2008 Annual Report
OFFICE OF THE CHIEF MEDICAL EXAMINER

MAYOR FENTY CONGRATULATES THE OFFICE OF THE CHIEF MEDICAL EXAMINER FOR OBTAINING PROVISIONAL ACCREDITATION FROM THE NATIONAL ASSOCIATION OF MEDICAL EXAMINERS (NAME)

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

Neil Albert, City Administrator
Executive Office of the Mayor

Marie Lydie Y. Pierre-Louis, MD – Chief Medical Examiner
Office of the Chief Medical Examiner

DISTRICT OF COLUMBIA
OFFICE OF THE CHIEF MEDICAL EXAMINER

MISSION:

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

The Executive Leadership Team

Marie-Lydie Y. Pierre-Louis, MD
Chief Medical Examiner

Sarah M. Colvin, MD
Deputy Chief Medical Examiner

Beverly A. Fields, Esq.
Chief of Staff

Lucas W. Zarwell, MFS
Deputy Chief Toxicologist

Peggy J. Fogg
Management Services Officer

Anna D. Francis
Executive Assistant

PRESENTED TO:

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

December 2009

A MESSAGE FROM THE CHIEF MEDICAL EXAMINER

Calendar year 2008 was a year of great achievement for the OCME with a major focus on obtaining accreditation by the National Association of Medical Examiners (NAME). The staff worked very hard to ensure that the agency's operations were in compliance with standards set forth by NAME. NAME inspected the office in July 2008 and on October 15, 2008; the agency received provisional accreditation by NAME through April 15, 2009. The agency subsequently provided a status report to NAME on December 19, 2008 outlining improvements and resolutions for specified deficiencies and implementation of recommendations made by the NAME Inspector.

Among the areas of improvement were the development, review and update of agency policies and procedures in key areas required by NAME; maintenance of core facility systems and equipment; construction of office and storage space; purchase and upgrade of essential equipment; and technological advances. In 2008, the agency also began the process of converting its evidence room in the autopsy suite into a histology laboratory so that the work can be performed in-house as opposed to contracting out these services.

The following systems and processes have been upgraded to digital forms of technology and are fully functional in-house: 1) forensic photography; 2) X-ray/Radiology equipment – both photo and X-ray film processing have been replaced with digital images and processing; and 3) fingerprinting. The Digital fingerprinting process replaces the manual ink fingerprinting process, so that all fingerprints can be stored electronically and immediately forwarded to MPD. The agency also prepares and stores specimens for DNA analysis for all decedents processed. This will result in a cost-savings to the agency in that unclaimed remains can be disposed of (after a set period) through cremation, as opposed to the more costly method of burial. Further, the agency's Forensic Automated Case Tracking System (FACTS) was maintained allowing efficient recordation, tracking and processing of medical examiner cases and production of statistical annual reports mandated by statute and Mayor's order.

Of note, is the agency's improvement in staffing levels in technical and critical positions, including full staffing of the Investigations Unit such that death scenes can be attended by an investigator on a 24-hour basis; hiring a Deputy Chief Toxicologist, a second forensic photographer, a Maintenance Mechanic; and developing an agency-wide quality control and assurance position. The workflow of the forensic pathology unit was reorganized to ensure that each Medical Examiner was assigned a Medical Transcriptionist for administrative and technical duties. Further, the agency standardized autopsy reporting; developed an internal process for completion of draft autopsy reports within five days; and implemented a formal quality assurance and control program to include a system to ascertain due dates of written autopsy reports.

The agency has been historically confronted with challenges that were addressed and resolved due to the dedication and hard work of the agency staff and support of the Mayor's administration. The NAME Inspector commended all staff for an exceptional effort in the forward progress of the agency and the receipt of provisional accreditation.

Of note, the agency was regularly rated in the highest percentage for customer service and received several letters of appreciation for staff and the agency's work.

Other activities throughout 2008 included the agency's coordination of emergency response planning in preparation for the upcoming Presidential Inauguration and processing of a high profile case involving numerous child deaths. In both complex situations, the staff was well-trained and worked in partnership with several District and federal agencies, private and public entities and the general public in an organized and professional manner. The agency also initiated an in-house formal training program, which included the first staff audio-conference training and a guest lecturer series featuring Dr. Michael Baden, famed forensic pathologist and host of HBO's *Autopsy*. Lastly, the agency staff continued to provide input to the architectural configuration and governance structure for the planned Consolidated Forensic Laboratory (CFL) which will house the OCME.

In conclusion, calendar year 2008 was rewarding for the D.C. OCME. We are pleased to present this annual report which details programmatic accomplishments and encompasses core statistical data regarding cause and manner of death based on the medical examiner caseload for the year. It is our hope that the information provided herein is useful to all stakeholders, District residents and the general public. We will continue to serve the District population with pride and will maintain our commitment to the mission of the agency.

Sincerely,

Marie-Lydie Y. Pierre-Louis, MD
Chief Medical Examiner

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Executive Summary

The Government of the District of Columbia Office of the Chief Medical Examiner (OCME) is pleased to present its Seventeenth Annual Report. This Report covers data that resulted from the investigation of 3,133 deaths that occurred in the District of Columbia during the Calendar Year (CY) 2008. Report data will also include: Weight Distributions for Body Mass Index, Internal Partnerships, Identification Process, Agency Management and Other Major Activities which include - Court Tracking, Mass Casualties, Educational Lectures and Presentations. 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 2008.

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 Executive Office of the Mayor. 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 has three programs: Death Investigation and Certification, Agency Management, and Fatality Review. This report will include data on the Death Investigation and Certification, and the Agency Management programs. Due to significant staffing modifications a summary review of the Fatality Review Program is not included in this year's annual report.

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.

Internal Partnerships (Grief Counseling)

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).

Mass Casualty

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 actively participate 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.

Social Activities

During 2008, 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.

Education

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, toxicology and mortuary science. The OCME also provided training for members of MPD, the United States Attorney's office, the State Department and soldiers of the Marine Corps.

As stated above there were a total of 3,133 deaths reported and investigated by the OCME, of which 1,677 were declined, and 1,405 cases were accepted for further investigation. Of those, 945 were autopsied (Full and Partials). The OCME also processed 1,884 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".

2008 Medical Examiner Cases by Manner of Death

Manner	Full Autopsy Examinations	Partial Autopsy Examination	External Examinations	Medical Record Reviews	Total
Accident	215	6	115	2	338
Homicide	191	0	0	0	191
Natural	341	90	326	7	764
Stillbirth	4	0	0	0	4
Suicide	62	0	1	0	63
Undetermined	35	1	1	0	37
Total	**848**	**97**	**443**	**9**	**1397**

Note: This table does not included data for neither **"***Non-Human Remains*" (n=7) nor "Anatomical Specimens (n=1)

SUMMARY OF FINDINGS FOR MANNER OF DEATH

HOMICIDES: The OCME investigated 191 homicides in the CY 2008. This report reveals that homicides continued to be more prevalent in black males and in persons between the ages of 20-29. The weapon of choice was firearms. The peak incidents occurred in July.
Toxicology Findings: Toxicology testing was requested for all 191 Homicide cases investigated. Drugs were present in 93 of the homicide cases investigated. The most commonly detected drugs in homicide cases were: Ethanol (N=56), PCP (17), Cocaine (16), Morphine (9) and MDMA/MDA (5).

SUICIDES: The OCME investigated 63 suicides in the CY 2008. This report reveals that deaths by suicide were more prevalent in black males and in persons between the ages of 30-39. Whites had the highest number of incidents (n=30) this year. Peak incidents occurred in April, May and November.
Toxicology Findings: Toxicology testing was requested for 62 of the 63 Suicide cases investigated. Overall, drugs were present in 38 of the suicide cases investigated. The most commonly detected drugs were: Ethanol (N=18), Diphenhydramine (5), Citalopram (5), Mirtazapine (4), Zolpidem (4). The trend continues to be that more prescription medications were detected in suicide cases than in homicide cases.

ACCIDENTS: The OCME investigated 338 accidents in the CY 2008. Of the 338 cases investigated, 187 cases were the result of trauma, of which 69 were traffic related deaths; and 110 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 50-59. Peak incidents for accidents overall occurred in July, but for traffic accidents the peak months were June and August.

Overall Toxicology Findings: Toxicology testing was requested for 216 of the 338 Accident cases investigated, and drugs were present in 160 of these cases. The most commonly detected drugs were: Cocaine (N=69), Ethanol (53), Opiates (43), Methadone (12), Carbon Monoxide (10), Oxycodone (7), PCP (6); and Diazepam (6)

Toxicology Findings for Traffic-related accidents: Toxicology testing was requested for 55 of the 69 Traffic Related Accidents, and drugs were present in 28 of these cases. The most commonly detected drugs were: Ethanol (N=15), Cocaine (4), Oxycodone (2) and Fentanyl (2). In the 15 traffic related deaths positive for ethanol, the average Blood Alcohol Concentration was 0.17 % (range 0.06 – 0.40%). 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 105 of the 110 Drug Overdose deaths, and drugs were present in 102 of these cases. Toxicology testing was not requested on five (5) of the Overdose cases, all of which were "External Examinations" with a medical history sufficient to confirm the cause of death as a Drug Overdose. The three (3) Overdose cases that were negative were due to a delayed death as a result of a drug overdose. A delayed death caused by a "Drug Overdose" occurs when the decedent is admitted to the hospital and by the time death occurred the drugs have dissipated from their system, however, the hospital did conduct toxicology testing upon admission with positive results. The most commonly detected drugs were: Cocaine (N= 63), Morphine (39), Ethanol (29), Methadone (10), PCP (6) and Diazepam/Nordiazepam (6).

NATURAL DEATHS: The OCME investigated 764 Natural deaths in CY 2008. This report reveals that the leading cause of death in Natural cases is Cardiovascular Disease with 508 deaths, followed by Alcoholism and Cancer both with 42 deaths.

Toxicology Findings: Toxicology testing was requested for 365 of the 764 Natural cases investigated. Drugs were present in 178 Natural cases investigated. The most commonly detected drugs were: Ethanol (N=57), Cocaine (27), Morphine (17), Acetone (12), Methadone (7), Phenytoin (7), Phenobarbital (7), Oxycodone (5) and Codeine (4), Tramadol (4), Codeine (4) and Citalopram (4).

UNDETERMINED: The OCME investigated 37 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.

SUIDI deaths are classified 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 35 of the 37 Undetermined deaths investigated. Drugs were present in 20 of the Undetermined cases investigated. The most commonly detected drugs were: Ethanol (N=3), Cocaine (3), Methadone (3), Oxycodone (2) and Quetiapine (2).

STILLBIRTHS: The OCME investigated 4 Stillbirth deaths in CY 2008.

Toxicology Findings: Toxicology testing was requested for all 4 Stillbirth cases investigated. Overall, drugs were present in 3 of the cases investigated; and cocaine was detected in 2 cases and PCP in 1case positive for drugs.

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 NAME accreditation, personnel management, contracting and procurement, and Information Technology.
2. *Internal Partnerships* – This segment provides an overview of OCME's continued partnerships with 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.

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OFFICE OF THE CHIEF MEDICAL EXAMINER

2008 Annual Report

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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 2008. This information is a reflection of the status of health of the District of Columbia residents, the level and types 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 Office of the Mayor, Office of the City Administrator, Department of Health (DOH), the D.C. Office of the Attorney General, 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 or maternal drug use; 11) deaths for which the Metropolitan Police Department (MPD), or other law enforcement agency, or the United States Attorney's Office requests, or a court orders investigation; and 12) dead bodies brought within the District without proper medical certification. (See Appendix A – (D.C. Law 13-172), DC Official Code §5-1401 et seq. (2001)).

All deaths under the jurisdiction of the OCME, as outlined above, are investigated irrespective of the location of the primary causative incident. The Chief Medical Examiner based on the evaluation of the circumstances surrounding the death determines the type of investigation to be performed, i.e. autopsy or external examination. This decision is not restricted by family preference or religious beliefs. The OCME Medico Legal Investigators, Forensic Investigators and the Detectives of MPD's Natural Squad in the Homicide and Traffic Divisions provide information related to the circumstances of the deaths. The autopsy helps answer questions as to time of death, pattern and/or sequence of injuries and the effect of natural diseases versus injuries; and 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 cardio pathology) are requested when appropriate.

The agency now has three programs: Death Investigation and Certification, Agency Management, and Fatality Review. This report will include data on the Death Investigation and Certification, and the Agency Management programs. Due to significant staffing modifications a summary review of the Fatality Review Program is not included in this year report.

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 associated with services provided and make relevant recommendations that address systemic issues related to services that the District of Columbia provides to the constituents of these vulnerable populations. Each review committee produces an annual report that summarizes relevant findings and recommendations issued as well as government agency responses to the recommendations.

In addition to its routine caseload, the office provides temporary storage of bodies for all hospices and local hospitals. The OCME morgue has a total capacity of 115, which can be easily exceeded. 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 has not only trained its technical staff to fingerprint decedents, but also works cooperatively with the Mobile Crime unit of MPD and the Federal Bureau of Investigation (FBI). OCME also uses comparative radiology and/or DNA analysis as necessary to ensure identification. The OCME also keeps specimens for DNA analysis on all decedents processed.

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 is developing alliances with area hospitals and with agencies in the Public Safety and Justice cluster with a goal to integrate our Mass Fatality plan with the Mayor's Disaster 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. 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.

During 2008**,** 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.

In the area of education, OCME provides academic training of 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 assistance, forensic sciences toxicology and mortuary science programs. The OCME also provided training for members of MPD and various law enforcement entities including the United States Attorney's office, and the soldiers of the Marine Corps.

2.0 – Medical Examiner Investigations and Medical Legal Autopsies

Overview of Cases Reported and Investigated

During the Calendar Year (CY) 2008, **3,133** cases were reported to and investigated by the Office of the Chief Medical Examiner (OCME). **1,667** of these cases were Declined by OCME; however, **18** of these Declined cases became Storage cases. **1,405** of the reported cases were Accepted for further examination, but **61** of the reported cases were Storage requests only. Of the Accepted cases **945** were autopsied. OCME also had a total of **1,884** Cremation requests submitted for approval.

Total Number of Cases Reported and Investigated by the OCME	**3,133**
Total Number of Declined Cases	**1,667**
Percent of Cases Reported & Investigated	*53%*
Total Number of Cases Accepted for Further Investigation	**1,405**
Percent of Cases Reported & Investigated	*45%*
Total Number of Autopsies *Full – 848* *Partial - 97*	**945**
Percent of Cases Accepted	*67%*
Number of Scene Visits by a Medical Examiner or Medico Legal/Forensic Investigator	**579**
Percent of Cases Reported & Investigated	*18%*
Total Number of Bodies Transported by OCME or by Order of the OCME: *Transported by Pick-up Service - 62* *Transported by Funeral Home - 41* *Transported by Other(EMS/FBI) - 2* *Transported by Office Personnel – 1,361*	**1466**
Percent of Cases Reported & Investigated	*47%*
Total Number of Organ/Tissue Donation Requests: *Number of requests OCME approved – 123* Number of requests OCME declined - *14* *Number of procured approved donations – 18*	**137**
Total Cases Autopsied at a Hospital, but retained under ME jurisdiction *One case OCME performed an External Exam* *One case OCME Reviewed the Medical Records*	**2**

Breakdown of Accepted Cases

Total Number of Cases Accepted and Investigated Further	**1,405**
Total Number of Autopsies	**945**
Percent of Cases Accepted	*67%*
Number of External Examinations	**443**
Percent of Cases Accepted	*32%*
Number of Non-Human Remains *	**7**
Percent of Cases Accepted	*0.005%*
Number of Medical Record Review *	**9**
Percent of Cases Accepted	*0.006%*
Number of Anatomical Specimen Disposals*	**1**
Percent of Cases Accepted	*0.00%*

*** 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.

- *Anatomical Specimen Disposals*: Cases where surgical specimens are received in formalin from area hospitals that were removed prior to a death associated with a current decedent at the OCME, or placental tissue that was with a newborn or fetus that was accepted as an OCME case.

