Medical Examiners Commission Meeting

February 4, 2025

Barbara C. Wolf, M.D. • Kenneth T. Jones • Nick Cox, 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

Orlando Marriott Lake Mary
1501 International Parkway
Lake Mary, FL 32751
February 4, 2025, 10:00 AM EST

Opening Remarks

Introduction of Commission Members and Staff

Approval of Meeting Agenda and Minutes from previous Commission Meeting of October 29, 2024

• Election of Chairman	Brett Kirkland, Ph.D.
• Sunshine Law	Jeff Dambly, J.D.
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.
• 2025 Reappointments/Assessments for Districts 8 – 14 & 25	Ashley Williams
• 2023 Annual Drugs in Deceased Persons Report	Megan Neel
• 2024 Interim Drugs in Deceased Persons Report	Megan Neel
• 2024 Annual Drugs in Deceased Persons Report	Megan Neel
• 2024 Annual Workload Report	Megan Neel
• 2023/2024 Coverdell Status Update	Ashley Williams
2. 2025 Coverdell Grant Proposals	Ashley Williams
3. 2025 Legislative Update	Jeff Dambly, J.D.
4. Seminole and Lake County – District Presentation	Kristian Swenson Tommy Carpenter Rachel Bartolowits
5. Mass Fatality Plans/FEMORS	Jason Byrd, Ph.D. Brett Kirkland, Ph.D.
6. Organ Procurement Organization Annual Report	Ginny McBride, OurLegacy
7. Emerging Drugs Update	Brett Kirkland, Ph.D.
8. 2025 FAME Educational Conference	Brett Kirkland, Ph.D.
9. Other Business	
• Public Records Request – New HIPAA Law	

The next MEC Meeting will be May 13th at Embassy Suites by Hilton Orlando.

MEDICAL EXAMINERS COMMISSION MEETING
Embassy Suites by Hilton Orlando Lake Buena Vista South
4955 Kyngs Heath Road
Kissimmee, Florida 34746
October 29, 2024 10:00 AM EDT

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

Commission staff present:

Brett Kirkland, Ph.D.
Jeff Dambly, J.D.
Megan Neel
Ashley Williams

District Medical Examiners present:

Deanna Oleske, M.D. (District 1)
Catherine Miller, M.D. (District 15)
Russell S. Vega, M.D. (Districts 12 & 22)
Sajid S. Qaiser, M.D. (District 18)

Other District personnel present:

Sheri Blanton (District 9/25)
Lindsey Bayer (District 5/24)
Dan Schebler (District 1)
Leah Henry (District 23)
Rob Padrino (District 9/25)
Kelly Boulos (District 23)
Ralph Saccone (District 15)
Paul Petrino (District 15)

Guests present:

Tinene Alter (NMS Labs)
Shane Lockwood (Department of Health)
Brittany Hill (LifeLink of Florida)
Sherry Groover (Citizen)
Susan Rabel (LifeLink of Florida)
Darren Lahrman (LifeLink of Florida)

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 MAY14, 2024 MEDICAL EXAMINERS COMMISSION MEETING.

ISSUE NUMBER 1: INTRODUCTION OF NEW LEGAL COUNSEL JEFF DAMBLY

- Introduction: Bureau Chief Brett Kirkland, Ph.D., introduced the Commission and audience members to new Legal Counsel Jeff Dambly. Mr. Dambly is replacing former Commission Legal Counsel Jim Martin.

ISSUE NUMBER 2: INFORMATIONAL ITEMS:

- Status Report: MEC Appointments and Reappointments: Dr. Kirkland informed the Commission that a letter was sent to the Governor's Appointments Office regarding all appointments and reappointments of District Medical Examiners by the Commission. Dr. Kirkland advised that we are still awaiting appointments/reappointments from the Governor's Appointments Office.

- Status Report: DME Appointment and Reappointments: Dr. Kirkland informed the Commission that all district medical examiners are currently pending either appointment or reappointment. Dr. Kirkland advised that he reached out to the appointment's office for a status, but we are still waiting on appointments from the Governor.

- District 8 Medical Examiner Vacancy: Joshua Stephany, M.D., informed the Commission that the District 8 District Medical Examiner's position is still vacant and has no news to report. Dr. Jon Thogmartin will continue to provide coverage.

- 2024 Interim Drug Report: Mrs. Megan Neel informed the Commission that drug data is due to her by November 30, 2024 and if this was going to be a problem to let her know. Dr. Kirkland informed the Commission that the laboratories are improving on turn-around times therefore the deadline for the 2025 Interim Drug Report will now be March 31, 2025. Mrs. Neel informed the medical examiners that they can submit their cases with pending information if needed and then a week before the deadline she will reach out to get finalized information on the pending cases.

- 2023 Annual Drug Report: Mrs. Neel informed the Commission that she has received all the data and is in the process of proofing it. Mrs. Neel advised she is looking to have it published by the end of November. Dr. Kirkland informed the Commission that the laboratories are improving on turn-around times therefore the deadline for the 2024 Annual Drug Report will also be September 30, 2025.

- 2023 Annual Workload Report: Mrs. Megan Neel advised that the report was posted and sent out on October 17, 2024.

- 2022 Paul Coverdell Forensic Science Improvement Grant Program Status Update: Mrs. Ashley Williams informed the Commission that we received the extension for the 2022 Paul Coverdell Grant. Mrs. Williams advised that if any districts need an extension to contact her or Candace Pridgeon to execute the extension.

- 2023 Paul Coverdell Forensic Science Improvement Grant Program Status Update: Mrs. Ashley Williams informed the Commission that funds have been released and Grants are working on reimbursements. Mrs. Williams reminded the districts to make their purchases and get the reimbursement forms submitted. Mrs. Williams also informed the Districts that Candace has sent out an email to the districts for UEI's and asked that those districts respond with the necessary information.

ISSUE NUMBER 3: UHR ID SERVICES AND FIGG UPDATE

- Deputy Director Leigh Clark of FDLE's Forensic Services gave an update on the Missing and Unidentified Human Remains (MUHR) Program and the Forensic Investigative Genetic Genealogy Grant (FIGG) Program. Ms. Clark gave an in-depth presentation on the expanded services that are being offered, the criteria for participation, and the FIGG-specific funding sources. The grant is open to local and state law enforcement agencies, Florida medical examiners offices, perpetrator cases, homicide victims, and unidentified human remains doe cases. Ms. Clark further explained the requirements for the FIGG Program submission process. PowerPoint presentation available by request.

ISSUE NUMBER 4: EMERGING DRUGS

- Bureau Chief Brett Kirkland, Ph.D. provided the Commission with an update on new drug trends on behalf of Bruce Goldberger, Ph.D. There were several new and significant findings of drugs in decedents during the last quarter. Most notably is the increase in the prevalence of N-isopropyl butylone, a novel synthetic stimulant and substituted cathinone. Further, there are additional reports of "pink cocaine" in Miami/Dade County. "Pink cocaine" is typically ketamine mixed with other substances including caffeine, cocaine, methamphetamine, MDMA and/or new psychoactive substances. Illicitly manufactured fentanyl is still the most frequently identified drug in decedents; and polysubstance use with fentanyl is common and includes cocaine and methamphetamine. Other drugs identified in decedents include bromazolam, N,N-dimethylpentylone, fluorofentanyl, PiHP, and xylazine. 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 Medical Examiners Commission, the Drug Enforcement Administration, and the Florida Department of Health. The last meeting of the toxicology directors was held on October 7, 2024.

ISSUE NUMBER 5: OTHER BUSINESS

- Ken Jones, State Registrar with the Florida Department of Health, Bureau of Vital Statistics, informed the Commission that out of state physicians were able to sign-off on death certificates. Mr. Jones advised the Commission and medical examiners to contact his office if there are any questions regarding the circumstances in which an out of state physician may sign-off on a death certificate. There was a discussion between Mr. Jones and the audience, unfortunately due to technical difficulties audio was not available. Please refer to Mr. Jones for any additional questions.

With no further business to come before the Commission, the meeting was adjourned at 11:12 A.M.

MEDICAL EXAMINERS COMMISSION

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Second Term: 2/10/2023 - 6/30/2023

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Third Term: 2/10/2023 - 6/30/2024

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VACANT
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Updated January 27, 2025

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District 1
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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.)
(Lisa Flannagan, 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.)
(Jason R. Van Roo, M.D.)

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ME Services Provided by District 4

District 4
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Jason R. Van Roo, M.D.
(Noel R. Agudo, M.D.)
(Michael Bell, M.D.)
(Leszek Chrostowski, M.D.)
(William F. Hamilton, 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.
Rachel A. Lange, M.D.
Chantel Njiwaji, M.D.
Tracey L. Shipe, D.O.
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(Michael Bell, M.D.)
(Thomas M. Coyne, M.D., Ph.D.)
(James W. Fulcher, M.D.)
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(Jason R. Van Roo, M.D.)

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(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.)

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(Noel A. Palma, M.D.)
(Jon R. Thogmartin, M.D.)
(Lee Tormos, M.D.)

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(Alexis Jelinek, M.D.)
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(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.)

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(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.)
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(Tracey L. Shipe, D.O.)
(Sajid S. Qaiser, M.D.)
(Vera V. Volnikh, M.D.)
(Barbara C. Wolf, M.D.)

