Mass Fatality Management
Office of the Chief Medical Examiner (OCME)

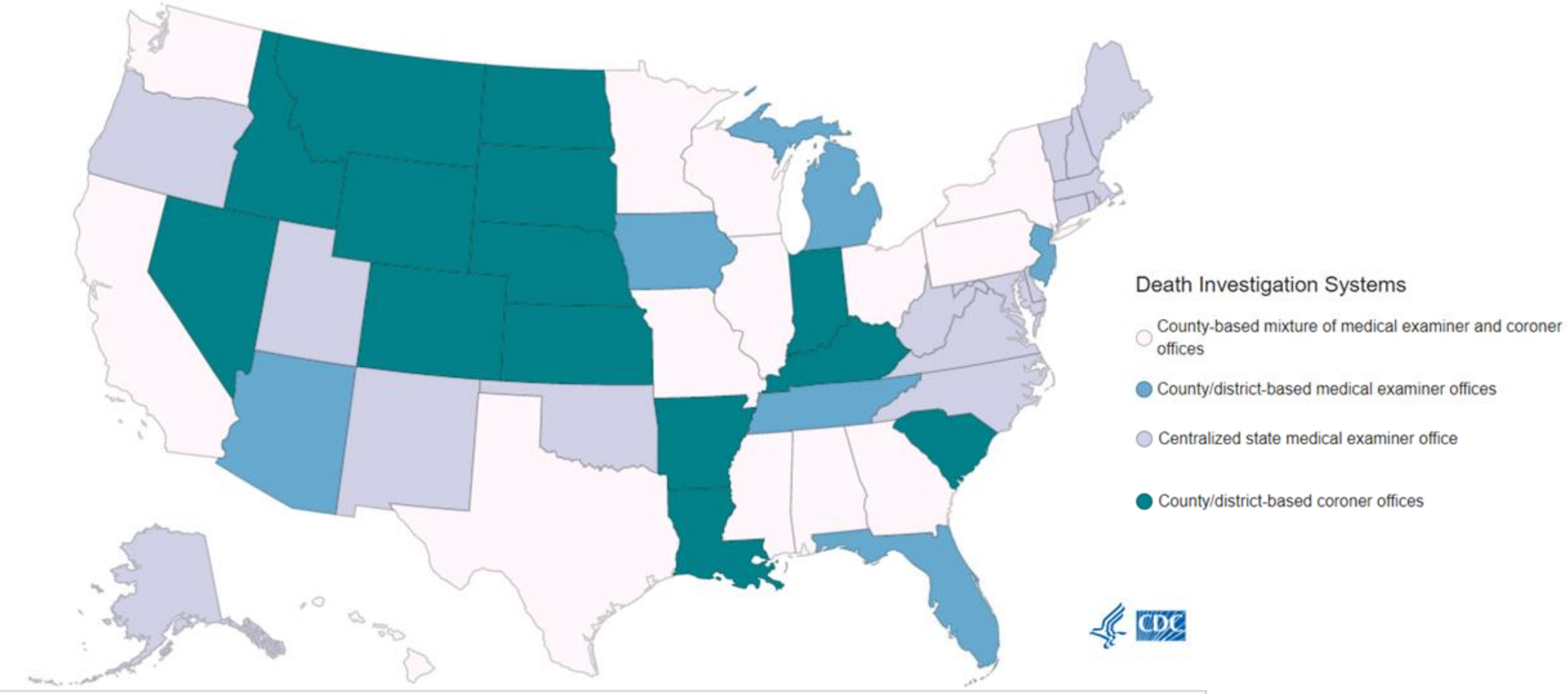
Presentation prepared by the Office of the Chief Medical Examiner

Coroner System
Vs.
Medical Examiner System

How are they DIFFERENT?

