FDLE
Florida Department of Law Enforcement

Medical Examiners Commission Meeting

October 28, 2025

Barbara C. Wolf, M.D. • Kenneth T. Jones • Brian Fernandes, J.D. • Charlie Cofer, J.D.
Robin Giddens Sheppard, L.F.D. • Sheriff Robert "Bob" Johnson
Joshua Stephany, M.D. • Amira Fox, J.D.

MEDICAL EXAMINERS COMMISSION MEETING

Embassy Suites by Hilton Orlando Lake Buena Vista
4955 Kyngs Heath Road
Kissimmee, Florida 34746
October 28, 2025 10:00 AM EDT

Opening Remarks

Introduction of Commission Members and Staff

Approval of Meeting Agenda and Minutes from previous Commission Meeting of August 12, 2025

	• Sunshine Law	Natalie Bielby
	ISSUE NUMBER	**PRESENTER**
1.	Informational Items:	
	• Status Update: MEC Appointments and Reappointments	Brett Kirkland, Ph.D.
	• Status Update: DME Appointments and Reappointments	Brett Kirkland, Ph.D.
	• District 8 Medical Examiner Vacancy	Joshua Stephany, M.D.
	• 2024 Annual Drugs in Deceased Persons Report	Megan Neel
	• 2024 Annual Workload Report	Megan Neel
	• 2025 Interim Drugs in Deceased Persons Report	Megan Neel
	• 2024 Coverdell Status Update	Ashley Williams
	• 2025 Coverdell Status Update	Ashley Williams
2.	Legislative Update	Natalie Bielby
	• SB 54 – Use of Substances Affecting Cognitive Function • SB 188 – Medical Examiners' Duties	
3.	Unidentified Deceased Initiative	Ashley Bullard
4.	Public Health Medicolegal Death Investigation Data Optimization Initiative	Shana Geary
5.	FDLE Forensic Update	Leigh Clark
6.	Emerging Drugs	Brett Kirkland, Ph.D.
7.	Other Business	Barbara C. Wolf, M.D.
	• Drugs Identified in Deceased Persons Dashboard	Brett Kirkland, Ph.D.

The next MEC Meeting will be February 17th at the Orlando Marriot Lake Mary, FL.

MEDICAL EXAMINERS COMMISSION MEETING
Sawgrass Marriott Golf Resort & Spa
1000 TPC Blvd.
Ponte Vedra Beach, FL 32082
August 12, 2025, 10:00 AM EDT

Commission Chairman Barbara C. Wolf, M.D., called the meeting of the Medical Examiners Commission (MEC) to order at **10:00 AM**. She advised those in the audience that the meetings of the Medical Examiners Commission are open to the public and that members of the public will be allowed five minutes to speak. She then welcomed everyone to the meeting and asked Commission members, staff, and audience members to introduce themselves.

Commission members present:

Barbara C. Wolf, M.D., Districts 5 & 24 Medical Examiner
Brian Fernandes, J.D., Chief Assistant Statewide Prosecutor, Office of the Attorney General
Robin Giddens Sheppard, L.F.D., Funeral Director
Kenneth T. Jones, State Registrar, Department of Health
Hon. Charlie Cofer, J.D., Public Defender, 4th Judicial Circuit
Joshua Stephany, M.D., Districts 9 & 25 Medical Examiner (Virtual)
Hon. Amira Fox, J.D., State Attorney, 20th Judicial Circuit

Commission staff present:

Brett Kirkland, Ph.D.
Ashley Bullard
Natalie Bielby, J.D.
Megan Neel
Ashley Williams

District Medical Examiners present:

Deanna Oleske, M.D. (District 1)
B. Robert Pietak, M.D. (District 4)
Jon R. Thogmartin, M.D. (District 6)

Other District personnel present:

Tim Crutchfield (District 4)
Dan Schebler (District 1)
Chrissy Nieten (District 1)
Ricardo Camacho (District 2)
Iana Lesnikova, M.D. (District 23)

Guests present:

Chad Brown, Director of Criminal Justice Professionalism Standards and Training Services (FDLE)
Casey Smith (FDLE)
Leigh Clark, Chief of Forensic Services (FDLE)
Amanda Ball, Chief of Staff (FDLE)
Shane Lockwood (Florida Department of Health, St. Johns County)
Yasmine Fucci (Florida Department of Health)
J. Peter R. Pelletier, M.D., FCAP, FASCP (FEMORS)
Bernard Brzezinski (FEMORS)
Larry R. Bedore, MS CJ (FEMORS)
Rachel Moore (FEMORS)
Heather Markuson (LifeQuest)
Brittany Hill (Lifelink of Florida)
Karen Schebler (Citizen)
Elizabeth Blemmon (Citizen)

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 13, 2025 MEDICAL EXAMINERS COMMISSION MEETING.

ISSUE NUMBER 1: INFORMATIONAL ITEMS:

- Status Report: MEC Appointments: Public Defender Charlie Cofer, J.D., and Sheriff Robert "Bob" Johnson, were nominated and unanimously recommended for reappointment to the Medical Examiners Commission for the cycle ending June 2029. Bureau Chief Brett Kirkland, Ph.D., advised that a recommendation letter will be sent to the Governor's Appointment Office. He also informed the Commission that the County Commissioner seat is still vacant.

- Status Report: DME Appointments and Reappointments: Dr. Kirkland informed the Commission that a letter was sent to the Governor's Appointment Office recommending the reappointments of District Medical Examiners by the Commission. We are currently awaiting appointments from the Governor's Appointments Office.

- District 8 Medical Examiner Vacancy: Dr. Barbara Wolf on behalf of Dr. Joshua Stephany informed the Commission that the District 8 Medical Examiner's position is still vacant and that there is no news to report. Dr. Jon Thogmartin will continue to provide coverage.

- 2024 Interim Drug Report: Ms. Megan Neel informed the Commission that drug data review has been completed and just awaiting final approval before publishing. Ms. Neel advised the Commission that it should be published soon.

- 2024 Annual Drug Report: Ms. Megan Neel informed the Commission that drug data has been received, and Ms. Neel advised the draft is completed and being reviewed for edits.

- 2024 Annual Workload Report: Ms. Megan Neel informed the Commission the draft is completed and being reviewed for edits.

- 2025 Interim Drug Report: Ms. Megan Neel informed the Commission that data has been received by a few districts and still waiting for the remainder. Ms. Neel reminded the Districts that the data is due by September 30, 2025.

- 2024 Paul Coverdell Forensic Science Improvement Grant Program Status Update: Ms. Ashley Williams informed the Commission that FDLE Grants unit is working on reimbursements and asked that districts continue to send is their reimbursement forms.

- 2025 Paul Coverdell Forensic Science Improvement Grant Program Status Update: Ms. Ashley Williams advised that 14 proposals were received for the 2025 Paul Coverdell Grant. Ms. Williams advised that there was indication that the 2025 Paul Coverdell Grant will be moving forward and we should have more information shortly.

ISSUE NUMBER 2: Disaster Reporting Form and Ready Op

MEC Staff Manager, Ashley Bullard informed the Commission of updates on disaster death reporting. Ms. Bullard advised that Commission staff would be using a program called ReadyOp which allows the electronic submission of the disaster death reporting forms. This system would make the information from the districts immediately available to FDLE. Ms. Bullard also went over the data management and what information would be required. Ms. Bullard advised that the paper form will still be available if needed.

ISSUE NUMBER 3: FDLE Forensic Update:

Bureau Chief Brett Kirkland, Ph.D., on behalf of Deputy Director Leigh Clark of FDLE's Forensic Services informed the Commission that Florida FIGG grant did not have funding appropriated for the 25-26 fiscal year. There were 86 applications received by FDLE for the 24-25 fiscal year, the funds of $500,000. 49 of the applications met all technical specifications and provided all application requirements. 48 of the applications were unidentified human remains doe cases and 1 suspect case. 10 applications met the Bureau of Justice Assistance (BJA) Missing and Unidentified Human Remains (MUHR) grants requirements and FDLE sent those cases for FIGG analysis using the funds. The solicitation for the grant closed on June 30, 2025. Dr. Kirkland also advised that the Department of Justice BJA has approved FDLE's request for an extension and the grant will continue until September 30, 2026, for the FDLE Missing and Unidentified Human Remains grant. The requirement is that the unidentified human remain cases be suspected homicide victim remains. FDLE continues to accept and test unidentified human remain cases for entry into CODIS or for direct comparisons to potential relatives. Since October 1, 2023, FDLE has facilitated the identification of 42 unidentified human remains, via CODIS hits, direct comparisons, fingerprint searches and FIGG. Dr. Kirkland advised that if there are unidentified human remain cases in CODIS, and FIGG analysis is needed regardless of manner of death to contact Marcie Scott at MarcellaScott@fdle.state.fl.us or Leigh Clark at LeighClark@fdle.state.fl.us.

ISSUE NUMBER 4: FEMORS Update

Deputy Commander Larry Bedore, MS CJ, of Florida Emergency Mortuary Operations Response System (FEMORS) gave an update on the Fatality Management Response Plan. Deputy Commander Bedore introduced the new FEMORS Command Team to the Commission. Commander J Peter R Pelletier, Logistics Chief Bernard Brzezinski, Fiscal Assistant III and Administrative Officer Rachel Moore, and Human Resource Officer Stacey Oliver. Deputy Commander Bedore also provided the Commission with updates and presented the newest draft of the Fatality Management Response Plan. The only addition for Fatality Management Plan was the Medical Examiners Staff's suggestion that was made at the February 2025 meeting, for adding the definitions for Direct and Indirect incident related. Mr. Bedore also advised that additional updates have been made due to federal changes. MEC Chairman

Dr. Barbara Wolf asked that MEC staff disburse copies of the update among the Commissioners for review and then have a vote at the February 2026 Medical Examiners Commission meeting.

ISSUE NUMBER 5: EMERGING DRUGS UPDATE

On behalf of Dr. Bruce Goldberger, Dr. Kirkland provided the Commission with an update on new drug trends. He informed the Commission that laboratories are seeing a significant decreases in the prevalence of novel benzodiazepines, carfentanil, cathinones, cocaine, fentanyl, fluorofentanyl, methamphetamine, and nitazenes in decedents. NPS and other substances identified in casework includes alpha-PiHPP (isoPV8), bromazolam, N-isopropyl butylone, ketamine, methylenedioxymethamphetamine, 3,4-methylenedioxy-α-pyrrolidinoisohexanophenone (MDPiHP), MDMB-4en-PINACA, ortho-methylfentanyl, and tramadol. Two new adulterants have been identified in the illicit fentanyl supply in the state of Florida – 1) BTMPS (bis(2,2,6,6-tetramethyl-4-piperidyl) sebacate), an industrial chemical; and 2) medetomidine, a veterinary sedative and anesthetic.

Furthermore, Dr. Kirkland informed the Commission that the toxicology laboratory directors continue to meet bimonthly to discuss the prevalence and emergence of drugs in the state of Florida. Participants of the meeting include representatives from the MEC, the Drug Enforcement Administration, the Florida Department of Health, and the Office of Statewide Intelligence.

ISSUE NUMBER 6: OTHER BUSINESS

- 2025 FAME Conference: District 1 Medical Examiner's Office Director of Operations, Dan Schebler informed the Commission of an update for the 2025 FAME Education Conference being held in Fort Walton Beach, Florida on September 10-12, 2025. Mr. Schebler advised that the program has been approved for a maximum of 18 CME credit hours. Also, 19 of the 25 districts have register to attend. Mr. Schebler informed the Commission that the program is available and can be found on the Medical Examiners Commission website.

- Medical Examiner's Environmental Analysis Report: Dr. Brett Kirkland and Ken Jones informed the Commission that the Department of Health has completed it analysis of data collection and reporting. Dr. Kirkland advised that the findings will be presented at the October 2025 Medical Examiners Commission meeting.

With no further business to come before the Commission, the meeting was adjourned at 10:46 A.M.

MEDICAL EXAMINERS COMMISSION

Barbara C. Wolf, M.D.
Chairman
District 5/24 Medical Examiner
809 Pine Street
Leesburg, Florida 34748
(352) 326-5961
E: barbara.wolf@marioncountyfl.org
First Term: 8/7/2015-7/1/2019
Second Term: 2/10/2023 - 6/30/2023

Robin Giddens Sheppard, L.F.D.
Funeral Director/Vice President
Hardage-Giddens Funeral Homes
4801 San Jose Boulevard
Jacksonville, Florida 32207
(904) 737-7171
E: Robin.Sheppard@dignitymemorial.com
First Term: 8/15/2013-7/1/2016
Second Term: 08/29/2018-07/01/2020
Third Term: 2/10/2023 - 6/30/2024

Honorable Charlie Cofer, J.D.
Public Defender, 4th Judicial Circuit
407 N. Laura Street
Jacksonville, Florida 32202
(904) 255-4673
E: ccofer@pd4.coj.net
First Term: 08/29/2018-07/01/2021
Second Term: 2/10/2023 - 6/30/2025

Mr. Kenneth T. Jones
State Registrar
Florida Department of Health
Bureau of Vital Statistics
Post Office Box 210
Jacksonville, Florida 32231
(904) 359-6900 ext. 1001
E: Ken.Jones@flhealth.gov
Term: Not Applicable

Brian Fernandes, J.D.
Chief Assistant Statewide Prosecutor
Office of the Attorney General
107 West Gaines Street, Suite 531
Tallahassee, FL 32399
850-414-3300
email: Brian.Fernandes@myfloridalegal.com
Term: Not Applicable

Honorable Amira Fox, J.D.
State Attorney
20th Judicial Circuit
PO Box 399
Fort Myers, Florida 33902
(239) 533-1100
email: afox@sao20.org
First Term: 2/10/2023 - 6/30/2023

VACANT
County Commissioner

Joshua Stephany, M.D.
District 9/25 Medical Examiner
2350 East Michigan Street
Orlando, Florida 32806
(407) 836-9400
email: joshua.stephany@ocfl.net
First Term: 2/10/2023 - 6/30/2024

Honorable Robert "Bob" Johnson
Sheriff
Santa Rosa County
5755 East Milton Road
Milton, Florida 32583
(850) 983-1100
email: rjohnson@srso.net
First Term: 2/10/2023 - 6/30/2025

STAFF

Medical Examiners Commission
Florida Department of Law Enforcement
Post Office Box 1489
Tallahassee, Florida 32302
(850) 410-8600

Bureau Chief Brett Kirkland, Ph. D.
(850) 410-8600
brettkirkland@fdle.state.fl.us

Government Analyst II Megan Neel
(850) 410-8664
meganneel@fdle.state.fl.us

Attorney Supervisor Natalie Bielby
(850) 410-7681
NatalieBielby@fdle.state.fl.us

Manager II Ashley Bullard
(850) 410-8639
AshleyBullard@fdle.state.fl.us

Government Analyst II Ashley Williams
(850) 410-8609
ashleywilliams@fdle.state.fl.us

FLORIDA DISTRICT MEDICAL EXAMINERS

District 1
Deanna Oleske, M.D.
Interim Medical Examiner
2114 Airport Blvd. Suite 1450
Pensacola, Florida 32504
Director of Operations Dan Schebler
(850) 332-7300
FAX: (850) 285-0774
e-mail: contactus@d1meo.org

District 2
Thomas M. Coyne, M.D., Ph.D
Interim Medical Examiner
560 Leonard Gray Way
Tallahassee, Florida 32304
Director of Operations Ricardo Camacho
(850) 606-6600
FAX: (850) 606-6601
e-mail: rcamacho@Dist2ME.org

District 3
Dixie Co.
ME Services Provided by District 8
Lafayette, Madison & Suwannee Co.
ME Services Provided by District 2
Columbia & Hamilton Co.
ME Services Provided by District 4

District 4
B. Robert Pietak, M.D.
Interim Medical Examiner
2100 Jefferson Street
Jacksonville, Florida 32206
Director of Operations Tim Crutchfield
(904) 255-4000
FAX: (904) 630-0964
e-mail: tcrutchfield@coj.net

District 5
Barbara C. Wolf, M.D.
809 Pine Street
Leesburg, Florida 34748
Director of Operations Lindsey Bayer
(352) 326-5961
FAX: (352) 365-6438
e-mail: Lindsey.Bayer@marionfl.org

District 6
Jon R. Thogmartin, M.D.
10900 Ulmerton Road
Largo, Florida 33778
Chief Investigator Damon Breton
(727) 582-6800
FAX: (727) 582-6820
e-mail: dbreton@co.pinellas.fl.us

District 7 (Home Rule)
James W. Fulcher, M.D.
3891 Tiger Bay Road
Daytona Beach, FL 32124-1001
Director of Operations Karla Orozco
(386) 258-4060
FAX: (386) 258-4061
e-mail: korozco@volusia.org

District 8
Jon R. Thogmartin
Interim Medical Examiner
3217 SW 47th Avenue
Gainesville, Florida 32608
(352) 273-9292
FAX: (352) 273-9288

District 9 (Home Rule)
Joshua D. Stephany, M.D.
2350 East Michigan Street
Orlando, Florida 32806
Program Manager Sheri Blanton
(407) 836-9400
FAX:(407) 836-9450
e-mail: Sheri.Blanton@ocfl.net

District 10
Stephen J. Nelson, M.A., M.D., F.C.A.P.
1021 Jim Keene Boulevard
Winter Haven, Florida 33880
Office Manager Sheli Wilson
(863) 298-4600
FAX:(863) 298-5264
e-mail: StephenNelson@polk-county.net

