medical examiners or medicolegal investigators; bodies transported by OCME or by order of OCME; hospital autopsies performed under the medical examiner's jurisdiction; bodies unidentified after examination; organ and tissue donations; and unclaimed bodies.

¹⁰ Draft publication *Detailed Building Program Consolidated Laboratory Facility, Washington, DC, April 26, 2005.*

¹¹ The language in this finding was amended based on comments from OCME. See Appendix 8. OCME's 2005 annual report was published in December 2006. OCME stated it expects to publish its 2006 annual report before the end of 2007.

**FINDING AND
RECOMMENDATIONS:**

**HEALTH
AND
SAFETY ISSUES**

HEALTH AND SAFETY ISSUES

X-Ray Operations Improved¹²

Original Finding 10:¹³ The use of x-ray equipment does not conform to District regulations and NAME recommendations, and employees are endangered.

During the initial 2003 inspection, the OIG asked the former CME for all written x-ray policies and procedures; however, none were provided. The OCME x-ray machine was not registered with the Department of Health (DOH), and OCME did not properly monitor employee radiation exposure. For calendar year 1999, OCME failed to send 99% of its radiation exposure badges to its monitoring company for evaluation. OCME employees were not properly trained or certified to operate x-ray equipment, and the equipment was not routinely inspected. The vests used for protection during x-rays were old, torn, and leaking threads, and x-ray films were not properly stored and secured.

Original Finding 10a: OCME does not properly monitor employee radiation exposures.

Original Recommendation

That the [CME] have all affected employees tested for possible overexposure to radiation because of the inadequate monitoring and evaluation of badge readings, the lack of inspections of radiation equipment, and the lack of employee training for operating the equipment.

Current Status: In compliance. OCME has secured contracting services to monitor employee radiation exposure on a regular basis.

Original Recommendation

That the [CME] ensure that monthly radiation monitoring of employees is carried out rigorously.

Current Status: In compliance. OCME has secured contracting services to monitor employee radiation exposure.

Original Recommendation

That the [CME] establish written policies and procedures for the use and storage of radiation monitoring badges.

Current Status: In compliance. The re-inspection team observed that OCME has developed dosimeter¹⁴ policies and procedures.

¹² The language in this finding was amended based on comments from OCME. *See* Appendix 8.

¹³ The findings and recommendations addressed in this section are derived from both the original Report of Inspection and a Management Alert Report (MAR) sent to the former CME regarding numerous problems in OCME's use of x-ray equipment. The MAR is included at Appendix 2 of this report.

¹⁴ A dosimeter measures the radiation exposure an individual receives from x-rays.

HEALTH AND SAFETY ISSUES

Original Finding 10b: OCME employees are not properly trained or certified to operate x-ray equipment.

Original Recommendation

That the [CME] provide training and certification for all employees who operate radiographic equipment.

Current Status: In compliance. Employees were trained by DOH on the use of x-ray equipment during July 2005.

Original Finding 10c: X-ray equipment has never been inspected.

Original Recommendation

That the [CME] have all radiographic equipment inspected and certified for safety as required by District regulations.

Current Status: In compliance. The District of Columbia Municipal Regulations for Radiation Protection require the owner or person having possession of any radiation producing machine to register the machine with the DOH. OCME registered its x-ray equipment with the DOH-Environmental Health Administration (EHA) on September 1, 2006. DOH and a contractor provide periodic inspections of OCME x-ray equipment to ensure that it is operating properly. In accordance with EHA guidelines, protective vests have been inspected and found to be in good condition.

Original Finding 10d: OCME does not properly store and secure x-rays.

Original Recommendation: None made.

Current Status: Since the initial inspection, OCME has developed x-ray policies and procedures, and has centralized its storage and security of x-ray film.

Stretcher and Cart Deficiencies Abated

Original Finding 11: Stretchers and carts used to move bodies are old, rusted, and dangerous.

The initial inspection team found that carts used by OCME presented a health and safety hazard to employees. The carts were over 20 years old, rusted, unstable, and had broken parts and sharp edges. Their wheels did not roll freely and brakes did not work properly. The carts would tip over frequently causing bodies to fall off and resulting in injuries to employees. The team also reported that due to the condition of the carts, they could not be cleaned properly and body fluids were present in the fibers of the fiberglass tops.

HEALTH AND SAFETY ISSUES

Original Recommendation

That the CME take steps to expedite the replacement of old and malfunctioning body carts.

Current Status: In compliance. The team observed during the re-inspection that stretchers and carts used to move bodies were sturdy, in good condition, and free of sharp edges.

Biohazardous Waste Policies, Procedures, and Training Established

Original Finding 12: OCME does not have written policies and procedures or training for the disposal of biohazardous waste.

During the initial inspection, the inspection team observed that the CME did not have written policies and procedures for the disposal of biohazardous waste. In addition, employees stated they had not been trained to properly dispose of such waste. The Office of Occupational Safety and Health Administration (OSHA) requires employers to ensure that all biohazard policies and procedures, both OSHA mandated and employer instituted, be followed. Additionally, NAME recommends that all affected employees be properly trained in the disposal of biohazardous waste.

Original Recommendation

That the CME provide OCME employees with training and written policies and procedures for the proper disposal for biohazardous waste.

Current Status: In compliance. Based on interviews and a review of documents by the re-inspection team, OCME has established policies and procedures for the disposal of hazardous and biological waste, including body fluids and tissue. Affected employees have been trained in the disposal of biohazardous waste.

Biohazardous Contamination Prevention Policies Established

Original Finding 13: Employees are not trained to avoid biohazardous contamination associated with body handling and transport.

During the initial inspection, the team reported that OCME did not have policies and procedures for handling biohazardous materials, and did not provide training to aid autopsy assistants in avoiding biohazardous contamination. Employees stated they transported bodies that were grossly decomposed, afloat in fluids, and covered with maggots. Some of the bodies had tested positive for tuberculosis, HIV, meningitis, and hepatitis. They also transported bodies that had been exposed to anthrax. Some employees stated they believed they had developed

HEALTH AND SAFETY ISSUES

allergies and asthma due to exposure to hazardous conditions experienced while transporting bodies.

Original Recommendation

That the CME establish written policies and procedures and provide training and protective equipment to body transport employees to prevent biohazardous contamination.

Current Status: In compliance. The CME has established written policies and procedures to help autopsy assistants avoid biohazardous contamination. There are procedures to minimize exposure to blood-borne pathogens and to implement decontamination initiatives. Personal protective equipment is provided to employees who transport bodies to prevent biohazardous contamination. OCME directs personnel to use Universal Precautions,¹⁵ and has a written policy that states, “It has been recommended that all bodies and body fluids should be considered potentially infected and appropriate barrier precautions taken to minimize exposure of personnel to blood-borne and air-borne pathogens.”

Written Hazardous Communication Program Established

Original Finding 14: OCME does not have a written hazardous communication program as required by federal law.

The initial inspection team determined that OCME lacked a written communication program for employees working with and in the proximity of hazardous chemicals. OCME employees stated they had not received training in the proper handling of hazardous chemicals and there was no written hazardous communication program in place. The lack of a hazardous communication program as required by federal law could jeopardize the health and safety of OCME employees.

Original Recommendation

That the CME oversee completion and implementation of a written hazardous communication program as required by 29 CFR § 1910.1200(e)(1) (LEXIS through July 23, 2003).

Current Status: In compliance. Based on interviews and a review of documents during the re-inspection, the team determined that OCME has established a written Hazardous Communication Program to alert workers to the existence of potentially dangerous substances in the workplace. The program incorporates OSHA Hazard Communication

¹⁵ *Universal Precautions* is a Center for Disease Control (CDC) term that refers to infection control measures that all health care workers should follow with the goal of protecting themselves from disease-producing microorganisms. The practice requires workers to treat all blood and various other body fluids as if infected with HIV, hepatitis B virus, and other blood-borne pathogens.

HEALTH AND SAFETY ISSUES

Standards (HCS) for compiling hazardous chemicals lists, utilizing material safety data sheets, and providing training.

Autopsy Suite Tissue Storage Area Ventilation Improved

Original Finding 15: The autopsy suite tissue storage areas are not properly ventilated.

During the initial inspection, the tissue storage area at OCME was not well-ventilated. The inspection team reported that during a period when dissections were in progress, the team smelled formaldehyde and putrefied tissue odors. Employees stated that the ventilation system did not adequately pull air from the dissection room, and during dissections, the odor was unbearable and made them sick.

Original Recommendation

That the CME have the ventilation system in the autopsy suite tissue storage areas inspected and upgraded as required.

Current Status: In compliance. During the re-inspection, the team sought information from OPM on actions taken by OCME to monitor and inspect its ventilation system. OPM provided documentation of ongoing improvements in the OCME autopsy suite cooling and ventilation system. The re-inspection team visited the tissue storage area on several occasions and did not smell formaldehyde or putrefied tissue odors. Employees stated that the ventilation system no longer makes them feel sick.

Procedures in Place for Safe Handling of Personal Protective Equipment

Original Finding 16: Handling of personal protective equipment (PPE) is unsafe.

Autopsy technicians and MLIs are exposed to body fluids and wear PPE (personal protective equipment) when conducting on-site death scene investigations and transporting bodies. The initial inspection observed that OCME had contracted with a private firm to clean PPE used in the autopsy suite (suite), but did not provide laundry facilities for PPE used outside of the suite by autopsy technicians and MLIs. In addition, the team found that autopsy technicians and MLIs were not removing and bagging their PPE prior to leaving their work areas. The team also found that employees often took their PPE to public laundromats or private cleaners without informing those establishments of potential contamination, which could place the health and safety of the employees, their families, and the general public at risk.

Original Recommendation (a.)

That the CME immediately forbid removal of PPE from the OCME facility.

HEALTH AND SAFETY ISSUES

Current Status: In compliance. Since the initial inspection, OCME has provided employees with disposable PPE and scrub suits that can be laundered. Autopsy technicians and MLIs remove and bag their disposable PPE as biohazardous waste prior to leaving their work areas and discard them as biohazardous waste.

Original Recommendation (b.)

That the CME provide on-site or contract for laundry services for PPE.

Current Status: In compliance. The re-inspection team interviewed staff to confirm that OCME has contracted with an off-site service to launder scrub suits. The off-site laundry service uses Universal Precautions in the handling of contaminated laundry. Laundry services handle PPE worn by autopsy technicians and MLIs. Employees no longer have to take their PPE to public laundromats or private cleaners.

Male Shower Used as a Storage Closet

Original Finding 17: Mortuary employees do not have adequate shower facilities for removing bodily fluids and contaminants.

The initial inspection team found that OCME did not have clean working showers for either male or female autopsy employees. There were broken tiles and unsanitary conditions in both male and female bath facilities. Employees stated that the shower facilities were not cleaned on a regular basis and needed renovation. They did not feel safe using the facilities and did not shower prior to leaving OCME. The lack of working shower facilities meant that employees could not thoroughly remove body fluids or contaminants prior to leaving OCME and could expose the public to contaminants after they left the facility. The former CME agreed to have the shower facilities repaired and to ensure that they were cleaned and disinfected daily.

Original Recommendation

That the CME have the shower facilities repaired and ensure that they are cleaned and disinfected daily.

Current Status: Partially in compliance. Upon re-inspection, the team observed that the male shower stall is used as a storage closet, and is not readily available for male employees to remove body fluids or contaminants prior to departing OCME.

A senior OCME employee gave a tour of the female changing room and stated that females do not use their shower facility to remove body fluids or contaminants prior to leaving OCME. According to the employee, the use of PPE minimizes the need for female employees to use the shower prior to exiting OCME. The female shower was unobstructed, in working condition, and available for use.

New Recommendation: The OIG recommends that OCME maintain male and female shower facilities that are immediately accessible by employees to remove body fluids or contaminants.

HVAC System Violation Received Due to Poor Ventilation

Original Finding 18:¹⁶ Odors from autopsy suite permeate public access areas.

The initial inspection team found that the OCME elevator used by both visitors and staff had an unpleasant odor that emanated from either the autopsy suite or the body cooler area. The team sent a MAR to the CME about this problem.

Original Recommendation

That the Chief Medical Examiner request an inspection of the OCME facility by the District of Columbia Office of Occupational Safety and Health (D.C. OSH) to determine whether there are any hazards to employees and visitors, and if any measures can be taken to address these hazards, to include minimizing the odor referenced in this report.

Current Status: Not in compliance. The re-inspection team obtained documentation from OCME regarding D.C. Office of Risk Management (ORM) inspections during 2004 and 2006. An ORM inspection report dated June 20, 2006, cited the OCME building as having poor ventilation, warranting an American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) violation. ORM recommended that OCME have its heating, ventilation, and air conditioning (HVAC) unit inspected and tested by a qualified technician to ensure appropriate ventilation. During the re-inspection, the team did not notice any unpleasant odors emanating from the autopsy suite or the body cooler area. OCME and OPM have initiated a contract to upgrade and renovate the cooling system. However, the OPM contract does not address air quality concerns identified in the ORM June 20, 2006, inspection report. As of March 26, 2007, OCME had not had its HVAC unit inspected to resolve the ORM ASHRAE violation.

New Recommendation: OIG recommends that OCME implement ORM recommendations to have its HVAC unit inspected and tested by a qualified technician to ensure appropriate air quality and ventilation.

¹⁶ The findings and recommendations addressed in this section are derived from both the original Report of Inspection and a MAR sent to the former CME regarding numerous problems regarding maintenance and safety in the OCME. The MAR is an appendix in the original Report of Inspection and may be found at Appendix 3 of this re-inspection report.

**FINDINGS AND
RECOMMENDATIONS:

MORTUARY**

MORTUARY

OCME Responsibility to Pronounce Death Unclear

Original Finding 19: OCME's death pronouncement process does not ensure that bodies are always officially pronounced dead prior to arrival at OCME.

The initial inspection team found that official pronouncements of death by the District's OCME were often delayed because of a lack of employees qualified to pronounce death. The CME, medical examiners, physicians, physician's assistants, MLIs, and advanced practice registered nurses could officially pronounce death, but were often not available, particularly after normal duty hours. If none of those individuals could go to the death scene, OCME autopsy technicians would transport a body to the mortuary prior to the pronouncement of death. Consequently, bodies arriving during evening hours or on weekends would not be pronounced dead for several hours until a qualified person was available. Although trained paramedics often arrive first at a death scene, District regulations do not permit them to pronounce death. OCME autopsy technicians stated that in the past, they transported bodies to a medical emergency room for the pronouncement of death prior to arriving at OCME.

Original Recommendation (a.)

That the CME consider contracting with private physicians to pronounce death at the scene when no qualified personnel are available. (The CME at the time of the initial inspection disagreed with this recommendation.)

Current Status: Not in compliance. During OIG's re-inspection, the inspection team found that there have been no changes in death pronouncement policies since 2003, and the OIG recommendations were not acted upon. OCME's policy is to pronounce the date and time of death if this task has not been performed by another agency, authorized medical professional, or medical facility upon OCME's retrieval of a body from a death scene or upon the body's arrival at the morgue. The CME stated that although OCME physicians and MLIs pronounce death both on the scene and at the OCME facility, she does not believe that pronouncement of death is a function of OCME. According to the CME, she needs assurance that a body is dead upon arrival at OCME. She noted that the D.C. Code does not identify a particular District agency as having pronouncement-of-death authority, and stated that the D.C. Hospital Association is conducting a review of the District's death pronouncement policies.

Original Recommendation (b.)

That the CME consider resumption of the practice of having autopsy technicians transport bodies to an emergency room for the pronouncement of death prior to arrival at OCME when no qualified personnel are available.

Current Status: Not in compliance. In response to this recommendation, the CME provided a document summarizing discussions from the District of Columbia Hospital Association, Medical Directors Forum on March 13, 2006. The document reports that the CME and District health administrators were debating which District agencies should be

MORTUARY

responsible for pronouncing death. Attendees discussed issues arising from completion of pronouncements in the field and the problem of incomplete death certificates. During the meeting, the CME discussed the possibility of authorizing Fire and Emergency Medical Services first responders to pronounce death.

Original Recommendation (c.)

That the CME consult with [the OAG] on proposing legislation to the Council that would permit qualified paramedics to officially pronounce death.

Current Status: Not in compliance. The CME has not proposed legislation that would permit qualified paramedics to officially pronounce death.

New Recommendation: That the CME draft a pronouncement of death policy for the District based on her knowledge and experience as well as guidance from NAME and the U.S. Department of Justice. The CME should then coordinate that draft with OAG, the D.C. Department of Health, the D.C. Fire and Emergency Medical Services Department, the Metropolitan Police Department, and the District of Columbia Hospital Association. On April 19, 2007, the OIG presented this new recommendation to OCME as part of Management Alert Report (MAR) 07-I-003. The MAR and OCME's written response to it are included as Appendix 4 and 5, respectively, to this report.

Policies in Place for Handling and Transporting Bodies

Original Finding 20: The lack of procedures, training, and equipment for efficient body handling and transport puts employees at risk.

The initial inspection reported OCME did not have written policies and procedures or training covering body handling and transportation. Guidelines were not available to ensure that employees used safe handling techniques to avoid mishap and personal injury. Autopsy assistants responsible for body handling and transport stated they were not provided formal training in this area and have sustained injuries handling and transporting bodies.

Original Recommendation

That the CME establish written policies and procedures and provide training for body handling and transport.

Current Status: In compliance. The re-inspection team interviewed staff and reviewed documents regarding body handling and transportation. OCME has established policies, procedures, and training covering body handling and transportation.

MORTUARY

Procedures in Place for Processing Bodies into the Morgue

Original Finding 21: The procedures for processing bodies into the morgue are inadequate.

During the initial inspection, the OCME had only verbal procedures for processing bodies into the morgue. The team noted there was no checklist for autopsy technicians to follow to ensure all steps of the check-in process were completed, and only a handwritten log was made of intake information. The team found that many of the steps in the verbal process were overlooked, such as logging in the time and date of arrival, and photographing and fingerprinting the body.

Original Recommendation

That the CME establish written policies and procedures for processing bodies into the morgue, including a checklist to be maintained with a decedent's case file.

Current Status: In compliance. The re-inspection team observed that OCME has established policies and procedures for processing bodies into the morgue, including a checklist that is maintained with a decedent's case file. The checklist is electronically generated and stored.

Skeletal Remains Identified, Labeled, and Removed

Original Finding 22: Unidentified skeletal remains have not been properly processed.

The initial inspection team observed an open cardboard box in the cold body storage area containing a partial skull and other bones. The remains were not labeled, and there was no record of when they arrived. OCME employees did not know how long the remains had been stored and could not locate a case file.

Original Recommendation

That the CME take steps to identify, label, and dispose of unidentified and unclaimed skeletal remains as appropriate.

Current Status: In compliance. The re-inspection team reviewed documents and conducted interviews to confirm that the CME has taken steps to identify, label, and dispose of the unidentified and unclaimed skeletal remains. No unidentified or unclaimed skeletal remains were observed during site visits.

MORTUARY

Fingerprinting Policies and Procedures Established

Original Finding 23: OCME does not fingerprint decedents in a timely manner.

OCME did not have the equipment or trained staff to fingerprint decedents timely, and did not have written policies or procedures for the fingerprinting process. OCME depended upon the MPD Mobile Crime Unit (MCU) for fingerprinting; however, there was no Memorandum of Agreement or Memorandum of Understanding between MPD and OCME for this arrangement. Consequently, MCU officers normally took fingerprints for OCME only in homicide cases investigated by MPD, and honored OCME requests for fingerprints of other bodies as time permitted. The initial team found unclaimed and unidentified bodies at OCME dating back to 1999 that needed fingerprinting, and this delayed the release of these bodies.

Original Recommendation (a.)

That the CME draft a Memorandum of Agreement or a Memorandum of Understanding with MPD for fingerprinting decedents, or provide equipment and training to OCME employees for fingerprinting.

Current Status: In compliance. OCME has established written policies and procedures, has acquired equipment and trained staff to fingerprint decedents when required, and no longer relies on MPD. It works with MPD and other law enforcement agencies such as the Federal Bureau of Investigation (FBI) when requested to perform fingerprint comparison studies to identify decedents.

Original Recommendation (b.)

That the CME require fingerprinting of all decedents upon arrival at OCME. (The CME at the time of the initial inspection disagreed with this recommendation.)

Current Status: Not in compliance. The current CME stated that most decedents are identified visually. Consequently, fingerprinting is not a routine part of the intake process because of the time and resources required.

Original Recommendation (c.)

That the CME take the steps necessary to have all bodies presently stored at OCME fingerprinted.

Current Status: Partially In compliance. Fingerprinting is done when a decedent cannot be visually identified, or at the behest of MPD, the FBI, or other law enforcement agencies.

MORTUARY

Policies Established for Visually Identifying Decedents

Original Finding 24: OCME does not have a consistent policy regarding identification of decedents.

During the initial inspection, OCME stated that all bodies had to be positively identified prior to being released to a funeral home. OCME did not have written policies and procedures concerning decedent identification, but according to employees, the verbal policy was to provide instant photographs to those making the identification and not allow viewing of the actual body. However, OCME employees stated that the CME at that time made exceptions, apparently for personal reasons, and sometimes allowed selected families to view bodies in an open hallway where other bodies or people were present. Employees complained that these exceptions confused employees about the unwritten policy of using photographs only.

Original Recommendation (a.)

That the CME clarify the identification and body viewing policy and procedure and commit it to writing.

Current Status: In compliance. The re-inspection team interviewed staff and reviewed documents and confirmed that the OCME has established written policies and procedures for the identification of decedents.

Original Recommendation (b.)

That the CME provide a private viewing space when there are exceptions to photographic identification. (The CME at the time of the initial inspection disagreed with this recommendation.)

Current Status: Not in compliance. OCME does not permit in-person viewings and the facility does not have space available to enable private viewings. Viewing the body of a loved one is highly stressful for grieving individuals and could pose a direct safety concern (i.e., fainting) for the identifying party and indirect safety concern (i.e., injury) for the OCME staff in attendance during the viewing. Photographs are taken of the decedent in the autopsy suite located in the basement. The photographs are shown to the person identifying the body in designated Family Rooms located in the lobby of the building.

MORTUARY

Policies and Procedures Established for Releasing Bodies

Original Finding 25: Employees do not have clear, established policies and procedures for releasing bodies.

