MEDICAL EXAMINERS COMMISSION MEETING
Epicurean Hotel
1207 South Howard Avenue
Tampa, Florida
August 14, 2015
10:00 AM

Chairman Stephen J. Nelson, M.A., M.D., F.C.A.P., called the meeting of the Medical Examiners Commission to order at **10:00 AM** at Epicurean Hotel, in Tampa, Florida. He welcomed everyone to the meeting and asked Commission members, staff, and audience members to introduce themselves.

Commission members present:

Stephen J. Nelson, M.A., M.D., F.C.A.P., District 10 Medical Examiner
Barbara C. Wolf, M.D., District 5 Medical Examiner
Wesley Heidt, J.D., Office of the Attorney General
Hon. James S. Purdy, J.D., Public Defender, 7th Judicial Circuit
Hon. Carol Whitmore, Commissioner, Manatee County
Robin Giddens Sheppard, L.F.D., Vice President/Funeral Director
Ken Jones, State Registrar, Department of Health
Hon. Angela B. Corey, J.D., State Attorney, 4th Judicial Circuit

Commission members absent:

Hon. Rick Beseler, Sheriff, Clay County

Commission staff present:

Vickie Koenig
Kipp Heisterman
Doug Culbertson
Jim Martin

District Medical Examiners present:

Sajid S. Qaiser, M.D. – District 18
Jon R. Thogmartin, M.D. – District 6
Russell S. Vega, M.D. – District 12
Joshua D. Stephany, M.D. – District 9
Bruce A. Hyma, M.D. – District 11
Craig T. Mallak, M.D. – District 17

Other District personnel present:

Jeff Martin (District 1)
Richard Bailey (District 13)
Craig Engleson – District 18
Cathy Weldon – District 8
Lindsey Crim – District 7&24
Lindsey Bayer – District 5
Sheri Blanton (District 9)
Peter Gillespie, M.D. – District 4
Robert Pfalzgraf, M.D. – District 21
Bill Pellan – District 6
Joe Mullin – District 7&24

Guests present:

Rebecca Sayer – LifeLink
Nancy Williams – Wuesthoff
Nick Waite – RTI Donor Services
Jon Crisler – Lions Eye Institute
James Rosa – LEITR
Bob Krauss, J.D.
Chandler Brownlee – LifeNet
Lynetta Oxendine – TransLife
Branch Ocampo
Linda Sullivan – Wuesthoff
Ricardo Camacho – UF
Laurie Ripp – RTI Donor Services
Christopher L. Hunter, Ph.D., M.D. – Orange County
Alphonso Everett – LEITR
Andrew Mullins – LEITR
Kimberly Owens – MEBPL
David DeStefano – TransLife

A MOTION WAS MADE, SECONDED, AND PASSED UNANIMOUSLY FOR THE COMMISSION TO APPROVE THE AGENDA.

A MOTION WAS MADE, SECONDED, AND PASSED UNANIMOUSLY FOR THE COMMISSION TO APPROVE THE MINUTES OF THE MAY 19, 2015, MEDICAL EXAMINERS COMMISSION MEETING.

ISSUE NUMBER 1: INFORMATIONAL ITEMS

- Status Update: District 14 Vacancy – Dr. Nelson reported that the State Attorney in District 14 (Bay, Calhoun, Gulf, Holmes, Jackson, and Washington counties) has appointed Jay M. Radtke, M.D., as interim District Medical Examiner pending the results of a local search committee.

- Status Update: District 9 – Dr. Nelson advised that District 9 (Orange and Osceola counties) was exploring the possibility of exercising Home Rule authority in appointing their medical examiner, and that Dr. Christopher L. Hunter from Orange County government was present to consult with the Commission. State Attorney Jeffrey L. Ashton has appointed Joshua D. Stephany, M.D., as interim District Medical Examiner.

- Status Update: MEC Appointments – Ms. Koenig announced that on August 7, 2015, Governor Scott reappointed 4th Judicial Circuit (Clay, Duval, and Nassau counties) State Attorney Angela B. Corey to an additional 4-year term on the Medical Examiners Commission. Ms. Corey's second term will expire on June 30, 2019. The Governor also appointed District 5 Medical Examiner Barbara C. Wolf, M.D., to the Commission for a four-year term. Dr. Wolf's term will end on June 30, 2019.

