Government of the District of Columbia
Office of the Chief Medical Examiner

2004 ANNUAL REPORT

Government of the District of Columbia
Anthony A. Williams, Mayor

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Deputy Mayor for Public Safety and Justice

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Office of the Chief Medical Examiner

DISTRICT OF COLUMBIA
OFFICE OF THE CHIEF MEDICAL EXAMINER

2004 ANNUAL REPORT

MISSION:

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

PRESENTED TO:

The Honorable Anthony A. Williams, Mayor, District of Columbia
and
The Council of the District of Columbia

July 2006

ACKNOWLEDGEMENT

Our continued gratitude and acknowledgement is extended toward the OCME staff, MPD's Natural Squad and the staff of the Wendt Center, all of whom continue to work together as a team to ensure that the families and visitors of the District of Columbia receive service that affords them dignity and respect during their time of loss and grief, as well as, ensuring that the office attains its core mission.

The OCME is fortunate to have a dedicated, reliable and assiduous staff whose services to the city are often unrecognized or overlooked. Those staff members provide assistance to the citizens of the District of Columbia at a time of great distress.

The staff deserves great praise for the work they accomplished this calendar year including the preparation of this report, which is a result of teamwork from members of different units. The staff is appreciative of the support they received from the Mayor, the City Administrator, and the Deputy Mayor during this period. In fulfilling their duties they demonstrate great compassion, devotion and comprehension while remaining firm about the realization of the agency's mission. The stress they withstand is largely unknown (See Appendix F – 2004 OCME Staff Listing).

We would like to thank the Mayor, the City Administrator and the Deputy Mayor of Public Safety and Justice, along with the other agencies that provide support to our office.

Executive Summary

The Government of the District of Columbia Office of the Chief Medical Examiner (OCME) is pleased to present its Thirteenth Annual Report. This Report covers data that resulted from the investigation of 3,144 deaths that occurred in the District of Columbia during the Calendar Year (CY) 2004. It will also cover an historical overview of compelling statistical data for the CY's 1972 through 2002. Also, new report data will be included for: Weight Distributions, Internal Partnerships, Identification Process, and Agency Management, along with Other Major Activities such as: Backlog Reporting; Expert Witness and Court Tracking; and Mass Casualties & Educational Lectures and Presentations.

During the years 1972 – 1981 Annual Reports were available for statistical compilations needed to produce this report. Unfortunately during the years 1982 –2002, when Washington, DC had become known as "*Dodge City (DC)*" and the "*Murder Capital of the US, "* only one (1992) annual report was published during this 20-year time span. The absence of the annual report during these years was primarily due to chronic understaffing secondary to high turnover. The 2004 OCME Annual Report will attempt to close this gap by providing statistical compilations for a subset of the data for these years with emphasis on homicides by gunfire and associated demographics, and the total number of autopsies performed.

The OCME was established as a Medical Examiners office system from a Coroner system in 1971. At that time the office had a single program, which was Death Investigations. The OCME has grown into a cabinet level agency that serves under the administrative authority of the Deputy Mayor for Public Safety and Justice. OCME's primary mission is to investigate all known or suspected homicides, suicides, accidents, drug-related and medically unattended deaths, all deaths in at risk populations; such as children and the intellectually and developmentally challenged individuals, as well as those deaths considered to be a threat to public health and safety. The agency has grown in many ways, and now has two programs, with one in development, and they are: Death Investigations, Agency Management and The Fatality Review Program respectively. This report will include data on all existing programs.

The goal of this report is to provide the public at large, the Executive Offices of the Mayor, and members of the Council for the District of Columbia with detailed information regarding deaths investigated during CY 2004.

As stated above there were a total of 3,144 cases reported and investigated by the OCME, of which 1,511were declined, and 1,633 cases were accepted for further examination, and of those, 1,136 were autopsied. The OCME also processed 1,542 cremations that were submitted for approval. The following table illustrates the number of autopsy examinations, external examinations, medical record reviews and partial autopsy examinations performed by "Manner of Death".

2004 Medical Examiner Cases by Manner of Death

Manner	Autopsy Examinations	External Examinations	Medical Record Reviews	Partial Autopsy Examination	Total
Homicide	201	0	0	0	201
Suicide	34	1	0	0	35
Accident	263	84	2	2	351
Natural	596	358	6	23	983
Undetermined	32	0	0	0	32
Stillbirth	11	0	0	0	11
Pending	0	0	0	0	0
Total	**1137**	**443**	**8**	**25**	**1613**

Note: "*Non-Human Remains*" (n=14) and "*Human Parts/Skeletal Remains*" (6) are not included in this table.

SUMMARY OF FINDINGS FOR MANNER OF DEATH

HOMICIDES: The OCME investigated 201 homicides in the CY 2004. This report reveals homicides to be more prevalent in black males and in persons between the ages of 20-29. The weapons of choice are still firearms. The peak incidents occurred in January and September.
Toxicology Findings: Toxicology testing was requested for 200 of the 201 Homicide cases investigated. Drugs were present in 93 of the homicide cases investigated. The most commonly detected drugs in homicide cases were: Ethanol (N=55), Cocaine (24), PCP (18), and Morphine (6) and Ecstasy (6).

SUICIDES: The OCME investigated 35 suicides in the CY 2004. This report reveals that deaths by suicide were more prevalent in white males and in persons between the ages of 40-49. Blacks closely followed Whites in number. Peak incidents occurred in April, July and October.
Toxicology Findings: Toxicology testing was requested for 34 of the 35 Suicide cases investigated. Overall, drugs were present in 22 of the suicide cases investigated. The most commonly detected drugs were: Ethanol (N=8), Cocaine (4), Morphine (3), Citalopram (3) and Methadone (3). More prescription medications were detected in suicide cases than in homicide cases.

ACCIDENTS: The OCME investigated 351 accidents in the CY 2004. Out of the 351 cases investigated, 196 cases were the result of trauma, of which 81 were traffic related deaths; 108 of the accidental deaths occurred as a direct result of illicit drug use. The majority of the traffic accident deaths occurred in the following categories: males, blacks, and drivers between the ages of 20-29. Peak incidents for accidents overall occurred in January, but for traffic accidents the peak months were March and July.
Overall Toxicology Findings: Toxicology testing was requested for 263 of the 351 Accident cases investigated, and drugs were present in 179 of these cases. The most commonly detected drugs were: Ethanol (N=67), Cocaine (64), Morphine (64), and Methadone (14).
Toxicology Findings for Traffic-related deaths: Toxicology testing was requested for 77 of the 81 Traffic Related Accidents, and drugs were present in 24 of these cases. The most commonly detected drugs were: Ethanol (N=13), Morphine (4), Ecstasy (3), Cocaine (2), and Methadone (2). In the 13 traffic related deaths positive for ethanol, the average Blood Alcohol Concentration was 0.16 %. The legal limit for Blood Alcohol Concentration in the District of Columbia is 0.08% while driving.
Toxicology Findings for Drug Overdose deaths: Toxicology testing was requested for 105 of the 108 Drug Overdose deaths, and drugs were present in 100 of these cases. The most commonly detected drugs were: Cocaine (N=57), Morphine (50), Ethanol (35), and Methadone (12). The three cases where toxicology testing was not requested are due to delayed deaths that occurred after hospitalization.

NATURAL DEATHS: The OCME investigated 983 Natural deaths in CY 2004. This report reveals that the leading cause of death in Natural cases is Cardiovascular Disease with 620 deaths, followed by Complications of Chronic Alcoholism with 67 deaths. Toxicology testing was requested for 606 of the cases investigated.
Toxicology Findings: Toxicology testing was requested for 606 of the 983 Natural cases investigated. Drugs were present in 236 Natural cases investigated. The most commonly detected drugs were: Ethanol (N=77), Morphine (38), Cocaine (33), Codeine (17), Methadone (17), Oxycodone (14) and Midazolam (8).

UNDETERMINED: The OCME investigated 32 cases where the manner of death was concluded to be "Undetermined". An "Undetermined" manner of death is a result of inconclusive evidence and/or investigatory efforts as to the circumstances of the death at the time. If additional information is discovered the manner of death will be amended at that time. The increased number of "*Undetermined Deaths*" results from a new process for determining cause and manner of child deaths. These deaths were previously classified with a cause of SIDS, and a manner of Natural. It was noted that many of these deaths were associated with bed-sharing, and improper bedding. The classification of these deaths as "SIDS, Natural" did not reflect the reality of the circumstances surrounding the event. It has been decided to classify the cause of death as "*Sudden Unexpected Deaths in Infancy Associated with Bed-sharing or **Soft** Bedding*" with a manner of "*Undetermined*".

Toxicology Findings: Toxicology testing was requested for 31 of the 32 Undetermined cases investigated. Drugs were present in 15 of the Undetermined cases investigated. The most commonly detected drugs were: Morphine (N=5), Ethanol (4), and Cocaine (3).

STILLBIRTHS: The OCME investigated 11 Stillbirth deaths in CY 2004.
Toxicology Findings: Toxicology testing was requested for all 11 of the Stillbirth cases investigated. Overall, drugs were present in 6 of the cases investigated; 4 cases had cocaine present; 1 case was positive for ethanol and 1 case was positive for meperidine.

Weight Distributions – (New Report Data)

This year OCME provides report data on the weight of the bodies brought to the agency for examination. This report data serves a dual purpose; 1) It serves as an indicator of the prevalence of obesity in the District of Columbia, and 2) It provides hard data for determining staffing levels at OCME.

OCME management emphasizes the necessity to always have 2 Autopsy Assistants available for body pick-ups to avoid injuries. The 2004 staffing levels of technicians did not allow for such, leaving the office in a precarious situation in cases of sickness, and unpredictable emergency leave.

SUMMARY OF SIGNIFICANT APPENDICES

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

1. *A 30-year Review of Homicides* – This segment provides statistical compilations for homicides by gunfire and associated demographics, and the total number of autopsies performed for calendar years 1972 through 2002.

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

3. *Internal Partnerships* – This segment provides an overview of OCME's partnerships with MPD's Natural Squad and the Wendt Center for Loss and Healing.

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

OFFICE OF THE CHIEF MEDICAL EXAMINER

2004 Annual Report

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APPENDICES:

Introduction

By law the Office of the Chief Medical Examiner (OCME) is required to produce an annual report. This annual report provides statistical data summarizing the results of investigations conducted by the OCME during calendar year 2004. This information is a reflection of the status of health of the District of Columbia residents, the level and the type of violence to which this population is subjected to, and the prevalence of drug use and its association with homicides and/or traffic accidents. The Office of the Mayor, Office of the City Administrator, Office of the Deputy Mayor for Public Safety and Justice, Department of Health (DOH), the D.C. Office of the Attorney General, United States Attorney's Office, the Public Defender Service and other entities can use these data to develop preventative and corrective policies for research purposes.

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

All deaths under the jurisdiction of the OCME, as outlined above, are investigated irrespective of the location of the primary causative incident. The Chief Medical Examiner based on the evaluation of the circumstances surrounding the death determines the type of investigation to be performed, i.e. autopsy or external examination. This decision is not restricted by family preference or religious beliefs. The OCME Medico Legal Investigators and the Detectives of MPD's Natural, Homicide, and Traffic Divisions provide information related to the circumstances of the deaths. The autopsy helps answer questions as to time of death, pattern and/or sequence of injuries and the effect of natural diseases versus injuries; and is also used to support or refute witness statements, or uncover completely unsuspected risk factors that may be useful to public health. The OCME works in close relationship with neighboring jurisdictions and is often called upon to provide expert testimony in these areas. Toxicological examinations are performed on most cases autopsied depending upon the conditions of the remains; to assist in the determination of the cause and manner of death. Typical examinations conducted by the laboratory provide information on the presence and amount of alcohol, volatiles, illegal drugs, and some commonly used prescription and non-prescription medications. Other expert consultations (for example: neuropathology, and cardiac) are requested when appropriate.

OCME at the direction of the Deputy Mayor established the "*Fatality Review Program*" that would include the Child Fatality Review Committee (CFRC), the Mental Retardation and Developmental Disabilities Fatality Review Committee (MRDD FRC) and the new DVFRB.

The Domestic Violence Fatality Review Board (DVFRB) was established by Public Law §14-296 passed on April 11, 2003. These committees examine causes and circumstances associated with deaths in their respective populations, evaluate issues associated with services provided and make relevant recommendations in order to decrease the number of preventable deaths. Each review committee produces an annual report that summarizes relevant findings and recommendations issued, as well as government agency responses to the recommendations.

In addition, to its routine caseload, the office provides temporary storage of bodies for all hospices and local hospitals. The OCME morgue has a total capacity of 115, which can be easily exceeded. Continuous and active efforts to locate family members, and bury or cremate unclaimed bodies are necessary to maintain available space. All efforts are made toward identification of the deceased before disposition. To achieve this goal, the OCME works cooperatively with the Mobile Crime unit of MPD and the Federal Bureau of Investigation (FBI) and trained its technical staff to fingerprint the decedents. OCME also uses comparative radiology and/or DNA analysis as necessary to ensure identification.

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

In preparation for possible terrorist attacks and mass disaster, OCME is developing alliances with area hospitals and with agencies in the Public Safety and Justice cluster with a goal to integrate our Mass Fatality plan with the Mayor's Disaster Response Plan. To practically accomplish this goal we are also participating in local and federal exercises to determine scenarios not considered, additional resources that may be necessary, and processes and authorities that must be established. OCME is a member of the Interstate Compact that seeks to develop interstate mutual aid and unites Maryland, Virginia, Delaware the District of Columbia, Federal Agencies and other jurisdictions.

During 2004, the OCME staff continued to be very active in social programs such as Operation Prevent Auto Theft (OPAT), Career Day at District of Columbia public and public charter schools, the Mayoral Toy Drive and the D.C. One Fund.

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

Finally, a 30-year review (1972-2002) of Homicides in the District of Columbia is also included in this years report. For calendar years 1972-1981 annual reports were available for data compilations. Unfortunately during the years 1982 –2002 only one (1992) annual report was published during this 20-year time span. The absence of the annual report during these years was primarily due to chronic understaffing secondary to high turnover. The 2004 OCME Annual Report will attempt to close this gap by providing statistical compilations for a subset of the data for these years with emphasis on homicides by gunfire and associated demographics, and the total number of autopsies performed.

2.0 – Medical Examiner Investigations and Medical Legal Autopsies

Overview of Cases Reported and Investigated

During the Calendar Year (CY) 2004, 3,144 cases were reported to and investigated by the Office of the Chief Medical Examiner (OCME). 1,511 of these cases were declined by OCME, and 1,633 cases were accepted for further examination, and of the accepted cases 1,162 were autopsied. OCME also had a total of 1,542 cremation requests submitted for approval.

Total Number of Cases Reported and Investigated by the OCME	**3,144**
Total Number of Declined Cases	**1,511**
Percent of Cases Investigated	*48.06%*
Total Number of Cases Accepted for Further Investigation	**1,633**
Percent of Cases Investigated	*51.94%*
Total Number of Autopsies	**1,162**
Percent of Cases Accepted	*71.15%*
Total Number of Cremation Approval Requests	**1,542**
Percent of Cases Reported	*49.05%*

Breakdown of Cases Investigated

Total Number of Cases Accepted and Investigated	**1,633**
Total Number of Autopsies	**1,162**
Percent of Cases Accepted	*71.15%*
Number of External Examinations	**443**
Percent of Cases Accepted	*28.41%*
Number of Non-Human Remains *	**14**
Percent of Cases Accepted	*1.32%*
Number of Medical Record Review *	**8**
Percent of Cases Accepted	*0.49%*
Number of Human Parts/Skeletal Remains	**6**
Percent of Cases Accepted	*0.37%*

*** Definition of Unfamiliar Case Classifications:**

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

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

Breakdown of Case Investigations and Autopsies by Month

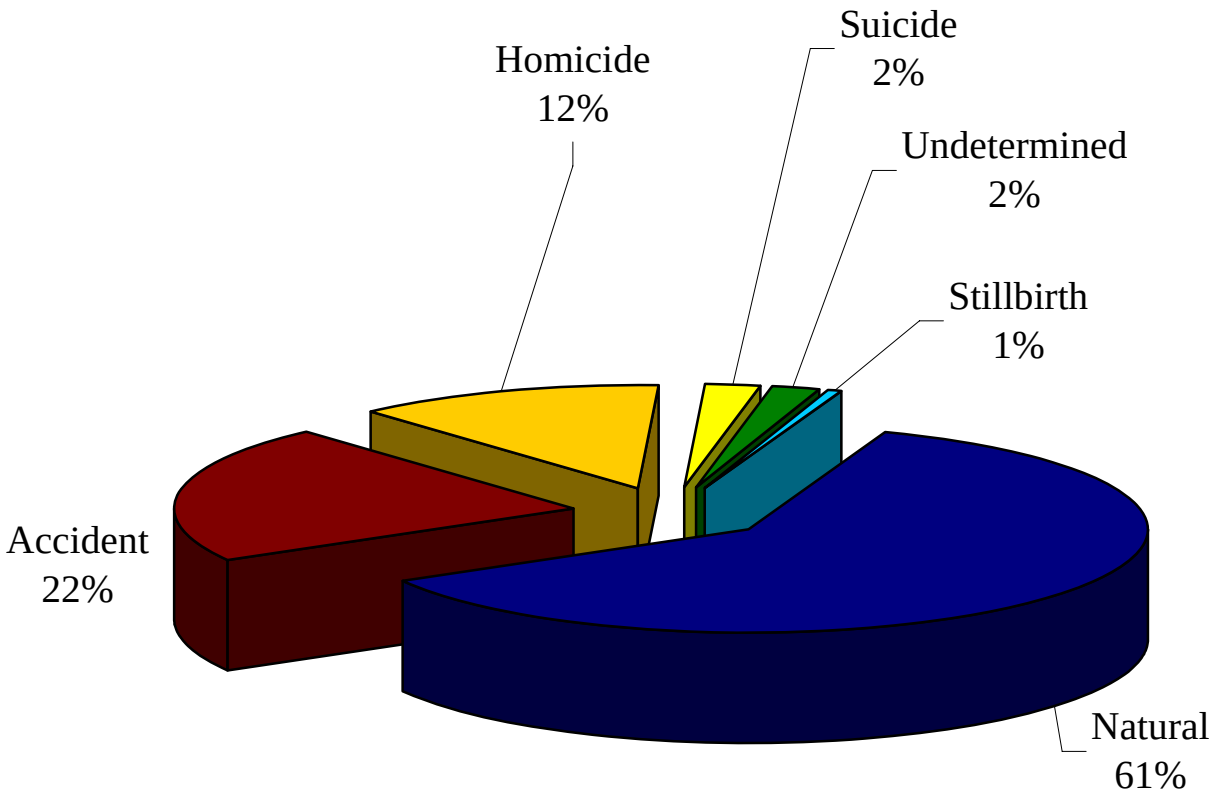
Month	Case Investigations	Full Autopsies
January	167	110
February	142	99
March	146	102
April	139	100
May	134	95
June	105	74
July	144	99
August	124	87
September	116	87
October	143	97
November	134	94
December	139	93
Total	**1633**	**1137**

Medical Examiner Case Investigations by Manner of Death

Manner	Full Autopsy Examinations	Partial Autopsy Examinations	External Examinations	Review of Medical Records	Total
Accident	263	2	84	2	351
Homicide	201	0	0	0	201
Natural	596	23	358	6	983
Pending	0	0	0	0	0
Stillbirth	11	0	0	0	11
Suicide	34	0	1	0	35
Undetermined	32	0	0	0	32
Total	**1137**	**25**	**443**	**8**	**1613**

Note: The above table does not include "*Human Parts/Skeletal Remains* (n=6)", "*Non-Human Remains* (n=14)."

Pie Chart - Medical Examiner Cases by Manner of Death



Postmortem Toxicology Summary

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

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

Total number of postmortem cases analyzed:

Description	Number of Cases	% of Cases
N=	**1145**	
Negative	594	51.90%
Positive	551	48.10%

Overall, drugs were absent in 594 postmortem cases; 372 cases had one drug present; 118 cases had 2 drugs present; 44 had 3 drugs present; 14 cases had 4 drugs detected; 2 cases had 6 drugs detected; and 1 cases had 8 drugs detected.