District 11 (Home Rule)
Kenneth Hutchins, M.D.
Medical Examiner
Number One on Bob Hope Road
Miami, Florida 33136-1133
Director of Operations Sandra Boyd
(305) 545-2400
FAX: (305) 545-2412
e-mail: sandra.boyd@miamidade.gov

District 12
Russell S. Vega, M.D.
4510 Fruitville Road
Sarasota, Florida 34232
Director of Operations David Winterhalter
(941) 361-6909
FAX: (941) 361-6914
email: rvega@fldist12me.com

District 13 (Home Rule)
Carolina McEnnan, M.D.
11025 North 46th Street
Tampa, Florida 33617
Manager of Operations Harrison Cowan
(813) 914-4500
FAX: (813) 914-4594
email: McEnnanC@hcfl.gov

District 14
Jay Radtke, M.D.
3737 Frankford Avenue
Panama City, Florida 32405
Director of Operations Whit Majors
(850) 747-5740
FAX: (850) 747-5745
e-mail: wmajors@baycountyfl.gov

District 15 (Home Rule)
Catherine R. Miller, M.D.
Medical Examiner
3126 Gun Club Road
West Palm Beach, Florida 33406
Forensic Supervisor Ralph Saccone
(561) 688-4575
FAX: (561) 688-4588
e-mail: rsaccone@pbcgov.org

District 16
Michael Steckbauer, M.D.
Interim Medical Examiner
56639 Overseas Hwy
Marathon, Florida 33050
(305) 743-9011
FAX: (305) 743-9013
e-mail: meo@monroecounty-fl.gov

District 17 (Home Rule)
Rebecca MacDougall, M.D.
Medical Examiner
5301 S.W. 31st Avenue
Ft. Lauderdale, Florida 33312
Division Admin Assistant Heather Galvez
(954) 357-5200
FAX: (954) 327-6580
e-mail: rmacdougall@broward.org

District 18
Sajid S. Qaiser, M.D.
1750 Cedar Street
Rockledge, Florida 32955
Program Manager Michael Szczepanski
(321) 633-1981
FAX: (321) 633-1986
e-mail: michael.szczepanski@brevardfl.gov

District 19
Patricia A. Aronica, M.D.
Interim Medical Examiner
2500 South 35th Street
Ft. Pierce, Florida 34981
Operations Manager Kimberly Loucks
(772) 464-7378
FAX: (772) 464-2409
e-mail: kimberly.loucks@stlucieco.gov

District 20
Marta U. Coburn, M.D.
3838 Domestic Avenue
Naples, Florida 34104
Adminsitrative Coordinator Michelle Correia
(239) 434-5020
FAX: (239) 434-5027
e-mail: naplesme@d20me.net

District 21
Rebecca A. Hamilton, M.D.
70 South Danley Drive
Ft. Myers, Florida 33907
Director of Operations Patti Wheaton
(239) 533-6339
FAX: (239) 277-5017
e-mail: pwheaton@leegov.com

District 22
Russell S. Vega, M.D.
Interim Medical Examiner
18130 Paulson Drive
Pt. Charlotte, Florida 33954
Director of Operations Penny Fulton
(941) 625-1111
FAX: (941) 627-0995
e-mail: pfulton@district 22me.com

District 23
Wendolyn Sneed, M.D.
Medical Examiner
4501 Avenue A
St. Augustine, Florida 32095
Forensic Operations Manager Kelly Boulos
(904) 209-0820
FAX: (800) 255-8617
e-mail: kboulos@sjcfl.us

District 24
Barbara C. Wolf, M.D.
ME Services Provided by District 5

District 25 (Home Rule)
Joshua D. Stephany, M.D.
ME Services Provided by District 9

FLORIDA ASSOCIATE MEDICAL EXAMINERS

District 1
Danielle R. Armstrong, D.O.
Lorraine Lopez-Morell, M.D.
Michael Pagacz, M.D.
(Wilson A. Broussard, M.D.)
(Thomas M. Coyne, M.D., Ph.D.)
(Jennifer Dierksen, M.D.)
(Emily R. Duncanson, M.D.)
(Lisa Flannagan, M.D.)
(James W. Fulcher, M.D.)
(Ami Murphy, D.O.)
(Maneesha Pandey, M.D.)
(Jay M. Radtke, M.D.)
(Brandy L. Shattuck, M.D.)

District 2
(Lisa M. Flannagan, M.D.)
(Jan M. Gorniak, D.O.)
(Noel R. Agudo, M.D.)
(Natalia Belova, M.D.)
(Kailee Imperatore, M.D.)
(Andrew Koopmeiners, M.D.)
(Noel A. Palma, M.D.)
(Heidi Reinhard, M.D.)
(Sarah C. Thomas, M.D.)
(Jason R. Van Roo, M.D.)

District 3
Dixie Co.
ME Services Provided by District 8
Lafayette, Madison, & Suwannee Co.
ME Services Provided by District 2
Columbia & Hamilton Co.
ME Services Provided by District 4

District 4
Robert Buchsbaum, M.D., J.D.
Peter Gillespie, M.D.
Brittany L. Glad, D.O.
Sherry L. Jilinski, M.D.
Aurelian Nicolaescu, M.D.
Robert R. Pfalzgraf, M.D.
Jason R. Van Roo, M.D.
(Noel R. Agudo, M.D.)
(Danielle R. Armstrong, D.O.)
(Michael Bell, M.D.)
(Leszek Chrostowski, M.D.)
(Iana Lesnikova, M.D.)
(Brandon M. Maveal, M.D.)
(Deanna A. Oleske, M.D.)
(Valerie J. Rao, M.D.)
(Sandra A. Siller, M.D.)
(Barbara C. Wolf, M.D.)

District 5
Tracey S. Corey, M.D.
Joy Edgebe, M.D.
Rachel A. Lange, M.D.
Chantel Njiwaji, M.D.
Tracey L. Shipe, D.O.
(Noel R. Agudo, M.D.)
(Michael Bell, M.D.)
(Thomas M. Coyne, M.D., Ph.D.)
(James W. Fulcher, M.D.)
(Susan S. Ignacio, M.D.)
(Kailee Imperatore, M.D.)
(Wayne D. Kurz, M.D.)
(Andrew Koopmeiners, M.D.)
(Stephen J. Nelson, M.D.)
(Aurelian Nicolaescu, M.D.)
(Noel A. Palma, M.D.)
(Joshua D. Stephany, M.D.)
(Jon Thogmartin, M.D.)
(Jason R. Van Roo, M.D.)

District 6
Noel R. Agudo, M.D.
Susan S. Ignacio, M.D.
Kailee Imperatore, M.D.
Wayne D. Kurz, M.D.
Andrew Koopmeiners, M.D.
Noel A. Palma, M.D.
Jason R. Van Roo, M.D.
(Wilson A. Broussard, M.D.)
(Marcela Chiste, M.D.)
(Tracey S. Corey, M.D.)
(Thomas M. Coyne, M.D., Ph.D.)
(Rebecca A. Hamilton, M.D.)
(Rachel A. Lange, M.D.)
(Wendy A. Lavezzi, M.D.)
(Rebecca MacDougall, M.D.)
(Stephen J. Nelson, M.D.)
(Chantel Njiwaji, M.D.)
(Shanedelle S. Norford, M.D.)
(Mark J. Shuman, M.D.)
(Phoutthasone Thirakul, M.D.)
(Suzanne R. Utley-Bobak, M.D.)
(Russell S. Vega, M.D.)
(Vera V. Volnikh, M.D.)
(Barbara C. Wolf, M.D.)

District 7
Ruth Kohlmeier, M.D.
Mary G. Ripple, M.D.
(Noel R. Agudo, M.D.)
(Marcela Chiste, M.D.)
(Susan S. Ignacio, M.D.)
(Kailee Imperatore, M.D.)
(Wayne D. Kurz, M.D.)
(Rebecca MacDougall, M.D.)
(Shanedelle S. Norford, M.D.)
(Noel A. Palma, M.D.)
(Jon R. Thogmartin, M.D.)
(Lee Tormos, M.D.)

District 8
(Noel Agudo, M.D.)
(Michael Bell, M.D.)
(Natalia Belova, M.D.)
(Alexander Blank, M.D.)
(Thomas M. Coyne, M.D., Ph.D.)
(Lisa Flanagan, M.D.)
(Alexis Jelinek, M.D.)
(Susan S. Ignacio, M.D.)
(Kailee Imperatore, M.D.)
(Andrew Koopmeiners, M.D.)
(Wayne D. Kurz, M.D.)
(Wendy Lavezzi, M.D.)
(Rebecca MacDougall, M.D.)
(Chantel Njiwaji, M.D.)
(Shanedelle S. Norford, M.D.)
(Noel Palma, M.D.)
(Heidi Reinhard, M.D.)
(Mark Shuman, M.D.)
(Jason Van Roo, M.D.)
(Barbara C. Wolf, M.D.)

District 9
Brooke Blake, M.D.
Joy Edegbe, M.D.
Marie H. Hansen, M.D.
Soren L. Jensen, D.O.
Jenaye L. Mack, M.D.
Sandra A. Siller, M.D.
Mariana Voudouri, M.D.
Sara H. Zydowicz, D.O.
(Tracey S. Corey, M.D.)
(James Fulcher, M.D.)
(D. Fintan Garavan, M.D., Ph.D.)
(Julia V. Hegert, M.D.)
(Ruth Kohlmeier, M.D.)
(Rachel A. Lange, M.D.)
(Stephen J. Nelson, M.D.)
(Chantel Njiwaji, M.D.)
(Mary G. Ripple, M.D.)
(Tracey L. Shipe, D.O.)
(Sajid S. Qaiser, M.D.)
(Vera V. Volnikh, M.D.)
(Barbara C. Wolf, M.D.)

District 10
D. Fintan Garavan, M.D., Ph.D.
Vera V. Volnikh, M.D.
(Kelly G. Devers, M.D.)
(Susan S. Ignacio, M.D.)
(Wayne D. Kurz, M.D.)
(Wendy Lavezzi, M.D.)
(Ryan D. McCormick, M.D.)
(Daissy C. McEnnan, M.D.)
(Noel A. Palma, M.D.)
(Ashley R. Perkins, D.O.)
(Jon R. Thogmartin, M.D.)
(Milad Webb, M.D.)
(Barbara C. Wolf, M.D.)

District 11
Nicholas Barna, M.D.
Jonathan Kanakaraj, M.D.
Katherine Kenerson, M.D.
Benjamin Mathis, M.D.
Attila Molnar, M.D.
Jusmita Saifullan, M.D.
Tiffany Sheganoski, D.O.
Tyson Sutherland, M.D.
Tuyet Tran, D.O.
(Michael D. Bell, M.D.)
(Iouri G. Boiko, M.D., Ph.D.)
(Manfred Borges, M.D.)
(Marcela Chiste, M.D.)
(Marta Coburn, M.D.)
(Gertrude M. Juste, M.D.)
(Rebecca MacDougall, M.D.)
(Craig Mallak, M.D.)
(Linda R. O'Neil, M.D.)
(Marlon S. Osbourne, M.D.)
(Stephen Robinson, M.D.)
(Stacey A. Simons, M.D.)
(Terrill Tops, M.D.)
(Lee Marie Tormos, M.D.)

District 12
Omar Ansari, M.D.
Wilson A. Broussard, M.D.
Phoutthasone Thirakul, M.D.
Suzanne R. Utley-Bobak, M.D.
(Leszek Chrostowski, M.D.)
(Stephen J. Nelson, M.D.)
(Robert R. Pfalzgraf, M.D.)
(Valerie J. Rao, M.D.)
(Wendolyn Sneed, M.D.)

District 13
Omar Ansari, M.D.
Kelly G. Devers, M.D.
Ryan D. McCormick, M.D.
Ashley R. Perkins, D.O.
Noah D. Reilly, D.O.
Milad Webb, M.D.
(Leszek Chrostowski, M.D.)
(Thomas M. Coyne, M.D.)
(D. Fintan Garavan, M.D., Ph.D.)
(Stephen J. Nelson, M.D.)
(Phoutthasone Thirakul, M.D.)
(Vera V. Volnikh, M.D.)
(Sara H. Zydowicz, D.O.)

District 14
(Noel R. Agudo, M.D.)
(Michael D. Bell, M.D.)
(Susan S. Ignacio, M.D.)
(Katherine L. Kenerson, M.D.)
(Andrea N. Minyard, M.D.)
(Mark J. Shuman, M.D.)
(Phoutthasone Thirakul, M.D.)

District 15
Natalia Belova, M.D.
Marcela Chiste, M.D.
Eric A. Eason, M.D.
Marlon S. Osbourne, M.D.
Heidi Reinhard, M.D.
Terrill Tops, M.D.
Lee Marie Tormos, M.D.
Anthony Vinson, DO
(Michael Bell, M.D.)
(Kenneth D. Hutchins, M.D.)
(Alexis Jelinek, M.D.)
(Stacey A. Simons, M.D.)
(Mark J. Shuman, M.D.)
(Michael Steckbauer, M.D.)
(Jon Thogmartin, M.D.)

District 16
(Iouri G. Boiko, M.D. Ph.D.)
(Marlon S. Osbourne, M.D.)
(Mark J. Shuman, M.D.)

District 17
Iouri G. Boiko, M.D., Ph.D.
Alexander Blank, M.D.
Yanel De Los Santos, M.D.
Erin Ely, M.D.
Alexis Jelinek, M.D.
Gertrude M. Juste, M.D.
Brandon M. Maveal, M.D.
Stephen Robinson, M.D.
Sierra A. Shoham, D.O.
(Natalia Belova, M.D.)
(Kenneth Hutchins, M.D.)
(Benjamin Mathis, M.D.)
(Heidi L. Reinhard, M.D.)
(Tuyet Tran, D.O.)

District 18
John S. Daniel, M.D.
Matrina J. Schmidt, M.D.
(Patricia A. Aronica, M.D.)
(May Jennifer Amolat-Apiado, M.D.)
(Raman Baldzizhar, M.D.)
(Jacqueline A. Benjamin, M.D.)
(Barbara Bollinger, M.D.)
(Thomas M. Coyne, M.D.)
(Brandon Maveal, M.D.)
(Aaron J. Rosen, M.D.)
(Adrienne Sauder, M.D.)

District 19
Raman Baldzizhar, M.D.
Barbara Bollinger, M.D.
Stefanie J. Grewe, M.D.
Adrienne Sauder, M.D.
(Michael D. Bell, M.D.)
(Joseph M. Curran, M.D.)
(Marie H. Hansen, M.D.)
(Gertrude M. Juste, M.D.)
(Wendy A. Lavezzi, M.D.)
(Rebecca M. MacDougall, M.D.)
(Stephen J. Nelson, M.D.)
(Joshua D. Stephany, M.D.)
(Sajid S. Qaiser, M.D.)
(Mark J. Shuman, M.D.)
(Vera V. Volnikh, M.D.)
(Barbara C. Wolf, M.D.)
(Sara H. Zydowicz, D.O.)

District 20
Andrea N. Minyard, M.D.
(Michael D. Bell, M.D.)
(Rebecca A. Hamilton, M.D.)
(Emma O. Lew, M.D.)

District 21
Colin D. Appleford, D.O.
Noelia Alemar Hernandez, M.D.
Sarah C. Thomas, M.D.
(Michael D. Bell, M.D.)
(Manfred C. Borges, M.D.)
(Wilson A. Broussard, Jr., M.D.)
(Leszek Chrostowski, M.D.)
(Marta U. Coburn, M. D.)
(Riazul H. Imami, M.D., Ph.D.)
(Katherine L. Kenerson, M.D.)
(Rachel A. Lange, M.D.)
(Stephen J. Nelson, M.D.)
(Valerie J. Rao, M.D.)
(Mark J. Shuman, M.D.)
(Phoutthasone Thirakul, M.D.)
(Vera V. Volnikh, M.D.)

District 22
Omar Ansari, M.D.
Leszek Chrostowski, M.D.
Valerie J. Rao, M.D.
(Wilson A. Broussard, Jr., M.D.)
(Phoutthasone Thirakul, M.D.)
(Suzanne R. Utley-Bobak, M.D.)

District 23
Iana Lesnikova, M.D.
(James W. Fulcher, M.D.)
(Ruth Kohlmeier, M.D.)
(Roshan Mahabir, M.D.)
(Robert Pfalzgraf, M.D.)

