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

2013 ANNUAL REPORT

Government of the District of Columbia
Vincent C. Gray, Mayor

Allen Y. Lew, City Administrator
Executive Office of the Mayor

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

DISTRICT OF COLUMBIA
OFFICE OF THE CHIEF MEDICAL EXAMINER

MISSION:

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

The Leadership Team
(2013)

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

Beverly A. Fields, Esq.
Chief of Staff

Mikelle Devillier, Esq.
General Counsel

Lucas W. Zarwell, MFS
Chief Toxicologist

Leautry Dixon
Agency Fiscal Officer

Michelle Mack, PA-C
Director of Investigations

Elizabeth Betts
Supervisory Pathologist Assistant

Michael Coleman, Lead IT Specialist

Anna D. Francis
Quality Assurance & Control Officer

PRESENTED TO:

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

A MESSAGE FROM THE CHIEF MEDICAL EXAMINER

Greetings,

The Office of the Chief Medical Examiner (OCME) was established in 1971. The system began as coroner system in the early 1870's and existed as such for 100 years before becoming a medical examiner system. It is with great pleasure and humility that I become the 12th Chief Medical Examiner for the District of Columbia.

The OCME now resides within the brand new Consolidated Forensic Laboratory (CFL) in Southwest. This state of the art facility is equipped with much of what is needed to carry out the mission of death investigation, forensic toxicology, fatality management, and fatality review for the District of Columbia.

Our mission is clear, to serve the families of residents and visitors in our nation's capital. This service comes at a time when families are most at need due to the loss of their loved one. Whether a gunshot wound homicide, a hanging suicide, a slip and fall of the elderly, or a sudden unexpected death in infancy, the OCME is here to serve. We operate 24 hours a day, 7 days a week, and 365 days a year. With 70 employees and a budget of nearly 10 million dollars, we investigate nearly 3,200 deaths and perform nearly 1100 examinations annually, including 108 homicides. We intend to serve our community and stakeholder groups through timely and accurate death investigations that ensure 90% of our reports are completed within 90 days.

OCME is working to achieve national accreditation from the National Association of Medical Examiners (NAME). NAME Accreditation requirements set the standards for medical examiner offices throughout the country. These standards include, but are not limited to: report turn-around time, staffing, facilities, and programmatic practices found in death investigation, toxicology, pathology, histology, identification, and mass fatality management. We are currently preparing ourselves for accreditation by undergoing a full internal gap analysis, reviewing all of our standard operating procedures, memoranda, statutory jurisdiction, staffing levels and assignments, as well as supply and equipment needs. As a result, we are developing an action plan to improve all elements of services as well as a timeline to undergo NAME Accreditation inspection by spring, 2015.

Our need to assess and improve day to day operations does not overshadow our need to prepare for catastrophic emergencies that may lead to mass fatality. Whether it is a natural disaster like Hurricane Sandy, or an active shooter like seen in the Washington Navy Yard, the OCME plays a significant role in ensuring proper handling of decedent remains. Placing emphasis on identification and expedited reunion with next-of-kin, we take seriously our role in a mass

casualty event. To ensure the proper medical examiner response in a mass fatality incident, we are an active participant and partner with HSEMA, DOH, FEMS and HEPRA.

Our role as the Medical Examiner is not limited to the determination of cause and manner of death only. Equally as important is the work we do within our fatality review committees. The Child Fatality Review, Developmental Disabilities Fatality Review and Domestic Violence Fatality Review Committees are intended to develop systemic recommendations that can be used to inform evidence-based programs and policy. We take this obligation very seriously and are working to improve our process of review and reporting.

We are proud of our Toxicology Unit and our ability to not only perform timely and accurate testing after death, but also to support our law enforcement partners in the form of Driving Under the Influence (DUI) testing, administering the District's Breath Alcohol Program, , and providing Drug Facilitated Sexual Assault (DFSA) testing on behalf of the Office of Victim Services.

Lastly, the OCME intends to put itself in position as a public health surveillance organization capable of answering questions surrounding the health and safety of the community. Data collected by OCME will help answer questions like, "What preventable disease or injury is claiming the lives of our citizens?" These answers will inform policy that may extend or improve the quality of life for District residents.

The medical examiner team is strong and committed. With an excellent staff that is well trained, the Office of the Chief Medical Examiner for the District of Columbia will lead the way in forensic medicine for the District and the Nation.

Thank you for your continued support!

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

Executive Summary

This Annual Report covers data that resulted from the investigation of 3,221deaths that occurred in the District of Columbia during the Calendar Year (CY) 2013. The report also presents key agency accomplishments and other major activities such as Expert testimony by the Medical Examiners, Decedents Identification, Disposition of Unclaimed Remains; Toxicological results in Driving Under the Influence (DUI), Drug Facilitated Sexual Assault (DFSA) cases and educational endeavors of all OCME units. The agency hopes that the information contained in the report will be useful to the Executive Office of the Mayor and the Council of the DC and be informative to the public at large.

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

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

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

Under the District Response Plan (DRP), the OCME is responsible for coordination of mass fatality efforts and is a support agency to several Emergency Support Functions (ESF's), including ESF's 4, 8, 9, 10 and 13. A unified approach is required as OCME works with law enforcement, firefighters, emergency management staff and public health officials for investigation of scenes, which may include remains, in an emergency incident. As such, OCME staff must report to such scenes during inclement weather, pandemic disasters or terrorism/emergency response events. Examples include OCME's response during: 1) the 2011 Metrorail incident in which staff was deployed for hours, alongside law enforcement officers, firefighters and emergency management personnel, in order to recover remains, conduct death scene investigation and allow for prompt autopsies and release of loved ones remains to the families; and 2) the 2013 Navy Yard Active Shooter incident in which staff was again deployed for hours, alongside law enforcement officers, in order to recover remains, conduct scene investigation and allow for prompt autopsies, so that decedents could be released to their loved ones as prompt as possible.

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

Accomplishments

A major accomplishment for the agency was the relocation to the new Consolidated Forensic Laboratory. The agency had been housed in its previous location for almost 40 years. The Medical Examiner staff successfully inventoried and classified all assets, in addition to performing their regular duties. The move was flawless and the agency seamlessly provided services to the community at large with the highest level of courtesy and professionalism.

Another major accomplishment is that the Toxicology laboratory implemented and continues to manage the breath alcohol testing program for the District according to industry standards. The agency made critical changes to existing software, hired essential staff, developed an operator training program; a quality management program; as well as certified and placed evidential instruments in the field. In Calendar Year 2013, the OCME successfully trained, licensed and/or recertified 57 MPD officers. In addition, the toxicology lab received re- accreditation in November 2013 with the American Board of Forensic Toxicologists (ABFT), and continues to plan for the accreditation of the Breath Program.

In 2013, the agency completed the digitization of over 62,000 agency medical examiner case records from 1972-2009. The purpose of the project is to ensure that data for these cases are readily accessible and to provide security and integrity to files that are comprised of historical paper documents that are fragile, 35mm slides, Polaroid's and X-rays, all of which have some degree of degradation or damage due to the archiving process and storage environment. Further, digitization will protect the records from loss due to natural disasters or human error. For a portion of the year, the project was supported through a sub-grant award from the D.C. Justice Grants Administration's National Institutes of Justice Coverdell Forensic Science Improvement grant. The focus of the grant is to improve the quality and timeliness of forensic science and medical examiner services, including services provided by the forensic toxicology laboratory and records managements units of the agency. A breakdown of total cases converted, as related to the digitization project, by material type is as follows:

TOTAL CASE COUNT FOR EACH CATEGORY OF MATERIAL			
Polaroid's (1973-1998)	35mm Slides (1999-2007)	X-rays (1985-2009)	Paper Case files (1996-2001)
22,292 cases	**13,298 cases**	**9,095 cases**	**17,860 cases**

Note: There is case overlap with the case materials for each year. For example, a 1996 Polaroid case number may be the same as a 1996 Paper Case file, but during the conversion process each case for each material type was treated as a unique item.

The Digitization project resulted with the Office of Public records being able to authorize the destruction of over 3 tons of images; 3 ½ tons of Radiographic materials; and over 18,000 case files.

Incident Management Planning: The OCME revised the following incident management plans: Emergency Response Plan (ERP); Continuity of Operations Plan (COOP); and its Mass Fatality Plan due to its relocation to a new facility. As required by the District's Office of Risk Management (ORM), the agency ERP was submitted to DC Fire and Emergency Medical Services (FEMS) and approved in September 2013. The OCME participated in all city-wide incident management exercises and conferences (i.e., tabletop and full), which involved staff training of procedures; training of staff roles and responsibilities; and retraining on OCME staff interaction with the EOC and other agencies. Further, the agency developed a guideline focused on procedures to be followed during a mass fatality or emergency incident involving the medical examiner's office. The pamphlet targets agency emergency management stakeholders and provides information on the agency's role in such incidents.

OVERVIEW OF CASES REPORTED AND INVESTIGATED

During the Calendar Year (CY) 2013, **3,221** cases were reported to and investigated by the District of Columbia - Office of the Chief Medical Examiner (DC OCME).

Medical Examiner Caseload

Accepted Cases - The OCME accepted jurisdiction of **1,089** decedent cases, of which 754 cases were autopsied.
Declined Cases - The OCME declined jurisdiction of **2,012** decedent cases, of which 63 became Storage Requests.
Storage Requests - The D.C. OCME provides a unique service to area nursing homes, hospices, and other like facilities by accommodating requests to store deceased bodies. **Fifty-six** of the reported cases were Storage Requests only. However, **63** of the "Declined" cases became storage requests, so as a result; the agency had a total of 119 Storage Requests, of which **117** were approved (See section 4.0 for additional statistics).
Cremation Requests: OCME reviewed a total of **2,453** Cremation requests (See section 4.0 for details).
Scene Visits - OCME investigation staff reported to **694** scenes.
Body Transport - The OCME transported the bodies of **1,181** decedents from scenes of death to the agency.
Organ/Tissue Donations - There were **101** organ donation requests during CY 2013.

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

2013 Medical Examiner Cases by Manner of Death

Manner	Full Autopsy Examinations	Partial Autopsy Examinations	External Examinations	Review of Medical Records	Non-Human	Total
Accident	211	1	94	10	0	316
Homicide	108	0	0	0	0	108
Natural	296	48	208	7	0	559
Stillbirth	2	0	2	0	0	4
Suicide	51	0	1	0	0	52
Undetermined	37	0	0	1	0	38
Other (Bones)[1]	0	0	1	0	11	12
Total	**705**	**49**	**306**	**18**	**11**	**1089**

SUMMARY OF FINDINGS FOR MANNER OF DEATH

HOMICIDES: The OCME investigated 108 Homicides in the CY 2013. This report reveals that homicides continued to be more prevalent in black males and in persons between the ages of 20-29 than any other category. The weapon of choice was firearms. The peak incidents occurred in September.

Toxicology Findings: Toxicology testing was requested on all 108 Homicide cases investigated. Drugs were present in 70 of the homicide cases investigated. The most commonly detected drugs in homicide cases were: Ethanol (N=41), Marijuana Metabolites[2] (23); Phencyclidine PCP (8), Cocaine and metabolites (6), Promethazine (4) and Morphine (3).

[1] The above table includes the following "Bone" cases: "*Non-Human Remains* (11 cases) and one External examination, which was a tooth fragment.

[2] Marijuana metabolites are not confirmed in homicide cases.

SUICIDES: The OCME investigated 52 suicides in the CY 2013. This report reveals that suicides were more prevalent in black males and in persons between the ages of 40-49. Overall whites represented 50% of the decedents (N=26) this year. Peak incidents occurred in August.
Toxicology Findings: Toxicology testing was requested for all 52 Suicide cases investigated. Overall, drugs were present in 36 of the suicide cases investigated. The most commonly detected drugs were: Ethanol (N=11), Zolpidem (5); Morphine (5); and Oxycodone (4).

ACCIDENTS: The OCME investigated 316 accidents in the CY 2013. Of the 316 cases investigated, 164 were the result of blunt force trauma, of which 51 were traffic-related deaths. Also, 98 of the accidental deaths occurred as a direct result of prescription and/or illicit drug use. Peak incidents for accidental deaths overall occurred in December.
*Toxicology Findings for Accidents***:** Toxicology testing was requested for 214 of the 315 Accident cases investigated, and drugs were present in 177 of these cases. The most commonly detected drugs were: Ethanol (N=61), Morphine/Heroin (57), Cocaine and metabolites (51), Marijuana Metabolites (18), Phencyclidine (16), Methadone (11), Diazepam (8), Oxycodone (7), and Acetone (7).
Traffic-related Accidents: The majority of traffic accident deaths occurred in the following categories: males, blacks, and drivers between the ages of 20-29. Peak incidents for traffic accidents only occurred in February.
Toxicology Findings for Traffic-related accidents: Toxicology testing was requested for 45 of the 51 Traffic-related Accidents, and drugs were present in 28 of these cases. The most commonly detected drugs were: Ethanol (N=13); Marijuana Metabolite (8); Cocaine and metabolites (3) and Phencyclidine PCP (2).

In the 13 traffic deaths positive for ethanol, 6 were greater than the legal limit (0.08 g/100 mL) for driving under the influence in the District of Columbia

NATURAL DEATHS: The OCME investigated 559 Natural deaths in CY 2013. This report reveals that the leading cause of death in Natural cases is Cardiovascular Disease with 371 deaths, followed by Alcoholism with 29 deaths. The majority of Natural deaths occurred in March for 2013.
Toxicology Findings: No toxicology reporting for natural deaths is being provided for 2013.

UNDETERMINED: The OCME investigated 38 cases where the manner of death was concluded to be "Undetermined." An "Undetermined" manner of death is a result of inconclusive evidence as to the circumstances of the death at the time and/or inconclusive examination results. As additional information is received, the death may be appropriately re-certified. Note: Sudden Unexpected Deaths in Infancy (SUID) carry an "Undetermined" manner of death.
Toxicology Findings: Toxicology testing was requested for 36 of the 38 Undetermined deaths investigated. Drugs were present in 23 of the Undetermined cases investigated. The most commonly detected drugs were: Ethanol (N=9), Morphine (5), Cocaine and metabolites (3); Phencyclidine (3); and Oxycodone (2).

STILLBIRTHS: The OCME investigated 4 Stillbirth deaths in CY 2013.
Toxicology Findings: No toxicology findings are being reported for stillbirth deaths in this annual report.

SUMMARY OF APPENDICES

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

A. 2013 OCME Organizational chart
B. Agency Management Updates: Which includes updates on personnel management, contracting and procurement, and Information Technology
C. Program Legislation
D. Internal Partnerships

OFFICE OF THE CHIEF MEDICAL EXAMINER

2013 Annual Report

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APPENDIXES:

1.0 - INTRODUCTION

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

In 2013, the agency had three primary programs: Death Investigation and Certification, Agency Management, and Fatality Review. This report will include data on the Death Investigation and Certification, and the Agency Management programs. Fatality Review Program Annual Report statistics are outside of the scope of this report.

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 order investigation; and 12) dead bodies brought within the District without proper medical certification. (See Appendix C – (D.C. Law 13-172), DC Official Code §5-1401 et seq. (2001)).

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

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

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

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

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

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

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

2.0 - ME INVESTIGATIONS AND MEDICAL LEGAL AUTOPSIES

Overview of Cases Reported and Investigated

During the Calendar Year (CY) 2013, there were **5, 589** deaths that occurred in the District of Columbia as reported by the Center for Policy, Planning and Evaluation for the District of Columbia, of which **3,221 or 58%** of these deaths were reported to and investigated by the Office of the Chief Medical Examiner (OCME). The following is a breakdown of where jurisdiction was "Accepted", "Declined" or where Storage was requested of the Medical Examiner.

Accepted Cases - The OCME accepted jurisdiction of **1,089** decedent cases, of which 754 cases were autopsied.
Declined Cases - The OCME declined jurisdiction of **2,012** decedent cases, of which 63 became Storage Requests.
Storage Requests - The D.C. OCME provides a unique service to area nursing homes, hospices, and other like facilities by accommodating requests to store deceased bodies. **Fifty-six** of the reported cases were Storage Requests only, and, Sixty-three of the storage requests were previously "Declined" cases, so as a result; the agency had a total of 119 Storage Requests, of which **117** were approved (See section 4.0 for additional statistics).
Cremation Requests – The DC OCME must review all cremations for deaths that occur in the District of Columbia. There were **2,453** Cremation Requests made to the DC OCME in 2013; **440** were OCME cases, **2,013** were "*New Reports*" submitted from area hospitals, clinics and nursing homes, the OCME took jurisdiction of **14** of these "*New Reports*" for further investigation and certification. (See section 4.0 for details).

Total Number of Cases Reported and Investigated by the OCME	**3,221**
Total Number of Declined Cases	**2,012**
Percent of Cases Reported & Investigated	*62%*
Total Number of Cases Accepted for Further Investigation	**1,089**
Percent of Cases Reported & Investigated	*34%*
Total Number of Autopsies *Full – 700; Partial 49; Performed in a University Hospital – 5*	**754**
Percent of Cases Accepted for Further Investigation	*69%*
Number of Scene Visits by a Medical Examiner or Medico Legal/Forensic Investigator	**694**
Percent of Cases Accepted for Further Investigation	*64%*
Total Number of Bodies Transported by OCME or by Order of the OCME: *Transported by Pick-up Service - 1015* *Transported by Funeral Home -11* *Law Enforcement -5* *Transported by Office Personnel –150* *Investigations:10; Mortuary*: 140	**1181**
Total Number of Organ/Tissue Donation Requests: *Number of requests OCME approved – 84 (15 procured)* *Number of requests OCME declined –* 8 *Permission "Not Required" – 6* *Approached without permission - 3*	**101**

Breakdown of Accepted Cases by Exam Type

Total Number of Cases Accepted and Investigated Further	**1,089**
Total Number of Autopsies *Full – 700* *Partial –49* *Performed at a University Hospital – 5*	**754**
Percent of Cases Accepted	*69%*
Number of External Examinations *On-site - 303* *Off-site - 2*	**305**
Percent of Cases Accepted	*28%*
Number of Non-Human Remains	**11**
Percent of Cases Accepted	*1%*
Number of Medical Record Reviews	**18**
Percent of Cases Accepted	*2%*

Definition of Unfamiliar Exam Type Classifications:

- **Autopsy Performed at a University Hospital:** During Calendar Year 2013 there were 5 cases where the autopsy was performed at a University hospital. The DC Code § 5-1409 authorizes the Chief Medical Examiner to deputize any "qualified pathologist" to perform an autopsy on a decedent that is deemed a Medical Examiner case. Some of these cases were initially declined by the OCME and later accepted based on additional information/autopsy findings. Cases in which the autopsy was completed at the hospital, still required review of the autopsy reports and completion of the death certificates be done by the Medical Examiner.

- **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.

Breakdown of Accepted Cases and Autopsies by Month

Month	Accepted Cases	Autopsies Full and Partials
January	103	65
February	89	65
March	108	75
April	96	63
May	87	65
June	79	55
July	78	48
August	73	53
September	100	67
October	92	63
November	84	58
December	100	77
Total	**1089**	**754**

Medical Examiner Case Examinations by Manner of Death

Manner	Full Autopsy Examinations	Partial Autopsy Examinations	External Examinations	Review of Medical Records	Non-Human	Total
Accident	211	1	94	10	0	316
Homicide	108	0	0	0	0	108
Natural	296	48	208	7	0	559
Stillbirth	2	0	2	0	0	4
Suicide	51	0	1	0	0	52
Undetermined	37	0	0	1	0	38
Other (Bones)[1]	0	0	1	0	11	12
Total	**705**	**49**	**306**	**18**	**11**	**1089**

[1] The above table includes the following "Bone" cases: "*Non-Human Remains* (11 cases) and one External examination, which was a tooth fragment.

Pie Chart - Medical Examiner Cases by Manner of Death

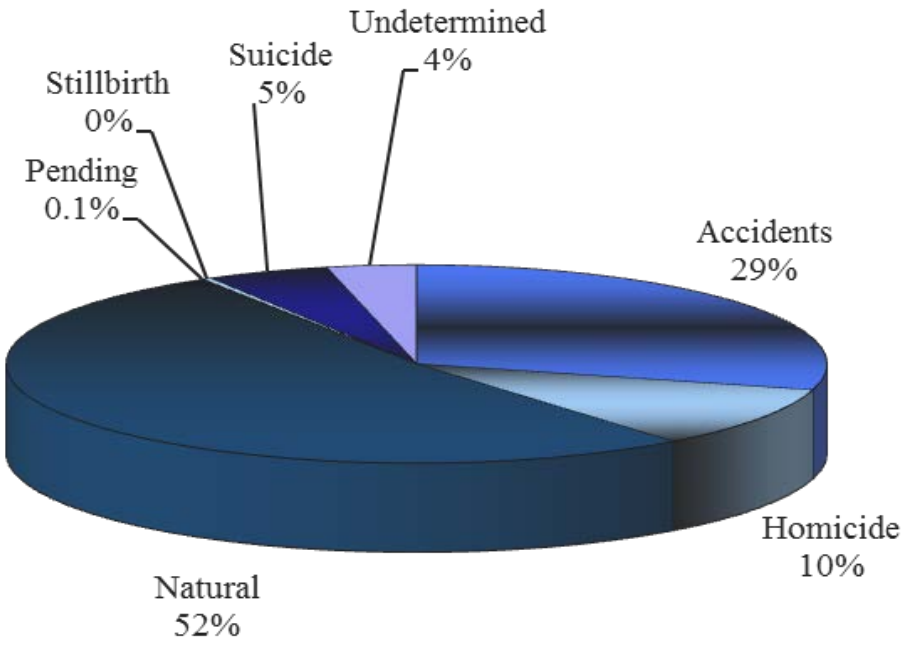
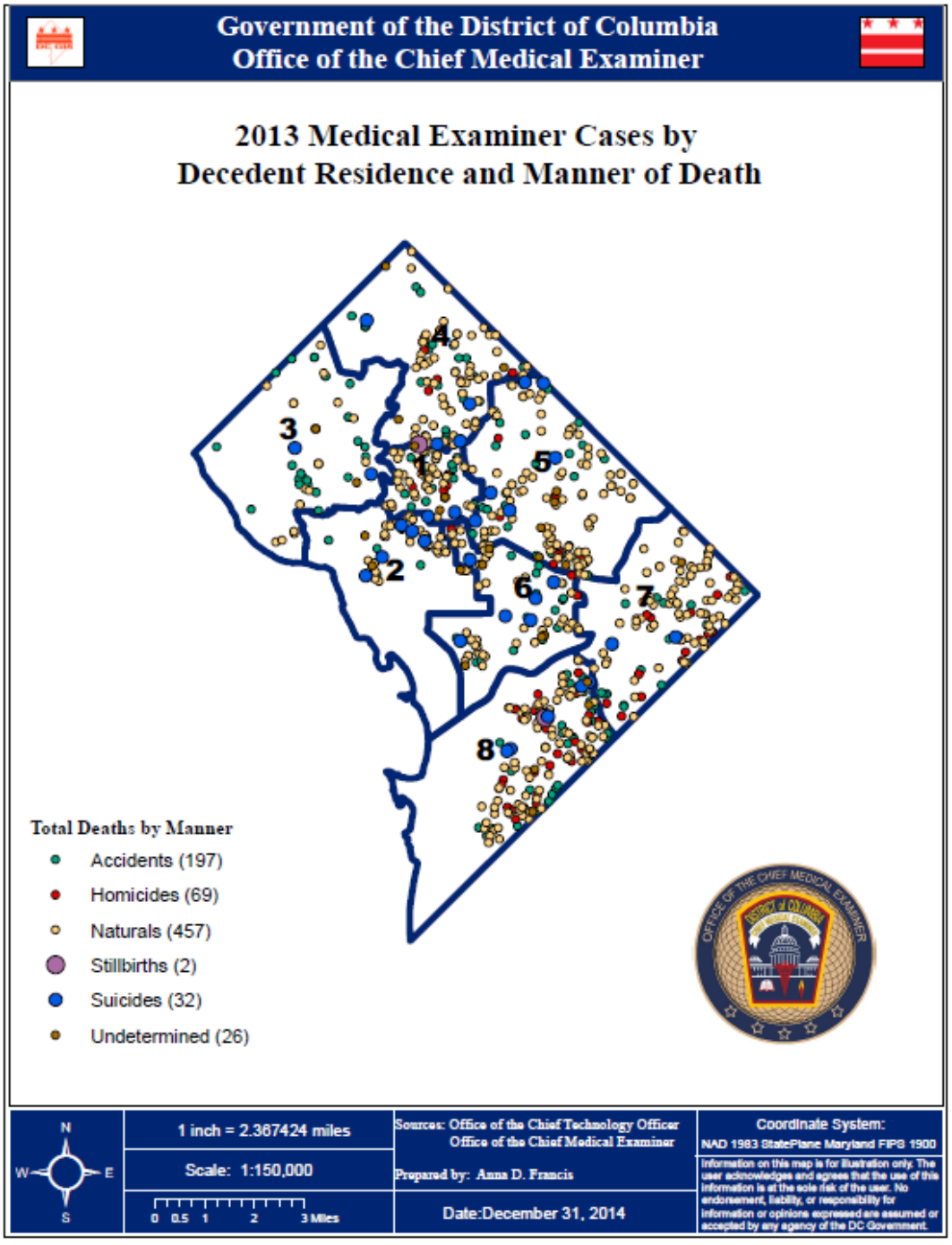


Table: Medical Examiner cases by Residence and Manner of Death

DC Deaths by Jurisdiction of Residence and Manner of Death							
Ward	**# of Deaths**	**Accidents**	**Homicides**	**Natural**	**Stillbirth**	**Suicide**	**Undetermined**
Ward 1	76	18	5	48	1	1	3
Ward 2	59	10	0	38	0	6	4
Ward 3	50	28	**0**	**18**	**0**	2	2
Ward 4	100	31	8	54	0	4	3
Ward 5	145	35	10	89	0	6	5
Ward 6	78	22	5	41	0	6	4
Ward 7	114	20	15	76	0	2	1
Ward 8	162	33	26	94	1	5	4
DC	**784**	**197**	**69**	**458**	**2**	**32**	**26**
MD	**186**	**82**	**28**	**63**	**0**	**6**	**7**
VA	**42**	18	7	10	0	4	3
Other	**33**	8	4	13	0	6	2
Unknown	**6**	0	0	3	2	1	0
Homeless	**26**	11	0	12	0	3	0
Total	**1077**	**316**	**108**	**559**	**4**	**52**	**38**

Map of OCME Decedents by DC Ward and Manner of Death

Of the 1,077 Decedent deaths investigated by the OCME, 784 (73%) were District of Columbia (DC) residents at the time of their death. The map below illustrates the deaths by DC ward and manner of death.



