Connecticut Office of the Chief Medical Examiner
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Date Inspected: January 17, 2017
Inspector: Joyce deJong
Office Contact: James Gill, M.D.

	Deficiencies		N/A		Not Answered	
Section	**Phase 2**	**Phase 1**	**Phase 2**	**Phase 1**	**Phase 2**	**Phase 1**
General	0	0	0	1	0	0
Investigations	0	0	0	2	0	0
Morgue	1	1	0	0	0	0
Histology	0	0	0	0	0	0
Toxicology	0	0	4	0	0	0
Reports	0	1	1	0	0	0
Personnel	3	4	4	1	0	0
Support	0	0	0	0	0	0
Total	4	6	9	4	0	0

Section	**Yes**	**No**	**N/A**	**Not Answered**	**Total**
General	61 (98.4%)	0 (0.0%)	1 (1.6%)	0 (0.0%)	62
Investigations	35 (94.6%)	0 (0.0%)	2 (5.4%)	0 (0.0%)	37
Morgue	83 (97.6%)	2 (2.4%)	0 (0.0%)	0 (0.0%)	85
Histology	10 (100.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	10
Toxicology	22 (84.6%)	0 (0.0%)	4 (15.4%)	0 (0.0%)	26
Reports	62 (96.9%)	1 (1.6%)	1 (1.6%)	0 (0.0%)	64
Personnel	40 (76.9%)	7 (13.5%)	5 (9.6%)	0 (0.0%)	52
Support	17 (100.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	17
Overall	330 (93.5%)	10 (2.8%)	13 (3.7%)	0 (0.0%)	353

Recommendation: **Provisional Accreditation**
Date Submitted: 2016

NAME Inspection and Accreditation

I. Authorization
At the request of and with authorization and consent by the Connecticut Office of the Chief Medical Examiner (OCME), Dr. Joyce L. DeJong, inspected the office on January 17, 2017.

II. Introduction
Introduction

Under the leadership of James Gill, M.D., the OCME received reports of nearly 21,000 deaths in 2015. An investigation was required in nearly 18,000 of the deaths reported, and about 2600 deaths required postmortem examinations. The Medical Examiner system is centralized, state operated, with a physical facility in Farmington, CT, serving a population of about 3.6 million. As detailed in the annual report, the number of postmortem examinations has significantly increased in recent years, largely due to the surge in opioid related fatalities.

Pre-Inspection Process

This was a re-inspection; the office is currently in a fully accredited status, although concerns about a potential loss of full accreditation were raised in October of 2016. The Consent for Inspection, Office Survey Information, the multiple required policies and documents, were provided by the OCME through the NAME Inspection website. The Accreditation Checklist was completed by the OCME in advance of the site visit with answers reflecting their self-evaluation of the office. Many of the checklist responses included photo documentation to substantiate the response. In addition to all of the required policies and procedures, a description of the office, the budget, a description of approved positions with a comparison to funded positions, and an annual report were provided for review. In the weeks preceding the visit and during the inspection, the responses provided by the OCME were evaluated and compared to the inspectorâ€™s findings. The documents provided by the OCME were thorough, neatly arranged, and also available in hard copy on the day of the inspection visit.

Inspection Day Process

The physical inspection day began with a brief meeting at 8:30 AM with the Chief Medical Examiner, Dr. James Gill and the Deputy Chief Medical Examiner, Dr. Maura DeJoseph. The inspection included attendance at the morning meeting, held in a conference room each day at 9 AM. The morning meeting includes all of the Medical Examiners, any residents or other students, and the investigators. Following the morning meeting, a very thorough tour of the entire building and facility was led by Drs. Gill and DeJoseph. After the tour, a secondary review of the checklist to identify any items which were not verified on the initial tour was followed by second tour directed to any items not observed during the initial tour. Additional meetings occurred with an individual from the contracted building maintenance company to discuss the physical facility and an administrator. In the afternoon, multiple randomly selected case files including homicides, accidents (traffics), accidents (drugs), suicides, infant deaths, undetermined manner, and natural deaths, with representation from all of the medical examiners, were examined. The inspection included attendance at a second meeting held each day at 2 PM

to review the findings from the days autopsies, to address challenges in select cases, and to share educational information from other cases. The late afternoon of the physical inspection day included a meeting with all available staff to provide information regarding the inspection process, general impressions of the office, and to answer questions regarding NAME Accreditation. The day concluded with an additional meeting with Drs. Gill and DeJoseph to clarify various findings and discuss the reporting process.