District 24
ME Services Provided by District 5

District 25
ME Services Provided by District 9

Coverage Map

Florida Medical Examiner Districts

District 1
Escambia
Okaloosa
Santa Rosa
Walton

District 2
Franklin
Gadsden
Jefferson
Leon
Liberty
Taylor
Wakulla

District 3 **Covered by*
Columbia ***4***
Dixie ***8***
Hamilton ***4***
Lafayette ***2***
Madison ***2***
Suwannee ***2***

District 4
Clay
Duval
Nassau

District 5
Citrus
Hernando
Lake
Marion
Sumter

District 6
Pasco
Pinellas

District 7
Volusia

District 8
Alachua
Baker
Bradford
Gilchrist
Levy
Union

District 9
Orange

District 10
Hardee
Highlands
Polk

District 11
Miami-Dade

District 12
DeSoto
Manatee
Sarasota

District 13
Hillsborough

District 14
Bay
Calhoun
Gulf
Holmes
Jackson
Washington

District 15
Palm Beach

District 16
Monroe

District 17
Broward

District 18
Brevard

District 19
Indian River
Martin
Okeechobee
St. Lucie

District 20
Collier

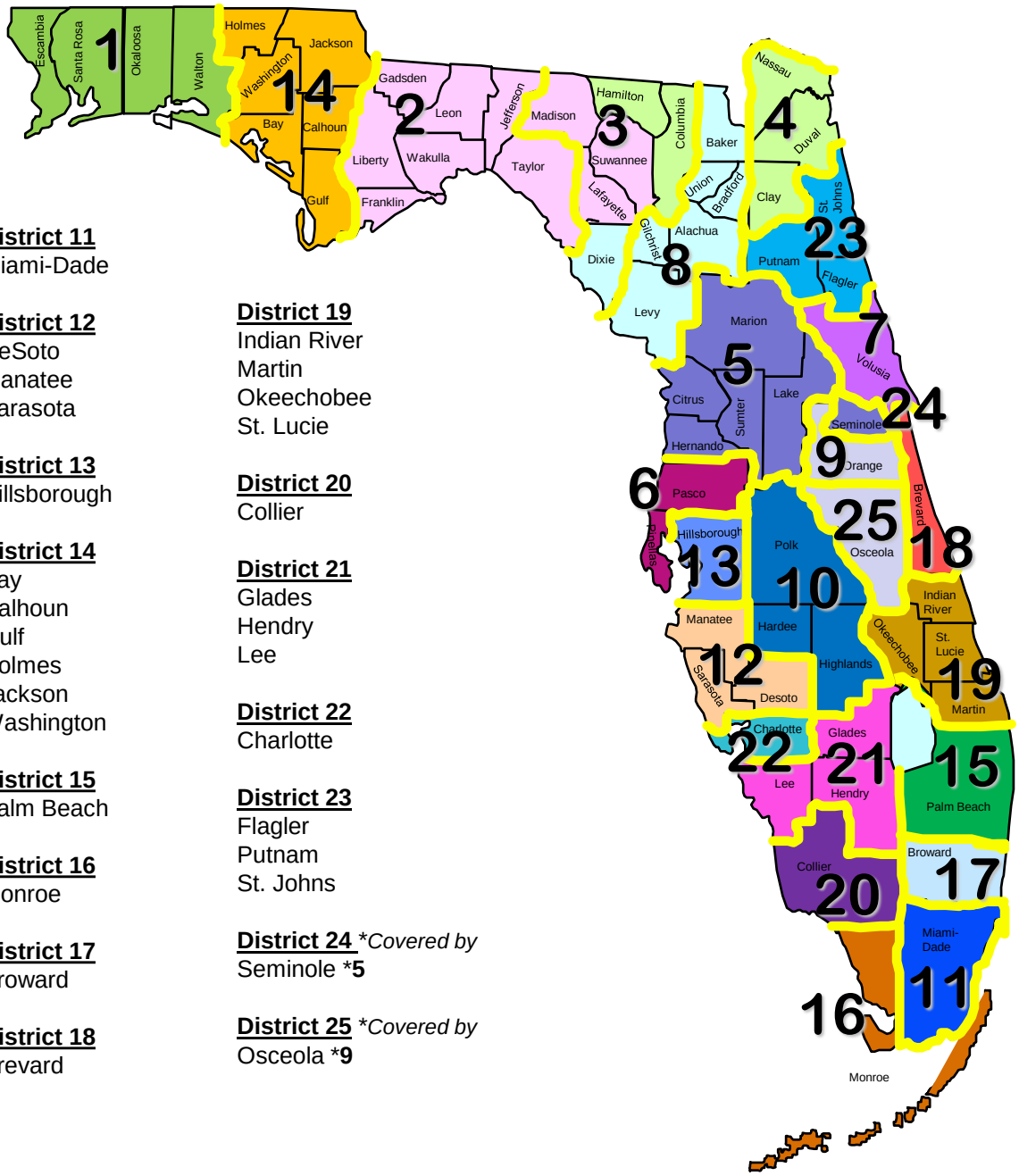
District 21
Glades
Hendry
Lee

District 22
Charlotte

District 23
Flagler
Putnam
St. Johns

District 24 *Covered by*
Seminole ***5***

District 25 *Covered by*
Osceola ***9***



By Senator Garcia

36-00570-26 2026188__

A bill to be entitled

An act relating to medical examiners' duties; amending s. 406.11, F.S.; defining terms; specifying autopsy requirements for certain cases involving sudden and unexpected deaths; requiring medical examiners to document certain information in the autopsy reports for such cases; requiring medical examiners to report specified cases to the national Sudden Unexpected Infant Death and Sudden Death in the Young Case Registry in accordance with protocols established by the Department of Health and the United States Centers for Disease Control and Prevention; requiring the department to impose certain administrative penalties against medical examiners for failure to report such cases in a specified timeframe; providing that compliance with specified provisions is deemed a permissible disclosure for purposes of state and federal medical privacy laws; providing an effective date.

WHEREAS, the United States Centers for Disease Control and Prevention operates the Sudden Unexpected Infant Death and Sudden Death in the Young Case Registry, a national surveillance program coordinated with the National Institutes of Health to establish a valuable repository of information for researchers studying the characteristics of sudden deaths in young individuals, and

WHEREAS, district medical examiners in this state are currently not required to report to the registry, resulting in

inconsistent data collection, and

WHEREAS, uniform reporting and the inclusion of relevant medical information, including recent immunizations and emergency countermeasures, are essential to strengthen public health research, identify risk factors, and improve prevention strategies, NOW, THEREFORE,

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsection (3) is added to section 406.11, Florida Statutes, to read:

406.11 Examinations, investigations, and autopsies.—

(3)(a) As used in this subsection, the term:

1. "Sudden Arrhythmic Death Syndrome(SADS)" means the sudden and unexpected death due to cardiac arrhythmia, as determined by performance of an autopsy or a clinical investigation, of a young, apparently healthy individual with no previously diagnosed structural heart disease.

2. "Sudden Death in the Young (SDY)" means the sudden and unexpected death of an individual younger than 20 years of age due to natural causes, including, but not limited to, sudden cardiac death or sudden unexpected death in epilepsy, which death remains unexplained after initial investigation.

3. "Sudden Infant Death Syndrome (SIDS)" means the sudden death of an infant younger than 1 year of age which remains unexplained after a thorough case investigation, including performance of an autopsy, scene investigations, and a review of clinical history.

4. "Sudden Unexpected Infant Death (SUID)" means the sudden

and unexpected death of an infant younger than 1 year of age, whether explained or unexplained, including, but not limited to, death caused by SIDS, accidental suffocation, and other potential causes.

5. "Sudden Unexpected Infant Death (SUID) and Sudden Death in the Young (SDY) Case Registry" means the national surveillance system coordinated by the Centers for Disease Control and Prevention and the National Institutes of Health which collects standardized data on sudden and unexpected deaths in individuals younger than 20 years of age.

(b) In the case of an infant or child who dies suddenly and unexpectedly, including cases of SIDS, SUID, or SDY, the autopsy must include microscopic and toxicology studies and a review of the child's immunization and medical records, as available through the state's immunization registry established pursuant to s. 381.003, from the child's pediatrician or primary care practitioner, or from other sources. The medical examiner shall document in the autopsy report any immunizations or emergency countermeasures administered to the child within 90 days before the child's death and report the case to the SUID and SDY Case Registry in accordance with protocols established by the Department of Health and the Centers for Disease Control and Prevention.

(c) In the case of a sudden death suspected to be caused by SADS in an individual of any age, the autopsy must include microscopic and toxicology studies and a review of the individual's immunization and medical records, as available through state health databases or other sources. The medical examiner shall document in the autopsy report any immunizations

or emergency countermeasures administered to the individual within 90 days before his or her death and report the case to the SUID and SDY Case Registry if the individual was younger than 20 years of age at the time of death, in accordance with protocols established by the Department of Health and the Centers for Disease Control and Prevention.

(d) The Department of Health shall impose the following administrative penalties against a district medical examiner who fails to report a case of SIDS, SUID, SDY, or SADS, for individuals younger than 20 years of age, to the SUID and SDY Case Registry within 30 days after completing the autopsy report:

1. For the first unreported case, a fine of up to $1,000.

2. For the second unreported case, a fine of up to $5,000.

3. For repeated noncompliance, referral to the Medical Examiners Commission for disciplinary action, which may include suspension or removal pursuant to s. 406.075.

(e) Compliance with the reporting and documentation requirements of this section is deemed a permissible disclosure under state and federal medical privacy laws, including the Health Insurance Portability and Accountability Act of 1996.

Section 2. This act shall take effect July 1, 2026.

By Senator Sharief

35-00071-26 202654__

A bill to be entitled

An act relating to the use of substances affecting cognitive function; creating s. 406.139, F.S.; defining the terms "mass shooting" and "psychotropic drug"; requiring medical examiners to take specified actions when performing an autopsy on a decedent reasonably suspected of committing a mass shooting; requiring that autopsy reports for such individuals include certain findings and information; providing construction; creating s. 901.225, F.S.; defining the terms "mass shooting" and "psychotropic drug"; requiring arresting law enforcement agencies to perform toxicology screenings of persons arrested on suspicion of committing a mass shooting or other violent crime; requiring that the results of the screening be noted in the suspect's case file; requiring law enforcement agencies to provide their law enforcement officers with certain training on the adverse effects of psychotropic drugs, illicit drugs, and controlled substances; amending s. 1006.07, F.S.; requiring school safety specialists to provide teachers with certain training on the adverse effects of psychotropic drugs, illicit drugs, and controlled substances; specifying requirements for the training; amending s. 1006.12, F.S.; requiring safe-school officers to complete certain training on the adverse effects of psychotropic drugs, illicit drugs, and controlled substances; specifying requirements for the training; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 406.139, Florida Statutes, is created to read:

406.139 Autopsies of suspected mass shooters.—

(1) DEFINITIONS.—As used in this section, the term:

(a) "Mass shooting" means an incident in which a person is suspected of intentionally causing the death of four or more individuals, not including the suspect, through the use of a firearm at a single location during a continuous period of time.

(b) "Psychotropic drug" means any drug prescribed to affect an individual's mental state, including, but not limited to, antidepressants, antipsychotics, mood stabilizers, and antianxiety medications.

(2) CONSULTATION; TOXICOLOGY SCREENING.—If a medical examiner's office performs an autopsy on a decedent reasonably suspected of committing a mass shooting, the medical examiner must do all of the following:

(a)1. Make reasonable efforts to determine the identity of any treating mental health professional or primary care physician of the decedent; and

2. Consult such individuals, if known and available, to obtain information regarding the decedent's history of psychotropic drug use, including any prescribed or discontinued medications.

(b) Order and perform toxicology screening on the decedent to determine whether any of the following are present in the decedent's body:

1. Psychotropic drugs.

2. Illicit drugs and controlled substances.

3. Alcohol or other substances commonly affecting cognitive function.

(3) AUTOPSY REPORT.—All findings under subsection (2) must be documented and included in the final autopsy report, along with any available corroborating information.

(4) PUBLIC RECORDS.—This section does not exempt any part of the autopsy report from public disclosure except as otherwise provided by state or federal law.

Section 2. Section 901.225, Florida Statutes, is created to read:

901.225 Toxicology screening of person arrested for mass shooting or other violent crime.—

(1) As used in this section, the term:

(a) "Mass shooting" means an incident in which a person is suspected of intentionally causing the death of four or more individuals, not including the suspect, through the use of a firearm at a single location during a continuous period of time.

(b) "Psychotropic drug" means any drug prescribed to affect an individual's mental state, including, but not limited to, antidepressants, antipsychotics, mood stabilizers, and antianxiety medications.

(2) If a person is arrested on suspicion of committing a mass shooting or other violent crime, the arresting law enforcement agency must perform a toxicology screening of the suspect for the presence of any psychotropic drugs, illicit drugs, controlled substances, alcohol, or other substances commonly affecting cognitive function. The law enforcement

agency shall note the results of the toxicology screening in the suspect's case file.

(3) All law enforcement agencies shall provide their law enforcement officers with training on the adverse effects of psychotropic drugs, illicit drugs, and controlled substances, including irrational, violent, or suicidal behavior that may be demonstrated by persons under the influence of such drugs or substances. The training must include instruction on how law enforcement officers can identify and safely interact with persons who may be under the influence of such drugs or substances to avoid violent escalation or exchanges.

Section 3. Paragraph (a) of subsection (6) of section 1006.07, Florida Statutes, is amended to read:

1006.07 District school board duties relating to student discipline and school safety.—The district school board shall provide for the proper accounting for all students, for the attendance and control of students at school, and for proper attention to health, safety, and other matters relating to the welfare of students, including:

(6) SAFETY AND SECURITY BEST PRACTICES.—Each district school superintendent shall establish policies and procedures for the prevention of violence on school grounds, including the assessment of and intervention with individuals whose behavior poses a threat to the safety of the school community.

(a) *School safety specialist.*—Each district school superintendent shall designate a school safety specialist for the district. The school safety specialist must be a school administrator employed by the school district or a law enforcement officer employed by the sheriff's office located in

the school district. Any school safety specialist designated from the sheriff's office must first be authorized and approved by the sheriff employing the law enforcement officer. Any school safety specialist designated from the sheriff's office remains the employee of the office for purposes of compensation, insurance, workers' compensation, and other benefits authorized by law for a law enforcement officer employed by the sheriff's office. The sheriff and the school superintendent may determine by agreement the reimbursement for such costs, or may share the costs, associated with employment of the law enforcement officer as a school safety specialist. The school safety specialist must earn a certificate of completion of the school safety specialist training provided by the Office of Safe Schools within 1 year after appointment and is responsible for the supervision and oversight for all school safety and security personnel, policies, and procedures in the school district. The school safety specialist, or his or her designee, shall:

1. In conjunction with the district school superintendent, annually review school district policies and procedures for compliance with state law and rules, including the district's timely and accurate submission of school environmental safety incident reports to the department pursuant to s. 1001.212(8). At least quarterly, the school safety specialist must report to the district school superintendent and the district school board any noncompliance by the school district with laws or rules regarding school safety.

2. Provide the necessary training and resources to students and school district staff in matters relating to youth mental health awareness and assistance; emergency procedures, including

active shooter training; and school safety and security.

3. Provide teachers with training on the adverse effects of psychotropic drugs as defined in s. 901.225, illicit drugs, and controlled substances, including the irrational, violent, or suicidal behavior that may be demonstrated by students under the influence of such drugs or substances. The training must include instruction on how teachers can identify and safely interact with students who may be under the influence of such drugs or substances, including de-escalation techniques to ensure student and teacher safety.

4. Serve as the school district liaison with local public safety agencies and national, state, and community agencies and organizations in matters of school safety and security.

5.~~4.~~ In collaboration with the appropriate public safety agencies, as that term is defined in s. 365.171, by October 1 of each year, conduct a school security risk assessment at each public school using the Florida Safe Schools Assessment Tool developed by the Office of Safe Schools pursuant to s. 1006.1493. Based on the assessment findings, the district's school safety specialist shall provide recommendations to the district school superintendent and the district school board which identify strategies and activities that the district school board should implement in order to address the findings and improve school safety and security. Each district school board must receive such findings and the school safety specialist's recommendations at a publicly noticed district school board meeting to provide the public an opportunity to hear the district school board members discuss and take action on the findings and recommendations. Each school safety

specialist, through the district school superintendent, shall report such findings and school board action to the Office of Safe Schools within 30 days after the district school board meeting.

6.~~5.~~ Conduct annual unannounced inspections, using the form adopted by the Office of Safe Schools pursuant to s. 1001.212(13), of all public schools, including charter schools, while school is in session and investigate reports of noncompliance with school safety requirements.

7.~~6.~~ Report violations of paragraph (f) by administrative personnel and instructional personnel to the district school superintendent or charter school administrator, as applicable.

Section 4. Subsection (6) of section 1006.12, Florida Statutes, is amended to read:

1006.12 Safe-school officers at each public school.—For the protection and safety of school personnel, property, students, and visitors, each district school board and school district superintendent shall partner with law enforcement agencies or security agencies to establish or assign one or more safe-school officers at each school facility within the district, including charter schools. A district school board must collaborate with charter school governing boards to facilitate charter school access to all safe-school officer options available under this section. The school district may implement any combination of the options in subsections (1)-(4) to best meet the needs of the school district and charter schools.

(6) CRISIS INTERVENTION TRAINING; SUBSTANCE USE TRAINING.—

(a) Each safe-school officer who is also a sworn law enforcement officer shall complete mental health crisis

intervention training using a curriculum developed by a national organization with expertise in mental health crisis intervention. The training must improve the officer's knowledge and skills as a first responder to incidents involving students with emotional disturbance or mental illness, including de-escalation skills to ensure student and officer safety.

(b) Each safe-school officer shall complete training on the adverse effects of psychotropic drugs as defined in s. 901.225, illicit drugs, and controlled substances, including the irrational, violent, or suicidal behavior that may be demonstrated by students under the influence of such drugs or substances. The training must include instruction on how a safe-school officer can identify and safely interact with students who may be under the influence of such drugs or substances and improve upon the officer's knowledge and skills as a first responder to incidents involving such students, including de-escalation skills to ensure student and officer safety.

If a district school board, through its adopted policies, procedures, or actions, denies a charter school access to any safe-school officer options pursuant to this section, the school district must assign a school resource officer or school safety officer to the charter school. Under such circumstances, the charter school's share of the costs of the school resource officer or school safety officer may not exceed the safe school allocation funds provided to the charter school pursuant to s. 1011.62(12) and shall be retained by the school district.

Section 5. This act shall take effect July 1, 2026.

