TMORT
TEXAS MASS FATALITY OPERATIONS RESPONSE TEAM

HISTORY AND CONTEXT

Presented by Dr. Amy Gruszecki,
Chief Forensic Pathologist
Active member, TMORT

American Forensics

1

DMORT

- Disaster Mortuary Operational Response Team
- FEDERAL system
- US department of Health and Human Services
- Responded to World Trade Center (9/11)
- Responded to Katrina, New Orleans

- But … Texas developed its own.

2

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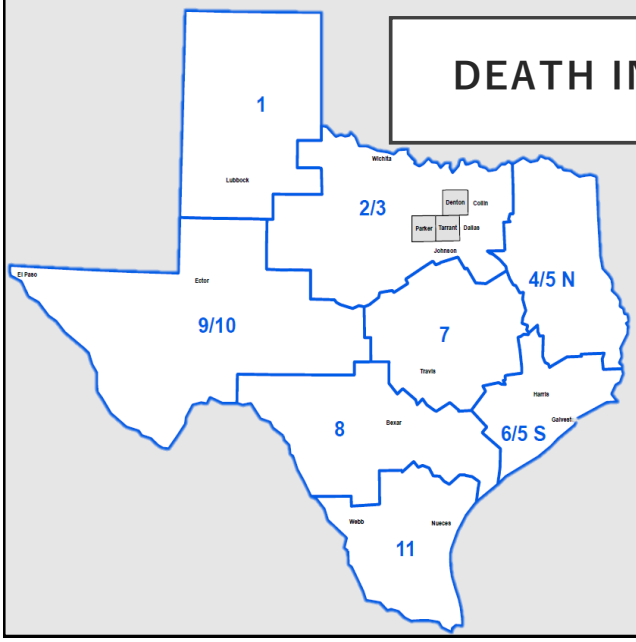
3



DEATH INVESTIGATION IN TEXAS

No	• State Medical Examiner
254	• Counties
16	• Medical Examiners
59%	• Population served by ME office
>2 million	• County population that requires ME office
At least 2	• Justice of the Peace (Coroner) in other counties

4

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

5

DEATH INVESTIGATION IN TEXAS

- Autopsy: highly specialized procedure that consists of a thorough examination of a decedent to determine the cause and manner of death.
  - Performed for either legal or medical purposes
  - Performed by a specialized medical doctor called a forensic pathologist.
  - Forensic Pathologist - American Board Certified, subspecialty of pathology.
  - Facility – Accreditation by National Association of Medical Examiners (NAME), ANAB, and/or IACME;

    - assures standards are adhered to (chain of custody, evidence protection).
- 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

6

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

7

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

8

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

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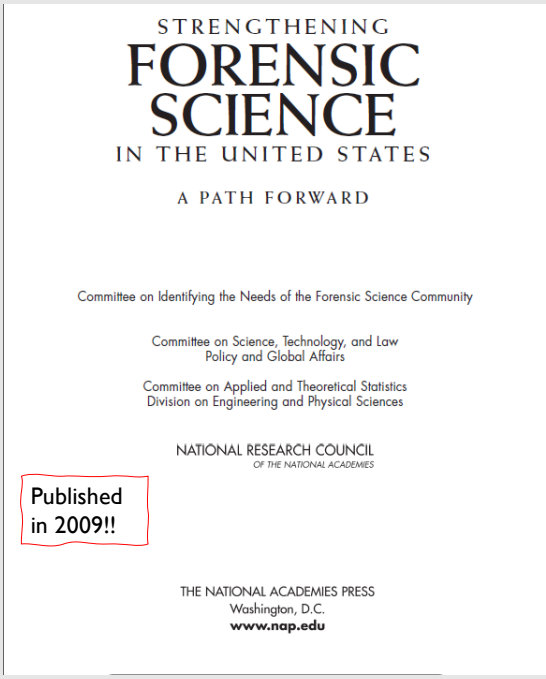


Published in 2009!!