- Status Update: Districts 1, 2, 4, 5, and 6 – Ms. Koenig reported that the reappointments of District Medical Examiners (DMEs) for districts 1, 2, 5 and 6 were made by Governor Scott on August 7, 2015. All reappointments will expire June 30, 2018. The Governor has not yet reappointed District 4 Medical Examiner Valerie J. Rao, M.D., nor has the Governor's Appointments Office requested additional names.

- 2014 Annual Drugs Identified in Deceased Persons Report – Mr. Heisterman reported that the 2014 annual drug report was nearing completion. He reminded the district to report Flakka deaths in the *Cathinones* section of the report and to name the drug in the *Cause of Death* field. Additionally, any deaths involving Kratom are to be reported separately to MEC staff through the remainder of the year.

- 2014 Annual Workload Report – Mr. Heisterman reported that the 2014 Annual Workload Report was under final review by Dr. Nelson and Dr. Hyma.

- 2014 Coverdell Grant – Mr. Heisterman announced that there was approximately $1200 in residual money available. Two districts were solicited to spend the residual money. No federal funding has been designated in proposed budget for 2016.

- Retention of Medical Records – Dr. Nelson advised that the Commission's recent Letter of Guidance regarding retention of medical records had apparently caused some confusion among some of the districts. Dr. Nelson repeated that this was merely a suggestion that was made by the Commission and that Schedule GS2 already stated how long records were to be retained. Dr. Nelson further advised that it is in everyone's best interest to keep medical records for longer than the time limit in Schedule GS2 due to the number of complaints that may be filed several years after the completion of an autopsy. A brief discussion followed in which the Commission was advised that FAME was forming a committee to discuss and address the definition of "administrative value". The outcome of this discussion would be presented to the Commission at a future meeting.

ISSUE NUMBER 2: District 9 Home Rule

Dr. Christopher L. Hunter, a representative from Orange County government, spoke to the Commission seeking guidance on Orange County's goal of exercising Home Rule authority to appoint a medical examiner, pursuant to s. 406.17, Florida Statutes. The issue in question was how to include Osceola County. Osceola County would prefer to continue contracting with Orange County for medical examiner services, but Orange County was unsure as to whether Osceola County could still be included in District 9.

Dr. Nelson informed them that Home Rule authority may only include one county. If Orange County were to proceed with Home Rule authority to appoint their medical examiner, Osceola County would become District 25 and then Osceola County could contract with District 9 (then Orange County alone) for services once Osceola County has enacted an Ordinance to exercise their own Home Rule authority for the appointment of their (Osceola County) medical examiner.

ISSUE NUMBER 3: DISTRICT 18 PROBABLE CAUSE PANEL REPORT

At Dr. Nelson's request, Dr. Bruce Hyma read the findings of the District 18 Probable Cause Panel into the record:

> In December 2014 the family of Mr. John McDonough filed a formal complaint against District 18 Medical Examiner Sajid S. Qaiser, M.D. The complaint alleged that Dr. Qaiser failed to perform an appropriate review of the medical information presented at the time of their father's death, and that he conducted an incomplete investigation into the cause and manner of death. Dr. Qaiser determined that Mr. John McDonough died due to chronic myelogenous leukemia and contributed a left humeral fracture, coronary artery disease and atrial fibrillation, and ruled the manner of death an accident.
>
> The complaint further alleged that a potential overdose of morphine by Mr. McDonough's current wife and her children were responsible for Mr. McDonough's death while he was in hospice care.

The Brevard County Sheriff's Office investigated the circumstances and found no criminal intent regarding Mr. McDonough's death.

Staff thoroughly reviewed the information in the complaint, as well as all case documents provided by the District 18 Medical Examiner's Office. It should be noted that the District 18 office had disposed of the medical records; however, they obtained copies at staff's request. Lacking in depth medical knowledge regarding the levels of morphine presented in the toxicology findings, staff requested that a probable cause panel be convened to determine if Dr. Qaiser's decisions in the case were sound and well-founded.

Probable Cause Findings

In response to your memorandum of April 14, 2015, the Probable Cause Panel convened on May 4, 2015 at the Plaza Hotel in Daytona Beach. All assigned panel members were present: Dr. Bruce Hyma, Mr. Ken Jones and Ms. Robin Giddens Sheppard. Also in attendance was Bruce A. Goldberger, Ph.D., as an ex-officio member of the panel, as well as Commission staff members Vickie Koenig, Doug Culbertson, Kipp Heisterman, Jim Martin, and Director Dean Register. Staff had already emailed the panel members the files containing their findings and the reference materials upon which they based their conclusions.

