GOVERNMENT OF THE DISTRICT OF COLUMBIA

THE OFFICE OF THE CHIEF MEDICAL EXAMINER

2014 ANNUAL REPORT

Roger A. Mitchell, Jr., MD – Chief Medical Examiner
Office of the Chief Medical Examiner

DISTRICT OF COLUMBIA
OFFICE OF THE CHIEF MEDICAL EXAMINER

MISSION:

The mission of the Office of the Chief Medical Examiner (OCME), for the District of Columbia, is to investigate all deaths in the District of Columbia that occur by any means of violence (injury), and those that occur without explanation or medical attention, in custody, or which pose a threat to the public health. OCME provides forensic services to government agencies, health care providers and citizens in the Washington D.C. metropolitan area to ensure that justice is served and to improve the health and safety of the public.

Executive Management

(2014)

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PRESENTED TO:

The Executive Office of the Mayor,
The Council of the District of Columbia
and
The Citizens of the District of Columbia

A MESSAGE FROM THE CHIEF MEDICAL EXAMINER

Greetings,

The Office of the Chief Medical Examiner (OCME) was established in 1971. The system began as coroner system in the early 1870s and existed as such for 100 years before becoming a medical examiner system. The OCME is now positioned to become one of the premier Medical Examiner Systems in the nation. This year marks my formal appointment as the Chief Medical Examiner of the District of Columbia. It is with great honor that I accepted this appointment prepared to lead the agency toward quality death investigation and certification.

During 2014, we set forth a vision that incorporates objectives and initiatives that will serve as the foundation of the agency's long-term strategic planning The vision includes a focus on violence prevention, fatality management, public health and safety surveillance and establishment of a data fusion center, grants management, and academic enrichment.

The District of Columbia experienced an increase in homicides, suicides, and overdoses during the year. With 71 employees and a budget of nearly 10 million dollars in 2014, we investigated nearly 5,139 deaths and performed 1120 post-mortem examinations, including 107 homicides. In addition to its day to day activities, we also worked towards obtaining accreditation from the National Association of Medical Examiners (NAME). Further, the OCME focused its efforts on building infrastructure in preparation for a mass fatality incident. The agency hired a Mass Fatality Coordinator with responsibility for ensuring that necessary emergency response and fatality management resources, training, staffing, and planning efforts are properly in place.

Key accomplishments during the year include:

- Recruitment efforts resulted in critical additions to a highly experienced and educated staff, including a Deputy Chief Medical Examiner, Forensic Anthropologist, Forensic Toxicologists and a Forensic Photographer.

- An agency needs assessment was completed which entailed gap identification and development of recommendations for improvement, as well as long and short term goals.

- As part of its accreditation efforts, the agency underwent a self-inspection of its facility and operations based on the NAME accreditation inspection checklist guidelines.

- The agency expanded its current identification unit to an Anthropology and Identification Unit to include an Anthropology Laboratory. The Unit, supervised by a Forensic

Anthropologist, will administer the agency's Decedent Identification Program and public disposition process of the agency.

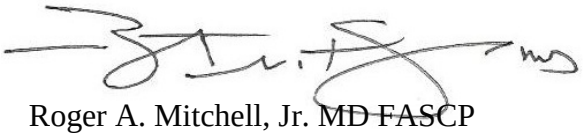
- The Department of Health's HEPRA provided a subgrant to the agency for the purchase of four mobile body storage units in preparation of surge capacity in a mass fatality management incident.

- The Fatality Review Division revised existing Standard Operating Protocols and Procedures applicable to the Child Fatality Review Committee.

Our mission is to serve the families, residents, and visitors of our nation's capital at a time when they are most vulnerable and grief stricken. The OCME operates 24 hours a day, 7 days a week, 365 days a year. Whether a gunshot wound homicide, a hanging suicide, a slip and fall of the elderly, or a sudden unexpected death in infancy, we are here to serve.

We are excited about the future of this organization and look forward to providing medically and scientifically sound investigations, analysis, and expert witness testimony.

In Truth and Service,



Roger A. Mitchell, Jr. ~~MD FASCP~~
Chief Medical Examiner

Executive Summary

This Annual Report covers data that resulted from the investigation of 3,063 deaths that occurred in the District of Columbia during the Calendar Year (CY) 2014. The report also presents key agency accomplishments and other major activities such as Expert testimony by the Medical Examiners, Decedents Identification, Disposition of Unclaimed Remains; Toxicological results in Driving Under the Influence (DUI), Drug Facilitated Sexual Assault (DFSA) cases and educational endeavors of all OCME units. The agency hopes that the information contained in the report will be useful to the Executive Office of the Mayor and the Council of the DC and be informative to the public at large.

The OCME serves the citizens of the District of Columbia and the Metropolitan D.C. area in their most difficult moments by providing timely removal of decedents from homes and public areas; thorough death investigation; prompt provision of death certificates and proofs of death to family members allowing for rapid funeral arrangements and access to insurance and other death benefits. The agency provides services to the public seven days per week during core business hours. However, deaths are reported to the agency and the agency responds to and investigates these reported deaths 24 hours a day, 7 days a week, which includes weekends and holidays. Autopsies are performed everyday of the year as well, and on occasion it is necessary for the Medical Examiner to perform them at night.

The Office of the Chief Medical Examiner has a dual role; Public Safety and Public Health.

As a Public Safety agency, the OCME conducts death investigations in an independent manner and without bias. The agency's involvement with a mandatory reported death starts with the death notification and continues through the possible provision of expert testimony in legal proceedings. The agency strives toward quickly responding to death scenes, allowing non-investigating police personnel to return to regular duty. At the death scenes, the OCME takes custody of the body and secures all evidentiary material associated with the body. OCME investigators, Forensic and Medicolegal, work cooperatively with the MPD to gather information useful to the interpretation of the circumstances of the death. When feasible, the OCME investigators will also ensure identification of the deceased by family members present at the scenes of death. In addition, the Medicolegal Investigators pronounce death at the scene or at the agency, as this function is reserved to specific professionals as specified in the DC Code.

Under the District Response Plan (DRP), the OCME is responsible for coordination of mass fatality efforts and is a support agency to several Emergency Support Functions (ESF's), including ESF's 4, 8, 9, 10 and 13. A unified approach is required as OCME works with law enforcement, firefighters, emergency management staff and public health officials for investigation of scenes, which may include remains, in an emergency incident. As such, OCME staff must report to such scenes during inclement weather, pandemic disasters or terrorism/emergency response events. Examples include OCME's response during: 1) the 2011 Metrorail incident in which staff was deployed for hours, alongside law enforcement officers, firefighters and emergency management personnel, in order to recover remains, conduct death scene investigation and allow for prompt autopsies and release of loved ones remains to the families; and 2) the 2014 Navy Yard Active Shooter incident in which staff was again deployed for hours, alongside law enforcement officers, in order to recover remains, conduct scene investigation and allow for prompt autopsies, so that decedents could be released to their loved ones as prompt as possible.

As a Public Health agency, the OCME is well suited to provide information on the state of health of the residents of the District of Columbia and recognize and alert appropriate officials of deaths that may present an immediate threat to its population. The agency provides the US Consumer Product Safety Commission with information regarding defects in equipment, machines, devices or products that are responsible for a death. Information on deaths related to hypo/hyperthermia and deaths of homeless individuals are immediately communicated to appropriate officials so corrective and/or preventative action can be promptly instituted.

Accomplishments in 2014

Human Resources

- Recruitment efforts resulted in critical additions to a highly experienced and educated staff, including a Deputy Chief Medical Examiner, Forensic Anthropologist, Forensic Toxicologists and a Forensic Photographer.

Accreditation Preparation

- An agency needs assessment was completed which entailed gap identification and development of recommendations for improvement, as well as long and short term goals.

- As part of its accreditation efforts, the agency underwent a self-inspection of its facility and operations based on the NAME accreditation inspection checklist guidelines.

Operational

- The agency expanded its current identification unit to an Anthropology and Identification Unit to include an Anthropology Laboratory. The Unit, supervised by a Forensic Anthropologist, will administer the agency's Decedent Identification Program and public disposition process of the agency.

- The Department of Health's HEPRA provided a sub-grant to the agency for the purchase of four mobile body storage units in preparation of surge capacity in a mass fatality management incident.

- The Fatality Review Division revised existing Standard Operating Protocols and Procedures applicable to the Child Fatality Review Committee.

OVERVIEW OF CASES REPORTED AND INVESTIGATED

During the Calendar Year (CY) 2014, **3,063** cases were reported to and investigated by the District of Columbia - Office of the Chief Medical Examiner (DC OCME). Overall, the number of deaths reported to the DC OCME has remained relatively consistent over the past five years, with approximately 37% of the total deaths reported being accepted cases.

Medical Examiner Caseload

Accepted Cases - The OCME accepted jurisdiction of **1,120** decedent cases, of which 736 cases were autopsied.

Declined Cases - The OCME declined jurisdiction of **1,812** decedent cases, of which 65 became Storage Requests.

Storage Requests - The D.C. OCME provides a unique service to area nursing homes, hospices, and other like facilities by accommodating requests to store deceased bodies. **Sixty-seven** of the reported cases were Storage Requests only, and **Sixty-five** of the storage requests were previously "Declined" cases, so as a result; the agency had a total of 132 Storage Requests, of which **125** were approved (See section 4.0 for additional statistics).Cremation Requests: OCME reviewed a total of **2,634** Cremation requests (See section 4.0 for details).

Cremation Requests: The D.C. OCME must review all cremations for deaths that occur in the District of Columbia. There were **2,634** Cremation requests made to the DC OCME in 2014; 559 were OCME cases, 2,075 were *"New Reports"* submitted from area hospitals, clinics and nursing homes, the OCME took jurisdiction of 6 of these *"New Reports*" for further investigation and certification. (See section 5.0 for details).

Scene Visits - OCME investigation staff reported to **712** scenes.

Body Transport - The OCME transported the bodies of **1,222** decedents from scenes of death to the agency.

Organ/Tissue Donations - There were **131** organ donation requests during CY 2014.

The following table illustrates the number of autopsy examinations, external examinations, medical record reviews and partial autopsy examinations performed by "Manner of Death".

2014 Medical Examiner Cases by Manner of Death

Manner	Full Autopsy Examinations	Partial Autopsy Examinations	External Examinations	Review of Medical Records	Non-Human	Anatomical Specimen Disposal	Total
Accident	193	0	95	14	0	0	**302**
Homicide	107	0	0	0	0	0	**107**
Natural	326	8	255	2	0	0	**591**
Stillbirth	1	0	1	0	0	0	**2**
Suicide	66	0	3	0	0	0	**69**
Undetermined	34	0	0	0	0	0	**34**
Other	0	0	0	0	14	1	**15**
Total	**727**	**8**	**354**	**16**	**14**	**1**	**1120**

SUMMARY OF FINDINGS FOR MANNER OF DEATH

HOMICIDES: The OCME investigated 107 Homicides in the CY 2014. This report reveals that homicides continued to be more prevalent in black males and in persons between the ages of 20-29 than any other category. The weapon of choice was firearms. The peak incidents occurred in **June, October and December**.

Toxicology Findings: Toxicology testing was requested on all 107 Homicide cases investigated. Drugs were present in 85 of the homicide cases investigated. The most commonly detected drugs in homicide cases were: Marijuana Metabolites (38); Ethanol (27); Cocaine and metabolites (11); PCP (9); Oxycodone (4) and Morphine (3).

SUICIDES: The OCME investigated 69 suicides in the CY 2014. This report reveals that suicides were more prevalent in white males and in persons between the ages of 20-29. Overall whites represented 61% of the decedents (N=41) this year. Peak incidents occurred in April and June.
Toxicology Findings: Toxicology testing was requested for 68 of 69 Suicide cases investigated. Overall, drugs were present in 40 of the suicide cases investigated. The most commonly detected drugs were: Ethanol (10); Benzodiazepines (8); Diphenhydramine (5); Morphine (4) and Fentanyl (3).

ACCIDENTS: The OCME investigated 302 accidents in the CY 2014. Of the 302 cases investigated, 152 were the result of blunt force trauma, of which 48 were traffic-related deaths and 101 were directly related to falls. Also, 116 of the accidental deaths occurred as a direct result of prescription and/or illicit drug use. Peak incidents for accidental deaths overall occurred in July.
*Toxicology Findings for Accidents***:** Toxicology testing was requested for 198 of the 302 Accident cases investigated, and drugs were present in 177 of these cases. The most commonly detected drugs were: Morphine (68)/Heroin (49); Ethanol (60); Cocaine and Metabolites (53); Oxycodone (19); Marijuana Metabolites (18); Methadone (15), Phencyclidine (11) and Fentanyl (10).
Traffic-related Accidents: The majority of traffic accident deaths occurred in the following categories: males, blacks, and drivers between the ages of 40-49. Peak incidents for traffic accidents only occurred in May.
Toxicology Findings for Traffic-related accidents: Toxicology testing was requested for 40 of the 48 Traffic-related Accidents, and drugs were present in 30 of these cases. The most commonly detected drugs were: Ethanol (11); Marijuana Metabolite (7); Morphine (2); Cocaine and Metabolites (2) and Phencyclidine (PCP) (1).

In the 11 traffic deaths positive for ethanol, 10 were greater than the legal limit (0.08 g/100 mL) for driving under the influence in the District of Columbia.

NATURAL DEATHS: The OCME investigated 591 Natural deaths in CY 2014. This report reveals that the leading cause of death in Natural cases is Cardiovascular Disease with 386 deaths, followed by Pulmonary Embolism with 28 deaths. The majority of Natural deaths occurred in March for 2014.
Toxicology Findings: No toxicology reporting for natural deaths is being provided for 2014.

UNDETERMINED: The OCME investigated 34 cases where the manner of death was concluded to be "Undetermined." An "Undetermined" manner of death is a result of inconclusive evidence as to the circumstances of the death at the time and/or inconclusive examination results. As additional information is received, the death may be appropriately re-certified. Note: Sudden Unexpected Deaths in Infancy (SUID) carry an "Undetermined" manner of death.
Toxicology Findings: Toxicology testing was requested for all 34 Undetermined deaths investigated. Drugs were present in 16 of the Undetermined cases investigated. The most commonly detected drugs were: Ethanol (8); Morphine (5); Diphenhydramine (3); Fentanyl (2); Marijuana (2) and Acetaminophen (1).

STILLBIRTHS: The OCME investigated 2 Stillbirth deaths in CY 2014.
Toxicology Findings: No toxicology findings are being reported for stillbirth deaths in this annual report.

SUMMARY OF APPENDICES

Also included in this year's report are the following Appendices:

A. 2014 OCME Organizational chart
B. Agency Management Updates: Which includes updates on personnel management, contracting and procurement, and Information Technology
C. Program Legislation
D. Internal Partnerships
E. Glossary

OFFICE OF THE CHIEF MEDICAL EXAMINER

2014 Annual Report

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APPENDIXES:

1.0 - INTRODUCTION

The Office of the Chief Medical Examiner (OCME) is required by DC Code §5-1412 to produce an annual report that provides statistical data summarizing the results of investigations conducted by the OCME during a calendar year. This information is a reflection of the status of health of the District of Columbia residents, the level and types of violence to which the population is subjected, the prevalence of drug use and its association with homicides and/or traffic accidents. The Executive Office of the Mayor, the Office of the City Administrator, the Office of the Deputy Mayor for Public Safety and Justice, the Department of Health (DOH), the D.C. Office of the Attorney General, the United States Attorney's Office, the Public Defender Service and other entities can use the data for research purposes and for the development of preventative and corrective policies.

In 2014, the agency had three primary programs: Death Investigation and Certification, Agency Management, and Fatality Review. This report will include data on the Death Investigation and Certification, and the Agency Management programs. The Fatality Review Committees are statutorily required to issue their own Annual Reports.

The OCME investigates the following types of human death occurring in the District of Columbia: 1) violent death, whether apparently homicidal, suicidal or accidental, including deaths due to thermal, chemical, electrical or radiation injury and deaths due to criminal abortion; 2) deaths that are sudden, unexpected or unexplained; 3) deaths that occur under suspicious circumstances; 4) deaths of persons whose bodies are to be cremated, dissected or buried at sea: 5) deaths at the workplace or resulting from work activity; 6) deaths that are due to diseases that may constitute a threat to public health; 7) deaths of persons who are Wards of the District government; 8) deaths related to medical or surgical intervention; 9) deaths that occur while persons are in the legal custody of the District; 10) fetal deaths related to maternal trauma or maternal drug use; 11) deaths for which the Metropolitan Police Department (MPD), or other law enforcement agency, or the United States Attorney's Office requests, or a court ordered investigation; and 12) dead bodies brought within the District without proper medical certification. (See Appendix C – (D.C. Law 13-172), DC Official Code §5-1401 et seq. (2001)).

All deaths under the jurisdiction of the OCME, as outlined above, are investigated irrespective of the location of the primary causative incident. The Chief Medical Examiner, based on the evaluation of the circumstances surrounding the death, determines the type of investigation to be performed, i.e. autopsy or external examination. This decision is not restricted by family preference or religious beliefs. The OCME Medico Legal Investigators, Forensic Investigators and the Detectives of MPD's Natural Squad in the Homicide and Traffic Divisions provide information related to the circumstances of the deaths. The autopsy examination helps answer questions as to time of death, pattern and/or sequence of injuries, and the effect of natural disease on the certification of cause and manner of death. Injury findings identified at the time of the autopsy may be used to support or refute witness statements and/or uncover completely unsuspected diagnosis of disease or injury. The OCME works in close relationship with neighboring jurisdictions and often provides expert testimony when called upon to do so. Toxicological examinations assist in the determination of the cause and manner of death, and are performed on most cases autopsied depending upon the c circumstances of death. Typical examinations conducted by the laboratory provide information on the presence and amount of alcohol, volatiles, illegal drugs, and some commonly used prescription and non-prescription medications. Other expert consultations (e.g. neuropathology and cardiovascular pathology) are requested when appropriate.

The Fatality Review Program includes the Child Fatality Review Committee (CFRC), the Developmental Disabilities Fatality Review Committee (DD FRC) and the Domestic Violence Fatality Review Board (DVFRB). These committees examine causes and circumstances associated with deaths in their respective populations, evaluate issues associated with services provided and make relevant recommendations that address systemic issues related to services that the District of Columbia provides to the constituents of these vulnerable populations. Each review committee produces an annual report that summarizes relevant findings and recommendations issued as well as government agency responses to the recommendations.

In addition to its routine caseload, the office offers temporary storage of bodies for all area hospices and local hospitals in the District of Columbia when disposition cannot be obtained by next-of-kin. The OCME has a total body storage capacity of 206. Dispositions of remains by the OCME will occur when the decedent is not identified or is identified but unclaimed. All efforts are made toward identification of the deceased before disposition. To achieve this goal, the OCME has not only trained its technical staff to fingerprint decedents, but also works cooperatively with the Department of Forensic Sciences, Mobile Crime unit of MPD and the Federal Bureau of Investigation (FBI). In addition, OCME uses comparative radiology and/or DNA analysis as necessary to ensure proper and timely identification. The OCME also procures specimens for DNA analysis on each decedent processed.

OCME is one of the few medical examiner offices in the nation that provides on-site grief counseling. This service was provided through a contractual agreement with the Wendt Center for Loss and Healing.

In preparation for possible terrorist attacks and mass disaster, OCME has developed alliances with area hospitals and with agencies in the Public Safety and Justice cluster with a goal to integrate its Mass Fatality Plan with the District's Disaster Response Plan. To practically accomplish this goal the agency's staff participates in local and federal exercises to determine scenarios not considered, additional resources that may be necessary, and policies and procedures that must be established.

Through the years, OCME staff has and continues to be very active in social programs such as Career Day at District of Columbia public and public charter schools, the Mayor's Summer Youth Employment Program and the D.C. One Fund.

In the area of education, OCME provides academic training of medical students, pathology residents from local hospitals, and students from national and international universities enrolled in diverse scientific disciplines such as: physician assistance, forensic science, toxicology, and mortuary sciences. The OCME professional staff teaches the Forensic Pathology and Medical Investigation sections of the GWU Graduate Program in Forensic Sciences. The OCME also provided training for members of MPD and various law enforcement entities including the United States Attorney's office and the soldiers of the Marine Corps.

2.0 - ME INVESTIGATIONS AND MEDICAL LEGAL AUTOPSIES

Overview of Cases Reported and Investigated

During the Calendar Year (CY) 2014, there were **5,495** deaths that occurred in the District of Columbia as reported by the Center for Policy, Planning and Evaluation for the District of Columbia, of which **3,063 or 56%** of these deaths were reported to and investigated by the Office of the Chief Medical Examiner (OCME). The following is a breakdown of where jurisdiction was "Accepted", "Declined" or where Storage was requested of the Medical Examiner. **The data presented within this report represents deaths occurring exclusively within the District of Columbia for which the Office of the Chief Medical Examiner has jurisdiction. The data does not represent all deaths of DC residents. The decedent's place of residence or location of injury may be outside of the District (See page 6).**

Accepted Cases - The OCME accepted jurisdiction of **1,120** decedent cases, of which 735 cases were autopsied.
Declined Cases - The OCME declined jurisdiction of **1,812** decedent cases, of which 65 became Storage Requests.
Storage Requests - The D.C. OCME provides a unique service to area nursing homes, hospices, and other like facilities by accommodating requests to store deceased bodies. **Sixty-seven** of the reported cases were Storage Requests only, and **Sixty-five** of the storage requests were previously "Declined" cases, so as a result; the agency had a total of 132 Storage Requests, of which **125** were approved (See section 5.0 for additional statistics).
Cremation Requests: The D.C. OCME must review all cremations for deaths that occur in the District of Columbia. There were **2,634** Cremation requests made to the DC OCME in 2014; 559 were OCME cases, 2,075 were *"New Reports"* submitted from area hospitals, clinics and nursing homes, the OCME took jurisdiction of 6 of these *"New Reports"* for further investigation and certification. (See section 5.0 for details).

Total Number of Cases Reported and Investigated by the OCME	**3063**
Total Number of Declined Cases	**1812**
Percent of Cases Reported & Investigated	*59%*
Total Number of Cases Accepted for Further Investigation	**1120**
Percent of Cases Reported & Investigated	*37%*
Total Number of Autopsies *Full – 725; Partial – 8; Performed in a University Hospital – 2*	**735**
Percent of Cases Accepted for Further Investigation	*66%*
Number of Scene Visits by a Medical Examiner or Medico Legal/Forensic Investigator	**712**
Percent of Cases Accepted for Further Investigation	*62%*
Total Number of Bodies/Cases Transported by OCME or by Order of the OCME: *Transported by Pick-up Service -1161* *Transported by Funeral Home -9* *Transported by Office Personnel –48* *(Investigations:14; Mortuary*: 33; *Medical Examiner: 1)*	**1218**
Total Number of Organ/Tissue Donation Requests: *(See Section 3 for breakdown)*	**131**

Breakdown of Accepted Cases by Exam Type

Total Number of Cases Accepted and Investigated Further	**1,120**
Total Number of Autopsies *Full – 725* *Partial –8* *Performed at a University Hospital – 2*	**735**
Percent of Cases Accepted	*66%*
Number of External Examinations *On-site -353* *Off-site - 1*	**354**
Percent of Cases Accepted	*32%*
Number of Medical Record Reviews *	**16**
Percent of Cases Accepted	*1%*
Number of Non-Human Remains *	**14**
Percent of Cases Accepted	*1%*
Number of Anatomical Specimen Disposal	**1**
Percent of Cases Accepted	*0%*
Number of Exhumations/Disinterment	**0**
Percent of Cases Accepted	*0%*

Definition of Unfamiliar Exam Type Classifications:

- **Autopsy Performed at a University Hospital:** During Calendar Year 2014 there were 2 cases where the autopsy was performed at a University hospital. The DC Code § 5-1409 authorizes the Chief Medical Examiner to deputize any "qualified pathologist" to perform an autopsy on a decedent that is deemed a Medical Examiner case. Some of these cases were initially declined by the OCME and later accepted based on additional information/autopsy findings. Cases in which the autopsy was completed at the hospital, still required review of the autopsy reports and completion of the death certificates be done by the Medical Examiner.

- **Medical Record Reviews**: Cases where the body is not available for examination and the investigation and determination of cause and manner of death are based solely on the review of available medical records.

- **Non-Human Remains**: Cases that are commonly identified as animal remains.

- **Anatomical Specimen Disposal:** Cases that are identified as those specimens received in formalin.

- **Exhumations/Disinterment:** Cases where the remains were unearthed from a burial site.