MEDICAL EXAMINER'S OFFICE

MEDICAL EXAMINER AND CORONER JURISDICTIONS IN THE UNITED STATES – 2019



The Office of the Chief Medical Examiner

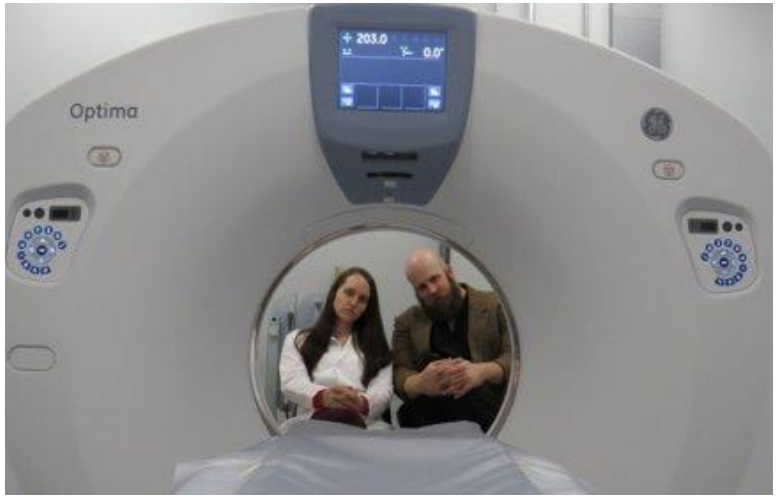
- Formed By General Assembly In **1946**
  - Code of VA §32.1-283. A. Investigations of Deaths
- Statewide Medical Examiner Death Investigation System
  - Chief Medical Examiner Dr. William T. Gormley Since 2013
- Accredited By The National Association Of Medical Examiners
- Each District Office Staffed By
  - Assistant Chief Medical Examiners
  - Medicolegal Death Investigators
  - Autopsy Technicians
  - Administrative Personnel
  - Security Officers
  - Local Medical Examiners are contractors OCME
- State Support

