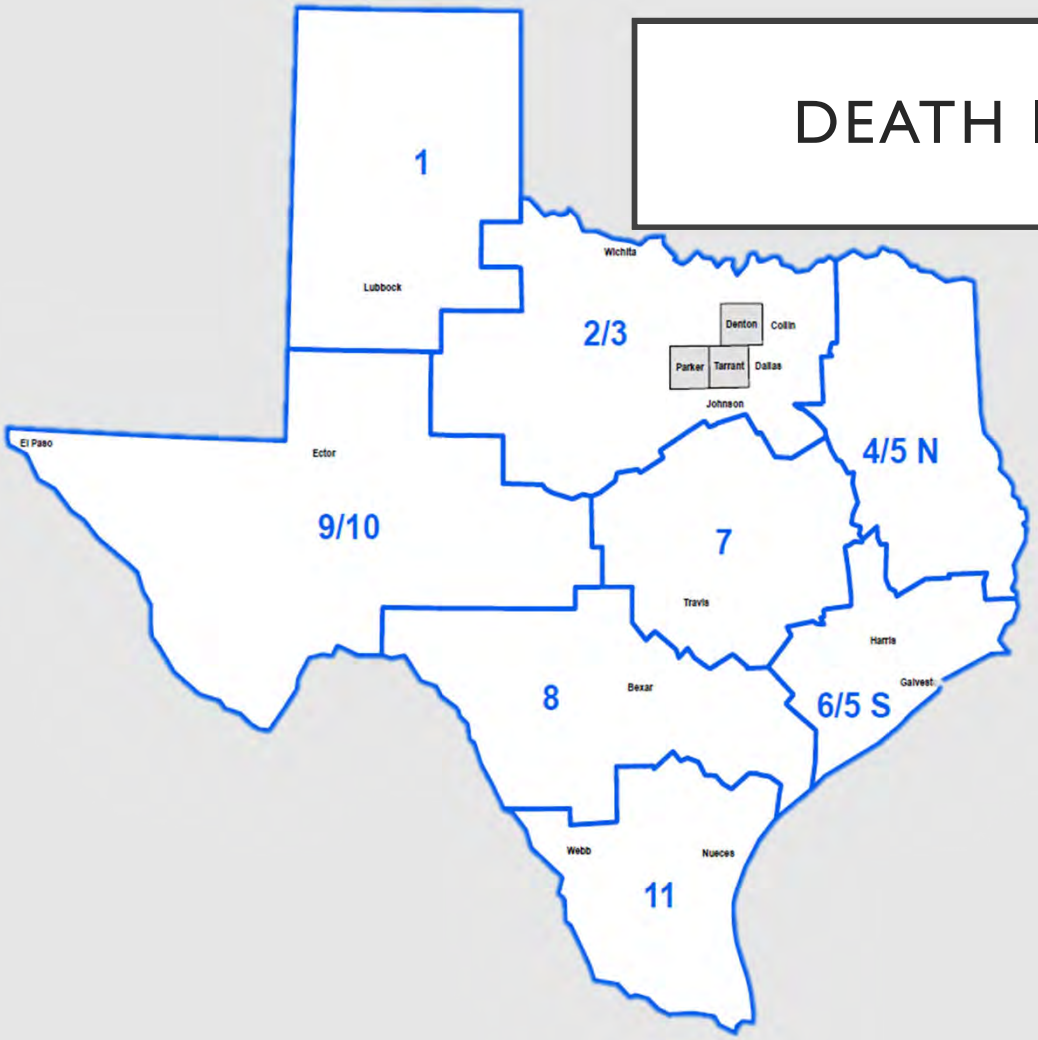
TMORT

TEXAS MASS FATALITY OPERATIONS RESPONSE TEAM

HISTORY AND CONTEXT

DEATH INVESTIGATION IN TEXAS



No	• State Medical Examiner
254	• Counties
>1 million	County population that requires ME office
59%	• Population served by ME office
13	Medical Examiners (serving 16 counties)
At least 1	• Justice of the Peace (Coroner) in other counties

DEATH INVESTIGATION IN TEXAS

- Inquest law: mandates the circumstances under which deaths are to be investigated, and how they are investigated.
  - Medical Examiner (Subchapter A), Coroner/Justice of the Peace (Subchapter B)
- Inquest: An inquest is a judicial inquiry conducted by a judge, jury or government official (in Texas a JP) to determine the cause of a person's death.
  - May or may not require an autopsy
  - Required for sudden or unexplained deaths
- Autopsy: highly specialized surgical procedure that consists of a thorough examination of a decedent to determine the cause and manner of death
  - Performed by a specialized medical doctor called a pathologist
  - Performed for either legal or medical purposes
- Medicolegal Authority: The entity in a local jurisdiction that is tasked with investigating unexpected deaths. This role is filled either by a Medical Examiner or by a Justice of the Peace

