

Chapter X

OFFICE OF THE CHIEF MEDICAL EXAMINER

On April 16, 2007, after the gunfire ceased on the Virginia Tech campus and the living had been triaged, treated, and transported, the sad job of identifying the deceased and conducting autopsies began. Since these were deaths associated with a crime, autopsies were legally required. The Office of the Chief Medical Examiner (OCME) had to scientifically identify each victim and conduct autopsies to determine with specificity the manner and cause of death. Autopsy reports help link the victim to the perpetrator and to a particular weapon. The OCME also has a role in providing information to victims' families.

To assess how these responsibilities were met, the panel interviewed:

- The parents and family members of the deceased victims
- Dr. Marcella F. Fierro, Chief Medical Examiner and her staff
- Colonel Steven Flaherty, Superintendent of Virginia State Police
- Mandie Patterson, Chief of the Victim Service Section, Virginia Department of Criminal Justice Services
- Jill Roark, Terrorism and Special Jurisdiction, Victim Assistance Coordinator, Federal Bureau of Investigation
- Mary Ware, Director of the Criminal Injuries Compensation Fund
- Numerous victim service providers.

The panel also reviewed the report issued by the OCME on areas for improvement, lessons learned, and recommendations.

LEGAL MANDATES AND STANDARDS OF CARE

The Office of the Chief Medical Examiner incorporates a statewide system with headquarters in Richmond and regional offices in Fairfax, Norfolk, and Roanoke. Commonwealth law requires the OCME to be notified and to investigate deaths from violence.¹

Autopsies are used to collect and document evidence to link the accused with the victim of the crime. In the Virginia Tech cases, this was ballistic evidence—bullets and fragments of bullets. The autopsies provided scientific evidence on the types and numbers of bullets that caused the fatal injuries.

The OCME also must ensure that there is complete, accurate identification of the human remains presented for examination. When there are multiple fatalities, the possibility exists that there could be a misidentification, which would result in the release of the wrong body to at least two families. Though a rare occurrence, there are examples of this type of error in recent history. The National Association of Medical Examiners (NAME) has adopted Forensic Autopsy Performance Standards, which are considered minimal consensus standards. The most recent version was approved in October 2006. Dr. Fierro is a member of the standards committee of NAME.

The NAME standards require several procedures to be performed if human remains are presented that are unidentified. A major issue with some of the families of those who were murdered, however, was that they felt they were capable of identifying the body of their family member; in other words, from their viewpoint, the remains were not unidentifiable.

¹ Sec. 32.1-283 Investigations of deaths. Section A, Code 1950

Family members of homicide victims are generally unaware that the medical examiner is required to complete a thorough, scientific investigation in order to identify a body, determine the cause of death, and collect evidence. For the family members of victims, the experience is focused on immediacy. Is my loved one dead? When can I see my loved one? As happened at Virginia Tech, a difference in perspectives can cause deep hurt and misunderstanding. A separate matter in some of the cases was whether it was advisable for a family to view the remains.

The Virginia Tech incident presented the potential for misidentification. Bodies were presented with either inconsistent identification or none at all. This is not uncommon in mass fatality scenes due to the amount of confusion that generally exists. In order to prevent misidentification, medical examiners have established a rigorous set of practices based on national standards to ensure that identification is irrefutable. The Virginia OCME followed these standards as well as Commonwealth law in identifying the deceased.

DEATH NOTIFICATION

The death notification process is the opening portal to the long road of painful experiences and varying reactions that follow in the wake of the life-altering news that a loved one has met with death due to homicide. This news that someone intentionally murdered a family member is the critical point of trauma and often inflicts its own wounds to the body, mind, and spirit of the survivors. From a psychological and mental health perspective, trauma is an emotional wounding that affects the will to live and one's beliefs, assumptions, and values.

