A MESSAGE FROM THE CHIEF MEDICAL EXAMINER

The calendar year of 2007 was a time of great accomplishment for the Office of the Chief Medical Examiner (OCME).
At the end of Fiscal Year 2006, the office had eliminated its historical backlog and began to work on solving core facility and staffing issues identified by the Inspector General's Office. In 2007, we concentrated our efforts towards bringing the office up to the standards set by the National Association of Medical Examiners (NAME). We developed and adjusted several agency programs including the Death and Investigation Unit and addressed many facility issues. These efforts were rewarded when the office received "*Provisional Accreditation*" from NAME – an accomplishment that has never before been achieved by this office since its inception.

I would like to recognize the staff of the OCME for their outstanding participation in community outreach programs throughout the year such as the DC One Fund, the Operation Prevent Auto Theft, as well as the DC Career Day's hosted at the local public schools.

I would also like to acknowledge the continued support of the Executive Office of the Mayor, the Council, as well as all the professional entities such as the Wendt Center, the Metropolitan Police Department, and Fire/EMS whose members are always ready to help in the retrieval and transport of extremely obese bodies (i.e. 500 lbs and above) all of which we collaborate with throughout the year. I am truly proud of the staff here at the OCME and the extraordinary work they have done over the course of the 2007 calendar year.

Sincerely,

Marie-Lydie J. Pierre-Louis, MD

Marie-Lydie Y. Pierre-Louis, MD
Chief Medical Examiner
Government of the District of Columbia

DISTRICT OF COLUMBIA
OFFICE OF THE CHIEF MEDICAL EXAMINER

2007 ANNUAL REPORT

MISSION:

The mission of the Office of the Chief Medical Examiner (OCME), for the District of Columbia, is to investigate and certify 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.

PRESENTED TO:

The Honorable Adrian M. Fenty, Mayor, District of Columbia
and
The Council of the District of Columbia

December 2008

Executive Summary

The Government of the District of Columbia Office of the Chief Medical Examiner (OCME) is pleased to present its Sixteenth Annual Report. This Report covers data that resulted from the investigation of 3,049 deaths that occurred in the District of Columbia during the Calendar Year (CY) 2007. Report data will be included for: Weight Distributions, Internal Partnerships, Identification Process, Agency Management and Other Major Activities which include - Court Tracking, Mass Casualties, Educational Lectures and Presentations.

The OCME was established as a Medical Examiner's system from a Coroner system in 1971. At that time the office had a single program, which was Death Investigation and Certification. The OCME has grown into a cabinet level agency that serves under the administrative authority of the Deputy Mayor for Public Safety and Justice. OCME's primary mission is to investigate all known or suspected homicides, suicides, accidents, drug-related and medically unattended deaths, all deaths in at risk populations (e.g. children and the intellectually and developmentally challenged individuals), deaths of those in custody and/or are wards of the District of Columbia, as well as those deaths considered to be a threat to public health and safety. The agency now has three programs: Death Investigation and Certification, Agency Management, and Fatality Review. This report will include data on all existing programs.

OCME is one of the few medical examiner offices in the nation that provides on-site grief counseling. We are pleased to be able to continue this service through a partnership with the Wendt Center for Loss and Healing (See Appendix C – Internal Partnerships, for more information on the program).

In preparation for possible terrorist attacks and mass disaster, OCME continues to develop alliances with area hospitals, the Department of Health (DOH), and with agencies in the Public Safety and Justice Cluster with a goal to enhance the agency's Mass Fatality Plan in coordination with the National and District Response Plans. To practically accomplish this goal, we participated in local and federal exercises to determine scenarios not considered, additional resources that may be necessary, and processes and authorities that must be established. OCME is a member of the Interstate Compact that seeks to develop interstate mutual aid and unites Maryland, Virginia, Delaware, the District of Columbia, Federal Agencies and other jurisdictions in the event of a mass incident.

During 2007, the OCME staff continued to be very active in social programs such as Operation Prevent Auto Theft (OPAT), Career Day at District of Columbia Public and Public Charter schools, the Mayoral Summer Youth Program and the DC One Fund.

OCME provided academic training to medical students and pathology residents from local hospitals, students from different universities located locally, regionally and abroad, from programs and scientific disciplines such as, physician assistants, forensic science and toxicology. The OCME also provided training for members of MPD, the United States Attorney's office and soldiers of the Marine Corps.

The goal of this report is to provide the public at large, the Executive Offices of the Mayor, and members of the Council for the District of Columbia with detailed information regarding deaths investigated during CY 2007.

As stated above there were a total of 3,049 deaths reported and investigated by the OCME, of which 1,477 were declined, and 1,458 cases were accepted for further examination. Of those, 949 were autopsied (Full and Partials). The OCME also processed 2,396 cremation requests that were submitted for approval. The following table illustrates the number of autopsy examinations, external examinations, medical record reviews and partial autopsy examinations performed by "Manner of Death".

2007 Medical Examiner Cases by Manner of Death

Manner	Full Autopsy Examinations	Partial Autopsy Examination	External Examinations	Medical Record Reviews	Total
Accident	204	5	112	3	324
Homicide	200	0	0	0	200
Natural	370	74	370	7	821
Other	0	0	1	0	1
Stillbirth	6	0	4	1	11
Suicide	44	0	2	0	46
Undetermined	46	0	2	0	48
Total	**870**	**79**	**491**	**11**	**1451**

Note: This table does not included data for **"***Non-Human Remains*" (n=7).

SUMMARY OF FINDINGS FOR MANNER OF DEATH

HOMICIDES: The OCME investigated 200 homicides in the CY 2007. This report reveals that homicides continued to be more prevalent in black males and in persons between the ages of 16-19. The weapons of choice were still firearms. The peak incidents occurred in June.
Toxicology Findings: Toxicology testing was requested for all 200 of the Homicide cases investigated. Drugs were present in 104 of the homicide cases investigated. The most commonly detected drugs in homicide cases were: Ethanol (N=60), PCP (31), Cocaine (21), Meth/Amphetamine (11), MDMA/MDA (10) and Morphine (3).

SUICIDES: The OCME investigated 46 suicides in the CY 2007. This report reveals that deaths by suicide were more prevalent in white males and in persons between the ages of 40-49 and 60-69. Blacks and Whites were equal in number (n=21) this year. Peak incidents occurred in March.
Toxicology Findings: Toxicology testing was requested for 45 of the 46 Suicide cases investigated. Overall, drugs were present in 29 of the suicide cases investigated. The most commonly detected drugs were: Ethanol (N=6), Cocaine (4), Morphine (3), Buproprion (3) and Sertraline (2). The trend continues to be that more prescription medications were detected in suicide cases than in homicide cases.

ACCIDENTS: The OCME investigated 324 accidents in the CY 2007. Of the 324 cases investigated, 184 cases were the result of trauma, of which 77 were traffic related deaths; and 93 of the accidental deaths occurred as a direct result of illicit drug use. The majority of the traffic accident deaths occurred in the following categories: males, blacks, and drivers between the ages of 20-29. Peak incidents for accidents overall occurred in June, but for traffic accidents the peak month was February.
*Overall Toxicology Findings***:** Toxicology testing was requested for 211 of the 324 Accident cases investigated, and drugs were present in 139 of these cases. The most commonly detected drugs were: Cocaine (N=70), Ethanol (36), Opiates (34), Methadone (12), Carbon Monoxide (11), PCP (7); MDMA/MDA (3) and Oxycodone (2)
Toxicology Findings for Traffic-related accidents: Toxicology testing was requested for 59 of the 77 Traffic Related Accidents, and drugs were present in 25 of these cases. The most commonly detected drugs were: Ethanol (N=17), Cocaine (4), PCP (2) and MDMA/MDA (2). In the 13 traffic related deaths positive for ethanol, the average Blood Alcohol Concentration was 0.16 %. The legal limit for Blood Alcohol Concentration in the District of Columbia is 0.08% while driving.
Toxicology Findings for Drug Overdose accidents: Toxicology testing was requested for 90 of the 93 Drug Overdose deaths, and drugs were present in 89 of these cases. Toxicology testing was not requested on three (3) of the Overdose cases because they were "Review of Medical Records" only. The one (1) Overdose case that was negative was due to a delayed death as a result of a drug overdose. A delayed death caused by a "Drug Overdose" occurs when the decedent was admitted to the hospital and by the time death occurred the drugs had dissipated

from their system, however the hospital did conduct toxicology testing upon admission with positive results. The most commonly detected drugs were: Cocaine (N= 59), Morphine (32), Ethanol (13), Methadone (12), PCP (5).

NATURAL DEATHS: The OCME investigated 821 Natural deaths in CY 2007. This report reveals that the leading cause of death in Natural cases is Cardiovascular Disease with 548 deaths, followed by Cancer with 44 deaths.
Toxicology Findings: Toxicology testing was requested for 396 of the 821 Natural cases investigated. Drugs were present in 157 Natural cases investigated. The most commonly detected drugs were: Ethanol (N=69), Cocaine (37), Morphine (31), Methadone (9), PCP (7), Phenytoin 2), Oxycodone (2) and Sertraline (2).

UNDETERMINED: The OCME investigated 48 cases where the manner of death was concluded to be "Undetermined." An "Undetermined" manner of death is a result of inconclusive evidence and/or investigatory efforts as to the circumstances of the death at the time. If additional information is discovered, the manner of death will be amended at that time.

The overall increase in the number of "*Undetermined Deaths*" results from a new process for determining cause and manner of child deaths. These deaths were previously classified with a cause of SIDS, and a manner of Natural. It was noted that many of these deaths were associated with bed-sharing and improper bedding. The classification of these deaths as "SIDS, Natural" did not reflect the reality of the circumstances surrounding the event. It has been decided to classify the cause of death as "*Sudden Unexpected Deaths in Infancy Associated with Bed-sharing or **Soft** Bedding*" with a manner of death as "*Undetermined*".
Toxicology Findings: Toxicology testing was requested for 45 of the 48 Undetermined deaths investigated. Drugs were present in 15 of the Undetermined cases investigated. The most commonly detected drugs were: Ethanol (N=7), Methadone (3), Morphine (3) and Cocaine (2).

STILLBIRTHS: The OCME investigated 11 Stillbirth deaths in CY 2007.
Toxicology Findings: Toxicology testing was requested for 9 of the 11 Stillbirth cases investigated. Overall, drugs were present in 3 of the cases investigated; and cocaine was detected in all 3 of the cases positive for drugs.

WEIGHT DISTRIBUTIONS

OCME has included in this report, data on Body Mass Index (BMI) for the population it served. BMI is a mathematical formula used to determine one's ratio of body height to their body weight, which correlates strongly (in adults) with body fat content. The level of BMI is also compared to the incidence of Hypertensive and Arteriosclerotic Cardiovascular Disease by age and race.

SUMMARY OF SIGNIFICANT APPENDICES

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

1. *Agency Management* - This segment outlines major activities such as personnel management, facilities, and Mass Fatality Management Planning.

2. *Internal Partnerships* – This segment provides an overview of OCME's continued partnerships with the Metropolitan Police Department's Natural Squad and the Wendt Center for Loss and Healing.

3. *Other Major Activities* – This segment highlights the following activities: Court Tracking, Education and an Overview of the Identification and Public Disposition Process.

OFFICE OF THE CHIEF MEDICAL EXAMINER

2007 Annual Report

Table of Contents

APPENDICES:

INTRODUCTION

By law the Office of the Chief Medical Examiner (OCME) is required to produce an annual report. This annual report provides statistical data summarizing the results of investigations conducted by the OCME during calendar year 2007. This information is a reflection of the status of health of the District of Columbia residents, the level and the type of violence, to which this population is subjected to, and 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 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 these data to develop preventative and corrective policies for research purposes.

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; 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 orders investigation; and 12) dead bodies brought within the District without proper medical certification. (See Appendix E – (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 and the Detectives of Metropolitan Police Department's Natural, Homicide, and Traffic Divisions provide information related to the circumstances of the deaths. The autopsy helps answer questions as to time of death, pattern and/or sequence of injuries and the effect of natural diseases versus injuries; it is also used to support or refute witness statements, or uncover completely unsuspected risk factors that may be useful to public health. The OCME works in close relationship with neighboring jurisdictions and is often called upon to provide expert testimony in these areas. Toxicological examinations are performed on most cases autopsied - depending upon the conditions of the remains - to assist in the determination of the cause and manner 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 (for example: neuropathology, and cardiac) are requested when appropriate.

The "*Fatality Review Program*" includes the Child Fatality Review Committee (CFRC), the Mental Retardation and Developmental Disabilities Fatality Review Committee (MRDD FRC) and the Domestic Violence Fatality Review Board (DVFRB). These committees examine causes and circumstances associated with deaths in their respective populations, evaluate issues associ-

ated with services provided and make relevant recommendations in order to decrease the number of preventable deaths. 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 provides temporary storage of bodies for funeral directors, nursing homes, all hospices and local hospitals. During calendar year 2007 OCME provided storage for 117 decedents.

The OCME morgue has a total capacity of 115, which can be easily exceeded. Therefore continuous and active efforts to locate family members, and bury or cremate unclaimed bodies are necessary to maintain available space. All efforts are made toward identification of the deceased before disposition. To achieve this goal, the OCME works cooperatively with the Mobile Crime unit of MPD and the Federal Bureau of Investigation (FBI) and trained its technical staff to fingerprint the decedents. OCME also uses comparative radiology, forensic odontology and/or DNA analysis as necessary to ensure identification. In 2007 the OCME buried or cremated 164 unclaimed decedents, of which 7 were transported to the Quantico National Cemetary.

OCME is one of the few medical examiner offices in the nation that provides on-site grief counseling. This service continues to be provided through a partnership with the Wendt Center for Loss and Healing (See page Appendix C for more information on the program).

In preparation for possible terrorist attacks and mass disaster, OCME continues to develop alliances with area hospitals, the Department of Health (DOH), and with agencies in the Public Safety and Justice cluster with a goal to integrate our Mass Fatality plan with the Mayor's District Response Plan. To practically accomplish this goal we are also participating in local and federal exercises to determine scenarios not considered, additional resources that may be necessary, and processes and authorities that must be established.

During 2007**,** the OCME staff continued to be very active in social programs such as Operation Prevent Auto Theft (OPAT), Career Day at District of Columbia public and public charter schools, the National Youth Leadership Forum on Medicine, the Mayor's Summer Youth program and the DC One Fund.

OCME also provides academic training of medical students and pathology residents from local hospitals, students of physician assistance, forensic sciences and toxicology programs from different universities located locally, regionally and abroad. The OCME also provided training for members of MPD, the United States Attorney's office and soldiers of the Marine Corps.

2.0 – Medical Examiner Investigations and Medical Legal Autopsies

Overview of Cases Reported and Investigated

During the Calendar Year (CY) 2007, **3,049** cases were reported to and investigated by the Office of the Chief Medical Examiner (OCME). **1,477** of these cases were declined by OCME, **1,458** cases were accepted for further investigation, and **117** were storage requests, of which 9 were declined, 108 were accepted and approved as storage cases, of which **3** became Medical Examiner cases also. Of the cases accepted for further investigation **949** were autopsied. OCME also had a total of **2,396** cremation requests submitted for approval.

Total Number of Cases Reported and Investigated by the OCME	**3,049**
Total Number of Declined Cases	**1,477**
Percent of Cases Investigated	*48.68%*
Total Number of Cases Accepted for Further Investigation	**1,458**
Percent of Cases Investigated	*47.80%*
Total Number of Autopsies (*870 were full autopsies and 79 were partial)*	**949**
Percent of Cases Accepted for Further Investigation	*59.63%*
Total Number of Scene Visits	**428**
Percent of Cases Investigated	*14.03%*
Total Number of Organ Donor's[1]	**13**
Percent of Cases Accepted for Further Investigation	*1.84%*

Total Number of Cremation Requests Submitted for Approval	**2,396**
Total Number of Approved Cremation Requests	**1609**
Percent of Cremations Requested	*67.15%*
Total Number of Denied Cremation Requests contingent on physician contact that was to be re-submitted for approval.	**787**
Percent of Cremations Requested	*32.85%*

[1] For calendar year 2007 there were 80 requests received from the Washington Regional Transplant Consortium (WRTC) to approach families for Organ donations. OCME approved 74 of these requests, and based on our records WRTC contacted 58 families, of which 38 approved the donation request, and 20 denied their request. However, WRTC only procured 13 donations. Therefore, 41 of the approved requests were not procured for reasons other than "family denied" which include – but are not limited to - unsuccessful contact with families, WRTC decided not to approach the family or WRTC decided not to procure an approved donation for reasons unknown to OCME.

Breakdown of Cases Accepted and Investigated

Total Number of Cases Accepted and Investigated by Exam type	**1,458**
Total Number of Autopsies • *Full – 870* • *Partial – 79*	949
Percent of Cases Accepted and Investigated	*65.09%*
Number of External Examinations	491
Percent of Cases Accepted and Investigated	*33.74%*
Number of Medical Record Reviews *	11
Percent of Cases Accepted and Investigated	*0.75%*
Number of Non-Human Remains *	7
Percent of Cases Accepted and Investigated	*0.004%*

*** Definition of Unfamiliar Case Classifications:**

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

- *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.

- *Storage Cases*: Cases that are received from hospitals, nursing homes or funeral homes where the family either cannot be located or is unable to provide disposition of the remains.

Breakdown of Case Investigations and Autopsies by Month

Month	Case Investigations	Autopsies (Full & Partial)
January	111	76
February	116	79
March	149	90
April	130	78
May	99	61
June	138	81
July	108	75
August	122	81
September	123	75
October	133	98
November	111	78
December	118	77
Total	**1458**	**949**

Medical Examiner Case Investigations by Manner of Death

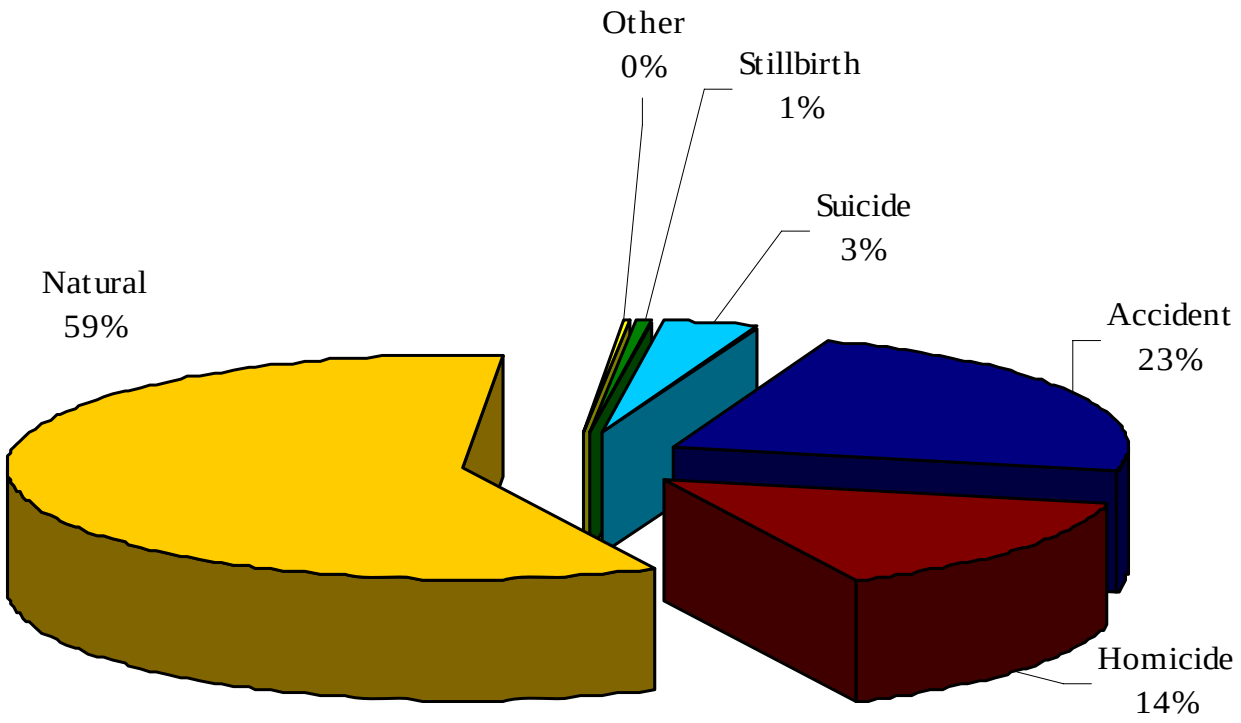
Manner of Death	Full Autopsy Examinations	Partial Autopsy Examinations	External Examinations	Review of Medical Records	Total
Accident	204	5	112	3	324
Homicide	200	0	0	0	200
Natural	370	74	370	7	821
Other[2]	0	0	1	0	1
Stillbirth	6	0	4	1	11
Suicide	44	0	2	0	46
Undetermined	46	0	2	0	48
Total	**870**	**79**	**491**	**11**	**1451**

Note: The above table does not include "*Non-Human Remains* (n=7)", which would bring the total cases investigated to 1,458 as reported on page 2.