DEATH INVESTIGATION IN TEXAS

- Justice of the Peace:
  - Elected county officials responsible for inquests
  - Hears traffic and other Class C misdemeanor cases punishable by fine only
  - Hears civil cases with up to $10,000 in controversy
  - Hears landlord and tenant disputes
  - Hears truancy cases
  - Performs magistrate duties
  - Conducts inquests
  - Justices of the peace are required to obtain 80 hours during their first year in office and 20 hours annually thereafter.
    - No medical or forensic qualifications or training required

DEATH INVESTIGATION IN TEXAS

- Homicide
- Suicide
- Motor vehicle crashes
- Overdoses
- No attending physician
- Confined to public institution (in custody)
- Industrial accidents
- On the job
- Child <6 years old
- Any death due to trauma
- Any death due to abuse or neglect
- Within 24 hours of admission to a hospital

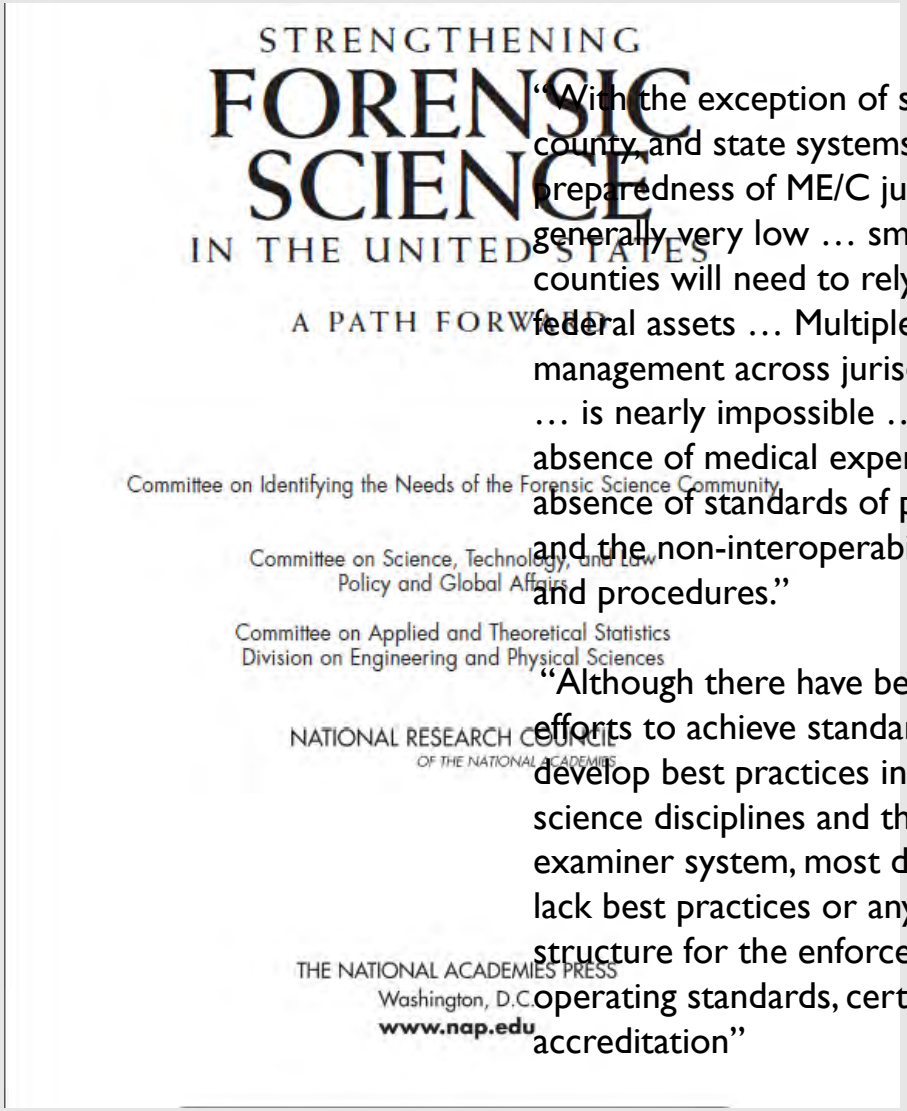
State law reads the same for both Medical Examiner ***and*** Justice of the Peace

DEATH INVESTIGATION IN TEXAS

- Medicolegal authority responsibilities:
  - Scene investigation
  - Decedent transport
  - Postmortem examination
    - Cause and manner certification
  - Decedent identification
  - Notification of NOK
  - Release to funeral agency

DEATH INVESTIGATION IN TEXAS

- 2014: 183,303 total deaths in Texas
  - The 16 medical examiner counties account for 96,888 (~6055)
  - The remaining 238 counties account for 86,415 (~363)
  - ~31,000 reported
  - ~60% of deaths reported are not ME jurisdiction (~18,600)
  - Non-ME jurisdictions averaged 52 medicolegal cases
- Mass fatality incident characteristics differ from typical casework
  - Multi-gunshot homicides
  - Fire, commingling
  - Complicated identifications
  - Media/political attention