A homicide affects victims' families differently than other crimes due to its high-profile nature, intent, and other factors. The act of informing family members of a homicidal death requires a responsible, well-trained, and sensitive individual who can manage to cope with this mutually traumatizing experience. Family members of

deceased victims have a wide range of needs and reactions to the sudden and untimely death of their loved ones. Consequently, the individuals who deliver the death notifications and the manner in which they carry out this duty factor significantly in the trauma experienced by the family. Death notifications must be delivered with accuracy, sensitivity, and respect for the deceased and their families. Ideally, death notification should be delivered in private, in person, and in keeping with a specific protocol adopted from one of the effective models.

EVENTS

Monday, April 16 – The closest OCME office to Virginia Tech is located in Roanoke. All remains from the western part of the commonwealth that require an autopsy are taken there. In addition to their full-time employees, the OCME has part-time and per-diem investigators to help conduct death investigations and refer cases to the regional offices.

The first news about the Virginia Tech shootings came to the OCME from the Blacksburg Police Department at 7:30 a.m. A police evidence technician there, who also is a per-diem employee for the ME, called to say he would not be able to attend a scheduled postmortem exam (autopsy) because there had been a shooting at the Virginia Tech campus. At this time, six cases were awaiting examination in the western regional office, an average caseload.

By 11:30 a.m., another per-diem medical examiner, who was a member of a local rescue squad, notified the regional OCME office of a multiple fatality incident at Norris Hall with upwards of 50 victims. It was at this time that one of the decedents from West Ambler Johnston (WAJ) residence hall was transported to Carillion Roanoke Memorial Hospital. The western office notified the central office in Richmond that additional assistance would be needed to handle the surge in caseload.

At 1:30 p.m., representatives from the Roanoke office arrived on campus and attended an incident management team meeting with the public

safety agencies that had responded. OCME representatives attended the operations section briefing. The activities in Norris Hall were organized by areas (classrooms and a stairway). Investigation teams of law enforcement and OCME employees were assigned specific tasks.

The OCME requested resources from the northern regional office in Fairfax and the central office in Richmond. They, along with Dr. Fierro, departed for Blacksburg by 3:00 p.m. The western office had two vacancies in forensic pathologist positions, so additional staff clearly was needed.

The first autopsy, that of one of the dormitory victims, began at 3:15 p.m. No autopsy could begin until after the crime scene had been thoroughly documented and investigated. As each decedent was transported from campus, the Roanoke regional office was notified so that a case number could be assigned.

By 5:00 p.m., the first victim from Norris Hall had been transported to the Roanoke office. Volunteer rescue squads were transporting the victims from campus to the regional office, a 45-minute trip.

At 6:30 p.m., Dr. Fierro and additional staff from Richmond arrived and met with representatives from state police and the Departments of Health and Emergency Management. The methods for identification were discussed, as was the process of documenting personal effects. The last victim was removed from Norris Hall and transported to Roanoke by 8:45 p.m. By 11:30 p.m., the first autopsy was completed; identification made, next of kin notified, and the remains released to a funeral home.

Tuesday, April 17 – In the early morning hours of the first day after the shooting, additional pathologists departed the Tidewater and central regional offices for Roanoke. A staff meeting was held at 7:00 a.m. to formulate the OCME portion of the incident action plan (IAP). Key points addressed for the morgue operations sections included:

- All victims were to be forensically identified prior to release.
- A second-shooter theory was still under consideration by law enforcement. As such, all ballistic evidence had to be collected and documented. The distribution of gunshot wounds was:
 - One victim with nine
 - One victim with seven
 - Five victims with six
 - One victim with five
 - Five victims with four

The remainder of the victims had three or fewer gunshot wounds. The complexity of tracking bullet trajectories and retrieving fragments would be especially time consuming for the multiple wounds.

It was decided to use fingerprints as the primary identification method and dental records as the secondary. The reasons for this decision were:

- Fingerprints were able to be taken from all of the victims.
- Foreign students had prints on file with Customs and Border Protection.
- There was an abundance of latent prints on personal effects in dorm rooms and apartments and on personal effects recovered on site.
- The Department of Forensic Services had adequate staff available to assist in the collection and comparison of the fingerprints. (The police reported that nearly 100 law enforcement officers from local, state, and federal agencies volunteered or were assigned to assist in gathering prints and other identification.)