THE STATE OF FLORIDA

FATALITY MANAGEMENT RESPONSE PLAN

of the FLORIDA MEDICAL EXAMINERS COMMISSION

Version 8.0 ~~7.0~~
~~February 4,~~
TBD 2026~~5~~

(To supplement the State Comprehensive Emergency Management Plan)

TABLE OF CONTENTS

I. Authority ~~3~~ 3
II. Responsibility ~~3~~
III. Plan Revision History ~~3~~
IV. Introduction ~~3~~
V. Concept of Operations ~~5~~
A. General ~~5~~
B. Organization 7
C. Notifications 8
D. Actions 9
E. Direction and Control 11
VI. Responsibilities - Medical Examiner 12
A. Tracking System 12
B. Remains Recovery 14
C. Initial Holding Morgue Operations 14
D. Pre Processing Transportation and Storage 15
E. Morgue Operations 15
F. Post Processing Transportation and Storage 18
G. Body Release for Final Disposition 18
H. Victim Information Center Support 19
I. Records Management (Victim Processing) 20
J. Records Management (Accounting and Finance) 21
K. Progress Reports and Public Information 21
VII. Multiple District Incident Coordination 23
A. Definition 23
B. Jurisdiction for Issuance of Death Certificate 23
C. Coordination of Resources 23
VIII. Mass Disposition of Human Remains (Rational for Identification before Disposition) 24
A. Governmental Authority 24
B. Epidemic Outbreak Myth 24
C. Identification of Victims Before Disposition 25
IX. References 26
X. Statutory Citations 26
XI. Medical Examiner Districts 26
XII. Fatality Management Branch ICS Organization Charts 28
Command 28
Recovery Unit 29
Morgue Unit 30
Victim Information Center (VIC) Unit 31
Morgue Identification Center (MIC) Unit 32
Logistics Group (includes the DPMU or Disaster Portable Morgue Unit) 33

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial, 12 pt

Formatted: Font: (Default) Arial, 12 pt

I Plan Authority

The Medical Examiners Act, Chapter 406, Part I, Florida Statutes, was enacted by the 1970 Legislature in order to establish minimum and uniform standards of excellence in statewide medical examiner services. The Florida ~~—~~Medical Examiners Commission provides guidance for districts throughout the state pursuant to its charge to initiate cooperative policies with any agency of the state or political subdivision thereof.

Under Chapter 406.11, Florida Statute, specific death scenarios fall under the jurisdiction of the medical examiner. Such scenarios include deaths resulting from accidents, homicides, suicides, and certain natural deaths which could include those constituting a threat to public health. The range of circumstances includes both man-made and natural disasters.

In addition, Chapter 11G, Florida Administrative Code, the rules of the Medical Examiner Commission, also provides specific guidelines and mandates certain procedures that should be considered even when dealing with a disaster.

II Plan Responsibility

The Florida Medical Examiners Commission has the responsibility to produce and maintain this State of Florida Fatality Management Response Plan.

III Plan Revision History

Version 1, Adopted at the Medical Examiner's Commission meeting of ~~January~~ Jan 17, 2007
Version 2, Adopted at the Medical Examiner's Commission meeting of May 21, 2010
Version 3, Adopted at the Medical Examiner's Commission meeting of May 25, 2012
Version 4, Adopted at the Medical Examiner's Commission meeting of May 4, 2018
Version 5, ~~-~~Adopted at the Medical Examiner's Commission meeting of ~~December~~ Dec 20, 2020
Version 6, Adopted at the Medical Examiner's Commission meeting of July 19, 2023
Version 7, Adopted at the Medical Examiner's Commission meeting of May 13, 2025.

IV Introduction

The focus of this plan is to identify methods through which medical examiners may obtain support assets to accomplish the goals of identifying the deceased and arranging proper final disposition. No attempt is made here to create a one- size-fits-all operational set of procedures, as each district is unique. Rather, it presents major categories of service response that must be adapted to the nature of disasters ranging from naturally occurring events (hurricanes, floods, fires, etc.) to manmade events including delivery of weapons of mass destruction (bomb/blast, chemical, nuclear, or biological). Natural disease outbreaks occurring under normal circumstances (e.g. not terrorist related) do not normally fall under the jurisdiction of the medical examiner. Planning for such outbreaks is covered in the

Formatted: Justified
Formatted ...
Formatted: Justified, Space Before: 0 pt
Formatted ...
Formatted: Justified
Formatted ...
Formatted ...
Formatted ...
Formatted ...
Formatted: Left
Formatted ...

Florida Natural Disease Outbreak and the Pandemic Influenza Fatality Management Response Plan (2008).

Support assets are provided to the medical examiner via the system of a County-level Emergency Operations Center's Emergency Support Function 8 (ESF-8) – Health and Medical Services. The purpose of ESF-8 is to coordinate the State's health, medical, and limited social service assets in case of an emergency or disaster situation. This includes adoption of a Catastrophic Incident Response Plan for response to events that create excessive surge capacity issues for pre-hospital, hospital, outpatient, and mortuary services. The Fatality Management Response Plan addresses mortuary surge capacity issues and methods to respond to and mitigate such issues.

~~The main rule of thumb for~~ The sequence for requesting support assets calls for exhausting local assets (city and/or county) before requesting state assets. Likewise, state assets ~~need to~~ should be exhausted before requesting federal assets.

There are two primary state-level teams, and one federal--level team, ~~organizations~~ that can provide major resources to a medical examiner district when having to deal with an incident that exceeds the assets of ~~the~~ local city, county, and state government.

The first is the Florida Emergency Mortuary Operations Response System (FEMORS) which is a State of Florida asset sponsored by the Florida Department of Health (ESF 8) that may be requested by the medical examiner when the Governor has issued an Executive Order declaring a state of emergency. It may also be requested in the absence of a declared emergency ~~as evidenced by the Jan 29, 2012 eleven fatality vehicular crash incident on Interstate 75 in Gainesville.~~ However, in such non-declaration cases the local government issuing the request would be responsible for reimbursing the State agency deploying FEMORS for costs incurred.

Another asset located within the state of Florida is the Florida Air National Guard, Fatality Search and Recovery Team (FSRT). This asset can be deployed by the National Guard (ESF 13) and FSRT members can provide field search and recovery, transport, and limited refrigerated human remains storage. FSRT members are not forensic scientists or crime scene analysts, and do not provide disaster victim identification services.

~~The federal asset is the National Disaster Medical System's~~ ~~The second is the federal government's~~ Disaster Mortuary Operational Response Team (DMORT). When a federal declaration has been made concerning a local disaster a request can be made via ESF 8 to deploy a DMORT team~~'s~~ (personnel and equipment) ~~can be deployed~~ to the disaster site.

The major distinction between ~~the two~~DMORT and FEMORS is that FEMORS respond more quickly and can ~~reasonably expect to~~ staff and manage an incident ~~event~~ for approximately 30 to 6040 days. If the activation period is anticipated to require a longer support time, DMORT may be called upon to assist. Any transitional change would not impact disaster operations and be totally seamless since both FEMORS

Formatted: Font: 12 pt, Condensed by 0.05 pt
Formatted: Body Text, Indent: Left: 0.59", Right: 0.28", Space Before: 0 pt
Formatted: Condensed by 0.05 pt
Formatted: Condensed by 0.05 pt
Formatted: Condensed by 0.05 pt
Formatted: Condensed by 0.05 pt
Formatted: Condensed by 0.05 pt
Formatted: Condensed by 0.05 pt
Formatted: Left, Right: 0.28", Space Before: 0 pt
Formatted: Condensed by 0.05 pt
Formatted: Condensed by 0.05 pt
Formatted: Condensed by 0.05 pt
Formatted: Left
Formatted: Font: 11.5 pt
Formatted: Font: 11.5 pt, Not Expanded by / Condensed by
Formatted: Font: 11.5 pt
Formatted: Font: 11.5 pt, Not Expanded by / Condensed by
Formatted: Font: 11.5 pt
Formatted: Font: 11.5 pt

and DMORT have a similar operational plan and equipment. ~~organizational models are very similar.~~

FEMORS can assist the medical examiner with an incident assessment within 2-4 hours~~,~~ and be onsite and operational in 1 to ~~2~~3 days. DMORT can take several days to arrive on site and commence operations,~~longer~~, especially for a no-notice event ~~such as an explosion~~.

Both teams can provide an incident morgue with all ~~of~~ its ancillary equipment and staffing of various forensic teams within the morgue (i.e. pathology, personal effects, evidence collection, radiology, fingerprints, odontology, anthropology, and DNA collection~~, and embalming)~~. They also may assist in initial scene evaluation, recovery of human remains, collection of missing person information, victim identification, records management, and disposition of human remains.

Formatted: Font: 11.5 pt, Not Highlight

Formatted: Font: 11.5 pt

Formatted: Font: 11.5 pt

V Concept of Operations

A. General

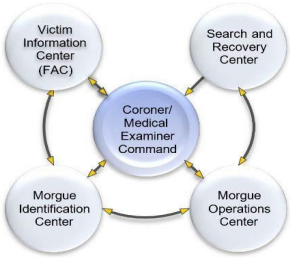
1. Mass fatality incidents ~~disasters~~ have the potential to quickly overwhelm the resources of a medical examiner's operation depending on the capacity of the facility ~~and~~ the number of ~~fatalities~~fatalities, and the condition of the human remains. Medical Examiner Offices that are overwhelmed may seek assistance at local, state, and federal levels.

2. Disaster incidents ~~situations~~ may range from just a few victims to very high numbers. Additionally, the incident ~~event~~ may involve one or more of the following complications:
   a. Biological agent exposure events resulting in infectious or toxic agent contaminated victims,
   b. Bomb/Blast events resulting in burned and fragmented human remains,
   c. Chemical exposure events resulting in hazardous material contaminated victims,
   d. Radiological exposure events resulting in radiation material contaminated victims.
   e. Transportation accidents resulting in fragmented human remains,
   f. Weather events resulting in drowning and blunt trauma victims, or
   g. Natural disease outbreaks.

3. These complications can arise regardless of whether the event was an act of nature, a minor or catastrophic accident, a terrorist act, an outbreak of infectious disease, or the intentional release of a weapon of mass destruction.

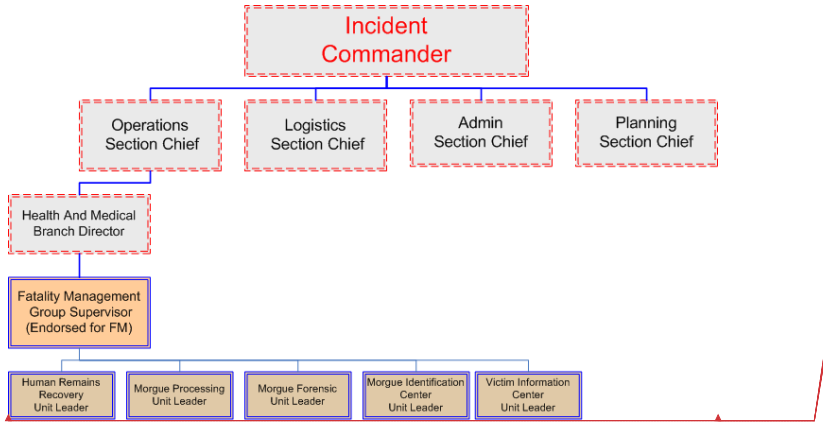
4. Deaths resulting from acts of homicide, suicide, or accident, and those constituting a threat to public health, fall under the jurisdiction of the medical examiner (Chapter 406.11, Florida Statutes). For this reason, the medical examiner assumes custody of any such death to determine the cause of death, document identity, and initiate the death certificate.

5. The five primary functions of the Fatality Management mission are:
   a. Command/Control,
   b. Recovery,
   c. Morgue (post-mortem processing),
   d. Victim Information (ante-mortem processing), and
   e. Identification confirmation.



6. Management of the overall disaster is accomplished using the Incident Command System (ICS) as codified by the National Incident Management System (NIMS). The primary functions of Command, Operations, Planning, Logistics, and Administration/Finance are the foundation of a

scalable platform that can expand or contract as the scope of the disaster dictates. Typically, under the Operations Section Chief, there will be a Health and Medical *Branch Director* managing a variety of *Group Supervisors* such as *for* Medical Response/EMS, Sheltering, Special Needs, **Fatality Management**, and others.



7. The medical examiner (serving as the ***Fatality Management*** *Group Supervisor*) may obtain additional resources by identifying equipment and personnel assets needed to manage the surge of deceased victims and channeling those requests through the local Emergency Operations Center. This would include specialized state and federal assets to assist with decontamination of victims of exposure to chemical, radiological, or biological agents.

8. Normally the local or State Emergency Operations Center processes such requests through its ESF-8 desk. Except in rare circumstances involving military or certain federal employees, the medical examiner retains control of, and responsibility for, handling the deceased. All assets activated to assist with fatality management operate under the direction of the medical examiner. Once the requested assets arrive, the medical examiner has the responsibility to coordinate, integrate, and manage those assets. ~~(Capstone)~~

~~9.~~ Resources available for activation may also include ~~provide~~ personnel experienced in Incident Command System operations capable of augmenting the medical examiner's staff in certain management functions and providing valuable liaison services to Incident Command and the ESF-8 desk. For example, the medical examiner may delegate the role of serving as the Fatality Management Group Supervisor to a member of the FEMORS team.

Formatted: Not Expanded by / Condensed by
Formatted: Font: Italic, Not Expanded by / Condensed by
Formatted: Font: Italic, Condensed by 0.05 pt
Formatted: Font: Bold
Formatted: Font: 12 pt, Italic
Formatted: Font: 12 pt, Italic
Formatted: Condensed by 0.05 pt
Formatted: Font: Italic
Formatted: Not Highlight
Formatted: Condensed by 0.05 pt
Formatted: Not Highlight
Formatted: Condensed by 0.05 pt
Formatted: Not Highlight
Formatted: Condensed by 0.05 pt
Formatted: Font: Not Bold, Not Italic
Formatted: Font: Not Bold, Not Italic, Condensed by 0.05 pt
Formatted: Font: Not Bold, Not Italic
Formatted: Font: Not Italic, Condensed by 0.05 pt
Formatted: Not Highlight

B. Organization

PRIMARY AGENCY:

Florida Department of Health

SUPPORT AGENCIES:

Florida Department of Law Enforcement (FDLE)
Florida Medical Examiners Commission (MEC)
Florida Emergency Mortuary Operations Response System (FEMORS)
Florida Air National Guard Fatality Search and Recovery Teams

FEDERAL AGENCIES:

Department Health and Human Services, National Disaster Medical System (NDMS) which provides:

- Disaster Mortuary Operational Response Team (DMORT) ~~and~~
- ~~Weapons of Mass Destruction (WMD) Team~~

1. Florida's Department of Health is designated as the lead agency for providing health and medical services under ESF-8. The roles of the primary and support agencies are enumerated in the state's Comprehensive Emergency Management Plan, specifically in Appendix VIII: ESF-8 – Public Health and Medical Services.

2. When necessary, federal ESF-8 resources will be integrated into the state ESF-8 response structure.

3. Local Health Departments and Emergency Operations Centers operate at the county level in each of Florida's 67 counties.

4. Medical Examiners operate under a district system whereby they exercise authority for a single county or multiple counties. The 25 districts are covered by 22 medical examiner offices because Districts 2, 4, and 8 cover District 3 (Columbia, Dixie, Hamilton, Lafayette, Madison, and Suwannee Counties), District 5 (Lake County)~~7 (Volusia county)~~ covers District 24 (Seminole County), and District 9 (Orange County) covers District 25 (Osceola County). (*See Section XI – Medical Examiner Districts.*)

5. The Florida Medical Examiners Commission provides oversight for districts throughout the state. In the absence of other reporting procedures, the Commission serves as the information clearinghouse on the status of reported fatalities due to a disaster.

6. Regional Domestic Security Task Forces (RDSTF) operate at a regional level with the State divided into 7 regions covering multiple counties each. Each RDSTF Region covers several medical examiner offices (while 5 medical examiner districts are covered by more than one RDSTF Region).

Formatted: Not Highlight
Formatted: Condensed by 0.05 pt
Formatted: Not Highlight
Formatted: Indent: First line: 0", Right: 0.25"
Formatted: Not Highlight
Formatted: Font: Italic

RDSTFs provide the law enforcement oversight for disasters and incorporate both local and state law enforcement agencies as well as ancillary agencies including fire service, search and rescue, health and medical services, and others. RDSTFs support the emergency management structure established for the disaster. This may be a single county Emergency Operation Center or, in the case of a multi-jurisdictional event, a Joint Emergency Operation Center as well as the State Emergency Operation Center. Close coordination of the medical examiner's role of processing human remains with law enforcement's role of investigating the incident ~~event~~ and tracking missing person reports is essential throughout the response effort.

7. Florida's Emergency Mortuary Operations Response System (FEMORS) is a team of qualified "reserve" forensic professionals who can be deployed by ESF-8 to supplement the needs of the medical examiner(s) affected by a mass fatality incident~~event~~. FEMORS is a sponsored activity of the University of Florida in collaboration with the Florida Department of Health.~~Maples Center for Forensic Medicine.~~

Formatted: Not Highlight

C. Notifications

1. Medical examiner notification to the local Emergency Operations Center is the first step in obtaining supplemental resources. If not already activated by another method of notification, this action results in contact through the State Warning Point to activate the State Emergency Operations Center.

2. Disaster notification to the medical examiner will normally come through routine law enforcement, emergency operations center channels, or news media broadcasts in advance of a request to respond to recover human remains. In rare cases, it is possible that the medical examiner would be the first to recognize a cause of death indicating a potential weapon of mass destruction release. In such an event, the medical examiner would be the one to initiate notification of appropriate authorities.

