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

ANNUAL REPORT
2011

Government of the District of Columbia

Allen Y. Lew, City Administrator

Vincent C. Gray, Mayor

Executive Office of the Mayor

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

DISTRICT OF COLUMBIA
OFFICE OF THE CHIEF MEDICAL EXAMINER

MISSION:

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

The Executive Leadership Team
(2011)

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

Beverly A. Fields, Esq.
Chief of Staff

Sharlene Williams, Esq.
General Counsel

Lucas W. Zarwell, MFS
Chief Toxicologist

Peggy J. Fogg
Management Services Officer

Anna D. Francis, IT Specialist
QA/QC Officer

Viola Hiers
Executive Assistant

PRESENTED TO:

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

A LETTER FROM THE CHIEF MEDICAL EXAMINER

As the agency moves toward transition from our longstanding facility at 1910 Massachusetts Ave. SE to the Consolidated Forensic Laboratory, I am persuaded to reflect on the many unsung accomplishments of the agency during my 27 year tenure serving the District. First, I remember entering a building filled with congenial staffers whose dedicated performance advanced the agency through years of heightened crime and an overwhelming number of homicides (i.e., murder capital of the world), chronic understaffing, lack of funding and only tolerable building conditions.

Mostly, I think of the last 10 years, when upon requests from successive Mayors and from the staff, I moved from my Deputy Medical Examiner position to the Chief Medical Examiner leading the agency towards accreditation of the former facility. This was possible due to the dedication and support of the staff, as the agency had several significant challenges including: a) a backlog of over 2000 incomplete autopsy reports which was eliminated by 2006; b) hundreds of bodies piled high in the morgue which were finally afforded proper burials; and c) thousands of pieces of personal property that had accumulated in safes were returned to grateful family members. Prior to 2003 several critical and required documents had not been written/published and since that time the agency has published timely annual reports and policies and procedures, incident plans (i.e., Mass Fatality, Emergency Response, COOP) and an employee manual.

Moreover, over the years, the following programs were established and implemented: quality assurance and control; facilitation of tissue/organ recovery; re-establishment of the histology laboratory; employee health and safety wellness program; grief counseling contract (a model in the nation); educational and training partnerships with District agencies (i.e., MPD, ORM, US Attorney's Office, Public Defenders Service); hospitals, universities; and the U.S. State Department.

Over the past 10 years, the agency focused significant efforts on incident planning, including the completion of a mass fatality plan (MFP), development of a Continuity of Operations Plan (COOP) and enhancement of the Emergency Response Plan (ERP). In addition to consistent in-house review and staff training on the plans with various incident scenarios, the agency participated in numerous city-wide emergency preparedness exercises conducted by District government public safety and emergency response agencies and private entities, such as universities and hospitals. However, the exercises had historically not included the OCME or "fatalities."   The agency continued to engage in various outreach efforts -- including provision of the agency's mass fatality plan, meetings with government and private entities involved in emergency response and after action report recommendations -- in order to explain the importance of exercising mass fatality incidents, as opposed to casualties only. As a result, recent exercises now include the agency and fatalities in incident training exercises.

Technology has also been a priority resulting in an advanced Forensic Automated Case Tracking System (FACTS); upgraded mobile technology and remote access from the field for the Investigations and Forensic Pathology units; digitization of fingerprinting, radiography and photography; digital recording of autopsy findings; implementation of electronic death registration system; and purchase of medical grade computer systems and multi-headed microscope. The agency also received the Paul Coverdell Forensic Science grant via the Department of Justice which allowed the implementation of an innovative digitization project that is being recognized as "best practice" amongst medical examiner offices and support a "paperless environment." This project involves digitizing all historical medical examiner case files, x-rays and photographs from 1972 to 2003. In 2003, the agency implemented an automated case tracking system for current cases, which produces an electronic version of key data within the case file.

During the past few years, the agency has also realized the professionalization of the staff as employees were hired with graduate and master's degrees in Forensic and Health Sciences within the mortuary and photography units. This has enabled the agency to meet objectives and key performance measures and keep up with advances in the forensic death investigation field.

Due to the accomplishments discussed above, the agency was in a position to apply for and achieved provisional accreditation status from the National Association of Medical Examiners (NAME) in 2008, a first in the agency's 39 year history which included five previous board-certified CMEs. Achieving this accreditation during my tenure was a result of the agency meeting the requirements with minimal deficiencies.   NAME policies state that provisional accreditation can be extended up to four times with a demonstration of a good faith effort to address deficiencies. While the agency's accreditation status was only extended twice, the agency and the District overall certainly made good faith efforts and believed the agency was deserving of such status per NAME policy. As such, the denial of accreditation extension remains a mystery. Ultimately, I am honored by the NAME Inspector stating that "[t]he remarkable turnabout of this office is a tribute to. . .[Dr. Pierre-Louis']. . .steady leadership and team-building. Considering the exceptional performance of this particular Chief, I would not recommend that she be replaced but rather be encouraged to remain as Chief Medical Examiner."

In 2011, the agency's Forensic Toxicology Laboratory was awarded accreditation status by the American Board of Forensic Toxicologists (ABFT) also for the first time in the history of the agency during my tenure. It is important to note that the forensic toxicology staff received extensive training in alcohol and highway safety and on the effects of drugs utilizing a portion of the Coverdell grant discussed above.

Such progress, training and advances enabled the laboratory to develop, takeover and operate a new Model Breathalyzer Program for the District, another successful endeavor.

My reflection of the past years and accomplishments, as I have discussed, demonstrate the agency's readiness to transition to a new, modern and technologically advanced environment as we look toward the future and the agency's continued growth. At last, we are there with the challenge of conducting business on the 1st, 5th and 6th floors of the CFL. I am grateful for a smooth, well planned and well executed transition with no flaws and, no mishaps and no interruption of workflow. To the staff of the OCME, I would like to acknowledge that you all are truly an amazing staff and I am proud to have been your leader this year.

Sincerely,

Dr. Marie-Lydie Y. Pierre-Louis
Chief Medical Examiner

Executive Summary

This Annual Report covers data that resulted from the investigation of 2,989 deaths that occurred in the District of Columbia during the Calendar Year (CY) 2011. The report also presents key agency accomplishments and other major activities such as Expert testimony by the Medical Examiners, Decedents Identification, Disposition of Unclaimed Remains, Toxicological results in Driving Under the Influence (DUI) and Drug Facilitated Sexual Assault (DFSA) cases and educational endeavors of all OCME units. The agency hopes that the information contained in the report will be useful to the Executive Office of the Mayor and the Council of the DC and be informative to the public at large.

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

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

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

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

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

Accomplishments

A major endeavor for the agency was the preparation for relocation in a new, combined forensic facility. The agency had been housed in its present location for almost 40 years and inventory and classification of assets as well as pre-moving meetings occupy a large amount of the Executive staff time. An inventory system was devised and implemented, and related tasks were assigned to different staff members depending on their skills and workload.

Another major accomplishment was the Inspection and Accreditation of the OCME Forensic Toxicology Laboratory by the American Board of Forensic Toxicologist (ABFT) for the first time since the creation of the agency. The accreditation date was December 2011.

The agency, again, received a US Department of Justice grant, the Paul Coverdell Forensic Science Improvement grant. This allowed the agency to continue the digitization of its historical records. About 30,000 medical examiners case files of fragile, degrading paper, and maintained in outside archiving facilities, and covering years 1972-2002 have been so preserved using the grant, making them more accessible and searchable.

The grant was also used for professional advancement of the members of the Forensic Toxicology division.

Customer Service

Throughout the year, the agency provided customer service consistent with the District's mission and is rated several percentage points above the city-wide average. The OCME staff is recognized for engaging in compassionate and efficient interactions with the next-of-kin, as well as for cooperative relationships with funeral directors, law enforcement and other institutions. The OCME continues to offer on-site grief counseling to family members who come to the agency to identify loved ones. The agency uniquely provides this well appreciated and well recognized service in the DC Metropolitan area through a contract with the Wendt Center for Loss and Healing.

Mass Fatality and Emergency Response

In preparation for possible terrorist attacks and mass disaster, OCME updated its mass fatality and Continuing Operations Plan (COOP) in coordination with the National and District Response Plans. It has also maintained alliances with area hospitals, the Department of Health (DOH), and agencies in the Public Safety and Justice Cluster. Its readiness was tested during the earthquake of August 23rd, 2011 and the HSEMA District-wide Response Full-Scale Exercise of September 28th, 2011. OCME is a member of the Interstate Compact that seeks to develop interstate mutual aid and unites Maryland, Virginia, Delaware, the District of Columbia, Federal Agencies and other jurisdictions in the event of a mass incident.

Education

The agency's staff presented numerous lectures and conferences at the facility and at other sites to different groups including Residents of local University Hospitals, medical students, law students of The American University, detectives of the MPD, US State Department Program, and various youth groups and students (The National Youth Leadership Program, LEAD America, Career Day a the District of Columbia Public and Public Charter schools, and the Mayoral Summer Youth Program). Qualified staff also taught a Graduate Student Class for the Forensic Sciences Program of the George Washington University Hospital. The CME is also a member of the Board of the UDC Mortuary Sciences Program. The agency offers several internship opportunities to the students of the above-mentioned programs as well as Physician Assistants from the Arcadia University. The OCME also provided training for the members of the MPD, the United States Attorney's office, the State Department personnel, and soldiers of the Marine Corps.

OVERVIEW OF CASES REPORTED AND INVESTIGATED

During the Calendar Year (CY) 2011, **2,988** cases were reported to and investigated by the Office of the Chief Medical Examiner (OCME).

Medical Examiner Caseload

Accepted Cases: The OCME accepted jurisdiction of 1,121 cases, of which 827 cases were autopsied.
Declined Cases: The OCME declined jurisdiction of 1,811 cases, of which 39 became Storage cases.

Storage Requests: The D.C. OCME provides a unique service to area nursing homes, hospices, and other like facilities by accommodating requests to store deceased bodies. **Fifty-six** of the reported cases were Storage Requests only. However, **one** (**1**) accepted case became a storage case and **39** of the declined cases became storage request so as a result; the agency had a total of **96** Storage Requests (See section 4.0 for additional statistics).

Cremation Requests: The OCME investigated 2,349 cremation requests.
Scene Visits: OCME staff reported to 511 scenes.
Body Transport: The OCME transported the bodies of 1,082 decedents from scenes of death to the agency.
Organ/Tissue Donations: There were 141 organ donation requests during CY 2011.

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

2011 Medical Examiner Cases by Manner of Death

Manner	Full Autopsy Examinations	Partial Autopsy Examinations	External Examinations	Review of Medical Records	Total
Accident	214	4	106	9	**333**
Homicide	125	0	0	0	**125**
Natural	343	50	135	15	**543**
Stillbirth	2	0	0	2	**4**
Suicide	42	0	2	0	**44**
Undetermined	47	0	3	0	**50**
Total	**773**	**54**	**246**	**26**	**1099**

Note: The above table does NOT include the following cases; because neither an Autopsy Report nor a Death Certificate is produced: "*Non-Human Remains*" - **22**.

SUMMARY OF FINDINGS FOR MANNER OF DEATH

HOMICIDES: The OCME investigated 125 homicides in the CY 2011. This report reveals that homicides continued to be more prevalent in black males and in persons between the ages of 20-29. The weapon of choice was firearms. The peak incidents occurred in October.
Toxicology Findings: Toxicology testing was requested on all 125 Homicide cases investigated. Drugs were present in 81 of the homicide cases investigated. The most commonly detected drugs in homicide cases were: Ethanol (N=46), Marijuana Metabolites[1] (34); Phencyclidine PCP (15), Cocaine (11), Pentobarbital (2) and Morphine (1).

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

SUICIDES: The OCME investigated 44 suicides in the CY 2011, which is a 5% decrease from 2010 (46). This report reveals that suicides were more prevalent in white males and in persons between the ages of 40-49. Overall whites represented 52% of the decedents (n=23) this year. Peak incidents occurred in May.

Toxicology Findings: Toxicology testing was requested for 43 of the 44 Suicide cases investigated. Overall, drugs were present in 25 of the suicide cases investigated. The most commonly detected drugs were: Diphenhydramine (N=8); Ethanol (7), Citalopram (6); Morphine (5); and Doxepin (4).

ACCIDENTS: The OCME investigated 333 accidents in the CY 2011. Of the 333 cases investigated, 165 were the result of blunt force trauma, of which 51 were traffic-related deaths. Also, 96 of the accidental deaths occurred as a direct result of prescription and/or illicit drug use. Peak incidents for accidental deaths overall occurred in June.

Traffic-related Accidents: 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 traffic accidents only occurred in January and March.

Other causes of accidental deaths included environmental exposure, asphyxial injuries, drowning, and therapeutic complications.

*Overall Toxicology Findings for Accidents***:** Toxicology testing was requested for 214 of the 333 Accident cases investigated, and drugs were present in 173 of these cases. The most commonly detected drugs were: Ethanol (83), Cocaine (N=59), Heroin (30), Codeine (20), Morphine (19), Phencyclidine (18), Marijuana Metabolites (16) Methadone (15), Oxycodone (10).
Toxicology Findings for Traffic-related accidents: Toxicology testing was requested for 44 of the 51 Traffic-related Accidents, and drugs were present in 26 of these cases. The most commonly detected drugs were: Ethanol (N=16), Marijuana Metabolite (5), Cocaine (2), and PCP (2). In the 16 traffic related deaths positive for ethanol, 8 or 50% were greater than twice the legal limit (0.16g/100mL) for driving under the influence in the District of Columbia. The legal limit for Blood Alcohol Concentration in the District of Columbia is 0.08% while driving.

DRUG OVERDOSES for ALL MANNERS OF DEATH: Toxicology testing was requested for 106 of the 117[2] Drug Overdose deaths (96 were Accidents; 11 were Suicides and 10 were Undetermined). Drugs were present in all 106 cases tested. The most commonly detected drugs were: Cocaine (N= 48), Ethanol (42), Heroin (28), Codeine (15), Methadone (14), Phencyclidine (13), and Oxycodone (8).

NATURAL DEATHS: The OCME investigated 543 Natural deaths in CY 2011. This report reveals that the leading cause of death in Natural cases is Cardiovascular Disease with 328 deaths, followed by Alcoholism with 39 deaths.
Toxicology Findings: Toxicology testing was requested for 343 of the 543 Natural cases investigated. Drugs were present in 199 Natural cases investigated. The most commonly detected drugs were: Ethanol (N=95), Acetone (30)[3], Morphine (27), Cocaine (22), Methadone (15), Oxycodone (16), Marijuana Metabolites (13), Citalopram (11), Diphenhydramine (11), Tramadol (9).

UNDETERMINED: The OCME investigated 50 cases where the manner of death was concluded to be "Undetermined." An "Undetermined" manner of death is a result of inconclusive evidence as to the circumstances of the death at the time and/or inconclusive examination results. As additional information is required, the death will appropriately re-certified. Note that Sudden Unexpected Deaths in Infancy (SUID) carry an undetermined manner of death.
Toxicology Findings: Toxicology testing was requested for 45 of the 50 Undetermined deaths investigated. Drugs were present in 26 of the Undetermined cases investigated. The most commonly detected drugs were: Ethanol (N=7), Morphine (5); Zoplidem (4), Nordiazepam (4), and Diazepam (6).

STILLBIRTHS: The OCME investigated 4 Stillbirth deaths in CY 2011.
Toxicology Findings: Toxicology analysis was not performed in any of the Stillbirth cases.

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[2] The cases that were not submitted were as follows: 3 of the accidents and 1 of the suicides were External examinations only with no tox requested; and 2 of the Accidental cases were a Review of Medical Records only.
[3] Fluids positive for Acetone (N=30) represented in this total are a by product of diabetes mellitus or products of decomposition and not due to ingestion.

SUMMARY OF APPENDICES

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

A. 2011 OCME Organizational chart
B. Agency Management Updates: Which includes updates on personnel management, contracting and procurement, and Information Technology
C. Program Legislation
D. Internal Services

OFFICE OF THE CHIEF MEDICAL EXAMINER

2011 Annual Report

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    Appendix A – OCME Organizational Chart (2011)
    Appendix B – Agency Management
    Appendix C – Program Legislation
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    Appendix D – Internal Services

INTRODUCTION

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

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

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

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

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

In addition to its routine caseload, the office offers temporary storage of bodies for all area hospices and local hospitals in the District of Columbia. The OCME morgue has a total capacity of 115, which can be easily exceeded. Continuous and active efforts to locate family members and bury or cremate unclaimed bodies are necessary to maintain available space. All efforts are made toward identification of the deceased before disposition. To achieve this goal, the OCME has not only trained its technical staff to fingerprint decedents, but also works cooperatively with the Mobile Crime unit of MPD and the Federal Bureau of Investigation (FBI). In addition, OCME uses comparative radiology and/or DNA analysis as necessary to ensure identification. The OCME also procures specimens for DNA analysis on each decedent processed.

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

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

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

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

2.0 – Medical Examiner Investigations and Medical Legal Autopsies

Overview of Cases Reported and Investigated

During the Calendar Year (CY) 2011, **2,988** cases were reported to and investigated by the Office of the Chief Medical Examiner (OCME).

Accepted Cases: The OCME accepted jurisdiction of 1,121 cases, of which 827 cases were autopsied.
Declined Cases: The OCME declined jurisdiction of 1,811 cases, of which 39 became Storage cases.

Storage Requests: The D.C. OCME provides a unique service to area nursing homes, hospices, and other like facilities by accommodating requests to store deceased bodies. **Fifty- six** of the reported cases were Storage Requests only. However, **one** (**1**) accepted case became a storage case and **39** of declined cases became storage requests, so as a result; the agency had a total of **96** Storage Requests (See section 4.0 for additional statistics).

Cremation Requests: OCME reviewed a total of **2,349** Cremation requests (See section 4.0 for details).

Total Number of Cases Reported and Investigated by the OCME	**2,988**
Total Number of Declined Cases	**1,811**
Percent of Cases Reported & Investigated	*61%*
Total Number of Cases Accepted for Further Investigation	**1,121**
Percent of Cases Reported & Investigated	*37%*
Total Number of Autopsies *Full – 762* *Partial –54* *Performed in a University Hospital – 11*	**827**
Percent of Cases Accepted for Further Investigation	*74%*
Number of Scene Visits by a Medical Examiner or Medico Legal/Forensic Investigator	**511**
Percent of Cases Accepted for Further Investigation	*43%*

Total Number of Bodies Transported by OCME or by Order of the OCME:
 Transported by Pick-up Service - 286
 Transported by Funeral Home -11
 Transported by Office Personnel –785
     Investigations:22
     Mortuary: 763
	1,082

Percent of Cases Accepted for Further Investigation	*95%*
Total Number of Organ/Tissue Donation Requests: *Number of requests OCME approved – 125* • *Nineteen of the approved donations were procured* *Number of requests OCME declined – 16*	**141**

Breakdown of Accepted Cases by Exam Type

Total Number of Cases Accepted and Investigated Further	**1121**
Total Number of Autopsies *Full – 762* *Partial –54* *Performed at a University Hospital – 11*	**827**
Percent of Cases Accepted	
Number of External Examinations *On-site - 241* *Off-site - 5*	**246**
Percent of Cases Accepted	
Number of Non-Human Remains *	**22**
Percent of Cases Accepted	
Number of Medical Record Reviews *	**26**
Percent of Cases Accepted	

*Definition of Unfamiliar Exam Type Classifications:

 ➢ *Autopsy Performed at a University Hospital*: During Calendar Year 2011 there were 11 cases where the autopsy was performed at a University hospital. The DC Code § 5-1409 authorizes the Chief Medical Examiner to deputize any "qualified pathologist" to perform an autopsy on a decedent that is deemed a Medical Examiner case. Some of these cases were initially declined by the OCME and later accepted based on additional information/autopsy findings. Cases in which the autopsy was completed at the hospital, still required review of the autopsy reports and completion of the death certificates be done by the Medical Examiner.

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

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

Breakdown of Case Investigations and Autopsies by Month

Month	Case Investigations	Autopsies Full and Partials
January	87	68
February	95	72
March	99	75
April	83	65
May	104	73
June	92	64
July	90	62
August	97	70
September	88	58
October	109	89
November	83	66
December	94	65
Total	**1121**	**827**

Medical Examiner Case Investigations by Manner of Death

Manner	Full Autopsy Examinations	Partial Autopsy Examinations	External Examinations	Review of Medical Records	Total
Accident	214	4	106	9	**333**
Homicide	125	0	0	0	**125**
Natural	343	50	135	15	**543**
Stillbirth	2	0	0	2	**4**
Suicide	42	0	2	0	**44**
Undetermined	47	0	3	0	**50**
Total	**773**	**54**	**246**	**26**	**1099**

Note: The above table does <u>NOT</u> include the following cases: "*Non-Human Remains* **22**" and **2** skeletal remains reported separately but represented one individual and were consequently merged.

Pie Chart - Medical Examiner Cases by Manner of Death
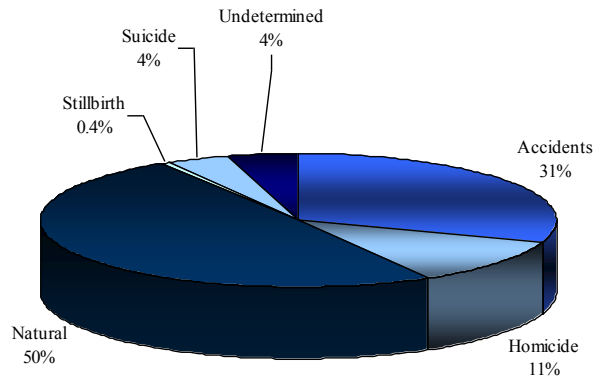
Trends for Violent Deaths in the District of Columbia

Total Homicides (2002-2011)

Total Number of Accidents (2002-2011)

Total Number of Suicides (2002-2011)
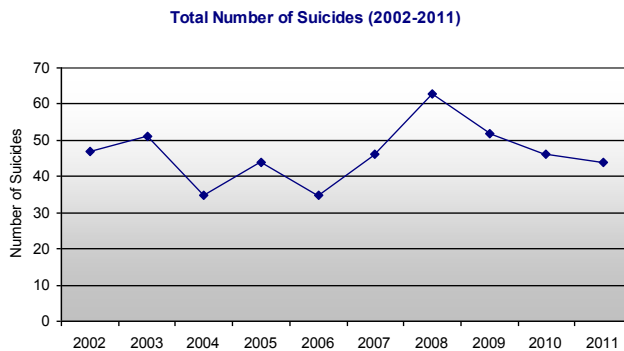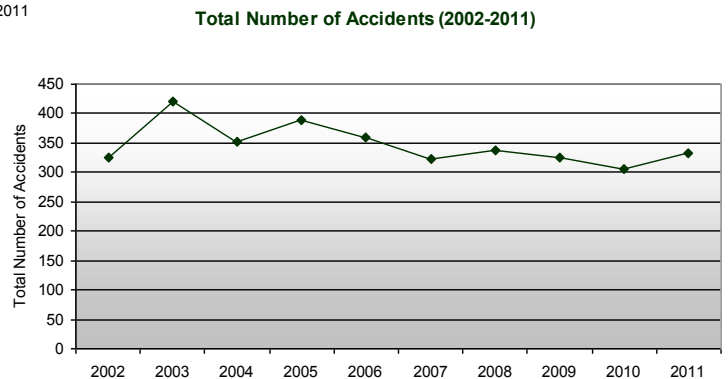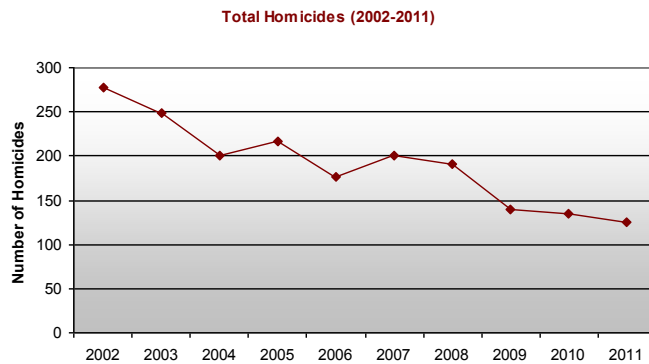
Postmortem Toxicology Summary 2011

All postmortem specimens received for routine toxicological testing were analyzed for alcohols (ethanol and other volatiles) and major classes of illicit and prescription medications. Additional screens were assigned depending on intake case history and special requests made by physicians. All significant drug results were confirmed by further testing. Typical case specimens received include blood, urine, bile, vitreous, liver, brain, and gastric contents. In 2011, the laboratory received and inventoried 7,430 postmortem specimens (767 cases) yielding 1,758 reported results.

