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

ANNUAL REPORT
2005

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

Edward D. Reiskin
Deputy Mayor for Public Safety and Justice

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

DISTRICT OF COLUMBIA
OFFICE OF THE CHIEF MEDICAL EXAMINER

2005 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

December 2006

A MESSAGE FROM THE CHIEF MEDICAL EXAMINER

Calendar Year 2005 was a year of many accomplishments for the Office of the Chief Medical Examiner (OCME). Tremendous improvements were made in the areas of staff and management relations, customer service, policies and procedures and death investigations. Most significantly the historical backlog of autopsy reports (initial backlog 1,997), which extended from 1993 through 2003 was reduced by 34%, which represented 679 reports completed in FY 05. This is an important achievement for the public in general since many cases needed the cause and manner of death determined in order to allow for insurance payments to survivors.

Other accomplishments should be mentioned. We expanded our vehicular fleet to include smaller vans, which easily navigate through the many narrow alley's in the District; long awaited regulations that govern the duties and responsibilities of the OCME as a sub-agency reporting directly to the Mayor were published; regulations were also published for the Child Fatality Review Committee; a new program was established to oversee and consolidate the work of all the Fatality Review Committees; the agency received an "*Outstanding 2005 Pothole Project Award*," which recognized the agency for providing superb Customer Service, a direct reflection of improved management and employee relations; and a pamphlet was developed that explains the process of the office for the benefit of the public.

I congratulate the dedication of the OCME staff for these accomplishments in the face of many challenges.

We continue to report on Weight Distributions in our deceased population, using the Body Mass Index (BMI). The level of BMI is compared to the incidence of Hypertensive and Arteriosclerotic Cardiovascular Disease by age and race. The goal of these special reports is to alert and educate the public and the government about different trends in the District, thereby, aiding in the provision of adequate services and the development of outreach programs.

We acknowledge the support of Mayor Anthony Williams, the Deputy Mayor for Public Safety and Justice, the City Administrator, and the Council for the District of Columbia. We particularly wish to thank former Deputy Mayor Margret Kellems and the former Chair of the Committee on the Judiciary, Councilmember Kathy Patterson for the attention and support they gave to the OCME.

Sincerely,

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

Executive Summary

The Government of the District of Columbia Office of the Chief Medical Examiner (OCME) is pleased to present its Fourteenth Annual Report. This Report covers data that resulted from the investigation of 3,145 deaths that occurred in the District of Columbia during the Calendar Year (CY) 2005. Report data will be included for: Weight Distributions, Internal Partnerships, Identification Process, and Agency Management. Other Major Activities include - Backlog Reporting, Expert Witness and Court Tracking, Mass Casualties, and Educational Lectures and Presentations.

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

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

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

During 2005, 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 provided academic training to medical students and pathology residents from local hospitals, and students from different universities located locally, regionally and abroad, from programs and scientific disciplines such as physician assistance, forensic science and toxicology. The OCME also provided training for members of MPD, the United States Attorney's office and soldiers of the Marine Corps.

As stated above there were a total of 3,145 deaths reported and investigated by the OCME, of which 1,542 were declined, and 1,603 were accepted for further examination. Of those, 1,142 were autopsied (Full and Partials). The OCME also processed 1,786 cremation requests that were submitted for approval. The following table illustrates the number of full and partial autopsy examinations, external examinations, and medical record reviews performed by "Manner of Death".

2005 Medical Examiner Cases by Manner of Death

Manner	Full Autopsy Examinations	Partial Autopsy Examination	External Examinations	Medical Record Reviews	Total
Homicide	216	0	0	1	217
Suicide	43	0	1	0	44
Accident	264	11	109	6	390
Natural	486	61	319	4	870
Undetermined	53	0	2	1	56
Stillbirth	8	0	5	0	13
Pending	0	0	0	0	0
Total	**1070**	**72**	**436**	**12**	**1590**

Note: "*Non-Human Remains*" (n=10) and "*Human Parts/Skeletal Remains*" (3) are not included in this table.

SUMMARY OF FINDINGS FOR MANNER OF DEATH

HOMICIDES: The OCME investigated 217 homicides in the CY 2005. 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 March and August.
Toxicology Findings: Toxicology testing was requested for 215 of the 217 Homicide cases investigated. Drugs were present in 118 of the homicide cases investigated. The most commonly detected drugs in homicide cases were: Ethanol (N=69), PCP (34), Cocaine (29), Ecstasy and/or Ecstasy related drugs (10), and Morphine (7).

SUICIDES: The OCME investigated 44 suicides in the CY 2005. This report reveals that deaths by suicide were more prevalent in white males and in persons between the ages of 20-29. Blacks closely followed Whites in number again this year. Peak incidents occurred in July, September, and October.
Toxicology Findings: Toxicology testing was requested for 43 of the 44 Suicide cases investigated. Overall, drugs were present in 29 of the suicide cases investigated. The most commonly detected drugs were: Ethanol (N=15), Sertraline (3), and Citalopram (3). More prescription medications were detected in suicide cases than in homicide cases.

ACCIDENTS: The OCME investigated 390 accidents in the CY 2005. Of the 390 cases investigated, 226 cases were the result of trauma, of which 63 were traffic related deaths; 122 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 September and December.
Overall Toxicology Findings: Toxicology testing was requested for 267 of the 390 Accident cases investigated, and drugs were present in 194 of these cases. The most commonly detected drugs were: Cocaine (N=87), Ethanol (61), Morphine (56), and Methadone (22).
Toxicology Findings for Traffic-related accidents: Toxicology testing was requested for 55 of the 63 Traffic Related Accidents, and drugs were present in 31 of these cases. The most commonly detected drugs were: Ethanol (N=16), Cocaine (4), and Morphine (4). In the 16 traffic related deaths positive for ethanol, the average Blood Alcohol Concentration was 0.15 %. The legal limit for Blood Alcohol Concentration in the District of Columbia is 0.08% while driving.

Toxicology Findings for Drug Overdose accidents: Toxicology testing was requested for 119 of the 122 of the Drug Overdose deaths, and drugs were present in 110 of these cases. The most commonly detected drugs were: Cocaine (N= 76), Morphine (43), Ethanol (27), Methadone (18), Citalopram (8), Oxycodone (7) and Amitriptyline (5). The three cases where tox was not requested, and the nine cases where toxicology results were negative are due in part to delayed deaths that occurred after hospitalization.

NATURAL DEATHS: The OCME investigated 870 Natural deaths in CY 2005. This report reveals that the leading cause of death in Natural cases is Cardiovascular Disease with 589 deaths, followed by Complications of Alcoholism with 62 deaths.
Toxicology Findings: Toxicology testing was requested for 521 of the 870 Natural cases investigated. Drugs were present in 259 of the Natural cases investigated. The most commonly detected drugs were: Ethanol (N=84), Cocaine (57), Morphine (27), Codeine (12), Methadone (10), Amitriptyline (9), Diazapam (9), Oxycodone (8) and Sertraline (8).

UNDETERMINED: The OCME investigated 56 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 52 of the 56 Undetermined deaths investigated. Drugs were present in 24 of the Undetermined cases investigated. The most commonly detected drugs were: Ethanol (N=14), and Cocaine (7), Phencyclidine (PCP) (2), Morphine (5), and Carbon Monoxide (CO) (2).

STILLBIRTHS: The OCME investigated 13 Stillbirth deaths in CY 2005.
Toxicology Findings: Toxicology testing was requested for 10 of the 13 Stillbirth cases investigated. Overall, drugs were present in 6 of the cases investigated; 4 cases had cocaine present; 1 case was positive for amantadine and 1 case was positive for phencyclidine (PCP), cocaine and nevirapine.

WEIGHT DISTRIBUTIONS

This year OCME will include report data on Body Mass Index (BMI). BMI is a mathematical formula used to determine one's ratio of body height to body weight, and which correlates strongly (in adults) with body fat content. The level of BMI is compared to age and race, along with the incidence of Hypertensive and Arteriosclerotic Cardiovascular Disease by age.

SUMMARY OF SIGNIFICANT APPENDICES

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

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

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

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

OFFICE OF THE CHIEF MEDICAL EXAMINER

2005 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 2005. 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 and law enforcement 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 agencies, or the United States Attorney's Office requests, or a court orders investigation; and 12) dead bodies brought within the District without proper medical certification. (See Appendix E – (D.C. Law 13-172), DC Official Code §5-1401 et seq. (2001 and Supp.)).

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 cases where the incident originated in another jurisdiction, but the death occurred within the District of Columbia. 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 (i.e. neuropathology, and cardiology) are requested when appropriate.

The "*Fatality Review Program*" includes the Child Fatality Review Committee (CFRC), the Mental Retardation and Developmental Disabilities Fatality Review Committee (MRDD FRC) and the newly established Domestic Violence Fatality Review Board (DVFRB). The 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 OCME's 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 easily be 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, the Federal Bureau of Investigation (FBI), and has trained its technical staff to fingerprint the decedents. OCME also uses comparative radiology and/or DNA analysis as necessary to ensure identification.

2.0 – Medical Examiner Investigations and Medical Legal Autopsies

Overview of Cases Reported and Investigated

During the Calendar Year (CY) 2005, 3,145 cases were reported to and investigated by the Office of the Chief Medical Examiner (OCME). 1,542 of these cases were declined by OCME, and 1,603 cases were accepted for further examination, and of the accepted cases 1,142 were autopsied. OCME also had a total of 1,827 cremation requests submitted for approval, and of the requested cremations 1,749 were approved.

Total Number of Cases Reported and Investigated by the OCME	**3,145**
Total Number of Declined Cases	**1,542**
Percent of Cases Investigated	*49.03%*
Total Number of Cases Accepted for Further Investigation	**1,603**
Percent of Cases Investigated	*50.96%*
Total Number of Autopsies (full and partial)	**1,142**
Percent of Cases Accepted	*36.31%*
Total Number of Cremation Requests Approved	**1,749**
Percent of Cases Reported	*55.61%*

Breakdown of Cases Accepted and Investigated

Total Number of Cases Accepted and Investigated further	**1,603**
Total Number of Autopsies (full and partial)	**1,142**
Percent of Cases Accepted	*71.24%*
Number of External Examinations	**449**
Percent of Cases Accepted	*28.01%*
Number of Non-Human Remains *	**10**
Percent of Cases Accepted	*0.62%*
Number of Medical Record Review *	**12**
Percent of Cases Accepted	*0.75%*
Number of Human Parts/Skeletal Remains	**3**
Percent of Cases Accepted	*0.19%*

*** 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	Cases Accepted	Autopsies
January	167	114
February	146	92
March	159	105
April	129	97
May	105	70
June	144	108
July	120	88
August	131	97
September	133	101
October	102	73
November	134	101
December	133	96
Total	**1603**	**1142**

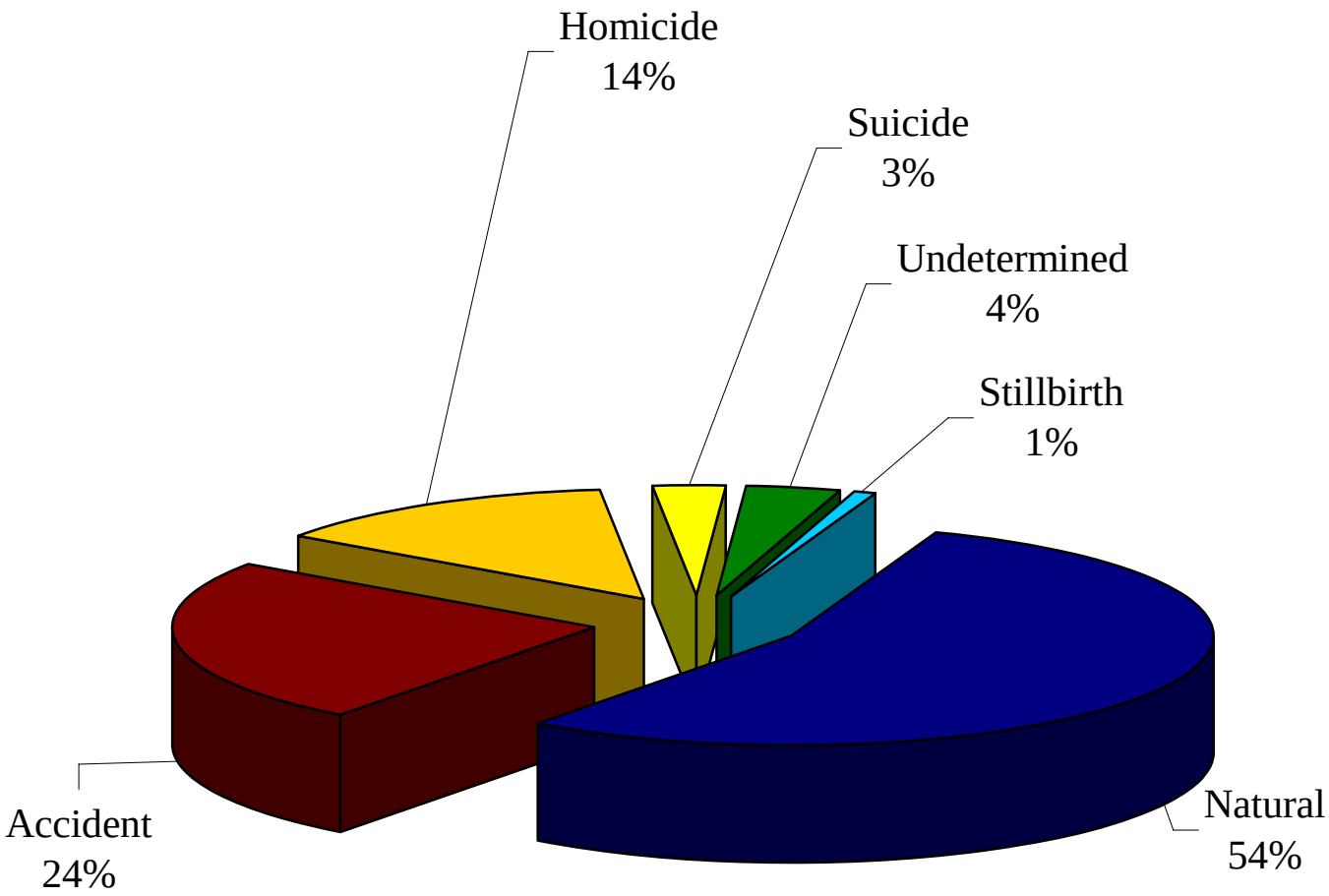
Note: The total for "Autopsies" includes Partial Autopsies.

Medical Examiner Case Investigations by Manner of Death

Manner	Full Autopsy Examinations	Partial Autopsy Examinations	External Examinations	Review of Medical Records	Total
Accident	264	11	109	6	390
Homicide	216	0	0	1	217
Natural	486	61	319	4	870
Pending	0	0	0	0	0
Stillbirth	8	0	5	0	13
Suicide	43	0	1	0	44
Undetermined	53	0	2	1	56
Total	**1070**	**72**	**436**	**12**	**1590**

Note: The above table does not include "*Human Parts/Skeletal Remains* (n=3)", "*Non-Human Remains* (n=10)."

Pie Chart – Total 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 drugs and prescription medications, and an additional screen for various illicit drugs, and prescription and 'over-the-counter' medications. All drugs of significance are then confirmed by further testing. Typical specimens received for each case 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 then one substance. The alcohol and/or drugs detected did not necessarily cause or contribute to death. Drugs that are excluded form this report include many of the 'over-the-counter' medications and substances 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 Postmortem Cases
Total	**1108**	
Negative	477	43.1 %
Positive	631	56.9 %

Overall, drugs were absent in 477 postmortem cases; 353 cases had one drug present; 181 cases had 2 drugs present; 66 cases had 3 drugs present; 19 cases had 4 drugs present; 9 cases had 5 drugs present; 2 cases had 6 drugs present; and 1 case had 7 drugs present.

Postmortem Toxicology - Most Commonly Detected Drugs

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

Name of Drug	Number of Cases	% of Postmortem Cases
Ethanol	242	21.8 %
Cocaine	187	16.9 %
Morphine[1]	94	8.5 %
Phencyclidine (PCP)	44	4.0 %
Methadone	39	3.5 %
Codeine	24	2.2 %
Diazepam	23	2.1 %
Amitriptyline	20	1.8 %
Citalopram	19	1.7 %
Oxycodone	18	1.6 %
Sertraline	18	1.6 %
MDMA and/or MDA[2]	17	1.5 %
Carbon Monoxide (CO)	12	1.1 %
Methamphetamine	7	< 1.0 %

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

[2] MDMA/MDA refers to Ecstasy and related drugs

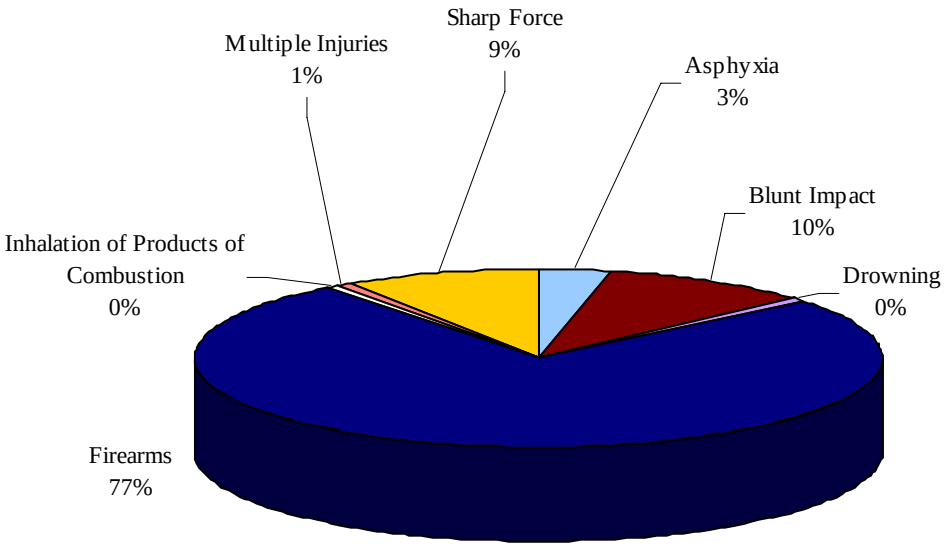
2.1 - HOMICIDES

The OCME investigated 217 homicides in the CY 2005. The following tables and graphs provide a distribution by cause, month, race, gender and age group. Death by homicidal acts is more prevalent in blacks males, and the age group 20-29. The weapon of choice remains to be firearms. The peak incidents occurred in March and August.

Homicides by Cause of Death

Cause	Number of Deaths	% of Total Homicides
Firearms	164	75.58%
Blunt Impact	22	10.14%
Sharp Force	20	9.22%
Asphyxia	7	3.23%
Multiple Injuries	2	0.92%
Drowning	1	0.46%
Inhalation of Products of Combustion	1	0.46%
Total	**217**	**100%**

Pie Chart – Homicides by Cause of Death

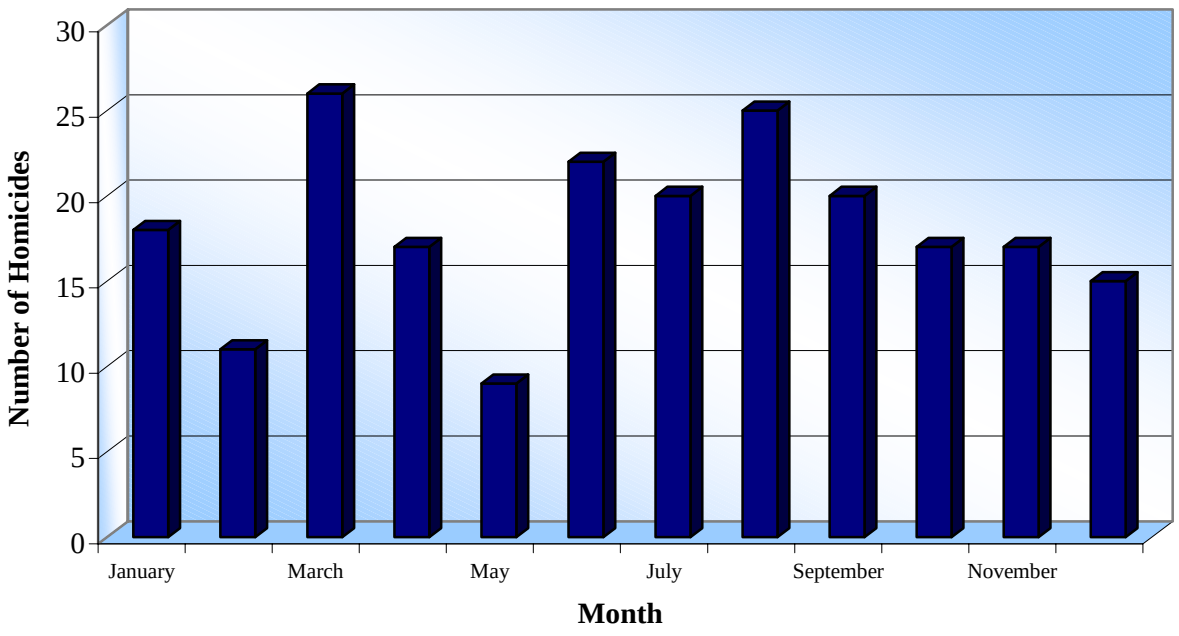


.**Note:** The percentages in the "Pie Charts" throughout this report are rounded up or down to nearest whole number

Homicides by Month

Month	Number of Homicides	% of Homicides
January	18	8.29%
February	11	5.07%
March	26	11.98%
April	17	7.83%
May	9	4.15%
June	22	10.14%
July	20	9.22%
August	25	11.52%
September	20	9.22%
October	17	7.83%
November	17	7.83%
December	15	6.91%
Total	**217**	**100%**

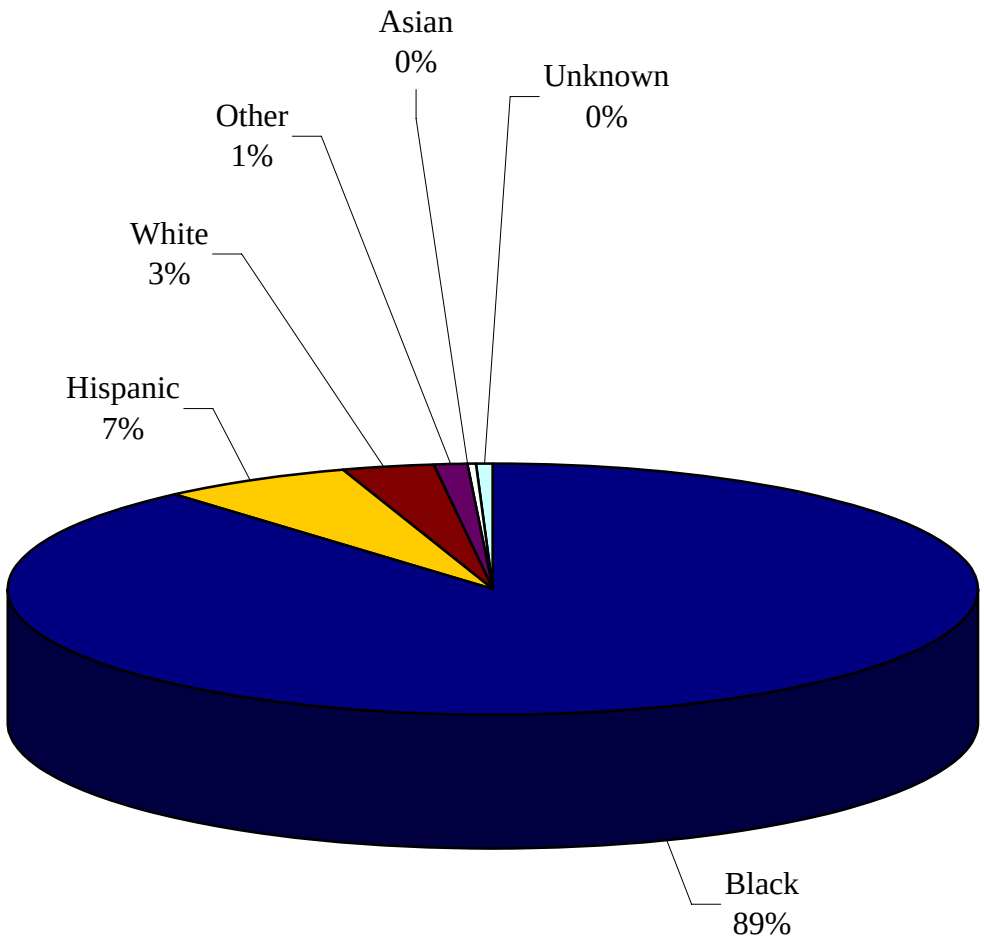
Graph - Homicides by Month



Homicides by Race

Race/Ethnicity	Number of Homicides	% of Homicides
Black	192	88.48%
Hispanic	14	6.45%
White	7	3.23%
Other	2	0.92%
Asian	1	0.46%
Unknown	1	0.46%
Total	**217**	**100.00%**

