<table>
<thead>
<tr>
<th>#</th>
<th>Section</th>
<th>Type of Comment (E-Editorial, T-Technical)</th>
<th>Comments</th>
<th>Proposed Resolution</th>
<th>Final Resolution</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>5.1.2</td>
<td>T</td>
<td>The first dot point: &quot;that confirmation testing is necessary for all potentially relevant findings&quot; should really just refer to the other ASB standard that is appropriate which is &quot;ASB 113, Standard for Identification Criteria in Forensic Toxicology&quot;</td>
<td>Change first dot point to &quot;Reporting all potentially relevant findings adheres to ASB 113, Standard for Identification Criteria in Forensic Toxicology&quot;</td>
<td>Reject: This section was removed from the document.</td>
</tr>
<tr>
<td>9</td>
<td>5.1.2</td>
<td>T</td>
<td>This states that laboratory procedures shall specify:</td>
<td>The language should be adjusted to allow a single procedure to direct these instructions. I strongly recommend avoiding standards for things that DO NOT affect quality. The standards will be long enough without adding purposeless items.</td>
<td>Accept with modification: This section was removed from the document.</td>
</tr>
<tr>
<td>49</td>
<td>5.1.2</td>
<td>T</td>
<td>This first dot point: &quot;that confirmation testing is necessary for all potentially relevant findings&quot; should really just refer to the other ASB standard that is appropriate which is &quot;ASB 113, Standard for Identification Criteria in Forensic Toxicology&quot;</td>
<td>Change first dot point to &quot;Reporting all potentially relevant findings adheres to ASB 113, Standard for Identification Criteria in Forensic Toxicology&quot;</td>
<td>Reject: This section was removed from the document.</td>
</tr>
<tr>
<td>53</td>
<td>5.1.2</td>
<td>T</td>
<td>There are often appropriate but not required modifications to scopes.</td>
<td>Change &quot;required&quot; to &quot;appropriate&quot; at the end of the sentence.</td>
<td>Reject: The sentence containing the word &quot;required&quot; was removed from the document.</td>
</tr>
<tr>
<td>10</td>
<td>5.1.3</td>
<td>E</td>
<td>This is a bit silly and a given for any competent lab, that your scope needs to adapt to changes appropriate for your region. Unnecessary but I suppose it is harmless. Defining the sky is blue seem a waste of time.</td>
<td></td>
<td>Reject: No proposed resolution was submitted.</td>
</tr>
</tbody>
</table>
Section should be "homicide, suspicious, accidental and suicides that have a suspected toxicological cause of death." The proposed wording is appropriate for the intent of the document. Additional testing may be performed to exceed the minimum standard.

Testing all toxicology-related cases for all B3 of the drugs listed poses an undue burden on laboratories without high resolution screening capability (i.e., TOF or Q-TOF technologies). This is particularly true if the COD is readily apparent (i.e., 6-AM) present in blood with corresponding presence of sympathomimetics (containing fenitroline) and benzodiazepines. Alter 5.2 to define the full B3 analyte panel as the scope of analyses for truly unknown cases where comprehensive testing is required; allow laboratories to manage their workflows based on laboratory resources, case circumstances and their personnel.

It is recognized that the committee had a formidable challenge in defining testing scope and sensitivity for postmortem testing. However, several selections require comment:

The language is appropriate for the intent of the document. Testing all toxicology-related cases for all B3 of the drugs listed poses an undue burden on laboratories without high resolution screening capability (i.e., TOF or Q-TOF technologies). This is particularly true if the COD is readily apparent (i.e., 6-AM) present in blood with corresponding presence of sympathomimetics (containing fenitroline) and benzodiazepines. Alter 5.2 to define the full B3 analyte panel as the scope of analyses for truly unknown cases where comprehensive testing is required; allow laboratories to manage their workflows based on laboratory resources, case circumstances and their personnel.