District 10
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(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.)

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Katherine Kenerson, M.D.
Michael Kritselis, M.D.
Benjamin Mathis, M.D.
Tiffany Sheganoski, M.D.
Tuyet Tran, M.D.
Mariana Voudouri, M.D.
(Michael D. Bell, M.D.)
(Iouri G. Boiko, M.D., Ph.D.)
(Manfred Borges, M.D.)
(Marcela Chiste, M.D.)
(Marta Coburn, M.D.)
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(Marlon S. Osbourne, M.D.)
(Stephen Robinson, M.D.)
(Stacey A. Simons, M.D.)
(Terrill Tops, M.D.)
(Lee Marie Tormos, M.D.)

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(Leszek Chrostowski, M.D.)
(William F. Hamilton, M.D.)
(Stephen J. Nelson, M.D.)
(Robert R. Pfalzgraf, M.D.)
(Valerie J. Rao, M.D.)
(Wendolyn Sneed, M.D.)

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(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
Omar Ansari, M.D.
Abigail Alexander, M.D.
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.
Darin Trelka, M.D., Ph.D.
(Natalia Belova, M.D.)
(Kenneth Hutchins, M.D.)
(Katherine L. Kenerson, M.D.)
(Emma O. Lew, M.D.)
(Benjamin Mathis, M.D.)
(Heidi L. Reinhard, M.D.)
(Wendolyn Sneed, M.D.)
(Tuyet Tran, M.D.)

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
Manfred Borges, Jr., M.D.
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.)

District 24
ME Services Provided by District 5

District 25
ME Services Provided by District 9

( ) Indicates secondary appointment for cross coverage

SEMINOLE COUNTY
FLORIDA'S NATURAL CHOICE

LAKE
COUNTY, FL
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LAKE AND SEMINOLE COUNTIES' MEDICAL EXAMINER REDISTRICTING REQUEST

Medical Examiners Commission Meeting

Orlando Marriott Lake Mary

1501 International Parkway

Lake Mary, FL 32746

February 4, 2025

Seminole County
Florida's Natural Choice

Lake County, FL
Real Florida • Real Close

Purpose

Lake and Seminole Counties jointly and formally request a redistricting of Medical Examiner Districts 5 and 24 to serve their constituents better and to improve the current medical examiner district sizing.

More specifically, it is jointly requested that Lake County be removed from District 5 and reassigned to District 24.

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Presentation Outline

- Background
- Current Status
- Proposed Change
- Compliance with Florida Statutes
- Requested Action

Background

§ 406.05, F.S.   Medical examiner districts

The Medical Examiners Commission shall establish medical examiner districts within the state, taking into consideration population, judicial circuits of the state, geographical size of the area of coverage, availability of trained personnel, death rate by both natural and unnatural causes, and similar related factors. No county may be divided in the creation of a district. However, this limitation shall not prohibit cooperative arrangements among the several districts.

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Background

- Current Districts

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

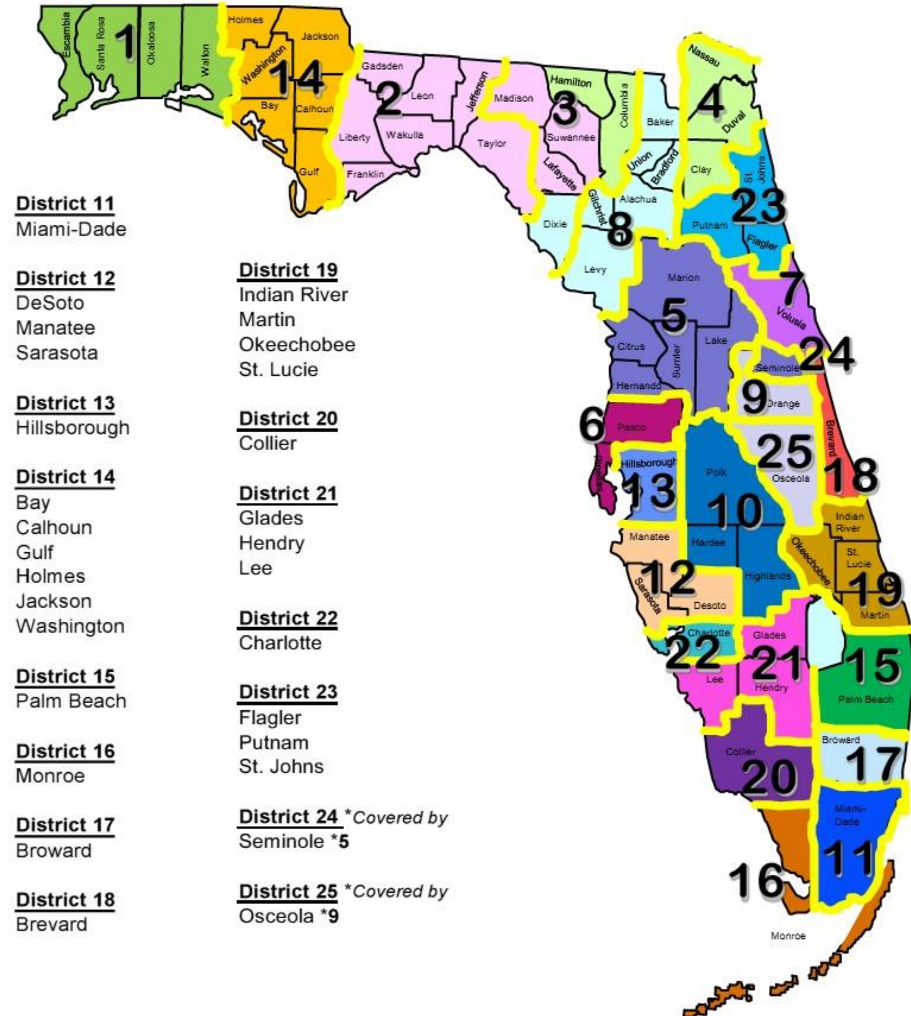
District 21
Glades
Hendry
Lee

District 22
Charlotte

District 23
Flagler
Putnam
St. Johns

District 24 *Covered by*
Seminole *5

District 25 *Covered by*
Osceola *9



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Current Status

- **District 5 – Citrus, Hernando, Lake, Marion, & Sumter Counties**
- **District 24 – Seminole County**
  - Currently, operates with District 5 under an Interlocal until 9/30/2029.
  - Services provided at the Medical Examiner facility located in Lake County at 809 Pine Street, Leesburg, Florida 32748.
  - The funding model is based upon a division of costs by population not services received.
  - All counties have one vote on a District Medical Examiner Committee established by the Interlocal Agreement.

SEMINOLE COUNTY
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Current Status

- Issues
  - The funding model is population-based. Lake and Seminole are subsidizing the services received by the other counties operating under this Interlocal Agreement.
  - Lake and Seminole pay approximately 49% of the cost while receiving 36% of the services.
  - Due to an increase in the need for services, the current facility is not large enough to support the work of all six (6) counties.
  - A new facility location was selected in Summerfield, Marion County.

SEMINOLE COUNTY
FLORIDA'S NATURAL CHOICE

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Proposed Change

- It is requested that Lake County be reassigned from the current Medical Examiner District 5 to District 24.
- Lake and Seminole Counties negotiated an Interlocal Agreement for the operation of a new two-county District 24 pending redistricting approval.
- Interlocal Agreement approved by Seminole County Board of County Commissioners on January 14, 2025.
- Interlocal Agreement approved by Lake County Board of County Commissioners on January 21, 2025.