Postmortem Toxicology - Most Commonly Detected Drugs

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

Drug Name	Number of Cases	% of Cases
Ethanol	212	18.5%
Cocaine	132	11.5%
Morphine[1]	116	10.1%
Methadone	39	3.4%
PCP	27	2.4%
Codeine	27	2.4%
Oxycodone	19	1.7%
Diazepam	19	1.7%
Citalopram	16	1.4%
Carbon monoxide	16	1.4%
Zolpidem	12	1.0%
MDMA or MDA[2]	10	0.1%

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

Drug Combinatins	Number of Cases
Ethanol and Morphine	17
Morphine & Cocaine	14
Ethanol and Cocaine	13
Ethanol, Cocaine, and Morphine	6
Ethanol and PCP	6
Ethanol and MDMA or MDA	5

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

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

2.1 - HOMICIDES

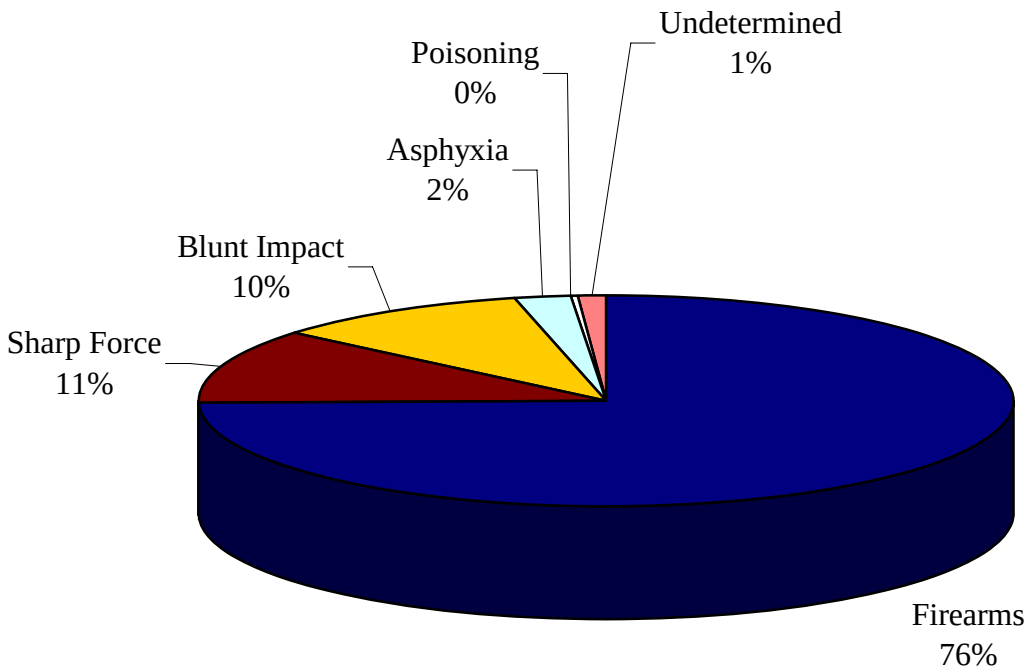
The OCME investigated 201 homicides in the CY 2004. The following tables and graphs provide a distribution by cause, month, race, gender and age group. Death by homicidal acts is more prevalent in black males, age 20-29 than in any other age group. The weapons of choice were again firearms. The peak incidents occurred in January, September and July.

Homicides by Cause of Death

Cause	Number of Homicides	% of Total Homicides
Firearms	150	74.62%
Sharp Force	23	11.44%
Blunt Impact	21	10.45%
Asphyxia	4	1.99%
Undetermined	2	1.00%
Poisoning	1	0.50%
Total	**201**	**100%**

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

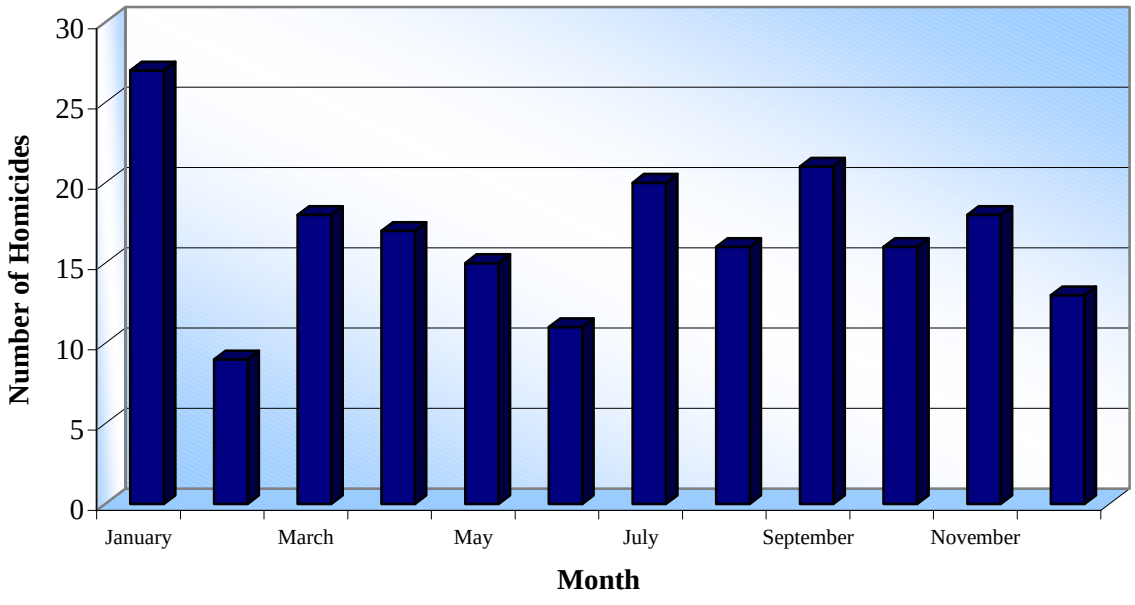
Pie Chart – Homicides by Cause of Death



Homicides by Month

Month	Number of Homicides	% of Homicides
January	27	13.43%
February	9	4.48%
March	18	8.95%
April	17	8.45%
May	15	7.46%
June	11	5.47%
July	20	9.95%
August	16	7.96%
September	21	10.44%
October	16	7.96%
November	18	8.95%
December	13	6.47%
Total	**201**	**100%**

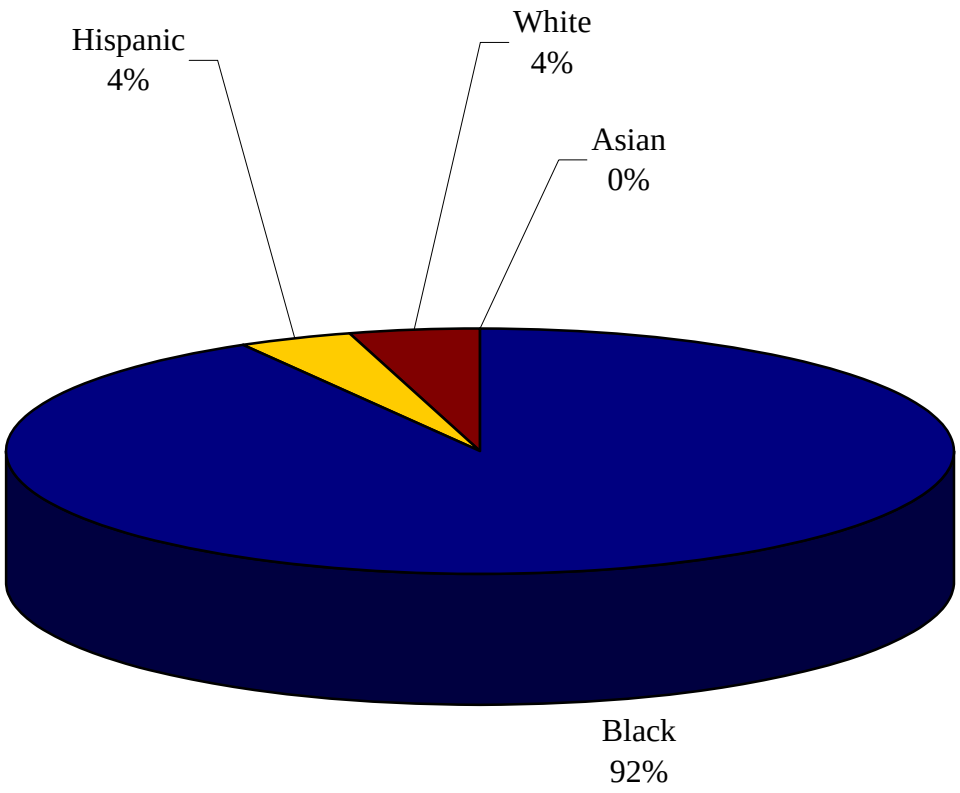
Graph - Homicides by Month



Homicides by Race

Race/Ethnicity	Number of Homicides	% of Homicides
Black	184	91.54%
White	9	4.48%
Hispanic	8	3.98%
Asian	0	0%
Total	**201**	**100.00%**

Chart - Percentage of Homicides by Race



Homicides by Gender

Gender	Number of Homicides	% of Homicides
Female	23	11.44%
Male	178	88.56%
Total	**201**	**100.00%**

Homicides by Race/Ethnicity and Gender

Race/Ethnicity by Gender	Number of Homicides	% of Homicides
Asian	**0**	**0%**
Female	0	0%
Male	0	0%
Black	**184**	**91.54%**
Female	20	9.95%
Male	164	81.59%
Hispanic	**8**	**3.98%**
Female	1	0.50%
Male	7	3.48%
White	**9**	**4.48%**
Female	2	1.00%
Male	7	3.48%
Total	**201**	**100.00%**

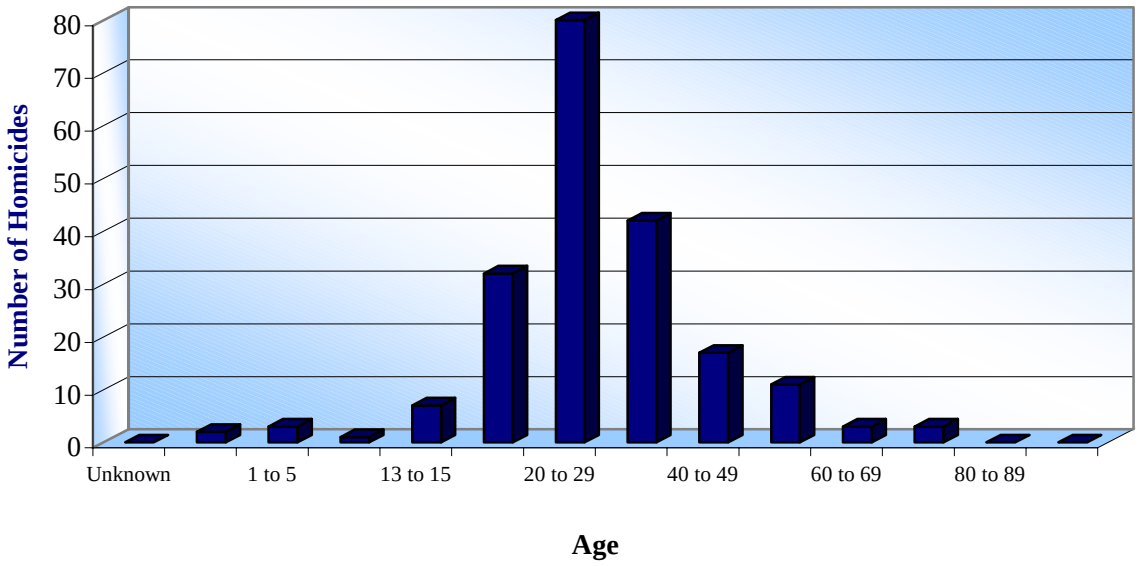
Homicides by Jurisdiction of Incident

Jurisdiction of Incident	Number of Homicides
DC	199
MD	2
Total	**201**

Homicides by Age

Age	Number of Homicides	% of Homicides
Unknown	0	0.00%
Under 1	2	1.00%
1 to 5	3	1.49%
6 to 12	1	0.50%
13 to 15	7	3.48%
16 to 19	32	15.92%
20 to 29	80	39.80%
30 to 39	42	20.90%
40 to 49	17	8.45%
50 to 59	11	5.47%
60 to 69	3	1.49%
70 to 79	3	1.49%
80 to 89	0	0.00%
90 +	0	0.00%
Total	**201**	**100.00%**

Chart - Homicides by Age Group



Toxicology Findings for Homicide Cases

Of the 201 Homicide deaths investigated by OCME, toxicology analysis was performed on 200 cases. Overall, drugs were absent in 107 homicide cases; 67 cases had one drug present; 22 cases had 2 drugs present; 3 had 3 drugs present; and 1 case had 4 drugs detected.

Description	Number of Cases	% of Cases
N=	**200**	
Negative	107	53.5%
Positive	93	46.5%

The most commonly detected drugs in the homicide cases were:

Name of Drug	Number of Cases	% of Homicide Cases
Ethanol	55	27.5%
Cocaine	24	12.0%
PCP	18	9.0%
Morphine	6	3.0%
MDMA/MDA	6	3.0%
Methadone	4	2.0%

The substances ketamine, methamphetamine, oxycodone and carbon monoxide were also detected in 2 cases each.

The four (4) homicide cases with the most drugs detected had the following toxicology:

a) ethanol, heroin/morphine, cocaine, and methadone
b) ethanol, heroin/morphine, and cocaine
c) ethanol, MDMA, methamphetamine; and
d) cocaine, methadone, and codeine

2.2 - SUICIDES

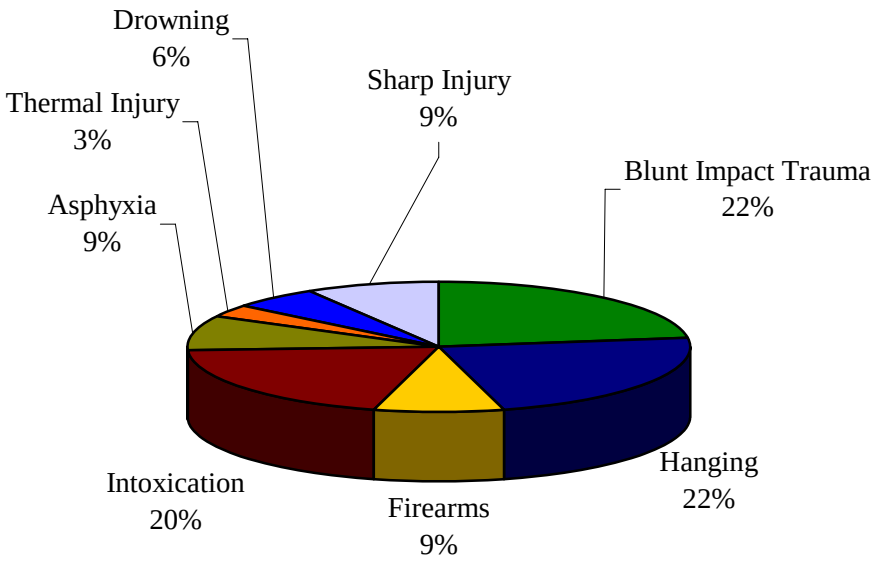
The OCME investigated 35 suicides in CY 2004. Deaths by suicidal acts are more prevalent in males and in persons between the ages of 40-49. Blacks closely follow Whites in number. Peaks incidents occurred in April, July and October.

Suicides by Cause of Death

Cause	Number of Suicides	% of Total Suicides
Blunt Impact Trauma	8	22.86 %
Hanging	8	22.86 %
Intoxication	7	20.00 %
Firearms	3	8.57 %
Asphyxia	3	8.57 %
Sharp Object	3	8.57 %
Drowning	2	5.71 %
Thermal Injury	1	2.86 %
Total	**35**	**100.00%**

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

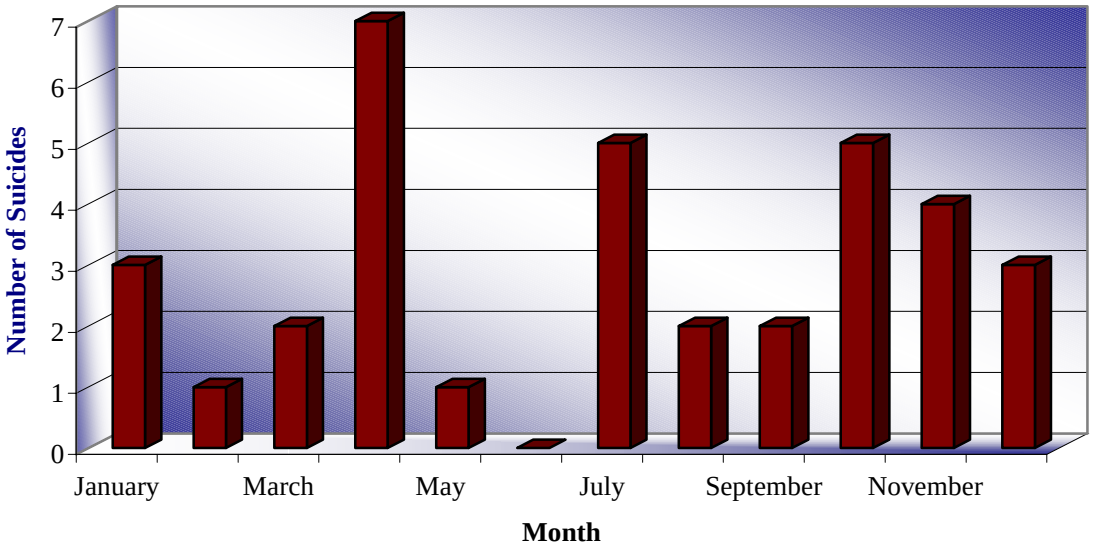
Pie Chart - Suicides by Cause of Death



Suicides by Month

Month	Number of Suicides	% of Suicides
January	3	8.57%
February	1	2.86%
March	2	5.71%
April	7	20.00%
May	1	2.86%
June	0	0.00%
July	5	14.28%
August	2	5.71%
September	2	5.71%
October	5	14.28%
November	4	11.43%
December	3	8.57%
Total	**35**	**100.00%**

Chart- Suicides by Month



Suicide by Race/Ethnicity

Race/Ethnicity	Number of Suicides	% of Suicides
White	15	42.86%
Black	13	37.14%
Hispanic	3	8.57%
Asian	2	5.71%
Other	1	2.86%
Unknown	1	2.86%
Total	**35**	**100.00%**

Suicides by Race/Ethnicity and Gender

Race/Ethnicity by Gender	Number of Suicides	% of Suicides
Asian	**2**	**5.71%**
Female	2	5.71%
Male	0	0.00%
Black	**13**	**37.14%**
Female	4	11.43%
Male	9	25.71%
Hispanic	**3**	**8.57%**
Female	1	2.86%
Male	2	5.71%
Other	**1**	**2.86%**
Female	0	0.00%
Male	1	2.86%
Unknown	**1**	**2.86%**
Female	1	2.86%
Male	0	0.00%
White	**15**	**42.86%**
Female	3	8.57%
Male	12	34.29%
Total	**35**	**100.00%**

Suicides by Gender

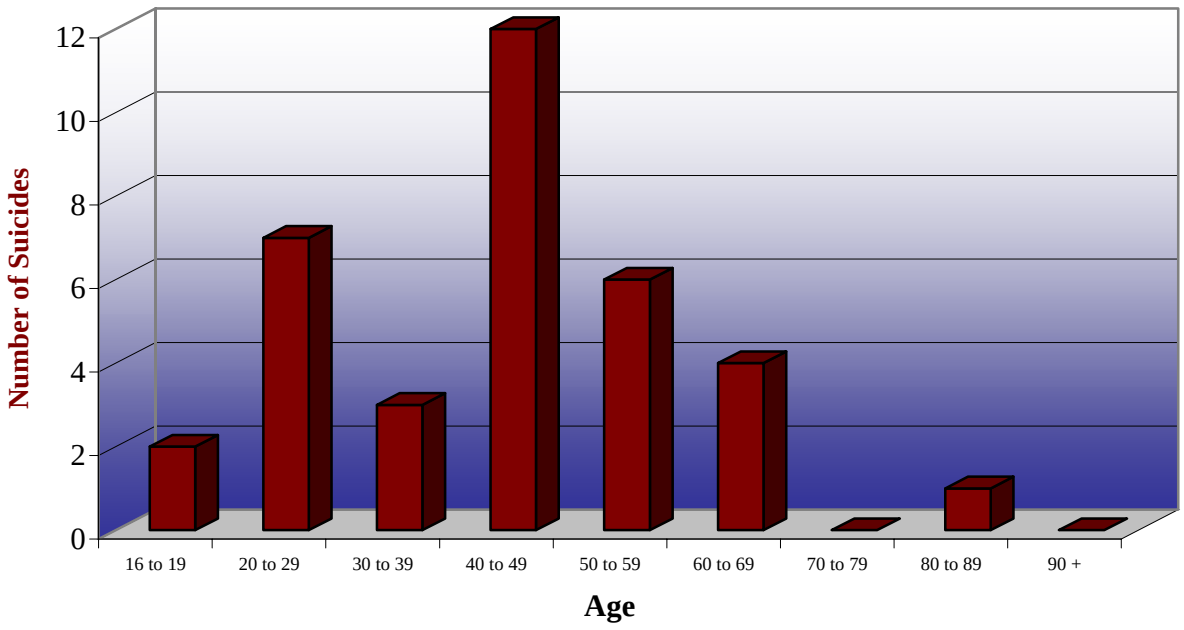
Gender	Number of Suicides	% of Suicides
Female	11	31.43%
Male	24	68.57%
Total	**35**	**100.00%**

Suicide by Age

Age	Number of Suicides	% of Suicides
16 to 19	2	5.71%
20 to 29	7	20.00%
30 to 39	3	8.57%
40 to 49	12	34.29%
50 to 59	6	17.14%
60 to 69	4	11.43%
70 to 79	0	0.00%
80 to 89	1	2.86%
90 +	0	0.00%
Total	**35**	**100.00%**

Note: There were zero (0) suicides for persons age 15 and under, 70 to 79 and 90+.

Chart - Suicides by Age



Toxicology Findings for Suicide Cases

Of the 35 Homicide deaths investigated by OCME, toxicology analysis was performed on 34 cases. Overall, drugs were absent in 12 suicide cases; 13 cases had one drug present; 5 cases had 2 drugs present; 2 had 3 drugs present; 1 case had 6 drugs detected; and 1 case had 8 drugs detected.

