Georgia Department of Audits and Accounts
Performance Audit Division
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Why we did this review

This follow-up review was conducted to determine the extent to which conditions identified in our December 2010 Performance Audit have been addressed.

The purpose of the original audit was to determine if: there was a best practice for how to manage death investigations at the state level; Georgia's model is cost-effective; deaths meeting statutory criteria are reported; the decisions regarding acceptance of jurisdiction are consistent; cases are completed within a reasonable timeframe; and coroners and other users of the SMEO's services are satisfied.

Who we are

The Performance Audit Division was established in 1971 to conduct in-depth reviews of state programs. The purpose of our reviews is to determine if programs are meeting their goals and objectives; provide measurements of program results and effectiveness; identify other means of meeting goals; evaluate the efficiency of resource allocation; assess compliance with laws and regulations; and provide credible management information to decision-makers.

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Follow-Up Review
State Medical Examiner's Office

Some activities have been improved; additional changes are needed

What we found

The State Medical Examiner's Office (SMEO) has taken steps to address several areas identified in the original performance audit. For example, we recommended SMEO develop processes for periodically reviewing autopsies to ensure they are performed according to national and agency quality standards. At the time of the audit, the SMEO was staffed with veteran medical examiners; however, we noted that formalizing the review process would help ensure the quality of autopsies was maintained even if the office experienced turnover. During the audit, all undetermined manner of death cases, homicides, high profile cases and complicated child death cases were classified as "priority cases" and, therefore, subject to supervisory review. Since the audit, the SMEO has expanded the definition of priority cases to include the category of drug-related deaths. As a result, the number of cases now subject to review has increased. Staff estimates the percentage of cases subject to supervisory review has increased from 25% in 2009 to approximately 45-50% currently.

We also found that the SMEO was not meeting the national standard that 90% of all autopsies be completed within 90 days of receipt. Staff noted that they recently filled a vacant medical examiner position, which has improved case turnaround time. While data is not yet available to demonstrate an improvement in turnaround time, GBI indicates it will be in the future and analysis will reflect the improvement.

The audit report also recommended changes that the GBI has not acted upon. According to the Georgia Death Investigation Act, the medical examiner determines if a postmortem

examination is required. The statute defines medical examiners as the State's Chief Medical Examiner, a regional medical examiner (employed by the SMEO), a county medical examiner, or a local medical examiner. Local medical examiners are appointed by the Chief Medical Examiner, after consultation with the coroner. At the time of the audit, statute allowed any licensed physician to be appointed as a local medical examiner with the authority to conduct full autopsy procedures. Forensic pathology training was not a prerequisite for the position, as it is for county, regional and state medical examiners. Our report noted that there were physicians trained in fields such as family and internal medicine, geriatrics, and orthopedics serving as local medical examiners, which could pose a risk due to errors in determining cause of death. In its response to the follow-up review, GBI staff indicated that it does not agree that the lack of forensic pathology training presents a risk of errors in determining cause of death because it believes that local medical examiners are unlikely to conduct forensic autopsies.

In the audit, we also noted that coroners were not reporting certain deaths to the GBI, as required by law. As a result, there was no assurance that cases meeting the requirements for a medical examiner's inquiry are actually reported. GBI acknowledges that such cases may not be reported as required; however, they have not taken action to address the issue. We suggested re-establishing the statutory requirement for coroners to provide information on all deaths under their jurisdiction would allow GBI to determine if cases are reported as required. However, GBI has not made efforts to re-establish this provision.

GBI Response: *In its response to the review, GBI noted that the two recommendations that were not implemented "cannot be implemented in whole or in part without changes in the law by the Georgia General Assembly. Any proposed legislation that originates from the GBI must be submitted to and approved by the Office of The Governor. To date, the more pressing needs of the GBI have supplanted the exploration of changes to the Georgia Death Investigation Act."*

In addition, GBI indicated that "until such time as the Death Investigation Act is legislatively amended to require that coroners report all appropriate cases to the GBI Medical Examiners' Office, it is impossible to enact and enforce such a requirement. It is not possible for the GBI to independently act to implement this recommendation."