SEMINOLE COUNTY
FLORIDA'S NATURAL CHOICE

LAKE COUNTY, FL
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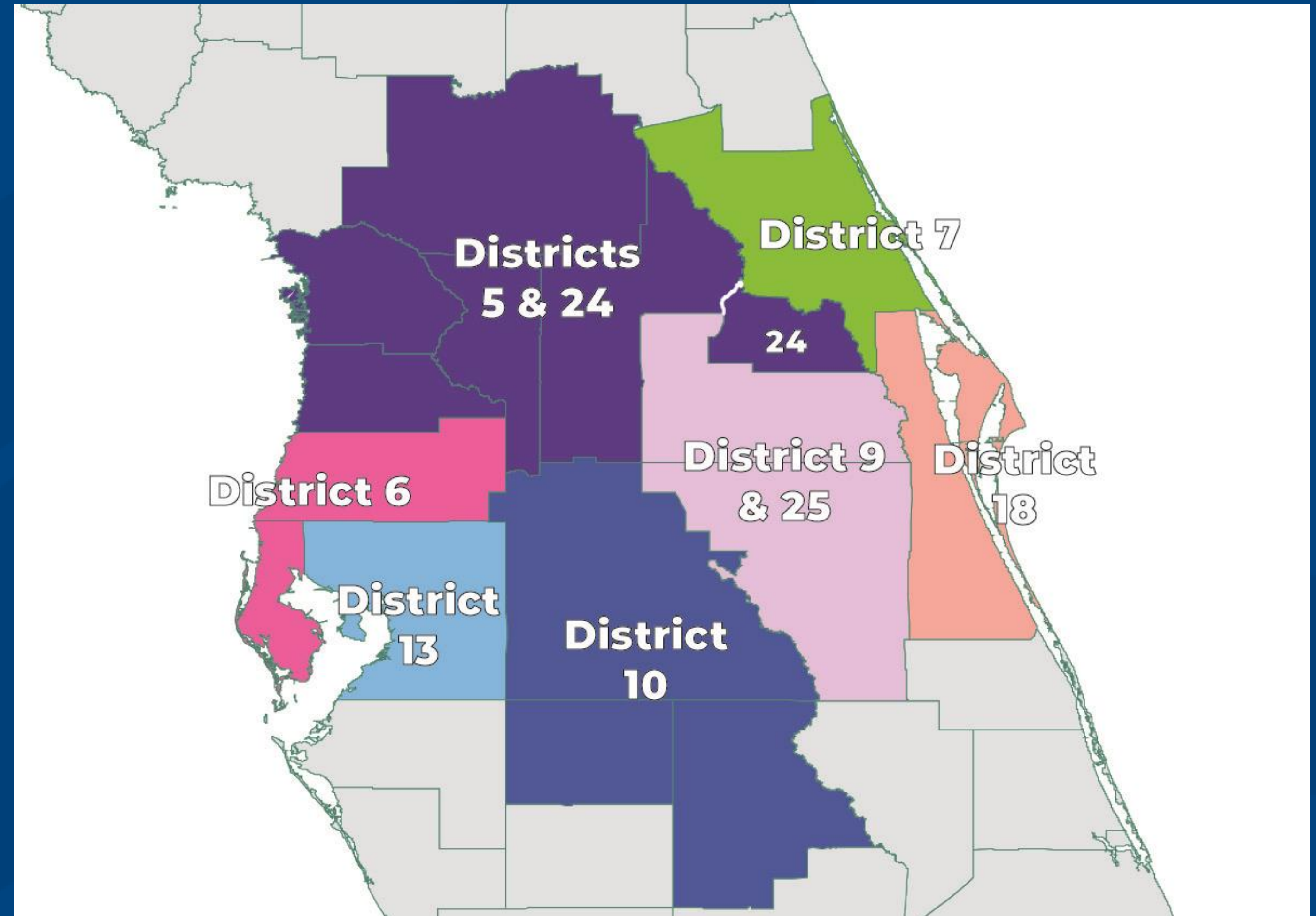
Proposed Change

- Existing District Map



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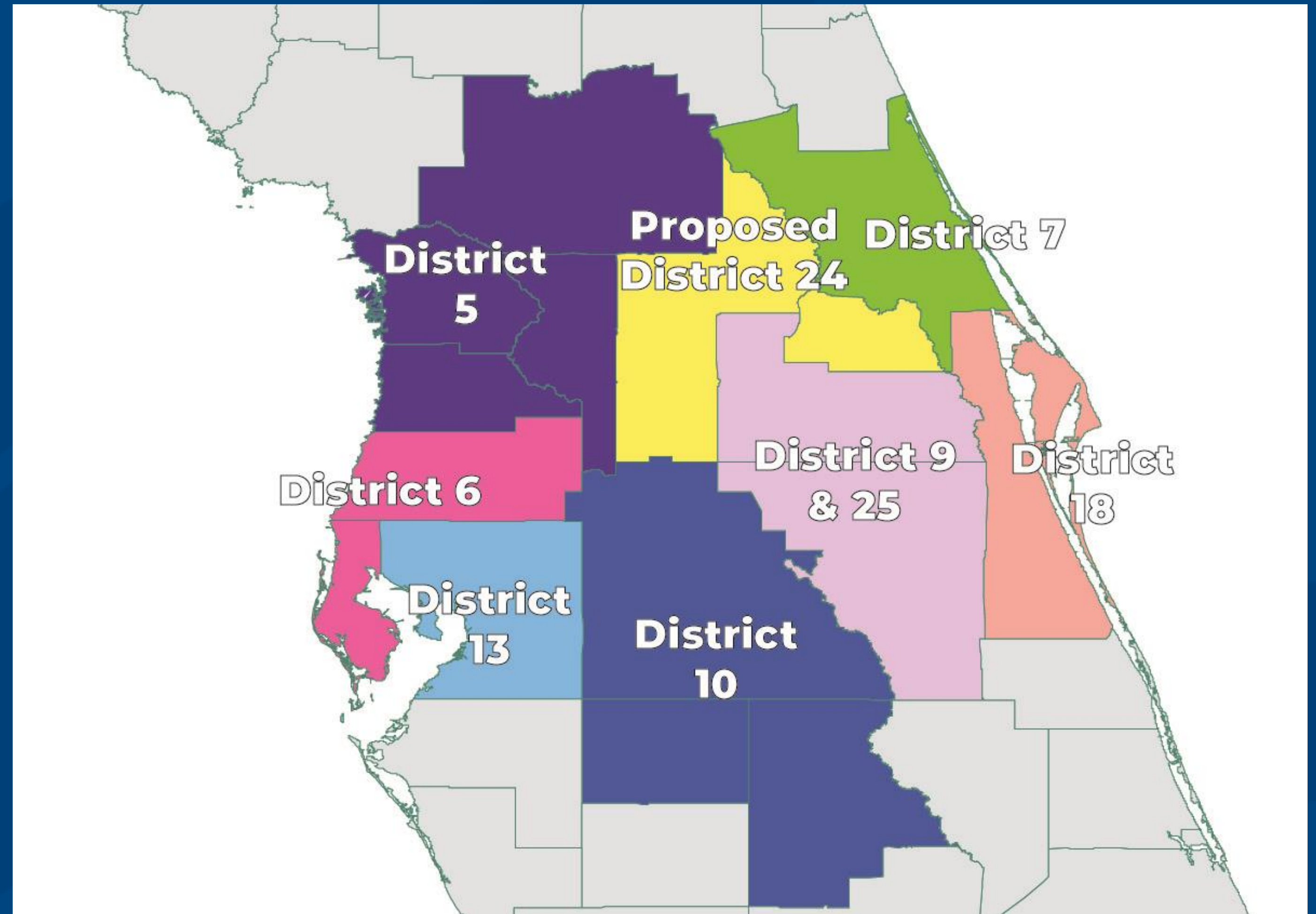
Proposed Change

- Proposed District Map



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Proposed Change

- Approved Interlocal Agreement Points:
  - Use the existing Medical Examiner Facility that is located in Lake County at 809 Pine Street, Leesburg, Florida 32748, as the new District 24 Medical Examiner Facility.
  - Seminole agrees to pay Lake half of the building cost to establish joint ownership.
  - Each county is to contribute 16% of the annual operating cost during the term of the Agreement into a building improvement fund for building expansion or improvement.
  - Seminole will become the Administrative Coordinator.
  - Fee for service cost share model based upon services used by each county vs. population.
  - Any other costs divided equally.

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Compliance with Florida Statute

- § 406.05, F.S. outlines the criteria for consideration in establishing medical examiner districts:
  - Population
  - Judicial Circuits
  - Geographical Size
  - Availability of Trained Personnel
  - Death Rate (natural and unnatural causes)
  - Similar Related Factors
  - No County may be divided in the creation of a district

Seminole County
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Statutory Compliance

- Population

MEDICAL EXAMINER DISTRICT BY POPULATION					
COUNTY	APR. 2024 (EST)	CURRENT DISTRICT 5	CURRENT DISTRICT 24	PROPOSED DISTRICT 5	PROPOSED DISTRICT 24
Citrus	166,151	166,151		166,151	
Hernando	210,577	210,577		210,577	
Lake	433,331	433,331			433,331
Marion	419,510	419,510		419,510	
Seminole	493,282		493,282		493,282
Sumter	156,743	156,743		156,743	
	TOTAL	**1,386,312**	**493,282**	**952,981**	**926,613**

SOURCE https://www.edr.state.fl.us/Content/population-demographics/data/index-floridaproducts.cfm

SEMINOLE COUNTY
FLORIDA'S NATURAL CHOICE

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Statutory Compliance

- Population

CURRENT MEDICAL EXAMINER DISTRICT BY POPULATION

DISTRICT	POPULATION	DISTRICT	POPULATION
DISTRICT 01	853,875	DISTRICT 14	322,731
DISTRICT 02	443,169	DISTRICT 15	1,545,905
DISTRICT 03	177,610	DISTRICT 16	84,147
DISTRICT 04	1,402,948	DISTRICT 17	1,981,888
DISTRICT 05	1,386,312	DISTRICT 18	653,703
DISTRICT 06	1,604,247	DISTRICT 19	761,858
DISTRICT 07	594,643	DISTRICT 20	408,381
DISTRICT 08	433,995	DISTRICT 21	885,244
DISTRICT 09	1,511,568	DISTRICT 22	210,645
DISTRICT 10	958,082	DISTRICT 23	543,927
DISTRICT 11	2,774,841	DISTRICT 24	493,282
DISTRICT 12	969,870	DISTRICT 25	451,231
DISTRICT 13	1,560,449		
AVERAGE			920,582
PROPOSED DISTRICT 5			952,981
PROPOSED DISTRICT 24			926,613

Statutory Compliance

- Judicial Circuits
  - The majority of Florida Medical Examiner Districts are operating in their same designated Judicial Circuit.
  - Approximately 12% of counties' Medical Examiner Districts are operating outside of their designated Judicial Circuit.
  - Lake and Seminole are neighboring counties; however, are not in the same Judicial Circuit.
  - Seminole has been operating its Medical Examiner services in a District different from its designated Judicial Circuit.
  - The proposed request is considered consistent with the Florida Statute because of its geographic proximity and the comparable operations of other Districts.