At the time of the original inspection, the release of bodies from OCME was handled by autopsy technicians who had verbal instructions but no detailed written procedures for verifying identity. Consequently, technicians occasionally released the wrong body to families or funeral directors. For example, the re-inspection team found that a body had been erroneously released in September 2005 when an autopsy assistant transposed the body's case identification number.

Original Recommendation

That the CME provide written policies and procedures for the release of bodies.

Current Status: In compliance. OCME now has written policies and procedures for the proper release of bodies.

OCME Retains Decedent Personal Property Dating from 1997

Original Finding 26: OCME does not have a system to document, transfer, and safeguard decedents' personal effects.

The initial inspection team reported that personal property of deceased persons and evidence transferred to MPD were not handled in accordance with District law. OCME held decedent personal property and MPD evidence dating back to 1990. OCME did not have written policies or procedures regarding the transfer of and chain of custody for personal property at death scene investigations. Personal property was transferred to MPD or remained with the decedent and was inventoried at OCME upon the decedent's arrival at the morgue. The initial team also noted that upon release of the body from OCME, there were no written policies or procedures for notifying the next of kin about the transfer of property.

Original Finding 26a.: OCME does not have written policies and procedures for the chain of custody of personal effects of deceased persons at death scenes.

Original Recommendation (a.)

That the CME establish policies and procedures for the transfer of property at death scene investigations.

Current Status: In compliance. OCME has established policies and procedures for the transfer of property at death scene investigations.

MORTUARY

Original Finding 26b.: OCME does not have adequate property/evidence forms.

Original Recommendation (b.)

The original recommendation (b.) was worded incorrectly and should have read as follows:

That the CME develop a property/evidence form that includes a required signature from the Mortuary Supervisor who has custody of personal effects and evidence after transfer from autopsy technicians.

Current Status: In compliance. OCME has developed a property/evidence form that includes a required signature from the Mortuary Supervisor who has custody of personal effects and evidence after transfer from autopsy technicians.

Original Finding 26c.: The property of deceased persons, as well as evidence transferred to MPD, is not handled in accordance with the D.C. Code.

Original Recommendation (d.)

That the CME work with the Chief of Police to develop and document a secure means of transferring property to MPD as required by the D.C. Code.

Current Status: Not in compliance. Since approximately 2003, OCME has not coordinated with MPD on transferring to the MPD Property Clerk property not claimed by next of kin or a funeral director, property of unidentified decedents, and evidence from a crime as required by D.C. Code § 5-1408. For example, the team found four sexual assault examination kits in MLI storage lockers that should have been transferred to MPD for investigative purposes.

OCME has written policies for its Communications Unit to release decedent's personal property. In order to release a decedent's personal property, OCME release procedures require the Communications Unit to:

- check Forensic Analytic Case Tracking System to determine if valuables or personal effects are being held by OCME;
- notify the next of kin of any personal property to be released by OCME;
- notify the funeral home representatives or next of kin if personal effects or valuables are left behind and make arrangements to have the items picked up as soon as possible; and
- send the personal effects and valuables of unclaimed bodies to MPD's Property Department.¹⁷

¹⁷ OCME Release Procedures, pages 15-16, 7 February 2006.

MORTUARY

The Director of Forensic Investigations has custody and accountability for decedents' personal property kept in OCME storage lockers. OCME maintains over 25 secured lockers containing jewelry, sentimental items, identification, credit cards, cash, passports, and numerous other items dating to 1997. During the re-inspection, the team found several instances of storage lockers containing personal property belonging to decedents with known next of kin. During a review of case files, the team found next of kin names, addresses, and telephone numbers that would enable OCME to notify them to retrieve decedents' personal effects. However, based on the team's interviews and review of case files, OCME is not contacting next of kin to inform them that decedents' personal property has been left behind after decedents depart the morgue.

The team asked two Communications Unit employees about their role in transferring a decedent's personal property to next of kin. They stated they do not notify next of kin about a decedent's personal property to be picked up from OCME when they come to identify them. Also, Communications Unit personnel do not inform next of kin about decedents' personal property left behind after decedents have left the morgue.

New Recommendation: That the CME inform the next of kin about the procedure to claim personal property by creating an information sheet or pamphlet.

Mortuary Technicians Receive Salary Increase

Original Finding 27: Mortuary technicians exposed to hazardous conditions do not receive environmental differential pay.

The original inspection found that mortuary technicians work under sometimes hazardous environmental conditions such as at homicide scenes, in abandoned and burned buildings, and areas that have been exposed to biohazardous chemicals. They lift and transport decedents of excessive weight, and may have to transport decomposed bodies down numerous flights of stairs. However, they do not receive the environmental differential pay authorized by the District Personnel Manual. The former CME sought such pay in discussions with the D.C. Office of Personnel (now DCHR) but was unsuccessful.

Original Recommendation

That the CME work with [DCHR] to determine if the exposure of mortuary technicians to environmental hazards warrants their receipt of environment differential pay.

Current Status: In compliance. Interviews and documents confirm that mortuary technicians' position descriptions were revised, resulting in increased wage grades in lieu of environmental differential pay.

**FINDINGS AND
RECOMMENDATIONS:**

FORENSIC INVESTIGATIONS

FORENSIC INVESTIGATIONS

OCME and MPD Collaborate on Investigations

Original Finding 28: Some Metropolitan Police Department (MPD) officers impede OCME death scene investigations.

During the initial inspection, OCME informed the team that MPD officers did not always immediately notify OCME of a homicide or suspected homicide. MLIs stated that often MPD would complete its death scene investigation before notifying OCME. This delayed the MLIs arrival at the scene, the OCME investigation, and the official pronouncement of death. In addition, MLIs informed the initial inspection team that they verbally requested that MPD notify OCME immediately when MPD became aware of a death, but MPD ignored their request.

Original Finding 28a.: Death scenes and bodies are disturbed prior to the arrival of OCME MLIs in violation of the D.C. Code.

Original Recommendation (a.)

That the CME collaborate with the Chief of Police on clarifying, in writing, the responsibilities of OCME and MPD personnel at death scenes, and that oversight procedures be put in place that will ensure the integrity of all death scenes is maintained.

Current Status: In compliance. Before the completion of the initial inspection, the former CME and the District of Columbia's former Chief of Police clarified in writing the responsibilities of OCME and MPD personnel at death scenes in accordance with applicable laws and regulations of the District of Columbia. The CME wrote a memorandum to MPD regarding MPD responding to a death scene in the absence of OCME. In addition, MPD provided a written response to the OIG stating that MPD and OCME signed an agreement that clarified responsibilities at death scenes. The former CME delegated authority to the MPD Homicide Unit to "disturb" the body at death scenes for investigative purposes when no MLI was available.

Original Finding 28b.: Some MPD officers delay the official pronouncement of death by not promptly notifying OCME of all deaths subject to investigation.

Original Recommendation (b.)

That the CME collaborate with the Chief of Police to ensure that OCME is promptly notified of all deaths subject to investigation as required by the D.C. Code.

Current Status: In compliance. The current CME informed the team that she has not updated, in writing, the collaborative efforts between OCME and MPD. However, since the initial inspection, three detectives of the MPD Natural Squad (NS) are now housed at OCME, and are on duty when the MLIs are not. According to an OCME manager, NS detectives complement OCME's medicolegal unit and work in parallel with the MLIs to investigate natural deaths. They also serve as liaisons with MPD homicide detectives to provide quick information to the medical examiners. NS also helps expedite

FORENSIC INVESTIGATIONS

identification of bodies in OCME through fingerprints and a search of missing person files. According to OCME management and NS detectives, MPD has continued to provide prompt notification to OCME of all deaths subject to investigation and the two agencies work well together.

New Recommendations: The OIG recommended that the Executive Office of the Mayor and the Office of the Attorney General (OAG), in coordination with OCME and MPD, review the investigative relationship between OCME and the MPD Natural Squad to determine if (a) OCME's use of the Natural Squad to conduct investigations on its behalf is in violation of the D.C. Code, and (b) if OCME's investigative collaboration with the Natural Squad jeopardizes OCME's ability to become accredited by the National Association of Medical Examiners. If the collaboration between OCME and MPD was found to be appropriate, the OIG also recommended that OCME and MPD formalize a Memorandum of Understanding detailing the nature of the relationship and its legal and regulatory basis.

On July 10, 2007, the OIG presented these recommendations to OCME, MPD, and OAG as part of Management Alert Report (MAR) 07-I-008. The MAR is included at Appendix 6 to this report. OCME's response to the MAR is at Appendix 7; OAG's response is at Appendix 9.

OCME Policies and Procedures for Death Scene Investigations Implemented; MLIs Certified

Original Finding 29: OCME does not have standard, written procedures for death scene investigations, and MLIs are not certified.

The initial inspection team observed that unlike OCME, nearby jurisdictions use trained investigators to conduct death scene investigations. The American Board of Medicolegal Death Investigators (ABMDI) trains and certifies MLIs. This national, not-for-profit, independent professional certification board was established to promote the highest professional standards for MLIs. The initial inspection team found that of the OCME's five MLIs, only one was ABMDI certified. In addition, the initial inspection team found that OCME did not have standard written procedures that explain when an investigator would go to a death scene and what they would investigate. MLIs decided whether they would conduct an on-site investigation and the bases for examining the body and death scene.

Original Recommendation (a.)

That the CME provide written policies and procedures for all aspects of death scene investigations. (The CME at the time of the initial inspection disagreed with this recommendation.)

Current Status: In compliance. The team found that the OCME has established written policies and procedures for death scene investigations that explain the types of deaths requiring investigation and the type of information to collect at the scene.

FORENSIC INVESTIGATIONS

Original Recommendation (b.)

That the CME require that all MLIs be formally trained and certified. (The former CME disagreed with this recommendation.)

Current Status: Partially in compliance. There are now six MLIs who are licensed physician assistants, and four are ABMDI certified. According to management, OCME investigations comply with the United States Department of Justice National Guidelines for Death Investigations.

New Recommendation: The OIG recommends that the CME ensure that all MLIs are ABMDI certified.

OCME Now Obtains Findings From Other Investigative Agencies

Original Finding 30: OCME does not obtain investigative findings from MPD, FEMS, and other investigative agencies.

During the initial inspection, the team reviewed OCME investigative reports and found that neither MPD nor Emergency Medical Technician (EMT) investigative findings nor reports were routinely obtained and included in the decedent's file. MLIs stated that they requested these investigative reports, but they were not always provided. As a result, OCME did not always have enough information to determine with reasonable medical certainty the cause and the circumstances of a death.

Original Recommendation

That the CME work with MPD, the FEMS, and other investigative agencies, as appropriate, to ensure that all necessary investigative reports are provided to OCME promptly when requested.

Current Status: In compliance. During the re-inspection, the team reviewed OCME case files and found that they contained police, accident, hospital, and MLI reports. According to OCME management and MPD homicide officials, OCME obtains all required reports from MPD and FEMS.

**FINDINGS AND
RECOMMENDATIONS:
OFFICE OF THE CHIEF MEDICAL
EXAMINER**

OFFICE OF THE CHIEF MEDICAL EXAMINER

OCME Establishes Workplace Health and Safety Program

Original Finding 31: OCME does not have a workplace health and safety program.

The initial inspection found that OCME did not have decontamination procedures, sufficient protective equipment, air purifying respirators, safety training programs, immunizations, health screenings, or procedures regarding blood-borne and airborne pathogens.

Original Finding 31a.: OCME has no written safety policies or procedures.

Original Recommendation (a.)

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

Current Status: Partially in compliance. Since the initial inspection, OCME has established written safety policies and procedures that are included in the agency's policy and procedures manual. Employees have access to this manual. When asked whether the safety policies and procedures conform to OSHA guidelines, employees informed the team that according to their sources, the District does not follow OSHA guidelines. OCME interpreted this to mean that they were not required to write its policies and procedures to conform to OSHA guidelines. However, there appears to be a conflict regarding OCME's position that it is not required to conform to OSHA guidelines.

On June 20, 2006, the District of Columbia Office of Risk Management (ORM) conducted an occupational safety and health inspection of OCME. The OIG obtained information from ORM indicating that the purpose of the inspection was to provide the agency with information and assistance *to ensure its compliance with OSHA standards and guidelines.*

New Recommendation: The OIG recommends that OCME clarify with the ORM whether OCME safety policies and procedures should conform to OSHA guidelines, and provide the OIG with the results of the clarification.¹⁸

Original Finding 31b.: There are no written standard operating procedures for decontamination of autopsy instruments and surfaces.

Original Recommendation: None made.

Current Status: Since the initial inspection, OCME has established written policies and procedures that address how employees should decontaminate equipment and surfaces.

¹⁸ In its comments on the draft report, OCME informed the OIG that according to ORM, the District follows OSHA guidelines.

OFFICE OF THE CHIEF MEDICAL EXAMINER

Original Finding 31c.: OCME does not provide sufficient protective equipment to autopsy workers.

Original Recommendation (c.)

That the CME provide alternative protection for [autopsy] employees allergic to latex gloves and masks.

Current Status: In compliance. An employee interviewed in the mortuary unit informed the team that employees who are allergic to latex gloves and certain masks are provided with alternative protection upon request.

Original Recommendation (f.)

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

Current Status: In compliance. OCME has established what protective equipment should be worn when exposed to harmful or contagious conditions, and has provided powered respirators in the autopsy suite.¹⁹

Original Finding 31d.: OCME does not have safety-training programs.

Original Recommendation (e.)

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

Current Status: Not in compliance. The initial inspection team found that OCME had not provided training to employees on the universal precautions to take when handling biological specimens. Since the initial inspection, OCME policies and procedures include information on universal precautions. However, OCME was unable to produce documentation to support claims that employees had received training in universal precautions.

Original Finding 31e.: OCME does not provide immunizations or proper health screenings.

Original Recommendation (b.)

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

Current Status: In compliance. OCME now offers hepatitis B vaccinations through the District of Columbia Department of Health to employees who handle decedents as a part of their job.

¹⁹ Based on OCME comments, OIG amended this finding. See Appendix 8.

Original Recommendation (d.)

That the CME provide periodic tuberculosis (TB) screenings for all at-risk employees.

Current Status: In compliance. OCME requires that all employees receive TB testing.

Original Finding 31f: Policies and procedures regarding employee exposure to blood-borne or airborne pathogens are inadequate.

Original Recommendation (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.

Current Status: Partially in compliance. The re-inspection team found that OCME has written policies and procedures to explain what actions employees should take if they are exposed to blood-borne pathogens. Employees must notify a supervisor or the Agency Risk Representative when an exposure incident occurs. The policies and procedures did not appear to contain procedures to address exposure to airborne pathogens, nor do they address immediate, no-cost access to health care.

New Recommendation: The OIG recommends that OCME ensure that its procedures address when powered respirators should be worn and what procedures to follow when exposed to airborne pathogens. OCME should offer an occupational medical services program that allows employees to obtain immediate access to appropriate health care, at no cost, after exposure to blood-borne and airborne pathogens. Further, OCME should maintain employee training and medical services records to ensure timely access to and accountability for this information.

OCME Establishes Mass Fatality Plan

Original Finding 32: OCME does not have a Mass Fatality or Disaster Plan.

During the initial inspection, the team found that OCME did not have a Mass Fatality Plan or a Mass Disaster Plan. OCME employees stated that they had not participated in any mass disaster exercises and had not been asked to participate in local mass disaster plan seminars or classes.

Original Recommendation (a.)

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

Current Status: Partially in compliance. Since the initial inspection, OCME has developed a formal Mass Fatality Plan (MFP). According to OCME management and the

OFFICE OF THE CHIEF MEDICAL EXAMINER

content of the MFP, the OCME activates the MFP when there is any major disaster, emergency, or incident within the District of Columbia resulting in a large number of fatalities. However, based on information in the plan, locations have not been selected for a temporary morgue site,²⁰ morgue examination center,²¹ long-term examination site,²² and family assistance center.²³

New Recommendation: The OIG recommends that OCME and OPM promptly select locations for a temporary morgue, morgue examination center, long-term examination site, and family assistance center to use in the event of a mass fatality disaster, and update the MFP accordingly.

Original Recommendation (b.)

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

Current Status: In compliance. OCME employees from various units have participated in emergency, shelter-in-place,²⁴ and mass fatality exercises and drills.

OCME Prepared to Respond to All After-Hours Requests

Original Finding 33: OCME is not prepared to handle after-hour autopsies in response to requests from other investigative agencies or District authorities.

During the initial inspection, the former CME stated that 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.

Original 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 and other District or

²⁰According to the OCME Mass Fatality Plan (Page 10), as [an] incident site is processed and cleared of remains, a temporary morgue site may be necessary as a holding area until the primary morgue examination center is prepared to receive additional remains.

²¹ According to the OCME Mass Fatality Plan (Page 10), the morgue examination center is a site for the processing and identification of remains. It is also where the remains will be prepared for release.

²²According to the NAME Mass Fatality Plan (Page 2), a long-term examination site is used to process biological specimens and evidence not originally accessed at the scene or morgue or examination center.

²³According to the OCME Mass Fatality Plan (page 19), the family assistance center is a multi-functional location where the following tasks are performed: collection of decedents' antemortem information; death notification; counseling services; release of personal effects and remains; issuing of death certificates; records maintenance; general inquiries; and daily briefings to families and to the media.

²⁴ Shelter-in-place means that rather than leaving your current location in an emergency, you instead take refuge in a small, interior room, with no or few windows.

OFFICE OF THE CHIEF MEDICAL EXAMINER

federal authorities, as may be required. (The CME at the time of the initial inspection disagreed with this recommendation.)

Current Status: In compliance. During the re-inspection, OCME management stated that staff is on duty 24 hours a day, 365 days a year. OCME now has designated emergency employees in the mortuary, administrative support, communication, investigations, and medical examiner units that are on call 24 hours. In addition to the employees on duty, OCME can call upon additional employees to respond if the Mayor requires an OCME response to unusual incidents.

OCME Establishes Tracking System for Complaints and Inquiries

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

During the initial inspection, the team observed that OCME did not have a tracking system for complaints and inquiries, even though it was responsible for investigating complaints and responding to inquiries.

Original Recommendation

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

Current Status: Partially in compliance. Since the initial inspection, OCME has established a tracking system and has written procedures for handling complaints. The executive assistant to the CME is responsible for recording, tracking, and responding to complaints and inquiries. The only record of complaints available for the team's review, however, was a complaint log from 2003, and many of the complaints entered appear to be unresolved. OCME informed the inspection team that the agency did not establish logs for 2004, 2005, and 2006 because the agency resolved these complaints within 1 to 2 days. Consequently, the team was unable to verify that complaints received during these years were in fact resolved.

New Recommendation: The OIG recommends that OCME log all complaints and inquiries. The log should reflect whether the entry is a complaint or inquiry; whether OCME received the complaint or inquiry by letter, telephone, email, or through referral; and how the complaint or inquiry was resolved.

Quality Assurance Program is in Place for Autopsies and Toxicology

Original Finding 35: OCME does not have a quality assurance program.

During the initial inspection, the team reviewed best practices in Maryland and Virginia and found that CMEs have a daily conference or meeting at the end of the day to discuss all autopsy cases conducted. These sessions constitute a qualitative assessment of autopsies, and allow a discussion of problems and pending cases.

OCME medical examiners stated that the former CME sometimes changed their autopsy reports, there were no written standards or criteria for making the changes, and there was no uniformity in how they presented their autopsy reports. In addition, the initial inspection team discovered that although surrounding jurisdictions had written policies and procedures for autopsy reports and randomly selected and evaluated them regularly, OCME did not. These evaluations ensure the integrity and completeness of the reports and their conformity with uniform standards established by the office.

Original Recommendation (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.

Current Status: In compliance. Since the initial inspection, OCME has instituted a formal quality control policy and process regarding autopsies and Toxicology Lab operations. The process includes peer reviews that consist of daily, weekly, and monthly conferences. The medical examiners and MLIs attend daily OCME conferences to discuss all autopsy cases. The weekly conference, which also includes the toxicology staff, is used to review pending cases that need further consultation. However, the CME does not have a quality control officer to manage OCME's quality assurance program and implement the quality control policy. This responsibility has been given to the Chief of Staff until an employee can be hired to manage the program.

New Recommendation: The OIG recommends that the CME hire a quality control officer quickly to manage its quality assurance program and ensure that the OCME quality control policy is implemented.

Original Recommendation (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. (The CME at the time of the initial inspection disagreed with this recommendation.)

Current Status: In compliance. OCME holds monthly conferences during the last week of the month that include the entire management team and other involved staff who meet for a peer review of four randomly selected autopsy cases.

OFFICE OF THE CHIEF MEDICAL EXAMINER

Some Support Positions Still Filled With Term Employees

Original Finding 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. The initial inspection team found that the former CME was allocated permanent positions to meet this requirement, but hired term employees who work 1 to 4 years and are then terminated and must be replaced.

Original Recommendation

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

Current Status: Partially in compliance. In 2004, all employees who were term employees at the time of the initial inspection were converted to permanent status, with the exception of one medical examiner hired to assist with the autopsy report backlog. Currently, OCME has an autopsy assistant, an administrative employee, and two intake assistants who are term employees. These employees have been in their positions for less than 1 year.

IT Consultant No Longer Supervises Staff Employees

Original Finding 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.

The initial inspection revealed that OCME and the Office of the Chief Technology Officer (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. The contractor performed supervisory duties for areas outside the scope of the contract. According to 27 DCMR § 1907.3(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.”

Original 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 are reassigned to appropriate OCME employee(s). (The CME at the time of the initial inspection disagreed with this recommendation.)

OFFICE OF THE CHIEF MEDICAL EXAMINER

Current Status: Overtaken by events. The contractor in question no longer works at OCME and the Chief of Staff manages and supervises the OCME IT unit. The IT unit has a database administrator and a computer specialist who handle IT issues.

Employees Now Receive Annual Evaluations but Seek Pay Review

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

During the initial inspection, many employees stated they were not receiving annual performance evaluations. Those who did receive evaluations said that management prepared them without discussing their content with employees.

Original 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.