Description	Number of Cases	% of Cases
N=	**34**	
Negative	12	35.3%
Positive	22	64.7%

The most commonly detected drugs in suicide cases were:

Name of Drug	Number of Cases	% of Suicide Cases
Ethanol	8	23.5%
Cocaine	4	11.8%
Morphine	3	8.8%
Citalopram	3	8.8%
Methadone	3	8.8%

The two (2) suicide cases with the most drugs detected had the following toxicology:

a) ethanol, propoxyphene, hydrocodone, zolpidem, citalopram, and diazepam; and
b) acetaminophen, salicylates, pseudo ephedrine, doxylaime, dextromethorphan, brompheniramine, hydrocodone, and zolpidem.

Overall, more prescription medications were detected in the suicide cases than in the homicide case, in particular antidepressant type medications.

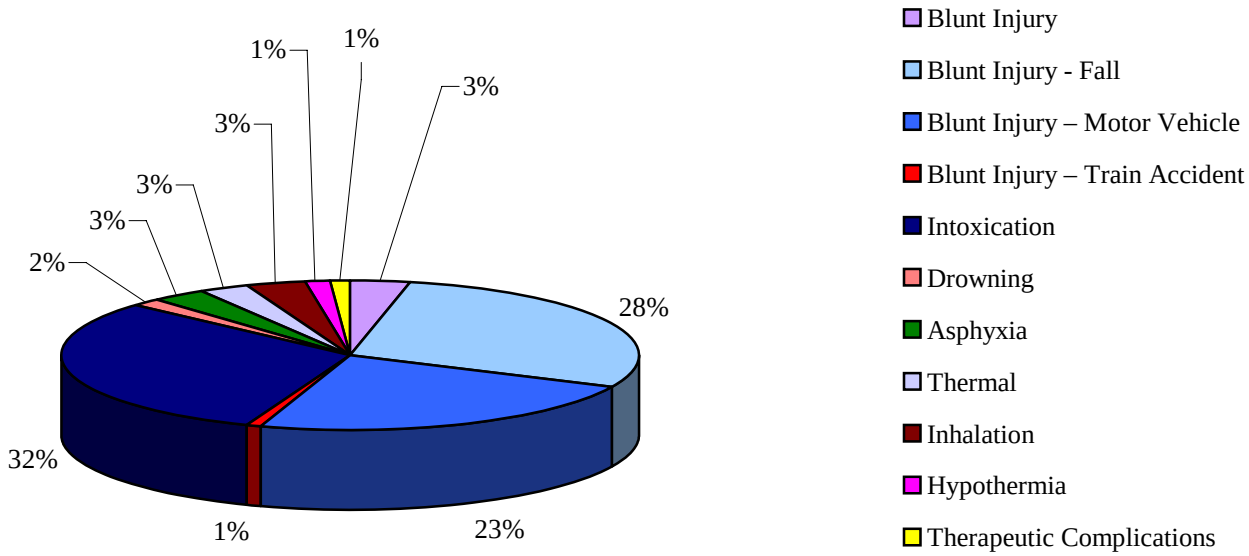
2.3 - ACCIDENTS

OCME investigated 351 accident cases in 2004. Out of the 351 cases investigated, 196 cases were the result of trauma, and of those 81 were traffic accidents. 108 cases were the direct result of illicit drug use. The peak incidents occurred in January and December.

Accidents by Cause of Death

Cause	Number of Deaths	% of Total Accidents
Intoxication	108	30.77 %
Blunt Injury - Fall	100	28.49 %
Blunt Injury – Motor Vehicle	81	23.08 %
Blunt Injury - Other	12	3.42 %
Asphyxia	11	3.13 %
Inhalation	11	3.13 %
Thermal	10	2.85 %
Drowning	6	1.71 %
Hypothermia	5	1.42 %
Therapeutic Complications	4	1.14 %
Blunt Injury – Train Accident	3	0.85 %
Total	**351**	**100 %**

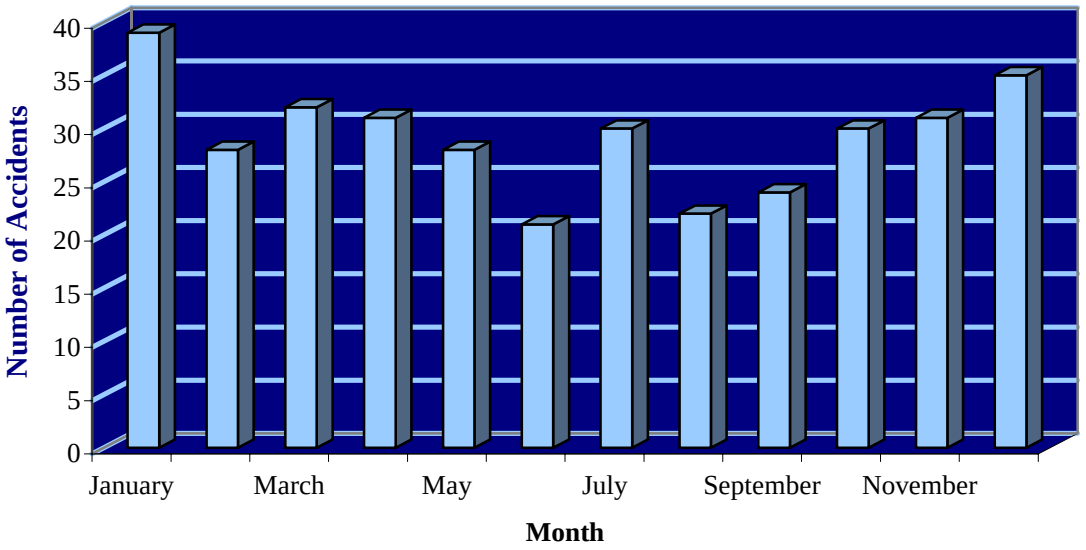
Pie Chart - Accidents by Cause of Death



Accidents by Month

Month	Number of Deaths	% of Accidents
January	39	11.11%
February	28	7.98%
March	32	9.12%
April	31	8.83%
May	28	7.98%
June	21	5.98%
July	30	8.54%
August	22	6.27%
September	24	6.84%
October	30	8.54%
November	31	8.83%
December	35	9.97%
Total	**351**	**100.00%**

Chart - Accidents by Month of Death



Accidental Deaths by Race

Race/Ethnicity	Number of Accidents	% of Accidents
Black	222	63.25%
White	100	28.49%
Hispanic	22	6.27%
Asian	4	1.14%
Alaskan Native	1	0.28%
Other	1	0.28%
Pacific Islander	1	0.28%
Total	**351**	**100.00%**

Accidental Deaths by Gender

Gender	Number of Accidents	% of Accidents
Female	116	33.05%
Male	235	66.95%
Total	**351**	**100.00%**

Accidental Deaths by Age

Age	Number of Accidents	% of Accidents
Age Unknown	0	0.00%
Under 1	0	0.00%
1 to 5	7	1.99%
6 to 12	12	3.42%
13 to 15	3	0.85%
16 to 19	9	2.56%
20 to 29	34	9.69%
30 to 39	25	7.12%
40 to 49	66	18.80%
50 to 59	63	17.95%
60 to 69	24	6.84%
70 to 79	39	11.11%
80 to 89	52	14.81%
90 +	17	4.84%
Total	**351**	**100.00%**

Toxicology Findings for Accident Cases

Of the 351 Accident Deaths investigated by OCME, toxicology analysis was performed in 263 cases. Overall, drugs were absent in 84 accident cases; 92 cases had one drug present; 56 cases had 2 drugs present; 23 cases had 3 drugs present; and 7 cases had 4 drugs detected and 1 case had 6 drugs detected.

Description	Number of Cases	% of Cases
N=	**263**	
Negative	84	32.0%
Positive	179	68.0%

The most commonly detected drugs in the accident cases were:

Name of Drug	Number of Cases	% of Accident Cases
Ethanol	67	25.5%
Cocaine	64	24.3%
Morphine	64	24.3%
Carbon Monoxide	16	6.1%
Methadone	14	5.3%
Codeine	9	3.4%
Diazepam	8	3.0%
Amitriptyline	6	2.3%
Citalopram	5	1.9%
Fluoxetine	5	1.9%
Oxycodone	5	1.9%
MDMA/MDA	4	1.5%
Sertraline	4	1.5%
PCP	3	1.1%

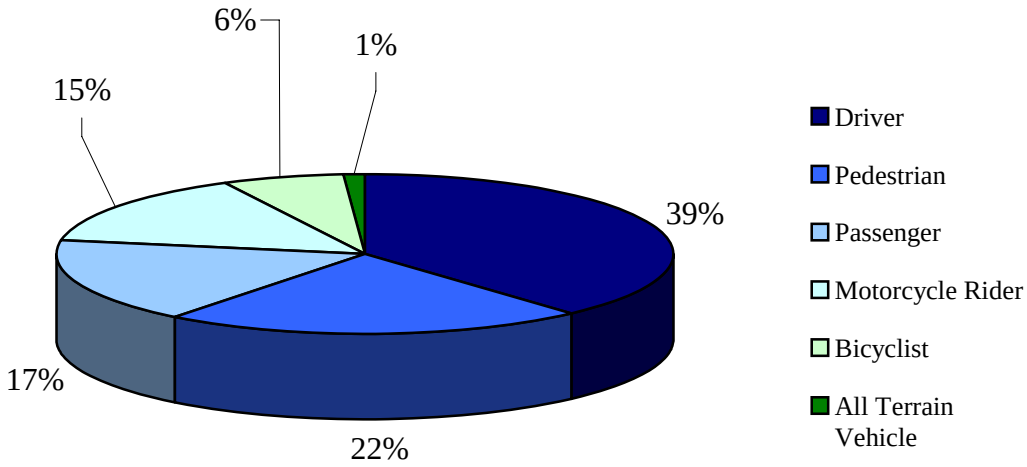
2.3.1 – Traffic Deaths

The majority of traffic fatalities occurred in the following categories: males, blacks, and drivers between the ages of 20-29. Peaks occurred in March and July.

Role of the Decedent in Traffic Death

Role	Traffic Deaths	% of Traffic Deaths
Driver	31	38.27%
Pedestrian	18	22.22%
Passenger	14	17.28%
Motorcycle Rider	12	14.81%
Bicyclist	5	6.17%
All Terrain Vehicle	1	1.23%
Total	**81**	**100.00%**

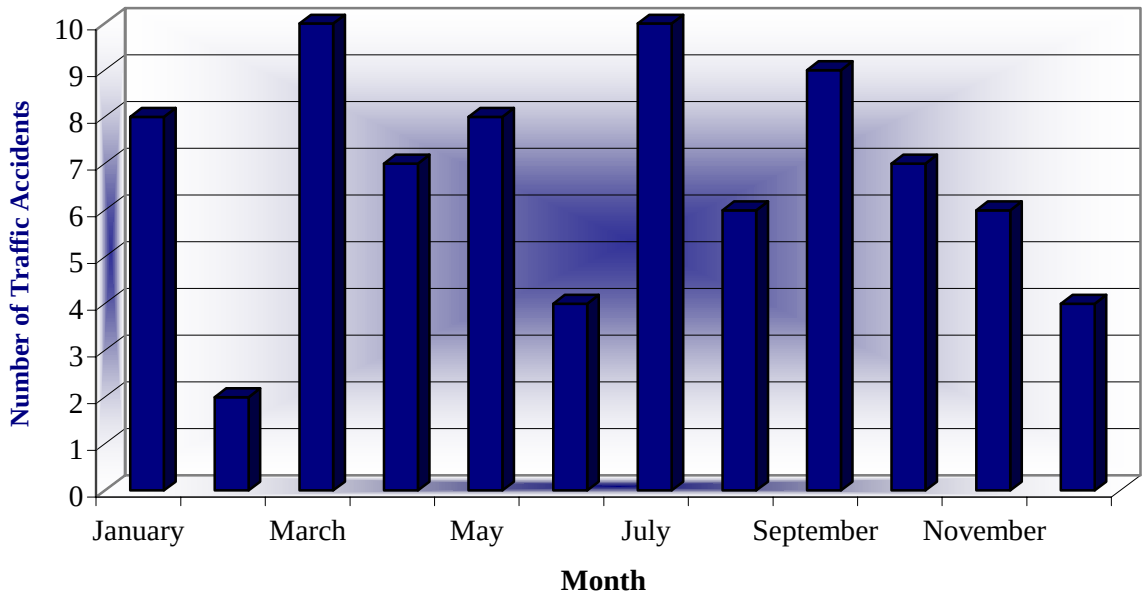
Pie Chart - Role of Decedent in Traffic Accident



Traffic Deaths by Month

Month	Number of Traffic Accidents	% of Traffic Accidents
January	8	9.88%
February	2	2.47%
March	10	12.35%
April	7	8.64%
May	8	9.88%
June	4	4.94%
July	10	12.35%
August	6	7.41%
September	9	11.11%
October	7	8.64%
November	6	7.41%
December	4	4.94%
Total	**81**	**100.00%**

Chart - Traffic Deaths by Month



Traffic Deaths by Race

Race	Number of Traffic Deaths	% of Traffic Deaths
Black	52	64.20%
White	21	25.93%
Hispanic	6	7.41%
Pacific Islander	1	1.23%
Other	1	1.23%
Total	**81**	**100.00%**

Traffic Deaths by Gender

Gender	Number of Traffic Deaths	% of Traffic Deaths
Female	19	23.46%
Male	62	76.54%
Total	**81**	**100.00%**

Traffic Deaths by Age

Age	Number of Traffic Deaths	% of Traffic Deaths
Under 1	0	0.00%
1 to 5	3	3.70%
6 to 12	8	9.88%
13 to 15	3	3.70%
16 to 19	6	7.41%
20 to 29	22	27.16%
30 to 39	7	8.64
40 to 49	9	11.11%
50 to 59	9	11.11%
60 to 69	2	2.47%
70 to 79	8	9.88%
80 to 89	4	4.94%
90 +	0	0.00%
Total	**81**	**100.00%**

Traffic Deaths by Jurisdiction of Incident

Jurisdiction of Incident	Number of Traffic Deaths	% of Traffic Deaths
DC	44	54.32%
MD	25	30.86%
VA	7	8.64%
WV	4	4.94%
Unknown	1	1.23%
Total	**81**	**100.00%**

Toxicology Findings for Traffic Accident Cases

Of the 81 Traffic-related deaths investigated by OCME, toxicology analysis was performed in 77 cases. Overall, drugs were absent in 53 traffic death cases; 12 cases had one drug present; 11 cases had 2 drugs present; and 1 case had 3 drugs present.

Description	Number of Cases	% of Cases
N=	**77**	
Negative	53	68.8%
Positive	24	31.2%

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

Name of Drug	Number of Cases	% of Suicide Cases
Ethanol	13	16.9%
Morphine	4	5.2%
MDMA/MDA	3	3.9%
Cocaine	2	2.6%
Methadone	2	2.6%

In the 13 traffic deaths positive for ethanol, the average Blood Alcohol Concentration was 0.16 % (range 0.01 – 0.37 %). The legal limit for Blood Alcohol Concentration in the District of Columbia is 0.08% while driving.

2.3.2 – Toxicology Findings for Deaths due to Drug Overdose

There were 108 OCME cases where death was directly related to drug use, and toxicology analysis was performed in 105 of these cases. The most prevalent drug in the population was cocaine alone or in combination with other drugs (most commonly morphine). Overall, 37 cases had one drug present; 33 cases had 2 drugs present; 21 cases had 3 drugs detected; 8 cases had 4 drugs detected; and 1 case had 6 drugs present.

Description	Number of Cases	% of Cases
N=	**105**	
Negative	5	4.8%
Positive	100	95.2%

The most commonly detected drugs in drug overdose cases were:

Contributing Drugs	Number of Cases	% of Cases
Cocaine	57	54.3%
Morphine	50	47.6%
Ethanol	35	33.3%
Methadone	12	11.4%
Codeine	7	6.7%
Oxycodone	5	4.8%
Amitriptyline	5	4.8%
Citalopram	4	3.8%
Diazepam	4	3.8%
Fluoxetine	3	2.8%

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

Toxicological examinations were performed on driving-under-the-influence (DUI) cases to assist law enforcement agencies in the investigation of such cases. Routine toxicological examinations for DUI cases include analysis for alcohols (ethanol and other volatiles), an initial screen for major classes of illicit and prescription medications, and an additional screen for various illicit, prescription and other-the-counter medications. All drugs of significance are then confirmed by further testing. Marijuana and its major metabolites are screened for in all DUI cases.

A negative case refers to the absence of any alcohol and commonly detectable drugs. A positive case refers to the presence of alcohol and/or drug(s), noting that a case can be positive for more than one substance.

Total number of DUI cases analyzed:

Description	Number of Cases	% of Cases
N=	**39**	
Negative	5	12.8%
Positive	34	87.2%

Type of Specimen Submitted:

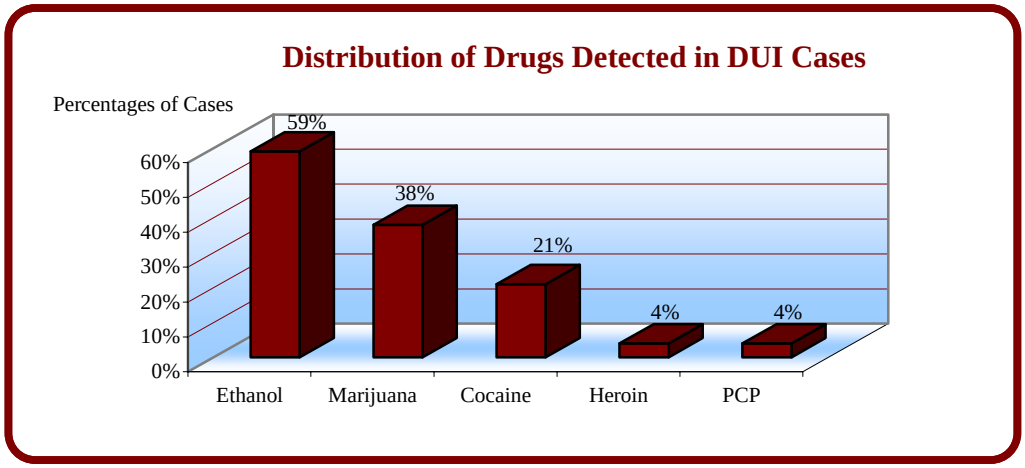
Description	Number of Cases	% of Cases
Blood	7	18%
Urine	32	82%

Age and gender of DUI cases:

Gender	Number of Cases	Age Range	Mean	Median
Male	33	19-72 (n=20)	43 yrs	38 yrs
Female	3	23 & 49 (n=2)	N/A	N/A
Not Specified	3	N/A	N/A	N/A

The most commonly detected drugs in the DUI cases were:

Name of Drug	Number of Cases	% of DUI Cases
Ethanol	23	59%
Marijuana	15	38%
Cocaine	8	21%
PCP	4	4%
Heroin	4	4%



Overall, drugs were absent in 5 DUI cases; 15 cases had one drug present; 12 cases had 2 drugs present; 5 had 3 drugs present; 1 case had 4 drugs present; and 1 case had 6 drugs detected.