The following table summarizes the findings and recommendations in our 2010 report and actions taken by the Department to address them. A copy of the 2010 performance audit report may be accessed at http://www.audits.ga.gov/rsaAudits.

State Medical Examiner's Office Follow-Up Review, April 2013	
Original Findings/Recommendations	**Current Status**
The General Assembly should consider amending the Georgia Death Investigation Act to specify that all medical examiners be trained in pathology.	**Not Implemented:** The statute allowing any licensed physician to be appointed as a medical examiner, even without training in forensic pathology, has not been modified. It should be noted that forensic pathology training is a prerequisite for county, regional and state medical examiners; only local medical examiners are exempt from the requirement. Our report found that there were physicians trained in other medical fields, including family and internal medicine, geriatrics, and orthopedics that are serving as local medical examiners. Under the current statute, these physicians have the authority to conduct full autopsy procedures. GBI contends that physicians designated as local medical examiners are likely not actually conducting forensic autopsies. However, the authority to conduct autopsies does rest with these positions. ***GBI Response:*** *In its response, GBI indicated that the Local Medical Examiners' function is to provide assistance to a coroner. It also noted that due to the "scarcity of pathologists within Georgia, it is extremely rare that a Local Medical Examiner is actually a pathologist; additionally, the suggestion that Local Medical Examiners have some experience in Forensic Pathology is impossible to achieve. Further, it is the opinion of the GBI Medical Examiner's Office that such training is not necessary."*
Under the current system, there is no assurance that all cases that should be reported to a medical examiner for a determination of whether an autopsy is necessary are actually reported.	**Not Implemented:** During the original audit, we found that coroners were not reporting certain deaths to GBI, such as suspected suicides, which are required by law. As a result, there is no assurance that cases meeting the requirements for a medical examiner's inquiry are actually reported. Furthermore, while GBI has acknowledged that many cases are likely not reported as required, they have taken no action to address the issue, or to consider other options to ensure that cases are reported as required. Such options include lobbying for the re-establishment of the statutory provision requiring coroners to provide information on all deaths under their jurisdiction. Such a provision would allow GBI to determine if cases are reported as required. GBI has made no effort to re-establish this provision. ***GBI Response:*** *In its response, GBI reported that, until such time as the Death Investigation Act is legislatively amended to require that coroners report all appropriate cases to GBI, it is impossible to enact and enforce such a requirement.*
While the SMEO's medical examination costs are in line with other states' costs for similar functions, other states employ various methods to recover costs.	**Partially Implemented:** GBI has considered the benefits of instituting a fee-based funding model for the Medical Examiner's Office; however, they have determined that enforcement of a fee-based system would not be practical.
The SMEO's rate of timely release of autopsy reports is below the national standard of releasing 90% of the reports within 90 days of receipt of the case.	**Partially Implemented:** The SMEO indicated that they have filled a vacant medical examiner position, which has improved case turnaround time. While data is not yet available demonstrating an improvement in turnaround time, GBI indicates an analysis of a future annualized period will reflect this trend.

State Medical Examiner's Office Follow-Up Review, April 2013	
Original Findings/Recommendations	**Current Status**
The SMEO has implemented policies and procedures to ensure proper review of referred cases.	**No Recommendation**
The SMEO has policies and procedures that generally guide the work of the medical examiners; however, the SMEO should consider formalizing the review of routine cases.	**Fully Implemented:** During the original audit, only those cases classified as "priority cases" were subject to supervisory review. Priority cases were defined as all undetermined manner of death cases, homicides, high profile cases and complicated child death cases. As a result, in 2009, approximately 25% of all autopsies were subject to supervisory review. While the SMEO was staffed with veteran medical examiners, we noted that adopting processes for the review of routine cases would help ensure the quality of autopsies was maintained, even if the office experienced turnover. Since the audit, GBI has added the broad category of "drug-related" deaths to the "priority cases" that are subject to supervisory review. By doing so, GBI estimates it has increased the percentage of cases subject to supervisory review from 25% in 2009 to approximately 45-50% currently.
5 Recommendations	**Fully Implemented: 1** **Partially Implemented: 2** **Not Implemented: 2**

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