Current Status: In compliance. Since the initial inspection, employees have been receiving annual performance evaluations in a timely manner, and they are discussed with each employee. Interviewed employees stated, however, that they have concerns that their pay is not adequate given their duties and responsibilities. In addition, employees seek a means to submit concerns or comments to management anonymously.

New Recommendations: The OIG recommends that OCME work with DCHR to address the concern of OCME employees who allege that the District government does not compensate them in accordance with their duties and responsibilities. In addition, the OIG recommends that OCME consider using a suggestion box to enable employees to present their concerns to management anonymously.

**FINDINGS AND
RECOMMENDATIONS:

ADMINISTRATION**

ADMINISTRATION

Case Records Security Improved

Original Finding 39: Case records are not properly secured and controlled.

Case files contain private, sensitive, and vital information needed to investigate the cause and manner of deaths occurring in the District. The initial inspection reported that OCME storage facilities for current records and investigative reports were not secure. The team found doors unlocked and access uncontrolled. The team found visitors and funeral directors who could easily remove a case file visiting with employees in the record storage areas. OCME did not have policies and procedures to track reports and records and ensure accountability for their security. The lack of proper oversight and security for records storage allowed possible loss, manipulation of findings, and unauthorized release of information to the public and media.

Original Recommendation (a.)

That the CME establish written policies and procedures in line with the District's records schedule for the storage, maintenance, and security of records.

Current Status: In compliance. The re-inspection team interviewed staff, visited the Records Office, and reviewed case files. The CME has established written policies and procedures in line with the District's records schedule for the storage, maintenance, and security of records.

Original Recommendation (b.)

That all spaces for sensitive record storage be secured at all times and that only authorized personnel have access.

Current Status: In compliance. OCME has installed two doors within the Records Office that control access to records by visitors and unauthorized personnel. An outer door controls access to the hallway. An inner door is divided in half to create a counter top that facilitates communication with persons needing service from the Records Office.

Original Recommendation (c.)

That OCME implement a sign-in and sign-out policy for all case files and investigative reports.

Current Status: In compliance.²⁵ OCME has a sign-in and sign-out system for tracking records removed from the Records Office.

²⁵ The language in this finding was amended based on comments from OCME. See Appendix 8.

ADMINISTRATION

Automated Records System Operational

Original Finding 40: Installation and implementation of a new automated system is behind schedule.

The initial inspection recommended that OCME give priority to implementing an automated software system for death reporting, investigations, and case management. The system should create records, track, and report demographic data of deceased persons and other information associated with a case, to include autopsy reports, investigations, and toxicology reports. The system should also track body intake, body release, evidence, property, body storage, and body disposition.

Original Recommendation

That the CME give priority to coordinating with OCTO to ensure that the Case Management System project gets on schedule, is completed expeditiously, and meets the terms of the contract. (The CME at the time of the initial inspection disagreed with this recommendation.)

Current Status: In compliance. During the re-inspection, the OCME Information Technology Strategic Business Project Manager stated that OCME has developed and implemented the Forensic Analytic Case Tracking System (FACTS) to automate operations and processes. The system tracks body intake, body release, evidence, property, body storage, and body disposition. It reports demographic data on deceased persons and other information associated with a case, including autopsy reports, investigations, and toxicology reports.

Power Deficiencies in Toxicology Lab Abated

Original Finding 41: The Toxicology Laboratory does not have sufficient electrical power and surge protection to support its operations.

The initial inspection team found that because of insufficient power sources, only 5 of OCME's 12 computer-based toxicology instruments were operational. In addition, there were no surge protectors to protect laboratory computers from electrical spikes that could damage expensive equipment. Consequently, the lab was unable to function at optimal capacity.

Original Recommendation

That the CME hire a contractor to correct the power and electrical surge deficiencies in the Toxicology Laboratory.

Current Status: In compliance. The re-inspection team interviewed the Chief Toxicologist and confirmed that the power and electrical surge protection deficiencies in the Toxicology Laboratory have been corrected.

APPENDICES

APPENDICES

- Appendix 1:** List of Original Findings and Recommendations
- Appendix 2:** MAR 03-I-005
- Appendix 3:** MAR 03-I-003
- Appendix 4:** MAR 07-I-003
- Appendix 5:** OCME Response to MAR 07-I-003
- Appendix 6:** MAR 07-I-008
- Appendix 7:** OCME Response to MAR 07-I-008
- Appendix 8:** OCME Response to OIG Draft Report of Re-inspection
- Appendix 9:** OAG's response to MAR 07-I-008

APPENDIX 1

LIST OF ORIGINAL FINDINGS AND RECOMMENDATIONS

Key Findings:

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

- a. That the CME immediately begin writing and implementing policies and standard procedures for the most critical operational areas (particularly those affecting employee health and safety) in order to bring consistency, efficiency, and safe practices to the way employees conduct OCME business from day-to-day.
- b. That the CME take a “lessons learned” approach to the information in this report and make adjustments in his management style and operational oversight in order to improve both the perception and the reality of a District agency that is performing poorly.
- c. That the Deputy Mayor for Public Safety and Justice review this and previous reports on OCME and work with the CME to develop both near- and long-term plans and specific goals for improving all OCME operations.

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

That the CME take the necessary steps to be inspected and evaluated by the National Association of Medical Examiners.

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

- a. That the CME consider contracting with private pathologists to reduce the backlog of autopsy reports.
- b. That the CME review the concerns and suggestions of his medical examiner team regarding reduction of the backlog.

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

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

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

- a. That the CME collaborate with his team of medical examiners to review the sufficiency of policies and procedures pertaining to autopsies and other OCME operations as pertinent, and give full consideration to their input.
 - b. That the CME establish written, standard criteria for agreeing to requests for special autopsy procedures based on a family’s religion.
-

LIST OF ORIGINAL FINDINGS AND RECOMMENDATIONS

- c. That the CME develop a policy and procedure for retaining and disposing of organ and tissue specimens.
6. **The Histology laboratory is not properly vented and waste chemicals are improperly stored and disposed of, causing the lab to be shut down in June 2003.**
- a. That the CME order and install fumigation hoods in the histology laboratory.
 - b. That the CME establish policies and procedures for the storage and disposal of waste chemicals.
7. **The CME's relationship with the Child Fatality Review Committee has been marred by problems.**
- a. That the CME make the appropriate personnel transfers and fill critically needed administrative staff positions for the CFRC.
 - b. That the CME provide the IG a detail accounting of all funds spent providing administrative support to the CFRC.
 - c. That the CME allow CFRC members to participate in the oversight and development of the CFRC administrative support budget to ensure the efficient use and proper accountability of funds.
 - d. That the CME provide the CFRC administrative staff with OCME policies and procedures.
 - e. That the Mayor review the appropriateness of the CME's oversight of the CFRC's administrative support staff and consider a more independent oversight location.
 - f. That the CME attend all CFRC meetings or send a designee as required by the D.C. Code.
8. **Staffing for some of the most critical areas is not adequate.**
- a. That the CME adequately staff OCME to provide on-site death scene investigations whenever required.
 - b. That the CME provide adequate staffing to ensure the timely transport of decedents.
 - c. That the CME increase Communication Unit staffing of the midnight tour for the 24-hour phone number to ensure proper and adequate coverage.
 - d. That the CME increase staffing for maintenance and upkeep of the OCME facility.
-

LIST OF ORIGINAL FINDINGS AND RECOMMENDATIONS

- e. That the CME work with the Office of Property Management to ensure that structural and equipment repairs are completed as required by the renovation contract.

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

That the CME provide the Mayor with an annual report as required by the D.C. Code and as recommended by NAME.

Health and Safety Issues:

10. **The use of x-ray equipment does not conform to District regulations and NAME recommendations, and employees are endangered.**

No recommendations.

11. **Stretchers and carts used to move bodies are old, rusted, and dangerous.**

That the CME take steps to expedite the replacement of old and malfunctioning body carts.

12. **OCME does not have written policies and procedures or training for the disposal of biohazardous waste.**

That the CME provide OCME employees with training and written policies and procedures for the proper disposal of bio-hazardous waste.

13. **Employees are not trained to avoid biohazardous contamination associated with body handling and transport.**

That the CME establish written policies and procedures and provide training, and protective equipment to body transport employees to prevent biohazardous contamination.

14. **OCME does not have a written hazardous communication program as required by federal law.**

That the CME oversee completion and implementation of a written hazardous communication program as required by 29 CFR § 1910.1200(e)(1) (*Lexis* through July 23, 2003).

15. **The autopsy suite tissue storage areas are not properly ventilated.**

That the CME have the ventilation system in the autopsy suite tissue storage areas inspected and upgraded as required.

LIST OF ORIGINAL FINDINGS AND RECOMMENDATIONS

16. Handling of personal protective equipment (PPE) is unsafe.

- a. That the CME immediately forbid removal of PPE from the OCME facility.
- b. That the CME provide on-site or contract for laundry services for PPE.

17. Mortuary employees do not have adequate shower facilities for removing bodily fluids and contaminants.

That the CME have the shower facilities repaired and ensure that they are cleaned and disinfected daily.

18. Odors from autopsy suite permeate public access areas.

No recommendations.

Mortuary:

19. OCME's death pronouncement process does not ensure that bodies are always officially pronounced dead prior to arrival at OCME.

- a. That the CME consider contracting with private physicians to pronounce death at the scene when no qualified personnel are available.
- b. That the CME consider resumption of the practice of having autopsy technicians transport bodies to an emergency room for the pronouncement of death prior to arrival at OCME when no qualified personnel are available.
- c. That the CME consult with OCC on proposing legislation to the City Council that would permit qualified paramedics to officially pronounce death.

20. The lack of procedures, training, and equipment for efficient body handling and transport puts employees at risk.

That the CME establish written policies and procedures and provide training for body handling and transport.

21. The procedures for processing bodies into the morgue are inadequate.

That the CME establish written policies and procedures for processing bodies into the morgue, including a checklist to be maintained with a decedent's case file.

22. Unidentified skeletal remains have not been properly processed.

That the CME take steps to identify, label, and dispose of unidentified and unclaimed skeletal remains, as appropriate.

LIST OF ORIGINAL FINDINGS AND RECOMMENDATIONS

23. OCME does not fingerprint decedents in a timely manner.

- a. That the CME draft a Memorandum of Agreement or a Memorandum of Understanding with MPD for fingerprinting decedents, or provide equipment and training to OCME employees for fingerprinting.
- b. That the CME require fingerprinting of all decedents upon arrival at OCME.
- c. That the CME take the steps necessary to have all bodies presently stored at OCME fingerprinted.

24. OCME does not have a consistent policy regarding identification of decedents.

- a. That the CME clarify the identification and body viewing policy and procedure and commit it to writing.
- b. That the CME provide a private viewing space when there are exceptions to photographic identification.

25. Employees do not have clear, established policies and procedures for releasing bodies.

That the CME provide written policies and procedures for the release of bodies.

26. OCME does not have a system to document, transfer, and safeguard the personal effects of deceased persons.

- a. That the CME establish policies and procedures for the transfer of property at death scene investigations.
- b. That the CME inform the next of kin how to claim personal property by creating an information sheet or pamphlet.
- c. That the CME revise the OCME property and evidence transfer procedures to accurately reflect the chain of custody.
- d. That the CME work with the Chief of Police to develop and document a secure means of transferring property to MPD as required by the D.C. Code.

27. Mortuary technicians exposed to hazardous conditions do not receive environmental differential pay.

That the CME work with DCOP to determine if the exposure of mortuary technicians to environmental hazards warrants their receipt of environmental differential pay.

LIST OF ORIGINAL FINDINGS AND RECOMMENDATIONS

Forensic Investigations:

28. **Some Metropolitan Police Department (MPD) officers impede OCME death scene investigations.**
- a. That the CME collaborate with the Chief of Police on clarifying in writing the responsibilities of OCME and MPD personnel at death scenes, and that oversight procedures be put in place that will ensure the integrity of all death scenes is maintained.
 - b. That the CME collaborate with the Chief of Police to ensure that OCME is promptly notified of all deaths subject to investigations as required by the D.C. Code.
29. **OCME does not have standard, written procedures for death scene investigations, and MLIs are not certified.**
- a. That the CME provide written policies and procedures for all aspects of death scene investigations.
 - b. That the CME require that all MLIs be formally trained and certified.
30. **OCME does not obtain investigative findings from MPD, FEMS, and other investigative agencies.**
- That the CME work with MPD, the FEMS, and other investigative agencies, as appropriate, to ensure that all necessary investigative reports are provided to OCME promptly when requested.

Office of the CME:

31. **OCME does not have a workplace safety and health program.**
- a. That the CME establish written safety policies and procedures in accordance with OSHA guidelines.
 - b. That the CME provide hepatitis B vaccinations to all at-risk employees.
 - c. That the CME provide alternative protection for employees allergic to latex gloves and masks.
 - d. That the CME provide periodic tuberculosis screenings for all at-risk employees.
 - e. That the CME provide adequate training in universal precautions when performing autopsies and handling biological specimens.
-

LIST OF ORIGINAL FINDINGS AND RECOMMENDATIONS

- f. That the CME provide powered respirators for use in the autopsy suite.
- 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 bloodborne and airborne pathogens.

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

- a. That the CME develop a written Mass Fatality and Disaster plan as soon as possible.
- b. That the CME send appropriate OCME employees to training on Mass Fatality and Disaster Planning.

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

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.

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

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

35. OCME does not have a quality assurance program.

- 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.
- 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.

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.

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.

LIST OF ORIGINAL FINDINGS AND RECOMMENDATIONS

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.**

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).

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

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.

Administration:

39. **Case records are not properly secured and controlled.**

- a. That the CME establish written policies and procedures in line with the District's records schedule for the storage, maintenance, and security of records.
- b. That all spaces for sensitive record storage be secured at all times and that only authorized personnel have access.
- c. That OCME implement a sign-in and sign-out policy for all case files and investigative reports.

40. **Installation and implementation of a new automated system is behind schedule.**

That the CME give priority to coordinating with OCTO to ensure that the CMS project gets on schedule, is completed expeditiously, and meets the terms of the contract.

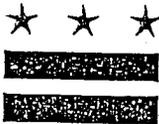
41. **The Toxicology Laboratory does not have sufficient electrical power and surge protection to support its operations.**

That the CME hire a contractor to correct the power and electrical surge deficiencies in the Toxicology Laboratory.

APPENDIX 2

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Office of the Inspector General

Inspector General



July 11, 2003

Jonathan L. Arden, M.D.
Chief Medical Examiner
Office of the Chief Medical Examiner
1910 Massachusetts Avenue, S.E.
Washington, D.C. 20004

Dear Dr. Arden:

This is a Management Alert Report (MAR 03-I-005) to inform you of a significant issue that has come to our attention as a result of our inspection of the Office of the Chief Medical Examiner (OCME). The Office of the Inspector General (OIG) provides these reports when we believe a serious matter requires the immediate attention of a District of Columbia government official.

Background:

The inspection team (team) observed what appeared to be safety and health hazards in the use of radiographic equipment by OCME employees. The autopsy staff conducts radiographs¹ on decedents every day. Radiographic equipment is located in a separate room in the autopsy suite in the basement of the OCME building, and employees entering this area may be exposed to some level of radiation if the machines are in use.

OCME has no written policies or procedures regarding the use, maintenance, and safety of radiographic equipment. Therefore, in conducting this evaluation, the team referenced standards established by the National Association of Medical Examiners (NAME)² and outlined in NAME's accreditation checklist.³ The team also referenced standard operating procedures for radiographic equipment in the surrounding jurisdictions of Maryland and Virginia.

¹ An image produced on a radio-sensitive surface, such as a photographic film, by radiation other than visible light, especially by x-rays passed through an object. The word *radiograph* is synonymous with the word *x-ray*.

² NAME is the national professional organization of physician medical examiners, medical death investigators, and death investigation system administrators who perform medicolegal investigations of deaths of public interest in the United States. Its mission is to improve the quality of death investigation nationally and to recognize excellence in death investigation systems.

³ See National Association of Medical Examiners Accreditation Checklist (Checklist) (1997) (amended 2002), available at <http://www.thename.org>.

Observations:

1. OCME does not properly monitor employee radiation exposure. OCME contracts with a monitoring company to provide monthly radiation monitoring badges, evaluation of the badges, and monthly radiation exposure reports for each employee who enters the autopsy suite. The film from the badges should be sent to the monitoring company monthly to determine the level of each employee's exposure to radiation. The company sends back fresh badges to OCME along with a report that notes the exposure readings for the previous month and any overexposures for each employee (see Attachment). The team found that:
 - OCME could only provide the team with monitoring reports for 1999. A review of these reports showed that OCME failed to send 99% of the radiation monitoring badges to the monitoring company every month. The reading of these badges is vital to ensure that overexposure to radiation is detected. The Risk Manager could not explain the absence of reports for the years 2000-2003.
 - The radiation monitoring badges are not stored properly. According to the monitoring company, when not in use, badges should be stored outside of the autopsy suite along with the control badge⁴ provided to OCME by the company each month. However, the team found badges stored adjacent to the radiograph room, not outside of the autopsy suite area as required. In addition, the control badge was found taped to the wall inside the radiograph room. Monitoring reports from 1999 showed that the control badge was not returned to the monitoring company as required for several months in 1999.
 - OCME has no written policies and procedures for the use of radiation monitoring badges. Employees stated that they have never been instructed as to when to wear the badges or where the badges should be worn. In addition, employees were not aware that badges should be stored with the control badge when not in use; the team found employees storing badges in their offices.
 - OCME does not ensure that all employees turn in badges each month for evaluation. Until the recent appointment of an employee as Risk Manager, no employee had been designated to ensure that all badges are collected and sent to the monitoring company. As a result, many employees failed to turn in badges for 6 months or more.

⁴ A control badge is provided with each monthly shipment of badges to OCME. The control badge is to be maintained away from the source of radiation at all times. The control badge is used to account for the occurrence of any accidental exposures during the monthly transport of the badges from OCME to the monitoring company. This ensures that the readings from the individual employee badges are accurate.

- The Risk Manager has not been trained to evaluate the monthly radiation reports, and has no instructions as to what actions to take when a positive reading above acceptable radiation levels is found. She stated that during October or November of 2002, all badges sent to the company tested positive for excessive radiation exposure; however, no action was taken by OCME upon receipt of the company's report.⁵
2. The inspection team found OCME radiographic equipment has never been inspected. NAME standards state that in-house radiographic equipment should be periodically assessed for performance improvement, radiation protection, and safety. Additionally, 20 DCMR § 2103.10 states that "[e]ach radiation device (x-ray machine) used in the District shall be re-tested at not longer than six (6) months month intervals, or at intervals not to exceed three (3) years as is specified in the label required by this section."⁶ The team also found that the Kevlar vests used for protection during x-rays are old, torn, and leaking threads and fibers.
 3. The team found OCME does not have a certified radiologist. NAME recommends that all operators of radiographic equipment be properly trained. OCME autopsy technicians who conduct radiographs daily have not been trained by a certified radiologist. Employees say they have requested training and certification but have not received any. They stated that they receive on the job training from fellow employees and are also responsible for training new employees. Employees further stated that they do not know how much radiation exposure to use when conducting radiographs, and they experiment with the process on a case-by-case basis.

The lack of monitoring, equipment inspections, and proper training may place the health and safety of OCME employees at risk for overexposure to radiation. Without periodic equipment inspections, the CME cannot ensure that all equipment is operating efficiently and safely. Additionally, OCME is wasting District funds by failing to send badges to the monitoring company on a monthly basis. OCME must pay for the badges and evaluation services each month whether they are evaluated or not. This amounts to approximately \$1,000 per month.⁷

Recommendations:

1. That the Chief Medical Examiner have all affected employees tested for possible overexposure to radiation because of the inadequate monitoring and evaluation of badge readings, the lack of inspections of radiation equipment, and the lack of employee training for operating the equipment.

⁵ OCME could not locate this monitoring report.

⁶ The Department of Health, Bureau of Food, Drug and Radiation Protection is responsible for the testing of District radiation devices. This provision will be recodified at 22 DCMR § 6803.10.

⁷ OCME could not provide a copy of the monitoring contract. These figures were obtained from a monthly purchase order provided by OCME.

Letter to Jonathan L. Arden

July 11, 2003

Page 4

2. That the Chief Medical Examiner have all radiographic equipment inspected and certified for safety as required by District regulations.
3. That the Chief Medical Examiner ensure that monthly radiation monitoring of employees is carried out rigorously.
4. That the Chief Medical Examiner provide training and certification for all employees who operate radiographic equipment.
5. That the Chief Medical Examiner establish written policies and procedures for the use and storage of radiation monitoring badges.
6. That the Chief Medical Examiner provide to OIG all radiation monitoring reports for 2000, 2001, 2002, and 2003.

Please provide your comments to this MAR by July 28, 2003. Your response should include actions taken or planned, dates for completion of planned actions, and reasons for any disagreement with the concerns and recommendations presented. Please distribute this Management Alert Report only to those personnel who will be directly involved in preparing your response.

Should you have any questions or desire a conference prior to preparing your response, please contact Alvin Wright, Jr., Assistant IG for Inspections and Evaluations, 202-727-9249.

Sincerely,


for Charles C. Maddox, Esq.
Inspector General

CCM/AW/LP/jcs

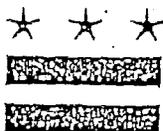
Attachment: As stated

cc: Mr. John A Koskinen, City Administrator, Office of the City Administrator
Mr. James Jacob, Director, Office of Risk Management
Ms. Margret Kellems, Deputy Mayor, Public Safety and Justice

APPENDIX 3

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Office of the Inspector General

Inspector General



January 31, 2003

Jonathan L. Arden, M.D.
Chief Medical Examiner
Office of the Chief Medical Examiner
1910 Massachusetts Avenue, Southeast
Washington, D.C. 20004

Dear Dr. Arden:

This is a Management Alert Report (MAR 03-I-003) to inform you of a significant issue that has come to our attention as a result of our inspection of the Office of the Chief Medical Examiner (OCME). The Office of the Inspector General (OIG) provides these reports when we believe a serious matter requires the immediate attention of a District of Columbia government official.