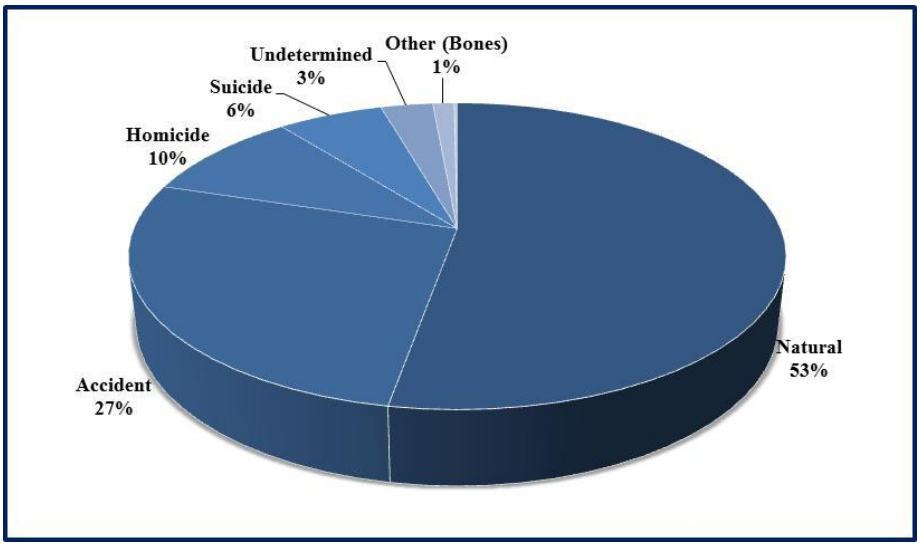
Breakdown of Accepted Cases and Autopsies by Month

Month	Case Investigations	Autopsies Full and Partials
January	92	68
February	86	57
March	100	65
April	85	60
May	102	55
June	103	72
July	95	65
August	91	60
September	93	67
October	90	60
November	82	50
December	101	56
Total	**1120**	**735**

Medical Examiner Case Examinations by Manner of Death

Manner	Full Autopsy Examinations	Partial Autopsy Examinations	External Examinations	Review of Medical Records	Non-Human	Anatomical Specimen Disposal	Total
Accident	193	0	95	14	0	0	**302**
Homicide	107	0	0	0	0	0	**107**
Natural	326	8	255	2	0	0	**591**
Stillbirth	1	0	1	0	0	0	**2**
Suicide	66	0	3	0	0	0	**69**
Undetermined	34	0	0	0	0	0	**34**
Other	0	0	0	0	14	1	**15**
Total	**727**	**8**	**354**	**16**	**14**	**1**	**1120**

Pie Chart - Medical Examiner Cases by Manner of Death



Breakdown of Accepted Cases by Residence of Decedents

By law the Medical Examiner (ME) must accept all traumatic, unwitnessed or suspicious deaths that occur in the District of Columbia (DC). As a result, residence of these decedents can be anywhere in the world. Nonetheless, the majority of the cases accepted by the DC Office of the Chief Medical Examiner were decedents that reside or were injured in DC, Maryland or Virginia. The breakdown by decedent residence is found below. Just as important, Medical Examiner cases accepted by the DC OCME do not represent all the suspicious or non-natural fatalities of District residents, who may have died in another state or country.

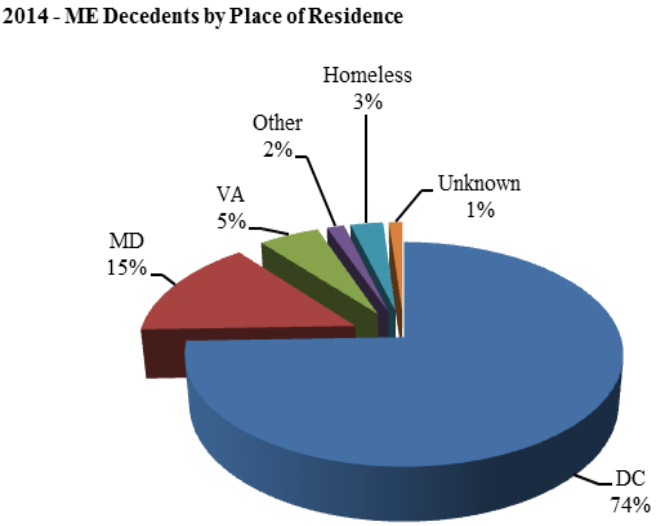


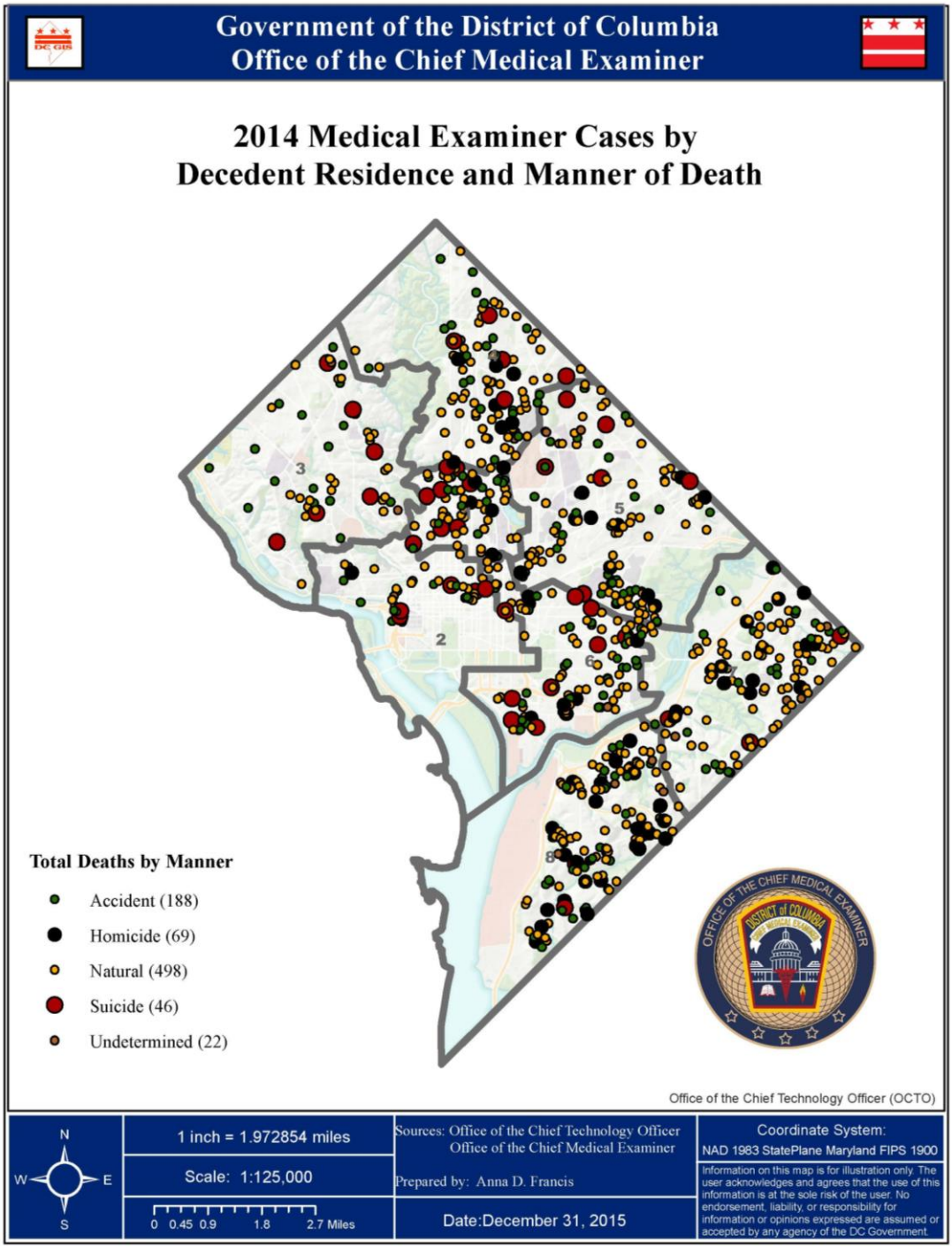
Table: Medical Examiner cases by Residence and Manner of Death

DC Deaths by Jurisdiction of Residence and Manner of Death							
Ward	**# of Deaths**	**Accidents**	**Homicides**	**Natural**	**Stillbirth**	**Suicide**	**Undetermined**
Ward 1	74	15	5	46	0	7	1
Ward 2	52	13	1	29	0	6	3
Ward 3	62	21	0	32	0	7	2
Ward 4	103	26	7	64	0	5	1
Ward 5	140	31	10	89	0	7	3
Ward 6	109	25	7	65	0	9	3
Ward 7	133	26	14	86	0	3	4
Ward 8	150	31	25	87	0	2	5
DC	**823**	**188**	**69**	**498**	**0**	**46**	**22**
MD	**161**	67	25	51	1	11	6
VA	**59**	30	5	10	0	11	3
Other	**17**	6	1	8	0	1	1
Unknown	**13**	5	6	1	1	0	0
Homeless	**32**	6	1	23	0	0	2
Total	**1105**	**302**	**107**	**591**	**2**	**69**	**34**

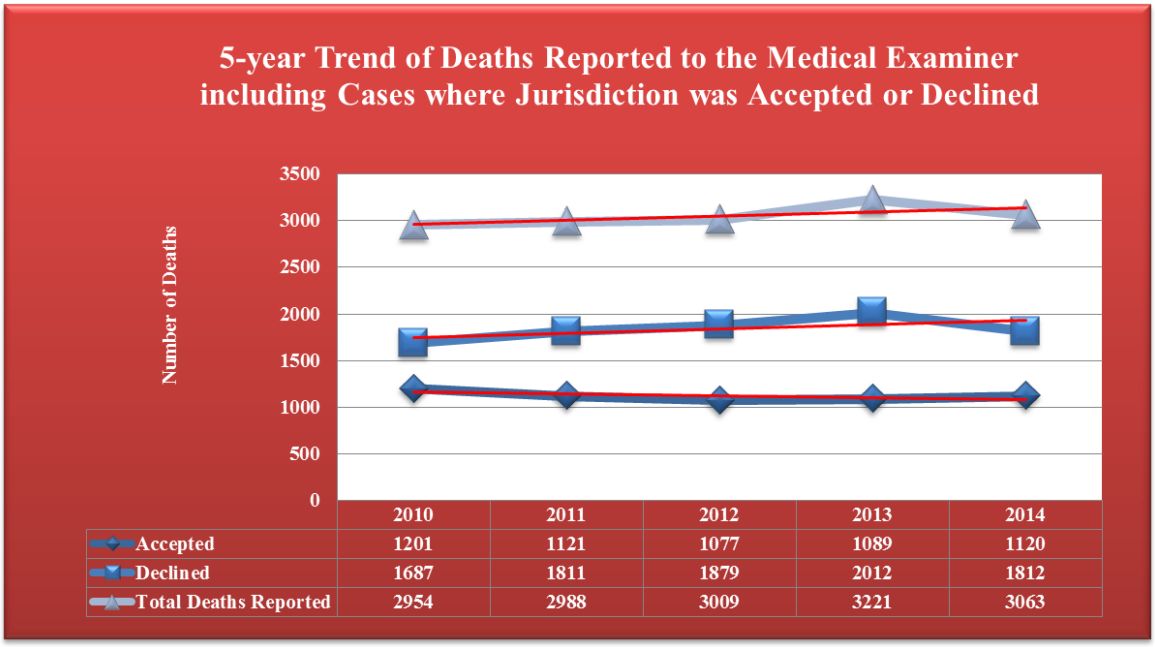
Note: The above table does not include Non-Human Remains (14) or the Anatomical Specimen Disposal (1).

Map of OCME Decedents by DC Ward and Manner of Death

Of the 1,105 decedent deaths investigated by the OCME, 823 (74%) were District of Columbia (DC) residents at the time of their death. The map below illustrates the deaths by DC ward and manner of death.



Five-year Overview of Deaths Reported to the Medical Examiner (2010– 2014)



	2010	2011	2012	2013	2014
Accepted	1201	1121	1077	1089	1120
Declined	1687	1811	1879	2012	1812
Total Deaths Reported	2954	2988	3009	3221	3063

Note: All accepted cases and all declined cases will not equal Total Deaths Reported, because there are other types of cases "Death Reports" not included in this illustration.

Postmortem Toxicology Summary 2014

All postmortem specimens received for routine toxicological testing were analyzed for alcohols (ethanol and other volatiles) and major classes of illicit and prescription medications. Additional screens were assigned depending on intake case history and special requests made by physicians. All significant drug results were confirmed by further testing. Typical case specimens received include blood, urine, bile, vitreous, liver, brain, and gastric contents. In 2014, of the 1,105 accepted Medical Examiner cases the laboratory received and inventoried 7,335 postmortem specimens (739 cases) yielding 1,899 reported results.

A negative case refers to the absence of any alcohol or detectable drug. A positive case refers to the presence of alcohol and/or drug(s), noting that a case can be positive for more than one substance. The alcohol and/or drugs detected do not necessarily cause or contribute to death. Drugs that are excluded from statistics include common compounds found in routine casework such as: lidocaine, caffeine, and nicotine. These compounds are not quantitated unless they contributed to the death or were detected in a significant concentration.

Total number of postmortem cases analyzed:

Description	Number of Cases	% of Cases
***N*=**	739	
Negative	170	23.0 %
Positive	544	73.6 %

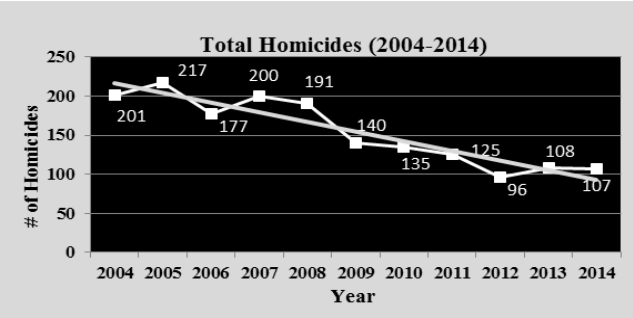
Postmortem Toxicology - Most Commonly Detected Drugs

The most commonly detected drugs in the postmortem cases overall were:

Drug Name	Number of Cases	% of Cases
Ethanol	171	23.1%
Morphine/Heroin	95/52	12.8%/7.0%
Marijuana Metabolites	91	12.3%
Cocaine and Metabolites	72	9.7%
Oxycodone	43	5.8%
Diphenhydramine	34	4.6%
Alprazolam	30	4.0%
Methadone	28	3.7%
Phencyclidine	28	3.7%
Fentanyl	23	3.1%
Nordiazepam	21	2.8%
Diazepam	20	2.7%
Temazepam	18	2.4%
Oxymorphone	17	2.3%
Sertraline	16	2.1%
Hydromorphone	16	2.1%
Zolpidem	16	2.1%

2.1 - Homicides

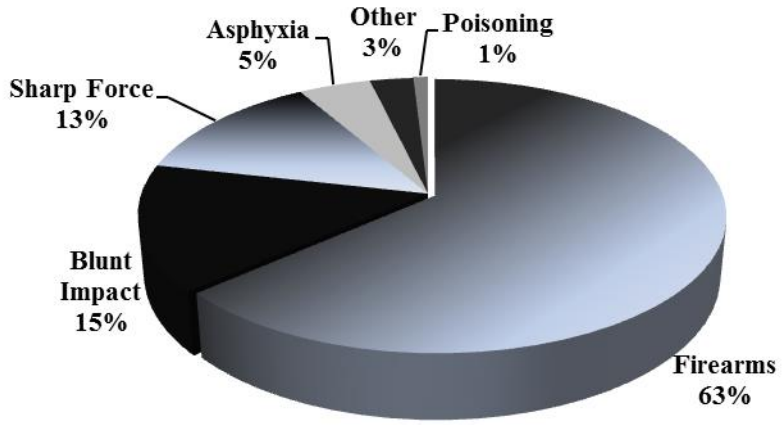
The OCME investigated **107** homicides in the CY 2014. The following tables and graphs provide a distribution by cause of death, month, race, gender and age group. Death by homicidal acts is more prevalent in black males and in the age group 20 to 29 years than any other group presented. The weapon of choice is firearms. In 2014 there were more homicides observed in **June, October and December** than any other months.



Homicides by Cause of Death

Cause	Number of Homicides	% of Total Homicides
Firearms	68	63.55%
Blunt Impact	16	14.95%
Sharp Force	14	13.08
Asphyxia	5	4.67%
Other	3	2.80%
Poisoning	1	0.93%
Total	**107**	**100%**

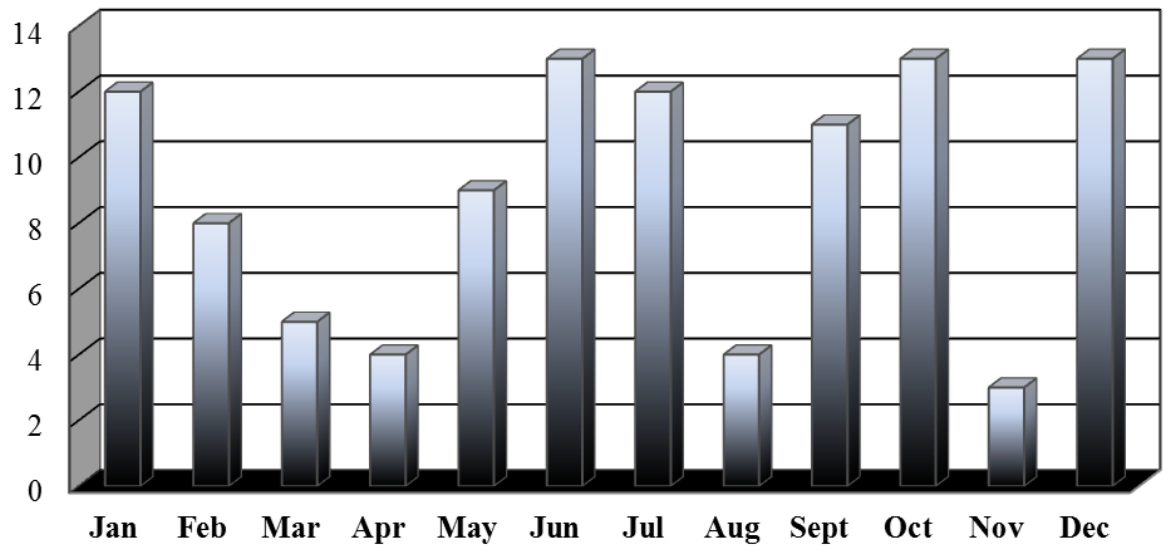
Pie Chart – Homicides by Cause of Death



Homicides by Month

Month	Number of Homicides	% of Homicides
January	12	11.21%
February	8	7.48%
March	5	4.67%
April	4	3.74%
May	9	8.41%
June	**13**	**12.15%**
July	12	11.21%
August	4	3.74%
September	11	10.28%
October	**13**	**12.15%**
November	3	2.80%
December	**13**	**12.15%**
Total	**107**	100.00%

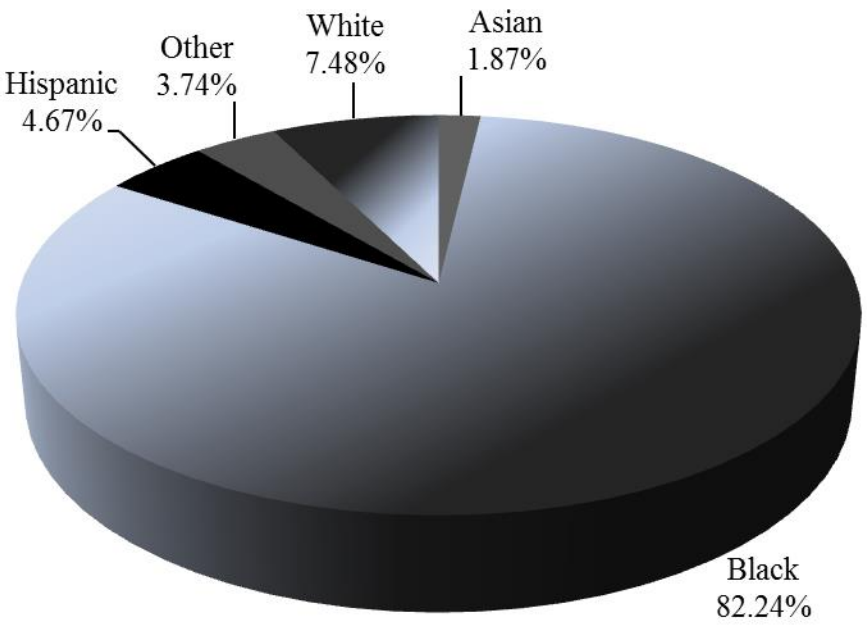
Graph - Homicides by Month



Homicides by Race

Race/Ethnicity	Number of Homicides	% of Homicides
Black	88	82.24%
White	8	7.48%
Hispanic	5	4.67%
Other	4	3.74%
Asian	2	1.87%
Total	**107**	**100%**

Chart – Percentage of Homicides by Race



Homicides by Gender

Gender	Number of Homicides	% of Homicides
Female	21	19.63%
Male	86	80.37%
Total	**107**	**100%**

Homicides by Race/Ethnicity and Gender

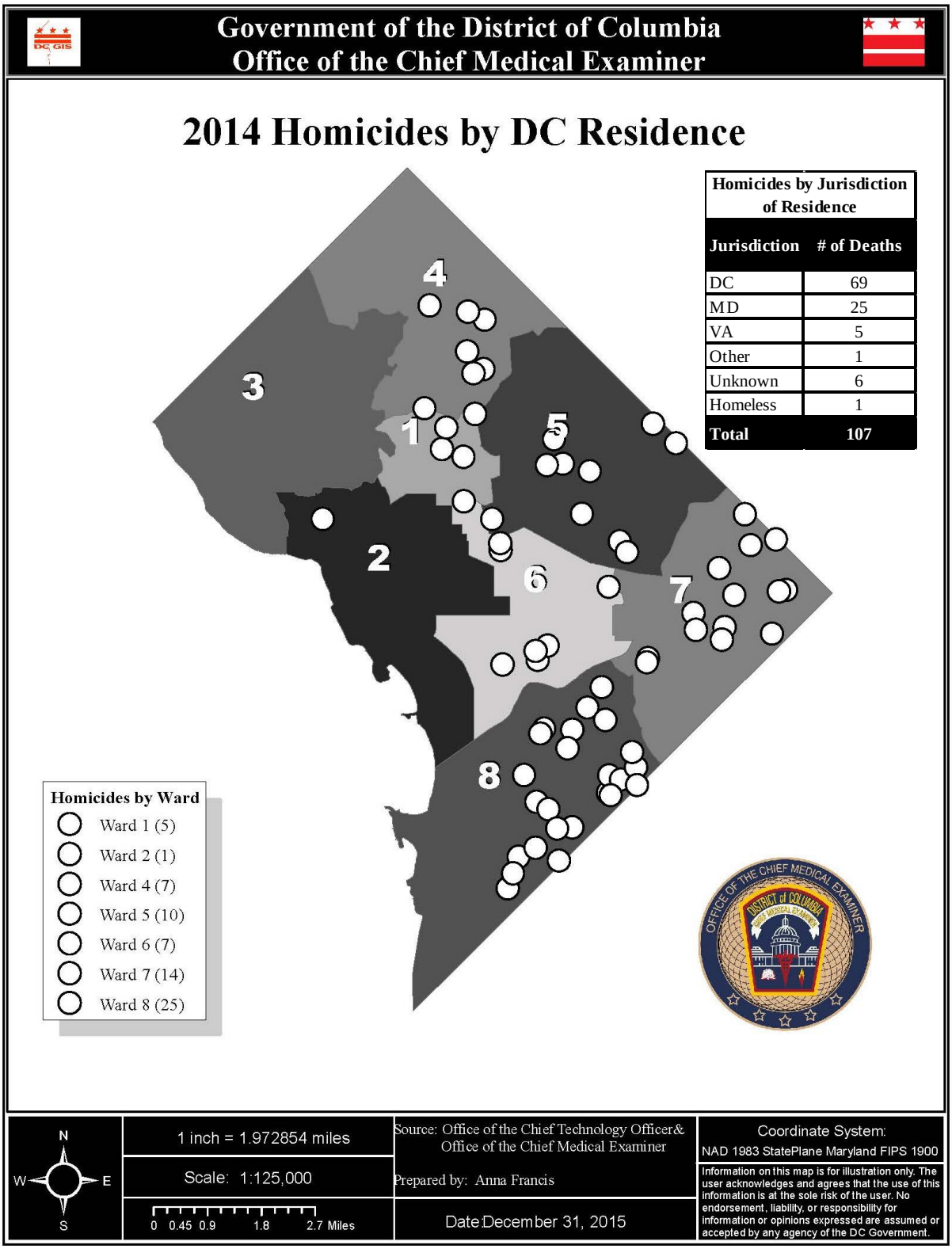
Race/Ethnicity by Gender	Number of Homicides
Black	**88**
Female	15
Male	73
Asian	**2**
Female	0
Male	2
Hispanic	**5**
Female	1
Male	4
White	**8**
Female	3
Male	5
Other	**4**
Female	2
Male	2
Total	**107**

Homicides by Jurisdiction of Incident that caused Death

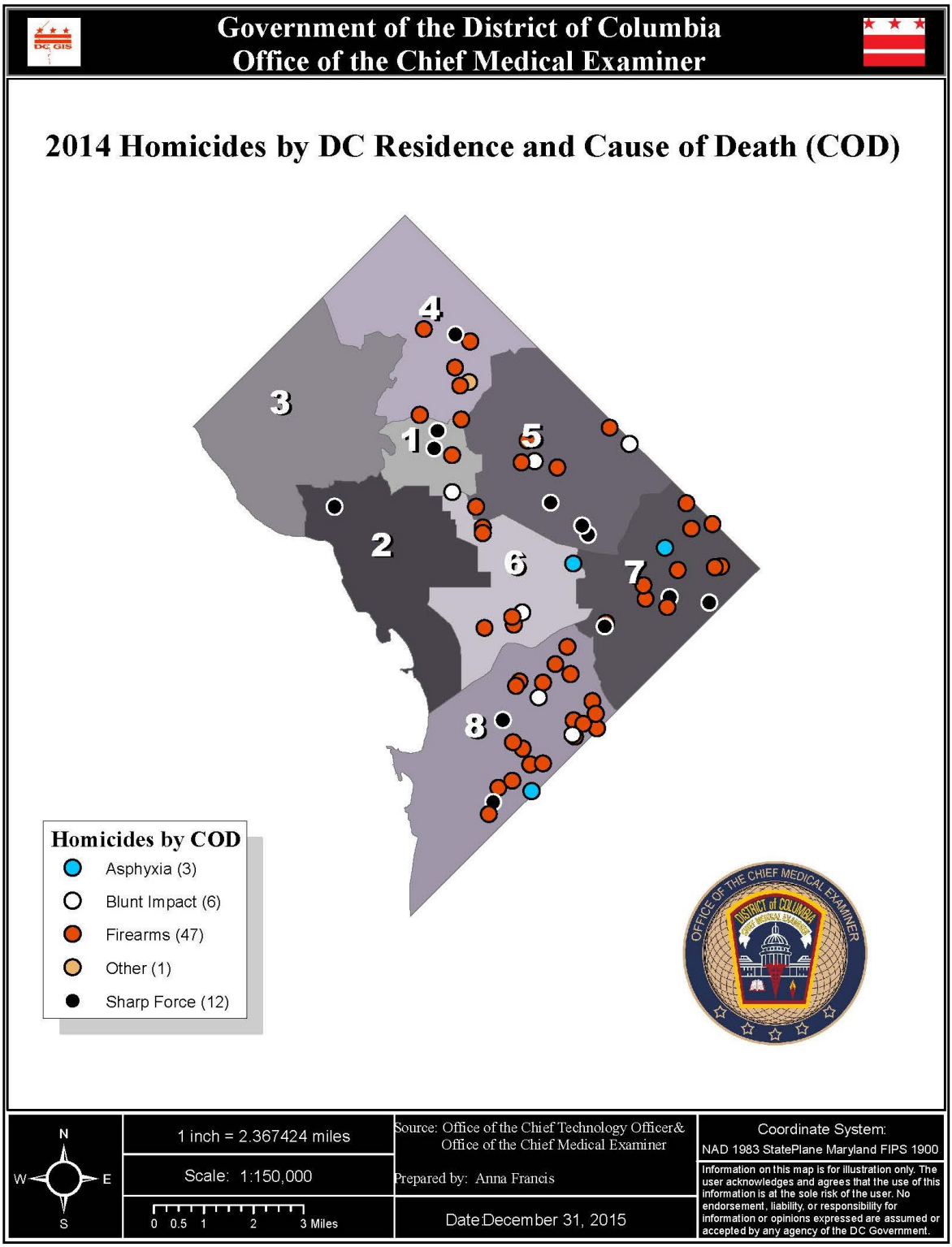
Jurisdiction	Number of Homicides	% of Homicides
District of Columbia	87	81.31%
Maryland	13	12.15%
Virginia	1	0.93%
UNKNOWN	6	5.61%
Total	**107**	**100%**

Map of Homicides by DC Ward

Of the **107** homicides in the District of Columbia, sixty-four (64%) of these decedents were District residents at the time of their death, as reported by their next of kin. The map below illustrates the residence location by District ward at the time of their death.