3. During an activation of the State Emergency Operations Center, the primary and support agencies of ESF-8 report ~~respond~~ directly to the Emergency Services Branch Chief who reports to the Operations Section Chief (see Chapter 4, Section M of the Basic CEMP).

4. State Emergency Operations Center activation of ESF-8 may result in immediate activation of an assessment team from FEMORS (or another fatality management support organization such as DMORT) that can initiate contact to ~~offer assistance to~~help the medical examiner in assessing the scope of the disaster and identifying assets required to process human remains.

D. Actions

1. Once notification is made of an ~~event~~ incident with a potential for significant loss of life, a medical examiner should attempt to assess the scope of the incident ~~event~~ and anticipate levels of additional resources that might be needed. This could include:
   a. modification of routine workflow within the facility to permit processing and segregation of daily casework from disaster-related victims;
   b. possible supplemental space and equipment requirements for refrigerated storage;
   c. temporary staff and supply increases to respond to the surge ~~event~~incident; and,
   d. if the facility has been damaged by the ~~event~~incident (e.g., hurricane, flood, etc.), consideration of location for placement of a temporary base of operations either adjacent to, or remote from, the damaged morgue facility.

2. Upon notification by a medical examiner of a request for assistance, ESF-8 may notify and activate an assessment team ~~-~~from~~of~~ FEMORS (or another fatality management support organization such as DMORT) to assist the medical examiner in assessing the situation.
   a. In the event of a known impending event like a hurricane, ESF-8 normally places the fatality management support organization on ALERT for possible activation.
   b. FEMORS activates its internal notification system to establish a Ready List of members capable of responding if needed.

3. FEMORS initiates contact with the medical examiner by telephone or in person, within 4 hours if possible, to ascertain if help is needed or to arrange for an appropriate meeting location.

4. Simultaneously, FEMORS initiates its Everbridge ~~telephone~~ notification process to assemble a list of members capable of responding within 24 hours, if needed.

5. If needed, FEMORS assists the medical examiner in planning for:
   a. special processing complications such as protection from chemical exposure of responders and decontamination of recovered remains prior to transportation to a temporary morgue site, if applicable;
   b. disaster site management of human remains with regard to recovery, preliminary documentation procedures, and refrigerated storage until transportation can be arranged;
   c. supplemental or temporary morgue operations for postmortem examination either in concert with the existing medical examiner facility or at a remote location with a Disaster Portable Morgue Unit setup;

Formatted: Not Highlight

Formatted: Not Highlight

d. supplemental refrigerated storage at the morgue both for remains received from the disaster site and for remains processed and awaiting release for disposition;
e. victim information center operations at a site removed from both the disaster site and the morgue; and
f. records management and computer networking for managing data generated about missing persons and remains processed.

6. The medical examiner, or designee, reports the assessment results back to ESF-8 to specify:
   a. estimated number of human remains to be processed if possible,
   b. types and number of personnel and equipment that will be needed,
   c. staging area(s) for arriving assets,
   ~~c.~~d. location for establishment of operations for each function needed, and
   ~~d.~~e. any special safety issues to advise responding personnel.

7. ESF-8 documents the medical examiner's requests for equipment assets, types and numbers of support personnel, ~~and~~ staging area instructions, and operational locations.

8. As directed by ESF-8, FEMORS contacts and activates the types and number of personnel requested by the medical examiner with instructions on staging areas and planned time of arrival.

9. ESF-8 initiates arrangements for travel, if necessary, and accommodations for responding personnel.

10. For any equipment requested that is not part of FEMORS response, ESF-8 initiates contact with appropriate vendors to supply equipment such as refrigerated trucks, x-ray machines and processors, etc.

~~11.~~ In the event the resources required for response to the disaster exceed the capabilities of FEMORS, or if decontamination of human remains is needed, ESF-8 initiates contact with appropriate HazMat decontamination teams or the Federal Department of Health and Human Services (HHS) to request the assistance of the Disaster Mortuary Operational Response Team (DMORT) and/or support from a federal decontamination team such as National Guard CBRNE teams.~~Weapons of Mass Destruction (WMD) Team.~~

Formatted: Not Expanded by / Condensed by

Formatted: List Paragraph, Justified, Don't adjust space between Latin and Asian text, Don't adjust space between Asian text and numbers, Tab stops: 1.48", Left

Formatted: Not Highlight

E. Direction and Control

1. All management decisions regarding response assets and resources are made at the State Emergency Operations Center by the Department of Health Emergency Coordination Officer.

2. Management of fatality related operations under the direction of the district medical examiner or designee is coordinated with the ~~field~~ Incident Commander or Unified Command. FEMORS' assets assigned to the medical examiner remain under the medical examiner's direction and may be used in any way to supplement the medical examiner's operations including liaison with the Incident Commander or Unified Command.

3. Volunteers and volunteer groups ~~and individuals~~ may also offer services to assist the medical examiner. Traditionally, this includes forensic pathologists from other districts, forensic anthropologists, and members of various funeral associations and dental societies. Experienced forensic pathologists can be appointed as Associate Medical Examiners pursuant to Chapter 406.06(2), Florida Statutes. Funeral service personnel can be a valuable asset to provide, at a minimum, additional staff to serve as "trackers" to monitor custody and processing steps for each set of remains through the morgue process. Likewise, dental personnel, even if they possess no forensic experience, can assist forensic odontologists in several ~~a number of~~ areas. It should be noted that:
   a. Members of FEMORS are provided liability coverage for worker's compensation and professional liability issues by activation as temporary employees of the University of Florida.
   b. For such volunteers who are not members of FEMORS, the medical examiner should ensure that each volunteer acknowledges a liability waiver for work-related injury and registers in for each period of service.

4. Regardless of the source of personnel (in-house, state or federal supplemental, or volunteer) detailed time records must be maintained to document the nature and periods of duty for each ~~and every~~ person assisting during the operation.

VI Responsibilities - Medical Examiner

The medical examiner is responsible for managing several operations that target the ultimate goals of identifying the dead, determining the forensic issues related to the cause and manner of death, and returning human remains to families, if possible.

In a disaster situation, in addition to notification, evaluation, and planning, incident specific caseload management consists of coordinating multiple functional areas.

- **A.** Tracking System Activation
- **B.** Remains Recovery
- **C.** Holding Morgue Operations
- **D.** Pre-Processing Transportation and Storage
- **E.** Morgue Operations (postmortem identifier collection)
- **F.** Post-Processing Transportation and Storage
- **G.** Body Release for Final Disposition
- **H.** Victim information Center Support (antemortem identifier collection)
- **I.** Records Management (Victim Processing)
- **J.** Records Management (Accounting and Finance)
- **K.** Progress Reports and Public Information Dissemination

A. Tracking System

When implementing a tracking system for recovery, the medical examiner should consider where remains are found, how fragmented portions are tracked, how case numbers are correlated, and how ante-mortem data (obtained from family members) can be cross referenced with other case numbers assigned to recovered remains. The tracking system should include a means for distinguishing disaster cases from other caseloads, it should also enable the cross sharing of data between several operational areas, such as, the morgue, the Victim Information Center, the incident site, or any location where case data is entered. (~~Capstone~~) Each set of remains processed will generate numerous items that need to be tracked by computer such as photographs, personal effects, tissue samples, etc.

Whether FEMORS, DMORT or another fatality management support organization is activated to assist the medical examiner, a Victim Identification Program (VIP) or similar database can be used to track and search for potential matching indicators. VIP stores known victim information provided by families at the Victim Information Center and data generated in processing the remains in the morgue. Likewise, both assets utilize a dental matching program called WinID to compare ante mortem dental records with post–mortem dental data obtained during the processing effort.

The American Academy of Forensic Sciences, Academy Standards Board has published ANSI/ASB Best Practice Recommendation 108. Forensic Odontology in Disaster Victim Identification: Best Practice Recommendations for the Medicolegal Authority. This document is maintained, updated, and can be found at https://femors.org/downloads/ (on FEMORS' website).

Formatted: Not Highlight

Formatted: Body Text, Left, Indent: Left: 0.59", Right: 0.07"

Formatted: Condensed by 0.05 pt

Formatted: Not Highlight

An accurate and reliable numbering system for all human remains (especially fragmented human remains) is crucial to an effective mission. The system must conform to the needs of the local medical examiner as well as be sufficient for proper evidence tracking. *In the absence of an established medical examiner system* the following guidelines may be employed, in part or in whole as deemed necessary by the medical examiner. There are several places where the numbering system must be carefully managed. The primary focus of all numbering is to end up with a **unique medical examiner case number** assigned for every case in which a *Death Certificate* issued.

1. Field or Disaster Site - The numbering system starts in the field.
   a. It should always be consecutive and non-repeating. A simple system is preferred (e.g., Bag 1, Bag 2, Bag 3, etc.).
   b. Prefixes MAY be used to clarify where they were found (e.g. F-1 for floating remains in the water, S-1 for submerged remains, Grid B-3, etc.). This is particularly important when remains are recovered simultaneously from multiple sites.
   c. In the field, all individual remains must be given their own unique reference number.
   d. If remains are not connected by clothing or tissue, they must be packaged separately and assigned different and unique reference numbers.

2. Morgue Operations -
   a. Often it is preferable to assign the unique Morgue Reference Number (MRN) once remains are received at the incident morgue. Although tracking starts at the point of recovery, it is better if an official case number is assigned at the location where remains are actually processed rather than at the recovery point(s), because co-mingled fragmentary remains may need to be separated and treated as multiple cases, versus one case.
   b. If appropriate, the MRN and suffixes may be used to further identify multiple items related to the same MRN.
      - Because of the way computers store and retrieve data, it is important to include the leading zero for numbers 01 through 09.
      - Summary of possible case numbering suffixes that may be applied (including the leading zero for numbers 01 through 09):
        - DM01 Digital Media
        - DP01 Digital Photos
        - PE01 Personal Effects
        - BX01 Body Radiographs~~X-rays~~
        - CT01 CT Scans
        - FP01 Fingerp ~~P~~rints
        - DX01 Dental Radiographs~~X-rays~~
        - DN01 DNA Specimens (post-mortem)
        - DB01 DNA Family Samples (Buccal swabs)
        - DR01 DNA Reference Specimens (known victim DNA)

Formatted: Not Highlight

Formatted: Not Expanded by / Condensed by

Formatted: Not Highlight

3. Identified Remains Case Number Conventions
   a. For death certificate purposes, each death requires one medical examiner case number.

~~b.~~a. The medical examiner may elect to enter identified remains in the district's existing computerized case file management system for that office after one or more MRN case files have been matched to a Reported Missing (RM) case file. Thus, a "Medical Examiner Case Number" may be issued.
- Cross reference notes should be made to indicate which Reported Missing (RM) case and MRN case(s) are associated with the master case number.
- Multiple MRN cases (fragmented remains) ~~–~~may be matched by dental ~~or DNA~~, DNA, or other unique feature ~~identification~~ to one individual.

~~c.~~b. The medical examiner may elect to use the first MRN identified with a particular Reported Missing (RM) as the PRIMARY number.
- Additional MRN cases identified as the same individual may be cross-referenced to the primary MRN for tracking purposes.
- Logs of MRN numbers should be updated to reflect the primary and secondary links for tracking purposes.

~~c~~c. The primary MRN will often be used to issue the **unique medical examiner case number** assigned for every case in which a *Death Certificate* issued.

Formatted: Not Expanded by / Condensed by
Formatted: Not Highlight
Formatted: Left, Right: 0.08", Space Before: 0.2 pt, Tab stops: Not at 1.58"

B. Remains Recovery

Management of mass fatality disasters begins at the scene. The medical examiner's accurate determination of the cause and manner of death, documentation of a victim's identity, and return of remains to families is dependent on the quality of the recovery effort. Except for ~~With the exception of~~ obvious weather caused incidents~~events~~, disaster sites should be considered and treated as crime scenes from the outset. The nature of the disaster site will dictate how the medical examiner coordinates with law enforcement and fire service personnel to locate, document, store, and transport victim remains.

The American Academy of Forensic Sciences, Academy Standards Board has published ANSI/ASB Best Practice Recommendation 008, Mass Fatality Scene Processing: Best Practice Recommendations for the Medicolegal Authority. This document is maintained, updated, and can be found at https://femors.org/downloads/ (on FEMORS' website).

Formatted: Not Highlight
Formatted: Left
Formatted: Not Highlight
Formatted: Not Highlight

If the site involves any form of hazardous contamination, it may be necessary to form a multidisciplinary team to evaluate the incident. The team should include:
1. HazMat, and any other relevant agencies (check required level of PPE),
2. Medical Examiner Death Investigation ~~death investigation~~ personnel, and
3. L~~l~~aw enforcement.

Recovery efforts must protect the health and welfare of recovery responders.

Formatted: Not Highlight

In the event of a disaster involving contaminated human remains, it may be necessary to request activation of the National Guard CBRNE teams, ~~the~~ local

HazMat teams, or a similar asset capable of decontaminating the remains before they are admitted to the morgue for processing.

C. Initial Holding Morgue Operations

Once remains have been recovered at the disaster site, an initial physical examination by medical examiner, law enforcement, or other appropriate personnel may be necessary at the scene prior to a more extensive external and internal examination at the morgue.

1. At the very least, remains must be documented for tracking purposes as they are recovered and placed in a transportation staging area.
2. In some circumstances, personnel may need to gather evidence, ~~and~~ document, remove, and track personal effects before remains are transferred for autopsy or identification.
3. In other cases involving contamination, remains may need to be decontaminated before they are transported to the morgue. Because the set up for a decontamination unit may take 48-72 hours to become fully operational, refrigerated storage of remains at the incident site may become necessary.
4. The type of disaster will determine the extent of the initial holding/incident morgue operation.

D. Pre-Processing Transportation and Storage

The number of fatalities may necessitate the expansion of the medical examiner's transportation, storage, and morgue systems.

1. To expand their refrigerated storage capabilities, medical examiners may need to incorporate the use of supplemental refrigeration (such as refrigerated trailer units).
2. Where possible, electric power should be utilized to run the refrigerated units instead of diesel power which creates ~~highly~~ toxic exhaust fumes.
3. The use of mobile refrigerated units for temporary staging storage at the disaster site can also be used to transport remains to a high-capacity medical examiner facility (even if outside the district).
4. Another option is to cool a suitable storage area to below 40° F (but above 32°F) with an industrial air conditioning unit.
5. Remains delivered from the incident site for processing must be kept segregated from remains already processed.
6. During the transporting and storing process, human remains should not be stacked upon one another or face down. They may be stored on shelving units (if available) provided there is a means for the safe lifting of those remains above waist level height.

E. Morgue Operations

Morgue case flow during disaster operations requires planning of multiple issues including location of processing areas, flow through the morgue ~~and~~, tracking, initial routine processing/triage, and autopsy (if indicated).

1. Location

   The medical examiner must determine if remains should be processed at the medical examiner office in the district in which the deaths occurred, within the district at another location, or at the nearest high-capacity medical examiner facility. Such a decision is based on the magnitude of the incident, the rate of recovery of remains, the potential for the medical

Formatted: Indent: Left: 1.08", No bullets or numbering

Formatted: Condensed by 0.05 pt

Formatted: Right: 0.08", Space Before: 3.45 pt, Line spacing: single

examiner headquarters to become damaged or inoperable as a result of the incidenta target of attack, and if the district (or alternate) medical examiner office has enough space to accommodate the additional caseload.

2. Morgue Stations
   a. Unlike routine casework where human remains are processed at one station, in a mass fatality incident remains are often processed in a multiple-station system. Generally, a well-organized incident morgue operation entails: intake/admitting, triage, photography, evidence, personal effects, pathology/toxicology, radiology (X-ray and/or CT), fingerprinting, odontology, anthropology, and DNA sampling.
   b. Extensive guidance on the function and operation of each morgue station is provided in the FEMORS Field Operation Guide (FOG).

3. Autopsy and External Evaluations
   a. For large numbers of fatalities, it may not be feasible to consider performing a complete autopsy on all remains. Although the medical examiner must determine which cases require an autopsy, he/shethey should think about discussing his/hertheir intentions with the lead law enforcement agency and the Department of Health, since each of these agencies has may have its own specific requirements for identifying autopsies to support the overall investigation. (Capstone)
   b. While a complete autopsy of every victim may be the desired goal, in the face of significant numbers of victims the medical examiner may need to seek authorization to apply professional discretion to autopsy only appropriate sample cases. Such authorization may be requested pursuant to a disaster declaration or Governor's Executive Order covering the state of emergency.
   b.c. The American Academy of Forensic Sciences, Academy Standards Board has published ANSI/ASB Best Practice Recommendation 009, Best Practice Recommendations for the Examination of Human Remains by Forensic Pathologists in the Disaster Victim Identification Context. This document is maintained, updated, and can be found at https://femors.org/downloads/ (on FEMORS' website).

4. Documentation of Processing
   a. In addition to assessment of anatomic findings (pathology/toxicology reports) to support a determination of cause of death, postmortem processing provides the only opportunity to preserve information needed to establish positive identification of the remains.
   b. Postmortem processing of each case includes photography, collection of evidence, and/or personal effects. Maintaining a pProperly documented "chain of custody" is essential for all such processing all items of personal effects.
   c. Personal effects may prove crucial in establishing presumptive identifications that may lead to positive identifications through accepted protocols. Even DNA may be obtained from some personal

Formatted: Font: 12 pt, Condensed by 0.05 pt
Formatted: Not Highlight
Formatted: Not Expanded by / Condensed by
Formatted: Font: (Default) Arial
Formatted: Left
Formatted: Not Highlight
Formatted: Font: Arial, 12 pt
Formatted: Not Highlight
Formatted: Not Highlight
Formatted: Not Highlight
Formatted: Font: (Default) Arial, 12 pt

effects bearing biological material. For that reason, a DNA specialist should be consulted before personal effects are cleaned for photographing, cataloging, and returning to families. Personal effects should always be treated with potential identification in mind.

d. Standardized processing forms available in the Victim Identification Program (VIP) ~~type~~ databases may be used to create a record of all processing efforts.

e. Data entry of post-mortem processing information is valuable for making the information searchable for clues to matching it with victim ante mortem information provided by families.