The first order of business was the election of a chairman, which Dr. Hyma accepted. Next the panel reviewed the statutory reference which established the panel as well as the procedures the panel and Medical Examiners Commission will follow in these proceedings. Staff then reviewed the reference material previously forwarded to the panel members.

The panel discussed the complaint in detail. During the course of the discussion, the panel determined that Dr. Qaiser accepted jurisdiction of a hospice case due to the allegations made by the decedent's children regarding the circumstances surrounding his death; however, he did not perform an autopsy, he was careless in his review of medical records, and he was not willing to quantify the toxicology results unless the family paid for the quantification.

With Dr. Goldberger's assistance the panel determined that the morphine concentration levels were typical for a hospice patient receiving 20mg every hour, and that opiate naivety was irrelevant. These morphine levels are necessary as part of hospice's comfort care during the decedent's end-of-life care for renal failure.

The panel felt that since the jurisdiction of a hospice case was accepted, and allegations of potential foul play had been made, Dr. Qaiser should have performed a more thorough investigation, and that an autopsy should have been performed. As a result the panel unanimously found *probable cause* that:

1. Dr. Qaiser violated § 406.075(1)(i), F.S., which states in part "Negligence or the failure to perform the duties required of a medical examiner with that level of care or skill which is recognized by reasonably prudent medical examiners as being acceptable under similar conditions and circumstances"; and

2. Dr, Qaiser violated Rule 11G-2.003(5)(b), F.A.C. which states "Absent good cause, an autopsy shall be performed when a reasonable suspicion exists that the death is by accident, suicide, or poison, unless the death is by poison and the deceased has survived in a hospital for a time sufficient to metabolize the poison; or the death is by accident or suicide and the

cause of death can be determined from a review of the circumstances, history, and available medical records.

The basis for the finding of probable cause is directly related to:

1. Dr. Qaiser did not perform an autopsy on the decedent.

2. Dr. Qaiser refused to quantify the toxicology results until the family had agreed to pay the expense associated with the quantification.

3. Dr. Qaiser failed to accurately determine the cause of death. He had no gross findings because an autopsy was not performed. The medical records were not thoroughly reviewed because there is documentation that Mr. McDonough did not have chronic myelogenous leukemia (CML) but rather had chronic myelomonocytic leukemia (CMML), which is a dysplastic, but benign, bone marrow condition and not the cause of death.

The panel further directed staff to conduct an additional administrative investigation at the District 18 Medical Examiner's Office in order to determine if these oversights indicated a pattern, or if it was an isolated incident. The panel requested that staff review all of the 2014 cases that consisted of visual inspections in order to determine if Dr. Qaiser's lack of performance in the McDonough case was an isolated incident or part of a performance deficiency effecting other investigations. .

Staff Review of District 18 (2014 Cases)

Staff notified the District 18 Medical Examiner's Office of the administrative investigation May 15th and asked that they arrange to have the files available for review upon arrival. The administrative investigation was conducted on May 20-21, 2015.

There were 303 cases involving inspections, including the McDonough case. Pursuant to state retention guidelines, medical records only need to be retained until obsolete. District 18 advised that not all the medical records are kept, but they would obtain any medical records needed upon request. Staff review indicated that most of the case files contained the salient medical records to support the conclusion and findings for the cause and manner of death. A practice of doing toxicology on inspection cases was not identified. Eleven cases were identified for review (see below). Staff noted that beginning in November 2014, District 18 included a new form, Toxicology Collection Sheet, in all case files regardless of whether toxicological results were obtained.

The District 18 Medical Examiner's Office consistently reports the manner of death as "accident" if the decedent experienced some type of trauma prior to death. This includes elderly decedents who may have fallen, broken a bone, and never fully recovered due to other medical conditions, and those who may have lingered in hospital or hospice care for some time prior to death.

Staff copied the following eleven inspection cases for the Probable Cause Panel's review.