The alternative method for identification, dental examination, required the name of the decedent's dentist to obtain dental records, and families were asked to provide the contact information in case that method was needed.

DNA was excluded as a means of identification because the collection and processing of samples would have taken weeks.

In addition to being short-staffed by two vacancies and one injured pathologist, the ME's office had to respond to the concerns and demands of a religious group that contested one of the autopsies. By the end of the first day of operations, all of the deceased, 33, had been transported to the western region office. Thirteen postmortem examinations had been completed, two positive identifications had been made, and two families were notified and the remains released and picked up by next of kin or their representative.

Wednesday, April 18 – On the second day of morgue operations, the process of forensic identification continued. Procedures began at 7:45 a.m. and continued until 8:00 p.m.

At 10:00 a.m., the chief medical examiner gave a press conference where she discussed forensic procedures and the methods employed.

At 11:00 a.m., a representative from OCME assisted in collecting antemortem data from the families who had gathered at the family assistance center at The Inn at Virginia Tech.

“VIP” AND MISUNDERSTANDINGS: The primary form OCME uses to collect antemortem data is called a Victim Identification Protocol (VIP) form. This form, used by many medical examiners and federal response teams, documents information on hair and eye color, medical history (such as an appendectomy), and other distinguishing marks such as scars or tattoos. During a postmortem examination, the pathologist conducting the autopsy comments on his or her findings and each identifier and that information is entered into a case file. Forensic odontology (dental) and fingerprint findings may also be incorporated. Both profiles can be compared electronically and possible matches or exclusions made. The pathologist then reviews these findings as part of the scientific identification.

As case files were compiled, a designation was made as to whether a VIP form was available

and included in the file. Some state officials, seeing the VIP acronym, mistakenly concluded that OCME had designated some victims as “VIPs” (very important persons), singling them out for special consideration. As it happened, several embassies did contact state officials to demand preferential treatment for their nationals who were among the victims. However, the OCME did not provide any preferential or “VIP” treatment.

MEDIA MISINFORMATION: Radio station K-92 announced that the “coroner” would be releasing all of the human remains on Wednesday, April 18. The origin of this incorrect report is unknown.

TRACKING INFORMATION: At the request of the governor's office, a spreadsheet that detailed specific information for each victim was developed. During this process, members of the governor's staff became concerned that the OCME had prioritized some cases. But in fact, cases were handled without a specific plan or intent to prioritize them.

Staff members from the OCME went to the Inn to assist in the operation of the FAC. The Virginia State Police and the OCME established a process and team to notify families that their loved ones had been positively identified.

IDENTIFICATION AND VIEWING: Family members of the deceased victims were anxious for the formal identification and release of the bodies to be completed. In response to the concerns of family members regarding the length of time involved in the identification process, some state officials suggested that the families should be permitted to go to the morgue and identify the bodies if they so chose. Though this would seem reasonable, it conflicts with current practice.

A public information officer at the FAC explained to families who were assembled there what the OCME policy was regarding visible presumptive identification. Then the public information officer (PIO) unfortunately asked the families for a “show of hands” of those who

wanted to view the remains of their loved ones in case that could be arranged.

Viewing and identifying remains is a significant issue for victim survivors. Even though identification of the body by family members is not always considered scientifically reliable, for various reasons, victim survivors often want to make that decision for themselves. At Virginia Tech, families were frustrated with the lack of information from OCME and why it was taking so long to identify and release the victims' remains. Medical examiners must be sensitive to the waiting family members' need to be kept informed when there are delays and when they can expect a status update

The remains of persons killed in a crime become part of the evidence of the crime scene, and are legally under the jurisdiction of the OCME until released. The OCME can set the conditions it thinks are appropriate for the situation. The standard of care does not include presumptive identification using visual means. The public information officer who asked for a show of hands should not have done so.

