GOVERNMENT OF
THE DISTRICT OF COLUMBIA

OFFICE OF THE CHIEF MEDICAL EXAMINER ANNUAL REPORT

2017

WE ARE WASHINGTON DC

DISTRICT OF COLUMBIA OFFICE OF THE CHIEF MEDICAL EXAMINER

MISSION

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

EXECUTIVE MANAGEMENT
(2017)

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

Francisco Diaz, MD
Deputy Chief Medical Examiner

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Chief of Staff

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Lucas W. Zarwell, MFS
Chief Toxicologist

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Deputy Chief Toxicologist

DATA ANALYSIS & QUALITY CONTROL
Chikarlo R. Leak, DrPH, MPH
Forensic Epidemiologist

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Quality Control Program and Records Manager

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

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A MESSAGE FROM THE CHIEF MEDICAL EXAMINER

Greetings,

On behalf of the Office of the Chief Medical Examiner (OCME), I am pleased to present the 2017 OCME Annual Report which provides key statistical data stemming from our critical work in death investigation and certification, as well as a snapshot of our key achievements over the year.

With almost one hundred employees and a budget of about 12 million dollars in FY2017, the agency investigated nearly 5,988 deaths and performed 1,353 post-mortem examinations, including 123 homicides. We performed 1,304 toxicological tests, processed 6,736 records and resolved numerous legal matters. These accomplishments were performed in a climate of fiscal responsibility and public stewardship.

This annual report includes statistical data focusing on the number and type of cases accepted and examined; cause and manner of death; decedent demographics (i.e., gender, age, race and residence); and toxicological findings. Moreover, certain agency functions, such as public dispositions, the Breath Alcohol Program and other toxicological services, organ procurement and Data Fusion Center special trend reports, are highlighted.

In addition to carrying out the agency's mission to perform sound medicolegal investigations and determine cause and manner of death, the agency experienced several key achievements during 2017.

» The agency's reaccreditation efforts via the National Association of Medical Examiners (NAME) were successful. Granted full accreditation by NAME, effective February 16, 2016 through February 16, 2021, the agency received its reaccreditation, through February 16, 2018. This was achieved with only six (6) Phase I and zero (0) Phase II deficiencies out of 351 NAME accreditation checklist items.

» Focusing on fiscal accountability and good governance, the agency was able to spend more than 99% of its FY17 local budget (below $100,000) and maintain a small position vacancy rate throughout the fiscal year. This was accomplished utilizing newly established standard operating procedures for budget, procurement and human resources; managerial oversight; and strategic and performance planning.

» By transferring its decedent transport function in-house, the agency realized a significant improvement in death scene response times with a reduction from over an hour to approximately forty minutes. With an agency Mortuary Examiner Transport Team (METT), in lieu of an external vendor, the agency not only improves upon response times, but increases efficiency in work processes such as autopsy assistance, body release, ancillary autopsy suite duties, fleet maintenance and inventory tasks.

» The OCME sponsored its second annual Fatality Management Symposium and Full-Scale Exercise from September 11-13, 2017. This "international" event focused on the development of District-wide mass fatality plans and training for all District and regional stakeholders. International guests included representatives from Belgium and Egypt who discussed experiences from mass fatality incidents in those jurisdictions. Emergency response local and regional stakeholders participated in workshops and fatality management exercises over a four day period.

» The agency's Data Analysis Fusion Center, established in 2015, provided several mortality data trend reports to stakeholders in their efforts toward prevention, detection and law enforcement. The Center was quite active in 2017 publishing reports on opioids, elderly falls, myocarditis, in-custody deaths, homelessness and hypothermia, public dispositions, infant mortalities, and traffic mortalities.

» Of note, the agency managed approximately $1.9 million in grant funding to support fatality management, toxicological testing, violence prevention, and the review of fatalities of specified populations.

The OCME operates 24 hours a day, 7 days a week, 365 days a year. With a dedicated staff, we will continue working toward our mission of public safety and justice, academic advancement and public health surveillance. Most importantly. we will also remain committed to serving as a voice for families, residents and visitors at a time when they are most vulnerable and grief stricken.

In Truth and Service,

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

Executive Summary

THIS ANNUAL REPORT COVERS DATA THAT RESULTED FROM THE INVESTIGATION OF 5,988 DEATHS THAT OCCURRED IN THE DISTRICT OF COLUMBIA (DC) DURING THE CALENDAR YEAR (CY) 2017. 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.

The agency hopes that the information contained in the report will be useful to the Executive Office of the Mayor, Councilmembers and the public at large.

The OCME serves the citizens of the DC and the Metropolitan DC 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 every day of the year as well, and on occasion it is necessary for the Medical Examiner to perform them at night. The data presented within this report represents deaths occurring exclusively within the District of Columbia for which the OCME has jurisdiction. The data does not represent all deaths of DC residents. The decedent's place of residence or location of injury may be outside of the District.

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 Metropolitan Police Department (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.

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. Critical to this work is the agency's Data Fusion Center, which conducts epidemiological research in support of the agency's public health surveillance initiative in an effort to reduce the incidence and prevalence of preventable fatalities in the District. Part of this initiative includes real-time analysis and reporting of mortality data to federal, state, and local entities for the purpose of detecting, investigating and predicting trends to better support at risk populations. Additional, key agency activities are outlined in Appendix B.

OVERVIEW OF CASES REPORTED AND INVESTIGATED

DURING THE CALENDAR YEAR (CY) 2017, 5,988 CASES WERE REPORTED TO AND INVESTIGATED BY THE DISTRICT OF COLUMBIA - OFFICE OF THE CHIEF MEDICAL EXAMINER (OCME). OVERALL, THE TOTAL NUMBER OF DEATHS REPORTED TO THE OCME HAS SLIGHTLY INCREASED OVER THE PAST FIVE YEARS, WITH APPROXIMATELY 38% OF THE TOTAL DEATHS REPORTED BEING ACCEPTED CASES.

Medical Examiner Caseload

Accepted Cases - The OCME accepted jurisdiction of 1,353 decedent cases, of which 963 cases were autopsied.

Declined Cases - The OCME declined jurisdiction of 1,890 decedent cases, of which 66 became Storage Requests.

Storage Requests - The OCME provides a unique service to area nursing homes, hospices, and other like facilities by accommodating requests to store deceased bodies. Two hundred and twenty-one of the reported cases were Storage Requests only, and sixty-five of the storage requests were previously "Declined" cases, so as a result the agency had a total of 286 Storage Requests, of which 277 were approved (See section 8.0 for additional statistics)

Cremation Requests: The OCME must review all cremations for deaths that occur in the District of Columbia. There were 3,224 Cremation requests made to the OCME in 2017; 772 were OCME cases, 2,452 were "New Reports" submitted from area hospitals, clinics and nursing homes, the OCME took jurisdiction of 15 of these "New Reports" for further investigation and certification. (See section 8.0 for details).

Scene Visits and Body Transport - OCME investigation staff reported to 805 scenes of accepted cases. The OCME transported the bodies of 1,609 decedents, of which, 918 were transported directly from scenes of death to the agency..

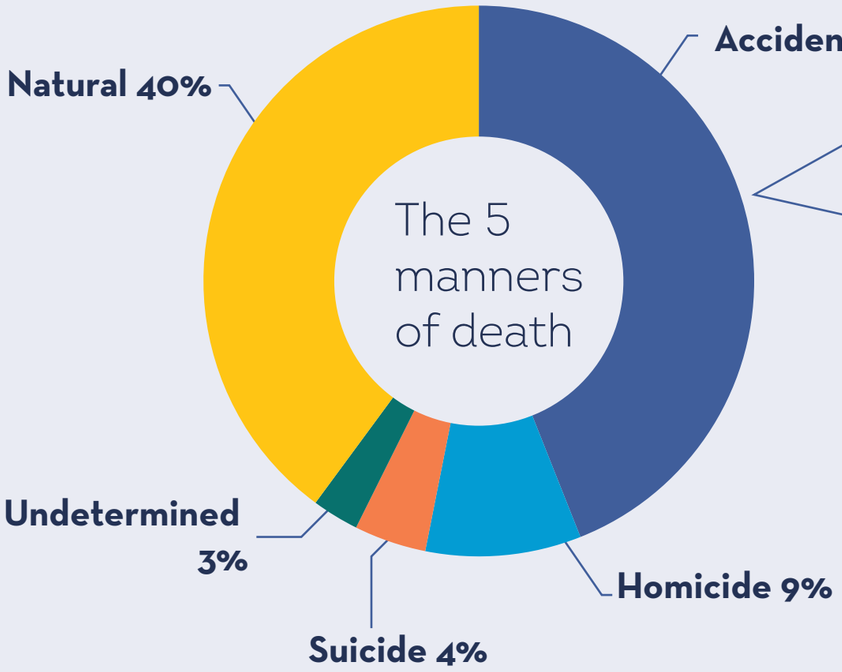
Organ/Tissue Donations - There were 128 organ donation requests during CY 2017.

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

2017 MEDICAL EXAMINER CASES BY MANNER OF DEATH

Manner	Full Autopsy Examinations	Partial Autopsy Examinations	External Examinations	Review of Medical Records	Non-Human	Anatomical Specimen Disposal	Total
Accident	455	0	118	19	0	0	592
Homicide	123	0	0	0	0	0	123
Natural	293	0	239	5	0	0	537
Stillbirth	0	0	0	0	0	0	0
Suicide	55	0	2	0	0	0	57
Undetermined	37	0	0	0	0	0	37
Other	0	0	5[1]	0	2	0	7
Total	**963**	**0**	**364**	**24**	**2**	**0**	**1353**

1 The above table includes the following "Other" cases: Cremains (5) and Non-Human Remains (2)



District of Columbia's Overdoses:

On avg. 1 fatal overdose per day

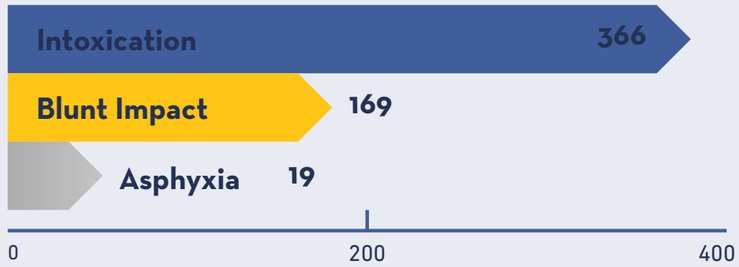
Overall Percent Total by Gender

67%

33%

Between 2016 and 2017, the number of accidental deaths have been abnormally higher than natural deaths. This is due to the increase of drug overdoses involving opioids.

Top 3 Causes of Accidental Deaths



NUMBER OF DEATHS

Overall Demographics

Gender	Female	Male	TOTAL
Accident	203	389	592
Homicide	22	101	123
Natural	181	356	537
Suicide	17	40	57
Undetermined	15	22	37
Total	**438**	**908**	**1346**

Top 3 Overall Causes of Death for 2017

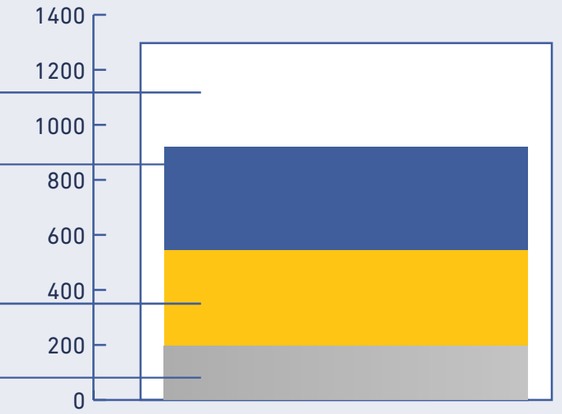
*The counts below include ALL Manners.

Overall Total of 2017 Deaths: **1346**

Total Number of Intoxication Related Deaths: **373***

Total Number of Cardiovascular Disease Related Deaths: **369**

Total Number of Blunt Trauma Deaths: **195***



***Note:** The data presented in this report represents deaths occurring in DC for which OCME has jurisdiction. The decedent's place of residence or location of injury may be outside of the District.

SUMMARY OF FINDINGS FOR MANNER OF DEATH

HOMICIDES: The OCME investigated 123 homicides in the CY 2017. 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 March.

Toxicology Findings: Toxicology testing was requested in 121 of 123 homicide cases investigated. Drugs were present in 89 of the homicide cases investigated. The most commonly detected drugs in homicide cases were: Marijuana Metabolites (52); Ethanol (30); Phencyclidine (13); Cocaine metabolites (8); Fentanyl (7); Morphine/Heroin (6/2); Hydromorphone (4); Alprazolam (3); Oxycodone (3).

SUICIDES: The OCME investigated 57 suicides in the CY 2017. This report reveals that suicides were more prevalent in white males and in persons between the ages of 20-29. Hanging was the most prevalent cause of suicide. Peak incidents occurred in April.

Toxicology Findings: Toxicology testing was requested for 56 of 57 suicide cases investigated. Overall, drugs were present in 42 of the suicide cases investigated. The most commonly detected drugs were: Ethanol (10); Marijuana Metabolite (7); Diphenhydramine (6); Amphetamine (5); Citalopram metabolite (5); Cocaine metabolites (4); Fentanyl (4) and Oxycodone (4).

ACCIDENTS: The OCME investigated 592 accidents in the CY 2017. Of the 592 cases investigated, 366 of the accidental deaths occurred as a direct result of prescription and/or illicit drug used. Also 169 deaths were the result of blunt force trauma, of which 57 were traffic-related deaths and 101 were directly related to falls. Peak incidents for accidental deaths overall occurred in May.

Toxicology Findings for Accidents: Toxicology testing was requested for 471 of the 592 accident cases investigated, and drugs were present in 423 of these cases. The most commonly detected drugs were: Fentanyl (179); Cocaine metabolites (163); Morphine (161)/Heroin (146); Codeine (122); Furanyl-Fentanyl (55); Marijuana Metabolites (43); Diphenhydramine (48); Phencyclidine (51); Quinidine/Quinine (38); Naloxone (36).

TRAFFIC-RELATED ACCIDENTS: The majority of traffic accident deaths occurred in the following categories: males, blacks, and drivers between the ages of 20-39. Traffic accidents were most prevalent in March and June.

Toxicology Findings for Traffic-related accidents: Toxicology testing was requested for 42 of the 57 Traffic-related Accidents, and drugs were present in 29 of these cases. The most commonly detected drugs were: Ethanol (18); Marijuana Metabolite (10); Fentanyl (4); Nordiazepam (3); Oxycodone (3); Midazolam (2); Morphine (2); Phencyclidine (2).

In the 18 traffic deaths positive for ethanol, 16 were greater than the legal limit (0.08 g/100 mL) for driving under the influence in the District of Columbia. The average blood alcohol concentration of the positive results is approximately 0.14 g/100 mL.

NATURAL DEATHS: The OCME investigated 537 Natural deaths in CY 2017. This report reveals that the leading cause of death in Natural cases is Cardiovascular Disease with 369 deaths, followed by Alcoholism with 43 deaths. The majority of Natural deaths occurred in January for 2017.

Toxicology Findings: No toxicology reporting for natural deaths is being provided for 2017.

UNDETERMINED: The OCME investigated 37 cases where the manner of death was concluded to be "Undetermined." An "Undetermined" manner of death is a result of inconclusive evidence 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 37. Undetermined deaths investigated. Drugs were present in 17 of the Undetermined cases investigated. The most commonly detected drugs were: Ethanol (5); Fentanyl (5); Morphine (3)/Heroin (1); Nordiazepam (3); Cocaine and Metabolites (2); Diazepam (2); Fluoxetine (2); Naloxone (2); Oxycodone (2); Temazepam (2).

SUMMARY OF APPENDICES

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

A. 2017 OCME Organizational Chart

B. Key Agency Activities

C. Internal Services

D. Glossary

SECTIONS 1–8

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, 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 2017, the agency had three primary programs: Death Investigation and Certification, Agency Management, and Fatality Review. This report will include data on the Death Investigation and Certification, and the Agency Management programs. The Fatality Review Committees are statutorily required to issue their own Annual Reports.

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

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. Autopsy procedure requires the retention of tissue specimens up to and including whole organ retention as needed. Tissue retention is for the purpose of ensuring timely and accurate diagnosis. The OCME works in close relationship with legal 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 the majority of cases autopsied depending upon the 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.

Fatality Review Program includes the Child Fatality Review Committee (CFRC) and, the Developmental Disabilities Fatality Review Committee (DD FRC). 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 District hospices and local hospitals in the District of Columbia when final disposition cannot be established by the next-of-kin. The OCME has a total body storage capacity of 206. Public 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 final public 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, Metropolitan Police Department and the Federal Bureau of Investigation (FBI). In addition, OCME uses comparative radiology, forensic odontology and/or DNA analysis as necessary to ensure proper and timely identification. The OCME also procures specimens for DNA analysis on each decedent.

OCME is one of the few medical examiner offices in the nation that provides on-site grief counseling. In addition and in preparation for possible terrorist attacks and mass natural disaster events, the 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. The agency also conducts a mass fatality exercise with local and federal partners in order to test the capacity of Mass Fatality Plan, train staff, develop policies and procedures and identify resources.

Through the years, OCME staff has been 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, My Brother's Keeper DC, Safer Stronger DC and the DC 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 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) 2017, THERE WERE 6,238 DEATHS THAT OCCURRED IN THE DISTRICT OF COLUMBIA (DC) AS REPORTED BY THE DEPARTMENT OF HEALTH, CENTER FOR POLICY, PLANNING AND EVALUATION FOR THE DISTRICT OF COLUMBIA, OF WHICH 3,536 OR 57% OF THESE DEATHS WERE REPORTED TO AND INVESTIGATED BY THE OFFICE OF THE CHIEF MEDICAL EXAMINER (OCME). THE FOLLOWING IS A BREAKDOWN OF HOW THE REPORTED CASES WERE TRIAGED. THE CATEGORIES INCLUDE "ACCEPTED", "DECLINED", "STORAGE" OR "CREMATION" CASES.

THE DATA PRESENTED WITHIN THIS REPORT REPRESENTS DEATHS OCCURRING EXCLUSIVELY WITHIN THE DISTRICT OF COLUMBIA FOR WHICH THE OCME HAS JURISDICTION. THE DATA DOES NOT REPRESENT ALL DEATHS OF DC RESIDENTS. THE DECEDENT'S PLACE OF RESIDENCE OR LOCATION OF INJURY MAY BE OUTSIDE OF THE DISTRICT (SEE PAGES 26-27).

Accepted Cases: The OCME accepted jurisdiction of 1,353 decedent cases, of which 963 cases were autopsied. There were scene visits for 805 of the 1,353 accepted cases.

Declined Cases: The OCME declined jurisdiction of 1,890 decedent cases, of which 66 became Storage Requests. There were scene visits for 74 of the 1,890 declined cases.

Storage Requests: The OCME provides a unique service to area nursing homes, hospices, and other like facilities by accommodating requests to store deceased bodies. Two hundred and twenty-one (221) of the reported cases were Storage Requests only, and 65 of the storage requests were previously "Declined" cases, so as a result the agency had a total of 286 Storage Requests, of which 277 were approved (See section 8.0 for additional statistics). There were scene visits for 116 of the 293 storage cases.

Cremation Requests: The OCME must review all cremations for deaths that occur in the District of Columbia. There were 3,224 Cremation requests made to the OCME in 2017; 772 were OCME cases, 2,452 were "New Reports" submitted from area hospitals, clinics and nursing homes, the OCME took jurisdiction of 15 of these "New Reports" for further investigation and certification. (See section 8.0 for details).

Total Number of Cases Reported and Investigated by the OCME	3,536
Total Number of Declined Cases	1890
Percent of Cases Reported & Investigated	53%
Total Number of Cases Accepted for Further Investigation	1353
Percent of Cases Reported & Investigated	38%
Total Number of Autopsies Full – 962; Partial –0; Performed in a University Hospital – 1	963
Percent of Cases Accepted for Further Investigation	71%
Number of Scene Visits by a Medical Examiner or Medico Legal/Forensic Investigator	805
Percent of Cases Accepted for Further Investigation	59%
Total Number of Bodies/Cases Transported by OCME or by Order of the OCME: Transported by Pick-up Service -208 Transported by Office Personnel –1395 (Investigations:10; Mortuary: 1385) Transported by Others -6 (FEMS -2, Funeral Home - 1 and Police/Park Police – 3)	1609
Total Number of Organ/Tissue Donation Requests:	127

BREAKDOWN OF ACCEPTED CASES BY EXAM TYPE

Total Number of Cases Accepted and Investigated Further	1,353
Total Number of Autopsies Full – 962 Partial –0 Performed at a University Hospital – 1	963
Percent of Cases Accepted	71%
Number of External Examinations On-site -360 Off-site - 0	360
Percent of Cases Accepted	27%
Number of Medical Record Reviews *	24
Percent of Cases Accepted	2%
Number of Non-Human Remains *	2
Percent of Cases Accepted	<1%
Number of Anatomical Specimen Disposal	0
Percent of Cases Accepted	0%
Number of Exhumations/Disinterment	0
Percent of Cases Accepted	0%

Definition of Unfamiliar Exam Type Classifications:

» **Autopsy Performed at an Area Hospital:** During Calendar Year 2017 there was one case where the autopsy was performed at a University hospital. The DC Official Code § 5-1409 authorizes the Chief Medical Examiner to deputize any "qualified pathologist" to perform an autopsy on a decedent that is deemed a Medical Examiner case. Some of these cases were initially declined by the OCME and later accepted based on additional information/ autopsy findings. Cases in which the autopsy was completed at the hospital, still required review of the autopsy reports and completion of the death certificates be done by the Medical Examiner.

» **Medical Record Reviews:** Cases where the body is not needed in order to make a forensic determination of cause and manner of death. The determination is based solely on the review of available medical records.

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

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

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

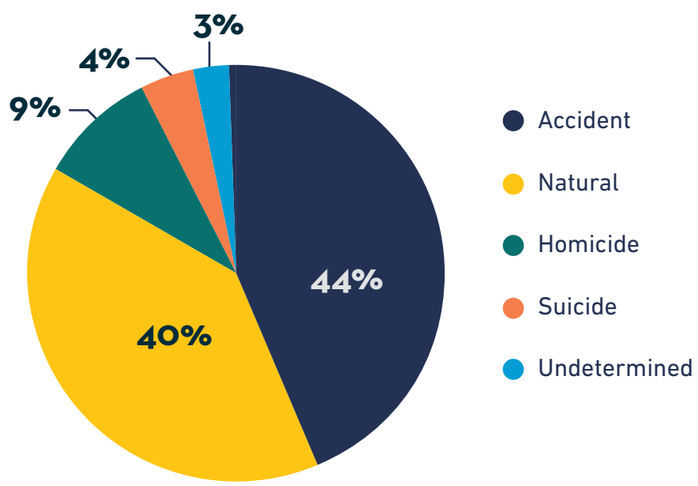
BREAKDOWN OF ACCEPTED CASES AND AUTOPSIES BY MONTH

Month	Case Investigations	Autopsies Full and Partials
January	133	101
February	105	77
March	132	96
April	112	73
May	124	87
June	122	84
July	113	77
August	105	80
September	115	84
October	99	76
November	92	62
December	101	66
Total	**1353**	**963**

MEDICAL EXAMINER CASE EXAMINATIONS BY MANNER OF DEATH

Manner	Full Autopsy Examinations	Partial Autopsy Examinations	External Examinations	Review of Medical Records	Non-Human	Anatomical Specimen Disposal	Total
Accident	455	0	118	19	0	0	592
Homicide	123	0	0	0	0	0	123
Natural	293	0	239	5	0	0	537
Stillbirth	0	0	0	0	0	0	0
Suicide	55	0	2	0	0	0	57
Undetermined	37	0	0	0	0	0	37
Other	0	0	5 [2]	0	2	0	7
Total	963	0	364	24	2	0	1353

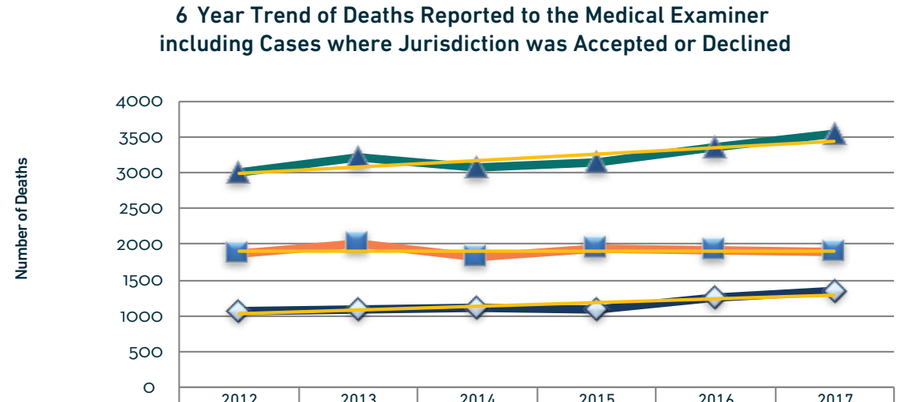
PIE CHART - MEDICAL EXAMINER CASES BY MANNER OF DEATH



Above chart doesn't include 7 cases classified as "Other"

2 The above table includes the following "Other" cases: Cremains (5) and Non-Human Remains (2)

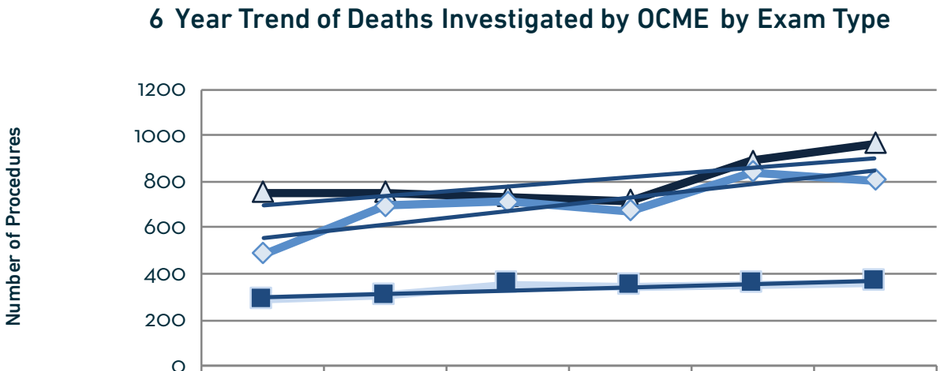
SIX-YEAR OVERVIEW OF DEATHS REPORTED TO THE MEDICAL EXAMINER (2012– 2017)



	2012	2013	2014	2015	2016	2017
Accepted	1077	1089	1120	1085	1267	1353
Declined	1879	2012	1812	1933	1926	1890
Total Deaths Reported	3009	3221	3063	3149	3362	3536

Note: All accepted cases and all declined cases will not equal Total Deaths Reported, because the Total Deaths Reported includes storage requests.

SIX-YEAR TRENDS IN DEATHS REPORTED AND INVESTIGATED BY EXAM TYPE (2012 – 2017)



	2012	2013	2014	2015	2016	2017
Autopsies	752	754	735	715	891	963
External Exams	288	305	354	345	353	360
Scene Visits	485	694	712	674	840	805

Breakdown of Accepted Cases by Residence of Decedents

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

ME CASES BY JURISDICTION OF RESIDENCE

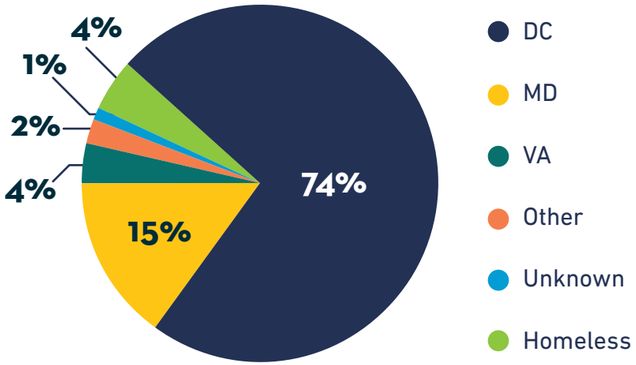


TABLE: MEDICAL EXAMINER CASES BY RESIDENCE AND MANNER OF DEATH

DC Deaths by Jurisdiction of Residence and Manner of Death								
Ward	# of Deaths	Accidents	Homicides	Natural	Stillbirth	Suicide	Undetermined	Other
Ward 1	72	22	6	35	0	7	2	0
Ward 2	56	21	2	26	0	6	1	0
Ward 3	48	20	0	24	0	4	0	0
Ward 4	104	40	6	51	0	6	1	0
Ward 5	177	66	16	84	0	6	5	0
Ward 6	127	48	6	66	0	6	1	0
Ward 7	183	75	13	84	0	4	7	0
Ward 8	223	107	29	78	0	3	6	0
DC	990	399	78	448	0	42	23	0
MD	199	108	27	52	0	4	8	0
VA	49	30	5	8	0	3	3	0
Other	30	9	3	13	0	5	0	0
Unknown	17	7	7	3	0	0	2	0
Undomiciled	61	39	3	13	0	3	3	0
Total	1346[3]	592	123	537	0	57	37	0

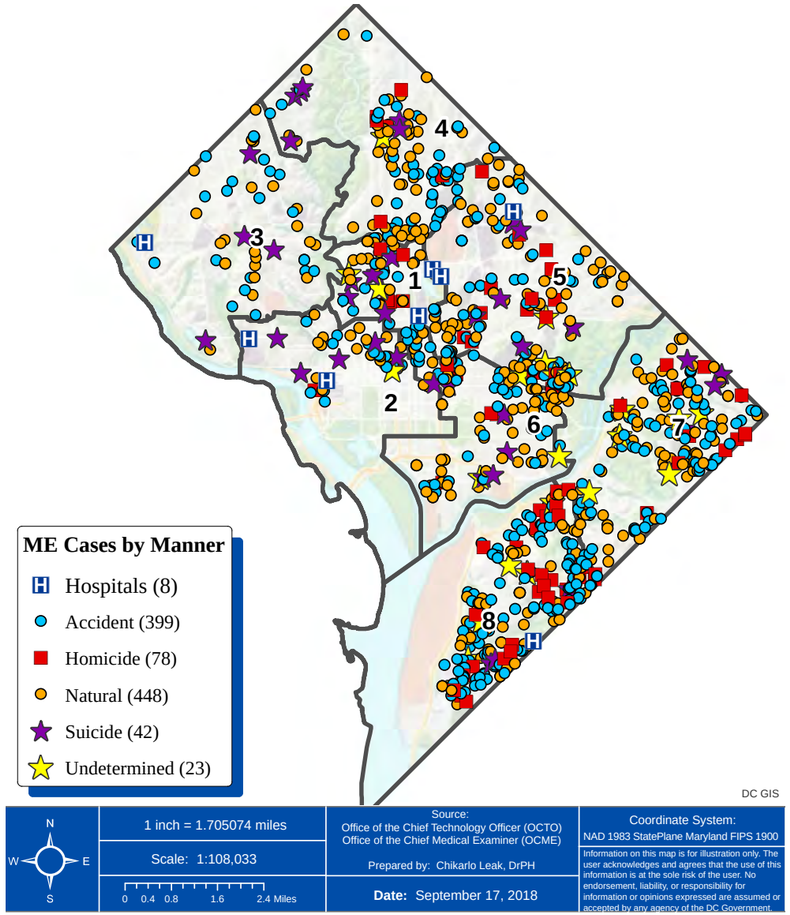
Note: "Total" is the sum of decedents with a jurisdiction of DC, MD, VA, Other, Unknown and Undomiciled.