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

Total number of postmortem cases analyzed:

Description	Number of Cases	% of Cases
N=	767	
Negative	258	33.6 %
Positive	509	66.3 %

Postmortem Toxicology - Most Commonly Detected Drugs

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

Drug Name	Number of Cases	% of Cases
Ethanol	241	31.4%
Morphine	113	14.7%
Cocaine	95	12.4%
Marijuana Metabolites	70	9.1%
Acetone	59	7.6%
Phencyclidine	42	5.5%
Methadone	38	5.0%
Diphenhydramine	35	4.6%
6-acetylmorphine	35	4.6%
Oxycodone	33	4.3%
Codeine	31	4.0%
Isopropanol	26	3.4%
Nordiazepam	25	3.3%
Citalopram	24	3.1%
Diazepam	22	2.9%
Dextromethorphan	18	2.3%
Alprazolam	16	2.1%
Temazepam	15	2.0%
Levamisole	15	2.0%
Phenobarbital	14	1.8%
Phenytoin	14	1.8%
Fentanyl	14	1.8%
Tramadol	14	1.8%
Acetaminophen	11	1.4%
Midazolam	11	1.4%
Levetiracetam	11	1.4%
Oxymorphone	9	1.2%
Mirtazapine	9	1.2%
Bupropion	8	1.0%
Carbamazepine	8	1.0%
Sertraline	8	1.0%
Trazodone	8	1.0%
Doxylamine	8	1.0%
Olanzapine	8	1.0%

2.1 - HOMICIDES

The OCME investigated **125** homicides in the CY 2011. The following tables and graphs provide a distribution by cause of death, month, race, gender and age group. Death by homicidal acts is more prevalent in black males and in the age group 20 to 29 years. The weapon of choice is fire-arms. The majority of incidents occurred in October.

Homicides by Cause of Death

Cause	Number of Homicides	% of Total Homicides
Firearms	84	**67%**
Sharp Force	25	**20%**
Blunt Impact	10	**8%**
Other	3	**2%**
Asphyxia	3	**2%**
Total	**125**	**100%**

Pie Chart – Homicides by Cause of Death
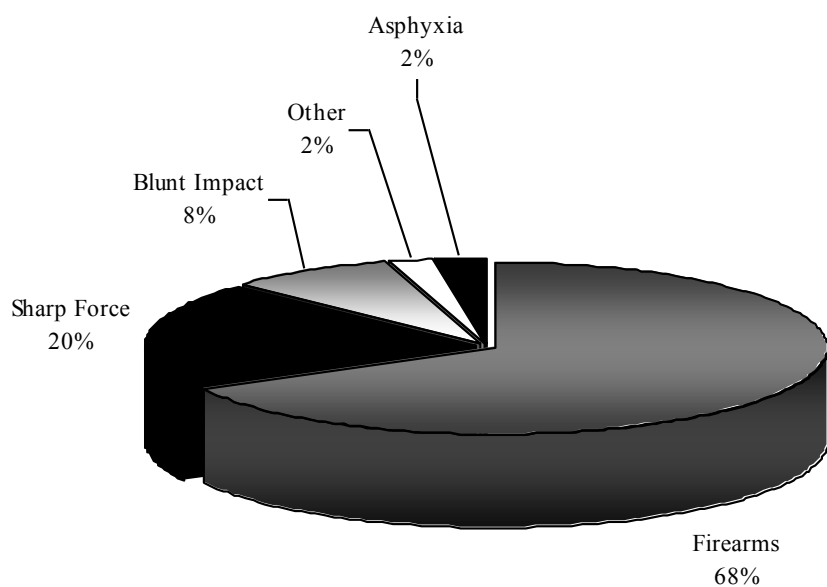
Homicides by Month

Month	Number of Homicides	% of Homicides
January	6	5%
February	8	6%
March	6	5%
April	13	10%
May	14	11%
June	12	10%
July	9	7%
August	14	11%
September	8	6%
October	15	12%
November	11	9%
December	9	7%
Total	**125**	**100%**

Graph - Homicides by Month
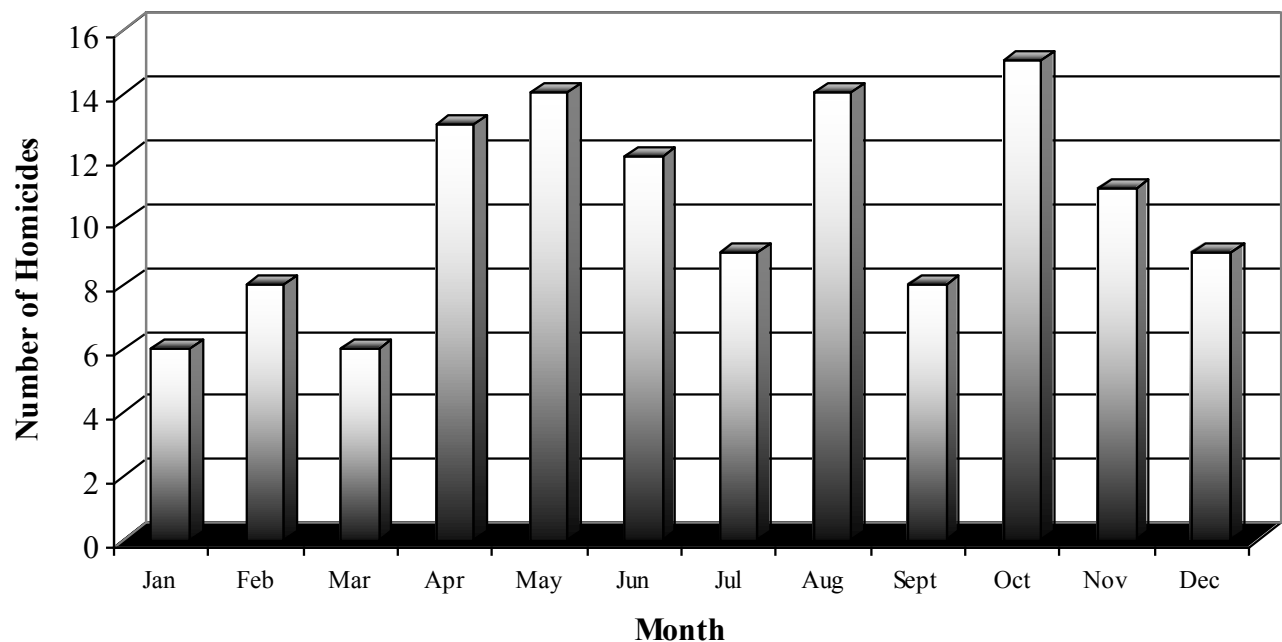
Homicides by Race

Race/Ethnicity	Number of Homicides	% of Homicides
Black	109	87%
Hispanic	9	7%
White	6	5%
Other	1	1%
Total	**125**	**100%**

Chart – Percentage of Homicides by Race

Other
1%

White
5%
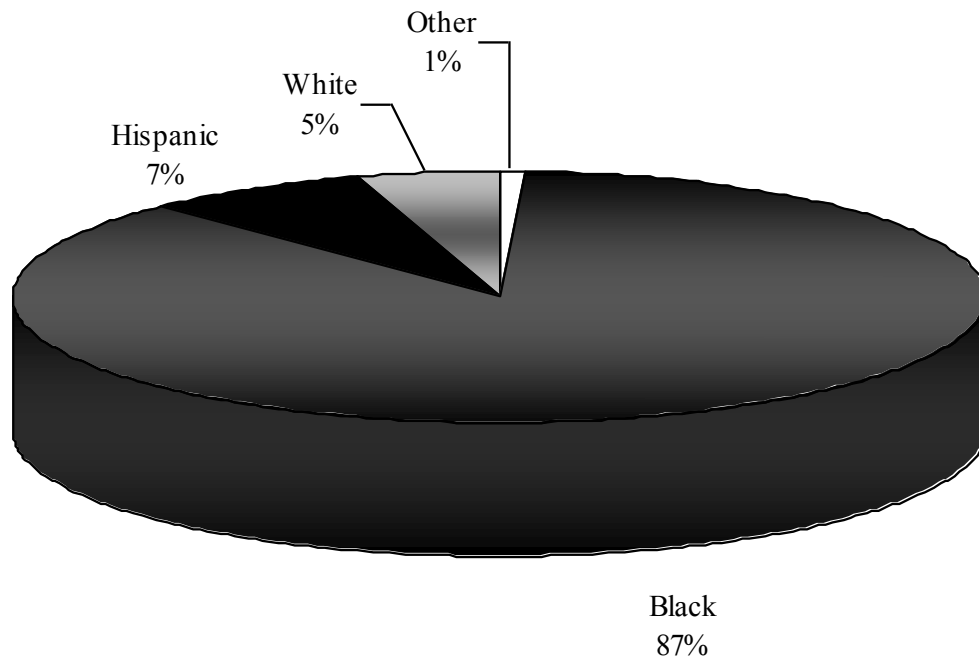
Hispanic
7%

Black
87%

Homicides by Gender

Gender	Number of Homicides	% of Homicides
Female	11	9%
Male	114	91%
Total	**125**	**100%**

Homicides by Race/Ethnicity and Gender

Race/Ethnicity by Gender	Number of Homicides
Black	**109**
Female	9
Male	100
Hispanic	**9**
Female	0
Male	9
White	**6**
Female	1
Male	5
Other	**1**
Female	1
Male	0
Total	**125**

Homicides by Jurisdiction of Incident

Jurisdiction of Incident	Number of Homicides	% of Homicides
District of Columbia	96	77%
Maryland	24	19%
New York	1	1%
Virginia	1	1%
UNKNOWN	3	2%
Total	**125**	

Homicides by Age

Age	Number of Homicides	% of Homicides
Under 1	3	2%
1 to 5	3	2%
6 to 12	**0**	**0%**
13 to 15	1	1%
16 to 19	17	14%
20 to 29	52	42%
30 to 39	23	19%
40 to 49	16	13%
50 to 59	6	5%
60 to 69	3	2%
70 to 79	**0**	**0%**
80 to 89	**0**	**0%**
90 +	1	1%
Total	**125**	**100%**

Chart - Homicides by Age Group
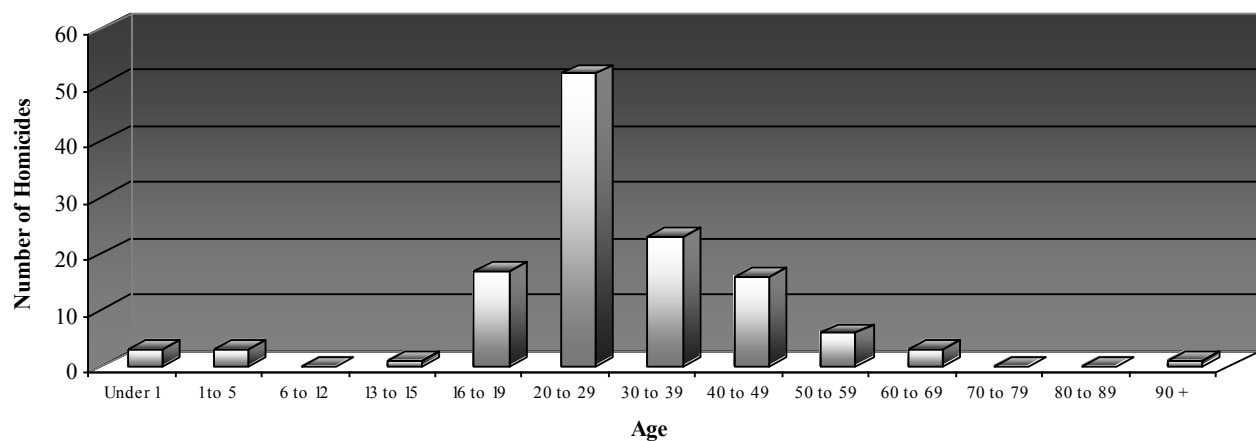
Toxicology Findings for Homicide Cases

Toxicology was performed on all 125 homicide cases investigated by the OCME. All 124 cases were screened for alcohol and major drugs of abuse. Drugs were absent in 44 homicide cases. Of the remaining positive cases, 26% had more than one drug present.

Description	Number of Cases	% of Cases
N=	**125**	
Negative	44	35.4 %
Positive	81	64.5 %

The most commonly detected drugs in the homicide cases were:

Name of Drug	Number of Cases	% of 124 Homicide Cases
Ethanol	46	37.0 %
Marijuana Metabo-lites*	34	27.4 %
Phencyclidine (PCP)	15	12.0 %
Cocaine	11	8.8 %
Pentobarbital	2	1.6 %
Morphine	1	0.8 %

*Marijuana metabolites are not confirmed in homicide cases.

2.2 - SUICIDES

The OCME investigated **44** suicides in CY 2011, which represents a 5% decrease from CY 2010 at (N=**46)**. Deaths by suicidal acts were more prevalent in white males and in persons between the ages of 40 to 49 years. Of note, suicides decreased by 50% in the age category. Hanging was the leading suicidal deaths. The majority of these incidents occurred in May.

Suicides by Cause of Death

Cause	Number of Suicides	% of Total Suicides
Hanging	13	30%
Blunt Impact Trauma	6	14%
Intoxication	9	20%
Firearms	8	18%
Suffocation (Plastic Bag over head)	3	7%
Thermal Injury	2	5%
Poisoning	2	5%
Sharp Object	1	2%
Total	**44**	**100%**

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

Pie Chart - Suicides by Cause of Death
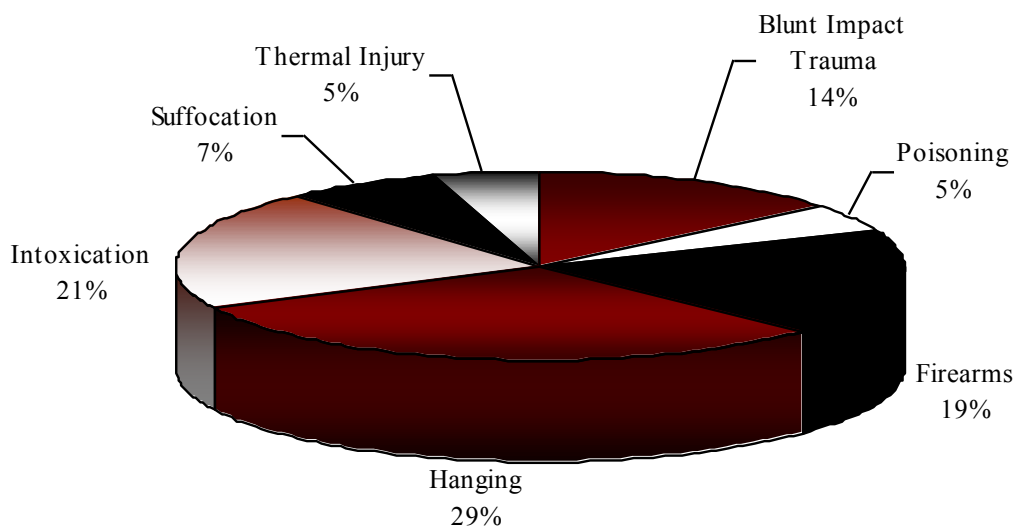
Suicides by Month

Month	Number of Suicides	% of Suicides
January	2	5%
February	3	7%
March	4	9%
April	5	11%
May	6	14%
June	5	11%
July	3	7%
August	2	5%
September	4	9%
October	5	11%
November	3	7%
December	2	5%
Total	**44**	**100%**

Chart- Suicides by Month
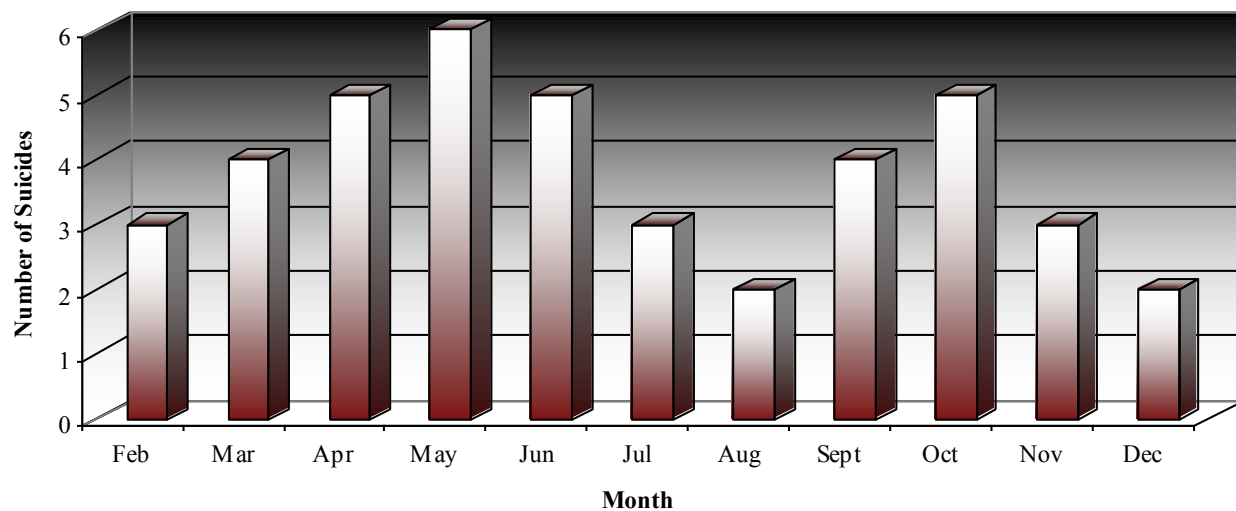
Suicide by Race/Ethnicity

Race/Ethnicity	Number of Suicides	% of Suicides
White	23	52%
Black	15	34%
Hispanic	4	9%
Asian	2	5%
Total	**44**	**100%**

Suicides by Race/Ethnicity and Gender

Race/Ethnicity by Gender	Number of Suicides
Black	**15**
Female	6
Male	9
White	**23**
Female	10
Male	13
Asian	**2**
Female	1
Male	1
Hispanic	**4**
Female	1
Male	3
Total	**44**

Suicides by Gender

Gender	Number of Suicides	% of Suicides
Female	18	41%
Male	26	59%
Total	**44**	**100%**

Suicides by Jurisdiction of Incident

Jurisdiction of Incident	Number of Suicides	% of Suicides
District of Columbia	36	82%
Maryland	6	14%
Virginia	1	2%
Unknown	1	2%
Total	**44**	**100%**

Suicide by Age

Age	Number of Suicides	% of Suicides
13 to 15	1	2%
16 to 19	3	7%
20 to 29	9	20%
30 to 39	6	14%
40 to 49	11	25%
50 to 59	10	23%
60 to 69	2	5%
70 to 79	1	2%
80 to 89	1	2%
90 +	0	0%
Total	**44**	**100%**

Note: There were zero (0) suicides for persons younger than 13 and those
Over 90 years.

Chart - Suicides by Age
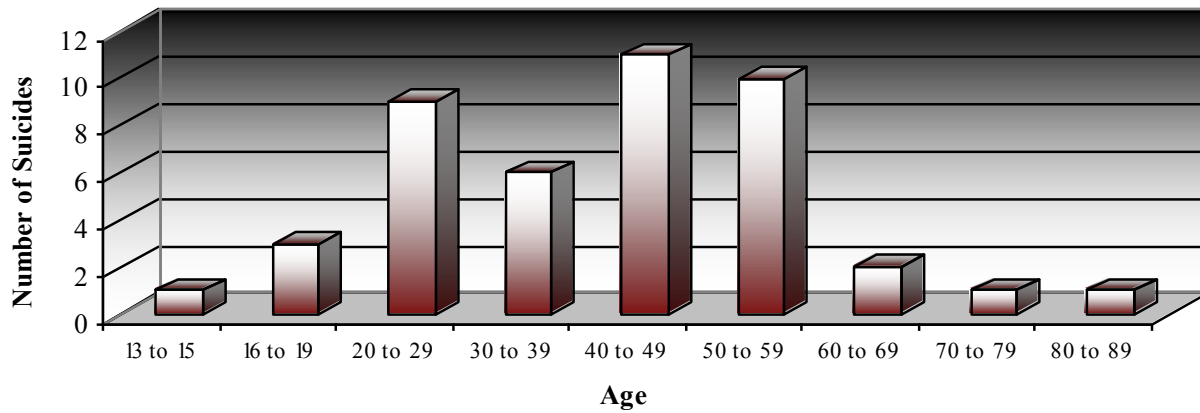
Toxicology Findings for Suicide Cases

Toxicology analysis was performed on 43 of 44 OCME suicide cases. Drugs were absent in 17 of these cases. Of the remaining positive cases, 44% had more than one drug present.

Description	Number of Cases	% of Cases
N=	**43**	
Negative	17	39.5 %
Positive	25	60.4 %

The most notable detected drugs in suicide cases were:

Name of Drug	Number of Cases	% of Suicide Cases
Diphenhydramine	8	18.6 %
Ethanol	7	16.2 %
Citalopram	6	13.9 %
Morphine	5	11.6 %
Doxepin	4	9.3 %

Toxicology results for suicides involving intentional overdose are included with table 1 in section 2.3.2. There were 8 of these cases. The table includes specimens, analytical methods used for confirmation, compound(s) present, and the measurable concentration.

2.3 - ACCIDENTS

OCME investigated **333** accidental deaths in CY 2011. Of the **333** cases investigated, **51** were related to motor vehicle accidents. **96** of the Accidental deaths were the direct result of prescription and/or illicit drug use. The majority of incidents occurred in June.

Accidents by Cause of Death

Cause	Number of Deaths	% of Total Accidents
Blunt Injury - Fall	114	34%
Intoxication	97	29%
Blunt Injury - Traffic	51	15%
Thermal	16	5%
Hypothermia	12	4%
Hyperthermia	10	3%
Asphyxia	7	2%
Drowning	7	2%
Therapeutic Complications	7	2%
Blunt Injury – Other	6	2%
Other	6	2%
Total	**333**	**100%**

Pie Chart - Accidents by Cause of Death[1]
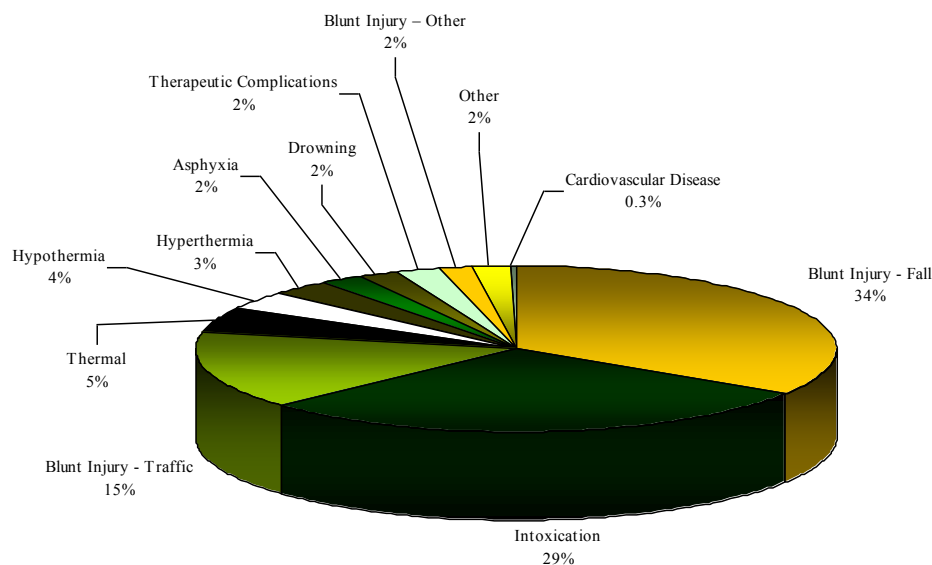
[1] This chart does not include causes of death that are 1% or less of the total number of deaths.