5. Radiological (X-Ray and/or CT) Processing
   a. Specialists with experience in the use of radiography equipment~~x-ray~~ should be used to process remains.
   b. Comprehensive radiographic~~x-ray~~ documentation should be ~~is~~ made of appropriate cases to identify commingled remains, artifacts (jewelry, evidence, etc.) imbedded in human tissue, and evidence of ante mortem skeletal injury, surgeries, or anomalies.
   c. Such features may aid in identification by correlation with ante mortem medical records.

6. Fingerprint Processing
   a. Specialists with experience in recognizing and preserving ridge detail for finger, palm, and footprints should be used to process remains.
   b. Preserved ridge detail records may be compared to ante-mortem print records supplied by families or other agencies to establish identification of the victim.
   ~~b.~~ c. The American Academy of Forensic Sciences, Academy Standards Board has published ANSI/ASB Best Practice Recommendation 007, Postmortem Impression Submission Strategy for Comprehensive Searches of Essential Automated Fingerprint Identification System (AFIS) Databases, and ANSI/ASB Best Practice Recommendation 094, Postmortem Impression Recovery: Guidance and Best Practices for Disaster Victim Identification. This document is maintained, updated, and can be found at https://femors.org/downloads/ (on FEMORS' website).

7. Dental Processing
   a. Specialists with experience in recognizing dental structures and recording by means of radiographs~~x-ray~~ and/or charting should be used to process remains.
   b. Standardized processing forms available in the dental identification program (WinID) may be used to compare with ante mortem dental records supplied by families or other agencies to establish identification of the victim.

8. Anthropology Processing
   a. Specialists with experience in recognizing skeletal structures and recording by means of radiographs~~x-ray~~ and/or charting, should be used to process remains.
   b. Comprehensive documentation is made of human skeletal and other fragmentary remains including assessment of bone, bone portion, anatomic side, chronological age, sex, stature, ancestral affiliation, ante- mortem trauma, and pathological conditions.
   c. Such features may aid in identification by correlation with ante mortem

Formatted: Not Highlight
Formatted: Condensed by 0.05 pt
Formatted: Condensed by 0.05 pt
Formatted: Condensed by 0.05 pt
Formatted: Condensed by 0.05 pt
Formatted: Condensed by 0.05 pt
Formatted: Condensed by 0.05 pt
Formatted: Condensed by 0.05 pt
Formatted: Condensed by 0.05 pt
Formatted: Condensed by 0.05 pt
Formatted: Condensed by 0.05 pt
Formatted: Not Expanded by / Condensed by
Formatted: Font: (Default) Arial, 12 pt
Formatted: List Paragraph, Left, Right: 0.33", Space Before: 0.35 pt, Don't adjust space between Latin and Asian text, Don't adjust space between Asian text and numbers
Formatted: Font: Arial, 12 pt, Not Highlight
Formatted: Not Highlight

medical records.

c.d. The American Academy of Forensic Sciences, Academy Standards Board has published ANSI/ASB Best Practice Recommendation 010. Forensic Anthropology in Disaster Victim Identification: Best Practice Recommendations for the Medicolegal Authority. This document is maintained, updated, and can be found at https://femors.org/downloads/ (on FEMORS' website).

9. DNA Processing
   a. Human remains that lack typical identifying features (tissues without fingerprint, dental, or anthropological material) can often be identified through DNA. For this reason, morgue processing should include a station to obtain and preserve a specimens for DNA testing from each case processed.

Formatted: Font: (Default) Arial, 12 pt

Formatted: List Paragraph, Left, Right: 0.33", Space Before: 0.35 pt, Don't adjust space between Latin and Asian text, Don't adjust space between Asian text and numbers

Formatted: Not Highlight

~~b.~~a. DNA specialists should be consulted or ~~even~~ incorporated into the morgue station to ensure proper sampling procedures, prevent cross contamination, and ensure the best possible specimen is collected.

b. The use of rapid DNA technology should be considered for use in morgue operations and in the Victim Information Center.

c. Laboratory testing of DNA specimens will need to be coordinated considering~~taking into account~~ the:
   - selection of the most appropriate specimen for testing,
   - number of specimens to be tested,
   - capacity of the laboratory to perform the testing, and
   - ~~o~~ standardization of test results for comparison with DNA testing of ante mortem reference materials collected through the Victim Information Center or other agencies.

d. DNA Sections of the Florida Department of Law Enforcement's Crime Laboratory System may be called upon to assist with managing such issues.

e. The American Academy of Forensic Sciences, Academy Standards Board, has published ANSI/ASB Best Practice Recommendation 006, Best Practices Recommendations for DNA Analysis for Human Identification in Mass Fatality Incidents. This document is maintained, updated, and can be found at https://femors.org/downloads/ (on FEMORS' website).

Formatted: Body Text, Space Before: 0 pt

Formatted: Not Highlight

Formatted: Not Expanded by / Condensed by

Formatted: Left, Indent: Hanging: 0.55", Right: 0", Line spacing: Exactly 14.1 pt, Bulleted + Level: 1 + Aligned at: 1.5" + Indent at: 2.05", Tab stops: 1.58", Left

Formatted: Font: (Default) Arial

Formatted: Left, Right: 0.33", Space Before: 0.35 pt

Formatted: Not Highlight

Formatted: Not Highlight

Formatted: Not Highlight

Formatted: Font: (Default) Arial

F. Post-Processing Transportation and Storage

Until the final disposition of remains is known, the medical examiner cannot determine to what extent this phase of the operation must function; for instance, when remains are going to be returned to family members, personnel may only need to establish a holding area for funeral directors to retrieve remains ~~(Capstone)~~. Storage areas should be segregated for coding of location by *Unidentified* remains and *Identified* remains. Unidentified remains may be returned to the morgue multiple times for additional processing as needed.

Law enforcement may require that the remains be retained or partially retained for evidentiary purposes, thus the medical examiner may need to further enhance the morgue's storage capacity.

G. Body Release for Final Disposition

When processing has been completed, final disposition normally involves burial or cremation at the family's request. Aside from the question of mass disposition (see Section VIII - Mass Disposition of Human Remains) a variety of tasks must be accomplished to authorize release of the human remains to a funeral service provider of the family's choice.

1. Once remains have been identified and are ready for release, the medical examiner certifies the cause and manner of death on the death certificate.
2. Typically, medical examiner staff ~~notifies~~ will notify the funeral service provider ~~home~~ selected by the family. The funeral service provider responds

to transport the remains and personal effects (if appropriate). Medical examiner staff will coordinate with the funeral service provider to record the death via the Electronic Death Registration System (EDRS)~~and complete filing of the death certificate~~ under procedures established by the Bureau of Vital Statistics.

3. Medical examiner staff and/or other involved agencies should confer with families and obtain documentation of the family wishes regarding notification when additional fragmentary remains are identified. Some

Formatted: Condensed by 0.05 pt

Formatted: Not Highlight

Formatted: Condensed by 0.05 pt

families desire to be notified of every identified fragment while others have reached closure and do not desire to be notified at all.

4. Provisions may be made for how unclaimed and unidentified remains will be memorialized or disposed of at the conclusion of the processing effort. This is often done in concert with the Incident Command management team and governmental officials.
5. Exceptions to release exist for remains that could not be decontaminated to a safe level. Emergency management powers of the Governor may need to be invoked to suspend routine regulations regarding the disposition of human remains and grant the Department of Health quarantine and human remains disposition powers including state sponsored burial or cremation in accordance with Chapter 381.0011(6), Florida Statutes.
6. In disaster incidents ~~situations~~ where there are no remains to recover for identification, or where scientific efforts to establish identity fail, the appropriate legal authority in accordance with Chapter 382.012, Florida Statutes may order a presumptive death certificate.

H. Victim Information Center Support

Emergency management agencies should be prepared to mobilize the appropriate resources to establish a missing persons Victim Information Center (VIC) in conjunction with Family Assistance or Family Reunification Center for the management of an incident with mass fatalities. This may be part of a Joint Family Support Operations Center ~~joint family assistance center~~ established by Incident Command for multiple service organizations. Nonetheless, staffing for the purpose of interviewing families for information essential to identification requires consultation with forensically trained specialists. The fatality management support organization will have experience and operating procedures for establishment of a VIC. The efforts of personnel at the VIC shall be coordinated with the involved law enforcement agency's missing persons investigators if applicable.

1. Interviewing of family and friends of the disaster victim provides an opportunity to obtain vital information that may lead to a positive identification of the victim. In addition to basic physical description and names of treating physicians or dentists, interviews may reveal unique features such as tattoos, piercing, jewelry, old injuries, etc.
   a. Standardized questionnaire forms are available in the Victim Identification Program (VIP).
   b. Interviewers should be limited to personnel specially trained in dealing with grieving individuals such as:
      - Victim Information Center specialists who have been trained in conducting interviews and using the VIP protocols.
      - medical examiner investigators,
      - funeral service personnel,
      - law enforcement agents, or
      - social workers.
      - ~~law enforcement agents,~~
      - ~~medical examiner investigators,~~

Formatted: Not Highlight

Formatted: Not Highlight

Formatted: Not Highlight

Formatted: Indent: Left: 1.63", Right: 0.08", Line spacing: single, Bulleted + Level: 4 + Aligned at: 1.33" + Indent at: 1.58", Tab stops: 1.48", Left + Not at 1.58"

- social workers,
- funeral service personnel, or
- Victim Information Center specialists who have been trained in conducting interviews and using the VIP protocols.

2. DNA Collection
   a. Family reference samples and personal effects of the victim containing biological material may provide the only method by which processed victim remains can be identified.
   b. DNA specialists should be incorporated into or consulted on the VIC interview process to ensure proper collection procedures, prevent cross contamination, and ensure the best possible specimens are collected for subsequent laboratory testing.
   c. Rapid DNA technology should be considered for use in the VIC.
   ~~b.~~d. Call Center electronic management software (e.g., ReadyOp) may be offered by the Florida Dept of Health.

I. Records Management (Victim Processing)

1. Segregation of disaster records from the normal office records is recommended.
2. All ante and post-mortem information and records should be handled as evidence. The chain of custody of records must be maintained via sign-out and sign-in logs. Records management personnel must be able to account for all received information/records, whether they are in ~~the~~ direct possession of the records management section or checked out to an authorized individual.
3. Digital versions of case file materials may (eventually) serve as the ***original or duplicate*** record when so defined according to the records management policies of the local jurisdiction and Florida Statutes.
   ~~2.~~a. In such cases, references to printed documents and CD storage may refer to redundant electronic media storage both onsite and off-site including cloud-based storage.

~~3.~~4. Four major file categories should be maintained:
   a. Unidentified Remains case files in morgue reference number (MRN) order and containing:
      - Processing paperwork,
      - Printouts of digital photos,
      - CD or other storage media copy of all photos taken,
      - Printouts of digital dental radiographs and/or CT scans ~~x-rays~~,
      - CD or other storage media copy of all digital dental radiographs and/or CT scans ~~x-rays~~ taken,
      - Printouts of digital body radiographs and/or CT scans ~~x-rays~~,
      - CD or other storage media copy of all digital body radiographs and/or CT scans ~~x-rays~~ taken,
      - Personal effects inventory.
   b. Reported Missing Person Reports (RM) case files in Last Name alphabetical order and containing:
      - Printed VIP interview form along with original hand completed forms,
      - Other police missing person reports submitted,
      - Medical ante mortem records or body x-rays submitted,
      - Fingerprint records,
      - Dental ante mortem records including x-rays, and

Formatted: Not Expanded by / Condensed by
Formatted: Not Highlight
Formatted: Font: (Default) Arial, 12 pt
Formatted: Font: Arial, 12 pt, Not Highlight
Formatted: Font: (Default) Arial, 12 pt
Formatted: List Paragraph, Right: 0.33", Don't adjust space between Latin and Asian text, Don't adjust space between Asian text and numbers
Formatted: Font: Arial, 12 pt, Not Highlight
Formatted: Font: (Default) Arial, 12 pt
Formatted: Not Highlight
Formatted: Not Expanded by / Condensed by
Formatted: Font: (Default) Arial
Formatted: Font: (Default) Arial, 12 pt
Formatted: List Paragraph, Right: 0.33", Don't adjust space between Latin and Asian text, Don't adjust space between Asian text and numbers, Tab stops: 1.48", Left + Not at 1.08"
Formatted: Not Highlight
Formatted: Not Highlight
Formatted: Not Highlight
Formatted: Not Highlight
Formatted: Not Highlight
Formatted: Indent: Hanging: 0.55", Right: 0", Space Before: 0 pt, Line spacing: Exactly 14.35 pt, Bulleted + Level: 1 + Aligned at: 1.48" + Indent at: 2.03"

- ○Notes of contacts for information gathering.

c. Identified Remains - Medical examiner determines which master number to use and merges into one file all related materials:
- ○RM ante mortem reporting forms,
- ○Ante mortem medical records,
- ○ Morgue reference number (MRN) folders (these may be multiple if DNA associates fragmented remainsparts),

Formatted: Not Expanded by / Condensed by
Formatted: Not Expanded by / Condensed by
Formatted: Font: Arial, Character scale: 100%
Formatted: Not Expanded by / Condensed by
Formatted: Not Expanded by / Condensed by
Formatted: Not Expanded by / Condensed by
Formatted: Not Expanded by / Condensed by
Formatted: Not Expanded by / Condensed by
Formatted: Indent: Hanging: 0.55", Right: 0", Space Before: 0 pt, Line spacing: Exactly 13.8 pt, Bulleted + Level: 1 + Aligned at: 1.48" + Indent at: 2.03"
Formatted: Not Expanded by / Condensed by

- ○
- ○Dental records (ante and post-mortem),
- ○Morgue Photographs,
- ○DNA submission documents,
- ○Body radiographs and/or CT scans ~~X-Ray~~ identification (ante and post-mortem),
- ○Fingerprints and comparisons made, and
- ○Remains release and funeral service provider ~~home~~ documentation.

d. Court Issued Presumptive Death Certificates and related documents (if applicable):
- ○Affidavits and supporting documents,
- ○Court order,
- ○Copy of presumptive death certificate issued,
- ○Record of transmittal of death certificate to Vital stats:
  - May require funeral director involvement,
  - May require family authorization for funeral home to handle,
  - Vital Stats coordination required.

○ If subsequently identified, an amended death certificate may be issued and all this material is moved to the Identified Remains file.

J. Records Management (Accounting and Finance)

1. Expenses incurred by a medical examiner in response to a disaster may be reimbursable depending on the nature of the disaster and whether a disaster declaration was issued at the state or federal level.
2. Expenses may include both personnel overtime and purchases of equipment and supplies when requested through and approved by the Emergency Operations Center process.
   a. Expenses incurred outside of the Emergency Operations Center process may not be reimbursable.
3. Extensive documentation of labor time (especially overtime) and purchases will be needed to seek reimbursement including:
   a. daily attendance rosters and time worked logs,
   b. mission number assignment from Emergency Operations Center or designee,
   c. purchasing and tracking of materials.

K. Progress Reports and Public Information

1. From the onset, demands for estimates of the number of victims missing, the number identified, and names of the missing arise from many sources.
2. Chief among these are: the Incident Commander, the Emergency Operations Center, and the Medical Examiners Commission.
   a. Early estimates contribute to the planning assumptions and provide a means to assess additional resources that may be needed.
   ~~b.~~ Periodic and later updates allow for fine tuning the response effort and determining the eventual demobilization strategy.
   b.

Formatted: Font: 12 pt
Formatted: Not Expanded by / Condensed by
Formatted: Space Before: 0 pt, Line spacing: Exactly 13.8 pt
Formatted: Not Highlight
Formatted: Condensed by 0.05 pt
Formatted: Condensed by 0.05 pt
Formatted: Condensed by 0.05 pt
Formatted: Justified, Right: 0.26", Space Before: 3.45 pt
Formatted: Condensed by 0.05 pt
Formatted: Condensed by 0.05 pt
Formatted: Condensed by 0.05 pt
Formatted: Body Text, Justified, Right: 0.26", Space Before: 3.45 pt, Numbered + Level: 3 + Numbering Style: a, b, c, … + Start at: 1 + Alignment: Left + Aligned at: 1.08" + Indent at: 1.48", Tab stops: 1.48", Left

c. Daily reporting to the Medical Examiners Commission during a disaster event involves reporting all confirmed disaster-related deaths to include ME case #, age, race, sex, a brief synopsis, and an indication of whether the case is a directly or indirectly related disaster death. This list becomes the official list managed by the State Emergency Operations Center.

d. The U.S. Department of Health, National Vital Statistics System reference guide for certification of disaster-related deaths defines directly and indirectly related deaths as follows:

- A **directly related death** is defined as a death directly attributable to the forces of the disaster or by the direct consequence of these forces, such as structural collapse, flying debris, or radiation exposure.
- An **indirectly related death** occurs when the unsafe or unhealthy conditions present during any phase of the disaster (i.e., pre-event or preparations, during the actual occurrence, or post-event during cleanup after a disaster) contribute to the death.