It is recognized that the committee had a formidable challenge in defining testing scope and sensitivity for postmortem testing. However, several selections require comment:

The language is appropriate for the intent of the document. Testing all toxicology-related cases for all B3 of the drugs listed poses an undue burden on laboratories without high resolution screening capability (i.e., TOF or Q-TOF technologies). This is particularly true if the COD is readily apparent (i.e., 6-AM) present in blood with corresponding presence of sympathomimetics (containing fenitroline) and benzodiazepines. Alter 5.2 to define the full B3 analyte panel as the scope of analyses for truly unknown cases where comprehensive testing is required; allow laboratories to manage their workflows based on laboratory resources, case circumstances and their personnel.

It is recognized that the committee had a formidable challenge in defining testing scope and sensitivity for postmortem testing. However, several selections require comment:

The language is appropriate for the intent of the document. Testing all toxicology-related cases for all B3 of the drugs listed poses an undue burden on laboratories without high resolution screening capability (i.e., TOF or Q-TOF technologies). This is particularly true if the COD is readily apparent (i.e., 6-AM) present in blood with corresponding presence of sympathomimetics (containing fenitroline) and benzodiazepines. Alter 5.2 to define the full B3 analyte panel as the scope of analyses for truly unknown cases where comprehensive testing is required; allow laboratories to manage their workflows based on laboratory resources, case circumstances and their personnel.
Table 1 T MDA and MEMA should be lowered to 25 ng/mL as they are typically seen and relevant in casework at these concentrations. Change MDA and MEMA to 25 ng/mL. accept:

27 Table 1 T Several drugs in the table are odd inclusions, given how infrequently they are prescribed and more over responsible for death. These drugs include: primidone, desipramine, imipramine, hydroxyzine, and cannabidiol. Remove primidone, desipramine, imipramine and cannabidiol.

28 Table 1 T The inclusion of cannabinoids seems to be an epidemiological choice, not a toxicological choice. Remove cannabinoids. reject: with modification: THC-COOH was removed from Table 2, and the concentration of THC was changed from 1 mg/mL to 2 ng/mL. The cannabinoid concentrations listed in Table 1 are analytically achievable and the presence of cannabinoids could be relevant as contributing circumstances to the cause and manner of death.

7 Table 1.0 T Acetone and lopropand concentrations below 20 mg/L are not relevant to death investigation. Cause of death, cause of death, a little AKA or fasting KA is not relevant in the vast majority of cases. All death investigation is case by case. The rare case were this actually sheds light on COD or a relevant factor DOES NOT justify requiring these limits. The same goes for these absolute limits in the benzodiazepine section, letamem, antihistamines, codeine, transal. It is important to remember that not all MDLs have a role in DUI/DUID investigation. Recognize in the language that while these limits may be relevant for these drugs in combination, we are not testing for present. But for relevance to cause of death. And without the presence of other cross reacting drugs these limits are RIVT too low. reject: with modification: 15-THC was removed from Table 3, and the concentration of THC was changed from 1 mg/mL to 2 ng/mL. The THC-COOH concentration listed in Table 2 is analytically achievable and the presence of cannabinoids could be relevant as contributing circumstances to the cause and manner of death.

21 Table 2 E Even with a known anatomic cause of death, such as coronary artery thrombus, the presence of cocaine can change the manner of death. Under “Cocaine” in the table, add cocaine (not just benzoylecgonine). reject: This is a minimum standard. Laboratories can always exceed the requirements by testing for additional analytes.

22 Table 2 E Even with a known anatomic cause of death, If testing reveals morphine, the presence of 6-monooctetyl morphine changes the significance of this finding and may underaid additional medicolegal action, as seen in the Bas Bas prosecution. Under “Opium” in the table, add 6-monooctetyl morphine (6-aceetyl morphine). reject: With a few analytes were removed or the concentrations adjusted, the revised concentrations listed in Table 1 are analytically achievable and could be relevant as contributing circumstances to the cause and manner of death, including infant fatalities and polydrug intoxications. The concentrations listed in Table 2 are also analytically achievable and could be relevant as contributing circumstances to the cause and manner of death in cases with known anatomical cause of death (e.g., a passenger in an automobile fatality; a gunshot fatality).

36 Table 2 T Why would THC-COOH be necessary in these types of cases? What is the significance of 10 ng/mL of THC-COOH? Remove Cannabinoids from Table 2. accept: If yes, add fentanyl to "opiods" section at 1 ng/mL.