Note: There is one decedent who died of "Natural" causes in Ward 8 whose residential address is not represented within the Geographical Information System for the District of Columbia, so as a result there were actually 458 Natural Deaths in total – that were investigated by the OCME - as illustrated in the preceding table.

Postmortem Toxicology Summary 2013

All postmortem specimens received for routine toxicological tests were analyzed for alcohols (ethanol and other volatiles) and major classes of illicit and prescription medications. Additional screens were assigned depending on intake case history and special requests made by physicians. All significant drug results were confirmed by further testing. Typical case specimens received include blood, urine, bile, vitreous, liver, brain, and gastric contents. In 2013, the laboratory received and inventoried 7,020 postmortem specimens (714 cases) yielding 1,471 reported results.

A negative case refers to the absence of any alcohol or detectable drug. A positive case refers to the presence of alcohol and/or drug(s), noting that a case can be positive for more than one substance. The alcohol and/or drugs detected do necessarily cause or contribute to death. The impact of drugs on the cause and manner of death is incorporated into the overall findings of a case and ultimately determined by the attending pathologist. Drugs that are excluded from typical toxicology reports include common compounds found in routine casework such as: lidocaine, caffeine, and nicotine. These compounds are not recorded unless they contributed to the death or were detected in a significant concentration.

Total number of postmortem cases analyzed:

Description	Number of Cases	% of Cases
***N*=**	714	
Negative	245	34.3 %
Positive	410	65.6 %

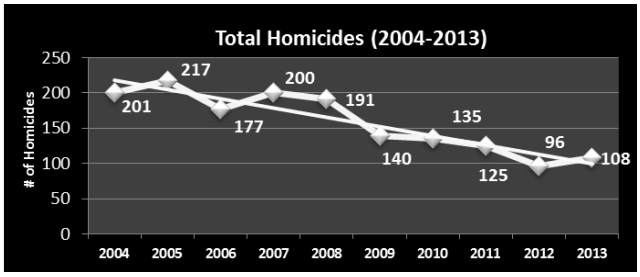
Postmortem Toxicology - Most Commonly Detected Drugs

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

Drug Name	Number of Cases	% of Cases
Ethanol	140	19.6%
Morphine/Heroin	89/44	12.5%/6.2%
Cocaine and Metabolites	89	12.5%
Marijuana Metabolites	51	7.1%
Phencyclidine	36	5.0%
Oxycodone	34	4.8%
Acetone	27	3.8%
Nordiazepam	27	3.8%
Codeine	23	3.2%
Diazepam	20	2.8%
Alprazolam	20	2.8%
Amitriptyline	19	2.7%
Citalopram	19	2.7%
Diphenhydramine	19	2.7%
Acetaminophen	18	2.5%
Methadone	18	2.5%
Nortriptyline	17	2.4%

2.1 - Homicides

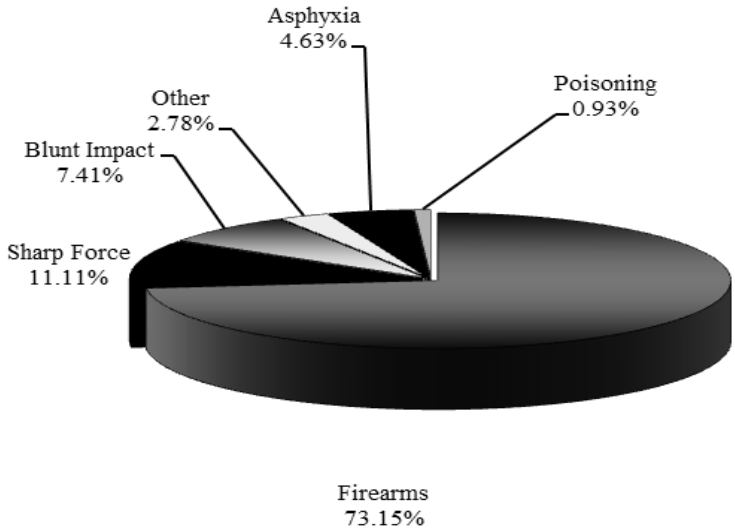
The OCME investigated **108** homicides in the CY 2013. The following tables and graphs provide a distribution by cause of death, month, race, gender and age group. Death by homicidal acts is more prevalent in black males and in the age group 20 to 29 years than any other group presented. The weapon of choice is firearms. The majority of incidents occurred in **September**.



Homicides by Cause of Death

Cause	Number of Homicides	% of Total Homicides
Firearms	79	73.15%
Sharp Force	12	11.11%
Blunt Impact	8	7.41%
Asphyxia	5	4.63%
Other	3	2.78%
Poisoning	1	0.93%
Total	**108**	**100%**

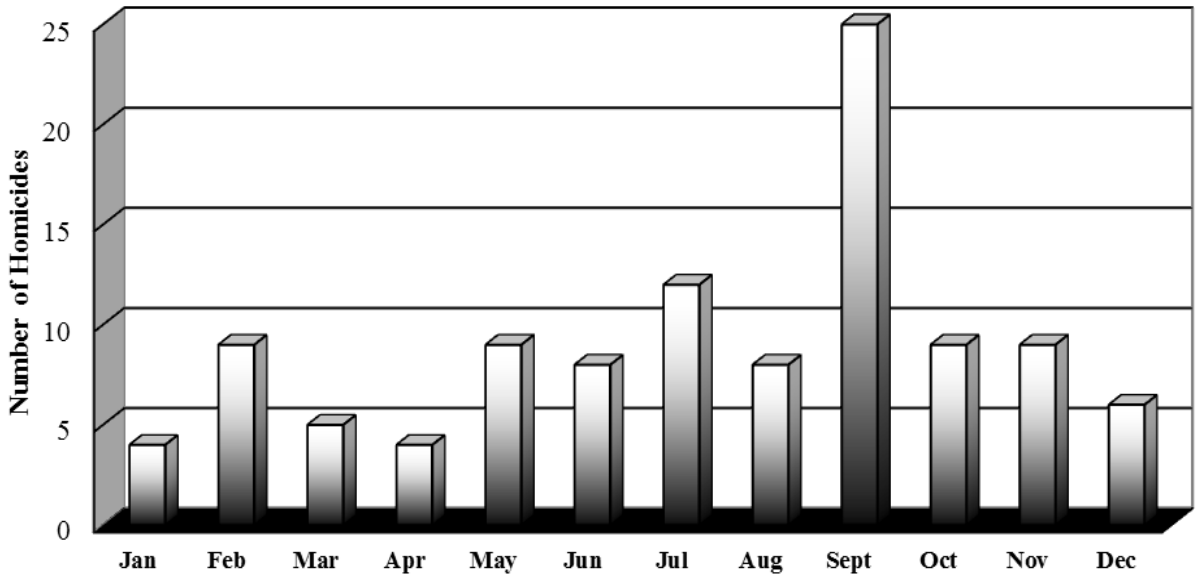
Pie Chart – Homicides by Cause of Death



Homicides by Month

Month	Number of Homicides	% of Homicides
January	4	3.70%
February	9	8.33%
March	5	4.63%
April	4	3.70%
May	9	8.33%
June	8	7.41%
July	12	11.11%
August	8	7.41%
September	**25**	**23.15%**
October	9	8.33%
November	9	8.33%
December	6	5.56%
Total	**108**	**100%**

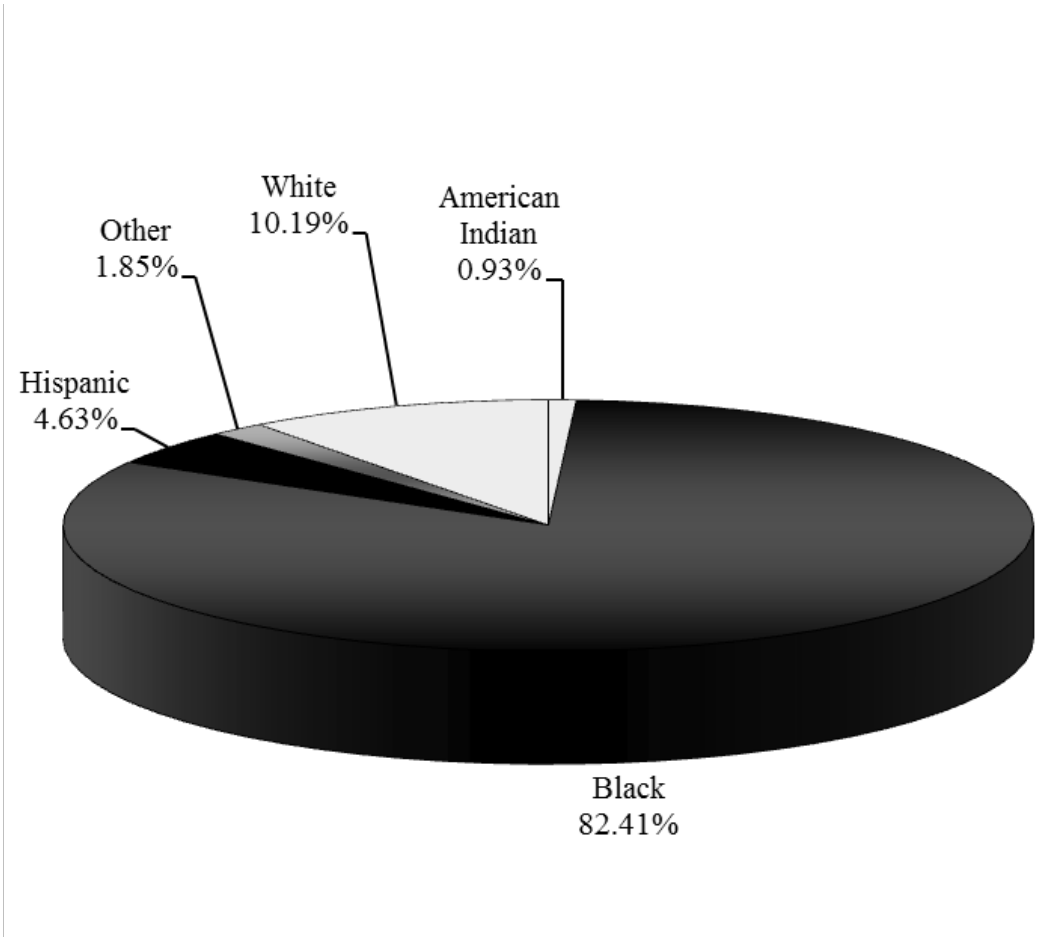
Graph - Homicides by Month



Homicides by Race

Race/Ethnicity	Number of Homicides	% of Homicides
Black	89	82.41%
White	11	10.19%
Hispanic	5	4.63%
Other	2	1.85%
American Indian	1	0.93%
Total	**108**	**100%**

Chart – Percentage of Homicides by Race



Homicides by Gender

Gender	Number of Homicides	% of Homicides
Male	94	87.04%
Female	14	12.96%
Total	**108**	**100%**

Homicides by Race/Ethnicity and Gender

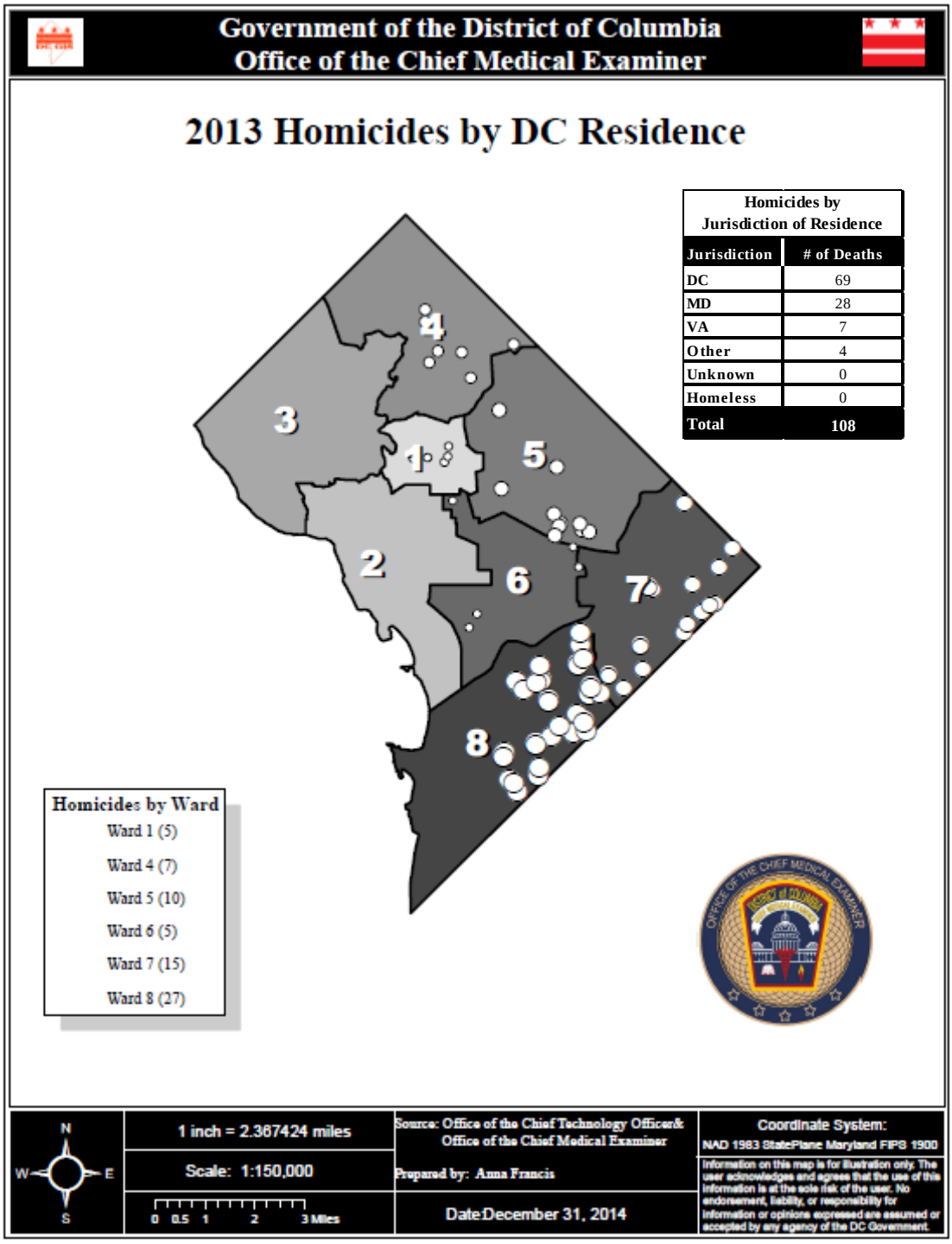
Race/Ethnicity by Gender	Number of Homicides
American Indian	**1**
Male	1
Female	0
Black	**89**
Male	78
Female	11
Hispanic	**5**
Male	5
Female	0
Other	**2**
Male	1
Female	1
White	**11**
Male	9
Female	2
Total	**108**

Homicides by Jurisdiction of Incident

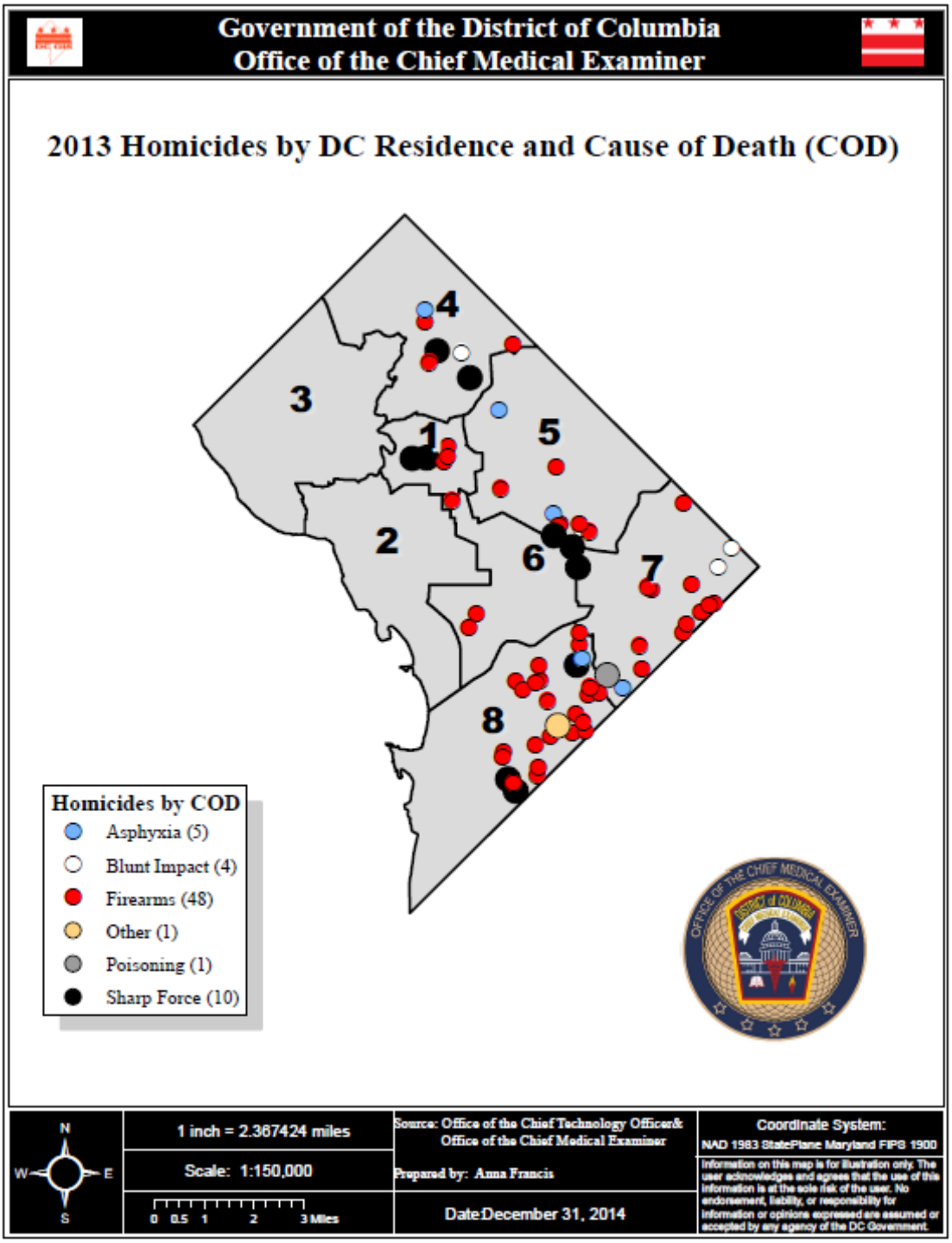
Jurisdiction of Incident	# of Homicides	% of Homicides
DC	94	87.04%
Maryland	9	8.33%
Virginia	1	0.92%
UNKNOWN	4	3.70%
Total	**108**	

Map of Homicides by DC Ward

Of the **108** homicides in the District of Columbia, sixty-nine (64%) of these decedents was District residents at the time of their death, as reported by their next of kin. The map below illustrates the residence location by District ward at the time of their death.