Map of Homicides by DC Ward and Cause of Death



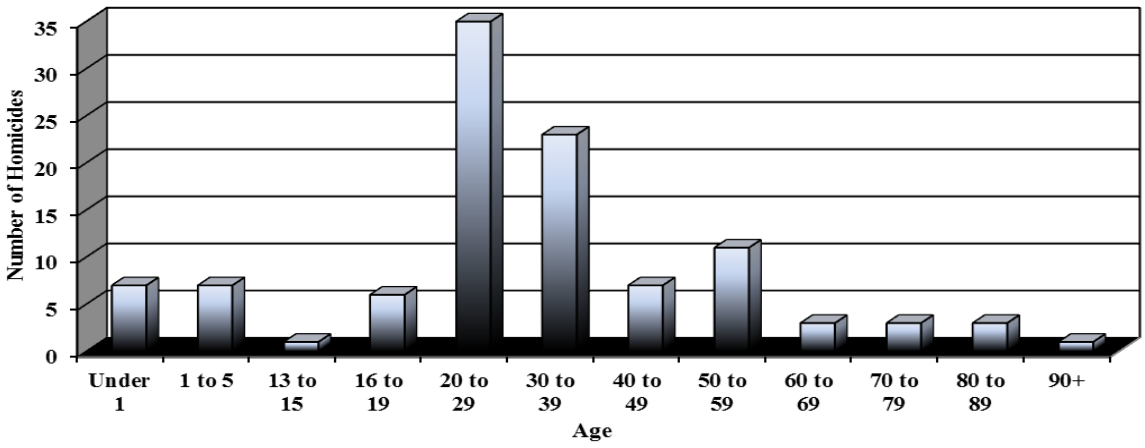
Homicides by Age

Age	Number of Homicides	% of Homicides
Under 1	7	6.54%
1 to 5	7	6.54%
6 to 12	0	0.00%
13 to 15	1	0.93%
16 to 19	6	5.61%
20 to 29	35	32.71%
30 to 39	23	21.50%
40 to 49	7	6.54%
50 to 59	11	10.28%
60 to 69	3	2.80%
70 to 79	3	2.80%
80 to 89	3	2.80%
90 +	1	0.93%
Total	**107**	**100%**

Adolescent and Young Adults
Homicides by Cause of Death

	< 1	1 to 5	13 to 15	16 to 19	20 to 29
Asphyxia	0	2	0	0	0
Blunt Impact	6	3	0	0	2
Firearms	0	1	1	5	31
Other	1	0	0	0	0
Poisoning	0	1	0	0	0
Sharp Force	0	0	0	1	2
Total	**7**	**7**	**1**	**6**	**35**

Chart - Homicides by Age Group



Toxicology Findings for Homicide Cases

Toxicology was performed on all 107 homicide cases investigated by OCME. All cases were screened for alcohol and drugs of abuse. Drugs were absent in 22 homicide cases.

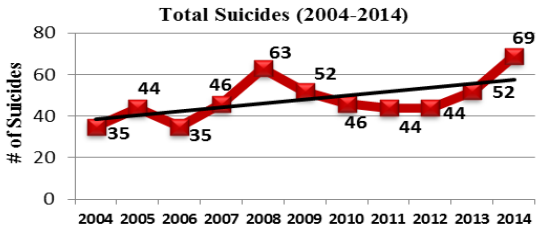
Description	Number of Cases	% of Cases
N=	107	
Negative	22	20.5 %
Positive	85	79.4 %

The most commonly detected drugs in the homicide cases were:

Name of Drug	Number of Cases	% of Homicide Cases
Marijuana Metabolites	38	37.9 %
Ethanol	27	21.3 %
Cocaine and metabolites	11	7.4 %
Phencyclidine (PCP)	9	5.5 %
Oxycodone	4	3.7 %
Morphine	3	2.7 %

2.2 - Suicides

The OCME investigated **69** suicides in CY 2014, which represents a **32.7%** increase from CY 2013 (52). Deaths by suicidal acts were more prevalent in white males and in persons between the ages of 20 to 29 years. Hanging was the leading cause of suicidal deaths. More incidents occurred in **April** and **June** than in any other month.

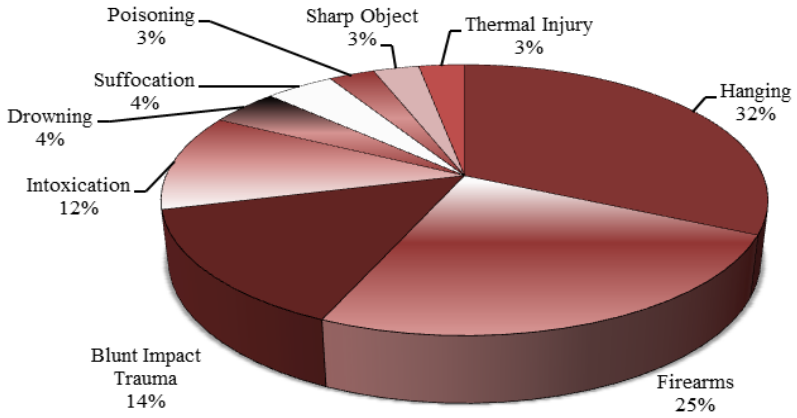


Suicides by Cause of Death

Cause	Number of Suicides	% of Total Suicides
Hanging	22	31.88%
Firearms	17	24.64%
Blunt Impact Trauma • Bridge - 4 • Building - 4 • Metro - 2	10	14.49%
Intoxication	8	11.59%
Suffocation (Plastic Bag over head)	3	4.35%
Drowning	3	4.35%
Thermal Injury	2	2.90%
Poisoning	2	2.90%
Sharp Object	2	2.90%
Total	**69**	**100.00%**

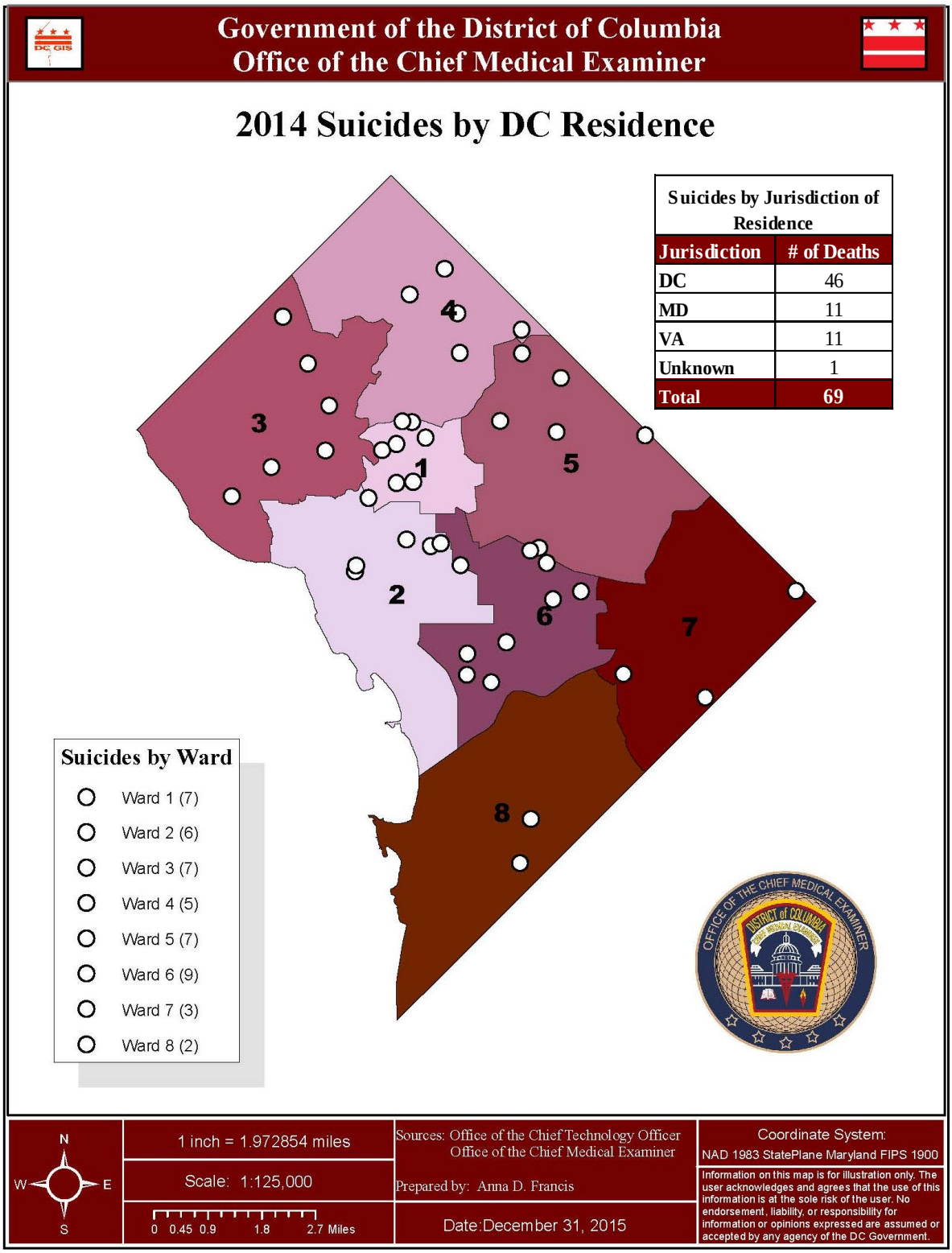
Note: The percentages in the "Pie Chart" are rounded up or down to nearest whole number.

Pie Chart - Suicides by Cause of Death



Map of Suicides by DC Ward

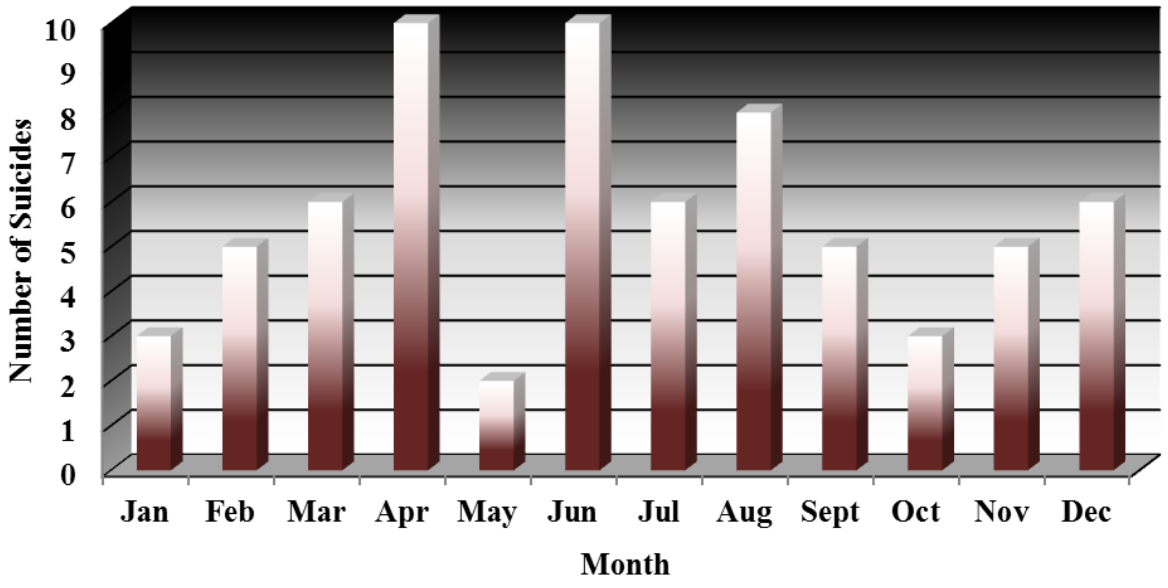
Of the **69** suicides in the District of Columbia, forty-six (67%) of these decedents were District residents at the time of their death, as reported by their next of kin. The map below illustrates the residence location by ward at the time of their death.



Suicides by Month

Month	Number of Suicides	% of Suicides
January	3	4.35%
February	5	7.25%
March	6	8.70%
April	10	14.49%
May	2	2.90%
June	10	14.49%
July	6	8.70%
August	8	11.59%
September	5	7.25%
October	3	4.35%
November	5	7.25%
December	6	8.70%
Total	**69**	**100%**

Chart- Suicides by Month



Suicide by Race/Ethnicity

Race/Ethnicity	Number of Suicides	% of Suicides
White	42	60.87%
Black	23	33.33%
Asian	2	2.90%
Hispanic	2	2.90%
	69	**100%**

Suicides by Race/Ethnicity and Gender

Race/Ethnicity by Gender	Number of Suicides
White	**42**
Female	10
Male	32
Black	**23**
Female	7
Male	16
Asian	**2**
Female	0
Male	2
Hispanic	**2**
Female	1
Male	1
Total	**69**

Suicides by Gender

Gender	Number of Suicides	% of Suicides
Female	18	26.09%
Male	51	73.91%
Total	**69**	**100%**

Suicides by Jurisdiction of Incident that caused Death

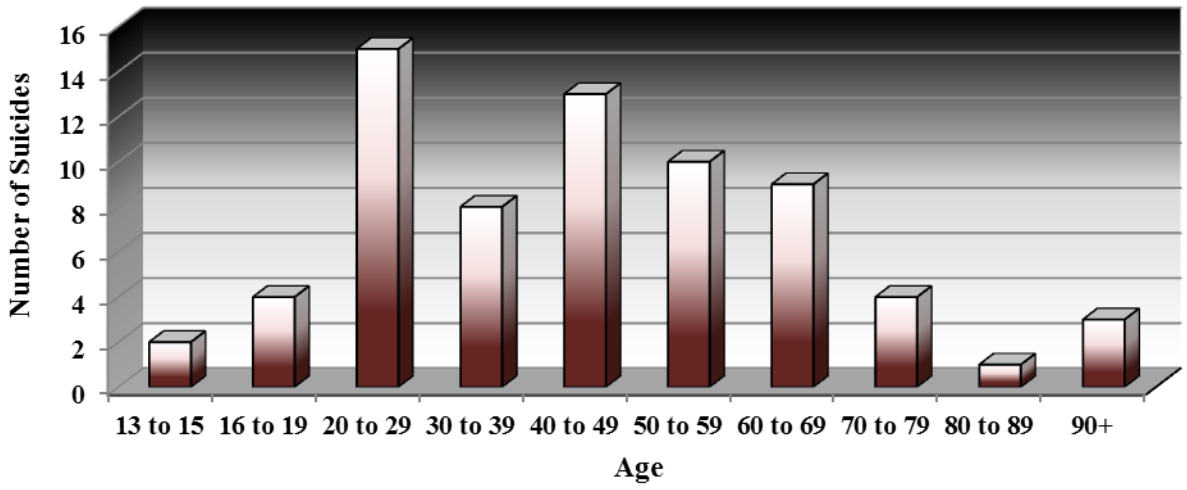
Jurisdiction of Incident	Number of Suicides	% of Suicides
District of Columbia	58	84.06%
Maryland	6	8.70%
Virginia	4	5.80%
Unknown	1	1.45%
Total	**69**	**100%**

Suicide by Age

Age	Number of Suicides	% of Suicides
13 to 15	2	2.90%
16 to 19	4	5.80%
20 to 29	15	21.74%
30 to 39	8	11.59%
40 to 49	13	18.84%
50 to 59	10	14.49%
60 to 69	9	13.04%
70 to 79	4	5.80%
80 to 89	1	1.45%
90 +	3	4.35%
Total	**69**	**100%**

Adolescent and Young Adult Suicides by Cause of Death			
	13 to 15	16 to 19	20 to 29
Blunt Impact	0	1	1
Drowning	0	0	1
Firearms	0	0	4
Hanging	1	1	6
Intoxication	1	0	1
Poisoning	0	0	1
Sharp Object	0	0	1
Suffocation	0	2	0
Thermal Injury	0	0	0
Total	**2**	**4**	**15**

Chart - Suicides by Age



Toxicology Findings for Suicide Cases

Toxicology analysis was performed on 68[1] of 69 OCME suicide cases investigated by OCME. Drugs were absent in 18 of these cases.

Description	Number of Cases	% of Cases
N=	68	
Negative	18	26.4 %
Positive	40	58.8 %

The most notable detected drugs in suicide cases were:

Name of Drug	Number of Cases	% of Suicide Cases
Ethanol	10	14.7 %
Benzodiazepines	8	11.7 %
Diphenhydramine	5	7.3 %
Morphine	4	5.8 %
Fentanyl	3	4.4%

[1] One of the suicide cases was not submitted for Toxicology testing due to delayed death as a result of an extended hospital stay.

2.3 - Accidents

OCME investigated **302** accidental deaths in CY 2014. Of the **302** cases investigated, **48** were related to motor vehicle accidents and **116** of the Accidental deaths were the direct result of prescription and/or illicit drug use. The majority of incidents occurred in **July**.

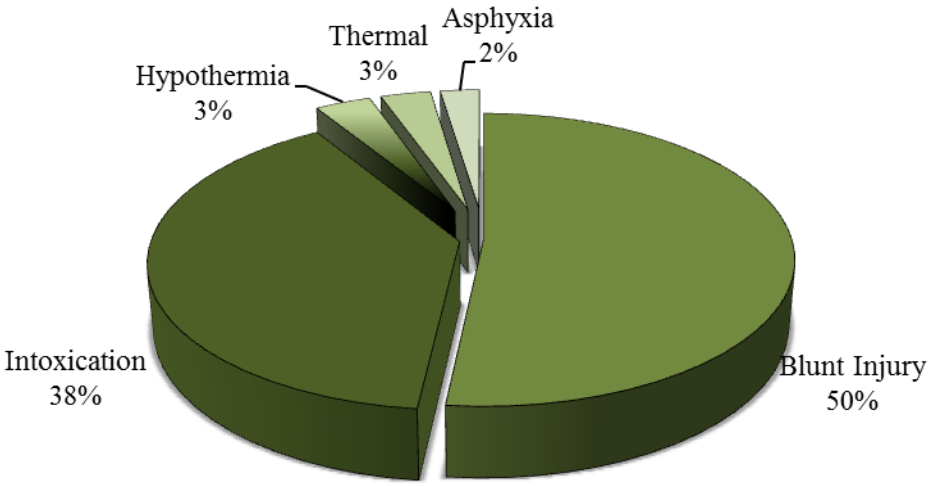
Accidents by Cause of Death

Cause	# of Deaths	% Accidents
Intoxication	116	38.41%
Blunt Injury - Due to Fall (101) - Due to Traffic (48) - Due to Other (3)	152	50.33%
Hypothermia	10	3.31%
Thermal	9	2.98%
Asphyxia	7	2.32%
Drowning	3	0.99%
Other	3	0.99%
Hyperthermia	1	0.33%
Electrocution	1	0.33%
Total	**302**	**100%**

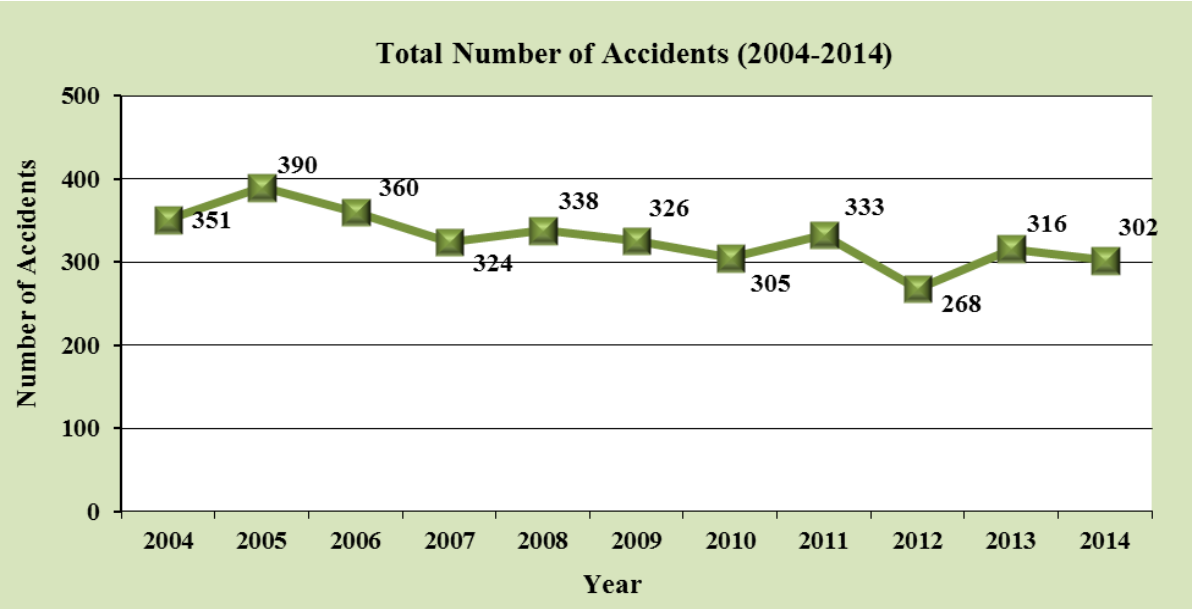
Age Group	Number of Deaths from Accidental Falls
20 to 29	3
30 to 39	2
40 to 49	5
50 to 59	7
60 to 69	14
70 to 79	18
80 to 89	33
90 and Over	19
Total	**101**

Decedents 60 and over represented 84% of all Accidental Deaths due to Falls

Pie Chart - Accidents by Cause of Death[2]



Graph – Eleven-year Overview of Accidents

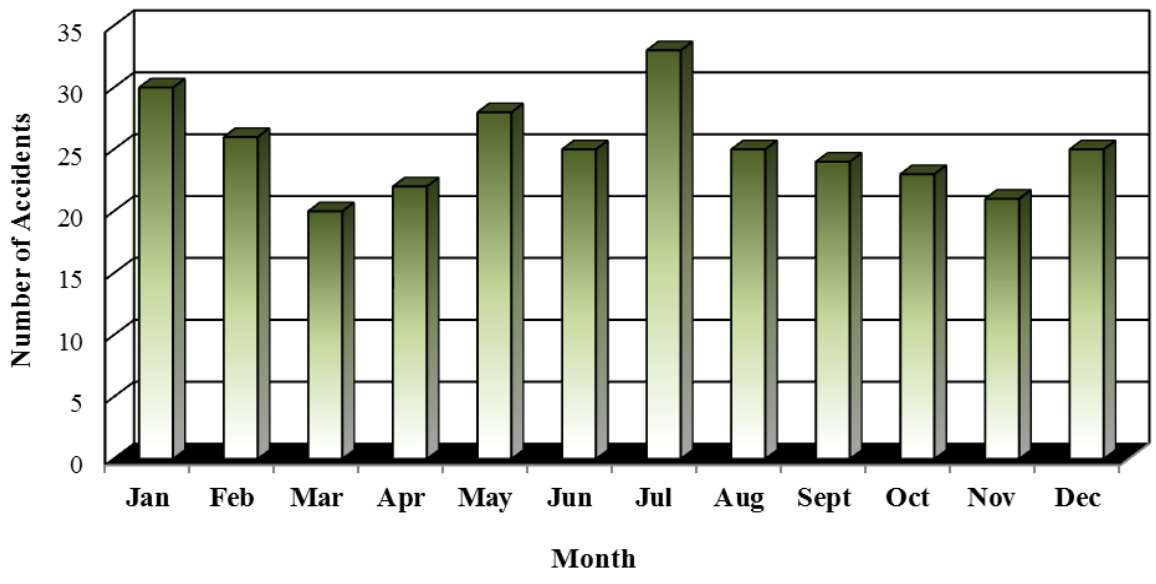


[2] For illustrative purposes this pie chart does not include causes of death that are 1% or less of the total number of deaths.