Observations:

The inspection team observed what appeared to be numerous safety and health issues during visits to the OCME facility. There are no District regulations or laws that directly relate to maintenance and safety in OCME facilities, nor does OCME have a set of written policies or procedures regarding maintenance and safety. Therefore, the inspection team referenced standards established by the National Association of Medical Examiners (NAME)¹ and outlined in NAME's accreditation checklist. See NATIONAL ASSOCIATION OF MEDICAL EXAMINERS ACCREDITATION CHECKLIST (Checklist) (1997) (amended 2002).

First, NAME standards state that public access areas should be comfortable, clean, and free of odor. Checklist § 1H.3. However, the inspection team found that the elevator used by OCME staff and visitors has an unpleasant odor that emanates directly from the autopsy suite and/or the body cooler area.

Second, NAME standards state that work areas should be clean and well-maintained, and that employees and visitors should be safe from physical, chemical, electrical, and biological hazards. Checklist §§ 1H.2 and 2.2. During our inspection of the body cooler area, our team observed that body fluids routinely collect on the floor and that these fluids are not draining properly. As

¹ NAME is the national professional organization of physician medical examiners, medical death investigators and death investigation system administrators who perform medicolegal investigations of deaths of public interest in the United States. As part of its mission to improve the quality of death investigation nationally and to recognize excellence in death investigation systems, NAME offers a voluntary inspection and accreditation program for medicolegal death investigation offices. This program is designed to offer expert evaluation and recommendations for improvement of functioning offices. The published NAME standards for a Modern Medicolegal Investigative System (<http://www.thename.org>) provide a model for jurisdictions seeking to improve death investigations.

January 31, 2003

Page 2

a result, employees are required to mop the cooler floor daily. Additionally, the inspection team observed that several employees were not wearing protective masks in areas where body fluids were present.

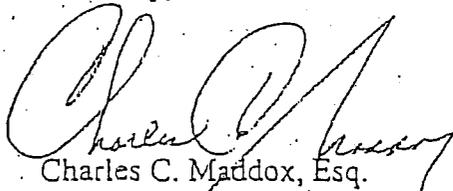
Recommendations:

1. That the Chief Medical Examiner request an inspection of the OCME facility by the District of Columbia Office of Occupational Safety and Health (D.C. OSH) to determine whether there are any hazards to employees and visitors, and if any measures can be taken to address these hazards, to include minimizing the odor referenced in this report.
2. That the Chief Medical Examiner require all employees to wear protective mask in areas where they may be exposed to body fluids.

Please provide your comments to this MAR by February 14, 2003. Your response should include actions taken or planned, dates for completion of planned actions, and reasons for any disagreement with the concerns and recommendations presented. Please distribute this Management Alert Report to only those personnel who will be directly involved in preparing your response.

Should you have questions or desire a conference prior to preparing your response, please contact
Director of Planning and Inspections, 202-727-8490.

Sincerely,



Charles C. Maddox, Esq.
Inspector General

CCM/LP/MLC/jcs

cc: Mr. John A. Koskinen, City Administrator, Office of the City Administrator
Mr. James Jacob, Director, Office of Risk Management
Ms. Margret Kellems, Deputy Mayor, Public Safety and Justice

APPENDIX 4



DISTRICT OF COLUMBIA
OFFICE OF THE INSPECTOR GENERAL
CHARLES J. WILLOUGHBY
INSPECTOR GENERAL

INSPECTIONS AND EVALUATIONS DIVISION
MANAGEMENT ALERT REPORT

**OFFICE OF THE CHIEF MEDICAL
EXAMINER**

**THE DISTRICT HAS NO STANDARD PROCESS
FOR A PROMPT, OFFICIAL
PRONOUNCEMENT OF DEATH**

MAR 07 - I - 003

APRIL 19, 2007

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Office of the Inspector General

Inspector General



April 19, 2007

Marie-Lydie Y. Pierre-Louis, M.D.
Chief Medical Examiner
D.C. Office of the Chief Medical Examiner
1910 Massachusetts Ave., S.E., Bldg. 27
Washington, D.C. 20002

Dear Dr. Pierre-Louis:

The Office of the Inspector General (OIG) provides a Management Alert Report (MAR) when it believes a serious matter requires the immediate attention of District government officials. This MAR (MAR 07-I-003) is to inform you that an OIG re-inspection of the Office of the Chief Medical Examiner (OCME) has found that the District continues to lack a clear point of responsibility and a process for the prompt, official pronouncement of death prior to a body's removal from a death scene for transport to the OCME. The U.S. Department of Justice¹ recommends that appropriate and qualified personnel officially pronounce death prior to the medical examiner assuming responsibility for a body.

Background

Prompt, official pronouncements of death prior to delivering bodies to OCME ensure that: (a) resuscitative efforts can be made on persons who may be perceived as having signs of life before transport to OCME, where there is no resuscitative equipment; (b) cause-of-death investigations in criminal cases will not be delayed; and (c) death certificates, which are vital for next of kin insurance claims, funeral arrangements, and other personal matters, are issued timely.

In 2003, an OIG inspection of OCME determined that official pronouncements of death were often delayed because qualified employees—the Chief Medical Examiner (CME), medical examiners, physicians, physician's assistants, medicolegal investigators, and advanced practice registered nurses—frequently were unavailable.² This was particularly true after normal business hours and on weekends. Consequently, OCME autopsy technicians have transported bodies to the mortuary to await a pronouncement of death by a qualified person, which might be

¹ U.S. DEPARTMENT OF JUSTICE, *DEATH INVESTIGATION: A GUIDE FOR THE SCENE INVESTIGATOR* 17-18 (1999).

² See D.C. OFFICE OF THE INSPECTOR GENERAL, *OFFICE OF THE CHIEF MEDICAL EXAMINER FINAL REPORT OF INSPECTION 55* (2003).

made many hours after the body has arrived at OCME. The inspection also found that in addition to the employees cited above, surrounding jurisdictions allow nurse practitioners with 4 years of experience and paramedics to pronounce death, thereby increasing the availability of qualified individuals. District regulations, however, do not allow paramedics to pronounce death, even though they are often first on the scene. Fairfax, Virginia and Baltimore, Maryland contract with private physicians to go to death scenes to pronounce death.

The 2003 inspection team recommended: (a) that the CME consider contracting with private physicians to pronounce death at the scene when no qualified personnel are available; (b) that the CME consider resumption of the practice of having autopsy technicians transport bodies to an emergency room for the pronouncement of death prior to arrival at OCME when no qualified personnel are available; and (c) that the CME consult with the Office of the Attorney General (OAG) on proposing legislation that would allow qualified paramedics to officially pronounce death.

Observations

During the OIG's current re-inspection of OCME, the inspection team found that there have been no changes in death pronouncement policies since the 2003 inspection, and the agreed-to OIG recommendations made then have not been acted upon. OCME's policy is to pronounce the date and time of death if this task has not been performed by another agency, authorized medical professional, or medical facility upon OCME's retrieval of a body from a death scene or upon the body's arrival at the morgue. The CME, medical examiners, physicians, physician's assistants, medicolegal investigators, and advanced practice registered nurses can officially pronounce death, but continue to be unavailable, particularly after normal duty hours. If none of those individuals can go to a death scene, OCME autopsy technicians transport bodies to the mortuary prior to the pronouncement of death.

You informed us that although OCME physicians and MLIs pronounce death both on the scene and at the OCME facility, you believe that pronouncement of death is not the primary function of OCME. During an interview with the team, you said that you need assurance that a body is dead upon arrival at OCME. However, according to your September 7, 2006, memorandum to this office, "OCME Physicians or Medico Legal Investigators (MLI's) do pronounce decedents that arrive at the OCME unpronounced as soon as it is feasible to do so." You further noted that the D.C. Code does not identify a particular District agency as having authority to make death pronouncements.

As you are aware, the District of Columbia Hospital Association³ Medical Directors Forum (Forum) has debated the District's death pronouncement policies. The Forum has discussed the possibility of supporting an OCME proposal to the Mayor of the District of Columbia that D.C.

³ "[T]he District of Columbia Hospital Association (DCHA) is a non-profit organization with 18 member hospitals and over 70 Associate Members whose mission is to provide leadership in improving the health care system in the District of Columbia, advocating for the interests of Member Hospitals as they support the interests of the community. To this end, DCHA will. . . [p]rovide a forum to solve common problems and achieve common goals..." See <http://www.dcha.org/AboutDCHA.htm>, (last visited April 2, 2007).

Fire and Emergency Medical Services Department personnel be responsible for death pronouncements.⁴

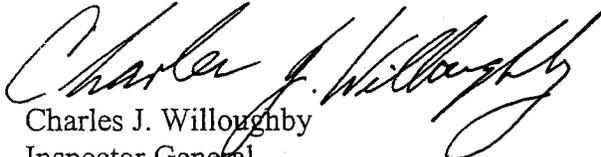
Recommendation

That the CME draft a pronouncement of death policy for the District based on her knowledge, experience, and opinions, as well as guidance from the National Association of Medical Examiners and the Department of Justice. The CME would then coordinate that draft with OAG, the D.C. Department of Health, the D.C. Fire and Emergency Medical Services Department, the Metropolitan Police Department, and the District of Columbia Hospital Association with the following objectives:

- to identify a single District agency or individual who will be responsible for ensuring the prompt pronouncement of death prior to a body's arrival at OCME;
- to identify the medically trained individuals authorized to officially pronounce death and the individuals authorized to give them direction and guidance when needed;
- to establish clearly written, specific procedures regarding all aspects of the actual pronouncement of death and any immediate follow-on actions to be taken; and
- to propose legislation to the D.C. City Council that will support the content of the coordinated policy, if required.

Please provide your comments on this MAR by May 3, 2007. Your response should include actions taken or planned, dates for completion of planned actions, and reasons for any disagreement with the concerns and recommendations presented. Please distribute this MAR only to those who will be directly involved in preparing your response. Should you have any questions or if you desire a conference before responding, please contact Lena Cockfield, Director of Planning and Inspections, at 202-727-9537.

Sincerely,


Charles J. Willoughby
Inspector General

CJW/ld

⁴ Minutes of the March 14, 2005, Meeting of the District of Columbia Hospital Association, Medical Directors Forum.

April 19, 2007

Letter to Dr. Pierre-Louis, M.D.

Page 4 of 4

cc: Daniel M. Tangherlini, City Administrator, Office of the City Administrator
The Honorable Phil Mendelson, Chairperson, Committee on Public Safety and the
Judiciary
The Honorable Carol Schwartz, Chairperson, Committee on Workforce Development and
Government Operations
Cathy L. Lanier, Chief of Police, Metropolitan Police Department
Dennis L. Rubin, Acting Chief, D.C. Fire and Emergency Medical Services Department
Gregg A. Pane, Director and State Health Officer, D.C. Department of Health
Linda Singer, Acting Attorney General, Office of the Attorney General
Robert Malson, President, District of Columbia Hospital Association

APPENDIX 5



GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF THE CHIEF MEDICAL EXAMINER
1910 Massachusetts Ave., S.E., Bldg. 27
Washington, D.C. 20003

RECEIVED
7/3/07

PH 3:25

Marie-Lydie Y. Pierre-Louis, MD
Chief Medical Examiner

202-698-9001 (Office)
202-698-9101 (Fax)

May 3, 2007

Charles J. Willoughby
Inspector General
Office of the Inspector General
717 14th St., NW
Washington, D.C. 20005

Dear Inspector General Willoughby:

This letter responds to the Management Alert Report dated April 19, 2007 and issued to the D.C. Office of the Chief Medical Examiner ("OCME") by the D.C. Office of the Inspector General. ("OIG").

In response to the Management Alert, the OCME agrees with the OIG's statement of the underlying facts surrounding the issue of death pronouncement in the District of Columbia. However, the OCME does not agree with the OIG's observations. Specifically, the OCME disagrees with the OIG's statement that the "agreed-to OIG recommendations made. . . [in the 2003 OIG-OCME Final Report of Inspection]. . . have not been acted upon."

As indicated in the 2003 Inspection Report, OCME did not agree with all of the OIG recommendations referred to. Further, it should be noted that the actions (i.e., meetings and frontburner reports) taken by OCME on the recommendations were discussed with OIG investigators prior to the issuance of the Management Alert. OCME met on several occasions with various stakeholders, including former Deputy Mayor Ed Reiskin; current City Administrator Dan Tangherlini (during Mayor Fenty's transition); two former Directors of Emergency Medical Services ("EMS"); current FEMS Medical Director, Dr. Michael Williams; Director of the Department of Health ("DOH"), Dr. Gregg Pane; and the District of Columbia Hospital Association ("DCHA"). The issue was also regularly addressed within the weekly OCME Frontburner Reports to the Mayor's Office during former Mayor Williams' Administration.

Since my appointment as CME in October 2003, the meetings with stakeholders were arranged to focus on the 2003 recommendations. As stated above, OCME did not agree to all of the recommendations. The first recommendation was that "the CME consider contracting with private physicians to pronounce death at the scene when no qualified personnel are available." While OCME did not agree with this recommendation, it was considered and investigated and a formal proposal was provided to the former Deputy Mayor's office. A copy of this proposal was

provided as well to OIG investigators. Further, EMS investigated this option. Ultimately, the proposal was rejected as cost prohibitive.

The OCME also evaluated the second recommendation that “the CME consider resumption of the practice of having autopsy technicians transport bodies to an emergency room for the pronouncement of death prior to arrival at OCME when no qualified personnel are available.” In 2004, a Memorandum of Understanding among Greater Southeast Community Hospital, FEMS and OCME was drafted adopting a pronouncement of death policy in the District between specified hours. The terms would allow FEMS and OCME to transport decedents to Greater Southeast for pronouncement. As stated in the OCME Frontburner Reports, on May 2, 2005, the CME and OCME General Counsel met with Dr. Wadwha, former EMS Director, and presented a draft of the MOU. EMS considered the proposed MOU, but was unable to reach agreement.

Moreover, because the recommendation to have autopsy technicians transport bodies to emergency rooms for death pronouncement would require agreement of the hospital administrations, the issue was presented to DCHA by the CME. According to the DCHA March 14, 2006 meeting minutes, which were provided to OIG investigators prior to the issuance of the Management Alert, the CME described the current death pronouncement problem and stated that it had been exacerbated by the closure of D.C. General Hospital. As indicated in the minutes, DCHA stated that the second recommendation would have an adverse impact on emergency departments and that DCHA would support a letter to the Mayor stating that Fire and Emergency Medical Services (“FEMS”) make arrangements for conducting death pronouncements.

The third recommendation, that “the CME consult with the Office of the Attorney General (“OAG”) on proposing legislation that would allow qualified paramedics to officially pronounce death,” was also investigated. OCME’s General Counsel, Sharlene Williams, discussed this option with the Mayor’s Office and exploring the provision of authority for death pronouncements to FEMS was made a part of the Mayor’s 100 Day Plan. Thus, it is OCME’s position that, while no city-wide death pronouncement policy has yet been established, the OIG recommendations made in the 2003 Inspection Report were acted upon.

On May 2, 2007, DOH, FEMS, OCME, and the Mayor’s Office met and reviewed several options. Several ideas for resolution to this issue were discussed and a proposal developed that must be agreed to by all the stakeholders and approved by the Mayor. An update to the OIG Management Alert will be provided by May 30, 2007.

Sincerely,

Marie-Lydie Y. Pierre-Louis
Marie-Lydie Y. Pierre-Louis, M.D. *per Beverly Fields*
Chief Medical Examiner *Chief of Staff*

Inspector General Willoughby

May 3, 2007

Page 3

Cc: Dan Tangherlini, City Administrator, Office of the City Administrator
The Honorable Phil Mendelson, Chairperson, Committee on Public Safety and the Judiciary
The Honorable Carol Schwartz, Chairperson, Committee on Workforce Development and
Government Operations
Cathy L. Lanier, Chief of Police, Metropolitan Police Department
Dennis L. Rubin, Acting Chief, D.C. Fire and Emergency Medical Services Department
Gregg A. Pane, Director and State Health Officer, D.C. Department of Health
Linda Singer, Attorney General, Office of the Attorney General
Robert Malson, President, District of Columbia Hospital Association

MPL/baf

APPENDIX 6

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Office of the Inspector General

Inspector General



July 10, 2007

Marie-Lydie Y. Pierre-Louis, M.D.
Chief Medical Examiner
D.C. Office of the Chief Medical Examiner
1910 Massachusetts Avenue, S.E., Bldg. 27
Washington, D.C. 20003

Daniel M. Tangherlini
City Administrator and Deputy Mayor
Office of the City Administrator
Government of the District of Columbia
John A. Wilson Building
Suite 310
1350 Pennsylvania Avenue, N.W.
Washington, D.C. 20004

Cathy L. Lanier
Chief of Police
Metropolitan Police Department
Government of the District of Columbia
300 Indiana Avenue, N.W.
Room 5080
Washington, D.C. 20001

Dear Dr. Pierre-Louis, Mr. Tangherlini, and Chief Lanier:

The Office of the Inspector General (OIG) provides a Management Alert Report (MAR) when it believes a serious matter requires the immediate attention of District of Columbia (District) government officials. This MAR (**MAR-07-I-008**) is to inform you that during the OIG re-inspection of the District's Office of the Chief Medical Examiner (OCME), the inspection team (team) found that OCME continues to have a shortage of the Medicolegal Investigators (MLIs) needed to respond to death scenes on a 24-hour basis. This deficiency was noted in the 2003 inspection of OCME, and may delay OCME's current efforts to be accredited by the National Association of Medical Examiners (NAME).¹

¹ "The National Association of Medical Examiners (NAME) is the national professional organization of physician medical examiners, medical death investigators and death investigation system administrators who perform the official duties of the medicolegal investigation of deaths of public interest in the United States."
[Http://www.thename.org](http://www.thename.org) (last visited June 5, 2007).

Background

OCME is required to investigate certain types of deaths occurring in the District as enumerated in D.C. Code § 5-1405 (Supp. 2005). According to the American Board of Medicolegal Death Investigators (ABMDI),² investigators conduct death scene investigations, collect evidence, and develop decedents' medical and social histories in order to assist medical examiners in determining the cause and manner of death. ABMDI guidelines state that an MLI should have a combination of education and skills in medicine and law, and must be the most medically knowledgeable person at a crime scene to determine if further investigation is necessary.³ In order to receive ABMDI certification, MLIs must have the proven knowledge and skills necessary to perform medicolegal death investigations as set forth in guidelines published in November 1999 by the National Institute of Justice (NIJ).⁴

According to the NIJ's detailed guidelines, MLIs should, among other things, establish scene safety;⁵ protect the integrity of the death scene and evidence from contamination; ensure that death is pronounced;⁶ participate in the death scene briefing with other agency officials; conduct a scene walk-through; establish a chain of custody for evidence; follow appropriate laws when collecting evidence; obtain detailed photographic documentation of the scene; provide written scene documentation; establish probable location of the injury or illness; collect, inventory, and safeguard property and evidence; interview witnesses at the scene; photograph and conduct a superficial examination of the body; and determine procedures for notifying next of kin.⁷

2003 OIG Initial Inspection of OCME

According to NAME's Accreditation Checklist, it is important to have "a medical examiner or investigator available on a 24-hour basis to respond for a [death] scene investigation."⁸ NAME considers this to be an essential requirement that if not met, "may seriously impact the work or adversely affect the health and safety of the public or agency staff." *Id.* at 1.

² "The American Board of Medicolegal Death Investigators (ABMDI) is a national, not-for-profit, independent professional certification board that has been established to promote the highest standards of practice for medicolegal death investigators." [Http://www.slu.edu/organizations/abmdi](http://www.slu.edu/organizations/abmdi) (last visited June 5, 2007).

³ *Id.*

⁴ The National Institute of Justice is the research, development, and evaluation agency of the U.S. Department of Justice and is dedicated to researching crime control and justice issues. See <http://www.ojp.usdoj.gov/nij/> (last visited June 5, 2007).

⁵ Scene safety is established by removing risks of environmental and physical injury such as hostile crowds, collapsing structures, traffic, and environmental and chemical threats. U.S. DEPARTMENT OF JUSTICE, DEATH INVESTIGATION: A GUIDE FOR THE SCENE INVESTIGATOR RESEARCH REPORT 16 (November 1999).

⁶ The NIJ guidelines state: "It is vital that this occur prior to the medical examiner/coroner's assuming any responsibilities." *Id.* at 18.

⁷ *Id.* at 15-36.

⁸ NATIONAL ASSOCIATION OF MEDICAL EXAMINERS, INSPECTION & ACCREDITATION POLICIES AND PROCEDURES MANUAL 12 (September 2003).

During the 2003 OIG initial inspection of the OCME, the Investigations Unit's five MLIs were not sufficient to conduct all required death scene investigations 24 hours per day. There were no MLIs on duty from 8 p.m. to 8 a.m. weekdays, and only one MLI on duty from 8 a.m. to 8 p.m. on Saturdays and Sundays. As a result, many deaths that occurred during these periods were not investigated at the scene. The 2003 inspection team found that OCME investigated approximately 4,000 deaths annually, but only 228 were investigated at the scene in 2000, and 508 in 2001. No figures were made available for 2002. OCME was so short-staffed that when multiple violent and suspicious deaths or homicides were called in on a particular shift, MLIs could not go to each death scene to investigate. Both the Chief Medical Examiner (CME) and MLI supervisor at the time stated that a minimum of five additional investigators were needed to adequately staff the Medicolegal Investigator's Unit (Investigations Unit).

Current Re-inspection Observations

1. **OCME still does not have MLIs available on a 24-hour basis to investigate death scenes.**

During the OIG's current re-inspection of OCME, the inspection team found that OCME is still not adequately staffed with MLIs to provide 24-hour coverage of the death scene investigations required to support autopsies. Currently, OCME has seven MLIs, including the director of the Investigations Unit. Five MLIs are scheduled for duty from 6 a.m. to 11 p.m. daily, and one MLI works from 8 a.m. to 8 p.m. on weekends and holidays. OCME management stated that OCME would need four additional MLIs in the Investigations Unit in order to provide 24-hour coverage of death scene investigations.