Seminole County
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Statutory Compliance

- Size

MEDICAL EXAMINER DISTRICT BY SIZE					
COUNTY	SQUARE MILES	CURRENT DISTRICT 5	CURRENT DISTRICT 24	PROPOSED DISTRICT 5	PROPOSED DISTRICT 24
Citrus	582	582		582	
Hernando	473	473		473	
Lake	938	938			938
Marion	1,584	1,584		1,584	
Seminole	309		309		309
Sumter	547	547		547	
	TOTAL	4,124	309	3,186	1,247

SEMINOLE COUNTY
FLORIDA'S NATURAL CHOICE

LAKE COUNTY, FL
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Statutory Compliance

- Size

CURRENT MEDICAL EXAMINER DISTRICT BY SIZE			
DISTRICT	SQUARE MILES	DISTRICT	SQUARE MILES
DISTRICT 01	3,635	DISTRICT 14	3,868
DISTRICT 02	4,801	DISTRICT 15	1,972
DISTRICT 03	3,945	DISTRICT 16	979
DISTRICT 04	2,014	DISTRICT 17	1,207
DISTRICT 05	4,124	DISTRICT 18	1,016
DISTRICT 06	1,021	DISTRICT 19	2,387
DISTRICT 07	1,102	DISTRICT 20	2,002
DISTRICT 08	3,466	DISTRICT 21	2,744
DISTRICT 09	903	DISTRICT 22	680
DISTRICT 10	3,453	DISTRICT 23	1,813
DISTRICT 11	1,893	DISTRICT 24	309
DISTRICT 12	1,936	DISTRICT 25	1,328
DISTRICT 13	1,019		
LARGEST AREA (DISTRICT 02)			4,801
SMALLEST AREA (DISTRICT 24)			309
AVERAGE			2,145
PROPOSED DISTRICT 5			3,186
PROPOSED DISTRICT 24			1,247

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Statutory Compliance

- Availability of Trained Personnel
  - Currently, District 24 partners with District 5 (Marion, Lake, Hernando, Sumter, Citrus) for medical examiner services provided by a private firm: Medicus Forensics, P.A.
  - Preliminary conversations with Medicus Forensics, P.A. has indicated a willingness and ability to continue to provide services for both Districts if the proposed redistricting is approved.
  - Effectively, the current workload of Medicus Forensics, P.A. will remain the same.

Seminole County Florida's Natural Choice

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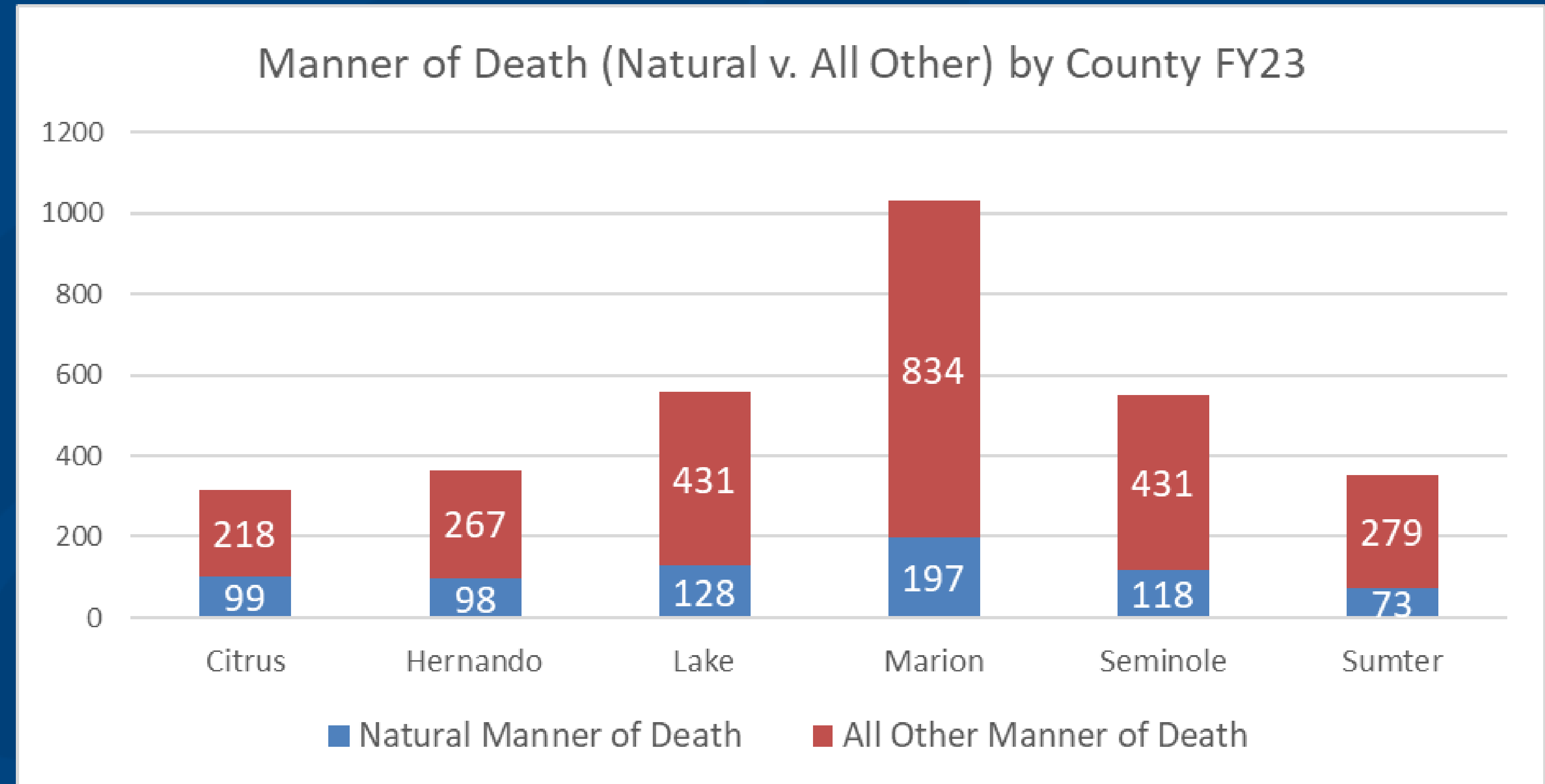
Statutory Compliance

- Death Rate

  (natural and unnatural causes)



SEMINOLE COUNTY
FLORIDA'S NATURAL CHOICE

LAKE COUNTY, FL
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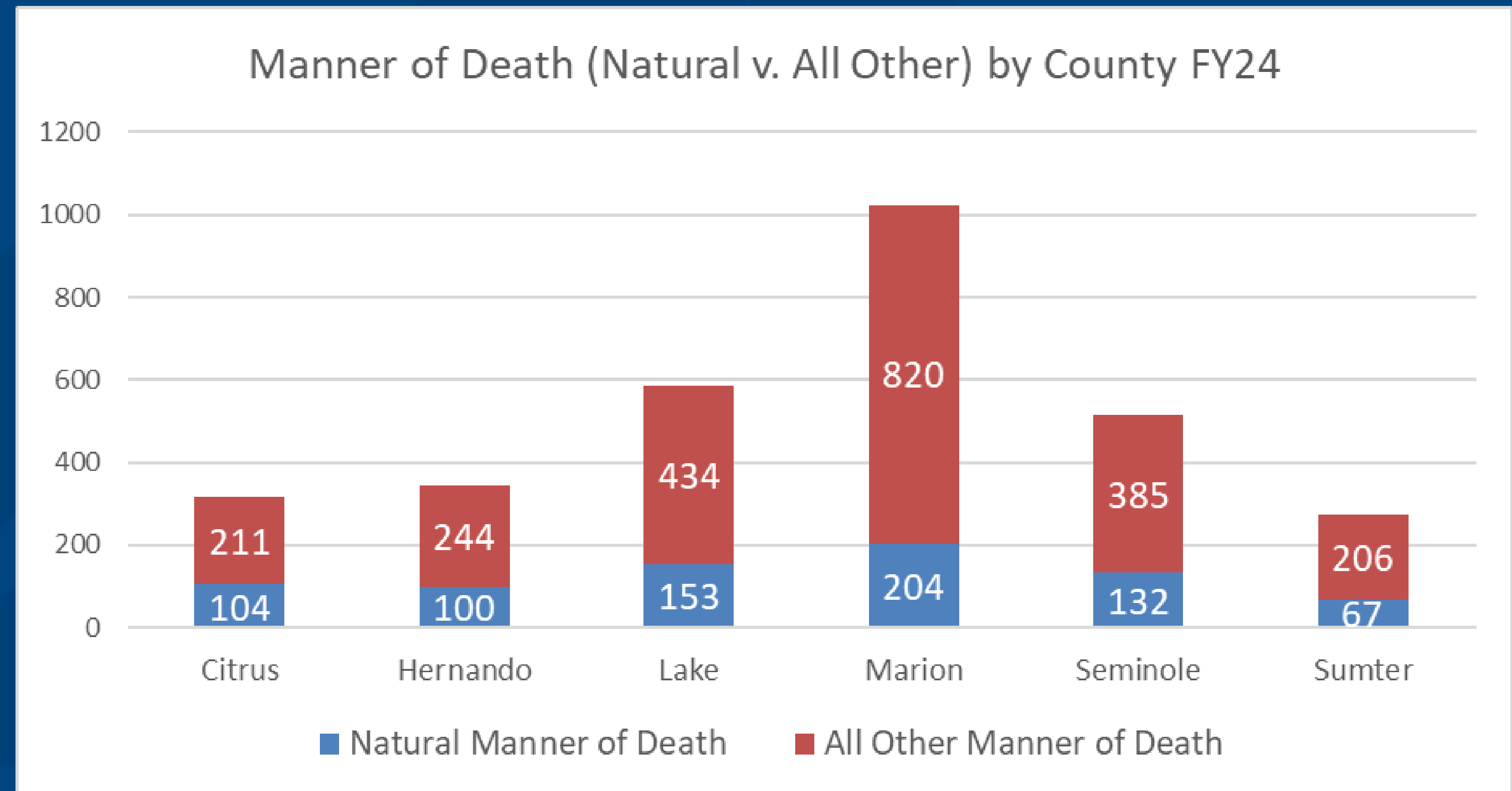
Statutory Compliance