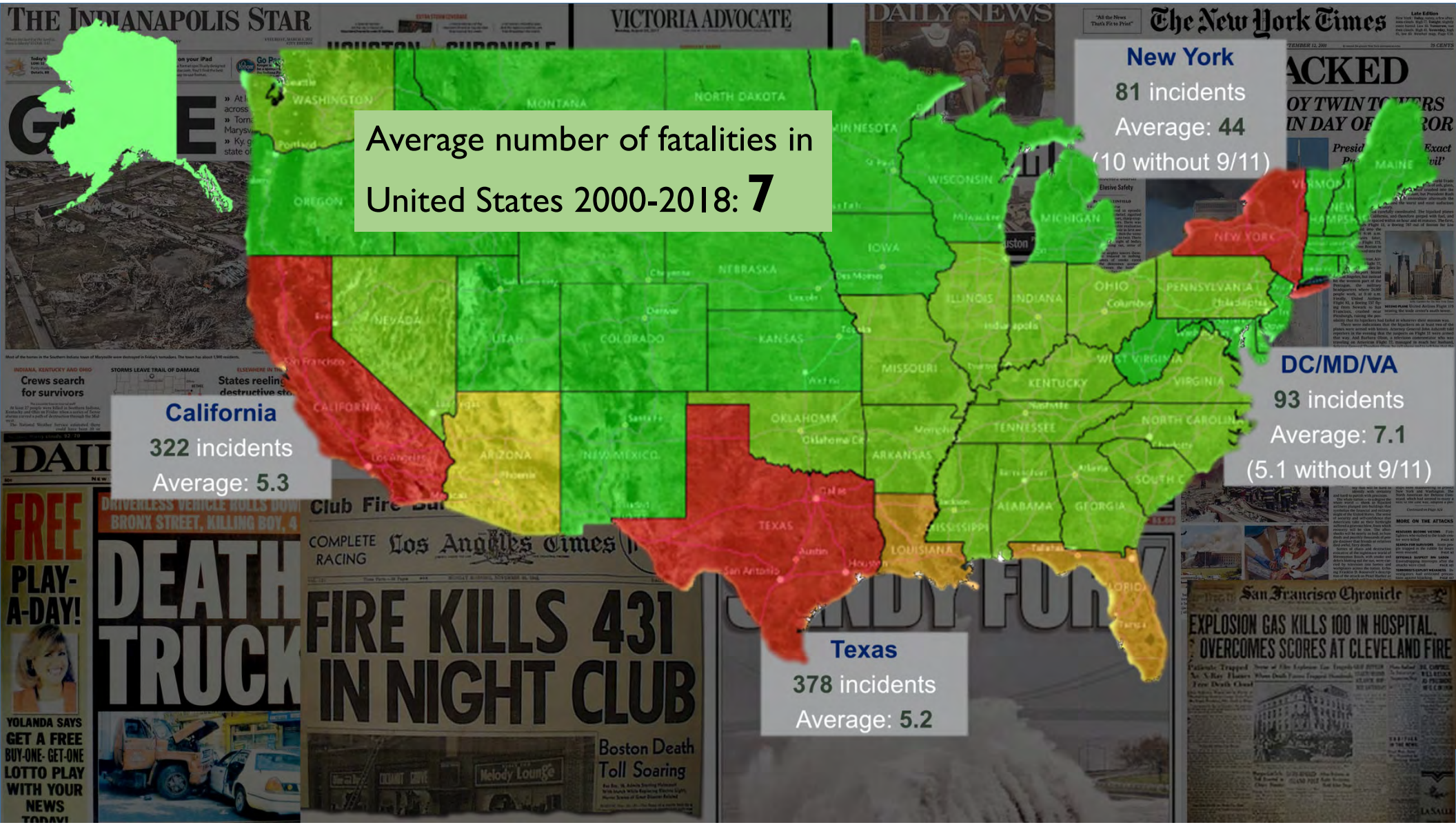


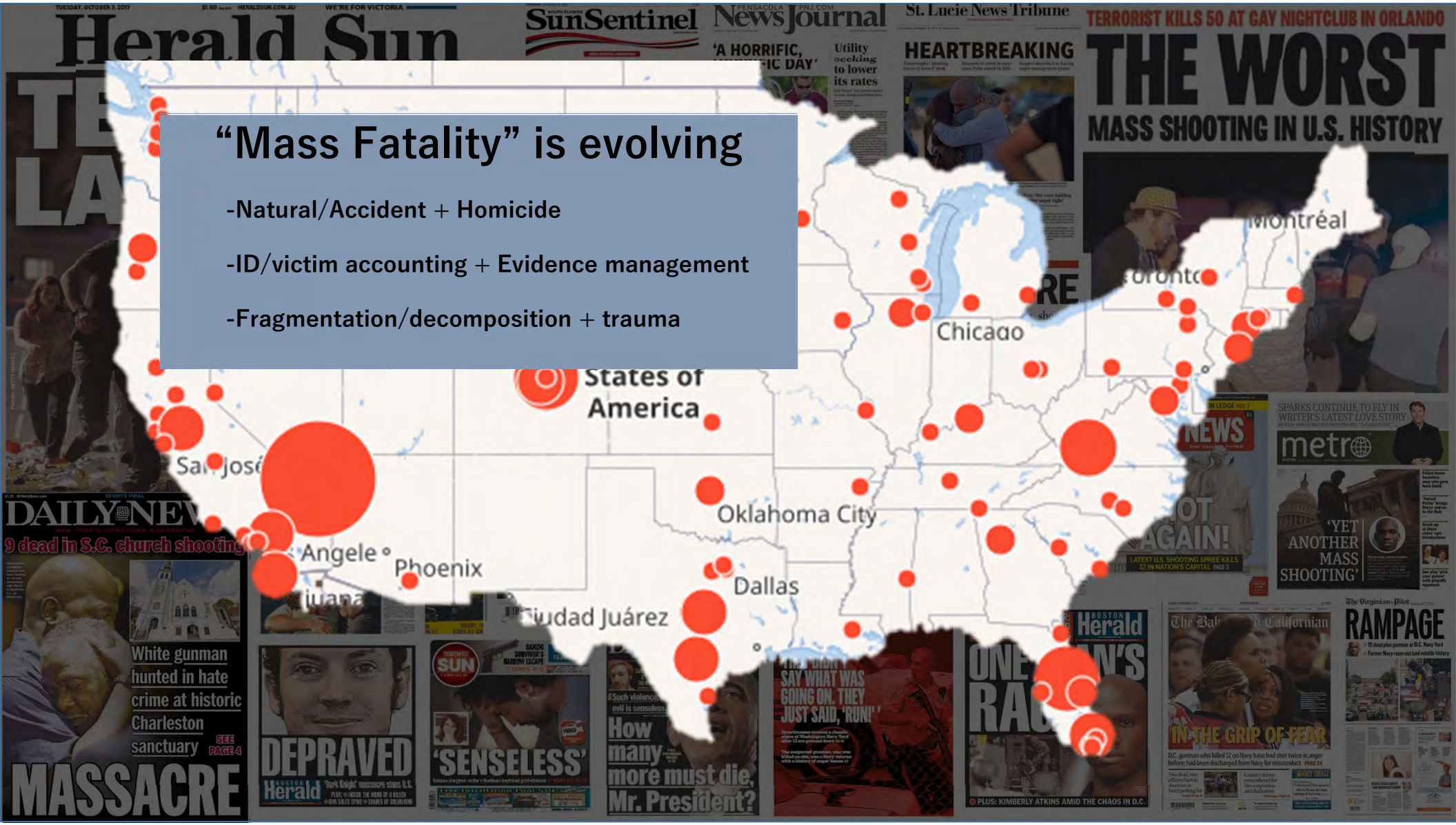
"With the exception of some large city, county, and state systems, the level of preparedness of ME/C jurisdictions is generally very low … smaller cities and counties will need to rely entirely on federal assets … Multiple fatality management across jurisdictional lines … is nearly impossible … given the absence of medical expertise, the absence of standards of performance, and the non-interoperability of systems and procedures."

"Although there have been notable efforts to achieve standardization and develop best practices in some forensic science disciplines and the medical examiner system, most disciplines still lack best practices or any coherent structure for the enforcement of operating standards, certification, and accreditation"

WHAT IS MASS FATALITY?

- What should we be planning for?
- Catastrophic mindset and body count fixation
- Intact body assumption
- Define based on response circumstances
- Incident specific assessment critical to informed response
- Mass Fatality incidents are evolving


Average number of fatalities in United States 2000-2018: 7
New York
81 incidents
Average: 44