III. Governance

Chapter 368q of the Connecticut General Statutes places OCME under the control and supervision of the Commission on Medicolegal Investigations. Commission membership includes representatives from the UConn School of Law, Yale School of Law, Yale Department of Pathology, the Connecticut Bar Association, the Department of Public Health, the Connecticut Medical Society and two individuals from the community.

The independence of the OCME, operating under their own Commission, and not under any other state department such as public health or law enforcement is a model that can and should be used in other states. Independence is absolutely critical to the successful operation of any medical examiner's office, and is not only required by NAME, but strongly recommended in the 2009 NAS report on forensic sciences. This is a very progressive system, and one you are encouraged to maintain.

IV. Checklist Review:

The following is the inspector's deficiency report resented by section and including each of the NAME I&A Checklist items that were assessed as deficient (marked as NO) and N/A with explanation:

Section A - General

Narrative

GENERAL - No deficiencies identified by first inspector.

Phase 1 Deficiencies

Standard A.9.j: Does the office annually compile statistical data on hospital autopsies retained under ME jurisdiction?

Finding: All OCME jurisdiction cases are autopsied at OCME, not at hospitals.

Section B - Investigations

Narrative

INVESTIGATIONS 1.g. and 1.h. Pronouncement of death and notification of next-of-kin are functions handled by other agencies. The OCME is not responsible for these functions and this inspector believes N/A is an appropriate designation for these checklist items.

Phase 2 Deficiencies

None

Phase 1 Deficiencies

Standard B.1.g: Does the medical examiner, if it is required, arrange for a formal pronouncement of death?

Finding: Death is pronounced by other agencies. It is the practice of the Medical Examiner's Office not to provide this service.

Standard B.1.h: Does the office attempt to notify the next-of-kin as soon as possible, if notification by another agency or individual cannot be confirmed?

Finding: Notification the next-of-kin of death is not required of the OCME.

Section C - Morgue

Narrative

MORGUE 2.d. The storage capacity in the current refrigerator is seriously inadequate. On the day of the inspection, it was very full and the OCME staff report having to frequently have bodies sent or held at other locations. Funding has been approved to expand refrigeration,architects and builders have planned, and completion is expected within months.

C.2.g The temperature monitoring alarm on the main cooler did not function. It was unplugged and it was non-operational.

Phase 2 Deficiencies

Standard C.2.d: Is refrigerated storage space sufficient to accommodate the number of bodies and their handling during usual and peak loads?

Finding: The storage in the current refrigerator is often times inadequate. On the day of the inspection, it was very full. Funding has been approved to expand refrigeration, architects and builders have planned, and completion is expected within months.

Phase 1 Deficiencies

Standard C.2.g: Are temperature monitoring devices present on each refrigerator and freezer space, is there an alarm system to warn of deviations from the acceptable range, and are monitoring records kept?

Finding: There are multiple refrigerators in the building. The refrigerator used for the storage of most of the bodies has a thermometer (monitored daily), however, the alarm system was not functional. The alarm requires repair or replacement. The cooler is next to an area that is staffed 24/7/365, so a simple alarm is adequate.

Section D - Histology

Narrative

HISTOLOGY - No deficiencies identified by first inspector.

Phase 2 Deficiencies

None

Phase 1 Deficiencies

None

Section E - Toxicology

Narrative

TOXICOLOGY - No deficiencies identified by first inspector. The complex testing is performed by NMS laboratories with a turn-around-time of days. Some of the testing, that which is a bit more straightforward, is performed by the State Forensic Laboratory, with a turn-around-time closer to weeks.

Phase 2 Deficiencies

Standard E.1.b: Does the toxicology laboratory have suitable space, equipment, scientific instrumentation, reagents, and supplies to manage the caseload?

Finding: Toxicology is no longer performed in-house.

No action needed.