Accidents by Month

Month	Number of Deaths	% of Accidents
January	25	8%
February	32	10%
March	26	8%
April	28	8%
May	25	8%
June	34	10%
July	30	9%
August	30	9%
September	25	8%
October	26	8%
November	27	8%
December	25	8%
Total	**333**	100%

Chart - Accidents by Month of Death
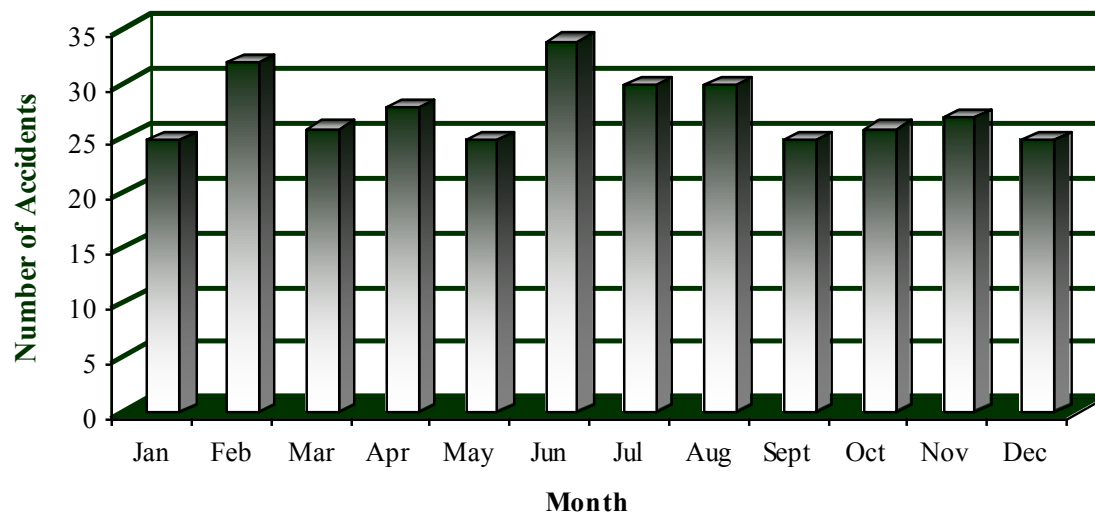
Accidental Deaths by Race

Race/Ethnicity	Number of Accidents	% of Accidents
Black	191	57%
White	111	33%
Hispanic	16	5%
Asian	6	2%
Other	5	2%
Unknown	4	1%
Total	**333**	**100%**

Accidental Deaths by Gender

Gender	Number of Accidents	% of Accidents
Female	131	39%
Male	202	61%
Total	**333**	**100%**

Accidental Deaths by Age

Age	Number of Accidents	% of Accidents
Under 1	0	0%
1 to 5	1	0%
6 to 12	3	1%
13 to 15	0	0%
16 to 19	8	2%
20 to 29	21	6%
30 to 39	28	8%
40 to 49	46	14%
50 to 59	74	22%
60 to 69	55	16%
70 to 79	35	10%
80 to 89	41	12%
90 +	20	6%
Unknown	1	0%
Total	**333**	**100%**

Toxicology Findings for Accident Cases

Of the 333 Accident Deaths investigated by OCME, toxicology analysis was performed in 214 cases. Drugs were absent in 41 accident cases. Of the remaining positive cases, 35.8 % had more than one drug present.

Description	Number of Cases	% of Cases
N=	**214**	
Negative	41	19.1 %
Positive	173	80.8 %

The most commonly detected drugs in the accident cases were:

Name of Drug	Number of Cases	% of Accident Cases
Ethanol	83	38.7 %
Cocaine	59	27.5 %
Heroin	30	14.0 %
Codeine	20	9.3 %
Morphine	19	8.8 %
Phencyclidine	18	8.4 %
Marijuana Metabolites*	16	7.4 %
Methadone	15	7.0 %
Oxycodone	10	4.6 %

*Marijuana metabolites are confirmed depending on case history.

2.3.1 – Traffic Deaths

Of the **51** traffic related deaths certified by the OCME in Calendar Year 2011 the majority involved pedestrians and decedents between the ages of 20 to 29. Most of the traffic fatalities occurred in January and March.

Role of the Decedent in Traffic Death

Role	Traffic Deaths	% of Traffic Deaths
Pedestrian	21	42%
Driver *- Motor Vehicle(10)* *- Motorcycle (3)* *- Moped(1)*	14	26%
Passenger *- Motor Vehicle (10)*	10	20%
Bicyclist	5	10%
Unknown *- Role Unknown*	1	2%
Total	**51**	**100%**

Pie Chart - Role of Decedent in Traffic Accident
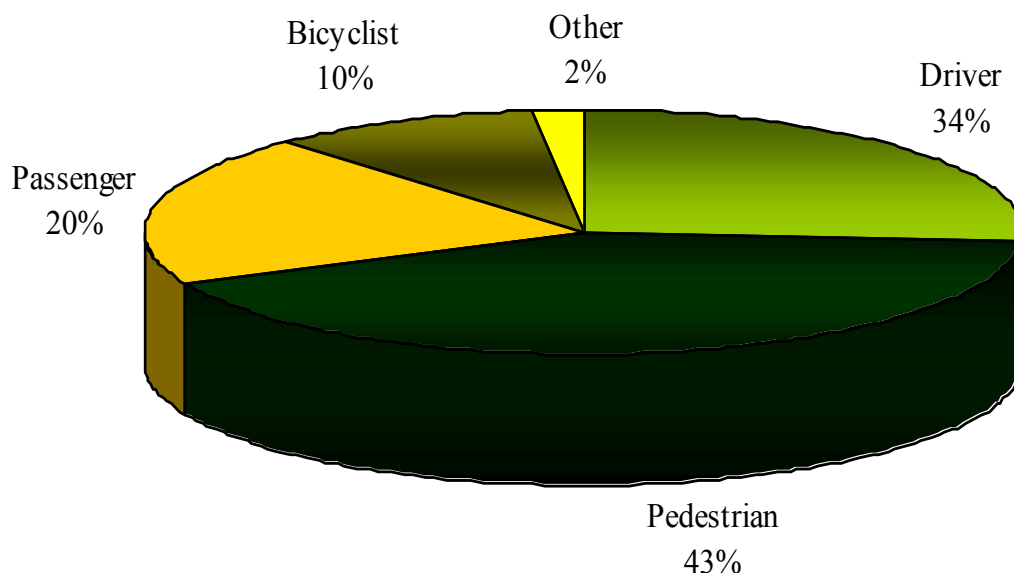
Traffic Deaths by Month

Month	Number of Traffic Accidents	% of Traffic Accidents
January	6	12%
February	4	8%
March	6	12%
April	3	6%
May	5	10%
June	5	10%
July	5	10%
August	4	8%
September	4	8%
October	4	8%
November	1	2%
December	4	8%
Total	**51**	**100%**

Chart - Traffic Deaths by Month
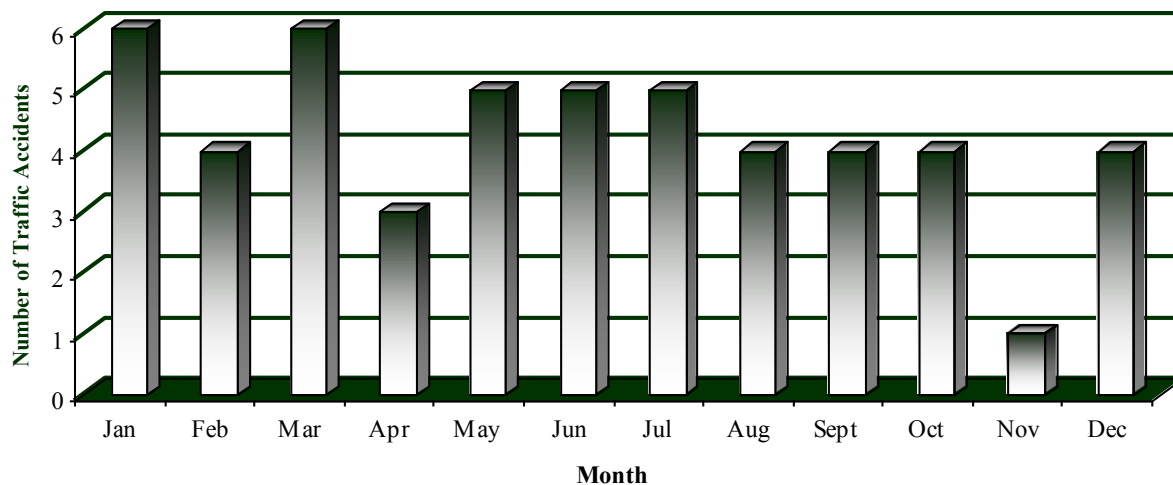
Traffic Deaths by Race

Race	Number of Traffic Deaths	% of Traffic Deaths
Black	21	42%
White	19	38%
Hispanic	8	14%
Asian	1	2%
Other	1	2%
Unknown	1	2%
Total	**51**	**100%**

Traffic Deaths by Gender

Gender	Number of Traffic Deaths	% of Traffic Deaths
Female	15	30%
Male	36	70%
Total	**51**	**100%**

Traffic Deaths by Age

Age	Number of Traffic Deaths	% of Traffic Deaths
6 to 12	1	2%
13 to 15	0	0%
16 to 19	6	12%
20 to 29	12	24%
30 to 39	7	14%
40 to 49	7	14%
50 to 59	7	14%
60 to 69	10	20%
Unknown	1	2%
Total	**51**	**100%**

Note: There were no traffic fatalities for children under 6 years old, nor were there any for adults in age groups greater than the 60-69 year age category.

Traffic Deaths by Jurisdiction of Incident

Jurisdiction of Incident	Number of Traffic Deaths	% of Traffic Deaths
District of Columbia	31	60%
Maryland	16	32%
Virginia	3	6%
Unknown	1	2%
Total	**51**	**100%**

Toxicology Findings for Traffic Accident Cases

Of the 51 Traffic-related deaths investigated by OCME, toxicology analysis was performed in 44 cases. Drugs were absent in 18 traffic accident cases. Of the remaining positive cases, 10.8% had more than one drug present.

Description	Number of Cases	% of Cases
N=	**44**	
Negative	18	40.9 %
Positive	26	59.0 %

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

Name of Drug	Number of Cases	% of Traffic Cases
Ethanol	16	36.3 %
Marijuana Metabolite	5	11.3 %
Cocaine	2	4.5 %
PCP	2	4.5 %

In the 16 traffic deaths positive for ethanol, 8 were greater than twice the legal limit (0.16 g/100 mL) for driving under the influence in the District of Columbia. The legal limit for Blood Alcohol Concentration in the District of Columbia is 0.08% while driving.

2.3.2 – Toxicology Findings for Deaths due to Drug Overdose

There were 117 OCME cases where death was directly related to drug use, and toxicology analysis was performed in 111 of these cases. Deaths due to substance abuse accounted for 96 of those. The most prevalent drug in the population was cocaine alone or in combination with other drugs. Drugs were present in 111 of 111 overdose cases. Of the positive cases, 72.0 % had more than one drug present. In addition, of the 42 cases which were positive for alcohol, all had at least one additional drug present. 11.7 % of cases were positive for both cocaine and heroin. Table 1 includes a detailed description of the toxicology in each case.

Description	Number of Cases	% of Cases
N=	111	
Negative	0	0 %
Positive	111	100.0 %

The most commonly detected drugs in drug overdose cases were:

Contributing Drugs	Number of Cases	% of Cases
Cocaine	48	43.2 %
Ethanol	42	37.8 %
Heroin	28	25.2 %
Codeine	15	14.1 %
Methadone	14	13.5 %
Phencyclidine	13	11.7 %
Oxycodone	8	7.2 %

Table 1. Summary of toxicology results for all accident, suicide, and undetermined cases involving intoxication. The table includes demographics by case, specimens, analytical methods used for confirmation, compound(s) present, and the measurable concentration. GC/MS = Gas Chromatograph/Mass Spectrometer, LC/MS = Liquid Chromatograph/Mass Spectrometer, HS/GC-2 = Headspace/Gas Chromatograph, LC/MS/MS = Liquid Chromatograph/Mass Spectrometer/Mass Spectrometer.

Case	Race	Sex	Age	Mode	Specimen	Drug	Confirm Method	Concentration	
1	Black	Female	54	Accident	Urine	6-acetylmorphine	GC/MS		detected
					Hospital Blood	Cocaine	GC/MS	0.03	mg/L
					Hospital Blood	Benzoylecgonine	GC/MS	1.88	mg/L
					Femoral - Blood	Morphine	GC/MS	0.08	mg/L
					Femoral - Blood	Cocaine	GC/MS	0.11	mg/L
					Femoral - Blood	Benzoylecgonine	GC/MS	2.01	mg/L
					Femoral - Blood	Alprazolam	LC/MS/MS		detected
					Femoral - Blood	Cocaethylene	LC/MS/MS		detected
2	Black	Male	48	Accident	Femoral - Blood	Methadone	LC/MS	0.56	mg/L
3	Black	Male	55	Accident	Femoral - Blood	Methadone	GC/MS	1	mg/L
					Urine	6-acetylmorphine	GC/MS		detected
					Femoral - Blood	Morphine	GC/MS	0.03	mg/L
4	Black	Male	76	Accident	Femoral - Blood	Dextromethorphan	Not Confirmed		
					Urine	6-acetylmorphine	GC/MS		detected
					Hospital Blood	Morphine	GC/MS	0.05	mg/L
					Femoral - Blood	Morphine	GC/MS	0.04	mg/L
5	Black	Male	60	Accident	Femoral - Blood	Ethanol	HS/GC-2	0.06	g/100mL
					Vitreous Humor	Ethanol	HS/GC-2	0.04	g/100mL
					Femoral - Blood	Benzoylecgonine	GC/MS	1.35	mg/L
					Femoral - Blood	Cocaethylene	GC/MS	0.08	mg/L
					Femoral - Blood	Cocaine	GC/MS	0.38	mg/L
6	Black	Male	33	Accident	Femoral - Blood	Benzoylecgonine	GC/MS	0.01	mg/L
					Femoral - Blood	Ethanol	HS/GC-2	0.25	g/100mL
					Urine	6-acetylmorphine	GC/MS		detected
					Vitreous Humor	Ethanol	HS/GC-2	0.33	g/100mL
					Femoral - Blood	Morphine	GC/MS	0.11	mg/L
7	Black	Male	59	Accident	Femoral - Blood	Levamisole	Not Confirmed		
					Femoral - Blood	Cocaine	GC/MS	0.17	mg/L
					Femoral - Blood	Benzoylecgonine	GC/MS	3.32	mg/L
8	Black	Male	50	Accident	Femoral - Blood	Benzoylecgonine	GC/MS	0.14	mg/L
					Vitreous Humor	Ethanol	HS/GC-2	0.35	g/100mL
					Femoral - Blood	Cocaethylene	GC/MS	0.01	mg/L
					Femoral - Blood	Ethanol	HS/GC-2	0.28	g/100mL
9	Black	Female	56	Accident	Femoral - Blood	Phencyclidine	GC/MS	0.14	mg/L

Case	Race	Sex	Age	Mode	Specimen	Drug	Confirm Method	Concentration	
10	Black	Female	30	Accident	Femoral - Blood	Doxylamine	LC/MS	2	mg/L
					Femoral - Blood	Isopropanol	HS/GC-2	0.019	g/100mL
					Femoral - Blood	Acetone	HS/GC-2	0.028	g/100mL
					Heart - Blood	Doxylamine	LC/MS	1.25	mg/L
					Vitreous Humor	Acetone	HS/GC-2	0.037	g/100mL
					Vitreous Humor	Isopropanol	HS/GC-2	0.016	g/100mL
					Brain	Doxylamine	LC/MS	2.66	mg/kg
11	White	Male	47	Accident	Femoral - Blood	Alprazolam	LC/MS/MS		detected
					Vitreous Humor	Ethanol	HS/GC-2	0.05	g/100mL
					Urine	6-acetylmorphine	GC/MS		detected
					Femoral - Blood	Morphine	GC/MS	0.19	mg/L
					Femoral - Blood	Ethanol	HS/GC-2	0.04	g/100mL
12	Black	Male	19	Accident	Hospital Blood	Nordiazepam	GC/MS	0.09	mg/L
					Femoral - Blood	Diazepam	GC/MS	0.04	mg/L
					Liver	Amiodarone	LC/DAD	24.2	mg/kg
					Brain	Tapentadol	LC/MS/MS	1.6	mg/kg
					Liver	Nortapentadol	LC/MS/MS	0.19	mg/kg
					Bile	Tapentadol	LC/MS/MS	1.24	mg/L
					Urine	Tapentadol	LC/MS/MS		detected
					Urine	Nortapentadol	LC/MS/MS		detected
					Hospital Blood	Diazepam	GC/MS	0.07	mg/L
					Hospital Blood	Tapentadol	LC/MS/MS	0.52	mg/L
					Heart - Blood	Tapentadol	LC/MS/MS	1.95	mg/L
					Heart - Blood	Nortapentadol	LC/MS/MS	0.09	mg/L
					Heart - Blood	Amiodarone	LC/DAD	4.8	mg/L
					Femoral - Blood	Tapentadol	LC/MS/MS	0.77	mg/L
					Femoral - Blood	Amiodarone	LC/DAD	5.3	mg/L
					Femoral - Blood	Nordiazepam	GC/MS	0.06	mg/L
					Liver	Tapentadol	LC/MS/MS	1.65	mg/kg
					Femoral - Blood	Nortapentadol	LC/MS/MS	0.07	mg/L
13	Black	Male	58	Accident	Femoral - Blood	Cocaine	GC/MS	0.03	mg/L
					Urine	6-acetylmorphine	GC/MS		detected
					Femoral - Blood	Dextromethorphan	Not Confirmed		
					Femoral - Blood	Morphine	GC/MS	0.2	mg/L
					Femoral - Blood	Codeine	GC/MS		detected
					Femoral - Blood	Benzoylecgonine	GC/MS	0.18	mg/L
14	Black	Male	58	Accident	Femoral - Blood	Dextromethorphan	Not Confirmed		
					Femoral - Blood	Morphine	GC/MS	0.14	mg/L
					Urine	6-acetylmorphine	GC/MS		detected

Case	Race	Sex	Age	Mode	Specimen	Drug	Confirm Method	Concentration	
15	Black	Male	47	Accident	Femoral - Blood	Morphine	GC/MS	0.04	mg/L
					Femoral - Blood	Methadone	LC/MS	0.47	mg/L
					Femoral - Blood	Ethanol	HS/GC-2	0.11	g/100mL
					Urine	6-acetylmorphine	GC/MS		detected
					Vitreous Humor	Ethanol	HS/GC-2	0.16	g/100mL
16	Black	Female	46	Accident	Femoral - Blood	Diazepam	LC/MS/MS		detected
					Femoral - Blood	Alprazolam	LC/MS/MS		detected
					Femoral - Blood	Temazepam	LC/MS/MS		detected
					Femoral - Blood	Cocaine	GC/MS	0.02	mg/L
					Femoral - Blood	Benzoylecgonine	GC/MS	3.97	mg/L
					Femoral - Blood	Cocaethylene	GC/MS		detected
					Femoral - Blood	Nordiazepam	LC/MS/MS		detected
17	Black	Female	60	Accident	Femoral - Blood	Methadone	LC/MS	0.3	mg/L
					Femoral - Blood	Acetone	HS/GC-2	0.014	g/100mL
					Vitreous Humor	Acetone	HS/GC-2	0.017	g/100mL
18	Black	Male	42	Accident	Hospital Blood	Morphine	GC/MS	0.27	mg/L
19	Black	Male	48	Accident	Femoral - Blood	Dextromethorphan	Not Confirmed		
					Vitreous Humor	Ethanol	HS/GC-2	0.22	g/100mL
					Urine	6-acetylmorphine	GC/MS		detected
					Femoral - Blood	Ethanol	HS/GC-2	0.16	g/100mL
					Femoral - Blood	Phencyclidine	GC/MS	0.03	mg/L
					Femoral - Blood	Morphine	GC/MS	0.17	mg/L
20	Black	Male	49	Accident	Femoral - Blood	Benzoylecgonine	GC/MS	0.82	mg/L
					Femoral - Blood	Cocaine	GC/MS	0.02	mg/L
21	Black	Male	51	Accident	Femoral - Blood	Cannabinoids	Not Confirmed		
					Vitreous Humor	Ethanol	HS/GC-2	0.15	g/100mL
					Femoral - Blood	Ethanol	HS/GC-2	0.12	g/100mL
					Femoral - Blood	Phencyclidine	GC/MS	0.01	mg/L
					Femoral - Blood	Codeine	GC/MS		detected
					Femoral - Blood	Morphine	GC/MS	0.25	mg/L
					Urine	Ketones	Not Confirmed		
22	White	Female	35	Accident	Vitreous Humor	Ethanol	HS/GC-2	0.22	g/100mL
					Urine	6-acetylmorphine	GC/MS		detected
					Femoral - Blood	Ethanol	HS/GC-2	0.18	g/100mL
					Femoral - Blood	Phencyclidine	GC/MS	0.05	mg/L
					Femoral - Blood	Morphine	GC/MS	0.25	mg/L

Case	Race	Sex	Age	Mode	Specimen	Drug	Confirm Method	Concentration	
23	Black	Female	48	Accident	Femoral - Blood	Cocaethylene	GC/MS		detected
					Femoral - Blood	Benzoylecgonine	GC/MS	0.12	mg/L
					Femoral - Blood	Cocaine	GC/MS	0.01	mg/L
					Femoral - Blood	Morphine	GC/MS	0.03	mg/L
					Femoral - Blood	Ethanol	HS/GC-2	0.13	g/100mL
					Vitreous Humor	Ethanol	HS/GC-2	0.15	g/100mL
24	Black	Female	52	Accident	Femoral - Blood	Benzoylecgonine	GC/MS	0.1	mg/L
					Femoral - Blood	Cocaine	GC/MS		detected
25	Black	Male	56	Accident	Femoral - Blood	Benzoylecgonine	GC/MS	0.06	mg/L
26	Black	Female	55	Accident	Vitreous Humor	Ethanol	HS/GC-2	0.29	g/100mL
					Femoral - Blood	Ethanol	HS/GC-2	0.23	g/100mL
					Femoral - Blood	Morphine	GC/MS	0.04	mg/L
27	Black	Male	47	Accident	Femoral - Blood	Cocaine	GC/MS		detected
					Femoral - Blood	Benzoylecgonine	GC/MS	0.21	mg/L
28	Black	Male	53	Accident	Femoral - Blood	Cocaethylene	GC/MS	0.01	mg/L
					Femoral - Blood	Cocaine	GC/MS		detected
					Femoral - Blood	Benzoylecgonine	GC/MS	1.72	mg/L
29	Black	Male	57	Accident	Femoral - Blood	Codeine	GC/MS	0.05	mg/L
					Femoral - Blood	Dextromethorphan	Not Confirmed		
					Femoral - Blood	Ethanol	HS/GC-2	0.07	g/100mL
					Urine	6-acetylmorphine	GC/MS		detected
					Vitreous Humor	Ethanol	HS/GC-2	0.08	g/100mL
					Femoral - Blood	Morphine	GC/MS	0.75	mg/L
30	Black	Female	32	Accident	Femoral - Blood	Phencyclidine	GC/MS	0.63	mg/L
					Femoral - Blood	Ethanol	HS/GC-2	0.02	g/100mL
					Vitreous Humor	Ethanol	HS/GC-2	0.04	g/100mL
31	Black	Female	52	Accident	Femoral - Blood	Nordiazepam	LC/MS/MS		detected
					Femoral - Blood	Diazepam	LC/MS/MS		detected
					Femoral - Blood	Venlafaxine	Not Confirmed		
					Femoral - Blood	Morphine	GC/MS	0.03	g/100mL
32	Black	Female	34	Accident	Heart - Blood	Dextrorphan	Not Confirmed		
					Heart - Blood	Doxylamine	LC/MS	0.45	mg/L
					Heart - Blood	Cannabinoids	Not Confirmed		
					Femoral - Blood	Codeine	GC/MS	1.2	mg/L
					Femoral - Blood	Morphine	GC/MS	0.04	mg/L
33	White	Male	53	Accident	Femoral - Blood	Morphine	GC/MS	0.14	g/100mL
					Femoral - Blood	Ethanol	HS/GC-2	0.04	g/100mL
					Bile	Ethanol	HS/GC-2	0.06	g/100mL

