



## Office of the Chief Medical Examiner OCME (FX)

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### MISSION

The Mission of the Office of Chief Medical Examiner (OCME) is to ensure that justice is served and that the health and safety of the public is improved by conducting quality death investigations and certification, and providing forensic services for government agencies, health care entities and grieving families.

### SUMMARY OF SERVICES

OCME provides forensic services to local and federal government agencies, health care providers, institutions of higher learning and citizens in the District and metropolitan area. Forensic services include: forensic investigation and certification of certain deaths (i.e., deaths occurring as a result of violence (injury) as well as those that occur unexpectedly, without medical attention, in custody, or pose a threat to public health); review of deaths of specific populations; grief counseling; performance of a full range of toxicological examinations; cremation approvals; and public dispositions of unclaimed remains.

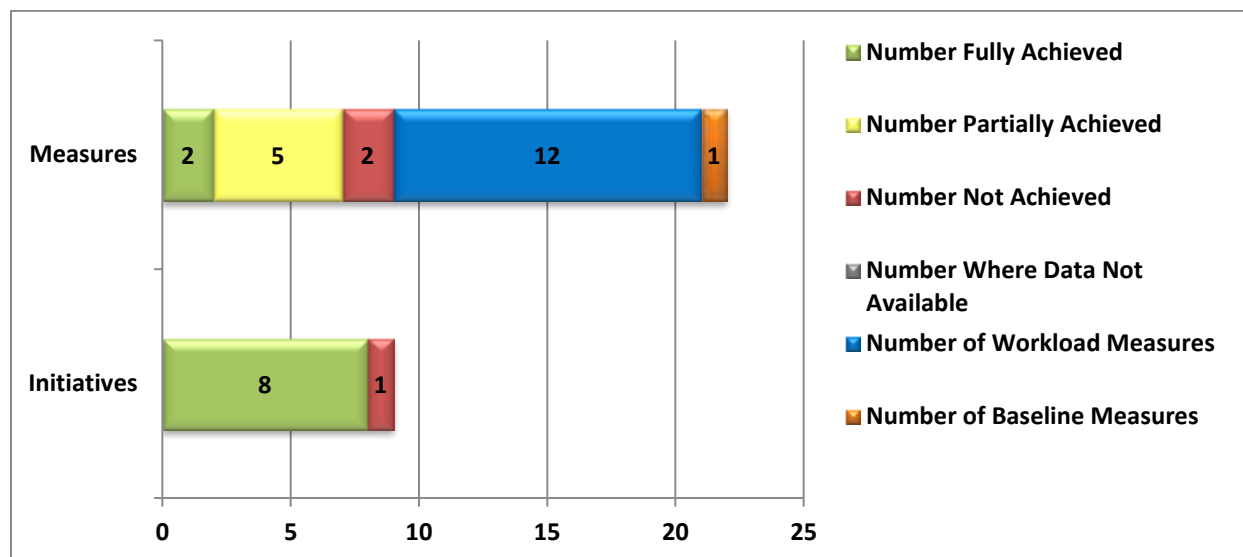
### ACCOMPLISHMENTS

- ✓ Efficient Facility Move: logistics, policies, equipment, training, outreach
- ✓ Coordinated Navy Yard Response: scene, body transport, autopsy, families, identification, media
- ✓ Digitization of 62,573 Records: files, slides, polaroid's, x-rays