Recommendation: No action needed.

Standard E.1.b: Does the toxicology laboratory have suitable space, equipment, scientific instrumentation, reagents, and supplies to manage the caseload?

Finding: Toxicology is outsourced to NMS.
No action needed

Standard E.1.b: Does the toxicology laboratory have suitable space, equipment, scientific instrumentation, reagents, and supplies to manage the caseload?

Finding: Contracted toxicology services by NMS and the State of CT Division of Scientific Services.

Standard E.1.c: Is there an appropriate and safe storage system in place for chemicals and reagents, and is there provision for recognition and proper disposal of outdated and expired items?

Finding: Toxicology is no longer performed in-house.

No action needed.

Recommendation: No action needed.

Standard E.1.c: Is there an appropriate and safe storage system in place for chemicals and reagents, and is there provision for recognition and proper disposal of outdated and expired items?

Finding: Contracted toxicology services by NMS and the State of CT Division of Scientific Services.

Standard E.1.d: Is there a properly ventilated and maintained fume hood in the laboratory or available to laboratory personnel for handling dangerous or unpleasant samples of reactions?

Finding: Toxicology is no longer performed in-house.

No action needed.

Recommendation: No action needed.

Standard E.1.d: Is there a properly ventilated and maintained fume hood in the laboratory or available to laboratory personnel for handling dangerous or unpleasant samples of reactions?

Finding: Contracted toxicology services by NMS and the State of CT Division of Scientific Services.

Standard E.1.e: Is the toxicology laboratory used by the office accredited by an Accreditation Body who is a signatory to the International Laboratory Accreditation Cooperation (ILAC) Mutual Recognition Arrangement (MRA) and offers forensic laboratory accreditation services or a major accreditation body acceptable to NAME?

Finding: Contracted toxicology services by NMS and the State of CT Division of Scientific Services.

Phase 1 Deficiencies

None

Section F - Reports

Narrative

F.4.l Are 90% of reports of all postmortem examinations completed within 60 calendar days from the time of autopsy? Phase 1

It is remarkable the physicians in the office are able to complete 90% of the postmortem examinations within 60 calendar days from the time of autopsy. Unfortunately, the completed reports sit for days-weeks waiting to be distributed because of too few support staff.

Phase 2 Deficiencies

Standard F.5.d: (Coroner Jurisdictions) Is there a system in place so that the death certificate's conclusions and wording reflect the findings and reasoning of the autopsy surgeon?

Finding: Not coroner jurisdiction

No action needed

Recommendation: No action needed

Standard F.5.d: (Coroner Jurisdictions) Is there a system in place so that the death certificate's conclusions and wording reflect the findings and reasoning of the autopsy surgeon?

Finding: The State of Connecticut is not a coroner's jurisdiction.

No action needed.

Recommendation: No action needed.

Standard F.5.d: (Coroner Jurisdictions) Is there a system in place so that the death certificate's conclusions and wording reflect the findings and reasoning of the autopsy surgeon?

Finding: Not a coroners jurisdiction.
No action needed

Standard F.5.d: (Coroner Jurisdictions) Is there a system in place so that the death certificate's conclusions and wording reflect the findings and reasoning of the autopsy surgeon?

Finding: Not a coroner jurisdiction.

Phase 1 Deficiencies

Standard F.4.l: Are 90% of reports of all postmortem examinations completed within 60 calendar days from the time of autopsy?

Finding: No, they are not.

Section G - Personnel

Narrative

G2i and G2j - NAME standard G2i states that the medical staff be of sufficient size so that no autopsy physician is required to perform more than 250 autopsies per year. The volume of cases at the OCME (approximately 2300 autopsies/year) with the current level of six Medical Examiners (including the Chief and Deputy Chief, allowing for no time for medical administration)result in an autopsy rate of 383/Medical Examiner. The complex administration of the office merits at least a 0.8 FTE by the Chief/Deputy Chief (combined). The Chief and Deputy Chief are actively involved in the management of the office, budget analysis, as well as with leadership duties. They participate with multiple medical institutions and health care organizations to provide feedback regarding deaths of their patients and they participate with the Child Death Review Team. They currently have only a fraction of the amount of time required to adequately address process challenges, management of records and specimens, and a host of other needs of the office. It requires time to ascertain records and specimens are being appropriately managed, the QA process is thorough and a regular event, and continuing education of all of the staff is provided.