When the protocol and policies of the OCME were explained to the families, some of the tension seemed to abate. The confusion and misunderstanding surrounding these issues involved misinformation, late information, no information, and the high emotional stress of the event. Had a public information officer with a background in the operations of the OCME been available or a representative from the OCME been present to answer these concerns, the controversy regarding this issue could have been reduced or eliminated.

IDENTIFICATION PROGRESS: The progress of the first day continued on the second day of morgue operations. The second-shooter theory had been discounted after it was determined forensically that Cho used two different weapons. By the end of the second day, another 20 autopsies had been completed, which meant that all 33 victims had received a postmortem exam. At this point, there were 22 total identifications and 22

remains released to next of kin. Morgue operations were conducted from 7:00 a.m. to 8:00 p.m.

Thursday, April 19 – The third day of morgue operations began at 7:00 a.m. It was determined that the OCME would work around the clock if necessary to complete the identification process this day. By this time, all of the antemortem records had arrived at the regional office.

The media had gathered in the area of the morgue and was covering the activities of representatives of the families—usually funeral homes—as they arrived to pick up the remains. Roanoke County law enforcement provided security.

All of the remaining decedents were identified and released by 6:00 p.m. The last case was a special challenge as there were no fingerprints on file and the victim did not have a dentist of record. The latent prints in the home were not readable. The identification was completed through a process of exclusion and definition of unique physical properties using the Victim Identification Protocol process. The Virginia OCME had completed 33 postmortem exams and correctly made 33 positive legal identifications within 3 working days.

Figure 23 summarizes the statistics for 3-day morgue operations. The figure shows that not all of the remains were picked up by the end of morgue operations because Cho's family did not pick up his remains for several days after the operations were shut down.

ISSUES

Three major issues surfaced during panel interviews and the collection of after-action reports in regards to the actions of the Virginia OCME; these were primarily issues presented by some families of the deceased:

- Some felt the autopsy process took too long.
- Some felt families should have been allowed to go to the morgue and visibly identify their family members.