[2] The one (1) External Examination with a Manner of Death as "Other" was a decomposed fetus, and it was determined that it should be treated as Medical Waste and was discarded in accordance with Medical Waste dispositions.

Medical Examiner Cases by Manner of Death

Of the total 1,451[3] cases accepted and investigated the percentage of cases by manner is shown in the figure below.



[3] This figure does not include *Non-Human Remains* (n=7), which would bring the total cases investigated to 1,458 as reported on page 2.

Postmortem Toxicology Summary

Depending on the specimens received and the degree of decomposition, routine toxicological testing includes analysis for alcohols (ethanol and other volatiles), an initial screen for major classes of illicit and prescription medications, and an additional screen for various illicit, prescription and "over-the-counter" medications. All drugs of significance are then confirmed by further testing. Typical specimens received include blood, urine, bile, vitreous, liver, brain, and gastric contents.

A negative case refers to the absence of any alcohol and commonly detectable drugs. 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 did not necessarily cause or contribute to death. Drugs that are excluded from this report include many of the "over-the-counter" medications such as: caffeine, nicotine, diphenhydramine, pseudoephedrine, ephedrine, dextromethorphan, salicylate, acetaminophen, and ibuprofen unless they contributed to the death or were detected in a significant concentration. Further, the data does not reflect the true prevalence of marijuana in the postmortem population, as marijuana was only confirmed in certain cases.

Total number of postmortem cases analyzed:

Description	Number of Cases	% of Cases
N=	**906**	
Negative	465	51.4 %
Positive	441	48.6%

Overall, drugs were present in 441 postmortem cases; 325 cases had one drug present; 101 cases had 2 drugs present; and 15 had 3 drugs detected

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	178	19.6 %
Cocaine	134	14.7 %
Morphine[4]	71	7.8 %
PCP	47	5.2 %
Methadone	26	2.9 %
MDMA or MDA[5]	15	1.7 %
Meth/Ampetamine	14	1.5 %
Carbon monoxide	13	1.4 %
Oxycodone	6	0.6 %
Bupropion	4	0.4 %
Sertraline	4	0.4 %
Citalopram	4	0.4 %

The most commonly detected drug combinations in the postmortem cases were:

Drug Combinatins	Number of Cases
Ethanol and Cocaine	22
Morphine and Cocaine	20
Morphine and PCP	11
Ethanol and PCP	11
Ethanol and Morphine	10
PCP and Cocaine	7

[4] Morphine includes both morphine only and heroin/morphine combined

[5] MDMA/MDA – Refers to “Ecstasy” related drugs

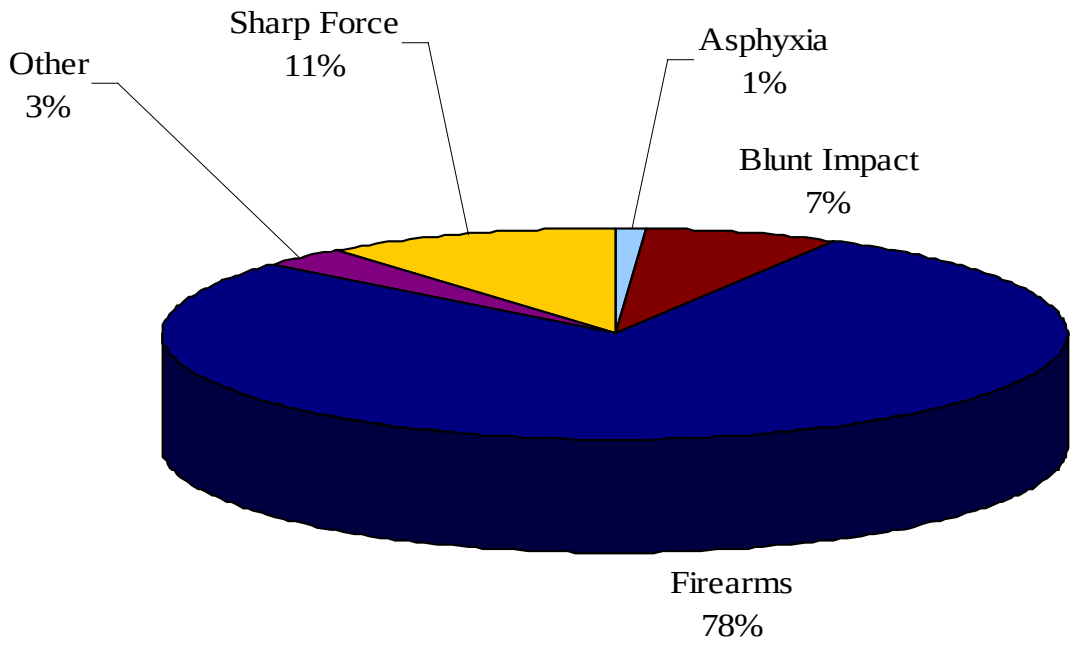
2.1 – HOMICIDE STATISTICS

The OCME investigated 200 homicides in CY 2007. The following tables and graphs provide a distribution by cause of death, month, race, gender and age group. Death by homicidal acts are more prevalent in black males (76.5%), and in the age group 16-19 years old (39%) than in any other age group. The weapon of choice continues to be firearms (78%), and the peak incidents occurred in June.

Homicides by Cause of Death

Cause of Death	Number of Homicides	% of Total Homicides
Firearms	157	78%
Sharp Force	21	11%
Blunt Impact	14	7%
Other	6	3%
Asphyxia	2	1%
Total	**200**	**200**

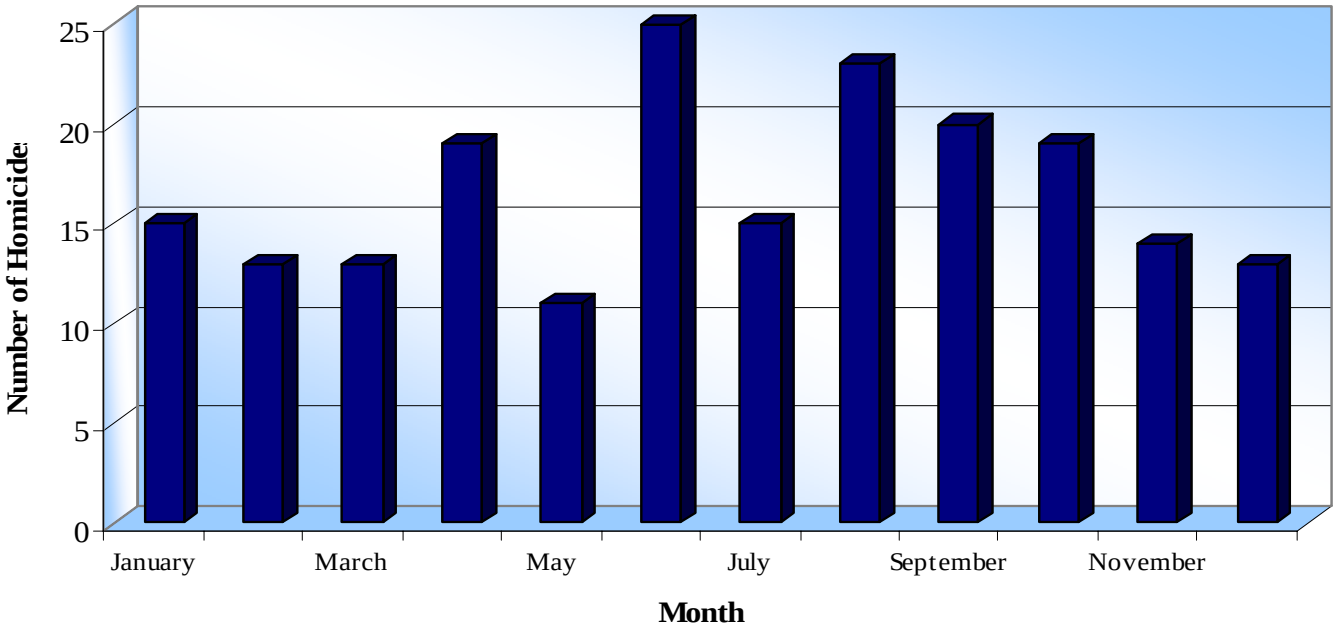
Homicides by Cause of Death *(Figure 1)*



Homicides by Month

Month	Number of Homicides	% of Homicides
January	15	8%
February	13	7%
March	13	7%
April	19	10%
May	11	6%
June	25	13%
July	15	8%
August	23	12%
September	20	10%
October	19	10%
November	14	7%
December	13	7%
Total	**200**	**100%**

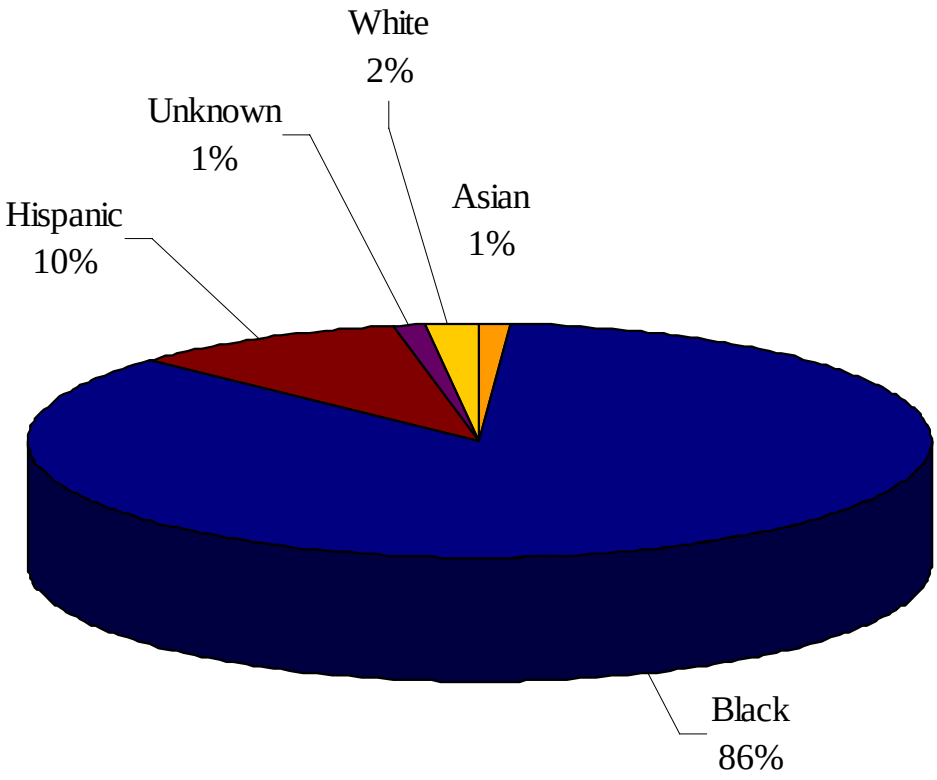
Homicides by Month *(Figure 2)*



Homicides by Race

Race/Ethnicity	Number of Homicides	% of Homicides
Asian	2	1%
Black	172	86%
Hispanic	20	10%
Unknown	2	1%
White	4	2%
Total	**200**	**100%**

Percentage of Homicides by Race *(Figure 3)*



Homicides by Gender

Gender	Number of Homicides	% of Homicides
Male	178	89%
Female	22	11%
Total	**200**	**100%**

Homicides by Race/Ethnicity and Gender

Race/Ethnicity by Gender	Number of Homicides	% of Homicides
Asian	**2**	**1%**
Female	0	0%
Male	2	1%
Black	**172**	**86%**
Female	19	9.5%
Male	153	76.5%
Hispanic	**20**	**10%**
Female	1	0.5%
Male	19	9.5%
White	**4**	**2%**
Female	1	0.5%
Male	3	1.5%
Total	**200**	**100.00%**

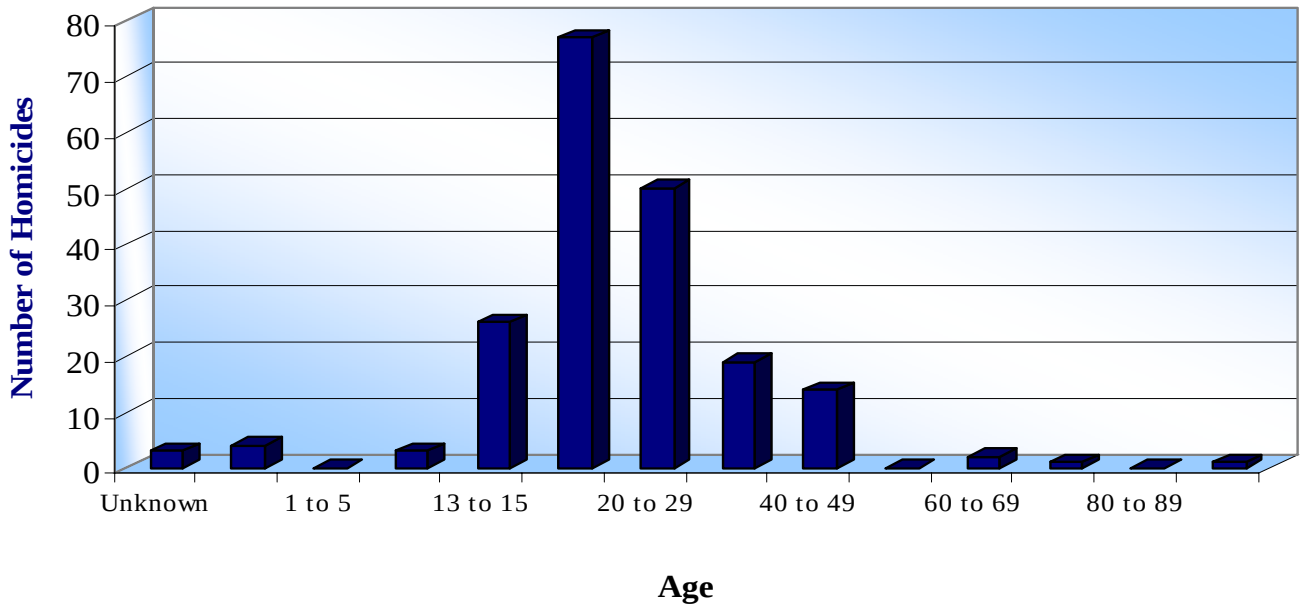
Homicides by Jurisdiction of Incident

Jurisdiction of Incident	Number of Homicides
DC	185
MD	15
Total	**200**

Homicides by Age

Age	Number of Homicides	% of Homicides
Unknown	3	2%
Under 1	4	2%
1 to 5	0	0%
6 to 12	3	2%
13 to 15	26	13%
16 to 19	77	39%
20 to 29	50	25%
30 to 39	19	10%
40 to 49	14	7%
50 to 59	0	0%
60 to 69	2	1%
70 to 79	1	0.50%
80 to 89	0	0%
90 +	1	0.50%
Total	**200**	**100.00%**

Homicides by Age Group ***(Figure 4)***



Toxicology Findings for Homicide Cases

Of the 200 Homicide deaths investigated by OCME, toxicology analysis was performed on all 200 cases. Overall, drugs were absent in 96 homicide cases; 63 cases had one drug present; 33 cases had 2 drugs present; and 8 cases had 3 drugs detected.

Description	Number of Cases	% of Cases
N=	**200**	
Negative	96	48.0 %
Positive	104	52.0 %

The most commonly detected drugs in the homicide cases were:

Name of Drug	Number of Cases	% of Homicide Cases
Ethanol	60	30.0 %
PCP	31	15.5 %
Cocaine	21	10.5 %
Meth/Amphetamine	11	5.5 %
MDMA/MDA	10	5.0 %
Morphine	3	1.5 %

The substances ketamine, methamphetamine, and oxycodone were also detected in 1 case each.

The 8 homicide cases with the most drugs detected had the following toxicology:

a) Ethanol, MDMA, methamphetamine, cocaine

b) Ethanol, MDMA, methamphetamine

c) Ethanol, PCP, and cocaine

d) Morphine, oxycodone, tramadol

2.2 – SUICIDE STATISTICS

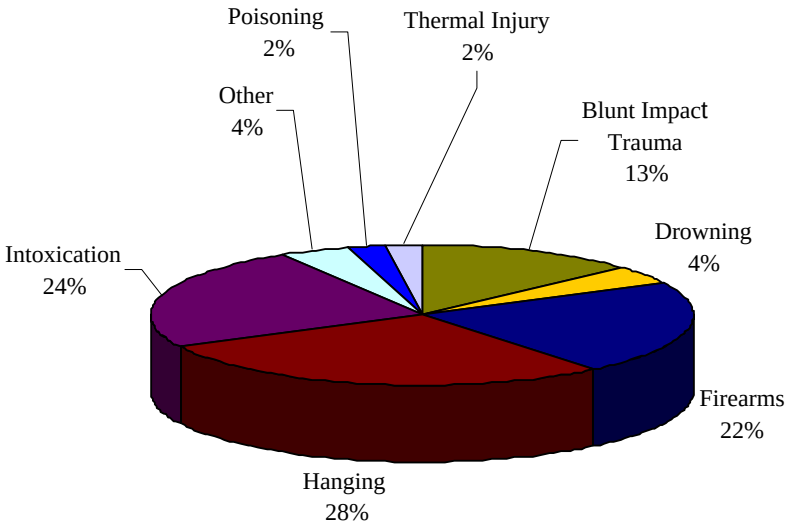
The OCME investigated 46 suicides in CY 2007. Deaths by suicidal acts are more prevalent in Whites males (37%), and in persons between the ages of 40-49 and 60-69 (both 20%). The data also reveals that the most prevalent method used was by hanging (28%). Peak incidents occurred in March.

Suicides by Cause of Death

Cause of Death	Number of Suicides	% of Total Suicides
Hanging	13	28%
Intoxication	11	24%
Firearms	10	22%
Blunt Impact Trauma	6	13%
Drowning	2	4%
Other	2	4%
Poisoning	1	2%
Thermal Injury	1	2%
Total	**46**	**100%**

Note: The percentages in "Figure 1" are rounded up or down to nearest whole number.