Based upon the complete year figures of 2015, for the OCME to be adequately staffed, in addition to filling the currently open position for the 7th medical examiner, it will require an additional 3 medical examiners to meet the recommendation of no more than 250 autopsies per year for autopsy physicians. If the final figures for 2016 are greater, the staffing levels should be increased to match the demand. When the medical staff is of sufficient size that no autopsy physician is required to perform more than 325 autopsies/year, although they are over the 250 autopsies per year, the result is a Phase I violation. For the OCME to achieve the recommended level of staffing, based upon the case volume of 2015 and allowing 0.8 of an FTE for administration, there must be a total of 8 medical examiners. If the final figures for 2016 are greater, the staffing levels should be increased to match the demand.

G.3.d A majority of the medical investigators who have worked in the office for over 5 years are NOT Registered Diplomats or Board Certified Fellows of the American Board of Medical Death Investigators. Although there are some ABMDI certified investigators, the chronic understaffing, budgetary constraints, and high case volume limits appropriate education and certification of these dedicated professionals. The motivation to achieve this level of certification is present; unfortunately, the resources to do so are not available. Phase 1

G.4.g Is there sufficient technical staff coverage to handle the routine daily caseload for investigations 24/7? There is not. Delays in responding to scenes and especially handling of deaths at hospitals are frequent. Phase 2

G.5.d Is there sufficient non-technical staff coverage to handle the routine daily caseload for records keeping? There is not. Stacks of records are in the office, awaiting attention, distribution, and filing. Phase 2

G.5.e Is there sufficient non-technical staff coverage to handle the routine daily caseload for data analysis? There is not. This had been handled by IT, but with only one person in IT, this is no longer appropriately handled. Phase 1

G.7.b. Is sufficient funding provided to each licensed professional employee for office approved and professionally required continuing education? There is not sufficient funding for the current professional staff. Some members are able to attend meetings, but the funding is extremely limited and considered inadequate.

Phase 2 Deficiencies

Standard G.2.i: Is the medical staff of sufficient size that no autopsy physician is required to perform more than 325 autopsies/year? (See note after G2j)

Finding: On the day of the inspection, there were six (6) full-time medical examiners (including the Chief and Deputy Chief), which is one less than what the office had at the time they submitted the checklist.

Standard G.4.g: Is there sufficient technical staff coverage to handle the routine daily caseload for investigations 24/7?

Finding: The current staffing does not allow for investigators to cover 24/7/365, and instead, an on-call system is used. By doing so, this results in a high rate of overtime when investigators are called in and a delay in response to deaths occurring in hospitals. Additional positions are pending.

Standard G.5.c: Is there sufficient non-technical staff coverage to handle the routine daily caseload for medical transcription?

Finding: No action needed

Standard G.5.c: Is there sufficient non-technical staff coverage to handle the routine daily caseload for medical transcription?

Finding: The medical transcription is performed by a contracted organization outside of the OCME. This service provides rapid turn-around-time at adequate quality.

Standard G.5.d: Is there sufficient non-technical staff coverage to handle the routine daily caseload for records keeping?

Finding: Once an autopsy report is complete, it is then the obligation of non-technical support staff to send this information to those who have requested the documents. Without adequate support by non-technical staff, this is not possible. Instead, the medical examiners complete their work and it then sits for weeks before being sent to families, compounding the problem. The Medical Examiners are working diligently to attempt to meet the 60 day requirement, are meeting the 90 day standard, only to have their reports not be provided to families, insurance companies, law enforcement for many weeks. Two full-time positions have been approved and are being recruited. Additional part-time positions are approved, as well.

Standard G.7.f: Is there a mechanism whereby the signed reports of trainees in forensic pathology are reviewed and approved in writing by a faculty pathologist?

Finding: Trainees include Pathology Assistant students and pathology residents. Trainees do not sign reports.

No action needed

Recommendation: No action needed

Standard G.7.g: Are the reports of trainees in forensic pathology who are not licensed to practice medicine in the state where they are training cosigned by a faculty pathologist?