Map of Homicides by DC Ward and Cause of Death

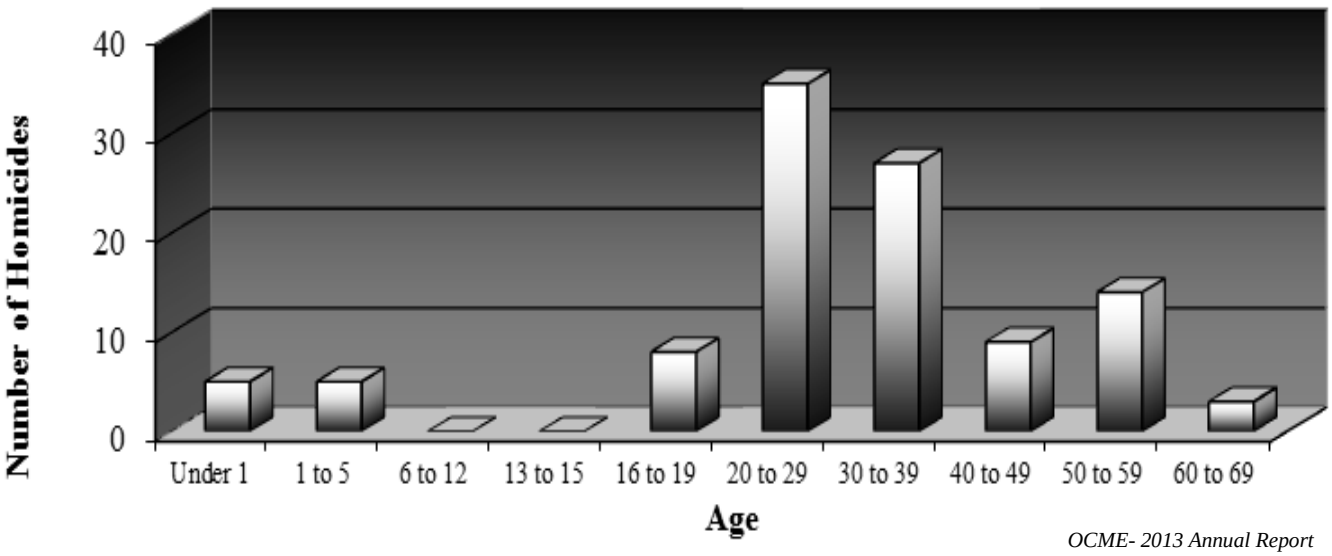


Homicides by Age

Age	# of Homicides	% of Homicides
Under 1	5	4.63%
1 to 5	5	4.63%
6 to 12	0	0.00%
13 to 15	0	0.00%
16 to 19	8	7.41%
20 to 29	35	32.41%
30 to 39	27	25.00%
40 to 49	9	8.33%
50 to 59	14	12.96%
60 to 69	3	2.78%
70 to 79	2	1.85%
80 to 89	0	0.00%
90 +	0	0.00%
Total	**108**	**100%**

Adolescent and Young Adult Homicides by Cause of Death				
	Under 1	**1 to 5**	**16 to 19**	**20 to 29**
Asphyxia	2	1	0	0
Blunt Impact	1	3	0	2
Firearms	0	0	8	31
Other	1	1	0	0
Poisoning	1	0	0	0
Sharpforce	0	0	0	2
Total	**5**	**5**	**8**	**35**

Chart - Homicides by Age Group



Toxicology Findings for Homicide Cases

Toxicology was performed on all 108 homicide cases investigated by OCME. All cases were screened for alcohol and drugs of abuse. Drugs were negative in 38 homicide cases. Of the remaining positive cases, 15.7% had more than one drug present.

Description	Number of Cases	% of Cases
N=	108	
Negative	38	35.1 %
Positive	70	64.8 %

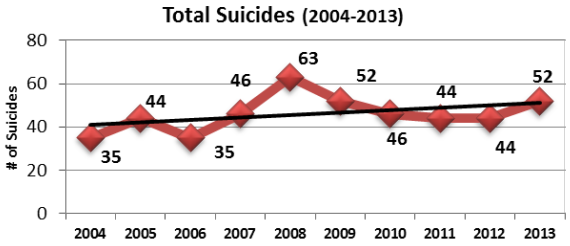
The most commonly detected drugs in the homicide cases were:

Name of Drug	Number of Cases	% of Homicide Cases
Ethanol	41	37.9 %
Marijuana Metabolites*	23	21.3 %
Phencyclidine (PCP)	8	7.4 %
Cocaine and metabolites	6	5.5 %
Promethazine	4	3.7 %
Morphine	3	2.7 %

*Marijuana metabolites are not confirmed in homicide cases.

2.2 - Suicides

The OCME investigated **52** suicides in CY 2013, which represents an **18.2%** increase from CY 2012 (44). Deaths by suicidal acts were more prevalent in white males and in persons between the ages of 40 to 49 years. **Hanging was the leading cause of suicidal deaths.** The majority of these incidents occurred in **August**.

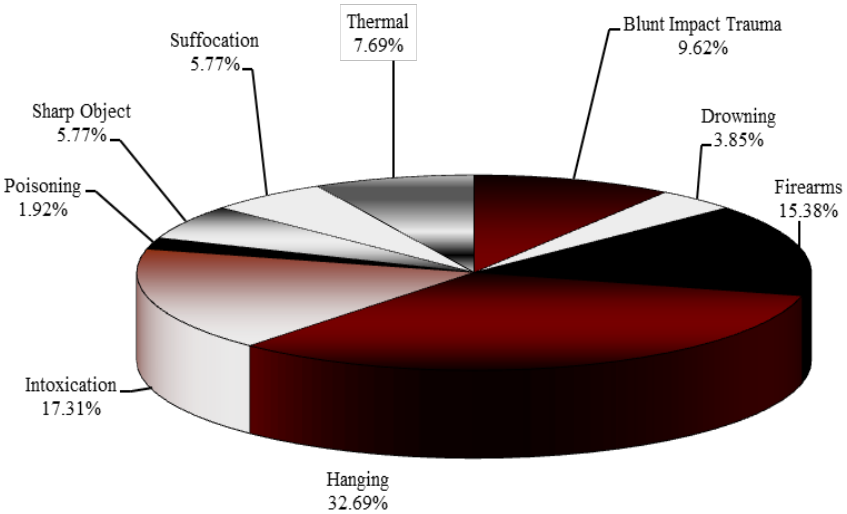


Suicides by Cause of Death

Cause	# of Sui-	% of Total Sui-
Blunt Impact Trauma • Bridge – 2 • Building –2 • Metro - 1	5	9.62%
Drowning	2	3.85%
Firearms	8	15.38%
Hanging	17	32.69%
Intoxication	9	17.31%
Poisoning	1	1.92%
Sharp Object	3	5.77%
Suffocation (Plastic Bag over head)	3	5.77%
Thermal Injury	4	7.69%
Total	**52**	100.00%

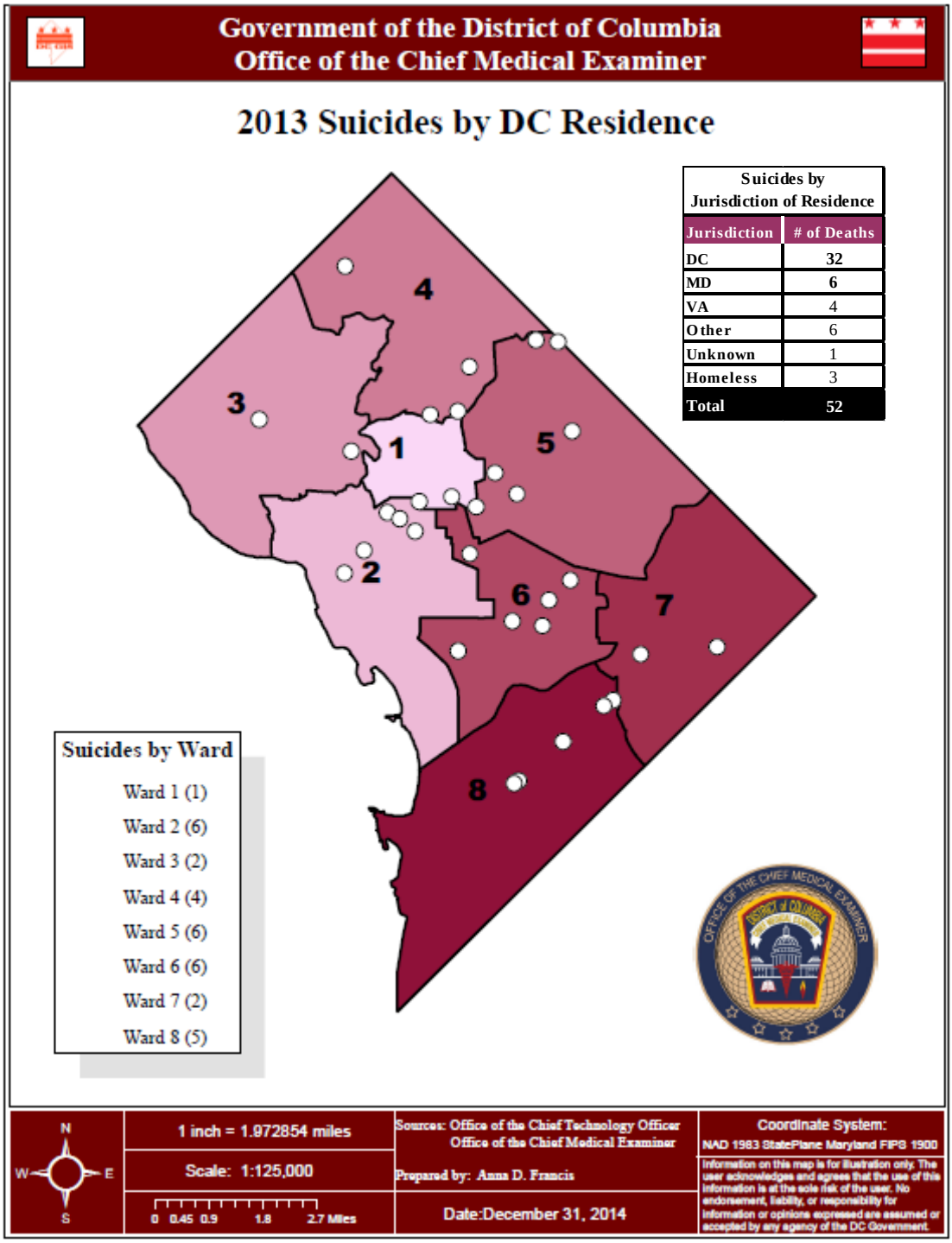
Note: The percentages in the "Pie Chart" are rounded up or down to nearest whole number.

Pie Chart - Suicides by Cause of Death



Map of Suicides by DC Ward

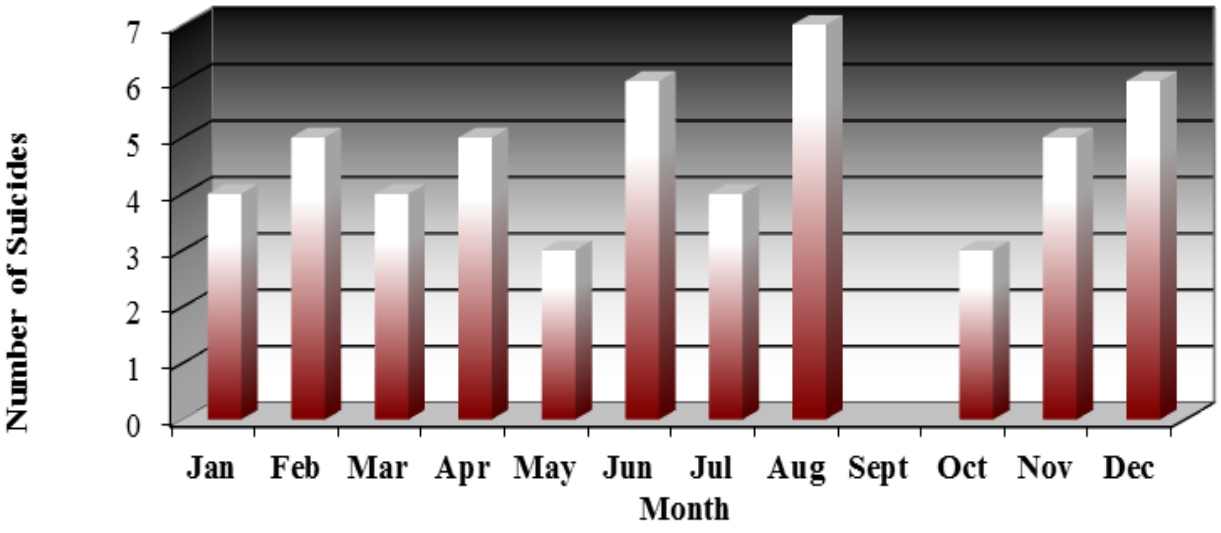
Of the **52** suicides in the District of Columbia thirty-two (62%) of these decedents were District residents at the time of their death, as reported by their next of kin. The map below illustrates the residence location by ward at the time of their death.



Suicides by Month

Month	Number of Suicides	% of Suicides
January	4	7.69%
February	5	9.62%
March	4	7.69%
April	5	9.62%
May	3	5.77%
June	6	11.54%
July	4	7.69%
August	7	13.46%
September	0	0.00%
October	3	5.77%
November	5	9.62%
December	6	11.54%
Total	**52**	**100%**

Chart- Suicides by Month



Suicide by Race/Ethnicity

Race/Ethnicity	Number of Suicides	% of Suicides
American Indian	1	1.92%
Asian	2	3.85%
Black	17	32.69%
Hispanic	3	5.77%
Other	3	5.77%
White	26	50.00%
Total	**52**	**100%**

Suicides by Race/Ethnicity and Gender

Race/Ethnicity by Gender	Number of Suicides
American 1ndian	**1**
Male	1
Female	0
Asian	**2**
Male	2
Female	0
Black	**17**
Male	14
Female	3
Hispanic	**3**
Male	3
Female	0
Other	**3**
Male	3
Female	0
White	**26**
Male	19
Female	7
Total	**52**

Suicides by Gender

Gender	Number of Suicides	% of Suicides
Female	10	19.23%
Male	42	80.77%
Total	**52**	**100%**

Suicides by Jurisdiction of Incident

Jurisdiction of Incident	Number of Suicides	% of Suicides
District of Columbia	44	84.62%
Maryland	4	7.69%
West Virginia	1	1.92%
Virginia	2	3.85%
Unknown	1	1.92%
Total	**52**	**100%**

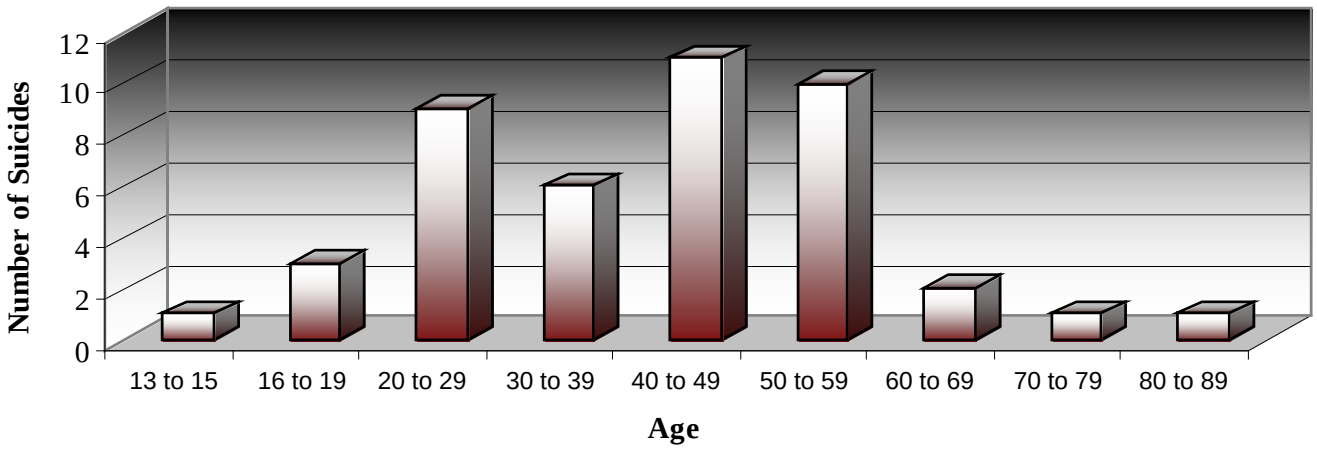
Suicide by Age

Age	Number of Suicides	% of Suicides
6 to 12	1	1.92%
13 to 15	2	3.85%
16 to 19	2	3.85%
20 to 29	7	13.46%
30 to 39	8	15.38%
40 to 49	13	25.00%
50 to 59	10	19.23%
60 to 69	6	11.54%
70 to 79	2	3.85%
80 to 89	1	1.92%
90 +	0	1.92%
Total	**52**	**100%**

Adolescent and Young Adult Suicides by Cause of Death

	6 to 12	13 to 15	16 to 19	20 to 29
Drowning	0	0	0	1
Firearms	0	0	1	2
Hanging	1	2	0	0
Intoxication	0	0	1	0
Poisoning	0	0	0	1
Suffocation	0	0	0	2
Thermal Injury	0	0	0	1
Total	**1**	**2**	**2**	**7**

Chart - Suicides by Age



Toxicology Findings for Suicide Cases

Toxicology analysis was performed on all 52 of the suicide cases investigated by OCME. Drugs were negative in 16 of these cases. Of the remaining positive cases, 26.9 % had more than one drug present.

Description	Number of Cases	% of Cases
N=	52	
Negative	16	30.7 %
Positive	36	69.2 %

The most notable detected drugs in suicide cases were:

Name of Drug	Number of Cases	% of Suicide Cases
Ethanol	11	21.1 %
Zolpidem	5	9.6 %
Morphine	5	9.6 %
Oxycodone	4	7.6 %

2.3 - Accidents

OCME investigated **316** accidental deaths in CY 2013. Of the **316** cases investigated, **51** were related to motor vehicle accidents - **98** of the Accidental deaths were the direct result of prescription and/or illicit drug use. The majority of incidents occurred in **December**.

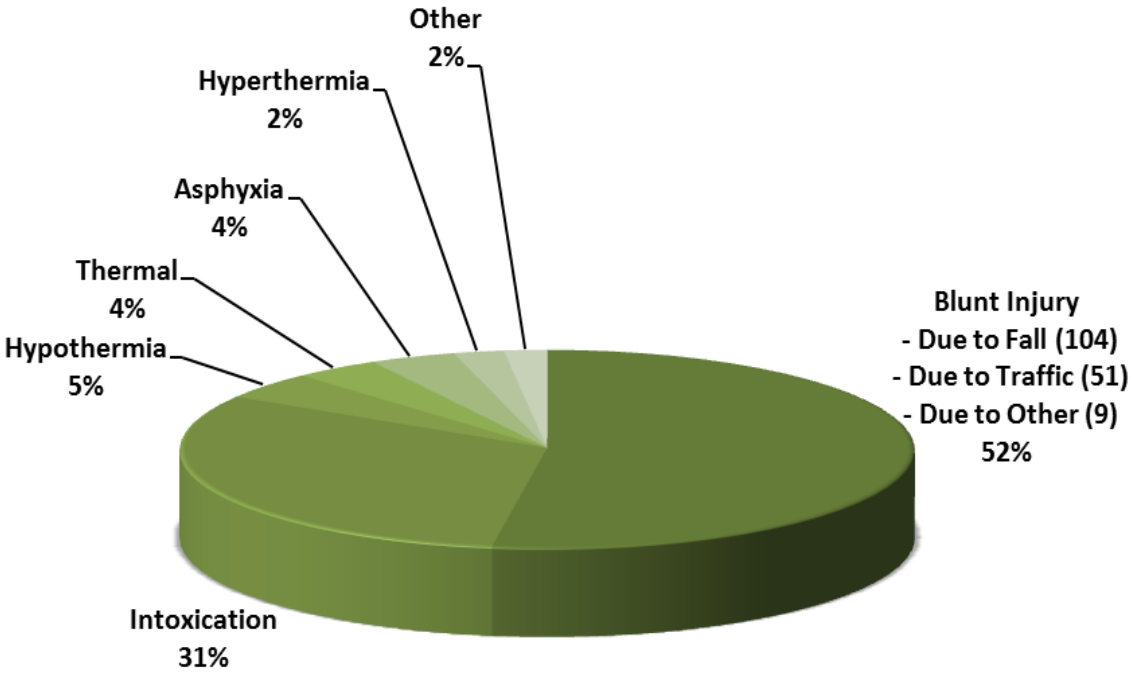
Accidents by Cause of Death

Cause	# of Deaths	% of Accidents
Blunt Injury - Due to Fall (104) - Due to Other (9) - Due to Traffic (51)	164	52.06%
Intoxication	98	31.11%
Hypothermia	14	4.44%
Asphyxia	13	3.81%
Thermal	12	3.81%
Hyperthermia	7	2.22%
Other	6	1.90%
Cardiovascular	1	0.32%
Therapeutic Complications	1	0.32%
Total	**316**	**100%**

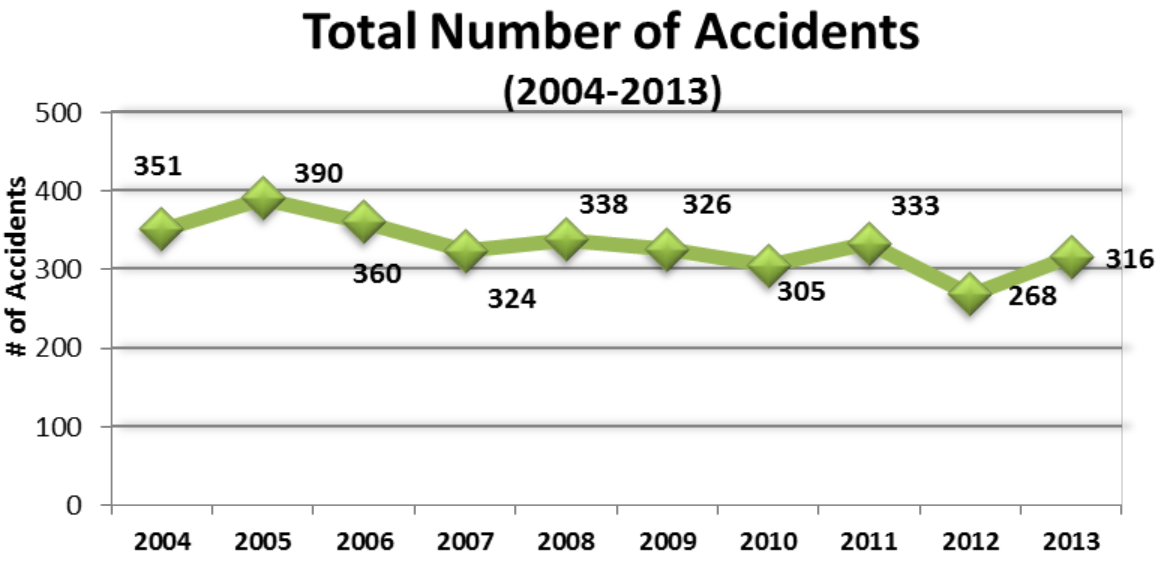
Accidental Falls	
Age Group	Number of Accidental Falls
20 to 29	1
30 to 39	3
40 to 49	5
50 to 59	4
60 to 69	10
70 to 79	15
80 to 89	41
90 and Over	25
Total	104

Decedents 60 and over represented 87% of all Accidental Deaths due to Falls

Pie Chart - Accidents by Cause of Death[2]



Graph – Five-year Overview of Accidents

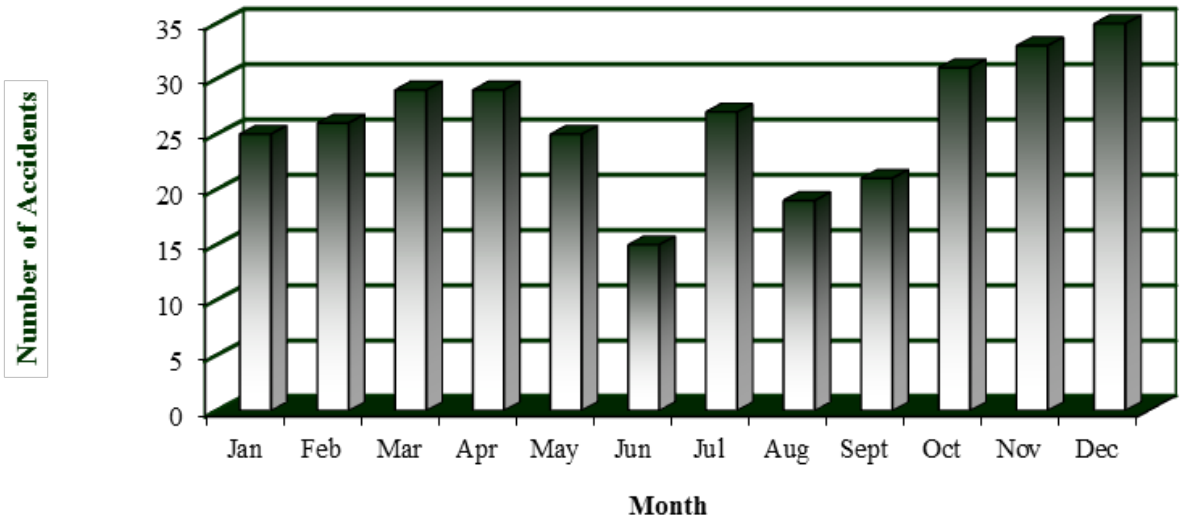


[2] For illustrative purposes this pie chart does not include causes of death that are 1% or less of the total number of deaths.