3 This table does not inlcude the 7 cases, 5 cremains and 2 non-humans. See note on page 24. Those cases are included in this table.

Map of OCME Decedents by DC Ward and Manner of Death

Of the 1,353 deaths investigated by the OCME, 990 (73%) were DC residents at the time of their death. Of the remaining 363 decedents, 55% were residents of MD and 13% were residents of VA. The map below illustrates the deaths by DC ward and manner of death. The data presented within this report represents deaths occurring exclusively within the District of Columbia for which the OCME has jurisdiction. The data does not represent ALL deaths of DC residents. The decedent's place of residence or location of injury may be outside of the District.

2017 MEDICAL EXAMINER CASES BY MANNER OF DEATH (DC RESIDENCE ONLY)



Postmortem Toxicology Summary 2017

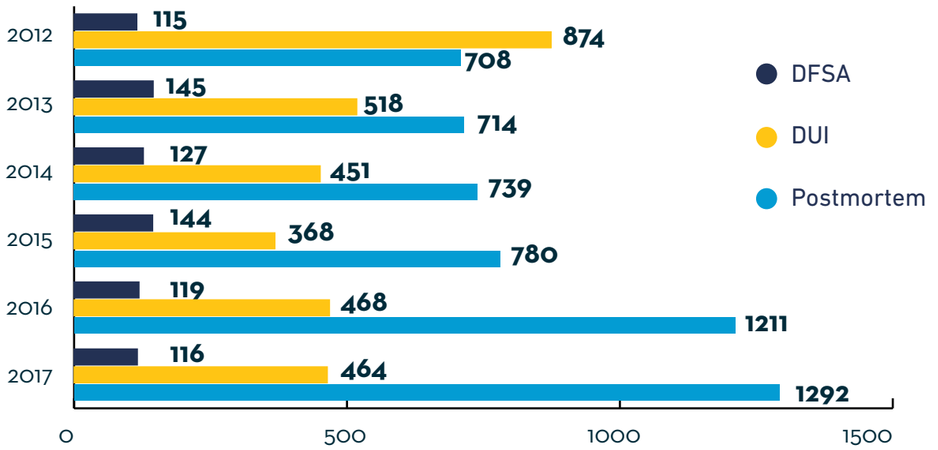
All postmortem specimens received for routine toxicological testing were analyzed for alcohols (ethanol and other volatiles) and major classes of illicit and prescription medications. Additional screens were assigned depending on intake case history and special requests made by physicians. All significant drug results were confirmed by further testing. Typical case specimens received include blood, urine, bile, vitreous, liver, brain, and gastric contents. In 2017, the Washington, DC, Office of the Chief Medical Examiner Toxicology Division received and inventoried 10,203 postmortem specimens (1,292 cases) yielding 4,723 reported results. This is an increase from 2016's 9,674 postmortem specimens, 1,211 cases and 2,847 reported results received by the toxicology laboratory.

Total number of postmortem cases processed:

Description	Number of Cases	% of Cases
N=	1,292	
Negative	232	17.9%
Positive	779	60.2 %
No testing requested or assigned	281	21.7%

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

TRENDS IN CASES PROCESSED BY TOXICOLOGY UNIT



Top 20 Most Prevalent Drugs in Postmortem Cases

The data below highlights the number of times a specific drug was identified in a case. However, most cases include mixed drug toxicity.

The most prevalent drugs in the postmortem cases overall were:[4]

	Drug Name	Number of Cases	% of Cases
1	Ethanol	254	25.1%
2	Fentanyl	203	20.0%
3	Cocaine and Metabolites	199	19.6%
4	Morphine/Heroin	192/149	18.9%/14.7%
5	Marijuana Metabolite	139	13.7%
6	Codeine	131	12.9%
7	Diphenhydramine	61	6.0%
8	Phencyclidine	57	5.6%
9	Furanyl-Fentanyl	56	5.5%
10	Oxycodone	53	5.2%
11	Naloxone	51	5.0%
12	Quinidine/Quinine	43	4.2%
13	Methadone	37	3.6%
14	Nordiazepam	35	3.4%
15	Acetone	33	3.2%
16	Hydromorphone	28	2.7%
17	FIBF/para-Fluorobutyryl fentanyl	27	2.6%
18	Alprazolam	26	2.5%
19	Norbuprenorphine	25	2.4%
20	Quetiapine	24	2.3%

4 This data does suggest individual cases and the majority of cases include mixed drug toxicity.

POLYSUBSTANCE USE AMONG POSTMORTERM CASES IN 2017

Major Common Illicit Drugs (listed in order of prevalence)	Total # Positive Major Illicit Drug Cases	Most Common Combination	% of Total # of Positive Major Illicit Drug Cases	2nd Most Common Combination	% of Total # of Positive Major Illicit Drug Cases	3rd most Common Combination	% of Total # of Positive Major Illicit Drug Cases
Ethanol	254	Fentanyl	25.5%	Heroin	22.8%	Cocaine Metabolites	22.4%
Fentanyl	203	Heroin	47.2%	Cocaine Metabolites	38.9%	Ethanol	32.0%
Cocaine Metabolites	199	Fentanyl	39.6%	Heroin	31.1%	Ethanol	28.6%
Heroin	192	Fentanyl	50.0%	Cocaine Metabolites	32.2%	Ethanol	30.2%
Marijuana Metabolite	139	Ethanol	25.8%	Cocaine Metabolites	19.4%	Fentanyl	17.2%
PCP	57	Ethanol	43.8%	Cocaine Metabolites	29.8%	Fentanyl	24.5%
Furanyl-Fentanyl	56	Heroin	67.8%	Ethanol	48.2%	Cocaine Metabolites	44.6%
Nordiazepam	35	Ethanol	40.0%	Heroin	37.1%	Fentanyl	34.2%
FIBF/para-Fluorobutyryl fentanyl	27	Heroin	59.2%	Cocaine Metabolites	44.4%	Ethanol	44.4%
Alprazolam	26	Heroin	30.7%	Fentanyl	26.9%	PCP/ Marijuana metabolite	19.2%

2.1 BREAKDOWN OF MEDICAL EXAMINER INVESTIGATIONS

The US Census estimates that during 2017, the total population within the District of Columbia was 681,170[5] inhabitants, which comprised primarily of the following racial/ethnic groups: White, Black, Hispanic, Asian and Other. There were a total of 6,238 deaths within the District of Columbia in 2017. In 2017, the OCME investigated 3,536 deaths that occurred in the District of Columbia or were wards of the District and died in another jurisdiction. Of those cases, 1,353 were accepted under the jurisdiction of the Medical Examiner for further investigation; of which 990 of them were known to be residents in the District of Columbia. The following table and charts summarize the manner of death by racial composition. Although a death occurs in the District of Columbia, the decedent's place of residence can be anywhere in the world.

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

2017 MANNER OF DEATH BY RACE WITH 2010 CENSUS DATA

Race	2010 Census	ME Cases DC Residents Only	Total ME Cases	Nat.	Sui.	Hom.	Acc.	Und.
Black (non-Hispanic)	301,053	798	981	410	25	102	416	28
White (non-Hispanic) [6]	209,464	146	277	104	27	6	135	5
Hispanic (any single race)	54,749	35	68	14	4	13	33	4
Asian (non-Hispanic)	20,818	7	11	4	1	0	6	0
Two or more races	12,650	0	0	0	0	0	0	0
Other (non-Hispanic)	1,451	1	4	1	0	2	1	0
American Indian and Alaska Native(non-Hispanic)	1,322	2	2	1	0	0	1	0
Pacific Islander (non-Hispanic)	216	1	3	3	0	0	0	0
Total Population	601,723	990	1,346 [7]	537	57	123	592	37
Total # of ME Cases								
				Manner of Death Among Deaths Reported to DC Vital Records				
	Deaths Reported to DC Vital Records	Deaths of DC Residents	ME Cases	Nat.	Sui.	Hom.	Acc.	Und.
2017 DC Vital Records Data. [8]	7,110	4,959	1,340	6,182	62	160	632	56

Legend for Manner of Death:
1. Nat. = Natural Deaths
2. Sui. = Suicide
3. Hom. = Homicide
4. Acc. = Accident
5. Und. = Undetermined

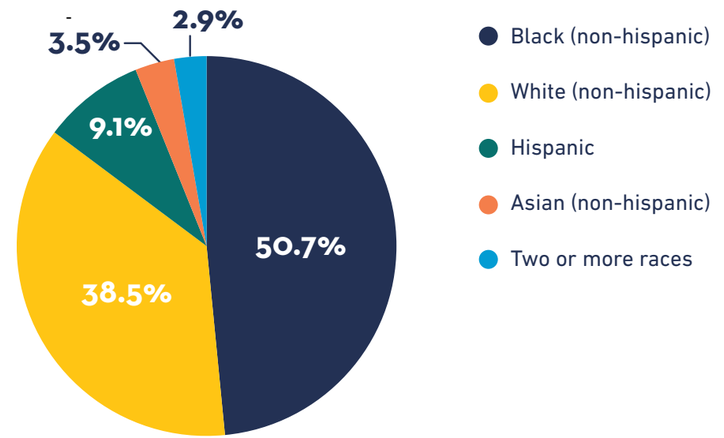
6 The (non-Hispanic) attribute only applies to the 2010 Census data and does not apply to the OCME statistics for race by "Manner of Death"

7 DC Death Data, Vital Records Division, Center for Policy Planning and Evaluation, D.C. Department of Health. Preliminary 2017 data file as of November 20, 2018. The data include four death records with the manner of death still "Pending Investigation" and 11 death records with missing information for the manner of death. The total number of deaths reported by DC Vital Records includes all DC residents, whether the deaths occurred in the District or in another jurisdiction

8 The DC DOH Center for Policy, Planning and Evaluation had 7 cases that were "Pending Investigation" and 218 cases that was missing manner of death at the time of submitting this data to the DC OCME. In addition, the total number of deaths were reported by DOH includes all DC residents, including deaths that occurred outside of the District of Columbia.

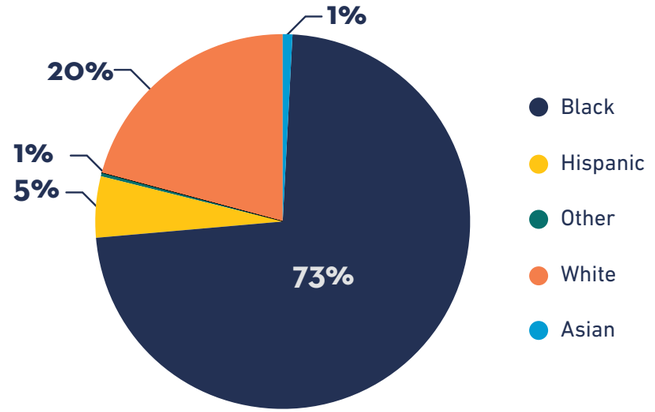
2.2 - TOTAL POPULATION

2010 US CENSUS POPULATION DATA BY RACE FROM THE DISTRICT OF COLUMBIA

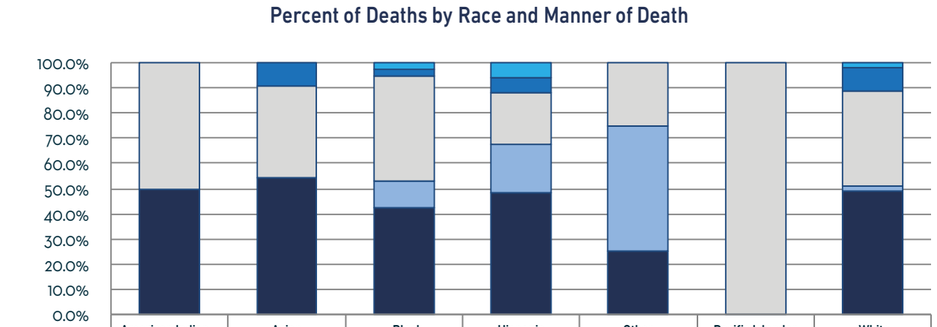


NOTE: The race categories American Indian/Alaska Native and Pacific Islander/Native Hawaiian are not represented in the above graph because they are both less than 1% of the total population in the District of Columbia. On the other hand, Hispanics are represented in this graph; although this classification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

2.3 - TOTAL ME CASES BY DEMOGRAPHICS AND MANNER OF DEATH

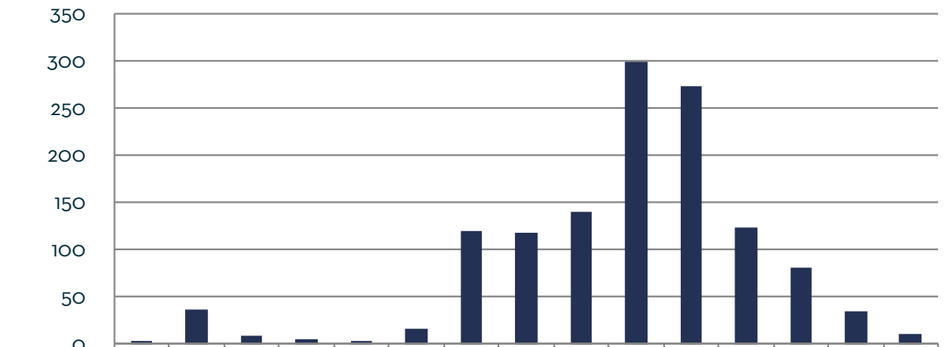


BY RACE AND MANNER OF DEATH [9]



	American Indian	Asian	Black	Hispanic	Other	Pacific Islander	White
Undetermined			2.9%	5.9%			1.8%
Suicide		9.1%	2.5%	5.9%			9.7%
Natural	50.0%	36.4%	41.8%	20.6%	25.0%	100.0%	37.5%
Homicide			10.4%	19.1%	50.0%		2.2%
Accident	50.0%	54.5%	42.4%	48.5%	25.0%		48.7%

2017 TOTALS BY AGE



	Fetus	< 1	1 to 5	6 to 12	13 to 15	16 to 19	20 to 29	30 to 39	40 to 49	50 to 59	60 to 69	70 to 79	80 to 89	90+	Unk.
Total Deaths	4	36	8	5	4	16	119	118	139	298	272	123	80	35	11
Percent	0.30%	2.80%	0.60%	0.40%	0.30%	1.20%	9.40%	9.30%	11%	23.50%	21.50%	9.70%	6.30%	2.80%	0.90%

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

2017 GENDER BY RACE

Race	Males	Females	Total
American Indian	1	1	2
Asian	7	4	11
Black	659	322	981
Hispanic	57	11	68
Other	1	3	4
Pacific Islander	2	1	3
White	181	96	277
Total	**908**	**438**	**1346**

2017 MANNER OF DEATH BY GENDER [10]

Gender	Accident	Homicide	Natural	Suicide	Undetermined	Totals	Percent
Female	203	22	181	17	15	438	32.5%
Male	389	101	356	40	22	908	67.5%
Total	**592**	**123**	**537**	**57**	**37**	**1346**	**100%**

NOTE: The above tables does not include – Cremains (5) and one Non-Human Remains (2).

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

10 In this report, gender in this context means sex at birth.

3.0

MANNER AND CAUSE OF DEATH

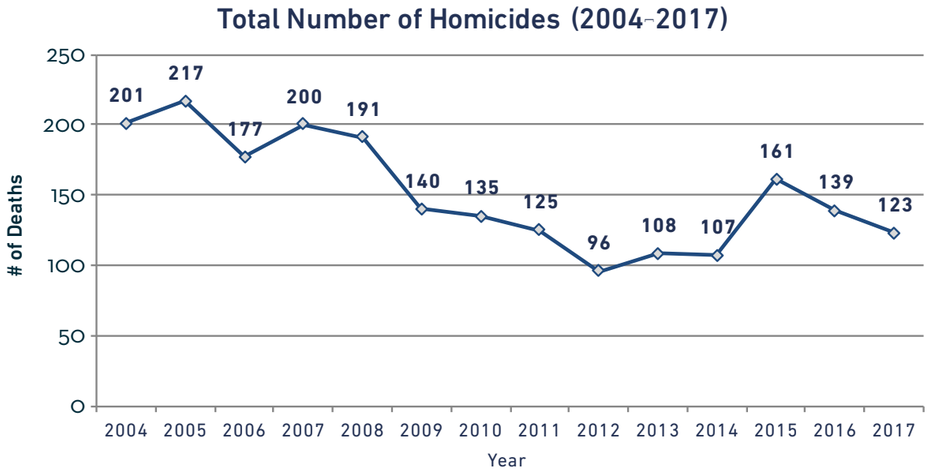
THE OCME ACCEPTED 1,353* CASES IN CALENDAR YEAR (CY) 2017 THAT REQUIRED FURTHER REVIEW AND INVESTIGATION. THIS SECTION HIGHLIGHTS THE OVERALL STATISTICS OF THE 5 MANNERS OF DEATH RECOGNIZED BY THE OCME. THIS SECTION REFLECTS THE DATA INCLUDING, BUT NOT LIMITED TO: DEMOGRAPHICS (AGE, RACE, GENDER), JURISDICTION OF RESIDENCE, AND SPECIFIC CAUSE OF DEATH. IN CY 2017, THE OCME INVESTIGATED 123 HOMICIDES, 57 SUICIDES, 592 ACCIDENTS, 537 NATURAL DEATHS AND 37 CASES WHERE THE MANNER OF DEATH WAS CONCLUDED TO BE "UNDETERMINED."

*The 2 non-human remains and 5 cremains are not included in these counts."

3.1 HOMICIDES

The DC OCME investigated 123 homicides in CY 2017. 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 of 20 to 29 years than any other group presented. The weapon of choice is firearms. In 2017, there were more homicides observed in March than any other month.



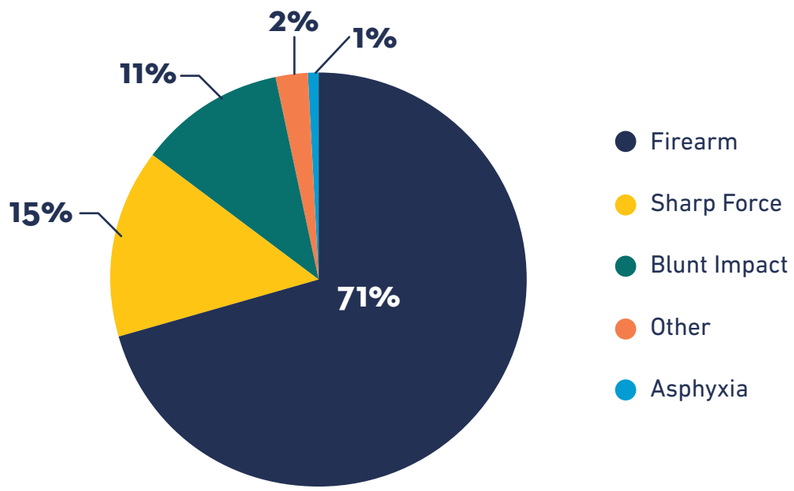
HOMICIDES BY JURISDICTION OF INCIDENT THAT CAUSED DEATH

Jurisdiction	Number of Homicides	% of Homicides
District of Columbia	94	76.42%
Maryland	15	12.20%
Virginia	4	3.25%
Unknown	11	8.13%
Total	123	100%

HOMICIDES BY CAUSE OF DEATH

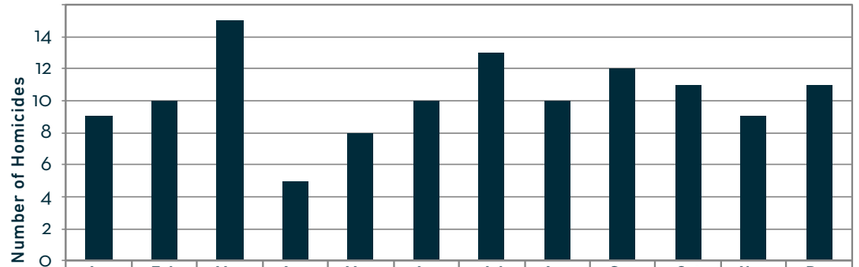
Cause	Number of Homicides	% of Total Homicides
Firearms	87	71%
Sharp Force	18	15%
Blunt Impact	14	11%
Other	3	2%
Asphyxia	1	1%
Total	123	100%

PIE CHART – HOMICIDES BY CAUSE OF DEATH



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

GRAPH - HOMICIDES BY MONTH



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Number of Deaths	9	10	15	5	8	10	13	10	12	11	9	11
% of Homicides	7%	8%	12%	4%	7%	8%	11%	8%	10%	9%	7%	9%

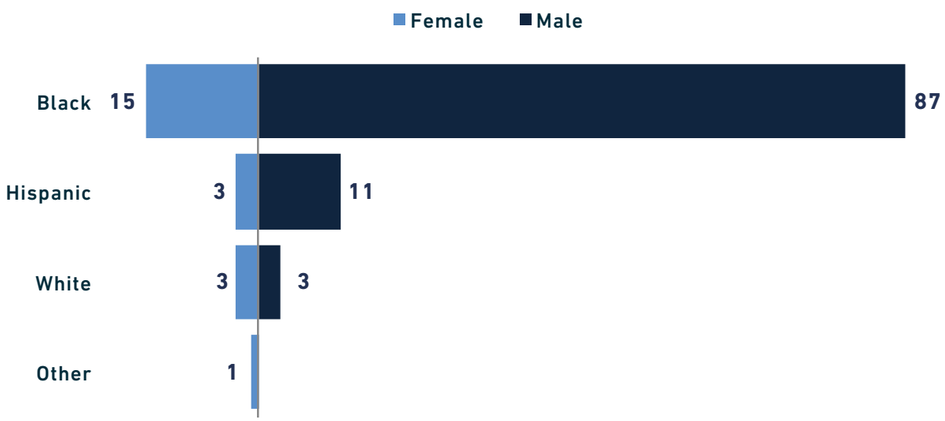
HOMICIDES BY RACE

Race/Ethnicity	Number of Homicides	% of Homicides
Black	102	83%
Hispanic	14	11%
White	6	5%
Other	1	1%
Total	123	100%

HOMICIDES BY GENDER

Gender	Number of Homicides	% of Homicides
Female	22	18%
Male	101	82%
Total	123	100%

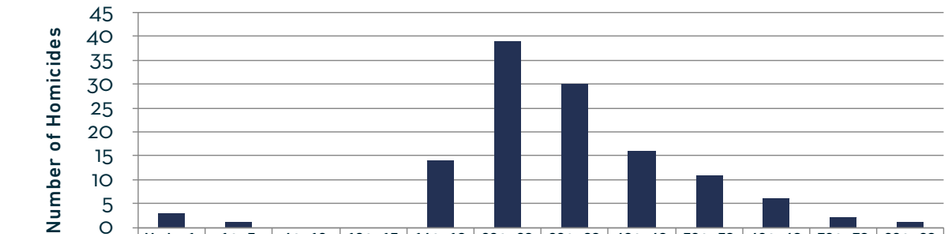
HOMICIDES BY RACE AND GENDER



HOMICIDES BY RACE/ETHNICITY AND GENDER

Race/Ethnicity by Gender	Number of Homicides
Black	**102**
Female	15
Male	87
Hispanic	**14**
Female	3
Male	11
White	**6**
Female	3
Male	3
Other	**1**
Female	1
Male	0
Total	**123**

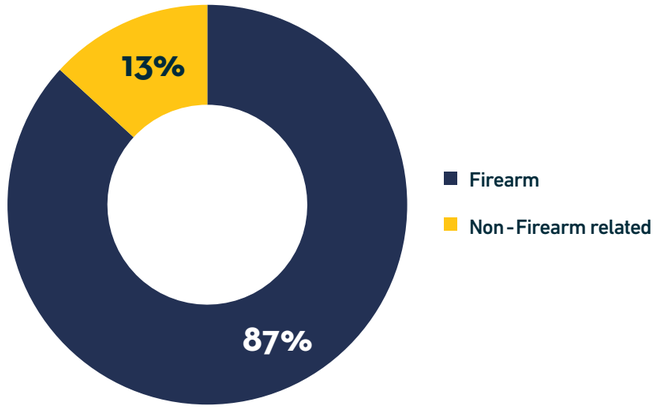
CHART - HOMICIDES BY AGE GROUP



	Under 1	1 to 5	6 to 12	13 to 15	16 to 19	20 to 29	30 to 39	40 to 49	50 to 59	60 to 69	70 to 79	80 to 89
Number of Deaths	3	1	0	0	14	39	30	16	11	6	2	1
% of Homicides	2%	1%	0%	0%	11%	32%	24%	13%	9%	5%	2%	1%

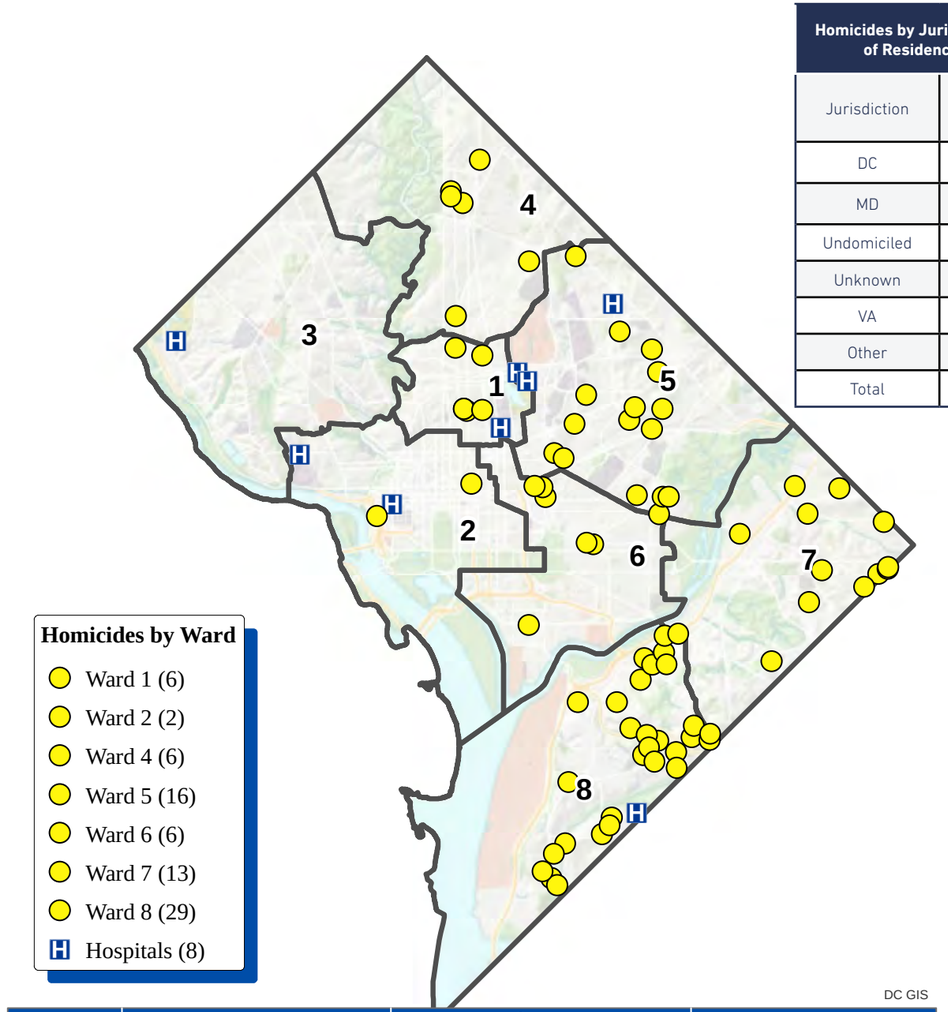
FIREARM-RELATED HOMICIDES BY ADOLESCENTS AND YOUNG ADULTS

Percentage of firearm-related Homicides among adolescents and young adults (16 to 29 yrs old)



Map of Homicides by DC Ward and Cause of Death

Of the 123 homicides in the District of Columbia, 78 (63%) of these decedents were District residents at the time of their death, as reported by their next of kin. The map below illustrates the residence location by District ward at the time of their death.