Case	Race	Sex	Age	Mode	Specimen	Drug	Confirm Method	Concentration	
34	Black	Male	54	Accident	Chest Cavity - Blood	Ethanol	HS/GC-2	0.1	g/100mL
					Chest Cavity - Blood	Diphenhydramine	Not Confirmed		
					Bile	Ethanol	HS/GC-2	0.04	g/100mL
					Chest Cavity - Blood	Oxymorphone	GC/MS	0.24	mg/L
					Chest Cavity - Blood	Oxycodone	GC/MS	4.51	mg/L
35	White	Male	42	Accident	Femoral - Blood	Nordiazepam	LC/MS/MS		detected
					Femoral - Blood	Morphine	GC/MS	0.41	mg/L
					Femoral - Blood	Alprazolam	LC/MS/MS		detected
					Femoral - Blood	Codeine	GC/MS	0.02	mg/L
					Femoral - Blood	Chlordiazepoxide	LC/MS/MS		detected
36	Black	Male	51	Accident	Femoral - Blood	Cocaine	GC/MS	0.13	mg/L
					Femoral - Blood	Benzoylecgonine	GC/MS	1.79	mg/L
					Femoral - Blood	Ethanol	HS/GC-2	0.02	g/100mL
					Urine	Ethanol	HS/GC-2	0.01	g/100mL
					Femoral - Blood	Levamisole	Not Confirmed		
37	White	Male	46	Accident	Other - Blood	Benzoylecgonine	GC/MS	1.37	mg/L
					Other - Blood	Cocaine	GC/MS		detected
					Hospital Blood	Benzoylecgonine	GC/MS	1.64	mg/L
38	Black	Male	58	Accident	Femoral - Blood	Cocaine	GC/MS	0.02	mg/L
					Femoral - Blood	Benzoylecgonine	GC/MS	0.24	mg/L
					Femoral - Blood	Dextromethorphan	Not Confirmed		
					Femoral - Blood	Morphine	GC/MS	0.03	mg/L
					Urine	6-acetylmorphine	GC/MS		detected
					Femoral - Blood	Methadone	LC/MS	0.04	mg/L
39	Black	Male	60	Accident	Femoral - Blood	Benzoylecgonine	GC/MS	0.11	mg/L
					Femoral - Blood	Cocaine	GC/MS		detected
40	Black	Male	47	Accident	Vitreous Humor	Ethanol	HS/GC-2	0.09	mg/L
					Femoral - Blood	Temazepam	LC/MS/MS		detected
					Femoral - Blood	Diazepam	GC/MS/NPD		detected
					Femoral - Blood	Benzoylecgonine	GC/MS	0.05	mg/L
					Femoral - Blood	Morphine	GC/MS	0.07	mg/L
					Femoral - Blood	Nordiazepam	GC/MS/NPD		detected
					Femoral - Blood	Ethanol	HS/GC-2	0.07	mg/L
					Femoral - Blood	Dextromethorphan	Not Confirmed		
					Urine	6-acetylmorphine	GC/MS		detected
41	Black	Male	56	Accident	Femoral - Blood	Morphine	GC/MS	0.06	mg/L
					Vitreous Humor	Ethanol	HS/GC-2	0.05	g/100mL

Case	Race	Sex	Age	Mode	Specimen	Drug	Confirm Method	Concentration	
					Femoral - Blood	Codeine	GC/MS		detected
					Femoral - Blood	Sertraline	Not Confirmed		
					Femoral - Blood	Norsertraline	Not Confirmed		
					Urine	6-acetylmorphine	GC/MS		detected
					Femoral - Blood	Ethanol	HS/GC-2	0.04	g/100mL
42	Black	Male	53	Accident	Femoral - Blood	Cocaine	GC/MS	0.05	mg/L
					Femoral - Blood	Alprazolam	LC/MS/MS		detected
					Femoral - Blood	Methadone	LC/MS	0.13	mg/L
					Femoral - Blood	Benzoylecgonine	GC/MS	0.89	mg/L
					Femoral - Blood	Morphine	GC/MS	0.07	mg/L
					Femoral - Blood	Promethazine	Not Confirmed		
					Urine	6-acetylmorphine	GC/MS		detected
43	Black	Male	64	Accident	Femoral - Blood	Levamisole	Not Confirmed		
					Hospital Blood	Cocaine	GC/MS		detected
					Femoral - Blood	Cocaine	GC/MS	0.39	mg/L
					Femoral - Blood	Cyclobenzaprine	Not Confirmed		
					Hospital Blood	Benzoylecgonine	GC/MS	1.04	mg/L
					Femoral - Blood	Trazodone	Not Confirmed		
					Femoral - Blood	Dextromethorphan	Not Confirmed		
					Femoral - Blood	Citalopram	Not Confirmed		
					Femoral - Blood	Tramadol	Not Confirmed		
					Femoral - Blood	Benzoylecgonine	GC/MS	1.75	mg/L
44	Black	Male	53	Accident	Urine	6-acetylmorphine	GC/MS		detected
					Femoral - Blood	Codeine	GC/MS	0.03	mg/L
					Femoral - Blood	Morphine	GC/MS	0.31	mg/L
45	White	Male	57	Accident	Femoral - Blood	Citalopram	Not Confirmed		
					Femoral - Blood	Difluoroethane	HS/GC-2		detected
46	Hispanic	Male	28	Accident	Hospital Blood	Nordiazepam	LC/MS/MS		detected
					Femoral - Blood	Morphine	GC/MS	0.05	mg/L
					Hospital Blood	Morphine	GC/MS	0.05	mg/L
					Hospital Blood	Ethanol	HS/GC-2	0.06	g/100mL
					Hospital Blood	Oxycodone	GC/MS	0.06	mg/L
					Hospital Blood	Alprazolam	LC/MS/MS		detected
					Femoral - Blood	Diazepam	GC/MS/NPD		detected
					Femoral - Blood	Oxycodone	GC/MS	0.04	mg/L
					Hospital Blood	Diazepam	LC/MS/MS		detected
					Femoral - Blood	Nordiazepam	GC/MS/NPD		detected

47	Black	Male	51	Accident	Femoral - Blood	Cocaine	GC/MS	0.04	mg/L
					Femoral - Blood	Benzoylecgonine	GC/MS	0.13	mg/L
					Femoral - Blood	Ethanol	HS/GC-2	0.04	g/100mL
48	Black	Female	64	Accident	Liver	Methadone	LC/MS	12.7	mg/kg
					Heart - Blood	Oxycodone	GC/MS	0.09	mg/L
					Heart - Blood	Methadone	LC/MS	1.28	mg/L
					Femoral - Blood	Nordiazepam	GC/MS	0.69	mg/L
					Femoral - Blood	Diazepam	GC/MS	0.33	mg/L
					Femoral - Blood	Temazepam	GC/MS	0.03	mg/L
49	Black	Female	48	Accident	Femoral - Blood	Cocaine	GC/MS	0.09	mg/L
					Femoral - Blood	Benzoylecgonine	GC/MS	1.56	mg/L
50	Black	Male	57	Accident	Femoral - Blood	Methadone	LC/MS	1.59	mg/L
					Liver	Methadone	LC/MS	8.84	mg/L
					Femoral - Blood	Promethazine	LC/MS	0.12	mg/L
51	Other	Female	39	Accident	Femoral - Blood	Nordiazepam	LC/MS/MS		detected
					Femoral - Blood	Temazepam	GC/MS	0.45	mg/L
					Femoral - Blood	Nordiazepam	GC/MS	0.04	mg/L
					Femoral - Blood	Ethanol	HS/GC-2	0.05	g/100mL
					Femoral - Blood	Diazepam	LC/MS/MS		detected
					Femoral - Blood	Temazepam	LC/MS/MS		detected
					Femoral - Blood	7-aminoclonazepam	LC/MS/MS	0.58	mg/L
					Femoral - Blood	Diphenhydramine	LC/MS/MS		detected
52	Black	Male	56	Accident	Femoral - Blood	Morphine	GC/MS	0.05	mg/L
53	Black	Female	57	Accident	Vitreous Humor	Ethanol	HS/GC-2	0.11	g/100mL
					Femoral - Blood	Ethanol	HS/GC-2	0.08	g/100mL
					Femoral - Blood	Cocaine	GC/MS	0.13	mg/L
					Femoral - Blood	Levamisole	Not Confirmed		
					Femoral - Blood	Benzoylecgonine	GC/MS	0.92	mg/L
					Femoral - Blood	Cocaethylene	GC/MS	0.12	mg/L
54	Black	Female	51	Accident	Hospital Blood	Cannabinoids	Not Confirmed		
					Chest Cavity - Blood	Cannabinoids	Not Confirmed		
55	Black	Female	30	Accident	Femoral - Blood	Oxymorphone	GC/MS	0	detected
					Femoral - Blood	Oxycodone	GC/MS	0.3	mg/L
					Femoral - Blood	Diphenhydramine	LC/MS/MS		detected
					Femoral - Blood	Alprazolam	GC/MS	0.02	mg/L
56	White	Male		Accident	Femoral - Blood	Morphine	GC/MS	0.16	mg/L
					Urine	6-acetylmorphine	GC/MS		detected

Case	Race	Sex	Age	Mode	Specimen	Drug	Confirm Method	Concentration	
57	Black	Male	53	Accident	Hospital Blood	Methadone	LC/MS	0.03	mg/L
					Femoral - Blood	Phencyclidine	GC/MS	0.02	mg/L
					Femoral - Blood	Cocaine	GC/MS	0.13	mg/L
					Femoral - Blood	Benzoylecgonine	GC/MS	1.25	mg/L
					Femoral - Blood	Diphenhydramine	LC/MS/MS		detected
					Femoral - Blood	Levamisole	Not Confirmed		
					Urine	6-acetylmorphine	GC/MS		detected
					Femoral - Blood	Methadone	LC/MS	0.12	mg/L
					Femoral - Blood	Morphine	GC/MS	0.02	mg/L
58	Black	Female	48	Accident	Femoral - Blood	Cocaine	GC/MS	0.01	mg/L
					Femoral - Blood	Benzoylecgonine	GC/MS	0.49	mg/L
59	Black	Male	48	Accident	Femoral - Blood	Cocaine	GC/MS	0.07	mg/L
					Femoral - Blood	Codeine	GC/MS	0.18	mg/L
					Vitreous Humor	Ethanol	HS/GC-2	0.07	g/100mL
					Femoral - Blood	Cocaethylene	GC/MS	0.06	mg/L
					Femoral - Blood	Benzoylecgonine	GC/MS	0.6	mg/L
					Femoral - Blood	Morphine	GC/MS	0.24	mg/L
					Femoral - Blood	Ethanol	HS/GC-2	0.05	g/100mL
					Urine	6-acetylmorphine	GC/MS		detected
					Femoral - Blood	Levamisole	Not Confirmed		
60		Male	47	Accident	Urine	6-acetylmorphine	GC/MS		detected
					Femoral - Blood	Codeine	GC/MS	0.05	mg/L
					Femoral - Blood	Morphine	GC/MS	0.19	mg/L
61	Black	Female	56	Accident	Heart - Blood	Ethanol	HS/GC-2		detected
					Heart - Blood	Benzoylecgonine	GC/MS	0.14	mg/L
					Other - Blood	Morphine	GC/MS	0.4	mg/L
					Bile	Ethanol	HS/GC-2	0.06	g/100mL
62	Black	Male	62	Accident	Femoral - Blood	Benzoylecgonine	GC/MS	0.01	mg/L
					Hospital Blood	Benzoylecgonine	GC/MS	0.46	mg/L
					Clot - Blood	Benzoylecgonine	GC/MS	0.144	mg/L
					Femoral - Blood	Morphine	GC/MS	0.49	mg/L
					Hospital Blood	Methadone	LC/MS	0.09	mg/L
					Femoral - Blood	Methadone	LC/MS	0.1	mg/L
					Femoral - Blood	Morphine	LC/MS/MS		detected
					Clot - Blood	Methadone	LC/MS	0.03	mg/L
63	Black	Male	63	Accident	Femoral - Blood	Benzoylecgonine	GC/MS	0.22	mg/L
					Femoral - Blood	Methadone	LC/MS	0.38	mg/L

Case	Race	Sex	Age	Mode	Specimen	Drug	Confirm Method	Concentration	
64	Black	Male	42	Accident	Femoral - Blood	Venlafaxine	Not Confirmed		
					Femoral - Blood	Alprazolam	LC/MS/MS	0	detected
					Femoral - Blood	Methadone	LC/MS	0.15	mg/L
65	Black	Female	37	Accident	Liver	Ethanol	HS/GC-2	0.17	
					Chest Cavity - Fluid	Levamisole	Not Confirmed		
					Chest Cavity - Fluid	Phencyclidine	GC/MS	0.17	mg/L
					Chest Cavity - Fluid	Cocaine	GC/MS	0.03	mg/L
					Chest Cavity - Fluid	Benzoylecgonine	GC/MS	0.87	mg/L
					Chest Cavity - Fluid	Diphenhydramine	LC/MS/MS		detected
					Chest Cavity - Fluid	Ethanol	HS/GC-2	0.16	g/100mL
					Chest Cavity - Fluid	Chlorpheniramine	LC/MS/MS		detected
66	Black	Male	44	Accident	Femoral - Blood	Phencyclidine	GC/MS	0.14	mg/L
					Urine	Codeine	GC/MS		detected
					Urine	Morphine	GC/MS		detected
					Femoral - Blood	Codeine	GC/MS	0.09	mg/L
					Urine	Hydrocodone	GC/MS		detected
					Femoral - Blood	Codeine	GC/MS/NPD		detected
67	White	Male	27	Accident	Urine	Morphine	GC/MS		detected
					Urine	6-acetylmorphine	GC/MS		detected
					Heart - Blood	Morphine	GC/MS	0.09	mg/L
					Urine	Codeine	GC/MS		detected
68	Black	Female	64	Accident	Femoral - Blood	Cannabinoids	Not Confirmed		
					Femoral - Blood	Levamisole	Not Confirmed		
					Femoral - Blood	Benzoylecgonine	GC/MS	0.7	mg/L
					Femoral - Blood	Cocaine	GC/MS	0.19	mg/L
69	Black	Female	51	Accident	Heart - Blood	Ethanol	HS/GC-2	0.06	g/100mL
					Chest Cavity - Blood	Methadone	GC/MS	0.22	mg/L
					Chest Cavity - Blood	Benzoylecgonine	GC/MS	0.05	mg/L
					Bile	Ethanol	HS/GC-2	0.09	g/100mL
					Chest Cavity - Blood	Cyclobenzaprine	Not Confirmed		
70	Black	Female	28	Accident	Femoral - Blood	Codeine	GC/MS		detected
					Vitreous Humor	6-acetylmorphine	GC/MS	0.009	mg/L
					Hospital Blood	Morphine	GC/MS	0.09	mg/L
					Femoral - Blood	Benzoylecgonine	GC/MS	1.5	mg/L
					Femoral - Blood	Levamisole	Not Confirmed	0	
					Femoral - Blood	Morphine	GC/MS	1.05	mg/L
					Femoral - Blood	Citalopram	Not Confirmed		

					Hospital Blood	Benzoylecgonine	GC/MS	1.25	mg/L
					Femoral - Blood	Cocaine	GC/MS	0.06	mg/L
					Femoral - Blood	Tramadol	Not Confirmed		
71	Asian	Male	50	Accident	Heart - Blood	Levamisole	Not Confirmed		
					Heart - Blood	Benzoylecgonine	GC/MS		detected
					Heart - Blood	Cocaine	GC/MS	0.02	mg/L
72	Black	Male	56	Accident	Chest Cavity - Fluid	Mirtazapine	Not Confirmed		
					Chest Cavity - Fluid	Morphine	GC/MS		detected
					Chest Cavity - Fluid	6-acetylmorphine	GC/MS		detected
					Femoral - Blood	Ethanol	HS/GC-2	0.03	g/100mL
					Chest Cavity - Fluid	Codeine	GC/MS	0.12	mg/L
					Chest Cavity - Fluid	Ethanol	HS/GC-2	0.13	g/100mL
73	Black	Male	33	Accident	Heart - Blood	Phencyclidine	GC/MS	0.07	mg/L
					Urine	Phencyclidine	GC/MS		detected
					Femoral - Blood	Phencyclidine	GC/MS	0.11	mg/L
					Hospital Blood	Phencyclidine	GC/MS	0.01	mg/L
74	Black	Female	41	Accident	Hospital Blood	Isopropanol	HS/GC-2	0.016	g/100mL
					Hospital Blood	Morphine	GC/MS	0.11	mg/L
					Hospital Blood	Acetone	HS/GC-2	0.036	g/100mL
75	Black	Female	58	Accident	Femoral - Blood	Cocaine	GC/MS	0.12	mg/L
					Femoral - Blood	Benzoylecgonine	GC/MS	1.11	mg/L
					Hospital Blood	Cocaine	GC/MS	0.01	mg/L
					Femoral - Blood	Levamisole	Not Confirmed		
					Hospital Blood	Benzoylecgonine	GC/MS	0.98	mg/L
76	Black	Female	56	Accident	Femoral - Blood	Cocaine	GC/MS	0.05	mg/L
					Hospital Blood	Morphine	GC/MS	0.15	mg/L
					Urine	6-acetylmorphine	GC/MS		detected
					Femoral - Blood	Hydrocodone	GC/MS	0.03	mg/L
					Femoral - Blood	Benzoylecgonine	GC/MS	1.39	mg/L
					Femoral - Blood	Morphine	GC/MS	0.11	mg/L
					Femoral - Blood	Dextromethorphan	Not Confirmed		
					Femoral - Blood	Levamisole	Not Confirmed		
77	Black	Female	60	Accident	Femoral - Blood	Nordiazepam	LC/MS/MS		detected
					Femoral - Blood	Temazepam	LC/MS/MS		detected
					Femoral - Blood	Fluoxetine	Not Confirmed		
					Femoral - Blood	Diazepam	LC/MS/MS		detected
					Femoral - Blood	Alprazolam	LC/MS/MS		detected
					Femoral - Blood	Dextromethorphan	Not Confirmed		
					Femoral - Blood	Oxycodone	GC/MS	0.07	mg/L
					Femoral - Blood	Morphine	GC/MS	0.27	mg/L

Case	Race	Sex	Age	Mode	Specimen	Drug	Confirm Method	Concentration	
					Urine	6-acetylmorphine	GC/MS		detected
78	Black	Male	59	Accident	Heart - Blood	Phencyclidine	GC/MS	0.02	mg/L
79	Black	Male	61	Accident	Vitreous Humor	Ethanol	HS/GC-2	0.06	g/100mL
					Femoral - Blood	Morphine	GC/MS	0.08	mg/L
					Femoral - Blood	Ethanol	HS/GC-2	0.04	g/100mL
					Urine	6-acetylmorphine	GC/MS		detected
80	Black	Female	23	Accident	Femoral - Blood	Phencyclidine	GC/MS	0.01	mg/L
					Femoral - Blood	Morphine	GC/MS	0.1	mg/L
					Femoral - Blood	Benzoylecgonine	GC/MS		detected
					Femoral - Blood	Cocaine	GC/MS	0.32	mg/L
					Vitreous Humor	6-acetylmorphine	GC/MS		detected
81	White	Male	27	Accident	Vitreous Humor	Ethanol	HS/GC-2	0.25	g/100mL
					Femoral - Blood	Methadone	GC/MS	0.1	mg/L
					Femoral - Blood	Ethanol	HS/GC-2	0.19	g/100mL
82	Black	Female	58	Accident	Femoral - Blood	Morphine	GC/MS	0.12	mg/L
					Femoral - Blood	Ethanol	HS/GC-2	0.2	g/100mL
					Vitreous Humor	Ethanol	HS/GC-2	0.24	g/100mL
83	White	Female	57	Accident	Hospital Blood	Zolpidem	LC/MS/MS	0.78	mg/L
					Femoral - Blood	Tramadol	GC/MS	0.42	mg/L
					Hospital Blood	Ethanol	HS/GC-2	0.14	g/100mL
					Hospital Blood	Dicyclomine	GC/MS	0.45	mg/L
					Femoral - Blood	Zolpidem	LC/MS/MS	0.24	mg/L
					Femoral - Blood	Dicyclomine	GC/MS	0.46	mg/L
					Femoral - Blood	Cannabinoids	Not Confirmed		
84	Black	Male	55	Accident	Femoral - Blood	Methadone	LC/MS	0.61	mg/L
					Femoral - Blood	Ethanol	HS/GC-2	0.06	g/100mL
					Vitreous Humor	Ethanol	HS/GC-2	0.07	g/100mL
85	Black	Male	41	Accident	Femoral - Blood	Morphine	GC/MS	0.27	mg/L
					Femoral - Blood	Benzoylecgonine	GC/MS	0.16	mg/L
					Urine	6-acetylmorphine	GC/MS		detected
					Femoral - Blood	Cocaine	GC/MS		detected
86	Black	Male	43	Accident	Femoral - Blood	Acetaminophen	LC/MS/MS	35.3	mg/L
					Femoral - Blood	Codeine	LC/MS/MS		detected
					Femoral - Blood	Fentanyl	GC/MS	0.007	mg/L
					Liver	Fentanyl	GC/MS	0.029	mg/kg
87	Black	Male	46	Accident	Femoral - Blood	Phencyclidine	GC/MS	0.09	mg/L
					Femoral - Blood	Atropine	Not Confirmed		
88	White	Male	48	Accident	Other - Blood	Oxycodone	GC/MS	0.34	g/100mL
					Other - Blood	Bupropion	Not Confirmed		

					Other - Blood	Norfluoxetine	LC/MS/MS	0.4	mg/kg
					Other - Blood	Fluoxetine	LC/MS/MS	0.36	mg/L
					Liver	Fluoxetine	LC/MS/MS	9.75	mg/kg
89	White	Male	28	Accident	Femoral - Blood	Ethanol	HS/GC-2	0.04	g/100mL
					Gastric Contents	Oxycodone	GC/MS	6.82	mg/L
					Vitreous Humor	Ethanol	HS/GC-2	0.07	g/100mL
					Femoral - Blood	Oxymorphone	GC/MS	0.03	mg/L
					Femoral - Blood	Oxycodone	GC/MS	0.3	mg/L
					Gastric Contents	Oxymorphone	GC/MS	0.04	mg/L
90	Black	Female	52	Accident	Hospital Blood	Benzoylecgonine	GC/MS	1.2	mg/L
					Femoral - Blood	Benzoylecgonine	GC/MS	0.6	mg/L
					Femoral - Blood	Acetone	HS/GC-2	0.016	
					Hospital Blood	Acetone	HS/GC-2	0.071	g/100mL
91	Black	Female	47	Accident	Femoral - Blood	Morphine	GC/MS	0.39	mg/L
					Femoral - Blood	Alprazolam	LC/MS/MS		detected
					Femoral - Blood	Cocaine	GC/MS	0.06	mg/L
					Femoral - Blood	Cocaethylene	GC/MS	0.01	mg/L
					Femoral - Blood	Benzoylecgonine	GC/MS	0.86	mg/L
					Urine	6-acetylmorphine	GC/MS		detected
92	White	Female	72	Suicide	Heart - Blood	Phenobarbital	GC/MS/NPD		detected
					Femoral - Blood	Nordiazepam	LC/MS/MS		detected
					Femoral - Blood	Diazepam	LC/MS/MS		detected
					Femoral - Blood	Zolpidem	GC/MS	0.11	mg/L
					Femoral - Blood	Oxycodone	GC/MS	0.67	mg/L
					Femoral - Blood	Temazepam	LC/MS/MS		detected
93	Black	Female	22	Suicide	Femoral - Blood	Diphenhydramine	GC/MS	12.3	mg/L
					Liver	Diphenhydramine	GC/MS	31.2	mg/kg
94	White	Female	42	Suicide	Bile	Ethanol	HS/GC-2	0.05	g/100mL
					Liver	Diphenhydramine	GC/MS	75	mg/kg
					Decomp Fluid	Ethanol	HS/GC-2	0.07	g/100mL
					Brain	Diphenhydramine	GC/MS	8.24	mg/kg
					Decomp Fluid	Diphenhydramine	GC/MS	3.26	mg/kg
95	Asian	Female	30	Suicide	Liver	Chloroquine	GC/MS	1290.2	mg/kg
					Heart - Blood	Chloroquine	GC/MS	112	mg/L
					Femoral - Blood	Mirtazapine	Not Confirmed		
					Femoral - Blood	Chloroquine	GC/MS	140	mg/L
96	Black	Female	43	Suicide	Femoral - Blood	Salicylic Acid	Not Confirmed		
					Liver	Butalbital	GC/MS	38	mg/L
					Femoral - Blood	Codeine	GC/MS	2	mg/L
					Femoral - Blood	Butalbital	GC/MS/NPD		detected