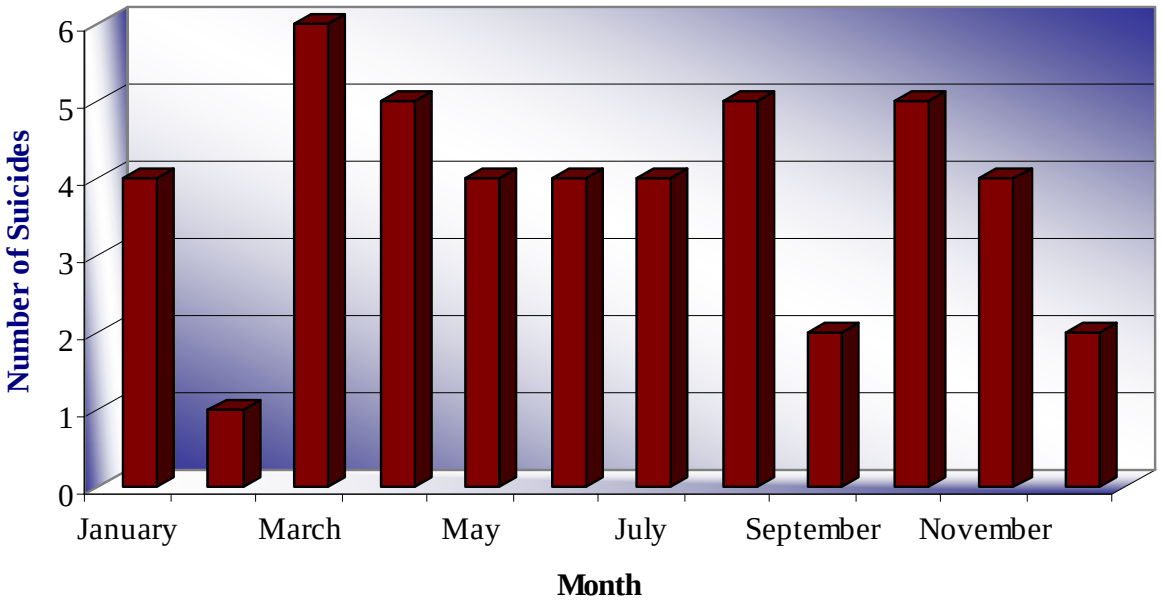
Suicides by Cause of Death *(Figure 1)*



Suicides by Month

Month	Number of Suicides	% of Suicides
January	4	9%
February	1	2%
March	6	13%
April	5	11%
May	4	9%
June	4	9%
July	4	9%
August	5	11%
September	2	4%
October	5	11%
November	4	9%
December	2	4%
Total	**46**	**100%**

Suicides by Month *(**Figure 2**)*



Suicide by Race/Ethnicity

Race/Ethnicity	Number of Suicides	% of Suicides
Asian	2	4%
Black	21	46%
Hispanic	1	2%
Unknown	1	2%
White	21	46%
Total	**46**	**100%**

Suicides by Race/Ethnicity and Gender

Race/Ethnicity by Gender	Number of Suicides	% of Suicides
Asian	**2**	**4.35%**
Female	2	4.35 %
Male	0	0.00 %
Black	**21**	**45.65 %**
Female	9	19.57%
Male	12	26.08 %
Hispanic	**1**	**2.17 %**
Female	1	2.17%
Male	0	0.00%
Unknown	**1**	**2.17%**
Female	1	2.17 %
Male	0	0.00%
White	**21**	**45.65%**
Female	4	8.70
Male	17	36.95
Total	**46**	**100.00%**

Suicides by Gender

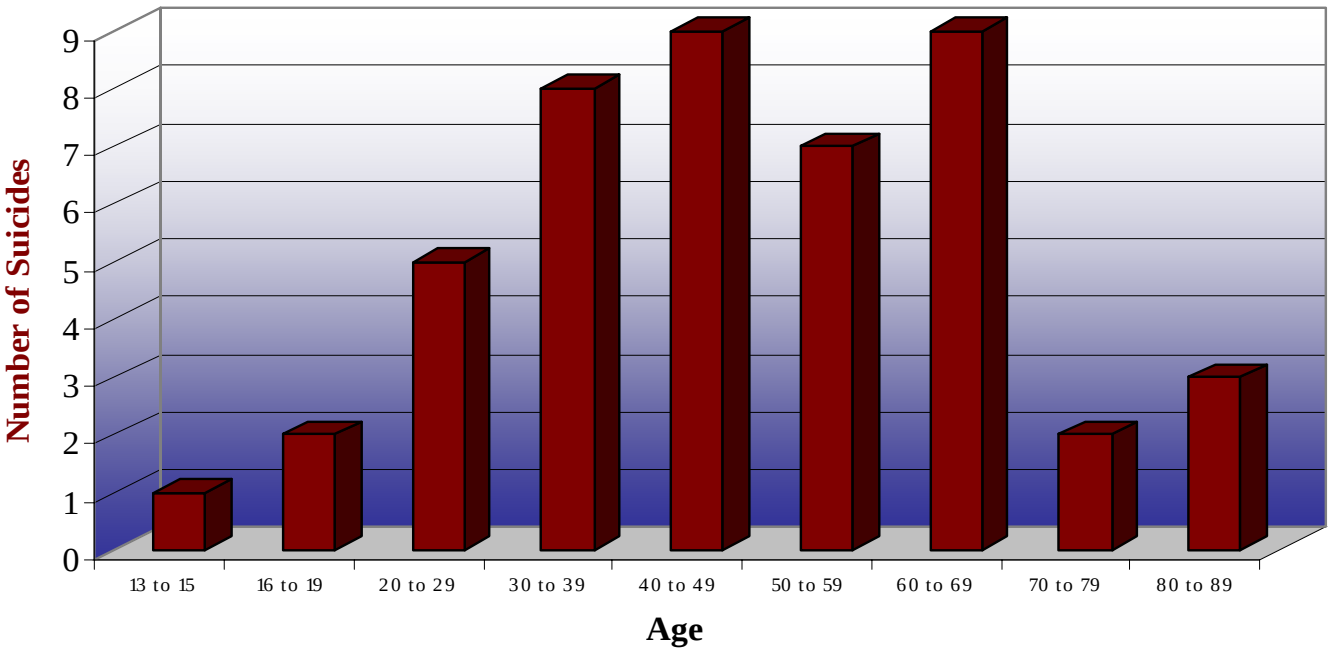
Gender	Number of Suicides	% of Suicides
Male	29	63.04%
Female	17	36.96%
Total	**46**	**100.00%**

Suicide by Age

Age	Number of Suicides	% of Suicides
13 to 15	1	2%
16 to 19	2	4%
20 to 29	5	11%
30 to 39	8	17%
40 to 49	9	20%
50 to 59	7	15%
60 to 69	9	20%
70 to 79	2	4%
80 to 89	3	7%
Total	**46**	**100.00%**

Note: There were zero (0) suicides for persons under 13 years old or for persons over 89.

Suicides by Age *(Figure 3)*



Toxicology Findings for Suicide Cases

Of the 46 suicide deaths investigated by OCME, toxicology analysis was performed on 45 cases. Overall, drugs were absent in 16 suicide cases; 24 cases had one drug present; and 5 cases had 2 drugs detected.

Description	Number of Cases	% of Cases
N=	**45**	
Negative	16	35.5 %
Positive	29	64.5 %

The most commonly detected drugs in suicide cases were:

Name of Drug	Number of Cases	% of Suicide Cases
Ethanol	6	13.0 %
Cocaine	4	8.8 %
Morphine	3	6.6 %
Buproprion	3	6.6 %
Sertraline	2	4.4 %

The 5 suicide cases with the most drugs detected had the following toxicology:

a. Bupropion and acetaminophen
b. Methamphetamine and MDMA
c. PCP and Cocaine
d. Ethanol and Zolpidem
e. Morphine and oxycodone.

Overall, more prescription medications were detected in the suicide cases than in the homicide cases.

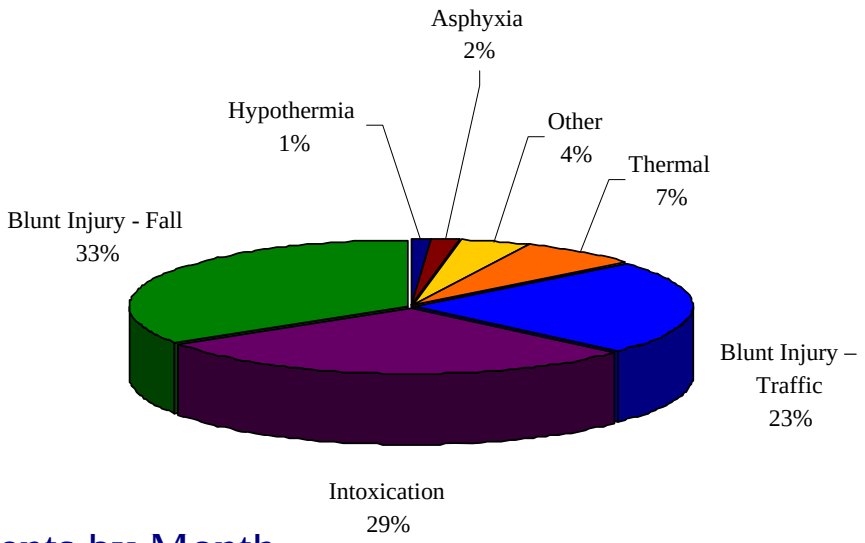
2.3 – ACCIDENTAL DEATH STATISTICS

OCME investigated 324 accident cases in 2007. Out of the 324 cases investigated, 184 cases were the result of trauma. There were 77 traffic accidents, and of those76 were trauma related, and 1 was caused by thermal injuries. However, 93 accident cases were the direct result of drug overdose. The peak incidents occurred in June

Accidents by Cause of Death

Cause of Death	Number of Accidental Deaths	% of Total Accidents
Blunt Injury - Fall	108	33%
Intoxication (Drug overdose)	93	29%
Blunt Injury – Traffic	76	24%
Thermal[6] (Burn)	23	7%
Other	13	4%
Asphyxia	5	2%
Hypothermia	4	1%
Drowning	1	0%
Therapeutic Complications	1	0%
Total	**324**	**100%**

Accidents by Cause of Death *(Figure 1)*

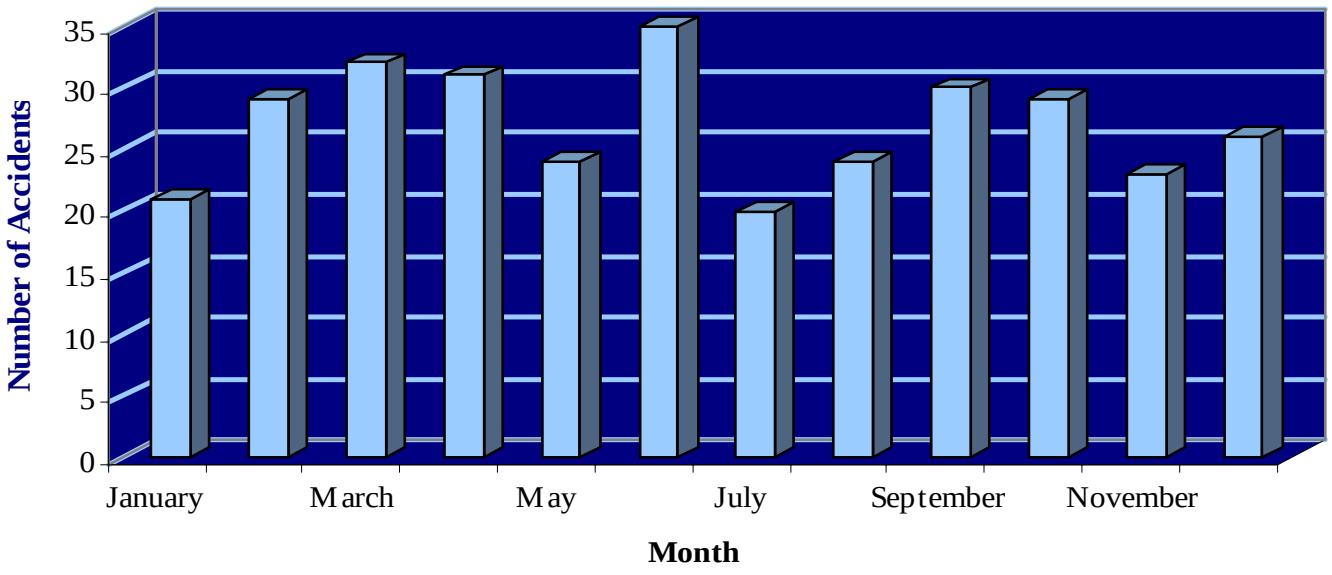


Accidents by Month

[6] One (1) of the thermal deaths was the result of a traffic accident.

Month	Number of Accidental Deaths	% of Accidental Deaths
January	21	6%
February	29	9%
March	32	10%
April	31	10%
May	24	7%
June	35	11%
July	20	6%
August	24	7%
September	30	9%
October	29	9%
November	23	7%
December	26	8%
Total	**324**	**100.00%**

Accidents by Month of Death *(Figure 2)*



Accidental Deaths by Race

Race/Ethnicity	Number of Accidental Deaths	% of Accidental Deaths
Asian	8	2%
Black	195	60%
Hispanic	18	6%
Other	3	1%
Unknown	1	0.31%
White	99	31%
Total	**324**	**100.00%**

Accidental Deaths by Gender

Gender	Number of Accidental Deaths	% of Accidental Deaths
Male	201	62%
Female	123	38%
Total	**324**	**100.00%**

Accidental Deaths by Age

Age	Number of Accidents	% of Accidents
Unknown	1	0.31%
Under 1	5	2%
1 to 5	7	22%
6 to 12	3	1%
13 to 15	4	1%
16 to 19	4	1%
20 to 29	22	7%
30 to 39	21	6%
40 to 49	49	15%
50 to 59	74	23%
60 to 69	25	8%
70 to 79	31	10%
80 to 89	46	14%
90 +	32	11%
Total	**324**	**100%**

Toxicology Findings for Accident Cases

Of the 324 Accident Deaths investigated by OCME, toxicology analysis was performed in 211 cases. Overall, drugs were absent in 72 accident cases; 97 cases had one drug present; 36 cases had 2 drugs present and 6 cases had 3 drugs detected.

Description	Number of Cases	% of Cases
N=	**211**	
Negative	72	34.1 %
Positive	139	65.8%

The most commonly detected drugs in the accident cases were:

Name of Drug	Number of Cases	% of Accident Cases
Cocaine	70	33.1 %
Ethanol	36	17.0 %
Opiates	34	16.1 %
Carbon monoxide	11	5.2 %
Methadone	12	5.6 %
PCP	7	3.3%
MDMA/MDA	3	1.4 %
Oxycodone	2	0.9 %

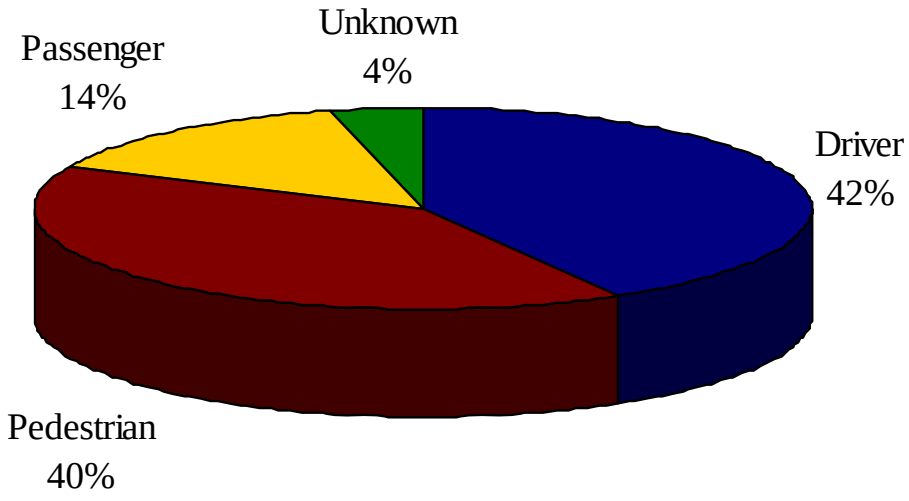
2.3.1 – Traffic Deaths

Of the three categories distinguished in traffic fatalities, Drivers were again impacted the most with of the total traffic deaths. The age group impacted the most was 20 to 29 (21%). Peak incidents occurred in February.

Role of the Decedent in Traffic Death

Role	Traffic Deaths	% of Traffic Deaths
Driver	**32**	**42%**
All Terrain Vehicle	1	
Automobile	22	
Bicyclist	4	
Motorcycle	5	
Pedestrian	**31**	**40%**
Automobile	21	
Bicycle	1	
Bus	4	
Motorcycle	1	
Truck/SUV	4	
Passenger	**11**	**14%**
Automobile	11	
Role Unknown	**3**	**4%**
Automobile	3	
Total	**77**	**100%**

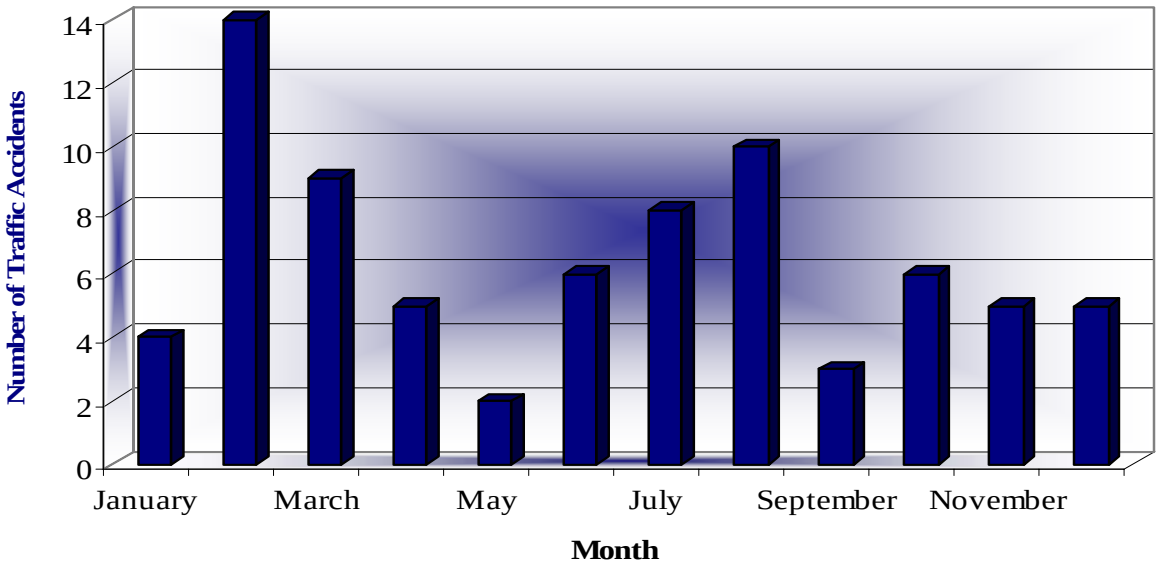
Role of Decedent in Traffic Accident *(Figure 1)*



Traffic Deaths by Month

Month	Number of Traffic Deaths	% of Traffic Deaths
January	4	5%
February	14	18%
March	9	12%
April	5	6%
May	2	3%
June	6	8%
July	8	10%
August	10	13%
September	3	4%
October	6	8%
November	5	6%
December	5	6%
Total	**77**	**100%**

Traffic Deaths by Month *(Figure 2)*



Traffic Deaths by Race

Race	Number of Traffic Deaths	% of Traffic Deaths
Asian	3	4%
Black	45	58%
Hispanic	6	8%
Other	1	1%
White	22	29%
Total	**77**	**100%**

Traffic Deaths by Gender

Gender	Number of Traffic Deaths	% of Traffic Deaths
Male	54	70%
Female	23	30%
Total	**77**	**100%**

Traffic Deaths by Age

Age	Number of Traffic Deaths	% of Traffic Deaths
1 to 5	3	4%
6 to 12	3	4%
13 to 15	3	4%
16 to 19	2	3%
20 to 29	16	21%
30 to 39	12	16%
40 to 49	10	13%
50 to 59	11	14%
60 to 69	3	4%
70 to 79	9	12%
80 to 89	5	6%
Total	**77**	**100%**

Note: There were no traffic deaths for decedents under 1 year old or over 89 years old.

Traffic Deaths by Jurisdiction of Incident

Jurisdiction of Incident	Number of Traffic Deaths	% of Traffic Deaths
DC	75	98%
MD	1	1%
VA	1	1%
Total	**77**	**100%**

Toxicology Findings for Traffic Accident Cases

Of the 77 Traffic-related deaths investigated by OCME, toxicology analysis was performed in 59 cases. Overall, drugs were absent in 34 traffic death cases; 20 cases had one drug present; and 5 cases had 2 drugs present.