3. Normally, the Incident Commander will arrange for an official Public Information Officer to provide updates to the media.
4. Medical examiner staff should be assigned as liaison with Incident Command staff to coordinate distribution of information relating to victims and progress of the response effort. Special care is needed to inform waiting family members of developments before information is released to the general media.
5. Potential types of medical examiner information that may be requested frequently, even daily, include:
   a. total number of victims,
   b. names of identified victims,
   c. method of identification,
   d. names and number of missing person reports,
   e. staffing levels and assistance provided, and
   f. estimate of time to complete identifications.

Formatted: Condensed by 0.05 pt

VII Multiple District Incident Coordination

A. Definition of Multiple District Incident

A mass fatality incident in which decedents are recovered from geographic locations crossing medical examiner district boundaries.

B. Jurisdiction for Issuance of Death Certificate

The district covering the county of death (or where the remains are found) determines which medical examiner signs the death certificate and records the official medical examiner case number (thus affecting year-end statistical reporting).

C. Coordination of Resources

This is a mutual agreement situation and rests upon the willingness of all involved medical examiners to make prudent, team-focused decisions to provide for the best way to serve law enforcement investigative needs as well as the needs of families involved.

If the desire is to have single processing center for both post–mortem examination (morgue) and ante–mortem collection (victim information call center) when multiple medical examiner districts are involved in a single ~~event~~incident, all of the medical examiners impacted would need to meet and agree on:

1. Central incident morgue and victim information call center locations.
   a. Governor's Declaration of Emergency or Executive Order authorizes the use of the State's assets including FEMORS and its cache of equipment to establish a portable morgue and/or victim information call center.
   b. Alternatively, each county would have to provide (i.e., pay for) the people and equipment needed for response to and management of a surge of deaths in that county.
2. A single medical examiner or designee is to serve as the Fatality Management Lead (or Fatality Management Group Supervisor) for that incident.
   a. This person is "in charge" of the overall fatality management operation (victim recovery, morgue operations, collection of ante mortem data, identification of the dead, and release for final disposition) and will adapt to the needs of all affected medical examiners for any variation in processing decisions.
3. Cross appointment of pathologists as Associate Medical Examiners as provided for in Chapter 406.06(2), Florida Statutes.
4. Procedures to ensure that death certificates are filed in the appropriate county of death.

Formatted: Font color: Text 1
Formatted: Font color: Text 1
Formatted: Font color: Text 1

VIII Mass Disposition of Human Remains (Rational for Identification before Disposition)

A. Governmental Authority

Under the emergency management powers of the Governor and pursuant to the authority vested under paragraph (a) of Chapter 252.36, Florida Statutes, the Governor may direct the Florida Department of Health to take certain actions to suspend routine regulations regarding the disposition of human remains. These actions may include directions for disposition of both identified and/or unidentified remains. Disposition of unidentified remains would follow the collection of items that are useful in the identification process: photographs, fingerprints, dental and somatic radiographs, and DNA.

Formatted: Condensed by 0.05 pt

B. Epidemic Outbreak Myth

Often a principalle reason proffered for taking the mass disposition course of action is based upon a fear of the outbreak of disease from human remains. Well-intentioned, but scientifically uninformed, decision makers often initiate the process as a natural aversion to the physical unpleasantness of the effects of decaying human remains and a fear that an epidemic of disease will break out.

A scientific review of past catastrophic disasters (PAHO, 2004) demonstrates that the risk of epidemic disease transmission from human remains is negligible. Unless the affected population was already experiencing a disease suitable for epidemic development, the catastrophic event cannot create such a situation. Most disaster victims die from traumatic events and not from pre-existing disease.

Disease transmission requires first, a contagious agent, second, a method of transmission, and third, a susceptible population to infect.

- Typical pathogens in the human body normally die off when the host dies, although not immediately. In the absence of the first requirement, therefore, risk of transmission is no greater than that for routine handling of human remains.
- Water supplies contaminated with decaying human remains can serve as a method of transmission of illnesses, particularly gastroenteritis, but a non-breathing body presents minimal transmissibility.
- With the use of universal precautions for bloodborne pathogens, under regulations of the Occupational Safety and Health Administration (OSHA), responders so equipped do not present a susceptible population to infect. Even the local population will usually avoid a water supply contaminated with human remains and use sheets or body bags to envelop decaying human remains.

C. Identification of Victims before Disposition

Traditional funeral practices include a variety of procedures designed to assist survivors of all religious practices or belief systems with the grieving process. Identification of the victim, however, is the first step in that process.

Government-ordered disposition by mass burial or cremation of unidentified victims creates numerous, and often unnecessary, complications for survivors. In addition to a delay in completing the grieving process, survivors face challenges settling legal affairs, determining rights of property ownership, and managing the welfare of the victim's offspring.

Both the World Health Organization (WHO) and the Pan American Health Organization (PAHO) advocate for the identification of all disaster victims before final disposition, regardless of number of victims. ~~In order to~~ To accomplish this in Florida, when faced with thousands of fatalities, extraordinary refrigeration resources will be required using the basic guidelines in Section VI (D) above. With adequate refrigeration capacity, supplemental morgue facilities, and sufficient forensic personnel to process human remains, identifying information from each set of remains can be secured before mass burial is contemplated as a last resort.

If the disaster ~~-~~results in several hundred or thousands of victims, "temporary interment" may be an appropriate course of action. The expectation is that each victim will be retrieved later, as time permits, for full documentation, identification, and release to appropriate family's choice of funeral service provider.

Temporary interment involves several expedient steps:

- Altered standard of forensic processing is limited to pre-interment:
  - Photographs
  - Fingerprints
  - DNA specimens
  - Body tag made of metal or impervious material and use of the indelible marking of reference number(s).
- Placement of each set of remains in a heavy-duty disaster body bag affixed with
  - Exterior duplicate bag tag made of metal or impervious material and use of indelible marking of reference number(s).
  - Long (e.g., six feet) wire leader with a third, duplicate bag tag.
- Placement of bagged victims in prepared designated sites (as determined by local authorities).
  - Victims may be placed in rows with the long wires placed out to one end.
  - Sand or other fill material is placed over the victims to a depth determined by local authorities.
  - The six-foot long wires and impervious bag tags are kept above the sand so that individual victims may be retrieved as needed (i.e., if later identified by fingerprints, DNA or other means.)
    - Durability and legibility of the tag is critical because such tags may be exposed to extreme sunlight and weathering until retrieval can take place.

IX References (Available through the Downloads ~~reference~~ library at www.FEMORS.org.)

1. "Mass Fatality Management for Incidents Involving Weapons of Mass Destruction" a draft capstone document (originally due for release September 2004) developed by the Department of Defense U.S. Army Soldier and Biological Chemical Command (SBCCOM), Improved Response Program (IRP), (cited throughout as "Capstone").
2. Florida Comprehensive Emergency Management Plan February, 2024~~2020~~, (https://www.floridadisaster.org/dem/response/all-hazards/comprehensive-emergency-management-plan/ ~~https://www.floridadisaster.org/globalassets/cemp/2020-cemp/2020-state-cemp.pdf~~)
3. CEMP Appendix VIII - Emergency Support Function 8 - Health and Medical Services (ESF 8: Health and Medical Annex ~~https://www.floridadisaster.org/globalassets/cemp/2020-cemp/2020-state-cemp.pdf~~)
4. FEMORS FOG Field Operations Guide, at https://femors.org/downloads/
5. Morgan O. "Infectious disease risks from dead bodies following natural disasters." Rev Panam Salud Publica. 2004;15(5):307–12.
6. ~~Florida Natural Disease Outbreak and the Pandemic Influenza Fatality Management Response Plan, (2008).~~

X Statutory Citations

1. Chapter 252.36, Florida Statutes, Emergency Management Powers of the Governor
2. Chapter 380.0011(6), Florida Statutes, Duties and Powers of the Department of Health
3. Chapter 382.012, Florida Statutes, Presumptive death certificate
4. Chapter 406, Florida Statutes, Medical Examiners; Disposition of Dead Bodies, Examinations, Investigations, and Autopsies

XI Medical Examiner Districts

District	Address	City	Office Phone
1	5151 North 9th Avenue	Pensacola 32504	(850) 416-7200
2	560 Leonard Gray Way	Tallahassee 32304	(850) 606-6600
3	*Dixie County Service by District 8 Lafayette, Madison, & Suwannee counties Service by District 2 Columbia & Hamilton County Service by District 4*		
4	2100 Jefferson Street	Jacksonville 32206	(904) 255-4000
5	809 Pine Street	Leesburg 34748	(352) 326-5961
6	10900 Ulmerton Road	Largo 33778	(727) 582-6800
7	1360 Indian Lake Road	Daytona Beach 32124	(386) 258-4060

Formatted: Left
Formatted: Not Highlight
Formatted: Not Highlight
Formatted: Not Highlight
Formatted: Not Highlight
Formatted: Not Highlight
Formatted: Not Highlight
Formatted: Not Highlight

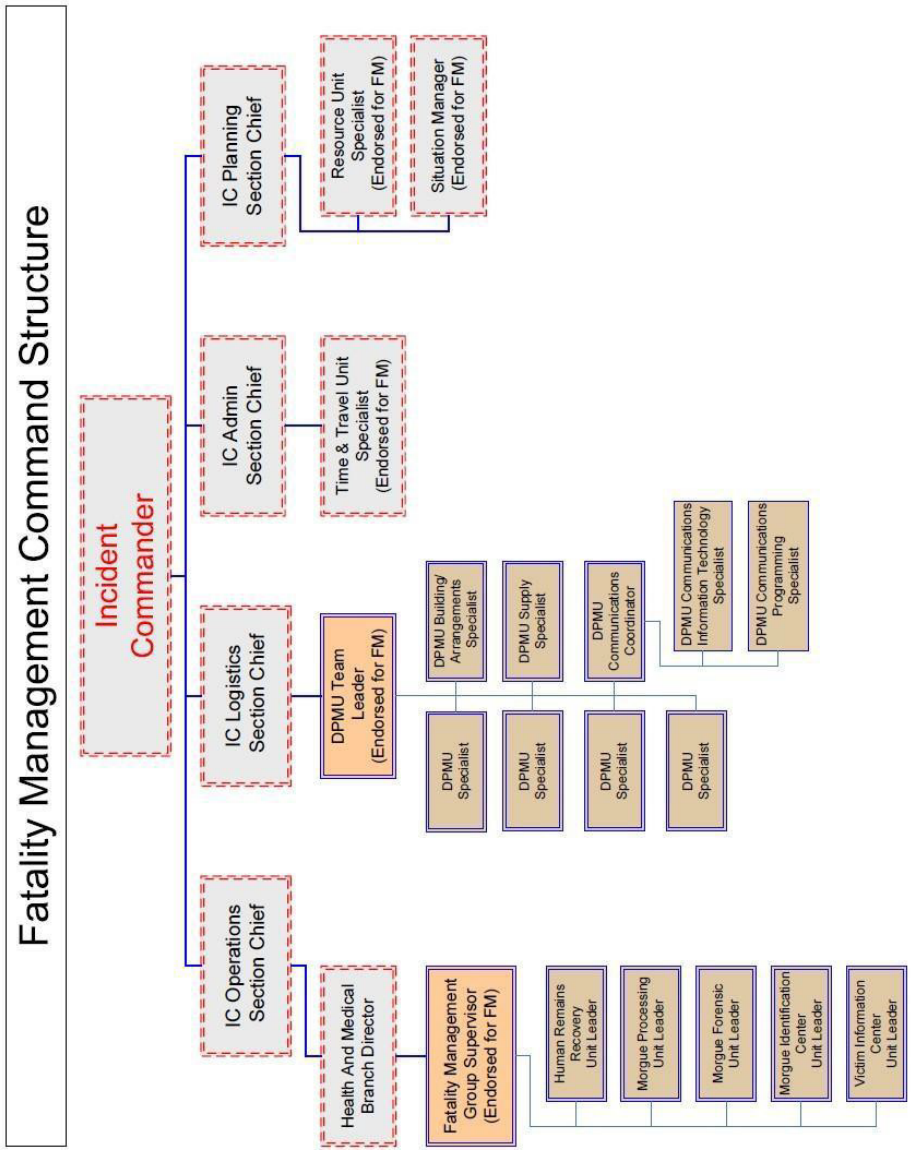
8	3217 SW 47th Ave	Gainesville 32608	(352) 627-2217
9	2350 East Michigan Street	Orlando 32806	(407) 836-9400
10	1021 Jim Keene Boulevard	Winter Haven 33880	(863) 298-4600
11	Number One on Bob Hope Rd	Miami 33136	(305) 545-2400

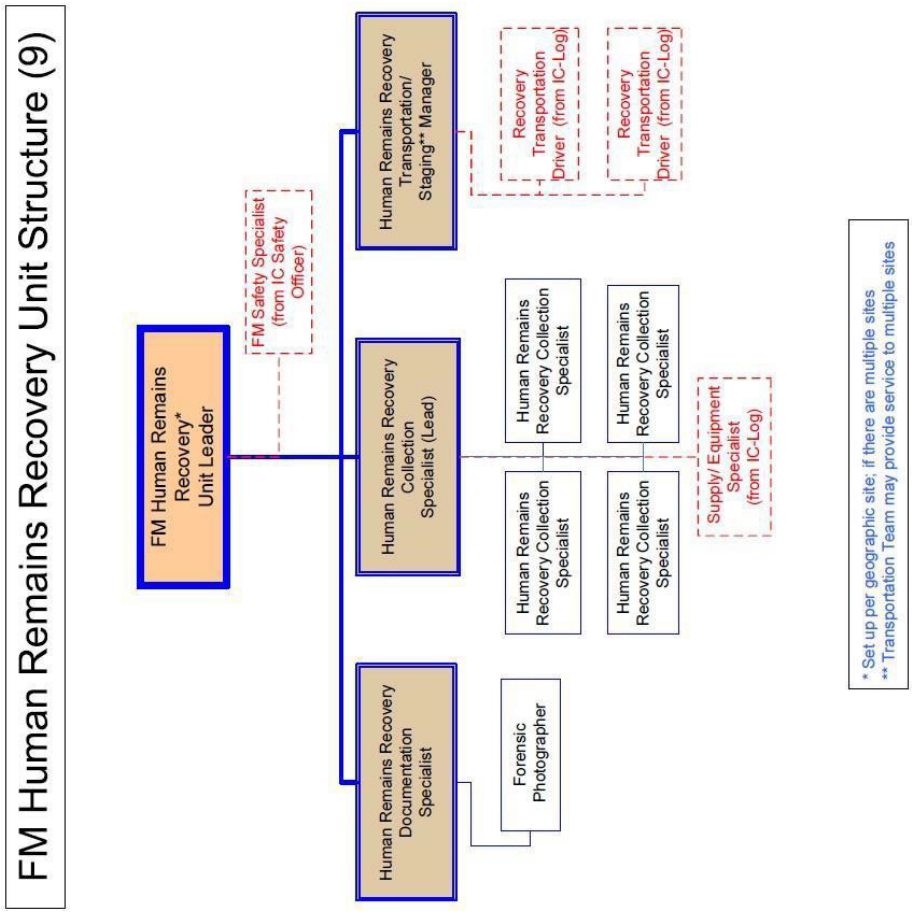
District	Address	City	Office Phone
12	2001 Siesta Drive, Suite 302	Sarasota 34239	(941) 361-6909
13	11025 North 46th Street	Tampa 33617	(813) 914-4500
14	3737 Frankford Avenue	Panama City 32405	(850) 747-5740
15	3126 Gun Club Road	West Palm Beach 33406	(561) 688-4575
16	56639 Overseas Highway	Marathon 33050	(305) 743-9011
17	5301 S.W. 31st Avenue	Ft. Lauderdale 33312	(954) 357-5200
18	1750 Cedar Street	Rockledge 32955	(321) 633-1981
19	2500 South 35th Street	Ft. Pierce 34981	(772) 464-7378
20	3838 Domestic Avenue	Naples 34104	(239) 434-5020
21	70 South Danley Drive	Ft. Myers 33907	(239) 533-6339
22	18130 Paulson Drive	Port Charlotte 33954	(941) 625-1111
23	4501 Avenue A	St. Augustine 32095	(904) 209-0820
24	*Services provided by District 5*		
25	*Services provided by District 9*		