Case	Race	Sex	Age	Mode	Specimen	Drug	Confirm Method	Concentration	
					Femoral - Blood	Morphine	GC/MS	0.22	mg/L
					Femoral - Blood	Butalbital	GC/MS	15.1	mg/L
97	Hispanic	Female	23	Suicide	Urine	Citalopram	GC/MS/NPD		detected
					Liver	Citalopram	GC/MS	6.91	mg/L
					Hospital Blood	Citalopram	GC/MS	0.23	mg/L
98	White	Female	58	Suicide	Femoral Blood	Dimethoxyphenol	GC/MS		detected
99	White	Female	53	Suicide	Liver	Diphenhydramine	GC/MS	78.1	mg/kg
					Brain	Doxepin	LC/MS/MS	60	mg/L
					Liver	Doxepin	LC/MS/MS	384	mg/kg
					Heart - Blood	Doxepin	LC/MS/MS	27.9	mg/L
					Femoral - Blood	Diphenhydramine	GC/MS	7.06	mg/L
					Femoral - Blood	Doxepin	LC/MS/MS	9.36	mg/kg
					Femoral - Blood	Nordoxepin	LC/MS/MS	1.26	mg/L
					Femoral - Blood	Citalopram	GC/MS	0.85	mg/L
					Liver	Nordoxepin	LC/MS/MS	47.9	mg/kg
100	White	Male	87	Suicide	Femoral - Blood	Trazodone	Not Confirmed		
					Femoral - Blood	Nordiazepam	LC/MS/MS		detected
					Femoral - Blood	Diazepam	LC/MS/MS		detected
					Femoral - Blood	Temazepam	LC/MS/MS		detected
					Femoral - Blood	Propoxyphene	LC/MS/MS	4.64	mg/L
					Femoral - Blood	Norpropoxyphene	LC/MS	1.24	mg/L
101	White	Male	43	Suicide	WRTC - Blood	Pentobarbital	GC/MS	28.5	mg/L
					WRTC - Blood	Temazepam	LC/MS/MS		detected
					WRTC - Blood	Morphine	LC/MS/MS		detected
					WRTC - Blood	Diazepam	LC/MS/MS		detected
					WRTC - Blood	Nordiazepam	LC/MS/MS		detected
					WRTC - Blood	Cannabinoids	Not Confirmed		
					WRTC - Blood	Midazolam	LC/MS/MS		detected
					WRTC - Blood	Morphine	GC/MS	0.17	mg/L
102	White	Female	54	Undetermined	Femoral - Blood	Cyclizine	Not Confirmed		
					Brain	Fentanyl	GC/MS	0.04	mg/L
					Liver	Fentanyl	GC/MS	0.135	mg/kg
					Heart - Blood	Fentanyl	GC/MS	0.047	mg/L
					Femoral - Blood	Fentanyl	GC/MS	0.039	mg/L
					Femoral - Blood	Doxylamine	Not Confirmed		
					Femoral - Blood	Nortriptyline	Not Confirmed		
103	Black	Female	48	Undetermined	Femoral - Blood	Morphine	GC/MS	2.92	mg/L
					Urine	6-acetylmorphine	GC/MS		detected
					Femoral - Blood	Codeine	GC/MS	0.02	mg/L

104	White	Male	20	Undetermined	Urine	Oxymorphone	GC/MS		detected
					Femoral - Blood	Oxymorphone	GC/MS	0.1	mg/L
					Urine	Doxylamine	LC/MS/MS		detected
105	Black	Female	49	Undetermined	Femoral - Blood	Levamisole	Not Confirmed		
					Urine	6-acetylmorphine	GC/MS		detected
					Femoral - Blood	Morphine	GC/MS	0.06	mg/L
					Femoral - Blood	Codeine	GC/MS	0.04	mg/L
					Femoral - Blood	Nortriptyline	LC/MS	1.47	mg/L
					Femoral - Blood	Dextromethorphan	GC/MS/NPD		detected
					Femoral - Blood	Benzoylecgonine	GC/MS	1.09	mg/L
					Femoral - Blood	Phencyclidine	GC/MS	0.02	mg/L
					Femoral - Blood	Amitriptyline	LC/MS	1.93	mg/L
					Femoral - Blood	Cocaine	GC/MS	0.05	mg/L
106	Black	Male	46	Undetermined	Femoral - Blood	Chlorpromazine	LC/MS	0.98	mg/L
					Heart - Blood	Chlorpromazine	LC/MS	2.85	mg/L
					Liver	Chlorpromazine	LC/MS	17.61	mg/kg
					Liver	Paroxetine	LC/MS	26.3	mg/L
					Femoral - Blood	Paroxetine	LC/MS	0.83	mg/L
107	White	Female	49	Undetermined	Gastric Contents	Venlafaxine	GC/MS	21.8	mg/L
					Liver	Diphenhydramine	GC/MS	14.53	mg/kg
					Liver	Venlafaxine	GC/MS	4.94	mg/kg
					Vitreous Humor	Ethanol	HS/GC-2	0.09	g/100mL
					Femoral - Blood	Ethanol	HS/GC-2	0.05	g/100mL
					Femoral - Blood	Venlafaxine	GC/MS	2.03	mg/L
					Femoral - Blood	Diphenhydramine	GC/MS	2.44	mg/L
					Gastric Contents	Diphenhydramine	GC/MS	29.8	mg/L
108	Black	Female	49	Undetermined	Femoral Blood	Ethanol	HS/GC-2	0.13	g/100ml
					Vitreous Humor	Ethanol	HS/GC-2	0.27	g/100mL
					Femoral Blood	Phencyclidine	GC/MS	0.03	mg/L
					Femoral Blood	Cocaine	GC/MS	0.02	mg/L
					Femoral Blood	Benzoylecgonine	GC/MS	0.40	mg/L
					Femoral Blood	Levamisole	Not Confirmed		
109	Black	Female	60	Undetermined	Femoral Blood	Diphenhydramine	Not Confirmed		
					Femoral Blood	Morphine	GC/MS	0.05	mg/L
110	White	Male	64	Undetermined	Femoral Blood	Morphine	GC/MS	7.09	mg/L
					Femoral Blood	Oxycodone	GC/MS	0.06	mg/L
					Femoral Blood	Oxymorphone	GC/MS	0.04	mg/L
111	Other	Male	29	Undetermined	Femoral - Blood	Methamphetamine	GC/MS	0.12	mg/L
					Femoral - Blood	Amphetamine	GC/MS	0.05	mg/L
					Urine	GHB	GC/MS		detected

Femoral - Blood	GHB	GC/MS	536 mg/L

Accidental Drug Overdose Fatalities by Age

The majority of overdose deaths occurred in decedents between the ages of 41 and 60 years. Opiates (Heroin, oxycodone) were the most frequent class of detected drug in most of these age groups, followed by cocaine, ethanol then methadone. The prevalence of phencyclidine (PCP) has been included.
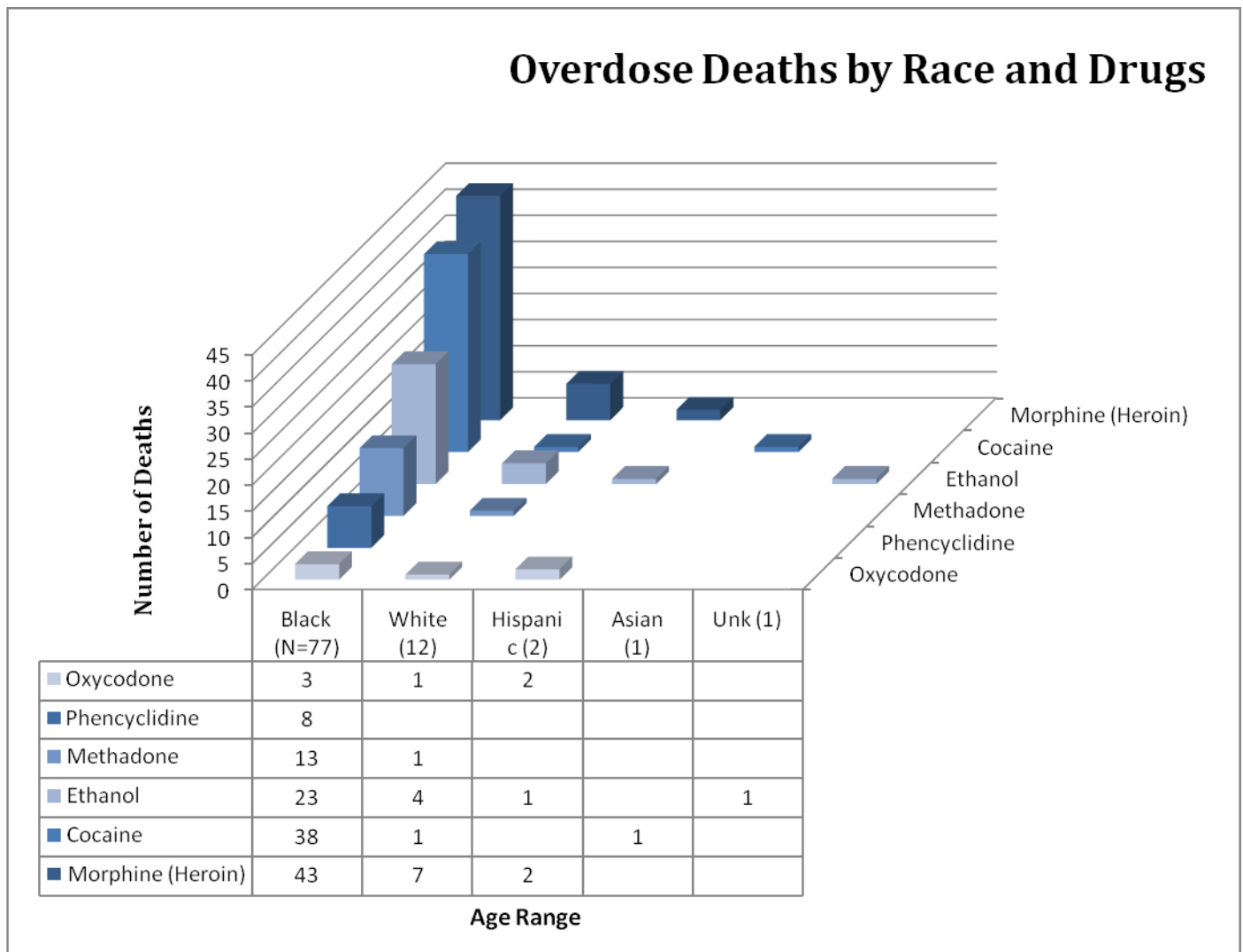
Overdose Deaths by Age and Drugs
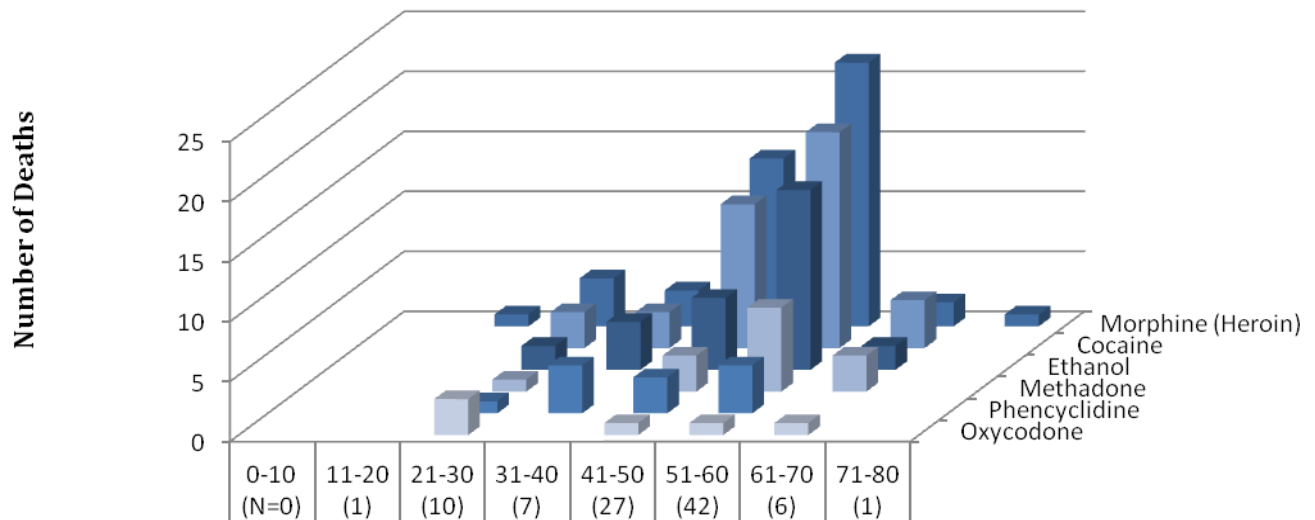
	0-10 (N=0)	11-20 (1)	21-30 (10)	31-40 (7)	41-50 (27)	51-60 (42)	61-70 (6)	71-80 (1)
Oxycodone			3		1	1	1	
Phencyclidine			1	4	3	4		
Methadone			1		3	7	3	
Ethanol			2	4	6	15	2	
Cocaine			3	3	12	18	4	
Morphine (Heroin)		1	4	3	14	22	2	1

Age Range

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. The prevalence of phencyclidine (PCP) has been included

Overdose Deaths by Race and Drugs

	Black (N=77)	White (12)	Hispanic (2)	Asian (1)	Unk (1)
Oxycodone	3	1	2		
Phencyclidine	8				
Methadone	13	1			
Ethanol	23	4	1		1
Cocaine	38	1		1	
Morphine (Heroin)	43	7	2		

Age Range

2.4 - NATURAL DEATHS

Deaths due to Cardiovascular Diseases continue to dominate in this category with 328 fatalities. Deaths due to the complications of alcohol abuse were a far second with 39 deaths. Blacks were more prevalent in this category representing 77% of the population affected. The majority of Natural deaths occurred in March.

Two contributing causes of Natural deaths need to be outlined. Diabetes Mellitus was a co-factor in 9% of the population studied and Obesity in %.

Natural Deaths by Cause

Cause	Number of Deaths	% Of Total Natural Deaths
Cardiovascular Disease	328	60%
Alcoholism	39	7%
Central Nervous System Diseases	25	5%
Infectious Disease	22	4%
Cancer	21	4%
Diabetes	21	4%
Therapeutic Complications	20	4%
Respiratory Diseases	15	3%
Other	14	3%
Infection	11	2%
Gastrointestinal Disease	9	2%
Obesity or Complications of Obesity	5	1%
Pulmonary	4	1%
Blood Disease/Hemopoietic System	2	0%
Complications of Drug Abuse	2	0%
Immune System Disease	2	0%
Complications of Pregnancy	1	0%
Connective Tissue Disease	1	0%
Genetic Disorder	1	0%
Total	**543**	**100%**

Pie Chart – Natural Deaths by Cause

Respiratory Disease, 3%

Other, 3%

Infection, 2%

Gastrointestinal Disease , 2%

Therapeutic Complications, 4%

Cancer, 4%

Diabetes , 4%

Infectious Disease, 4%

Cardiovascular, 60%

Central Nervous System Diseases, 5%

Alcoholism , 7%
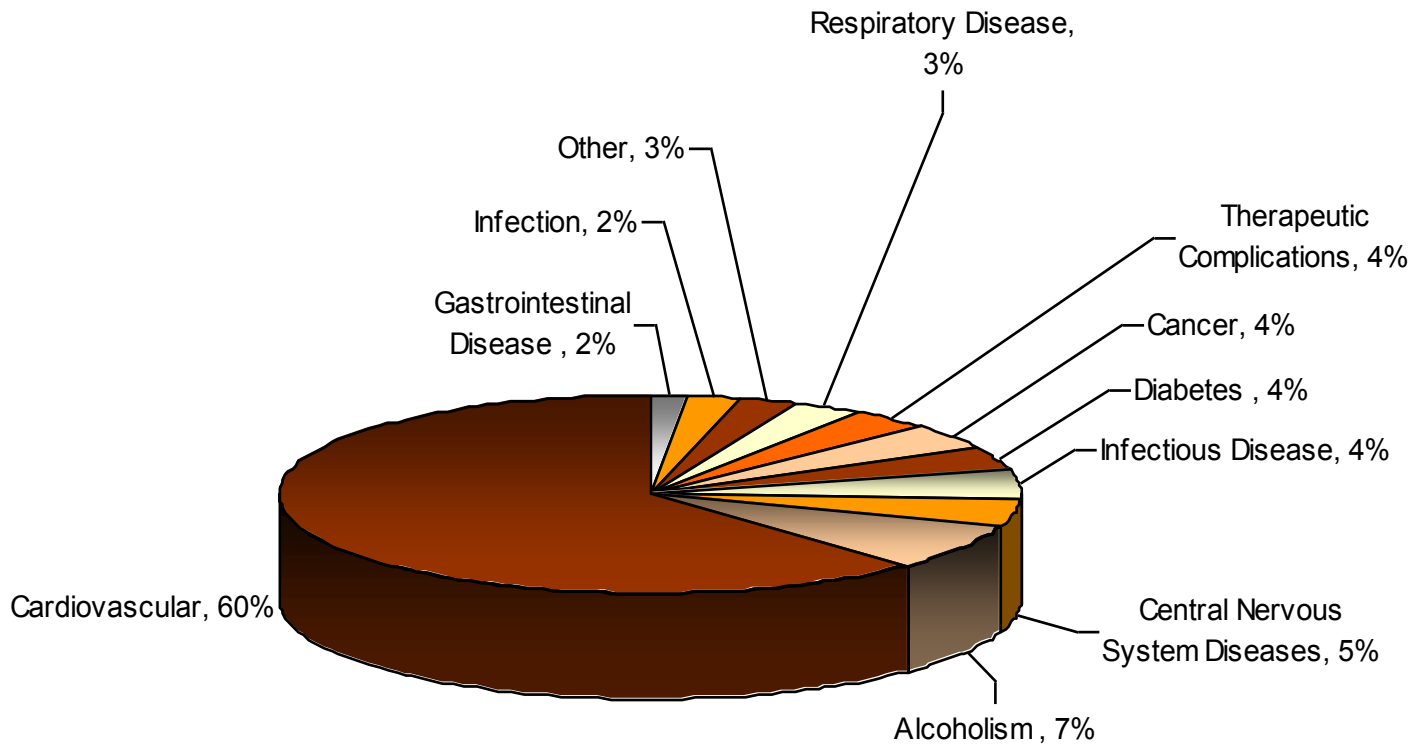
Note: Causes of Death that are less than 2% is not included in this chart.

Natural Deaths by Month

Month	Number of Deaths
January	50
February	49
March	58
April	35
May	52
June	40
July	37
August	39
September	44
October	51
November	40
December	48
Total	**543**

Chart- Natural Deaths by Month
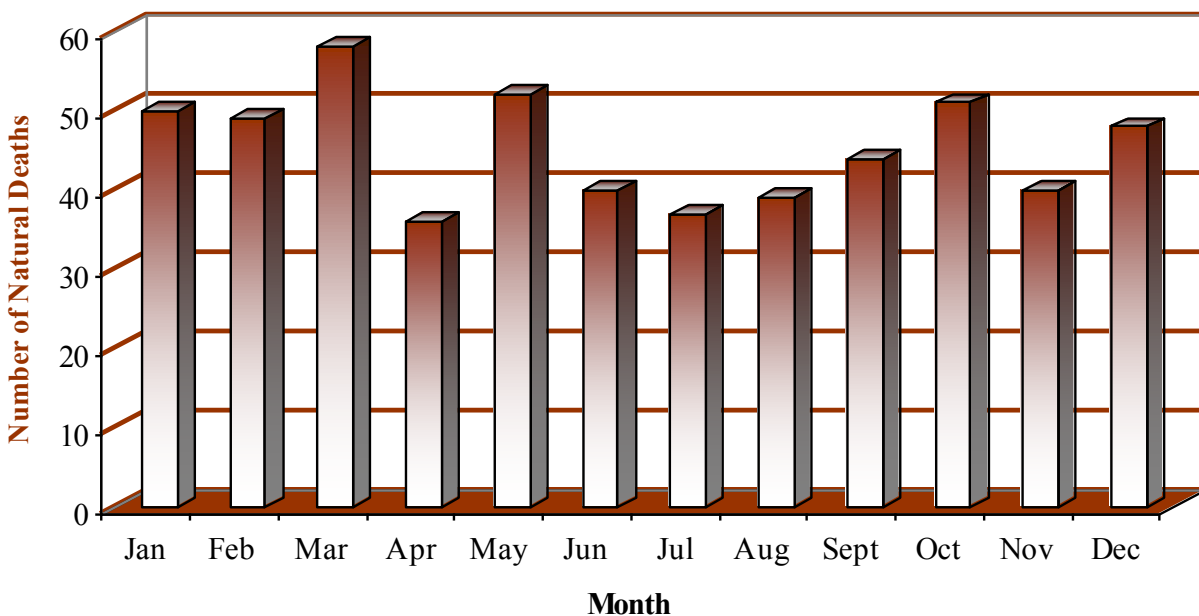
Natural Deaths by Race

Race	Number of Natural Deaths	% of Natural Deaths
Alaskan Native	1	0%
Asian	4	1%
Black	417	77%
Hispanic	12	2%
Other	1	0%
Unknown	1	0%
White	107	20%
Total	**543**	**100%**

Natural Deaths by Gender

Gender	Number of Natural Deaths	% of Natural Deaths
Female	206	38%
Male	337	62%
Total	**543**	**100%**

Natural Deaths by Age

Age	# of Natural Deaths	% of Natural Deaths
Under 1	6	1%
1 to 5	2	0%
6 to 12	3	1%
13 to 15	2	0%
16 to 19	1	0%
20 to 29	14	3%
30 to 39	23	4%
40 to 49	78	14%
50 to 59	147	27%
60 to 69	140	26%
70 to 79	63	12%
80 to 89	55	10%
90 +	8	1%
Unknown	1	0%
Total	**543**	**100%**

Toxicology Findings for Natural Deaths

Of the 543 Natural Deaths investigated by OCME, toxicology analysis was performed in 343 cases. Drugs were absent in 144 natural cases.

Description	Number of Cases	% of Cases
N=	**343**	
Negative	144	41.9 %
Positive	199	58.0 %

The most commonly detected drugs in the natural cases were:

Name of Drug	Number of Cases	% of Natural Cases
Ethanol	95	27.6 %
Acetone[2]	30	8.7 %
Morphine	27	7.8 %
Cocaine	22	6.4 %
Methadone	15	4.3 %
Oxycodone	16	4.6 %
Marijuana Metabolites*	13	3.7 %
Citalopram	11	3.2 %
Diphenhydramine	11	3.2 %
Tramadol	9	2.6 %

*Marijuana metabolites are confirmed depending on case history.

[2] Fluids positive for Acetone (N=30) represented in this total are a by product of diabetes mellitus or products of decomposition and not due to ingestion.

2.5 – UNDETERMINED DEATHS

Undetermined by Cause of Death

The OCME investigated **49** cases in which the <u>manner of death</u> was concluded to be "Undetermined," and of these **12** cases or 24% also had a <u>cause of death</u> classified as "Undetermined".

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

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

There were no deaths classified as "Undetermined" in the following age groups: 40 to 49 years, or those over 80 years old. Peak incidents occurred in July.