- Death Rate

  (natural and unnatural causes)



Seminole County
Florida's Natural Choice

Lake
County, FL
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Statutory Compliance

- Death Rate FY23

FY 23 TOTAL DEATHS					
COUNTY	TOTAL DEATHS	CURRENT DISTRICT 5 TOTAL DEATHS	CURRENT DISTRICT 24 TOTAL DEATHS	PROPOSED DISTRICT 5 TOTAL DEATHS	PROPOSED DISTRICT 24 TOTAL DEATHS
Citrus	317	317		317	
Hernando	365	365		365	
Lake	559	559			559
Marion	1031	1031		1031	
Seminole	549		549		549
Sumter	352	352		352	
	TOTAL	2,624	549	2,065	1,108

SEMINOLE COUNTY
FLORIDA'S NATURAL CHOICE

LAKE COUNTY, FL
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Statutory Compliance

- Death Rate FY24

FY 24 TOTAL DEATHS					
COUNTY	TOTAL DEATHS	CURRENT DISTRICT 5 TOTAL DEATHS	CURRENT DISTRICT 24 TOTAL DEATHS	PROPOSED DISTRICT 5 TOTAL DEATHS	PROPOSED DISTRICT 24 TOTAL DEATHS
Citrus	315	315		315	
Hernando	344	344		344	
Lake	587	587			587
Marion	1024	1024		1024	
Seminole	517		517		517
Sumter	273	273		273	
	TOTAL	**2,543**	**517**	**1,956**	**1,104**

Statutory Compliance

- Natural Death Rate FY23

FY 23 NATURAL DEATHS						
COUNTY	NATURAL DEATHS	% NATURAL	CURRENT DISTRICT 5 NATURAL DEATHS	CURRENT DISTRICT 24 NATURAL DEATHS	PROPOSED DISTRICT 5 NATURAL DEATHS	PROPOSED DISTRICT 24 NATURAL DEATHS
Citrus	99	31%	99		99	
Hernando	98	27%	98		98	
Lake	128	23%	128			128
Marion	197	19%	197		197	
Seminole	118	21%		118		118
Sumter	73	21%	73		73	
		TOTAL	595	118	467	246

SEMINOLE COUNTY
FLORIDA'S NATURAL CHOICE

LAKE COUNTY, FL
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Statutory Compliance

- Natural Death Rate FY24

FY 24 NATURAL DEATHS						
COUNTY	NATURAL DEATHS	% NATURAL	CURRENT DISTRICT 5 NATURAL DEATHS	CURRENT DISTRICT 24 NATURAL DEATHS	PROPOSED DISTRICT 5 NATURAL DEATHS	PROPOSED DISTRICT 24 NATURAL DEATHS
Citrus	104	31%	104		104	
Hernando	100	27%	100		100	
Lake	153	23%	153			153
Marion	204	19%	204		204	
Seminole	132	21%		132		132
Sumter	67	21%	67		67	
		TOTAL	**628**	**132**	**475**	**285**

SEMINOLE COUNTY
FLORIDA'S NATURAL CHOICE

LAKE
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Summary

- Lake and Seminole Counties have executed an Interlocal Agreement subject to the approval of both the Medical Examiner Commission and the Governor.
- The proposed District change would be consistent with statutory requirements.
- The proposed District would be more conveniently located to better serve the citizens of Lake and Seminole counties.
- The funding model is more appropriate and equitable for each county and its citizens.

SEMINOLE COUNTY
FLORIDA'S NATURAL CHOICE

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Requested Action

Lake and Seminole Counties would like to formally request that the Medical Examiner Commission approve a redistricting of Medical Examiner Districts 5 and 24 to move Lake County from District 5 to District 24 and to recommend approval of said redistricting to the Governor.

Thank you

THE STATE OF FLORIDA

FATALITY MANAGEMENT RESPONSE PLAN

of the FLORIDA MEDICAL EXAMINERS COMMISSION

Version ~~6~~7.0
~~July 19~~February 4, 2025~~3~~

(To supplement the State Comprehensive Emergency Management Plan)

*** These are recommendations from the Medical Examiners Commission staff ***

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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 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 20, 2020
Version 6, Adopted at the Medical Examiner's Commission meeting of July 19, 2023

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

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 requesting support assets calls for exhausting local assets before requesting state assets. Likewise, state assets need to be exhausted before requesting federal assets.

There are two primary organizations that provide major resources to a medical examiner having to deal with an incident that exceeds the assets of the local government.

The first is the Florida Emergency Mortuary Operations Response System (FEMORS) which is a State of Florida asset 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.

The second is the federal government's Disaster Mortuary Operational Response Team (DMORT). When a federal declaration has been made concerning a local disaster DMORT's personnel and equipment can be deployed to the disaster site.

The major distinction between the two is that FEMORS can reasonably expect to staff and manage an event for approximately 30 to 40 days. If the activation period is anticipated to require a longer support time, DMORT may be called upon to assist. Any transitional change would be totally seamless since both 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 3 days. DMORT can take several days 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, fingerprint, odontology, anthropology, 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.

V Concept of Operations

A. General

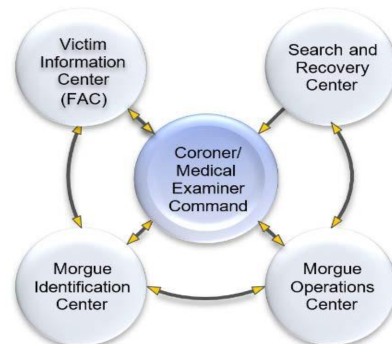
1. Mass fatality disasters have the potential to quickly overwhelm the resources of a medical examiner's operation depending on the capacity of the facility and the number of fatalities. Offices that are overwhelmed may seek assistance at local, state and federal levels.

2. Disaster situations may range from just a few victims to very high numbers. Additionally, the 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.

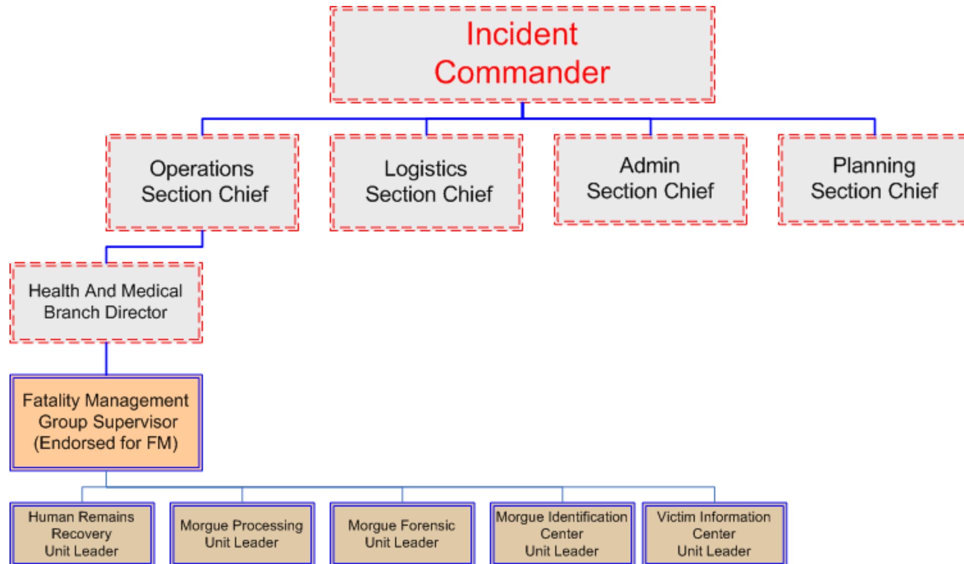
4. Deaths resulting from acts of homicide, suicide, or accident, and those constituting a threat to public health, fall under the jurisdiction of the medical examiner (Chapter 406.11, Florida Statutes). For this reason, the medical examiner assumes custody of any such death to determine the cause of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



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 *Groups* such as Medical Response/EMS, Sheltering, Special Needs, Fatality Management, and others.