2. **OCME's delegation of some of its investigative responsibilities to MPD raises questions.**

Although there is no provision in the D.C. Code for delegating or otherwise reassigning OCME's investigative responsibilities, the CME informed the team of an informal arrangement between OCME and the Metropolitan Police Department (MPD) in which MPD's Natural Squad supplements OCME death investigation activities. The Natural Squad is a component of the MPD Violent Crimes Unit, and its primary mission is to investigate natural deaths to rule out any unnatural cause. The Natural Squad was relocated to the OCME facility in the fall of 2004 and, according to the CME, works "in parallel" with MLIs, fills in the night shift that MLIs cannot staff, and "allows for OCME's presence at scenes of death in a timely manner...." In an e-mailed response to questions from the team, a senior manager stated that there is no formal Memorandum of Understanding between OCME and MPD documenting this arrangement because:

An MOU is typically utilized to facilitate a transfer of goods or services along with funds. In this case, MPD is not performing or providing services for OCME nor is it providing goods and no

funds are transferred. MPD detectives are simply housed at the OCME to do their own work and not OCME work.⁹

The D.C. Code does not state that OCME may delegate its investigative responsibilities as OCME appears to have done by supplementing its MLI staff with Natural Squad detectives, nor has there been a Mayor's Order delegating these responsibilities. However, OCME informed the OIG that from 2004 through 2006, MPD's Natural Squad rather than OCME MLIs conducted over 1,000 death scene investigations of deaths reported to OCME. In addition to OCME using the Natural Squad to supplement MLI staffing, OCME allows Natural Squad detectives to access its Forensic Automated Case Tracking System¹⁰ (FACTS) to enter investigative data. Question 5A.8 on NAME's Accreditation Checklist addresses the independence of OCME investigations by asking, "Are office investigations autonomous and independent of law enforcement investigations?" When the team posed this question to OCME, a senior manager replied that "The Office of the Chief Medical Examiner is an independent agency; keeping in mind that death investigation is a collaborative effort." The OIG believes that the interaction of the MPD Natural Squad and OCME investigators may create the impression that OCME investigations are not, in fact, autonomous and independent.

Recommendations

1. That OCME take steps to hire enough MLIs to investigate the death scenes of all deaths designated by the D.C. Code for OCME investigation. The re-inspection team notes that D.C. Code § 5-1418 (LEXIS through May 17, 2007), Office of the Chief Medical Examiner Management Fund, establishes a separate, non-lapsing fund that "shall be used exclusively for OCME personnel and non personnel expenditures."
2. That the Mayor's Office and the Office of the Attorney General, in coordination with OCME and MPD, review the investigative relationship between OCME and the MPD Natural Squad to determine if (a) OCME's use of the Natural Squad to conduct investigations on its behalf is in violation of the D.C. Code, and (b) if OCME's investigative collaboration with the Natural Squad jeopardizes OCME's ability to become accredited by the National Association of Medical Examiners. The results of this review should be reported to the Inspector General within 60 days of receipt of this MAR.
3. If the collaboration between OCME and MPD is determined to be appropriate, that OCME and MPD formalize a Memorandum of Understanding detailing the nature of the relationship and its legal and regulatory basis.

⁹ OCME Responses to OIG Inquiries, dated October 19, 2006, at 1.

¹⁰ According to OCME, the Forensic Automated Case Tracking System is used by OCME to compile and track statistical data used to produce reports based on the search or category of data requested.

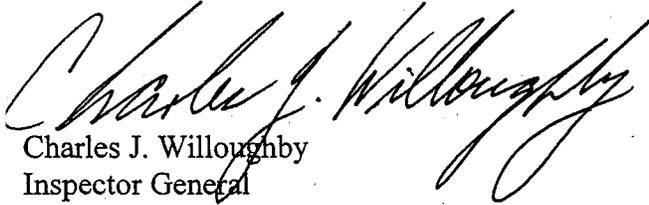
July 10, 2007

Letter to Marie-Lydie Y. Pierre-Louis, Daniel M. Tangherlini, and Cathy L. Lanier

Page 5 of 5

Please provide your comments by July 24, 2007. Your response should include actions taken or planned, dates for completion of planned actions, and reasons for any disagreement with the concerns and recommendations presented. Please distribute this MAR to only those personnel who will be directly involved in preparing your response. Should you have any questions or if you desire a conference prior to preparing your response, please contact Edward Farley, Deputy Assistant Inspector General for Inspections and Evaluations, at 202-727-2540.

Sincerely,



Charles J. Willoughby
Inspector General

CJW/tc

cc: Linda Singer, Attorney General, Office of the Attorney General for the District of
Columbia

APPENDIX 7

RECEIVED
8/7/07



GOVERNMENT OF THE DISTRICT OF COLUMBIA

OFFICE OF THE CHIEF MEDICAL EXAMINER 07 AUG -7 PM 3:33

1910 Massachusetts Ave., S.E., Bldg. 27

Washington, D.C. 20003

Marie-Lydie Y. Pierre-Louis, MD
Chief Medical Examiner

202-698-9001 (Office)
202-698-9101 (Fax)

August 7, 2007

Charles J. Willoughby
Inspector General
Office of the Inspector General
717 14th St., NW
Washington, D.C. 20005

Dear Inspector General Willoughby:

The Office of the Chief Medical Examiner ("OCME") has reviewed your July 10, 2007 Management Alert Report (MAR), and appreciates the opportunity to respond.

The MAR focuses on OCME's lack of an adequate number of medicolegal investigators to conduct death scene investigation on a 24 hour basis and also questions OCME's collaboration with the Metropolitan Police Department's (MPD) Natural Squad in conducting death investigations. However, as acknowledged in the Commentary of the National Institute of Justice's "U.S. Department of Justice, Death Investigation: A Guide for the Scene Investigator Research Report" (November 1999) (hereinafter the "DOJ Guidelines"),¹ a death investigation requires the proper coordination of a number of agencies with diverse and mutual responsibilities. Consequently, the DOJ Guidelines are "comprehensive but flexible and capable of being adapted to operations that utilize a variety of investigative officials including police officers, sheriffs, justices of the peace, physicians, and pathologists."² OCME's operating model thus accomplishes the kind of coordination envisioned and allowed by the DOJ Guidelines.

Historically, the OCME had no investigators and conducted investigations utilizing medical examiners and MPD detectives. In 1997, OCME began to hire its own death investigators. In 2000, OCME established an investigative unit, which included persons with medical backgrounds, in order to expand the scope of its death investigations. As stated by the MAR, in 2004, OCME appointed MPD Natural Squad detectives as duly authorized representatives of the OCME to increase the number of investigators and to facilitate communication and expedite identifications. OCME is in the process of hiring additional investigators and in FY2008 will have a total of 11 funded investigative positions which will allow OCME to rotate its investigators on a 24-hour basis.

It should be noted that the DOJ Guidelines do not apply to "medicolegal investigators," as suggested by your letter, but apply to "death investigators," a term that can encompass a broad

¹ (*Id.* at p. xx).

² (*Id.* at p. xxvi).

category of investigators from different disciplines, depending on the practice and laws of a given jurisdiction. In the District, the OCME created the position of medicolegal investigator to expand the scope of its death investigations, as stated above. It should also be noted that the position titled medicolegal investigator, with the credentials as required by OCME, is not necessary for National Association of Medical Examiners (NAME) accreditation. In fact, the Maryland Medical Examiner's office has investigators, but not the position titled, "medicolegal investigator" and the office is NAME accredited. Moreover, according to the American Board of Medicolegal Death Investigators (ABMDI), a medicolegal death investigator "should have a combination of education and skills encompassing areas of medicine and law," however, it also states that "there are no formal requirements to become a medicolegal investigator"³ and that each medical examiner office or coroner has different hiring practices.⁴

In its discussion of the DOJ Guidelines and its concern about MPD Natural Squad detectives working with OCME to conduct death investigations, the MAR misinterprets the DOJ Guidelines by attributing the duties of other coordinating agency investigators to the OCME, specifically its medicolegal investigators. As noted above, the DOJ Guidelines do not provide a specific reference to or duties associated with a medicolegal investigator but instead refer to scene or death investigators, which may include investigators from various entities, depending on the jurisdiction. In the District, various types of first responders (i.e., law enforcement, emergency medical support, fire personnel, U.S. Park and Capitol police, and the FBI) fulfill the responsibilities referred to as medicolegal investigator responsibilities on page 2 of the MAR. For example, by District and Federal law, other agency investigators are responsible for performing scene security and collecting and safeguarding property and evidence. The OCME investigator (i.e., medical examiner, medicolegal investigator, and duly authorized representative) must then obtain clearance from the responsible agency investigator prior to entering the scene and taking jurisdiction of a dead person's body.

The District's practice and law is consistent with the Handbook of Forensic Pathology ("Handbook"),⁵ which states that scene and death investigators have various duties, which include the following:

- a. The law enforcement agency has legal responsibility for and authority over the death scene.
- b. Law enforcement personnel also have the initial responsibilities of securing the death scene and witnesses, determining scene safety, notifying the medical examiner/coroner of the death and defining the scene perimeter.

The Handbook states that other agencies may also be involved in the investigation, such as the Federal Bureau of Investigation (FBI), the Occupational Safety and Health Administration (OSHA) and the National Transportation Safety Board (NTSB).

³ ABMI's website: <http://www.slu.edu/organizations/abmdi/index.phtml?page=faq>.

⁴ (*Id.*)

⁵ See Attachment, 2d Edition, College of American Pathologists at p.4-5 (2003).

OCME Response to OIG's Current Re-Inspection Observations

1. OCME Has Investigative Capacity on a 24-hour basis and meets NAME accreditation requirements.

The NAME Accreditation Checklist, used for the purpose of inspecting medical examiner facilities for accreditation, states that it is essential that "a medical examiner or investigator. . . [be]. . . available on a 24-hour basis to respond for a scene investigation." OCME meets this requirement in that it has personnel available on a 24-hour, call-in basis to report for a scene investigation. The agency has a rotating staff to attend death scenes on a 24-hour basis, including medical examiners, medicolegal investigators and detectives who are statutorily appointed as duly authorized representatives of the OCME.⁶ The medical examiners, per a collective bargaining agreement, are afforded an on-call rate of pay for each hour of on-call scheduling and a monthly schedule is prepared for this duty. As discussed previously, every death scene is investigated by the appropriate agency, depending on the circumstances. A medical examiner or investigator only responds to the scene of those cases where it is deemed necessary by the Chief Medical Examiner, as required by the NAME accreditation checklist.

As noted above, the OCME is in the process of hiring two forensic investigators to optimize the performance of the unit bringing the current total number of investigators for the unit to nine. As previously stated, as of FY2008, the OCME will receive two additional investigative FTEs so that there will be a total of 11 funded positions, enough to rotate on a 24-hour basis. This will allow for an expansion of the scope and improvement in the quality of the investigations and will assist all agencies involved in operating more efficiently. This need is separate and distinct from the overall death investigation and NAME accreditation requirements, which OCME meets. Moreover, the medicolegal investigators perform additional duties, such as review of cremations, public dispositions and review of hospital records. They also bring special focus to perioperative and obstetrical deaths and deaths of developmentally disabled persons and children.

2. OCME has Statutory Authority to delegate investigative responsibilities to MPD

The MAR states that "OCME's delegation of some of its investigative responsibilities to MPD raises questions." It further states that "the D.C. Code does not state that OCME may delegate its investigative responsibilities. . ."

In its discussion of these issues, the MAR appears to focus on scene investigation. OCME, however, has legal authority over the dead person's body and not the scene itself. The OCME Investigations Unit performs a myriad of tasks when investigating deaths and scene response is one such task for the purpose of evaluating and taking jurisdiction of the body. Contrary to the MAR's position, there is a provision in the D.C. Official Code for the delegation or reassignment of OCME's response to a scene of death. D.C. Official Code §5-1406(a) states (emphasis added):

⁶ The detectives of the Metropolitan Police Department (MPD) are duly authorized representatives of the OCME per D.C. Official Code §5-1406(a).

(a) For all deaths described in §5-1405(b), the CME shall take charge of the body upon the mandatory and direct notification of the death required by subsection (b) of this section. **The CME, or duly authorized representatives of the CME, shall have authority to respond to the scene of the death.** The body of the decedent shall not be disturbed unless the CME, or the CME's designee, grants permission to do so.

Again, legal responsibility and authority over the death scene rests with MPD and OCME has legal responsibility and authority over a dead person's body. Because OCME's investigation relates to the body and related circumstances in order to determine the cause and manner of death, OCME personnel and its duly authorized representatives perform investigations at the scene for this purpose.

It is instructive to review a December 13, 1991 Report of Consultation by NAME of an evaluation of the OCME, at a time when OCME had no investigators of its own and relied on the Homicide Squad for investigation and utilized such detectives as agents. In the report, the Review Team stated the following: "The lack of an intrinsic investigative staff is of some concern. NAME Standards indicate that the staff shall be directly responsible to the Chief Medical Examiner, **that police may be utilized as investigators**, and that continuing education on a regular basis is recommended. **Whether or not investigators are employed directly by the OCME, the standards also suggest that the investigator should record all the facts of the scene and complete an investigative report to be available to the medical examiner prior to the autopsy.**" The report references MPD detectives serving as agents to OCME but does not in any way state that this relationship is inappropriate or would jeopardize accreditation. Although written in 1991, the report provides insight into how NAME would view this relationship today, specifically the autonomy and independence of OCME investigations, given that any concerns related to this issue therein have been addressed by OCME.

Recommendations

OIG Recommendation 1:

That OCME take steps to hire enough MLIs to investigate the death scenes of all deaths designated by the D.C. Code for OCME investigation.

Response:

The OCME is in the process of hiring two forensic investigators to optimize the performance of the unit bringing the current total number of investigators for the unit to nine. As previously stated, as of FY2008, the OCME will receive two additional investigative FTEs so that there will be a total of 11 funded positions, enough to rotate on a 24-hour basis.

OIG Recommendation 2:

That the Mayor's Office and the Office of the Attorney General (OAG), in coordination with OCME and MPD, review the investigative relationship between OCME and the MPD Natural Squad to determine if (a) OCME's use of the Natural Squad to conduct investigations on its behalf is in violation of the D.C. Code, and (b) if OCME's investigative collaboration with the Natural Squad jeopardizes OCME's ability to become accredited by NAME.

Inspector General Willoughby
8/7/2007
Page 5

Response:

The OAG is conducting such a review and a response will be provided by the OAG.

OIG Recommendation 3:

If the collaboration between OCME and MPD is determined to be appropriate, that OCME and MPD formalize a Memorandum of Understanding detailing the nature of the relationship and its legal and regulatory basis.

Response:

OCME has statutory authority to delegate its response to death scenes and has delegated such authority to the MPD Natural Squad, as discussed above. OCME believes that this collaboration is appropriate and at this time, it would be helpful to all parties to formalize the exiting procedures and protocols. As such, OCME will work with MPD to establish a Memorandum of Understanding detailing the nature of the relationship and its legal and regulatory basis.

Sincerely,


Marie-Lydie Y. Pierre-Louis, M.D.
Chief Medical Examiner

Attachment

cc: Dan Tangherlini, City Administrator and Deputy Mayor, Office of the City Administrator
Cathy L. Lanier, Chief of Police, Metropolitan Police Department
Linda Singer, Attorney General, Office of the Attorney General

MPL/baf

APPENDIX 8

OCME RESPONSES TO 2007 OIG FINDINGS AND RECOMMENDATIONS¹

Organization Chart

The Organization Chart included in the Draft Report was provided to the Office of the Inspector General (OIG) by OCME in response to an inquiry regarding the status of OCME staffing. It is an in-house document utilized by OCME Management for accountability of vacancies, classification and recruitment efforts and is not a static document, as the type of positions, grades and status of vacancies frequently changes. Because the staffing fluctuates, OCME has provided a static organization chart outlining the agency units. See Appendix A.

FINDINGS AND RECOMMENDATIONS: KEY FINDINGS

Management of Personnel and Operations Improved

'03 Finding 1: Long-standing operational and personnel management problems continue under the current CME.

Original Recommendation: That the Deputy Mayor for Public Safety and Justice review this and previous issues on OCME and work with the CME to develop both the near- and long-term plans and specific goals for improving all OCME operations.

'07 Finding: Overtaken by events.

The specific collaboration between OCME and the Mayor's office cited in this recommendation was overtaken by events due to personnel changes. . . According to OCME internal documentation containing Key Result Measures that the agency tracked from October 31, 2003, through May 31, 2006, OCME achieved 8 out of 13 of its published target goals.

OCME Response: In Compliance. Data Correction.

The current CME abided by the recommendation to work with the former Deputy Mayors for Public Safety and Justice to develop near- and long-term plans and goals to improve all OCME operations. The agency developed Strategic Business Plans and established an Executive Management Team to continuously review operations in conjunction with the plans. This work continues with the new Mayoral Administration. The Key Result Measures establish OCME's performance as follows for the fiscal years indicated: FY2004 – 8 of 13 achieved; FY2005 – 9 of 13 achieved; and FY2006 – 8 of 12 achieved. Year to date, OCME has achieved 9 of 12 of the Key Result Measures for FY2007.

New Recommendation:

¹ OCME responds to those 2007 findings and recommendations that the agency maintains are in full compliance or overtaken by events. The responses also include corrections to data and information even in instances where the agency is deemed to be in compliance. Otherwise, OCME concurs with the remaining OIG Findings and Recommendations

The OIG recommends that OCME put copies of the policies and procedures manual in areas of the facility that are easily accessible to employees of all units.

OCME Response:

While all agency policies and procedures are available through managers of the various units and within the main office, OCME will place a bound copy of applicable policies and procedures within each unit.

OCME Takes Steps Toward Inspection and Accreditation

'03 **Finding 2:** OCME has not been inspected and accredited as have its counterparts in surrounding jurisdictions.

Original Recommendation: That the CME take necessary steps to be inspected and evaluated by the National Association of Medical Examiners.

'07 **Finding: Partially in compliance.**

The current CME stated that since the OIG's initial inspection, OCME has conducted a self-inspection as recommended by NAME, in line with NAME's inspection and accreditation policies and procedures. OCME is using NAME's Accreditation Checklist to identify the deficiencies that need correcting before submitting an application to NAME for an accreditation inspection.

OCME's Response: In Compliance.

OCME has "taken necessary steps" to be inspected and evaluated by NAME. As the OIG stated, the agency conducted a self-inspection in 2005. The agency's Strategic Business Plan for FY2007-2008 included Strategic Result Goal #4, "to move OCME toward accreditation status, OCME will apply for inspection of the OCME facility for accreditation purposes by the end of 2007." OCME still has plans to do so. Within the new Mayoral format of Performance Plans for FY2008, the agency's long-range objective is to actually obtain accreditation of the agency. During FY2005, the OCME conducted a self-inspection and is currently working on a daily basis to address any deficiencies indicated during the self-inspection that are within our power and ability to correct.

Autopsy Backlog Reduced But Remains High

'03 **Finding 3.** OCME has a significant backlog of unwritten autopsy reports.

Original Recommendation (a): That the CME consider contracting with private pathologists to reduce the backlog of autopsy reports.

'07 **Finding: In compliance.**

OCME has eliminated the backlog of autopsy reports from 1996 through 2005. OCME reported a backlog of 146 autopsy reports for 2006. Further,

OCME reported having five uncompleted homicide autopsy reports thus far for 2007.

OCME Response: Data Correction.

The OCME eliminated the historical backlog of over 1900 autopsy reports from 1996-2004 by June 30, 2006. By September 30, 2006, any additional backlogged reports from 2005 and 2006 were also completely eliminated. In June 2007, the OCME increased the medical examiner staff from three to six forensic pathologists, including the Chief Medical Examiner (CME). The agency is confident that this will help to eliminate any future backlog of autopsy reports and increase the timeliness with which reports are completed. The agency's Performance Plan includes an initiative to obtain the timing of autopsy reporting as required by NAME.

New Recommendation:

That the CME work with the Department of Human Resources (DHR) to explore all recruitment avenues to fill the vacant positions in the Medical Examiner's Unit.

OCME Response: In Compliance.

The OCME has worked with DHR to recruit and fill vacant medical examiner positions and to date all positions are filled.

Number of Stored Bodies Significantly Reduced

'03 Finding 4: Unidentified, unclaimed bodies date back to 2000 and are a health hazard.

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

'07 Finding: Partially In Compliance:

At the time of this writing, OCME had 13 bodies that had been stored over 30 days. OCME was storing one body over 30 days in response to a mandate from the United States Attorney's Office.

According to OCME management, the agency does not interpret the phrase "after a period of thirty (30) days" to mean that OCME is violating the 30-day period if unidentified or unclaimed bodies are stored more than 30 days. It is viewed as a flexible tool designed to balance the agency's need to transfer bodies as quickly as possible to the appropriate next of kin, while preventing a buildup of bodies stored in the morgue. OCME management also stated that the 30-day guideline allows most families sufficient time to receive notice of the death of a loved one and to contact the facility to make plans for quick disposition of the remains. According to OCME, most families can do this in less than 30 days.

New Recommendation:

That OCME release and/or dispose of bodies that have been stored at OCME for more than 30 days.

OCME Response: In Compliance.

The agency does not interpret the phrase “after a period of thirty (30) days” to mean that OCME is violating the 30-day period if unidentified or unclaimed bodies are stored more than 30 days. In the OIG’s Office of the Chief Medical Examiner’s Final Report of Inspection, dated September 2003 (hereinafter “September 2003 Report”), the former CME comments that the regulation should be interpreted as the OCME not being able to dispose of bodies until after 30 days have passed. September Report, p. 4. Moreover, within the September 2003 Report, the OIG concurred with this interpretation. Id.

Subsequent to an evaluation of the OCME by NAME in December 1991, NAME provided a Summary of Recommendations in which it also interprets the regulation as one providing a minimum storage period by stating “District law permits the cremation of unidentified and unclaimed bodies after a waiting period of 30 days.” See Appendix B. In fact, NAME recommended that “the unclaimed and unidentified bodies should be stored for a minimum of 90 days after their registration in a National Identification Program (NCIC Unidentified Persons Registry) before cremation.” Id.

The regulation is intended to ensure that bodies are stored for a reasonable time period in order to allow for families to come forth and identify or claim the bodies. This does not preclude the agency from storing bodies past 30 days based on the status of a death investigation, investigation to locate family members or the identification process.