In the 23 DUI cases positive for alcohol, the average alcohol concentrations were as follows:

Description	N=	Average	Range
Average Blood Alcohol Result	7	0.16%	0.09-0.32%
Average Urine Alcohol Result	16	0.15%	0.01-0.32%

Common drug combinations for DUI cases include:

Name of Drugs	Number of Cases
Ethanol + Marijuana	6
Ethanol + Cocaine	3
PCP + Marijuana	3

The 2 DUI cases with the most drugs detected had the following toxicology:

a) ethanol (0.05 **%**), heroin, propoxyphene, sertraline, promethazine, and bupropion
b) ethanol (0.01 **%**), amphetamine, marijuana, and hydrocodone

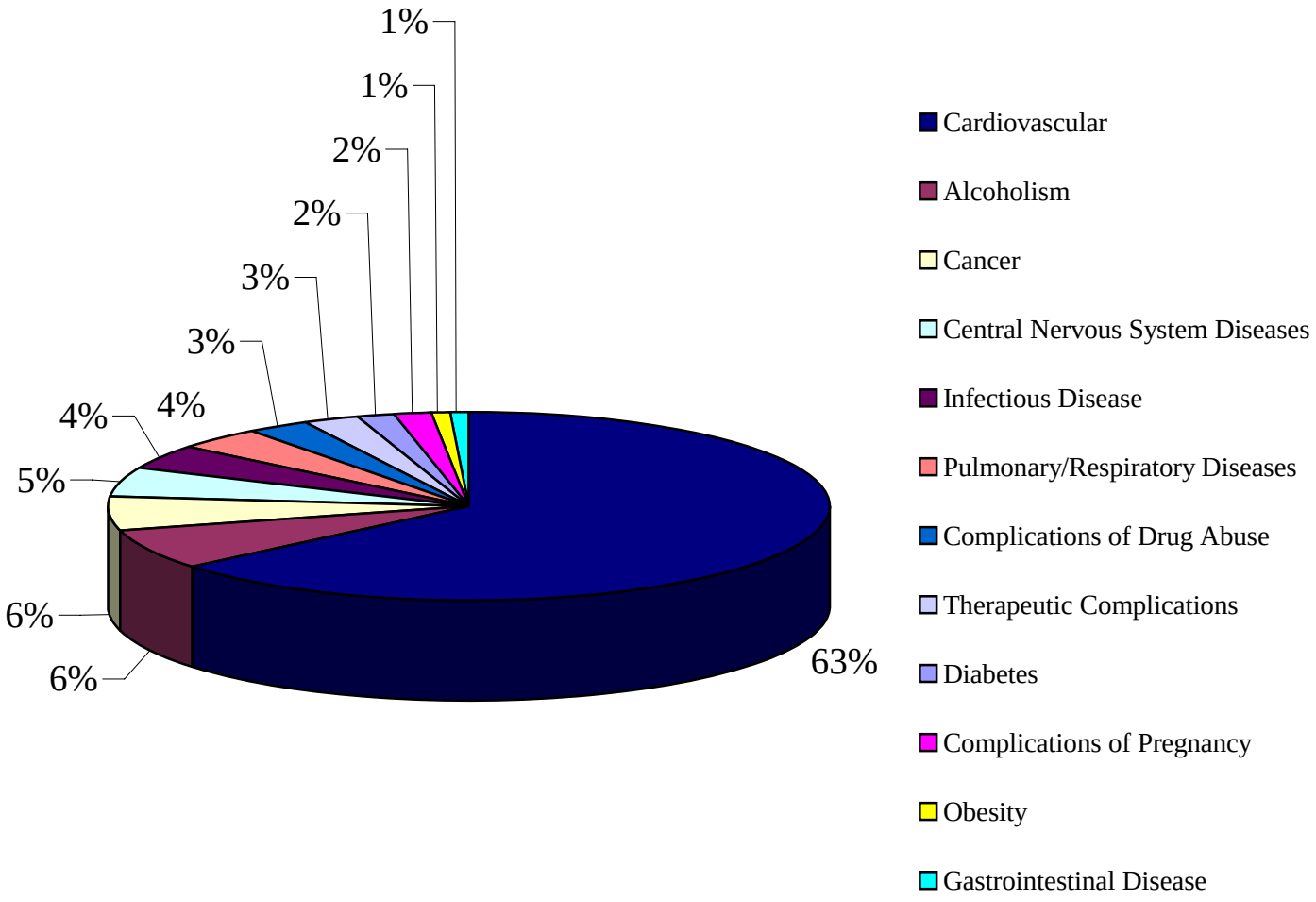
2.4 - NATURAL DEATHS

The majority of deaths investigated by OCME fall into the Natural Death category. The most prevalent cause of death involves diseases of the cardiovascular system. Peaks occurred in January, February, March and December. Blacks/African Americans represented 79% of the affected population, followed by Whites, which represented 17% of the population.

Natural Deaths By Cause

Cause	Number of Deaths	% Of Total Natural Deaths
Cardiovascular	620	63.07 %
Alcoholism	67	6.82 %
Cancer	57	5.80 %
Central Nervous System Diseases	47	4.78 %
Pulmonary/Respiratory Diseases	39	3.97 %
Infectious Disease	29	2.95 %
Complications of Drug Abuse	26	2.64 %
Diabetes	25	2.54 %
Gastrointestinal Disease	17	1.73 %
Therapeutic Complications	15	1.53 %
Genetic Disorder	11	1.12 %
Complications of Pregnancy	8	0.81 %
SIDS	8	0.81 %
Congenital Malformations	5	0.51 %
Endocrine Disease	2	0.20 %
Muscular Diseases	1	0.10 %
Blood Disease	1	0.10 %
Connective Tissue Disease	1	0.10 %
Urinary Tract Disease	1	0.10 %
Obesity	1	0.10 %
Undetermined	1	0.10 %
Total	**983**	**100 %**

Pie Chart – Natural Deaths by Cause

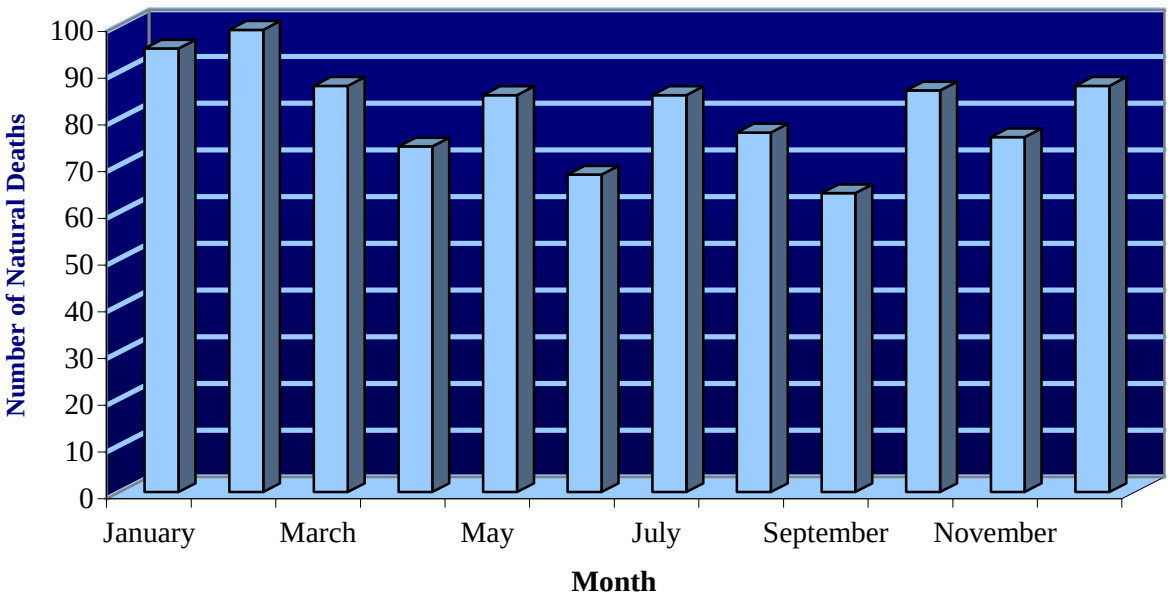


Note: Causes of Death that are less than 1% are not included in this chart.

Natural Deaths by Month

Month	Number of Deaths
January	95
February	99
March	87
April	74
May	85
June	68
July	85
August	77
September	64
October	86
November	76
December	87
Total	**983**

Chart- Natural Deaths by Month



Natural Deaths by Race

Race	Number of Natural Deaths	% of Natural Deaths
Black	777	79.04%
White	167	16.99%
Hispanic	25	2.54%
Asian	6	0.61%
Other	5	0.51%
Unknown	2	0.20%
Pacific Islander	1	0.10%
Total	**983**	**100.00%**

Natural Deaths by Gender

Gender	Number of Natural Deaths	% of Natural Deaths
Female	393	39.98%
Male	590	60.02%
Total	**983**	**100.00%**

Natural Deaths by Age

Age	Number of Natural Deaths	% of Natural Deaths
Fetus	1	0.10%
Under 1	15	1.53%
1 to 5	4	0.41%
6 to 12	6	0.61%
13 to 15	4	0.41%
16 to 19	4	0.41%
20 to 29	23	2.34%
30 to 39	63	6.41%
40 to 49	157	15.97%
50 to 59	230	23.40%
60 to 69	168	17.09%
70 to 79	172	17.50%
80 to 89	104	10.58%
90 +	32	3.26%
Total	**983**	**100.00%**

Toxicology Findings for Natural Deaths

Of the 983 Natural Deaths investigated by OCME, toxicology analysis was performed in 606 cases. Overall, drugs were absent in 370 natural cases; 186 cases had one drug present; 30 cases had 2 drugs present; 14 had 3 drugs present; and 6 cases had 4 drugs detected.

Description	Number of Cases	% of Cases
N=	**606**	
Negative	370	61%
Positive	236	39%

The most commonly detected drugs in the natural cases were:

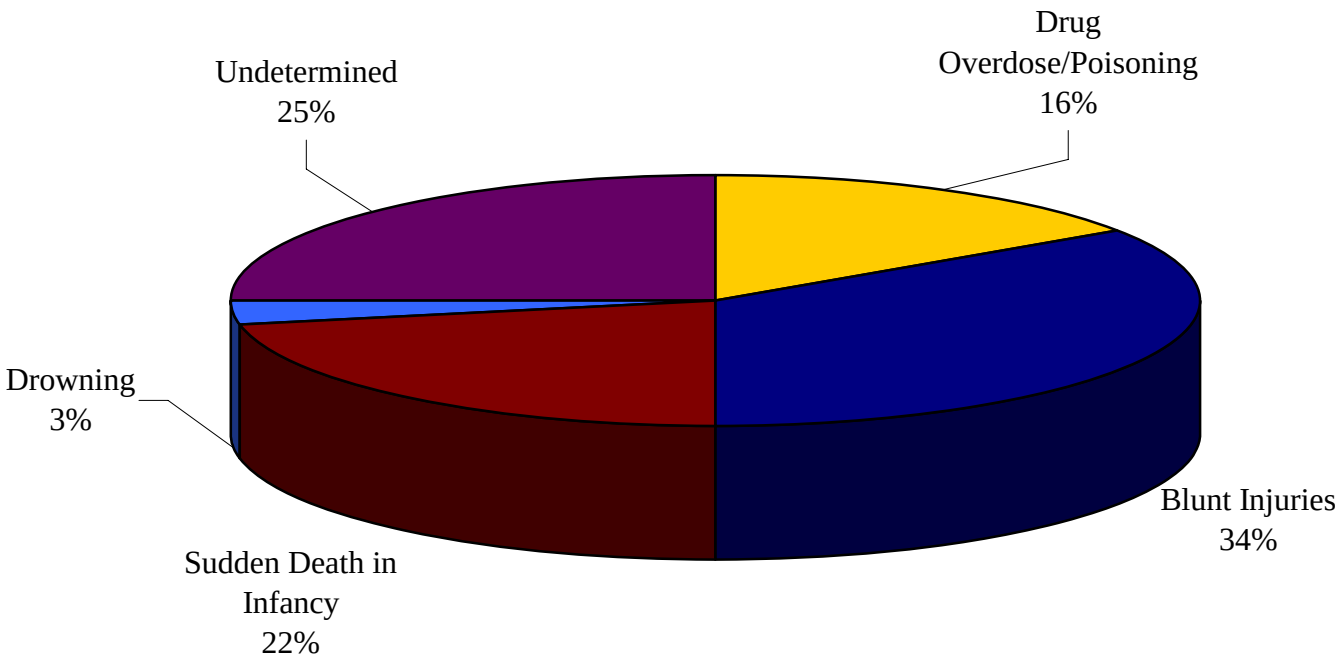
Name of Drug	Number of Cases	% of Natural Cases
Ethanol	77	12.7%
Morphine	38	6.3%
Cocaine	33	5.4%
Codeine	17	2.8%
Methadone	17	2.8%
Oxycodone	14	2.3%
Midazolam	8	1.3%
Diazepam	6	1.0%
PCP	5	0.8%
Zolpidem	5	0.8%
Tramadol	5	0.8%
Meperidine	5	0.8%
Hydromorphone	4	0.7%
Olanzapine	3	0.5%

2.5 – UNDETERMINED DEATHS

Undetermined by Cause of Death

Cause	Number of Deaths	% of Total Accepted Cases
Blunt Injuries	11	34.38%
Undetermined	8	25.00%
Sudden Death in Infancy	7	21.88%
Drug Overdose/Poisoning	5	15.63%
Drowning	1	3.13%
Total	**32**	**100.00%**

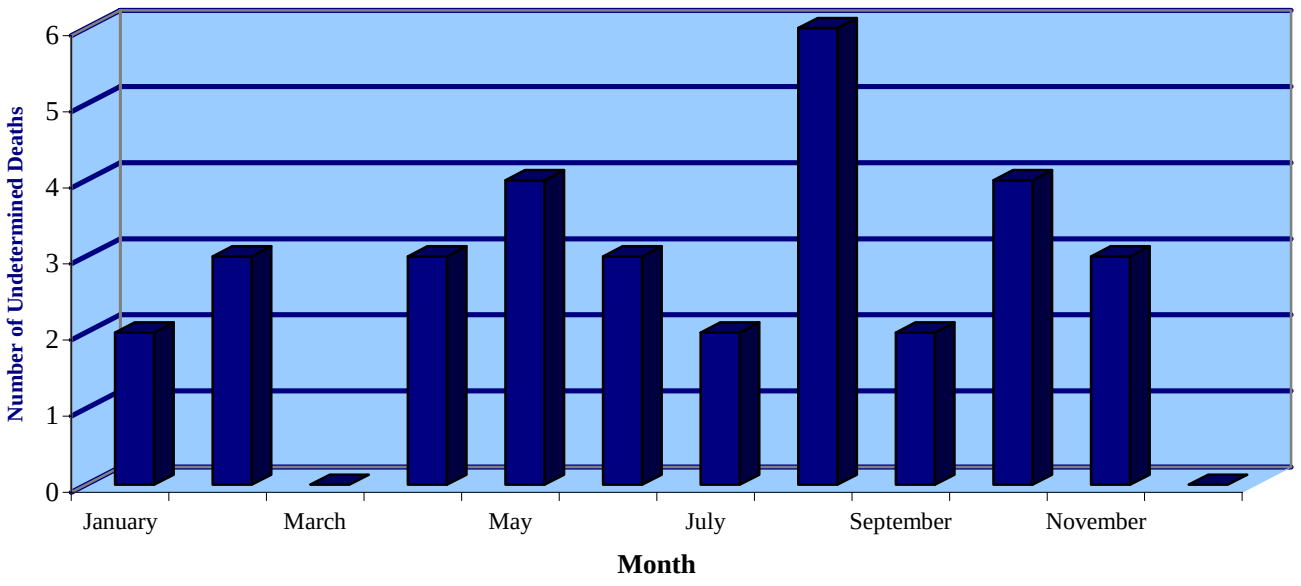
Pie Chart – Undetermined by Cause of Death



Undetermined Deaths by Month

Month	Number of Deaths
January	2
February	3
March	0
April	3
May	4
June	3
July	2
August	6
September	2
October	4
November	3
December	0
Total	**32**

Chart - Undetermined Deaths by Month



Undetermined Deaths by Race

Race	Number of Undetermined Deaths
Black	23
White	3
Hispanic	4
Unknown	2
Total	**32**

Undetermined Deaths by Gender

Gender	Number of Undetermined Deaths
Female	14
Male	17
Unknown	1
Total	**32**

Undetermined Deaths by Age

Age	Number of Undetermined Deaths
Unknown	1
Under 1	10
1 to 5	2
6 to 12	0
13 to 15	0
16 to 19	0
20 to 29	3
30 to 39	6
40 to 49	3
50 to 59	3
60 to 69	1
70 to 79	2
80 to 89	1
90 +	0
Total	**32**

Toxicology Findings by Undetermined Deaths

Of the 32 Undetermined Deaths investigated by OCME, toxicology analysis was performed in 31 cases. Overall, drugs were absent in 14 undetermined cases; 6 cases had one drug present; 2 cases had 2 drugs present; and 3 cases had 3 drugs present.

Description	Number of Cases	% of Cases
N=	**31**	
Negative	16	51.6%
Positive	15	48.4%

The most commonly detected drugs in the undetermined cases were:

Name of Drug	Number of Cases	% of Undetermined Cases
Ethanol	4	13%
Cocaine	3	10%
Morphine	5	16%

Toxicology for Stillbirths

Toxicology analysis was performed in all 11 Stillbirth Deaths investigated by OCME. Overall, drugs were absent in 5 stillbirths; 1 case had ethanol present; 1 case had meperidine detected; and 4 cases had cocaine detected.

Description	Number of Cases	% of Cases
N=	**11**	
Negative	6	54.5%
Positive	5	45.5%

3.0 – Child Fatality Review Committee (CFRC)

The District of Columbia Child Fatality Review Committee, which operates under the auspices of the Office of the Chief Medical Examiner, is a citywide effort that is authorized by District statute (DC Law 14-028) for the purpose of conducting retrospective examinations of the circumstances that contributed to the deaths of infants, children and youth who were residents or wards of the city. Identifying risk reduction, prevention and system improvements factors; recommending strategies to reduce the number of preventable child deaths; and improving the quality of residents' lives are the primary goals of the District's child death review process. The Committee focuses on using information gained from fatality reviews as a means of understanding the following:

- The manner in which District children are dying and patterns/trends associated with preventable child deaths;
- The type of services/interventions and resources needed by families;
- The appropriateness of current child/family-focused policies, legislation and practices; and
- The changes required for ensuring a citywide continuum of care for children and families and for the protection of our children.

The mandated case review criteria include the following:

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

The child death review process is intended to assist in identifying family and community strengths, as well as deficiencies and improvements needed in service delivery systems, to better address the needs of children and families served. It is an opportunity for self-evaluation, through a multi-agency, multi-disciplinary approach. This process can provide a wealth of information regarding ways to enhance services and systems in an effort to reduce the number of preventable deaths and improve the quality of children's lives.

During the 2004 calendar year, the Committee identified the deaths of 155 children/youth, from birth through 23 years of age. This represents a 33% change in trend from four years of a consistent decline. In 2004 the number of child/youth deaths increased by 17% from the 133 deaths in 2003. The 2004 fatalities included children who died from a multitude of causes including extreme prematurity, congenital anomalies, diseases, homicide and unintentional injuries. Out of the 155 fatalities identified from the 2004 calendar year, 78, or 50% were reported to the DC Office of the Chief Medical Examiner and were accepted for autopsy. The following charts and graphs represent a summary of the data that resulted from the 2004 deaths reviewed:

3.1 – CFRC Decedent Population Breakdown

CFRC Decedent Population by Age

Age	Number	% of Total Population by Age
Under 1 Year	68	44%
1 thru 4 Years	8	5%
5 thru 10 Years	12	8%
11 thru 14 Years	13	8%
15 thru 20 Years	49	32%
Over 20 Years	5	3%
Total	**155**	**100%**

CFRC Decedent Population by Race

Race	Number	% of Total by Population Race
Black/African American	140	90%
Hispanic	8	5%
White	6	4%
Other	1	1%
Asian	0	0%
Total	**155**	**100%**

CFRC Decedent Population by Gender

Gender	Number	% of Total by Gender
Female	56	36%
Male	99	64%
Total	**155**	**100%**

CFRC Decedent Population by Ward

Ward of Residence	Number
Ward One	14
Ward Two	15
Ward Three	2
Ward Four	15
Ward Five	19
Ward Six	25
Ward Seven	29
Ward Eight	27
Other State	8

CFRC Decedent Population by Manner of Death

Manner	Number	% of Total
Natural	77	49.6%
Homicide	54	34.8%
Accident	15	9.6%
Undetermined	8	5.1%
Unknown	1	.6%
Suicide	0	0%
Pending	0	0%

3.2 – CFRC Cases Autopsied at OCME

Description of DC-OCME Decedent Population

Age/Gender	Subtotal	Total
Under 1		**16**
Female	9	
Male	7	
1 thru 4		**6**
Female	3	
Male	3	
5 thru 10		**5**
Female	2	
Male	3	
11 thru14		**8**
Female	5	
Male	3	
15 thru 20		**38**
Female	3	
Male	35	
Over 20		**5**
Female	0	
Male	5	

Age - DC OCME Population

Decedent's Race	Number	% of Total
Black	76	97%
White	2	3%
Hispanic	0	0%
Asian	0	0%
Other	0	0%

Ward - DC OCME Population

Ward of Residence	Number
Ward One	2
Ward Two	6
Ward Three	0
Ward Four	7
Ward Five	13
Ward Six	14
Ward Seven	14
Ward Eight	19
Other State	3

Manner of Death - DC OCME Population

Manner	Number	% of Total
Homicide	43	55%
Natural	18	23%
Accident	10	13%
Undetermined	7	9%
Suicide	0	0%

Causes of Homicides - DC OCME Population

Cause	Number
Blunt Impact (Shaken Baby)	5
Fire Arms (15 years of age or older)	36
Sharp Force (Under Age 3)	1

Causes of Accidents - DC OCME Population

Cause	Subtotal	Total
Motor Vehicle		**5**
Pedestrian	2	
Passenger	0	
Driver (2 motorbikes/1bicycle)	3	
Smoke Inhalation/Asphyxia		**4**
Other (TV fell on child)		**1**

Causes of Natural Deaths - DC OCME Population

Cause	Number
Prematurity (under 38 wks)	6
Infection	4
Respiratory	2
Central Nervous System	2
SIDS	2
Skeletal	1
Diabetes Mellitus	1

Causes of Undetermined Deaths

"Undetermined" as a final manner of death is declared when a reasonable classification of manner cannot be established after a full and comprehensive analysis of the post-mortem examination, police and forensic investigation, toxicology screens and any other social, familial, medical and other specific events leading to or surrounding the fatal incident. In 2004, there were seven of the eight child deaths in which the manner of death was Undetermined received autopsies by the DC Office of the Chief Medical. Based on a review of the 2004 "Undetermined" OCME deaths, the following findings were identified:

- The majority of the decedents were infants (n = 6), with ages that ranged from one to four months and an average age of two months. One of the eight decedents was two years of age. All the decedents were Black/African American and the majority were females (n = 5, or 71%).
- All of the infants were born full term (n = 6) and all had birth weights greater than 1800 grams.
- The majority of the causes of death (n = 5) were "Sudden Unexplained Death in Infancy" with two death certificates noting co-sleeping and/or bed sharing as a concern. However, based on a review of hospital records and death scene investigations, the majority of the investigations revealed problems with co-sleeping and/or inappropriate sleeping positions and/or sleeping environments.
- Two of the "Undetermined" manner of deaths also had an Undetermined cause of death. These children were one month and two years of age respectively.