Description	Number of Cases	% of Cases
N=	**59**	**100%**
Negative	34	55.9 %
Positive	25	44.1 %

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

Name of Drug	Number of Cases	% of Traffic Cases
Ethanol	17	28.8 %
Cocaine	4	6.7 %
PCP	2	3.3 %
MDMA/MDA	2	3.3 %

In the 13 traffic deaths positive for ethanol, the average Blood Alcohol Concentration was 0.16 % (range 0.02 – 0.33 %). The legal limit for Blood Alcohol Concentration in the District of Columbia is 0.08% while driving.

2.3.2 – Toxicology Findings for Accidental Deaths due to Drug Overdose

There were 93 OCME cases where death was directly related to drug use, and toxicology analysis was performed in 90 of these cases. The most prevalent drug in the population was cocaine alone or in combination with other drugs (most commonly morphine). Overall, 1 case was negative, 58 cases had one drug present; 26 cases had 2 drugs present; and 5 cases had 3 drugs present.

Description	Number of Cases	% of Cases
N=	**90**	**100%**
Negative	1[7]	1.1 %
Positive	89	98.9 %

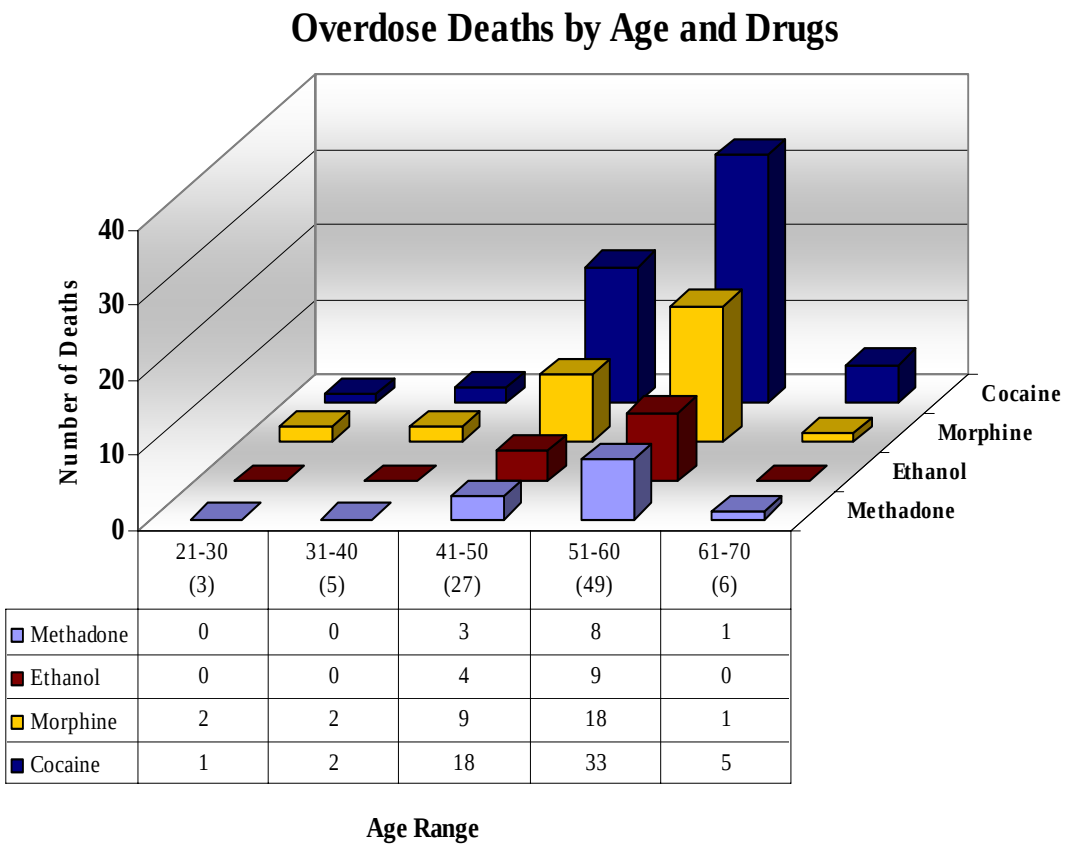
The most commonly detected drugs in drug overdose cases were:

Contributing Drugs	Number of Cases	% of Cases
Cocaine	59	64.8 %
Morphine	32	35.1 %
Ethanol	13	14.2 %
Methadone	12	13.1 %
PCP	5	5.4 %

[7] In this case the decedent was admitted into the hospital, which resulted in the death being delayed, and as a result to the time delay the drugs dissipated from the body by the time the death occurred. However, the hospital did conduct Toxicology testing at the time of admission with positive results.

Accidental Drug Overdose Fatalities by Age and Drugs Detected

Figure 1 indicates the number of overdose deaths by age and by the number of times a drug was detected within that age category. For example in the age group 41-50 there were 27 overdose deaths, and methadone was detected in 3 cases; ethanol was detected in 4 cases; morphine was detected in 9 cases; and cocaine was detected in 18 cases, so the fact that the total sum (N=34) of all drugs detected exceeds the total number of deaths in the age category 41-50 (N =27) indicates that some decedents were positive for a combination of drugs at the time of death..



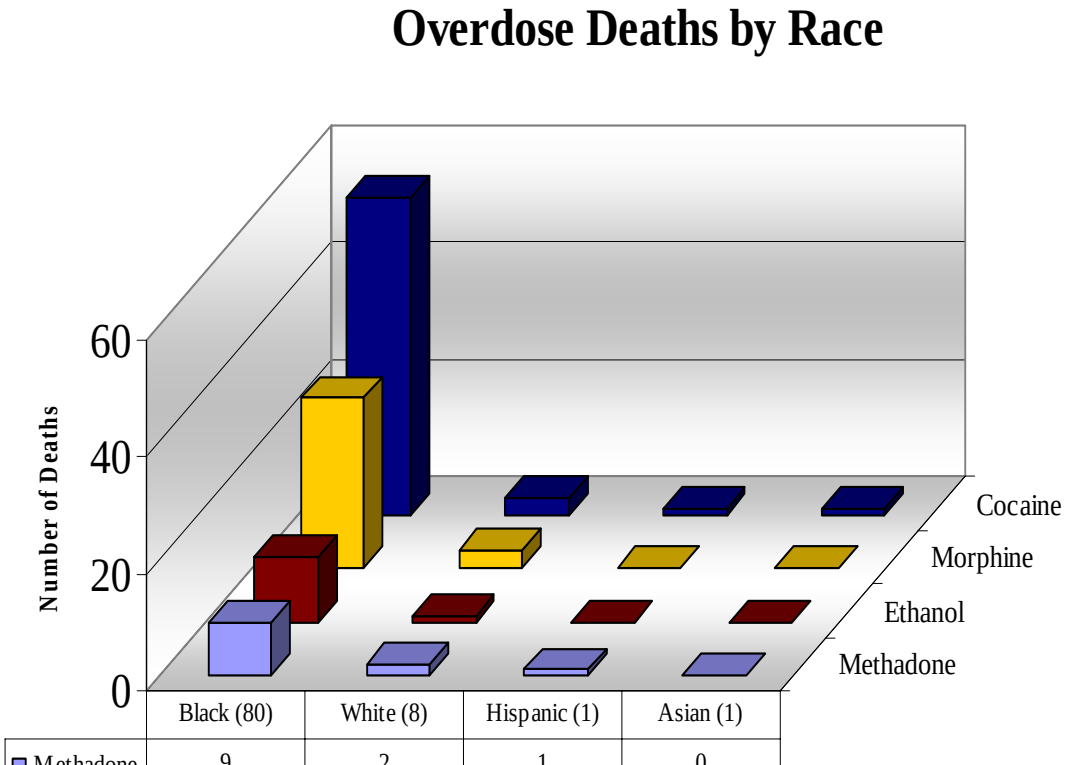
	21-30 (3)	31-40 (5)	41-50 (27)	51-60 (49)	61-70 (6)
Methadone	0	0	3	8	1
Ethanol	0	0	4	9	0
Morphine	2	2	9	18	1
Cocaine	1	2	18	33	5

Figure 1

Note: There were no recorded overdose deaths in age categories under 21 years or above 70 years.

Accidental Drug Overdose Fatalities by Race and Drugs Detected

Figure 2 below indicates the number of overdose deaths by race and by the number of times a drug was detected within that race category. For example, there were 80 overdose deaths within the black race, and cocaine was detected in 54 cases; morphine/heroin was detected in 29 cases, ethanol was detected in 11 cases and methadone was detected in 9 cases. So based on the statistics, no one drug was detected in all 80 cases, but there were some cases where a combination of drugs was found.



	Black (80)	White (8)	Hispanic (1)	Asian (1)
Methadone	9	2	1	0
Ethanol	11	1	0	0
Morphine	29	3	0	0
Cocaine	54	3	1	1

Figure 2

2.3.3 - 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), an initial screen for major classes of illicit and prescription medications, and an additional screen for various illicit, prescription and other-the-counter medications. All drugs of significance are then confirmed by further testing. Marijuana and its major metabolites are screened for in all DUI cases.

A negative case refers to the absence of any alcohol and commonly detectable drugs. 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.

Total number of DUI cases analyzed:

Description	Number of Cases	% of Cases
N=	**405**	
Negative	14	3.5 %
Positive	391	96.5 %

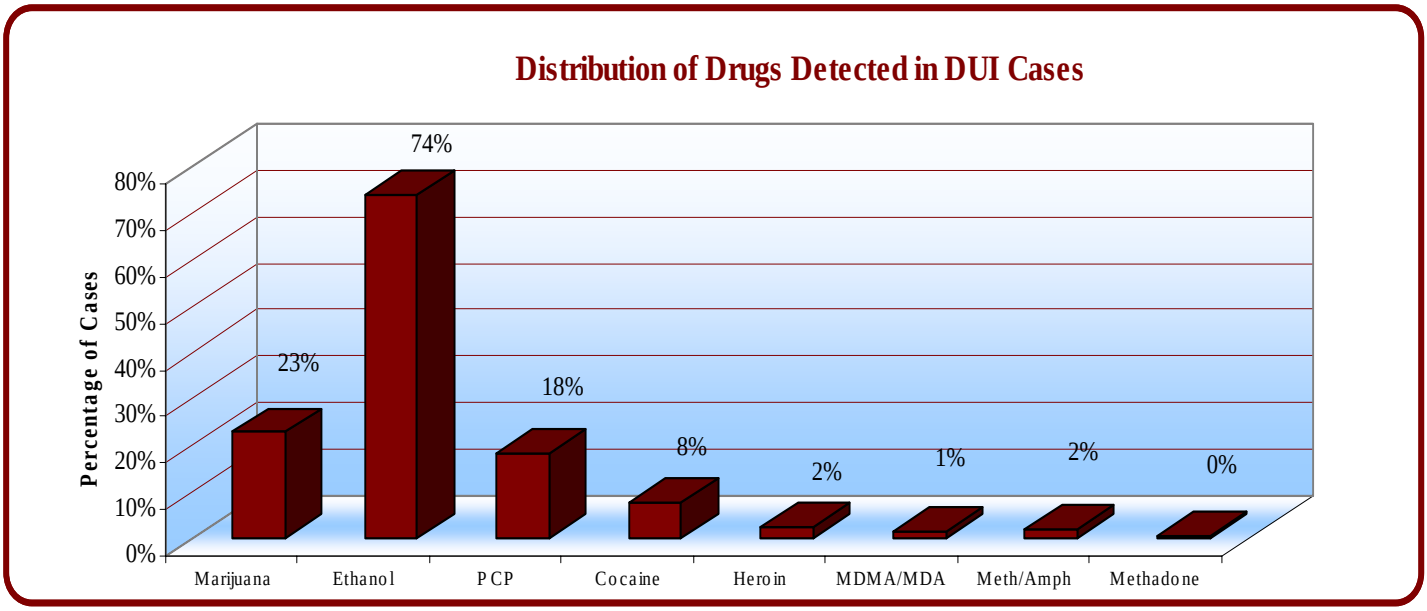
Type of Specimen Submitted:

Description	Number of Cases	% of Cases
Blood	291	72.2 %
Urine	114	27.8 %

Overall, drugs were absent in 14 DUI cases; 276 cases had one drug present; 92 cases had 2 drugs present; and 23 case had 3 drugs detected.

The most commonly detected drugs in the DUI cases were:

Name of Drug	Number of Cases	% of DUI Cases
Ethanol	299	69.2 %
Marijuana	92	21.3 %
Cocaine	31	7.2 %
PCP	74	17.1%
Morphine	9	2.1 %



In the 299 DUI cases positive for alcohol, the average alcohol concentrations were as follows:

Description	N=	Average	Range
Average Blood Alcohol Result	242	0.16	0.01-0.36
Average Urine Alcohol Result	57	0.13	0.01-0.46

Common drug combinations for DUI cases include:

Name of Drugs	Number of Cases
Ethanol + Marijuana	57
Ethanol + Cocaine	19
PCP + Marijuana	29

The 23 DUI cases with the most drugs detected had the following toxicology:

a. Marijuana, Ethanol, PCP (10 cases)
b. Marijuana, Ethanol, Cocaine (4 cases)
c. Marijuana, PCP, Cocaine (3 cases)
d. Marijuana, Ethanol, MDMA (2 cases)
e. PCP, Cocaine, Ethanol (2 cases)
f. Ethanol, Cocaine, Methamphetamine (1 case)
g. Methadone, Cocaine, Morphine (1 case)

Figure 1.

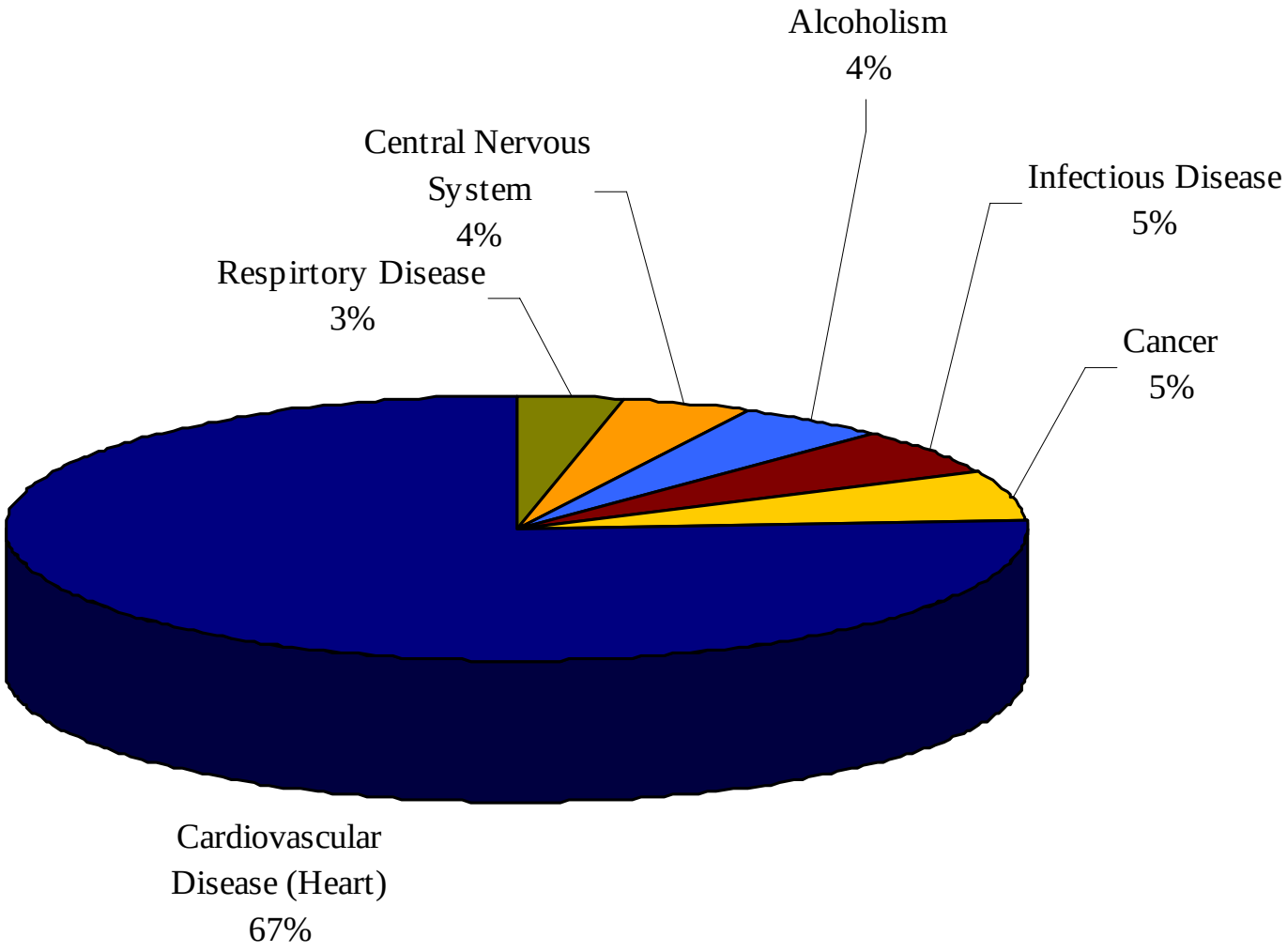
2.4 - NATURAL DEATH STATISTICS

The majority of deaths investigated by OCME are caused by "Cardiovascular Disease". In other words the most prevalent cause of death involves diseases of the cardiovascular system. Peak incidents occurred in March. Blacks represented 79% of the affected population, followed by Whites, which represented 17% of the Natural Deaths.

Natural Deaths By Cause

Cause of Death	Number of Deaths	% of Total Natural Deaths
Cardiovascular Disease	548	66.75%
Cancer	44	5.36%
Infectious Disease	42	5.12%
Alcoholism	35	4.26%
Central Nervous System (Brain)	29	3.53%
Respiratory Diseases	25	3.05%
Complications of Drug Abuse	18	2.19%
Gastrointestinal Disease	17	2.07%
Diabetes	15	1.83%
Other	15	1.83%
Therapeutic Complications	14	1.71%
Immune Diseases	7	0.85%
Blood Disease	5	0.61%
Obesity or Complications of Obesity	5	0.61%
Genetic Disorder	2	0.24%
Total	**821**	**100 %**

Natural Deaths by Cause *(Figure 1)*

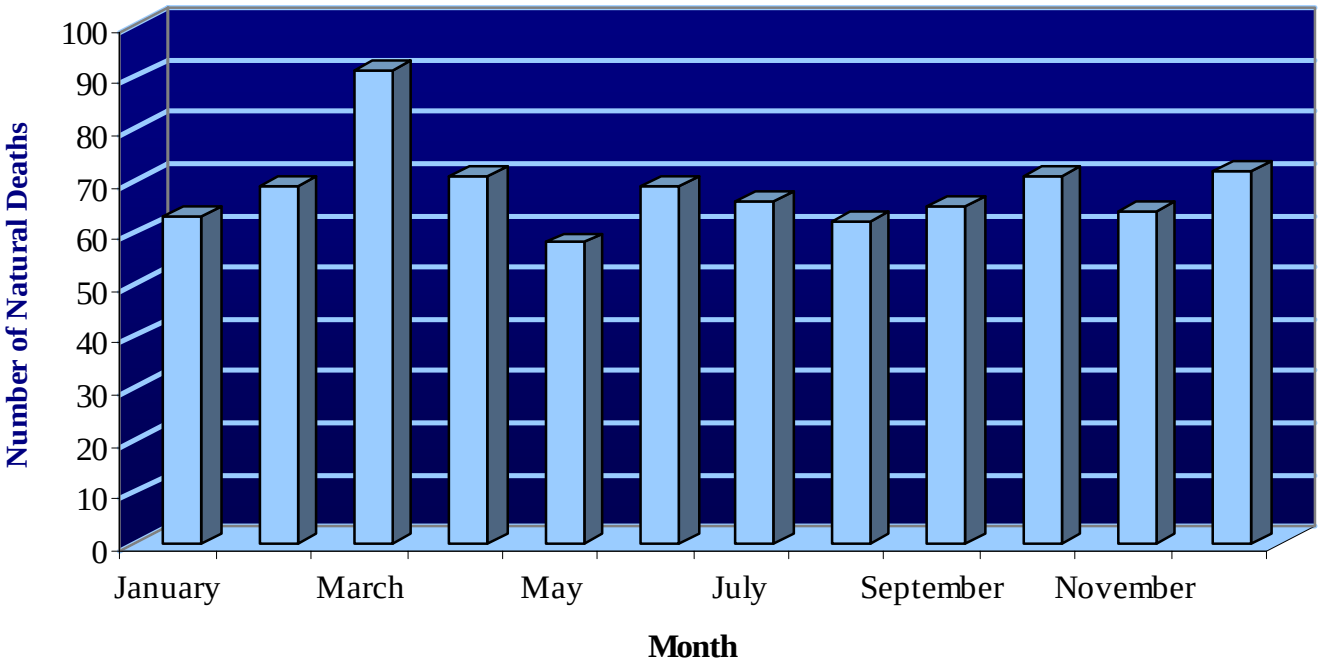


Note: Causes of Death that are less than 3% are not included in this figure.