Breakdown of Case Investigations and Autopsies by Month

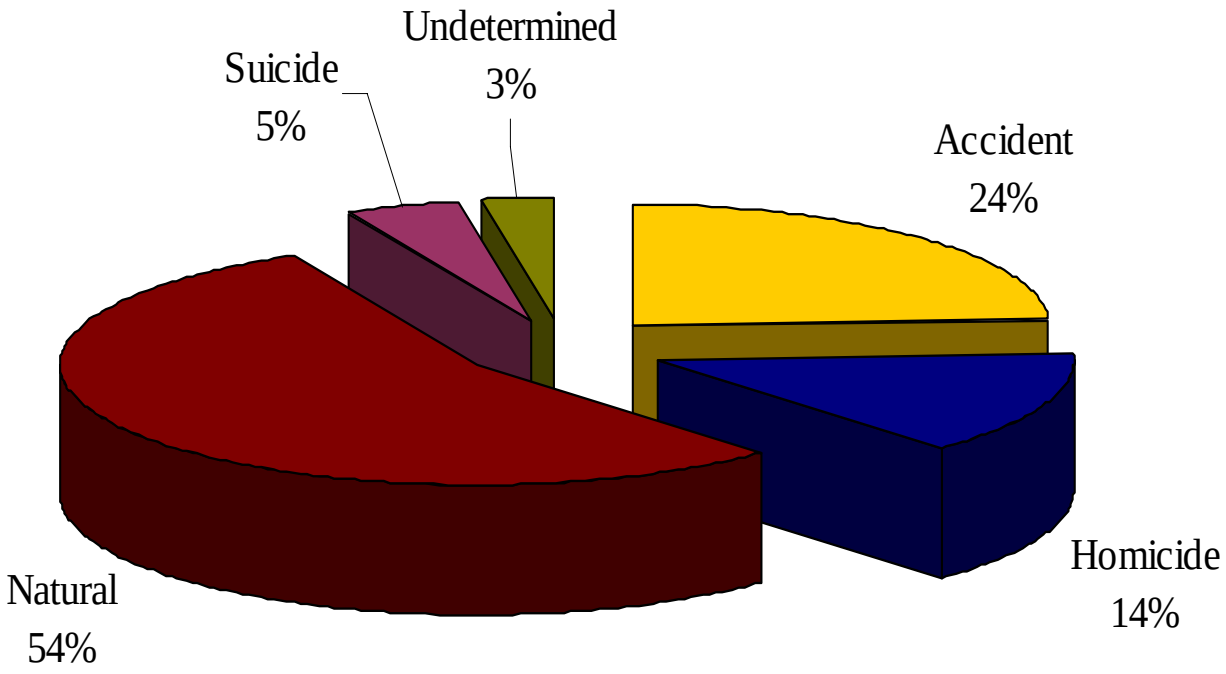
Month	Case Investigations	Autopsies Full and Partials
January	278	69
February	222	56
March	276	89
April	272	75
May	279	92
June	263	92
July	242	87
August	227	79
September	244	78
October	264	77
November	258	73
December	308	78
Total	**3,133**	**945**

Medical Examiner Case Investigations by Manner of Death

Manner	Full Autopsy Examinations	Partial Autopsy Examinations	External Examinations	Review of Medical Records	Total
Accident	215	6	115	2	338
Homicide	191	0	0	0	191
Natural	341	90	326	7	764
Stillbirth	4	0	0	0	4
Suicide	62	0	1	0	63
Undetermined	35	1	1	0	37
Total	**848**	**97**	**443**	**9**	**1397**

Note: The above table does not include "*Anatomical Specimen Disposals* (n=1)", "*Non-Human Remains* (n=7)."

Pie Chart - Medical Examiner Cases by Manner of Death



Note: For the purpose of this illustration "Stillbirths" have been omitted because they are less than 1% of the total number of deaths.

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=	**881**	
Negative	381	43.3 %
Positive	500	56.7 %

Overall, drugs were absent in 381 postmortem cases; 317 cases had one drug present; 122 cases had 2 drugs present; and 34 had 3 drugs detected, and 27 cases had greater than 4 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	201	23.0 %
Cocaine	125	14.3 %
Morphine[1]	77	8.8 %
PCP	28	3.2 %
Methadone	22	2.5 %
Oxycodone	18	2.0 %
Diazepam	13	1.4 %
Carbon monoxide	11	1.2 %
Phenobarbital	11	1.2 %
Amitriptyline/Nortriptyline	10	1.1 %
Zolpidem	9	1.0 %
Hydromorphone	8	0.9 %
Mirtazapine	7	0.8 %
Quetiapine	6	0.7 %
Trazadone	6	0.7 %
Meth/Amphetamine	6	0.7 %
Sertraline	6	0.7 %
MDMA or MDA[2]	5	0.5 %
Fentanyl	4	0.4 %

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

Drug Combinations	Number of Cases
Ethanol and Cocaine	27
Morphine and Cocaine	20
Morphine and PCP	19
Ethanol and PCP	7
PCP and Cocaine	6
Ethanol and Morphine	3

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

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

2.1 - HOMICIDES

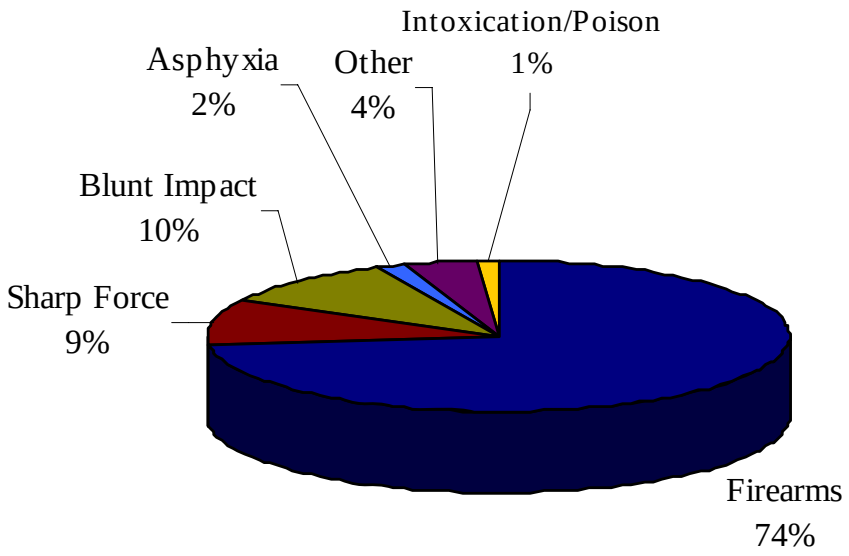
The OCME investigated 191 homicides in the CY 2008. The following tables and graphs provide a distribution by cause, month, race, gender and age group. Death by homicidal acts is more prevalent in black males, and the age group 20 to 29. The weapon of choice continues to be fire-arms. The peak of incidents occurred in July.

Homicides by Cause of Death

Cause	Number of Homicides	% of Total Homicides
Firearms	140	73.30%
Sharp Force	18	9.42%
Blunt Impact	20	10.47%
Asphyxia	3	1.57%
Other	8	4.19%
Intoxication/Poison	2	1.05%
Total	**191**	**100.00%**

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

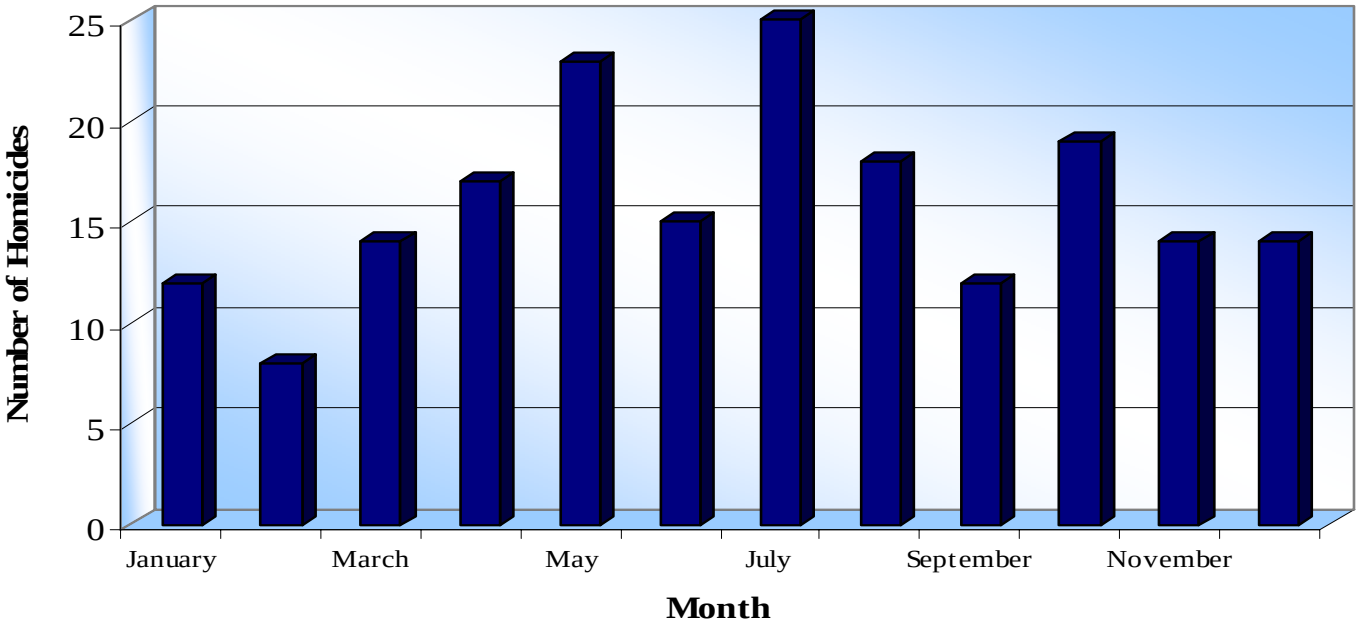
Pie Chart – Homicides by Cause of Death



Homicides by Month

Month	Number of Homicides	% of Homicides
January	12	6%
February	8	4%
March	14	7%
April	17	9%
May	23	12%
June	15	8%
July	25	13%
August	18	9%
September	12	6%
October	19	10%
November	14	7%
December	14	7%
Total	**191**	**100%**

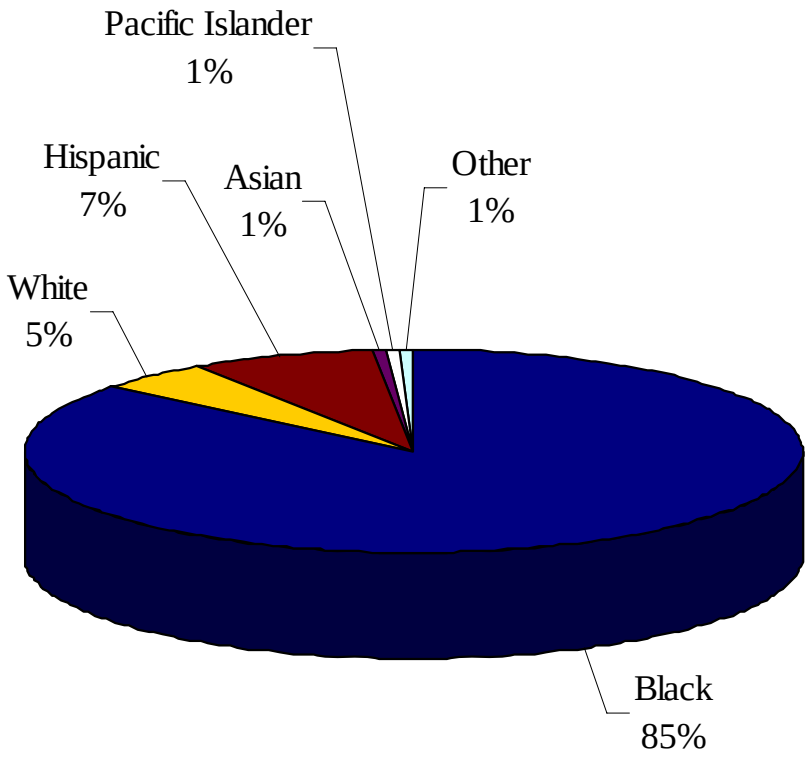
Graph - Homicides by Month



Homicides by Race

Race/Ethnicity	Number of Homicides	% of Homicides
Black	164	86%
White	9	5%
Hispanic	15	8%
Asian	1	1%
Pacific Islander	1	1%
Unknown	1	1%
Total	**191**	**100%**

Chart – Percentage of Homicides by Race



Homicides by Gender

Gender	Number of Homicides	% of Homicides
Female	25	13%
Male	166	87%
Total	**191**	

Homicides by Race/Ethnicity and Gender

Race/Ethnicity by Gender	Number of Homicides
Asian	**1**
Female	0
Male	1
Black	**164**
Female	18
Male	146
Hispanic	**15**
Female	2
Male	13
Pacific Islander	**1**
Female	0
Male	1
White	**9**
Female	4
Male	5
Unknown	**1**
Female	1
Male	0
Total	**191**

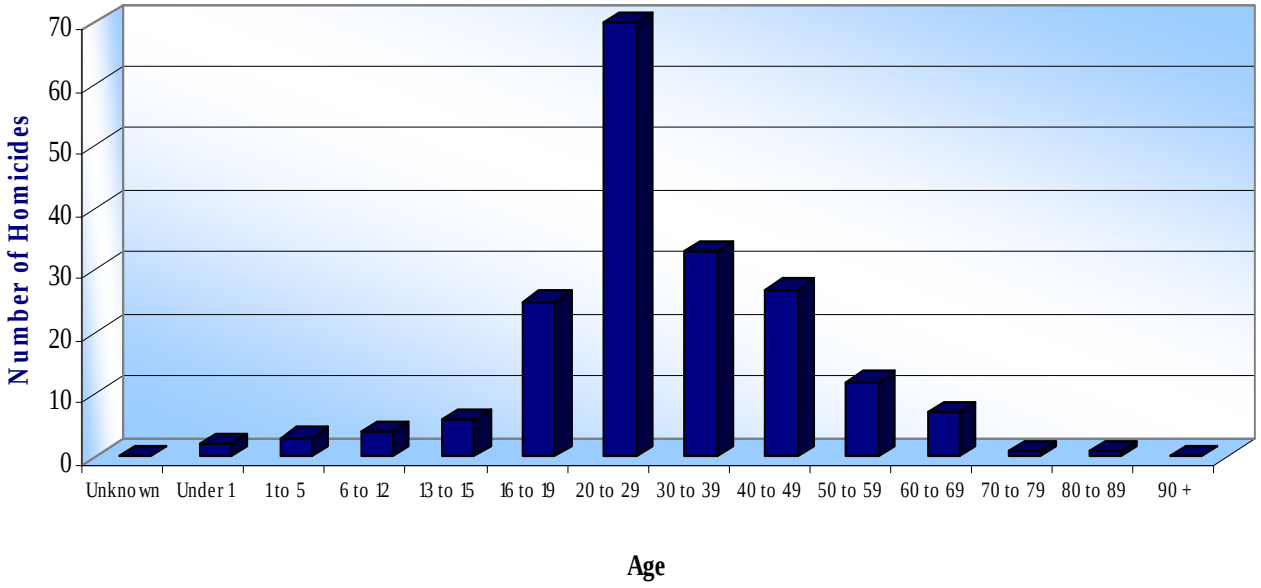
Homicides by Jurisdiction of Incident

Jurisdiction of Incident	Number of Homicides
DC	188
MD	3
Total	**191**

Homicides by Age

Age	Number of Homicides	% of Homicides
Under 1	2	1%
1 to 5	3	2%
6 to 12	4	2%
13 to 15	6	3%
16 to 19	25	13%
20 to 29	70	37%
30 to 39	33	17%
40 to 49	27	14%
50 to 59	12	6%
60 to 69	7	4%
70 to 79	1	1%
80 to 89	1	1%
90 +	0	0%
Total	**191**	**100%**

Chart - Homicides by Age Group



Toxicology Findings for Homicide Cases

Of the 191 Homicide deaths investigated by OCME, toxicology analysis was performed on all 191 cases. Overall, drugs were absent in 98 homicide cases; 66 cases had one drug present; 24 cases had 2 drugs present; and 3 cases had 3 drugs detected.

Description	Number of Cases	% of Cases
N=	**191**	
Negative	98	51.3 %
Positive	93	48.6 %

The most commonly detected drugs in the homicide cases were:

Name of Drug	Number of Cases	% of Homicide Cases
Ethanol	56	29.3 %
PCP	17	8.9 %
Cocaine	16	8.3 %
Morphine	9	4.7 %
MDMA/MDA	5	2.6 %

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

The 3 homicide cases with the most drugs detected had the following toxicology:

a) MDA, MDMA, and methamphetamine
b) Morphine, PCP, and ethanol
c) Oxycodone, hydromorphone, and ethanol

2.2 - SUICIDES

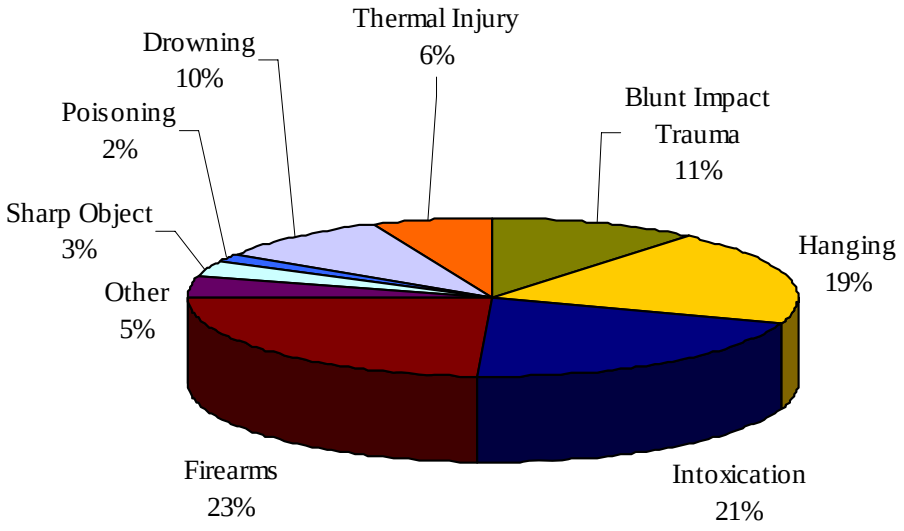
The OCME investigated 63 suicides in CY 2008, which is a 36% increase when compared to the number of suicides in calendar year 2007 (n = 47). Deaths by suicidal acts were more prevalent in black males and in persons between the ages of 30 to 39. An alarming fact regarding this age group (30-39) is that suicides more than doubled from 8 in 2007 to 18 in 2008. Also of note, suicides more than quadrupled in the age group 70-79 years from 2 in 2007 to 9 in 2008, and suicides for white females almost tripled during the same timeframe, 2007 (n=4) to 2008 (n=11). The majority of incidents occurred in April, May and November.