Homicides by Jurisdiction of Residence	
Jurisdiction	# of Deaths
DC	78
MD	27
Undomiciled	3
Unknown	7
VA	5
Other	3
Total	123

Toxicology Findings for Homicide Cases

Toxicology was performed on 121 of 123 homicide cases investigated by OCME. All cases were screened for alcohol and major drugs of abuse, Marijuana being the most prominent substance in all homicide case. Drugs were absent in 30 homicide cases. Approximately, 24% of the homicide cases received by the laboratory were negative for drugs and alcohol. This was a slight decrease from 2016 (25% of cases were negative).

Description	Number of Cases	% of Cases
N=	123	
Negative	30	24.3%
Positive	91	73.9%
No testing requested or assigned [11]	2	1.6%

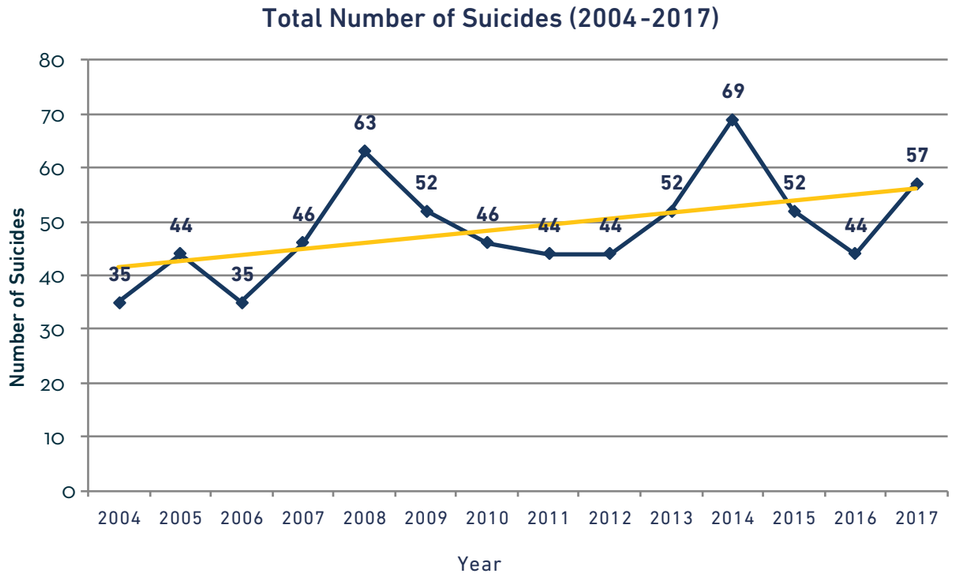
The most commonly detected drugs in the homicide cases were:

Name of Drug	Number of Cases	% of Homicide Cases
Marijuana Metabolites	54	44.6%
Ethanol	30	24.7%
Phencyclidine	13	10.5%
Cocaine and Metabolites	8	6.6%
Fentanyl	7	5.6%
Morphine/Heroin	6/2	4.9%/1.6%
Hydromorphone	4	3.3%
Alprazolam	3	2.4%
Oxycodone	3	2.4%

11 There were two babies that were born prematurely and did not receive toxicology testing.

3.2 SUICIDES

The OCME investigated 57 suicides in CY 2017, which represents a 30% increase from CY 2016 (44). Deaths by suicidal acts were more prevalent in white males and in persons between the ages of 20 to 29 years. Hanging was the leading cause of suicidal deaths. More incidents occurred in April than in any other month.



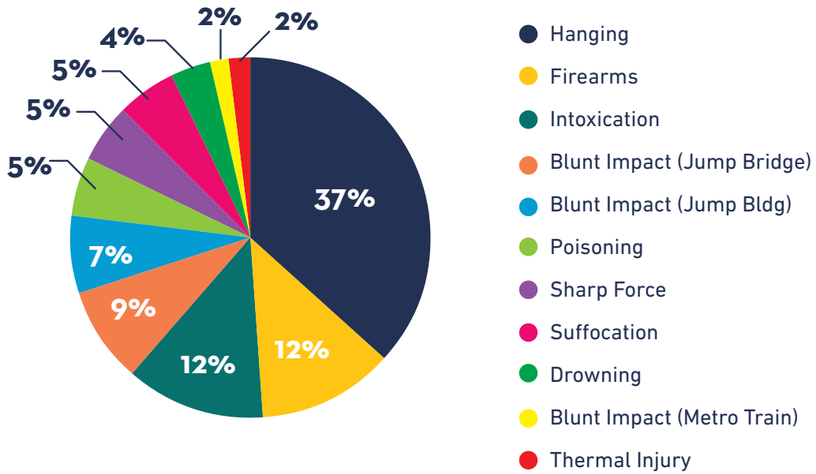
SUICIDES BY JURISDICTION OF INCIDENT THAT CAUSED DEATH

Jurisdiction of Incident	Number of Suicides	% of Suicides
District of Columbia	51	89.47%
Maryland	1	1.75%
Virginia	2	3.51%
Unknown	3	5.26%
Total	57	100%

SUICIDES BY CAUSE OF DEATH

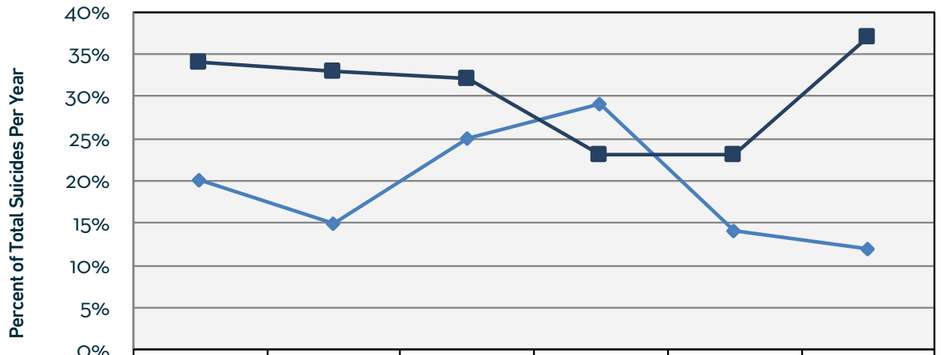
Cause	Number of Suicides	% of Total Suicides
Hanging	21	37%
Firearms	7	12%
Intoxication	7	12%
Blunt Impact (Jump Bridge)	5	9%
Blunt Impact (Jump Bldg)	4	7%
Poisoning	3	5%
Sharp Force	3	5%
Suffocation	3	5%
Drowning	2	4%
Blunt Impact (Metro Train)	1	2%
Thermal Injury	1	2%

SUICIDES BY CAUSE OF DEATH



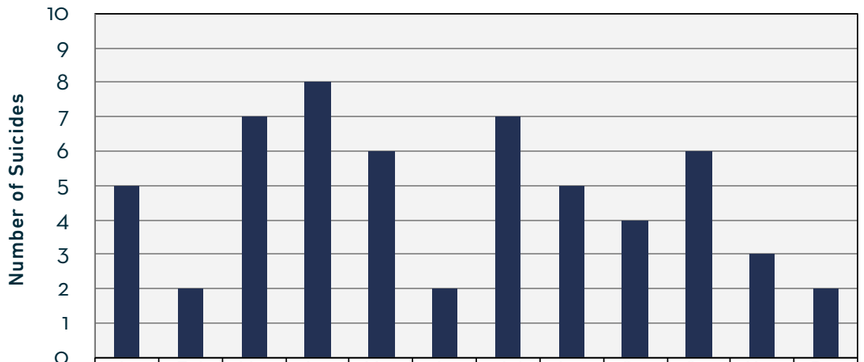
Note: The percentages in the "Pie Chart" are rounded up or down to nearest whole number.

CHART - 6-YEAR TREND OF SUICIDES BY FIREARMS AND HANGING



	2012	2013	2014	2015	2016	2017
Firearms	20%	15%	25%	29%	14%	12%
Hanging	34%	33%	32%	23%	23%	37%

SUICIDES BY MONTH



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Number of Suicides	5	2	7	8	6	2	7	5	4	6	3	2
Percent of Suicides	9%	4%	12%	14%	11%	4%	12%	9%	7%	11%	5%	4%

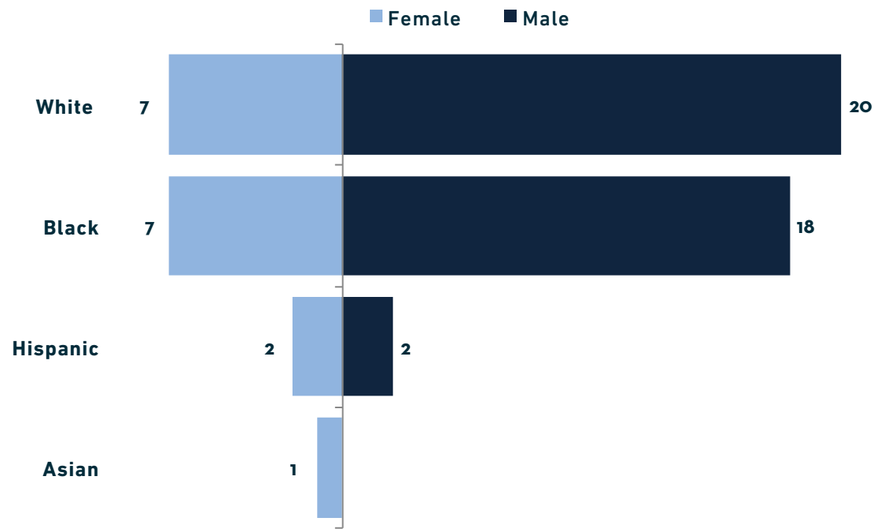
SUICIDE BY RACE/ETHNICITY

Race/Ethnicity	Number of Suicides	% of Suicides
White	27	47.37%
Black	25	43.86%
Hispanic	4	7.02%
Asian	1	1.75%
Total	57	100%

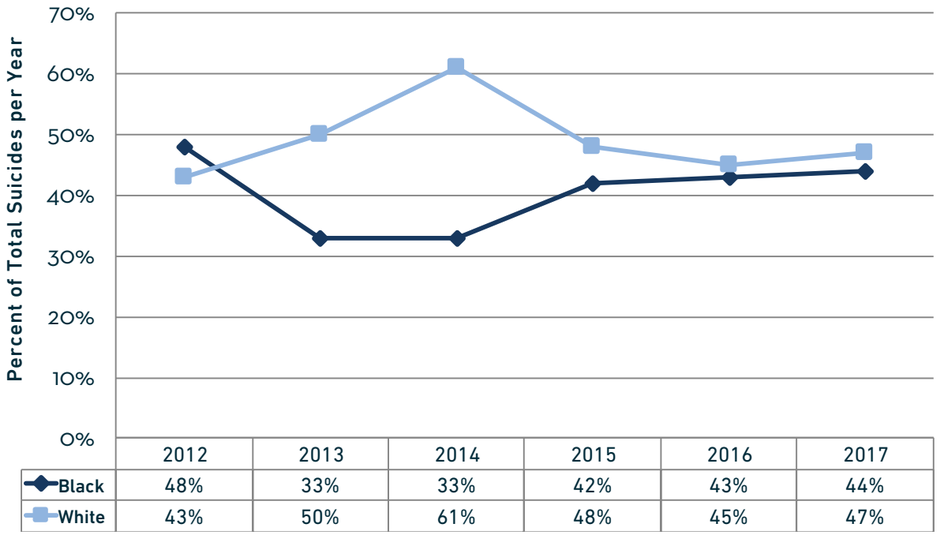
SUICIDES BY GENDER

Gender	Number of Suicides	% of Suicides
Female	17	29.82%
Male	40	70.18%
Total	57	100%

SUICIDES BY RACE AND GENDER



6-YEAR TREND OF SUICIDE BY RACE/ETHNICITY

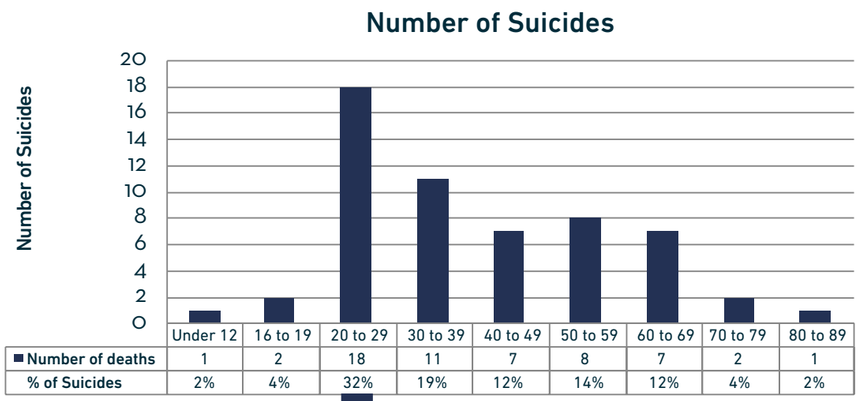


	2012	2013	2014	2015	2016	2017
Black	48%	33%	33%	42%	43%	44%
White	43%	50%	61%	48%	45%	47%

SUICIDES BY RACE/ETHNICITY AND GENDER

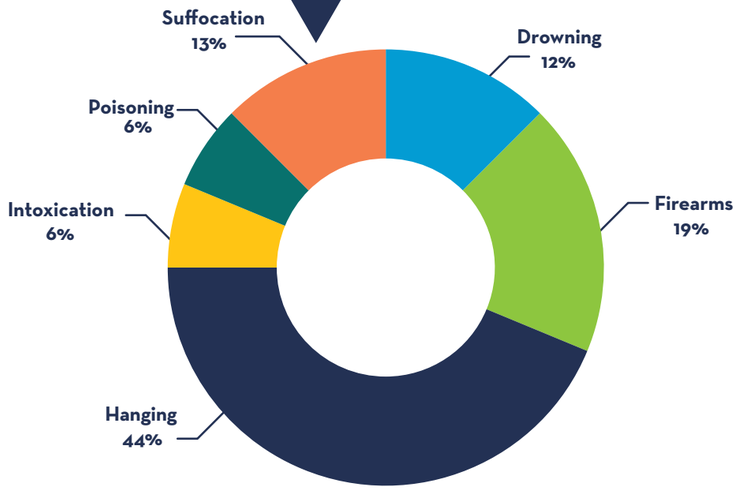
Race/Ethnicity by Gender	Number of Suicides
White	**27**
Female	7
Male	20
Black	**25**
Female	7
Male	18
Hispanic	**4**
Female	2
Male	2
Asian	**1**
Female	1
Male	0
Total	**57**

CHART - SUICIDES BY AGE GROUP



	Under 12	16 to 19	20 to 29	30 to 39	40 to 49	50 to 59	60 to 69	70 to 79	80 to 89
Number of deaths	1	2	18	11	7	8	7	2	1
% of Suicides	2%	4%	32%	19%	12%	14%	12%	4%	2%

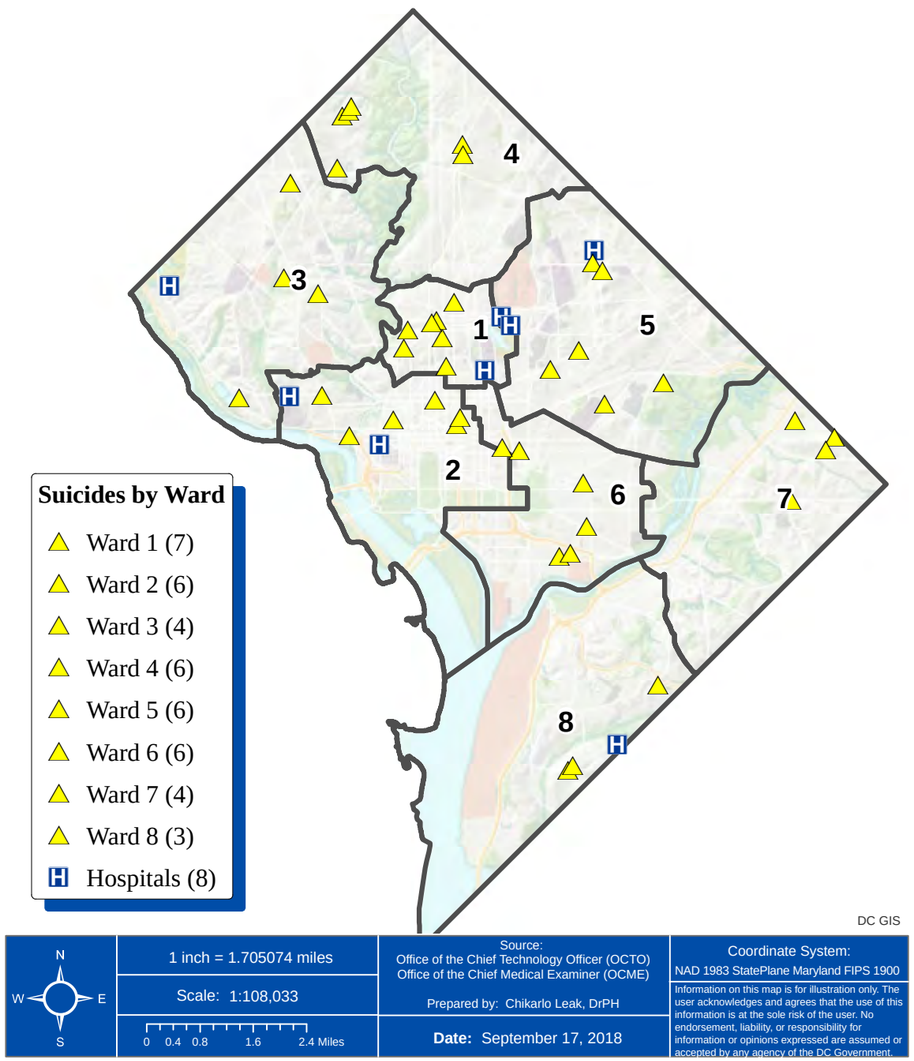
Suicides by Cause of Death among Young Adults, 20-29 year old



MAP OF SUICIDE BY DC WARD

Of the 57 suicides in the District of Columbia, 42 (74 %) 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.

2017 Suicides by DC Residence



TOXICOLOGY FINDINGS FOR SUICIDE CASES

Of the 57 suicide cases investigated by OCME, toxicology analysis was performed in 56 cases. Drugs were absent in 14 suicide cases. When compared with 2016, there was a slight decrease in the number of suicide cases with positive toxicology results (82 % of cases were positive for drugs and alcohol in 2016). Of the positive cases, ethanol is the most prominent substance in all suicide case.

Description	Number of Cases	% of Cases
N=	57	
Negative	14	24.5%
Positive	41	71.9%
No testing requested or assigned	2	3.5%

The most notable detected drugs in suicide cases were:

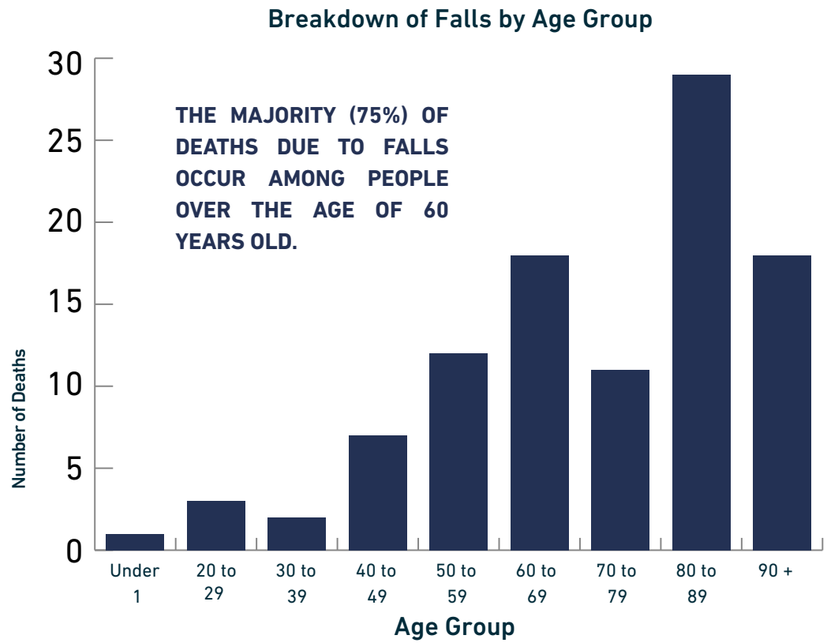
Name of Drug	Number of Cases	% of Suicide Cases
Ethanol	10	18.8%
Marijuana Metabolite	7	12.7%
Diphenhydramine	6	10.9%
Amphetamine	5	9.0%
Citalopram metabolite	5	9.0%
Cocaine and metabolites	4	7.2%
Fentanyl	4	7.2%
Oxycodone	4	7.2%

3.3 ACCIDENTS

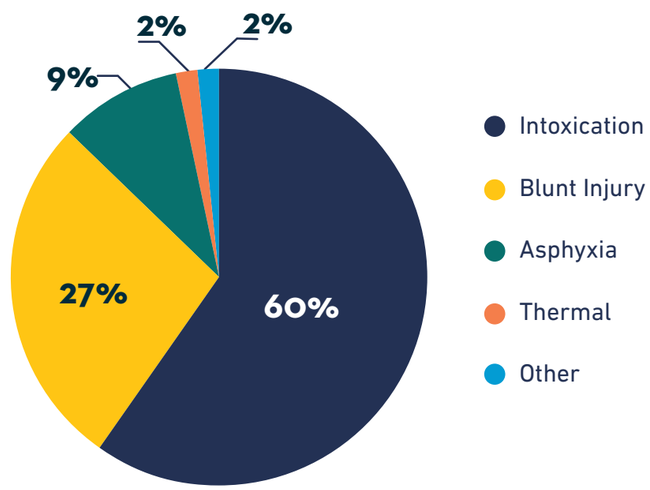
OCME investigated 592 accidental deaths in CY 2017. Of the 592 cases investigated, 57 were related to motor vehicle accidents, 101 were related to falls and 366 of the accidental deaths were the direct result of prescription and/or illicit drug use. There was an increase in the total number of deaths due to accidents in 2017. The difference is largely driven by the increase in the number of accidental intoxications (drug overdoses). The special report section of this annual report highlights the increase in the number of opioid-related fatal overdoses seen at the OCME.

ACCIDENTS BY CAUSE OF DEATH

Cause	# of Deaths	% Accidents
Intoxication	366	61.82%
Blunt Injury - Due to Fall (101) - Due to Traffic (57) - Due to Other (11)	169	28.55%
Asphyxia	19	3.21%
Other	10	1.69%
Thermal	10	1.69%
Drowning	6	1.01%
Inhalation of Combustible Product	4	0.68%
Hypothermia	4	0.68%
Hyperthermia	2	0.34%
Electrocution	1	0.17%
Firearms	1	0.17%
Total	592	100%



PIE CHART - ACCIDENTS BY CAUSE OF DEATH[12]



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

GRAPH – 14 YEAR OVERVIEW OF ACCIDENTS

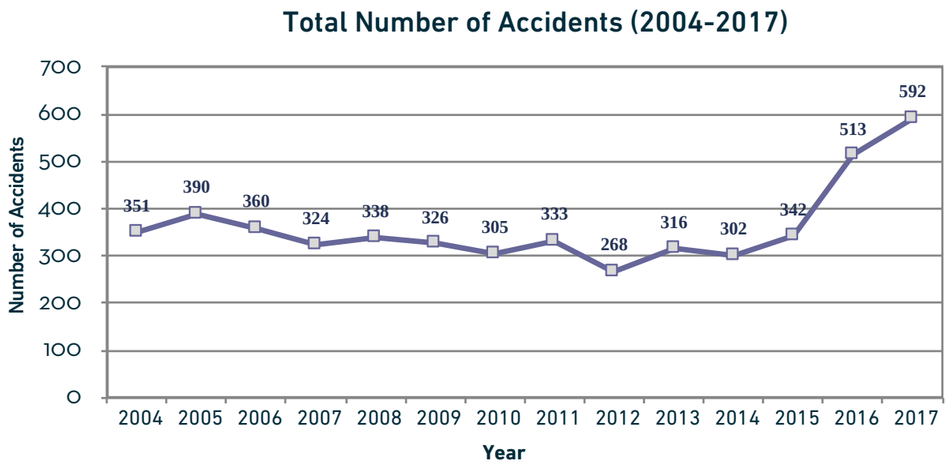
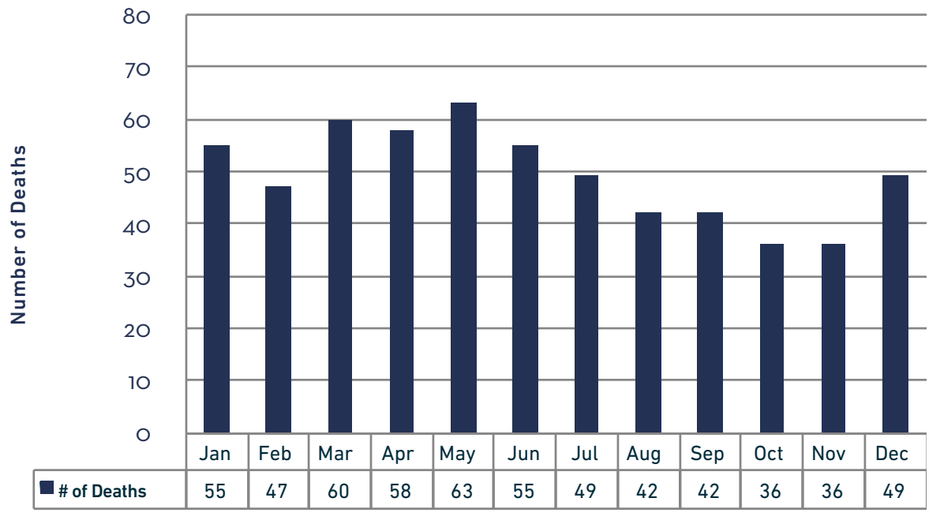


CHART - ACCIDENTS BY MONTH OF DEATH



ACCIDENTS BY MONTH

Month	Number of Deaths	% of Accidents
January	55	9.29%
February	47	7.94%
March	60	10.14%
April	58	9.80%
May	63	10.64%
June	55	9.29%
July	49	8.28%
August	42	7.09%
September	42	7.09%
October	36	6.08%
November	36	6.08%
December	49	8.28%
Total	592	100%

ACCIDENTAL DEATHS BY RACE

Race/Ethnicity	Number of Accidents	% of Accidents
Black	416	70.27%
White	135	22.80%
Hispanic	34	5.74%
Asian	6	1.01%
American Indian	1	0.17%
Total	592	100%

ACCIDENTAL DEATHS BY GENDER

Gender	Number of Accidents	% of Accidents
Female	203	34.29%
Male	389	65.71%
Total	592	100%

ACCIDENTAL DEATHS BY AGE

Age	Number of Accidents	% of Accidents
Under 1	15	2.53%
1 to 5	7	1.18%
6 to 12	2	0.34%
13 to 15	1	0.17%
16 to 19	4	0.68%
20 to 29	41	6.93%
30 to 39	62	10.47%
40 to 49	78	13.18%
50 to 59	170	28.72%
60 to 69	121	20.44%
70 to 79	31	5.24%
80 to 89	38	6.42%
90 +	22	3.72%
Total	592	100%

TOXICOLOGY FINDINGS FOR ACCIDENT CASES

Of the 592 Accident Deaths investigated by OCME, the toxicology division received 569 of those cases and toxicology analysis was performed in 471 cases. Drugs were absent in 48 accident cases. There was a slight increase in negative accident cases in 2017 when compared with 2016 (6%). Of the positive cases, Fentanyl is the most prominent substance in all accident case.

Description	Number of Cases	% of Cases
N=	569	
Negative	50	8.7%
Positive	427	75.0%
No testing requested or assigned	92	16.1%

The most commonly detected drugs in the accident cases were:

Name of Drug	Number of Cases	% of Accident Cases
Fentanyl	183	38.3%
Cocaine and Metabolites	162	33.9%
Morphine/Heroin	162/149	33.9%/31.2%
Codeine	124	25.9%
Furanyl-Fentanyl	54	11.0%
Marijuana Metabolites	53	11.1%
Diphenhydramine	50	10.4%
Phencyclidine	40	8.3%
Quinidine/Quinine	38	7.9%
Naloxone	36	7.5%
Methadone	30	6.2%
FIBF/para-Fluorobutyryl fentanyl	27	5.6%
Norbuprenorphine	27	5.6%
Nordiazepam	24	5.0%

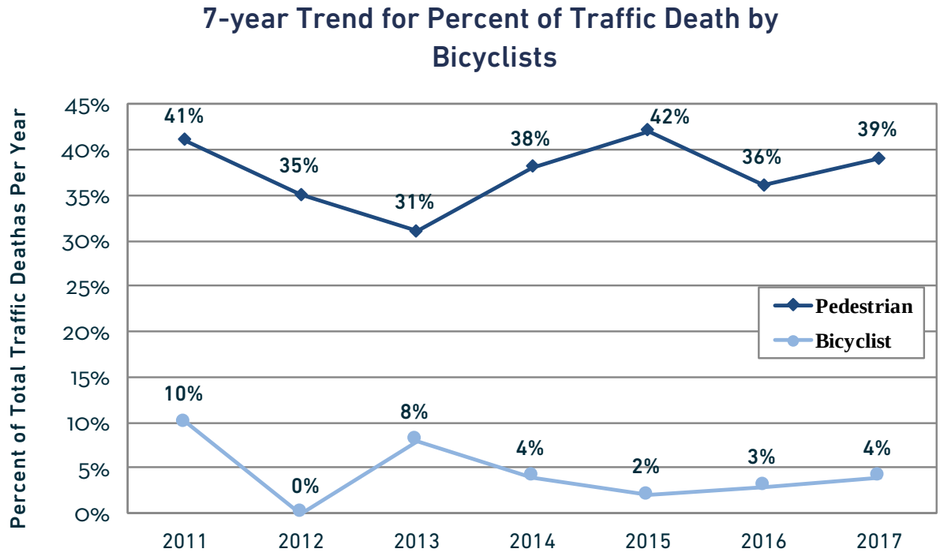
3.3.1. Traffic Deaths

Of the 57 traffic related deaths certified by the OCME in Calendar Year 2017 the majority involved drivers of motor operated vehicles (all types). The majority of decedents were between the ages of 20 to 39. Traffic fatalities were most prevalent in the months of March and June.