Natural Deaths by Month

Month	Number of Deaths
January	63
February	69
March	91
April	71
May	58
June	69
July	66
August	62
September	65
October	71
November	64
December	72
Total	**821**

Natural Deaths by Month ***(Figure 2)***



Natural Deaths by Race

Race	Number of Natural Deaths	% of Natural Deaths
Asian	5	1%
Black	651	79%
Hispanic	21	3%
Other	4	0%
Unknown	2	0%
White	138	17%
Total	**821**	**100%**

Natural Deaths by Gender

Gender	Number of Natural Deaths	% of Natural Deaths
Male	519	63%
Female	302	37%
Total	**821**	**100%**

Natural Deaths by Age

Age	Number of Natural Deaths	% of Natural Deaths
Under 1	9	1%
1 to 5	4	0%
6 to 12	5	1%
13 to 15	0	0%
16 to 19	1	0%
20 to 29	18	2%
30 to 39	52	6%
40 to 49	114	14%
50 to 59	198	24%
60 to 69	189	23%
70 to 79	116	14%
80 to 89	88	11%
90 +	27	3%
Total	**821**	**100%**

Toxicology Findings for Natural Deaths

Of the 821 Natural Deaths investigated by OCME, toxicology analysis was performed in 396 cases. Overall, drugs were absent in 239 natural cases; 132 cases had 1 drug present; 24 cases had 2 drugs present; and 1 case had 3 drugs detected.

Description	Number of Cases	% of Cases
N=	**396**	
Negative	239	60.4%
Positive	157	39.6 %

The most commonly detected drugs in the natural cases were:

Name of Drug	Number of Cases	% of Natural Cases
Ethanol	69	17.4 %
Morphine	31	7.8 %
Cocaine	37	9.3 %
Methadone	9	2.3 %
Oxycodone	2	0.5 %
PCP	7	1.7 %
Phenytoin	2	0.5 %
Sertraline	2	0.5 %
Amitrtiptyline	1	0.2 %
Tramadol	1	0.2 %
Trazadone	1	0.2 %
Citalopram	1	0.2 %

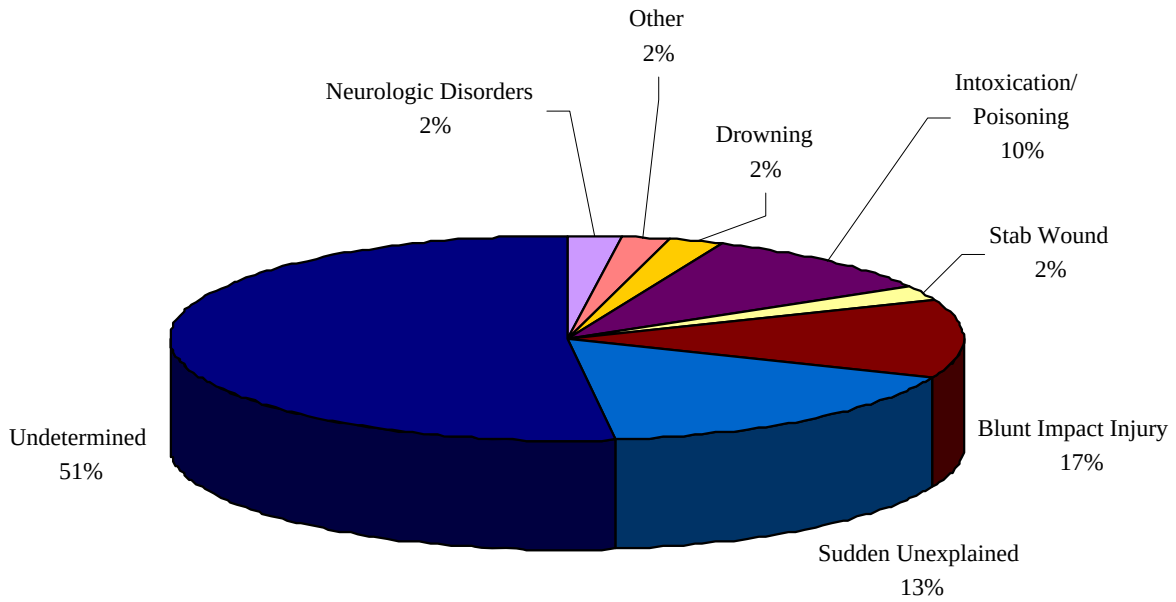
2.5 – UNDETERMINED DEATH STATISTICS

Undetermined by Cause of Death

The OCME investigated 48 cases where the manner of death was concluded to be "Undetermined," and of these 48 cases 25 or 51% also had a cause of death classified as "Undetermined". An "Undetermined" manner of death is a result of inconclusive evidence and/or investigatory efforts as to the circumstances of the death at the time. If additional information is discovered, the manner of death will be amended to indicate those new findings. There were no deaths classified as "Undetermined" in the following age group(s): 1 to 5 and 6 to 12 years.

Cause of Death	Number of Deaths	% of Total Accepted Cases
Undetermined	25	51.06%
Blunt Impact Injuries	8	17.02%
Sudden and Unexplained	6	12.77%
Intoxication/Poisoning	5	10.64%
Drowning	1	2.13%
Neurologic Disorders	1	2.13%
Other	1	2.13%
Stab Wound	1	2.13%
Total	**48**	**100.00%**

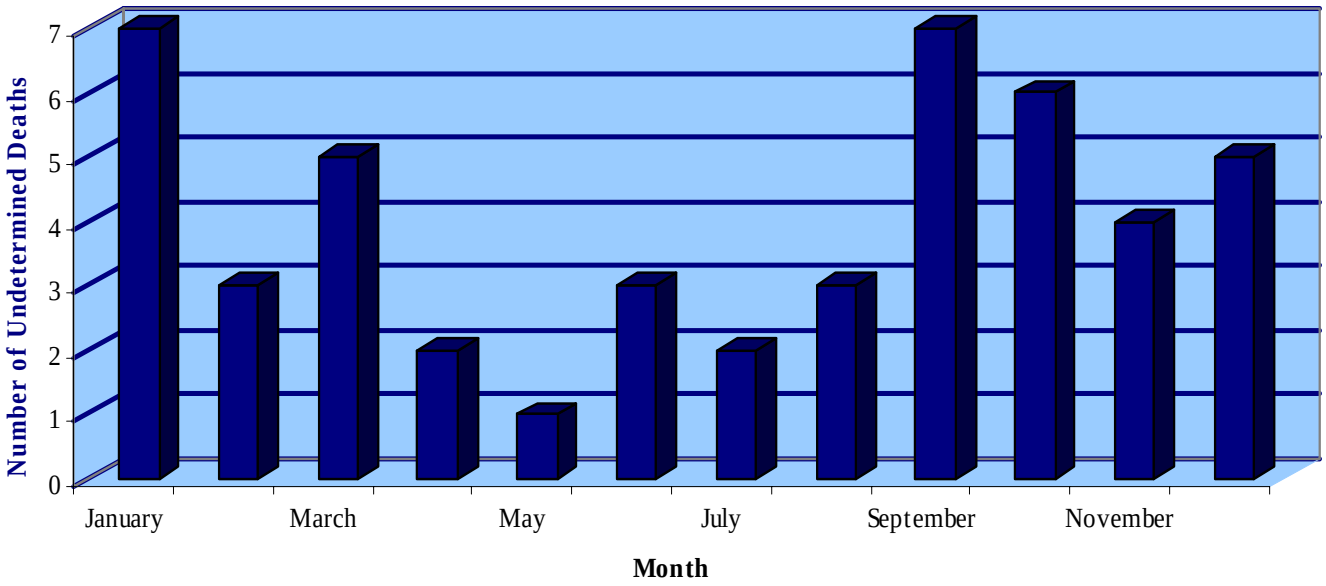
Undetermined by Cause of Death *(Figure 1)*



Undetermined Deaths by Month

Month	Number of Deaths
January	7
February	3
March	5
April	2
May	1
June	3
July	2
August	3
September	7
October	6
November	4
December	5
Total	**48**

Undetermined Deaths by Month ***(Figure 2)***



Undetermined Deaths by Race

Race	Number of Undetermined Deaths
Asian	1
Black	33
Hispanic	1
Other/Unknown	2
White	11
Total	**48**

Undetermined Deaths by Gender

Gender	Number of Undetermined Deaths
Male	29
Female	19
Total	**48**

Undetermined Deaths by Age

Age	Number of Undetermined Deaths
Unknown	1
Under 1	11
1 to 5	0
6 to 12	0
13 to 15	1
16 to 19	4
20 to 29	3
30 to 39	10
40-to 49	11
50 to 59	2
60 to 69	1
70 to 79	2
80 to 89	1
90 +	1
Total	**48**

Toxicology Findings for Undetermined Deaths

Of the 48 Undetermined Deaths investigated by OCME, toxicology analysis was performed in 45 cases. Overall, drugs were absent in 15 undetermined cases; 10 cases had one drug present; and 5 cases had 2 drugs present.

Description	Number of Cases	% of Cases
N=	**45**	**100%**
Negative	30	66.7 %
Positive	15	33.3 %

The most commonly detected drugs in the undetermined cases were:

Name of Drug	Number of Cases	% of Undetermined Cases
Ethanol	7	15.5 %
Methadone	3	6.8 %
Morphine	3	6.8 %
Cocaine	2	4.4 %

Toxicology for Stillbirths

Toxicology analysis was performed in 9 of the 10 Stillbirth Deaths investigated by OCME. Overall, drugs were absent in 6 stillbirths; cocaine was detected in 3 cases.

Description	Number of Cases	% of Cases
N=	**9**	**100%**
Negative	6	66.6 %
Positive	3	33.3 %

3.0 – FATALITY REVIEW PROGRAMS

The Fatality Review Unit was established under the auspices of OCME in October of 2005 as a means of centralizing all District based fatality review functions. The purpose of the fatality review process is to conduct retrospective reviews of deaths of specific populations as identified by DC Law and/or Mayor's Order to reduce the number of preventable deaths and/or to improve the quality of life for DC residents. Each death review process is intended to assist in identifying systemic and community strengths, as well as improvements needed in service delivery systems in order to better address the needs of the residents of the District. It is an opportunity for self-evaluation through a multi-agency and multi-disciplinary approach. This process provides a wealth of information regarding ways to enhance services and systems.

Considering that each fatality review process is similar in purpose, goals, objectives and basic operating processes, the centralization fatality review office will create a congruent and collaborative operating structure while maintaining the unique features of the individual components. The objectives of the fatality review processes are as follows:

- To identify trends and patterns related to the deaths of specific populations through collecting, reviewing and analyzing standardized data and to use such information to improve understanding of the causes and factors that may contribute to the fatalities.
- To work to ensure that all systems, both public and private, which are responsible for serving, assisting and protecting District residents are effective, efficient and accountable.
- To improve and optimize systemic responses to violence/abuse/neglect of vulnerable populations by evaluating existing statues, policies and procedures.
- To recommend appropriate modifications to existing systems and develop new mechanisms to reduce the incidence of unexpected and preventable fatalities.
- To encourage inter and intro-agency and interdisciplinary education, communication, coordination and collaboration in the prevention of fatalities.

Currently there are three fatality review processes that operate within the FRU, the Child Fatality Review Committee (CFRC), Mental Retardation and Developmental Disabilities Fatality Review Committee (MRDD FRC) and the Domestic Violence Fatality Review Board (DVFRB). Following is a brief synopsis of the work achieved during the 2007 calendar year for all three of the operating fatality review processes.

3.1 - Child Fatality Review Committee

The mandated case review criteria include the following:

- All children/youth between the ages of birth through 18 years of age;
- Youth over the age of 18 who were known to the child welfare system within four years prior to the death; and
- Youth over the age of 18 who were known to the juvenile justice system and/or the mental retardation and developmental disabilities system within two years of the death.

The above includes children whose ages ranged from birth through 23 years and who died from a multitude of causes in all manners of death categories. Of the 160 child deaths that were reviewed by CFRC in calendar year 2007, 59 or 37% were accepted by OCME for autopsy. The following graphs and charts represent a summary of the data that resulted from the deaths reviewed.

DECEDENT DEMOGRAPHIC DATA
DECEDENT'S AGE AND GENDER – DC OCME POPULATION

Age/Gender	Subtotal	Total Deaths
Under 1 Year		**14**
Female	10	
Male	4	
1 thru 4 Years		**6**
Female	4	
Male	2	
5 thru 10 Years		**6**
Female	3	
Male	3	
11 thru 14 Years		**2**
Female	0	
Male	2	
15 thru 20 Years		**27**
Female	6	
Male	21	
Over 20		**4**
Female	0	
Male	4	

Race of Decedents – DC OCME Population:

Race	Number	% of Total
Black	55	93%
White	1	2%
Hispanic	3	5%
Asian	0	0
Other	0	0

Decedents' Ward of Residence – DC OCME Population:

Ward of Residence	Number
Ward One	4
Ward Two	3
Ward Three	1
Ward Four	4
Ward Five	9
Ward Six	8
Ward Seven	15
Ward Eight	14
Maryland	1

Manner of Death – DC OCME Population

Manner	Number	% of Total
Homicide	32	54%
Natural	9	15%
Accident	8	14%
Undetermined	9	15%
Suicide	1	2%

Causes of Death categorized by manner of death
Homicides:

Cause	Number
Firearms	29
Blunt Impact (Under 2)	3

NATURAL DEATHS:

Cause	Number
Complication of Pregnancy	1
Infectious Disease	3
Respiratory	1
Cardiovascular	2
Central Nervous System	1
Gastrointestinal	1

ACCIDENTS:

Cause	Subtotal	Total
Motor Vehicle/Subway		**4**
Pedestrian	2	
Passenger	1	
Driver (1 motorbike)	1	
Smoke Inhalation/Asphyxia		**1**
Asphyxia (Choking)		**2**
Electrocution		**1**

UNDETERMINED DEATHS

Cause	Number
Sudden Unexplained Death in Infancy	8
Undetermined	1

3.2 - Mental Retardation and Developmental Disabilities Fatality Review Committee

The Mental Retardation and Developmental Disability Fatality review committee (MRDD FRC) is required to examine events that surround the deaths of individuals diagnosed with mental retardation and developmental disabilities that were wards or the District and/or receiving care from the Department of Disability Services. During calendar year 2007, a total of 30 individuals served by DDS died, representing 1.5 percent of the total DDS population for that year (N = 2018). During 2007, the Committee reviewed 18 deaths of DDS customers who died during calendar years 2006 and 2007. The following tables and charts represent a summary of the data that resulted from the DDS deaths reviewed in 2007.

STATUS OF DEATHS IDENTIFIED AND REVIEWED BY CALENDAR YEAR

Year	# Deaths Identified By Year	# Deaths Reviewed By Year	# Deaths Pending Review
2007	30	21	*9*
2006	30	19	*11*
2005	34	24	*10*
2004	36	26	*10*
2003	31	23	*8*
2002	26	21	*5*
2001	32	32	*0*
Total	**219**	**166**	***53***

AGES, RACE AND GENDER OF DECEDENTS OF 2007 CASES REVIEWED (N = 18)

Age and Gender By Year of Death (N = 18 Cases Reviewed)				
	2006 (N = 16)		2007 (N = 2)	
	Male	Female	Male	Female
Under 41	0	1	1	0
41 – 50	1	1	1	0
51 – 60	2	4	0	0
61 & Over	4	3	0	0

Decedents by Race for Cases Reviewed				
	2006 (N=14)		2007 (N=2)	
Race	Male	Female	Male	Female
Black	5	6	2	0
Caucasian	2	3	0	0

PLACE/WARD OF RESIDENCE AT TIME OF DEATH (N = 18)

Ward/State of Residence By Year of Death		
District Ward/State	2006 (N=16)	2007 (N=2)
One	0	0
Two	0	0
Three	1	0
Four	4	1
Five	3	0
Six	2	0
Seven	2	0
Eight	1	1
Maryland	3	0

Place of Residence By Year of Death		
Place of Death	2006 N=14	2007 N=2
Own Home (independent)	1	1
Nursing Home	5	1
Foster Home	2	0
ICF/MR	7	1

MANNER OF DEATH (N = 18)

Consistent with previous years, the majority of the 18 deaths reviewed in 2007 were determined to be Natural deaths (N = 17, or 94%). There was one death attributed to Suicide that involved an African American male under the age of 35 years who lived independently. There were no fatalities attributed to Homicide, Accident or Undetermined manners of death.

3.3 - Domestic Violence Fatality Review Board

The Domestic Violence Fatality Review Board (DVFRB) is responsible of reviewing homicides and suicides that are determined to be related to domestic violence. The DVFRB deaths are selected for review based on referrals from the US Attorneys Office, the Metropolitan Police Department, the Office of the Attorney General and the Office of the Chief Medical Examiner. Based upon protocols established by the Board, Homicides are reviewed after closure of the criminal case and, Suicides are reviewed upon closure of the law enforcement investigation.

Between July 2007 and May 2008 the DVFR Board reviewed 15 domestic violence deaths that occurred in calendar years 2004 through 2007. Two of the deaths reviewed were Suicide and as such did not involve perpetrators. The following tables and charts summarize data from the 15 cases reviewed during July 2007 and May 2008. The data includes one additional number in the perpetrator categories, as one homicide involved two perpetrators.

RACE, GENDER AND AGE OF TOTAL DVFRB DEATHS IDENTIFIED

- The majority of the victims identified as domestic violence fatalities were Black African American. The number of Black African American decedents ranged from 75% to 93% annually. White decedents ranked second with domestic violence related fatalities, followed by Hispanics.

DECEDENT'S RACE BY YEAR (N = 15 CASES REVIEWED			
YEAR	BLACK	WHITE	HISPANIC
2004	14	1	0
2005	12	2	1
2006	13	0	1
2007	10	1	0
2008	6	2	0

GENDER OF PERPETRATOR/DECEDENT

- ***Perpetrators –*** Twenty percent (N = 3) of the 15 homicides involved females as the perpetrator and 73% (N = 11) were males. One homicide involved two perpetrators.
- ***Decedents –*** Twenty-seven percent (N = 4) of the 15 decedents were males, and 73% (N = 11) were females.
- ***Gender By Year of Death –*** Based on the 15 deaths reviewed, Table 3 illustrates the gender of the perpetrators and the decedents by year of death.

TABLE 3: GENDER BY YEAR (N = 15)	2004		2005		2006		2007	
	MALES	FEMALES	MALES	FEMALES	MALES	FEMALES	MALES	FEMALES
Perpetrators	1	1	3	1	4	1	3	0
Decedents	0	2	2	3	0	4	2	2

AGE OF PERPETRATOR AND DECEDENT

Data from the domestic violence cases reviewed indicate four females and one male were over the age of 60 years. Two female decedents and one male perpetrator were over age 80.

- ***Perpetrator*** – The age of the perpetrators ranged from 18 to 87 years. The average age was 37.3, and the median age was 41.
- ***Decedent*** - The ages of the decedents ranged from 18 to 84 years. The average age of the decedents was 47, and the median age was 42.