7. The medical examiner 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 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 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.

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)

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 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).

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 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 event. FEMORS is a sponsored activity of the University of Florida in collaboration with the Maples Center for Forensic Medicine.

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 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 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 with a potential for significant loss of life, a medical examiner should attempt to assess the scope of the 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; and,
   d. if the facility has been damaged by the event (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 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, within 4 hours if possible, to ascertain if help is needed or to arrange for an appropriate meeting location.

4. Simultaneously, FEMORS initiates its 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 either in concert with the existing medical examiner facility or at a remote location;

   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, and
   d. 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.

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 Weapons of Mass Destruction (WMD) Team.

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. 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.

3. 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 a number of areas.
   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
- **F.** Post-Processing Transportation and Storage
- **G.** Body Release for Final Disposition
- **H.** Victim information Center Support
- **I.** Records Management (Victim Processing)
- **J.** Records Management (Accounting and Finance)
- **K.** Progress Reports and Public Information

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.

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.

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 number.
   d. If remains are not connected by clothing or tissue, they must be packaged separately and assigned different 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 X-rays
        - FP01 Finger Prints
        - DX01 Dental X-rays
        - DN01 DNA Specimens (post mortem)
        - DB01 DNA Family Samples (Buccal swabs)
        - DR01 DNA Reference Specimens (known victim DNA)

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

b. 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 may be matched by dental or DNA identification to one individual.

c. 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.

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. With the exception of obvious weather caused 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.

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. death investigation personnel, and
3. law enforcement.

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 storage capabilities, medical examiners may need to incorporate the use of supplemental refrigeration (such as refrigerated 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 with an industrial air conditioning unit.
5. Remains delivered from the incident site must be kept segregated from remains already processed.
6. During the transporting and storing process, human remains should not be stacked upon one another. 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.

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

examiner headquarters to become a target of attack, and if the district 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 morgue operation entails: intake/admitting, triage, photography, evidence, personal effects, pathology/toxicology, radiology, 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/she should think about discussing his/her intentions with the lead law enforcement agency and the Department of Health, since each of these agencies has 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.

4. Documentation of Processing
   a. In addition to assessment of anatomic findings (pathology/toxicology reports) to support a determination of cause of death, processing provides the only opportunity to preserve information needed to establish positive identification of the remains.
   b. Processing of each case includes photography, collection of evidence, and/or personal effects. Properly documented "chain of custody" is essential for all such processing.
   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 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) Processing
   a. Specialists with experience in the use of x-ray should be used to process remains.
   b. Comprehensive x-ray documentation 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.

7. Dental Processing
   a. Specialists with experience in recognizing dental structures and recording by means of x-ray and 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 x-ray and 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, 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 medical records

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 specimen for DNA testing from each case processed.

b. 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.

c. Laboratory testing of DNA specimens will need to be coordinated 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
- 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.

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 the funeral home selected by the family. The funeral service provider responds to transport the remains 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

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 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 the management of an incident with mass fatalities. This may be part of a 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, 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:
      - law enforcement agents,
      - medical examiner investigators,
      - 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.

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. 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 x-rays,
      - CD or other storage media copy of all digital dental x-rays taken,
      - Printouts of digital body x-rays,
      - CD or other storage media copy of all digital body 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
      - 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 parts),

- Dental records (ante and post mortem),
- Morgue Photographs,
- DNA submission documents,
- Body X-Ray identification (ante and post mortem),
- Fingerprints and comparisons made, and
- Remains release and funeral 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, 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.

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, ~~and~~ a brief synopsis, and an indication of whether the case is a directly or indirectly related disaster death. This list becomes the official list ~~as~~ 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.

~~c.~~

3. Normally, the Incident Commander will arrange for an official 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.

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, 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 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.

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 items that are useful in the identification process: photographs, fingerprints, dental and somatic radiographs, and DNA.

B. Epidemic Outbreak Myth

Often a principle 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 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 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, 2020, (https://www.floridadisaster.org/globalassets/cemp/2020-cemp/2020-state-cemp.pdf)
3. CEMP Appendix VIII - Emergency Support Function 8 - Health and Medical Services (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

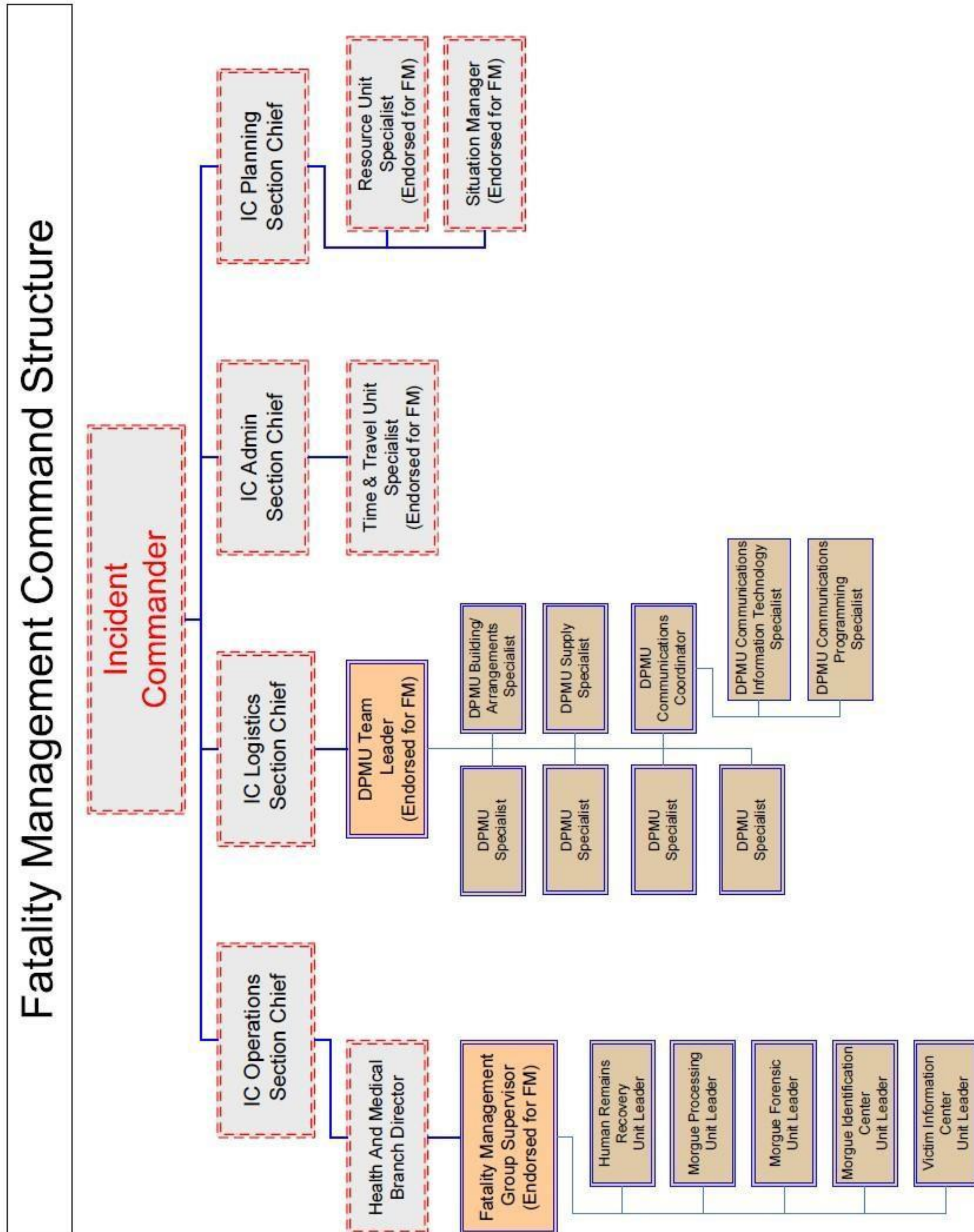
XI Medical Examiner Districts

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 Co. Service by District 8 Lafayette, Madison, & Suwannee counties Service by District 2 Columbia & Hamilton counties 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
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