CFRC Manner by Month – DC OCME Population

Manner	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Natural	3	2	1	2	0	1		1	1	4	2	1
Homicide	11	4	4	4	4		5	1	3	5	0	2
Accident	1	1	1	0	0	0	0	1	0	2	0	4
Suicide	0	0	0	0	0	0	0	0	0	0	0	0
Undetermined	0	2	0	0	2	0	1	0	1	1	0	0

4.0 – Mental Retardation Developmental Disability Fatality Review Committee (MRDD FRC)

This report is a composite summary of work of the District of Columbia Mental Retardation and Developmental Disability Fatality Review Committee (MRDD FRC) for the calendar years 2001 through 2004. The MRDD FRC was re-established by Mayor's Order 2005-143 effective September 30, 2005 (See Appendix E) (herein referred to as the Order). The Order mandates that the MRDD FRC examine events that surround the deaths of District wards or residents 18 years of age and older with mental retardation and/or developmental disabilities.

The MRDD FRC is comprised of members who represent public and private community organizations from a broad range of disciplines to include health, mental retardation and mental health, social services, public safety, judicial and law enforcement. These individuals come together as a collective body for the purpose of examining and evaluating relevant facts associated with services and interventions that were provided to deceased persons with mental retardation and developmental disabilities (MRDD).

During the fatality case reviews, the MRDD FRC examines an independent investigative report and a forensic autopsy report prepared by the Office of the Chief Medical Examiner. The reports highlight each deceased individual's social history including family and care giver's relationships with the deceased, living conditions prior to death; medical diagnosis; medical history; services provided; and cause and manner of death. These fatality reviews examine compliance with regulations and recommendations by service providers, and may lead to identification of systemic health care and service concerns. The MRDD FRC recommends strategies to promote comprehensive health care and improve the quality of life for persons with MRDD.

During the calendar year 2004 the MRDD FRC reviewed deaths that occurred during 2001-2004. The Committee identified 125 deceased persons with MRDD. These decedents died from a multitude of causes, which included: Neurologic Diseases, Cardiovascular Diseases, Gastrointestinal Diseases, Cancer, Trauma, Drug intoxication, and Therapeutic Complications. Of the 125 fatalities identified from 2001 – 2004 calendar years, all were reported to the DC Office of the Chief Medical Examiner and 121 were autopsied. The following charts and graphs represent a summary of the data that resulted from the MRDD FRC review of the deaths.

4.1 – MRDD FRC Decedent Population Breakdown

MRDD Population

Year	Population	Deaths	Percentage
2001	1547	32	2%
2002	1703	26	1.5%
2003	1790	31	1.7%
2004	1915	36	1.9%

MRDD Deaths by Age

Age and Mortality

In calendar year 2004, the FRC reviewed the deaths of 26 persons with MRDD who ranged in age from 23 to 87 years. Of the 26 deaths reviewed, 8 (31%) were 61 years of age and older, 9 (35%) were between 51-60 years, 4 (15%) were age 41-50, 1 (4%) were 31-40, and 4 (15%) were age 21-30.

Age Range	2001 N=4	2002 N=2	2003 N=7	2004 N=13
18-20	0	0	0	0
21-30	2	0	2	0
31-40	0	0	0	1
41-50	1	0	1	2
51-60	1	1	2	5
61 and Over	0	1	2	5

MRDD Deaths by Cause

Cause of Death	Deaths
Cardiovasecular Diseases (Hypertension, Atherscleros is)	10
Neurologic Diseases	6
Cancer	3
Gastrointestinal Diseases	2
Trauma	2
Therapeutic Complications	2
Drug Intoxication	1

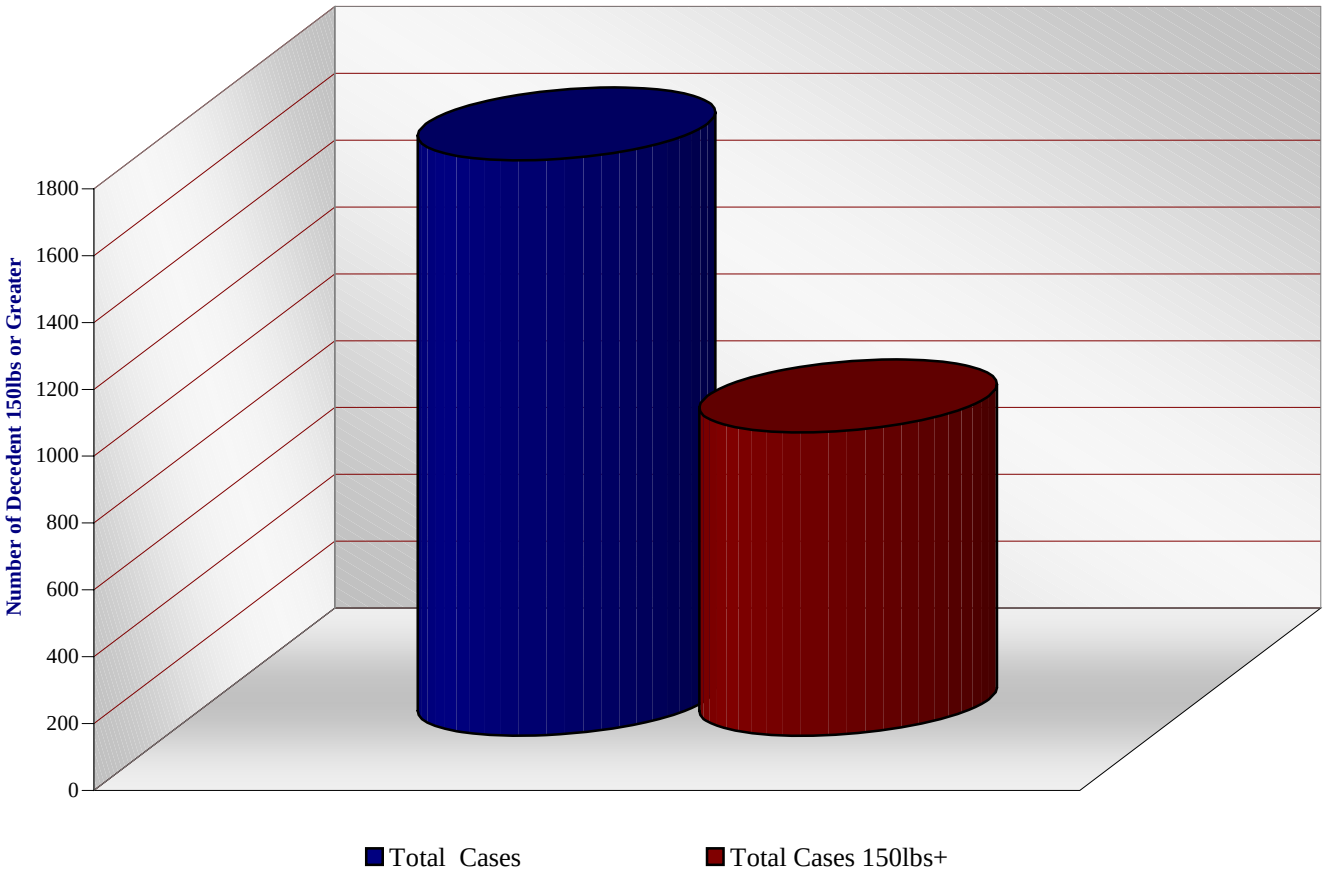
5.0 – Data on Weight Distribution of Accepted OCME Cases for 2004

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

The data presented was gathered on decedents who were processed by the OCME between January 1, 2004 and December 31, 2004.

Included are a few graphs that show the distribution of weights for calendar year 2004. They show that the weight distribution is consistently skewed toward the heavier end, with more than 50% of all decedents exceeding 150 pounds.

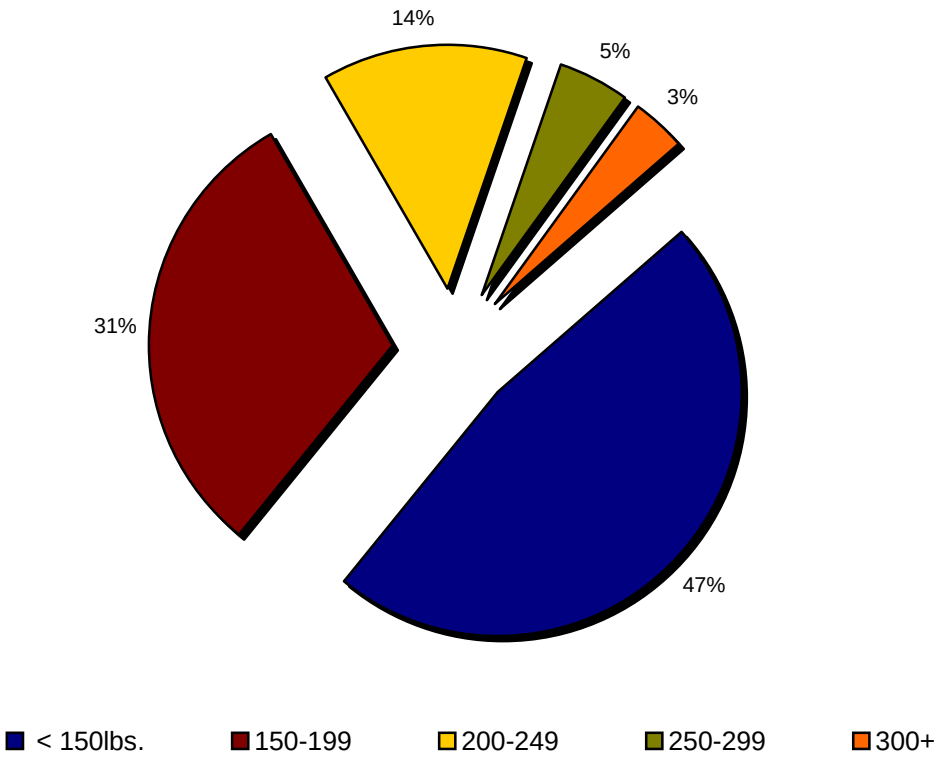
Comparison of 2004 Total Cases to Total Number of Cases Exceeding 150lbs



2004 - WEIGHT DISTRIBUTIONS

Weight	< 150lbs	150-199	200-249	250-299	300+	Total Cases 150lbs or more	Total Cases
Number of Decedents	814	531	234	83	60	908	1722[3]

Distribution of OCME Cases by Weight (2004)



[3] This data includes "Storage cases", which is not included in the "Accepted case" tabulations, but is tallied and included in the work of the Mortuary Unit and recorded in their logbooks.

6.0 – Breakdown of Medical Examiner (ME) Investigations by Race and Manner of Death

During 2004, the total population of the District was 553,523[4] inhabitants comprised mainly of the following groups: White, Black, American Indian/Asian and Hispanic. In 2004, the OCME investigated 3,113 of the deaths that occurred in these populations and 1,908 were accepted under the jurisdiction of the Medical Examiner for further investigation. The following table and charts summarize the manner of death by racial composition.

Manner of Death by Race with 2004 Population

Race	2000 Census	Total Number of ME Cases	Natural	Suicide	Homicide	Accidents (Traffic-Related)	Accidents (All)
White	197,168	295	167	15	9	21	100
Black/ African American	349,390	1,229	777	13	184	52	222
Hispanic/Latino (of any race)	44,953	61	25	3	8	6	22
Asian	15,762	12	6	2	0	0	4
Pacific Islander	412	2	1	0	0	1	1
Alaskan Native	1,961	1	0	0	0	0	1
Other[5]	7,366	7	7	2	0	1	1
Total Population	**553,523**						
Total # of ME Cases		**1,633**	**983**	**35**	**201**	**81**	**351**

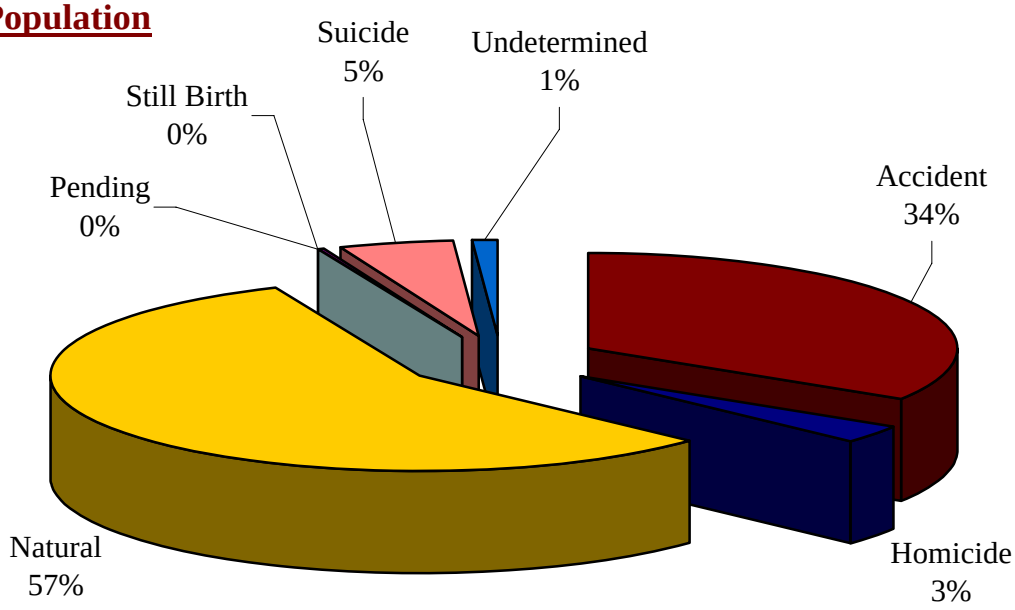
Note: Undetermined deaths are not included in this table.

[4]The 2004 census information indicates an estimated total population of 553,523.

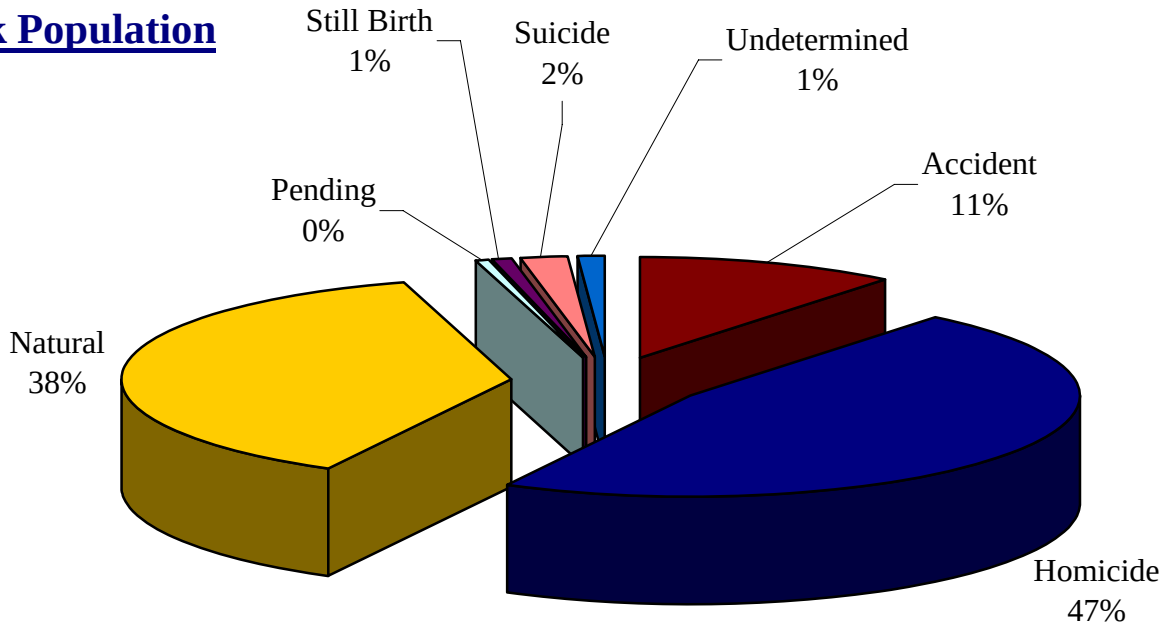
[5] Where **Race** is categorized as "*Other*" the data represents the following: Unknown and two or more races

Pie Chart of ME Cases by Race and Manner of Death

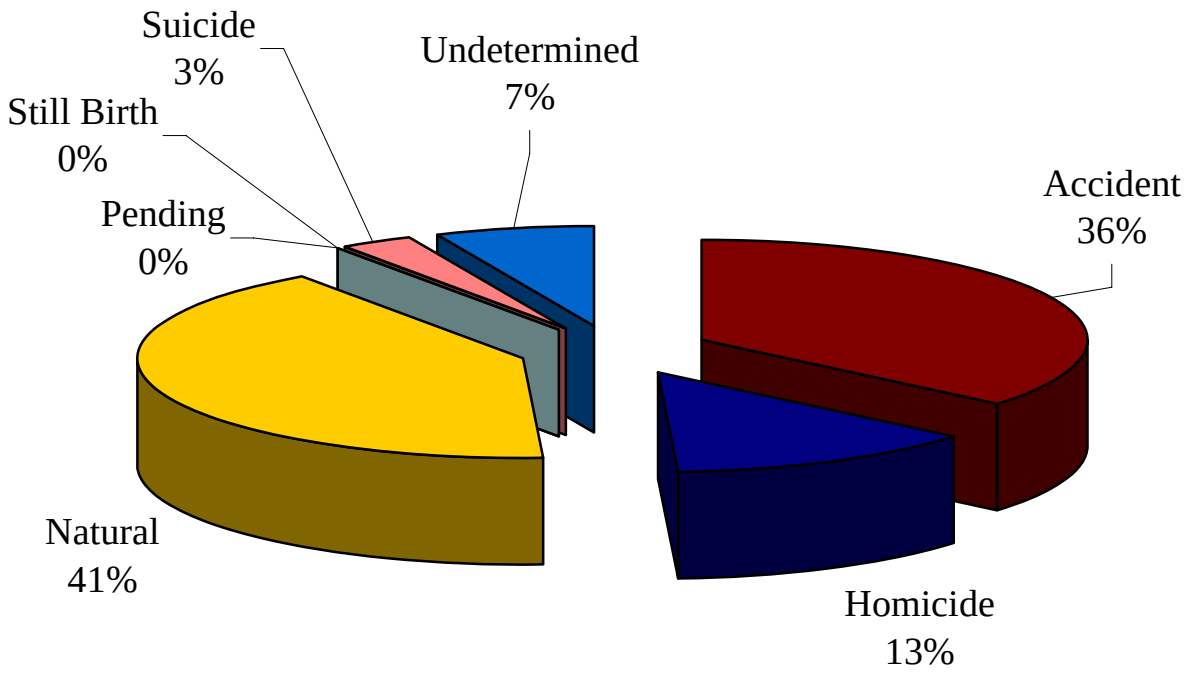
White Population



Black Population



Hispanic/Latino (of any race) Population



APPENDIX A

A 30-Year Review of Homicides in the District of Columbia (1972-2002)

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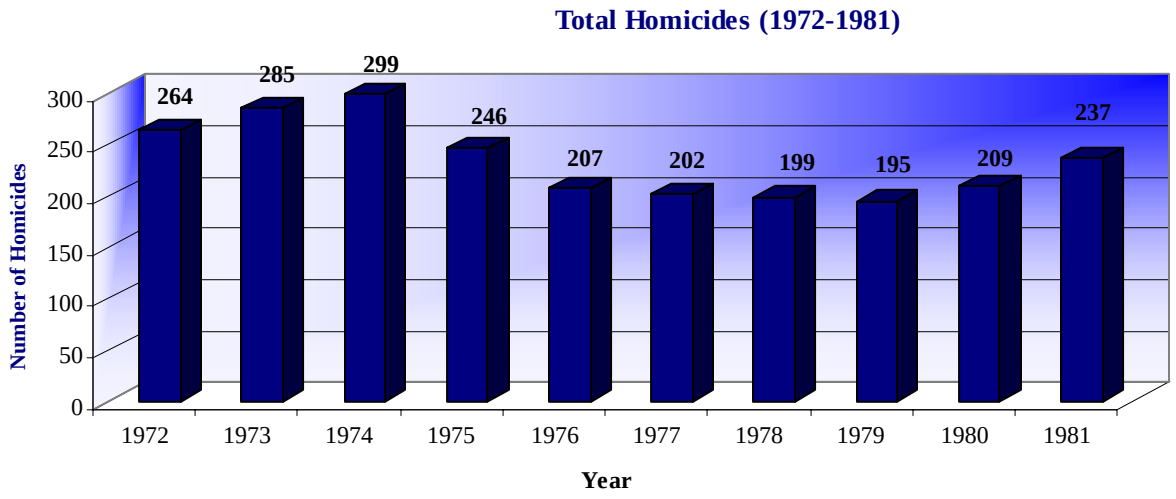
A 30-YEAR REVIEW OF HOMICIDES IN THE DISTRICT OF COLUMBIA (1972-2002)

INTRODUCTION

During the years 1972 – 1981 Annual Reports were available for statistical compilations needed to produce this report. Unfortunately during the years 1982 – 2002, when Washington, DC had become known as "*Dodge City (DC)*" and the "*Murder Capital of the US,* " only one (1992) annual report was published. A dramatic spike in homicides is revealed during this 20-year interval of time, spanning the years 1988 to 1998, so as a result the data for the entire twenty years (1982-2002) is compared. The absence of the annual report during these years was primarily due to chronic understaffing secondary to high turnover. The 2004 OCME Annual Report attempts to close this gap by providing statistical compilations for a subset of the data for these years with emphasis on homicides by gunfire, demographics, and the number of autopsies performed.