RACE OF PERPETRATORS

- ***PERPETRATOR*** – Thirteen (93%) of the 14 perpetrators were Black African-American and one (7%) was White. This number includes three (3) female and 11 male perpetrators.
- ***DECEDENTS*** **–** Fifteen (15) or 100% of the decedents were Black African American (four males and 11 females).

MANNER OF DEATH

Thirteen or 87% of the DVFRB deaths reviewed were ruled Homicides and two (2) or 13% were ruled as Suicides.

Homicides

- Eleven (11) or 81% of the 15 cases reviewed were prosecuted and ten (10) of the perpetrators are currently incarcerated.
- Two (2) or 18% of the 11 cases prosecuted were viewed to most likely have been accidental homicides that were not attributed to malice.

Suicides

- Of the 15 cases reviewed, two or 13% of the fatalities were determined to be suicides.
- One of the two suicide victims had been in an eight-year relationship and there had been a history of prior domestic violence.

LOCATION/WARD OF RESIDENCE AND FATAL INCIDENT

- Based on the 15 cases reviewed, the majority of the domestic violence victims resided in Wards 5 and 8. Combined there were seven (46%) decedents who were residents of these Wards.
- The majority of the 15 fatal incidents occurred in Wards 5 (N = 4), 6 (N = 3) and 8 (N = 5). Eighty percent (80%) of the deaths occurred in these Wards.

4.0 – Data on Weight Distribution of Accepted OCME Cases for 2007

This year's data will report on the distribution of weights with emphasis on the Body Mass Index (BMI). BMI is a mathematical formula used to determine the ratio of body weight to body height, which correlates strongly (in adults) with body fat content. Individual adults with a BMI between 25 and 30 are considered overweight, and those with a BMI over 30 are considered obese. This report also includes a correlation of BMI with deaths due to Arteriosclerotic and Hypertensive Cardiovascular Diseases.

The obesity rate is rising in all age groups throughout the nation. According to a recent study conducted by CalorieLab[8], in 2007 Washington DC ranks 40th in the nation amongst those adults calculated as obese and overweight combined. Obesity increases the risks of cardiovascular diseases and diabetes mellitus. The following report provides data on Weight Distribution and the Body Mass Index of adult decedents (age 20 and older) and children (2-19 years) that were brought to the D.C. Office of the Chief Medical Examiner (OCME) for examination.

According to the CDC[9], when states were ranked (see below table) in 2007 for persons who had a BMI of 30 or more, "only one state (Colorado) had a prevalence of obesity less than 20%. Thirty states had prevalence equal to or greater than 25%; three of these states (Alabama, Mississippi and Tennessee) had a prevalence of obesity equal to or greater than 30%, and Washington, DC had a prevalence of 21.8%.

2007 State Obesity Rates

State	%	State	%	State	%	State	%
Alabama	30.3	Illinois	24.9	Montana	21.8	Rhode Island	21.4
Alaska	27.5	Indiana	26.8	Nebraska	26.0	South Carolina	28.4
Arizona	25.4	Iowa	26.9	Nevada	24.1	South Dakota	26.2
Arkansas	28.7	Kansas	26.9	New Hampshire	24.4	Tennessee	30.1
California	22.6	Kentucky	27.4	New Jersey	23.5	Texas	28.1
Colorado	18.7	Louisiana	29.8	New Mexico	24.0	Utah	21.8
Connecticut	21.2	Maine	24.8	New York	25.0	Vermont	21.3
Delaware	27.4	Maryland	25.4	North Carolina	28.0	Virginia	24.3
Washington DC	21.8	Massachusetts	21.3	North Dakota	26.5	Washington	25.3
Florida	23.6	Michigan	27.7	Ohio	27.5	West Virginia	29.5
Georgia	28.2	Minnesota	25.6	Oklahoma	28.1	Wisconsin	24.7
Hawaii	21.4	Mississippi	32.0	Oregon	25.5	Wyoming	23.7
Idaho	24.5	Missouri	27.5	Pennsylvania	27.1		

[8] http://calorielab.com/news/2008/07/02/fattest-states-2008/

[9] **Reference**: The Center for Disease Control's (CDC) website at www.cdc.gov

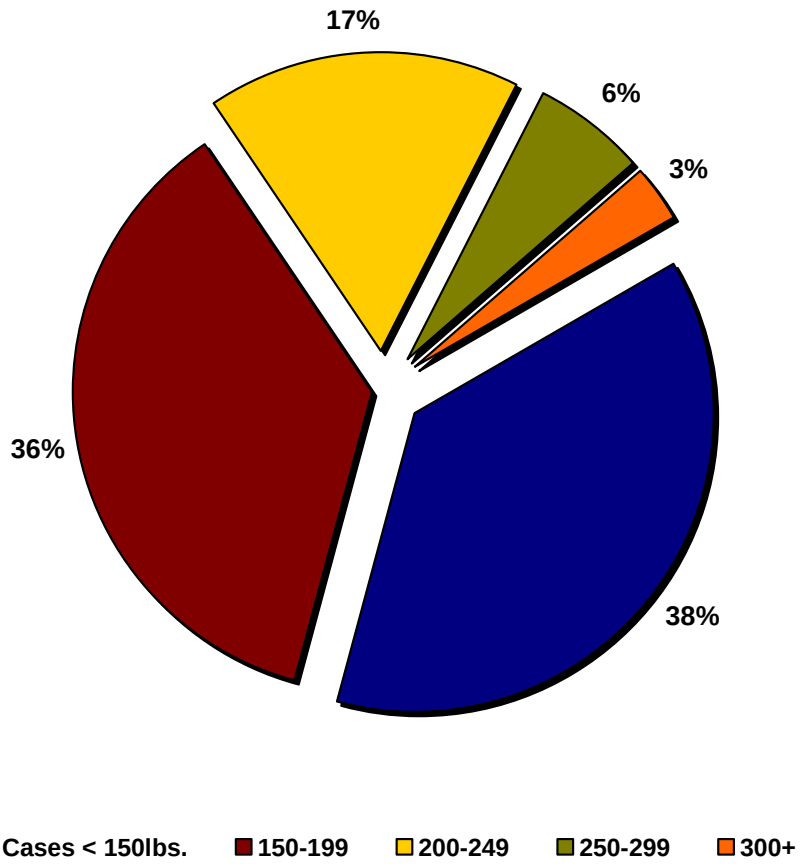
2007 - WEIGHT DISTRIBUTIONS

Weight	< 150lbs	150-199	200-249	250-299	300+	Total Cases 150lbs or more	Total Cases
Number of Decedents	523	510	239	85	42	876	1399[10]

Although all persons over the weight of 150 pounds are not necessarily considered overweight, there is a direct correlation with the weight of a decedent and work related injuries for OCME personnel. As a result, adequate staffing, training, and equipment are necessary to prevent injuries related to the lifting of bodies as required at the time of pick-up and during the autopsy procedure.

Of the 1,399 cases studied in this report, 1,337 were adult decedents, and 62 were child decedents between the ages of 2-19 years old.

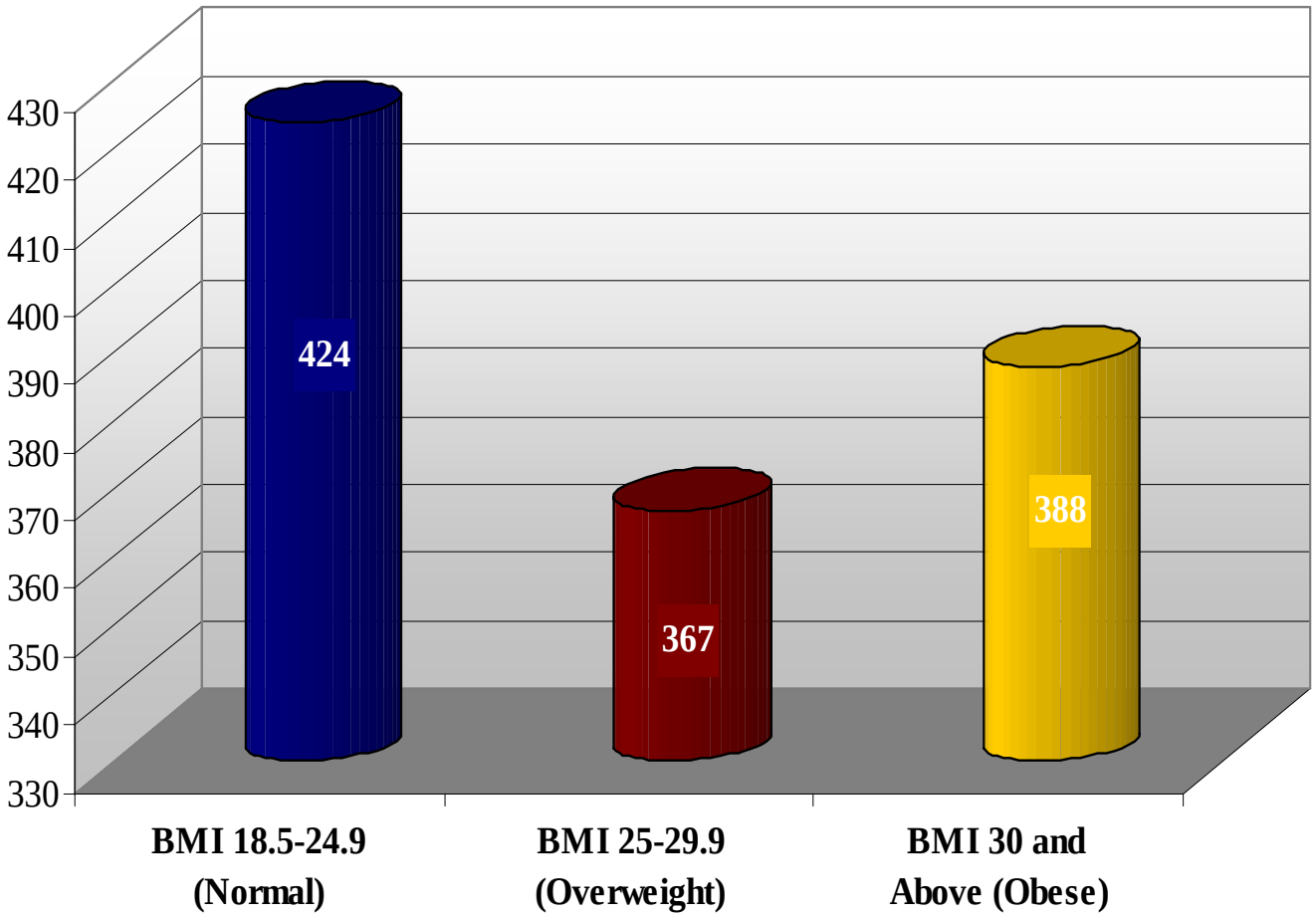
Distribution of Accepted OCME Cases by Weight 2007



[10] As stated previously OCME accepted and investigated 1,458 cases. No weight data is available for 11 cases because they were Review of Medical Records only. In addition, for the purposes of BMI reporting, the following case types are not included in this data: Children under 2 yrs old (32)**;** Fetuses (9); **N**on-Human Remains (7).

Body Mass Index (BMI)

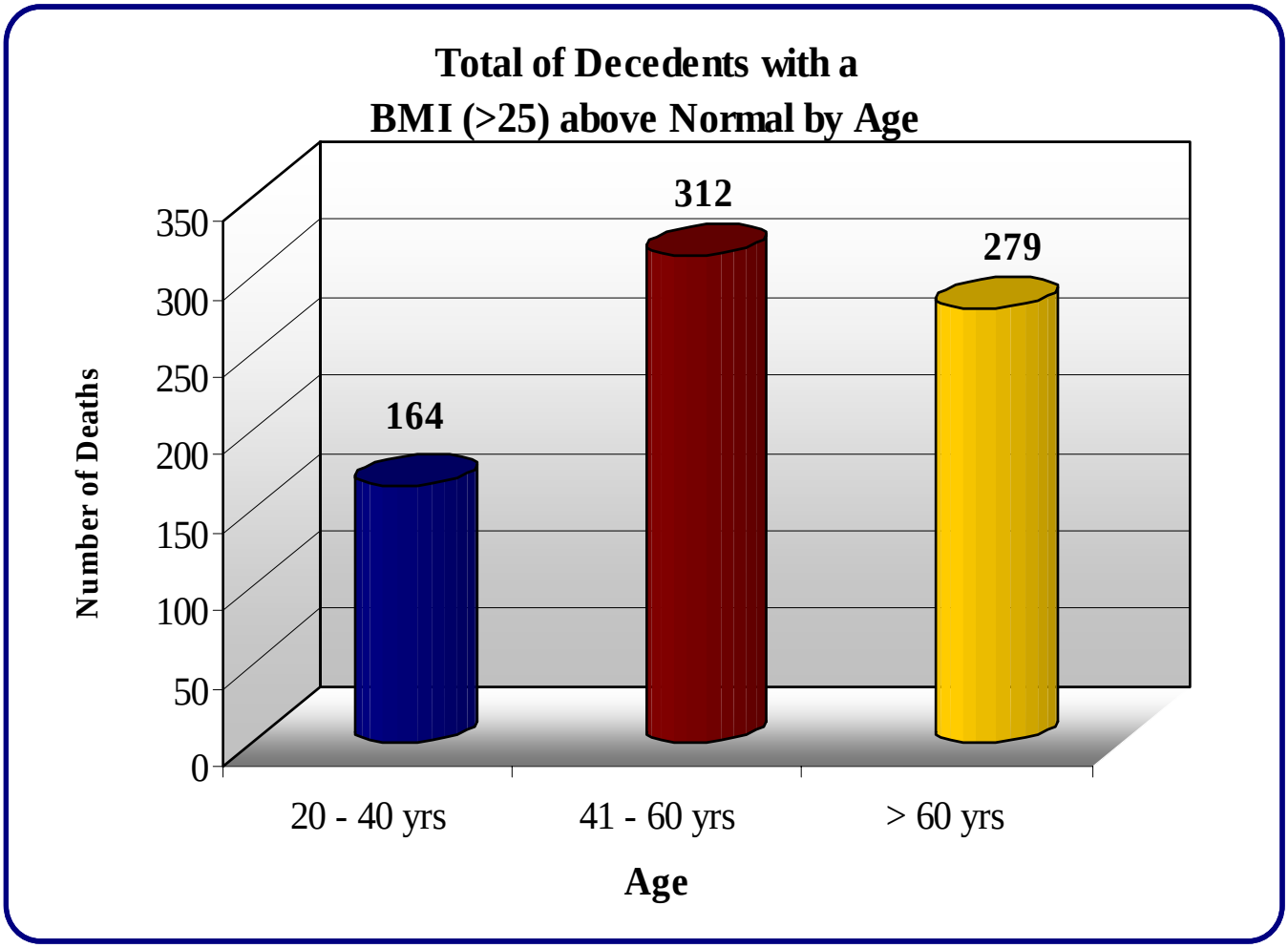
The BMI figure below illustrates that of the 1,337[11] adult cases that OCME accepted for further investigation, 424 were normal, but 755 cases or 56% had a Body Mass Index above normal, of which 367 were overweight (BMI 25 – 29.9), and 388 were obese (BMI 30 and above).



[11] The remaining 158 adult decedents were below the normal range (underweight) as established by the Center for Disease Control., and for the purposes of this illustration are not included in the above figure/graph.

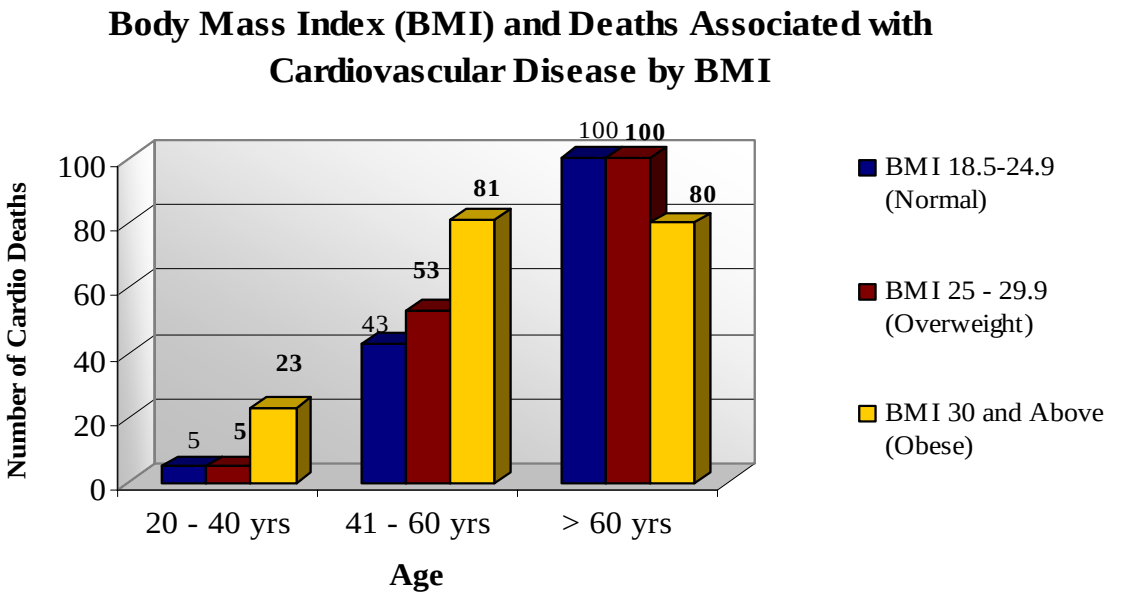
BMI by Age

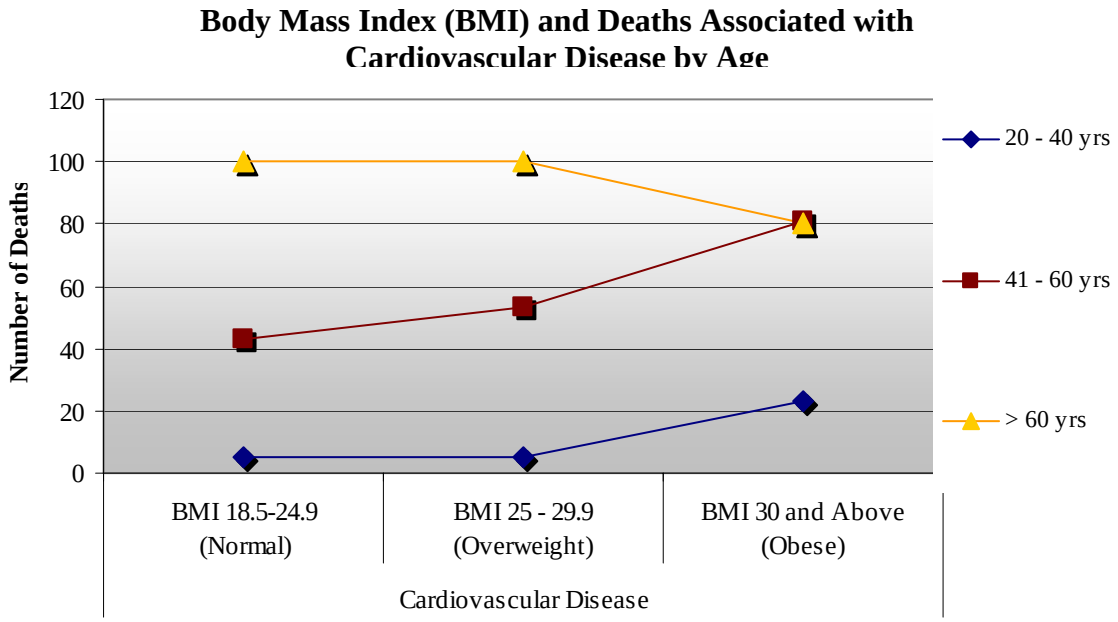
Of the 755 decedents with a BMI above normal (> 25), the age group with the highest number of deaths was 41 - 60 years old with 312 deaths.