The decedent identification process itself may take more than 30 days. Positive identification of deceased persons must be accomplished by visual identification through use of a photograph of the decedent’s face or a forensically validated method such as:

comparison of ante-mortem and post-mortem dental or frontal sinus x-rays (primarily) or chest, spine, pelvis or other body part;
comparison of ante-mortem and post-mortem fingerprints; and
DNA analysis and comparison with a reference specimen by an accredited DNA laboratory.

Again, these methods may take more than 30 days dependant on the state of decay of the body and the timing required for any DNA analysis and comparison (i.e., DNA testing may take six to eight weeks). Until the identification process has been completed and a determination made as to whether the body can or cannot be identified, the agency cannot publicly dispose of or release bodies to a family member.

Moreover, there are cases where the U.S. Attorney's Office or other official entities may request that the OCME store bodies longer than 30 days. Moreover, at times, the Toxicology Laboratory may request submission of additional tissue to confirm results.

OCME's policies and procedures in this area do not affect the availability of free space within the morgue. The agency is striving to maintain 30 to 50 spaces available at all times in the morgue and has been successful throughout the last two years.

Autopsy Policies and Procedures Vetted by the OCME Staff

'03 Finding 5: Policies and procedures for conducting autopsies are inadequate.

Original Recommendation (a): That the CME collaborate with his team of medical examiners to review the sufficiency of policies and procedures pertaining to autopsies and other OCME operations as pertinent, and give full consideration to their input.

'07 Finding: In Compliance.

OCME could strengthen the written procedures by including more detail regarding the role of the autopsy technician.

OCME Response: Comments.

The written autopsy procedures outline the methodology of the autopsy while the respective job descriptions of the Medical Examiner and Autopsy Assistants provide the duties and roles. In October 2006, OCME hired a Supervisory Pathologist Assistant to supervise the mortuary unit and in June 2007, OCME has established the position of Pathologist Assistant. Given the three types of staff working in the mortuary unit, OCME is in the process of developing Standard Operating Procedures (SOPs) to define daily operations and roles of the Autopsy Assistants and Pathologist Assistants.

New Recommendation:

The OIG recommends that the CME, medical examiners and autopsy technicians jointly review the autopsy policy and procedure to ensure clarity of the role of autopsy technicians.

OCME Response:

OCME will coordinate a joint review of autopsy policy and procedure with the CME, Medical Examiners, the Supervisory Pathologist Assistant, Autopsy Assistants and Pathology Assistants.

Support to Child Fatality Review Committee Improved

'03 Finding 7: The CME's relationship with the Child Fatality Review Committee (CFRC) has been marred by problems.

Original Recommendation (a): That the CME make appropriate personnel transfers and fill critically needed administrative staff positions for the CFRC.

'07 Finding: In Compliance

CFRC has become a part of the new Fatality Review Unit (FRU), which has a budget separate from OCME. CFRC has selected individuals for its two vacant support positions. The CFRC has access to the FRU budget and can staff all of its positions with permanent employees without using employees detailed from DOH and or DHS.

OCME Response: Information Correction

The FRU does not have a budget separate from OCME. As indicated on the OCME organization chart (See Appendix A), the Fatality Review Unit is a unit within the agency and its operational expenses are part of OCME's budget. The OCME's performance-based budget is established such that it addresses the needs of each unit of the agency and each unit has funding earmarked toward its operations.

Through the Budget Support Act of 2005, OCME established and began planning for a new program – Fatality Review – to encompass the Child Fatality Review Committee (CFRC) and Mental Retardation and Developmental Disability Review Committee (MRDD FRC), as well as a newly established Domestic Violence Review Board (DVRB) and an upcoming Maternal Review Committee. The four committees are coordinated under one Program Manager and share support staff and office space. A Program Manager, new Secretariat to the Committee (CFRC), Domestic Violence Review Coordinator and support staff were hired by OCME. Currently, the Fatality Review Unit has no detailed employees.

Staffing for Some Critical Areas Remains Inadequate

'03 Finding 8: Staffing for some of the most critical areas is not adequate.

Original Recommendation (a): That the CME adequately staff OCME to provide on-site death scene investigations whenever required.

'07 Finding: Not in Compliance.

As was true during the initial inspection, the investigations unit remains understaffed. . . OCME is still not reporting to all death scenes to conduct on-site death scene investigations. . . Therefore, MLIs do not always have first-hand knowledge of the information gathered at on-site death scene investigations, and the official pronouncement of death for some decedents occurs the next day when

MLIs are not on-site at the death scenes. . . OCME management informed the inspection team that the NS. . . [(Natural Squad)]. . . detectives fill in for MLIs during the night shift because of the limited number of MLIs in the unit. . . The statute does not state that OCME may delegate this responsibility, nor has there been a Mayor's Order delegating this responsibility to MPD.

OCME Response: In Compliance.

The CME has adequately staffed OCME to provide on-site death scene investigations **whenever required**. Neither District law or regulations, nor NAME require that OCME report to **all** death scenes to conduct on-site death scene investigations. In fact, the NAME Accreditation Checklist requires that “the medical examiner or investigator respond to the scene of those cases **deemed necessary by the chief medical examiner**.” The checklist also requires that a “medical examiner or investigator. . . [be]. . . **available** on a 24-hour basis to respond for a scene investigation.” Moreover, D.C. Official Code §5-1406(a) provides that “[t]he CME, or duly authorized representatives of the CME, shall have authority to respond to the scene of the death.” An OCME medical examiner or investigator (i.e., Medicolegal Investigator or duly authorized Metropolitan Police Department investigator, who when duly authorized, are agents of OCME) is available on a 24-hour basis to respond for a scene investigation that is deemed necessary by the chief medical examiner.

In reviewing files of the former CME, OCME management obtained an April 20, 2003 memorandum from the former CME to an MPD Assistant Chief regarding death scene investigation in the absence of OCME. See Appendix C. This Memorandum provided authorization, based on the D.C. Code outlined above, from the CME to MPD Violent Crime Unit (VCU) detectives to make a preliminary examination of the body for detecting injuries, obtaining evidence leading to identification, recovering evidence that would likely be lost during transport, or securing valuables, personal property or contraband. The memorandum states that it was effective immediately and remained in effect until further notice. This demonstrates that an official partnership was established between OCME and MPD and that the former Chief of Police and the Deputy Mayor for Public Safety and Justice were informed.

For a more detailed discussion of this issue, see OCME's August 7, 2007 response to the OIG's Management Alert Report (July 10, 2007). See Appendix D.

New Recommendation:

The Executive Office of the Mayor and the Office of the Attorney General (OAG), in coordination with OCME and MPD, review the investigative relationship between OCME and the MPD Natural Squad.

OCME Response: In Compliance.

OCME and MPD are awaiting OAG's findings and recommendation on this issue.

Original Recommendation (c): That the CME increase Communications Unit staffing of the midnight tour for the 24-hour phone number to ensure proper and adequate coverage.

'07 Finding: Not in Compliance.

The re-inspection team found that the Communications Unit has its full complement of employees, eight FTEs. . . According to OCME management, the CU only has one Intake Assistant (IA) on duty from 12 a.m. to 8:30 a.m. and 4 p.m. – 12:30 a.m. However, if the IA assigned to rotation duty during the shifts in question is unable to report to work or must leave the office due to illness or emergency, another IA is contacted to fill in and if another IA is not available, the Lead Intake Assistant covers for the absent IA. However, no one answers the 24-hour telephone number when the IA is at lunch during the shifts in question. The IA checks the voicemail for messages after coming from lunch.

OCME Response: In Compliance.

The current complement of eight IAs with one IA working on the evening and one on the night shift does ensure proper and adequate coverage. During the evening (4 pm-12:30 am) and night (12 am-8:30 am) shifts, the CU is staffed by one Intake Assistant which is sufficient coverage for the significant decrease in calls and work in comparison to the day shift. Coverage has always been available and during the current CME's tenure (October 2003 to present), no shift has gone uncovered. In September 2005, a Lead Intake Assistant was hired to monitor scheduling of shifts and ensure that all shifts are covered on a 24-hour, seven days a week basis. During the evening and midnight shifts it is not common for an Intake Assistant to leave the building. However, in such a circumstance the Intake Assistant would notify a Medicolegal Investigator or Autopsy Assistant on duty and the phones would be covered. Moreover, if an employee wants to take a break, a break room is available with a phone so that the phones can continue to be answered if necessary. At no time, are the phones left unmanned. The agency has not received any complaints regarding non-staffing of the phones and, in fact, has received 100% for phone answering coverage from the Mayoral Customer Service phone testing program.

New Recommendation:

The OIG recommends that OCME increase Communications Unit staffing of the 12 a.m.-8:30 a.m. and 4 p.m.-12:30 a.m. shifts for the 24-hour telephone number to ensure proper and adequate coverage.

OCME Response: In Compliance.

The evening and midnight shifts are adequately covered for the amount of work and number of calls received. Further, the OCME is in the process of establishing a 24-hour, seven days a week Investigations Unit staffed with Medicolegal

Investigators and Forensic Technicians. Consequently, additional OCME staff will be available during these shifts for phone coverage.

Original Recommendation (e): That the CME work with the OPM to ensure that structural and equipment repairs are completed as required by the renovation contract.

'07 Finding: Partially in Compliance.

The re—inspection team photographed five of the nine structural and equipment items listed. . .[in the September 2003 Report]. . .that were in need of urgent repair during the initial inspection that were still in disrepair: (1) the eyewash station drain empties onto the floor and not into a drainage pipe; (2) improper drainage in the cold body storage area (the floor is flat rather than concave to direct water flow); (3) plumbing problems with the waste disposals from autopsy tables cause periodic spilling of biohazardous materials on the floor; (4) the cold room storage door needs repair or replacement; and (5) hoses and sprayers for autopsy tables need replacement. According to information from OCME management, these problems exist because employees did not bring them to management's attention. In addition, OCME management stated that it may not be feasible to make the remaining structural and equipment repairs because the District is moving forward to establish a Consolidated Laboratory Facility (CLF).

New Recommendation:

The OIG recommends that CME work with OPM to repair the noted outstanding structural and equipment items and ensure that the noted disrepairs do not pose a health and safety risk to employees in the meantime.

OCME Response: In Compliance.

All five of the items listed in need of urgent repair during the initial inspection [in the September 2003 Report] were completed in Fiscal Year 2006 by private contractors by purchase orders let by OCME through OCP using operating dollars.

Annual Report Production Improved, but Statistics are Insufficient

'03 Finding 9: The CME is not producing statistical data and annual reports on deaths and autopsies as required by District law.

Original Recommendation: That the CME provide the Mayor with annual reports as required by D.C. Code and as recommended by NAME.

'07 Finding: Partially in Compliance.

Since the initial inspection, the CME has published annual reports for FY2003 and FY2004, but not FY2005 and FY2006. The information included in the published reports pertains to the number of autopsies performed, statistics as to the causes of death, and other relevant information as required by D.C. Code §5-

1412(d). Although the statistical information in the reports was sufficient according to District law, the reports do not contain all the statistical data recommended by NAME such as: data regarding death scene visits by medical examiners or medicolegal investigators; bodies transported by OCME or by order of OCME; hospital autopsies performed under the medical examiner's jurisdiction; bodies unidentified after examination; organ and tissue donations; and unclaimed bodies.

OCME Response: In Compliance.

D.C. Official Code §1412(d) states that "the CME shall prepare an *annual* report that includes information on the number of autopsies performed, statistics as to the causes of death and any other relevant information the Mayor may require." The current CME, who began her tenure in October 2003, has published an annual report for 2003, 2004 and 2005. Great efforts have been made to fill the statistical gap left by the nonpublication of the annual report between the years 1992 and 2002. For example, the 2004 Annual Report includes a special report entitled, "A 30-Year Review of Homicides in the District of Columbia (1972-2002)." The 2006 annual report is currently in production, which also contains statistics on suicidal deaths, will be published by the end of 2007 and.

Please note that these are Calendar Year reports and not Fiscal Year reports, as indicated by the OIG.

OCME has augmented its annual reports with statistical data as recommended by NAME and outlined above, beginning with the 2006 Annual Report.

Most X-Ray Operations Improved

'03 **Finding 10:** The use of x-ray equipment does not conform to District regulations and NAME recommendations, and employees are endangered.

OCME Comment: In Compliance: OCME notes that all recommendations were found to be in compliance. Thus, the title should read "All X-ray Operations Improved" as opposed to "most."

Male Shower Used as a Storage Closet

'03 **Finding 17:** Mortuary employees do not have adequate shower facilities for removing bodily fluids and contaminants.

Original Recommendation: That the CME have the shower facilities repaired and ensure that they are cleaned and disinfected daily.

'07 Findings: Partially in Compliance.

Upon re-inspection, the team observed that the male shower stall is used as a storage closet, and is not readily available for male employees to remove body fluids or contaminants prior to departing OCME. A senior OCME employee gave a tour of the female changing room and stated that female do not use their shower facility to remove body fluids or contaminants prior to leaving OCME. The female shower was unobstructed, in working conditions, and available for use.

New Recommendation: That OCME maintain male and female shower facilities that are immediately accessible by employees to remove body fluids or contaminants

OCME Response: In Compliance.

The OCME has provided adequate male and female shower facilities to remove body fluids or contaminants prior to an employee departing OCME. However, male Autopsy Assistants have utilized the space for storage. The space has been cleared such that the shower can be utilized. Moreover, signs indicating OCME's policy recommending showers prior to leaving the mortuary suite or facility have been placed in the locker rooms. The Autopsy Assistant staff will be encouraged to utilize the shower facilities on a more consistent basis.

HVAC System Violation Received Due to Poor Ventilation

'03 Finding 18: Odors from autopsy suite permeate public access areas.

Original Recommendation: That the CME request an inspection of the OCME facility by the DC Office of Occupational Safety and Health (D.C. OSH) to determine whether there are any hazards to employees and visitors, and if any measures can be taken to address these hazards, to include minimizing the odor referenced in this report.

'07 Findings: Not in Compliance.

The re-inspection team obtained documentation from OCME regarding D.C. Office of Risk Management (ORM) inspections during 2004 and 2006. AN ORM inspection report dated June 20, 2006, cited the OCME building as having poor ventilation, warranting an American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) violation OCME and OPM have initiated a contract to upgrade and renovate the cooling system. However, the OPM contract does not address air quality concerns identified in the Office of Risk Management (ORM) June 20, 2006 inspection report. As of March 26, 2007, OCME had not had its HVAC unit inspected to resolve the ORM ASHRAE violation.

New Recommendation:

OCME implement ORM recommendations to have its HVAC unit inspected and tested by a qualified technician to ensure appropriate air quality and ventilation.

OCME Response: Comments.

The renovation and upgrade work on the HVAC system at the OCME is an ongoing Capital Project that is administered by the Office of Property Management (OPM). OCME does not have the authorization or expertise to determine if work is properly and/or correctly performed, therefore, any inspection and/or re-inspection are the responsibility of OPM and is initiated by OPM as well. OCME will request that OPM make these inspections.

OCME Responsibility to Pronounce Death Unclear

'03 Finding 19: OCME's death pronouncement process does not ensure that bodies are always officially pronounced dead prior to arrival at OCME.

Original Recommendation (a): That the CME consider contracting with private physicians to pronounce death at the scene when no qualified personnel are available.

'07 Finding: Not in Compliance:

During the OIG's re-inspection, the inspection team found that there have been no changes in death pronouncement policies since 2003, and the OIG recommendations were not acted upon. OCME's policy is to pronounce the date and time of death if this task has not been performed by another agency, authorized medical professional, or medical facility upon OCME's retrieval of a body from a death scene or upon the body's arrival at the morgue. The CME stated that although OCME physicians and MLIs pronounce death both on the scene and at the OCME facility, she does not believe that pronouncement of death is a function of OCME. According to the CME, she needs assurance that a body is dead upon arrival at OCME. She noted that the D.C. Code does not identify a particular District agency as having pronouncement-of-death authority, and stated that the D.C. Hospital Association is conducting a review of the District's death pronouncement policies.

OCME Response: Overtaken by Events.

This issue has been overtaken by events in that it has been determined by the D.C. Office of the City Administrator that the issue is not within OCME's jurisdiction. The City Administrator's Office informed the OIG's Office of this decision on May 30, 2007. We have subsequently learned that the City Administrator has assigned this responsibility to the Fire and Emergency Medical Services Department (FEMS). The Office of the City Administrator (OCA) is currently working with FEMS to evaluate the legal and training requirements associated with this decision, and to formulate a plan for implementation.

Background: OCME pronounces death as a courtesy to the funeral directors when they are unable to obtain pronouncement from clinicians and the bodies are brought to the facility and have not been previously pronounced. Further, OCME pronounces death at scenes where response is required as part of death

investigation and the bodies are left unpronounced. Note that OCME is not the first on a death scene and in many instances a body may be brought to OCME in a period after the time of death or after it has been in the jurisdiction of a first responder.

OCME met with the OIG Inspection Team frequently to discuss the issue of death pronouncement. The CME explained that it is not within OCME's jurisdiction to pronounce death, as OCME's mission is to determine the cause and manner of death through death investigation. In fact, D.C. Official Code §5-1406(b) and OCME policies and procedures establish that OCME's first contact with a death case is a **death notification** from MPD or anyone who has knowledge of a death.

OCME informed the OIG Inspection Team that the CME arranged several meetings with stakeholders to address the issue. OCME also provided the OIG Inspectors with a written statement on death pronouncement which outlines the fact that OCME has neither legal authority nor professional ability to perform clinical functions such as death pronouncement. OCME alerted the OIG Inspectors that the Mayor and City Administrator agreed that the issue is not within OCME's jurisdiction and that as part of the "100 Days and Beyond: 2007 Action Plan for the District of Columbia," the Mayor committed to "exploring expanding death pronouncement authority to FEMS. . .[Fire and Emergency Medical Services]."

Subsequent to these discussions and provision of the above information, the OIG forwarded a Management Response Alert (MAR) dated April 19, 2007 recommending that the CME draft a pronouncement of death policy for the District. The OCME responded on May 3, 2007 indicating that several ideas for resolution had been discussed with the stakeholders and that any proposal would be approved by the Mayor. See Appendix E. Finally, the City Administrator's Office informed the OIG through conversation and in writing on May 30, 2007 that ***"responsibility for this issue no longer resides with the OCME and, therefore. . .the CME is not required to respond to the April 19, 2007 Management Alert Report. The OCA will, however, advise you of when this policy issue is resolved and what final decision is ultimately made."*** See Appendix F.

Based on the above-outlined events, it is OCME's position that this issue has been "Overtaken by Events," as the agency is no longer involved in the process of development and implementation of a death pronouncement policy.

Original Recommendation (b): That the CME consider resumption of the practice of having autopsy technicians transport bodies to an emergency room for the pronouncement of death prior to arrival at OCME when no qualified personnel are available.

'07 Finding: Not in Compliance.

In response to this recommendation, the CME provided a document summarizing a discussion from the District of Columbia Hospital Association, Medical Directors Forum on March 13, 2006. The document reports that the CME and District health administrators were debating which District agencies should be responsible for pronouncing death. Attendees discussed issues arising from completion of pronouncements in the field and the problem of incomplete death certificates. During the meeting, the CME discussed the possibility of authorizing Fire and Emergency Medical Services first responders to pronounce death.

OCME Response: Overtaken by Events

See OCME Response above to Original Recommendation (a) under Finding 19.

Original Recommendation (c): That the CME consult with [the OAG] on proposing legislation to the Council that would permit qualified paramedics to officially pronounce death.

'07 Finding: Not in Compliance.

The CME has not proposed legislation that would permit qualified paramedics to officially pronounce death.

OCME Response: Overtaken by Events.

See OCME Response above to Original Recommendation (a) under Finding 19.

New Recommendation:

That the CME draft a pronouncement of death policy for the district based on her knowledge and experience as well as guidance from NAME and the U.S. Department of Justice. The CME should then coordinate that draft with OAG, the D.C. Department of Justice. The CME should then coordinate that draft with OAG, the D.C. Department of Health, the D.C. Fire and Emergency Medical Services Department, Metropolitan Police Department, and the District of Columbia Hospital Association. On April 19, 2007, the OIG presented this new recommendation to OCME as part of Management Alert Report (MAR) 07-I-003.

OCME Response: Overtaken by Events.

See OCME Response above to Original Recommendation (a) under Finding 19.

As stated within the response, the Office of City Administrator also responded on May 30, 2007 to the OIG MAR informing the OIG's office that this issue is no longer under OCME's jurisdiction.

Given all of the above actions and factors, it is OCME's position that the title to this section should read: "OCME Does Not Have Responsibility to Pronounce Death."

Policies in Place for Handling and Transporting Bodies

'03 Finding 23: OCME does not fingerprint decedents in a timely manner.

Original Recommendation (b): That the CME require fingerprinting of all decedents upon arrival at OCME.

'07 Finding: Not in Compliance.

The current CME stated that most decedents are identified visually. Consequently, fingerprinting is not a routine part of the intake process because of the time and resources required. Fingerprinting is done when a decedent cannot be visually identified, or at the behest of MPD, the FBI, or other law enforcement agencies.

OCME Response: In Compliance.

OCME accepts the OIG's recommendation and has augmented its identification process to include fingerprinting of all decedents after medical examiner viewing. However, OCME maintains that fingerprinting is not required in all cases. Generally, dead bodies will fall into one of two categories regarding identification:

1. Bodies that are not decomposed or mutilated, that could be identified visually.
2. Bodies that could not normally be identified by visual means.
 - a. Decomposed bodies (wet and dry floaters);
 - b. Bodies badly burned beyond recognition;
 - c. Skeletonized bodies by animal activity or decomposition; and
 - d. Cremated bodies.

OCME's Identification Policy is as follows:

Positive identification of deceased persons may be accomplished by visual identification through use of a photograph of the decedent's face or a forensically validated method, such as:

comparison of ante-mortem and post-mortem dental or frontal sinus x-rays (primarily) or chest, spine, pelvis or other body part;

comparison of ante-mortem and post-mortem fingerprints; and

DNA analysis and comparison with a reference specimen by an accredited DNA laboratory.

With respect to NAME Accreditation Checklist standards, NAME requires that the office have: a) a written and implemented policy covering identification procedures; b) a case body numbering system for labeling all bodies; c) the method of identification recorded; and d) access to the following for identification of bodies: fingerprint comparison, dental examination, body x-rays, forensic anthropology and forensic serology and DNA analysis. NAME also requires that prior to the disposition of *unidentified bodies*, the office perform fingerprinting.