Suicides by Cause of Death

Cause	Number of Suicides	% of Total Suicides
Firearms	15	23.81%
Intoxication	13	19.05%
Hanging	12	19.05%
Blunt Impact Trauma	7	11.11%
Drowning	6	9.52%
Thermal Injury	4	6.35%
Other	3	4.76%
Sharp Object	2	3.17%
Poisoning	1	1.5%
Total	**63**	**100.00%**

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

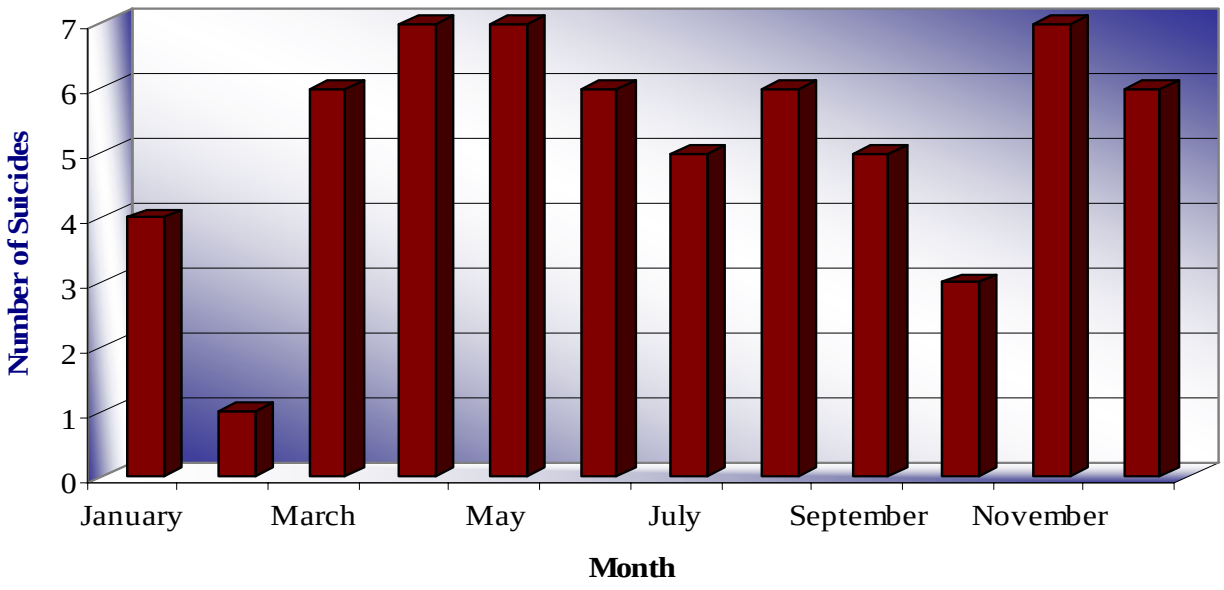
Pie Chart - Suicides by Cause of Death



Suicides by Month

Month	Number of Suicides	% of Suicides
January	4	6%
February	1	2%
March	6	10%
April	7	11%
May	7	11%
June	6	10%
July	5	8%
August	6	10%
September	5	8%
October	3	5%
November	7	11%
December	6	10%
Total	**63**	**100%**

Chart- Suicides by Month



Suicide by Race/Ethnicity

Race/Ethnicity	Number of Suicides	% of Suicides
White	30	48%
Black	25	40%
Hispanic	2	3%
Asian	3	5%
Other	2	3%
Pacific Islander	1	2%
Total	**63**	**100%**

Suicides by Race/Ethnicity and Gender

Race/Ethnicity by Gender	Number of Suicides
Asian	**3**
Female	2
Male	1
Black	**25**
Female	4
Male	21
Hispanic	**2**
Female	1
Male	1
Other	**2**
Female	1
Male	1
Pacific Islander	**1**
Female	0
Male	1
White	**30**
Female	11
Male	19
Total	**63**

Suicides by Gender

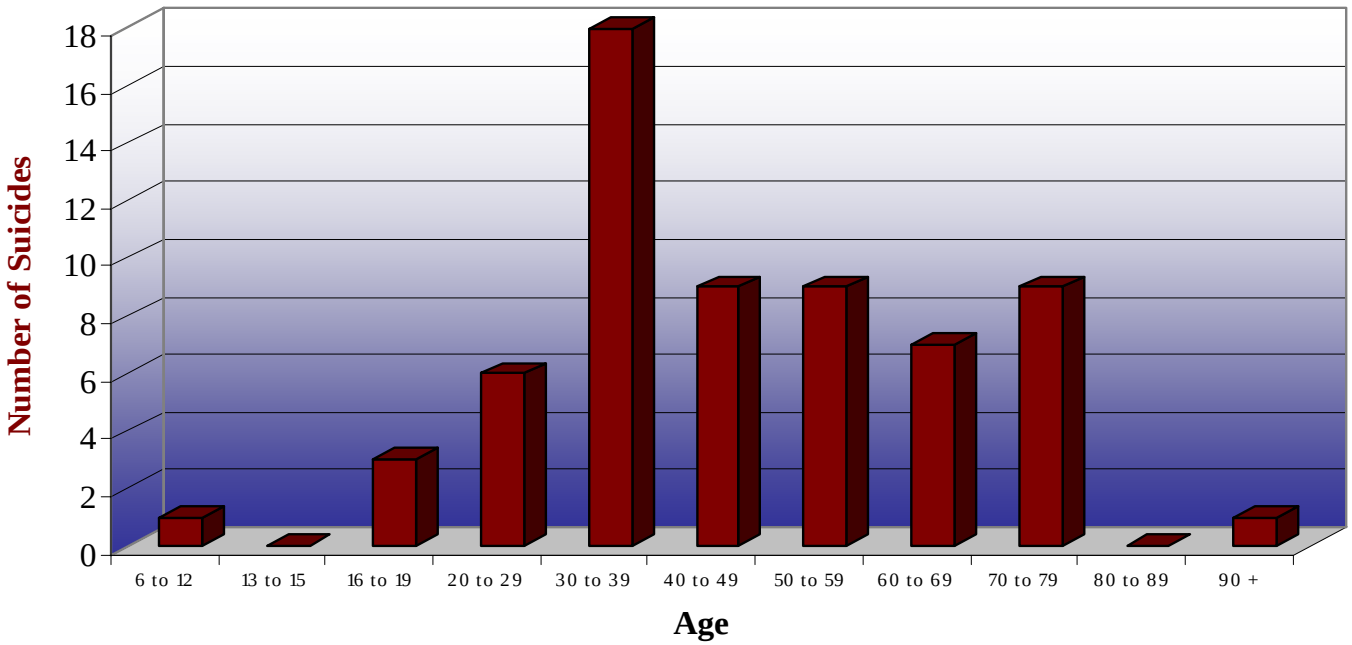
Gender	Number of Suicides	% of Suicides
Female	19	30%
Male	44	70%
Total	**63**	**100%**

Suicide by Age

Age	Number of Suicides	% of Suicides
6 to 12	1	2%
13 to 15	0	0%
16 to 19	3	5%
20 to 29	6	10%
30 to 39	18	29%
40 to 49	9	15%
50 to 59	9	15%
60 to 69	7	11%
70 to 79	9	15%
80 to 89	0	0%
90 +	1	2%
Total	**63**	**100%**

Note: There were zero (0) suicides for persons age 1 to 5 and 13 to 15.

Chart - Suicides by Age



Toxicology Findings for Suicide Cases

Of the 63 suicide deaths investigated by OCME, toxicology analysis was performed on 62 cases. Overall, drugs were absent in 24 suicide cases; 17 cases had one drug present; 13 cases had 2 drugs detected, and 8 cases had 3 drugs or more detected.

Description	Number of Cases	% of Cases
N=	**62**	
Negative	24	38.7 %
Positive	38	61.2 %

The most commonly detected drugs in suicide cases were:

Name of Drug	Number of Cases	% of Suicide Cases
Ethanol	18	29.0 %
Diphenhydramine	5	8.0 %
Citalopram	5	8.0 %
Mirtazapine	4	6.4 %
Zolpidem	4	6.4 %

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

a. Oxycodone, nordiazepam, diazepam, fluoxetine, norfluoxetine, morphine, hydromorphone, and bupropion
b. 7-aminoclonazepam, bupropion, mirtazapine, doxepin, nordoxepin, and zolpidem
c. Cocaine and metabolites, nortriptyline, and amitriptyline
d. Ethanol, zolpidem, diphenhydramine, and citalopram
e. Ethanol, zolpidem, dextromethorphan, and mirtazapine

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

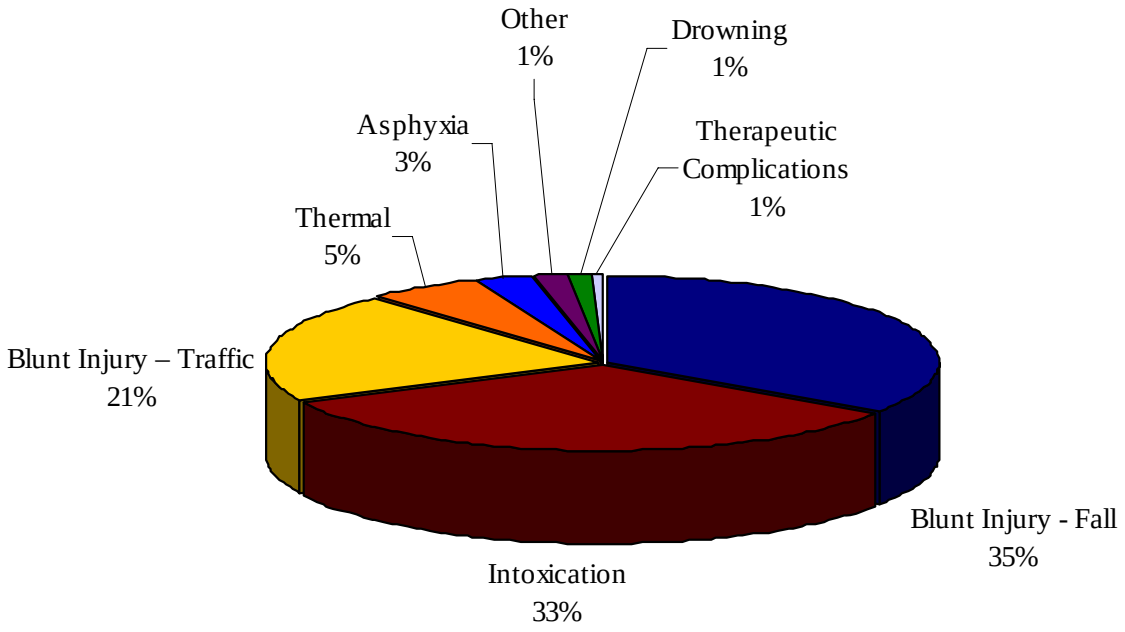
2.3 - ACCIDENTS

OCME investigated 338 accident cases in 2008. Of the 338 cases investigated, 187 were the result of trauma and of those 69 were traffic accidents. 110 of the Accidental deaths were the direct result of illicit drug use. The peak of incidents occurred in July.

Accidents by Cause of Death

Cause	Number of Deaths	% of Total Accidents
Blunt Injury - Fall	118	34.62%
Blunt Injury – Traffic	69	20.41%
Intoxication	110	32.84%
Thermal	18	5.33%
Asphyxia	10	2.96%
Other	5	1.48%
Drowning	4	1.18%
Therapeutic Complications	2	0.59%
Firearms	1	0.30%
Hypothermia	1	0.30%
Total	**338**	**100.00%**

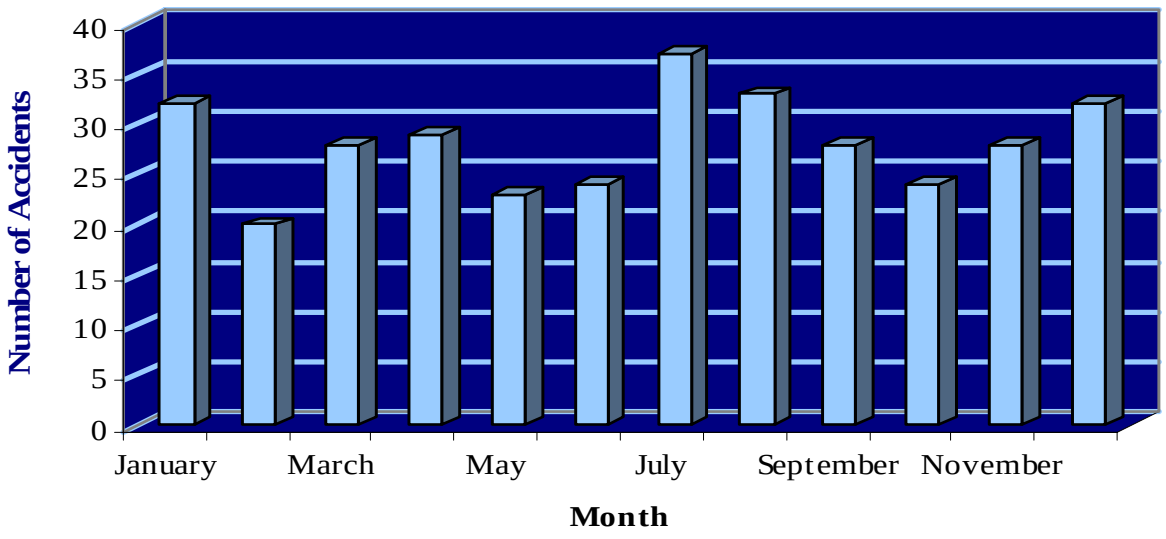
Pie Chart - Accidents by Cause of Death



Accidents by Month

Month	Number of Deaths	% of Accidents
January	32	9%
February	20	6%
March	28	8%
April	29	9%
May	23	7%
June	24	7%
July	37	11%
August	33	10%
September	28	8%
October	24	7%
November	28	8%
December	32	9%
Total	**338**	**100%**

Chart - Accidents by Month of Death



Accidental Deaths by Race

Race/Ethnicity	Number of Accidents	% of Accidents
Asian	3	1%
Black	194	57%
Hispanic	28	8%
White	113	33%
Total	**338**	**100%**

Accidental Deaths by Gender

Gender	Number of Accidents	% of Accidents
Female	109	32%
Male	229	68%
Total	**338**	**100%**

Accidental Deaths by Age

Age	Number of Accidents	% of Accidents
Under 1	6	2%
1 to 5	8	2%
6 to 12	4	1%
13 to 15	1	0%
16 to 19	3	1%
20 to 29	24	7%
30 to 39	22	7%
40 to 49	55	16%
50 to 59	79	23%
60 to 69	38	11%
70 to 79	26	8%
80 to 89	45	13%
90 +	27	8%
Total	**338**	**100%**

Toxicology Findings for Accident Cases

Of the 338 Accident Deaths investigated by OCME, toxicology analysis was performed in 216 cases. Overall, drugs were absent in 56 accident cases; 79 cases had one drug present; 51 cases had 2 drugs present, 17 cases had 3 drugs present, 6 cases had 4 drugs present, and 7 cases had 5 or more drugs detected.

Description	Number of Cases	% of Cases
N=	**216**	
Negative	56	25.9 %
Positive	160	74.1 %

The most commonly detected drugs in the accident cases were:

Name of Drug	Number of Cases	% of Accident Cases
Cocaine	69	31.9 %
Ethanol	53	24.5 %
Opiates	43	19.9 %
Methadone	12	5.5 %
Carbon monoxide	10	4.6 %
Oxycodone	7	3.2 %
PCP	6	2.7 %
Diazepam	6	2.7 %

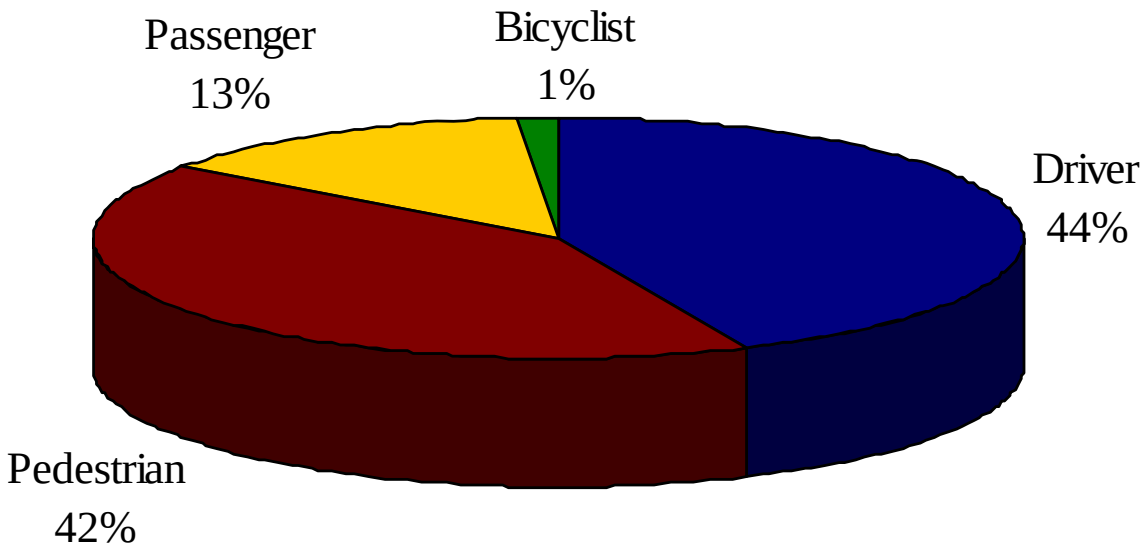
2.3.1 – Traffic Deaths

The majority of traffic fatalities occurred in the following categories: Driver and Pedestrian between the ages of 50 to 59. Peaks occurred in June and August.