BMI by Age and Cardiovascular Disease

The OCME identified 544[12] decedents with a cause of death directly associated with Arteriosclerotic and Hypertensive Cardiovascular Disease, of which 342 cases or 63% had a Body Mass Index above normal (158 were overweight and 184 were obese). The figures below outline the prevalence of cardiovascular disease and its association with being overweight by age and BMI.

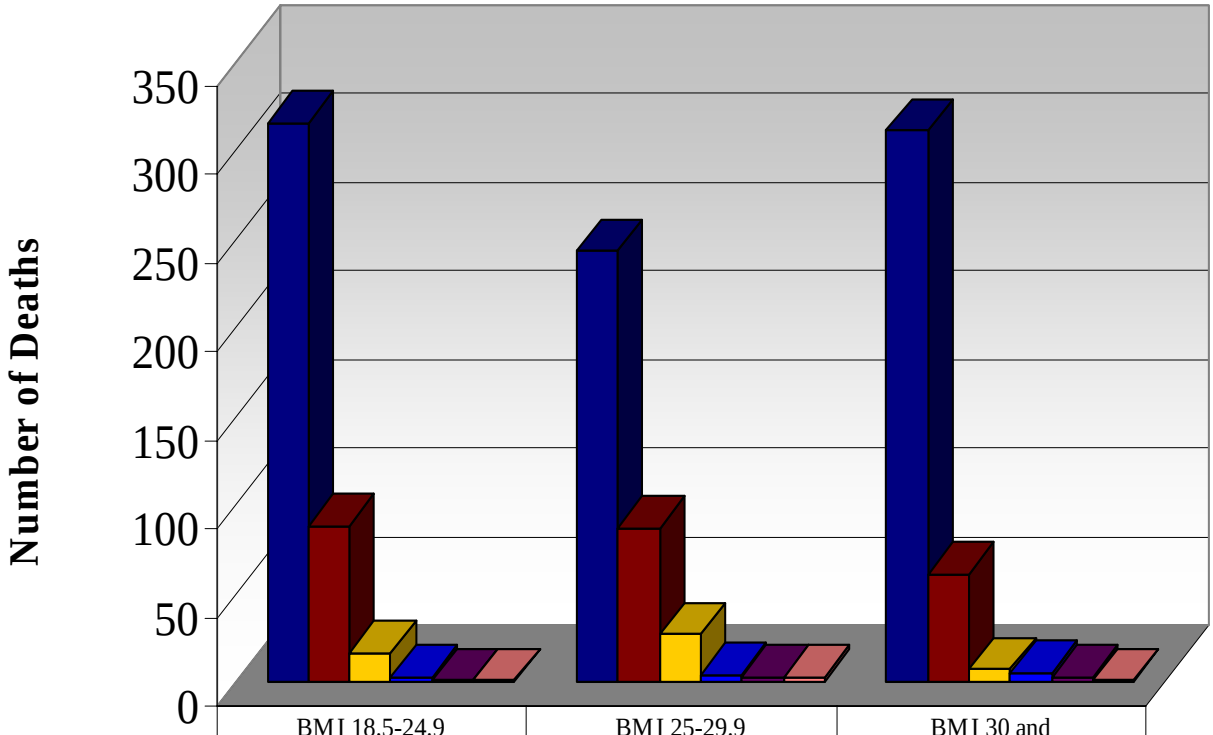




[12]This total includes decedents with a BMI that is less than 18.5 (in most instances these decedents are considered underweight); however, for the purposes of this illustration this weight classification is not included in the charts.

BMI by Race

The demographics for this population decreased slightly between 2006 and 2007. Of the 755 decedents above the normal BMI, 554 or 73% were Black/African American, 148 or 20% were White, 34 or 4.5% were Hispanic and less than 3% were Asian, Other or Unknown.



	BMI 18.5-24.9 (Normal)	BMI 25-29.9 (Overweight)	BMI 30 and Above (Obese)
Blacks	315	243	311
Whites	88	87	61
Hispanics	16	27	7
Asians	3	4	5
Other	1	3	3
Unknown	1	3	1

4.1 - BMI Calculations for OCME Decedents between the Ages of 2-19 years

How is BMI Determined for Children?

The BMI calculation for children between the ages of 2 and 19 years is calculated for each child separately using the following information.

1) Date of Birth
2) Date of Measurement
3) Gender
4) Height
5) Weight

Once the above information is entered for each child, it is used to calculate where the child falls in an established percentile as compared to other children in their age and gender group. More information on how BMI is determined for boys and girls between the ages 2-19 years can be found at the CDC website:

http://www.cdc.gov/nccdphp/dnpa/bmi/childrens_BMI/about_childrens_BMI.html

BMI Statistical Data

OCME had a total of 94 child decedent cases in 2007 that were accepted for further investigation. Of the 94 cases 32 were under the age of two, and currently there is not a BMI calculation available for this subset of children. There were a total of 62-child decedent's age 2 years old and above where BMI calculations could be determined (with 1 exception, see footnote) and they are displayed below by gender and age.

FEMALES

Age	Underweight		Healthy		Overweight		May be Obese		Total
	BMI Range	No.	BMI Range	No.	BMI Range	No.	BMI Range	No.	
2-5 yrs	14.1	2[13]	15.3 – 20.3	3	*n/a	0	20.2	1	6
6-11 yrs	*n/a	0	*n/a	0	17.7 – 20.3	2	*n/a	0	2
12-16yrs	*n/a	0	19.0	1	24.9	1	33.8	1	3
17-19yrs	*n/a	0	20.4 – 24.5	4	28.0	1	32.6	1	6
Total		**2**		**8**		**4**		**3**	**17**

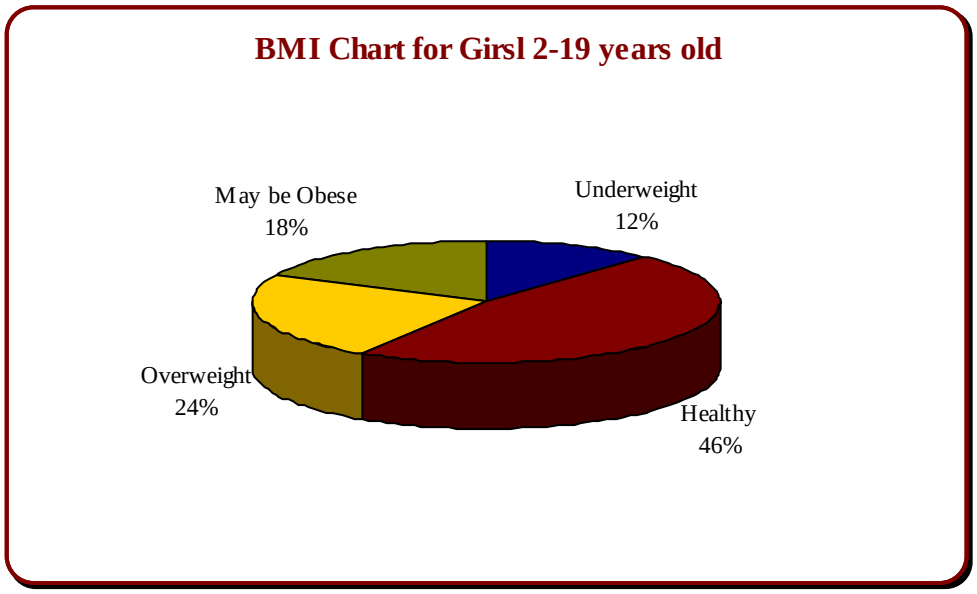
MALES

Age	Underweight		Healthy		Overweight		May be Obese		Total
	BMI Range	No.	BMI Range	No.	BMI Range	No.	BMI Range	No.	
2-5 yrs	*n/a	0	15.6 – 15.9	2	*n/a	0	19.0 – 22.0	4	6
6-11 yrs	*n/a	0	14.9 – 18.4	5	22.8	1	*n/a	0	6
12-16 yrs	14.3	1	18.4 – 22.3	7	24.8	1	27.1 – 30.0	2	11
17-19 yrs	17.8	1	19.0 – 23.5	16	16.5 – 28.8	3	32.0 – 32.7	2	22
Total		**2**		**30**		**5**		**8**	**45**

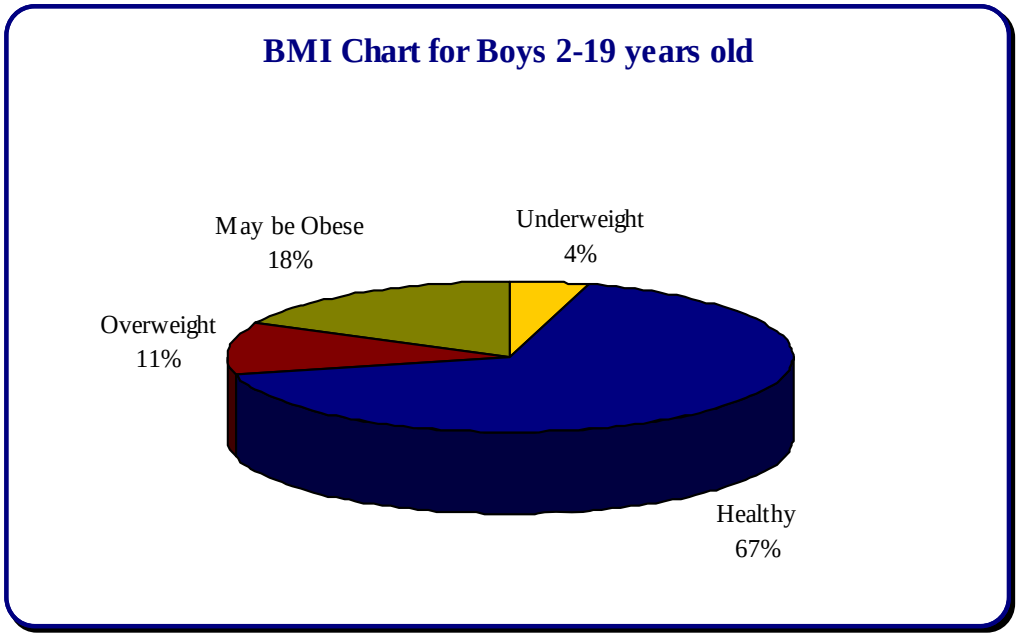
***n/a**= not applicable

[13] The CDC BMI calculation for one of the two (2) female children in this age group had the following statement: "This child is outside of the BMI range of expected values. This child may be underweight.

There was a total of 17 female youths from 2-19 years, and 54% were found to be outside the healthy range. There were female decedents in all age categories.



There were a total of 45 male youths from 2-19 years, and 67% were found to be within the healthy range. There were male decedents in <u>all</u> age categories.



5.0 – Breakdown of Medical Examiner (ME) Investigations compared to Census Population Data

According to the US Census Bureau, 2007 American Community Survey the estimated population for calendar year 2007[14], in the District of Columbia was 588,292 inhabitants. The DC population is comprised primarily of the following ethnic groups: White, Black, American Indian/Asian and Hispanic. In 2007 the OCME investigated 3,049 deaths that occurred in these populations and 1,458 were accepted under the jurisdiction of the Medical Examiner for further investigation. The following table and figures summarize the manner of death by gender and racial composition.

2007 Manner of Death by Race with 2005 Census Data

Race	2007 Census	Natural	Suicide	Homicide	Accidents	Undetermined	Total ME Cases
White	231,657	138	21	4	99	11	273
Black/African American	324,875	651	21	172	195	33	1,072
Hispanic/Latino[15] (of any race)	49,061	21	1	20	18	1	61
Asian	19,799)	5	2	2	8	1	18
Other	n/a	6	1	2	4	2	15
Total Population	**588,292**	N/A	N/A	N/A	N/A	N/A	N/A
	N/A	**821**	**46**	**200**	**324**	**48**	**1439**[16]

2007 Manner of Death by Gender

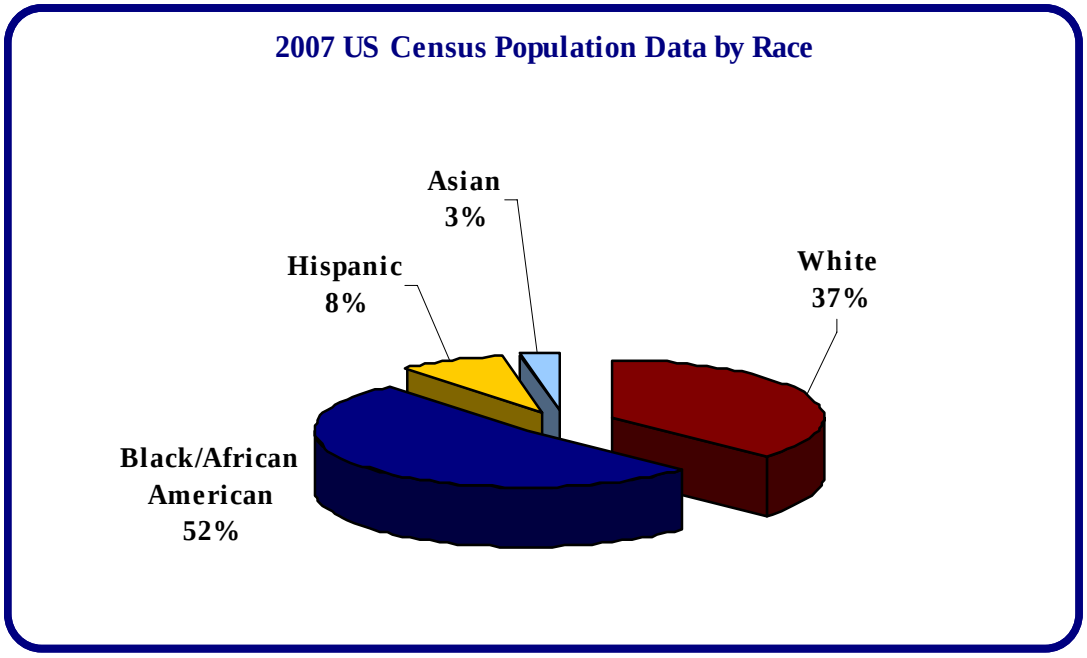
Gender	Naturals	Suicide	Homicides	Accident	Undetermined	Totals	Percent
Female	302	17	22	123	19	483	34%
Male	519	29	178	201	29	956	66%
Totals	**821**	**46**	**200**	**324**	**48**	**1,439**	**100%**

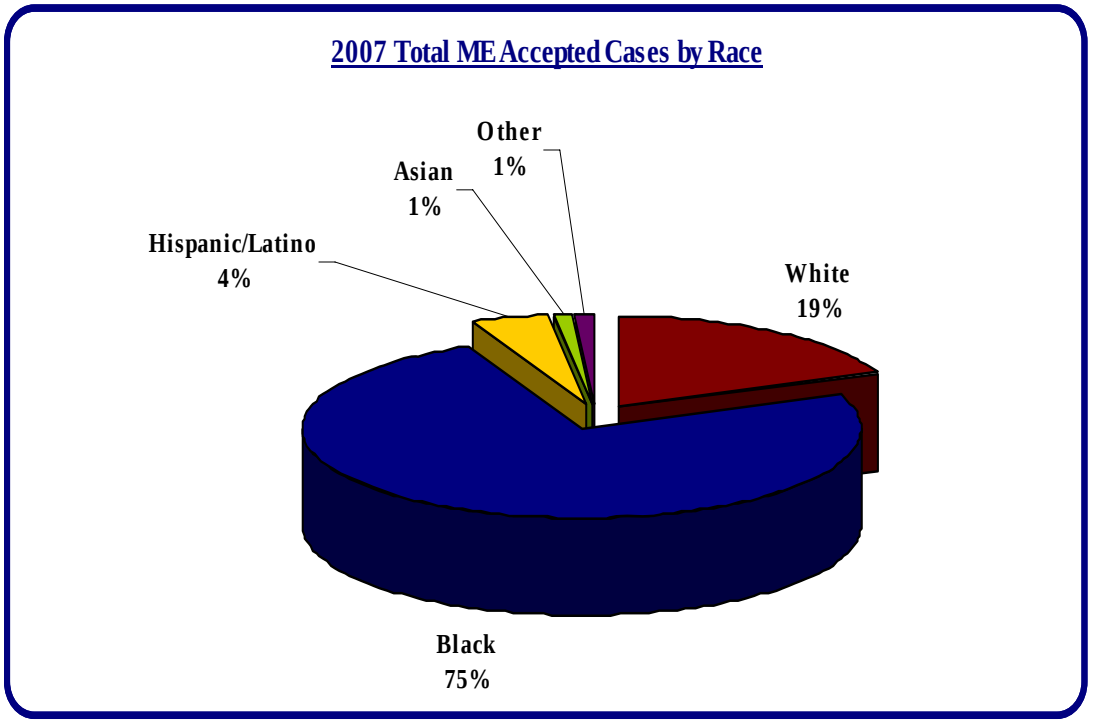
[14] http://factfinder.census.gov/servlet/QTTable?-ds_name=PEP_2007_EST&-qr_name=PEP_2007_EST_DP1&-geo_id=04000US11n

[15] According to the US Census Bureau, Hispanic origin is considered an ethnicity, not a race. Hispanics may be of any race.

[16] The above tables do not include Stillbirths (N=11); Non-Human remains (7); or where the Manner of Death was "*Other* (Medical Waste, 1)"

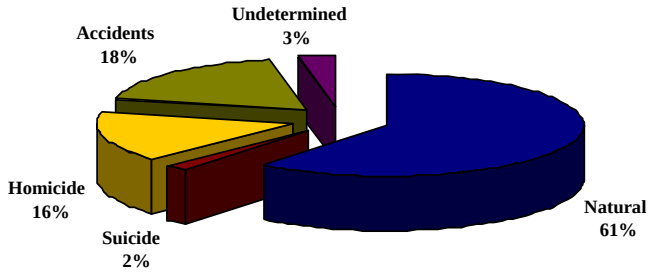
Total Population & Total ME Cases by Race and Gender