CALENDAR YEARS 1972 THROUGH 1981

The number of Homicides in the DC area, though demonstrating a modest increase from 1972 to 1974 (264 to 299), showed a progressive decline until 1979 when it went down to 195. Then, in 1980 the Homicide rate started rising again reaching a peak of 237 in 1981.



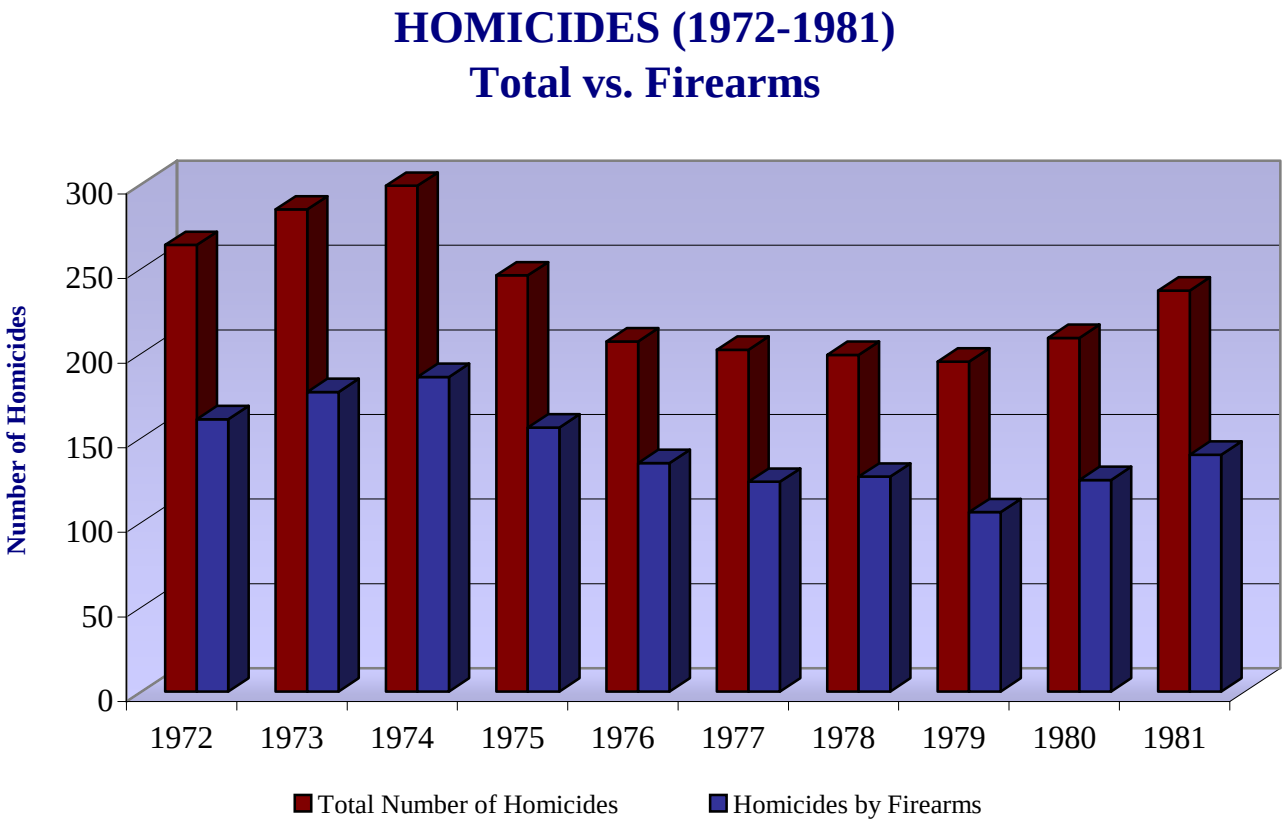
The study of these years reveals several compelling facts. We will begin with the use of firearms and end with alarming data regarding race, age and gender. The first annual report ever produced by the Medical Examiner's Office in 1972, after it transitioned from the Coroner's System, contained a startling statement made by then Chief Medical Examiner, Dr. James Luke:

> "*Homicide by gunfire is by far the leading cause of death among all causes of death in the nation's capital for persons between the ages of 15 and 44 years*" (OCME Annual Report 1972 p. 2)

HOMICIDE BY FIREARMS

The statistics show that from 1972 through 1981 there were 2,343 homicides in the District of Columbia, and 1,437 or 63% of them occurred as a direct result of Gunfire.

Year	Homicides by Firearms	Total Number of Homicides
1972	161	264
1973	177	289
1974	186	299
1975	156	246
1976	135	207
1977	124	202
1978	127	199
1979	106	195
1980	125	209
1981	140	237
Total	**1,437**	**2,343**



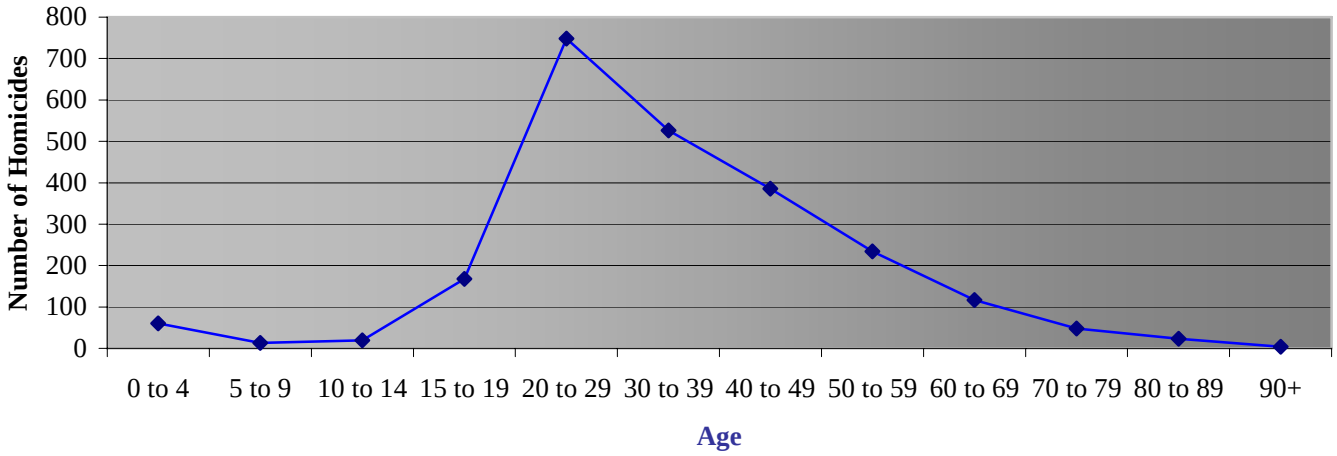
HOMICIDE BY AGE (1972-1981)

A study of the data reveals that of the 2,343 homicides that occurred during the 1972 through 1981 period, 748 of the decedents were between 20 and 29 years of age. This age group was affected more than any other. The number of homicides for those between the ages of 15 and 44 showed little variation.

HOMICIDES BY AGE

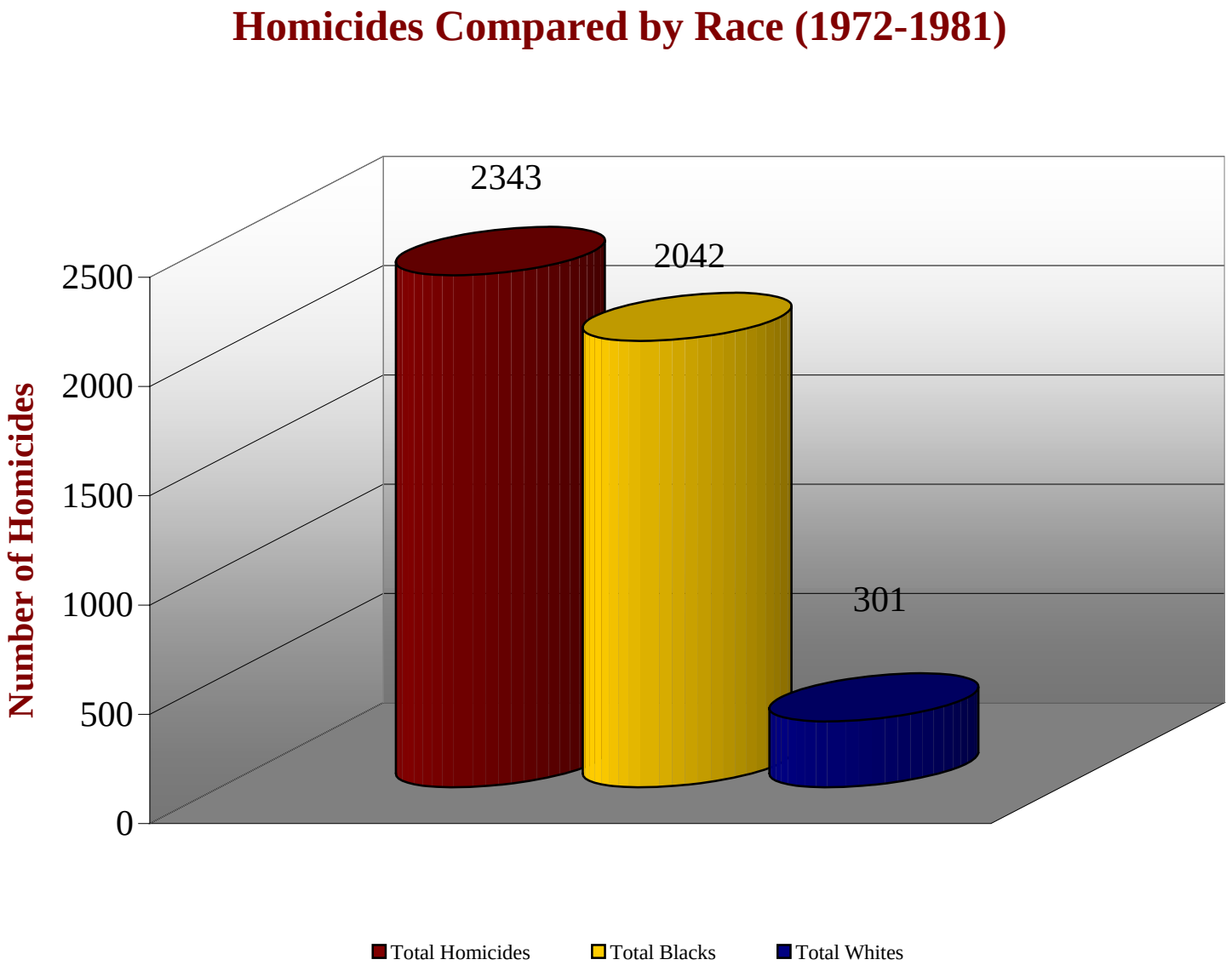
Year	0 to 4	5 to 9	10 to 14	15 to 19	20 to 29	30 to 39	40 to 49	50 to 59	60 to 69	70 to 79	80 to 89	90+
1972	8	2	0	27	78	52	51	27	10	6	2	1
1973	13	2	5	14	100	57	46	23	15	7	3	0
1974	8	2	2	18	95	70	54	27	14	4	5	0
1975	5	1	3	15	80	49	45	30	6	11	1	0
1976	3	1	2	18	61	51	33	19	14	4	1	0
1977	2	0	2	14	60	49	31	20	19	3	2	0
1978	3	0	0	10	61	53	32	23	13	2	2	0
1979	5	0	4	14	62	36	33	29	9	3	0	0
1980	4	2	1	26	71	52	25	13	8	2	5	0
1981	6	3	0	12	80	57	36	23	9	6	2	3
TOTAL	57	13	19	168	**748**	**526**	**386**	234	117	48	23	4

TOTAL HOMICIDES BY AGE (1972-1981)



HOMICIDE BY RACE AND GENDER

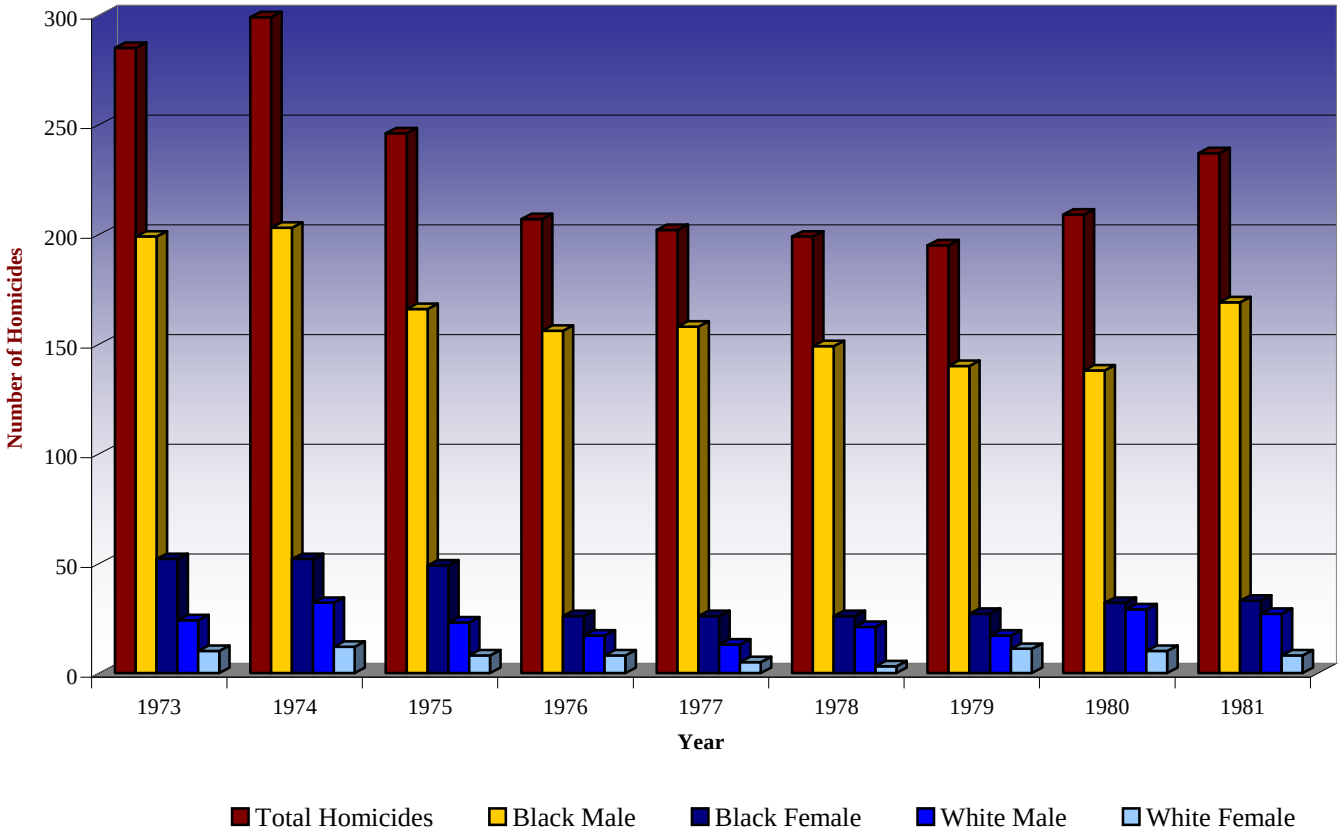
The demographics of the affected population remained constant throughout this study period. Blacks/African Americans consistently represented 88 to 91% of the victims; Black/African American males paid the highest toll making up 70 to 81% of the group. The number of deaths for Black/African American women varied from a low of 20 to a high of 69. Homicides in the White population peaked at 32 for males and 12 for females in 1974.



HOMICIDE BY RACE AND GENDER

HOMICIDE BY RACE, AND GENDER OF VICTIM							
Year	Black Male	Black Female	Total Black	White Male	White Female	Total Whites	Total Homicides
1972	N/A	N/A	**241**	N/A	N/A	**23**	**264**
1973	199	52	**251**	24	10	**34**	**285**
1974	203	52	**255**	32	12	**44**	**299**
1975	166	49	**215**	23	8	**31**	**246**
1976	156	26	**182**	17	8	**25**	**207**
1977	158	26	**184**	13	5	**18**	**202**
1978	149	26	**175**	21	3	**24**	**199**
1979	140	27	**167**	17	11	**28**	**195**
1980	138	32	**170**	29	10	**39**	**209**
1981	169	33	**202**	27	8	**35**	**237**
Total	1,478	323	**2,042**	203	75	**301**	**2,343**

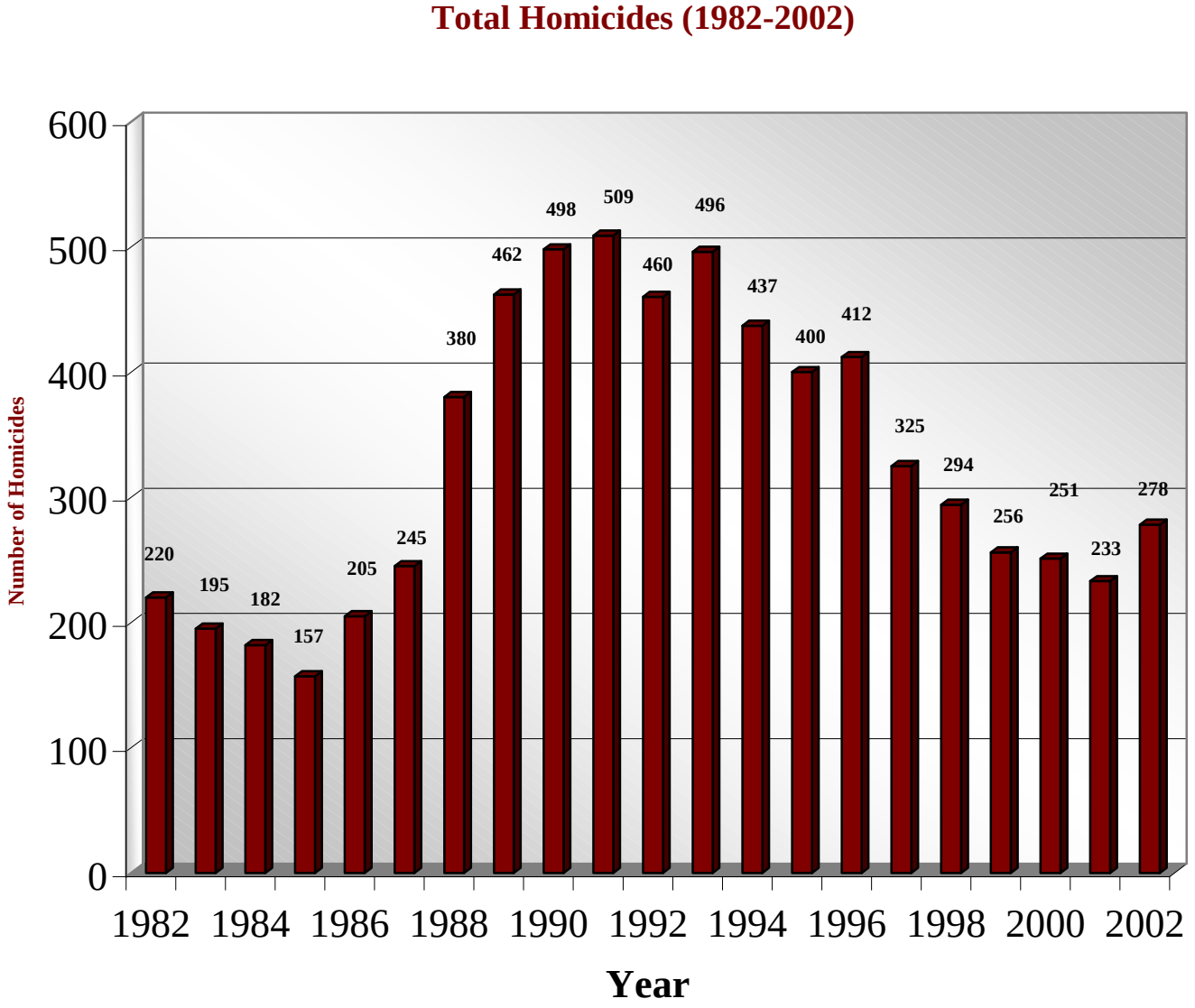
Homicides by Race and Gender
(1973-1981)



Note: The Annual Report for 1972 does not provide a breakdown of the data for "*Race*" and "*Gender*".