Chart - Number of Homicides by Race



Homicides by Gender

Gender	Number of Homicides	% of Homicides
Female	20	9.22%
Male	197	90.78%
Total	**217**	**100.00%**

Homicides by Race/Ethnicity and Gender

Race/Ethnicity by Gender	Number of Homicides	% of Homicides
Asian	**1**	**0.46%**
Female	0	0%
Male	1	0.46%
Black	**192**	**88.48%**
Female	17	7.83%
Male	175	80.65%
Hispanic	**14**	**6.45%**
Female	1	0.46%
Male	13	5.99%
Other	**2**	**0.92%**
Female	0	0%
Male	2	0.92%
Unknown	**1**	**0.46**
Female	0	0%
Male	1	0.46
White	**7**	**3.23%**
Female	2	0.92%
Male	5	2.31%
Total	**217**	**100.00%**

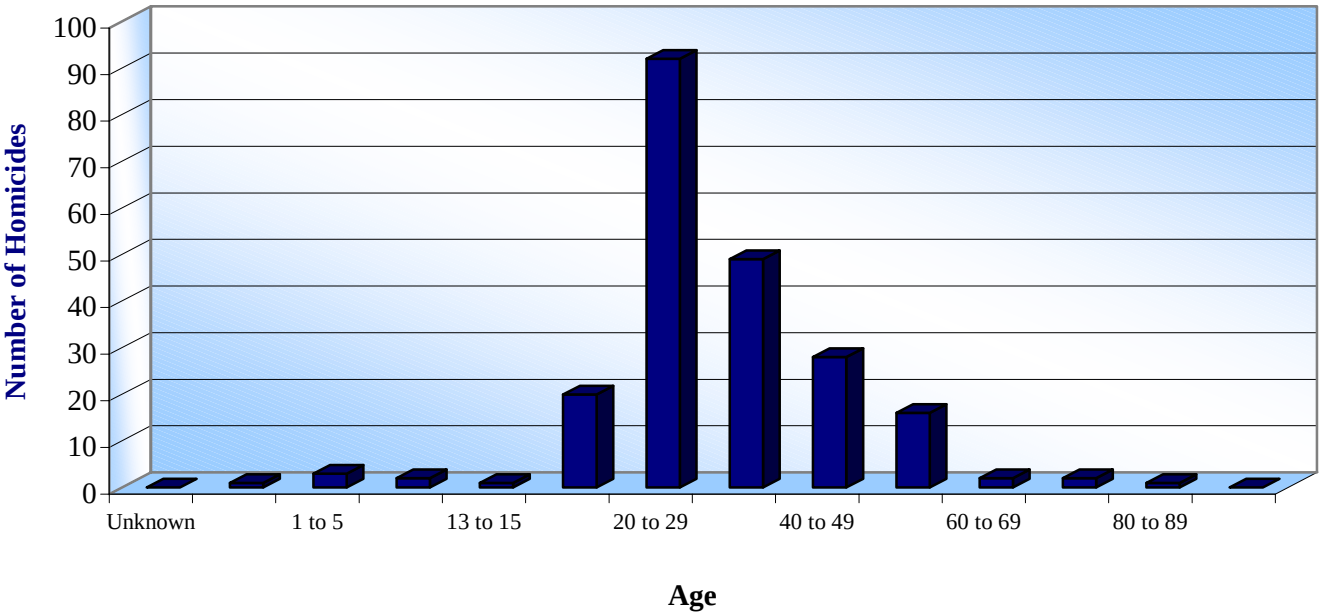
Homicides by Jurisdiction of Incident

Jurisdiction of Incident	Number of Homicides
DC	214
MD	3
Total	**217**

Homicides by Age

Age	Number of Homicides	% of Homicides
Under 1	1	0.46%
1 to 5	3	1.38%
6 to 12	2	0.92%
13 to 15	1	0.46%
16 to 19	20	9.22%
20 to 29	92	42.40%
30 to 39	49	22.58%
40 to 49	28	12.90%
50 to 59	16	7.37%
60 to 69	2	0.92%
70 to 79	2	0.92%
80 to 89	1	0.46%
90 +	0	0.00%
Total	**217**	**100.00%**

Chart - Homicides by Age Group



Toxicology Findings for Homicide Cases

Of the 217 Homicides investigated by OCME, toxicology analysis was performed on 215 cases. Overall, drugs were absent in 97 homicide cases; 67 cases had one drug present; 42 cases had 2 drugs present; 6 cases had 3 drugs present; 2 cases had 4 drugs presented; and 1 case had 5 drugs present.

Description	Number of Cases	% of Cases
N=	**215**	
Negative	97	45.1%
Positive	118	54.9%

The most commonly detected drugs in the homicide cases were:

Name of Drug	Number of Cases	% of Homicide Cases
Ethanol	69	32.1%
PCP	34	15.8%
Cocaine	29	13.5%
MDMA/MDA	10	4.7%
Morphine	7	3.3%
Methadone	5	2.3%
Methamphetamine	4	1.9%

Ethanol was detected in 69 Homicide cases with blood concentrations ranging from 0.02 – 0.30 % (average 0.12 %, median 0.12 %).

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

a) ethanol (0.12 %), methamphetamine, Ecstasy, phencyclidine (PCP), and diphenhydramine
b) ethanol (0.12 %), methamphetamine, Ecstasy, and phencyclidine (PCP); and
c) ethanol (0.05 %), methamphetamine, Ecstasy, and ephedrine

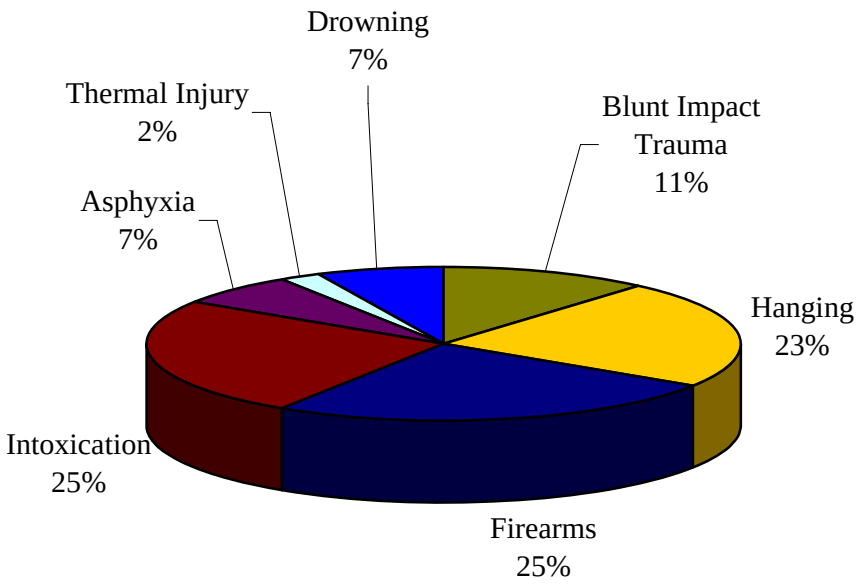
2.2 – SUICIDES

The OCME investigated 44 suicides in CY 2005. Deaths by suicidal acts were more prevalent in males, black and whites (equal in number), and in persons between the ages of 20-29. Peaks incidents occurred in July, September and October.

Suicides by Cause of Death

Cause	Number of Suicides	% of Total Suicides
Firearms	11	25.00%
Intoxication	11	25.00%
Hanging	10	22.73%
Blunt impact	5	11.36%
Asphyxia	3	6.82%
Drowning	3	6.82%
Thermal Injury	1	2.27%
Total	**44**	**100.00%**

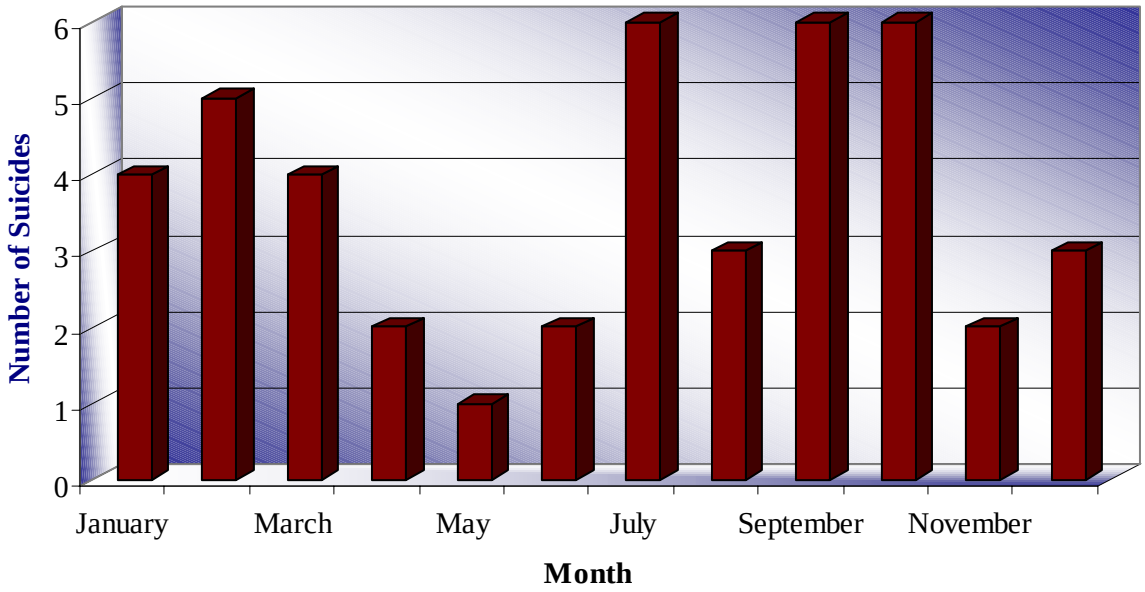
Pie Chart - Suicides by Cause of Death



Suicides by Month

Month	Number of Suicides	% of Suicides
January	4	9.09%
February	5	11.36%
March	4	9.09%
April	2	4.55%
May	1	2.27%
June	2	4.55%
July	6	13.64%
August	3	6.82%
September	6	13.64%
October	6	13.64%
November	2	4.55%
December	3	6.82%
Total	**44**	**100.00%**

Chart- Suicides by Month



Suicide by Race/Ethnicity

Race/Ethnicity	Number of Suicides	% of Suicides
White	20	45.45%
Black	20	45.45%
Hispanic	1	2.27%
Asian	2	4.55%
Other	0	0.00%
Unknown	1	2.27%
Total	**44**	**100.00%**

Suicides by Race/Ethnicity and Gender

Race/Ethnicity by Gender	Number of Suicides	% of Suicides
Asian	**2**	**4.55%**
Female	0	0.00%
Male	2	4.55%
Black	**20**	**45.45%**
Female	6	13.64%
Male	14	36.36%
Hispanic	**1**	**2.27%**
Female	1	2.27%
Male	0	0.00%
Other	**0**	**0.00%**
Female	0	0.00%
Male	0	0.00%
Unknown	**1**	**2.27%**
Female	0	0.00%
Male	1	2.27%
White	**20**	**45.45%**
Female	5	11.36%
Male	15	34.09%
Total	**44**	**100.00%**

Suicides by Gender

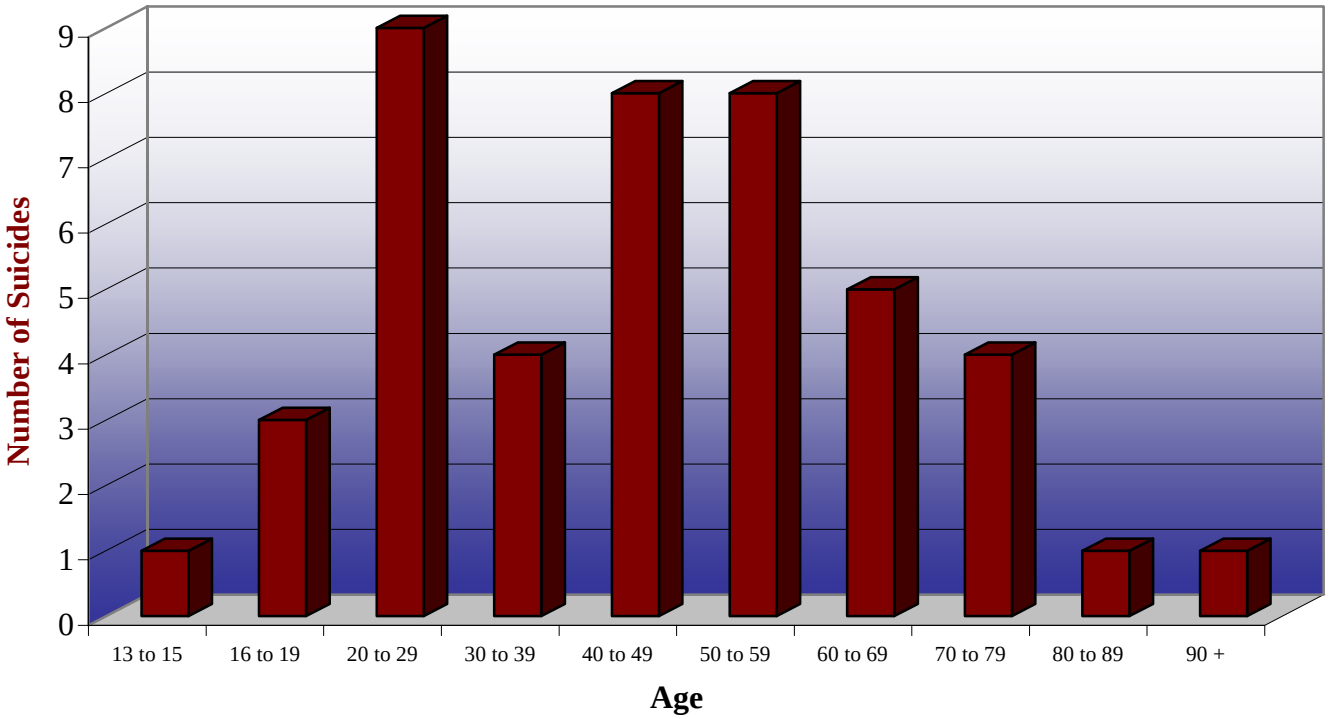
Gender	Number of Suicides	% of Suicides
Female	12	27.27%
Male	32	72.73%
Total	**44**	**100.00%**

Suicide by Age

Age	Number of Suicides	% of Suicides
13 to 15	1	2.27%
16 to 19	3	6.82%
20 to 29	9	20.45%
30 to 39	4	9.09%
40 to 49	8	18.18%
50 to 59	8	18.18%
60 to 69	5	11.36%
70 to 79	4	9.09%
80 to 89	1	2.27%
90 +	1	2.27%
Total	**44**	**100.00%**

Note: There were zero (0) suicides for persons age 12 and under.

Chart - Suicides by Age



Toxicology Findings for Suicide Cases

Of the 44 Suicide deaths investigated by OCME, toxicology analysis was performed on 43 cases. Overall, drugs were absent in 14 suicide cases; 16 cases had one drug present; 6 cases had 2 drugs present; 4 cases had 3 drugs present; 1 case had 4 drugs detected; 1 case had 5 drugs detected; and 1 case had 6 drugs present.

Description	Number of Cases	% of Cases
N=	**43**	
Negative	14	32.6%
Positive	29	67.4%

The most commonly detected drugs in suicide cases were:

Name of Drug	Number of Cases	% of Suicide Cases
Ethanol	15	34.9%
Citalopram	3	6.9%
Sertraline	3	6.9%
Cocaine	2	4.7%
Morphine	2	4.7%
Phencyclidine (PCP)	2	4.7%
Hydrocodone	2	4.7%
Propoxyphene	2	4.7%
Amitriptyline	2	4.7%
Doxepin	2	4.7%
Diazepam	2	4.7%
Doxylamine	2	4.7%

Ethanol was detected in 15 Suicide cases with blood concentrations ranging from 0.02 – 0.23 % (average 0.08 %, median 0.08 %).

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

a) ethanol (0.03 %), cocaine, olanzapine, mirtazepine, venlafaxine, and citalopram
b) ethanol (0.04 %), morphine, meperidine, phenobarbital, and acetaminophen; and
c) ethanol (0.09 %), sertraline, diazepam, and diphenhydramine

Overall, more prescription medications were detected in the suicide cases than in the homicide cases, in particular antidepressant, antipsychotic, benzodiazepines and analgesic medications.

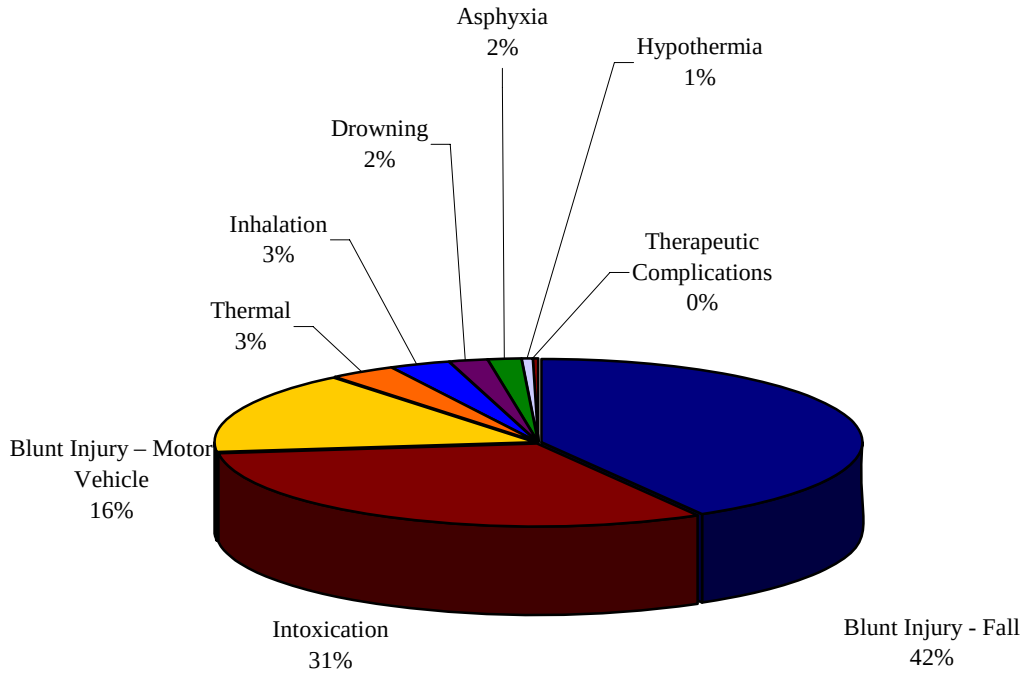
2.3 - ACCIDENTS

OCME investigated 390 accident cases in CY 2005. Out of the 390 cases investigated, 226 cases were the result of trauma, and of those 63 were traffic accidents. 122 cases were the direct result of illicit drug use. Accidental Deaths were more prevalent in males, blacks and the age group 40 – 49 years. The peak incident occurred in January.

Accidents by Cause of Death

Cause	Number of Deaths	% of Total Accidents
Blunt Injury - Fall	163	41.79 %
Intoxication	122	31.28 %
Blunt Injury – Motor Vehicle	63	16.15%
Thermal Injury	13	3.33%
Inhalation	12	3.08%
Asphyxia	7	1.79%
Drowning	7	1.79%
Hypothermia	2	0.51%
Therapeutic Complications	1	0.26%
Total	**390**	**100 %**

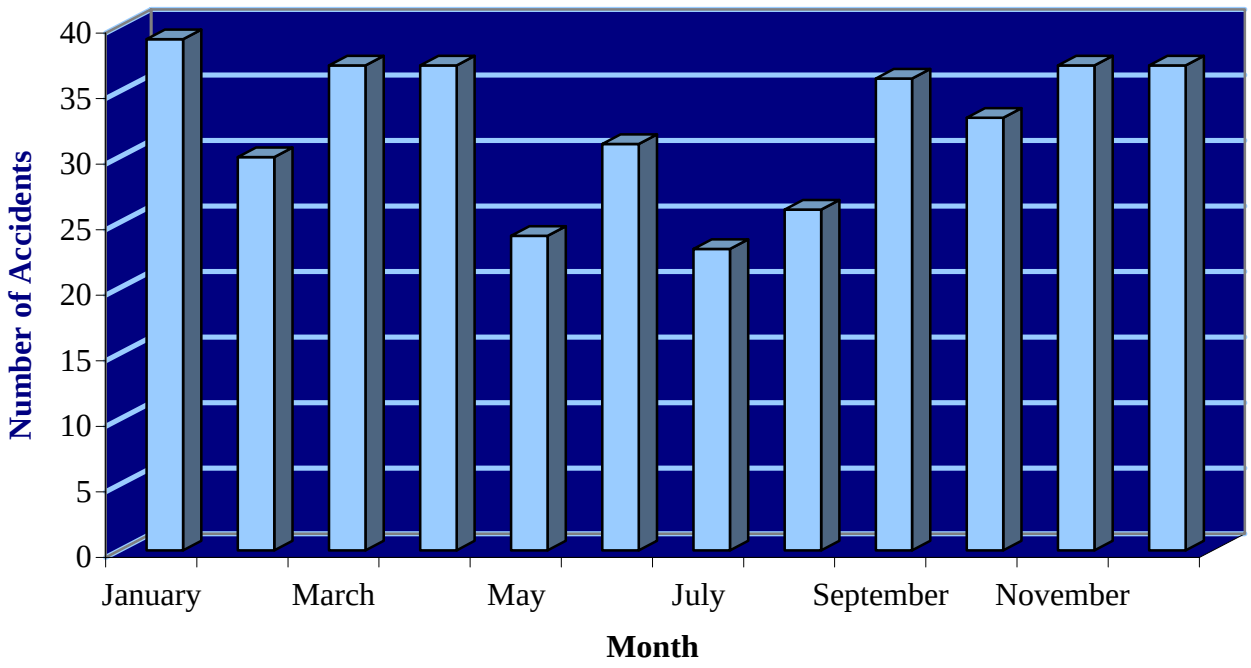
Pie Chart - Accidents by Cause of Death



Accidents by Month

Month	Number of Deaths	% of Accidents
January	39	10.00%
February	30	7.69%
March	37	9.49%
April	37	9.49%
May	24	6.15%
June	31	7.95%
July	23	5.90%
August	26	6.67%
September	36	9.23%
October	33	8.46%
November	37	9.49%
December	37	9.49%
Total	**390**	**100.00%**

Chart - Accidents by Month of Death



Accidental Deaths by Race

Race/Ethnicity	Number of Accidents	% of Accidents
Black	214	54.87%
White	134	34.36%
Hispanic	30	7.69%
Asian	6	1.54%
Unknown	3	0.77%
Other	2	0.51%
Pacific Islander	1	0.26%
Total	**390**	**100.00%**

Accidental Deaths by Gender

Gender	Number of Accidents	% of Accidents
Female	134	34.36%
Male	256	65.64%
Total	**390**	**100.00%**

Accidental Deaths by Age

Age	Number of Accidents	% of Accidents
Age Unknown	2	0.51%
Under 1	3	0.77%
1 to 5	4	1.03%
6 to 12	5	1.28%
13 to 15	2	0.51%
16 to 19	11	2.82%
20 to 29	33	8.46%
30 to 39	45	11.54%
40 to 49	65	16.67%
50 to 59	74	18.97%
60 to 69	32	8.21%
70 to 79	45	11.54%
80 to 89	50	12.82%
90 +	19	4.87%
Total	**390**	**100.00%**

Toxicology Findings for Accident Cases

Of the 390 Accidental Deaths investigated by OCME, toxicology analysis was performed in 267 cases. Overall, drugs were absent in 73 accident cases; 84cases had one drug present; 67 cases had 2 drugs present; 29 cases had 3 drugs present; and 10 cases had 4 drugs present; 3 cases had 5 drugs; and 1 case had 6 drugs present.