  Forensic Epidemiologist — Program Support

  Chief MDI — **Mass Fatality Planner**

  Division of Death Prevention

DONATE YOUR BODY.
LIVE ON THROUGH SCIENCE.
Virginia State Anatomical Program

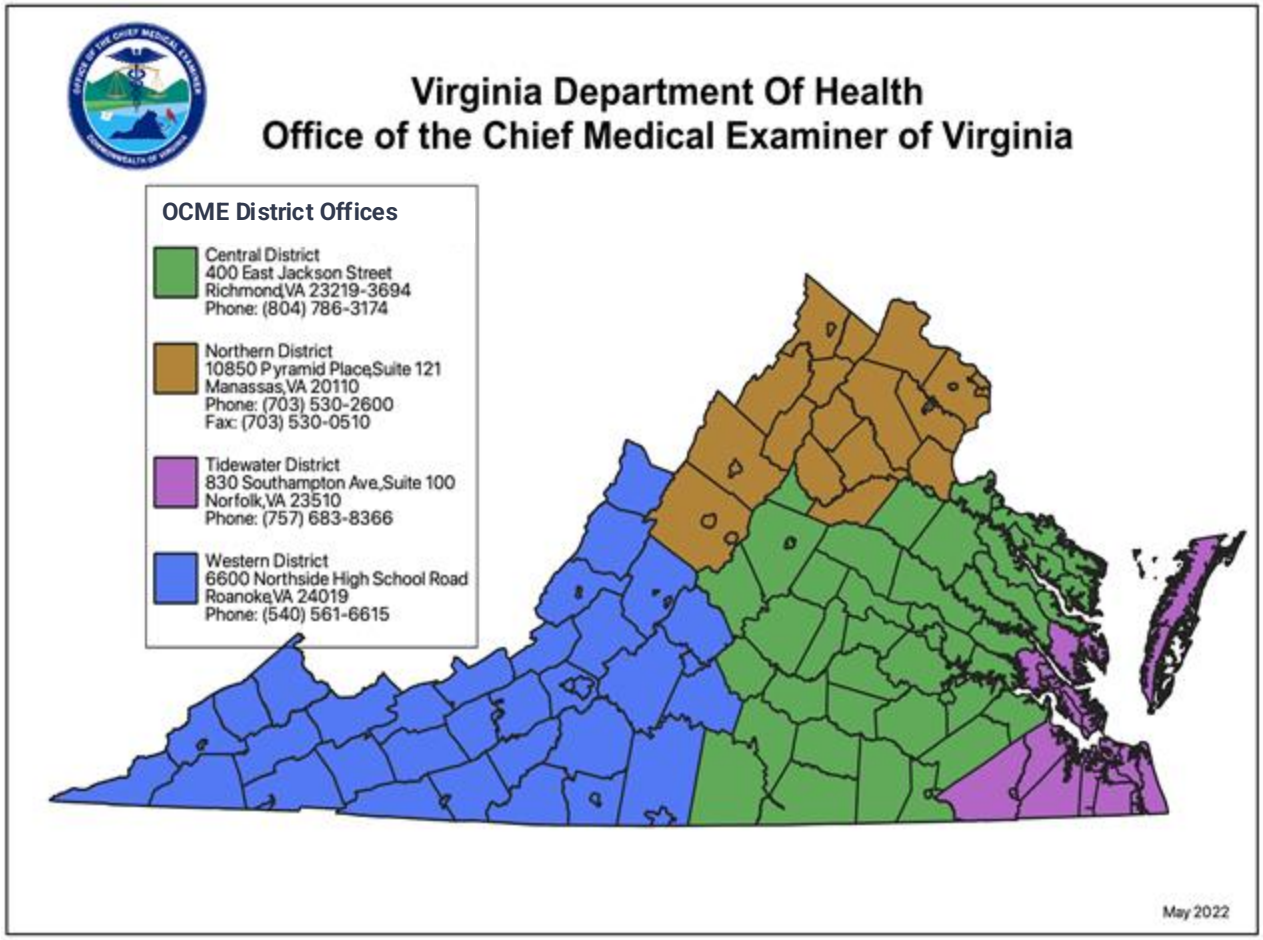


CODE OF VIRGINIA
§32.1-283. A. INVESTIGATION OF DEATHS…

Upon the death of any person from **trauma, injury, violence, poisoning, accident, suicide or homicide**, or **suddenly when in apparent good health**, or when **unattended by a physician**, or in **jail, prison, other correctional institution or in police custody**, or who is an individual **receiving services in a state hospital or training center operated by the department of behavioral health and developmental services**, or suddenly as an apparent result of **fire, or in any suspicious, unusual or unnatural manner**, or the **sudden death of any infant,** the office of the chief medical examiner shall be notified by the physician in attendance, hospital, law-enforcement officer, funeral director, or any other person having knowledge of such death.

JURISDICTION

- Under Ordinary Circumstances, If A Disease Is Naturally Occurring And Results From The Normal Course Of Life, **The Associated Deaths Are Natural Deaths And Are Not Medical Examiner Cases.**