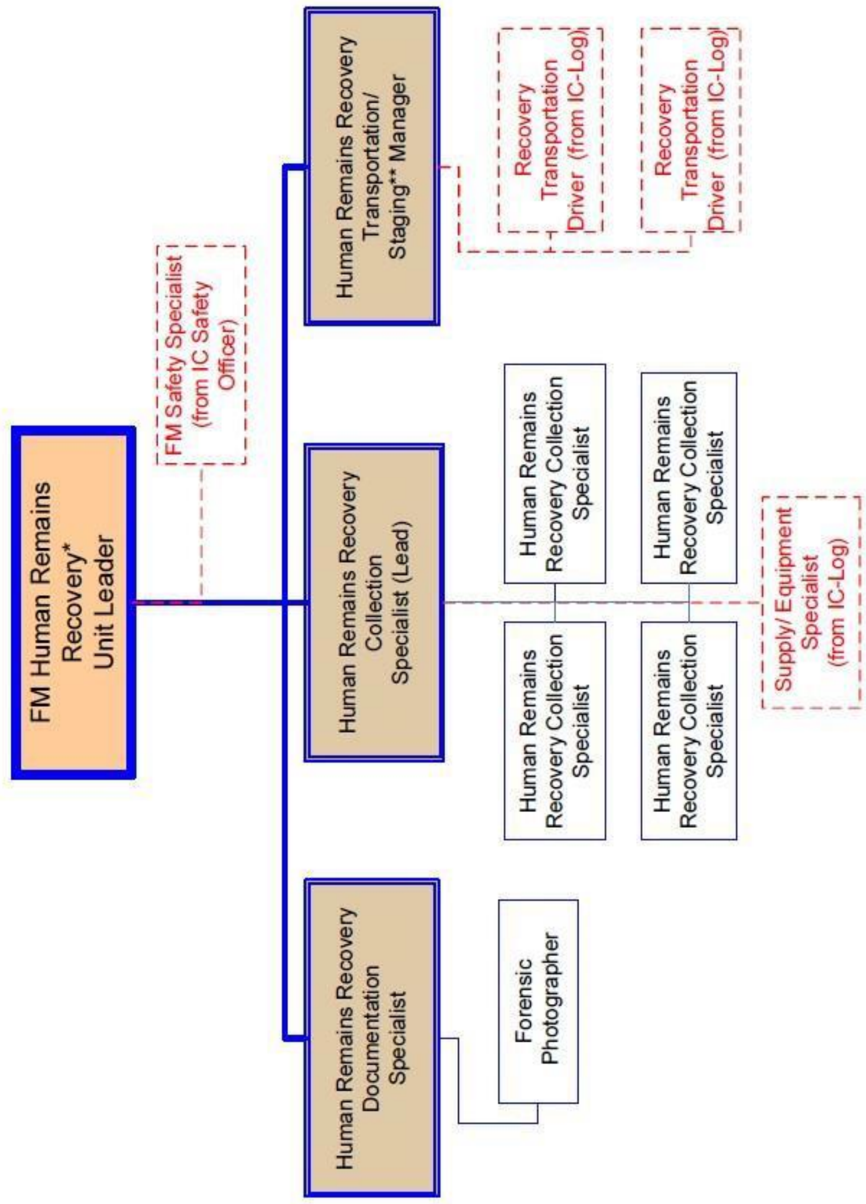
District	Address	City	Office Phone
12	2001 Siesta Drive, Suite 302	Sarasota 34239	(941) 361-6909
13	11025 North 46th Street	Tampa 33617	(813) 914-4500
14	3737 Frankford Avenue	Panama City 32405	(850) 747-5740
15	3126 Gun Club Road	West Palm Beach 33406	(561) 688-4575
16	56639 Overseas Highway	Marathon 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

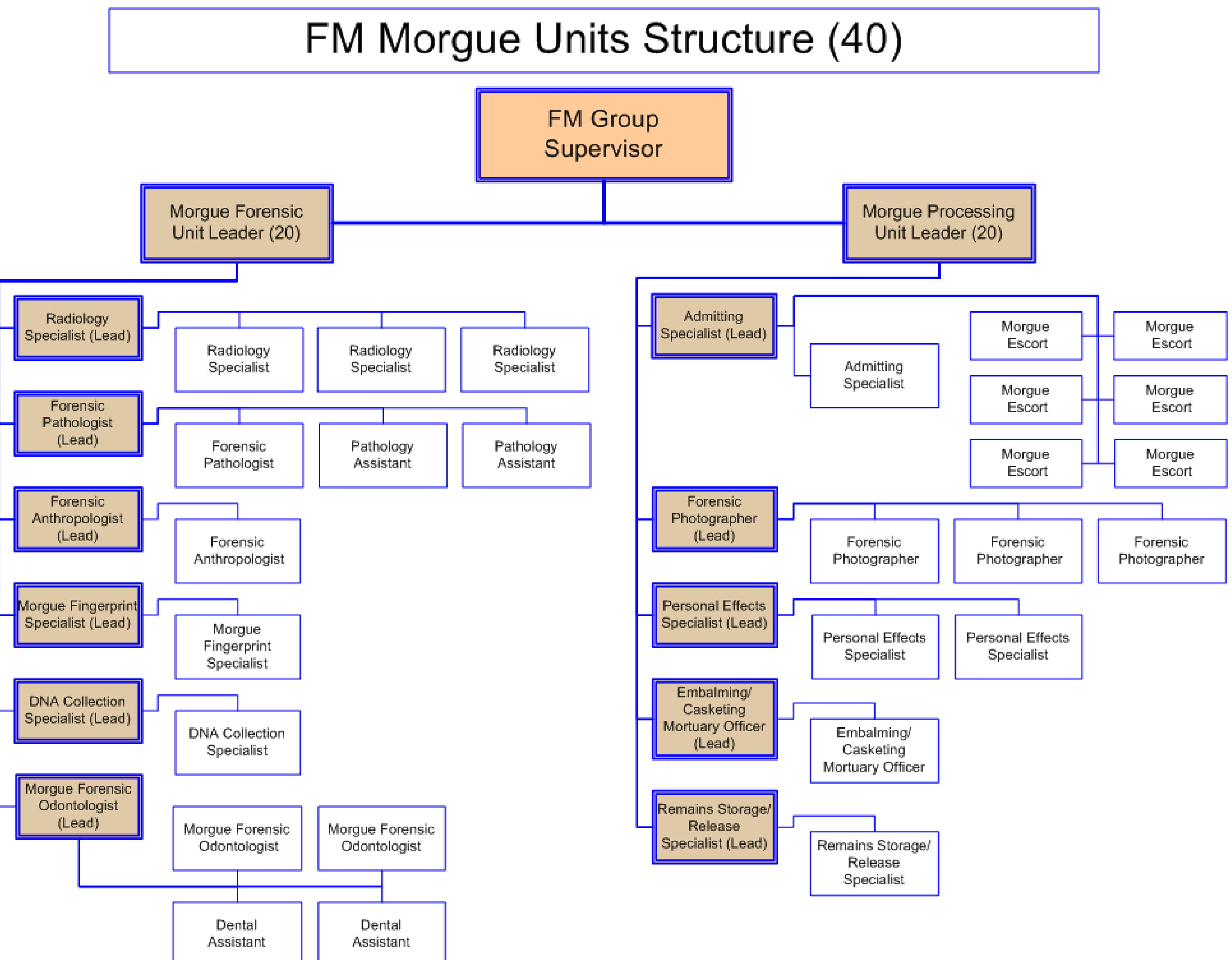
XII Fatality Management ICS Organization Charts
(Dotted lines indicate positions supplied by the overall Incident Command)