Role of the Decedent in Traffic Death

Role	Traffic Deaths	% of Traffic Deaths
Driver - *Bicyclist (3)* - *Motorcycle (7)*	29	42%
Pedestrian	28	41%
Passenger - *Motorcycle (1)*	9	13%
Other - *Bicyclist (1)*	3	1%
Total	**69**	**100%**

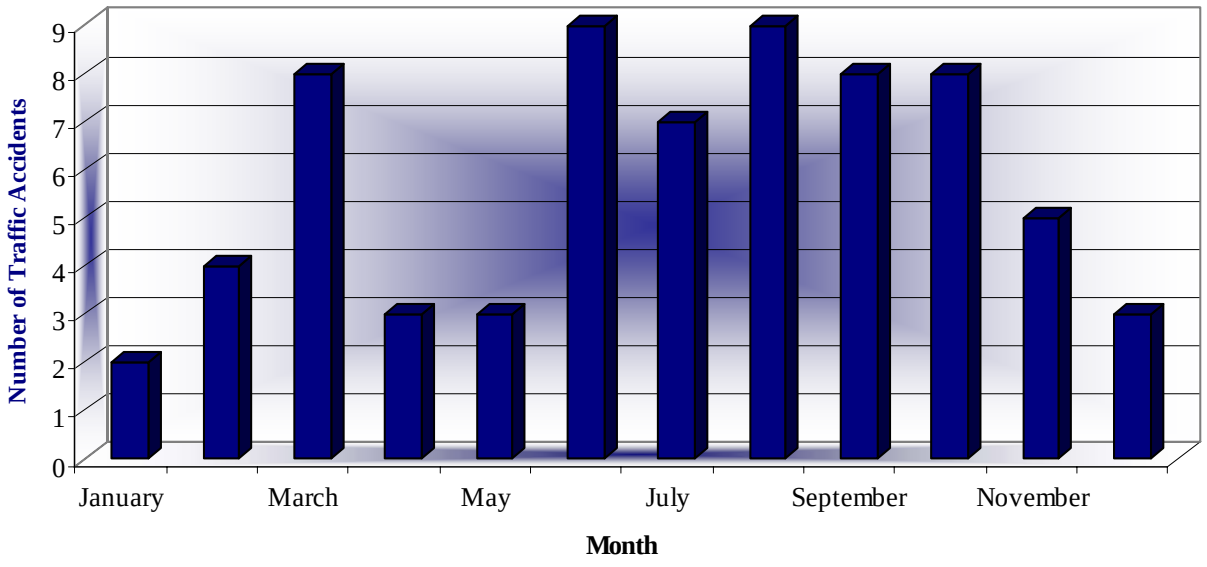
Pie Chart - Role of Decedent in Traffic Accident



Traffic Deaths by Month

Month	Number of Traffic Accidents	% of Traffic Accidents
January	2	3%
February	4	6%
March	8	12%
April	3	4%
May	3	4%
June	9	13%
July	7	10%
August	9	13%
September	8	12%
October	8	12%
November	5	7%
December	3	4%
Total	**69**	**100%**

Chart - Traffic Deaths by Month



Traffic Deaths by Race

Race	Number of Traffic Deaths	% of Traffic Deaths
Asian	1	0%
Black	32	9%
Hispanic	12	4%
White	24	7%
Total	**69**	**100%**

Traffic Deaths by Gender

Gender	Number of Traffic Deaths	% of Traffic Deaths
Female	18	26%
Male	51	74%
Total	**69**	**100%**

Traffic Deaths by Age

Age	Number of Traffic Deaths	% of Traffic Deaths
Under 1	2	1%
1 to 5	2	1%
6 to 12	1	0%
13 to 15	1	0%
16 to 19	3	1%
20 to 29	12	4%
30 to 39	8	2%
40 to 49	8	2%
50 to 59	13	4%
60 to 69	6	2%
70 to 79	4	1%
80 to 89	7	2%
90 +	2	1%
Total	**69**	**100%**

Traffic Deaths by Jurisdiction of Incident

Jurisdiction of Incident	Number of Traffic Deaths	% of Traffic Deaths
DC	37	54%
MD	24	35%
VA	6	9%
Unknown	2	3%
Total	**69**	**100%**

Toxicology Findings for Traffic Accident Cases

Of the 69 Traffic-related deaths investigated by OCME, toxicology analysis was performed in 55 cases. Overall, drugs were absent in 27 traffic death cases; 20 cases had one drug present; and 7 cases had 2 drugs present.

Description	Number of Cases	% of Cases
N=	**55**	
Negative	27	49.0 %
Positive	28	50.9 %

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

Name of Drug	Number of Cases	% of Traffic Cases
Ethanol	15	27.2 %
Cocaine	4	7.2 %
Oxycodone	2	3.6 %
Fentanyl	2	3.6 %

In the 15 traffic deaths positive for ethanol, the average Blood Alcohol Concentration was 0.17% (range 0.06 – 0.40 %). The legal limit for Blood Alcohol Concentration in the District of Columbia is 0.08% while driving.

2.3.2 – Toxicology Findings for Deaths due to Drug Overdose

There were 110 OCME cases where death was directly related to drug use, and toxicology analysis was performed in 105 of these cases. Toxicology testing was not requested on five (5) of the Overdose cases, all of which were "External Examinations" with a medical history sufficient to confirm the cause of death as a Drug Overdose. The most prevalent drug in the population was cocaine alone or in combination with other drugs (most commonly morphine). Overall, 3 cases were negative (due to a delayed death[3]), 39 cases had one drug present; 36 cases had 2 drugs present; 15 cases had 3 drugs present; 5 cases had 4 drugs present; and 7 cases had more than 5 drugs present

Description	Number of Cases	% of Cases
N=	**105**	
Negative	3	2.8 %
Positive	102	97.1 %

The most commonly detected drugs in drug overdose cases were:

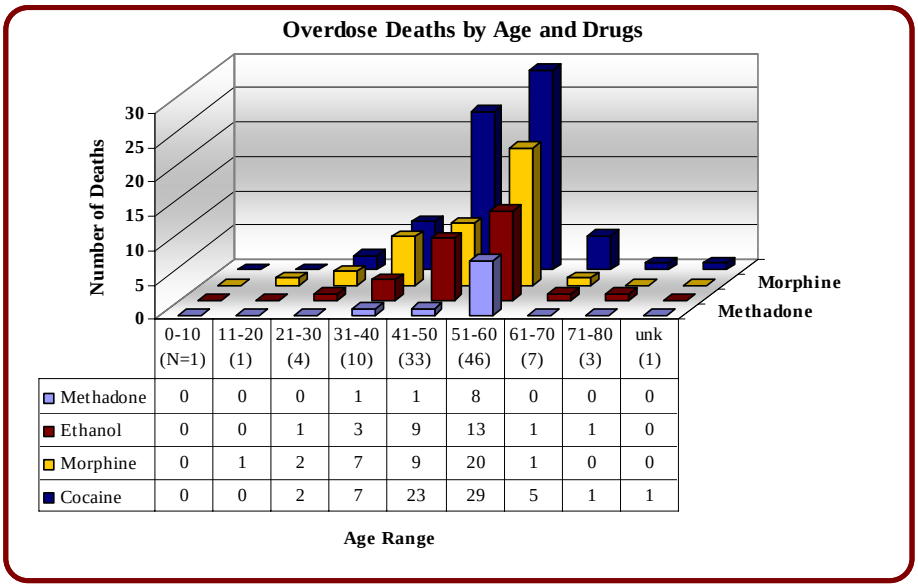
Contributing Drugs	Number of Cases	% of Cases
Cocaine	63	62.3 %
Morphine	39	38.6 %
Ethanol	29	28.7 %
Methadone	10	9.9 %
Diazepam / Nordiazepam	6	5.9 %
PCP	6	5.9 %

[3] A delayed death caused by a "Drug Overdose" occurs when the decedent is admitted to the hospital and by the time death occurred the drugs have dissipated from their system, however, the hospital did conduct toxicology testing upon admission with positive results.

Accidental Drug Overdose Fatalities by Age

The majority of overdose deaths occurred in decedents between the ages of 51 and 60 years. Cocaine was the most frequently detected drug in all of these age groups except 31-40 years, which had a higher instance of morphine. In all other age groups cocaine was followed by morphine, ethanol and then methadone.

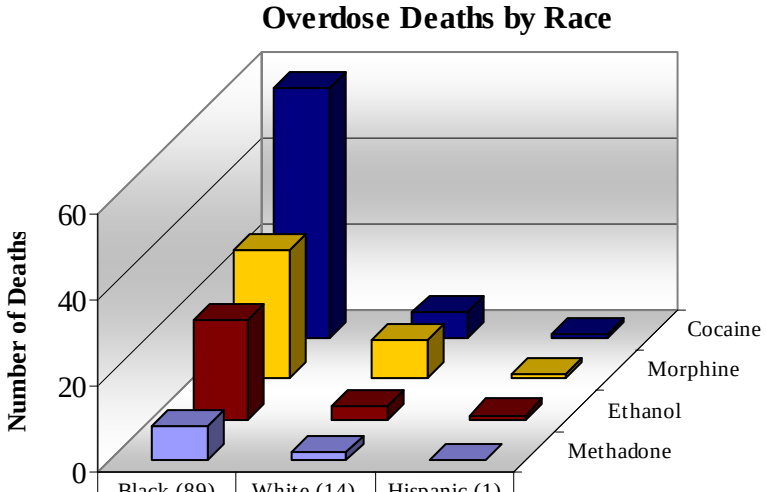
Note: "N" represents the total number of deaths found within the stated age group.



	0-10 (N=1)	11-20 (1)	21-30 (4)	31-40 (10)	41-50 (33)	51-60 (46)	61-70 (7)	71-80 (3)	unk (1)
Methadone	0	0	0	1	1	8	0	0	0
Ethanol	0	0	1	3	9	13	1	1	0
Morphine	0	1	2	7	9	20	1	0	0
Cocaine	0	0	2	7	23	29	5	1	1

Accidental Drug Overdose Fatalities by Race

The vast majority of overdose deaths occurred in black decedents, and again the most frequently detected drugs in both black and white decedents were cocaine, morphine, ethanol and methadone.



	Black (89)	White (14)	Hispanic (1)
Methadone	8	2	0
Ethanol	23	3	1
Morphine	30	9	1
Cocaine	58	6	1

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:

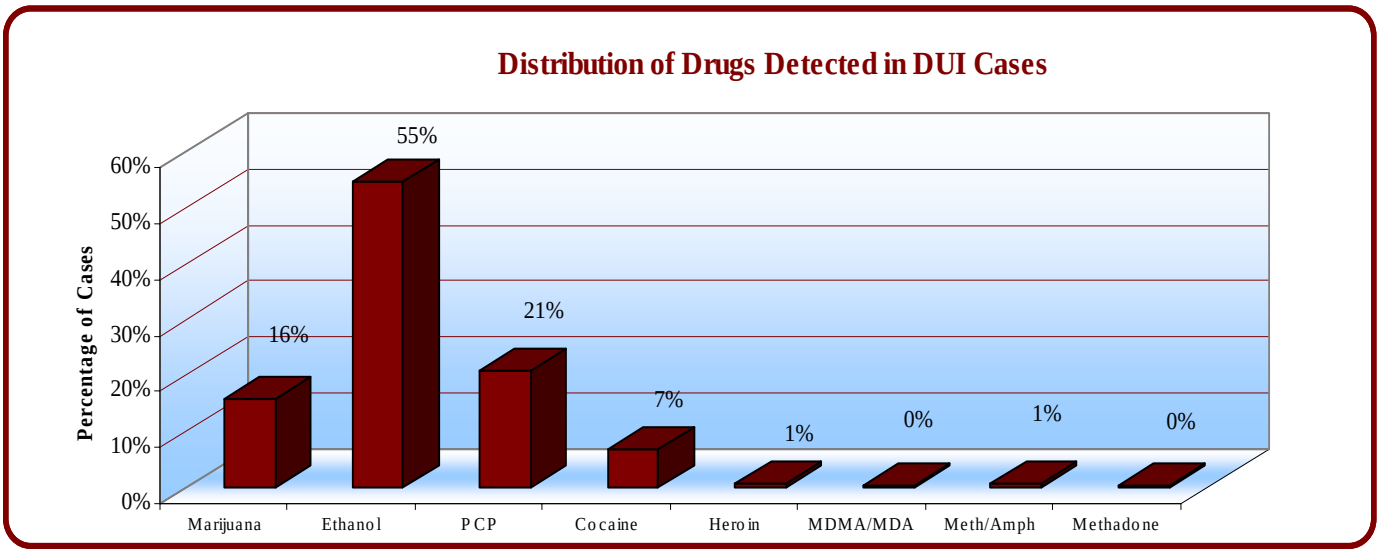
Description	Number of Cases	% of Cases
N=	**377**	
Negative	25	3.5 %
Positive	352	96.5 %

Type of Specimen Submitted:

Description	Number of Cases	% of Cases
Blood	261	72.2 %
Urine	116	27.8 %

The most commonly detected drugs in the DUI cases were:

Name of Drug	Number of Cases	% of DUI Cases
Ethanol	250	66.3 %
PCP	96	25.4 %
Marijuana	72	19.0 %
Cocaine	31	8.2 %



Overall, drugs were absent in 25 DUI cases; 257 cases had one drug present; 69 cases had 2 drugs present; 21 cases had 3 drugs detected; 4 cases had 4 drugs detected; and 1 case had 5 drugs detected

In the 250 DUI cases positive for alcohol, the average alcohol concentrations were as follows:

Description	N=	Average	Range
Average Blood Alcohol Result	141	0.15	0.01-0.36
Average Urine Alcohol Result	109	0.11	0.01-0.39

Common drug combinations for DUI cases include:

Name of Drugs	Number of Cases
Ethanol + Marijuana	35
Ethanol + Cocaine	18
Ethanol + PCP	25
Marijuna + PCP	30

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

a. Marijuana, Ethanol, PCP (11 cases)
b. Marijuana, Ethanol, Cocaine (3 cases)
c. Marijuana, PCP, Cocaine (3 cases)
d. Ethanol, PCP, Cocaine (3 cases)
e. Marijuana, Ethanol, MDMA (2 cases)
f. Methadone, alcohol, and 7-aminoclonazepam (1 case)
g. Methamphetamine, amphetamine, methadone, acetone, marijuana (1 case)
h. Marijuana, PCP, amphetamine, methamphetamine

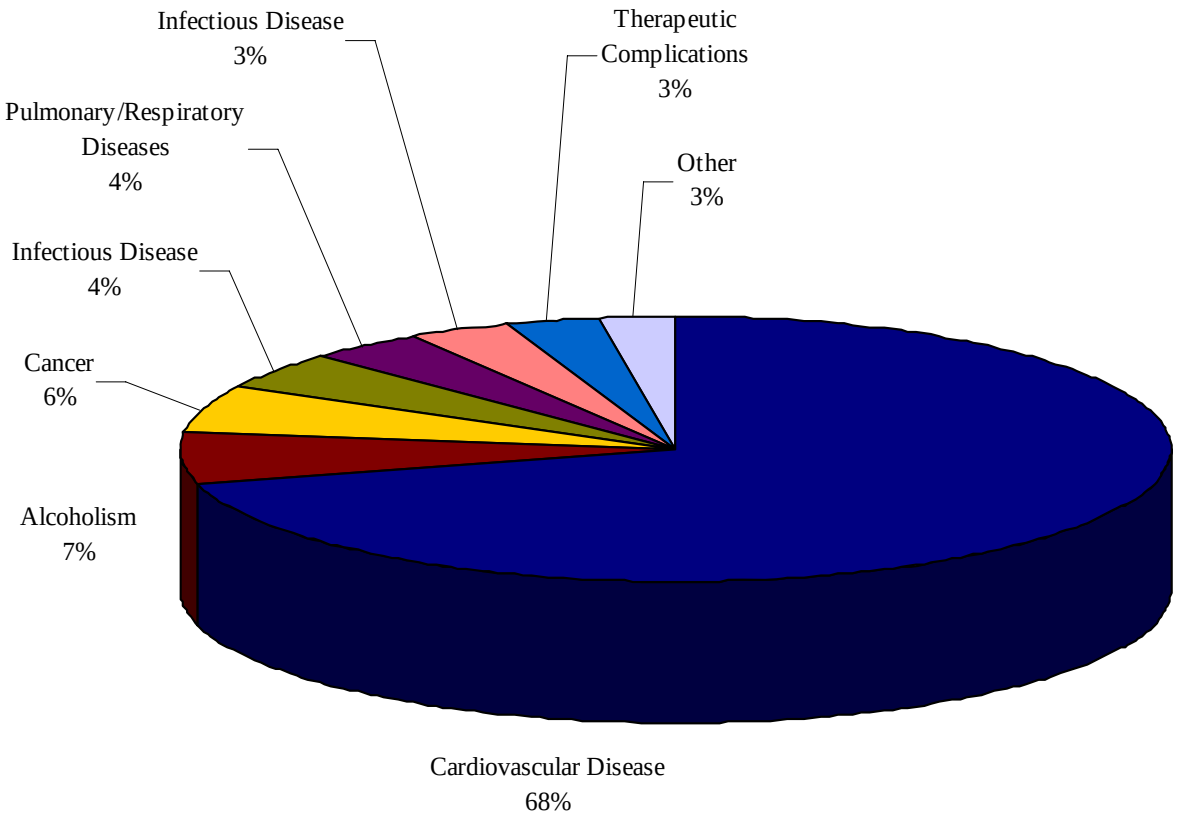
2.4 - NATURAL DEATHS

The majority of Natural deaths investigated by OCME have been caused by "Cardiovascular Disease". Peaks occurred in June and December. Blacks represented 76% of the affected population, followed by whites, which represented 20% of the affected population.