Accidents by Month

Month	Number of Deaths	% of Accidents
January	30	9.93%
February	26	8.61%
March	20	6.62%
April	22	7.28%
May	28	9.27%
June	25	8.28%
July	33	10.93%
August	25	8.28%
September	24	7.95%
October	23	7.62%
November	21	6.95%
December	25	8.28%
Total	**302**	**100%**

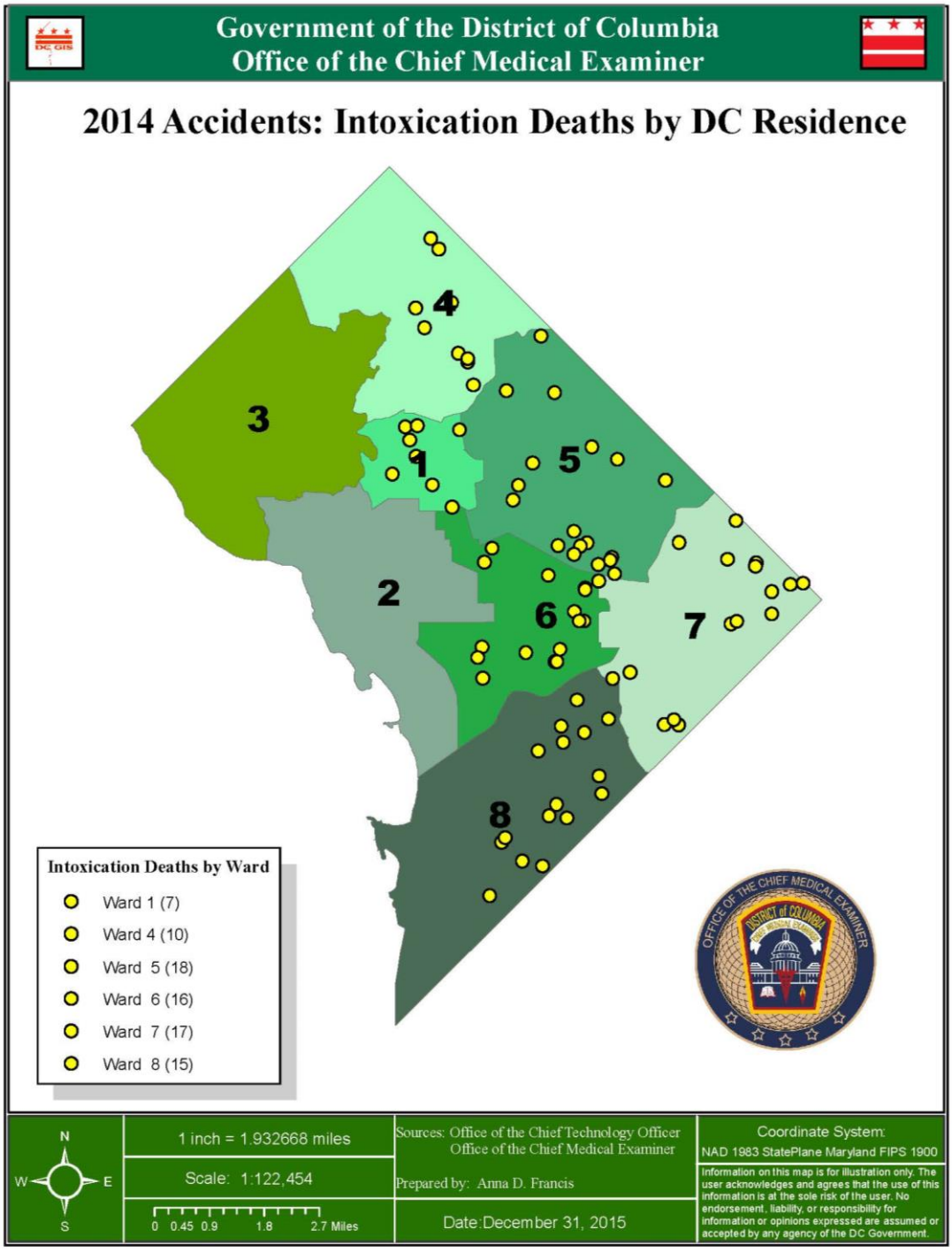
Chart - Accidents by Month of Death



Map of Intoxication Deaths by DC Ward

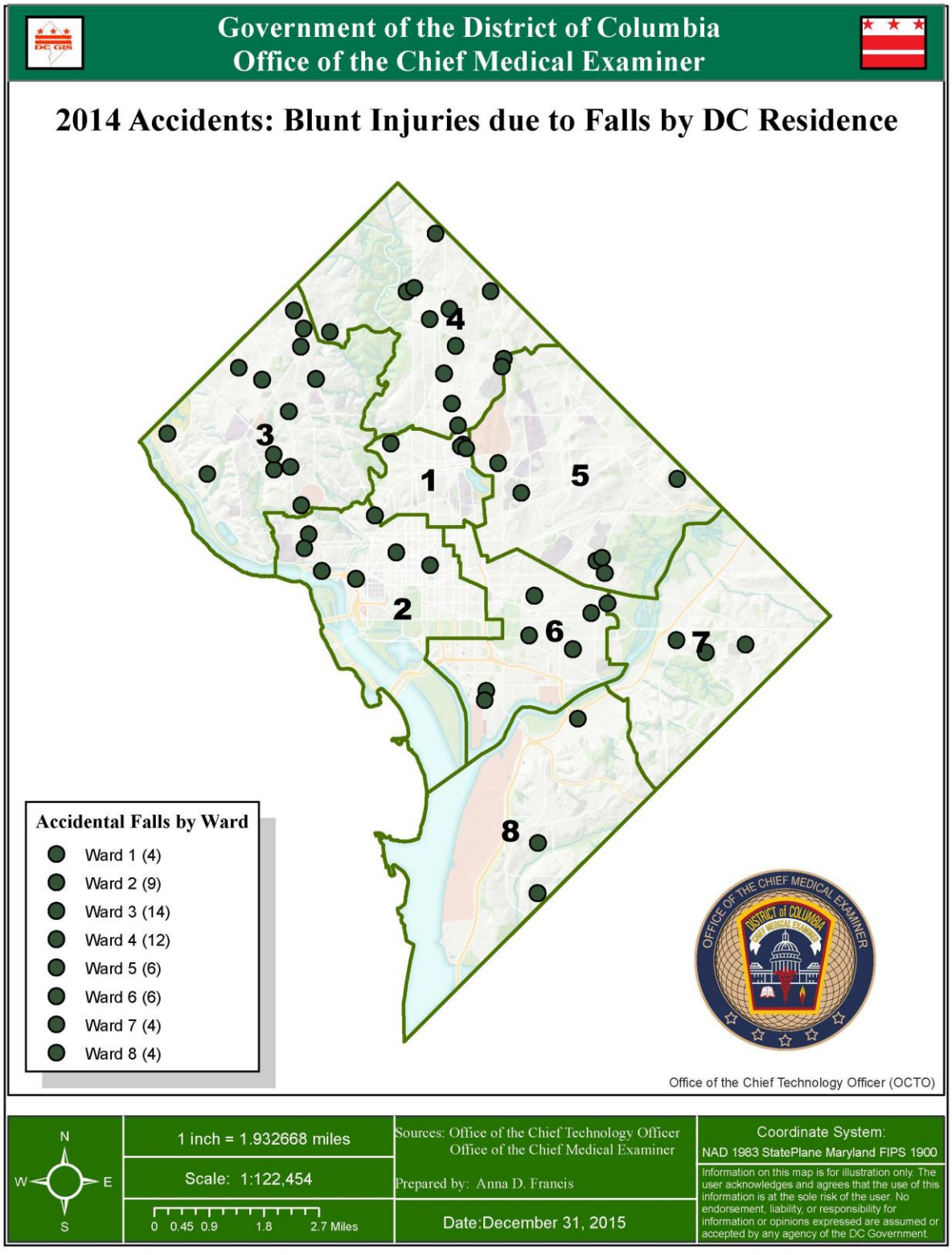
There was a total of **116** Accidental Intoxication Deaths in the District of Columbia in 2014, of which eighty-eight (75%) were residents of the District of Columbia. The map below illustrates the location of the decedent's residence by ward at the time of their death, as reported by the decedent's next of kin.

Accidents by Jurisdiction of Residence	
Jurisdiction	**# of Deaths**
DC	188
MD	67
VA	30
Other	6
Unknown	5
Homeless	6
Total	**302**



Map of Blunt Injuries due to Falls by DC Ward

There was a total of **101** Accidental Deaths caused by Blunt Injuries due to Falls in the District of Columbia in 2014, of which sixty (59%) were residents of the District of Columbia. The map below illustrates the location of the decedent's residence by ward at the time of their death, as reported by the decedent's next of kin.



Accidental Deaths by Race

Race/Ethnicity	Number of Accidents	% of Accidents
Black	174	57.62%
White	101	33.44%
Hispanic	17	5.63%
Asian	5	1.66%
Other	0	0.00%
Unknown	5	1.66%
Total	**302**	**100%**

Accidental Deaths by Gender

Gender	Number of Accidents	% of Accidents
Female	114	37.75%
Male	188	62.25%
Total	**302**	**100%**

Accidental Deaths by Age

Age	Number of Accidents	% of Accidents
Under 1	5	1.66%
1 to 5	4	1.32%
6 to 12	1	0.33%
13 to 15	1	0.33%
16 to 19	1	0.33%
20 to 29	24	7.95%
30 to 39	31	10.26%
40 to 49	37	12.25%
50 to 59	68	22.52%
60 to 69	42	13.91%
70 to 79	25	8.28%
80 to 89	40	13.25%
90 +	23	7.62%
Total	**302**	**100%**

Toxicology Findings for Accident Cases

Of the 302 Accident Deaths investigated by OCME, toxicology analysis was performed in 198 cases. Drugs were absent in 21 accident cases.

Description	Number of Cases	% of Cases
N=	198	
Negative	21	10.6 %
Positive	177	89.3 %

The most commonly detected drugs in the accident cases were**:**

Name of Drug	Number of Cases	% of Accident Cases
Morphine/Heroin	68/49	34.3 %/24.7%
Ethanol	60	30.3 %
Cocaine and Metabo-lites	53	26.7 %
Oxycodone	19	9.5 %
Marijuana Metabolites	18	9.0 %
Methadone	15	7.5 %
Phencyclidine	11	5.5 %
Fentanyl	10	5.0 %

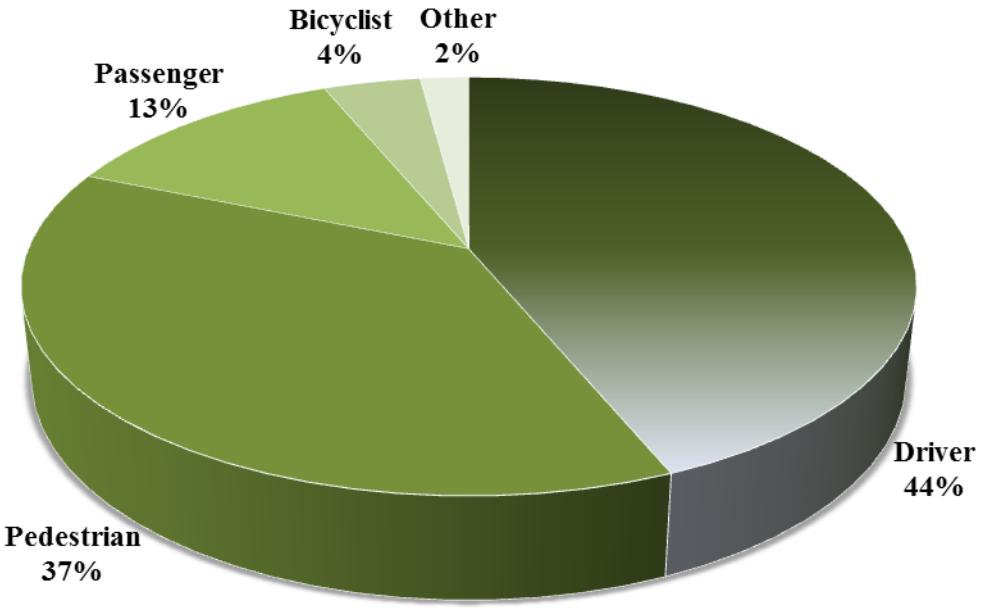
2.3.1 – Traffic Deaths

Of the **48** traffic related deaths certified by the OCME in Calendar Year 2014 the majority involved drivers of motor operated vehicles (all types) and decedents between the ages of 40 to 49. Traffic fatalities were more prevalent in the month of May.

Role of the Decedent in Traffic Death

Role	Traffic Deaths	% of Traffic Deaths
Driver *- Motor Vehicle(15)* *- Motorcycle (5)* *- Moped (1)*	21	43.75%
Pedestrian	18	37.50%
Passenger *- Motor Vehicle (6)*	6	12.50%
Bicyclist	2	4.17%
Other	1	2.08%
Total	**48**	**100%**

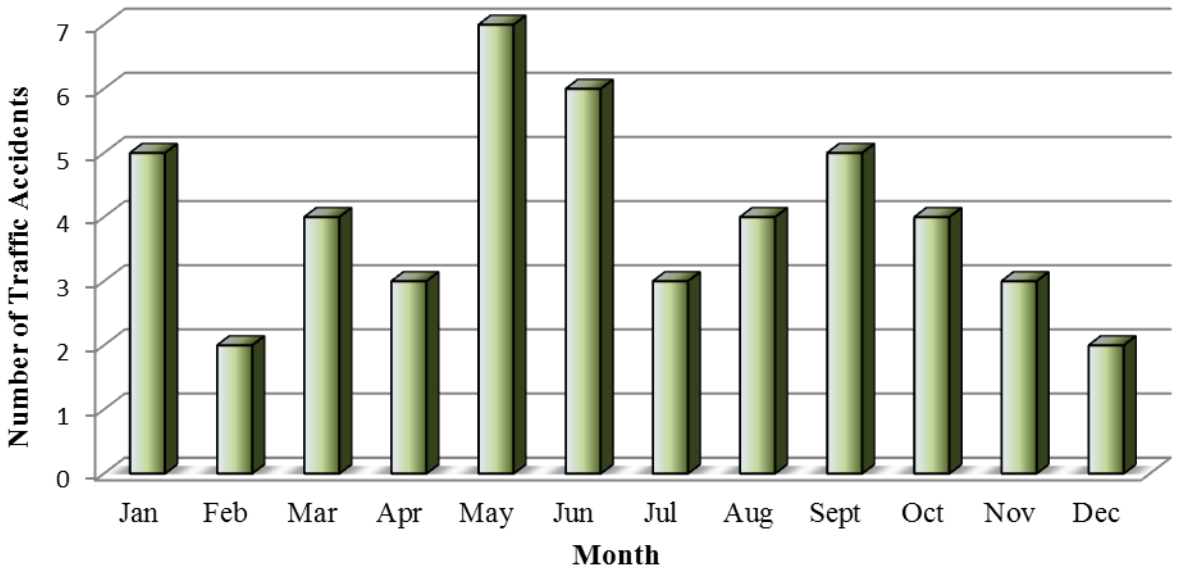
Pie Chart - Role of Decedent in Traffic Accident



Traffic Deaths by Month

Month	Number of Traffic Accidents	% of Traffic Accidents
January	5	10.42%
February	2	4.17%
March	4	8.33%
April	3	6.25%
May	7	14.58%
June	6	12.50%
July	3	6.25%
August	4	8.33%
September	5	10.42%
October	4	8.33%
November	3	6.25%
December	2	4.17%
Total	**48**	**100.00**

Chart - Traffic Deaths by Month



Traffic Deaths by Race

Race	Number of Traffic Deaths	% of Traffic Deaths
Black	23	47.92%
White	15	31.25%
Hispanic	9	18.75%
Asian	1	2.08%
Total	**48**	**100%**

Traffic Deaths by Gender

Gender	Number of Traffic Deaths	% of Traffic Deaths
Female	14	29.17%
Male	34	70.83%
Total	**48**	**100%**

Traffic Deaths by Age

Age	Number of Traffic Deaths	% of Traffic Deaths
1 to 5	3	6.25%
13 to 15	1	2.08%
16 to 19	1	2.08%
20 to 29	10	20.83%
30 to 39	7	14.58%
40 to 49	11	22.92%
50 to 59	6	12.50%
60 to 69	6	12.50%
70 to 79	2	4.17%
80 to 89	1	2.08%
Total	**48**	

Note:

Traffic Deaths by Jurisdiction of Incident that caused Death

Jurisdiction of Incident	Number of Traffic Deaths	% of Traffic Deaths
District of Columbia	26	54.17%
Maryland	17	35.42%
Virginia	4	8.33%
Arizona	1	2.08%
Total	**48**	**100%**

Toxicology Findings for Traffic Accident Cases

Of the 48 Traffic-related deaths investigated by OCME, toxicology analysis was performed in 40 cases. Drugs were absent in 17 traffic accident cases. Of the remaining positive cases, 15.5% had more than one drug present.

Description	Number of Cases	% of Cases
N=	40	
Negative	10	25.0 %
Positive	30	75.0 %

The most commonly detected drugs in the traffic accident cases were:

Name of Drug	Number of Cases	% of Traffic Cases
Ethanol	11	27.5 %
Marijuana Metabolite	7	17.5 %
Morphine	2	5.0 %
Cocaine and Metabolites	2	5.0 %
Phencyclidine	1	2.5 %

In the 11 traffic deaths positive for ethanol, 10 were greater than the legal limit (0.08 g/100 mL) for driving under the influence in the District of Columbia

2.3.2 – Toxicology Findings for Deaths due to Drug Overdose

There were 116 OCME cases where death was directly related to drug abuse, and toxicology analysis was performed in 116 of these cases. The most prevalent drug in the population was heroin alone or in combination with other drugs. Drugs were present in all overdose cases. Of the positive cases, 86.0 % had more than one drug present.

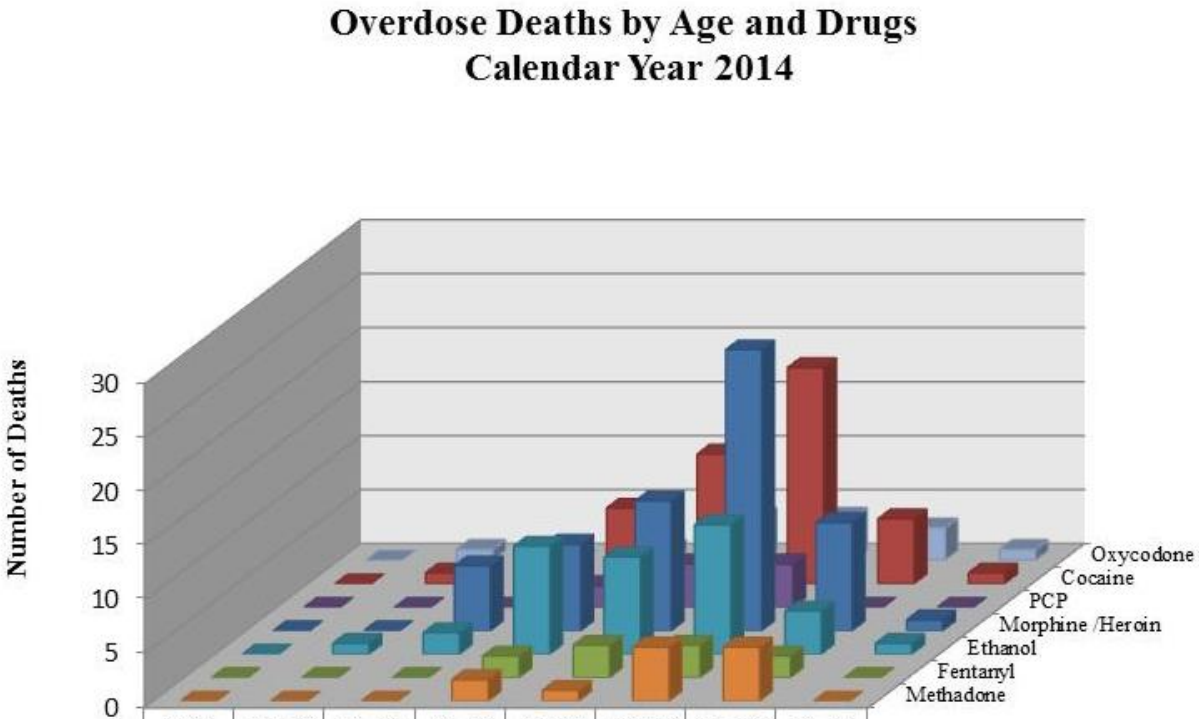
Description	Number of Cases	% of Cases
N=	116	
Negative	0	0 %
Positive	116	100.0 %

The most commonly detected drugs in drug overdose cases were:

Contributing Drugs	Number of Cases	% of Cases
Morphine/Heroin	63/49	54.3%/42.2%
Cocaine and Metabolites	50	60.2 %
Ethanol	39	46.9 %
Oxycodone	14	12.0 %
Methadone	13	11.2 %
Phencyclidine	11	9.4 %
Fentanyl	10	8.6%

Accidental Drug Overdose Fatalities by Age

The majority of overdose deaths occurred in decedents between the ages of 41 and 60 years. Opiates (Heroin, morphine) were the most frequent class of detected drug in most of these age groups, followed by cocaine, ethanol then methadone. The prevalence of phencyclidine (PCP), fentanyl, and methylone (a bath salt) has been included.



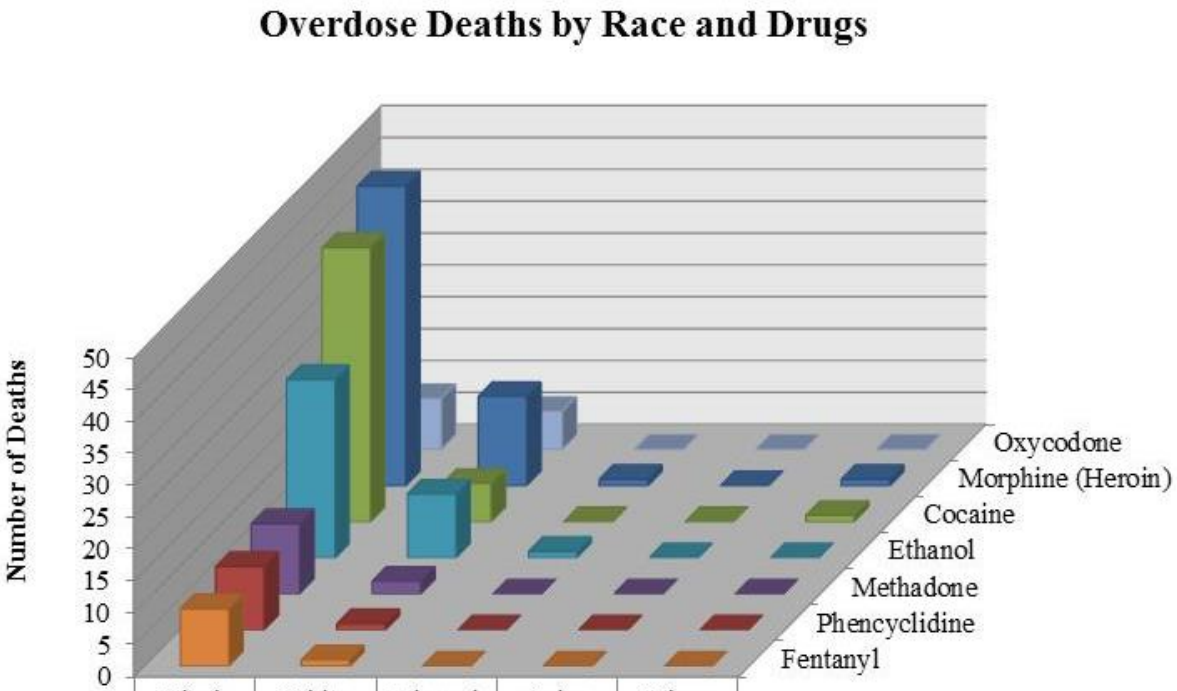
	0-10 (N=0)	11-20 (1)	21-30 (10)	31-40 (20)	41-50 (24)	51-60 (43)	61-70 (16)	71-80 (2)
Methadone	0	0	0	2	1	5	5	0
Fentanyl	0	0	0	2	3	3	2	0
Ethanol	0	1	2	10	9	12	4	1
Morphine /Heroin	0	0	6	8	12	26	10	1
PCP	0	0	0	2	4	4	0	0
Cocaine	0	1	3	7	12	20	6	1
Oxycodone	0	1	0	1	4	4	3	1

Age Range

Note: "N" represents the total number of deaths found within the stated age group.

Accidental Drug Overdose Fatalities by Race

The vast majority of overdose deaths occurred in black decedents, and again the most frequently detected drugs in both black and white decedents were cocaine, heroin, ethanol and methadone. The prevalence of phencyclidine (PCP), fentanyl, and methylone (a bath salt) has been included.