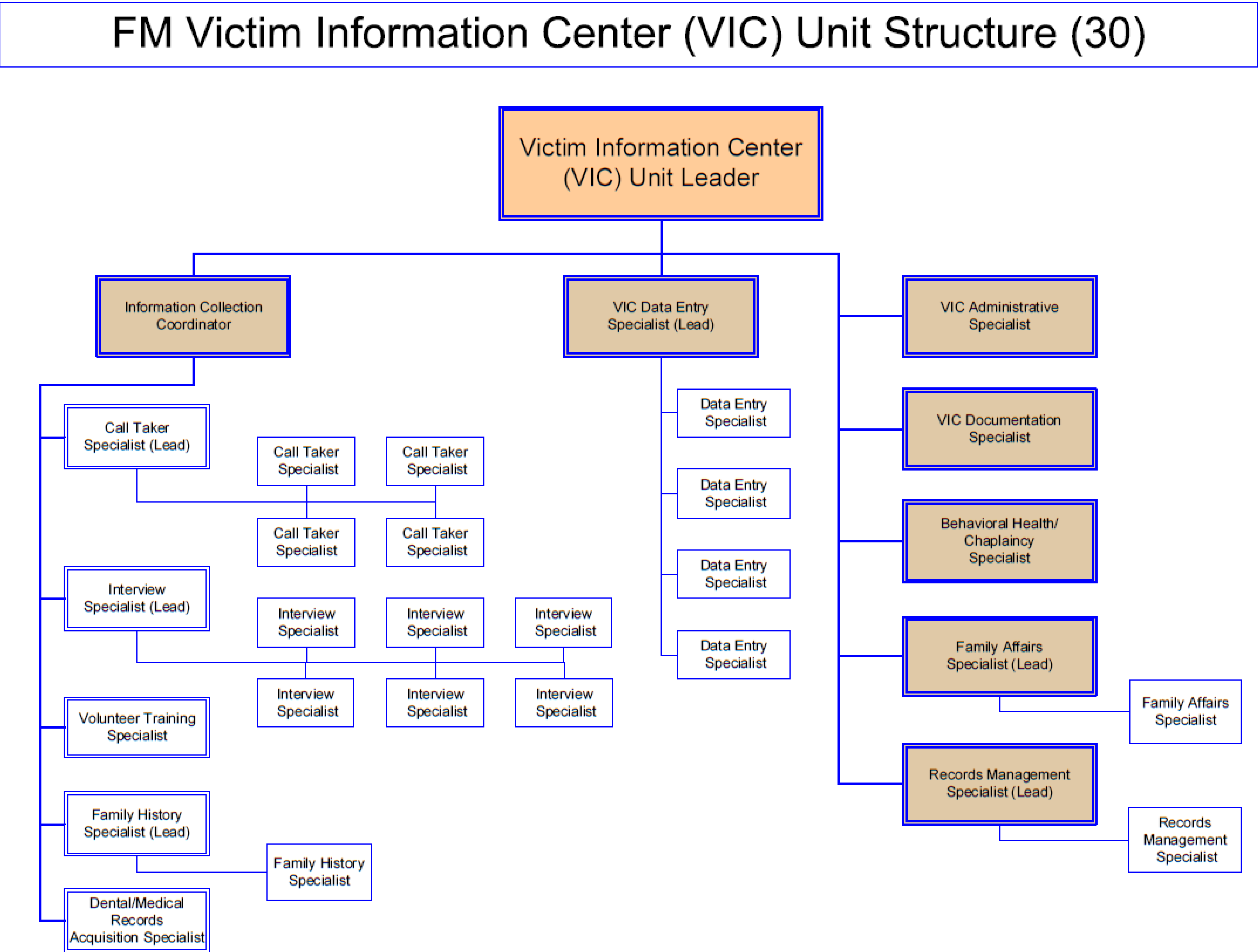


FM Human Remains Recovery Unit Structure (9)

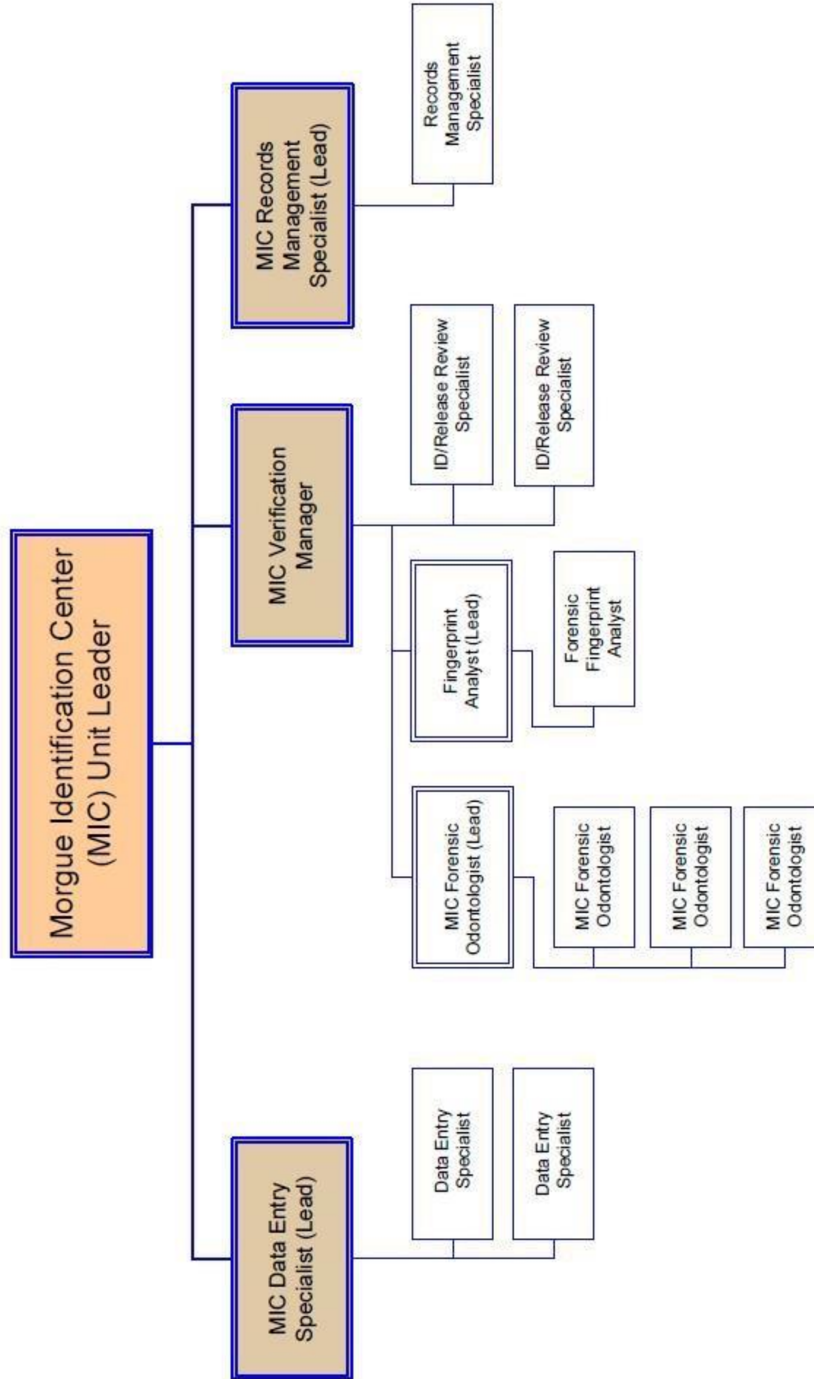


* Set up per geographic site; if there are multiple sites
** Transportation Team may provide service to multiple sites

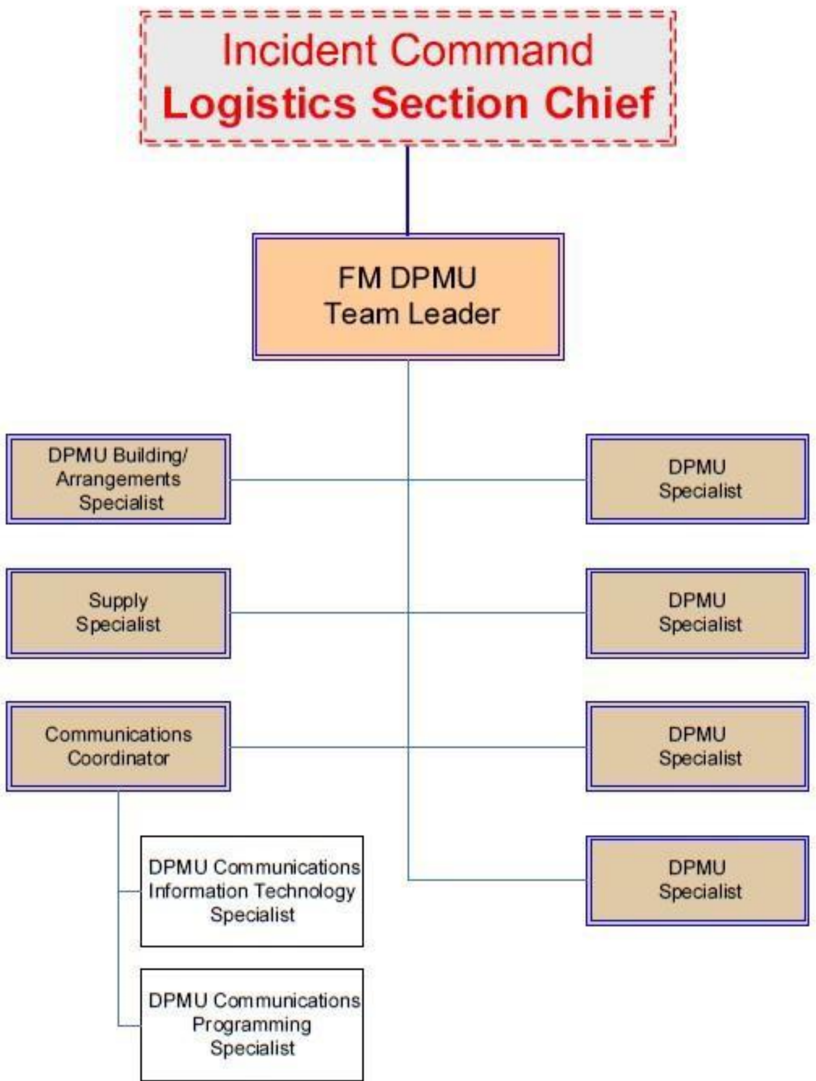

FM Morgue Units Structure (40)
FM Group Supervisor
Morgue Forensic Unit Leader (20)
Morgue Processing Unit Leader (20)
Radiology Specialist (Lead)
Radiology Specialist
Radiology Specialist
Radiology Specialist
Forensic Pathologist (Lead)
Forensic Pathologist
Pathology Assistant
Pathology Assistant
Forensic 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
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


FM Victim Information Center (VIC) Unit Structure (30)
Victim Information Center (VIC) Unit Leader
Information Collection Coordinator
VIC Data Entry Specialist (Lead)
VIC Administrative Specialist
VIC Documentation Specialist
Behavioral Health/ Chaplaincy Specialist
Family Affairs Specialist (Lead)
Family Affairs Specialist
Records Management Specialist (Lead)
Records Management Specialist
Data Entry Specialist
Data Entry Specialist
Data Entry Specialist
Data Entry Specialist
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
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)



Fatality Management DPMU Team (State Level-10)



DPMU – Disaster Portable Morgue Unit