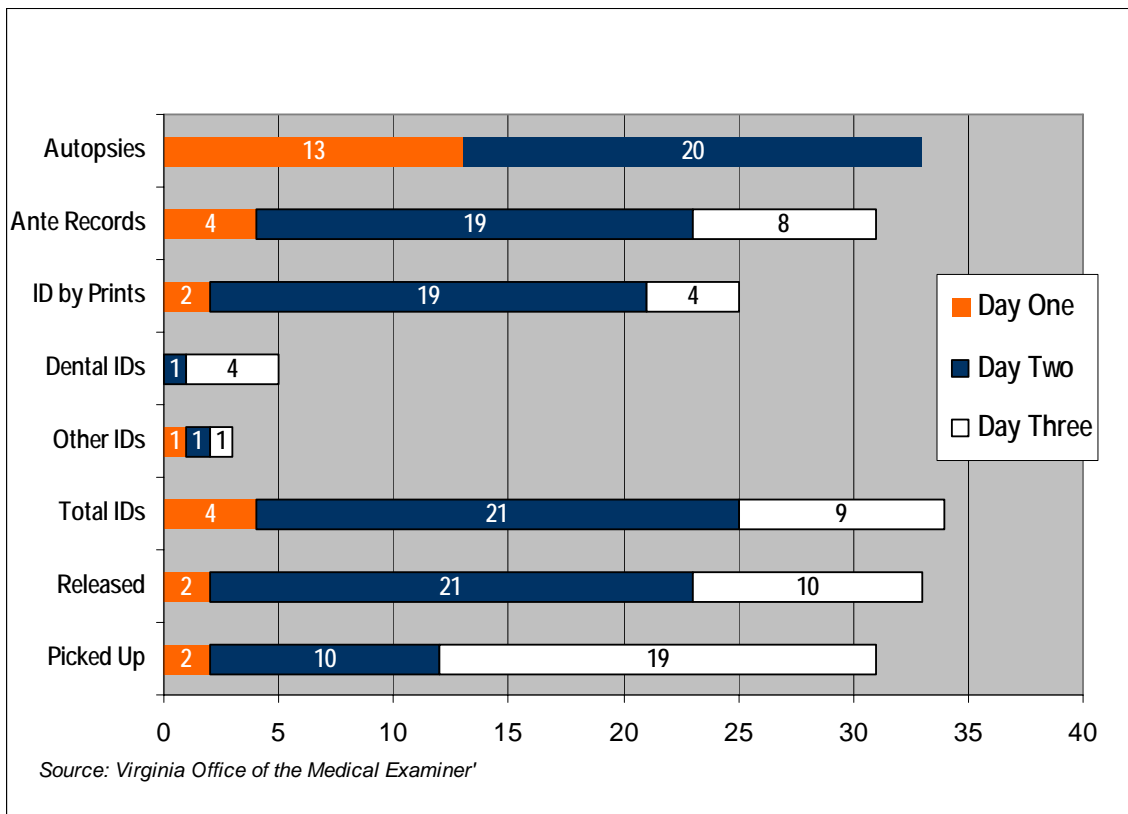


Figure 23. Progress and Activity of the OCME Over the 3-Day Period April 17–19, 2007

- Many felt the process of notifying the families and providing assistance to the families was disjointed, unorganized, and in several cases insensitive.

Speed – There is no nationally accepted time standard for the performance of an autopsy. The NAME standards mentioned earlier do not set time standards.

The average duration of the postmortem exams was just under 2 hours. Had the OCME office been fully staffed, it may have been able to perform the identifications and examinations somewhat more rapidly. The OCME did have a disaster plan that it implemented upon notification of the events. The plan called for staff from the regional and central offices to deploy to the regional office where the disaster occurred to meet the surge in caseload, which was done.

The OCME did not call for federal assistance, which is available from the Department of Health and Human Service’s National Disaster

Medical System (NDMS) program. That program can deploy a disaster mortuary operational response team (DMORT) composed of forensic specialists who can assist medical examiners in the event of mass fatality incidents. The DMORT system has three portable morgue units. DMORT resources (in this case, just personnel) could have been requested and probably been in place within 24 hours of mobilization.² For example, a DMORT was used in the Station Nightclub fire in Rhode Island in February 2003 to assist the Rhode Island medical examiner in the identification of the victims of that fire.

Once antemortem information had been gathered, DMORT personnel could have worked a second shift and might have reduced the elapsed time of morgue operations by 24 hours. Given the information regarding the performance of

² A member of TriData’s support staff to the panel is a member of a DMORT and provided first-hand information on its operation.

the family assistance center, which also was the responsibility of OCME, this early collection may or may not have occurred. The time delay for identifications came from delays in gathering antemortem information and then providing that information to the OCME, a task outside the control of the OCME.

Identification and Viewing – The second issue was the insistence by the OCME to perform forensic identifications of the victims as opposed to presumptive identifications. Forensic identifications use methods such as fingerprinting, dental records, DNA matches, or other scientific means for identification. Presumptive identification includes photographs, driver's licenses, and visual recognition by family or friends.

Some of the families wanted to go to the regional office of the OCME to view the remains and identify the victims. The OCME did not permit this for several reasons. For one, the regional office does not have an area large enough to display all the bodies for families to view each one to determine whether it is their family member

As noted earlier, the idea of families viewing their loved one and making a legally binding identification is not the current practice of the OCME because it is not considered scientifically reliable. Nevertheless, it was emotionally wrenching for families not to have a choice in this matter. Presumptive identification is acceptable in some communities under certain conditions. OCME noted that several female victims had no personal effects such as a driver's license or student identity card when they were transported to the hospital or morgue. At the same time, some families told the medical examiner's office about specific moles, scars, or other distinguishing marks that were far more reliable than a purse and could not be confused with another victim.