Case Number	Decedent's Name	Date of Death	Manner of Death
E-14-216	Regina White	4/18/2014	Suicide
E-14-224	Shelia Carnley	4/21/2014	Suicide
E-14-451	Loria Lewis	7/21/2014	Accident
E-14-454	James Barbree	8/7/2014	Accident

E-14-488	Keia Knight	8/22/2014	Natural
E-14-489	Gene Prospero	8/23/2014	Accident
E-14-555	Michael Moloney	9/20/22014	Natural
E-14-585	Kelly Maldonado	10/2/2014	Accident
E-14-595	Joseph Dunham	10/6/2014 (found)	Natural
E-14-701	Robert Knight	11/24/2014	Natural
E-14-711	Danielle Remaley	12/1/2014	Natural

Probable Cause Panel Review of Additional Cases

On July 31, 2015, the Probable Cause Panel reconvened at the Department of Health in Jacksonville, Florida to discuss the additional cases presented by staff. Mr. Ken Jones and Ms. Robin Giddens Sheppard were present, and both Bruce A. Hyma, M.D. and Bruce A. Goldberger, Ph.D. attended via teleconference. Staff members present were Vickie Koenig, Doug Culbertson, and Kipp Heisterman.

- Case #216 – Regina White: Her death was delayed 7 weeks after alleged drug ingestion. No medical records were in the case file and no data to indicate toxicology testing that would support the conclusion of cause and/or manner of death.

- Case #224 – Shelia Carnley: No medical records and no hospital toxicology report were in the case file. This was a 15-day delayed death due to Diazepam toxicity.

- Case #451 – Loria Lewis: The decedent died hours after admission. The case file contained no medical records and no toxicology report from the hospital. Cause of death was most likely drug intoxication; however, no autopsy was performed. Admission blood was not requested.

- Case #454 – James Barbree: The case file contained no medical records or hospital toxicology report to support the conclusions. This was a 10-day delayed death due to a stroke with Cocaine, Hypertension and Diabetes as contributing causes.

- Case #488 – Keia Knight: The case file contained no medical records. The panel determined that this would not normally be a medical examiner case if there are medical records to support the cause and manner of death.

- Case #489 – Gene Prospero: Mr. Prospero died less than 72 hours after collapsing at a bus stop. His core body temperature was 109' Fahrenheit. The case file contained no medical records, no toxicology report, no police report, and no autopsy was performed. The panel felt that this case fell below the standard of care.

- Case #555 – Michael Moloney: The decedent had a history of prescription drug abuse and had recently talked of suicide. He was found unresponsive in his bedroom by his roommates. The case file contained no toxicology report, and an autopsy was not performed. The cause of death was right heart failure with lymphoma, cirrhosis and COPD as contributing causes

- Case #585 – Kelly Maldonado: A 3-day delayed death. The decedent was found submerged in the bathtub after huffing "Dust Off". The case file contained no medical records and no hospital toxicology report to support the diagnosis.

- Case #595 –Joseph Dunham: The decedent was found dead at home and had a history of ethanol abuse. Drugs were found at the scene of the death; however, the case file did not have a toxicology report, police report or medical records. An autopsy was not done and the cause of death was Chronic Ethanolism.

- Case #701 – Robert Knight: The decedent was found dead at home with a blood glucose greater than 500 mg/dL by EMS; no history of Diabetes. The case file did not have medical records to support the diagnosis and no autopsy was performed. Cause of death was Diabetic Ketoacidosis with obesity as a contributing cause.

- Case #711 – Danielle Remaley: The cause of death is septic shock due to Influenza A and streptococcus. Medical records are in the file supporting this diagnosis. This should not have been a medical examiner case.

The panel determined that the District 18 Medical Examiner's Office should not have taken jurisdiction in two of the cases (488 and 711). The case files were severely lacking in supporting documentation, investigative reports lacked pertinent information and that autopsies should have been performed in several cases. Medical records and police reports must be obtained and retained, especially if they support the cause and manner of death opinion, Additionally, eight of the eleven cases reviewed had "Date and time of *autopsy*" on the cover sheet of the external examination report. The panel found that these cases showed a pattern of substandard work. The panel found probable cause on these cases in addition to the original complaint involving Mr. McDonough.

Upon secondary review of the McDonough case file, it was noted that the cover sheet of the external examination report reflected "Date and time of *autopsy*" and stated "*Autopsy* Findings" when describing general observations to support conclusions for the cause and manner of death.