Accidents by Month

Month	Number of Deaths	% of Accidents
January	25	7.94%
February	26	8.25%
March	29	9.21%
April	29	9.21%
May	25	7.94%
June	15	4.76%
July	27	8.57%
August	19	6.03%
September	21	6.67%
October	32	9.84%
November	33	10.48%
December	35	11.11%
Total	**316**	**100%**

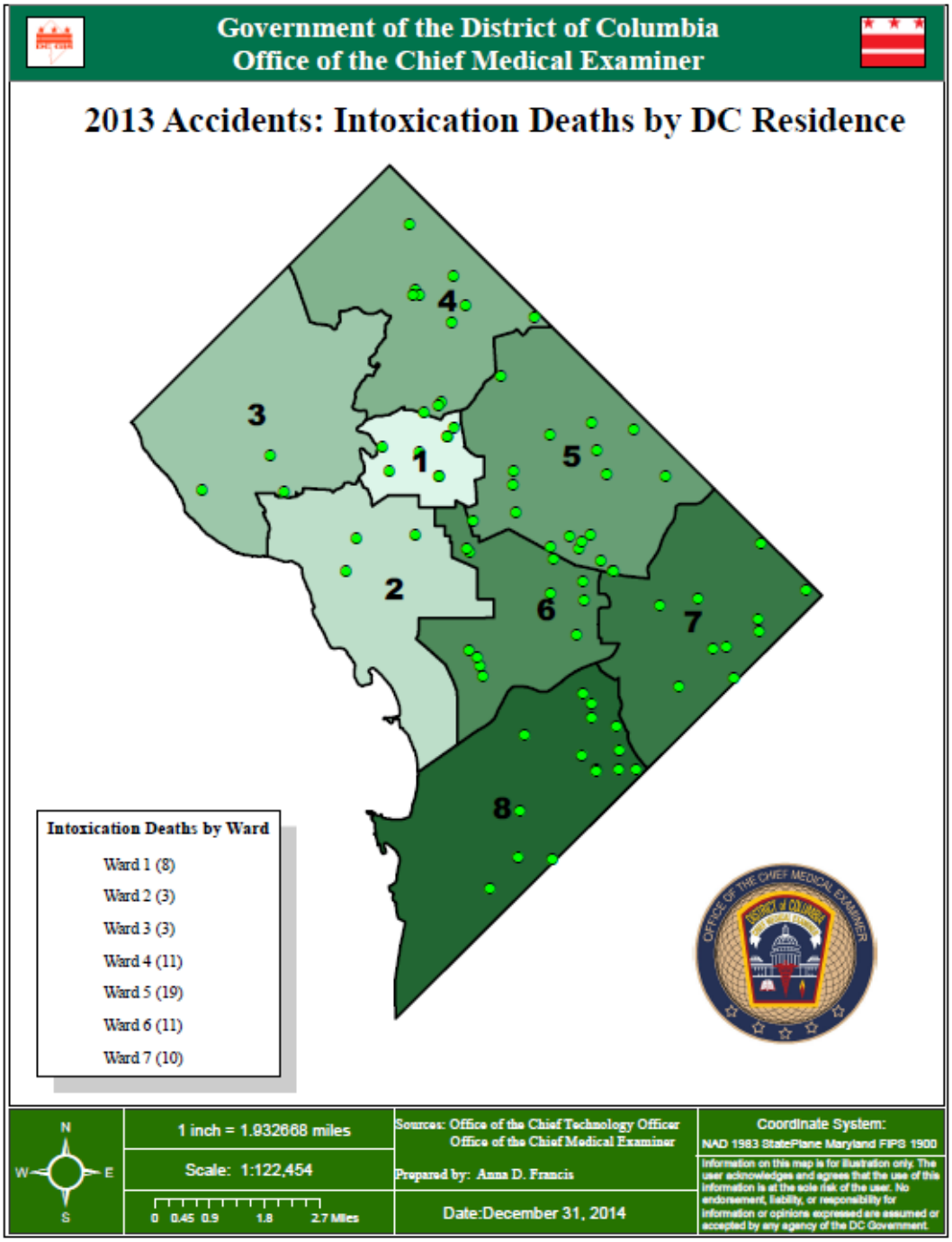
Chart - Accidents by Month of Death



Map of Intoxication Deaths by DC Ward

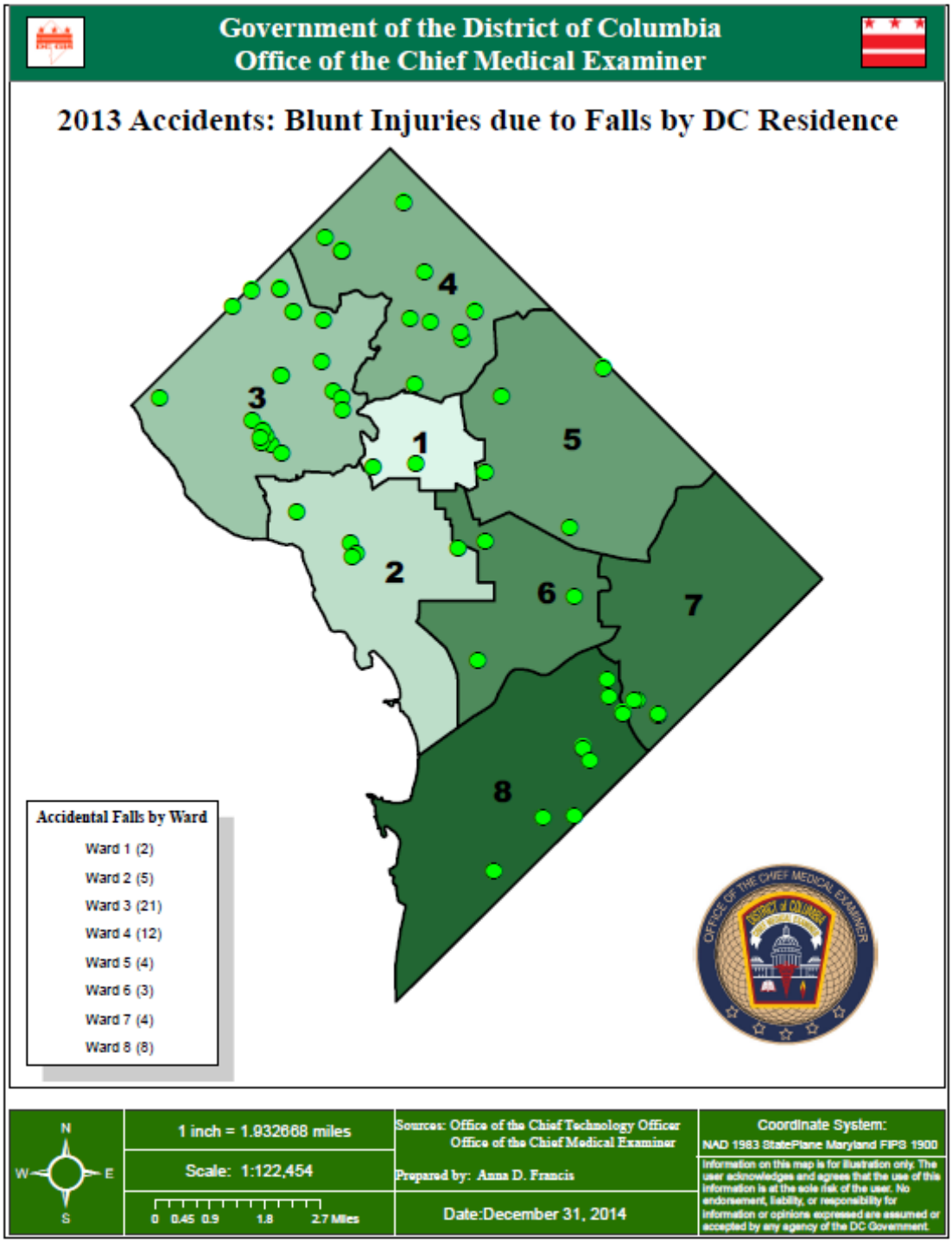
There was a total of **98** Accidental Intoxication Deaths in the District of Columbia in 2013, of which sixty-five (66%) were residents of the District of Columbia. The map below illustrates the location of the decedent's residence by ward at the time of their death, as reported by the decedent's next of kin.

Accidents by Jurisdiction of Residence	
Jurisdiction	**# of Deaths**
DC	**197**
MD	**82**
VA	18
Other	8
Unknown	0
Homeless	11
Total	**316**



Map of Blunt Injuries due to Falls by DC Ward

There was a total of **104** Accidental Deaths caused by Blunt Injuries due to Falls in the District of Columbia in 2013, of which fifty-nine (57%) were residents of the District of Columbia. The map below illustrates the location of the decedent's residence by ward at the time of their death, as reported by the decedent's next of kin.



Accidental Deaths by Race

Race/Ethnicity	Number of Accidents	% of Accidents
Asian	3	0.95%
Black	188	59.68%
Hispanic	16	5.08%
Other	4	0.95%
White	105	33.33%
Total	**316**	**100%**

Accidental Deaths by Gender

Gender	Number of Accidents	% of Accidents
Female	115	36.51%
Male	200	63.49%
Total	**315**	**100%**

Accidental Deaths by Age

Age	Number of Accidents	% of Accidents
Under 1	0	1.59%
1 to 5	5	1.59%
6 to 12	5	0.00%
13 to 15	0	0.63%
16 to 19	2	7.94%
20 to 29	25	7.30%
30 to 39	23	10.79%
40 to 49	34	19.05%
50 to 59	60	15.56%
60 to 69	49	8.89%
70 to 79	28	15.24%
80 to 89	48	11.43%
90 +	36	1.59%
Total	**315**	**100%**

Toxicology Findings for Accident Cases

Of the 315 Accident Deaths investigated by OCME, toxicology analysis was performed in 214 cases. Drugs were negative in 37 accident cases. Of the remaining positive cases, 58.9% had more than one drug present.

Description	Number of Cases	% of Cases
N=	214	
Negative	37	17.2 %
Positive	177	82.7 %

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

Name of Drug	Number of Cases	% of Accident Cases
Ethanol	61	28.5 %
Morphine/Heroin	57	26.6 %
Cocaine and Metabo-lites	51	23.8 %
Marijuana metabolites*	18	8.4 %
Phencyclidine	16	7.4 %
Methadone	11	5.1 %
Diazepam	8	3.7
Oxycodone	7	3.2
Acetone	7	3.2%

*Marijuana metabolites are confirmed depending on case history

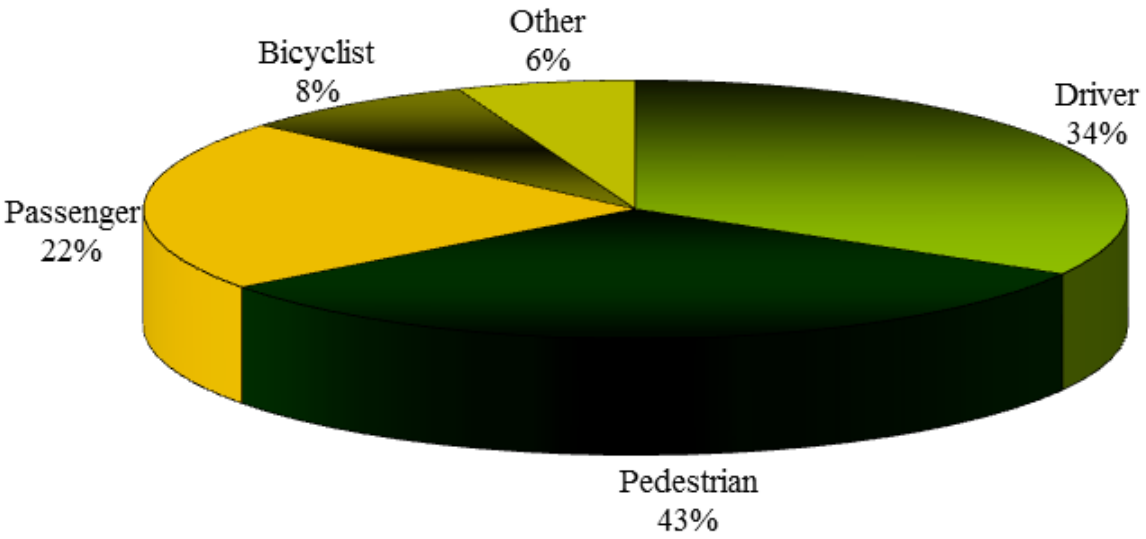
2.3.1 – Traffic Deaths

Of the **51** traffic related deaths certified by the OCME in Calendar Year 2013 the majority involved pedestrians and decedents between the ages of 20 to 29. Most of the traffic fatalities occurred in February.

Role of the Decedent in Traffic Death

Role	Traffic Deaths	% of Traffic Deaths
Pedestrian	16	31.37%
Driver *- Motor Vehicle(13)* *- Motorcycle (3)* *- All Terrain(1)*	17	33.33%
Passenger *- Motor Vehicle (11)*	11	21.57%
Bicyclist	4	7.84%
Other *- Role Unknown (2)* *- Skateboarder (1)*	3	5.88%
Total	**51**	**100%**

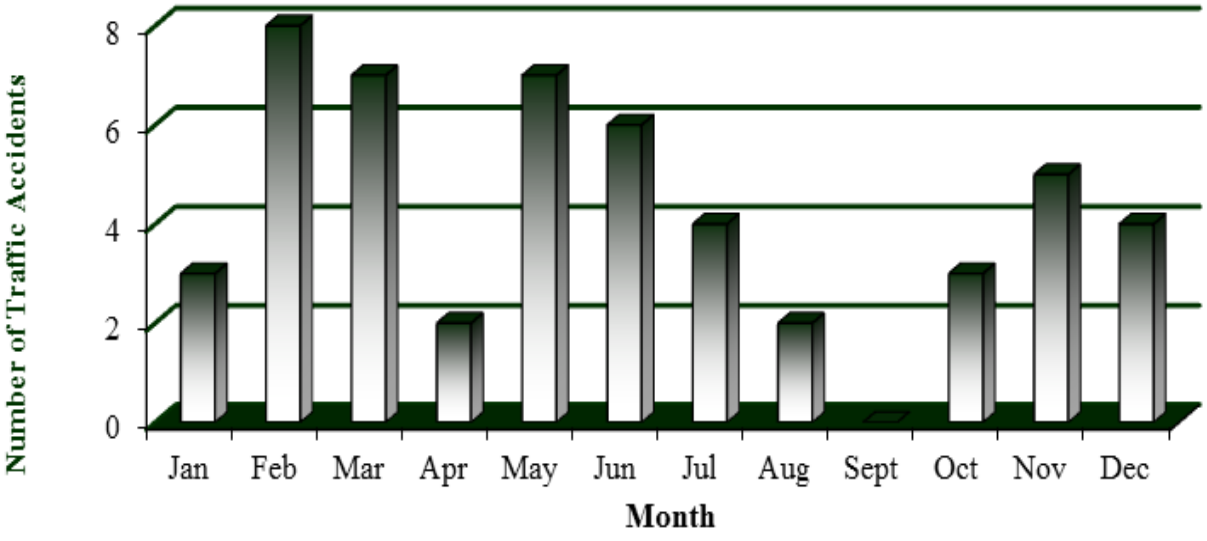
Pie Chart - Role of Decedent in Traffic Accident



Traffic Deaths by Month

Month	Number of Traffic Accidents	% of Traffic Accidents
January	3	5.88%
February	8	15.69%
March	7	13.73%
April	2	3.92%
May	7	13.73%
June	6	11.76%
July	4	7.84%
August	2	3.92%
September	0	0.00%
October	3	5.88%
November	5	9.80%
December	4	7.84%
Total	**51**	**100%**

Chart - Traffic Deaths by Month



Traffic Deaths by Race

Race	# of Traffic Deaths	% of Traffic Deaths
Asian	1	1.96%
Black	27	52.94%
Hispanic	4	7.84%
White	19	37.25%
Total	**51**	**100%**

Traffic Deaths by Gender

Gender	# of Traffic Deaths	% of Traffic Deaths
Female	19	37.25%
Male	32	62.75%
Total	**51**	**100%**

Traffic Deaths by Age

Age	# of Traffic Deaths	% of Traffic Deaths
1 to 5	5	9.80%
6 to 12	2	3.92%
13 to 15	0	0.00%
16 to 19	1	1.96%
20 to 29	12	23.53%
30 to 39	8	15.69%
40 to 49	5	9.80%
50 to 59	4	7.84%
60 to 69	3	5.88%
70 to 79	5	9.80%
80 to 89	1	1.96%
90 +	5	9.80%
Total	**51**	**100%**

Note:

Traffic Deaths by Jurisdiction of Incident

Jurisdiction of Incident	Number of Traffic Deaths	% of Traffic Deaths
District of Columbia	25	49.02%
Maryland	19	37.25%
Virginia	3	5.88%
Unknown	4	7.84%
Total	**51**	**100%**

Toxicology Findings for Traffic Accident Cases

Of the 51 Traffic-related deaths investigated by OCME, toxicology analysis was performed in 45 cases. Drugs were negative in 17 traffic accident cases. Of the remaining positive cases, 15.5% had more than one drug present.

Description	Number of Cases	% of Cases
N=	45	
Negative	17	37.7 %
Positive	28	62.2 %

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

Name of Drug	Number of Cases	% of Traffic Cases
Ethanol	13	28.8 %
Marijuana Metabolite	8	17.7 %
Morphine	3	6.6 %
Cocaine and Metabolites	3	6.6 %
Phencyclidine	2	4.4 %

In the 13 traffic deaths positive for ethanol, 6 were greater than the legal limit (0.08 g/100 mL) for driving under the influence in the District of Columbia

2.3.2 – Toxicology Findings for Deaths due to Drug Overdose

There were **98** OCME cases where death was directly related to drug abuse, of which toxicology analysis was performed in 96 of these cases. In the two cases where no toxicology was submitted – both were originally "*Cremation Requests*" that were converted to Medical Examiner cases, of which one was an "External Examination" and the other was a "Review of Medical Records".

Prevalence: The most prevalent drug in the population was heroin alone or in combination with other drugs. Drugs were present in all overdose cases. Of the positive cases, **73.9 %** had more than one drug present. In addition, of the 25 cases which were positive for alcohol, all but one had at least one additional drug present. **16.6 %** of cases were positive for both cocaine and heroin.

Mixed Drug Toxicity: There were a total of 28 cases or 29% of all Drug Overdose deaths resulted from mixed drug toxicity. The breakdown by "Cause of death" is as follows:

Cause of Death as stated on Death Certificate	# of Deaths
Mixed drug intoxication	10
Acute Intoxication by the combined effects of…	5
Combined Toxic Effects of…	13

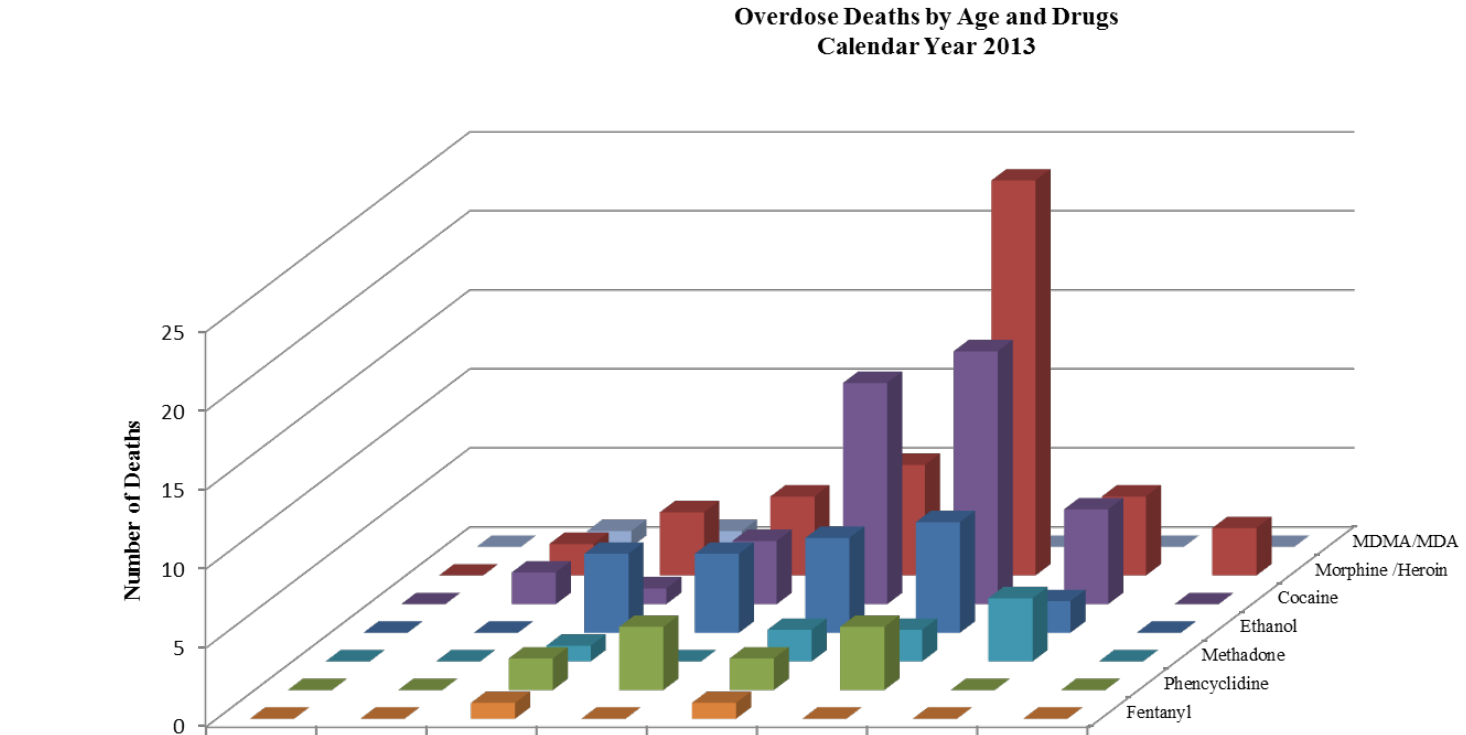
Description	Number of Cases	% of Cases
N=	96	
Negative	0	0 %
Positive	96	100.0 %

The most commonly detected drugs in drug overdose cases were:

Contributing Drugs	Number of Cases	% of Cases
Morphine/Heroin	51/42	53.1%/43.7%
Cocaine and Metabolites	43	44.7 %
Ethanol	25	26.0 %
Phencyclidine (PCP)	12	12.5 %
Methadone	9	9.3 %
MDMA	2	2.0 %
Fentanyl	2	2.0 %