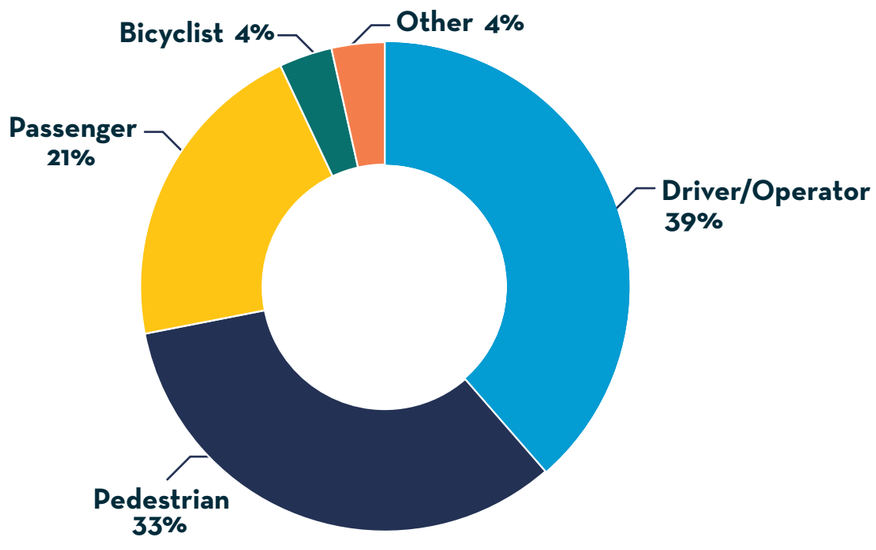
ROLE OF THE DECEDENT IN TRAFFIC DEATH

Role	Traffic Deaths	% of Traffic Deaths
Driver - Motor Vehicle(15) - Motorcycle (5) - Moped (2)	22	38.60%
Pedestrian	19	33.33%
Passenger - Motor Vehicle (12)	12	21.05%
Bicyclist	2	3.51%
Skateboarder	1	1.75%
Other	1	1.75%

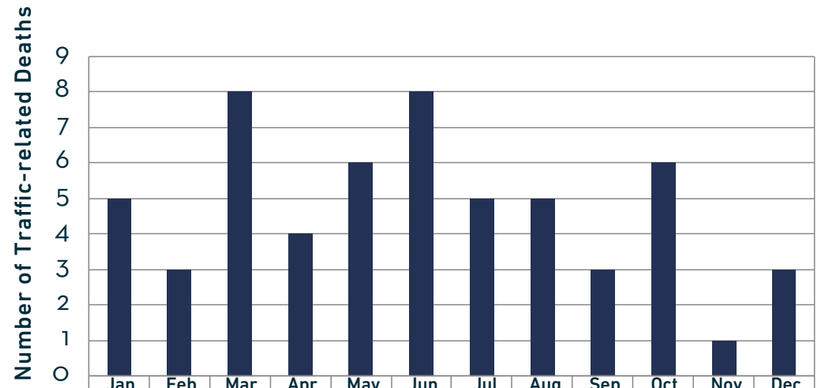
CHART - 7-YEAR TREND OF ROLE OF DECEDENT IN TRAFFIC ACCIDENT



PIE CHART - ROLE OF DECEDENT IN TRAFFIC ACCIDENT

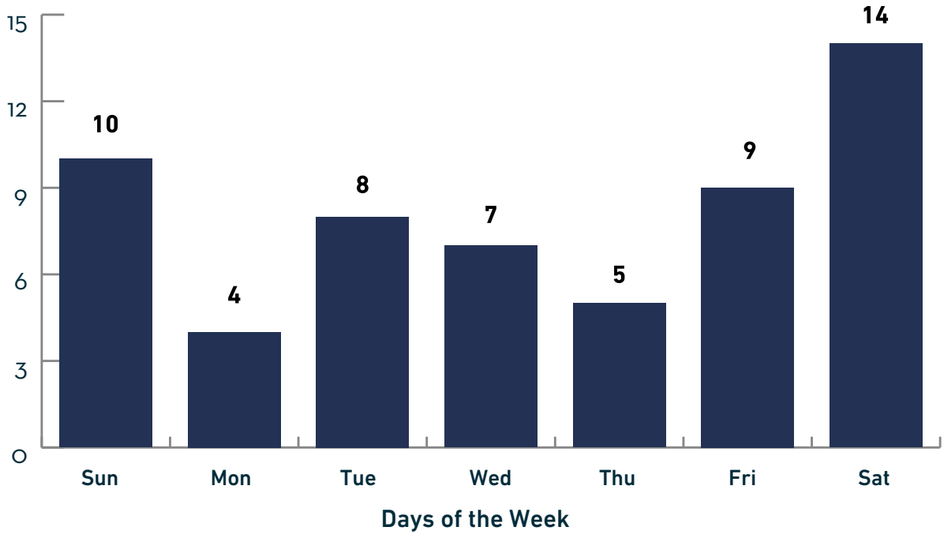


TRAFFIC DEATHS BY MONTH



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Number of Deaths	5	3	8	4	6	8	5	5	3	6	1	3
% of Traffic Accidents	9%	5%	14%	7%	11%	14%	9%	9%	5%	11%	2%	5%

TRAFFIC DEATHS BY DAY



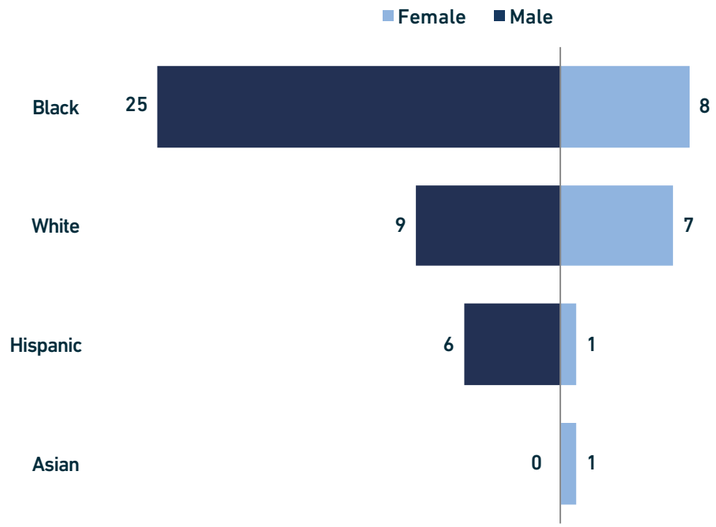
TRAFFIC DEATHS BY RACE

Race	Number of Traffic Deaths	% of Traffic Deaths
Black	33	57.89%
White	16	28.07%
Hispanic	7	12.28%
Asian	1	1.75%
Total	57	100%

TRAFFIC DEATHS BY GENDER

Gender	Number of Traffic Deaths	% of Traffic Deaths
Female	17	28.82%
Male	40	70.18%
Total	57	100%

TRAFFIC DEATHS BY RACE AND GENDER



TRAFFIC DEATHS BY AGE

Age	Number of Traffic Deaths	% of Traffic Deaths
Under 5	5	8.77%
5 to 11	1	1.75%
6 to 12	1	1.75%
13 to 15	1	1.75%
16 to 19	2	3.51%
20 to 29	14	24.56%
30 to 39	7	12.28%
40 to 49	9	15.79%
50 to 59	3	5.26%
60 to 69	6	10.53%
70 to 79	4	7.02%
80 to 89	3	5.26%
90+	1	1.75%
Total	57	100%

TRAFFIC DEATHS BY JURISDICTION OF INCIDENT THAT CAUSED DEATH

Jurisdiction of Incident	Number of Traffic Deaths	% of Traffic Deaths
District of Columbia	28	49.1%
Maryland	25	43.9%
Virginia	4	7.0%
Total	57	100%

Toxicology Findings for Traffic Accident Cases

Of the 57 Traffic-related deaths investigated by OCME, toxicology analysis was performed in 42 cases. Drugs were absent in 13 traffic accident cases. Of the positive cases, ethanol is the most prominent substance in all traffic accident cases followed by marijuana. Of the remaining positive cases, 36.3% had more than one drug present.

Description	Number of Cases	% of Cases
N=	57	
Negative	13	23.6%
Positive	29	52.7%
No testing requested or assigned	14	23.6%

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

Name of Drug	Number of Cases	% of Traffic Cases
Ethanol	18	42.8%
Marijuana Metabolite	10	23.8%
Fentanyl	4	9.5%
Nordiazepam	3	7.1%
Oxycodone	3	7.1%
Midazolam	2	4.7%
Morphine	2	4.7%
Phencyclidine	2	4.7%

In the 18 traffic deaths positive for ethanol, 16 were greater than the legal limit (0.08 g/100 mL) for driving under the influence in the District of Columbia. The average blood alcohol concentration of the positive results is approximately 0.14 g/100 mL

3.3.2 – Toxicology Findings for Deaths due to Accidental Drug Overdose

There were 366 OCME cases where death was directly related to drug abuse. Toxicology analysis was performed on 362 cases. Four (4) cases were determined to be accidental overdoses by re-viewing hospital records; therefore, no specimens were submitted for toxicology. The most prevalent drug in the population was fentanyl. Of the positive cases, more than 94% had more than one drug present**. Additional information regarding accidental intoxications can be found in Section 4.1: Special Report on Opioid Overdoses.**

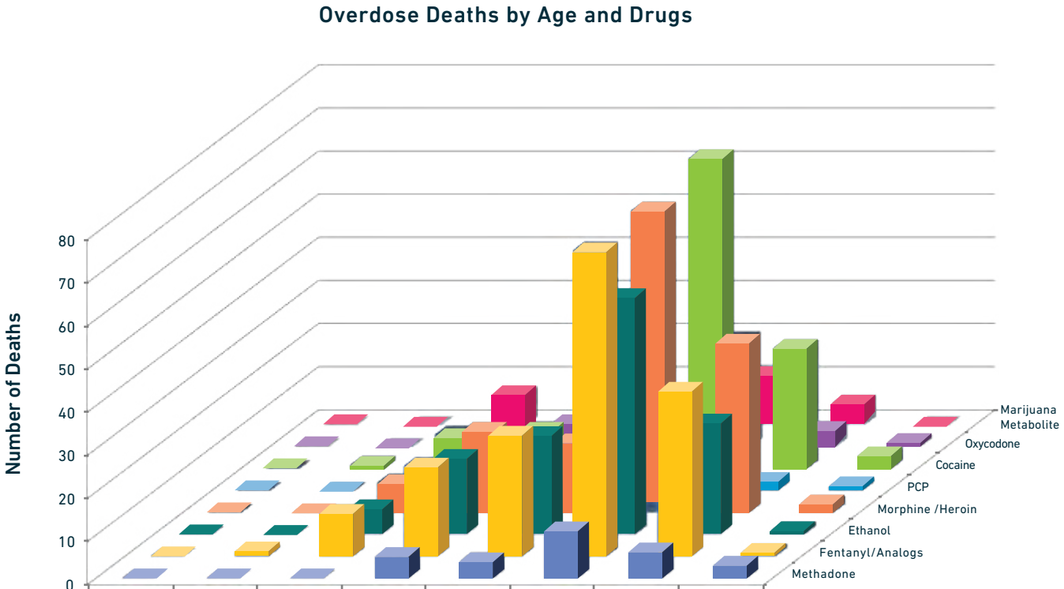
Description	Number of Cases	% of Cases
N=	362	
Negative	1	0.2 %
Positive	357	98.6 %
Storage	4	1.1%

The most commonly detected drugs in drug overdose cases were:

Contributing Drugs	Number of Cases	% of Cases
Fentanyl	174	48.6%
Cocaine Metabolites	157	43.8%
Morphine/Heroin	155/147	43.2/43.2%
Ethanol	128	35.7%
Codeine	123	34.3%
Furanyl-Fentanyl	53	14.8%
Diphenhydramine	44	12.2%
Marijuana Metabolite	41	11.4%
Naloxone	33	9.2%
Phencyclidine	33	9.2%
Methadone	29	8.1%
FIBF/para-Fluorobutyryl fentanyl	27	7.5%
Norbuprenorphine	24	6.7%
Oxycodone	20	5.5%

Accidental Drug Overdose Fatalities by Age

The majority of overdose deaths occurred in decedents between the ages of 51 and 70 years. Opiates (Heroin, morphine) were the most frequent class of detected drug in most of these age groups, followed by ethanol, cocaine then fentanyl. The prevalence of phencyclidine, oxycodone, methadone, and marijuana metabolites has been included.



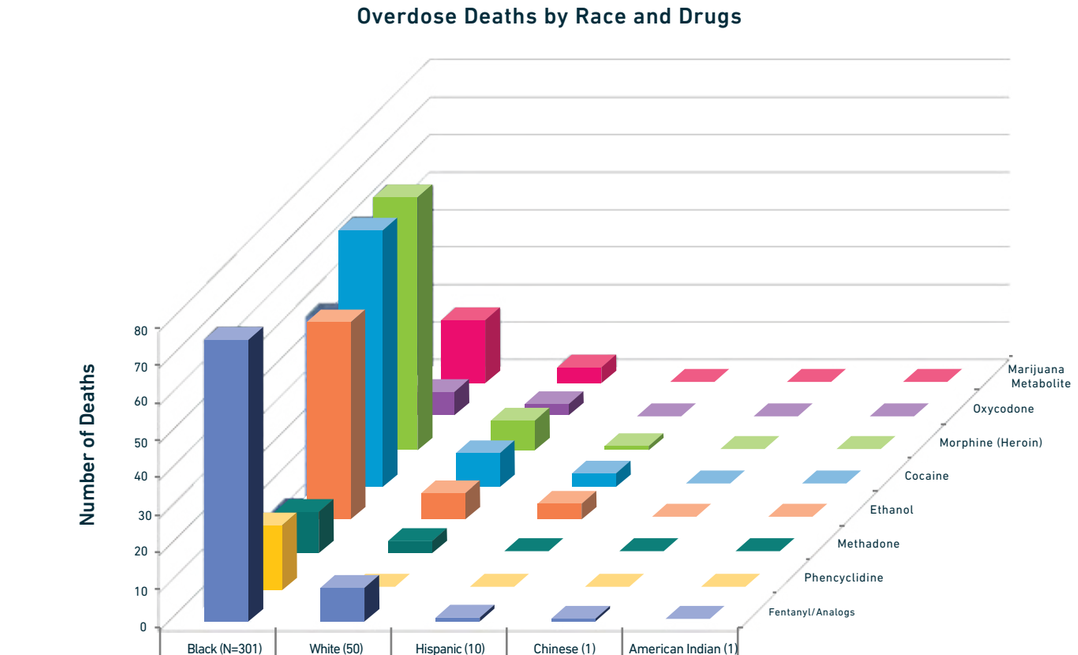
	0-10(N=0)	11-20 (1)	21-30 (22)	31-40 (48)	41-50 (64)	51-60 (148)	61-70 (73)	71-80 (7)
Methadone	0	0	0	5	4	11	6	3
Fentanyl/Analogs	0	1	10	21	28	71	38	1
Ethanol	0	0	6	18	23	55	26	1
Morphine /Heroin	0	0	7	19	16	70	40	2
PCP	0	0	2	7	10	11	2	1
Cocaine	0	1	8	9	37	72	28	3
Oxycodone	0	0	1	5	1	8	4	1
Marijuana Metabolite	0	0	7	10	7	12	5	0

Age Range

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

Accidental Drug Overdose Fatalities by Race

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



	Black (N=301)	White (50)	Hispanic (10)	Chinese (1)	American Indian (1)
Fentanyl/Analogs	150	170	2	1	0
Phencyclidine	32	1	0	0	0
Methadone	22	6	0	0	1
Ethanol	108	13	7	0	1
Cocaine	136	17	5	0	0
Morphine /Heroin	135	16	2	1	0
Oxycodone	14	6	0	0	0
Marijuana Metabolite	33	8	0	0	0

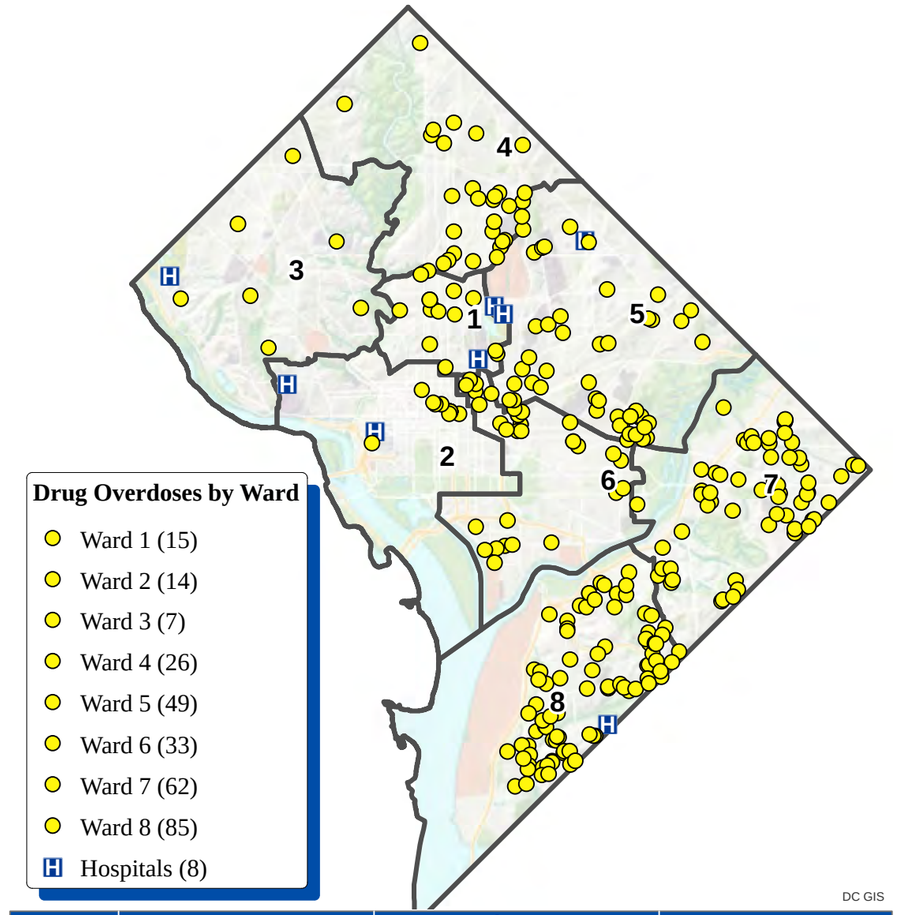
Age Range

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

MAP OF ACCIDENTAL DRUG OVERDOSES BY DC WARD

Of the 592 accidental deaths, 399 (67%) were DC residents. There were a total of 366 accidental intoxication deaths in the District of Columbia in 2017, of which 291 (80%) 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. Additional information regarding accidental intoxications can be found in Section 4.2: Special Report on Opioid Overdoses.

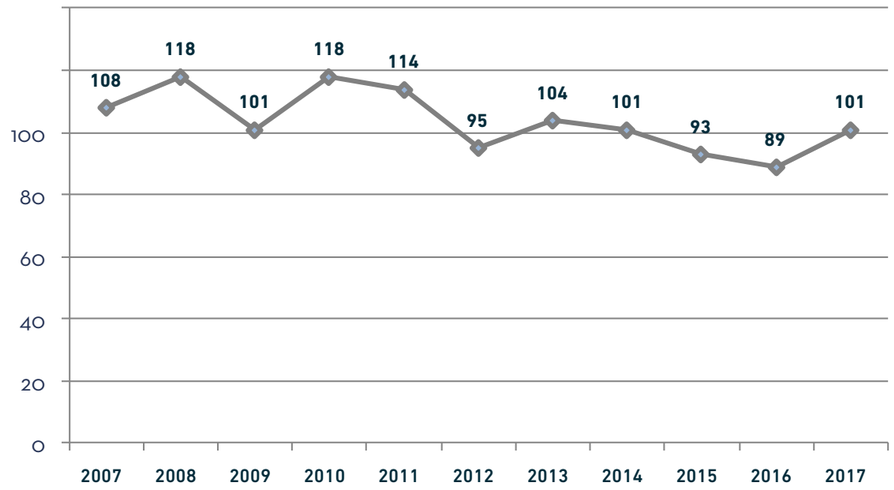
2017 Accidental Intoxications by DC Residence



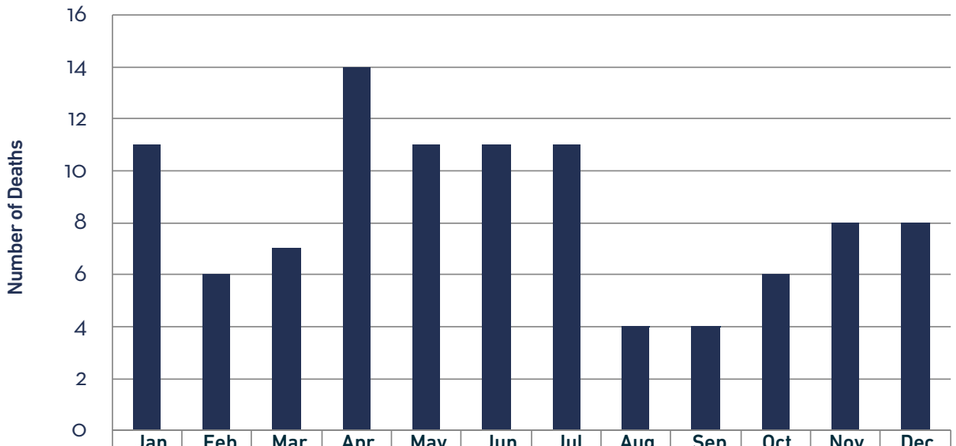
3.3.3. Accidental Blunt Injuries due to Falls

Of the 101 blunt injuries due to falls certified by the OCME in Calendar Year 2017 the majority involved decedents 60 and above. Except for one fetal death, there were no accidental deaths due to falls of persons younger than 20 years of age. The majority of decedents were male and primarily Black or White. Deaths due to falls were most prevalent in April.

11-year Trend in Deaths due to Falls



ACCIDENTAL FALLS BY MONTH



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
# of Deaths	11	6	7	14	11	11	11	4	4	6	8	8
% of Deaths	10.89%	5.94%	6.93%	13.86%	10.89%	10.89%	10.89%	3.96%	3.96%	5.94%	7.92%	7.92%

ACCIDENTAL FALLS BY RACE

Race	Number of Accidental Falls	% of Accidental Falls
Black	45	44.55%
White	45	44.55%
Hispanic	8	7.92%
Asian	3	2.97%
Total	101	100%

ACCIDENTAL FALLS BY GENDER

Gender	Number of Accidents	% of Accidents
Female	46	45.54%
Male	55	54.46%
Total	101	100%

ACCIDENTAL FALLS BY AGE

Age	Number of Accidental Falls	% of Accidental Falls
Fetus	1	0.99%
20 to 29	3	2.97%
30 to 39	2	1.98%
40 to 49	7	6.93%
50 to 59	12	11.88%
60 to 69	18	17.82%
70 to 79	11	10.89%
80 to 89	29	28.71%
90+	18	17.82%
Total	101	100%

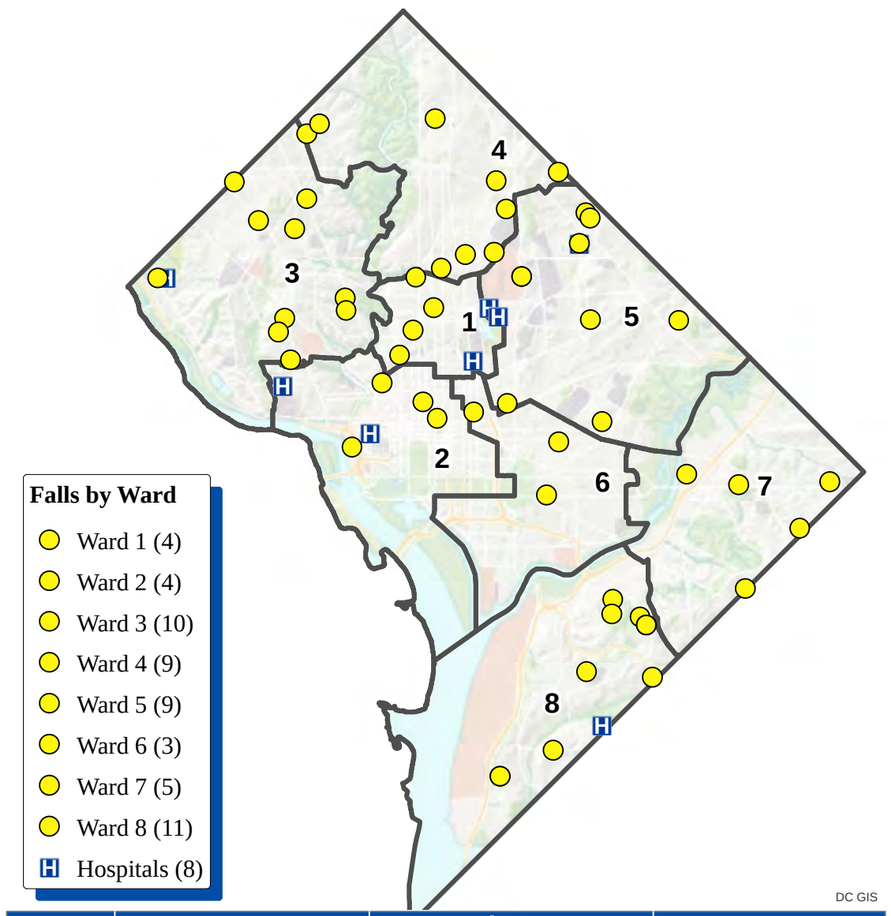
ACCIDENTAL FALLS BY JURISDICTION OF RESIDENCE

Jurisdiction of Residence	Number of Accidental Falls	% of Accidental Falls
District of Columbia	55	54.45%
Maryland	33	32.67%
Virginia	7	6.93%
Other	1	0.99%
Undomiciled	4	3.96%
Unknown	1	0.99%
Total	101	100%

MAP OF BLUNT INJURIES DUE TO FALLS BY DC WARD

There was a total of 101 accidental deaths caused by blunt injuries due to falls in the DC in 2017, of which 55 (54%) were residents of DC. 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.

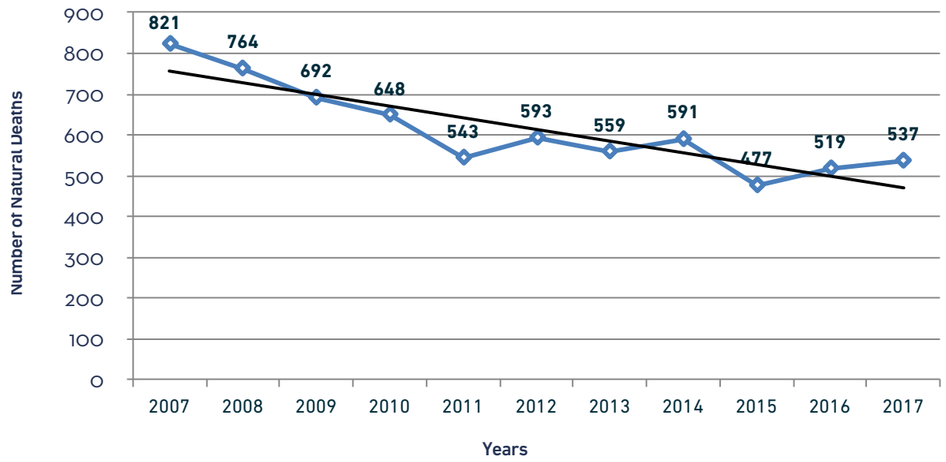
2017 Accidental Falls by DC Residence



3.4 – NATURAL DEATHS

Natural deaths continue to account for a large majority of cases reported to and accepted by the OCME. In 2017, 537 deaths were determined to be a result of natural disease. Deaths caused by Cardiovascular Diseases continue to dominate in this category with 369 fatalities. Deaths due to the alcoholism continued to be the second highest (43) cause of natural deaths. Blacks were more prevalent in this category representing 76.4% of the population affected. More Natural deaths occurred in January than in any other month.