Conclusions

The panel found probable cause exists that there was a violation of § 406.075(1)(i), F.S. and Rule 11G-2.003(5)(b), F.A.C., by the District 18 Medical Examiner's Office regarding its investigation of the death of John McDonough, as well as the eleven additional cases reviewed at the July 31, 2015 meeting. The panel felt that the District 18 Medical Examiner's Office needs clear policies and procedures to ensure that this type of violation does not occur again. The Panel further finds that there is no excuse for making a grieving family pay for quantification of toxicology results, and that any new policies created should address that concern.

The panel recommends that Dr. Qaiser be placed on a probationary period of one year, during which time clear policies and procedures should be enacted that guarantee no family should pay for a toxicology quantification, and that any death in which jurisdiction is taken under similar circumstances will have a complete autopsy performed. The recommendation of probation shall include a provision for Commission staff to conduct a review of all case files for all external examination death investigations conducted during the probationary period.

The panel is prepared to discuss this matter and the reasoning behind their conclusions.

Following Dr. Hyma's report, District 18 Medical Examiner, Sajid S. Qaiser, M.D., was provided the opportunity to address the Commission. Dr. Qaiser told the Commission that he did not take Mr. McDonough's case because of the allegation of intentional overdose of morphine; rather it was

because Mr. McDonough had suffered a broken shoulder in a fall. Dr. Qaiser said that he does not believe that he did anything wrong in his investigation of Mr. McDonough's death, and that the diagnosis of chronic myelogenous leukemia (CML) was proper. Dr. Qaiser produced an article from Wikipedia that said that CMML is cancerous, and that an autopsy would have revealed cancer.

Dr. Nelson asked Dr. Qaiser if Mr. McDonough had CML or CMML, and Dr. Qaiser replied that it was definitely CML. Dr. Nelson asked if an autopsy would have been able to distinguish between whether the decedent had CML or CMML. Dr. Qaiser stated it would not be distinguished without specialized testing.

Dr. Wolf asked Dr. Qaiser how he could reach that conclusion without conducting an autopsy, and Dr. Qaiser once again referred to the Wikipedia. Dr. Wolf reiterated her concerns, and stated that the proper diagnosis in this case should have been chronic myelomonocytic leukemia (CMML), and that a proper blood test and autopsy would have revealed if Mr. McDonough had died of CML. Dr. Wolf further stated that CMML had been reclassified as a myelodysplastic syndrome, and was no longer considered to be a cancer. Dr. Qaiser once again referred to the same Wikipedia article from the Internet.

Dr. Nelson asked Dr. Qaiser why he thought that it was proper to charge the family of the decedent for the quantification of toxicology. Dr. Qaiser stated that he did not have the budget to pay for all toxicology quantifications, so it was necessary to charge the family. Dr. Qaiser stated that since this was a hospice case, he expected to see morphine. He stated that the family was told they would be reimbursed if the levels were too high. Dr. Nelson said that this was unacceptable, and that quantification of toxicology is required in cases of suspected drug overdoses. Dr. Nelson told Dr. Qaiser that if he did not have the money in his budget to perform his job as required it is up to him as the District Medical Examiner to go to his County Commission to request additional funding.

Dr. Nelson then asked Dr. Qaiser about the other eleven (11) cases that were reviewed by staff, and Dr. Qaiser informed the Commission that his staff had not included everything in the case file copies requested by Commission staff during their review of the files; therefore MEC staff did not have all of the information available.

Ms. Koenig asked Dr. Qaiser if there was any possibility that the additional information had been added after staff had visited his office, and Dr. Qaiser stated emphatically that nothing had been added since staff had been to his office for the review. Dr. Nelson asked if Dr. Qaiser recalled the date that staff had conducted the review of his files, and Dr. Qaiser stated that it was sometime in July. Ms. Koenig reminded Dr. Qaiser that staff was at his office May 20-21, 2015. Ms. Koenig also asked if it was possible that some of the medical records were in the file room and not in the case file when staff reviewed the files. Again, Dr. Qaiser stated that the files were complete when staff reviewed them and nothing had been added to the files.

Dr. Nelson recommended that the issue be tabled until Commission staff is able to review the files again and present the findings to the Probable Cause Panel for review.