- The **OCME Has No Jurisdiction Over Natural Deaths** Even If The Numbers Are Large
    - COVID-19 fatalities are considered a natural death
- Circumstances Surrounding Death Are Important
    - Deliberate Release Of Disease Such As Smallpox
    - Lab Spill Resulting In Laboratory Worker Exposure



Mass Fatality Events

and OCME's Role

What is a mass fatality event?

- The Virginia Office of the Chief Medical Examiner has defined a Mass Fatality Incident as a single event that overwhelms its local capabilities

  - Natural Events
  - Floods
  - Earthquakes
  - Hurricanes
  - Accidents
  - Transportation
  - Industrial
  - Terrorism
  - Explosives
  - Chemical Agents
  - Biological Agent

At least 59 dead, more than 500 injured after shooting on Las Vegas Strip

OCME'S Mission in a Mass Fatality Event

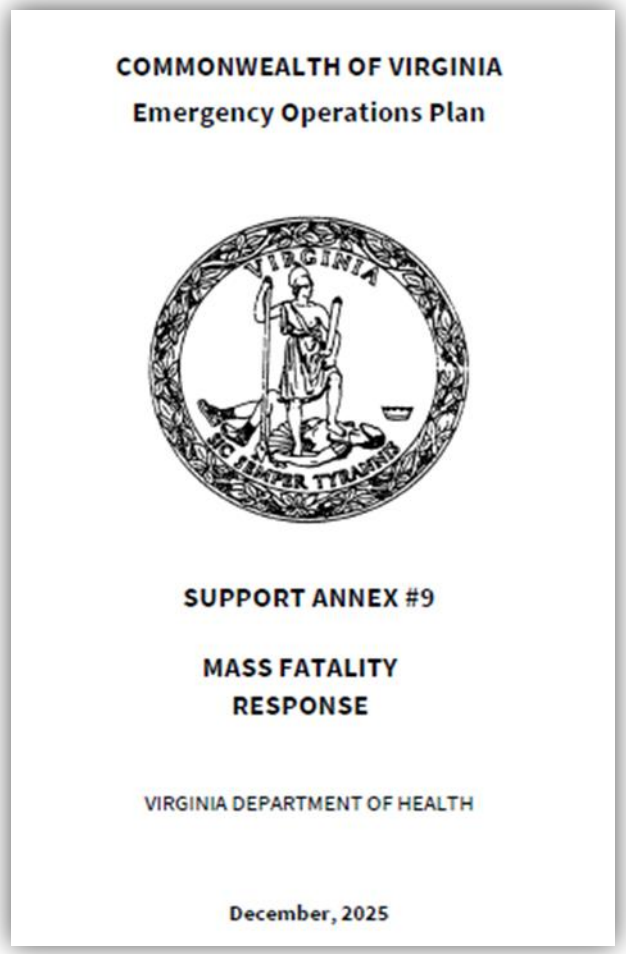
- The Office of the Chief Medical Examiner (OCME) will effectively manage a fatality incident resulting from a chemical, biological, radiological, nuclear, or explosive (CBRNE) event or any other catastrophic event such as a hurricane, flood, or plane crash that causes a large number of fatalities.