Description	Number of Cases	% of Cases
N=	**267**	
Negative	73	27.3%
Positive	194	72.7%

The most commonly detected drugs in the accident cases were:

Name of Drug	Number of Cases	% of Accident Cases
Cocaine	87	32.6%
Ethanol	61	22.8%
Morphine	56	21.0%
Methadone	22	8.2%
Citalopram	10	3.7%
Diazepam	9	3.4%
Carbon Monoxide	8	3.0%
Amitriptyline	8	3.0%
Oxycodone	8	3.0%
Codeine	6	2.2%
Sertraline	6	2.2%

Ethanol was detected in 61 Accident cases with blood concentrations ranging from 0.02 – 0.35 % (average 0.12 %, median 0.10 %).

The 4 accident cases with the most drugs detected had the following toxicology:

a) ethanol (0.03 %), morphine, dextromethorphan, doxylaime, chlorpheniramine, and pseudoephedrine
b) cocaine, morphine, phencyclidine (PCP), dextromethorphan, and brompheniramine
c) cocaine, methadone, quinine, chloroquine, and pheniramine; and
d) ethanol (0.10 %), cocaine, codeine, olanzapine, and citalopram

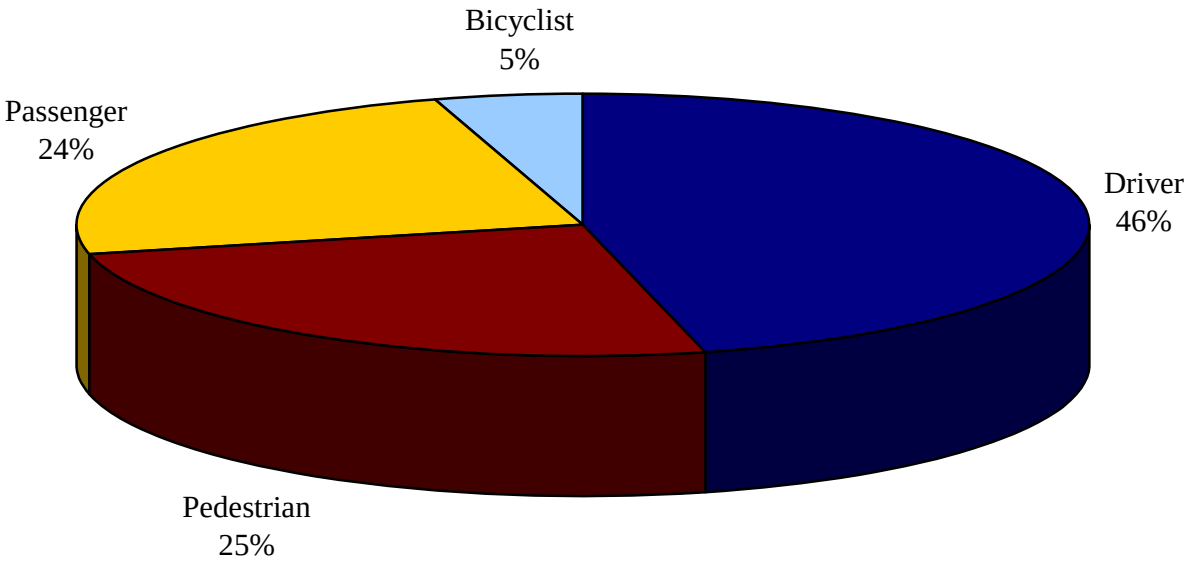
2.3.1 – Traffic Deaths

The majority of the 63 traffic related fatalities occurred in the following categories: males, blacks, and drivers between the ages of 20-29. Peaks occurred in September and December.

Role of the Decedent in Traffic Death

Role	Traffic Deaths	% of Traffic Deaths
Driver	29	46.03%
Pedestrian	16	25.40%
Passenger	15	23.81%
Bicyclist	3	4.76%
Total	**63**	**100.00%**

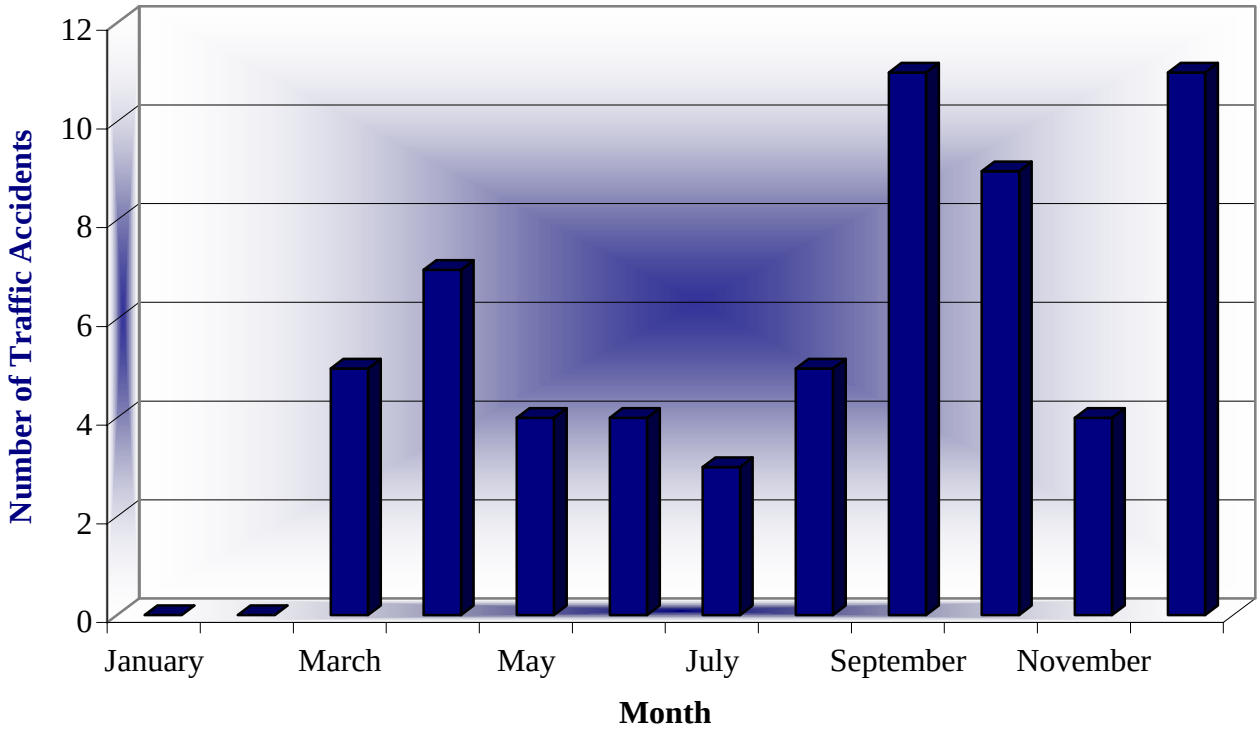
Pie Chart - Role of Decedent in Traffic Accident



Traffic Deaths by Month

Month	Number of Traffic Accidents	% of Traffic Accidents
January	0	0.00%
February	0	0.00%
March	5	7.94%
April	7	11.11%
May	4	6.35%
June	4	6.35%
July	3	4.76%
August	5	7.94%
September	11	17.46%
October	9	14.29%
November	4	6.35%
December	11	17.46%
Total	**63**	**100.00%**

Chart - Traffic Deaths by Month



Traffic Deaths by Race

Race	Number of Traffic Deaths	% of Traffic Deaths
Black	33	52.38%
White	19	30.16%
Hispanic	10	15.87%
Other	1	1.59%
Total	**63**	**100.00%**

Traffic Deaths by Gender

Gender	Number of Traffic Deaths	% of Traffic Deaths
Female	19	30.16%
Male	44	69.84%
Total	**63**	**100.00%**

Traffic Deaths by Age

Age	Number of Traffic Deaths	% of Traffic Deaths
1 to 5	1	1.59%
6 to 12	1	1.59%
13 to 15	0	0.00%
16 to 19	8	12.70%
20 to 29	18	28.57%
30 to 39	10	15.87%
40 to 49	7	11.11%
50 to 59	10	15.87%
60 to 69	2	3.17%
70 to 79	3	4.76%
80 to 89	3	4.76%
90 +	0	0.00%
Total	**63**	**100.00%**

Traffic Deaths by Jurisdiction of Incident

Jurisdiction of Incident	Number of Traffic Deaths	% of Traffic Deaths
DC	59	93.65%
MD	4	6.35%
Total	**63**	**100.00%**

Toxicology Findings for Traffic Accident Cases

Of the 63 Traffic-related deaths investigated by OCME, toxicology analysis was performed in 55 cases. Overall, drugs were absent in 24 traffic death cases; 25 cases had one drug present; 2 cases had 4 drugs present; and 4 cases had 2 drugs present.

Description	Number of Cases	% of Cases
N=	**55**	
Negative	24	43.6%
Positive	31	56.4%

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

Name of Drug	Number of Cases	% of Suicide Cases
Ethanol	16	29.1%
Morphine	4	7.3%
Cocaine	4	7.3%

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

a) ethanol (0.14 %), methamphetamine, Ecstasy, and diphenhydramine; and

b) ethanol (0.02 %), cocaine, morphine, and promethazine.

In the 16 Traffic Accident deaths positive for ethanol, the average Blood Alcohol Concentration was 0.15 % (range 0.02 – 0.26 %). The legal limit for Blood Alcohol Concentration in the District of Columbia is 0.08 % or below while driving.

2.3.2 – Toxicology Findings for Deaths due to Drug Overdose

There were 122 OCME cases where death was directly related to drug use, and toxicology analysis was performed on 119 cases. Overall, drugs were absent in 9 drug overdose cases; 31 cases had one drug present; 47 cases had 2 drugs present; 23 cases had 3 drugs present; 6 cases had 4 drugs present; 2 cases had 5 drugs present; and 1 case had 6 drugs present.

Description	Number of Cases	% of Cases
N=	**119**	
Negative	9	7.6%
Positive	110	32.4%

The most commonly detected drugs in drug overdose cases were:

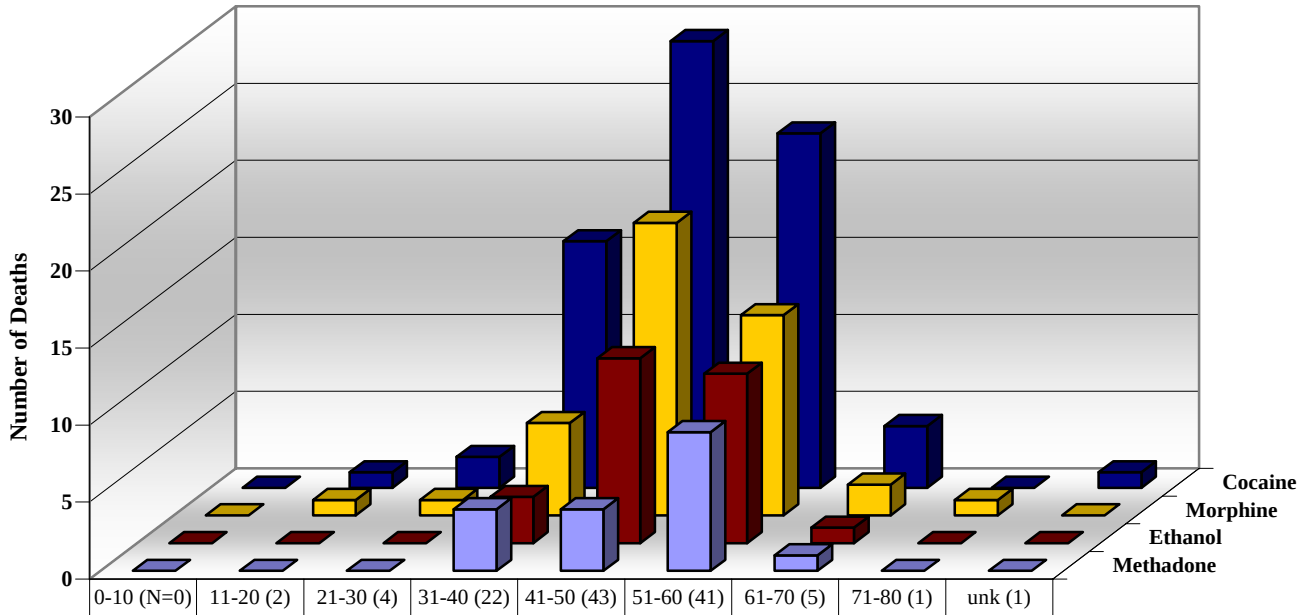
Contributing Drugs	Number of Cases	% of Cases
Cocaine	76	63.9%
Morphine	43	36.1%
Ethanol	27	22.9%
Methadone	18	15.1%
Citalopram	8	6.7%
Oxycodone	7	5.9%
Amitriptyline	5	4.2%

The most prevalent drug in the drug overdose population was cocaine alone or in combination with other drugs, most commonly morphine and/or ethanol. Ethanol was detected in 27 Overdose cases with blood concentrations ranging from 0.02 – 0.35 % (average 0.10 %, median 0.08 %).

Accidental Drug Overdose Fatalities by Age

The majority of overdose deaths occurred in decedents between the ages of 31 and 60 years. Cocaine was the most frequently detected drug in all of these age groups, followed by morphine, ethanol then methadone.

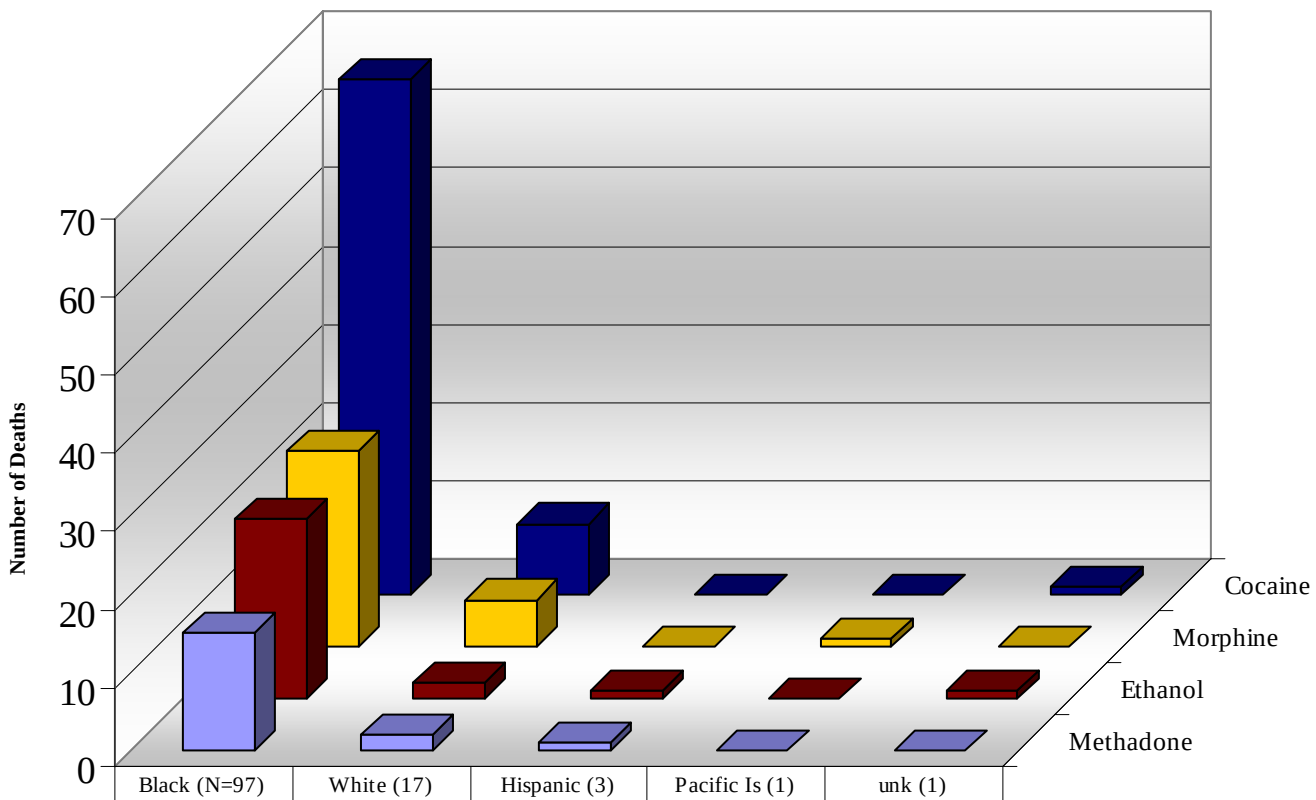
Overdose Deaths by Age and Drugs



	0-10 (N=0)	11-20 (2)	21-30 (4)	31-40 (22)	41-50 (43)	51-60 (41)	61-70 (5)	71-80 (1)	unk (1)
Methadone	0	0	0	4	4	9	1	0	0
Ethanol	0	0	0	3	12	11	1	0	0
Morphine	0	1	1	6	19	13	2	1	0
Cocaine	0	1	2	16	29	23	4	0	1

Accidental Drug Overdose Fatalities by Race

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



	Black (N=97)	White (17)	Hispanic (3)	Pacific Is (1)	unk (1)
Methadone	15	2	1	0	0
Ethanol	23	2	1	0	1
Morphine	25	6	0	1	0
Cocaine	66	9	0	0	1

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

Toxicological examinations were performed on driving-under-the-influence (DUI) cases to assist law enforcement agencies in the investigation of such cases. DUI cases were submitted to OCME from the District's Metropolitan Police Department, the U.S. Secret Service, and the FBI.

Routine toxicological examinations for DUI cases include analysis for alcohols (ethanol and other volatiles), an initial screen for major classes of illicit drugs and prescription medications, and an additional screen for various illicit drugs and prescription and 'over-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 then one substance.

Total number of DUI cases analyzed:

Description	Number of Cases	% of Cases
N=	**63**	
Negative	14	22.2%
Positive	49	77.8%

Type of Specimen Submitted:

Description	Number of Cases	% of Cases
Blood	6	9.5%
Urine	57	90.5%

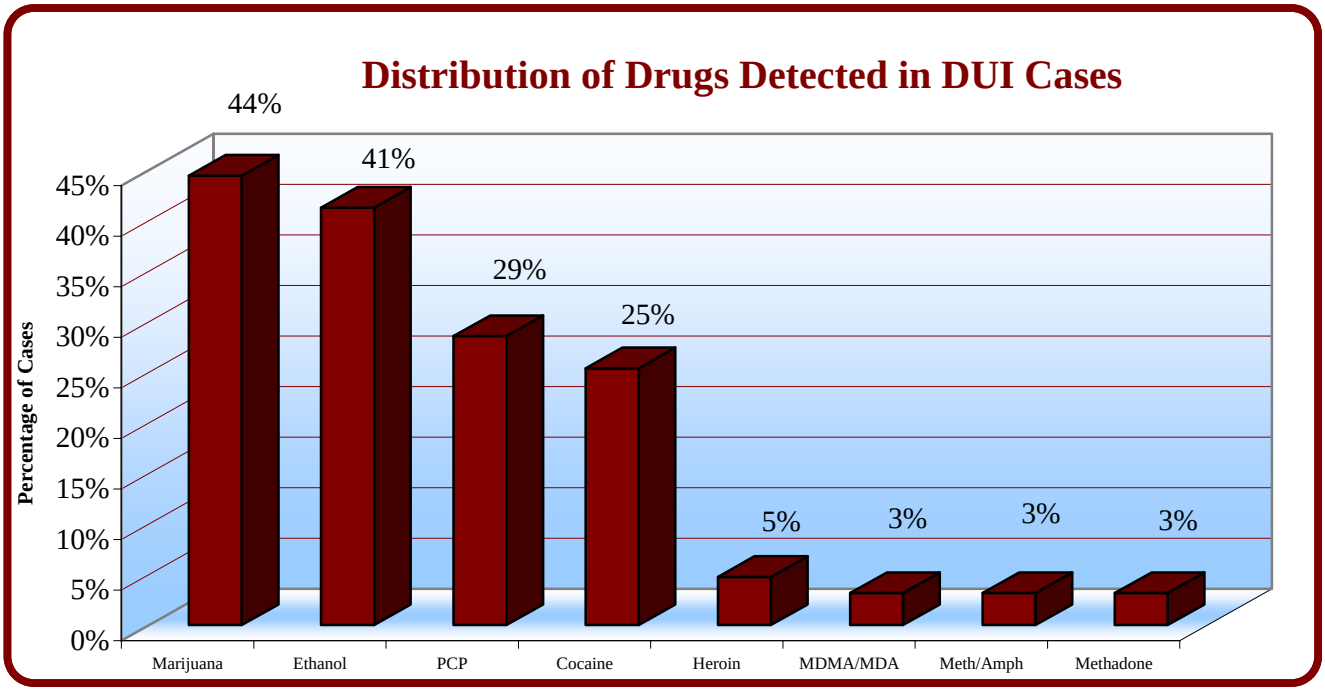
Age and gender of DUI cases:

Gender	Number of Cases	Age Range	Mean	Median
Male	54	18-53 (n=20)	34 yrs	36 yrs
Female	9	27 & 48 (n=3)	34 yrs	27 yrs

Overall, drugs were absent in 14 DUI cases; 20 cases had one drug present; 23 cases had 2 drugs present; 6 cases had 3 drugs present; 4 cases had 4 drugs present; 1 case had 5 drugs present; and 2 cases had 6 drugs present.