A MOTION WAS MADE, SECONDED, AND PASSED UNANIMOUSLY FOR THE COMMISSION TO TABLE THIS ISSUE UNTIL STAFF HAS HAD SUFFICIENT TIME TO REVIEW THE ADDITIONAL ELEVEN DISTRICT 18 FILES.

ISSUE NUMBER 5: UNIDENTIFIED DECEASED INITIATIVE

Mr. Culbertson reported that this was the best quarter for success stories in the last five years.

Mr. Culbertson described the following success story on behalf of District 20 Medical Examiner Marta U. Coburn, M.D. In an initiative set forth by the medical examiner to positively identify the unidentified, cases are in constant review. As technology advances and databases are created, each case is re-examined and updated.

Due to the state of the remains at time of discovery, visual identification was not possible. The medical examiner asked a forensic anthropologist to review the skeletal remains to build a profile, including approximate age at time of death, sex, height, ancestry, and trauma analysis.

Patricia Minnis was one case that the medical examiner always believed could be identified because she had a surgical implant in her back. The ME office obtained the serial number and contacted the manufacturer who advised that, regrettably, once the device leaves the site there is no way to track that piece to an individual. District 20 also contacted area hospitals and obtained a list of patients that had received those implants within a particular time frame. Unfortunately, those efforts did not yield any results.

In 1999, Patricia Minnis's skull was given to a forensic reconstructionist. In 2005, portions of bone were submitted to the University of North Texas and they received confirmation that STR and mDNA was cataloged in January 2008.

Patricia Minnis's daughter submitted her DNA in California, possibly sometime in 2006. In June 2015, the District 20 Medical Examiner received a letter from UNT stating that a possible match of our unidentified to Ms. Minnis's daughter, and the Collier County Sherriff's Office was notified.

District 7 and 24 investigator Joe Mullin reported that on May 2, 1990, a white male was found floating in a canal adjacent to 11th Street in Daytona Beach. A watch, keys, and a comb were found in his pockets, but there were no personal effects from which a positive identification could be made. Over the last 25 years, multiple leads were discovered and ultimately ruled out.

This case remained cold until May 2015 when Sgt. Patrick Thomas of the Volusia County Sheriff's Office had their Technical Services Unit re-run the fingerprints taken from the unidentified male against their databases. Incredibly, a match was found. The fingerprints matched a man named Richard John Ryan, who had been arrested previously by multiple local police departments. Many of the fingerprints from that period were only available on paper, so earlier databases searches were unsuccessful. Over time, all of these paper fingerprints are slowly being added to the electronic databases; Richard Ryan happened to be one of those records.

The second case involved a 1989 case in which a 36-hour old infant's body was found behind a dumpster. The case went cold until this year when additional documents were requested. The documents revealed the arrest of an individual who stated that in 1990, he dated a woman who told him that she had given birth to a child and that the child was discarded. This information was given to local authorities and the woman was located and a DNA sample was obtained. The DNA was a match to the child's body and the woman confessed that she had discarded the infant in a panic.

Bill Pellan reported two success stories from District 6. The first case involved a runaway from Virginia who died in 1973 when she was pushed in front of a car. In 2010, the District 6 ME Office

reached out to the University of South Florida, which pulled in anthropologist Erin Kimmerle, Ph.D. Together they disinterred Jane Doe and two other bodies from unmarked graves. They collected a sample of the girl's DNA but found no matches.

In October 2013, the National Center for Missing and Exploited Children posted a reconstructed picture of the girl on Facebook asking "Do you recognize this teenage girl who was in St. Petersburg, Florida, in 1973?" The post listed the name she had given police: Janice Marie Brock.

The following January, the missing girl's brother searched for her using her birth name and came upon the post from NCMEC, after which he contacted police in Florida and gave a DNA sample. The sample was a match with the unidentified remains, and she was identified as Janice Marie Young.

The second case was from 1999 and involved a missing person who no longer had any immediate family living. Both parents were dead and he didn't have any siblings or children. The ME office used an old envelope from a letter he sent a friend to get a profile to compare to the unidentified decedent. The envelope was also sent to the Pinellas County DNA lab for analysis, where a match was made to a missing person named Stewart Fletcher Currin.

Mr. Pellan informed the Commission that in December of 2000, he and Dr. Thogmartin came to the District 6 Office. At that time, there were 32 persons unidentified going back to 1961. They have now successfully identified 15 of those 32 unidentified persons from prior to their time in District 6. Since 2000, they have only had 2 persons remain unidentified, leaving a current total number of unidentified persons of 19.