Natural Deaths By Cause

Cause	Number of Deaths	% Of Total Natural Deaths
Cardiovascular Disease	508	58.32%
Alcoholism	42	4.82%
Cancer	42	4.82%
Central Nervous System Diseases	32	3.67%
Pulmonary/Respiratory Diseases	28	3.21%
Infectious Disease	24	2.76%
Therapeutic Complications	22	2.53%
Other	18	2.07%
Gastrointestinal Disease	11	1.26%
Diabetes	9	1.03%
Immune System Disease	8	0.92%
Complications of Drug Abuse	7	0.80%
Blood Disease/Hemopoietic System	5	0.57%
Genetic Disorder	2	0.46%
Obesity	2	0.23%
Total	**764**	**100.00%**

Pie Chart – Natural Deaths by Cause

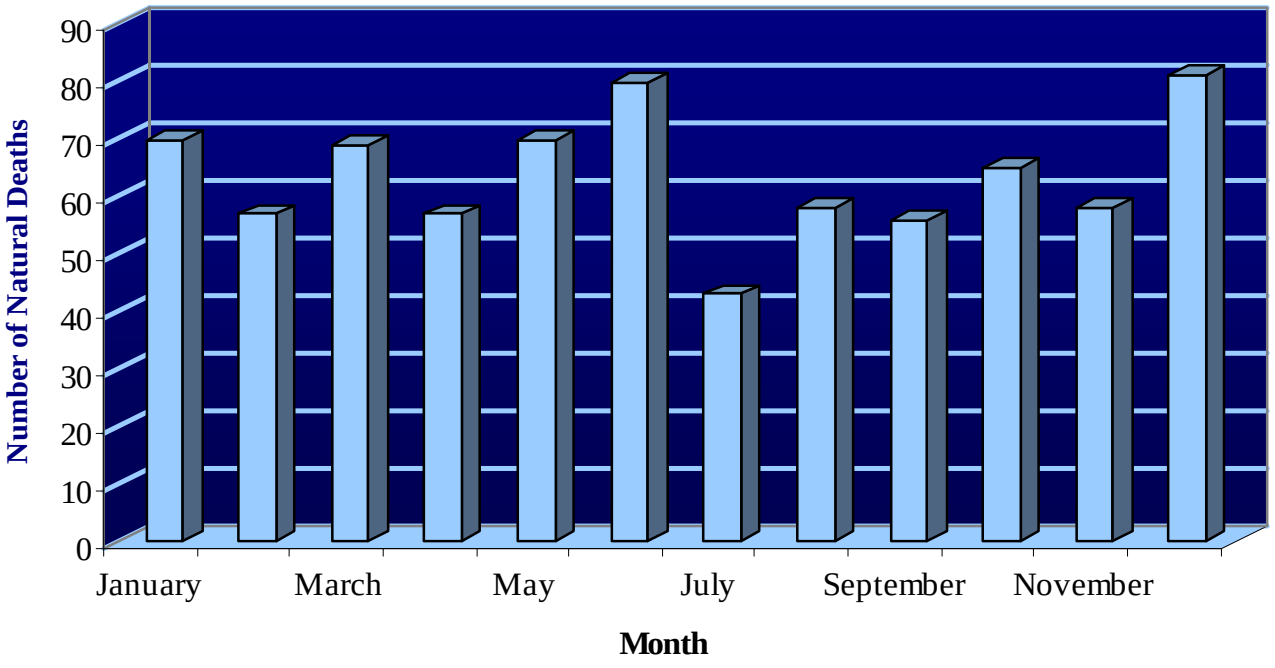


Note: Causes of Death that are less than 1% is not included in this chart.

Natural Deaths by Month

Month	Number of Deaths
January	70
February	57
March	69
April	57
May	70
June	80
July	43
August	58
September	56
October	65
November	58
December	81
Total	**764**

Chart- Natural Deaths by Month



Natural Deaths by Race

Race	Number of Natural Deaths	% of Natural Deaths
Asian	10	1%
Black	583	76%
Hispanic	17	2%
Other	4	1%
Unknown	1	0%
White	149	20%
Total	**764**	**100%**

Natural Deaths by Gender

Gender	Number of Natural Deaths	% of Natural Deaths
Female	284	37%
Male	480	63%
Total	**764**	**100%**

Natural Deaths by Age

Age	Number of Natural Deaths	% of Natural Deaths
Under 1	10	1%
1 to 5	8	1%
6 to 12	7	1%
13 to 15	2	0%
16 to 19	5	1%
20 to 29	14	2%
30 to 39	40	5%
40 to 49	99	13%
50 to 59	186	24%
60 to 69	160	21%
70 to 79	120	16%
80 to 89	88	12%
90 +	25	3%
Total	**764**	**100.00%**

Toxicology Findings for Natural Deaths

Of the 764 Natural Deaths investigated by OCME, toxicology analysis was performed in 365 cases. Overall, drugs were absent in 187 natural cases; 132 cases had 1 drug present; 31 cases had 2 drugs present; 10 cases had 3 drugs present; 4 cases had 4 drugs present; and 1 case had 6 drugs detected.

Description	Number of Cases	% of Cases
N=	**365**	
Negative	187	51.2 %
Positive	178	48.7 %

The most commonly detected drugs in the natural cases were:

Name of Drug	Number of Cases	% of Natural Cases
Ethanol	57	15.6 %
Cocaine	27	7.3 %
Morphine	17	4.7 %
Acetone	12	3.2 %
Methadone	7	1.9 %
Phenytoin	7	1.9 %
Phenobarbital	7	1.9 %
Oxycodone	5	1.3 %
Codeine	4	1.0 %
Tramadol	4	1.0 %
Codeine	4	1.0 %
Citalopram	4	1.0 %

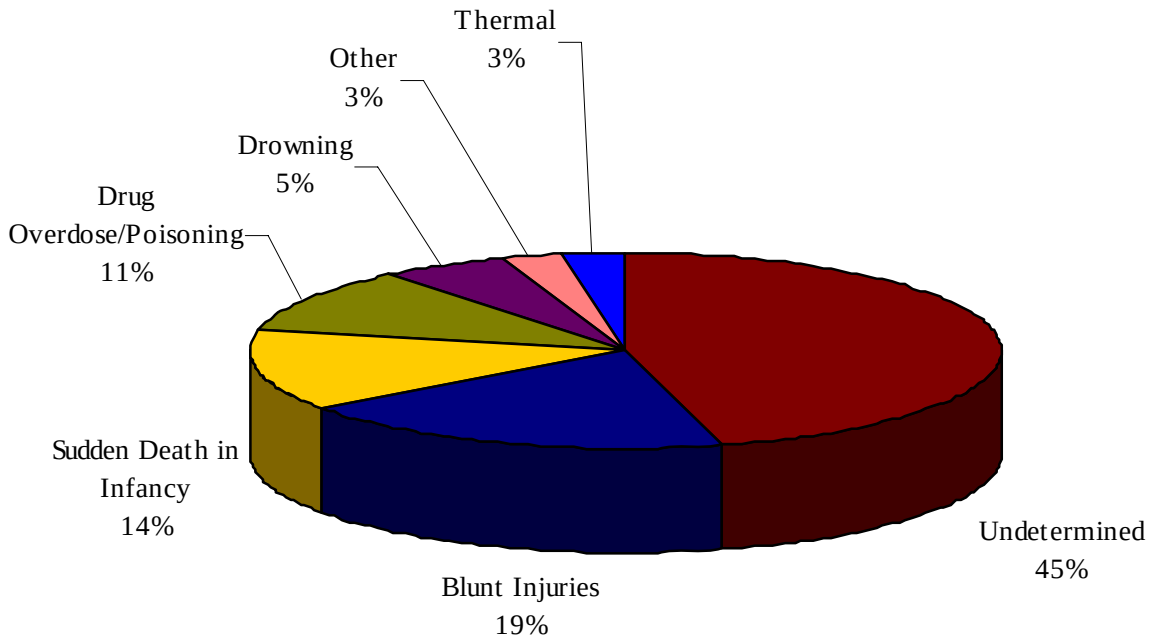
2.5 – UNDETERMINED DEATHS

Undetermined by Cause of Death

The OCME investigated 37 cases where the manner of death was concluded to be "Undetermined," and of these 37 cases 17 or 45% 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 any of the age groups between 1 and 15 years, or in those decedents over 80 years old.

Cause	Number of Deaths	% of Total Accepted Cases
Blunt Injuries	7	46%
Drowning	2	19%
Drug Overdose/Poisoning	4	14%
Other	1	11%
Sudden and Unexplained	5	5%
Thermal	1	3%
Undetermined	17	3%
Total	**37**	**100%**

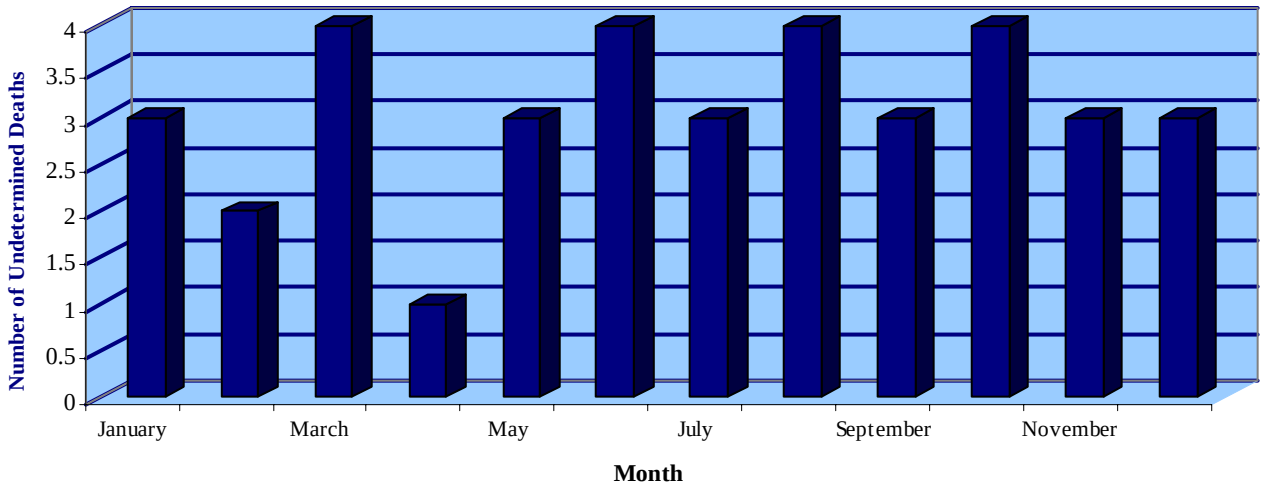
Pie Chart – Undetermined by Cause of Death



Undetermined Deaths by Month

Month	Number of Deaths
January	3
February	2
March	4
April	1
May	3
June	4
July	3
August	4
September	3
October	4
November	3
December	3
Total	**37**

Chart - Undetermined Deaths by Month



Undetermined Deaths by Race

Race	Number of Undetermined Deaths
Asian	2
Black	26
White	7
Hispanic	2
Total	**37**

Undetermined Deaths by Gender

Gender	Number of Undetermined Deaths
Female	15
Male	22
Total	**37**

Undetermined Deaths by Age

Age	Number of Undetermined Deaths
Under 1	13
1 to 5	0
6 to 12	0
13 to 15	0
16 to 19	1
20 to 29	4
30 to 39	2
40 to 49	4
50 to 59	8
60 to 69	4
70 to 79	1
80 to 89	0
90 +	0
Total	**37**

Toxicology Findings by Undetermined Deaths

Of the 37 Undetermined Deaths investigated by OCME, toxicology analysis was performed in 35 cases. Overall, drugs were absent in 15 undetermined cases; 13 cases had one drug present; 3 cases had 2 drugs present; 2 cases had 4 drugs present and two cases had 5 drugs present.

Description	Number of Cases	% of Cases
N=	**35**	
Negative	15	42.8 %
Positive	20	57.1 %

The most commonly detected drugs in the undetermined cases were:

Name of Drug	Number of Cases	% of Undetermined Cases
Ethanol	3	15.5 %
Cocaine	3	4.4 %
Methadone	3	6.8 %
Oxycodone	2	6.8 %
Quetiapine	2	6.8 %

Toxicology for Stillbirths

Toxicology analysis was performed in 4 Stillbirth Deaths investigated by OCME. Overall, drugs were absent in 1 stillbirth; cocaine was detected in 2 cases and PCP in 1 case.

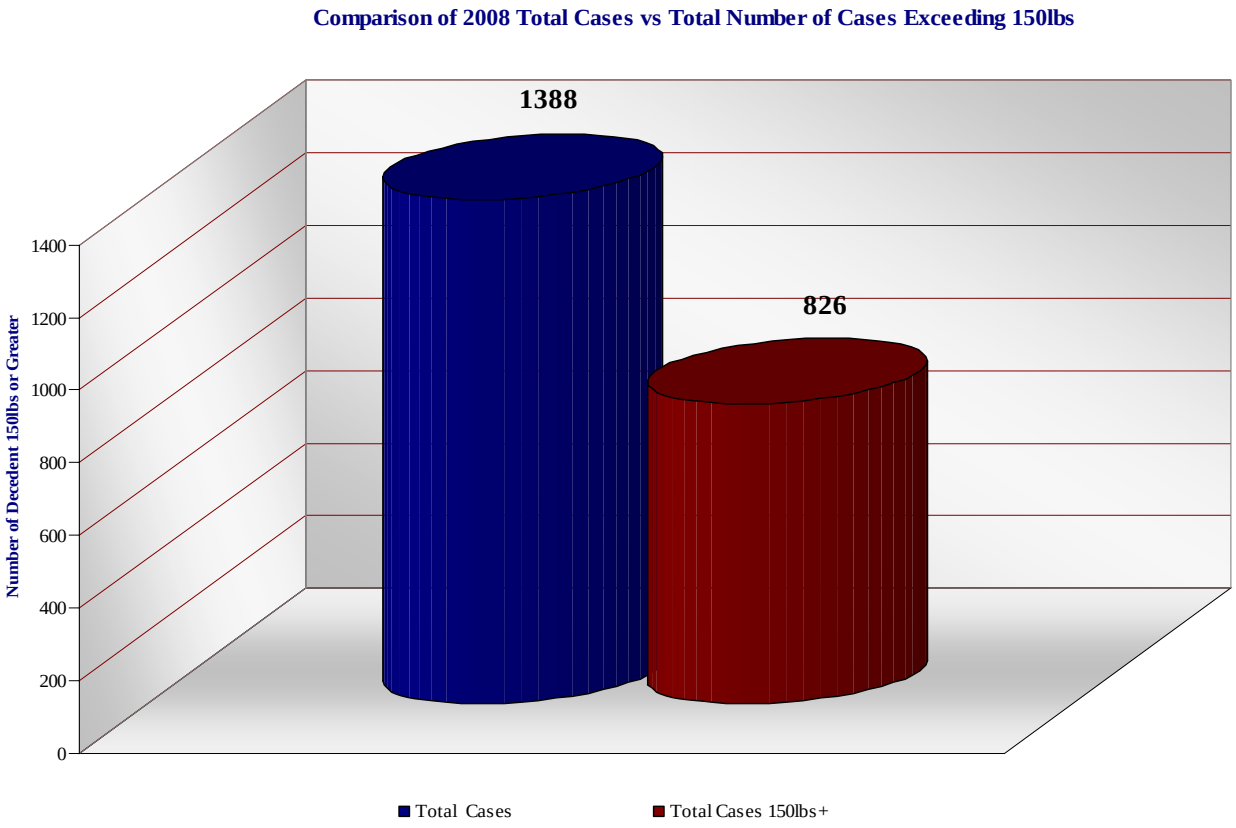
Description	Number of Cases	% of Cases
N=	**4**	
Negative	1	25.0 %
Positive	3	75.0 %

3.0 – WEIGHT DISTRIBUTION DATA

The following data was compiled in an effort to show the weight distribution of decedents transported to the D.C. Office of the Chief Medical Examiner (OCME). Data was compiled using the FACTS Case Management System and cross-referenced with the Mortuary Case Log Book for accuracy.

The data presented was gathered on decedents who were processed by the OCME between January 1, 2008 and December 31, 2008.