The most commonly detected drugs in the DUI cases were:

Name of Drug	Number of Cases	% of DUI Cases
Marijuana	28	44.4%
Ethanol	26	41.3%
Phencyclidine (PCP)	18	28.6%
Cocaine	16	25.4%
Heroin/Morphine	3	4.8%
MDMA and/or MDA	2	3.2%
Methamphetamine or Amphetamine	2	3.2%
Methadone	2	3.2%



In the 26 DUI cases positive for alcohol, the average alcohol concentrations were as follows:

Description	N=	Average	Median	Range
Blood Alcohol Result	4	0.23%	0.20%	0.18-0.34%
Urine Alcohol Result	22	0.11%	0.09%	0.01-0.39%

Common drug combinations for DUI cases include:

Name of Drugs	Number of Cases
Ethanol + Marijuana	6
PCP + Marijuana	6
PCP + Ethanol	4
Cocaine + Marijuana	4
PCP + Cocaine	3

A selection of DUI cases with numerous drugs detected are as follows:

a) marijuana, cocaine, morphine, codeine, hydrocodone, and alprazolam

b) marijuana, cocaine, oxycodone, oxymorphone, methadone, and propoxyphene

c) ethanol (0.09 %), phencyclidine (PCP), marijuana, and cocaine

d) phencyclidine (PCP), marijuana, cocaine, and propoxyphene; and

e) phencyclidine (PCP), marijuana, MDMA (Ecstasy)

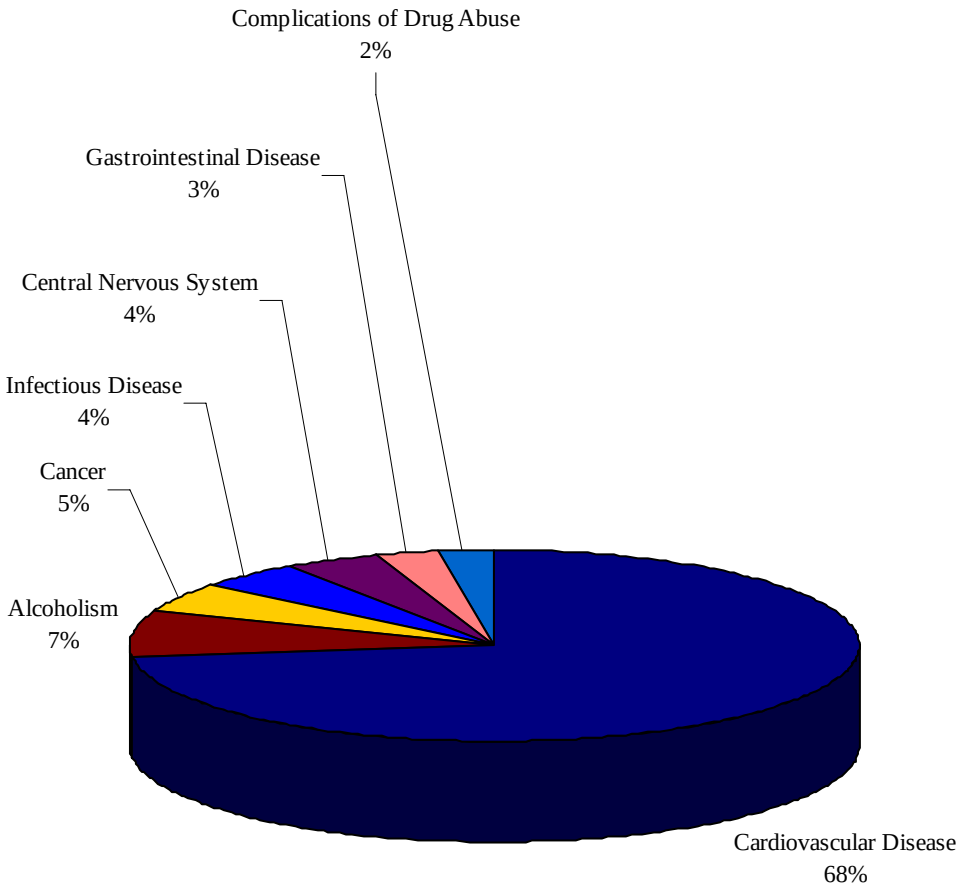
2.4 - NATURAL DEATHS

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. Blacks represented approximately 77% of the affected population, followed by Whites, which represented 19% of the population. The prevalent age group was 50-59 years. The peak incident occurred in January.

Natural Deaths By Cause

Cause	Number of Deaths	% Of Total Natural Deaths
Cardiovascular Disease	589	67.62%
Alcoholism	62	7.12%
Cancer	41	4.71%
Infectious Disease	38	4.36%
Central Nervous System	33	3.79%
Gastrointestinal Disease	22	2.53%
Complications of Drug Abuse	20	2.30%
Respiratory	14	1.61%
Diabetes	10	1.15%
Therapeutic Complications	10	1.15%
Blood Disease	7	0.80%
Genetic Disorders	6	0.69%
Complications of Pregnancy	6	0.69%
Connective Tissue Disease	4	0.46%
Immune System Disease	4	0.46%
Geriatrics (Protein-Energy Under nutrition)	2	0.23%
Renal Disease	1	0.11%
SIDS	1	0.11%
Total	**870**	**100.00%**

Pie Chart – Natural Deaths by Cause

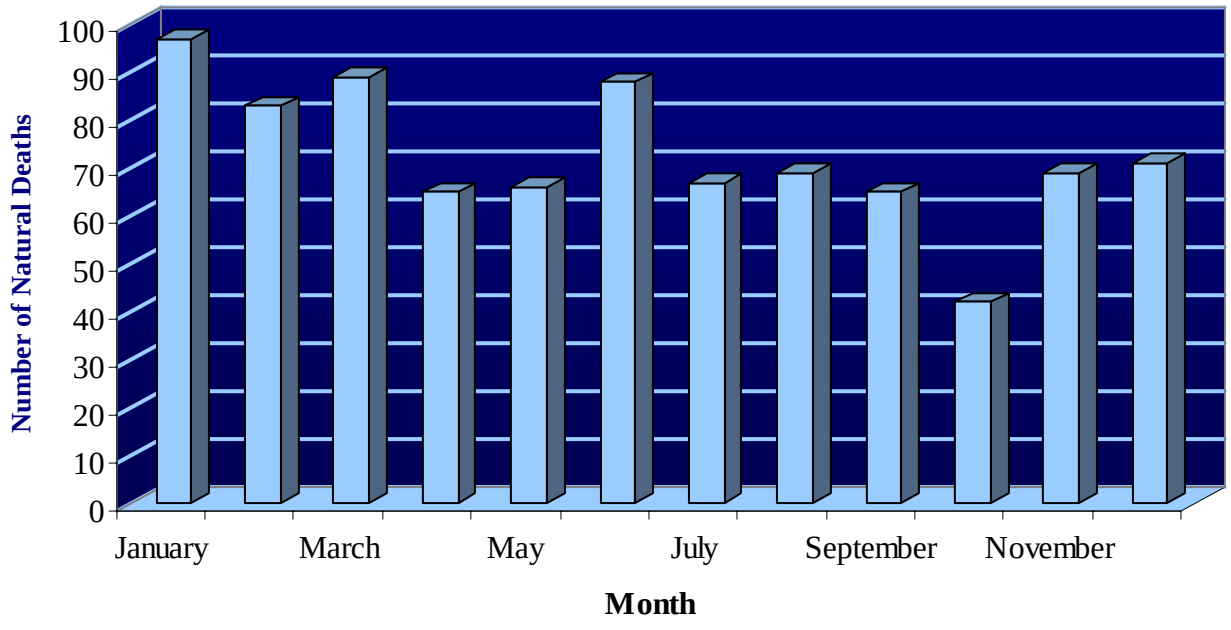


Note: For visual purposes, causes of death that are less than 2% are not included in this chart.

Natural Deaths by Month

Month	Number of Deaths
January	97
February	83
March	89
April	65
May	66
June	87
July	67
August	69
September	65
October	42
November	69
December	71
Total	**870**

Chart- Natural Deaths by Month



Natural Deaths by Race

Race	Number of Natural Deaths	% of Natural Deaths
Black	668	76.81%
White	164	18.83%
Hispanic	28	3.21%
Asian	6	0.69%
Other	3	0.34%
Unknown	1	0.11%
Total	**870**	100.00%

Natural Deaths by Gender

Gender	Number of Natural Deaths	% of Natural Deaths
Female	338	38.81%
Male	532	61.19%
Total	**870**	**100.00%**

Natural Deaths by Age

Age	Number of Natural Deaths	% of Natural Deaths
Fetus	3	0.34%
Unknown	4	0.46%
Under 1	10	1.15%
1 to 5	4	0.46%
6 to 12	1	0.11%
13 to 15	2	0.23%
16 to 19	4	0.46%
20 to 29	17	1.95%
30 to 39	32	3.79%
40 to 49	160	18.37%
50 to 59	216	24.80%
60 to 69	160	18.37%
70 to 79	141	16.19%
80 to 89	89	10.22%
90 +	27	3.10%
Total	**870**	**100.00%**

Toxicology Findings for Natural Deaths

Of the 870 Natural Deaths investigated by OCME, toxicology analysis was performed in 521 cases. Overall, drugs were absent in 262 natural cases; 172 cases had one drug present; 64 cases had 2 drugs present; 14 had 3 drugs present; and 9 cases had 4 drugs detected.

Description	Number of Cases	% of Cases
N=	**521**	
Negative	262	50.3%
Positive	259	49.7%

The most commonly detected drugs in the natural cases were:

Name of Drug	Number of Cases	% of Natural Cases
Ethanol	84	16.1 %
Cocaine	57	10.9 %
Morphine	27	5.2 %
Codeine	12	2.3 %
Methadone	10	1.9 %
Amitriptyline	9	1.7 %
Diazepam	9	1.7 %
Oxycodone	8	1.5 %
Sertraline	8	1.5 %

Ethanol was detected in 84 Natural cases with blood concentrations ranging from 0.02 – 0.51 % (average 0.11 %, median 0.06 %).

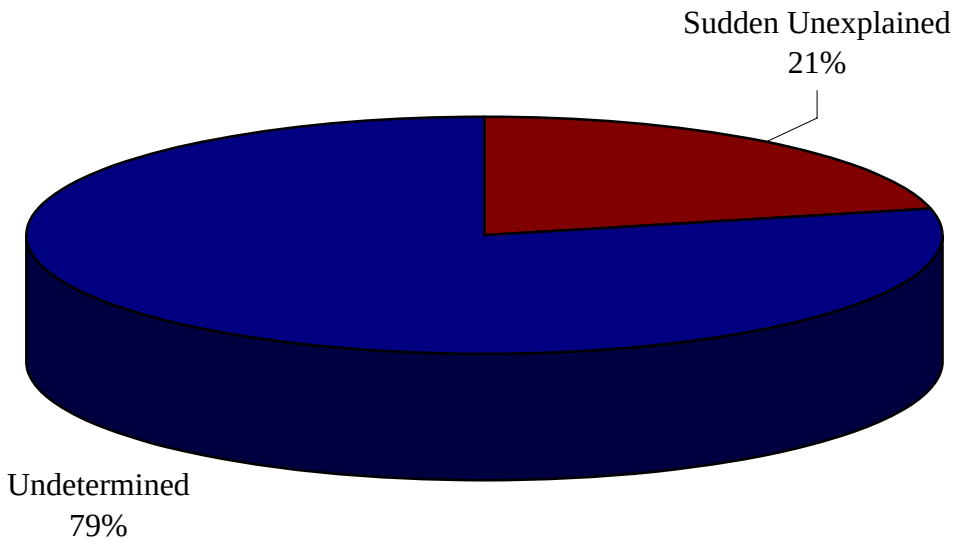
2.5 – UNDETERMINED DEATHS

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*"

Undetermined by Cause of Death

Cause	Number of Deaths	% of Total Accepted Cases
Undetermined	44	78.57%
Sudden Unexplained	12	21.43%
Total	**56**	**100.00%**

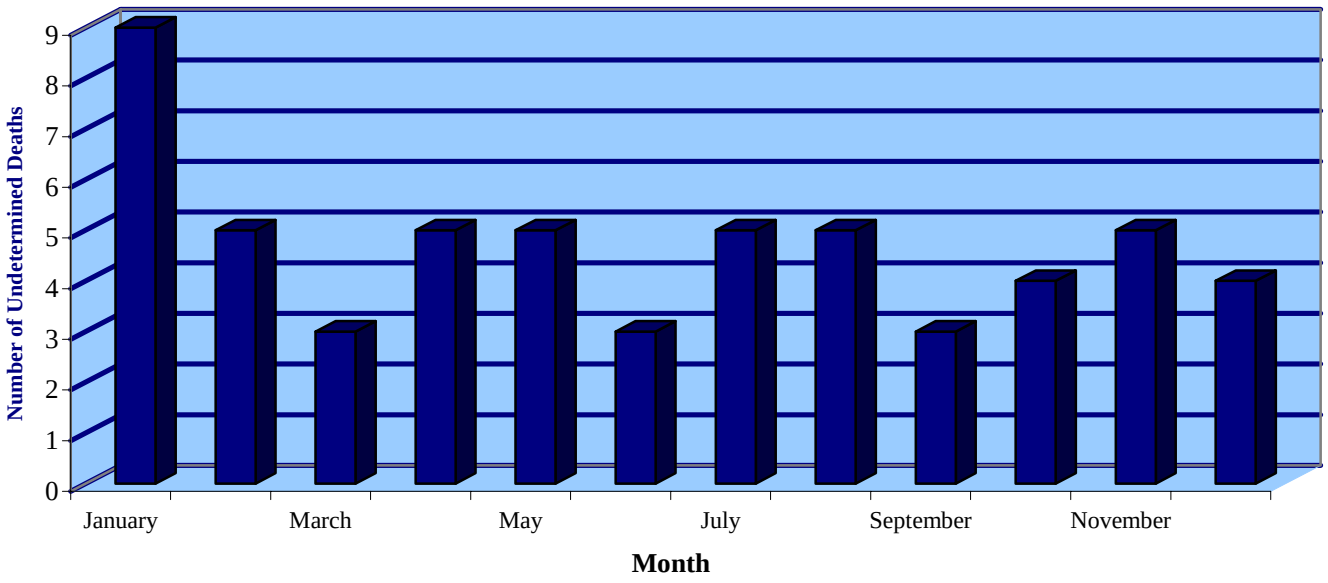
Pie Chart – Undetermined by Cause of Death



Undetermined Deaths by Month

Month	Number of Deaths
January	9
February	5
March	3
April	5
May	5
June	3
July	5
August	5
September	3
October	4
November	5
December	4
Total	**56**

Chart - Undetermined Deaths by Month



Undetermined Deaths by Race

Race	Number of Undetermined Deaths
Black	44
White	6
Unknown	4
Hispanic	2
Total	**56**

Undetermined Deaths by Gender

Gender	Number of Undetermined Deaths
Female	23
Male	33
Total	**56**

Undetermined Deaths by Age

Age	Number of Undetermined Deaths
Unknown	6
Under 1	16
1 to 5	1
6 to 12	1
13 to 15	0
16 to 19	0
20 to 29	5
30 to 39	4
40 to 49	13
50 to 59	7
60 to 69	2
70 to 79	1
80 to 89	0
90 +	0
Total	**56**

Toxicology Findings by Undetermined Deaths

Of the 56 Undetermined Deaths investigated by OCME, toxicology analysis was performed in 52 cases. Overall, drugs were absent in 28 undetermined cases; 11 cases had one drug present; 9 cases had 2 drugs present; 3 cases had 3 drugs present and 1 case has 4 drugs present.

Description	Number of Cases	% of Cases
N=	**52**	
Negative	28	53.8%
Positive	24	46.2%

The most commonly detected drugs in the undetermined cases were:

Name of Drug	Number of Cases	% of Undetermined Cases
Ethanol	14	26.9%
Cocaine	7	13.5%
PCP	2	3.8%
Morphine	2	3.8%
Carbon Monoxide (CO)	2	3.8%

The 4 undetermined cases with the most drugs detected had the following toxicology:

a) ethanol (0.07 %), methadone, quetiapine, and citalopram
b) ethanol (0.39 %), cocaine, and diphenhydramine
c) carbon monoxide, cocaine, and dextromethorphan; and
d) sertraline, quetiapine, and bupropion

Toxicology for Stillbirths

Of the 13 Stillbirth Deaths investigated by OCME, toxicology analysis was performed in 10 cases. Overall, drugs were absent in 4 stillbirths; 4 cases had cocaine present; 1 case had amantadine present; 1 and case had phencyclidine (PCP), cocaine and nevirapine present.

Description	Number of Cases	% of Cases
N=	**10**	
Negative	4	40%
Positive	6	60%

3.0 – Fatality Review Program

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

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

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

Currently there are three fatality review processes that operate within the FRU, the Child Fatality Review Committee (CFRC), Mental Retardation and Developmental Disabilities Fatality Review Committee (MRDD FRC) and the newly established Domestic Violence Fatality Review Board (DVFRB). Following is a brief synopsis of the work achieved during the 2005 calendar year for two of the operating fatality review processes. The DVFRB was established in October 2005 and all work during the 2005 calendar year was associated with developing policies, protocols, data instruments and other operational modules to fully implement the program. Therefore, a synopsis of progress and work achieved for the DVFRB will be included in the 2006 Annual Report.

Child Fatality Review Committee (CFRC)

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.

During the 2005 calendar year, the CFRC identified the deaths of 154 children/youth, from birth through 23 years of age. This represents a slight decrease from the 155 deaths identified and reviewed in 2004. The 2005 fatalities included children who died from a multitude of causes in all manners of death categories. The following charts and graphs represent a summary of the data that resulted from the 2005 deaths reviewed:

TOTAL 2005 CFRC DECEDENT POPULATION

DESCRIPTION OF TOTAL CFRC DECEDENT POPULATION

Following is a description of the 154 child/youth deaths identified and reviewed during 2005:

Ages of Decedents:

Age	Number	% of Total
Under 1 Year	81	53%
1 thru 4 Years	8	5%
5 thru 10 Years	6	4%
11 thru 14 Years	5	3%
15 thru 20 Years	47	31%
Over 20 Years	7	4%

Race of Decedents:

Race	Number	% of Total
Black	138	90%
White	6	4%
Hispanic	10	6%
Asian	0	0%
Other	0	0%

Gender of Decedents:

Gender	Number	% of Total
Female	47	31%
Male	107	69%

Decedents' Ward of Residence:

Ward of Residence	Number
Ward One	17
Ward Two	4
Ward Three	4
Ward Four	13
Ward Five	21
Ward Six	18
Ward Seven	21
Ward Eight	50
Other State	6

MANNER OF DEATH – TOTAL CFRC POPULATION

Manner	Number	% of Total
Natural	82	53%
Homicide	43	28%
Accident	11	7%
Suicide	1	1%
Undetermined	17	11%

DC OCME CHILD DEATHS ACCEPTED FOR AUTOPSY

Out of the 154 fatalities identified from the 2005 calendar year, 67 of these deaths were reported to the DC Office of the Chief Medical Examiner and were accepted for autopsy.

Description of DC-OCME Decedent Population

Age and Gender of Decedents – DC OCME Population:

Age/Gender	Subtotal	Total Deaths
Under 1		**24**
Female	10	
Male	14	
1 thru 4		**6**
Female	4	
Male	2	
5 thru 10		**3**
Female	0	
Male	3	
11 thru 14		**2**
Female	0	
Male	2	
15 thru 20		**28**
Female	4	
Male	24	
Over 20		**4**
Female	1	
Male	3	

Race of Decedents – DC OCME Population:

Decedents' Race	Number	% of Total
Black	62	93%
White	2	3%
Hispanic	3	4%
Asian	0	0%
Other	0	0%

Ward of Residence – DC OCME Population:

Ward of Residence	Number
Ward One	11
Ward Two	2
Ward Three	1
Ward Four	4
Ward Five	10
Ward Six	10
Ward Seven	4
Ward Eight	22
Other State	3

Manner of Death – DC OCME Population

Manner	Number	% of Total
Natural	14	21%
Homicide	29	43%
Accident	9	13%
Suicide	1	2%
Undetermined	14	21%

CAUSES OF DEATH

Homicides:

Cause	Number
Fire Arms (1 under 10/24 over 14 yrs of age)	25
Bunt Impact (Ages 2 months, 1 yr, 20 yrs)	3
Multiple Injuries (Drowning and Blunt Impact (6 yr old)	1

Accidents:

Cause	Subtotal	Total
Motor Vehicle/Subway		**5**
Pedestrian	1	
Passenger	3	
Driver (1 motorbikes)	1	
Smoke Inhalation/Asphyxia		**2**
Drowning		**1**
Asphyxia (overlay)		**1**

Natural Deaths:

Cause	Number
Prematurity (under 38 wks)	4
Infectious Disease	3
Respiratory	2
Blood Disorder	1
Central Nervous System	1
Gastrointestinal	1
Metabolic Disease	1
Complications of Drug Abuse	1

Undetermined Deaths

Cause	Number
Sudden Unexplained Death in In-fancy	10
Gunshot Wound	1
Undetermined	3

"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 2005, 14 of the 17 Undetermined manners of death received autopsies by the DC Office of the Chief Medical. Based on a review of the 2005 "Undetermined" OCME deaths, the following findings were identified:

- The majority of the decedents were infants (n = 12), with ages that ranged from one to three months. One of the 12 decedents was one year and nine months and one 20 years of age. All the decedents were Black/African American and the majority were males (n = 8, or 57%).
- Nine of the infants were born full term (n = 62%) and three were preterm (gestational age was not known for two infant deaths). All of the infant who died from Undetermined causes had birth weights greater than 2200 grams.
- The majority of the causes of death (n = 10) was "Sudden Unexplained Death in Infancy" and seven of the death certificates for these cases directly linked co-sleeping and inappropriate sleeping environments to the death.
- One cause was associated with a gunshot and three of the cases also had Undetermined causes of death.

Manner By Month – DC OCME Population:

Manner	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Natural		1	1		1	1	1	1	3	1	1	3
Homicide	3	1	2	3	1	3	1	2	1	4	6	2
Accident	3		1		1		1		1	1		1
Suicide								1				
Undetermined	2	1			1		2	1		4	2	1

Mental Retardation and Developmental Disabilities Fatality Review Committee (MRDD FRC)

The Mental Retardation and Developmental Disability Fatality Review Committee, established in February 2001 by Mayor's Order 2001-27 and re-established in September of 2005 by Mayor's Order 2005-143, mandates the Fatality Review Committee examine events that surround the deaths of individuals diagnosed with mental retardation and other developmental disabilities, wards of the District or receiving care from the Mental Retardation and Developmental Disabilities Administration.

During calendar year 2005, 34 persons died who were diagnosed with mental retardation and other disabilities and served by the Mental Retardation and Developmental Disabilities Administration. The Fatality Review Committee reviewed 31 cases during the same calendar year. These reviews represented deaths that occurred during calendar years 2003 through 2005.

Table 1: Total DC MRDDA Population and Deaths 2001 to 2005.

Year	Population	Number of Deaths	Percentage
2005	1993	34	1.7%
2004	1915	36	1.9%
2003	1790	31	1.7%
2002	1703	26	1.5%
2001	1547	32	2%

Table 1 illustrates the total number of persons served by MRDDA and the actual number of deaths per year of MRDD decedents for calendar years 2001 though 2005.

Table 2: FRC Cases Pending Review

Year	Number of Deaths By Year N=159	Number of Cases Reviewed by Year	Number of Cases Pending Review
2005	34	14	20
2004	36	25	11
2003	31	21	10
2002	26	19	7
2001	32	32	0
Total	**159**	**111**	**48**

Table 2 summarizes the number of cases by calendar year reviewed by the FRC since its inception. The total number of cases reviewed (N=111) spans years 2001-2005. Since 2001, the number of deaths reviewed by the FRC has increased yearly, from 9 in 2001 to 31 in 2005, a 41% increase. Table 2 also illustrates pending cases by calendar year.