Finding: Trainees do not sign reports.

Recommendation: No action needed

Standard G.7.h: If the office has a training program for forensic pathologists, is the program accredited by the American Council for Graduate Medical Education (ACGME)?

Finding: The office does not have a forensic pathology fellowship program.

No action needed

Recommendation: No action needed

Phase 1 Deficiencies

None

Standard G.2.j: Is the medical staff of sufficient size that no autopsy physician is required to perform more than 250 autopsies/year?

Finding: NAME recommends the medical staff be of sufficient size so that no autopsy physician is required to perform more than 250 autopsies per year. The volume of cases at the OCME (approximately 2300 , and the complex administration of the office merits at least a 0.8 FTE by the Chief/Deputy Chief (combined).

Based upon the complete year figures of 2015, for the OCME to be adequately staffed, in addition to filling the open position for the 7th medical examiner, it will require an additional 3 medical examiners to meet the recommendation of no more than 250 autopsies per year for autopsy physicians. If the final figures for 2016 are greater, the staffing levels should be increased to match the demand.

When the medical staff is of sufficient size that no autopsy physician is required to perform more than 325 autopsies/year, although they are over the 250 autopsies per year, the result is a Phase I violation. For the OCME to achieve a minimal level of staffing, based upon the case volume of 2015 and allowing 0.8 of an FTE for administration, there must be a total of 8 medical examiners. If the final figures for 2016 are greater, the staffing levels should be increased to match the demand.

Standard G.3.d: Are a majority of the medical investigators who have worked in the office for over 5 years Registered Diplomates or Board Certified Fellows of the American Board of Medical Death Investigators?

Finding: None Noted.

Standard G.4.f: Is there sufficient technical staff coverage to handle the routine daily caseload for toxicology?

Finding: The ME office uses NMS for the majority of their testing. The State Laboratory is performing toxicology on traumatic suicides and motor vehicle collision deaths. The turn-around-time for the more complex toxicology performed by NMS is many days shorter than what is provided by the State Laboratory.

Standard G.5.e: Is there sufficient non-technical staff coverage to handle the routine daily caseload for data analysis?

Finding: Only 1 IT person in the office creates a situation of putting out fires, being on call 24/7/365. Having only one IT person is not sustainable.

Standard G.7.b: Is sufficient funding provided to each licensed professional employee for office approved and professionally required continuing education?

Finding: Funding to allow the professional employees, physicians who are highly trained sub-specialists with few options within their specialty, should be provided with adequate funding to obtain CME in their chosen specialty to meet requirements imposed by the state. Not only are physicians required to obtain CME credits for licensure, many now require (MOC) to maintain their board certification.

Section H - Support

Narrative

No deficits identified by this inspector.

Phase 2 Deficiencies

None

Phase 1 Deficiencies

None

Section I - Final Summary

Narrative

As the on-site inspector, it is clear that all staff, from transporters and morgue attendants to the Chief Medical Examiner, are highly dedicated and professional individuals. Many of the staff at the OCME have been working there for decades; all seemed genuinely committed to providing a high level of care and to hearing suggestions regarding how to potentially improve their work product, to becoming more efficient, and to improving safety.

In general, the physical facility is in good working order. The areas of the building where the public would have access appear neat, clean and well-maintained. The body storage refrigerator is too small to handle the current volume, even despite recently expansion using a rack and tray storage system. The autopsy area is functional and cleaned daily, however, clearly a room that has experienced a very high volume of cases for many years. The x-ray equipment is functional, although dated, and for an office serving such a high population, although not yet required by NAME, an upgrade to a Lodox rapid scanner and/or a CT scanner would result insignificantly greater efficiency.