A textbook for students of forensic pathology discusses the identification of human remains. Regarding the topic of reliable visual identification:

The operative word in this method of identification is *reliable* [italics added]. Personal recognition of visage or habitus, under certain circumstances, is less reliable than fingerprints, dental data, or radiology. It (this method) relies on memory and a rapid mental comparison of physical features under stressful conditions and often a damaged body....

Another hazard in visual identification is denial. The situation may be so stressful or the remains altered by age, injury, disease or changes in lifestyle that identification is denied even if later confirmed by fingerprints or dental examination.³

In *Clinics in Laboratory Medicine*, Victor Weedn writes:

Visual recognition is among the least reliable forms of identification. Even brothers, sisters and mates have misidentified victims. ...Family members may find it emotionally difficult and uncomfortable to carefully gaze at the dead body, particularly a loved one. Identification requires a rapid mental comparison under stressful conditions. The environment in which the identification is made and the appearance of the person at death are unnatural and strange....⁴

Family Treatment – The third issue was the treatment of the families of the decedents regarding official notification and support while waiting for positive identification. Their treatment was haphazard, inconsistent, and compounded the pain and trauma of the event.

Victims of crime are afforded a number of rights, among them the right to be treated with dignity and respect. The right of respect speaks to victims being given honest and direct information free of any attempt to protect them from perceived emotional injury or their inability to process information. Crime victims rights are protected by federal and state laws. Basic rights

³ Spitz and Fisher, *Medicolegal Investigation of Death*, 3rd edition, Edited by Werner U. Spitz. 1993, pages 77–78.

⁴ Victor Weedn, "Postmortem Identification of Remains," *Clinics in Laboratory Medicine*, Volume 18, March 1998, page 117.

for victim survivors generally include the right to be notified and heard, and to be informed.

In 1996, following several airline accidents, the families of the victims felt the airline companies and government officials did not address their needs, desires, or expectations. In that year, Congress passed the Aviation Disaster Family Assistance Act. This law holds airline companies and government officials, such as medical examiners and coroners, accountable to the National Transportation Safety Board for compassionate, considerate, and timely information regarding the disposition of their loved ones or next of kin.

The U.S. Department of Justice, through its Office of Justice Programs, has an Office for Victims of Crime (OVC) that can provide support for victims of federal crimes such as terrorism.

To this end, many medical examiners' offices have developed plans for the establishment of family assistance centers. A FAC serves several purposes. First, it is the location where families can receive timely, accurate, and compassionate information from officials. Second, medical examiner's office staff can collect vital ante-mortem information from families there to assist in the positive identification of the deceased. Third, it can be the location where private, compassionate notification of the positive identification of the deceased can be conducted with next of kin.

A FAC was established in Oklahoma City in April 1995 following the Murrah Building bombing. Families were notified in private, before the media was notified. This model for the compassionate, accurate information exchange was published by the federal OVC.⁵

Although a FAC was established at The Inn at Virginia Tech, reports received by the panel indicate that what was provided was not

adequate. Many complaints were lodged by families regarding what they perceived as an insensitive attitude and manner of communication from the medical examiner's office. Some families also objected to the rigid application of the scientific identification process. Among the complaints and questions relevant to the ME functions were the following:

- Inadequate communication efforts (lack of information).
- Lack of sensitivity to the emotions of survivors.
- Lack of a central point of contact for information for responders, victims, and family members.
- Lack of a security plan that resulted in an inability to distinguish personnel, responding service providers, and other agents with authority to enter the FAC and surrounding areas.
- Confusion regarding the Victim Identification Profile form.
- Confusion regarding the identification process as to length and method used and its necessity.
- Failure to provide adequate isolation for parents in receiving information.
- Location of the media relative to the FAC; media management in general was lacking.
- Issues surrounding the source and responsibility for death notifications.
- Lack of personnel trained, skilled, and prepared to assist victims upon receipt of death notification.
- Concern that no one was addressing the needs of all family members, and awareness that some family members were having great difficulty in coping.
- No timely or consistent family briefings.
- Confusion about who is responsible for the death notifications and family assistance.