CALENDAR YEARS 1982 THROUGH 2002

During the period of 1986 through 1998 homicides in the District of Columbia reached epidemic proportions, rapidly doubling and tripling in numbers to attain a peak of 509 in 1991. The loss of lives declined thereafter, and from 2000 – 2002 homicides remained between 200 and 300, which are the same as the numbers of the 1970's.

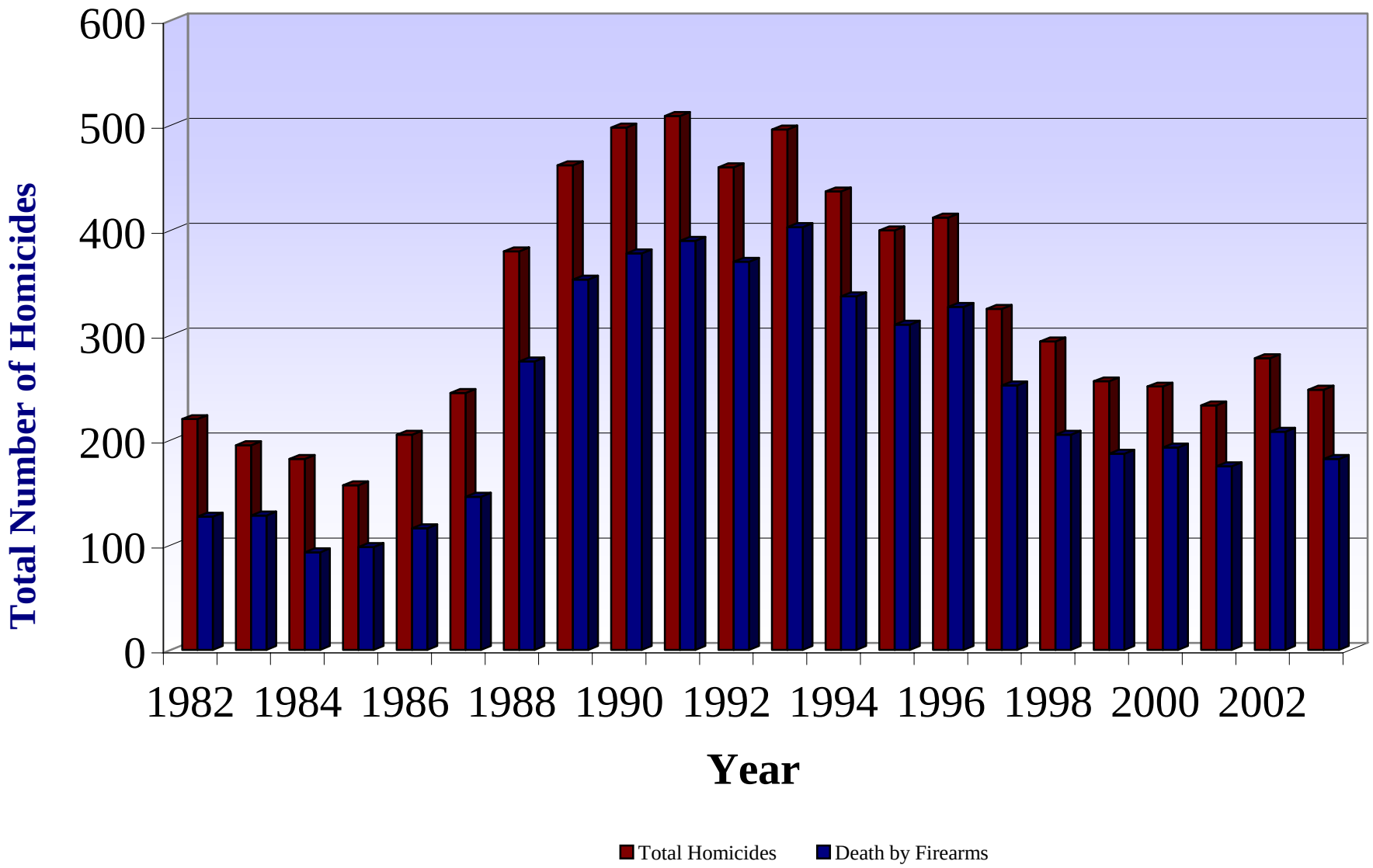


HOMICIDES BY FIREARMS (1982-2002)

The statistics show that from 1982 through 2002, there were 6,895 homicides in the District of Columbia; 5,071 or 74% of them occurred as a direct result of Gunfire.

Year	Death by Firearms	Total Homicides
1982	127	220
1983	128	195
1984	93	182
1985	98	157
1986	116	205
1987	146	245
1988	275	380
1989	353	462
1990	378	498
1991	390	509
1992	370	460
1993	403	496
1994	337	437
1995	310	400
1996	327	412
1997	252	325
1998	205	294
1999	187	256
2000	193	251
2001	175	233
2002	208	278
Total	**5,071**	**6,895**

HOMICIDES (1982-2002)
Total Homicides vs. Death by Firearms



HOMICIDES BY AGE (1982-2002)

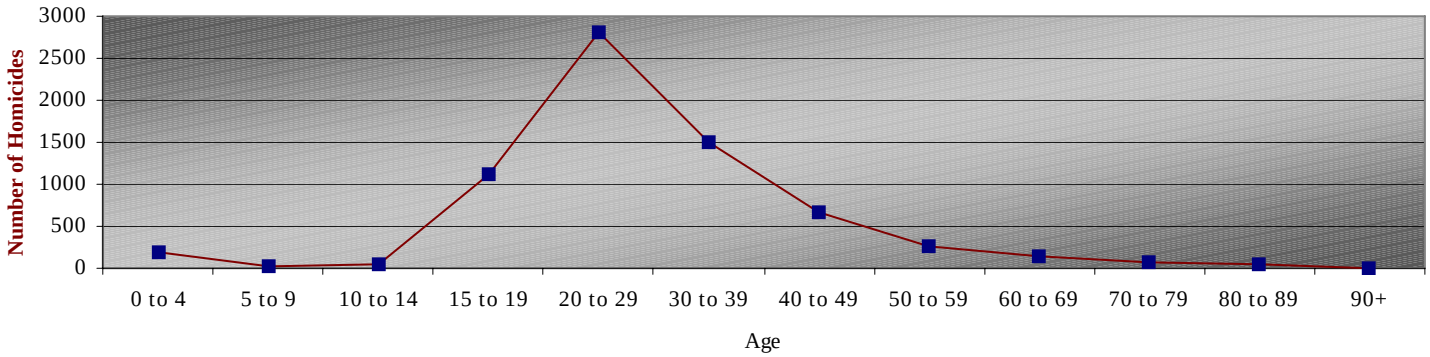
The age group with the highest number of deaths changed, especially in the Black/African American population. While the number of homicides generally affected the age group 20 to 49, there was a marked increase in the 15-19-age range during 1988 through 1997, far exceeding the numbers (10 to 20) seen in the 1970's. The number of cases in this population more than doubled in 1988 and jumped to 113 in 1993. Afterwards the count steadily declined to a minimum of 34 in 2001 and 2002, but remained twice as high as the numbers reported in the previous period.

HOMICIDES BY AGE

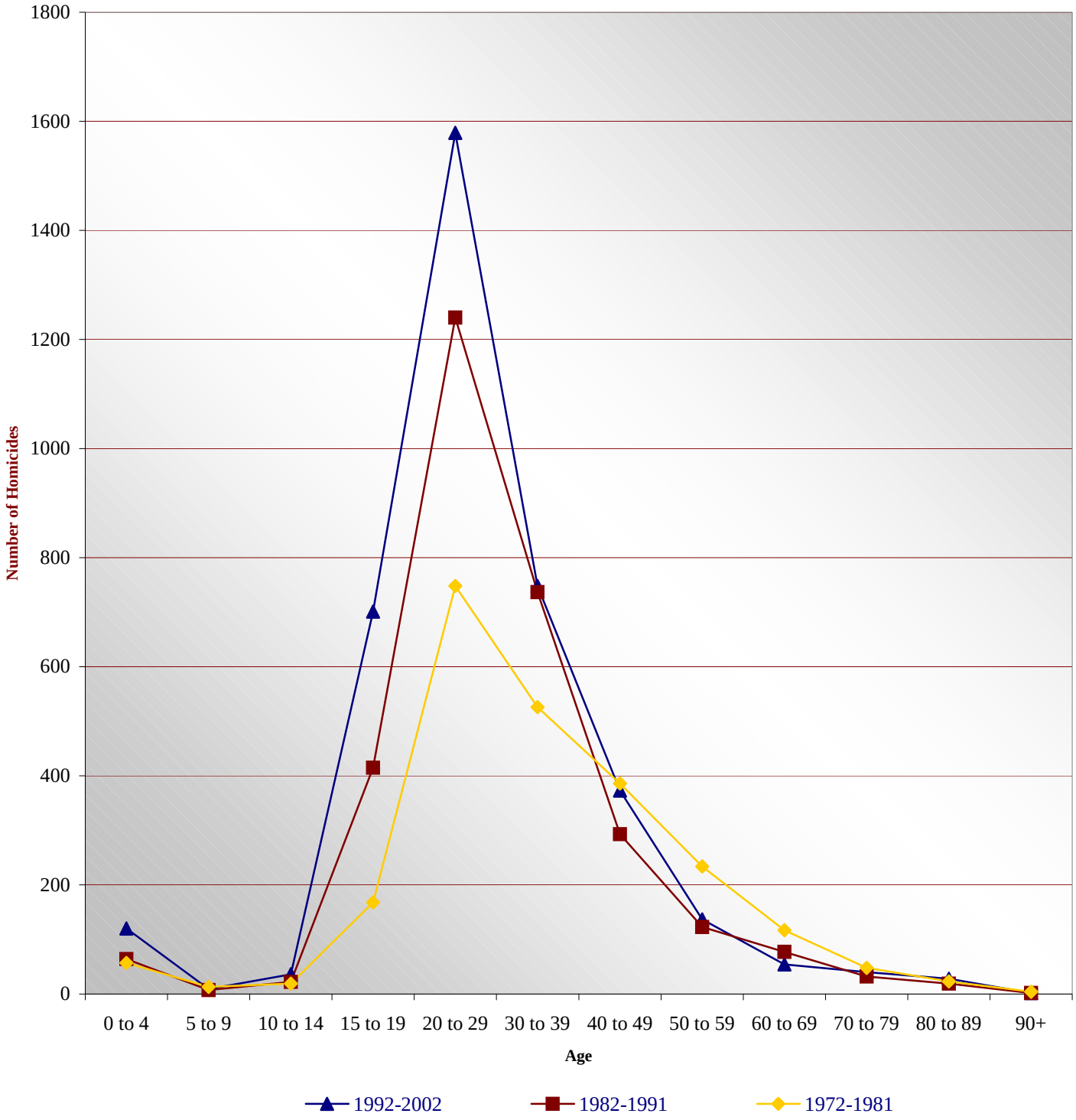
Year	0 to 4	5 to 9	10 to 14	15 to 19	20 to 29	30 to 39	40 to 49	50 to 59	60 to 69	70 to 79	80 to 89	90+	Total
1982	8	1	1	13	72	66	26	13	15	3	1	0	219
1983	5	0	1	17	72	50	23	14	6	6	1	0	195
1984	3	0	1	17	79	41	19	11	10	0	1	0	182
1985	6	0	1	14	53	45	23	8	6	1	0	0	157
1986	7	1	0	17	69	68	23	8	6	5	1	0	205
1987	11	0	3	21	110	53	25	8	6	4	2	0	243
1988	4	3	2	49	170	92	31	14	5	4	2	1	**377**
1989	8	1	5	79	188	114	34	11	7	6	2	1	**456**
1990	5	0	1	92	212	110	38	21	8	1	5	0	**493**
1991	7	1	7	96	215	98	51	15	8	2	4	0	**504**
1992	13	0	5	76	206	92	40	12	7	4	2	0	**457**
1993	12	1	6	113	191	92	45	16	9	5	4	0	**494**
1994	10	0	5	84	171	96	41	14	11	3	2	0	**437**
1995	7	1	5	91	166	79	25	11	4	7	2	1	**399**
1996	9	3	6	72	180	75	47	8	5	4	2	0	**411**
1997	10	1	3	70	125	54	36	15	3	3	2	0	**322**
1998	15	0	1	39	110	66	30	18	6	5	3	0	293
1999	16	0	1	51	93	50	23	14	2	3	3	0	256
2000	8	1	2	37	107	49	24	10	5	2	4	0	249
2001	8	0	1	34	103	50	24	10	0	1	1	0	232
2002	12	2	1	34	127	45	38	9	2	3	3	1	277
Total	184	16	58	**1116**	**2819**	**1485**	666	260	131	72	47	4	**6858**

Note: The category "Age Unknown (n=37)" is not included in this chart.

Total Homicides by Age (1982-2002)



HOMICIDES BY AGE A 30-YEAR COMPARISON



HOMICIDE BY RACE AND GENDER (1982-2002)

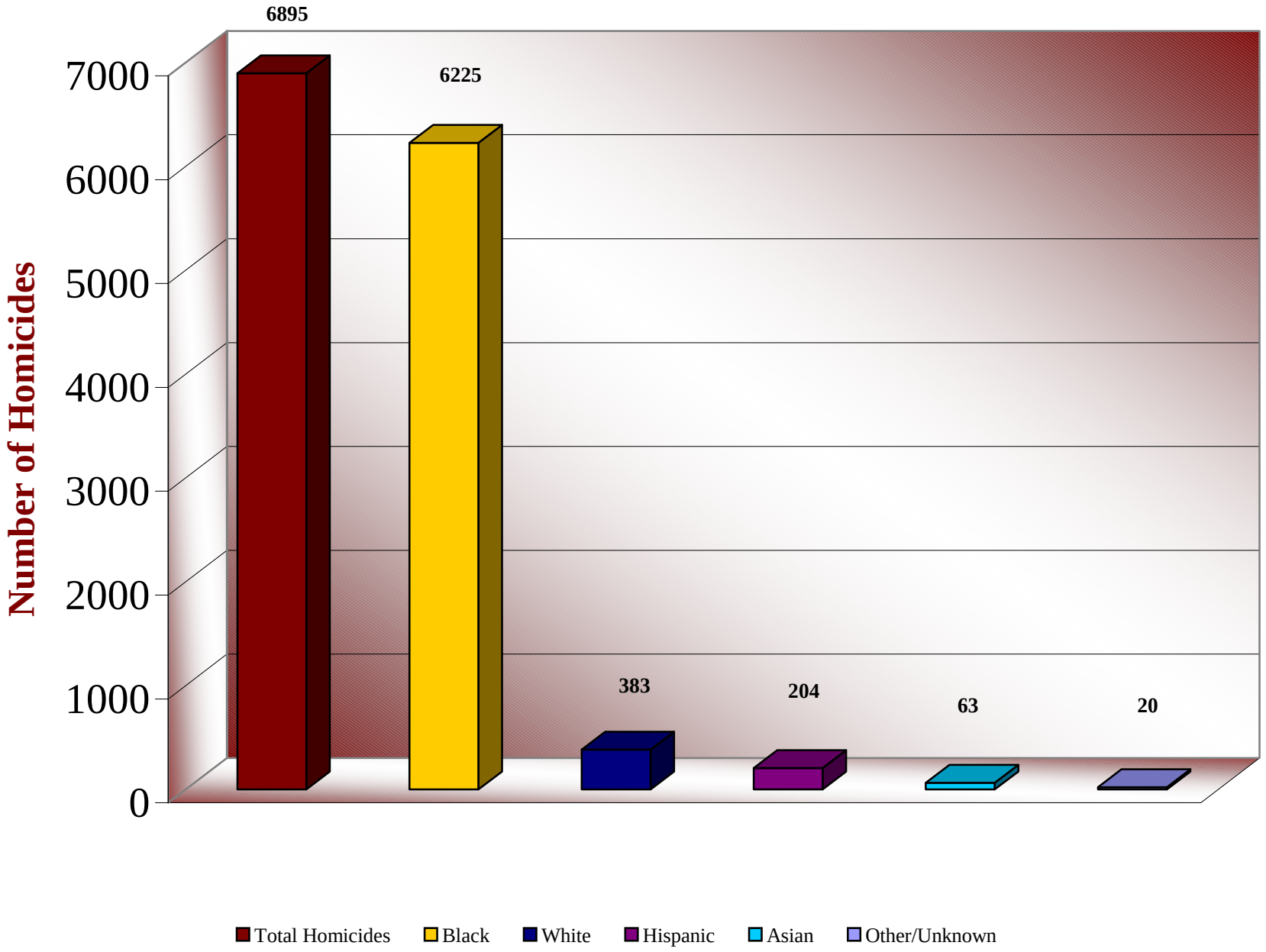
From 1986 through 1998, when the number of homicides per year surged in the District of Columbia, the number of homicides was more dominant in the black and white races, so our comparison will focus on these 2 primary races. The data reflects that white males peaked at 22 in 1990, but during this same timeframe the peak for black males were 409 in 1993. White females had the lowest number of deaths, reaching a peak of 10 in 1989, but in general this category remains below 10 homicidal deaths per year, while their counterpart the black female peaked at 69 in 1991.

HOMICIDES BY RACE, AND GENDER OF VICTIM							
Year		Black	White	Hispanic	Asian	Other/ Unknown	Total Homicides
1982	Male	147	20	5	2	2	176
	Female	33	9	1	0	1	44
Total by Race		180	29	6	2	3	220
1983	Male	149	9	4	1	2	165
	Female	19	8	1	0	2	30
Total by Race		168	17	5	1	4	195
1984	Male	127	18	4	0	0	149
	Female	30	3	0	0	0	33
Total by Race		157	21	4	0	0	182
1985	Male	114	10	2	1	0	127
	Female	26	2	1	1	0	30
Total by Race		140	12	3	2	0	157
1986	Male	144	11	3	3	2	163
	Female	35	4	2	1	0	42
Total by Race		179	15	5	4	2	205
1987	Male	182	12	3	2	0	199
	Female	42	3	1	0	0	46
Total by Race		224	15	4	2	0	245
1988	Male	305	10	9	5	0	329
	Female	47	3	0	1	0	51
Total by Race		352	13	9	6	0	380
1989	Male	375	21	12	2	1	411
	Female	39	10	1	1	0	51
Total by Race		414	31	13	3	1	462
1990	Male	395	22	14	4	1	436
	Female	58	2	2	0	0	62
Total by Race		453	24	16	4	1	498
1991	Male	400	14	14	2	0	430
	Female	69	6	1	3	0	79
Total by Race		469	20	15	5	0	509
1992	Male	388	20	9	1	0	418
	Female	36	4	1	1	0	42
Total by Race		424	24	10	2	0	460
1993	Male	409	12	6	10	0	437
	Female	54	3	1	1	0	59
Total by Race		463	15	7	11	0	496

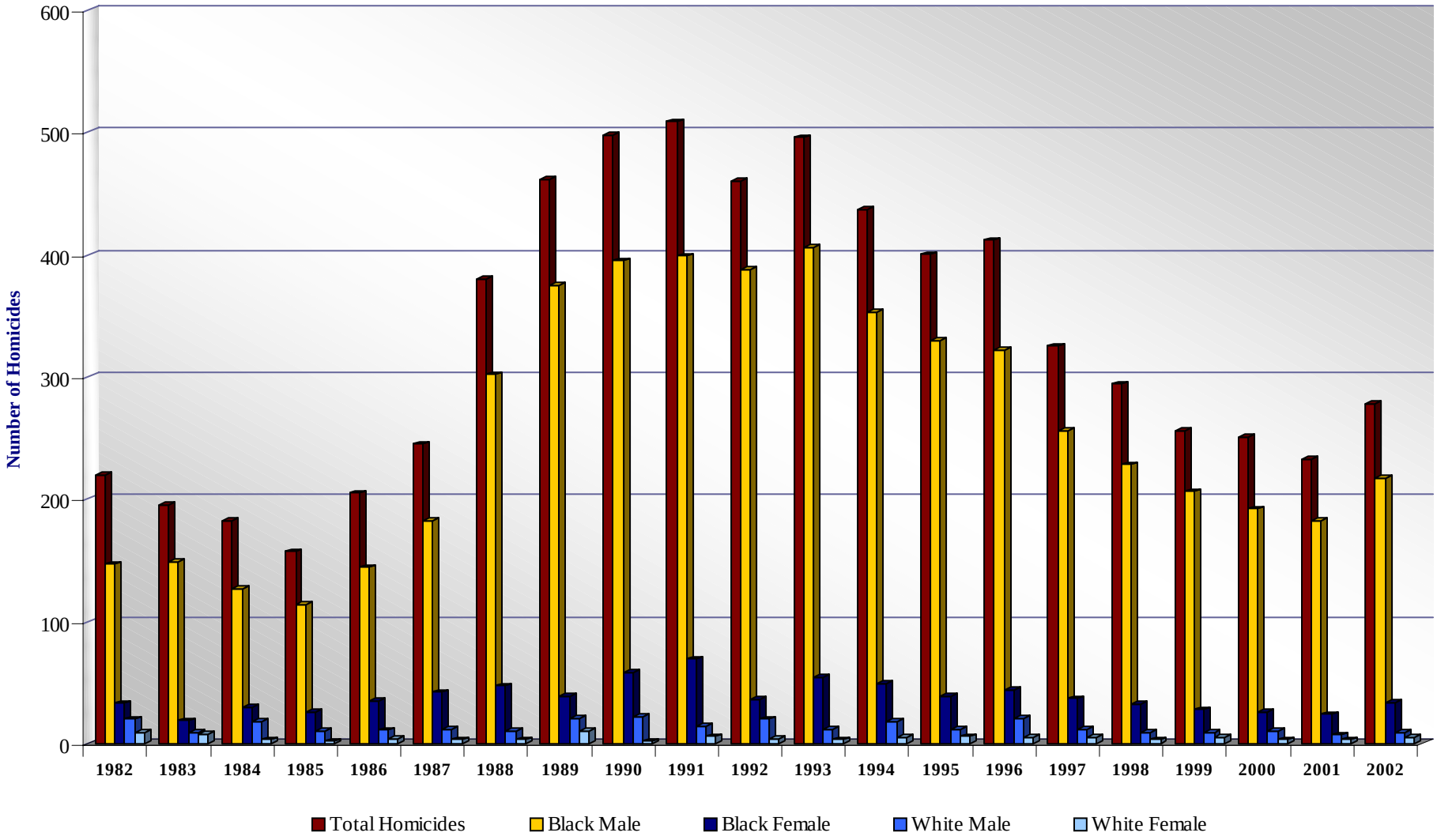
HOMICIDE BY RACE AND GENDER (1982-2002) - Continued