(10 without 9/11)
DC/MD/VA
93 incidents
Average: 7.1
(5.1 without 9/11)
California
322 incidents
Average: 5.3
Texas
378 incidents
Average: 5.2
THE INDIANAPOLIS STAR
VICTORIA ADVOCATE
DAILY NEWS
The New York Times
Crews search for survivors
STORMS LEAVE TRAIL OF DAMAGE
FREE
PLAY-A-DAY!
YOLANDA SAYS GET A FREE BUY-ONE- GET-ONE LOTTO PLAY WITH YOUR NEWS
DEATH TRUCK
FIRE KILLS 431 IN NIGHT CLUB
Boston Death Toll Soaring
Los Angeles Times
San Francisco Chronicle
EXPLOSION GAS KILLS 100 IN HOSPITAL.
OVERCOMES SCORES AT CLEVELAND FIRE


“Mass Fatality” is evolving
-Natural/Accident + Homicide
-ID/victim accounting + Evidence management
-Fragmentation/decomposition + trauma
Herald Sun
SunSentinel
News Journal
St. Lucie News Tribune
HEARTBREAKING
TERRORIST KILLS 50 AT GAY NIGHTCLUB IN ORLANDO
THE WORST
MASS SHOOTING IN U.S. HISTORY
Montréal
Chicago
States of America
San José
Oklahoma City
Phoenix
Dallas
Ciudad Juárez
9 dead in S.C. church shooting
White gunman hunted in hate crime at historic Charleston sanctuary
MASSACRE
DEPRAVED
‘SENSELESS’
How many more must die, Mr. President?
SAY WHAT WAS GOING ON. THEY JUST SAID, ‘RUN!’
IN THE GRIP OF FEAR
RAMPAGE
‘YET ANOTHER MASS SHOOTING’
metro
NEWS