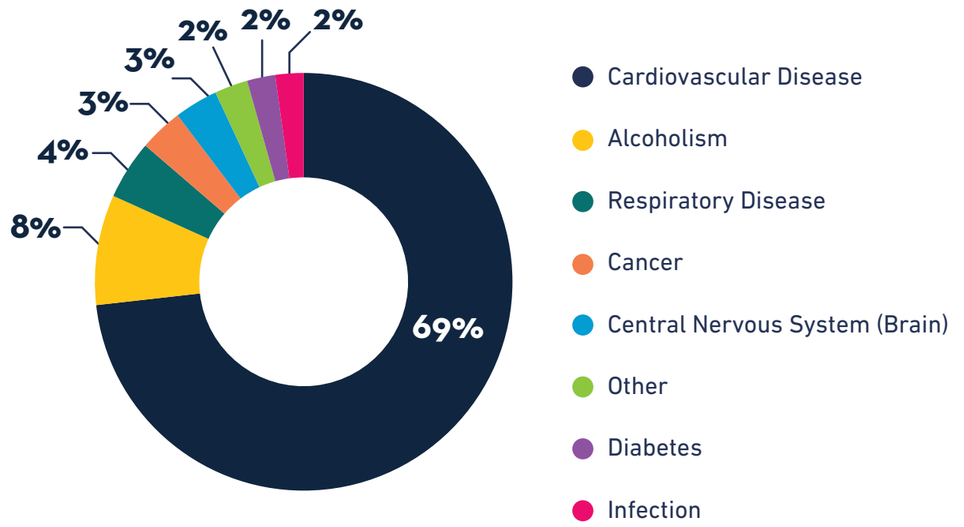
11 Year Trend in Natural Deaths



NATURAL DEATHS BY CAUSE

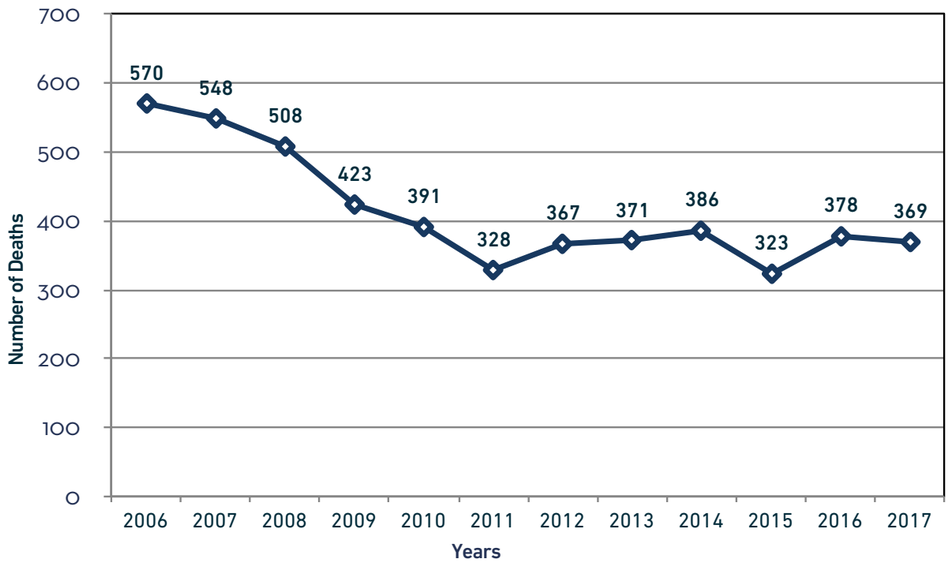
Cause	Number of Deaths	% Of Total Natural Deaths
Cardiovascular Disease	369	68.72%
Alcoholism	43	8.01%
Respiratory Disease	23	4.28%
Cancer	17	3.17%
Central Nervous System (Brain)	17	3.17%
Other	13	2.42%
Diabetes	11	2.05%
Infection	11	2.05%
Gastrointestinal Disease	7	1.30%
Obesity or Complications of Obesity	5	0.93%
Blood Disease/ Hemopoietic System	5	0.93%
Infectious Disease	5	0.93%
Auto Immune/Immune System Disease	4	0.74%
AIDS	2	0.37%
Complications of Drug Abuse	2	0.37%
Genetic Disorder	1	0.19%
Complications of Pregnancy	1	0.19%
Connective Tissue Disease	1	0.19%
Total	**537**	**100**

NATURAL DEATHS BY CAUSE



NOTE: This graph does not include causes of death that are less than 2%.

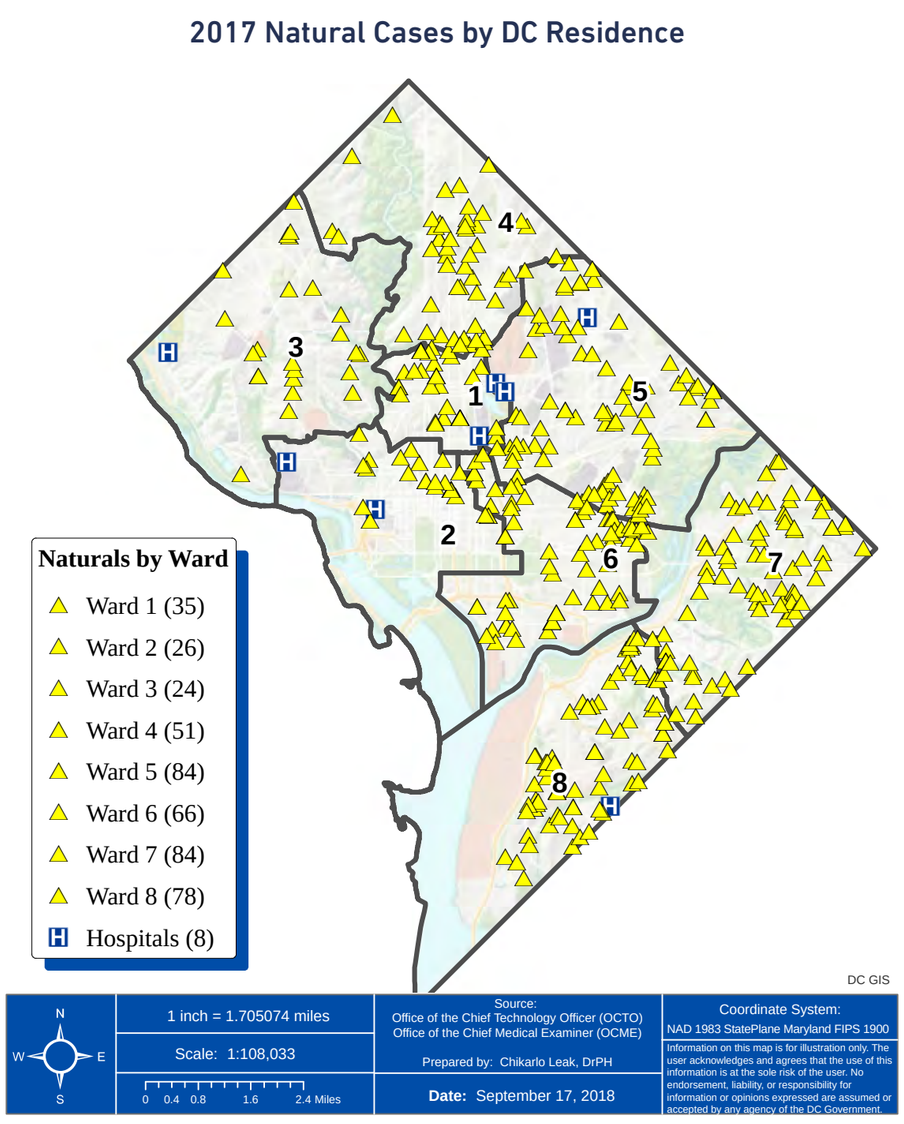
TOTAL NATURAL DEATHS DUE TO CARDIOVASCULAR DISEASE REPORTED TO THE OCME (2006 – 2017)[13]



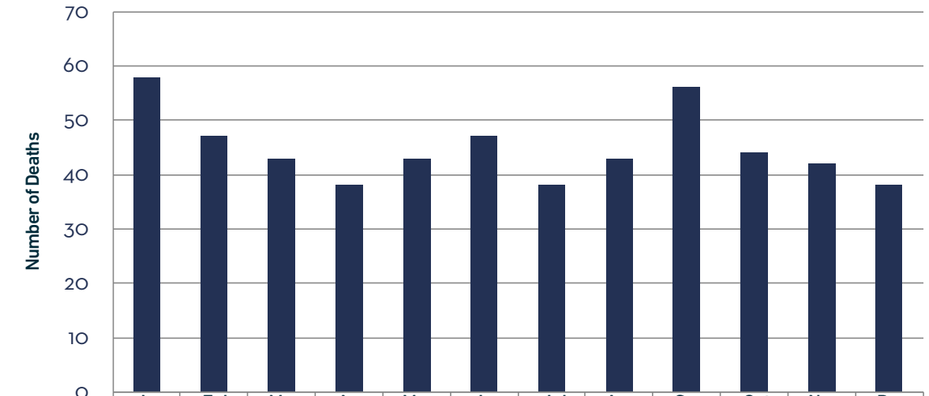
13 This includes the total number of natural deaths due to cardiovascular disease that have been reported to the Medical Examiner. Not all natural deaths are reported to the Medical Examiner.

MAP OF NATURAL DEATHS BY DC WARD

Of the 537 Natural deaths in the District of Columbia, 448 (83%) of these decedents were District residents at the time of their death, as reported by their next of kin. The map below illustrates the residence location by ward at the time of their death.



NATURAL DEATHS BY MONTH



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
# of Deaths	58	47	43	38	43	47	38	43	56	44	42	38
% of Deaths	10.80%	8.75%	8.01%	7.08%	8.01%	8.75%	7.08%	8.01%	10.43%	8.19%	7.82%	7.08%

NATURAL DEATHS BY EXAM TYPE

Exam Type	Number of Natural Deaths	% of Natural Deaths
Autopsy	293	54.56%
External Exam	239	44.51%
Review Medical Records	5	0.93%
Total	**537**	**100%**

NATURAL DEATHS BY RACE

Race	Number of Natural Deaths	% of Natural Deaths
Black	410	76.35%
White	104	19.37%
Hispanic	14	2.61%
Asian	6	1.12%
Other	3	0.56%
Total	**537**	**100%**

NATURAL DEATHS BY GENDER

Gender	Number of Natural Deaths	% of Natural Deaths
Female	181	33.71%
Male	356	66.29%
Total	**537**	**100%**

NATURAL DEATHS BY AGE

Age	# of Natural Deaths	% of Natural Deaths
Under 1	6	1.12%
1 to 5	1	0.19%
6 to 12	1	0.19%
13 to 15	3	0.56%
16 to 19	2	0.37%
20 to 29	4	0.74%
30 to 39	28	5.21%
40 to 49	52	9.68%
50 to 59	128	23.84%
60 to 69	160	29.80%
70 to 79	98	18.25%
80 to 89	45	8.38%
90 +	9	1.68%
Total	537	100%

3.5 – UNDETERMINED DEATHS

The OCME investigated 37 cases (3% of total Accepted Cases) in which the manner of death was concluded to be "Undetermined," and of these 24 cases or 65% also had a cause of death classified as "Undetermined".

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

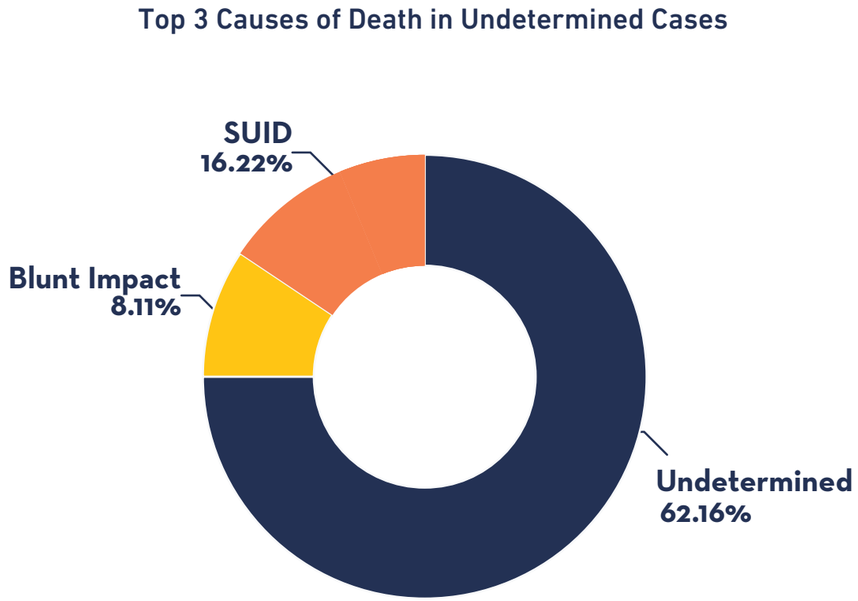
A separate category of "undetermined" manner of death involve infants whose deaths are associated with unsafe sleep environments to including bed/sharing, inappropriate bedding, or other related, similar circumstances, for whom no definite cause of death can be determined despite full autopsy, metabolic,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

There were no deaths classified as "Undetermined" in people between the ages of 1 to 19 years old. Peak incidents occurred in June.

CAUSE OF UNDETERMINED DEATHS

Cause of Death	Number of Deaths	% of Total Accepted Cases
Undetermined	23	62.16%
Sudden Unexpected Infant Death (SUID)	6	16.22%
Blunt Impact Injuries	3	8.11%
Asphyxia	1	2.70%
Drowning	1	2.70%
Firearms	1	2.70%
Skeletal Remains	1	2.70%
Thermal Injury	1	2.70%
Total	37	100%

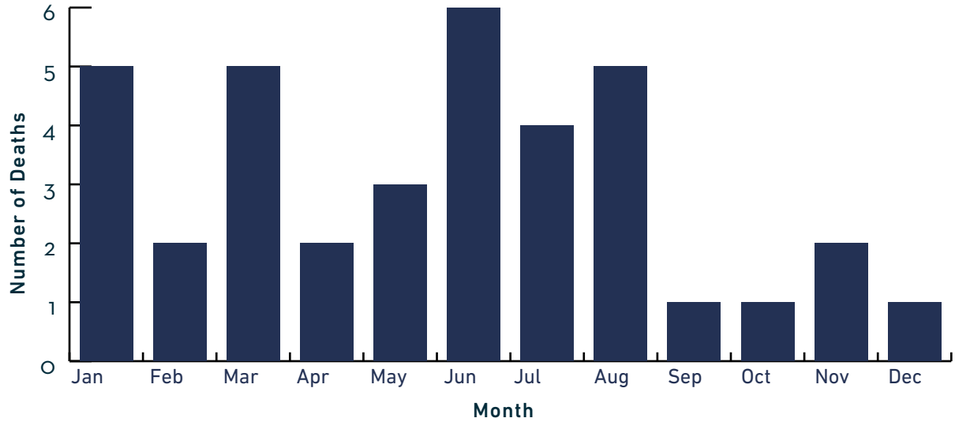
UNDETERMINED BY TOP 3 CAUSES OF DEATH



UNDETERMINED DEATHS BY MONTH

Month	Number of Deaths
January	5
February	2
March	5
April	2
May	3
June	6
July	4
August	5
September	1
October	1
November	2
December	1
Total	37

UNDETERMINED DEATHS BY MONTH



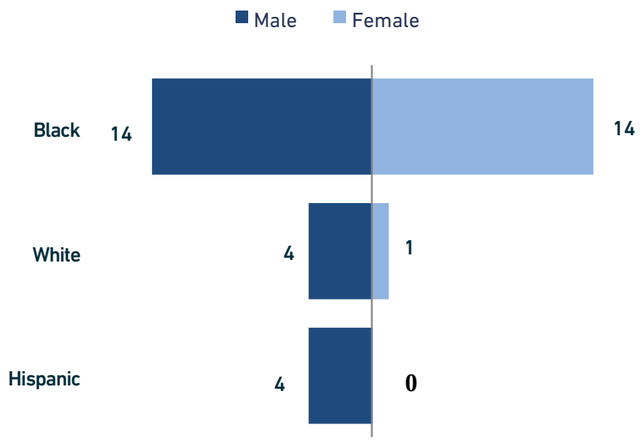
UNDETERMINED DEATHS BY RACE

Race	Number of Undetermined Deaths	% of Undetermined Deaths
Black	28	75.68%
White	5	13.51%
Hispanic	4	10.81%
Total	37	100%

UNDETERMINED DEATHS BY GENDER

Gender	Number of Undetermined Deaths	% of Undetermined Deaths
Female	15	40.54%
Male	22	59.46%
Total	37	100%

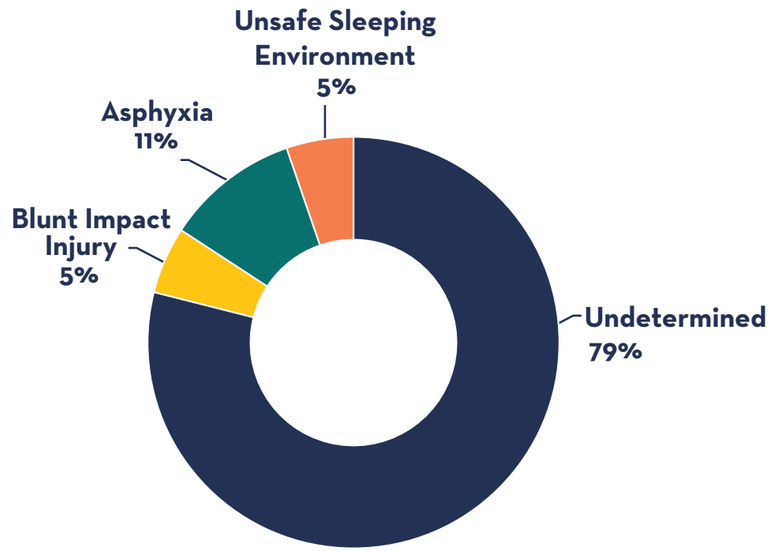
UNDETERMINED DEATHS BY RACE AND GENDER



UNDETERMINED DEATHS BY AGE

Age	Number of Undetermined Deaths
Under 1	19
1 to 5	0
6 to 12	0
16 to 19	0
20 to 29	3
30 to 39	5
40 to 49	3
50 to 59	2
60 to 69	3
70 to 79	1
80 to 89	1
90+	0
Total	37

Breakdown of Cause of Death for Infants



TOXICOLOGY FINDINGS BY UNDETERMINED DEATHS

Of the 37 Undetermined Deaths investigated by OCME, toxicology analysis was performed on 36 cases. Drugs were absent in 19 undetermined deaths.

Description	Number of Cases	% of Cases
N=	37	
Negative	19	51.3 %
Positive	17	45.9 %
Storage	1	2.7%

The most commonly detected drugs in the undetermined cases were:

Name of Drug	Number of Cases	% of Undetermined Cases
Ethanol	5	13.8%
Fentanyl	5	13.8%
Morphine/Heroin	3/1	8.3/2.7%
Nordiazepam	3	8.3%
Cocaine and Metabolites	2	5.5%
Diazepam	2	5.5%
Fluoxetine	2	5.5%
Naloxone	2	5.5%
Oxycodone	2	5.5%
Temazepam	2	5.5%

2017 Overview of Infant Sleeping Deaths That Occurred in the District of Columbia by Jurisdiction of Residence

Although a death of an infant may occur in the DC, the infant's place of residence can be anywhere in the world. For the purpose of this annual report, infant deaths are defined as babies that are age one year old or less at the time of death. This report will identify the residential jurisdiction of the infant by using the parental residence at the time of the infant's death. The American Academy of Pediatrics recommends using the term bed-sharing instead of the term co-sleeping due to the ability to misconstrue the sleeping arrangement. Co-sleeping refers to when a parent and infant sleep in close proximity to each other. Bed-sharing refers to a specific type of co-sleeping in which the infant is sleeping on the same surface as another person. This report includes any infant deaths in which bed-sharing or co-sleeping in the same bed was related to the cause of death.[14]

14 SIDS and Other Sleep-Related Infant Deaths: Evidence Base for 2016 Updated Recommendations for a Safe Infant Sleeping Environment. Rachel Y. Moon, TASK FORCE ON SUDDEN INFANT DEATH SYNDROME. Pediatrics Oct 2016, e20162940; DOI: 10.1542/peds.2016-2940

Co-sleeping/Bedsharing

There were a total of 15 co-sleeping/bed-sharing infant fatalities that were certified with a Manner of Death as "Undetermined" or "Accident" in calendar year 2017. These accidential infant fatalities were caused by Asphyxia due to overlay (asphyxia due to overlay was the result of a co-sleeping environment). Of the 15 deaths due to bedsharing, ten had parents that were residents of the District of Columbia, and four had parents that lived outside of the District (Maryland). Although the numbers are low, there were more sleeping deaths in wards seven and eight than the other six wards. Within this review period, there were no co-sleeping/bedsharing fatalities where the parental residence was in the DC wards 2 or 3.

Unsafe sleeping environment or Inappropriate bedding

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

There were eight cases in 2017 where the infant died as a result of unsafe sleeping or inappropriate bedding, yet was NOT attributed to co-sleeping or bed-sharing based on the investigation. With the exception of 3 cases, all of these cases had a Manner of Death of "Undetermined".

Infant Deaths by Cause of Death, Manner of Death and Contributing Factors				
Cause of Death	Manner	Co-sleeping/ Bed-sharing	Unsafe Sleep Environment/ Inappropriate Bedding	Total
Asphyxia	Accident	7	3	10
Asphyxia	Undetermined	1	0	1
SUID	Undetermined	2	1	3
Undetermined	Undetermined	5	4	9
Total		15	8	23

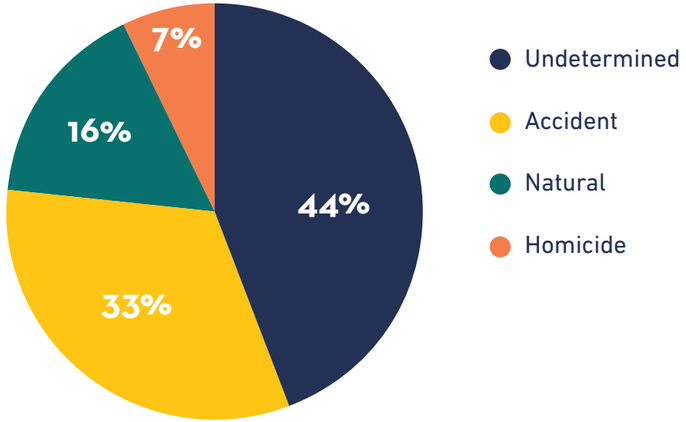
Jurisdiction of Parental Residence and Manner of Death

In 2017 there were a total of 43 infant deaths investigated by the OCME. The below table provides a breakdown by manner of death and the parental residence at the time of the infant's death.

Total Infant Deaths by Jurisdiction and Manner of Death

Jurisdiction of Parental Residence	Total	Accident	Homicide	Natural	Undetermined
DC	24	9	0	4	11
MD	17	5	3	3	6
VA	2	0	0	0	2
Other	0	0	0	0	0
TOTALS	43	14	3	7	19

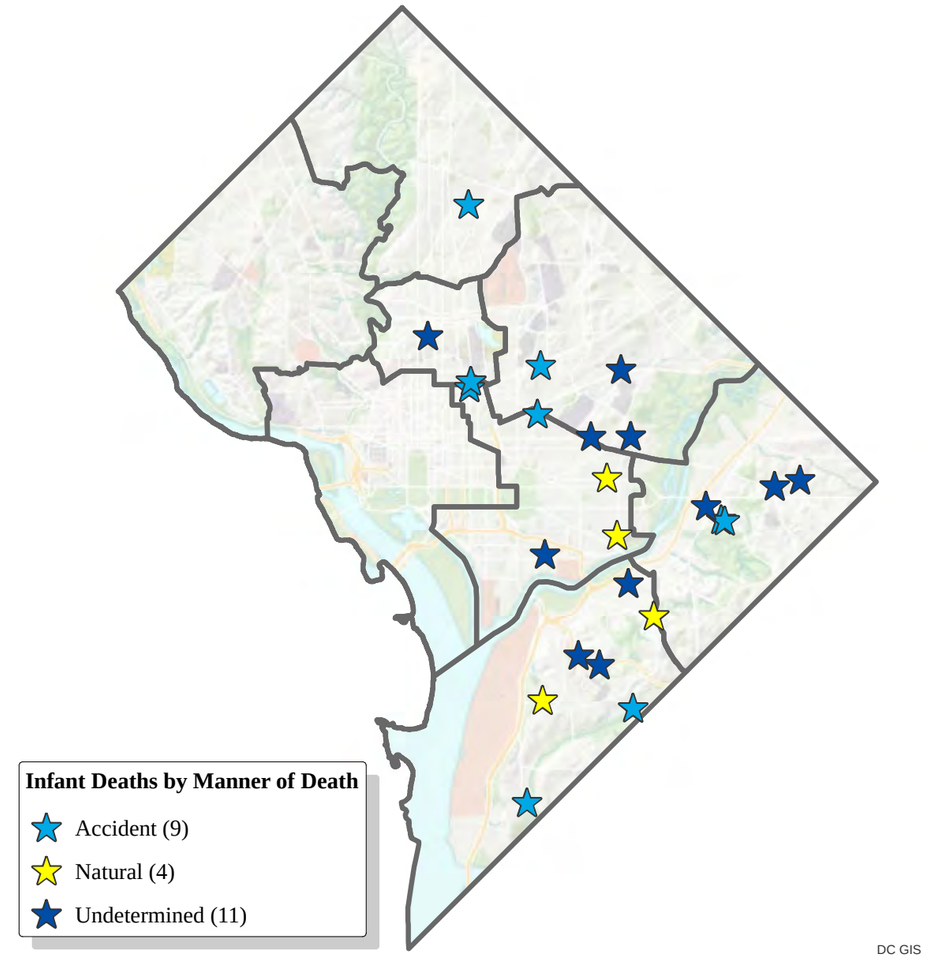
INFANTS < 1 YEAR BY MANNER OF DEATH



MAP OF INFANT DEATHS BY WARD AND MANNER OF DEATH

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

2017 Infant Deaths by DC Residence & Manner of Death



4.0
Special Reports

4.1 DCVDRS

Since its genesis in 2002, the National Violent Death Reporting System (NVDRS) has functioned as a public health surveillance system generated by the Centers for Disease Control and Prevention (CDC) that records the who, what, when, where, why and how of violent fatal incidents for participating states/localities/jurisdictions.

Because the system centers on the incident instead of the victim, data such as multiple homicides within a 24-hour period, homicide-suicides, and connections between suspect(s) and victim(s) over a period time can be collected.

The system has grown from originally supporting six states to 42 states in 2017, including the District of Columbia and Puerto Rico. Death certificates, police reports/records, and coroner and medical examiner records are the three core sources among others used in collecting detailed information on violent fatalities occurring in DC involving deaths due to violence related to suicide, homicide, unintentional firearm deaths, legal intervention, and those of undetermined intent. Individually, these sources satisfy their intended uses for their agencies, but collectively, they develop a more complete picture surrounding the nature of violent deaths occurring within a state/jurisdiction and aid community partners and agencies in identifying strategies for their prevention or intervention.

In 2016, the District of Columbia's Department of Health (Now known as DC Health) and the District of Columbia's Office of the Chief Medical Examiner (DCOCME) was awarded CDC funds for a 5-year period to initiate the District of Columbia Violent Death Reporting System (DCVDRS) and began collecting data in 2017. The contribution of the District of Columbia Metropolitan Police Department (DCMPD) and DC Health as DCVDRS partnering agencies have been invaluable resources toward the efforts to understand violent deaths in DC. The success of DCVDRS, as a whole, would otherwise be unachievable without the collaborative effort of these partnering agencies.

Advantages to utilizing the DCVDRS include, but are not limited to:

- Collaborative input from partnering agencies-DCMPD and DC Health on circumstances surrounding a single violent death
- The recording of incidents involving more than one death or deaths related to one another (i.e. multiple homicides, incidents involving a homicide and suicide
- The complete picture surrounding the who, what, when, where, how and why the violent death occurred (i.e. suspect information in homicides, mental health and recent stressors for suicides, crimes committed before fatal injury, etc.).
- Extensive collection of data involving Intimate-Partner Violence (IPV), Fatalities involving infants, children, teens and wards of the state and Accidental Overdoses.

The following report reflects DCVDRS data from 2017.

SUICIDE

Among the **57** suicides in 2017, suicides were more prevalent in white males and in persons **between the ages of 20 to 39 years.** Hanging and Blunt Impact Trauma were the leading causes of suicidal deaths. More incidents occurred in **April** than in any other month.

Amongst the relationship stressors for suicide victims,

52%
had issues within their families, and

44%
had intimate partner problems.

37% made at least one past suicide attempt before their final fatal attempt.

58%
had at least one mental illness or emotional disorder diagnosis.

Depression was the most prevalent mental illness among those diagnosed peaking at

58%

HOMICIDE

The **123** homicides in 2017 were more prevalent in black males and in persons **between the ages of 20 to 39 years**. Firearm and Sharp Force Trauma were the leading causes of homicidal deaths. More incidents occurred in **March** than in any other month.

The highest level of education of

62%
of the homicide victims was a high school degree/GED or lower.

33%
homicides occurred along the street/sidewalk/alley, not including those decedents who were killed in their vehicles.

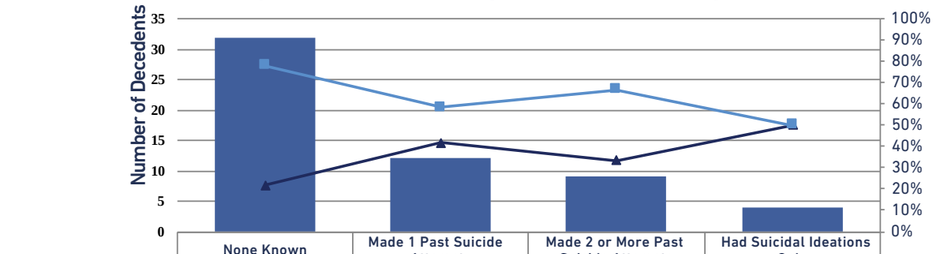
26%
had at least one crime other than the final homicide either immediately precede the final fatal incident or be a contributing factor to it.