⁵ OVC, "Providing Relief After a Mass Fatality, Role of the Medical Examiners Office and the Family Assistance Center," Blakney, 2002

Some of these complaints are associated with the medical examiner's office, but others are not. In fact, no one individual agency or department of government is charged with the responsibility of organizing and maintaining a fully operational family assistance center. This is an oversight in federal and state policies. Existing planning guidance, such as the National Response Plan, parcels out pieces of the FAC function to various lead agencies, but places no one agency in charge. The OCME is clearly identified as being responsible for fatality management, including death notifications; also, the state plan calls for OCME to set up a family victim identification center within the FAC. Who is supposed to run the FAC is not addressed.

The university attempted to provide these services. In the Virginia Tech Emergency Operations Plan, the Office of Student Programs is responsible to:

Develop and maintain, in conjunction with the Schiffert Health Center, Cook Counseling Center, the University Registrar, and Personnel Services, procedures for providing mass care and sheltering for students, psychological and medical support services, parental notification and other procedures as necessary,⁶

A university the size of Virginia Tech must be prepared for more than emergencies of limited size and scope. Universities need plans for major operations. If the situation dictates the need for additional help from outside the university, then all concerned must be prepared to proceed in that direction.

The university turned to the state for help on Wednesday, April 17. It should have done so earlier. The *Commonwealth Emergency Operations Plan* in its "Emergency Support Function (ESF) #8" addresses public health and fatality issues. The Health Department is the lead agency for this ESF. The OCME mass fatality plan is found in Volume #4, "Hazardous

⁶ "VA Tech Emergency Response Plan," Appendix 10 to Functional Annex A, page 45.

Materials and Terrorism Consequence Management Plan," part 14-D-2.

The OCME plan considers 12 or more fatalities in 1 day in one regional office to be the trigger point for implementation of the emergency plan. The plan calls for the establishment of both a family assistance center and a family victim identification center. At this location, the OCME and law enforcement agencies would conduct interviews to gather antemortem information and notify next of kin. The OCME, however, does not have sufficient personnel to perform this task, and its plan indicates as much (page 16). To their credit, the OCME has recruited a team of volunteers through the Virginia Funeral Directors Association to assist in the operation of a FAC. Funeral directors by training and disposition have experience in interactions with bereaved families. This group is an ideal choice to provide assistance to the OCME. Unfortunately, this team was not available for the Virginia Tech incident because the state requires background checks and ID cards for these teams and funding was not provided for them.

What evolved by Wednesday, April 18, was an uncoordinated system of providing family support. It was too late and inadequate.

KEY FINDINGS

Positive Lessons

The part of the OCME disaster plan related to postmortem operations functioned as designed. The internal notification process as well as staff redeployments allowed the surge in caseload generated by the disaster to be handled appropriately as well as existing cases and other new cases that were referred to the OCME from other events statewide.

Thirty-three positive identifications were made in 3 days of intense morgue operations.

The contention that the OCME was slow in completing the legally mandated tasks of investigation is not valid.

Crime scene operations with law enforcement were effective and expedient.

Cooperation with the Department of Forensic Services for fingerprint and dental comparison was good.

The OCME performed their technical duties well under the pressures of a high-profile event.

Areas for Improvement

The public information side of the OCME was poor and not enough was done to bring outside help in quickly to cover this critical part of their duties. The OCME did not dedicate a person to handle the inquiries and issues regarding the expectations of the families and other state officials. This failure resulted in the spread of misinformation, confusion for victim survivors, and frustrations for all concerned.

The inexperience of state officials charged with managing a mass fatality event was evident. This could be corrected if state officials include the OCME in disaster drills and exercises.