Commuter plane crash, Kirksville, MO, 2004
Apartment fire, San Marcos, TX 2018
Fertilizer Plant Explosion, West, TX 2013
Bridge collapse, Minneapolis, MN, 2007
Mass Shooting, San Bernardino, CA, 2015
LIVE
BREAKING NEWS
CALIFORNIA SHOOTING RAMPAGE
AT LEAST 14 DEAD, SEARCH FOR SUSPECTS UNDERWAY
abc NEWS .com
LIVE
Santa Fe High School Shooting 2018
BREAKING NEWS
GOOD MORNING TAMPA BAY
POLICE RESPONDING TO ACTIVE SHOOTER AT TX HIGH SCHOOL

BEST PRACTICES

- DOJ/NIST Partnership (2014)
  - NCFS (National Commission on Forensic Science)
  - OSAC (Organization of Scientific Area Committees)

  - OSAC: Developed to create technically sound, consensus-based documentary standards and guidelines for widespread adoption throughout the forensic science community

BEST PRACTICES

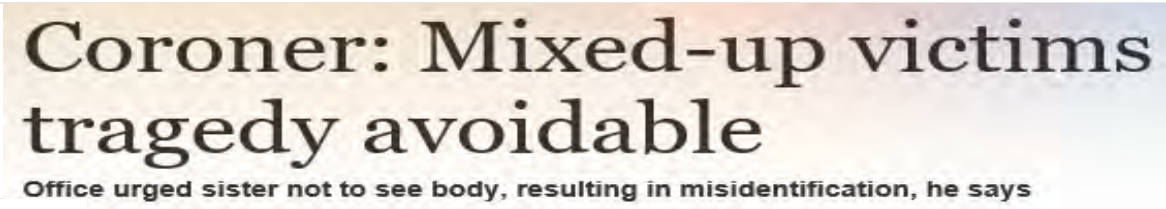
- Mass Fatality Incident Data Management: Best Practice Recommendations for the Medicolegal Authority
- Best Practices Recommendations for DNA Analysis for Human Identification in Mass Fatality Incidents
- Postmortem Impression Submission Strategy for Comprehensive Searches of Essential Automated Fingerprint Identification System Databases
- Mass Fatality Scene Processing: Best Practice Recommendations for the Medicolegal Authority
- Examination of Human Remains by Forensic Pathologists in the Disaster Victim Identification Context
- Forensic Anthropology in Disaster Victim Identification: Best Practice Recommendations for the Medicolegal Authority
- Ethical Considerations in Disaster Victim Identification: Best Practice Recommendations for the Medicolegal Authority
- Postmortem Fingerprint Recovery: Guidance and Best Practices for Disaster Victim Identification
- Forensic Odontology in Disaster Victim Identification: Best Practice Recommendations for the Medicolegal Authority
- Disaster Victim Identification and Reconciliation: Best Practice for the Medicolegal Authority
- Mass Fatality Incident Management: Best Practice Recommendations for the Medicolegal Authority

LOCAL

MAY 02, 2014 9:20 PM

NC agency: State liable for medical examiner's body swap error

By Fred Clasen-Kelly - frkelly@charlotteobserver.com



Coroner: Mixed-up victims tragedy avoidable

Office urged sister not to see body, resulting in misidentification, he says

Coroner: Misidentification Began With Students' ID Cards

Identities Of Crash Survivor, Dead Woman Mixed For Weeks

POSTED: 1:36 PM, Jun 1, 2006

Lawsuit: Wrong family got body because of misidentification

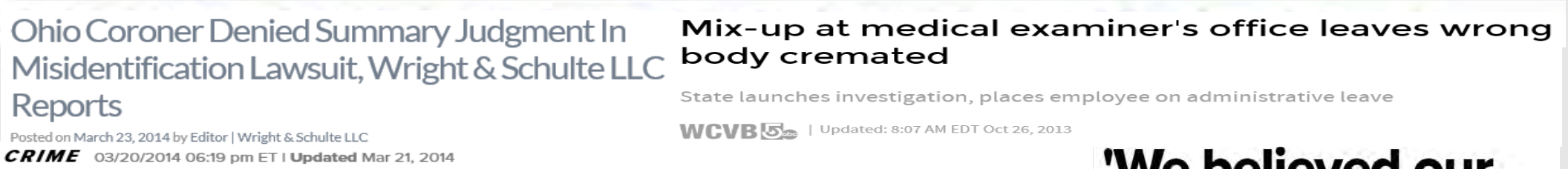
By Travis Fain
travis.fain@news-record.com Apr 30, 2013 (0)

A Dead Woman Was Misidentified By A Medical Examiner

March 20, 2014 4:17 PM

Ind. coroner regrets case of mistaken ID

California man mistakenly buried in body mix-up is exhumed



Ohio Coroner Denied Summary Judgment In Misidentification Lawsuit, Wright & Schulte LLC Reports