What needs to be of primary emphasis and focus for those who provide funding and support to the OCME is the need to meet the industry standard for medical examiner offices is critically important to those who use the information provided and to those who are providing care to the decedents. It is critical to know the results of the examinations are reliable and adequately documented. It is critical the health and safety of those caring for the decedents is protected. It is critical the information gathered be efficiently exchanged and protected. When the medical standard of care is not met, when physicians are required to perform too many procedures, when information is not shared promptly, the potential for mistakes rises. Just a few examples of mistakes that occur in Medical Examiner offices that are chronically understaffed include failure to diagnose a medical condition that may occur in other family members or children, inadequate documentation of findings that prevent exoneration of an innocent or prosecution of a perpetrator, failure to correctly identify a decedent, release and cremation of the wrong body resulting in additional emotional trauma to the family, and performing an autopsy on the wrong body. When the next-of-kin do not receive the information required following a death, life insurance benefits are delayed, answers for closure are not provided, prosecutions are delayed. Chronic understaffing also places the staff at an increased risk of injury and creates an undesirable work environment with low morale.

The Connecticut OCME is striving to meet the industry standard, however, the resources provided to do so are not being provided. Although time is limited, the leadership has found opportunities to apply for grants to attempt to supplement the funding. In some cases, the staff are stretched too thin to even make applications for additional funding. An example of this include current opportunities to obtain grant money to fund a Forensic Pathology Fellowship to train physicians to become forensic pathologists, however, the current staff does not have adequate time even to apply, much less administer a training program that would be of significant benefit to the OCME and the greater forensic pathology community. Given the level of expertise at the OCME, with personnel who are nationally recognized as leaders in their field, a training program would be a natural fit to the academic community of the OCME.

NAME accreditation "standards represent minimum standards for an adequate medicolegal system, not guidelines. NAME accreditation is an endorsement indicating that the office or system provides an adequate environment for a medical examiner in which to practice his or her profession and provides reasonable assurances that the office or system well serves its jurisdiction."

Since the OCME was notified in October of 2016 of the potential loss of full accreditation, we are encouraged to see that steps to provide some additional resources have occurred to address medical records, investigations, and refrigeration. Additional resources are needed to address the deficiencies identified. Based on this evaluation and the information available at this time, given the office has four (4) Phase 2 Deficiencies and six (6) Phase 1 Deficiencies, the Connecticut OCME should move from Full Accreditation to Provisional Accreditation for a period of twelve (12) months beginning as of the date (day and month) of the issuance of the first (original) notice of conferment of provisional accreditation status following the on-site external inspection. During this time, the OCME will have the opportunity to return to full accreditationat any time. To request a return to full accreditation, the office should make the request inwriting, accompanied by written or photographic documentation that the necessary deficiencieshave been corrected or addressed. This status conversion request package will then be sent to theChair of the SI&A Committee and the original Inspector. The Inspector will discuss the requestwith, and make a recommendation to, the Chair to approve or deny conversion to fullaccreditation status. NAME reserves the right to require an on-site follow•site follow-up inspection to verify the elimination of deficiencies at the expense of the Applicant. The Chairwill then make a determination of the accreditation status. The full Standards, Inspection andAccreditation Committee will be consulted if a difference in opinion as to appropriateaccreditation status exists between the original Inspector and the SI&A Chair. If a decision ismade to convert the office from Provisional to Full accreditation, a written report will besubmitted by the original Inspector to the NAME office detailing the original inspectiondeficiencies, the means of correction and the final remaining (if any) deficiencies. The reportwill conclude with a statement indicating that the office is to be advanced to Full Accreditationstatus.

Provisional accreditation may be extended for up to four (4) subsequent sequential twelve (12) month periods, each upon separate written application prior to the end of each twelve (12) month period and proof to the satisfaction of the Chair of the NAME Standards, Inspection and accreditation Committee that there have been and are ongoing efforts to address deficiencies that continue to foreclose full accreditation. If an office/system holding provisional accreditation status does not make written application for extension of the provisional accreditation prior to the end of any twelve (12) month period (initial period or any period of extension), the accreditation will automatically lapse. The office/system will then be non-accredited and will have to reapply for inspection for accreditation. Such application may not be made for at least six (6) months from the time non-accredited status begins (end of the provisional status period). NAME will send a written Notice of Extension of Provisional Accreditation to the office or system within five (5) working days of the approval of extension of provisional accreditation and retain a copy. The provisional accreditation period for any twelve month extension begins as of the date (day and month) of the issuance of the first (original) notice of conferment of provisional accreditation status following the on-site external inspection (first/original external inspection).