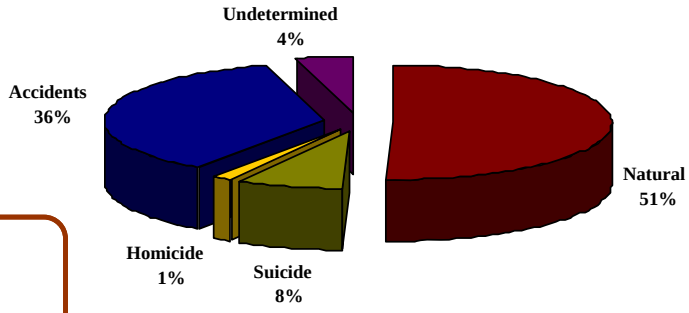


Total ME Cases by Race and Manner of Death

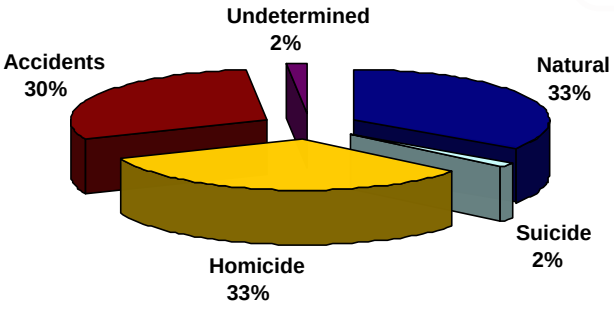
Black Population



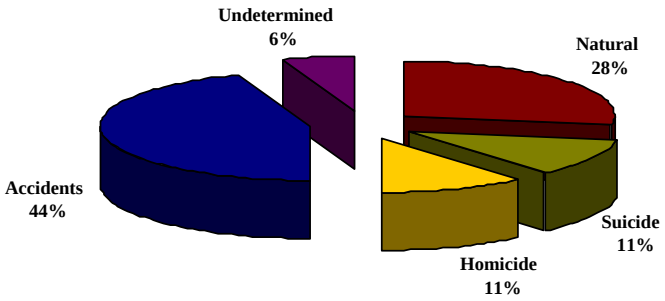
White Population



Hispanic Population



Asian Population



APPENDIXES

APPENDIX A

2007 OCME Organizational Chart

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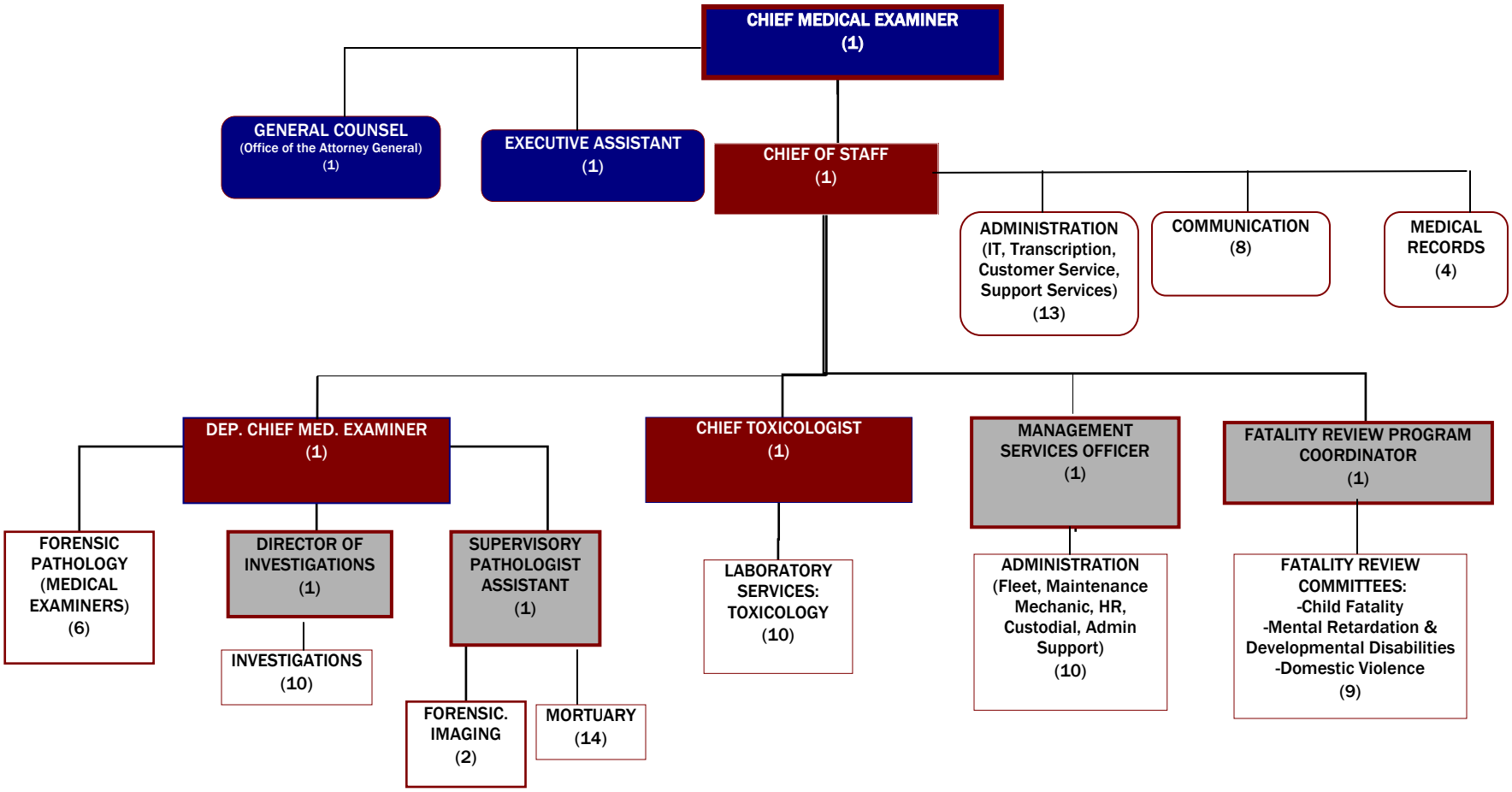
OFFICE OF THE CHIEF MEDICAL EXAMINER
ORGANIZATIONAL CHART
FY2007



APPENDIX B

AGENCY MANAGEMENT

AGENCY MANAGEMENT

Facility Accreditation:

In 2007, the Office of the Chief Medical Examiner (OCME) began formal efforts toward facility accreditation by the National Association of Medical Examiners (NAME), which included contacting NAME officials and obtaining information regarding the application, inspection and accreditation process. The OCME implemented the NAME self-inspection process by utilizing the NAME Accreditation Checklist; and working cooperatively with District agencies to resolve operational, facility and staffing barriers per the self-inspection. As part of the accreditation process, all required written standard operating procedures must be signed within 2 years of the inspection. As such, management staff started work to ensure that the agency's Policy and Procedure Manual was updated and that the required policies and procedures developed and implemented were signed prior to an inspection. The agency application for accreditation is planned for early 2008.

Inspector General Re-Inspection

In May 2006, the D.C. Office of the Inspector General (OIG) began a re-inspection of the agency as a follow-up to an initial September 2003 inspection. Agency employees worked cooperatively from May 2006 through September 2007 to provide requisite information and answer all inquiries. The OIG's Report of Re-Inspection was issued in October 2007 and found that "[o]f 79 recommendations made in our initial inspection report, OCME has complied fully with 50; 12 are in partial compliance; 11 have not been complied with, and 6 were overtaken by events." The IG commended OCME "for the improvements represented by those recommendations complied with . . ."

Among the achievements noted by the IG are the development of "formal policies and procedures that provide guidelines for decedent identification, autopsies, biohazardous waste and chemicals, tissue disposal and retention, release of bodies and security and maintenance of records." The IG stated that "these guidelines are instrumental in helping OCME employees bring consistency, efficiency and safe practices to OCME's day-to-day business." The IG also noted that the agency "[s]ignificantly reduced the backlog of autopsy reports and unclaimed or unidentified bodies." The IG further stated that "[r]eductions in these areas allow OCME to generate death certificates with minimal delay, maintain sufficient refrigerated storage space, and maintain sanitary conditions." Also of note are the IG's observations that long-standing operational and personnel management problems have improved.

Personnel Management:

During 2007, OCME focused on maintaining a qualified and diverse workforce through the implementation of employee retention and recruitment efforts. Employee retention efforts included hosting workshops and training sessions during monthly general staff meetings, including those focused on the District's Employee Assistance Program (EAP); various District and agency policies and procedures; disability insurance; and forensic pathology issues. The agency also implemented a monthly forum sponsored by the Wendt Center for Grief Counseling related to stress management. In the recruitment area, of 88 authorized positions for FY2007, 69 were filled; 16 were in the recruitment or classification process; and 3 were held vacant.

Contracting & Procurement:

OCME's contracting and procurement or purchasing unit provided contracts management, purchasing and technical assistance to department management and staff, so that services and commodities were obtained within budget and in a timely manner according to customer specifications during the calendar year.

Pursuant to Title 27, DCMR Chapter 8, Local, Small and Disadvantaged Business Enterprises (LSDBE) Contracting regulations, each agency of the District of Columbia must allocate fifty (50%) of its expendable budget for use with Local Business Opportunity Commission certified Small Business Enterprises (SBE). For 2007, the agency met these LSDBE requirements in providing services to decedents' families, law enforcement, the health community, officials, and the community at large. As in past years, this accomplishment is significant because the agency's contracting needs are often highly specialized and result in limited options for securing services. The agency will continue to encourage non-

LSDBE vendors (that appear to be eligible) to apply for certification which may allow us to achieve higher annual set-aside goals.

In preparation for a NAME inspection toward accreditation, the agency ensured continuation or arrangement of expert consultation for neuropathology, anthropology, pediatric pathology, radiology and odontology. These consultations are provided via contracts or by existing staff.

Property Management:
Throughout 2007, OCME worked with the Office of Property Management (OPM) on several capital projects, including: a) repair of the HVAC system; b) various in-house renovations; and c) a move to external facility for additional staff spacing. While the HVAC system repair was completed in 2005, problems with temperature variances and water leakage continued. An additional assessment of the exhaust system by OPM revealed that more work was required to address the air quality problems and a new design for the exhaust system was developed. OCME worked with OPM regarding the work to be completed on the system.

NAME requirements for accreditation include appropriate staff and storage spacing for all employees and agency records. OCME also worked with OPM on Phase II of in-house renovations to accommodate OCME spacing challenges for current staff and new hires. (Phase I, completed in 2006, included expanding the reception area and renovation of office spaces to increase the number of offices and spacing for employees.) Phase II renovations started in 2007 include additional security measures; safety measures for the toxicology laboratory and autopsy suite; and renovation of the mortuary unit office space such that the Forensic Imaging Unit would have secure space for photographs, slides and x-rays and the mortuary staff would have appropriate workspace. Further, a separate office for the Mortuary Supervisor (Supervisory Pathologist Assistant) and larger office space for Autopsy Assistants was planned.

OCME has been in need of additional storage space for medical records (due to the Millicent Allewelt Act's requirement to store certain records for 65 years); equipment used on a daily basis; and equipment and resources for mass fatality purposes. In 2007, OPM identified temporary storage space within the old D.C. General Hospital and began preparing the space for agency use. The storage space will also accommodate toxicology, histology, and mortuary equipment.

During 2007, management focused on the move of the Fatality Review Unit (FRU) to a second site in order to ensure appropriate staffing and storage space for the agency at its core facility and to ensure cohesiveness, security and confidentiality for the FRU. Spacing on the 4th Floor of the Reeves Center was provided as an option by OPM to ease the pressure. The space has been renovated and the staff is currently moving to the site.

Information Technology:
In 2007, the Information Technology (IT) Unit focused on several projects to enhance the operations of the agency. First, enhancements were made to the agency's Forensic Automated Case Tracking System (FACTS), which is used to log all information associated with a case from the time of the initial intake call through the release of remains to the final completion of the autopsy report (when applicable). With an automated search, OCME can provide information on various aspects of a case, such as: a) whether it is pending jurisdiction, has been accepted or declined; b) the type of examination; c) the cause and manner of death; and d) other key case notes about the deceased or investigation. OCME also uses FACTS to compile statistics for the agency's Monthly Performance Scorecard reports and its annual reports. OCME's case tracking system (FACTS) is recognized as a national model. Enhancements included modifications and additions to existing modules dealing with cremations, intake and investigative reports, property/evidence and autopsy reporting.

Work also continued on the deployment of a system from Smart Board Technology, Inc., which consists of equipment, software and interactive capabilities that allows one to input and compile data while performing an autopsy. The Medical Examiners were trained on the use of the equipment and the autopsy report module within FACTS which enables them to enter autopsy findings directly from the autopsy suite.

The information and data will be input at the autopsy table, so that the findings or a draft report can be generated from the desktop and ready for transcription. This technology will be invaluable to the agency's efforts to comply with the protocol to complete a draft autopsy report within five days of the autopsy. It will also enable OCME to meet the NAME timing requirements for completed autopsy reports. During this period, the IT Team focused on installation of the equipment (i.e., "smart boards") in the autopsy suite and usage of the tough book laptops with the "smart boards."

The IT Team worked with management on the development of an agency website including formatting and content.

Risk Management:
The agency's Risk Assessment Control Committee ("RACC") met all D.C. Office of Risk Management (ORM) requirements in 2007, which included: holding monthly meetings, which included minutes and cost of risk reports; developing and implementing an Agency Risk Management Plan; training on the Continuation of Operations Plan (COOP); updating and training the Emergency Response Plan (ERP); and providing quarterly updates and a year-end report to the Office of Risk Management. As part of Risk Management, health and safety issues continue to be addressed. The agency continues to provide radiation monitoring and annual tuberculosis testing. The agency has trained staff on the procedures to be followed in the event of an injury, including immediate emergency health care and completion of an accident report.

As discussed above, the risk management activities also included stress management monthly sessions sponsored by the Wendt Center

OCME's emergency response planning also included:
- staff training and participation in various emergency preparedness conferences;
- agency quarterly emergency response drills;
- participation in District Emergency Response Drills;
- participation on the Emergency Preparedness Council (EPC);
- DC Hospital Association's Emergency Preparedness Committee (EPC); and
- participation in Forensic Lab planning.

Labor Relations:
OCME's Labor Management Partnership Council (comprised of labor and management employees) was active in 2007 and continued a focus of the implementation of a Health and Wellness program for agency employees. The Wendt Center stress management monthly sessions is part of this effort. Employees were provided stress management workbooks and pamphlets by the agency.

In 2007, OCME labor and management worked together to raise funds for the D.C. Government Employees 52nd Annual One Fund Drive and the agency's participation level exceeded reached Platinum status for achieving over 200% of the goal. Employees also worked to provide Thanksgiving baskets to needy District families and had an Employee Holiday Celebration in December 2007. The Holiday Celebration was held in honor of two long-time employees that passed away in 2007 (Valjean Valentine and William Clack).

Emergency Response/Mass Fatality Planning:
Over the course of 2007, OCME actively pursued activities to support its mass fatality and emergency response planning. The agency's Mass Fatality Plan establishes the framework for response to mass disasters; describes OCME's roles and responsibilities; and outlines OCME's relationships with local, federal and volunteer agencies that may support OCME in its functions. OCME's emergency response planning also included:
- staff training and participation in various emergency preparedness conferences;
- agency quarterly emergency response drills;
- participation in the Council of Governments Mass Fatality Surge Committee
- participation in District National Response Drills; and
- participation in Forensic Lab planning.

APPENDIX C

INTERNAL PARTNERSHIPS

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INTERNAL PARTNERSHIPS

OCME/MPD Natural Squad Collaborative

The collaboration between the OCME Investigative Unit and the MPD Natural Squad was established in 2004. This collaboration continues to augment the investigative skills of both the MLI's and the Detectives as they share ideas and discuss investigative techniques and approaches.

The MPD detectives assigned to our office continue to help with expediting the identification process through access to FBI files and/or AFIS, facilitating contact with their counterparts for neighboring jurisdictions, which enables OCME to expeditiously obtain necessary investigative information for case evaluation. This ability continues to be an invaluable asset to the OCME in helping to streamline the investigation process.

OCME/Wendt Center for Loss and Healing Collaborative

The Wendt Center continues to provide extraordinary grief counseling services to the residents and visitors that come to Office of the Chief Medical Examiner on a daily basis. They also provide presentations and lectures for professional groups that visit the agency on a regular basis.

Due to the nature of our services, and the complexity of our work, in 2007 the OCME management team requested that the Wendt Center counselors provide stress support session for the staff. They immediately began to develop a program that utilizes talk, yoga and art to allow the OCME staff to express their stress and anxiety through different creative processes.

During 2007 the Wendt Center staff provided 10 support group sessions, which have been a huge success. The OCME staff attends regularly and looks forward to the monthly sessions. These sessions have definitely impacted the morale of the staff in very positive ways, and are achieving the goal of reducing stress and tension in the office. The OCME would like to express a very special thank you for the overall services that the Wendt Center staff provides to the public and our staff. We are extremely grateful for their professionalism and compassion toward the families and staff, and all the work they do to make the process as tolerable as possible under extremely difficult circumstances.

In 2007 they assisted OCME staff with 1,074 identifications, of which 161 were homicide cases and 64 were child deaths. These statistics are indicative of the type of services they provide and their participation in the work of the office.

APPENDIX D

OTHER MAJOR ACTIVITIES

Court Testimony
Education –Lecture and Presentations
Overview of ID and Public Disposition Process

OTHER MAJOR ACTIVITIES

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. OCME includes tabulated data for expert services provided in calendar year 2007.

Type of Judicial Service	Number of Court related Activities
Court Testimony	61
Depositions	2
Grand Jury	1
Pre-trial Conference	68
Other	2
Total	**134**

Court Services by Jurisdiction	Number of Court related Activities
DC	121
Maryland	11
Virginia	2
Total	**134**

Court Services by Type	Number of Court related Activities
Civil	11
Criminal	121
Hearing	2
Total	**134**

For calendar year 2007 the above data represents approximately 258 hours of Medical Examiner time. The Chief Medical Examiner (CME) handled 48 of these court-related activities, which represents 46% of the total court service caseload. The CME's caseload is heavier because she provides expert court services for most of the cases where a Medical Examiner is no longer with the District Government. The least amount of time recorded in 2007 on an activity was a half of an hour, and the most amount of time spent on a court-related activity was 8 hours.

Educational Activities

OCME continues to welcome students and residents from area universities and hospitals for their teaching requirements. In addition, the agency either hosted or was invited to lecture and/or provide presentation at the following medical institutions and/or major conference:

1) 2007 ICITAP Basic Homicide Investigation Course – 4-day course hosted by OCME, May 21 through May 24, 2007
2) Operation Prevent Auto Theft – Monthly lecture and tour (seasonal)
3) 2007 National Youth Leadership Forum on Medicine – Half day of lecture and tour (annually)
4) DC Medical Examiner's Office Familiarization Training for Metro Transit Police Officers, Metropolitan Police Department Cadets and Mobile Crime technicians, Public Defenders Service Interns – held at various times throughout 2007.
5) Partners in Education with Arlington Public Schools – Annual Presentation, November 9, 2007.
6) Physician Assistants in Forensic Medicine – American Academy of Physician Assistants – Annual National Conference, Philadelphia , PA – May, 30, 2007.

Overview of Identifications and the Public Disposition Process

The process of identification can be a complex and lengthy procedure. The preferred method of identification, whenever circumstances of death and discovery allow, is by visualization of a Polaroid photograph. Immediate family, close friends, neighbors or colleagues provide verification for visual identifications. In all other cases, the identification process may involve fingerprinting, DNA Analysis, dental charting, or comparative studies of ante-mortem and post-mortem body and dental x-rays. Staff members of different divisions and outside consultants participate in this process including members of MPD's Natural Squad.

The Washington, DC area enjoys a large number of national and international visitors. The city has many embassies and a diverse population of immigrants. Often the next of kin is not available for identification purposes; hence another set of procedures must be followed through official headquarters of different countries to ensure proper identification and release of remains to appropriate family members.

Bodies examined at 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 as "Unclaimed bodies" and have to be disposed of by the agency. In addition, the OCME provides storage of remains for nursing homes, hospices and area hospitals. A minimal one-time fee is charged to these facilities and the remains are kept until family members are located.

Unclaimed remains from hospitals are also by regulation to be stored and disposed of by OCME (DC Code §5-1411). 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 contracts with local funeral homes. Unclaimed ***identified*** bodies are cremated, but identified, unclaimed US military veterans - after authorization is granted - are transported to Quantico National Cemetery in Triangle, VA, for burial. Unclaimed ***unidentified*** bodies are buried through contracts with local funeral directors, unless there is a concern for public health and safety that would require cremation; then additional measures are taken to ensure proper identification.

It is important to note that Public Dispositions are not performed by Medical Examiners in neighboring jurisdictions. For instance in Maryland, bodies are released to the Anatomic Board after 3 days if they are not claimed by Next of kin.

Breakdown of Public Dispositions and the Associated Costs

Public Disposition by type	Number of Cases	Cost Per Disposition	Total Dollar Amount Per Type
Burials – unidentified adults	15	$1988.00	$29,820.00
Burials- unidentified child	1	$ 895.00	$895.00
Burial of cremated remains	1	$400.00	$400.00
Cremations – identified adults	108	$490.00	$52,920.00
Cremations - infants	15	$234.00	$3,510.00
Cremations – fetal remains	17	$105.00	$1,785.00
Transport to Quantico National Cemetery – identified US Military Veterans	6	$529.00	$3,174.00
Transport to Quantico National Cemetery – identified US Military Veteran with transport container provided by vendor	1	$690.00	$690.00
TOTALS	**164 unclaimed remains**		**$93,194.00**

APPENDIX E

PROGRAM LEGISLATION/MAYORAL ORDERS

OCME, DC Law 13-172, codified at DC Official Code §5-1401 et seq. (2001)
CFRC Legislation and Mayoral Order 98-67
MRDD FRC Mayoral Order 2005-143
DVFRB, DC Law 14-296, codified at DC Official Code §16-1051 et seq. (2001)

All of the DC Code for District of Columbia Government agencies can be found at:
http://www.dccouncil.washington.dc.us/dcofficialcode