Cause of Death	Number of Deaths	% of Total Accepted Cases
Blunt Impact Injuries	5	10%
Drowning	5	10%
Drug Overdose/Poisoning	10	20%
Neurologic Disorders	1	2%
Other	2	4%
Sharp Force Injury	1	2%
Sudden and Unexplained	3	6%
SUID	8	16%
Thermal Injury	2	4%
Undetermined	13	26%
Total	**50**	**100%**

Pie Chart – Undetermined by Cause of Death
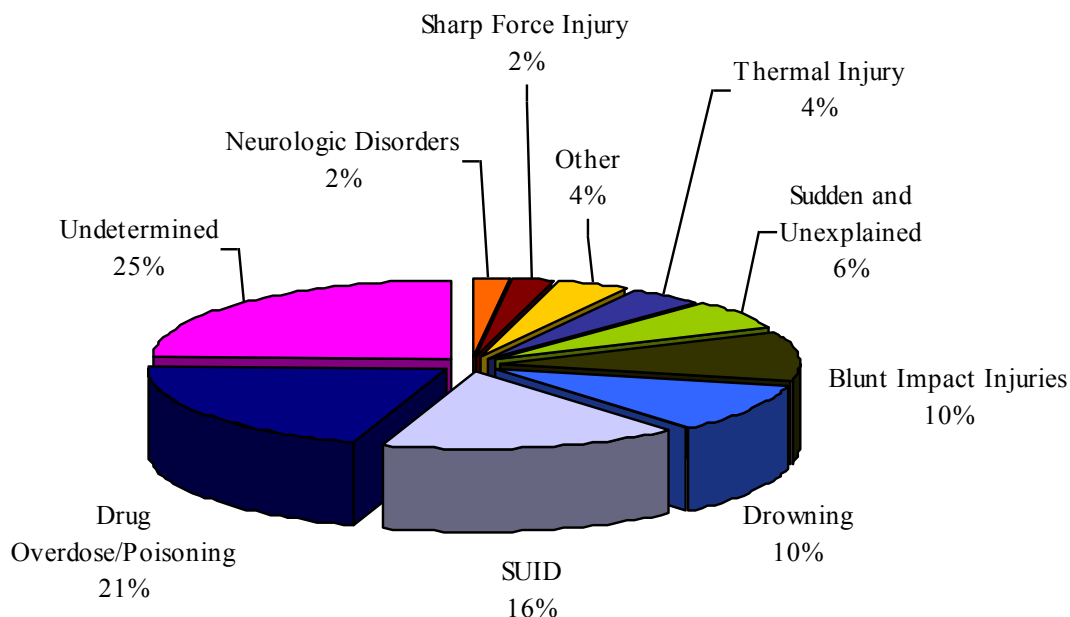
Undetermined Deaths by Month

Month	Number of Deaths
January	3
February	6
March	1
April	2
May	3
June	2
July	7
August	5
September	5
October	8
November	2
December	6
Total	**50**

Chart - Undetermined Deaths by Month
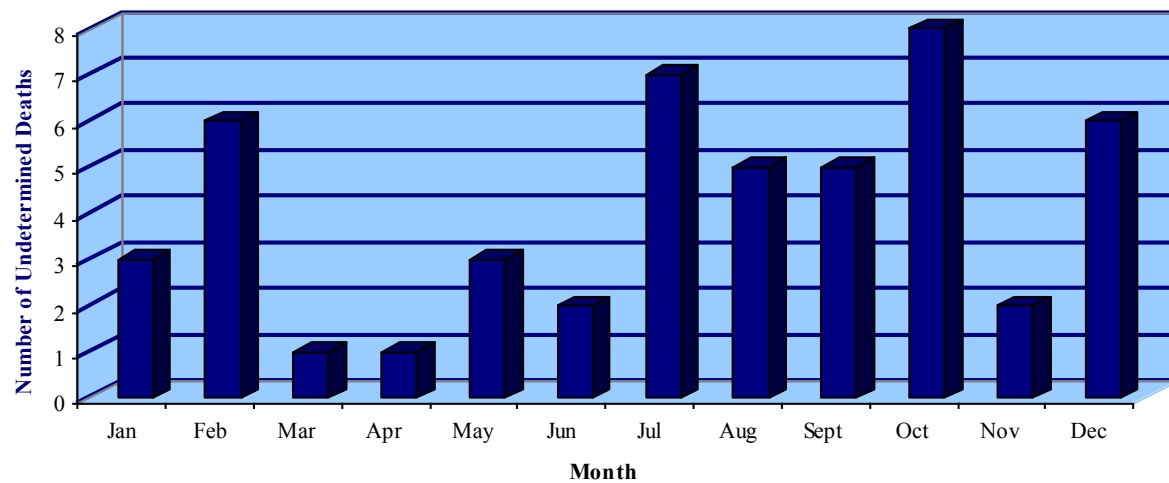
Undetermined Deaths by Race

Race	Number of Undetermined Deaths
Asian	1
Black	36
Hispanic	2
Other	2
White	9
Total	**50**

Undetermined Deaths by Gender

Gender	Number of Undetermined Deaths
Female	17
Male	33
Total	**50**

Undetermined Deaths by Age

Age	Number of Undetermined Deaths
Under 1	11
1 to 5	4
20 to 29	4
30 to 39	1
40 to 49	13
50 to 59	10
60 to 69	5
70 to 79	2
Total	**50**

Note: There were no deaths classified as "Undetermined" in the following age groups 16 to 19; 80-89 and 90 and Above.

Toxicology Findings by Undetermined Deaths

Of the 49 Undetermined Deaths investigated by OCME, toxicology analysis was performed in 45 cases. Drugs were absent in 19 undetermined deaths. Of the positive cases, 40% had more than one drug present.

Description	Number of Cases	% of Cases
N=	45	
Negative	19	42.2 %
Positive	26	57.7 %

The most commonly detected drugs in the undetermined cases were:

Name of Drug	Number of Cases	% of Undetermined Cases
Ethanol	7	15.5 %
Morphine	5	11.1%
Zoplidem	4	8.8 %
Nordiazepam	4	8.8 %
Diazepam	2	4.4 %

Toxicology for Stillbirths

There were 4 Stillbirth Deaths investigated by the OCME; however, Toxicology analysis was not performed in any of these cases.

3.0 – WEIGHT DISTRIBUTION DATA

The agency is presenting data on the weight and the Body Mass Index (BMI) of the population it has studied through this calendar year as an indication of the state of obesity and overweight in the District of Columbia.

Since the agency is responsible for transport of decedents from scenes of death to the facility, this information also has a budgetary as well as a safety impact for the agency. As illustrated in the table and graph below 64% of all decedents transported to the OCME weighs 150 lbs or more.

Comparison of 2011 Total Cases Transported vs Total Number of Cases Exceeding 150lbs

1057

681

Number of Decedent 150lbs or Greater

1200

1000

800

600

400

200

0

■ Total Cases Transported   ■ Total Cases 150lbs+
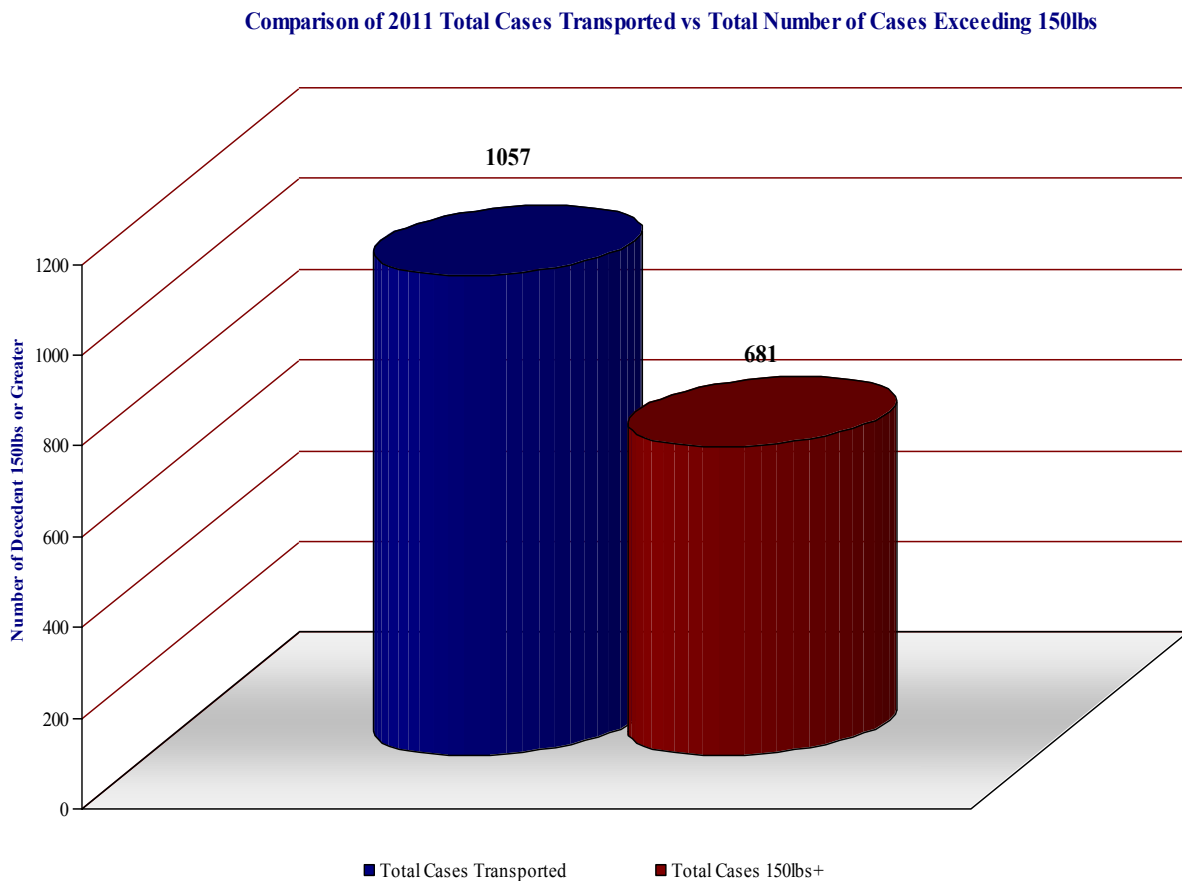
2011 - WEIGHT DISTRIBUTIONS

Weight	Total Cases 149lbs or less	150-199	200-249	250-299	300+	Total Cases 150lbs or more	Total Cases
Number of Decedents	376	387	179	73	42	681	1057

2011 - Distribution of Cases Transported to OCME by Weight

17% **7%** **4%**

36%

36%

■ Cases < 150lbs. ■ 150-199 ■ 200-249 ■ 250-299 ■ 300+
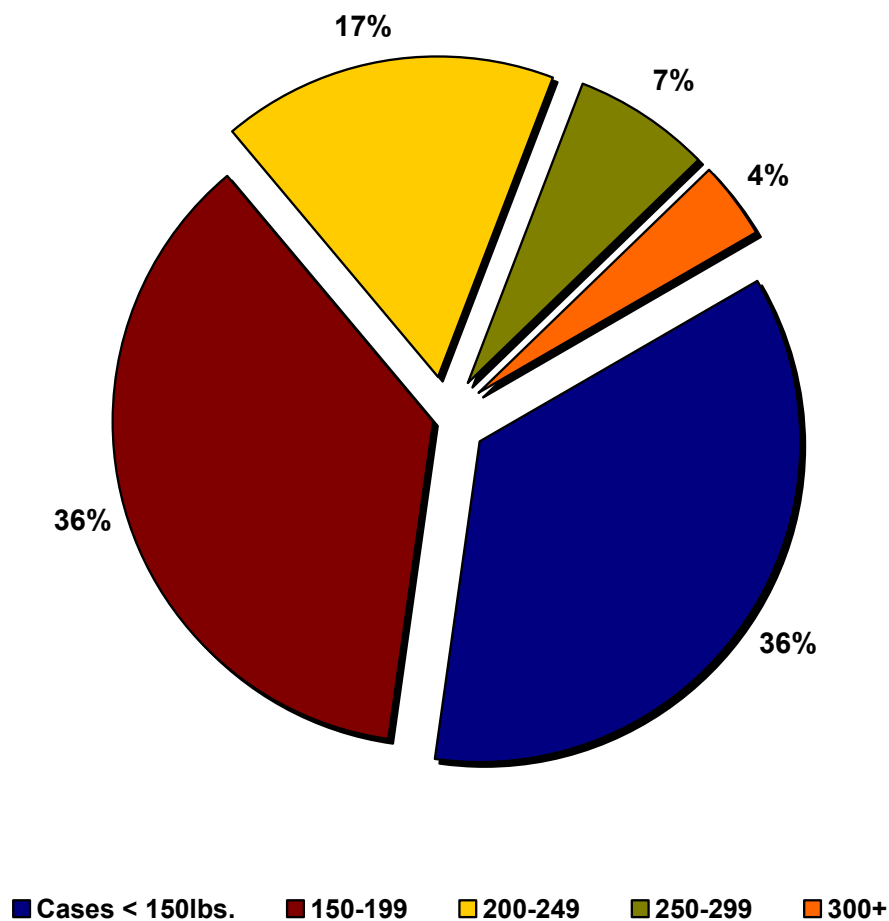
Body Mass Index (BMI) - Adults Only

The World Health Organization (WHO) defines Body Mass Index (BMI) as a "simple index of weight-for-height that is commonly used to classify overweight and obesity in adults. According to the National Institutes of Health (NIH) a normal BMI range is from 18.5 to 24.9. Obesity has emerged as a leading public health concern in the United States.

The Body Mass Index (BMI) of 916 adult decedents investigated by OCME in 2011 is presented in the adjacent figure.
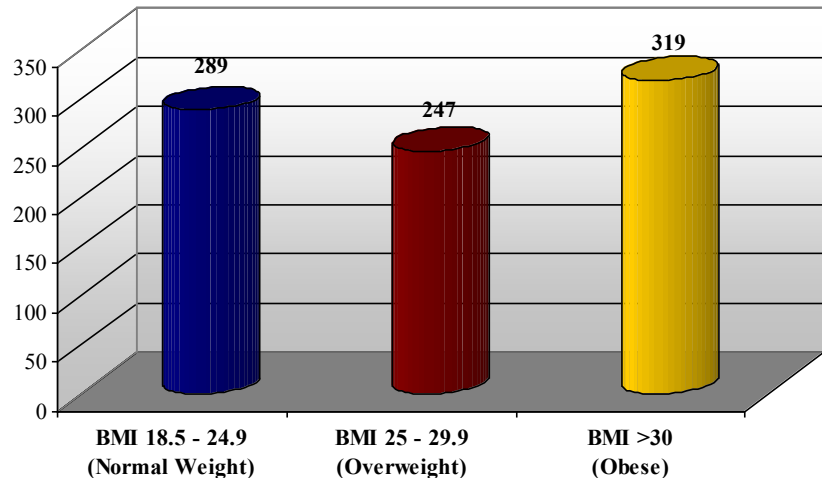
Note: The 61 decedents that are underweight are not included in the above graph.

Seven-year Overview of Adult Decedents with a BMI above 24.9

The number of decedents with a BMI above the normal range seems to be decreasing as shown in the figure below.
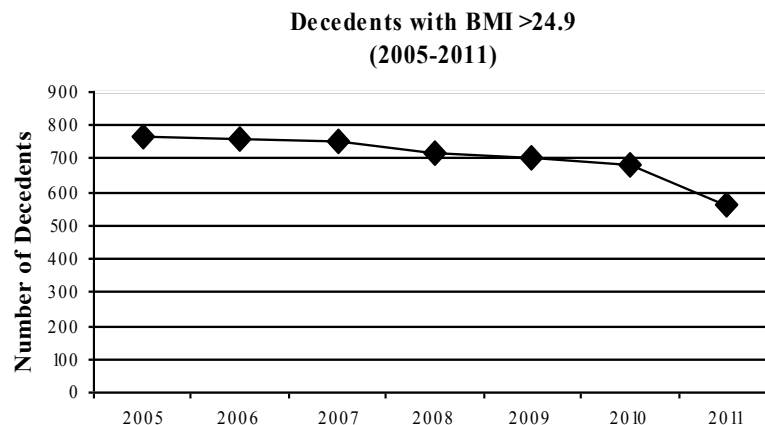
BMI by Race (Adults only)

Of the **566** decedents above the normal weight in 2011, 69% were Black/African American, 24% were White, 5% were Hispanic and those races that were Asian and Other were both 1%. The chart below displays the BMI data by race.

	BMI 18.5 - 24.9 (Normal Weight)	BMI 25 - 29.9 (Overweight)	BMI >30 (Obese)
■ Asians	6	4	1
■ Blacks	206	158	233
■ Hispanics	7	17	13
■ Whites	68	65	69
■ Other	1	3	3
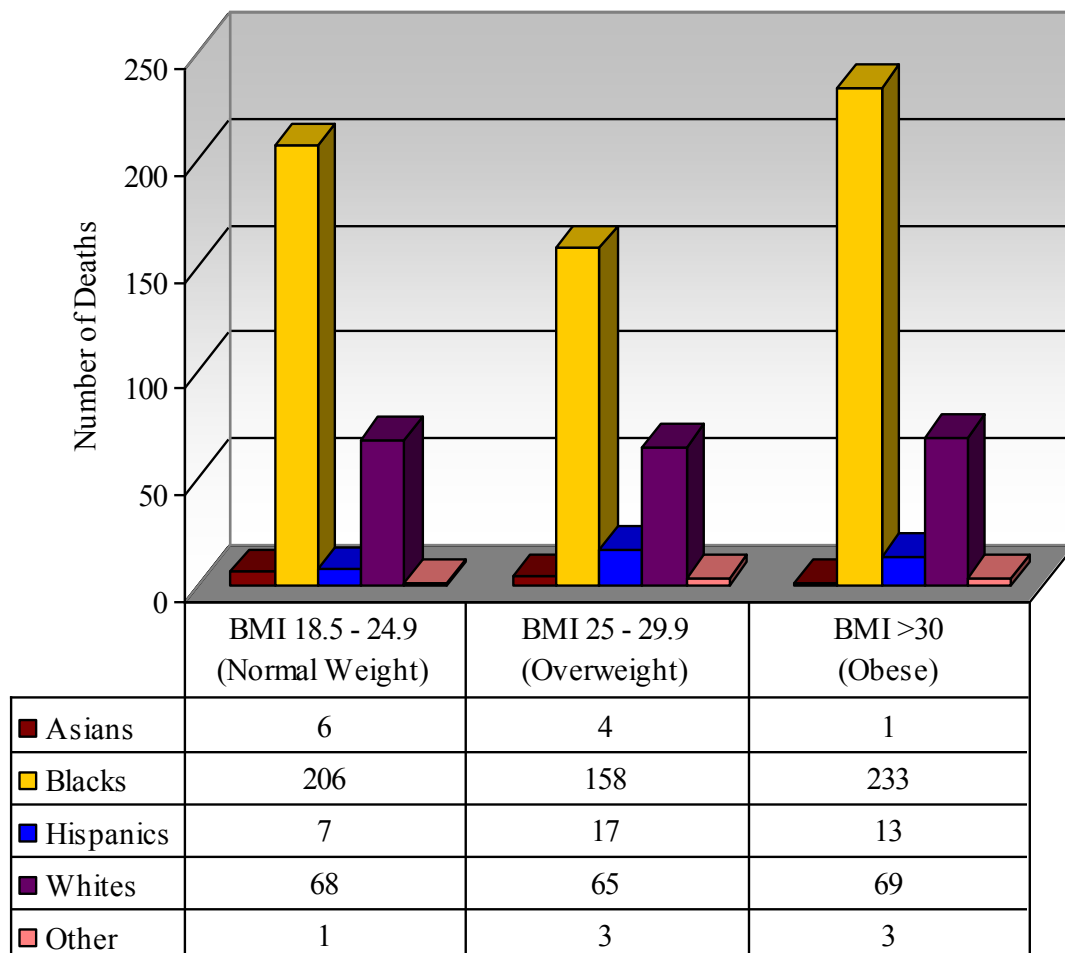
BMI by Age (Adults only)

Of the **566** adult decedents with a BMI above normal (>24.9) during 2011, the age group with the highest number of deaths was 40-59 years old with **257** deaths recorded.

Total of Decedents with a BMI (>24.9) above Normal by Age

Age	Number of Deaths
20 - 39 yrs	116
40 - 59 yrs	257
60 - 79 yrs	154
80 yrs and Above	39

BMI by Age

	BMI 18.5 - 24.9	BMI 25 - 29.9	BMI 30 and Above
20 - 39 yrs	56	61	55
40 - 59 yrs	97	97	160
60 - 79 yrs	84	63	91
80 yrs and Above	52	26	13
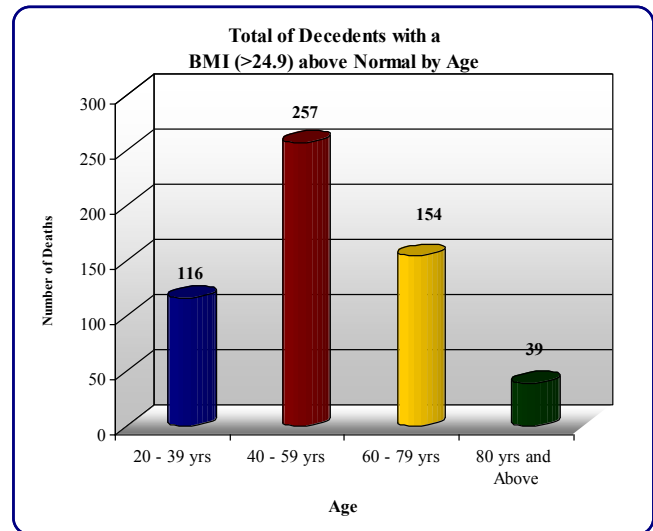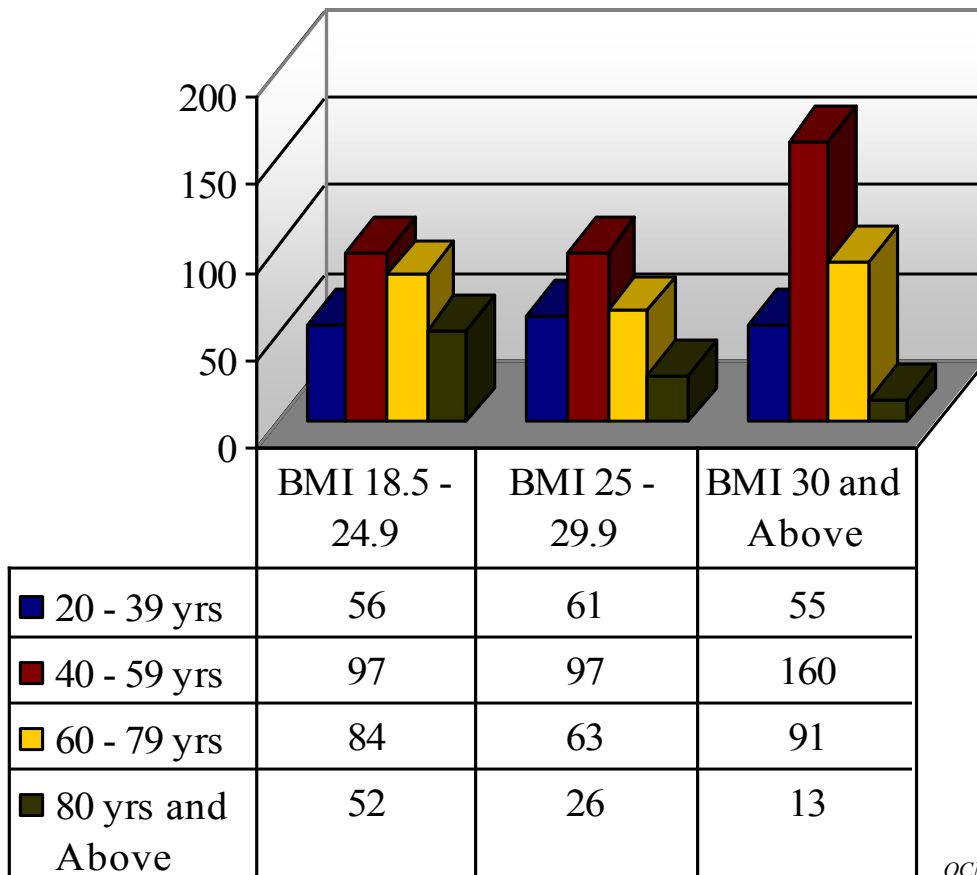
BMI by Age and Cardiovascular Disease

(Adults only)

The charts below provide a breakdown of the prevalence of cardiovascular disease by age and BMI. [3]278 adult decedents died of complications of Cardiovascular Disease 120 were obese and 5 were overweight (64%).

Body Mass Index (BMI) and Deaths Associated with Cardiovascular Disease by BMI

Number of Cardio Deaths

Age group	BMI 18.5-24.9 (Normal Weight)	BMI 25 - 29.9 (Overweight)	BMI 30 and Above (Obese)
20 - 39 yrs	3	2	9
40 - 59 yrs	28	26	64
60 - 79 yrs	29	23	44
80 yrs and Above	19	7	3

■ BMI 18.5-24.9 (Normal Weight) ■ BMI 25 - 29.9 (Overweight) □ BMI 30 and Above (Obese)

Body Mass Index (BMI) and Deaths Associated with Cardiovascular Disease by Age

Number of Deaths

Cardiovascular Disease

◆ 20 - 39 yrs
■ 40 - 59 yrs
▲ 60 - 79 yrs
● 80 yrs and Above

3.1 - BMI Calculations for OCME Child Decedents between the Ages of 2-19 years

BMI Statistical Data

OCME investigated **66** child decedent cases in 2011. Of the **66** cases **25** were under the age of two, and no formula exits to calculate their BMI. The BMI of the remaining **41**-child decedents is tabulated below.