Accidental Drug Overdose Fatalities by Age

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

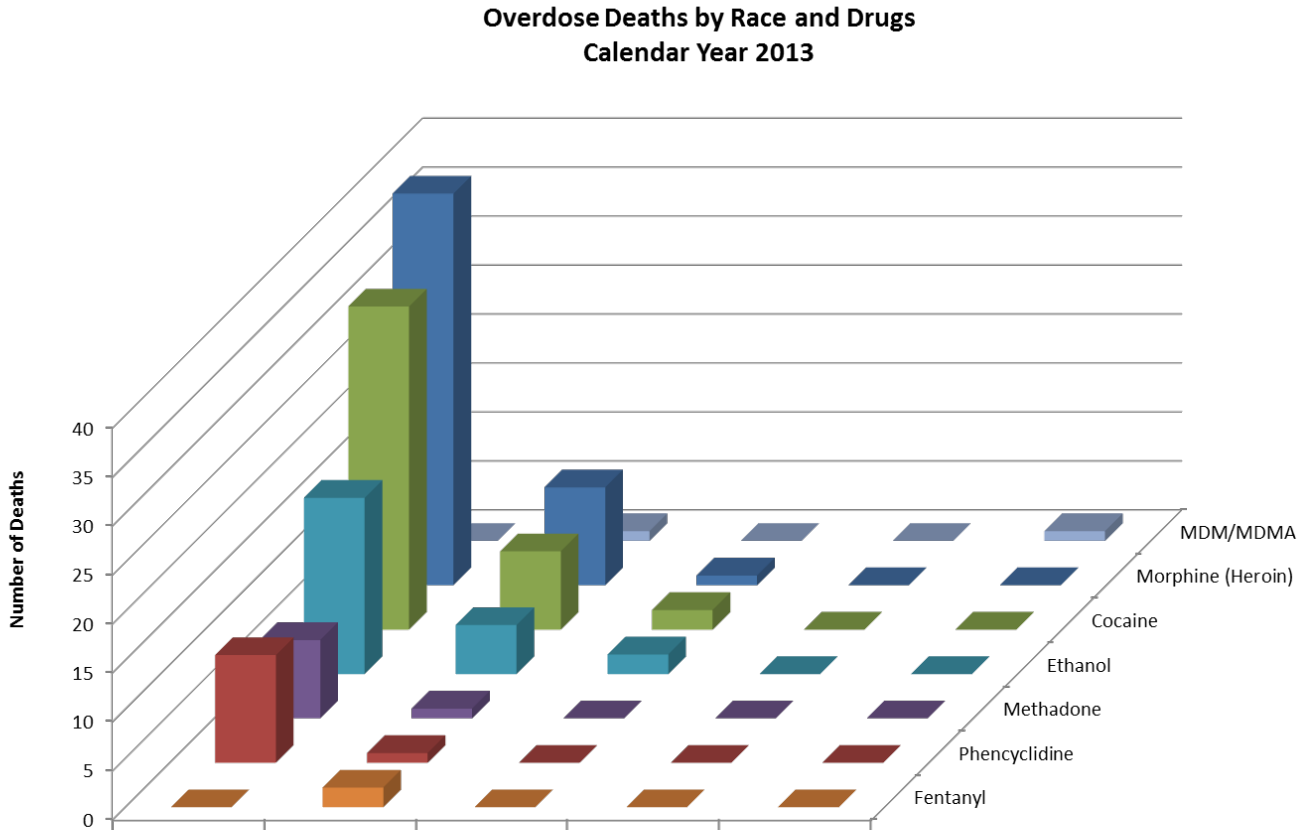


	0-10 (N=0)	11-20 (3)	21-30 (10)	31-40 (10)	41-50 (22)	51-60 (35)	61-70 (13)	71-80 (3)
Fentanyl	0	0	1	0	1	0	0	0
Phencyclidine	0	0	2	4	2	4	0	0
Methadone	0	0	1	0	2	2	4	0
Ethanol	0	0	5	5	6	7	2	0
Cocaine	0	2	1	4	14	16	6	0
Morphine /Heroin	0	2	4	5	7	25	5	3
MDMA/MDA	0	1	1	0	0	0	0	0

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

Accidental Drug Overdose Fatalities by Race

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



	Black (N=75)	White (17)	Hispanic (3)	Asian (0)	Others (1)
Fentanyl	0	2	0	0	0
Phencyclidine	11	1	0	0	0
Methadone	8	1	0	0	0
Ethanol	18	5	2	0	0
Cocaine	33	8	2	0	0
Morphine (Heroin)	40	10	1	0	0
MDM/MDMA	0	1	0	0	1

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

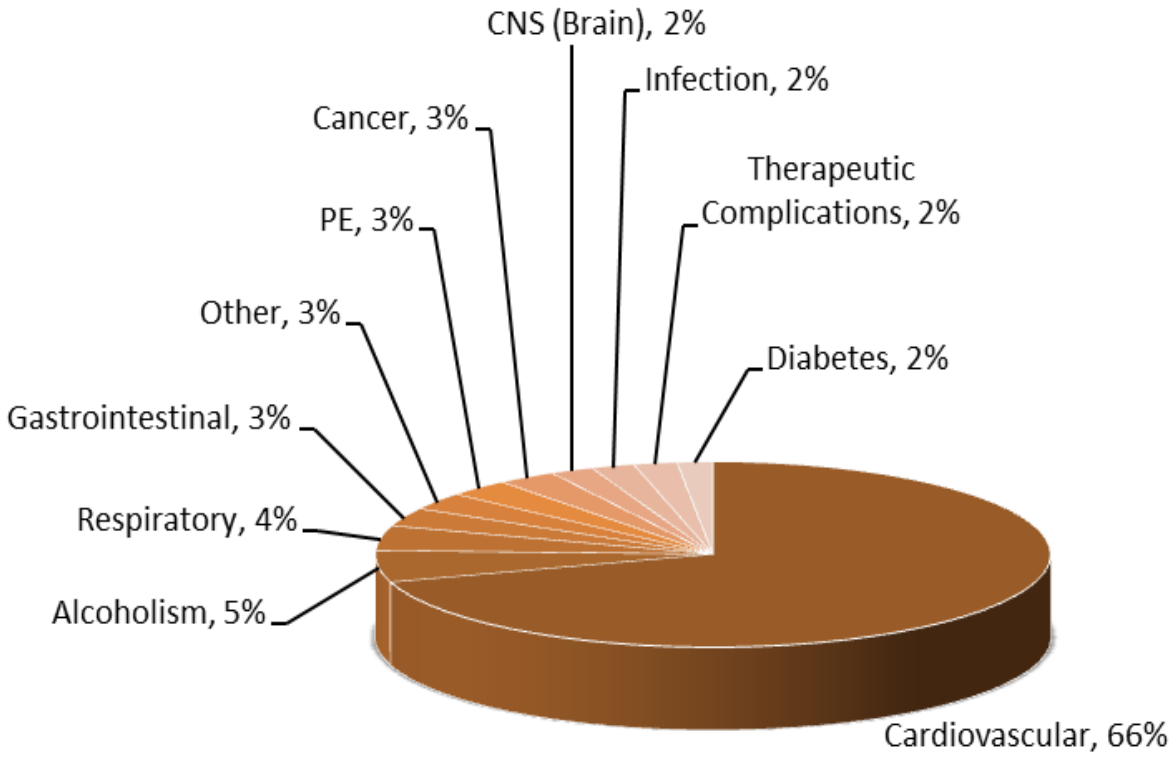
2.4 – Natural Deaths

Natural Deaths continue make up the majority of cases reported to and accepted by the Office of the Chief Medical Examiner. In 2013 **559** deaths were determined to be as a result of natural disease. 61% of Natural Death Cases required autopsy examination. Deaths caused by Cardio-vascular Diseases continue to dominate in this category with **371** fatalities. Deaths due to the complications of alcohol abuse were a far second with **29** deaths. Blacks were more prevalent in this category representing **77 %** of the population affected. The majority of Natural deaths occurred in **March.**

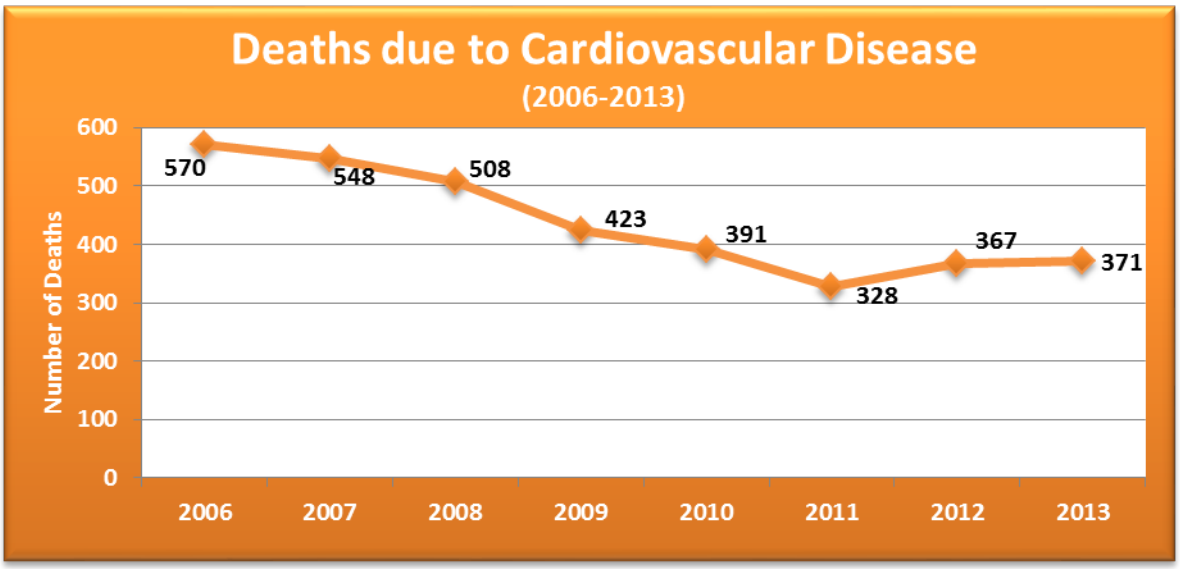
Natural Deaths by Cause

Cause/Disease	Number of Deaths	% Of Total Natural Deaths
Cardiovascular Disease	371	66.37%
Alcoholism	29	5.19%
Respiratory Diseases	23	4.11%
Gastrointestinal Disease	17	3.04%
Other	16	2.86%
Pulmonary Embolism (PE)	16	2.86%
Cancer	15	2.68%
Central Nervous System Diseases (CNS)	11	1.97%
Infection	11	1.97%
Therapeutic Complications (TC)	11	1.97%
Diabetes	9	1.61%
Obesity or Complications of Obesity	8	1.43%
Complications of Drug Abuse	7	1.25%
Connective Tissue Disease	4	0.72%
Blood Disease/Hemopoietic System	3	0.54%
Infectious Disease	3	0.54%
Complications of Pregnancy	2	0.36%
Genetic Disorder	2	0.36%
AIDS	1	0.18%
Total	**559**	**100%**

Pie Chart – Natural Deaths by Cause

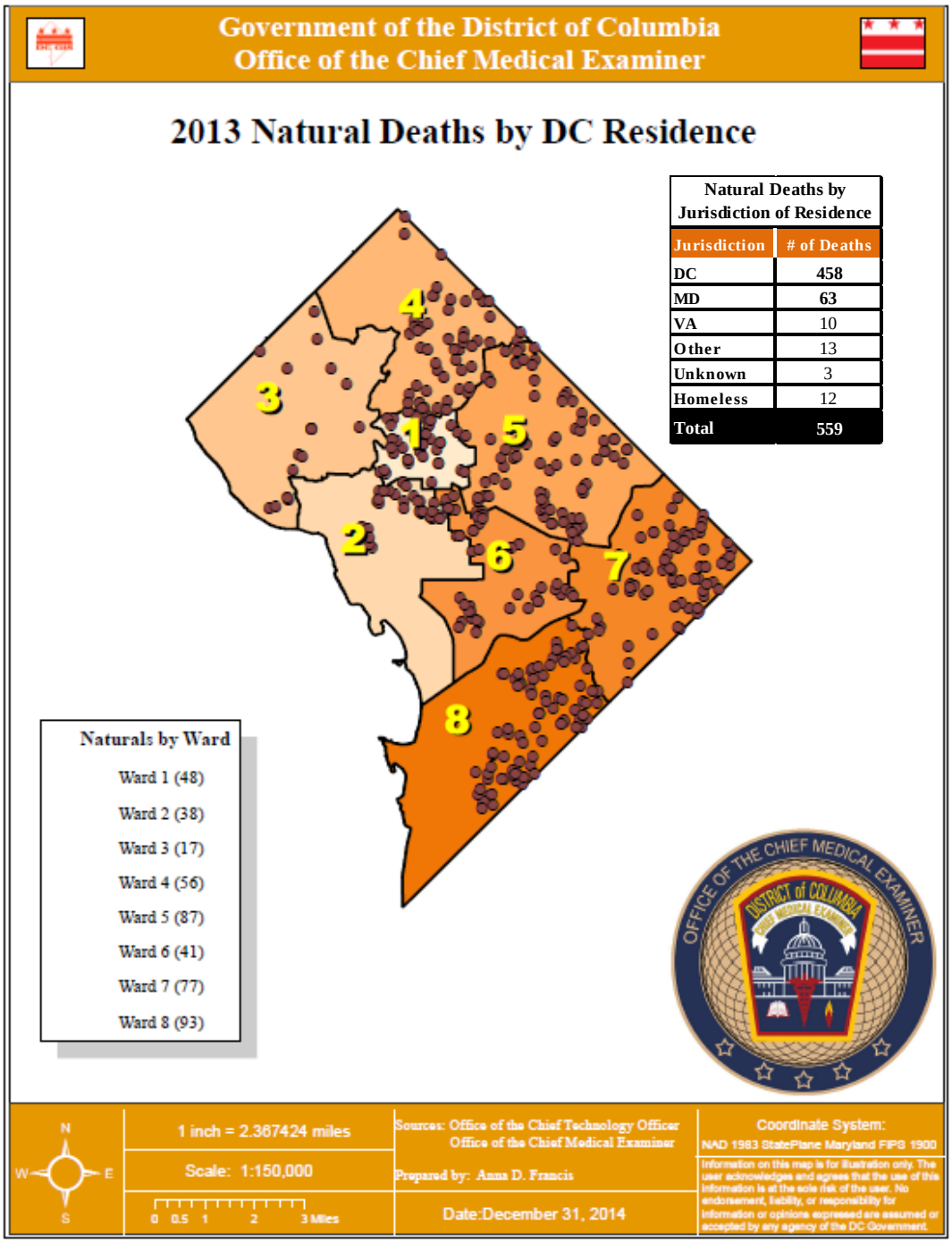


Note: Causes of Death that are less than 2% are not included in this chart.



Map of Natural Deaths by DC Ward

Of the **559** Natural deaths in the District of Columbia 458 (82%) of these decedents were District residents at the time of their death, as reported by their next of kin. The map below illustrates the residence location by ward at the time of their death.

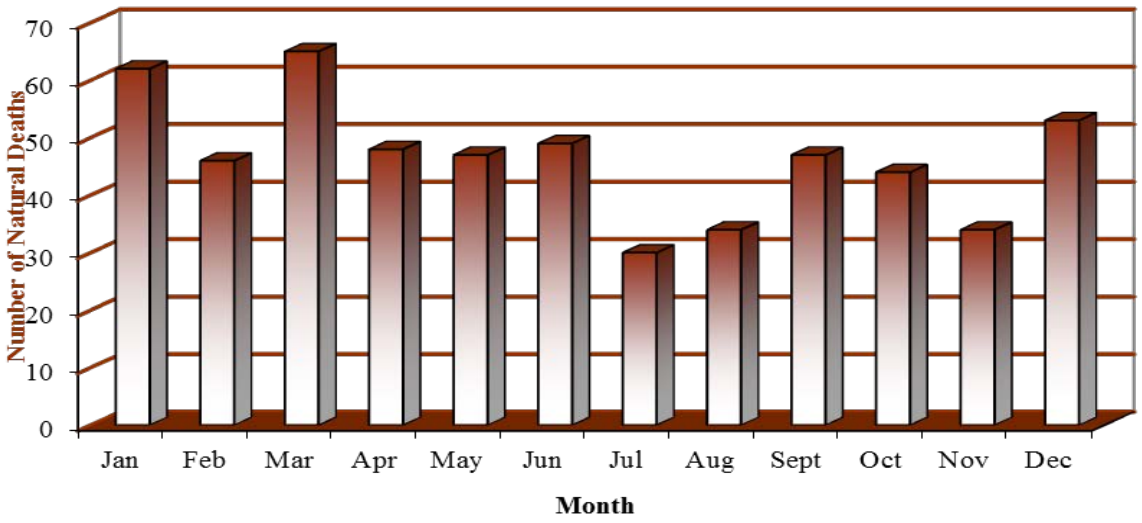


Note: There is one decedent who died of "Natural" causes in Ward 8 whose residential address is not represented within the Geographical Information System for the District of Columbia, so as a result there were actually 94 Natural Deaths in Ward 8 that were investigated by the OCME.

Natural Deaths by Month

Month	Number of Deaths	% of Naturals
January	62	11.09%
February	46	8.23%
March	65	11.63%
April	48	8.59%
May	47	8.41%
June	49	8.77%
July	30	5.37%
August	34	6.08%
September	47	8.41%
October	44	7.87%
November	34	6.08%
December	53	9.48%
Total	**559**	**100%**

Chart- Natural Deaths by Month



Natural Deaths by Exam Type

ExamType	# of Natural Deaths	% of Natural Deaths
Autopsy	292	52%
Autopsy (At Hospital)	4	1%
External Exam	208	37%
Partial	48	9%
Review Medical Records	7	1%
Total	**559**	**100%**

Natural Deaths by Race

Race	Number of Natural Deaths	% of Natural Deaths
Pacific Islander	1	0.18%
Asian	6	1.07%
Black	431	77.10%
Hispanic	15	2.68%
Other	7	1.25%
Unknown	2	0.36%
White	97	17.35%
Total	**559**	**100%**

Natural Deaths by Gender

Gender	Number of Natural Deaths	% of Natural Deaths
Female	207	37.03%
Male	352	62.97%
Total	**559**	**100%**

Natural Deaths by Age

Age	# of Natural Deaths	% of Natural Deaths
Under 1	6	1.07%
1 to 5	2	0.36%
6 to 12	6	1.07%
13 to 15	0	0.00%
16 to 19	1	0.18%
20 to 29	11	1.97%
30 to 39	25	4.47%
40 to 49	65	11.63%
50 to 59	142	25.40%
60 to 69	153	27.37%
70 to 79	77	13.77%
80 to 89	52	9.30%
90 +	19	3.40%
Total	**559**	**100%**

2.4.1 - Body Mass Index (BMI)

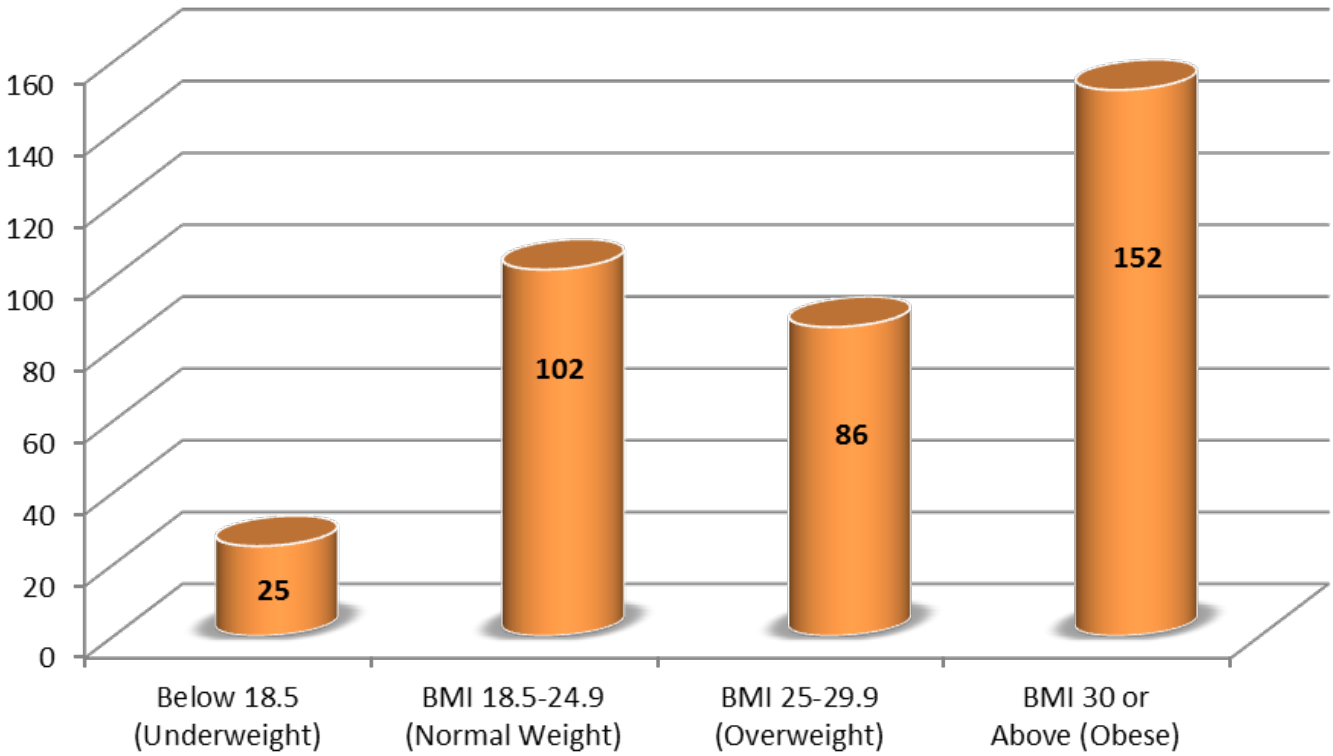
The World Health Organization (WHO) defines Body Mass Index (BMI) as a "simple index of weight-for-height that is commonly used to classify overweight and obesity in adults. According to the National Institutes of Health (NIH) a normal BMI range is from 18.5 to 24.9. Obesity has emerged as a leading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

There were a total of **544** adult decedents that the Office of the Chief Medical Examiner certified as natural deaths, of which 370 were due to cardio vascular disease, of which three were an exam type "Review of Medical Records" and two were authorized to be autopsied at an area hospital, so as a result the below statistics will represent 365 decedents that died as a result of a Cardiovascular Disease.