- OCME will ensure the
  - complete collection and examination of the dead,
  - determination of the nature and extent of injury,
  - recovery of forensic, medical and physical evidence (associated with remains)
  - identification of the fatalities using scientific means,
  - and certification of the cause and manner of death.

  All activities will be sufficiently documented for admissibility in criminal and/or civil courts.

- The OCME will continue to complete the daily non-event demands of the community.

Mass Fatality Plan – Support Annex # 9


COMMONWEALTH OF VIRGINIA

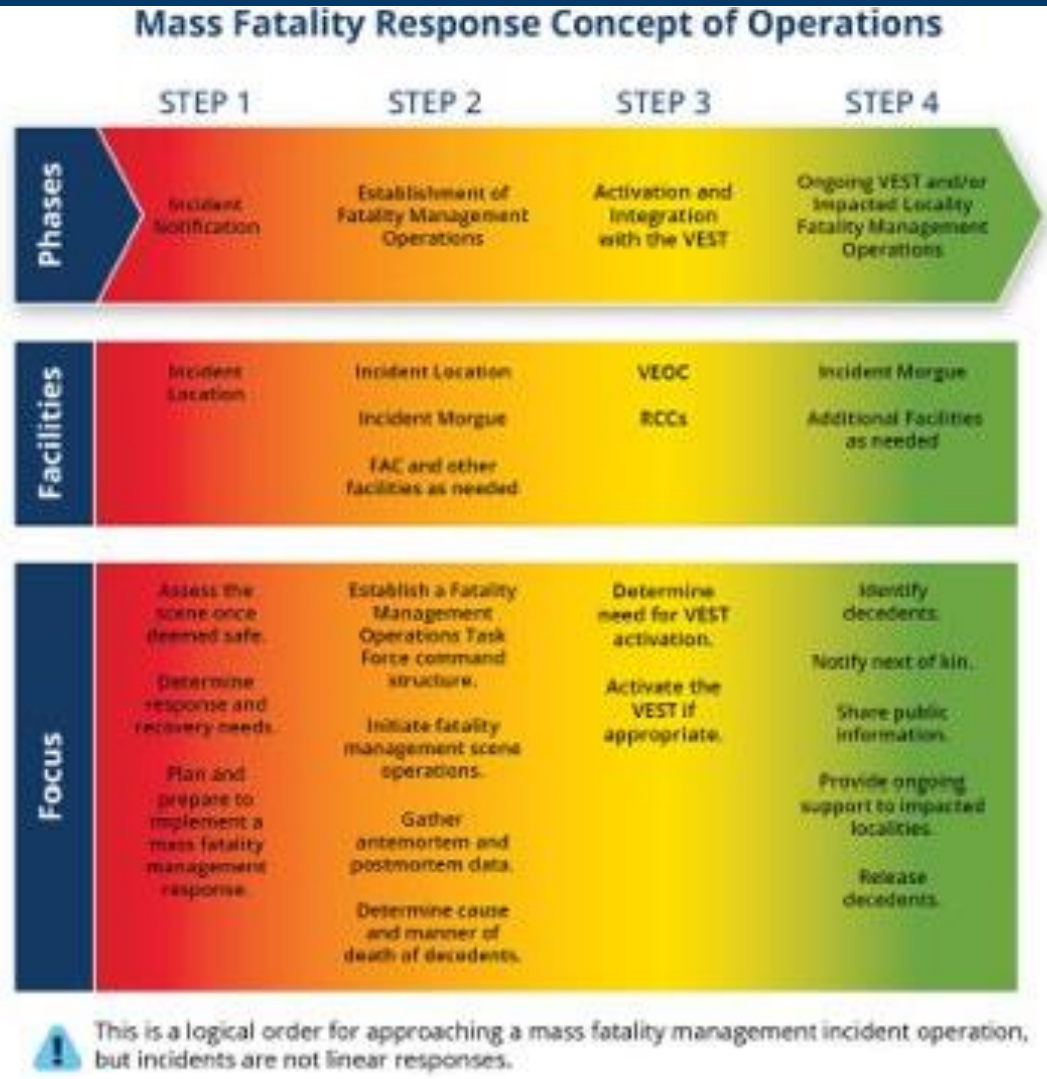
Emergency Operations Plan

SUPPORT ANNEX #9

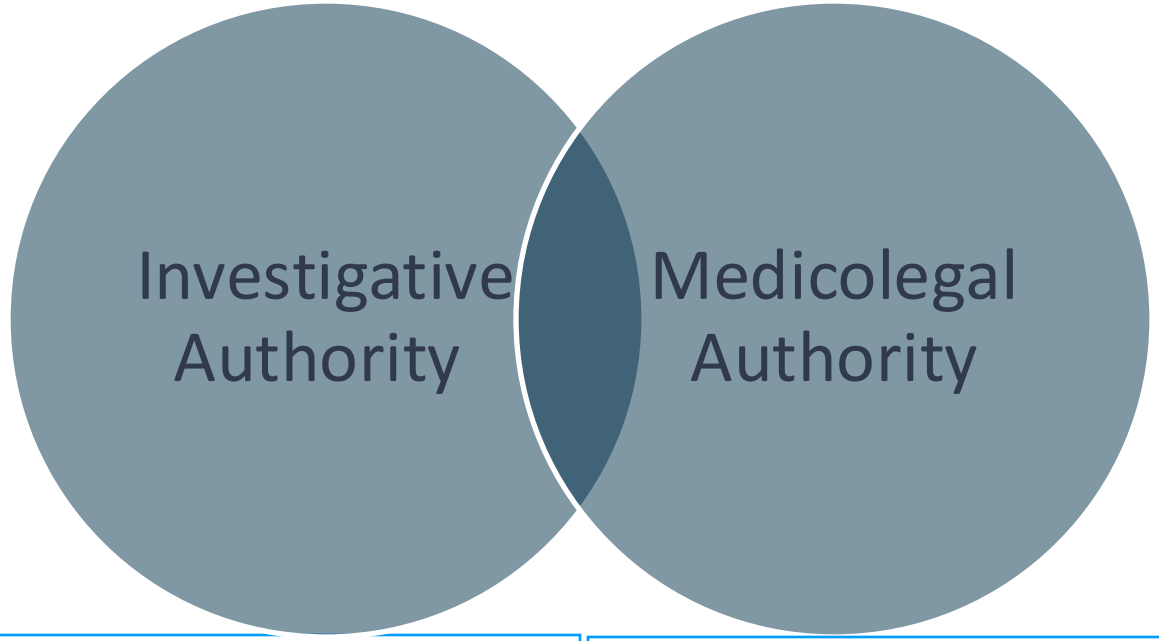
MASS FATALITY RESPONSE

VIRGINIA DEPARTMENT OF HEALTH

December, 2025



Incident Legal Authority



- Law Enforcement: Violent Deaths Not Attributed To Terrorism
- FBI: Acts of Terrorism
- NTSB: Aviation and Interstate Passenger Rail- incident only

- All non-natural deaths
  - Forensic Evidence Directly Associated with Remains
  - Context of decedents

Morgue Operations Branch

Incident Morgue

Field Morgue

District Office

Assist In Scientific ID

Done by comparison of unique features documented prior to death and from the remains.

Takes time and does not happen rapidly

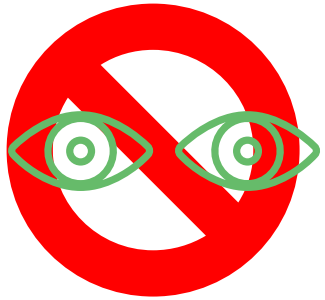
Anthropometrics, Reference samples, Medical records.

The quickest, most efficient way to get this information is from a decedent's family and friends.

Why scientific identification for MFI?

Visual Identification

- OCME does not have the facilities to accommodate viewings
- Families and friends should NOT report to the morgue for visual identification.
- **Not a reliable** form of identification during a mass fatality incident.
- <u>Do not want to traumatize the families any further.</u>



Scientific Identification

- Standard for incidents with multiple fatalities whenever possible.
- Comingling of remains
- Reliable
- Frustrating to have to wait
- Need reference samples