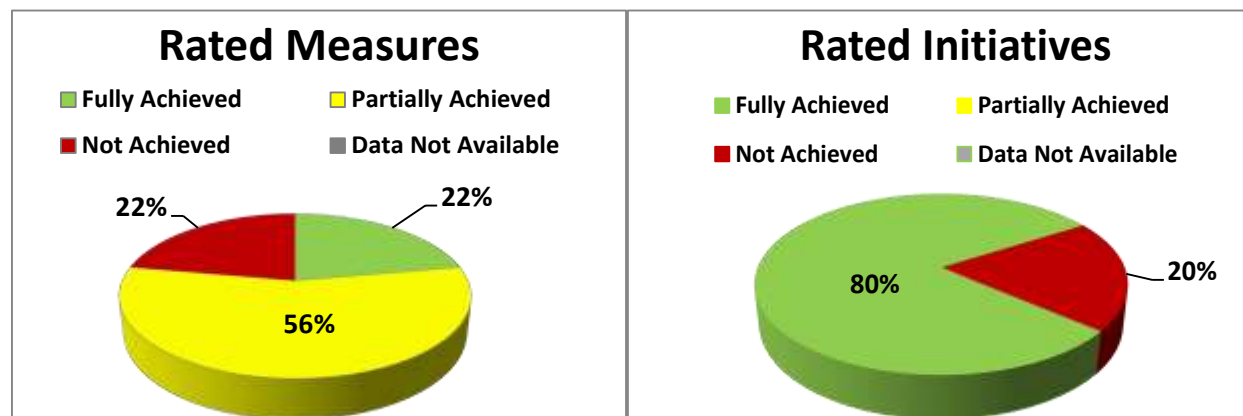


**OVERVIEW AGENCY PERFORMANCE**

**TOTAL MEASURES AND INITIATIVES**



**RATED MEASURES AND INITIATIVES**



**Note:** Workload and Baseline Measurements are not included

Default KPI Rating:	
>= 100%	Fully Achieved
75 - 99.99%	Partially Achieved
< 75%	Not Achieved



## Performance Initiatives – Assessments Details

### Performance Assessment Key:



Fully achieved



Partially achieved



Not achieved



Data not reported

## Death Investigations

### OBJECTIVE 1: Provision of Accurate and Timely Death Investigation and Certification

#### INITIATIVE 1.1: Meet National Association of Medical Examiners (NAME) industry standards for autopsy and postmortem examination reporting. (PUBLIC SAFETY)

**Not Achieved:** NAME accreditation processes provide guidelines for autopsy reporting to include that 90% of homicide cases be completed in 90 days and non-homicide cases in 60 days. The agency did not meet the targets due to several challenges. For the entire fiscal year, the agency had two medical examiner vacancies reducing the staff from six to four, including the Chief Medical Examiner. This created an overload on the current staff, with challenging cases unique to a metropolitan area and several high profile cases (i.e., Navy Yard, Capitol Hill Shooting, and Self-inflicted Fire Death). The agency experienced a backlog of cases due to the lack of reliable and accurate histology services. The agency was unable to utilize the in-house histology laboratory in the newly built CFL because the room was too small to fit all the equipment purchased by DGS. So, contracting out the services was required. The agency's vendor relocated without notice taking agency specimens/slides out of the area. The vendor incorrectly billed the agency and sent back inaccurate and incomplete results often without the specimens/slides. The agency was forced to cease using the vendor in April 2013. Despite numerous attempts by the agency and OCP, the challenge to procuring another vendor lasted until August resulting in a backlog. (Issue Resolved: Vendor Procured; Billing Disputes Resolved with former Vendor). The agency was also significantly impacted by a full move to a new facility during the 1st quarter. This required learning a new format and new equipment and development of new work processes and policies. While technologically advanced, the new equipment and spacing innovations in the mortuary were such that training was required and the medical examiners and mortuary staff had to become acclimated to the equipment for performance of autopsies. The agency certainly has adopted, but the impact was realized.

#### INITIATIVE 1.2: Conduct a Death Investigation and Certification Public Service Announcement Campaign focusing on various aspects of the death investigation and certification process

**-Fully Achieved:** The agency has conducted a death investigation and certification public service announcement campaign through the enhancement of its website; outreach to customers due to its move to a new facility; through seminars and workshops; and with one page FAQ sheets and modification of its agency pamphlet of FAQs that are provided to the public. The pamphlets, FAQ sheets and the FAQs on the website specifically address the identification and DNA process; autopsy reporting and obtaining reports; public disposition; cremation approvals; records requests; toxicology services; and mass fatality.



Workshops have included the National Youth Leadership Program (two sessions); toxicology presentations; and workshops to individual schools (i.e., Cesar Chavez Public Charter School). The FAQ sheets and agency pamphlets describe the agency operations and the procedure outlined herein and is available to customers and the information provided on the agency website and the mass fatality guideline explains agency procedures for mass incidents.