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 one's ratio of body height to body weight, and which correlates strongly (in adults) with body fat content. BMI is used to assess how much a person's weight departs from what is desirable for their height. Individuals with a BMI between 25 and 29.9 are considered overweight, and those above 30 are considered obese. This report will include the number of decedents examined by the OCME this year weighing over 150 lbs and with a BMI above normal (e.g. over 25). We also compare the BMI with deaths due to Arteriosclerotic and Hypertensive Cardiovascular Diseases.

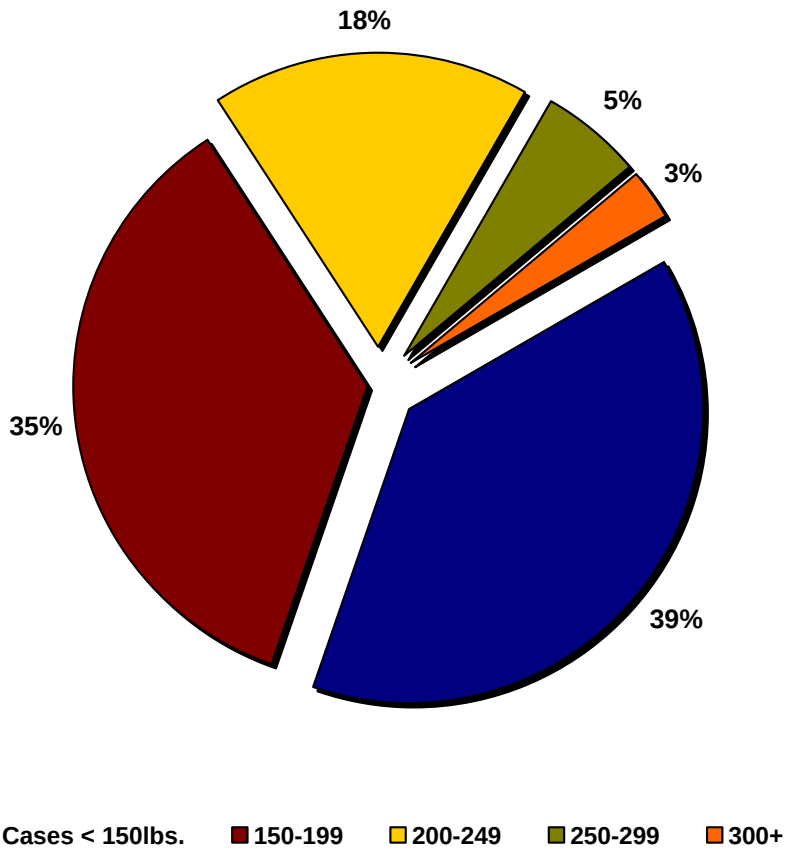


Note: There were a total of 1,405 Accepted cases, of which 7 were Non-Human, 7 had an exam type of "Review Medical Records" with no height and weight data; 2 child cases are without height data, and 1 was an Anatomical Specimen. so because these cases does not have either the needed height and/or weight information only the remaining 1,388 cases are considered for the 2008 BMI study.

2008 - WEIGHT DISTRIBUTIONS

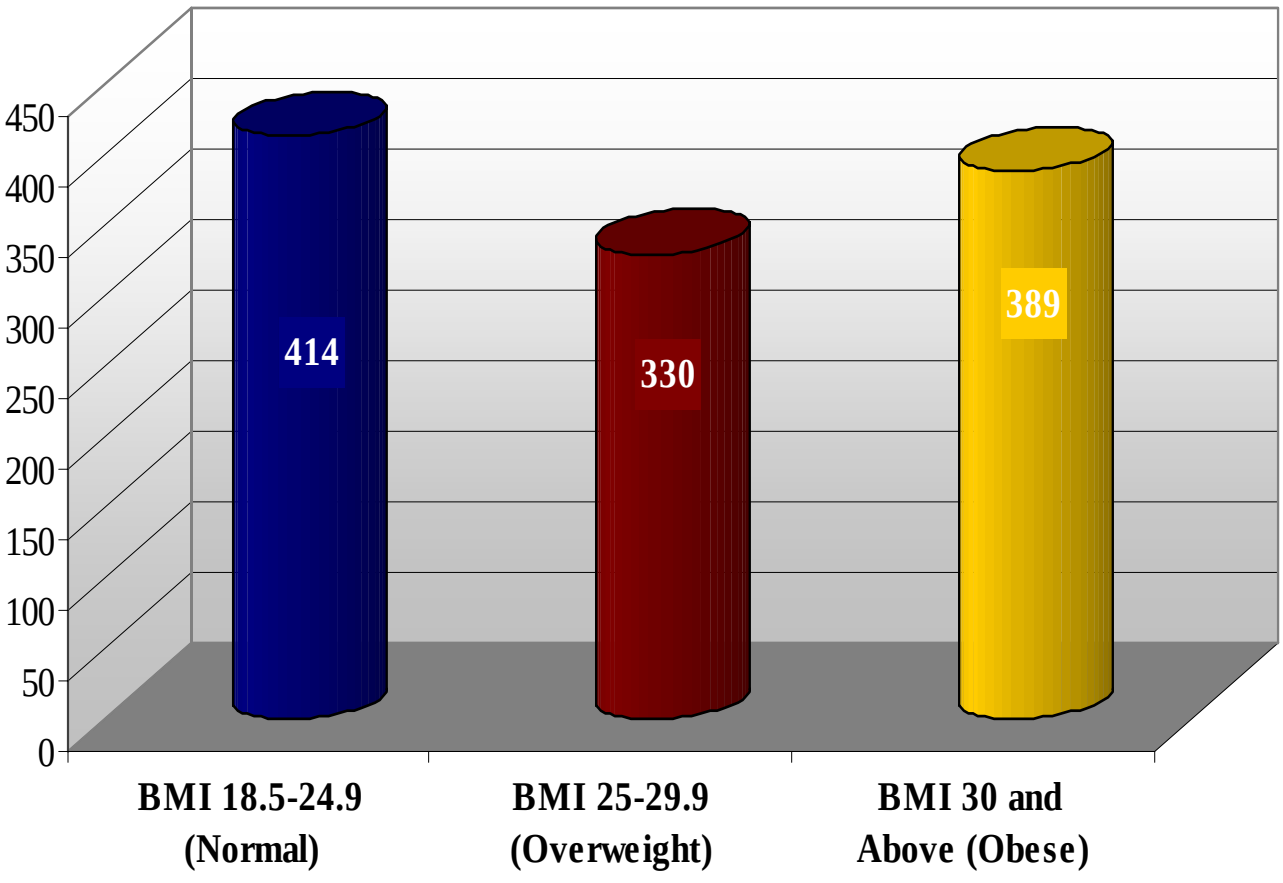
Weight	Total Cases 149lbs or less	150-199	200-249	250-299	300+	Total Cases 150lbs or more	Total Cases
Number of Decedents	**562**	477	238	73	38	**826**	**1388**

Distribution of Accepted OCME Cases by Weight 2008



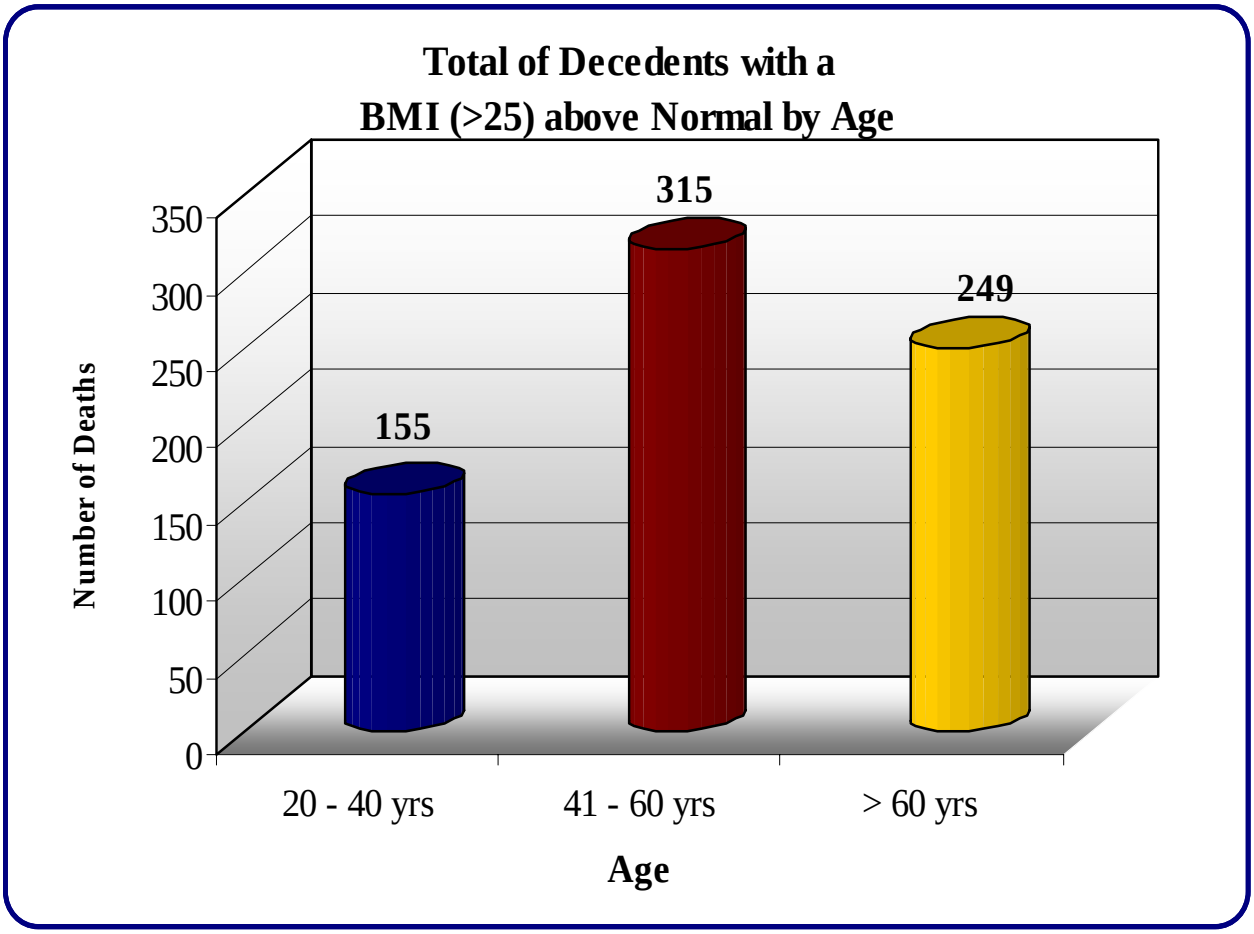
Body Mass Index (BMI)

Of the 1,388 cases studied, 1,274 were adult decedents and 114 were child decedents. However, 143 of the adult decedents were below the normal range (i.e. malnourished/underweight, skeletonized or mummified) as established by the Center for Disease Control, and there were 3 additional cases whose height could not be accurately assessed; therefore no BMI could be calculated for these 146 cases. So for the purposes of the adult case studies only 1,128 cases are included. Of the 1,128 adult cases studied 414 were of a normal weight, but 719 cases or 64% had a Body Mass Index above normal, of which 330 were overweight (BMI 25– 29.9), and 389 were obese (BMI 30 and above)



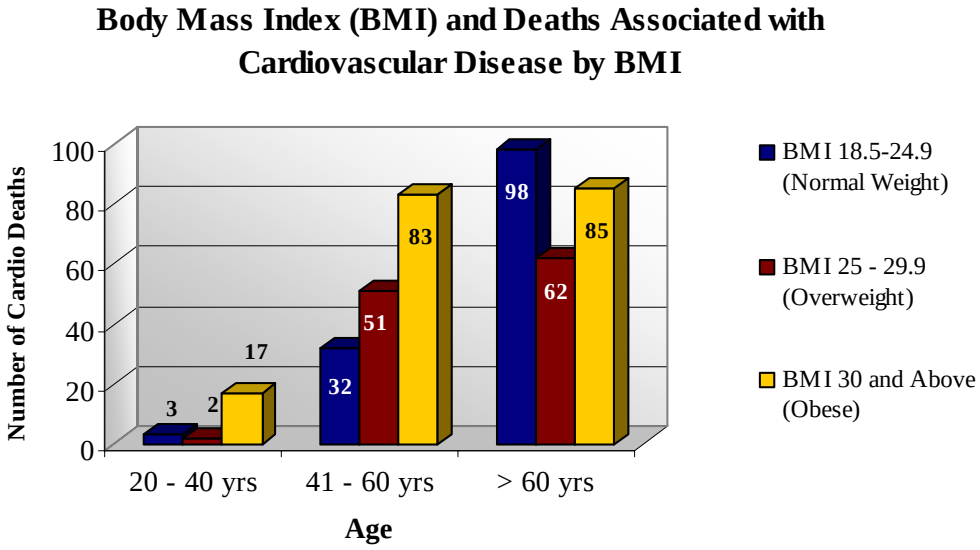
BMI by Age (Adults only)

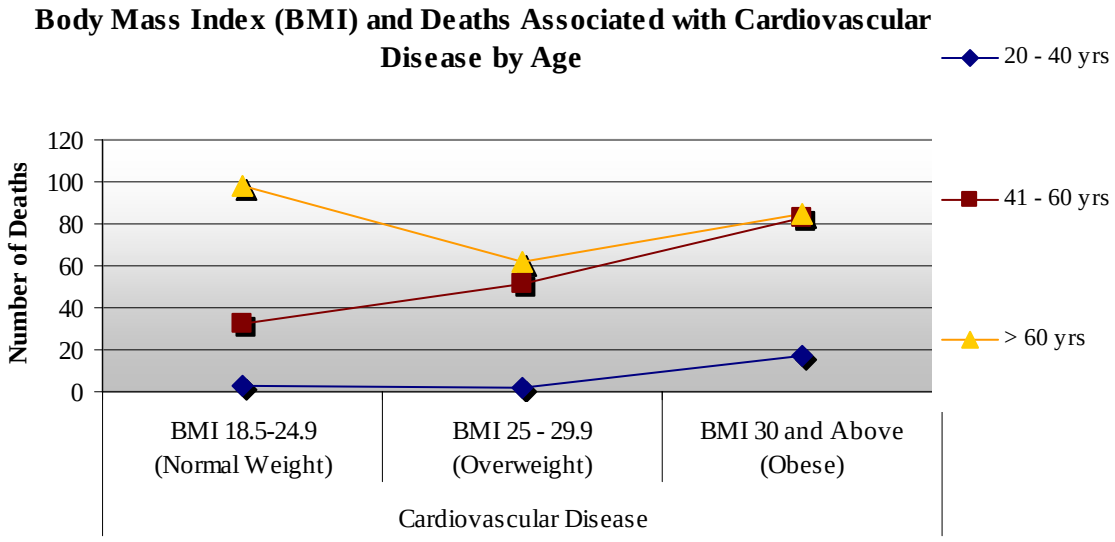
Of the 719 adult decedents with a BMI above normal (>25) during 2008, the age group with the highest number of deaths was 41 - 60 years old with 315 deaths recorded.



BMI by Age and Cardiovascular Disease
(Adults only)

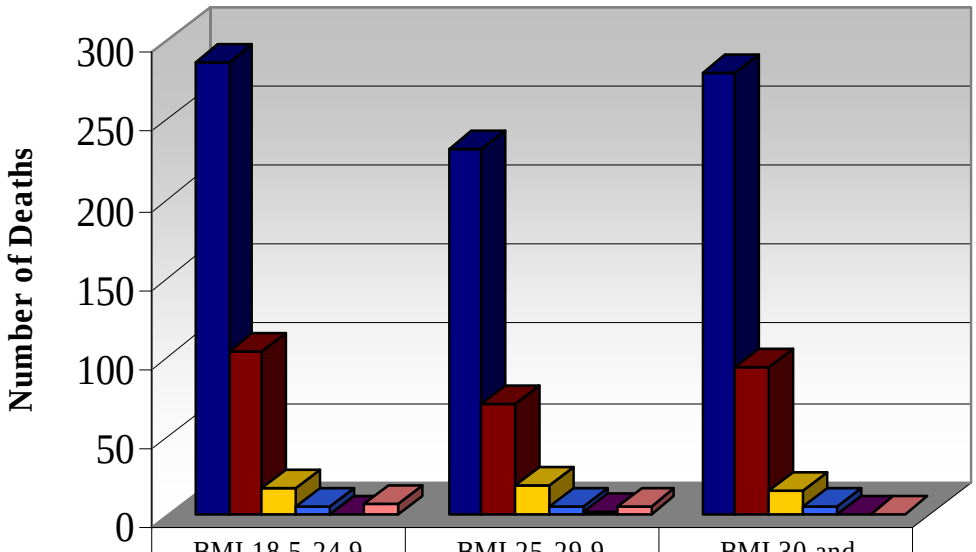
There were 504 adult decedents whose cause of death was directly attributed to complications of Arteriosclerotic and Hypertensive Cardiovascular Diseases. Of these decedents 70 were underweight; 134 were of normal weight; 115 were overweight and 185 were obese. The charts below provide a breakdown of the prevalence of cardiovascular disease by age and BMI. For the purpose of this study decedents that are classified as underweight are not included in the graphs below.