Public Information & Notifications

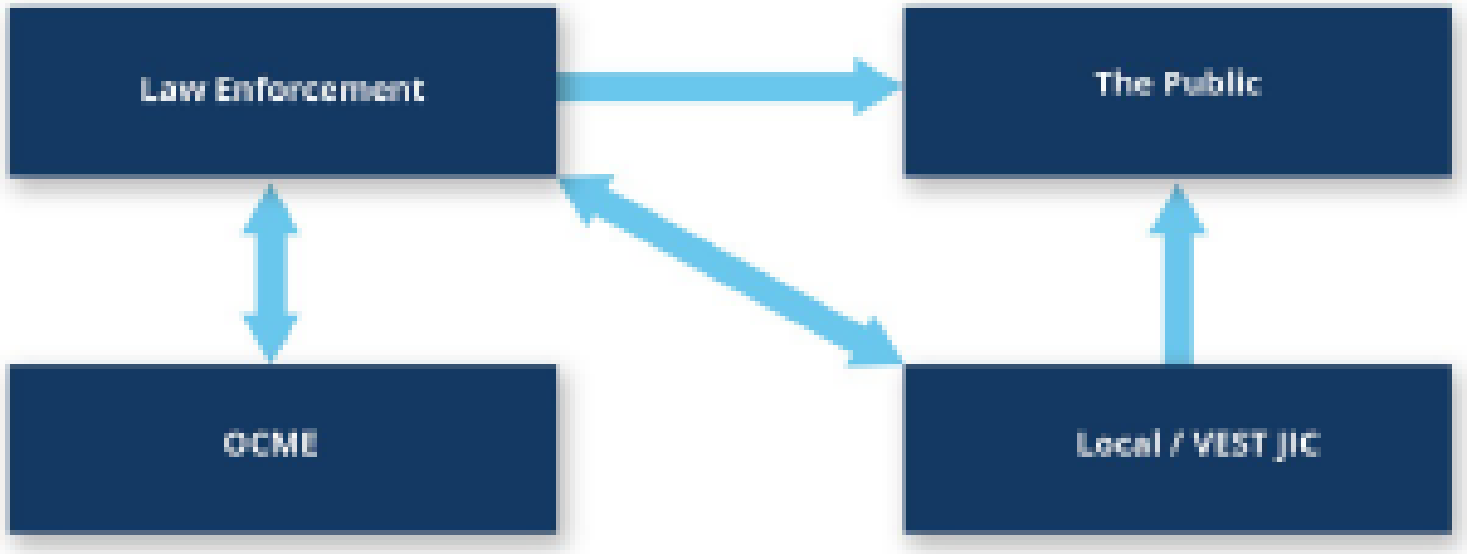