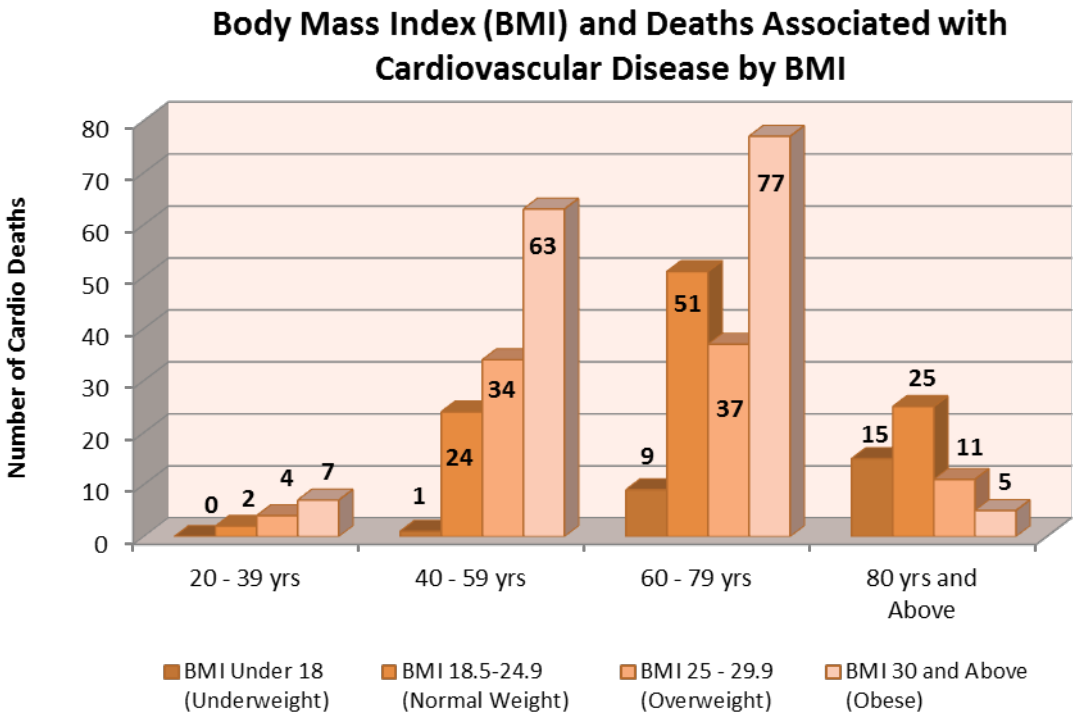
BMI and Deaths Associated with Cardiovascular Disease (CD)[3]

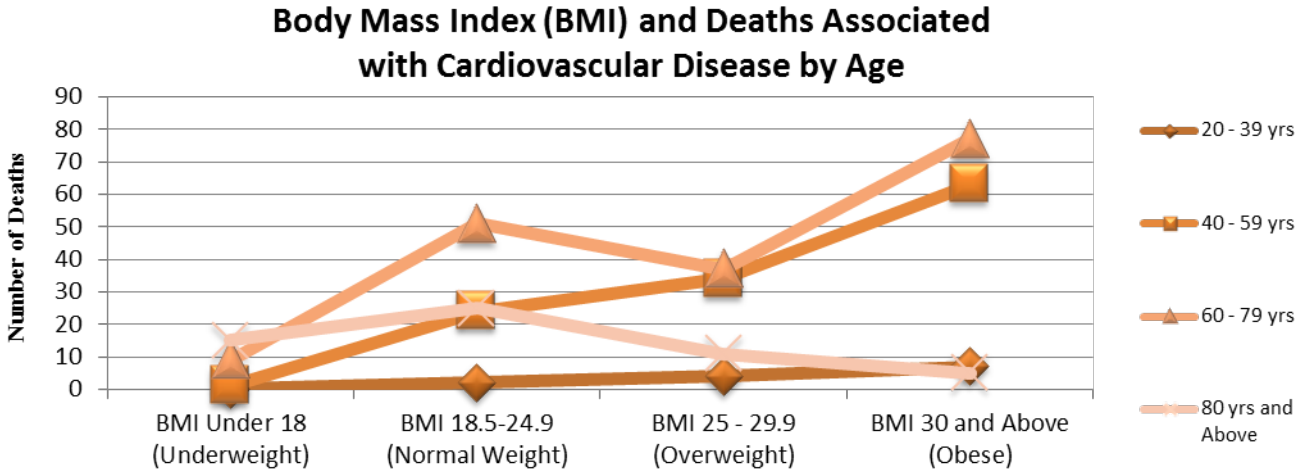
(Adults only)

The charts below provide a breakdown of all adult decedents by BMI classification, by age and by race as related to the prevalence of cardiovascular disease. Of the adult decedents that died of complications of Cardiovascular Disease **152** were obese and **86** were overweight.



BMI and Heart Disease by Age (Adults only)

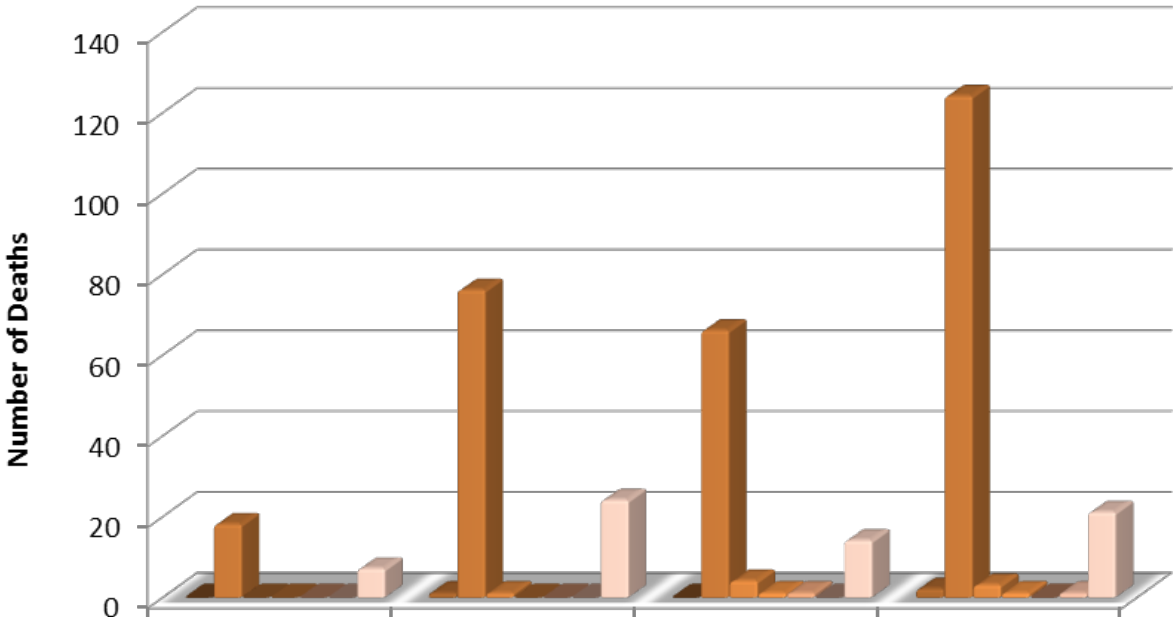




[3] The BMI statistics only include OCME cases where the body came into the office and a height and weight was obtained; therefore cases with following exam types are not included: Review of Medical Records, and Autopsy at hospital.

BMI for Adult Decedents with Heart Disease by Race

Of the 238 decedents above the normal weight in 2013, **80%** were Black/African American **15%** were White, **3%** were Hispanic and those races that were Asian and Other were both **2%**. The chart below displays the BMI data by race.



	Below 18.5 (Underweight)	BMI 18.5-24.9 (Normal Weight)	BMI 25-29.9 (Overweight)	BMI 30 or Above (Obese)
Asians	0	1	0	2
Blacks	18	76	66	124
Hispanics	0	1	4	3
Other	0	0	1	1
Pacific Islander	0	0	1	0
Unknown	0	0	0	1
Whites	7	24	14	21

2.5 – Undetermined Deaths

Undetermined by Cause of Death

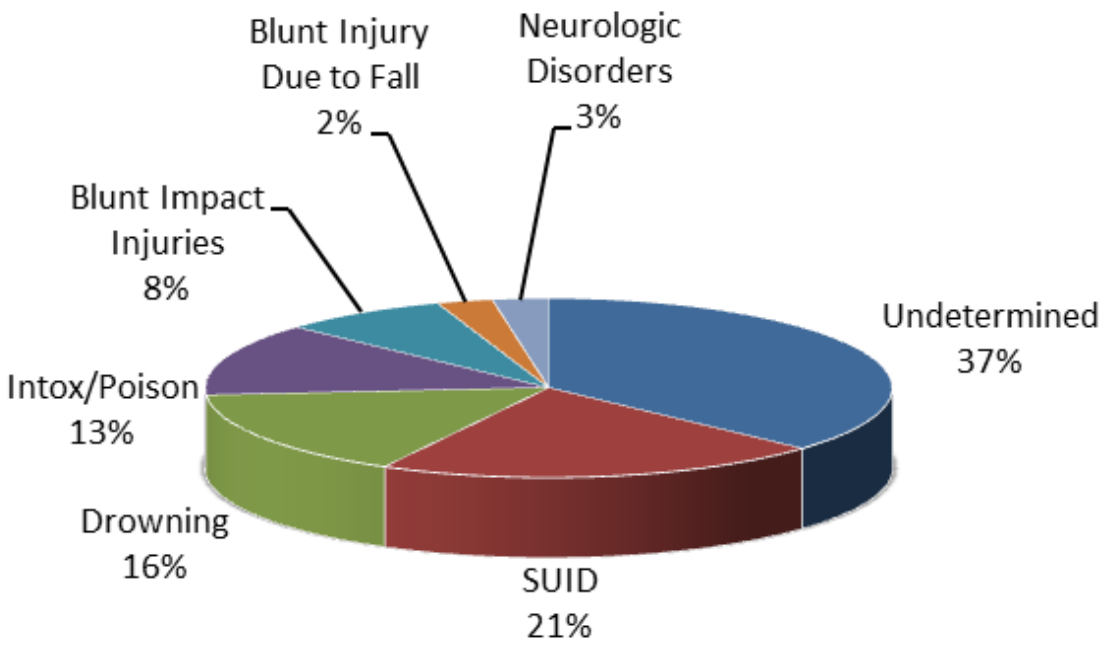
The OCME investigated **38** cases in which the manner of death was certified as "Undetermined," in fourteen (**14)** of these cases the cause of death was also certified as "Undetermined". Undetermined cases make up 4% of the total accepted caseload for OCME.

An "Undetermined" manner of death is established when there is (1) inconclusive or incomplete evidence/investigative information as to the circumstances surrounding death, (2) there are competing/conflicting injury or disease findings at autopsy that prohibits the clear definition of manner. The manner of death can be amended when/if additional information becomes available that informs or clarifies circumstances/findings surrounding the death case.

The Undetermined Cause and Manner of Death are often used when infants are found bed-sharing with an adult or in an unsafe sleeping environment. When certified as such it is intended to communicate the inability to rule out an asphyxia cause of death.

Cause of Death	Number of Deaths	% of Total Accepted Cases
Undetermined	14	36.84%
Sudden Unexpected Infant Death (SUID)	8	21.05%
Drowning	6	15.79%
Intoxication/Poisoning	5	13.16%
Blunt Impact Injuries	3	7.89%
Blunt Injury Due to Fall	1	2.63%
Neurologic Disorders	1	2.63%
Total	**38**	**100%**

Pie Chart – Undetermined by Cause of Death



2013 Overview of Infant Sleeping Deaths that occurred in the District of Columbia by Jurisdiction of Residence

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

Co-sleeping/Bedsharing

There were a total of **five** co-sleeping/bed-sharing infant fatalities that were certified as "***Undetermined***" in calendar year 2013, and the residence of the parents were in the following jurisdictions: District of Columbia (one in ward 5, one in ward 7, and two in ward 8), and one in Maryland. Ward eight had the highest prevalence of co-sleeping deaths in 2013. Within this review period, there were no co-sleeping/bedsharing fatalities where the parental residence was in the District of Columbia wards 2, 3, or 4, or in the state of Virginia.

Sudden/Unexpected or SUID – Unsafe sleeping environment or Inappropriate bedding

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

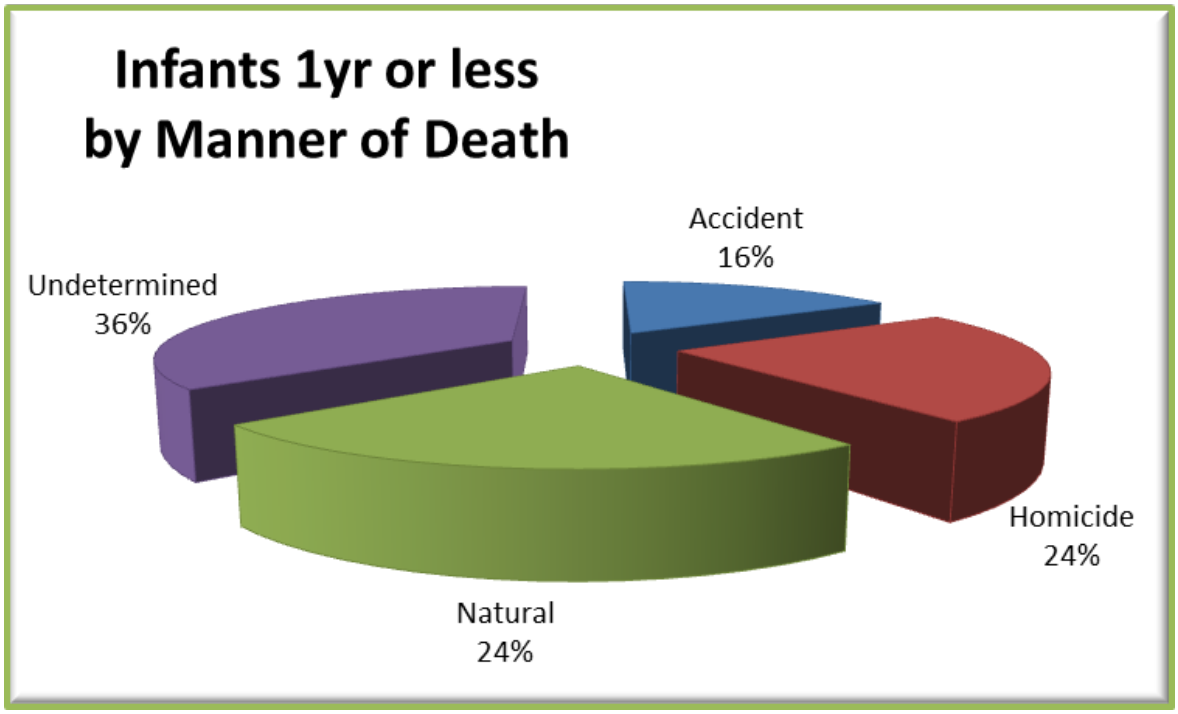
There were **five** cases in 2013 where the infant died as a result of unsafe sleeping or inappropriate bedding, yet was NOT co-sleeping or bed-sharing based on the investigation.

Cause of Death	Co-sleeping	Unsafe Sleep Environment /Inappropriate bedding
Undetermined	0	1
SUID	5	3
Asphyxia	1	0
TOTAL	**6**	**4**

2013 Summary of all Infant Deaths by Jurisdiction of Parental Residence and Manner of Death

In 2013 there were a total of **25** infant deaths[4] investigated by the DC OCME. The below table provides a breakdown by manner of death the parental residence at the time of the infant's death

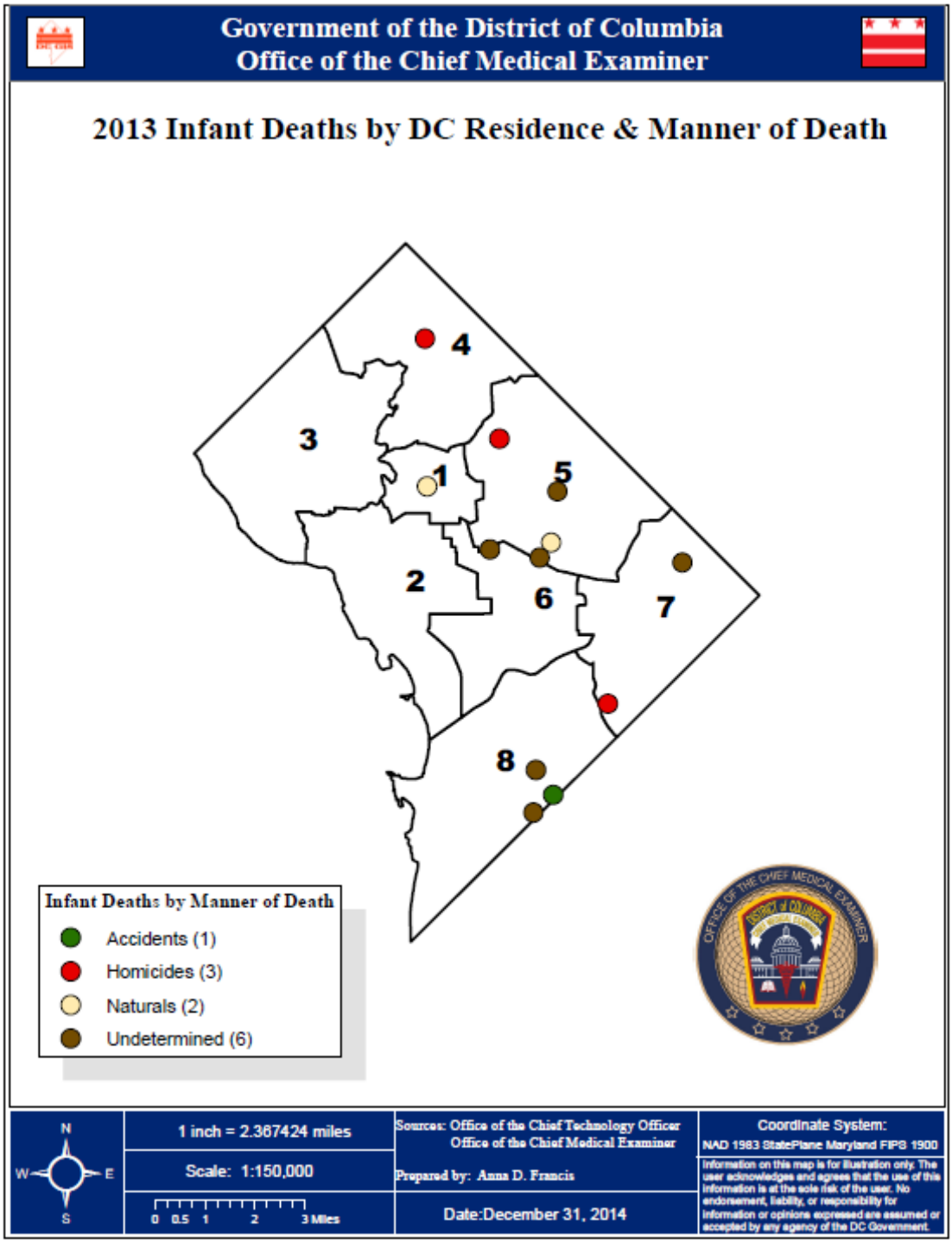
Jurisdiction of Parental Residence	Total	Accident	Homicide	Natural	Undetermined
DC	12	1	3	2	6
MD	11	3	3	2	3
VA	1	0	0	1	0
Unknown	1	0	0	1	0
TOTALS	**25**	**4**	**6**	**6**	**9**



[4] For the purpose of this report "Infants" are defined as those babies one year old or less.

Map of Infant Deaths by Ward and Manner of Death

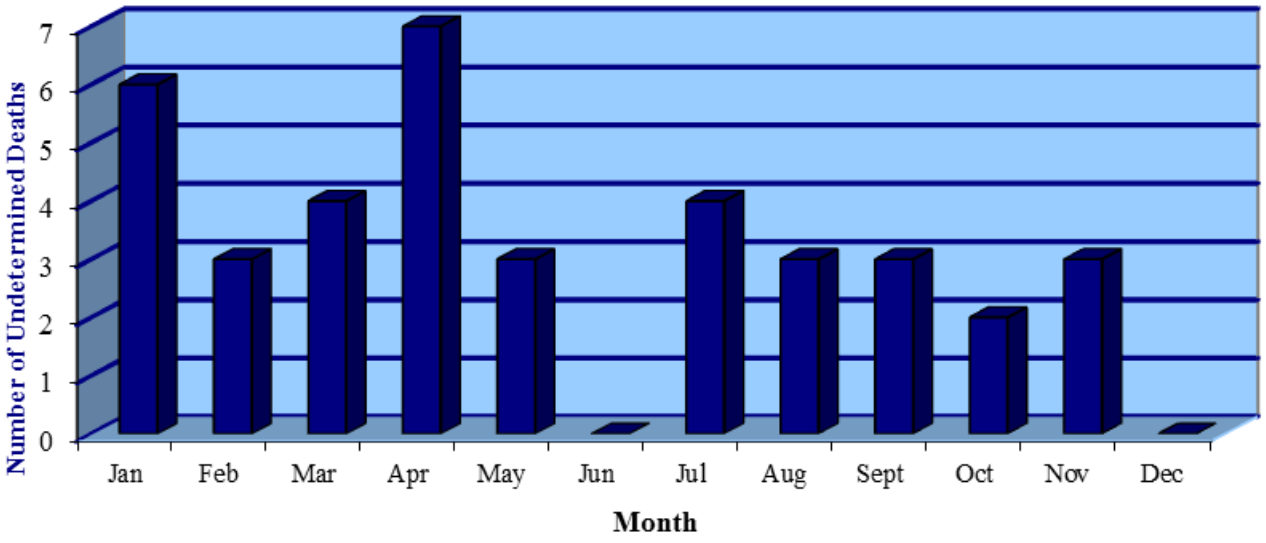
The below map illustrates those decedents whose parents were residents of the District of Columbia by Ward.



Undetermined Deaths by Month

Month	Number of Deaths
January	6
February	3
March	4
April	7
May	3
June	0
July	4
August	3
September	3
October	2
November	3
December	0
Total	**38**

Chart - Undetermined Deaths by Month



Undetermined Deaths by Race

Race	Number of Undetermined Deaths
Asian	2
Black	23
Other	1
White	12
Total	**38**

Undetermined Deaths by Gender

Gender	Number of Undetermined Deaths
Female	19
Male	19
Total	**38**

Undetermined Deaths by Age

Age	Number of Undetermined Deaths
Under 1	9
20 to 29	4
30 to 39	4
40 to 49	3
50 to 59	10
60 to 69	2
70 to 79	3
80 to 89	3
Total	**38**

Breakdown by Cause of Death		
	SUID	**Undetermined**
Under 1	8	1
Note: All the infant decedents were between 13 days and 7 months old.		

Toxicology Findings by Undetermined Deaths

Of the **38** Undetermined Deaths investigated by OCME, toxicology analysis was performed in **36** cases. Drugs were absent in **13** undetermined deaths. Of the positive cases, **18** had more than one drug present.

Description	Number of Cases	% of Cases
N=	**36**	
Negative	13	52.7%
Positive	23	46.6%

The most commonly detected drugs in the undetermined cases were:

Name of Drug	Number of Cases	% of Undetermined Cases
Ethanol	9	25%
Morphine	5	13.8%
Cocaine and Metabolites	3	8.3%
Phencyclidine (PCP)	3	8.3%
Oxycodone	2	5.5%

3.0 – ORGAN PROCUREMENT

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

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

Permission Granted?	# of Requests	# Procured
Yes	74	13
No	8	0
Request Abandoned	10	0
Not Required	6	2
Approached w/o Permission	3	0
Total Requests	**101**	**15**

In Calendar Year 2013 there were eight cases where "Permission" was **not** granted. See table below for details.

Case #	WRTC Donation Request	Reason Denied	Manner of Death
1	Bone, Cornea, Heart valves, and skin	Due to lack of medical/ investigative information	Natural
2	No specifics provided	Permission not granted due to circumstances surrounding case.	Homicide
3	Everything and small bowel and pericardium	Permission given for ONLY skin and bone post-autopsy. WRTC no longer pursuing Traffic Accident of a child	Accident (Traffic)
4	Heart, Valves and Cornea	Permission not granted for pre-autopsy donation due to circumstances.	Accident (Traffic)
5	Bone, Cornea, Heart, skin	Permission not granted for pre exam donation due to circumstances.	Homicide
6	Bone, Liver, Heart, Pancreas and Lungs	Permission is not granted for any part of the request due to circumstances.	Accident (Infant)
7	Bone, skin, cornea and Heart Valves	Permission not granted due to circumstances.	Homicide
8	Cornea, Heart and Heart Valves	Pre exam donation Denied.	Natural

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

4.0 – TOXICOLOGY SERVICES

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

Toxicological examinations were performed on driving-under-the-influence (DUI) cases to assist law enforcement agencies in the investigation of such cases. Routine toxicological examinations for DUI cases include analysis for alcohols (ethanol and other volatiles) and major classes of illicit and prescription medications. Additional screens were assigned depending on requests made by law enforcement. In 2013, the laboratory received 307 cases from the Metropolitan Police Department (MPD) 173 cases from the United States Parks Police (USPP), 21 specimens from the United States Capitol Police (USCP), and 17 specimens from the United States Secret Service (USSS). Specimens received where either blood or urine, and multiple specimens could be received with each of the 518 cases.