DESCRIPTION OF TOTAL MRDD DEATHS REVIEWED DURING 2005

Decedents by Age Range and Gender of Cases Reviewed (N=31)

Age Range	2003 N=5		2004 N=12		2005 N=14	
	Male N=3	Female N=2	Male N=4	Female N=8	Male N=8	Female N=6
18-20	1	0	0	0	0	0
21-30	1	0	0	0	0	0
31-40	0	0	1	1	0	0
41-50	0	0	1	1	3	1
51-60	1	0	1	2	2	2
61-over	0	2	1	4	3	3

Decedents by Race for Cases Reviewed

Race N=31	2003		2004		2005	
	N=5	Average Age	N=12	Average Age	N=14	Average Age
Black	4	41	9	59	12	65
White	1	84	3	62	2	60
Other	0	N/A	0	N/A	0	N/A

Ward/Jurisdiction of Residence at Time of Death (N=31)

District Ward/ *Jurisdiction*	Deaths by Calendar Year		
	2003 N=5	2004 N=12	2005 N=14
One	1	0	0
Two	0	0	1
Three	1	0	0
Four	1	3	1
Five	0	2	0
Six	0	0	0
Seven	1	5	7
Eight	0	2	3
Maryland	1	0	1
Virginia	0	0	1

Location of Decedents At Time of Death

Place of Death	2003 N=5	2004 N=12	2005 N=14
Hospital	5	8	12
Nursing Home	0	0	0
Hospice	0	0	1
Residential	0	4	1
Other, e.g., specialized home care (foster homes)	0	0	0

Manners of Death

Manner of Death	Number N=31			Percentage
	2003 N=5	2004 N=12	2005 N=14	
Natural	5	11	14	97%
Accident	0	1	0	3%
Suicide	0	0	0	0
Homicide	0	0	0	0
Undetermined	0	0	0	0

Causes of Death

During calendar year 2005 autopsies were mandatory for all persons with MRDD who received services and support from MRDDA. Of the 31 cases reviewed, thirty decedents had autopsies (97%), and one decedent (3%) had no autopsy due to burial prior to OCME notification.

- Of the 2003 decedents (N=5), the District's OCME accepted jurisdiction and performed autopsies on three decedents (60%) and Maryland and Virginia each conducted one autopsy.
- Of the 2004 decedents (N=12), OCME accepted jurisdiction and performed autopsies on 11 decedents (92%) and one case was not autopsied.
- Of the 2005 decedents (N=14), OCME accepted jurisdiction and performed autopsies on 12 (86%) and one case was autopsied in Maryland and Virginia respectively.
- For all years combined (2003, 2004 and 2005), five autopsies (16%) were performed in out-of-state facilities, and in one case (3%) no autopsy was performed.

The table below lists the proximate causes of death or the underlying pathological condition responsible for the demise in the 31 cases reviewed

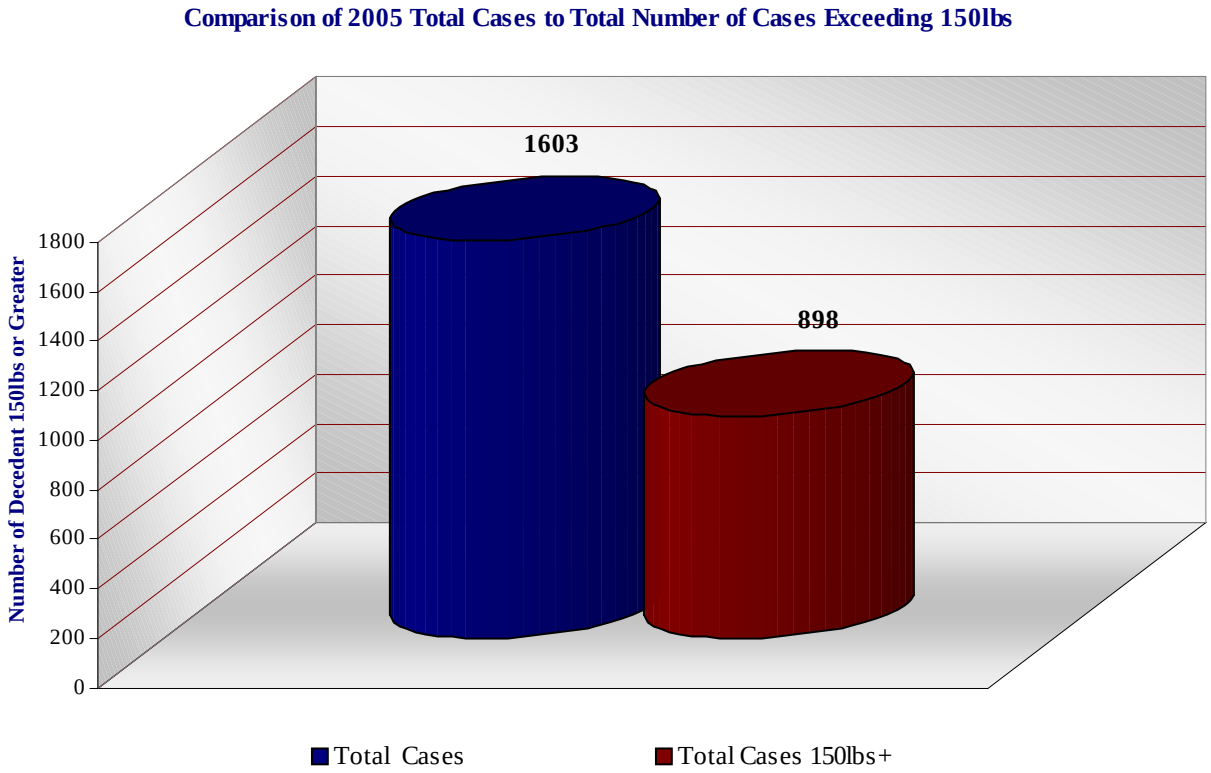
Cause of Death	Deaths (N=31)
Cardiovascular Diseases (Hypertension, Atherosclerosis, and Mitral Valve Insufficiency)	11
Infectious Diseases	6
Cancer (breast, ovary, and esophagus)	3
Primary Neurologic Disease	3
Gastrointestinal tract	2
Primary Pulmonary Conditions	2
Melodysplastic Disorder	1
Morbid Obesity	1
Therapeutic Complications	1
Chocking (due to aspiration of a bolus of food)	1

4.0 – Data on Weight Distribution of Accepted OCME Cases for 2005

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, 2005 and December 31, 2005.

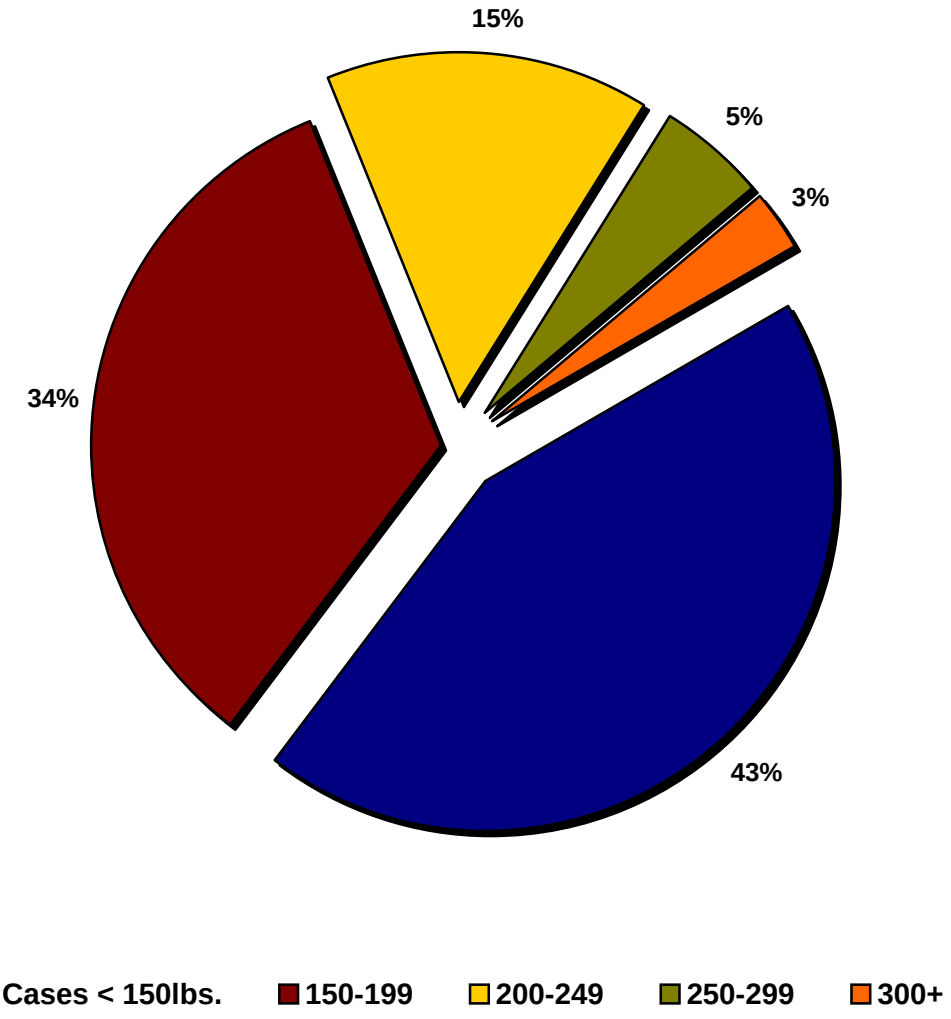
This year's data will report on the distribution of weights with emphasis on the Body Mass Index (BMI). BMI is a mathematical formula used to determine one's ratio of body height to body weight, and which correlates strongly (in adults) with body fat content. BMI is used to assess how much a person's weight departs from what is desirable for their height. Individuals with a BMI between 25.1 and 30 are considered overweight, those between 30.1 and 40 - obese, and those with a BMI over 40 – morbidly obese. This report will include the number of decedents examined by the OCME this year weighing over 150 lbs and with a BMI above normal (e.g. over 25). We also compare the BMI with deaths due to Arteriosclerotic and Hypertensive Cardiovascular Diseases.



2005 - WEIGHT DISTRIBUTIONS

Weight	< 150lbs	150-199	200-249	250-299	300+	Total Cases 150lbs or more	Total Cases
Number of De-cedents	691	534	239	83	42	898	1603[3]

Distribution of Accepted OCME Cases by Weight (2005)

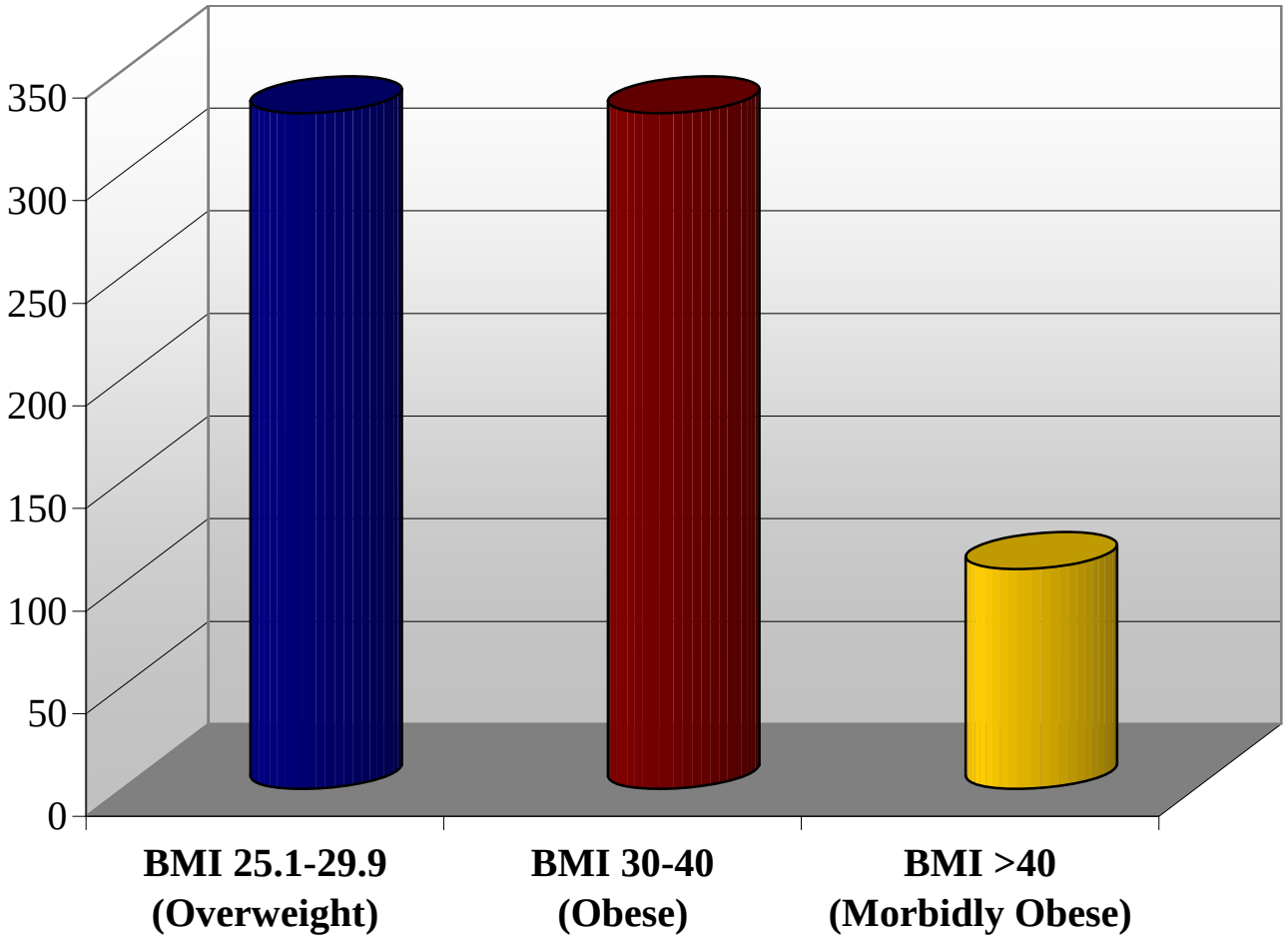


[3] This data includes "Storage cases", which is not included in the "Accepted case" tabulations, but is tallied and included in the work of the Mortuary Unit and recorded in their logbooks.

Body Mass Index (BMI)

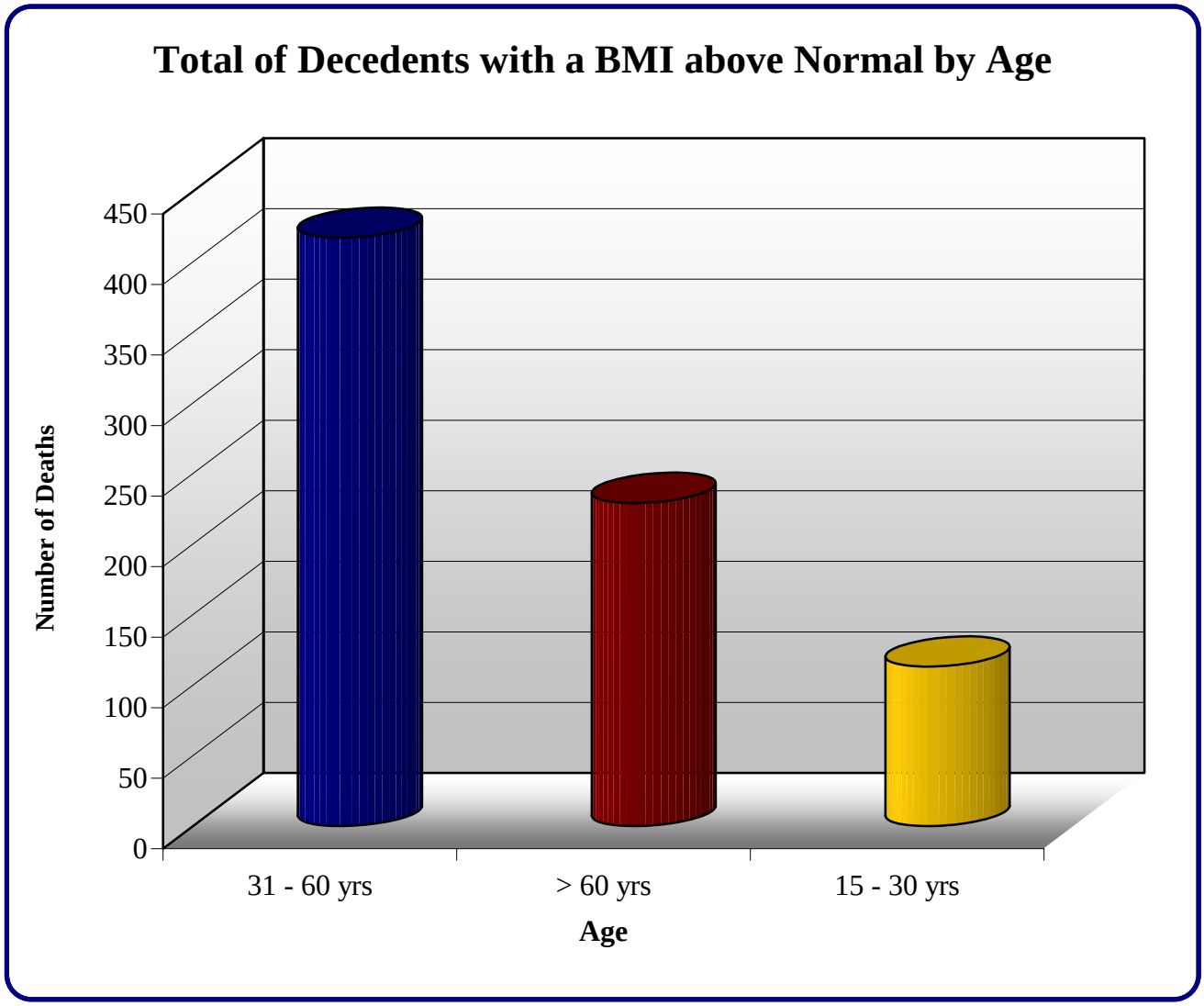
Of the 1,603 cases OCME accepted for further investigation, 765 cases or 48% had a Body Mass Index above normal. 329 were overweight (BMI 25.1 – 29.9), 329 were obese (BMI 30 – 40), and 107 were morbidly obese (BMI > 40).

Comparison of BMI by Index Classification



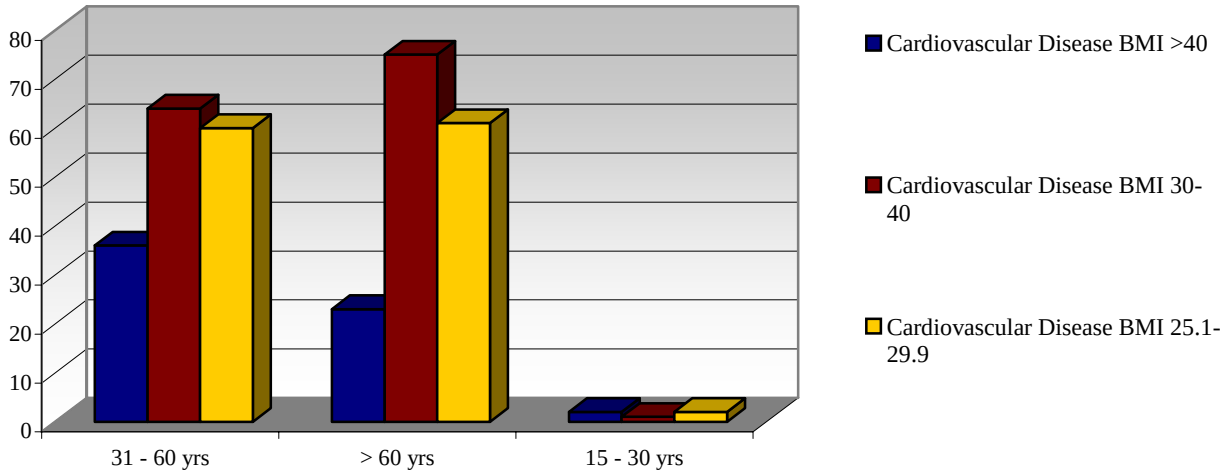
BMI by Age

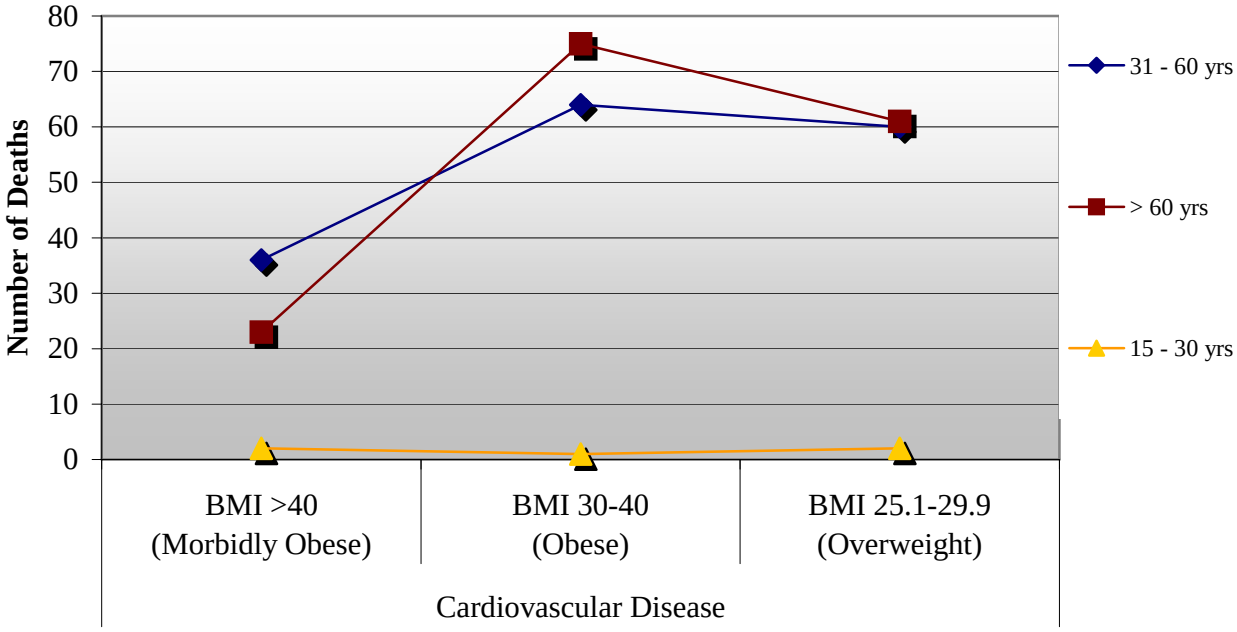
Upon further examination, the data revealed that of the 765 decedents with a BMI above normal (>25) during 2005, the age group with the highest number of deaths was 31 - 60 years old with 417 deaths recorded.