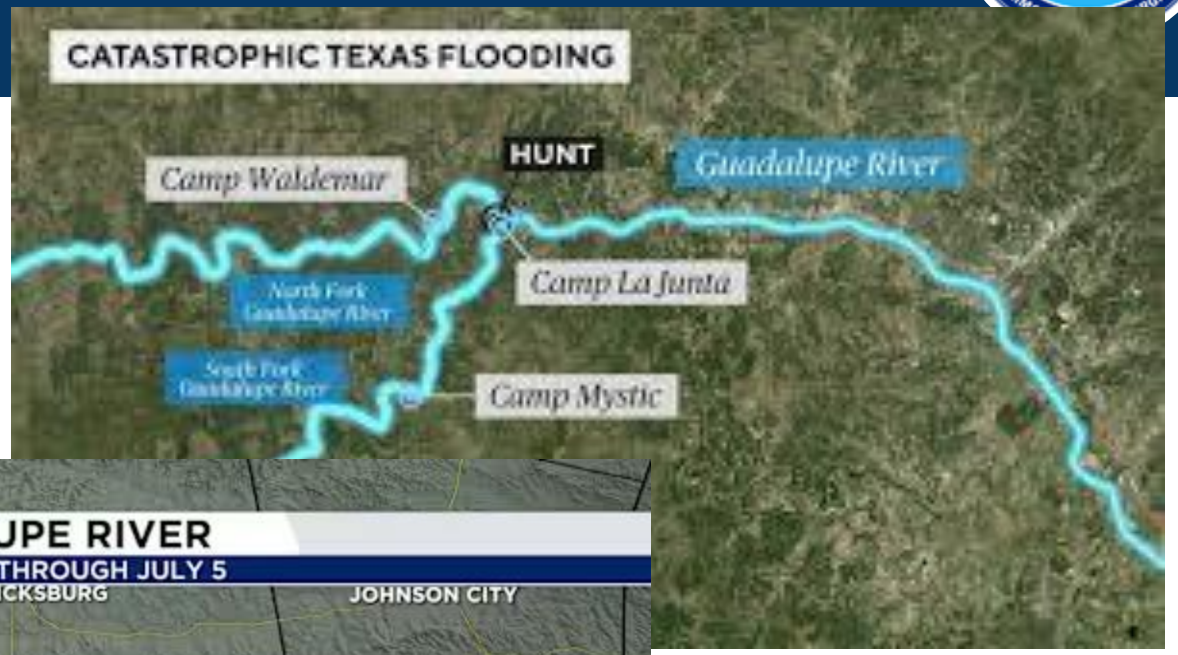
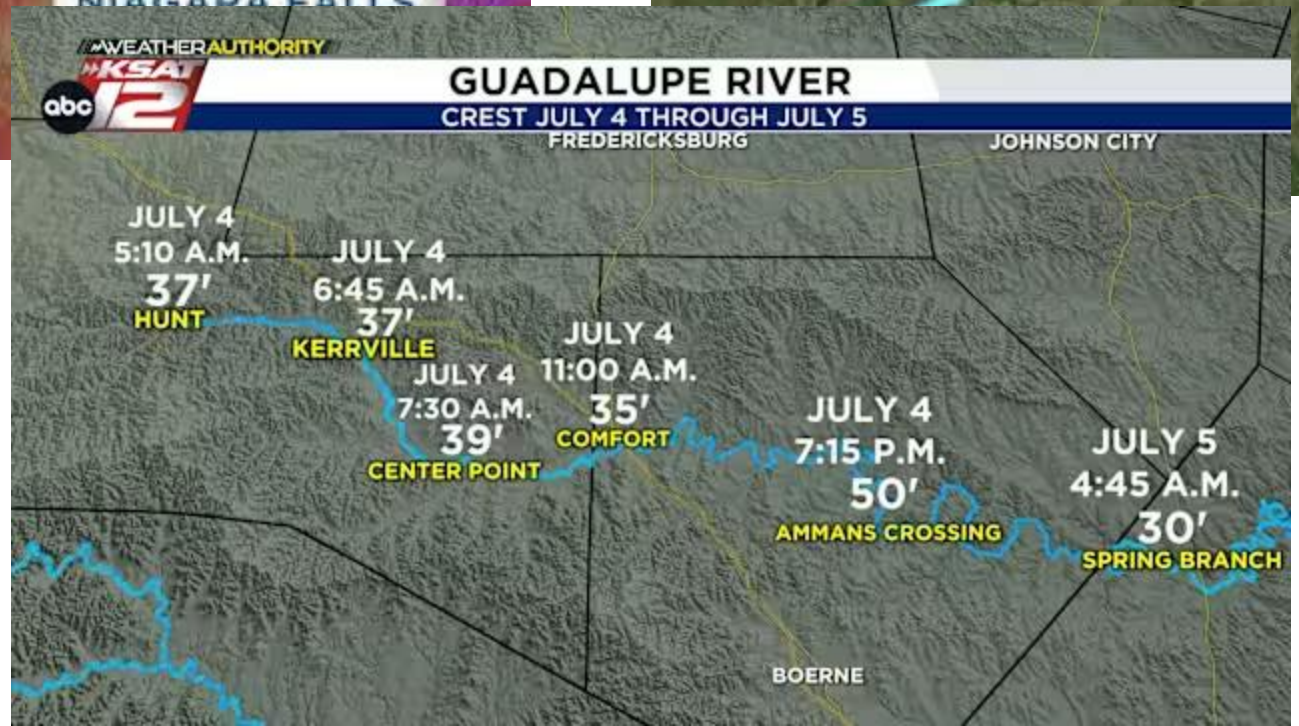