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

Total number of DUI cases analyzed:

Description	Number of Cases	% of Cases
N=	518	
Negative	22	4.2 %
Positive	496	95.7 %

The % prevalence of Ethanol, Phencyclidine, Marijuana, Cocaine, and Morphine in DUI casework submitted by all three enforcement agencies

Agency	MPD	USPP	USCP	USSS	Average %
Total Cases	**307**	**173**	**21**	**17**	
Ethanol	71.3%	78.0%	71.4%	100.0%	74.5%
Phencyclidine (PCP)	27.0%	17.9%	19.0%	29.4%	23.7%
Marijuana Metabolite	25.4%	8.1%	28.6%	41.2%	20.3%
Cocaine	14.0%	2.3%	14.3%	5.9%	9.8%
Morphine	5.5%	1.7%	4.8%	0.0%	4.1%

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

Toxicological examinations were performed on drug facilitated sexual assault cases to assist law enforcement agencies in the investigation of such cases. Routine toxicological examinations for DFSA cases include analysis for alcohols (ethanol and other volatiles), major classes of illicit and prescription medications, and targeted drugs commonly used in DFSA. Additional screens were assigned depending on requests made by law enforcement. In 2013, the laboratory received 145 cases from District government agencies. Specimens received where either blood or urine, and multiple specimens could be received with each of the 145 cases.

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

Total number of DFSA cases analyzed:

Description	Number of Cases	% of Cases
N=	**145**	
Negative	36	24.8 %
Positive	93	75.1 %

The most commonly types of detected drugs in DFSA cases were

Drug Class	Report	Non-Report
Negative	17.6%	35.2%
Ethanol	75.8%	33.3%
Marijuana	20.9%	14.8%
PCP	12.1%	3.7%
Cocaine	17.6%	9.3%
Opioids	2.2%	7.4%
Illicit Stimulant	3.3%	5.6%
Benzodiazepine	31.9%	7.4%
Antidepressants	17.6%	18.5%
Over the Counter	15.4%	20.4%

Subject demographics for DFSA cases were:

Average Age (years)	29.0

Gender	% of Total
Male	6.2%
Female	93.8%
Total	**100%**

Age Range	# of Cases
Ages ≥15 and <20	10
Ages ≥20 and <25	60
Ages ≥25 and <30	28
Ages ≥30 and <35	19
Ages ≥35 and <40	8
Ages ≥40 and <65	18
Ages ≥65	2
Total	**145**

4.3 - Breath Testing Program

In 2013, five 40-hour Operator Training Courses were offered, licensing a total of 57 operators. This resulted in 1152 evidential breath tests and the deployment of 4 additional instruments into the field, totaling seven evidential instruments available for testing.

Program Facts

- Total 40 Hour Operator Trainings Provided: 5
- Total officers Trained: 57
- Number of evidential instruments in the field: 7
- Total Evidential Tests Taken: 1152

Tests taken by District:

1D: 193

2D: 123

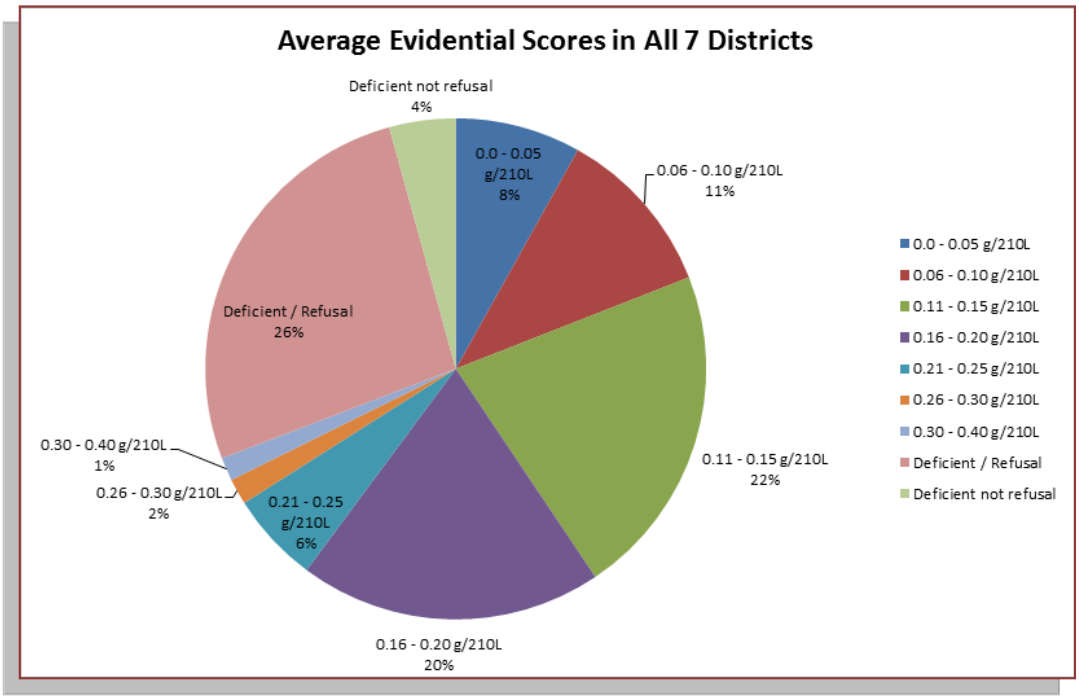
3D: 332

4D: 76

5D: 122

6D: 48

7D: 258



Additional FACTS

- The program maintains an average of 24% refusals (a refusal is when someone elects to not take an evidential breath test)
- 82% of evidential tests are taken on individuals from D.C., Maryland and Virginia
- 12% of evidential tests are taken from individuals driving without a permit
- 6% of evidential tests are taken from individuals outside

5.0 – OTHER MAJOR ACTIVITIES

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

5.1 - Court-related Activities

A parameter not often considered in evaluating the Medical Examiners workload is time spent in pre-trial conferences, depositions and expert testimony provided in family, civil and criminal litigations. This annual report presents tabulated data for these expert services provided in OCME calendar year 2013.

Type of Judicial Service	Number of Court related Activities
Court Testimony	10
Depositions	2
Grand Jury	0
Pre-trial Conference	13
Other	2
Total	**27**

Court Services by Type	Number of Court related Activities
Civil	5
Criminal	22
Other	0
Total	**27**

Court Services by Jurisdiction	Number of Court related Activities
DC	24
Maryland	3
Out of Metro Area	0
Total	**27**

For calendar year 2013 the above data represents approximately **47** hours of Medical Examiner time. In general the least amount of time spent on this activity was **20 minutes**, and the maximum recorded time spent on a court-related activity was **4** hours.

5.2 - Identifications

Identifications

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

By Visual identification: This method is used whenever circumstances of death and discovery allow. In general the immediate family, close friends, neighbors or colleagues provide verification for visual identifications. A Digital photograph is taken of the decedent's face for presentation at the OCME facility. **Timeframe: Instant**

By Fingerprint: This method requires that a good clean set of fingerprints be obtained from the decedent for comparison. **Timeframe: Up to 3 weeks**

By Radiograph (X-ray) Comparison: Post-mortem (after death) radiographs of the entire body and teeth are taken, at most morgues, as a standard practice for other forensic purposes and can be used for identification purposes if required. In addition, the most recent ante-mortem (before death) dental and/or body x-rays are obtained from the presumed person's physician -when available – so that the before and after x-rays can be compared to confirm or. **Timeframe: Up to 1 month**

ID Method	# of ID's
ID By Dental X-ray	4
ID By DNA	6
ID By Fingerprints	49
ID By Medical Device	3
ID By Visual • at OCME – 826 • at Scene - 127	953
ID By X-ray	17
ID Other	3
ID Waived	42
Non-Human Remains	11
Unidentified	1
Total	**1089**

By DNA testing: This method requires an acceptable post-mortem specimen (i.e. femur bone, blood, teeth or deep muscle tissue) be acquired from the decedent for comparison to a validated specimen of the person the decedent is presumed or thought to be for DNA analysis and comparison. Another validation procedure requires a potential family member provide a specimen (saliva, blood, hair urine etc.), for comparison to the decedents post-mortem specimen. **Timeframe: Up to 4 – 6 months**

However, if all methods identified above provide a negative result, then other methods are considered and additional time may be required.

By Other Methods: Other methods of identification vary; however, in calendar year 2013 there were three decedents where other methods were used for identification and they were as follows:

1. Notarized letter accompanying OCME photo confirming identity. Approved by OCME General Counsel
2. ID was confirmed via MPD report – based on physical interview with decedent's mother. Approved by OCME General Counsel
3. ID was confirmed via ID paperwork received from Funeral Home. This case was a Cremation Request turned ME case.

Staff members of different divisions and outside consultants participate in this process including members of MPD's Natural Squad.

5.3 - Public Dispositions

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 A 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 Anatomical Board after 3 days if they are not claimed by Next of kin.

There were a total of **92** Public Disposition cases, of which **46** were Medical Examiner cases and 46 were Storage cases. There was only one unidentified decedent. The breakdown by Adult, Children and Fetuses:

Description	# of Public Disposition
Adults	86
Children	3
Fetus	3
Total	**92**

Breakdown of Public Dispositions and the Associated Costs

Public Disposition by type	Number of Unclaimed Remains
Cremations – identified adults	84
Cremations – infants	3
Cremations – fetal remains	3
Transport to Quantico National Cemetery – identified US Military Veteran (1 transport to Arlington)	2
TOTAL	**92 unclaimed remains**

Cremation Requests

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

Storage Requests

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

During Calendar Year 2013 there were **119** Storage Requests made to the DC OCME

6.0 – BREAKDOWN OF MEDICAL EXAMINER INVESTIGATIONS

The US Census estimates that during 2013, the total population within the District of Columbia was **646,449** [5] inhabitants, which comprised primarily of the following ethnic groups: White, Black, Hispanic, Asian and Other. In 2013, the OCME investigated **3,221** deaths that occurred in the District of Columbia or were wards of the District and died in another jurisdiction. **1,089** of these cases were accepted under the jurisdiction of the Medical Examiner for further investigation; of which **784** of them were known to be residents in the District of Columbia. The following table and charts summarize the manner of death by racial composition.

2013 Manner of Death* by Race with 2010 Census Data

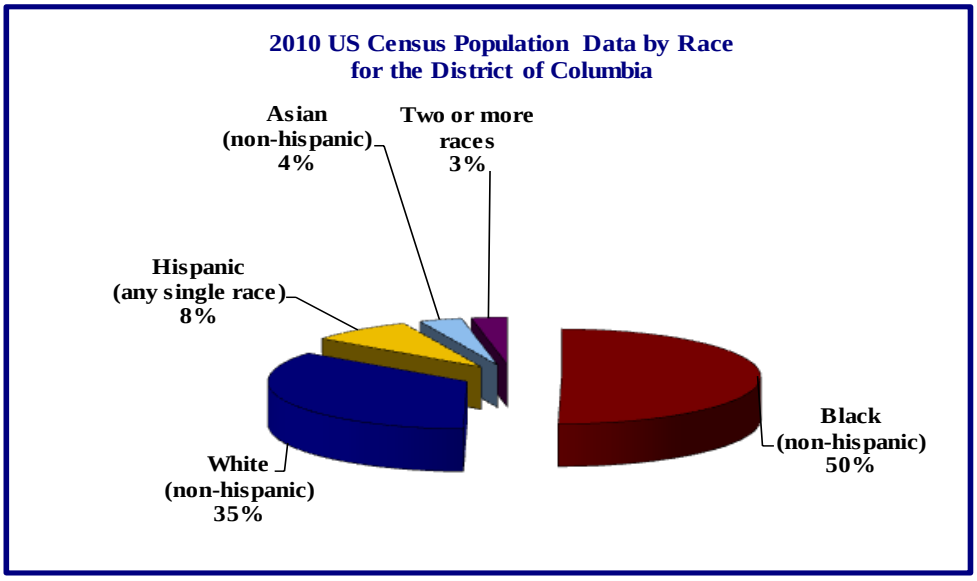
Race	2010. Census	Natural	Suicide	Homicide	Accidents	Undetermined	Stillbirth	Total ME Cases
Black (non-Hispanic)[6]	301,053	432	17	89	188	23	3	**752**
White (non-Hispanic)	209,464	96	26	11	105	12	0	**250**
Hispanic (any single race)	50,083	15	3	5	16	0	0	**39**
Asian (non-Hispanic)	20,818	6	2	0	3	2	0	**13**
Two or more races	17,316	0	0	0	0	0	0	**0**
Other (non-Hispanic)	1,451	7	3	2	4	1	0	**17**
American Indian and Alaska Native (non-Hispanic)	1,322	0	1	1	0	0	0	**2**
Pacific Islander (non-Hispanic)	216	1	0	0	0	0	0	**1**
Unknown	n/a	2	0	0	0	0	1	**3**
Total Population	**601,723**							
Total # of ME Cases		**559**	**52**	**108**	**316**	**38**	**4**	**1077**

*The following accepted cases are not represented in the table: Non-Human Remains (11); Tooth fragment (1).

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

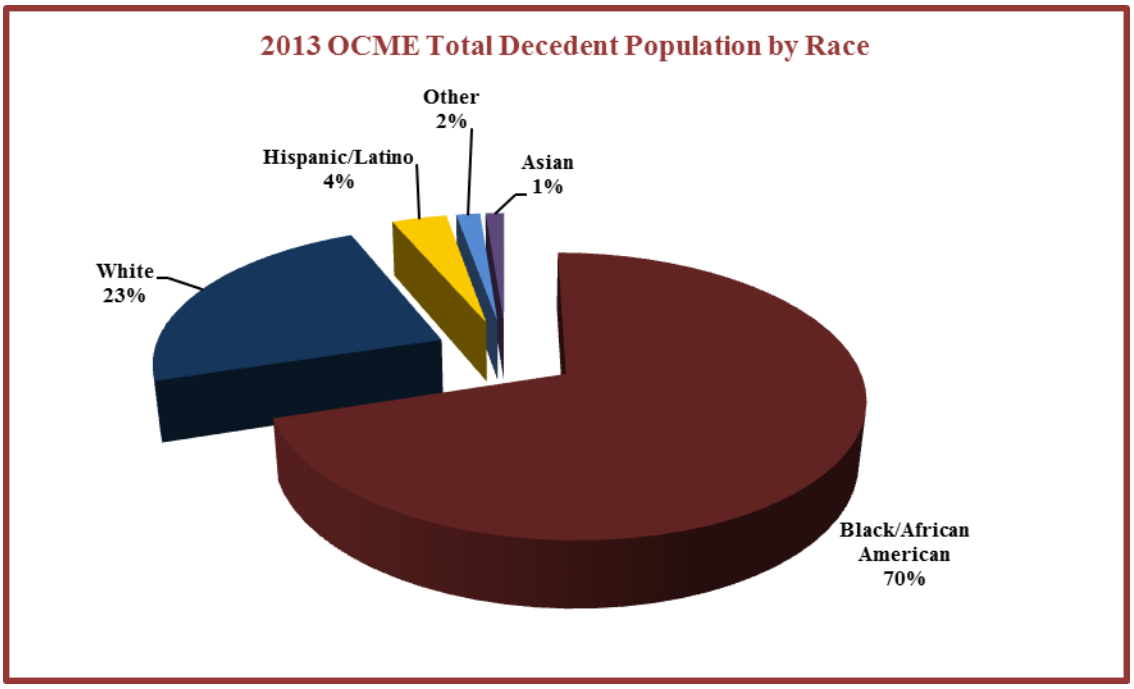
[6] The (non-Hispanic) attribute only applies to the 2010 Census data and does not apply to the OCME statistics for race by "Manner of Death"

6.1 - Total Population



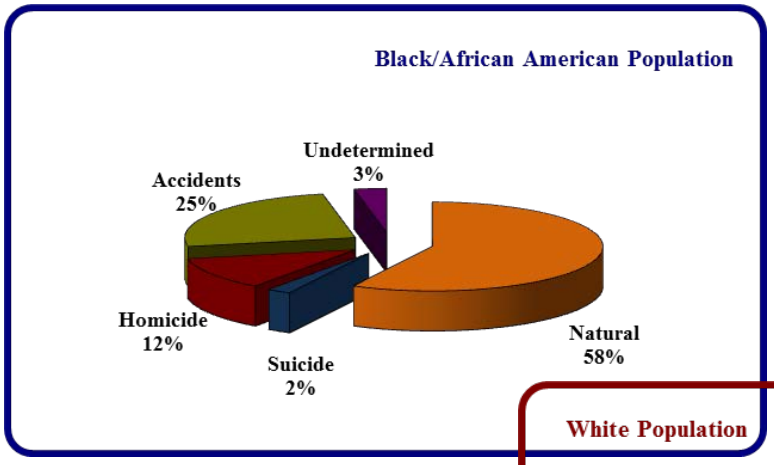
Note: The race categories American Indian/Alaska Native and Pacific Islander/Native Hawaiian are not represented in the above graph because they are both less than 1% of the total population in the District of Columbia. On the other hand, Hispanics are represented in this graph; although this classification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

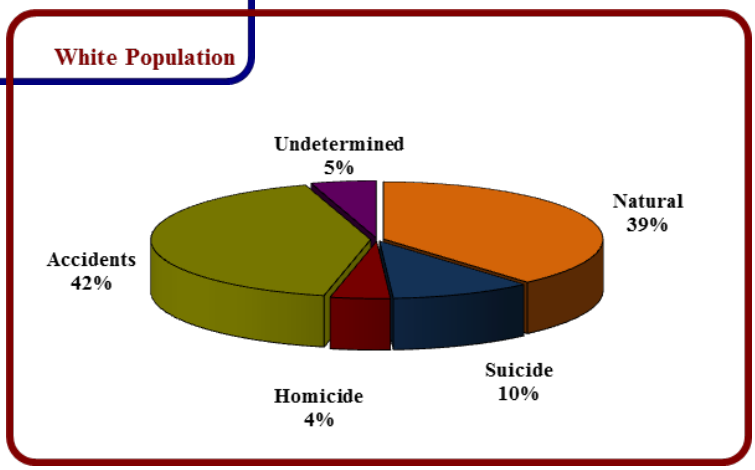
6.2 - Total ME Cases by Demographics and Manner of Death

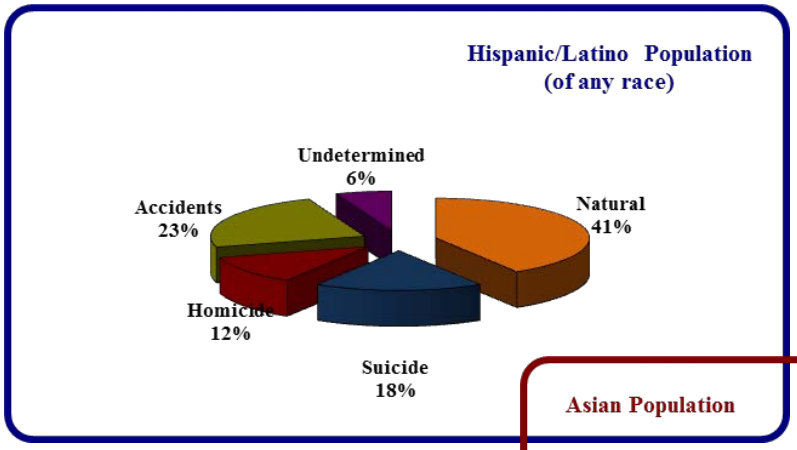


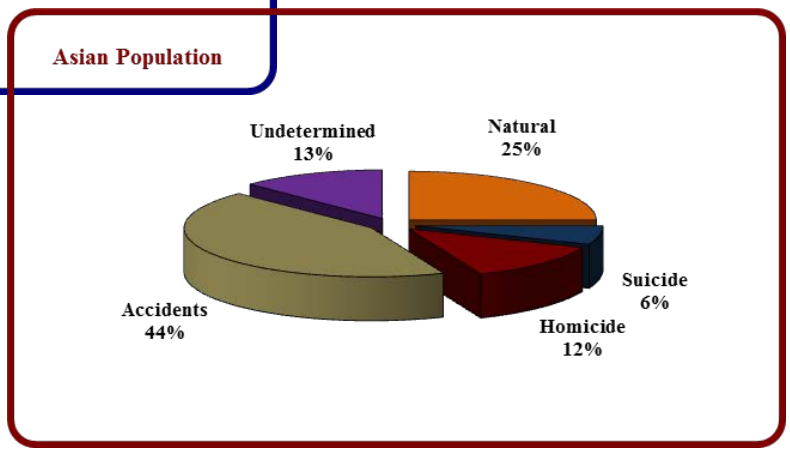
Note: Race is recorded by the District of Columbia OCME as reported by the decedent's next of kin. Also, for illustrative purposes those races that are less than 1% are not included in the OCME Total Population chart.