OCME meets all of the above NAME requirements for accreditation. NAME does not require that all bodies be fingerprinted, only those that are unidentified. As such, fingerprinting does not have to be included as a routine part of the intake process. However, bodies that are unidentified or those where family members are not yet available are routinely fingerprinted in order to permit potential future identification. Further, OCME stores specimens of all unidentified bodies for DNA analysis and a blood card is kept on every decedent as long as blood is available. All homicide, suicide victims or wards of the District are fingerprinted at OCME.

Again, OCME accepts the OIG's recommendation and has expanded its identification procedure to include fingerprinting of all deceased after viewing by the medical examiner.

Original Recommendation (c): That the CME take the steps necessary to have all bodies presently stored at OCME fingerprinted.

'07 Finding: Partially in Compliance.

Fingerprinting is done when a decedent cannot be visually identified, or at the behest of MPD, the FBI, or other law enforcement agencies.

OCME Response: In Compliance.

See OCME Response to Original Recommendation (b) under Finding 23.

Policies Established for Visually Identified Decedents

'03 Finding 24: OCME does not have a consistent policy regarding identification of decedents.

Original Recommendation (b): That the CME provide a private viewing space when there are exceptions to photographic identification.

'07 Finding: Not In Compliance

OCME does not permit in-person viewings and the facility does not have space available to enable private viewings. Viewing the body of a loved one is highly stressful for grieving individuals and could pose a direct safety concern (i.e., fainting) for the identifying party and indirect safety concern (i.e., injury) for the OCME staff in attendance during the viewing. Photographs are taken of the decedent in the autopsy suite located in the basement. The photographs are shown to the person identifying the body in designated Family Rooms located in the lobby in the building.

OCME Response: Comments.

NAME's Accreditation Checklist states that a facility should have a "method by which family or friends can make positive identification of decedents, (e.g., a

viewing room, instant photography, closed circuit television, digital photography, etc.).” As such, NAME does not require in-person viewing and positive identification can be made through the use of a photograph, as is OCME’s policy. Photographs of the decedent are taken in the mortuary suite and shown to the next of kin or friend in designated family or grieving rooms in the facility.

OCME Retains Decedent Personal Property Dating from 1997

’03 Finding 26: OCME does not have a system to document, transfer, and safeguard decedents’ personal effects.

Original Recommendation (d): That the CME work with the Chief of Police to develop and document a secure means of transferring property to MPD as required by the D.C. Code.

’07 Finding:

Since approximately 2003, OCME has not coordinated with MPD on transferring to the MPD Property Clerk property not claimed by next of kin or a funeral director, property of unidentified decedents, and evidence from a crime as required by D.C. Official §5-1408. For example, the team found four sexual assault examination kits in MLI storage lockers that should have been transferred to MPD for investigative purposes. During the re-inspection, the team found several instances of storage lockers containing personal property belonging to decedents with known next of kin. During a review of case files, the team found next of kin names, addresses, and telephone numbers that would enable OMCE to notify them to retrieve decedents’ personal effects. However, based on the team’s interviews and review of case files, OCME is not contacting the next of kin to inform them that decedents’ personal property has been left behind after decedents depart the morgue.

The team asked two Communications Unit employees about their role in transferring a decedent’s personal property to next of kin. They stated they do not notify next of kin about a decedent’s personal property to be picked up from OCME when they come to identify them. Also, Communications Unit personnel do not inform next of kin about decedent’s personal property left behind after decedents have left the morgue.

OCME Response: In Compliance.

The four sexual examination kits were taken in the very early stage of investigation out of precaution by the medical examiners. Three of the cases were determined to be natural and one was an accidental death. Thus, no further investigation was necessary and the kits have been disposed of.

OCME has inventoried all stored property (much of which was stored prior to the current CME’s tenure) and is in the process of gathering all valuable properties (i.e., cash, jewelry etc.) to be transferred to the MPD Property Clerk. In those

cases where family members are known, the families will be contacted to alert them that they may claim property of their deceased loved one.

The OCME policies and procedures address the disposition of personal property of decedents. The policy and procedures will be reviewed and updated and a training session for all staff involved held.

New Recommendation:

That the CME inform the next of kin about the procedure to claim personal property by creating an information sheet or pamphlet.

OCME Response: In Compliance.

In October 2005, OCME developed an informational pamphlet about OCME's mission, autopsy procedures and other information that would be pertinent to next of kin, including "how a family member can claim personal property at OCME." This pamphlet was provided to the OIG Inspection Team. If modifications to the property release policies and procedures are made, the pamphlet will be modified. See Attachment G.

OCME and MPD Collaborate on Investigations

'03 **Finding 28:** Some Metropolitan Police Department (MPD) officers impede OCME death scene investigations.

Original Recommendation (a): That the CME collaborate with the Chief of Police on clarifying, in writing, the responsibilities of OCME and MPD personnel at death scenes, and that oversight procedures be put in place that will ensure the integrity of all death scenes is maintained.

Original Recommendation (b): That the CME collaborate with the Chief of Police to ensure that OCME is promptly notified of all deaths subject to investigation as required by the D.C. Code.

New Recommendation:

OIG recommends that the Executive Office of the Mayor and the Office of the Attorney General (OAG), in coordination with OCME and MPD, review the investigation relationship between OCME and MPD Natural Squad (NS) to determine if (a) OCME's use of the Natural Squad to conduct investigations on its behalf is in violation of the D.C. Code, and (b) if OCME's investigative collaboration with the Natural Squad jeopardizes OCME's ability to become accredited by the National Association of Medical Examiners. If the collaboration between OCME and MPD is determined to be appropriate, the OIG also recommends that OCME and MPD formalize a Memorandum of Understanding detailing the nature of the relationship and its legal and regulatory basis.

from different disciplines, depending on the practice and laws of a given jurisdiction. However, the OCME's Medicolegal Investigators do follow the DOJ Guidelines, in addition to the agency Policies and Procedures on Investigation and Investigative Reporting.

OCME Established Workplace Health and Safety Program

'03 Finding 31: OCME does not have a workplace health and safety program.

Original Recommendation (a): That the CME establish written policies and procedures in accordance with OSHA guidelines.

'07 Finding: Partially in Compliance.

When asked whether the safety policies and procedures conform to OSHA guidelines, employees informed the team that according to their sources, the District does not follow OSHA guidelines. OCME interpreted this to mean that they were not required to write its policies and procedures to conform to OSHA guidelines. However, there appears to be a conflict regarding OCME's position that it is not required to conform to OSHA guidelines.

On June 20, 2006, the District of Columbia Office of Risk Management (ORM) conducted an occupational safety and health inspection of OCME. The OIG obtained information from ORM indicating that the purpose of the inspection was to provide the agency with information and assistance to *ensure its compliance with OSHA standards and guidelines*.

OCME's Response: In Compliance.

According to the June 20, 2006 and November 21, 2006 ORM Inspection Report of Findings and Recommendations, OCME's written policies and procedures are in accordance with OSHA guidelines (the ORM inspection included a review of all OCME policies and procedures).

New Recommendation:

The OIG recommends that OCME clarify with the ORM whether OCME safety policies and procedure should conform to OSHA guidelines, and provide the OIG with the results of the clarification.

OCME's Response: In Compliance.

OCME has discussed OSHA guidelines with the Office of Risk Management's (ORM) Occupational Safety and Health Operations Manager. While the District does not have OSHA guidelines or policies of its own, ORM reports that the District follows federal OSHA guidelines, as well as other similar health and safety regulations (i.e., International Fire Code, EPA etc.).

OCME Response: Comments.

See OCME Response to New Recommendation under Finding 8 at page 8.

**OCME Policies and Procedures for Death Scene Investigations Implemented;
MLIs Certified**

'03 **Finding 29:** OCME does not have standard, written procedures for death scene investigations, and MLIs are not certified.

Original Recommendation (b): That the CME require that all MLIs be formally trained and certified.

'07 **Finding: Partially in Compliance.**

There are now six MLIs who are licensed physician assistants, and four are ABMDI certified. According to management, OCME investigations comply with the United States Department of Justice National Guidelines for Death Investigations.

OCME Response: In Compliance.

The OCME created the position of medicolegal investigator to expand the scope of its death investigation. It should also be noted that the position titled medicolegal investigator, with the credentials as required by OCME, is not necessary for National Association of Medical Examiners (NAME) accreditation. In fact, the Maryland Medical Examiner's office has investigators, but not the position titled, "medicolegal investigator" and the office is NAME accredited. According to the American Board of Medicolegal Death Investigators (ABMDI), a medicolegal death investigator "should have a combination of education and skills encompassing areas of medicine and law," however, it also states that "there are no formal requirements to become a medicolegal investigator"² and that each medical examiner office or coroner has different hiring practices.³

As acknowledged in the Commentary of the National Institute of Justice's "U.S. Department of Justice, Death Investigation: A Guide for the Scene Investigator Research Report" (November 1999) (hereinafter the "DOJ Guidelines"), a death investigation requires the proper coordination of a number of agencies with diverse and mutual responsibilities. Consequently, the DOJ Guidelines are "comprehensive but flexible and capable of being adapted to operations that utilize a variety of investigative officials including police officers, sheriffs, justices of the peace, physicians, and pathologists." OCME's operating model thus accomplishes the kind of coordination envisioned and allowed by the DOJ Guidelines.

The DOJ Guidelines do not apply to "medicolegal investigators," but apply to death investigators," a term that can encompass a broad category of investigators

² ABMI's website: <http://www.slu.edu/organizations/abmdi/index.phtml?page=faq>.

³ (*Id.*)

Original Recommendation (f): That the CME provide powered respirators for use in the autopsy suite.

'07 Finding: In Compliance.

OCME has established what protective equipment should be worn when exposed to harmful or contagious conditions, and has provided powered respirators in the autopsy suite. However, there are no instructions regarding when powered respirators are to be used.

OCME Response: Comment.

OCME's Policies and Procedures Manual, as provided to the Inspection Team, include a Safety Section on the use of masks, such as N95 and powered respirators and when they are to be used. The use of powered respirators is determined on a case-by-case basis by the medical examiner and in cases of suspected or documented tuberculosis or other air-borne pathogens. The OCME has a sign (present during the Inspection Team Visit) in the mortuary suite prior to entering the autopsy suite that warns employees that upon entering the autopsy suite, a N95 mask must be worn. OCME has developed additional signage to provide procedures to minimize exposure to blood-borne or air-borne pathogens, including when to wear certain masks and eyewear such as powered respirators. The signs are posted throughout the mortuary suite, including the autopsy room. See Appendix H.

All OCME employees were fit-tested for appropriate N95 masks and all who failed were required to use PPE. OCME has worked over the past few months with DC Fire/EMS to provide additional fit-testing for new employees and those who previously failed testing and the testing was conducted on Monday, August 27 and Wednesday, August 29, 2007.

Original Recommendation (e): That the CME provide adequate training in universal precautions when performing autopsies and handling biological specimens.

'07 Finding: Not in Compliance.

Since the initial inspection, OCME policies and procedures include information on universal precautions. However, OCME was unable to produce documentation to support claims that employees had received training in universal precautions.

OCME Response: In Compliance.

OCME has provided several trainings on universal precautions. However, prior to September 2, 2004 there were no sign-in sheets to document such trainings. Sign-in sheets after September 2, 2004 are attached at Appendix I for all other trainings where universal precautions were addressed. Those trainings were held as follows:

- 1) Health and Safety Update and Hepatitis B Immunizations (June 3, 2004)
- 2) Lecture on Biological Agent "Tularemia" (September 2, 2004)

- 3) Nerve Agent Presentation (November 4, 2004)
- 4) Hazard Communication (December 9, 2004)
- 5) Health and Safety Precautions (October 18, 2006)
- 6) Pandemic Influenza Policy (April 19, 2006)
- 7) Universal Precautions for Health and Safety (May 17, 2006)

Original Recommendation (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 bloodborne and airborne pathogens.

'07 Finding: Partially in Compliance.

The reinspection team found that OCME has written policies and procedures to explain what actions employees should take if they are exposed to bloodborne pathogens. Employees must notify a supervisor or the Agency Risk Representative when an exposure incident occurs. The policies and procedures did not appear to contain procedures to address exposure to airborne pathogens, nor do they address immediate, no-cost access to health care.

OCME Response: In Compliance.

Airborne Pathogens: The Office of Risk Management (ORM) has informed the OCME that the District does not have occupational safety and health regulations of its own but follows the federal Office of Safety and Health Administration (OSHA) regulations, 29 CFR 1910. Upon researching the applicable OSHA regulations (29 CFR 1910), it is noted that OSHA has a required Bloodborne Pathogen Standard and a voluntary Tuberculosis (Airborne Pathogen) Program. Moreover, the OSHA Respiratory Protection Guidelines, applicable to protect against airborne pathogens, requires the use of N95 masks. The employer must supply the mask free of charge.

As the OIG noted, OCME's Policies and Procedures Manual includes a Bloodborne Pathogen program that mandates Universal Precautions. The OCME is operating in accordance with OSHA guidelines in that the Manual includes a Safety Section that outlines procedures to address exposure to airborne pathogens. The Manual requires that employees wear the N95 masks and in specified cases, powered respirators to protect them from air-borne pathogens. The Safety Section then states that if exposure occurs the employee should report to an available emergency health facility (i.e., hospital). OCME provides TB surveillance for all employees through the District's TB Clinic and is currently adopting the nonmandatory Tuberculosis Standard to address exposure to TB and other airborne pathogens. See Appendix J.

Health Care: The District provides health care insurance for all employees which can be utilized in an emergency incident upon suspected or documented exposure to bloodborne or airborne pathogens or any claimed workplace injuries. Further, once a workplace injury claim has been reported, investigated and accepted by the

D.C. ORM Office of Disability Compensation, the employee receives workers' compensation for the injury. With regards to an occupational medical services program that allows employees to obtain immediate access to appropriate health care, the District government does not provide such a program. An individual agency must receive appropriated funds to establish such a program and cannot independently provide such services.

As discussed with the OIG Inspection Team, OCME explored the option of providing a health and wellness program with a local hospital. A tentative contract (copy was provided to the Inspection Team) was developed between OCME and the hospital entity for required testing (i.e., TB and Hepatitis B) and for emergency room services on a 24-hour basis, seven days a week. OCME, however, is not currently budgeted to implement such a contract.

OCME will continue to maintain employee training through monthly general staff meetings and individual unit workshops. Medical services records are maintained by the Agency Risk Management Representative (ARMR).

New Recommendation:

The OIG recommends that OCME ensure that its procedures address when powered respirators should be worn and what procedures to follow when exposed to airborne pathogens. OCME should offer an occupational medical services program that allows employees to obtain immediate access to appropriate health care, at no cost, after exposure to blood-borne and airborne pathogens. Further, OCME should maintain employee training and medical services records to ensure timely access to and accountability for this information.

OCME Response:

See OCME Response above to Original Recommendation under Finding 31. Moreover, OCME has a centralized method to process training requests and the agency is working on developing a centralized method of recording employee training.

OCME Establishes Mass Fatality Plan

'03 Finding 32: OCME does not have a Mass Fatality or Disaster Plan.

Original Recommendation (a): That the CME develop a Mass Fatality Plan and a Disaster Plan as soon as possible.

'07 Finding: Partially in Compliance.

Since the initial inspection, OCME has developed a formal Mass Fatality Plan (MFP). . However, based on the information in the plan, locations have not been selected for a temporary morgue site, morgue examination center, long-term examination site, and family assistance center.

New Recommendation:

That OCME and OPM promptly select locations for a temporary morgue, morgue examination center, long-term examination site, and family assistance center to use in the event of a mass fatality disaster, and update the MFP accordingly.

OCME Response: In Compliance.

The OIG's recommendation is inconsistent with national, regional and local emergency response plans and trainings that provide the protocols for response to a disaster incident. The District follows National Incident Management System (NIMS) and all first and second responders are trained in NIMS and the Office of Risk Management has currently scheduled such training for agency risk managers. The OCME Agency Risk Management Representative and approximately 17 employees have been officially trained in NIMS. The OCME MFP was developed according to NIMS, National Response Plan (NRP) and District Response Plan (DRP) protocols. **These protocols specifically provide that determination of the location of facilities to respond to an incident is made only after evaluation of the incident and incident site and development of an Incident Action Plan specific to that incident.**

Under the NRP and DRP, first responders and second responders (i.e., OCME) are trained through NIMS on managing a disaster incident. The major focus of such an incident is the Incident Command System which consists of five major management functions: Incident Command, Operations, Planning, Logistics and Finance/Administration. The role of the Planning Section is to develop an Incident Action Plan (IAP) which would include: a) what is to be done; b) **where it is to be done**; c) when it is to be done; d) who is responsible for doing it; and e) communication methods. The Logistics Section is responsible for providing resources and services to support the incident and to develop portions of the IAP.

NIMS requires that the five management functions be performed at every incident or event. *The problem must be identified and assessed, a plan to deal with it developed and implemented and the necessary resources procured and paid for.* Consequently, the locations of facilities to respond to an incident are determined within the development of an IAP and the logistical determinations made in the implementation of the plan.

The OCME's MFP follows NIMS protocol. On page 9, the MFP states that an Incident Action Plan (IAP) for the recovery, documentation, transportation, processing, examination and release of remains is formulated after an evaluation of the incident and incident site. **Key to this planning is selecting appropriate locations for the temporary morgue, morgue examination center and family assistance center.** Consistent with NIMS protocol, the NRP and DRP, the MFP calls for the determination of these locations **after** an incident plan is developed. These sites are **not** determined prior to an incident as they are dependant on the type and location of the incident.

OCME Establishes Tracking System for Complaints and Inquiries

'03 Finding 34: OCME does not have a tracking system for public complaints and inquiries.

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

'03 Finding: Partially in Compliance.

The only record of complaints available for the team's review was a complaint log from 2003, and many of the complaints entered appear to be unresolved. OCME informed the inspection team that the agency did not establish logs for 2004, 2005 and 2006 because the agency resolved these complaints within 1 to 2 days. Consequently, the team was unable to verify that complaints received during these years were in fact resolved.

OCME Response: In Compliance.

The original logs submitted to the Office of the Inspector General on October 19, 2006 via e-mail was an excel spreadsheet. The log contained all 2003 complaints and a few requests received from constituents, US Attorney's office and law enforcement. The data was organized by complaints and requests sent to the Mayor, Congress, Council and internal (i.e. to the CME). Also submitted was a document entitled, "Procedures for Handling Complaints Reported to the Chief Medical Examiner, the Mayor's Office, Council, or Congress, which explained that for years 2004, 2005 and 2006 internal logs were not maintained because the complaints were few and resolved within 48 hours. Mayoral, Congressional or complaints from Council members were generally received through the Mayor's Intranet Quorum (IQ) system, which is maintained by the Mayor's office. The Executive Office of the Mayor provides quarterly reports by Agency and indicates any outstanding correspondence. However, the report does not differentiate between a complaint and an inquiry.

The OIG's DRAFT report mistakenly indicates that the information received was only from 2003 and that most of the complaints did not seem to have a resolution. After investigation, OCME became aware that the data presented was so exhaustive that the text was hidden within the cell. Extending the height of the cell revealed the final data that initially appeared to be missing.

To correct this problem, please find attached at Appendix K, a revised compilation of the following:

- 1) A consolidated listing of all 2003 CONSTITUENT complaints with the resolution in bold;

- 2) A consolidated listing of all 2003 Mayoral complaints with resolution in bold. Added to this log is all 2004, and 2005 Mayoral complaints that was sent via e-mail through the Mayor's Intranet Quorum (IQ) system;
- 3) The Executive Office of the Mayor's Intranet Quorum Aging Reports for 2003, 2004, 2005, 2006 and 2007; and
- 4) A Customer Service Family Request Report (For Internal Purposes Only) for requests and inquiries made during 2005.

New Recommendation:

The OIG recommends that OCME log all complaints and inquiries. The log should reflect whether the entry is a complaint or inquiry, whether OCME received the complaint or inquiry by letter, telephone, email, or through referral, and how the complaint or inquiry was resolved.

OCME Response: In Compliance.

The OCME's tracking system will log whether a complaint or inquiry is received, the requisite method of receipt and how the complaint or inquiry was resolved.

Quality Assurance Program is in Place for Autopsies and Toxicology

'07 Finding 35: OCME does not have a quality assurance program.

Original Recommendation (a): That the CME consider holding conferences at days end to address cases and backlogs, and to solicit employee views and ideas on improving OCME operations.

'07 Finding: In Compliance.

Since the initial inspection, the OCME has instituted a formal quality control policy and process regarding autopsies and Toxicology Lab operations. However, the CME does not have a quality control officer to manage OCME's quality assurance program and implement the quality control policy. This responsibility has been given to the Chief of Staff until an employee can be hired to manage the program.

New Recommendation:

The OIG recommends that the CME hire a quality control officer quickly to manage its quality assurance program and ensure that the OCME quality control policy is implemented.

OCME Response: Comments.

The OCME's Quality Control and Assurance Program not only covers autopsies and Toxicology Lab operations, but also intake procedures, medical records,

transcription, mortuary unit responsibilities and investigations. In addition to the peer reviews, autopsy case conferences, and review of pending cases, OCME also conducts a monthly quality control and assurance meeting. Several cases are randomly selected prior to the meeting. During each meeting, the CME, select Executive Staff, Medical Examiner staff, General Counsel, Mortuary Unit staff, and Investigations staff review the cases for inconsistencies in the implementation of policies and procedures and death certification (including death certificates) and provide recommendations for agency improvements. A position description for a person to manage OCME's quality assurance and control program and other analytical duties has been developed and was submitted to the Department of Human Resources in early 2007. It is currently undergoing classification to prepare for advertisement and hiring.

Some Support Positions Still Filled With Term Employees

'03 Finding 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.

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

'03 Finding: Partially in Compliance.

In 2004, all employees who were term employees at the time of the initial inspection were converted to permanent status, with the exception of one medical examiner hired to assist with the autopsy report backlog. Currently, OCME has an autopsy assistant, an administrative employee and two intake assistants who are term employees.

OCME Response: In Compliance.