Figure 3. Initial mass fatality incident communication flow.

Hill Country Floods, 2025

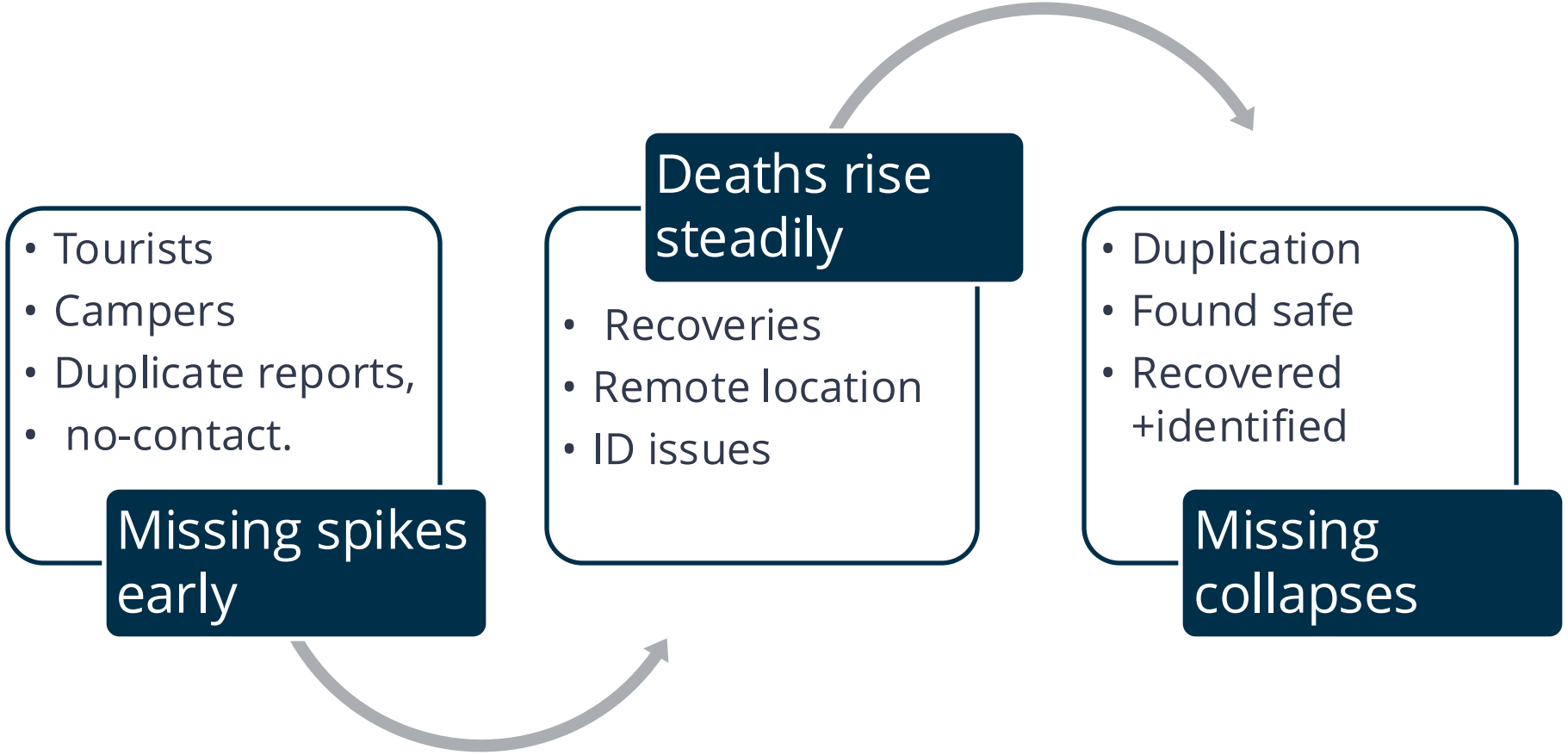




Hill Country Floods, 2025

Date (2025)	Operational situation	Kerr County	Other affected counties	Statewide snapshot
Jul 4–5	Initial catastrophe; rapid-onset flash flooding along Guadalupe River	Early reports of 20+ missing, camps & river recreation areas impacted	Fatalities reported in Travis County, Burnet County, Williamson County (small numbers, no missing counts released)	Early death reports in the 20s
Jul 7–8	Transition from SAR to recovery; fatality operations ramping up	94 bodies recovered by Jul 8; missing count fluctuating innitial counts over 500	Additional deaths confirmed outside Kerr (typically 1–9 per county, depending on location)	109+ deaths statewide
Jul 13–14	Missing list reconciliation begins in earnest	Missing reduced to 97 after deduplication & survivor confirmation	Other counties continue confirming fatalities but do not report active missing lists	~132–135 deaths statewide
Jul 15	Operational counts still shifting	97 missing, 107 confirmed dead	Deaths confirmed in Travis, Burnet, Williamson, Tom Green County	132 deaths statewide
Jul 20	Late recovery phase; ID pipeline active	Missing reduced to 3	No missing publicly reported outside Kerr	≥135 deaths statewide, 3 missing total
Aug 8	Identification milestone	119 confirmed dead (names released)	Other counties' deaths incorporated into statewide	137 confirmed deaths (end-

Flood Pattern



Comparison Matrix

Incident	Event type	Fatality profile	“Missing” behavior	Fatality management stressors	FM- Groups
Central TX floods (July 2025)	Flash flood / debris field	Large 100+, dispersed, environmentally challenging	Spikes high, collapses after dedup + found safe + ID	Cold storage surge; commingled recovery locations; ID lag	State MF teams + local ME/JPs + mortuary surge
Surfside condominium collapse	Building collapse	98 deaths	“Unaccounted for” becomes the driver metric until final ID	Confined rubble, prolonged recovery, heavy forensic ID workload	Urban USAR + ME + DMORT-style incident morgue support
Eastern Kentucky floods (2022)	Flood (Appalachian)	30+ early; later reporting cites 45 dead and 1 still missing	Missing persists longer in terrain/river settings	Rural access, scattered recoveries, longer-term reconciliation	County coroners + state support; mutual aid
Hurricane Ian	Hurricane	Deaths counted through ME certification process	Often shifts from “missing” to “storm-related deaths” tracking	Multi-jurisdiction, prolonged outages, indirect deaths	Statewide ME commission reporting + EM coordination

Discussion…

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