18%
of the homicides were caused by the victim's family member or intimate partner.

DCVDRS SUICIDE DATA

In 2017, the District of Columbia OCME saw 57 suicides. * The DCVDRS suicide report reflects any mental illness diagnoses/emotional disorders, history of suicide attempts or ideations, and recent stressors to victim. This information was provided from medical records, evidence found on scene, investigative reports and interviews of witnesses/family/friends. A number of decedents had a history of either suicide attempts or suicidal ideations. Twenty-one people (or 37%) made at least 1 past suicide attempt before their final fatal attempt.

History of Suicide Attempts or Ideations by Gender



	None Known	Made 1 Past Suicide Attempt	Made 2 or More Past Suicide Attempts	Had Suicidal Ideations Only
Number of Decedents	32	12	9	4
Female	22%	42%	33%	50%
Male	78%	58%	67%	50%

Thirty three decedents (58%) had mental heath diagnoses: 24 people had only one diagnosis, 9 people had two or more diagnoses. A breakdown of all diagnoses can be found in the table below.

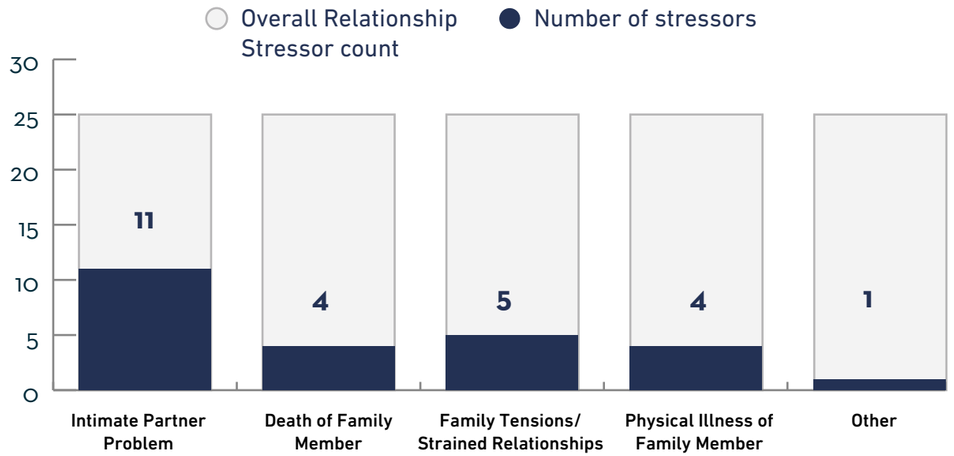
Mental Health Diagnoses	Black	Hispanic	White	TOTAL Diagnoses	Percent of Affected Victims Amongst Diagnosed (n=33)[15]
Depression	6	1	12	19	58%
Bipolar	6	--	1	7	21%
Schizophrenia	5	1	--	6	18%
Other	1	2	3	6	18%
Anxiety	--	--	3	3	9%
ADD/ADHD	--	--	2	2	6%
TOTAL	18	4	21	43	

15 Percentages in this column are calculated from the decedents diagnosed (33) and not the overall total 57 suicides.

In addition, 37 decedents (or 65%) had at least 1 life-stressor appearing to be contributory to their deaths. Some of these decedents had multiple stressors, which are included in the counts below. Thirty-three percent of the stressors were relationship related. In an extensive breakdown on the relationship stressors, 52% had issues within their families, and 44% had intimate partner problems such as a recent break-up, marital issues, divorce and arguments preceding incident. Table below does not include stressors below 5% percent of the data.

Stressors Contributing to Suicide	Number of Stressors	Percentage of Stressors
Relationships	25	45%
Finances	8	15%
Physical/ Mental Health	7	13%
Job/ Fired/ Unemployed	6	11%
Home/ Eviction	5	9%
Legal Factors	4	7%

Breakdown of Relationship Stressors

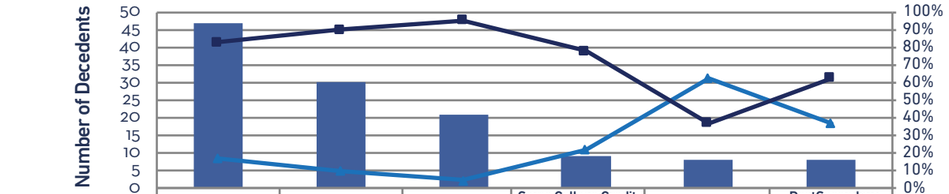


DCVDRS HOMICIDE DATA

In 2017, the District of Columbia OCME saw 123 homicides. All of the data regarding relationship of suspects to victim, location of injury, crimes in progress preceding fatal injury, occurrence of argument or dispute prior to fatal injury and level of education of homicide victims are collected in the DCVDRS among other variables. This information was provided by legal/court press releases, news reports, evidence found on scene, investigative reports, death certificates, and interviews of witnesses/family/friends.

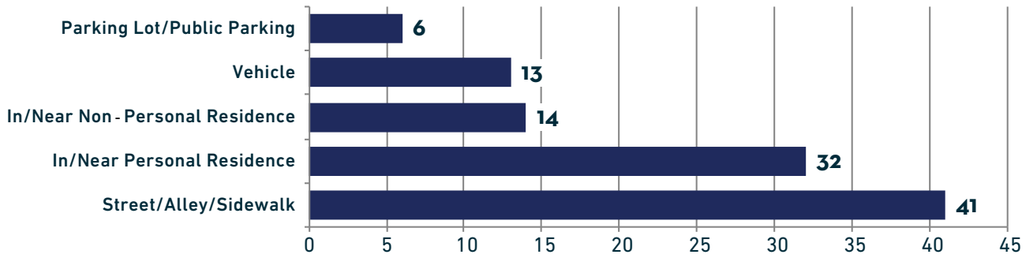
Sixty-two percent (62%) of the homicide victims had a high school degree/GED or less. Most homicides occurred along the street/sidewalk/alley, not including those decedents who were killed in their vehicles. Thirty-six incidents (or 29%) involved a prior argument or ongoing dispute between suspect(s) and victim(s). Thirty-three victims (or 27%) were either related to or had known or met the suspect prior to the homicide. Due to the nature of homicide investigations, circumstances surrounding these incidents such as suspect information, evidence and motive could change over the course of time.

Level of Education Amongst Homicide Victims by Gender

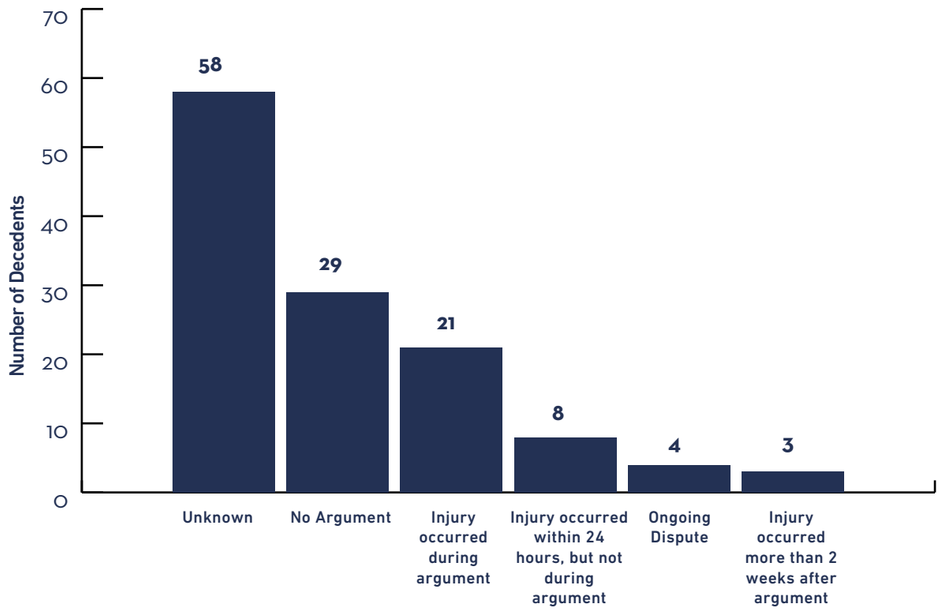


	High School/ GED	9th-12th Grade	Unknown	Some College Credit, but No Degree	Less than 8th Grade	PostSecondary Degree
Number of Decedents	47	30	21	9	8	8
Female	17%	10%	5%	22%	63%	37%
Male	83%	90%	95%	78%	37%	63%

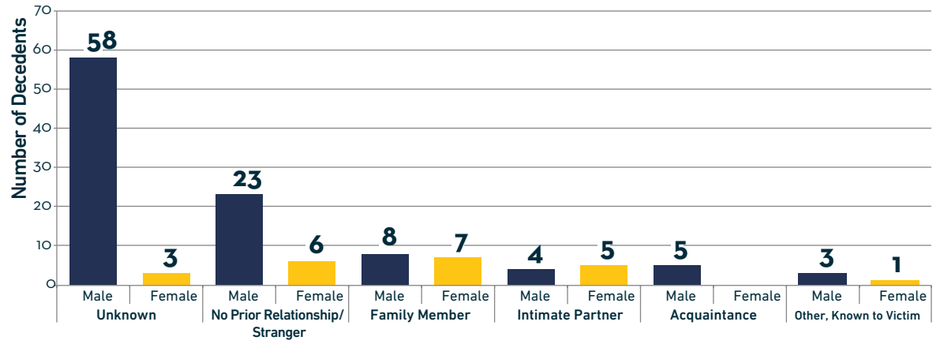
Top 5 Locations of Injury in Homicides



Timing of Argument in Relation to Homicide

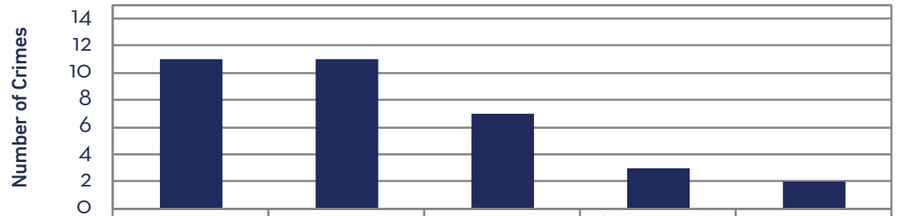


Relationship of Suspect to Victim by Gender



Thirty-two decedents (or 26%) had at least 1 crime other than the final homicide either immediately precede the final fatal incident or be a contributing factor to it. These cover a variety of cases with various surrounding circumstances. Victims ranged between being bystanders, interveners, accomplices and perpetrators to a crime prior to death. The data below also includes cases where multiple crimes may have occurred prior to death. Overall, thirty-five crimes were in progress some period of time before the victim's death. Robbery/Money schemes and assaults were the most prevalent of all crimes preceding victim's death for 2017.

Crimes Preceding Incident



	Assault	Robbery/ Money Scheme	Drug Involvement	Criminal Justice Issue	Other
Number of Crimes	11	11	7	3	2
Percent of Occurrence	32%	32%	21%	9%	6%

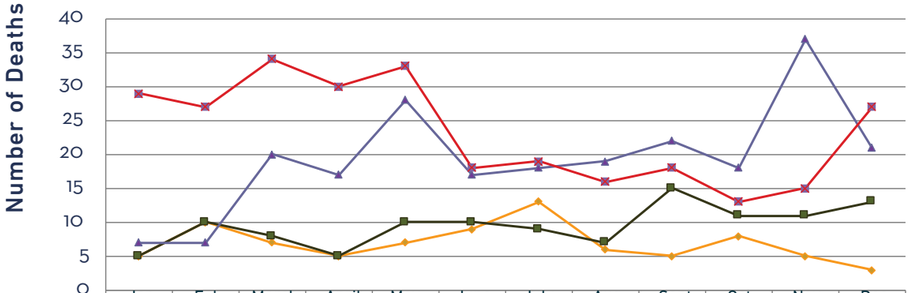
4.2 – DC OPIOID EPIDEMIC REPORT

The DC Office of the Chief Medical Examiner (OCME) investigated a total of 707[16] deaths due to use of opioids from January. 1, 2014 through December 31, 2017: 83 deaths in CY 2014, 114 in CY 2015, 231 deaths to in CY 2016 and 279 deaths in CY 2017 respectively. This report examines the presence of opioids (heroin, fentanyl, fentanyl analogs, morphine, prescription opioids and the general category of opiates) in deaths observed at OCME. Tables and graphs below present decedent information by trends, demographics and jurisdiction of residence.

Trends in Deaths due to Opioid Use

The number of deaths due to opioid use in November 2016 was higher than any other month over the past three years (Fig. 1). Overall, there was a 178% increase in fatal overdoses due to opioid use from 2014 (n=83) to 2016 (n=231). Despite the downward trend observed between June and November of 2017, there were 27 fatal overdoses in December. Moreover, there was 21% increase in opioid overdoses between 2016 and 2017.

Fig. 1: Number of Drug Overdoses due to Opioid Use by Month and Year (N=707)



	Jan.	Feb.	March	April	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.
2014 (n=83)	5	10	7	5	7	9	13	6	5	8	5	3
2015 (n=114)	5	10	8	5	10	10	9	7	15	11	11	13
2016 (n=231)	7	7	20	17	28	17	18	19	22	18	37	21
2017 (n=279)	29	27	34	30	33	18	19	16	18	13	15	27

Incidence of Opioids by Year

Each drug is counted independently in fatalities involving more than one of these drugs and ranged from 1 to 7 opioids identified per death. There were a total of 120 opioids found in the 83 deaths in 2014, 160 opioids found in the 114 deaths in 2015 and 407 opioids found in the 231 deaths in 2016. In 2017, there have been 530 opioids found in the 279 deaths. As depicted in Figure 2(a), the total number of opioids that caused a death has steadily increased from 2014 to 2017.

16 The data presented in this report includes 11 cases with a Manner of Death other than Accidental Intoxication- three cases in 2014, one case in 2015, and one case in 2016 in which the Manner of Death was Undetermined but the Cause of Death was due to opioid drug use. Additionally there were two cases with Manner of Death of Suicide in 2014, one case in 2015 and three cases in 2016

Fig. 2(a): Total Number of Opioid Drugs Contributing to Drug Overdoses by Year (All Opioids)

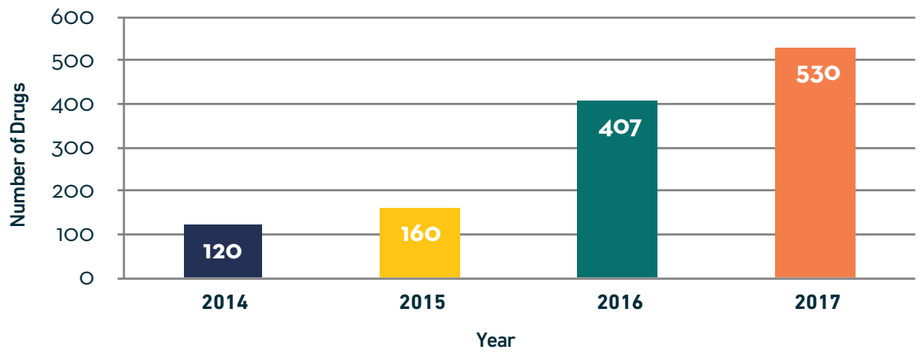


Figure 2(b) displays the illicit and prescription opioids identified through toxicology testing of the 707 decedents from 2014 to 2017. The most prevalent drugs identified are heroin followed by fentanyl. Figure 3 highlights the dramatic increase in the number of opioid overdoses that contain fentanyl/fentanyl analogs. The percentage of cases containing fentanyl has remained relatively steady over the past two quarters of 2017.

Fig. 2(b): Number of Opioid Drugs Contributing to Drug Overdoses by Year

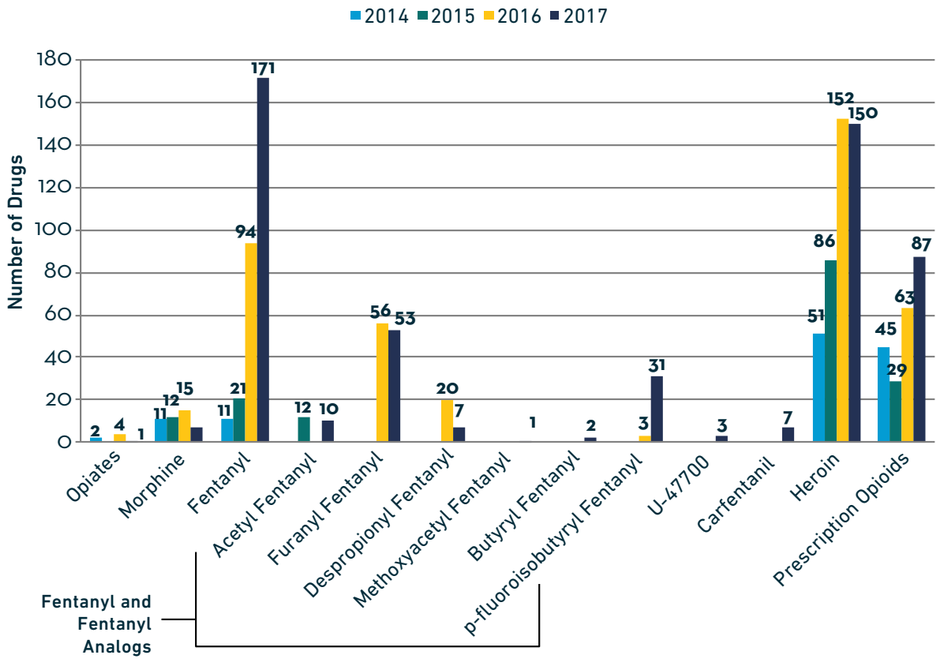


Fig. 3 Number of Opioid Overdoses Containing Fentanyl/Fentanyl Analogs by Quarter, 2015-2017

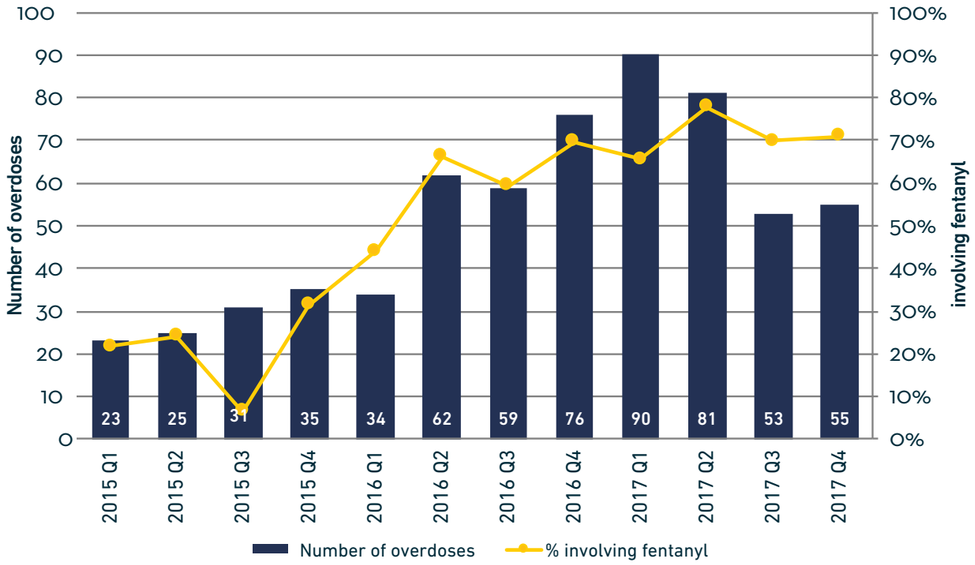
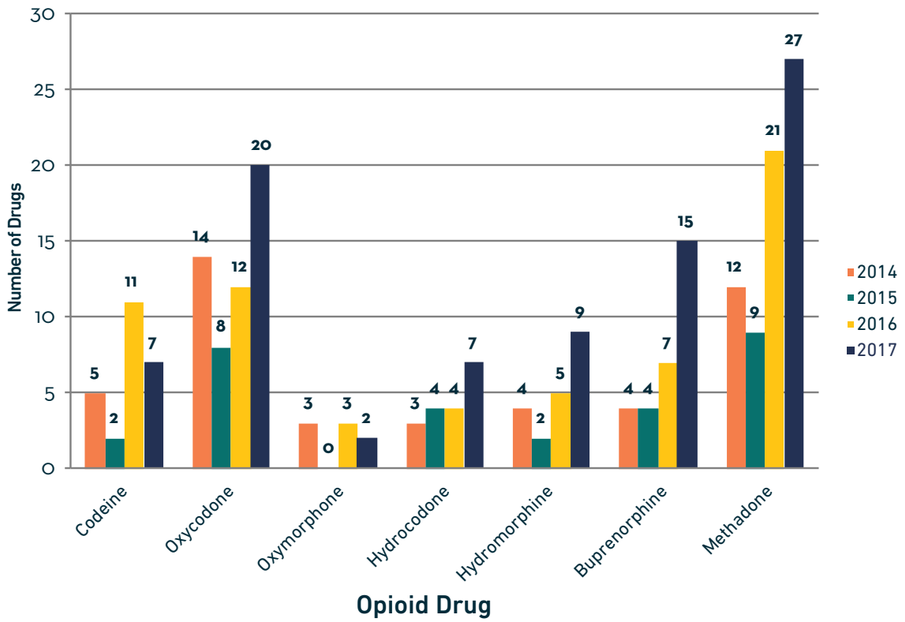


Fig. 4: Number of Prescription Opioids Contributing to Drug Overdoses by Year (n=224)



Prescription Opioids

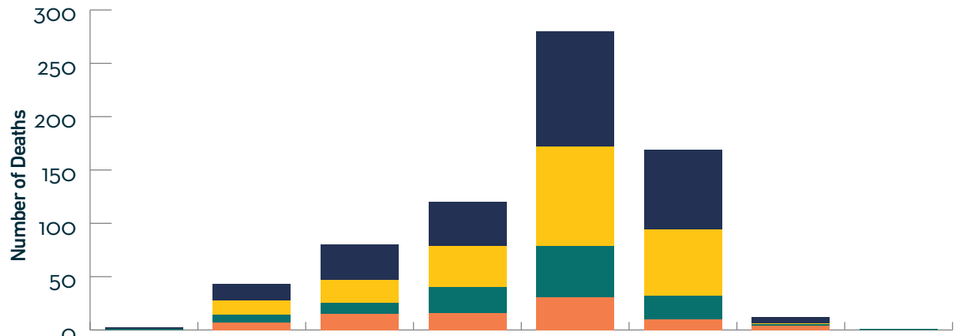
There were 224 prescription opioids found in the 707 drug overdoses between January 2014 and December 2017. Despite the downward trend in the number of fatal overdoses related to prescription opioids between 2014 (n=45) and 2015 (29), the number of fatal overdoses involving prescription opioids has consistently increased over the past two years. There were 63 prescription opioids found in 2016 and 83 prescription opioids in 2017.

Demographics

Age

Approximately 80% of all overdoses due to opioid drug use happened among adults between the ages of 40-69 years old (Fig. 5). Deaths due to opioid use were most prevalent among people ages 50 to 59 (n=40%).

Fig. 5: Drug Overdoses due to Opioid Use by Age



	16-19	20-29	30-39	40-49	50-59	60-69	70-79	80-89
2017	1	15	33	41	108	75	6	0
2016	0	14	22	39	93	62	1	0
2015	1	7	10	24	48	22	1	1
2014	0	7	15	16	31	10	4	0

Race/Ethnicity

Overall, 559 or 81% of all deaths due to opioid use were among Blacks (Fig. 6). This trend remains consistent across years.

Gender

Fatal overdoses due to opioid drug use were more common among males (Fig. 7).

Jurisdiction of Residence

The majority of the decedents were residents of DC (Fig.8). From 2014 to 2017, opioid-related fatal overdoses were most prevalent in Wards 7 & 8 (n=223) (Fig.9). However, there are variations across years.

Fig. 6: Number of Drug Overdoses due to Opioid Use by Race/Ethnicity and Year

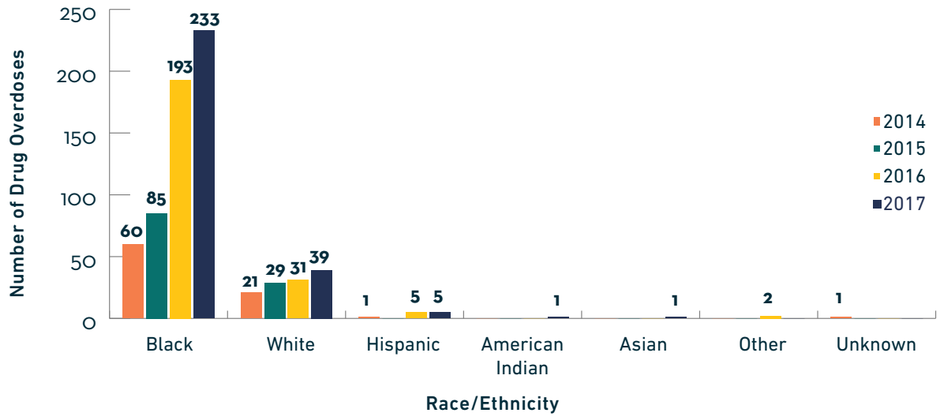


Fig. 7: Percentage of Drug Overdoses due to Opioid Use by Gender and Year

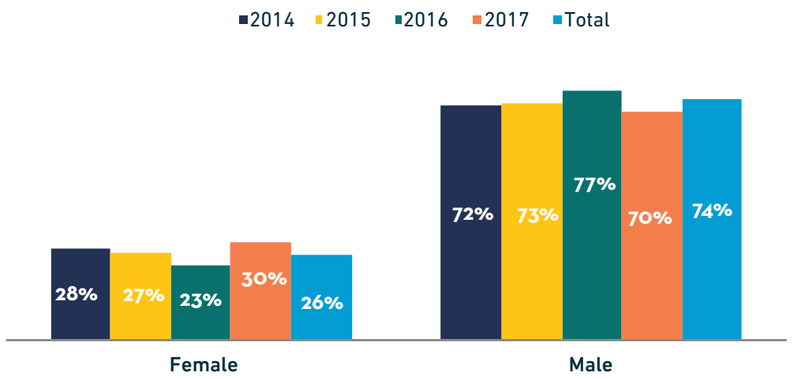


Fig. 8: Number of Drug Overdoses due to Opioid Use by Jurisdiction of Residence and Year

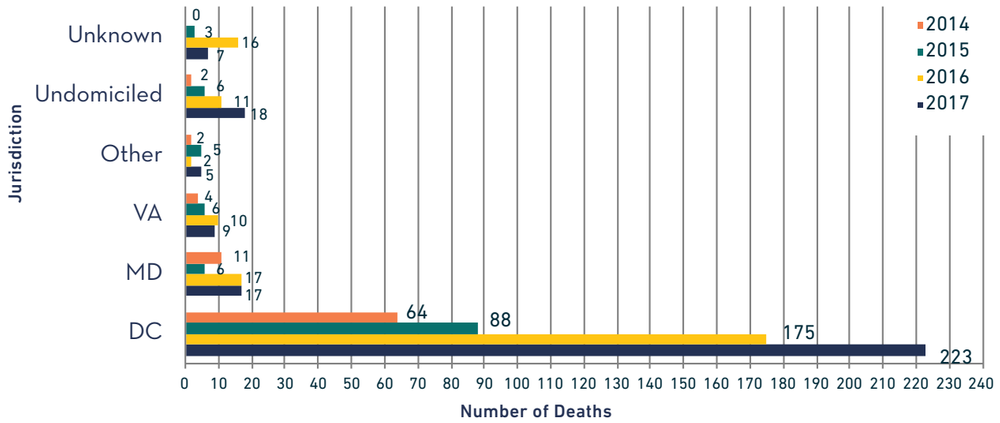
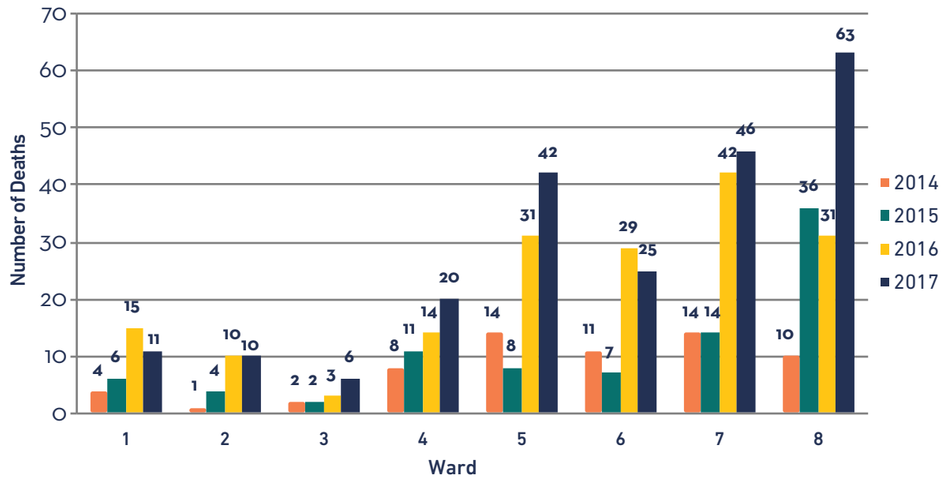