BMI by Race (Adults only)

The demographics for this population decreased slightly between 2007and 2008. Of the 719 decedents above the normal BMI, 74.5% were Black/African American, 19% were White, 4% were Hispanic and less than 2% were either Asian or had an Unknown ethnicity. The chart below displays the BMI data by race.



	BMI 18.5-24.9 (Normal)	BMI 25-29.9 (Overweight)	BMI 30 and Above (Obese)
Blacks	286	231	278
Whites	102	70	93
Hispanics	16	18	14
Asians	4	5	4
Pacific Islander	0	2	0
Other	6	4	0

3.1 - 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

Overall OCME had a total of 116 child decedent cases in 2008 that were accepted for further investigation. Of the 116 cases 42 were under the age of two, and cannot be considered for the BMI study, because currently there is not a BMI calculation available for this subset of children. There were a total of 74-child decedent's age 2 years to 19 years old; however, there were 7 cases in which the remains were either skeletonized or had severe deformities and therefore BMI calculations could not be done. So, as a result only 67 cases will be represented in the study indicated below.

FEMALES

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	16	1	n/a	0	21.2	1	2
6-11 yrs	*n/a	0	20.7	1	17.8 & 18.9	2	n/a	0	3
12-16yrs	*n/a	0	n/a	0	23 – 29.6	3	n/a	0	3
17-19yrs	n/a	0	20.3-25.1	6	n/a	0	n/a	0	6
Total		**0**		**8**		**5**		**1**	**14**[4]

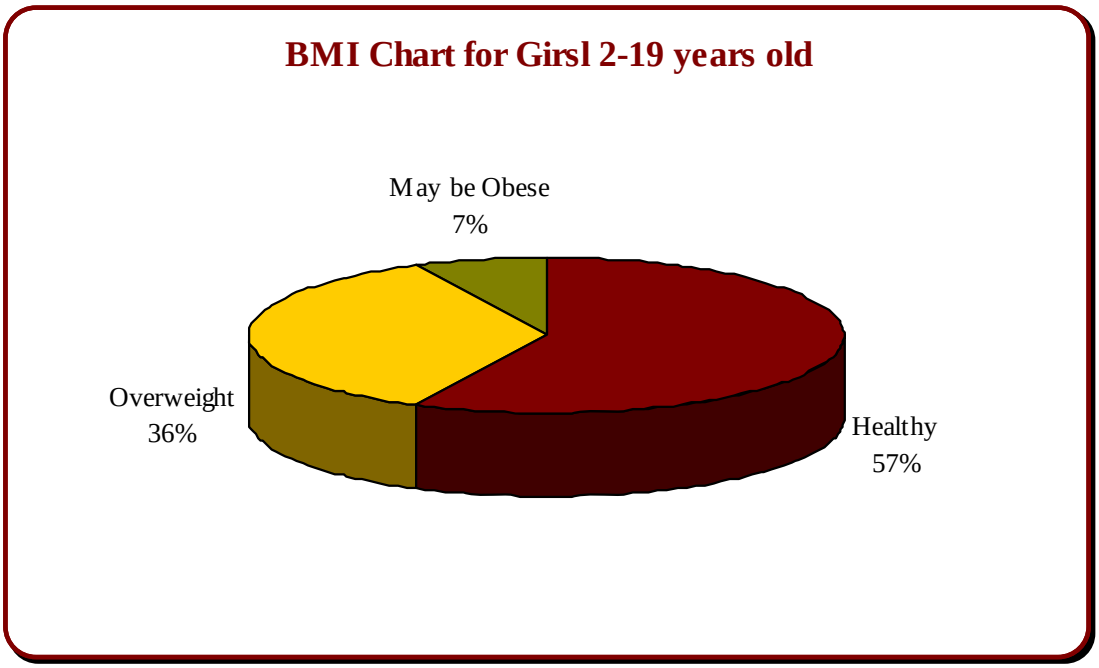
MALES

Age	Underweight		Healthy		Overweight		May be Obese		Total
	BMI Range	No.	BMI Range	No.	BMI Range	No.	BMI Range	No.	
2-5 yrs	13.8	1	15.2	1	17.9 & 18.3	2	19 – 23.1	4	8
6-11 yrs	14.3	1	14.3 & 24.9	2	17.5	1	21.7	1	5
12-16 yrs	*n/a	0	17.5 – 21.8	8	22.5	1	28.1 – 34.6	4	13
17-19 yrs	18.4	1	18.7 – 26.5	22	33.2	1	36.2	1	25
Total		**3**		**33**		**5**		**10**	**51**

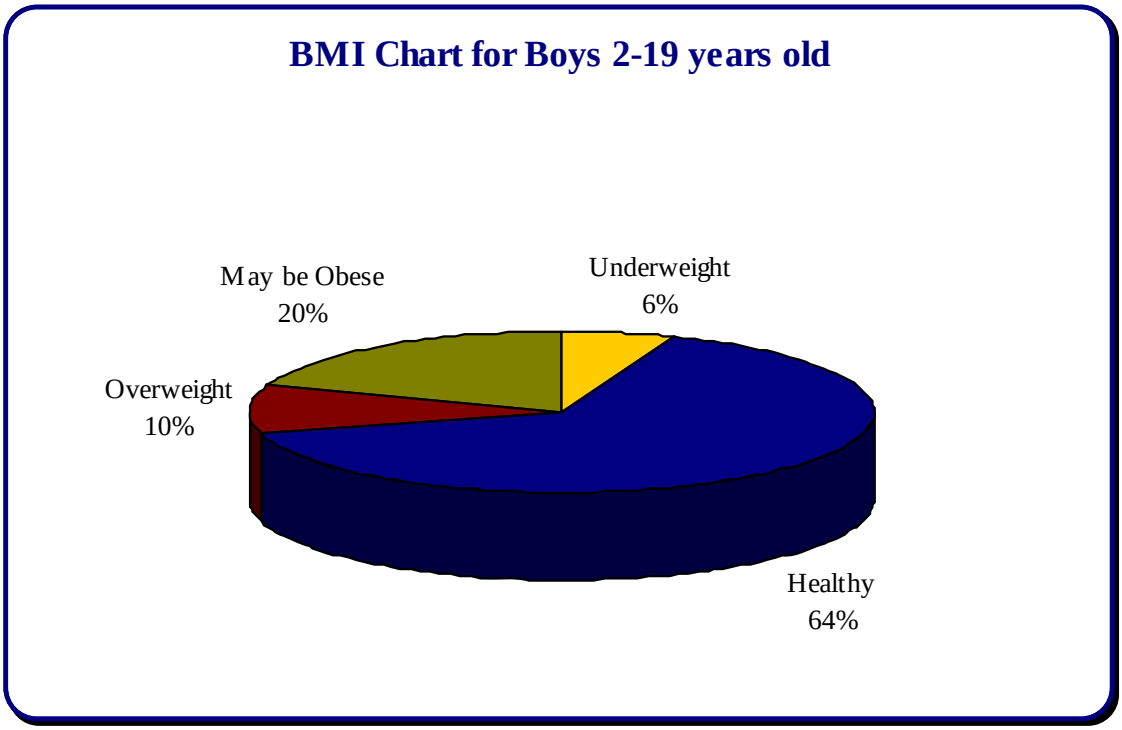
***n/a**= not applicable

[4] **Note**: There are 6 Female child decedents where BMI could not be calculated.

There was a total of 14 female youths from 2-19 years, and 57% were found to be within the healthy range. There were female decedents in <u>all</u> age categories.



There was a total of 51 male youths from 2-19 years, and 64% were found to be within the healthy range. There were male decedents in <u>all</u> age categories.



4.0 – Breakdown of Medical Examiner Investigations

The US Census estimates that during 2008, the total population within the District of Columbia was 591,833[5] inhabitants, which comprised primarily of the following ethnic groups: White, Black, Hispanic, Asian and Other. In 2008, the OCME investigated 3,133 deaths that occurred in the District of Columbia or were wards of the District and died in another jurisdiction. 1,405 of these cases were accepted under the jurisdiction of the Medical Examiner for further investigation, of which 1,107 were known to be residents in the District of Columbia. The following table and charts summarize the manner of death by racial composition.

2008 Manner of Death by Race with 2008 Census Data

Race	2008 est. Census	Natural	Suicide	Homicide	Accidents	Undetermined	Total Number of ME Cases
White (Not Hispanic)	196,049	149	30	9	113	7	308
Black (Not Hispanic)	314,537	583	25	164	194	26	992
Hispanic/Latino (of any race)	51,124	17	2	15	28	2	64
Asian	19,699	10	3	1	3	2	19
Pacific Islander	413	0	1	1	0	0	2
Alaskan Native	1,592	0	0	0	0	0	0
Other[6]	8,419	4	2	1	0	0	7
Unknown	n/a	1	0	0	0	0	1
Total Population	**591,833**						
Total # of ME Cases		**764**	**63**	**191**	**338**	**37**	**1,393[7]**

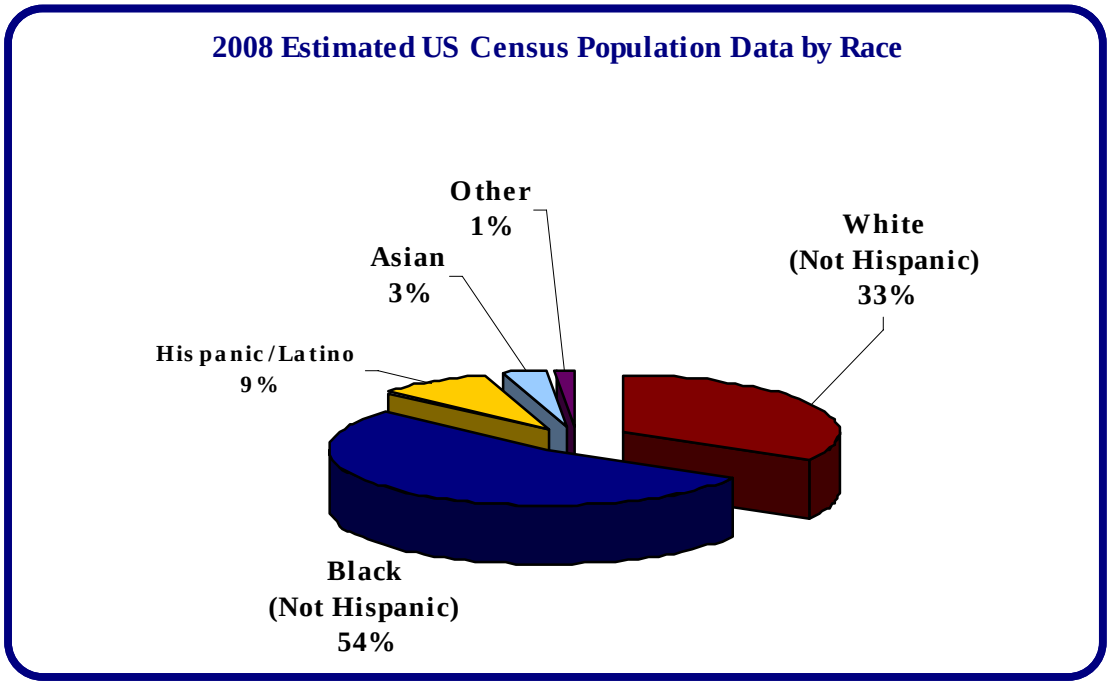
2008 Manner of Death by Gender

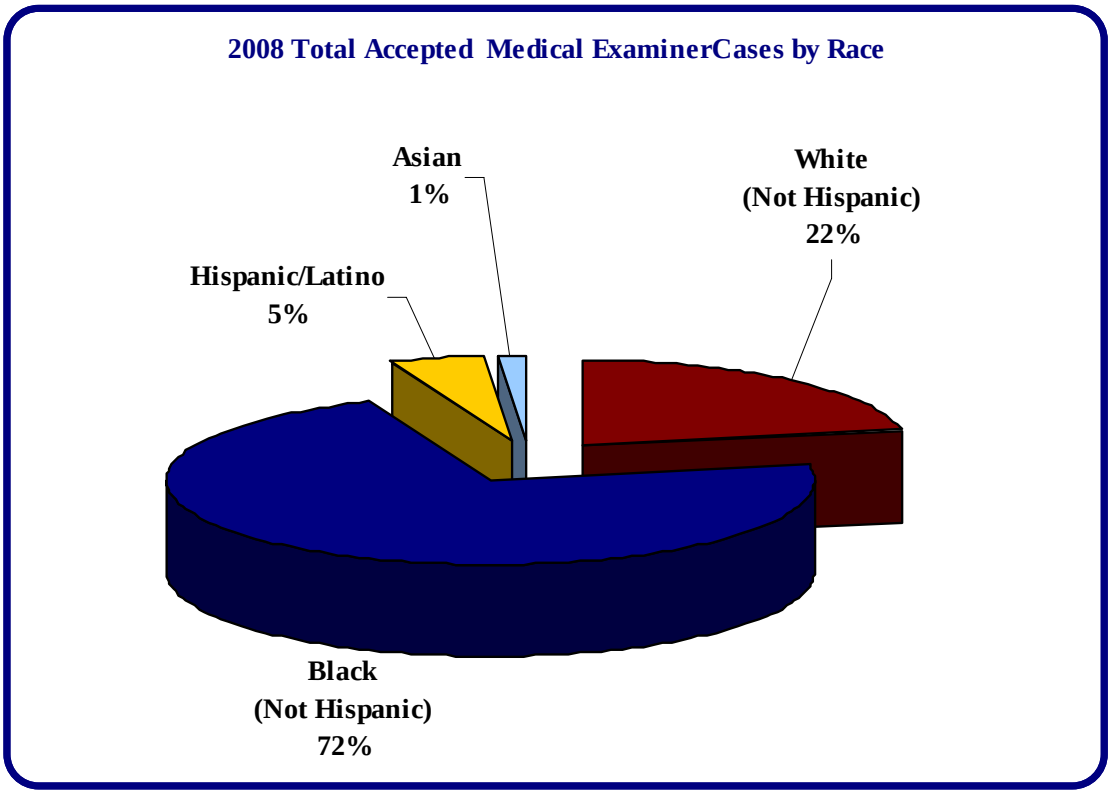
Gender	Naturals	Suicide	Homicides	Accident	Undetermined	Totals	Percent
Female	284	19	25	109	15	452	32%
Male	480	44	166	229	22	941	68%
Totals	**764**	**63**	**191**	**338**	**37**	**1393**	**100%**

[5]Source: US Census Bureau at http://quickfacts.census.gov/qfd/states/11000.html.
[6] Where **Race** is categorized as "*Other*" the data represents the following: Unknown and two or more races

[7] The above tables do not include Stillbirths (N=4); Non-Human remains (7); or Anatomical Specimens (1).

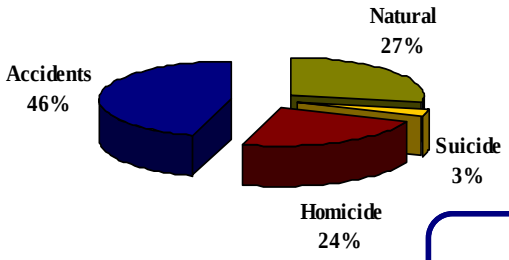
4.1 - Total Population & Total ME Cases by Race