BMI by Age and Cardiovascular Disease

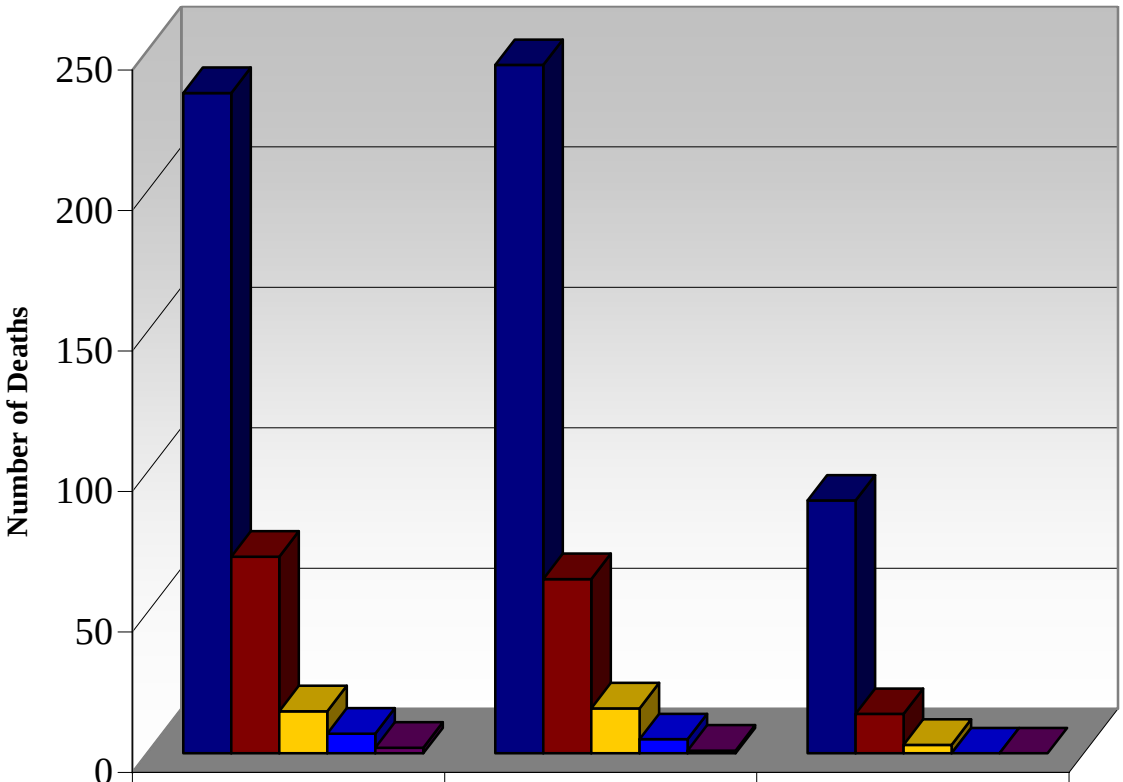
324 of the overweight to the morbidly obese deaths were directly attributed to complications of Arteriosclerotic and Hypertensive Cardiovascular Diseases. The charts below outline the prevalence of cardiovascular disease by age and BMI.





BMI by Race

The demographics for this population decreased slightly between 2004 and 2005. Of the 765 decedents above the normal BMI, 74.5% were Black/African American, 19% were White, 4% were Hispanic and less than 2% were Asian and Unknown combined. The chart below displays the BMI data by race.



	BMI 25.1-29.9 (Overweight)	BMI 30-40 (Obese)	BMI >40 (Morbidly Obese)
Blacks	235	245	90
Whites	70	62	14
Hispanics	15	16	3
Unknown	7	5	0
Asians	2	1	0

Chart: BMI data by race

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

According to the 2005 American Community Survey as reported by the US Census Bureau, the total estimated population in the District of Columbia was 515,118 inhabitants comprised primarily of the following groups: White, Black, Hispanic and Asian. (ACS, 2005) In 2005, the OCME investigated 3,145 of the deaths that occurred in these populations and 1,603 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 2005 Population

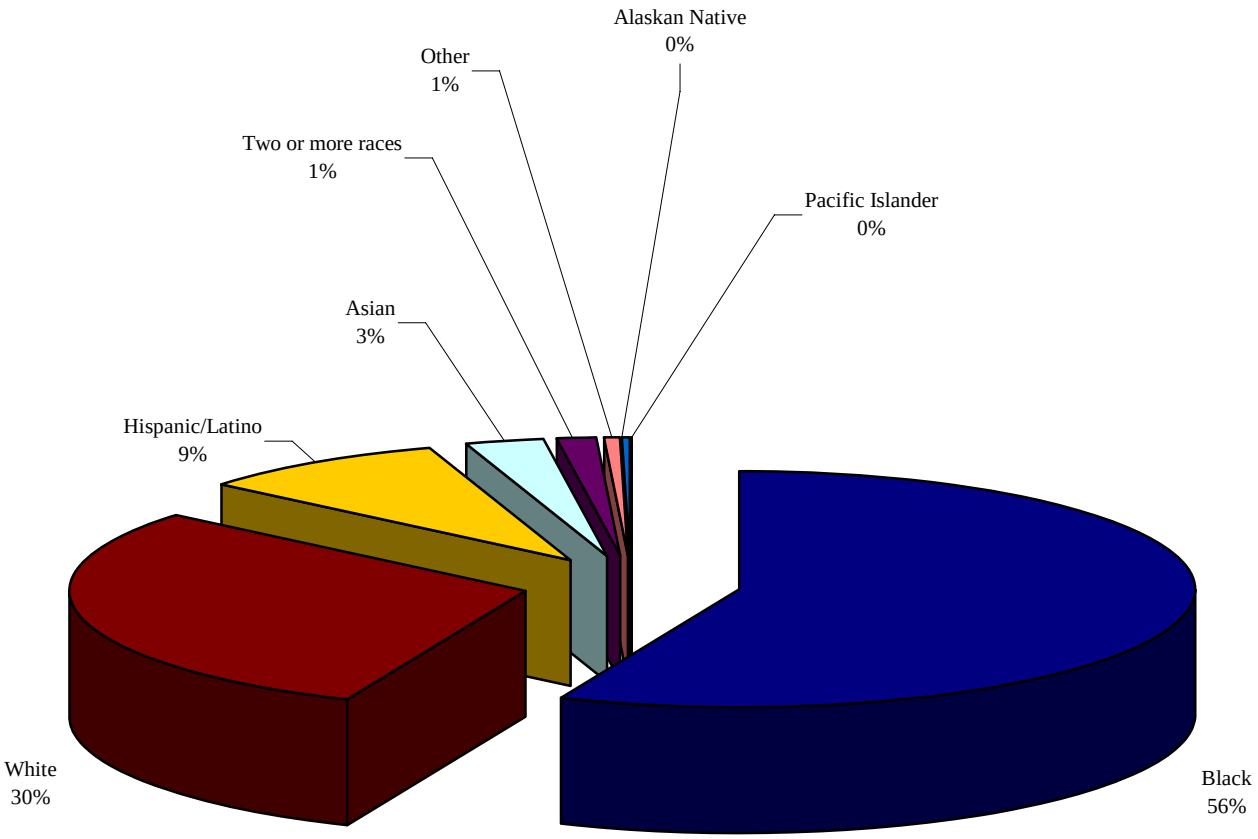
[4]Race	2005 Census	Total Number of ME Cases	Natural	Suicide	Homicide	Accidents (Traffic-Related)	Accidents (All)
Black/ African American	290,128	1,094	668	20	192	33	214
White	152,879	325	164	20	7	19	134
Hispanic/Latino (of any race)	45,901	73	28	1	14	10	30
Asian	14,997	15	6	2	1	0	6
Two or more races	6,441	n/a	n/a	n/a	n/a	n/a	n/a
Other	3,451	7	3	0	2	1	2
Alaskan Native	1,132	0	0	0	0	0	0
Pacific Islander	189	1	0	0	0	0	1
Total Population	**515,118**						
Total # of ME Cases		**1,515**	**869**	**43**	**216**	**63**	**387**

Note: Neither the OCME race identified as "Unknown (n=25)" nor the manner of deaths classified as "Undetermined (n=56)" and "Stillbirth (n=13)" are included in this table.

[4] The statistics by "Race" for categories other than Hispanic are reported as "only" (i.e. White only and Black only).

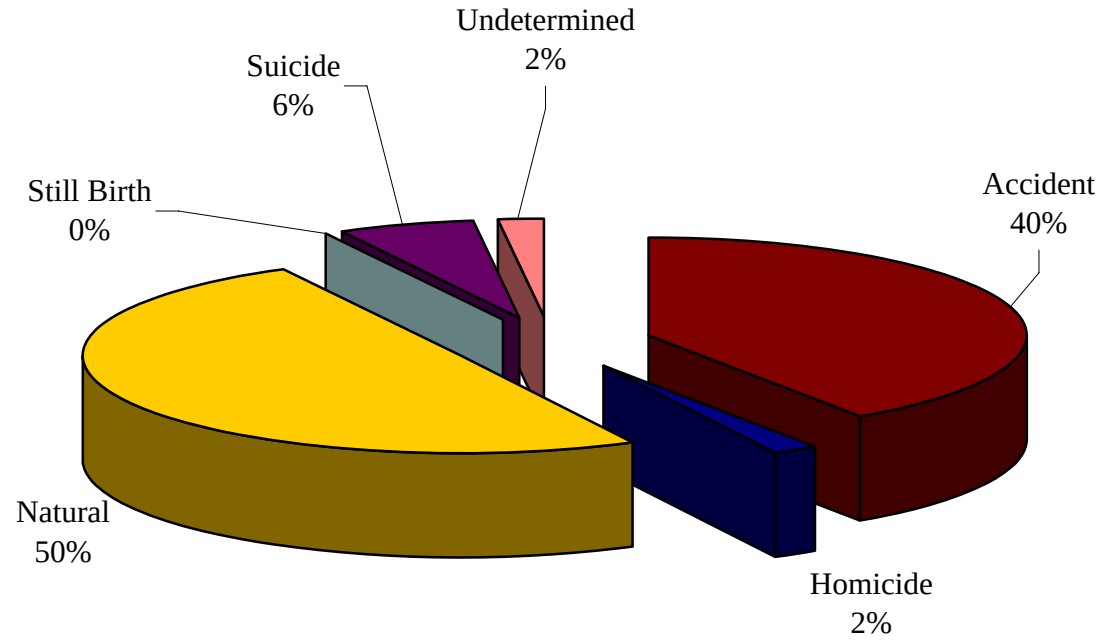
POPULATION DATA RELATIVE TO RACE

2005 US Census Population Data by Race

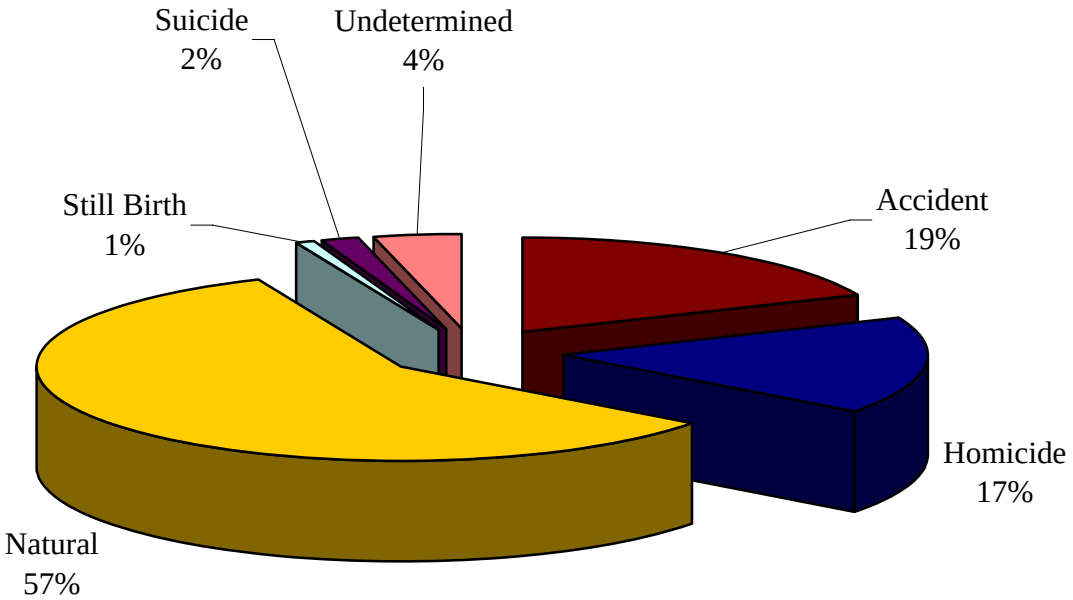


Pie Chart of ME Cases by Race and Manner of Death

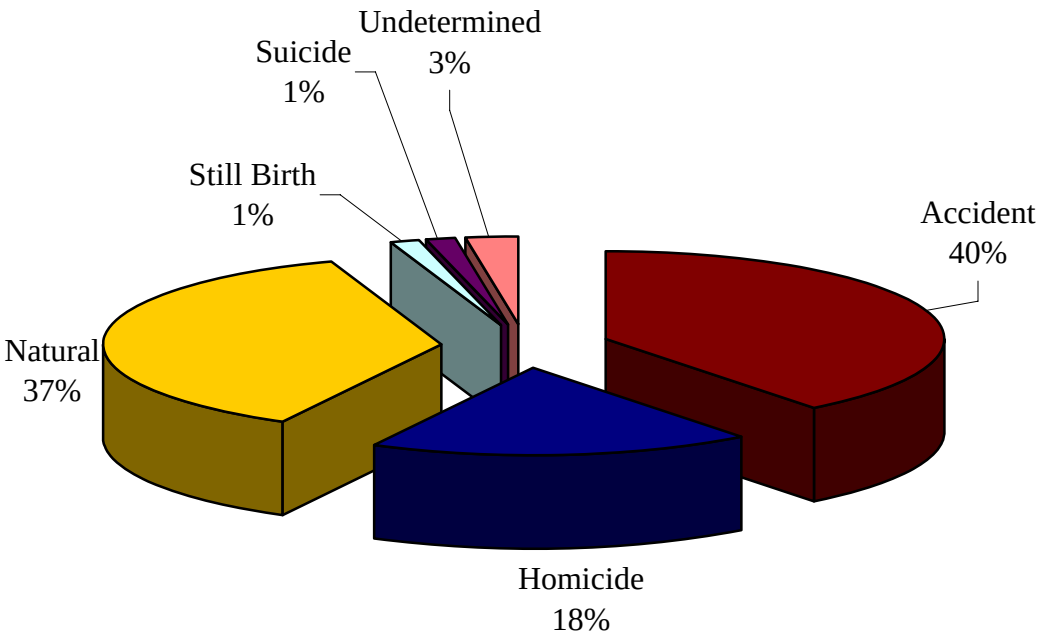
White Population



Black Population



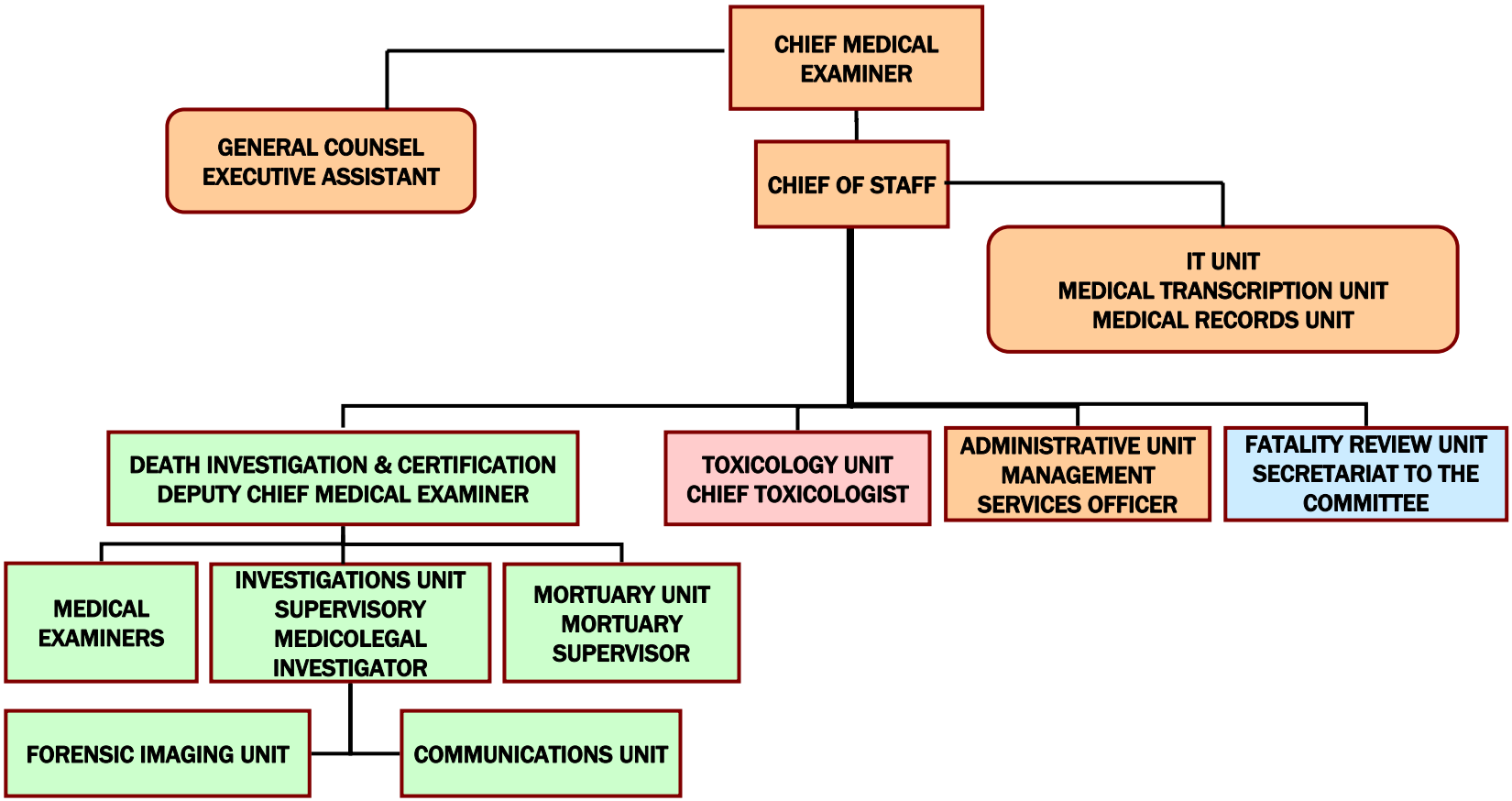
Hispanic/Latino (of any race) Population



APPENDIX A

2005 OCME Organizational Chart

OFFICE OF THE CHIEF MEDICAL EXAMINER
2005 ORGANIZATION CHART



APPENDIX B

AGENCY MANAGEMENT

AGENCY MANAGEMENT

Personnel Management:
During 2005, OCME focused on maintaining a qualified and diverse workforce through the implementation of employee retention and recruitment efforts. Employee retention efforts include workshops and training sessions during monthly staff meetings, continuous improvement and clarification of agency policies and procedures, Employee Incentive Awards (monetary and non-monetary) for performance, and a focus on labor relations. The number of full time positions increased from 66 to 89 positions throughout two existing programs (Death Investigation & Certification and Agency Management) and a third, newly established program (Fatality Review). Of 89 authorized positions, 73 were filled; 14 were in the recruitment or classification process; and 2 were vacant.

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

Pursuant to Title 27, DCMR Chapter 8, Local, Small and Disadvantaged Business Enterprises (LSDBE) Contracting regulations, each agency of the District of Columbia must allocate fifty (50%) of its expendable budget for use with Local Business Opportunity Commission certified Small Business Enterprises (SBE). For 2005, the agency met these LSDBE requirements. This accomplishment is significant because the agency was allowed to continue to provide highly professional service to the decedents' families, law enforcement, health community, officials, and the community at large. The agency will continue to 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 2005, 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. Over the course of 2005, the HVAC system continued to cause water leakage and damage and temperature variances throughout the facility. Work on the HVAC system was completed, however, the problems continued. After evaluation, OPM determined additional repairs were needed to address air quality issues and began the design work and contracting process.

OCME also worked with OPM on in-house renovations to accommodate OCME spacing challenges for current staff and new hires. The renovations began in the fall of 2005 and included expanding the reception area and renovation of office spaces to increase the number of offices and spacing for employees. 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. While all of these projects were forecast to be completed in 2005, they were continued into 2006.

Information Technology:
During FY 2005, 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 2006.

The IT team focused on the development of a FACTS mass fatality module so that staff is able to utilize the system in an emergency incident. Additionally, the agency deployed smart board technology, which will enable medical examiners to enter autopsy findings into protocols and templates directly from the autopsy suite during the autopsy. The information and data is input at the autopsy table and a report generated from the desktop ready for transcription. Digital photography has also been implemented in the autopsy suite and on death scene investigations. Additional projects include bar coding and establishment of an OCME website.

Risk Management:
The agency's Risk Assessment Control Committee ("RACC") met all D.C. Office of Risk Management (ORM) requirements in 2005, which included: holding monthly meetings and providing monthly meeting minutes and cost of risk reports; implementing an Agency Risk Management Plan; developing a Continuation of Operations Plan; updating its Emergency Response Plan; and providing quarterly updates and a year-end report to the Office of Risk Management. As part of Risk Management, health and safety issues continue to be addressed. The agency continues to provide radiation monitoring and annual tuberculosis testing. OCME also coordinated emergency response planning activities with other emergency responders, locally, regionally and federally. The agency has worked on developing citywide collaborations with funeral directors and their association's board members, as well as the Pathology departments of universities and DC hospitals to set forth protocol for assistance during a mass fatality. The agency is also a member of the Interstate Compact Committee (comprised of the surrounding jurisdiction medical examiner offices and other entities), which engages in mass fatality planning and live exercises. The agency has attempted to hire a consultant through grant funding to assist in review and implementation of its mass fatality plan. Unfortunately, the requisite experience and qualifications have not yet been identified for a project of this type.

Labor Relations:
OCME's Labor Management Partnership Council, comprised of labor and management employees, was active in 2005 and completed several projects. In 2005, OCME labor and management worked together to raise funds for the D.C. Government Employees 50th 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.

The agency's LMPC also focused on ensuring that all employees were aware of union membership and were provided the appropriate union representation. Further, the agency is proud to have been awarded third place in the District-wide Labor Management Partnership Pothole Awards for its exemplary work in Customer Service during FY2005.

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 had an Employee Holiday Celebration in December 2005. As part of its LMPC initiatives, OCME provided clothing, school supplies and toiletry items to various charitable organizations throughout the city.

Emergency Response/Mass Fatality Planning:
Over the course of 2005, OCME actively pursued activities to support its mass fatality and emergency response planning. The agency's Mass Fatality Plan establishes the framework for response to mass disasters; describes OCME's roles and responsibilities; and outlines OCME's relationships with local, federal and volunteer agencies that may support OCME in its functions. OCME's emergency response planning also included:

- staff training and participation in various emergency preparedness conferences;
- agency quarterly emergency response drills;
- participation in District National Response Drills; and
- participation in Forensic Lab planning.