The process of notifying family members of the victims and the support needed for this population were ineffective and often insensitive. The university and the OCME should have asked for outside assistance when faced with an event of this size and scope.

Training for identification personnel was inadequate regarding acceptable scientific identification methods. This includes FAC personnel; Virginia funerals directors; behavioral health, law enforcement, public health, and public information officials; the Virginia Dental Association; and hospital staffs.

Adequate training for PIOs on the methods and operations of the OCME was lacking. This training had been given to two Health Department public information officers prior to the shootings. However, since neither was available, information management in the hands of an inexperienced public information officer proved disastrous. This in turn, allowed speculation

and misinformation, which caused additional stress to victims' families.

No one was in charge of the family assistance center operation. Confusion over that responsibility between state government and the university added to the problem. Under the current state planning model, the Commonwealth's Department of Social Services has part of the responsibility for family assistance centers. The university stepped in to establish the center and use the liaisons, but they were not knowledgeable about how to manage such a delicate operation. Moreover, the university itself was traumatized.

RECOMMENDATIONS

The following recommendations reflect the research conducted by the panel, after-action reports from Commonwealth agencies, and other studies regarding fatality management issues.

X-1 The chief medical examiner should not be one of the staff performing the post-mortem exams in mass casualty events; the chief medical examiner should be managing the overall response.

X-2 The Office of the Chief Medical Examiner (OCME) should work along with law enforcement, Virginia Department of Criminal Justice Services (DCJS), chaplains, Department of Homeland Security, and other authorized entities in developing protocols and training to create a more responsive family assistance center (FAC).

X-3 The OCME and Virginia State Police in concert with FAC personnel should ensure that family members of the deceased are afforded prompt and sensitive notification of the death of a family member when possible and provide briefings regarding any delays.

X-4 Training should be developed for FAC, law enforcement, OCME, medical and mental health professionals, and others

regarding the impact of crime and appropriate intervention for victim survivors.

X-5 OCME and FAC personnel should ensure that a media expert is available to manage media requests effectively and that victims are not inundated with intrusions that may increase their stress.

X-6 The Virginia Department of Criminal Justice Services should mandate training for law enforcement officers on death notifications.

X-7 The OCME should participate in disaster or national security drills and exercises to plan and train for effects of a mass fatality situation on ME operations.

X-8 The Virginia Department of Health should continuously recruit board-certified forensic pathologists and other specialty positions to fill vacancies within the OCME. Being understaffed is a liability for any agency and reduces its surge capability.

X-9 The Virginia Department of Health should have several public information officers trained and well versed in OCME operations and in victims services. When needed, they should be made available to the OCME for the duration of the event.

X-10 Funding to train and credential volunteer staff, such as the group from the Virginia Funeral Director's Association, should be made available in order to utilize their talents. Had this team been available, the family assistance center could have been more effectively organized.

X-11 The Commonwealth should amend its Emergency Operations Plan to include an emergency support function for mass fatality operations and family assistance. The new ESF should address roles and responsibilities of the state agencies. The topics of family assistance and notification are not adequately addressed in the National Response Plan (NRP) for the federal government and the state plan that mirrors the NRP also mirrors this weakness. Virginia has an opportunity to be a national leader by reforming their EOP to this effect.

A FINAL WORD

The weaknesses and issues regarding the performance of the OCME and the family assistance process that came to light in the aftermath of the Virginia Tech homicides did not reveal new issues for this agency. In July 2003, the Commonwealth published "Recommendations for the Secure Commonwealth Panel." Appendix 1-3 of this report addressed mass fatality issues. Although the intent of the report was to assess the state of preparedness in Virginia for terrorist attacks, many of the issues that arose following the Virginia Tech homicides were identified in this report. Had the recommendations in this report been implemented, many of the problems cited above might have been averted.

Therefore, the panel also recommends that the recommendations found in Appendices 1-3 of the Secure Commonwealth Panel from 2005 be implemented.