By Race and Manner of Death









2013 Totals by Age

Age Group	Total Deaths	Percent
Fetus	4	0%
Under 1	21	2%
1 to 5	12	1%
6 to 12	12	1%
13 to 15	2	0%
16 to 19	13	1%
20 to 29	82	8%
30 to 39	87	8%
40 to 49	124	12%
50 to 59	236	22%
60 to 69	213	20%
70 to 79	112	10%
80 to 89	104	10%
90 and Over	55	5%
Unknown	1	0%
TOTAL	**1078**	**100%**

2013 Gender by Race

Race	Males	Females	Unknown	Total
American Indian	2	0	0	2
Asian	10	3	0	13
Black	498	254	0	752
Hispanic	23	16	0	39
Other	11	6	0	17
Pacific Islander	0	1	0	1
Unknown	2	0	2	4
White	164	86	0	250
TOTAL	**710**	**366**	**2**	**1078**

2013 Manner of Death by Gender

Gender	Naturals	Suicide	Homicides	Accident	Undetermined	Pending	Stillbirth	Totals	Percent
Female	207	10	14	115	19	1	0	**366**	**34%**
Male	352	42	94	200	19	0	3	**710**	**66%**
Unknown	0	0	0	0	0	0	1	1	0%
Totals	**559**	**52**	**108**	**315**	**38**	**1**	**4**	**1077**	**100%**

Note: The above table does not include – Tooth Fragment (1)

APPENDIX A

OCME Organizational Chart

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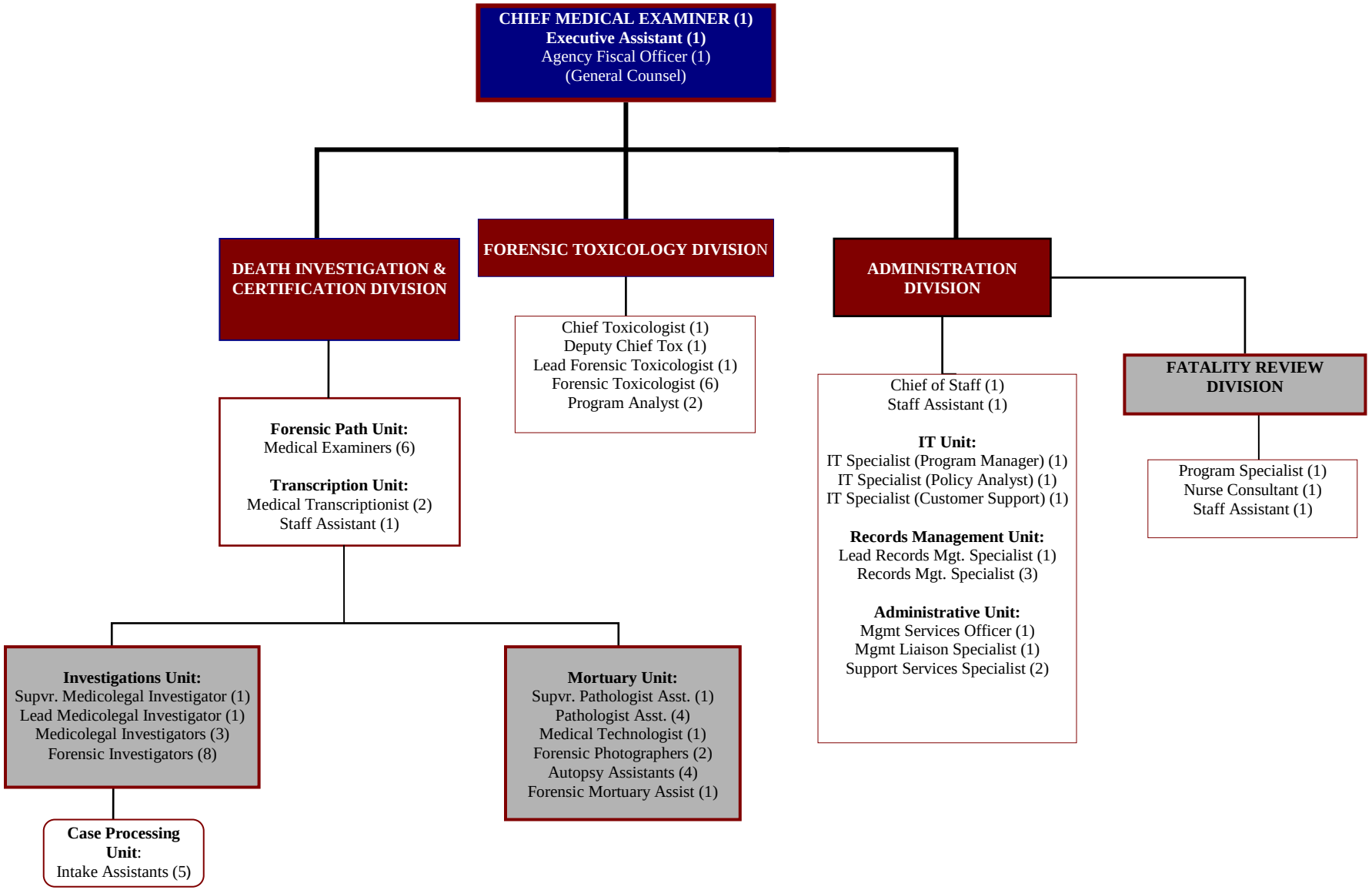
OFFICE OF THE CHIEF MEDICAL EXAMINER
ORGANIZATIONAL CHART FY 2013



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APPENDIX B

AGENCY MANAGEMENT

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AGENCY MANAGEMENT

Administration Peformance Management

The agency's Administrative Division provides support to the work discussed within this annual report in the areas of: property/facilities management; finance and procurement; personnel; information technology; quality assurance and control; legal management; risk management; labor management; and incident management. The Administrative Division is also responsible for monitoring and ensuring efficient operations via establishment and compliance of a performance plan that includes key performance indicators – the performance component of agency management. Throughout 2013, the agency worked to meet performance for agency divisions are included herein.

Property Management:

During 2013, the OCME adjusted to its transition to the Consolidated Forensic Laboratory located at 401 E St., SW, Washington, DC 20024 – a move that occurred in three phases during the last quarter of 2014. The move to a larger facility and one with a makeup of three floors (1st, 5th and 6th) required a revision of protocols, policies and procedures, and work processes. As such, throughout the year, the agency underwent a major overhaul in these areas and proceeded to revise agency standard operating procedures and implement staff trainings. Further, the move resulted in a significant amount of new equipment in the mortuary and toxicology laboratory that also required calibration, testing and staff training during the year. The agency also conducted an outreach effort to agency constituents to ensure awareness of the new location and new procedures. Specifically, information materials were developed and disseminated to next of kin, the agency's website was updated with transition information and several meetings and workshops were held with funeral directors to discuss new procedures for decedent pickup and release, as well as cremation approvals.

Incident Management Planning:

The OCME revised the following incident management plans: Emergency Response Plan (ERP); Continuity of Operations Plan (COOP); and its Mass Fatality Plan due to its relocation to a new facility. As required by the District's Office of Risk Management (ORM), the agency ERP was submitted to DC Fire and Emergency Medical Services (FEMS) and approved in September 2013. The OCME participated in all city-wide incident management exercises and conferences (i.e., tabletop and full) which involved staff training of procedures; training of staff roles and responsibilities; and retraining on OCME staff interaction with the EOC and other agencies. Further, agency developed a guideline focused on procedures to be followed during a mass fatality or emergency incident involving the medical examiner office. The pamphlet targets agency emergency management stakeholders and provides information on the agency's role in such incidents.

Of note, the District experienced two high profile emergency incident involving fatalities -- the Navy Yard and Capitol Hill Incidents. The incident (both involving active shooters and one involving the use of a vehicle as a weapon) required the agency to activate its mass fatality plan, including: initial evaluation of the scenario, death scene response and investigation, body transport, completion of autopsies and reporting, interaction with next of kin and response to media and other entities. The staff performed professionally with dedication to the mission of the agency and compassion to the victims and their next of kin despite challenging scene and resource dynamics and agency understaffing. With regard to the Navy Yard Incident, the agency participated in several after-action conferences and prepared an extensive after-action report on the Navy Yard Incident that was provided to the District's Homeland Security and Emergency

Management Agency (HSEMA) and the Office of the Deputy Mayor for Public Safety and Justice (ODMPSJ). The report included recommendations for improved communication and interaction between the incident responders; procurement of an agency scene operations center; and addition of agency staffing.

Website Enhancement
The OCME website was significantly enhanced during 2013 to include: 1) implementation of the credit card payment system as fully operational for funeral homes to submit cremation requests and fees (development was completed during the 1st quarter; the system underwent testing in the 2nd qtr. with a pilot program and went "live" during the 3rd qtr with funeral homes added each week; the system was fully implemented in the 4th quarter); 2) a statistics section entitled "Public Safety Corner" (i.e., Homicide and Suicide Statistical studies); 3) a "Requested Documents" section; 4) an Educational Section to provide information on training, seminars and internship programs; 5) a Public Safety Corner, with surveillance reports on suicides, hypothermia, homeless, homicides and public disposition; 6) a Scientific Presentations section that included a study on "Falling Furniture & Deaths in Children"; 7) an Academic Affiliations section; 8) the OCME FAQ's pamphlet; and 8) a section entitled "How to Become a Medical Examiner."

Digitization Project:
Over the past four years the agency has been engaged in an effort to digitize all of its historical records and for the first three years funded the project through a Paul Coverdell Forensic Science grant. . In 2013, OCME continued this effort to support the Mayor's Sustainable DC Initiative and over the past four years has been engaged in an effort to digitize all of its records. For the first three years of the project, the agency secured funding through a Paul Coverdell Forensic Science grant to digitize about 16,000 records. In FY2013, a vendor was procured to complete the digitization of the remaining 18,000 case files, as well as its slides, Polaroid's and x-rays. During the year, the digitization portion of the project was completed with approximately 62,573 records digitized.

Risk Management:
The agency's Risk Assessment Control Committee ("RACC") met on a quarterly basis to discuss and evaluate various facility, employee and other incidents that potentially bring risk or liability to employees, the facility or the District overall. During 2013, meetings focused on the risk associated with the agency move to the Consolidated Forensic Laboratory. The risk control efforts evaluated and recommended by the RACC were implemented by the agency and proved successful. The Office of Risk Management (ORM) provides requirements for a successful agency risk assessment and control program, including: conducting quarterly meetings; submittal of cost of risk reports; developing and implementing Agency Risk Management Plans; updating the agency's Continuity of Operations Plan (COOP); providing training for the agency's revised Emergency Response Plan (ERP); and conducting emergency response drills. The agency met all requirements.

Customer Service:
As part of the review of work processes to be conducted in the new facility, management staff recognized a challenge for funeral home clients in visiting the facility numerous times in order to complete the cremation approval process. Challenges included parking, security and the inability to provide payment prior to obtaining service. The agency responded by implementing the build-out of a "credit card payment" service on its website. This would allow funeral homes to pay prior to service beginning resulting in the elimination of a visit to the facility just for that purpose. In 2013, a pilot program was implemented with approximately 10 funeral homes and by mid-2013 was open to all funeral homes.

Death Investigation and Certification Management

The OCME's Death Investigation and Certification Division is responsible for forensic pathology, forensic investigation and mortuary services. These programs work toward achieving the mission of the agency which is to prepare reports of findings and conclusions (i.e., cause and manner of death) on any autopsy or examination performed. The death investigation and certification program thrived in 2013 with: a 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; b) maintenance of an emergency body transport service; and c) implementation of advanced technology.

Key Performance Indicators[1]

Measure One:
This measure requires that the agency complete 90% of reports of all postmortem examinations within 90 calendar days from the time of autopsy in homicide cases, based on National Association of Medical Examiner (NAME) standards. For FY2013, the agency completed 73.26% of these reports within 90 calendar days.

Measure Two:
This measure requires that the agency complete 90% of reports of all postmortem examinations within 60 calendar days from the time of autopsy in all cases (excluding homicides), based on NAME standards. For FY2013, the agency completed 35.54% of these reports within 60 calendar days.

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

Measure Three:
The third measure requires that 95% of positively identified bodies be ready for release within forty-eight hours. For FY2013, the agency reached an actual percentage of 91.15%, slightly 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; cases being reported on holidays or weekends when it is difficult to reach attending physicians for information; and the need to hold cases over for examination due to a large workload or other workflow issues.

Measure Four:
The fourth measure assesses the percent of preliminary investigative reports complete for utilization in the daily case review morning meetings. The goal (90%) is to ensure that the reports are available and complete for review and discussion the next morning prior to the postmortem examination. Over ninety percent or 90.61% of the investigative reports were complete for use in the morning meetings in FY2013.

[1] The District's Agency Key Performance Indicators (KPIs) are compiled on a fiscal year basis. Thus, all KPI data included in this report reflects FY2012 -- the time period between October 1, 2012 through September 30, 2013.

Measure Five:
In FY2013, OCME's mortuary staff arrived on scene within one hour of notification of case acceptance 84% of the time, below the 95% target.

During the course of 2013, the agency fully achieved several of its performance initiatives in this arena.

The agency conducted a death investigation and certification public service announcement campaign to bring awareness to various aspects of the policies and procedures of a medical examiner's office and the process of medicolegal death investigation. The agency utilized its websites, conducted seminars and workshops, developed a specialized one page FAQ sheet and revised the OCME General FAQ sheet. The pamphlets and FAQ sheets specifically address the identification and DNA process; autopsy reporting and obtaining reports; public disposition; cremation approvals; records requests; toxicology services; mass fatality; and overall agency standard operating procedures. The FAQ sheets and agency pamphlets also describe agency operations and the procedure. The seminars and workshops were conducted with the national youth organizations, as well as with individual District of Columbia Public Schools (i.e., Cesar Chavez Public Charter School). The OCME's Forensic Toxicology staff also presented toxicology workshops at various conferences.

During the year, the agency hosted the National Youth Leadership Program, with which it has had a longstanding partnership. This year's the curriculum focused on encouraging students to pursue the field of forensic pathology. It was particularly significant given the new state-of-the art facility and students' interest in the technology associated with the job. The students received college credit for completion of the curriculum in the program, which included a conference at the medical examiner's office, tour and associated workshops/lectures.

Forensic Toxicology Laboratory Management

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

Moreover, the laboratory continues to provide testing services to external local and federal agencies. For example, during FY2013[2], the laboratory processed 707 Driving Under the Influence (DUI) cases for outside agencies. Members of the toxicology laboratory staff are also trained to provide interpretive services and expert testimony on a variety of drug and alcohol related matters and provides such service to the Office of the Attorney General (OAG), the Public Defenders Service, and the United States Attorney's Office (USA).

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

[2] The workload measures included herein, including the number of DUI cases processed by the toxicology laboratory, are based on FY2013 -- the time period between October 1, 2012 through September 30, 2013.

During 2013, the laboratory provided its first in-depth annual report of drug facilitated sexual assault testing results to the District's Office of Victim Services (OVS). Finally, training was provided to university students in the form of lectures and internships. There were four interns, lectures twice a year for George Washington (GW) University's pathology course and an in-house laboratory training for graduate students from the GW Forensic Toxicology program.

The Toxicology Division worked with the IT Unit in 2013 to implement the Toxicology Case Management Module to the agency's case management system -- Forensic Analytic Case Tracking System (FACTS) – to improve overall workflow. The staff worked with the vendor to install and provision the server to be utilized for the module and evaluated and tested the system and user interface such that the system could be fully integrated with the agency's database.

Key Performance Indicators

Measure Six:
Measure six provides results of toxicology laboratory performance requiring for FY2013 that 90% of negative toxicology examinations be completed within 30 calendar days of case. The actual percentage was 50.70%.

Measure Seven:
Measure seven required for FY2012 that 90% of positive toxicology examinations be completed within 60 calendar days of case. The actual percentage was 81.22%.

Fatality Review Management

The Fatality Review Division (FRD) is tasked with fulfilling the agency mission of facilitating the operation of two committees and one board: Child Fatality Review Committee (CFRC); Developmental Disabilities Fatality Review Committee (DDFRC); and the Domestic Violence Review Board (DVRB). These committees and boards conduct reviews of to provide analysis and recommendations to the public and District entities serving defined populations, so they can address syste4mic problems, provide better services and be held accountable. In 2013, these reviews were held and recommendations to prevent deaths were developed for other agencies and entities with respect to policies and procedures and operations.

In 2013, the FRD enhanced reporting by developing statistical reports on deaths among children, domestic violence victims and the developmentally disabled in the District. These reports are to be included in the 2012 Annual Reports of the following reviews: Child Fatality Review Committee, Domestic Violence Review Board and the Developmentally Disabled Review Committee. Note the reports are due to be published by the end of the year following the reporting year. The educational level of child death statistics are included in the agency KPI workloads.

Key Performance Indicators

Measure Eight:
This measure required the CFRC to hold 80% of child fatality reviews within six months of notification of the death. In FY2012, the CFRC completed 79.76% of multi-agency and statistical reviews of child fatalities within six months of notification of death.

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

Other Activities

OCME continues to provide customer service consistent with the District's mission in welcoming students and residents from area universities and hospitals. In 2013, the agency maintained its partnership with George Washington University (GW) in which agency personnel (including the Medical Examiners, Supervisory Medicolegal Investigator and Deputy Chief Toxicologist) served as GW faculty to teach forensic pathology, toxicology and death investigation for the GW Forensic Sciences graduate program. The agency continues to offer internship opportunities for students in forensic science and physician assistant programs throughout the nation.

APPENDIX C

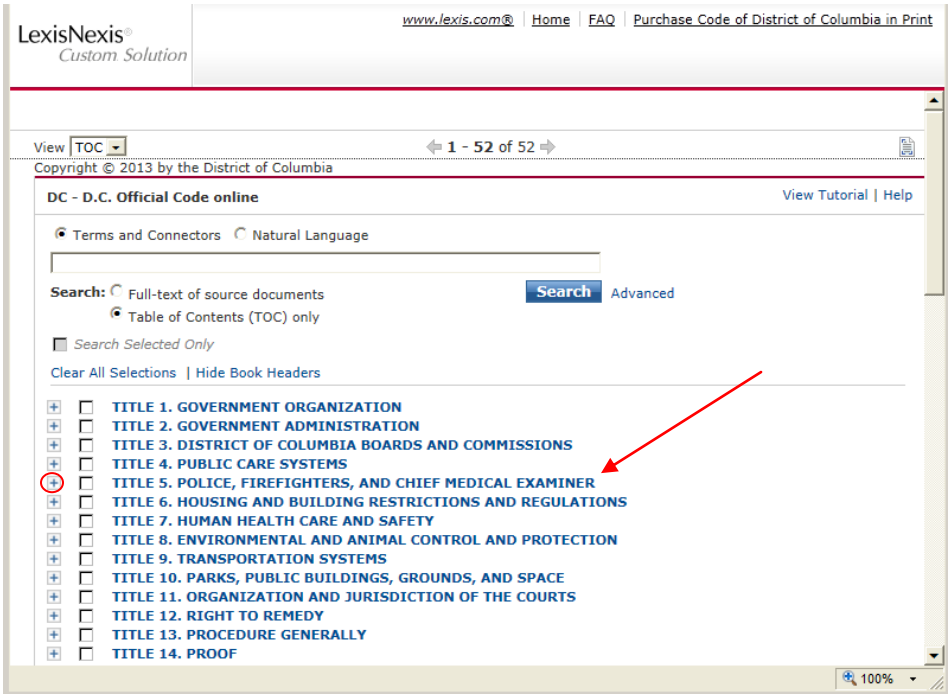
PROGRAM LEGISLATION

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

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

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

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



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

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

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

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APPENDIX D

INTERNAL SERVICES

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Wendt Center for Loss and Healing
RECOVER Program
January 2013- December 2013

The Wendt Center transitioned its RECOVER program to the Consolidated Forensic Lab to join the rest of the OCME operating staff in early 2013. While the facility changed, the Wendt Center's RECOVER program maintained its commitment to supporting and serving families through the process of identification, supporting OCME staff with onsite stress release group sessions and individual support as well as being trained and ready for any mass community or crisis.

The RECOVER team is comprised of counselors, social workers and masters graduate interns who are trained in grief, trauma, loss and crisis. Staff counselors are present at the OCME 7 days a week, 365 days a year to provide support, education and resources to individuals and families as they navigate the decedent identification process. Staff counselors work closely with OCME investigators, communications and medical examiners to best provide families with appropriate and helpful information in an effort to decrease the anxiety and stress that can often accompany the identification process and a sudden death.

RECOVER Staff provided informational packets and support to nearly one thousand seven hundred (1700) individuals who presented to complete over eight hundred (800) identifications. The informational packets provide families with a better understanding of the policies and procedures of the OCME, how to talk to children and teens about grief and loss, preparing for a funeral or memorial service, accessing a community based Vigil program, common reactions to death, concrete recommendations for taking care of oneself after a death and resources for crisis, burial assistance and social services. Informational handouts in both English and Spanish are made available in both identification rooms, by the Wendt Center. The RECOVER staff believes in empowering survivors through education, normalization and compassionate emotional support. Regardless of cause of death, all individuals completing decedent identifications are treated with respect and dignity.

Each month a RECOVER staff counselor facilitates a staff stress relief session to OCME staff. Sessions provide educational material on issues including vicarious trauma, loss, self care, stress, mindfulness and grief. Utilizing art, music, food and talk staff members are invited to explore the impact of working in a high stress environment on their body, mind and spirit and focus and learning healthy ways of taking care of themselves.

As part of a community collaboration, a RECOVER staff member has participated in Child Fatality Review Committee meetings, providing necessary and appropriate information regarding child decedents and their families. On occasion clinical perspective and recommendations were shared with the committee in regards to issues related to trauma, grief, loss, attachment, child development and therapy.

The Wendt Center's RECOVER staff worked closely with OCME and FBI staff in helping to expedite the identification process for the traumatized surviving family members following the tragic Navy Yard shooting in September 2013. Onsite crisis support and a staff who was familiar with OCME policies and procedures proved beneficial in the wake of this community tragedy. RECOVER staff was available to support and help OCME staff cope in the days and weeks following the shooting. The Wendt Center was honored on Capitol Hill by the Congressional Victims' Rights Caucus as part of the DC Crisis Response Team for its work in the aftermath of the Navy Yard shootings.

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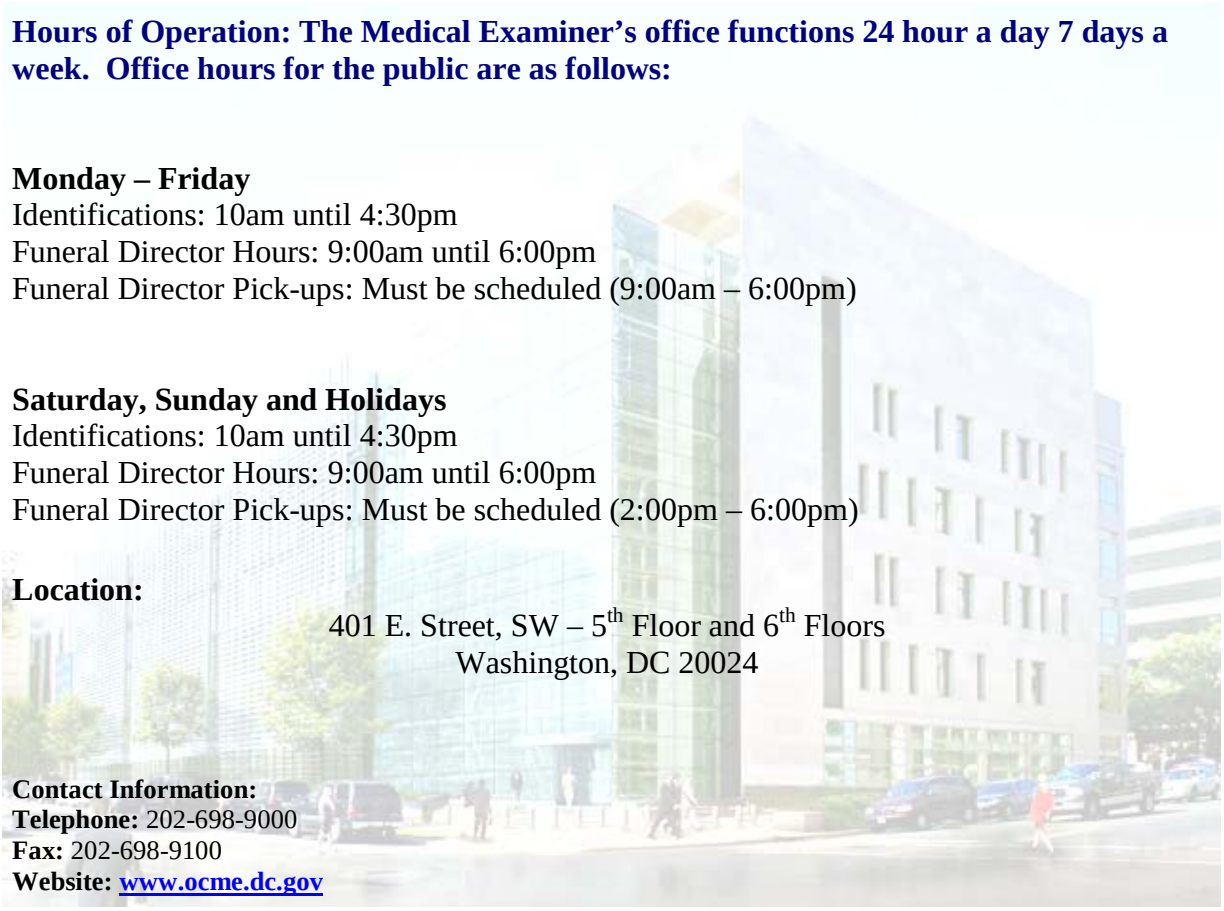
GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF THE CHIEF MEDICAL EXAMINER

HOURS AND LOCATION



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

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

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

Location:

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

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

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

William Gladstone,
Prime Minister of England

Office of the Chief Medical Examiner
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Washington, DC 20024
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