APPENDIX C

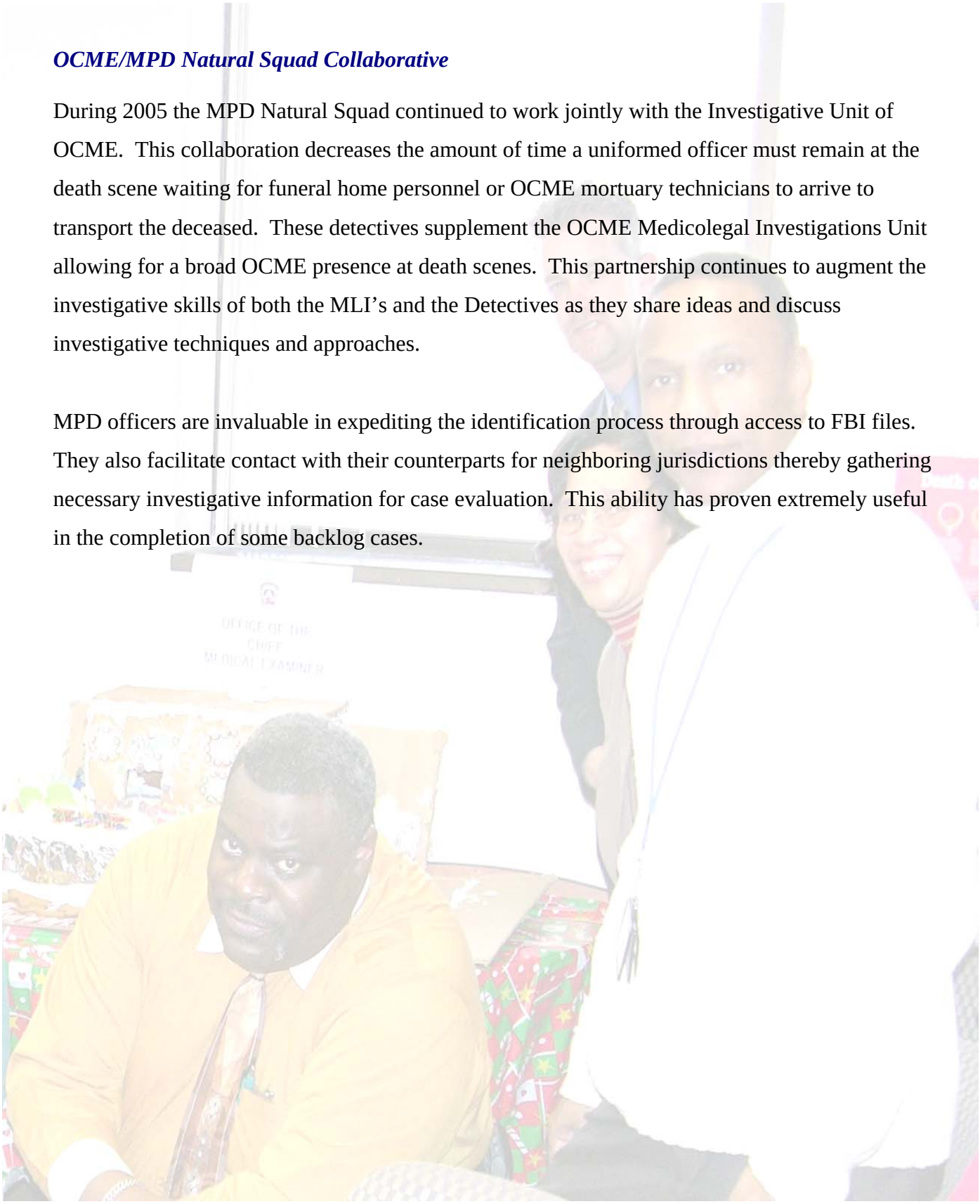
INTERNAL PARTNERSHIPS

INTERNAL PARTNERSHIPS

OCME/MPD Natural Squad Collaborative

During 2005 the MPD Natural Squad continued to work jointly with 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 continues to augment 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.



OCME/Wendt Center for Loss and Healing Collaborative

During 2005 the staff members of the Wendt Center for Loss and Healing continue to provide grief counseling services for the Office of the Chief Medical Examiner (OCME), 8 hours a day, 365 days a year.

The staff of the Wendt Center not only provides grief counseling to the family members we serve, but they also provide counseling to the OCME staff when needed. We continue to embrace and encourage the expert and compassionate service they provide to the citizen's of the District of Columbia and the staff of the office.

This collaborative continues to educate the OCME staff and the public. As exhibited in the photo above, the Wendt Center has provided an invaluable resource center for all who are grieving, with special emphasis on how to help children through the grieving process.

APPENDIX D

OTHER MAJOR ACTIVITIES

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

OTHER MAJOR ACTIVITIES

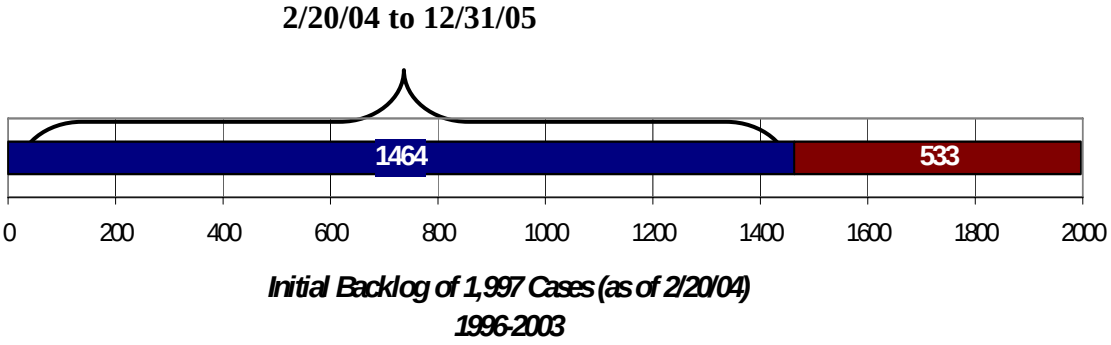
Backlog

As reported in 2004, this backlog of autopsy reports accumulated during the years 1996 through 2003 due to various factors, but 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, however during 2005 a second, more exhaustive, recount was performed in response to a Freedom of Information Act (FOIA) request, which revealed an additional 134 cases. As a result the new total was reported as 1,997. This recount took an enormous amount of manpower and resources; the OCME management staff is very grateful to all who went above and beyond the call of duty to fulfill this request.

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.

Year	Initial Backlog as of 2/20/04	Cases Completed during CY 05	Remaining Backlog as of 12/31/05	% of Total Cases Completed as of 12/31/05
1996	2	Completed	0	**100%**
1997	85	11	19	**78%**
1998	19	Completed	0	**100%**
1999	201	51	69	**66%**
2000	300	119	151	**50%**
2001	295	154	98	**67%**
2002	348	123	175	**50%**
2003	747	215	21	**97%**
TOTALS	**1997**	**673**	**533**	**73%**

Table 1: Backlog of Autopsy Reports by Year (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 family, civil and criminal litigations. OCME includes tabulated data for expert services provided in calendar year 2005.

Type of Judicial Service	Number of Cases
Court Testimony	51
Depositions	3
Pre-trial Conference	74
Total	**129**

Note: For 2005 "*Depositions*" has been included in all of the total calculations.

Court Services by Jurisdiction	Number of Cases
DC	120
Maryland	5
Virginia	4
Total	**129**

Court Services by Type	Number of Cases
Civil	5
Criminal	123
Family	1
Total	**129**

Note: The Chief Medical Examiner provides expert court services for most of the cases where a Medical Examiner is no longer with the District Government. For 2005 these additional services represented 37% of the CME's total court caseload.

Education

OCME continues to welcome students and residents from area universities and hospitals for their teaching requirements. We also participated in the 2005 Career Day Activities hosted by the local public schools here in the District of Columbia. In addition, the agency either hosted or was invited to lecture and/or provide presentation at the following medical institutions and/or major conference:

1) DC Veteran's Administration Medical Center - Death Certificate Presentation for the Geriatrics Medicine Fellows and Medical students, Washington, DC, June 27, 2005
2) 2005 ICITAP Basic Homicide Investigation Course – 4-day course hosted by OCME, June 21 through June 24, 2005
3) National Center for Victims of Crime: 1st National Conference – presentation on homicide statistics for 2004, Washington, DC, June 21, 2005
4) Operation Prevent Auto Theft – Monthly lecture and tour (seasonal)
5) DC Medical Examiner's Office Familiarization Training for Metro Transit Police Officers
6) Partners in Education with Arlington Public Schools – Annual Presentation
7) Mental Health and Mental Retardation free one-day Conference and Luncheon for Support and Services for Seniors with Co-occurring Disabilities, Washington, DC, November 16, 2005

Additional Educational Services provided by the Toxicology Unit

Lectures / Presentations:

1) A Combined Drug Intoxication Involving Metaxalone (Skelaxin®) – presentation at the Joint SOFT-TIAFT-FBI Forensic Toxicology meeting, Washington DC
2) The Role of the Toxicology Laboratory in DUI Cases – presentation at the D.C. United DWI Training (for OAG, MPD, USCP, USPP, USSS, FBI), Washington DC
3) Drug-Facilitated Sexual Assaults – presentation to the U.S. Attorney's Office, Metropolitan Police Department and U.S. Park Police sexual assault investigators, Washington DC, June 28, 2005

Peer-reviewed publications:

1) Forensic Applications of New Analytical Technologies –Forensic Magazine April/May 2005.
2) Fatal Methadone Intoxication in an Infant –Forensic Science International, 2005
3) Substance misuse: Cocaine and other stimulants – Encyclopedia of Forensic and Legal Medicine; Elsevier Limited; UK, 2005
4) Substance misuse: Sedatives – Encyclopedia of Forensic and Legal Medicine; Elsevier Limited; UK, 2005
5) Substance misuse: Miscellaneous (volatiles, hallucinogens and 'club' drugs) – Encyclopedia of Forensic and Legal Medicine; Elsevier Limited; UK, 2005

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
DVFRB, DC Law 14-296, codified at DC Official Code §16-1051 et seq. (2001)

OCME - DC Official Code §5-1401 et seq (2001 and Supp.)

CFRC Legislation and Mayoral Order 98-67

MRDD FRC Mayoral Order 2005-143

DVFRB – DC Official Code §16-1051 et seq. (2001 and Supp.)

APPENDIX A

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

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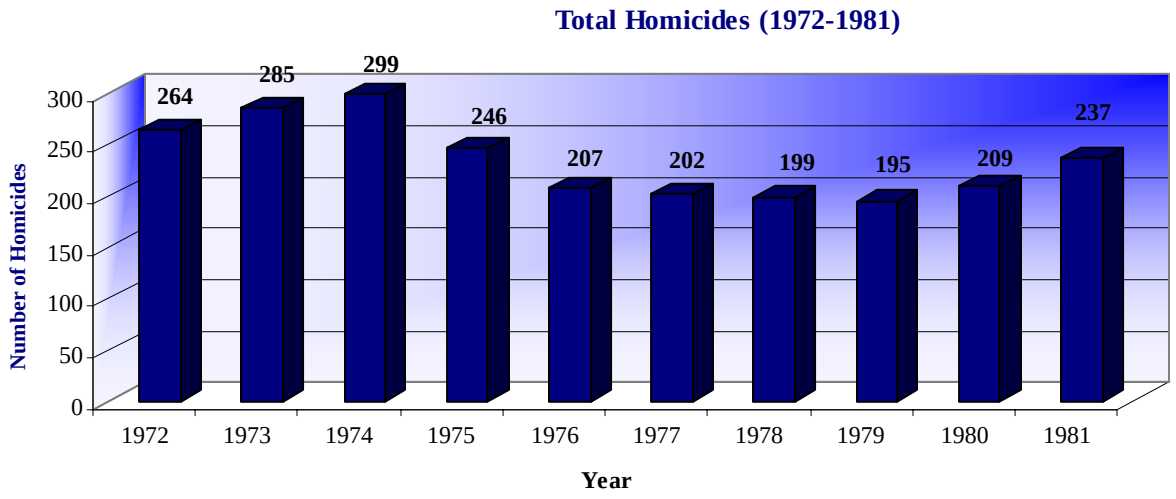
A 30-YEAR REVIEW OF HOMICIDES IN THE DISTRICT OF COLUMBIA (1972-2002)

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.



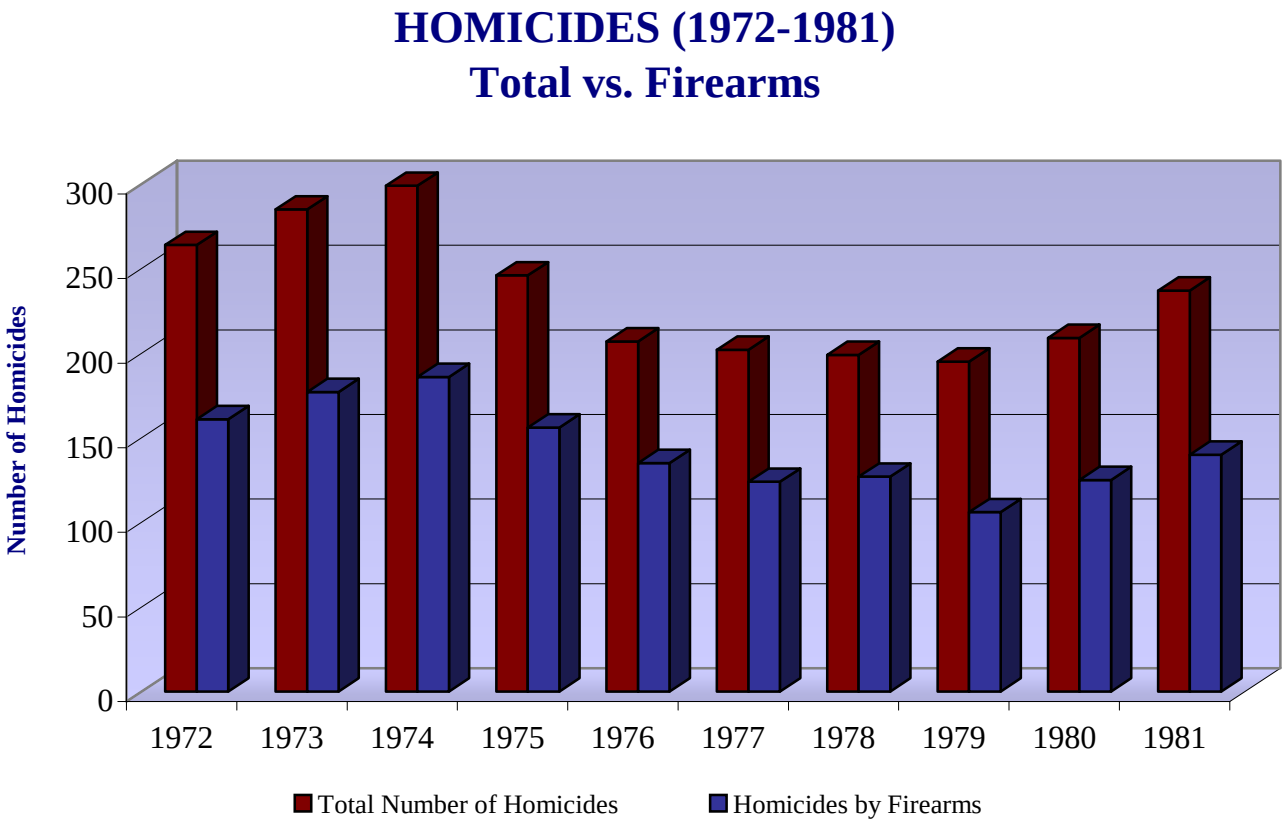
The study of these years reveals several compelling facts. We will begin with the use of firearms and end with alarming data regarding race, age and gender. The first annual report ever produced by the Medical Examiner's Office in 1972, after it transitioned from the Coroner's System, contained a startling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



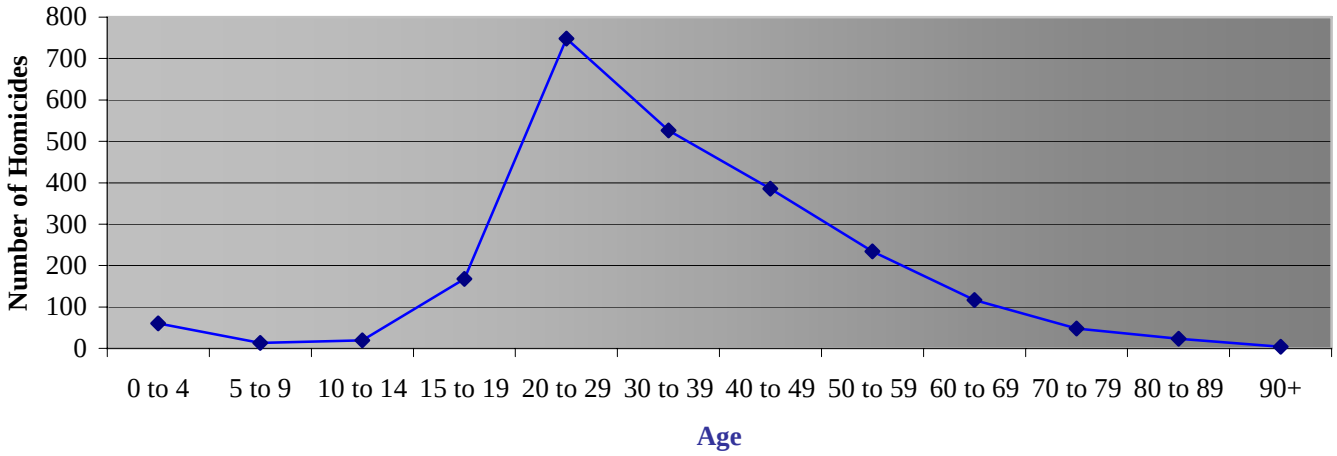
HOMICIDE BY AGE (1972-1981)

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

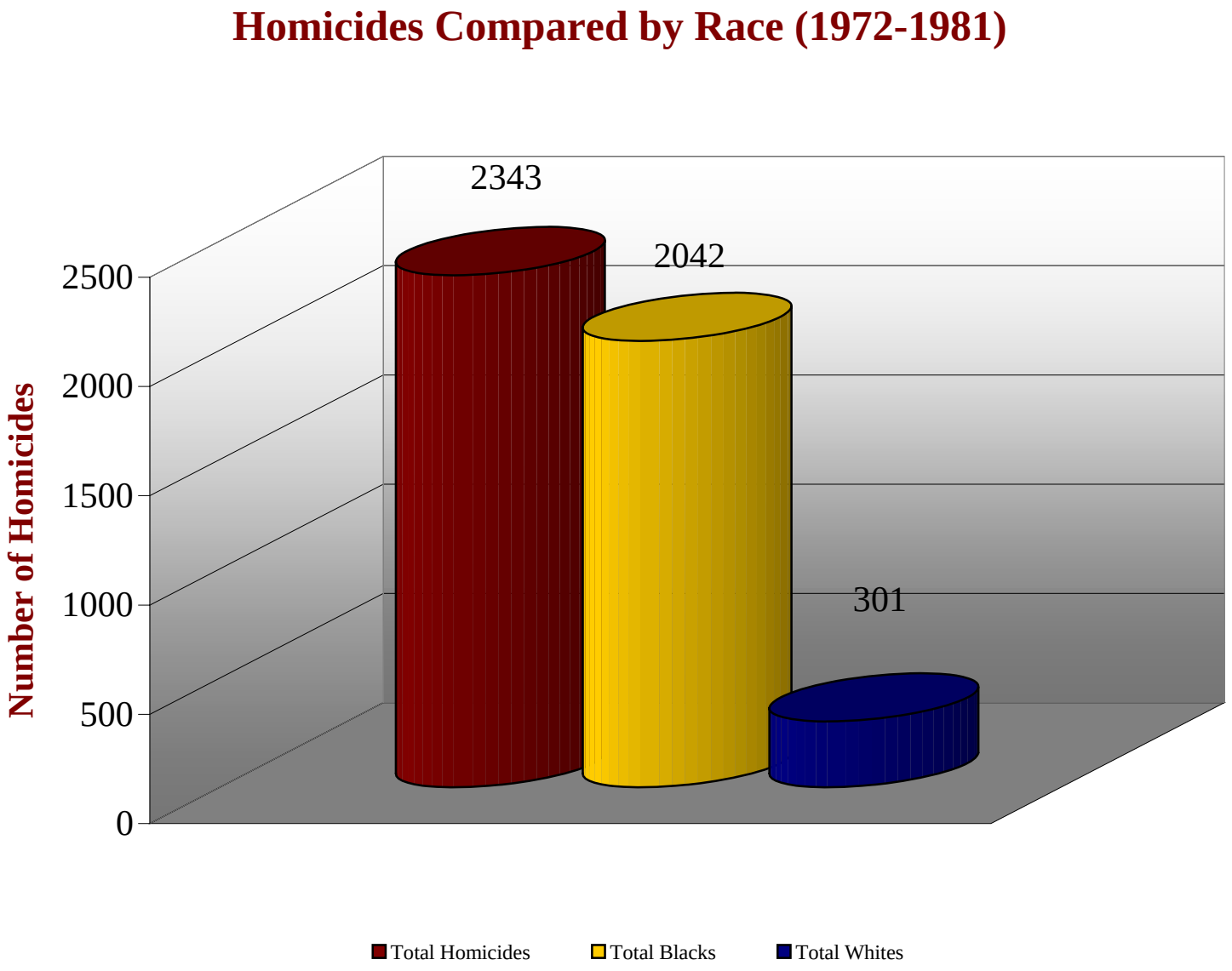
Year	0 to 4	5 to 9	10 to 14	15 to 19	20 to 29	30 to 39	40 to 49	50 to 59	60 to 69	70 to 79	80 to 89	90+
1972	8	2	0	27	78	52	51	27	10	6	2	1
1973	13	2	5	14	100	57	46	23	15	7	3	0
1974	8	2	2	18	95	70	54	27	14	4	5	0
1975	5	1	3	15	80	49	45	30	6	11	1	0
1976	3	1	2	18	61	51	33	19	14	4	1	0
1977	2	0	2	14	60	49	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

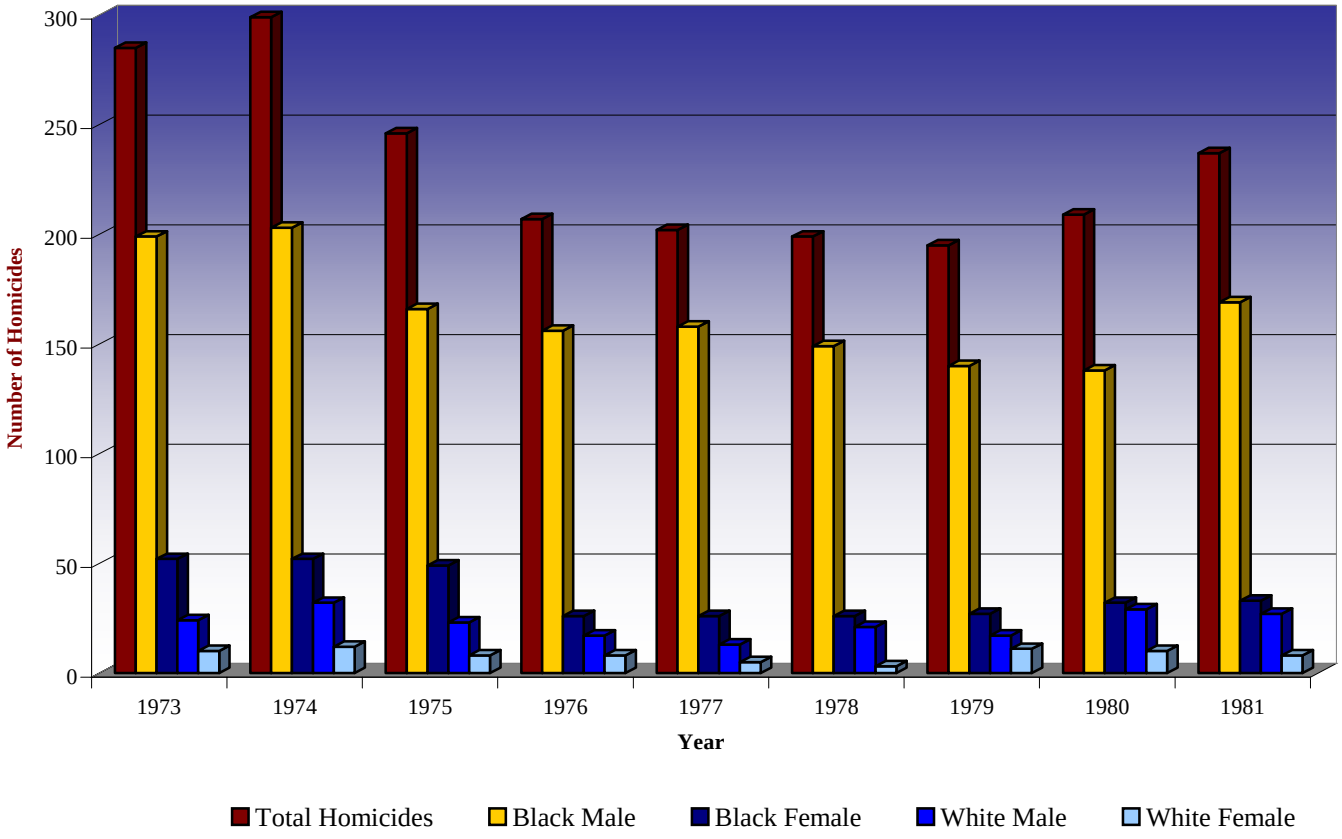
The demographics of the affected population remained constant throughout this study period. Blacks/African Americans consistently represented 88 to 91% of the victims; Black/African American males paid the highest toll making up 70 to 81% of the group. The number of deaths for Black/African American 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**