	Black (N=86)	White (26)	Hispanic (2)	Asian (1)	Others (1)
Fentanyl	9	1	0	0	0
Phencyclidine	10	1	0	0	0
Methadone	11	2	0	0	0
Ethanol	28	10	1	0	0
Cocaine	43	6	0	0	1
Morphine (Heroin)	47	14	1	0	1
Oxycodone	8	6	0	0	0

Note: "N" represents total number of deaths found within the stated race

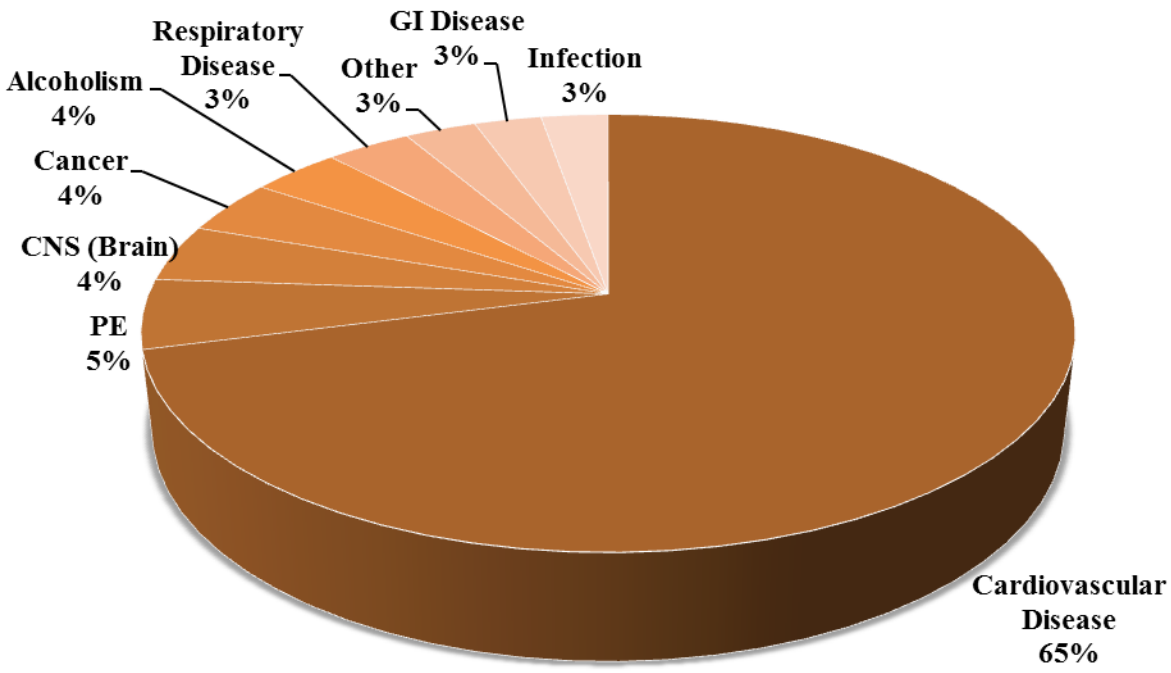
2.4 – Natural Deaths

Natural deaths continue to account for the majority of cases reported to and accepted by the Office of the Chief Medical Examiner. In 2014, **591** deaths were determined to be a result of natural disease. Deaths caused by Cardiovascular Diseases continue to dominate in this category with **386** fatalities. Deaths due to the pulmonary embolism were the second highest cause with **28** deaths. Blacks were more prevalent in this category representing **75.47%** of the population affected. More Natural deaths occurred in **March** than in any other month.

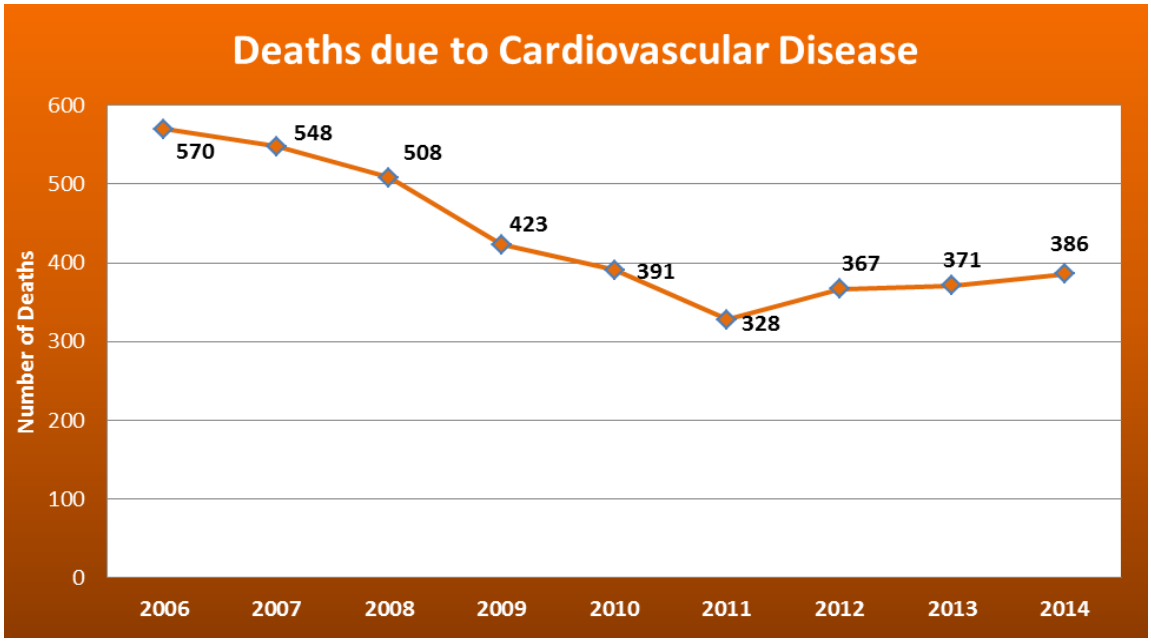
Natural Deaths by Cause

Cause	Number of Deaths	% Of Total Natural Deaths
Cardiovascular Disease	386	65.31%
Pulmonary Embolism (PE)	28	4.74%
Central Nervous System Diseases	23	3.89%
Cancer	22	3.72%
Alcoholism	20	3.38%
Respiratory Diseases	19	3.21%
Other	16	2.71%
Infection	15	2.54%
Gastrointestinal Disease	15	2.54%
Infectious Disease	8	1.35%
Diabetes	8	1.35%
Therapeutic Complications	8	1.35%
Obesity or Complications of Obesity	7	1.18%
AIDS	4	0.68%
Blood Disease/Hemopoietic System	3	0.51%
Complications of Pregnancy	3	0.51%
Immune System Disease	2	0.34%
Genetic Disorder	2	0.34%
Complications of Drug Abuse	1	0.17%
Connective Tissue Disease	1	0.17%
Total	**591**	**100**

Pie Chart – Natural Deaths by Cause

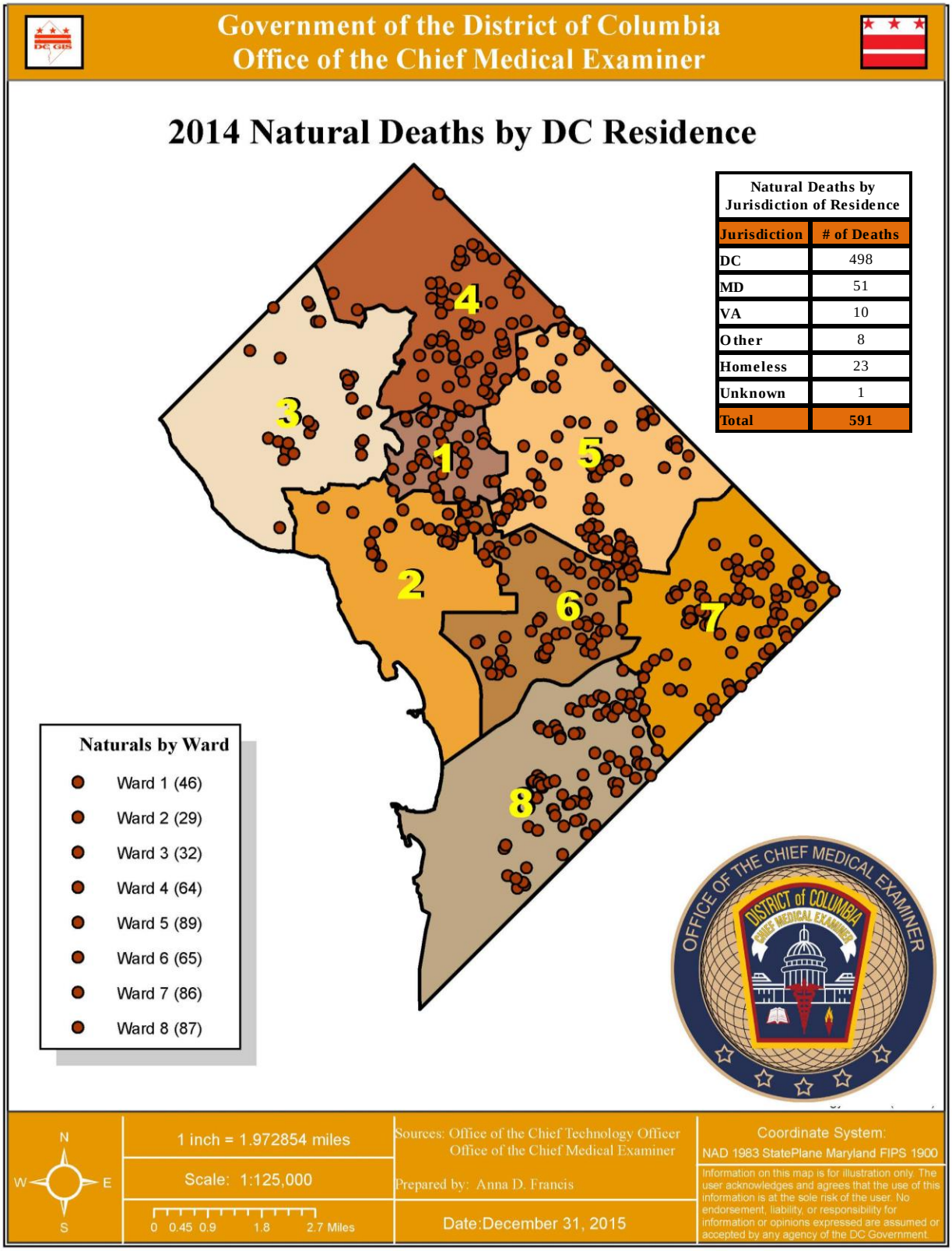


Note: Causes of Death that are less than 2% are not included in this chart.



Map of Natural Deaths by DC Ward

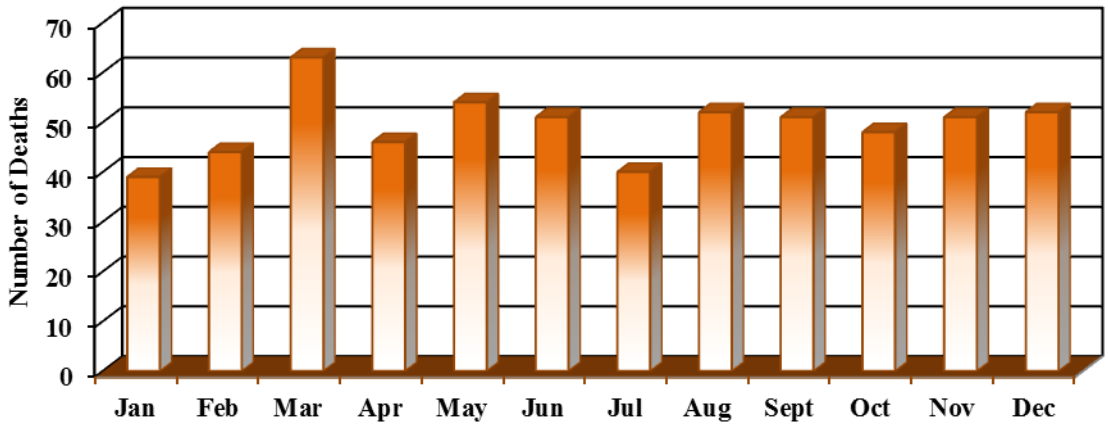
Of the **591** Natural deaths in the District of Columbia, 498 (84%) of these decedents were District residents at the time of their death, as reported by their next of kin. The map below illustrates the residence location by ward at the time of their death.



Natural Deaths by Month

Month	Number of Deaths	% of Naturals
January	39	6.60%
February	44	7.45%
March	63	10.66%
April	46	7.78%
May	54	9.14%
June	51	8.63%
July	40	6.77%
August	52	8.80%
September	51	8.63%
October	48	8.12%
November	51	8.63%
December	52	8.80%
Total	**591**	**100%**

Chart- Natural Deaths by Month



Natural Deaths by Exam Type

Exam Type	Number of Natural Deaths	% of Natural Deaths
Autopsy	325	54.99%
Autopsy (At Hospital)	1	0.17%
External Exam	254	42.98%
External Exam (Off-site)	1	0.17%
Partial	8	1.35%
Review Medical Records	2	0.34%
Total	**591**	**100%**

Natural Deaths by Race

Race	Number of Natural Deaths	% of Natural Deaths
Black	446	75.47%
White	113	19.12%
Hispanic	18	3.05%
Other	6	1.02%
Asian	6	1.02%
American Indian/ Alaskan Native	1	0.17%
Unknown	1	0.17%
Total	**591**	**100%**

Natural Deaths by Gender

Gender	Number of Natural Deaths	% of Natural Deaths
Female	213	36.04%
Male	378	63.96%
Total	**591**	**100%**

Natural Deaths by Age

Age	# of Natural Deaths	% of Natural Deaths
Under 1	9	1.52%
1 to 5	4	0.68%
6 to 12	3	0.51%
13 to 15	1	0.17%
16 to 19	5	0.85%
20 to 29	12	2.03%
30 to 39	31	5.25%
40 to 49	70	11.84%
50 to 59	138	23.35%
60 to 69	165	27.92%
70 to 79	81	13.71%
80 to 89	56	9.48%
90 +	15	2.54%
Unknown	1	0.17%
Total	**591**	**100%**

2.4.1 - Body Mass Index (BMI)

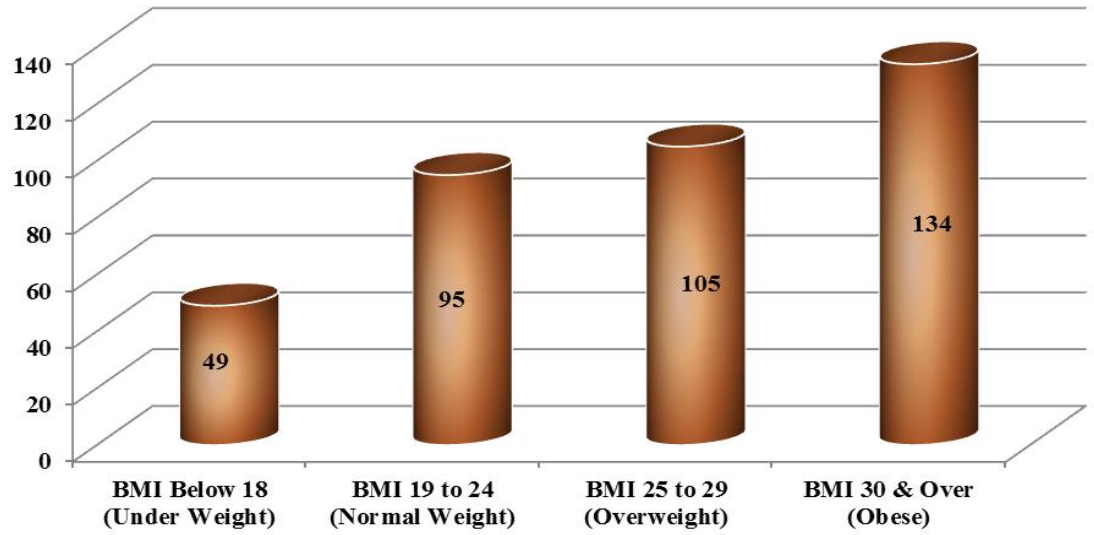
The World Health Organization (WHO) defines Body Mass Index (BMI) as a "simple index of weight-for-height that is commonly used to classify overweight and obesity in adults. According to the National Institutes of Health (NIH) a normal BMI range is from 18.5 to 24.9. Obesity has emerged as a leading public health concern in the United States. This section will report on BMI data for OCME adult decedents as related to those deaths associated with cardiovascular disease.

There were a total of **569** adult decedents that the OCME certified as natural deaths, of which **385** were due to cardiovascular disease. However, the below statistics will represent **383** decedents that died as a result of cardiovascular disease, because one case was authorized to be autopsied at an area hospital, and the height was not obtained for the other case, which was an "External Exam".

BMI and Deaths Associated with Cardiovascular Disease (CD)[3]

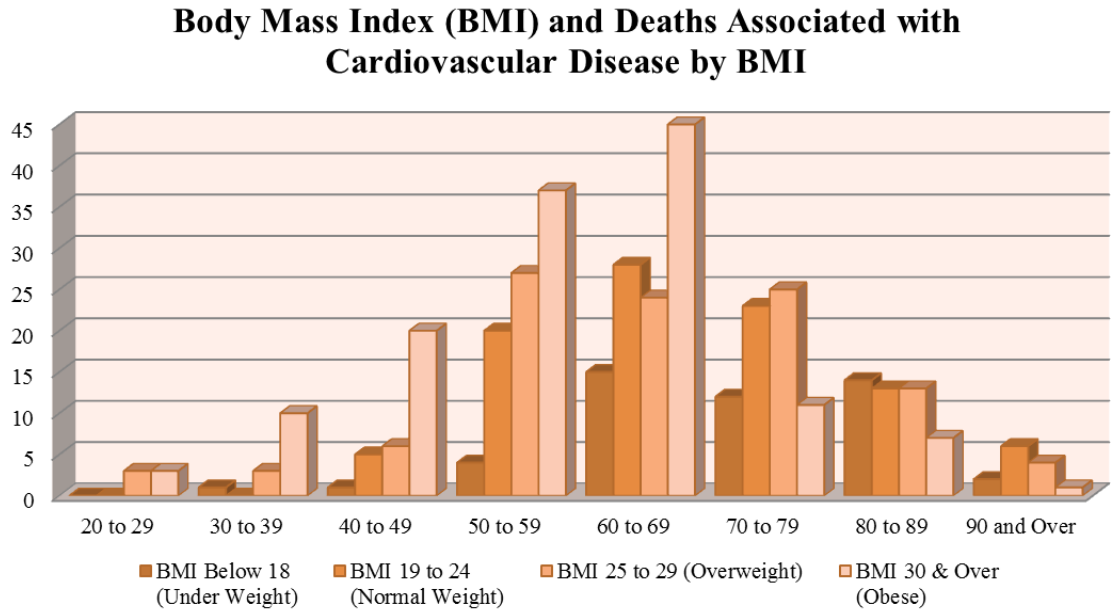
(Adults only)

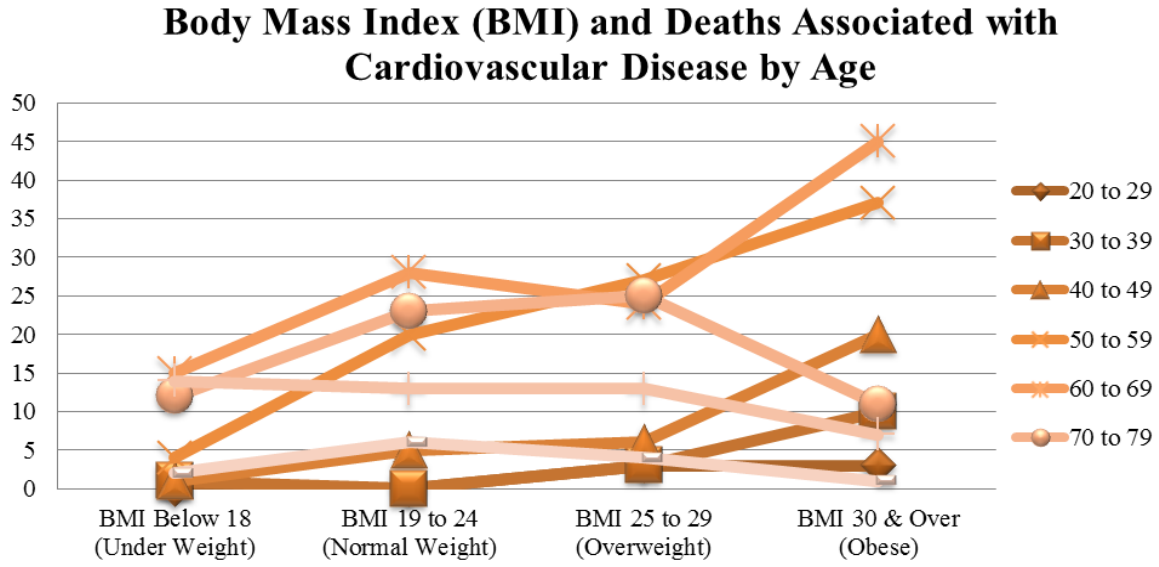
The charts below provide a breakdown of all adult decedents by BMI classification, by age and by race as related to the prevalence of cardiovascular disease. Of the adult decedents that died of complications of cardiovascular disease **134** were classified as obese and **105** were classified as over-weight.



[3] The BMI statistics only include OCME cases where the body came into the office and a height and weight was obtained; therefore cases with following exam types are not included: External exams with missing data, and Autopsy at hospital.

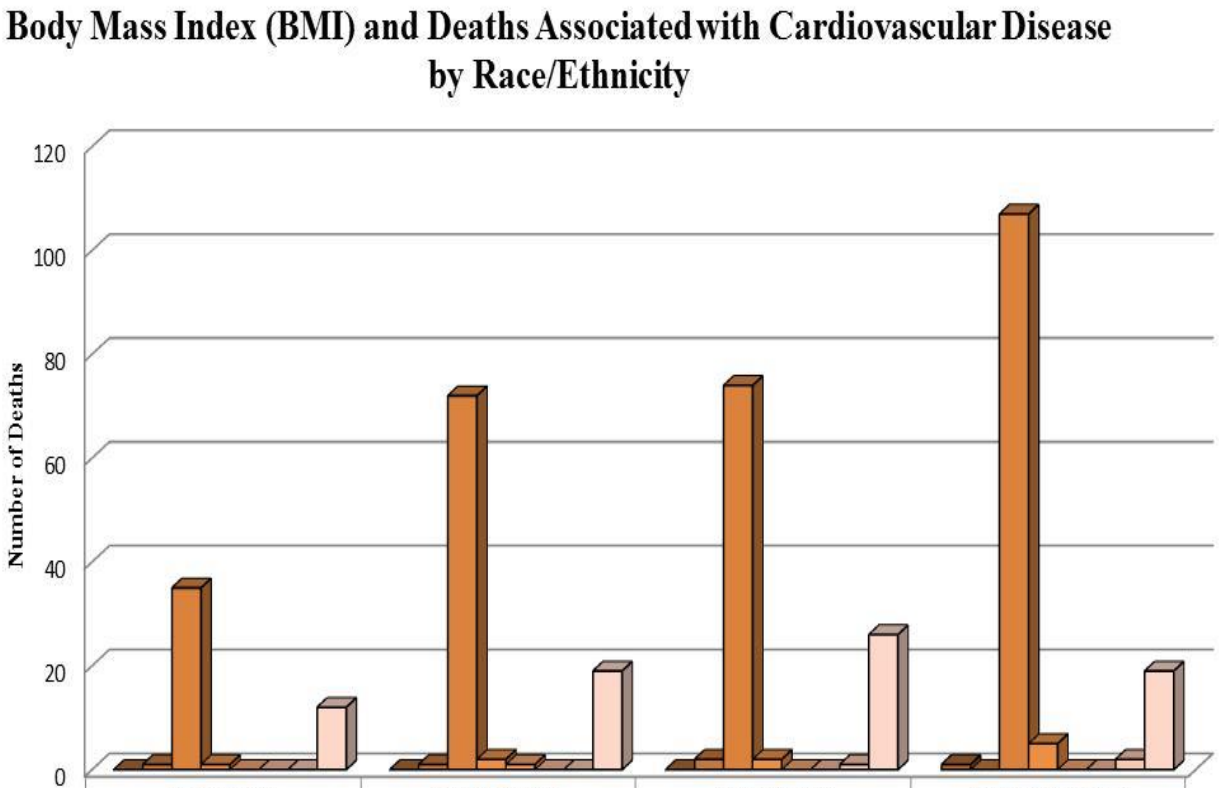
BMI and Heart Disease by Age (Adults only)





BMI for Adult Decedents with Heart Disease by Race

Of the 239 decedents above the normal weight in 2014, **76%** were Black/African American **19%** were White, **3%** were Hispanic and those races that were American Indian, Asian, Pacific Islander and Other were less than **2%**. The chart below displays the BMI data by race.



	Below 18.5 (Underweight)	BMI 18.5-24.9 (Normal Weight)	BMI 25-29.9 (Overweight)	BMI 30 or Above (Obese)
American Indian	0	0	0	1
Asian	1	1	2	0
Black	35	72	74	107
Hispanic	1	2	2	5
Other	0	1	0	0
Pacific Islander	0	0	0	0
Unknown	0	0	1	2
Whites	12	19	26	19

2.5 – Undetermined Deaths

Undetermined by Cause of Death

The OCME investigated **34** cases (3.0% of total Accepted Cases) in which the manner of death was concluded to be "Undetermined," and of these **12** cases or **35.29%** also had a cause of death classified as "Undetermined".

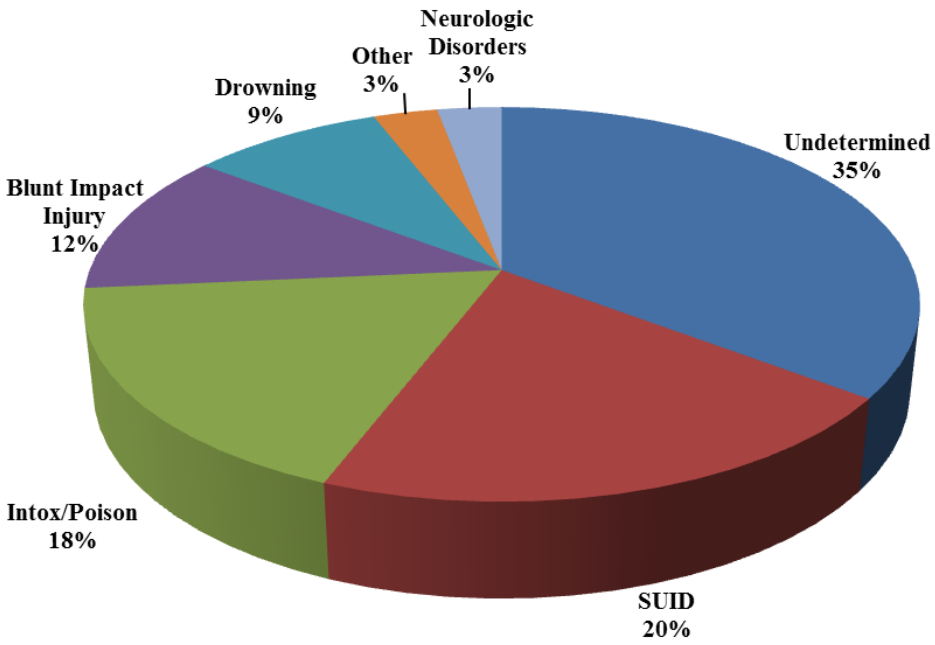
An "Undetermined" manner of death is determined when there is inconclusive evidence or investigatory efforts as to the circumstances of the death. This manner of death can be amended as additional information is received as it infers a continuous investigation/search for clarification of the events surrounding the death. At times, the cause of death can also be certified as "Undetermined" when autopsy findings are not decisive. This is often the case in skeletonized or markedly decomposed remains.