FEMALES

Age	Underweight		Healthy		Overweight		May be Obese		Total
	BMI Range	No.	BMI Range	No.	BMI Range	No.	BMI Range	No.	
2-5 yrs	n/a*	0	n/a*	0	n/a*	0	n/a*	0	0
6-12 yrs	n/a*	0	n/a*	0	23	1	16 and 33.6	2	3
13-15yrs	n/a*	0	n/a*	0	n/a*	0	n/a*	0	0
16-19yrs	12	1	20.6 and 25	2	26	1	30 and 31	2	6
Total		**1**		**2**		**2**		**4**	**9**

BMI Chart for Girsl 2-19 years old
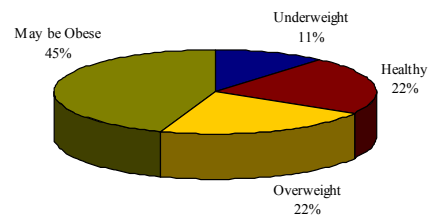
- May be Obese 45%
- Underweight 11%
- Healthy 22%
- Overweight 22%

MALES

Age	Underweight		Healthy		Overweight		May be Obese		Total
	BMI Range	No.	BMI Range	No.	BMI Range	No.	BMI Range	No.	
2-5 yrs	n/a*	0	n/a*	0	n/a*	0	18.5 and 20	2	2
6-12 yrs	12.1	1	15.9	1	n/a*	0	19.1	1	3
13-15 yrs	n/a*	0	19.5 – 23.2	4	n/a*	0	n/a*	0	4
16-19 yrs	17 and 18	2	20-25.8	16	28.6	1	30.7 to 72	4	23
Total		**3**		**21**		**1**		**7**	**32**

*n/a= not applicable

BMI Chart for Boys 2-19 years old

- May be Obese 22%
- Overweight 3%
- Underweight 9%
- Healthy 66%
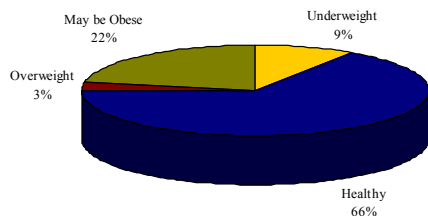
[3] The **21** decedents who were underweight are not included in the graphs below.

4.0 – OTHER MAJOR ACTIVITIES

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

Court-related Activities

A parameter not often considered in evaluating the Medical Examiners workload is time spent in pre-trial conferences, depositions and expert testimony provided in family, civil and criminal litigations. This annual report presents tabulated data for these expert services provided in OCME calendar year 2011.

Type of Judicial Service	Number of Court related Activities
Court Testimony	29
Depositions	2
Grand Jury	0
Pre-trial Conference	47
Other	5
Total	**83**

Court Services by Type	Number of Court related Activities
Civil	14
Criminal	68
Other	1
Total	**83**

Court Services by Jurisdiction	Number of Court related Activities
DC	71
Maryland	11
Out of Metro Area	1
Total	**83**

For calendar year 2011 the above data represents approximately **97.5** hours of Medical Examiner time. In general the least amount of time spent on this activity was ½ hour, and the maximum recorded time spent on a court-related activity was 9 ½ hours.

Educational Activities

OCME continues to welcome students and residents from area universities and hospitals for their teaching requirements. In addition, the agency either hosted or was invited to lecture and/or provide presentation at the following medical institutions or major conferences:

1. 2011 National Youth Leadership Forum on Medicine
2. 2011 National Youth Leadership Forum on Law and Crime Scene Investigation
3. DC Medical Examiner's Office Familiarization Training for Metro Transit Police Officers, Metropolitan Police Department Cadets and Mobile Crime technicians, Public Defenders Service Interns, Assistant U.S. Attorney Interns, and Foreign Service Officers from the US Dept. of State
4. Partners in Education with Arlington Public Schools
5. DCPS– Career Day
6. Forensic Analysis of Victims of Violence, undergrad program GTU – Death Investigation, the Ins and Outs
7. Defiance College, Defiance, Ohio
8. George Washington University – Graduate program in Forensic Science, Medico legal Death Investigation.
9. American University Law School

Publications by OCME Staff

Lochmuller, CM., Pestaner, JP (2011) The Importance of Histological Evaluation in Death Investigation: Two Cases of Fatal Proximal Airway Masses.

Identifications and Public Dispositions

The process of identification can be a complex and lengthy procedure. The preferred method of identification, whenever circumstances of death allow, is by visualization of a printed 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, or comparative studies of ante-mortem and post-mortem body and dental x-rays. Staff members of different divisions and outside consultants participate in this process including members of MPD's Natural Squad.

The Washington, DC area enjoys a large number of national and international visitors. The city has many embassies and a diverse population of immigrants. Often –in these cases - the next of kin is not available for identification purposes; hence another set of procedures must be followed through official headquarters of different countries to ensure proper identification and the release of remains to appropriate family members. All bodies examined at the OCME are stored by the agency until families make funeral arrangements. Usually this occurs in a matter of days. However a portion of the population remains "Unclaimed" or "Unidentified" and has to be disposed of by the agency. A minimal one-time fee is charged to these facilities and the remains are kept until family members are located. Unclaimed remains from hospitals are also by regulation to be stored and disposed of by OCME (DC Code §5-1411). The process for which unclaimed bodies are handled is called "Public Dispositions." After a 30-day waiting period and after all efforts to locate family members are exhausted the OCME makes final arrangements for these bodies through contracts with local funeral homes. All Unclaimed bodies (whether Identified or Unidentified) are cremated after collection of all necessary identification data (photographs, body and dental x-rays, DNA cards and fingerprints), unless there exists a concern for public health and safety that would require burial. Those unclaimed bodies identified as United States military veterans, are transported to Quantico for burial in the National Cemetery.

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

Breakdown of Public Dispositions and the Associated Costs

Public Disposition by type	Number of Unclaimed Remains	Cost Per Disposition	Total Dollar Amount Per Type
Cremations – identified adults	109	$590.00	$64,310.00
Cremations - infants	1	$234.00	$234.00
Cremations – fetal remains	2	$105.00	$210.00
Transport to Quantico National Cemetery – identified US Military Veteran	6	$690.00	$4140.00
TOTAL	**118**	**n/a**	**$68,894.00**

Cremation Requests

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

During Calendar Year 2011 there was a total of **2,349** Cremation Requests made to the DC OCME; 526 were OCME cases, 1,823 were cases submitted from area hospitals, clinics and nursing homes, the OCME took jurisdiction of 21 of these cases for further investigation and certification.

Storage Requests

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

During Calendar Year 2011 there were **96** Storage Requests made to the DC OCME

Toxicology Findings for Driving Under the Influence (DUI) Cases

Toxicological examinations were performed on driving-under-the-influence (DUI) cases to assist law enforcement agencies in the investigation of such cases. Routine toxicological examinations for DUI cases include analysis for alcohols (ethanol and other volatiles) and major classes of illicit and prescription medications. Additional screens were assigned depending on requests made by law enforcement. In 2011, the laboratory received 663 cases from the Metropolitan Police Department (MPD) 225 cases from the United States Parks Police (USPP), 22 specimens from the United States Capitol Police (USCP), and 3 specimens from the United States Secret Service (USSS). Specimens received where either blood or urine, and multiple specimens could be received with each of the 913 cases. In total, the laboratory inventoried 1165 DUI specimens yielding 1383 reported results.

A negative case refers to the <u>absence</u> of any alcohol or detectable drug. A positive case refers to the <u>presence</u> of alcohol and/or drug(s), noting that a case can be positive for more than one substance. Drugs that are excluded from typical DUI toxicology reports include common compounds found such as caffeine and nicotine. The following statistics are from cases received in 2011.

Total number of DUI cases analyzed:

Description	Number of Cases	% of Cases
N=	913	
Negative	30	3.2 %
Positive	883	96.7 %

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

Agency	MPD	USPP	USCP	USSS
Total Cases	663	225	22	3
Ethanol	89.7%	68.9%	68.2%	0.0%
Phencyclidine (PCP)	13.1%	28.0%	27.3%	0.0%
Marijuana Metabolite	17.9%	11.1%	31.8%	0.0%
Cocaine	8.9%	8.0%	4.5%	0.0%
Morphine	1.5%	0.9%	9.1%	100.0%

The following two graphs represent the number of suspected DUI cases positive for drugs of abuse or in combination with ethanol. The number of cases for each drug are sorted by blood or urine alcohol concentration.
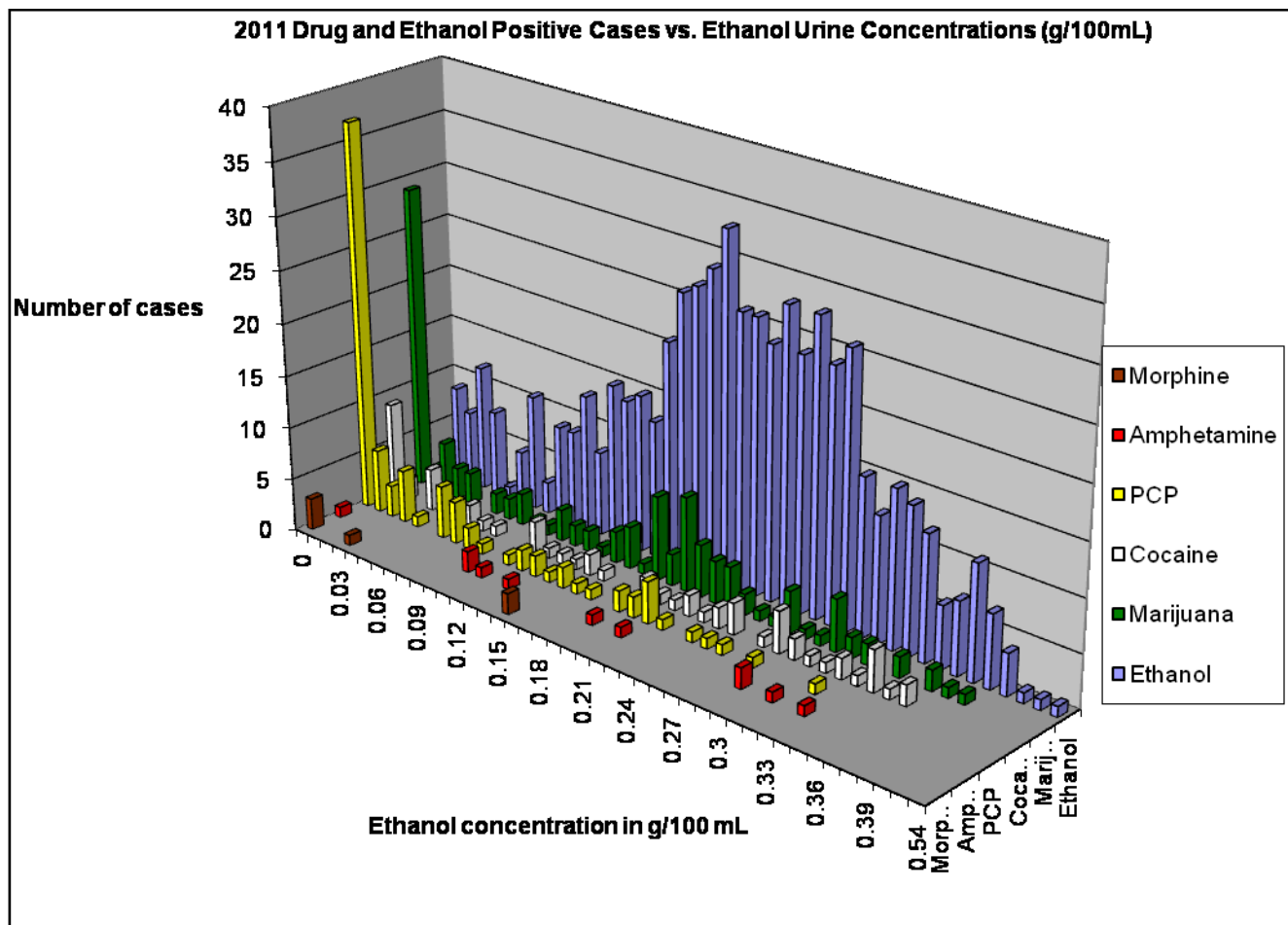

Chart 1. This chart represents the prevalence of drugs compared to ethanol concentrations from urine specimens collected from 2011 suspected DUI cases (n=677)
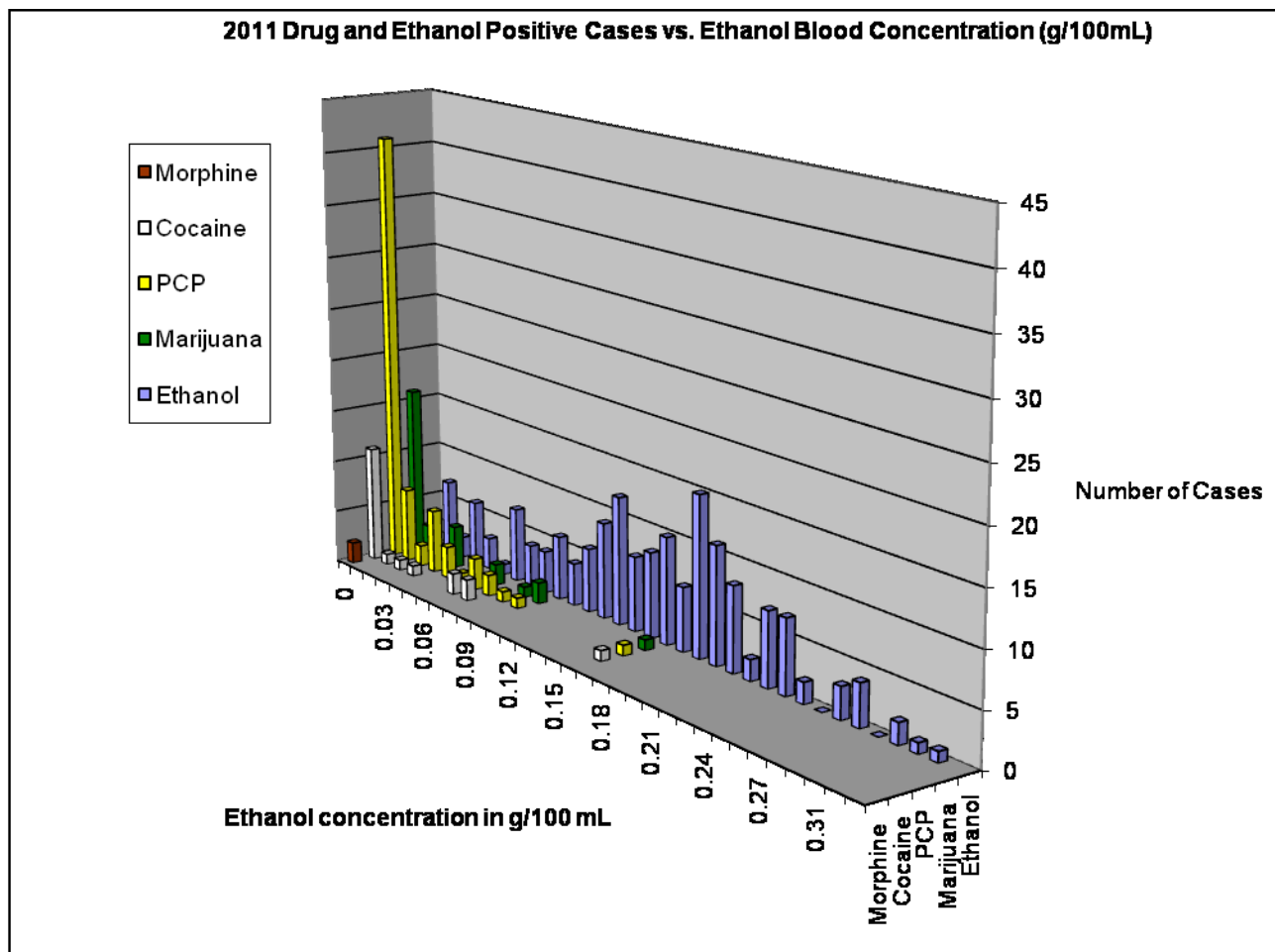
Chart 2. This chart represents the prevalence of drugs compared to ethanol concentrations from blood specimens collected from 2011 suspected DUI cases (n=236). **Please note:** In 2011, USPP requested that specimens with an ethanol concentration < 0.10 g/100mL were not screened for drugs of abuse. This has affected the distribution.

5.0 – BREAKDOWN OF MEDICAL EXAMINER INVESTIGATIONS

The US Census estimates that during 2011, the total population within the District of Columbia was 601,723[4] inhabitants, which comprised primarily of the following ethnic groups: White, Black, Hispanic, Asian and Other. In 2011, the OCME investigated 2,988 deaths that occurred in the District of Columbia or were wards of the District and died in another jurisdiction. 1,121 of these cases were accepted under the jurisdiction of the Medical Examiner for further investigation; of which 866 of them were known to be residents in the District of Columbia. The following table and charts summarize the manner of death by racial composition.

2011 Manner of Death* by Race with 2010 Census Data

Race	2010. Census	Natural	Suicide	Homicide	Accidents	Undetermined	Total Number of ME Cases
Black (non-Hispanic)[5]	301,053	417	15	109	191	35	**767***
White (non-Hispanic)	209,464	107	23	6	111	10	**257***
Hispanic (any single race)	50,083	12	4	9	16	3	**44**
Asian (non-Hispanic)	20,818	4	2	0	6	1	**13**
Two or more races	17,316	n/a	n/a	n/a	n/a	n/a	**n/a**
Other (non-Hispanic)	1,451	1	0	1	5	1	**8**
American Indian and Alaska Native (non-Hispanic)	1,322	1	0	0	0	0	**1**
Pacific Islander (non-Hispanic)	216	0	0	0	0	0	**0**
Unknown	n/a	1	0	0	4	0	**5**
Total Population	**601,723**						
Total # of ME Cases		**543**	**44**	**125**	**333**	**50**	**1095**

*The "Manner of Death" **Stillbirth** is not included in the above table, which represent the 4 missing cases from the total (1099); however the race and gender of these four cases are reported in the tables to follow.

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

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

5.1 - Total Population

2010 US Census Population Data by Race for the District of Columbia

Two or more races
3%

Asian (non-hispanic)
3%

Hispanic (any single race)
8%

White (non-hispanic)
35%

Black (non-hispanic)
51%
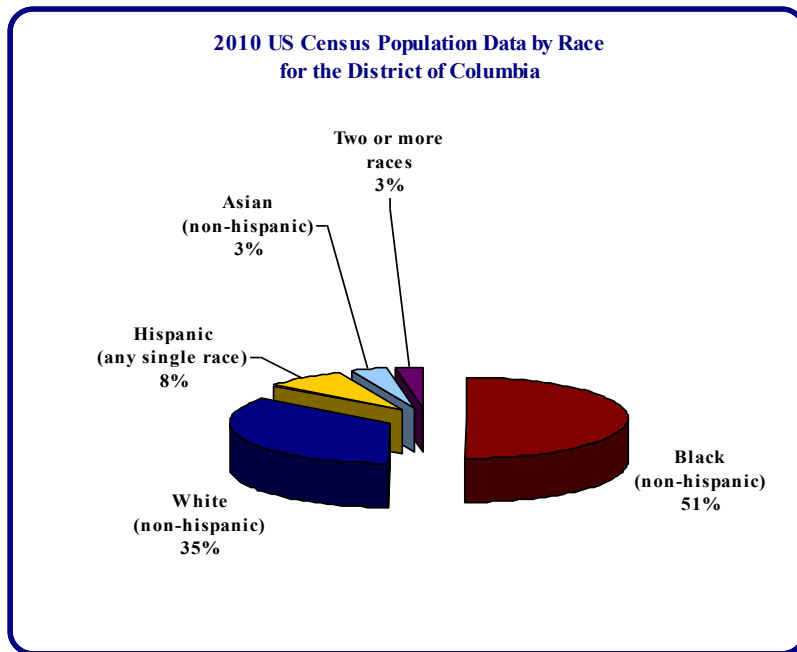
Note: The race categories American Indian/Alaska Native and Pacific Islander/Native Hawaiian are not represented in the above graph because they are both less than 1% of the total population in the District of Columbia. On the other hand, Hispanics are represented in this graph; although this classification is considered to be an ethnicity and NOT a race.

5.2 - Total ME Cases by Demographics and Manner of Death

2011 Totals by Age

Age Group	Total Deaths	Percent
Under 1	21	2%
1 to 5	10	1%
6 to 12	6	1%
13 to 15	4	0%
16 to 19	29	3%
20 to 29	100	9%
30 to 39	81	7%
40 to 49	164	15%
50 to 59	247	22%
60 to 69	205	19%
70 to 79	101	9%
80 to 89	97	9%
90 and Over	29	3%
Unknown	5	0%
TOTAL	**1099**	**100%**

2011 Gender by <u>Race</u>

Race	Males	Females	Total
Alaskan Native	0	1	1
Asian	11	2	13
Black	506	263	769
Hispanic	31	13	44
Other	3	5	8
Unknown	3	2	5
White	161	98	259
TOTAL	**715**	**384**	**1099**

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2011 <u>Manner of Death</u> by Gender

Gender	Naturals	Suicide	Homicides	Accident	Undetermined	Stillbirth	Totals	Percent
Female	206	18	11	131	17	1	**384**	**35%**
Male	337	26	114	202	33	3	**715**	**65%**
Totals	**543**	**44**	**125**	**333**	**50**	**4**	**1099**	**100%**

Note: The above total figures include the Stillbirth decedents (2 were black and 2 were white)

2011 Total Accepted Medical Examiner Cases by Race

- Unknown 0.5%
- Asian 1%
- Hispanic/Latino 4%
- Alaskan Native 0.1%
- White 24%
- Black 71%
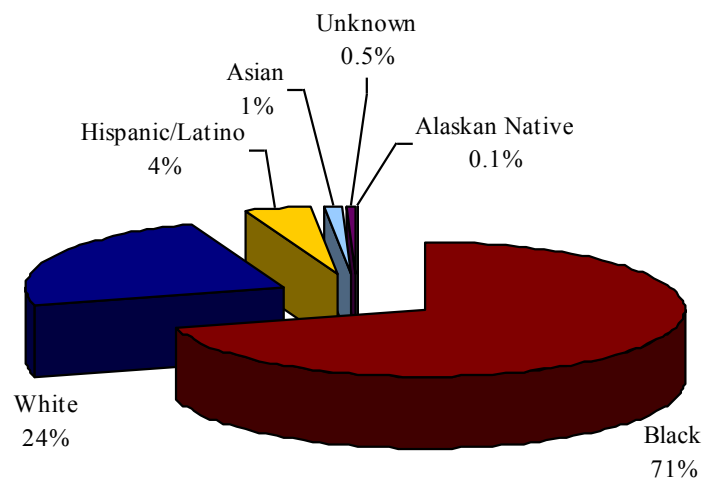
Hispanic/Latino Population (of any race)

- Natural 27%
- Suicide 9%
- Homicide 21%
- Accidents 36%
- Undetermined 7%

Asian Population

- Natural 31%
- Accidents 46%
- Undetermined 18%
- Suicide 15%
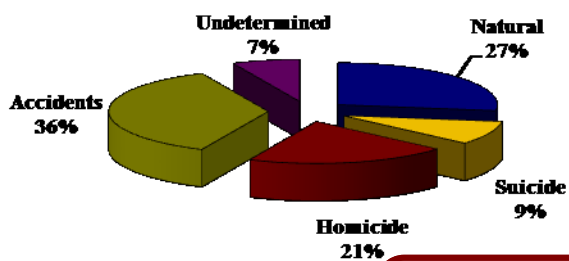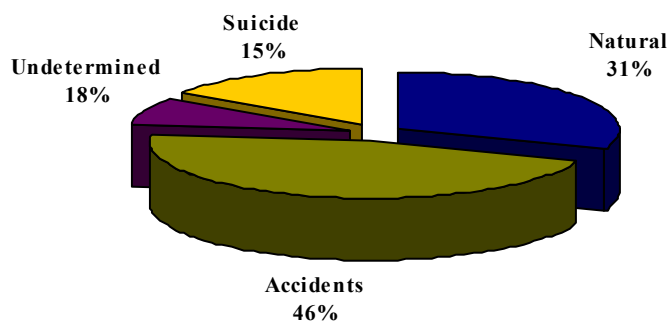
Black/African American Population