Dr. Nelson congratulated all of the districts for these success stories, and reminded everyone of the importance of collecting as much evidence as possible in attempting to identify the unidentified deceased.

ISSUE NUMBER 4: NATIONAL GUARD MASS CASUALTY/FATALITY EXERCISE

Dr. Hyma informed the Commission that the mock mass casualty/fatality exercise would take place in March 2016. Jason H. Byrd, Ph.D., director of FEMORS, is the Commander-In-Charge of the exercise. The exercise will be held at the Dade-Collier Training and Transition Airport (TNT) located in Collier County, and District 20 Medical Examiner Dr. Marta U. Coburn will be the medical examiner point person. The Florida National Guard will be utilizing a lot of resources, including aircraft. Dr. Hyma said that a request had been made to "borrow" the unidentified bodies in his office, and Dr. Hyma said that he declined that request.

ISSUE NUMBER 6: REPORT OF 2015 FAME EDUCATIONAL CONFERENCE, JULY 15-17, 2015

Dr. Nelson reported that the 42nd FAME Educational Conference held July 15-17, 2015 in Daytona Beach Shores was a success, and was well attended.

ISSUE NUMBER 7: SOLICITATION FOR 2016 FAME EDUCATIONAL CONFERENCE

Dr. Nelson said that according to Bruce A. Goldberger, Ph.D., the most successful FAME educational conferences were held along the I-4 corridor, and that future meetings would be held in that area. Dr. Nelson asked that anyone interested in hosting the 2016 FAME Educational Conference to please contact Dr. Goldberger at the University of Florida.

ISSUE NUMBER 8: OTHER BUSINESS

- Dr. Nelson read the following resolution for Dr. Hyma into the record:

  WHEREAS the Medical Examiners Commission was created in 1970 by the passage of Chapter 406, Part I, Florida Statutes, also known as the Medical Examiners Act; and

  WHEREAS this Commission plays a vital role in support of the State of Florida's criminal justice system, to the families of the deceased in determining the cause and manner of death of their loved ones whose deaths come under the jurisdiction of the medical examiner, and by contributing to the protection of the public health of the citizens of the State of Florida; and

  WHEREAS Dr. Bruce A. Hyma has proudly served the District Eleven Medical Examiner's Office since 1988, and has served as the Chief Medical Examiner since 2001; and

  WHEREAS Dr. Bruce Hyma has been passionate about the Commission's Unidentified Deceased Initiative, and has reached out to law enforcement agencies throughout his district in order to coordinate efforts to bring closure to the families of unidentified decedents; and

  WHEREAS since Dr. Hyma was first appointed to the Commission by Governor Charlie Crist in 2007, he was elected as the Commission's chairman every year from 2009 until 2014, and during his tenure has assertively and wisely overseen the many very important and sometimes difficult issues that have come before the Commission; and

  WHEREAS Dr. Bruce A. Hyma was the recipient of the prestigious American Academy of Forensic Sciences' Milton Helpern Award, which recognizes individuals for outstanding lifetime contributions to forensic pathology;

  NOW THEREFORE let it be resolved that this Commission on behalf of Florida's Medical Examiners, the medical-legal community, and all of the citizens of Florida whom he has served so well, does hereby recognize and commend Dr. Bruce A. Hyma for the dedication, service and valuable guidance he has offered to the Florida Medical Examiners System and hopes that he maintains this same enthusiasm, professionalism, and success in all his future endeavors.

  PASSED AND RECORDED, in the official minutes of the Medical Examiners Commission meeting on this Friday, the 14th day of August, 2015, in Tampa, Hillsborough County, Florida.

- District 11 Accreditation – Chairman Nelson congratulated Dr. Bruce A. Hyma on the District 11 M.E. Office attaining NAME accreditation.

- District 4 Associate Medical Examiner Peter Gillespie, M.D. informed the Commission that District 4 was in the process of finalizing a contract with NMS Laboratories for toxicology services, and that

NMS would be housed in District 4's former toxicology building. Dr. Gillespie said that this was the final step toward obtaining NAME accreditation for District 4.

With no further business to come before the Commission, the meeting was adjourned at 12:09 P.M.