Posted on March 23, 2014 by Editor | Wright & Schulte LLC

Mix-up at medical examiner's office leaves wrong body cremated

State launches investigation, places employee on administrative leave

WCVB | Updated: 8:07 AM EDT Oct 26, 2013

CRIME 03/20/2014 06:19 pm ET | **Updated** Mar 21, 2014

Morgue Mix-Up Leads Mom To Believe Daughter Is Dead

Mistaken identity case puts spotlight on coroners

Jun 2, 2006 0

Coroner: Wrong body buried after crime lab mix-up in Georgia

The Associated Press
UPDATED: 02/19/2015 06:57:38 PM EST

'We believed our authorities my son was dead,' American dad recalls of ID mix-up

BY COLIN PERKEL, THE CANADIAN PRESS
POSTED APR 9, 2018 2:13 PM EDT LAST UPDATED APR 10, 2018 AT 8:41 AM EDT

Sheriff: Misidentification of woman killed by deputies 'tragic'

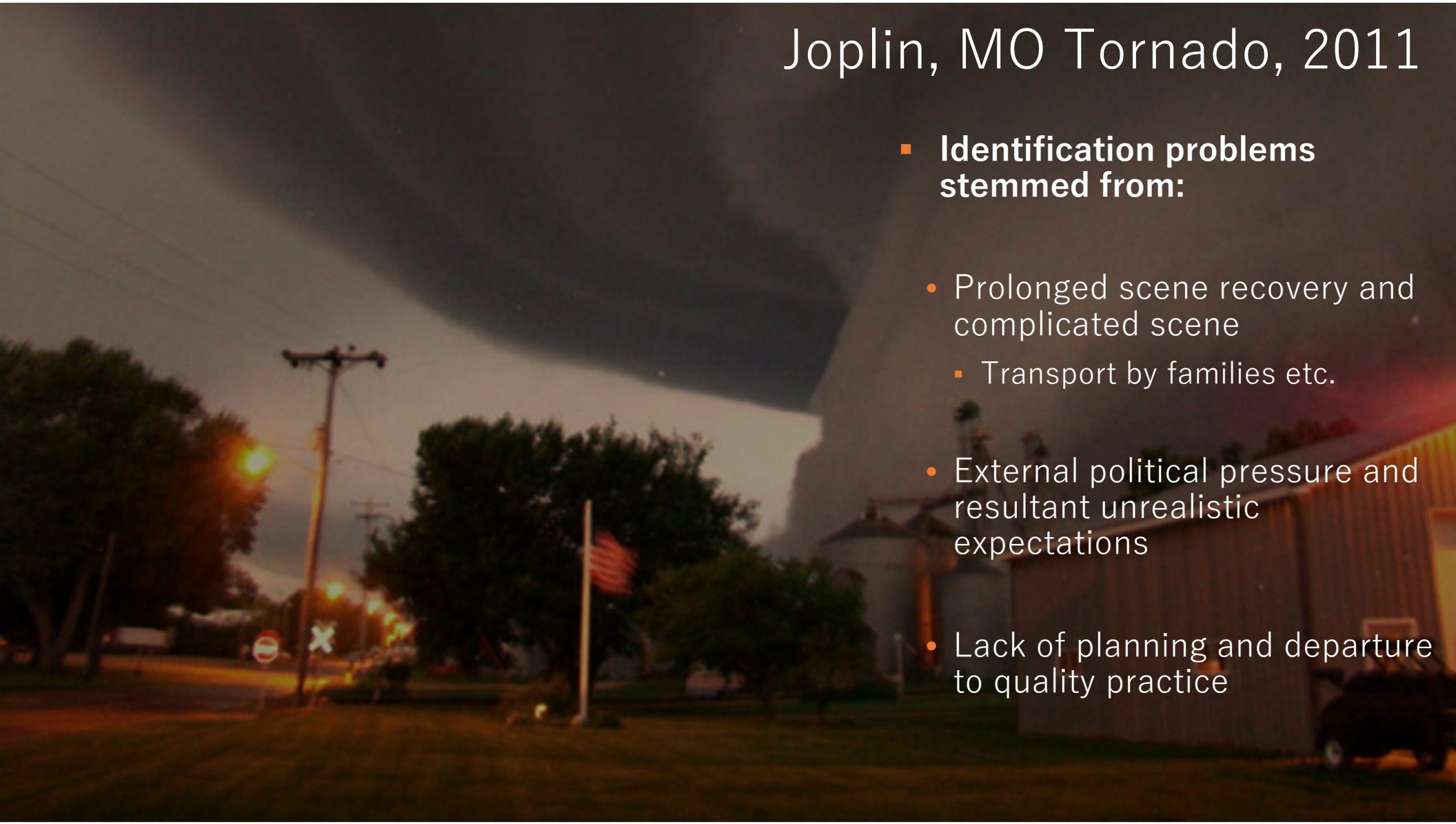
May 28th, 2011
12:39 AM ET

BY STEVE LEVIN Californian staff writer slevin@bakersfield.com Aug 4, 2014 0

Macabre body ID process adds to Joplin's pain

Case of mistaken identity stuns families

Updated 6/1/2006 3:40 PM ET



Joplin, MO Tornado, 2011

- **Identification problems stemmed from:**
  - Prolonged scene recovery and complicated scene
    - Transport by families etc.
  - External political pressure and resultant unrealistic expectations
  - Lack of planning and departure to quality practice