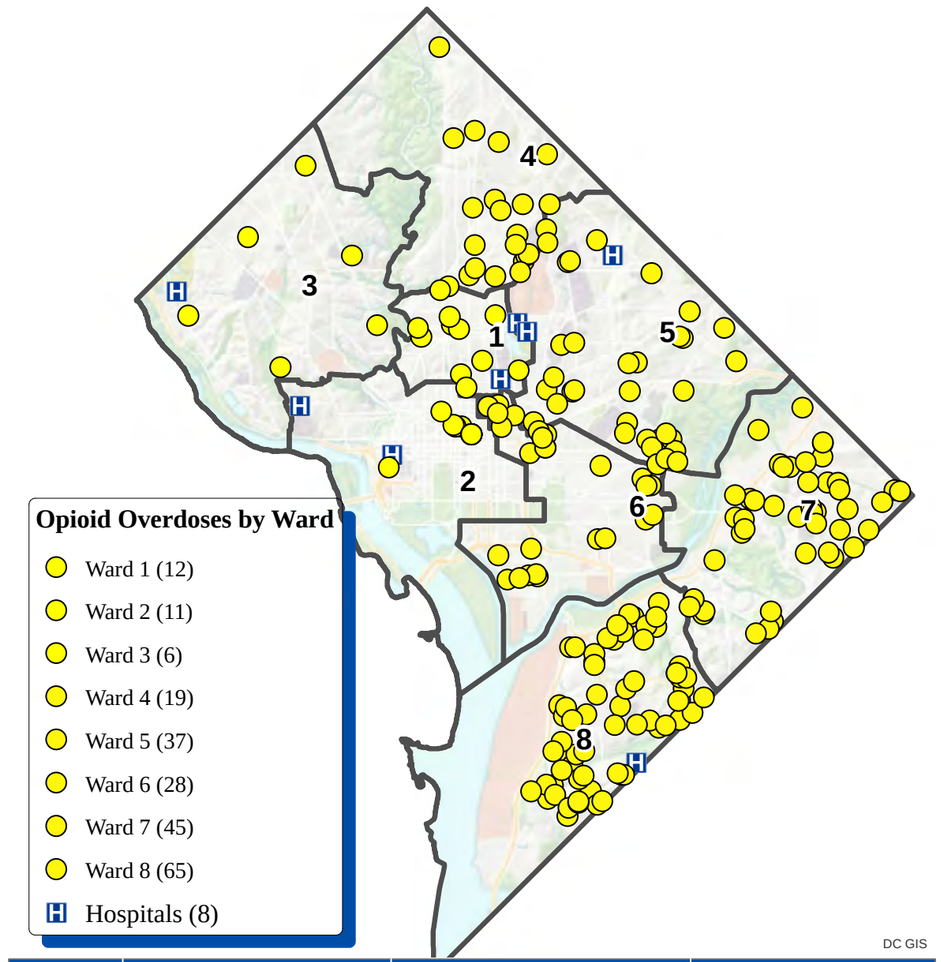
Fig. 9: Number of Drug Overdoses due to Opioid Use by Ward of Residence and Year



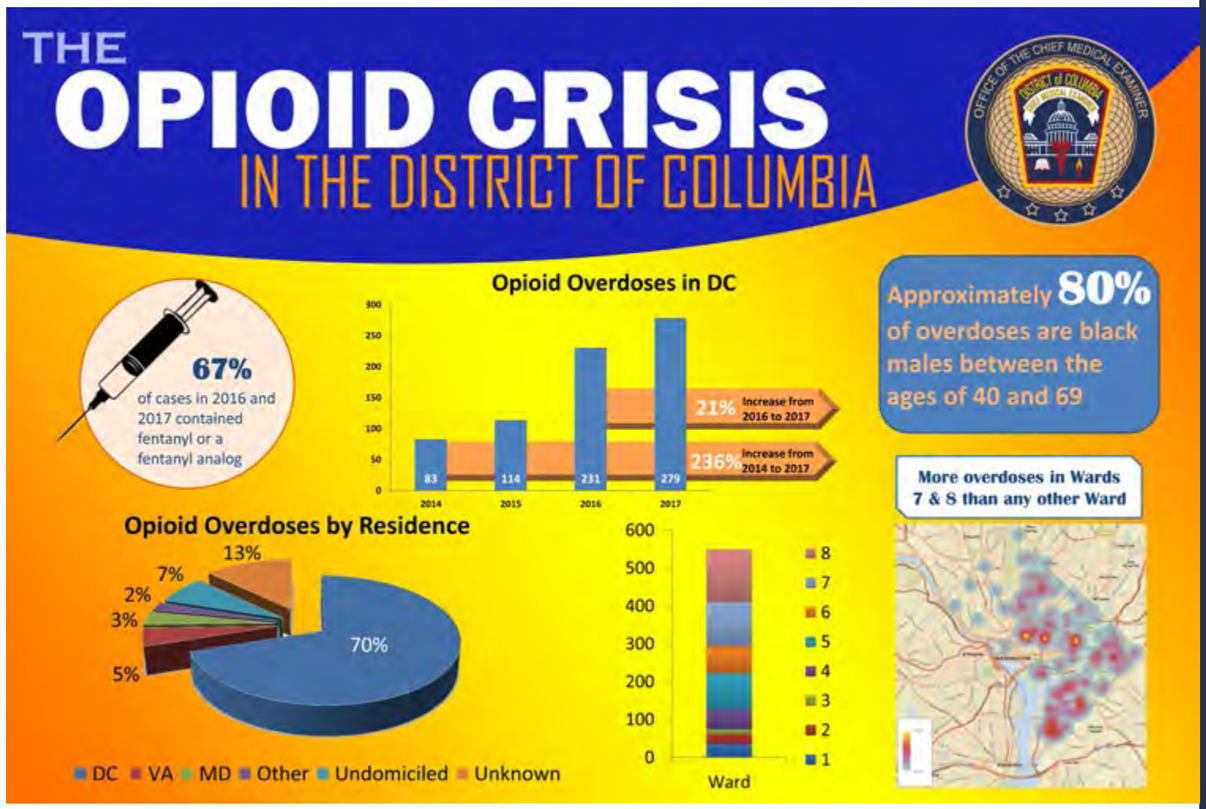
MAP OF OPIOID RELATED DEATHS BY JURISDICTION OF RESIDENCE

The map below displays opioid overdoses in 2017 by jurisdiction of residence. As stated previously, opioid overdoses are prevalent in Wards 5, 6, 7 and 8. The map also highlights a hotspot in Ward 2.

2017 Opioid Overdoses by Ward



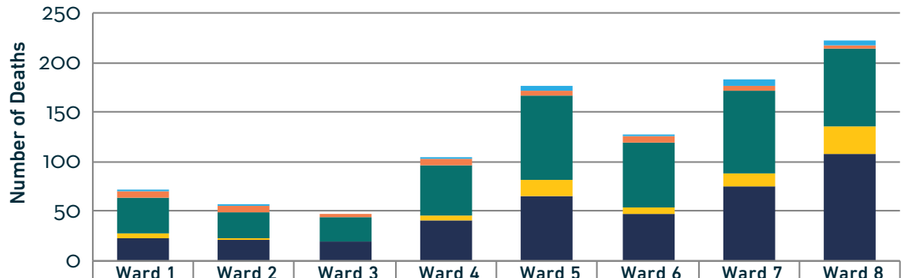
DEATHS DUE TO OPIOID DRUG USE: JANUARY 1, 2014 TO DECEMBER 31, 2017



5.0 Ward Highlights

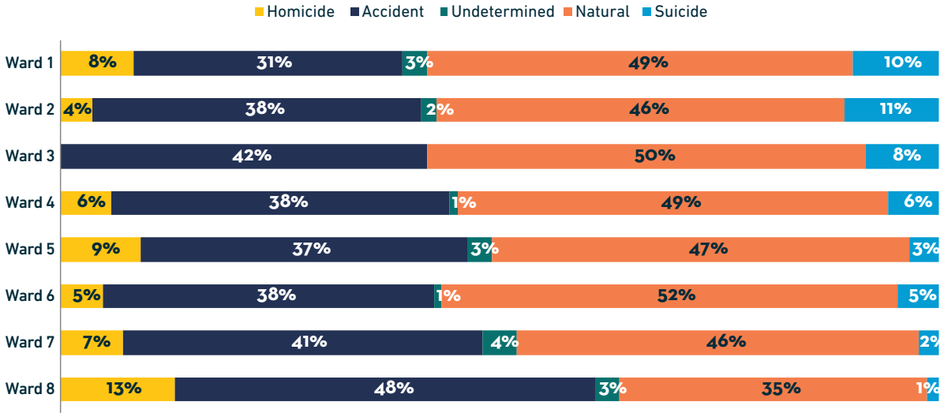
OVERALL, 990 OR 74% OF ALL DECEDENTS WERE RESIDENTS OF THE DISTRICT OF COLUMBIA. THIS SECTION HIGHLIGHTS THE LEADING MANNER AND CAUSES OF DEATH BY WARD. THE TABLES BELOW PROVIDE THE LEADING CAUSES OF DEATH (MANNER) BY THE DECEDENT'S JURISDICTION OF RESIDENCE.

Leading Causes of Death by Ward



	Ward 1	Ward 2	Ward 3	Ward 4	Ward 5	Ward 6	Ward 7	Ward 8
Undetermined	2	1	0	1	5	1	7	6
Suicide	7	6	4	6	6	6	4	3
Natural	35	26	24	51	84	66	84	78
Homicide	6	2	0	6	16	6	13	29
Accident	22	21	20	40	66	48	75	107
TOTAL	72	56	48	104	177	127	183	223

Leading Causes of Death by Ward (Percent)



Ward 1

Of the 990 DC residents seen at the OCME, there were 72 decedents from Ward 1. With the exception of Ward 2, there were more deaths due to suicides than any other Ward (see Leading Manner of Deaths graphs). The most prevalent cause of death was cardiovascular disease (29) followed by drug overdoses (16) and firearm-related violent deaths (5). However, the number of homicides in Ward 1 were relatively low compared to Wards 5, 7, and 8 and exactly the same as Wards 4 and 6.

Ward 2

There were 56 decedents from Ward 2. Similar to Ward 1, the most prevalent cause of death was cardiovascular disease (16) followed by intoxications (14), and blunt injury due to falls (4).

Ward 3

There were 48 decedents from Ward 3, the fewest of any Ward. Similar to last year, there was no undetermined manner of deaths. In addition, there were no homicides in Ward 3. The most prevalent cause of death was cardiovascular disease (14) followed by, blunt injury due to falls (10) and drug overdoses (7). With the exception of Ward 8 (11), more deaths due to falls were experienced by residents of Ward 3 (10).

Ward 4

There were 104 decedents from Ward 4. The most prevalent cause of death was cardiovascular disease (35) followed by drug overdoses (27), and blunt injury due to falls (9).

Ward 5

There were 177 decedents from Ward 5, the third most among the 8 DC Wards. The most prevalent cause of death was cardiovascular disease (61) followed by drug overdoses (52), and firearm-related violent deaths (10). Ward 5 had the second highest number of homicides, following Ward 8.

Ward 6

There were 127 decedents from Ward 6. The most prevalent cause of death was cardiovascular disease (47) followed by drug overdoses (34), and firearm-related violent deaths (6).

Ward 7

There were 183 decedents from Ward 7, the second most of any Ward. In addition, Ward 7 had the second highest number of deaths due to accidents (75), and tied with Ward 5 for the most natural deaths (84). The most prevalent cause of death was drug overdoses (62), followed by cardiovascular disease (60), and firearm-related violent deaths (10).

Ward 8

There were 223 decedents from Ward 8, the most of any Ward. There were more deaths with a manner of death of accident (107) and homicide (29) than any other Ward. Ward 8 was the only Ward to have more deaths with a manner of death of accident than natural. In addition, the fewest number of suicides was observed in Ward 8. The most prevalent cause of death was drug overdoses (85) followed by cardiovascular disease (55), and firearm-related violent deaths (22).

6.0 Organ Procurement

THE UNIFORM ANATOMICAL GIFT REVISION ACT OF 2008 MANDATES IN SEC. 22 (A) [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 by OCME	# of Requests	# Procured
Yes	126	29
No	2	0
Request Abandoned	0	0
Total Requests	**128**	**29**

7.0
Toxicology Services

7.1 - 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) major classes of illicit and prescription medications. Additional screens were assigned depending on requests made by law enforcement. In 2017, the laboratory received 355 cases from the Metropolitan Police Department (MPD), 78 cases from the United States Parks Police (USPP), 19 specimens from the United States Capitol Police (USCP), 10 specimens from the United States Secret Service (USSS), and 2 specimens from the Central Intelligence Agency (CIA). Specimens received were either blood or urine, and multiple specimens could be received with each of the 464 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:

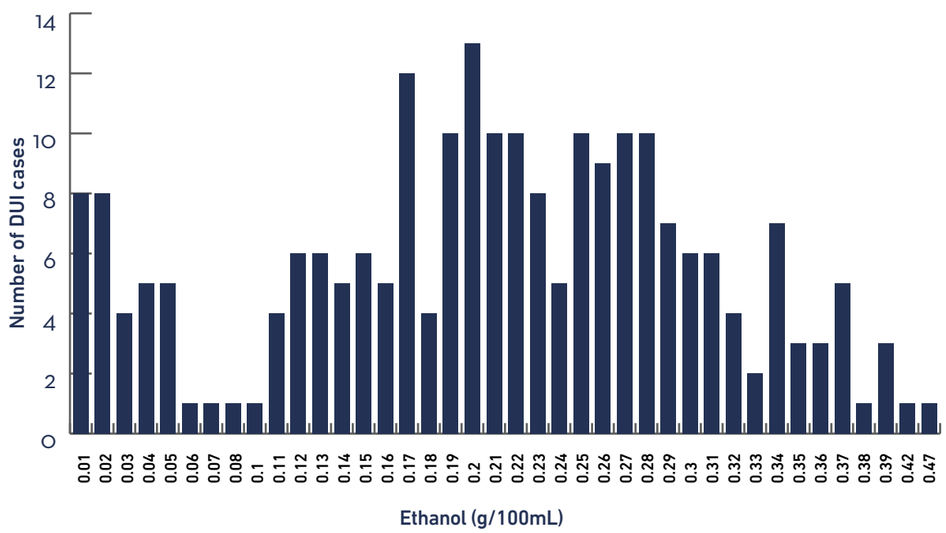
Description	Number of Cases	% of Cases
N=	464	
Negative	20	4.3 %
Positive	444	95.6 %

The chart below displays the prevalence of illicit substances in DUI casework submitted by all enforcement agencies.

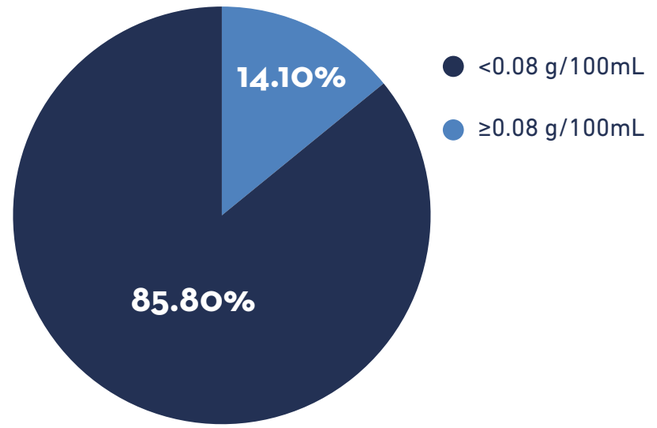
Drug	Number of Cases	% of Cases
Ethanol	297	64.0 %
Marijuana Metabolite	161	34.6 %
Phencyclidine (PCP)	97	20.9 %
Cocaine Metabolite	53	11.4 %
Fentanyl	33	7.1 %
Morphine/Heroin	21/23	4.5/4.9 %
Codeine	18	3.8 %
Alprazolam	15	3.2%
Oxycodone	13	2.8%

NOTE: Additional information regarding driving under the influence of controlled substances can be found in Section should be 7.3- Breath Alcohol Program.

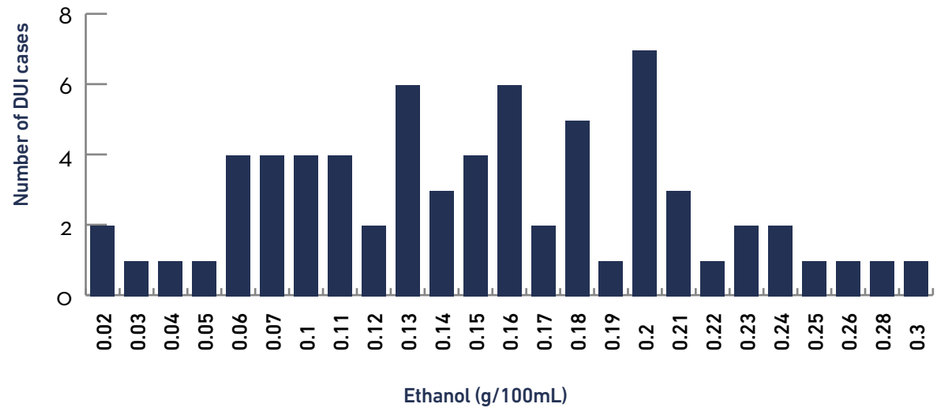
Alcohol Case Distribution by Urine Driving Under the Influence Results



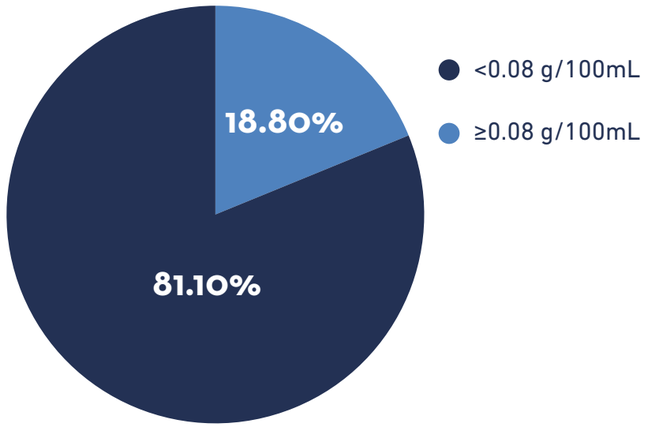
Urine Alcohol Results based on Per Se Law



Alcohol Distribution by Blood Driving Under the Influence Results



Blood Alcohol Results based on Per Se Law



7.2 - 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 cases. Additional screens were assigned depending on requests made by law enforcement. In 2017, the laboratory received cases from District government agencies including 67 cases from Metropolitan Police Department and 49 cases from the Office of Victim Services. Specimens received were blood and urine, and multiple specimens were received with each of the 116 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=	116	
Negative	4	3.4 %
Positive	112	96.5 %

The most commonly types of detected drugs in DFSA cases were:

Drug Class	% Prevalence
Ethanol	33.6 %
Marijuana	32.7 %
Cocaine Metabolite	18.1 %
Quinidine/Quinine	13.7 %
Diphenhydramine	10.3 %
Phencyclidine	7.7%
Bupropion	6.8%
None were detected	3.4%

Subject demographics for DFSA cases were:

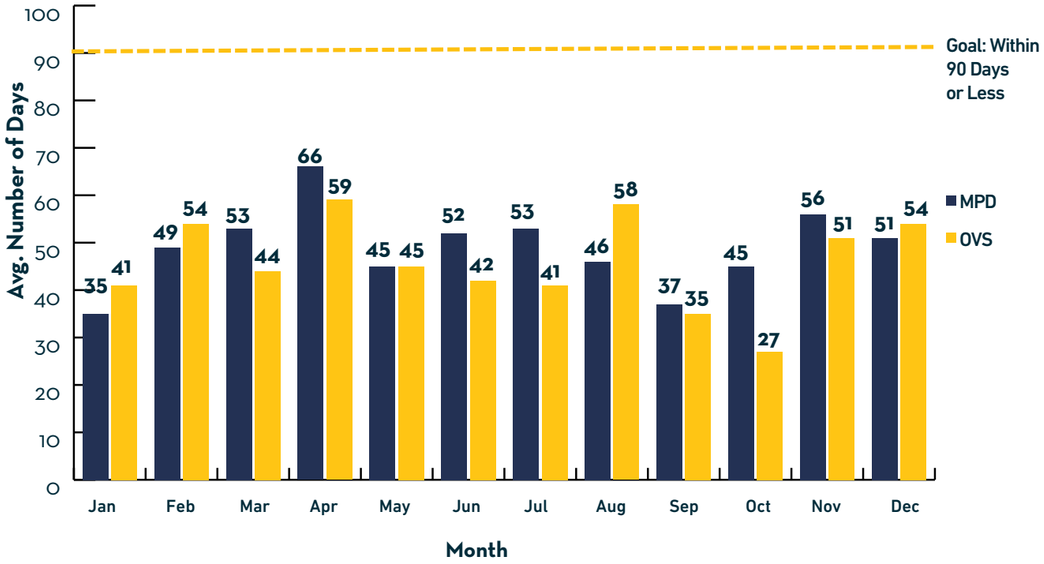
Gender	% of Total
Male	7.5%
Female	92.4%
Total	**100%**

AVERAGE AGE (YEARS) 31	
Age Range	**# of Cases**
Ages ≥10 and <15	0
Ages ≥15 and <20	12
Ages ≥20 and <25	35
Ages ≥25 and <30	23
Ages ≥30 and <35	22
Ages ≥35 and <40	10
Ages ≥40 and <50	7
Ages ≥50 and <70	3
Age Unknown	4
Total	**116**

Cases submitted by Agency and cases processed:

Agency	Cases Received	% Processed
MPD	67	100%
OVSJG (DC SANE)	49	100%

AVERAGE MONTHLY TURNAROUND TIME FOR DFSA CASES SUBMITTED TO OCME



Turnaround Time (TA) for Each Case submitted to OCME:

The Sexual Assault Victims Right Act of 2014 (SAVRA) is the result of survivor and systems advocacy efforts to improve the District's response to sexual assaults. SAVRA requires OCME to disclose the amount of time taken to process each sexual assault kit submitted for toxicology testing. The goal is complete toxicology testing within 90 days. The turnaround time for each case submitted to OCME is listed below by submitting agency, date received and date reported.

Turnaround Time for Cases Submitted to OCME by Agency

Submitting Agency	Received Date	Report Date	TAT (Days)	Submitting Agency	Received Date	Report Date	TAT (Days)
MPD	1/17/17	2/13/17	27	OVS	7/12/17	8/11/17	30
MPD	1/17/17	2/13/17	27	OVS	7/12/17	8/11/17	30
MPD	1/19/17	2/23/17	35	MPD	7/17/17	9/22/17	67
OVS	1/24/17	4/5/17	71	MPD	7/20/17	9/1/17	43
OVS	1/24/17	3/1/17	36	MPD	7/31/17	9/15/17	46
OVS	1/24/17	2/21/17	28	OVS	8/7/17	9/15/17	39
OVS	1/24/17	2/21/17	28	OVS	8/9/17	10/24/17	76
MPD	1/26/17	3/17/17	50	OVS	8/9/17	10/17/17	69
MPD	2/2/17	3/17/17	43	MPD	8/10/17	10/6/17	57
MPD	2/9/17	4/28/17	78	MPD	8/10/17	9/15/17	36
MPD	2/9/17	3/17/17	36	MPD	8/14/17	10/17/17	64
OVS	2/9/17	3/17/17	36	MPD	8/14/17	9/21/17	38
OVS	2/15/17	4/28/17	72	OVS	8/21/17	10/6/17	46
OVS	2/15/17	4/11/17	55	MPD	8/21/17	10/6/17	46
MPD	2/27/17	4/11/17	43	MPD	8/24/17	10/6/17	43
MPD	2/27/17	4/11/17	43	MPD	8/28/17	10/6/17	39
OVS	3/15/17	5/25/17	55	MPD	9/6/17	10/17/17	41
OVS	3/15/17	4/24/17	40	OVS	9/6/17	10/6/17	30
OVS	3/15/17	4/20/17	36	OVS	9/6/17	10/5/17	29
MPD	3/17/17	5/23/17	67	OVS	9/6/17	10/5/17	29
MPD	3/20/17	5/9/17	50	OVS	9/6/17	10/5/17	29
MPD	3/20/17	4/28/17	39	MPD	9/11/17	10/17/17	36
MPD	3/23/17	5/9/17	47	MPD	9/14/17	10/17/17	33
MPD	3/27/17	6/23/17	88	OVS	9/18/17	11/13/17	56
MPD	3/27/17	5/7/17	41	OVS	9/18/17	10/24/17	36
MPD	3/30/17	5/15/17	46	MPD	9/18/17	10/17/17	29
MPD	3/30/17	5/15/17	46	MPD	9/29/17	11/13/17	45
OVS	4/3/17	6/29/17	87	MPD	10/10/17	11/16/17	37
OVS	4/3/17	6/13/17	71	MPD	10/12/17	11/21/17	40
OVS	4/3/17	5/15/17	42	MPD	10/12/17	11/16/17	35
OVS	4/3/17	5/15/17	42	MPD	10/18/17	1/19/18	93

Turnaround Time for Cases Submitted to OCME by Agency (continued)

Submitting Agency	Received Date	Report Date	TAT (Days)	Submitting Agency	Received Date	Report Date	TAT (Days)
MPD	4/13/17	6/20/17	68	OVS	10/20/17	11/17/17	28
MPD	4/18/17	6/20/17	63	OVS	10/20/17	11/17/17	28
OVS	4/19/17	8/1/17	104	OVS	10/30/17	11/29/17	30
OVS	4/19/17	5/25/17	36	OVS	10/30/17	11/20/17	21
OVS	4/19/17	5/18/17	29	MPD	10/30/17	11/20/17	21
MPD	5/4/17	6/20/17	47	MPD	11/13/17	1/5/18	53
OVS	5/8/17	6/26/17	49	OVS	11/15/17	1/5/18	51
MPD	5/8/17	6/20/17	43	MPD	11/16/17	1/22/18	67
OVS	5/8/17	6/20/17	43	MPD	11/16/17	1/22/18	67
OVS	5/8/17	6/13/17	36	MPD	11/16/17	1/5/18	50
MPD	5/11/17	6/20/17	40	MPD	11/20/17	1/5/18	46
MPD	5/15/17	6/26/17	42	MPD	11/30/17	1/22/18	53
MPD	5/25/17	7/18/17	54	MPD	11/30/17	1/22/18	53
OVS	5/31/17	7/18/17	48	MPD	12/7/17	1/26/18	50
OVS	5/31/17	7/18/17	48	OVS	12/11/17	3/14/18	59
MPD	6/5/17	8/8/17	64	OVS	12/11/17	2/13/18	64
MPD	6/12/17	8/1/17	50	OVS	12/11/17	2/8/18	59
MPD	6/15/17	8/1/17	47	OVS	12/11/17	1/29/18	49
OVS	6/16/17	10/5/17	53	MPD	12/14/17	2/13/18	61
OVS	6/16/17	8/1/17	46	MPD	12/14/17	1/29/18	46
OVS	6/16/17	7/20/17	34	MPD	12/18/17	2/13/18	57
OVS	6/16/17	7/20/17	34	MPD	12/18/17	1/30/18	43
MPD	6/29/17	1/5/18	64	MPD	12/21/17	1/29/18	39
MPD	6/29/17	8/17/17	49	OVS	12/22/17	1/30/18	39
MPD	6/29/17	8/7/17	39	MPD	12/26/17	3/12/18	76
MPD	7/6/17	9/1/17	57	MPD	12/26/17	2/14/18	50
OVS	7/12/17	9/13/17	63	MPD	12/26/17	1/30/18	35

7.3 - BREATH ALCOHOL PROGRAM

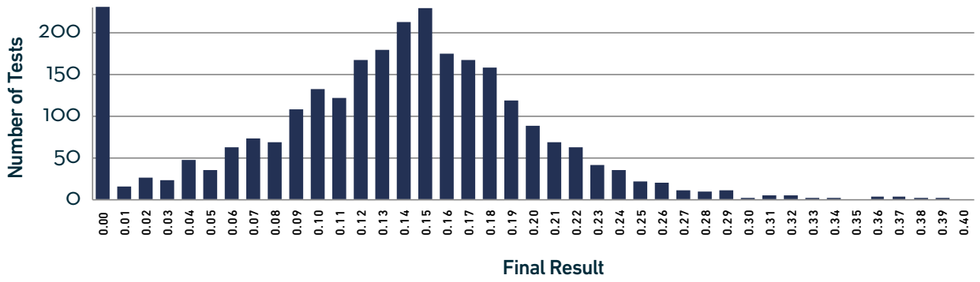
In 2017, four 40-hour Operator Training Courses were offered, licensing a total of 55 operators. Twenty-four operators were recertified; therefore there were a total of 147 licensed operators. This resulted in 4,365 evidential breath tests being administered through the deployment of 8 instruments into the field.

Program Facts

- Total 40-hour Operator Trainings Provided 7: 4
- Total New Breath Test Operators Trained: 55
- Total Recertification Trainings: 5
- Total Operators Recertified: 24
- Total Licensed Breath Test Operators: 147
- Breath Alcohol Technicians Trained: 5
- Breath Alcohol Maintenance Technician Trained: 2
- Breath Alcohol Toxicologist Trained: 1
- Total Certified Active Technicians: 8
- Number of evidential instruments in the field (cumulative): 8
- Total Evidential Tests Taken from 2012-2016: 4,365

Tests Taken in 2017 by District:

1D: 146
2D: 119
3D: 140
4D: 93
5D: 103
6D: 115
7D: 77
MPD Alc. Van: 4
Total: 797



Final Results from all Districts from 2012 – 2017: The most prevalent final result is 0.00 g/210L. This can be due to the impairment of a subject by a substance other than ethanol. The most prevalent breath alcohol concentrations range from 0.13 – 0.19 g/210L.