A separate category of "undetermined" manner of death involve infants whose deaths are associated with unsafe sleep environments to include bed/sharing, inappropriate bedding, or other related, similar circumstances., for whom no definite cause of death can be determined despite full autopsy, metabolic, microbiologic, viral or toxicological studies. Many of these deaths were previously certified as SIDS with a Natural manner of death.

Cause of Death	Number of Deaths	% of Total Accepted Cases
Undetermined	12	35.29%
Sudden Unexpected Infant Death (SUID)	7	20.59%
Intoxication/Poisoning	6	17.65%
Blunt Impact Injuries	4	12.12%
Drowning	3	9.09%
Neurologic Disorders	1	3.03%
Other	1	3.03%
Total	**34**	**100%**

There were no deaths classified as "Undetermined" in the following age groups, **13 to 15 and 90 and above** years. Peak incidents occurred in **January**.

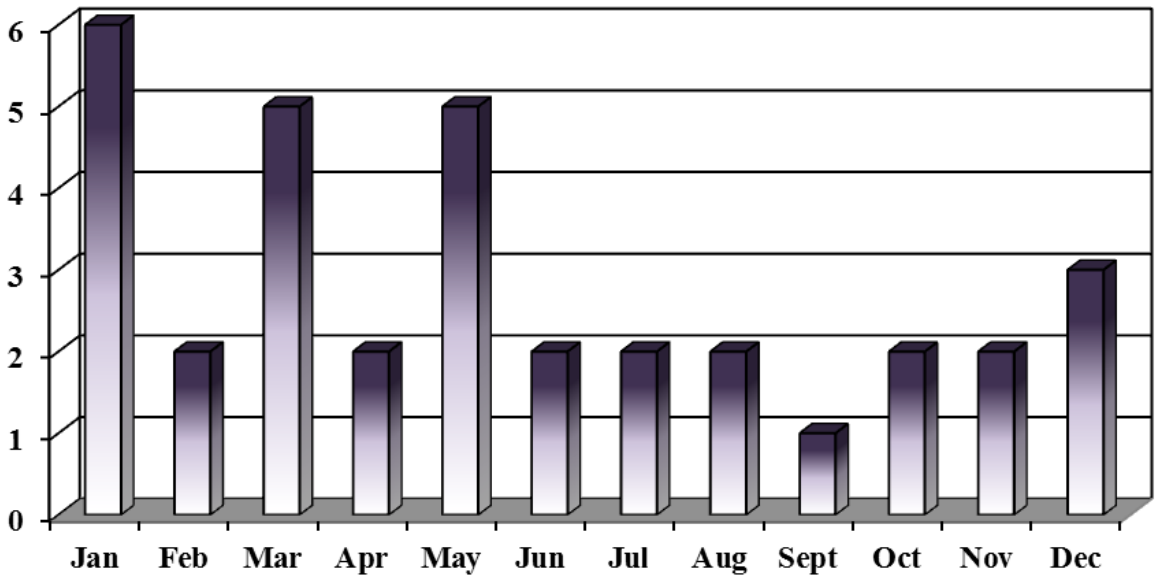
Pie Chart – Undetermined by Cause of Death



Undetermined Deaths by Month

Month	Number of Deaths
January	6
February	2
March	5
April	2
May	5
June	2
July	2
August	2
September	1
October	2
November	2
December	3
Total	**34**

Chart - Undetermined Deaths by Month



Undetermined Deaths by Race

Race	Number of Undetermined Deaths	% of Undetermined Deaths
Asian	0	0.00%
Black	23	67.65%
Hispanic	1	2.94%
Other	0	0.00%
White	10	29.41%
Total	**34**	**100%**

Undetermined Deaths by Gender

Gender	Number of Undetermined Deaths	% of Undetermined Deaths
Female	10	29.41%
Male	24	70.59%
Total	**34**	**100%**

Undetermined Deaths by Age

Age	Number of Undetermined Deaths
Under 1	11
1 to 5	1
6 to 12	1
16 to 19	1
20 to 29	1
30 to 39	4
40 to 49	4
50 to 59	5
60 to 69	2
70 to 79	2
80 to 89	2
Total	**34**

Breakdown of Cause of Death			
	SUID	Undetermined	Intox./Poison
Under 1	7	3	1
Note: All of the infant decedents were less than 1 year old (age range between 1 month and 8 months old).			

Toxicology Findings by Undetermined Deaths

Of the 34 Undetermined Deaths investigated by OCME, toxicology analysis was performed on all 34 cases. Drugs were absent in 16 undetermined deaths.

Description	Number of Cases	% of Cases
N=	34	
Negative	16	47 %
Positive	18	53 %

The most commonly detected drugs in the undetermined cases were:

2014 Summary of all Infant Deaths by

Name of Drug	Number of Cases	% of Undetermined Cases
Ethanol	8	24 %
Morphine	5	14.7 %
Diphenhydramine	3	8.8 %
Fentanyl	2	5.9 %
Marijuana	2	5.9 %
Acetaminophen	1	2.9 %

2014 Overview of Infant Sleeping Deaths that occurred in the District of Columbia by Jurisdiction of Residence

Although a death of an infant may occur in the District of Columbia, the infant's place of residence can be anywhere in the world. For the purpose of this annual report, infant deaths are defined as babies that are age one year old or less at the time of death. This report will identify the residential jurisdiction of the infant by using the parental residence at the time of the infant's death.

Co-sleeping/Bedsharing

There were a total of **five** co-sleeping/bed-sharing infant fatalities that were certified with a Manner of Death as "***Undetermined***" in calendar year 2014, of which, three had parents that were residents of the District of Columbia (one in ward 6, and two in ward 8), and two had parents that lived in Maryland. Ward eight had the highest prevalence of co-sleeping deaths in 2014. Within this review period, there were no co-sleeping/bedsharing fatalities where the parental residence was in the District of Columbia wards 1, 2, 3, 4, 5, or 7 or in the state of Virginia. In addition, there were **two** cases were certifed with a Manner of Death as ***"Accident"***. These accidential infant fatalities were caused by Asphyxia due to overlay (asphyxia due to overlay was the result of a co-sleeping environment).

Unsafe sleeping environment or Inappropriate bedding

Although "*Unsafe sleeping environment*" and "*Inappropriate bedding*" are classified independently in the circumstances and cause of death, these classifications are very similar as it relates to the sleeping environment of the infant. For example, an adult bed is identified by the DC Medical Examiner as an unsafe sleeping environment, yet it is also known as inappropriate bedding for an infant.

There were **four** cases in 2014 where the infant died as a result of unsafe sleeping or inappropriate bedding, yet was NOT attributed to co-sleeping or bed-sharing based on the investigation. **Two** of these cases had a Manner of Death of "Undetermined" and **two** were "Accidents".

Undetermined/Crib Death

Based on the investigation by the Medical Examiners Office, there were **three** deaths where the sleeping environment of the infant was a crib and therefore the Cause and Manner of Death were classified as either "SUID/Undetermined" or "Undetermined/Undetermined".

Infant Deaths by Cause of Death, Manner of Death and Contributing Factors

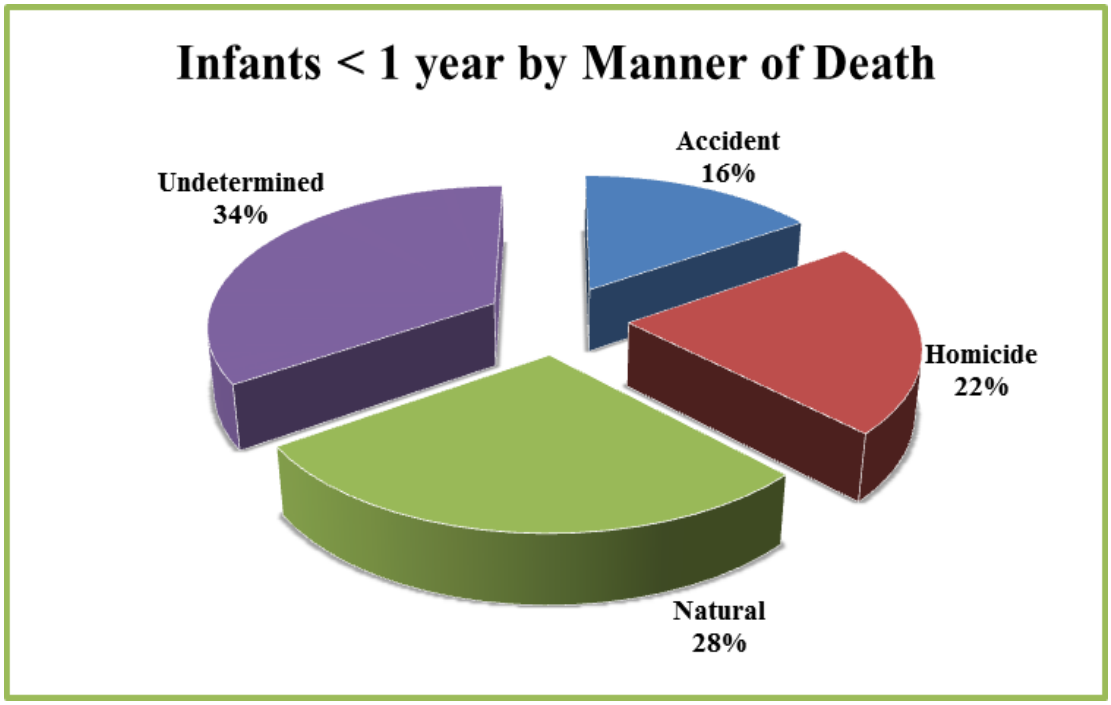
Cause of Death	Manner	Co-sleeping/ Bed-sharing	Unsafe Sleep Environment/ Inappropriate Bedding	Total
Asphyxia	Accident	2[4]	2	**4**
SUID	Undetermined	4	3	**7**
Undetermined	Undetermined	1	2	**3**
Total		**7**	**7**	**14**

[4] These two deaths were classified as "Asphyxia due to Overlay" however; the overlay was the result of a co-sleeping environment.

Jurisdiction of Parental Residence and Manner of Death

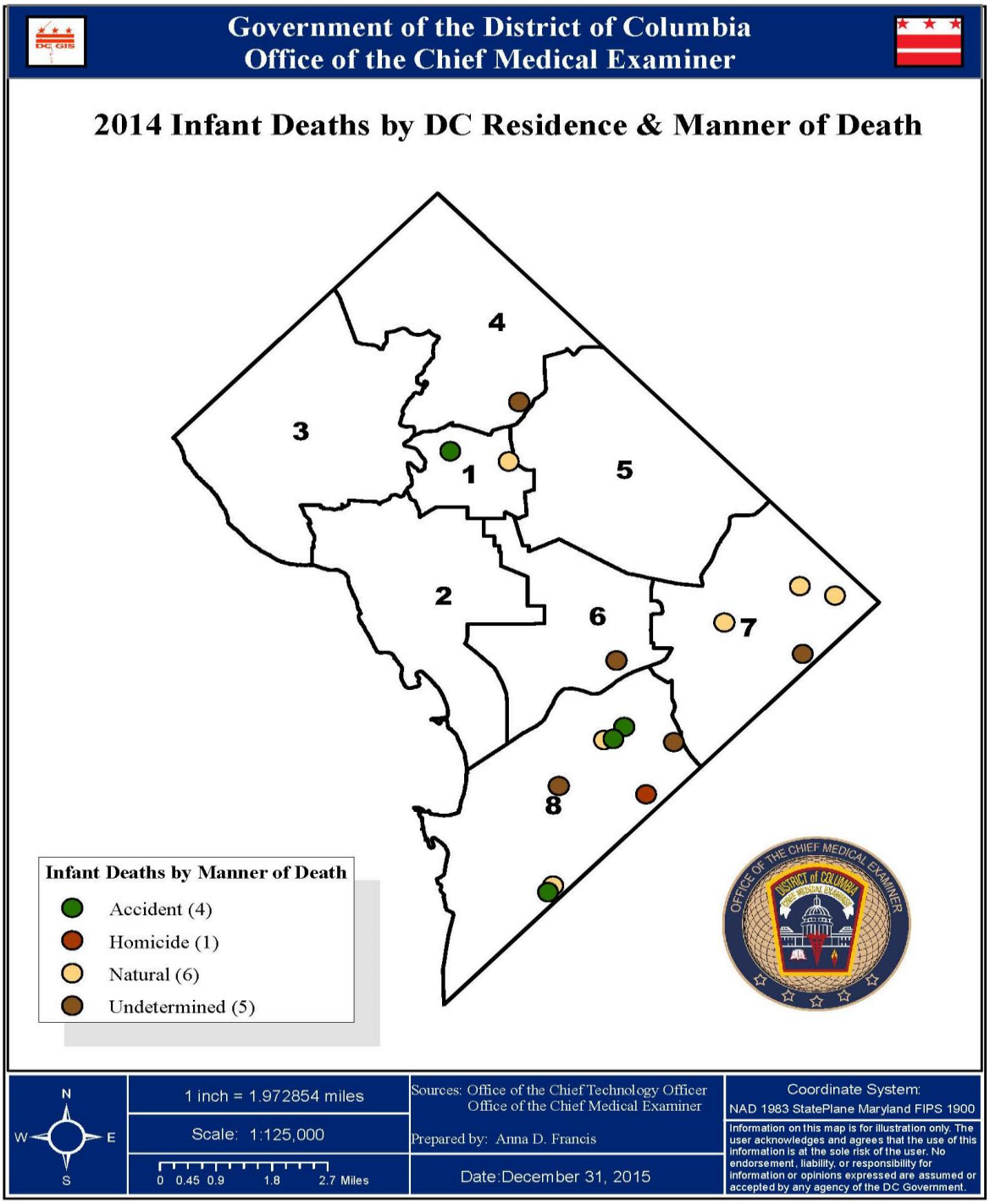
In 2014 there were a total of **32** infant deaths investigated by the DC OCME. The below table provides a breakdown by manner of death the parental residence at the time of the infant's death

Total Infant Deaths by Jurisdiction and Manner of Death					
Jurisdiction of Parental Residence	**Total**	**Accident**	**Homicide**	**Natural**	**Undetermined**
DC	14	3	1	5	5
MD	14	2	3	4	5
VA	2	0	2	0	0
Other	1	0	1	0	0
Homeless	1	0	0	0	1
TOTALS	**32**	**5**	**7**	**9**	**11**



Map of Infant Deaths by Ward and Manner of Death

The CDC defines infants as those children 1 year old or less; whereas the DC OCME reports children "Under 1" and children "1 to 5" separately throughout this report. The map below illustrates those decedents who are 1 year old or less as defined by the CDC and whose parents were residents of the District of Columbia by Ward. See note below for details regarding decedents that were 1 year old at the time of death.



Note: Data includes 1 infant in Ward 7 that was 1 year 1 month old (Natural) and 1 infant in Ward 8 that was 1 year 3 months old (Accident). This data was not included in the previous table of Infant Deaths by Jurisdiction and Manner of Death.

3.0 – ORGAN PROCUREMENT

The Uniform Anatomical Gift Revision Act of 2008 mandates in Sec. 22 [The] cooperation between the Chief Medical Examiner and procurement organization (a) The Chief Medical Examiner and the Office of the Chief Medical Examiner shall cooperate with procurement organizations to maximize the opportunity to recover anatomical gifts for the purpose of transplantation, therapy, research, or education. The primary entity that procures organ donations in the District of Columbia is the Washington Regional Transplant Consortium (WRTC). To maintain compliance with this law and ensure full cooperation is occurring with and between the OCME and WRTC - the Medical Examiner monitors and tracks all organ donation requests. However, the OCME also has a regulatory obligation to ensure that donation request do not compromise the ethical standards, investigation efforts or evidence of the remains, and that the process is conducted with respect and honor to the decedents and their families.

The following tables provide a statistical rendering of all work related to organ requests and the procurement of organs where approval has been provided, as well as where approval is not required.

Permission Granted?	# of Requests	# Procured
Yes	72	29
No	6	0
Request Abandoned	37	0
Not Required	14	2
Approached w/o Permission	2	1
Total Requests	**131**	**32**

In Calendar Year 2014 there were six cases where "Permission" was **not** granted. See table below for details.

Case #	WRTC Donation Request	Reason Denied	Manner of Death
1	Skin, bone, corneas, heart valves and saphenous vein.	Permission not granted due to the circumstances of the death	Suicide
2	Skin, bone, corneas, heart valves and saphenous vein.	ME denied WRTC's request for tissue since MPD could not rule out foul play.	Accident
3	Heart Valves	Little information is known about the circumstances surrounding this case, therefore the request for donation was declined.	Undetermined
4	Bone, Cornea, and Skin	CME denied request because a full dissection must be done, and by that time unfortunately the decedent would have timed out.	Accident (Traffic)
5	Bone, Cornea, Heart, Skin, and Other (Pericardium, Saphenous veins)	Permission denied due to lack of information.	Natural
6	Bone, Cornea, Heart, Skin, and Other (Pericardium, Saphenous veins)	Permission not granted due to the circumstances surrounding the death; therefore pre-autopsy organ donation could not be approved.	Homicide

Note: Authority to "Deny" an Organ donation request is at the discretion of the Medical Examiner.

4.0 – TOXICOLOGY SERVICES

4.1 - Toxicology Findings for Driving Under the Influence (DUI) Cases

Toxicological examinations were performed on driving-under-the-influence (DUI) cases to assist law enforcement agencies in the investigation of such cases. Routine toxicological examinations for DUI cases include analysis for alcohols (ethanol and other volatiles) and major classes of illicit and prescription medications. Additional screens were assigned depending on requests made by law enforcement. In 2014, the laboratory received 292 cases from the Metropolitan Po lice Department (MPD) 135 cases from the United States Parks Police (USPP), 7 specimens from the United States Capitol Police (USCP), and 15 specimens from the United States Secret Service (USSS). Specimens received were either blood or urine, and multiple specimens could be received with each of the 451 cases.

A negative case refers to the absence of any alcohol or detectable drug. A positive case refers to the presence of alcohol and/or drug(s), noting that a case can be positive for more than one sub-stance. Drugs that are excluded from typical DUI toxicology reports include common compounds found such as caffeine and nicotine.

Total number of DUI cases analyzed:

Description	Number of Cases	% of Cases
N=	451	
Negative	24	5.3 %
Positive	427	94.6 %

The table below displays the prevalence of ethanol, phencyclidine, marijuana, cocaine, morphine, and synthetic cannabinoids in the DUI casework submitted by all enforcement agencies.

Drug	Number of Cases	% of Cases
Ethanol	293	64.9%
Phencyclidine (PCP)	130	28.8 %
Marijuana Metabolite	103	22.8 %
Cocaine	35	7.7 %
Morphine / Heroin	16	3.5 %
Synthetic Cannabinoids	15	3.3 %

4.2 - Toxicology Findings for Drug Facilitated Sexual Assault (DFSA) Cases

Toxicological examinations were performed on drug facilitated sexual assault cases to assist law enforcement agencies in the investigation of such cases. Routine toxicological examinations for DFSA cases include analysis for alcohols (ethanol and other volatiles), major classes of illicit and prescription medications, and targeted drugs commonly used in DFSA. Additional screens were assigned depending on requests made by law enforcement. In 2014, the laboratory received 127 cases from District government agencies. Specimens received were either blood or urine, and multiple specimens could be received with each of the 127 cases.

A negative case refers to the absence of any alcohol or detectable drug. A positive case refers to the presence of alcohol and/or drug(s), noting that a case can be positive for more than one substance. Drugs that are excluded from typical DFSA toxicology reports include common compounds found such as caffeine and nicotine.

Total number of DFSA cases analyzed:

Description	Number of Cases	% of Cases
N=	127	
Negative	5	3.9 %
Positive	121	95.2 %

The most commonly types of detected drugs in DFSA cases were

Drug Class	% Prevalence
Negative	3.9%
Ethanol	44.0%
Marijuana	30.7%
PCP	12.5%
Cocaine	11.0%
Opioids	1.0%
Illicit Stimulant	5.5%
Benzodiazepine	9.4%
Antidepressants	19.7%
Over the Counter	17.3%

Subject demographics for DFSA cases were:

Average Age (years)	28.7

Gender	% of Total
Male	7.9%
Female	92.1%
Total	**100%**

Age Range	# of Cases
Ages ≥15 and <20	15
Ages ≥20 and <25	38
Ages ≥25 and <30	34
Ages ≥30 and <35	20
Ages ≥35 and <40	4
Ages ≥40 and <65	16
Total	**127**

4.3 - Breath Testing Program

In 2014, four 40-hour Operator Training Courses were offered, licensing a total of 35 operators. Twenty-four Operators were recertified; therefore there was a total of 132 Licensed Operators. This resulted in 2,253 evidential breath tests being administered through the deployment of 7 instruments into the field.

Program Facts

- Total 40-hour Operator Trainings Provided in 2014: 4
- Total Operators Trained in 2014: 35
- Total Operators Recertified in 2014: 24
- Total Licensed Operators since September 2012: 132
- Number of evidential instruments in the field (cumulative): 7
- Total Evidential Tests Taken since September 2012: 2253

Tests Taken in 2014 by District:

1D: 160

2D: 134

3D: 291

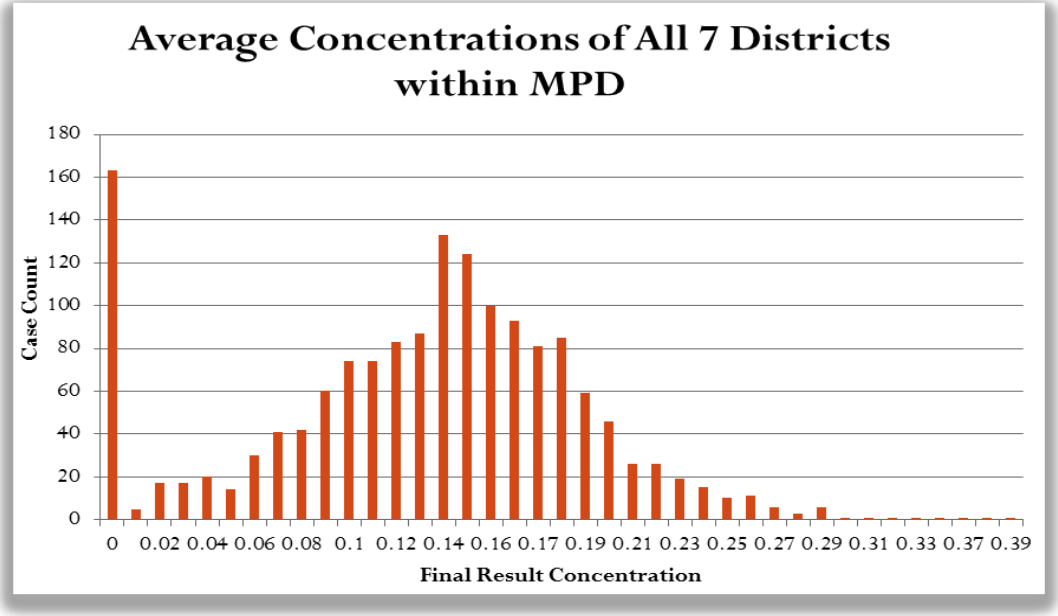
4D: 88

5D: 159

6D: 113

7D: 142

Total: 1087



Additional Facts:

Overall, the program maintains an average of 29% refusals (a refusal is when someone elects to not take an evidential breath test)
83% of evidential tests are taken on individuals from D.C., Maryland and Virginia
10% of evidential tests are taken from individuals driving without a permit (did not provide a Driver's License at the time of test)
7% of evidential tests are taken from individuals with a Driver's License from outside DC, MD, VA

5.0 – OTHER MAJOR ACTIVITIES

All other major activities are conducted under the oversight and strict supervision of the Chief Medical Examiner and/or his designee.

5.1 - Court-related Activities

A parameter not often considered in evaluating the Medical Examiners workload is time spent in pre-trial conferences, depositions and expert testimony provided in family, civil and criminal litigations. This annual report presents tabulated data for these expert services provided in OCME calendar year 2014.

Type of Judicial Service	Number of Court related Activities
Court Testimony	9
Depositions	3
Grand Jury	0
Pre-trial Conference	37
Other	1
Total	**50**

Court Services by Type	Number of Court related Activities
Civil	6
Criminal	43
Other	1
Total	**50**

Court Services by Jurisdiction	Number of Court related Activities
DC	47
Maryland	3
Out of Metro Area	0
Total	**50**

For calendar year 2014 the above data represents approximately **75** hours of Medical Examiner time. In general the least amount of time spent on this activity was 30 minutes, and the maximum recorded time spent on a court-related activity was 2 hours.

5.2 - Identifications

Identifications

The Office of the Chief Medical Examiner is mandated by law DC Code § 5-1412 to "… [give] the name, if known, of every person whose death is investigated." The process of identification can be a complex and lengthy procedure. The methods used to identify decedents whose deaths are investigated by the OCME are detailed below. The methods of identification are listed from the most to least commonly used.