"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."

Rely on federal resources

"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"

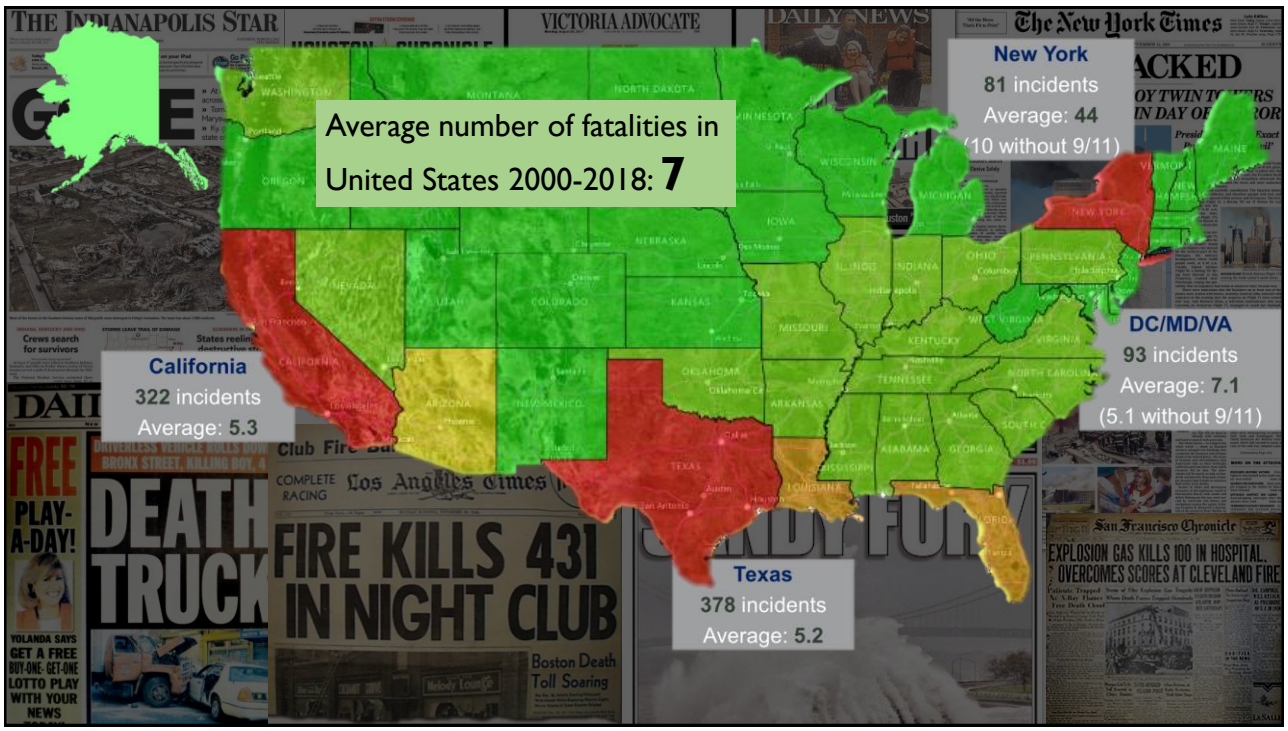
Lack of standards and accreditation

10

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

11



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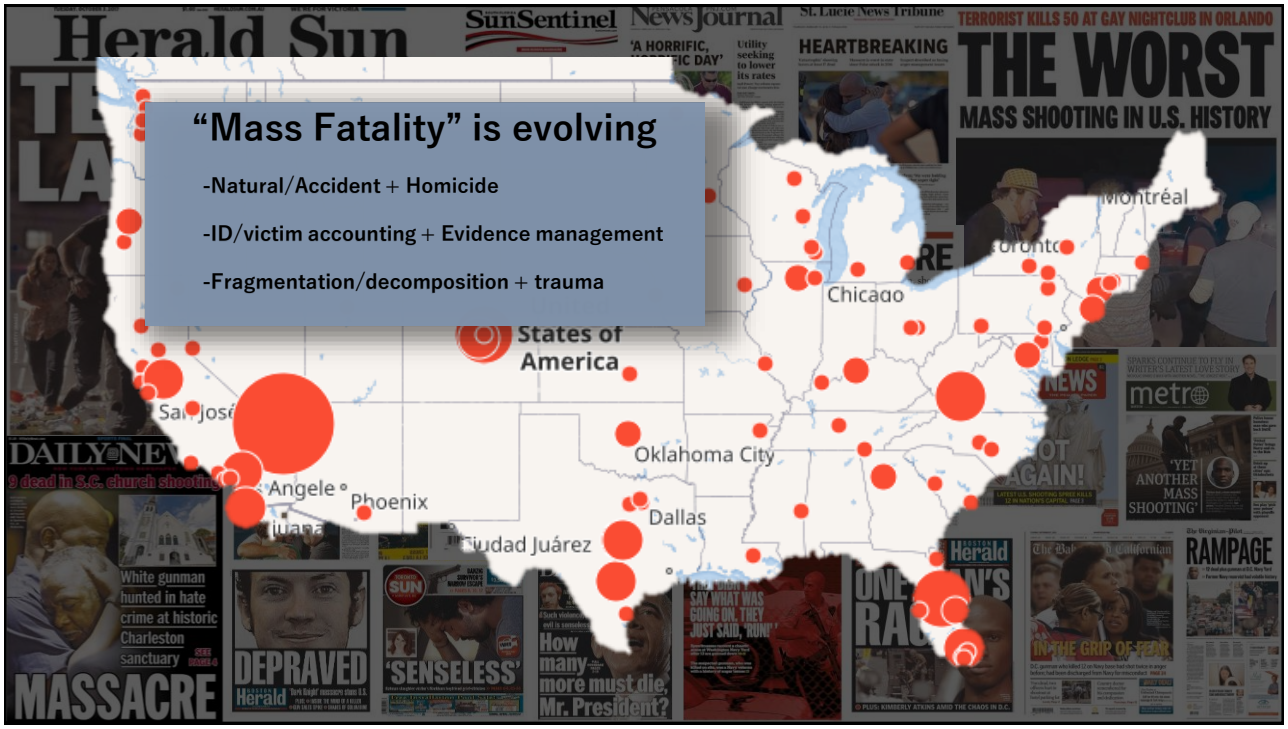

"Mass Fatality" is evolving
-Natural/Accident + Homicide
-ID/victim accounting + Evidence management
-Fragmentation/decomposition + trauma
Herald Sun
SunSentinel
News Journal
St. Lucie News Tribune
HEARTBREAKING
TERRORIST KILLS 50 AT GAY NIGHTCLUB IN ORLANDO
THE WORST
MASS SHOOTING IN U.S. HISTORY
Montréal
Chicago
States of America
Oklahoma City
Dallas
Phoenix
Ciudad Juárez
DAILY NEWS
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
'YET ANOTHER MASS SHOOTING'
RAMPAGE
metro