BEST PRACTICES VS REALITY

- **Best practices are not being applied:**
  - Because locals are unaware or unable, or
  - Because they're not needed in all cases

- **Risk: Perception**
  - Big jurisdiction that takes a "long time" to process an incident because of legitimate incident characteristics (commingling, fragmentation)
  - Small jurisdiction handles large incident quickly with apparent success

So how do we create a system that can address the shortcomings that we all know exist while ensuring the practical value of the end product to locals?


TMORT
TEXAS MASS FATALITY OPERATIONS RESPONSE TEAM

HISTORY

- Regional planning began in 2008
- Regional Catastrophic Grant 2010
  - TMORT concept originated
- TDMS involvement 2010
  - Mass Fatality Working Group to develop mass fatality response strategy
- 2014 First meeting with Chief Medical Examiners


Texas Chief Medical Examiner
Meeting 2014
Allison Woody, M.S.


Housing Agency
Function


TMORT
FRAMEWORK
HOUSING AGENCY
State + University
Medical Examiner Reps
Regionally Dispersed
Central Inventory
Standard package (cost)
FUNDING SOURCE
Combination
State Funded
Grants funded
DEPLOYMENT STRATEGY
State Team
COMMAND & CONTROL
Optional Transfer of Operational Command
no transfer of legal authority
Temporary Appointment of (1) Operational Commander
approval agencies
Coordinate deployment as independent agents
RESEARCH
Research
TRAINING STRATEGY
pre req training
Standard Fatality Management Training
Specialized Training
online training
Topic Training
Outside Training
Just-in-Time Training
One Training Location
Rotate Training Locations
Topic Exercises
Specialized Exercises
Support Position Training
ICS Courses
annual conference
in person training
Multi-Agency Training
Standard Fatality Management Exercises
Support Position Exercises
Multi-Agency Exercises
TMORT
COMPONENTS
VICTIM ACCOUNTING
State TMORT Call Center
INCIDENT SITE
Intact Remains: TMORT
Intact Remains: TFDA
Contaminated Remains: Texas Military Forces FSRT
Disinterred Remains: TFDA
Complicated Recovery Environment: TXTF-1
Anthropology/Archaeology
Fragmented Remains
TRANSPORT
Site to Staging: TFDA
Staging to Morgue: TFDA
Victim Information Center Only
Family Interviews
Antemortem Records Retrieval
DNA Sample Collection
Notification
Family Briefings
Release
Victim Information Center Equipment
MORGUE
Embalming/Casketing: TFDA
Fingerprint
Pathology
Anthropology
Dental
Radiography
DNA Collection
Triage
Evidence
Photography
Equipment
STORAGE
Human Remains Inventory: TMORT
TMORT Management of Long-Term Storage
TMORT Management of Memorial Development
TMORT Management of Disposition of Unidentified Common Tissue
TMORT Management of Temporary Interment
Call Center Expertise
Family Assistance Center Expertise
Network Support Expertise
Computers/Servers/Network
TMORT
PERSONNEL
RECRUITMENT SOURCES
Medical Examiner's Office
Private Sector: Pathology Services
Private Sector: Funeral Homes
Private Sector: Private Labs
Law enforcement
Universities: Students
Universities: Staff
Unaffiliated Personnel
Pre-deployment Requirements
Fit Testing
Post-deployment Care/
Long-term Monitoring
COMPENSATION
Employer Reimbursement
workers comp
unaffiliated personnel
CREDENTIALING
Application w/ References
Pre-credentialing
Just-in-Time Credentialing
Set Minimum Qualifications
Standard Licensing Requirements

2014 TMORT MEETING

In the opinion of the Chief Medical Examiners in Texas, a statewide mass fatality response system should:

1) be a state health and medical function that is housed on the campus of a state public university

2) be funded in part by the presiding state agency, the housing university, and federal grant programs