### **INITIATIVE 1.3: Mass Fatality and Emergency Incident Planning Guidelines**

- **Fully Achieved:** A pamphlet, entitled "Guidelines for Reporting and Managing Mass Fatality Events With The DC Medical Examiner System" was developed, printed in color and disseminated throughout the agency and in the public area on the first floor. The pamphlet includes the definition of mass fatality; the agency mission and jurisdiction; initial response procedures and immediate needs; and the three major operations (scene, temporary morgue and family assistance center) that must be set up and coordinated during a mass fatality. The pamphlet also includes other key issues to consider (legal, personnel injuries, financial accounting, personnel procurement and the PIO). Lastly, the pamphlet covers Weapons of Mass Destruction and Mass Burial Guidelines.

### **INITIATIVE 1.4: Promotion of the Fields of Forensic Pathology**

- **Fully Achieved:** The Chief Medical Examiner conducted several sessions including "How to Become a Medical Examiner" as follows: 1) 6/20/13 and 7/8/13 - OCME Hosted the National Youth Leadership: The OCME's partnership with this group is longstanding and the agency hosts a group of students a few times a year. This year the curriculum included "How to Become a Medical Examiner" in order to encourage the students to pursue the field of forensic pathology. It was particularly significant given the new facility and students were most interested in the technology associated with the job. The students receive college credit for completion of the curriculum in the program, which includes a conference at the medical examiner's office and associated workshops/lectures. The group received a lecture and tour of the facility on both dates. Further, the agency has included the information on how to become a medical examiner on the agency's District website. 2) The Chief Medical Examiner conducted a presentation at Cesar Chavez Public Charter School in the District regarding forensics, the medical examiner's office and becoming a medical examiner. The agency has also included "How to Become a Medical Examiner" on its website in order to further promote the field. The agency receives numerous inquiries from students regarding the issue as their interests and the agency can refer them.

## **Fatality Review**



**OBJECTIVE 1: Provide analysis and make recommendations that result in improved services and outcomes for those populations served by the Fatality Review Division**

**INITIATIVE 1.1: Enhanced Reporting of Key Factors Recognized in Deaths Reviewed by the Fatality Review Division (SUSTAINABILITY)**

**Fully Achieved:** The FRD enhanced reporting by developing statistical reports on deaths among children, domestic violence victims and the developmentally disabled in the District. These reports are to be included in the 2012 Annual Reports of the following reviews: Child Fatality Review Committee, Domestic Violence Review Board and the Developmentally Disabled Review Committee. Note the reports are due to be published by the end of the year following the reporting year. The educational level of child death statistics are included in the agency KPI workloads.

**Forensic Toxicology**

**OBJECTIVE 1: Implementation of FACTS Forensic Toxicology Module**

**INITIATIVE 1.1: Implementation of Toxicology Case Management Module and full integration into the Agency's Case Management System (FACTS)**

**Fully Achieved:** The agency worked with its Forensic Case Tracking Analytic System toward the development of a forensic toxicology laboratory module to improve overall work flow. The contracting and procurement process, including statement of work, was completed and the services and software licenses procured. During the fiscal year, OCME staff consistently worked with the vendor to install and provision the server to be utilized for the module. Further, through continued evaluation/testing OCME staff continued to identify improvements to the system/user interface with the goal of more closely corresponding to the laboratory's work flow. The initial implementation continues with user acceptance testing (UAT). This phase of the project was fully achieved such that the agency is in the position to begin the second phase as outlined in the fiscal year performance plan -- full integration into the agency's case management database system.

**OBJECTIVE 2: Provision of Statistical Reporting of Public Interest**

**INITIATIVE 2.1: Contribute to the scientific community through academic presentation/publication of toxicological findings (PUBLIC SAFETY, FISCAL STABILITY)**

**Fully Achieved:** In 2013, the Toxicology Unit provided monthly in-depth statistical reports to the Metropolitan Police Department using data obtained from the breath testing program. These statistics included how many officers were successfully certified, how many tests were taken per trained officer, and subject refusal rates. In addition, the Unit provided its first in-depth annual report of drug facilitated sexual assault testing results to the Office of Victim Services. Finally, the Toxicology Unit continues to provide training to university students in the form of lectures and internships. The Unit currently has 4 interns, lectures twice a year for George Washington University's pathology course, and conducts an in-house laboratory training for graduate students from the GW Forensic Toxicology program.