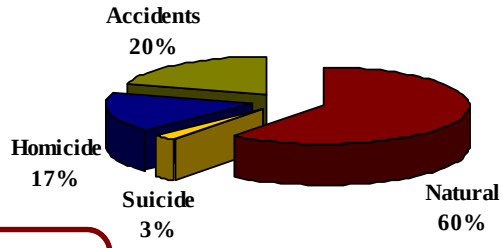


4.2 - Total ME Cases by Race and Manner of Death

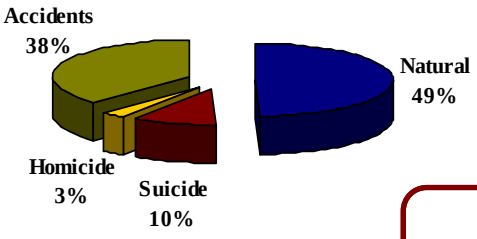
Hispanic/Latino Population



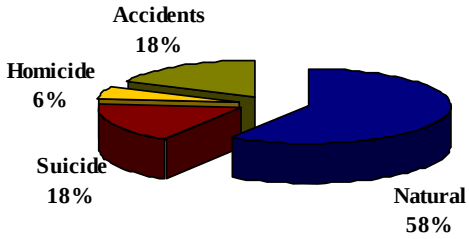
Black/African American Population



White Population



Asian Population



APPENDIXES

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APPENDIX A

2008 OCME Organizational Chart

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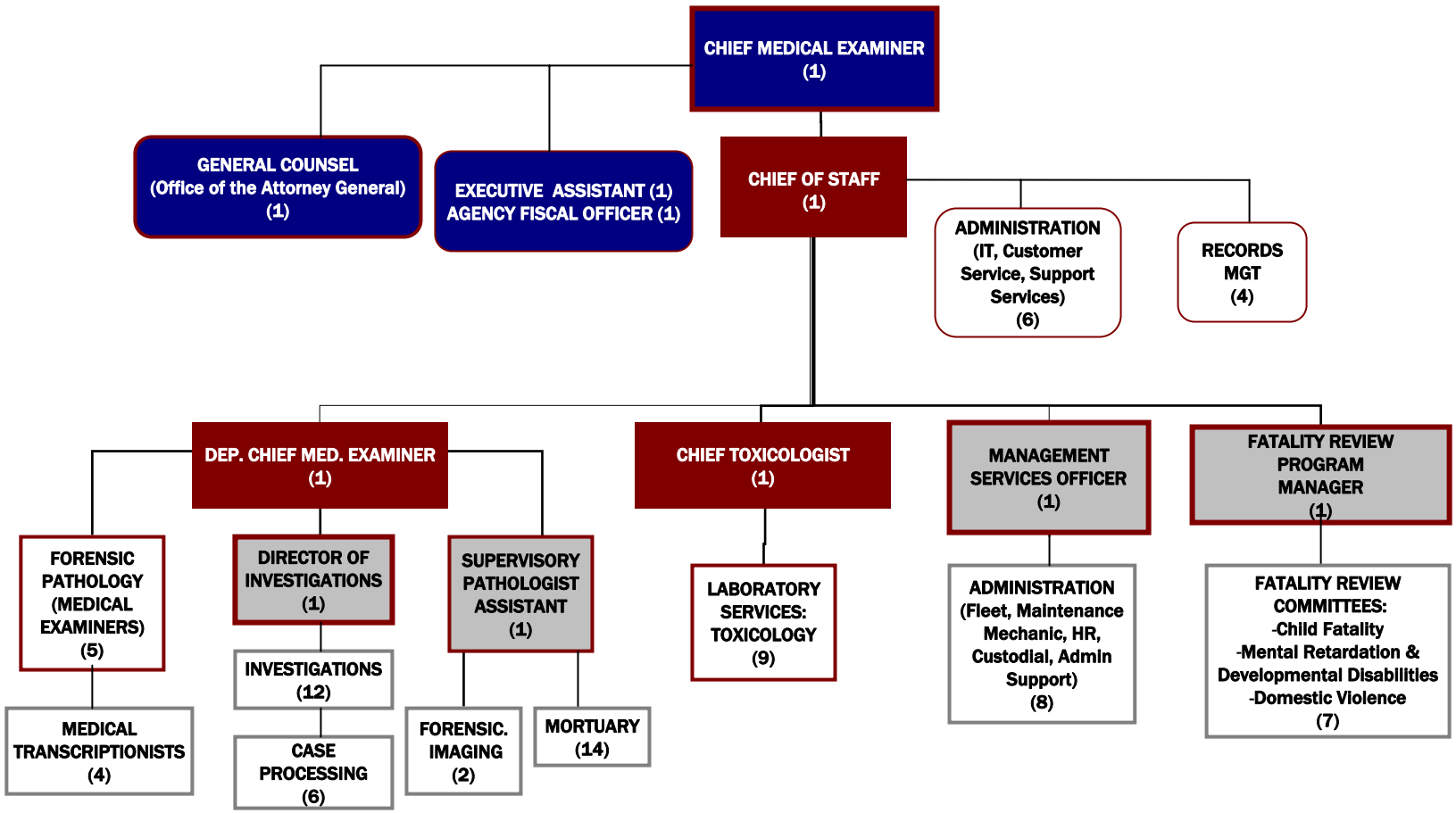
OFFICE OF THE CHIEF MEDICAL EXAMINER
ORGANIZATIONAL CHART
FY2008



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APPENDIX B

AGENCY MANAGEMENT

AGENCY MANAGEMENT

Facility Accreditation:

On October 15, 2008, the National Association of Medical Examiners (NAME) granted the D.C. Office of the Chief Medical Examiner (OCME) provisional accreditation through April 15, 2009. The accreditation resulted from an inspection of the facility conducted July 11-12, 2008 and the subsequent October 7, 2008 Inspection Report. On March 15, 2009, NAME extended OCME's provisional accreditation through October 15, 2009. The current NAME standards allow provisional accreditation to be extended a total of five times. The OCME will continue to provide the requisite documentation of continued progress in addressing recommendations included in the October 7, 2008 Inspection Report such that it may apply for such accreditation extension.

Personnel Management:

During 2008, OCME continued to focus on maintaining a qualified and diverse workforce through the implementation of employee retention and recruitment efforts. Employee retention efforts included monthly workshops and training sessions during general staff meetings, but most significantly the implementation of a Safety, Illness & Injury Prevention Program for all staff. This program included 10 modules. Various staff members also voluntarily participate in a monthly forum sponsored by the Wendt Center for Grief Counseling related to stress management. In the recruitment area, of 87 authorized positions for 2008, 75 were filled; 11 were in the recruitment or classification process; and 1 was held vacant. It is worthy to note that we have achieved an unprecedented 86% rate of employee retention.

Contracting & Procurement:

OCME's contracting and procurement staff 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 management 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 2008, the agency met these LSDBE requirements in providing services to decedents' families, law enforcement, the health care 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 order to meet NAME accreditation guidelines, 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 2008, OCME worked with the Department of Real Estate Services (DRES) (formerly Office of Property Management) to address ongoing HVAC issues and on the completion of in-house renovations at the agency's core facility within the Mortuary Unit. These renovations included a separate office for the Mortuary Supervisor (Supervisory Pathologist Assistant) and a larger office space for Autopsy Assistants.

Further, discussions were initiated with DRES on modifying the space currently used as an evidence room for use as a histology laboratory such that these services (that are currently contracted out) can be brought in-house.

OCME had 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 2008, OPM identified temporary storage space within the old D.C. General Hospital. The space was renovated and is currently being utilized.

Near the end of 2007, the Fatality Review Unit moved into an offsite location in the Reeves Center in order to expand staff and provide additional storage space. This enabled the Unit's former space at the agency's core facility (1900 Massachusetts Ave., S.E., Bldg 27) to be used beginning in 2008 for staff that did not have appropriate work space.

Information Technology:
In 2008, the Information Technology (IT) Unit focused on several projects to enhance the operations of the agency. The IT team worked to implement a digital X-ray imaging program to replace the old manual process facilitating the radiologic imaging procedure, allowing better viewing and interpretation of the images obtained, which also affords the access to the images at the MEs desktops through the FACTS system and better storage of the images through CDs and servers. A digital fingerprinting process was also established so that all fingerprints are stored electronically and can be easily transmitted to Metropolitan Police Department (MPD). The IT Team also worked with the agency General Council to respond to mandates by the Office of the Attorney General (OAG) to place all agency policies and procedures, annual reports and employee manuals on the agency website.

The IT Unit continues to develop an electronic recording system to gather data from the Autopsy Suite and include them in a framework upon which an Autopsy or External Examination Report can be built. The system, from Smart board Technology Inc. makes the data collected in the Autopsy Suite during examination available at the ME's desktop who can electronically transmit a draft report to their Secretaries. This technology is invaluable in the agency's efforts in following the protocol to complete a draft autopsy report within five days of the autopsy examination, and in meeting NAME timing requirements for completed autopsy reports.

Risk Management:
The agency's Risk Assessment Control Committee ("RACC") met all D.C. Office of Risk Management (ORM) requirements in 2008, which included: holding monthly meetings, documenting monthly meeting minutes and developing cost of risk reports; developing and implementing an Agency Risk Management Plan; update and provide training for the agency's Continuity of Operations Plan (COOP); obtaining approval from the Department of Fire and Emergency Medical Services (FEMS) for our updated Emergency Response Plan (ERP) and provided ERP training for the agency staff as well; and providing quarterly updates and a year-end report to the Office of Risk Management (ORM). As stated above, the agency implemented its first full-course Safety and Illness & Injury Prevention training, which included 10 modules. The modules included the bi-weekly training in the following courses: Office Safety; PPE/Universal Precautions, Bloodborne Pathogens, Airborne Pathogens (Tuberculosis), Hazard Communication, Radiation Safety, Incident Management/Emergency Response, Ergonomics, and Mass Fatality and Continuity of Operations Planning. 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;
- Emergency Liaison Officer (ELO) training at the Emergency Operations Center (EOC);
- 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 Relations includes the agency's efforts in employee relations activities such as implementing e-time; addressing general disciplinary matters; collective bargaining negotiations; and disability compensation issues. The agency also supported the District's Annual One Fund Drive. The agency also sponsored holiday celebrations.

Customer Service

OCME also provided customer service consistent with the District's mission in welcoming students and residents from area universities and hospitals. Agency personnel presented in-house lectures and conferences (i.e., MPD Homicide School), conducted presentations at various meetings and conferences within and outside the city and even hosted an international medical examiner. The agency continued to recognize the importance of customer service and staff have been recognized for compassionate and efficient interactions with next of kin; as well as cooperative relationships with funeral directors, law enforcement and other customers. Overall, the agency maintained efficient operations and excellent customer service and consistently met administrative mandates from executive offices and other agencies.

Death Investigation and Certification Management

OCME's Death Investigation and Certification Program is based on the mission of the agency to prepare reports of findings and conclusions on any autopsy or examination performed. The death investigation and certification program thrived in 2008 with: a) timely autopsy reporting with no or minimal backlog throughout the year; b) quick decedent identification and release to next of kin or public dispositions such that the agency continued to maintain a 35% morgue emergency surge capacity; c) establishment of emergency body transport service; and d) implementation of advanced technology.

Key Performance Indicators[1]

Measure One:

Measure one requires that the agency complete 90% of homicide autopsy reports within 60 days. The OCME has made steady improvement in this area with 84.42% of autopsy reports on homicide cases completed within 60 days in FY2008, an increase over the FY2007 percentage of 80.29. Of note are the first and second quarter results for the year which resulted in peaks of 88.7% and 88.6% completion rates.

[1] The District's Agency Key Performance Indicators (KPIs) are compiled on a fiscal year basis. Thus, the KPI data included in this report is for FY2008 covers the time period between October 1, 2007 through September 30, 2008.

Measure Two:
The target for the second measure is to complete 85% of non-homicide autopsy reports within 90 days. In FY2008, 76.12% of autopsy reports on non-homicide cases were completed within this timeframe, an increase over the FY2007 percentage of 71.03. Moreover, Quarters 1 and 4 resulted in peaks of 79.1% and 79.31%.

Measure Three:
The third measure requires that 95% of positively identified bodies be ready for release within forty-eight hours. For FY2008, the agency reached an actual percentage of 93.8, approximately one percentage point below the target. Those bodies that are not ready for release within 48 hours represent a variety of situations ranging from cases requiring further investigation or examination and cases being reported on holidays or weekends when it is difficult to reach attending physicians for information.

Measure Four:
The fourth measure assesses the percent of primary contacts made within eight hours of case assignment to an investigator, of which the agency scored 90%, which was the FY2008 target.

Measure Five:
In FY2008, OCME's mortuary staff arrived on scene within one hour of notification of case acceptance 87.5% of the time, exceeding the 85% target for measure five.

Measures Six and Seven:
Regarding measures six and seven, OCME's toxicology laboratory[2] continued to perform well in FY2008, completing 94.3% negative toxicology examinations within 30 days and completing 99% of positive examinations within 60 days.

Measure Eight:
This measure required the CFRC to hold 90% of child fatality reviews within six months of notification of the death. In FY2008, the CFRC completed 87% of multi-agency and statistical reviews of child fatalities within six months of notification of death, just short of the 90% target.

Measure Nine:
This measure required the MRDD FRC to review 90% of fatalities within three months of receipt of the investigative report from DDS (formerly MRDDA). Eighty-six percent were reviewed, again short of the target.

[2] Locally, the toxicology laboratory provided interpretive services and expert testimony on a variety of drug and alcohol related matters for the Office of the Attorney General (OAG), the Public Defenders Service, and the United States Attorney's Office (USA). Also, in FY2008, the laboratory processed 392 cases for outside agencies, including: 259 for the United States Park Police, 123 for Metropolitan Police Department (MPD); 7 for the U.S. Capitol Police; and 3 for the U.S. Secret Service.

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APPENDIX C

INTERNAL PARTNERSHIPS

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INTERNAL PARTNERSHIPS

OCME/Wendt Center for Loss and Healing Collaborative

November, 1999 marked the 10th anniversary of the collaborative relationship between the Wendt Center for Loss and Healing and the Office of the Chief Medical Examiner. The Wendt Center's RECOVER program is housed within the OCME facility and provides support to individuals and families to help guide them through the process of decedent identification. All RECOVER staff is licensed mental health professionals who have a specialty in trauma, bereavement, crisis and loss. Goals of the RECOVER program include 1) providing immediate crisis support; 2) educating OCME staff and families about trauma, death, and grief as well death's impact on children; 3) providing community based resources to individuals and families who must complete the process of decedent identification at the OCME; and 4) supporting OCME staff who experience work related stress.

RECOVER counselors help decrease anxiety, stress, anger and preconceived misnomers of the OCME by explaining the ID process, guiding families through necessary paperwork, preparing them for the identification photograph, and connecting them with Medico-legal/Forensic investigators, Medical Examiners or other necessary OCME staff, that will help to get answers to questions. Depending on the needs of the individual or family RECOVER staff may discuss talking to children about death, preparing for a funeral, making funeral decisions, common reactions to death as well as accessing community resources. RECOVER staff works closely with OCME staff to make the Identification process for families as smooth, informative and compassionate as possible.

Since the inception of the program in November 1999, RECOVER staff has supported families through nearly 10, 000 decedent identifications. During fiscal year 2009 (October 2008-September 30, 2009) RECOVER staff helped families through 1,000 Identifications. During that year a total of 2,500 people received therapeutic support, trauma/crisis/grief education and community based resources.

This year the RECOVER team continued to provide a monthly staff support session for OCME staff to address stress related issues, as well as teaching them to identify new and effective coping strategies. Some of the strategies we have used is music, art, games, yoga and laughter. The OCME technicians, transcriptionist, doctors, investigators, intake specialists and medical records staff have had the opportunity to decompress and take care of themselves while at work. Over the year, nearly all the OCME staff has taken advantage of this opportunity for self care.

Staff Support 2009

In addition to meeting the needs of families completing the process of identification and supporting OCME staff, RECOVER has also worked closely with the Medico-legal team in providing trainings to consular members of the State Department. RECOVER staff has explored grief and trauma reactions, personal triggers in relation to death and working with the bereaved as well as self care with 400 members of the State Department.

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 2008.

Type of Judicial Service	Number of Court related Activities
Court Testimony	53
Depositions	4
Grand Jury	2
Pre-trial Conference	81
Other	1
Total	**141**

Court Services by Jurisdiction	Number of Court related Activities
DC	129
Maryland	10
Delaware	1
West Virginia	1
Total	**141**

Court Services by Type	Number of Court related Activities
Civil	9
Criminal	132
Total	**141**

For calendar year 2008 the above data represents approximately **233** hours of Medical Examiner time. The Chief Medical Examiner (CME) handled **44** of these court-related activities, which represents **31** % of the total court service caseload. In general the least amount of time spent on this activity was one hour, and the maximum recorded 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) 2008 ICITAP Basic Homicide Investigation Course – 4-day course hosted by OCME, May 21 through May 24, 2008
2) 2008 National Youth Leadership Forum on Medicine – Half day of lecture and tour (annually)
3) DC Medical Examiner's Office Familiarization Training for Metro Transit Police Officers, Metropolitan Police Department Cadets and Mobile Crime technicians, Naval District Washington Police Academy Cadets, Public Defenders Service Interns, AUSA Interns, and Foreign Service Officers from the US Dept. of State – held at various times throughout 2008.
4) Partners in Education with Arlington Public Schools – Annual Presentation, November 2008.
5) George Washington University – Graduate program in Forensic Science, Medico legal Death Investigation – lecture series, Fall 2008 semester.

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 –in these cases - 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 the release of remains to appropriate family members.

All bodies examined at the OCME are stored by the agency until families make funeral arrangements. Usually this occurs in a matter of days. However a portion of the population remains "Unclaimed" or "Unidentified" and has to be disposed of by the agency. In addition, the OCME provides storage of remains for nursing homes and hospices that do not have refrigerated facilities to store bodies.

A minimal one-time fee is charged to these facilities and the remains are kept until family members are located. 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. All Unclaimed bodies (whether Identified or Unidentified) are cremated through contracts with local funeral directors, unless there exists a concern for public health and safety that would require burial. Those unclaimed bodies identified as United States military veterans, once verified, are transported to Quantico for burial in the National Cemetery again, through contracts with local funeral directors.

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	1	$1988.00	$1988.00
Burials- unidentified child	0	-	-
Cremations – identified adults	67	$490.00	$32,830.00
Cremations - infants	4	$234.00	$936.00
Cremations – fetal remains	4	$105.00	$420.00
Transport to Quantico National Cemetery – identified US Military Veteran	8	$690.00	$5,520.00
GRAND TOTAL	**84 unclaimed remains**		**$41,694.00**

APPENDIX E

PROGRAM LEGISLATION

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

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

GOVERNMENT OF THE DISTRICT OF COLUMBIA
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NOTICE

In an effort to preserve resources the District of Columbia Office of the Chief Medical Examiner (DC OCME) has decided not to include a printed copy of the DC Code for OCME in this years report. However, a current version of the DC Code for OCME can be found at:

http://government.westlaw.com/linkedslice/default.asp?SP=DCC-1000

Then Click the link that says:

TITLE 5. POLICE, FIREFIGHTERS, AND CHIEF MEDICAL EXAMINER

Then Click the "+" next to:

Chapter 14. Chief Medical Examiner.:

Then the Table of Contents will be expanded so that all the sections for the OCME are available for selection by subject matter, which includes sections - "**§ 5-1401 through § 5-1418**"