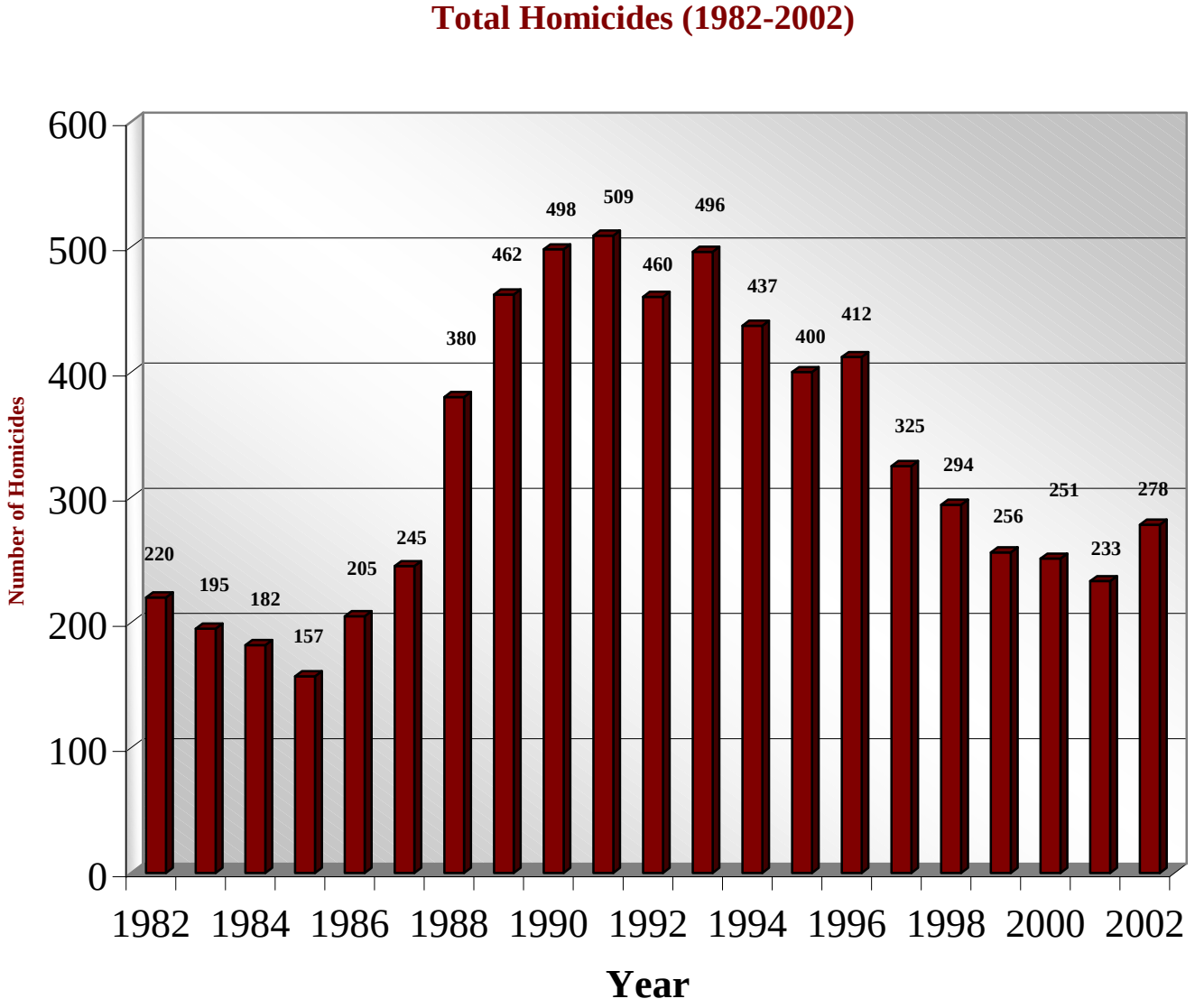
Homicides by Race and Gender
(1973-1981)



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.

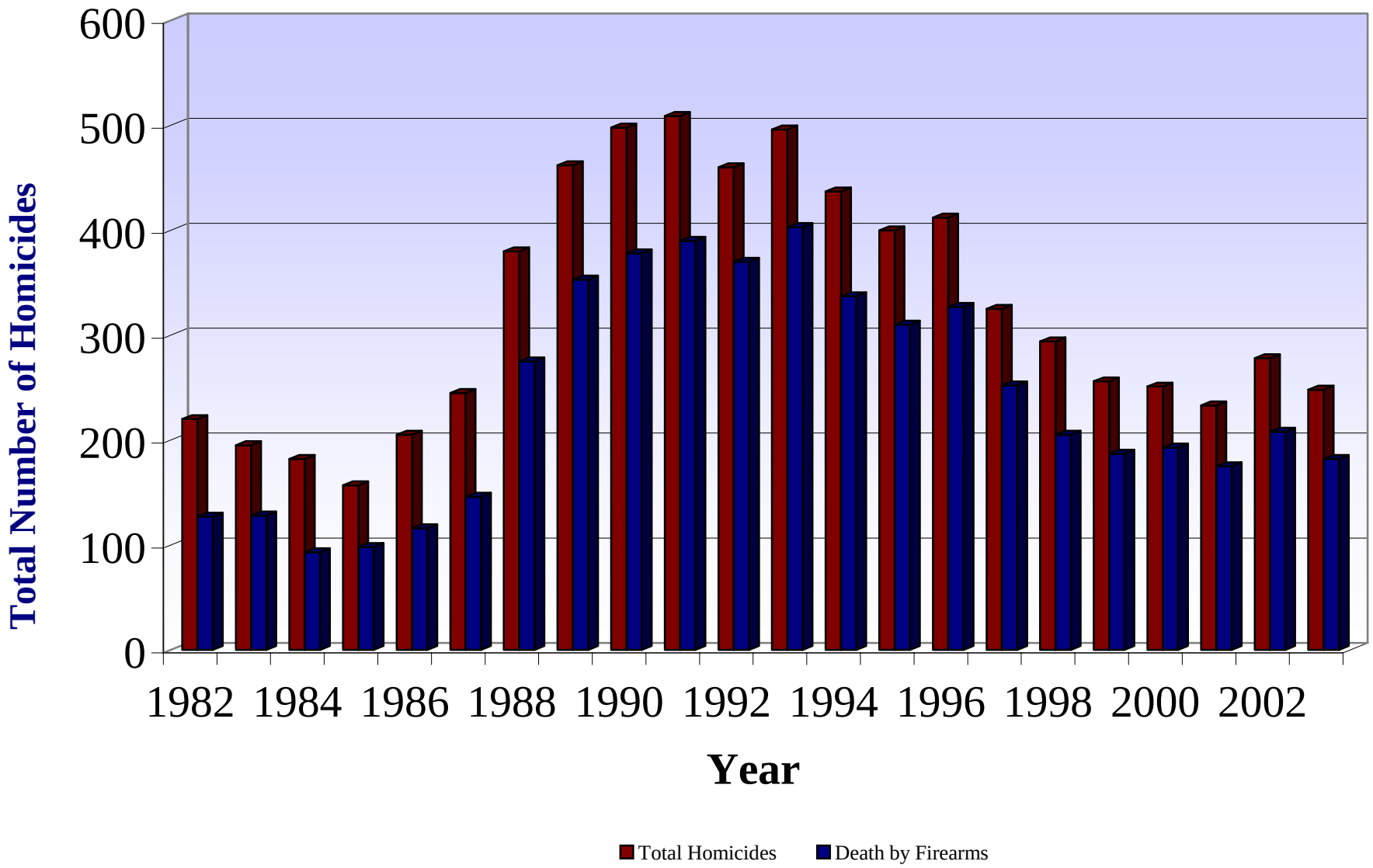


HOMICIDES BY FIREARMS (1982-2002)

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)

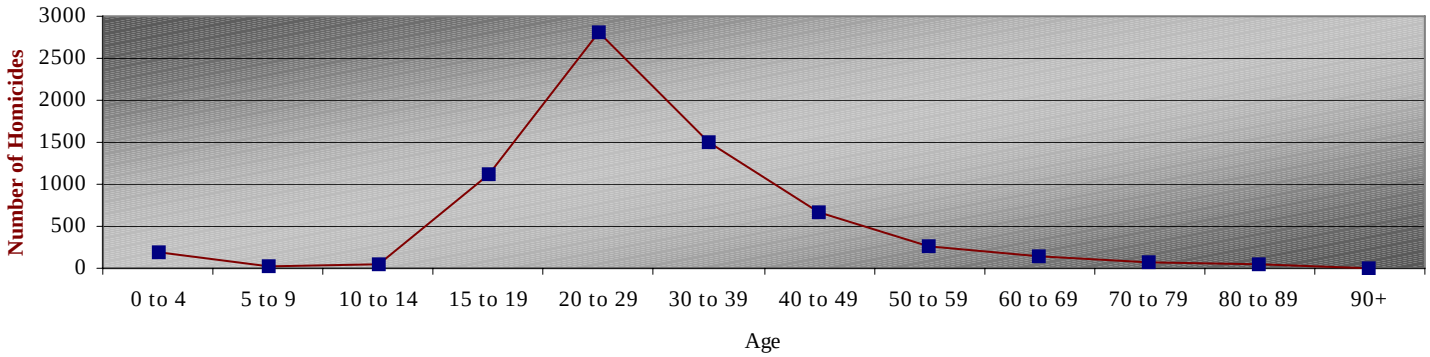
The age group with the highest number of deaths changed, especially in the Black/African American population. While the number of homicides generally affected the age group 20 to 49, there was a marked increase in the 15-19-age range during 1988 through 1997, far exceeding the numbers (10 to 20) seen 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

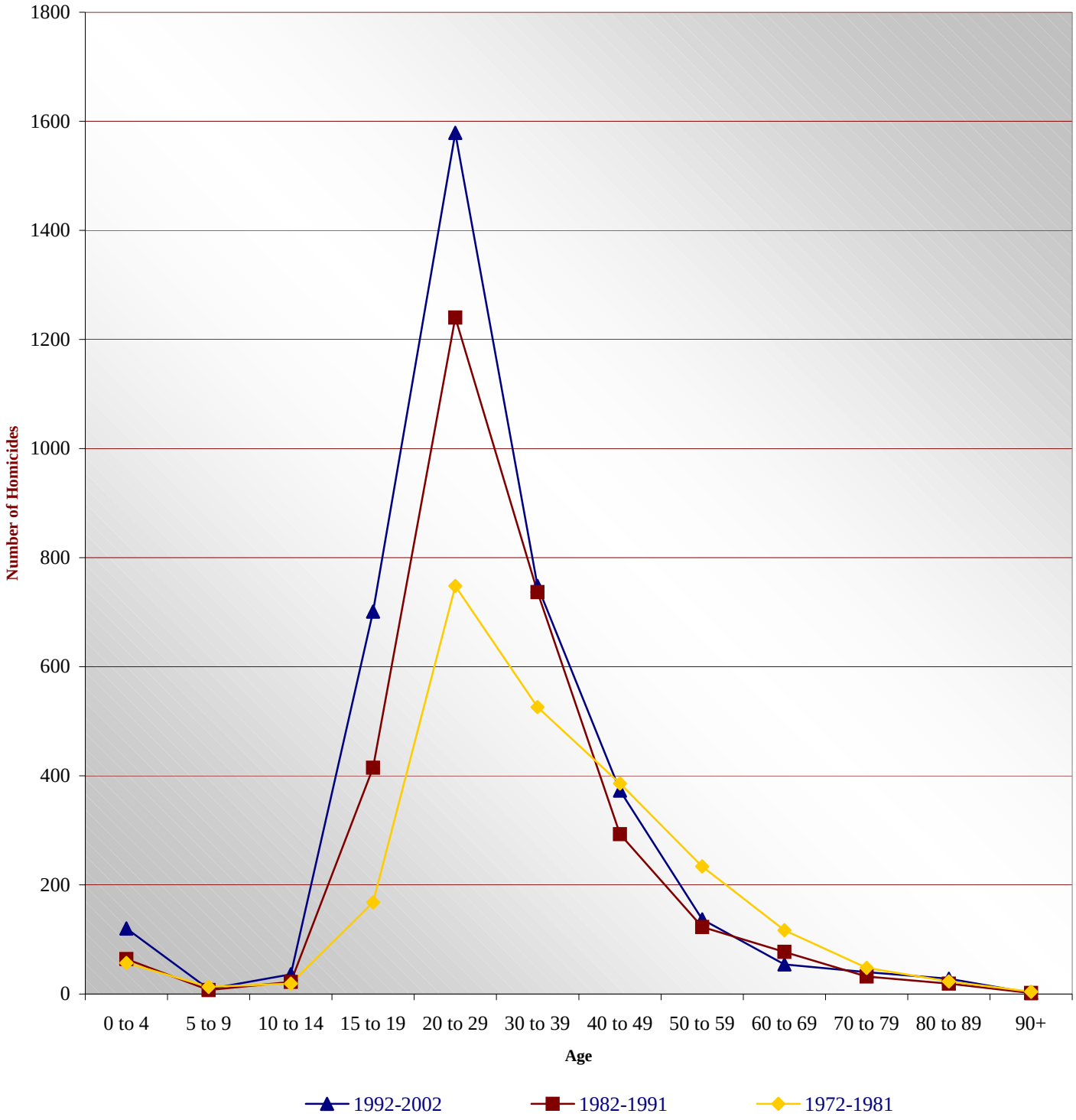
Year	0 to 4	5 to 9	10 to 14	15 to 19	20 to 29	30 to 39	40 to 49	50 to 59	60 to 69	70 to 79	80 to 89	90+	Total
1982	8	1	1	13	72	66	26	13	15	3	1	0	219
1983	5	0	1	17	72	50	23	14	6	6	1	0	195
1984	3	0	1	17	79	41	19	11	10	0	1	0	182
1985	6	0	1	14	53	45	23	8	6	1	0	0	157
1986	7	1	0	17	69	68	23	8	6	5	1	0	205
1987	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)

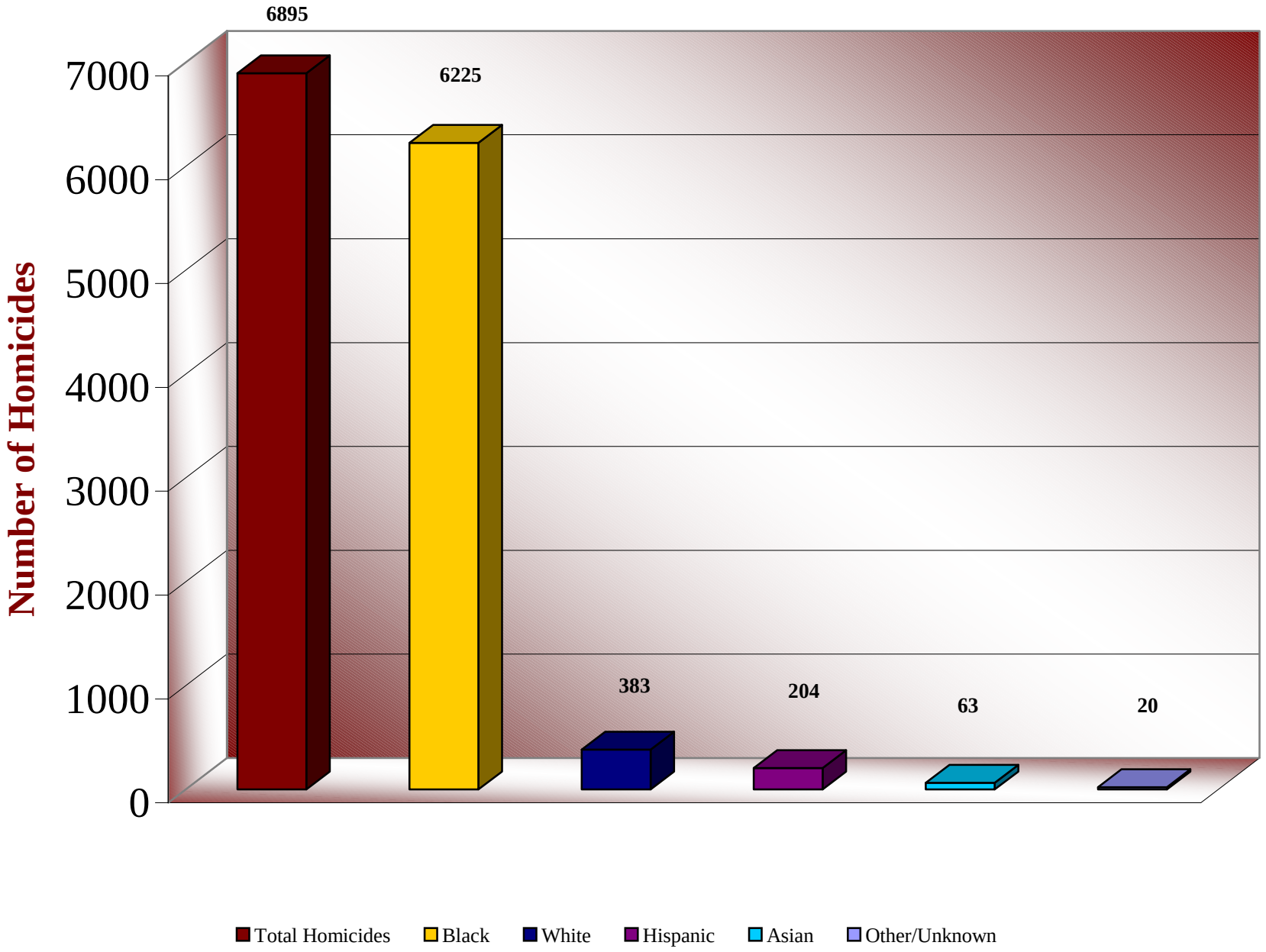
From 1986 through 1998, when the number of homicides per year surged in the District of Columbia, the number of homicides was more dominant in the black and white races, so our comparison will focus on these 2 primary races. The data reflects that white males peaked at 22 in 1990, but during this same 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

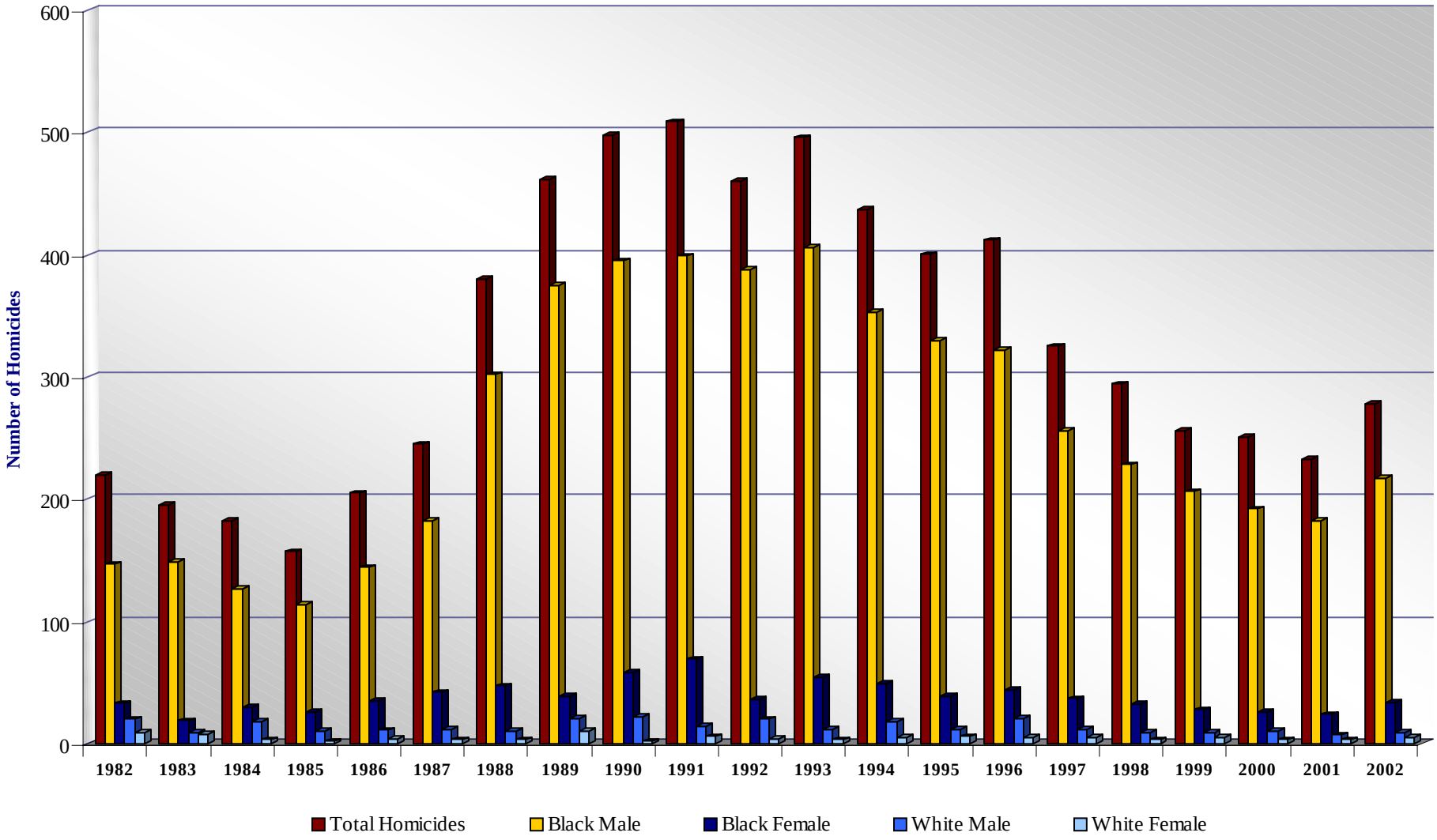
HOMICIDE BY RACE AND GENDER (1982-2002) - Continued

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

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