**Offices of the Chief & Administration**



**OBJECTIVE 1: Maintain high quality office and system operations to support effective medico legal death investigation, efficient and quality autopsy reporting, and accurate certification of deaths.**

**INITIATIVE 1.1: Modification of policies and procedures, training of staff and outreach to customers resulting from a transition to the Consolidated Forensic Laboratory**

**Fully Achieved:** During the first quarter, three phases of an agency move were successfully completed, including move of staff, equipment, bodies, specimens etc. The logistics included assignment of staff to offices/work spaces and a parking plan; procurement/installation of furniture/equipment and setting work processes on 4 floors. The agency reviewed workflows and processes based on real-time operations and made required modifications. The following procedures were significantly modified and completed in writing based on the new facility and modified operations: Death Investigation SOPs updated; Histology SOPs initiated; COOP updated and accepted by ORM; Emergency Response Plan updated and approved by FEMS and ORM; and an online cremation payment process established. Others have been revised: mortuary, identification, autopsy performance and reporting; notification/acceptance and release.

- Staff has been trained on new polices/procedures and use of new and/or modified equipment (i.e., toxicology instrumentation/equipment and mortuary autopsy tables, body rack system and lifts, new computer software, telecom etc.) and workflows. There has also been outreach to agency customers regarding the new location and procedures, particularly next of kin (i.e., informational materials) and funeral directors (i.e., meeting/workshop with funeral directors). The agency worked with DGS to procure services through OCTO to modify its website to accommodate funeral homes in the cremation review and approval process. The agency now accepts submittal of the cremation requests and payment online eliminating at least one trip of several in the process to the agency by the funeral homes. The agency worked with DGS on several major construction modifications to office and laboratory space, including redesign of case processing and identification suites; histology lab and tissue specimen room; as well as modifications to the body rack system.

**INITIATIVE 1.2: OCME Website Enhancement**

**Fully Achieved:** The website was significantly enhanced with new information and items. The major part of the project, enhancement for cremation requests and payment of services online was implemented and has been highly successful. The OCME website was enhanced to include: 1) implementation of the credit card payment system as fully operational for funeral homes to submit cremation requests and fees(OCTO development was completed during the 1st quarter; the system underwent testing in the 2nd qtr. with 5 funeral homes and went "live" during the 3rd qtr with funeral homes added each week; with access to all funeral homes during the beginning of the 4th qtr.); 2) a statistics section entitled "Public Safety Corner" (which now includes a Homicide and Suicide Statistical studies) and annual statistical reports in a "requested documents" section; 3) an Educational Section to provide information on training, seminars and internship programs; 4) Public Safety Corner (the name was changed as more appropriate to the agency's



mission) with surveillance reports on suicides, hypothermia, homeless, homicides and public dispositions included therein; 5) a scientific presentation section that includes a study on "Falling Furniture & Deaths in Children"; 6) Academic Affiliations section; 7) the agency's entire FAQ's pamphlet (another language is premature for District websites in FY13); and 8) How to Become a Medical Examiner. The NAMUs, virtual tour of the facility, and Organ & Tissue Donation sections were not approved for various confidential and security reasons.