37 Table 1 and 2 T Review MDL concentrations to reflect what might be relevant. These concentrations should not be what you expect most labs might be able to achieve, but what would be relevant for these cases. Many concentration levels seem too low to be relevant [see other comments above]. Review MDL concentrations to be more relevant for PM cases and more appropriate for an achievable minimum standard.

58 Table 2 T I would prefer that this table be removed. There should be no need to differentiate analytical regimes between “Cause of Death Determination” and “Cases with a Known Anatomical Cause of Death” cases. The sensitivities should certainly be the same, but also the scope. Add fentanyl to “opiods” section at 1 ng/mL. accept: If yes, add fentanyl to “opiods” section at 1 ng/mL.

59 Table 2 T Add fentanyl to “opiods” section at 1 ng/mL. accept: If yes, add fentanyl to “opiods” section at 1 ng/mL.

52 Table 2 T For postmortem cases with a known anatomical cause of death, I don’t see the use in testing for the inactive metabolite THC-COOH. The THC-COOH concentration listed in Table 2 is analytically achievable and the presence of cannabinoids could be relevant as contributing circumstances to the cause and manner of death.

8 Table 2 T No just no. If you have a case where a piano falls on a passerby (not workers comp) you do not need any toe As above not all MDLs are mandated or even allowed a role in DUI/DUID investigation, and the decedent is in fact dead and will not be prosecuted. These limits are really, really irrelevant for CAUSE OF DEATH. The language should explicitly recognize every case is different and some cases simply are not toe case.While other do not require pursuit of many of these drugs especially at these ridiculous low limits. The language should also recognize different jurisdictions have different responsibilities, some of which are covered by a variety of Agencies in different spreads of responsiblity. Also note that for the mentioned drugs I don’t list in column O, the limits do seem reasonable. Remove the anticonvulsants. Raise limits to appropriate concentrations. Remove ripentidine. Remove buprenorphine. This is very rare to not seen COD in many jurisdictions. Remove acetaminophen and salicylates. I have NEVER seen a salicylate death where it was not diagnosed antemortem so testing to confirm a diagnosis, yes, random screening for every case, NO. A silly waste of Taxpayers funded time and money. reject: in a case with a known anatomical cause of death, Table 2 is followed. Table 2 does not include many of the drugs listed in the comment. The compounds and concentration listed in Table 1 and Table 2 are analytically achievable and could be relevant contributing circumstances to the cause and manner of death.

15 Anticonvulsants T Pregabalin has a low risk of toxicity and is not included in other established scopes (e.g., CAP forensic toxicology) Remove pregabalin from anticonvulsants

16 Opioids E Fentanyl is to the right of Buprenorphine in the Opioids table while all other analytes are listed in column format Move fentanyl below buprenorphine

17 Muscle Relaxants T Meprobamate blood concentrations tend to be greater than 1000 ng/mL, even following therapeutic use Increase cut-off for meprobamate from 500 to 1000 ng/mL

18 Over the Counter T Salicylates are commonly used which may lead to unnecessary confirmation in cases of incidental use. Increase cut-off for salicylates from 50 to 150 mg/mL

19 Cannabinoids T Prenanalytical variability of this analysis makes it misleading to report concentrations in postmortem blood. Remove THC from the table

59 Comment submitted with the CB ballot I am writing you; however, I stand by my comments in earlier discussions (in OSAC) that I don’t believe testing for THC-COOH in a known anatomical cause of death case is necessary nor would our ME/coroners find this information useful. I also question its worth in ALL unknown causes of death circumstances would guide this. We’ve moved away from an immunoassay screen and our TOF doesn’t pick up THC/cannabinoids, so this means an extra screen on a whole list of death cases where the MT/coroners (in our state at all) do not care for this info. If they need to know if marijuana was ingested at all, they know to request it. reject: No comment resolution submitted. Note that the THC-COOH concentration listed in Table 2 is analytically achievable and the presence of cannabinoids could be relevant as contributing circumstances to the cause and manner of death. 5.4 addresses directed analysis for unique circumstances.