13


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

14

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

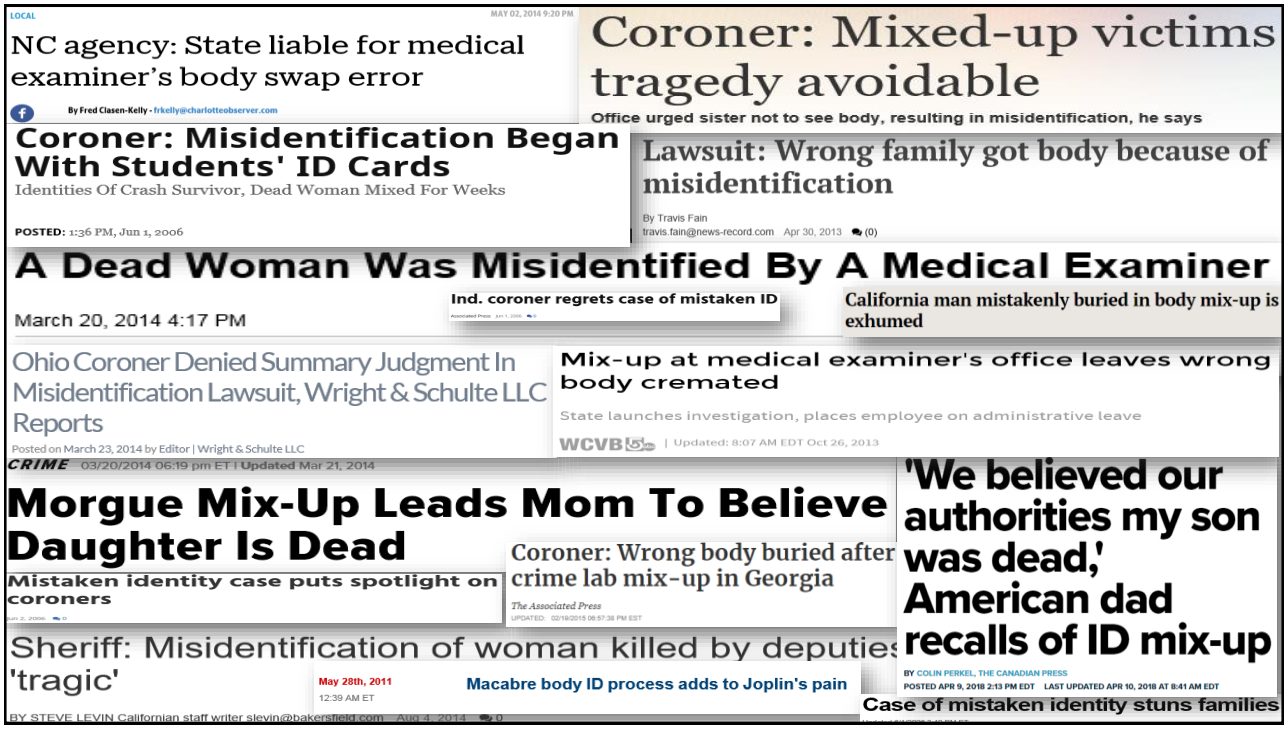
    (website 182 Standards as of March 2024)