## Key Performance Indicators – Details

**Performance Assessment Key:**

Fully Achieved   
 Partially Achieved   
 Not Achieved   
 No data reported   
 Workload Measure  
 Baseline Measure

	KPI	Measure Name	FY 2012 YE Actual	FY 2013 YE Target	FY 2013 YE Revised Target	FY 2013 YE Actual	FY 2013 YE Rating	Budget Program
<b>Death Investigation</b>								
		<b>1.1</b> Percent of reports of all postmortem examinations completed within 90 calendar days from time of autopsy in homicide cases	80%	90%		73.26%	81.40%	Death Invest. & Certifications
		<b>1.2</b> Percent of positively identified bodies ready for release within 48 hours	87.24	90%		91.15%	101.28%	Death Invest. & Certifications
		<b>1.3</b> Percent of preliminary investigative reports complete for utilization in the daily case review morning meetings	9%0	95%		90.61%	95.38%	Death Invest. & Certifications
		<b>1.4</b> Percent of mortuary scene response within one hour of transport notification by an investigator or medical examiner of an accepted case	86%	95%		84.02%	88.44%	Death Invest. & Certifications





	KPI	Measure Name	FY 2012 YE Actual	FY 2013 YE Target	FY 2013 YE Revised Target	FY 2013 YE Actual	FY 2013 YE Rating	Budget Program
●	1.5	Number of Postmortem Examinations Performed	1,061	Target Not Required		1,049	Workload Measure Not Rated	Death Invest. & Certifications
●	1.6	Number of Deaths Due to Traffic Accidents	36	Target Not Required		49	Workload Measure Not Rated	Death Invest. & Certifications
●	1.7	Number of Deaths Due to Hypertensive Cardiovascular Disease	288	Target Not Required		358	Workload Measure Not Rated	Death Invest. & Certifications
●	1.8	Number of Court-related Activities – Death Investigation	49	Target Not Required		17	Workload Measure Not Rated	Death Invest. & Certifications
●	1.9	Percent of reports of all postmortem examinations completed within 60 calendar days from time of autopsy (homicide cases excluded)	74%	90%		35.54%	39.49%	Death Invest. & Certifications
●	1.1	Percentage of unclaimed cases where the public disposition process is initiated three days after positive identification	NA	90% (Baseline)		41.81%	Not Rated (Baseline)	Death Invest. & Certifications
●	1.11	Number of fire deaths due to cigarette smoking	NA	Target Not Required		3	Workload Measure Not Rated	Death Invest. & Certifications



	KPI	Measure Name	FY 2012 YE Actual	FY 2013 YE Target	FY 2013 YE Revised Target	FY 2013 YE Actual	FY 2013 YE Rating	Budget Program
●	1.12	Number of deaths due to obesity	NA	Target Not Required		6	Workload Measure Not Rated	Death Invest. & Certifications
●	1.13	Number of deaths due to jumping suicides (bridges)	NA	Target Not Required		2	Workload Measure Not Rated	Death Invest. & Certifications
●	1.14	Number of deaths due to jumping suicides (Metrotrain)	NA	Target Not Required		2	Workload Measure Not Rated	Death Invest. & Certifications
●	1.15	Number of youth deaths due to homicide where youth education level is not age-appropriate	NA	Target Not Required		26	Workload Measure Not Rated	Death Invest. & Certifications
<b>Forensic Toxicology</b>								
●	2.1	Number of Court-related Activities – Forensic Toxicology	1,140	Target Not Required		1391	Workload Measure Not Rated	Forensic Toxicology
●	2.2	Percent of negative toxicology examinations completed within 30 calendar days of case submission	88%	90%		50.70%	56.33%	Forensic Toxicology
●	2.3	Percent of positive toxicology examinations completed within 60 calendar days of case submission	98%	90%		81.22%	90.24%	Forensic Toxicology



	KPI	Measure Name	FY 2012 YE Actual	FY 2013 YE Target	FY 2013 YE Revised Target	FY 2013 YE Actual	FY 2013 YE Rating	Budget Program
●	2.4	Number of DUI Cases Performed	927	Target Not Required		707	Workload Measure Not Rated	Forensic Toxicology
<b>Fatality Review</b>								
●	1.1	Percent of CFRC fatality reviews held within six months of notification of death	45%	80%		79.76%	99.70%	Fatality Review Committees
●	1.2	Percent of DD fatality reviews held within 3 months of receipt of the investigative report from DHS/DDS and determination of the cause and manner of death	100%	100%		100%	100%	Fatality Review Committees
●	1.3	Number of Child Deaths Due to Inappropriate Bedding	7	Target Not Required		2	Workload Measure Not Rated	Fatality Review Committees