OCME is in compliance with the original recommendation. OCME has consulted the Department of Human Resources (DCHR), formerly the D.C. Office of Personnel, and is aware of the regulatory requirements and proper use of term appointments. The District Personnel Manual provides that "[a] personnel authority may make a term appointment for a period of more than one (1) year when the needs of the service so require and the employment need is for a limited period of four (4) years or less." Further, the CME and current term employees are fully versed on their separate responsibilities and entitlements.

Currently, OCME is under the process of converting positions of Autopsy Assistant, Staff Assistant and Intake Assistant (positions that were filled on an emergency basis) from term positions through a competitive process as required by DHR. The Medical Examiner hired to assist with the autopsy report backlog is no longer employed with the agency as of the end of May 2007.

Employees Now Receive Annual Evaluations but Seek Pay Review

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

Original Recommendations: 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.

'07 Finding: In Compliance.

Interviewed employees stated that they have concerns that their pay is not adequate given their duties and responsibilities. In addition, employees seek a means to submit concerns or comments to management anonymously.

New Recommendation:

The OIG recommends that OCME work with DHR to address the concern of OCME employees who allege that the District government does not compensate them in accordance with their duties and responsibilities. In addition, the OIG recommends that OCME consider using a suggestion box to enable employees to present their concerns to management anonymously.

OCME Response: Comments.

DCHR's Office of Compensation, Classification and Benefits Administration is responsible for setting employee salary schedules and they are approved by the D.C. Council. OCME understands that position descriptions, upon which salaries are based, are to be reviewed and submitted every three years, to the Classification Division for any modifications or upgrades that are merited based on the actual duties of the employees in the job at the time. Based on the modifications, salaries are established.

OCME has an ongoing process to submit positions to the Classification Division and has submitted the following: Medicolegal Investigator, Staff Assistant and Autopsy Assistant. OCME plans to submit other key positions during FY2007 and during the first quarter of FY2008. The Classification process will include a review of compensation and benefits.

The OCME has had a suggestion box available in the conference room (since the beginning of 2006) for employees to anonymously report concerns to management. No suggestions or concerns have been placed in the box. Employees have been informed about the box and will be reminded during General Staff meetings.

Case Records Security Improved

'03 Finding 39: Case records are not properly secured and controlled.

Original Recommendation (c): That OCME implement a sign-in and sign-out policy for all case files and investigative reports.

'07 Finding: Not in Compliance.

OCME does not have a sign-in and sign-out system for tracking records removed from the Records Office.

New Recommendation:

The OIG recommends that the OCME develop procedures for signing out and signing in case files and investigative reports.

OCME Response: In Compliance.

The Medical Records Unit does have a sign-in and out procedure to track records removed from the office. This system has been in place since the fall of 2003, the beginning of the current CME's tenure, and is strictly adhered to.

APPENDIX 9

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Office of the Attorney General for the District of Columbia

RECEIVED
305

07 SEP 12 PM 2:54



ATTORNEY GENERAL

September 7, 2007

Mr. Charles J. Willoughby
Inspector General
Office of the Inspector General
717 14th Street, N.W.
Washington, D.C. 20005

RE: Management Alert Report 07-1-008

Dear Inspector General Willoughby:

At your request, this Office has conducted a review of the relationship between the Office of the Chief Medical Examiner ("OCME") and the Metropolitan Police Department ("MPD") Natural Squad¹ regarding death investigations to determine whether the procedures followed comply with District law and whether OCME's coordination with MPD in these investigations jeopardizes its ability to become accredited by the National Association of Medical Examiners ("NAME"). You raised these concerns in a Management Alert Report ("MAR"), issued July 10, 2007. Specifically, you found that notwithstanding OCME's statutory responsibility to investigate all deaths enumerated in section 2906 of Title XXIX of the Fiscal Year 2001 Budget Support Act of 2000 ("OCME Act" or "Act"), effective October 19, 2000 (D.C. Law 13-173; D.C. Official Code §5-1405 (2006 Supp.)), the agency lacked sufficient Medicolegal Investigators ("MLI's) to respond to death scenes, particularly during night and weekend shifts; and consequently, in some instances, is compelled to rely on information, observations, and evidence from the death scene provided by MPD's Natural Squad.

As is discussed below, based on our review of District law, information obtained from OCME and MPD², and accreditation and other relevant guidelines cited in the MAR, I conclude that OCME's coordination with MPD in investigating deaths under OCME's jurisdiction is lawful. Further, in my opinion, OCME has taken necessary steps to ensure that its coordination with MPD does not jeopardize its ability to obtain NAME accreditation.

¹ The Natural Squad is a part of MPD's Homicide Section in the Violent Crimes Unit ("VCU"). It is housed at the OCME, but works under the supervision of MPD. The squad is responsible for responding to every death scene in the District and investigating all deaths, except for deaths where a physician has been in attendance and violent deaths that are normally investigated by homicide detectives.

² In conducting its investigation, OAG reviewed OCME's response to the MAR, dated August 7, 2007 ("OCME Response"). This Office has not reviewed the MPD response, which MPD advises has not yet been finalized, but has had oral discussions with MPD regarding the issues raised in the MAR.

District of Columbia Law

Pursuant to section 2906(a) of the OCME Act (D.C. Official Code §5-1405(a) (2006 Supp.)), OCME has the authority and responsibility for investigating all deaths in the District of Columbia under its jurisdiction, as enumerated in section 2906(b) (D.C. Official Code §5-1405(b) (2006 Supp.)).³ The Chief Medical Examiner (“CME”), other medical examiner⁴, or licensed MLI is required to make a determination of death in all of these situations. In investigating deaths, OCME has responsibility for the dead body from the time the death is reported, and also is required to consider information from the death scenes. Section 2907(a) of the Act (D.C. Official Code §5-1406 (2001)) provides that OCME shall take charge of the body after notification of deaths under its jurisdiction and that the body shall not be disturbed unless the CME “or designee” grants permission. Section 2907(a) also authorizes the CME or “duly authorized representatives” of the CME to respond to the scene of the death.

OCME’s well-established practice has been to designate detectives from MPD’s VCU, which includes the Natural Squad, as its “designees” and “duly authorized representatives” (“collectively “representatives”) under section 2907(a) of the Act for purposes of investigating death scenes.⁵ OCME’s designation of VCU detectives as its representatives is a reasonable interpretation of its statutory provision and therefore is entitled to deference. *Mushroom Transportation and National Union Fire Insurance Co. v. DOES*, 761 A.2d 840, 842 (D.C. 2000).

Moreover, the designation of VCU detectives as the representatives of OCME in death investigations was formalized in a memorandum, dated April 20, 2003, from Jonathan Arden, then CME, to Assistant MPD Chief Alfred Broadbent (“Arden Memorandum”). (A copy of the memorandum from Dr. Arden is attached as Appendix A.) In this memorandum, the CME authorized VCU detectives to respond to the death scene under OCME investigation when no investigative response to that scene was possible from OCME, and to provide a “preliminary examination for detecting injuries, obtaining evidence that would likely be lost during transport, or securing valuables, personal property or contraband.” The Arden Memorandum noted that the MLIs were the duly authorized representatives of the CME for purposes of routine responses to death scenes, but because of limited budget authority, there were not sufficient MLIs to respond to death scenes during night hours. For this reason, the VCU detectives were authorized to fill in for OCME investigators as the OCME representatives during the shifts when OCME

³ These include violent deaths, unexplained deaths not cause by readily recognizable disease, deaths under suspicious circumstances, deaths related to disease which might constitute a threat to public health, and deaths of persons while in legal custody of the District government.

⁴ Medical examiners are physicians working at OCME.

⁵ According to OCME, it was not until the late 1990’s that it began hiring its own investigative taff. Prior to that time OCME did not have the capability to send its own investigators to the death scene and therefore had to depend totally on MPD input.

coverage at death scenes was unavailable. The memorandum emphasized that in accordance with OCME's responsibility to investigate deaths under its jurisdiction, MPD's role was a limited one, while the OCME retained the final authority for examining the bodies and investigating the deaths.

In addition to the arrangement with the VCU's Natural Squad regarding a back-up response to death scenes, the CME or other medical examiner is available 24 hours and seven days a week to respond to a death scene when circumstances warrant. According to OCME, the CME and the other medical examiners are on-call for this purpose and 40% of their salaries is compensation for their on-call services.

OCME's current regulations prescribe procedures by which OCME and MPD coordinate coverage at death scenes, secure the body, and gather relevant information on death investigations. On August 27, 2007, OCME promulgated emergency rules amending the OCME regulations which appear in Chapter 50 of Title 28 of the District of Columbia Municipal Regulations ("DCMR") to further clarify the role of MPD in death investigations and how OCME and MPD interact to complete death investigations. These emergency rules are also being proposed as a final rulemaking.⁶ (A copy of the emergency and proposed rulemaking is attached as Appendix B.) The amended subsection 5003.2 provides that OCME shall obtain from VCU "circumstantial information, medical histories, witnesses statements, and other pertinent facts regarding the death"⁷; that the members of the Natural Squad are "designated as agents" of the CME to obtain hospital records⁸; and that VCU "may, when circumstances warrant, request that the Chief Medical Examiner be present at the scene of death to assist in the investigation."⁹

It is important to emphasize that, in addition to acting at times as the representatives of OCME, MPD has an independent role at death scenes. It is MPD's responsibility to secure any death scene where a death has occurred "without a physician having been in attendance." 6 DCMR 200.21 (1988). Therefore, as the OCME is responsible for securing the body at the scene of the death directly or through a representative, D.C. Code §5-1406(a), MPD is responsible for securing the death scene and gathering evidence from the scene. In all cases, whether or not the OCME is present at the death scene, the Natural Squad responds to all unattended deaths and completes a report (MPD 120), which contains information that may aid the OCME in certifying the cause and manner of death.

⁶ The emergency and proposed rulemaking has been delivered to the Office of Documents and Administrative Issuances for publication.

⁷ Subsection 5003.2(b).

⁸ Subsection 5003.2(c).

⁹ Subsection 5003.2(d).

In my opinion, the interaction and coordination between OCME and MPD in death investigations is authorized under District law. While OCME relies in part on information obtained by MPD, it has not abdicated its statutory responsibility for investigating the deaths under its jurisdiction. Moreover, I believe that the interactions between OCME and MPD are adequately outlined in the Arden Memorandum and the newly amended OCME regulations. I note that your Office has recommended that the two agencies formalize their relationship in a Memorandum of Understanding to more clearly delineate the agencies' roles in death investigations. While such a Memorandum is not legally necessary in the absence of exchange of services or funds between these agencies¹⁰, I believe that it would be helpful in detailing the procedures for coordinating death investigations.¹¹ Further, management from both OCME and MPD have expressed a willingness to collaborate on such an agreement.

Accreditation

The MAR raises concerns that the current practice under which OCME is not present at every death scene, particularly during night hours, and relies on reports from the Natural Squad regarding the scene, could jeopardize OCME's ability to become accredited by NAME. The MAR references Question 5A.8 on the NAME Accreditation Checklist (adopted September 2003) ("NAME Checklist") which poses the question: "Are office investigations autonomous and independent of law enforcement investigations?"

According to information that this Office has reviewed, the interaction between OCME and MPD is an issue that could be raised by NAME if OCME seeks accreditation. This issue was raised by NAME's accreditation team during its last review of the OCME in 1991.¹² It is important to note that at the time of the 1991 review, OCME did not directly employ MLIs or any investigators and could not respond to death scenes, except for exceptional circumstances when a medical examiner responded to a scene at the request of MPD. NAME's concern in the December 13, 1991 report ("NAME Report") was that OCME then relied almost exclusively on police investigative reports for death scene facts and that these facts were recorded from a "police orientation rather than with a medical investigative orientation." *Id.* at 22. While the NAME Report did not state that OCME had to directly employ all of the scene investigators, it did recommend an increased participation by OCME in death scene investigations. *Id.* at 23.

¹⁰ See D.C. Official Code §1-201.01(k) (2006 Repl.) which provides that the Office of Contracting and Procurement may usually authorize the exchange of material, work or services between District government agencies. These arrangements are memorialized in Memoranda of Understanding.

¹¹ A Memorandum of Understanding may also be helpful in addressing issues raised concerning accreditation. See the discussion below.

¹² At that time, OCME was not a separate agency, but instead operated under the Commission of Public Health.

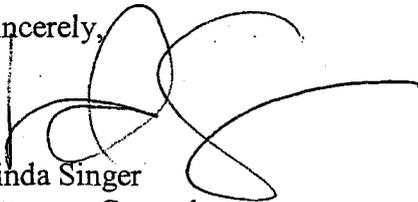
Since the issuance of the NAME Report, the OCME has changed its investigation procedures and now directly employs a staff of MLIs and other investigators. According to the OCME Response, the agency is in the process of hiring two forensic investigators and will hire two additional investigators in Fiscal Year 2008.¹³ With these hirings, the OCME investigative staff will total 11, which the agency asserts will be sufficient to rotate on a 24-hour basis. Although not all of these investigators will be MLIs available for other duties at OCME, the 11 positions will allow response to all death scenes.¹⁴

In my view, the fully staffed investigative unit should eliminate concerns over OCME's autonomy in death scene investigations with respect to NAME accreditation.¹⁵

Conclusion

Based on this Office's review, the interaction between OCME and MPD in death investigations is in accordance with District law. Further, OCME is taking action to increase its investigatory capacity, which will enhance its accreditation potential.

Sincerely,



Linda Singer
Attorney General

LS/sk

Attachments (2)

¹³ The FY 2008 positions are currently being advertised.

¹⁴ The NAME accreditation guidelines do not require that only MLIs investigate deaths.

¹⁵ The autonomy criterion in investigations is classified by NAME as a Phase I criterion, which is not essential for obtaining accreditation. See *Inspection and Accreditation Policies and Procedures Manual* (September 2003) at 1-2. However, NAME allows only 15 Phase I deficiencies; therefore avoiding a possible deficiency by fully staffing the OCME investigative unit is desirable. Also, it should be noted that a NAME Phase II, or essential accreditation requirement, is that a medical examiner have access to investigative findings of the police, fire department and other investigative agencies in criminal cases and violent deaths. NAME Checklist at Question 5.6. Based on our review, OCME would satisfy this criterion as to MPD investigative records.

IG Letter
OCME/MPD Relationship
September 7, 2007

Page 6 of 6

cc: Dan Tangherlini
City Administrator

Marie-Lydie Y. Pierre-Louis, M.D.
Chief Medical Examiner

Cathy L. Lanier
Chief of Police

OFFICE OF THE CHIEF MEDICAL EXAMINER

NOTICE OF EMERGENCY AND PROPOSED RULEMAKING

The Chief Medical Examiner ("CME"), District of Columbia Office of the Chief Medical Examiner ("OCME"), pursuant to the authority set forth in Title XXIX of the Fiscal Year 2001 Budget Support Act of 2000, effective October 19, 2000 (D.C. Law 13-172), D.C. Official Code § 5-1401 *et seq.* and Mayor's Order 2001-04 dated January 5, 2001, gives notice of the adoption on an emergency basis of amendments to Chapter 50 of Title 28 of the District of Columbia Municipal Regulations (DCMR). The purpose of the amendments is to set forth additional requirements for ensuring the integrity and autonomy of OCME death investigations and clarify the procedures for conducting the death investigations.

This emergency action is based on a Management Alert from the Office of the Inspector General ("OIG") that was issued noting certain deficiencies in procedures to investigate deaths under the CME's jurisdiction. The CME agrees that there needs to be clarification in the procedures that are followed in completing death investigations. Therefore, to protect and preserve the public health, safety, and welfare, it is necessary that the CME promulgate these rules to govern the death investigations under her jurisdiction. The rules were adopted and became effective on August 27, 2007 and will expire in one hundred twenty (120) days.

The CME also gives notice of intent to take final rulemaking to adopt these amendments in not less than thirty (30) days from the date of publication of this notice in the *D. C. Register*.

The emergency rules will expire on December 25, 2007, or upon publication of a notice of Final Rulemaking in the *Register*, whichever occurs first.

28 DCMR Chapter 50, the OFFICE OF THE CHIEF MEDICAL EXAMINER, is amended to read as follows:

Section 5001.3 is amended to read as follows:

- 5001.3 The CME and other medical examiners are authorized to determine with reasonable medical certainty the cause and the circumstances surrounding each death required to be investigated. To protect the integrity and autonomy of these death investigations, the following shall apply:
- (a) Neither the CME nor his/her agents or designees shall accept any money or other compensation, or benefit, either directly or indirectly, that could appear to create a potential conflict or influence over the death investigation.

- (b) Unless the CME or other medical examiner deems it necessary to determine the cause and manner of death, he/she shall not attend or participate in any organ harvest procedure.
- (c) In all cases in which the CME has jurisdiction for investigating a death pursuant to D.C. Official Code §5-1405(b), the physician performing an organ harvest shall immediately stop the procedure and notify the CME or other medical examiner if any unforeseen injury/trauma is discovered during the procedure.
- (d) A physician performing an organ harvest as described in paragraph (c), above, is required to provide a detailed description of the procedure in the Medical Examiner's format to the Medical Examiner in accordance with D.C. Official Code § 5-1406(b).

Section 5001.4 is amended to read as follows:

- 5001.4 The Chief Medical Examiner shall investigate those types of deaths enumerated in D.C. Official Code § 5-1405(b), which include but are not limited to, the following:
- (a) All known or suspected unnatural deaths;
 - (b) All deaths occurring without medical attention within a period of ten (10) days prior to death;
 - (c) All deaths occurring within twenty four (24) hours of hospital admission.

Section 5003.2 is amended to read as follows:

- 5003.2 Information and evidence surrounding the circumstances of death shall be acquired as follows:
- (a) The CME is authorized to issue a subpoena for confidential medical records and relevant information from physicians, hospitals, nursing homes, residential care facilities and other health care providers as in his/her opinion is necessary for investigating deaths under D.C. Official Code § 5-1407 (2001).
 - (b) In investigating a death under its jurisdiction, OCME shall obtain from the Violent Crimes Unit ("VCU") of the Metropolitan Police Department, which includes the Natural Squad, circumstantial information, medical histories, witnesses' statements, and other pertinent facts regarding the death.

- (c) Hospital records shall be made available to members of the Natural Squad, who, for purposes of this subsection, are designated as agents of the Chief Medical Examiner
- (d) The VCU may, when circumstances warrant, request that the Chief Medical Examiner be present at the scene of death to assist in the investigation.

Section 5007.1(g) is amended to read as follows:

(g) "Medicolegal Investigator" or "MLI" means a physician assistant or advanced practice registered nurse licensed under the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code § 3-1201 et seq. (2001)), who is also a forensic investigator and employed by OCME and who conducts death investigations including the use of scene investigations, body examinations and medical history documentation to support forensic investigations and death certifications by OCME.

Section 5007.1 is amended to add new paragraphs (n) and (o) as follows:

- (n) "Organ Harvest Procedure" – includes the recovery, screening, testing, processing, storage, or distribution of tissue and organs by a procurement organization.
- (o) "Medical Examiner" – A physician who is officially authorized by a governmental unit to ascertain causes of death, especially those not occurring under natural circumstances.

All persons desiring to comment on the subject matter of this proposed rulemaking should file comments in writing not later than 30 days after the date of publication of this notice in the D.C. Register. Comments should be filed with the General Counsel, District of Columbia Office of the Chief Medical Examiner, 1910 Massachusetts Ave., SE, Bldg. 27, Washington, D.C. 20003. Copies of the proposed rules may be obtained from the Office of the Chief Medical Examiner at the above address.

***GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF THE CHIEF MEDICAL EXAMINER
1910 Massachusetts Avenue, S.E., Bldg. 27
Washington, D.C. 20003

Telephone: 202-698-9000

Fax: 202-698-9100

MEMORANDUM

COPY

To: Assistant Chief Alfred Broadbent, Metropolitan Police Department

From: Jonathan L. Arden, MD, Chief Medical Examiner 

Date: 20 April 2003

Re: Death Scene Investigations in Absence of OCME

The Office of the Chief Medical Examiner (OCME) has the responsibility to investigate and certify certain types of human death occurring within the District of Columbia, as enumerated in the DC Code, Title 5, Chapter 14. Specifically, § 5-1406(a) states:

"For all deaths described in § 5-1405(b), the CME shall take charge of the body upon the mandatory and direct notification of the death required by subsection (b) of this section. The CME, or duly authorized representatives of the CME, shall have authority to respond to the scene of the death. The body of the decedent shall not be disturbed unless the CME, or the CME's designee, grants permission to do so."

The OCME Medicolegal Investigators (MLIs) are the duly authorized representatives of the Chief Medical Examiner (CME) for the purpose of routine responses to death scenes, including examining the body of the decedent prior to moving it or removing evidence from it. Although this responsibility exists 24 hours/day, current staffing patterns as established by OCME budget authority allow death scene responses by MLIs for only approximately 12 hours/day (from 0730 to 1930 hours). Outside these hours, detectives from the MPD Violent Crimes Unit (VCU) respond to death scenes without a response from OCME.

In consideration of the above, by this memo, I authorize the detectives of the MPD VCU to disturb the body of a decedent at the death scene under their investigation when no investigative response to that scene will be made by OCME, subject to the following conditions:

- That this be limited to a preliminary examination for detecting injuries, obtaining evidence leading to identification, recovering evidence that would likely be lost during transport, or securing valuables, personal property or contraband;
- That timely notification of the death as required under § 5-1406(b) was made first to OCME to ensure that no scene response by OCME is forthcoming.

MPD Authorization *re* death scenes with no OCME response. 20 April 2003. Page 2

Please note:

- This does not provide authorization for extensive or intrusive examinations by MPD personnel at death scenes, nor any procedure that would significantly alter the body. Any such exceptions (such as fingerprinting bodies at scenes) must be approved by the CME (or designee) individually.
- If a medical examiner is responding to the scene, then MPD may not disturb the body prior to his or her arrival (consistent with the procedures if a MLI were responding).
- Any designation of authority from the CME to MPD is limited to that expressly stated above.

This is effective immediately, and remains in effect until further notice.

Cc: Charles Ramsey, Chief of Police, MPD
John Barrett, Commander of Detectives, MPD
Margret N. Kellems, Deputy Mayor for Public Safety and Justice
Adrienne Lavallee, General Counsel, OCME