15

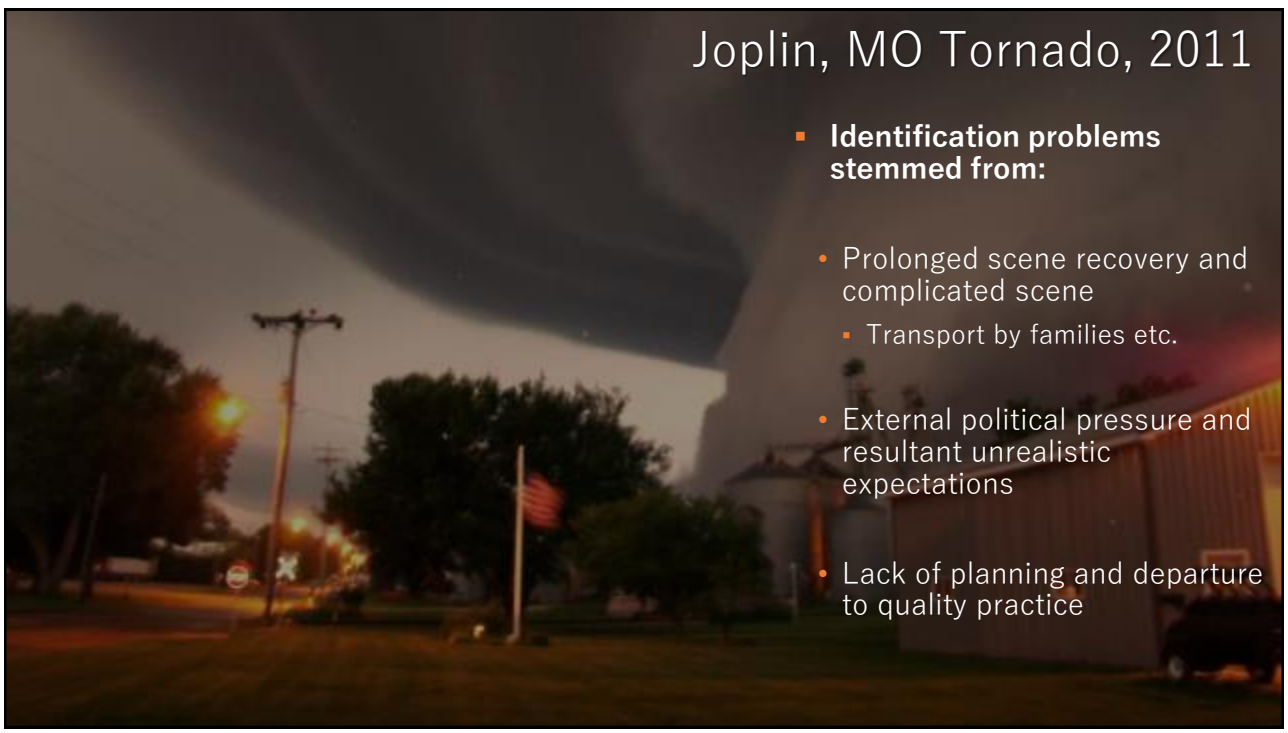
BEST PRACTICES

- 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

16


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
Coroner: Wrong body buried after crime lab mix-up in Georgia
The Associated Press
'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
Macabre body ID process adds to Joplin's pain
Case of mistaken identity stuns families
BY STEVE LEVIN Californian staff writer slevin@bakersfield.com Aug 4, 2014 0

17


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

18

LESSONS LEARNED FROM MAUI

- Identifications were difficult
- Remains were removed from cars
- Remains were removed from houses.

- These places were possible identifying locations and would have helped greatly in determining identity.

- After action reports are helpful – what could we have done better?

19

BEST PRACTICES VS REALITY

- **Best practices are not being applied:**
  - Because local authorities 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 result to local authorities?

20

21

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

22

23

24

25

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

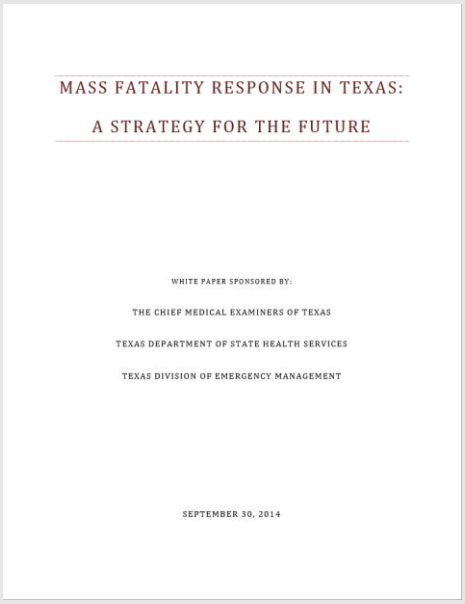
5) have a mission that includes deployment, training, and research.

26

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)

27


MASS FATALITY RESPONSE IN TEXAS:

A STRATEGY FOR THE FUTURE

WHITE PAPER SPONSORED BY:

THE CHIEF MEDICAL EXAMINERS OF TEXAS

TEXAS DEPARTMENT OF STATE HEALTH SERVICES

TEXAS DIVISION OF EMERGENCY MANAGEMENT

SEPTEMBER 30, 2014

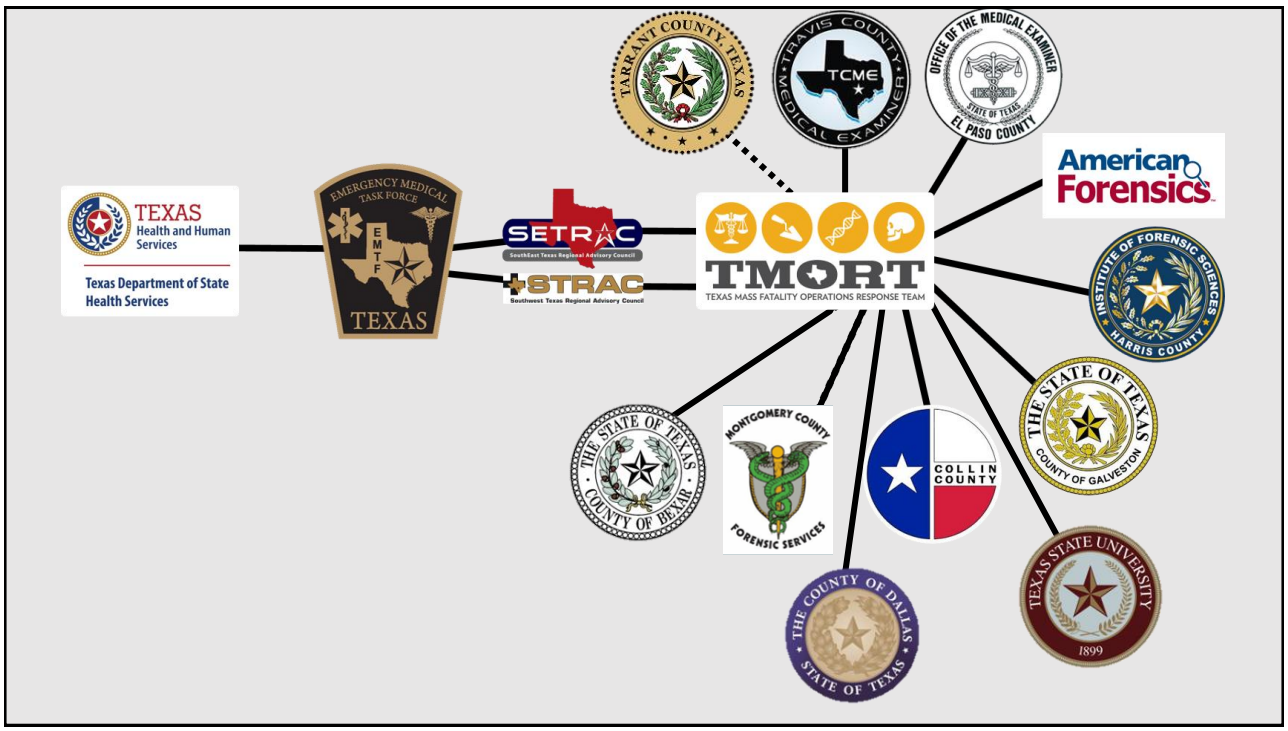
- Reviewed existing in state deployable teams and precedents from other states (FEMORS etc.)
- Met with universities interested in the program

28

TMORT HISTORY

- 2016: Formally adopted into Texas 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

29



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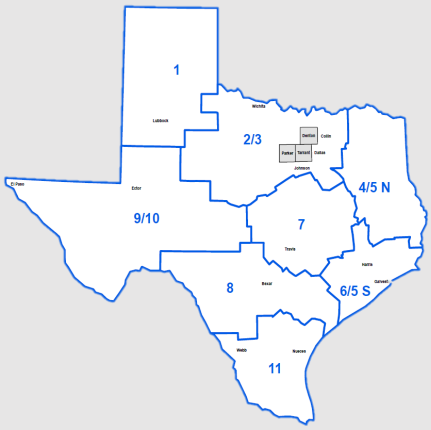
- Active group
- Meet monthly via Zoom
- We have a GroupME for immediate communication
- Actively engaging contracted partners for all the regions of Texas