3) develop a statewide rather than a regional or local response strategy

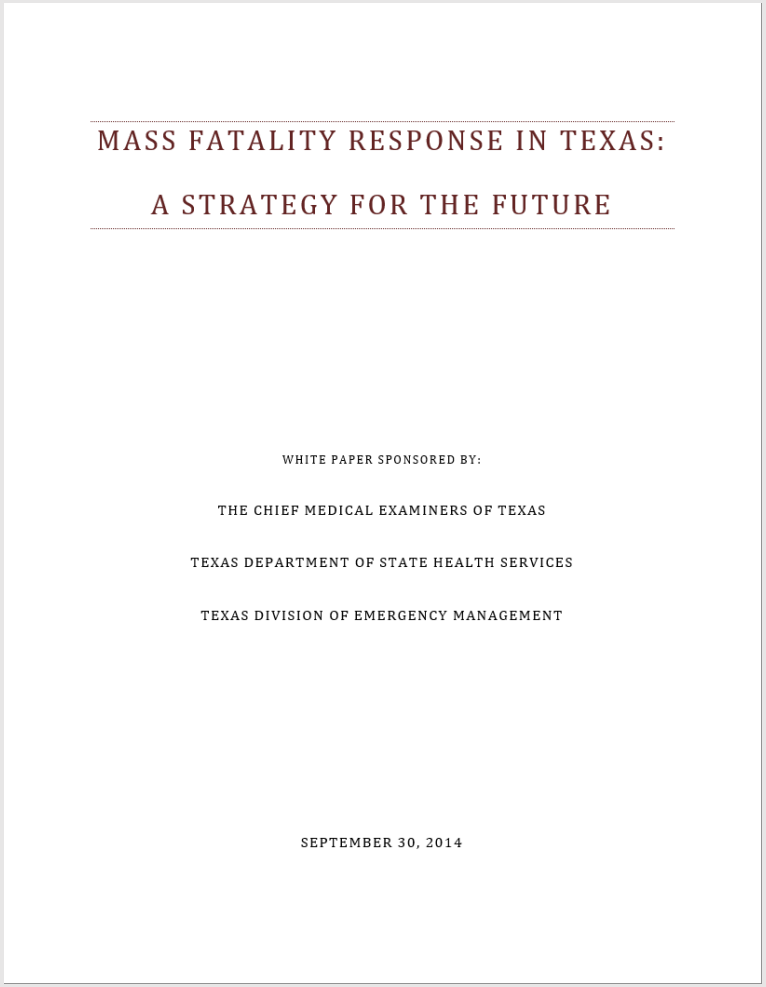
4) incorporate subject matter experts from the public and private sector, and

5) be inclusive of all medicolegal operational components to include morgue operations, site operations, victim information and victim accounting, but should not extend into mortuary (funerary) services or family assistance support operations

5) have a mission that includes deployment, training, and research.

SERVICES NOT PROVIDED BY TMORT

- Mortuary (funerary) services
- Family Assistance Center staffing such as childcare, feeding, spiritual, or behavioral health care
- Human remains transportation operations
- Long term human remains storage operations (pre- and post-processing)
- Manage unassociated personal effects
- Seek medicolegal authority in any local jurisdiction
- ESF 6-Mass Care services (shelter, housing, feeding, etc)



- Reviewed existing in state deployable teams and precedents from other states (FEMORS etc.)
- Met with universities interested in the program

TMORT HISTORY

- 2016: Formally adopted into EMTF
- Developed team typing
- TMORT Addendum to EMTF MOA developed and distributed to possible contributing agencies:
  - ME offices
  - Universities
- Training program
  - In-person
  - Computer-based


TEXAS STATE UNIVERSITY
American Forensics
TEXAS
Health and Human Services
Texas Department of State Health Services
TEXAS
SETRAC
STRAC
TMORT
TEXAS MASS FATALITY OPERATIONS RESPONSE TEAM
TRAVIS COUNTY MEDICAL EXAMINER
TCME
INSTITUTE OF FORENSIC SCIENCES
HARRIS COUNTY
in progress
OFFICE OF THE MEDICAL EXAMINER
EL PASO COUNTY
COLLIN COUNTY
THE STATE OF TEXAS
COUNTY OF GALVESTON
MONTGOMERY COUNTY
FORENSIC SERVICES
THE COUNTY OF DALLAS
STATE OF TEXAS
THE STATE OF TEXAS
COUNTY OF BEXAR

EL PASO SHOOTING DEPLOYMENT

- Request for assistance on August 3
  - Arrived on the morning of August 4
  - Departed afternoon of August 6
- Assistance with postmortem exams requested (no scene, no ID)
- 5 people from 3 different offices were deployed
  - HCIFS: 1 pathologist, 1 autopsy technician, 1 photographer
  - Collin County: 1 autopsy technician
  - Galveston county: 1 autopsy technician
- Deployment shortened medicolegal response by at least one full day
- Significant reduction in potential for error

EL PASO SHOOTING DEPLOYMENT: LESSONS LEARNED

- Deployment highlighted importance of support staff
  - Photography
  - Evidence management
- No high-throughput morgue protocols used, and were not needed
- Rapid assessment guide:
  - Should have been utilized
  - Needs streamlining (draft completed)
  - Enhance the equipment/materials needs assessment component
  - Pre-deploy?

EL PASO SHOOTING DEPLOYMENT: LESSONS LEARNED

- Rostering
  - Finalize messaging strategy to rostered people
  - Add to roster
    - Subject matter experts and support staff
- TMORT members examined shooting deaths (not routine deaths)
- Debriefing at end of deployment resulted in standardized death certificates
- Logistics:
  - Some concerns already resolved (rental car, reimbursement)
  - Logistical support would have been helpful even on this small deployment
  - Supplies
- Capabilities/needs assessment of existing ME facilities
  - Develop/maintain relationships between TMORT and ME office staff

THANK YOU