- Natural 55%
- Suicide 2%
- Homicide 14%
- Accidents 25%
- Undetermined 4%

White Population

- Natural 42%
- Suicide 9%
- Homicide 2%
- Accidents 43%
- Undetermined 4%
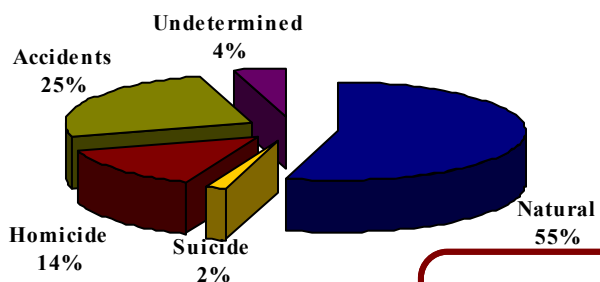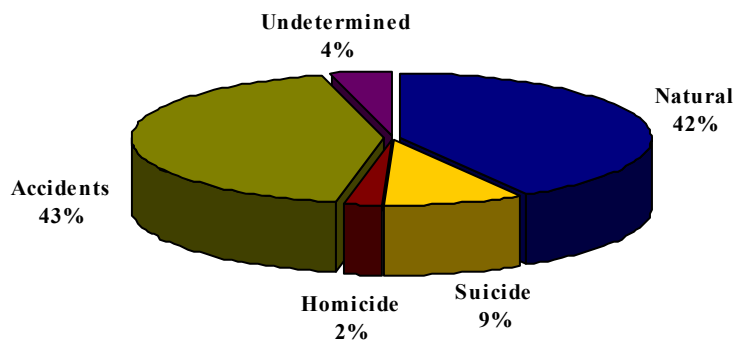
APPENDICES

OCME Organization Chart	**A**
Agency Management	**B**
Program Legislation	**C**
Internal Services	**D**

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APPENDIX A

OCME Organizational Chart

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OFFICE OF THE CHIEF MEDICAL EXAMINER
ORGANIZATIONAL CHART FY 2011

CHIEF MEDICAL EXAMINER (1)
Executive Assistant (1)
Agency Fiscal Officer (1)
(General Counsel)

FORENSIC TOXICOLOGY DIVISION

Chief Toxicologist (1)
Deputy Chief Tox (1)
Lab Quality Control Manager (1)
Forensic Toxicologist (6)
Program Analyst (2)

ADMINISTRATION DIVISION

Chief of Staff (1)
Staff Assistant (1)

IT Unit:
IT Specialist (Program Manager) (1)
IT Specialist (Policy Analyst) (1)
IT Specialist (Customer Support)(1)

Records Management Unit:
Supvr. Records Mgt Specialist (1)
Records Mgt. Specialist (3)

Administrative Unit:
Mgmt Services Officer (1)
Mgmt Liaison Specialist (1)
Program Analyst (2)
Support Services Specialist (2)
Maintenance Worker (1)

FATALITY REVIEW DIVISION

Program Specialist (1)
Nurse Consultant (1)
Staff Assistant (1)

DEATH INVESTIGATION & CERTIFICATION DIVISION

Investigations Unit:
Supvr. Medicolegal Investigator (1)
Lead Medicolegal Investigator (1)
Medicolegal Investigators (3)
Forensic Investigators (6)

Mortuary Unit:
Supvr. Pathologist Asst. (1)
Pathologist Asst. (4)
Forensic Photographers (2)
Autopsy Assistants (6)

Forensic Path Unit:
Medical Examiners (5)

Transcription Unit:
Transcriptionist (2)
Staff Assistant (1)

Case Processing Unit:
Intake Assistants (5)

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APPENDIX B

AGENCY MANAGEMENT
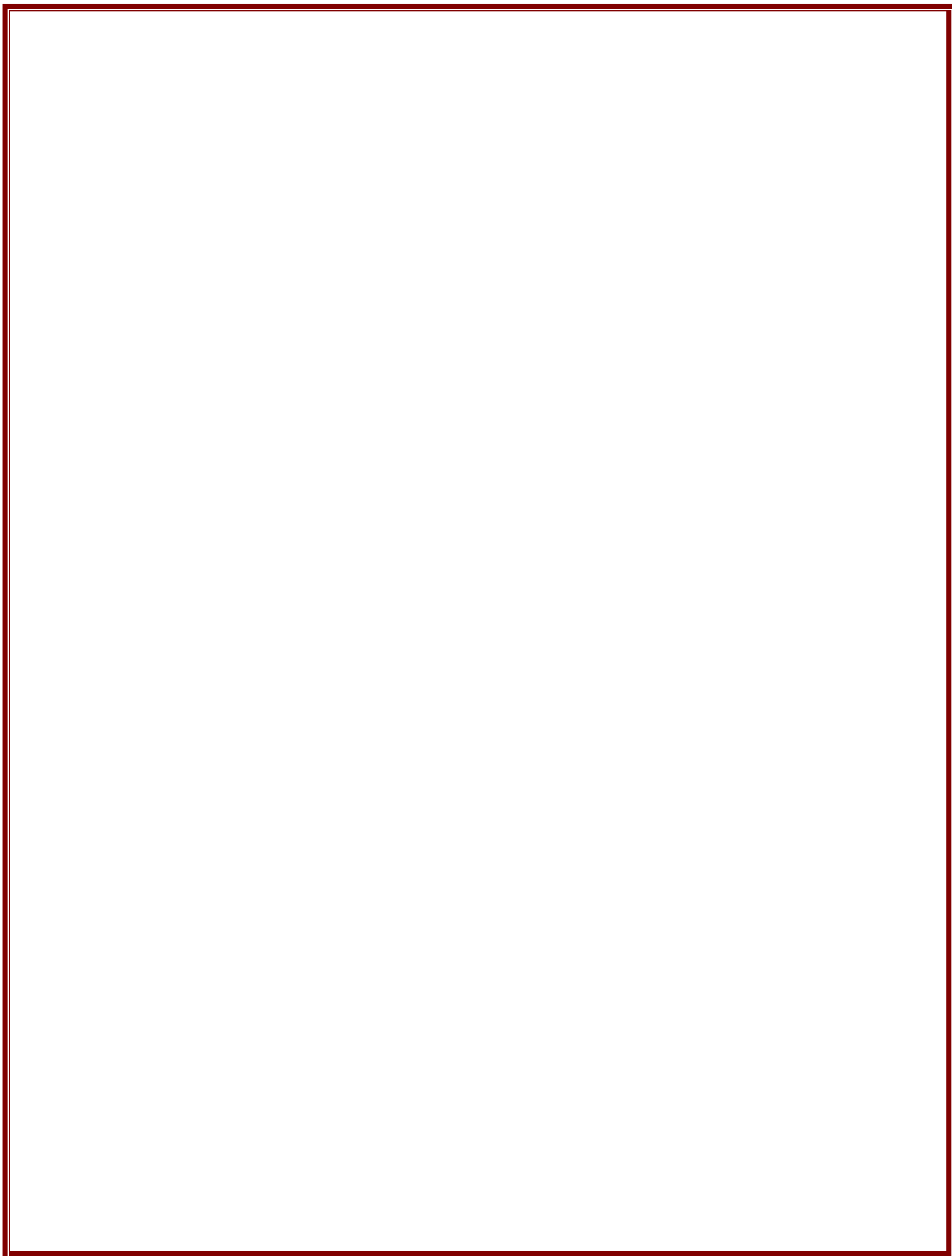
AGENCY MANAGEMENT

Administration Peformance Management
The agency's Administrative Division provides support to the work discussed within this annual report in the areas of: property/facilities management; finance and procurement; personnel; information technology; quality assurance and control; legal management; risk management; labor management; and incident management. The Administrative Division is also responsible for monitoring and ensuring efficient operations via establishment and compliance of a performance plan that includes key performance indicators – the performance component of agency management. Throughout 2011, the agency met performance deadlines and highlights of key initiatives are included herein, as well as results on key performance indicators for the various divisions.

Property Management:
During 2011, the OCME's death investigation and certification activities were conducted at its core facility at 1910 Massachusetts Ave, Bldg. 27, Washington, D.C. Throughout the year, agency staff dedicated numerous hours to the design, governance and transition process for a move to a Consolidated Forensic Laboratory (CFL). Specifically, the following activities were implemented in preparation for the move: 1) a transition plan was completed which included an inventory of 100% of all agency assets; 2) a list of new and enhanced scientific IT, Mortuary and Toxicology equipment was developed; 3) floor plans for the autopsy suite, toxicology laboratory and office space were reviewed and modified; 4) policies and procedures were reviewed for agency-specific and stakeholder shared activities; 5) security plans and procedures; and 6) designations of staff seating were made.

Incident Management Planning:
The OCME revised the following incident management plans: Emergency Response Plan (ERP); Continuity of Operations Plan (COOP); and its Mass Fatality Plan. The OCME participated in all city-wide incident management exercises and conferences (i.e., tabletop and full) which involved staff training of procedures, recently purchased equipment (such as a body storage unit that must be assembled and activated with gas and water); retraining of staff roles and responsibilities; and retraining on OCME staff interaction with the EOC and other agencies. The agency prepared an extensive after-action report that was provided to HSEMA and ORM and focused on exercises and real-life incidents (e.g., earthquake and hurricane). The agency also partnered with DCHA and the Joint Logistics and Engineering Board regarding Mass Fatality Planning Efforts. The agency was also able to test and practice wireless systems and tough books in the field through the exercises and was able to assess capabilities and challenges for case management during an incident. The appropriate adjustments and additional equipment/resource needs were noted.

Grant Activity:
In 2011, the D.C. Justice Grants Administration awarded OCME its third National Institutes of Justice Coverdell Forensic Science Improvement subgrant. The focus of the grant is to improve the quality and timeliness of forensic science and medical examiner services, including services provided by the forensic toxicology laboratory and records managements units of the agency. Forensic toxicology staff was enrolled in a driving under the influence ("DUI") and driving under the influence of drugs ("DUID") testimony course to improve the quality and availability of DUI and DUID toxicological testimony. The grant was also used to continue implementation of a project to digitize over 30,000 agency medical examiner case records from 1972-2002.

The purpose of the project is to ensure that data for these cases is readily accessible and to provide security and integrity to files that are comprised of paper documents that are fragile and have some degree of degradation or damage due to the archiving process and storage environment. Further, digitization will protect the records from loss due to natural disasters or human error.

Employee Summit:
The OCME conducted its First Annual Employee Death Investigation and Certification Summit on June 22, 2011. The OCME employees perform independent functions that are intermingled toward accomplishing the agency's mission in providing timely and accurate death investigation. The purpose of the Summit was to ensure that all employees understand: 1) their role in the full scheme of the mission; 2) the work of other employees and services provided by other divisions within the agency; and 3) the interaction between divisions.

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

Customer Service:
In order to improve services to agency "clients" and provide a mechanism for external evaluation of office and system operations, the agency developed a customer service satisfaction program. The program involved development of a survey that was provided to "clients" – funeral homes - for evaluation of office and system operations. The surveys overwhelmingly indicated that OCME operations were efficient and staff customer service was excellent. The surveys also expressed the significant improvement noted within the past few years and rendered an overall good evaluation. It is also of significance that the office continues to rank in the highest of agencies regarding customer service within the Mayoral program.

Death Investigation and Certification Management
OMCE's Death Investigation and Certification Program is based on the mission of the agency to prepare reports of findings and conclusions (i.e., cause and manner of death) on any autopsy or examination performed. The death investigation and certification program thrived in 2011 with: a) autopsy reporting resulting in no or minimal backlog throughout the year; b) quick decedent identification and release to next of kin or public dispositions such that the agency continued to maintain a 35% morgue emergency surge capacity; c) maintenance of an emergency body transport service; and d) implementation of advanced technology.

Key Performance Indicators[1]

Measure One:
This measure requires that the agency complete 90% of reports of all postmortem examinations within 60 calendar days from the time of autopsy, based on National Association of Medical Examiner (NAME) standards. For FY2011, the agency completed 88.74% of its reports within 60 calendar days, slightly below the 90% goal.

Measure Two:
The second measure requires that 95% of positively identified bodies be ready for release within forty-eight hours. For FY2011, the agency reached an actual percentage of 93.04%, slightly below the target. Those bodies that are not ready for release within 48 hours represent a variety of situations ranging from cases requiring further investigation or examination; cases being reported on holidays or weekends when it is difficult to reach attending physicians for information; and the need to hold cases over for examination due to a large workload or other workflow issues.

Measure Three:
The third measure assesses the percent of primary contacts made within eight hours of case assignment to an investigator, of which the agency scored 92.29%, below the 95% target.

Measure Four:
In FY2010, OCME's mortuary staff arrived on scene within one hour of notification of case acceptance 91.50% of the time, below the 95% target.

Forensic Toxicology Laboratory Management
The forensic toxicology laboratory, which is currently fully staffed, has made key strides in support of its efficient operations and provision of service. In December 2011, the agency was informed that the Forensic Toxicology Laboratory was awarded accreditation status by the American Board of Forensic Toxicology. This achievement was the result of hard work by the toxicology staff, with the support of management, to complete a self-inspection and application and facilitation of an inspection performed by ABFT. This is the first time in the history of the agency that the laboratory has received such accreditation status.

Additional members of the toxicology laboratory staff were also been trained to provide interpretive services and expert testimony on a variety of drug and alcohol related matters and can provide such service to the Office of the Attorney General (OAG), the Public Defenders Service, and the United States Attorney's Office (USA). Also, during FY2011[2], the laboratory processed 915 Driving Under the Influence (DUI) cases for outside agencies (about twice that of the previous year), including: 221 for the United States Park Police, 665 for Metropolitan Police Department (MPD); 28 for the U.S. Capital Police; and 1 for the United States Secret Service. The laboratory managed a 26% increase in the caseload from MPD during FY2011.

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[1] The District's Agency Key Performance Indicators (KPIs) are compiled on a fiscal year basis. Thus, all KPI data included in this report reflects FY2011 -- the time period between October 1, 2010 through September 30, 2011.

[2] The workload measures included herein, including the number of DUI cases processed by the toxicology laboratory, are based on FY2011 -- the time period between October 1, 2010 through September 30, 2011.

The laboratory contributed to the scientific community through academic presentations and publication of toxicological findings to the National Youth Leadership Forum; DC Office of the Attorney General; and the Alcohol Pharmacology, Alcohol Beverage Regulation Administration; George Washington University and the Alcohol, Drugs and Traffic Safety Annual meeting.

<div align="center">Key Performance Indicators</div>

Measure Five:
Measure five provides results of toxicology laboratory performance. The agency overwhelmingly surpassed the FY2011 KPI which required that 90% of toxicology examinations be completed within 90 calendar days of case submission (a new NAME standard adopted in September 2009). The actual percentage was 99.62%, exceeding the target.

Fatality Review Management
During FY2010, the Fatality Review unit staffing was significantly reduced from eight to three due to a Reduction-in-Force, retirement and attrition. This reduction included loss of the Program Manager and of a Program Coordinator. There has been an overall reduction of 10 staff over the past two years. While staffing has presented challenges, the agency was able to conduct reviews for the two committees and one board: Child Fatality Review Committee; Developmental Disabilities Fatality Review Committee; and the Domestic Violence Review Board. Recommendations to prevent deaths were also developed for other agencies and entities with respect to policies and procedures and operations.

<div align="center">Key Performance Indicators</div>

Measure Six:
This measure required the CFRC to hold 90% of child fatality reviews within six months of notification of the death. In FY2011, the CFRC completed 88% of multi-agency and statistical reviews of child fatalities within six months of notification of death, slightly below the target

Measure Seven:
This measure required the MRDD FRC to review 90% of fatalities within three months of receipt of the investigative report from DDS (formerly MRDDA). Only 78.38% of the cases were reviewed in this timeframe.

APPENDIX C

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

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

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

1) Click the "+" sign next to: **TITLE 5. POLICE, FIREFIGHTERS, AND CHIEF MEDICAL EXAMINER**
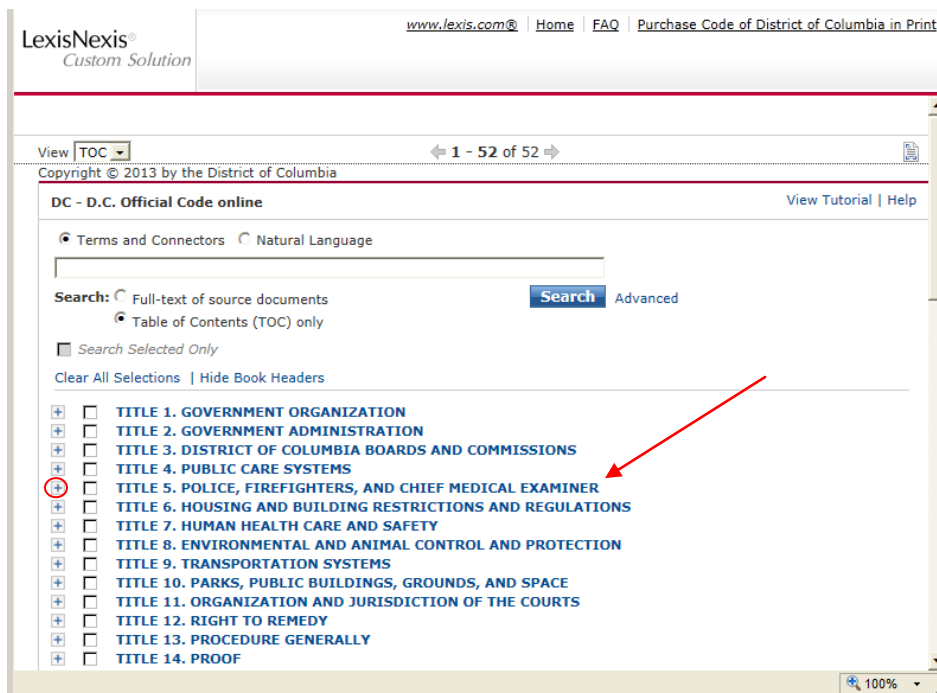
2) Then select: **Chapter 14. Chief Medical Examiner**

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

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

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APPENDIX D

INTERNAL SERVICES

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GRIEF COUNSELING SERVICES

Introduction

November, 2011 marked the 12th year of the collaborative relationship between the Wendt Center for Loss and Healing and the Office of the Chief Medical Examiner. The Wendt Center's RECOVER program housed within the OCME provides support to individuals and families and helps guide them through the process of decedent identification during hours of identification. All RECOVER staff are licensed mental health professionals and mental health graduate clinicians whom have a specialty in trauma, bereavement, crisis and loss.

Support during the Identification Process

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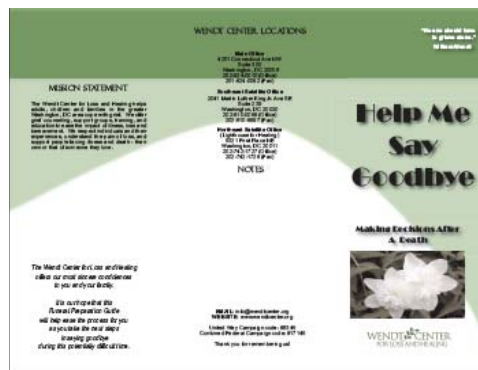
Summary of Statistics

In the time period of January through December 2011 RECOVER counselors completed 750 decedent identifications with 1,860 families, friends and other community connections.

Customer Service

Beginning in April 2011, all individuals who completed decedent identifications had the opportunity to provide RECOVER programmatic feedback via a self -addressed feedback card. By December 2011, 50 responses had been received. Ninety-four percent of the recipients responded that the RECOVER counselor was "*Sensitive*" to "*Very Sensitive*" to their needs during the ID process, and 88% of recipients found the grief and trauma information to be "*Helpfu*l" to "*Very Helpful*".

Anecdotal responses included:

"*the attention received was unexpectedly wonderful, very professional and caring*,"
"*the take care of yourself resource information is very beneficial- I continue to use it*,"
"*your kindness was greatly appreciated at a most difficult time*,"
"*extremely helpful. This was my first time having to complete and identification and you were sensitive to that*."

OCME Staff Support

RECOVER continued to provide a monthly staff support session for OCME staff to address stress related issues, as well as learn new effective coping strategies. Printed educational material is available for staff to access on specially chosen topics of interest and need. Using music, art, games, and laugh OCME technicians, transcribers, doctors, investigators, intake specialists and medical records staff had the opportunity to decompress and take care of themselves while at work. Over the year, nearly 120 people have taken advantage of this opportunity for self -care. Throughout the building work created in these Chief OME sanctioned sessions adorns staff cubicles.

Other Support
RECOVER staff is present at all Child Fatality Review Committee Members, providing pertinent information to the committee to best understand how families of child decedents have received immediate support after a death at the OCME, as well as families who have engaged in therapeutic services through the Wendt Center to cope with the ongoing effects of traumatic death. The RECOVER program works to provide comprehensive therapeutic care throughout the trajectory of a grief cycle- always reassuring the community that "no one should have to grieve alone."

HOURS AND LOCATION

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

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

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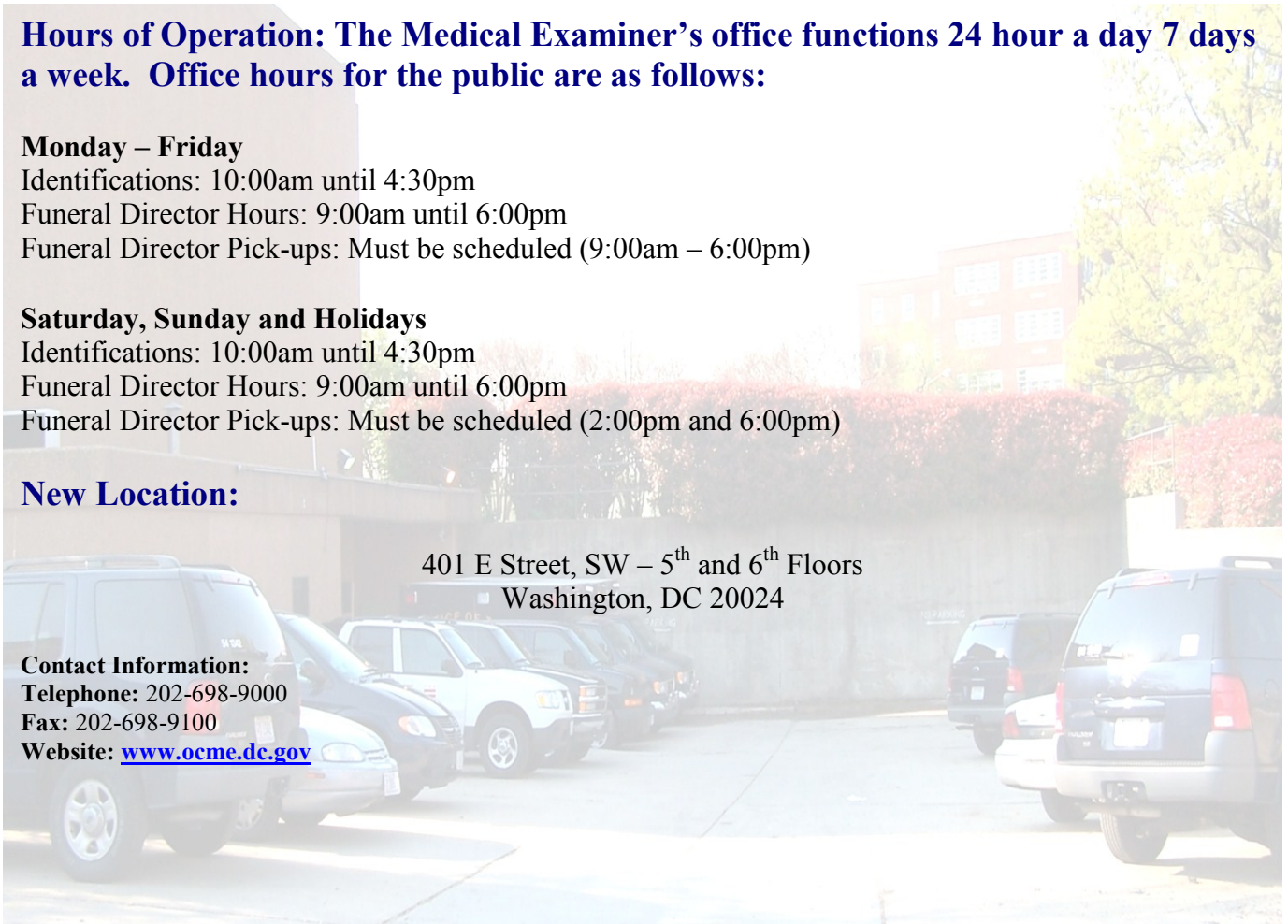Funeral Director Pick-ups: Must be scheduled (2:00pm and 6:00pm)

New Location:

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

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

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

William Gladstone, Prime Minister of England

Office of the Chief Medical Examiner
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