31

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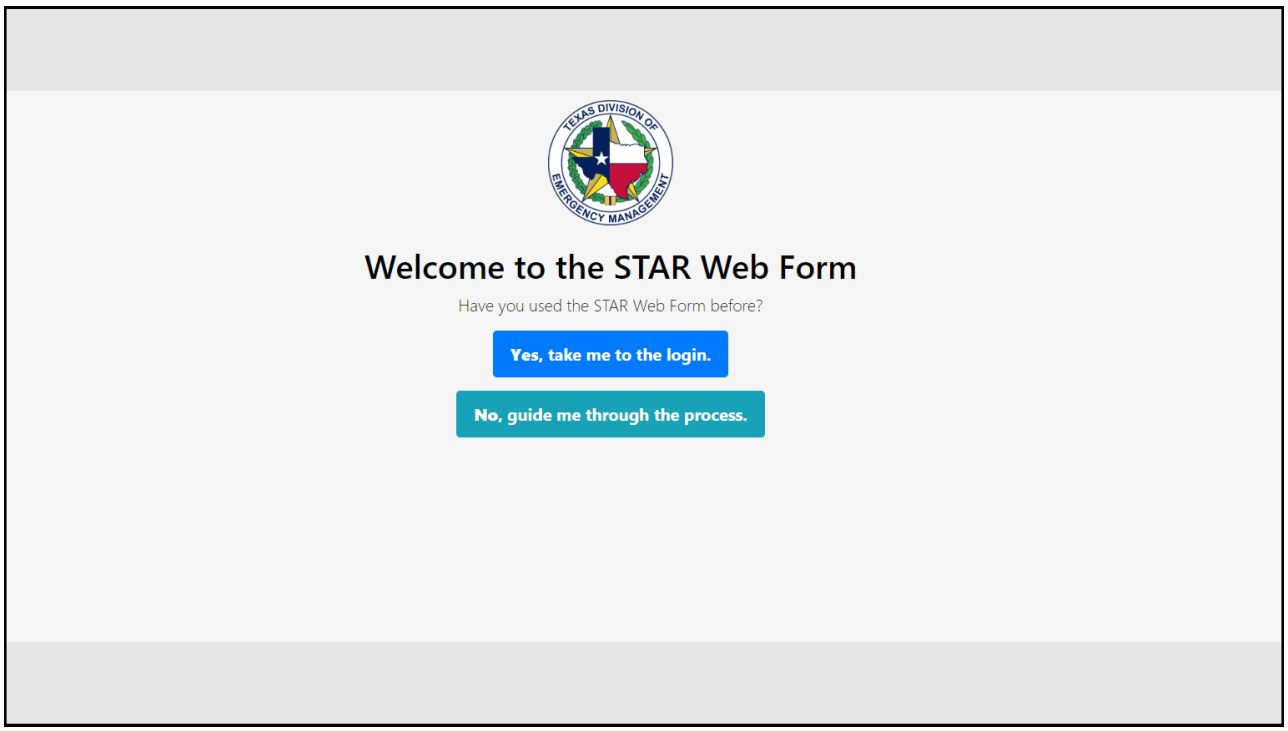
- TMORT Held a virtual drill in October 2023
- Gave us a chance to "practice" responding to a multisite fatality.

32

ACCESS TMORT

- County Office of Emergency Management via STAR request
- https://star.tdem.texas.gov/
- When the county can't fill it, they'll pass to the state

33



34

35

DISASTER DRILLS

- Participate with your County Emergency Management Teams
- Have a plan for mass fatalities
- Make sure that plan includes the entity who performs your autopsies.
  - know what assistance they can provide for you
  - how many decedents can they accommodate? And over what period of time?
  - will they come to the scene? - do you need them to?
- COMMUNICATION before an event is key.