Visual identification: This method is used whenever circumstances of death and discovery allow. In general, the immediate family, close friends, neighbors or colleagues provide identification verification through viewing a photograph of the decedent. At the OCME facility, a digital photograph is taken of the decedent's face and presented to the family or other appropriate individual. Also, visual identification may occur at the death scene if an appropriate individual observed the decedent and is available to speak with the medicolegal death investigator. **Timeframe: Instant**

ID Method	# of ID's
ID By Dental X-ray	10
ID By Circumstantial Evidence	2
ID By Fingerprints	72
ID By Visual • at OCME – 755 • at Scene - 200	955
ID By X-ray	29
ID Other	6
ID Waived	15
Unidentified	1
ID Not Required[5]	30
Total	**1120**

Fingerprint: When the physical state of the decedent allows, fingerprints are captured. These fingerprints are sent to the FBI and processed through the Automated Fingerprint Identification System (AFIS). Fingerprints are searched through both the criminal and civil databases. If the fingerprint search returns a negative hit, the fingerprints are sent to the Metropolitan Police Department for a search at the local level. **Timeframe: Typically 1-5 hours, but may take up to 3 days.**

Radiograph (X-ray) Comparison: Individualizing skeletal characteristics are captured during routine medical and dental radiographs. Antemortem (before death) radiographs are compared to post-mortem (after death) radiographs and these individualizing characteristics are targeted to confirm identification. **Timeframe: Up to 1 week**

DNA testing: This method requires the decedent's DNA profile to be compared to the DNA profile of a close biological relative, preferably a parent or child. The DNA profiles are obtained from a decedent specimen (i.e. femur bone, blood, teeth or deep muscle tissue) and a buccal (cheek) swab collected from the biological relative. Alternatively, the decedent's DNA profile can be compared to the DNA obtained from the decedent's personal item such as a tooth brush or hair brush. **Timeframe: Up to 4 – 6 months**

Circumstantial Identification: Circumstantial identification is utilized when no other means of identification are available and the investigative information strongly supports the identification. Investigative information may include: discovery location (i.e., locked and secured residence); decedent's physical state and date last known to be alive; and, physical description of the decedent (i.e., sex, age, and race).

[5] There were a total of thirty accepted Medical Examiner cases that were not required to be identified, because fourteen were Non-Human Remains and sixteen were Review of Medical Records, where the remains were not required to be transported to the Medical Examiner's office.

Unidentified: Individuals are classified as unidentified when a tentative name cannot be confirmed by the methods listed above or no tentative name is known and fingerprint submissions result in negative hits. Prior to final disposition of the decedent, the case is entered into the National Missing and Unidentified Persons System (NamUs). NamUs is a database managed by the US Department of Justice (DOJ) and is available to the public. Included in a NamUs entry are the decedent's physical description, circumstances surrounding death, identification photograph, photographs of tattoos and clothing, dental and skeletal radiographs and fingerprint cards. Additionally, a biological sample is submitted to a DOJ funded DNA laboratory for analysis and the decedent's DNA profile is uploaded to the Combined DNA Index System (CODIS).

Family members searching for lost love ones have access to NamUs through the internet (http://www.namus.gov/) and may submit a buccal swab for processing and uploading to a family member specific DNA database. The unidentified decedent's DNA profile is regularly compared to all the family member profiles in the database. Positive matches are reported to the investigating agencies.

5.3 - Public Dispositions

All bodies examined at the OCME are stored by the agency until families make funeral arrangements. Usually this occurs in a matter of days. However a portion of the population remains "Unclaimed" or "Unidentified" and final disposition must be arranged by the agency.

Additionally, the OCME provides storage of remains for nursing homes and hospices that do not have refrigerated facilities to store bodies. A minimal one-time fee is charged to these facilities and the remains are kept until family members are located or able to make funeral arrangements. By regulation (DC Code §5-1411), OCME is required to arrange final disposition for unclaimed remains housed at local hospitals.

The process for which unclaimed bodies are handled is called "Public Dispositions." After a 30-day waiting period and after all efforts to locate family members are exhausted the OCME makes final arrangements for these bodies through a contracted local funeral home. All unclaimed decedents (whether identified or unidentified) are cremated and the cremains are buried.

Unclaimed decedents identified as United States military veterans are provided a burial at Quantico National Cemetery. First, veteran status is verified through the National Scheduling Office. Then, a burial is scheduled and the decedent is transported, dressed and casketed by the contracted local funeral home. Family members may attend the interment service.

Notably, Public Dispositions are not performed by Medical Examiners in neighboring jurisdictions. For instance, in Maryland bodies are released to the Anatomical Board after 3 days if they are not claimed by Next of kin.

There were a total of **137** Public Disposition cases, of which **75** were Medical Examiner cases and 62 were Storage cases. There were no unidentified decedents that were released for Public Disposition in 2014. The breakdown by Adult, Children and Fetuses:

Description	# of Public Disposition
Adults	128
Children	5
Fetus	4
Total	**137**

Breakdown of Public Dispositions and the Associated Costs

Public Disposition by type	Number of Unclaimed Remains
Cremations – identified adults	128
Cremations – infants	5
Cremations – fetal remains	4
Transport to Quantico National Cemetery – identified US Military Veteran	6
TOTAL	**143 unclaimed remains**

Cremation Requests

Pursuant to DC Code §5-1405 the OCME must investigate and approve all Cremation requests for deaths that have occurred in the District of Columbia "regardless of where the cremation will occur". This involves review of the cause and manner of death to be sure it is an etiologically specific disease process and that the manner is natural. Should the cause of death not be appropriately documented, the certifying physician is contacted, the cause of death reviewed and the appropriately formatted cause of death is determined. If this review reveals the manner of death is not natural, the death then falls under the jurisdiction of OCME.

Storage Requests

The OCME offers temporary body storage for individuals as well as institutions unable to make immediate funeral arrangements. Institutions – but not families – are charged a $150.00 fee for such requests. In these instances, death certificates are also reviewed for appropriate causation.

During Calendar Year 2014 there were **132** Storage Requests made to the DC OCME

6.0 – BREAKDOWN OF MEDICAL EXAMINER INVESTIGATIONS

The US Census estimates that during 2014, the total population within the District of Columbia was **658,893**[6] inhabitants, which comprised primarily of the following ethnic groups: White, Black, Hispanic, Asian and Other. In 2014, the OCME investigated **3,063** deaths that occurred in the District of Columbia or were wards of the District and died in another jurisdiction. **1,120** of these cases were accepted under the jurisdiction of the Medical Examiner for further investigation; of which **823** of them were known to be residents in the District of Columbia. The following table and charts summarize the manner of death by racial composition. *Although a death occurs in the District of Columbia, the decedent's place of residence can be anywhere in the world.*

2014 Manner of Death* by Race with 2010 Census Data

				BY MANNER OF DEATH					
Race	**2010 Census**	**ME Cases DC Residents Only**	**Total ME Cases**	**Nat.**	**Sui.**	**Hom.**	**Acc.**	**Und.**	**Stillbirths**
Black (non-Hispanic)[7]	301,053	**623**	**753**	445	23	88	174	23	0
White (non-Hispanic)	209,464	**166**	**274**	113	42	8	101	10	0
Hispanic (any single race)	54,749	**23**	**43**	18	2	5	17	1	0
Asian (non-Hispanic)	20,818	**5**	**14**	5	2	2	5	0	0
Two or more races	12,650	**0**	**0**	0	0	0	0	0	0
Other (non-Hispanic)	1,451	**4**	**11**	6	0	4	0	0	1
American Indian and Alaska Native (non-Hispanic)	1,322	**0**	**1**	1	0	0	0	0	0
Pacific Islander (non-Hispanic)	216	**0**	**0**		0	0	0	0	0
Unknown	n/a	**2**	**9**	3	0	0	5	0	1
Total Population	**601,723**								
Total # of ME Cases		**823**	**1,105**	**591**	**69**	**107**	**302**	**34**	**2**
2014 Data – Center for Policy, Planning and Evaluation, DC DOH[8]	**5,495**	**3,732**	**1,105**	**4,982**	**68**	**107**	**300**	**31**	**0**

*The following accepted cases are not represented in the table: Non-Human Remains (14); Anatomical Specimen Disposal (1).

Legend for Manner of Death:

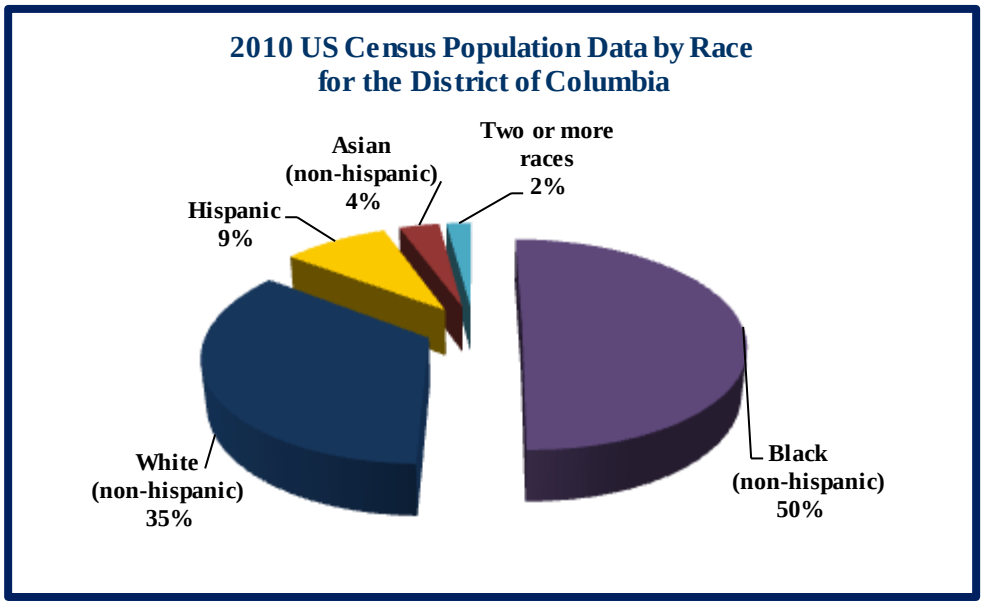
1. Nat. = Natural Deaths
2. Sui. = Suicide
3. Hom. = Homicide
4. Acc. = Accident
5. Und. = Undetermined
6. Stillbirth = Fetal Deaths

[6] Source: US Census Bureau at http://quickfacts.census.gov/qfd/states/11000.html.

[7] The (non-Hispanic) attribute only applies to the 2010 Census data and does not apply to the OCME statistics for race by "Manner of Death"

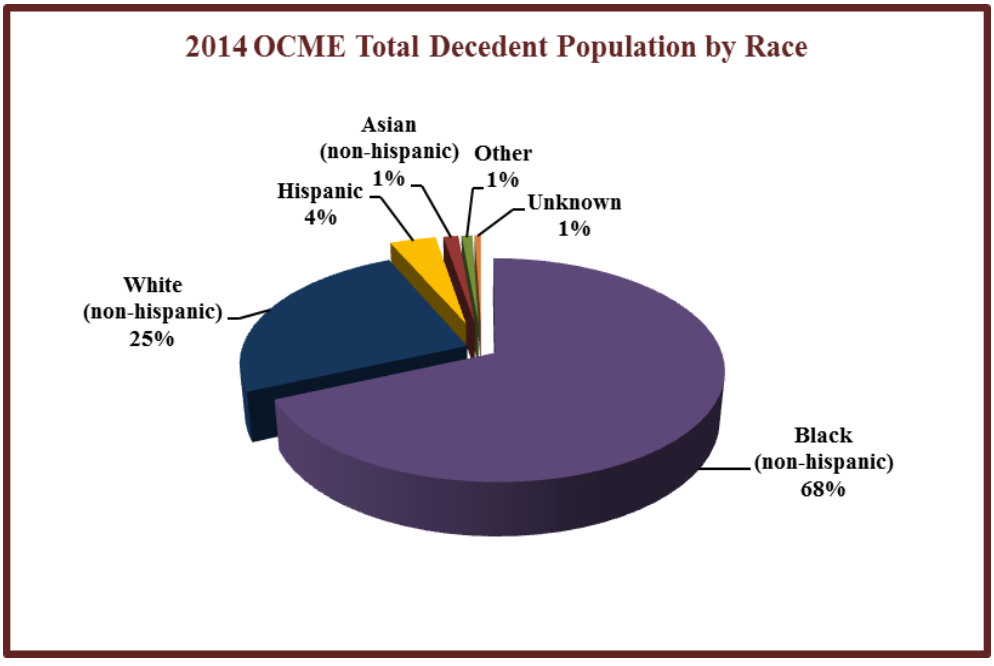
[8] The DC DOH Center for Policy, Planning and Evaluation had 7 cases that were "Pending Investigation" at the time of submitting this data to the DC OCME. In addition, the total number of deaths reported by DOH includes all DC residents, including deaths that occurred outside of the District of Columbia.

6.1 - Total Population



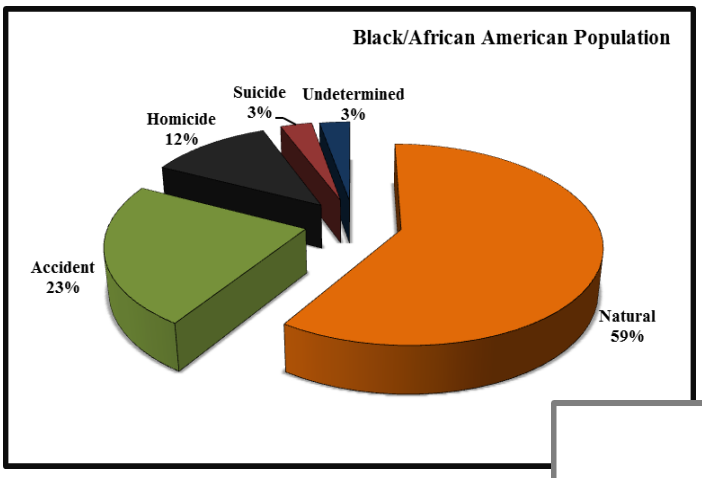
Note: The race categories American Indian/Alaska Native and Pacific Islander/Native Hawaiian are not represented in the above graph because they are both less than 1% of the total population in the District of Columbia. On the other hand, Hispanics are represented in this graph; although this classification is considered to be an ethnicity and NOT a race.

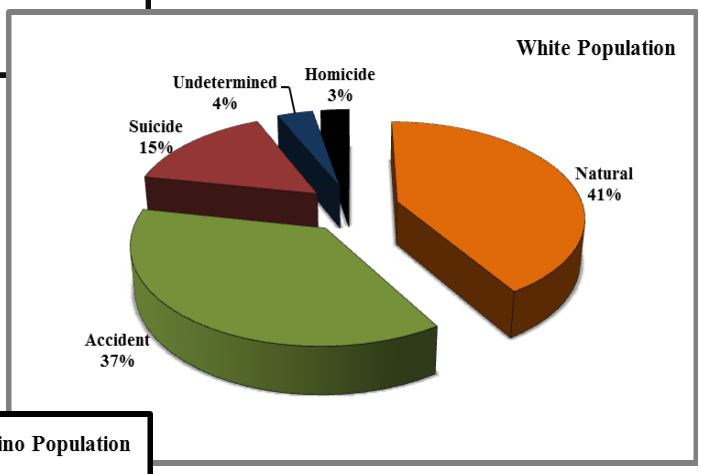
6.2 - Total ME Cases by Demographics and Manner of Death

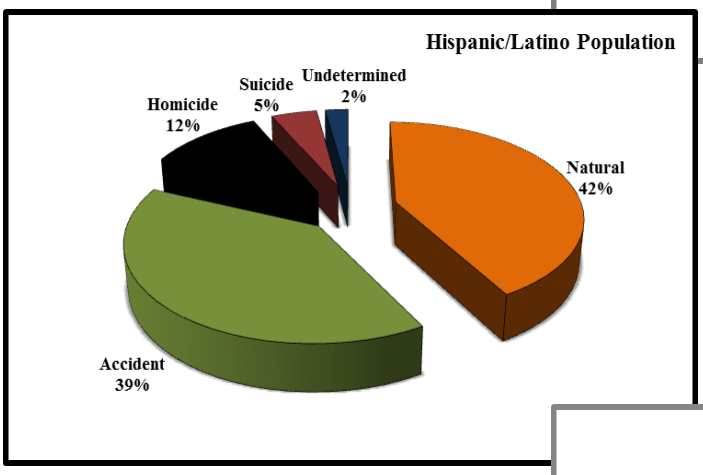


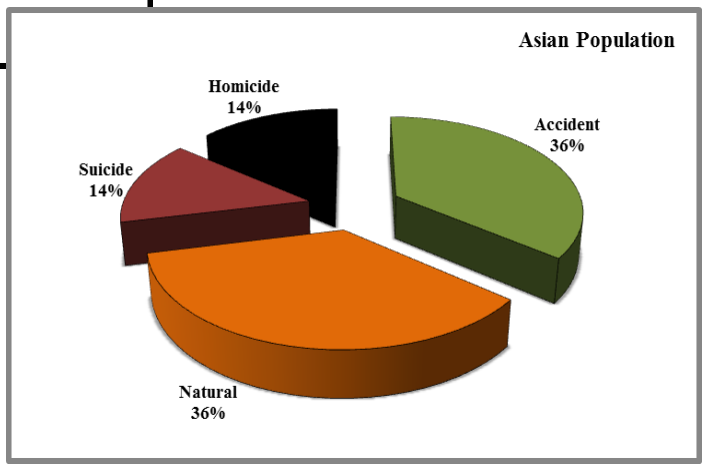
Note: Race is recorded by the District of Columbia OCME as reported by the decedent's next of kin. Also, for illustrative purposes those races that are less than 1% are not included in the OCME Total Population chart.

By Race and Manner of Death[9]









[9] The graphs above represent all accepted Medical Examiner cases, but these decedents do NOT represent District residents only.

2014 Totals by Age

Age Group	Total Deaths	Percent
Fetus	2	0%
Under 1	32	3%
1 to 5	16	1%
6 to 12	5	0%
13 to 15	5	0%
16 to 19	17	2%
20 to 29	87	8%
30 to 39	97	9%
40 to 49	131	12%
50 to 59	232	21%
60 to 69	221	20%
70 to 79	115	10%
80 to 89	102	9%
90 and Over	42	4%
Unknown	1	0%
TOTAL	**1105**	**100%**

2014 Gender by Race

Race	Males	Females	Total
American Indian	1	0	1
Asian	11	4	15
Black	502	252	754
Hispanic	29	14	43
Other	4	7	11
Pacific Islander	0	0	0
Unknown	3	3	6
White	178	97	275
TOTAL	**728**	**377**	**1105**

2014 Manner of Death by Gender

Gender	Naturals	Suicide	Homicides	Accident	Undetermined	Pending	Stillbirth	Totals	Percent
Female	213	18	21	114	10	0	1	**377**	**34%**
Male	378	51	86	188	23	1	1	**728**	**66%**
Totals	**591**	**69**	**107**	**302**	**33**	**1**	**2**	**1105**	**100%**

Note: The above table does not include – Non-Human Remains (14) and Anatomical Donations (1)

[1] The tables above represent all accepted Medical Examiner cases, but these decedents do NOT represent District residents only.

APPENDIX A

OCME Organizational Chart

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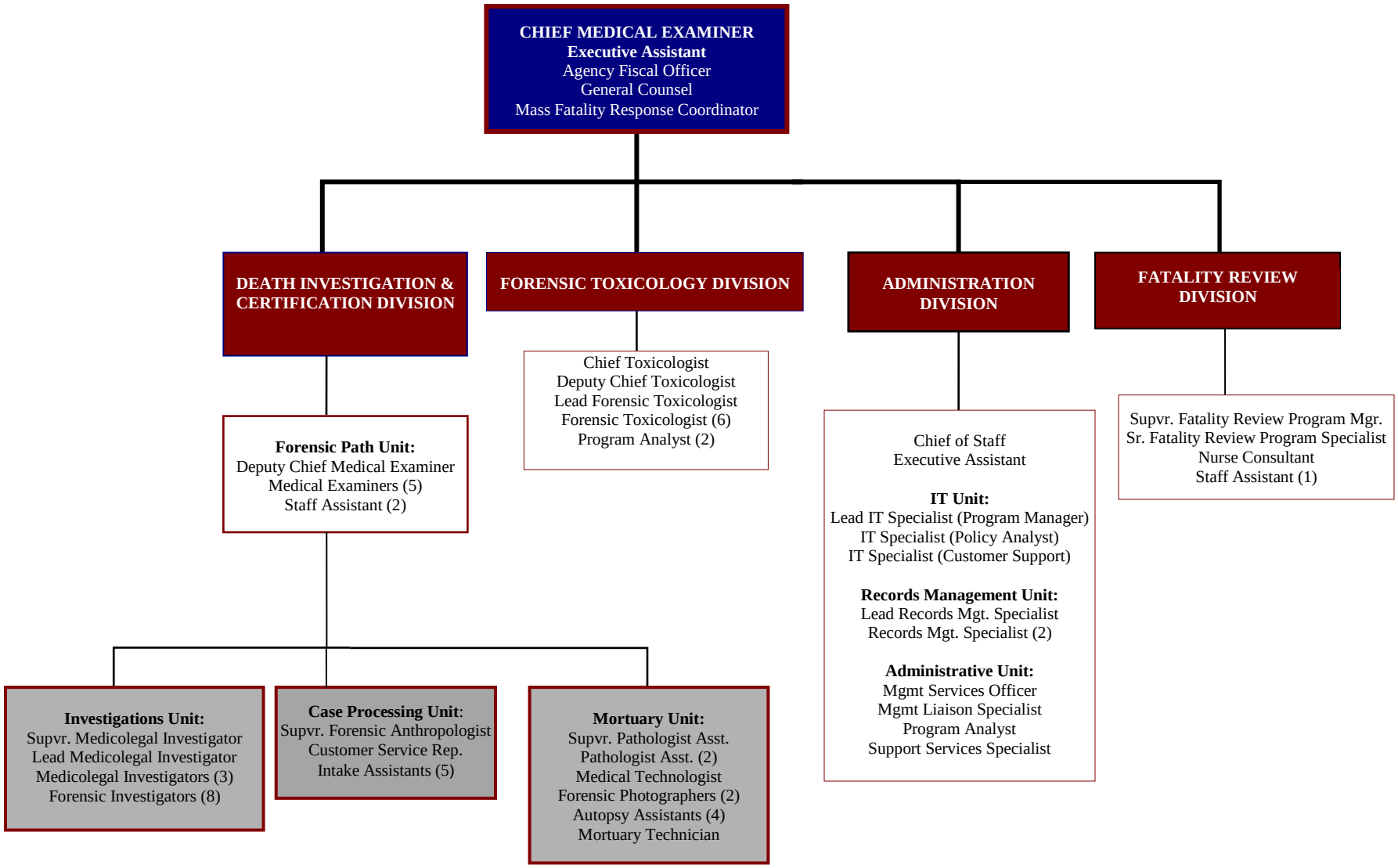
OFFICE OF THE CHIEF MEDICAL EXAMINER
ORGANIZATIONAL CHART FY 2014



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APPENDIX B

AGENCY MANAGEMENT

AGENCY MANAGEMENT

Administration Peformance Management

The agency's Administrative Division provides support to the work discussed within this annual report in the areas of: strategic planning; finance and procurement; human resources; information technology; quality assurance and control; legal management; risk management; labor management; and incident management. The agency's administration and key managers also facilitated key strategic partnerships in the fields of forensic services, education, emergency services, health care, research, grants and law enforcement. The agency also continues to offer internship opportunities for students in forensic science and physician assistant programs throughout the nation.

The Administrative Division is responsible for monitoring and ensuring efficient operations via establishment and compliance of an agency performance plan that includes key performance indicators – the performance component of agency management. The agency performance accountability per performance plan objectives and KPIs is included herein. Agency Management underwent a transition in 2014 with the hiring of a Chief Medical Examiner that is fully board-certified and a highly experienced and educated managerial staff. This management team was successful in shepherding the initiatives outlined herein.

I. Strategic Planning:

A. Mission Statement

During 2014, the agency enhanced its mission statement to include various aspects of its services and goals. The mission now provides more specificity for staff and external entities on the agency short and long term objectives as follows:

"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.

The mission is achieved through:

- provision of vision and leadership for the OCME;
- achievement and maintenance of excellent forensic service, education and research in the critical areas of:
  - Investigation, Response, and Reporting of the Cause & Manner of Death;
  - Expert Witness Testimony;
  - Education and Training of law enforcement, health care providers and other stakeholders; and
  - Provision of family assistance in understanding the cause and manner of death of decedents;
- support of law enforcement and public health related initiatives at the state, local, and county levels (i.e. Gang Violence, Drug Abuse); surveillance of critical mortality data; and identification of emerging public health/law enforcement trends; and

- development of partnerships with county/state agencies geared toward mass fatality preparedness."

B. Five Year Strategic Plan

The agency also began developing a five-year strategic plan. The Chief Medical Examiner worked with the management team to complete a Needs Assessment in 2014 which entailed: a) gap identification and development of recommendations for improvement and short term goals; b) foundation building and implementation of recommendations and short term goals; and c) development of a longevity study focused on organizational framework. Subsequently, the Strategic Planning/Agenda for Service Optimization will be developed utilizing the information and data gathered from the Needs Assessment process. This 24 month to 5 year plan will include review of facilities, training/education, staffing models, budget, inventory, data outcomes etc. The purpose will be to determine gaps; to recommend and implement short-term and long-term changes in the organization; and to provide a foundational strategic plan for the present and future to mirror the District's budget and performance planning process that is currently ongoing.

II. Accreditation

In 2014, the agency began preparation for inspection and application for accreditation by the National Association of Medical Examiners (NAME). As part of the process, the agency completed a Self-Inspection in December of 2014 consisting of reviewing the NAME inspection checklist of standards that assess the quality of a medical examiner system. The agency also completed a revision of agency Standard Operating Procedures (SOPs) regarding general office operations, investigations; morgue operations, histology, toxicology, reports and recordkeeping, personnel and staffing and support services and consultants.

III. Incident Management Planning:

Per its mission and responsibility as the agency responsible for fatality management within the District, the agency focused on incident management planning. The agency's Mass Fatality and Continuity of Operations Plans were set for revision and the agency focused on building stakeholder partnerships on a local, regional and federal level with key entities responsible for incident planning within the region. A Mass Fatality Coordinator was hired during the year for this purpose. Staff emergency and incident planning trainings began on 9/8/14 and included a full-scale internal exercise on 9/15/14, as well as after action meeting and reports and weekly sessions with the Chief Medical Examiner. Throughout the year, the staff participated in several City-wide exercises, including a Hurricane and Cyber Security exercise.