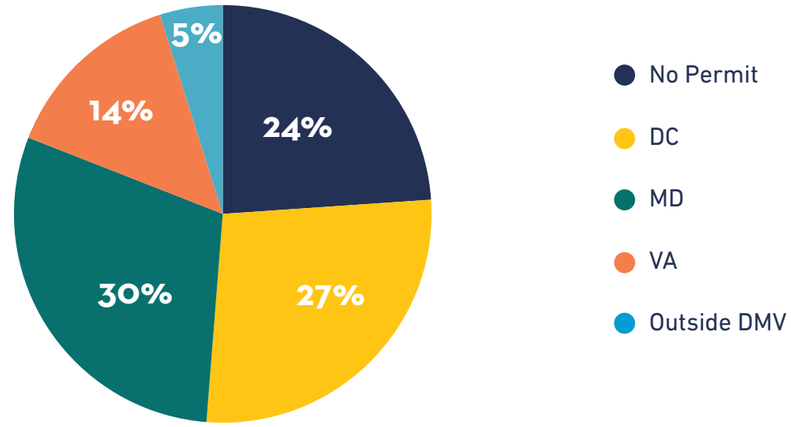
TOTAL NUMBER OF BREATH ALCOHOL TESTS BY DISTRICT AND YEAR

Evidential Breath Tests Taken by MPD District							
Serial Number (district)	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**Total**
013303 (1D)	40	192	151	106	103	146	738
013304 (2D)	0	100	126	99	105	119	549
013305 (3D)	83	330	281	131	179	140	1144
013306 (4D)	0	55	76	54	77	93	355
013307 (5D)	0	102	149	111	97	103	562
013308 (6D)	0	46	99	37	57	115	354
013309 (7D)	96	255	128	55	42	77	653
013310 (Alcohol Van)	0	0	0	2	4	4	10
Total Evidential Tests as of 12/31/2017	219	1080	1010	595	664	797	4365

Additional Facts:

Overall, the program maintains an average of 13% refusals (a refusal is when someone elects to not take an evidential breath test). These statistics do not include refusals of the PD 29 Implied Consent form. These are refusals captured by the breath testing instrument due to a deficient sample or refusal during the breath test.

EVIDENTIAL TESTS BY LICENSE STATE OF ISSUANCE



8.0
Other Major Activities

ALL OTHER MAJOR ACTIVITIES ARE CONDUCTED UNDER THE OVERSIGHT AND STRICT SUPERVISION OF THE CHIEF MEDICAL EXAMINER AND/OR HIS DESIGNEE.

8.1 - 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 2017.

Type of Judicial Service	Number of Court related Activities
Court Testimony	13
Depositions	0
Grand Jury	0
Pre-trial Conference	33
Other	5
Total	51

Court Services by Type	Number of Court related Activities
Civil	0
Criminal	51
Other	0
Total	51

For calendar year 2017 the above data represents approximately 50 hours of Medical Examiner time. In general the least amount of time spent on this activity was 15 minutes, and the maximum recorded time spent on a court-related activity was 8.00 hours.

8.2 - IDENTIFICATIONS

Identifications

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

ID Method	# of ID's
ID By Visual at OCME – 323 at Scene - 291	614
ID By Fingerprints	329
ID By X-ray	55
ID Waived	326
ID By Dental X-ray	8
ID By Circumstantial Evidence	7
ID by DNA	1
ID Other	5
Unidentified	0
ID Not Required	8
Total	1353

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

Fingerprint: When the physical state of the decedent allows, fingerprints are captured. These fingerprints are sent to law enforcement and processed through the Automated Fingerprint Identification System (AFIS). Fingerprints are searched through both the criminal and civil databases. If the fingerprint search returns a negative hit, the fingerprints are sent to the Department of Homeland Security for a search of individuals in the immigration database. Timeframe: Typically 1-5 hours, but may take up to 3 days.

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

DNA testing: This method requires the decedent's DNA profile to be compared to the DNA profile of a close biological relative, preferably a parent or child. The DNA profiles are obtained from a decedent specimen (i.e. femur bone, blood, teeth or deep muscle tissue) and a buccal (cheek) swab collected from the biological relative. Alternatively, the decedent's DNA profile can be compared to the DNA obtained from the decedent's personal item such as a tooth brush or hair brush. Timeframe: Up to 3 to 6 weeks.

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

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

Family members searching for lost love ones have access to NamUs through the internet (http://www.namus.gov/) and may submit a buccal swab for processing and uploading to a family member specific DNA database. The unidentified decedent's DNA profile is regularly compared to all the family member profiles in the database. Positive matches are reported to the investigating agencies. Entry of a missing person's description into NamUs and submission of a family reference DNA sample are handled by law enforcement in the locale where the person went missing.

8.3 - PUBLIC DISPOSITIONS

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

Additionally, the OCME provides storage of remains for nursing homes and hospices that do not have refrigerated facilities to store bodies. A minimal one-time fee is charged to these facilities and the remains are kept until family members are located or able to make funeral arrangements, or until the expiration of 30-days and at such time public disposition can occur. By regulation (DC Code §5-1411), OCME is required to arrange final disposition for unclaimed remains housed at local hospitals.

The process for which unclaimed bodies are handled is called "Public Dispositions." After a 30-day waiting period and after all efforts to locate family members are exhausted the OCME makes final arrangements for these bodies through a contracted local funeral home. Unclaimed decedents are cremated and the cremains are buried. At the discretion of the medical examiner, unclaimed or unidentified decedents may be buried. Furthermore, the OCME has a memorandum of understanding with the National Museum of Health and Medicine allowing the museum to serve as a repository for unidentified skeletal remains. The museum archives the remains until the individual is identified and can be returned to his or her family.

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

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

There were a total of 142 Public Disposition cases, of which 79 were Medical Examiner cases and 60 were Storage cases. There were no unidentified decedents that were released for Public Disposition in 2017. The breakdown by Adult, Children and Fetuses:

Description	# of Public Disposition
Adults	137
Children	1
Fetus	1
Cremains	3*
Total	**142**

*At times, cremains are found in the community and submitted to the medical examiner's office. The OCME buries these cremains held in individual urns with the cremains of the unclaimed decedents.

Breakdown of Public Dispositions and the Associated Costs

Public Disposition by type	Number of Unclaimed Remains
Cremations – identified adults	134
Buried children	1
Cremations – fetal remains	1
Transport to Quantico National Cemetery – identified US Military Veteran	3
Burial of cremains	3
Total	**142 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 2017 there were 286 Storage Requests made to the DC OCME.

APPENDIX A

OCME Organizational Chart

D.C. OFFICE OF THE CHIEF MEDICAL EXAMINER

CHIEF MEDICAL EXAMINER

AGENCY FISCAL OFFICER

GENERAL COUNSEL

EMERGENCY RESPONSE

D.C. OFFICE OF THE CHIEF MEDICAL EXAMINER

& SAFETY ADMINISTRATOR

EPIDEMIOLOGIST

EXECUTIVE ASSISTANT

FORENSIC TOXICOLOGY DIVISION

Chief Toxicologist
Deputy Chief Toxicologist
Staff Assistant

Forensic Toxicology Laboratory
Forensic Toxicologist (Breath Program Mgr)
Forensic Toxicologist (QA/QC Mgr)

Forensic Toxicologist (7)

Laboratory Support Specialist

Grant Funded Positions:
DUI (2)
DFSA (2)

DEATH INVESTIGATION & CERTIFICATION DIVISION

Deputy Chief Medical Examiner
Staff Assistant

Forensic Pathology Unit
Medical Examiner (5)

Anthropology & Identification Unit
Forensic Anthropologist (Supervisor)
Customer Service Representative
Intake Assistant (5)

HIstology Laboratory
Medical Technologist

Death Investigation Unit
Supervisory Medicolegal Investigator
Lead Medicolegal Investigator
Medicolegal Investigator (3)
Forensic Investigator (8)

Mortuary Unit
Supervisory Pathologists' Assistant
Lead Forensic Autopsy Assistant
Pathologists' Assistant (2)
Autopsy Assistant (Grade 9) (3)
Lead Forensic Photographer
Forensic Photographer (2)
Autopsy Assistant (Grade 8)/
(Mortuary Technician) (7)
Supply Technician

ADMINISTRATION DIVISION
Chief of Staff
Executive Assistant

Human Resources Unit
Management Liaison Specialist

IT Unit
Chief Information Officer
IT Specialist (Customer Service)
Office of Risk Management –
Returned to Work Employee – Staff Assistant

Contracts & Procurement Unit Management
Services Officer
Program Analyst
Support Services Specialist

Records Management Unit
Sup. Quality Control/Records Manager
Quality Control & Records Management
Specialist
Quality Assurance Specialist
Records Management Specialist (2)

FATALITY REVIEW DIVISION
Supervisory Fatality Review Program
Manager

Child Fatality Review Committee
Developmental Disabilities Fatality Review Cmt

Sr. Fatality Review Specialist
Fatality Review Program Specialist
Staff Assistant

Grant Funded Positions:
Office of Victim Services/Child Fatality Review
Coordinator
Office of Victim Services/Male Survivors

Office of Risk Management –
Returned to Work Employee – Staff Assistant

APPENDIX B

KEY AGENCY ACTIVITIES

KEY AGENCY ACTIVITIES

Mayoral & District-wide Initiatives

Learn, Earn, Advance, Prosper (L.E.A.P.) Program

The District's L.E.A.P. Program is a network of interconnected partners utilizing the "earn-and-learn" approach that links the District's unemployed residents with employment, education and training opportunities. The earn-and-learn approach applies the apprenticeship model to skill development, allowing individuals to earn a wage while participating in an on-the-job training experience and concurrently participating in related technical instruction. This framework allows individuals to earn wages and accumulate work experience thus bolstering their ability to advance along a career pathway and into the middle class.

The agency hired L.E.A.P. participants in 2016 and in July of 2017. This participation resulted in the agency hiring these participants for full-time positions in various areas of the agency to include histology, fatality review, records management and administration.

Administration Performance Management

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

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

I. STRATEGIC PLANNING:

A. Mission Statement

"The mission of the Office of Chief Medical Examiner (OCME) is to ensure that justice is served and that the health and safety of the public is improved by conducting quality death investigations and certification, and providing forensic services for government agencies, health care entities and grieving families."

The mission is achieved through:

» provision of vision and leadership for the OCME;

» achievement and maintenance of excellent forensic service, education and research in the critical areas of:

- Investigation, Response, and Reporting of the Cause & Manner of Death;
- Expert Witness Testimony;
- Education and Training of law enforcement, health care providers and other stakeholders; and
- Provision of family assistance in understanding the cause and manner of death of decedents;

» support of law enforcement and public health related initiatives at the state, local, and county levels (i.e. Gang Violence, Drug Abuse); surveillance of critical mortality data; and identification of emerging public health/law enforcement trends; and

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

II. ACCREDITATION

For the first time in its history, the OCME was fully accredited by NAME through a period of February 16, 2016 through February 16, 2021. NAME accreditation is based on an inspection and accreditation guideline checklist that consists of 351 item focusing operations, resources, the facility, standard operation procedures and staff interviews. During 2017, the agency was reaccredited as required annually.

Overall, the agency has been able to maintain the standards and guidelines of operation for medicolegal death investigation, forensic pathology, histology, forensic toxicology, anthropology and other services performed as established by those professional and peer-review organizations that provide accreditation and professional training and oversight of these particular disciplines

and industries. These include the National Association of Medical Examiners (NAME), American Board of Forensic Toxicologists (ABFT), American Board of Medicolegal Death Investigators (ABMDI) and the American Board of Forensic Anthropologists (ABFA), amongst others.

To this end, in 2017, the agency facilitated ISO (International Organization for Standardization) 17020 training to several staff persons, including managers. The agency provided the training as part of its continued efforts to maintain accreditation standards set by the National Association of Medical Examiners (NAME) and as a foundation to ISO accreditation as the agency begins the process to meet standards and guidelines now required for medical examiner offices as part of accreditation.

III. PUBLIC SURVEILLANCE

The agency's Data Fusion and Analysis Center evaluates mortality statistics in order to determine outcomes and trends toward the improvement of public health and safety. Several critical trend reports were published.

Opioids: In March 2015, the DEA issued a nationwide alert identifying fentanyl as a threat to public health and safety. This was followed by a DEA National Heroin Threat, which noted that beginning late 2013 through 2014, several states reported spikes in overdose deaths due to fentanyl and its analog acetyl-fentanyl. The DC Office of the Chief Medical Examiner (OCME) investigated a total of 707 deaths due to use of opioids from Jan. 1, 2014 through Dec. 31, 2017. This included: 83 deaths in CY 2014, 114 in CY 2015, 231 deaths in CY 2016, and 279 deaths in CY 2017 respectively. The percentage of overdoses that contained fentanyl or a fentanyl analog is responsible for the observed increase. Approximately 67% of the opioid overdoses in 2017 contained fentanyl. OCME has been integral member of the DC Opioid Working Group and continued to work with stakeholders in order to educate community members, and to develop policies, interventions, and prevention strategies.

Dr. Roger A. Mitchell, Jr., (CME) participated in a Regional Opioid and Substance Abuse Summit hosted by Mayor Muriel Bowser and MWCOG. Per a press release: "The OCME and DFS were mentioned for their collaboration to improve toxicology testing around opioid abuse. In the past, OCME reported deaths from mixed drugs as 'mixed drug toxicity' on death certificates. For the past three years, the city has mandated that the drug or drugs be listed on a person's death certificate, allowing the District to better track specific drugs. Additionally, the OCME now collaborates with the District's new Forensic Chemistry Unit to collect and test syringes found on the scene of potential opioid overdoses. As new synthetic drugs emerge, this testing will provide more information about addiction in Washington, D.C." Dr. Mitchell is also featured in an MPD video that outlines the serious nature of this challenge: https://youtu.be/77zkN_XjNCk

Of note, the agency's Supervisory Medicolegal Death Investigator, Dan Morgan, published an article to the Academic Forensic Pathology (the Official Publication of the National Association of Medical Examiners) entitled, "Opioid Drug Death Investigations." The article was published in March 2017 and focused on the transition of opioid related deaths over the past 15 years beginning with a steady increase in the incidence of fatal prescription overdoses, followed by a dramatic increase in deaths caused by illicit opioids, namely heroin and fentanyl. The article highlighted that these trends are identified by medical examiners and coroners and that medicolegal investigators, being first responders, often recognize spates of drug-related deaths in real time.

National Violent Death Reporting System (NVDRS):

Along with the Department of Health and MPD, OCME participates in the NVDRS. The NVDRS grant is unique and includes a comprehensive surveillance system of violent deaths in District. The surveillance system creates an efficient and comprehensive system to track and describe violent deaths that can be used to inform prevention efforts and reduce the number of deaths. The NVDRS grant enables the stakeholders (e.g. OCME, DC Health and MPD) to evaluate surveillance systems and build enhanced reporting methodologies toward improved data collection to include demographic data, trends analysis and epidemiology studies which provide sound foundations for violence prevention strategies.

Enhanced State Opioid Overdose Surveillance (ESOOS)

Similar to NVDRS and along with the Department of Health, the OCME participates in the ESOOS grant. One of the main activities of the ESOOS grant is the State Unintentional Drug Overdose Reporting System (SUDORS). SUDORS captures detailed information on fatal overdoses in the District and includes de-identified information such as toxicology, death scene investigations, route of administration, and other risk factors that may be associated with fatal overdoses. In addition, SUDORS supports improving the timeliness and comprehensiveness of toxicology results. Given the increase in opioid overdoses in the District, it is imperative for OCME to participate in ESOOS in order to enhance surveillance efforts and inform drug use, misuse and abuse policies.

Other public surveillance reports published in 2017 include: Elder Falls, Unsafe Sleeping Environment, Hyper- & Hypothermia, Homicide, Public Dispositions, and Traffic Accidents.

IV. INCIDENT MANAGEMENT PLANNING

Per its mission and responsibility, the agency is responsible for fatality management within the District. This includes development and overall coordination of the District-wide mass fatality plan; the recovery and transport of remains; identification of remains -- often requiring anthropological expertise, as well as dental, DNA and digital X-ray services; evidence recovery; critical involvement in a Family Assistance Center (FAC); and coordination of numerous stakeholder partnerships.

The OCME not only participated in District-wide and federal emergency response exercises but also coordinated its first full-scale exercise in June 2017 for District area hospitals. The focus was to ensure hospital preparedness in managing a mass fatality incident. The agency also worked with the hospitals to develop their mass fatality plans.

The OCME sponsored its second annual Fatality Management Symposium and Full-Scale Exercise from September 11, 2017 to September 13, 2017. This "international" event focused on the development of District-wide mass fatality plans and training for all District and regional stakeholders. International guests included representatives from Belgium and Egypt who discussed experiences from mass fatality incidents in those jurisdictions. Emergency response local and regional stakeholders participated in workshops and fatality management exercises over a three day period.

The event included involvement of the agency's forensic pathology, death investigation, mortuary, identification and anthropology and records unit, as well as agency appointed emergency liaison officers and Medical Examiner Transport Team (METT).

The agency also managed about $700,000 in grants slated for fatality management to include administration of fatality management equipment and cache, development of mass fatality plans and associated fatality management trainings and exercises, a field deployable forensic processing unit, as well as the hiring of fatality management staff.

V. LEGISLATIVE ACTIVITIES

Death Pronouncements

An Emergency Resolution regarding death pronouncements was passed on December 20, 2017. The legislation for remote death pronouncements by District FEMS EMTs is now in effect. FEMS now performs death pronouncements in the field for unattended home deaths per their termination of resuscitation protocols.

Maternal Mortality Review Committee

The agency heeded the call of community members and stakeholders, such as the American College of Obstetricians and Gynecologists (ACOG), to create a District Maternal Mortality Review Committee (MMRC) in support of the national trend to review maternal deaths that have increased across the country. The agency assisted in the legislative process of establishing the legislation.

Death With Dignity Act

In 2017, the District's Department of Health (DC Health) established a Mayor's Order that has given the agency concurrent rulemaking authority on the Death with Dignity Act.

VI. ACADEMIC ACTIVITIES

The provision of industry specific training or continuing education opportunities was a key priority of the OCME management. As such, staff received in-house training or attended seminars/ conferences in: forensic pathology; digital imaging; root cause analysis; medicolegal death investigation, including SUIDI training; Qualtrax (an electronic document management system) software use and application and electronic documents management; forensic toxicology method development and forensic laboratory practices; alcohol pharmacology and traffic safety; anthropology; and geospatial technology. There was a specific focus on fatality management with an overall mass fatality incidence response training, including the table top and full scale exercises. Furthermore, in keeping with an agency vision to obtain ISO accreditation, managers and toxicology staff completed ISO 17020 and 17025 courses.

The agency utilized a NIJ- Paul Coverdell Forensic Science Improvement - Continuing Education subgrant from OVSJG in the amount of $31,515 to support continued medical education and training for agency staff in order to improve the quality and timeliness of services and augment the agency's knowledge base.

The OCME also provided training to external stakeholders in several areas. In addition to the table top and full scale fatality management exercises, the agency conducted a Homicide School for twenty-two Metropolitan Police Department (MPD) officers for the purpose of providing an overview of death scene investigation and other critical operations of the medical examiner systems, including forensic pathology and forensic toxicology services.

Dr. Roger A. Wll, Chief Medical Examiner, traveled to Cairo, Egypt (via the U.S. Department of Justice-International Criminal Investigative Assistance Program (ICITAP), to the Egyptian Ministry of Justice's Forensic Medicine Authority (FMA) to conduct training and a needs assessment with Egyptian forensic officials. In March 2017, Dr. Mitchell conducted a video conference workshop from Egypt with agency staff and the Egyptian Ministry's FMA in order to form a collaboration with fatality management, information technology and administrative staff. A presentation on the OCME's 2016 Fatality Management Symposium and Full Scale Exercise was provided. The Egyptian FMA participated in the second annual symposium and exercise held in September 2017. A discussion was facilitated on how to improve fatality management in Egypt, particularly in the decedent identification arena. This type of information exchange and training is critical to the continued process improvement for emergency preparedness for cities on an international level.

Lastly, agency staff published numerous publications and papers and the agency engaged in partnerships with area universities, including Howard University (residency rotation), George Washington University (residency rotation and forensic pathology instruction), and the University of the District of Columbia (donation of decedent bodies to Mortuary Science Program and Continuity of Operations planning).

Death Investigation and Certification Management

The OCME's Death Investigation and Certification Division is responsible for forensic pathology, forensic investigation and mortuary services. The forensic pathology, investigation, identification and mortuary staff work toward the determination of cause and manner of death and completion of postmortem examination reports. This entails ensuring that appropriate death scene response and investigation, investigative reporting, postmortem examination reporting, public disposition and other factors that are measured by agency performance management.

The Identification Unit administers the agency's Decedent Identification Program ensuring that identifications are made in an accurate and efficient manner according to agency and District policies and procedures and utilizing principles of medicolegal death investigation and forensic anthropology. Furthermore, the OCME's Histology Laboratory, led by a Medical Technologist, provides additional support to the determination of cause and manner of death.

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. Re-accredited by the American Board of Forensic Toxicology (ABFT) for the period November 1, 2015 to October 31, 2017, the forensic toxicology laboratory has 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 FY2017[1], the laboratory processed 439 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 (USAO).

During 2017, the agency continued to administer the District's Breath Alcohol Testing and Calibration Program with updated protocols which ensure the integrity and continuity of the program. All MPD's Breathalyzers (in all Districts), as well as the Mobile Unit, are recertified and continuously monitored and law enforcement operator certification classes are ongoing. Toxicologists have also been trained as Maintenance Technicians and Breath Alcohol Technicians.

Note that the toxicology laboratory provides Drug Facilitated Sexual Assault (DFSA) testing for victims of rape, sexual assault, and other sex crimes. Biological samples are obtained through the Metropolitan Police Department (MPD) and DC Sexual Assault and Nurse Examiner (SANE) Program and are submitted to the agency. Cases from individuals who initially reported to law enforcement that they were victims of sexual assault are termed "reports." Cases from individuals who decided against or were unable to officially report the crime to MPD are termed "non-reports". Report and non-report specimens submitted through chain of custody are tested by the Toxicology Unit within the agency and results are released to MPD or DC SANE depending on their report/non-report classification.

Lastly, the OVSJG awarded the toxicology laboratory funding in the amount of $180,640 for Victim Report and Non-Report Drug Facilitated Sexual Assault Testing: Service Provision and Improvements for FY2016. Additionally, the laboratory received grant funding in the amount of $800,000 from the Department of Transportation for DUI and DUID testing while reducing turnaround times, as well as $200,000 from DFSA to perform toxicology testing on cases involving sexual assault as the primary allegation.

Fatality Review Management

The Fatality Review Division (FRD) is tasked with fulfilling statutory mandates for the operation of two fatality review committee's board: Child Fatality Review Committee (CFRC), which includes the Infant Mortality Review Team subcommittee, and the Developmental Disabilities Fatality Review Committee (DDFRC). These committees and boards conduct reviews of the death to provide analysis and recommendations to the public and District entities serving defined populations, so they can address systemic problems, provide better services and be held accountable. In 2017, these reviews were held and recommendations to prevent deaths were developed for other agencies and entities with respect to policies and procedures and operations.

Per statutory mandate, the FRD worked diligently to publish the 2016 CFRC Annual Report in and continued to provide critical administrative support and facilitation of the developmental disabilities fatality review committee. The FRD interacts with the Mayor's Office of Talent of Appointments in monitoring and filling committee/board vacancies for the DDFRC and CFRC.

The FRD secured grant funding from the OVSJGS for a total of approximately $100,000 for a Male Survivors of Crime Project – Project Change for the purpose of staff and resource support to the project. The OCME's role is to provide administrative support and facilitation of case conferences and fatality reviews of male survivors and victims of crime in conjunction with OVSJG. Funding was also received from OVSJG for outreach coordination efforts, including one staff, training and conference travel to support the Child Fatality Review Committee (CFRC).

On September 15, 2016, the Office of the D.C. Auditor initiated a study of child fatalities in the District. The purpose of the study was to address the trends in child fatalities over time with regard to the number of fatalities, demographics of child decedents, and the cause and manner of death; how the Child Fatality Review Committee (CFRC) recommendations align with the trends in child fatalities and service delivery issues identified by the CFRC in its annual reports; and how selected CFRC recommendations have been implemented. The study was completed in 2017 with successful outcomes and recommendations.

1 The number of DUI cases processed by the toxicology laboratory, are based on FY2017 -- the time period between October 1, 2016 through September 30, 2017.

APPENDIX C

INTERNAL SERVICES

Wendt Center for Loss and Healing RECOVER Program

January 2017- December 2017

The Wendt Center's RECOVER program continued to work collaboratively with the Office of the Chief Medical Examiner to support the community through the process of decedent identification by providing crisis and early intervention bereavement support, education and resources to all individuals who come to the office to complete decedent identification. The RECOVER staff works closely with the OCME staff as policies change and to best meet the needs of families in the community. Ensuring a positive identification and the emotional well-being of surviving family members are both of critical importance. Recognizing the impact of vicarious trauma, monthly stress release workshops and the option to schedule 1:1 support sessions continued to be offered to all OCME staff members.

The RECOVER team is comprised of counselors, social workers and masters graduate interns who are trained in the topics of grief, trauma, loss and crisis intervention. To the best of scheduling ability, staff counselors are present at the OCME 7 days a week to provide support, education and resources to individuals and families as they navigate the decedent identification process. The RECOVER staff believes in empowering survivors through education, normalization and compassionate emotional support. All individuals completing decedent identifications are treated with respect and dignity. Staff counselors work closely with OCME investigators, communications staff and medical examiners to provide families with appropriate and helpful information in an effort to decrease the anxiety and stress that can often accompany sudden death and the identification process. Staff assists families in thinking about next steps, preparing children for funerals and recognizing acute reactions to crisis, loss and trauma. It is within the identification suite that RECOVER staff will often teach individuals grounding and stabilizing techniques to manage the overwhelming feelings experienced during an ID. Educational resources (in Spanish and English) are displayed in the family ID rooms with full permission to families to take what they need or want. Themes of the educational material include grief, trauma, violence, supporting children and self –care.

RECOVER Staff provided informational packets and support to nearly seven hundred and fifty people (750) who presented to complete 288 identifications. The informational packets provide families with a better understanding of the policies and procedures of the OCME, how to talk to children and teens about trauma, understanding grief and loss, preparing for a funeral or memorial service, accessing a community based vigil program, identifying common reactions to death, identifying concrete recommendations for taking care of oneself after a death and resources for crisis, burial assistance and social services. Informational handouts were made available in both English and Spanish. Follow up phone calls are made to the majority of families for continuity of care and to increase awareness of the continued impact of trauma and grief beyond the identification.

During 2017, members of the Wendt Center participated in a day long mass fatality exercise in which they worked closely with the OCME staff. The role playing and exercise debriefing provided opportunities to explore how the Wendt Center's mental health team can respond during the critical first few hours and days of a community crisis. Wendt Center staff attended additional training on mass disaster and community crisis response throughout the year.

The Wendt Center staff no longer attends the CFRC meetings yet clinical program information is provided on each case being reviewed. Given that the Wendt Center staff meets with families at the OCME for decedent identification, provides follow-up phone calls, facilitates vigils and offers a variety of therapeutic interventions following a death, it has made sense to integrate Wendt Center clinical program information into CFRC case discussions.

RECOVER staff has collaborated with the OCME Supervisor of Medicolegal Investigation to present workshops to high school students participating in the National Student Leadership Conference. Workshops focused on the pursuit of forensic investigation as a career choice and understanding vicarious trauma and self-care when exposed to death, gore, violence and extreme emotion. RECOVER staff was also invited to present on self - care at the upcoming 2018 Homicide and Death Investigation Course to be hosted at the OCME.

Each month, a RECOVER counselor facilitates a staff stress relief session to OCME staff. Staff members attend hour long sessions during which they are invited to explore different outlets to express stress and improve well- being. Sessions provide educational material on issues including vicarious trauma, loss, self - care, stress, mindfulness and grief. Multiple sessions are now being offered to accommodate differing schedules and increase opportunities for staff attendance. RECOVER staff conduct outreach and support to OCME staff who are unable to attend scheduled sessions. RECOVER staff receives very positive feedback from OCME staff regarding the impact of the sessions. Additionally, RECOVER staff offers 1:1 support for any OCME staff person in need of additional time to explore secondary traumatic stress and self-care.

Within the community, Wendt Center staff often connect with children, teens and adults who have had deceased family members come through the OCME. The connectivity and collaboration between Wendt Center programs and community based programs can increase how supported families can feel by external interventions. Within this year the Wendt Center began working with District communities impacted by violence through our new Male Survivor/Project Change program, where we provide crisis support and counseling to attempted homicide survivors and their families. Additionally, through our Resilient Scholars Project, we provide trauma counseling in schools and homes to a portion of DC's youngest residents who suffer the consequences of violence. Many of these children and teens also participate in our annual summer grief camp, where homicide is among the leading causes of death experienced by campers.

APPENDIX D

GLOSSARY

Glossary

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

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

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

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

Fentanyl/Fentanyl Analogs – According to the National Institute of Drug Abuse, fentanyl is a synthetic and short-acting opioid analgesic, is 50-100 times more potent than morphine and approved for managing acute or chronic pain associated with advanced cancer. Although fentanyl may be prescribed to treat severe pain, most of the fentanyl highlighted in this report is illicitly produced non-pharmaceutical fentanyl and fentanyl analogs

These non-pharmaceutical drugs are commonly laced in heroin, causing significant problems across the country, particularly as heroin abuse has increased.

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

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

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

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

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

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

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

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

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

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

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

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

Toxicology Terms

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

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

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

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

GOVERNMENT OF
THE DISTRICT OF COLUMBIA

Office of the Chief Medical Examiner Annual Report

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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.

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