36

CANNOT IGNORE THE POTENTIAL PROBLEM

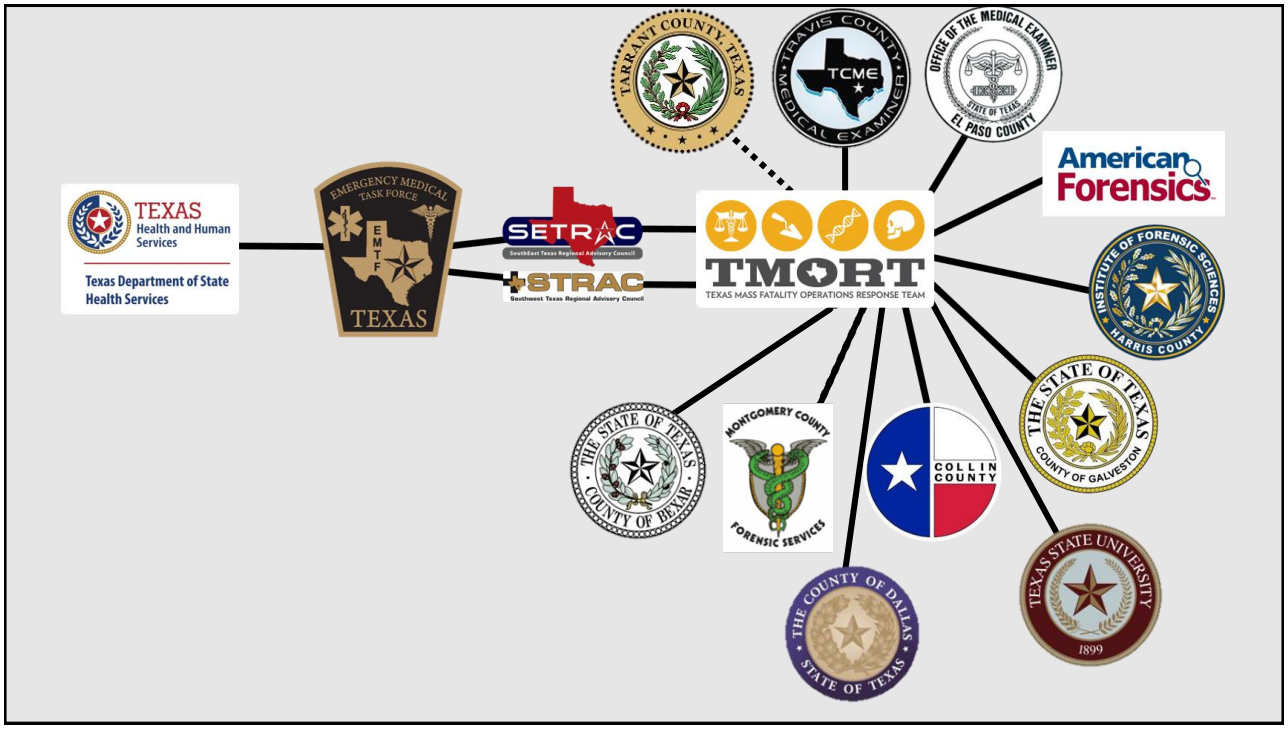
37

PLANNING AND PREPARATION

- We cannot know what will happen
- Or when it will happen

- We can know what resources are available to help us when the unimaginable does happen.

38


TARRANT COUNTY TEXAS
TRAVIS COUNTY MEDICAL EXAMINER
TCME
OFFICE OF THE MEDICAL EXAMINER
EL PASO COUNTY
American Forensics
TEXAS
Health and Human Services
Texas Department of State Health Services
EMERGENCY MEDICAL TASK FORCE
E M T F
TEXAS
SETRAC
SouthEast Texas Regional Advisory Council
STRAC
Southwest Texas Regional Advisory Council
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INSTITUTE OF FORENSIC SCIENCES
HARRIS COUNTY
THE STATE OF TEXAS
COUNTY OF GALVESTON
THE STATE OF TEXAS
COUNTY OF BEXAR
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STATE OF TEXAS

39