HOMICIDES BY RACE, AND GENDER OF VICTIM							
Year		**Black**	**White**	**Hispanic**	**Asian**	**Other/ Unknown**	**Total Homicides**
1994	**Male**	353	18	10	2		383
	Female	49	5	0	0		54
Total by Race		**402**	**23**	**10**	**2**	**0**	**437**
1995	**Male**	330	12	10	1	1	354
	Female	39	6	1	0	0	46
Total by Race		**369**	**18**	**11**	**1**	**1**	**400**
1996	**Male**	322	21	15	4	n/a	362
	Female	44	5	0	0	n/a	49
Total by Race		**366**	**26**	**15**	**4**	**1**	**412**
1997	**Male**	257	12	9	1	0	279
	Female	37	5	2	2	0	46
Total by Race		**294**	**17**	**11**	**3**	**0**	**325**
1998	**Male**	228	9	12	2	4	255
	Female	32	3	4	0	0	39
Total by Race		**260**	**12**	**16**	**2**	**4**	**294**
1999	**Male**	206	9	6	1	0	222
	Female	28	5	0	1	0	34
Total by Race		**234**	**14**	**6**	**2**	**0**	**256**
2000	**Male**	192	10	11	5	3	221
	Female	26	3	1	0	0	30
Total by Race		**218**	**13**	**12**	**5**	**3**	**251**
2001	**Male**	182	7	13	0	0	202
	Female	24	3	2	2	0	31
Total by Race		**206**	**10**	**15**	**2**	**0**	**233**
2002	**Male**	218	9	11	0	0	238
	Female	35	5	0	0	0	40
Total by Race		**253**	**14**	**11**	**0**	**0**	**278**
GRAND TOTAL		**6,225**	**383**	**204**	**63**	**20**	**6,895**

Total Homicides Compared by Race (1982-2002)



TOTAL HOMICIDES COMPARED BY RACE AND GENDER (1982-2002)



Note: For visual purposes, only the statistically higher races are compared in this chart.

TOTAL HOMICIDES AND AUTOPSIES PERFORMED (1972-2004)

Presented below are the total number of homicides and the number of autopsy examinations performed between 1972 and 2004.

Year	Total Number of Homicides	Total Number of Autopsies
1972	264	1,142
1973	285	1,147
1974	299	1,112
1975	246	1,105
1976	207	1,040
1977	202	1,066
1978	199	978
1979	195	1,005
1980	209	1,041
1981	237	1,040
1982	220	1,092
1983	195	940
1984	182	1,010
1985	157	1,126
1986	205	1,147
1987	245	1,283
1988	380	1,383
1989	462	1,380
1990	498	1,385
1991	509	1,333
1992	460	1,234
1993	496	1,088
1994	437	1,339
1995	400	1140
1996	412	1129
1997	325	1118
1998	294	1129
1999	256	1297
2000	251	1367
2001	233	1303
2002	278	1328
2003	248	1337
2004	201	1137

APPENDIX B

AGENCY MANAGEMENT

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AGENCY MANAGEMENT

Personnel Management:

OCME made great strides during 2004 within its personnel management function in the areas of employee retention and recruitment and development and implementation of agency policies and procedures to provide guidance to employees in carrying out their roles and responsibilities. The number of full time positions increased from 48 to 66 positions; employee retention was improved and the agency filled critical vacancies such as, Chief of Staff, General Counsel, Mental Retardation and Developmental Disabilities FRC Coordinator, Maintenance Mechanic, Forensic Photographer and Autopsy Assistants.

OCME developed, in 2004, the first comprehensive Policies and Procedures Manual in the history of the agency, which sets forth the organization, general functions and uniform practices of the agency. The Manual provides an overview of agency operation and includes guidelines on administration of the agency; the provision of forensic services (i.e., death investigation and certification) and protocols for various fatality review committees. The Manual also includes emergency preparedness procedures, including: the first Emergency Response and Evacuation Plan and Hazard Communication Program -- both approved by the Office of Risk Management (ORM) – as well as the first Mass Fatality Plan which has been reviewed by the Emergency Management Administration (EMA) and distributed to all OCME employees.

Contracting & Procurement:

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

Pursuant to Title 27, DCMR Chapter 8, Local, Small and Disadvantaged Business Enterprises (LSDBE) Contracting regulations, each agency of the District of Columbia must allocate fifty (50%) of its expendable budget for use with Local Business Opportunity Commission certified Small Business Enterprises (SBE). The agency did meet these LSDBE requirements. This accomplishment is significant because the agency was allowed to continue to provide highly professional services to the decedents' families, law enforcement, health community, officials, and the community at large. Several funeral service businesses have become LSDBE vendors, which will allow us to set-aside a larger portion of our expendable total dollars. We shall continue to diligently direct our non-LSDBE vendors that appear to be eligible to apply for certification, which will allow us to continue to strive for higher annual set-aside goals.

Property Management:

Throughout 2004, OCME faced numerous challenges regarding its capital projects. OCME met with the Office of Property Management (OPM) regarding the projects, including: a) repair of the HVAC system; b) mitigating mold contamination; and c) various in-house renovations; and d) move to external facility for additional staff spacing. In the spring of 2004, OPM began the process to develop a Scope of Work that would entail a complete redesign of the HVAC system. OCME also initiated an assessment of the HVAC system's mold contamination. A study was completed in March and June of 2004 that did not reveal any immediate threat to the staff. Over the course of 2004, the HVAC system continued to cause water leakage and other facility damage. While this work was critical to the health and wellness of the employees, the work did not commence during 2004.

OCME also worked with OPM on in-house renovations to accommodate OCME spacing challenges for current staff and new hires. OPM worked with the Office of Contracting and Procurement (OCP) to hire a contractor for this work. However, spacing remained a challenge throughout 2004, as a contract for the in-house renovations was not implemented. In addition to in-house renovations, a building design was being developed for a move to an external space to provide workspace for the Fatality Review Committee staff. This would in turn provide additional spacing within OCME's core facility. These projects were ultimately forecast to be complete in early 2005.

Information Technology:
During FY 2004, OCME continued the development phase of a Forensic Analysis and Case Tracking System (FACTS). The system is used to log all information associated with a case from the time of the initial intake call through the release of remains to the final completion of the autopsy report. With an automated search, OCME can provide information on various aspects of a case, such as: a) whether it is pending jurisdiction or has been accepted; b) status of the autopsy or examination; c) the cause and manner of death; and d) other key case notes about the deceased or investigation. OCME also used FACTS to compile statistics for the agency's Monthly Performance Scorecard reports and its annual reports. OCME's FACTS is recognized as a national model. The development of this project will continue in 2005.

Risk Management:
The OCME Risk Assessment and Control Committee (RACC) met each month of 2004 to discuss maintenance and development of risk mitigation strategies and policies and specific employee or facility incidents that occurred during the year.

Labor Relations:
OCME's Labor Management Partnership Council, comprised of labor and management employees, was active in 2004 and completed several projects. The agency was awarded First Place-Small Agency for staff participation in the District's December 2003 Annual Toy Drive. In April 2004, OCME labor and management worked together to raise funds for the D.C. Government Employees 49th annual One Fund Drive and, as a result, the agency was recognized as the recipient of a Gold Award for achieving 100 – 199% of the agency dollar goal.

In October 2004, OCME sponsored an Employee Incentive Awards Program to recognize those employees that provided service to the agency and community above and beyond their duties. Employees also worked to provide Thanksgiving baskets to needy District families and to plan an Employee Holiday Celebration held in December 2004. As part of its LMPC initiatives, OCME also provided workshops and employee training in the areas of mass fatality, Disaster Mortuary Operational Response Team (DMORT) Procedures, the aspects of biological agents, and on diseases such as, Hepatitis B and Tuberculosis.

Emergency Response/Mass Fatality Planning:
Over the course of 2004, OCME actively pursued activities to support its mass fatality and emergency response planning. Of significance, the agency completed its first Mass Fatality Plan which establishes the framework for response to mass disasters; describes OCME's roles and responsibilities; and outlines OCME's relationships with local, federal and volunteer agencies that may support OCME in its functions. OCME's emergency response planning also included:

- the identification and procurement of possible resources and materials for readiness;
- staff training and participation in various emergency preparedness conferences;
- meetings with D.C. funeral directors and associations to assess space for body storage and concerns regarding the ability to cremate remains;
- outreach to university Pathology Departments and D.C. hospitals to collaborate on the autopsy and identification process during a mass disaster;
- participation in District National Response Drills;
- provision of workshops on biological and chemical agents and Disaster Mortuary Operational Response (DMORT) training; and
- Participation in Reservation 13 – Forensic Lab planning.

Given the scope of possible natural and terrorist's disasters and the ever-changing nature of these occurrences, an FTE dedicated to Mass Fatality Management is a must for the OCME. This person would be responsible for coordinating and overseeing all preparations and exercises as well as being cognizant of all current and new trends and materials to be of use for diagnostic purposes, disposition of remains and protection of staff. This FTE would also oversee documents (including plans and policies) ensuring rotation and timely replacements.

APPENDIX C

INTERNAL PARTNERSHIP

INTERNAL PARTNERSHIPS

OCME/MPD Natural Squad Collaborative

Several members of the MPD Natural Squad out of the Violent Crimes Unit have joined the Investigative Unit of OCME. This collaboration decreases the amount of time a uniformed officer must remain at the death scene waiting for funeral home personnel or OCME mortuary technicians to arrive to transport the deceased. These detectives supplement the OCME Medicolegal Investigations Unit allowing for a broad OCME presence at death scenes. This partnership has augmented the investigative skills of both the MLI's and the Detectives as they share ideas and discuss investigative techniques and approaches.

MPD officers are invaluable in expediting the identification process through access to FBI files. They also facilitate contact with their counterparts for neighboring jurisdictions thereby gathering necessary investigative information for case evaluation. This ability has proven extremely useful in the completion of some backlog cases.

Front (left to right): *Michelle Mack, Director of Investigations, Leanne Courtney, Medicolegal Investigator, Det. Randy Brooks, MPD Natural Squad, and Det. Ray Crawford, MPD Natural Squad (Standing).* ***Rear (left to right)****: Marybeth Petrasek, Medicolegal Investigator, Cheree Jamison, Medicolegal Investigator, Dr. Marie Pierre-Louis, Chief Medical Examiner and Det. Christopher MacWilliams, MPD Natural Squad.* ***OCME staff not shown:*** *Theresa Reiner-Massey, Medicolegal Investigator and Denise Lyles, Medicolegal Investigator.*

OCME/Wendt Center for Loss and Healing Collaborative

The OCME also has a unique relationship with the Wendt Center for Loss and Healing. The members of the Center are present at the office 8 hours a day, 365 days a year, providing grief counseling to family members and assisting with the facilitation of the identification process. Below is a summary of services and the collaboration that has been established to serve the constituents of the District of Columbia, from the Wendt Center's 2004 Annual Report.

Recover Program

THROUGH A UNIQUE COLLABORATION WITH THE DC Office of the Chief Medical Examiner (OCME), the Wendt Center created our nationally recognized Recover Program to assist families with the identification process of their deceased loved one. Launched in 1999, the Recover Program remains the only program in the United States that provides on-site support and counseling to individuals by professional grief counselors in a city morgue. Our staff is at the OCME seven days a week, 52 weeks of the year making us the frontline mental health provider for countless families who experience the tragic and sudden death of a family member.

"We accompanied our good friends when they had the most horrible appointment a parent could have — to go to the Coroner's office and identify their child who had been killed in a tragic accident. Your counselor's gentleness in dealing with them made the situation bearable. Hopefully, not many people will ever face this kind of tragedy, but the fact that you are there and are comforting people where and when they most need it is gratifying."

— INDIVIDUAL MET AT THE OFFICE OF THE CHIEF MEDICAL EXAMINER

In addition to offering immediate comfort and support, Wendt Center grief therapists distributed information about the Wendt Center and other community agencies' services; a variety of grief-related materials with local and national resources; Recover cards with information on children's grief, suicide, homicide and child loss; and brochures on crime victims' programs and resources. Our Resource area in the OCME waiting room offers families educational information on the grief process and children's books to assist them and their children.

The unexpected, often violent death, of a loved one leaves many of those who come to the morgue overwhelmed with grief. Our special emphasis on educating and supporting children and adolescents is intended to lessen any traumatic effects and subsequent emotional or behavioral challenges that can come from unresolved grief. Our Recover Program has been recognized and promoted by the National Child Traumatic Stress Network as a "best practice" model in responding to traumatic death.

From top to bottom:
Counselor meeting with client at the OCME.
Resource area in waiting room at the OCME.
Outside view of the OCME.

***Note**: This is a page from the 2004 Wendt Center for Loss and Healings Annual Report and is used in the OCME 2004 Annual Report with their expressed permission.*

APPENDIX D

OTHER MAJOR ACTIVITIES

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

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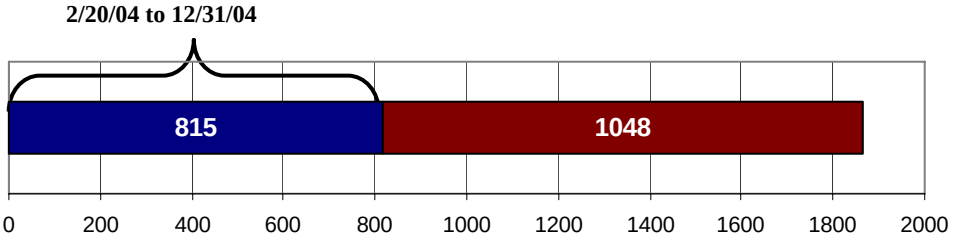
OTHER MAJOR ACTIVITIES

Backlog

Included in this year's annual report is a presentation on the autopsy report backlog, which has plagued the OCME for years. This backlog accumulated during the years 1996 through 2003 due to various factors, one of the most prevalent being chronic staff shortages, and rapid staff turnover. In February of 2004 the OCME performed a manual audit to determine the exact number of cases associated with the backlog so that a plan of action could be established. One Thousand Eight Hundred Sixty Three (1,863) cases were initially identified in February 2004. To determine cause and manner of death and complete these reports, required review of the following: written reports (sometimes handwritten notes on body diagrams), photographs and radiographs (x-rays), and in some cases research of hospital or investigative reports dating back to 1996. Nevertheless, due to the valiant efforts of the Medical and support staff by December 31, 2004, Eight Hundred and Fifteen (815) backlog cases had been completed as outlined below.

Year	Initial Backlog as of 2/20/04	Cases completed as of 12/31/04	Backlog Remaining YTD	% of Total Cases Completed YTD
1996	2	2	0	**100%**
1997	85	53	32	**62%**
1998	19	19	0	**100%**
1999	201	81	120	**40%**
2000	286	30	256	**10%**
2001	257	43	214	**17%**
2002	333	50	283	**15%**
2003	680	537	143	**79%**
TOTALS	**1863**	**815**	**1048**	**44%**

Table 1: Backlog of Autopsy Reports by Year (1996-2003)



Initial Backlog of 1,863 Cases (as of 2/20/04)
1996-2003

Court Testimony

A parameter not often considered in evaluating the Medical Examiners workload is time spent in pre-trial conferences, depositions and expert testimony provided in civil and criminal litigations. OCME includes tabulated data on the time spent on such activities in calendar year 2004 and will include this data in subsequent annual reports.

Type of Judicial Service	Number of Cases
Court Testimony	54
Depositions	27
Grand Jury	1
Other	2
Pre-trial Meetings	96
Total	**180**

Court Services by Jurisdiction	Number of Cases
DC	148
Maryland	3
Virginia	2
Total	**153**

Court Services by Type	Number of Cases
Civil	11
Criminal	139
Family	2
Hearing	0
Other	1
Total	**153**

Note: The Chief Medical Examiner provides expert court services for most of the cases where the Medical Examiner is no longer with the District Government. For 2004 these additional services represented 25% of the CME's total caseload.

Education

OCME continues to welcome students and residents from area universities and hospitals for their teaching requirements. In addition the office has held numerous conferences, lectures and presentations. We also participated in the 2004 Career Day Activities hosted by the local public schools here in the District of Columbia, and hosted or was invited to a medical institution or conference to provide the following major conferences, lectures and presentations:

1) 2004 ICITAP Basic Homicide Investigation Course – 4-day course hosted by OCME
2) Operation Prevent Auto Theft – Monthly lecture and tour (seasonal)
3) Youth Support Employment Program - Lecture
4) DC Medical Examiner's Office Familiarization Training for Metro Transit Police Officers.
5) International Symposium of Forensic Pathology: Firearms and Explosives
   Barcelona, Spain – 1-day Symposium
6) National Youth Leadership Conference on Medicine - Lecture
7) Marian Koshland Science Museum of the National Academy of Sciences – Lecture
8) Partners in Education with Arlington Public Schools – Annual Presentation

Additional Educational services provided by the Toxicology Unit

Lectures:

1) FBI Laboratory Symposium on Forensic Toxicology, Washington D.C. – 2 day symposium
2) Society of Forensic Toxicologists Annual Meeting, Washington D.C. – 2 presentations
3) Department of Criminal Justice, Indiana University, Indiana – 4-day course
4) Justice Program, School of Public Affairs, American University, Washington D.C. – lecture
5) Arizona Department of Public Safety, Crime Laboratory, Arizona – 5-day course.

Peer-reviewed publications:

1) Drugs and Human Performance Fact Sheets – U.S. Department of Transportation, *NHTSA Technical Report No. DOT HS 809 725*, April 2004.
2) Suspected GHB Overdoses in the Emergency Department – Journal of Analytical Toxicology, 2004.
3) Addicted to Driving Under the Influence – a GHB/GBL Case Report – Journal of Analytical Toxicology, 2004.

Overview Of Identifications and the Public Disposition Process

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

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

Bodies examined at OCME are stored by the agency until families make funeral arrangements. Usually this occurs in a matter of days. However a portion of the population remains as "Unclaimed bodies" and have to be disposed of by the agency. In addition the OCME provides storage of remains for nursing homes, hospices and area hospitals. A minimal one-time fee is charged to these facilities and the remains are kept until family members are located. Unclaimed remains from hospitals are also by regulation to be stored and disposed of by OCME (DC Code §5-1411). The process for which unclaimed bodies are handled is called "Public Dispositions." After a 30-day waiting period and after all efforts to locate family members are exhausted the OCME makes final arrangements for these bodies through contracts with local funeral homes. Unclaimed identified bodies are cremated, whereas unclaimed unidentified bodies are buried through contracts with local funeral directors, unless there exists a concern for public health and safety that would require cremation; then additional measures would be taken to ensure proper identification.

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

APPENDIX E

PROGRAM LEGISLATION/MAYORAL ORDERS

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

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OCME, DC Law 13-172, codified at

DC Official Code §5-1401 et seq (2001)

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CFRC Legislation and Mayoral Order 98-67

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MRDD FRC Mayoral Order 2005-143

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APPENDIX F

2004 OCME STAFF LISTING

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OCME FTE POSITIONS

Of the 76 authorized FTE's, OCME had funding for only 62 FTE's, of which 55 were filled. The following table shows the number of employees by position title.

Position Title	Number of FTE Positions
Administrative Support Assistant	1
Autopsy Assistants (incl. Supervisor)	12
Chief & Deputy Medical Examiners	8
Chief of Staff	1
Clerical Assistant	2
Community Health Nurse	1
Computer Specialist	1
Custodial Worker	1
Executive Assistant	1
Forensic Photographer	2
General Counsel	1
HR Advisor	1
Intake Assistants	10
Maintenance Foreman	1
Management Services Officer	1
Medical Records Tech (incl. Supervisor)	4
Medical Technologist	1
Medical Transcriptionist	3
Medicolegal Investigator (incl. Director)	7
Motor Vehicle Operator	1
Program Assistant	2
Secretary	1
Social Worker Program Specialist	1
Staff Assistant	2
Statistic Assistant	1
Supervisory Program Coordinator	2
Toxicologist (incl. Chief)	7
TOTAL	**76**

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