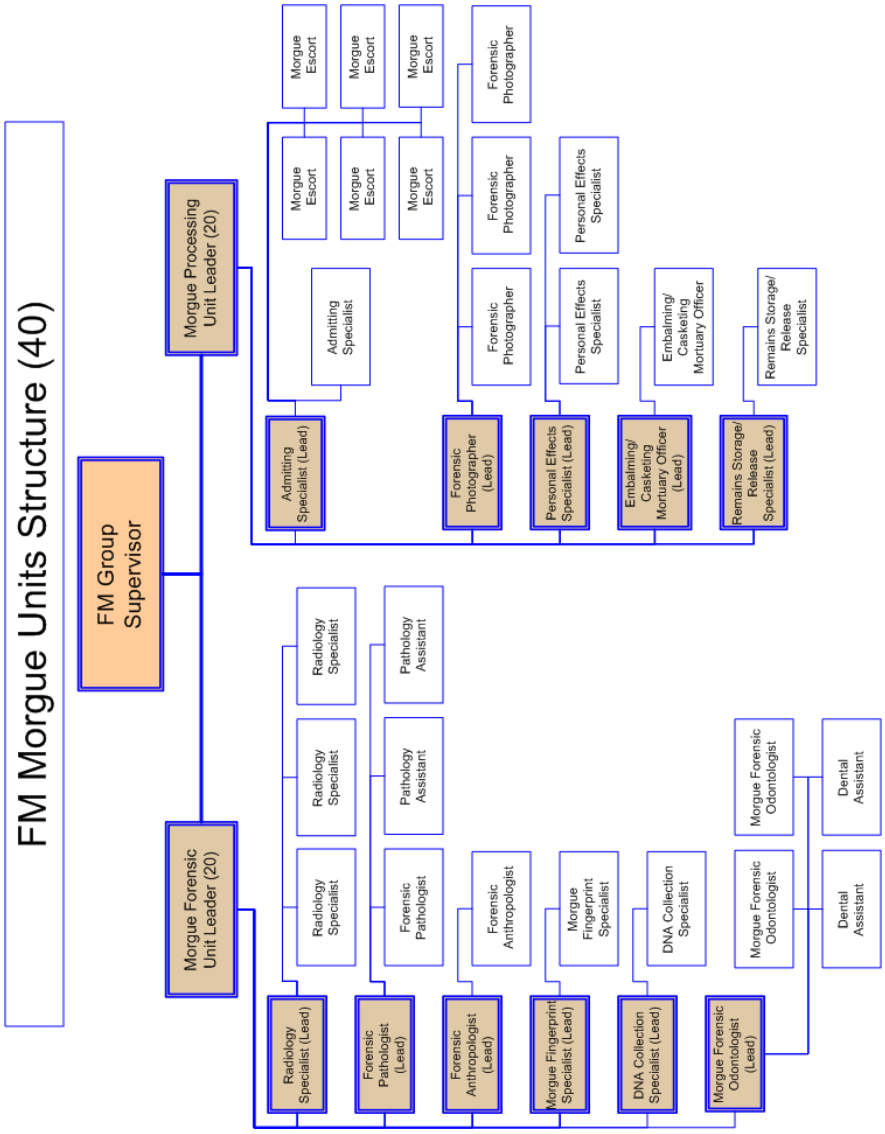
District	Jurisdiction
1	Escambia, Okaloosa, Santa Rosa, and Walton counties
2	Franklin, Gadsden, Jefferson, Leon, Liberty, Taylor, and Wakulla counties
3	Columbia, Dixie, Hamilton, Lafayette, Madison, and Suwannee counties
4	Clay, Duval, and Nassau counties
5	Citrus, Hernando, Lake, Marion, and Sumter counties
6	Pasco and Pinellas counties
7	Volusia County
8	Alachua, Baker, Bradford, Gilchrist, Levy, and Union counties
9	Orange County
10	Hardee, Highlands, and Polk counties
11	Miami-Dade County
12	DeSoto, Manatee, and Sarasota counties
13	Hillsborough County
14	Bay, Calhoun, Gulf, Holmes, Jackson, and Washington counties
15	Palm Beach County
16	Monroe County
17	Broward County
18	Brevard County
19	Indian River, Martin, Okeechobee, and St. Lucie counties
20	Collier County
21	Glades, Hendry, and Lee counties
22	Charlotte County
23	Flagler, Putnam, and St. Johns counties
24	Seminole County
25	Osceola County

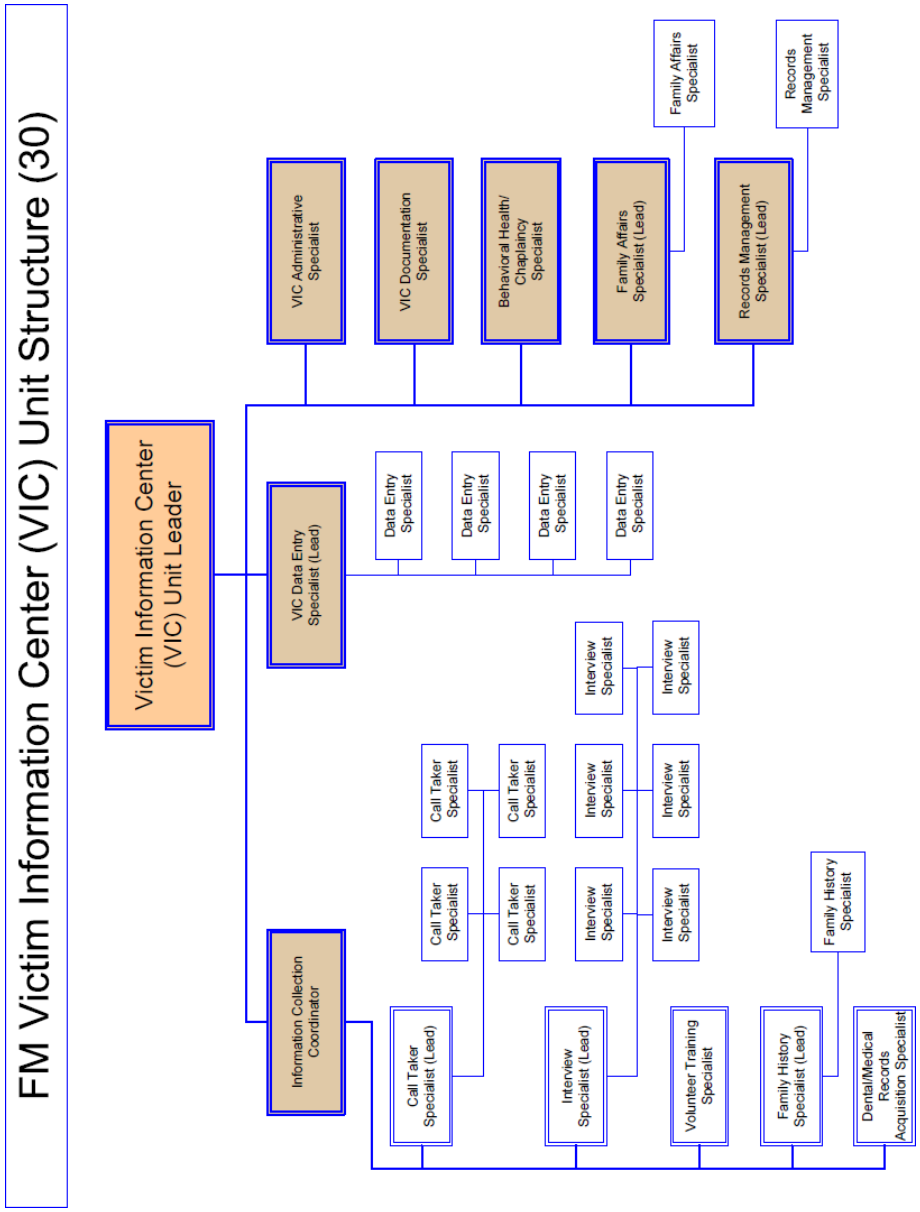
XII Fatality Management ICS Organization Charts

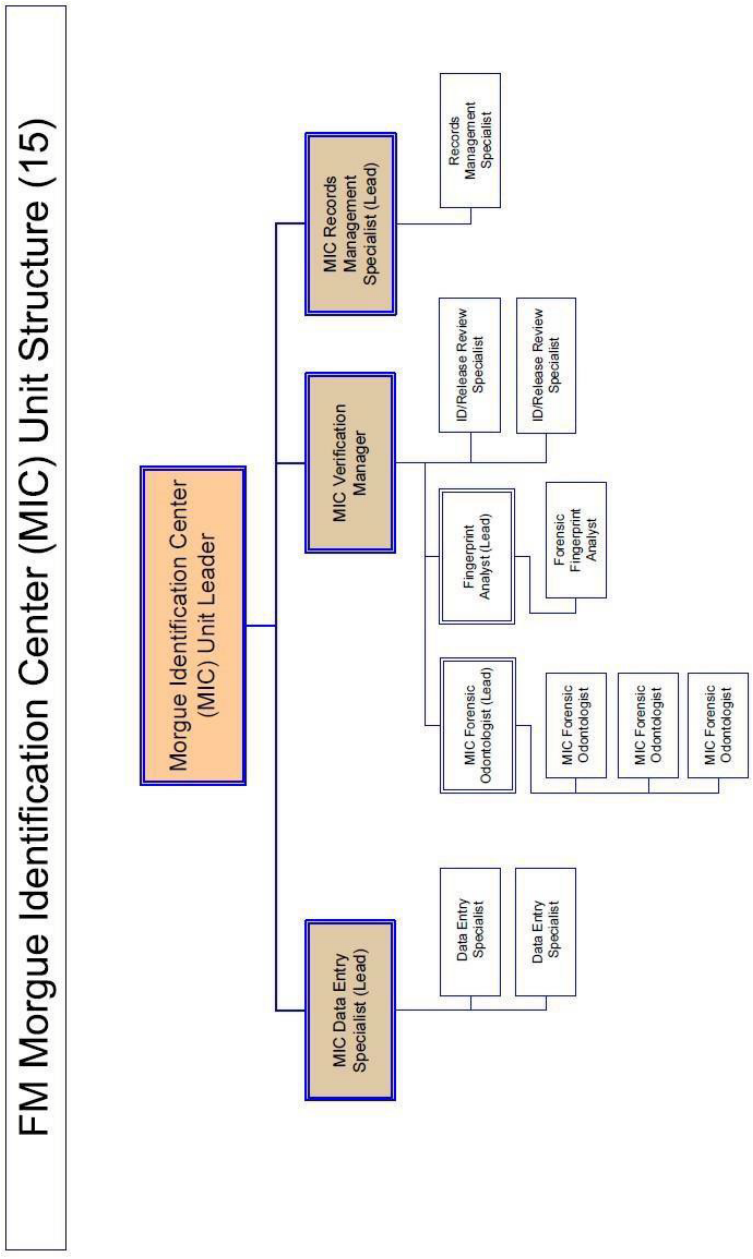
(Dotted lines indicate positions supplied by the overall Incident Command)

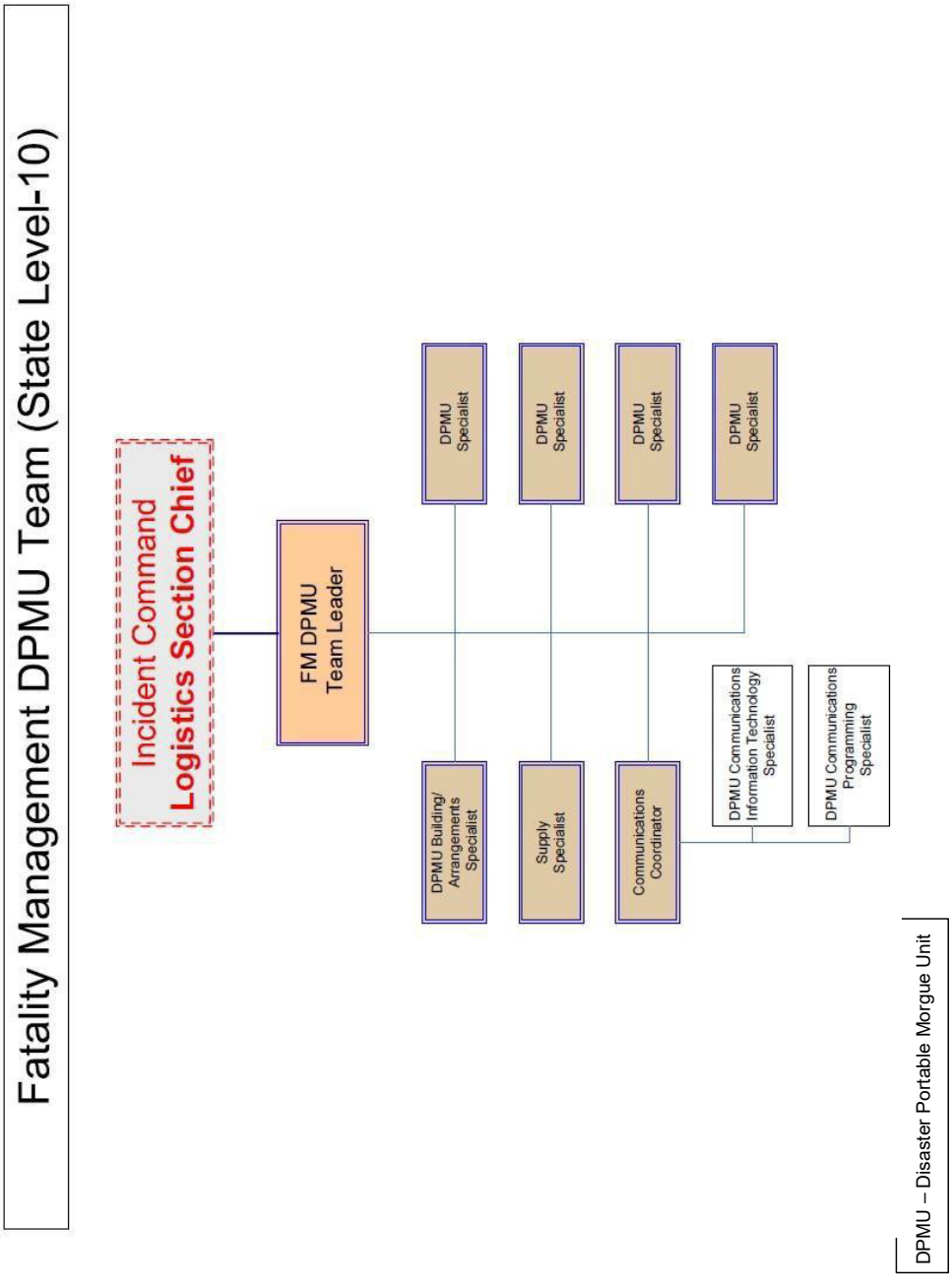



FM Human Remains Recovery Unit Structure (9)
FM Human Remains Recovery* Unit Leader
FM Safety Specialist (from IC Safety Officer)
Human Remains Recovery Transportation/ Staging** Manager
Recovery Transportation Driver (from IC-Log)
Recovery Transportation Driver (from IC-Log)
Human Remains Recovery Collection Specialist (Lead)
Human Remains Recovery Collection Specialist
Human Remains Recovery Collection Specialist
Human Remains Recovery Collection Specialist
Human Remains Recovery Collection Specialist
Supply/ Equipment Specialist (from IC-Log)
Human Remains Recovery Documentation Specialist
Forensic Photographer
* Set up per geographic site; if there are multiple sites
** Transportation Team may provide service to multiple sites


FM Morgue Units Structure (40)
FM Group Supervisor
Morgue Processing Unit Leader (20)
Morgue Forensic Unit Leader (20)
Admitting Specialist (Lead)
Admitting Specialist
Morgue Escort
Morgue Escort
Morgue Escort
Morgue Escort
Morgue Escort
Morgue Escort
Forensic Photographer (Lead)
Forensic Photographer
Forensic Photographer
Forensic Photographer
Personal Effects Specialist (Lead)
Personal Effects Specialist
Personal Effects Specialist
Embalming/ Casketing Mortuary Officer (Lead)
Embalming/ Casketing Mortuary Officer
Remains Storage/ Release Specialist (Lead)
Remains Storage/ Release Specialist
Radiology Specialist (Lead)
Radiology Specialist
Radiology Specialist
Radiology Specialist
Forensic Pathologist (Lead)
Pathology Assistant
Pathology Assistant
Forensic Pathologist
Forensic Anthropologist (Lead)
Forensic Anthropologist
Morgue Fingerprint Specialist (Lead)
Morgue Fingerprint Specialist
DNA Collection Specialist (Lead)
DNA Collection Specialist
Morgue Forensic Odontologist (Lead)
Morgue Forensic Odontologist
Morgue Forensic Odontologist
Dental Assistant
Dental Assistant


FM Victim Information Center (VIC) Unit Structure (30)
Victim Information Center (VIC) Unit Leader
VIC Administrative Specialist
VIC Documentation Specialist
Behavioral Health/ Chaplaincy Specialist
Family Affairs Specialist (Lead)
Family Affairs Specialist
Records Management Specialist (Lead)
Records Management Specialist
VIC Data Entry Specialist (Lead)
Data Entry Specialist
Data Entry Specialist
Data Entry Specialist
Data Entry Specialist
Information Collection Coordinator
Call Taker Specialist (Lead)
Call Taker Specialist
Call Taker Specialist
Call Taker Specialist
Call Taker Specialist
Interview Specialist (Lead)
Interview Specialist
Interview Specialist
Interview Specialist
Interview Specialist
Interview Specialist
Volunteer Training Specialist
Family History Specialist (Lead)
Family History Specialist
Dental/Medical Records Acquisition Specialist


FM Morgue Identification Center (MIC) Unit Structure (15)
Morgue Identification Center (MIC) Unit Leader
MIC Records Management Specialist (Lead)
Records Management Specialist
MIC Verification Manager
ID/Release Review Specialist
ID/Release Review Specialist
Fingerprint Analyst (Lead)
Forensic Fingerprint Analyst
MIC Forensic Odontologist (Lead)
MIC Forensic Odontologist
MIC Forensic Odontologist
MIC Forensic Odontologist
MIC Data Entry Specialist (Lead)
Data Entry Specialist
Data Entry Specialist


Fatality Management DPMU Team (State Level-10)
Incident Command
Logistics Section Chief
FM DPMU
Team Leader
DPMU
Specialist
DPMU
Specialist
DPMU
Specialist
DPMU
Specialist
DPMU Building/
Arrangements
Specialist
Supply
Specialist
Communications
Coordinator
DPMU Communications
Information Technology
Specialist
DPMU Communications
Programming
Specialist
DPMU – Disaster Portable Morgue Unit