IV. Risk Management

The agency's Risk Assessment Control Committee ("RACC") met on a quarterly basis to discuss and evaluate various facility, employee and other incidents that potentially bring risk or liability to employees, the facility or the District overall. During 2014, meetings focused on the risk associated with safety and health aspects of work processes and laboratory operations. The agency has increased efforts for laboratory equipment inspections, staff training in safety procedures in laboratories and the mortuary, as well as health and wellness. A Safety & Health Committee was established as a subcommittee of the RACC. The Office of Risk Management (ORM) provides requirements for a successful agency risk assessment and control program, including: conducting quarterly meetings; submittal of cost of risk reports; developing and implementing Agency Risk Management Plans; updating the agency's Continuity of Operations Plan (COOP); providing training for the agency's revised Emergency Response Plan (ERP); and conducting emergency response drills. The agency met all requirements.

Death Investigation and Certification Management

The OCME's Death Investigation and Certification Division is responsible for forensic pathology, forensic investigation and mortuary services. Of note, during 2014, the agency formed a new Anthropology Laboratory & Identification Unit, initiated by the hiring of a Forensic Anthropologist in September. The agency currently did not have a fully functional anthropology laboratory and outsourced this service. Equipment for the Anthropology Laboratory was purchased and work began immediately in October 2014, eliminating the need for outsourcing. The Identification Unit administers the agency's Decedent Identification Program ensuring that identifications are made in an accurate and efficient manner according to agency and District policies and procedures and utilizing principles of medicolegal death investigation and forensic anthropology.

The forensic pathology, investigation, identification and mortuary staff work toward the determination of cause and manner of death and completion of postmortem examination reports. This entails ensuring that appropriate death scene response and investigation, investigative reporting, postmortem examination reporting, public disposition and other factors that are measured by agency Key Performance Indicators.

Key Performance Indicators[1]

Measure One:
This measure requires that the agency complete 90% of reports of all postmortem examinations within 90 calendar days from the time of autopsy in homicide cases, based on National Association of Medical Examiner (NAME) standards. For FY2014, the agency completed 64.1% of these reports within 90 calendar days.

Measure Two:
This measure requires that the agency complete 90% of reports of all postmortem examinations within 60 calendar days from the time of autopsy in all cases (excluding homicides), based on NAME standards. For FY2014, the agency completed 47.16% of these reports within 60 calendar days. Note that during the fiscal year, the agency did achieve 90% of all postmortem examinations completed within 90 days, which is the current NAME standard.

> *Note on Measures One and Two:*
> The agency continues to work to improve in this area with the implementation of technology; establishment of timelines; and weekly reporting to medical examiners regarding their caseload; status of pending cases. Of importance is the fact that some cases do not meet the timeline due to one or all of the following factors: the need for outside consultation; challenges in obtaining histology services; need to review toxicological findings; requests for Metropolitan Police Department (MPD), Fire and Emergency Medical Services (FEMS) or other investigatory reports; or due to the fact that the case is complex. Further, the agency experienced vacancies in medical examiner staffing.

Measure Three:
The third measure requires that 95% of positively identified bodies be ready for release within forty-eight hours. For FY2014, the agency reached an actual percentage of 94.02%, exceeding the target. Those bodies that are not ready for release within 48 hours represent a variety of situations ranging from cases requiring further investigation or examination; cases being reported on holidays

[1] The District's Agency Key Performance Indicators (KPIs) are compiled on a fiscal year basis. Thus, all KPI data included in this report reflects FY2014 -- the time period between October 1, 2013 through September 30, 2014.

or weekends when it is difficult to reach attending physicians for information; and the need to hold cases over for examination due to a large workload or other workflow issues.

Measure Four:
The fourth measure assesses the percent of preliminary investigative reports complete for utilization in the daily case review morning meetings. The goal (95%) is to ensure that the reports are available and complete for review and discussion the next morning prior to the postmortem examination. Approximately ninety percent or 89.82% of the investigative reports were complete for use in the morning meetings in FY2014.

Measure Five:
In FY2014, OCME's body transport vendor or mortuary staff arrived on scene within one hour of notification of case acceptance 90.33% of the time meeting the 90% target.

Forensic Toxicology Laboratory Management

The OCME Forensic Toxicology Laboratory maintains standards of practice for the detection, identification and quantitation of alcohol, drugs and other toxins in biological specimens. Accredited by the American Board of Forensic Toxicology (ABFT), the forensic toxicology laboratory made key strides in support of efficient operations and provision of service on medical examiner cases.

Moreover, the laboratory continues to provide testing services to external local and federal agencies. For example, during FY2014[2], the laboratory processed 707 Driving Under the Influence (DUI) cases for outside agencies. Members of the toxicology laboratory staff are also trained to provide interpretive services and expert testimony on a variety of drug and alcohol related matters and provides such service to the Office of the Attorney General (OAG), the Public Defenders Service, and the United States Attorney's Office (USA).

The laboratory maintained administration of the District's Breath Alcohol Testing Program according to industry standards, including training MPD officers. Staff also provided monthly in-depth statistical reports to MPD using data obtained from the program. These statistics included how many officers were successfully certified, how many tests were taken per trained officer, and subject refusal rates.

During 2014, the laboratory conducted a surveillance project on the prevalence of synthetic drug usage in the District. Approximately 500 suspected DUI cases and 100 postmortem cases were analyzed for the prevalence of synthetic cannabinoid (K2, spice) metabolites. Cases which screened positive were forensically confirmed using an identical method and reported. Based on those results, only DUI casework will continue to be routinely screened for synthetic cannabinoids.

The Toxicology Division worked with the IT Unit in 2014 to complete the Toxicology Case Management Module to the agency's case management system -- Forensic Analytic Case Tracking System (FACTS) – to improve overall workflow. The staff worked with the vendor to install and provision the server to be utilized for the module and evaluated and tested the system and user interface such that the system could be fully integrated with the agency's database. Testing was

[2] The workload measures included herein, including the number of DUI cases processed by the toxicology laboratory, are based on FY2014 -- the time period between October 1, 2013 through September 30, 2014.

done on a day to day basis from office and home systems. Staff was trained on the system, the module went "live" and protocols integrated into the laboratory's SOPs.

Key Performance Indicators

Measure Six:
Measure six provides results of toxicology laboratory performance requiring for FY2013 that 90% of negative toxicology examinations be completed within 30 calendar days of case. The actual percentage was 29.93%.

Measure Seven:
Measure seven required 90% of positive toxicology examinations be completed within 60 calendar days of case. The actual percentage was 62.46%.

Fatality Review Management

The Fatality Review Division (FRD) is tasked with fulfilling the agency mission of facilitating the operation of two committees and one board: Child Fatality Review Committee (CFRC); Developmental Disabilities Fatality Review Committee (DDFRC); and the Domestic Violence Review Board (DVRB). These committees and boards conduct reviews of to provide analysis and recommendations to the public and District entities serving defined populations, so they can address syste4mic problems, provide better services and be held accountable. In 2014, these reviews were held and recommendations to prevent deaths were developed for other agencies and entities with respect to policies and procedures and operations.

In 2014, the FRD revised existing Standard Operating Protocols and Procedures. The agency also began a review of staffing alignments and work processes in order to implement an improved organization structure. While work of the FRD is currently divided amongst three staff persons, more structure and additional staffing is required in order to increase overall productivity. A plan was developed to assess the gaps and provide a long term strategy.

Key Performance Indicators

Measure Eight:
This measure required the CFRC to hold 80% of child fatality reviews within six months of notification of the death. In FY2012, the CFRC completed 90% of multi-agency and statistical reviews of child fatalities within six months of notification of death, exceeding the target.

Measure Nine:
This measure required the DDFRC to review 80% of fatalities within three months of receipt of the investigative report from DDS (formerly MRDDA). One hundred percent (100%) of the cases were reviewed in this timeframe.

APPENDIX C

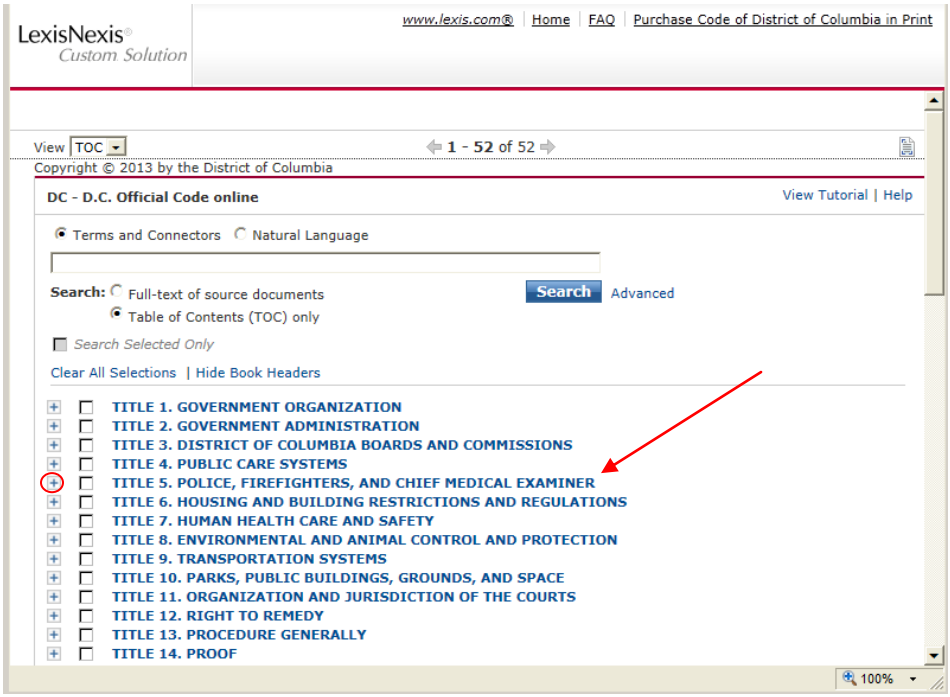
PROGRAM LEGISLATION

OCME, DC Law 13-172, codified at DC Official Code §5-1401 et seq. (2001)

All of the DC Code for District of Columbia Government agencies can be found at:
http://www.lexisnexis.com/hottopics/dccode/

Follow these steps to access the DC Code for the Office of the Chief Medical Examiner:

1) Click the "+" sign next to: **TITLE 5. POLICE, FIREFIGHTERS, AND CHIEF MEDICAL EXAMINER**



2) Then select: **Chapter 14. Chief Medical Examiner**

3) Then click the appropriate portion of the DC Code you prefer to review.

(i.e. § 5-1402. Establishment of the Office of the Chief Medical Examiner; appointments, qualifications, and compensation.)

APPENDIX D

INTERNAL SERVICES

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Wendt Center for Loss and Healing
RECOVER Program
January 2014- December 2014

November 2014 marked the 15th anniversary of a successful collaborative contract between the Wendt Center and the DC Office of the Chief Medical Examiner. The Wendt Center's RECOVER program continued to work collaboratively with the Office of the Chief Medical Examiner to support the community through the process of decedent identification by providing crisis and early intervention bereavement support, education and resources to all individuals who come to the office to complete decedent identification. Recognizing the impact of vicarious trauma, monthly stress release workshops and the option to schedule 1:1 support sessions continued for all OCME staff members.

The RECOVER team is comprised of counselors, social workers and masters graduate interns who are trained in grief, trauma, loss and crisis. Staff counselors are present at the OCME 7 days a week, 365 days a year to provide support, education and resources to individuals and families as they navigate the decedent identification process. The RECOVER staff believes in empowering survivors through education, normalization and compassionate emotional support. All individuals completing decedent identifications are treated with respect and dignity. Staff counselors work closely with OCME investigators, communications staff and medical examiners to provide families with appropriate and helpful information in an effort to decrease the anxiety and stress that can often accompany sudden death and the identification process. Staff assists families in thinking about next steps, preparing children for funerals and recognizing acute reactions to crisis and trauma. It is within the identification suite that RECOVER staff will often teach individuals grounding and stabilizing techniques to manage the overwhelming feelings experienced during an ID.

RECOVER Staff provided informational packets and support to nearly twelve hundred people (1200) who presented to complete nearly 550 identifications. The informational packets provide families with a better understanding of the policies and procedures of the OCME, how to talk to children and teens about trauma, grief and loss, preparing for a funeral or memorial service, accessing a community based vigil program, common reactions to death, concrete recommendations for taking care of oneself after a death and resources for crisis, burial assistance and social services. Informational handouts were made available in both English and Spanish.

Each month, a RECOVER staff counselor facilitated a staff stress relief session to OCME staff. Sessions provide educational material on issues including vicarious trauma, loss, self care, stress, mindfulness and grief. Utilizing art, music, food and talk staff members are invited to explore the impact of working in a high stress environment on their body, mind and spirit and focus and learn healthy ways of taking care of themselves. A specially developed training module on crisis, grief, trauma and the decedent identification process was presented to the identification unit of the OCME staff. This is a team that works directly with funeral homes and family members.

This year the Wendt Center staff continued to participate in the Fatality Committee meetings providing clinical perspective and direct service data.

APPENDIX E

GLOSSARY

Glossary

Autopsy – A detailed postmortem external and internal examination of a body to determine cause and manner of death, collect evidence, and determine the presence or absence of injury.

Cause of Death – The disease, injury, or poison that results in a physiological derangement or biochemical disturbance that is incompatible with life. The result of post-mortem examination, including autopsy and toxicological findings, combined with information about the medical history of the decedent, serves to establish the *cause of death*.

Chief Medical Examiner – The head of the *Office of the Chief Medical Examiner*. The Chief Medical Examiner must be a board certified forensic pathologist licensed to practice medicine in the District of Columbia and may appoint a *Deputy Chief Medical Examiners* and other forensic pathologists.

Drug Caused Death – A death caused by a drug or combination of drugs.

External Exam- A detailed postmortem external examination of the decedent's body, clothing, and injuries that may have caused or contributed to their death another.

Jurisdiction–The jurisdiction of the Medical Examiner extends to all reportable deaths occurring within the boundaries of the District of Columbia, whether or not the incident leading to the death (such as an accident) occurred within the district. The Office of the Chief Medical Examiner functions pursuant to District of Columbia Code, Division I, Title 5, Ch.14. (DC Law 13-172). Reportable deaths are defined by DC Official Code §5-1401 et seq. (2001), as explained in the "Introduction" section of this report. Not all natural deaths reported fall within the jurisdiction of the Medical Examiner**.**

Manner of Death – The general category of the circumstances of the event which causes the death. The categories are *accident, homicide, natural, suicide,* and *undetermined*.

Manner: Accident – The *manner of death* used when there is no evidence of intent; an unintentional, sudden, and unexpected death.

Manner: Homicide – The *manner of death* in which death results from the intentional harm of one person by another, including actions of grossly reckless behavior.

Manner: Natural – The *manner of death* used when a disease alone causes death. If death is hastened by an injury, the *manner of death* is not considered natural.

Manner: Suicide – The *manner of death* in which death results from the purposeful attempt to end one's life.

Manner: Undetermined – The *manner of death* for deaths in which there is insufficient information to assign another manner. An undetermined death may have an undetermined cause of death and an unknown manner, an undetermined cause of death and a known manner, or a determined cause of death and an unknown manner.

Motor Vehicle Collision Related Death – A death involving a motor vehicle. Motor vehicles include automobiles, vans, motorcycles, trucks, aircraft, and trains. The decedent is usually a driver of, a passenger in, or a pedestrian who is struck by a motor vehicle. The death of a bicyclist that is struck by a motor vehicle is considered to be a motor vehicle related death.

Office of the Chief Medical Examiner – The Office of the Chief Medical Examiner (OCME) is responsible for the investigation of sudden, violent, or unexpected death.

Race/Ethnicity– The racial categories used in this report are: African American, American Indian/Alaska Native, Asian/Pacific Islander, Other, and White. Hispanic is the only ethnicity included in data.

Stimulant – A class of drugs, including cocaine and oral amphetamines, whose principal action is the stimulation of the central nervous system.

Sudden and Unexpected Infant Death – A diagnosis designated for infants (children under the age of 1 year). Sudden and Unexpected Infant Death (SUID) is a diagnosis made in cases in which autopsy does not reveal a definitive medical or traumatic cause of death and the circumstances surrounding the death suggest that there is an associated risk factor for dying, such as unsafe bedding or co-sleep, or some other external factor, but the contribution of this factor cannot be determined with certainty. The diagnosis may also be used in the situation where a medical disease is identified, but it is uncertain that this disease caused death.

Toxicology Terms:

Ethanol – An alcohol, which is the principal intoxicant in beer, liquor, and wine. A person with an alcohol concentration in blood of 0.08 percent by weight by volume (0.08%) is legally intoxicated in the District of Columbia.

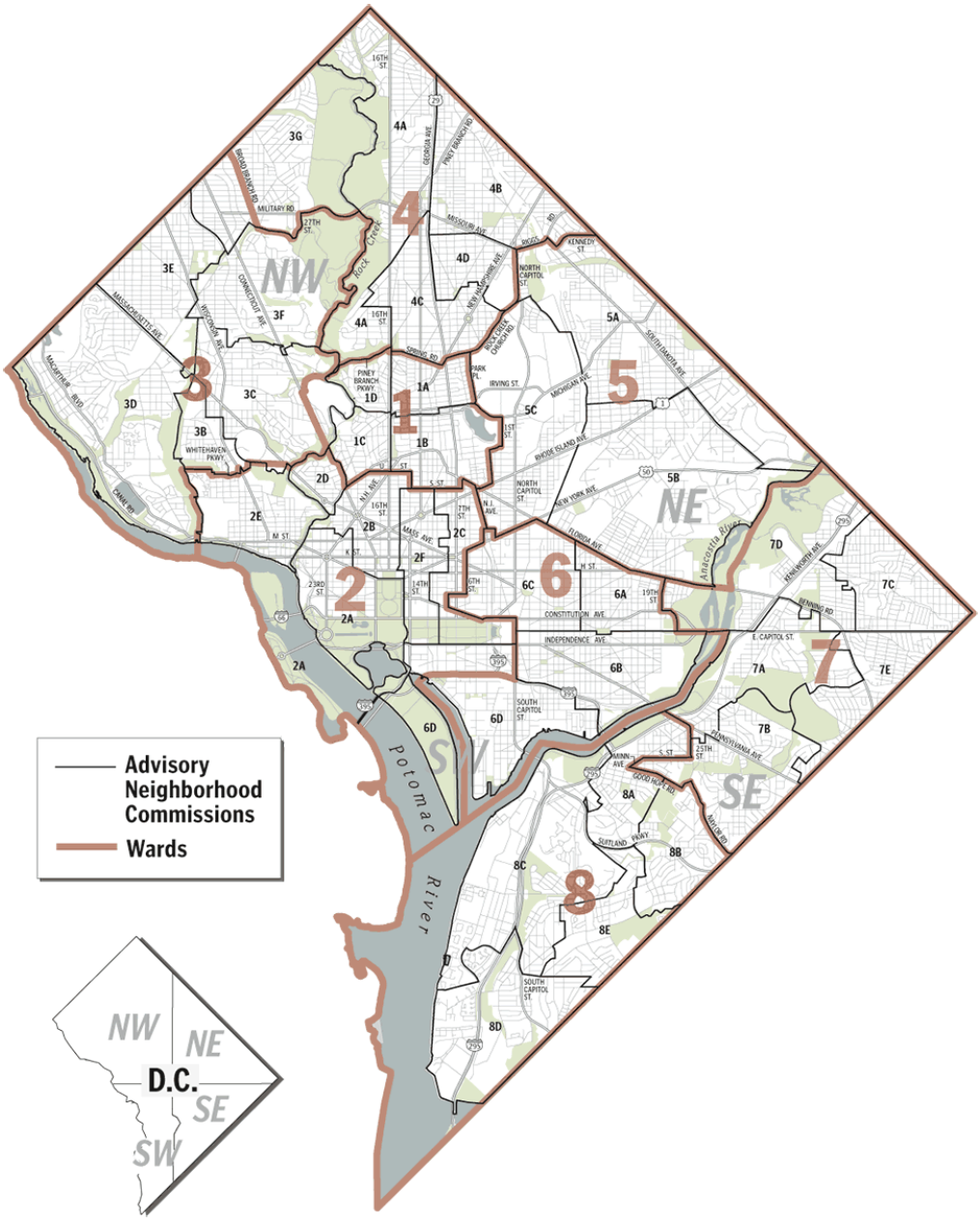
Ethanol Present – Deaths in which toxicological tests reveal a reportable level of *ethanol* (0.01% W/V or greater) at the time of death.

Opiate – A class of drugs derived from the opium poppy plant (*Papaver somniferum*). “Opioid” is often used interchangeably with opiates, and describes chemical/pharmaceutical narcotics that bind to the opiate receptors of the brain and work very similarly to opiates.

Poison – Any substance, either taken internally or applied externally, that is injurious to health or dangerous to life, and with no medicinal benefit.

Medical Examiner Wards (MAP)

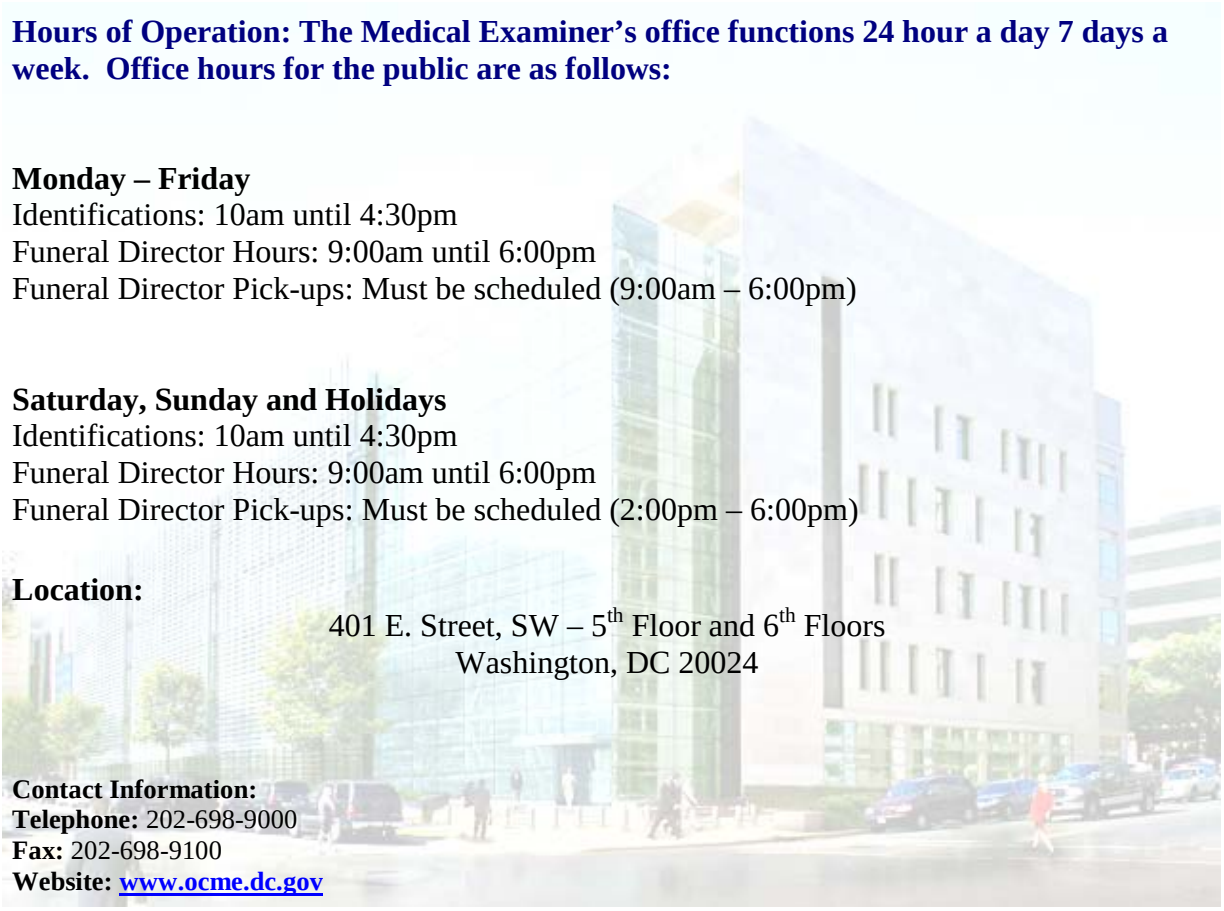
The DC Office of the Chief Medical Examiner can accept jurisdiction of any death within the eight (8) wards in Washington DC and/or neighboring states or communities. The ward boundaries are defined every 10 years on the 2nd year of the decade.



Source: http://www.washingtonpost.com/wp-srv/metro/specials/theguide/maps05/dc_anc.html

GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF THE CHIEF MEDICAL EXAMINER

HOURS AND LOCATION



Hours of Operation: The Medical Examiner's office functions 24 hour a day 7 days a week. Office hours for the public are as follows:

Monday – Friday
Identifications: 10am until 4:30pm
Funeral Director Hours: 9:00am until 6:00pm
Funeral Director Pick-ups: Must be scheduled (9:00am – 6:00pm)

Saturday, Sunday and Holidays
Identifications: 10am until 4:30pm
Funeral Director Hours: 9:00am until 6:00pm
Funeral Director Pick-ups: Must be scheduled (2:00pm – 6:00pm)

Location:

401 E. Street, SW – 5th Floor and 6th Floors
Washington, DC 20024

Contact Information:
Telephone: 202-698-9000
Fax: 202-698-9100
Website: www.ocme.dc.gov

"Show me the manner in which a nation or a community cares for it's dead, and I will measure with mathematical exactness the tender sympathies of it's people, their respect for the laws of the land and their loyalty to high ideals."

William Gladstone,
Prime Minister of England

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